Proceed with Caution

Renewed Calls to End Medicare as We Know It Because We Can’t Afford It Misunderstand the Facts

Judy Feder and Marilyn Moon May 2011

Introduction

The trustees of Medicare, our nation’s public health insurance program for elderly and some disabled Americans, predicted today that Medicare’s Part A trust fund, which pays primarily for hospital care, would be empty by 2024—five years earlier than they predicted a year ago. As the trustees observe, the earlier date primarily reflects lower-than-expected revenues from payroll taxes due to the Great Recession and slow economic recovery. In 2015, for example, income to the trust fund is expected to be $297 billion—nearly $19 billion less than projected just last year. The trustees further emphasize that payment changes in the Affordable Care Act have significantly strengthened the trust fund.

Nevertheless, Medicare’s critics will undoubtedly latch onto this new and earlier date for the exhaustion of the trust fund to call for an end to Medicare as we know it—whether explicitly by privatizing through vouchers, or implicitly, through arbitrary caps on federal health spending. Neither of these misguided proposals to gut Medicare recognizes the basic facts about this government health care program.

Medicare is and remains the best option for ensuring quality health care for our retirees, for controlling costs for taxpayers, for administering benefits to Medicare patients, and for spreading the risks of insuring our elderly across our nation. There is always room for improvement, and the Medicare program is in the midst of exactly that—implementing its responsibility under the Affordable Care Act to lead the way in payment and delivery reform in the nation’s health care system—but proposals to end Medicare by relying on the private sector or gutting the program are simply wrong.

Instead, the vigilant stewardship of Medicare’s resources is essential. Between now and 2035, Medicare’s rolls will expand to accommodate the aging of the Baby Boom generation that is just now starting to turn age 65. But even as Medicare does a better job of controlling its spending per beneficiary due to forthcoming payment reforms through the Affordable Care Act, additional revenues will be needed to cover more enrollees.
Those who would place arbitrary limits on Medicare spending as enrollment begins to expand ignore both Medicare’s efficiencies and its new demands. They would simply renege on Medicare’s promise of retirement with dignity, returning to the days when growing old meant growing poor in increasingly poor health due to lack of affordable, quality medical care.

The better path—for the nation, its seniors, and their families—is to take action to fulfill that promise. This issue brief documents Medicare’s fair, efficient, and effective performance—along with its commitment to improvement in light of the latest spending projections. The purpose: to demonstrate why this government health care program is so essential to our society in assuring affordable, quality care for older and disabled Americans.

Medicare’s effectiveness

From its inception, Medicare was designed to avoid the problems that plague the private health insurance market. Unlike private insurers, for whom administration, marketing, and profits absorb as much as 15 percent to 20 percent of the health care premiums paid by consumers, Medicare spends only about 3 percent of revenues on program administration.

Further, private insurers compete to enroll the healthy and avoid the sick, but Medicare pools the overwhelming majority of its beneficiaries in a single program—avoiding discrimination based on pre-existing conditions and denials of coverage when people are sick. Medicare takes the sickest and frailest Americans and covers them for the rest of their lives alongside those who are healthier, spreading the risk of insuring all of our elderly.

And when it comes to costs, Medicare’s ability to purchase care from hospitals, doctors, and other health care providers on behalf of virtually all its beneficiaries—rather than having individual beneficiaries or even several insurers negotiate on their own—has historically kept its payments below private insurers’ payments. Growing more slowly than the private sector, however, does not mean that Medicare uses its dollars as efficiently and effectively as it should. Public and private insurers alike pay too much for too many services—rewarding providers for the volume of services they deliver, rather than their value to health.

Recognizing that fact, the Affordable Care Act includes measures to reduce excessive payment growth under Medicare’s current payment arrangements, and commits Medicare to pursue new and innovative ways to reform our health care payment system—with the potential to generate substantially more in savings, as well as improvements in quality from more efficiently coordinating the delivery of care.
Indeed, reforming our nation’s health care system by enabling Medicare to take the lead will in turn enable the results to be shared broadly with all those institutions that pay for health care, including private insurers. Private-sector innovations in payment reform remain under the proprietary control of companies, but public experimentation and evaluation can serve the public good, not only for Medicare but for all Americans.

Even holding the potential of future innovations aside, the reductions in projected payment increases for hospitals, skilled nursing facilities, and home health providers because of the Affordable Care Act will significantly reduce the growth in spending per beneficiary for the coming decade and beyond. According to the Congressional Budget Office’s most recent analysis, per beneficiary spending is expected to grow at 2.8 percent per year from 2010 to 2021—a full percentage point below expected growth in per capita GDP.

As a result, Medicare becomes an even better “buy” for beneficiaries and taxpayers than private insurance would be in the future. The CBO analysis of the proposal to replace Medicare with vouchers for private insurance makes this fact crystal clear, even assuming a spending increase to address problems with the physician payment formula. In 2011, CBO finds the cost of insuring a 65-year-old Medicare beneficiary in a private health insurance plan would be 12.3 percent higher than in the traditional Medicare program—a function of its higher administrative costs and higher payments to providers. By 2022, CBO projects that cost in a private insurance plan, rather than in traditional Medicare, to be 38.9 percent higher, as Medicare exercises its purchasing power to keep payments under control, while costs in the private sector continue to rise.

Ending Medicare as we know it

From a cost perspective, then, transforming Medicare from a public insurance program to vouchers for the purchase of private insurance—the approach recently embraced by the Republican-led House of Representatives in its fiscal year 2012 budget resolution—clearly makes no sense. There is little evidence that it would improve efficiency or quality of care. The only way to ensure this approach would result in savings for the federal government would be to arbitrarily fix the voucher amount so that beneficiaries would become responsible for cost growth over time.

Indeed, a Center for American Progress analysis of CBO data on this approach shows the extra premium that beneficiaries would have to pay in a private plan would increase from $6,000 in 2022, at the start, to $11,000 in 2030, reflecting an increasing gap between the public contribution and the actual costs of private coverage. But this conservative “solution” just shifts those costs to individual retirees, many of them with limited incomes. Under one conservative plan, for example, Medicare beneficiaries would have to choose to pay exorbitant amounts or to purchase increasingly inadequate plans, leaving them vulnerable to insufficient protection to meet their health care needs over time. This is not protecting Medicare for our children, but rather guaranteeing its inadequacy over time.
Contrary to what some would have us believe, the vast majority of older Americans are not rich. In 2010, about half of all Medicare beneficiaries had incomes less than $21,000, less than $2,000 in retirement savings, and modest home equity and other financial assets. Although incomes and resources for the next generation of elderly will be higher, the improvements are concentrated among the better-off. In 2030, about a quarter of the elderly will have incomes less than $15,000 in today’s dollars, and half will have incomes below $26,400.

What about options to cap the amount spent on Medicare? Proposals to arbitrarily cap either overall federal spending or federal health spending without regard to the costs of overall health spending could fatally undermine Medicare’s capacity to provide care. The Center on Budget and Policy Priorities estimates that a cap on federal health spending like that proposed by Sens. Claire McCaskill (D-MO) and Bob Corker (R-TN) would reduce Medicare spending by $856 billion over the next decade. That could lead to a voucher with even less purchasing power, dramatic reductions in provider payments, the undermining of beneficiaries’ access to quality care, or other major restrictions in the program’s protections.

Instead, Medicare’s leadership in controlling and reforming its payments to providers will lead the whole health care system to provide better care at lower costs. Medicare has taken aggressive action to spend less in the past without negative consequences, but this needs to be done in a manner that recognizes that Medicare cannot get too far in front of the rest of the health care system. If too wide a gap emerges between public and private payments, beneficiaries will suffer from limited access to care or providers will go after private payers to make up the difference. To further constrain Medicare on its own without assuring that hope is realized puts the program—and the beneficiaries and providers who count on it—at serious risk.

Fulfilling Medicare’s responsibilities

Over the next two decades, Medicare will welcome the baby boom generation—people born between 1946 and 1964—onto its rolls as they turn age 65. By 2035, 20 percent of the U.S. population will be aged 65 or over, up from 13 percent today. Starting in 2011, Medicare enrollment will increase by a million people every year. Even with efficiencies that slow Medicare cost growth, taking care of a substantially larger older population will simply require spending more.

These future beneficiaries have not fully “prepaid” their Medicare costs through their payroll taxes over their careers. Given ever-improving medical care and ever-increasing medical costs, we could not expect them to have done so. Yet these beneficiaries have paid premiums year after year, financing care for the generation that preceded them, on the “promise” that future generations would do the same for them. This is an intergenerational commitment that must be met.
Further, Medicare benefits are not generous. In particular, Medicare lacks the catastrophic coverage that private insurance typically provides. Medicare’s actuarial value—the share of expenses it covers—is only at 76 percent of average health care costs, compared to the 83 percent coverage afforded federal employees, carried by most members of Congress.

The modest incomes of most Medicare beneficiaries mean that even with no policy changes, seniors will be spending an ever-rising share of their incomes on health care. Through a combination of premiums (for Medicare and supplementary private coverage) and direct spending on copays, deductibles, and services Medicare does not cover (most importantly, long-term health care services), the typical Medicare beneficiary spent 16.2 percent of income out of pocket in 2006, and, costs, which rise faster than their incomes, are projected to exceed a quarter of income in 2020.

In fact, the Affordable Care Act tightened and extended requirements that higher income beneficiaries pay higher premiums. Those who propose that Medicare spend less by having Medicare beneficiaries pay more will have to answer the question, “How Much ‘Skin in the Game’ is Enough?”

The bottom line

Looking at Medicare’s performance to date and projections for its future, the evidence is clear. This key component of our nation’s public insurance program has insured virtually all senior citizens without discrimination based on health status—at administrative and service costs the private sector simply can’t match. “Privatizing” Medicare—replacing public insurance with vouchers for private insurance—would increase, not reduce, the cost of insurance—and shift responsibility for paying ever-increasing costs to Medicare beneficiaries and their families. Alternatively, arbitrarily capping federal health spending would reduce the cost of insurance but would threaten its value as the gap between Medicare and private-sector payments create access barriers to Medicare beneficiaries.

Neither approach is acceptable—whether for current or for future beneficiaries.

Whether the issue is Medicare solvency or the federal deficit, an alternative approach is needed. Responsible proposals to reduce the deficit—to which Medicare spending growth contributes significantly—rely on a combination of spending reductions and revenues. Measures in the Affordable Care Act have already lowered projected growth in Medicare’s per beneficiary spending below the rate of growth in the economy.

Going forward, the new health law will facilitate achievement of these reductions by requiring experimentation with new payment methods. And processes put in place by the new law will enforce their achievement by establishing a target growth rate for
Medicare-per-beneficiary spending, overseen by an independent board. This represents a responsible approach to containing per beneficiary costs through payment methods that ideally will be adopted by the private as well as the public sector.

What’s missing is an equally responsible approach to ensuring the revenues to support growing numbers of Medicare beneficiaries are in place over the next several decades. That is what members of Congress should focus on.

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