



Issue Brief

Medicare Under Attack: Will Privatizing Measures Destroy the Program?

August 2007

Introduction

Medicare, a social insurance program that provides health care coverage for individuals over age 65 or with disabilities, was created in 1965.

Medicare consistently has been popular with beneficiaries because the program provides a guaranteed and defined set of benefits with a choice of providers at the same price nationwide, regardless of a beneficiary's health status or income. The administrative costs are considerably less than those of private health plans. Medicare works to contain costs, monitor quality, and support America's health care system.

Recent legislative and administrative changes, however, are shifting Medicare from a reliable federal program with defined benefits to a vast array of local and regional private health plans driven by the marketplace with the financial risk falling on plan participants.

Although private health plans have been allowed to contract with Medicare since the 1970s, participation was erratic until recently. The 2003 Medicare Prescription Drug, Improvement and Modernization Act (MMA) not only created the Medicare Part D prescription drug benefit that is administered by private insurers, but also includes other provisions that lead to a reduced role for Medicare in providing health care services and an accelerated involvement of insurance companies.

This issue brief from the Alliance for Retired Americans Educational Fund (ARAEF) outlines the evolution of the privatization of Medicare and what it means to the future of the program and well-being of Medicare beneficiaries. The brief should be read in conjunction with another ARAEF issue brief specifically on Medicare Advantage plans: *Medicare Advantage: A Windfall for Insurers; Downfall for Beneficiaries*.

Background

Since the 1965 enactment of Medicare, the program has provided hospital and outpatient health care coverage for persons over age 65 and younger adults with permanent disabilities.

Medicare Part A covers most costs of in-patient hospital and limited post-acute care services. It is primarily financed by a 1.45 percent payroll tax from both employees and employers. Medicare Part B helps cover the cost of doctor services, outpatient care, and other post-acute services. It is financed through a combination of beneficiary premiums and federal general revenues. The two-part scheme of the program reflected the structure of private insurance in the 1960s that generally had separate insurance for hospital and physician care. Although coverage of some preventive services has been added over the decades, the program does not provide coverage for all health care needs. Medicare currently covers only 58 percent of beneficiaries' health care expenses.

Until the Balanced Budget Act (BBA) of 1997, most Medicare beneficiaries were enrolled in the traditional Medicare fee-for-service program, meaning that their providers charged the program for the covered services that they provide. Managed care health plans such as health maintenance organizations (HMOs) had been authorized since 1976 but few plans participated. The BBA created Medicare+Choice as Medicare Part C, allowing managed care plans to be paid a flat rate to care for the Medicare beneficiaries they enrolled. The less expensive the care, the more the plans made in profits. However, in order to maintain profits, plans began to concentrate within urban areas and reduce benefits or increase enrollee cost-sharing. Many plans withdrew from participation altogether because they claimed that changes in the Medicare payment structure reduced their profits.

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003

The MMA not only produced new opportunities for private sector involvement but also provided monetary incentives for their participation. Along with adding a privately run prescription drug benefit, the MMA has provisions that undermine the foundation of the Medicare program, chipping away at Medicare's universality by supporting the growth of private plans as substitutes and throwing Medicare into an uneven competition experiment with private plans.

Increased Role for Private Plans

MMA created a prescription drug benefit, known as Medicare Part D, which took effect January 1, 2006. The benefit is provided either through stand-alone drug plans (PDP) or Medicare Advantage (MA) managed care plans administered by private insurers and not the Medicare program. Beneficiaries who choose a stand-alone drug plan continue to receive their other Medicare benefits under Parts A and B through the traditional Medicare program. Beneficiaries enrolled in a Medicare Advantage plan with prescription drug coverage receive their other Medicare benefits through that plan.

Proponents of the law claimed that private insurers could provide the same services as Medicare at lower cost but that is a false premise. The primary objective of bringing private plans into Medicare is to reduce government control. As the drug benefit is offered by private plans, the formulary, drugs, premiums, co-payments, and pharmacy network may vary substantially and change from year to year. The costs are often greater for many beneficiaries—if not initially, then later. As experience with the Medicare+Choice program demonstrated, private plans, unlike Medicare, have to market their product and show a profit.

MMA established a stabilization fund, initially \$10 billion over ten years, to provide incentives for regional preferred provider organizations (PPOs) to enter into and to remain in the MA program. This fund is in addition to the subsidies provided to every plan. The intent is to make plans available in all areas of the country and also provide them with the means to entice beneficiaries away from Medicare. Once in a plan, enrollees are locked in for one year. Every Medicare beneficiary now has access to at least one MA plan primarily due to private fee-for-service (PFFS) plans, which have fewer restraints than other MA plans, and regional PPOs in rural areas.

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The stabilization fund and method of calculating payments to MA plans have resulted in expenditures considerably higher than what it costs traditional Medicare. An analysis by the Medicare Payment Advisory Commission (MedPAC), the independent body that advises Congress on Medicare, shows that Medicare payments on behalf of enrollees in MA plans generally average 112 percent of the cost of serving the same beneficiary in traditional Medicare; PFFS plans are paid, on average, 119 percent of the cost to traditional Medicare. The Congressional Budget Office says the overpayments are a threat to Medicare's financial future and accelerates depletion of the Medicare Trust Fund by two years.

The subsidies create an uneven playing field for Medicare as private insurers can offer improved benefits and lower costs targeted to younger and healthier beneficiaries. At the same time, plans can deter prospective enrollees with chronic and costly conditions from enrolling by placing limits on coverage of essential services and imposing higher cost-sharing.

2010 Premium Support/Privatization Demonstration

Starting in 2010, the Medicare program will be forced to compete with Medicare Advantage plans in an experiment that would further advance the privatization effort. Seniors in six metropolitan areas will receive from Medicare a set premium payment like a voucher—referred to as “premium support”—to purchase their health care coverage. The voucher amount is to be based on a combination of the costs for traditional Medicare fee-for-service coverage and local bids by the MAs in any given area.

Since the private plans serve healthier, less costly beneficiaries, it is expected that the fixed amount will generally be under the average cost for beneficiaries enrolled in traditional Medicare but above the average cost for beneficiaries enrolled in private plans. If a senior chooses Medicare or a plan that costs more than the voucher would pay for, he or she must make up the difference in higher premiums. If a chosen plan is below the benchmark, the enrollee will receive premium reductions. Under the premium support demonstration, the beneficiary premium will no longer be fixed and national as it is now but will vary widely throughout the country and within states.

Beneficiaries who stay in the traditional Medicare program are likely to be those with greater health care needs—partially because the plans can “cherry pick” or enroll the healthiest seniors through exclusionary practices. Those left will have to pay more over time for their coverage because Medicare will need to charge higher premiums to cover their costs (25 percent of Medicare Part B is paid from beneficiary premiums and the remainder from general revenues). As Medicare becomes more expensive—premiums could increase 25 percent over the course of the demonstration—it is likely that even more seniors will leave the program for less costly managed care plans triggering what some have called a “death spiral” for Medicare with steadily rising premiums and falling enrollment.

This privatization experiment is authorized for up to six years but Congress could also extend it to other parts of the country or make the competition permanent. If that occurs, traditional Medicare would disappear—except perhaps for the sickest and poorest beneficiaries—and all other beneficiaries would be required to shop among private plans for one they can afford, that appropriately meets their needs, and then hope that quality standards are enforced by some entity.

45 Percent Rule Caps Medicare Spending

The MMA established a “trigger” that requires the President to propose legislation to reduce Medicare spending if for two years in a row the Medicare trustees, in projecting seven years ahead, foresee that Medicare spending is more than 45 percent of its funding from general revenues. There is no basis for the 45 percent figure; it is entirely arbitrary. Congress designed Medicare Part B and Part D to be paid for, in large part, from general revenues. Thus, the 45 percent rule sets up a Catch-22 scenario: With the prescription drug benefit, the MMA provides for an increase in spending that is going mostly to private health plans and drug manufacturers without an increase in revenues; then it sets a limit on the spending, creating an artificial crisis that could result in benefit cuts or increased premiums.

Increased spending for Part D prescription drugs under Medicare has already triggered the trustees’ warning for two years in a row. Since the MMA took effect, Medicare is now the largest public payer of prescription drugs, with Medicare spending rising to 22 percent of total U.S. prescription spending in 2006, up from 2 percent in 2005. The President will have to make a recommendation on cutting Medicare funding when he submits his next budget to Congress. Although Congress must consider the proposal, it does not have to act upon it. However, there will likely be pressure to do so. There are alternative ways of addressing

Medicare's long-term solvency, including an examination of its payment structure and investment in information technology initiatives, without resorting to benefit cuts.

Other Measures Destabilizing Medicare

The MMA contains additional provisions that will contribute to Medicare's collapse. They include higher Part B premiums for wealthier beneficiaries, a prohibition on price negotiation with drug manufacturers, and continuation of a ban on importation of drugs from Canada and other developed countries.

Higher Part B Premiums

The MMA undermines the universality of Medicare as, beginning in 2007, it introduced means-testing by requiring wealthier beneficiaries to pay more of their Medicare Part B premiums. As with the 2010 competition experiment, over time upper income individuals may withdraw support for the program by choosing not to participate, leaving Medicare to become a program for lower and middle income seniors only and not for everyone of all income levels.

Non-negotiation and Importation Ban

The MMA prevents effective cost containment on prescription drug spending. The Act explicitly prohibits the federal government from using its purchasing power on behalf of 44 million Medicare beneficiaries to bargain with drug companies for lower prices. Drug companies lobbied hard for this, as it is more advantageous for them to bargain with dozens of small plans than a single federal agency.

MMA also continues a ban on importing safe, affordable drugs from countries such as Canada by requiring certain safety certifications from the Secretary of Health and Human Services (HHS), which the Secretary has refused to do.

Protecting Medicare

Injecting private insurance companies into Medicare's jurisdiction and providing monetary incentives that assure their growth can only lead to the ultimate breakup of a universal program into a jigsaw of multiple health plans each with attendant deficiencies such as limitations on provider choices and services, less access, and varied cost-sharing.

It may not be possible to reverse the trend toward privatization completely. Over half of Medicare beneficiaries receive their Part D prescription drug coverage through stand-alone drug plans or MA plans. Beneficiaries currently in private plans who are fortunate to receive extra benefits will be unlikely candidates to

return to traditional Medicare. One way to prevent privatization altogether is to at least give Medicare a level playing field against MA plans.

Legislation that passed in the House of Representatives in August 2007 would help thwart this march toward Medicare's destruction. The Children's Health and Medicare Protection Act (CHAMP) of 2007 (H.R. 3162) addresses several of the above MMA provisions. It would equalize payments between MA plans and traditional Medicare over four years, thereby making the playing field more equitable. It would eliminate the remainder of the stabilization fund. Savings from these and other provisions would be used to add and improve benefits. The CHAMP Act would also repeal the 2010 competition experiment and 45 percent trigger on Medicare spending.

Other bills would allow safe importation of drugs from Canada and other developed countries (S. 242, H.R. 380). A bill to require Medicare negotiation on prescription drug prices passed in the House of Representatives (H.R. 4), but an effort to break a filibuster threat on a similar bill (S. 3) failed in the Senate.

Conclusion

Access to affordable health care is an essential element of retirement security. Privatizing Medicare transforms a treasured social insurance program into a defined contribution arrangement whereby beneficiaries assume all the risks. This can only lead to reduced benefits or coverage and increased out-of-pocket costs for older and disabled individuals.

It is an ironic twist of history and political intent that Medicare was created because older Americans had trouble obtaining health insurance. With the MMA, many will again be at the mercy of private health insurers for their health care.

There does remain a challenge of addressing Medicare's long-term financing and payment systems, but that should come about only after an independent and impartial study. Rather than dismantling the Medicare program that provides critical health services for the nation's older and disabled populations, policy makers should focus on building on Medicare's strengths and improving the program with a comprehensive benefits package, including a prescription drug benefit, which enhances the health and quality of life for all.

Resources

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