The Heritage Foundation
LEADERSHIP FOR AMERICA

ISSUE BRIEF

No. 3721 | SEPTEMBER 10, 2012

Why Traditional Medicare Must (and Will) Be Reformed

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Medicare must undergo structural reform. Its deficiencies undercut patients' comprehensive and integrated care while increasing costs and generating debt. Medicare's inadequate benefit package causes big gaps in coverage, requiring patients to buy costly supplemental insurance. Its outdated administrative payment system routinely overpays and underpays for benefits and services; such price distortions are worsened by narrow special-interest lobbying, an avalanche of red tape, and massive cost shifting to patients in private health plans.

Altogether, these structural flaws result in a substandard insurance program that generates unsustainable costs and a crushing debt.

A Complex and Outdated Structure. Medicare's four-part complexity contributes to confusion among patients, inefficiency among providers, and higher costs for taxpayers. Care is chopped up and fragmented, reimbursed under an old and complicated fee-for-service payment system created in the 1960s that has long since disappeared from the private sector.

Each part of the program is financed differently and operates under its own set of payment rules. Part A covers inpatient hospital costs; it is funded through a hospital insurance (HI) trust fund that younger working families finance through a federal payroll tax. But Medicare patients must pay progressively more the longer they require hospital care—exactly the opposite of most private plans, which cap patients' out-of-pocket costs.

Part B covers physician and outpatient services, and Part D covers prescription drugs. Taxpayers automatically pay 75 percent of the total costs of both programs out of general revenues; beneficiaries are responsible for the other 25 percent through a monthly premium.

Part C, Medicare Advantage, is an alternative to traditional Medicare, but plan payment is tied to Medicare's inflexible payment formula, guaranteeing unnecessary increases in Medicare spending.

An Outdated and Inadequate Benefits Package. Medicare still does not protect beneficiaries from catastrophic costs. Thus, about 90 percent of beneficiaries must purchase supplemental coverage to protect them from such costs, adding another premium payment to cover their expenses. While supplemental coverage fills benefit gaps, it also covers cost sharing and thus encourages first-dollar coverage and excessive utilization.

As President Obama and others recognize, this arrangement drives up total costs of the program, including seniors' premium costs. Walton Francis, a prominent Washington-based health care economist, estimates that this structural feature adds between 15 percent and 25 percent to program costs.[1]

A Bureaucratic and Highly Politicized Payment System. Medicare's deadly combination of lower payments and the transactional costs imposed by Medicare's regulatory machinery incentivizes physicians and other medical professionals to increase the volume of services rather than providing a higher quality of care.

Medicare payment is not linked to the real cost of providing medical services. Today, Medicare doctors

This paper, in its entirety, can be found at **http://report.heritage.org/ib3721**

Produced by the Center for Health Policy Studies

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are paid about 80 percent of private rates, and if current law governing the Medicare physician payment update is enforced, doctors' Medicare payment would decline to 55 percent of private rates in 2013.[2] Medicare's bureaucratic formulas have encouraged "gaming" by providers seeking higher reimbursement. The result is increased cost shifting to privately insured persons, even more inefficiency, and the prospect of low-quality care for the rapidly growing cohort of America's seniors.

Medicare pays hospitals for inpatient care at about 67 percent of private rates. Because hospitals are paid the same amount of money no matter how long a patient stays in the hospital, hospital administrators encourage shorter patient stays and a high turnover rate. This can result in hospitals discharging too many patients too soon. Approximately 20 percent of discharged Medicare patients are readmitted within a month of discharge.[3] Unplanned rehospitalizations cost $17.4 billion in Medicare spending in 2004 alone.[4]

In addition, there is evidence that as Congress and the Administration try to rein in Medicare costs by arbitrarily slashing hospital payments, the hospitals simply shift costs to the private sector. Hospitals made up a total of 37 percent of the Medicare cuts enacted in the Balanced Budget Act of 1997 through higher private insurance payments.[5]

Flawed Medicare physician payment formulas and their annual updates have left doctors at the mercy of Congress each year.[6] Physician payment updates are determined by a 1997 congressional formula that links physician payment to the performance of the general economy (the Sustainable Growth Rate, or SGR). Of course, there is no logical relationship between the cost of providing a medical service and economic growth. But outdated Medicare payment and the annual SGR formula for updating payment remain on the books. On January 1, 2013, Medicare physician payments rates are scheduled to be slashed by 31 percent.

An Engine of Crushing Debt. Many seniors today erroneously believe that they have paid for their benefits. In fact, on average, today a one-earner couple who retired at age 65 in 2011 and earned the average wage will have paid just $60,000 into the program but will receive and estimated $357,000 worth of benefits.[7]

The Medicare trustees say that the HI trust fund that finances Part A fails both the short-run and the long-run "test of financial adequacy." Since 2008, HI spending has exceeded HI revenues and has run tens of billions of dollars annually in cash deficits. The HI trust fund is now projected to be insolvent by 2024 and, under worst-case scenarios, could be insolvent by 2017.

Under the most realistic assumption of Medicare's Office of the Actuary, total Medicare spending is projected to increase from 3.67 percent of the entire national economy in 2011 to 5.8 percent of the economy by 2030.[8] Furthermore, when using realistic assumptions, the Medicare trustees predict that Medicare faces a long-term unfunded obligation over the next 75 years of $37 trillion.[9]

Status Quo Is Not an Option. Today, Medicare enrollment and the demand for medical services is

1. Walton J. Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, DC: AEI Press, 2009), p. 27.
2. John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures Under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services, Office of the Actuary, May 18, 2012, p. 8.
3. David C. Goodman, Elliott S. Fisher, and Chiang-Hua Chang, "After Hospitalization: A Dartmouth Atlas Report on Post-Acute Care for Medicare Beneficiaries," Dartmouth Institute for Health Policy and Clinical Practice, September 28, 2011, http://www.dartmouthatlas.org/downloads/reports/Post_discharge_events_092811.pdf (accessed August 30, 2012).
4. Stephen F. Jencks, Mark V. Williams, and Eric A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Vol. 360 (April 2, 2009), pp. 1418–1428, http://www.nejm.org/doi/full/10.1056/NEJMsa0803563#t=articleBackground (accessed August 30, 2012).
5. Vivian Y. Wu, "Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997," *International Journal of Health Care Finance and Economics*, Vol. 10, No. 1 (2010), pp. 61–83, http://www.ncbi.nlm.nih.gov/pubmed/19672707 (accessed August 30, 2012).
6. For more on the flaws of government price controls, see Kathryn Nix, "Government Price Controls for Health Care: A Deficit-Reduction Strategy to Avoid," Heritage Foundation *Backgrounder* No. 2627, November 30, 2011, http://www.heritage.org/research/reports/2011/11/government-price-controls-for-health-care.
7. C. Eugene Steuerle and Richard B. Fisher, "How Lifetime Benefits and Contributions Point the Way Toward Reforming Our Senior Entitlement Programs," National Institute for Health Care Management Foundation, August 2011.
8. Shatto and Clemens, "Projected Medicare Expenditures."
9. Suzanne Codespote, "Medicare Unfunded Obligations for 2012 Trustees Report," Centers for Medicare and Medicaid Services, Office of the Actuary, letter to the Senate Budget Committee, April 23, 2012.

manageable. Tomorrow it is not. The massive baby boomer generation (77 million strong) and its demand for medical services over the next two decades will put unprecedented strains on Medicare's creaky bureaucratic structure. Enrollment is expected to jump from 48 million beneficiaries in 2011 to 81 million by 2030.

The doubling of beneficiaries is also accompanied by longevity increases of nearly 10 years by 2020. Worse, the growing Medicare population will be supported by a relatively smaller number of workers. The Medicare trustees project a 50 percent decline in the ratio of workers contributing to the HI trust fund per beneficiary by 2030.[10]

A New Direction. Today's Medicare program is structurally flawed and fiscally unsustainable. Obamacare's projected savings from its Medicare payment cuts will not secure Medicare's financial future, including the HI trust fund. On that point the Congressional Budget Office is explicit: "Unified budget accounting shows that the majority of the HI trust fund savings under [Obamacare] *would be used to pay for other spending* and therefore would not enhance the ability of the government to pay for future Medicare benefits" (emphasis added).[11]

While most of today's seniors choose their own doctors, tomorrow's seniors will face a very difficult challenge in accessing the physicians and the quality of care they want. Replacing Obamacare with structural reform based on "premium support," like the defined-contribution financing of Medicare Part D, would update Medicare's insurance program and improve its financial condition, and it would also ensure access to better benefits and quality care for baby boomers and future generations.

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10. Centers for Medicare and Medicaid Services, *2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, April 23, 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf (accessed September 9, 2012).
11. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to the Honorable Jeff Sessions, U.S. Senate, January 22, 2010, p. 3.