Medicare Privatization and the Erosion of Retirement Security

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ABSTRACT. This paper describes initiatives to privatize the Medicare program over the last 10 years and the implications of these initiatives for the future of retirement security. Our analysis focuses on the privatization provisions of the Medicare Modernization Act, which is largely designed to benefit the corporate health care sector without containing costs or significantly reducing the threat of rising health care costs to the economic security of current and future retirees. In fact, as designed, the Medicare Modernization Act is likely to increase the threat to retirement security in the years ahead. We conclude with a series of policy alternatives to the neoliberal agenda for the privatization of Medicare.

KEYWORDS. Medicare, privatization, retirement security

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**THE MEDICARE MODERNIZATION ACT AND THE FUTURE OF MEDICARE**

After the fierce conflicts surrounding the creation of Medicare in the mid-1960s (Quadagno, 2005 and Oberlander, 2003), a bipartisan consensus emerged in support of the fundamental structure of Medicare. In 1994, however, when the Republicans gained control of Congress, this consensus disintegrated as the Republican leadership began a systematic initiative to privatize Medicare by expanding the participation of managed care organizations (MCOs). This initiative culminated in the implementation of the Medicare+Choice program in 1997, which was designed to increase the percentage of beneficiaries in managed care but fell far short of the 30% goal after an initial increase from 11% to 16%. Reimbursement rates were simply too modest to maintain increased MCO participation, and the percentage of beneficiaries in managed care fell back to 11% in 2003 after MCOs began to withdraw from Medicare.

The failure of past efforts to use managed care as a privatization vehicle, however, has not lessened the enthusiasm of privatization supporters for a greatly expanded managed care role in the Medicare program. The Medicare Modernization Act (MMA), which was passed in 2003 (Medicare Prescription Drug Improvement and Modernization Act of 2003), provides large increases in reimbursement levels for private plans in the Medicare Advantage (MA) program. These increases have been used to increase the number of beneficiaries in private plans from 5.3 million in 2003 to 8.5 million, or 19% of all beneficiaries, in March 2007.

The privatization proponents argue that putting control of Medicare resources under private plans, especially HMOs, will increase the program’s efficiency and cost-effectiveness. This rationale for privatization has little, if any, factual support, however. Medicare is more efficient than the private insurance market, while covering a population that is at substantially greater risk for needing health care than populations covered under private plans (Moon, 2006).

According to Moon (2006), from 1970 to 2000, Medicare achieved greater cost-containment than private plans after controlling for coverage of comparable services. Managed care interventions, mainly reductions in hospital lengths of stay, reduced cost increases in the private sector in the 1990s. Between 1999 and 2003, however, private insurance costs increased at about twice the rate of Medicare before returning to comparable annual cost increases in 2004. Moon estimates that when comparing rates of growth for comparable benefits, Medicare’s cumulative cost rate from
1970 to 2000 is 19% below that of private insurance. The major factor accounting for Medicare's efficiency edge is its lower administrative costs, which constitute just 2% or 3% of total expenditures compared to 10% to 15% in private plans and much higher in many managed care plans, which have actually increased costs in the Medicare program. Medicare HMO enrollees now cost 112% of what it costs to pay for fee-for-service beneficiaries with similar risk characteristics (Medpac, 2007). As poorly designed as the fee-for-service (FFS) system is to provide care efficiently, it is less expensive than private managed care plans in the Medicare context.

The fastest growing parts of the MA program are the private FFS (PFFS) plans, which have grown from 26,000 members in 2003 to 1.5 million members in 2007. These plans are also the most expensive, costing 19% more than the traditional Medicare program, compared to 10% more for HMOs and 17% more for PPOs (Medpac, 2007). A recent analysis by Marsha Gold (2007) found that the more expensive PFFS plans actually offer less comprehensive benefits than HMOs. Out-of-pocket costs for beneficiaries with extensive needs for hospital and physician services average $2,254 annually in a PFFS plan compared with $1,488 in an HMO. Gold concludes that PFFS plans:

- do relatively little to improve care management because they are precluded from doing so by both Medicare and their own reservations. To the extent that PFFS enrollment grows, Medicare's risk pool is fragmented, and the program's purchasing power with providers is diluted (p. 454).

She also notes that:

- Although individual enrollees may gain, beneficiaries as a whole may be harmed if higher payments add to the fiscal stress on Medicare, making the program less viable in the long run (p. 454).

Moon (2006) also points out that Medicare regulatory interventions designed to contain hospital and physician reimbursement rates have probably accomplished more sustained cost containment than any private sector initiatives such as managed care gate keeping and hard bargaining in the 1990s, which generated cost savings that have been largely erased by large premium increases since 1999. It should be recognized, however, that steady advances in medical technology, the fragmented nature of the
U.S. health care system, and the power of providers to set prices have frustrated efforts to contain costs through either government regulation or private-market mechanisms.

The relative efficiency of private vs. public systems of health care is a critical issue that is likely to become even more salient with the growth of the older populations and increasingly expensive, and often effective, medical technology. Chernew, Goldman, Pan, and Shang (2005) have developed projections of disability and health care costs that indicate that declining disability rates among the elderly are not likely to slow Medicare cost increases very much over the next 25 to 30 years, as expenditures on the less impaired, healthier elderly continue to grow and costly medical technologies are used to treat an increasing percentage of the Medicare population. Many of these technologies are likely to generate favorable cost-benefit ratios of the kind identified by Cutler (2004) and will be very difficult to control, even with powerful technical review boards. We may see some limits imposed on medical technologies in the future, but they are not likely to contain cost increases significantly below the levels of the last 30 years. These are major factors in the Medicare trustee projections that show that Medicare will increase from 2.62% of GDP to 4.75% by 2030.

In addition to enhanced payments to MCOs, the privatization-related provisions in the MMA also include the following: the administration of the drug benefit through private companies rather than through the Medicare program, which will add expensive layers of administration and help HMOs consolidate their position in Medicare; a managed care vs. traditional Medicare experiment to begin in 2010 in six metropolitan areas; a health savings account (HSA) program that many privatization advocates would like to see grow into a premium support approach to privatization; and a Medicare solvency provision that calls for Congress to consider alternative financing strategies once Medicare’s general revenue reached 45%. This could create an opportunity for reducing provider reimbursements and for increasing the share of costs borne by beneficiaries through premiums, co-payments, and deductibles.

These provisions are designed to alter the traditional Medicare program "in ways that could ultimately shift the public-private balance and lead to long-term structural changes" (Gold, 2005, p. 1303). The MMA includes a provision that will increase annual payments to private plans by the larger of either a 2% increase (the pre-MMA standard) or the national growth percentage (6.6% in 2005), regardless of the extent to which plans benefit from favorable selection among beneficiaries who
chose to join them. The overall effect of this payment arrangement and the other subsidies will raise the cost of private plans in MA (the MMA managed care option) to 116% of what Medicare pays for the same beneficiary in traditional Medicare. This extra money, in combination with an integrated Part D (drug) benefit and the continuing capacity of private plans to benefit from favorable selection, will make it possible for the plans to offer benefits (low or no co-payments and premiums) not available in traditional Medicare. Gold notes:

Although traditional Medicare is a popular program, some beneficiaries are likely to select MA plans because they integrate all benefits in a single package, often at an attractive price. On the other hand, MA plans’ financing may do little to stem the growth of Medicare spending and may even increase it. If Congress cuts back, beneficiaries either will face the disruptions common under Medicare + Choice or will have to pay more for MA coverage. The capitated MA program is better suited than the current Medicare program to support a shift from a defined-benefit to a defined-contribution program in which the government limits its fiscal contribution. Under this scenario, beneficiaries will either pay more or receive less from Medicare if costs continue to rise (Gold, 2005, p. 1309).

The MMA requirement that the prescription drug benefit be administered by private plans is an important step toward Medicare privatization. Supporters of this provision claim that it will increase market-based competition in the program and is a better method of containing drug benefit costs than having the federal government negotiate reductions as is now done by the Veteran’s Administration. The more likely motives are to provide financial incentives for the spread of private plan participation in Medicare and to erode the notion that Medicare should administer benefits directly, as it has done historically.

The MMA provision mandating six demonstration projects, beginning in 2010, is designed to test the competitive advantage of managed care vs. the traditional Medicare program. The latter, however, is likely to be at a major disadvantage because it will be reimbursed at levels no higher than the average level for HMOs and PPOs in the demonstration sites, even though they are likely to be serving sicker, higher-cost beneficiaries for whom the traditional program is the provider of last resort. Risk corridors and stabilization funds are likely to give private plans the false appearance of greater efficiency (lower premiums) in competition with the traditional program.
COMPARATIVE OUTCOMES

Does the higher cost of managed care plans justify their relative effectiveness in terms of health care outcomes and consumer satisfaction? The existing research provides no evidence in support of managed care’s (mainly HMOs’) superiority in comparison to the traditional Medicare program. In fact, the findings from this research tend to move in the opposite direction—better outcomes in the FFS system.

A study by Ware, Bayliss, Rogers, Kosinski, and Tarlov (1996) found substantial differences in 4-year outcomes for elderly and poor chronically ill patients treated in HMOs vs. FFS systems in four urban areas. For elderly patients (those aged 65 years and older) treated under Medicare, declines in physical health were more common in HMOs than in FFS plans (54% vs. 28%; \( P < .001 \)). In one site, mental health outcomes were better \( (P < .05) \) for elderly patients in HMOs relative to FFS, but not in two other sites.

Goldzweig and colleagues (1997) conducted a study comparing rates of cataract extraction in prepaid health settings versus those in FFS settings in southern California. The study included more than 62,000 Medicare managed care enrollees in a staff model HMO and an independent practice association (IPA) and 47,150 FFS Medicare beneficiaries (a 5% sample of all Southern California FFS beneficiaries.) After controlling for age, sex, and diabetes status, FFS beneficiaries were twice as likely to undergo cataract extraction as prepaid beneficiaries were.

The most recent study by Safran, Wilson, Rogers, Montgomery, and Chang (2002) is based on data from 8,828 respondents (Medicare beneficiaries) who were in either the Medicare FFS or Medicare HMO in 13 states with Medicare HMO markets. The authors found that the traditional FFS Medicare system performed better on 9 of 11 quality care outcomes that were examined in the study.

The results did not differ for patients in better or worse health, and the relative performance of the systems was the same in all 13 states, with the exception of one staff/group model HMO that outperformed FFS and IPA/networks in its area (Arizona) on three aspects of care. The findings are markedly consistent—in both direction and magnitude of effect—with previous comparisons of indemnity and managed care systems’ performance on the defining elements of primary care (p. 757).
The MMA also includes an expansion of the Medical savings account program that was initiated in the Balanced Budget Act of 1997. Medical savings accounts or HSAs are strongly supported by the Bush Administration as part of its “ownership society” agenda and as its preferred strategy for containing costs and increasing insurance coverage of some form. The essential features of this approach, often referred to as consumer-driven health care, include a tax-sheltered HSA with capped annual contributions, a catastrophic insurance plan, and out-of-pocket purchasing of health care until the annual catastrophic plan deductible of $1,000 to $2,000 for individuals and $2,000 to $4,000 for families is reached. These insurance premiums and deductible levels are likely to increase as the number of those with HSAs grows and the percentage with more expensive health care needs expand, driving up average out-of-pocket expenditures. The rationale for consumer-directed care is that by making consumers responsible for a greater share of their health care costs, they will become prudent purchasers of the care they receive, which will reduce increases in overall health care spending.

Many private plans and employers are actively promoting HSAs, and more than 3 million people now have them in one form or another. The initial findings, however, from a recent survey of those with HSAs are not encouraging (Fronstin & Collins, 2005). Compared to those with conventional insurance, those with HSAs are substantially less likely to seek care, spend substantially more out-of-pocket when they do, and are 15% to 20% less likely to be satisfied with their insurance plan. A study of HSAs in the Federal Employees Health Benefits Program found that those with HSAs were significantly younger, healthier, and more affluent than those with more conventional insurance (U.S. General Accounting Office, 2006).

Rather than reducing costs and improving the quality of care by creating more informed, cost-conscious consumers, HSAs are more likely to increase out-of-pocket expenses; undermine insurance pools by segregating younger, healthier, and wealthier people from older, sicker, and poorer people; increase costs and reduce access for those who need health care the most; and further fragment an already splintered U.S. health care system. These tendencies would have even more deleterious consequences for the older, more medically vulnerable population in Medicare than for the younger population in which HSAs are now beginning to take root. HSAs would, however, be a vehicle for reducing Medicare costs for the federal government by shifting a greater share of the costs to beneficiaries and making health care increasingly too expensive to use, especially among the poorest, who are often the sickest, beneficiaries. HSAs would essentially
achieve the same result at the individual level that HMOs achieve at the group level through favorable selection—the shifting of health care costs onto those who can least afford them.

The ultimate objective of the Medicare privatization proponents may be to use HSAs as a vehicle for converting Medicare to a premium support program based on vouchers that beneficiaries would use to join an HMO or to purchase a high-deductible plan and set up tax-sheltered savings accounts for out-of-pocket expenditures. This approach would accelerate the shifting of costs to beneficiaries, allow the federal government to cap expenditures, make Medicare a defined-contribution insurance program, and create a windfall for financial institutions, which have recently flocked to the private HSA market as employers move to limit their health insurance costs by shifting them to employees in HSA plans.

Banks and others are drawn by the promise of lucrative fees they can generate by offering consumers mutual funds and other investment vehicles as their account balances grow. Most also charge $50 to $75 to set up an HSA, and they collect perhaps $40 or more each year in maintenance charges and service fees (Dash, 2006).

An HSA makeover of the Medicare program could have serious deleterious financial and health status consequences for many Medicare beneficiaries, especially the most vulnerable (women, minorities, and the chronically ill). According to Moon (2006), voucher-based HSAs would:

offer less in the way of guarantees for continued protection under Medicare. They are most appealing as a way to substantially cut the federal government’s contributions to the plan indirectly, by eroding comprehensive coverage that the private sector offers, rather than as stated policy. The risks under such a plan would be borne by beneficiaries, which is of particular concern in an era when pensions and retiree health benefits from employers are less certain, and Social Security benefits may be reduced (p. 152).

**MEDICARE AND RETIREMENT SECURITY**

The retirement security of future retirees (the baby boomers) is threatened by several trends that have emerged over the last 3 decades. The greatest threat to retirement security may be the projected increase in
retiree out-of-pocket health care costs over the next several decades, which will occur under current provisions in Medicare law. These costs are likely to be even higher if Medicare undergoes further privatization through conversion to a defined-contribution program based on a premium support strategy.

Other threats to the future of retirement security include the rapid decline in defined-benefit private pensions and their replacement by inadequately funded defined-contribution plans (401(k), IRA); the underfunding of many of the remaining defined-benefit plans in both the private and public sectors; the meager savings and stagnant incomes of most working families; the increasing costs of education, housing, and health care; the declining wage replacement value of Social Security; and the attack on Social Security by conservatives who want to privatize the program by turning it into a defined-contribution plan similar to the tax-sheltered savings and investment plans now dominant in the private sector. The collective impact of these trends, according to Munnell and Soto (2005a; 2005b), may cause baby boomer retirees to look back on the current period as the “golden age” of retirement income.

Today’s retirees are claiming Social Security benefits before the rise in the retirement age to 66 and then 67, which is equal to an across-the-board cut in benefits. Today’s retirees also do not face the huge deductions in their Social Security check to cover Medicare premiums for Parts B and D that tomorrow’s retirees will. And today, the average retiree does not pay personal income tax on his [or her] Social Security benefits, whereas future retirees will increasingly see a portion of benefits subject to taxation. Finally, most of today’s retirees are covered primarily by a defined-benefit plan and do not face the uncertainty associated with the inadequate lump-sum payments from 401(k) plans.

In short, the economic status of most future retirees is likely to be about the same as current retirees and for many, it will be worse. Most future retirees will have no more private retirement wealth than the current 65+ population and are likely to be as dependent as publicly provided retirement benefits (Social Security and Medicare) for their economic well-being, which makes the preservation of these benefits a critical political challenge.

In assessing the financial preparedness of baby boomers for retirement, Delorme, Munnell and Webb (2006) found that they have been accumulating
wealth at about the same pace as previous cohorts. The ratio of wealth to income remained unchanged between 1983 and 2001 for any given age, with those aged 59 to 61 having accumulated wealth that is four times their income, which is the same ratio achieved by their parents at the same age. This regularity, however, does not mean that the boomers and following cohorts are as well set for retirement as current retirees. The authors note that:

while the boomers have been accumulating wealth at much the same pace as their parents, the world has changed in three important ways: (1) the prevalence of defined-benefit pension plans . . . has declined dramatically over the last 20 years; (2) interest rates have fallen significantly, so a given amount of wealth will now produce less retirement income; and (3) life expectancy has increased, so accumulated assets must support a longer period of retirement.

Medicare beneficiaries have been experiencing a steady growth in out-of-pocket spending for health care for several years. This percentage of income spent on health care has increased to 22% on average (Caplan & Brangan, 2004) and is now over 30% for lower-income beneficiaries. These increasing costs have put routine medical care beyond the reach of many less affluent older people, especially women. Adding a prescription drug benefit to Medicare will help reduce out-of-pocket costs for some retirees, but many older people will not have adequate access to health care until Medicare co-payments and deductibles are contained.

Current projections (Johnson & Penner, 2004) indicate that Medicare beneficiaries’ out-of-pocket expenditures will rise from 22% in 2004 to between 30% and 40% in 2030.

If current entitlement policies continue . . . typical older married couples will devote almost all of these income gains to taxes and health care. Between 2000 and 2030, federal tax liabilities will more than quintuple, and total out-of-pocket health care spending will nearly triple, primarily because of rising Medicare premiums and payments to health care providers. As a result, the share of after-tax income that the typical older married couple devotes to health care will increase from 16% in 2000 to 35% in 2030. Real after-tax income net of health spending will rise slowly between
2000 and 2030 and then decline between 2020 and 2030. Median income next of out-of-pocket health spending and taxes for older married couples in 2030 will not significantly exceed what it was in 2000.

The authors also note that health care spending as a share of after-tax income for married couples will rise from around 20% in 2000 for those in the bottom 40% of the income distribution to between 48% and 52% in 2030. These projected increases represent a profound threat to the economic security and health status of future retirees and their families and the further privatization of Medicare.

To keep health care affordable for millions of current and future beneficiaries, out-of-pocket expenditures must be limited. A recent proposal to strengthen the traditional Medicare program (Davis, Moon, Cooper, & Schoen, 2005) would cap out-of-pocket spending on Medicare-covered services at $3,000 annually, eliminate the prescription drug doughnut hole, and offer a competitive alternative to MA (managed care) and current Medigap plans by adding a comprehensive benefit option (Medicare Extra) to the Medicare program. The authors’ proposal (Part E) would reduce the annual deductible for hospital and physician services from $1,226 to $250, reduce physician cost sharing from 20% to 10%, eliminate the prescription drug deductible and limit cost sharing to 25% for all purchases (no doughnut hole), and set premiums for all Medicare components, including the new Part E benefit, at the new benefit premium which would cost $92.00 a month/$2,220 annually with a $3,000 cap on out-of-pocket costs. The authors note that one of the major advantages of their proposal (Part E):

would be that beneficiaries could obtain benefits in one plan, rather than needing a private drug plan and a Medigap plan to go with basic Medicare (Davis et al., 2005, p. 451).

And that:

providing comparable benefits in the Part E and managed care parts of the program would provide a genuine market test and choice. Forcing beneficiaries to enroll in managed care plans or in multiple sources of coverage to obtain comprehensive benefits runs counter to the principle of choice. Doing so also artificially increases enrollment in private plans (Davis et al., 2005, p. 452).
This approach is not only sound public policy but could also be an effective political strategy that builds on the wide and deep popularity of the traditional Medicare program. It offers a relatively comprehensive alternative to privatization through managed care and HSAs and takes the progressive program for Medicare reform beyond a mere patching up of the MMA legislation and helps protect the retirement security of future retirees.

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