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RECONSTRUCTING MEDICARE IN THE PUBLIC INTEREST

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[Editors Note: The following represents the opinion of the authors, and not the opinion of the Society of Actuaries or the opinion of SOA's Social Insurance and Public Finance Section. The suggestions made below have not been quantified or validated by the SOA or its researchers.]

In the June, 2012 publication, we explored numerous problems plaguing the Medicare program and the Federal Budget. As a follow-up to that article, we are presenting possible solutions to these problems. We feel that it is necessary to reconstruct the Medicare program.

All of the ideas we will present are intended to mitigate the extraordinary high cost and inefficiencies found in the program. The focus of our proposed actions is to reduce overuse of medical treatment, third party payment, and fraud and other abuses, while maintaining or improving access to treatment. Within the Medicare program, we have spent many decades gradually encouraging behaviors such as overuse and numerous other problems that exist today. We, the citizens of the United States, should realize that we cannot expect behavior change overnight. The fixes will take time, and they should be implemented gradually.

Listed below are 10 proposed adjustments to reconstruct Medicare, designed so the program will use resources more efficiently and, ultimately, become self-sustaining. Note that the proposed items below are presented at a high level. These ideas are the opinions developed by some members of the Government Health Care Subgroup of the SIPF and are not intended to be an exhaustive list of all changes that could be implemented.

1. Increase the age of eligibility for Medicare benefits over time (i.e., two or three months every year, over 50 years, to an eligibility age of 73 to 77). This would reduce the average benefit lifetime by somewhat more than would occur if the eligibility age was increased consistent with life expectancy increases. This will serve as a slight "catch-up" for the oversight in not previously incorporating a benefit age increase, with no impact to current beneficiaries. Individuals under age 65 would need to adjust their retirement health benefit planning accordingly, but at least they would have some time to do so. Plans for medical care reform for younger populations would also need to be adjusted accordingly due to the increase in eligibility age that the Affordable Care Act (ACA) does not currently have provisions for.

The fixes will take time, and they should be implemented gradually.

2. Move disabled (under age 65) into the Medicare program and duals (who are on both Medicaid and Medicare) into the Medicaid disabled program, or a separate program, based on need. These populations should have a benefit program that includes a cost sharing subsidy for families that cannot afford the yearly cost. These groups could be included in the state exchanges cre-

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ated under the ACA, as long as the subsidy level was appropriately established for this group. Another solution would be to include these individuals under a separate program; subpopulations of disabled individuals and dual-eligibles could be combined or maintained in a completely separate program. Combining these groups with the Medicare aged population under the same benefit design is not appropriate, as the needs and resources of the aged and the disabled subpopulations are not consistent.

3. Increase Part A and B deductibles (particularly Part B) substantially, along with implementing other cost reduction and risk reduction provisions. The current benefit structure should be modified to create incentives to control utilization by consumers, provide more complete catastrophic benefits, use care management where appropriate, and modify benefits/contributions consistent with need. Integration of Parts A, B, C and D of Medicare will require modifying some provisions so that the new benefit structure is consistent across types of services. This would eliminate inconsistencies that exist today such as those between physician services in Part B and drug services in Part D. Changes could include:

   i. Substantially higher deductibles for Part B services.
   ii. Covering Part B catastrophic costs.
   iii. Integrating Part D into Part B and applying deductibles to these services as well.
   iv. Covering catastrophic Part D claims.
   v. Removing the concept of lifetime reserve days on Part A and adjusting any deductible consistent with medical trends.
   vi. Encourage use of care management for more serious medical conditions.

4. Provide subsidies to poor individuals to pay part of premiums and reduce cost sharing to some degree.

5. Continue to provide options to individuals to purchase Medicare Advantage. This could be accomplished with a payment equal to something a little less than the projected cost for Medicare coverage each year. The minimum benefits required to be purchased should be substantially less than currently exists under Medicare, perhaps 50 to 75% of total current benefit levels, so that people are not required to spend all of the money on health coverage. Any money not spent on health coverage would go into individual medical accounts that could be spent on cost sharing. Medicare Supplement carriers could expand to include this type of coverage, although no coverage for services under deductibles would be allowed.

6. Undo price controls gradually so that Medicare reimbursement is much closer to or consistent with average commercial rates. This change should occur concurrently with the implementation of incentives to control utilization and along with greater transparency of charges, thereby allowing consumers to participate in cost control.

7. For individuals who are under some prescribed age of 25 or 30, allow their Medicare contributions to accumulate into a separate, interest-earning fund that belongs to the individual and is accessible after the eligibility age for their Medicare benefits. Prior to the Medicare eligibility age, money in these separate funds would remain with the government for accounting purposes, in order to avoid creating a bigger Federal deficit in the short term. This approach includes some redistribution of monies from high earners to low

earners, so that all eligible individuals have a minimum amount in their account each year and at their eligibility age. However, for those individuals between the new prescribed young individuals and the Medicare eligibility age, a combination of the two benefit funding systems might be used, or, alternatively, the current system with adjustments as noted above. This change represents a gradual movement from a defined benefit to a defined contribution system. Implementation would take place within the next 50 years or more. Covering the cost of the gradual amortization of the current unfunded liabilities will come from:

a. The savings from changes in the benefit structure that reduces utilization substantially
b. Additional pre-tax contributions as described in item #8, below
c. Investment income on both the utilization savings and additional contributions

8. Additional pre-tax contributions under age 65 to fund future benefits and slowly amortize the unfunded liabilities of today.

9. Add a new safety net that covers the costs for individuals who exhaust their accounts, including insurance coverage purchased.

10. Create a risk management system that:
    a. For the youngest individuals, the new system is effectively a 401(k) type system for healthcare. The only safety net needed in this group is for those individuals whose accounts become exhausted.
    b. For those individuals who will soon be eligible, increases in the eligibility age, deductibles, cost sharing, and changes in price control schedules are made consistent with differences in actual versus expected experience over time, through a yet-to-be-developed formula.
    c. For individuals whose eligibility age falls between the ages of the individuals in Item a. and Item b., the risk management system is a blend of the two.

In general, the changes suggested above would very slowly modify the current Medicare system from a defined benefit system to a defined contribution system. This would slowly eliminate the huge unfunded liabilities and debts created by Medicare. The current system, where the Federal Government sets the rules, pays all the benefits, and continually pushes more and more liabilities and problems to future generations, would change to one where the Federal Government oversees and manages Medicare, but users, payers and providers have more control. The defined contribution system would include special protections for those most in need, and accounts would eventually become the property of the individual/family estate. However, this change must be implemented very slowly, so that the Federal Budget is not compromised. Providers would have every incentive to help and to treat individuals/families, rather than being coerced to participate by the Federal Government. If this provider motivation is not corrected, it will ultimately threaten the availability of treatment and the development of medical innovations for this population.

Our proposal, if enacted, would create a self-sustaining Medicare system within which future generations pay for their own aged healthcare, replacing the inter-generational subsidies that currently fund Medicare. We will no longer ask future generations to bear a burden that is increasingly beyond their means. In addition, our ideas reflect an alternative that we believe better conforms to the intent of Medicare, which is to protect seniors against costs they cannot afford, while enabling them to secure high quality medical treatment when necessary.

We invite others to respond to our proposal and engage in an ongoing dialogue about shaping the future of Medicare.

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