INTRODUCTION

The growth in Medicare spending is bringing with it a close re-examination of assets and expenditures. Even with recent lower growth rates in Medicare spending, the total Medicare budget is projected to increase substantially, and will continue to have a large effect on the federal deficit. Changes in benefits and increases in premiums are being actively discussed by policy makers as a way to reduce the deficit, with cost-shifting to beneficiaries being a common feature of budget proposals.

Changes to Medicare premiums and benefits may affect access to quality health care if beneficiaries don’t have resources to pay out-of-pocket expenses. Increased health expenses will likely have a disproportionate impact on vulnerable populations. Financial vulnerability has the potential to decrease the ability to purchase adequate coverage if a beneficiary cannot meet premiums and deductibles required by the different parts of Medicare.

Decrease access to timely health care if a beneficiary is unable to pay for expenses such as doctor visits and/or medications;

Increase poverty among the elderly, if health care costs overwhelm them;

Increase overall costs to Medicare, if beneficiaries’ chronic conditions are undertreated or improperly treated, and consequently worsen;

Increase costs of Medicaid, if those with lower income and assets turn to that program for assistance.

Vulnerable Seniors

The vulnerability of Medicare beneficiaries may derive from chronic health conditions, lack of financial resources, or both. According to CMS, 69% of beneficiaries have two or more chronic health conditions, and 14% have six or more. Poorer health creates financial vulnerability because of the higher-intensity use of health services and products, and the corresponding higher expenses.

Another source of vulnerability is race and ethnicity. Significant income and asset disparities exist among racial and ethnic groups for Medicare beneficiaries. Black and Hispanic beneficiaries had lower income in retirement and lower total assets than whites. According to an Urban Institute report, during years in the workforce, whites had twice the average income as minority group members, and six times as much wealth. These ratios persist even for minority individuals with higher education.

Another economic shift which adds to vulnerability is that many fewer beneficiaries will enjoy employer-sponsored health benefits. The portion of all U.S. employers who offer retiree health benefits fell from 66% in 1988 to 28% in 2013. This means that a growing proportion of people over 65 will be asked to meet larger out-of-pocket expenses for their health care.

Out of Pocket Costs

The Employee Benefits Research Institute has estimated that Medicare covers 62% of seniors’ health care costs, excluding long-term care. In 2013, a 65-year-old couple with median Rx use needed $151,000 in savings to have a 50% chance at covering their health care costs in retirement, and $255,000 to have a 90% chance of meeting these expenses. These estimates take into account the closing of the Medicare Part D “donut hole” under the Affordable Care Act, and the dollar amounts are lower than they were even a few years earlier.

A 2012 report found that beneficiaries had an average out-of-pocket expense of $36,688 in the last five years of life, with long-term care being the top expense category. For one-quarter of seniors, their final expenses exceeded the total value of all their remaining assets. Half of beneficiaries have $63,100 or less in savings, and minorities have far less; therefore, the proportion of seniors depleting their lifetime assets to pay for health care will increase.

CONCLUSIONS

Current strategies don’t address the fundamental structural problem of Medicare insurance, which is its exposure to socioeconomic externalities. Medicare absorbs:

Income and wealth differences
Race and gender differences
Prior health status differences
Prior health care access differences

Current proposals focus on costs and deficits. Shifting the focus to health outcomes will have beneficial fiscal effects. Incentives should be designed to match desired outcomes. Putting health first will protect the federal budget.

RECAPTURE EXTERNALITIES

• Create a rebate system aimed at states and/or insurers who deliver healthier people to Medicare - allows for innovation of care models and fits with ACO structures;
• Reward individuals for better choices;
• Formulate income-related deductibles: reward those who use fewer resource and subsidize those who need more care.

REFERENCES