

How Medicare Was Saved from Rationing— And Why It's Now in Danger

By Burke J. Balch

Editor's note: Since its inception, the National Right to Life Committee has been equally concerned with protecting older people and people with disabilities from euthanasia as with protecting the unborn from abortion. We have recognized that involuntary denial of lifesaving medical treatment is a form of involuntary euthanasia, and therefore have opposed government rationing of health care. In 1997 and 2003, NRLC successfully fought to amend Medicare by allowing older people the right to use their own money to obtain unrationed care; shockingly, under the new leadership of Congress that right is now at risk. Here's the background:

Most people are aware that Medicare—the government program that provides health insurance to older people in the United States—faces grave fiscal problems as the baby boom generation ages.

Medicare is financed by payroll taxes, which means that those now working are paying for the health care of those now retired. As the baby boom generation moves from middle into old age, the proportion of the retired population will increase, while the proportion of the working population will decrease. The consequence is that the amount of money available for each Medicare beneficiary, when adjusted for health care inflation, will shrink.

Three alternatives exist. In theory, taxes could be increased dramatically to make up the shortfall. Few knowledgeable observers consider this likely, regardless of which party is in power in Washington.

The second alternative—to put it bluntly but accurately—is rationing. Less money available per senior citizen would mean less treatment, including less of the treatments necessary to prevent death. For want of treatment, many people whose lives could have been saved by medical treatment will perish against their will.

The third alternative is that, as the government contribution decreases, the shortfall is made up by payments from older people themselves, so that their Medicare health insurance premium is financed partly by the government and partly from their own income and savings.

Although it goes against the conventional wisdom, there is reason to believe that on average Americans could afford to pay for this. (See "Why America Can Afford Unrationed Health Care," p. 16.)

What most people do not realize is that, as a result of legislative changes in 1997 and 2003, supported by the National Right to Life Committee, this third alternative is now law. Under the title of "private fee-for-service plans," there is an option in Medicare under which senior citizens can choose health insurance whose value is not limited by what the government may pay toward it. These plans can set premiums and reimbursement rates for providers without upward limits set by government regulation.

This means that such plans will not be forced to ration treatment, as long as senior citizens are willing and able to pay more to choose them. Over 1 million older Americans are now enrolled in private fee-for-service plans, about 2% of all Medicare beneficiaries.

This option means that Medicare can operate in such a way that whatever the government provides serves as the floor, not the ceiling, for what health care senior citizens can get. As government contributions sink, private fee-for-service plans can provide an escape hatch from rationing.

However, a concerted effort is now underway in Congress to take away this option and force older Americans back into those aspects of the Medicare program that limit the availability of health care essentially to what the government is willing and able to pay for. House Health Subcommittee Chair Pete Stark (D-Ca.) hopes to abolish the private fee-for-service option. While clever attempts are being made to couch the assault on private fee-for-service plans as protecting consumers from exploitive insurance companies, there is little doubt about Stark's underlying motivation.

As far back as 1997 Stark introduced a bill to repeal the private fee-for-service option, scornfully stating, "This proposal is the brainchild of some in the right-to-life community who believe that Medicare payment rates are so strict that some doctors may not provide adequate care under traditional Medicare. Therefore, to avoid euthanasia one can join one of these plans and let your doctor charge you extra. It is too bad that those who care about killing seniors spend so much time helping the rich find fire escapes, and so little time helping the uninsured and those who are not rich live in a good system."

Apart from Stark's apparent assumption that middle-income senior citizens are "rich," this perspective apparently assumes that if we care about the poor, the "just" thing to do is to force everyone to be equally at risk of rationing regardless of economic status.

In fact, trying to subject everyone to equal rationing, regardless of income, will cause greater harm to the very group whose interests it is supposed to protect—those who are poor. When people are permitted to spend their own money for health insurance, and those who can afford it select the more expensive unrationed, unmanaged fee-for-service plans, this adds money to the system. Part of that extra money becomes available for private-sector cost-shifting to help meet the needs of the poor.

This provides the means for doctors and health care facilities to continue to provide services for poorer people at government reimbursement rates below actual costs. If it is illegal for older Americans to use their own money to supplement government payments when buying health insurance, little or no such cost-shifting will be possible. Poorer people will be far more likely to be denied lifesaving medical treatment than if supplementation were permitted.

There is a particular irony in Stark's attack on allowing those who can afford to do so to use their own money to escape rationing. Unlike Medicaid, which is designed specifically to help those of low incomes, Medicare covers everyone of retirement age, regardless of income or assets. Yet, because of budget constraints, the Medicare reimbursement rates for health care providers tend to be below the cost of giving the care—a deficit that can only accelerate as cost pressures on Medicare increase with the retirement of the baby boomers.

This means that providers engage in "cost shifting" by using funds they receive in payment for treating insured working people to help make up for what the providers lose when treating retirees under Medicare. Thus, comparatively low-income workers often effectively subsidize higher-income retirees.

However, when middle-income retirees are free voluntarily to add their own money on top of the government contribution, through a private fee-for-service plan, they stop being the beneficiaries of cost-shifting and become contributors to it. If successful in abolishing the private fee-for-service alternative, Representative Stark will be locking in subsidies to the more well-to-do at the expense of retirees who are poor.

Thus, the lives of older people of all income levels hang in the balance in the critical battle that will be fought in Congress this year over Medicare rationing. In the absence of a truly massive outpouring of protest from grassroots Americans outraged that government could take away their right to spend their own money to save their own lives, there is grave danger that Stark and his allies will succeed in abolishing that choice in all of Medicare.