Midlife Medicare

The case for reform heats up

BY BETTY JOYCE NASH

Like the boomer birth cohort that threatens its existence, midlife Medicare needs an overhaul. But it will take more than a facelift and weight loss for the plan to function through the biggest challenge of its 42 years — seeing the post-World War II generation through old age.

Consider that one in every five West Virginians use Medicare, the biggest percentage of beneficiaries in the nation, a reflection of that state's aging population. Nationwide, the average is one in seven.

Medicare is the nation's public health pledge, placed into the Social Security program as the centerpiece of President Lyndon Johnson's Great Society along with its sister Medicaid, to ease medical expense for the elderly. (Medicaid pays for poor peoples' medical care and long-term care.)

At last count, some 37 million use Medicare, along with 6 million disabled people. About 7.5 million of those are "dual eligibles" — they use both Medicare and Medicaid.

The first of the boomers will arrive at Medicare's door in 2010, at a time when there will be 3.6 workers per beneficiary (compared with four today) forking out to keep the system going. By 2030, when the last boomer turns 65, only 2.3 workers will be paying in. Policymakers may have to consider major changes sooner rather than later.

Challenge and Opportunity

Medicare is plagued by some of the same inefficiencies that dog the health care system overall. Competitive markets can match prices to costs pretty well, but health care markets are imperfect, a result mainly of the third-party payment system, whether under government or private insurance. Health care markets have problems with information asymmetries (when one party in a transaction knows more than the other), moral hazard (when people use more of something than they otherwise would because they're not paying the bill), and adverse selection (when the price of insurance or care doesn't depend on how sick you are; the sickest, who are the most costly to treat, get a relatively better deal), among others.

Current projections indicate that by 2050, Medicare may balloon to account for 9 percent of the nation's total of goods and services, compared with 2.7 percent in 2005, according to the 2006 report of the Trustees of Social Security and Medicare trust funds. Funding problems have been discussed for decades, especially during recent debates over the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), which passed in 2003.

Medicare's hospital fund (paid for through a 2.9 percent payroll tax shared equally by employers and employees) in 2005 spent $183 billion on income of $199 billion. By 2010 expenses will overtake income, exhausting trust fund reserves in 2018, according to trustees' projections. By then the fund won't generate enough to pay benefits. (That's two years earlier than the trustees reported in 2005.) Medicare's supplemental program, Part B, which pays for doctors, outpatient work, lab work, supplies, and home health, is funded through premiums (25 percent) deducted from Social Security payments, and general tax revenues (75 percent). Only continued hikes in premiums and general revenue contributions will sustain the fund under current design. Many Medicare beneficiaries also pay for "Medigap" coverage, private insurance that helps cover co-pays and services Medicare doesn't cover.

It's worth noting that nearly all elderly beneficiaries on Medicaid are also on Medicare, and about 40 percent of the disabled who are on Medicaid are also on Medicare. Together they make up a big share of the Medicare population, particularly among the sickest, according to Leighton Ku of the Center on Budget and Policy Priorities. States share the funding of Medicaid with the federal government, while Medicare is mostly a federal program.

The two programs are inextricably linked. For example, poor people use Medicaid to pay Medicare premiums. Because Medicaid sneezes when Medicare catches a cold, any fixes to Medicare need to be well thought out.

Now Hear This

By 2008, arguments over Medicare funding will intensify. That's because the MMA triggers a presidential warning when trustee forecasts say general revenues will finance 45 percent or more of total Medicare spending in any of the next seven fiscal years. Two warnings trigger legal obligation for the president to submit legislation to Congress.

OK, so here's the first warning, says the 2006 report. And according to trustee and economist Tom Saving, "Unless things are dramatically different, we'll do it again in 2007." If so, in January 2008, the president would submit a plan to Congress, forcing debate. (However, Congress doesn't have to act.)

Politically palatable solutions are scarce, owing to philosophical differences about the extent of government responsibility for health care. Some people consider keeping current benefits intact a moral obligation, others favor trimming benefits, and others want people in charge of their own medical accounts so they'll have an incentive to monitor spending. Mainstream economists, for the most part, think such "consumer-directed" care will introduce competition and efficiency. The MMA calls for trying out that savings account idea in 2007.

More Money, More Life

Medicare spending grows each year, but its average per-capita spending growth between 1969 and 2003 (9 percent) was less than for private insurance (10 percent), according to Centers for Medicaid and Medicare Services (CMS). (Joseph Antos, a health care economist who serves as a Commissioner of the Maryland Health Services Cost Review Commission, has disputed this estimate, pointing out that private firms expanded coverage over that span. In 1970 private insurance paid 60 percent of hospital and doctor services, but 85 percent in 1999.)

Overall, health care costs rose about 7 percent in 2005. Cutting-edge cures and life-prolonging drugs push up costs. Just as longer lives create payment problems for Social Security, ditto for health care. People can expect to live 18 years in retirement, much longer than expected when the plan was unveiled in 1965. Somebody will have to pay for those extra years of health care. For instance, implanting defibrillators for cardiac arrhythmia, if expanded to half of the elderly with new cases of heart attacks, would mean about 374,000 annual procedures in 2015 and cost $14 billion, adding up to $132,000 per additional year of life, according to the RAND Corporation's "Future Health and Medical Care Spending of the Elderly."

Reducing chronic illness among Medicare beneficiaries could save money, but only slightly. Overall, RAND's "Future Elderly Model" found that people will live better and live longer, but the innovations increase rather than decrease costs.

Obesity may be a different story. Researchers found that starting at age 70, an obese person will cost Medicare about $149,000 over a lifetime, the highest level of any group, 20 percent higher than for the next closest group, the overweight, and 35 percent higher than normal weight people. Medicare could spend $38,000 more over the lifetime of an obese 70-year old than a beneficiary of similar age and normal weight. If obesity is responsible for the health differences, then preventing or curing it would save Medicare money, according to the RAND report.

Competitive Edge

Politicians of every stripe, accompanied by health care policy experts, are searching for a way to get seniors through old age without dragging down the economy and discouraging young workers in the bargain.

Trimming costs and adding payers, such as through more and higher-paid immigrants, may help. And worker productivity is expected to increase, so the necessary tax rate need not rise appreciably if productivity increases slightly more than historical rates, according to health economist Mark Pauly of the University of Pennsylvania.

The source of Medicare's malady may lie in the third-party insurance payment system itself. If you don't pay for services out of your own wallet, then you tend not to pay attention to the bill. Was the proper service rendered, how much did it cost, and are those prices true? If you bought a television set over the holidays, you probably surfed the Internet and combed newspaper ads for the best price. But few people do that with medical costs — unless they're uninsured or self-insured — because few pay out of pocket for services. That leads to vast inefficiencies in health care even in the private sector.

"One of the biggest problems with Medicare and health care even is customers don't care what it costs. If the buyers don't care when they go in, the sellers aren't going to care," says economist Saving, who in addition to serving as a trustee on the Social Security and Medicare Trust Funds teaches at Texas A&M University. He points out a case of cheating in 2000 with some providers improperly coding conditions so they would be reimbursed at a higher level. After a policing effort, costs came in below forecasts. "The real problem is that the prices are all fiction," he says. In a true market, with winners and losers, accurate pricing emerges through competition, but Medicare sets prices administratively.

Inefficiencies abound in the entire health care system, not just in Medicare, and they include lack of accountability and care coordination, technology that may not be worth the cost, and little incentive for cost-effectiveness. Paying providers the same rate regardless of the quality of care doesn't do anybody any good. Moreover, "perverse payment system incentives, lack of information, and fragmented delivery systems are barriers to full accountability," according to a 2006 Medicare Payment Advisory Commission (MedPAC) report to Congress. Under Medicare's fee-for-service system, "doing more pays more, regardless of the quality or efficacy of what is done."

A wide range of proposals could "fix" Medicare, Saving suggests, but he warns that "anything will be a benefit reduction." Which might not be such a bad thing, he says. "If the benefit reduction is big enough, customers might start caring what things cost." Raising the eligibility age, which has been suggested, is unlikely to help because younger enrollees are responsible for a relatively small percentage of total Medicare expenditures. This is in contrast to Social Security. Raising the age at which people would begin receiving benefits from that program could help its potential fiscal imbalance. This is one of many reasons why some economists believe Medicare is a tougher problem to fix than Social Security.

Cost sharing shows promise. According to the 15-year RAND Health Insurance Experiment, hefty deductibles reduce spending through careful use of services. Saving says a $5,000 deductible would protect people from catastrophe while dramatically reducing the necessary transfers from general revenues. Plus, the money would stimulate competition. "In reality if you looked at 79 million retired people — $5,000 times 79 million — the providers would be competing for that money."

Other Medicare fixes range from enticing more private payers into the market for competition's sake, including incentives for disease prevention, benefit cutting, or means testing, among other policy combinations.

Means testing is coming. The MMA will vary premiums and benefits by income, setting higher premiums for well-off seniors. In a 2004 paper, economist Pauly proposed "a strategy in which future Medicare beneficiaries with higher incomes will pay for cost-increasing but quality-improving new technology, possibly with prefunding that begins before retirement."

Further regulation, especially clamping down on prices, may produce undesirable results. Reducing payments to providers is an idea economists don't like because economic theory suggests it can induce shortages, which has happened with Medicaid, says Robert Helms, director of health policy studies at the American Enterprise Institute. Or it can also cause a jump in service, as providers make up for lost revenue. Such changes would likely be more noticeable in regions with high percentages of Medicare enrollees, like West Virginia.

"[There are] lots of ways physicians can skimp on the service, and some are subtle," he notes. "Just cutting the rates is a short-term and misguided policy. You have to get to a situation where everyone has an incentive, patient and provider, to worry about cost and quality and cost-effectiveness."

In an effort to keep rural doctors from becoming scarcer than they already are, Medicare is paying them a bonus, part of the MMA of 2003. That's good news for rural states like West Virginia. In addition to its aging population, with more deaths than births, the state is overwhelmingly rural. Forty-five of its 55 counties are rural.

Clamping down on prices often backfires. In the 1990s, a supplemental Medicare + Choice plan was done in by "top down price setting and com-

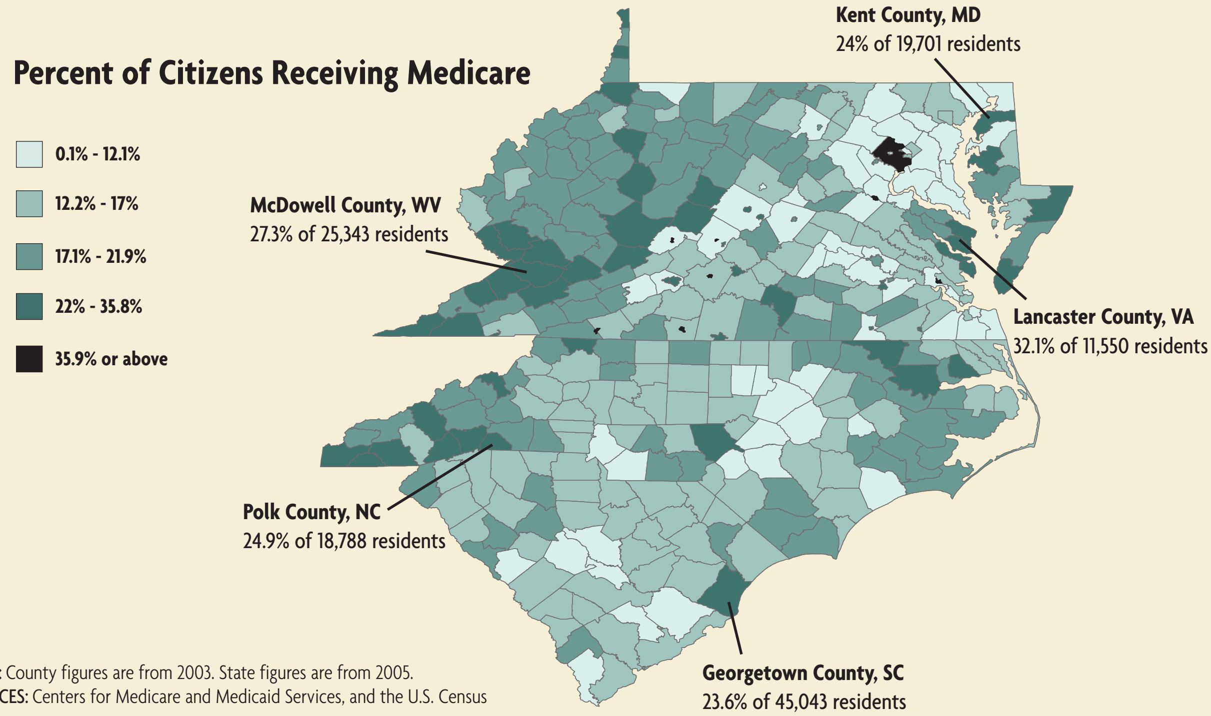
Rural Density

Fifth District counties with the biggest percentage of Medicare enrollees tend to be rural, a designation that varies according to federal agency and program.

Some 19 percent of West Virginians use Medicare, compared with 14 percent nationwide, reflecting the fact that 45 of the state's 55 counties are rural. A bulging pocket of elderly live in southern West Virginia's McDowell County, where the decline in coal mining has hurt the local economy. About 27 percent of the county's 25,343 people are Medicare beneficiaries.

Other Fifth District counties with high percentages of Medicare enrollees include growing retirement locales such as Polk County, N.C., near Asheville, and coastal Georgetown County, S.C., as well as the Chesapeake Bay area's Kent County, Md., and Lancaster County, Va.

Also noteworthy: North Carolina and South Carolina exceed the national average for Medicare enrollees who are disabled, with percentages of 19 and 20 respectively compared with 15 percent, the U.S. average. About 23 percent of West Virginia's Medicare enrollees are disabled.



NOTE: County figures are from 2003. State figures are from 2005.
SOURCES: Centers for Medicare and Medicaid Services, and the U.S. Census

plex regulation," health economist Antos writes. Providers can always get creative and expand services to counter price controls, according to Antos, who has written extensively about using markets to strengthen Medicare.

"Tighter controls that also restrict the use of services could prevent that, but such restrictions would have adverse consequences for the health of beneficiaries," he writes. In 2002, Medicare cut doctors' fees by 5.4 percent, which prompted service disruptions in some geographic areas and didn't save money. Payments increased by nearly $3 billion, thanks to extra service volume, a 7.9 percent increase in 2002 compared to a 3.5 percent increase in 2000 and 2001. "It would be difficult to argue that such a sharp increase in volume last year was justified solely on clinical grounds."

Medicare Woos Private Payers

Medicare Advantage, a transformation of the old Medicare + Choice plan, aims to reinvigorate private plan participation (through various financial incentives) and competition after many insurers left the program. Their defection was a response to restricted payment rate growth in high-cost areas. Private plans have been an option since 1982, with enrollment peaking at 17 percent of enrollees in 1999 and declining to 12 percent by 2004, according to MedPAC.

Medicare Advantage lets participants choose private plans in lieu of the traditional fee for service plan. Under some plans, participants may receive more benefits than Medicare offers, and they'll pay more in premiums. Medicare pays plans a capitated (per person) rate that amounted to $55 billion in 2005, or 17 percent of total Medicare spending, according to MedPAC. Plans bid and the bids are compared with county-level benchmarks to determine payment. If the plan bids above benchmark, then that's the payment and participants pay the difference. But if the bid is under benchmark, then the Medicare program keeps 25 percent of the difference, and 75 percent is rebated to the plan, which is obligated to return it to the enrollees in the form of lower cost sharing. Enrollment is now about 7 million of the 46 million beneficiaries.

Among plan advantages is the emphasis on coordination of care, says Teresa DeCaro, acting deputy director of the Medicare Advantage Group at CMS. Medicare's fee-for-service program has no incentive to manage care among providers, she notes. "In a capitated arrangement, the plan is only profitable if the costs incurred match or beat expected costs," she says. "They're always looking to arrange services and put cost-effective administrative structures in place so beneficiaries are receiving the best mix of services to keep them out of hospitals and nursing homes, the kinds of things that are really expensive to do. That's where all the dollars are."

In addition to reviving competitive alternatives, the MMA introduced Medical Savings Accounts in 2007. Medicare pays for a high-deductible plan for enrollees, establishing an account with the designated funds. The money and its earnings are tax free as long as it's used for health care. After meeting the deductible, the health plan covers the medical services. Unused amounts are rolled over even if the enrollee opts into a different plan. This provides an incentive for relatively healthy people to be discriminating when choosing care while the catastrophic limits protect very sick people from facing huge bills.

Antos has floated a Medicare reform that uses as a model the Federal Employees Health Benefits Program (which includes retirees as well as active employees). Beneficiaries would choose from competitive plans including a Medicare fee-for-service plan. A common objection to market-based Medicare reforms is that insurers will choose only healthy people, what's known as risk selection. Antos suggests more compensation for sicker enrollees to provide incentives (as well as oversight for corrective action if necessary). For example, the federal employee health program subsidizes enrollee premiums. Because of the high subsidy, a recent study found small differences in the average age of enrollees in low- and high-cost plans. Currently, consumer-driven plans, typically low-premium but high-deductible plans, account for about 3 percent of the private health insurance market.

Competition will improve efficiency, the theory goes. But a careful, cost-conscious health care consumer is the critical link to competition. And with new choice in Medicare plans and Medical Savings Accounts, that's the aim, according to DeCaro.

"The presumption is that beneficiaries are more engaged, more aware of the costs of health care," she says. "Therefore they're more inquisitive and more interested in good information about health care choices."

Informed health care consumers? Efficient health care markets? No matter what, soon we will likely see the end of Medicare as we know it. Come 2008, some of these proposals could become policy. **RF**

Readings

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