**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 people’s 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 billion 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 buyer 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 dra-
matically 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 
revenue, as providers make up for lost 

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 popu-
lation, 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 supplement-
metal 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.

Percent of Citizens Receiving Medicare

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


Readings


