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Medicare, Medicaid challenge looming

Fixing Social Security woes will seem easy in comparison with health insurance programs

By Michael Hill
Sun Staff

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While everyone is talking about what to do with Social Security, there's a far-larger fiscal iceberg floating dead-ahead that is getting little attention - possibly because no one knows what to do about it.

The bill for Medicare and Medicaid - the government's health insurance programs for seniors and the poor - is expected to far surpass the cost of Social Security in coming decades as they take on a surge of aging baby boomers in an era of skyrocketing health care expense.

"Medicare obviously faces the same demographic challenges that Social Security does, but the extent of the spending problem is substantially worse," says Ken Thorpe, chairman of the department of health policy and management at Emory University's School of Public Health.

Consider this year's report by the trustees of the trust funds of Social Security and Medicare. "Medicare's financial difficulties come sooner - and are much more severe - than those confronting Social Security," it says. "While both programs face essentially the same demographic challenge, health care costs per enrollee are projected to rise faster than the wages per worker. ...

"As a result, while Medicare's annual costs are currently 2.7 percent of GDP, or about 60 percent of Social Security's, they are now projected to surpass Social Security expenditures in 2024 and reach almost 14 percent of GDP in 2078, more than twice the percent for Social Security in that year."

Add in Medicare expenses that are paid out of general revenue, and the percentage of gross domestic product (the output of goods and services) rises to 20 percent in 2078. Thorpe says that Social Security will account for only 3 percent of GDP then. "It's just an order of magnitude different in terms of a spending problem," he says of Medicare's projected money problems.

So why aren't people in Washington doing anything more than wringing their hands while watching things like the projections of the cost of the new prescription drug benefit rise?

"It's a lot more attractive to take on a program like Social Security with a plan to give a ton of money to Wall Street that wants it," says Rick Mayes of the department of political science at the University of Richmond. "There's not a huge political payoff to taking on Medicare, almost none, because any reform is going to be resented by somebody.

"But if you had to choose between the two, which one needs financial fixing first, it would be Medicare hands down," he says.

Legacies

Just as Social Security was the legacy of President Franklin D. Roosevelt's New Deal, Medicare - celebrating its 40th birthday - is the legacy of President Lyndon B. Johnson's Great Society. And, while both programs have come under extensive criticism for the burden they impose on the federal budget, both have done what they were supposed to do.

Judith Stein, executive director of the Center for Medicare Advocacy, says that when Medicare came into existence, about 50 percent of people older than of 65 had no health insurance. Now, studies show, 96 percent are signed up for both parts of Medicare coverage - hospitals and doctors.

"It has dramatically increased the amount of coverage available to the elder population and in doing that, decreased poverty, both for elders and for their families," Stein says, noting studies that show poverty among the elderly declining from 29 percent in 1965 to 10.5 percent in 1995.

Medicare has similarities and differences with Social Security. Its Part A - which covers hospitalization and similar costs - is paid for out of a trust fund similar to Social Security's, financed by payroll taxes matched by employers. As with Social Security, the trust fund is projected to run out - the latest trustee report projects it will be exhausted in 2019, seven years sooner than the previous year's projection.

Doctors and other outpatient costs are covered under Part B of Medicare which, like Medicaid - the government's health insurance program for the poor of any age - is paid for out of general revenue funds. The law requires Medicare recipients to pay a premium covering 25 percent of those costs, a cost that has been rising rapidly in recent years. General funds also will be the source of money for prescription drug benefits when that comes on line.

As with Social Security, which has about 1 percent in administrative costs, Medicare can boast of its bureaucratic efficiency, using only 2 percent of its dollars for administration, far below the 12 percent to 16 percent costs of private plans.

What worries Medicare advocates is that cries of crisis in the plan will result in privatization schemes similar to those being suggested for Social Security. The 2003 Medicare Modernization Act that introduced drug benefits moved in that direction.

'Faith-based approach'

"It's a faith-based approach to health insurance," Stein says. "I say that because experience shows that these managed-care plans did not save Medicare a nickel."

Mayes says this is not surprising. "The reason Medicare came into existence is that these were people who were uniquely unqualified for private insurance," he says. "Why would we expect the private companies to come back in now? Old people get sick."

Thorpe says that solving the Social Security's financing problem is basic arithmetic compared with the advanced calculus required for Medicare.

"Social Security is a simple fix," he says. "We have direct control over how much money we spend. You

just have to change that formula. Medicare is a much more complicated set of issues because we do not have direct control over how much money is spent."

No one can predict how many people will need care, what form it's going to take and how much it's going to cost. "In Medicare, there are hundreds of different spigots that the money flows out of," Thorpe says.

And then there's Medicaid which has fiscal problems of its own. It faces the same problems with rising health costs. Since it serves the poor, it is most needed when the economy goes sour, when tax revenues for states - which jointly fund the program - go down.

Marty Ford, director of legal advocacy with the Arc and United Cerebral Palsy, says the recently released federal budget calls for allowing the states certain "flexibility" in Medicaid payments without specifying any financial impact. "I'm afraid that means lessening the protection for people who are disability beneficiaries," she says.

Lois Quam, chief executive officer of Minnesota-based health care company Ovations, says that if Medicaid isn't fully funded, hospitals will be forced to pay for indigent care.

"You really don't save anything, you simply shift the cost to local facilities, community hospitals," she says.

So what to do?

"The answer is surely not just to cut," says Quam, who worked on the 1993 White House Task Force on National Health Care Reform. "Then all the gifts of modern medicine will not be available to people who need them the most."

Thorpe says Medicare needs to be redesigned.

'Very reactive'

"Today's delivery of health care is very reactive: People get sick, they show up and you treat them," he says. "That made sense 40 years ago when primarily patients were acutely ill. Now patients coming in are chronically ill. So we do need a different treatment model."

Taking a different approach to these chronically ill patients could yield fiscal results because, as Quam says, 50 percent of Medicare resources are consumed by 5 percent of the beneficiaries, while 80 percent of Medicare money goes to less than 20 percent of those in the program.

Thorpe says these patients need coordinated care. The current system does not encourage that as dollars follow the patient from doctor to therapist to hospital.

He says a more efficient way to treat people with diseases like diabetes is for Medicare to give the dollars to someone who coordinates care of the chronically ill, making sure they get what they need with no questions about what is and isn't covered.

"You provide an annual payment to somebody to manage the case, you have clinical performance measurements there to make sure what is supposed to happen is actually happening," he says.

Thorpe says this is a way to introduce competition into Medicare as recipients could look at understandable results - not a bunch of numbers that don't relate to their care - when choosing managers for their care.

Quam, whose company provides coordinated care for some of Medicare's most expensive patients - those with multiple chronic conditions - in pilot programs, says this is the proper role for private companies: to bring the kind of innovation that is difficult in a large bureaucracy.

"We are accountable for the results," she says of her company's Medicare programs. "If we can't keep people healthy enough ... we go under."

'Root causes'

Thorpe says Medicare has to go beyond better treatment for chronic conditions and look at the root causes, such as the extent of obesity in the country.

Robert Hunt Sprinkle of the School of Public Policy at the University of Maryland says this points out a fundamental flaw in the health care system that puts a burden on Medicare.

"If you want to decrease the toll of chronic illness, I tell you the last way you want to do that is start insuring people at age 65," says Sprinkle, who is an M.D. and has a Ph.D. "I think we have messed up our lives here in a way that is the amazement of the developed world."

Marilyn Moon, director of the health program at the American Institutes for Research, says that when Medicare's problems start getting Washington's attention, beware of anyone promising a simple solution.

"This is not something that is going to be taken care of by the magic bullet everybody is always looking for," she says. "It's not a problem that can't be taken care of, it can be. But taxpayers is going to have to take a crowbar to their wallets. ..."

"If you want to pay Kmart prices, you are going to get Kmart health care."

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