A More Efficient System

The debt ceiling has finally been raised and once again no real solution has appeared to handle our ballooning debt. Most notable, all cuts are discretionary spending and none will be applied to the true beasts of Medicare, Medicaid and Social Security. The debt deal cuts two and a half trillion over ten years, assuming spending stays the same over the time, is less then ten percent of our future budget (CBO, 2011). President Obama called this a “Serious down payment.” For most of us buying a house or car, a “serious down payment” includes more than six percent down. Even the “bold” plan that was proposed by the President of four and a half trillion in reductions was still far from a balanced budget. The reality is that there cannot be a true balanced budget without changes made to entitlements, a hard fact to swallow, especially for politicians.

Publicly funded insurance and payments to the elderly are growing at a rapid rate. With baby boomers reaching the golden age it is already beginning to strain both systems. Politicians can no longer use social security revenues to balance their budgets and now may need to start puling money from their discretion and use it towards supporting our elders. The good news is that there are a few fixes to Social Security that, while not being popular, could bring solvency to the system without hurting our seniors. Proposals such as removing the cap of taxable income for wealthier earners and raising the retirement age, or making it more flexible, will go a long way.

Healthcare through Medicare is a completely different animal. When care was cheap and money abundant, our tax dollars went a long way to insuring the health of citizens, but as the cost has been growing at more than twice the rate of inflation (Peters, 270) it has quickly come to a point where our tax dollars are not able to keep

up. This has caused many cries for change, all of which are unpopular and most likely will result in an increase in cost to the individual receiving care.

When Lyndon B. Johnson signed Medicare into law in 1965 I doubt he could predict the strain this would put on the taxpayers forty-five years later. In the first five years Medicare stayed below the one percent of our Gross Domestic Product, however in 2005 it was well over two percent and rising (CBO,2005). This helps us realize the growth of the expenditures compared to the revenue coming in. Over time this includes changes to the system, both extending coverage and limiting it.

Some of the measures taken have been the Medicare Secondary Payer Act of 1980 that helped Medicare seek reimbursement on behalf of the beneficiary. In 1988, Congress passed the Medicare Catastrophic Coverage Act of 1988 that relaxed many limits and removed caps on coverage (CBO, 1988), but most major provisions were repealed in 1989 (Kaiser Family Foundation, 2009). The Clinton Administration further cut Medicare in the Balanced Budget Act of 1997 by reducing spending on Medicare, raising premiums and establishing the Medicare+Choice program. The Republican controlled Congress and the Bush Administration signed The Medicare Prescription Drug, Improvement, and Modernization Act in 2003. This act created a new Part B option, provided an outpatient prescription drug benefit, and provided various incentives for private health insurance plans to contract with Medicare. The most recent change to Medicare has been Barack Obama's Patient Protection and Affordable Care Act (PPACA) of 2010. This was actually later amended the same year through The Health Care and Reconciliation Act.

PPACA was a huge overhaul to the entire healthcare system, although many say not enough, which included changes to Medicare. One important change is that it intends to close the “doughnut hole” in Part D care for prescription drugs over time. It also provides incentives through a ten percent bonus to doctors that move to underserved areas, which as Peters points out (269), is a major problem. There are many provisions in the bill that attempt to put improvements to the Medicare system. One is to start a pilot program aimed at saving money through a bundled payment for services, another offers incentives to physicians to practice more preventative care. A final improvement based provision establishes a value-based payment program to encourage hospitals to improve their quality by paying out less for lesser quality care (Kaiser Family Foundation, 2011).

Many cost savings measures are attempted for Medicare in this Act as well. A restructuring of the Medicare Advantage plan will begin and be fully implemented by 2019. It freezes the income threshold for Part B plans until 2019 and then lowers the subsidy for Part D holders to couples that earn under one hundred and seventy thousand dollars a year. As is always popular in Washington, a committee was created called the Independent Payment Advisory Board is created to offer recommendations on further cost saving measures. The bill goes on to reduce Medicare Disproportionate Care Hospital payments and instead increase payments to hospitals based on uninsured users and uncompensated care provided. Perhaps one of the most important keys is that it allows health care providers share in the savings by becoming an “accountable care organization,” which allow better oversight to prevent price gouging. The bill eliminates the Medicare Improvement Fund but creates Innovation Centers to

test new ways of payments to improve care while reducing expenditures. Finally, payment reduction programs to reduce payments based on preventable readmissions are made and hospital acquired conditions, beginning in 2012 and 2014 respectively (Kaiser Family Foundation, 2011).

There are four main parts of Medicare commonly referred to as Part A, Part B, Part D, and Medicare Advantage Plans also called Part C. Part A is for Hospital Insurance and Part B is Medical coverage. Part D was created in 2006 to cover Prescription drugs when it was removed from Parts A and B. Medical Advantage plans are private insurance plans subsidized by Medicare, an outcome from The 1997 Balanced Budget Act.

Part A coverage will cover inpatient stays, food, tests and doctors fees when staying in a hospital. It will also sometimes cover skilled nursing facilities depending on the circumstances. Currently the plan will cover skilled nursing homes for a certain amount of time with a fraction of it fully covered and the rest of time it will require a co-payment. A person will be eligible for coverage of a skilled nursing home again after not receiving any care for a period of sixty days or longer.

After the deductable is met for Part A, Part B will kick in to cover about eighty percent of services. Part B will also cover things that Part A does not. It is most often used to cover doctor's visit treatments and tests. When you see the Scooter Store advertisements on television stating Medicare will pay for your new scooter, if is often covered by Part B.

Part D was created with the Medicare Prescription Drug, Improvement, and Modernization Act. A patient must be enrolled in an Advantage plan or a Private Drug

Plan. There is a lot of criticism of a so called “doughnut hole” in coverage. After the covered patient racks up three thousand and five hundred dollars in prescription drugs they must pay out of pocket for the next thousand and then the coverage kicks back in. However, as I pointed out earlier the PPACA will slowly fill the hole by 2019.

Medicare Advantage was a large shift in the outlook of Medicare. This outlook resides with many politicians today to completely privatize the system. It almost doubled in Enrollees between 2003 and 2009 (Kaiser Family Foundation, 2009). This popularity may be due to the government’s generous payment system. The payment system works with a bidding system based off a formula in statute. If the bidding stays below the cap then the bid is accepted and three fourths of the difference is kept by the insurer and the remaining fourth goes to Medicare. Paul Ryan’s proposal to privatize Medicare and offer vouchers would include many provisions from the Advantage program.

House Appropriations Chairman Paul Ryan introduced a budget bill that would set up a voucher program in Medicare for 8,000 dollars per year to purchase a private healthcare that would rise with consumer price index to urban consumers (CPI-U) for inflation (Kaiser Family Foundation, 2011). This sounds like a lot of money for a healthcare plan, however with healthcare costs double normal inflation and seniors being such a high-risk pool, it may not be enough to keep up with covering the costs of premiums. I suppose the idea may be that if seniors can’t afford to pay so much for their insurance that insurers will compete and lower their costs. That outcome may hold true to an extent but I cannot imagine it would alone bring medical costs in line with normal inflation. Compared to most developed countries our health care is definitely one of the most market based healthcare systems that exists, however, our payment as a

percentage of Gross Domestic Product is the second highest in the world, second only to the Marshal Islands (go figure) (World Health Organization). Most European Nations lie in the ten to eleven percent range compared to the sixteen percent that the United States spends. This is evidence that a free market system is not working to lower costs and freeing the market more likely will not have Chairman Ryan's desired effect.

Another issue is once you receive your healthcare using the voucher, what kind of health care is it? Will it cover the prescription drugs needed for your condition? Tony Carrk claims that it will double the cost of health care on seniors which would be more than a great majority of seniors could financially absorb. From the research I conducted the bill does not stipulate any specific standard of care for recipients of medical coverage. It appears that again Chairman Ryan is depending on the market and competing insurers to provide the most service for the amount equal to the voucher received. Again, I have little faith in the industry to provide good service without regulation considering the trend of the past half-century.

Further, Ryan's proposal would raise the Medicare eligibility age two more years to sixty seven starting in 2022. This would bring it in line with Social Security and relieve some stress on the system. Since seniors are continually living longer it makes sense to start to roll back the age a little to compensate for the extra time added on towards the end of their lives. Theoretically if you are living longer, you live a healthier life and probably wont need medical attention until later. However eligibility must not be moved back later then the expected retirement age for seniors otherwise there will be a gap between the time the retiree leaves their job and lose their insurance coverage and the time Medicare will be there to help them pick up the tab in case of an emergency.

The impact on seniors if Ryan's H. CON. RES. 34 was enacted is fairly consensual. Seniors will pay more. Although Mr. Carrk's statement may be worst-case scenario, his point is well taken and provides an outlook for what it is worth. The CBO estimates that in 2030 a senior would pay sixty-eight percent of their "benchmark" compared to the twenty-five of the "extended baseline scenario" and thirty percent in their "alternative scenario." In fact in the letter to Congressman Ryan on April fifth from the CBO states "private plans would cost more than traditional Medicare because of the net effect of differences in payment rates for providers, administrative costs, and utilization of health care services (Douglas Elmendorf, 2011)."

This is exactly the opposite of what needs to be done. Before healthcare costs became so expensive everybody loved Medicare. Medicare is not the problem, it is the cost of the service that Medicare is providing that is the issue. Making healthcare cheaper for everyone should be the main goal. As the CBO stated, Paul Ryan's proposed plan will only raise costs not only for seniors but effectively all Americans. If a reduction in cost were to occur, or at least a reduction in the growth rate, it would relieve the strain on our budget. At this time Medicare costs are expensive but are manageable, most politicians and analyst fears are for the future, not present expenditures. Getting medical inflation in line with CPI is a valiant goal if reductions in costs are not attainable.

Managing the costs of products or services is a taboo topic in the United States. Many fear it too closely resembles Socialism and are afraid to move toward a more nationalistic approach to providing healthcare for our citizens. We can see this in the staunch opposition to President Obama's original proposal for PPACA that included a

public option with managed costs to help in providing a competitive premium for patients. The intent was to have the government regulate the price so that private insurers would have to keep theirs low to still compete against the public option. However as the bill moved through the democratic process it became obvious that the President could not get enough support in the Senate.

Another option is to take measures to reduce administrative costs. As Frontline: Sick in America points out the Americans spend twice as much in administration costs then Canadians. Twenty six percent of all money spent in the health industry is on administering. More than a quarter of our expenses are not directly being provided to patients at all. If there were a way to start to reduce the ratio of administrative costs versus services and equipment, efficiency would grow tremendously.

Designing cheaper medical equipment could make a tremendous difference in total costs. In Japan, because of their strict price structure for medical care, a MRI machine was designed for the fraction of the price of traditional ones to allow cash strapped doctors to install one in their business (Frontline: Sick Around the World, 2008). Since it is common practice for hospitals to want their own expensive equipment, reducing the cost of this equipment would make that much more of a difference.

TORT reform for malpractice lawsuits is another option for government to take to provide more protection for doctors against frivolous lawsuits. Currently a doctor buys insurance for malpractice lawsuits so they have piece of mind that they wont go bankrupt because of an incidental mistake or even a situation out of their control. Doctors have to reflect their insurance premiums in the price of their services, which raises our price to see the doctor. However, the premium may be a fraction of the real

cost of malpractice lawsuits. Doctors will also put patients through numerous tests and scans that may be unnecessary to insure that they have proof to show that they took extra precaution if a lawsuit should come up (Peters, 272). Of course these extra tests are directly reflected in insurance premiums.

More emphasis on preventative care would not only reduce emergency healthcare costs but also would improve the general health of Americans. People need to take better care of themselves, whether it is eating healthy or seeing a doctor in a timely manner when they are aware of a health issue. The PPACA has a provision to encourage this in Medicare, we can only wait to see if it makes progress in the right direction. One issue is that there is not a profit to be made from preventing sickness by private businesses so this is an area that government should take action, especially since it will directly affect their costs in providing Medicare and Medicaid.

Through many of these changes our government could curb the rampant inflation of healthcare and reduce the cost for all Americans instead of only reducing the cost to itself in Medicare and Medicaid. If the latter path is taken then the result cannot be anything more than higher costs for our seniors and poor. This would be an irresponsible step to take in an ever-threatening sector for the people who have sacrificed so much for us.

The CBO has certified Chairman Ryan's plan as a deficit closer and debt reducer. However amazing Republicans will tout this plan though it does not produce a surplus in the budget until 2040. It is an extremely long term goal, which is not bad because there are rarely long term goals coming from Washington, however, I worry that the burden of a balanced budget shouldn't be put on our senior's backs. It is

thoroughly clear that even though H. CON. RES. 34 makes the voucher indexed to inflation that it would still result in more out of pocket costs for those who rarely have money to spare. Reduction in cost, whether for seniors or children, to get medical attention is what is needed to curb Medicare costs, make healthcare more available to all, and improve the future and health of our country.

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