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***Medicare: What do we do with it now?***

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**For:**

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Synthesis

## *Medicare: What do we do with it now?*

In 1965, President Johnson created a government-funded program that would help the elderly with the rising cost of health care. This program was called Medicare. The Medicare program was designed to lower cost of health care for the elderly. President Johnson did not predict on the population explosion of the elderly due to the baby boom. For example, in 1981 there were 21.5 million people enrolled in the Medicare program. In 1995, the number has risen to 22.6 million people. <sup>That's not too very big ↑.</sup> And, the enrollment of within the program will only rise. ([WWW.cdc.gov/nchswww/ssbr/hus96136.htm](http://WWW.cdc.gov/nchswww/ssbr/hus96136.htm))

The Medicare program began in 1965 to help provide health care services to the elderly. The program design in the 1960's was built on acceptability. The most appealing group in which to provide coverage was the elderly. Seniors at the time used almost twice as much medical care as young people, those between the ages of 22 – 55 years of age. Much like today, the elderly is on limited resources more so than the rest of the population. Private insurance was available but was so expensive that most individuals could not afford the high premiums. Group insurance plans were mainly used for the working population and did not extend services to the elderly. What little coverage the elderly population received was inadequate to meet the demands the elderly needed. Medicare was given its first title in 1956 when it was used to cover military personnel and their families. In 1965, the Medicare enactment provided a program to help cover the high costs of health care similar to the insured participant. When the Medicare program was being implemented, hospitals became concerned about what was

This is not true. Elderly are above average for income.

going to happen to “hands on” education to the elderly. Most elderly people were willing to follow student recommendations as long as the students were under the supervision of doctors. With Medicare in place the government believed that they should cover every bill obtained by the participant. The government soon found that the bills were escalating too fast, because of the increasing elderly population. The government soon amended the original recommendation. Medicare has been through many changes in the last thirty-three years, but in order to continue the programs into the twenty-first century there must be changes.

There are two parts to the Medicare program. Part A of the original Medicare program required no premiums if you or your spouse paid Medicare taxes while working. Part A of the program covers hospital bills for the elderly and disabled persons in this country. Money for Part A is obtained from the Medicare Trust fund. This Medicare Trust fund is currently projected to go bankrupt by the year 2010. The number of baby boomers approaching the age to enroll in Medicare is increasing such that, the Trust fund could be depleted sooner than projected. If the costs of Part A continue to escalate, then it is estimated that almost 20% of the taxable payroll will be used to cover Part A of the Medicare program. (Consumer Research Magazine, Feb. 1998).

Part B of the program is not currently at risk for financial trouble. The money for Part B is generated from the participant’s premiums and through money obtained from the General Revenue Fund. Part B strictly covers doctors’ bills and outpatient services. This part of the Medicare program is set up on a pay per visit schedule. The original program was set up to allow participants to seek care from hospitals, doctors, or other health care providers of their choice. This allowed freedom of choice by the participant.

The system is currently seeking network providers with more focus on HMO, Health Management Organization, style of health care. What this results in is that beneficiaries have to seek doctors within a specific health care network for the cost to be lowered to the beneficiary. Currently, Part B is responsible for covering services such as physical therapy and speech therapy. Part B can be used in a hospital setting, nursing homes, or at the home of the patient. Individuals who qualified for Part A automatically qualify for Part B. Part B is strictly voluntary to the participant. If individuals were qualified for Part A, they do not have to participate in Part B even though they are eligible for the benefits. For those individuals who do not automatically qualify for Part B, they can purchase Part B for \$43.80 per month. This money will automatically be deducted from the individuals Social Security benefits, Civil Service benefits, or their Railroad Pension.

The original Medicare plan pays for a large portion of the medical expenses, but requires the participant to pay for prescriptions, yearly physicals, dental care, and hearing aids. This is only a small portion of items that are not covered by the Medicare program. Part B currently accounts for 5.8% of the taxable payroll. This number will continue to rise as medical cost increase and as more individuals enroll in the Medicare program. According to the April 1995 issue of The New England Journal of Medicine, the estimated average lifetime payment for a participant turning sixty-five in the year 2020, with a 1996 income level, was \$54,326. This is not a very big difference when looking at an average in 1990 dollars only. The total payments for those turning sixty-five in 1990 were \$112 billion and \$210 billion for those turning sixty-five by 2020. This is an escalating number within a thirty-year time span. The larger figure is due to participants

living longer, requiring more medical treatments, and how medical advancements continue to compound monetary requirements.

As mentioned previously, the population of the elderly is on the rise due to the baby boomers reaching the age of 65. This leads into a critical depletion of the Medicare Trust fund. In the 1992 fiscal year, the federal budget was approximately \$1.5 trillion. The generated taxes for the same fiscal year was \$1.1 trillion. This leads to a \$400 billion deficit for the 1992 fiscal year, which is added on to the \$4 trillion accumulated debt.

The government must operate on a daily schedule and they depend on the revenues generated from tax dollars. Thus, the term deficit financing was created. Deficit Financing is the art of creating a budget with more expenses than income generated and forcing increased production of currency within an economy. The U.S. government is

over

masters of this type of financing. Only one-third of the budget is allocated for discretionary spending, which must be approved by the congressional and executive branch. The remaining two-thirds of the budget is obligated to mandatory programs, Social Security, Welfare programs, Medicaid, and Medicare. Of the two-thirds of this budget, only \$300 billion goes to Social Security, the remainder of the budget goes to the other mandated programs an estimated \$4.33 billion. (Kerrey & Hofschire, March 1993,

262.) This type of money management can only lead into an increased deficit, which in

turn increases the accumulated National debt.

NOT TRUE. Deficit occurs if spending > tax revenue. Even if 2/3 of the budget is non-disc. A deficit may not

Living in a free market system, we, as consumers, demand increased services and occur is disc. spending is ↓ or taxes ↑ - as has happened recently in U.S.. the willingness from providers to deliver these services to us. This only compounds the

rising spiral of health care cost. As the elderly live longer due to medical advancements in treatments and diagnosis, Medicare is the expected partner for financial aid to the

Deficits don't have to be financed by  
↑ money supply.

elderly. Individuals want increased utility from their health care in order to live a long and happy life. To prevent any loss in utility through illness or disease, the elderly need to seek out the best health care available. Unfortunately, this type of health care does not come with out a price tag. The downward spiral of Medicare funds means the elderly must turn to other sources of income to fulfill the rising cost of health care. Medicare can not be expected to help the elderly in the near future due to loss of Medicare funds.

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In the Subcommittee Hearing on Health Care February 12, 1997 on the topic of the Magnitude of the Financial Crisis in Medicare, the opening statement by Senator Phil Gramm states that within four years of date, the Medicare Trust Fund will be depleted. In addition, the Senator states that within the coming decade the Medicare Trust Fund will accumulate an estimate of \$600 billion debt. This type of debt puts a strain on not only the elderly expecting Medicare to help pay for some of the health care cost, but also to the United States' economy. This debt will only add fuel to the fire of the national debt.

Medicare covers 97% of the elderly in the United States (Subcommittee Hearing on Health Care, February 12, 1997. 4). This type of participation within the Medicare Program is reason enough to prevent the bankruptcy of the Medicare programs. But to address this problem, Medicare must look into problems that inflict harm to this health care program. Such problems include "cost-shifting", malpractice, medical training, and technological development. These factors must be investigated before deciding on a course of action. (Kerrey & Hofschire. March 1993. 263)

"Cost-shifting" is the common practice by hospitals to charge paying patients more in order to pay for the services received by those individuals who can not pay for the services rendered. We as consumers must protest this type of financial logic to

VJ

cost-shifting to mandators by a # of laws.

prevent our cost from rising due to those unable or unwilling to pay for services rendered.

But, no individual is ruthless enough to prevent an individual from receiving medical attention that is needed to save his or her life just because the individual can not pay for the service. Thus, we as consumers must reach a compromise with hospitals in order to lower our cost and to prevent "cost-shifting." (Kerry and Hofschire, March 1993, 263)

Technological development is the creation and the use of advanced medical techniques for treating illness and disease. But, at what price are consumers willing to stop medical advancement? The answer is none. Consumers want technological advancement in order to increase our health, prevent illness, and to create new better treatments for diseases. By increasing our health, we increase our utility. Thus, we are happy. All tech. development? Technological development is wanted. (Kerry and Hofschire, March 1993, 263)

A topic that consumers do not think about when dealing with health care is the rising cost of medical training. The U.S. government promotes young students to seek out medical training. The way the government promotes this by means of increasing the amount of subsidies given to deserving medical students. This in turn lowers the cost of attendance at medical schools and other health care institutions. The amount of subsidies given to students in order to pay for schooling creates a loss in government funding to other government medical programs, such as Medicare. Consumers are willing to accept this loss in order to keep a steady supply of medical specialists, doctors, nurses, physical therapist, etc., to meet the high demand for medical services. But, the cost of education of these students has led to a higher cost on delivery of medical attention (Kerry and Hofschire, March 1993, 263).



Of the four topics that are problems for Medicare “cost-shifting”, technological development, medical training, and malpractice, only malpractice can be controlled. Health care malpractice is a major health care issue that concerns all. Doctors and nurses who cause medical malpractice by either an accident or purposely create huge cost and fees for the medical society and consumers. We as consumers must lobby government to establish stricter laws and larger fines for medical personnel that cause malpractice.

(Kerry and Hofschire, March 1993, 263) *why don't you think the current system works?*

What do these issues mean to Medicare? These issues create increased financial burdens to Medicare. Individuals who are enrolled in Medicare and seek medical attention and can not pay for the services cause a “cost-shifting” of funds. Hospitals, in order to cover their losses, then charges other patients and the government more money to cover the cost of an individual unable to pay for the medical services rendered.

Technological advancements cost money to research and develop. Once new treatments and advancements are proven safe to the public, patients who use the medical advance service, pay more for the medical service. Medicare participants who also use the advancement pay the same amount as others, but Medicare pays the majority of the services. Government subsidies for medical training and the higher cost for delivering medical care is also a major financial burden for the Medicare program. Malpractice is a

financial nightmare. All four of these issues cause Medicare to not only pay for the original treatments and services but also the additional treatments and services to correct the problem. These are a few of the problems that must be answered before developing a positive solution to the growing Medicare debt.

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why?

JS

To prevent the Trust funds from going bankrupt, Congress must shift more of the costs to those participants who pay premiums for Part B of Medicare. The biggest change to decrease spending is based on the new Medicare +Choice option. This new option shifts Medicare from a social program to a contribution plan. The new program is focusing on HMO's, fee for service, Provider Sponsored Organization (PSO), private contracting, and medical savings accounts. In order to pick the service that best fits the individuals health care needs, the individual needs to make a choices from the above new services mentioned. Then the individual must chose the service(s) that provides the best care for the individual's health care needs with as little out of pocket costs as possible.

Another answer to the Medicare financial problem is a program called Medigap, recommended by the AMA, American Medical Association. The Medigap Plan C program is an extension of Medicare Part B. First Medicare would have to raise its enrollment age to 67 years old. The Medigap and Medicare works together to generate revenues and lower cost. What this program does is to collect a deductible, and use this deductible to pay for the first dollar of health care. This neutralizes the first dollar charge for Medicare. This would produce a savings of \$273 per beneficiary. In the long run, this would generate a \$8 billion dollar revenue for Medicare per year. This money can go to Medicare Part A to aid in its financial crisis. (Bristow, 1997, 306 - 308)

There are many economic problems that Medicare suffers from. From "cost-shifting" to medical training to the ever expanding population of Medicare participants, Medicare is a growing problem. We, as consumers, must lobby the government to find a solution to this problem. Not just to maintain Medicare for the present participants, but to keep this great program going for future generations.

↳ which of these 2 proposed  
"solutions" is better. You should  
provide some analysis.

Medicare has grown from a \$5 billion dollar program in 1966 to a \$180 billion dollar program for our nations elderly (Bristow, 1997, 303). This number has risen due to the following reasons; increased enrollment by the elderly into the Medicare program, increased life span of the elderly population, the increased cost of medical advancements, increased cost in medical training, and the higher cost of medical delivery to participants of Medicare. This list can go on-and-on. In addition, there will be only a growing increase in the number of participants enrolled in Medicare due to the baby boom explosion. The government must recognized this problem and find a solution to the Medicare problem.

In conclusion, the Medicare program has been a successful program for providing healthcare for the elderly. This program has allowed access for the elderly to receive and be delivered the latest high-quality health care available. (Lave, 1996, 19) Although, there is still a need to solve the growing problem of how to fund Medicare in the long run. Our concern for Medicare is how to increase revenues to keep Medicare operating on a daily basis for now and for years to come. There have been mentioned many different economic problems that have lead to the demise and lack of funds to operate Medicare. In addition, there have been many different ideas on how Medicare can be saved and taken out of debt. Thus, it can be concluded that Medicare can be solved. *Really?*

From a quote from AMA's Immediate-Past President Lonnie Bristow, "Medicare. Protect it for our parents. Save it for our kids. And above all do it. Do it now." (311).

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## General Comments

The paper reads somewhat chaotic, partially because your topic was never defined very well. The paper also lacks any meaningful analysis ~~of~~, especially of alternatives.