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Medicare Must Adapt for Aging Baby Boomer Population

J. Paul Nielsen

Sustained growth in Medicare expenditures and the aging of the "baby boom" generation are placing growing strains Medicare's financial sustainability.¹ Unless the system is drastically changed, the funds drawn upon by Medicaid users will run out in less than 10 years.¹ Since Medicare was established in 1965 to provide insurance for the elderly and handicapped, the benefits offered by Medicare have scarcely changed except for a few added preventive services.^{2,3} Similar to the Social Security program, Medicare is grounded in the principle of social insurance. Employers and employees are required to make payments to a trust fund that provides for medical care for the elderly and handicapped. Medicare spent \$215 billion in 1997 as part of two divisions: Part A for hospital services and Part B for physicians' services. These two divisions are funded from four separate sources: contributions by employers and employees, general tax revenues, premiums paid by beneficiaries, and deductibles and copayments.³

Medicare's Part A Hospital Insurance Trust Fund is provided for by the hundreds of millions of employees that plan to receive the benefits during retirement. The money paid by employees to the Hospital Insurance Trust Fund is not directly saved for their own personal future health expenses. Instead, it covers the medical bills of the people who are currently enrolled in Medicare. Eligible citizens are automatically enrolled in Part A, which pays for inpatient services, continued treatment or rehabilitation in a skilled-nursing facility, and hospice care for the terminally ill.³

Part B of Medicare is voluntary but almost everyone enrolled in Part A is also in Part B. Part B provides for physician services and outpatient services, including but not limited to emergency room visits, ambulatory surgery, diagnostic tests, laboratory services, and medical equipment. Medicare pays 80% of the pre-approved amount for covered services in excess of an annual deductible of \$100. Currently, 89% of Medicare's revenue comes primarily through payroll taxes, income taxes, and interest on the trust fund from people not enrolled in the program, and 11% comes from the monthly premiums contributed by elderly beneficiaries.³

Under current practices, the Center for Medicare and Medicaid Trustees estimate that the Part A Hospital Insurance (HI) Trust Fund will only remain solvent until the year 2018. The proportion of HI costs that can be paid by HI tax income is projected to decline over time as costs continuously inflate. This cost growth is due to continuing increases in medical utilization via an aging population and an increase in the intensity of services. Income cannot match cost growth as the number of Medicare beneficiaries increasing much more rapidly than the number of workers. Today, there are 3.9 workers for every beneficiary; by 2030, there will only be about 2.4 workers for every beneficiary.¹

In their defense, Medicare is currently attempting to reduce costs. Improved access to Medicare Advantage plans can save beneficiaries around \$100 a month through promoting care coordination and prevention. To better control costs, Medicare plans to shift focus to prevention of complications and getting the right care to each patient. Additionally, Medicare made available Health Savings Accounts in 2007 to give people favorable tax treatment for accounts used solely for medical expenses. The disadvantage of such accounts is that to be eligible you must

be enrolled in a healthcare plan with a deductible of over \$1000 for self coverage or over \$2000 for family coverage.¹

On January 1, 2006 Medicare's new Plan D prescription-drug coverage plan was launched. The new plan reimburses purchasing from stand-alone private drug plans that work with the traditional Medicare program or with the Medicare Advantage plan. Plan D is more flexible than A and B and allows for customization of benefits. The "standard benefit" defined in the statute is a \$250 annual deductible, followed by 75% coverage for the next \$2,000 in drug costs, then by a "doughnut hole" in which patients pay the next \$2,850 in drug costs, and finally by catastrophic coverage for 95% of any further prescription-drug costs in a given year. Thus far, many beneficiaries have elected to modify their plans, as only 17% of beneficiaries electing a free-standing prescription-drug plan and 5% of those electing a Medicare Advantage plan selected the standard benefit. Conversely, 78% of beneficiaries opted for plans with no deductible, and 18% elected a plan that offered some coverage in the doughnut hole.⁴

Competition is providing better coverage options and producing lower costs than anticipated for beneficiaries and taxpayers. As of April 2006, the average monthly premiums for beneficiaries were 32% less than predicted. The overall cost to taxpayers for 2006 has dropped by about 20% from the mid-session estimates from last year. These savings are a direct result of the negotiating leverage and access to information on how much a beneficiary can save by switching to a generic or preferred brand-name drug.⁴

Critics have charged that unlike existing government health plans, Part D does not allow Medicare to directly negotiate drug prices with pharmaceutical companies. As a result, these companies may be charging taxpayers up to 80% more for drugs purchased under Part D than for those purchased under other plans.⁵ Government sponsors of the plan point out that the increased savings and decreased costs of drugs and premiums speak for themselves.⁴ Although more than 31 million beneficiaries are now enjoying the drug benefits, we must ensure that choices are available and easy to comprehend and that formularies provide a broad range of therapeutic options at a reasonable cost to patients.

So Medicaid has made some attempts to reduce costs, but will such reductions be adequate to maintain coverage of seniors as the population ages? To maintain coverage I believe that we will need a substantial restructuring of the funding for programs like Medicare. Perhaps a nationalized healthcare plan would help alleviate the financial strain on Medicare programs.

REFERENCES

- [1] "Centers for Medicare and Medicaid: 2006 Medicare Trustees Report." *CMS Office of Public Affairs*. 1 May 2006. Accessed 3 May 2007. <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1846>
- [2] Shi L and Singh DA. 2004. *Delivering Health Care in America: a System Approach*. 3rd ed. Sudbury, MA: Jones and Bartlett Publishers.
- [3] Iglehart JK. 1999. Medicare. *N Engl J Med*, 340: 327-332.
- [4] Bach PB and McClellan MB. 2006. The First Months of the Prescription-Drug Benefit -- A CMS Update. *N Engl J Med*, 354: 2312-2314.
- [5] Slaughter LM. 2006. Medicare Part D -- The Product of a Broken Process. *N Engl J Med*, 354: 2314-2315.