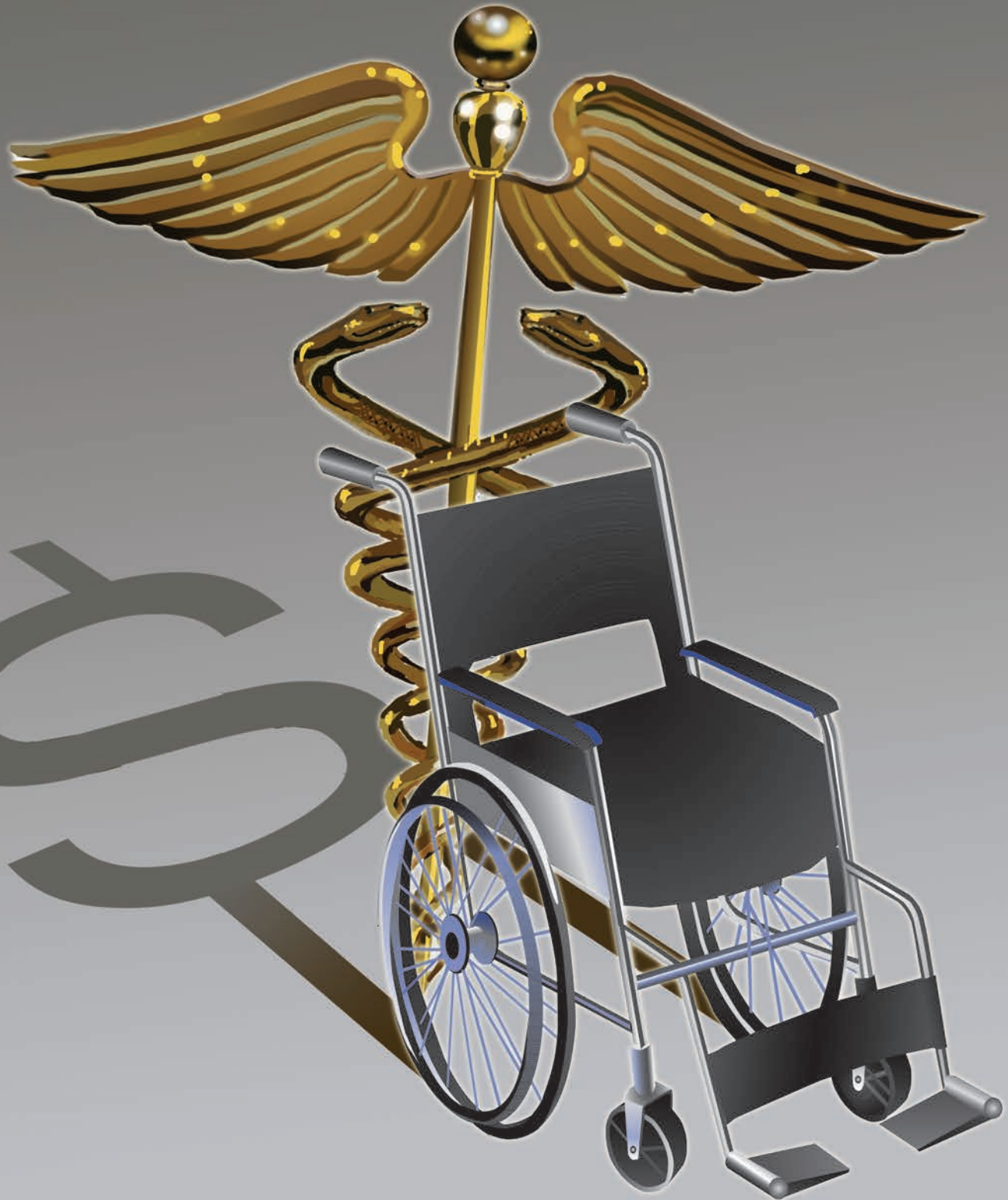




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>> Medicare and Medicaid How Can We Afford Them?



About This Issue Guide

Current national budget problems, have shone a spotlight on one of this nation's biggest expenses—Medicare and Medicaid, government supported health care for Americans who are retired, in poverty, or disabled. Deliberative forums on this issue will not be easy. It will be important to remember, and remind participants, that the objective of these forums is to begin to work through the tensions between collective well-being, individual responsibility, and our responsibility as a compassionate society.

Participants in these forums may become angry. Those with strong feelings may feel attacked by those who hold other points of view. This can sidetrack the deliberation. In productive deliberation, people examine the advantages and disadvantages of different options for addressing a difficult public problem, weighing these against the things they hold deeply valuable.

The framework in this issue guide presents several options as an alternative means for moving forward in order to avoid polarizing rhetoric. Each option is rooted in a shared concern, proposes a distinct approach to addressing the problem, and includes roles for citizens to play. Equally important, each option presents the drawbacks inherent in each action. Recognizing these drawbacks allows people to see the trade-offs that they must consider in pursuing any action. It is these drawbacks, in large part, that make coming to shared judgment so difficult—but ultimately, so productive.

One effective way to hold deliberative forums on this issue:

- Ask people to describe how Medicare and Medicaid have affected them, their families, or their friends. Many of them will have had direct experience and they are likely to mention the concerns identified in the framework.
- Consider each option one at a time, using the actions and drawbacks as examples to illustrate what each option entails.
- Review the conversation as a group, identifying any areas of common ground as well as issues that still must be worked through.

The goal of this issue guide is for people to move from initial reactions to more reflective judgment. That requires deliberation, or weighing options for action, against the things people hold valuable.

The National Issues Forums Institute

This issue guide was prepared for the National Issues Forums Institute in collaboration with the Kettering Foundation. Issue guides in this series are used by civic and educational organizations interested in addressing public issues. These organizations use the books in locally initiated forums convened each year in hundreds of communities. For a description of the National Issues Forums, log on to the website: www.nifi.org.

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Recent topics in this series include economic security, higher education, bullying, and US politics. For more information, please visit www.nifi.org.

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*Medicare and Medicaid:
How Can We Afford Them?*

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ISBN: 978-1-943028-07-8

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Founded in 1927, the Kettering Foundation of Dayton, Ohio (with offices in Washington, DC, and New York City), is a nonprofit, nonpartisan research institute that studies the public's role in democracy. It provides issue guides and other research for the National Issues Forums. For information about the Kettering Foundation, please visit www.kettering.org or contact the foundation at 200 Commons Road, Dayton, Ohio 45459.



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>> Medicare and Medicaid How Can We Afford Them?

FOR MANY PEOPLE, MEDICARE AND MEDICAID, the main public health-care programs in the United States, are an important safety net. Medicare provides health care to seniors and people with disabilities. Medicaid provides health care to people in poverty, many of them working families and seniors. These two programs make up nearly half of all health-care spending in the United States.

Nearly everybody will, at some point, get sick and need the help of health-care professionals. Finding the resources to cover these public programs is an ever-increasing challenge at a time when our national debt is at an all-time high. Ultimately, all Americans—policymakers as well as citizens—will have to face painful decisions about reducing the cost. This may mean fewer choices in health care for the tens of millions of people enrolled in these programs. The choices are difficult; the stakes, enormous.

The United States established both Medicare and Medicaid in 1965 as a way of addressing the needs of seniors and the poor.

Medicare is the federal program that pays for health care for elderly Americans as well as for younger ones who are disabled. Everyone over age 65 is automatically enrolled in this program. It covers nearly 49 million people, of whom a little more than 8 million are disabled and just over 40 million are 65 years or older. In all 50 states, coverage is financed through expenditures from the federal government and payroll taxes. Medicare accounts for 15 percent of the federal budget.

Medicaid covers just over 68 million low-income Americans of any age. Individuals and families can get Medicaid coverage if their incomes are within a certain percentage of the federal poverty level. The cost is shared between the federal government and the states. The federal government

picks up between one-half and three-quarters of the cost of medical care, depending on people's income in each state, with richer states getting less money and poorer states getting more.

Although all states must offer a core set of services, Medicaid benefits, which take up about seven percent of the federal budget, vary widely. And although families with children make up most Medicaid enrollees, the program spends relatively little on them. In contrast, the elderly poor, many in nursing homes, take up nearly 25 percent of the Medicaid budget, and about 40 percent is spent on medical care for low-income disabled people.

Both programs have a big impact on state and federal budgets. The cost of these programs exceeds revenues. Spending on health care has increased during the recent recession with the number of Medicaid enrollees rising, along with the uninsured. Medicaid is now either the largest or second largest program in nearly all state budgets. Next to education, Medicaid is the costliest program for which states pay.

In addition, fraud and waste in medical care are big problems—the “Bonnie and Clyde” of the American health-care system, according to one government official, because they rob the system of needed dollars. By some estimates they account for nearly one-third of all medical spending. According to the Institute of Medicine, waste includes

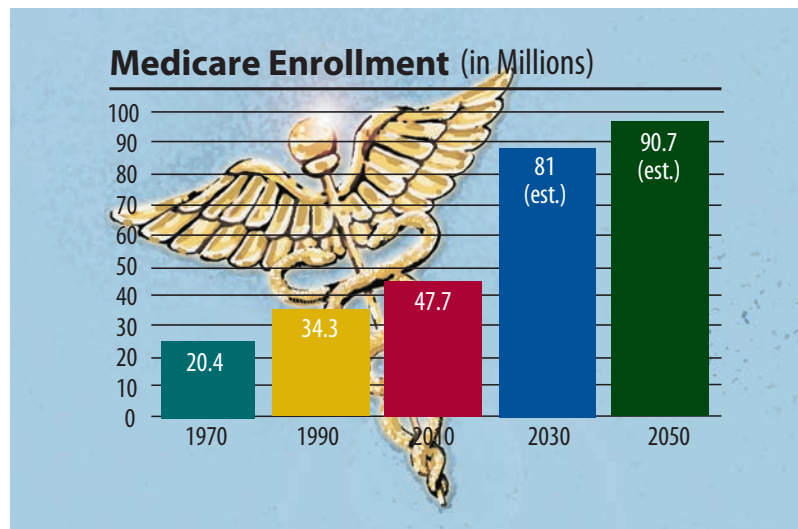
things like inefficiencies in processing claims, giving antibiotics when none are needed, and unnecessary testing.

Waste and fraud together cost the nation's health-care system an estimated \$750 billion. Of the two, waste is by far the biggest issue. It accounts for 90 percent of the dollars that don't add value to the system. Because Medicare and Medicaid make up nearly half of American spending on health care, reducing fraud and waste are priorities.

There is little doubt that both programs will continue to need more resources. The huge generation of Baby Boomers born between 1946 and 1964 began to turn 65 in 2011, qualifying them for Medicare. They will add around 1.5 million beneficiaries to the Medicare rolls annually for years to come, inflating the number of people covered by Medicare to 64 million in 2020 and 85 million in 2035.

The Patient Protection and Affordable Care Act, or “Obamacare,” addresses the problem of the many uninsured Americans by greatly expanding Medicaid and giving states more money to manage health care, among other steps. Many of the sickest and poorest Medicare beneficiaries are also covered by Medicaid, so that program, too, faces more challenges.

The question we must address is: How can we pay for these important programs?



Source: Board of Trustees, Medicare and Medicaid

We need to do what is necessary to continue the commitment even if that costs everyone more.



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>> Do What It Takes to Maintain Our Commitment

THIS OPTION ARGUES THAT CARING FOR THE POOR, disabled, and elderly is fundamental to a compassionate society. We must do what is necessary to stabilize the finances of both programs, so they can continue serving present and future individuals—even if that means changing the rules.

The federal government pays one-half to three-quarters of Medicaid costs in each state. Even so, the rising expense has made Medicaid the second most expensive program after education in nearly every state budget.

Medicare expenses are shared, too. But the monthly premiums the elderly pay cover just a small portion of the price of Medicare. The federal government and workers' payroll taxes pay for the rest.

One way to help shore up Medicare is by gradually raising the age at which people qualify to enroll. It's not a new idea. "I don't think you can look at entitlement reform without adjusting the age for retirement," Senator Lindsey Graham, said on ABC's *This Week* in November 2012. "Let it float up another year or so over the next 30 years; adjust Medicare from 65 to 67."

This option says that it's an action worth trying. Instead of allowing individuals to automatically qualify for the program at 65, the government could raise the age even up to 69. With fewer medical bills to pay, the program would cost taxpayers less money. If the age of enrollment went up to age 67 between 2012 and 2021, the country would save \$148 billion, according to the Congressional Budget Office. States could also save money in their Medicaid programs by insisting that only the poorest people qualify for public coverage of health care.

Tax hikes may make sense

The most direct action the government could take would be just to raise taxes to pay for Medicaid and Medicare. Currently, employers and employees pay a combined total of 2.9 percent of wages to help fund Medicare. Those who favor raising the Medicare tax point out that the rate hasn't gone up since 1986, even though health-care costs have risen so they now amount to 17 percent of income.

Although, "You paid for it—you earned it," is a common rallying cry," Philip Moeller wrote in *US*

News and World Report. “Medicare pays far more in benefits than it receives in tax payments,” even for wealthy Americans. Medicaid, on the other hand, has no income stream from specific payroll taxes to pay for the cost of health care. Instead, the federal government allows states to impose “provider taxes” on hospitals, nursing homes, and other health-care facilities. Nearly every state uses such taxes to help pay for Medicaid. But if those taxes aren’t adequate to pay the bills, it only makes sense to raise them, this option says.

Another alternative in line with this option would be to ask retirees on Medicare and people on Medicaid to share more in the cost of coverage. Premiums currently cover just one-quarter of the cost of care. If the government raised premiums to cover even 35 percent of the cost, the federal government would save \$241 billion over 10 years, according to the Congressional Budget Office. That would be a big help in paying for the program. Instead of covering all retirees, more well-to-do seniors could get a voucher with which to buy either Medicare insurance or a private policy. That would bring the cost down for the government.

Sharing in the cost

Many states ask people on Medicaid to pay something toward their coverage. In nearly all states, those on Medicaid must cover the cost of copayments for drugs and for doctor’s appointments. Raising the price of copayments is another option to help states offset the cost of Medicaid. In recent years, many states have increased those copayments. Some Medicaid beneficiaries surveyed in Oregon even reported that it made them feel good to pay more for these services.

The main difference between covering the cost of health care for the poor and for older people is this: if you are poor you are covered as long as your income remains below a certain level. If you start making more money, you start paying for your own health care. However, seniors who have paid Medicare taxes during their working years are entitled to coverage, at minimal cost, no matter what their income level. That doesn’t strike everyone as fair. This option says that it is time to ask the well-off elderly to pay substantially more for Medicare premiums.



Under the Affordable Care Act, Medicare premiums will rise for seniors who make more than \$85,000 or couples who make \$170,000 or more. This would save \$30 billion over a decade. But limiting the price hike to this group will cover only five percent of seniors. Raising premiums for an even larger portion of well-off seniors makes sense, Option One argues.

Finally, one reason the government spends so much on health care could be because, unlike many insurance policies, Medicare and Medicaid coverage is unlimited. This option says that it is time for the government to impose a cap on how much it will spend on each person, as was proposed in 1995.

If the federal government imposed a limit for what it would spend on each Medicaid beneficiary, some argue that this would provide states with an incentive to reform their health-care systems to save money. People on Medicare would have an incentive to be wiser consumers of health care and might even purchase extra insurance if they needed it. A cap would be a constructive step toward reining in costs.

What we could do

Option One says that Medicare and Medicaid are valuable programs that express the priorities of a compassionate society: Seniors and people in poverty deserve health care at little or no cost. We

should do what it takes to make these programs financially stable, even in the face of rising health-care costs. Here are some things this option suggests that we could do, along with some drawbacks:

- ◆ The government could raise the age at which people qualify for Medicare and lower income levels for people to qualify for Medicaid so only the poorest people get help. These actions would save taxpayers' money.

But... *Either action would increase the number of people without insurance. It would put pressure on hospitals, which would face higher costs because fewer people would have coverage. Eventually, everyone would bear the higher costs of caring for the uninsured.*

- ◆ Higher-income retirees should pay most or all of the cost of Medicare coverage. (This is called means-testing.) Many older people who qualify for Medicare can afford to pay far more for premiums. As the rules now stand, even the very wealthy are

entitled to taxpayer-subsidized health care. This isn't fair, particularly since employees with lower incomes pay a portion of their salaries for elderly health care.

But... *Making Medicare an income-based program would erode the near-universal support that now exists for this program. Means-testing something as basic as elderly care would increase class divisions and may do more to divide us than to unite us.*

- ◆ Employers and employees could pay a higher payroll tax to better finance Medicare, since the tax hasn't gone up since the mid-1980s. States could ask those on Medicaid to pay a larger portion of the cost of services they receive.

But... *Forcing employers to pay higher taxes could result in fewer jobs, as employers cut back to reduce their tax burden. Many workers can ill-afford to pay higher taxes, and some are less well-off than the elderly their taxes support. The poor who get Medicaid may see more cost sharing as too difficult and will avoid getting needed medical care until their health is at risk—and even more expensive to address.*

These and other possible actions are summarized in the table on page 14.



OPTION TWO

Slowing down the rising cost of health care is critical to putting Medicare and Medicaid on a better financial footing.



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>> Reduce Health-Care Costs Throughout the System

IF FOOD PRICES HAD RISEN AS MUCH AS THE COST OF MEDICAL CARE since 1945, a bag of oranges would cost \$134, a gallon of milk \$48, and a dozen eggs \$55, according to a report from the Institute of Medicine. This option says that the problem with Medicare and Medicaid isn't just that enrollment is expanding. The problem is the rise in the cost of American health care. The cost of medical care overall must somehow be contained to put both programs on a sounder financial footing.

Waste robs health-care dollars

Experts in the cost of health care point out that an estimated one-third of American health-care dollars are wasted. Many doctors order more tests than are necessary. "Nobody ever gets sued for ordering too many tests," family physician Dr. Doug Campos Outcalt told the *Washington Post*. "If a doctor says, 'Let's talk about weight control,' patients aren't usually too happy," he said. "They feel like there should be some testing."

Some physicians also prescribe antibiotics even when the drugs will do little or nothing to improve patients' health, authorities say. Such practices contribute to the development of stronger strains of bacteria, which have greater resistance to overused drugs. This option argues that the need for prescribing fewer tests and antibiotics is so clear that

doctors should be required to reduce the frequency with which they order them.

The expense of many unnecessary tests and overuse of antibiotics motivated nine of America's top medical organizations to launch the "Choosing Wisely" campaign, which lists tests that physicians routinely overprescribe. The groups behind the campaign urged patients to discuss such tests with their doctors and challenge them if need be.

Reducing medical costs also might mean making difficult choices, particularly in patients' final days. End-of-life health care is frequently the most costly. This is no revelation for the residents of Royal Oak, Michigan, where, in 2007, patients had the distinction of receiving some of the most intensive end-of-life care in the country. Nearly 60 percent of chronically ill patients there saw as many as 10 doctors in the last half-year of their lives.

That type of intensive treatment is not only very expensive, but leads to a poor quality of life in a person's final days, experts say. Hospice care, which is designed to enhance dying patients' medical, emotional, and spiritual needs along with those of their families, is becoming more heavily utilized among the elderly. Hospice care doubled between 2000 and 2009. But often, the use of this service occurs only for three days or less and is frequently treated as a last resort after lengthy intensive-care

treatment, according to a study in the *Journal of the American Medical Association*.

This option says that the use of hospice should not be an afterthought; it should be the norm. Because of its emphasis on patient comfort, patients and their families get needed support during what is often an emotional end-of-life experience. It saves money, too.

Bargaining over drug prices

Prescription drugs are another part of the problem for many families. They cost more in America than they do in most other countries, and Option Two argues that America needs to change that to lower the cost of medical care. For example, Lipitor, a commonly prescribed drug to lower cholesterol, cost up to \$134 in the United States in 2010. But the same drug cost \$39 in the United Kingdom, \$31 in Canada, and 43 cents in France, according to a report by the International Federation of Health Plans.

This and other examples have caused some states to pass their own laws to help residents buy drugs from other countries. In Maine, the state legislature passed a law allowing its citizens to buy prescriptions from Canada, where many drugs are



cheaper. “People need to be able to access life-saving drugs at a reasonable price, and this law gives Mainers more options,” Maine state senator Troy Jackson, who sponsored the legislation, told the Associated Press.

Many other countries negotiate lower prices for drugs so patients can buy them at a discount. The United States does the same for a few government programs, but not the general population. For example, American law requires drug companies to sell pharmaceuticals to the Medicaid program at a 23 percent discount, but not to Medicare, which

has provided drugs to the public since 2006.

This option says that getting a better deal on the price of drugs for tens of millions of customers on a government program makes sense. If Medicare patients got drugs at the same cost as those provided to Medicaid beneficiaries, the government would save \$150 billion over 10 years. Proponents say that this is one example of cost-cutting that would improve health care. Pharmaceutical companies say that paying them less would wind up curbing innovation in developing new treatments for diseases.

Some who study this issue say that there is an often-overlooked reason that our health-care system is so expensive: prices for medical procedures vary widely from hospital to hospital, and secrecy prevails. A March 2013 study published in *JAMA Internal Medicine* revealed that only half of more than 100 hospitals contacted could give an estimate on how much a hip replacement for a 62-year-old woman would cost. The estimates of those that could provide a price varied widely, from \$11,100 to \$125,798.

Hospitals should post the prices for medical procedures so patients can shop for the best price. This option says that openness would foster true competition and result in a drop in the overall cost of health care, and Medicare and Medicaid would reap the benefit.

Finally, one of the differences between American health care and that of the rest of the world is that while an American medical education is extremely expensive, doctors also make more money here than nearly anywhere else. American doctors are usually paid for each procedure they order or operation they perform, and the costs of such services are high.

Besides increasing the cost of care, such an approach has an inherent problem, said Dr. Denis Cortese, president of the Mayo Clinic, during an interview with National Public Radio in 2009. “If your salary or the amount of money that you are paid varies depending on how much you do to people, there can be a conflict of interest for a physician because if they end up doing less, keep people healthier, they may actually make no money,” he said.

That’s one reason the Mayo Clinic pays its doctors salaries. If doctors were compensated with salaries, instead of fees based on each service

they give, costs would go down. Or, if the government and insurance companies could insist on lower prices across the board for which they compensate doctors, health-care costs would go down. It would be less expensive to pay for Medicare and Medicaid.

What we could do

Option Two says that to put Medicare and Medicaid on a sounder financial footing, the cost of health care must come down. America spends far more on health care than any other country in the world without getting demonstrably better results. To stabilize the system, and make Medicare and Medicaid more affordable as enrollment grows, reining in cost is crucial. Here are some actions we could take, as well as possible negative consequences:

- ◆ Doctors order too many medical tests and, too often, order antibiotics when they are not needed. These are persistent factors in the 30 percent of American health-care dollars wasted annually. Physicians should order fewer tests. They should not overprescribe antibiotics, because overuse of antibiotics helps create bacteria that are resistant to modern drugs and even more difficult and expensive to treat.

***But...** Doctors order tests because not all diagnoses are clear. Medical practitioners need leeway to order the tests they need to ensure that treatments they select result in the best possible outcomes. Antibiotics might not always work, but they remain lifesavers for many, and for others they reduce discomfort and shorten the course of illnesses. Doctors need freedom to do what they think is best.*

- ◆ End-of-life treatment is often the most expensive. To lower cost, and add to patients' quality of life, hospice care should be the norm, not the exception, particularly for the elderly. Such care not only meets the medical needs of dying patients, but their emotional needs and those of their families, too.

***But...** Some would view hospice care as a form of giving up on life. They want to fight for their lives until the end, and they should have that right. Aggressive treatment might be expensive, but it can extend the lives of patients for whom those extra weeks or months are critically important.*

- ◆ The cost of medical care is hampered by secrecy. Patients don't know what procedures and operations cost until they get the bill. Even when they have insurance, many people have to pay for a portion of their care, and not knowing the price ahead of time curbs their ability to make sound choices. The cost of health care won't come down until there is more transparency regarding prices. Hospitals and medical centers should post the prices of their operations and procedures.

***But...** There are good reasons why some hospitals charge more than others, and a simple price list can't reflect the differences. Some specialists may be more experienced at performing certain operations. And the cost of many operations can't be predicted ahead of time. Expensive complications can occur in the simplest of medical procedures. Medical services are much more than items to be bought and sold. They shouldn't be treated that way.*

These and other possible actions are summarized in the table on page 15.

OPTION THREE

One major reason Medicare and Medicaid are headed for a crisis is that so many Americans have unhealthy lifestyles that cause them to develop preventable illnesses like diabetes and heart disease.



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>> Get Serious about Prevention

OF THE TRILLIONS SPENT ON MEDICAL CARE IN THE UNITED STATES, more than 75 percent is spent on treating chronic, largely preventable diseases like diabetes and high blood pressure, according to a report from the US Centers for Disease Control. Many of the most common ailments in US society—diabetes, heart disease, cancer—can be largely avoided if people embrace low-fat diets and regular exercise, drink in moderation, and refrain from smoking.

American medical care emphasizes the treatment of chronic illnesses, which is very expensive for large programs, such as Medicare and Medicaid. This option says that we need to put far more efforts into prevention to reduce the cost of medical care—even to the point of penalizing those who have unhealthy lifestyles and refuse to change.

That's what Medicis Pharmaceutical Corp. of Phoenix, Arizona, did. After offering employees "every conceivable" resource to help them attain healthy lifestyles, according to CEO Jonah Shacknai, it began to charge workers more money for health-care insurance if they continued to smoke.

The state of Connecticut, with more than 50,000 state employees, decided in 2011 to force more workers to get preventive medical care as well as treatment for chronic conditions. The state proposed to increase the cost of health-care premiums by \$100 a month for those who refused to enroll in an employee wellness program.

Many employees initially opposed the move as

an invasion of privacy. But in the end, 96 percent of state employees enrolled in wellness services, a move that advocates said would save the state tens of millions of dollars in medical care. Such actions, this option says, make sense if we are ever to reduce the incidence of chronic disease that is a factor in the high cost of health care.

Curb alcohol use, not just smoking

Although smoking, obesity, and lack of exercise are frequently cited as factors in chronic illness, there is one often-overlooked culprit that also contributes to poor public health nationwide: alcohol. Many use it responsibly, but too many do not. This option contends that to reduce Medicare and Medicaid, costs we should take steps to reduce alcohol use, such as curbing alcohol advertising.

Such an idea may seem radical to some, but studies have shown that tobacco bans on advertising in dozens of countries have reduced smoking. Heavy drinking is a serious problem in America, causing 80,000 deaths annually. Drinking too much is a contributing factor in violence, heart disease, strokes, and cancer, making heavy alcohol use the third-leading cause of preventable death in the United States, according to the Centers for Disease Control.

It's bad enough that adults harm themselves, but many minors also drink to excess: two-thirds of high school students who drink alcohol report



that they binge drink, having four to five drinks in a short period of time. It's especially disturbing because the younger people are when they begin drinking, the more likely they are to become addicted to alcohol at some point in their lives.

This option says that alcohol abuse is a threat to public health. The least we should do is to ban TV commercials that celebrate alcohol and encourage drinking, particularly among the young.

Of course, even nondrinkers will face an increased risk of becoming obese and developing chronic diseases if they don't have access to nutritious, healthy food. Too many people have poor eating habits or live in "food deserts," areas more than three miles away from the nearest grocery stores. Option Three says that it's important to give everyone access to healthy, fresh food.

Put farmers' markets on wheels

One idea is to bring fresh farm produce to neighborhoods in need. In Baltimore, a mobile farmer's market has regularly scheduled stops in neighborhoods that have little access to fresh food. Farmers load their produce into trucks and bring them to needy areas, sometimes even making home deliveries. Some cities have asked farmers to set up markets in poor neighborhoods, advertising the time and place ahead of time and providing coupons to residents to ensure that they will buy what farmers come to sell.

In addition, the nonprofit Wholesome Wave offers incentives for people who are enrolled in the Supplemental Nutritional Assistance Program (SNAP, formerly known as food stamps) to buy

produce from farmer's markets. Wholesome Wave matches every \$10 in fresh produce that people buy in farmer's markets using SNAP benefits, with a \$10 coupon. These and other actions, Option Three says, would help people eat better and reduce the number of people who are overweight or obese—conditions that lead to chronic diseases, such as diabetes and heart trouble.

Better eating would certainly improve the health of many people. But for some things, a doctor's care is critical. That's why Option Three advocates for annual physicals and says that the government should make them mandatory if necessary.

During annual exams, physicians could talk to people about prevention. They could do blood tests and lab work to assess people's health. They could talk to overweight patients, about the importance of shedding extra pounds. Many schools require children to get regular physicals, but it's even more necessary as people get older. An annual physical is invaluable in giving people a picture of their health. It will also help them understand what they need to do to remain healthy as they age.

Care for seniors and the disabled at home

Finally, perhaps the best way that people could help reduce the amount of money government spends on Medicare and Medicaid is simply to take more responsibility for elder and disabled care—and for patients to insist on it. In years past, families assumed the bulk of care for aging relatives. One reason that the cost of Medicaid is so high is because it pays for nursing home care. That comes at a hefty price tag. In 2012, the cost of staying in an American nursing home was \$248 a day, accord-



ing to the *Wall Street Journal*. That comes to well over \$90,000 a year.

People should make it a priority to keep their loved ones out of institutions, this option says, keeping them in their homes and ensuring families take care of the elderly. This isn't just an issue in the United States. China recently passed a law requiring children to visit their elderly parents. It is seen as critical to elders' *jing shen xu qiu*—translated as “mental need” or “spiritual need.” Many aging Americans would agree.

A Medicaid program called, “Cash & Counseling,” lets elderly patients who need skilled nursing care, help with daily living skills like bathing or cooking, or who have dementia, stay in their homes by providing an “allowance” that patients can use to get help. Started as a pilot program in 15 states during the late 1990s, it has proven to be so popular that most states now have some form of the program. It gives patients themselves many options and puts them in charge of a monthly allowance to hire caregivers—including family members.

A study of the approach said that patients in the program were more likely to get treatment and be far more satisfied with their care. In Minnesota, a woman who juggled caring for her disabled husband and holding down a job was able to quit working outside the home once her spouse enrolled in the program. A man in New Jersey opted to hire his sister for the help he needed in the morning and evening. Creative approaches that give individuals choices over their care and keep them out of institutions, would make many patients happier and cost families and the government alike less money.

What we could do

This option says that costs caring for poor people and seniors won't go down unless we get serious about prevention. Too many of our health-care dollars go to treat chronic illnesses, such as obesity, heart disease, and breathing problems, that could have been prevented. Instead of spending the bulk of our resources treating acute illnesses, we need to spend more money on keeping people from getting sick in the first place. Here are some actions we could take along with some drawbacks:

- ◆ If people persist in pursuing unhealthy lifestyles, such as smoking and drinking, they

should have to pay substantially higher health insurance premiums. Others should not have to pay increased health-care costs incurred by those who make bad choices.

But... *America was built on individual freedom and rights. Penalizing people for their lifestyle choices would erode that core value, allowing employers and the government to intrude in matters that are none of their business.*

- ◆ Too many people drink too much, and while alcohol is a legal beverage, alcohol ads on TV should be banned, particularly since young people are so vulnerable to their influence. The less people drink before the age of 21, the less likely it is that they will develop an alcohol addiction.

But... *Banning television ads, even for a good reason, would be a serious violation of the First Amendment guarantee of free speech.*

- ◆ Fresh produce should be available to everyone. Not everyone lives near grocery stores, so communities should give farmers incentives to bring their crops into areas that have limited access to fresh food. People would be more likely to substitute healthier foods for the fast food that is making many Americans obese.

But... *Just because people have access to fresh food doesn't mean they will eat it. Many people prefer french fries and hamburgers to green salads. Ultimately, diet is an individual choice and some people will choose to eat the high-fat, unhealthy foods they like no matter how many fruits and vegetables they are offered.*

These and other possible actions are summarized in the table on page 15.



S U M M A R Y

THERE IS LITTLE DOUBT THAT UNLESS WE DO SOMETHING to stabilize the nation's biggest publicly financed health programs—Medicare and Medicaid—the demands on them may soon overwhelm their resources. Medicare pays most of the health care costs of all Americans over the age of 65, regardless of income. Medicaid covers these costs for low-income Americans regardless of age. Both programs are currently paying out more than they are taking in. And both continue to eat into federal and state budgets at a time when deficits in Washington and many state capitals are reaching all-time highs.

The flood of retiring baby-boomers (born between 1945 and 1965) adds to the strains on Medicare every year, while

the continually rising costs of health care itself makes increasing demands on both programs. Waste, fraud, and economic recession have played a role as well. What is to be done?

One way to ease the financial strain on a public program is to spend less or tighten eligibility for funds. Another is to raise the taxes that pay for it. Still another is to reduce the need for health care through much more serious prevention. But who suffers when we spend less? What sacrifices are called for if we raise taxes? What promises are broken by declaring some ineligible? We must navigate through the trade-offs involved between practical solutions and the values we hold as a compassionate nation. The only choice we will not have for long is to do nothing.

OPTION ONE

Do What It Takes to Maintain Our Commitment

Keeping the programs solvent may mean higher taxes for workers and companies, or raising the age of eligibility for Medicare. It could mean asking Medicaid patients to share

the cost of their coverage. We need to do what is necessary to continue the commitment even if that costs everyone more.

But, raising taxes to pay for both programs may cost them the broad-based support they now enjoy. Making people wait longer to collect Medicare or forcing the poor to pay part of their health care may cause people to delay getting help, resulting in higher costs later on.

Examples of What Could Be Done

- Government could raise the age for Medicare to 68 or 69, and lower the poverty level to qualify for Medicaid.
- Employers and employees could be required to pay more in payroll taxes (currently 1.45%) to shore up financing for both Medicare and Medicaid.
- Individuals could be asked to be responsible for paying more of their own health care coverage.
- Medicare could be means-tested so that people with high incomes would have to pay significantly more for coverage.
- Limits benefits for Medicaid and Medicare patients. Few private health insurance policies are open-ended.

Some Trade-Offs to Consider

- Raising the age of eligibility for Medicare and making it tougher to qualify for Medicaid would result in more people becoming uninsured.
- Many workers could balk at paying higher taxes to benefit the elderly who are often better off than they are. Businesses whose taxes went up might hire fewer workers.
- Some people would delay or avoid treatment they could not afford. This could end up costing the government more money.
- This could erode universal support for the program.
- This could mean that the sickest people would die because their health care needs would exceed the spending limits.

OPTION TWO

Reduce Health-Care Costs Throughout the System

It is critical to put Medicare and Medicaid on a better financial footing. We need to pay for fewer lab tests people get and reduce money spent on end-of-life care. The U.S. government

should negotiate for lower drug costs as other countries do.

But, fewer tests may mean more people will die from undiagnosed illnesses. Less end-of-life intervention may mean that more people will die sooner than they would otherwise need to. And lowering the profits of drug companies will mean less money for research into better drugs that benefit everyone.

Examples of What Could Be Done	Some Trade-Offs to Consider
<ul style="list-style-type: none"> Hospice care rather than hospital stays should be the norm, not the exception, for people who are terminally ill. 	<ul style="list-style-type: none"> This requires people to forego potentially life-extending treatment simply because a doctor has determined they are unlikely to benefit.
<ul style="list-style-type: none"> Doctors should be required to order fewer tests, and order fewer antibiotics. 	<ul style="list-style-type: none"> Fewer tests would mean that more people would die because some diseases would probably go undetected.
<ul style="list-style-type: none"> The government should negotiate much lower prices for pharmaceuticals and other needed medicines. 	<ul style="list-style-type: none"> If Americans pay less for drugs, drug companies will have less money for research and development.
<ul style="list-style-type: none"> Hospitals should be encouraged to compete on price, posting their charges for each procedure on websites so everyone can see them. Patients should shop for the lowest prices. 	<ul style="list-style-type: none"> Competition among hospitals could cause some very good ones to close, potentially depriving communities of important sources of medical care.
<ul style="list-style-type: none"> Insurance, government and hospitals should pay medical doctors less for procedures, or put doctors on salary. 	<ul style="list-style-type: none"> Fewer doctors will accept Medicare or Medicaid patients.

OPTION THREE

Get Serious about Prevention

One reason Medicare and Medicaid are headed for a crisis is because so many Americans have unhealthy lifestyles that cause them to develop preventable illnesses like diabetes and heart disease. We should stop expecting others to pay for

the consequences of our bad choices. Government incentives should reward those who weigh less, eat right, and exercise more.

But, an emphasis on prevention and requiring that people adopt healthier lifestyles would invite unfair scrutiny of their behavior and would increase government intrusion into people's lives.

Examples of What Could Be Done	Some Trade-Offs to Consider
<ul style="list-style-type: none"> Employers could charge higher insurance premiums for people with unhealthy lifestyles, such as smokers, and charge less to reward workers with healthier habits. 	<ul style="list-style-type: none"> Many would see this as an unfair intrusion on people's personal freedom.
<ul style="list-style-type: none"> Government should take ads for alcohol off the air as it did for tobacco years ago. 	<ul style="list-style-type: none"> This could be a violation of the First Amendment right to free speech.
<ul style="list-style-type: none"> Communities could give incentives to farmers to sell fresh produce in neighborhoods to increase access to healthy, fresh food. 	<ul style="list-style-type: none"> Making fresh, healthy food more easily available is no guarantee that more people would buy it.
<ul style="list-style-type: none"> Government could make annual physicals mandatory for everyone. 	<ul style="list-style-type: none"> This would be a waste of money and unnecessarily clog up the medical system, since many healthy people would be forced to see a doctor for a physicals.
<ul style="list-style-type: none"> Families should take more responsibility for keeping elderly relatives and the disabled out of nursing homes and other institutions. The elderly and disabled could take charge of their own health affairs, insisting on their right to care at home. 	<ul style="list-style-type: none"> This could result in elderly people being inadequately cared for, since even the most involved relative may not have the ability to care for infirm or disabled people. Not every elderly person or disabled person is in the position to direct their own care.



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