

STOPPING BOOMER HEALTH CARE BUDGETS FROM GOING BUST

*The Imperative of Taking Greater Advantage of Markets, Families, and Faith
in Assuring First-Rate and Affordable Health Care
for the Coming Surge of Seniors*

A Project of Research, Publications, Public Programs, and Advocacy

**Center of the American Experiment
Minneapolis**

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(I) Aim

“Stopping Boomer Health Care Budgets from Going Bust” is a Center of the American Experiment project of research, publications, public programs, and advocacy aimed at constraining health care costs borne especially by government in Minnesota and nationally as the massive Baby Boom Generation speeds into retirement and old age. Why and how must we better rely on free markets, personal responsibility, generous families, and religious organizations if we are to keep immense spending increases as non-crippling as possible in a country with the most expensive health care system in the world already? At root, why and how must citizens retrieve responsibility from governmental agencies for their own well-being and that of loved ones as we grow old?

(II) Background

While they weren't his best applause lines, President George W. Bush's best laugh lines in his 2006 State of the Union address had to do with how “two of my Dad's favorite people” would be turning 60 years old later in the year: One, naturally, was “W” himself . . . with President Clinton the other. “This milestone,” the younger but three-score Mr. Bush said, “is more than a personal crisis, it is a national challenge.”

He then added a few sentences that were anything but funny.

“The retirement of the baby boom generation will put unprecedented strains on the federal government,” he said. “By 2030 spending on Social Security, Medicare, and Medicaid alone will be almost 60 percent of the entire federal budget. And that will

present future Congresses with impossible choices – staggering tax increases, immense deficits, or deep cuts in every category of spending. . . . And every year we fail to act, the situation gets worse.”

President Bush was right, of course, though his framing – stark as it was – didn’t begin to capture the severity of our nation’s in-train crisis. Consider numbers and projections like the following.

Unless policy-makers take essential but exceedingly difficult steps, Brian Riedl of the Heritage Foundation envisions federal revenues down the road totaling 18 percent of Gross Domestic Product, while federal (non-interest) *spending* totals 28 percent of GDP. This 10-percentage-point gap, he predicts, would lead to budget deficits large enough to increase the national debt from 40 percent of GDP to more than 300 percent. This, in turn, would “set off a vicious circle of rapidly increasing debt translating into higher net interest spending (exacerbated by higher interest rates), which would increase debt even further – possibly to 500 percent of GDP.” Increases in governmental borrowing of this exponential magnitude, he concludes, would “devastate financial markets and eventually could trigger a financial and economic crisis.”¹

The only suspect word in this last paragraph is the qualifier “could” in the last sentence, as there is not the smallest chance that “devastated” financial markets would *not* result in financial and economic crises.

A favorite rhetorical device of polemicists is predicting that if something is not done immediately to constrain governmental spending in a particular area, before long, every single dime of public spending will wind up going to it, be the “it” in question health care, corrections, or another big-ticket item. They’re absurd extrapolations, needless to say, which is not to say they can’t illuminate. Riedl, for example, predicts that if nothing is done to change Medicare, Medicaid, and Social Security, by 2045, all federal spending would be consumed by those three programs alone, along with interest on the national debt. At that point, and in keeping with the wishes of a famous bumper sticker, the Pentagon really would have to hold bake sales in order to buy battleships.

Brian Riedl is a very good budget analyst for the Heritage Foundation, which is a very good conservative think tank. How might two very good liberal or centrist economists, under the aegis of the liberal and centrist Brookings Institution (which, like Heritage, is an exceptional policy organization) describe matters?

With the exact same urgency.

Alice Rivlin and Isabel Sawhill, both of whom held senior positions in the Clinton administration, write of what it will take to meet the “unprecedented challenge” of balancing federal budgets as more than 75 million Boomers age. Only three options for doing so exist, they argue: reducing current commitments to senior citizens; “slashing” other governmental programs; or getting the public to “accept” higher taxes.

Relying exclusively on even “draconian cutbacks” in programs like Social Security and Medicare, they write, would be insufficient given the sheer increase in the number of elderly. “Squeezing down” most other federal programs would prove inadequate as well as “detrimental to the well-being of younger families and children.” And if the preferred route is higher taxes, Rivlin and Sawhill estimate that federal tax bills would consume at least another 6 percent of GDP.²

None of these choices, whether employed alone or in combination, would be pretty. In fact, it’s tantamount to impossible imagining any of them as politically tenable – at this stage, anyway.

So what to do? What changes in public policies – and perhaps more importantly, in cultural attitudes – are demanded by such severe fiscal prospects?

(III) Markets

In thinking about free markets as discussed below, keep in mind that while the United States, compared with much of the rest of the world, does not have a nationalized or single-payer health care system, that’s not to say the public sector isn’t heavily involved. Government, through Medicare and Medicaid mostly, directly pays for health care for more than one-quarter of the U.S. population. This translates into approximately 44 percent of all medical care consumed. If one takes into account tax exemptions for insurance premiums and deductions for certain out-of-pocket expenses, government is directly or indirectly on the hook for about 75 percent of all medical costs.³

It’s also essential to keep in mind how American brilliance in science and technology – a product of free markets and free inquiry – often leads to higher health care costs, since prolonging life also can mean stretching out death. This can be very expensive if the accounting is strictly in financial rather than human terms.

Economist Arnold Kling describes medical care in the United States as “premium medicine” because of its heavy reliance on specialists and advanced technology. Notwithstanding the fact that such sophisticated care doesn’t always lead to better health outcomes, he argues that if we were to return to health care standards of 1975 – meaning, if doctors and health care professionals were restricted to procedures and machines available that year – “what is commonly described as America’s health care crisis” would be resolved. This is another way of saying, Kling concludes, the problem we face is fundamentally one of abundance.⁴ Of all problems to have, those of abundance are generally far from the worst, but they can be handicapping pains nonetheless.

A market-based counterweight to such cost pressures is pharmacological and other miracles which, in addition to enriching the quality of life for scores of millions, also reduce hospital stays that are exorbitantly more expensive than any pills. Then, again, pharmaceuticals, by staving off death at younger ages, can cause higher costs at older ages as people grow frail and infirm.

Prof. Regina Herzlinger of Harvard's business school writes of how only a "true market," which she defines as the "great confluence of consumers and providers that characterizes virtually every other sector of our economy," can "provide the solution to the deep problems that plague the American health care system." In the same way the market "revived our flagging manufacturing sector, once given up for dead, and created our world-class service and high-technology firms, the market and only the market," she says, "can provide the health care that the American people want at a price they are willing to pay."⁵

Michael Cannon and Michael Tanner of the Cato Institute argue similarly:

Economic competition searches for information and answers that are constantly changing. What is the best way to lower the price of health care and increase quality? How many doctors does the United States need? Or hospitals? Or magnetic resonance imaging (MRI) machines? In what parts of the country are these most needed? What should the prices be for MRI services? Can some tasks that are usually performed by physicians be performed as reliably by other medical professionals?⁶

Answers to questions like these change as rapidly as technology, demographics, and the rest of the landscape. As a result, Cannon and Tanner write, good answers lie best in the kind of experimentation and learning implicit in competition. Politics and bureaucracies are no match for it.

Present and future attempts to improve health care efficiency and, therefore, access will fall short in Minnesota and nationally unless consumers – be they old or young, covered by Medicare or Medicaid or not – are afforded reasonable choices in selecting physicians, hospitals, and other providers. Unless potential providers are freer than they currently are to enter often cramped markets. Unless consumers have convenient ways of learning about prices charged and success rates realized for specific services and treatments by specific providers. And unless tax and other policies, such as Health Savings Accounts, cause consumers to become more sensitive to costs which, because of over-reliance on third-party reimbursements, *feel* to be smaller than they really are.

A retired physician, who critiqued an earlier version of this proposal, wrote succinctly about how more personal responsibility and consumer control are essential if people are to "buy" only what's necessary. With "better management of resources," as much as 30 percent of health care services, he claimed, could be eliminated, including unnecessary doctor visits, redundant procedures, over-management of episodic illness, and overly-intensive therapies in the final stages of life. "This will only be realized," he argued, "when the consumer cares, questions, and demands outcomes information."⁷

Questions: How to reach a point where consumers have more to say and shoulder and government has less? How to win such changes, especially in Minnesota? How,

especially, insofar as at least one Minnesota economist believes the “only” problem with our health care system, is the “total disruption of the health care price system.”⁸

A few words are in order about institutional modesty and comparative advantages.

The most seminal and far-reaching research aimed at strengthening health care markets continues to be pursued by national think tanks such as the CATO Institute, American Enterprise Institute, Heritage Foundation, National Center for Policy Analysis, and the Galen Institute. While American Experiment indeed will conduct research and host public programs in this area, our highest priority will be on doing what we do best, rather than on untangling sea-to-sea knots that others are better equipped to undo.

This means (1) making the Center’s market-based research as Minnesota-specific as possible; (2) actively promoting and amplifying the path-breaking research of CATO *et al.* throughout the state via public forums and other means; and (3) building on the Center’s long-standing interest and expertise in the cultural and social components of the most vexing problems facing Minnesota and the nation. In matters at hand, this means pursuing seminal and far-reaching research in how families, houses of worship, other faith-based organizations, and the rest of civil society can ease health-related financial burdens that increasingly will weigh down public bodies at all levels.

(IV) Families

As teased by the reference to HSA’s above, “patient-centered” health care pertains not only to keeping government intruding as little as possible, but also to the increasing and inescapable need for individuals and families to take on larger proportions of their own health care expenses. Even more so than the case with Social Security, the twin programs of Medicare and Medicaid will convulse in debt unless major changes are made in them. And if families continue to fragment routinely, governmental resources will stretch even further beyond breaking points, as too few people will have the wherewithal – financial and otherwise – to adequately fend for themselves, much less their loved ones.

In the matter of Medicare, the time has come to means-test it by reducing benefits, on a sliding scale, to senior citizens able to cover larger portions of their health care costs. And as is the case already with Social Security, it’s also necessary to begin slowly increasing the age of eligibility (now 65) for Medicare. Question: How best to accomplish that both efficiently and fairly?

As opposed to Medicare, Medicaid is a means-tested welfare program, underwritten by both Washington and the states, and originally conceived to help cover health care costs mainly for poor women and their children. While most recipients remain single women and their kids, the bulk of Medicaid dollars have come to pay for long-term care, mostly for older citizens in nursing homes, with a significant number of such residents not financially wanting by any reasonable definition.

Washington and the states (Minnesota in the forefront) have done a good job in recent years in slowing down exploitation of eligibility rules by disqualifying certain asset transfers from parents to their children and others individuals. But there is an important difference between making it tougher to game the system (on the one hand), and overcoming a widespread notion (on the other) that non-poor men, women, and families are somehow *entitled* to public funds that are expressly intended for people who truly are poor. Such assumptions need to be replaced by more explicit and internalized recognition that financial responsibility for long-term care lies principally with older Americans themselves, in collaboration with their adult children when necessary. This, in turn, calls for greatly expanded use of long-term-care insurance, which needs to be made more attractive.

Will such a shift place new and unwelcome financial burdens on millions of families who, while not poor, are far from rich? Yes, very much so. But there's no alternative. One question of many: How exactly can long-term-care insurance become more practicable? On reading an earlier draft of this proposal, another retired physician suggested a potentially ingenious idea: Making the purchase of long-term coverage whole-family projects, rather than what might be a too expensive responsibility of parents alone.⁹ Ideally, adult children – not parents – would most often take the gracious lead in orchestrating such efforts.

Why, again, are tough changes like these necessary? The number of men and women in the United States age 65 and older is expected to double by 2030,¹⁰ with long-term care costs, according to the Congressional Budget Office, growing at an even faster 140 percent over that relatively short period.¹¹ In 2004, public dollars covered 64 percent of all costs nationally for long-term care; this was 10 percentage points higher than just five years earlier.¹² And for untenable measure, Medicaid, which is the primary funding source for long-term care, recently surpassed K-12 education as the single largest budget item, on average, among the 50 states.¹³ If left unchecked, these trends portend more than poorly for state and federal budgets.

A free market question: What market-based improvements would be of particular value in constraining Medicaid costs?

Pressure on governmental budgets also would be eased if more senior citizens lived, as in the “old days,” at least for spells, in the homes of their adult children rather than in nursing homes or other publicly subsidized settings. But these are very much new days in which families tend to be geographically scattered and potential caregivers (practically speaking, daughters and daughters-in-law most of the time) tend to work outside of the home. Add lower fertility rates, and increasing numbers of families don't have enough children and in-laws to begin with – scattered or not, working for income or not.

Questions: Without seeking to impossibly re-create earlier decades and generations, what can be done to encourage more families to provide homes for their elders? For that matter, and without trampling on the preferences and prerogatives of elders, what can be done to encourage more of them to live with their children and grandchildren and other

family members? Or short of such major moves and sacrifices on the part of all concerned, how can younger kin better help older kin in other ways?

Still, it's hard to imagine families being capable, much less disposed, to reaching out more vigorously to grandparents, elderly parents, and other older members given the cold landscape described by scholars Eric Cohen and Leon Kass:

[I]n an aging society, we stand in greatest need of families just as family life has been most weakened. There are the well-known and widespread phenomena of divorce and family rupture, lower birth rates, geographical mobility, and the weakened social importance of extended family. Moreover, many of today's old people – and many aging baby boomers – never had children, and many more have little claim on their children's loyalty. When a neglectful parent needs care from the children he neglected, the sins of the absent father or rejecting mother are often repaid in kind.¹⁴

Incumbent here is a redoubling of American Experiment's long-time research and advocacy on behalf of stronger families, particularly in terms of reducing non-marital births and divorce. Accentuated is recognition that not only are children generally better served in what often are derided as "traditional" two-parent families, but increasingly, their parents and grandparents will be, too. Question: How exactly to realize progress in such intimate spheres of life?

(V) Faith

In the same way that American Experiment from the start has made the case for invigorated fatherhood and marriage, we have made the case for taking greater advantage of our religious institutions and traditions when it comes to helping people in need – doing so, always, with reverence for constitutional safeguards and American variety. Failing to take appropriate and sufficient advantage of spiritually animated organizations, we've argued, amounts to needlessly tying powerful and healing arms behind our backs. Updating matters, given the many hard and painful demands described in these pages, an ever more compelling case can be made that churches, synagogues, mosques, and kindred organizations are uniquely equipped to serve older men and women. For society not to better tap such wellsprings of spirit and talent would be unwise and, not least, unkind.

Question: How would a renewed and measured reliance on religious institutions square with our nation's history? Perfectly. It also would be perfectly in step with who we are – and always have been – as a diverse people. For proof, one need only read the Founders and go from there. Various interests which, in recent decades, have argued and litigated for closing public squares to religious expression misread that history radically.

A next question: What, exactly, might religiously affiliated groups do to help? Here are just two ideas, with litanies more to emerge, in part from American Experiment, but in vastly bigger numbers from meeting rooms and basements in thousands of houses of

worship. In considering possibilities, please keep in mind, as one of our retired physicians wrote, that religious groups not only can “alleviate logistical problems,” but more profoundly, they can help “substitute contentment, peace, and serenity for despair and depression.”¹⁵

Many religious organizations run food shelves, with many also delivering groceries and meals to shut-ins, right to their door. These are great services. But questions: What if, in addition to *bringing* bread, more members of more congregations also regularly *broke* bread with elderly couples and individuals, be it in their homes, in restaurants, or back at church? Might well-constructed and conscientious programs of this sort delay, at least for a while, the necessity of some older men and women giving up their homes for more structured, publicly-subsidized settings? How exactly might a venture like this work?

Second, it’s hard to imagine a more solemn but affirming ministry than hospice. Not incidentally for our purposes, taking greater advantage of hospice beds, instead of acute-care beds in the final days of life, can save significant amounts of money – even as it simultaneously achieves its more central and uplifting purpose of soothing both those who die and loved ones left behind. In the same way it’s hard to imagine a more compelling calling than providing hospice care, it’s hard to envision institutions better suited for answering such calls than communities of faith. Question: How exactly might an idea like this work in terms of funding streams, legal liabilities, and other complexities?

The Bush administration early on gave promise of beneficially redefining and enlarging the role of religiously affiliated organizations in addressing social welfare needs. That policy emphasis has weakened for a number of reasons, starting with the nation’s necessary preoccupation with the war on terror. But the president’s faith-based initiative was important then and remains so now. Likewise, his concept of “compassionate conservatism,” though still ridiculed by critics who don’t understand its rigor and the heavy-duty demands it puts on those who seek to help, remains essential. Question: How exactly to revive these approaches?¹⁶

(VI) Next

The following American Experiment studies and forums are in the pipeline.

- A statistical portrait of long-term care in Minnesota and the nation, by Peter Nelson, a Center research fellow.
- An anthology of brief essays in which health care, religious, and other leaders from Minnesota and across the nation propose specific ways for houses of worship and other faith-based organizations to better serve older people in need, edited by Mitch Pearlstein, the Center’s founder and president.

- A proposal aimed at making health care directives clearer, more readily available, and more likely to be honored by families and physicians by putting them securely on-line, by Dr. Pearlstein.
- A Luncheon Forum on Health Savings Account, led by Grace Marie Turner, president of the Virginia-based Galen Institute, on November 1.

(VII) Personnel

The project will be led by American Experiment’s founder and president, Dr. Mitch Pearlstein. His principal in-house colleague will be Peter Nelson, the Center’s policy fellow and an attorney. Scholars and other experts from both Minnesota and the nation will be commissioned to conduct studies, write essays, and speak at public events. They also will lead roundtables with health care, governmental, business, and other leaders. Biographical information on Messrs. Pearlstein and Nelson is attached.

(VIII) Funding

In the interest of prudent budgeting and operations, the Board of Directors strongly prefers that gifts be made for American Experiment’s overall mission rather than for specific projects. In light, this proposal respectfully solicits support for the Center’s full range of programs. For perspective, expenditures for the Center’s health care work are estimated to average \$110,000 annually for the project’s first three years.

Pro-rated compensation for staff annually	\$75,000
Three public forums annually	15,000
Three studies or other significant publications annually (includes dissemination)	15,000
Travel, administrative, and other expenses annually	5,000
TOTAL (average for each of three years)	\$110,000

All contributions to Center of the American Experiment, a 501(c)(3) nonprofit and educational institution, are tax deductible.

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- ¹ Brian M Riedl, “Entitlement-Driven Long-Term Budget Substantially Worse Than Previously Projected,” Backgrounder #1897, Heritage Foundation, Washington, DC, November 30, 2005, p. 14.
- ² Rivlin, Alice M. and Isabel Sawhill, eds., *Restoring Fiscal Sanity 2005* (Washington, DC: Brookings Institution Press, 2005), pp. 35; 51.
- ³ Prof. Bryan Dowd, University of Minnesota, personal email correspondence, May 6, 2005.
- ⁴ Arnold Kling, *Crisis of Abundance: Rethinking How We Pay for Health Care* (Washington, DC: Cato Institute, 2006), pp. 2-3.
- ⁵ Regina Herzlinger, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America’s Largest Service Industry* (New York: Basic Books, 1997), p. xiii.
- ⁶ Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What’s Holding Back Health Care and How to Free It* (Washington, DC; Cato Institute, 2005), p. 3.
- ⁷ Dr. Richard J. Frey, personal correspondence, July 10, 2006.
- ⁸ Roger Conant, personal email correspondence, June 26, 2006
- ⁹ Dr. Tom Votel, personal correspondence, July 2, 2006.
- ¹⁰ U.S. Census Bureau, Population Division, “Table B1. The total population by selected age groups,” *State Interim Population Projections by Age and Sex: 2004-2030*.
- ¹¹ Congressional Budget Office, “Projections of Expenditures for Long-Term Care Services for the Elderly,” *CBO Memorandum*, March 1999.
- ¹² Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Expenditure Web Tables*.
- ¹³ National Association of State Budget Officers, “Table 3: Comparison of Shares of State Spending with Fund Sources, Fiscal 1994 to 2004,” *2003 State Expenditure Report*, p. 8.
- ¹⁴ Eric Cohen and Leon R. Kass, “Cast Me Not Off in Old Age,” *Commentary*, January 2006.
- ¹⁵ Dr. Richard Frey.
- ¹⁶ In responding to an earlier version of this proposal, historian Marvin Olasky, who has done more than any other scholar in conceptualizing “compassionate conservatism,” wrote: “Besides spending time with the elderly and developing hospices, churches have clinics that save millions of dollars by substituting for much more costly emergency room care (I visited one in Leesburg, Florida last year. . .).” He also wrote of another faith-based group “setting up a hospital in Aruba where Americans can get lower-cost surgery.” Personal email correspondence, June 24, 2006.