# 8. Medicare and Medicaid

***The federal government should***

- maintain the Medicare Rx drug discount card program as an alternative to implementing the Medicare Rx benefit in 2006,
- allow seniors to opt out of Medicare entirely without loss of Social Security benefits,
- allow Medicare beneficiaries and their doctors to contract privately for Medicare-covered services,
- give current Medicare beneficiaries a risk-adjusted voucher to purchase health insurance and/or deposit in a health savings account,
- let workers save their Medicare payroll taxes in a retirement health savings account to purchase medical care and coverage in their golden years,
- freeze Medicaid spending at current levels and distribute Medicaid funds to states as unrestricted block grants, and
- eliminate Medicaid spending and cut taxes concomitantly.

***State governments should***

- demand full flexibility in administering Medicaid,
- experiment with Medicaid benefits structures that mirror health savings accounts, and
- deregulate health insurance markets to make health insurance more affordable for low-income individuals and families.

## *Introduction*

Government directly finances health care for more than one-quarter of the U.S. population—some 77 million people in 2003. As shown in Chapter 7, that translates into nearly half (44 percent) of all medical care

consumed in the United States. Two government programs account for most of the spending. Medicare is a federal program that creates a legal entitlement to health benefits for the elderly and disabled. Medicaid is a joint federal-state program that creates an entitlement to health benefits for the poor. Each was enacted by President Lyndon Johnson as part of the Great Society, and each will mark its 40th anniversary in July 2005. Their creation was a milestone for supporters of national health insurance, who had lobbied for greater federal involvement in the health care sector since before the New Deal.

In the 40 years since their enactment, Medicare and Medicaid have imposed a large and growing burden on taxpayers and the economy, a burden that soon will become unsustainable. According to the federal Office of Management and Budget, together they will account for one-fifth of all federal outlays in 2005 and one-fourth of outlays by 2009.

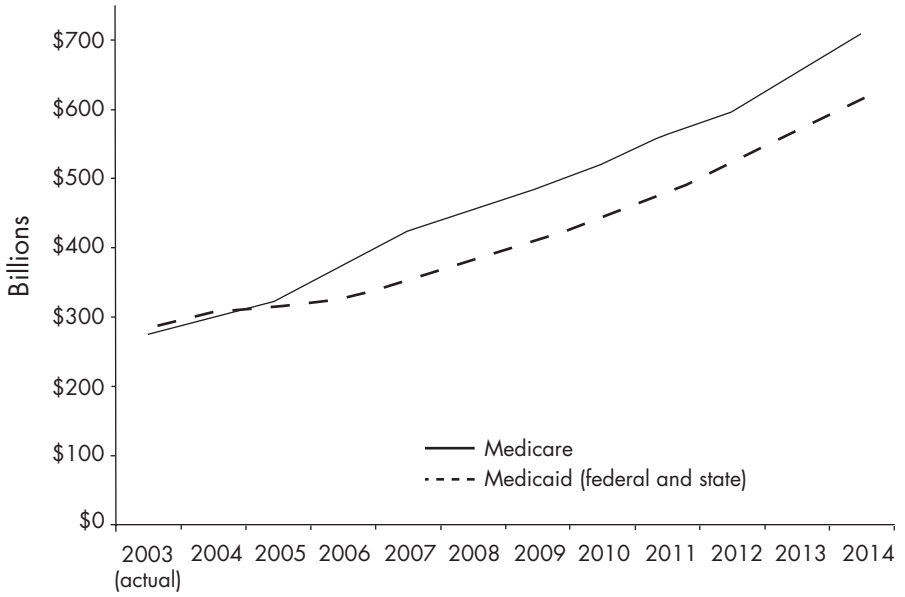
- In 2005 the federal government will spend $481 billion on Medicare and Medicaid (including the State Children's Health Insurance Program, a Medicaid offshoot), more than on national defense and homeland security combined ($478 billion).
- When state Medicaid spending is included, the two programs ($624 billion) dwarf even Social Security ($513 billion).

According to the Congressional Budget Office, Medicare spending will double from 2005 levels in eight years and federal Medicaid spending will nearly double in nine years (Figure 8.1). To keep funding those programs as they exist would require massive tax increases.

Those projections probably understate how much the programs will spend in the coming years. It is an iron-clad rule that government handouts grow beyond expectations. In 1965 the federal government projected that Medicare hospital insurance would cost $9 billion in 1990. Its actual cost in 1990 was $66 billion. Costs grow rapidly because people eligible for the handout both change their behavior to maximize their gain and pressure government to enlarge the handout. Recent examples of the latter include the addition of Medicare coverage for outpatient prescription drugs and obesity treatments.

Third-party payment insulates Medicare and Medicaid beneficiaries from the cost of care, leading to increased demand, overconsumption, higher prices, and enormous waste. Nobel laureate Milton Friedman estimates that third-party payment caused real per capita health spending to reach $3,625 in 1997, or more than twice what it otherwise would have

***Figure 8.1***
***Projected Medicare and Medicaid Spending, 2003–14***




SOURCE: Congressional Budget Office and author's calculations.

been. Medicare and Medicaid accounted for 43 percent of the increase. A study by Dartmouth's Jonathan Skinner, Elliot Fisher, and John Wennberg found that nearly 20 percent of Medicare spending is wasted (i.e., ''appears to provide no benefit in terms or survival, nor is it likely that this extra spending improves the quality of life''). That translates to more than $58 billion in 2005, a figure that does not include waste from medical care that provides some value but less than it costs.

Part of the waste is created by the efforts of government bureaucrats to determine what medical suppliers should be paid for providing services to beneficiaries. In a free health care market, the natural interplay between supply and demand would determine prices. Prices send signals that encourage suppliers to devote resources where they best satisfy consumers' needs. However, because prices for Medicare and Medicaid transactions are set by bureaucrats who cannot possibly have all the information captured by markets, pricing errors are inevitable. Prices no longer convey the information that consumers and producers need to coordinate their activities, and resources are diverted from where they are needed most.

Further waste is created as producers and patient groups expend vast resources to influence the price-setting process and other policies to their benefit. Medicare and Medicaid are leading reasons why health care interests spent more than $600 million on political contributions and lobbying activities in the 2001–02 election cycle, health professionals made the second-highest contributions to congressional campaigns, and health care groups ranked second in terms of dollars spent on lobbying activities in 2000. Moreover, Medicare and Medicaid crowd out private efforts to provide for their target populations, discourage saving and work, and infringe on the rights of individual Americans to control their income and medical decisions.

Neither program is sustainable in its current form. Unreformed, those programs will impose an ever-increasing burden on taxpayers, deliver fewer benefits to beneficiaries, and exacerbate the spiraling costs and loss of patient control that fuel calls for government-run health care.

The U.S. Constitution does not give Congress the power to create government health insurance schemes. The federal and state governments should hew to the Constitution and drastically liberalize these programs as a first step toward privately funding health care for the elderly and indigent. First and foremost, lawmakers should transform Medicare and Medicaid into programs that encourage responsible stewardship by giving beneficiaries ownership of their health care dollars. The federal and state governments should act before the 45th anniversary of Medicare and Medicaid.

## *Medicare*

Though popular among seniors and those who might otherwise have to care for them, Medicare infringes on the right of workers to control their retirement savings and the freedom of seniors to control their own health care.

Medicare was founded on a number of premises that are either impractical or morally suspect, or both. One is that young workers should be taxed to pay for the health care needs of their elders, many of whom do not need it and many of whom never contributed to the program. The first generation of Medicare beneficiaries essentially got something for nothing, receiving subsidies without having contributed to the program. As if to immortalize this premise, the honorary first Medicare beneficiary was a man who neither contributed to Medicare nor needed it: former president Harry S Truman. Since Medicare's enactment, each generation of seniors

has demanded that the debt it is owed by its elders be paid by its children and grandchildren. Moreover, successive generations of seniors have added to that debt burden by voting themselves greater subsidies to be financed by future generations. The most recent example is the prescription drug benefit added to Medicare by Congress and President Bush in 2003. (Often, benefit increases are not even subject to a vote. In 2004 the Bush administration unilaterally announced that Medicare would cover obesity treatments.)

Medicare's obligations and financing structure are unsustainable. A number of factors will fuel growth in Medicare spending in the coming years. First, demographic trends will reduce the number of workers available to finance Medicare relative to the number of beneficiaries. According to Medicare's trustees, the ratio will fall from about four workers per beneficiary in 2003 to about 2.4 workers per beneficiary in 2030 and continue to fall until there are only 2 workers per beneficiary in 2078. Second and related to that, those seniors will live longer. Social Security's trustees estimate that from 2003 to 2030 life expectancy at age 65 will grow from 16.0 years to 17.7 years for males and from 19.0 years to 20.3 years for females. Third, health care costs will continue to climb. In 2003 the Congressional Budget Office estimated that a mere 30 percent of Medicare's future growth would be due to society's aging, while 70 percent would be due to the rising cost of health care. Those factors exert a multiplying effect on each other; together they make Medicare as we know it unsustainable. Medicare's short-term cost growth is depicted in Figure 8.1.

Over the longer term, the situation becomes more severe. According to Medicare trustee Prof. Tom Saving, Medicare consumed 8 percent of federal income tax revenue in 2003—in addition to the Medicare payroll tax, beneficiary premiums, and other funding sources. As Medicare's implied promises come due, the share of federal income tax revenue that will have to be devoted to Medicare will grow, reaching half of all federal income tax revenue by 2042. Maintaining the Medicare program in its current form would require enormous tax increases. As a measure of how much Medicare has promised versus what its current funding mechanisms can deliver, Medicare's trustees calculate that we would need to deposit $61.6 *trillion* in an interest-bearing account in 2004 to cover all of Medicare's future deficits.

Another suspect premise is that government can or should devise a one-size-fits-all set of medical coverage benefits for tens of millions of

senior citizens. The character of government subsidies is determined through the political process, which guarantees perverse results. Whereas insurance leaves individuals responsible for routine expenses and protects against catastrophic losses, Medicare does the opposite. Subsidies begin at very low levels of consumption and disappear when beneficiaries' needs become greatest. The reason is politics: popularly elected lawmakers win more votes by spreading the ''insurance'' around to many people than by concentrating it on the few who need it most. When Medicare was enacted, it effectively destroyed a large and growing private market for health insurance for seniors. By 1962 an estimated 60 percent of seniors had voluntary health insurance coverage, up from 31 percent in 1952. Today, seniors essentially have only one place to go for health insurance, though they may augment the coverage Medicare offers by signing up for a Medicare health maintenance organization or by purchasing Medicare supplemental or ''Medigap'' coverage. Often, those additional benefits make seniors even less price sensitive and more likely to overconsume medical care.

A third premise is that participation in Medicare is voluntary. In fact, Medicare greatly restricts the freedom of workers, seniors, and the medical community. Even if Medicare neither crowded out other health insurance options for seniors nor forced seniors who decline Medicare benefits to forfeit all past and future Social Security benefits, funding Medicare would still be compulsory for all Americans forced to pay the 2.9 percent Medicare payroll tax or other federal taxes that finance the program through general revenues. Augmented by participants' Medicare premiums, those funds are distributed to medical professionals who provide care to Medicare beneficiaries and to the Medicare bureaucracy that sets and enforces the terms of the exchange. Providers often find dealing with Medicare nightmarish. Improperly billing Medicare can lead to criminal prosecution for fraud. Yet the Government Accountability Office found that in 2004 Medicare call centers answered providers' billing questions accurately and completely only 4 percent of the time. It is no wonder, then, that the Department of Health and Human Services reports improper Medicare payments were $12.1 billion in 2001. Moreover, Medicare prohibits participating providers from delivering Medicare-covered services to beneficiaries on a private basis, an affront to the right of patients and doctors to make mutually beneficial exchanges that affect no one else.

Reforming Medicare will require a multipronged approach. First, Congress should immediately repeal or delay implementation of the prescrip-

tion drug benefit enacted in 2003 before it takes effect in 2006. The Medicare trustees report that this program accounts for one-quarter of Medicare's projected deficits. This obligation would substantially increase the burden Medicare places on taxpayers and hinder further efforts at Medicare reform; it is already fueling calls for price controls on pharmaceuticals even before it has taken effect. A far less harmful alternative would be to retain the ''transitional'' drug subsidy that took effect in 2004. In that program, the federal government provides aid to low-income seniors primarily through a $600 subsidy in a quasi–health savings account for prescription drug expenses. In addition, Congress should immediately restore to seniors the freedom to contract privately with their physicians without penalty to either party and allow seniors to opt out of Medicare without forfeiting their Social Security benefits.

More fundamentally, Medicare must be transformed into a program in which seniors have an ownership interest in the money they are spending and medical care for the elderly is privately financed. The federal government should give all beneficiaries a voucher—which could be supplemented with private funds—to purchase health insurance from a variety of competing private insurers and/or to deposit in a health savings account. Any unused health savings account funds could be spent on nonmedical items. Seniors could then purchase coverage that suited their individual needs and would have incentives to be more prudent consumers. Seniors would conduct much more effective oversight of quality and fraud than the Medicare bureaucracy does because their own money would be on the line. Vouchers should be risk adjusted (less healthy seniors would receive larger amounts) to prevent insurers from accepting only healthy applicants. As Profs. Saving and Andrew Rettenmaier propose, the federal government should allow for long-term health insurance policies, which give insurers further incentive to pursue less-healthy seniors.

The federal government should allow workers to deposit some or all of their Medicare payroll taxes in a personal account for their health care needs in retirement. (This proposal would work much like Social Security personal accounts. See Chapter 4.) These funds would add to the capital stock, boost economic growth, and finance workers' health coverage in their golden years. It would move Medicare from a system of intergenerational transfers, with the inevitable political friction that results, to a prefunded system in which each generation pays its own way. In 1999 Harvard University Prof. Martin Feldstein estimated that diverting 1.4 percentage points of the current 2.9 percent Medicare payroll tax ''would

eventually be enough to pay for the full increase in the cost of Medicare, obviating a nine percentage point payroll tax increase.''

## *Medicaid*

The federal government and state and territorial governments jointly administer Medicaid—or more precisely, the 56 separate Medicaid programs throughout the United States. Medicaid participation is ostensibly voluntary for states, if not for taxpayers. States that wish to participate (all states do) must provide a federally mandated set of health benefits to a federally mandated population of eligible individuals. In return, each state receives federal funds in proportion to what it spends. The ratio of federal to state contributions, or ''match,'' is determined according to a state's relative wealth: poorer states receive a higher match, and wealthier states receive a lower match. On average, 57 percent of Medicaid funding comes from the federal government and 43 percent comes from the states. The more a state spends on its Medicaid program, the more it receives from the federal government. States can make their Medicaid benefits more generous than the federal government requires and can also extend eligibility to more people than the federal government requires. For beneficiaries, Medicaid is an entitlement. So long as they meet the eligibility criteria, they can receive benefits. Medicaid primarily serves four low-income groups: mothers and their children, the disabled, the elderly, and those needing long-term care.

Because the federal government provides an open-ended commitment to match state Medicaid spending, states have an incentive to underfund other priorities. Spending $1 on police buys $1 of police protection, but spending $1 on Medicaid buys $2 or more of health care. That financing structure also encourages states to pretend to increase Medicaid spending in order to draw down federal matching funds. States have used illegitimate schemes to lay hold of billions of federal dollars. The more a state expands its Medicaid program, the more harm it does to its health care sector. Medicaid eligibility induces many individuals (and their employers) to drop private coverage and take advantage of the ''free'' medical care, forcing taxpayers to purchase medical care for those who were able to obtain it anyway. Studies have shown that up to half of those who enrolled under Medicaid expansions already had private coverage. As Medicaid expands, more patients enter the medical marketplace with no regard for the cost of the items they consume.



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It makes little sense for taxpayers to send money to Washington, DC, so those funds can be sent back to their state capitol with strings (and perverse incentives) attached. Control over Medicaid should be devolved to the states. The states can then decide whether and how to maintain their own programs and learn from the successes and failures of each other's experiments.

In 1996 Congress eliminated the federal entitlement to a welfare check, placed a five-year limit on cash assistance, and froze federal spending on such assistance, which was then distributed to the states in the form of block grants with fewer federal restrictions. The results were unquestionably positive. Welfare rolls were cut in half, and poverty reached the lowest point in a generation (see Chapter 5). The federal government should emulate this success by eliminating the entitlement to Medicaid benefits, freezing federal Medicaid spending at current levels, and distributing Medicaid funds to the states as unrestricted block grants. That would eliminate the perverse incentives that favor Medicaid spending over other state priorities and lead to gaming of Medicaid's funding rules. According to Congressional Budget Office projections, freezing Medicaid spending at 2005 levels would produce $749 billion in savings by 2014, or enough to reduce the cumulative 10-year federal deficit of $2.3 trillion by one-third. In time, the federal government should give the states full responsibility for Medicaid by eliminating federal Medicaid spending while concomitantly cutting federal taxes.

States should pressure the federal government for maximum flexibility in administering their Medicaid programs. With unrestricted Medicaid block grants, states that wanted to spend more on their Medicaid programs would be free to raise taxes to do so, and vice versa. States should redesign their Medicaid benefits to emulate health savings accounts. (For more on health savings accounts, see Chapter 7.) In essence, states should give beneficiaries vouchers (perhaps risk adjusted) to purchase private health insurance and/or deposit in a health savings account for their medical expenses. By giving beneficiaries ownership of their Medicaid benefits rather than an open-ended entitlement, states would encourage beneficiaries to avoid wasteful consumption. That would eliminate administrative costs and rein in medical inflation.

Granted, more beneficiaries may show up to claim Medicaid vouchers than currently show up for free medical care, which raises cost implications. Though states can experiment with ways to counteract this problem, all subsidies increase the incidence of that which is subsidized and become

more attractive the more control they grant the recipient. Rather than an argument against Medicaid vouchers, however, this is an argument against subsidies. The only way to eliminate the problem is to eliminate the subsidy. Ultimately, states should phase out their Medicaid programs, cut taxes, and reduce regulations (see Chapter 7) to enable the market and private charities to meet the needs of the medically indigent.

## Conclusion

Medicare and Medicaid reform must be waged on many fronts. In addition to giving individuals an ownership interest in their benefits under those programs, policymakers must simultaneously reform other areas of the health care system to curb rising health care costs and with them the burden of health care entitlements.

### Suggested Readings

Blevins, Sue A. *Medicare's Midlife Crisis.* Washington: Cato Institute, 2001.

Edwards, Chris, and Tad DeHaven. ''War between the Generations: Federal Spending on the Elderly Set to Explode.'' Cato Institute Policy Analysis no. 488, September 16, 2003.

Epstein, Richard. *Mortal Peril: Our Inalienable Right to Health Care?* Reading, MA: Addison-Wesley, 1997.

Feldstein, Martin. ''Prefunding Medicare.'' National Bureau of Economic Research, Working Paper no. 6917, January 1999.

Friedman, Milton. ''How to Cure Health Care.'' *Public Interest*, Winter 2001.

Goodman, John C., and Gerald Musgrave. *Patient Power.* Washington: Cato Institute, 1992.

Goodman, John C., Gerald Musgrave, and Devon Herrick. *Lives at Risk: Single-Payer National Health Insurance around the World.* Lanham, MD: Rowman & Littlefield, 2004.

Hoff, John S. *Medicare Private Contracting: Paternalism or Autonomy?* Washington: AEI Press, 1998.

Pipes, Sally. *Miracle Cure: How to Solve America's Health-Care Crisis and Why Canada Isn't the Answer.* San Francisco: Pacific Research Institute, 2004.

Rettenmaier, Andrew J., and Thomas R. Saving. *The Economics of Medicare Reform.* Kalamazoo, MI: W. E. Upjohn Institute for Employment Research, 2000.

Teske, Richard. ''Abolishing the Medicaid Ghetto: Putting 'Patients First.' '' American Legislative Exchange Council, The State Factor no. 0206, April 2002.

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