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12. Medicare

Congress should

- establish, in all parts of Medicare, premiums proportionate to lifetime earnings;
- allow seniors to opt out of Medicare completely, without losing Social Security benefits;
- give Medicare enrollees a means-tested, risk-adjusted voucher with which they may purchase the health plan of their choice;
- limit the growth of Medicare vouchers to the level of inflation;
- allow workers to save their Medicare taxes in a personal, inheritable account dedicated to retirement health expenses; and
- fund any ''transition costs'' by reducing other government spending, not by raising taxes.

Medicare is the federal entitlement program that provides health insurance to the elderly and disabled. Despite its popularity with seniors, the disabled, and those who might otherwise have to care for them, Medicare infringes on the right of workers to control their retirement savings and on the freedom of seniors to control their own health care. Medicare has done enormous damage to the U.S. health care sector and to individual liberty. Absent congressional action, that damage will only increase over time. Medicare reform is the nation's highest health-policy priority.

Rising Costs and Restricted Freedom

Congress created Medicare in 1965 on premises both morally suspect and impractical. (The same legislation created Medicaid; see Chapter 13.) One premise is that government should tax young workers 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 celebrate this inequity, the 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 its children and grandchildren pay the debt it is owed by its elders. Yet successive generations of seniors have voted themselves greater subsidies to be financed by younger taxpayers. The most recent example is Medicare Part D, the prescription drug benefit created by Congress and President Bush in 2003. Less expensive benefit expansions occur routinely, without congressional action, every time Medicare approves an expensive new technology for coverage. In 2004, the Bush administration unilaterally announced that Medicare would cover obesity treatments. The growing generosity of Medicare benefits is the principal reason why Medicare has been responsible for at least a dozen tax increases in its 43-year history. Medicare thus enables each generation to extract more from its children and grandchildren than it gave to its parents and grandparents.

Medicare's obligations and financing structure are unsustainable. A number of factors will fuel growth in Medicare spending in the coming years. 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 4 workers per beneficiary in 2003 to about 2.4 workers per beneficiary in 2030 and will continue to fall until there are only 2 workers per beneficiary in 2078. Health care costs will continue to climb. In 2003, the Congressional Budget Office estimated that 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. Existing revenue streams for Medicare are insufficient to keep the promises that Congress has made to future beneficiaries. Medicare's trustees estimate that Congress would need to put over $80 trillion in an interest-bearing account in 2008 to cover those future funding gaps. In 2008, the entire economic output of the United States was less than $15 trillion. The $700 billion bailout of the financial sector enacted by Congress in late 2008 is less than 1 percent of the amount required to bail out Medicare. The Congressional Budget Office estimates that if Congress were to meet that shortfall by raising income taxes, federal individual income tax rates would roughly double by 2050, with the top marginal rate reaching 66 percent. The CBO further estimates that tax increases of that magnitude could suppress national income by as much as 20 percent.

A second suspect premise is that participation in Medicare is voluntary. In fact, Medicare greatly restricts the freedom of workers, seniors, and entrepreneurs. Medicare crowds out other health insurance options for seniors and forces seniors who decline Medicare benefits to forfeit all past and future Social Security benefits. It 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. And of course funding Medicare is hardly voluntary; Americans are required to pay the 2.9 percent Medicare payroll tax and other federal taxes, which finance the program through general revenues.

A third premise is that government can or should devise a one-size-fits-all package of health insurance benefits for tens of millions of senior citizens. To reduce opposition within the health care industry and ensure enactment, Medicare's sponsors modeled Medicare coverage on Blue Cross Blue Shield coverage as it existed in 1965. The industry wanted Medicare to pay physicians on a fee-for-service basis and to have little ability to refuse payment for low-value or inefficient services. That sounds appealing on the surface—few people like the idea of having government ration medical care. Yet Medicare ends up committing the opposite sin—wasting money on useless services—which can be just as harmful as government rationing. There is considerable evidence that Medicare wastes vast sums of money on low-value services and that fee-for-service payment is a prime contributor to such waste. Researchers at Dartmouth Medical School estimate that 30 percent of Medicare spending does nothing to make beneficiaries healthier or happier. That suggests that Medicare spends about $150 billion each year—roughly the entire economic output of South Carolina—on medical services of no discernible value. Political pressure from the industry prevents Congress or the Medicare bureaucracy from dealing with those problems. (Every dollar of wasteful Medicare spending is a dollar of income to *somebody*, and that somebody typically has a lobbyist.) Having locked in a payment system based on fee-for-service reimbursement and a fragmented delivery system, Medicare suppresses competition from alternative payment and delivery systems (see also Chapter 15, ''Health Care Regulation'').

When Medicare was enacted, it effectively destroyed a large and growing private market for health insurance for seniors that would have enabled greater experimentation and competition. 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. They may augment their Medicare coverage by enrolling in a private Medicare Advantage health plan or by purchasing Medicare supplemental or ''Medigap'' coverage. Medigap plans typically make seniors even less price sensitive and more likely to overconsume care. Medicare Advantage plans (previously known as Medicare + Choice plans) tend to provide an unstable alternative to traditional Medicare, as Congress frequently adjusts payment levels and private plans enter and exit the program on the basis of the (perceived) adequacy of those payments.

Supporters claim that Medicare is more efficient than private insurance because it has lower administrative costs. To reach that conclusion, they ignore many of Medicare's administrative costs, in particular the ''excess burden'' or reduced economic output caused by Medicare taxes. Those costs are estimated at 20 to 100 percent of Medicare's expenditures, dwarfing any administrative costs of private firms. And decades of reports by government watchdogs demonstrate that the main way Medicare avoids administrative costs is by failing to scrutinize claims to prevent fraud or to ensure value. 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 of $12.1 billion in 2001. Medicare's avoidance of administrative expenses is a vice, not a virtue.

Reform of Priorities

Medicare should be policymakers' top health care priority, and the program demands immediate reform. Congress should focus immediately on two steps. First, it should charge premiums for all parts of Medicare, charging higher premiums to seniors with higher lifetime earnings (i.e., ''means-tested'' premiums). Generally, seniors pay premiums only for Part B (physician insurance) and Part D (prescription drug coverage), not for Part A (hospital insurance). Those combined premiums currently account for about 13 percent of total Medicare spending. Congress should increase premiums for high earners until premiums cover at least 25 percent of total outlays.

Increasing premiums on high-income earners creates a problem: it discourages high-income seniors from working by penalizing them with higher premiums. Charging higher premiums to seniors with high *lifetime* incomes can mitigate that problem. (If *past* earnings are the primary factor

influencing Medicare premiums, strategic behavior becomes more difficult. Seniors would be unable to alter their past earnings, and reducing their current earnings would have less of an effect on their premiums. The Social Security Administration already possesses the data necessary to calculate seniors' lifetime earnings.)

Second, Congress should allow seniors to opt out of Medicare without losing their Social Security benefits.

Broader means-testing and permission for seniors to opt out of Medicare would achieve only modest progress in shoring up the program's finances and restoring seniors' freedom. They would have an enormous effect, however, on the politics of Medicare. As well-to-do seniors see their premiums rise, many will decide that Medicare is a bad deal and will leave the program. If they are allowed to retain their Social Security benefits, even more will exit the program. Today, Medicare covers nearly all seniors, whose medical care is heavily subsidized by younger workers. Reducing those subsidies, and reducing the share of seniors dependent on Medicare, will change the political dynamics of the program and build a constituency among seniors for further and more substantial Medicare reforms.

Critics will object to broader means-testing and permission for seniors to opt out of Medicare for those very reasons. Yet the history of Medicare is one of politically powerful seniors uniting against the interests of younger workers. If such reforms can improve Medicare's financial picture as well as weaken the political coalition that persistently and increasingly raids the paychecks of working Americans, then those are two arguments in their favor.

Next, Congress should end federal micromanagement of the health care sector and replace Medicare with a prefunded system where workers invest their Medicare taxes in personal accounts dedicated to their health needs in retirement. There is no need for Congress to dictate what health insurance benefits seniors should obtain or how physicians, hospitals, and so forth should be paid. Congress should grant all Medicare beneficiaries a voucher that they may use to purchase the health plan of their choice. Overall, the amount that Congress allots to Medicare vouchers should grow no faster—and could grow more slowly—than overall inflation. To enable the poor and sick to obtain a minimum level of coverage, Congress could provide larger vouchers to them, and smaller vouchers to healthy and wealthy beneficiaries. Seniors who desire more expensive health insurance could supplement their vouchers with private funds, just as they do now with

Medicare Advantage and Medigap plans. Medicare vouchers would let the market—rather than the Medicare bureaucracy—determine prices, payment systems, delivery systems, and how to reward quality.

Finally, Congress should stop the looting of the young by the old. Congress should allow workers to put their full 2.9 percent Medicare payroll tax in a personal savings account dedicated to their retirement health needs. Workers could invest those funds in a number of vehicles and augment those funds in retirement with other savings. This proposal for Medicare personal accounts is similar to many Social Security reform proposals (see Chapter 17).

One similarity is that diverting workers' tax payments into personal accounts makes it difficult to pay current benefits. Congress can make up much of those ''transition costs'' by cutting Medicare outlays. As noted earlier, an estimated 30 percent of Medicare outlays do nothing to improve beneficiaries' health or make them any happier, which suggests that Medicare spending could be reduced by as much without harming seniors' health. Identifying and eliminating those wasteful expenditures will be extremely difficult, and Congress has proved spectacularly inept at the task. Yet competition can achieve what Congress cannot: giving seniors vouchers and the freedom to make their own health care decisions would encourage them to select health plans that eliminate those unnecessary costs. In giving vouchers to seniors, Congress could cut overall Medicare outlays by as much as 30 percent, again with little if any adverse effect on health outcomes. If Congress is unable or unwilling to cover all transition costs by reducing Medicare outlays, it should make up the gap by cutting other government spending (see Chapter 4)—not by raising taxes.

Suggested Readings

Brown, Kent Masterson. ''The Freedom to Spend Your Own Money on Medical Care: A Common Casualty of Universal Coverage.'' Cato Institute Policy Analysis no. 601, October 15, 2007.

Cannon, Michael F. ''Bill Gates Doesn't Need Any Help from Younger Workers.'' In *Should Medicare Be Means-Tested? A Symposium*. Minneapolis: Center of the American Experiment, 2007.

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Hyman, David A. *Medicare Meets Mephistopheles*. Washington: Cato Institute, 2006.
Kling, Arnold. *Crisis of Abundance: Rethinking How We Pay for Health Care*. Washington: Cato Institute, 2006.
Pauly, Mark V. *Markets without Magic: How Competition Might Save Medicare.* Washington: American Enterprise Institute, 2008.
Saving, Thomas S., and Andrew Rettenmaier. *The Diagnosis and Treatment of Medicare*. Washington: American Enterprise Institute, 2007.
Zycher, Ben. ''Comparing Public and Private Health Insurance: Would A Single-Payer System Save Enough to Cover the Uninsured?'' Manhattan Institute Medical Progress Report no. 5, October 2007.

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