Medicare Reforms

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Overview

The federal government subsidizes medical care for more than 45 million elderly and disabled Americans through Medicare. Medicare is the third-largest federal program after Social Security and defense, and it will cost taxpayers about $430 billion in fiscal year 2010. Medicare is one of the fastest-growing programs in the federal budget, with spending likely to double over the next decade and to surpass Social Security spending by 2028. Numerous studies suggest that about one-third of Medicare spending is wasted.

At the signing ceremony for the new Medicare program in 1965, President Lyndon Johnson declared, "No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents." Since then, taxes to support the program's skyrocketing outlays have grown steadily for 45 years, eating away at the incomes and hopes of young families—exactly the opposite of what Johnson promised.

Medicare's spending needs to be controlled, but high costs aren't the only problem with the program. Medicare reduces individual freedom, and its price and exchange controls increase costs and reduce the quality of medical care for all patients. The program is also subject to high levels of waste, fraud, and abuse.

Polling data that show public support for Medicare do not prove that the program is a success. Such polls reflect the fact that the government has made enrollees dependent on Medicare by taking away their freedom to choose better health insurance options. It is only natural that Medicare enrollees would want to protect the only source of health insurance coverage they have left to them.

Medicare reforms that allow individuals to control their health care dollars would eliminate wasteful spending, would provide enrollees better choices and better medical care, and would do so at a lower cost to taxpayers. Congress should move retiree health care from today's dysfunctional system of central planning to an innovative system based on personal savings, individual choice, and competition. Medicare vouchers and expanded health savings accounts would dramatically improve the nation's health care system.

Medicare Basics

In the 20th century, Congress replaced personal savings, family obligations, and charity with giant centralized programs to support the elderly. Congress funds the two main programs for the elderly—Social Security and Medicare—primarily by taxing younger workers. That intergenerational funding structure has set the nation on a financial collision course because the number of elderly people in the nation will grow 75 percent by 2030, while the number of working-age people supporting them will grow by just 11 percent.

Congress created Medicare in 1965 as part of President Lyndon Johnson's Great Society agenda and has expanded the program almost continuously since. Medicare subsidizes medical care for 45 million Americans who are age 65 and older, are disabled, have end-stage renal disease, or have amyotrophic lateral sclerosis. Today, Medicare provides coverage for hospital care (Part A), physician services and outpatient care (Part B), and prescription drugs (Part D). Researchers call Parts A and B "traditional" Medicare because they date back to 1965. Many enrollees augment traditional Medicare by purchasing private supplemental insurance called Medigap coverage. In lieu of traditional Medicare, about 20 percent of enrollees choose to participate in the Medicare Advantage program (Part C), where Medicare pays private insurers to deliver Medicare's standard package of subsidized services, as well as additional coverage.

About 10 percent of Medicare revenue comes from enrollee premiums, but most Medicare revenue comes from taxes on younger workers. The main funding sources are a 2.9 percent federal payroll tax and general revenues, which are mainly income tax revenues.

Medicare is less a "sacred bond between the generations" than a pyramid scheme allowing each generation to take advantage of the next. Since the elderly are a politically powerful group, each generation has been able to secure larger Medicare subsidies at the expense of young working-age Americans. Medicare has spawned an average of one tax increase every three years for the past 45 years.
This pyramid scheme cannot last. Medicare spending is rising much faster than tax revenue, thanks to the escalating retirement of the baby-boom generation, increasing longevity, and rising outlays per enrollee. The ratio of workers paying Medicare taxes to Medicare enrollees was four to one not long ago. It has fallen to 3.7 workers today. It will reach 2.4 by 2030 and will continue to fall after that. The gap between projected Medicare spending and dedicated revenues is mind-bogglingly large. In 2009, Medicare's trustees reported that if Congress wanted to cover all future gaps in Medicare's finances, it would have to deposit a staggering $86 trillion in an interest-bearing account. For comparison, the U.S. gross domestic product was about $14 trillion in 2009. The Medicare financing gap dwarfs the federal government's public debt from accumulated deficits of about $9 trillion.

Younger workers will face massive tax increases unless Congress cuts Medicare spending. Jagadeesh Gokhale has estimated that Congress would have to increase the Medicare payroll tax sixfold—from 2.9 percent to 17.8 percent of all wages—to pay for all of Medicare's current promises. Martin Feldstein estimates that such a tax increase would so damage the economy that the total burden would equal nearly 25 percent of wages. Congress cannot solve the Medicare-financing problem by borrowing money. Government debt is just a promise to raise taxes in the future. It obliges future generations to pay the cost of today's spending, plus interest. Not only would additional government debt damage the economy and risk a Greek-style default crisis, but also it is unjust to saddle future generations with that burden. Lawrence Kotlikoff and Jagadeesh Gokhale write that debt financing of the entitlement programs amounts to "borrowing from our grandchildren and their children without their consent." Joe Antos and Mark Pauly note, "The older generation made a generous promise to itself—then imposed the cost without their consent." The Congressional Budget Office provides another perspective on Medicare's finances. If Congress fails to reform entitlement programs, and other federal programs remain at their current shares of GDP, federal spending will double from 21 percent of GDP in 2008 to a staggering 42 percent by 2050. Given that state and local taxes consume more than 10 percent of GDP, the size of government in the United States would climb to more than half of the economy. The largest factor driving that growth is Medicare, which would grow from 3.2 percent of GDP in 2008 to 9.5 percent by 2050. Contrary to President Johnson's pledge, it is Medicare that is eating away at the incomes and hopes of young families. It will continue to do so unless Congress dramatically reduces Medicare spending.

Causes of Rising Costs

Since the creation of Medicare in 1965, the program's basic structure has caused spending to grow rapidly decade after decade. Even aside from the role of general inflation and demographic factors in rising health costs, there are at least four additional cost drivers built into Medicare's current design. First and foremost, Medicare allows enrollees and health care providers to spend other people's money. That all but eliminates any incentive for either party to economize and invites waste, fraud, and abuse. Researchers at the Dartmouth Atlas Project and elsewhere estimate that about 30 percent of Medicare spending does nothing to make patients healthier or happier. That estimate does not include fraud and abuse, which adds an extra layer of waste and invites fraud, abuse, and waste. Researchers at the Dartmouth Atlas Project and elsewhere estimate that about 30 percent of Medicare spending does nothing to make patients healthier or happier. That estimate does not include fraud and abuse, which adds an extra layer of waste and invites fraud, abuse, and waste.

Second, Medicare spending grows because the government keeps expanding the list of goods and services that Medicare subsidizes. Congress created the huge Part D prescription drug program in 2003, which has added hundreds of billions of dollars to the federal debt because legislators provided no funding source. Other expansions occur, without any congressional action or approval, when Medicare officials deem new procedures eligible for subsidies. In 2004, the Bush administration unilaterally announced that Medicare would begin subsidizing obesity treatments.

Third, Medicare overpays for many items because it often sets prices higher than a free market would. In the 1990s, for example, ambulatory surgical centers (ASCs) increased their productivity. A competitive market would have quickly translated those gains into lower prices for consumers. Yet Medicare took 16 years to lower the prices it paid ASCs. Those artificially high prices encouraged excessive use of ASC services with taxpayers footing the bill. Medicare sets prices too high in many other areas of medicine, including cardiovascular care.

Fourth, Medicare's fee-for-service structure—based on price and exchange controls—encourages providers to deliver too many services because that is what the structure rewards. That fact does not imply any greediness on the part of providers. Medicine entails considerable uncertainty, and Medicare encourages providers to respond to that uncertainty by delivering more services. These factors help explain why actual Medicare spending usually surpasses projections. When Congress created Medicare in 1965, officials projected Part A would cost $9 billion by 1990; it ended up costing $67 billion. In 1967, official estimates projected the cost of the entire Medicare program would reach $12 billion in 1990; it cost $110 billion that year. When Congress created Medicare's home-care subsidies in 1988, official estimates projected it would cost $4 billion in 1993, but it ended up costing $10 billion.

So when the Congressional Budget Office projects that Medicare spending will grow at an annual rate of 7.0 percent during the next decade, it is important to take that projection with a grain of salt, given that Medicare grew at an average annual rate of 9.3 percent over the past decade.

Fraud and Abuse
Taxpayers foot the bill for an alarming amount of fraudulent and improper Medicare spending. Medicare’s massive size and the huge numbers of doctors and hospitals in the system make it very difficult to police. The government processes 1.2 billion Medicare claims each year by computer, generally without human eyes checking them for accuracy.

The Government Accountability Office estimates that Medicare makes about $17 billion in improper payments each year, defined as fraudulent or erroneous overpayments to health care providers. That figure does not include the Part D prescription drug program, which auditors believe is highly susceptible to abuse.

Other estimates of improper Medicare payments are higher. Malcolm Sparrow of Harvard University, a top specialist in health care fraud, argues that estimates by federal auditors do not measure all types of improper payments. He believes improper payments account for as much as 20 percent of federal health spending, which would be about $85 billion a year for Medicare.

Sparrow says that criminals can easily rip off federal health care programs by carefully filling out and submitting the proper electronic forms, because the "claims will be paid in full and on time, without a hiccup, by a computer, and with no human involvement at all." The abuses do not stem just from occasional overbilling by doctors but also from organized looting of health care programs by criminals. The Washington Post reported a good example in 2008. A high-school dropout in Miami with a laptop computer single-handedly cheated taxpayers out of $105 million by electronically submitting 140,000 fraudulent Medicare claims for equipment and services over a four-year period.

There are many ways that Medicare allows people to rip off taxpayers: "Billing by health care providers for services not rendered, billing for products not delivered, misrepresenting services, unbundling services, billing for medically unnecessary services, duplicate billing, increasing units of service which are subject to a payment rate, falsifying cost reports resulting in increased payment to the health care provider, kickbacks, and on and on." One area of rampant fraud is Medicare's medical equipment subsidies. One scam occurs when doctors steer patients to purchase (Medicare-subsidized) motorized wheelchairs that they don't really need, for which the doctors receive "kickbacks" from wheelchair supply companies or other operatives. A 2008 report by Senate investigators found that 30 percent of medical equipment payments that they examined appeared to be fraudulent.

Fraud appears to be an important cause of the growth in Medicare home health care spending. Medicare pays for home visits by health professionals under certain limited conditions, but patients find ways to skirt those limits. Criminal gangs have simply looted this program by submitting false claims. The costs of Medicare home health care coverage soared 44 percent over five years to 2009, and fraud appears to be an important cause of the increase.

Efforts to combat Medicare fraud frequently fail, and they can involve a vicious cycle. Cracking down on fraud may open new opportunities for fraud. And fighting fraud often involves new layers of complex regulations that may "discourage organizational innovation and market entry, and [ensnare] innocent providers." To get out of the vicious cycle of government health care fraud, we should move toward a consumer-driven system where patients and providers would have strong incentives to be frugal with health care dollars and crack down on waste.

Central Planning

Medicare is a centrally planned economic system, and it has many of the failings of centrally planned economies in communist and socialist countries. Congress and Medicare administrators dictate prices and other terms of exchange for thousands of different medical services that Medicare purchases from about 650,000 physicians and 30,000 health care facilities. These price and exchange controls fill more than 100,000 pages of regulations and related guidance, and the controls have a large effect on the availability and quality of medical goods and services in the United States.

Medicare operates 16 different pricing systems for different types of health care services. Physician services provided under Part B, for example, use a complex pricing scheme based on the "resource-based relative value scale" (RBRVS). The government assigns each of 6,700 distinct physician services a value, which is then adjusted for each of 89 regions in the United States and converted to dollars. The result is that the government sets about 600,000 different prices for just this part of Medicare. A 29-member board of doctors sets the "relative values" of medical procedures under the RBRVS. The values are based on the inputs to medical care, such as the cost of procedures, but they do not take into account consumer-side factors, such as the quality or outcomes of procedures, or the demand.

Medicare's Part A, which covers hospital services, has its own centralized pricing scheme based on the diagnosis-related group (DRG) classification system, which includes more than 500 different types of patient cases. Other Medicare pricing schemes include those for ambulance services, home health agencies, skilled nursing facilities, and long-term care facilities. Each is a hugely complex price-setting system that generates a range of economic distortions.

Free-market prices are much different from these government-set prices. Market prices emerge through the voluntary interaction of consumers and competing producers, and they guide consumers to use resources wisely and guide producers to make goods and services more efficiently and more widely available. The Medicare Payment Advisory Commission notes that "competitive markets demand continual improvements in processes and quality.

Medicare's price and exchange controls stymie improvements in efficiency and innovation because controlled prices cannot capture the information that producers and consumers reveal when they buy and sell items in open markets. Even if a government bureaucracy could capture this information at a point in time, economic conditions change too frequently for the government to keep pace. Larry Summers, a key economic adviser to President Obama, has observed: "Price and exchange controls inevitably create harmful economic distortions. Both the distortions and the economic damage get worse with time."
pricing algorithms and backroom negotiations used in communist systems.... Not surprisingly, we reap the same inefficient results that characterized communism." In a joint report, the Federal Trade Commission and Department of Justice explained that the "unintended consequence of [Medicare's] administered pricing systems has been to make some hospital services extraordinarily lucrative and others unprofitable. As a result, some services are more available (and others less available) than they would be in a competitive market." When setting medical prices, the government causes damage when it sets prices either too high or too low. If Medicare sets prices too low, it creates shortages of goods and services. For example, Medicare's pricing structure has helped create a shortage of primary care physicians relative to specialist doctors because specialist procedures generally receive high Medicare reimbursements.

If Medicare sets prices too high, resources are wasted on services that provide less value than their cost, as is the case for ambulatory surgical centers and cardiovascular care. The FTC-DOJ report noted, "This pricing distortion creates a direct economic incentive for specialized cardiac hospitals to enter the market; such entry reflects areas that government pricing makes most profitable, which may or may not reflect consumers' needs and preferences." Excessive Medicare prices can also have a negative effect on quality. Research suggests that Medicare overpays specialists, leading to an excess of specialists, even though having a high proportion of specialists increases spending and may reduce quality. When Medicare sets prices too low, the FTC and DOJ write, it creates shortages, "lowers the quality of the services that are provided, and diminishes the incentives for innovation." Medicare's exchange controls are even more harmful. Researchers describe Parts A and B as "fee-for-service" Medicare because those programs dictate that providers receive a fee for each individual service or hospitalization, rather than for each patient or illness they treat. That locks most of the U.S. health care sector into fee-for-service payment, which encourages providers to deliver unnecessary and expensive services because providers make more money the more services they deliver. Medicare's fee-for-service exchange controls also penalize providers who adopt many quality-improvement efforts—such as coordinated care, electronic medical records, comparative-effectiveness research, and error reduction—because those efforts result in fewer services. The Medicare Payment Advisory Commission reports that Medicare pays providers "even more when quality is worse, such as when complications occur as the result of error." Providers cannot reduce errors as much as they should because, as Christensen and his coauthors write, "there literally is no money to be made from doing it." Medicare is, therefore, helping fuel America's epidemic of medical errors, which may claim as many as 100,000 lives each year.

Researchers are well aware of Medicare's poor record on quality. Former Medicare administrator Tom Scully notes that within a region, Medicare pays "the exact same amount for hip replacement and the same amount for a heart bypass, if you're the best hospital or the worst hospital." The FTC-DOJ report notes that Medicare does "not reward providers who deliver higher-quality care or punish providers who deliver lower-quality care." Even as Medicare spends hundreds of billions of dollars on unnecessary and harmful services, it fails to deliver high-quality services to many enrollees. One study estimated that for 16 indicators, Medicare enrollees receive recommended care less than two-thirds of the time. Harvard economists Katherine Baicker and Amitabh Chandra found that across states, higher Medicare spending "is not merely uncorrelated with the quality of care provided" but "negatively correlated with the use of effective care." When politicians and health care analysts complain about the harms created by America's fee-for-service payment system, they are complaining about Medicare's price and exchange controls.

Those price and exchange controls harm more than just Medicare enrollees. Medicare is the largest purchaser of medical services in the world. Thus, its price and exchange controls shape the entire U.S. health care sector. Non-Medicare patients use the same hospitals as Medicare patients, and all hospitals operate according to the incentives created by their largest customer. Tom Scully has noted: "Sadly, Medicare and Medicaid are such dominant players that the private sector has been forced to follow along—shadow pricing [Medicare's price and exchange controls] in recent years.... In the long run, government price fixing for services has never worked in any system in any society, and I don't think it can work here, either. Having federal price fixing, no consumer information or pricing sensitivity, and no measurement of quality has led to predictable results: artificially high prices and uneven quality." Forty-five years of central planning have increased costs and reduced the quality of care for patients both inside and outside the Medicare program, leaving Americans with medical care that is inferior to what they would have otherwise received. Making health care better and more affordable requires eliminating Medicare's price and exchange controls, letting consumers choose the payment system that best serves their needs, and letting prices emerge through competition.

Restricting Freedom

Medicare's supporters erroneously describe it as a voluntary program. In fact, Medicare is a compulsory program that restricts the freedom of taxpayers, the elderly, and health care providers.

Taxpayers have less economic freedom as a result of the Medicare program. The trillions of dollars that they pay in income and payroll taxes to support Medicare leaves them with less income to pay for food, clothing, and other items.

The elderly can, in theory, opt not to enroll in Medicare. However, the reality is that the government forces people who opt out of the program to forfeit all their Social Security benefits, past and future. That makes Medicare enrollment essentially compulsory for all but the wealthiest seniors.

The introduction of Medicare showered massive subsidies on seniors, but it largely destroyed their freedom to choose alternative health insurance plans. Before 1965, about half of elderly Americans already had health insurance, and the private health insurance market had been growing and covering an increasing share of seniors. But thanks to the federal government, the elderly ultimately lost their private health insurance upon retirement because Medicare crowded out private options.
Medicare even restricts its enrollees’ ability to control their health care decisions. Similar to Britain’s National Health Service, the federal government’s Centers for Medicare and Medicaid Services has the legal authority to deny patients services that they and their doctor think are medically necessary, based on the Medicare bureaucracy’s arbitrary valuation of those patients’ lives.  

Medicare also restricts enrollees’ freedom to choose their doctor and spend their own money on medical care. If a Medicare enrollee purchases medical services with his or her own funds, the government bans his or her health care provider from the Medicare program for two years. Few providers can survive without Medicare patients. Thus, this regulation effectively prohibits most enrollees from spending their own money on medical care as they see fit. Canada’s socialized health care system maintained a similar prohibition on purchasing private health insurance until Canada’s Supreme Court struck down that measure in 2005 as a violation of Canadians’ human rights.

Finally, Medicare denies producers and consumers the freedom to engage in mutually beneficial exchanges. Only the wealthiest Americans can afford to decline Medicare coverage, and if entrepreneurs step outside Medicare’s price and exchange controls, those are the only patients they will be able to serve. Medicare, therefore, denies entrepreneurs—including doctors and health plans—the freedom to devise new and better ways of financing and delivering medical care. This situation denies Medicare enrollees the benefits of robust competition between clinicians, medical facilities, medical suppliers, and health plans, and the innovations that competition would bring.

Cutting Spending

Congress must cut Medicare spending, both to avert a fiscal crisis and to reduce the huge and unfair government transfers from the young to the old. At the same time, the vast amounts of waste in the current Medicare structure indicate that Congress can cut spending without harming the health of enrollees.

The elderly are more prosperous today than ever before. When Congress created Medicare, the elderly poverty rate (28.5 percent) was nearly double the overall poverty rate (14.7 percent). But today, the elderly poverty rate (9.7 percent) is lower than the overall poverty rate (13.2 percent). The average net worth of Americans aged 65 to 74 is also the highest of any age group. Even though the elderly’s ability to work has risen, today’s elderly are working less and consuming more than in the past. This is all good news for the elderly, but it’s not clear why the young should bear an increasing tax burden to support the elderly’s lifestyles.

How Congress reduces Medicare spending is extremely important. Using comparative-effectiveness research to ration care or tweaking Medicare’s price and exchange controls does not improve quality and usually doesn’t contain outlays. One reason is that every dollar of wasteful Medicare spending is a dollar of income to someone, and that someone always hires a lobbyist to protect him or her. The larger reason, however, is that health care is too complex and personal to be planned by a central authority. Even if some central authority—such as the newly created Independent Payment Advisory Board—could run Medicare insulated from political pressure, it could not possibly collect or use all the necessary information about available resources and consumers’ needs.

A variety of Medicare proposals would create modest taxpayer savings, but these reforms would not address the program’s fundamental problems.

- **Increasing premiums.** Part B premiums originally covered 50 percent of Part B outlays, but today they cover just 25 percent with taxpayers picking up the other 75 percent. Enrollees currently pay for about 10 percent of Medicare’s overall outlays, so it’s not unreasonable to ask them to pay a larger share. Were Congress to increase Part B premiums to 35 percent of outlays, the 10-year savings would be $217 billion.

- **Increasing cost sharing.** In 2009, Part B had a deductible of just $135 annually and 20 percent coinsurance above that. Such low cost sharing leads to overconsumption, as do Medigap policies that often provide first-dollar coverage. The Congressional Budget Office estimates that increasing and conforming the deductibles for Parts A and B and Medigap policies would save taxpayers $73 billion by 2020. Those changes would reduce Medigap premiums, which would partly offset enrollees’ higher out-of-pocket costs.

- **Increasing the eligibility age.** Average life expectancy in the United States has risen from about 70 in 1965 to 78 today, and it may reach 80 by 2020. In 1983, Congress began gradually increasing Social Security’s normal retirement age from 65 to 67. The Congressional Budget Office estimates that doing the same with Medicare could reduce federal outlays by $92 billion over 10 years.

- **Means-testing premiums.** Congress currently requires higher-income Medicare enrollees to pay for a larger share of their Part B and Part D coverage than other enrollees pay. In 2009, for example, Medicare enrollees with incomes above $213,000—a very small segment of enrollees—paid 80 percent of the cost of their Part B coverage, compared to the usual 25 percent. The Congressional Budget Office estimates that expanding means testing to just 5 percent of Part B enrollees could save $21 billion over 10 years. Extending Part B’s current means test to Part D could save $10 billion over 10 years. Congress should expand "means testing" to more higher-income enrollees and require those enrollees to shoulder a larger share of the cost of their coverage.

Some of these modest changes would make the public more receptive to more fundamental Medicare reforms because they would help expose what a lousy deal the current program provides. In terms of fixing the system, however, these changes amount to bailing water from a sinking ship rather than repairing the hull.

Congress won’t eliminate wasteful health care spending or substantially reduce the growth rate in Medicare spending as long as enrollees and their health care providers are spending other people’s money. Nor can Congress improve the quality of care for enrollees or the rest of us until it frees the marketplace from Medicare’s price and exchange controls.

The next two sections describe the fundamental Medicare reforms that Congress should enact: individual vouchers and large health savings accounts. Those changes promise to dramatically reduce health care costs and improve the quality of care for Medicare enrollees and other Americans. They would also help put the nation in a position to phase out federal health care subsidies in the long run in favor of a system built around personal savings, individual choice, and competition.
Congress should end traditional Medicare and give each enrollee a voucher to purchase the health plan of his or her choice. Subsidizing Medicare enrollees through fixed-dollar vouchers would give enrollees more control over their medical care, encourage them to be more cost conscious, spur innovation by eliminating Medicare's price and exchange controls, and contain federal spending.

Vouchers would also promote all dimensions of health care quality by allowing open competition between fee-for-service and other payment systems. If fee-for-service health plans allowed too many medical errors, for example, consumers would switch to prepaid plans. If prepaid plans refuse to cover all necessary services, patients would flee to fee-for-service plans.

Congress should provide larger vouchers to sick and poor enrollees to put them on a similar footing with healthy and wealthy enrollees when shopping for health insurance. Congress could adjust voucher amounts for health status using methods already in use by the Centers for Medicare and Medicaid Services, and for lifetime income using data already on hand at the Social Security Administration.

Enrollees could purchase a more expensive plan by supplementing the Medicare voucher with their own funds. Alternately, enrollees could choose a lower-cost plan and deposit unspent voucher funds in a personal health savings account that could be used for out-of-pocket medical expenses and future premiums. Unlike today's Medicare program, vouchers would give enrollees an incentive to choose health plans that weed out wasteful spending.

Vouchers are the only way to protect Medicare enrollees from government rationing of medical care. Congress has no choice but to reduce Medicare spending. Only vouchers can give Medicare enrollees the freedom to retain the coverage and medical services they value most. Otherwise, politicians and government officials will decide which medical services enrollees will and will not receive.

Vouchers would enable Congress to contain runaway Medicare spending. Each year, Congress would be able to adjust total Medicare outlays for the growth in enrollees and overall inflation. That change would put Medicare outlays on a reasonable and predictable path and would permit current and future enrollees to adjust over time. Given that the best evidence suggests that about one-third of Medicare spending does nothing to make enrollees happier or healthier, slowing the growth of Medicare outlays should not harm enrollees' health.

Congress should allow Medicare enrollees—and all consumers—to purchase any health insurance plan licensed by any of the 50 states. That change would tear down barriers that currently prohibit purchasing health insurance across state lines, and it would enable Medicare enrollees to purchase health insurance that provides them the coverage and consumer protections they demand at an affordable premium. Restoring the freedom to choose one's own health plan would also deny Congress and state governments the power to impose unwanted regulatory costs on Medicare enrollees.

Congress should provide vouchers to current Medicare enrollees, not just future enrollees. Delaying implementation would deny enrollees the benefits of greater choice and higher-quality health care. Delay would also unnecessarily burden current and future workers with higher taxes and greater debt. Today's seniors are enjoying more in Medicare subsidies than they ever paid in Medicare taxes, and they have already left their descendants with a greater tax burden than they ever faced. It is unreasonable to ask today's seniors to start being more careful with their grandchildren's money.

Some voucher proposals would preserve traditional Medicare (Parts A, B, and D) as one of the insurance plans from which enrollees would choose. But Congress simply cannot offer such a "public option" that does not enjoy some implicit taxpayer subsidies. Moreover, supporters of a single-payer health care system would agitate to expand those subsidies, which would enable traditional Medicare to undercut private insurance options despite offering an inferior product. Vouchers would offer enrollees a wide array of private plans from which to choose, and the freedom to leave health plans that fail to meet their needs, rendering traditional Medicare unnecessary.

Medicare enrollees should have the freedom to place their full Medicare voucher into a personal account dedicated to out-of-pocket medical expenses and future premiums. Giving Medicare enrollees the freedom to save their vouchers rather than purchase health insurance is essential to making and keeping health insurance affordable. That freedom would force insurance companies to compete against banks and other financial institutions to manage enrollees' health care dollars. Having to compete with nonconsumption would place enormous pressure on insurers and health care providers to reduce the cost of coverage and medical care. That pressure would most benefit lower-income Medicare enrollees. With vouchers designed this way, few enrollees would choose not to purchase coverage. Seniors and the disabled need and want health insurance, and innovation would make health insurance more affordable. Those people who did forgo coverage would accumulate large balances in their accounts, which they would then want to protect by purchasing health insurance.

Another advantage of letting Medicare enrollees save their vouchers is that it would limit the ability of politicians and government bureaucrats to micromanage the health insurance market. Any mandate that Medicare enrollees must purchase health insurance would give politicians and bureaucrats the power to design enrollees' health insurance. Experience at both the federal and state levels has shown that when politicians possess the power to decide what goes into your health plan, interest groups capture that power and force consumers to purchase unwanted coverage, driving premiums higher.

Rep. Paul Ryan (R-WI) has offered a detailed proposal for Medicare vouchers. The Ryan plan would affect only people who are currently age 55 or younger. When those individuals start reaching age 65 after 2020, the federal government would give them a fixed voucher to buy private insurance. The Ryan plan sets the average voucher amount by taking Medicare spending per enrollee in 2010 (about $11,000) and adjusting annually by the average of the general inflation rate and the medical inflation rate. Sicker and poorer enrollees would receive larger vouchers. Low-income enrollees would receive an additional payment into a health savings account to cover out-of-pocket expenses.

The Ryan proposal would neither give vouchers to current enrollees nor give enrollees the freedom to save their entire voucher in a personal account. Correcting these shortcomings would substantially improve the Ryan plan.
As it is, however, the Ryan plan illustrates the power of market-oriented Medicare reforms to avert a coming fiscal crisis. A related essay presents Congressional Budget Office projections of the possible budget savings from the Ryan plan.

Large Health Savings Accounts

At the same time policymakers begin transitioning Medicare to a voucher-based system, they should take steps to expand the ability of younger Americans to save for their future medical needs. As a first step, Congress should expand current health savings accounts (HSAs) to give workers ownership over all their health care dollars, including the portion that their employers now control. As a second step, Congress should give workers the freedom to deposit their Medicare payroll taxes into these "large HSAs" to fund their medical needs in retirement.

Nine out of 10 Americans with private health insurance obtain that insurance through an employer. Federal tax laws encourage employers to reduce workers' wages and use the funds to purchase health benefits. Thus, most Americans with private health insurance do not get to choose their own health plan. In 2003, Congress let workers control a portion of those wages when it created tax-free health savings accounts. Workers who have a qualified high-deductible health plan may deposit up to $6,150 of their earnings tax-free into an HSA every year and may make tax-free withdrawals for medical expenses. HSAs create incentives for consumers to economize because account holders keep whatever HSA funds they do not spend, and earnings on unspent balances are also tax-free. About 10 million Americans have HSA-compatible high-deductible health plans, but only a portion of those people open HSAs.

Congres can encourage individuals to build larger health care nest eggs during their working years by taking three steps that would turn today's health savings accounts into large HSAs. First, Congress should roughly triple the current HSA contribution limits to allow nearly all workers to take the full amount of their employer's premium payments as a tax-free deposit into their HSA. Second, Congress should let HSA holders purchase health insurance, from any source, tax-free with their HSA funds. That capability would dramatically expand consumer choice and competition in health insurance markets. Third, Congress should remove any requirements that HSA holders obtain health insurance, including the individual mandate set to take effect in 2014. As with Medicare enrollees, we predict that few large HSA holders would choose not to purchase health insurance, in part because forcing insurers to compete for every customer would make insurance better and more affordable for everyone.

Large HSAs are an important component of reforming Medicare and the entire health care sector. When workers are free to own their health care dollars and free to choose their health plans, they will gravitate toward more economical plans because they will reap the savings. Those savings would grow tax-free in their large HSAs and would be available for their future medical needs. Such prefunding of future health benefits would help avert the coming fiscal crisis.

As an additional step toward a prefunded Medicare system, Congress should give workers the freedom to deposit their full 2.9 percent Medicare payroll tax into their large HSAs. Those deposits would grow tax-free along with their regular deposits. Upon retirement, balances in large HSAs would be used to pay health insurance premiums and out-of-pocket expenses, or to purchase annuities that would cover these expenses in perpetuity. Any leftover balances in these accounts would be inheritable. To ensure compliance with this proposal for mandatory savings, Congress could impose stiff penalties for withdrawal of payroll-tax contributions prior to age 65.

Before the creation of Part D, Harvard University's Martin Feldstein calculated that personal savings accounts financed by worker deposits averaging 1.4 percent of wages would be enough to make up Medicare's future funding shortfall. That percentage would certainly be higher today, but the basic idea hasn't changed: if workers spend their working lives saving for their health care needs in retirement, the power of compound interest would allow the payroll contribution to be modest. Economists at the National Center for Policy Analysis have also proposed ideas for retirement health savings accounts.

In the near term, diverting Medicare taxes into workers' health savings accounts would leave less federal revenue to finance vouchers for current enrollees. Congress should fill that gap with major cuts across the federal budget, as outlined elsewhere on this website. In the long run, Congress could phase out Medicare vouchers, since balances in large HSAs would rise to a point where most Americans could completely prefund their retirement medical expenses.

As Congress phases out Medicare vouchers, there would be a small number of Americans who would not be able to afford the medical care they need, whether because they did not or could not save enough or because they managed their savings poorly. This problem is similar to that faced by many Medicare enrollees today, who cannot afford their Medicare premiums or cost sharing. A reformed Medicaid program would encourage states to offer help to the truly needy, while discouraging nonneedy people from abusing that generosity.

Conclusions

Medicare spending will skyrocket in coming decades absent fundamental reform. Yet it is unlikely that Congress could increase taxes to match this projected rise in spending. For one thing, the level of taxation in America has been about the same share of the economy for decades, and voters would surely reject changes that increased the tax burden very much. Furthermore, every effort to fill Medicare's funding gap with higher taxes would damage the economy, increase tax avoidance, and shrink the federal tax base, which, in turn, would create economic and political barriers to further tax increases.

Congress must cut Medicare spending substantially and give enrollees the freedom to choose the coverage and services that mean the most to them, rather than subject them to government rationing. The way to do so is to transform Medicare into a system based on individual savings, choice, and vigorous private competition, using individual vouchers and large HSAs. Doctors, hospitals, and insurance firms would have strong incentives to innovate and reduce prices to serve their newly cost- and quality-conscious consumers. We might see greater use of retail clinics, telemedicine, integrated delivery systems, electronic medical records, comparative-effectiveness research, care coordination, and other innovations.
Cutting Medicare is a fiscal necessity, but it's also a great opportunity for structural reforms that could improve medical care for all Americans.

1 Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2010 to 2020," January 2010, p. 48. Aside from the direct budget cost of Medicare, it imposes a large additional burden because of the economic distortions caused by the higher taxes needed to support it. This hidden burden of Medicare may cost the U.S. economy about $100 billion a year. See Christopher J. Conover, "Congress Should Account for the Excess Burden of Taxation," Cato Institute Policy Analysis, forthcoming.


6 Medicare also contracts with private insurers to deliver prescription drug coverage through Part D.

7 In 2013, the 2.9 percent Medicare payroll tax will rise to 3.8 percent on wages over $200,000 for single filers and $250,000 for joint filers, and a new 3.8 percent tax will apply to investment income above those thresholds. Those thresholds are not indexed for inflation. Patricia A. Davis et al., "Medicare Provisions in PPACA (P.L. 111-148)," Congressional Research Service Report no. R41196, April 21, 2010, p. 63.

8 Social Security also operates on the basis of intergenerational transfers and creates the same perverse incentives.


17 Congressional Budget Office, "The Long-Term Budget Outlook," June 2009. We are referring to the CBO's "alternative fiscal scenario."


19 Amy Finkelstein and Robin McKnight, "What Did Medicare Do? The Initial Impact of Medicare on Mortality and Out of Pocket Medical Spending," 2008, Journal of Public Economics 92: 1644–69. The authors find that the risk protection Medicare provided to seniors can justify only two-fifths of the program's cost. Note that Medicare may have generated other health improvements that would not appear in mortality figures.

20 Budget of the United States Government, Fiscal Year 2011, Historical Tables (Washington, DC: Government Printing Office, 2010), Table 3.2 and Table 10.1. We used the nondefense deflator to convert to 2010 dollars.


46 Medicare Payment Advisory Commission, "Report to Congress: Aligning Incentives in Medicare," June 2010, p. 117. See also Kate Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," Health Affairs (April 2004): W4-184–W4-197.


48 Parts C and D, by contrast, employ price and exchange controls that pay private insurers a government-determined fee per enrollee. This differs from capitation in that the government pays this fee to insurers rather than providers.

49 Fee-for-service payment performs well on other dimensions of quality, like giving patients a wide choice of providers and encouraging providers to deliver all necessary care. See Arnold Kling and Michael F. Cannon, "Does the Doctor Need a Boss?" Cato Institute Briefing Paper no. 111, January 13, 2009; and see Michael F. Cannon, "A Better Way to Generate and Use Comparative-Effectiveness Research," Cato Institute Policy Analysis no. 632, February 6, 2009.


See Michael F. Cannon and Alain Enthoven, "Markets Beat Government on Medical Errors," American Spectator, May 13, 2008. Other payment systems—such as paying health care providers a fixed fee for all the medical care that a consumer needs, known as "prepayment" or "capitation"—reward error reduction, effectiveness research, and care coordination. Prepayment allows providers to profit from reducing unnecessary services and medical errors because whatever money they save, they get to keep. Fee for service, capitation, and all hybrids of the two are each strong on some dimensions of quality but weak on others. A free market promotes all dimensions of quality by forcing diverse payment systems to compete on a level playing field. If fee-for-service plans allow too many medical errors, consumers will switch to prepaid plans; if prepaid plans refuse to cover all necessary services, patients will flee to fee-for-service plans.


Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," Health Affairs (April 7, 2004): 192.


Several citizens have filed suit to overturn this unconstitutional requirement. See Brian Hall, et al. v. Kathleen Sebelius, et al., http://medicarelawsuit.org.


In 1999, the National Commission on Retirement Policy favored raising the retirement age to 70 by 2029. Also in 1999, the National Bipartisan Commission on the Future of Medicare considered proposals to increase the eligibility age in step with the retirement age.


