

## 38. Medicare

### *Congress should*

- allow seniors to opt out of Medicare without losing Social Security benefits;
- limit the growth of Medicare spending to the level of growth in GDP;
- take all the money Congress currently spends on Medicare and give it directly to enrollees as cash, as with Social Security, adjusting individual enrollees' "Medicare checks" so that lower-income and sicker enrollees receive larger checks;
- allow workers to save their Medicare payroll taxes in personal, inheritable retirement health savings accounts that will gradually replace Medicare transfers; and
- fund any transition costs by reducing other government spending, not by raising taxes.

Medicare is a **\$600 billion** federal entitlement program that provides health insurance to **nearly 60 million** Americans who are elderly or disabled or meet other criteria. It is the largest purchaser of health care goods and services in the world and effectively controls even more of the U.S. health care sector than federal Medicare outlays suggest. It is also the single greatest obstacle to making U.S. health care better, more affordable, and more secure.

Medicare is lousy health insurance. When people complain about excessive U.S. health spending, they are complaining about Medicare. When they complain about the fee-for-service payment system; about wasteful care, harmful care, and medical errors; about health care fraud and excessive profits; about federal deficits and debt, the time bomb of entitlement

spending, and special-interest influence over health care; about the lack of innovation, evidence-based medicine, electronic medical records, accountable care organizations, telemedicine, and coordinated care, they are complaining in every case about *Medicare*.

Since 1965, Medicare has blocked innovations that would improve health care, to say nothing of how it has denied workers the right to control their earnings. 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” of taxation, or the reduction in economic output caused by all the taxes necessary to finance Medicare spending. Estimates place those costs between 20 percent and 100 percent of Medicare expenditures, dwarfing any administrative costs of private insurance. Decades of reports by government watchdogs demonstrate that the main way Medicare avoids administrative costs is by failing to conduct oversight. The result is rampant waste and fraud. The Government Accountability Office reports that **13 percent** of traditional Medicare payments in 2014 were fraudulent or improper. Medicare’s low administrative spending is one of its flaws, not one of its virtues.

Perhaps Medicare’s only success has been to concentrate power in Washington, D.C. It is indeed **popular** among enrollees—not because it is better than the alternatives, but because it has eliminated better alternatives and thereby made seniors and the disabled utterly dependent on the government for their health care.

### **Low-Quality Care**

A landmark **study** by economists Amy Finkelstein and Robin McKnight made the following conclusion:

Using several different empirical approaches, we find no evidence that the introduction of nearly universal health insurance for the elderly had an impact on overall elderly mortality in its first 10 years. . . . Our findings suggest that Medicare did not play a role in the substantial declines in elderly mortality that immediately followed the introduction of Medicare.

The authors estimated that the reduction in out-of-pocket medical spending among seniors that followed Medicare’s introduction produced benefits of less than 40 percent of the program’s total cost. Data limitations prevented them from estimating any nonmortality health benefits from Medicare. Nevertheless, at a minimum, Medicare appears not to have

saved a single life in its first decade, calling into question whether the program has been net beneficial. Elsewhere, Finkelstein [found evidence](#) that Medicare has been a driving force behind the growth of health spending on both the elderly and the nonelderly.

Additional evidence suggests Medicare may not pass a cost–benefit test. The Dartmouth Atlas of Health Care and other researchers estimate that [a third or more](#) of Medicare spending provides no value whatsoever: it makes the patient no healthier or happier. If we were to add to that figure spending on services whose costs exceed the benefit to the patient, it would show an even larger share of Medicare spending to be wasteful. As noted in Chapter 35, Medicare may be one of the factors behind the United States’ leading role in developing new diagnostic tests and medical treatments. If so, it appears that once those goods and services become available, Medicare pays for them whether or not they benefit a particular patient.

One factor that contributes to the epidemic of wasteful Medicare spending is that the program generally provides open-ended subsidies for whatever medical care providers recommend. The Medicare Payment Advisory Commission (MedPAC) is a federal bureaucracy that advises Congress on how to set prices and other terms of exchange with Medicare-participating providers. MedPAC itself [reported](#) the following:

Medicare, the largest single payer in the system, pays all of its health care providers without differentiation based on quality. Providers who improve quality are not rewarded for their efforts. In fact, Medicare often pays *more* when a serious illness or injury occurs or recurs while patients are under the system’s care. The incentives of this system are neutral or negative toward improving the quality of care. [emphasis added]

Medicare generally pays providers on a “fee-for-service” basis, meaning a separate fee for each individual service or hospitalization, rather than paying for a particular health outcome (which can be exceedingly difficult) or paying a fixed or “capitated” amount per patient. Fee-for-service payment has benefits: it gives patients a wide choice of providers, for example. However, it creates incentives for providers to recommend services that offer little or no benefit, even services that end up being harmful. It allows multiple providers to treat a shared patient without coordinating their efforts (a job that then falls to the patient). Medicare even rewards medical errors and punishes efforts to reduce them. When a medical error results in the patient’s requiring more services, Medicare pays for the initial, harmful service and pays *again* for the remedial care. Medicare thus pays

hospitals and other providers less when they improve the quality of care by reducing medical errors. This system fuels the problems of wasteful spending and medical errors.

By heavily subsidizing fee-for-service payments and fragmented delivery, Medicare prevents competition that could lead to alternative ways of financing and delivering medical care. A market system would find ways to reduce wasteful care and medical errors and to promote coordinated care, electronic medical records, effectiveness research, and evidence-based medicine. In particular, Medicare has inhibited competition from integrated, prepaid group plans such as Kaiser Permanente and Group Health Cooperative (see Chapter 35). Along with other government interventions—such as clinician licensing and the tax preference for employer-sponsored insurance (see Chapter 37)—Medicare has dramatically tilted the playing field in favor of fee-for-service payment and uncoordinated care.

Congress has attempted to mitigate the perverse incentives and unintended consequences of Medicare's payment systems. Various tweaks and demonstration programs have tried to eliminate financial rewards for medical errors, promote coordinated care, and fund effectiveness research. Yet demonstration programs aimed at improving quality or reducing spending in Medicare [have not been successful](#).

### ***The Dinosaur's Veto***

There are *reasons* such efforts are [not successful](#). Any effort to increase quality or reduce costs in Medicare represents a threat to high-cost, low-quality providers. If those efforts are voluntary, inefficient providers just avoid them and keep getting paid for doing what they have always done. Analyst Robert Laszewski [describes](#) this dynamic in the context of the Affordable Care Act's (ACA) attempt to promote "accountable care organizations" (ACOs). "Here's a flash for the policy wonks pushing ACOs: They only work if the provider gets paid less for the same patient population. Why would they be dumb enough to voluntarily accept that outcome?"

Reforms intended to force Medicare-participating providers to become more efficient usually die under intense lobbying from the high-cost, low-quality providers who stand to lose. A market system would force those providers out of business. Instead, Medicare creates a dinosaur's veto that allows lousy providers to protect their revenue streams and sticks Medicare patients and taxpayers with low-quality, high-cost care.

## Medicare Advantage

One bright spot, of sorts, is the Medicare Advantage program. Traditionally, Medicare has been a government-run health insurance scheme that writes checks directly to doctors, hospitals, and other providers. In the Medicare Advantage program, the government pays insurance companies to play that role. Medicare enrollees may choose among competing Medicare Advantage plans, which often offer more coverage than traditional Medicare. Some 30 percent of enrollees opt for Medicare Advantage plans, a share the Congressional Budget Office projects will grow to 40 percent by 2026. In effect, Medicare Advantage plans compete for enrollees against the “public option” of traditional Medicare.

Medicare Advantage creates more competition in the delivery of medicine by extending government subsidies to different ways of financing and organizing health care. Some Medicare Advantage plans are fully integrated and capitated plans, such as Kaiser Permanente. Others are fee-for-service plans like traditional Medicare. Other plans fall somewhere in between.

Medicare Advantage mitigates some of the problems traditional Medicare creates. A former chief executive of Kaiser Permanente—the original accountable care organization—*noted* that the ACA’s effort to tweak traditional Medicare’s payment systems “is not as good as [the] Medicare Advantage program” at promoting integrated, accountable care. One *review* of the literature found that Medicare Advantage plans score higher on some quality measures, including use of preventive care. Medicare Advantage health maintenance organizations appear to do a better job of avoiding unnecessary hospitalizations and encouraging less-expensive care. One study *estimated* that Medicare Advantage plans reduce hospitalizations by a third without any negative impact on mortality. Medicare Advantage *appears* to have spillover effects that reduce unnecessary spending in traditional Medicare.

There is nothing inherently superior about the government writing checks to insurance companies instead of health care providers, however. There is evidence Medicare pays more to cover enrollees through Medicare Advantage than it would cost to cover them through traditional Medicare. The projected growth in Medicare Advantage enrollment suggests this may be the case. This may be because participating insurers tend to market themselves to Medicare enrollees who will cost them less (and to avoid patients who would cost them more) than the government is paying. The result is akin to the dynamic in the ACA’s Exchanges: government-determined prices lead insurers to make their plans attractive to relatively

healthy enrollees and unattractive to relatively sick enrollees. Traditional Medicare receives **higher marks** from enrollees with expensive illnesses, likely because it provides relatively—albeit dangerously—easy access to care.

To build on the meager progress of Medicare Advantage, Congress should take three steps to liberalize health care for the elderly and disabled.

### ***Reform: Sever the Tie between Medicare and Social Security***

At present, people who are eligible for Medicare but do not enroll forfeit all Social Security benefits—past and future. Conditions on government subsidies become problematic when they require recipients to accept a second government subsidy. The main problem with this condition, however, is that it has no basis in statute. Federal bureaucrats just made it up. It is fairly clear why they did. Withholding Social Security benefits makes it harder for seniors to leave Medicare, which has the effect of both quashing the market for alternative forms of health insurance and making more Americans dependent on Medicare.

Congress should allow seniors to opt out of Medicare without losing Social Security benefits. Removing this condition would curb executive overreach, expand the market for alternatives to Medicare, and create a political constituency of seniors that is more open to fundamental Medicare reform.

### ***Reform: Make Medicare like Social Security***

The single, most dramatic thing Congress can do to make health care better, more affordable, and more secure is to take the \$600 billion it currently spends on Medicare and simply give it to Medicare enrollees as cash. Currently, Medicare sends those billions to providers and insurers, who fight fiercely to protect their revenue streams, and who can increase their haul by providing more low-quality services or lobbying for greater subsidies. Seniors often join providers and insurers to lobby for protecting or expanding access to low-quality care—because it is taxpayers' money on the line, not their own. The rules Medicare attaches to these subsidies stifle innovation, while keeping quality low and costs high.

One bipartisan proposal would create a more level playing field between traditional Medicare and private plans. “Premium support” would give enrollees a fixed subsidy they could apply toward either traditional Medicare or the private health plan of their choice. A fixed subsidy would

encourage enrollees to choose less wasteful coverage. If enrollees chose plans that cost more than their premium subsidy, they would pay the balance. If they chose a less expensive plan, they could keep the unspent portion of their subsidy, perhaps in a health savings account. A level playing field would reveal to enrollees the full cost of all health plans and allow enrollees to decide which ones provide the greatest value. Efficient and innovative health plans would thrive. The rest would not.

Premium support is a step in the right direction. It would acclimate more enrollees to choosing their health plans and being cost-conscious consumers. But Medicare would continue to suppress desperately needed innovations. And the government would still be in the business of specifying rules for participating insurers (e.g., what types of coverage they must offer) and prices and other terms of exchange for providers participating in traditional Medicare. It is simply not possible to level the playing field between government and private-sector competitors. For example, private insurers pay taxes; government programs don't.

Converting Medicare into a program like Social Security—that is, distributing cash to beneficiaries—would spark an innovation revolution. Enrollees could receive “Medicare checks” at the same time they receive their Social Security checks. Medicare checks would average more than \$10,000 per enrollee per year. Enrollees could use those funds to purchase the health plan of their choice at actuarially fair rates. Enrollees who want more expensive health insurance could supplement their subsidy with private funds, just as they do now with Medicare Advantage and Medigap plans. Alternatively, seniors who choose a lower-cost plan could save their extra health care dollars in a tax-free health savings account.

The size of each enrollee's Medicare check would depend on their health status and income. When an individual enrolls in the program, Medicare would use competitive bidding or risk-adjustment formulas to adjust the amount of that enrollee's check according to that individual enrollee's health status. It would use Social Security Administration data to calibrate the amount of the enrollee's check according to the enrollee's lifetime income. Low-income and sicker enrollees would get Medicare checks large enough to enable them to afford a standard package of insurance benefits. Healthier and higher-income enrollees would get smaller checks. As with Social Security, enrollees would then be free to spend that money as they see fit. They could use their Medicare checks to purchase whatever health plan they choose, to purchase preexisting conditions insurance (see Chapter 36), to save for future medical expenses, or to purchase other items, like

tuition for their grandchildren. The availability of guaranteed-renewable health insurance (see Chapter 36), and the fact that Medicare would use lifetime rather than current income to adjust for income, means Medicare would only need to adjust for income and health status once, at enrollment. If enrollment growth times medical inflation grows faster than gross domestic product (GDP), Medicare would reduce checks for healthier and higher-income enrollees to preserve the ability of sicker and low-income enrollees to afford a standard package of insurance benefits.

Critics worry that, to the extent the risk-adjustment does not perfectly track the risk of health claims, some enrollees would have insufficient funds to purchase health plans at actuarially fair rates. This objection fails for two reasons. First, to the extent Medicare's competitive-bidding processes or risk-adjustment formulas are imperfect, they are already harming the sick by leading Medicare Advantage plans to avoid relatively sick enrollees. Second, even when the government imperfectly calibrates the amount, giving the money to enrollees would create incentives for insurers to find innovative ways to cover the sick, rather than to avoid them. If Medicare can risk-adjust the payments it makes to insurance companies, then there is no reason not to give that money directly to enrollees.

Another objection is that, whereas Medicare currently offers an open-ended entitlement to health care subsidies, giving enrollees a fixed subsidy means some enrollees would run out of money. That could happen if enrollees' current income and assets were less than their lifetime income would suggest, or if enrollees frittered away their subsidy. Implicit in the latter concern is the worry that Medicare enrollees could not spend \$600 billion as competently as government bureaucrats can. This objection likewise fails. If any enrollees were to run out of money, they would most likely become eligible for Medicaid (see Chapter 39).

More important, enrollees are unlikely to run out of money because consumers can make \$600 billion go a lot farther than the government can. First, subsidizing seniors with cash would encourage cost-saving innovations. Medicare enrollees would spend that \$600 billion much more cost-consciously when it is *their* money than when it is the taxpayers' money. That would put downward pressure on prices in a way Medicare simply cannot. Enrollee cost-consciousness would spark and reward innovations like the "reverse deductibles" (discussed in Chapter 36) that have led to price reductions of thousands or tens of thousands of dollars. Second, it would remove regulatory barriers to such innovations. Removing Medicare from its role as a purchaser of medical services would eliminate

the restrictive price and exchange controls that have stifled innovation in health care delivery. Finally, Medicare checks would come with a built-in buffer. Ironically, the fact that Medicare likely wastes at least one out of every three dollars means enrollees could waste one-third or more of that \$600 billion without any adverse health effects for the average enrollee. All that wasteful Medicare spending is usually a problem. When reforming Medicare, it is an absolute boon.

Reforming Medicare by letting enrollees control that \$600 billion would end federal micromanagement of the health care sector. It would spark an innovation revolution by allowing the consumers' choices and competition—rather than a government bureaucracy—to determine prices, payment systems, delivery systems, and how to reward quality. It would unlock the potential of integrated delivery systems, effectiveness research, coordinated care, and other reforms that Medicare is struggling—and failing—to deliver. Just as Medicare has spillover effects that increase costs for non-Medicare patients, and just as Medicare Advantage has [spillover effects](#) that reduce spending in traditional Medicare, both elderly and nonelderly patients would see the benefits of these innovations in the form of better, more affordable, and more secure health care.

### **Reform: Prefund Retiree Health Care**

Finally, Congress should replace Medicare's inequitable system of intergenerational transfers with a prefunded system in which workers invest their Medicare taxes in personal accounts dedicated to their own health needs in retirement. Congress should allow workers to put their full Medicare payroll tax payment in a personal savings account. Workers could invest those funds in a number of vehicles and augment those funds in retirement with other savings. Over time, Congress could make contributions to these personal accounts voluntary.

This proposal for Medicare personal accounts is similar to many Social Security reform proposals (see Chapter 40). One similarity is that diverting workers' tax payments into personal accounts would make it difficult to pay current benefits. Congress could make up much of those "transition costs" by cutting Medicare outlays. As noted earlier, an estimated one-third of Medicare outlays do nothing to improve beneficiaries' health or make them any happier. Thus, Congress could allow per-enrollee Medicare spending to grow at a rate less than GDP without harming the health of enrollees. 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 32)—not by raising taxes.

### **Suggested Readings**

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