



Medicare and the Reform of U.S. Health Care

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Introduction

The election of Barack Obama as the President of the United States has pushed major reform of U.S. health care to the top of the policy agenda. Powerful Democratic Congressional leaders, from Speaker of the U.S. House of Representatives, Nancy Pelosi to Massachusetts Senator, Ted Kennedy, have pledged to take up a sweeping health-care measure over the course of the coming summer months, with the hope of having a bill on the president's desk by August 2009.

Thus far, the primary focus of the debate has been over what to do about the nation's 46 million uninsured residents. Mr. Obama's plan, released as a white paper during his campaign for the presidency in mid-2007, proposed major revisions in the regulatory structure for health insurance for the working-age population (those under 65 years old) and their families. He would also provide substantial new subsidies for low-income households (perhaps those with incomes below 350 per cent of the poverty line) to make insurance more affordable.

But lack of coverage is only part of the problem. Health care costs continue to rise rapidly, driving up premiums for the federal and state governments, employers, and households. Indeed, escalating costs for the federal Medicare insurance programme for senior citizens is viewed by many to be the most serious threat to long-term prosperity in the United States. Sooner or later, America's political leadership will need to grapple with the difficult reality that Medicare is not sustainable in its current configuration.

Medicare is the product of the unusual political history of health care insurance in the U.S. Unlike other industrialized countries, the U.S. has never extended a universal entitlement to health insurance to all of its citizens. Instead, in 1965, President Lyndon B. Johnson believed it was possible to move toward a national approach by first covering vulnerable segments of the population with Medicare, for those age 65 and older, and with Medicaid (jointly run with the states) for certain low-income families. In the four decades since these programmes were enacted, they have become the dominant forces in how American health care is organised and financed.

Medicare's current design and financing gap

Medicare is built somewhat like the Social Security programme, with trust funds tracking income and expenses, and eligibility being determined by worker contributions and premiums. Currently, workers and their employers each pay taxes on wages—1.45 per cent—to gain eligibility for hospital insurance. At age 65, senior citizens must also pay a premium equal to 25 per cent of costs for coverage of physician services, and a 35 per cent premium for coverage for prescription drugs.

Medicare can best be understood as really two programmes. First, it is guaranteed-issue, community-rated insurance. Everyone age 65 and older gets their insurance for the same premium and they cannot be denied coverage based on their health status. These features of the programme are highly valued by

beneficiaries and for good reason. Without a regulatory structure putting all seniors into the same risk pool, insurance would naturally move to cover healthier seniors at lower premiums than the unhealthy.

But Medicare is also a large tax-and-transfer programme. And it is this feature of Medicare that is substantially out of financial balance today.

The latest report from Medicare's Board of Trustees, issued in late March 2008, revealed that the programme's unfunded liability now stands at an astounding *US\$86 trillion* and the trust fund which pays for hospital services is expected to be depleted of reserves in 2019. Total Medicare spending is projected to more than triple over the projection period as a share of the national economy, from 3.2 per cent of GDP in 2007 to 6.3 per cent in 2030, 8.4 per cent in 2050, and 10.7 per cent in 2080. Federal individual income tax collections only amount to about 8.5 per cent of GDP. Covering just the increase in Medicare spending expected by 2030 would require a 36 per cent across-the-board individual income tax hike.

Many analysts in the U.S. have put forward plans to restore financial balance to Social Security, but there are very few credible Medicare reform proposals to guide policymakers. Why? Because Medicare's financial problems are much more severe and the policy environment is much more complex as well.

Unlike Social Security, the Medicare entitlement is not defined by a mathematical formula related to payroll tax contributions. Rather, enrollees get government-sponsored insurance coverage, the cost of which is mainly a function of ever-changing standards of medical practice. Today, Medicare pays for many services, diagnostic tests, operating procedures and products that did not even exist when the programme was created. And there is no limit on the quantity of services Medicare beneficiaries can use each year, so both the volume and intensity of care provided can go up over time without Congress passing benefit expansions.

The Congressional Budget Office (CBO) estimates that, between 1975 and 2005, Medicare's cost per enrollee went up, on average, 2.4 percentage points faster than per capita GDP growth each year. Medicare's Trustees make the reasonable assumption that, absent new information, this long-standing trend of costs outpacing the source of programme income (i.e. the U.S. economy) will continue into the indefinite future (though the Trustees do expect cost growth will moderate somewhat from its recent trajectory).

Medicare's tax on work

In addition to a large financing gap, Medicare's current configuration also discourages long careers at a time when continued work by able and willing seniors should be rewarded.

Currently, Medicare becomes the "secondary payer" when a person age 65 and older works for a firm with at least 20 employees and a company-sponsored health insurance plan. In these cases, the job-based health insurance pays first for any medical care used by Medicare-eligible workers, and Medicare pays only those costs not covered by the company plan.

This "secondary payer" rule was put in place in the early 1980's as a cost-cutting measure, but it also imposes an onerous tax on work. Most economists believe that, in a competitive labour market, when an employer pays for health insurance, the premium effectively comes out of the total compensation the employing firm is willing to pay for a worker. Consequently, when Medicare pushes more health-care costs onto employers, it is workers who end up paying with lower cash wages.

A 2007 analysis by respected economists shows this Medicare "tax on work" to be considerable. They found that Medicare's "secondary payer" rule imposes a 15 to 20 per cent tax on wage income for workers at age 65, and the implicit rises to 40 to 75 per cent for those approaching 80 years old.

The problem is further compounded by Medicare's payroll tax financing. Workers age 65 and older who are already getting Medicare benefits must nonetheless continue paying Medicare's payroll tax (2.9 per cent of wages, for the combined employee-employer tax) even though they get no additional benefit for doing so.

Reforming the programme

Some health-care analysts believe that it would be unfair to focus cost-control efforts just on Medicare because rising costs is a system-wide phenomenon. To these analysts, Medicare is just one of many rail cars hooked onto a runaway cost train. The solution, these analysts argue, is not Medicare reform but a concerted effort led by the federal government to implement changes that will improve efficiency and eliminate low value services for everyone buying insurance and services, including employers.

This seems to be the thinking behind the health-care plan of the Obama administration. To slow cost escalation, the administration's top officials have suggested three basic ideas: more and better health information technology, funding for an ambitious "comparative effectiveness research" programme and more use of value indicators in Medicare's reimbursement system. While widely supported as sensible steps, most analysts do not think such measures are sufficiently robust to really control costs. Even the CBO has said that these measures are likely to fall far short of effective cost control unless coupled with other, more far-reaching changes.

One approach to aggressive cost control would have the federal government enforce tight budgets for hospitals and other provider groups and impose price controls on the purchase of certain services and supplies, as many European countries do today. But this approach to cost control raises concerns about government-rationed care and deterioration in quality. In the U.S., many voters would react negatively to the prospect of a distant federal bureaucracy having the power to deny access to health care to a citizen based on a perceived need for budgetary control.

But strong, centralized cost control need not be the only option under consideration. There is an alternative approach to improving efficiency in the health sector, based on a different perspective on why costs are high and rising in the first place.

A 2006 study by an economist at the Massachusetts Institute of Technology (MIT) showed that the creation of Medicare in the mid-1960's triggered an explosion in the health-care infrastructure in regions with previously low levels of private insurance enrolment among seniors. Hospitals were built, and physicians and others opened up offices to provide newly enrolled Medicare beneficiaries with a much improved level of service. This was, of course, generally to the good, as the primary purpose of Medicare was to improve the quantity and quality of health care services available to seniors. But, four decades later, with cost escalation now a major concern, policymakers must also understand that expansive, third-party insurance is also one important reason for expensive care and rising costs. The MIT economist suggested that about half of the real cost increase in health care spending in the United States from 1950 to 1990 is attributable to the spread of Medicare and other, expansive third-party insurance.

Medicare's current design also provides strong financial incentives for ever-increasing use of services. Four out of five enrollees are in the traditional programme, which is fee-for-service insurance. That means Medicare pays a pre-set rate to any provider for any service rendered on behalf of a programme enrollee, with essentially no questions asked. Nearly all Medicare beneficiaries also have supplemental insurance, from their former employers or purchased in the Medigap market. With this additional coverage, they pay no charges at the point of service because the combined insurance pays 100 per cent of the cost. This kind of first-dollar coverage provides a powerful incentive for beneficiaries to use as many services as their physicians suggest might help improve their health. Whole segments of U.S. medical industry have been built around the incentives embedded in these arrangements. To be sure, Medicare's payment rates are low, but political pressure ensures they are just high enough to protect the status quo and allow doctors and hospitals and others to continue operating autonomously, thus underwriting continued fragmentation of health-care delivery.

Instead of centralizing cost-control efforts even further, Medicare could be re-structured into an entitlement with more decentralized budgetary control and incentives for cost-conscious consumption. Under this approach, Medicare would continue to provide guaranteed issue, community-rated insurance to everyone age 65 and older, but future retirees would be eligible for premium subsidization commensurate with the tax base associated with each generation's working years (a large exception would be made for seniors in the lowest fourth or fifth of the wealth distribution). This change would ensure that programme spending rose in tandem with the programme's revenue. In addition, workers

age 65 and older could be exempted from further payroll tax contributions and the “secondary payer” rule, thus eliminating today’s disincentives for continued work.

Proponents of this type of reform believe it would provide strong incentives for a more efficient health sector, with consumers choosing from among a large number of insurers and suppliers of services competing based on price and quality. Indeed, it is just this kind of model which has been used to provide drug coverage in Medicare and costs for that portion of the programme are coming in 40 per cent below initial expectations.

Opponents argue that controlling the entitlement in this manner would be dangerous for future retirees because health care costs might rise faster than the financial support provided by Medicare. But does it really make sense for the government to pre-commit health entitlement spending 25 and 50 years from today that is unaffordable? It seems much better to build a programme that is solvent by definition, with ample room for future policymakers to make adjustments if evidence indicates that seniors need more taxpayer support to secure appropriate health care.

The United States can provide generous health insurance coverage for seniors in the future through Medicare, even coverage that costs much more than it does today. But Medicare’s costs cannot rise indefinitely at rates well above growth in the programme’s revenue base. The sooner U.S. policymakers face up to this reality, the better.

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