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RESTORING SOLVENCY TO THE MEDICARE SYSTEM[1]

By Stuart M. Butler, Ph.D.
Vice President and Director, Domestic and Economic Policy Studies

Others have testified before Congress on the chronic financing problems facing the Medicare program, and so it is not necessary to dwell on the need for Congress to take, in the words of the Medicare Trustees, "prompt, effective and decisive action."[2] Needed now is a discussion of the reasons why the program is so out of balance and the shape of reform suggested by these root causes.

There are three principal causes of the Medicare predicament. They are structural problems and they need structural solutions. Implementing these solutions will permit the quality of medical services to be improved while the trend in the cost of providing these services is moderated. This is the key to restoring financial soundness and thus assuring future generations that Medicare will be able to serve them without draining resources from other parts of the budget. The structural problems are:

❶ Medicare attempts to moderate costs through the use of ineffective price controls.

❷ Medicare's price control and central planning philosophy necessarily resists service delivery innovations.

❸ Part B of Medicare heavily subsidizes Americans who do not require taxpayer support.

1) THE FAILURE OF PRICE CONTROLS.

Any student of economics looking at Medicare would recognize immediately that it is a classic example of the failures of price controls and that it exhibits all the chronic distortions and inefficiencies that typically accompany a price control system.[3] It is ironic that when countries around the world are abandoning price control and central planning, America tries to use these tools to deliver health care to the elderly. And it is rather astonishing that some lawmakers are surprised that these tools do not work.

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1 Substantial portions of this were delivered in testimony to the Senate Finance Committee on May 16, 1995.

2 *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, p. 4.

3 See Stuart M. Butler, "The Fatal Attraction of Price Control," in Robert B. Helms, *Health Policy Reform: Competition and Controls* (Washington, D.C.: The AEI Press, 1993).

Price controls in Medicare take the form of such things as the DRG system for hospital payments and the RBRVS system for physician services—the latter explicitly designed by a Harvard social scientist according to the labor theory of value, which is the basis of socialist economics. Besides the failure of these controls to hold down the rate of growth of expenditures to a degree comparable with the private sector, they have led to distortions and inefficiencies familiar to any student of price controls. For example, squeezing prices in Medicare has led to significant cost shifting (or, more accurately, "price shifting") to non-Medicare services and to providers seeking to increase volume (with the typical government response of attempting to control volume). Diagnoses are widely modified to qualify for better payments. Or, in an attempt to improve profit margins under price controls, costs are moved to other places in a hospital's accounts—such as capital expenditures—which might qualify for separate payments.

The history of price controls in Medicare exemplifies the games that naturally occur in any price control system. Providers, and sometimes patients, react to each control by seeking ways to evade it, with a loss of general efficiency; then government introduces a new, more elaborate control in an attempt to address the deficiencies of the first control. Then the cycle continues as the providers find a way around that control. Meanwhile, efficiency suffers and expenditure targets are exceeded.

This chronic problem cannot be solved with tighter controls and new rules. The system of price controls itself is flawed as a method of controlling expenditures. Needed instead is a switch in policy towards a system in which expenditures are held in check in a Medicare program based on consumer choice among competing plans.

2) Resistance to Efficiency-Improving Innovations.

In addition to the distortions and evasions implicit in a price control system, such a system also fails to control costs because its bureaucratic nature reduces the pace at which efficiency-improving innovations are introduced. In a competitive market-based system, choice and competition lead to a decentralized, continuous, and rapid introduction of ideas to improve the ratio of quality to price. These are accepted or rejected in the system to the degree that buyers and sellers agree that they are an improvement. In a centrally planned system, like Medicare, the process is entirely different. Ideas must "trickle up" to senior officials responsible for the program. Typically, they must then be evaluated by officials and boards, proposed to politicians, and subjected to the pressures of competing interests before they take effect. The result is both slow and likely to result in politically influenced decisions.

While Congress is responsible for creating the Medicare laws, it is the bureaucracy within the Health Care Financing Administration (HCFA) which is to blame for the denial of "state-of-the-art" medical technology to our nation's seniors in the Medicare program. For example, denying reimbursements to hospitals conducting clinical studies on Medicare patients means seniors are adversely affected by being denied access to medical innovations invented in the United States. As highlighted in the cover story of *USA Today* on May 10, 1995, "Faced with possible federal charges and potentially millions of dollars in fines, hospitals slammed on the brakes...shutting down all device studies or excluding Medicare patients from them. Doctors were no longer able to provide what they considered the latest treatments to many older patients."[4]

This happens not only because HCFA must formulate guidelines for every category of medical equipment, but because it also must decide whether each new medical device or treatment meets the criteria for coverage under Medicare Part B. This highly regulatory process has proven to be extremely expensive for taxpayers and dangerous for patients.

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4 Tim Friend, "Clinical Trials in U.S. Called Endangered," *USA Today*, May 10, 1995, p. 2A.

It is thus no surprise that tools to control costs efficiently that are widespread in the private sector are not used, or used only sparingly, in the Medicare program. Some examples:

- ✗ **Medicare is essentially only a "fee-for-service" insurance program.** It has made little progress in allowing, as an option to the elderly, managed care plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs) or the use of medical savings accounts and flexible benefit plans. Moreover, with the rigid guidelines established by the Health Care Financing Administration, Medicare's payment scheme to HMOs is crude. For example, Medicare should not be using local fee-for-service Medicare costs as the means of setting HMO payment rates.[5] As a result, former HCFA administrator Gail Wilensky has recently testified before the House Ways and Means Committee that inadequate adjustments appear to have produced overpayments to many HMOs and underpayments for other HMOs.

- ✗ **Unlike typical insurance plans available to working Americans, Medicare has a very unsophisticated system of insurance copayments.** Most Medicare enrollees purchase "Medigap" policies to cover Medicare's 20 percent coinsurance requirement. But under current Medicare law, Medigap policies are required to cover all coinsurance costs under Medicare, and the typical plan also covers the HI deductible; and some even cover the SMI deductible. Because 80 percent of Medicare beneficiaries are covered by additional insurance policies, they face little or no out-of-pocket costs for Medicare-covered services and thus little incentive to question costs or the need for services. According to the Congressional Budget Office, the use of medical services by those with additional private insurance coverage is 24 percent higher than by those with only Medicare coverage.[6]

- ✗ **While the Medicare Part B program appears to be a comprehensive benefit package at a superficial glance, closer scrutiny reveals that it is nothing more than a standardized and quite limited benefit package locking our nation's elderly into a one-size-fits-all health plan.** Such a standardized benefit package does not take into account the different needs and desires of individuals and lacks, for example, catastrophic coverage or a drug benefit.

This problem of slow service design innovation is endemic to Medicare's price control/central planning system. While conceivably the process could be speeded up, it cannot even theoretically match the pace of innovation in a competitive marketplace. The solution to this problem thus is the same as the solution to the first problem: Change the underlying economic dynamic of the Medicare system.

3) PART B HEAVILY SUBSIDIZES MANY UNDESERVING AMERICANS.

The first two problems discussed are generic features of the Medicare program that contribute to unnecessarily rapid increases in expenditures. But, in addition, net Medicare outlays are higher than they need be because Part B (SMI) is so heavily subsidized.

Medicare Part B is a voluntary program. Unlike Part A, Americans do not make explicit contributions to the program during their working life, and there is no obligation whatsoever for citizens 65 or over to participate in this part of Medicare. It is merely a heavily subsidized, federally run physician-care "insurance" plan available at a community-rated price to older Americans without regard to income.

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5 General Accounting Office, "Medicare, Health Maintenance Organization Rate-Setting Issues," GAO Report to Congressional Committees, GAO/HRD-89-46, January 1989, p. 4.

6 Congressional Budget Office, "Restructuring Health Insurance for Medicare Enrollees," CBO Report, August 1991.

When Medicare was established in 1965, the Part B monthly premium was originally set at a level to finance 50 percent of the Part B program costs, irrespective of the income of the beneficiary.[7] However, when the Part B costs began to increase at a faster rate than inflation, the Congress decided to limit the percentage increase in the premium to the same percentage as Social Security benefits were made for cost of living adjustments. Under this new formula, revenues from Medicare Part B premiums decreased from 50 percent to roughly 25 percent of the Part B expenditures. This is because the Part B costs increased at a faster rate than inflation as measured by the Consumer Price Index. Beginning in the early 1980s, Congress has consistently voted to set the Part B premiums at a level which would cover about 25 percent of the program's costs. Thus, enrollees in the Part B program enjoy a very generous 75 percent subsidy paid by taxpayers—irrespective of the beneficiary's income. Thus, unlike the Part A program, which is primarily financed through the taxation of wages, general revenues are used to pay for Part B.

There is little justification for a flat 75 percent subsidy without regard to income. Congress should reduce or eliminate this subsidy for upper-income Americans.

ACHIEVING TRUE MEDICARE REFORM

Large savings and efficiency improvements are possible in the Medicare program only by changing fundamentally the way the program functions. That structural reform must move Medicare away from the current highly regulated system towards a system based on consumer choice among competing health plans. This change would not just save money. In this reformed Medicare system, retirees would have the widest possible discretion to enroll in plans of their own choosing, with the benefits they and their doctors feel are right for the retiree, and with the government making an appropriate contribution towards the cost of the chosen plan.

The way to achieve this reform is to convert Medicare from a **defined benefit** program to a **defined contribution** program—in effect, a voucher program. In this arrangement, the Medicare program would make a contribution to the health plan of the elderly but retirees would be given a very wide range of plans in which to enroll, keeping part of the savings if they choose a less costly way of obtaining their care. A Medicare enrollee would have the option of using the voucher to stay in the current government-designed benefits and reimbursement system or applying the voucher towards the cost of any Medicare-approved private health insurance plan on the market. If the private plan cost more than the worth of the voucher, the enrollee would be responsible for the difference. However, if the plan cost less than the value of the voucher, all or part of the savings would go to the enrollee. An alternative to a voucher program would be the agreement by Medicare to cover a certain percentage of the premium and out-of-pocket costs in the selected plan.

In order to reflect the true value of retirees' health care needs, the voucher amount would be adjusted based upon the beneficiaries' age, gender, and geographic location (but not health condition). To be eligible to market to the Medicare population, plans would have to meet certain criteria. They would have to use the underwriting principles that mirror those used to set the value of the voucher. They would have to include catastrophic protection (and perhaps a limited core set of benefits). And they would have to meet certain financial viability requirements and perhaps guidelines in stating their benefits and cost (to make comparisons easier for the elderly). Plans could offer an insurance/medical savings account option and be eligible to receive the Medicare voucher.

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7 Mark Merlis and Richard Price, "Medicare: 1994 Budget," Congressional Research Service, June 28, 1993, p. 6.

The new program offering more choices thus would be structured much like the Federal Employee Health Benefits Program (FEHBP) which covers approximately 10 million federal employees, their families—and retirees. To be sure, the proposed Medicare reform would not incorporate the rigid community rating in the FEHBP, but it would function much as the FEHBP does for retired federal employees. And just as many FEHBP plans are organized by associations, such as the mailhandlers union, it is likely that organizations with a strong link to the elderly, such as AARP or certain churches and unions, would have an interest in designing a health plan to market to the elderly. Even if such organizations did not actually market plans, they could play a valuable role in providing consumer information to the elderly to assist them in making choices.

Congress in reality only has two choices when considering the future of Medicare:

CHOICE #1: Make no change in the way in which Medicare is run by the government and pay for future trust fund shortfalls by raising new revenues through higher payroll and other taxes, or by diverting money from other programs. This means Medicare survives only by draining money away from the rest of the budget or by raising taxes.

CHOICE #2: Change the way Medicare is run so that benefits are delivered more efficiently, avoiding future tax increases or a diversion of money from other programs. Making the program more efficient would improve the quality of benefits and the choices available to retirees while reducing the double-digit rate of outlay increases. This would slow the depletion of the trust fund and stabilize the program.

The second choice is the only responsible one. That means Congress must address the chronic design flaws of the Medicare program.