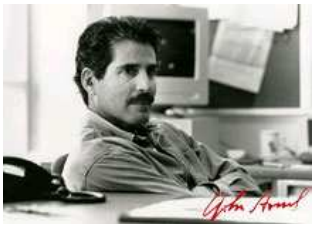
John Stossel's Take

Commentary from Co-Anchor of ABC News' "20/20"



John Stossel is ABC News' Co-Anchor of "20/20" and New York Times best-selling author of Give Me A Break & Myths, Lies and Downright Stupidity. His "Give Me a Break" commentaries take a skeptical look at a wide array of issues, such as education, the economy, parenting, and more.

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Medicare's “Efficiency”

06/30/2009 11:22 AM

Strong piece yesterday by Tom Bevan at Real Clear Politics on the media-fueled myth of Medicare’s “efficiency.”

It’s important because as the Obama administration ramps ups it's push for a "public option" - it's worth taking a sober look at Medicare, the existing federal entitlement anew "public option" would most closely resemble. Medicare frequently gets a free pass not only from the pubic but from the media. Why? In part because it hasn’t exploded yet, and for now, people seem to be getting free stuff. Most of the media are too intellectually lazy to report on entitlements. I haven’t done it as often as I should because—face it—its not exciting TV.

But last month on "20/20" producer Miguel Sancho and I reported on Medicare’s $34 trillion in unfunded liabilities, on how Medicare is a prime example of government promising MUCH more -- that it is prepared to deliver. But the Obama administration has succeeded in promoting the fiction that Medicare as a shining example of government working well. Statists suggests that because Medicare only spends two or three percent of its budget on overhead, that means it's a smoothly running machine. Bevan cites recent columns by Jonathan Alter and Paul Krugman, and “West Wing” fans will remember Jimmy Smits’ Matt Santos making the same argument in the famous “live debate” episode.

Bevan argues persuasively that Medicare’s low overhead is the product of government accounting sleight-of-hand. But there’s a bigger point – the connection between “low” administrative costs and staggeringly HIGH levels of fraud and waste. As Michael Cannon at the Cato Institute and Regina Herzlinger at Harvard Business School have pointed out, much of the 10 to 20 per cent of private insurance administrative costs goes to preventing fraud. Private insurers, you see, care about whether or not they lose money. Medicare, with its unlimited claim on the public purse, does not. It's only taxpayer money, after all.

The results are predictable, but breathtaking nonetheless: an estimated $68 billion (with a B) in outright Medicare fraud every year (About $3 billion in Miami-Dade county ALONE.) On top of that, according to well-respected Dartmouth researchers, roughly a third of Medicare's total $400 billion annual spending goes to procedures which were medically unnecessary.

Health care reform sounds so good. It's an idea that makes us feel better about ourselves. The president's plan deserves a hearing, But the country is drowning in unfunded future liabilities. Regardless of one's philosophical leanings about the merits of another large federal entitlement program, we cannot afford one as wasteful as Medicare.

June 30, 2009 in healthcare | Permalink | Share | User Comments (14)

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John - I agree with you here, but you should make honest comparisons. You state that Medicare spends only 3% on overhead, but that that 20% of private insurance overhead is sent preventing abuse. Those are only comparable figures if private insurers spend 100% on overhead (which I'm fairly certain is not the case).

A better comparison would be this:

Percentage of overhead dedicated to fighting insurance fraud:
Private insurers: 20%-30%
Medicare: 0%

Posted by: not the real jb | Jun 30, 2009 11:32:35 AM

John - so if Medicare somehow worked well, had truly low overhead costs, no unfunded liabilities, and little or no fraud, would that make it alright?

While yours is a good argument, the only principled response to Medicare is to point out the proper role of government - to uphold and protect the individual rights of life, liberty, property, etc, as realized through the courts, police, and military. Any other services, if provided by the government, must invariably violate one of those individual rights. In this case, the right to your property - to do with your money as you see fit, to support only yourself and those who you freely choose to support.

Posted by: Brian | Jun 30, 2009 11:54:45 AM

John -
"We began talking about the various proposals being touted in Washington to fix the cost problem. I asked him whether expanding public-insurance programs like Medicare and shrinking the role of insurance companies would do the trick in McAllen.

“I don’t have a problem with it,” he said. “But it won’t make a difference.” In McAllen, government payers already predominate—not many people have jobs with private insurance.

How about doing the opposite and increasing the role of big insurance companies?

“What good would that do?” Dyke asked.

The third class of health-cost proposals, I explained, would push people to use medical savings accounts and hold high-deductible insurance policies: “They’d have more of their own money on the line, and that’d drive them to bargain with you and other surgeons, right?”

He gave me a quizzical look. We tried to imagine the scenario. A cardiologist tells an elderly woman that she needs bypass surgery and has Dr. Dyke see her. They discuss the blockages in her heart, the operation, the risks. And now they’re supposed to haggle over the price as if he were selling a rug in a souk? “I’ll do three vessels for thirty thousand, but if you take four I’ll throw in an extra night in the I.C.U.”—that sort of thing? Dyke shook his head. “Who comes up with this stuff?” he asked. “Any plan that relies on the sheep to negotiate with the wolves is doomed to failure.”

Instead, McAllen and other cities like it have to be weaned away from their untenably fragmented, quantity-driven systems of health care, step by step. And that will mean rewarding doctors and hospitals if they band together to form Grand Junction-like accountable-care organizations, in which doctors collaborate to increase prevention and the quality of care, while discouraging overtreatment, undertreatment, and sheer profiteering. Under one approach, insurers—whether public or private—would allow clinicians who formed such organizations and met quality goals to keep half the savings they generate. Government could also shift regulatory burdens, and even malpractice liability, from the doctors to the organization. Other, sterner, approaches would penalize those who don’t form these organizations."

-http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande?currentPage=8

Posted by: Jeffrey West | Jun 30, 2009 12:16:36 PM

John--
That 20% "fraud" number is highly misleading, since the insurance companies are essentially spending some money to avoid having to spend even more an actual treatment of actual people. When you are on the table facing surgery, who do you want making the insurance decision: someone making sure the insurance company they work for is still profitable to stockholders, or someone who will err on the side of "wasting" money so that you get the treatment you need.

Your trust in insurance company bean-counters is admirable. And its understandable, since you can afford to pay if the insurance company says "no."

But that is *not* how a civilized country should treat its people. Health care is not a widget to b subject to routine market forces.

Oh, and you know damn well that the 34 trillion number is BS. Its the cost of medical care carried out forever. No other government spending is analyzed that way. Only the ones that people like you dislike.

Posted by: Cap'n Dunsel | Jun 30, 2009 12:17:02 PM

I realize that you have a short article primarily aimed at Medicare, but may I suggest you avoid "intellectual laziness" yourself and examine the problems with the insurance industry as well?

Take a look at this article from the New Yorker: http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande

Posted by: Matt | Jun 30, 2009 12:23:00 PM

For people who reflexively believe government is bad at everything, it must seem unlikely that a large federal program can do something more efficiently than private markets. But the key is in the inherent advantages the government has.

Medicare undergoes minimal sales and marketing costs, takes no profit and enjoy tremendous economies of scale (that is, being big means cheaper). Mostly though, it's advantage is in underwriting. Most of what insurers spend that admin money on is risk analysis, to prevent themselves from having to insure people who will actually get sick.

Medicare skips all that. THAT's how it is able to run at ~4% admin costs, while insurers of employer sponsored group plans spend ~16% on admin costs (even with the added benefit of dealing with a group instead of individuals).

What's even more telling and alarming though is the admin cost for private insurers to cover individuals. This is an important number, because if we believe the Republicans who say they want to goose private markets to cover more people, those policies will fall in this category unless they can create groups somehow. Private insurers spend a staggering 33% on admin costs for individuals ... again in large part because underwriting is expensive.

So ask yourself, how do all those uninsured individuals ever get coverage without a large federal program? Does anyone have an answer for that?

PS. "Research" from Heritage and Cato - being partisan think tanks whose only job is to come up with the partisan answers their partisan sponsors want - is not reliable.

Posted by: sanjait | Jun 30, 2009 12:26:57 PM

John - You make a compelling argument but maybe what is missing from the health care debate is how to turn these facts into actionable and successful policies.

- If the private insurers are effective at combating fraud, why do they not propose to fight fraud for medicare? Perhaps they could receive a percentage of the savings they generate which would be a profitable venture for both medicare and private insurers.

- If so much of Medicare spending is on non-essential services, why don't the reform proposals set out to cut non-essential services and divert these savings to covering the uninsured?

- Lastly, why don't the reforms push private insurers to incorporate those things that medicare does well into the private system.

Maybe these are issues that future 20/20 stories need to address while this debate is proceeding.

Posted by: mike | Jun 30, 2009 12:28:24 PM

Please proofread -- "pubic" instead of public and "that" instead of than, and that was on a skim.

rs

Posted by: rs | Jun 30, 2009 12:31:49 PM

No one says Medicare is not full of fraud. So perhaps the 1st step is to find a way to punish those who are cheating the system? I like the idea of having the people finding fraud sharing in the savings as a way to pay for their services.

But the biggest problem with the proposed Universal Health Care is the *fact* that the only way to save significant amounts of money is to limit or ration service. To do that some people will not get something because they are old. After all, why buy a heart for 95 year old grandpa? If you think 95 is reasonable, how about 90? 85? 75? 60? Where do you draw the line and say he or she is too old? Who makes that decision? SOme unelected bureaucrat? That's the problem with the health care system obama is pushing. And once a system like this is in place it will be impossible to dismantle or to even reduce funding.
While a discussion of Medicare is important, it's the devil we know and have - obama plan is the devil we won't know until it's law - because our congress has a habit of voting for bills without knowing what is included in them - in come cases before they're even *written* !

Posted by: LT | Jun 30, 2009 12:57:29 PM

The information that you gave on the fraud that goes on in Medicare hit home with a vengeance to me. Let me tell you what happened to my sister (who is medically disabled and is receiving disability pay from Social Security as well as being eligible for Medicare due to her disability). About 6 or 7 years ago, she was a patient at a hospital when her purse was stolen. Her credit cards, California ID (she's not able to drive so it wasn't a drivers license) and her Medicare card were stolen.

The difference between the private sector and Medicare is enormous. We immediately called the credit card companies and also the credit reporting bureaus to report the stolen cards. The credit cards were immediately made inactive so as to prevent their unauthorized use. Only one card was used for a gas purchase for about $20 before it was "turned off" by the credit card company and she wasn't responsible for that charge. New cards were issued and there was no further fraud as a result of the stolen credit cards.

The Medicare card? That's a whole different story. About a month after the card was stolen, there started to be charges made to my sisters account from doctors, medical equipment stores and other areas all through the southwest. These were immediately reported and, of course, my sister wasn't responsible or the costs didn't go against her account (although the government paid all of these at the taxpayers expense). When we reported this, it was turned over to an investigator who took the information to "investigate" this fraud. I personally talked to him and asked how long this might continue and he indicated that it usually gets resolved in about 5 years. With a credit card, they can change the card number and the old card can't be used anymore, with Medicare, since it's a Social Security number, it can't be changed and the card can be used forever. We were told that when the monthly or quarterly statement comes to us, we're to look at it and forward on to the investigator those charges which are not my sisters. We do this each time the statement comes in and the card has made it's way all throughout the southwest United States from California, to Arizona, to Nevada to New Mexico and the charges range from things like medical tests (for thousands and thousands of dollars) to a plethora of expensive medical equipment like wheel chairs, oxygen etc. It is obvious that it's not just the "Medicare card" that's being used now, it's her card and Medicare number (which is the social security number with and additional letter/number added to it). Also, what is painfully obvious is that by the time my sister has identified the fraudulent charge and informed the investigator of the charge, the charge is 3 to 5 months old and the bad guys have moved on to another area.

Each time, all we can do is contact the investigator and send the information to him. I've tried calling the medical equipment retail store where some of the equipment was bought to see if an investigator had been out there and they told me that they had never been contacted. When looking at all the charges that have been paid by Medicare on behalf of my sister that were fraudulent, it amounts to hundreds of thousands of dollars (which Medicare cheerfully tells us is not being charged against my sisters "account"). It is being charged against the taxpayer account however.

The private sector has it figured out. A simple phone call or two and the card that was stolen becomes useless to the bad guys. The credit card company turns off that card and deactivates that card's number. Medicare honors the little cardboard Medicare card and we're helpless to get that number "deactivated" because it's the social security number plus one other alphanumeric character.

Efficiency? You tell me which protects the public's interests better, the private sector or the public sector. To me, the answer is obvious. What a pain in the butt it is working with the Medicare "fraud" investigators. 6 years and (hundreds of thousands of dollars) and counting to get the Medicare fraud addressed (and it isn't over yet) and with the credit card companies, it only took a few phone calls and a matter of hours to get that squared away.

Posted by: John | Jun 30, 2009 1:24:09 PM

John:

You should talk with Mark Litow of Milliman. He is a consulting actuary who performed a study on Medicare vs private plan expense ratios. His study is summarized here:

http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf

By the way, actuaries are the type of expert anlysts that need to be brought into this discussion. They are the "bean-counters" that understand the drivers of health care costs and they can root out BS very quickly. It is no wonder that all of the current reform plans are designed by lawyers and ideological economists. They haven't the training or experience to really solve the current problem.

Posted by: Joe | Jun 30, 2009 1:30:21 PM

Thanks for a great article John. Those links were fantastic.

Posted by: Mark | Jun 30, 2009 1:31:06 PM

Re: "...much of the 10 to 20 percent private insurance companies' administrative costs is spent on preventing fraud."

This is simple false. My nonprofit organization has studied insurer funding for anti-fraud activities, and it is a small fraction of overall admin costs.

I'm always amazed that some people just make stuff up to support their partisan views.

Posted by: Dennis Jay | Jun 30, 2009 1:47:29 PM

It'd be much better to have a free market in health care. The arguments for government healh care might as well be made for government provided food, shelter and clothing. Do we really want that?

Also worth considering is how much more expensive Medicare is compared to the initial projections. "The costs of Medicare doubled every four years between 1966 and 1980" per http://en.wikipedia.org/wiki/Medicare_(United_States).

A basic problem government has created with health care is insulating the cost from the consumer: starting with making health coverage deductible for employers. Medicare and Obama's plan will make it even further insulated. This has the effect of driving up demand for services that may not otherwise be purchased. Government spending has also lead to "cost shifting" from government sponsored patients to privately insured patients. This has driven up private health insurance, and driven doctors to avoid taking Medicare patients.

The health care problem is really out of control government spending on health care, not health spending as a percentage of GDP.

Before government got involved, doctors actually made house calls. While I'm only 51, I remember them as a child.

Posted by: Dan | Jun 30, 2009 1:59:06 PM

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