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The Politics of Plunder

The Real Medicare Debate: Deciding Who Decides

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Medicare, perhaps even more than Social Security, has become the Third Rail of American politics. Touch it and you die. At least that is the common fear on Capitol Hill.

Congressional Democrats voted to slash Medicare benefits last year as part of health care "reform" and paid a high price in November. Republican House Budget Committee Chairman Paul Ryan recently offered his own plan and has come under ferocious attack. But he offers the far better proposal.

Americans risk spending themselves into bankruptcy. Medicare is big part of the problem. The program fails to adequately meet seniors' needs. It also is fiscally unsustainable.

Medicare was part of Lyndon Johnson's Great Society. The program created a "fee-for-service" system but limited coverage, leading many retirees to buy supplemental "MediGap" insurance. Nevertheless, the program was expensive, with taxpayers forced to supplement beneficiary "contributions."

Unfortunately, Medicare illustrated an immutable law of economics: Cut the marginal price and demand will skyrocket. With Medicare services seemingly free, the elderly used far more services. Costs raced upwards.

In 1967 Medicare debuted with a cost of $2.5 billion. The same year the House Ways and Means Committee predicted that Medicare would cost $12 billion in 1990. Alas, that turned out to be *an $86 billion underestimate*. Medicare first exceeded $12 billion in 1975.

At $494 billion this year Medicare is the second largest domestic expenditure and will pass Social Security in the near future. The 2009 Medicare trustees' report estimated the program's total unfunded liability to be $89.3 trillion, roughly five times that for Social Security.

Medicare also helped turn American medicine generally into a system of third party payment, with roughly nine of ten dollars in the first instance now paid by someone else. Although we all ultimately pay through either taxes or insurance premiums, health care *seems* almost free. So we expect more and better care.

This rise in overall medical expenses reinforced underlying demographic trends in pushing up Medicare costs. Our society is aging, with a larger proportion of people who are elderly and living longer. They require far more medical attention than younger Americans. The combination is a fiscal atomic bomb.

One "solution," used by Congress over the last quarter century, is to impose price controls on Medicare and hope everything works out. That is, the government promises to cover most everything but refuses to pay market prices. Many doctors and hospitals have responded by gaming the system, attempting to make up lost revenue by collecting for extra services.

Other physicians simply refuse to accept Medicare, restricting access for seniors. Reported *USA Today* last year: "The number of doctors refusing new Medicare patients because of low government payment rates is setting a new high, just six months before millions of Baby Boomers begin enrolling in the government health care program."

ObamaCare reinforced this strategy. Medicare continues to provide a one-size-fits-all set of government-dictated benefits, irrespective of elder needs. But the administration and Congress based the legislation's dubious financing on cutting $523 billion of Medicare expenditures over the next decade. In coming years an unelected panel backed by "comparative effectiveness research" is supposed to adjust payments to keep elder health care affordable.

However, the claim of fiscal responsibility is an illusion. Although Medicare could better match market prices—the government pays too much for some specialty services and too

little for primary care—it is impossible to set artificial prices without distorting the health care marketplace.

If the government promises to insure beneficiaries for medical services, it will inflate demand. If the government refuses to pay providers for medical services, it will decrease supply. Doing both simultaneously ensures disaster.

The Medicare trustees' latest report incorporates ObamaCare's planned program cuts. The administration shamelessly engaged in double-counting: in March 2010 the administration said it planned to use the money saved to expand health care coverage; in August 2010 the administration said it planned to use the money saved to improve Medicare's finances. It is impossible to do both with the same dollars.

Worse, most of the promised savings are fake. In his three-page Statement of Actuarial Opinion at the end of the 283-page report, Richard S. Foster, Chief Actuary of the Centers for Medicare and Medicaid Services, politely declared the rest of the report to be a fraud. The projected cuts are unrealistic and the financial estimates are meaningless.

The forecasts were based on existing legislation, but, he wrote, "Current law would require physician fee reductions totaling an estimated 30 percent over the next 3 years—an implausible result." Moreover, "there is a strong likelihood that certain of [ObamaCare's] changes will not be viable in the long range." Prices are supposed to be reduced in accordance with economy-wide productivity improvements, but "The best available evidence indicates that most health care providers cannot improve their productivity to this degree—or even approach such a level—as a result of the labor-intensive nature of these services."

Thus, "the prices paid by Medicare for health services are very likely to fall increasingly short of the costs of providing these services," to less than half of costs under long-range forecasts. Reimbursement rates would fall well below those for Medicaid, "which have already led to access problems for Medicaid enrollees." In effect, ObamaCare plans on saving money simply by denying the elderly access to care. Seniors had good reason to be upset.

However, a vote-minded Congress is unlikely to stand by as the elderly wander aimlessly looking for a doctor. Thus, argues Foster, "Congress would have to intervene to prevent the withdrawal of providers from the Medicare market." But "Overriding the productivity adjustments, as Congress has done repeatedly in the case of physician payment rates, would lead to far higher costs for Medicare in the long range than those projected under current law."

Concluded Foster: "For these reasons, the financial projections shown in this report for Medicare do not represent a reasonable expectation for the actual program operations in either the short range (as a result of the unsustainable reductions in physician payment rates) or in the long range (because of the strong likelihood that the statutory reductions in price updates for most categories of Medicare provider services will not be viable)."

Thus, the Democratic approach fails to either ensure senior access to medicine or prevent Uncle Sam from going bankrupt.

Rep. Ryan has proposed a better strategy. He would in effect turn Medicare from a defined benefit (where the government promises specific coverage) into a defined contribution (where the government promises specific support) program. The federal government would offer "premium support," adjusted for income and set to grow with inflation, allowing retirees to purchase their own health insurance through a federal exchange.

One can argue over the specifics of his initiative, but it offers honest policy-making. Under Ryan's approach, the federal government would stop promising benefits for which it has no intention of paying. And Washington would stop hoping to get by on the cheap, expecting physicians and hospitals to simply eat their losses from accepting Medicare recipients.

Moreover, Washington could make accurate spending predictions. By deciding how much premium support to offer, the government would know how much it was going to spend. Obviously, Congress could change the federal contribution, but legislators at least would know the fiscal impact of doing so.

Turning Medicare into a defined contribution program also would invite legislators to start making the sort of hard decisions necessary to restrain federal spending. Ryan would reduce payments for wealthier Americans; best would be to phase out benefits for the middle class as well.

Taxpayers cannot afford a program which gives every retiree government health insurance. People who don't need it should buy their own. Granted, most recipients believe they have paid for the benefits. But a typical senior receives $355,000 back for $114,000 paid in Medicare taxes. (Social Security has the opposite problem—new workers *lose* money.) That's why the program is destroying Uncle Sam's finances.

Utilizing premium support—or, even better, a formal voucher without the spending restrictions imposed by Ryan—also would expand elder options. In fact, this is what ObamaCare is supposed to do: subsidize the purchase of health insurance through government exchanges (though with heavy government regulation). The biggest problem with the Democratic program is the limit on private choice.

Nevertheless, the Democrats are trying to demonize premium support by using the word "voucher." The reason? *Because it expands personal choice* where little presently exists. But the basic question for Medicare should be: who decides? Retirees or government?

In fact, this always was the issue underlying health care "reform." Nearly two decades ago Wall Street analyst Kenneth Abramowitz advocated expansion of managed care: "Right now, health care is purchased by 250 million morons called U.S.

citizens." It was, he added, necessary to "move them out, reduce their influence, and let smart professionals buy it on our behalf."

Last year the president and Democratic Congress demonstrated that they believed "smart professionals," or successful politicians, at least, should decide how much health care all the "morons called U.S. citizens" should receive. And that is always how Medicare has operated. Recipients get one set of benefits. Government sets the payment rates. If a retiree doesn't like it, tough!

Instead, people should be able to choose the health insurance plan which best meets their and their family's needs. Obviously, purchasing medical care isn't as simple as buying a car. Most of us are going to want to rely on advice from "smart professionals." But ultimately, only individuals and families can decide the best coverage and the right trade-offs. Instead of voting to nationalize medical decisions, Congress should have encouraged more personal decision-making in the purchase of health insurance.

Legislators also should apply this principle to Medicare. Help those who need help, but let them choose the benefits best for them.

Last year, in the midst of fevered debate over ObamaCare, Newfoundland Premier Danny Williams flew to Miami for heart surgery. It seems Canada's vaunted socialized system limited his treatment options. Williams responded to criticism: "This is my heart, it's my choice and it's my health."

So it is for all of us.

Those who advocate government control of health care decision-making contend that "rationing" is inevitable. If the government's doesn't do it, someone else will do it.

But there is a dramatic difference between individuals deciding how to spend limited resources while choosing among competing goods and services and government telling individuals how to spend their money or spending it for them. Even in today's highly regulated and restricted health care system some choices remain. Ever greater government control ultimately means no exit for anyone—except the wealthy, who can afford to go anywhere for any treatment.

Thus, genuine health care reform means increased patient power. The health care system should allow people to make their own health care decisions, including what kind of insurance to buy and what kind of coverage to choose.

The same goes for Medicare reform. ObamaCare institutionalizes politicized rationing. Rep. Ryan's plan would emphasize private decision-making. His approach also would restrain Medicare's exploding budget. What is Congress waiting for?