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Curb debt by means-testing Medicare

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Medicare changes are not a part of this week's deal to increase the nation's debt limit. During the drawn-out negotiations, however, President Barack Obama reportedly offered to means-test Medicare and increase the age of eligibility. Both are worthwhile reforms that should be seriously considered by the super committee constituted under the deal.

Increasing the eligibility age is a no-brainer — for the same reasons many people now say that increasing Social Security's retirement age is necessary. Medical advances and better lifestyle choices have improved the health of many older Americans compared with the mid-1960s — when Medicare's current eligibility age of 65 was designated.

We must remember that the goal should be to provide for the health care that Americans need — not what providers wish to supply under Medicare's market-distorting, fee-for-service payment system. In addition, we should restrict Medicare eligibility in a sensible way — excluding the Bill Gateses and Warren Buffetts.

The current system is riddled with inefficiencies, arbitrary price controls and arbitrary coverage decisions by federal bureaucrats. Indeed, these restrictions are so onerous that many Gateses and Buffetts would give up their eligibility — if they could.

The claim that a private system would cost more administratively is no longer valid — for health information technology now promises to revolutionize care management without large nonmedical overhead costs.

Medicare expenses per beneficiary have soared far higher than anticipated when the program was started in 1965. Spending growth now averages almost twice the rate of gross domestic product growth. There is no magic bullet for reining in Medicare costs: The fundamental reasons for spending hikes are pervasive subsidies to the health care sector and supply-reducing government regulations — a system that also distorts the private health care market.

The introduction of comprehensive health subsidies — Medicare for the elderly, Medicaid for low-income households and tax exclusions for employer health insurance provisions for the rest — has expanded the intensity of health care services use and has sucked resources from the private payer health sector.

This has also stratified health care providers — with the more qualified, skilled and successful providers remaining in the lucrative private-payer sector.

So it is not surprising that, as public subsidies ballooned, the use-intensity and resource-siphoning effects led to bigger cost increases in the private-payer sector. It is a classic cart-before-the-horse argument to use the faster spending increase in the private-payer health sector as justification for expanding the government-payer sector — all the way to adopting the public option.

The payment structure of our public health care subsidies introduces a vicious cycle: Given

supply-limiting health care regulations, those subsidies initially increase health care demand and prices and also spur innovations in costly medical technologies. Our open-ended health subsidy system then responds to higher prices of health care goods and services by diverting more resources from the rest of the economy toward the health sector.

The truth is that the only way to control health costs is to stop collaring funds from the rest of the economy and channeling them to this sector — as we have for the past 45 years.

A system with greater patient control and choice would work far better. That's best achieved by allowing younger Americans to save for and choose coverage appropriate for themselves.

The correct policy would be to expand health savings accounts for younger cohorts, means-test Medicare eligibility and restructure Medicare benefits as annual lump-sum grants to those eligible.

These reforms should be introduced gradually. Nobody's recommending throwing today's retirees off Medicare's rolls.

Unfortunately, negotiations to achieve a "grand bargain" on the nation's debt limit — including significant Medicare reforms — fell through. The political reality is that successfully concluding a large deal that sensibly reverses the health care policies we've inherited will most likely require a considerable commitment to resist attempts at government expansion via tax increases.

Some suggest that means-testing Medicare is like imposing a tax on better-off Americans, so why not just raise their taxes? But resolving Medicare's fiscal imbalance by increasing taxes would only increase the distorting redirection of the economy's resources toward the health care sector.

Imposing a tax on better-off Americans by means-testing Medicare and restructuring benefits as annual lump-sum grants would be more effective in bending the health care spending trajectory downward — by making health care consumers more responsive to market prices and increasing their demand for signals of provider quality.

The 2010 election signaled that voters want less government and lower taxes. A large deal including Medicare means-testing would be the right way to deliver what they desire. It would also begin to restore balance to the federal budget.

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