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Fixing Medicare requires seniors to pay quite a bit more

Higher payments would cut Medicare expenditures. They would also compel beneficiaries to be more price sensitive and better balance benefits against costs.

By Jeffrey Miron
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In the Obama campaign's attack on the Romney-Ryan proposal to "voucherize" Medicare, one accusation is that the plan would force seniors to pay more of their healthcare costs: about $6,400 more per beneficiary, according to a recent TV ad known as "Facts." Regardless of the "facts" in the ad, this attack takes as a given that any such outcome is undesirable.

Yet asking seniors to pay substantially more is precisely the way to improve Medicare. Here's why.

The purpose of insurance is to protect against large, unforeseeable expenses. If everyone faces some risk of substantial health costs, but no individual can predict whether or when these will occur, everyone can benefit by pooling these risks via insurance.

This argument does not apply, however, to small or predictable expenditures. It makes no sense to buy insurance against the "risk" of routine medical care, such as annual checkups, or against the risk of moderate expenses, such as many medication regimes, minor surgeries or treatments. Homeowners insurance does not cover broken toilets or snow removal, only major events such as a fire. These expenditures may well be worthwhile. For example, annual checkups might help avoid larger medical expenses in future. But most consumers can afford these without insurance.

In addition, insurance can make the healthcare market less efficient by reducing consumer incentive to economize on health costs. This "moral hazard" is a major reason behind escalating costs. When consumers are not paying for their care, the incentives for excessive utilization are huge: unnecessary tests, too much surgery rather than watchful waiting, doctor visits with minimal value, brand name versus generic drugs and more.

The way to diminish moral hazard is with large deductibles. If the first, say, $6,400 of medical costs per year must be paid by the insured, people would economize on healthcare and shop for lower prices when care was needed. And

such high-deductible policies still accomplish insurance's main goal: protecting against catastrophic risks.

Medicare, alas, makes minimal use of deductibles (or copays, a related mechanism for reducing moral hazard). Patients are, therefore, insensitive to costs and demand ever more healthcare as technological progress yields new tests, drugs, devices, treatments and procedures. Costs therefore escalate. Insurance and the extent of coverage, not technological progress, is the culprit.

So Medicare should phase in a much higher deductible, starting now. The increase would presumably be small or zero for those already retired; somewhat higher for those nearing retirement; but gradually rise to a substantial value (e.g., $6,400) for those decades away from eligibility.

The improvement in Medicare's finances would be huge. Assume at least 40 million elderly beneficiaries pay an increased deductible of $6,400. That would reduce Medicare expenditure by roughly $250 billion per year once fully phased in. And this does not affect the poorest elderly, who are eligible for Medicaid rather than Medicare.

This reduction in Medicare's expenses is not the main benefit, however. Lower Medicare expenditure is just the flip side of the higher deductibles paid by seniors and therefore not a net benefit to the economy.

The payoff is that beneficiaries would be more price sensitive, so decisions about medical care would better balance benefits against costs. This means a better allocation of resources to health and nonhealth uses, as well as reduced pressures for health-cost inflation. In short, the healthcare system would operate more efficiently, which is a true net benefit to the economy.

President Obama's approach to fixing Medicare has little hope of achieving these gains because it does nothing to put more consumer skin in the game. His approach, which consists mainly of regulating prices and quantities via the Independent Payment Advisory Board, can in theory slow expenditure but it would generate rationing, creative accounting and myriad distortions in the healthcare system. No government panel can effectively set the prices and quantities in a large, complicated and ever-evolving industry.

The Romney-Ryan proposal, which allows seniors to opt out of Medicare and get what is essentially a voucher to purchase health insurance, has some chance of improving Medicare, but the devil is in the details. In theory, consumers with vouchers would become price sensitive about their insurance policies, often choosing ones with high deductibles and thereby restoring consumer stake in the system.

But that will happen only if the health insurance market becomes truly competitive, which depends crucially on how the government defines the

vouchers and whom it allows to accept them. Generating a competitive marketplace will not be easy.

Regardless, any approach that makes Medicare better requires seniors to pay more of their own costs.

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