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Is Medicare a Lean, Mean, Money-Saving Machine?

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During last week's Democratic primary debate, Sen. Bernie Sanders continued to sell his Medicare for All healthcare plan on the basis of cost-saving. "Every study done shows that 'Medicare for All' is the most cost-effective approach for providing health care to every man woman and child in this country," Sanders bellowed from the stage at Texas Southern University.

In the past, Sen. Sanders and advocates for single-payer healthcare have specifically claimed that "Medicare for All" would save the country billions of dollars by eliminating wasteful administrative costs. But right now, Medicare's rampant fraud and waste complicates this. In fact, it should serve as a warning to those who would expand the program to cover the entire country.

Administrative spending is a lousy way to measure efficiency, which is why fact checkers have disputed these numbers in the past. But focusing on administration ignores a fundamental truth about Medicare. If Medicare spends less on administration, it's not because the program is efficient, it's because those who oversee the program don't have the capacity to properly examine each claim. In their 2018 book, *Overcharged*, Cato Institute scholars Charles Silver and David Hyman demonstrate how Medicare's nets fail to catch fraudsters.

Healthcare providers often take advantage of Medicare by lying or exaggerating about their patients' conditions. Take, for example, a practice little-known outside the medical community called "upcoding," in which providers wrongly bill Medicare to receive higher payments. Silver and Hyman write that from 2008 to 2010, the Chino Valley Medical Center in California claimed 35.2% of its patients had acute heart failure as a secondary condition — a rate that was 15 times the state average. Further investigation revealed the hospital had actually upcoded to receive bonus payments, which could amount to as much as $6,000 for each patient with acute heart failure as a secondary condition. This practice isn't unique to California — Silver and Hyman also reference a study conducted by Christopher S. Brunt in Health Economics that reports 15% of what Medicare pays for general office visits can be attributed to upcoding.

Silver and Hyman give plenty more examples of providers lying to Medicare. They cited a Bloomberg article that reported on a horrifying trend in the '90s. During that time, doctors performed chemical castration — a treatment reserved for prostate cancer — on hundreds of thousands of male patients who didn't need it, all because Medicare's reimbursements were so high. The authors also recount how pharmacists often report paying higher prices for drugs so they can get higher Medicare reimbursements. The practice is so common, industry-insiders have

joked that AWP, which stands for drugs' "average wholesale price" that providers are supposed to report to Medicare, actually means "ain't what's paid."

Providers commit fraud every day because they can. After all, as Silver and Hyman point out, "Medicare relies on hospitals to bill honestly." If they don't, it's likely no one will find out. The *Overcharged* authors elucidate the problem well by noting it would "require 125,000 people each working 2,000 hours a year" to examine Medicare and Medicaid's three billion claims for five minutes each. "That's not enough time to find and flag a fraud, much less to investigate one."

Instead of solving the problem, transitioning to a single-payer system would make it worse. A single national system in a country as large as the United States would be astronomically harder to manage. Medicare would have to adopt rationing strategies like the United Kingdom's single-payer National Health System (NHS), which recently put thousands of elderly patients at risk of going blind by limiting their access to cataract treatment — all in an effort to save money.

It's true that health insurance markets are inefficient. But Silver and Hyman emphasize the main driver of America's healthcare costs is public policy that incentivizes third-party payments and overinsurance. Insurance coverage spread after the government exempted employer-sponsored health insurance from taxes in 1954. And more insurance meant higher costs. MIT Economist Amy Finkelstein is referenced in *Overcharged* estimating that "insurance was responsible for about half of the six-fold increase in health care spending per capita that occurred from 1950 to 1990."

Even if the healthcare sector's many regulations and inefficiencies are acknowledged, "Medicare for All" advocates are wrong to use administrative rates to portray Medicare as more efficient than private insurance. Whatever options lawmakers consider to improve our healthcare system, scaling Medicare for the entire country certainly shouldn't be one of them.