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‘Medicare Works!’ Or Does it?

Several of the 2016 candidates have been praising Medicare. Why?

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What’s with all the newfound love for Medicare? Last week, at a rally in New Hampshire, Donald Trump proclaimed, “Medicare works! You get rid of the fraud, waste, and abuse, and it works!” That probably shouldn’t come as a surprise from Trump, who once advocated a single-payer health-care system for the U.S., and who also still believes that the Canadian and British health-care systems “work.” But Trump is hardly alone.

Among his fellow Republicans, Mike Huckabee criticizes Medicare reform plans for attempting “to rip this rug out from under people who have dutifully paid in their entire lives to a system.” And John Kasich has dismissed critics of the program as “crazy.”

Meanwhile, on the Democratic side, Bernie Sanders is calling for “Medicare for all.” And Hillary Clinton warns that any attack on Medicare “is an attack on seniors and vulnerable Americans.”

One would hardly know that Medicare is, simply put, a mess.

Medicare is currently facing unfunded liabilities of more than $43 trillion. And that assumes that the slowdown in the growth of health-care costs that began in 2007 continues. If health-care costs return to traditional growth rates — and there is some evidence that this may happen — then the unfunded liabilities could be trillions more.

Sure, there is a great deal of fraud, waste, and abuse in Medicare. Some estimates put the combined cost of fraud and improper payments at almost $60 billion per year. Much of Medicare’s waste and abuse stems from the program’s structure. Medicare’s advocates are always bragging about how the program’s overhead and administrative costs are lower than those for private insurance companies. It’s true that Medicare’s administrative costs are low (although often understated). But that is because Medicare is essentially a check-writing program. A provider sends in a bill; Medicare sends back a check. That’s an open invitation to error and fraud.

But Medicare’s real problem is not fraud and abuse but basic math. For example, according to the left-of-center Urban Institute, a married couple with two average earners turning 65 in 2020 will have paid roughly $154,000 in Medicare payroll taxes over their lifetimes. That certainly

seems like a lot of money. But, given average life expectancy, that same couple can expect to receive $479,000 in benefits (net of any Medicare premiums they pay). It's hard to see a program that loses $325,000 per couple as "working."

Or consider the demographics. In 1987, there were just under 25 million Americans on Medicare, and the program spent roughly $2,000 per year in benefits for every enrollee. But we are aging as a society, and health-care costs have risen. Today, there are nearly 56 million Medicare recipients, and the annual cost of treating each of them has risen to more than $12,500. And projecting forward, in less than a decade there will be 72 million enrollees, each with an annual cost of almost $19,000. It's hard for a program to work by losing money on every transaction and trying to make up for it in volume.

And, because Medicare plays such an outsized role in overall U.S. health-care spending — more than one out of every five dollars in health-care spending takes place in the Medicare system — the program may well have helped drive up overall health-care costs in this country.

One thing that is not driving Medicare's impending bankruptcy is overpaying doctors. Medicare generally pays doctors far less than private health insurance, in many cases less than the actual cost of providing care. The result is that providers shift costs to those with private insurance, meaning the rest of us subsidize Medicare recipients through higher premiums as well as higher taxes. Other doctors simply drop out of the system. Fewer than 84 percent of doctors accept new Medicare patients. And this problem will only grow worse in the future. The Affordable Care Act established the Independent Payment Advisory Board (IPAB) and gave it the power to further reduce provider reimbursement. Some estimates suggest that IPAB could eventually push reimbursements as low as 50 cents on the dollar. Not only will this force even more physicians out of the program, but, according to actuaries at the Centers for Medicare and Medicaid Services, this combination of effects could lead to roughly half of hospitals, 70 percent of skilled nursing facilities, and 90 percent of home health agencies losing money by 2040, which could lead to widespread closures.

It is not as if this tide of red ink is buying us the highest possible quality of health care. For example, in 20 years of intensive research, the Dartmouth Atlas Project, which uses Medicare data to examine the relationship between expenditures and outcomes, has found that death rates and other outcomes are no worse in areas with low Medicare spending than they are in areas with the highest per-patient costs. The Atlas researchers estimated that as much as 30 percent of Medicare spending provided little or no benefit.

Another study, published in the Journal of the American Medical Association, found that for 16 of 40 standard indicators, Medicare patients received recommended care less than two-thirds of the time. Other studies have shown that Medicare patients receive a lower quality of care than do similar patients with private insurance. And a study in the Journal of Health Services Research found that "Medicare coverage at age 65 for the previously uninsured is not linked to improvements in overall health status." Similarly, a study by Amy Finkelstein and Robin McKnight for the National Bureau of Economic Research found that Medicare has had little effect on mortality rates among the elderly.

Notably, Medicare payments are not generally based on quality of outcomes. Payment is generally the same regardless of the result. In fact, it was only recently, under Obamacare, that

Medicare began to crack down on double payments for readmission. As the Medicare Payment Advisory Commission points out, "Medicare payment systems have created little or no incentive for providers to spend additional resources on improving quality."

If that isn't enough, Medicare's entire structure makes little sense. The program consists of four distinct parts (Parts A, B, C, and D), each with its own funding mechanism, cost-sharing requirements, and other rules. This can't help leading to bureaucratic confusion. Worse, the program's structure is essentially upside down. Deductibles are extremely low (as little as $147 a year under Part B, for instance), encouraging enrollees to overconsume routine care. But the program reduces coverage the longer you are sick, providing no coverage for those hospitalized for more than 90 days. It is as if your car insurance paid for oil changes but wouldn't cover you if you totaled your car.

Maybe Medicare isn't so lovable after all.

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