

MEDICARE REFORM

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I. Problems with Medicare: The Four I's

The National Bipartisan Committee on the Future of Medicare has distilled the problem in the current Medicare System into the four I's (as coined by witness Robert Reischauer): Insolvency, Inadequacy, Inefficiency and Inequity.¹

Insolvency: First, the Part A Trust fund (Hospital Insurance) will go broke by the year 2008 (according to CBO projections), a full two years before the first wave of Baby Boom beneficiaries enters the Medicare System. Second, Part B (Supplemental Medical Insurance), which was originally priced such that beneficiaries paid for one-half of the cost, now only covers one-quarter of the cost. Together, Medicare (Parts A and B) will grow from 12 percent of the current Federal Budget to 28 percent of the Federal Budget by 2008, even under the CBO's most optimistic projections.

Inadequacy: Medicare's Package A benefits are deemed basic by current notions of the level of health care service. Not surprisingly, government regulation and controls seriously affect the availability and participation of service providers in the program. Also, medication is currently excluded from Medicare due to the lobbying and justified concerns of the pharmaceutical lobby. In home health care is also not part of Medicare.

Inefficiency: The current system is dramatically inefficient both from the perspective of health care suppliers and health care consumers, due to the inefficiencies in the pricing of health care services and the inefficiencies in financing these services. The funding inefficiencies parallel those of Social Security. First, it is 'pay as you go,' as pointed to by the trust shortfall mentioned above. Second, as funding is generated primarily from payroll taxes and general revenue receipts, this is an inefficient way to finance a service that many recipients currently have or would have had the means to self finance. Finally,

given the vast regulation of the provision of health care services and the lack of price incentives facing beneficiaries, there are simply no incentives for either side of the health care market to reduce costs in supplying or receiving services.

Inequitable: Benefit levels may vary state by state, although payroll taxes and other fees do not. Also, benefit levels do not match up with contributions on a generational basis: just as in Social Security, Medicare is a spin of demographic roulette. Jagadeesh Gokhale and Laurence Kotlikoff (1999) calculate that a representative male who was age 70 in 1995 would receive \$51,600 worth of Medicare services during their lifetime (calculated in 1995 dollars.)² In comparison, a representative male who was age 35 in 1995 would receive \$17,800 worth of Medicare services during their lifetimes. The figures for the representative woman are \$51,800 and \$19,100 for the 70-year old and 35-year old, respectively.³ Generational redistribution brought about by Medicare (as well as by other programs such as Social Security) dominate the within generation redistribution that policymakers rally around in order to drum up support for a large government presence in health care.

So what is the Commission considering? First, they wish to combine government regulation with market based competition, while maintaining protection for low-income beneficiaries by charging more to those with higher incomes. Second, they suggest improving Medigap funding so that more beneficiaries can find private supplemental insurance so as to afford additional treatment, while reducing 'first dollar contributions.' Third, they are likely to advocate postponing the age of eligibility for joining (this contrasts with President Clinton's pledge in his State of the Union speech) and impose deductibles and cover only a fraction of the cost of services. Finally, a likely outcome will be that the government will decrease the fraction of Medicare's funding from payroll taxes (though not lowering the tax rate) and increase the fraction of funding by general funds. According to the draft working document cited above, the fraction from general funding would rise to 64-70 percent by the year 2030.

II. The Principles of Insurance

Before analyzing the current thinking of the Commission's proposals, we should first remind ourselves of the principles that make insurance socially desirable. First, insurance provides the benefit that it allows individuals to diversify their individual (or family) specific risk. By pooling risk, individuals benefit overall on an *ex ante* basis, though with any insurance system some will receive more benefits *ex post* than others. Second, it should be based on the criteria that on an *ex ante* basis, no group or individual should receive a net benefit. This should hold regardless of the year that an individual was born or even the region where they live. Third, since some level of health services is viewed by society as basic human need, some redistribution from richer to poor households is in order, although the scale is obviously an open issue. As mentioned above, currently Medicare redistributes from younger households to older ones, which is unfortunate given that older households have more wealth, on average, than younger households—see Javier Diaz-Gimenez, Vincenzo Quadrini and Jose Victor Rios-Rull (1997).⁴ Fourth, the method of financing the insurance should involve as few distortions as possible so that the recipient of the services sees their true costs.

Of course, the private insurance market may not be able to deliver all of these services from a theoretical standpoint. Adverse selection (i.e. bad health risk individuals will disproportionately join) and moral hazard (i.e. why should an insured beneficiary help keep costs down) considerations always disrupt insurance markets. However, society has in general though found a way around these roadblocks: first, make obtaining the insurance mandatory (like auto insurance) and to impose a deductible and cover only a fraction of the expenses (typically 80 percent for private medical insurance after a co-payment).

III. The Medicare Commission Versus the Principles of Insurance

So how does the Commission's attributed view square with the principles of socially beneficial insurance? Not well.

Inefficiency: The Medicare system would still rely heavily on tax funding, despite the ability for many beneficiaries to finance their shares. The switch to financing from

general revenue tends to make matters even worse as it further separates those who pay for the system versus those who benefit from the system.

Insolvency: Politics work so that Medicare's books will appear balanced for some time (consider prior Commissions) by jiggling expenditures and revenues. Then, low and behold, the crisis re-appears somewhere down the road. However, fundamental reform is needed given the adverse demographic shifts that the system will face over the next one or two generations.

Inequity: The Medicare Commission, by still relying on a 'pay as you go' system, will continue to exacerbate generational inequities, though it may create a better environment for re-distributing the net benefits within a given generation.

Inadequacy: As long as the economic incentives facing producers and consumers of health care services are ignored, there will continue to be a mismatch in the quality and quantity of health care services that we receive, resulting in a lower and more expensive standard of care.

IV. Private Alternatives

Health care is a growth industry in the U.S. The Urban Institute projects that health care spending will be 25 percent of the GDP by the year 2025.⁵ A significant share of this will be attributed to Medicare. Their figures suggest that Part A will account for 2.5 percent of GDP while Part B will account for 2.8 percent of GDP for a total of 5.3 percent of GDP by the year 2025. These numbers accord well with those by the CBO. The CBO also projects that Medicare spending will be 5.5 percent of GDP by the year 2030, and will approach 7 percent of GDP by 2070. Regardless of political affiliation, policymakers must face the reality that unless a fundamental, market-based reform of Medicare and the health care industry takes place, an increasingly large share of U.S. economic activity will be re-allocated to the government sector and away from the private sector.

To reverse this ominous trend, a number of economists have advocated ways of privatizing aspects of Medicare. Recently, Martin Feldstein (1999) has suggested the initiation of investment based individual retiree health accounts (RHA's).⁶ Based on a 1.4 percent payroll deduction that the government deposits in an individual's investment account, these funds could be used for a fee for service plans, HMO memberships, and/or a medical savings account with high deductibles. If these investment accounts earn an average of a 5.5 percent real return, he calculates that this small payroll tax would be able to finance a Medicare system that accounts for 7 percent of GDP by 2070 which is the CBO's projection. The alternative is a nine-percentage point increase in payroll taxes to finance this same amount. Obviously, the increase in payroll taxes would have a large distortionary impact on household decisions resulting in an adverse supply impact on the economy.

Based on the principles of socially beneficial insurance, the Feldstein plan would be an improvement. By reducing reliance on a 'pay as you go' system his plan would improve intergenerational equity and efficiency would also be enhanced by the greatly reduced reductions from workers' payrolls. It also makes some improvements on inadequacy and inefficiency as it would make individual's more responsible for keeping costs down, as they will be more exposed to their individual costs. The mandatory aspect of the payroll deduction would also help to maintain the solvency of the system and avoid adverse selection issues.

However, a number of worries concerning the Feldstein plan are still in order. First, the introduction of the government into overseeing private investment accounts may be too tempting for those politicians who wish to meddle. Of course if sufficient safeguards can be put in place then this would be less of a worry. Second, the Feldstein plan does not make much progress on the inefficiencies and inadequacies of the provision of services, which is also a large part of what is wrong with Medicare. However, by focusing on just the privatization of the financing of these services, much is still likely to be gained by his plan, although a comprehensive reform of both health services and its financing is currently needed.

Notes

¹National Bipartisan Commission on the Future of Medicare, “Draft Working Document,” January 22, 1999 (9:30 am) as found on <http://thomas.loc.gov/medicare/breauxplan.html>.

²Jagadeesh Gokhale and Laurence J. Kotlikoff, “Medicare from the Perspective of Generational Accounting,” National Bureau of Economic Research, working paper #6596, June 1998.

³These contribute a fraction equal to approximately one-seventh (on average) to the higher net tax burden that a 35-year old individual will be faced with as compared to the 70-year old. The average 35-year old in 1995 will have a net tax payment of \$189,800 over his lifetime while the 70-year old will receive a net tax payment of -\$89,200 a difference of almost \$280,000. The corresponding figures for the representative 35 and 75 year old women are -\$101,000 and \$113,800, respectively. These include tax payments from all sources less transfers received such as Social Security, Medicare, Medicaid and Welfare.

⁴Javier Diaz-Gimenez, Vincenzo Quadrini, and Jose Victor Rios-Rull, “Dimensions of Inequality: Facts on the U.S. Distributions of Earnings, Income, and Wealth,” Federal Reserve Bank of Minneapolis Quarterly Review; 21(2), Spring 1997, pages 3-21.

⁵See http://www.urban.org/health/medicare_growth.html#sett.

⁶Martin Feldstein, “Prefunding Medicare,” National Bureau of Economic Research, working paper #6917, January 1999. To be published in the Proceedings of the American Economic Review, May 1999. See also Andrew Rattenmaier and Thomas Saving, The Economics of Medicare Reform, mimeo, 1998, and Peter J. Ferrara, “The Next Steps for Medicare Reform,” Policy Analysis, Cato Policy Analysis #305, April 29, 1998.