



## **The Never-Ending Dilemma Over Medicare and Social Security**

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There is a basic mismatch in the national debate on health care. On the one hand, the actuaries tell us that the Medicare program will run into very serious financial problems in the years ahead. In contrast, the public concern is focusing on the inadequacy of benefits and the lack of health insurance on the part of many Americans. In effect, the experts are saying that there is not enough revenue coming into the health care system, while the public is saying we are not spending enough. That is going to be a very difficult question of public policy to deal with.

Unfortunately, there is no simple way of cutting medical costs. Of course, there is a certain amount of avoidable waste and more widespread use of information technology would make for both cost efficiency and perhaps fewer medical errors. Also, legal reform might reduce medical insurance costs. All that would help, but the major driver in increasing medical costs is technological advance.

Let us remember that Americans are living longer. That is not merely good luck or adopting healthier lifestyles such as better diets. In this case, bigger is not better. Americans are getting bigger, or rather fatter. The real life extenders are those MRIs and other medical gadgets that minimize invasive surgery and enable physicians to successfully do procedures which were not feasible a generation ago. Let us not forget the medicines that cure or contain many diseases without surgery and the research breakthroughs that are increasing physicians' knowledge of our illnesses. They all have one characteristic in common: They are very expensive.

After all, nobody wants to shorten his or her life in order to balance the health care budget. Rather, the general attitude is often, "I want the best possible medical care, especially if I don't have to pay for it."

To summarize a great amount of professional research and writing on the subject of financing Medicare and health care, there are no simple or straightforward answers. It will probably take a combination of actions over a long period of time without any assurance that the problem will be solved. Some background information may be a useful start.

The average citizen is not aware of or concerned about the financial status of the Medicare Trust Fund, or the rising share of GDP going to health care. Citizens worry about losing their health insurance, especially if they lose their job or if the employer cuts the benefits. That is

becoming increasingly likely, with employees sharing more of the costs. However, all those factors are pressures to maintain demand for health care. So is the concern over those who lack health insurance. That makes dealing with the financial problem very difficult.

Some factual background: today, about 85 percent of the population has health care coverage, mainly working people and their families through their jobs. In contrast, buying a policy for an individual or a family is very expensive. People over 65 receive health care through Medicare. That federal program is financed primarily by a payroll tax and a deduction from the monthly social security benefit. In addition, the Medicare Trust Fund receives a large and growing contribution from the Treasury paid by taxpayers generally (mainly from income taxes).

Most of the uncovered 15 percent work for very small businesses (plus their families). The problem here essentially is the high insurance costs faced by small businesses. A little explanation is in order. There are huge economies of scale in insurance premiums. First of all, the labor forces of large firms are more representative of population as a whole (they constitute good "risk pools"). Moreover, overhead costs for health insurance coverage varies from 5 percent for employers of 10,000 or more, to 25 percent for employers of 20-49, and 40 percent for employers of 1-4.

As a result, premiums for small business (per worker) are much higher than on bigger companies. Off the record, insurance companies tell us that they lose money on the Mom-and-Pop businesses. As a practical matter, they cannot raise premiums high enough to cover their costs.

To compound the problem, state governments mandate the minimum composition of health insurance policies. That provides great opportunity for lobbying. For example, some states require covering hair transplants and other optional items. Thus, the small company cannot buy a "Chevy" when it comes to health insurance. It must buy a Cadillac or Lincoln - or nothing.

Many other uncovered people are young. They turn down health insurance if they have to pay a part of the cost. They think they are too healthy to bear the cost. We forget that one-third of the uninsured report household incomes of more than \$50,000 a year. Also, one-fourth are covered by Medicaid, which they do not consider as insurance. About one-fifth without healthcare coverage are foreign born, including many illegal aliens.

Some historical perspective is useful. Prior to World War II, most people paid their own medical bills directly, like other essentials such as food, clothing, and shelter. Health insurance (and company-paid retirement) developed as a loophole in government regulation of business. During World War II, government tightly controlled wages in an effort to fight inflation. So how did employers react to the labor shortages which occurred? At that time, military demand for equipment was rising rapidly, while many workers went into the armed forces. In response, employers offered generous fringe benefits, which were not covered by the wage controls.

After the war, fringe benefits continued to be popular. This was especially so because employees realized they did not have to pay tax on the employer payments on their behalf. Excluding employer-financed health care from taxable income is now the largest loophole in the Internal Revenue Code. It costs the Treasury \$126 billion a year.

Unions especially pushed hard for these "freebies." Not taking courses in economics, most people did not realize that wages and fringes are both part of the same compensation package.

The upshot of all this is the rise of third-party payers. Even during the depression of the 1930s, the patient paid the doctor and the hospital. Today, a third party makes most of these payments, especially insurance companies and government agencies (Medicare for those over 65, Medicaid for poor people, and veterans hospitals). Most of us are only aware of our co-payments (if any), rather than the full cost of providing the medical care we receive.

What can we do to improve the situation? Let us start with Medicare, which has two parts: the Hospital Insurance Fund and the Supplementary Trust fund covering doctors' bills. The actuaries tell us that the Hospital Fund is already running in the red. The situation will worsen as baby boomers start to retire. The Fund will be exhausted in about 2020. The second Medicare fund also covers the new prescription drug benefits. That will require a massive bailout, mainly from the general taxpayer who already provides three-fourths of the money.

Unlike Social Security, hardly anybody is even beginning to talk about reforming Medicare. The problem is too massive, and it is tied up with health care generally. That is why everybody shies away from the Medicare issue except some business leaders. Of course, they oppose new government programs in general - but would love the government to take the responsibility for the entire subject of health care. As they point out, most of the nations we compete against do just that. Moreover, the United States already spends more on health care per person than any other nation.

Let us explore the major alternatives. (1) Government provides health care (socialized medicine), (2) Government provides health insurance for all (single payer), (3) We let the market work and the patient pays (eliminate or reduce third party payments), and (4) make marginal improvements now (no grand solution), using feedback from experience for further rounds of reform. Each of these approaches has pluses and minuses.

In the case of socialized medicine, it seems fair because, supposedly, everybody gets the care they need. We save some money by eliminating all those insurance forms and other paperwork. Costs are controlled directly because the government hires all medical personnel and tells them how much they will be paid. The government uses its monopoly position to set prices of medicines and medical equipment.

Of course, there are many counterarguments. For example, government will have to ration health care somehow. There just are not enough resources to give everyone all the care they want. Some nations use waiting or delay as their rationing method. In the United Kingdom, 36 percent of patients wait more than 4 months for non-emergency surgery. In contrast, the

average wait in the United States is only 5 percent. Likewise, quality of health care also suffers. In the United Kingdom, the average physician sees 3,176 patients while doctors here average 2,222 patients.

Another argument against socialized medicine is that the government will find it difficult to attract and keep good health care personnel. They will go to other countries or into other fields. In many countries, with socialized medicine, two health care systems arise: (1) A private system for the wealthy, and (2) a bureaucratic system for those who cannot afford better. More fundamentally, there is a lack of economic incentives to improve efficiency or curb use.

Under the single payer system, everybody automatically receives health insurance and much paperwork is eliminated. However, providing universal health insurance does not deal with the basic issue as to how to ration a limited supply of health care. Nevertheless, government inevitably winds up restricting use arbitrarily or bureaucratically because here, too, there is a lack of economic incentives. We can imagine rules limiting transplants to people under a certain age, also restricting serious surgery for those over another age. What about comatose patients? Politically weak groups might suffer.

The third major approach to fundamental health care is to let the market work. Advantages include eliminating lots of paperwork and promoting patient choice. In general, we could expect more pressure for economy and efficiency in health care, although competition in some circumstances may raise costs with every hospital wanting an MRI facility to increase its market share.

Many counterarguments have been made, such as consumer ignorance prevents informed choices on technical matters involving disease treating and surgery. As a practical matter, the family physicians will still make the major decisions, although they are interested parties in those transactions. It is also contended that letting the market work is unfair. Rich people will bid away preferred doctors and hospitals. The rest of the society will be unable to afford good health care. Moreover, the political process will determine tax and other benefits, and provide new subsidies to politically powerful groups.

The final alternative to health care reform is to avoid any of these grand solutions. That approach reduces the risk of upheaval in what is now a world class, health care system. Marginal changes are more likely to be enacted and sooner. This approach also provides feedback as we see the effects of initial reforms. An example that comes to mind is to introduce information technology more widely. For example, a simple medical data card would reduce clerical errors and save lots of clerical time. Raising deductibles and co-payments would reduce demand for health care. Also increases in taxes to pay for Medicare would help deal with the fiscal squeeze.

On a different approach, the medical profession could do more self-policing. That would be a positive response to all those legal problems. We are told that much of the bad-quality medicine arises from three sources: (1) physicians who themselves suffer from serious medical problems, (2) physicians who just are not very competent, and (3) competent

physicians who take on cases outside of their expertise. Many inside and outside the medical profession say it is very difficult to get medical societies to sanction bad practitioners.

The major criticism of the marginal approach to health care reform is that it is inadequate to meet the major fiscal and program challenges facing the United States. These include the impending fiscal collapse of Medicare and the accelerated reductions in employer-financed health insurance that are occurring, especially for retirees, particularly those not covered by union contracts.

The long-term outlook may be more favorable than the short-term. A common experience in public policy is that the situation has to get really bad before the country takes serious action. Then we act decisively or even overreact. However, we are now far from a meeting of minds on the issue of health care reform. In this regard, delay can be useful. It provides time to raise public knowledge and awareness - if we take advantage of the time. It is likely that we may never get a neat once-and-for-all solution to Medicare and other health financing and service issues. What may result is an eclectic combination of elements of several of the four approaches presented here.

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