IRET Congressional Advisory

INSTITUTE FOR RESEARCH ON THE ECONOMICS OF TAXATION

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MEDICARE BILL: DANGERS AND OPPORTUNITIES

The Medicare bill has called forth a lot of emotion, sound, and fury, but it is neither the cure-all nor the disaster that is it has been made to seem. It is a hard bill to analyze due to its length and complexity, and to the high degree of uncertainty about the responses it will trigger on the part of consumers and employers.

The program will not leap at once to socialized medicine. It is certain to cover many of the needy elderly. But, as currently drafted, it will not be attractive to the entire elderly population. It even provides some additional payments to induce private health care providers to return to the MedicarePlus Choice system. However, it micro-manages the process and threatens to stifle that initiative as it strangled the previous attempt. Therefore, the outcome of this experiment will depend heavily on how Congress and the Administration act in the future. If they do not work hard in the future to preserve the limited private sector initiative in the bill, and if the program is not on target with its various balancing schemes, the program could easily spin out of control into a heavily subsidized, universal, single payor system. If, instead, the Congress and the Administration work hard to expand the private plan options, it could lead to a better health system down the road.

Helping the poor is a national consensus.

Society has chosen to aid the poor in obtaining the many new life-saving medicines that have become available since Medicare was established, just as it helps them to obtain food and shelter. Drugs are a far larger part of medicine today than they were when the Medicare program was founded. It makes little sense to provide subsidized hospital and physician care while leaving drugs out of the program. Some conditions that can be kept in check with medication can, if left untreated, lead to expensive hospital stays. Thus, there will be some efficiency gains from reducing the price distortion between Medicare-covered hospitalization benefits and privately-borne drugs costs. Nonetheless, the Medicare bill is a very cumbersome way of helping the poor to afford drugs.

Who needed help?

Over 75 percent of the elderly have drug coverage under Medicaid, Medigap polices, MedicarePlus Choice plans and HMOs, employer retirement health plans, or other private insurance. Of the roughly one-quarter of the age group that is not covered, many are not poor, but are healthy and feel no need for the protection.

The only pressing problem is how to help the near-poor who are too rich for Medicaid but, because they require multiple, high-value prescriptions, are badly stressed by their drug outlays. The concern for such individuals could have been addressed with a low-income drug subsidy, such as a beefed-up version of the $600 drug discount cards being offered in the Medicare bill.

The discount card could also be a useful tool to enable consumers to negotiate a better deal of some medications. It should be noted, however, that several drug companies are already offering discount

cards for low-income users of their medicines. These cards will be rendered obsolete by the new government program.

Congress, of course, wants to offer something to everyone. It is offering drug coverage to the rest of the elderly population in competition with employers' retirement health plans, private Medigap policies, and personal insurance. To avoid driving such arrangements out of existence, and raising participation and the cost of the program, the bill offers incentives, also costly, for businesses to maintain their private plans for retirees. It is impossible to tell if the incentives will work, and one cannot claim to be able to predict the outcome. The bill, therefore, could have the serious side-effect of discouraging private insurance that does a better job of fostering intelligent consumption of medicines.

Extra payments to private health plans the real route to reform.

Under the bill, payments to MedicarePlus Choice plans (to be renamed Medicare Advantage plans) will more accurately reflect the cost of care. The intent is to restore the incentives for private plans to come back into the program. Many were driven out by the payments squeeze Congress undertook in recent years to save money, and by the over-regulation and micro-management of these plans by a hostile Centers for Medicare and Medicaid Services bureaucracy.

These plans are the key to future Medicare reform. They are essential to give consumers a real choice as to what type of coverage they can have, and to foster innovation and competition to hold down costs. They are a vehicle through which a sound program of premium support could operate.

Joe Antos of AEI points out that, if this effort is to succeed, the White House will have to give a strong push to the Department of Health and Human Services to ensure that there is minimal regulatory interference by the bureaucracy and the Congress in the plans offered by the private providers. He fears that Congress is still unwilling to let consumers make up their own minds about what coverage to choose, and suggests that the standards being set are too uniform and too detailed.

There are some pluses in the bill.

The drug benefit is voluntary, and if the premiums for the non-poor are set high enough to cover the costs, as would be the case in any true insurance system, then many elderly will prefer to stick with the coverage they now have.

The Health Savings Accounts (HSAs) will offer the same tax-favored access to health care for individuals that is now available only through employer-sponsored health plans. The HSAs should be made more broadly available, with fewer restrictions than are in the present bill.

There are some non-positives in the bill.

Do not count the proposed competition between Medicare and private plans beginning in 2010 as a plus, as it is highly unlikely that they will ever be put into effect in any manner that could succeed.

There are some non-negatives in the bill.

If the additional help to the poor was inevitable, then the added cost of the drug benefit would have been incurred one way or another (although it could have been done for less). It is not, in fact, all that large ($40 billion a year, which is more than matched by waste in the rest of the budget). This will rise over time as more drugs are developed to treat more diseases (which is a good thing, not a bad thing), and as the population ages. But if the assistance is directed at the poor, and if the country gets richer, poverty abates, and more people save for retirement through the expanded tax-favored savings programs enacted in recent years, then the number of people dependent on the subsidized program may not grow as fast as is feared. The federal drug program would quickly turn into a negative, however, if it devolves into a general subsidy of all the elderly, regardless of income, by the rest of the population, as is the case in Medicare Parts A and B.

Many people are disappointed that the bill contains no meaningful reform of the existing Medicare programs, which are projected to run enormous deficits in the years ahead. That was an unrealistic expectation. Unfortunately, Congress will not bite the bullet on that sort of reform until the system is at death's door. If the added outlays for the subsidized drug benefits take us closer to that event, the reformers will have a stronger case for serious action.

The bill's provision requiring added payments for Medicare Part B from upper-income seniors, reducing the 75% federal subsidy for that program, are a bad arrangement, imposing an implicit marginal tax rate increase on these participants. Over time, however, this could be expanded to all Part B enrollees (except the very poor), making premiums more nearly cover the cost of the program and reducing the federal subsidy. Ultimately, premiums could be set at a fair actuarial level, at which point private firms could take over the business.

Bottom line:

The real concern with the bill is that is could, if it is later maladministered, or expanded in the wrong direction, drag a large part of the elderly population away from a market-provided service offering many options, and put them under a one-size-that-doesn't-fit-all government provided benefit plan. It must on no account be the start of another major transfer of income from working age people to the elderly.

It is strongly to be hoped that new medicines for treating ancient scourges will be developed, and that millions of people will live longer as a result. If that occurs, the nations's spending on drugs will soar, and that will be a good thing.

If people want those additional drugs, however, then the premiums on their comprehensive insurance plans must rise to cover the added outlays. When a private plan raises a premium, consumers may grouse, and may switch to a plan that covers fewer new medicines, but they will not necessarily complain to Congress.

But if drug insurance is a government plan, it is Congress that will face the blame for rising costs. Some future Congress may not wish to be the "bad guys" who raise premiums. They may not wish to offer several drug plans with a variety of levels of coverage (subject to egalitarian demagoguery). They may not want to cut other spending to subsidize the elderly. That Congress may be tempted to resort to price controls that throttle innovation and research, or to refuse to cover or to delay coverage or new drugs, as many foreign health services do today. Such behavior would be a medical disaster. For its own sake, as well as that of the public, it would be far better for Congress to stay out of the health insurance and health care provider business as much as possible.

This bill is likely to pass. If it does, it will just be the start of the effort to make it a benefit rather than a disaster.

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