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BOOK FORUM

"MEDICARE'S MIDLIFE CRISIS"

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Moderator:

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Cato Institute

Featuring the Author: Sue A. Blevins

With comments by:

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American Medical Association; and

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P R O C E E D I N G S

MR. MILLER: Good afternoon, everyone. Welcome to the Cato Institute. I am Tom Miller, Director of Health Policy Studies.

I had a dental appointment yesterday, and that got me thinking about Medicare policy. You have most of the images of dental care coming to mind -- slow decay, a chronic toothache, spreading disease below the gum line, putting on some porcelain veneers to improve its appearance.

Well, if we keep putting off our free-market flossing of our health care system for seniors, it looks like there is some serious pain ahead, maybe a root canal, and some benefits extractions. But there is also an opportunity to address the challenge of health care for seniors in better ways. Although the Medicare issue has temporarily moved off the front burner and the main attention of the policymakers in Washington over the last couple of months, we still need to come to terms with the rising cost of Medicare, the inadequacy of its benefits, and its misincentives for waste and inefficiency. It is just as important today as it ever was.

I normally turn to my health policy guru in this area for advice. And, of course, Yogi Berra would say, "If you come

to a fork in the road, take it." But what he would also probably say is you will not know where you're going until you know where you've been before. And Sue Blevins new book, "Medicare's Midlife Crisis," addresses both of those issues. She looks through the history of Medicare to reveal the lessons as to how we got here, and then suggests some positive steps for dealing with what has been delivered to us, in our health care system for seniors of 35 years, in a more effective manner.

Sue is Founder and President of the Institute for Health Freedom, which focuses on consumers' freedom to choose their health care. And she has had a rich experience in the direct delivery of health care, as a registered nurse in both the United States and Canada. She received a master's in public health from Harvard and a master of science and a bachelor of science degrees from Johns Hopkins University. And Sue is here to talk about our Medicare past and our Medicare future.

Sue Blevins.

SUE A. BLEVINS,
AUTHOR, "MEDICARE'S MIDLIFE CRISIS"

MS. BLEVINS: Good afternoon, and thank you all for joining us today. I would like to thank the Cato Institute for publishing the book, "Medicare's Midlife Crisis." And I would especially like to thank Tom Miller, the Director of Health Policy Studies, for spending countless hours reviewing drafts, for providing insightful critiques, and for getting national policy experts -- some of whom are here today -- to review and comment on the book. The feedback was invaluable, and I really appreciate Tom's time and expertise.

Well, as the nation prepares for a potentially long and costly war on terrorism, Americans are going to be scrutinizing the role of government, and in particular the size and makeup of the Federal budget, like never before. Some citizens are already beginning to question whether we should be spending a greater share of our Federal pie on national security and less on domestic programs.

Well, as these issues are debated in the next few months, and possibly few years, one of the government programs that will need to be carefully examined in terms of our budget priorities is the Medicare program. Let me just tell you a few things about Medicare.

Medicare is currently the largest single payer, government health care program in the United States and in the world. In the Year 2000, the program costs more than \$221

billion, and it covered approximately 39 million seniors and disabled persons. The program currently consumes about 12 percent of our Federal budget, but that share is expected to increase to at least 25 percent by as early as mid-century. In the next 10 years alone, just in the next decade, Medicare is going to require some \$645 billion in Federal general revenue subsidies just to keep the program afloat; that is just over the next decade. After that, with the large number of baby boomers entering the program, costs are going to grow more rapidly.

Now, consider this. By the Year 2030, the number of Medicare beneficiaries is predicted to be about 90 percent greater than today, but the number of workers paying Medicare taxes will be only about 15 percent greater than it is now. So, consequently, the Hospital Trust Fund is projected to be completely depleted by the Year 2029.

Well, these are just some of the key reasons why financial experts have been warning Congress that if the United States is going to maintain a balanced budget in the coming years, then the Medicare program will certainly require a major overhaul. And with the recent unexpected attacks on our country and on our economy, Medicare's looming financial crisis represents an even greater challenge in the coming years. So anyone interested in reexamining our budget priorities, and especially those of you who are interested in planning for your

own future health care needs during retirement, should become fully informed about the Medicare program.

Now, I think it is important to point out that when you think about Medicare, many of today's seniors have had it quite easy with Medicare. And that is because many have received more in terms of paid medical claims than what they actually paid in taxes. However, tomorrow's seniors are going to be quite different. The demanding baby boomers are going to expect catastrophic health coverage when they retire, given all the taxes that they paid into the Medicare program for over 35 years. But they are going to be quite surprised at what they face when they retire.

The purpose of the book, "Medicare's Midlife Crisis," is to explain how we have reached this critical point where we are with Medicare's financing today. I want to put up front that the book is not intended to provide a panacea for how to fix the program; although, I do mention a solution proposed by Dr. Savings, who is here today, and he can tell you about that wonderful idea.

Rather, in order to cure the problems that we face with Medicare, I think that we need to first find the accurate diagnosis. And that is what this book does. It provides an accurate diagnosis. It provides policymakers with a way of understanding how to resolve the problem in the near future.

Now, I have just highlighted the financial crisis with Medicare, but now what I would like to do is summarize six facts, what I call things that most people probably do not know about Medicare but should, especially, again, as you're planning for your own retirement. I want to highlight six aspects of the book that affect our individual liberty and also the Federal budget. There is much, much more in the book, but I am going to just focus on these six.

The first -- I like saying, "did you know" -- did you know that when you retire and you go to apply for your Social Security benefits that you will be forced to enroll in Medicare Part A in order to get your Social Security benefits? You cannot reject that entitlement. Now, I am not talking about you wanting to not have to pay taxes. Let's say you have already paid taxes, you go in, you sign up for Social Security; you have to take that Medicare Part A. The only way you can forego enrollment is to forego all the Social Security benefits that you were taxed for and promised your entire working lives.

Well, since giving up Social Security benefits is too costly for most seniors, most are not going to have a choice but to participate in Medicare. And then, once enrolled, they are going to be forced to abide by more than 100,000 pages of Medicare rules and regulations that dictate what services are covered for most seniors.

Medicare Part A is the hospital portion. People are familiar with that part. What is also important to recognize is the Federal Government also automatically enrolls seniors in Part B, which is the outpatient doctor portion, when they enroll them in Part A. Now, technically, seniors do have the freedom to reject Part B without losing their Social Security benefits. But here's the kicker. Although Part B is considered voluntary, you really do not have any other choice. And the reason is because there are not any other options for seniors to buy private, comprehensive health insurance in the free market.

This situation came about because when Medicare was created in 1965, insurance companies began canceling policies for seniors and encouraged them instead to enroll in Medicare. Today, there are not any health insurance companies that will sell, again, its comprehensive health coverage to Medicare-eligible seniors. And, in fact, Patrick Rooney of the Golden Rule Insurance Company, filed an affidavit in 1997, in a lawsuit, affirming that, to the best of his knowledge, there is no health insurance product available in the U.S. market to U.S. citizens who are 65 years of age or older that would provide coverage in lieu of Medicare.

Now, of course, seniors who continue working can maintain their employee-based coverage, and those retirees in Medicare can purchase supplemental insurance to cover things that

Medicare does not cover. But you are not going to be able to opt out of Medicare Part B because there is nothing else in the marketplace that exists to provide coverage.

Why is this first point so important? I think it is important because this is not the case in other countries. It is worth noting that even in socialistic countries like the U.K. and the Netherlands, they do not force their seniors to give up their private health insurance and join a government program when they turn 65. In fact, those countries allow seniors, and their marketplaces allow seniors, to maintain private coverage as long as they like.

Now, you might be thinking, well, what is the big deal about being enrolled in Medicare? I pay taxes to support the program; of course, I want so-called free care when I retire. Well, the second point that I would like to highlight is the fact that once you're enrolled in Medicare, the Federal Government effectively prevents seniors from paying privately and spending their own money on things that Medicare covers.

Consider this. You're 64; you're working. You are free to go out and spend your own money on anything you want, assuming that the health care is legal. Your employers really don't care whether you spend your own money on services that your employer-sponsored health insurance would pay for. And, in fact,

most employers would be quite happy for their workers to spend more of their own money on health care.

Yet, at age 65, when Americans become eligible for Medicare, and they are forced to enroll, at that moment you automatically lose your freedom to spend your own money on services that Medicare covers. Now, this provision -- I call it the Canadian style Medicare system -- that was adopted in 1997, was adopted when Congress passed the Balanced Budget Act of 1997.

And you probably recall that the United Seniors Association challenged that section of the Medicare law. And it went up to an appeals court. But the court never addressed the constitutionality of that provision. Instead, the court focused on whether or not seniors are free to spend their own money on things that Medicare does not cover, which, of course, you know they are free to spend their money on things that Medicare does not cover. But the court never addressed what happens when you want to spend your own money on things that Medicare does cover.

What is the problem with this policy? I say it leads to what I call underground rationing. And I call it underground rationing because many doctors do not want to have to admit publicly that they are currently rationing medical care to seniors in the United States. However, I have had physicians admit to me personally, and regretfully I might add, that because government payments are inadequate in some cases to treat

patients, and because physicians are not free to set their own prices, they simply cannot afford to provide some services to some of the oldest and sickest people in this country.

Now, what is interesting is that the government's rationale from restricting seniors from paying privately is that they are afraid that greedy doctors are going to defraud poor, innocent seniors. Yet, when you look at what happens under the currently federally regulated system, Medicare fraud and abuse, with the Federal Government watching our dollars, amounts to \$32 million per day. That is \$32 million per day, or approximately \$11.9 billion per year.

Now, because of this enormous amount of fraud and abuse, the FBI now deploys hundreds of agents to try to weed out Medicare fraud. Well, I don't know about you, but I would rather see our FBI officials spending more time helping to protect our property and our freedoms and less time poring over an individual's personal medical records, trying to hunt down doctors who miscode Medicare claims. There are plenty of retired seniors that have lots of time on their hands, who could monitor their own medical bills, if indeed they were free to pay privately for their care.

Now, you might be wondering, Sue, I really don't care that I am forced to enroll in the Medicare program. It is technically free care as far as I am concerned. And secondly,

why in the world would I ever want to pay for something that Medicare pays for in the first place? Two very legitimate questions.

This brings me to the third point, and a point that many people probably are not aware of. And that is that the Medicare program invades seniors' medical and home privacy. Let me tell you a little bit about this fact.

In 1999, Medicare established new rules to monitor health services delivered to seniors in their homes. The program is called the Outcome and Assessment Information Set, and it is referred to as OASIS. Under the OASIS program, government contractors, who are mainly home health care nurses, are required to compile information about home-care patients, including medical and psychosocial information. They are required to document things, for example, such as whether or not a patient has expressed depressed feelings or -- this one really gets me -- whether a senior has used excessive profanity in his or her own home.

Now, additionally under the OASIS program, Medicare not only collects information on the patients -- the seniors -- but also on their caregivers, too, such as wives, husbands, children, and anyone else who is assisting you in your home. Now, technically, you have the right to refuse to answer these questions, but if you do -- you, the senior -- the health care

worker then has to act as a proxy and answer the questions for you.

The detailed, fully-identifiable information is then collected and turned over to State and Federal Governments. Now, Medicare officials are assuring the public that they're doing everything to protect patients' privacy under this massive program -- again, the world's largest single-payer health care system. But let me share just one example of how seniors' personal information may be in jeopardy.

A few years ago, the Medicare Agency discovered an employee was accessing Medicare beneficiary files. Imagine that database now -- 39 million Americans. This employee was accessing the beneficiary files more than what was necessary to perform his job. When approached about the possible violation of confidentiality, the employee admitted that he was looking for the files of famous people, rummaging through Medicare files looking for the files of famous people.

Now, I'll admit, this may be an anomaly. It might be the rare circumstances where you have an employee doing such a thing. But when it comes to medical privacy it is difficult to compensate for invasions of privacy. Government simply cannot take back leaked information, nor can it easily repair damaged reputations, especially those of famous people.

Well, the next few points get a little faster here. I pointed out that the program is mandatory, seniors cannot pay privately, it invade seniors' privacy. The fourth, and I think really important fact -- and especially I think anyone interested in the free market should be concerned about -- is that Medicare actually forbids competitive bidding for most contractor services. It is a very anti-competitive program.

One of the biggest problems with the traditional Medicare fee-for-service program is that the insurance companies chosen to administer the program and process the claims don't have to competitively bid, unlike companies that serve other large sectors of our government, such as defense. The insurers who have obtained that privilege to process claims gained tremendously in 1965 when Medicare was passed, because, quite frankly, they got to drop the high-risk seniors from their risk pools, and instead make millions of dollars simply processing claims for the Medicare program.

The fifth point that I think many people do not know about Medicare -- and this is something that I think especially baby boomers should be very concerned about, and I never knew this, as a nurse taking care of patients -- I never knew that Medicare is not catastrophic insurance, and it doesn't cover long-term care. Now, despite the resources that we have paid into the program since its inception, I think baby boomers in

particular are going to be shocked when they reach retirement and find out that Medicare only pays for about 55 percent of their medical bills. That does not include long-term care and nursing home care, which is a real problem.

Now, what is interesting about this is two things. When Medicare was being debated in the 1960's, the whole rationale for needing a Medicare program was that seniors could face financial bankruptcy if they ever had a catastrophic illness. And the second argument was that seniors were paying too much out of pocket for their own medical care. Well, Medicare is not catastrophic and, today, seniors are paying about the same percentage, about 19 percent, as they were before Medicare was passed on 1965.

I could name many points about Medicare that, probably, a lot of people are not aware of, and should be. But this is a very important historical point that I think anyone who is debating the role of government, and why we need Medicare, why we should consider alternatives, should consider the fact -- and my sixth point -- is that Medicare really had more to do about politics and less to do about comprehensive coverage when it was passed in 1965.

And the reason that I make that claim is that most people are not aware that we already had a safety net in place -- a government safety net -- when Medicare was passed in 1965. The

safety net was signed into law September 13, 1960, by President Dwight Eisenhower. And it was called the Medical Assistance for the Aged Program, or the Kerr-Mills Law. That program extended coverage to 10 million seniors who were receiving Social Security benefits, and another 2.4 million who were on old-age assistance.

So altogether, five years before Medicare was created -- the universal program that is now mandatory for nearly everyone -- we already had a safety net in place. It was a Federal-State program. It covered 77 percent of seniors. But those who wanted the big government universal program were not happy with it because it was a means-tested program, and they wanted everyone in a single program. So we ended up having Medicare passed in 1965.

Those are just six of the points. I am excited about this book because there are many, many things in here that has taken me a few years to pull together, condense it into 100 pages, so that you will not have to do this research. And you can sit down at your comfort. And thank goodness, Tom, that Cato put an index in that book, because I am really using the index myself, quite a bit, to look facts up. It is full of facts that I think would take a researcher several years to pull together.

So I am thrilled that Cato is presenting this book to the public. And I just want to summarize by stressing that, as everyone else will say here today, Medicare undoubtedly is going

to need to be reformed and restructured in the very, very near future. If we as citizens, and also as policymakers, want to help the Federal Government make well-informed priority decisions regarding our budget, then we really have to become informed about Medicare. And as future retirees, once informed, I think we are probably going to be pushing for the freedom to pay privately for the quality of health care that we desire during retirement.

And one final statement is, I just do not understand why seniors that have money -- Bill Gates, why should he be forced to take taxpayer dollars to pay for his health care when he retires and turns 65? I think that those precious tax dollars could be better allocated to other programs with more pressing national issues. Thank you.

(Applause.)

MR. MILLER: Thank you, Sue.

We have been able to round up three top Medicare policy experts who actually believe that individual choice and market competition might offer some better alternatives to the Medicare status quo today. And they will be commenting on Sue's new book, and representing the perspectives of private medical practice, government service and academia, sometimes more than one in the single person.

Our first commenter will be Dr. Daniel "Stormy" Johnson. He is a diagnostic radiologist. He owns and operates Clearview Medical Imaging, an outpatient facility in Louisiana, just outside of New Orleans. He has served as an officer of the American Medical Association, first as Vice Speaker and then Speaker of the AMA House of Delegates, and finally as President of the AMA in 1996 and 1997. He has also been active in the Louisiana Medical Society, as a past president and chairman of several committees, as well as Speaker and Vice Speaker of its House of Delegates.

Dr. Johnson is a Clinical Professor of Radiology at Tulane University. He earned his medical degree from the University of Texas at Galveston. He is also a Visiting Fellow at the Heritage Foundation, and his activities there continue his long involvement in promoting free-market solutions to our health care problems, with an emphasis on patient choice and defined-contribution financing of health benefits. Stormy hopes that those two elements have a greater role in Medicare's future than they do today.

Dr. Stormy Johnson.

DANIEL "STORMY" JOHNSON,
PAST PRESIDENT, AMERICAN MEDICAL ASSOCIATION

DR. JOHNSON: Thank you very much, Tom. And it is a privilege to appear on this distinguished panel. And I want to thank you, Sue, not only for the good job you just did of presenting the key features of your book, but for taking the time and the effort to write such an excellent book. And I am going to come back to that point in just a moment.

I want to tell you just a quick story about a couple of colleagues down in Louisiana, Alfonse and Pierre. And it is that time of year, and Alfonse and Pierre went out and went hunting. And they were in the midst of their hunt, when all of a sudden Alfonse grabbed his chest, and he looked at Pierre with a distressed look on his face, and said, "Pierre, I think I'm having the big one." And boom, he fell down on the ground.

And Pierre got all excited, "Oh, my God." And he whipped out his cell phone, and he called 911. And he told the operator, "Operator, Alfonse done fell out on the ground. I think he's had the big one. What to do? What to do? I'm so excited. I don't know what -- I mean, this is just terrible."

And the 911 operator said, "Pierre, just calm down. Now, everything's going to be fine. We're going to take this one step at a time. The first thing you've got to do is make sure that Alfonse is dead." Pierre said, "Okay." "Blam!" "Now what?"

(Laughter.)

DR. JOHNSON: So we have to be careful, I think, with this program, that we approach it in the right way. It is a program that is an enormous difficulty. I think "Midlife Crisis" is a wonderful way to express it in the title of the book. And what I would like to do, just in a few minutes, is kind of give you a little overview of how this practicing physician sees the problems and weigh it against the background that I have had and the activity in organized medicine; make a couple of comments about Sue's book, and one in particular on a kind of a personal note; maybe talk a little bit about what is needed in terms of looking ahead, leading to our other panelists; and also what is not needed as we look at this situation; and then pose two or three questions to you, as well as some ideas about what we might do.

The core problems of the Medicare program I believe can be boiled down into three areas. One is the requirement. And, basically, just as the requirement that you sign up, even though it's not really, is a de facto requirement that you sign up, it is a de facto requirement that you buy gap insurance. The exposure if you do not buy gap insurance is so severe that any prudent person would buy the gap insurance. And when that person buys gap insurance, it converts Medicare to first-dollar coverage and insulates the person from the cost of any services that he or she obtains from that point forward. So it is a sort of catch-22

situation that is one of the major dilemmas that needs to be fixed.

The second one is the explicit price controls in the system. Sue mentioned the underground rationing. I'll just give you an example of that, that an internist told me. It's so simple. Because the payment for the services is so low, and because sometimes the elderly patient can be the most difficult of all patients -- the most demanding -- because of the nature of illnesses that we get as we get older. And as I get closer and closer to that stage in life, I begin to understand it more and more. The patient can be very time consuming. And one of the ways that the physician can ration the services when confronted with this duality of dilemmas is to say, well, instead of coming back every two weeks, maybe come back in three weeks. Just stretch that period out a little bit. It is a way of rationing. It is an example. It is not something the physician wants to do, but it is something the physician really cannot afford not to do. So it is a significant offshoot of the price controls.

But, of course, the major dilemma with the price controls is the fact that you take market forces right out of the equation. So now you have someone who is insulated from the cost of making decisions, and then you're going to make sure that that is maintained by eliminating any potential for market forces to straighten that out.

And then the final and third major core problem is -- as is very nicely pointed out in the book -- is that Medicare is a pay-as-you-go system. And Sue mentioned it in terms of percentages, but let me rephrase that comment in a different way. In 1965, there were 5.5 workers for each beneficiary. Currently, there are something like 3.9 workers for each beneficiary. We are paying the freight for the people who are consuming the services now. By the year 2030, that is going to drop to 2.2 workers per beneficiary. So if the system is unsustainable now, imagine what it is going to be when you have just over half the number of people paying the freight as we do currently.

So the pay-as-you-go system needs to be converted into a pre-funded system. And I am going to yield at the conclusion of my remarks to a colleague who is going to be able to explain what to do about that in far better fashion than I ever could.

But there are some secondary problems too. And this comes from the perspective, I think, of the practicing physician. And I would be remiss if I did not point those out to you.

The first one is the hassle factor. It is the paperwork, the denied claims, simply to irritate the physician in hope that one day we will just give up and not file the claim. The carriers themselves -- you cannot blame this completely on the government; it is the people they contract with, and the rules are different in every jurisdiction, or the same rules are

applied differently in every jurisdiction. So the hassle is something that you have heard about. I can tell you, in day-to-day practice, it is enormously problematic for physicians.

The notion of the fraud police -- no one wants to see limited resources diverted to fraudulent consumption of those resources. Nobody is in favor of that. But the approach to fraud that is taken now, by setting up task forces in communities to come into a physician's office right in the middle of the office hours, march right in like the Gestapo, and seize the office, and seize the records, with patients sitting right there in the facility, is just absolutely ludicrous. And yet, I am told over and over again of clear examples of fraud by patients who come to me to tell me some experience that they have had. And when they tried to alert someone to the fact that there was blatant fraud going on in, hopefully, isolated situations, the response is always, "We cannot do anything about that."

So, on the one hand, we have this new community of people who are there to harass the people who make mistakes; and, yet, the genuine examples of fraud sometimes escape that. I think the problem is not as great as it is stated to be, but there clearly is, and always will be. When you have money on the table, there is always an opportunity for mischief. And, unfortunately, that applies in the medical profession just like it does in every other profession. I am sorry that it exists.

No physician in any leadership position is in favor of that, but we need a more logical way to deal with fraud than the way we have it right now.

The complexity of the system is enormous. Sue mentions a quote in the book about the number of pages of regulation, quoting Bob Waller, formerly from the Mayo Clinic. And I think his number is actually 133,000. You say 130,000-plus. I have read 115,000; I have read 150,000.

Now, let me just ask you real quick. How important is it whether there are 115,000 pages of regulation, or 130,000 pages of regulation, or 150,000 pages of regulation? To an old jacklegged radiologist from Metairie, Louisiana, who is trying to function under that system, it is ludicrous. It does not really make any difference how many tens of thousands of pages there are; the clear answer is that it is too complex, and that needs to be fixed.

I would like to speak just a moment about the prohibition of private contracting that you mentioned as a secondary issue. It is not a core problem, but it derives from the core problems. But it is so bizarre not to be able to sell your services to somebody that you want to for the price that you want to sell those services. I mean, to be told in this country that you cannot sell your services -- but maybe you can understand that.

But suppose I flip it the other way and tell you that it is also against the law to give away the services? If I have a physician who is a friend of mine, and he wants to come for an MRI, and he is over 65, and I want to give him the MRI, it is against the law. If I have a patient who is financially disadvantaged and cannot pay the small difference between what Medicare will pay and what Medicare will allow me to charge that patient under the price-control system, and I want to forgive that financially-disadvantaged person that small amount of money, I have violated the law. It is crazy.

Now, the importance of this book -- and I happen to think that if you have any interest in Medicare, that this book is one of the most important things to come along, which is why I thanked you before and thank you again for the book -- the importance of the book is that it gives a wonderful historical perspective of what kind of mess we are in, how we got into this mess, and why we are in the mess. And I think that we cannot possibly craft solutions if we do not have an understanding of that background.

Now, as Sue just told us, she goes into some of the things that we can do about that, and I am largely in agreement with those. But the important thing that this book brings is the legwork, the research, and the intense effort it took to tie all those historical things together.

When I was given the book to look over, I realized that even though I'm getting long in the tooth that there were historical things about this that I did not know from my own perspective. And so I turned to a fascinating fellow, whose name is Ed Annis, who was President of the American Medical Association back around the time that Medicare was enacted. It was very aggressive in terms of advocacy with whether or not this should be done, and if so, how. He is a brilliant man. He is in his middle eighties now and he is just as sharp now as he was then. He is an amazing fellow.

I showed it to Ed, and he just could not believe how thorough and how well done the book is, and just bent over backwards to tell me that. And I think there is a quote from him on the back jacket cover that certainly testifies to that point. So I am convinced of the legitimacy of that historical effort that you have done.

In terms of what to do, just some quick things. Nothing less than a fundamental change in the way that the traditional medical program is structured. Get rid of the need for that gap coverage by restructuring the cost-sharing. We can talk about that in the Q&A. Eliminate the price controls so that you can have some kind of meaningful and worthwhile competition about price and bring some market sense to this program. Move to an actuarially sound pre-funded mechanism, instead of the

pay-as-you-go mechanism we have. But, above all, apply the KISS principle. KISS, "keep it simple, Stormy." In other words, the way we have it now is just crazy.

What we do not need to do, and it is important that we not do, is what I heard Mr. Scully say. And I hope that he rethinks this. But in his first weeks as the head of CMS, at the time when they were still figuring out what the new name would be, he was basically suggesting that we want to move as many as possible of the seniors into HMO's. Now, if the dilemma is the insulation of the person from the cost, limited choice, and price controls, how do you solve that by moving someone into a situation in which he or she is insulated from the cost, in which he or she has limited choice, and in which there are explicit price controls? So I suggest that is not where we want to go; however, HMO's belong in the mix.

Just some quick questions. Which one is better? Is it better to insulate people from the cost of the services they are acquiring or to link them in some way to the cost? If you link them, is it better to punish them for not using the system in a cost-effective way or reward them for using the system in a cost-effective way? Which one is a more efficient market, one that limits choice or one that expands choice?

My suggestion to you is that what we should do for Medicare is the same thing we ought to be doing for the private

sector. Instead of limiting choice, expand choices; but include a restructured traditional Medicare as one of the options. To move to a defined contribution, or premium support, or whatever kind of name you want to give the system, whatever moniker you want to apply, but where the government puts up the same amount of money no matter what choice the person makes. Have the individual be the one who picks the plan that he or she is going to use, with the periodic opportunity to change if dissatisfied with that.

And then the final thing I would suggest is we need to confront the devil. In this town, the cliché that operates and that prevents progress more than anything else is that the devil is in the details. That is correct. But if you get so hung up on the details that you never have a vision for the future, you will be like we typically are inside the Beltway, and never get anything done. So instead of saying that the devil is in the details, say you're right; let's work on the details. And one of the most important details in giving people choices is adverse selection. Don't sweep it under the rug; confront that. That needs to be done in our debate.

In sum, Tom, I would suggest to you -- and Sue has this in the book in slightly different words, but I am going to use my own way to do this -- instead of insulating people from the cost and declaring them too stupid to make decisions for themselves,

we need to restructure the Medicare program to put the patient in the driver's seat.

Thank you.

(Applause.)

MR. MILLER: Thank you very much, Stormy.

Dr. Joseph Antos recently joined the think tank world as resident scholar at the American Enterprise Institute.

How is it outside of government?

DR. ANTOS: Great.

MR. MILLER: He is specializing in health care policy, Medicare, which he has long experience in, and private health insurance, at AEI. And he has a rich and varied background in health policy issues at the Federal Government level, most recently as Assistant Director for Health and Human Resources at the Congressional Budget Office; and prior to that time at HCFA. That was before they went into the witness protection program and called themselves CMS. That was the Health Care Financing Administration. And he was Director of the Office of Research and Demonstrations; also, Deputy Director of the Office of Actuary; and Acting Associate Administrator for Management.

Before then, Joe was at the Department of Health and Human Services as Deputy Chief of Staff, and also Principal Deputy Assistant Secretary for Management and Budget. He was at the Council of Economic Advisors as a Senior Staff Economist, at

the Office of Management and Budget as a Senior Economist; and started his government service at the U.S. Department of Labor in the Bureau of Labor Statistics.

So I think just about any Medicare policy or proposal, at one time another, Dr. Antos has analyzed, scored, said kind things about, and sometimes criticized. His background is a doctorate in economics from the University of Rochester. And we are going to hear what might be on the table for Medicare policymaking from Dr. Joseph Antos.

JOSEPH ANTOS,

RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

DR. ANTOS: Yes, I'm a man who can't hold down a job.

(Laughter.)

DR. ANTOS: Well, I want to thank Stormy for saying everything I was going to say.

Thank God, people have good imaginations on how to title a book -- "Midlife Crisis." So I decided to find out, what is a midlife crisis? And I found out that this is a term that was coined by -- wouldn't you know it, the French -- a French psychologist in 1965. A coincidence? I think not.

So what is a midlife crisis? Well, according to him, it is a feeling that at about age 40, time is running out. But

not everybody in the psychology business actually agrees that a midlife crisis actually exists. There are experts who say that, well, there may be concern or dissatisfaction but no actual crisis. That captures I think the policy situation with Medicare.

Many of us think time is running out with the program as the baby boomers inexorably -- and, thank God -- age into the program. And they would like to do something before it is too late. But there are others -- and you know who you are; I don't see anybody in this room -- who say, "No, no, it will be too late to save Medicare. All we have to do is raise the payroll tax a little. That's not a crisis."

Sue's book is really a good read. It is a really interesting book. As I think she indicated in her presentation, she spent a lot of time working on issues that are of great importance. She explained how Medicare works, the cost involved, the complications, and mentioned at least one reform idea. These are very important topics, of course. But I've lived with this stuff for years, so this part of it was not as interesting to me as it will be to a lot of other people.

But, like Stormy, I liked the historical part of it. Much of the book deals with the political history of national health insurance in the U.S. This is a tale of trickery, deceit and deal-making that goes back 60 years before the enactment of

Medicare. Okay. So that's business as usual in Washington, but I still found it interesting.

Anyway, the problems with Medicare. Medicare is the ideal government program. It is taxpayer financed. It is modeled after and run by the Blue Cross system -- the Blue Cross system of 1965, private sector -- and it is guided by the steady and clear vision of Congress.

It has proven to be unresponsive to both consumer demand and to provider concerns. Many people think you cannot change Medicare. The program is too important to risk any changes, they say, or it is too dangerous politically. Maybe the latter is true. As a result, we tinker with Medicare. We find more complicated ways to fix prices and regulate behavior, and we see no end to the rising costs.

Sue's book points out all of the problems. I am going to mention them briefly and then move on to some other issues, some reform ideas. The program is hemorrhaging cash; we know that. This past year spending grew by 10 percent. By the way, the economy grew by 3 percent. So, Medicare is still winning.

This spending problem, as both Sue and Stormy mentioned, will get worse in the next few decades as people like ourselves age into the program and expect services. That is not a bad thing from my perspective. However, something they did not mention was that spending per beneficiary will also

continue to grow. This is actually the real source of the Medicare spending crisis, the financial crisis. It is not the people coming into the program; it is that the dollars per person are growing very rapidly. And when you look at some of the reports, it looks like maybe it slowed down, but that is not true.

Corrected for inflation, Medicare spending per beneficiary has grown, on the average, 5 percent a year for the last 30 years. I looked at it by decade. For the last 30 years, 5 percent a year, real expenditure growth. Those are more resources going into those services that could have been spent in other consumer goods or services.

Now, some of that is good. A lot of that is good. This is partly attributable to the growth in medical technology, which has certainly contributed to better care, safer care, longer lives, and better outcomes. But the Medicare program has certainly not fostered complete efficiency and use of those resources. And the question is, can we continue to go on like this?

Finally, as everybody knows, despite all the money that is going to the program, it really does not give a very good benefit. People are dissatisfied. We all know that people would like outpatient prescription drugs covered by Medicare. That is

certainly part of most good employer-sponsored health plans, and has been the case for at least a decade.

The liability for cost is unlimited. And Medicare has a peculiar way of making you feel vulnerable. Not many health plans would have \$800 deductibles for entering the hospital, for example. Not many health plans would start charging you \$400 a day once you got past 60 days. And I hope I got that right. I know it is \$400, but I can't remember if it was 60 days. Those don't provide useful economic incentives for anybody. People are not going to the hospital because it is fun or it is optional; they go to the hospital because they have to. The program has all the incentives wrong.

And, finally, the program fundamentally does not work well. Medicare has created an adversarial situation with doctors and hospitals through its many complex regulations and price-setting schemes and by its variable enforcement of these arcane rules. The impact of these rules, by the way, is not confined to Medicare. So this is not just some government program. Medicare's rules are, by and large, adopted throughout the health system. If everybody in this room who has employer-sponsored coverage would go to the hospital, the financial aspects of your stay are, at least indirectly, greatly influenced by the Medicare payment system and the rules that

exist. So this is a bigger problem in Medicare, not that that is not big enough.

And then, finally, Medicare Plus Choice. This was the program that was invented in 1997 to try to bring more choice of health plans to Medicare beneficiaries. Well, Medicare Plus Choice didn't provide them a choice. And there is still no price competition among those plans. There is less choice than every before. And Medicare has simply, over the years, become less and less able to respond to the changing pressures from the marketplace.

So what can we do about this? Well, essentially there are three kinds of policies that could be pursued. They are obvious. The first one is to increase Medicare revenues. The second one is to cut Medicare spending -- that's the traditional way. And the third one is to take the bull by the horns and try to improve the economic incentives in the program. That's the tough one. That's the one we haven't tried yet.

Let me say something about increasing revenues. This is a policy preferred by many of those who want to preserve Medicare just the way it is. And there are a lot of people out there who feel this way. According to the latest trustees report, an immediate payroll tax increase, from 2.9 percent to 4.9 percent, forever, would preserve the Medicare program for the next 75 years.

Now, what does that mean in real terms? For a family earning \$50,000 a year, which is actually a little bit less than average, that's a total of \$2,450 in payroll taxes for Medicare. People who like this policy would like to tell you, well, that's only another \$1,000, but it's a total of \$2,450. And that isn't the only payment that family is going to make for Medicare; because, after all, Medicare isn't fully funded. On top of payroll taxes, that family is going to pay about \$400 in income taxes to help pay for the Medicare costs that come out of general revenues.

I don't think the man on the street would be very happy if he actually understood that's what that policy meant. And yet there are a lot of people in Washington who still think that's the way to go; and don't make any big changes.

I might add that, although those numbers seem pretty big to me, they are actually going to be bigger. Because, of course, the trustees could not have accounted for a big, expensive drug benefit program. And my apologies to Tom; but, frankly, the trustees did not really take into account fully enough -- and I think he probably agrees with this -- the possible increases in spending per person that I already talked about. So that's not going to work. More tax revenues -- that is not the answer.

Why don't we just cut payment rates? Why don't we create new perspective payment systems? Isn't that the thing to do? Well, that certainly has been the thing to do in Congress. Can't we audit all those bills and eliminate fraud? Good idea. This is the easy one. Well, that is the strategy that the government has been pursuing, not just for the last couple years but in the last 20. And the record shows that government price setting does not work.

Here is a recent example. It would be humorous if it were not true. Congress wanted to make sure that the new payment rules for hospital outpatient departments would not restrict the use of high-tech drugs and medical devices. And that is a good goal. Outpatient services are now reimbursed on, basically, a fixed-price schedule. Which gives hospitals, naturally, the incentive to use the lowest-cost methods of treatment, the lowest-cost efforts.

So Congress, in its wisdom, created a special payment called the "pass-through," which would pay extra for the use of these high-cost drugs and devices. That is a good thing; allow a little innovation in the delivery of health care. And for 2002, the amount of the pass-through was going to be 2.5 percent in total outpatient payments, which the maximum, therefore, was going to be about \$440 million for 2002. However, hospitals have jumped into this payment loophole. When you make a rule, people

find a way to make use of it. And actuaries project that the actual amount of pass-through payments will be something more like \$2.25 billion. So I guess, probably, price setting does not really work that well for Medicare.

Obviously, the government is not good at all at guessing what the market-clearing price would be or guessing what new developments might actually occur in the course of providing care. But certainly the price signals are very important to economists. And if the price signals are wrong, then the resource allocation decisions made on the basis of those prices will be wrong, too.

Moreover, the government creates more and more complications as it attempts to limit the response of providers to financial incentives. In other words, they set up a system, they don't like what happens, so let's try to hem everybody in. The resulting system is incredibly complex; the complexity breeds fraud; but it also breeds mistakes. And all of those things -- all billing errors are called fraud and abuse. And that does not probably make too many doctors very happy.

I am not saying we should not try to improve payment methods or audit the books, and if we could find a better way to do it, that would be great, but this does not solve the problem. So what can we do about improving incentives?

Well, there seems to be in Washington two basic ideas. And Stormy mentioned them, so I do not have to say too much about them. One of them actually is the idea that Tom is going to tell us about, so I am not going to say too much about it. It is pre-funding the program. And Tom can correct me on this, but that is a method that intends to have beneficiaries take more control over their spending, and that beneficiaries actually know what the cost of using those services is -- something that you cannot find out now. It is a good goal. I have some concerns about exactly how it would work, and we might discuss that. And I am especially concerned about how the incentives really work for the supply side of the market, which I would love to hear Tom say something about.

What is the other idea? Well, the other idea is sometimes called premium support. And in the bad old days it used to be called vouchers. I am a voucher guy myself. And what is that? Well, that is sort of halfway between cashing out the program and leaving it the way it is. It still has substantial government involvement in most of the plans that you hear about. It still has the government kind of laying the ground rules.

And people often point to the Federal Employees Health Benefits Program as that kind of a model. But in reality you have to be careful, because people will point to that. And being

a graduate of that program, it is a pretty good program. However, that is a phrase that has certain meanings.

And I think people will claim that they are suggesting that kind of an approach when they are really talking about proposals that do not involve competitive bidding, do not involve real choice for beneficiaries, and, in fact, really have many of the characteristics of the current program just dressed up a little bit differently. In particular, I thought that the Clinton proposal, which kept fee-for-service Medicare in the driver's seat, was probably the best example of that.

There are a lot of big choices to be made. It is really very difficult. Stormy is right -- the devil is in the details, the fun is in the details. But you know what the real problem is in the details? The real problem is the political guts. Good things actually cost money. I just left CBO. It always annoyed me -- this is a personal peeve -- that politicians would say, "Oh, those guys at CBO, they gave us a bad estimate, so we can't do it." Baloney. Of course, you can do it if it is a good idea. But you have to have the nerve.

Thanks.

(Applause.)

MR. MILLER: Thank you, Joe.

Dr. Thomas Savings is a late but a most welcome addition to our program. He was able to wiggle free of his other

duties at the President's Commission to Strengthen Social Security, which was doing the staff work today for tomorrow's meeting. He is also a public trustee, the Board of Trustees for both the Social Security trust funds and the Medicare trust funds. And he is a professor at Texas A&M University.

Several years ago, he proposed a long-term savings ladder to get out of the hole of our intergenerational financial pressures facing Medicare. So he is going to provide us today with a bottom-line analysis of where the Medicare program is, where it will be heading if left on auto pilot, and how we might change its flight plan.

Dr. Thomas Savings.

THOMAS SAVINGS,

PRESIDENT'S COMMISSION TO STRENGTHEN SOCIAL SECURITY

DR. SAVINGS: I hate to have Tom introduce me, saying all these great things that I am going to do. It is free for him to do that, of course, because he does not have to do any of them.

As long as I have been involved in this research on Medicare reform, I have known Sue. Actually, she came to some of the very early things I was involved in. And so it was very nice to see her do this book. I read the early drafts of it, and have

a little comment on the back of it. And it is a nice history of what was going on, and also kind of recitation of the problems that Medicare has.

We can start off with those by just talking about the size of the program. And that becomes very important because, last year, as some of you may know, we had a technical panel to look at the way we were forecasting the growth of Medicare in the trustees report. And they suggested that rather than the assumptions that we had made, which in the past -- and I cannot say I was a party to those because I was not a trustee at that time -- I should say, of course, we would not have made those had I been a trustee -- and the assumptions were that Medicare's share of growth domestic product was growing, that clearly could not happen forever. It could not grow faster than income was growing. And this was an assumption, because, as Herb Stein used to say, "Things that cannot happen, won't happen."

Well, taking that approach, our approach was to say that what will happen here is that the growth of Medicare, as a share of gross domestic product, will have to start to stabilize at some point. Well, the technical panel pointed out to us by arguing and saying, what if health care for the aged is a superior good? What that means is, of course, its share of the budget would continue to rise. Now, that does not mean as income rises, it only means that it will exhaust the entire rise in

income. What it means is it will rise more and take up more of its share all the time. But the rest of consumption can still always be rising.

So it is not the case that it is not possible for the Medicare share of GDP to keep rising. And, accordingly, we took the advice of the technical panel and said we are going to assume that, in fact, it is going to rise 1 percent faster than per capita GDP.

Now what that did, of course, to the Medicare deficits that we are forecasting -- we made them much larger than we have before -- that means that if we are going to ever cover that gap, and looking at those estimates -- the 2001 Trustees Report -- you estimate the current debt that is associated with the Medicare program, and it is on the order of \$26 trillion. If you combine that with the current Social Security program, looked at the same way -- meaning that you stopped all payments into it and simply looked at the debt that you have -- it is on the order of \$13 trillion. So these two programs together are like \$39 trillion.

Some estimates are that by 2060 or so, these entitlement programs, plus Medicaid, would totally exhaust a Federal budget that was 20 percent of gross domestic product. Okay, that cannot happen. Well, I might have said that cannot happen. Obviously, maybe it can happen, because the Federal budget could be 40 percent of gross domestic product. We like to

believe that those are tax levels that the American public would not tolerate. But, of course, the tax levels we now have, people 50 years ago might have said these are tax levels -- absent war -- that the American public will not tolerate. Certainly, the Europeans tolerate them, but I am hoping that we will not tolerate those taxes.

So that is the nature of the problem that we have. The question is, what is the solution, or are we just going to pay these? Of course, we are wrestling with that in the Social Security Commission, to say what is the solution. I have suggested in the past, one of the solutions to that problem is prepayment.

Now, in and of itself, prepayment does not change the current Medicare system. All it does is to say that what we are going to do is this common property debt that we have, which people believe their future is going to be taken care of, so instead of building a factory to take care of their retirement, they let the government do it. So we are short one factory. For every person that does that, we are short a factory. And we are short of a lot of factories, so we are short of a lot of output. And we can get that output back by prepaying, but that does not change the fundamental problems with the system. And those problems pointed out by Sue, and certainly pointed out by Stormy and Joe, are that no one has an incentive.

When I testified before the House Budget Committee, I was talking about this. You know, I have a dream. I was driving to Dallas, and I see these big billboards. And the billboards are about LASIK surgery. And the biggest thing on the billboard is the price. And then I see an ad for the hospital. And as you drive into downtown Dallas, it is a huge, 15-floor, white building. And you see their ads; price is never mentioned. Nobody cares what it costs at the Baylor Hospital. LASIK surgery, everybody cares.

Why have prices in LASIK surgery been coming down? Because people care what it cost. Nobody pays for it except the customer. And when the customer pays, there are two things happen to you. One, they care what it cost, so they watch what they are doing. And they also care whether you do it right. And they can make choices between buying glasses and buying LASIK surgery. They have two things which do exactly the same thing -- correct your vision. And a lot of people choose glasses. And the elasticity of demand for LASIK surgery depends on that difference between that price of glasses and the price of LASIK surgery. And it has been coming down; it would be very nice.

And innovation in that industry is cost-reducing. And that is a different issue that we have. The current structure of Medicare is such that the incentives are not to find cost-reducing technology; there is no benefit. It is to find new

things to do. And at my age maybe I like some of those new things to do. I mean, they may allow me to replace lots of wearing-out body parts. If I had to make choices about lifestyle now as to whether I am going to be able to replace body parts, I might choose to go to Paris instead of replacing a body part. But if someone else is going to pay for it, I am going to replace the body parts and go to Paris. And I think that is the problem.

So how do we solve that problem? Well, in the work that we have done on prepayment -- which is important I think, and it is also important for Social Security -- we also said we have to get rid of first-dollar coverage. Well, how do you do that? You might do it with large-deductible policies, which we were suggesting, but you also have to have a lot of other changes in the current system.

It is interesting that MedPac, the people who fix all the prices in medical care, is probably, since the demise of the Soviet Union, the biggest price-fixing agency in the world. And the question is, is that doing us any good? As Stormy has indicated and Joe has indicated, it is not doing us any good. It is not working. How do we change that?

When I was at this same budget committee, Marilyn Moon was there; the Democrats had her there. When I was saying that one of the problems with lack of health insurance among young people, for example, is young people are low-income people. We

have community rating for the health insurance, so they are going to have to pay for -- I cannot say me, because, obviously, I have to be on Medicare; I am 67 years old -- but for those of you out there in the audience who are much older than these young people and not as healthy, they have to average cost. And they, sensibly, opt out.

And her response was, "We cannot have risk adjusting to these premia because then we are not diversifying our risk."

And I said, "Wait a minute. You diversify risk by having many people in the same risk category." That is what diversification means. You do not diversify by having equal pricing for people in different risk categories. That is not diversification; that is welfare. And we have to get rid of it. So how do we do it? How do we better risk adjust?

Well, there are several ways you might do it. I don't know if I can give you a full answer to this. One of those is going to defined contributions. Stormy talked about defined contributions as a way of redoing Medicare, for example. But, still, that does not do you any good unless you risk adjust. And CMS, the Balanced Budget Amendment required them, in fact, to try to risk adjust. Of course, they are at a disadvantage over a real health care provider in risk adjusting, because there are a lot of factors that are real in determining risks that they are

not allowed to take account of legally. So that is a real problem for them.

But the real question is, what is the information content in last year's expenditures or the year before expenditures? We have done a lot of work on this because we have the continuous Medicare history file for all of the years in which it has existed. And the nice thing about that file -- those of you who are not familiar with it -- is they take a random sample of people turning 65 who get into the Medicare program. They stay in there until they die.

So this is not a sample; it is a really, nice longitudinal system. Plus, it gives you a cross-section of people, using different ones at different ages. So you can ask certain questions about how are expenditures related to age, for example. It is very interesting, in taking the first sample that they took, people who are going to die at 70 in that sample, on the average, have higher expenditures when they are 65, when they are 66, when they are 67, 68, 69. And, of course, the year they die, they have the peak expenditures.

You take someone, compare them to the person who is going to die at 75, they will have lower expenditures than the 70-year-old dier; the 80-year-old person will have lower expenditures every year of their life than the 70-year-old dier.

So if you only knew when someone was going to die, you would have a lot of information about this.

But the other aspect is, if you were going to sell them long-term care -- I don't mean long-term care in the sense of a long-term care facility; I mean a long-term contract with this individual -- it is not clear that the person who is going to die when they are 65. Now, that is the high-cost person at 65 to get into your program if you are a provider, because they have the dying expense, which is the biggest expense that people have. But if you were to sell them a lifetime contract and collect the money, you would prefer the person who is going to die right away, because then you do not have to provide service for them for the next 25 years.

As a matter of fact, the present value of those from that longitudinal file probably peaks at about someone who is going to die at 75, 78, somewhere in there, and declines for people who live longer than that, and declines for anyone who lives less time than that. So long-term contracts are one way, perhaps, to handle this thing, and better risk adjusting, and allowing risk adjusting to go on. But what that implies if you are Medicare -- and we use the bad word that Joe likes, the "V" word, the "voucher" word -- you have to give those people bigger vouchers. Because what you want to do is to give them a voucher for their health care status and let the market compete for what

people are willing to take this person for with that health care status.

And what we do now, of course, is we give the HMO something that is actually based on the fee-for-service, and last year's fee-for-service. So we do not take bids from anybody to find out what they are willing to actually take a certain risk category for. And we have to change in that direction.

Risk-adjusting premiums, trying to bring the market to bear on innovations, I think that is important. Get rid of first-dollar coverage. If we do not do those things, we cannot make the customers care what it costs. If the customers do not care what it costs, the providers certainly are not going to care what it costs. And I think that is where we have to go. And this book gives you a historical perspective, and a perspective on what the issues are and what some of those solutions might be.

We are a long way from doing this. Here we are doing Social Security, perhaps, when it is half the problem of Medicare. So we will have to get to this bigger problem soon I hope. And hopefully Sue and Cato will have a big part in doing that.

(Applause.)

MR. MILLER: Thank you very much, Dr. Savings.

We have had a wide-ranging discussion, so let's go right to our questions from the audience. I would ask that you

would first wait for a microphone to come to you, and identify yourself. And also, you will be in double jeopardy if you do not phrase your answers to Medicare's problems in the form of a question to the speakers.

DR. MARSHALL: I'm Dr. Joseph Marshall, a private physician, practicing gynecology. And I guess I want to be in double jeopardy because it is not going to be a question.

Sue was here a couple of years ago on the same subject, and I, in fact, made this comment. And I think it is appropriate to make this very brief comment about how it is to practice as a physician under Medicare, and to reiterate what Dr. Johnson had mentioned. A few years ago, because the system was so incredibly in disarray and the paperwork was just absolutely insane, I made a decision that I was no longer going to charge my Medicare patients; I was going to see them free of charge. And I decided that maybe it would be an economic problem for me, but it would be easier for the patients.

So I called up Medicare and told them what I was going to do. And they in fact said, "Well, Doc, if you do that, you will be fined \$10,000 a day, and you'll go to jail." And I asked them for a reason. And they said, "Because it is the law, and you're breaking the law."

So I am right back in the system doing what I have to do. And my wife, who is my secretary, she is on the phone 35-40

minutes on hold -- it is not an 800 number -- to try and clear up a \$2.50 bill, and our phone bill is \$5.00. So it is a crazy system. That is my comment.

(Applause.)

MR. MILLER: Any other questions? Ed Hudgins?

MR. HUDGINS: Ed Hudgins.

All of the speakers talked about what can be done to the system except for our first speaker, Ms. Blevins. Perhaps you could give us some thoughts about what might be done with the system. I know that's book number two that you will be writing, and we will be anxiously awaiting it, but perhaps you could give us a few previews.

MS. BLEVINS: The book does not provide a panacea for solutions, but it rather diagnoses the problem. And the goal, really, is to get everyone involved and focused on the Medicare issue. And if I put out a solution right away, I think it could be very divisive, and I did not want to do that. I purposely did not want to do that.

Having said that, though, I think the first three steps -- the first one would be to let people, when they retire -- Bill Gates, when he turns 65 and he goes and applies for his Social Security benefits, assuming that he is going to do that -- allow him to reject Medicare Part A. Just do not force this man to

take tax dollars from younger workers. Let him completely opt out.

I am dealing with the current system. I am not changing the taxes. I am not changing payments. The second point is, I would say, absolutely let patients pay privately for things that Medicare covers, at a basic minimum. It is sort of like the educational system. We do not say to people, well, gee, because you pay taxes for public education, you have to send your children to public school. We say, well, you can go to private school if you want. And I am not even disrupting the Tax Code at this point.

And the third thing that I would say is absolutely allow doctors and patients to have the private contracts, to keep the confidentiality as they want. I could spend a lot of time -- but I will not -- going into anecdotes. I have worked in hospitals. I have worked as a home care nurse. I have been in an individuals' homes and seen very personal information, intimate details, that people do not want collected -- whether it is about their sexuality, whether it is about they are really dirty. I mean, you name it, they just do not want this information collected and sent to State and Federal governments.

So I think the three very minimum, basic things that should be done immediately should be those three things.

MR. MILLER: Another question over here, Greg Scandlen.

MR. SCANDLEN: I am actually kind of disappointed with the remedies that have been suggested by the three gentlemen. It seems to me that there is an insufficient vision happening, particularly because you all seem to be accepting the notion that Medicare is and should be a distinct program that kicks in upon the miracle age of 65; that there is one health care system for people up to age 64 and 11 months, and then as soon as you move into that last month, suddenly there is an entirely different health care system.

I would encourage you to think about the future of the work force. Will we be working into age 70, 75, 80 in the future? Will we be tapering off into retirement, instead of just suddenly going into retirement? On the under-65 side, if we do move decisively towards defined contribution, portability, individual ownership, wouldn't people demand to take their under-65 health care with them into retirement?

It seems to me that this is not the time for a lack of imagination. And I would encourage you all to think more broadly.

DR. ANTOS: Greg, that is a good point. But, of course, one has to be careful because there are plenty people who completely agree with you. That is why they wanted a Medicare buy-in. They want to extend Medicare down to lower ages. So you have to be specific about what you mean. We know what you mean,

but there are plenty people who would say, "Greg Scandlen supports federalizing all of health insurance, one age group at a time."

MR. MILLER: Stormy?

DR. JOHNSON: One of the most important advantages of the concept of medical savings accounts is that a young person who has a medical savings account and builds up an account over time takes pressure off the Medicare system and helps relieve this problem. I did not go into the notion of what I meant by pre-funding, but to take the pressure off the system, much in the way that Sue was just talking about in terms of the people who can do so for whatever reason, because of generous benefits from their employer or whatever, but to have the right to carry forward something they began a long time ago and not be a burden on this system should be an option. And, clearly, that is not possible under the current system. So I could not agree with you more.

MR. MILLER: Let's see if I can cobble together something that Dr. Savings left out on the table in terms of risk adjustments. What Greg is suggesting is integrating the private system before you get to Medicare later. One of the odd things, Dr. Savings, about Medicare is, when we kind of go to Medicare Plus Choice or other types of vouchers, we think these are always individual payments for individuals. Yet, most of the private

health care system for folks who are working, they are part of pre-formed groups which they might be able to carry over. And my recollection of the research on risk adjustment is it is a lot easier to make it predictable if you are predicting the risk in a formed group as opposed to individual by individual. Is there some way to maybe harmonize those two together?

DR. SAVINGS: Well, I think you have hit on something. But if you are looking across risk groups, diversification is really within kind of risk groups and you cannot diversify across these people if you are going to charge them the same premium. So I think you cannot do that.

Now, one thing the prepayment does do is when you reach 65 -- or whatever age we want to talk about -- you have the funding to buy the health care for the rest of your life in a sense. So you can move from the same one you have -- this is not a federally-run program -- once every individual has the funding. And there is a real issue as to whether we ought to just say we are going to combine all retirement income into one lump and let people decide whether they want health care or trips to Paris. And they ought to be able to make that choice.

And now you cannot make that choice. You have to have the health care, and you might as well consume it. But if you could actually take some of that funding, I think that that is part of it. I had not mentioned it, but I think it is important

to see that, if we want to have choice, we have to have health care providers bidding to get customers.

And there are some very interesting long-term contract issues that are out there. There was a JP paper three or four years ago that addressed some of those. And it is kind of interesting how long-term contracts might work. We could address that, but not here.

MR. BRODERICK: I'm Dave Broderick, from the Bill of Rights Foundation.

I have two quick questions. Number one, the physician behind me said he could not give free care. Does that include free clinics? Has that dried up the free clinics? In other words, if someone who is at the 65-year age and, say, has Medicare, but for whatever reason arrives at a free clinic, how is that handled?

And the second question is, has anyone ever been charged successfully? And what defense has ever been made for giving free care? In other words, if this doctor went on and did it anyway and defended himself, what would be the possibilities of him prevailing in the legal system?

MS. BLEVINS: I think that is a question for Stormy.

DR. JOHNSON: I am not sure I know the answer to that. The threat is such that I am not aware of many people, if any, who would want to take a chance. In point of fact, for example,

even in the limited amount of balance, people frequently will forgive the balance, but they technically are required to bill at least once for it. And rather than face a \$10,000 fine per incident, most of us go ahead and send a bill that we have no intention of collecting. So that just makes the complicated situation more complicated that we don't have the option.

By the way, there is a basis for that. It goes back to earlier times in a flawed payment mechanism -- and Sue actually speaks to that in the book -- where you charge more so that you get what you want out of it, and then graciously forgive the balance. And that way you got paid what you thought your service was worth, but your patient, who you want to be your friend, did not have to pay anything out of pocket. So everybody theoretically won except the system, and that wasn't effective cost sharing. That is the fundamental problem of the 80/20 split. It is very inflationary, not because it is fee-for-service but because of this cost-plus mentality.

I would say that anybody who is in the program now who does not pay attention to that is taking a substantial risk. Do I know anybody personally who has experienced the end results of that? The answer is no. I am sorry, I cannot comment one way or the other. I would be glad to look that up for you if you would like to talk to me afterwards. The free clinic I do not think is an issue.

MS. BLEVINS: I would like to add just as an anecdote from when I worked at Johns Hopkins. And let me just stress that this book is not about saying, "Oh we do not want seniors to have health care." I want seniors in this country to have as much health care as they want, the quality of health care that they want, especially when they retire and are in their golden years. So this book is to be a constructed way to lay the groundwork for finding a better way to deliver care in a better and a more efficient system.

Having said that, there are a lot of reasons that I went into why I care and thought a lot about this issue. And I will just share one real-life example. And that is when I worked at Johns Hopkins on a urology unit for a very famous urologist, a renown urologist. We had a patient who had prostate surgery. It wasn't cancer surgery. It was a TURP. He had his surgery. He was fine the next day. He asked if he could stay an extra day. He said, "You don't understand. I had this surgery before, and the last time I bled when I went home. Please let me stay. Please let me stay." We checked with the administration; we checked with the doctors.

Now, technically, what you are bringing up, probably the doctors could have figured out the rules and regulations and allowed him. But because of the fear, they are afraid of just their reputations, they are afraid of having to deal with the

paperwork, they are afraid of getting kicked out of the Medicare program, because of just the fear alone they said, "Nope. Sorry."

And his wife had died, he lives alone. He tells me the whole problem; that if he goes home in northern Baltimore, starts to bleed, calls an ambulance, that ambulance will not bring him back to Johns Hopkins. It will take him to Mount Sinai, because it is closer. The ambulance will not take him where he wants to go. Then he will have to be admitted in Mount Sinai, go through the whole processing there, and then be transferred to Johns Hopkins.

He tells me the story again. I repeated, "No, the administration is not going to do it, and for legitimate reasons." He is willing to pay out of pocket. Not allowed. He is sent home. Sure enough, he does end up bleeding, and he ends up two days later back at Johns Hopkins. And that is just one example where you have a person wanting to pay cash, and they cannot.

And, quite frankly, this is a problem, but it is trying to quantify it. When I was doing research I had doctors that told me things. But I do not know many that want to come forward, and put their name and their reputation and their business on the line, saying, gee, I was investigated by the

Health Care Financing Administration, or the CMS. It is not something that people want to discuss openly.

MR. MILLER: We will take two more questions.

MR. SNYDER: My name is Kent Snyder.

Would any of the panelists endorse what I would call, "the emperor has no clothes option"? And that is, for people such as myself, who are 42, totally opting out, forfeiting whatever money that I have paid in the system, and from this point on, similar to Social Security, just forget about it, and then I will take care of myself.

DR. JOHNSON: I guess the point that Sue makes in the book, I think rather effectively, by the way, is that when you do that you give up not only what you think is due to you in terms of all the money you have spent in the Medicare tax but also the Social Security program. If you are willing to give up both the Social Security and the Medicare payments, and your "entitlement," there is no barrier to that. Most people don't want to do that.

DR. ANTOS: That is not true. You are still obligated for payroll taxes.

MR. SNYDER: theoretically, it is a trust fund. Theoretically, you pay in so much and you are suppose to get so much back; which it is not and which we all know. But the thing

is, it is simply opting out. Because, in my opinion, listening to all this, as well as reading some other things and personal experience, this is like trying to manage neurons; it is going to be impossible to do. And so instead of continuing to pay and continuing to pay, just opt out and then let the individual decide, and that is it.

DR. JOHNSON: There is one other facet. And, again, this is carefully pointed out in the book I think. And Sue did, if I'm not mistaken, in her presentation. You cannot buy insurance, so you are, basically, going to put yourself at enormous risk. And let me tell you something, it is the same risk that young people take. And they are foolish to take it when they are 21. When they get to be 65, they would be several times more foolish.

Maybe Bill Gates can afford that, and your resources may be such that you can do that. Or what happens then, and it becomes a societal interest in this, it is like the guy riding on the motorcycle with no helmet. If he survives the crash and he has no money, the system takes care of him anyway. And then we have the cost shift that results from that. So there is another facet of this for another day's discussion.

DR. SAVINGS: Because you could have a market that would develop if there were enough people like you. But at this point, of course, that is not an option. You cannot do it alone.

And some people have suggested that for both Social Security and Medicare, that if you let the right kind of people opt out, you can help the system. But you would have to have this other market develop that Stormy says does not exist at the moment.

MR. MILLER: Let me get in two more questions.

MR. HERSHEY: I am Bob Hershey. I am a management consultant.

To what extent can we tell the public about numbers such as Dr. Savings is going over, and get them so they understand how much it is costing them? Such as the risk numbers or growth of money over time, such has been used more in the Social Security analysis.

DR. SAVINGS: Well, I can tell you from Social Security that educating the public is the biggest job that we have. And I do not think we have been very effective at it, as I see what happened even after we introduced our interim report. And that was not about Medicare, but you did the same thing about Medicare. It is just that there is a lot of demagoguery going on out there, and it is hard to educate the public and find the right way to do it. I may not be the right person to do that because I am sort of an academic. And we have these PR kind of people who always tell us we are doing this wrong.

There has to be a better way to explain it to individuals. Because I think we have the right message, but we

have to get it across to them. I certainly have not been effective at it.

DR. ANTOS: As someone who has dealt with numbers all his life, I can tell you, it is really disappointing how many people does not like numbers.

MR. MILLER: Final question patiently waiting back there.

QUESTION: A number of the panelists have pointed out different ways in which the separation of the payer from the beneficiary results in inefficiencies and additional costs. One aspect that was not mentioned -- and I would like any of you to comment on it -- is whether it would be possible to reform the system in such a way that reuniting payment with the beneficiary could affect prevention. In other words, healthier lifestyles, avoiding smoking or drinking, getting exercise and so on -- preventive medicine -- could actually reduce the cost of health care. The current system has no incentives for that; in fact, it may have counter-incentives.

MS. BLEVINS: I would add that the best example of how a system can work -- because we have proof -- and that is we had a free-market system up until about 1965, and it worked. Insurers were able to charge people according to their risks. They were able to ask people, "Do you smoke?" and charging them

more accordingly. But after Medicare was passed, it distorted the whole market.

I think this book does a good job of explaining how Blue Cross and Blue Shield cut a deal with the Johnson administration, and Johnson more or less said, hey, drop all those seniors and we will let you have the contract to process claims. And so it was not like all of a sudden seniors ran out in 1965 and said, "Give me Medicare, give me Medicare." They were forced out of their programs. And Dr. Antos actually told me about his mother, who was just basically dropped from her plan and told to go get Medicare.

So can a program exist? And, Greg, you raise an excellent question, which is we do need some really good, sexy solutions. It is a boring topic. It is very boring, but we have to do something to call for solutions together.

And just one last thing that I will add. We have proof that the free market can work for health care. It has worked in this country, and can. And, Ken, I am going to get in a lot of responses that I wanted to give. In the book I actually cite, on page 85, there was a poll taken by the Third Millennium Group, or they commissioned a poll, and basically asked baby boomers, 18 to 34 -- first they asked, which do you think is going to be around longer, the soap opera, General Hospital, or the Medicare program, which were both created in 1965. And 53 percent of the

Generation X-ers thought that the soap opera, General Hospital, was going to outlive Medicare.

And then they were asked, if the program is not going to be saved and is not going to be financially sound, how many would like to opt out. And 59 percent of just Generation X-ers wanted to opt out altogether, as you suggested, and pay for their own health insurance.

MR. MILLER: Sue, that raises the question of whether Luke and Laura will get back together before Part A and Part B do.

(Laughter.)

MR. MILLER: With that, let's thank all of our speakers for a thorough discussion.

(Laughter.)

MR. MILLER: And you can thank Sue by buying her book outside. And we will be adjourning upstairs for a reception. Thank you very much.

(Applause.)

(Whereupon, the Cato Institute Book Forum concluded.)