

Cato Institute Policy Analysis No. 230: The Wrong and Right Ways to Reform Medicare

June 8, 1995

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Executive Summary

The combination of the latest report from the trustees of the Medicare Trust Fund and the debate over balancing the federal budget has moved the need for Medicare reform to center stage. The trust fund, which finances Medicare Part A, will be bankrupt by the year 2002. Medicare Part B, which pays for physician services, diagnostic tests, and other outpatient services, is funded through general revenues and premiums from the elderly and therefore is not going broke. However, its rapidly escalating costs will add more than \$100 billion per year to the federal deficit by the year 2000.

In response, many members of Congress have fallen back on such traditional remedies as increasing the payroll tax, raising Medicare premiums, pushing the elderly into managed care, and restricting reimbursements to providers. There is little evidence that any of those proposals will succeed in restraining the growth of Medicare spending. However, there is evidence that many of those approaches will be harmful to the economy, the health care industry, and the elderly.

Congress should seize this opportunity to fundamentally reform the Medicare system, transforming it from a first-dollar insurance plan to a back-up catastrophic program. Only through such a transformation of the Medicare system can we ensure that the elderly will continue to have access to the health care they need.

Introduction

Officially designated Title XVIII of the Social Security Act, Medicare was enacted in 1965 as one of the cornerstones of Lyndon Johnson's Great Society. Johnson traveled all the way to Independence, Missouri, to sign the bill under the watchful eye of former president Harry Truman. As he did so, Johnson claimed, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that have been so carefully put away over a lifetime so that they might enjoy dignity in their later years."^[1]

Increasingly, Johnson's words are being revealed as a chimera. Medicare is failing. The elderly face rationing and the denial of "the healing miracle of modern medicine." The steps necessary to continue to finance the system threaten to "crush and destroy the savings that have been so carefully put away over a lifetime," for both the elderly themselves and their children and grandchildren.

The crisis in Medicare is very real. According to the government's own actuaries, the Hospital Insurance Trust Fund, which finances Medicare Part A, will be broke by the year 2002.^[2] Medicare Part B, which pays for physician services, diagnostic tests, and other outpatient services, is funded through general revenues and premiums from the elderly and therefore is not going broke. However, its rapidly escalating costs may bankrupt the country.

The Medicare Program

Nearly all Americans are automatically enrolled in Medicare Part A, whether they like it or not, on their 65th birthday. In addition, individuals under the age of 65 who are receiving disability-based Social Security benefits are eligible for Medicare Part B after a two-year waiting period, as are most individuals suffering from chronic kidney disease. Medicare Part B is voluntary. Individuals age 65 or older may choose to enroll in the program by paying the monthly premium. Individuals under age 65 who are eligible for Medicare Part A because of disability or chronic kidney disease may also choose to enroll in Medicare Part B.[3]

In 1994 approximately 32.1 million elderly and 4.1 million disabled Americans were covered under Medicare Part A. Approximately 7 million elderly and just under 1 million disabled persons actually received reimbursed services in 1994. Slightly fewer Americans, 31.4 million aged and 3.7 million disabled persons, were enrolled in Medicare Part B. Of those, 26.7 million of the aged and 3 million of the disabled received Part B reimbursed services last year.[4]

Combined spending for Medicare Parts A and B exceeded \$181.5 billion for fiscal year 1995, approximately 12 percent of the entire federal budget. If the Medicare system does not undergo serious systematic reform, disaster looms. Unfortunately, the reforms currently being discussed in Washington are unlikely to address the system's fundamental flaws.

Fundamental Flaws

Medicare is unsustainable on three counts: demographics, technology, and third-party payment. First, America is growing older because the baby-boom generation is aging and life expectancy is increasing. In 1965, when Medicare was established, the average American lived just over 70 years. Today, life expectancy has risen to nearly 76 years. By 2025 Americans can expect to live over 78 years, on average, even without any major new life-prolonging medical breakthroughs. Moreover, in 1965 a person who reached age 65 could expect to live an additional 14.6 years. That figure has now risen to 17.5 years, and by 2025 it will increase to 18.8 years. As a result, in the next 30 years the proportion of Americans over the age of 65 will increase from 13 percent of the population to more than 20 percent. The number of Americans over the age of 70 will double.[5] Indeed, Americans age 85 and older are now the fastest growing segment of the population.[6] With medical breakthroughs and new technology, we can expect life expectancy to continue to increase, leading to even greater numbers of elderly citizens.

The older people become, the more, and the more expensive, health care they consume.[7] Individuals over the age of 65 see physicians nearly twice as frequently as do younger Americans and enter the hospital twice as often.[8] Average per capita health care spending is approximately four times higher for the elderly than for the nonelderly, and the rate of increase in such spending for the elderly is nearly three times that for the nonelderly.[9] In general, half of a person's lifetime health care expenses are incurred after age 65.[10] Therefore, as the number of elderly people continues to grow, Medicare expenses will continue to increase.

Second, medical treatments and technologies exist today that were not even dreamed of when Medicare was conceived. Those new treatments and technologies have saved lives and increased the quality of life, but they have also undeniably increased the cost of health care.[11]

Third, Medicare suffers from the problems inherent in any third-party payment system. Numerous studies have demonstrated that individuals will consume more, and more expensive, health care services if someone other than the consumer is bearing the cost.[12]

The deductible levels for Medicare are extremely low. Under Medicare Part B, for example, the deductible is an absurdly low \$100, although there is a 20 percent copayment. The deductible under Part A is higher, \$716 on the first 60 days of each hospital stay. There is also a copayment required for hospitalization for longer than 60 days. However, nearly 70 percent of the elderly have some form of "medigap" insurance that covers all or part of the deductibles and copayments.[13] Not only are the deductible levels low, but the value of those deductibles has been steadily declining relative to both beneficiaries' income and medical inflation (Figure 1).[14]

Thus, recipients pay very little out of their own pockets for Medicare services and have little incentive to be good

consumers and avoid unnecessary expenses or seek the best deal for their dollar. Guy King, former chief actuary for the Health Care Financing Administration, says that third-party payment is one of the primary causes of the rapid growth in Medicare expenditures. King explains, "When people, either patients or doctors, are spending other people's money, they do not worry about the cost or number of services consumed." [15]

Moreover, as Nobel laureate Milton Friedman has pointed out, not only has third-party payment driven up the cost of Medicare, but by dramatically increasing the portion of health care spending covered by a third-party payer, the Medicare system has driven up health care costs for all Americans. As Friedman notes, health care spending was rising only modestly before 1965. But, as Figure 2 illustrates, since the enactment of Medicare (and Medicaid), health care spending has skyrocketed. [16]

Figure 1

Actual Medicare Part B Deductible vs. Deductible Indexed to Medical Inflation

[Graph Omitted]

Source: Calculated from data in Social Security Administration, Annual Statistical Supplement to the Social Security Bulletin (Washington: Government Printing Office, 1994); and Bureau of Labor Statistics, "Monthly Labor Review and Labor Statistics," U.S. Department of Labor.

Figure 2

Medicare and Rising Health Care Costs per Patient Day (1982 dollars)

[Graph Omitted]

Source: Milton Friedman, "Gammon's Law Points to Health Care Solution," Wall Street Journal, November 12, 1991, p. A1.

Finally, Medicare Part A suffers from the same inherent problems as do other pay-as-you-go systems, including Social Security. In theory, Medicare Part A is supposed to be funded through the Hospital Insurance portion of the payroll tax, currently 2.9 percent for employer and employee combined. In a pay-as-you-go system, today's benefits to the old are paid by today's taxes from the young. Tomorrow's benefits to today's young are to be paid by tomorrow's taxes from tomorrow's young. A pay-as-you-go structure is an intergenerational transfer from younger workers to older retirees.

If the benefits paid to each recipient approximated the amount that that worker had previously paid in taxes, there would be no problem. However, each Medicare Part A recipient currently receives \$5.19 in benefits for every dollar contributed. [17] Therefore, like a chain letter or a pyramid scheme, the Health Insurance Trust Fund depends on a large pool of workers paying into the system for each recipient taking out of the system. Unfortunately, the ratio of workers to recipients has been steadily declining. As noted above, the number of elderly Americans continues to grow. At the same time, the birth rate has been steadily declining since the beginning of the century, meaning that ever-fewer young workers are entering the labor force. The result: today there are almost five working-age persons for each person over 65. By 2030, when today's workers have retired and our children are in their prime working years, there will be fewer than three working-age persons for each person over 65 (Figure 3). [18]

As a result, the Health Insurance Trust Fund is currently paying out more in benefits than it is collecting in payroll taxes, and it is relying on previously accumulated surpluses to cover the shortfall. By 2002 those surpluses will be exhausted and Medicare Part A will no longer be able to meet its commitments (Figure 4). [19]

The problem with Medicare Part B is no less serious. Approximately 75 percent of Medicare Part B is funded from general federal revenues, while about 25 percent is financed through premiums paid by beneficiaries. Since the program began, premiums have increased by a phenomenal 1,800 percent. [20] General revenue contributions increased from \$600 million in 1966 to nearly \$40 billion in 1995. Driven by the structural flaws noted above, spending under Medicare Part B has increased by 59 percent in the aggregate and 45 percent per enrollee over the past five years. [21]

If the current rate of spending growth is not reduced, by 2010 federal spending on Medicare Part B alone will be equal to more than 2 percent of the nation's gross domestic product. [22] As Figure 5 shows, the growth in Medicare is currently contributing \$52 billion per year to the federal budget deficit. By 2000 that figure will have risen to more than \$110 billion in constant 1995 dollars. [23] Clearly, no serious attempt to balance the budget can take place without

reform of the Medicare system.

Figure 3
Worker-to-Beneficiary Ratio
[Graph Omitted]

Source: Bipartisan Commission on Entitlement and Tax Reform, Final Report to the President (Washington: Government Printing Office, 1995), p. 16.

Figure 4
End-of-Year Hospital Insurance Trust Fund Balance (\$ billions)
[Graph Omitted]

Source: 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (Washington: Government Printing Office, 1995), p. 17.

Figure 5
Medicare's Contribution to the Budget Deficit
[Graph Omitted]

Source: Peter Ferrara, "A Proposal for Reform: Resolving the Medicare Crisis," United Seniors Association Issue Analysis no. 4, April 1995, using figures from 1994 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and 1994 Annual Report of the Board of Trustees of the Supplemental Medical Insurance Trust Fund.

Of course, all government projections of future Medicare spending should be treated with a certain amount of skepticism, since the government has consistently underestimated how fast Medicare would grow.

The Wrong Ways to Fix Medicare

Increasing Payroll Taxes

It is theoretically possible to keep the Health Insurance Trust Fund solvent by radically increasing the payroll tax. But the increase would have to be quite large, taking an enormous toll on the American economy and employment. According to the Health Insurance Trust Fund's trustees, if Congress acted immediately, an additional 1.3 percent tax would be required to keep the trust fund solvent for the next 25 years. To preserve the trust fund beyond 2020 would require hiking the tax increase to 3.52 percent.[24] That increase would amount to a tax increase of \$1,584 on a salary of \$45,000.[25] If Congress delayed action, even larger tax hikes would be required. By 1997 a 3.65 percent increase would be required; by 2002 the tax hike would have to be 3.9 percent. Some outside observers believe that the trustees' assumptions are overoptimistic and understate the size of the tax increase required to keep the fund solvent. For example, Michelle Davis, an economist formerly with the Joint Economic Committee, estimates that a tax as high as 11 percent would be required.[26]

Past payroll tax increases are indicative of the impact a payroll tax increase would have on the American economy. According to the Congressional Budget Office, payroll tax increases between 1979 and 1982 produced a loss of 500,000 jobs per year.[27] Likewise, a study by economist Aldona Robbins estimated that the payroll tax increases from 1985 to 1990 cost at least 900,000 jobs and reduced the U.S. gross national product by \$25 billion per year.[28] A subsequent study of the 1988 and 1990 payroll tax hikes estimated lost jobs at 500,000 per year.[29] Moreover, it is important to note that those payroll tax increases were much smaller than the ones needed to keep the Health Insurance Trust Fund solvent.

Increasing Premiums

The Part B equivalent to increasing the payroll tax is to raise the premiums that the elderly pay for Part B services. That approach has been endorsed by several conservative organizations, including the Heritage Foundation.[30] However, at \$1,106.40 per year for a couple, premiums already represent a significant burden for many elderly Americans. Any major increase in premiums, therefore, risks pushing large numbers of the elderly into poverty.

And major increases in premiums would be required. Under the trustees' intermediate assumptions, premiums would have to increase nearly 10-fold in constant 1995 dollars by 2015 to keep pace with Medicare spending. Even allowing for expected higher incomes in the future, the premium burden would be four and a half times greater for the average elderly recipient. Under the trustees' pessimistic assumptions, premiums would have to increase 13-fold in constant 1995 dollars, a relative increase in the premium burden of 900 percent.[31]

Technically, groups such as the Heritage Foundation are correct when they argue that a premium increase would not be a tax increase. As Stuart Butler, Heritage's director of domestic policy, explains, Medicare premiums are payments for a "commercial" service. Thus, increasing Medicare premiums would be no different from a private insurer's increasing its prices.[32] That would be true if Medicare recipients realistically had the opportunity to go elsewhere for their medical care. But, despite Medicare Part B's "voluntary" status, in today's market, Medicare is a government-run monopoly. Most elderly Americans have few alternatives to Medicare. Under today's conditions, mandating a premium increase would have the same practical impact on the elderly as would a tax increase.

Even more important, a premium increase would do nothing to fix the system's fundamental flaws. A premium increase would simply pour more money into a failing system. Unless costs are constrained, that will simply result in a never-ending chase, with ever-increasing revenues (from both premiums and general revenues) vainly attempting to catch ever-increasing spending.

Reduce Reimbursement Rates

Traditionally, the answer to rising Medicare costs has been to attempt to squeeze providers by enacting price controls or reducing reimbursement rates, or both. Virtually the entire history of the Medicare program has been a litany of one form or another of price controls. From cost-plus to diagnostic related groups, to the Resource-Based Relative Value Scale, attempts at Medicare price controls have failed to reduce the program's skyrocketing costs.[33]

Such cost controls have managed to reduce provider reimbursements to the point where many providers now receive barely half the fee that private insurance pays. That has had two major results. First, much of the program's costs have been shifted to the private insurance market.[34]

Second, evidence is growing that Medicare price controls put at risk the quality of care. For example, a 1988 report of the Department of Health and Human Services warned that 540,000 Medicare patients were receiving poor care and increasing numbers were being discharged before their conditions stabilized. The House Government Operations Committee figured the cost at 3,269 avoidable deaths, a high price to pay for uncertain budget savings.[35] In 1993 the Physician Payment Review Commission worried that declining Medicare reimbursement levels might "compromise access to care for Medicare beneficiaries." [36]

Other research confirms the deleterious impact of Medicare price controls on patient care. Economist Michele Davis warns, "Hospitals respond to the [Prospective Payment System] the way all producers respond to fixed, below-market prices: they curtail the supply of service, thereby rationing care to Medicare beneficiaries." [37] Surveys of doctors have found that many feel they are being pressed to discharge patients too soon and that the quality of care has suffered as a result. Reviews of discharges of heart and hip fracture patients have found evidence of premature discharges.[38]

Another study, published in the federal government's own Health Care Financing Review, concluded that "the intensity of care" fell after implementation of the prospective payment system, though the impact on quality was harder to assess.[39] The authors found significant evidence that the conditions of patients when discharged were less stable than they had been before the implementation of the prospective payment system.[40] Another review came to similar conclusions: though anecdotal evidence of premature discharges was not backed by any firm statistical evidence of increased mortality, patients were in less stable condition when they were discharged.[41]

Managed Care

Many politicians have fixated on managed care with an almost religious fervor. But their faith may be badly misplaced. Managed care is not new to Medicare. For the last 10 years Medicare recipients have been allowed to enroll in health

maintenance organizations (HMOs), with Medicare paying a capitated amount per enrollee. Currently, about 2 million Medicare recipients are enrolled in one of 136 risk-based HMO plans.[42]

However, predicted cost savings have not materialized. In 1992 the Congressional Budget Office reported that shifting Medicare patients to HMOs "had little or no effect on hospital use and costs." [43] Indeed, an evaluation of the program by an outside consulting firm found that the policy actually raised government costs. The researchers that the "program does not save money for HCFA [Health Care Financing Administration]--in fact, costs are higher than they would have been had the enrollees not joined the HMOs." [44]

The experience of the private sector also suggests that managed care is unlikely to be a panacea for rising Medicare costs. For instance, a study by the General Accounting Office found "little empirical evidence" that managed care cut costs.[45] The best that can be said for managed care is that it appears to have lowered participants' cost base line, though the amount is in dispute. Consider HMOs. Their expenses are somewhat lower, but that in part reflects patient self-selection--healthier people are more likely to join HMOs, a phenomenon noted by HCFA and GAO alike. As a result, reports Stanley Wallack of Brandeis University's Bigel Institute for Health Policy, "HMOs seem to serve a healthier group of enrollees." [46] The benefits consulting firm A. Foster Higgins Company reports that nearly 6 of 10 employers believe that HMOs attract better health care risks from their employees.[47]

Moreover, while HMOs are, on average, cheaper than other plans, they are by no means uniformly less expensive. Two recent business surveys, one by KPMG Peat Marwick in 1992, the other a 1991 review published in Health Affairs, found little difference in premiums and premium growth rates between managed care and fee-for-service plans.[48] Moreover, warned the GAO, "Some firms have found that their total health care costs have increased after implementing network- based managed care." [49] Foster Higgins found that HMOs averaged 14.7 percent less expensive in 1991, yet 35 percent of corporations surveyed stated that their HMO rates were higher than those for traditional indemnity plans.[50]

Any cost reduction due to managed care is largely a limited, one-time phenomenon. Although the expansion of managed care may have cut the costs of some individual plans immediately after implementation, it has done little to reduce systemwide costs and has not halted medical cost inflation. Wallack has commented on "the inability of managed care to control system costs, as health care expenditures have continued to rise rapidly with the widespread adoption of managed care." [51] A 1988 study found that managed care had "a one-time effect of reducing use and expenditures" that did not recur in future years, a conclusion reaffirmed by other researchers a year later.[52]

Managed care does not change the underlying incentive structure created by pervasive third-party payment. Observes Dr. Thomas Rice, at UCLA's School of Public Health, HMOs' "record of accomplishment is no better than that of fee-for-service medicine, probably because HMOs are not insulated from any of the underlying causes of health care cost inflation." [53]

Although managed care appears to have little impact on Medicare costs, it does have a significant impact on the quality of care delivered. Quality problems as a result of the government's attempt to shift Medicare recipients to managed care have already begun to come to light. A recent report by the Department of Health and Human Services' inspector general found "pervasive" quality problems throughout managed care programs for Medicare, including difficulties in getting access to care.[54]

Such quality problems are well known in the private sector. In general, HMOs are significantly less likely to use diagnostic tests, such as MRI and CAT scans, than are fee-for-service plans.[55] Patient complaints about HMOs are common; some dissatisfied patients (and their families, when the patient has died) have sued over denial of treatment. Doctors report that managed care organizations pressure them to save money even at the cost of quality.[56] One-third of doctors surveyed by the American Medical Association in 1988 stated that patients were harmed by delays or nontreatment under managed care.[57]

Managed care's tradeoff between cost and quality is particularly threatening to elderly patients. Observers have long noted that individuals incur the majority of health care costs in the last few months of life. Nearly 30 percent of Medicare expenditures occur during a person's last year of life.[58] Indeed, on a per admission basis, Medicare spends four times as much money on patients who die as on those who live. It seems likely, therefore, that in cases presumed

to be terminal, there would be a great deal of pressure to save money by simply denying treatment. However, health economist Anne Scitovsky found that the most money was spent caring for the patients for whom the doctors' predictions--that the person would die or live--turned out to be wrong.[59] Similarly, elder-care specialists Dennis Jahnigen and Robert Binstock warn that age is an extremely poor predictor of clinical success, because of the diversity of seniors. "In fact, the elderly display greater heterogeneity than do younger adults in many measurable aspects of physiologic and psychological function." [60] So much for allowing administrators, bureaucrats, and politicians to decide which treatments are unneeded.

The Right Way to Fix Medicare

Successful reform of Medicare must address the program's fundamental structural flaws. The program cannot continue as a third-party first-dollar payer for the health care needs of a growing elderly population. Spending additional revenues will simply throw good money after bad. Reducing reimbursement rates or forcing the elderly into managed care will not yield significant savings, but it could compromise the quality of care. There is no way to preserve Medicare as we know it.

Raise Deductibles

Accordingly, Congress should resist calls to increase Medicare premiums on the elderly or payroll taxes. General revenue contributions to Medicare Part B should also be allowed to grow no faster than the economy.

Medicare benefits under both Part A and Part B should then be subject to an increased deductible, adjusted each year to be large enough to keep Medicare expenditures no greater than Medicare revenues. That would be a modest amount in the first year and would grow slowly over time. Several decades down the line, the deductible would be several thousand dollars per year. If necessary, vouchers could be provided to low-income elderly, sufficient to enable them to cover part or all of the added deductible. At the same time, limits on Medicare reimbursements should be removed so that the program would cover catastrophic expenses without limit. In the end, Medicare would be transformed from a first-dollar insurance plan to a back-up catastrophic program.

While that transformation is taking place, workers should be provided with incentives to start saving to cover their future noncatastrophic expenses below the deductible. That can be done by expanding individual retirement accounts and establishing medical savings accounts.[61]

Allow the Elderly to Opt Out

In addition, each retiree should have the right to opt out of the Medicare system by receiving a voucher equal to the average annual per capita expenditure under Medicare. That voucher could be used to purchase private insurance or HMO coverage or, better yet, to make contributions to a medical savings account. The elderly who chose that option would be protected from both catastrophic expenses and increasingly burdensome Medicare premiums. The vouchers would also allow them to escape the increased rationing and reduced quality of care under Medicare and choose the private coverage and services they prefer.

Some people are concerned that allowing such an opt-out provision would lead to adverse selection, with the healthiest recipients opting for private coverage, leaving the government to provide care for the sickest and most expensive. There is evidence that that has already occurred with Medicare's managed care option. Mathematica Policy Research reports that "beneficiaries with chronic health problems were less likely than healthy beneficiaries to enroll in HMOs." [62]

That is not surprising. In the private sector, HMOs have proven to be more popular among the young and the healthy.[63] Individuals with serious or chronic illnesses are more likely to be concerned about retaining their current physicians, seeing specialists on demand, and avoiding the rationing inherent in managed care. However, evidence from the private sector also indicates that adverse selection does not occur when people can choose medical savings accounts.[64]

There are several ways to minimize the adverse selection problem. For example, adverse selection is likely to be more

pronounced when individuals are able to move freely between types of plans--selecting a medical savings account or managed care when healthy, for example, and shifting back to traditional Medicare when sick. Therefore, the decision to opt out of Medicare should be irrevocable.

Second, the amount of the voucher could be risk adjusted to reflect beneficiaries' age, sex, geographic location, and health status. Thus, older and sicker individuals would receive a larger voucher than younger and healthier beneficiaries. Larger vouchers would increase the options of the former.

Finally, it should be noted that if the current trend toward reducing benefits and rationing care under the Medicare program continues, private-sector options will begin to look increasingly attractive to all Medicare beneficiaries, including those with chronic illnesses.

Raise the Eligibility Age

Finally, the age at which an individual becomes eligible for Medicare should be gradually increased. When Medicare began, its eligibility age was 65, the same as for Social Security. However, the retirement age for Social Security is currently scheduled to be gradually increased to age 67 by 2022. Many proposals for Social Security reform would increase the eligibility age to 70 and make the phase-in more rapid.[65] However, the eligibility age for Medicare will remain 65.

Logically, the eligibility age for Medicare should be linked to that for Social Security and raised at the same rate. That would bring eligibility for Medicare in line with the increase in life expectancy since the program's inception.

Conclusion

The Medicare system is no longer sustainable in its current incarnation as a first-dollar insurance plan. Demographics, technology, and the incentives of a third-party payment system will continue to drive up costs.

The most commonly suggested solutions--raising the payroll tax, increasing premiums, reducing reimbursements, and forcing the elderly into managed care--will not address the problem. Instead, Congress should increase the age of eligibility, raise deductible levels, and allow the elderly to opt out of the system. That would begin the transformation of Medicare to a back-up catastrophic insurance program.

Only through such a revolutionary transformation of the Medicare system can we ensure that the elderly will continue to have access to the health care they need.

Notes

[1] U.S. Department of Health and Human Services, *Medicare and Medicaid: The First Two Decades* (Washington: Government Printing Office, 1985), p. 2.

[2] 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (Washington: Government Printing Office, 1995).

[3] U.S. House of Representatives, Committee on Ways and Means, *1994 Green Book: Overview of Entitlement Programs* (Washington: Government Printing Office, 1994), p. 123.

[4] *Ibid.*

[5] Bipartisan Commission on Entitlement and Tax Reform, *Final Report to the President* (Washington: Government Printing Office, 1995), pp. 12-15.

[6] Lynn Schneider and James Guralnik, "The Aging of America: Impact on Health Care Costs," *Journal of the American Medical Association* 263, no. 17 (May 2, 1990): 229.

[7] David Waldo et al., "Health Expenditures by Age Group, 1977-1987," *Health Care Financing Review* 10, no. 4

(Summer 1989): 118.

[8] Robert Paul and Diane Disney, eds., *The Sourcebook on Post-Retirement Health Care Benefits* (Greenvale, N.Y.: Panel, 1986), p. 296.

[9] Deborah Chollet and Robert Friedland, "Employer-Paid Retiree Health Insurance: History and Prospects for Growth," in *The Changing Health Care Market*, ed. Frank McArdle (Washington: Employee Benefit Research Institute, 1987), p. 206.

[10] U.S. Department of Health and Human Services, *Catastrophic Illness Expenses: Department of Health and Human Services Report to the President* (Washington, November 1986), p. 8.

[11] William Schwartz, "The Inevitable Failure of Current Cost-Containment Strategies," *Journal of the American Medical Association* 257, no. 2 (January 9, 1987): 220-24.

[12] See, for example, Joseph Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine* 305, no. 25 (December 17, 1981): 95-112; Willard G. Manning et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review*, June 1987, pp. 251-73; Martin Feldstein, "Econometric Studies of Health Economics," in *Frontiers of Quantitative Economics*, ed. David Kendrick and M. Intriligator (Amsterdam: North Holland, 1974); Richard Eichhorn and Lu Ann Aday, *The Utilization of Health Services: Indices and Correlates: A Research Bibliography*, NTIS no. PB-211 720 (Beverly Hills, Calif.: Sage, 1972); and Adam Donabedian, *Benefits in Medical Care Programs* (Cambridge, Mass.: Harvard University Press, 1974).

[13] "Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans," Urban Institute, Washington, April 19, 1994.

[14] Michele Davis, "Medicare's Self-Destruction," *Citizens for a Sound Economy Foundation Economic Perspective*, Washington, January 22, 1993, pp. 12-14.

[15] Guy King, remarks delivered to a conference on "The New Medicare Trust Fund Report: Have Things Really Changed?" American Enterprise Institute, Washington, April 1995.

[16] Milton Friedman, "Gammon's Law Points to Health Care Solution," *Wall Street Journal*, November 12, 1991.

[17] Guy King, "Health Care Reform and the Medicare Program," *Health Affairs* 13, no. 5 (Winter 1994): 39-43.

[18] *Bipartisan Commission on Entitlements and Tax Reform*, p. 16.

[19] Using intermediate assumptions. It is worth pointing out that the trustees' intermediate assumptions have almost always proved unduly optimistic. For example, the intermediate assumptions assume that between now and 2002, (1) inflation will remain under 4 percent, (2) real wage growth will average 1.1 percent, (3) life expectancy will not increase by more than 20 percent, and (4) birth rates will remain near their 20-year high. Essentially, the trustees assume that there will be no recessions, wars, natural disasters, or new advances in medical technology. Peter Ferrara, "A Proposal for Reform: Resolving the Medicare Crisis," *United Seniors Association Issue Analysis* no. 4, Washington, April 1995.

[20] 1995 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (Washington: Government Printing Office, 1995), Table II.B.1.

[21] *Ibid.*, Table I.C.3.

[22] *Ibid.*, Table I.C.4.

[23] Ferrara, "A Proposal for Reform," calculated from data in 1994 Annual Report of the Board of Trustees of the

Federal Hospital Insurance Trust Fund and 1994 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund

- [24] 1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, Table I.A.1.
- [25] Donald Lambro, "Swimming Upstream to Rescue Medicare," *Washington Times*, May 11, 1995. p. A17.
- [26] Davis, p. 8.
- [27] Congressional Budget Office, "Aggregate Economic Effects of Changes in Social Security Taxes," August 1982.
- [28] Aldona Robbins, "Social Security: At What Price?" Fiscal Associates, Alexandria, Va., 1986.
- [29] Aldona Robbins and Gary Robbins, "The Effect of the 1988 and 1990 Social Security Tax Increases," Institute for Research on the Economics of Taxation, Washington, 1991.
- [30] Stuart Butler, "Medicare Part B Reform," Heritage Foundation Committee Brief no. 4, Washington, February 15, 1995.
- [31] Peter Ferrara, "A Proposal for Reform," extrapolating from Trustees Reports.
- [32] Butler, p. 4.
- [33] See, for example, Gerald Kominski et al., "The Impact of Medicare's Prospective Payment System on the Use of Hospital Inpatient Services," in *Lessons from the First Twenty Years of Medicare*, ed. Mark Pauly and William Kissick (Philadelphia: University of Pennsylvania Press, 1988). pp 215-35; H. E. Frech, ed., *Regulating Doctors' Fees: Competition, Benefits, and Controls under Medicare* (Washington: American Enterprise Institute, 1991); and Robert Helms, ed., *Health Policy Reform: Competition and Controls* (Washington: American Enterprise Institute, 1993).
- [34] See Michael Morrissey, *Cost Shifting in Health Care* (Washington: American Enterprise Institute, 1993).
- [35] Kevin Hopkins, *Time to Die: The Coming Destruction of American Health Care*, unpublished manuscript, pp. 96-97.
- [36] Robert Pear, "Medicare Paying Doctors 59% of Insurers' Rate, Panel Finds," *New York Times*, April 5, 1994, p. A16.
- [37] Davis, p. 23.
- [38] M. Stanton Evans et al., "Denying Health Care to the Elderly," *Consumers' Research*, July 1992, p. 11.
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