

Staticide

America's Suicidal Healthcare Status Quo

by

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Driving Off a Cliff

The status quo, we're inured to believe, is the safe bet, the conservative option, the riskless alternative. But when the status quo involves driving off a cliff, maintaining it is the risky, radical, indeed, suicidal choice. The United States is now engaged in such *staticide* -- the maintenance of a suicidal status quo. Its policies, primarily those connected with Medicare, Medicaid, and rest of the healthcare system, are driving the country to fiscal, financial, and economic ruin. The only question is when the crash will occur and who will be in the passenger seats.

Financial markets have, it seems, no inkling of what's coming. But these markets often need a two-by-four across the forehead to come to their senses. This is one of those times. Long-term U.S. Treasuries are yielding less than five percent when, in fact, the United States is facing bankruptcy.

Bankruptcy is a very strong word and not to be used lightly. It's particularly hard to justify when the economy is growing well, the deficit is shrinking as a share of GDP, and the stock market is rising. But economic growth and rising stock markets don't preclude economic collapse. Recall that the Great Depression followed the "Roaring" Twenties. Or consider Argentina's decade of outstanding growth and stock market appreciation prior to going belly-up in 2002.

As with physical health, when it comes to economic health, what you don't see can hurt you, even kill you. What the politicians and public don't see, or don't want to see, are the enormous future fiscal obligations facing our government. These obligations are gargantuan for two reasons. First, we have 77 million baby boomers slated to retire over the next 25 years. That's more than twice the number of current elderly. Second, the combined Medicare,

Medicaid, and Social Security (MMS) benefit per boomer will average well over \$30,000 measured in today's dollars. Thirty thousand dollars is incredibly high. It's more than three quarters of current per capita income!¹

Could a time come when Uncle Sam provides the elderly, on average, benefits that exceed three quarters of per capita income? The answer is yes. In fact, Uncle Sam is already doing just that. Today's MMS payment per elderly is \$30,304, which is 79 percent of the current \$38,367 level of per capita income!

Uncle Sam wasn't always this generous. In 1965 the MMS payment to the elderly averaged only 28 percent of per capita income. But over time Uncle Sam has opened his wallet. In 1980 he handed the elderly average MMS benefits equal to 63 percent of per capita income. By 1995 his generosity reached 76 percent. And today it's 79 percent.

The Giver Who Keeps On Giving

Clearly, Uncle Sam is on a roll, and there's every reason to expect his largess to continue. Indeed, in adding Part D – prescription drug coverage – to Medicare, Uncle Sam helped ensure that MMS benefits at the end of this decade will equal 83 percent of Americans' standard of living. And, based on the Congressional Budget Office's intermediate projections, the MMS payment will grow to 88 percent of per capita income by 2020, 91 percent by 2030, 98 percent by 2040, and 106 percent by 2050.

Today's 50 year olds were born smack dab in the middle of the baby boom. In 2035, they'll be smack dab in the middle of their retirements. Their MMS benefit in that year, measured in today's dollars, will average \$50,540-- two thirds higher than today's average.

¹ Per capital income is measured as national income divided by the size of the population.

Multiply 77 million baby boomers by \$50,540 and you arrive at an annual aggregate Medicare, Medicaid, and Social Security payment in 2035 of \$3.9 trillion! That's one colossal amount. To put it in perspective, it's thirty percent of our current \$13.3 trillion GDP.

Of course 25 years from now is a long time and our economy will be much larger than it is today. But it won't take 25 years for the total costs of MMS (Medicare, Medicaid (federal plus state), and Social Security) to become exceptionally large compared to GDP; indeed, they're already very large.

Back in 1965 MSS costs represented 2.5 percent of GDP. Today they represent 9.4 percent. In a decade, they'll constitute 11.9 percent. By 2020 they'll be 13.6 percent. In 2035 they'll represent 18.4 percent. In 2050, they'll total 21.8 percent.

The main culprits here with respect to expanding costs are Medicare and Medicaid. The reason is simple. Their benefits levels have risen and are expected to continue to rise much more rapidly than will Social Security's. Today Medicare plus Medicaid expenditures represent just over half of total MMS spending. But by 2035, the Medicare + Medicaid share of MMS spending will reach two thirds. By 2050 it will reach 70 percent.

If moving from spending 8.7 percent of our nation's output on the elderly to spending 21.8 percent sounds problematic, it is. But given the way Medicare and Medicaid are structured, we'll be incredibly lucky to get away with this size increase. The CBO "intermediate" projection, which entails the aforementioned rise in the MMS-GDP spending share to 21.8 percent by mid century, assumes that Medicare and Medicaid benefits per beneficiary grow in the future at a rate that is only 1.0 percentage point higher than the growth rate of per capita

GDP. That's a truly heroic assumption given that over the past three-plus decades the differential has been not 1.0 percentage point, but 2.6 percentage points.²

When the CBO assumes "higher spending" on Medicare and Medicaid (namely a 2.5 percentage point rather than a 1.0 percentage point differential), the MMS benefit level rises from its current 79 percent share of per capital income to 90 percent in 2015, 96 percent in 2020, 107 percent in 2030, 129 percent in 2040, and 159 percent in 2050. Total MMS spending rises from 9.4 percent of GDP today, to 20.5 in 2035, to 28.5 percent in 2050!

Paying the Piper

Can our country afford to allocate an ever increasing share of its output to the care and sustenance of the elderly? The answer is clearly no. The cost of paying for this largess, given everything else the country has on its plate, far exceeds the capacity or willingness of current and future taxpayers to pay.

The elderly are surely highly valued. Indeed, they are, in many ways revered members of our society. But they are not the majority of the population and never will be, notwithstanding the significant aging of our country. Indeed, according to current projections, the elderly will never constitute more than one quarter of the population. The rest of the population – the children, teenagers, young adults, and the middle aged – also have economic and healthcare needs. And their needs are becoming increasingly pronounced, both in absolute and relative terms.

² See Hagist, Christian and Laurence J. Kotlikoff, "Who's Going Broke? Comparing Healthcare Costs in Ten OECD Countries." NBER working paper, no. 11833, December 2005. Benefit level refers to average benefit paid per person in a given age group. Increasing Medicare or Medicaid coverage among people of a given age as well as raising the benefits paid to those already covered jointly explain the referenced increases over time in benefit levels.

Since 1970 the elderly have received, on average, real (measured in today's dollars) Medicare and Medicaid benefit hikes of 4.6 percent per year.³ At the same time the workers paying for these benefits have experienced real increases in total compensation per hour of only 1.7 percent per year.⁴ In the past 15 years the MMS benefit has risen in real terms by almost 52 percent, whereas median household income has risen by less than 12 percent.

Moreover, much of the increase in total compensation per hour has taken the form of higher employer payments for health insurance, which hardly feels like getting a raise. If you leave out employer-paid health insurance premium payments and other fringe benefits, you find something truly striking -- workers have seen their real wages decline over time at the same time the elderly have been enjoying benefit increases. Average real hourly wages are now actually 3.4 percent lower than they were in 1970! Average weekly earnings are 11.8 percent lower!⁵ In comparison, the real MMS benefit is 200 percent higher today than it was in 1970!

As the elderly have sat back and enjoyed ever greater healthcare benefits – extra benefits that will have to be paid for by today's and tomorrow's workers – working families have experienced more and more difficulty protecting themselves financially from adverse health events. Today 47 million Americans, almost all of working age or younger, have no health insurance. In 1987 the number of uninsured was 32 million. Thus, in two decades we've seen almost a fifty percent rise in the number of uninsured!⁶

Think about 47,000,000. It's an absolutely enormous number on its own terms, but also relative to the number of young and middle-aged Americans. Since there are 267 million Americans under 65, we're talking about almost one in five working age and younger Americans

³ As indicated in the previous note, part of the benefit increase referenced here reflects increases in Medicare and Medicaid coverage rates.

⁴ See table B49, Economic Report of the President, 2006, p. 340.

⁵ See table B47, Economic Report of the President, 2006, p. 338.

⁶ <http://www.ebri.org/pdf/publications/testimony/T126.pdf>

having no health insurance. Lots of our uninsured compatriots are very young, i.e., they are children. Indeed, more than of 8 million of America's uninsured are below age 19.⁷

What happens when uninsured folks show up at the ER with no medical insurance? It used to be they'd get seen and sent the bill later. That's no longer the case. Today many hospitals require that the uninsured charge their treatment. This explains why one in five low- and middle-income households now report charging major medical expenses on their credit cards.⁸ When these households fail to pay their hospital bills, it's not the hospital they stick with the bills. It's the credit card companies. And the credit card companies aren't in the habit of getting stuck. They have no compulsion against charging fantastically high interest rates on outstanding balances and forcing delinquents into bankruptcy.

What a marvelous country we live in. All of a sudden your gall bladder goes south and bingo, you lose your house.

Why Remain at Risk?

Well, you might ask (if you aren't currently paying for your own health insurance), why would anyone remain uninsured if doing so entails so much financial risk? The answer is that buying health insurance on one's own (outside of an employer's plan) is astronomically expensive. Today Blue Cross Blue Shield is charging a family of four living in Boston \$19,757 to buy a plan with full coverage. United Health is charging \$45,166 – an amount larger than U.S. per capita income.⁹

The average premium costs to employers of insuring the health expenses of their employees and their families is lower, but still incredibly high. It's now over \$12,000 per

⁷ Paul Krugman, "A Healthy New Year," *The New York Times*, Monday, January 1, 2007, p. 23.

⁸ Bob Herbert, "Your Master Card or Your Life," *The New York Times*, January 22, 2007, p. 23.

⁹ <http://www.mass.gov/?pageID=ocatic&L=3&L0=Home&L1=Consumer&L2=Insurance&sid=Eoca>

worker for large firms with large numbers of employees. Small businesses with few employees aren't so lucky. They have to pay 80 to 90 percent of the price charged to individual purchasers of health insurance.¹⁰

If all this weren't bad enough, rising healthcare costs are driving American companies broke. Collectively, our nation's firms are now paying some \$500 billion annually in employee and retiree health insurance premiums and health expenditure claims (in the case of companies that self insure).¹¹ It's no coincidence that Ford Motor Company is spending over \$3 billion per year for healthcare for its retirees and current workers, that these costs are rising annually, in real terms, at roughly 6 percent, and that Ford is in the process of laying off 40 percent of its workforce.¹² Nor is it a coincidence that General Motors is sitting on a \$15 billion healthcare liability.¹³

Many employers are starting to wise up and get out of the business of providing health insurance coverage for their workers. In 2000, 66 percent of non-elderly Americans were covered by employer-based health insurance. Today's figure is 59 percent.¹⁴ Those employers that continue to offer their employees health insurance are asking their employees to pay for ever larger shares of the premiums. As a consequence, millions of U.S. workers are declining coverage in their employer's plans.¹⁵

¹⁰ <http://www.kff.org/insurance/7527/upload/7561.pdf>

¹¹ <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.pdf>

¹² <http://www.ford.com/en/company/about/sustainability/report/finCosts.htm>

¹³ http://www.gm.com/company/gmability/workplace/100_news/120_news/uaw_101705.html

¹⁴ <http://www.kff.org/uninsured/upload/7570.pdf>

¹⁵ <http://www.rwjf.org/newsroom/newsreleasesdetail.jsp?id=10408>

What Can't Go On Can Stop Too Late

Herb Stein, the distinguished economist, used to say, "Something that can't go on will stop." That's absolutely true. But when it comes to growth in public and private healthcare costs and the effects of this on individual welfare, employers' bottom lines, and our nation's overall finances, what can't go on can, and likely will, stop too late.

Take the MMS benefit. The level of this benefit is already so high that were it simply to remain steady over time at 79 percent of per capita income, the aging of our population would, by mid-century, raise the share of GDP spent on MMS from 9.3 percent to 14.7 percent. That's 5.4 more percent points of GDP. To put this figure in perspective, total FICA tax revenues currently amount to only 6.4 percent of GDP. So just the aging of our population will eventually require close to a doubling of our current 15.3 percent combined employee-employer payroll tax unless, laugh, laugh, we make provision in advance.

The Overall Fiscal Gap

Given a projection of future MMS spending as well as all other government expenditures, how does one tally up total future spending and compare the size of this fiscal bill with all the tax and other receipts the government can expect to collect in the short, medium, and long runs? The answer is called the *fiscal gap*, which measures the value in the present (the *present value*) of all the government's projected future expenditures (including servicing the national debt) and compares this amount with the present value of all the government's future taxes.

It's very hard to believe, but the U.S. fiscal gap is now close to \$70,000,000,000,000. That's \$70 trillion if you're not used to this many zeros. It corresponds to roughly \$230,000 per American man, woman, and child. Eliminating this fiscal gap will require radical changes in our

nation's fiscal policy, starting with sea changes in the way the government provides healthcare to Medicare and Medicaid participants. But reforming Medicare and Medicaid, while absolutely critical, will do nothing to deal with our two other healthcare crises – the fact that 47 million Americans are uninsured and that exploding health insurance costs are driving companies out of business.

What's needed and what this monograph offers is a universal healthcare plan that provides a single fix for each of these interrelated problems. I call the solution the Medical Security System. It's simple to state and easy to understand. Indeed, its key provisions fit on a postcard permitting even politicians to follow along.

The Game Plan

Before presenting the Medical Security System, I need to lay some groundwork. My first task is to show that the current Medicare and Medicaid systems are driving the nation to the poor house. I do so by documenting the incredibly high historical benefit growth rate in these programs and by pointing out that this growth is excessive both on its own terms and by international standards.

My second task is showing the extent to which excessive growth in Medicare and Medicaid benefit levels is increasing the fiscal gap and how much taxes will have to be raised or spending on other programs cut to accommodate this growth. Be forewarned. This analysis may scare the daylights out of you. If so, that's good. We all need to understand the extent of our staticide if we are going to make the tough decisions needed to change direction.

To be sure, my goal is not to write an economics horror novel. It's to lay out the facts and let you draw your own conclusion. The facts, in the case of the fiscal gap, are not even of

my own assembly. Instead they come by way of a very credible source – the United States Treasury, whose economists first measured the fiscal gap in 2002. These same economists – Jagadeesh Gokhale (now at the Cato Institute) and Kent Smetters (now at the University of Pennsylvania) – have updated their analysis over time. In discussing the current fiscal gap, I'll be simply reporting their latest findings.¹⁶

The initial 2002 Treasury study was commissioned by then Treasury Secretary Paul O'Neill in consultation with then Federal Reserve Chairman Alan Greenspan.¹⁷ The study, which showed a \$45 trillion gap, was due to be included in the President's 2003 Budget. In what was no coincidence, the study was censored by the White House two days after O'Neal was fired (actually drop-kicked) by the President. To their lasting credit and the nation's great benefit, Gokhale and Smetters quickly left the Treasury and published the study as an American Enterprise Institute book.¹⁸

Two tax cuts, huge expansions of Medicare and Medicaid, major military and other discretionary spending hikes, and the accrual of three years of interest later, the fiscal gap stands at close to \$70 trillion. That's right. The true measure of our fiscal shortfall rose by 56 percent in just five years. This is a record of unparalleled fiscal profligacy.

Once one comprehends the magnitude of the U.S. fiscal gap and sees how much Medicare and Medicaid benefit growth contributes to its size, there's only one conclusion to draw. We must stop excessive benefit growth dead in its tracks. The question is how.

This brings me to my third task -- pointing out, albeit briefly, why it's essentially impossible to limit growth in Medicare spending and, to a lesser extent, Medicaid spending given

¹⁶ During 2002 Gokhale was working at the Treasury while on leave from the Federal Reserve Bank of Cleveland. Their most recent fiscal gap study is posted at <http://www.nber.org/papers/w11060>.

¹⁷ Add reference to page in the book on Paul O'Neill.

¹⁸ http://www.aei.org/books/bookID.426.filter.all/book_detail.asp.

the way these programs are structured. This structure has left and will continue to leave the government on the hook to pay for the medical care that its Medicare and, to a lesser extent, Medicaid participants wanted and will want rather than for the medical care the government could and can afford.

There has never been and is not today a fixed/rigid federal budget for Medicare and Medicaid that absolutely cannot be exceeded, come what may. Instead, the government has positioned itself to be responsible, at the margin, for paying whatever the healthcare delivery system and the Medicare and Medicaid participants using the system collectively decide they want to provide and receive in terms of healthcare services. Indeed, the vast majority of Medicare participants and two fifths of Medicaid participants are receiving healthcare under *fee-for-service*. Under this system participants receive the services they want or can cajole out of providers and the government gets to pay the bill; i.e., the fee.

Limiting the Government's Exposure Can Work

There has been a concerted effort in Medicaid to limit costs by enrolling participants, whether they like it or not, in managed care programs. Back in 1991, only 9.5 percent of Medicaid participants were in managed care. Today's figure is 64.1 percent.¹⁹ This growth in managed care has helped limit growth in real Medicaid benefits per enrollee to only 1.02 percent per year since the early '90s. The corresponding annual growth rate between 1970 and 1990 was 5.33 percent. Indeed, while it's not well known, real Medicaid benefits per enrollee were actually lower in 2005 than they were in 2000.

¹⁹ <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/>

Notwithstanding the dramatic decline in the rate of growth of Medicaid benefit levels since 1990, total Medicaid expenditures have continued to explode. The explanation lies in a huge expansion in enrollment in the ensuing years. Medicaid enrollment in 1990 stood at 25.3 million. Today it's north of 60 million!

The fact that growth in Medicaid benefit levels has been held in check coincident with a policy of states contracting with private health maintenance organizations to pay a fixed amount, and no more, to cover their Medicaid participants over the course of the year tells us that moving away from fee for service can work.

But, to be clear, what's special in the Medicaid case is that the government has a degree of coercive power in dealing with the poor that it doesn't have in dealing with the general population, particularly the elderly. The government, in the form of state Medicaid officials, can tell Medicaid participants – “You're in this HMO, like it or not. And whatever the plan covers, that's the maximum you'll get.” Also, the states are free to enroll all their Medicaid participants in a single HMO. This is critically important. It means they can act like a large employer that can get a group rate because the HMO can be relatively assured of the healthcare status of the entire pool of participants. Were the states instead to tell their participants, “Please choose among whatever HMO you'd like.,” the HMOs would need to worry about *adverse selection* – the propensity of those with the greatest risks to seek the most insurance coverage. They'd also have to worry about other HMOs establishing features of their own services, such as free gym privileges, that were designed to attract and thus siphon off the most healthy Medicaid participants and leave the remaining HMOs with the least healthy to insure.

Medicare – You Can’t Get to Medicaid From Here

Could one treat Medicare participants the same as Medicaid participants? In theory, yes. In practice, no. Most Medicare participants are elderly and either middle class or rich. Most are used to getting their way in life. And most vote with great regularity. Politicians know this and live in mortal fear that they will even mildly perturb the powerful oldsters’ lobby group – the AARP (formerly called the American Association of Retired Persons).

Consequently, Uncle Sam has never forced Medicare participants to join HMOs. Instead, Uncle Sam has left the choice up to Medicare participants as to whether or not they’d like to join an HMO. The notion was that HMOs would have every incentive to limit unnecessary medical care because, at the margin, they’d have to pay for it. The hope was that HMOs would introduce enough competition into the medical sector that Medicare would also save money on participants who remained in the traditional fee-for-service program.

Things didn’t work out as expected. The HMOs realized what Congress was up to and sought out the healthiest Medicare participants. At the same time, the least healthy Medicare participants realized that joining HMOs would mean facing restrictions on their access to care. So they stayed away. The result was that the government overpaid many HMOs for taking on the relatively healthy and inexpensive Medicare beneficiaries who actually signed up.

In the case of HMOs who accidentally found themselves with particularly sick and expensive Medicare beneficiaries, the solution was simple – ask the government for more money. When the government refused, these HMOs simply kicked out their existing Medicare patients and stopped taking on new ones. In recent years, half of the HMO programs established by private companies to enroll Medicare participants have closed. In so doing, they told 1.1 million Medicare beneficiaries to get lost.ⁱ

In short, giving Medicare participants discretion in choosing whether or not to join HMOs encouraged *adverse selection*, with the good risks joining the HMOs and the bad risks remaining in traditional Medicare. And since the payments to the HMOs made by Medicare were based on the average cost of participants, Medicare ended up over-paying the HMOs to cover the participants who signed up, thereby costing, rather than saving, the system money.

If repeating the successes of Medicaid in limiting Medicare benefit growth is not possible, what is? The answer is a system of universal healthcare coverage that explicitly limits government payments at the margin, permits consumer choice, but also overcomes adverse selection. Before presenting this proposed new system, I'm going to ask why it is that government is in this business in the first place. The answer is a combination of paternalism and self interest.

The Imperatives of Paternalism

Personally, I'm a paternalist. But my point is not to argue the pros and cons of paternalism, in general, or to defend our nation's particular brand of paternalism. My point is that virtually all Americans, no matter what their political affiliation, religious orientation, or ethnic background subscribe to a common set of paternalistic desiderata, which I'll call the *principles of American paternalism*. Once we collectively and clearly acknowledge this fact and examine where our paternalism begins and ends, it's a pretty straightforward matter to design health insurance and other social insurance programs that satisfy our paternalistic principles at least cost.

As things now stand, we have a set of paternalistic policies, most notably healthcare policies, that don't work, and they don't work in large part because of the desire of certain segments of society to disguise their paternalism for fear of being labeled a liberal, a socialist, a Democrat, an advocate of big government, or something else of that nature.

Worrying about how we sound rather than what we are doing has kept us from enunciating and, thereby, hearing/perceiving our shared beliefs. An example here is providing healthcare to the uninsured. The fact of the matter is that our country – right here and right now -- has universal healthcare; everyone, even the uninsured, gets healthcare in this country. Anyone who is really sick can walk into most emergency rooms in the country's hospitals and receive care regardless of whether or not she/he can pay for it. (They may get stuck with a big credit card bill, but they'll be seen and treated.)

The reason that we effectively have universal healthcare is that almost all Americans feel that someone who is sick and needs to be treated by a doctor, must, in the end, be so treated even if he or she can't pay for the treatment. Whether one wants to call healthcare a right or use some other words is irrelevant to the basic fact that we are securing this outcome for all Americans, albeit in one of the most inefficient and nasty ways possible.

Who picks up the tab for those who aren't packing credit cards when they show up at the ER and who really can't pay their emergency room bills? The answer is the hospitals. And who supports the hospitals? The answer is federal, state, or local government. It may be that a local hospital receives support from local authorities who, in turn, receive support from state authorities, who, in turn, receive support from federal authorities. This support can be of a general nature or earmarked toward healthcare. It doesn't matter. A dollar's a dollar.

By setting things up so that the hospitals look like they are covering those uninsured who either can't or won't pay out of the goodness of their institutional hearts (not to suggest that their hearts aren't good), we try to cover up the fact that it is the government that's really paying these bills. This lets us pretend that this part of our healthcare system is private, when it's actually best characterized as a combined public/private system.

The mixed public/private nature of our nation's healthcare system is, in fact, ubiquitous. There is no element of our current system that doesn't incorporate very significant public as well as private components. Employer-provided health insurance is a case in point. The fact that employer-based health insurance premiums are not taxable represents an enormous public subsidy. Indeed, one can just as well say that what's going on is that a) the workers covered by these policies receive no tax break, but b) the government directly pays part of the workers' insurance premiums.

The bottom line is that we have now and have long had what amounts to universal healthcare. And this system has been and still is neither public nor private, but public/private. Our current public/private healthcare system delivers, as a rule, excellent care. But it's also incredibly expensive, inefficient, and exceptionally dangerous to maintain.

Our goal then should be to come up with a new healthcare system that works rather than perpetuate the old one that doesn't. In the process we can kill three birds with one stone. First, we can eliminate runaway spending on Medicare and Medicaid by incorporating all their participants and all other Americans in the new Medical Security System that will operate under a planned and affordable budget.²⁰ Second, we can provide explicit, rather than implicit insurance coverage to the 47 million Americans now uninsured. Third, we can get the 800-pound health insurance-cost gorilla off the backs of America's businesses by providing all Americans, including all American workers, with a new public/private healthcare insurance system.

²⁰ Together with Scott Burns, I proposed the MSS plan in our recent book, *The Coming Generational Storm*, MIT Press, 2004. As we indicated in the book, the essence of the plan was originally conceived by economists Peter Ferrara at the Institute for Policy Innovation and John Goodman, President of the National Center for Policy Analysis. Economists Victor Fuchs and Ezekiel Emanuel proposed essentially the same reform in June 2005: <http://www.washingtonmonthly.com/features/2005/0506.emanuel.html>. Niall Ferguson and I also advance the plan in *The New Republic* in August 2005: <http://people.bu.edu/kotlikof/The%20New%20Republic%208-15-05.pdf>

This will be my final task – persuading you that the Medical Security System is precisely the medicine needed to cure the patient. But before prescribing this penicillin, I will consider and critique alternative universal healthcare reforms, including the plan developed by Senator Clinton in the early 1990s and the state-managed healthcare systems that are prevalent in many parts of the developed world. I’m going to do this quickly. My goal is not to get into the myriad details of what’s been proposed and what’s being used elsewhere, but to explain these options in broad terms and point out why they don’t really fit the bill.

I also want to persuade you that the Medical Security System (MSS) will not only save an immense amount of money over time, but that its short-term costs are much smaller than you might think (and I also thought). The reason is that the government, by which I mean federal, state, and local governments combined, is already paying a very large share of the country’s total health expenditures and an even larger share of the health expenditures that the MSS plan would cover.

With respect to overall healthcare expenditures, the government’s (federal, state, and local) current spending share is roughly 60 percent.²¹ This 60 percent figure includes not only direct expenditures on Medicare, Medicaid, workers’ compensation, the Department of Veterans Affairs, public hospitals, and government public health activities. It also includes what now amounts to over \$200 billion in so-called *tax expenditures*.²² In this context, tax expenditures reference the loss of federal income and payroll tax revenue and state and local income tax revenue due to the exemption of employer-paid health insurance premiums as well as a range of tax breaks provided for employee-paid health insurance premiums.

²¹ <http://jama.ama-assn.org/cgi/reprint/289/9/1165.pdf>

²² <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.pdf>

Over time the government's share of *total* U.S. healthcare spending will rise significantly for three reasons. The first involves the recently-enacted Medicare Part D prescription drug benefit. Expenditures on Medicare Part D net of participant and state premium payments are slated to grow rapidly over time due to projected increases in enrollment and increases in the real costs of prescription medications.²³

The second reason is demographic. Recall that compared with health expenditure in general, government healthcare spending is concentrated on the elderly. A total of 84 percent of Medicare participants are aged, with the remainder being disabled workers, most of whom are older workers. As for Medicaid, although three quarters of its enrollees are children and their parents, 70 percent of Medicaid spending is on elderly and disabled participants, most of whom are at least middle aged if not older. Consequently, as the nation ages, Medicare and Medicaid spending will rise as a share of national health expenditures.

A third factor is the likely further decline in employer-provided health insurance coverage. As indicated above, employers are slowly, but it appears surely, getting out of the health insurance business, which is one of the main reasons that the ranks of the uninsured swelled by over 5 million between 2000 and 2003.²⁴ As the number of the uninsured continue to expand, more and more of the responsibility of covering their healthcare costs will fall on Medicaid as well as the largesse of public hospitals and clinics. Indeed, in recent years most of Medicaid expenditure growth has been driven by increases in enrollment. Between 2000 and 2003, for example, the number of families enrolled in Medicaid grew by 19.5 percent!²⁵

²³ Over the next decade alone the CBO forecasts that Medicare Part D net spending will rise from .3 to .8 percent of national income. <http://www.cbo.gov/showdoc.cfm?index=6139&sequence=0>

²⁴ <http://www.kff.org/medicaid/upload/Medicaid-Enrollment-and-Spending-Trends-Fact-Sheet.pdf>

²⁵ *Ibid.* My sense is that the CMS has not yet fully incorporated the imminent meltdown of employer-provided health insurance in either its Medicaid or Medicare spending projections.

A fourth factor is the ongoing rise in income inequality. Between 1980 and 2000 the share of pre-tax income received by the 1 percent of Americans with the highest pre-tax incomes rose from 8 percent to 14 percent.²⁶ Since higher-income Americans are in higher tax brackets and have relatively more expensive health insurance policies, increases in income inequality means increases in the size of overall federal and state health-related tax expenditures – the income and payroll tax breaks associated with employer-paid and, to a lesser extent, employee-paid health insurance premiums.

What do these four factors imply for the likely rise in the government share of overall health expenditures? My reading of CMS (Centers for Medicare and Medicaid Services) projections,²⁷ my consultation with economist John Shields, who has done a careful recent study of healthcare tax expenditures, and my consideration of trends in health insurance coverage and employer-provided health insurance suggests that the government share of total U.S. health expenditures will rise from its current roughly 60 percent value to 70 percent within a decade.

This 70 percent figure means that, in the short term, government healthcare spending would need to rise by only 43 percent (30 percent divided by 70 percent) were the government to pay for all current U.S. healthcare expenditures. But this overstates the requisite short-term rise in government spending under the MSS plan for two reasons. First, only about 90 percent of national healthcare expenditures represent expenditures that would need to be covered by the MSS plan. For example, the MSS plan would not cover routine dental care, plastic surgery, or non prescription medications. Nor would it need to cover private healthcare investment.

Second, there is surely another 10 percent of costs that can be wrung out of the system by having a uniform method of administering and insuring for healthcare. Indeed, of every dollar

²⁶ Picketty, Thomas and Emanuel Saez, “The Evolution of Top Incomes: A Historical and International Perspective,” National Bureau of Economic Research working paper no. 11955, 2006.

²⁷ http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage

now spent on U.S. healthcare some 20 to 30 percent appears to be spent on bureaucracy and administration.²⁸ The typical U.S. hospital spends a quarter of its budget on billing and administration, which has, as far as one can tell, no curative powers!

Once one adjusts for the healthcare spending that would not need to be covered by MSS and also accounts for administrative saving, it appears that what our government (broadly defined) will likely spend on healthcare in the short term would cover almost 90 percent of what the MSS would cost!

²⁸ See Anna Bernasek, "Healthcare Problems? Check the American Psyche." *New York Times*, December 31, 2006. <http://www.nytimes.com/2006/12/31/business/yourmoney/31view.html?pagewanted=2&ei=5088&en=3e09a7e6344af55a&ex=1325221200&partner=rssnyt&emc=rss>

*Who's Watching the Shop?*²⁹

The table below shows two sets of average annual real growth rates for ten OECD countries over the 32 year period 1970 to 2002. The first column records growth rates in benefit levels, by which I mean the real levels of government healthcare spending *per person at a given age*. The second column shows growth rates in real levels of per capita output. The third column provides the ratio of the entries in column one to those in column two.

The age-specific benefit level, as defined here, can rise for two reasons. First, the government can increase the medical goods and services provided to those of a given age group who are enrolled in its healthcare programs. Second, the government can enroll in its programs a larger share of the population at that age.

As the table shows, benefit level growth rates are *very* high in all ten of the OECD countries considered. But they are particularly high in the case of the U.S., Spain, and Norway. Norway's 5.04 percent rate is the highest, Spain's 4.63 percent rate is second highest, and the U.S.'s 4.61 percent rate is third highest. Canada recorded the lowest growth rate in benefit levels, namely 2.32 percent. Canada and Sweden are the only countries among the ten with a benefit growth rate below 3.00 percent.

The U.S. 4.61 percent annual benefit growth rate is 2.29 times higher than the growth rate in its living standard, measured by per capita GDP. The absolute difference between the U.S. benefit and per capital GDP growth rates is 2.60 percentage points. This is huge and, to repeat, far greater than the 1.00 percent points assumed by the Congressional Budget Office in projecting future Medicare and Medicaid benefit growth.

²⁹ This chapter draws heavily on Hagist and Kotlikoff (2005), *op. cit.*

Benefit levels have grown faster than living standards in all ten countries. But the U.S. is at the top (or bottom, depending on your perspective) of the class when it comes to the size of the differential. This has important implications for assessing the relative fiscal health of the U.S.

**Average Annual Real Growth Rates from 1970 to 2002
in Healthcare Benefits and Per Capita GDP³⁰**

Country	Benefit Level	Per Capita GDP	Ratio
US	4.61%	2.01%	2.29
Germany	3.30%	1.54%	2.14
Australia	3.66%	1.76%	2.08
Spain	4.63%	2.34%	1.98
Norway	5.04%	3.06%	1.65
UK	3.46%	2.11%	1.64
Austria	3.72%	2.44%	1.52
Japan	3.57%	2.44%	1.46
Sweden	2.35%	1.68%	1.40
Canada	2.32%	2.04%	1.14

Source: Hagist and Kotlikoff (2005)

Compare, for example, the U.S. and Japan. As indicated in the table below, both countries are aging, but Japan is aging much more rapidly and extensively. Indeed, thanks to its incredibly low fertility rate of roughly 1.2, Japan's population is already shrinking. By mid

³⁰ The growth rates are geometric averages.

century 37 percent of Japan's population will be age 65 and older. In comparison, the U.S. elderly population share will equal only 21 percent. The ratio of 37 to 21 is 1.76, which is pretty sizable.

But that's not the only factor involved in determining overall healthcare costs. The other key factor is the growth in benefit levels. If the U.S. and Japan experience for the next 44 years the same average annual growth rates that they clocked between 1970 and 2002, benefit levels in the U.S. in 2050 will be 7.26 times higher than they are today. In Japan they'll only be 4.68 times higher. The ratio of 7.26 to 4.68 is 1.55, which is also quite sizable.

Elderly Share of the Population

(percent)

Country	2002	2030	2050	2070
Australia	12.2	20.4	24.0	25.2
Austria	15.5	24.4	29.1	31.1
Canada	13.0	23.6	26.7	27.1
Germany	17.1	26.3	30.6	31.3
Japan	18.0	29.9	36.8	37.7
Norway	15.1	21.0	23.6	24.5
Spain	16.2	24.2	34.0	30.0
Sweden	17.2	25.5	28.5	29.3
UK	15.9	22.9	26.1	27.3
US	12.4	19.1	21.3	21.6
Average	14.8	22.6	25.9	25.6

Source: United Nations (2005)

Of course, the differential in benefit growth rates could continue beyond 2050. The differential could also widen over the short and medium term. In fact, there is good reason to expect such a widening. The Japanese government, like all OECD governments apart from the U.S., has direct control over its healthcare expenditures; i.e., the government directly funds the hospitals, hires the doctors and nurses, buys the medicines, determines who gets what operations, etc. If the Japanese government so desires, it can directly limit spending on healthcare from one day to the next. In the U.S. case there is no such direct control. To reiterate, Medicare and, to a lesser degree, Medicaid participants effectively decide how much healthcare services they'd like and send most of the bills for these services down to Washington. Uncle Sam has no surefire way to turn off the faucet.

The Japanese are now facing intense budgetary pressures because Japan is already very old and will get much older over time. Consequently, the Japanese government has begun to exercise its direct control over healthcare expenditures and appears very serious about bringing an expedient end to benefit growth in excess of growth in per capita GDP.³¹

What's true of Japan is also true of other OECD countries. The governments in those countries are all likely to be much more effective over the short and medium terms in limiting their spending on healthcare than is the U.S.

So what? What's the import of U.S. benefit growth rates outstripping most other OECD countries in the future by an even greater margin? The import is that this factor can readily leave the U.S. in the worst long-term fiscal position of any developed country. Yes, aging matters. And yes, compared with other OECD countries, the U.S. is relatively young and will remain so

³¹ <http://content.healthaffairs.org/cgi/content/abstract/23/3/26?ck=nck>

over time. But the power of compound growth is staggering and potentially a much more significant factor than demographics in determining the relative sizes of countries' fiscal gaps.

The table below confirms this point. It shows the present value of government healthcare projections as a share of the present value of GDP for the ten OECD countries. This analysis fully incorporates projected demographic changes in each country and assumes that the historic (1970-2002) benefit growth rates will prevail for the next four decades after which point benefit growth will fall in line with growth in per capita GDP. The calculations use a 3 percent real discount rate, which seems reasonable given recent real returns on U.S. inflation-indexed bonds.

**Present Value of Government Healthcare Expenditures
as a Percent of the Present Value of GDP**

Country	Percent
U.S.	18.8%
Germany	15.0%
Australia	13.7%
Spain	11.9%
Norway	17.2%
UK	11.4%
Austria	9.5%
Japan	12.9%
Sweden	10.6%
Canada	11.7%

Source: Hagist and Kotlikoff (2005)

Once again we see the U.S. in a “leadership” position. Its present value government healthcare costs equal 18.8 percent of the present value of each dollar of the nation’s projected future output. The size of this figure is astounding in its own right. In non-economese it means that the U.S. is, under the stated assumptions, on a course to spend close to one fifth of all future output (measured in the present) on two healthcare programs that, to repeat, cover only a minority of the population.

Equally astounding is the top ranking of the U.S. with respect to long-term health costs measured as a share of its long-term output. This is true despite the U.S. having the youngest population of any of the ten countries over the long term. Japan, which is the oldest of the ten countries and will remain so throughout the century, has present value healthcare costs totaling only 12.9 percent of its future output. This figure is almost one third less than the U.S. figure.

What’s the upshot of this international comparison? First benefit growth can be more important than demographics in determining how much Uncle Sam will spend in the future on healthcare. Second, the U.S. may be in the worst long-run fiscal shape of any of the OECD countries because it has had, and may well continue to have, explosive benefit growth that either outstrips or far outstrips benefit growth in other developed countries.

Who’s To Blame?

The 4.61 percent U.S. annual Medicare and Medicaid benefit growth rate recorded between 1970 and 2002 is not the achievement of one administration or one political party. Five Republican presidents – Nixon, Ford, Reagan, Bush I, and Bush II – and two Democratic

presidents – Carter and Clinton – were nominally watching the shop as money flew out its windows to fund ever higher levels of benefits.

Of course each year that benefits rose, on average, by 4.61 percent, the benefit increase represented not just a bonus for Medicare and Medicaid participants in that year, but in future years as well. The reason is that, in this country, benefit increases have never been reversed and likely never will.

Thus, when President Clinton permitted real Medicare benefit levels to rise by 25 percent in his first term in office, he was effectively increasing not just immediate Medicare spending by one quarter, but the present value of all future expenditures as well. That increase in future obligations was not reported in the President’s budget for a good reason. The Clinton administration did just what the Bush II administration did in 2002. It censured a long-term fiscal analysis a few weeks before it was to be published in the President’s budget.³²

The motivation for the censorship was, in both cases, the same. First, make sure no one focuses on the true increase in the nation’s indebtedness. Second, maintain public focus on the official deficit even though official debt represents less than 10 percent of the overall fiscal shortfall that we “grownups” apparently expect to bequeath to our children.

The current occupant of the White House is certainly doing nothing to limit growth in healthcare spending. Indeed, according to the General Accountability Office, the new Medicare Part D prescription drug benefit has a present value cost in excess of \$8 trillion. Its introduction is one reason annual growth in Medicare benefit levels is projected to average 5.52 percent per year over the course of George Walker Bush’s eight years of “leadership.”

³² Gene Sperling is the “economist” primarily responsible for this censoring OMB’s generational accounting analysis, which I helped co-author. Sperling now claims to be seriously concerned about the nation’s long-term fiscal problems; see, e.g., http://www.ndol.org/ndol_ci.cfm?contentid=250877&kaid=125&subid=162.

Understanding Growth in Benefit Levels

Clearly, the introduction of new types of healthcare coverage, like prescription drug coverage, can play a major role in explaining growth in healthcare benefit levels. But there are two other critically important factors. One is a rise in usage of the healthcare system and the existing specific services it provides. The other is the introduction of new services, which are often more advanced and, in many cases, more costly.³³

The acquisition of CT scanners in Spain illustrates the role of these other two factors. In 1984 Spain had only 1.6 CT scanners per one million inhabitants compared with 11 per million in the United States.³⁴ By 2001 Spain had 12.3 CT scanners per one million inhabitants versus 12.8 in the United States.³⁵ Of course having so many more CT scanners meant being able to serve a lot more people. Consequently, there was a huge expansion in CT usage in Spain. Japan also expanded its availability and use of medical technology over the 32-year period. In fact, Japan now appears to have the largest number of CTs of any developed country.³⁶

Sometimes new technologies can provide a cheaper solution to an existing medical problem yet still end up costing more money by inducing much greater demand, especially when the government is paying for their use. Health economists David Cutler and Mark McClellan provide a good example of this in their study of angioplasty.³⁷ They point out that prior to the

³³ See Joseph P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives*, Vol. 6, No. 3, 1992, pages 9-16; and Peter Zweifel, "Medical Innovation: A Challenge to Society and Insurance," *Geneva Papers on Risk and Insurance: Issues and Practice*, Vol. 28, No. 2, 2002, pages 194-202.

³⁴ As reported in Organization for Economic Coordination and Development, *Health Data 2004*, 3rd. edition (Paris: OECD, 2004).

³⁵ See OECD, *Health Data 2004*.

³⁶ For this point, see also Uwe E. Reinhardt, Peter S. Hussey and Gerald F. Anderson, "Cross-National Comparisons Systems Using OECD Data," *Health Affairs*, Vol. 21, No. 3, 2002, pages 169-181.

³⁷ Cutler, David and Mark McClellan, "Is Technological Change in Healthcare Worth It?," *Health Affairs*, 20(5), 2001, 11-29.

introduction of angioplasty (rotor rootering one's arteries), heart patients who wanted to have their pipes cleaned (actually replaced) had to undergo painful and risky coronary bypass surgery. Given the pain and risk of the procedure, bypass surgery was only used for those in critical need. But with the advent of angioplasty, which involves much less invasive surgery, the demand for pipe-cleaning shot way up. And so did the collective pipe-cleaning expenditure, much of which, of course, is being paid by Uncle Sam or should I say our kids?

Consumer Sovereignty or Fiscal Child Abuse?

As our country has grown richer, we've spent an ever larger share of our output on healthcare services and products. In 1960 the share was just 5 percent. Today it's 17 percent.³⁸ The association of higher incomes with disproportionately higher healthcare spending is evident in the table as well. The ratios of the ten OECD countries' benefit growth rates to their per capita GDP growth rates range from 1.14 (Canada) to 2.29 (the United States). The average value of this ratio equals 1.73 meaning that for each 10 percent increase in per capita income there is a 17.3 percent increase in government spending on healthcare.³⁹

Many economists view the income-healthcare spending relationship as evidence that healthcare is a "superior good."⁴⁰ A luxury good refers to a good or service that garners a larger share of a household's budget as its income rises. The fact that there are superior goods as well as *inferior* goods, like Spam, to which households allocate a smaller fraction of their incomes as

³⁸ <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf>,
<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

³⁹ See Table 3 in Laurence J. Kotlikoff and Christian Hagist, "Who's Going Broke?"

⁴⁰ For a discussion and an overview of several studies concerning income elasticities of healthcare expenditures, see Jennifer Roberts, "Sensitivity of Elasticity Estimates for OECD Healthcare Spending: Analysis of a Dynamic Heterogeneous Data Field," *Health Economics*, Vol. 8, No. 5, 1999, pages 459-472.

their incomes rise, is reflective, to these economists, of consumer preferences and viewed as a legitimate exercise of consumer sovereignty.

But what's going on with respect to government healthcare spending cannot simply be viewed as the government acting as the faithful servant of today's households, applying their preferences, and exercising their consumer sovereignty. The reason is that current governments are not necessarily spending the incomes of current households. Indeed, given the way the U.S. and many other OECD countries have been financing healthcare spending, one might best characterize what's going on as today's households deciding how to spend on themselves the incomes of tomorrow's households and using governments to implement these decisions.

Stated differently, given the way the U.S. and other governments do their bookkeeping and discuss their policies, it's very hard to know how the cost of paying for a given year's rise in government healthcare spending and, indeed, any type of government spending will be allocated across generations. Consequently, we can't simply view growth in the ratio of government healthcare spending to GDP as a benign process in which today's households decide to allocate a larger share of their higher incomes on existing and improved medical goods and services. Instead, we might best consider this process as a manifestation of intergenerational expropriation whose full extent is unclear.

Expenditure Growth through Enrollment

As indicated, much of the recent growth in total Medicaid spending has arisen due to growth in enrollment. The government, noticing an ever larger fraction of the population without insurance coverage, has stepped in to provide direct coverage, particularly to households that are not far above the poverty line. Medicare spending growth has also been fueled by

enrollment growth, in this case by the inclusion of the disabled and the growth in their numbers. Today there are more than 42 million Medicare enrollees – roughly one quarter more than in 1990. Our nation now has over 300 million people. Medicare and Medicaid together cover 100 million. This leaves another 200 million Americans who can be added to the rolls by politicians seeking re-election. This potential for expanding enrollment in conjunction with explosive growth in benefits per enrollee, which, by and large, has been the historic norm, has the potential to expand our nation’s fiscal gap well beyond its current level of \$70 trillion.

Benefit Growth and the Fiscal Gap

The fact that the vast majority of Medicare plus Medicaid expenditures go to the elderly, that average Medicare plus Medicaid payments rise with age, and that the U.S. is aging all suggest that higher benefit growth could substantially worsen the fiscal gap. Gokhale and Smetters’ work supports this concern. Their analysis suggests that were Uncle Sam to let benefit levels grow 2 percentage points faster than per capita GDP rather than just 1 percentage point faster (CBO’s assumption), the fiscal gap could widen by over 30 trillion!⁴¹ (Recall, the historic average is 2.6 percent faster.) Conversely, limiting benefit growth immediately to the rate of growth of per capita GDP could rid the country of close to half of its fiscal gap.

⁴¹ Gokhale, Jagadeesh and Kent Smetters, *Fiscal and Generational Imbalances –New Budget Measures for New Budget Priorities*, The American Enterprise Institute, 2003, http://www.aei.org/docLib/20040217_book426.pdf

Restraining Expenditure Growth – An Anatomy of Failure

The government has tried over the years to limit Medicare and Medicaid expenditure growth using various means. In the case of Medicare, Uncle Sam tried before 1983 to pay Part A (hospital care) providers on “a reasonable cost basis.” Since then it’s been using the *prospective payment system* (PPS), which entails classifying each patient as falling into a diagnosis-related group (DRG) and giving the hospital a fixed amount of money for that DRG. Part B (outpatient care) Medicare reimbursements were also originally set on a “reasonable charge” basis. But since 1992 most reimbursements have been made on the basis of a fee schedule. Medicare Part C pays a fixed amount per Medicare participant who enrolls in an HMO. And Medicare Part D pays a variable amount based on a pre-set formula for prescription medications.

Medicaid has similar reimbursement methods and, as indicated, is increasingly enrolling participants in HMOs. One big difference between Medicare and Medicaid is that the federal and state governments share Medicaid costs. The federal share differs by state, but can range from 50 to 83 percent. The fact that states don’t pay, at the margin, the full cost of expanding their Medicaid coverage and benefit levels is part and parcel of why Medicaid spending has grown and continues to grow so rapidly.

In a recent study, Kenneth Thorpe and David Howard, two professors at Emory University’s School of Public Health, took a careful look at total Medicare spending growth between 1987 and 2002.⁴² They did so by allocating expenditures based on medical conditions. They focused especially on the top ten medical conditions, which, according to their calculations, are associated with two-thirds of the growth in Medicare expenditures over the 15-year period.

⁴² Kenneth E. Thorpe and David H. Howard, “The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity,” *Health Affairs*, 25, no. 5 (2006): 378-88.

One of these conditions is heart disease. According to their exhibit 1, reproduced below, 12.4 percent of the 15-year increase in total Medicare spending fell into the heart disease category.⁴³ A total of 61.3 percent of this 12.4 percent figure can be traced to there simply being more Medicare participants who happened to have heart conditions. Another 33.0 percent of the 12.4 percent arose from higher costs per heart disease case. And the final 5.7 percent share of the 12.4 percent is due to higher prevalence, meaning that any given Medicare enrollee had a higher chance of being treated for heart disease in 2002 than in 1987.

The explanation of the expenditure increases differ from condition to condition. In the case of diabetes, for example, prevalence is a much more important factor, explaining a third of the spending increase in that category.

In general, prevalence shows up in the table as a major force behind the increased spending. Thorpe and Howard's second table, reproduced below, shows that prevalence rose across all medical conditions. For example, in 1987 there was a 34.8 percent chance that a Medicare beneficiary was treated for hypertension. In 2002 there was a 44.9 percent chance.

The high and rising prevalence rates for so many conditions suggests that Medicare participants typically have more than one condition and that more participants are developing multiple ailments over time. This, in fact, is exactly the case. According to Thorpe and Howard, 31 percent of 1987 participants were treated for 5 or more conditions, with these participants accounting for half of total Medicare spending. In 2002 over half of Medicare participants were treated for 5 or more conditions! This is quite remarkable.

⁴³ Please note that in both exhibits 1 and 2 presented here "Source: authors'" refers to Thorpe and Howard.

EXHIBIT 1**Change In Health Care Spending And Treated Disease Prevalence Among Medicare Beneficiaries For The Top Ten Medical Conditions, 1987–2002**

Condition	Percent of change in total health care spending associated with the condition, 1987–2002	Percent of change due to		
		Change in prevalence	Change in cost per case	Change in enrollment
Heart disease	12.39	5.7	33.0	61.3
Mental disorders	9.65	42.3	26.5	31.2
Trauma	7.50	2.9	53.1	44.0
Arthritis	6.83	19.5	38.6	41.8
Hypertension	6.76	13.7	65.6	35.7
Cancer	6.08	35.7	0.8	63.5
Diabetes	5.46	33.9	24.3	41.8
Pulmonary conditions	4.28	42.1	10.9	47.0
Hyperlipidemia	3.86	64.9	7.2	27.9
Cerebrovascular disease	3.40	50.3	4.8	44.9
Total	66.20			

SOURCE: Authors' tabulations based on data from the 1987 and 2002 Medical Expenditure Panel Survey (MEPS), using methods based on S.W. Zuvekas and J.W. Cohen, "A Guide to Comparing Health Care Expenditures in the 1996 MEPS to the 1987 NMES," *Inquiry* 39, no. 1 (2002): 76–86.

The multiple-sick Medicare participants are costing the system big bucks. To quote Thorpe and Howard, "Virtually all of the spending growth since 1987 can be traced to patients treated for five or more conditions."

What's going on? Are the elderly getting sicker or are they simply seeing their doctors more often, being screened for and diagnosed with particular diseases at earlier stages, or are they just being classified in multiple morbidity categories in order to enhance Medicare reimbursement?

EXHIBIT 2
Age-Adjusted Treated Disease Prevalence Among Medicare Beneficiaries, 1987, 1997, And 2002

Condition	1987	1997	2002
Hyperlipidemia	2.6%	10.7%	22.2%
Mental disorders	7.9	13.1	19.0
Hypertension	34.8	37.6	44.9
Osteoporosis and other bone disorders	2.2	5.2	10.3
Pulmonary disorders	15.5	22.0	23.5
Endocrine disorders	14.5	21.4	22.4
Arthritis	21.2	21.5	27.0
Diabetes	11.4	13.7	17.5
Upper GI	6.6	10.3	16.4
Back problems	6.2	8.4	11.3
Other GI	3.4	7.4	7.6
Skin disorders	12.9	14.4	16.8
Lupus	7.7	10.0	11.9
Cancer	10.3	12.5	13.0
Infectious disease	5.3	6.0	6.8
Heart disease	27.0	26.1	27.8
Cerebrovascular disease	2.5	4.6	4.1
Kidney disease	2.2	2.3	3.3
Pneumonia	2.3	3.8	3.4
Trauma	15.8	14.3	16.4

SOURCE: Authors' tabulations based on data from the 1987 National Medical Expenditure Survey (NMES) and the 1997 and 2002 Medical Expenditure Panel Survey (MEPS).

NOTE: GI is gastrointestinal.

All three factors are at play. One indication that the elderly are, indeed, experiencing more morbidity is the size of their waist lines. Back in 1987, fewer than one in ten Medicare beneficiaries were obese. Today's figure exceeds two in ten. Clearly, all those Krispy Kreme

donuts are doing real damage. But Thorpe and Howard also point a finger at the docs for more aggressively treating and, in some cases, over-treating their patients. They report, in this regard, that three of every five Medicare participants with 5-plus conditions claimed in 2002 to be either in excellent or in good health! In 1987 the proportion was only one in three.

In addition to seeing doctors for more ailments, patients are seeing their doctors for any given ailment more often, and each ailment is being treated over time with a different, and generally more expensive, mix of services (e.g., MRI rather than X-Ray).

In considering this expenditure growth process the key thing to keep front and center is that the government has very limited control over what it spends. Uncle Sam may say that he'll pay \$X and only \$X when a doctor sees a patient with condition Y. But the patient is free to see the doctor as often as they both deem appropriate; the patient is free to see multiple doctors for the same ailment; any of these doctors can determine that the patient has conditions Q, R, and S as well as Y; and each can prescribe the most expensive testing and treatment plan available.

I trust you are getting the point. This is no fixed limit on the government's combined Medicare and Medicaid expenditure liability in a given year or over time. Instead, these spending machines are largely on autopilot and will remain that way until we radically change the way the government organizes and pays for healthcare.

The Stakes Involved

Let's assume, for the moment, that we make no changes to our current healthcare system and that future growth in Medicare and Medicaid spending accords with the Congressional Budget Office's projections. Under this *highly optimistic* scenario, the country is, as we know, short today, not tomorrow, a measly \$70 trillion.

It's hard to wrap one's brain around \$70 trillion. But let's try. The following are four ways one could come up with \$70 trillion in present value without cutting future growth in Medicare and Medicaid. Each of these policies would need to be implemented *immediately and permanently*.

- **Raise personal and corporate federal income taxes by 70 percent.**
- **Raise payroll tax rates by 109 percent.**
- **Cut federal discretionary spending by 91 percent.**
- **Cut Social Security benefits by 90 percent.**

Adopting any of these policies or some combination would be incredibly painful. But waiting is no alternative. It just makes the requisite adjustments larger and more difficult. Another option is to partially implement each of the four policies; for example, we could implement each policy at one fourth strength. But implementing one fourth of four terribly painful policies still adds up to one terribly painful course of action.

The reality is that no American politician would endorse any of these policies or, for that matter, any combination of them that produces \$70 trillion in present value.

So what exactly will happen if we don't radically reform the healthcare system and simply let Medicare and Medicaid expenditures continue to grow? The answer is that the government will need to make money by making money, i.e., *by printing it*. This practice dates to at least the 3rd Century AD when the Romans ran a tremendous hyperinflation.

In the last century 20 countries ran hyperinflations by printing money to pay their bills. The most famous example is the hyperinflation in the early 1920s in Weimar Germany. Prices rose so fast that workers were paid in wheelbarrows full of cash, which they immediately used to purchase goods so their money wouldn't be worthless by the next day.⁴⁴

The U.S. is hardly immune to hyperinflation. This is why David M. Walker, Comptroller General of the United States, and Ben Bernanke, Chairman of the U.S. Federal Reserve, are pulling their remaining hairs out worrying about our long-run fiscal situation.⁴⁵ They realize that financial markets can turn on a dime when they start to smell a problem. Doing so in this context means that investors would lose confidence in the dollar and unload their holdings of U.S. securities, particularly long-term U.S. Treasury bonds. This would lead to a crash of both U.S. bond and stock markets, drive up nominal and real interest rates, and force the Federal Reserve to try to lower interest rates by buying up U.S. bonds. Doing so will require the Fed to create (print) money -- precisely what the financial markets will come to fear because they know it fuels inflation.

The point of describing this process is to indicate that when fiscal policy gets sufficiently out of control (the U.S. situation), central banks start to lose control of their monetary independence and are forced to accommodate the inflationary process.

⁴⁴ http://www.pbs.org/wgbh/commandingheights/shared/minitext/ess_germanhyperinflation.html provides a nice description of the German hyperinflation.

⁴⁵ See <http://www.gao.gov/cghome.htm> and <http://www.federalreserve.gov/boarddocs/testimony/2007/20070118/default.htm>

How high would inflation get in the U.S.? Very high. Most federal government expenditures are explicitly or implicitly indexed to inflation, so to really make money by making money the government will have to beat the indexation, which means running ever higher levels of inflation. Running a high inflation, let alone a hyperinflation, would mean dramatic increases in not just nominal, but also real interest rates, which would severely damage the economy as well as its revenue-generating capacity.

Ok, so is it time to panic? No, it's time to take a clear look at what we are doing with respect to healthcare and make the radical changes in policy needed to shave trillions off the country's fiscal gap while also providing healthcare on a uniform basis to all Americans. To that end, let's start by recognizing the imperatives of our nation's paternalism.

The Imperatives of Paternalism

Socialism is, of course, the boogeyman of libertarians and many Republicans, and for good reason. They connect the word “socialism” with Soviet-style collectivization, which represented the ultimate form of state control and which trampled the rights and liberties of hundreds of millions of people for much of the last century. State power, state control, state intervention, state regulation – the very recitation of these words makes a true libertarian’s blood boil.

What makes him smile is the thought of restraining the state, limiting its power, keeping it at bay, and circumscribing its influence. Eliminating all centralization of power is the ultimate dream of a true libertarian. The name of the nation’s leading libertarian think tank -- the Cato Institute – was not chosen by accident. Cato, after all, was the Roman Senator who chose suicide over submission to Julius Caesar’s dictatorship.

Given their visceral reaction to anything that smacks of socialism, libertarians and others who share their concerns often have a hard time acknowledging that they are paternalistic. Being paternalistic, after all, means you know what’s best for someone else and are prepared to make sure that what you know is best for that person actually happens. Examples here are forcing children to go to school, requiring parents to seek medical care for their children, and making people save for their retirement.

No self-respecting libertarian is likely to proclaim his or her paternalism. You won’t hear the Cato Institute publicly deny anyone the right to lay down sick in the gutter and die. Instead, the organization’s macho creed is that people should look after themselves and that no one should be forced to help anyone else unless he or she really wants to do so. This “let them eat cake” mantra works just fine for fund raising, but when it really comes down to setting policies

that would actually let children and others suffer from a curable disease or actually let people starve, the Cato Institute sings a different tune.

Part of this may be simply bowing to political reality, but I think there is a deeper explanation. At the core of a libertarian's belief system is that each of us is his own person and that what someone else does to himself and what happens to someone else is that person's own business and no one else's. That proposition works fine except for the fact that almost all of us care about other people. We aren't simply self interested. We are, at least to some degree, altruistic. And this caring for others means that when someone else hurts himself or allows himself to get hurt, that person is doing real damage not just to himself, but also to us.

The fact that libertarians, no matter their pretensions, also feel other peoples' pain means that they too have a personal interest in compelling and controlling other people's behavior and outcomes. Thus, it should be no real surprise that if you look closely at what the Cato Institute advocates, it often entails a fair amount of paternalism. Take Social Security reform. Cato doesn't advocate abolishing compulsory saving. Instead, it implicitly accepts the need to force people to save, but wants people to be able to choose their investments.⁴⁶

Members of the Cato Institute are far from the only closet paternalists around. One can make the case that the Republican party is now and has long been a bastion of paternalism. George Walker Bush and the 2004 Republican Congress are, after all, the architects of the most recent and one of the most expensive paternalistic policies ever adopted in the U.S. I speak, of course, of Medicare Part D, which assures low-income households that they will no longer need to choose between cat food and medicine by effectively inducing the elderly to acquire government-provided prescription-drug insurance coverage.

⁴⁶ http://www.cato.org/pub_display.php?pub_id=1618

Moving back in time, we find that both Presidents Eisenhower and Nixon dramatically expanded the scale of Social Security, that President Nixon introduced Supplemental Security Income and expanded Medicaid, that Presidents Reagans and Bush (the first) expanded Medicaid, and that the 1997 Republican Congress established the State Childrens' Health Insurance Program (SCHIP), which provides health coverage to low-income children who don't qualify for Medicaid. Tellingly, Senator Orrin G. Hatch, the noted conservative Republican senator from Utah, was the author of SCHIP together with none other than Senator Edward Kennedy, arguably the nation's most liberal senator.

Yet another example of Republican paternalism is the initiatives undertaken in 2006 by Massachusetts Governor Romney and in 2007 by California Governor Schwarzenegger – both staunch Republicans – to compel universal healthcare for all of their state citizens. Many other states around the nation with either Republican Governors or legislatures are also considering mandating universal health insurance coverage.

Politicians are, of course, strongly guided by public opinion. In the case of universal healthcare, opinion is heavily in favor of the introduction of such a system. Indeed, a recent Pew poll determined that two thirds of Americans support universal healthcare even at the cost of higher taxes. Among self-described “social conservatives” support was almost as strong, namely 59 percent.⁴⁷

To be sure, much of the support for universal healthcare is coming from the 47 million uninsured; and much is coming from the millions of insured who see the prospects of losing their own coverage and even their jobs because of escalating healthcare costs. But my sense is that the vast majority of Americans would endorse the following ten fundamental principles of paternalism even were their own healthcare and jobs fully secure.

⁴⁷ <http://www.everybodyinnobodyout.org/DOCS/Polls.htm>

Principles of Paternalism

- 1. No American should go without food and water.**
- 2. No American should go without shelter.**
- 3. No American should go without clothing.**
- 4. No American should go without sanitary facilities.**
- 5. No American should go without physical protection.**
- 6. No American should go without legal representation.**
- 7. No American should go without equal opportunity.**
- 8. No child should go without education.**
- 9. No child should go without vaccination.**
- 10. No American should go without basic medical care.**

Self-inspection is a good way to check if the nation supports these principals. If our country has policies in place that uphold these principles, we can safely conclude that they have broad support. I refer to this as *revealed societal paternalism* and want to ask whether our country does, in fact, support these principals in deed as well as discourse.

Consider first principles 1 through 4. Although one can argue that America's soup kitchens, homeless shelters, Goodwill stores, food drives, religious charities, Food Stamps program, TAFDC program, WIC program, LIHEAP program, SSI program, HUD shelter and low-income housing assistance programs, and similar private and public initiatives, institutions, and policies could be better funded and organized, they do seem to reflect strong support for the first four principles.

Next, think about principles, 5, 6, and 7. They are fundamental features of our civil justice system. The poorest and weakest members of society can call 911 for police protection, obtain a public defender if they are subject to criminal prosecution, and obtain redress in the courts against employment discrimination.

All right, how about principles 8 and 9? Well, every public school district in the country makes sure these two principles are enforced.

This leaves principle 10, which I'd like to consider bit by bit since the definition of "basic medical care" is up for grabs. Let's start with emergency medical care. It's obvious that such care is available to everyone. No matter who you are and where you live, you can call 911 for emergency medical assistance and expect an ambulance to rush to your side. You may be penniless and have no prospect of securing future income. Yet the ambulance will come when called and find a hospital to fix your broken leg, treat your heart attack, dress your burns, etc. And no one will ask for your credit card prior to administering CPR.

The story is no different if instead of calling an ambulance you drag yourself into the emergency room. You may be pressed for payment information or a payment method, but you will almost always be seen and given proper medical treatment even if you are dirt poor and can't pay for the treatment.

Next consider more routine outpatient care as well as scheduled tests and operations at hospitals. To get this care, you will be pressed for a payment method. But many clinics, hospitals, and doctors will provide assistance for little or no compensation if you have no way to pay. And if you do have a payment means, but are forced to use up your assets and income in the process of paying for your healthcare, the medical establishment won't terminate your treatment just because you've run out of resources. Indeed, once you dissipated your own resources, the government will step in, enroll you in Medicaid, and pay your medical bills through that program.

The point is that principle 10 is satisfied in the United States, albeit not without putting a lot of low- and middle-income people through the ringer and into the poor house. So why is

that? Why is it that we a) want everyone to have good medical care, but b) don't want them to get it for free if they can afford to pay for it?

The answer is that we don't want others to free ride on our generosity – to take advantage of us and make us pay for something they should buy for themselves.

Economists call this problem “the Samaritan’s Dilemma.”⁴⁸ The title derives from Jesus’ story about the Good Samaritan in which a good person Y takes care of a poor person X. Clearly Y cares about X and this caring underlies Y’s paternalistic actions.

Jesus says that Y should love X and that X should love Y and I should love you and you should love me and that we should all be one big loving family and automatically take care of each other.

But what Jesus omits is that in helping X, Y has to worry that X will take advantage of his caring and press him for more help in the future.

This is Y’s dilemma – the Samaritan’s dilemma.

Jesus was no economist. Had he been one, he might have had Y tell X. “You know X, I’d really like to help you, but I’m worried you’ll take advantage of me. Furthermore, we might be in opposite shoes tomorrow, in which case if you were to help me, I’d be tempted thereafter to take advantage of you. So let’s do the following. Let’s get Uncle Sam, over here, to force us both to work, save, and insure so that we can both take care of ourselves and neither can free-ride on the other.”

This is the simple solution. It explains why we established the Social Security and Medicare systems. In so doing we effectively forced ourselves to save, to buy life insurance, and to buy old age health insurance. Come again? Well, when we pay payroll taxes we secure claims

⁴⁸ Buchanan, J. (1975), “The Samaritan’s Dilemma”, in E. Phelps (ed.), *Altruism, Morality, and Economic Theory*, New York: Russel Stage Foundation.

to Social Security retirement and survivor benefits as well as to future Medicare benefits.⁴⁹ Yes, any given contributor may not get back, on an actuarial basis, what she contributes; there is certainly massive redistribution across and within generations associated with these programs. But that doesn't negate the fact that these policies, to a large extent, compel one's own provision for one's own future.

Mind you we could arrange things differently. We could leave people to save, buy life insurance, and buy old age health insurance completely on their own and then a) provide it for them if they failed to do so and b) extract some awful penalty if they failed to comply.

Were we to do this, we'd have roughly parallel treatment with how we provide universal healthcare. Recall, we most certainly do provide universal healthcare in this country. We just do so in a way that leaves many low-income (but not super low-income) and middle-class workers facing an awful penalty – huge financial losses, including, potentially, bankruptcy – if they fail to buy their own pre-retirement health insurance and wind up needing extensive medical care.

Why have we arranged things like this for the working, but not the retired population?

Is there something intrinsically different about our paternalism with respect to people's health when they are young and old? I don't really think so. I don't think we feel less bad about seeing a 30 year-old suffer from a curable medical condition than a 70 year-old.

What is different is that, at least in the past, a 30 year-old had a pretty good chance of receiving health insurance coverage on the job. And 30 year-olds who didn't were able, in the past, to purchase reasonably priced private health insurance to avoid financial ruin from gall bladder surgery or some other relatively expensive unexpected medical problem.

⁴⁹ Paying other types of taxes can also be viewed as securing claims to future benefits because other taxes directly or indirectly finance these benefits; i.e., a dollar's a dollar.

Today employers are busy getting out of the health insurance business. Moreover, buying health insurance as an individual has, as mentioned, become prohibitively expensive. So we need a new solution to healthcare paternalism as it applies to children, the young, and the middle aged who are not covered by Medicaid and who are not rich enough to self insure.

As with the case of guaranteeing that our landmen/women have enough to live on in old age, receive medical care in old age, and provide for their dependents if they die before reaching old age, there is a solution that avoids the Samaritan's dilemma. The solution is compulsion -- force people to purchase their health insurance for themselves and their children when they are young just like we force them to purchase assets (future Social Security retirement and dependent benefits), life insurance (Social Security survivor benefits), and old age health insurance (Medicare benefits) when they are young.

In the latter three cases, the forcing comes in the form of having to pay FICA as well as federal income and other taxes. And yes, I realize that there is no strict accounting that connects what one person pays when young and receives when old. Money is fungible, and there is no way that one can prove he or she is paying for his own future benefits with specific taxes. But this point has a corollary; there is also no one that one can disprove such a proposition.

But set this argument aside. The main point is that we are all compelled to pay taxes and that we are all endowed with (provided entitlement to) these three types of benefits.

If you've followed my drift, you'll know that I'm advocating more of what works. I'm for compelling both X and Y to purchase medical insurance when they are young so that X (Y) doesn't need to help pay Y's (X's) medical bills if Y (X) gets sick.

There are lots of ways to compel payment for medical insurance, but the most efficient way is to use the tax system. The reason is that the government can garner workers' wages

before they are potentially dissipated on a variety of “necessities” that don’t include health insurance premiums.

Of course having the government collect all the money for health insurance premiums also means that the government would be paying out this money to cover the relevant population with medical goods and services. This starts sounding like the government would directly provide the medical goods and services for the entire population, which starts sound like European, Japanese, Canadian, etc. healthcare systems.

Not the case.

Collecting the money that ultimately will pay for medical goods and services doesn’t mean providing those goods and services directly. The structure of current-day Medicare and Medicaid makes that clear. Uncle Sam and Aunt Sally (she runs state government) don’t directly buy the pills and hire the doctors and train the nurses and build the hospitals and ... that treat the Medicare and Medicaid populations. Uncle Sam and Aunt Sally just pay the providers. But it is the providers and their patients who jointly determine the nature and extent of medical expenditures. The fact that this method of determining what gets spent is designed to be extraordinarily expensive and inefficient (particularly in the case of Medicare) is true, but that’s besides this particular point.

The Medical Security System (MSS), that I’ll present shortly, would achieve our paternalistic objectives in the area of healthcare without having the government micromanage the delivery of care. *It would implement universal health insurance, not universal healthcare per se.*

Of course, the MSS would need to be paid for. But as demonstrated at the start, the government is already collecting enough taxes to cover the vast majority of the expenses associated with implementing the MSS. This fact alleviates not just the concern with how to pay

for MSS, but also the worry that in going to universal health insurance one would need to enact much higher taxes and that these much higher taxes would significantly undermine incentives to work and save.

Adverse Selection – the Bugaboo of Healthcare Reform

In compelling everyone via their collective tax contributions to purchase health insurance, the MSS plan recognizes and deals with the biggest problem facing private insurance companies in the healthcare arena, namely the fact that they don't know who they are dealing with. This is less of a problem when insurance companies are insuring large number of workers of a major company. These workers will, as a group, be close to the average when it comes to their ultimate healthcare costs.

But when insurance companies, no matter how large, are asked by someone off the street for an insurance policy quote – someone who may know, but not reveal, that, for example, she has a family history of breast cancer --- insurers get mighty nervous. Their response is to set very high insurance premiums to make sure they don't get stuck insuring someone with a high probability of major medical expenses.

As indicated above, economists refer to the tendency of bad (adverse) risks to demand (select) higher levels of insurance coverage insurance as adverse selection. The adverse selection problem plagues most insurance markets and can often effectively prevent the marketing of insurance to the general public by the private market. If insurance companies need to protect themselves from bad risks by setting super high premiums then only the bad risks will be willing to buy the insurance, leaving all the regular as well as good risks uninsured. This is called a *lemons market*, because only the bad risks (the lemons) are left in the market.

One glance at today's private insurance market, which has left 47 million people out in the cold, shows that adverse selection is strongly at play and has effectively destroyed the non-employer based private health insurance market.

Any government policy that encourages or compels the public to purchase a healthcare insurance policy from a private insurance carrier must recognize this paramount problem of adverse selection. Specifically, if the government gives every citizen the same amount of money to purchase a policy, the insurance companies will naturally try to figure out who are the good and bad risks and choose to insure the good risks and turn away the bad.

The way around this is to recognize that the heart of the adverse selection problem is asymmetry in information – the fact that potential insurees know more about their healthcare than the insurers and a) make this information available to insurers and b) compensate those insurers focusing higher expected costs for finding themselves in this situation. Doing so will give the insurance companies the incentive to cover the bad as well as the good risks. The reason is that the bad risks will now be able and willing to pay higher premiums in light of their higher expected costs. This, as I'll indicate shortly, is the essence of my MSS proposal. But before presenting this plan, let me examine what others have proposed with respect to providing health insurance to the uninsured. Let's start with the President's proposal.

Universalizing Health Insurance

I've just argued that paternalism is at the heart of why we are concerned not just about our own, but also about everyone else's healthcare. I've also claimed that the Samaritan's dilemma naturally leads paternalists (including libertarian paternalists) to compel the public to provide for its own healthcare. And I've pointed out that for any plan to work that entails private insurance companies marketing health insurance policies to the general public must directly confront the adverse selection problem. So in considering alternative schemes for expanding health insurance coverage, bear in mind these three requirements – insurance coverage must be universal, insurance coverage must be compulsory, and insurance coverage must be affordable even for those with bad information (pre-existing conditions or medically suspect family histories).

In his January 31, 2007 address, President Bush said “We will strengthen health savings accounts, making sure individuals and small-business employees can buy insurance with the same advantages that people working for big businesses now get.” According to the President's plan all married (single) workers would be able to deduct up to \$15,000 (\$7,500) in annual health insurance premium payments from their taxes. This policy would replace the current tax treatment of health insurance that allows employers to treat premiums they pay for their group plans as an employment expense, but not include those payments on their workers' W2 forms as part of their taxable compensation. Consequently, employees covered by employer health insurance plans don't have to pay income or payroll taxes on that part of their compensation that goes to purchase health insurance on their behalf.

For workers now covered by an employer plan, there would be no change in tax treatment provided the current premiums paid by employers on their behalf do not exceed \$15,000. If they do exceed \$15,000, the difference would become taxable income to the worker. Apparently, some 20 percent of workers have plans that entail more than \$15,000 in annual premium payments, and these workers would see their taxes rise.

The President's proposal would effectively remove employers from deciding how much one pays in taxes, at least in the healthcare arena. In this regard, the President's plan is long overdue. But as a scheme to expand health insurance coverage his plan has four fatal flaws.

First, there is no compulsion. No one is compelled under the President's plan to purchase health insurance. This means everyone is free to remain uninsured and thereby free-ride on everyone else's altruism. Second, there is nothing in the President's plan that deals with adverse selection. True the plan permits states to experiment with different mechanisms to subsidize insurance purchase, but there is no suggestion of a role for the federal government in *experience rating* (assessing expected healthcare costs of) individual Americans and compensating those with pre-existing conditions for their higher expected costs.

Third, the proposal treats premium payments as tax deductible, rather than as a refundable tax credit. Consequently, low-income households who don't pay income taxes or whose income taxes are very small won't receive any help or very much help in purchasing health insurance. Such households are currently the least likely to purchase health insurance. Fourth, since higher-income households are in higher tax brackets, the President's plan, although it caps the subsidy on health insurance premiums, still provides a higher subsidy rate (up to the ceiling) for the rich than for the poor.

The President's healthcare plan is not the first time he has proposed something that won't work. Early in his first administration, the President proposed and Congress enacted legislation establishing Health Savings Accounts (HSAs). These accounts let people save up on their own for their future health bills on an after-tax basis provided they purchase a high-deductible health insurance policy.

Some 3 million Americans may end up choosing HSAs. That's the good news. The bad news is that HSAs suffer from the same four shortcomings as the President's latest initiative. In addition, they leave their participants exposed to significant medical expense risk since insurance projection only kicks in after a relatively high deductible has been satisfied. One of the goals of implementing HSAs was to extend the tax breaks afforded to employees of firms providing health insurance to those not so covered. But HSA's catch – that you need to remain fully exposed to small and moderate health insurance expenditure risks – hardly makes it a level playing field with respect to employer-provided plans.

The reason the Bush administration has been so keen to ensure that health insurance not include too much insurance is the view that when people have to pay, at the margin, on their own (out of their own pockets), they will limit what they spend on healthcare. In general Americans pay only 14 cents of each additional dollar spent on healthcare thanks to Medicare, Medicaid, and private insurers. And because no one has much incentive to keep track of all this spending, medical goods and services prices have been rising like crazy. The one area of medicine where prices have actually declined in real terms is cosmetic surgery.⁵⁰ Between 1992 and 2005, the price rises of all medical goods and services averaged 77 percent, whereas the CPI (the consumer

⁵⁰ <http://www.ncpa.org/pub/ba/ba572/>

price index), rose by 39 percent. Cosmetic surgery prices, on the other hand, went up by only 22 percent.

There is, of course, nothing to stop employers from designing their health insurance compensation to make their workers pay high or even super high deductibles. The fact that they haven't done so strongly suggests that workers desire full or very close to full coverage.

This brings me to the fourth major problem with the President's latest initiative – the ongoing marginal subsidization of health insurance. As with the existing primarily employer-based health insurance system, the President's plan continues to use the tax system to subsidize the purchase of health insurance. It does so by maintaining the deductibility of contributions, at least up to the \$15,000 ceiling. This means that for typical households it costs less to buy a dollar of health insurance coverage than it does to buy a dollar of other goods and services.

This is surely one of the key reasons that private sector health expenditures have been rising so rapidly. Take someone earning below the payroll tax ceiling who is in the 28 percent federal income tax bracket and 5 percent state income tax bracket. Each dollar spent on health insurance premiums saves 28 cents in income taxes plus 5 cents in state income taxes plus 15 cents in payroll taxes; so a dollar's expenditure on health insurance premiums only costs 52 cents on net. The MSS proposal has none of this. It entails no subsidy *at the margin* with respect to the purchase of extra health insurance.

Hillary Care

In 1993 the Clinton Administration proposed an elaborate plan to mandate that all Americans not in Medicare purchase health insurance coverage through HMOs. The scheme has been dubbed Hillary Care since it was developed by a task force chaired by then First Lady Hillary Rodham Clinton. The proposed legislation was entitled the Health Security Act.⁵¹ The plan would have formed large participant groups on a region-specific basis to pool risks. Insurers providing coverage to anyone in the pool would have been required to cover anyone else in the pool who also requested coverage.

Members of a particular pool would have been free to select their own HMO. The government would have limited growth in the premium payments exacted by the HMOs. Each participating HMO would have been required to provide a minimum set of benefits (coverages). Each participant would have made different co-payments and faced different deductibles depending on his/her choice of an HMO plan. Regional and Corporate Health Alliances would have organized the health pool groups and contracted with HMOs. Corporate Alliances would have been made up of firms with 5,000 or more employees. All employers would have been forced to contribute on behalf of their employees to their employees' health alliance. Individuals who were not employed would have been forced to contribute to their alliance on their own subject to government income-based subsidies. The government would have experience-rated each alliance and redistributed income between them.

Hillary Care, for all its bad press, had a number of very sensible features. First it compelled participation and provided universal coverage. Second, it dealt with adverse selection

⁵¹ http://fraser.stlouisfed.org/publications/ERP/issue/1600/download/6055/ERP1994_Chapter4.pdf.

using cross-alliance experience rating. Third, it ensured that those with pre-existing conditions or bad family health histories were not subject to discrimination. Fourth, it permitted some flexibility in the design of insurance co-payments, deductibles, and related financial arrangements, thereby permitting the introduction of incentives to limit overuse of the healthcare system. But the system would have required a huge bureaucracy to implement and was exceedingly hard for the public to grasp. Finally, Hillary Care would have done nothing to reign in run-away expenditures on Medicare since it exempted Medicare participants entirely from the program.

The Massachusetts and California Mandatory Health Insurance Plans

In April 2006 Republican Governor Mitt Romney signed a law mandating that all employers with 10 or more employees pay \$300 annually per otherwise uninsured employee to assist in the purchase for them of health insurance coverage. The new law also created a Commonwealth Health Insurance Connector to direct the uninsured to quality insurance products. And it called for the state to heavily subsidize premium payments for low-income households. The state also indicated it would significantly expand its enrollment within Medicaid of otherwise uninsured children. Finally, the state indicated that it intended to pay for a basic plan for the uninsured from its own general revenues, from Medicaid funds, and from the annual \$300 employer premium payments. Recently, however, the state has indicated that it may need to pare down the coverage provided by the basic plan due to higher than expected costs. Moreover, the Bush Administration has told Massachusetts and other states that it's not willing to approve their planned expansions of the SCHIP portion of Medicaid.

Governor Schwarzenegger's mandatory health insurance plan is also short of cash. The Governor is proposing taxing both doctors and hospitals to come up with needed revenue to pay doctors and hospitals. Employers who aren't currently providing health insurance for their workers would be required to pay a 4 percent payroll tax for that purpose. Like Massachusetts, the California plan seeks to expand Medicaid to cover many of its currently uninsured children. In addition, all individuals would be required by law to purchase a policy with a minimum benefit if they were not already covered. Low-income individuals would be eligible for a generous state subsidy that would help them purchase this plan. Finally, the Governor proposed a reward system, such as subsidized gym membership, for those who participate in public health programs, including, no doubt, body building.

The Massachusetts and California plans would provide some health insurance coverage for the uninsured. But both do so by relying on a significant expansion of their Medicaid populations and as well as the receipt of additional federal assistance. As such they will exacerbate the federal government health financing problem were the federal government to comply. In addition, rather than get employers out of the health insurance business, the Massachusetts and California plans effectively lock them into it.

In mandating employer payments for health insurance, these plans could have some very negative repercussions. Employers who might otherwise be willing to maintain health insurance coverage for their new hires may worry that they'll lose the ability to cut back on health insurance coverage for new hires in the future. Consequently, they may choose to freeze their existing health insurance plans to cover only existing employees and announce that they will contribute the state-specified and state-sanctified minimum for any new employee. Another

concern involves finding insurance carriers willing to insure at a rock-bottom price populations that will almost surely have much worse health outcomes than those of the general public. Inducing these carriers to provide health insurance to these segments of society will surely require highly complex experience-rating mechanisms of precisely the same nature as those that made Hillary Care look like a bureaucratic nightmare.

There are other national and state plans for covering the uninsured, including those of the current presidential candidates, but all seem to be variants on those just discussed. There is, however, one notable exception -- a proposal by Dr. Ezekiel Emanuel of the National Institutes of Health and Stanford Economics Professor Victor Fuchs entitled *Universal Healthcare Vouchers*. This plan is very similar to the MSS. I became aware of the Emanuel/Fuchs plan only recently in the course of doing research for this monograph. Emanuel and Fuchs appear to have developed their plan at roughly the same time I was working on the MSS proposal.⁵² Apparently other economists have been thinking for some time about a health insurance voucher. According to Princeton health economist Ewe Reinhardt the idea was first proposed in 1971 by Paul M. Ellwood, viewed by many as the father of managed competition among private insurance carriers.⁵³ It was subsequently proposed in the early 1970s by Herman and Anne Somers, two Princeton economists. I first heard of the idea of providing individually experience-rated health insurance vouchers from Dr. John Goodman, Director of the National Center for Policy Analysis. Goodman, as I understand it, worked on the idea in the 1990s with economist Dr. Peter Ferrara.⁵⁴

⁵² The MSS proposal is included in *The Coming Generational Storm*, which I co-authored with Scott Burns and which was published in early 2004 by MIT Press. Emanuel and Fuchs first offered their plan in a November 2003 op ed.

⁵³ http://www.rojo.com/story/QnIHILVpXmOI_RYC_Single-Payer_Health_Care_and_Vouchers

⁵⁴ The fact that both Goodman and Ferrara have strong libertarian leanings, but, nonetheless, have spent considerable time considering how to efficiently mandate universal healthcare is indicative of the point made above that paternalism is alive and well among all segments of our society.

The Medical Security System

It's time to face facts. Our government is going broke paying for healthcare. So are many of our top companies, and so are millions of individual American households. It's time to take a radical approach to fixing healthcare in America before it fixes us.

The root of the Medicare spending-growth problem is the program's "fee for service" structure. This stands for the fact that healthcare providers can charge Medicare a fee when they provide Medicare participants a service. One might think that capping the fees would limit total expenditure, but doctors and hospitals simply change the classifications of the services they provide to ones that provide higher fees. Or they schedule more visits. Or they order more expensive tests and procedures. Or they do all of the above.

As if growth in benefit levels didn't generate enough overall spending growth, the government has deemed it necessary over time to expand what's covered by Medicare, with prescription drugs being the latest and most expensive addition to the list. According to George Will, it represents "the largest expansion of the welfare state since the Great Society 40 years ago."⁵⁵ Enrollment has been another huge driver of Medicare costs. Population growth of the elderly plus the extension of Medicare coverage to the disabled in the early 1970s have been the major factors in this regard.

Looking ahead there is every reason for Medicare costs to continue to explode and threaten our nation's finances and our children's economic futures. "Fee for service" remains the predominant payment mechanism for Medicare and is likely to permit benefit growth in excess of per capita income growth as far as the eye can see. Even under recklessly optimistic

⁵⁵ George Will, "Bush's Bad News for the Right," *The Boston Globe*, July 24, 2003, A11.

assumptions under which the excess Medicare benefit growth rate in the future is only two fifths of its historic value, the nation faces a Medicare bill that it simply cannot afford.

Medicaid, for its part, has achieved some success in recent years in limiting the growth in the level of real benefits per beneficiary. It's done so by enrolling the majority of its participants in HMOs under fixed price contracts. But thanks to the meltdown in private sector insurance arrangements, the Medicaid participant population has boomed. Many state governments now intend to enroll millions of more children in the program as part of their plans to achieve universal health insurance coverage.⁵⁶

The problems with private-sector health insurance should come as no surprise. The government has, for decades, strongly encouraged growth in private healthcare spending by using the tax system to subsidize healthcare. This is particularly the case for high-income workers with employer-provided health insurance. For such workers every dollar spent on healthcare costs roughly 45 cents on an after-tax basis.

The government-induced healthcare spending spree in conjunction with rising incomes among high-skilled workers has led to much better and much more expensive procedures, treatments, and medications. Rather than restrict the use of these new medical goods and services and, thereby, risk being sued, health insurers have simply passed on their costs in terms of higher premiums. In the process health insurers are increasingly pricing low-skilled workers and firms hiring such workers out of the market. In addition the increasing morbidity of the American population, stemming to a significant degree from our collective addiction to junk food and its associated consequences – incredible rates of obesity, with its attendant diabetes,

⁵⁶ The Bush Administration, which has to approve these planned expansions of Medicaid's enrollment, appears disinclined to do so.

cardiovascular, and other problems -- has exacerbated the ever prevalent insurance market boggy man, namely adverse selection.

Getting Real

It's time to get real. There is just no way that we can maintain Medicare's fee-for-service method of paying the medical bills of the elderly. We can't maintain that program in full. And we can't maintain it in part. There is also no way we can let 47 million Americans, 8 million of whom are children, continue to be exposed to devastating financial risk because they can't afford or don't choose to buy health insurance. Nor can we "fix" this problem by letting the uninsured impoverish themselves to the point that their incomes and assets are so low that they can qualify for Medicaid.

The Medical Security System offers a solution that satisfies our paternalistic imperatives as well as our individual and collective pocketbooks. Its eleven provisions fit on the following postcard (which may be cut out and mailed to your Congressperson!).

The Medical Security System

- 1. All Americans are enrolled in the MSS. (Medicare and Medicaid are abolished.)**
- 2. All Americans receive an annual voucher to buy a basic health insurance policy for the year.**
- 3. The government experience-rates each participant on an annual and region-specific basis.**
- 4. Government receives all participant medical records for use in its experience-rating.**
- 5. Government maintains strict confidentiality of all medical records.**
- 6. The size of each year's voucher is based on the participant's expected healthcare costs over the year.**
- 7. New vouchers are issued annually and participants choose insurers/HMOs annually.**
- 8. Insurers/HMOs participating in MSS cannot deny coverage or delay service.**
- 9. Basic policy covers prescription drug benefits, some home healthcare, and nursing home care.**
- 10. Insurers/HMOs can offer participants rebates in exchange for accepting co-payments and deductibles.**
- 11. Government sets voucher amounts to limit per capital MSS growth to that of per capita income.**
- 12. Government determines annually the coverages of the basic policy.**

How MSS Would Work

MSS participants would receive a voucher each year, on October 1st, to use to purchase insurance coverage for the following calendar year. By January 1st of each year everyone would be signed up with an insurance provider for the year.

The size of the annual voucher would be based on the participant's current medical condition. Hence, a perfectly healthy 67 year-old might get a voucher for \$8,000, whereas an 85 year old with diabetes might get a voucher for \$80,000. Because those in the worst medical shape would have the largest vouchers, insurance carriers would be just as happy to have them as customers as their healthy contemporaries.

Once a participant signs up with an insurance company/HMO that insurer/HMO would pay all medical bills incurred over the course of the year. If the initially healthy 67 year-old gets a heart attack during the year and requires \$28,000 in care, the insurer/HMO will lose \$20,000 on that customer. If the 85 year-old with diabetes ends up requiring only \$20,000 in care, the insurer/HMO will earn \$60,000 on that customer.

The government would determine the size of each participant's voucher. It would do this by *experience rating* each participant. Experience rating refers to determining an individual's expected healthcare costs under the basic MSS policy. The experience rating would be done on an annual basis. Hence, if a participant's health deteriorated (improved) over the course of the year, thereby raising her future expected healthcare costs, she'd receive a larger (smaller) voucher for the following year.

The MSS plan is highly progressive. The poor, who are more prone to illness than the rich, would, on average, receive higher vouchers than the rich. And, because we'd be eliminating the deductibility of health insurance premium payments, the tax breaks going

disproportionately to the rich in the form of non-taxed health insurance premium payments would vanish.

All medical test results, diagnoses, medical histories, etc. would be transmitted electronically to the government for purposes of its experience rating. The confidentiality of these medical records would be strictly maintained. The insurer one picked would, of course, learn the size of one's voucher. In this way, the insurer would be able to infer the client's true expected healthcare costs. Hence, the insurer would, in effect, receive the information that would not be available in a standard insurance setting. The insurer would, however, be required to keep this information confidential.

Can we trust the government to keep these records safe? Absolutely. The government has been keeping medical records in the strictest confidence since 1965 for tens of millions of Medicaid and Medicare participants. Take Medicare. It knows the hospital DRGs against which it has been paying claims for each of its participants. It also knows a host of other information about each of its participants, such as which doctors they see on an outpatient basis for what conditions. But it certainly isn't reporting any of this information to the local newspaper.

The key thing from a cost perspective is that the government can establish the values of the vouchers each year such that its total expenditure on vouchers per MSS beneficiary grows only as fast as per capita national income. This would slice tens of trillions of dollars off our \$70 trillion fiscal gap.

Yes, Medicare participants would no longer be able to look forward to growth in real medical benefits that far outstrips the growth in the nation's per capita income, but those benefit hikes are simply no longer affordable. Today's elderly, like everyone else, will, however, be able to look forward to benefits rising at the same rate as per capita income, which is significant

in its own right. Furthermore, today's elderly will be able to sleep at night knowing they are no longer participating in a healthcare system that is facing financial ruin.

All insurers/HMOs who wished to enroll MSS participants would be required to cover the government-determined set of basic benefits, including prescription drug coverage and nursing home care. But the insurers would be free to provide rebates to participants in exchange for including co-payments and deductibles in their policies that would limit their use of the healthcare system. The insurers could also provide monetary rewards for healthy behavior, such as reducing one's weight, smoking less, going to the gym, etc. Such arrangements would be subject to government approval.

In determining on an annual basis the set of medical goods and services that the basic policy would have to cover, the government would clearly be rationing healthcare or, at least, the healthcare that it is willing to pay for. But insurers would be free to offer supplemental policies that covered medical goods and services (e.g., a private room in a hospital) that are not covered under the basic policy.

At the margin, insurers/HMOs, not Uncle Sam and Aunt Sally, would be on the hook to pay for MSS participants' healthcare. Hence, they'd have a strong profit motive to find ways to tailor their insurance policies and contracts with hospitals and healthcare professionals to limit costs.

Although policies would differ from insurer to insurer, the government would develop and require a single electronic system of insurance record-keeping and reporting. This, by itself, could squeeze out huge amounts of wasted administrative costs from our healthcare system.

MSS Versus UHV

The MSS proposal differs from its close cousin, Universal Healthcare Vouchers (UHV), in three principal ways. First, MSS avoids adverse selection by experiencing rating each individual separately and compensating each individual in terms of the size of his/her voucher for his pre-existing medical conditions. Hence, insurers/HMOs will no longer have an incentive to cherry-pick participants; i.e., their sickest participants will present as fine a profit opportunity as their healthiest.⁵⁷ In contrast, UHV appears to do its experience rating at the level of the insurer/HMO. This would, I believe, be much less accurate because it wouldn't make use of all available participant-specific data. As such, it may still leave insurers/HMOs with strong incentives to find subtle and not-so-subtle ways to avoid insuring the sickest members of society.

Second, UHV calls for a value added tax (an indirect way to tax consumption) to finance the costs of its vouchers. I don't believe major additional revenues would be needed for MSS. But careful study would be needed to determine whether or not this is the case. Were additional revenues needed, I too would favor using a consumption tax, but I'd advocate a progressive federal retail sales tax. Indeed, I've proposed elsewhere replacing our entire federal tax system with the FairTax -- a federal retail sales tax that includes a monthly rebate.⁵⁸

The third difference, and this one is major, is that UHV would leave Medicare in place for all existing Medicare participants. This option is simply unaffordable. Medicare on its own is fully capable of sinking our fiscal ship and its spending needs to be brought under control. Furthermore, there is no reason to treat the elderly any different from the rest of the population in terms of the quality of their healthcare.

⁵⁷ The experience rating may need to be adjusted not just for differences across participants in expected healthcare costs, but also for differences in the distributions (riskiness) of those costs.

⁵⁸ See Ferguson, Niall and Laurence J. Kotlikoff, "Benefits Without Bankruptcy – the New New Deal," *The New Republic*, August 2005.

Conclusion

Thanks to decades of fiscal profligacy and the impending retirement of the baby boom generation, the United States is essentially bankrupt and requires critical and immediate fiscal surgery. The single biggest threat to our nation's finances is the government's runaway spending on Medicare and Medicaid. The decades-long explosion in Medicare and Medicaid expenditures reflect real benefit levels that have been rising at a much faster clip than real income per capita, the expansion of the programs to cover ever more medical goods and services, and major growth in enrollments.

The financial markets have yet to see the fire at the end of this tunnel, but it's there and burning ever brighter. Unless we immediately and radically change directions, it will be too late. Seventy-seven million baby boomers will retire and become injured to receiving ever higher benefits notwithstanding the economic toll this will place on the economy and on their children. Unfortunately, neither Republican nor Democratic politicians are offering medicine strong enough to cure this patient. Indeed, many of their proposals will make the overall cost problem much worse.

The MSS proposal offered here is simple, straightforward, and intrinsically foolproof. Whatever the government decides it can afford to spend on the public's health, it simply hands out in the form of universal health insurance vouchers. Yes, MSS entails a single payer, but it's not a single payer for healthcare, it's a single payer for health insurance. The U.S. healthcare industry will remain competitive, innovative, strong, and private.

The MSS is not a form of socialized medicine. It is first and foremost a plan for universal health insurance. Because everyone will be insured, there will also be universal healthcare. But, make no mistake, our nation already has universal healthcare and our

government already pays for the vast majority of it either explicitly or implicitly via tax breaks and other means.

In this monograph I've tried to see the forest for the trees, specifically to show that our country's current version of universal healthcare is a haphazard, inefficient, and incredibly costly means of meeting our paternalistic imperatives. It's time to clean house, retire Medicare and Medicaid, and put in place one system that works for everyone and that will help secure our nation's fiscal and economic future.
