

Vouchers: Medicare's only hope.

MEDI-CHOICE

By Einer Elhauge

They're right: Medicare is out of control. It's growing at more than 10 percent a year, almost twice as fast as private-sector medicine and four times the rate of the national economy. The Clinton-appointed Trustees of Medicare themselves recognize that "The Medicare program is clearly unsustainable in its present form." Next year the payroll tax will no longer cover hospital benefits, and within seven years Medicare will exhaust reserves and be unable to pay hospitals at all. Indeed, Medicare is almost single-handedly responsible for our national budgetary mess. Restrain its growth to a still-hefty 6.4 percent a year, and a balanced budget is within reach by 2002.

The waste Medicare generates is legendary. Platoons of Medicare consultants advise doctors how to "code" their patients' diagnoses to maximize hospital revenue. Worse, Medicare gives incentives to perform unnecessary—and often unwanted and even harmful—operations on the elderly because it pays doctors per procedure. Yet despite all the money poured into Medicare, coverage and medical treatment are getting worse, not

better. Growing deductibles, copayments, premiums and gaps in Medicare coverage have forced the elderly to buy Medigap insurance and make other out-of-pocket payments totaling more than \$3,000 per person. The stunning result is that the average elderly person now has to spend a *higher* percentage of income on health care than *before* Medicare was enacted.

The Republican reform bill before Congress contains a serious alternative to this system: a provision effectively allowing individuals to exchange their Medicare benefits for vouchers. The core idea is delightfully simple. Instead of having Medicare bureaucrats make health care spending decisions for everyone, each person would make such decisions for his or her share of Medicare funds.

There are competing reform proposals floating through Washington these days, some of which the GOP has included in its reform package as well: lowering reimbursement rates, restricting coverage or eligibility and raising Medicare premiums, copayments, deductibles or payroll taxes. But these strategies have all been tried before and failed because they do not challenge Medicare's basic premise: that if care is medically beneficial, it should be provided and reimbursed. Since most experts believe we could spend 100 percent of our GDP on health care without running out of services that have a positive health benefit, this is insanity. Only vouchers address the problem at its root.

The consequences of Medicare's absolutist financing were predictable from the start. The government begins by using the previous year's figures to predict how much Medicare will cost. But, knowing that further care will be reimbursed, the medical industry expands. A Medicare deficit ensues. Unwilling to trade off health benefits against costs, Medicare administrators declare a crisis and insist on more funds. Congress raises Medicare payroll taxes or premiums, or takes more from general tax revenues. But any higher level of spending invites more expansion, causing a deficit that demands more funds.

Because scarcity ultimately imposes limits, sometimes the budget cannot be increased. But lawmakers cannot admit that some medical care has benefits too marginal to fund. Instead, they generally maintain the public commitment to covering all medical care, but lower payments. Deductibles or copayments are raised, or reimbursements to doctors or hospitals are lowered or capped. Some slowdown may result. But because payments are still made per service or diagnostic treatment, and physicians largely control what services are performed and what diagnoses are made, the restrictions fail to stem the expansion. Patients follow their doctors' recommendations and have little incentive to cease overconsuming health care since Medicare still covers 80 percent of the costs and Medigap insurance usually covers the rest. And setting service payments equal to their marginal cost does nothing to discourage low-benefit services. Other times, lawmakers respond with cutoffs and exclusions. Coverage is limited to a number of hospital days, or some services are deemed experimental or nonmedical. But neither strategy stops open-ended expansion in the

hospital days or categories of medical care that remain covered.

The ill effects are not limited to Medicare. By fueling medical inflation, Medicare has helped increase national medical costs per person from \$211 in 1965 to \$3,393 in 1994, making health insurance unaffordable for many and perversely increasing the number of uninsured. It also retards the evolution of medical practice. The changes in organization, practice and financing sweeping privately funded medicine cannot be fully accommodated when hospitals must simultaneously comply with a Medicare model as economically archaic as vacuum-tube computers.

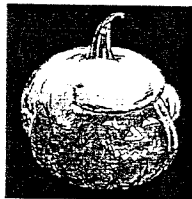
Sure, there are other popular scapegoats for Medicare cost increases. Medicare administrator Bruce Vladeck blames an expanding Medicare population and costly medical innovations. But the Medicare population is expanding by only 1 to 2 percent a year and cannot explain 10 percent annual increases. And blaming medical innovation confuses the symptom with the underlying disease. The *reason* we have ever more costly medical drugs and technology is that the financing system encourages it.

Suppose the standard drug for treating heart disease is 98 percent effective, and a new drug is 99 percent effective but ten times more costly. Under an absolutist financing scheme, the new drug must be reimbursed. Medical innovation is blamed for the tenfold price increase. But, like Sherlock Holmes's dog that did not bark, the interesting point is what we do *not* observe: the development of a new drug that is 97 percent effective but one-tenth as costly. Why? Because no one would use it under such a financing regime.

Researchers thus focus on developing a slightly more effective drug, no matter what the additional cost. This is the *Field of Dreams* problem of health care innovation: if we'll pay for it, it will come.

Vouchers are an elegant solution to these problems. Because they give beneficiaries a fixed amount to spend, each has incentives to choose insurance plans that use those limited funds wisely. Plans that fail to maximize health benefits per dollar spent would lose enrollees to competitors. Successful plans would demand the most cost-effective care from doctors and hospitals. And researchers would have incentives to investigate ways of making care less expensive.

Various objections have been raised to vouchers. One, asserted by HHS Deputy Assistant Secretary Judith Feder, is that vouchers amount to "fiscal coercion." Nonsense. Vouchers are no more coercive than handing someone a check with the amount filled in rather than left blank. Second, many fear the elderly will make poor choices. To some extent this reflects unattractive paternalism. The more serious concern is that they might be duped by flimflam operations. But this is amply addressed by requiring plans taking vouchers to meet solvency standards and to provide core medical and hospital coverage. Third, some argue that resolving Medicare's problems must await national health reform. This gets the priority backwards. Voters will not accept serious



overall reform until Washington shows it can effectively run the part of health care it already controls.

The fourth concern, often raised by the Clinton administration, is that insurers will "cherry pick," insuring only healthy Medicare beneficiaries who will not spend their entire voucher. This is a real worry. But it has two responses, both of which the Republican plan adopts. One is legal prohibition: requiring insurers to accept everyone regardless of their health. But the incentive to risk select would remain huge and the means often subtle and difficult to regulate. Plans have, for example, been known to accept all applications but require that they be picked up at a second-floor office without elevator access, thus effectively selecting only the ambulatory.

So voucher amounts should also be adjusted for the beneficiary's age, sex, residence and health status. The less healthy would get a higher voucher and, thus, may be no less attractive to insurers than the more healthy. To be sure, within any subcategory lies a spectrum of health risks. Because our ability to subcategorize is limited, some room for risk selection will always remain. But, as long as adjustments put voucher amounts in the ballpark of predictable costs, they probably suffice when coupled with regulation. In any event, risk selection plagues any program that offers individuals a choice of plans. Indeed, the Clinton health plan presented the same problem and responded to it in the very ways the administration now finds inadequate.

I would add a third response: require plans to spend all collected voucher amounts on health care. This undermines the incentive to cherry pick because insurers could not profit by spending less than the voucher amount. Rather, their only profits would come from a bonus paid to them per enrollee. For the same reason, they would have far less incentive to undertreat enrollees. Plans' sole incentive would be to do a good enough job allocating their voucher budget to attract more enrollees (and bonuses) the next year. The Republican plan does something similar by requiring insurers with costs below the voucher amount to spend the difference on providing more health care to their enrollees.

The Republican plan's guarantee that seniors have the right to stay in the traditional Medicare system creates another danger of potential risk selection. The 1985 creation of a Medicare HMO option contained a similar provision, and the unhealthy disproportionately stayed in the traditional system. The result: although nominally costing 95 percent as much, HMOs only fueled cost escalation because their enrollees were more than 5 percent healthier. The GOP bill redresses this problem, however, by adjusting provider payment rates yearly to equalize the budgetary growth of vouchers and traditional Medicare. Those staying in traditional Medicare would thus find it increasingly difficult to find doctors and hospitals willing to treat them and would no longer gain an advantage of open-ended funding over those who exit. Even the unhealthy would thus have incentives to switch to private plans that can squeeze more from the same funds.

The economic advantages of voucherizing Medicare

are only reinforced by political and moral considerations. Because no centralized bureaucracy can possibly possess the case-specific information necessary to make wise health care decisions for 37 million individuals, it must inevitably rely on broad rules that offer at best crude justice and rapidly fall out of date. Vouchers instead decentralize power to those who are better informed about their own circumstances and can more nimbly adjust to changes in costs and practices. Government officials are also prone to favor politically salient heroic care to identifiable individuals over preventive care that has a bigger health impact but is statistical and too dull for television. And because studying the details of what health care to provide is so difficult and technical, only special interests are likely to incur the high costs of analyzing and expressing views about such details. Vouchers lessen the political bias toward identifiable patients and interest groups by limiting ongoing political decisions to one overarching issue with relatively low information costs: How big should the voucher amount (and associated tax) be? Morally, vouchers can implement any legitimate redistributive justice goal advanced by the current system while respecting an individual's right to make health care tradeoffs rather than imposing one tradeoff on everyone.

Although the "MedicarePlus" or "Medicare Choice" plans in the Medicare reform bill represent a move toward vouchers, they contain a troubling deviation. MedicarePlus plans are prohibited from allowing seniors to make their own choices about what services they want covered. They must instead cover everything that Medicare does. Taken literally, this is a disaster for the voucher concept. Expansionist pressures cannot be curbed, and cost-benefit tradeoffs cannot be made, if insurers must comply with Medicare's absolutist imperative. Moreover, such a system means the power to decide what services to buy is left not to individuals but to centralized governmental mandate.

Nonetheless, the GOP bill does set some limit on voucher amounts, which will no longer blindly follow cost increases as in an open-ended fee-for-service system. This means MedicarePlus plans will inevitably have to engage in the denial of some beneficial care. Even such implicit rationing should lead to more sensible allocation decisions than the current system. But allowing explicit rationing would make the choices available to the elderly more transparent, and so help them make more informed choices.

Perhaps Republicans made the political calculation that these imperfections are worth bearing for the soundbite that under their plan no one will receive fewer benefits than they do currently. But perhaps they may truly believe that greater efficiency can spare us the need to ration health care. It's a comforting delusion, but a dangerous one, for it obscures the real problem: our tragic failure to make choices limiting the beneficial health care we're willing to fund.

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