Comment on "Alternative Medicare Financing Sources"

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WHEN A PROBLEM IS COMPLEX, WE USUALLY TRY to break it down into separate pieces each of which can be analyzed more easily than the whole. The Medicare financing problem surely qualifies as being complex. Both analytically and politically it is several orders of magnitude more challenging than the Social Security financing problem which livened up the Christmas and New Year's season a scant twelve months ago.

The piece of the problem that Stephen H. Long and Timothy M. Smeeding examine is the menu for ways to increase the revenue flow to the Medicare trust funds. I believe that they have done a solid job in carrying out this task and I shall have a number of comments on their specific results.

But there is always a danger in pursuing the strategy of breaking up complex problems into bite-size pieces. The connections and interdependencies among the various pieces may be overlooked or underemphasized. So, I shall begin my comments with some remarks that only touch the Long-Smeeding paper tangentially, before I turn to their specific results. I have no reasons to think that they would disagree with any of my obiter dicta.

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The Environment for Decisions

The central point about the Medicare problem is that it must be dealt with. This requirement is political, not legal. Congress could deal with the Medicare problem, as it could have handled the Social Security financing problem, by authorizing the trust funds to borrow from the Treasury and to run negative balances. That course was not followed last year, and it will not and, in my view, should not be followed for Medicare. That means that either benefits will be cut or revenues flowing into the funds will be increased. Some moves in one direction or the other, or both, must be made before the end of this decade. On narrow Medicare grounds, however, no steps have to be taken immediately.

The corollary of this observation is that the environment within which decisions about Medicare are taken will be defined by whether or not Congress and the president find some way to close the overall budget deficit before the big decisions on Medicare are taken. The fact is that cuts in Medicare spending can make only a small contribution in the next two or three years toward closing the overall deficit, unless Medicare is radically changed. If the deficit is reduced to manageable levels by, say, fiscal year 1989, the debate on Medicare is likely to take place as part of a broad national examination of how we wish to organize and pay for the delivery of medical services. If the overall deficit lingers at or near its current size, the debate on Medicare inevitably will be enveloped in a continuing effort to bring overall federal spending and taxes into line.

The difference between these two points of view is profound. If the overall deficit has been narrowed, we can begin from the recognition that most of our methods of paying for medical care—public and private—encourage the provision of all services promising any benefit, even benefits that cost far more than they are worth to society.

Beginning from this understanding, we recognize that the nature of the problems facing Medicare are no different from the issues that we face in deciding how to organize and pay for medical services for all groups. It would lead us to consider limits on overall hospital budgets, changes in tax rules, and other steps to increase price sensitivity by all consumers and providers, revision of reimbursement rules for services to all patients, and other measures to alter general incentives.

The second point of view, the one colored by unresolved budget

deficits, forces us to worry about how to cut federal spending and/or to raise federal taxes. It tends to downgrade the urgency of reforms in the overall financing and reimbursement systems as second-order questions that must be set aside until the budget issues have been addressed.

While Congress no doubt has the ingenuity to close the Medicare deficit without materially altering other financing arrangements, it would be a public-policy tragedy if it did so. The problem of restoring the reality of a budget constraint in the health care plans of all patients and providers is perhaps the most important issue of domestic social policy in the remainder of this century.

Reviewing Revenue Sources

The burden of the foregoing comments is that readers of the Long-Smeeding paper should keep in mind the environment within which the issues it addresses will be resolved. To begin with the introduction, the fact that the Medicare trust funds face trouble has little to do with the fundamental problem that Medicare and our health care system face. The trust fund problem, like the promised execution on which Samuel Johnson commented, may marvelously concentrate the mind, but I fear it may divert us from the reasons why we got into the mess we are in.

Furthermore, the analytical approach of breaking the problem up into little pieces pushes us in exactly the same direction. Thus, Long and Smeeding were requested to explore the consequences of alternative revenue sources for closing a large part of the Medicare trust fund deficit. After an opening paragraph in which they press their noses against the window and look somewhat wistfully at the broader policy issues, they proceed to an expert and meticulous dissection of their piece of the problem.

Under "Financing Alternatives" the authors list seven major options—four kinds of taxes on the general population, and three taxes on beneficiaries. Long and Smeeding have rounded up the usual suspects: payroll taxes, general revenues, a value-added tax, and excises on alcohol and tobacco. The list of revenue raisers from beneficiaries contains some familiar items: premiums, a tax on premiums for supplementary insurance, and a slightly more outré item—a personal income tax surcharge on the elderly and disabled.

The next section briefly provides motivation for considering each of these revenue sources. Payroll taxes are familiar, and no current or immediately prospective beneficiary has paid more than a fraction of the actuarial value of entitlements to Medicare benefits. General revenues already pay for most of Supplementary Medical Insurance (SMI), just as they have been used for Social Security cash benefits. The value-added tax has long held some attractions for political swains, but it has not been the kind they want to marry. (They may be getting desperate, however.) And excise taxes on tobacco and alcohol have the obvious appeal that they penalize actions that increase medical outlays. Moreover, the real levels of these taxes are lower than in the past.

Premiums on beneficiaries are that rara avis of economics, a tax that causes no change in the relative price of various goods or activities. This premium in no sense is a means test, because eligibility does not hinge on it. It is simply a disguised reduction in Social Security cash benefits.

So, too, is the personal income tax surcharge. But the surcharge is a more progressive change; how much more progressive would depend on its structure.

The tax on supplementary insurance would help fight deficits in two ways; it would raise revenues directly and reduce costs by discouraging the purchase of cost-desensitizing medigap plans. In an interesting section, Long and Smeeding suggest that the burden of such a tax may differ less than one might suppose from that of increased cost-sharing. The latter would drive more people into buying more insurance. In both cases, they suggest, the distribution of the extra costs would be similar to that of premiums.

The authors then list a number of evaluative criteria: distributive equity; efficiency and behavioral effects; revenue potential and stability; and administration and compliance costs. Equity is viewed in three ways: across generations, across income classes, and among equals.

The "Analysis of Revenue Sources" describes how each of the alternative taxes stands up to these criteria. Most of the results concern distribution among income quintiles of a tax increase of $5 billion in 1975, which is roughly equivalent to $10 billion in 1985. The authors successively assume that all of the added revenue is collected from each tax.

The results are contained in two tables. Data on the institutional population are missing, as they are from most surveys. The tables contain no surprises: general revenues and the income tax surcharge

are progressive; the burden of payroll tax as a percent of income is hump-shaped; the value-added tax and selected excises rise with income, but less than proportionately and they are regressive. Premiums and the supplementary insurance tax are almost flat per capita and are highly regressive.

These results follow a long tradition in tax analysis and partake of the same virtues and flaws. The results assume behavior is unchanged, and they ignore life-cycle effects, to mention just two shortcomings that I think are serious, but which I will not go into here. The virtue is that if these other problems are not too serious the results give a crude and easily understood sense of distribution among income classes.

The tables give little guide to intergenerational distribution, which requires explicit attention to how people's incomes and consumption change over their life cycles. They give no guide at all to horizontal equity, which requires that one go behind broad aggregates such as income quintiles.

Table 3 summarizes the strengths and weaknesses of all seven revenue sources by the four major, evaluative criteria.

Considering Tax Policies

It is at this point that the bite-sized-chunk approach to analyzing the Medicare problem begins to be most troublesome. Three examples will illustrate the problem.

First, take the value-added tax. Tables 1 and 2 indicate it is regressive. But that conclusion is misleading on several grounds. European experience indicates that the regressivity can be largely eliminated by differential rates on luxuries and necessities. Furthermore, the value-added tax can be part of a progressive tax reform package as it was in Margaret Thatcher's first tax bill. For example, the United States could use part of the revenues from a value-added tax to free low-tax-bracket families from the personal income tax and to increase the earned-income tax credit. But one is diverted from thinking about these possibilities if one approaches the value-added tax as a possible fix for the Medicare system. The point, surely, is that the introduction of a value-added tax should be considered within the broad context of revenue needs and tax structure.

Second, consider the selective excise taxes. Should the supposition that they are regressive have any material bearing on whether we

impose them? Should they be linked to Medicare? The answer to both questions, I think, is no. Increased taxes on alcohol and tobacco are justified as mechanisms for internalizing some of the costs from which our methods of pricing third-party coverage inevitably protect people. They may be regressive, but if that consideration is controlling, perhaps we should also provide special income tax concessions to smokers and drinkers because their habits reduce their ability to pay. The point, surely, is that we should take such public steps as we think appropriate to influence the distribution of income. We should then consider, on their own merits, taxes that are intended to make people recognize or pay for the burdens their actions impose on others. Once again, one is diverted from putting these issues in full context if one confronts them in the constricting framework of the Medicare financing problem.

Finally, there is the supplementary health insurance tax. I believe that the Internal Revenue Code is a great untapped resource for the conscious regulation of health care. The president suggested a cap on the allowable exclusion from the personal income tax of health insurance premiums purchased by employers. But most changes in health insurance, from the reduction of first-dollar coverage to the use of fee schedules or other changes in reimbursement could be encouraged, if not compelled, by use of the Internal Revenue Code. We should think carefully about whether and how to use the Internal Revenue Code as an instrument of health policy and until we have done so, we should not use it for the small contribution it could make to closing the Medicare deficit.

Beyond "Fixing" Medicare

The inexorable drive of technology, rising incomes, and an aging population is causing health expenditures to rise. We rejoice at similar trends in computer expenditures as a sign of progress. But we grow restive at rising health costs because these outlays do not meet a market test and because we suspect that increasing amounts are being spent at the margin for meager benefits. The Medicare system presents us with this problem in full color because legislated tax rates are flat and because the numbers of the medically costly over-75-year-old population are rising very fast.

To be sure, we can fix Medicare—by curtailing covered services,

by cost-sharing that shifts outlays off-budget, or by relying on one or more of the taxes that Long and Smeeding examine. If that is all we do, we will have done little. We will have shifted the accounts where outlays appear and have marginally changed income distribution.

But we should be and are already doing more. Diagnosis-related groups (DRGs) are being put in place. Several states are implementing hospital budget limits, some of which (New York and Massachusetts, for example) are severe. If these limits spread, and I think they are likely to do so, a whole range of changes will be set in motion, forcing administrators and providers to decide which care should not be offered and compelling patients to adjust to queues and nonprovision. If such limits become the norm and our tax laws are modified to discourage overinsurance, we should recognize that the price of Medicare is the price of health coverage for the aged commensurate with that available to the nonaged. If we wish to retain the self-financing character of part A (Hospital Insurance) of Medicare, the case for increased payroll taxes will be strong. If we want to continue the joint financing of part B (Supplementary Medical Insurance), we should increase premiums and general revenues to cover its costs. I see no case for the use of major new earmarked taxes until and unless they are considered as elements of an overall tax structure adequate to pay for the expenditures which our political process deems to be necessary.

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