Americans are fascinated by new things—new cars, fancier cell phones, handheld computers that one can use to surf the Net and store family photos. For many, new is better and old is, well, old and out of date. As Medicare reaches the venerable age of thirty-five, there is a lot of talk of “reforming” it in the sense of changing the program substantially. The baby boomers’ aging has fueled the sense that Medicare is—or soon will be—in crisis. Many believe this demographic shift demands a major recasting of the program. Simply increasing funding (for Medicare), in the words of one of today’s politicians, is like “putting more gas in an old car—it still runs like an old car and doesn’t have any of the features of a new car.”

My aim is not to prescribe how Medicare should or should not be changed. That role I have played elsewhere. As someone who has spent

a career studying Medicare (and medical care more generally), I want to raise some questions and question some assumptions. What, for instance, lies behind claims that America needs a “new” Medicare? Are those assumptions accurate? Such a critical examination is a precondition of sensible policy choice. Before deciding which new car to buy, we should first ask whether we need a new car at all.

I characterize and challenge four common assumptions that are employed to support the idea that Medicare requires transformative change. Again, my purpose is not to tell you what an ideal Medicare program would be. It is, rather, to suggest how not to think about Medicare reform.

**Assumption #1. The Aging of the Baby Boomers Is a Fiscal Tsunami**

The aging of the baby boomers, it is widely claimed, will bankrupt Medicare. This argument, popularized by Peter Peterson’s *Gray Dawn* (1999), has been reiterated by many journalists and politicians in recent years. This claim makes the mistake of confusing an incontrovertible fact—that the population is aging—with an unwarranted conclusion—that aging will produce “unsustainable” expenditures for Medicare as currently structured.

The truth is that despite the seemingly obvious causal connection, demography is not financial destiny. It is not the case that increasing numbers of elderly—even the “old old” (over eighty-five group) requires unaffordable outlays. Other industrial democracies have already experienced the aging we anticipate. Their experience is relevant and counter-intuitive. There is no correlation between the aging of the population and spending on medical care, as shown in Figure 1. For those who have a hard time making sense of the scatter plot, take a look at Table 1, which demonstrates the same point. Indeed, as health economist Thomas E. Getzen (1994: 102) reports, “In those [OECD] countries where the fraction of population over age 65 has grown most rapidly, spending has not increased any more rapidly than in countries where the elderly population has grown most slowly.” It is true that the United States spends a higher percentage of its GDP on health care than does any other OECD nation. But that spending is not significantly “caused” by the growth of our elderly population so much as it is a reflection of inflationary forces in American medical care generally.

The assumption that an aging population will bankrupt Medicare
Figure 1  Relationship between Age of Population and Health Spending, OECD 1994

Table 1  Relationship between Age of Population and Health Spending, OECD 1994

<table>
<thead>
<tr>
<th>OECD Nations</th>
<th>Percentage of Population over Sixty-Five</th>
<th>Percentage of GDP on Health</th>
<th>Age Rank</th>
<th>Health Spending Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>11.6</td>
<td>8.5</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Austria</td>
<td>15.0</td>
<td>9.7</td>
<td>9</td>
<td>3</td>
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<td>Belgium</td>
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<td>8.2</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Canada</td>
<td>11.9</td>
<td>9.8</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
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<td>6.6</td>
<td>6</td>
<td>18</td>
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<td>Finland</td>
<td>14.0</td>
<td>8.3</td>
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<td>Netherlands</td>
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<td>Norway</td>
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<tr>
<td>United States</td>
<td>12.7</td>
<td>14.2</td>
<td>15</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Age rank lists countries by percentage of population over sixty-five, with the oldest country having a rank of 1. Health rank lists countries by percentage of GDP spent on health care, with the country with the highest expenditures having a rank of 1.

ignores other factors. The affordability of any societal spending depends on the output of the workforce and, of course, the size of the workforce relative to those not working. When looking at demographics, therefore, one needs to look not at the ratio of elderly to workers but of all non-workers to workers. As Figure 2 shows, the answer to this question—the so-called dependency ratio—does not conform to the conventional portraiture of a dire future. Note that although the ratio of nonworkers to workers will rise from current levels, the dependency ratio projected for 2040 is still substantially lower than what was the case in the 1950s, 1960s, and 1970s. What we have as burdens depends, in short, on what else we are supporting. These projections, of course, are not infallible predictions. They do not assume, for example, that individuals over sixty-four will be gainfully employed. Improved health and extended life expectancy may well increase the number of workers over age sixty-four decades hence.

A final note on the implications of aging. If aging creates greater financial demands in certain sectors—say, nursing homes—it does not mean those needs are unaffordable. Imagine a parallel argument about the Defense Department. At the time of the Gulf War, no one argued that U.S. military involvement would cause the Department of Defense department to go bankrupt. In a democracy we constantly make choices between competing demands. A zero-base budgeting approach across
decades and generations is unrealistic. No one would suggest that every school should be kept open and the total number of teachers kept at year 2000 levels if the school-age population were to drop by a third. That a larger percentage of the population will receive Medicare in thirty years does not by itself demonstrate any one point. It does not prove that Medicare should be restructured. It does not show that the federal share of funding should be held constant. Rather, public choices about the allocation of government funds should be expected to change over time as successive generations address different social circumstances.

**Assumption #2. Medicare Must Be Reformed Because It Has Been Unable to Control Its Costs**

Another asserted but inaccurate assumption is Medicare’s alleged inability to control its costs. Proponents of remaking Medicare in the image of private health insurance are quick to highlight seemingly decisive examples of profligate spending. So, for instance, critics point to Medicare’s growing portion of the spending pie, up nearly 30 percent between 1980 and 1996—from 15.2 percent to 19.6 percent. Another picture, using other years and/or other bases of comparison, is different. Indeed, over the past twenty-five years, Medicare has on average done as well as private health insurance in controlling its per capita costs, as Figure 3 illustrates. The more recent data (from the period 1993–1999) is, forgive the expression, manic-depressive: a sharp increase in Medicare’s relative spending from the period 1993–1995 is followed in the period 1996–1999 by an equally sharp relative decrease.

In assessing Medicare’s performance, one must be certain to compare apples to apples, not to oranges. For an accurate and meaningful per capita comparison, costs must be for services covered by both Medicare and private insurance. As everyone knows all too well, many of the per capita savings in private insurance have been achieved by decreasing or denying coverage—by risk shifting and risk selecting. (In contrast, Medicare has reduced expected outlays largely by reducing payments to providers.) Figure 3 shows how Medicare’s expenditure growth rate, through such instruments as DRGs in 1983 and RBRVS in 1989, fell below that of private insurance. On careful examination, it turns out that the conventional image of a Medicare program ballooning wildly out of control is inaccurate: an example of how not to think about Medicare.
Assumption #3. Forecasts of Medicare’s Future Require That It Be Transformed

Much of the debate over Medicare’s future has been based on forecasts: forecasts of the program’s likely aggregate cost, forecasts of the number of elderly beneficiaries, forecasts of the depletion of the Medicare Hospital Trust Fund, and so on. I won’t say that forecasts are foolish; forecasts can be useful in public policy making. They can alert one to potential troubles and in that way prompt reflection. But extended forecasts cannot and should not be the dominant justifications for reform.

Nearly everyone who has looked seriously at the Medicare program agrees about the perils of forecasting in this area. Henry J. Aaron’s (1999) recent remarks are illustrative when he spoke of a fog of a fundamental unknowability surrounding Medicare cost projections beyond just a few years into the future.² Indeed, they do, as Aaron’s figure (Figure 4) illustrates. Congressional Budget Office (CBO) forecasts have varied dramatically over less than a decade. The longer the time frame, the less realistic is any forecast. Different rates of expected economic growth, for instance, dramatically change the projection of government revenues.

Consider the following illustration of forecasting variability in Figure 5. Total government expenditures—federal, state, and local—are pro-

². Also see the recent piece by Paul Starr (2000) in the American Prospect.
jected to rise from 34 percent of GDP in 1997 to a stunning 61 percent in 2030 if one assumes that the U.S. economy grows 1 percent a year in real terms over the next thirty years. That crushing burden disappears if one changes a single variable. With real economic growth of 3 percent annually, government spending as a percentage of GDP is projected to decrease to 32 percent. Uncertain and debatable assumptions drive the forecasts, and there lies the peril of fatalistic futurology.

This variability is at least as great for Medicare projections, as the most recent CBO figures illustrate (Pear 2000). In 1993, the CBO projected that the Medicare Part A Trust Fund would run out of money by 1999. In 1999, the projection of so-called insolvency had moved to 2015. By March of 2000, the projection had moved to 2023. Obviously, the booming economy explains the increasingly optimistic estimates. But economic growth is not the only important variable here. Projections of the number of elderly, their state of health, their preferences for medical care, the types and cost of medical services in thirty years all make it very difficult to predict Medicare expenditures with any degree of certainty. Technological advances may transform the care the elderly receive (and its costs) in ways that we cannot now begin to anticipate (Marmor 1998: 551–571).

This is not to claim, I repeat, that forecasting is fruitless. It is to say that one should be skeptical about long-range forecasts as the foundation for wholesale change now. As my colleague Jon Oberlander has documented, interest in “re-forming” Medicare peaks every time the Medi-

Figure 4  Medicare + Medicaid Spending, CBO Projections, Selected Years. Source: Aaron 1999: 21.
The care Trust Fund is projected to become “insolvent” in seven or fewer years (Marmor 2000: 130). Although such crisis “trip-wires” are understandable, and prompt attention to costs, they do not justify transformative policy changes.3

Assumption #4. Medicare Should Be Transformed to Mirror Current Private Health Insurance Plans

One of the most striking assertions about Medicare’s future is the claim that the program should mirror the now-prevailing structure of private health insurance markets. To illustrate: During the Medicare debates of 1995, for example, Aaron and Bob Reischauer (1995: 8–9) asserted that “congressional reforms will—and should—bring Medicare more in line with the structure of health care financing and delivery that is evolving to serve the non-Medicare population.”4

Figure 5  Total Government Expenditures as a Percentage of GDP through 2030, Using Two Assumptions of Economic Growth

Source: NAAS 1999: 27.

3. For a more extensive discussion of the fallacy of speaking of “insolvency” of a public fund, see Marmor 2000: 135–137.

4. See also the similar remarks of Stuart Butler of the Heritage Foundation in 1997: “Medicare should provide health insurance comparable to that received by others. Most workers have a choice among managed care plans with a defined contribution by employers” (NASI 1997: 2).
Human beings like parallels. That may help explain the appeal of calls for a public sector program to mirror the private sector pattern. But in the case of Medicare, the parallelism starts from a false analogy to Medicare’s birth. At the time of Medicare’s enactment in 1965, fee-for-service Blue Cross/Blue Shield plans were the norm for working Americans. The elderly sought, and with the passage of Medicare secured, a government program that mirrored what was viewed by the elderly themselves as desirable private insurance plans. The creation of separate Part A (hospital) and Part B (physician) coverage reflects Medicare’s borrowing from private health insurance plans of the period.

Some point to this historical parallelism to suggest that today, when most American families are covered by “managed care,” Medicare should be changed from fee-for-service to a more “modern” managed care format. The argument is not that the elderly want such a change or that they would be better off with such a change. No, the argument is that the elderly should not be allowed to have “gold-plated” fee-for-service coverage when the rest of Americans struggle along with increasingly restrictive HMOs and prepaid group practices.

It is no surprise that the public is far from enthusiastic about “managed care.” In a 1998 Harris poll, managed care firms ranked second from the bottom in terms of the public’s positive feelings about the industry. Whom did the public like less? Only tobacco companies (Blendon et al. 1998). If anything, those negative feelings have increased recently. Federal and state legislatures are deluged with constituent complaints about private “managed care” plans. So the argument for parallelism is particularly weak now.

Rather than using private sector comparisons to improve Medicare’s coverage, as was done at Medicare’s birth, the current proposals embrace more restrictive models. What explains these calls for “equal treatment”? The calls are not coming from the elderly. If one looks at what the elderly themselves want, one finds overwhelming support for Medicare in its present, largely fee-for-service form. Then why? Presumably to avoid resentment by those not in Medicare. If true, that resentment would indeed become a threat to Medicare’s viability. Is there any basis for the assumption that Part B’s less restrictive and arguably preferable medical coverage for the elderly has or will lead to resentment? Although younger age cohorts express concern for the long-term financial well-being of Medicare (ibid.), there is no evidence that they support changes to remake the program in the image of much-criticized managed care.
Conclusion

My topic here is framed negatively: how *not* to think about Medicare reform. This was my choice and that I have done, emphasizing currently fashionable presumptions that are false, misleading, or inadequate as bases for adjusting Medicare to contemporary circumstances. I want to close with two qualifications, qualifications without which my message will not be understood. I, as well as others, recognize that Medicare could use adjustments. Any substantial program does after more than three decades of operation. As an advocate, I have ideas about prescription drugs, about changes in local offices handling Medicare questions, and so on. But I am not a policy advocate here, or in the book on Medicare’s politics that I have recently published (Marmor 2000). As a scholar, I am concerned about how to *understand* Medicare and the discussion about change. And to do that, one must avoid common sources of distortion. They include conflating description with criticism, understanding with evaluating, unsure forecasts with accurate predictions, and the like.

I will have accomplished my task if my thoughts about how not to think about Medicare appear to readers well grounded and not, as Mencken sardonically wrote, “prejudice made plausible.”

References


Marmor, Theodore R. 1998. Forecasting America Health Care: How We Got Here