

POLICY NOTE

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Key Findings

1. *The federal Medicare and Medicaid programs turn 50 years old this year. They have become two of the largest health insurance plans in the country and account for an ever-increasing share of federal and state taxpayer dollars.*
2. *Today almost 30 percent of Americans are enrolled in these two programs. In Washington state, some 1.13 million people are in Medicare and 1.8 million are in Medicaid. This means over 40 percent of the state's population has health insurance paid for by taxpayers.*
3. *If Medicare is to continue in its present form, one or more of three things must happen:*
 - *Benefits will need to be decreased;*
 - *payroll taxes will need to be increased, or;*
 - *seniors will need to pay more out of pocket.*

A fourth option, of course, would be to use general taxes to cover more of Medicare deficits.

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Introduction

The federal Medicare and Medicaid programs turn 50 years old this year. They have become two of the largest health insurance plans in the country and account for an ever-increasing share of federal and state taxpayer dollars. For the next 50 years, they will also require more public spending than any government program, and they will add significantly to the national debt unless they are restructured and reformed. The survival of Medicare and Medicaid for future generations depends on patient-oriented reforms that must occur sooner rather than later to protect vital health services for patients.

Today almost 30 percent of Americans are enrolled in these two programs. In Washington state, some 1.13 million people are in Medicare and 1.8 million are in Medicaid. This means over 40 percent of the state's population has health insurance paid for by taxpayers.

This paper reviews the history of Medicare and Medicaid, describes their original purpose, explains the deep problems they face today, and suggests constructive ways to modernize these programs so they remain strong and effective into their next half-century.

History

In 1946, Congress passed the Hill-Burton Act, requiring hospitals to provide free care to people who were unable to pay. The bill provided public funding for 500,000 additional hospital beds. The federal government contributed \$4.4 billion, and state and local taxing agencies added \$9.1 billion to fund the program. The Hill-Burton Act expired in 1978, but established the precedent for substantial and permanent government funding of the U.S. health care system.¹

By 1960, the majority of employees had health insurance through their employers, and this insurance also covered their families. In addition, veterans were covered by both out-patient medical and hospital care through the Veterans Administration System. The Indian Health Services covered the Native American population. It was essentially the poor, the elderly, and the unemployed who were not provided specific

1 "The Patient-Centered Solution; Our Health Care Crisis, How It Happened, and How We Can Fix It," by R. Stark, 2012.

Key Findings

(Continued from last page.)

4. *The Medicaid entitlement has resulted in several harmful consequences. First, it discourages work and job improvement for low-paid employees, since with increasing income workers lose their Medicaid benefits. It also encourages low-wage paying employers to not offer health benefits. The real tragedy for people in Medicaid is the program provides no better medical outcomes than having no insurance.*
5. *More government intervention can control costs, but only by rationing health care services people may receive. To increase choice, maintain or improve quality and control costs, seniors and low-income patients must be allowed to control their own health care dollars and make their own health care decisions. This patient-centered approach is the only practical and moral way to make the Medicaid and Medicare programs financially viable over the long term.*

health care by a third party. It should be noted, however, that they did have hospital coverage through the Hill-Burton Act, and everyone had access to health insurance through commercial carriers if they chose to buy it.

From 1952 to 1962, the number of seniors with health insurance doubled from 30 percent to 60 percent. Officials in Washington, D.C., were still concerned, however, about the low-income senior group. To assist these poorer seniors, the Kerr-Mills law was added to the Social Security Act in 1960. This was a landmark bill in the sense that it was a precursor to the 1965 Medicare Act.

The Kerr-Mills law was a “means-tested” program. In other words, it provided health care for financially qualified poor seniors based on income. Also, it was a voluntary program, run by the states (although funded by the federal government), and it was actually more generous than the original Medicare program in that it included coverage for such things as eye glasses, prescription drugs and dental care.

By 1962, at least 60 percent of seniors had individual health care insurance and low-income seniors were covered by the Kerr-Mills law. Employees were covered by their employer plans. There was also a thriving private health insurance market and virtually everyone in the U.S. had access to this market. Charities and county hospital facilities provided care for the poor and indigent through the Hill-Burton Act.

Whether it was simply government bureaucracy or a political effort to sabotage the Kerr-Mills law, the Health, Education and Welfare Department (HEW) continually stalled reimbursing states for health care utilization through the program. The suspicion at the time was that HEW opposed both the voluntary nature of the program and its means-testing requirement, two features that ran counter to the universal coverage, socialized medicine ideology envisioned by many federal officials.

With President Kennedy’s death in 1963, several important factors changed the political climate in Washington, D.C. First, obviously Lyndon Johnson, already one of the most powerful political leaders of the time, became president. Second, the Democrats enjoyed a landslide victory in 1964. Third, President Johnson’s first one hundred days in office were more than a honeymoon period with Congress. There were strong emotional feelings over President Kennedy’s death, and consequently, it seemed that President Johnson and the Democratic Congress were able to pass nearly any legislation that President Kennedy had supported.

Health care for seniors had been one of President Kennedy’s main interests, and in 1965 President Johnson, as part of his Great Society legislation, pushed the Medicare bill through Congress. Interestingly enough, the Medicare bill was tied to a seven percent increase in Social Security (SS) benefits paid to seniors, the first increase since 1959. Obviously, seniors would be much more likely to support any health care legislation that was combined with an increase in the monthly Social Security checks they received. From its inception, Medicare has been tied to Social Security benefits, lending political

support to the program. To the present day, if a senior citizen opts out of the Medicare program, he will lose his Social Security benefits.

In the early years Medicare looked great. Seniors were provided with essentially free care, hospitals and doctors were given financial support from government payments, and the insurance companies were given the financial benefit of administering the whole program. Not surprisingly, the insurance companies discontinued private individual policies for seniors, since they could not compete with a government-funded program. Consequently the free market for senior health insurance collapsed and millions of senior citizens lost their private health insurance and were forced in the federal program.

When comparing Medicare with the Kerr-Mills law, several glaring differences stand out. First of all, the Kerr-Mills program was voluntary, whereas Medicare is tied with Social Security benefits and is essentially mandatory. If seniors try to leave Medicare, they will lose their Social Security benefits. This was not true of Kerr-Mills coverage.

Second, there was no means testing for Medicare to target benefits to low-income citizens. It includes every senior no matter how wealthy.

Finally, Medicare was less comprehensive than the Kerr-Mills law. Originally drug benefits, eye glasses and dental care were not provided with Medicare, though Kerr-Mills included these things.

At the time Medicare and Medicaid were created in 1965, health care made up 5.9 percent of the U.S. gross domestic product. Compare this with health care's 17.8 percent share in 2014.

Although the majority of people in the U.S. favored some type of assistance for seniors, especially low-income elderly, the specifics of the Medicare bill were a mystery to most of Americans in 1965.

No surprise was the fact that health care demand exploded after passage of the Medicare and Medicaid bill. Basically, free and unlimited health care was the driver behind the massive expansion in utilization. Within several years of passage, the federal government realized they were dealing with out-of-control entitlement programs. The wisdom of the day suggested that if the country could only train more doctors and build more hospitals, competition would increase and costs would decrease. Obviously, this was faulty economic thinking, since government dominance prevented any real competition or consumer choice. Instead, costs skyrocketed.

The 2010 Affordable Care Act (ACA), or Obamacare, extends Medicaid to all low-income adults, although the U.S. Supreme Court ruled that states have the option of not expanding the program if they choose. A majority of states have done so because the federal government will initially pay 100 percent, and ultimately 90 percent, of the new costs. Of course, federal taxpayers are also state taxpayers, so all costs are born by the same people.

The Medicare program today

At Medicare's outset in 1965 at least 60 percent of all seniors already had some form of health insurance. Also, low-income seniors were provided with health insurance on a voluntary basis through the Kerr-Mills law of 1960. These facts raise the question of why a new program was needed, whether Medicare was simply pandering to the senior vote, and whether Medicare was being used as the first step to complete socialization of health care in the U.S.

From the start, the cost of the Medicare program was grossly underestimated. The Health, Education, and Welfare Department told Congress in 1965 that the funding would require much less than 1 percent of payroll taxes. By the late 1980s, however, this was increased to 1.6 percent and subsequently to 2.9 percent. In inflation-adjusted dollars, spending on Medicare was \$4.6 billion in 1967 but had increased to \$7.9 billion by 1971. This represented a 22 percent increase, whereas enrollment had increased only six percent. By 1990, Medicare was nine times over its original budget.

In 2013, 54 million seniors received their health insurance from Medicare at a cost of \$512 billion. At the current rate of growth, it is estimated that Medicare costs will almost double to \$940 billion in 2019. Last year, 1.13 million Washington residents, or 16 percent of the population, were enrolled in Medicare.

Medicare is set up in four parts, A through D. Part A covers hospital and other non-physician payments. It is financed through the 2.9 percent payroll tax which has increased to 3.8% for high-wage earners since the Affordable Care Act (ACA) took effect in 2014. If all of Medicare deficits were to be covered, the payroll tax would have been raised to 18 percent in 2004, and to provide a break-even cash flow, each worker would have paid 20 percent in taxes in 2008. A payroll tax increase of this magnitude is not politically or economically possible, especially when stacked on top of worker income taxes. For this reason Medicare remains unsustainable and cannot continue as currently structured.

Initially, only the first \$6,600 of a worker's income was taxed to pay for Medicare. By 1993, Congress had increased the wage basis to \$135,000 and the following year this cap was eliminated completely, so that all wages are now taxed in an attempt to cover sky-rocketing Medicare expenses.

Like Social Security, Medicare was set up as a pay-as-you-go system, where today's benefits are mainly funded by current taxes. Obviously, the first wave of recipients had contributed nothing in payroll tax to the program. With the decreasing proportion of workers in future generations, and with the massive number of baby boomers approaching retirement, this pay-as-you-go system represents a financial catastrophe and is not viable.

Medicare Part B makes payments to physicians. Not surprisingly, Congress had no budget schedule for Part B. It was originally set up so that seniors would pay part and the federal government would match that to cover doctors' fees. In 1967 the total cost of Part B was \$2 billion, but by 2000, the total expense was \$90 billion a year. Taxpayers were funding 75 percent of that \$90 billion instead of the originally-proposed 50 percent match. Part B does include some degree of means

testing, where wealthier seniors pay a higher premium percent than lower-income people.

Medicare Part C, or Medicare Advantage, began in 1997 and offers seniors essentially a health maintenance

organization (HMO) insurance plan. For a set fee paid to a private insurance company, enrollees have most of their needed health care services provided. Part C is one of the fastest growing parts of Medicare.

Medicare Part D was added in 2003 and provides drug purchasing benefits to seniors who want a separate plan for pharmaceuticals.

The Johnson Administration's belief that increasing the number of hospitals and doctors would increase competition and bring costs down proved to be false logic. Their economic model failed because they did not consider that seniors do not spend their own money for the health care they receive, the bill is paid by a third party, the government. Not surprisingly, demand for free health care went up sharply and supply was increased as access was made easier. Increasing health care supply was only met with increasing demand. For example, the number of medical operations on seniors increased two and a half times in the first ten years of Medicare, in spite of a fairly constant rate of enrollment.

As with so many government bureaucratic programs, Medicare is associated with a significant amount of cheating and waste. It is estimated that fraud, abuse, and waste together cost taxpayers almost \$12 billion per year.

At least 20 percent of Medicare spending provides no benefit in lives saved or in improved quality of life for our senior citizens.²

Today seniors are paying almost as much out of pocket for health care through their Medicare co-pay as they were for private insurance before passage of the Medicare bill. It is projected that seniors will be paying approximately 30 percent of their income for Medicare coverage by 2025.³

Since the late 1980s, Congress has been gradually decreasing hospital and physician reimbursements. Just like any other government wage-and-price control policy, supply is reduced, and seniors access to health care services is now being restricted. In many communities throughout the nation, seniors are finding decreasing access to primary care because doctors cannot cover their office overhead cost with Medicare low reimbursement payments. Clearly this restricts health care choices for seniors.

It should also be noted that Medicare law requires that if a physician accepts payment for a senior's health care from a source other than Medicare, that doctor can then not accept any Medicare patients for two years. Because the private

2 "Waste, fraud and abuse in government health care," by Michael Cannon, Testimony before Congress, April 5, 2011 at <http://www.cato.org/publications/congressional-testimony/waste-fraud-abuse-government-health-care>.

3 "Growth in Medicare and out-of-pocket spending: Impact on vulnerable beneficiaries," by S. Maxwell, M. Moon, M. Segal, The Urban Institute, 2000, pdf.

insurance market for seniors has essentially been eliminated in the U.S., even the wealthier elderly have no other option other than to participate in Medicare. Doctors cannot accept cash or private insurance and still serve Medicare patients. It is ironic that a patient can offer to pay extra to the cab driver who takes him to a medical appointment, but offering extra money to a doctor is illegal.

Not only is Medicare nearly bankrupt now, but its financial future is actually much more dismal. With a proportionally decreasing labor force and an increasing number of seniors 65 and older, the Medicare pay-as-you-go system is on a course for fiscal disaster. Most young people in their twenties and thirties do not believe the program will exist for them when they reach age 65. The reality is that the payroll taxes paid by seniors during their working years account for, on average, only one third of their individual Medicare utilization costs.⁴

The most recent Medicare Trustee report indicates that Medicare has grown from 0.8 percent of the gross domestic product (GDP) in 1974 to 3.5 percent last year. Future projections in the 21st century are for spending somewhere between six and nine percent of GDP. The trustees also report that the Medicare Trust Fund, or the plan's dollar reserves, will be depleted by 2030.⁵

The Affordable Care Act makes Medicare's funding problem worse. A large part of the payment for the ACA comes from financial cuts to Medicare. To limit future health care services under Medicare, the ACA directs officials to establish a non-elected committee, the Independent Payment Advisory Board (IPAB), to determine "best practices" for providers. The IPAB theoretically cannot use cost as a criteria for imposing limits, but for the panel to be effective in controlling costs, prices of tests and treatments will have to be considered. Medicare clearly needs reform, but the ACA reduces doctor and hospital reimbursement substantially and potentially eliminates Medicare Advantage.

Although these planned doctor and hospital cuts may not ultimately happen, it is obvious that supporters of the ACA want to fund new entitlement programs by reducing doctor payments in Medicare even further. This will make access to health care for seniors all the more difficult.

If Medicare is to continue in its present form, one or more of three things must happen:

- Benefits will need to be decreased;
- payroll taxes will need to be increased, or;
- seniors will need to pay more out of pocket.

A fourth option, of course, would be to use general taxes to cover more of Medicare deficits. From an economic standpoint, none of these policies would predictably

4 "Social Security and Medicare Taxes and Benefits over a Lifetime," by C.E. Steuerle and C. Quakenbush, The Urban Institute, 2013.

5 "2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Insurance Trust Fund," pdf.

rein in the costs or decrease the demand for health care on the part of Medicare beneficiaries.

A number of government officials also believe increasing the productivity of doctors will make Medicare more efficient and will improve its financial status. Historically, the government has done nothing but increase the regulatory burden on providers, which has resulted in more inefficiency and waste.

It is somewhat unbelievable that people are calling for complete socialization of health care in the U.S. when Medicare, a socialized-medicine program itself, has been in such a dismal financial condition since its inception. By the mid-twenty-first century, Medicare expenditures will dwarf the yearly cost of Social Security

The Medicaid program today

There are currently four groups of people receiving assistance through the traditional Medicaid program that began in 1965. These are the poor, the disabled, low-income mothers and children, and those individuals needing long-term care. Although mothers and children make up most of the beneficiaries, long-term care accounts for 70 percent of Medicaid dollars spent.

Medicaid expenditures are the fastest-growing budget item for virtually all states, even though the federal government supplies, on average, 57 percent of all Medicaid dollars spent in the legacy program and at least 90 percent of dollars in the new ACA-expanded Medicaid program. State reimbursement by the federal government for the traditional Medicaid is based on the wealth of the state, with poorer states receiving a higher percentage match of federal money than wealthier ones.

Physician participation is voluntary, and doctor reimbursement from Medicaid has always been lower than that of any other payer, including Medicare. Consequently, an increasing number of physicians are withdrawing from the program, thus decreasing beneficiaries' access to health care by limiting their physician choices.

The cost of Medicaid was \$1 billion in its first year, exploding to \$450 billion by 2013. At the present rate of growth, the cost will be \$900 billion by 2019. By the year 2030, it is estimated that nursing home expenditures in Medicaid alone will equal the size of the entire Social Security program today.

The Medicaid entitlement has resulted in a number of harmful consequences. First, it discourages work and job improvement for low-paid employees, since with increasing income workers lose their Medicaid benefits. It also encourages low-wage paying employers to not offer health benefits. They assume, or hope, taxpayers will provide those benefits. Medicaid also discourages private insurance companies from offering nursing-home policies, and this market shrinks farther every year. Lastly, Medicaid discourages charity care and philanthropic work in the health care sector – if the government is already funding health care, donors are more likely to contribute money to other worthy causes.

The real tragedy for people in Medicaid is the program provides no better medical outcomes than having no insurance. In 2008, Oregon lawmakers decided

they had enough additional public money to put 10,000 more people on the state's Medicaid program. So, Oregon officials held a lottery that ultimately signed up 6,400 new Medicaid enrollees. A further 5,800 people were eligible for the program, but were not selected. People in this group had the same health and economic profile as the lottery winners, allowing researchers to make valid comparisons. This created the perfect test-case on the effectiveness of Medicaid in providing care. These 5,800 people became the control group in an objective, randomized health care study.

It turns out that being put on Medicaid does not improve health outcomes nor does it improve mortality statistics, compared to having no insurance coverage at all. The Medicaid group had no improvement in the important objective measurements of blood sugar levels, blood pressure, and cholesterol levels. The study did find that vaguely-defined "mental health" was improved, however this was done via subjective telephone interviews, not objective clinical data. For those few people requiring prolonged medical and hospital treatment, Medicaid did improve the financial status of those patients, because their medical bills were covered by federal and Oregon taxpayers.⁶

State lawmakers unfortunately have been caught in a vicious cycle in which the more they spend on traditional Medicaid, the more money they receive from the federal government because of the 50/50 match. The ACA requires the federal government to pay for the entire Medicaid expansion for the first three years. Then states will pay 10 percent of the expansion costs. It is therefore no surprise that Medicaid is the largest, and fastest growing, budget item for almost all states in the country. For example, last year 1.8 million Washington residents, 25 percent of the state population, were enrolled in the Medicaid program.

The public's perception of Medicare and Medicaid

For meaningful reforms of Medicare and Medicaid to occur, it is important to understand the American public's perceptions of the programs now and in the future. A recent telephone survey by the Kaiser Family Foundation shows that 77 percent and 63 percent of those polled believe Medicare and Medicaid respectively to be "very important."⁷

For Medicare, 48 percent of poll respondents want funding to stay the same, but 41 percent want to see it increased. The numbers are similar for Medicaid at 47 percent and 37 percent respectively.

However, those polled were not too optimistic about Medicare's future. Only 44 percent of respondents were "somewhat" or "very" confident that Medicare would exist for future generations. The number dropped to 40 percent for people 18 to 54 years of age.

6 "The Oregon experiment – Effects of Medicaid on clinical outcomes," by K. Baicker, et. al., *NEJM* 2013; 368:1713-1722, May 2, 2013 at <http://www.nejm.org/doi/full/10.1056/NEJMsa1212321>.

7 "Medicare and Medicaid at 50," by M. Norton, B. DiJulio, and M. Brodie, The Henry J. Kaiser Family Foundation, July, 2015 at <http://kff.org/medicaid/poll-finding/medicare-and-medicaid-at-50/>.

In other words, there is considerable inconsistency in how the public views Medicare. The vast majority of those polled believe we should spend at least as much, if not more, than we do now. Yet only a minority are confident that Medicare will be available in the future. Two thirds, or 68 percent, believe that “changes need to be made to Medicare” to sustain the program.

The most popular changes are negotiating drug prices with pharmaceutical companies, increasing premiums paid by wealthy seniors and decreasing the amount paid to insurance companies. The most unpopular changes are increasing eligibility age, increasing premiums for all seniors and making deductibles higher. The vast majority, 70 percent, want to see a continuation of fixed benefits rather than a premium support or voucher system.

Policy recommendations to reform and modernize Medicare

There is virtually complete agreement that the federal Medicare program is not financially sustainable in its present form. The program’s costs are rising, the number of workers paying monthly taxes into the program is proportionately decreasing, and the number of elderly recipients is about to dramatically increase as more members of the baby boomer generation reach age 65.⁸

We now have an entire generation of people who has grown up with Medicare, has paid into it and now expects full medical services in return. We also have people in younger generations who understand the bankrupt nature of the program and do not believe Medicare will still exist when they reach age 65.

A fair and workable solution to the Medicare problem must account for the reasonable expectations of both of these generations, as well as provide reliable health coverage for future generations. As a country, we have a moral obligation to seniors already enrolled in the program and to those approaching retirement age.

A simple first step to Medicare reform would be to gradually raise the age of eligibility. When the program started in 1965, the average life expectancy in the U.S. was 67 years for men and 74 years for women. Average life expectancy is now up to 76 years for men and 81 years for women, straining an entitlement program that was not designed to provide health services to people for so many years late in life.

Another simple Medicare reform would be more thorough means-testing, not just in Part B. Wealthier seniors would pay more and low-income people would pay less.

As it stands now, there is, understandably, no private insurance market for seniors. Any private market was crowded out long ago by Medicare. It is virtually impossible to compete with the government, which has monopoly power and an unlimited ability to fix prices and lose money while any potential competitors go out of business.

8 “Health Care Reform; Lowering Costs by Putting Patients in Charge,” by R. Stark, Policy Brief, Washington Policy Center, 2015.

The private market for the elderly could be resurrected by allowing people to opt out of Medicare voluntarily and allowing those seniors to purchase HSAs and high-deductible health plans. Low-income seniors could use vouchers or some type of subsidized premium support that would allow them to purchase health insurance in the private market.

Physicians should be allowed to seek partial payments from patients or their insurance companies, which by law, they cannot do now unless they leave the Medicare program entirely.

Future generations should be allowed to continue the individual health insurance they want to keep into retirement. Not surprisingly, younger people as a group are healthier than older people, so as the younger generation saves, their health insurance nest egg would build until they need it in their later years. This is the same strategy that millions of individuals and families use today to prepare for retirement. The federal government informs people that they cannot rely only on Social Security to support them after age 67, and that all working people need to plan for the expected living expenses they will incur later on. The same should be true of Medicare regarding future health care costs.

Policy recommendations to reform and modernize Medicaid

The most important first step to reforming the federal Medicaid program is to redesign it so it no longer functions as an unsustainable, open-ended entitlement. Welfare reform in the late 1990s was successful because it placed limits on how many years people could expect to receive taxpayer support. Medicaid recipients should have a co-pay requirement based on income and ability to pay.

Where applicable, Medicaid enrollees should have a work requirement. Like welfare, Medicaid should be viewed not as a permanent lifestyle, but as a transition program to help low-income families achieve self-confidence, economic independence and full self-sufficiency.

It is condescending to believe poor families cannot manage their own health care. Allowing them to control their own health care dollars through subsidized HSAs or premium vouchers would financially reward enrollees for leading a healthy lifestyle and making smart personal choices. It would also show respect for low-income families, allowing them to be treated equally with others in the community.

Local control of the management and financing of entitlement programs works best. States, rather than the federal government, should be placed in charge of administering Medicaid. Block grants and waivers from the federal government would allow states to experiment with program designs that work best for their residents and to budget for Medicaid spending more efficiently.

The income requirement should be returned to 133 percent of the federal poverty level. Medicaid should not be a subsidized “safety-net” for middle-income people by encouraging those who can live independently to become dependent for their health care on a tax-subsidized entitlement program.



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Conclusion

We now have 50 years of experience with two socialized health care entitlement programs in the U.S. There is no question they have helped millions of people, though it is not clear they have served people better than private coverage. There also is wide-spread agreement that they deny people access to many physician services because of low doctor reimbursement rates, and that they are not sustainable in their present forms.

More government intervention can control costs, but only by rationing health care services people may receive. Countries with socialized medicine use patient waiting lists to ration health care. This approach would not be acceptable in the United States. Instead, to increase choice, maintain or improve quality and control costs, seniors and low-income patients must be allowed to control their own health care dollars and make their own health care decisions. This patient-centered approach is the only practical and moral way to make the Medicaid and Medicare programs financially viable over the long term.