

MEDICARE: THE FISCAL CHALLENGE

Medicare expenditures are expected to be one of the most rapidly increasing components of federal spending from now through the year 2050 (Aaron, 2010, Table 1). Projected increases in Medicare outlays amount to 6.4 percentage points of GDP and are driven both by population aging and by assumptions regarding future rates of inflation for medical care. How to think about these developments is problematic. Are spending increases of this size plausible or realistic?

Providing greater long-term fiscal stability for the Medicare program is a complex challenge. Possible policy alternatives include changes in dedicated program and income taxes, different models of service delivery to help reduce the rate of increase in health care costs, and changes in coverage. Additionally, the Affordable Care Act (HR 3590) instituted a number of programmatic changes designed to moderate the growth in Medicare costs while creating other budgetary obligations. In this Point/Counterpoint, I invited Joseph Antos along with Ted Marmor, Jon Oberlander, and Joseph White to discuss the following questions:

1. Can reforms within the current structure of Medicare improve its fiscal stability or is structural change necessary?
2. How will Medicare's finances be impacted by the Affordable Care Act and the retirement of the baby boom generation?
3. Does it make sense to budget Medicare in the long term?
4. What are the most promising methods of health care cost control in Medicare (and in the rest of the health system)?

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MEDICARE AND THE FEDERAL BUDGET: MISDIAGNOSED PROBLEMS, INADEQUATE SOLUTIONS

Theodore Marmor, Jonathan Oberlander, and Joseph White

This exchange focuses on one part of American health care spending: Medicare. In 2009, Medicare accounted for about 20 percent of all health care spending in the U.S. (Martin et al., 2011). Federal actuaries project that Medicare's share of national health expenditures (NHE) will remain stable or slightly shrink between now and 2019 (Sisko et al., 2010).¹ An alternative forecast, which assumes increased payments for physician services, projects Medicare spending rising modestly to 20.9 percent of NHE during this decade.²

These data raise an important question: Why focus on Medicare, rather than on the costs of American health care overall? The answer is that it has become conventional in Washington to view health care costs through the lens of federal budgeting. Deficit hawks have, for over two decades, defined the deficit as a long-term problem that could destroy the economy. Many budget analysts view projected Medicare and Medicaid spending as part of a broader "entitlement crisis," a future that is conventionally portrayed as both frightening and unsustainable (Aaron, 2010; National Commission on Fiscal Responsibility and Reform, 2010; White, 2003). That crisis, in turn, is said to require immediate structural changes to Medicare that will generate sizable savings in coming decades. But the fact that a policy analysis is conventional does not make it either right or wise.

MEDICARE AND STRUCTURAL REFORM

Does Medicare require structural change? What exactly constitutes its structural problems, as opposed to issues one might consider minor or temporary? There are no clear answers because no consensus exists on Medicare's purposes or its performance. Medicare is often said to be unsustainable in its current form, but what precisely does that mean? Is the problem who Medicare insures and for what benefits? Is it how or how much the federal government pays medical providers for services delivered to Medicare beneficiaries? Or is the problem that Medicare's current financing sources are not adequate to absorb the baby boom generation now entering the program?

Nor is it clear what qualifies as structural reform in Medicare. When Medicare reformed its payment systems for hospitals and doctors in the 1980s, was that structural change? Or does structural reform encompass only policies that transform how Medicare beneficiaries obtain health insurance? What about the 2003

¹ This assumes the implementation of current law, an assumption that is, of course, open to challenge.

² Authors' calculation. The Office of the Actuary at the Centers for Medicare and Medicaid Services (2010) projected costs of Part B if physician fees were raised each year by the amount of the Medicare Economic Index instead of being cut as a result of Sustainable Growth Rate formula. We added the \$70 billion difference in 2019 into both Medicare spending and total NHE as projected in Exhibit 1 of Sisko et al. (2010), and then computed the adjusted ratio.

addition of coverage for outpatient prescription drugs, which altered Medicare's traditional insurance model by relying exclusively on private plans while also raising federal Medicare spending substantially?

Regardless of whether they are considered structural changes, in practice three major approaches to Medicare reform have emerged. The first proposes turning Medicare into a voucher program. In 2011, Congressman Paul Ryan's (R-WI) plan—approved by the Republican majority in the House of Representatives as part of the budget resolution—called for the federal government to stop offering traditional Medicare insurance for those turning 65 in 2022. Medicare instead would provide a fixed payment that beneficiaries would have to use to purchase private insurance. Medicare's costs to the federal government would equal the voucher amount (with adjustments for health status and other factors) times the number of beneficiaries. In short, federal spending on Medicare would be firmly constrained and subject, in effect, to a prospective budget.

The costs to Medicare beneficiaries, however, would not be capped. In fact, Ryan's proposal indexes the voucher amount to the Consumer Price Index (CPI), and as the rate of increase in medical costs exceeded that in the CPI, Medicare beneficiaries would have to pay a rapidly increasing share of their medical bills (Aaron, 2011). Over time, such a federal voucher would become increasingly inadequate. According to Congressional Budget Office (CBO) projections, the federal government's commitment to Medicare would by 2030 erode to the point where a typical 65-year-old would pay 68 percent of the costs of their medical care, compared to 25 to 30 percent under current law (CBO, 2011, p. 21). In other words, the federal government would limit its spending, but spending by Medicare beneficiaries would rise dramatically.

Conservatives like Ryan believe that private insurers provide better value for the money than the traditional Medicare program. Evidence suggests otherwise. The Medicare Payment Advisory Commission concludes that costs per capita within Medicare have increased by about 1 percentage point less per year than costs per capita for comparable services within private insurance (Medicare Payment Advisory Commission, 2010). CBO reports that the traditional Medicare program is 11 percent less expensive than private insurance. Medicare's size—and thus its market power—enables it to obtain lower prices from medical care providers than private insurers. Medicare also has lower administrative costs than private insurance. Consequently, CBO concludes that the Ryan voucher plan, by shifting all program beneficiaries into more expensive private insurance, would *increase* health care spending for the Medicare population (CBO, 2011).

In sum, vouchers would save the federal government money but worsen the nation's health care spending problem while shifting the growing financial burden of hospital care and medical treatment to elderly and disabled Medicare beneficiaries.

A second group of Medicare reform proposals aims to moderate program spending by paying for care differently and reorganizing the delivery of medical services to promote efficiency and better health outcomes (Cutler, Davis, & Stremikis, 2010). Such proposals include Accountable Care Organizations (ACOs) that seek to integrate medical care delivery by partnering hospitals with physician networks and medical homes that emphasize giving patients access to better coordinated primary care. Comparative effectiveness research aims to identify more cost-effective medical treatments, while the spread of electronic medical records would, its supporters argue, reduce administrative costs as well as the use of unnecessary services. Pay for performance (P4P) attempts to move American medical care toward "value-based" reimbursement by varying payments to medical providers on the basis of patients' medical outcomes or providers' adherence to treatment guidelines. And bundled payments move away from the traditional fee-for-service reimbursement system by giving providers a fixed lump sum per medical episode, diagnosis, or person.

Yet there is little evidence that any of these measures will have much, if any, effect on Medicare spending (CBO, 2008; Marmor, Oberlander, & White, 2009). Delivery

system reform is more wishful thinking than a reliable mechanism of cost control. Many of these initiatives—like electronic medical records—may be able to improve the quality of our medical care, but have little to do with health care spending. Other initiatives that address spending more directly—such as bundled payment—have to date received only limited support from public and private insurers. While cutting down on waste and unnecessary care appears to be an appealing way to reduce health care spending, it is much easier said than done. There are many recommendations that medical providers only offer—and get paid for—services that work. Unfortunately, nobody knows how to specify policies that achieve such goals. Even systems credited with more appropriate medical practice, such as the Mayo Clinic, have difficulty replicating themselves (Dartmouth Institute, 2008, p. 61). Similarly, finding politically feasible policies to bring high-spending Medicare regions in line with lower-cost areas of the country, another idea in vogue, is extraordinarily difficult. Moreover, health policy researchers continue to debate the magnitude of this variation, as well its causes (Zuckerman et al., 2010).

The third approach to Medicare reform protects the federal budget by directly reducing program benefits—for example, by increasing patient cost-sharing or raising the age of eligibility for Medicare. There are serious downsides to both of these proposals. Raising the eligibility age for Medicare would shift the burden to private payers and could create an uninsurance problem among seniors. Meanwhile, Medicare's benefit package is not, by either the standards of good employer-based plans in the U.S. or national health systems abroad, especially generous. Medicare already requires considerable cost-sharing, with beneficiaries paying, on average, over \$4,000 annually in out-of-pocket medical expenses every year, amounting to over 16 percent of their income (Kaiser Family Foundation, 2010). Some enrollees face much higher burdens: Medicare beneficiaries in poor health have, at the median, out-of-pocket spending exceeding 20 percent of their income (Kaiser Family Foundation, 2010, p. 73).

Additionally, the case for using patient cost-sharing to contain medical costs is much weaker than many commonly believe (Evans et al., 1993; Jost & White, 2010; Remler & Greene, 2009). After all, nations like Canada have no cost-sharing at the point of service yet spend far less than the U.S. on medical care. No industrial democracy depends on cost-sharing policy as a primary tool for cost control—and for good reason. Deductibles inhibit access to preventive care and other beneficial medical services. They, along with co-insurance, redistribute the costs of health insurance in ways that hurt chronically ill and low-income patients. These distributional effects are precisely what Medicare was originally designed to avoid. In short, increasing patient cost-sharing diminishes Medicare's social insurance role, which is protecting family income from large budgetary burdens when sick or in need of costly care.

THE MEDICARE COST CRISIS AND POPULATION AGING

The major solutions to restructure Medicare and reduce its spending growth would, then, do little to curtail Medicare spending or simply shift the burden of rising costs to program beneficiaries. Furthermore, the conventional story about Medicare, the entitlement crisis, and ostensibly required structural changes distorts our understanding of health care spending in another way.

The United States is the only rich democracy to have a separate public health insurance program for its elderly citizens. Elsewhere, public medical care is financed by general taxation, as in Canada and the United Kingdom, or by compulsory contributions to nongovernmental organizations, as exemplified by German sickness funds. In all these nations, policymakers do worry both about financing their health care systems and the costs of an aging society. They are, though, much more concerned by the financial effects of population aging on retirement pensions

than on medical care costs. When a person reaches age 65 in Canada or Sweden or France, there is little extra reason for worry about medical costs. They are only the difference between expected costs at age 64 and at age 65, which is trivial.

In the U.S., however, those reaching 65 leave private insurance and come onto the government budget through Medicare. Suddenly there is an identifiable and significant increase in government spending. This is especially relevant to fearful projections regarding the baby boom's retirement. Medicare spending, according to one estimate, would nearly double as a share of GDP over the period during which the baby boom cohort reaches age 65 even if costs were controlled more tightly within Medicare than in the private sector.³ Yet before and beyond the baby boom retirement period, long-term increases in the costs of federal medical care programs are overwhelmingly due to the rising costs of medical care—at rates in excess of GDP growth—rather than to population aging. Even during the time that the baby boomers are reaching age 65, less than half the increase in medical program costs will be due to demography (CBO, 2010, p. 11).

The budgetary effect of population aging is greatly amplified by the fact that the U.S. government has historically guaranteed medical care to the elderly and not to other people. *It is a shift of costs to federal budgets, not a societal cost increase.* Other budgets benefit as costs move onto Medicare. This fiscal effect is much bigger than elsewhere because our health care costs are so much higher to begin with. Put another way, what is shifted onto the U.S. government budget is much larger than the cost of a 65-year-old for comparable benefits in other countries.

Had the United States enacted national health insurance or effective cost control (preferably both), the budgetary “crisis of the aging society” would seem and be smaller. The real problems in American medical care are excessive costs for everyone—as well as insufficient coverage for the non-elderly. The conviction that Medicare is unaffordable rests on a policy illusion created by the unique structure of government financing of health care in the U.S. That structure makes the challenge of paying for medical care for an aging population seem bigger than it really is. It also focuses attention narrowly on the federal budget, rather than on the societal burdens and value of medical care.

CONTROLLING MEDICARE SPENDING

Notwithstanding misunderstandings about the impact of population aging on health spending as well as misplaced enthusiasm for vouchers and other dubious solutions, Medicare costs are a serious concern. The retirement of the baby boom generation—quite apart from deficit concerns—means that Medicare will cover a larger share of the population, making control of program spending even more important. The cost control task is twofold: short-term restraint and the creation of policies and institutions that improve the odds of long-term constraint. In the short term, Medicare must continue to muddle through by pursuing reforms that will slow the rate of growth in program spending, which will lower the base on which future spending increases compound.

Here there is reason for cautious optimism. Medicare has an established record of reforming payment policies to generate savings, a record that refutes the myth that Medicare costs are uncontrollable. In 1983, the federal government adopted prospective payment for hospitals, and in 1989 it established the Medicare fee

³ We compare spending in 2008 (3.18 percent of GDP) to projected spending in 2030—6.02 percent of GDP (Office of the Actuary, Centers for Medicare and Medicaid Services, 2010, p. 16). The last of the baby boom cohort reaches age 65 in 2029. The estimate assumes that the physician payment restraints in standard baselines are not implemented and the measures in the Patient Protection and Affordable Care Act of 2010 to restrain other payments are phased out after 2020. But the assumptions still involve more price restraint than is likely in the private sector.

schedule for physicians. The 1997 Balanced Budget Act extended prospective payment to skilled nursing facilities and home health services and reduced payments to private insurers enrolling Medicare beneficiaries (simultaneously, new efforts were made to reduce fraud and abuse). Those policies worked: Excess cost growth (beyond general economic growth and changes in the age profile of Medicare beneficiaries) in per capita Medicare spending fell from 5.5 percent during 1975 to 1983 to 0.9 percent during 1992 to 2003 (White, 2006).

Moreover, the 2010 Patient Protection and Affordable Care Act (ACA) builds on this record with reforms projected to produce substantial savings in Medicare. CBO estimates that those changes, including reduced payments to hospitals and private Medicare Advantage plans, will save nearly \$400 billion in Medicare during 2010 to 2019, reducing its annual growth rate from 6.8 to 5.5 percent (Cutler, Davis, & Stremikis, 2010). The ACA also created the Independent Payment Advisory Board (IPAB), a commission empowered to make recommendations on slowing Medicare costs if specified spending triggers are met (Congress would consider these reforms under expedited rules and if it did not act, the Secretary of Health and Human Services would implement IPAB's recommendations). The ACA additionally unleashes in Medicare the potpourri of delivery system and payment reforms discussed earlier.

Those delivery system reforms are too small or too ineffective to make much of a difference to Medicare spending in the short run. While the IPAB has more potential to rein in spending over the long term, that makes it a political target. There already are calls to repeal the Medicare board, though President Barack Obama has proposed strengthening its powers to help meet the deficit challenge. Medical care providers will certainly try to overturn scheduled reductions in their payments, but given deficit pressures, that will not be easy. Medicare's history suggests that once federal policymakers adopt payment cuts, they generally stick with them (Horney & Van de Water, 2009). By 2035, according to CBO, the ACA will reduce projected Medicare spending from 7.2 percent of GDP to 5.5 percent of GDP (Center for American Progress, 2010). Still, even if the ACA and other cost control efforts succeed—and clearly, further efforts to constrain Medicare spending will be necessary—additional revenues will be required to meet Medicare's financing challenge in coming decades. The question of what kind of Medicare program Americans can afford ultimately is more about societal commitments and values than economics or budgeting.

BEYOND MEDICARE: THE NEED FOR SYSTEM-WIDE REFORM

Over the long run, successful cost control in Medicare depends on effective measures to control spending in the broader U.S. health system. There is much Medicare can do to moderate its spending, but the program is also constrained in important ways. Medicare could further tighten some of its prices. Yet given that it already pays providers lower rates than private insurers, additional cuts could, as health economist Joe Newhouse argues, “jeopardize Medicare beneficiaries’ access to mainstream medical care” if a significant portion of physicians refuse to see program enrollees (Newhouse, 2010, p. 1721). Nor can Medicare policy by itself reduce all incentives for purchase of excess equipment. Medicare could lower payments for those services, but effects would be stronger if other payers’ fees were also reduced.

The United States has a system-wide health care cost problem, not a Medicare cost problem. If forecasts of future increases in medical care spending make Medicare seem unsustainable, so too must private insurance be unsustainable. The U.S. spends substantially more than other nations on medical care, without evidence of commensurately greater value or better outcomes, as a result of higher prices per service, higher administrative costs, and excessive supply of some equipment (but not of hospital beds or physicians) and use of selected expensive procedures in the United States. These sources of medical cost growth cannot be changed by addressing Medicare alone. The U.S. needs system-wide policies to control spending.

What, then, can be done? The most promising strategy would be to adopt an all-payer system. Under that system, used in nations like Germany and Japan, all insurers would pay medical care providers according to the same fee schedule, perhaps with modest variations (e.g., private payers might pay 5 percent higher than Medicare across the board). An all-payer system would concentrate purchasing power and allow public and private insurers to hold down prices, while alleviating problems of vastly divergent prices across insurers that can impede patient access to medical services (Oberlander & White, 2009; Newhouse, 2010). It would also allow policymakers to use prices to relocate supply by altering relative prices across the board so that, for example, doctors' offices did not find it profitable to buy and operate CT scanners. All-payer reform would additionally address administrative waste. The American insurance system currently generates extra costs because doctors and hospitals have to deal with the immense variety of different contracts and pay schedules. Standardization would reduce those costs.

It is time for the U.S. to do what all other rich democracies do: regulate prices for the system as a whole, thereby reducing both payments for care and administrative costs, and moderate excessive growth in the use of certain services. That is the best approach for controlling health care costs—and, along the way, Medicare costs.

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MEDICARE REFORM AND FISCAL REALITY

Joseph Antos

Demographic, economic, and political forces have placed unprecedented demands on Medicare that cannot be met without major program reform. The oldest baby boomers have just turned 65, heralding the start of a 70 percent expansion in the Medicare population over the next two decades (Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2010, Table II.A3). Continued improvement in our ability to diagnose and treat disease has meant greater longevity and better quality of life, but will drive Medicare costs more sharply upward in the years to come (Congressional Budget Office [CBO], 2010a, Box 1–2). These factors will drive up demand for Medicare-covered services while the country's worsening fiscal crisis increases the pressure to reduce the growth of Medicare spending.

It is only natural in politics and human nature to want more while spending less. If the discrepancy between desires and willingness to pay is not too great, we could get along as we have in Medicare for the past several decades—trimming provider payment rates, rooting out fraud and abuse, and occasionally risking a more significant change in Medicare policy (such as hospital prospective payment or competitive bidding for durable medical equipment). But we face a much larger problem that is not likely to resolve on its own. Policies are needed to change the fundamental incentives that drive provider and patient behavior in Medicare—and ultimately the entire health sector.

DEFICITS, DEMOGRAPHICS, AND DESTINY

The U.S. is in a serious fiscal crisis. The recession that ended in 2009 was the longest downturn since the Great Depression. The ensuing recovery has been anemic, with unemployment hovering around 9 percent. According to President Obama's National Commission on Fiscal Responsibility and Reform, the nation is on an unsustainable fiscal path, with spending well above tax revenue (National Commission on Fiscal Responsibility and Reform, 2010). Federal debt is likely to increase dramatically, rising from 62 percent of GDP in 2010 to 87 percent in 2020 under realistic assumptions (CBO, 2010a, Figure A-2).¹

There is widespread agreement that the growth of federal health spending is our largest fiscal challenge (see Bipartisan Policy Center, 2010; Galston & MacGuineas, 2010). The technical challenge is identifying policies that can successfully harness Medicare's spending growth with the least impact on access to services and quality

¹ Estimates based on CBO's alternative fiscal scenario. That scenario assumes an extension of the 2001/2003 tax cuts (effectively what was passed in December 2010, after the CBO report was issued). It also assumes other tax changes that reduce revenue, permanent deferral of reductions in Medicare physician payments, and more rapid spending growth for health and discretionary spending than under its "extended baseline" scenario.

of care. The political challenge is mustering the will and bipartisanship necessary to take difficult policy actions in a program that will serve a rapidly growing number of voters.

Demographics may not be destiny, but they are highly predictable in Medicare. The entry of the baby boom generation into the program follows several decades of slow but steady enrollment growth. Their impact on program spending will not be felt for some years, however, because younger Medicare beneficiaries are healthier on average and use fewer services.

According to the Medicare Trustees, program spending (as a share of GDP) will decline over the next few years before it accelerates with an aging baby boom generation.² Between 2010 and 2020, Medicare spending in real terms is projected to grow by 9 percent even though enrollment will increase by 34 percent. Between 2020 and 2030, the trends are more similar, with 30 percent real spending growth and 27 percent enrollment growth. This pattern could buy policymakers a little more time to settle their differences and address Medicare's spending problem in a serious way.

Those estimates may be overly optimistic. They are based on the assumption that the reductions in Medicare provider payment rates enacted in the Patient Protection and Affordable Care Act (PPACA), as well as previously legislated cuts in physician payment, will be implemented in full. Medicare's chief actuary has characterized those cuts as "unsustainable," driving Medicare payment rates below those of Medicaid by 2019, which would cause substantial reductions in the number of providers able to serve the Medicare population (Foster, 2010).

If future Congresses fail to implement PPACA's Medicare cuts, program spending would grow significantly faster than currently expected. Assuming that reductions in Medicare physician payments are abolished (which is the *de facto* policy) and other provider cuts are phased out after 2019, Medicare spending (as a share of GDP) will grow 68 percent between 2010 and 2030 rather than the 42 percent assumed by the Trustees (Shatto & Clemens, 2010).

It is clear from these studies that there is considerable uncertainty about PPACA's ability to stabilize Medicare's financing. Even if the new law's provisions to reduce Medicare spending are implemented,³ there is no reason to think that those policies will remain in place permanently, particularly in the face of mounting pressure from providers whose incomes are adversely affected. This political challenge is faced by any strategy intended to make Medicare financially sustainable over the long term.

OLD POLICIES, OLD PROBLEMS

The 2010 health reform legislation was an exercise in fiscal musical chairs. New subsidies for health insurance in the exchanges and expanded Medicaid eligibility were funded by new taxes and cuts in payments to Medicare providers. Health care providers hope that most of the revenue they lose through reductions in Medicare payments will be made up through increased payments from the formerly uninsured. At least initially, there are no significant changes in the way Medicare operates, and no significant changes in the way health care is delivered to seniors.

The bulk of Medicare budget savings comes from across-the-board reductions in provider payment rates. Euphemistically labeled "productivity adjustments" lower

² Despite the growth in enrollment, Medicare spending declines 2.8 percent in real terms between 2010 and 2013 before returning to its previous level by 2017. Author's calculations; Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (2010, Tables III.A2 and III.A3).

³ It has been argued that most provisions enacted in the past 20 years to produce Medicare savings were successfully implemented, but that analysis ignores subsequent legislation that undermined those savings. See Van de Water and Horney (2010).

the market basket updates for hospitals and other institutional providers, generating \$156 billion in savings through 2019 (CBO, 2010b). Those reductions will be taken whether or not providers are able to increase their productivity and reduce their operating costs. Another \$40 billion is saved by cutting payment rates for home health care.

Focusing on payment rates is business as usual in Medicare. But program costs are driven more by growth in the volume and complexity of services than by prices, so business as usual is not fiscally sustainable.

PPACA also targeted Medicare Advantage (MA) plans for \$135 billion in payment reductions. MA plans will now be paid at or very close to the equivalent rates in fee-for-service Medicare, reducing many plans' ability to offer additional benefits and reducing their attractiveness to beneficiaries. This is a false economy since traditional Medicare's costs are above the bids of MA plans in many local markets. Even greater savings are possible by creating head-to-head competition between MA plans and traditional Medicare, and paying the lowest bid that clears the market (Coulam, Feldman, & Dowd, 2009).

NEW POLICIES, NEW PROBLEMS

If there is a virtue in traditional price-setting policies in Medicare, it is that the Congressional Budget Office (CBO) will usually score them as budget savers. However, policymakers recognized that price controls are not sufficient to sustain the massive expansion of federal health subsidies in PPACA. Other, more speculative, policies were advanced that intend to change the practice of medicine and the delivery of care.

ACOs

Perhaps the most widely touted initiative is the creation of accountable care organizations (ACOs). ACOs are supposed to offer the care management and cost containment possible under managed care, but in a fee-for-service context (Daly & Zigmond, 2011). Rather than formally enrolling in an ACO, beneficiaries in traditional Medicare would be assigned to one based on their use of providers and health services. This kinder and gentler version of an HMO would not restrict the beneficiary's choice of providers but would hold the ACO accountable for the total use of Medicare-covered services, including services rendered by non-ACO providers.

The logic behind this initiative is elusive, to put it mildly. Because patients will suffer no consequences if they seek care outside the ACO network, ACO providers will have very little ability to prevent the potentially wasteful treatment that characterizes fee-for-service Medicare—but they will be penalized for it. Moreover, the clear political need to micromanage these new plans—amply demonstrated in the 429-page proposed regulation (U.S. Department of Health and Human Services, 2009)—in an attempt to anticipate and prevent everything that could go wrong will stifle the private-sector innovation that policymakers say they want to encourage.⁴ It is no surprise that the high-profile health care centers (including the Mayo Clinic, the Cleveland Clinic, Intermountain Healthcare, and Geisinger Health System) that are claimed to be the models for ACOs are unlikely to participate (Adams, 2011).⁵

This does not mean that we should not seek new ways of organizing the business of health care. It does mean that detailed government direction of such an effort is

⁴ Experts who support the ACO concept also have concerns about its feasibility in light of the new regulation. See, for example, Lieberman (2011).

⁵ Marshfield Clinic, the biggest financial winner in the Medicare physician group practice demonstration that is the precursor the ACOs, likely will not initially participate in the ACO project because of its restrictions. See Wilkerson (2011).

unlikely to produce workable models. Policymakers cannot readily accept political risks and failed initiatives, but innovation is unavoidably a risky process that builds on failure and learns from mistakes. This is inevitably a process driven from below—in the market—not directed from above.

Comparative Effectiveness

One of the ongoing concerns about our health system that drives up costs unnecessarily is the lack of solid evidence on what works for which patient. PPACA established the Patient Centered Outcomes Research Institute as an independent nonprofit organization that sponsors comparative clinical effectiveness research (CER) intended to better inform treatment decisions. In addition, the American Recovery and Reinvestment Act of 2009 provided \$1.1 billion to the U.S. Department of Health and Human Services (HHS) for CER.

Although government and private organizations (including health insurers and academic researchers) have been conducting CER for some time, the research and its potential use to influence clinical care is controversial.⁶ There are many technical concerns, including how the research should be conducted (clinical trials, analysis of claims data, systematic reviews of existing clinical research), what constitutes sufficient evidence to drive clinical decisions, how to stay abreast of the plethora of treatment innovations that are developed every year, and how to be sure that CER-based recommendations take appropriate account of variation in patient response to treatment.

Even if those thorny problems are resolved eventually, it is not clear how CER results will be used. CER raises the prospect that insurers or the government could formally ration medical care without direct input from the patient or physician. That concern is heightened by the prospect that the results of CER studies are likely to change as more evidence is gathered. HHS Secretary Kathleen Sebelius was caught up in the kind of controversy that CER could spawn on the sensitive topic of mammography guidelines. She essentially overruled the recommendations of the U.S. Preventive Services Task Force regarding routine mammograms for women under age 50, stating that this is “an area where the recommendations have gone back and forth for years” (Condon, 2009).

There is no question that patients and their physicians need better information regarding clinical choices, and there is no avoiding the fact that insurers will continue to make coverage decisions using the information that is available. Medicare has tested ways of bringing more evidence to bear on coverage determinations (notably through “coverage with evidence development”; Tunis & Pearson, 2006), but it seems likely that the program will not take the lead given the sensitivity of such issues.

Moreover, traditional Medicare provides no incentives to patients or providers to make cost-effective decisions. Most patients have no financial incentive to refuse high-cost, low-value services because they have supplemental insurance (through Medigap, retiree plans, or Medicaid) that covers the cost-sharing requirements they would otherwise pay out of pocket. Fee-for-service providers similarly have no financial reason to refrain from prescribing a service or a clinical test that might have some value to the patient, even though the odds are low. Such incentives are likely to overwhelm all but the clearest recommendations arising from CER.

New Payment Methods

The just-described perverse incentives of fee-for-service payment are well known. The search for new payment methods that retain the character of fee-for-service but

⁶ The challenges of CER are reviewed in Congressional Budget Office (2007) and Harrington (2011).

can promote more efficient delivery of services has been ongoing for decades. New payment approaches involve variants of bundling (making one payment for a series of related services) and pay-for-performance (making higher payments for better results).

The best-known refinement of fee-for-service payment is the hospital prospective payment system (PPS), which provides a single payment for all hospital services provided during a patient's inpatient stay. Medicare's adoption of PPS in 1983 revolutionized hospital care in the U.S. as other insurers also converted from cost-based reimbursement to the new system. Hospital stays shortened, as an additional day no longer added to the hospital's payment, but also sparked the growth of post-acute care services needed by many elderly patients who no longer need the more intensive care. The portion of patient care covered by the fixed prospective payment has become more efficient, but the incentive to push services that may previously have been provided by the hospital into the hands of a different fee-for-service provider is clear.⁷

New fee-for-service payment methods build on the PPS concept, expanding the range of services covered by the payment. A bundled payment is likely to include inpatient services, some pre-admission services, and post-discharge services for 30 days or some other relatively brief period. Other new payment approaches offer rewards, in the form of quality bonuses or shared savings, for more effective clinical and financial performance.

These methods remain developmental, however. The PPS example illustrates the fact that there are unforeseen problems with any payment system as providers respond to the new incentives and restructure the way they provide services. More importantly, such methods generally rely on centralized price setting rather than the interplay of market forces. That means payments will adapt less rapidly and less completely to changes in the way medicine is practiced, and payment policies will remain as much political as they are financial. At best, the new payment approaches will prop up Medicare's fee-for-service system based primarily on supply-side concerns, without fully engaging the power of competitive markets to drive health system improvement.

PUTTING MEDICARE ON A BUDGET

As we have seen, there are many interesting ideas that might eventually yield practical policies to rein in the growth of Medicare spending. But that is far from certain. If we want to ensure Medicare's fiscal stability, we must put the program on a budget. If we are fortunate, that budget does not need to be a binding constraint if developments in the health sector yield efficiencies without the threat of limiting payments. That happy circumstance does not appear likely to this observer.

Placing a responsible limit on Medicare's spending trend can spur transformation in the delivery of health care that could benefit everyone. The way that is done will determine how well our health dollars are spent and whether we find a satisfactory balance between health spending and other national priorities.

Two basic approaches have emerged from the political debate. President Barack Obama has proposed using the Independent Payment Advisory Board (IPAB) to limit the growth in Medicare spending through reductions in provider payment and other policies that focus primarily on the supply side of the health market (White House, 2011). Rep. Paul Ryan (R-WI) has proposed a premium support system for Medicare, which offers beneficiaries a choice of health plans but limits the growth

⁷ A host of other issues have been identified with PPS, including the risk that hospitals may be less careful to prevent complications after admission because more complex cases are paid at higher rates and the disincentives to adopt new technology because payment may not reflect the additional cost. See Averill et al. (2006) and Medicare Payment Advisory Commission (2010).

in government subsidies for that coverage (House Committee on the Budget, 2011; CBO, 2011).

One is a top-down approach, relying on the regulatory power and financial leverage of the federal government. The other is a bottom-up approach, relying on health plans to tailor their offerings and trim their costs to attract market share. Despite their major philosophical differences, either approach could be strong medicine for the Medicare program.⁸

The IPAB was created to circumvent Congress's endemic failure to take the difficult actions needed to ensure Medicare's financial stability. Attempts to limit Medicare spending are pilloried by politicians as depriving seniors of "necessary" care, no matter how dubious that may be. Regrettably, this is one of the few points of bipartisanship in the current health policy debate.

Instead of leaving Medicare policy solely to elected officials, PPACA established an independent board charged with holding Medicare spending growth to no more than the rate of growth in the economy plus 1 percentage point.⁹ (The president's framework toughened the standard to economic growth plus 0.5 percentage point.) The board would make policy recommendations to Congress, which the latter could replace with actions of its own but only if the new policies resulted in an equal or greater reduction in Medicare spending.

Absent congressional action, IPAB recommendations would have the force of law. Moreover, PPACA specifies that IPAB actions are not subject to judicial review. These procedures raise constitutional questions, including whether Congress has the right to delegate its legislative responsibilities to an unelected board.

The board is prohibited from recommending policies that ration health care, raise revenue or beneficiary premiums, increase cost-sharing, or otherwise restrict benefits or modify eligibility criteria. In other words, no actions that would directly affect potential voters are permitted.

Instead, IPAB will rely heavily on cuts in provider payment rates, changes in conditions of provider participation, and potentially new payment models. Although nothing precludes IPAB's adoption of competitive bidding methods and other market-based payment arrangements, an Obama-appointed board would likely favor more centralized pricing approaches. With the likely decline in Medicare Advantage due to payment reductions and other restrictions imposed by PPACA, beneficiaries will have few alternatives to the tightly constrained fee-for-service Medicare program.

In contrast, premium support promises to expand plan choices, allowing beneficiaries to express their preferences about how they want to receive their care in a world of restricted budgets. Instead of focusing on the supply side of the market, premium support limits the subsidy provided to Medicare plans. Within limits, competing health plans could adjust their benefits, provider networks, cost-sharing requirements, and premiums to attract enrollees. Beneficiaries choosing more expensive plans would pay higher premiums.

A prototype of premium support already operates as Medicare's Part D program. Beneficiaries wishing to purchase prescription drug coverage through Medicare have a range of plan choices that offer varying combinations of local pharmacy networks, mail order pharmacy, preferred drug lists, cost-sharing requirements, and premiums. Part D plans must meet Medicare's standards, and HHS provides standardized information that helps beneficiaries compare their plan alternatives. Competition is

⁸ The Obama "framework" establishes a spending target that is tighter than prescribed in PPACA for IPAB, whose policies would begin to take effect as early as 2015. The Ryan proposal establishes the premium support program in 2022, but its deficit reduction goal is more ambitious than the president's. Obviously, either target can be ratcheted up or down. A comparison of the fiscal effects of the proposals is available; see Committee for a Responsible Federal Budget (2011).

⁹ Specifically, the rate of growth in Medicare spending per beneficiary may be no greater than the rate of growth of GDP per capita plus 1 percentage point.

robust, resulting in lower costs for both the government and the beneficiary than anticipated when the program was enacted.

The key difference between the IPAB model and premium support is the degree of consumer involvement and plan innovation that is permitted. Premium support assumes that seniors have varying preferences with regard to the details of their health plans and that enough of them would act on those preferences if given the chance. That would motivate health plans to refine their offerings to increase market share, and would make the plans sensitive to the changing demands of consumers.

Since seniors live on limited incomes, plans will be motivated to find more efficient ways to deliver services that cut cost without unduly burdening patients. They cannot simply order more tests or procedures to increase their profits, as is the case in a fee-for-service world, because the total payment for an enrollee is limited. That provides a strong incentive to seek ways to deliver care that are both more efficient and attractive to consumers.

CONCLUSION

Incentives drive behavior, in life and in the health sector. Medicare's uncapped entitlement and fee-for-service incentives have driven a steady but unsustainable rise in program spending. The baby boom generation, which financed much of that expansion during their working years, is beginning to retire and enroll in Medicare. That means even greater financial burdens on younger generations—and on younger baby boomers.

It is not surprising that policymakers from across the political spectrum are proposing to put Medicare on a budget. How they do that matters a great deal.

A top-down regulatory approach is akin to trying to hold back the tide. Eventually the tide rolls in, in this case because regulators can never anticipate the imaginative ways people have of evading the rules if that is in their best interest. Instead, policymakers should take full advantage of economic incentives by not stifling that ingenuity under a blanket of excessive rules.

Premium support accepts the fact that resources available to Medicare are not limitless, and it provides beneficiaries with realistic health plan options. It also is a wake-up call to the health industry to provide more efficient and effective care if plans expect to operate successfully in a world of resource constraints. If the industry responds in that way, unnecessary costs will be trimmed by the providers themselves. But the industry might seek political relief instead, which would mean higher taxes rather than increased efficiency. Our health care and our fiscal future depend on Congress just saying no, and meaning it.

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MEDICARE'S REALITY IS NOT WHAT IT SEEMS: RESPONSE TO JOSEPH ANTOS

Theodore Marmor, Jonathan Oberlander, and Joseph White

We agree with Joseph Antos on two important matters. Medicare spending, both essays suggest, should be subject to budgetary control. We also agree that the delivery system reforms now in vogue have been oversold as solutions to rising health care costs. From there, however, our diagnoses of Medicare's special concerns and conceptions of desirable policy remedies differ profoundly.

Antos begins with an implicit syllogism. His initial premise is that Medicare faces "unprecedented demands that cannot be met without major program reform." His second premise is that competition in medical care reduces health care spending growth by transforming economic incentives for patients and medical care providers. Thus, according to Antos, it follows that competition reform (illustrated by Congressman Paul Ryan's plan) is the solution to Medicare's sobering "fiscal reality."

This syllogism, common in Beltway thinking about Medicare, is seriously misleading. The initial premise assumes a level of agreement on Medicare's fiscal problem that does not exist. The second premise is false empirically. And the resulting conclusion reflects misplaced faith in the power of markets to control health spending while ignoring the downsides of applying competition in Medicare.

DEFICITS, DEMOGRAPHICS, AND DESTINY

We disagree with the claim that the growth of federal health spending is currently America's "largest fiscal challenge." That assertion ignores other crucial parts of the budget. Massive current deficits are due to a combination of excessive tax cuts, unwillingness to pay for national defense, grievous mismanagement of the economy, and the resulting recession. Increases in the national debt in the next decade will arise largely from those policies and the costs of associated interest payments.

Federal health spending is our "largest fiscal challenge" only if one chooses to emphasize the uncertain world after the next decade and ignore the more predictable near future. We do not believe that is a good way to budget. Indeed, overemphasis on Medicare provides a cover of seeming fiscal responsibility for the House Republican budget plan. This plan calls for deep cuts in Medicare and Medicaid while simultaneously extending tax cuts for upper-income Americans, which would substantially worsen the deficit. That incongruity underscores a different reality: The movement to privatize Medicare has an ideological rather than a fiscal rationale.

We do agree that, if left to continue at present rates of growth, Medicare will create powerful pressures on government revenues and other public programs. The rate of growth in Medicare spending requires moderation. But differences emerge on how to treat the program growth arising from demography as distinct from increases in prices and volume. As we argued in our opening essay, a 64-year-old worker who turns age 65 does not transform anything other than the sources of

payment for the medical care used. If a population group increases by 50 percent, one should expect any program serving that population to grow by 50 percent. This is not a problem of medical care burdens, but an issue of sources of finance. Medicare will surely require additional revenues as its enrollment grows.

The claim that demography is destiny is false. The experience of northern Europe over the past three decades illustrates why. Germany, Norway, Sweden, Denmark, and Holland experienced the proportional growth in their older population that the U.S. will experience from 2000 to 2020. None of them made structural changes in their broad medical care programs in response to that aging. Yet their costs did not spiral out of control. Studies have repeatedly shown that population aging's contribution to increases in health care spending across industrialized democracies is modest.

COMPETITION IS NOT THE ANSWER

Antos describes what he sees as the Obama Administration's "top-down" regulatory approach to controlling costs, exemplified by the newly created Independent Payment Advisory Board (IPAB). As Antos rightly notes, the IPAB will likely focus on cutting Medicare's payments to medical providers and adopting changes in payment methods.

In contrast to this top down approach, Antos touts the Republican voucher plan, which emphasizes competition among private insurers. He prefers this "bottom-up" approach to cost control because it will produce greater "consumer involvement." Antos further argues that fixed voucher payments will provide health plans "a strong incentive to seek ways to deliver care that are both more efficient and attractive to consumers."

The IPAB's potential, as well as that of delivery system reforms embedded in the ACA, to impact Medicare spending is highly uncertain. The United States needs an effective system of cost control that extends beyond Medicare to restrain spending growth across the entire health care system. That is why we made the case for all-payer rate regulation that would encompass public and private insurance plans. Such policies are widely used in other industrialized democracies to contain health care spending.

But is Antos's bottom-up model of vouchers and private insurance competition preferable to all-payer reform or regulatory approaches to cost control? Clearly not. For starters, other industrialized nations like Canada and France spend far less on medical care than the U.S. without using a voucher system, belying the claim that competition is essential to controlling health spending. The few international examples of private insurance competition have produced high administrative and out-of-pocket expenses (Switzerland) and declining enrollment with costs rising much more rapidly than projected (Holland).

Antos overlooks Medicare's own checkered history with private plans—his faith in such plans' "ingenuity" is not matched by their performance. The federal government has long lost money on private insurance plans contracting with Medicare, and private insurance continues, as the Congressional Budget Office recently concluded, to be more expensive than traditional Medicare. Privatizing Medicare would *raise* health care spending for program beneficiaries.

Antos also does not mention myriad problems with the Medicare Part D program for prescription drug coverage, which he cites as a model of competition. Those problems include massive confusion among beneficiaries, marketing abuses, rising premiums (up 57 percent since 2006), the failure of most private insurers to develop comprehensive coverage that filled gaps in the infamous "doughnut hole," and lower than expected enrollment in both the program overall and subsidy arrangements for lower-income enrollees, which is one reason Part D costs were lower than initially forecast. In addition, nearly 30 percent of Medicare beneficiaries have

cognitive and mental impairments, raising serious questions about their ability to thrive in a competitive insurance system.

We also wonder what is consumer friendly about Republican voucher proposals, like the Ryan plan, that greatly reduce federal benefits and shift the majority of medical care costs to Medicare beneficiaries. Antos speaks of meeting the “changing demands of consumers” and “allowing beneficiaries to express their preferences.” But that market rhetoric obscures a less appealing reality. The Ryan plan’s fixed voucher payments would leave Medicare beneficiaries to fend largely for themselves in paying rising medical bills. That burden would accelerate over time as the voucher’s value declined. “Consumer involvement,” in this context, is merely a euphemism for cutting benefits and forcing patients to pay more. Nor would the Ryan plan expand beneficiaries’ health plan choices. It would in fact reduce their options by eliminating traditional Medicare, which ensures broad access to hospitals and physicians, the choice that matters most to patients.

In sum, we agree that widely promoted ideas to reform the health care delivery system do not provide easy answers to control Medicare spending. But it does not follow that vouchers, which would limit federal spending while shifting the burden of rising costs to Medicare beneficiaries, are the answer. We need not abandon the idea that the elderly and disabled should be guaranteed decent health insurance. Medicare as we know it is manageable if we actually learn—from the experience of others—how to combine fair access to medical care with budgets and restrained spending for all Americans.

TOP-DOWN CONTROLS NOT THE SOLUTION: RESPONSE TO MARMOR,
OBERLANDER, AND WHITE

Joseph Antos

Ted Marmor and colleagues argue that the problem is not Medicare but the entire health system. We do indeed have a system-wide problem, but if we expect to solve it we have to start with Medicare. The program sets the pace for the rest of the system through its myriad regulations, instructions, and other guidance, which have tremendous influence on how health care is delivered in this country. Medicare is not only the largest individual payer, but it also has the threat of legislative, judicial, and political action to ensure that providers fall into line. Changes in Medicare quickly spread throughout the system as providers and private insurers adapt to the latest fiat.

Although Medicare has considerable leverage over the health system, that does not mean Medicare's rules will produce exactly what policymakers have in mind. Despite considerable expertise at the Centers for Medicare and Medicaid Services (CMS), information about the program's operation is incomplete and slow to arrive. Even if the information was comprehensive and could be analyzed in a timely manner—an unrealistic expectation now and in the future—neither the experts nor Congress can accurately anticipate how patients, providers, and plans will react to a change in policy. This uncertainty partly explains why Congress enacts so many changes in Medicare's statute and why CMS issues so many regulations, attempting to perfect a system that is constantly changing.

The single-payer policy supported by Marmor, Oberlander, and White is subject to the same lack of accurate information and inability to predict behavioral responses to policy changes. Their vision of an orderly society ignores the failures of economic planning and price controls around the world. Bad guesses about either the absolute price level or relative prices misallocates resources, leading to shortages or surpluses.

Moreover, a central price authority will set rules defining not only the prices but also which products get which price. That will spawn efforts by suppliers to either change their product enough to be reclassified into a higher payment category (even if the alteration makes the product somewhat less desirable to consumers) or to use their political clout to get an exception.

Sound familiar? The Balanced Budget Act of 1997 attempted to expand health plan choices for seniors, but overly tight limits on payments caused half of the plans to drop out within two years. The Medicare physician fee schedule was supposed to increase payments for primary care, but the physician experts who advise CMS have done the reverse. The Affordable Care Act (ACA) was supposed to guarantee that insurance would have a generous annual limit on benefits, but hundreds of union and employer plans that would have had to drop their coverage received waivers from a chastened U.S. Department of Health and Human Services (HHS). These examples are clearly not the outcomes that proponents of price-setting policies—including Republicans—wanted, but they are the kind of unanticipated reactions that we can expect.

Expert judgment, including that of top economists, can easily lead policy astray. Indeed, Marmor, Oberlander, and White fall into a logical trap set unwittingly by the

Congressional Budget Office (CBO), which estimated Medicare beneficiary costs under ACA and Representative Ryan's version of premium support (CBO, 2011).

CBO assumed that ACA would be fully and permanently implemented, driving costs down sharply. A recent analysis for the Medicare actuary shows that Medicare payment rates would drop permanently to Medicaid levels (Centers for Medicare and Medicaid Services, 2011), which means seniors would face the same access problems Medicaid enrollees now face. In contrast, CBO assumes that private plans would have to pay the market rate to maintain current levels of access. Hence, the performance standard set for premium support through this exercise is far higher than for Medicare under ACA. The higher cost under premium support assumes ACA works perfectly and premium support fails to work at all.

Marmor, Oberlander, and White seem to believe that Congress would be able to maintain Medicare pricing at Medicaid levels without much question, citing a study by two of my former CBO colleagues (Horney & Van de Water, 2009). Cuts have been implemented with regularity—but so have later legislative acts that give back much of the money. Even the substantial payment cuts in the Balanced Budget Act of 1997 were negated by subsequent legislation, culminating in the 2003 prescription drug legislation that raised Medicare Advantage payments to levels at least as high as fee-for-service costs. Can we really expect system-wide price controls to be less vulnerable to political manipulation?

The power to price is the power to micromanage, and the wrong price signals will retard changes that can improve efficiency, effectiveness, and patients' satisfaction with their health care. Experts cannot anticipate the innovations in medicine and management that could allow us to get more for our dollars. A macro approach that gives patients and their providers a say in the resource allocation decisions allows the flexibility needed to create a health system we can live with.

As Marmor, Oberlander, and White state, deciding what kind of Medicare the country can afford is primarily a question of social values. The health policy debate for too long has focused on health and nothing else. That is why the budget perspective is valuable. We need to find a sustainable balance between health spending and other priorities, both now and for future generations. Implemented carefully, premium support provides the kind of flexibility and responsiveness that can allow the health sector to find innovative solutions to our most fundamental problems.

Medicare is a social insurance program that has the unfortunate characteristics to be expected from any centrally controlled provision of services. It is inflexible and proven to be unable to respond to improvements in benefit design embraced by private insurers. The program did not cover essential prescription drugs for more than three decades and still does not provide protection against catastrophic health care costs. Seniors say they are happy with Medicare, but most have supplemental coverage that fills in Medicare's gaps. Without that coverage, they would be far less satisfied. Those who support a Medicare-for-all model should look first to restructuring Medicare into a sensible insurance plan before taking on the rest of the system.

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