The Medicare Bind

Democrats should defend Medicare. But if they want to accomplish much else, they will have to change it.

BY PAUL STARR

Medicare now faces a more uncertain future than at any time in its history. That's not because it has lost popularity or failed to control costs as effectively as private insurance has. On the contrary, the program continues to enjoy overwhelming public support, and since the late 1990s, its costs per beneficiary have grown more slowly than those of private insurers. Nor does Medicare confront an imminent crisis; in fact, its costs have decelerated in the past year.

But with the aging of the baby-boom generation and the general trend toward higher health expenditures, federal spending on Medicare is set to increase sharply over the next decade, making it a prime target for deficit reduction. Seizing on projected deficits as their rationale, Republicans have called for a drastic solution: eliminating the traditional, public Medicare program in favor of a voucher for private insurance, which would save the government money by paying a diminished share of health costs and shifting more of the burden to seniors. Even if Democrats succeed in blocking that change, they find themselves in a bind. Medicare's rising expenditures threaten to crowd out other critical priorities from the federal budget. Protecting Medicare cannot mean sacrificing every other public purpose.

Is there any way out of the Medicare bind? There is, but it requires careful thinking about the short-term pressures and a comprehensive strategy to respond to the long-term problem posed by growing costs.

The immediate challenge is to avoid impairing Medicare's fundamental protections while meeting targets for deficit reduction set in August's debt-ceiling legislation, which will trigger automatic spending cuts if Congress and the president fail this year to pare the cumulative, ten-year deficit by at least $1.2 trillion. As part of its effort to reach that target, the congressional "super committee" due to report in November will likely consider an increase in the age of eligibility for Medicare from 65 to 67 and other changes that reduce protections for seniors. If Democrats are to defeat those proposals, they will have to win support for substantial alternative Medicare savings or else hope for a deadlock to trigger the automatic cuts, which spare beneficiaries but include a 2 percent reduction in Medicare payments to health-care providers. Congress and the president could also agree on a deficit-reduction package under $1.2 trillion, which would then trigger smaller automatic cuts to make up the difference.

No matter how Congress resolves the immediate budget issue, the long-term problem will remain. Medicare's share of the federal budget, which rose from 8.5 percent in 1990 to 15.1 percent in 2010, is projected to hit 17.4 percent in 2020—a percentage that will almost certainly increase because of implausible cuts in doctors' fees written into current law and will rise higher still if budget cuts fall disproportionately on other programs. The way out of the Medicare bind cannot involve changes only to Medicare itself; the cost of caring for seniors reflects the overall costs of the health-care system, and spending on Medicare will become manageable only through measures that bring total costs under control. We do not have to start from scratch; the 2010 health-reform legislation has already laid the groundwork for intelligent cost containment and significantly improved Medicare's long-term outlook. Ultimately, however, we need to recognize that establishing a separate health-insurance program for seniors was not a good idea in the first place, and the fairest and most effective way to control Medicare's costs will be to bring health insurance for seniors under the same rules and policies that govern health insurance for everyone else—though, as the varied systems of other countries show, there is more than one way to achieve that goal.

The Making of the Medicare Bind

No other country has a separate program of health insurance for the elderly; it is a peculiar American invention, devised without a full appreciation of its economic and political consequences.

In the late 19th and early 20th centuries, the major European governments enacted health-insurance programs for industrial workers around the time they established old-age pensions and unemployment compensation. But the United States followed a different sequence. In 1935, the Social Security Act introduced old-age and unemployment insurance, while efforts to pass publicly funded health insurance failed. After the American Medical Association (AMA) and its allies defeated President Harry Truman's call for national health insurance in the late 1940s, some of Truman's advisers came up with the idea of building on Social Security by adding to it a limited benefit for hospital care for seniors. By that time, employers were providing health insurance to a growing number of workers, and in 1954, Congress passed legislation codifying a rule that employer contributions to health insurance would not count as taxable income. But because the employment-based system didn't help most seniors, the idea of a separate program for them gained momentum.

Even though the political winds shifted in a liberal direction in the 1960s, Democrats stuck with the idea of a hospital insurance program limited to the elderly. That proposal became a top priority after Lyndon Johnson's landslide victory in 1964, and the following year, it passed Congress in an expanded form designed to satisfy diverse political constituencies.

The 1965 legislation had three elements. The Democrats' hospital-insurance program, financed by a dedicated payroll tax, became Part A of Medicare, while a Republican plan for a voluntary insurance program subsidized out of general revenues became Part B of Medicare and covered physicians' bills for seniors. The legislation's third part, growing out of an AMA proposal, provided funds to the states to pay a share of medical costs for some of the poor, mainly those who qualified for welfare. Tagged on almost as an afterthought, this mixed federal-state program became Medicaid.

Medicare's benefit package was not extravagant. It called for patients to bear a substantial share of costs and included no coverage of prescription drugs, dental care, vision or hearing, long-term care, or catastrophic medical expenses. But Medicare originally paid doctors and other providers all too generously. The Johnson administration and congressional leaders were so anxious to placate health-care interests that they imposed no restraint on prices. The law denied the government power to "exercise any supervision or control" over the amount paid to an institution or individual providing services. Following the practice of Blue Cross, Medicare paid hospitals on the basis of their costs—the higher their costs, the greater the payment they received. Physicians were paid "reasonable" charges, but the law did not define what "reasonable" was, and the payment of claims was turned over to private contractors who merely passed the costs along to the government. The entire system was based on fee-for-service—the greater the volume of services, the greater the income providers could generate from Medicare. It would be difficult to create surer methods of raising the cost of health care.

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As ingenious as it was as a political compromise, the 1965 legislation also added a great deal of complexity to health-care finance. The law resulted in four different systems for financing health care for the elderly. Medicare itself was divided into two parts working on different principles. Its limited benefit package led many of the elderly to buy private "Medigap" insurance, and if they were poor enough or spent down their assets and ended up in a nursing home, Medicaid would cover them. The administrative costs of Medicare were far lower than those of private insurance because the government didn't do any marketing, selection of applicants, or even much questioning of claims—it just paid them. But along with myriad private plans, the multiple government payment systems required providers to hire legions of administrative personnel and created burdensome paperwork for patients. Critics of a single system of

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national health insurance had said it would be top-heavy with bureaucracy, but such systems in other countries have much less overhead than ours. It was the celebrated art of political compromise that made health care in the United States a bureaucratic nightmare.

To be sure, compared to the private-insurance market, Medicare has had many advantages. Once they reach age 65, many people with serious health problems receive better insurance protection from Medicare than they were previously able to buy, if they could buy it at all. Beginning in the 1980s, Congress passed payment reforms, replacing the original methods of cost-based reimbursement and "reasonable" charges with administratively set, prospective rates and eventually holding down the growth of costs below the level in private insurance. But even with these changes, Medicare continued to pay hospitals on a cost basis for medical training and capital expenditures, and the method for paying doctors overvalued subspecialists' services relative to primary care. All these biases skewed the system toward expensive, high-tech medicine.

The decision in the 1980s to continue paying for capital costs was particularly important. Because Medicare beneficiaries represented roughly 40 percent of hospital revenue, Medicare defrayed 40 percent of the cost of any new hospital investment. The federal government did not cover 40 percent of a new school building that a local district wanted to build, but it paid for 40 percent of a new wing built by the local hospital, no questions asked. Although capital costs have now been folded into Medicare's prospective rates, the long contrast in federal policy toward health care and education helps explain why so many communities in the United States have gleaming hospitals and run-down schools.

Most people see Medicare as a program serving the elderly; what they miss is that Medicare has also been a program serving the health-care industry, financing its expansion. Instead of establishing programs to fund medical training and hospital construction on a limited, discretionary basis—as the nation did after World War II—Congress has funneled money to the industry through special add-ons to Medicare rates. The result is that the spending for those purposes is automatic. Both political parties have been involved in creating these nearly invisible streams of money. Democrats have used Medicare to support teaching hospitals and other institutions, often safety-net providers for low-income communities. Republicans have passed Medicare provisions that overpay private insurers for enrolling the healthiest seniors. When Republicans enacted a Medicare prescription-drug benefit in 2003—Medicare Part D, yet another layer in financing for seniors—they created a bonanza for private insurers, pharmaceutical companies, and employers.

1.6 MILLION

The annual net increase in Medicare beneficiaries from 2010 to 2030, compared to 623,000 from 1995 to 2009

The result of these varied influences is an uneven pattern. Overall, because of the shift to prospective payment, Medicare rates are now on average about 30 percent less for hospitals and 20 percent less for physicians than what the privately insured pay, but the ratio of Medicare to private rates varies from one region and sector of the industry to another. Geographic variations in physician-practice patterns—wide differences in decisions about hospitalization, surgery, and drug prescribing, without evidence of better outcomes from more intensive treatment—also contribute to Medicare spending per beneficiary that runs 50 percent higher in some regions than in others.

Many of those who originally supported Medicare saw it as a first step, hoping to build a universal system on the basis of its principles. The 1965 legislation, however, did not create favorable conditions for program expansion; the early costs of the program far exceeded projections and sowed doubt that enlarging it was fiscally responsible. In 1972, Congress extended Medicare to the disabled and end-stage renal disease patients, but no other group has subsequently gained eligibility. During the 1980s, when growing numbers of low-income children and pregnant women began obtaining gov-

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ernment-financed health coverage, the program Congress enlarged was Medicaid, which could be extended through mandates on the states at less cost to the federal government than if Medicare eligibility had been broadened. Liberals long regarded Medicaid as a distinctly inferior program and expected Medicare to be the framework for broader public coverage, but it has not worked out that way. Medicaid has been enlarged to serve more people. Efforts to extend Medicare coverage have been stymied; instead, the program has been enlarged to serve politically influential interests within the health-care industry.

Since their enactment, Medicare and Medicaid have no doubt done a great deal of good, increasing access to medical care, reducing financial stress from health costs, and improving the health and quality of life of seniors and those of the poor eligible for coverage. Similar things may be said of other federal health programs if each is considered separately. The tax subsidy for employer-paid health benefits—which has annually cost the federal government more than Medicaid—has helped millions of people afford health insurance. The Veterans Affairs (VA) hospitals and clinics provide a high standard of health care to veterans.

Taken as a whole, however, American health policy has not worked out well. Decade by decade, health costs have grown faster than the economy: From 1970 to 2010, health-care expenditures jumped from 7 percent to 17.6 percent of gross domestic product (GDP) in the United States—an increase far out of line with the other wealthy democracies, where costs have risen but still average only about 9 percent of GDP. The primary reason for that gap is that Americans pay higher prices for health-care goods and services. Because the increase in health costs has driven up insurance rates faster than median incomes, the share of the population without coverage has risen from between 10 percent and 12 percent in the early 1970s to 16.3 percent in 2010—or to about 50 million people.

Yet by protecting the larger part of the public, concealing the system's true costs, and enriching the health-care industry, the nation's policies have made every attempt at reform politically treacherous. The United States has cleverly ensnared itself in a policy trap: an increasingly expensive, complex, and dysfunctional system that has nonetheless resisted fundamental change.

Although Medicare provides seniors relief from the inequities of private insurance, it has complicated the politics of reform. General federal revenues subsidize Medicare, but the fiction that seniors have paid enough in taxes during their working years to earn their Medicare benefits has encouraged them to see themselves as a distinct group with interests morally superior to those of the uninsured or the poor on Medicaid. Together with the tax subsidy for employer-provided insurance, Medicare has created a large bloc of voters who do not realize how great a public subsidy they receive and who think that other people shouldn't expect government to help pay for their health care.

Seniors strongly approve of Medicare—in fact, they are the age group most satisfied with their health insurance. But they are also the age group most resistant to a universal, public program. A 2008 national survey by the Harvard School of Public Health and Harris Interactive asked whether the health-care system would be better, worse, or about the same if the United States had "socialized medicine." Among those who said they understood the term, there was a striking difference in responses by age. Fifty-five percent of the youngest group—those 18 to 34 years old—said socialized medicine would be better, while 30 percent said it would be worse. Among the 35- to 64-year-olds, 45 percent said it would be better, while 38 percent said it would be worse. Just one age group had a majority against socialized medicine—the one age group that, according to conservatives' definition of the term, has socialized medicine: 57 percent of people over age 65 said it would be worse, while only 30 percent thought it would be better.

When Democrats in Congress finally passed health-reform legislation in 2010, they did so without the support of seniors. The Affordable Care Act was not socialized medicine; it was an effort to fill in the holes of the existing insurance system with a minimum of disruption to established institutions and the protected public. But much of the protected public could never be won over to a program that they perceived as primarily benefiting the poor and minorities. No age group objected to the Affordable Care Act more than the elderly. Indeed, in some polls, they were the only age group against the law; a Gallup poll in June 2010 found 60 percent of seniors saying the adoption of reform was a "bad thing," while 57 percent of 18- to 29-year-olds and a plurality of other age groups said it was a "good thing." Beginning with Sarah Palin's charge in 2009 that the legislation would set up "death panels," Republicans and conservative organizations played on the fears of older people that health-care reform would hurt them and during the 2010 congressional campaign, ran ads accusing the Democrats of cutting Medicare.

This was not the first time that the elderly reacted sharply against new health-care legislation. Their opposition to the Medicare Catastrophic program passed in 1988 led to its repeal the following year; seniors also opposed the Republicans' Medicare prescription-drug program when it was passed in 2003. The elderly may be particularly susceptible to anxiety and fear about any change in policy that affects their health care. The Affordable Care Act had the support of AARP and included benefits for the elderly, but polls indicated those benefits made little impression. Discussing a survey from July 2010, Drew Altman, president of the Kaiser Family Foundation, noted, "Fifty percent [of seniors] said the law cut benefits previously provided to all people on Medicare when it does not, and another 16 percent didn't know. Only 33 per-

cent knew that it eliminated co-pays and deductibles for many preventive services under Medicare ... 14 percent that it would extend the life of the Medicare Trust Fund (by twelve years according to government estimates)." Just half knew the law would fill the gap in coverage in the prescription-drug benefit known as the "donut hole."

Although the legislation's ostensible cuts in Medicare did not reduce any legislated benefits, many seniors heard the opposite from private insurers. Under the formula that Republicans passed in 2003, private Medicare plans were receiving $1,100 more per enrollee than it would have cost had their beneficiaries remained in traditional Medicare. The Affordable Care Act reduces those overpayments, providing incentives instead for improved quality of care. Recent reports indicate that despite these changes, the private plans have cut the premiums they charge seniors.

In addition, the Affordable Care Act reduces future increases in Medicare payments to hospitals. That reduction, however, reflects an agreement with the major hospital associations, which recognized that hospitals stand to receive substantially higher revenue as a result of the extension of insurance coverage to more than 30 million people. The law is written so that neither the hospitals nor the elderly stand to lose anything.

Republicans nonetheless hit Democrats hard for supposedly cutting Medicare, and in the 2010 election, seniors turned out in droves for the GOP. With youth turnout down sharply, the elderly represented twice the share of the electorate as in 2008, and they swung to the Republicans by 21 points, the biggest shift among any age group. Last April, the Republican House rewarded those voters by approving the budget introduced by Representative Paul Ryan of Wisconsin, which repealed the expansion of insurance coverage in the Affordable Care Act but kept the reduced Medicare payments to providers, which would then become real cuts. The Ryan budget, though, was more significant for other reasons.

Under the Ryan plan, beginning in 2022, the federal government would end the public Medicare program for people turning 65, replacing it with a voucher—or as Republicans prefer to call it, a "premium support"—for private insurance. As of 2012, the plan would also replace Medicaid with a block grant to the states. These proposals reflect the same underlying idea. They would convert the two major federal health programs from defined-benefits to defined-contribution plans—that is, instead of guaranteeing to the elderly and the poor a specific package of benefits (hospital care, physicians' services, and so on), the federal government would contribute a sum of money. What if the money proved insufficient to buy the earlier package of benefits? That would be someone else's problem.

The Ryan plan's most important effect would be to eliminate the rights to health care that the elderly and the poor enjoy under current law. In the United States, unlike many other democracies, there is no constitutional right to health care; the only such rights under American law are the rights provided by statutes, primarily Medicare and Medicaid. While the Ryan plan would leave the elderly with a right to an allotment of funds, the original right to specific medical benefits would be gone, and low-income Americans would have no rights under federal law either to Medicaid benefits or to the subsidies for private coverage of "essential health benefits" under the Affordable Care Act. For the ten years beginning in 2012, the Ryan budget would cut Medicaid spending by about one-third, and as a result, according to estimates by the Urban Institute and the Kaiser Family Foundation, between 31 million and 44 million people would lose Medicaid coverage—a disaster for low-income Americans and the health-care providers that serve them.

As of 2022, the Ryan plan would also begin gradually raising the age of Medicare eligibility to 67, eventually terminating coverage of 65- and 66-year-olds. On reaching eligibility, beneficiaries would get a voucher whose value would increase only with the general consumer price index, not with medical costs. A "typical beneficiary," according to the Congressional Budget Office (CBO), "would spend more for health care under the proposal" for two reasons: "Private plans would cost more than traditional Medicare," and "the government's contribution would grow more slowly than health care costs, leaving more for beneficiaries to pay." The CBO projects that the typical 65-year-old in 2022 would pay twice as much a year out of pocket under the Ryan plan as under the current Medicare program—$12,500 compared with $6,150.

Since nearly all Republicans in both the House and Senate voted for the Ryan budget this past spring, they may well do so again if their party wins control of both chambers in 2012. But it is an open question as to whether they could carry out such a plan as its full implications became apparent. People looking to retire in 2022 and later would be staring at substantially increased health costs. Medicare beneficiaries today already spend three times the share of income on out-of-pocket health costs as people under 65 (about 15 percent of income compared to 5 percent). The higher out-of-pocket costs for retirees under the Ryan plan would place on many of them a burden that they couldn't bear.

By deferring the major changes in Medicare for a decade, Ryan tried to avoid alienating people now 55 and older. Even so, the immediate public reaction to his plan was distinctly unfavorable. Among whites, a substantial constituency leans in a conservative direction on most social-spending issues except for Medicare and Social Security, which they want to preserve. Seeking to win support from this group as well as to keep faith with their party's core supporters, many Democrats rejected not only the Ryan plan but any Social Security or Medicare cuts. On that issue, however, President Barack Obama broke party ranks during his deficit negotiations with Republi-

cans last July, when he said he would accept cuts in both programs as part of a grand bargain. At that time, he indicated he would accept two changes in Medicare—means-testing and an increase in the eligibility age—that dismayed liberals and thrilled centrists. Although the Medicare cuts Obama submitted in September did not include the big concessions that centrist entitlement-cutters were looking for, his signals during the summer may well encourage Republicans and some centrist Democrats to continue to push them. But neither means-testing nor a higher eligibility age stand up to scrutiny, especially when there are so many more substantial and legitimate ways to achieve Medicare savings.

The Immediate Choices

To those who see Medicare as a bulwark of the middle class, means-testing is a red flag because it might result in policies limiting the program to the elderly poor, turning it, in effect, into a second Medicaid. Obama has not proposed anything so drastic. In July he told ABC News: "I've said that means-testing on Medicare, meaning people like myself ... you can envision a situation where, for somebody in my position, me having to pay a little bit more on premiums or co-pays or things like that would be appropriate." Obama seemed to imply that people at his income level aren't already paying higher premiums and tax rates for Medicare, but they are. In fact, as a result of a series of little-noticed changes, Medicare has become America's most progressively financed social-insurance program.

For Medicare Part B, premiums in 2011 rise from $96 a month for some individual seniors with incomes below $85,000 to as high as $369 a month for those making more than $214,000. Obama is not proposing to raise premiums for individuals with incomes below $85,000, who currently represent 95 percent of seniors. Under a provision of the Affordable Care Act, however, instead of being indexed to inflation, the $85,000 level will remain frozen, and the share of beneficiaries who pay higher premiums will consequently rise from 5 percent today to 14 percent by 2019. In September, Obama proposed maintaining that freeze until 25 percent of seniors pay the higher level. But while more seniors will pay income-adjusted premiums, there is a practical limit to how much they can be asked to pay. Remember, Medicare Part B is voluntary; if the premiums are raised higher for high-income seniors, the younger and healthier among them may be able to buy cheaper private coverage outside of Medicare. So, in the sense that Obama suggested, means-testing can't generate all that much additional revenue.

By protecting the larger part of the public, concealing the health-care system's true costs, and enriching the health-care industry, the nation's policies have made every attempt at reform politically treacherous.

To raise more money for Medicare from the affluent, Paul Krugman and many other liberals argue, the more straightforward and administratively efficient method is through the taxes that pay for Part A, not the premiums for Part B. At 2.9 percent, the Medicare tax rate for most people has remained unchanged since 1986, but Congress has taken steps to require higher-income people to pay more. While the Social Security tax still applies only to earned income up to a cap ($106,800 in 2011), the Medicare tax has been levied on all earnings since 1994. As of 2013, under the Affordable Care Act, there will be an additional Medicare tax of 0.9 percent on earned income over $200,000 for individuals and $250,000 for married couples. Furthermore, in a major shift, the full tax (3.8 percent) will also apply for the first time to interest, dividends, rents, and other unearned income over the $200,000 and $250,000 thresholds. These new revenues are a key element in the Affordable Care Act's strengthening of Medicare's finances, but they are not a complete and permanent solution. Because of the aging of the population and rising health costs, the program will eventually need more revenue no matter how brilliant cost-containment measures are. But with increases already slated for 2013, a further increase in the Medicare tax now may risk a backlash.

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During his negotiations with House Speaker John Boehner in July, the president reportedly offered to accept an increase in the Medicare eligibility age to 67. Raising the eligibility age would have drastically different implications depending on whether the Affordable Care Act's major provisions go into effect in 2014. If the law is carried out and 65- and 66-year-olds receive its full benefits, they could turn to the new insurance exchanges to buy private coverage, and those with low incomes would receive subsidies for premiums and cost-sharing. As a result of those subsidies, according to an analysis by the Kaiser Family Foundation, low-income 65- and 66-year-olds would be better off in the new system than in Medicare, while those in the middle- and upper-income brackets would be worse off.

Excluding younger seniors from Medicare would affect other groups as well. Adding 65- and 66-year-olds to the pool in employee health plans and the exchanges would raise average insurance costs for people under age 65. Because the average age in the Medicare population would also increase, so would premiums for Part B. Raising the Medicare eligibility age, in other words, shifts health costs; it does nothing to control them, though it would direct federal money more toward seniors with lower incomes if the reforms passed in 2010 are carried out in 2014.

If those reforms were firmly established, there would be a legitimate debate about the merits of moving younger seniors gradually into the new system. But with Republicans calling for repeal of the Affordable Care Act, 65- and 66-year-olds could have nowhere to turn. If you're that age, in poor health, and without health benefits from an employer, good luck trying to find affordable coverage in the current insurance market. Taking Medicare away from seniors that age would also make it harder for many of them to find a job; small businesses would be especially reluctant to hire them. Obama wants to go down in history as the president who finally achieved health security for all Americans. But if he presides over an increase in the Medicare eligibility age and Republicans later repeal the 2010 legislation, the result would be less security than Americans had before he was elected.

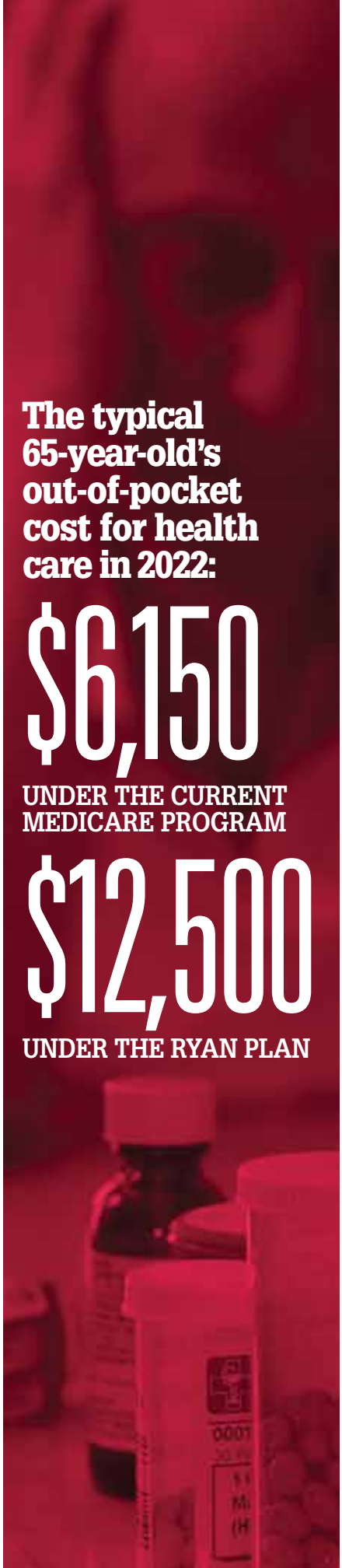
The typical 65-year-old's out-of-pocket cost for health care in 2022:

$6,150

UNDER THE CURRENT MEDICARE PROGRAM

$12,500

UNDER THE RYAN PLAN



There are better ways to rein in Medicare costs, some of them already enacted as part of the Affordable Care Act. That legislation laid out a strategy for reforming Medicare over the next decade: It financed research and experiments to test methods for improving quality and controlling costs, set targets for reduced growth in spending, and created a new mechanism—the Independent Payment Advisory Board (IPAB)—for making politically difficult decisions to reach those targets. The lessons from Medicare, the law's supporters hoped, would provide the basis for controlling costs and improving the quality of care throughout the entire health system.

These reforms, as Peter Orszag, former director of the Office of Management and Budget, argues, may already be having a positive impact as hospitals and other providers anticipate coming changes and try to become more efficient. An August report by the CBO showed Medicare costs declining slightly in the current fiscal year. For the year ending in June 2011, while Standard & Poor's index for commercial health insurance increased 7.5 percent, its index for Medicare costs rose only 2.5 percent.

That edge for Medicare may continue. As a result of the 2010 law, the CBO projects Medicare costs per beneficiary rising only 3.5 percent annually from 2010 to 2019, significantly less than the 5.4 percent growth rate per capita it forecasts for private insurance. But Medicare's chief actuary has raised worries about the implications of some of the cost-containment provisions, suggesting that they may hold down Medicare payments so well that they fall *below* Medicaid rates and lead providers to stop serving seniors.

Critics of the Affordable Care Act, skeptical that Medicare will achieve its

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targets for reduced spending growth, often cite the failure of the "sustainable growth rate," a formula that Congress introduced in 1997 to trigger across-the-board cuts in doctors' fees if total physician expenditures exceed a target rate. Beginning in 2003, however, Congress has always come up with additional funds whenever the formula has threatened to cut fees, potentially endangering beneficiaries' access to doctors. Nonetheless, the sustainable growth rate remains on the books, and if nothing is done, it will trigger a 29.4 percent cut in Medicare fees on January 1, 2012. No one expects that to happen. Instead, there is widespread agreement that the formula needs to be fixed once and for all. Cutting doctors' fees by nearly 30 percent is impossible, and the original idea of cutting them across the board was ill-conceived from the start. The policy doesn't focus cuts in payment on the medical specialties and geographic areas where fees are exceptionally high or the use of services is excessive.

The failure of the sustainable growth rate, however, has not been typical of all cost-containment measures. The prospective hospital-payment system adopted in 1983 slowed the rise in expenditures dramatically by providing hospitals a flat amount per admission, varying only according to the patient's diagnosis, not the length of stay or intensity of treatment. That innovation resulted from an experiment undertaken in New Jersey, and it's this experimental path to cost containment that the Affordable Care Act aims to emulate. For example, the legislation authorizes Medicare on an experimental basis to take prospective payment a step further, bundling together payment for an entire episode of care—inpatient and outpatient hospital treatment as well as physician services—from three days before hospitalization to 30 days after. The law also calls for initial steps in Medicare toward paying for value rather than volume by rewarding hospitals and other providers for getting treatment right the first time, avoiding complications, and having the best outcomes. In another measure aimed at improving quality as well as controlling cost, the legislation authorizes the creation of "accountable care organizations" to provide medical care to a defined population through providers that agree to meet standards for their performance.

No doubt some of these experiments will fail. But even if they identify successful models, political obstacles may still stand in the way of scaling them up and carrying them out nationally. That's part of the rationale for the independent payment board, which, beginning in 2014, is to recommend ways to reduce Medicare spending in any year the growth rate exceeds the average of the increases in the consumer price index and the price index for medical care. By 2018, the IPAB is to recommend cuts in spending if on a per capita basis, Medicare's growth exceeds GDP growth plus 1 percent. (Obama now proposes a more stringent target for 2018 and after: GDP growth plus half a percent.) The IPAB is greatly limited in its authority: It cannot ration care, cut benefits, change cost-sharing rules, or increase revenues. What it can do is recommend changes in payment methods and rates. Although Congress can override the board's recommendations, they will go into effect if Congress fails to achieve equal savings.

The clear function of the board is to facilitate changes that provider interests see as a threat to profits. In the past, if resistance to cost-cutting measures paralyzed Congress, nothing happened. With the IPAB, congressional paralysis will not stop change—though a refusal by Senate Republicans to confirm any nominees could prevent the board from going into operation in the first place.

Health-care interest groups limited immediate cost containment in the Affordable Care Act. To obtain support for the bill in 2009, the White House and Senator Max Baucus, chair of the Senate Finance Committee, reached agreements with the hospital and pharmaceutical industries on how much they would be asked to sacrifice. For example, while the drug companies agreed to make some concessions, the Democrats agreed not to require direct negotiations between Medicare and the industry that could cut drug costs. But the political circumstances have changed, and the savings that were off-limits in 2010 must now be part of the mix.

The deficit-reduction menu for Medicare ought to have drug costs right at the top. For the next decade, the CBO projects that the prescription-drug program's annual costs will rise from $68 billion to $175 billion—an average of 10 percent a year. Both Medicaid and the VA have held down drug costs more effectively. According to a recent report from the inspector general of the Department of Health and Human Services, Medicaid's system of legislated rebates cuts costs for 100 major brand-name drugs by 45 percent from retail prices, compared with only 19 percent in rebates obtained by the private plans that run Medicare Part D. The VA negotiates directly with drug companies and, like Medicaid, pays lower prices than Medicare does.

As a fragmented industry, Medicare's private plans don't have the bargaining power of the VA. In addition, congressional requirements that Medicare's drug plans cover all drugs in certain classes undercut their their negotiating leverage and would do so even if federal Medicare officials negotiated directly with the industry. Applying Medicaid's legislated rebates to Medicare would get the surest results. Short of that step, Congress should take back the gift that Republicans gave the drug industry in 2003 when they moved drug purchases for the elderly poor from Medicaid to Medicare. Applying Medicaid drug rebates to low-income seniors is a big item: The version of this idea endorsed by Obama in September would, according to the White House, save $135 billion over 10 years, more than half of the $248 billion in Medicare cuts that the president proposed at that time. There's also another group of seniors—elderly veterans—whose drugs costs could be cut in an analogous way. As health economist Austin B. Frakt and his col-

leagues have proposed, the VA could use its existing purchasing system to offer a low-cost pharmacy plan for veterans on Medicare who do not otherwise use VA facilities. The general principle should be that whenever a senior is eligible for more than one government program, drug purchases should go through the program that pays the lowest prices.

Drug prices usually go down dramatically when patents expire and drugs become available in generic form, but some brand-name pharmaceutical manufacturers have thwarted that process through "pay for delay" agreements with makers of generics. Congress should ban those agreements. In addition, Medicare should adopt "generic reference pricing": If a physician prescribes a brand-name drug when a generic equivalent is available, Medicare should pay only as much as the generic drug costs.

The concept of "reference pricing" has wider relevance beyond pharmaceuticals: If one medical procedure is no more effective than another for a particular condition but the second is less expensive, Medicare should pay providers only the lesser amount. Reference pricing should receive a boost from one of the major initiatives in healthcare reform—research on the comparative effectiveness of different treatments, which ought to begin providing better data on what works at what cost and what doesn't work at all.

The more difficult but necessary step is that when treatments have been repeatedly shown to be ineffective, Medicare should stop paying for them altogether. There is no need here for any new legislation; Medicare is authorized to cover only "necessary and appropriate" care. But as Rita Redberg, a San Francisco cardiologist who edits the *Archives of Internal Medicine*, wrote in a *New York Times* op-ed last May, "Medicare spends a fortune each year on procedures that have no proven benefit and should not be covered." For example, the program spends about $1 billion a year for two surgical procedures for vertebral fractures, kyphoplasty and vertebroplasty, despite evidence that they provide patients no more relief than a sham procedure while carrying substantial risks.

Would such decisions amount to "rationing"? Rationing means limiting medical services with clinical value. Refusing to pay for clinically ineffective services protects patients from unnecessary risks. So much excess is now built into the American health system that we have a long way to go before cost containment should mean cutting back "necessary and appropriate" care. That's why the move to link cost containment and quality improvement—championed by the current director of the Centers for Medicare and Medicaid Services, Donald Berwick—makes so much sense. Much of what needs to be done involves preventing medical errors that lead to higher costs and reducing excessive treatment that harms patients.

In the effort to achieve savings by reducing overtreatment, Medicare should focus on the regions with the highest costs per beneficiary. Led by John Wennberg, researchers at Dartmouth have highlighted the striking geographic differences in the use of medical services and pointed to local physician-practice patterns as a likely cause. Drawing on that research, a 2008 CBO report suggested that Medicare could cut its spending by 30 percent if high- and moderate-spending areas could cut their costs to those of the low-spending areas. Several recent studies, however, indicate that higher rates of illness and other factors that legitimately raise costs in some areas account for more of the variation than was earlier thought. Still, even when the raw data on geographic variations are properly adjusted, there appear to be substantial, unjustified differences in the use and cost of services. It simply makes sense to focus cost containment on regions with the highest medical costs in what is by far the world's highest-cost nation.

Some of the innovations begun by the Affordable Care Act—such as accountable care organizations—would offer the best means for bringing costs down in high-spending regions. But those innovations will take years to develop and may never reach communities like McAllen, Texas—the area with the second-highest Medicare costs in the country, featured in a much-discussed 2009 *New Yorker* article by Atul Gawande. To accelerate change, Congress should apply pressure on high-cost areas through fee-for-service Medicare. The sustainable-growth-rate formula is too blunt an instrument, hitting low- and high-spending doctors alike. National policy ought to be signaling physicians and other providers in the high-utilization areas that they're out of line, and the best way to do that is to step up payment cuts in those areas and avoid them in low-spending regions.

Similarly, Congress should re-examine how much it pays subspecialists. In determining physician payment levels, Medicare has for years relied on a private body with no accountability—the subspecialist-dominated Relative Value Scale Update Committee of the AMA, now being challenged by primary-care physicians because of a pattern of decision-making that has contributed to a wide disparity in incomes within the medical profession. Primary-care physicians earn median incomes that run $135,000 a year less than what subspecialists make, amounting to a gap of $3.5 million over the course of a career. That difference has contributed to the skewed incentives encouraging too few doctors to enter primary care.

Medicare's funding for graduate medical education—training of residents—has also amplified that problem. Medicare payments to teaching hospitals include direct support, covering such things as residents' salaries, and indirect support for expenses associated with teaching, such as extra tests residents may order. But, according to the congressionally established Medicare Payment Advisory Commission (MedPAC), the true indirect costs are substantially lower than what Medicare has been paying. Besides cutting back that excess, the report from the deficit com-

mission chaired by Democrat Erskine Bowles and Republican Alan Simpson recommends limiting the top salaries paid to medical residents to 120 percent of the national average, for a total savings of $60 billion through 2020.

The more fundamental change, though, would be to take funds for medical training entirely out of mandatory, entitlement spending, put them into a discretionary program, and force specialty training programs to compete for a limited budget that reflects national priorities. Medicare funds for doctors' training should be scaled down gradually; for example, under one option analyzed by the CBO, all funds for graduate medical education would be consolidated into a grant program with a budget that would grow only according to the consumer price index for urban areas minus 1 percent, a move that would save $69 billion over the next decade and by 2021 would cut funds for residency training by about 60 percent compared with the level they would reach under current law. As shocking as that may be to teaching hospitals, it is what we need to do to take the skewed incentives out of the system. There never was any justification for making funds for medical training an entitlement; no other scientific field has that privileged a place in the federal budget, and it especially makes no sense in view of the incomes that physicians earn after their training.

The focus of another line of Medicare reforms, generally favored by conservatives, is to make seniors pay more out of pocket to deter unnecessary use of health services. The evidence is that increased patient cost-sharing does reduce health costs to some extent. But as a general remedy for rising health costs, this approach has much less to recommend it than many people assume. Americans already pay a higher percentage of health-care costs out of pocket than do people in the other rich democracies, yet total costs are much higher in the United States than anywhere else. In the United States, health-care spending tends to be highly concentrated in a small proportion of high-cost cases; during the course of a year, the most costly 5 percent of people typically account for more than 50 percent of health-care costs, and the top 10 percent of people account for 70 percent of costs. These high-cost cases are little affected by cost-sharing; once a patient is in the system, physicians make most of the decisions affecting costs. Rather than expecting patients to economize, much less to bargain over prices when they're ill, we should focus incentives on physicians and providers—to try to influence the "supply" rather than the "demand" side of the market, because in health care, unlike other markets, the suppliers drive so much of the demand.

17.6 PERCENT

Health care's portion of GDP in 2010. It was 7.2 percent in 1970.

MIGUEL MALO / ISTOCKPHOTO

Nonetheless, Medicare's cost-sharing does need reform. The current system is unnecessarily complicated, with separate deductibles and different cost-sharing rules for hospital care, doctors' services, skilled nursing facilities, home health visits, and drugs. Altogether—including the premiums for Part B, Part D, and Medigap coverage as well as uncovered dental, vision, hearing, and long-term care—beneficiaries pay out of pocket for about one-quarter of their total health-care costs, while Medicare pays for just under half, and other payers such as employers pay for the remainder.

Some relatively small changes in cost-sharing policy should not be hard to accept; for example, introducing a small co-payment (or "hesitation" fee) for home health visits would help deter fraud as well as excessive use of services. (Obama proposes a $100 home-health co-payment per episode of care.) But the big question about cost-sharing is whether to institute comprehensive change, not just in Medicare's deductibles and co-payments but also in regulations governing private Medigap insurance. One such proposal, supported by the Simpson-Bowles report, calls for a single annual deductible of $550 for Parts A and B of Medicare, 20 percent cost-sharing on the next $5,000, and 5 percent cost-sharing above that level, with an annual cap on out-of-pocket costs of

$7,500. In addition, the Simpson-Bowles proposal would prohibit Medigap plans from covering any of the first $500 and more than 50 percent of the next $5,000 in cost-sharing. Together, these policies would save Medicare a projected $110 billion through 2020.

As cost-containment measures go, these are pretty good; Democrats should not reject them out of hand. The $7,500 limit on out-of-pocket costs would give seniors catastrophic coverage for the first time, and the proposal as a whole would make cost-sharing far more rational and understandable. Although some seniors would resent the ban on Medigap policies that cover 100 percent of the deductible, first-dollar coverage in any form of insurance is always a terrible buy for consumers—the cost of the insurance far exceeds the likely benefits. A good compromise would be to let current beneficiaries keep the old Medicare cost-sharing if they want it and apply the new rules for new enrollees. The new cost-sharing provisions would bring Medicare coverage more into line with the insurance that Americans under age 65 have—and that may eventually make it easier to create a unified and simpler insurance system.

The Long-Term Alternatives

The changes that I've discussed in Medicare's drug-prescription program, graduate medical education payments, pricing, coverage policies, and cost-sharing could achieve major savings in the program and help avert more drastic cuts such as an increase in the eligibility age. Further long-run discipline of Medicare spending could also result from the experiments initiated by the Affordable Care Act, together with the new payment board. Carrying out those measures ought to be a top priority, but they may not be enough to escape from the Medicare bind. Medicare buys care for seniors from the larger health-care system, and if costs for the system as a whole continue to increase sharply, Medicare's will follow. A national health strategy should include Medicare, but it cannot just be a strategy for Medicare alone.

The Ryan plan offered one of three general visions for the future. By giving seniors a fixed sum of money to buy private insurance and the states a fixed amount for health care for the poor, Ryan would put federal health spending on a budget unrelated to the cost of health care. That would limit the federal government's exposure, but it wouldn't solve the cost problem that consumers face. Millions of people would lose insurance coverage, and others would likely face increasing financial burdens. Ryan assumes that if consumers have more at stake, the market will respond. But it will respond mainly by excluding those who can't pay—and, under the Ryan approach, if you can't pay for health care, that would just be too bad for you.

A second general alternative is the antithesis of the Ryan plan—a single, universal, tax-financed, federally run insurance system. Instead of disengaging from health-care finance, the federal government would take it over and become the single payer. In one respect, single-payer proposals resemble Ryan's; federal health spending would be budgeted. But because coverage would be comprehensive under single-payer, the budget would protect consumers from financial risk rather than exposing them to it. To create a single-payer system, however, the government would have to expropriate a big private industry (health insurance), which it has never done. If the public had a deep trust in government, perhaps it might support nationalizing the health-insurance industry, but trust is scarce. Americans would also need to accept higher taxes, and although these would substitute for insurance premiums, they would seem to be large increases in cost to people with employer health benefits.

Recognizing the obstacles to single-payer, progressives settled on an optional, federally run insurance plan—the "public option"—as a more feasible proposal during the battle over health-care reform. If a public plan paid Medicare rates and benefited from its low administrative costs, progressives reasoned, it could attract an overwhelming share of the market and serve as a bridge to single-payer. But though that version of the public option might have had great appeal, a key provision—the use of Medicare rates—couldn't even get through Nancy Pelosi's House. The opposition came not just from conservative Democrats but also from some moderate to liberal representatives from states where Medicare rates are especially low relative to what the privately insured pay. Hospitals and other providers said the resulting loss of revenue would have devastating effects. In response, the House passed a watered-down public option, which, according to the CBO, would have had disproportionately high-risk enrollees and higher costs than private insurers, handicapping it as a competitor—and that proposal died in the Senate in December 2009.

Another Medicare-enlargement strategy, advanced by the Clinton administration in the late 1990s, would enable people age 55 to 64 to buy into Medicare. Al Gore supported that idea when he ran for president in 2000, and it might have been adopted if Gore had won. A Medicare buy-in came up again in late 2009 and, like the public option, was killed in the Senate.

If a new opportunity for reform emerges, progressives could return to a strong version of the public option or a Medicare buy-in for 55- to 64-year-olds. Both proposals have their merits, but without more comprehensive regulation, Medicare enlargement on an optional basis has some inherent difficulties. An optional public plan would always be in jeopardy of "adverse selection" (attracting disproportionately high-cost enrollees), in part because private insurers might use it as a dumping ground for the unprofitable sick. Providers could also respond to the public plan's cost-containment efforts by shifting costs to other payers, as they do with Medicare and Medicaid today. The only way to avoid those problems is through a comprehensive framework of regulation that applies to all payers, public and private.

The Ryan plan's reliance on the market and single-payer's reliance on government represent the two ideological poles in the debate about national health policy. Between those two positions lies a family of hybrid strategies for health-care reform that would, to varying degrees, turn health insurers and major providers into regulated public utilities. Both Medicare and the Affordable Care Act are steps in this direction; each establishes a public framework of rules and subsidies for the choice of an insurance plan. Bringing the two programs together under one consistent set of policies may eventually be a means of controlling system-wide costs and putting America's fragmented health system back together.

The Affordable Care Act prescribes rules for private insurance purchased by individuals and small businesses, whether sold to them directly or through the new state-run insurance exchanges. If the law survives challenges, the exchanges could assume wider functions. Rather than contracting directly for insurance, more employers may decide to make a contribution to health coverage and allow their employees to pick among the plans offered through the public exchange. From the consumer's standpoint, the great advantage of the exchange is that it makes health insurance fully portable from one job to another—and perhaps portable into retirement. If the Medicare and state-based exchanges were eventually merged, the public Medicare plan could remain an option for those turning 65 and perhaps become an option for people younger than 65 if progressives succeed in opening up the program to wider enrollment.

A single public exchange for health insurance, with or without a public plan, is not single-payer, but it could become a basis for a more effectively regulated insurance system. Not all the democracies with universal health coverage have one payer; multiple insurance funds are common. But the countries with multiple funds typically have high levels of regulation, often with national negotiations over payment rates and expenditure limits. It's that kind of institutional structure that provides the basis for controlling total costs. Something like it might have evolved from the 1993 Clinton health plan, which would have created insurance exchanges for nearly the entire population below age 65 and limited increases in a region's average premium so as to set a "global budget" for health spending. The more modest Affordable Care Act includes no federal authority to control insurance rates, but it does limit how much insurers can spend on profits and administration and calls for the review of rate increases over 10 percent. Although the law is limited in its reach, the regulated-utility model is implicit in some of its provisions, and some states like Massachusetts are taking the model further in pursuit of more effective methods of controlling costs.

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Health policy is not like a mathematical problem that has only one correct solution. The many countries that provide good health care at a reasonable cost do so in a variety of ways that reflect their distinctive institutions and history. The United States could yet evolve a distinctive, rational solution of its own even though the poisonous air of American politics today gives little reason for hope. In the short run, we need to defend the protections offered by existing programs, including Medicare—and savings are feasible without compromising the protections that Americans now enjoy. The Affordable Care Act sets in motion other changes that should help control costs and extend coverage over the next decade. But we should be looking toward a more distant possibility: a simpler, fairer, and comprehensive system that would incorporate the many fragmented programs that have grown up in the past half-century. A fair universal system was the impetus behind Medicare in the first place; coverage for seniors was just supposed to be the first step. Although the road has been long and winding and the destination is only hazily in view, we may still get there. ▣

The historical portion of this article draws on Paul Starr's recently published Remedy and Reaction: The Peculiar American Struggle over Health Care Reform *(Yale University Press).*

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