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Have Health Reformers Forgotten Medicare?

By Joseph Antos

According to some politicians, health reform will bring everyone more affordable insurance, more effective and higher-quality care that provides real value, continued advances in medical technology, and relief from the fiscal pressures that the current system places on the federal budget. These are great goals, but how do advocates expect to accomplish this transformation when they do not want to talk about the ailing five-hundred-pound gorilla of the health system—Medicare? Is Congress making the task of reforming Medicare even harder by its action, and inaction, this year?

There is a growing consensus in the United States that the health system should be reformed. In 2008, we are likely to spend $2.4 trillion—16.6 percent of GDP—to meet the health needs of Americans and to invest in the research and infrastructure that will support future advances in medicine.[1] By 2012, health spending is projected to exceed $3 trillion, or 17.7 percent of GDP. Despite those huge sums, approximately 47 million people are uninsured, and there is a growing sense that quality of care has suffered. It is becoming apparent that we are not getting our money's worth from the health system.

Proposals from the candidates in this year's presidential campaign and a diverse group of business and community organizations have focused on the problems of the uninsured and reforms of health insurance for people under age sixty-five. Largely overlooked in the current debate is the pivotal role of the Medicare program in shaping the financing and delivery of health care. Medicare accounts for about 20 percent of our health spending, and its rules and payment approaches are widely adopted by private insurers in setting their own policies for coverage and reimbursement of health services. With regard to health financing, as Medicare goes, so goes the nation.

The problems plaguing the broader health system also challenge Medicare. The program is threatened by rising costs, and widely varying practice patterns are evidence that Medicare does not ensure a consistent standard of high-quality care in all communities across the country. Although Medicare provides essentially universal coverage to people over age sixty-five, beneficiaries face mounting out-of-pocket costs. Budget-driven pricing policies have caused some physicians to close their practices to new Medicare patients, impeding access for the aged to specialists in parts of the country. Medicare's financing and performance problems will become acute when the baby boomers begin to enroll in the program starting in 2011. According to the Medicare trustees, assets in the Part A trust fund will be exhausted in 2019.[2]

It is uncertain whether broad health system reform will be accomplished in the next four years, but it is clear that reform will fail—or fall short of its goals—if Medicare is not an integral part of the proposal. The program cannot continue to run on autopilot. Medicare policies must be consistent with broader health system objectives or they will undermine efforts to improve the private health

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insurance system. By the same token, if the country is not ready for broad reform, that need not be the excuse to avoid making prudent changes in Medicare.

No Ideological Purity

Two basic approaches dominate the ongoing debate among experts and policymakers about the best strategy for health reform: market competition versus government regulation. Rising health care costs and growing dissatisfaction with health system performance create a new opportunity for each side in the ideological debate to promote its own vision of the world, for Medicare, and for the broader system. Progovernment reformers, notably Senators Barack Obama (D-Ill.) and Hillary Clinton (D-N.Y.), support the creation of a federal health insurance plan as one of the choices available to everyone. Promarket reformers, including Senator John McCain (R-Ariz), argue against "government-run" health care in favor of personal ownership of health insurance.

In the Medicare context, progovernment reformers favor reducing or eliminating the role of Medicare Advantage (MA) plans and expanding the scope of fee-for-service Medicare. Cutting payments to MA plans, giving the Centers for Medicare and Medicaid Services (CMS) the authority to negotiate drug prices directly, and expanding access to Medicare for persons below age sixty-five are high on their legislative agenda. A top-down approach to quality (with more restrictive federal standards) and program cost (with tighter payment limits) is predictable, and changes in Medicare would be used as leverage to make similar changes in the private health system.

By contrast, promarket reformers favor the "premium support" model for Medicare, replacing the open-ended entitlement with a fixed subsidy to help beneficiaries cover the cost of a competing health plan. They would expand the MA program to include the traditional Medicare program, which would be equipped with new authority to run its affairs as a private insurer would. Instead of the promise of unlimited program payment for health services, beneficiaries would be given set amounts of subsidy (adjusted for health risk) and allowed to select the health plan that they prefer.

If and when Congress takes up Medicare as a serious fiscal challenge, we will almost certainly end up somewhere in the middle of this policy debate. Medicare Advantage is widely popular with its enrollees, particularly those who live in rural states and those who often can gain additional benefits by enrolling in an MA plan. Enrollment in such plans has doubled since 2005 and now stands at 9.6 million members.[3] Generous payments to the health plans help explain the strong enrollment growth. According to the Medicare Payment Advisory Commission, the government spends an average of 13 percent more for enrollees in MA plans than for enrollees in traditional Medicare.[4] Even though the plans frequently offer more generous coverage to their enrollees than the traditional program does, prominent Democrats have demanded an end to those "overpayments."[5] Despite that criticism, Congress is unlikely to cut payments so severely that many MA plan sponsors would leave Medicare, displacing millions of beneficiaries.

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The traditional Medicare program is so widely popular with beneficiaries that changing the nature of its entitlement to a fixed subsidy does not seem probable in the near term. Instead, we are likely to see an extension of the more technical reforms that are already being tested, including such ideas as pay for performance and paying for full episodes of care (rather than for each individual service) that could promote better value in health care delivery. Even though use of services is the more important driver of Medicare spending, limits on pricing will be the central strategy for controlling costs.

As program costs rise, beneficiaries will pay more for Medicare-covered services, but there is great political sensitivity about overtly asking seniors to do so. Understandably enough: seniors' groups, including AARP, have been effective in pushing the senior agenda, and seniors are a more cohesive voting bloc on issues affecting their pocketbooks than younger people. Congress is likely to find ways to protect most beneficiaries from higher costs, even though immunizing them from the cost of services will increase demand for treatment and make fiscal matters worse.

The exception is higher-income seniors, who must pay a premium that increases with income to enroll in Part B. In 2008, most enrollees in Medicare Part B pay the standard monthly premium of $96.40. Individuals with taxable incomes over $82,000 pay as much as $238.40 per month to enroll in Part B.[6] The Bush administration has proposed a similar income-related

premium for high-income individuals who enroll in the prescription drug benefit under Part D.[7]

When such policies are adopted, they are often combined with a benefit enhancement that, on balance, increases program spending. For example, the Medicare Modernization Act of 2003 included two provisions that directly raised the amount beneficiaries would have to pay: an increased deductible and the income-related premium for Part B. Even though those provisions were fairly modest (saving Medicare about $25 billion over ten years, or about 0.6 percent of the program's total outlays), they almost certainly could not have been enacted without the new drug benefit—estimated at the time of enactment to cost $410 billion.[8]

Medicare's Dilemma

Medicare is caught in a dilemma of its own making. It is hugely popular with the public, which does not want to see substantial changes in the program that could reduce benefits or impose additional costs on beneficiaries. Yet, if strong actions are not taken, Medicare will soon be unable to fulfill the public's expectation of generous health coverage that guarantees to millions of Americans access to the latest medical treatments, regardless of cost.

Medicare spending is a growing threat to the budget. That threat escalated when Congress created Part D, which added hundreds of billions of dollars to the cost borne by taxpayers. New calamities—the housing market collapse, skyrocketing gasoline prices, global warming, and the like—will place additional demands on the budget at the same time that the economy is weakening. As in the past, Congress will look to Medicare cuts to help with a growing deficit problem. Providers will once again see little relief from Medicare in dealing with their own cost problems.

The hope that broad health system reform would lessen the likely budget blow is unrealistic. If some system reform is adopted, it is likely to require funds to pay for expanded subsidies for the uninsured or other objectives. If Congress acts on the belief that we already have enough money in the health system to cover all of the uninsured, one can expect to see even more pressure on Medicare to cut spending. In the beneficiary-dominated political calculus, that equates to reductions in payments to providers—even though such cuts could impose costs on seniors by reducing access to health services.

We may not see a sweeping reform of Medicare or the broader health system in the next four years, but we will see change. Cost, access, and quality problems will force changes in the way medicine is paid for and the way it is practiced. Medicare will play a major role in developing and advancing policy change. Decisions made in that arena will help shape the future direction of the entire health system.

No Solutions This Year

Congress is not considering any substantial Medicare reforms this year, but there remain important issues that must be resolved immediately. The most publicized problem is the 10 percent reduction in the fees Medicare pays to physicians, which became effective July 1. Although the vast majority of policymakers wanted to avoid this cut and all knew when it was scheduled to occur, Congress missed the deadline to delay it.[9] This is not the first time Congress has had to deal with the issue, and thanks to the complexities of the budget and a failure of political nerve, it will not be the last.

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A 10 percent cut in prices paid by their largest purchaser can be difficult for physicians to accommodate, particularly for practices that primarily serve the elderly. The real problem, however, is not the fee cut itself. The problem is Medicare's administered pricing system, which is unable to set prices that fully reflect the market's valuation of specific services provided by particular physicians. The price may be too high or too low, but it is the same regardless of the skill of the physician or the outcome for the patient.

Budget politics have compounded this inherent defect of top-down price-setting, creating an unsustainable yet seemingly irresolvable situation. In 1997, Congress created the Sustainable Growth Rate (SGR) formula to limit the growth of Medicare physician payments. Under the SGR, Medicare payments can accommodate increases in the volume and complexity of physician services, but only at a rate supported by growth in national income.[10] Increases in payments that exceed

the SGR would cause an automatic cut in fees in subsequent years.

Predictably, the SGR formula provided no incentive for physicians to moderate their practice patterns and may have encouraged *greater* use of services as the actions of an individual physician would have no perceptible impact on the growth in payments over the entire nation. Also predictably, Congress did not want to enforce the fee cuts determined by the formula. That set up a vicious cycle: outlays for physicians would grow faster than permitted by the SGR, resulting in a substantial fee reduction that would be imposed automatically. Wishing to avoid such a reduction, Congress defers the immediate fee cut only to face an even larger cut in a later year. The longer this process continues, the more unreasonable the SGR-calculated fee cut becomes and the greater the cost of a temporary fix.

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Over the years, the accrued reductions that will, in theory, someday have to be taken have mounted. If Congress allows the July 1 cut to stand, physicians will face consecutive 5 percent fee reductions in future years. If Congress defers the cut until 2010, Medicare physician fees could be reduced by 21 percent in that year and cut further in later years, although Congress would almost certainly again take action to avoid an even less realistic payment reduction.[11] The repeated pattern of a large SGR cut and a last-minute reprieve creates a more uncertain business climate for physicians.[12] That uncertainty can discourage long-term investments in health information technology and other equipment to make physician practices more efficient, and it can discourage physicians from expanding their Medicare patient load.

This is clearly not a sound way to run the Medicare program, but Congress has painted itself into a corner. If an SGR cut is deferred one year, Medicare outlays might increase by a few billion dollars—an amount that would be difficult, but not impossible, to offset with other reductions in the program. If the SGR policy is scrapped, outlays could increase by more than $300 billion over the next decade.[13] Moreover, every extra dollar paid to physicians increases the Part B premium. It is doubtful that policymakers would be able to swallow that high a budget cost in one gulp, particularly if it meant hiking the cost borne by seniors.

This budget charade cannot continue indefinitely, although it is certain to complete at least one more cycle. Congress will eventually be forced to admit that Medicare's rate-setting policy is broken. More regulations will not solve this problem, and neither will more money, if that means repeating the mistakes we are now making. Instead of trying to hide the physician payment problem, policymakers should use it to start the debate on what kind of Medicare program we want for ourselves and our grandchildren.

Notes

1. Sean Keehan et al., "Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming to Medicare," *Health Affairs* 27, no. 2 (March/April 2008): w145–55.

2. See Social Security and Medicare Boards of Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 2008 Annual Reports* (March 25, 2008), available at www.ssa.gov/OACT/TRSUM/trsummary.html (accessed April 10, 2008).

3. Plan enrollment for 2005 taken from Marsha Gold, "Private Plans in Medicare: Another Look," *Health Affairs* 24, no. 5 (September/October 2005): 1302–1310. Current enrollment is from Centers for Medicare and Medicaid Services (CMS), *Monthly Contract and Enrollment Summary Report* (June 2008), available at www.cms.hhs.gov/MCRAdvPartDEnrolData/MCESR/list.asp (accessed July 2, 2008).

4. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2008), available at www.medpac.gov/documents/Jun08_EntireReport.pdf (accessed July 2, 2008).

5. For example, Representative Pete Stark (D-Calif.) has repeatedly urged Congress to "eliminat[e] government overpayments to HMOs" and pay Medicare Advantage plans "the same as traditional Medicare." He argues that "the only rational explanation for Republicans' desire to overpay HMOs is that they intend to undermine fee-for-service Medicare." See Office of Representative Pete Stark, "Stark Spotlights Medicare HMO Overpayments," news release, June 6, 2006, available at www.house.gov/stark/news/109th/pressreleases/20060606_MedPAC.htm (accessed July 2, 2008).

6. Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (March 25, 2008), available at www.cms.hhs.gov/ReportsTrustFunds (accessed April 10, 2008).

7. U.S. Department of Health and Human Services, *Budget in Brief: Fiscal Year 2009* (2008), available at www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf (accessed July 2, 2008).

8. Estimate for 2004–2013. See Douglas Holtz-Eakin (then-director of the Congressional Budget Office [CBO]), letter to Representative Bill Thomas (R-Calif.), "H.R. 1, Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Cost Estimate for the Bill Conference Agreement," November 20, 2003, available at www.cbo.gov/ftpdocs/48xx/doc4808/11-20-MedicareLetter.pdf (accessed July 2, 2008). For CBO-projected total Medicare spending (excluding Part D) of $3.9 trillion for the same period, see CBO, *The Budget and Economic Outlook: An Update* (August 2003), available at www.cbo.gov/doc.cfm?index=4493 (accessed July 2, 2008).

9. When it comes to Congress, CMS can be a forgiving agency. Even though Medicare fees are supposed to be cut beginning with services provided July 1, CMS announced that it will hold all new claims for ten days, giving congressmen three days to approve legislation to modify payment rates after they return from recess on July 7. If Congress takes action after the ten-day period, CMS would have to process some bills twice in order to comply with the law. See Robert Pear, "Senate Democrats Attack Republicans on Medicare," *New York Times*, June 28, 2008.

10. CBO, "The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates," *CBO Economic and Budget Issue Brief*, September 6, 2006.

11. Peter R. Orszag (director of the CBO), letter to Representative John D. Dingell (D-Mich.), June 24, 2008, available at www.cbo.gov/ftpdocs/94xx/doc9493/DingellLtrHR6331.pdf (accessed July 2, 2008).

12. Steve Twedt, "Medicare Policies Take Toll on Doctors," *Pittsburgh Post-Gazette*, June 29, 2008.

13. The CBO estimates that holding physician fees at June 30 levels through 2009 and, in subsequent years, imposing the Sustainable Growth Rate (SGR) cuts would increase program outlays by $8.1 billion between 2008 and 2018. Eliminating the SGR entirely and allowing physician fees to increase with inflation would increase outlays by $288 billion. Protecting Medicare beneficiaries from the premium increases associated with the latter policy would raise that cost to $364 billion. See CBO, "Estimated Changes in Net Federal Outlays from Alternative Proposals for Changing Physician Payment Rates," March 14, 2008, available at www.cbo.gov/ftpdocs/90xx/doc9055/03-14-SGR_Options.pdf (accessed July 2, 2008).