The Medicare Solution

And why myths, misinformation and mudslinging—from both parties—won't get us there

BY TED MARMOR

Political amnesia—abandoning overnight the position you once staked your political capital on—is nothing new in Washington, but rarely have the reversals been as bold as in the recent debates over health care reform. Throughout the 1993 fight over Clinton's reform plan, Republicans kept Medicare off the table and proclaimed the horrors of managed care. This year, suddenly, they discovered the Medicare crisis. "The choice we face is simple," says Representative John Kasich. "We can either strengthen Medicare and preserve it for current and future beneficiaries, or we can do nothing ... and ensure Medicare's demise." And as a solution, they are trumpeting—you guessed it—managed care.

Democrats who advocated health care reform, meanwhile, are trying to stymie radical change this year by using dire rhetoric that also ends up feeding beneficiaries' fears. "Those who want to gamble with Medicare are asking Americans to bet their lives," President Clinton warned during a celebration of Medicare's 30th anniversary. Congressional Democrats have taken a page straight from Republican strategist Bill Kristol's health care playbook: Deny the problem's seriousness and block your opponents' solution.

For observers of health care politics, the images of politicians thriving on conflict—and journalists obligingly covering every jab and duck—evoke an unshakable sense of déjà vu. The target is narrower. The party in the driver's seat is different. Controlling the deficit, rather than expanding access, is the engine driving reform. But in many respects, the fight over Medicare is shaping up to be much like the last Congress's fight over health care reform. Even many of the same interest groups are squaring off with overblown rhetoric.

Irrational fears based on misinformation helped derail last year's debate. To prevent that this time around, a whole new set of Medicare myths needs debunking. For starters, Medicare doesn't need "saving" or "rescuing" or any of the other hyperbolic turns of phrase the press and politicians use to discuss the program's future. To borrow from

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Twain, reports of a crisis are greatly exaggerated. Medicare needs fixing, to be sure, both to contain costs and to expand the range of covered services. But that's hard to do rationally in a climate of confusion. As political temperatures run high, deficit pressures mount, and the whole process collides with presidential politics, what's best for Medicare and American medical care as a whole may get short shrift.

The Republicans assume that the market—in the form of vouchers for private HMOs—will save Medicare. But in truth, it is possible to control Medicare's costs and improve its coverage without a wholesale conversion to HMOs. The stakes here are enormous. Medicare reform done badly will only worsen the problems of the elderly, the uninsured, and the underinsured. No reform at all will worsen the problems of the federal budget. But done right, Medicare reform could be a first step toward universal health insurance, showing that not only is the government the only party willing to cover people private insurers won't touch, but that it can control costs and quality when it does so.

The Road to Nowhere

Medicare's enactment 30 years ago, in fact, was to lead to universal health coverage. Since before World War I, the idea of national health insurance had fallen in and out of favor as America's economic fortunes fluctuated. With strong public support, New Deal liberals had come close to incorporating universal health insurance into the emerging welfare state, but conservatives in Congress blocked the effort. So reformers revised their approach, adopting an incremental strategy that at first would cover only Social Security beneficiaries, and the idea of Medicare was born.

Restricting the program to the elderly was not what social reformers really wanted—it was what they believed they could get. The same pragmatism shaped the program itself. In the face of opposition from the medical establishment, Medicare was to begin with only 60-day hospital insurance; physician services were at first excluded. When doctor visits finally were included, they were funded separately, from beneficiary-paid premiums and general revenues, rather than Social Security financing. That was the historical accident that divided Medicare into Hospital Insurance (part A) and Supplementary Medical Insurance (part B).

Politically, this worked. But in its incipient form, Medicare couldn't come near to fulfilling what its designers promised: to protect the elderly from the unbudgetable expenses of illness. After all, the program excluded long-term care, the catastrophic expenses of chronic illness, and prescription drugs. But it was assumed that more benefits would follow for the elderly, and that eventually, eligibility would be expanded to include most, if not all, of the population. In the context of the Great Society, the Medicare law of 1965 was seen as but a first step on the road to more accessible and affordable medical care for all Americans.

Medicare's proponents were far too optimistic. America has never been able to enact universal government health coverage. That's why today the U.S. is the world's only industrial democracy with compulsory health insurance for only its elderly. Equally important, Medicare itself was never restructured to better serve the distinctive needs of its target population, and its flaws today very much reflect its understandably flawed design 30 years ago. Due to the need to placate an uneasy medical establishment, the program was shaped and defined by what it was not.

That's why the program omits coverage of those services that are arguably what the elderly need most. With the provision of only acute hospital care and intermittent physician treatment, Medicare simply does not provide adequate coverage for many elderly Americans, particularly the frail elderly who require comprehensive and continuing care. Older Americans often have conditions, such as adult-onset diabetes and hypertension, that will not improve dramatically over time. Yet Medicare does not pay for either insulin, which costs $50 to $100 a month, or hypertension medication, which costs $75 to $125 per month.

Another flaw in Medicare's original design—the omission of a global budget—plagues the program today. No limit was placed on what the government would pay for its beneficiaries' care. Again, Medicare's proponents feared spooking the medical establishment. They thought keeping a hands-off approach was es-

sential to getting the program in place. But the lack of a mechanism to control costs turned out to have massive unforeseen consequences.

In the program's first years, benefit and payment arrangements were adopted to appease providers preemptively. The government agreed to pay "reasonable costs" and "reasonable and customary charges"—whatever the providers receiving the checks thought was reasonable, that is. Such vague standards became sure-fire openings for gaming the system and encouraging inflation in medical prices. By having private insurers act as intermediaries between Medicare administrators and doctors and hospitals, government further weakened its capacity to control costs. The program's leaders recognized these inflationary dangers, but they were seen as a necessary price to avoid the confrontations cost control would inevitably have brought.

Mythstakes

Contrary to popular belief and seemingly informed commentary, however, Medicare's record of cost control has not been one of uniform failure. Ignorance of that fact gives rise to the first myth clouding the Medicare debate:

• **Medicare's costs are uncontrollable.** In its first five years, growth in the program's expenditures was indeed explosive, rising over 70 percent from 1967 to 1971. Over the same period, the number insured by Medicare rose only 6 percent. Throughout the seventies, Medicare costs grew significantly, but so did the rest of the medical economy, which, like Medicare, lacked cost control and felt the burden of developments in medical technology and techniques that proved extraordinarily expensive. In the first half of the eighties, Medicare grew more rapidly than American medical care generally—but in the second half, through 1991, Medicare rose *less* rapidly.

That change was no accident. Driven by the ghosts of inflation past and deficits future, the federal government in the early eighties began making significant regulatory adjustments in the way it paid its providers, most notably by setting uniform hospital rates for particular treatments. The government cut what it paid, not what it covered. The result was a slowdown in the growth of medical expenditures without a loss of benefits.

Controls for hospital costs were much tighter than for physician costs, and in the late eighties growth in expenditures for doctors' payments hovered around 15 percent a year. Over the same period, growth in expenditures for hospital insurance dropped from around 15 percent to 2 or 3 percent annually.

The lesson of the eighties—that Medicare has the instruments of control when it has the will and congressional support to use them—has been lost. And so we come to the second major myth of Medicare, fueled by politicians of both parties and accepted unquestioningly by much of the press:

• **The program is hurtling towards bankruptcy in 2002.** *The New York Times* and *The Washington Post*, for example, rustle up the trust fund's looming bankruptcy as standard context in every Medicare story, without bothering to analyze what it actually means or whether it matters. "A major part of the program, the trust fund that pays hospital bills for the elderly, is projected to go bankrupt by 2002," the *Times*' Todd Purdum wrote after a

rally celebrating Medicare's 30th anniversary. Political rhetoric runs apace: "Whether we balance the budget or not, Medicare goes belly up in 2002," House Commerce Chairman Thomas Bliley warned recently.

Feeding this hysteria is the corollary myth of the bankrupt trust fund. First of all, the trust fund does not include supplementary medical insurance—so it's not relevant to a big chunk of the program. What's more important to understand, though, is that the trust fund is simply an accounting term, designed to illustrate how expenditures balance against tax revenues. It is *not* a bank account; its checks will not bounce.

If it chooses, Congress can appropriate more money to Medicare; it can change the tax schedule, and so on. To say that "by law" Medicare beneficiaries will stop receiving hospital benefits in 2002 is to imply that laws are immutable. The only thing that matters is whether Congress will raise taxes to meet expenditures, or control expenditures to stay within revenues. The affordability of the program is indeed a significant issue, but to focus on the trust fund as a symbol occludes, rather than illuminates, the debate.

Finally, one more myth that has taken root:

• **Cost-shifting is inevitable.** In other words, the idea that reducing what Medicare pays doctors and hospitals will mean a larger bill for other patients. It's true that, in the eighties, cost-shifting was a real problem. As Medicare instituted cost control, hospitals used private insurers or other patients' bills to make up the difference. In the 1992 campaign, a Bush Administration plan to cap Medicare expenditures became a hot issue when Clinton warned that, without wider medical care reforms, hospitals would likely make up the lost revenues by shifting costs to employers who would shed millions of jobs as a result.

The fear was legitimate, because expenditures weren't being well-controlled in the rest of the medical economy. That's no longer true. One positive effect of the dismal health care debate has been intense awareness and scrutiny of health costs in private medical care. Employers and insurers are increasingly unwilling to accept paying prices higher than, or even as much as, Medicare.

And so concern about cost-shifting is less and less relevant: You can't shift costs if there is nowhere to shift them to. If Medicare limits payment increases for services to growth in national income and the rest of medical payers follow suit, hospitals cannot screw other players. Real cost control—whether in physician fees or in deciding which services are rendered, and for what price—becomes the only option, within and outside Medicare. That's why, for example, some academic medical centers in New York City hospitals have cut house care staff by 5 percent, and Connecticut hospitals have cut their staffs by 25 to 30 percent.

All of this doesn't mean there aren't real threats lurking in Medicare's revamping. The Republicans, in their preliminary proposals for reform, are ignoring the major flaw that marked the program's beginnings, namely the failure to structure the program's benefits for the distinctive needs of the elderly. This danger is most glaring in the glorification of HMOs, which have a track record of providing primary care to healthier, younger patients, but lack similar success in catering to the specific needs of the elderly. Some, in fact, have a history of shunning the chronically sick and the elderly.

The Republican mantra for Medicare is now "Give 'em what federal employees have." But a superficially sensible solution may not be so easily transferable. Federal employees choose from 345 HMOs and 14 fee-for-service plans. Health-service consumers who are old and chronically sick or disabled deserve a consumer-friendly form of health insurance. Offering this group the smorgasbord of choices currently available to federal employees may sound good to the Health Insurance Association of America and certain market theorists, but if you're old and sick, you shouldn't be expected to wade through hundreds of choices with immensely complicated variations to find the best deal. Structuring the system this way could also require politically unpalatable federal regulation to prevent HMOs from "cherry-picking"—skimming off the patients who will cost them less to serve.

Voucher-based care, then, to which the federal employee plan is akin, raises all sorts of questions. What sort of regulation will ensure that the elderly, particularly the sick elderly, get adequate care? Competition may restrain costs,

but can it maintain quality? Will vouchers for Medicare segregate the elderly into a multi-tiered system of medical care? And will the beneficiaries be able to afford whatever additional costs are put on their shoulders? Until they satisfy these qualms, Republicans open themselves up to legitimate attacks from millions of Medicare beneficiaries already seething that they may be asked to pony up more in premiums and deductibles, only to get less in return.

Global Solutions

Clearly, there are more problems to be solved than the current debate suggests, but there are also more solutions. Other nations have universal coverage and wider benefits—and still spend less than we do per capita for their elderly. That suggests that it is possible both to control rising expenditures and widen coverage. What if some of the gaps left in the program 30 years ago, such as the lack of prescription drugs, were filled? In return, politicians could, at the very least, ask current beneficiaries to pay higher physician insurance premiums. If they knew they were getting something in return, Medicare's beneficiaries would be more willing to endorse cost control in the form of more reasonable choices being made about care.

No matter what, we can no longer afford health expenditures that increase at twice the rate at which our national income rises. The Republican solution—"voucherization" of Medicare—does nothing to guarantee cost control across the board. What's too often ignored is that the government itself can, and ought to, control costs in order to both reach deficit targets and expand coverage. Here's how:

• **Cap Medicare expenditures.** Limiting Medicare's budget will eliminate its perennial tendency to foil budget planners with unpredictable rates of growth, it will keep its expenditures in line with inflation, and it will force the tough decisions and hard bargaining necessary for cost control. HMOs are nothing more than capped programs with various strategies towards cost control, so in supporting HMOs, Republicans are at least on the right track to a global budget. But HMOs are not the only way to cap expenditures. Now, for example, we pay too much for procedures like magnetic resonance imaging (MRI), and do them too casually. Either pay less per MRI or don't pay in cases where it has been misused. With or without a widescale shift to HMOs, Medicare needs a global budget.

• **Pay providers less.** A global budget needn't mean reducing coverage but it absolutely demands reining in payments to providers. The key here is tough bargaining with doctors and hospitals. The larger the insurer, the more bargaining power it has. In the number of people it provides for, Medicare outranks the nation's largest private health care plan by more than two-and-a-half to one. That ought to give it phenomenal clout on the health care market. In California, some groups interested in cost control have reduced fees for surgical procedures by 25 to 35 percent. Medicare could do the same.

Medicare can make turnabout fair play and take advantage of market reductions in rates of pay using the "reasonable and customary" charge standard. Now that private medical costs are decreasing, Medicare should insist that doc-

tors and hospitals charge it less, too. But Medicare should also cast a wider net: If open heart surgery costs 40 percent less in Toronto than it does in Chicago, Medicare ought to exert pressure to see its costs lowered here.

• **Do less of what makes less sense.** Doctors, too, need the power to help control Medicare's costs. They, not bureaucrats, should make decisions as to what of questionable value should be done less often. That means, for example, fewer heroic last efforts—an enormous amount of Hospital Insurance benefits are now spent in the last three months of life. The medical profession, led by the American Medical Association and other industry groups, needs to make a good faith commitment to bargain over rates, and a professional commitment to curb improper or wasteful use of medical care. Until now, care providers haven't had incentive to do that, but with limits on the amounts available for treatment, they'll learn.

• **Try administering Medicare directly.** The idea of administering Medicare through intermediaries like Blue Cross was another costly legacy of its birth, an effort to buffer hospitals and doctors from wily bureaucrats. In the headlong rush to managed care, administration as a target for cost control has been pushed off the table. Put it back on.

Medicare reform is possible now that medical payers are at work on cost control and Medicare's system of pre-set payments has demonstrated that it too can restrain hospital costs. More than that, reform is desirable. Done properly, it could have benefits far beyond deficit reduction—it could offer a frustrated public an example of incremental improvement by the government.

A successfully revamped Medicare could also offer a blueprint for what American national health insurance should look like: coverage for all those eligible, with wide but manageable choice, accountable administration, fair and sustainable financing, a minimum of reliance on supplementary insurance plans, and a firm reliance on serious bargaining over expenditure levels and price. With an affordable model of national health insurance in public view, the drive for universal health insurance could begin again. □

The Washington Monthly

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May 1995

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June 1995

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