The Washington Post

The Medicare reform illusion

By Michael O. Leavitt
Friday, August 27, 2010

Despite the report from Medicare's trustees this month that the hospital insurance trust fund will not be depleted until 2029, 12 years later than was predicted just last year, Medicare is no better off than it was a year ago.

The administration credits Medicare's seemingly healthier financial outlook to changes made by the new health-care law. In fact, the legislation has weakened the program. Worse, its changes create the perception of progress, making it more difficult to pursue the reforms that would put Medicare on sound financial footing so future generations of seniors will benefit.

The problem begins with double counting. The Congressional Budget Office estimates that the health law will reduce Medicare spending by about $450 billion over 10 years. But all of those savings, plus massive tax increases, are used in the new law to pay for an expansion of Medicaid and a new entitlement program to subsidize insurance premiums for low-income households.

The Medicare cuts can be used to improve the government's capacity to finance benefits in the future or to pay for another entitlement. But they can't be used for both -- a point the CBO *and* Medicare's actuaries made in their cost estimates. On paper, the Medicare trust fund appears to have additional reserves because of government accounting peculiarities. But Congress has already committed those funds elsewhere.

Then there is the nature of the cuts. The administration recently penned a taxpayer-subsidized mailer for seniors touting the benefits the health law is to provide. Not mentioned are the deep cuts to Medicare Advantage, the private insurance component of Medicare, that will reduce benefits for the average enrollee by $800 per year later this decade.

Further, the new law imposes about a half-percentage-point cut every year in the annual increases in Medicare payment rates for hospitals and other institutional providers of care. Those increases are meant to cover inflation in the costs of providing services. Over time, the compounding effect of the cuts will be so large that the program's chief actuary says they are unlikely to be sustained. He estimates that if these cuts are implemented, 15 percent of the nation's hospitals would have to stop seeing Medicare patients. Despite all the talk of "delivery system reform," these cuts would be applied without regard to quality or performance. Every hospital and nursing home would experience reductions, no matter how well or badly they treat their patients.

We know full well that this kind of arbitrary cost-cutting in Medicare doesn't work. Since 1989, Congress has tried to put a lid on total fees paid to physicians. The use of physician services has soared under Medicare's fee-for-service arrangements. The automatic formula has tried to offset the higher costs with lower fees, across the board. But the cuts are so draconian that they drive physicians out of the program and reduce beneficiaries' access to care. The result is a bipartisan rush to undo the cuts every year. Why would we expect a different result from arbitrary cost-cutting in the new health law?

The administration has also pointed to the Independent Payment Advisory Board as a "game changer" for Medicare and the broader health system. The 15-member board is charged with finding savings in Medicare to keep spending growth below fixed targets, starting in 2015. Its recommendations will take effect automatically unless overruled in a new law.

Although Congress handed off substantial power to the board, lawmakers did so by removing its potency. The board can change only Medicare's payment rates for services and products (and it can't touch hospitals until 2020). The board can't change the nature of the Medicare entitlement or try to impose more market-based discipline on the program. That means the only way it can hit the budget targets is with reductions in reimbursement rates for those taking care of patients. That approach never works to control costs because the volume of services used is left unchecked. This undermines quality by penalizing high and low performers alike.

The fundamental problem is that Medicare's dominant fee-for-service structure rewards volume, not quality or value. Over the past quarter-century, Medicare administrators -- appointed by both political parties -- have tried to leverage the government's purchasing power to get more value from what is spent on behalf of seniors. Those efforts have not succeeded in altering the program's unsustainable course. The Medicare bureaucracy, even with the Independent Payment Advisory Board attached to it, does not have the capacity to engineer a more efficient health delivery system through complicated payment regulations.

What's needed is a new vision for Medicare. Instead of micromanaging prices, the federal government should provide oversight of a marketplace in which cost-conscious seniors choose among competing insurance and delivery system options. That's how the new drug benefit works, and costs have come in much lower than expected because genuine price competition drives down costs much more than any payment regulation can.

What Congress passed this spring is the illusion of Medicare reform. It does not ease cost pressures but papers over them with unsustainable price controls. It will end in disappointment, just as every other such effort has.

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