Real Medicare Reform

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In 1994, during the fight over President Bill Clinton’s health-care reform proposal, Senator John Breaux told a story meant to illustrate how confused Americans were about health-care policy. Breaux, a Louisiana Democrat, described being accosted at the New Orleans airport by an elderly constituent, who yelled at him: “Don’t you let the government get a hold of my Medicare!” It was meant to be a funny anecdote: Medicare, which provides health coverage to the elderly and disabled, is of course a huge government program. The fact that people wanted to keep the government out of it suggested that opposition to increased federal involvement in health care was motivated not by concerns about government’s administrative abilities, but rather by an ignorant resistance to change.

Joking aside, Breaux’s constituent made a point—whether she intended to or not—that today’s Medicare reformers would be wise to keep in mind. The administration of government programs can be influenced to greater or lesser degrees by politics, and Medicare suffers enormously from its constant micromanagement by Congress and the executive branch. The current debate over Medicare reform is often framed as a choice between centralized administration and market mechanisms, but there is a more clarifying way to evaluate the various reform proposals: by examining how much they would allow politics into the program, and how they would manage the competing desires of lawmakers, administrators, interest groups, health-care providers, and beneficiaries.

In recent years, reform proposals have fallen into two broad categories. Both aim to restrain the ballooning costs of Medicare without
undermining the program’s ability to provide comprehensive coverage for the elderly. The first category of reform would layer changes to Medicare on top of its current structure, in which the government sets the terms of coverage and the prices for health services. President Obama and Congress adopted this model in the recent health-reform law, which created the Independent Payment Advisory Board (IPAB), a 15-member panel tasked with recommending annual changes to Medicare payment rates and other policies in order to keep the program’s costs down.

The second approach to reform would instead transform Medicare into a marketplace of regulated, private health plans with government-provided subsidies for the premiums. This “premium support” model has been proposed most recently by Democratic senator Ron Wyden of Oregon and Congressman Paul Ryan (a Wisconsin Republican and now the party’s vice-presidential nominee), but versions of the premium-support idea have been around for many years. Under the Wyden-Ryan plan, the government would each year set a standard for coverage, stipulating the basic procedures and treatments any eligible plan would have to include. Private insurers would then submit bids to see who could provide the required coverage at the lowest cost. (A federal fee-for-service insurer would also submit a bid, so that traditional Medicare-style coverage would be considered along with private-sector bids.) The government would set the level of the premium subsidy to match the cost of the second-cheapest plan (allocating more generous premium subsidies to the poorest, sickest, and oldest seniors), ensuring that there would always be one option less expensive than the subsidy amount. If a senior chose this least expensive option, he could pocket the difference; if he chose a more expensive option, he would have to make up the difference on his own. Such a mechanism would provide beneficiaries with incentives to choose less costly plans, in turn giving insurers incentives to organize their networks of health-care providers as efficiently as possible. This would restrain the overall costs of Medicare, and the costs of health care more generally.

These models embody the two basic approaches to curbing cost growth in Medicare and, as such, have been debated extensively in the ongoing political fight over Medicare reform. But largely missing from this debate has been a consideration of Medicare’s politics, and of the ways each approach would lessen or increase lawmakers’ ability
to tamper with the program’s administration to serve their own ends (and those of their supporters). Few comparisons of these two approaches to reform have touched on the ways in which such meddling, and the perverse incentives it has created, have made Medicare inefficient. It is therefore worth considering how these influences have brought us to where we are today. It is also worth examining which reform approach does the most to address the problems those influences have caused—and thereby does the most to improve Medicare.

**THE TROUBLE WITH MEDICARE**

The fiscal trajectory of the federal government is completely unsustainable. If current trends continue, government debt held by the public will grow rapidly for the foreseeable future, quickly eclipsing the size of our entire economy. By 2022, America’s debt will exceed 90% of gross domestic product; by 2037, it will be nearly 200%, according to the Congressional Budget Office. As a consequence of this debt explosion, interest payments will start to squeeze out other public spending. Policymakers will be less able to respond to unexpected challenges, lacking the funding to pay for military operations or disaster response. We will be at risk of a sudden fiscal crisis if investors lose confidence in our ability to make good on our obligations.

Higher taxes alone cannot pay the bills coming due; repealing the Bush-era tax cuts, as some have suggested by way of a solution, would not even come close. The Congressional Budget Office’s latest Long Term Budget Outlook shows that achieving fiscal sustainability through tax increases alone would require every source of government revenue—personal income taxes, corporate taxes, firearm-license fees, everything—to go up by more than 20%, starting immediately. And these figures don’t account for the effects of higher taxes on behavior—driving people to work less, alter investment strategies, or simply engage in more evasion. This means that taxes for everyone else would have to go far higher still. Such staggering tax hikes are, of course, politically impossible.

The fiscal gap will therefore have to be addressed largely through spending restraint, which will need to focus on the main causes of our deficits and debt. Without a doubt, the foremost driver of our long-term fiscal problems is the Medicare program, the growth of which has vastly outstripped all other increases in spending in recent decades. In 1970, according to the CBO, Medicare spending equaled 0.7% of GDP, while
all other federal spending combined (except interest on the debt) was 17.9% of GDP. This year, Medicare spending will equal 3.7% of GDP (more than five times what it was in 1970), while all other federal spending will be 18.3% of GDP. And that trend is expected to continue: In the future, CBO expects Medicare costs to continue to increase as a share of the economy, while all other federal spending combined will remain roughly constant or actually decline.

To be sure, some of this additional Medicare spending is worthwhile. It is indisputable that health care in the United States has made remarkable advances over the past 50 years. Dramatic improvements in medical technology have expanded both the length and the quality of life. Even taking dramatic cost increases into account, no one would seek to turn back the clock on medical care or medical spending to the 1960s.

But at the same time, the volume of resources that we spend unwisely—on care that delivers minimal or no medical benefit—has also increased enormously. And this waste is a huge driver of Medicare’s cost increases. Although reasonable people disagree about the precise magnitude, there is no disputing that the amount of low-value treatment is large and growing. The problem is that, in the field of medicine, it can be difficult to determine what precisely constitutes waste: An important treatment for one patient may be useless for most others, and vice versa. As CBO director Douglas Elmendorf has put it, “[a] significant share of health spending is not contributing to health. But rooting out that spending without taking away spending that is beneficial to health is not straightforward.”

In order to distinguish wasteful from helpful treatments and to root out inefficiency, Medicare would have to be sharply and relentlessly focused on high-value care. But in its current form, the program is simply incapable of rising to this challenge. The problem is not one of government incompetence: The program is administered by a highly knowledgeable, professional staff at the Centers for Medicare and Medicaid Services (CMS), part of the Department of Health and Human Services. Rather, the problem is fundamentally political. Medicare is not focused on high-value care because it is structured in a way that allows other priorities to take precedence.

To begin with, Congress routinely intervenes in Medicare’s operations, in both formal and informal ways. It has the final authority over the many complex formulas that determine the administrative prices
that Medicare pays for everything from days in intensive care to MRI scans, home health-care visits, and wheelchairs. One need not be a political-science professor to see that this offers Congress plentiful opportunities to dole out benefits to well-organized constituencies.

And Congress has seized these opportunities, over and over again. To cite one egregious example, Congress has exploited Medicare rules that base reimbursement rates for hospitals on geography (hospitals in cities with high costs of living, for instance, are reimbursed at higher rates than those hospitals located in less expensive areas). In a shameless effort to help hospitals game the system, lawmakers have created a process through which hospitals can “reclassify” themselves into geographic areas that receive higher reimbursements. Hospital A, located in Town B, can suddenly get paid as if it were in City C—even if none of its buildings, doctors, or patients moves an inch. To the outside observer, the conditions under which reclassification is allowed are almost impossible to understand, occupying several pages in the Code of Federal Regulations. Yet reclassifications are a big business: According to the CMS website, 394 hospitals successfully availed themselves of this provision in fiscal year 2011-12. And as a 2008 study by the Robert Wood Johnson Foundation noted, geographic reclassification increases Medicare reimbursement to eligible hospitals by about 10%. But the same study also noted that this increase produces no measurable benefit to patient health outcomes. Such political games are played often and enthusiastically by both parties, and they cost taxpayers billions of dollars each year.

There is nothing surprising about spendthrift politicians, of course. But what makes Medicare different is the vast amount of money involved—the program now spends over half a trillion dollars a year—and the complexity of modern medicine, which makes it difficult for opponents of waste to identify and eliminate it. Political scientists describe this state of affairs as a “public-choice failure”—a situation in which the political incentives all point toward waste, and focused interest groups are rewarded at the expense of society as a whole.

It is important to understand how central this public-choice problem is to Medicare’s cost crisis. The sheer fact of congressional micromanagement of a massive system that disburses hundreds of billions of dollars annually must be taken into account when considering the potential of any proposed reform of the program—because it is precisely that
micromanagement that has stood in the way of many past reforms. For more than three decades, reformers both within CMS and in Congress have tried various means of containing cost growth through administrative requirements: price controls, pre-set maximum growth rates for physician reimbursement, and assorted payment schedules and mechanisms. And all have failed, because Congress ultimately was not willing to see them implemented.

The most prominent example of this phenomenon is the recurring story of the Medicare “doc fix.” In the Balanced Budget Act of 1997, Congress established a limit on the growth of Medicare spending. The formula was complicated, but it essentially required that the annual growth in spending per beneficiary not exceed the growth of GDP. At the end of each year, CMS was to report to Congress on the growth of spending over that year; if the percentage increase exceeded GDP growth, then CMS would have to reduce physician payments to offset the excess. But the 1997 law allowed Congress to perpetually suspend the payment reductions and adjust the formula—and rather than face a backlash from health-care providers, Congress has availed itself of this option 13 times. Indeed, the required reductions in physician payments have taken place only once, and Congress now routinely averts them in advance. Any effective solution to Medicare’s fiscal woes would have to find some way to address this and other manifestations of the public-choice problem.

Beyond the danger of direct congressional intervention, Medicare’s centralized design and its exposure to political micromanagement also mean that it is subject to intense pressures from key interest groups—like providers of medical products and services, as well as lobbies that benefit financially from the current system. These pressures push the system toward more spending rather than more value, prevent the usual interplay of supply and demand from informing prices, and leave no one with any incentive to curb fraud and abuse.

Any proposal for Medicare reform must be evaluated on its ability to mitigate these related problems, all of which result from the fact that Medicare is often directly manipulated by politicians. There is of course no way to free the program from political influence: As it is a government program funded by taxpayers, it should be answerable to the people’s representatives. But there are different ways to control that influence and to direct its power, and some clearly make for better policy than others.
LIMITING CONGRESS

Both the IPAB approach and premium support reflect an awareness of the danger of direct congressional micromanagement of Medicare. Both proposals tie the hands of Congress and delegate many responsibilities for particular decisions about prices and payments to an entity that is less subject to political pressure.

In the case of IPAB, that entity is an appointed expert board that makes recommendations that Congress must consider within ten weeks. If Congress does not approve the recommendations or find other means of achieving the same level of savings within six months, the board’s proposals are implemented automatically.

In the case of premium support, the price-setting entity is the market. Although the required minimum level of insurance coverage would still be defined each year by CMS (a federal agency answerable to Congress), the original cost of providing coverage, and the annual growth of that cost, would be determined by an annual bidding process among competing insurers. Decisions about which benefits or payment rates to cut or restructure would be determined by supply and demand (though would still be subject to significant political oversight through regulation).

Thus both proposals attempt to tackle the great challenge of reining in political influence. But they are not equally well suited to the task. IPAB’s most serious limitation on this front is that its charter does not require Congress to hold up-or-down votes on the panel’s recommendations. Instead, the law allows Congress to consider amendments to IPAB’s cost-cutting proposals as long as the changes “meet the same fiscal criteria under which the Board operates” — meaning they achieve the same level of savings. This provision enables Congress to, for example, replace the changes recommended by the board with lawmakers’ own reimbursement-rate cuts — which can then be undone by subsequent legislation — and still satisfy the health-care law’s requirements. This provision re-introduces politics into Medicare’s management at a crucial juncture. As to what the effects might be, Congress’s repeated undoing of required “cuts” under the “doc fix” offers a useful illustration.

As a 2011 report from the Kaiser Family Foundation explains, IPAB suffers from other flaws. There are statutory limits to its authority. Payments for inpatient and outpatient hospital services — the lion’s share of Medicare’s expenditures — are exempt from IPAB-proposed reductions in payment
rates until 2020, for instance. IPAB is also prohibited from making any recommendation that would ration care, restrict benefits, raise beneficiary premiums or cost-sharing, or modify eligibility criteria. These constraints make it hard to see how IPAB could achieve savings of the magnitude our fiscal situation demands. IPAB’s charter also requires its mandated spending reductions to be “scoreable” by CBO within a single implementation year. Such a requirement virtually guarantees that the board will seek savings by reducing reimbursement rates rather than by making more fundamental changes (which take longer to kick in), despite the fact that such fundamental changes would likely be more effective and more difficult to undo.

Some defenders of the IPAB approach argue that it will allow for the use of an alternative payment system—one with a better chance of controlling costs—within Medicare’s current administrative structure. This approach, known as “bundled payment,” involves making one payment for an “episode of care”—including, say, the hospital charges, surgeon’s fees, and follow-up visits for a hip replacement—rather than a separate payment for each individual service. The idea behind bundling is to create incentives for providers to manage care better, which would ultimately reduce low-value spending.

Although bundled payment is a good idea, there is little evidence to suggest that it will be enough to overcome Medicare’s fundamental public-choice problem. From 2005 through 2010, CMS conducted an experiment called the Physician Group Practice Demonstration Project (or PGP). PGP paid the physician groups that participated on a bundled basis, allowing them to keep a portion of the savings they generated for Medicare (relative to a projected spending target). The results suggested that bundled payment might be able to improve quality of care, but would have a much harder time generating savings. Overall, the demonstration saved Medicare a little over $100 per beneficiary per year. Given average Medicare spending of roughly $9,200 per beneficiary in 2010, this amounts to savings of slightly more than 1%. Perhaps more disappointing, CMS’s independent evaluator questioned whether even these meager savings were real. They may have just represented the medical groups’ efforts to exaggerate patients’ diagnoses upon enrollment in the demonstration—thereby raising the spending targets and inflating the estimates that formed the basis for the demonstration’s savings. If this is the kind of innovation that IPAB’s defenders believe would be its most promising outcome, then the IPAB approach is unlikely to work.
Premium support stands a much better chance of insulating the system from political manipulation. Although the IPAB may be more removed from interest-group interference than Congress is, it too is a fundamentally political institution. Premium support, on the other hand, entrusts decisions about particular cuts to a market. In doing so, it not only takes some power over Medicare administration away from Congress, but also weakens the incentives of organized interests to lobby against spending restraint in a way that IPAB does not.

Of course, in premium support’s initial phase, patient and provider groups will lobby to make the support payment and the required benefit package as generous and favorable to their interests as possible. Even so, they will have far less incentive to rig the system than they would under IPAB, because each party will be able to capture only a fraction of the benefits of any victory the group as a whole might achieve. As Michael Cannon of the Cato Institute has pointed out, anyone trying to wring extra money out of the system would have to invest resources lobbying up front without any sense of how the increased funding would eventually be distributed. For instance, if hospitals lobbied for higher premium-support payments, how would they know that the extra funding would flow to them rather than to ambulatory surgical centers, doctors, or medical-device manufacturers? That distribution would eventually be determined by who is best able to offer an attractive insurance product to consumers on an open market. And since no one knows for sure what his competitors will do, there is less of an incentive to fight for the program’s expansion and more incentive to focus on providing a more attractive service at lower cost.

In this way, premium support does more than simply create a formal limit on Congress’s involvement in payment decisions. It also reduces the current incentive for providers in the system to manipulate Congress. In a reasonably functional market system—one in which insurers compete to supply a defined package of benefits—providers are likely to focus far more on efficiency than they do under today’s system, or than they would under IPAB.

Setting Prices

Beyond the question of shielding the Medicare system from direct manipulation by Congress, premium support and the IPAB approach must be compared on the basis of how they address the most troubling
inefficiencies of the Medicare system. And on this front, too, the political character of Medicare poses a major challenge.

Prominent among the sources of inefficiency in the Medicare system today is how the program sets prices. Medicare currently uses a top-down approach: Starting with direction from Congress and the administrator of CMS, the program’s staff determines what goods and services Medicare wants to offer to beneficiaries and what it will pay on the basis of internal analysis and the input of interested external parties. The alternative is a bottom-up approach, in which CMS would solicit bids from sellers to obtain information about the costs and characteristics of available goods and services and make its decisions accordingly.

Economists describe these two approaches as “administrative pricing” and “competitive pricing,” respectively. As Robert Coulam, Roger Feldman, and Brian Dowd explained in the *Journal of Health Politics, Policy, and Law* in 2011, administrative pricing has a fundamental disadvantage: It reverses the natural flow of information. Under competitive pricing, providers (who know a lot about the cost of care) tell Medicare staffers (who unavoidably know much less) about the resources that are required to provide a given product or service. In administrative pricing, information flows in the other direction: from the party that knows little about costs to the party that knows a lot.

At first glance, it might seem like administrative pricing gives CMS an advantage over the providers it works with, since those providers have to deal with the prices and payments dictated by the agency. But the opposite is true. Administrative pricing is good for providers for the same reason that it is bad for society: It allows providers to exercise their natural informational advantage over Medicare. They organize their work with knowledge of how particular products and services will be reimbursed, and thus design their care with the aim of receiving maximal reimbursements, rather than of providing the best form of the service or product CMS wants at the lowest possible price. This advantage has only grown as technology has become more complex, widening the knowledge gap between CMS and providers. It is thus not surprising that providers’ opposition to competitive pricing in Medicare has been so vigorous: They stand to lose out under a more efficient, market-based system that makes Medicare rules more difficult to manipulate. (The public, however, would gain.)

Competitive pricing is not inconsistent with the current structure of Medicare—but it is inconsistent with Congress’s interests. Again,
the problem is politics. Administrative pricing creates opportunities to make decisions that favor narrow groups of providers, thereby giving politicians valuable benefits to distribute to their advantage. A series of articles in Health Affairs by researchers from the Medicare Payment Assessment Commission (also known as MedPAC) — an independent agency that advises Congress on Medicare policy — offers several examples of providers’ using the political process in this way. Many of Medicare’s administrative prices exceed market prices for the same goods and services, leading providers to furnish more of these “profitable” services than beneficiaries need. This system may be good for providers, but it is harmful to patients: In addition to causing wasteful spending, unnecessary procedures increase the risk of medical errors.

Premium support breaks this link between politics and pricing in a way that IPAB and bundled payment do not. Once the value of the overall support payment is determined, the myriad individual prices that the competing insurance plans pay and charge will be determined by the market. Different insurers will offer different approaches to care; consumers will see what most appeals to them. And the result of that process is more likely to be politically stable. Under traditional Medicare, providers who oppose competitive pricing have no natural counterparty pushing against them; under premium support, however, both insurers (who would claim some of the residual profits of successfully competing for customers) and beneficiaries (who would share in efficiency gains through lower premiums) would play this role.

Premium support would make use of markets on the demand side as well. Insurers would be forced to offer good value relative to their competitors; if they failed to do so, they would lose customers’ business. Beneficiaries, too, would face tradeoffs: between the extra features of more expensive coverage and their own money (in the form of savings from unspent premium subsidies or out-of-pocket spending for premiums above the legislated support level). Premium support would thus encourage innovation in spending-control techniques in ways that the current system does not — techniques that could be useful throughout the American health sector, not just in Medicare.

**Fighting Fraud**

Defenders of today’s Medicare program often point out that Medicare spends much less on administrative activities than private health-insurance
plans do. A major appeal of the IPAB over premium support, they suggest, is that it would retain Medicare’s administrative structure, which seems to involve significantly less overhead. Premium support, by contrast, would involve private insurers far more extensively in the operation of Medicare, and they tend to have higher administrative costs.

But are Medicare’s low administrative costs really a strength of the program? Is a dollar spent making sure that a doctor is really delivering the care he claims to deliver a dollar wasted? Like everything else, spending on administration is sometimes good and sometimes bad: It is good when it generates savings that exceed costs and bad when it does not.

By any realistic measure of this sort, Medicare spends too little, not too much, on administration and oversight. The program’s standards for the enrollment and payment of providers are notoriously lax, having been well documented in a series of 2011 reports by the U.S. Government Accountability Office. The GAO found that CMS had not adhered to its own internal procedures for determining whether a potential provider was a legitimate business before enrolling it in the program and making payments. Medicare itself has identified two groups of providers—home health-care agencies and suppliers of durable medical equipment—that are especially prone to fraud.

To illustrate the point, GAO investigators ran an experiment in which they created two fictitious suppliers of durable medical equipment using undercover names and bank accounts. GAO’s fictitious companies were approved to bill Medicare despite having no clients and no inventory. CMS initially denied the requests, but undercover investigators fabricated contracts with non-existent wholesalers to convince the agency that the companies had access to supplies. The contact number that GAO gave for the phony contracts rang on an unmanned telephone in the GAO building. When CMS’s agent left a message looking for further information about the contracts, a GAO investigator left a vague message in return. As a result of these simple methods of deception, both companies were given Medicare billing numbers and allowed to start charging the government.

Medicare also routinely under-invests in pre-payment review of claims—automated payment controls that delay or select for further scrutiny questionable claims, such as those associated with unusually rapid increases in billings or items or services unlikely to be prescribed in an appropriate course of medical care (like removing the same
patient’s gallbladder twice on the same day). Indeed, in 2006, the GAO estimated that a one-dollar investment in pre-payment review would save $21 in improper Medicare payments. But by 2011, CMS had only partially implemented the GAO’s recommendations for the redesign of its pre-payment review process. This year, CMS has made changes designed to address some of these vulnerabilities, but it is clear that many problems remain.

Why does this laxity continue? Again, the reason is political. In traditional Medicare, even honest providers have an incentive to lobby against aggressive efforts to control fraud and abuse. They have no opportunity to share in the gains of rooting out fraud; for reputable providers, stricter auditing requirements simply result in higher accounting costs.

Neither IPAB nor bundled payment would change this dynamic, because both would leave the basic structure of Medicare unchanged. Indeed, putting more financial pressure on providers in the form of tighter price controls would increase their incentive to lobby against greater administrative requirements (since those requirements would increase providers’ costs). Premium support, by contrast, would change the political dynamic. Privately administered health plans can (and do) offer to share gains from controlling fraud and abuse with the vast majority of legitimate providers, thereby weakening their incentive to oppose anti-fraud measures. Similarly, beneficiaries in traditional Medicare have no reason to demand tighter oversight because any gains accrue entirely to the program without the beneficiaries’ even knowing about them. With premium support, however, this situation would change: Seniors would enjoy some of the benefits of rooting out fraud in the form of lower premiums and costs. The result would be greater recognition of the tradeoffs that must be confronted to ensure that Medicare’s resources are spent wisely.

**Driving Out the Rent-Seekers**

To be sure, health-care providers are not the only parties with an interest in preserving Medicare as we know it. Special-interest groups, too, are deeply invested, and thus highly engaged in the politics of entitlement reform. One powerful advocacy group in particular—the AARP—merits special attention. The motives behind its fierce opposition to the Wyden-Ryan premium-support proposal illustrate further advantages to moving from administrative to competitive pricing in Medicare.
It is not immediately obvious why the AARP—formerly known as the American Association of Retired Persons—should so strenuously oppose a reform that would not affect current seniors or anyone now over 55. Nor is it clear why the group would agitate against a proposal that could save the Medicare program from future collapse while retaining a guaranteed and comprehensive insurance benefit for seniors—both today and in the future. The group may well judge the IPAB’s administrative-pricing model to be superior, but such a policy preference seems unlikely to account for the intensity of the AARP’s opposition to premium support.

A look at what the AARP actually is and does helps to solve the mystery. As the country’s largest non-profit advocacy group, the AARP has always been an important player in Washington. In recent years, however, its size and funding sources have changed. In 1990, the AARP had gross receipts of $300 million (which would be about $525 million in 2009 dollars); by 2009, gross receipts had grown to $2.2 billion. This makes the organization eight times as large as the second-largest non-profit advocacy group, the National Rifle Association. In 1990, AARP membership dues were one-third of gross receipts, but by 2009, they had fallen to one-ninth.

Where is the rest of the money coming from? The key to answering this question lies in understanding Medicare supplemental insurance: private policies that pay for services not covered by Medicare, or that cover the program’s co-payments and deductibles. These policies have an adverse effect on Medicare’s finances, because they effectively eliminate cost-sharing as a motivator to keep health-care consumption in check. After all, if seniors have supplemental insurance, they basically have free health care—which means they pay no price for seeking more and more care. Several studies have shown that this leads to significantly greater spending, and only marginal medical benefit. Indeed, one recent study conducted for MedPAC showed that, all else being equal, supplemental coverage led to 33% more spending, largely in the form of elective outpatient procedures (as opposed to emergency or other urgent, non-discretionary inpatient services).

Supplemental insurance is thus harmful to Medicare’s finances. But it’s great for the AARP. Why? Choosing among the different supplemental plans—sorting through their various benefits and coverage differences, and weighing those against prices—can be a daunting task
for seniors. The AARP steps in by lending its name to commercial insurers for the sale of AARP-approved and -branded Medicare supplemental, Medicare Advantage, and Medicare prescription-drug policies. AARP earns enormous royalties from these sources; indeed, they now account for about half of the group’s income.

It is therefore not surprising that the AARP is deeply committed to—and in fact dependent upon—preserving this state of affairs. Hence the ferocity of the group’s opposition to premium support. In a system like the one proposed by Wyden-Ryan, seniors would select coverage from among plans that all have the same required minimum benefits; as a result, there would be much less uncertainty about what one plan or another would or would not cover. This, in turn, would reduce seniors’ reliance upon AARP endorsements or branding to select plans. And from the insurers’ perspective, being forced to compete for seniors’ business—by offering a good product at the lowest possible price—would give them every incentive to eliminate unnecessary costs. Immense royalty payments to the AARP in order to borrow the group’s name would surely be among the first expenses to go. Moreover, any serious premium-support insurance plan would probably eliminate traditional Medicare’s unlimited cost-sharing—thereby undermining the political and economic rationales for Medicare supplemental policies in the first place.

This would be a disaster for the AARP, but a boon to the cause of making Medicare more efficient (and thus more sustainable). Given that countless other powerful advocacy groups have similar stakes in keeping Medicare as it is, the story of the AARP is yet another example of how premium support would keep politics out of the system, and thereby help keep spending under control.

**Provider Power**

To be sure, premium support is not without its drawbacks. But the common criticisms of such a market-based approach are not persuasive. One set argues that premium support would hurt the poorest, sickest, and oldest—and thus the most vulnerable—Medicare beneficiaries. For these seniors, the argument goes, higher health-care costs would not be covered as easily by a set payment, and so patients would confront gaps in coverage.

Although premium support could be implemented in such a way, no realistic proposal would do so. All serious premium-support proposals,
including Wyden-Ryan, graduate their support payments on the basis of income (more for the poor than for the rich), health status (more for the sick than for the healthy), and age (more for older retirees than for younger ones). Given the extensive racial and socioeconomic disparities in the quality of care provided by Medicare today, arguing for the status quo on the grounds of fairness is particularly unreasonable. Indeed, premium support has the potential to do better in this respect, by explicitly giving a larger payment to people who are socioeconomically disadvantaged.

Another set of criticisms argues that the poor cost performance of the Medicare Advantage (MA) program—a feature of Medicare that allows beneficiaries the option of obtaining their care through a private health plan financed by a support payment from the government—means that premium support will not work. But this criticism ignores several liabilities of MA that would disappear in a well-designed premium-support system.

The most important reason that MA plans cost more than traditional Medicare is not that private plans are inefficient, but rather that Congress has set the support-payment amount above traditional Medicare’s spending levels. Each year, CMS determines what it will pay MA plans for covering a Medicare patient in each county in the United States; in a separate process, plans offer bids showing how cheaply they can provide that coverage. For each plan, if the CMS benchmark is above the bid amount (which it almost always is), the federal government keeps 25% of the difference and the insurer providing the plan keeps the other 75%—which it is required to return to beneficiaries in the form of expanded benefits, reduced co-payments, or (subject to certain restrictions) lower premiums. As an accounting matter, it is therefore impossible for MA to save money for the federal government. It’s easy to see why this practice has continued as long as it has: MA’s generosity is immensely popular with both health-care providers and beneficiaries, even though it comes at the program’s expense.

And yet, even under these conditions, there is evidence that MA plans are more efficient than traditional fee-for-service Medicare. A 2012 study by Zirui Song, David Cutler, and Michael Chernew in the *Journal of the American Medical Association* examined the bids plans made, rather than just the payments they received, to consider how the premium-support plan proposed by Wyden and Ryan would have worked had it been in effect in 2009. Under that plan, Medicare’s costs would have been
determined by the second-lowest bid in each county. The study found that the second-lowest bid by MA plans in 2009 was 9% lower than the cost of traditional Medicare, which suggests that MA plans were able to provide the same benefits as traditional Medicare for less.

The study rightly points out that these savings might be overstated. The apparent cost advantage of MA could be the result of adverse selection: MA plans could be enrolling healthier patients. CMS adjusts payments to MA plans to prevent exactly this sort of behavior — rewarding those that enroll the sick and penalizing those that enroll the healthy — but such risk adjustment is necessarily imperfect. Yet the study might also be understating the savings that could have been achieved through premium support. Because it looked only at Medicare Advantage — with its peculiar rule that withholds 25% of the savings from enrollees who choose low-bidding plans — the study could not take account of the full potential of premium support to create incentives to lower costs.

Both concerns — about the possible overstatement and understatement of premium support’s potential — are valid. On balance, however, the argument that MA proves that premium support cannot work seems unfounded.

One concern about premium support does merit further consideration. Some areas of the country are served by only one or two hospitals, particularly for certain high-level, technologically intensive procedures like treatment for trauma, rare cancers, or serious cardiac illnesses. In these places, a premium-support system might give providers market power over private insurers, and thus increase the effective price that beneficiaries pay for care. Today’s Medicare program exercises nationwide, take-it-or-leave-it buying power, which gives it negotiating leverage over even these regional health-care powerhouses. That take-it-or-leave-it monopoly status is, of course, part of the problem with Medicare. But while eliminating that power would improve efficiency in some ways, in these areas, it might tip the balance of power back to the regional behemoths — thereby leading to price increases so large as to outweigh premium support’s other gains.

Empirical evidence about the effects of provider market power — particularly hospital market power — suggests that this is a real problem. But it remains an open question whether retaining Medicare’s administrative-pricing structure is the appropriate policy response. In
other contexts, giving a public agency the power to determine prices is not generally seen as a way to address failures of competition. Smarter and more assertively enforced anti-trust laws would be a superior alternative. This concern has not been prominent enough on the agendas of advocates of premium-support reforms; if such reforms are to proceed, these advocates will need to take the problem seriously and provide substantive means of addressing it. Premium support depends on healthy competition, and there is a role for regulators in ensuring such competition and combating monopoly power.

Solving the Medicare Riddle

Medicare’s out-of-control spending is the natural result of its centralized, politicized structure. The creation of a centralized board of cost controllers—all political appointees—is thus not the way to address it.

Premium support, in contrast, would deal with Medicare’s fundamental problems far better. It would commit the program to a structure more resistant to lobbying by interest groups and meddling by Congress. It would create incentives for insurers and beneficiaries to avoid low-value care and invest appropriately in controlling fraud and abuse. And its market mechanisms would allow Medicare to make greater use of prices in order to transmit information about the real costs of treatment decisions and insurance-policy design. All of these factors would make Medicare better at delivering good value and controlling spending.

Premium support does carry risks, but when compared against the idea’s advantages—and against the vastly greater danger of national fiscal collapse—those risks are worth taking. No approach to reforming Medicare is perfect or certain to work. But the question of how we keep the program’s spending under control, protect the poorest and sickest beneficiaries, and preserve the program for the future is one that nevertheless needs answering. Of the available options, premium support is the best approach.