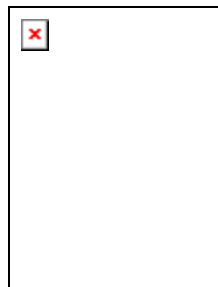


# Why the Obama Health Plan Is *Not* Entitlement Reform

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## Introduction

“Health care reform is entitlement reform.”<sup>1</sup>

So said Peter Orszag, President Barack Obama’s first budget director, at a bipartisan fiscal responsibility summit called by the president in February 2009. President Obama had assumed office just a little over a month earlier, and he was signaling to the country and to those present at the White House that his top domestic priority during his first year in office — securing a health care law that covered all Americans with health insurance — was consistent with his commitment to impose renewed fiscal discipline.

He and his team knew there would be many in Congress, even among members of his own party, who would be wary of mounting an all-out effort to pass an ambitious health reform program given the expected cost of such an initiative and the daunting budgetary challenges already facing the country. Most House and Senate members have been aware for many years that rising health entitlement costs — in the form of Medicare and Medicaid expenditures — threaten to push the nation’s finances past the breaking point. If the country can’t pay for its existing health care commitments, how could the president afford to make expensive new promises of subsidized health care to millions of new beneficiaries?

The president wanted to pre-empt this kind of cost and budget critique by making a bold pronouncement. Not only would his reform program cover millions of people with insurance, it would also “bend the cost-curve,” and thereby begin to make the nation’s health entitlement commitments — new as well as old — more affordable for future generations of taxpayers. This argument that health reform would actually improve the nation’s budgetary outlook even as it moved the country toward “universal coverage” became the centerpiece of the administration’s push for Congressional passage.

After a long and divisive legislative debate that lasted well over a year, the president succeeded in getting a health reform bill. Congress passed the legislation, and he signed it into law in March 2010.

Enactment of the new law hasn’t settled matters, though. The public debate continues, and the country remains deeply divided over what was passed. In part, that is due to the unusual and polarizing manner in which the Congressional majority pushed the bill through during its final stages of consideration. It was a bruising battle, and many Republicans believe the steps the administration and Congressional leadership took to avoid the need for bipartisan support simply went too far and ensured the law would be viewed suspiciously by a large percentage of the electorate.

But even if the process used to pass the legislation had been less polarizing, the new law still would be highly controversial. That’s because there are deep and enduring

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<sup>1</sup> Peter Orszag, Director of the Office of Management and Budget, at the White House Fiscal Responsibility Summit, February 23, 2009 ([http://www.whitehouse.gov/omb/press\\_releases/022309\\_reform/](http://www.whitehouse.gov/omb/press_releases/022309_reform/)).

disagreements over the substantive merits of its main provisions, and most especially over how much they actually will cost, now and in the future, and who ultimately will shoulder the burden of extending the law's new entitlement promises to large numbers of Americans.

These concerns over the costs of the health law have only been reinforced by growing worldwide recognition of the economic risks associated with excessive governmental borrowing and debt. As the rest of the developed world is moving toward retrenchment of their welfare states, Americans are rightly concerned that their government has just piled an enormous new budgetary risk onto an already precarious fiscal outlook. This concern is so pervasive among the electorate that it could very well force Congress to revisit the recently passed health law, and sooner rather than later.

### The Nature of the Existing Entitlement and Fiscal Crisis

Just as President Obama was assuming office in early 2009, the United States was entering a period of budgetary and economic risk unlike anything experienced in the post-war era.

In 2008, the U.S. economy fell into a very severe recession, triggered by a calamitous housing and financial crisis. Revenue plummeted, and obligations soared. The federal government ran a budget deficit of 9.9 percent of GDP in 2009 — the highest since World War II, and more than four times the recent historical average of 2.4 percent.<sup>2</sup> The gap between federal spending and revenue in 2010 is expected to again approach 10 percent of GDP.<sup>3</sup>

These deficits are far in excess of what has been experienced during past recessions. Moreover, projections show that even after a sustained recovery has been underway for several years, and unemployment has fallen to more normal, non-recessionary levels, federal deficits will not return to their post-war norm. If the Obama administration's 2010 budget plan were to be adopted in full by Congress, the Congressional Budget Office (CBO) projects the federal budget deficit in 2020 would be 5.6 percent of GDP, and the nation's debt would have reached 90 percent of annual GDP, up from about 40 percent at the end of 2008 (see Figure 1). The cumulative budget deficit over the period 2011 to 2020 from the Obama budget plan would be nearly \$9.8 trillion.



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<sup>2</sup> The average federal budget deficit, as a percentage of GDP, was 2.4 percent from 1970 through 2008. See Historical Tables, Congressional Budget Office. ([http://www.cbo.gov/ftpdocs/108xx/doc10871/Historicaltables2010Jan\\_forweb.XLS](http://www.cbo.gov/ftpdocs/108xx/doc10871/Historicaltables2010Jan_forweb.XLS)).

<sup>3</sup> *An Analysis of the President's Budgetary Proposal for Fiscal Year 2011*, Congressional Budget Office, March 2010.

This large run-up in governmental debt is of course partly attributable to the continuing fallout from an unusual and very severe recession. All of the borrowing that has occurred in 2009 and 2010 will drive up net interest costs on a permanent basis, among other things. By 2020, CBO expects net interest on the national debt to rise to more than \$900 billion, up from only \$187 billion in 2009.<sup>4</sup> But the large deficits and debt projected for the coming years also reflect increased budgetary pressure from the rapid growth in federal entitlement spending.

In 1970, the federal government spent four percent of GDP on Social Security, Medicare, and Medicaid. Based on projections made last year, CBO expected spending on the “Big Three” entitlements to reach 9.8 percent of GDP in 2010 and 11.4 percent of GDP in 2020, or almost triple what it was a half century earlier.<sup>5</sup>

The growth in entitlement spending has been fueled by two basic factors — rapidly rising per capita health costs and a growing elderly population. CBO has calculated a useful measure of the capacity to finance health costs over time — so-called “excess cost growth,” or real per capita growth in health costs in excess of real per capita GDP growth.

This measure is useful because it shows the extent to which health spending commitments have been taking up a larger and larger share of limited resources. It is quite natural for societies to spend more on health as incomes rise. But spending more on health means less for other priorities, and to many people and businesses, health care is more a fixed cost that they can’t control than a discretionary budget item. Moreover, in the public sector, if health spending continuously grows more rapidly than the tax base, then the government must either perpetually increase tax rates or cut other programs on a regular basis to make room for more health spending.

As shown in Figure 2, “excess cost growth” in Medicare averaged 2.3 percent annually from 1975 to 2007. For Medicaid, the average was 1.9 percent annually during the same period.



Rapidly rising health care costs are expected to continue into the indefinite future, even as the country also experiences an unprecedented demographic transformation with the retirement of the baby boom generation. Between 2010 and 2030, the population aged 65 and older is projected to increase from 41 million to 71 million people (see Figure 3), swelling the ranks of Social Security and Medicare program beneficiaries, as well as those qualifying for long-term care services under Medicaid.



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<sup>4</sup> *Ibid.*

<sup>5</sup> *The Long-Term Budget Outlook*, Congressional Budget Office, June 2009 (supplemental data at: <http://www.cbo.gov/ftpdocs/102xx/doc10297/SupplementalData2009LTBO.xls>).

Rising health costs and an aging population will drive up entitlement spending in the coming years even more rapidly than it has grown in the past. Last year, before the health law was enacted, CBO expected the combined costs of Social Security, Medicare, and Medicaid to rise from 9.8 percent of GDP in 2010 to 14.4 percent in 2030 and 17.9 percent of GDP in 2050 (see Figure 4). The jump in spending over just the next two decades — 4.6 percent of GDP — is roughly equivalent to the size of Social Security today. In other words, the federal government would be adding new spending commitments to the budget equal to the size of the current Social Security program without any new funding to pay for it.



### Official Cost Assessments of the Health Law, and Their Limitations

Prior to becoming the president's choice for Director at the Office of Management and Budget in early 2009, Peter Orszag served as head of CBO. While there, he made it something of a personal crusade to advise the media and members of the House and Senate that the long-term budget problem was really a health cost problem. To make his point, he frequently displayed charts showing that, over the next twenty years or so, about two-thirds of the entitlement cost growth would be attributable to factors other than population aging, and mainly rising health costs.<sup>6</sup>

That was the kind of reasoning that administration officials and other proponents of the recently enacted health law brought to their efforts. They never claimed that the health law would address the set of issues surrounding the aging of the population and the additional budgetary burdens associated with moving toward a lower ratio of workers to retirees — in part because they had minimized the significance of this aspect of the problem in their own minds.

Orszag's claim that population aging is a less significant factor in the entitlement crisis was always a controversial point because it depended on a particular slicing of the cost projections data. Others, looking at exactly the exact same numbers, came away with very different conclusions.<sup>7</sup>

Ironically, with Orszag's departure from CBO to become President Obama's first OMB Director in early 2009, CBO's assessments of the relative importance of aging and rising health cost in the entitlement crisis began to change, and it now tracks with what the critics contended more than two years ago when Orszag was beginning his "health reform is entitlement reform" drumbeat. CBO's long-term budget projections from last year show that before enactment of the health law, population aging would be responsible for at least 56 percent of the spending growth for the major entitlement programs between

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<sup>6</sup> See "Health Care: Capturing the Opportunity in the Nation's Core Fiscal Challenge," Peter Orszag, Director of the Congressional Budget Office, Presentation for Princeton University, March 12, 2008 (<http://www.cbo.gov/ftpdocs/90xx/doc9054/03-12-Princetonwnews.pdf>).

<sup>7</sup> See, for instance, "Honey, I Shrunk the Demographics," Neil Howe and Richard Jackson, *Facing Facts*, December 2007 (<http://www.concordcoalition.org/files/uploaded-pdfs/ff-1220-demographics.pdf>).

now and 2035, and rising health care costs would account for just 32 percent of the cost growth (see Figure 5).



This is not to suggest that rising health care costs are not a major budget problem. They are. But even if that cost growth decelerated, the U.S. would still be under extreme budgetary pressure as the tidal wave of retiring baby boomers hit federal program enrollment. The health law does absolutely nothing to address this fundamental aspect of the entitlement crisis.

What's even more troubling is that the problem the president and his advisors said they would address hasn't come close to being solved either. Both CBO and the Chief Actuary at the Centers for Medicare and Medicaid Services (CMS) have rendered preliminary judgments on whether or not the president succeeded in bending the cost-curve for entitlements, or the health system more generally, as he promised he would. And their answer, for now, lies somewhere between highly doubtful and no, though they never say so explicitly.

CBO recently released an updated version of its projections for federal spending, revenue, deficits, and debt over the coming decades, this time incorporating the expected impact of the provisions of the new health law. As shown in Figure 6, CBO's new long-term projections still show a crushing burden from entitlement spending growth in coming years. In 2030, spending on Social Security and federal health entitlement programs will reach 14.7 percent of GDP, a jump of 4.3 percent of GDP in just twenty years.<sup>8</sup>



And even that is a rosy scenario, assuming as it does that all of the law's controversial cuts and taxes will get implemented exactly as written. If those provisions do not survive — and even CBO hints this is a distinct possibility — total entitlement spending will rise even more rapidly, adding another 1 percent of GDP to federal spending in 2030 (see “Alternative Scenario” in Figure 6).

Unfortunately for the White House, the administration's own employee — Richard S. Foster, the Chief Actuary at CMS — is even more pessimistic than CBO. In an official estimate released after passage of the legislation, he projected that overall national health expenditures would be higher in 2019 than they would be if the law had not been enacted at all. Moreover, he raised serious questions about whether the provisions that do cut costs could be sustained over coming years, especially the across-the-board payment rate reductions in the Medicare program which would drive reimbursement rates down even as health care input costs continued to rise rapidly. If those cuts do not hold — and it is clear he does not think they will — federal and national

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<sup>8</sup> *The Long-Term Budget Outlook*, Congressional Budget Office, June 2010 (supplemental data at: <http://www.cbo.gov/ftpdocs/115xx/doc11579/LTBO-2010data.xls>).

health spending would go up even more rapidly than his estimates now indicate.<sup>9</sup>

For its part, the administration has continued to point to CBO's official cost estimate of the legislation to validate its claim that the law will reduce the federal budget deficit.<sup>10</sup> That claim — which is not the same as saying the health “cost-curve” has been bent downward — is itself subject to strong criticism because of a series of budgetary gimmicks and implausible assumptions which are in the legislation and therefore were required to be considered in CBO's analysis. Among other things, the new law doublecounts premiums collected for a new long-term care insurance program, using the premiums both to bolster the claim of deficit reduction in the first ten years of implementation and then to finance new long-term benefits in later years. Of course, the same dollar can't be spent twice, no matter how much Congress wishes it were not so. Using the long-term care premiums to mask the costs of the health entitlement expansions over the next ten years only means that more debt will have to be incurred later when long-term care benefit claims come due and the premiums, which should have been “saved” for that purpose, are found to have already been spent.<sup>11</sup>

Still, even the administration has essentially admitted that these official cost projections do not validate the claim that cost escalation for the federal health entitlement programs will moderate in any meaningful way due to the legislation. Indeed, Orszag has said that he agrees with a cautious assessment of the cost-cutting potential of the new law. But he also has argued that the potential for cost cutting from the new law is far greater than the official projections indicate, which he believes will become evident as implementation proceeds.<sup>12</sup>

Orszag's reaction to the official cost assessments of the new health law is illuminating. It's an acknowledgement of the limits of those projections for policymaking. Yes, CBO and the Chief Actuary provide important information that must be taken into account in the health policymaking process. And the budget process must be built on a foundation of hard numbers produced by independent parties.

But cost estimating is no substitute for sound judgment about setting the basic direction for policy. What's needed more than anything else in health care is a coherent, reality-based policy prescription for altering the basic dynamics away from cost escalation to productivity improvement and more efficient patient care. That's the goal. But getting there requires a clear and accurate diagnosis of what is creating the cost

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<sup>9</sup> “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended,” Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, April 22, 2010 ([http://www.politico.com/static/PPM130\\_oact\\_memorandum\\_on\\_financial\\_impact\\_of\\_ppaca\\_as\\_enacted.html](http://www.politico.com/static/PPM130_oact_memorandum_on_financial_impact_of_ppaca_as_enacted.html)).

<sup>10</sup> See Letter to House Speaker Nancy Pelosi from CBO Director Douglas Elmendorf on the cost estimates for the Patient Protection and Affordable Care Act, March 20, 2010 (<http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>).

<sup>11</sup> See “The CLASS Act: Repeal Now, or Expect a Permanent Taxpayer Bailout Later,” Brian Riedl and James C. Capretta, The Heritage Foundation (forthcoming).

<sup>12</sup> “Orszag: CBO lowballs savings from Obama's healthcare reform,” Walter Alarcon, *The Hill*, April 11, 2010.

problem in the first place.

### Diagnosing the Core Cost Problem

The year-long debate over the future of U.S. health care policy was polarizing, but beneath the surface, a surprising consensus was forming around a crucial issue. As the search for answers on rising costs intensified through hearings and briefings with experts from around the country, analysts from both sides of the debate were reaching the same conclusion: The Medicare program, as it operates today, is a primary cause of the cost problem.

Of course, that's not a conclusion that every member of Congress would agree with. In particular, a sizeable number of House and Senate Democrats made the "public option" modeled on Medicare their highest legislative priority during the legislative debate. Not only do those members disagree that Medicare is the problem, they believe Medicare is the solution. Indeed, support for the "public option" was so important to elements of the Democratic political coalition that President Obama went out of his way to show support for the concept as well — though he moved away from that support when it was clear that the public option's inclusion in the legislation would doom the entire health reform effort.

Nonetheless, there was more consensus around Medicare's role in high costs than most debate observers realized. Among the health policy team at the White House and the staff working for Senate Democrats, there was a clear recognition that there would never be any meaningful "bending of the cost-curve" so long as Medicare continued to operate as it does today.

It is hard to overstate the importance of this epiphany. For many years, most Democrats in Congress believed Medicare was more or less an innocent bystander to escalating health care costs, something like a railcar hooked onto a runaway freight train. The only way to slow down Medicare would be to slow down the whole train, and especially the engine pulling the other cars down the tracks. But now there is widespread recognition on both sides of the aisle that Medicare *is* the engine (or, at a minimum, the most important engine) pulling the rest of the health system down the tracks at an accelerated and dangerous rate.

Of course, no prominent Democrat from the Obama administration or in Congress ever came out and expressed their views on Medicare's cost-escalating incentives so bluntly. But they didn't need to. It was obvious in the remedies they were pushing. The White House and leading Senate Democrats argued repeatedly throughout the legislative process that the only way to slow cost growth and build a more efficient health sector would be with "delivery system reform" — in other words, reforms which would alter the ways in which physicians and hospitals provide services to patients. And the key to reforming the delivery system, according to these Democrats, would be changing the Medicare program.

They're right. Medicare is *the* problem. Not the only problem, of course. There are other factors which are also driving up costs, including unreformed medical malpractice laws, open-ended federal tax subsidization of job-based insurance, perverse incentives in the federal-state matching program for Medicaid, lack of price transparency, and the growing demand for better medical care that comes with increasing wealth and higher incomes. But the most important reason health care is expensive and needlessly inefficient in the United States is Medicare.

American health care has virtues. The system of job-based insurance for working age people and Medicare for retirees provides ready access to care for most citizens (although there is more problematic access for the poor through Medicaid). We have highly skilled physicians and capital-intensive inpatient institutions that can deliver medical miracles for the sickest among us. U.S. health care is also open to medical innovation in ways that other health systems around the world are not.

But there is no denying that health care in the U.S. is all too often highly inefficient. The system is characterized by extreme fragmentation. Physicians, hospitals, clinics, labs, and pharmacies are all autonomous units that are financially independent. They bill separately from the others when they render services to patients; what's worse, there's very little coordination of care among them, which leads to a disastrous level of duplicative services and low quality care that is dangerous for the patients. The bureaucracy is maddening, the paperwork is burdensome and excessive, and there is very little regard for making the care experience convenient and pleasant for the patient.

At the heart of all this dysfunction is Medicare — and more precisely, Medicare's dominant fee-for-service (FFS) insurance structure.

In June 2009, Atul Gawande wrote an influential article for *The New Yorker* magazine in which he contrasted the high use, high cost care provided in McAllen, Texas, to the less costly and higher quality care provided at institutions such as the Mayo Clinic.<sup>13</sup> But what Gawande never really explored is what allowed a volume-driven delivery structure as epitomized by McAllen to develop in the first place. The answer is Medicare. Without Medicare payments for every physician-prescribed diagnostic test and surgical procedure, the expensive infrastructure that was built in McAllen would never have been viable.

Medicare's FFS insurance is the largest and most influential payer in most markets. As the name implies, FFS pays any licensed health care provider when a Medicare patient uses services — no questions asked. More than 75 percent of Medicare enrollees — some 35 million people — are in the FFS program.<sup>14</sup> Physicians, hospitals, clinics, and other care organizations most often set up their operations to maximize the revenue they can earn from Medicare FFS payments.

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<sup>13</sup> “The Cost Conundrum: What a Texas town can teach us about health care,” Atul Gawande, *The New Yorker*, June 1, 2009 ([http://www.newyorker.com/reporting/2009/06/01/090601fa\\_fact\\_gawande](http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande)).

<sup>14</sup> 2009 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds*, May 2009, Table IV.C1.

For FFS insurance to make any economic sense at all, the patients must pay some of the cost when they get health care. Otherwise, there is no financial check against the understandable inclination to agree to all of the tests, consultations, and procedures that could be possible, but not guaranteed, steps to better health.

But Medicare's FFS does not have effective cost-sharing at the point of service. Yes, the program requires cost-sharing, including 20 percent co-insurance to see a physician. But the vast majority of FFS beneficiaries — nearly 90 percent, according to the Medicare Payment Advisory Commission (MedPAC) — have additional insurance, in the form of Medigap coverage, retiree wrap-around plans, or Medicaid, which fills in virtually all costs not covered by FFS (see Figure 7). Further, Medicare's rules also require providers to accept the Medicare reimbursement rates as payment in full, effectively precluding any additional billing to the patient.



In the vast majority of cases, then, FFS enrollees face no additional cost when they use more services, and health care providers earn more only when service use rises. It is not at all surprising, then, that Medicare has suffered for years from an explosion in volume of services used by FFS participants.

CBO reports that the average beneficiary used 40 percent more physician services in 2005 than they did just eight years earlier.<sup>15</sup> Spending for physician-administered imaging and other tests was up approximately 40 percent in 2007 compared to 2002, according to MedPAC.<sup>16</sup>

FFS also stifles much needed service delivery innovation. The payment rules, established in regulation, reward higher use of last year's services, offered by last year's list of qualified providers. New service delivery organizations, pricing approaches, and ways of taking care of a patient (such as over the Internet and phone) are simply not accommodated by payment rules in some cases written a decade ago. Even marginal changes can take years to implement, often after a multi-year test. Providers are thus understandably reluctant to invest in new approaches, no matter how promising, which will only pay off if Medicare accommodates the change. The result is that today's fragmented and dysfunctional system is virtually frozen in place — for all users of U.S. health care, not just Medicare beneficiaries.

Medicare administrators have understood for many years the problems created by Medicare's FFS payment systems. They have tried to control costs, despite the rising volume, with ever more intense scrutiny of the payment rates per service. Indeed, the on-going maintenance of the arcane and complex payment systems for hospitals, physicians,

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<sup>15</sup> “Factors Underlying the Growth in Medicare's Spending for Physician Services,” Congressional Budget Office, June 2007, table 3.

<sup>16</sup> *Healthcare Spending and the Medicare Program: A Data Book*, Medicare Payment Advisory Commission, June 2009, p. 102.

nursing homes, and other provider categories is an all-consuming enterprise for the Medicare bureaucracy — and the provider groups that watch the bureaucracy’s every move.

Despite curbing some abuses, these payment systems have not worked to control Medicare costs. As often happens, the regulated have learned how to work the regulator. Politicians and program officials do not want to be accused of disrupting how and where seniors get care. So, naturally, health care providers use exactly that threat — closed facilities and reduced service levels — to narrow the range of possible payment changes from year to year. The yearly ritual to keep physician fees at least even with the level from the prior year is just one example of this phenomenon. With an effective “political” floor on their Medicare payments, many health care providers see no reason to move away from their autonomous structures and integrate with others in a more organized system of care.

### The Folly of a Top-Down “Solution”

Although analysts from both sides of the aisle recognize the same problem in Medicare’s current design, they have come to very different conclusions about the remedy.

The Obama White House and its allies observed the problem and concluded that what was needed were better payment systems to encourage integration, instead of fragmentation, and to reward quality instead of volume. From their perspective, the solution to today’s inefficient delivery arrangements is a top-down payment reform program, with the federal government using the leverage of Medicare payment policy to essentially build new organizational arrangements through which patients would get their care. The explicit goal is to have Mayo-like delivery systems in every community in the country.

To get there, the administration pushed a number of changes in Medicare, two of which are particularly noteworthy.

The first is a new pilot program to test what are called Accountable Care Organizations, or ACOs. ACOs are the brainchild of Mark McClellan, the former administrator of the Centers for Medicare and Medicaid Services, and Elliott Fisher, a health policy researcher at Dartmouth College, and a number of collaborators — all of whom have been studying the problems in the nation’s delivery system from a number of governmental and academic vantage points for years.<sup>17</sup>

The ACO concept is to allow doctors and hospitals to voluntarily join up with others in new legal entities that are accountable for providing care across institutional and outpatient settings. The idea is to get physicians and hospitals in new organizational

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<sup>17</sup> See “Fostering Accountable Health Care: Moving Forward in Medicare,” Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, and Jonathan S. Skinner, *Health Affairs* (web exclusive), January 27, 2009.

arrangements in which they share revenue and keep the savings if they provide quality care at less cost than what FFS Medicare would normally pay. The physicians and hospitals participating in an ACO would keep most of the resulting savings.

In effect, then, ACOs are the latest in a long series of efforts to get physicians and hospitals to form provider-run — as opposed to insurance-driven — managed care entities.

But the key to understanding the ACO concept is that beneficiaries play no role whatsoever in selecting where they get care. They are supposed to get assigned to an ACO based strictly on whom their primary care physician is, and which ACO that physician is affiliated with.

This is an implausible assumption, to say the least. The only way ACOs can work to reduce costs is to become a more integrated and closed network of providers who follow data-driven protocols for care. That means they can't let their beneficiaries go to see just any specialist. The ACO needs patients to see only the ACO's preferred list of specialists. But that will be nearly impossible to enforce if beneficiaries never agreed to become part of the managed care environment of an ACO in the first place.

The other prominent Medicare reform pushed by the White House in the health law is the Independent Payment Advisory Board, or IPAB.

The IPAB is a 15-member independent panel appointed by the president and confirmed by the Senate and charged with enforcing an upper limit on annual Medicare spending growth. The IPAB has been given the authority to make recommendations for further cuts in Medicare's costs. Those recommendations will automatically go into effect unless Congress overrides them.

But the IPAB is strictly limited in what it can recommend and implement. It can't change cost-sharing for covered Medicare services. Indeed, it can't change the nature of the Medicare entitlement at all, or the rules governing Medigap insurance, or any aspect of the beneficiary's relationship to the program. The only thing it can do is cut Medicare payment rates for those providing services to the beneficiaries.

This limitation on the IPAB's mandate reflects the cost-control vision of those who wrote the bill.

The flaw in both the ACO and IPAB concepts is that they assume the federal government will be now able to enforce a vision for cost control that has eluded Medicare's administrators for more than forty years. The private sector delivery models the White House so admires — like Geisinger, and the Cleveland Clinic, and Intermountain Health Care — operate on a principle of provider exclusivity. They don't take just any licensed provider into their fold. They operate highly selective, if not totally closed, networks. That's the way they get control over the delivery system. Low-quality

performers are dropped or avoided altogether, and tight processes are established to streamline care and eliminate unnecessary steps.

The federal government has never shown any capacity to enforce what might be called a Medicare “preferred provider network.” Indeed, the whole point of the fee-for-service model that Congress has so jealously protected over the years is that beneficiaries get to see any licensed provider of their choosing, to whom Medicare pays a fixed reimbursement rate. When attempts have been made in the past to steer patients toward preferred physicians or hospitals, they have failed miserably because politicians and regulators find it impossible to make distinctions among hospitals and physician groups based on quality measures that can themselves be disputed.

Instead, the way Congress and Medicare’s regulators have cut costs is with across-the-board payment rate reductions that apply to every licensed provider, and without regard to any measures of quality or efficient performance. Tellingly, that’s exactly how the recent health law achieves most of its Medicare budget cuts. The big savings came from arbitrary cuts in payment updates for institutional providers of care. When push comes to shove, the IPAB will almost certainly fall into the same trap. To cut spending fast and with certainty, the preferred solution will always be deeper payment rate reductions.

### **The Ryan Roadmap: The Right Way to Transform Health Care Delivery**

Many people suppose that the heart of the disagreement over health care policy was whether or not to expand coverage to more people. But the real debate was over how to allocate resources in the health care sector. Both sides agree that the status quo is unsustainable because federal health entitlement spending will cripple the nation’s economy unless changed, and both sides agree that the country cannot afford to simply subsidize millions of people in a system with runaway cost growth.

So the crucial question was always what to do about cost escalation. Or, more precisely, what changes in Medicare have the best chance of bringing about continual improvement in the productivity and quality of patient care? Resources in health care are scarce, just like they are in every sector of the economy. How can they be allocated so that the interactions between doctors and hospitals and the patients they serve become ever more productive over time? That’s the only way to slow the pace of rising costs without hurting the quality of the care provided to patients or resorting to non-price rationing of services (queues).

The Obama administration believes that a top-down, governmental process is the answer, and that the government can use Medicare’s market dominance to leverage a more efficient health sector nationwide.

But there is nearly half a century of experience with the Medicare program indicating that confidence in “government-engineered” efficiency improvement is entirely misplaced. Efforts to control costs from the top-down have always devolved into

price setting and across-the-board payment-rate reductions, which is detrimental to the quality of American medicine. Price controls drive out willing suppliers of services, after which the only way to balance supply and demand is with waiting lists.

The alternative is a bottom-up approach, in which cost-conscious consumers choose between competing insurers and delivery systems based on price and quality. That's the basis for Congressman Paul Ryan's reforms to the Medicare program.<sup>18</sup>

Rep. Ryan's "Roadmap" is much, much more than a Medicare reform plan. It is nothing less than a comprehensive plan to put the nation's finances on a sustainable trajectory, with policies that will promote economic growth and prosperity. It is a top-to-bottom rewrite of the nation's entitlement program and tax laws. It would completely overhaul today's anti-growth personal and corporate income tax system, reform Social Security to encourage work and savings, and establish a universal health insurance coverage program through refundable tax credits.

CBO has carefully examined the Roadmap and found that it would bring federal spending commitments (excluding net interest) down from about 27 percent of GDP under a pre-health law baseline in 2040 to about 19 percent of GDP, which is much more in line with the nation's historical average.<sup>19</sup> It is the only credible plan now pending before Congress that would actually solve the long-run budget problem.

But there's no doubt that the key reform upon which the rest of the plan hinges is Medicare. The Roadmap's Medicare reform would convert the program into a defined contribution program for new entrants after 2020. Instead of a defined benefit entitlement, new Medicare beneficiaries starting in 2021 would get to decide how to use a fixed-dollar contribution provided to them by the Medicare program. In general, the beneficiaries would get to decide which insurance plan they want to enroll in. If the premium were more than the amount they are entitled to from Medicare, then they would pay the difference. If it were less, they would keep all of the savings. The Roadmap includes several other changes to Medicare as well (such as an increase in the retirement age and more income-testing of its benefits), but the core reform is the conversion of the entitlement from a defined-benefit to a defined-contribution model.

The Roadmap's critics certainly view this change in Medicare as the most important entitlement shift proposed in the Roadmap. They argue that it would do nothing to control health care costs, but would only shift the burden and risk of rapidly rising costs onto individuals because the government's financial support for Medicare would no longer keep pace with premium growth.

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<sup>18</sup> "A Roadmap for America's Future: Version 2.0," Representative Paul D. Ryan, Ranking Member, U.S. House Committee on the Budget, January 2010 (<http://www.roadmap.republicans.budget.house.gov/UploadedFiles/Roadmap2Final2.pdf>).

<sup>19</sup> Letter to the Honorable Paul Ryan, Ranking Member, Committee on the Budget, U.S. House of Representatives from Douglas W. Elmendorf, Director, Congressional Budget Office on the Roadmap for America's Future Act of 2010, January 27, 2010, Table 1 (<http://www.cbo.gov/ftpdocs/108xx/doc10851/01-27-Ryan-Roadmap-Letter.pdf>).

But that's the wrong way to look at what the Roadmap's Medicare reform is about and aims to achieve. The goal is not to shift rising premium costs from the government and onto the beneficiaries. The goal is to move away from the cost-increasing incentives of Medicare FFS as the default option for all new Medicare enrollees and set in motion an entirely different market dynamic to achieve greater efficiency and cost-effectiveness. In time, with the Roadmap's reform, millions of otherwise passive Medicare participants would become active, cost-conscious consumers of insurance and alternative models for securing needed medical services. With cost-conscious consumers looking for the best value for their money, cost-cutting innovation would be rewarded, not punished as it is today. Physicians and hospitals would have strong financial incentives to reorganize themselves to become more productive and efficient and thus capable of capturing a larger share of what would become a highly competitive marketplace. That's the way to slow the growth of health care costs. Indeed, it's the only way to do so without harming the quality of care.

How much would a truly reformed Medicare program slow the pace of rising costs? No one knows for sure, including CBO, because it is very difficult to predict the dynamics of this new marketplace. And certainly the other elements of a broader reform of health care — especially the move toward refundable tax credits for health insurance for the working age population — would need to reinforce the benefits of a Medicare reform to realize its full potential. But uncertain cost projection is no reason not to enact this kind of reform. Cost estimates are unlikely to ever provide definitive guidance one way or another. Fundamentally, policymakers must decide what policy approach is most likely to lead a virtuous cycle of productivity improvement and higher quality throughout the health sector. Can the government impose such improvements through a top-down payment reform through Medicare? Or is it more likely that a well-functioning marketplace would set in motion the forces needed to transform American medical care into a model of efficient, patient-centered care? The Roadmap comes to the sound conclusion that there's no reason American health care would not benefit from the same transformational power of the marketplace that has done so much to improve products and services in other sectors of the American and global economy.

The government can and should play an important oversight role in such a reformed system. But the difficult organizational changes and innovations necessary to provide better care at lower cost must come from the bottom up, not the top down. In other words, changes should come from those actually delivering the services, not the Congress, or the Department of Health and Human Services, or even an independent rate setting board.

The new Medicare prescription drug benefit was constructed just this way when it was enacted in 2003. Beneficiaries get a fixed dollar entitlement that they can use to buy coverage from a number of different competing plans. The insurers understand that they have to keep costs down to attract price-sensitive enrollees. And the government has no role in setting premiums or drug prices. And how is it working? Costs have come in 40 percent below original expectations.

## Conclusion

The United States is fast approaching a crisis. The federal government has made spending commitments that far exceed the capacity of the country to finance them. There is a growing consensus that the status quo cannot hold much longer. Something is going to give, perhaps in a very severe debt crisis.

The question is, what kind of proactive reforms could head off a calamity that everyone can now see coming?

President Obama passed his health care program through Congress in large part based on the argument that it did, in fact, represent a clear break from past practice. Yes, the bill expanded entitlement spending to millions of new beneficiaries. But the architects of it all contend that it will also slow the pace of rising health costs, and thus markedly improve the nation's budget outlook, by fundamentally transforming the way medical care is practiced around the country.

But is that true? The federal government's health care administrators have been trying to implement exactly the kinds of reforms touted as groundbreaking initiatives in the health law for decades, with little success. The new law provides the possibility of swifter implementation, but the political and information obstacles that have always stymied progress in the past remain. Indeed, the reforms to Medicare in the recently enacted health bill are better much described as more of the same rather than a clear break with past practice.

A more promising approach for addressing the significant challenges we face is a completely new relationship between the government and the beneficiaries of its programs. That's the premise of the Ryan Roadmap. In particular, in Medicare, the key to changing the cost dynamic is to give more power and control to the beneficiaries themselves. Their choices can lead the health sector to make the revolutionary and cost-cutting changes the government has never been able to successfully impose by regulatory fiat.

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