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Sowing Containment of Medicare Expenditures

A consensus exists among health policy analysts that there is no single remedy to rein in the rapid pace at which the nation's health care costs are rising. What we often label as our "health care system" is really a massive labyrinth of economic activity with a few big players but mostly a vast array of suppliers (doctors and hospitals), financial entities (governments, health care companies, and private insurers), and consumers (a population of nearly 300 million).

With the federal government's Medicare program being the nation's largest financier of health care—paying for an estimated 20 percent of the medical services the public consumes—any comprehensive effort to slow the growing costs of health care would be incomplete without an examination of how Medicare can contribute. In fact, Medicare may be the logical place to start.

Since its creation over four decades ago, Medicare, and Medicaid, its companion program for the poor, have greatly increased demand for medical care by making it more broadly available. Today, there are some 45 million Medicare enrollees and 60 million Medicaid recipients. Clearly this has been beneficial to society as a whole, contributing to longer and healthier lives for the aged, disabled, and lower-income segments of the population. But increasing coverage increases demand and rising demand affects prices. Moreover, the emergence of the two programs increased the amount of health care paid for by third parties. Third-party payments, whether through government entitlement programs such as Medicare and Medicaid or private insurance plans, tend obscure costs and make patients and providers less cost conscious than they might otherwise be if those seeking treatment had to pay for services directly "out-of-pocket."

For decades, spending on Medicare has been growing faster than the economy. While that growth has been largely attributed to factors affecting health care costs in general, the aging of society and imminent impact of retiring baby boomers on government spending, notably under Medicare, Medicaid, and Social Security, will eventually create large and lasting fiscal strains on the U.S. Treasury.

Routinely under long-range spending projections, rising health care expenditures are the largest contributor to the future growth of the federal budget. Under its most recent forecast, the Congressional Budget Office (CBO) projected that federal expenditures on Medicare and Medicaid, measured as a share of the gross domestic product (GDP), will rise from 4 percent in 2007 to 12 percent in 2050 and 19 percent in 2082—which is

roughly equal to the total share of the economy that the federal government has traditionally spent on everything it does.[1]

If left unabated, those rising costs will likely result in a squeeze on all other functions of government (e.g. maintaining a national defense, building roads and bridges, etc.), a rising federal tax burden, an unsustainable federal debt, or more likely a combination of the three. Avoiding those outcomes will inevitably require containing the growth of Medicare and Medicaid. It can happen now or be deferred, but given the way the government's health care burden has been rising, there is little to suggest that the problem will resolve itself without serious legislative action.

Since its policymaking is concentrated within the federal government, Medicare provides an opportunity for Congress and the President to change its payment practices and apply them in a way that might be replicated by private insurers. In effect, Medicare can be an incubator for strategies to constrain the rise in overall national health care spending.

What is not clear is whether a strategy to reform Medicare's payment practices or even a broader approach to revamp the payment practices of all who finance health care will suffice in taming the beast. With much of Medicare's growth in the next two decades coming from the aging of society, the program will drive the demand side of the health care equation whatever its system of payment. As such, key features of the program may need to be re-examined independently of efforts to slow growing health care costs through payment practices. Its generosity as an entitlement program may need to be revisited. In a recent report, CBO expressed the problem more bluntly—

> *…efforts to reduce overall government spending will require potentially painful actions to slow the rise of health care costs. There may be ways, however, in which policymakers can reduce costs without harming the health of Medicare and Medicaid beneficiaries. Changing those programs in ways that reduce the growth of costs—which will be difficult, in part because of the complexity of health policy choices—is ultimately the nation's central long-term challenge in setting federal fiscal policy.*[2]

The Inefficiencies of "Fee-for-Service" Payments

Perhaps the most complex and disconcerting aspect of the nation's health care system is the fee-for-service mechanism and how it has matured as the dominant financing model for medical care delivery. Simply stated, fee-for-service means paying the doctor or medical facility for the actual service they provide. It is preferred by the nation's insured population because of the apparent freedom it affords to seek out a doctor, hospital, or other medical facility of personal choice. It differs from an HMO or related managed-care arrangement, where an insured pays a health care insurer a fixed premium and, with a small co-payment per visit, is covered for a wide array of medical services coordinated

[1] See CBO, "The Long Term Outlook for Health Care Spending," November, 2007, and "The Long Term Budget Outlook," December, 2007.
[2] CBO, "The Long Term Budget Outlook," December, 2007..

by an insurer's health manager who attempts to identify and coordinate the appropriate treatment from a range of physicians and hospitals under the insurer's immediate control.

There has been a growing consensus among health policy analysts that fee-for-service has transformed health care entities from being a means for medical delivery to what have been judgmentally labeled "revenue centers." What the term implies is that whether it is hospital or physician based, the goal of the provider is to deliver service at a price that exceeds cost—i.e., at a profit. While each facility or practitioner attempts to treat the insured's medical condition, they do so from the perspective of their specific specialty or emphasis. If it works, great. If not, the insured moves on to the next facility or practitioner with a different specialty or emphasis. All will use the full range of tools in their arsenals, many of them being tools that are readily available from another provider down the hall or down the street. In a sense, it's a competition of sorts among providers that requires "keeping up" not only with the science, but with the technology, whether it be lab work, the use of sophisticated diagnostic instruments, or the treatment itself. It sometimes promotes excessive testing, excessive examinations, the use (or under-use) of costly medical instruments and technology, and ineffective or unnecessary treatments. Combined with third-party payments (e.g., Medicare or private insurance) that shield both the provider and the patient from the real expense, it promotes behavior that is insensitive to cost.

CBO describes the condition this way—

> *The current financial incentives facing both providers and patients tend to encourage or at least facilitate the adoption of expensive treatments and procedures, even if the evidence about their effectiveness relative to other therapies is limited. For doctors and hospitals, those incentives stem from fee-for-service reimbursement. Such payments can encourage health care providers to deliver a given service in an efficient manner but also provide an incentive to supply additional services—as long as the payments exceed the costs. For their part, insured individuals generally face only a portion of the costs of their care and thus have only limited financial incentives to seek lower-cost treatments. Private health insurers have incentives to limit the use of ineffective care but are also constrained by a lack of information about what treatments work best for which patients.*[3]

In a 2007 congressional hearing, then CBO director Peter Orszag elaborated—

> *Another important factor that both reflects and has contributed to rising health costs is the declining proportion of those costs that are paid out of pocket. Out-of-pocket payments accounted for 33 percent of all personal health care expenditures in 1975, but by 2005, that share had fallen to 15 percent. It is projected to decline a little more in the future, reaching 13 percent in 2015. Consumers facing lower out-of-pocket costs tend to demand more health care services than consumers facing higher out-of-*

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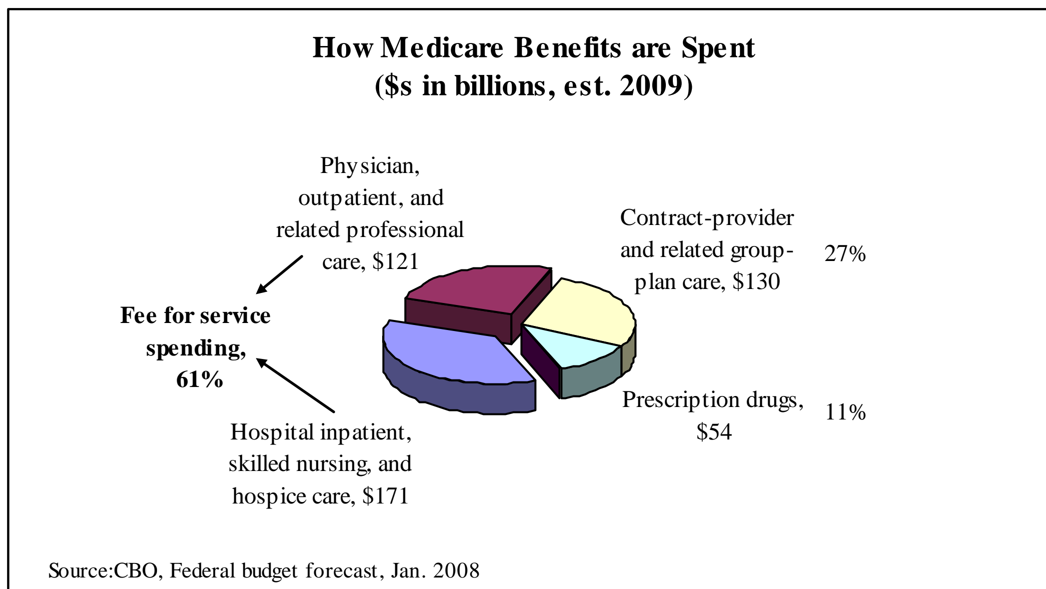
[3] Ibid.

pocket costs. At the same time, rising health care costs (as a share of income) have probably led individuals to seek more extensive insurance in order to keep the variability of their out-of-pocket expenses from increasing.[4]



Most Medicare enrollees—about 75 percent of them—receive hospital and doctor services through a fee-for-service arrangement. While those enrollees pay for a portion of their care through deductibles and coinsurance, there is no annual cap on what they must pay unlike many private insurance plans. That said, however, nearly 90 percent of them have supplemental insurance that covers many or all of those cost-sharing expenses, either through plans furnished by their former employers, individual policies they purchase from private insurers (referred to as Medigap policies), or state-administered Medicaid programs. Thus, for a large majority of Medicare enrollees, there typically is relatively low out-of-pocket spending expected of them for the health care services they receive.[5]

The Medicare System of Hospital Payments Seems to Have Saved Money

As a means of exchange between buyers and sellers, there is nothing unique about fee-for-service. It's basic—if you receive something, you pay for it. In medicine, one seeks

[4] See statement of Peter R. Orszag, CBO Director, before the Committee on the Budget, United States Senate, "Health Care and the Budget: Issues and Challenges for Reform," June 21, 2007.

[5] Part A of Medicare, or Hospital Insurance, covers inpatient services provided by hospitals and skilled nursing facilities as well as hospice care. Part B, or Supplementary Medical Insurance, covers services provided by physicians and other practitioners, hospitals' outpatient departments, laboratories, suppliers of medical equipment, and certain drugs administered directly by physicians. Home health care may be covered by either Part A or Part B. Part C provides benefits through health care contractors who administer a range services to Medicare enrollees who sign up to receive their benefits through providers under the contractor's plan. The newly created Part D pays for a portion of prescription drugs.

services to resolve a medical problem. The practice of medicine, however, is not the same as buying a commodity—a car, a house, food, etc. While medical science has come a long way, paying for a successful outcome is often more a goal than a given. A diagnosis can be simple or complex; so can testing, evaluation, and treatment. A medical service can remedy an ailment, hold it in check, or fail to do anything. Hence, a visit to the doctor may or may not remedy a problem, but whatever the outcome, a service has been rendered and a payment is due. More importantly, the approach taken to deal with a medical problem could vary from one provider to the next, and thus the costs may differ.

While problems with fee-for-service are numerous, various studies have found that Medicare's current approach to controlling hospital payments—in place now for 25 years—has produced notable savings over the original fee-for-service structure it operated under when enacted in 1965.

In 1983, the program moved away from paying for inpatient treatment based on the actual cost of the service provided to a fixed pre-determined rate based on the type of admission involved. With the change, admissions and payments had to fall within a specified diagnostic-related grouping (a so-called DRG), of which 467 were initially established. There are now more than 700. Under this system, if a hospital treated the enrollee at a lower cost than the set rate, it could keep the difference. Thus, the new system gave hospitals a significant incentive to treat Medicare patients at a lower cost. Considerable Medicare savings subsequently emerged, most of which appear to be the result of shorter lengths of stay.

In the years following its adoption, annual updates have been made to the DRG payment rates based on recommendations from a commission charged with determining how much the rates should rise.[6] The commission first calculates what the costs of an "efficient hospital" would be taking into account the prices hospitals pay for labor, equipment, and supplies—creating what has been termed a "hospital market basket index"—and then makes a variety of adjustments for such things as productivity and the need to increase efficiency.

For the most part, studies have shown that the system has resulted in substantial savings in Medicare's hospital payments. Studies, however, also suggest that the system may have shifted costs to post-hospitalization skilled-nursing and home-health care, albeit probably at lower costs than longer hospital stays. Similarly, some studies suggest hospitals may have shifted part of the costs to non-Medicare patients by raising charges to private insurers. As a result, there is still some debate about the impact of the DRG system on health care costs in general.[7]

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[6] The Medicare Payment Advisory Commission (MedPAC).

[7] "Cost Containment in Medicare; A Review of What Works and What Doesn't," prepared by The Urban Institute and Health Policy Alternatives, Inc., for AARP (written by Robert Berenson, Michael Hash, Thomas Ault, Beth Fuchs, Stephanie Maxwell, Lisa Potetz and Stephen Zuckerman, and Sarah Thomas, project manager for AARP's Public Policy Institute). December 2008.

The impact of prospective rate setting on skilled nursing facilities—adopted in 1998—is less clear. The introduction of the system sharply reduced Medicare payments for some services and caused significant disruptions among providers for a number of years—including some closures. Although the provider community has since adjusted and studies show they have been able to reduce their Medicare costs, spending for skilled nursing care since 2000 has continued to rise rapidly. Much of the rise, however, has been due to industry lobbying for higher annual updates than the Medicare commission recommended, which Congress has granted. Nonetheless, an 11 percent average annual rate of growth in this later period is substantially lower than the 25 percent annual rate that prevailed before the new system took affect, suggesting that the rise in Medicare costs for skilled nursing has been slowed.[8]

A 30 percent annual growth rate in Medicare spending for home health care between 1988 and 1996 led to prospective rate setting for these services too. Since its adoption in 2000, home health care providers adapted relatively quickly and together with other changes in eligibility have increased the efficiency of their operations. Spending has since been reduced to a 7 percent annual growth rate.[9]

In the aggregate, Medicare spending on inpatient hospital, skill nursing, and home health care does appear to have been affected by legislatively-directed efforts to limit its costs through deliberative and systematic rate setting. Although much of the evidence about how the changes have affected the medical care received by the Medicare population is subjective, there is considerable literature suggesting there have been little adverse effects on access to services or overall quality.

Constraining Spending for Physician Services Has Been More Problematic

Medicare's experience with controlling physician spending has been notably less successful. With the exception of a 10-year period beginning in the early 1990s, spending for physician services has exceeded the overall growth of the program through much of its four-decade existence.[10]

When Medicare began, its payments to physicians were derived from the fees they charged, a circumstance that resulted in its aggregate physician expenditures growing at an average rate of 13 percent annually from 1967 through 1974. Attempting to constrain that growth, over the following two decades, lawmakers repeatedly mandated fee limits. However, the bulk of those actions met with limited success. The problem was that fee limits alone did little to control the volume of services physicians provided (i.e., the types and quantity), and various actions to control volume proved to be uneven or inequitable. For the entire period from 1975 to 1991, Medicare physician spending grew at an average

[8] Ibid.
[9] Ibid.
[10] For a detailed description of the evolution of Medicare's payments to physicians, see statement of Douglas Holtz-Eakin, Director, CBO, "Medicare's Physician Fee Schedule," before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representative. May 5, 2004.

annual rate of 15 percent, and the program's payments per physician increased almost twice as fast as the overall economy.[11]

Reacting again to unchecked growth, Congress authorized a new fee schedule in 1992 that based physician payments on measures of the resources used to provide each service, and put other measures in place to control volume. But these new measures caused year-to-year problems, and even a revised system enacted in 1997 (the Sustainable Growth Rate, or SGR) proved difficult to sustain. The threat of physicians turning Medicare patients away moved lawmakers to suspend the constraints repeatedly. Analysis done by CBO shows that over the 1997 to 2005 period per enrollee spending on physician services rose by 65 percent, in contrast to a 35 percent rise for the rest of Medicare's fee-for-service expenditures.[12]

The summation of Congress's actions has basically been to increase physician payment rates with little or no control for the volume of services or other physician practices that have historically contributed to Medicare's expenditures outstripping the growth of the economy.

On the Hunt for Cost Containment

While efforts to control Medicare costs have been mixed, the need for cost containment grows more pressing each year as the baby boomers hover on the edge of their senior years. Their numbers will soon swell the Medicare rolls as the percentage of the population age 65 and older grows from 13 percent today to nearly 20 percent over the next two decades. People consume more health care as they age, and the coupling of the rapid rise in Medicare enrollees with limited or absent cost containment will inevitably threaten the viability of the program.

To date, there has been little political attention to that threat, but there is a growing recognition by economists and health policy analysts that something needs to be done. A variety of proposals and strategies for reform have emerged. With a number of them, the belief is that the cost pressures on Medicare and perhaps the health care system in general can be eased without creating undue harm to the availability and quality of medical care. Others, however, notably those expected to result in the largest savings, would result in higher out-of-pocket spending by Medicare recipients and/or considerable constraints on provider payments. Here are some of those options:

Waste, Fraud and Abuse

The most commonly repeated phrase in Washington is that we have to cut "waste, fraud and abuse." Although the amount of savings available from such steps pales in comparison to the total savings needed, attacking fraud and waste is important in order to keep politicians and the public supportive of the public program and attempts to obtain

[11] Ibid.
[12] CBO, "The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates," September 6, 2006.

greater, yet more painful savings in other areas. Medicare has had success in recent years by bearing down on provider fraud and payment abuses. Significant savings have been realized through recoveries, judgments, and settlements using audits and prosecution of fraud and abuse cases brought under the federal *False Claims Act*. In addition, actions taken under the *Medicare Integrity Program* have reduced error rates on claims and increased recoveries from private insurers who should have paid for services instead of Medicare. A published study shows that increasing administrative funds for those types of efforts could lower expenditures without adversely affecting the health care of enrollees. And further savings could come about from conducting a more rigorous review of provider qualifications and greater oversight of Medicare contracts with its private service providers.[13]

Medicare Advantage Reform

Another measure receiving considerable attention involves private companies that Medicare has contracted with to supply services to enrollees. As an alternative to fee-for-service medicine, over the years, Medicare has made a variety of attempts to use contracts with health care institutions to provide and manage a broad range of services to enrollees who elect to use those institutions. Those contract arrangements—now operating under what is called the Medicare Advantage program (also known as Part C of Medicare)—will account for nearly 25 percent of Medicare's spending and enrollees in 2009.[14] They include HMOs, PPOs, and other private group providers.

When this approach was added to the Medicare program as an option for enrollees, the expectation was that it would better coordinate services and treatment of enrollees, and allow them and the program to benefit from efficiencies that are harder to achieve through the traditional fee-for-service portion of the program. Here too, however, Medicare has had little success with cost containment.

Financing under these group arrangements centers around a series of per-person spending benchmarks that are calculated on a county-by-county basis. Health care contractors then submit bids showing how much they want Medicare to pay per enrollee, and the government compares those bids to the benchmarks. If the bids are lower, much of the difference is returned to the enrollees in the form of greater services or lower out-of-pocket spending. In many counties, the benchmarks have turned out to be consistently higher than the per-person costs for those in the fee-for-service portion of the program. In 2007, CBO calculated that the benchmarks would be 17 percent higher and per enrollee spending would be about 12 percent higher. Thus, while the Medicare Advantage plans often offer enrollees greater benefits and services than the traditional fee-for-service program, their higher overall cost has become conspicuous, and a number of proposals have emerged to reduce or eliminate the differential.

[13] Ibid.
[14] Source: CBO, "Update of the 2008-2018 Budget Baseline," March, 2008.

Pursuing Greater Mass Purchasing

A third area of interest is having the federal government make greater use of its size as a health-care purchaser. Where many private insurers have limited ability to press health care providers and manufacturers to lower their prices, public purchasers like the Medicare program, by virtue of their size, can use the power of the vast numbers of people they cover to take advantage of economies of scale and market presence.

As previously described, Medicare has done this to some extent with hospital care. However, there is considerable interest in having the program engage in mass purchasing to coax drug companies and other providers of health care—i.e., durable medical equipment suppliers—to lower their prices. State Medicaid agencies and the Veteran's Administration, for instance, have used their size in setting up purchasing arrangements that yield prices for drugs below those paid by private-sector purchasers. Similarly, two competitive bidding demonstration projects that Medicare has conducted for durable medical equipment resulted in estimated savings of 20 percent over its traditional methods of payment, and ten additional urban areas have been selected for further testing.[15]

Health IT

A fourth area of possible savings—one that is gaining increasing support, although with some apprehension—involves promotion of greater use and networking of electronic health records. The Congress recently committed upwards of $30 billion in the recent economic stimulus legislation to promote the adoption of electronic medical files.[16] The use of technology by medical providers and insurers has come a long way in dealing with the vast paperwork maze of personal patient files and the idiosyncratic requirements of claims for reimbursement from governmental payers and private insurers. But "paper" still abounds and many more technological improvements—some requiring greater legal flexibility to establish and use uniform formats and for transmission of medical histories and the like—hold the promise of both considerable administrative savings and improved medical care from more cohesive tracking of background information underlying a person's health.

However, while the means and opportunities are apparent, the conversion of medical records to electronic formats, including a national health card incorporating a uniform format, raises many concerns about maintaining the privacy of that information. Moreover, as the CBO has concluded, "By itself, the adoption of more health IT offers many benefits, but it is generally not sufficient to produce substantial cost savings because the incentives for many providers to use that technology to control costs are not strong."[17]

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[15] Cost Containment in Medicare; A Review of What Works and What Doesn't," loc. cit.
[16] Public Law No. 111-5, the American Reinvestment and Recovery Act of 2009.
[17] CBO, Key Issues in Analyzing Major Health Insurance Proposals, December, 2008, p.147.

Care Coordination

A fifth area for potential savings involves the lack of systems to coordinate care for enrollees who suffer from a number of chronic conditions. Frequently under fee-for-service arrangements, both public and private insurers tend to view each condition and treatment of an individual independently and as such fail to approach his or her care in a comprehensive or holistic fashion. It is particularly relevant for public programs serving the elderly, who often have multiple conditions affecting their health. In 2001, for example, CBO points out that 25 percent of Medicare enrollees accounted for 85 percent of the program's costs, and more than three-quarters of them had one or more of seven prominent chronic conditions (including coronary artery disease, diabetes, and congestive heart failure).[18]

Medicare has conducted demonstration projects involving what is referred to as disease management or care coordination. However, the evidence from those projects suggests that while such practices may improve patient care and result in better outcomes, their potential to constrain costs is less certain. Most of the demonstrations did not reduce program costs significantly. Care coordination approaches that better use primary care physicians and establish a patient-centered "medical home" are thought to be more promising and will be tested over the next few years.[19]

For the most part, the aforementioned cost-containment strategies are relatively piecemeal, and while not necessarily minor in scope or controversy, they are less likely to be broadly contentious with the public and provider community. However, they also are less likely to place a major brake on the upward spiral of program costs.

Tying Payments to Effectiveness Research

More fundamental changes promise more savings but also more controversy and uncertainty. One larger-scale approach garnering interest is the idea of altering payment practices to take account of the relative cost effectiveness of one treatment over another. CBO describes the opportunity that exists—

> *Some studies have found that the spread of new medical technology has yielded benefits that clearly justify the added costs on average, but other evidence also strongly suggests that additional treatments and services are being provided broadly to patients who could do just as well with less-expensive care. Significant evidence exists that more-expensive care need not mean higher-quality care—suggesting an opportunity to reduce costs without impairing health outcomes. Perhaps the most compelling evidence of that opportunity comes from the substantial geographic differences in spending on health care within the United States—and the fact that they do not translate into higher life expectancy or measured advantages in other health statistics in the higher-spending regions. For*

[18] CBO, "The Long Term Outlook for Health Care Spending," loc. cit.
[19] Cost Containment in Medicare; A Review of What Works and What Doesn't," loc. cit.

example, Medicare's costs per enrollee vary significantly from regions to region: from as low as $4,000 to more than $11,000 in 2003. Research has shown that much of that variation in spending cannot be explained by differences in the population or medical prices and that the higher-spending regions do not generate better health outcomes than the lower-spending regions.[20]

Incentivizing treatments by paying more or less for one over another would be a major change in reimbursement policy. Today, Medicare does not take costs into account in determining what services are covered, nor does it structure its payments based on their relative effectiveness. Extensive research and assimilation of information about the relative effectiveness of different treatments would need to be done—which itself promises controversy within the medical profession. And Medicare would need greater legal authority to make the change possible. CBO explains—

… if statutory changes permitted doing so, the program could use information about comparative effectiveness to promote higher value care. For example, Medicare could tie its payment to providers to the cost of the most effective or most efficient treatment. If that payment was less than the cost of providing a more expensive service, then doctors and hospitals would probably elect not to provide it—so the change in Medicare's payment policy would have the same practical effect as a coverage decision. Alternatively, enrollees could be required to pay for the additional costs of less effective procedures (although the impact on incentives for patients and their use of care would depend on whether and to what extent they had supplemental insurance coverage that paid some or all of Medicare's cost-sharing requirements)…

To affect medical treatment and reduce health care spending, the results of comparative effectiveness analyses would ultimately have to change the behavior of doctors and patients—that is, to get them to use fewer services or less intensive and less expensive services than are currently projected, which, for Medicare, would require changes to current law. More modest steps that Medicare could be authorized to take would include smaller-scale financial inducements to doctors and patients to encourage the use of cost-effective care. Doctors and hospitals could receive modest bonuses for practicing effective care or modest cuts in their payments for using less effective treatments. Likewise, enrollees could be required to pay a portion of the additional costs of less efficient procedures (rather than the full difference in costs). Or Medicare could provide information

[20] See statement of Peter R. Orszag, CBO Director, before the Committee on the Budget, United States Senate, "Health Care and the Budget: Issues and Challenges for Reform, " June 21, 2007.

> *to doctors and their patients about doctors' use of various treatments, which would create some pressure for them to use more-efficient approaches…*[21]

Bundling Payments

The debate arising from basing payments on cost effectiveness would likely be intense, but one limited approach already being explored is the bundling of payments to cover the multiple services associated with a treatment, illness, or individual patient. Bundling charges shows potential to reduce or eliminate incentives to provide additional services that might be of little worth. In the 1990's, several hospitals were selected to bundle charges arising from heart-bypass surgery. Evaluations in seven sites show it resulted in an average savings of 10 percent.[22]

Cost Sharing Measures Affecting the Consumer

As unsettling as incentive-based payments to providers might be, even greater controversy is likely to arise from measures affecting the consumer side—i.e., imposing higher our-of-pocket spending on enrollees and patients. Clearly, putting greater financial responsibility on the consumer will test the political will of elected officials. It is the ultimate test of an entitlement structure that for nearly 75 years has undergone mostly expansion. Increasing out-of-pocket expenditures is viewed as retrenchment. From a political perspective, retrenchment is symbolic, portending erosion of a form of government long held as sacrosanct. Just five years ago Congress and President Bush greatly expanded Medicare by adopting coverage of prescription drugs, adding trillions of dollars to already unsustainable long-range program costs. And even then many saw the expansion as inadequate.

That said, unbridled growth of our nation's health care expenditures threatens the viability of our entire economic system and at some point may leave policymakers with few other options. What is anathema today may be inevitable tomorrow. Numerous studies show that use of medical services declines as prices paid by patients increase. For instance, studies have shown that limiting Medicare to a single deductible, 20 percent coinsurance, and an annual out-of-pocket spending cap would generate substantial savings.[23] Moreover, the perception of the adverse effects of consumer restraints may be larger than reality. A landmark health insurance experiment by the RAND Corporation showed that higher cost sharing reduced spending—particularly when compared with a plan offering free care—with little or no adverse effects on health. It was a large-scale, randomized study conducted between 1971 and 1982 in which 2,750 families encompassing more than 7,700 individuals participated—all were under the age of 65. They were chosen from six sites across the United States to provide regional balance. The study found that cost sharing reduced the use of both highly effective and less

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[21] Ibid.
[22] Cost Containment in Medicare; A Review of What Works and What Doesn't," loc. cit.
[23] Ibid.

effective services equally, and it did not materially affect the quality of care received and generally had no adverse effects on participant health.[24]

Cost sharing can take a number of forms, but most often it involves co-payments, co-insurance, higher deductibles, or excluding various forms of service. Obviously, the last—excluding services from coverage—would be the most controversial. Additionally, the size of a deductible (i.e., requiring a certain amount of annual out-of-pocket spending by the enrollee before benefits can be paid), the share of a service charge to be paid by the patient, or a co-payment amount determine the magnitude of the potential savings. The higher those requirements are, the greater the savings, and obviously, the greater the potential controversy. However, a key question with any of those actions is the extent to which they would produce real savings in health care expenditures overall, or only shift costs to other insurers (private Medigap policies, for instance) or to other segments of the population not covered by Medicare.

Conclusion

Medicare can be both a contributor and catalyst for health care cost containment. Ideally, the strategy most desired would be to do no harm—slowing spending growth without lowering quality or access to care. Even more desirable would be for efforts to constrain growth becoming a channel for improving the quality of care. Other countries appear to have done so.[25] Allowing Medicare, for instance, to develop and use payment practices comparing the effectiveness of various treatments might show promise for broader application by other financiers of health care.

Much of Medicare's cost containment efforts to date have attempted to reduce growth by squeezing providers. And the argument repeatedly arises that with too much of that, providers will resist serving the Medicare population. Interest groups then form defenses and Congress acquiesces. Putting the squeeze on recipients is considered even more detestable, raising charges that the public's health will be harmed. If it is easy to shoot at entitlement restraint, the many vested interests will.

Perhaps the largest objection to constraining public financing of health care is that it merely redistributes who pays for it. Whatever truth there is to that, establishing health care cost containment as a national priority has to start somewhere. Accepting that there will be some redistribution of costs may be an imperfect consequence, but a necessary one in order to move forward. Whether publicly or privately induced, incentives for paying and delivering health care have to be altered. Incentives change behavior, and it is only with that that real cost control will emerge. That said, for patient and provider acceptance, the two forms of change may need to merge—a coupling of financial

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[24] Rand Corporation, "Research Highlights: The Health Insurance Experiment—a Classic RAND Study Speaks to the Current Health Care Reform Debate," December 13, 2007. Among a few notable exceptions was that with some of the sickest and poorest participants, free care led to improvements in hypertension, dental health, vision, and a few selected serious symptoms.

[25] Karen Davis, Ph.D., "Slowing the Growth of Health Care Costs—Learning from International Experience." The New England Journal of Medicine, October 23, 2008.

incentives with improvement in service, i.e., better medical outcomes. Potentially harming Medicare enrollees by constraining provider payments, paying more for some treatments and less for others, or raising enrollees' out-of-pocket responsibility may seem like the "dark side." However, selectively doing so may encourage providers to do fewer wasteful tests, better coordinate care, and apply cheaper forms of treatment.

It is easier to speculate harm than to see restraint as a means of improving health care. But whatever efforts are made to address our health care problems, the status quo is not a viable option. Both providers and recipients need a wake up call. Without it, today's resistance to change could very well become tomorrow's balloon payment.

Suggestions for Further Reading:

The Congressional Budget Office has analyzed some of the options discussed in this brief to determine the impact they would have on the federal budget over 10 years. Their full report can be accessed at www.cbo.gov. Some relevant options are:

Payment Reforms: Options 30-42 & 50-52

Changes to Medicare Advantage: Options 63-66

Health Information Technology: Options 46 & 47

Chronic Care Coordination: Option 39

Comparative Effectiveness Research: Options 45 &110

Consumer Cost Sharing: Options 87, 90 & 91