

BACKGROUND

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Medicare's Outdated Structure—and the Urgent Need for Reform

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Abstract

The structure of Medicare determines how it functions. It also entails undesirable consequences, such as requiring Medicare beneficiaries to pay additional premiums and purchase supplemental coverage; employing price controls that often result in underpayment or overpayment for medical goods and services; placing massive regulation on doctors, hospitals, and other medical professionals; generating tens of billions of dollars annually in waste, fraud, and abuse; and using an administrative payment system that, as an arena for special interest lobbying, results in the politicization of decisions over health care financing and delivery for America's senior and disabled citizens. The best policy for fixing the inherently flawed and outdated Medicare program, while improving it as an insurance program for seniors, is structural Medicare reform based on a defined-contribution ("premium support") program of financing.

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Traditional Medicare, which liberals once envisioned as the foundation for national health insurance for all ages,¹ is a fee-for-service model rooted in the 1960s. Its outdated structure makes the program fundamentally flawed, as the editors of *The Washington Post* remarked recently: "Medicare as we know it is not sustainable" and the "ultimate solution" is structural reform.²

Medicare's current structure determines the way it functions. It also entails certain undesirable consequences. For example, it requires Medicare beneficiaries to pay additional premiums and purchase supplemental coverage; employs price controls to control costs that often result in underpayment or overpayment for medical goods and services; places massive levels of detailed regulation on doctors, hospitals, and other medical professionals; generates tens of billions of dollars annually in waste, fraud, and abuse; and uses an administrative payment system that, as an arena for special interest lobbying, results in the politicization of decisions over health care financing and delivery for America's senior and disabled citizens.

While Congress should enact comprehensive reform based on a defined-contribution system, like

KEY POINTS

- The structure of traditional Medicare, which determines how it functions, is inherently flawed and outdated.
- Medicare's outdated structure results in: additional premiums and costs for seniors; price controls that often result in underpayment or overpayment for medical goods and services; massive regulation of doctors, hospitals, and other medical professionals; tens of billions of dollars annually in waste, fraud, and abuse; and an administrative payment system that acts as an arena for special interest lobbying.
- The Patient Protection and Affordable Care Act doubles down on Medicare's flawed usage of price controls, and its delivery reforms are likely to fail at reducing costs or improving quality.
- The best solution is structural Medicare reform based on a defined-contribution ("premium support") program of financing. Competition among plans and providers, driven by personal choice, will secure better value for Medicare dollars, and will reduce the growth in Medicare spending.

that which funds the Medicare drug-benefit program, there are several short-term measures that can improve the structure of the existing program: the unification of Parts A, B, and D into a single plan; reform of Medicare cost sharing combined with the addition of a Medicare catastrophic benefit; and a restructuring of the Medicare-Medigap relationship with a view toward limiting first-dollar coverage and the excessive use of medical services that drives up beneficiary premiums and taxpayer costs.

A Complex and Costly Structure

Today's Medicare program is organized into four parts. Each part is financed on an entirely different basis, with different streams of premium payments, revenue, and taxpayer subsidies, as well as complex cost-sharing arrangements.

Medicare Part A. The Hospitalization Insurance (HI) program pays for hospital and certain home health care services; it is funded by a 2.9 percent Medicare payroll tax, equally divided (1.45 percent each) between employers and employees. These funds are deposited in the Hospital Insurance Trust Fund (often called the "Medicare Trust Fund" in the media) to pay hospital insurance benefits. Part A benefits are thus available "premium free" except for persons who have not worked and paid sufficient Medicare payroll taxes.³ So, the Medicare hospitalization program is a classic pay-as-you-go system; today's workers primarily fund today's retirees—not tomorrow's. Unlike Social Security, there is no cap on this portion of the federal payroll tax.

Beginning in 2013, under the euphemistically named Patient Protection and Affordable Care Act, the payroll tax for upper-income citizens (defined as individuals with annual incomes of more than \$200,000 and couples with more than \$250,000) is increased by 0.9 percent,

for a total of 3.8 percent. In addition, for upper-income Americans, the "Medicare Payroll Tax" is also extended to "unearned income," including stocks, bonds, mutual funds, and, in certain cases, proceeds from the sale of a home. This revenue does not, in fact, go into the Medicare Trust Fund, but instead funds the provisions of the Affordable Care Act.⁴

Medicare Part B. The Supplementary Medical Insurance (SMI) program pays doctors, funds outpatient medical services, and covers payments for a certain class of drugs, usually physician-infused chemotherapy or biologics. Part B is financed by a combination of beneficiary premiums and federal taxpayer subsidies; federal taxpayer subsidies from general revenues automatically pay 75 percent of the program's total costs, while beneficiaries pay only 25 percent of total premium costs. Unlike Medicare Part A, which has a fixed funding stream based on payroll taxes, Part B expenses are covered automatically by general revenues from federal income taxes and business taxes.

Medicare Part C. Medicare Advantage (MA) is a system of competing and regulated private health plans. It enrolls about 27 percent of all Medicare beneficiaries. The program is financed by a combination of Part B premiums and federal payments. Unlike traditional Medicare, the payments to these plans are geographically based on a system of "competitive bidding" to provide Medicare A and B benefits. But the actual payments to these plans are not based on pure market bidding—rather, the government payments are "benchmarked" to Medicare's existing administrative payments in the geographical area for traditional Medicare benefits.⁵

If a plan's bid is lower than the government benchmark, it must rebate 75 percent of the savings to the beneficiary in the form of lower premiums or richer benefits; the

1. "The original hope was that Medicare would grow into a universal health insurance, not coverage only for the elderly, the disabled and those suffering from renal failure." Theodore Marmor, Spencer Martin, and Jonathan Oberlander, "Medicare and Political Analysis: Omissions, Understandings and Misunderstandings," *Washington and Lee Law Review*, Vol. 60, No. 4 (Fall 2003), p. 1151. On the Left, this old hope is very much alive, as evidenced by periodic proposals calling for "Medicare for All."
2. "Repairs to Medicare," *The Washington Post*, January 6, 2013, http://www.washingtonpost.com/opinions/repairing-medicare/2013/01/06/1646366c-56a3-11e2-a613-ec8d394535c6_story.html (accessed March 6, 2013).
3. A person must have worked for at least 10 years to qualify for Part A benefits without paying a monthly premium.
4. As Medicare Trustee Charles Blahous explains, "Though termed an 'Unearned Income Medicare Contribution' (UIMC) under the law, this revenue would not come from Medicare's traditional contribution base and it would not be allocated to a Medicare Trust Fund. The \$200,000 and \$250,000 income thresholds for triggering this tax would not be indexed and would thus capture (if the law remains unchanged) an increasing number of taxpayers over time." Charles Blahous, "The Fiscal Consequences of the Affordable Care Act," Mercatus Center at George Mason University, April 10, 2012, p. 49, http://mercatus.org/sites/default/files/publication/The-Fiscal-Consequences-of-the-Affordable-Care-Act_1.pdf (accessed March 6, 2013).
5. For further explanation of Medicare Advantage's financing, see Jeet S. Guram and Robert E. Moffit, "The Medicare Advantage Success Story—Looking beyond the Cost Difference," *The New England Journal of Medicine*, March 29, 2012, pp. 1177-1179, <http://www.nejm.org/doi/full/10.1056/NEJM1114019> (accessed March 6, 2013).

remaining 25 percent of the savings is retained by the federal government. A majority of MA plans bid below the benchmark; thus, since 2007, between 85 percent and 94 percent of participating seniors have had the option of enrolling in private plans while paying *no premium* other than the standard Medicare Part B premium.⁶

In addition, because of the rebates, MA plans offer more comprehensive coverage. Most notably, unlike traditional Medicare, MA plans cap out-of-pocket costs, which eliminates the need for beneficiaries to purchase separate supplemental insurance. Further, many plans include prescription drug coverage. In fact, 21 percent of all beneficiaries in 2010 received their drug coverage through a Medicare Advantage prescription drug plan.⁷

Medicare Part D. The Medicare prescription drug program provides stand-alone drug coverage for Medicare beneficiaries through a system of competing private plans. About 90 percent of seniors today have drug coverage, and about 60 percent of them get that coverage through prescription drug plans. Part D is also financed by a combination of beneficiary Part D premiums and state and federal taxpayer subsidies. Federal revenues account for roughly 80 percent of program costs. A crucial difference in Part D, however, is that the payment to plans for providing a standard drug benefit is based solely on a competitive bidding process among competing plans; it is not tied to traditional Medicare's administrative payment system, but represents the plans' market bids for the standard drug benefit. The government makes its payment 75 percent to the plan of the beneficiary's choice. Medicare Part D, in other words, operates on a defined-contribution ("premium support") basis similar to that of the Federal Employees Health Benefits Program (FEHBP).⁸

Consequences of the Current Structure

Traditional Medicare has certain undesirable consequences. These are inevitable as long as the basic structure of this Great Society program remains as it is today. For example:

The Need for Supplemental Coverage. Medicare still does not protect beneficiaries from catastrophic costs, causing about 90 percent of all beneficiaries enrolled in traditional Medicare (Parts A and B) to enroll in supplemental insurance plans, mostly private plans or Medigap plans. Seniors pay extra premiums and enroll in these private plans to plug the coverage gaps in traditional Medicare and limit out-of-pocket costs.

While supplemental coverage fills benefit gaps, it also covers cost sharing and thus encourages first-dollar coverage, especially in Medigap plans, which leads to excessive use of medical services. The cost estimates vary, but point to much higher total costs for the Medicare program. As Daniel P. Kessler, professor at the graduate school of business at Stanford University, says,

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.⁹

Outpatient elective procedures, says Kessler, is where one finds the greatest utilization, and the Medicare Payment Advisory Commission, the panel that advises Congress on Medicare reimbursement, has estimated that today's supplemental coverage arrangements have resulted in 33 percent more Medicare spending.¹⁰ Summarizing earlier literature on the subject, Walton Francis, a prominent Washington-based health care economist, estimates that this structural feature adds between 15 percent and 25 percent to program costs.¹¹

The Distortions of Flawed Price Controls. Medicare's rigid price controls and massive regulatory regime reflect its structural design. The complexity of the varying processes and payment rates results in a patently

6. Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, June 2012, p. 159, <http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf> (accessed March 6, 2013).

7. Ibid.

8. For more information on the FEHBP and its defined-contribution financing, see Stuart Butler and Robert Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (1995), pp. 47–61, <http://content.healthaffairs.org/content/14/4/47.full.pdf> (accessed March 6, 2013).

9. Daniel P. Kessler, "Real Medicare Reform," *National Affairs* (Fall 2012), p. 90, <http://www.nationalaffairs.com/publications/detail/real-medicare-reform> (accessed March 11, 2013).

10. Ibid.

11. Walton J. Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, DC: AEI Press, 2009), p. 27.

nonsensical detachment from the real conditions of supply and demand for medical care.

Price controls and payment restrictions placed on health plans, doctors, hospitals, home health agencies, nursing homes, and other medical professionals directly affect the beneficiaries who depend on their services.

For doctors, traditional Medicare provides fee-for-service medical care in name only, because all fees are capped by price controls. Since 1989, fees for physicians have been governed by a complex set of administrative payments. Medicare's physician fee for any given medical procedure or service is based on a formula called the resource-based relative value scale (RBRVS). This payment formula used to calculate the time, energy, effort, and practice costs—that is, the resources—that constitute the provision of a medical service. It is a social science exercise, removed from the dynamic conditions of the supply and demand for medical services that would otherwise exist in a real market. Physicians are thus paid for thousands of medical services on the basis of this fee schedule, but the payments, as noted, are also capped. The physician payment is also annually updated on the basis of another formula, the sustainable growth rate (SGR). The SGR ties physician payments to the growth of the economy, even though there is also no necessary relationship between the macro-conditions of the general economy and the micro-conditions of supply and demand for medical services.¹² The SGR is so unrealistic that Congress has routinely blocked its implementation since 2003.

In 2011, Medicare paid hospitals only about 69 percent of what private insurers paid, for which Medicare also uses a fixed-payment system.¹³ The determination of Medicare payment rates and how they are calculated varies by setting (such as inpatient acute-care hospitals, hospital outpatient departments, physician offices, home health agencies, or skilled nursing facilities). For example, the payment formula for the operating costs of acute-care

hospital inpatient stays under Medicare Part A is based on prospectively set rates, called the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into one of the 751 Medicare severity diagnosis-related groups (MS-DRGs), which are updated annually.¹⁴ Each has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that MS-DRG. The base payment rate is divided into a labor-related and non-labor share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. The wage-adjusted base payment rate is then multiplied by the DRG relative weight to determine the payment for the case.

There is evidence that, as Congress tries to rein in Medicare costs by arbitrarily slashing hospital reimbursements, the hospitals try to make up the difference by shifting costs to the private sector. Hospitals, in particular, make up their losses and maintain their profit margins by charging privately insured patients more than patients who have government-funded insurance. As Dennis Cortese, MD, a professor of health policy at Arizona State University, and his colleagues, observe, “In essence, individuals in the employer-sponsored insurance category are paying an undeclared tax to fund the low reimbursement rates from government programs.”¹⁵ Before the enactment of the Affordable Care Act in 2010, perhaps the largest Medicare payment reductions were embodied in the Balanced Budget Act (BBA) of 1997. Research shows that “[a]t hospitals where Medicare is a small payer relative to private insurers, up to 37 percent of BBA cuts was transferred to private payers through higher payments. In contrast, hospitals with greater reliance on Medicare were more financially distressed, as these hospitals saw large BBA cuts but were limited in their abilities to cost shift.”¹⁶

Not all medical professionals are equally capable of shifting the burden of Medicare reimbursement cuts. But the lower Medicare payment rates incentivize more

12. Under the SGR formula, in any given year, if physician payment is higher than the growth in GDP, it is automatically reduced the following year. In 2013, Medicare doctors faced a 27 percent payment cut, which, of course, was blocked once again by congressional intervention.

13. American Hospital Association, *Chartbook: Trends Affecting Hospitals and Health Systems*, “Chapter 4: Trends in Hospital Financing,” Table 4.4, February 26, 2013, <http://www.aha.org/research/reports/tw/chartbook/ch4.shtml> (accessed March 6, 2013).

14. For a list of DRGs in fiscal year 2013, see the Centers for Medicare and Medicaid Services, “Acute Inpatient PPS, Details for Title: FY 2013 Final Rule Tables,” <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page-Items/FY2013-Final-Rule-Tables.html> (accessed March 6, 2013).

15. Dennis Cortese, Natalie Landman, and Robert K. Smoldt, “A Roadmap to Medicare Sustainability,” a paper prepared by analysts from Arizona State University and the Healthcare Transformation Institute, February 2013, p. 66.

16. Vivian Y. Wu, “Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997,” *International Journal of Health Care Finance and Economics*, Vol. 10, No. 1 (March 2010), pp. 61-83, <http://link.springer.com/article/10.1007%2Fs10754-009-9071-5?LI=true> (accessed March 6, 2013).

and more doctors to favor private patients over Medicare patients, which is why seniors sometimes experience difficulty finding a doctor or accessing care.

The Costs of Regulatory Overkill. Enactment of major amendments to the Medicare law (legislation such as the Balanced Budget Act of 1997, the Medicare Modernization Act of 2003, and the Affordable Care Act of 2010) has added tens of thousands of pages of Medicare rules that are tying up doctors, hospitals, and other medical professionals in fat reams of red tape, reporting requirements, and paperwork.¹⁷ For example, an estimated 80 percent of Medicare doctors are projected to incur financial penalties in 2015 under the Affordable Care Act for not complying with Medicare's quality reporting standards, at least based on current trends.¹⁸ Compliance with these and other rules imposes a transactional cost on medical practice that affects patient care. Douglas Perednia, MD, formerly a principal investigator of computer imaging for the National Cancer Institute, observes,

A wide range of state and federal rules suck up enormous amounts of provider time and overhead. As time is the only inventory clinicians have, more time spent on administration means that less time will be spent on providing services to patients. Less time with patients yields fewer services and lower total bills. The *de facto* result is a rationing of care.¹⁹

Medicare is pumping out thousands of pages of new rules, regulations, and guidelines. New rules, published in 2011 and 2012 governing Medicare physicians and hospitals—including updates to the prospective payment system, hospital-based value purchasing, hospital outpatient services, and updates to the physician fee

schedule—totaled 4,643 pages in the *Federal Register*.²⁰ While seniors are spared the direct impact of the regulatory regime, they are not immune to its consequences, such as difficulty finding a doctor, lost quality time with a physician, or reduced access to care.

More Costly Waste, Fraud, and Abuse. In contrast to consumer-driven insurance systems like the FEHBP, and private insurance in general, traditional Medicare generates enormous costs to the taxpayer from waste, fraud, and abuse. Medicare administrators merely process taxpayers' dollars, rather than operate under intense market pressures to root out questionable practices that undercut private insurers' competitive position.

Largely due to the program's size and complexity, Medicare is at a high risk for waste, fraud, and abuse that leads to improper payments, both overpayments and underpayments. Once again, there is a range of estimates. In 2008, Senator Charles Grassley (R-IA) charged that Medicare was losing approximately \$60 billion a year to waste, fraud, and abuse.²¹ On the discrete issue of "improper payments," the Centers for Medicare and Medicaid Services determined in 2011 that Medicare fee-for-service for Parts A and B had an improper payment rate of 8.6 percent, representing \$28.8 billion in improper payments.²² In trying to reduce this cost to taxpayers, the federal government allocated over \$608 million in 2011 in an effort to combat health care fraud and abuse.²³

Honest doctors struggle to cope with the administrative costs imposed on them by this vast regulatory regime, properly fearful of audits, investigations, and fines and penalties. This vast and impenetrable array of rules and restrictions also inhibits innovation in the delivery of care. Not surprisingly, the very complexity of this regime creates exactly the kind of cluttered and confusing

17. Regulatory excess has been a periodic theme in Medicare reform efforts. Fifteen years ago, the Mayo Foundation for Medical Education and Research presented its findings on Medicare paperwork to the National Bipartisan Commission on the Future of Medicare, and then estimated Medicare's paperwork burden at 110,758 pages, with the total volume of federal health care regulation, including Medicaid rules, amounting to 132,720 pages. With the Affordable Care Act, another massive expansion of Medicare regulation is well underway.
18. Elise Viebeck, "Study: Most Medicare Docs Set to Face Performance Penalties," *The Hill*, January 8, 2013, http://thehill.com/blogs/healthwatch/medicare/275987-study-most-medicare-docs-set-to-pay-performance-penalties?wpisrc=nl_wonk#ixzz2HULSNo6x (accessed March 6, 2013).
19. Douglas A. Perednia, *Overhauling America's Healthcare Machine* (Upper Saddle River, New Jersey: FT Press, 2011), p. 93.
20. Cortese et al. "A Roadmap to Medicare Sustainability," p. 58.
21. Rita Numeroff and Michael Abrams, *Healthcare at a Turning Point: A Roadmap for Change* (Boca Raton: CRC Press, 2013), p. 107.
22. Centers for Medicare and Medicaid Services, "Medicare Fee-for-Service 2011 Improper Payments Report," <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf> (accessed March 6, 2013).
23. The Department of Health and Human Services and the Department of Justice, Health Care Fraud and Abuse Control Program, "Annual Report for Fiscal Year 2011," February 2012, p. 7, <https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2011.pdf> (accessed March 6, 2012).

environment where dishonest providers can navigate undetected at taxpayers' expense.²⁴

The Continued Politicization of Health Care.

Medicare's coverage and payment decisions are subject to detailed congressional micromanagement. Instead of routine business and medical decisions, Medicare financing and delivery is a great arena for special-interest politics and provider income redistribution, the playground of the "Medicare Industrial Complex."²⁵ Rent-seeking lawyers, lobbyists, and consultants, acting on behalf of powerful medical interests and organizations, feverishly engage in an annual fight to secure higher federal payments for themselves and lower federal payments for others. As Heritage Foundation Distinguished Fellow Stuart Butler has observed,

Providers included in the [benefits] package fight diligently—and usually effectively—to block serious attempts to scale back outdated coverage for their specialties. Meanwhile, talk of upgrading the Medicare benefits package unleashes an intense lobbying battle among other specialties that seek to be included in the Medicare benefits package. Invariably, the result depends as much (if not more) on shrewd lobbying than on good medical practice.²⁶

The centralized structure of traditional Medicare guarantees this politicization and directly contributes to the program's notorious waste. In a seminal article for *Health Affairs* in 1999, former Medicare administrator Bruce Vladeck observed,

There are plenty of \$400 toilet seats in the Medicare program, because Medicare cannot deliver services to its beneficiaries without providers and because providers are major sources of employment, political activity

and campaign contributions in every congressional district in the nation.²⁷

Impact of the Affordable Care Act

The voluminous Patient Protection and Affordable Care Act of 2010 contains an estimated 165 provisions that affect Medicare. So, the law will indeed make major changes in Medicare "as we know it." But these changes do not alter the basic structure of the traditional Medicare program. Foremost among these are the enactment of record-breaking payment reductions, a hard cap on the growth of future spending to be enforced by a newly created Independent Payment Advisory Board, and the enactment of new provisions designed to improve the conditions and outcomes of medical practice.

The new law also creates various agencies and programs to accomplish its payment and quality improvement objectives. These include the creation of Accountable Care Organizations (ACOs),²⁸ which are designed to bring together doctors and hospitals to coordinate care for Medicare patients, apply the government's quality standards, and allow providers to share savings from compliance with those standards; the Patient-Centered Outcomes Research Institute (PCORI) that will conduct comparative effectiveness research;²⁹ the Physician Feedback Program, which reports on resources that physicians use in patient care; the creation of a "quality of care" modifier to be factored into the Medicare physician payment system; the extension of the Physician Quality Reporting Initiative, which ties physician bonus payments to reporting data to the Department of Health and Human Services in compliance with government quality standards; and the Center for Medicare and Medicaid Innovation, which is charged with developing new payment and delivery reforms.

Delivery Reforms. A key objective of the new law is to secure lower Medicare costs through the provision of

24. For an account of federal efforts to combat Medicare fraud and abuse, see Cliff Binder, "Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse," Congressional Research Service, June 23, 2011. Senators Tom Coburn (R-OK) and Thomas Carper (D-DE) have co-sponsored remedial legislation: The Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayer Dollars Act (S. 1251).
25. Bruce C. Vladeck, "The Political Economy of Medicare," *Health Affairs*, Vol. 18, No. 1 (January/February 1999), pp. 22-36. This essay is the best account yet of the political dynamics of the program.
26. Stuart M. Butler, "Principles for a Bipartisan Reform of Medicare," Heritage Foundation *Backgrounder* No. 1247, January 29, 1999, <http://www.heritage.org/Research/Reports/1999/01/Principles-for-a-Bipartisan-Reform-of-Medicare>.
27. Vladeck, "The Political Economy of Medicare," pp. 30-31.
28. For a further discussion on Accountable Care Organizations, see John S. Hoff, "Accountable Care Organizations: Obamacare's Magic Bullet Misfires," Heritage Foundation *Backgrounder* No. 2592, August 10, 2011, <http://www.heritage.org/research/reports/2011/08/accountable-care-organizations-obamacares-magic-bullet-misfires>.
29. For an excellent explanation of comparative effectiveness research and its potential impact, see Kathryn Nix, "Comparative Effectiveness Research Under Obamacare: A Slippery Slope to Health Care Rationing," Heritage Foundation *Backgrounder* No. 2679, April 12, 2012, <http://www.heritage.org/research/reports/2012/04/comparative-effectiveness-research-under-obamacare-a-slippery-slope-to-health-care-rationing>.

better quality of care. Various provisions are designed to accomplish this goal, including the Hospital Value-based Purchasing Program, which will adjust Medicare payments to reflect hospital compliance with government quality standards, and the Hospital Readmission Reduction Program, which would impose Medicare payment penalties for hospitals with high readmission rates.

Medicare bonus payments and penalties for under-performance are at the heart of the Administration's delivery reform initiative. Thus far, the best that can be said about this strategy is that the jury is still out. As yet, there is no solid evidence to support the contention that "value-based purchasing" for hospitals or "pay for performance" for physicians will yield serious Medicare cost savings. When the Congressional Budget Office (CBO) initially scored the Affordable Care Act on March 20, 2010, the agency concluded that most of the new law's delivery reforms would have little if any effect on health care spending. For example, the CBO's 10-year savings estimate for hospital-based value purchasing, required by Section 3001 of the statute, was zero dollars.³⁰ The following year, the Medicare Trustees observed, "The ability of new delivery and payment methods to significantly lower cost growth rates is very uncertain at this time, since specific changes have not yet been designed, tested or evaluated."³¹

In 2012, the CBO released a more comprehensive report on demonstrations of delivery reforms, and concluded:

Results from demonstrations of value-based payment systems were mixed. In one of four demonstrations examined, Medicare made bundled payments

that covered all hospital and physician services for heart bypass surgeries; Medicare's spending for those services was reduced by about 10 percent under the demonstration. Other demonstrations of value-based payment appear to have produced little or no savings for Medicare.³²

The success of the Administration's "carrots and sticks" cost-reduction strategy depends on complex interactions among physicians, hospitals, and government authorities, as well as on the ability and willingness of physicians and hospital administrators to continue to comply with the government's rules and standards for care delivery and reimbursement. But pursuing that strategy may prove to be a serious challenge.³³ There is a clear decline in the morale of the medical profession, and based on a recent survey conducted on behalf of the Physicians Foundation, 59.3 percent of physicians report that they are less positive about the direction of health care because of the enactment of the Affordable Care Act.³⁴ That survey also shows that, as a result of "ongoing problems" with Medicare payment, 22.9 percent are going to place new or additional limits on their Medicare practice, and 12.6 percent will not accept new Medicare patients.³⁵

Short-Term Reform

There is nothing inherently rational about traditional Medicare's current structure. As a health insurance program, it is clearly deficient.³⁶ Today's different parts, with diverse funding streams, are not so much a product of sound policy as they are the vicissitudes of congressional politics.³⁷ Compatible with comprehensive structural reform, Congress should take these initial steps:³⁸

30. Congressional Budget Office, Douglas Elmendorf, letter to Speaker Nancy Pelosi, March 20, 2010, Table 5, <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf> (accessed March 6, 2013).
31. Centers for Medicare and Medicaid Services, *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, April 23, 2012, p. 41, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2011.pdf> (accessed March 7, 2013).
32. Congressional Budget Office, "Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment," January 18, 2012, <http://www.cbo.gov/publication/42860> (accessed March 7, 2013).
33. Nix, "Comparative Effectiveness Research Under Obamacare."
34. The Physicians Foundation, "A Survey of America's Physicians: Practice Patterns and Perspectives," September 2012, p. 29.
35. *Ibid.*, p. 41.
36. "Medicare fails to perform its insurance function." Katherine Baicker and Helen Levy, "The Insurance Value of Medicare," *The New England Journal of Medicine*, October 31, 2012, <http://www.nejm.org/doi/full/10.1056/NEJMp1210789?viewType=Print&viewClass=Print> (accessed March 7, 2013).
37. Marilyn Moon, "Modernizing Medicare's Benefit Structure," *Washington and Lee University Law Journal*, Vol. 60, No. 4 (Fall 2003), p. 1207.
38. For a further discussion of initial Medicare reform steps, see Robert E. Moffit, "The First Stage of Medicare Reform: Fixing the Current Program," Heritage Foundation *Background* No. 2611, October 17, 2011, <http://www.heritage.org/research/reports/2011/10/the-first-stage-of-medicare-reform-fixing-the-current-program>.

- Unify Medicare Parts A, B, and D into a single plan and streamline Medicare's cost sharing with one premium, one deductible, and a unified trust fund.
- Turn Medicare into a true insurance plan by adding a catastrophic benefit.
- Reduce costs and utilization by limiting first-dollar coverage by Medigap plans.

Variations of such an approach have long attracted broad, bipartisan support—such as from the Bipartisan Policy Center, the National Commission on Fiscal Responsibility and Reform, and The Heritage Foundation. As Henry Aaron of the Brookings Institution and Robert Reischauer of the Urban Institute argued in 1995: “Whatever rationale may once have existed for the distinction between services in Parts A and B, medical technology, the development of new forms of service delivery, and new payment structures have rendered it obsolete.”³⁹ Their argument is even more compelling today.

Long-Term Reform

As Kessler has argued, “Medicare's out-of-control spending is the natural result of its centralized,

politicized structure.”⁴⁰ The best policy for fixing the inherently flawed and outdated Medicare program, while improving it as an insurance program for seniors, is structural Medicare reform based on a defined-contribution (“premium support”) program of financing. The Heritage Foundation has developed the components of such a reform in detail.⁴¹

Under premium support, which would build on the experience of Medicare Part D and the success of the popular Federal Employees Health Benefits Program, government payment to competing health plans (including traditional Medicare) would be calculated on market-based bids to provide Medicare benefits, and beneficiaries would choose the plan that best meets their personal needs. Intense market competition among plans and providers, driven by personal choice, will not only secure better value for Medicare dollars but also slow the growth in Medicare spending.

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39. Henry J. Aaron and Robert D. Reischauer, “The Medicare Reform Debate: What is The Next Step?” *Health Affairs*, Vol. 14, No. 4 (1995), p. 14.

40. Kessler, “Real Medicare Reform,” p. 94.

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