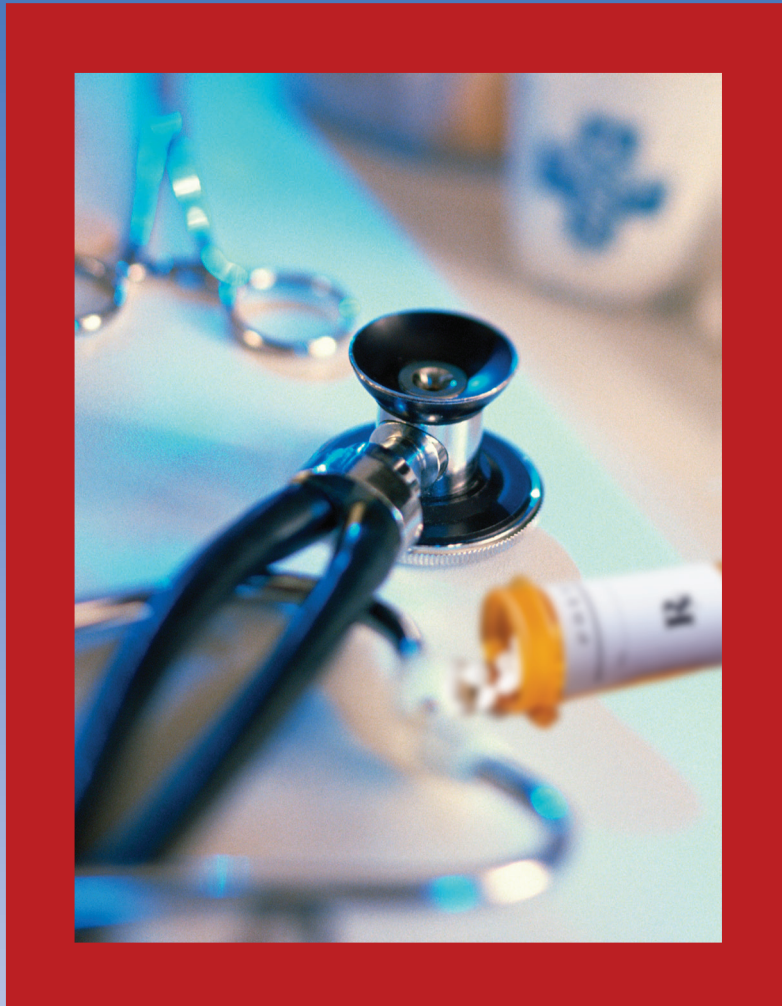


# To Reform Medicare, Reform Incentives and Organization

Alain C. Enthoven



Committee for Economic Development

2011

Policy Brief



## Foreword

Alain C. Enthoven's paper, *To Reform Medicare, Reform Incentives And Organization*, explains how the principles of cost-responsible consumer choice among competing health-insurance plans, sometimes called "managed competition," can both improve quality and reduce cost in the federal government's Medicare program.

Medicare is both the essential "insurer of insurance" for the U.S. elderly population, and by far the most important cause of the long-term crisis in the federal budget. Its role as a cost driver in the budget is indirectly linked to rising cost throughout the U.S. health-care industry. While its essential function of providing coverage to senior citizens must be fulfilled, its cost growth must be slowed – or else the federal government will be forced to make very painful choices, among which will be renegeing on that commitment to our seniors. And ideally, the steps to control its cost growth should contribute to both cost savings and improvements in quality throughout the healthcare system.

Professor Enthoven, who was a pioneer of the concept of managed competition, shows how that concept can be applied to Medicare – which today, though heavily managed in many respects, is largely devoid of competition. The objective is to give insurance plans, healthcare providers and the elderly reasons to seek high quality, efficient health care – which they do not have under today's largely fee-for-service system. The result should be providers and insurers who see that they can prosper *if* they deliver quality health care to consumers at attractive prices. Those providers and

insurers then will seek every possible way to reduce costs while maintaining and even improving quality – which they have little reason to do now.

The analysis in and findings of this paper are fully consistent with the CED policy statement, *Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System*, published in October of 2007, and for which Professor Enthoven was the project director. CED is pleased to endorse this paper and to make it available to policymakers and the public.

Patrick W. Gross  
William W. Lewis  
Co-Chairs  
Policy & Impact Committee

### ABOUT THE AUTHOR

Alain C. Enthoven is the Marriner S. Eccles Professor of Public and Private Management, Emeritus, at the Stanford University Graduate School of Business. He has published widely in the fields of the economics, organization, management and public policy of health care in the United States and the United Kingdom. Professor Enthoven holds degrees in Economics from Stanford, Oxford, and MIT. He served as Assistant Secretary of Defense for Systems Analysis, and joined the faculty of Stanford University in 1973. He has been the recipient of numerous awards and honorary positions in the fields of economics, management, and health care.

## Executive Summary

**Medicare expenditures, about \$556 billion in 2011, have been growing more than three percentage points per year faster than the GDP over the past 25 years.** In the next 10 years, with the retirement of the baby-boomers, the growth rate of the beneficiary population will increase from 2 to 3 percent per year. Under present policies, annual Medicare expenditures are likely to reach \$1 trillion. Growth in Medicare outlays must be brought into line with growth of GDP.

Medicare spending has grown faster than GDP because of aging of the population; a large increase in the prevalence of costly chronic conditions and in the costs of treating them (which requires a healthcare system that is oriented to prevention and care of chronic conditions instead of today's acute-care-oriented system); advancing technology, which expands what medical care can do to improve and lengthen lives; and our fragmented financing and delivery system that is filled with cost-increasing incentives and cost-unconscious demand. American medicine is dominated by uncoordinated open-ended fee-for-service (FFS) which encourages providers to deliver greater volumes of care, not necessarily improved outcomes.

In 2005, a Committee of the National Academy of Sciences reported "an estimated thirty to forty cents of every dollar spent on health care...is spent on costs associated with overuse, underuse, misuse, duplication, system failures, unnecessary repetition, poor communication and inefficiency." Curing these problems will require a profound change in organization and incentives.

**Integrated delivery systems (IDS) can cure fragmentation and perverse incentives.** An effective IDS management structure gives all participants information, incentives and resources – all components necessary for high-quality comprehensive care – to work together to do what is best for patients. There are many ways to cut costs while improving quality, including but not limited to: best practices for prevention of infections; stronger primary care for prevention, early detection and treatment of disease; provider incentives aligned with needs of members for high-quality, affordable care; and active management of chronic

diseases to reduce need for hospital care. Potential cost savings depend on circumstances, but generally are on the order of 20 to 30 percent for premium and out-of-pocket costs.

The best and probably only way to move from today's fragmented system to IDS is through informed cost-conscious consumer choice -- under which people decide for themselves and keep the savings if they choose wisely. This would require insurance exchanges, that is, organized markets where consumers choose plans with rules to promote efficiency and equity.

**The "managed competition" idea** (sometimes called "premium support" in the Medicare context) is based on the successful experience of some employment groups that offer an annual choice among plans based on IDS and others based on FFS. The employer offers a defined contribution, often set at or below the price of the lowest-priced alternative, so that the employees choosing the least-costly plan save money, but others who want more costly plans must pay the full premium difference out of pocket. Experience in large employment groups that offer such choices is that most people choose IDS. Competition among integrated plans ensures cost control and consumer satisfaction. "Managed competition" is not a "free market" without rules. It is not a "voucher" plan in which people are left to fend for themselves. Rules include a guaranteed right to enroll in the plan of the consumer's choice; the same price for same coverage without discrimination against the sick; risk-adjusted payments by government or employer so that plans are not penalized for enrolling sick people; and one or a few standard coverage contracts to make comparisons easy.

Versions of managed competition for Medicare reform have been proposed by, among others, the Bipartisan Commission on the Future of Medicare ("Breaux-Thomas") in 1999, and more recently by the Bipartisan Policy Center's Debt Reduction Task Force ("Domenici-Rivlin"), and by Congressman Paul Ryan. The idea could lead to bipartisan agreement.

**What are the alternatives to managed competition?** **First**, in the Affordable Care Act (ACA) in the context of FFS Medicare, the Congress created "Accountable

Care Organizations”, a new form of IDS. They are voluntary arrangements, and the incentives for providers to leave FFS and form ACOs and cut costs are weak. Ninety-three percent of the members of the American Medical Group Association said they would not participate under the proposed rules. Second, within the ACA framework, Congress may expect to rely on cutting provider payments. This approach has all the problems of price controls. Doctors may refuse to accept new Medicare patients. Third, the ACA includes a board of 15 appointed experts, the “Independent Payment Advisory Board” (IPAB), serving full time with the government with no conflicts of interest. The IPAB is charged with inventing and recommending cost-cutting ideas, which go into effect unless the Congress substitutes equally effective measures or overrides them with a super-majority. Most of the waste described in the National Academy of Sciences report is local in nature, as are the potential cures through process improvement, but the Washington-based IPAB is unlikely to focus effectively on local issues.

**What else must be done?** Employment-based insurance provides a market full of cost-unconscious demand that will undermine Medicare reform by

competing with Medicare for resources. (See the 2007 CED report.) To stop the open-ended tax subsidy to more-costly health insurance, the exclusion of employer contributions from the taxable incomes of employees should be abolished and replaced by a refundable tax credit usable only for purchase of health insurance, independent of the employer. The range of choices available to employees should be broadened by phasing in a requirement that small employers with under 500 employees (about half the work force) buy health insurance through the exchanges, while continuing to contribute a substantial part of the costs themselves. Also, an effective anti-trust policy for health care is essential for true savings from competition.

**Conclusion.** The savings from a system made up of mostly competing IDS or ACOs, each financed by risk-adjusted global per-capita payment, marketed through exchanges, could be very large. Of the 30 to 40 percent waste described in the National Academies’ report, waste reduction equal to 30 percent of total spending might be a feasible target over a decade or two. Eventually, these fundamental changes could yield improved quality of care and healthcare expenditures half of what they would be if we stayed with the failed model we have today.

## To Reform Medicare, Reform Incentives and Organization

The United States faces an enormous economic challenge: Our stumbling economy is beset by a large and rapidly growing burden of public debt. The newly created Joint Select Committee on Deficit Reduction has a priceless opportunity to meet this challenge. Success would lift American spirits far beyond the confines of the financial system and the economy. But the Committee must not squander this opportunity. The global economic and financial environment is fraught. Failure by the Committee would send a chilling signal to the entire world economy. The members of the Joint Select Committee must reject their partisan urges to engineer failure as a political weapon to be used in the next election.

But with all of the will in the world, the task of the Joint Select Committee is perhaps the most complex in modern economic history. Strengthening the dangerously weak economy now would seem contrary to the need to reduce the current oversized federal budget deficits, and thereby slow the excessive accumulation of debt. Squaring this circle will require a debt deficit-reduction policy that builds business confidence today by providing demonstrated long-run relief from the pressures on the budget.

Before the business community will make investment decisions and put more Americans back to work, there must be predictability in the economy, a sustainable fiscal outlook, and some assurance that the tax burden will not grow out of control. And to expand in the United States rather than overseas, business decision makers also need a productive and educated work force able to learn and perform new tasks effectively.

Present trends are not positive in these respects. Our unsustainable situation leaves too many “unknown unknowns.”

Perhaps dominating this environment, health care spending in the United States has grown much faster than the Gross Domestic Product (GDP) for many years. And because the government’s health care programs also have been growing faster than the GDP, they strain public finances at every level of government. They crowd out other important public programs, such

as infrastructure and education, which are necessary for economic growth.

Medicare expenditures have been growing more than three percentage points per year faster than the GDP over the past 25 years. In the next 10 years, with the retirement of the baby-boom generation, the growth rate of the beneficiary population will increase from 2 percent to 3 percent per year. Already, in 2010, health care (including the tax exclusion of employer contributions to employee health insurance) drained the federal budget by about \$1.2 trillion. And under present policies, the annual expenditures of Medicare alone are likely to come close to \$1 trillion in ten years – more than 80 percent greater than they are today.

Growth in government outlays for these healthcare programs must be brought into line with growth in the GDP because, with stable tax rates, tax revenues grow approximately with the GDP, and not much faster. In fact, if current projections hold true – and there is no reason to expect natural causes to correct our course – no other remotely feasible policy change will solve our budget problem. If the prodigious growth of health costs cannot be curbed, it will explode not only federal finances, but also business budgets as well. Employers have struggled with health-cost inflation on a day-to-day basis, and see this threat to our prosperity with painful clarity.

### Causes Of Excess Spending Growth

Healthcare costs have outstripped the nation’s income for many and complex reasons. Here are some of the most important.

First, the overall growth in age of the population adds a modest amount to per capita expenditure, about 0.5 percent per year in total. But aging is a particular concern for government costs, because the retirement of the baby boomers will increase the Medicare-eligible population rapidly, from 47.1 million in 2010 to 63.5 million in 2020, and the even-more-rapidly growing population of the very old will add to public costs for long-term care.

Second, there has been a large increase in the prevalence of costly chronic conditions and in the costs of treating them. Kenneth Thorpe reported that from 1987 to 2002, for example, the prevalence of diabetes in the Medicare population increased by one third, and the cost per case increased by about one fourth.<sup>1</sup> The healthcare financing and delivery system cannot solve this problem on its own. A large change in American culture and lifestyle is needed. But, as a part of the overall solution, we do need a health care system that is fundamentally oriented to disease prevention and care of costly chronic conditions. Today's system is oriented instead to acute care, and programs like Medicare do a poor job of managing chronic conditions before they become acute. Medicare pays a great deal for the amputation of the leg of a diabetic patient, but nothing for nurses whose care could have headed off that dreadful condition.

Third, advancing technology expands what medical care can do to improve and lengthen the lives of patients. Much of this is valuable and worth the cost. But much new technology is not well evaluated before it is deployed. Some is found actually to be harmful (e.g. VIOXX, and all-metal joint implants). And many highly touted innovations do not necessarily improve outcomes. Typically, clinical trials of new drugs compare them for safety and efficacy to a placebo, not the best existing generic drug. Other innovations are very costly for the little medical benefit they confer, or are used in cases where the benefit is small or non-existent. Recognizing this, the Congress in the Affordable Care Act (ACA) established a Patient-Centered Outcomes and Research Trust Fund to finance comparative effectiveness research. Such research is important and deserves strong continuing financial support, despite the opposition of drug and medical device companies.

Of course, comparative effectiveness information alone will not avoid waste. We need a healthcare financing and delivery system that motivates decision-makers to avoid wasteful spending, and to demand value for money in their purchasing decisions.

And the fourth major cause of health-cost inflation is our fragmented financing and delivery system that is filled with cost-increasing incentives and cost-unconscious demand. With consequences that are becoming increasingly apparent, American medicine is dominated by our uncoordinated open-ended fee-for-service (FFS) system, which encourages providers to deliver greater volumes of care, not improved outcomes, and in which insured patients have little information and no financial incentive to avoid costly but worthless care. (Open-ended means no budget. The decision-makers perceive no limit on resources they can spend in making treatment decisions.) Open-ended FFS exacerbates the problem of futile spending on end-of-life care. Open-ended fee-for-service and the traditional medical culture of autonomy work against the kind of teamwork (sharing of information and best practices) needed to improve the quality and economy of care.

In 2009, the Massachusetts Special Commission on the Health Care Payment System said, "FFS rewards over use of services, does not encourage consideration of resource use, and thus cannot build in limitations on cost growth." The Commission concluded that "risk-adjusted prospective payment models that provide appropriate incentives for efficiency...should serve as the direction for payment reform..."<sup>2</sup> ("Risk-adjusted" means that the payments to insurers are adjusted to take account of the health status of the enrolled patients. Such methods exist and are in practical application today.)

In a 2005 report, a committee of the Institute of Medicine and the National Academy of Engineering reported "an estimated thirty to forty cents of every dollar spent on health care, or more than a half-trillion dollars per year, is spent on costs associated with overuse, underuse, misuse, duplication, system failures, unnecessary repetition, poor communication, and inefficiency."<sup>3</sup> As the Government Accountability Office has recently reported, Medicare and Medicaid are particularly vulnerable to waste, fraud, abuse and improper payments.<sup>4</sup>

1 Kenneth E. Thorpe and David H. Howard, "The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence And Changes in Treatment Intensity," *Health Affairs*, Web Exclusive 26 August 2006, w378-88.

2 Recommendations of the Special Commission on the Health Care Payment System, State of Massachusetts, July 16, 2009

3 National Academy of Engineering and the Institute of Medicine of the National Academies of Science, *Building a Better Delivery System: A New Engineering/Health Care Partnership*, Washington DC, July 20, 2005

4 U.S. Government Accountability Office, "Improper Payments: Reported Medicare Estimates and Key Remediation Strategies," GAO-11-842T, July 28, 2011.

Curing these problems will require a profound change in organization and incentives. As the Massachusetts Special Commission concluded, we need to move from today's system dominated by solo or small single-specialty group practice to one made up of organized, integrated financing and delivery systems paid for by risk-adjusted per-capita payments set in advance. And we need a fundamental change from cost-unconsciousness and the expenditure-increasing incentives of FFS to a model that rewards both consumers and providers for making wise use of resources.

## Medicare Is Fragmented In Many Ways

Fragmentation of decision-making in Medicare costs money and reduces the quality of care at the same time.

Most of the physicians who care for Medicare patients have no steady continuing relationship with Medicare. Medicare is just one payer among many. This affects those physicians' behavior for the worse.

And for most beneficiaries, Medicare is actually four separate insurance plans, not one. (The 25 percent of beneficiaries who join Medicare Advantage do get a single integrated health plan.) They are Medicare Part A, an insurance plan for inpatient hospital care; Medicare Part B for physician services and outpatient hospital care; Medicare Part D for prescription drugs; and either Medicare supplemental insurance ("Medi-Gap") from private companies, or the public federal-state Medicaid program for the poor aged and disabled. Besides adding to complexity for patients and providers, these different insurance plans in their different "silos" lack a coordinating mechanism to harmonize decisions, improve outcomes and reduce costs.

The Medicare and Medicaid programs fight over which plan must pay for some services to people covered by both. Physicians paid under Part B have no economic stake in the costs or effectiveness of drugs paid for in

Part D. Some drugs may cost more than others and be more or less effective in reducing patients' needs for hospital or more doctor visits. Drugs should be chosen with the total health benefit and system cost in mind, but there is nothing in traditional Medicare to encourage or facilitate that. Medicare Parts A and B include deductibles and coinsurance to give beneficiaries incentives to use resources wisely, but Medicare supplemental insurance covers the deductibles and coinsurance, defeating this design objective of Parts A and B.

The hospitals and the doctors serving Medicare often have conflicting incentives. Doctors can demand that hospitals deploy very costly technologies at the hospital's expense, which may facilitate doctors charging higher fees for more complex services – even though such services have little or no benefit to the patient.

## What Can Be Done? Integrated Delivery Systems Cure Fragmentation And Perverse Incentives

People want to choose their own health care, and they deserve that right. However, healthcare costs will continue spiraling out of control unless efficiency improves dramatically. By all indications, the current state of the art in healthcare delivery could achieve that improvement – if only it were more widely applied.

In "Integrated Delivery Systems" (IDS), an effective management structure gives all participants information, incentives and resources to work together to do what is best for patients. Medicare beneficiaries would be better off if, just as many did in their pre-Medicare working years, they could choose among comprehensive health plans whose management sought to give them good experiences and outcomes. The best systems align incentives so that doctors are rewarded for high-quality, efficient care that satisfies patients, and for teamwork. Their hospitals work with doctors to deliver affordable service, including programs that reduce patients' needs for hospital inpatient care.<sup>5</sup>

---

5 Some healthcare analysts have favored Consumer Directed Health Plans (CDHPs), involving high-deductible insurance with tax-favored Medical Savings Accounts (MSAs) to cover partially the non-covered expenses. This approach has significant weaknesses, especially in the context of Medicare. Most healthcare expenses arise from the small proportion of beneficiaries who have the most costly illnesses. Those expenses rise far beyond any conceivable deductible amount, and so would not be affected by any incentives that would tend to reduce consumer expenditure. And that is especially true for the elderly, who would be the least able and likely to shop for lower-cost providers and treatments for serious illnesses. Cost-conscious choice among health plans, during an annual open-season period rather than under the time pressure associated with a serious medical condition, holds a far better prospect of reducing cost growth without reducing the quality of care.



The term “integrated” means that all components necessary for high-quality comprehensive care work together. Usually, such systems emphasize primary care – relying on the primary-care physician, aided by a comprehensive health record, to coordinate care, resolve conflicts between specialists, and fill gaps left by them. The primary care physician acts as the “prime contractor” who sees to it that the patient’s care is complete and coordinated.

The exact savings achieved by IDS vary with circumstances, but generally are on the order of 20 percent to 30 percent for premium and out-of-pocket costs. And these savings are achieved by islands of efficiency in the midst of the overall U.S. healthcare system that is dominated by open-ended fee-for-service medicine, driven by cost-unconscious consumers and providers. It seems reasonable that the savings would be much greater if many more efficient systems competed with each other to serve cost-conscious consumers, and if all consumers who chose such efficient systems could save money by doing so. Of course, the other side of that coin would be that consumers who chose open-ended FFS – as should be their right – in effect had to pay the extra costs of that option out of their own pockets. Such a fundamental shift of incentives would require at least a prospective effective date, to give individuals time to plan. Some might argue for grandfathering of current beneficiaries, but the merits of that option must be weighed against any delay in fundamental change of a dysfunctional system.<sup>6</sup>

Congress pursued such organized systems of care through *Accountable Care Organizations* (ACOs) in the Affordable Care Act (ACA). An ACO is a group of physicians and hospitals that accept joint responsibility for the quality and cost of comprehensive care provided to their beneficiaries. Unfortunately, the ACA provisions are so limited that they are unlikely to have much effect on Medicare costs (see below).

The best and probably only way to move from today’s fragmented system to IDS is through informed cost-conscious consumer choice – to let people decide

for themselves and to keep the savings if they choose wisely. This would require insurance exchanges, that is, organized markets that manage consumer choices with rules to promote equity and efficiency. The exchanges contract with participating health plans or ACOs to offer coverage contracts that meet established standards, among which all beneficiaries can choose in a convenient annual open enrollment process.

Some such exchanges already exist in the private and government sectors. The best examples have web sites and call centers staffed by certified benefits counselors who assist beneficiaries in their choices.<sup>7</sup> They also offer software that simplifies choices and helps people who prefer that medium to focus on the few alternatives most likely to meet their needs and preferences. When consumers choose through exchanges rather than dealing with insurers directly, insurers cannot use the enrollment process to select risks. Perhaps even more important, this is a far less costly way to distribute insurance than practices in the private market today, with their high costs of designing, underwriting and selling non-standard contracts to individuals and small groups. In the exchange model, insurers sell standard contracts to hundreds of thousands of people, realizing great economies of scale. That plus competition reduces greatly insurers’ distribution costs.

This “managed competition” idea (sometimes called “premium support” in the Medicare context) is based on the successful experience of some employment groups that offer an annual choice among plans based on IDS and others based on FFS.<sup>8</sup> The employer offers a fixed-dollar contribution, often set at or below the price of the lowest-priced alternative, so that the employee choosing the least-costly plan saves money, but others who want more-costly plans must pay the full premium difference (not the total cost) out of pocket. Employees who are not satisfied with their plans may change plans at the next annual open enrollment. Typically, very high percentages choose the less costly plans that involve, to some extent, global prospective payment<sup>9</sup> rather than FFS. At Stanford, the University of California and the California system for

6 Younger, newly eligible Medicare beneficiaries certainly would be the most likely to be acquainted with the notion of choosing among alternative healthcare plans. Many might welcome the opportunity to stay with coverage like what they have now, rather than be forced to transfer into the different conventional Medicare system, which might require that they change physicians.

7 For an example, see Extend Health Insurance Exchange at [www.extendhealth.com/about/contact](http://www.extendhealth.com/about/contact).

8 Alain C. Enthoven, “The History and Principles of Managed Competition,” *Health Affairs*, Vol. 12, Supplement 1993.

9 In California, this is called “per capita prepayment.”

state employees, typically some 80 percent of employees choose the economical plans. Among Wisconsin state employees, the percent is higher. This should not be surprising. In a voluntary process, people migrate to what they see as value for money.

Meanwhile, competition among integrated plans ensures cost control and consumer satisfaction. With the anti-managed-care backlash of the 1990s, it became conventional wisdom that people would not accept any insurance contract that limited their choice of doctors. But research showed that dissatisfaction with managed care was concentrated among those who were assigned to it by their employers without a choice and without being offered the financial savings.<sup>10</sup> Through those years, the percentage of employees who *chose* managed care held up well, and the most satisfied consumers were in the plans with the narrowest physician networks. Although it was the forced change that, understandably, angered people, the conventional wisdom unjustifiably implicating *all* managed care became a force in policy making.

How can a limited choice of provider, rather than traditional insurance with a free choice of provider at all times, yield both higher-quality and less-costly care? The answer is that medical care has become extremely complex, far beyond the ability of any individual doctor to master, and so the best medicine has become team medicine. To explain this, Laura Tollen and I wrote:

We need systems to ensure that providers are carefully selected, trained and proficient in the specific diagnosis and treatment needed by the patient; deployed in the appropriate numbers and specialties to meet a population's needs efficiently; current on evidence-based practice and supported by tools to overcome widespread practice variations and quality failures; supported by a complete up-to-date and accurate medical history (preferably electronic) of each patient; supported by teams of colleagues sharing goals work processes and information and able to coordinate care across multiple settings; a system that records test

results, diagnoses and treatments and transmits orders accurately; supported by a system of knowledge management so that the massive flow of research literature can be translated into bedside guidelines for each doctor.

It takes systems to improve quality and economy: systems of doctors working together to evaluate the outcomes produced by their care and to design improved care processes, to select doctors for quality, efficiency and teamwork, to develop and share best practice guidelines and to train their doctors in them, to devise payment systems that reward innovation in developing better care, to share information on care patterns and outcomes in order to be able to evaluate what works best and to educate all the doctors in best practices. Doctors in the best integrated delivery systems share complete information on what they do, which exposes doctors to review and evaluation by their peers, allowing their peers to approach them with advice about how to do better.<sup>11</sup>

Managed competition is not a "free market" in which anyone can sell any kind of health insurance to anyone else. There are many reasons why such a free market has not worked. For one, health insurance is an extremely complex business. Almost no consumer really understands or has even read his or her health insurance contract. And if allowed, insurance companies offer very complex products that only a persistent Ph.D. in actuarial science could compare with the alternatives – attenuating price competition, and deterring people from switching plans to save money. Also, complex non-standard insurance contracts increase administrative cost, because each provider of care must figure out from each patient's own almost-unique insurance contract who is supposed to pay what. Insurance companies resist standardization in large part because they, like any other business, want to avoid price competition. Managed competition would standardize contracts to save money and to make it easier for people to make valid side-by-side comparisons.

10 Alain Enthoven, Helen Halpin Schaffler, and Sara McMenamin, "Consumer Choice and the Managed Care Backlash," *American Journal of Law and Medicine*, 27(1), 2001, p. 1-15. Atul Gawande, et.al. "Does Dissatisfaction with Health Plans Stem from Having No Choices?," *Health Affairs* 17, no.5 (1998), pp.184-194. Karen Davis, et.al. "Choice Matters: Enrollees' Views of their Health Plans," *Health Affairs* 14, no.2 (1995) pp.99-112.

11 Alain Enthoven and Laura Tollen, "Competition in Health Care: It Takes Systems To Pursue Quality and Efficiency," *Health Affairs* Web Exclusive 7 September 2005, also Volume 24, supplement 3.

In a totally free market, insurers can reject applicants, and so they can avoid insuring the people who need insurance most. In managed competition, by contract with the exchange, every participating insurer must accept every applicant, regardless of health status. Risk adjustment compensates those insurers who enroll sicker people.

Also, in a totally free market, young, healthy people can refrain from buying insurance until they get sick. And if insurers must sell to anyone who wants it, then people will wait to insure until they are sick, driving up the cost of insurance. So an obligation for insurers to sell insurance must be balanced by a reciprocal obligation on consumers to buy, even when they are healthy. This can be enforced by the individual mandate in the ACA, now the subject of many lawsuits, or by a system of taxes and subsidies to induce even the healthy to insure.<sup>12</sup> In the case of Medicare, this is not an issue as long as the premium support payments are reasonably close to the low-priced plan in each area. Medicare Part A beneficiaries will have already paid for their hospital coverage through a working lifetime of payroll taxes.

In sum, the managed competition framework includes, for the participating consumers, providers and insurers,

- a guaranteed right to enroll in the plan of the consumer's choice;
- the same price to all consumers for the same coverage (without discrimination against the sick);
- periodic open enrollment for covered beneficiaries managed through an exchange;
- full responsibility on the part of consumers for premium differences;
- risk-adjusted payments by government or the employer so that plans are not penalized for enrolling sick people, or alternatively, to make it profitable to develop expertise in caring for predictably sick people (e.g. diabetics);

- one or a few standard coverage contracts to make comparisons easy and to simplify provider billing;
- reliable and unbiased accessible information on prices, quality and consumer satisfaction; and
- insurance transactions executed through an exchange to facilitate consumer choice and achieve economies in marketing.<sup>13</sup>
- This clearly is not a proposal for “vouchers,” in which a senior would be handed a coupon and told to go and see if he or she can find a private insurance company that will offer them coverage.

## Managed Competition For Medicare In The Political Arena

If it has not already, it must soon dawn on current and future beneficiaries – and healthcare providers as well – that Medicare as we know it, based on open-ended fee for service, is unsustainable. It must, one way or another, be curbed severely. On the present course, that is likely to be done by reductions in provider payment rates and imposed price discounts for drugs and devices. Part B premiums will increase. Medicare Advantage payments in excess of fee-for-service costs will phase out, and so participation of carriers in the program will decline. As this process plays out, growing numbers of physicians will opt out of Medicare participation, and so Medicare will increasingly come to resemble Medicaid. As in Canada, waiting times for elective hospital care will grow. Cost-shifting to the private sector will increase. And, ironically, at the same time, the 30 to 40 percent waste identified by the National Academy of Sciences will remain untouched; there will be no meaningful delivery system reform.

Obviously, this status quo track leads to a dead end. What can we do to make Medicare financially sustainable, while not diminishing – or even improving – its quality of care? Not surprisingly, there will be resistance to any attempt to slow the growth of healthcare spending. Every dollar of spending is income to some provider, and those providers believe in what they

12 Committee for Economic Development, *Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health Insurance System*, Washington DC 2007. [http://ced.issuelab.org/research/listing/quality\\_affordable\\_health\\_care\\_for\\_all\\_moving\\_beyond\\_the\\_employer\\_based\\_health\\_insurance\\_system](http://ced.issuelab.org/research/listing/quality_affordable_health_care_for_all_moving_beyond_the_employer_based_health_insurance_system)

13 Alain Enthoven, “Reform Medicare by Reforming Incentives,” *The New England Journal of Medicine*, 2011; 364e44, May 26, 2011.

do. It might be daunting for policymakers to face the arguments of trained medical professionals. But those trained medical professionals differ among themselves. Practice patterns differ widely from one physician or hospital to another, in ways that cannot be explained by differences among cases. So industry objections to saving money by treating patients the right way the first time should not be allowed to end the debate; and resistance from different sectors of the industry should be expected, and should be received openly but critically. And both policymakers and healthcare providers must recognize and accept that the unsustainable status quo is by definition not an option. Once the inevitability of change is understood, an efficient and fair market system may become the preferred alternative.

**Retirees.** Under most market reform proposals, people now on traditional Medicare will be able to remain so, though possibly at a growing out of pocket cost. Under managed competition, beneficiaries who switch to IDS will be able to gain financial savings, better-coordinated care, and an easier system to navigate. Many will be able to remain with the IDS that served them in pre-retirement years; the one-fourth of beneficiaries who have chosen Medicare Advantage plans will be able to remain with them, provided the health plans remain in the program.

**Physicians.** Traditionally, the medical profession has fought hard for open-ended fee for service and for professional autonomy.<sup>14</sup> They resisted multi-specialty group practice and selective provider contracting by insurers. Some physicians, particularly older ones, will not support a reform that creates incentives for integration of care and physician financial responsibility for costs. However, physician dissatisfaction with the present state of affairs and trends in payment may change these attitudes.

In the absence of fundamental reform, spending will be controlled by bureaucrats or insurance companies, not physicians. In contrast, physicians who choose to give up individual autonomy by forming groups that take responsibility for managing cost and quality will be able to regain professional autonomy within their self-governing medical groups. Someone may still ask them to change practice patterns, but at least the

recommendations will be made by similarly situated physician partners.

Prepaid group practice offers many advantages for physicians, including better professional support systems, freedom from non-medical administrative chores, controllable hours, and collegiality. Research shows that the most professionally satisfied physicians in California are in prepaid group practice. They have to deal with only one insurance company, and that is their responsible partner that does not attempt to interfere with medical decisions.

**Hospitals** have traditionally favored open-ended fee for service and full-cost reimbursement. They do not favor vigorous anti-trust enforcement in the hospital industry. Their main motivation under existing payment models has been to keep the beds full. In an IDS, hospitals work with doctors to keep people from needing to be hospitalized. The hospital becomes a partner in a system designed to reduce overall cost per covered consumer. Many hospital boards and managers will recognize that we will always need hospitals and that their roles as non-profit community service providers would be best served by forming efficient delivery systems.

**Pharmaceutical companies** have traditionally favored open-ended fee for service and have resisted the formation of systems with cost-conscious purchasers. However, they may prefer a managed-competition market to the almost inevitable government price controls on the European model that would be likely to follow a continued explosion of Medicare spending.

**Device companies** favor the present system in which their customers are fragmented between doctors and hospitals, and they are free to influence purchases by doctors who are not financially responsible for the costs. This will have to change. Device companies may well come to prefer market reform in which purchasers pay for value to government-imposed discounted prices and Medicare coverage decisions that block implementation of product innovations.

**Health insurance companies** developed their business models to conform to open-ended fee for service. But some of them have been innovative in introducing

---

14 Alain Enthoven, "Curing Fragmentation With Integrated Delivery Systems: What They Do, What Has Blocked Them, Why We Need Them, And How To Get There From Here," in Einer Elhauge, ed. *The Fragmentation of U.S. Health Care: Causes and Solutions*, Oxford Press 2010.

models of per-capita prepayment. Generally, they do not like managed competition because it would make them compete to provide value for money. Exchanges in some states are seen as a platform for attacking Blue Cross Blue Shield virtual monopolies. However, an important role for private insurance companies would remain in a managed competition system – but subject to fair rules and driven by value-conscious consumers.

**Brokers** inevitably see the growth of exchanges as a threat to their health insurance business relationships. Exchanges would be wise to find a way to work with them provided the costs are not too high. Some brokers have formed private-sector exchanges for Medicare.

As for the Congress itself, fee-for-service Medicare gives some members of Congress a large supply of potential particularized benefits to use to reward supporters and contributors. Turning Medicare over to market forces driven by fair rules and informed consumer choice will be a loss of power for them. However, as Medicare spending growth forces more and more cutbacks to programs Members hold dear, Congressional attitudes are likely to change. When cutting expenses is the rule, being the bearer of bad news in the form of payment reductions is a less appealing role than the previous role of giving out more money.

Versions of managed competition for Medicare reform have been proposed by, among others, the Bipartisan Commission on the Future of Medicare (“Breux-Thomas”) in 1999, and more recently by the Bipartisan Policy Center’s Debt Reduction Task Force chaired by former Senator Pete Domenici and former Budget Director Alice Rivlin, and by Congressman Paul Ryan, Chairman of the House Budget Committee. Other policymakers who have supported similar ideas include Senator Ron Wyden, a member of the Finance Committee, and Congressman Jim Cooper, a leader of the Blue Dog Democrats, and their bi-partisan co-sponsors in their proposals. The idea appeals to centrists seeking bipartisan agreement. However, it does not appeal to the traditional interest groups, and will not until they look hard at the inevitable and clearly less attractive alternatives.

The rip tides of current politics, driven by tactical positioning, have produced an ironic situation in

which Democrats favor managed competition in the context of the ACA, where exchanges play a key role for subsidized people without employer coverage, while opposing it for Medicare; while Republicans, following the leadership of Paul Ryan, favor managed competition in Medicare and voted for it in their Fiscal 2012 budget resolution, but oppose the ACA’s inclusion of exchanges. In fact, some Republican governors are rejecting exchanges for their states, a baffling stance for people who usually profess a belief in free markets.

### **What Would Happen If Managed Competition Were Adopted For Medicare?**

There has been relatively extensive research about a managed-competition regime for the general population. However, there may need to be more thought on the current, post-ACA environment and how it affects choices moving forward with Medicare.

First, a sensible strategy ought to build on the 25 percent of Medicare beneficiaries who have chosen Medicare Advantage plans in which they can get coordinated comprehensive care from familiar providers. Insurers have argued for Medicare Advantage payments from government higher than the cost of FFS Medicare, which has the advantages of government-administered price and lower administrative costs. This argument may apply to private health insurance plans that are basically FFS, but would not apply to IDS-based health plans that can lower costs below those of FFS by their superior care management efficiency.

Next, many hospitals and their medical staffs would see in managed competition both a threat and an opportunity – an opportunity to keep their patients and attract more by organizing a higher-value delivery system and marketing it on the Medicare exchange, but a threat that they would lose out to other providers if they did not offer a competitive service. The ACOs that would be formed in response to the opportunity would contract with insurance companies to provide marketing advice, actuarial services, information systems, capital to finance expansion, and reinsurance or other forms of risk sharing. The ACOs’ motivation to form competitive IDS would be much stronger than it is under existing laws and regulations, because they would need to do so to avoid losing their patients to more efficient providers. ACOs would want to have

their own insurance plans to market their superior value for money. The penalty for lack of performance on cost and quality would be loss of patients and their premium revenues.

Having done this, the ACOs could then go to work on reducing the estimated 30 to 40 percent of spending that is waste. There are precedents and examples in existing IDS that the ACOs could use, such as this list of ways to cut cost while improving quality published in a *Perspective in the New England Journal of Medicine*:

- ✦ Implement best practices for prevention of infections.
- ✦ Strengthen primary care for prevention, early detection and treatment of disease.
- ✦ Align incentives of providers with needs of members for high-quality, affordable care.
- ✦ Active management of chronic diseases to reduce need for hospital care.
- ✦ Share comprehensive medical records to improve physicians' knowledge of patients' history and eliminate duplication of tests.
- ✦ Track patient outcomes and feed results back into decisions.
- ✦ Implement effective evaluation, selection, and purchasing of drugs and devices.
- ✦ Substitute less costly personnel where equally or more effective than MDs.
- ✦ Continuously improve quality and redesign processes.
- ✦ Rely on evidence based guidelines to eliminate unwanted variation and accelerate application of the latest science.
- ✦ Use information technology for caregiver support tools such as reminders, alerts, and secure messaging between doctors and patients.<sup>15</sup>

In some areas now dominated by FFS solo practice, doctors might form Independent Practice Associations, acquire information technology, and work on their own insurance plans or collaborate with

existing insurance companies. In other words, not all ACO providers need to share the same four walls.

Next, existing large Multi Specialty Group Practices (MSGP) that do not have their own insurance plan would create one or contract with an insurance company to partner with them. When most of their revenues come in the form of premiums, their situation approximates per capita prepayment. Owning or controlling their own health plans would enable them to align incentives more completely, so that a dollar saved in the delivery system could be translated into a dollar saved by the consumers they are seeking to attract.

The many prominent large MSGPs that already have their own insurance plans – e.g., the Dean Clinic in Wisconsin, Intermountain Healthcare in Utah, Scott and White Health Plan in Texas, the Marshfield Clinic in Wisconsin – would offer their plans through the Medicare Exchange. In many cases, they already offer Medicare Advantage plans. These organized systems would have a large head start in the race for patients, based on their years of developing and improving performance. This would enable them to grow their membership. They therefore would need more doctors, who could be recruited from the traditional sector that would be losing members. Other healthcare systems like Ault Care in Ohio or Advocate in Illinois could team up with insurance companies to offer their services on the Medicare exchange.

The successful nonprofit prepaid group practices like Kaiser Permanente, Group Health Cooperative of Puget Sound, and the Group Health Cooperatives in Wisconsin, which already serve many Medicare members, would have larger markets in which to compete and would be able to offer their efficiency to members in the form of reduced premiums. Per capita prepayment eliminates the cost of billing and collecting for individual items of care.

Many of these organizations could expand geographically (as some have) by creating primary care outposts, staffed by primary care physicians supported by Nurse Practitioners or Physician Assistants, plus other allied health professionals such as physiotherapists, all linked to the main medical centers by electronic information systems that would enable them to share

---

<sup>15</sup> Alain Enthoven, "Reforming Medicare by Reforming Incentives," *op. cit.*

up to date records. Patients would be able to have their blood tests and x-rays sent electronically to specialists at the medical center. Radiologists could read the x-rays and report back. Telemedicine could provide patients with accessible specialist consultations. This is already happening and working. For health plans to be able to serve people in thinly populated areas, some changes in regulation, such as existing requirements that an HMO cannot cover a service area unless it has a hospital within convenient distance of members plus a full complement of specialists, would be needed. If we want rural areas to have access to IDS, and through them high-quality cost-efficient health care, it will be necessary for governments to permit substitution of telemedicine for the physical presence of specialists, and to allow short-stay holding beds and transportation to substitute for full hospitals. There are now several famous rural integrated delivery systems, including the Marshfield Clinic in Wisconsin, Scott and White in Temple, Texas, and Intermountain Healthcare in Utah, which is both urban in Salt Lake City and also in rural areas. So it would not be accurate to suggest that integrated systems cannot work in rural areas. Electronic technology promises to facilitate this development.

The probable outcome of opening the market to efficient delivery systems, and allowing them to pass on their economies in the form of savings to enrolled members, would be the transformation of America's healthcare system into a multiplicity of organized integrated delivery systems, competing to offer greater value to their enrolled members.

Traditional wide-access FFS would continue to exist because some people prefer it and are willing to pay the extra cost for extra freedom, and also because it might serve people in areas not yet served by competing systems.

For example, the Health Benefits Division of the California Public Employees' Retirement System (CalPERS) brokers insurance for some 1.3 million people, a large exchange for public employees in California. They found that some people lived in areas not yet served by IDS, and some others preferred wide-access fee-for-service health care, perhaps because of strong attachments to their doctors. So CalPERS hired a private insurance carrier to participate in their system, offer wide-access FFS insurance, and pay

providers negotiated rates. (These plans are self-insured by the state but they operate on a breakeven non-subsidized basis.)

## **Must Traditional FFS Medicare Continue As An Option?**

Some kind of wide access FFS coverage will be needed to serve people who do not live in areas served by ACOs and people who have a strong preference for that type of coverage and are willing to pay for it. CalPERS has shown one way to do that.

Some have proposed that in the transition to managed competition in Medicare, traditional FFS Medicare should be retained as an option. Traditional FFS Medicare has many problems, as is being increasingly acknowledged. They include rigidity. It is very hard to change a program that is managed in detail by the Congress, and needs political consensus and an Act of Congress to change. For example, it has been well known for years that Congress overpays specialist physicians relative to generalists, so that now we often have too many specialists and too few generalists. Attempts to correct this are blocked by the fact that the specialists can recycle some of those overpayments into political contributions to block needed change.

If the traditional FFS option has to play by the same rules as the other competitors (i.e. consumers who choose it must pay the full excess costs associated with it; it must pay negotiated market prices and not administered prices that allow it to shift costs to the private sector; and it must not be subsidized to preserve its market viability and become a "Fannie-Med," i.e. a competitor unfairly advantaged, and a sink hole for taxpayers), then the goals sought by preserving such an option ought to be achievable.

## **Controlling The Growth In Government Medicare Outlays**

The government's contributions to individual Medicare beneficiaries' purchases can be managed in a variety of ways.

The National Bipartisan Commission on the Future of Medicare (the "Breaux-Thomas" Commission of 1998-1999) proposed that the government would pay 88 percent of the weighted-average premium for

the standard benefits package, and the beneficiaries would pay the rest. This is a “beneficiary friendly” approach in which personal contributions would grow in proportion to the increase in overall costs, but not more. Deficit reduction would depend on the effectiveness of competition in “bending the cost curve,” which in turn would depend a great deal on reform of the non-Medicare market (see below).

In the Wisconsin State employee, University of California and Stanford groups, the employer contribution is set (approximately) at the price of the low-priced plan in each service area. This maximizes the incentive for the employee to migrate to less-costly plans, but cannot be expected to “bend the curve” unless most other employers in the area also practice managed competition. If most employers remain with open-ended FFS, the providers will serve that large market of cost-unconscious FFS patients, and simply ignore the competitive sub-sector.

There is sound reason to believe that competition among healthcare plans serving empowered cost-conscious consumers would “bend the curve” and slow the growth of the federal government’s cost. However, the workings of the free market are always unpredictable, and in the context of essential and urgent budget deficit reduction there is a need to achieve more-predictable, “scorable” budget savings. Two current approaches to healthcare reform would achieve those scorable savings in different ways.

The Bipartisan Policy Center Debt Reduction Task Force (the “Domenici-Rivlin” proposal)

will transition Medicare to a premium support program, and will control the growth of the total cost of the program. Starting in 2018, federal support per Medicare enrollee will be limited to the 2017 level and will be allowed to grow no faster than a five-year moving average of GDP growth plus one percentage point.... Like today, Medicare enrollees will be in the

traditional fee-for-service program unless they choose a private plan. However, if federal spending per enrollee for the benefits specified in legislation rises faster than GDP growth plus one percent, beneficiaries will have to pay an additional premium to cover the difference. They can avoid that additional premium, however, and potentially get higher quality health care, if they choose a private health plan offered on a new Medicare Exchange. The expectation is that increased competition among plans fostered by the Medicare Exchange, and increased beneficiary interest in these plans, will keep costs from rising rapidly and result in higher quality, more cost-effective health care.<sup>16</sup>

Thus, Domenici-Rivlin proposes limiting the growth in federal support per beneficiary to one percentage point per year higher than a five-year moving average of GDP growth. Because the number of beneficiaries will grow at 3 percent per year instead of 2 percent per year, this precise formula (which could be changed) will allow an increase in Medicare’s share of the GDP.<sup>17</sup> But there is reason to hope that the healthcare system, in response to competition, will limit cost growth even more, and that the statutory restraint on the increase in premiums will not bind.

Congressman Ryan’s proposal is more aggressive. It would index the premium support payments to the overall Consumer Price Index (CPI) for urban consumers, which would be less than GDP growth.<sup>18</sup> Also, in the Ryan proposal, premium support payments would be means tested, so that, for example, people in the top 2 per cent of the Medicare income distribution would receive just 30 per cent of the full premium support payments. People in the lower 92 percent of the income distribution would receive the full payment. Indexing to the CPI would send a stronger signal to the health services industry that health care funds would be limited. But some have argued that it would shift too high a burden to beneficiaries.

16 The Debt-Reduction Task Force, Senator Pete Domenici and Dr. Alice Rivlin, Co-Chairs, *Restoring America’s Future: Reviving the Economy, Cutting Spending and Debt, and Creating a Simple, Pro-Growth Tax System*, Bipartisan Policy Center, Washington, November 10, 2010.

17 From 1980 to 2005, Medicare spending per member grew 7.5 percent per year, GDP grew 6.2 percent per year. The number of Medicare beneficiaries will grow 3 percent per year. So Domenici-Rivlin would allow Medicare spending to grow 6.2 percent + 3 percent + 1 percent, or 10.2 percent, consuming a rising share of GDP.

18 From 1980 to 2005, GDP grew 6.2 percent per year, and the CPI-U grew 3.5 percent.



## Quoting from the CBO summary of the Ryan proposal

Among other changes, the proposal would convert the current Medicare program to a system under which beneficiaries received premium support payments – payments that would be used to help pay the premiums for a private health insurance policy and would grow over time with overall consumer prices. The change would apply to people turning 65 beginning in 2022; beneficiaries who turn 65 before then would remain in the traditional Medicare program with the option of converting to the new system.<sup>19</sup>

Thus, although the Ryan plan aims to eliminate the current Medicare FFS program, it would grandfather all beneficiaries or prospective beneficiaries age 55 and over. They could stay in traditional FFS Medicare. Potentially, this could keep a “long tail” of declining numbers of FFS beneficiaries for 45 years or more, and the need to continue to operate this program. To mitigate this prospect, the Ryan proposal would need to be modified to increase incentives to switch to a competing comprehensive care plan along the lines of the Domenici-Rivlin proposal.

The likely alternative will be for the Congress to adjust the increase in the premium support payments annually, depending on conditions at the time, in a manner similar to the way it adjusts hospital prospective payments now. This model would make Medicare outlays controllable expenses instead of uncontrollable expenses on auto pilot as is the case now.

In all of the current proposals, the indexing does not begin until around 2018-2021, so there is plenty of time for Congress to reconsider what it plans to do. It would be a mistake for partisans on either side to declare political war now over amounts that can and quite likely will be adjusted annually by Congress seven to ten years from now. The important thing today is to get the managed competition framework into place and allow market forces to attack the 30 percent to 40 percent waste in the system.

## What Is The Alternative To Managed Competition?

Although the case for the managed competition model in Medicare would seem persuasive, the ACA went in a different direction.

First, the ACA proposes ACOs, but in the context of FFS Medicare. These are voluntary arrangements in which many groups are likely to choose not to participate (contrary to what would happen in a managed competition framework.) ACOs accept responsibility for the cost and quality of care for populations ascribed to them based on past use patterns, except that in the ACA concept, ACOs would not know who their patients are. Unlike an HMO or a Medicare Advantage plan, in this case the beneficiaries do not choose to commit to one ACO for all their care. They are free to go elsewhere for care whenever they want. In fact, they may not even know they are doing so. So the ACO providers complain that they do not know the names of the people whose health they are supposed to safeguard, and for whom they can be held responsible. The assignment of members to ACOs is retrospective. An ACO may get a bad score because some of its ascribed patients went out of the ACO for some very expensive and possibly unnecessary care.

Why didn't the Congress design the program in such a way that patients could be enticed to choose to enroll by being allowed to keep the savings if they did join? As noted above, apparently Congress misread the experience of the 1990s and thought that people would not elect to join an ACO because they did not want to limit their choices of provider, despite the fact that about 25 percent of Medicare beneficiaries have chosen Medicare Advantage programs already. (And in Medicare Advantage, enrollees can get better benefits, but not money back.) Alternatively, perhaps, under the influence of an overwhelming lobbying campaign, Congress simply chose to stop short of an effective program.

Compared to remaining with open-ended FFS, the incentives for providers to form ACOs are weak, possibly non-existent. The shared savings models say to providers, “If you will reduce your revenues from

---

<sup>19</sup> Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to the Honorable Paul Ryan, Chairman Committed on the Budget, U.S. House of Representatives, Washington D.C. 20515 , April 5, 2011

Medicare by \$1 million, Medicare will give you back \$500,000.” Some providers are likely to think, “Why don’t we just stay out of the ACO, and keep the whole million?” And added to this, there will be substantial, if worthwhile, costs in organizational development and information technology just to get into the game. It was not surprising when the American Medical Group Association (AMGA), the association of doctors most likely to form and develop ACOs, reported that 93 percent of their members would not participate, at least in the models described in the first regulations. CMS is now designing what may be more attractive models. But the fundamental flaws remain.

Second, within the ACA framework, Congress may expect to rely on cutting provider payments. For example, the ACA did not repeal the Sustainable Growth Rate (SGR) formula, leaving in place large scheduled cuts in the amounts Medicare pays doctors. This permitted CBO to estimate \$250 billion lower costs to the federal budget than would have been incurred if the SGR had been repealed. For over 10 years now, the Congress has relented at the last minute and postponed the cuts in doctor fees. The postponements were doubtless encouraged by the fear that doctors would respond by refusing to add new Medicare patients to their practices, a pressure that Congress has been unable to resist for over a decade.

Beyond that problem, history has shown that doctors have been able to offset to some extent the revenue losses from Medicare fee cuts by increasing the volume and intensity of services. Some of that is likely to be more surgery of doubtful necessity and other services that increase the demand for hospital services. This is the source of much of the heroic but futile, or purely symbolic, services that we now refer to as “end-of-life care.”

The ACA did reduce the scheduled increases in hospital payments, potentially saving \$500 billion over a decade. It remains to be seen how well that will hold up when financially weak hospitals plead hardship. On the other hand, many hospitals have market power and are able to shift the costs not reimbursed by Medicare to private-sector payers, thus driving up costs to the private sector. Some of those costs will fall back on the government either through the tax exclusion of employer payments for employee health care, or through

Federal subsidies to people buying coverage through the exchanges.

Finally, the ACA includes a board of 15 experts, the “Independent Payment Advisory Board”(IPAB), appointed by the President, serving full time on government pay with no outside financial connections or conflicts of interest. The IPAB is charged to invent cost-cutting ideas, recommend them, and see them go into effect unless the Congress substitutes equally effective measures or overrides them with a super majority. The IPAB will work under tight constraints – for example, it cannot touch hospital payments until 2020, and cannot touch covered benefits. These central planners are most unlikely to do as good a job as hundreds of doctors and managers in local delivery systems working under the strong incentives of competition to improve value for money for their enrolled members. Most of the waste described in the National Academy of Sciences report is local in nature, as are the potential cures through process improvement – but the IPAB is unlikely to focus effectively on local issues. The IPAB is now under heavy fire in the Congress, by some Democrats as well as Republicans, and its survival is not assured.

## **What Else Must Be Done?**

Reforming Medicare along managed competition lines would have a large impact. While per-beneficiary spending on Medicare is at least twice that of employed people, still about three times as many people get their care through employer-sponsored insurance, and many of them are locked into open-ended FFS by their employers. Thus, employment-based insurance provides a market full of cost-unconscious demand that will undermine Medicare reform. Some strong action must be taken to reform the employment sector and make it a rich market for competitive IDS and ACOs. For example, the exclusion of employer contributions from the taxable incomes of employees should be abolished and replaced by a refundable tax credit usable only for purchase of health insurance, independent of the employer, to stop the open-ended tax subsidy to more-costly health insurance. This would also help balance the budget, and it might come about in the context of budget-balancing tax reform, to broaden the tax base and reduce marginal tax rates. It would also

help if tax-excludable employer health plans had to use defined contributions.

Another measure that would be of great value would be to reform the ACA to broaden the choices available to employees by phasing in a requirement that all small employers (under 500 employees) buy health insurance through the exchanges, while continuing to contribute a substantial part of the costs themselves. This would account for about half the labor force which, when combined with dependents, would greatly increase the market for cost-effective ACOs. It would give millions of employees and their families the opportunity to save substantial amounts of money by choosing efficient providers, and it would give them more stable rates than today because many such small employers do not individually constitute viable risk pools.

A necessary policy change is to develop and enforce an effective anti-trust policy for health care. Many large hospital systems have formed with the result, if not the intent, of greatly increasing market power. Some of these must be rolled back, or else individual hospitals must be required to negotiate their own prices. Even a much-more-efficient potential new entrant into a local market could be deterred if that market already is oversupplied with hospital beds (or some other crucial resource) by a monopoly that “earns” its profits by keeping those beds unproductively filled.

Responsible tort reform could help reduce expenditures and is surely well worth doing on its own merits. A recent comprehensive study finds that “Overall annual medical liability system costs, including defensive medicine, are estimated to be \$55.6 billion in 2008 dollars, or 2.4 percent of total health care spending.”<sup>20</sup> Tort reform may yield only a one-time change in the level of expenditures, with no long-term reduction in their growth rate. Still, “safe harbors” for physicians based on best-practice guidelines and specialized healthcare courts could result in both better practice of medicine and quicker, less-costly delivery of compensation to those who are harmed by poor medical practice.

## Conclusion

If public policy were to convert the American open-ended fee-for-service healthcare system to one made up of mostly competing ACOs, each financed by risk-adjusted global per-capita prepayment, and marketed mostly through exchanges, the financial savings could be very large, and quality and service could be improved. Current waste-rewarding incentives would be transformed to encourage patients and providers to make wise choices in use of resources. Of the 30 percent to 40 percent waste described by the National Academies’ Report, waste reduction equal to 30 percent of total spending might be a feasible target over a decade or two. For example, about 10 percent could be saved by eliminating the costs of preparing and collecting bills for items of service. About another 20 percent might be saved by replacing insurance administrative costs for dealing with many individuals and small firms, by marketing standard contracts on exchanges for tens of thousands of people. And Medicare Parts A,B,D and “Medigap” would be replaced by single standard comprehensive care contracts.

Such a model would encourage development of cost-reducing technologies. Such competition-driven cost-reducing innovation would help to offset expenditure-increasing effects of new costly technologies.

The future of reformed health care is uncertain, given all the complex interacting factors. But these fundamental changes in organization and incentives could, over a decade or two, yield health care expenditures half of what they otherwise would be if we stayed with the failed model we have today – with improved quality of care at the same time.

---

20 Mello, M.M., Chandra, A., Gawande, A.A. and Studdert, D.M. “National Costs of the Medical Liability System,” *Health Affairs* 29 no.9 (2010) 1569-1577.



Committee for Economic Development

2000 L Street N.W., Suite 700  
Washington, D.C. 20036  
202-296-5860 Main Number  
202-223-0776 Fax  
1-800-676-7353

[www.ced.org](http://www.ced.org)