

Medicare's Future: Policy Ideas and the Coming Reform Debate

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Introduction

Age fifty is a symbolic marker for most of us. On July 27 and 28, 1965 Congress the House and Senate passed the Medicare bill, which was signed by President Johnson on July 30th. Thus, in a little more than two years we will celebrate the 50th birthday of Medicare, which is with little doubt the most significant health legislation in the history of the country.ⁱ

Most of the key participants in the battle for Medicare are gone, and in many ways the country is a very different place. The Viet Nam War had not yet escalated into a major conflict. Cars made by General Motors and Ford represented the dominance of American industry in the world. The first of the baby boom generation was entering college, and it was not yet understood that this bulge in the population was about to end. In the nearly five decades that have passed Medicare has become the centerpiece for financing the American health system, and two generations of the elderly have used the program to pay their health expenses after retirement.

In 1966 the 19 million Medicare recipients represented almost 10% of the population. If we exclude the nonelderly disabled, who were not part of the original Medicare population, the current 39 million Medicare recipients are 13% of the population. If we include the disabled, the number is 47 million. In less than two decades the Medicare enrollment is expected to grow to 81 million by 2030. Medicare spending in 1968 represented .6% of GDP. Today it is 3.6% of GDP, and is projected by the Medicare Trustees to be 5.1% of GDP by 2030, when the first of the baby boom generation will be in their early 80s.

As Medicare approaches age fifty, we celebrate its success and worry about whether the organizational and financial premises on which the policy was constructed are sustainable. A long shelf of excellent books has been written on the subject of Medicare over the last five decades, and surely more will be added. This little paper seeks the modest goal of exploring the central policy ideas that have evolved around the Medicare program. For a program as large and expansive as Medicare, it is remarkable in its consistency over time. The Medicare program in 2013 is in most fundamental respects very much like the program that began to pay doctors and hospitals in July 1966 for the services they rendered to those 65 and over.

ⁱ The companion Medicaid piece (Title 19 of the SSA of 1935) has grown to be almost as significant a Medicare, but would have never become law on its own in 1965, and the Affordable Care Act of 2010 has yet to demonstrate the comprehensive reach of Medicare.

After a brief consideration of why ideas are important for understanding policy and the process by which ideas shape the formulation and revision of policy, we will examine three large central Medicare policy ideas. In the concluding sections of the paper a political analysis will appraise the nexus of ideas and policy-making in the evolution of Medicare to date as well as offer parting thoughts on the critical decade between Medicare's fiftieth and sixtieth birthdays.

Policy Ideas- Why Do They Matter?

They float around in the “policy primeval soup” according to John Kingdon.¹ Beland and Cox see them as “causal beliefs about social phenomenon”² New ones can disrupt existing policy networks.³ They “instill in policy actors the passion and drive for political engagement and confrontation”.⁴ “Coherent systems” of them can constitute a policy paradigm that becomes the lens that filters interpretative information.⁵

These policy theory discussions refer, of course, to policy ideas. Kingdon quotes Keynes as observing that ideas—right and wrong- rule the world”⁶ Following Kuhn, Hall, Beland-Cox and others have observed policy paradigms are clusters of ideas that both dominate policy discussion and shape the causal belief systems that determine how participants in policy networks view ideas as they float in the primeval soup.⁷

Two decades ago Sabatier lamented that political science too often neglected the force of ideas to concentrate instead on institutions and political behavior.⁸ The subsequent policy studies literature has rendered this observation less relevant, as there is now a rich conceptual and research exploration around the significance of ideas in the formulation and modification of policy.

The focus of this paper will be policy ideas that have been crucial to the debates about Medicare that have taken place over the past five decades and are likely to continue into its sixth. Kingdon aptly observed that it both hard to precisely trace the origins of policy ideas (because they emerge from the primeval soup at an opportune time and have undergone metamorphosis in the process), and that the origin is trivial compared to understanding why the idea took hold and grew at a pivotal time in the process.⁹

For our purpose here policy idea refers to an integrated set of proposals designed to address a problem that has a place on the policy agenda. The idea may have quickly emerged in response to events that created a threat or opportunity, or it may have been percolated for years in the primeval soup of one or more policy communities. Such long-term ideas might emerge periodically in response to an immediate agenda and then, if not adopted, slink back into the mud until the next opportunity. No doubt one could find dozens of such ideas in the fifty years of Medicare public discussion, but we will concentrate on the handful that have both been at the center of discussion and have seemed to have persisted over time, even as some of the elements have been transformed.

The related concept of the policy paradigm also serves a useful purpose in this discussion. Hall and others have found clusters of ideas that are adopted by policy communities as

belief systems.¹⁰ When a strong policy paradigm exists this belief system can be a powerful interpretative filter that rejects new ideas. Ultimately if the psychological attachment to a policy paradigm within a policy network leads to resistance to change over time, even in the face of evidence of serious problems, then conditions may be propitious for the emergence of a new policy paradigm that may ultimately supplant the dominant one.

In the sections that follow, the paper will begin by exploring the dominant Medicare policy paradigm as well as an alternative formulation that has emerged in the last decade and a half to challenge the status quo. Additionally, there are three policy ideas that have been at the center of Medicare debates for decades and are likely continue as focal points in the decade ahead.

Medicare Big Ideas

Central Policy Paradigm

The origins of Medicare as a policy idea can be traced back almost a hundred years to the early years of the 20th century.¹¹ President Franklin D. Roosevelt's social insurance advisors wanted to include health care as part of the Social Security legislative package, but this was rejected because of anticipated opposition that might threaten the entire bill. A decade and half later President Truman proposed a National Health Insurance plan identical to the earlier proposal, but Congress ignored it. In the 1950s the cadre of academics/social security administrators who had developed the National Health Insurance idea decided to scale back the proposal to only apply it only to retirees, who were left out of the expanding work based system.¹² The idea had apparently first been suggested by Dr Thomas Parran of the Public Health Service in 1937. He suggested it as an interim step.¹³

Since the New Deal era there has been a health policy advocacy coalition or policy network that has nurtured and advocated the social insurance approach to financing health care. I have previously labeled them "Social Insurance Advocates".¹⁴ By the mid 1960s they succeeded in achieving the enactment of their goal of expanding the social insurance system to include national health insurance for the elderly with the passage of Medicare.

At the time Medicare was enacted social insurance advocates saw Medicare as the first legislative step toward a single universal national health insurance. When Senator Ted Kennedy, as the crown prince of the Democratic party, took up the banner to advocate for this idea in the late 1960s, most assumed it would be enacted within a short period of time. The Viet Nam War, impeachment politics, and a growing conservative and anti-government strain of public opinion all worked against achieving this goal in the 1970s.¹⁵

In the ensuing decades universal national health insurance has remained an ideal for some, but its decline as a practical goal is illustrated by the almost complete support by social insurance advocates of the Affordable Care Act of 2010. This probably signals the end of the prospect for a single national program to finance all health care.

However, the social insurance advocates policy network continues to strongly promote sustaining Medicare as a public insurance program. There is a regular flow of books and articles that uphold the idea and offer supporting analysis.¹⁶ The National Academy of Social Insurance is a formal organization of scholars and researchers, and their publications represent an effort to strengthen and defend the social insurance principle. Their 1999 report, “Medicare and the American Social Contract” still represents a cogent argument for Medicare as social insurance.¹⁷

The core of the social insurance idea is that a public social insurance program is the best way to provide for the financing of health care. Everyone is part of the same large risk group, which accommodates the large variations in individual yearly expenses incurred. There is a sense that everyone has a stake in the system because the rich and poor, the healthy and sick all share the same insurance program. Current beneficiaries pay part of the cost of the program through premiums and cost sharing, but most of the cost of the program is borne by the working public through payroll and general tax revenue. The working public, who are not yet eligible for the program, but will be at age sixty-five, raises most of the revenue. Thus, it is an intergenerational transfer program with an implied social contract. This generational compact guarantees health insurance coverage upon retirement as the trade-off for contributions to the program during one’s working years through payroll and income tax payments. It is a shared national benefit of citizenship, not a welfare program for the poor. The identical argument on the principle of social insurance has been the core belief of those who support Social Security. In fact the same people often make the arguments.

Social insurance advocates never envisioned a British style National Health Service with the public sector as owner of all health facilities and employer of all employees. Rather the scope of government’s role allows it to maintain an arm’s length relationship with doctors and hospitals as paymaster to private sector health providers. This division between government as collector of Medicare revenue through the taxing power, and payer through a system of administratively determined prices for services has created the largest fault-line in the system.

Judith Feder observed that in the early days of Medicare’s implementation that the mindset of the original administrators was one of fair payment for rendering health services to beneficiaries. Later when costs began to rise more sharply than projected and threatened the sustainability of the program, a series of policies to control spending were enacted and implemented.¹⁸ As early 1967 Herman and Anne Sommers in their book Medicare and the Hospitals: Issues and Prospects raised doubts about the long-term viability of cost-reimbursement as a way to pay hospitals.¹⁹ In less than a decade all social insurance advocates recognized the fatal flaw in cost-based reimbursement, but struggled to find an acceptable alternative.ⁱⁱ

Thus, the social insurance policy paradigm has its origins in the early 20th Century and has been sustained and expanded by succeeding generations of scholars and policy

ⁱⁱ More on ideas around reimbursement will be provided below

research experts. Many elite opinion-makers (journalists, politicians, etc) fully accept and support the paradigm. To the extent that policy paradigms filter down to the general public there remains a sense of Medicare as appropriately a public program, even if all the administrative details are not fully understood.

Rise of Alternative Paradigm: Premium Support

It is Alan Enthoven's fault! Beginning in the late 1970s Enthoven began to argue for what might be called the "Kaiserization" of health finance and organization. He named it "managed competition".²⁰ Enthoven first articulated an idea for organizing health finance that involved market competition, but was an annual competition for consumers who would select an organization to deliver their health services. Employers would assist in subsidizing premium costs, but the individual would select their insurance carrier. The first articulation of this idea was a response to an invitation by President Carter's Secretary of HHS, Joe Califano. This occurred when the Carter Administration was preparing its National Health Insurance proposal. Enthoven's idea was not accepted, but he wrote about it in a New England Journal of Medicine piece among others.²¹

In reality the idea can be traced even further back in time. The Kaiser system of HMOs in California had been a significant part of the health system since soon after WWII, but the model had not significantly expanded elsewhere. CALPERS (the California public employee system and the FEHBP (federal employees system) were examples of broad funding mechanisms in which individuals with a common third-party funding source could select from among competing insurance companies or HMOs. In Enthoven's view these "purchasing cooperatives" would be the marketplace with health providers organizing themselves into units similar to Kaiser HMOs. Beneficiaries would choose among competing Kaiser-like HMOs on the basis of a calculation of price/value. Only part of the cost would be subsidized, providing an incentive to select the HMO that offered the best value for the price.

This idea was partially validated when the Clinton reform proposal used this model as the organizing principle for his comprehensive health reform proposal. From the mid-1980s forward businesses began to be alarmed by the rapidly rising cost of health care. With varying levels of comprehensiveness and enthusiasm many large corporations began supporting HMOs, managed care, and consumer choice. The Clinton plan never left the runway in Congress. But, within a few years a new Medicare policy paradigm had emerged around the idea of managed competition.

Jonathan Oberlander in his insightful book on Medicare chronicles the national consensus that existed around the program from its early days until the political upheavals of the mid-1970s when an alternative paradigm began to emerge as a serious contender for the dominant way to perceive how we as a nation ought to organize the financing of health care for retirees.²² There were several factors that contributed to the end of the Medicare consensus. One was the dire projections of the Medicare Trustees for the sustainability of the program to the end of the 1990s. Thus, Medicare was elevated to an agenda item. In 1995 the new Republican majority in Congress was concerned about the short-term threat of Part A-"bankruptcy", but also raised alarms about the long-term problems with the program when baby boomers began to retire in a little more than a decade. It was hard

to see how the federal budget could be balanced in future years without reducing the trajectory of Medicare spending.

In the preceding decade managed care and use of market competition to reduce health care spending growth had been the mantra for corporations newly worried about the impact of employee health insurance costs. In retrospect it should be no surprise that Republicans in Congress would see this as a viable idea to change Medicare as costs were reduced.

In a 1995 issue of Health Affairs, Medicare policy scholars of various political persuasions weighed in on the how Medicare might be transformed from a social insurance system to one that essentially provides a voucher to Medicare recipients to use in purchasing a private insurance plan. It came to be called a “premium support” approach because the idea envisioned a major subsidy by the Medicare Administration to make the premium affordable.²³

In 1995 the Republican proposal to make this change in Medicare failed to become law when President Clinton choose to let the federal government shut down rather than sign the bill. In this showdown the President ultimately prevailed, although the subsequent compromise legislation created more choice for Medicare recipients under the expanded Medicare +Choice option. A few years later the Bipartisan Commission on the Future of Medicare came one vote short of recommending a premium support system near the end of the Clinton Administration.²⁴

Early in the Bush Administration there were initial attempts to use the pending prescription drug legislation to begin a transformation of Medicare to the premium support approach, but even many Republicans in Congress resisted.²⁵ When Republicans regained control of the House of Representatives in 2010 their alternative budget proposal prominently featured shifting Medicare to a premium support system for those under 55.²⁶ This issue became a prominent piece of the Presidential campaign debate in 2012.

Over the past two decades a comprehensive Medicare policy paradigm has emerged. Let’s call it the Consumer Choice approach. The policy network advocacy coalition supporting this other way of viewing the Medicare program I have elsewhere referred to as Consumer Choice Champions.²⁷

In this alternative belief system Medicare recipients would be better served and the program would be more fiscally sound if the federal government ceased to pay providers on behalf of beneficiaries, and instead provided them with the equivalent of a voucher to cover most of the cost of purchasing a private insurance policy in something like a purchasing exchange to evaluate their options.

They believe this competition would better restrain costs than the Medicare administrative price system, and would allow the Medicare system to be more flexible and adapt to changes in technology and medical practice. Since the financial responsibility of the federal government would be limited to the value of the voucher

each year, it is more likely that the federal government would be able to keep its costs within the range of revenue collected annually.²⁸

Paradigm shift and exercise of power

Beland and Cox argue that ideas are “causal beliefs about social phenomenon.” Clusters of these ideas may constitute a policy paradigm.²⁹ Such paradigms are not just debating society positions, but represent core beliefs of policy process participants.³⁰ For most of the past twenty years these two competing paradigms have formed the intellectual case for either maintaining the Medicare status quo or transforming it.

The argument is unlikely to be settled on its merits. Both sets of protagonists can and do offer cogent arguments for their position. No set of computer models will settle the question of which paradigm offers the best set of ideas for the future. We will discuss below a political analysis of how ideas and the exercise of power intersect in the process of picking winners and losers in a paradigm debate.

Big Idea 2—program sustainability

Will Medicare last another fifty years? In the midst of seemingly incessant media coverage of the latest “Perils of Pauline” budget drama in Washington it is hard to avoid concluding that Medicare is about to fall into a huge policy sinkhole and disappear from sight before tomorrow morning.

This second major policy idea is the persistent sustainability threat that keeps pushing Medicare back on the policy agenda. One needs to have only a passing acquaintanceship with the Medicare policy literature of the past forty years to see the issue of sustainability has been a constant subject of discussion.³¹ For those who wish to argue for major changes in Medicare the threat of insolvency is a handy cry to push Medicare back onto the agenda.

One of the pieces of received wisdom among Medicare aficionados is that the Social Security actuaries in 1965 seriously underestimated how quickly the program would grow and thus abetted a solvency crisis within the first few years of the program that has never disappeared. However, Somers pointed out in his 1967 book that hospital costs had been increasing much faster than the CPI for several years before Medicare was enacted. He indicated the actuarial estimates had attempted to be conservative, but still might not be accurate.³² Robert Myers, the actuary responsible for the estimates, years later pointed out that if one compares actual future expenses as a percent of taxable payroll rather than in dollars the original estimates were not so out of line.³³ The unexpected factor was the strong inflationary trends in both the economy and the health industry that began with the escalation of the Viet Nam war soon after the Medicare enactment.

Nevertheless, it has become a standard assumption that Medicare costs have been “out of control” since the early days of the program. Since the Part A Trust Fund is solely dependent on the payroll tax if health costs are rising faster than growth in the economy,

the projections will mark a line in the sand showing when the fund will have less cash than needed to pay hospitals.

By 1970 the Medicare Trustees were projecting this to happen in two years. In the decades that followed the pattern persisted. Health industry inflation coupled with economic slowdowns resulted in a threat to the solvency of the Part A Trust Fund. Each time the doomsday approached Congress would take some action, increasing revenue or reducing reimbursements, to alter the projection trajectory. By 1975 the Trustees saw a twenty-year solvency. The pattern persisted.

Patashnik and Zelizer argue that the Trust Fund structure of Medicare was a conscious attempt to assure cost restraint was a constant program goal with an automatic elevation to the policy agenda when program expenditures began to outrace inflation.³⁴ Whether intentional or not, the consequence has been to elevate potential insolvency to an idea that has become an essential characteristic of the program.

Richard Forster and Kent Clemens of the office of the CMS Actuary have usefully stated that the financial status of the Medicare Trust Funds is a fairly straightforward calculation. Likewise, the impact of Medicare on the federal budget can be determined without much disagreement. Sustainability, on the other hand, poses the question of whether or not the program will meet its substantive goals in a fiscally acceptable manner. This is a political judgment about success at what cost.³⁵

In the debate over sustainability there has frequently been a presumption that the Part A Trust Fund structure is immutable, program spending trends will never change, or that new sources of revenue can never be considered. The Medicare Actuary, and Congressional Budget Office are the official sources of financial projections. They utilize standard sets of rules as the basis for their projections. The statute requires the Medicare Trustees to publish long-term projections, but Joseph White has critiqued the use of these estimates as a basis for policy-making. He argued that use of projections of current policy over decades into the future distorts current assessment of program options because there are too many variables in which small shifts can lead to very different conclusions. White contends the long-term estimates bias policymakers toward comprehensive and radical program change. In his view regular incremental change and adjustment has and will produce a better outcome.³⁶

The sustainability policy idea plays out in several ways. First is the question of Part A Trust Fund solvency. The Trustees annually project current revenue and expenditure trends for the Hospital Insurance Trust Fund and after accounting for the existing surplus estimate when the Fund will no longer have sufficient revenue to pay for all services. The most recent projection is for insolvency in 2024.³⁷

The CBO annually projects anticipated federal revenues and expenditures over the next ten years. This budget projection looks at Medicare spending as a whole without a focus on the individual trust funds or program components. In particular the CBO projections focus on Medicare spending as a share of the total federal budget. There are tables produced that show projections beyond ten years, but they reflect the same uncertainty problems White has cited. The CBO projects federal health spending in both adjusted

dollars and as a percent of GDP. The most recent estimate is that for 2012 Medicare spending will be 3.7% of GDP. Their twenty-five year projection is for this to rise to 6% by 2037.³⁸ As a share of total federal spending Medicare was 15.1% in 2010 and will increase to 17% by the end of the decade.³⁹ The CBO analysts recognize the fragile nature of these projections but are limited by the neutral constraints of the agency protocols.

The sustainability idea plays out in the policy arena when participants seek to use the projections to support policy change that would move the projections downward. If for example, Congress passed legislation this year that stated those over age eighty would no longer be eligible for Medicare, this would immediately have a very positive impact on the Medicare spending projections. Medicare would be seen as sustainable for decades. This “saving” does not render it a good policy. There is zero chance such legislation will pass, but other less radical proposals have been seriously proposed.

Despite assumptions that may create anomalies, the Trustee and CBO projections represent the official statements of the long-term program health. Even with recognized flaws, they are the standard starting point for discussion of Medicare’s future. In the policy debate, the interpretation of the impact of spending growth diverges widely.⁴⁰

Sustainability is in the eye of the beholder.

At what share of GDP is Medicare no longer sustainable?

How much of a Medicare share of total federal spending is too much to sustain?

Should the Medicare program be radically changed to make it sustainable for the next several decades?

Will incremental program changes limit the growth of program spending sufficiently to render it sustainable for the next several decades?

Are there likely changes in the practice of medicine and treatment technology that will impact the sustainability of Medicare spending trends?

These types of questions are at the center of the discussions about the idea of Medicare sustainability.

Big Idea 3- Cost Containment strategy

“Every Dollar of Health Expenditure is a Dollar of Someone’s Income”--Robert Evans

In that short sentence Robert Evans, the Canadian health economist, has nailed the essence of the health cost problem. The third of our three big policy ideas is cost containment strategy. Much time, energy, and intellectual effort has been devoted to seeking viable cost containment strategies than any other element of Medicare policy. The books and papers written on the subject since 1967 would fill a good-sized room floor to ceiling.

Of course, no one seriously argues that Medicare costs will remain stable year after year, but they have risen faster than general inflation in the economy since the program began. And so have health care costs in general. During the history of the program Medicare expenses have sometimes risen faster than health costs as a whole, and other times not. Because of Medicare's huge role in the total system, they are likely to track fairly close.

Medicare and general health costs have both usually been higher than the increase in GDP or the CPI, although they were very close in past two years.⁴¹ What follows is not a chronological development of attempts to control Medicare costs, but rather the identification of six distinct strategies that have either been used or seriously discussed at multiple times since the Medicare cost issues first emerged in the late 1960s. Today Medicare represents 20% of total health expenses, 15% of the federal budget, and 3.6% of GDP. Together inpatient/outpatient hospital, physician/clinical payments represent about three-quarters of Medicare spending, and are thus the primary focus of cost reduction strategies. Even small changes reducing the trajectory of Medicare spending could make a significant impact in the years ahead.

A. Global Budgeting

Most public agencies are funded by a global budget. The local police department receives a fixed appropriation per year from the City Council. They use this money to pay police officers, run a dispatching system, and buy police cars. It is the task of the Chief to allocate the budget to be able to meet the service demands. The budget does not depend on how many bank robbers were apprehended, or how many murders occurred. For many years one of the major health finance reform ideas was to follow in general the global budget model that existed in Great Britain and later at the provincial level in Canada. Hospitals would receive an annual budget and just like the police chief would be expected to provide all necessary services with the funds.

Because Medicare never represented more than fraction of the to flow of funds into the health system for hospitals, this was never a serious idea for Medicare alone. But, in the national health reform discussions of the late 60s and 70s, this idea remained a centerpiece of the discussion for social insurance reformers. The tag "single-payer system" was given to this approach. Those 1970s proposals for comprehensive National Health Insurance proposed folding Medicare into a single comprehensive plan that covered all citizens.⁴² It harkened back to the original Franklin Roosevelt era idea that the new Social Security system would include coverage for health care.

The August 2009 issue of the Journal of Health Politics, Policy, and Law was devoted to a series of articles on the single-payer system idea.⁴³ This demonstrated that the idea has not disappeared. Social insurance reformers continue to see this as the "gold standard" approach to cost containment and often cite the much low level of expenditure in Great Britain and the much slower trajectory of expenditure growth in Canada since they adopted national health insurance with a single payer system at the provincial level.⁴⁴

Since this was never under active discussion as a policy idea for Medicare alone, we conclude by stating that it applies as a Medicare cost containment strategy only if Medicare is expanded to include all or most of the population.

B. Supply restrictions

The intellectual foundation for capital expenditure regulation is found in the 1959 articulation of Roemer's Law. Roemer postulated that an excess supply of hospital beds in a region leads to greater utilization. As far back as the 1930s some in the hospital industry called for state regulation to control the tendency of hospitals to overbuild. In the 1950s civic leaders instituted planning processes in an attempt to determine the ideal number of hospital beds for the community. The New York Legislature in 1964 established the first state Certificate of Need Program (CON). Any new hospital construction needed to be reviewed by a regional planning agency, and approved ultimately by the state Public Health Department. The new construction would not be licensed as a hospital without an approved certificate showing the need. No institution could build or expand without first receiving a certificate of need.

Congress in 1968 established a grant program to assist regions in establishing health-planning agencies. In states with CON laws, Comprehensive Health Planning Agencies (CHP) did the local review of hospital capital projects. Later in the mid-1970s Congress replaced CHPs with Health Systems Agencies (HSA). Under this 1974 health planning law each regional was to have a planning agency and review capital projects. States were to establish CON agencies, but in the interim, failure to gain HSA approval would result in reduced Medicare/Medicaid reimbursement for services provided in the new facilities. The Section 1122 provision of the Social Security Amendments of 1972 allowed the Secretary to withhold a portion of Medicare capital expenditure reimbursement from a facility that was constructed without compliance with local plans.

During the 1970s most states and regions adopted a comprehensive planning process, including CON legislation. The results were mixed. Powerful local institutions were often able to gain approval for their projects, even if they did not meet the guidelines. Planning agencies also wrestled with how to regulate new technology, such as CT scanners.⁴⁵ The CON process seemed more successful at controlling the entry of new institutions (especially for-profit hospitals) into the market.

The Carter Administration sought to have what amounted to a national CON program administered by the HSAs with regional limit or cap on the amount of capital spending. Institutions would need to compete for limited health care capital dollars. Congress did not approve this proposal. The Reagan Administration shifted the emphasis in health policy toward market-oriented approaches and ended federal support for HSAs and the regional planning process. CON has survived in a number of states, but it has not been a key part of the national cost containment strategy for thirty years.

For more than a decade capital expenditure regulation to control the supply of beds and expensive new equipment was seen as a critical component of a Medicare cost containment strategy. In part the idea became discredited as a result of a growing perception that it had not been successful. The nature of the process was such that local institutions were usually successful at pressuring planning agencies to approve their

projects. The Carter proposal would have treated it more as a budget process with a regional limit per year, but Congress did not accept this idea. Finally, the enactment of the Prospective Payment System and the ultimate inclusion of capital expenditures as part of the standard payment cause capital expenditure decisions for institutions focus on the basic economics of the use institutional funds for the project. A few states have continued to operate aggressive CON programs and others have programs with limited effect and scope. It is hard to find recent research that even examines the relationship between supply and cost, or resurrect the idea that control of the supply of hospital beds or major equipment will have significant impact on cost. One exception is the Dartmouth Project. A recent publication describing their analysis of geographic differences in Medicare costs stated:

.....in regions where there are more hospital beds per capita, patients will be more likely to be admitted to the hospital—and Medicare will spend more on hospital care. In regions where there are more intensive care unit beds, more patients will be cared for in the ICU—and Medicare will spend more on ICU care. And the more CT scanners are available, the more CT scans patients will receive. Conversely, in regions where there are relatively fewer medical resources, patients get less care—and Medicare spends less. So geography becomes destiny for Medicare patients.⁴⁶

Thus, the supply regulation idea as a strategy for cost containment has not completely disappeared, but one finds very little active policy debate over how to contain Medicare costs by supply limitations.

C. System consolidation

Another Medicare provision of the Social Security Amendments of 1972 allowed HMOs to be reimbursed on a percapita basis for services rendered to Medicare recipients. The idea of system consolidation that brought physicians and hospitals into the same organizational unit had been discussed for decades. Citing especially the Kaiser-Permanente experience in California, advocates argued that bringing together into one organizational unit physicians and the inpatient hospital would lead to cost savings in three important ways. First, by pre-payment financing the provider incentive to overuse inherent in the fee for service system would be eliminated. Second, making both physician and hospital part of the same organizational structure would enhance the coordination of services. Third, with prepayment there would be an incentive for the HMO (both physicians and the hospital) to provide preventive services and thus avoid costly unnecessary hospitalization.

Paul Ellwood in 1971 coined the phrase Health Maintenance Organization (HMO). As the debater over National Health Insurance accelerated both reform proponents and those who wished to see a more market oriented approach to health finance supported expansion of HMOs. For social insurance reformers who were seeking NHI legislation HMOs represented an organizational reform that promised better care at lower costs. Plus the prepaid element made it a perfect vehicle for the budget approach that was an essential element of the major NHI proposals. For those who preferred a more market model to the major public sector expansion approach that had been the essence of the

NHI proposals, the HMO offered a novel way to think about organization and finance without the obvious cost control problems of the pure fee for service market.⁴⁷

National health insurance was not adopted, but Congress enacted legislation that provided grants to accelerate the development of HMOs. They became eligible for Medicare reimbursement on a capitated basis in the Social Security Amendments of 1972,

In the 1980s and 1990s the HMO expanded in use both among those insured in the workplace and Medicare recipients. There were some cost savings, but not as extensive as originally anticipated. The other side of cost savings also appeared in the form of complaints about inadequate care as HMOs sought to restrain cost with stringent utilization controls. Most states now have regulations that require some type of appeal process for HMO denial of service complaints.⁴⁸

The managed care backlash of the late 1990s caused HMOs to appear less of a defensible cost control idea. By the end of the 1990s it was a lot harder to find examples of advocacy of HMOs as a means to control costs. In the mid-1990s debate over premium support Medicare Advantage was created as a private plan alternative to traditional Medicare. This was a continuation and broadening of the trend toward the use of Medicare payments to private plans as an option of recipients. This was first authorized in Social Security Amendments of 1972 and expanded in the Balanced Budget Act of 1997 with the creation of Medicare + Choice. In 2003 the further expansion led to another renaming, Medicare Advantage.

Premium support advocates argued that the market competition among plans (many of which were HMOs) would result in significant cost savings for the Medicare program. Thus, the HMO integrated model remained a significant cost control strategy, even if use of the HMO name had tended to disappear.

The current iteration of the consolidation idea comes in the form of Accountable Care Organizations (ACO). The Affordable Care Act of 2010 (ACA) includes significant provisions for pushing the use of ACOs with bundled payments as ways of improving the quality of care and simultaneously reducing the rate of growth of Medicare expenses. A 2006 article in *Health Affairs* by Elliott Fisher and colleagues is credited as the first example of the use of the term “Accountable Care Organization” in the literature.⁴⁹ This was followed by a series of articles on this strategy for controlling Medicare expenses.⁵⁰

The idea emerged at the right time. The term and the idea became Section 3022 of the Affordable Care Act of 2010. Under this provision physician groups and hospitals linked by common patients are encouraged to form Accountable Care Organizations (ACO), which will coordinate care and receive bundled payments. When quality maintenance can be demonstrated, they will share in Medicare savings. Unlike HMOs, the ACAs will not be at risk except they will not receive a savings bonus if their effort does not lead to reduced expenses.

The concept continues the long fascination among health policy scholars and administrators to find a way to bring hospitals and physicians into the same organizational unit. The premise is that when they are part of one bureaucracy with a

single Medicare payment stream there will be much more powerful incentives to avoid overutilization. The shared savings creates an incentive for both physicians and administrators to seek cost-effective treatment systems. The required quality measures and the absence of a mandate for patients to seek care within the ACO protect patients against cost savings achieved at the expense of the best care.

The ACO idea has not been the subject of hostile criticism in the same way as other provisions of the ACA, such as the individual mandate. This may be due to less visibility or because the idea is to provide financial incentives without stringent provider regulation or mandates on consumers. There are critics of ACOs, who argue the concept will flounder during implementation because it has inherent contradictions and the medical system culture will make the desired cooperation impossible outside of limited experiments that are in essence special cases.⁵¹ At the moment use of ACOs offers the most significant new idea to control the long-term control of Medicare costs. Even ardent supporters concede it will be several years before the impact of ACOs can be verified.⁵²

D. Administered payments

Hospital Payments

Medicare has proved to be both a lasting program and a popular one. Thus, we sometimes forget that its passage in 1965 was not assured. One of the key pieces in the negotiations between the Administration, the Congress, and interest groups had to do with how doctors and hospitals would be paid.⁵³ These discussions took place over the years leading up to final passage. The issue was sometimes framed in terms of government control, but it was also about money. Hospitals in particular did not want to commit to a system in which the ebb and flow of annual budgets squeezed their anticipated large new revenue stream from Medicare. The Social Security Administration was responsible for the development of the legislation and negotiation with Congress. They were not oblivious to cost issues, but the first priority was passage and successful implementation of Medicare to provide financial coverage for the vulnerable retired population.⁵⁴

The initial idea for reimbursing hospitals and doctors fit this need for accommodation. Hospitals were to be paid for costs incurred. Medicare patients received services and the bill was sent to the Social Security Administration. In order to further assure Congress and the providers the government was going to use fiscal intermediaries (especially Blue Cross) to serve as a buffer between the government and the providers. Thus, government control over the delivery of health services would be minimized under this system. Physicians were to be paid on the basis of their “reasonable and customary” fees, and hospitals on their actual cost to deliver the medical services.

The initial estimates of total program cost were soon exceeded because of both general and medical inflation and increased intensity of services provided. The first attempt to modify the original cost based reimbursement was to tinker with the cost based method. Section 223 of the Social Security Amendments of 1972 authorized program administrators to distinguish between routine and ancillary costs. Routine costs were

seen as the “hotel” costs of hospitalization and needed to be “reasonable”. This led to further manipulation of cost reports by hospitals.⁵⁵

Section 222 of the SSA of 1972 did authorize payment experiments, and this ultimately led to changes in the way Medicare paid providers, especially hospitals. A 1974 article in Inquiry by Dowling first raised the idea of a prospective payment system.⁵⁶ This represented a new conceptual approach to paying hospitals, but retained the fee for services rendered element. Thus, it continued to represent use of an administratively determined payment, although this began to recognize in law what had been obvious for several years, payments could not be based solely on what hospitals determined to be their cost to provide services to Medicare patients.

Following Dowling’s model, a group from Yale developed a methodology for determining the fee that utilized Diagnostic Related Groups (DRGs) to determine an average set of hospital costs associated with treatment of a patient with a set of medical problems associated with that DRG. This prospectively determined payment was annually adjusted. The size of the adjustment was based on the appropriate inflation determination of an independent commission and approved by Congress. The annual adjustment was a mechanism to control the growth of Medicare hospital costs.

Years later the first chairman of the Prospective Payment Assessment Commission, Stuart Altman, reflected that savings on hospital spending did occur, but slowly and with lower savings than had been hoped for because of the complexity of the enterprise and ability of hospitals to adjust practices to the new system.⁵⁷

The politics surrounding 1983 enactment of the Prospective Payment System (PPS) were unique and benefitted from a contemporary crisis in the Social Security system as well as a broad concern that rising Medicare hospital costs required a different method of payment.⁵⁸ The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) represented the final rejection of cost based reimbursement for hospitals. It extended limits on payments to ancillary as well as hotel costs and put a cap on future growth of Medicare reimbursement for hospitals.⁵⁹ Thus the idea of cost-based reimbursement had come to be seen as untenable. By the time the Medicare TEFRA provisions were passed it was clear to everyone that a new and permanent system was needed. TEFRA was not that system, but was rather the signal to the industry that cost-based reimbursement was over.

The prospective payment system based on cost per DRG was an idea that had been under development and refinement for a decade. The New Jersey Public Health Department had received a Medicare waiver to experiment with this idea at the state level. When the Reagan Administration wanted to move quickly to institute a permanent system to replace the TEFRA rules, the PPS/DRG idea appeared to be the best available solution. The New Jersey experiment, although short-lived, showed it was feasible. Even at that point some in the Reagan Administration preferred moving in a market approach rather than use of an administrative fee schedule. PPS was an idea ready to fast track to implementation with the likelihood of cost control success in a few years.⁶⁰

Physician Payment

Physician fees have proven to be a greater payment dilemma. The Medicare “customary, prevailing, and reasonable fees” principle for physician reimbursement was to linger for several additional years. Similar to initial hospital reimbursement, physicians were reimbursed by Medicare based on their usual fees. In 1965 this fee-for-service approach was both the only politically feasible method for paying doctors, and the only way consistent with the dominant organizational arrangements. Few physicians who would be treating Medicare patients worked for a salary, and capitation payments would at best have been only used for primary care. With capitation there can be both the perception and the real danger of inadequate levels of service. There was no alternative policy idea to physician reimbursement on the fee-for-service principle. Milton Roemer in a 1962 article described fee-for-service, capitation, and salary as the basic alternatives for paying physicians.⁶¹ Fifty years later these three remain the choices.⁶²

The initial Medicare fee-for-service system was the physician equivalent of cost-based hospital payments. This approach was also inherently inflationary. Congress in 1972 put a limit on annual growth of physician fees as a first attempt to halt high growth in physician costs.⁶³ A decade later with physician fees rising more rapidly than hospital costs Congress put a temporary freeze on physician fees.

The next step in the attempt to reform physician payment was the creation of the Physician Payment Review Commission (PPRC) to study new ways to pay physicians and report to Congress. They utilized the research of Harvard economist William Hsiao, who analyzed the value of physician services based on the resources used.⁶⁴ This work led the PPRC to recommend to Congress a Medicare physician fee schedule based on a resource determined relative value scale.

The problem had been twofold. Aggregate physician costs were rising much faster than growth in the economy, and there was an obvious distortion in the differences in fees paid for various types of services. This was causing unintended volume escalation in those services in which the fees were “overvalued”. The Omnibus Budget Reconciliation Act of 1989 established the new Medicare physician fee schedule to begin in 1992. In addition to the fee schedule, the problem of service volume was addressed by the adoption of Volume Performance Standards (VPS). This was a response to the likelihood of increases in volume of services because of restrictions in the growth of fees. The VPS approach would limit fee updates based on maintaining total Medicare physician spending within an established target.⁶⁵ The law also restricted the extent to which physicians could charge patients fees above what Medicare would pay.

In 1997 Balanced Budget Act (BBA-97) Congress modified the VPS to use per capita growth in the GDP as the target for aggregate physician growth. It was called the Sustainable Growth Rate (SGR) formula. When the previous year’s growth in Medicare physician fees exceeded the target, fees would be reduced in the following year.⁶⁶ This began to occur in 2002. In 2003 Congress ignored the SGR provision and provided a small fee increase. This pattern continued in subsequent years. However, the SGR formula itself was never repealed or changed. Under the budget scoring rules of the CBO, eliminating the SGR formula would add hundreds of billions of dollars to the projected

federal deficit, because future Medicare physician fees would need to be calculated on a more realistic basis.

In 2013 the lingering impact of the SRG formula has come to be one of the dominant Medicare issues on the policy agenda. This has become a debacle with everyone now recognizing that the annual “Doc Fix” has been a prominent example of kicking the can down the road with what has become a difficult budget issue. Today a good question is “why did anyone really think the volume penalty idea was really going to work?”

William Glaser has written extensively on physician payment both here and in Europe. He initially expressed reservations about the feasibility of expenditure caps and targets; especially ones set unilaterally by the government and applied across the board.⁶⁷ In the late 1980s there were a number of international examples of the use of expenditure targets to control the volume of services used with a fee schedule. Canada and Germany were often cited examples.⁶⁸ The perceived success of this approach elsewhere, and the absence of viable competing ideas led to the VPS and later its SGR modification.

Administered payments today

By the 1980s Congress, health policy scholars, and the journalistic community were all part of a consensus that Medicare payment policies in the 1970s had contributed to rapidly growing costs because both hospitals and doctors were able to set their own fees. Short term freezing of payments to the level of the previous year was at temporary fix at best. Bundling hospital payments around an episode of care with a formula based on average payments per DRG proved to be a successful model. Once the political stage for hospital payment reform was set and idea gained broad acceptance in the policy community, the passage and implementation moved rather quickly. A mechanism for regular updates was put in place with an independent commission recommending annual updates and other adjustments basis on professional analysis. Congress ultimately makes the updates, but the Commission recommendation is the basis for that decision.

As we noted above, there are new policy ideas, especially for system reorganization (see above) to further control the rate of growth of costs, but there are not ideas under active discussion for a major overhaul of the way hospitals are paid. There are constant discussions in MedPac and the literature about hospital payment policy adjustment. One cannot dismiss the aggregate impact of these small changes over time, but there is little current discussion about major change in the fundamental way that Medicare pays hospitals within the context of the PPS system of administered payment formula.

On the other hand the problems with the SRG part of the physician payment system has created a payment crisis for both physicians and the government. In the late 1980s a consensus developed around a new methodology to pay physicians. Early in the Reagan Administration some consideration was given to a major shift in the way physicians would be paid by Medicare. Both a precompetitive (privatization approach) or capitation were favored by some in the Administration, but neither were very well developed ideas. There was no prospect for any short-term savings from such a major change.⁶⁹ There was also little prospect that Congressional Democrats would support such a different approach. Thus the retention of a fee-for-serve methodology with the fees set

administratively, rather than by physicians themselves, became an acceptable policy idea to address the problem. This was combined with an attempt at volume control that is now widely regarded as a major failure. For a decade failure to deal with the consequences of the SRG debacle has continued to exacerbate the problem.

Ideas for Medicare physician payment reform

With the question of how Medicare ought to pay physicians high on the policy agenda because of the broad recognition that the current system is broken and needs fixing, there are several policy ideas under active discussion.

The policy ideas for reform of Medicare physician payments come in three types: SRG fixes, bundled payments, and shifts away from a fee schedule to some form of capitation. The latter two are accompanied by technical measures that attempt to reward quality outcomes in the reimbursement process.

Potential SRG fixes are one of the policy topics high on the agenda of policymakers and analysts because everyone across the policy spectrum recognizes the serious Medicare physician reimbursement and budget problems created by SRG and the continued failure to address them.

The “doc fix” budget problem directly flows from the way the CBO has scored what has become the annual override adjustment to the SRG. When VPS and then SRG were enacted it was correctly understood that a fee schedule only creates common payments for defined services. It does not control volume. There is a real problem with volume abuse. In essence the SRG became not a mechanism for control of volume of services, but a budget smoke and mirror scoring mechanism that hid for years the real long-term budget costs of the annual fee adjustments. The fees needed adjustment to avoid too large a gap between Medicare and private payers. Congress was unwilling to either pay for the increases or find a new way to address volume. The proposed solutions all try to minimize the long-term price tag with fundamentally changing physician reimbursement.⁷⁰

The VPS/SRG model assumed that aggregate limits on total physician spending with a downward adjusting of fees for breaking limit would moderate the behavior of individual physicians. The problem with the logic was that an individual physician could not exercise any control of the aggregate behavior of all colleagues. Increasing volume to make-up for declining fees was the way to game the system. This was exactly the opposite of the intent of VPS/SRG.

More physicians are gravitating toward salary compensation, and there has been policy idea flirtation with again looking at some form of capitation. Ginsburg in a recent article reminds the policy community that fee-for-service is likely to be the basis for most Medicare physician reimbursement in the foreseeable future. He is skeptical that forms of capitation, such as bundled payments, medical homes, or accountable care organizations will broadly displace fee-for-service anytime soon.⁷¹

Two former Medicare administrators were recently pessimistic about an easy solution. Bruce Vladeck suggested that only by putting more money in the system for physician fees could be solved without created inequity or public/private fee distortion.⁷² Gail Wilensky saw a rather intractable problem with expansion of bundled payments and closer scrutiny of outliers as the best solutions.⁷³ This is not to criticize them for lack of imagination, but to illustrate the paucity of policy ideas about how to pay physicians fairly and still retain control of aggregate Medicare physician costs.

E. Use of private insurance plans

As noted above, an important subset of the health policy community has fostered an alternative policy paradigm that rejects the argument for tinkering with the administrative payment system as the best strategy for containing costs. The Consumer Choice Champions favor a radical change in the structure of Medicare. They contend that ending traditional fee-for-service Medicare and replacing it with a system of vouchers to purchase private insurance is the only way costs will be controlled.⁷⁴

As early as 1970, the Brookings annual assessment of the federal budget indicated that the Nixon Administration was considering encouraging the use of pre-payment plans to control Medicare costs.⁷⁵ At the beginning of the Reagan Administration there was already a vigorous policy debate over the merits of a market based health system (including Medicare) as opposed to a more significant role for government in utilizing more regulation and administered price reimbursement to control costs.⁷⁶ In the mid-1990s Republicans gained a Congressional majority and in a series of confrontations with the Clinton Administration sought to legislate major Medicare changes with a precompetitive approach.⁷⁷ Despite the legislative failure by Congressional Republicans to shift Medicare to a premium support system during the Clinton Administration, efforts to push for this alternative policy idea have continued to this day.

There are two arguments that seek to demonstrate how the use of private insurance plans will restrain the long-range growth of Medicare expenditures. The first is simple and almost self-evident. If Medicare is moved from a defined benefit to a defined contribution system of vouchers to purchase a private plan, the federal government will be able to cap its annual financial responsibility by limiting the growth of the voucher. The federal budget would be spared rapid growth by shifting additional costs to beneficiaries. Whether or not this would be good public policy has been and continues to be the subject of intense political debate.

What is more relevant here is the disputed contention that extensive or exclusive use of private insurance plans would lower Medicare costs because market force negotiations over service and payment is superior to an administered price system for paying hospitals and physicians. This is the policy idea addressed here.

After the 1972 Social Security Amendments Medicare paid health plans (usually HMOs) a fixed price per year to provide comprehensive services at least as good (and often more inclusive) as that found in traditional Medicare. This was further expanded by actions in the BBA-97 and 2003 Medicare Modernization Act of 2003, which enhanced the expansion of the private insurance plan option in Medicare. Today 27% of all Medicare

recipients are in Medicare Advantage. Since the payments to Medicare Advantage plans are benchmarked against regional fee-for-service costs, it is not possible to draw a definitive conclusion from the current data about whether or not private plans are more cost-effective than Medicare fee-for-service.⁷⁸ MedPac has estimated that recent Medicare Advantage costs are higher than they would have been had the recipients been in traditional Medicare.⁷⁹ This is unlikely to convince proponents of premium support, who argue that an entirely redesigned system will produce lower costs.

Actual proposals for expanding private plans in Medicare have usually projected implementation ten years or more into the future. Policy change would therefore only impact those at least a decade from retirement. The most radical of these proposals would entirely eliminate traditional Medicare. Others would retain it as one of the choices, but Medicare funding would depend on a competitive bid process.⁸⁰ Inherent in all of the premium support proposals is a belief that private insurance companies in a competitive environment will be better able to foster innovation in the delivery of care and create reimbursement policies that will not provide incentives to overuse or unnecessary tests/procedures.⁸¹

Those opposed to moving away from traditional Medicare have pointed to historically lower Medicare costs compared to private insurance,⁸² greater projected costs for beneficiaries in various analyses of premium support plans,⁸³ and the growing body of evidence that concentration of providers and insurance plans weakens market power to constrain reimbursement costs.⁸⁴

The dueling numbers are not going to decide the issue. Each policy paradigm camp regularly produces analytic papers supporting their position and debunking the opposition. This philosophic debate over a policy idea is not going to be resolved by a better econometric model or a more elegantly designed analytic study. There have been some suggestions for a compromise. Judith Feder and her colleagues at the Urban Institute have suggested that a better (and quicker) way to introduce the benefits of competition into Medicare would be a strengthening the competitive opportunities of Medicare Advantage by ending overpayments, and at the same time implement great cost savings in Medicare.⁸⁵

F. All-Payer rate setting

The cost containment strategy literature is replete with suggestions that Medicare pays too much or too little compared to private insurance companies. For decades there have been complaints about cost shifting from Medicare to private pay patients. This is a basis for some to call for a single-payer system, which was the original strategy for those who sought universal health insurance under Social Security. To most observers this seems to be politically unacceptable, or at least an idea that would generate such controversy that policy entrepreneurs are dissuaded from even suggesting the concept.

However, in the last few years there have been several voices urging a new consideration of the idea of an all-payer approach.⁸⁶ The major long-term example of this payment method is found in Maryland. In the 1970s they obtained a waiver to include Medicare as they established an all-payer rate setting commission for hospital payments.⁸⁷ The

evidence of success is not universally accepted, but it is nevertheless a model. Also this approach has been utilized in other places, notably in Japan,⁸⁸ and Germany.⁸⁹

In 1992 Ginsberg and Thorpe made the case of an All-Payer system rate setting system that used the emerging PPS and RBVS methodology would offer an opportunity for cost control without the type of single payer system that was still favored by many. They perceived this as accommodating competition among insurance plans and HMOs because rates could still be negotiated below the established payment standards.⁹⁰

Ewe Reinhardt in 2010 argued for an All-Payer system to level the playing field since weaker payers were absorbing a disproportionate share of the total costs of services. His model looked to the negotiated approach of Germany, rather than PPS/RBVS, as the best approach to determine the appropriate common rate for services.⁹¹ Joseph White in his All-Payer proposal pointed out that the system must be and perceived to be fair to both buyer and sellers of medical care. Rates should cover the cost of providing necessary services, reflect geographic differences, and be subject to regular adjustment.⁹²

One of the central arguments of those who have advocated an All-Payer cost containment strategy is that it is necessary to end the complaints of unfairness from providers who claim that Medicare does not pay either hospitals or physicians for the real costs of providing services. Therefore, they need to receive payments from private insurance plans, which are excess of real costs to provide quality services. Because a point of argument is constantly made does not make it true. Advocates contend that an All-Payer system would be inherently fair because everyone would receive the same payment for providing the same service.

The All-Payer idea in practice, in places such as Germany, has been built around a process of negotiation between payers and provider groups, such as associations representing doctors and hospitals. In a large diverse health system environment such as the United States, it is hard to conceptualize how such a negotiated system would work in practice without some definitive body to resolve disputes. A set of administrative payments, such as the PPS system, could be applied to all payers. In fact some health plans use a modified form of Medicare payment as a basis for their negotiations with providers. However, expanding the role of a MedPac type commission to set national all-payer rates is hard to envision. Each state could have a commission to set rates, such as Maryland uses for hospitals⁹³, but some policy scholars have argued that Maryland has not been able to control total health costs in the state any better than comparable states.⁹⁴

The All-Payer idea has continued to receive consideration as a path toward lowering total health costs. However, from the perspective of Medicare cost containment, it is unlikely that the all-payer rates for hospitals and physicians would in the end be any less than current payments. Thus, such a system may modify the overall cost curve, but probably will not significantly reduce Medicare's share.

Conclusion-- Medicare Ideas and Policy Making: The Decade Ahead

Even a casual observer of Medicare policy may observe that many additional policy ideas have not been addressed here. Many currently argue that the age of Medicare eligibility, 65, ought to be increased to 67 or even 70 to reflect increased longevity over the last five decades. From the very beginning the Medicare benefit structure has been inadequate. Most beneficiaries need to purchase supplemental insurance to protect themselves against high deductibles and co-insurance, as well as catastrophic costs. Long-term institutional care is not covered for the chronically ill Medicare beneficiary. Each of these and other elements of Medicare could have been explored as well.

The central policy paradigm, program sustainability, and cost containment strategies were selected as the major policy ideas floating around the Medicare program today. The three are intertwined. Whether or not one accepts the central policy paradigm or not, tends to be the prism through which one views sustainability and cost containment. The need and viability of benefit expansion depends on a perspective about sustainability of the current program, and whether a cost containment strategy is likely to be successful.

The Congressional Budget Office projection of the future Medicare costs for the federal budget is a critical part of the view of the debt, deficit, and state of federal government finances for the next two decades. This places Medicare at the center of current and future policy discussions of the federal government finances.

The policy ideas discussed are likely to frame the discussion for several years to come. Even if Medicare per recipient costs grow no faster than the CPI over the next two decades, program costs will rise because the babyboom generation has already begun to retire, and this will increase the absolute number of Medicare recipients in a significant way.

The average voter may not frame their opinions about Medicare in terms of competing policy paradigms, but most are likely to align with either the dominant view of Medicare as a social insurance program, or see a competitive system as superior. Policy elites and opinion makers have for years been viewing Medicare as either an essential system of social insurance, or one that ought to be transformed into a market-based system. As Feder and Rivlin have independently suggested, a political compromise might be possible among partisans on each side.⁹⁵

For this to happen the major participants in the policy process must come to the conclusion that Medicare is more sustainable and more likely to adopt a successful cost control strategy with a compromise approach. Otherwise the political forces in what Kingdon called the political stream⁹⁶ will each seek to develop a majority coalition that supports its view of the future of the program.

If the Congressional majorities and the President in 2015 and beyond, find the social insurance policy paradigm the best way to view Medicare, we might expect one type of policy path, with a view to sustainability and cost containment consistent with that policy

paradigm. On the other hand, if the President and Congressional majorities in 2016 and beyond come to understand Medicare as Consumer Choice Champions, this will lead to very different approaches to sustain Medicare and contain the growth of program costs. Many of the ideas likely to be at the center of the debate over the next decade are not new. Most have been studied and debated for decades in one form or another. Majority coalition shifts, not new ideas are likely to be the decisive element in Medicare over the next fifty years.

If policy entrepreneurs are able to refashion existing policy ideas in ways that social insurance advocates and consumer choice champions find acceptable, a window of opportunity may exist in the next few years to strengthen Medicare for the next fifty years.

Notes

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- ¹ John Kingdon, Agendas, Alternatives, and Public Policies, Second Edition, (New York: Harper-Collins, 1995), p.116
- ² Daniel Beland and Robert Cox, "Ideas, Power, and Policy Paradigms: From Globalization to Sustainability," A Paper prepared for presentation at the Annual Meeting of the American Political Science Association, Washington DC, September 3, 2010, p. 4
- ³ Silke Adam and Hanspeter Kriesi, "The Network Approach," in Paul A. Sabatier, ed, Theories of the Policy Process, 2nd edition, (Cambridge: Westview Press, 2007, pp. 142-3.
- ⁴ Steven Nye, Messy Issues, Policy Conflict and the Differentiated Polity: Analysing Contemporary Policy Responses to Complex, Uncertain and Transversal Policy Problems, Universitetet i Bergen, 2006, p 18
- ⁵ Peter Hall, "Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain," Comparative Politics, April, 1993, p 279
- ⁶ Kingdon, op cit. p.125
- ⁷ Thomas Kuhn, The Structure of Scientific Revolutions, (Chicago: University of Chicago Press, 1962).; Hall, op.cit. Daniel Beland, "Ideas and Social Policy: An Institutionalist Perspective," Social Policy & Administration, Vol 39 No 1, February 2005, pp. 1-18; Kingdon, op.cit.
- ⁸ Paul Sabatier, "Policy Change over a Decade or More," in Paul A. Sabatier and Hank Jenkins-Smith (ed) Policy Change and Learning: An Advocacy Approach, (Bolder: Westview Press, 1993), p.15.
- ⁹ Kingdon, op.cit. 72
- ¹⁰ Hall, op. cit. Beland, op. cit.
- ¹¹ Theodore Marmor, The Politics of Medicare, (Chicago: Aldine Publishing, 1970)
- ¹² Marmor, op. cit.
- ¹³ retrieved from Social Security Online, Chapter 4: The Fourth Round-1957 to 1965
<http://www.ssa.gov/history/corningchap4.html>
- ¹⁴ James M. Brasfield, Health Policy: The Decade Ahead, (Boulder: Lynne Rienner Publishers, 2011), Chapter 7.
- ¹⁵ For example see, Rick Mayes, Universal Coverage: The Elusive Quest for National Health Insurance,(Ann Arbor: University of Michigan Press, 2001) and Jill Quadagno, One Nation, Uninsured: Why the US has NO National Health Insurance, (New York: Oxford U Press, 2005)
- ¹⁶ Judy Feder, Paul Van de Water, and Henry Aaron, "The Case Against Premium Support" Brookings Institution, December 2011; Theodore Marmor, Jonathan Oberlander, and Joseph White, " Medicare and the Federal Budget: Misdiagnosed Problems, Inadequate Solutions," Journal of Policy Analysis and Management, Vol 30 NO 4, 2011, pp. 927-46.
- ¹⁷ Final Report of the Study Panel on Medicare's Larger Social Role, "Medicare and the American Social Contract", NASI, February 1999.
http://www.nasi.org/sites/default/files/research/med_report_soc_contract.pdf
- ¹⁸ Rick Mayes and Robert Berenson, Medicare Prospective Payment and the Shaping of US Health Care, (Baltimore: Johns Hopkins University Press, 2006, Chapter 1.
- ¹⁹ Herman Sommers and Anne Sommers, Medicare and the Hospitals: Issues and Prospects, Washington: Brookings Institution Press, 1967, p155.
- ²⁰ Alain Enthoven, "The History and Principles of Managed Competition," Health Affairs Supplement 1993, pp. 24-48.
- ²¹ Alain Enthoven, "Consumer-Choice Health Plan. "A National Health Insurance proposal based on regulated competition in the private sector". NEJM March 23 and March 30,, 1978, No 12 pp. 650-658 and No 13, pp709-20.
- ²²Jonathan Oberlander, The Political Life of Medicare, (Chicago: University of Chicago Press, 2003), especially Chapter 7.
- ²³ "Medicare and Market Change" Health Affairs, Winter 1995 Vol 14, no 4.
- ²⁴ Oberlander, op. cit, p. 183-9
- ²⁵ Thomas Oliver, Philip Lee and Helene Lipton, " A Political History of Medicare and Prescription Drug Coverage," Milbank Quarterly, Vol 82 No 2, pp. 283-354.

²⁶ Alex Roarty, “House GOP Confident on Paul Ryan’s Medicare Plan,” National Journal, March 11, 2013.; “Understanding Rep Ryan’s Plan for Medicare”, Kaiser Health News, April 4, 2011. <http://www.kaiserhealthnews.org/stories/2011/april/05/ryan-plan-for-medicare-vouchers-vs-premium-support.aspx>

²⁷ Brasfield, Ibid.

²⁸ see for example, Joseph Antos, “Premium Support Proposals for Medicare Reform,” Testimony before the House Committee on Ways and Means, Subcommittee on Health, April 27, 2012.

²⁹ Beland-Cox, op. cit.

³⁰ Sabbatier, op. cit.

³¹ Patricia A. Davis, “Medicare: History of Insolvency” Congressional Research Service, June 11, 2012.

³² Sommers, op. cit p. 243

³³ Robert Myers, “How bad were the original actuarial estimates for Medicare’s hospital insurance program?” The Actuary, February 1994, p. 6.

³⁴ Eric Patashnik and Julian Zelizer, “Paying for Medicare: Benefits, Budgets, and Wilbur Mills’s Policy Legacy”, Journal of Health Politics, Policy, and Law, Vol 26 No 1, February 2001, p. 7-36.

³⁵ Richard Foster and Kent Clemens, “Medicare Financial Status, Budget Impact, and Sustainability—Which Concept is Which?” Health Care Financing Review, Winter 2005-06 Vol 27 Number 2, p. 134.

³⁶ Joseph White, “Uses and Abuses of Long-Term Medicare Cost Estimates,” Health Affairs, January-February 1999. Pp 63-79.

³⁷ Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, April, 2012, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2012.pdf>, and Sabiha Zainulbhai and Lee Goldberg, “Medicare Finance: Findings of the 2012 Trustees Report”, NASI, April 2012.

³⁸ Congressional Budget Office, The 2012 Long-Term Budget Outlook, June 2012, Chapter 3.

³⁹ Lee Goldberg and Sabiha Zainulbhai and, “Is Medicare Solvent and Sustainable,” NASI, October 2012 and “Health Care Spending Trends, NASI October 2012

⁴⁰ Goldberg-Zainulbhai, Ibid. ; Joseph Antos, “Medicare’s Fiscal Crisis and Options for Reform, American Enterprise Institute for Public Policy Research, April 30, 2012. <http://www.aei.org/article/health/healthcare-reform/medicares-fiscal-crisis-and-options-for-reform/> ; Paul Van de Water, “Medicare is not “Bankrupt”: Health Reform Has Improved Program’s Financing,” Center for Budget and Policy Priorities, April 24, 2012.

⁴¹ Mitch Hartman, et al , “US Health Spending in 2011: Overall Growth Remains Low, But Some Payers and Services Show Signs of Acceleration,” Health Affairs, 32(1) January 2013, pp. 87-98

⁴² Karen Davis, National Health Insurance: Benefits, Costs, and Consequences, (Washington: Brookings Institution, 1975.

⁴³ Journal of Health Politics, Policy and Law,

⁴⁴ see website of Physicians for a National Health Program, <http://www.pnhp.org> ; David U. Himmelstein and Steffie Woolhandler, Single-payer health care would save billions for Massachusetts. Boston Globe, June 1., 2012.; Single Payer: A Conversation with David Himmelstein and Steffie Woolhandler, Health Care Cost Monitor, The Hastings Center, Health Care Cost Monitor, August 27, 2009. <http://healthcarecostmonitor.thehastingscenter.org/admin/rss-to-pdf/makepdf.php?feed=http://healthcarecostmonitor.thehastingscenter.org/admin/single-payer-a-conversation-with-david-himmelstein-and-steffie-woolhandler/%3Ffeed%3Drss2%26withoutcomments%3D1&order=desc&submit=Create+PDF>

⁴⁵ James M. Brasfield "Health Planning Reform: A Proposal for the Eighties", Journal of Health Politics Policy and Law (Winter 1982), p. 718-38

⁴⁶ “Health Care Spending, Quality, and Outcomes,” A Dartmouth Atlas Project Topic Brief, The Dartmouth Institute for Health Policy and Clinical Practice, February 27, 2009., p. 2

⁴⁷ Lawrence Brown, Politics and Health Care Organization: HMOs as Federal Policy, (Washington: Brookings Institution Press, 1983)

- ⁴⁸ Steven Balla, "Markets, Governments, and HMO Development in the 1990s," Journal of Health Politics, Policy, and Law, Vol 24 No 2, April, 1999.
- ⁴⁹ Elliott Fisher, et al, "Creating Accountable Care Organizations: The Extended Hospital Medical Staff", Health Affairs, December 5, 2006.; Elliott Fisher, et al, "Fostering Accountable Care: Moving Forward in Medicare", Health Affairs Web Exclusive, January 27, 2009.
<http://content.healthaffairs.org/content/28/2/w219.full.html>
- ⁵⁰ see for example, Elliott Fisher, et al, "A Framework for Evaluating The Formation, Implementation, and Performance of Accountable Care Organizations, Health Affairs, Vol 31 No 11, November, 2012, pp. 2368-78.; American Hospital Association Committee on Research, Accountable Care Organizations: AHA Research Synthesis Report, The American Hospital Association, June 2010; Mark Shields, et al, "A Model for Integrating Independent Physicians into Accountable Care Organizations", Health Affairs, Vol 30 No 1, January, 2011, pp 161-72.
- ⁵¹ Clayton Christensen, et al, "The Coming Failure of Accountable Care", Wall Street Journal, February 18, 2013, <http://online.wsj.com/article/SB10001424127887324880504578296902005944398.html> ; Gail Wilensky, "Lessons from the Physician Group Practice Demonstration: A Sobering Reflection," NEJM, 365:18, November 3, 2011, pp. 1659-61.
- ⁵² Fisher, et al, "A Framework for Evaluating The Formation, Implementation, and Performance of Accountable Care Organizations, op. cit.
- ⁵³ see Marmor, op. cit. and Oberlander, op. cit.
- ⁵⁴ Judith Feder, "Medicare Implementation and the Policy Process," Journal of Health Politics, Policy, and Law. Vol 2 pp. 173-90, Summer, 1977.
- ⁵⁵ Mayes-Berenson, op.cit, p. 20.
- ⁵⁶ William L. Dowling Inquiry Vol. 11, No. 3 (September 1974), pp. 163-180
- ⁵⁷ Stuart Altman, "The Lessons of Medicare's Prospective Payment System Show That The Bundled Payment Program Faces Challenges," Health Affairs, Vol 31 No 9, September, 2012. Pp.1923-31.
- ⁵⁸ David G. Smith, Paying for Medicare: The Politics of Reform, (Hawthorne NY: Aldine de Gruyer, 1992), and Mayes-Berenson, op cit.; Rick Mayes, "The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System, Journal of the History of Medicine and Allied Sciences, Vol 62 No 3, January 2007, pp 21-55.
- ⁵⁹ Mayes-Berenson, op.cit, pp. 38- 9
- ⁶⁰ Smith, op.cit and Mayes-Berenson, op. cit.
- ⁶¹ Milton Roemer, "On Paying the Doctor and the Implications of Different Methods," Journal of Health and Human Behavior, Vol 3 No 1 (Spring, 1962), pp. 4-14.
- ⁶² Cyanne Demchak, "Physician Payment: Is There a Better way to Pay? Robert Wood Johnson Foundation Findings Brief, Vol X No 5, May, 2007.
- ⁶³ Mayes-Berenson, op. cit. p. 82
- ⁶⁴ W. Hsiao and W. Stason, "Toward Developing a Relative Value Scale for Medical and Surgical Services," Health Care Financing Review, Fall, 1979, pp. 23-38; W. Hsiao, et al, "Results and Policy Implications of the Resource-Based Relative Value Scale Study," NEJM, September 29, 1988, pp. 881-8.; Paul Ginsburg, "Physician Payment Policy in the 101st Congress, Health Affairs, Spring, 1989, pp. 5-20.
- ⁶⁵ Paul Ginsburg, et al. "Medicare Physician Payment Reform," Health Affairs, Spring 1990, pp. 178-88.
- ⁶⁶ "Medicare Payments to Physicians," Health Affairs Health Policy Brief, February 13, 2013.
- ⁶⁷ William Glazer, The Politics of Paying American Physicians, Health Affairs, Fall 1989, pp.129-46
- ⁶⁸ Klaus-Dirk Henke, et al, "Global Budgeting in Germany: Lessons for the United States," Health Affairs, Fall, 1994, pp. 7-21.; Jonathan Lomas, et al., "Paying Physicians in Canada: Minding Our Ps and Qs," Health Affairs, Spring, 1989. Pp. 80-102.
- ⁶⁹ Smith, op cit. Chapter 5.
- ⁷⁰ "Medicare Payments to Physicians," op.cit.
- ⁷¹ Paul Ginsburg, "Fee-For-Service Will Remain A Feature of Major Payment Reforms, Requiring More Changes in Medicare Physician Payment." Health Affairs, Vol 31 No 9, pp. 1977-83.
- ⁷² Bruce Vladeck, "Fixing Medicare's Physician Payment System," NEJM 362:21 May 27, 2010, pp. 1955-7
- ⁷³ Gail Wilensky, "Reforming Medicare's Physician Payment System," NEJM, 360:7, February 12, 2009, pp.653-5.

⁷⁴ Joseph Antos, et al, “Bending the Cost Curve through Market-Based Incentives, *NEJM*, 367:10, September 6, 2012, pp. 954-8; Stuart Butler, “Six Key Elements of Medicare Premium Support Proposals,” Heritage Foundation, February 7, 2012.

⁷⁵ Charles Schultze, *Setting National Priorities: The 1971 Budget*, (Washington: Brookings Institution, 1970), p.73.

⁷⁶ Paul Ginsburg, “Medicare Vouchers and the Procompetition Strategy,” *Health Affairs*, Vol 1 No 1, 1981, pp. 39-52; David Stockman, “Premises for a Medical Marketplace: A Neoconservative’s Vision of How To Transform the Health System,” *Health Affairs*, Vol 1 No 1, 1981, pp. 5-18.

⁷⁷ Smith, op. cit and Oberlander, op.cit.

⁷⁸ GAO, “Medicare Advantage: Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments,” January, 2013. GAO-13-206; Margot Sanger-Katz, “Quick Take: GAO Report Shows Government Overpays for Medicare Advantage”, *National Journal*, January 26, 2012.

⁷⁹ see Judith Feder, et al, “ Why Premium Support? Restructure Medicare Advantage, Not Medicare,” Urban Institute, September 2012, and MedPac, Report to the Congress: Medicare Payment Policy, March, 2012. Chap 12.

⁸⁰ Kaiser Commission on Medicaid and the Uninsured, “Comparison of Medicare Premium Support Proposals,” op. cit.

“Comparison of Premium Support Proposals,” July 20, 2012. <http://www.kff.org/medicare/8284.cfm>

⁸¹ Alice Rivlin, A Bipartisan Approach to Reforming Medicare, “ Testimony Before the House Ways and Means Subcommittee on Health, April 27, 2012. ; Antos, “Premium Support Proposals for Medicare Reform”, op.cit.; James Capretta, “The Advantages of Reforming Medicare with Premium Support,” Brookings Institution, Paper as part of Premium Support: A Primer, December, 2011. ;

⁸² see Feder, et.al. op cit.

⁸³ Gretchen Jacobson, et al, “Transforming Medicare into a Premium Support System: Implications for Beneficiary Premiums,” Kaiser Family Foundation, October, 2012

⁸⁴ James Robinson, More Evidence of the Association Between Hospital Market Concentration and Higher Prices and Profits,” National Institute for Health Care Management, November 2011.; Martin Gaynor and Robert Town,” The Impact of hospital consolidation—Update”, The Robert Wood Johnson Foundation, June 2012.

⁸⁵ Feder et al, op. cit

⁸⁶ Uwe Reinhardt,” The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for A More Rational All-Payer System?” *Health Affairs*, Vol 30 No 11, November, 2011, pp. 2125-33. Joseph White, “Cost Control and Health Care Reform: The Case for All Payer Regulation,” Campaign for America’s Future, May 22, 2009, <http://www.ourfuture.org/healthcare/white>

⁸⁷ Robert Murray, “Setting Hospital Rates To Control Costs and Boost Quality: The Maryland Experience,” *Health Affairs*, Vol 28 No 5, September-October, 2009.

⁸⁸ Naoki Ikegami and Gerard Anderson, “In Japan, All-Payer Rate Setting Under Tight Government Control Has Proved to Be an Effective Approach to Containing Costs,” The Commonwealth Fund, May 7, 2012

⁸⁹ Cathy Schoen, et al, “Harnessing Health Care Markets for the Public Interest: Insights for U.S. Health Reform from the German and Dutch Multipayer Systems,” Commonwealth Fund & Academy Health, December 2009. www.academyhealth.org/files/publications/AH_CMWFInternationalLessons.pdf.pdf

⁹⁰ Paul Ginsburg and Kenneth Thorpe , “Can All-Payer Rate Setting and The Competitive Strategy Coexist?,” *Health Affairs*, Summer, 1992, pp. 73-86.

⁹¹ Reinhardt, op.cit.

⁹² White, op.cit.

⁹³ “Equalizing Health Provider Rates” National Conference of State Legislatures, June 2010.

⁹⁴ Mark Pauly and Robert Town, “Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency,” Journal of Health Politics, Policy, and Law, Vol 37 No 4, August, 2012, pp. 697-707.

⁹⁵ Kingdon, op. cit. Chapter 7

⁹⁶ Feder, et al, op.cit; Alice Rivlin, “A Bipartisan Approach to Reforming Medicare,”op.cit.