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Review of Reforming Medicare: Options, Tradeoffs, and Opportunities

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I Health, Education, and Welfare

Reforming Medicare: Options, Tradeoffs, and Opportunities. By Henry J. Aaron and Jeanne M. Lambrew. With Patrick F. Healey. A Century Foundation Book. Washington, D.C.: Brookings Institution Press, 2008. Pp. xi, 202. \$28.95. ISBN 978-0-8157-0124-8.

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Medicare needs fixing. The program has its strengths; it is popular among beneficiaries, has very low administrative costs (maybe too low), and, since its inception, has greatly reduced financial risk exposure among beneficiaries. Nevertheless, it is unaffordable and inefficient. Jeanne Lambrew and Henry Aaron take up both of these challenges for Medicare reform in great detail in *Reforming Medicare*.

Even for well-seasoned readers of the annual health spending accounts, Aaron and Lambrew's table of projected Medicare spending registers quite a shock (table 3-4, p. 45). Because predicting cost growth for health care seventy years out is a fool's errand, albeit a legally mandated one, one should not worry too much about the longest range estimates. The more reliable, near term estimates, however, look exceptionally grim. Assuming that the only source of cost growth is from changes in the number and demographics of Medicare beneficiaries related to the inclusion of the baby boomers—an unrealistically low rate of growth—Medicare spending will account for 3.9

percent of GDP by 2020 (compared to 3.1 percent in 2007). Using CBO projections that assume a *reduction* in physician payments by about 5 percent annually through 2016, a reduction that seems implausible given Congress' inability to make such reductions stick in the past, Medicare spending will be 4.7 percent of GDP by 2020. If these numbers are not sufficiently dramatic to rouse the reader, consider that “[b]etween 2008 and 2018, Medicare’s share of non-interest federal spending is expected to rise from 14.8 to 17.1 percent” (p. 9).

This level of spending may very well be worth it (David M. Cutler 2004), but funding must be found somewhere. Medicare’s Hospital Insurance Trust Fund will spend more than it collects in 2009 and, according to its Trustees, is once again on its way to insolvency (Trustees of the Social Security and Medicare trust funds 2009). Congress’ response to the Trustee’s even gloomier predictions in 1996 and 1997, when the reports predicted insolvency in only four or five years, was to cut waste, focusing on fraud-ridden home health care billings.

Addressing widespread inefficiencies in Medicare, and American medicine more generally, is a part of the right strategy. Aaron and Lambrew survey the many sources of quality deficiencies in the health care system: (1) outdated treatment, (2) overuse, underuse, and misuse, (3) low value spending, (4) iatrogenic injury, and (5) dramatic geographic variation in spending (p. 33, et seq.). While policymakers have recently embraced reductions in small area spending variation as the magic health reform bullet, Aaron and Lambrew offer a more restrained analysis. In page after detailed page, they demonstrate the difficulty of translating research into quality improvements and cost savings, making clear that no single policy response will solve our problems (see, e.g., p. 42).

In the heart of the book, Aaron and Lambrew outline three possible reforms: strengthening Medicare as a social insurance system, premium support, and consumer-directed Medicare. They argue that although each has its strengths and weaknesses, the first—which is based on the notion that beneficiaries are entitled to the same, defined benefits—is the most promising. This view turns out to have been prescient.

With President Obama's election, the recent and widespread loss of faith in fully private market solutions, and a Congress eager for reform, the remaining two policy prescriptions are probably off the table for Medicare. Aaron and Lambrew's analysis of the remaining two options is nonetheless still useful; even if they are not viable as public sector reforms for now, they remain models for private sector reform. Employers, therefore, may wish to consult *Reforming Medicare* before following Whole Foods' example of addressing selection and unsustainable premium growth by offering its employees only one plan. The grocery chain offers a health savings account coupled with Whole Food's paying the entire premium for a high-deductible, catastrophic coverage plan.

Reforming Medicare is essential reading for anyone who wants to understand the background of the current health care reform urgency. It is an excellent and current primer for policymakers, benefits managers, students, and scholars. Because the authors are central players on the Democratic policy stage, the book is also a window into the thinking and analysis that have gone into the current health care reform effort. Nevertheless, *Reforming Medicare* should not be read alone.

The major obstacle to reform has not been that policymakers (or stakeholders, or even voters) cannot reason through the strengths and weaknesses or the economic effects of various reform proposals. They can, and they do. Decades of previous attempts have failed not only because health care is complex, but also because of the "limitations of our political system and the power of the interest groups—doctors, hospitals, insurers, drug companies, researchers, and even patient advocates—that have a direct stake in it" (Tom Daschle 2008, p. xiii). It is the political economy of health reform, not only the technical policy prescriptions, that desperately needs our attention. Fortunately, Lambrew addresses these issues in another, albeit less scholarly, book on health reform that she published last year—*Critical: What We Can Do about the Health-Care Crisis*, by Senator Tom Daschle with Scott Greenberger and Lambrew.

All reforms have winners and losers, and those parties are paying more attention to the technical details of health policy than almost all other

Americans. This has been true since the start of Medicare, and has continued to make it difficult for Congress to base its decisions on the best scientific evidence regarding cost or medical effectiveness. Organized patient-group advocacy was key to the process that led Congress to grant Medicare coverage to anyone diagnosed with end-stage renal disease (ESRD), regardless of age and despite the fact that ESRD was not a uniquely expensive or deadly disease at the time (Marilyn Moon 1993). Physician groups have successfully lobbied Congress to override Medicare's Sustainable Growth Rate (SGR), the target rate of growth in spending on physician services, every year since it was passed in 1997 based on the argument that the formula is flawed.

More recently, there has been widespread industry opposition to using comparative effectiveness studies in making coverage determinations. Congress overcame opposition to provisions in the stimulus bill that would fund new comparative effectiveness research, but attempts at broadening the role of such research in the health system will be opposed by advocates who worry that it will be used to restrict Medicare coverage decisions (Jerry Avorn 2009). Similarly, the Centers for Medicare and Medicaid, which may only approve new treatments within benefit categories (Congress must approve all new benefit categories) and must cover treatments that are "reasonable and necessary" for diagnosis and treatment, has faced strong protest from patient, provider, and industry groups when they have tried to limit payment for high-cost treatments of uncertain benefit, such as anti-anemia bio-pharmaceuticals and off-label use of colorectal cancer chemotherapies (Patricia Seliger Keenan, Peter J. Neumann, and Kathryn A. Phillips 2006).

These examples illustrate why it is critical that, in this round of health reform, health policy scholars consider not only lessons from health economics but also lessons from political economy. (They will play out dramatically if the tax status of health insurance, once seen as sacrosanct, remains on the reform table as it seems to be now).

In addition, *Critical* is a nice place to continue where *Reforming Medicare* leaves off, placing Medicare in the context of overall health reform. As Aaron and Lambrew conclude:

Medicare, though important, accounts for less than a quarter of personal health care spending. *Systemic reforms in the U.S. health care system would do far more to control Medicare spending than any reform in the program alone.* Policies such as promulgating an evidence-based benefit design, steering patients toward high-value services, and reorienting payment policy toward the prevention of acute and chronic disease have the potential to curtail spending across the population, not just among the elderly. *Systemwide health reform is the best way to make Medicare economically sustainable and enable it to provide beneficiaries with high-quality and affordable health care.* (p. 137, emphasis added)

Medicare faces many of the same problems as health insurance for the rest of the population, including variation in treatment and quality, reimbursement linked to individual services rather than episodes of illness, and fragmentation among doctors and payment systems. Since “[s]ome of Medicare’s quality shortcomings are endemic to the U.S. Health system,” proposals to reform Medicare may apply to the entire health care system (p. 116).

But as Aaron and Lambrew note, Medicare does not operate in a vacuum. Medicare policy affects health care for the nonelderly, and health policy for the nonelderly affects Medicare. The very enactment of Medicare, for example, had enormous spillover effects on the American health care system. Amy Finkelstein (2007) has estimated that the implementation of Medicare caused six times more hospital spending than what similar increases in individual insurance take-up, rather than through a public program, would have predicted. The generosity of the Medicare benefit package directly affects the size and characteristics of the retiree population seeking health insurance from their former employers and through the private Medigap insurance market.

Similarly, health policy developments outside of the program also affect Medicare. The HMO Act of 1973, coupled with ERISA in 1974, paved the way for the growth of HMOs within the employer-financed health insurance sector that, eventually in 1997, led to the introduction of

Medicare managed care through the introduction of Medicare Part C (aka “Medicare+Choice,” now known as “Medicare Advantage”). A new and large group of retirees leaving the private work force, where virtually no one gets fee-for-service medicine, will bring with them their expectations that they must ask for permission before using health care resources, even if they despise doing so. Experience with such techniques among new beneficiaries will likely make care management reforms in Medicare more politically palatable.

Reforming Medicare offers a subtle analysis of Medicare’s problems and the trade-offs among three major approaches to addressing them. As a briefing book for a policy analyst, teaching tool, or reference, the book has great strengths, including its analysis of new programs like Medicare Part D. We need answers to questions Aaron and Lambrew address, such as “What gets covered?,” “How should we decide?,” “How much will it cost?,” and “Who pays?” But we also need to know what those decisions mean for the distribution of health and wealth. Only then can we understand, and engage, the interests that will support or oppose reform. Fortunately, in addition to *Reforming Medicare*, Lambrew provides another source to begin the political economy inquiry.

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