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Medicare Whac-A-Mole

Why health care price controls always fail

By Peter Suderman **From the January 2012 issue**

House Republicans, you may have heard, are trying to "end Medicare as we know it." And well they should—Medicare as we know it is the nation's biggest fiscal disaster. For years members of Congress and the executive branch have been trying, and failing, to find ways to restrain the growth of government health spending on seniors. Medicare is a $500 billion program on track to become a $1 trillion program before hitting insolvency in 2024, even under the rosiest projections. The program looms as a threat not only to itself but to the budgetary health of the nation. It is the single largest driver of long-term federal debt.

Despite the potential campaign effectiveness of the political charge that Republicans want to gut Medicare, President Barack Obama has positioned himself as a willing butcher of his own party's sacred cow. "We have to tackle entitlements" to control the federal debt, the president said in June, and "Medicare has to bear a greater part of the burden." Over the summer, Obama signed a debt deal with Republicans that allowed for a 2 percent cut to Medicare spending should a bipartisan deficit committee fail to come up with savings. In September he endorsed $248 billion in Medicare cuts as part of his own debt reduction proposal.

The cuts Obama proposed were not part of a fundamental Medicare overhaul, but they were cuts all the same. "Despite what some in my own party have argued," he said, "I believe that we need to make some modest adjustments to programs like Medicare to ensure that they're still around for future generations." Obama claimed he was open to reforms that would bring down the cost of Medicare, "not by shifting those costs to seniors but rather by actually reducing those costs."

"Actually reducing" the cost of Medicare has long represented the biggest pot of gold at the end of the public policy rainbow. It is treasure that Obama has been promising to deliver since early in his presidency. "If we do nothing to slow these skyrocketing costs," he said in 2009, "we will eventually be spending more on Medicare and Medicaid than every other government program combined. Put simply, our health care problem is our deficit problem. Nothing else even comes close.…We know we must reform this system. The question is how."

So what innovative solution does Obama propose to begin fixing America's biggest fiscal problem? Simple: He would change the way providers are paid for Medicare's services. Pay less, spend less. Right? It is so obvious that one might wonder why it hasn't been tried before. The answer is that it has—many, many times.

It is often said that you can't put a price on health. But for decades that is exactly what the federal government has attempted. Since the birth of the entitlement, a parade of legislators and bureaucrats has been playing billion- and trillion-dollar games of Whac-A-Mole with Medicare, knocking down spending with an elaborately constructed set of technocratic payment schemes in one area only to see it rise back up in some other part of the system. Obama is merely proposing to try it one more time.

All-You-Can-Eat Health Care

When Medicare, the federally run health care financing system for Americans who are 65 or older, passed in 1965, supporters knew the program would be expensive. Its lack of cost controls was the price of passage. Wilbur Cohen, a top health bureaucrat dubbed "The Man Who Built Medicare" by *Medical World News*, admitted that "the sponsors of Medicare, including myself, had to concede in 1965 that there would be no real controls over hospitals and physicians. I was required to promise before the final vote in the executive session of the House Ways and Means Committee that the federal agency would exercise no control."

Indeed, that promise was explicitly built into the legislation, which declared that "nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided…or to exercise any supervision or control over the administration or operation of any such [health-care] institution, agency, or person." In other words, no rationing, no death panels. As Richmond University political scientist Rick Mayes explained in a 2007 essay for the *Journal of the History of Medicine*, Medicare was inaugurated with "a reimbursement system that neither imposed limits nor required outside approval." As a result, "unrestricted cost reimbursement became the *modus operandi* for financing American medical care."

Even then, the program's supporters grossly underestimated how expensive the program would be. The House Ways and Means Committee projected that 95 percent of the elderly would enroll in the program's doctor insurance component during 1967, its first year of operation. That estimate proved accurate. But the committee also projected that total costs for the first year would run no more than $1.3 billion. Total spending in the first year instead ran a whopping $4.6 billion.

As the program continued, its true costs rapidly departed even further from initial expectations. The committee had projected that hospital spending would amount to just $3.1 billion in 1970. Instead it was $7.1 billion. Hospital spending in 1975, initially expected to be around $4.2 billion, was actually $15.6 billion. The estimates were off because they didn't account for the increase in demand spurred by the program's offer of essentially unlimited benefits.

This was a new problem for America. "Prior to Medicare,"explains John Goodman, president of the National Center for Policy Analysis and a frequent contributor to the health policy journa l*Health Affairs*, "we maintained a system that took up a reasonable percentage of the national income," holding more or less steady at 5 percent of GDP. But after Medicare, he says, the country "began to have health inflation that has never quit."

Coincidence? Not at all. Medicare was a major contributor to the problem. For beneficiaries, it transformed the health care system into a generously subsidized, all-you-can-eat buffet. For

providers, it offered a steady revenue stream that they used to rapidly build out expensive new services. In 2007 MIT economist Amy Finkelstein published a paper estimating that the introduction of Medicare accounted for a 23 percent increase in total hospital expenditures between 1965 and 1970, with an even larger effect in the subsequent five years.

Part of the problem was that the program served up its smorgasbord all at once. On July 1, 1966—Medicare's very first day of operation—19 million individuals were instantly eligible for its benefits. Not one of them had ever paid a dime to directly support the program, but they collected full benefits anyway. That situation was at odds with the way the program had been sold, which was not as an entitlement but as a government-managed savings mechanism. When President John F. Kennedy outlined his original vision of the program, he declared, "We're not asking for anybody to hand this out—we are asking for a chance for the people who will receive the benefit to earn their way." In reality, when the program began, it was pure handout.

Seniors got the medical benefits, but doctors got the money. The payment system offered doctors and hospitals essentially unrestricted payments. Providers invoiced their expenses, and the government paid. The system gave doctors and hospitals both license and incentive to spend—and spend and spend and spend. Which is exactly what they did.