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On the Issues

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Hitting the Snooze Button on Our Medicare Fiscal Alarm Clocks

By Thomas P. Miller

In a recent speech, AEI resident fellow Thomas P. Miller tackled the topic of what to do about Medicare. He argues that presidential candidates, policymakers, and the public do not yet want to deal with its fundamental problems. Until they do, he says, we need incremental action on many fronts to get better results for the money we will continue to spend in the traditional Medicare program.

The periodic ritual of announcing the mounting size of the fiscal problem posed by Medicare has never been, and will never be, enough to generate productive reform. Most of us got the memo that we are overcommitted and underfunded. Merely pointing to the size of the problem—in terms of Medicare's massive unfunded long-term liabilities, near-term budget imbalances, future rates of taxation that will be needed to sustain the program, or Medicare's preemption of national resources that crowds out funding for other important public programs and private activities—has had little effect.

There is no shortage of reform ideas and proposals that are interesting and potentially promising, though difficult to prove workable while they stay on the policy shelves. The issue is that our political officeholders and even those portions of the voting public that are at least partly aware of the problems do not really want to deal with them—at least not until the more visible consequences of what some of us rail against actually become tangible, immediate, and inescapable. At that point, most of the remaining options to fix the program will be even more unpleasant than the ones we resist or avoid today, and it will be time to load into an inadequate supply of political life rafts.

We need to get started as soon as possible on many fronts, in ways that may not seem transformative but still would be somewhat useful today. What we do not need is another round of "national conversations." (Remember how well that worked for Social Security reform?) We need much more than modest budget process changes that make it slightly more difficult to once again avert our eyes from what we would rather leave until another day. And there will not be enough rich seniors around—particularly after our revenue-hungry tax and budget system gets through with them in the coming decades—to income-relate Medicare's budget into a significantly better balance. We have squandered decades of time that would have made the transition to deep, lasting, sustainable reform less wrenching and difficult.

The noble appeal to current Medicare beneficiaries and those positioned soon to swell their ranks to think about the burdens they are imposing on future generations has fallen on deaf ears. Their response has been, "What have future generations ever done for me? I'm ready for what was promised to me, including the upgrades since I started participating as a working taxpayer or dependent years ago."

Thomas P. Miller is a resident fellow at AEI. This article is adapted from his remarks at the "Medicare: Drifting Towards Disaster" forum in Washington, D.C., on April 29, 2008.

There are no cleverly designed political strategies to transform our political system into embracing action on what it should have started doing a long time ago. Note the deafening silence on the part of the various presidential campaigns this year regarding substantial Medicare reform, even as they highlight what they think are the most important health care problems to be addressed.

I am, however, optimistic for three basic reasons that in the long run Medicare, our health care system, and our fiscal balance sheets will improve.

First, they have to, because we will eventually run out of money. For a while, I thought that was the Bush administration's secret strategy behind the Medicare Part D expansion, but it stumbled into executing the early years of the new program somewhat less expensively than expected. The meter is still running, however.

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Second, we have already tried most of the wrong or illusory solutions to Medicare's long-term problems. There may be a few more of those left, but it is getting harder to avoid accidentally pulling out the overlooked effective ones still waiting at the bottom of the political barrel. If only through random error by policymakers, combined with bounded irrationality in our political system, the odds ultimately favor improved reform efforts.

Third, at the end of the day, most Americans will grow increasingly dissatisfied with an expensive health care system, led by Medicare, that not only does not deliver enough value for money, but also falls short of rising expectations year after year. The winning arguments for change will involve how to get better health outcomes at lower costs in the near term, as Medicare increasingly delivers far too much of the opposite.

Buying Time

Even though it might be grander to imagine a sudden groundswell of support for transformational change of our health care entitlement programs, I would start in sizing up the remaining options more realistically. Medicare is not a blank sheet of paper. Too much history, politics, interest-group cross pressure, multigenerational reliance, sunk costs, and transition complexity exist in the cluttered and unlevel playing field of health care for the elderly. It is never just about the math. Emotions, security needs, perceptions of fairness, and shifting expectations and capabilities all interact with Medicare and the rest of the health care system.

We can, however, get started—more likely by around 2011—by beginning to move in the right direction structurally. That means cutting in proper sequence the color-coded wires leading to the time bomb we have constructed. First, we need to modify and counteract past mistakes and then level the field of subsidized coverage and health care reimbursement for a modified restart, which opens the door wider to choice, competition, and dynamic evolution toward health care options that are better, but far from perfect.

There are three generic solutions to Medicare's fiscal sustainability problems, although they are not bioequivalent: lower its costs (pay less to providers, cover fewer benefits, and leave more expenses to beneficiaries); increase the program's income (higher taxes, higher beneficiary premiums); and improve Medicare's efficiency (better value in terms of lower all-in-costs for treating and managing particular episodes of care to produce a desired level of health outcomes).

We should do as much as we can on the efficiency front, but our politics, the underlying fiscal math, and the calendar mean all three types of solutions will be needed. Even if we close the gap between Medicare's costs and its benefits, a more attractive and efficient program will stimulate greater demand for its services and remain difficult to finance within current program parameters. As long as we are likely to keep spending a lot more money than is sustainable, we should at least start getting something better for it. All of the remaining policy pathways to progress in Medicare reform remain insufficient by themselves, but they still make necessary contributions to filling some of the hole instead of digging a deeper one.

We have to reduce demands on Medicare. This mostly involves identifying and implementing earlier and smarter interventions to reduce health care problems and lower cost trends. Beneficiaries would get sicker later, get sick less frequently, and stay in costly chronic health status for shorter periods of time. Some of the tools here involve enhanced, but more targeted, benefits (preventive care, more customized drugs, cost-effective technology) and more effective case management, care

coordination, and information therapy (the timely prescription and availability of evidence-based health information to meet individuals' specific needs and support their engagement in sound decision-making). If we could target populations at risk more effectively, the potential high-cost cases would be caught earlier, while low-cost beneficiaries would be left alone. It would be even more helpful, however, if the components of the health care system that deal with everyone below age sixty-five delivered a healthier population into Medicare when they first become eligible.

We should reward efficiency gains in the delivery of care that provide much more intelligent and targeted pay-for-performance incentives (focused on health outcomes), squeeze out high-cost/low-value extremes of care delivery by medical providers, reduce its geographic variation, converge medical practice toward more efficient health delivery models, and measure and make more transparent the relative performance of accountable health care providers. We need to discover better value and the real costs of care through competitive bidding mechanisms, tiered cost-sharing tied to value at the point of purchase and decision-making by consumers, and better differentiated private plan options. We also must develop new delivery systems that focus on a life cycle of care and reward a broader array of health-enhancing investments.

And when reducing demand and rewarding efficiency nevertheless come up short of what our economy can and will hand over to the Medicare program, the less satisfying but necessary tools of fiscal triage must prioritize and target public spending on the basis of medical and income need, combined with the greatest opportunities for improvement in the value of care delivered and received.

A decade or two ago, prefunding our Medicare promises to younger and future generations might have offered a promising, though challenging, alternative policy path. But today, that will not work. Too much time has elapsed to pull off that difficult transition, given the changing demographics of the current and future cohorts of Medicare beneficiaries and working taxpayers. A modified version of the traditional Medicare fee-for-service program will be with us for many more decades.

I would personally favor another run at building the foundation for true competition between traditional Medicare and private plans, operating off a competitive bidding/premium support model, but we have lost too much time and political ground since the late 1990s to move very far in that direction now. Even an indexed voucher, whose initial level was set politically, as suggested by Mark V. Pauly in his new AEI Press book, *Markets Without Magic: How Competition Might Save Medicare*, remains off the political table in the near term. Like it or not, a good bit of the necessary improvement in Medicare will have to come from a better managed traditional program that tears down its longstanding structural silos that impede the efficient and more affordable delivery of health care, and finally uses value-based purchasing tools more effectively and strategically.

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