MEDICARE:

A SEASONED ADULT CONCEIVED AND BORN IN SIN

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NATIONAL ACADEMY OF SOCIAL INSURANCE

MEDICARE AND MEDICAID: THE NEXT 50 YEARS

January 28-29, 2015

I. FIRST,

MEDICARE AND MEDICAID !

We all know you had breech births and your life has been tough.

But you made it to your 50th birthday in spite of all your handicaps, that that is an achievement!

In the meantime, you have kept us in the club of civilized nations.

I. FIRST, HAPPY 50TH, MEDICARE AND MEDICAID !

II. MEDICARE: BORN IN SIN

Prior to passage of Medicare and Medicaid, close to 40% of America's elderly were too poor to afford the then available, modern health care, as were millions of non-elderly Americans.

Leading members of the WWII generation who had emerged from the Great Depression and WWII with a strong egalitarian streak sought to respond to this problem.

But the providers of health care – chiefly doctors and hospitals – permitted the U.S. Congress to express this egalitarian sentiment in legislation only on the condition that it surrender to them the key to the U.S. Treasury.

- **Retrospective full-cost reimbursement for each hospital**
- **Payment of each physician's "usual, customary and reasonable (UCR)" fees –although Medicare called it CPR.**
- **Absolutely no interference in the practice of medicine or hospital operations – i.e., no such thing as "managed care."**

As Wilbur Cohen, one of the chief architects of Medicare and subsequently U.S. Secretary of Health, Education and Welfare (Now Health and Human Services) put it succinctly:

"The sponsors of Medicare, myself included, 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 [to be in charge of administering Medicare] would exercise no control". [1]

[1] Cited in Rick Mayes, "The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System," Journal of the History of Medicine, vol. 62, January 2007: 25. Available at https://facultystaff.richmond.edu/~bmayes/pdf/JHMAS_Jan2006_RMayes.pdf

Or, to quote Rick Mayes in his 2007 review of the history of Medicare:

"With hospitals and physicians in control of American medicine, those who paid the bills they charged had little to no means of questioning either the legitimacy or the necessity of the care that patients received. The not-for-profit Blue Cross (hospital) and Blue Shield (physician) systems, along with commercial insurers, essentially served as efficient payment operations. As such, they made the practice of medicine very lucrative." [1]

[1] Rick Mayes, op. cit.: 3.

The title of this talk is *"Medicare born in sin,"* because making these outrageous demands on policy makers who merely sought to relief American citizens from distress was a sin that now is part of the American hospital industry and organized medicine.

It was unseemly for powerful interest groups to demand from Congress the key to the nation's Treasury.

Of course, it was also clear that the promises made to these interest groups sooner or later would have to be broken because they did not make economic sense.

It seems to come as surprise to many that in spite of these earlier, built-in handicaps imposed on Medicare, over the long run Medicare actually has been able to constrain the growth of Medicare spending per beneficiary better than has been the growth of per-capita health spending in the private sector.

ANNUAL GROWTH RATE IN PER-CAPITA HEALTH SPENDING, 1969-2012

PERIOD	ALL BENEFITS		COMMON BENEFITS	
	Medicare	Private Insurance	Medicare	Private Insurance
1969-1993	10.9%	12.8%	10.7%	12.2%
1993-1997	7.2%	4.3%	5.9%	2.0%
1997-1999	-0.4%	6.2%	1.6%	4.6%
1999-2002	6.4%	8.5%	5.6%	8.0%
2002-2007	7.8%	6.7%	4.7%	7.2%
2007-2012	2.8%	4.7%	2.2%	5.2%
1969-2012	8.4%	9.7%	7.7%	9.2%

SOURCE: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf, **Table 21.**

How was this possible?

The answer is that under the sponsorship of two Republican presidents – Ronald Reagan and George H.W. Bush – the original sin of Medicare's birth was washed away by the imposition on Medicare of what Joe Antos of the *American Enterprise Institute* has described as *"Soviet-style pricing".*

Joseph Antos, "Confessions of a Price Controller," American Enterprise Institute, http://www.aei.org/publication/confessions-of-a-price-controller/

I recall that to highlight the delicious irony of two stalwart Republican champions of the free market – Presidents Reagan and Bush Sr. – introducing Soviet-style pricing into American health care, I once wore a Soviet uniform at the podium before the Missouri Hospital Association, claiming that is how we now dressed a HCFA (the Health Care Financing Administration in charge of Medicare).

I then put on the screen this slide:

Reagan Apparatchik Announcing Hospital-DRG Update

“If you don’t like the update, look into the muzzle of this gun and smile when it flashes!”

At a dinner in California later that day, sponsored by former Congressman Pete Stark, we plied an initially reluctant Stuart Altman, then Chair of the *Prospective Payment Advisory Commission* that recommended DRG updates to Congress, with enough Chardonnay to induce him to don that uniform as well.

It provided us with a marvelous photo op, as shown on the next slide.

PROPAC-Politbureau Commissar Stuart Altman, persuading Congressman Pete Stark to set the DRG Update for 2006 at 0%, give or take 0%.

So ever since these two stalwart Republican defenders of the free market did their Soviet magic on Medicare, the rules of the game in U.S. health care have been this:

- **Medicare cannot control the utilization of health care, but it can control the prices of health care.**
- **Private health insurers can somewhat control the utilization of health care through "managed care," but traditionally they have had only very feeble control over the prices they are made to pay for health care.**

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II. MEDICARE: BORN IN SIN

III. IS MEDICARE A "DUMB PRICE FIXER"?

Some years ago, in an interview published in Health Affairs, my good friend Tom Scully called Medicare a "dumb price fixer."

And I'm, like, "Oh, really?"

Tom's dictum kindled my interest in how Medicare and the private sector determine prices of health care.

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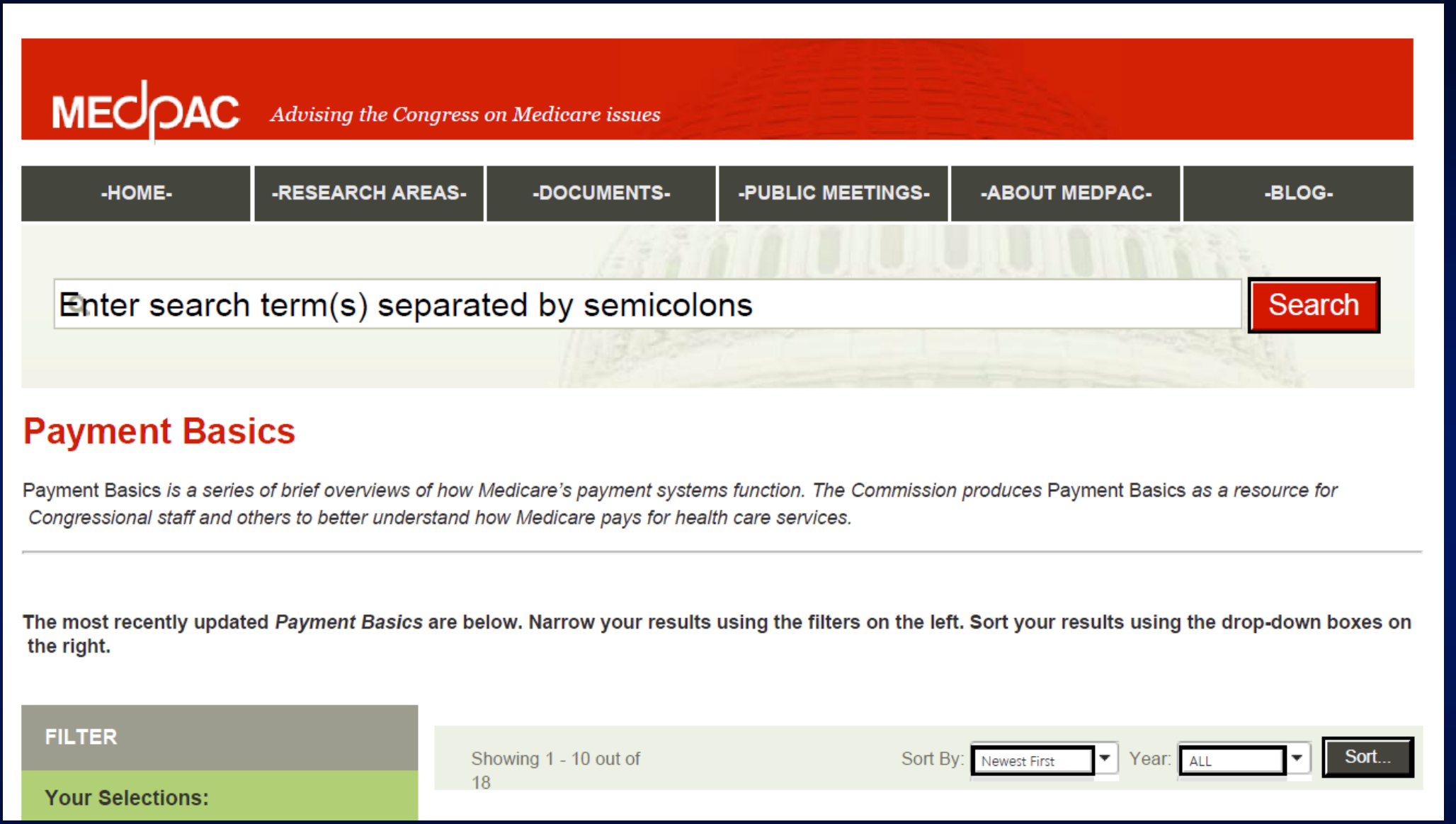
III. IS MEDICARE A "DUMB PRICE FIXER"?

A. How Medicare sets prices

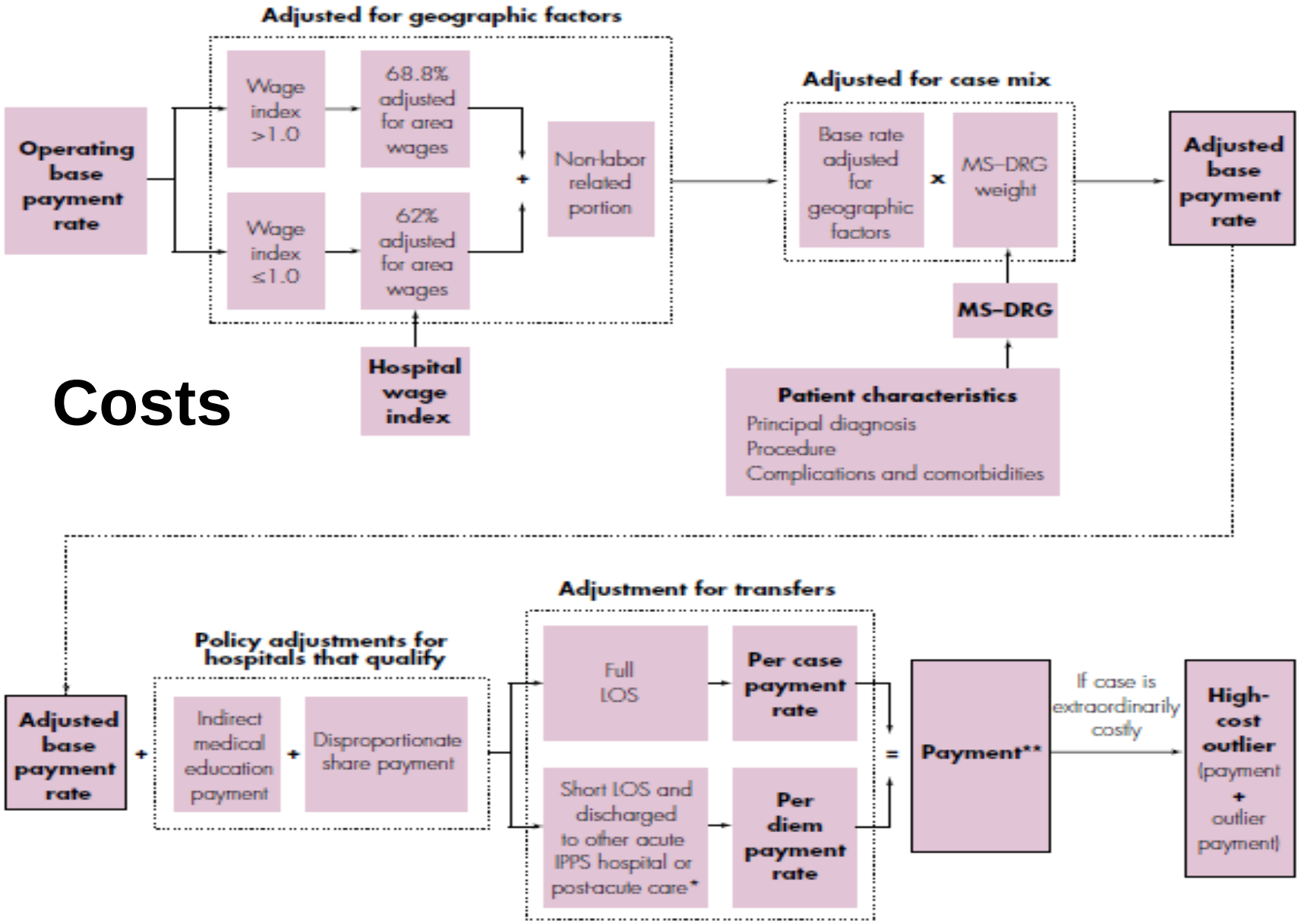
Whatever you may say or think about the pricing of Medicare services, the methodology of Medicare fee setting is fully transparent to anyone interested in it, as are the fees paid by Medicare.



http://medpac.gov/-documents-/payment-basics

Here's a sketch how bundled fees for hospital care – the Diagnostic Related Groupings or DRGs – are determined by Medicare.

Figure 1 Acute inpatient prospective payment system



This may look like a mind-boggling approach, but in fact it is a fairly sophisticated and thoughtful approach to apply a basically common fee schedule, with a common nomenclature nationwide with some adaptations to local market conditions.

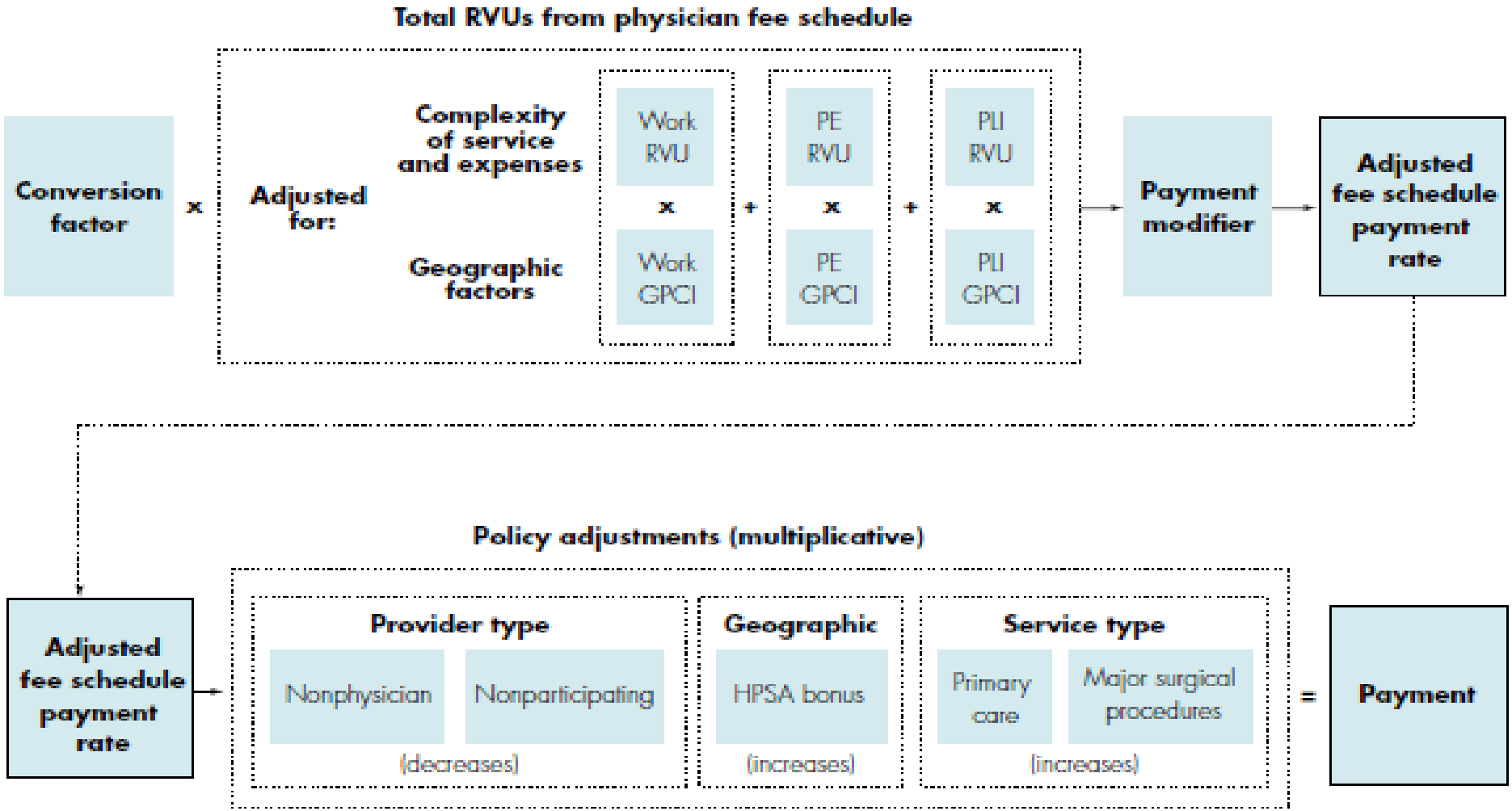
The quality of this highly innovative approach can be seen in the fact that it has been copied by now by many other nations and, indeed, by the private U.S. health insurance industry as well.

And here's a sketch how the fees Medicare care pay physicians are determined are determined.

Medicare's fee schedule now typically forms the basis for bargaining over physician fees in the private sector.

So who has been the chief innovator in methods of paying the providers of health care – Medicare or the private sector?

Figure 1 Physician services payment system



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A. How Medicare sets prices

B. How fees are determined in the private sector.

Secret chamber where prices for health care in the private sector are negotiated.

The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy

An economist's insights into what causes the variation in pricing, and what to do about it.

by Uwe E. Reinhardt

ABSTRACT: Although Americans and foreigners alike tend to think of the U.S. health care system as being a "market-driven" system, the prices actually paid for health care goods and services in that system have remained remarkably opaque. This paper describes how U.S. hospitals now price their services to the various third-party payers and self-paying patients, and how that system would have to be changed to accommodate the increasingly popular concept of "consumer-directed health care." [*Health Affairs* 25, no. 1 (2006): 57–69]

DOI 10.1377/hlthaff.25.1.57

Every hospital, for example, has its own "chargemaster," which that hospital updates from time to time by a process well explained to *The Wall Street Journal:*

"There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges."

William McGowan, CFO of UC Davis Health System, 30-year veteran of hospital financing, quoted in *The Wall Street Journal*, December 27, 2004.

EXCERPT FROM CALIFORNIA'S SAMPLE CHARGEMASTER

3043442	CATH MAHURKAR	510.00
3043445	CATH MRI SINGLE	1,642.00
3043446	CATH MRI DUAL	2,181.00
3043448	CATH PERITONEAL TENCHOFF	396.00
3043449	CATH PORTA CATH ARTERIAL	2,842.00
3043450	CATH PORTA CATH INTRO 9FR	198.00
3043451	CATH PORTA CATH PERIT	1,878.00
3043452	CATH PORTA CATH TITANIUM	2,875.00
3043453	CATH PORTA CATH VENOUS A	2,842.00
3043454	CATH PORTA CATH VENOUS B	* 1,416.00
3043455	CATH ROUND 6FR	76.00
3043456	CATH TPN	99.00
3043459	CLIP APPLIER	420.00
3043462	CLIP WECK	180.00

Under Consumer Directed Health Care, the now empowered consumer probably would opt for the *Cath Porta Cath Venous B* model. (S)he could always upgrade later.

Actual prices paid in the private U.S. health care sector vary enormously and seemingly capriciously even within small geographic regions, like a city or town.

These price variations are not correlated with either the quality of health-care services or their cost.

Table 6.3:

Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	$178 to $431
Hospital	$716 to $3,717
ASC	$443 to $1,395

Table 6.5:

Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy[1]	CABG[2]
Hospital A	$1,800	$33,000
Hospital B	$2,900	$54,600
Hospital C	$4,700	$64,500
Hospital D	$9,500	$72,300
Hospital E	$13,700	$99,800

[1] Cost per case (DRG 167)
[2] Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

A Study of Cost Variations for Knee and Hip Replacement Surgeries in the U.S.

January 21, 2015

BlueCross BlueShield

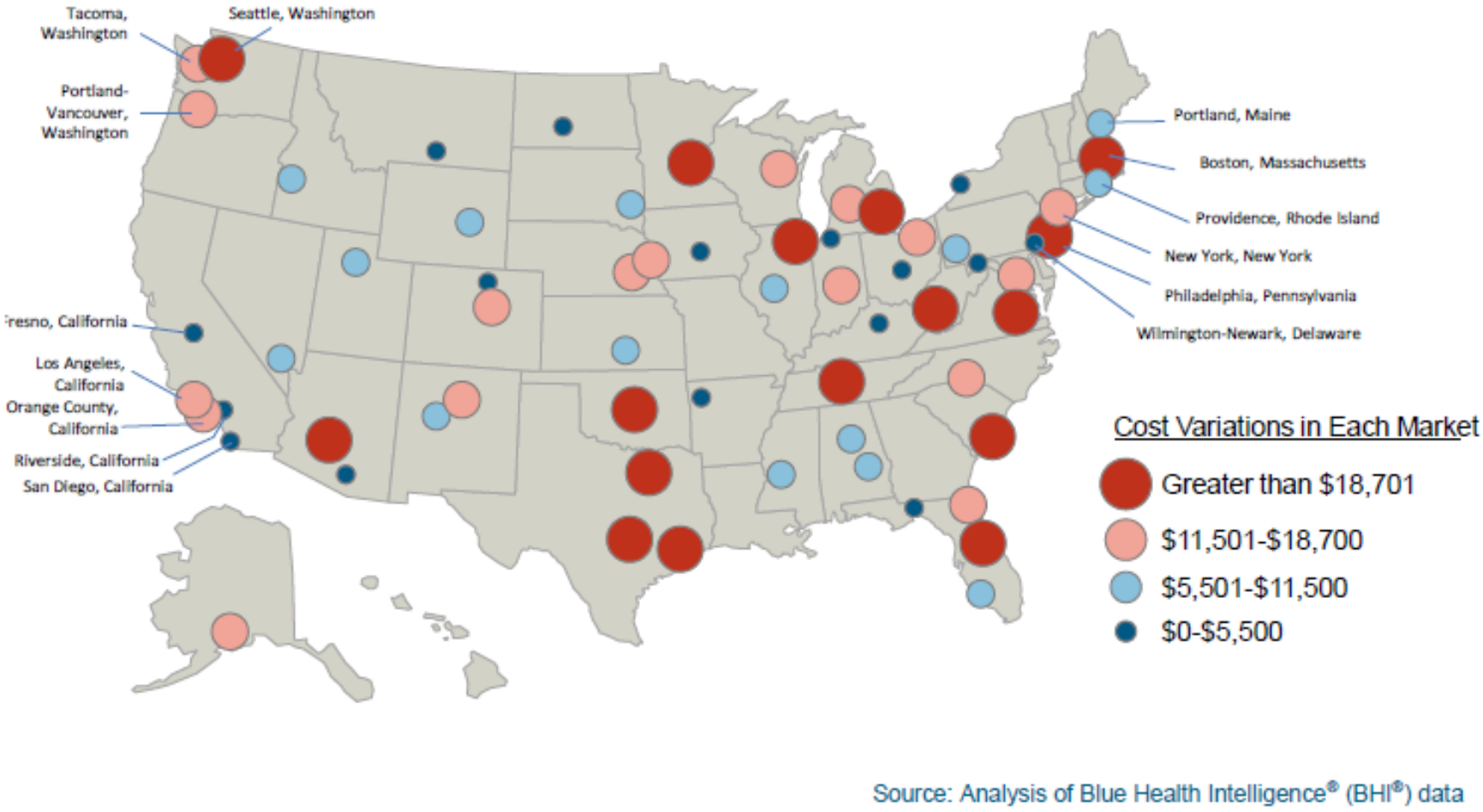
bhi

POWERED BY Blue Health Intelligence

THE HEALTH OF AMERICA REPORT

Figure 1: Cost Variation for Knee Replacement Procedures Across the Country

Appendix A contains a list of plotted markets showing the Minimum Cost, Average Cost, Maximum Cost and Percent Differential between the Minimum and Maximum.



Source: Analysis of Blue Health Intelligence® (BHI®) data

Unfortunately, and remarkably, this report uses the words "charges," "prices" and "facilities costs" interchangeably, as if they were synonyms of one another.

They are not.

So we end up with the fundamental question:

“Who’s the dumb price fixer in the U.S. health system”?

One is tempted here to draw on Jon Gruber’s rich vocabulary

PROPOSITION

In regard to paying the providers of health care, Medicare, not the private sector, actually has been the great innovator:

- **DRGs (bundled payments) for hospital care, now widely copied by private insurers;**
- **the Resource-Based relative Value Scale (RBRVS), not also widely copied by private insurers.**
- **the OPPS (outpatient prospective payment system) for hospital outpatient care (the APC);**
- **Etc.**

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IV. IS MEDICARE SUSTAINABLE?

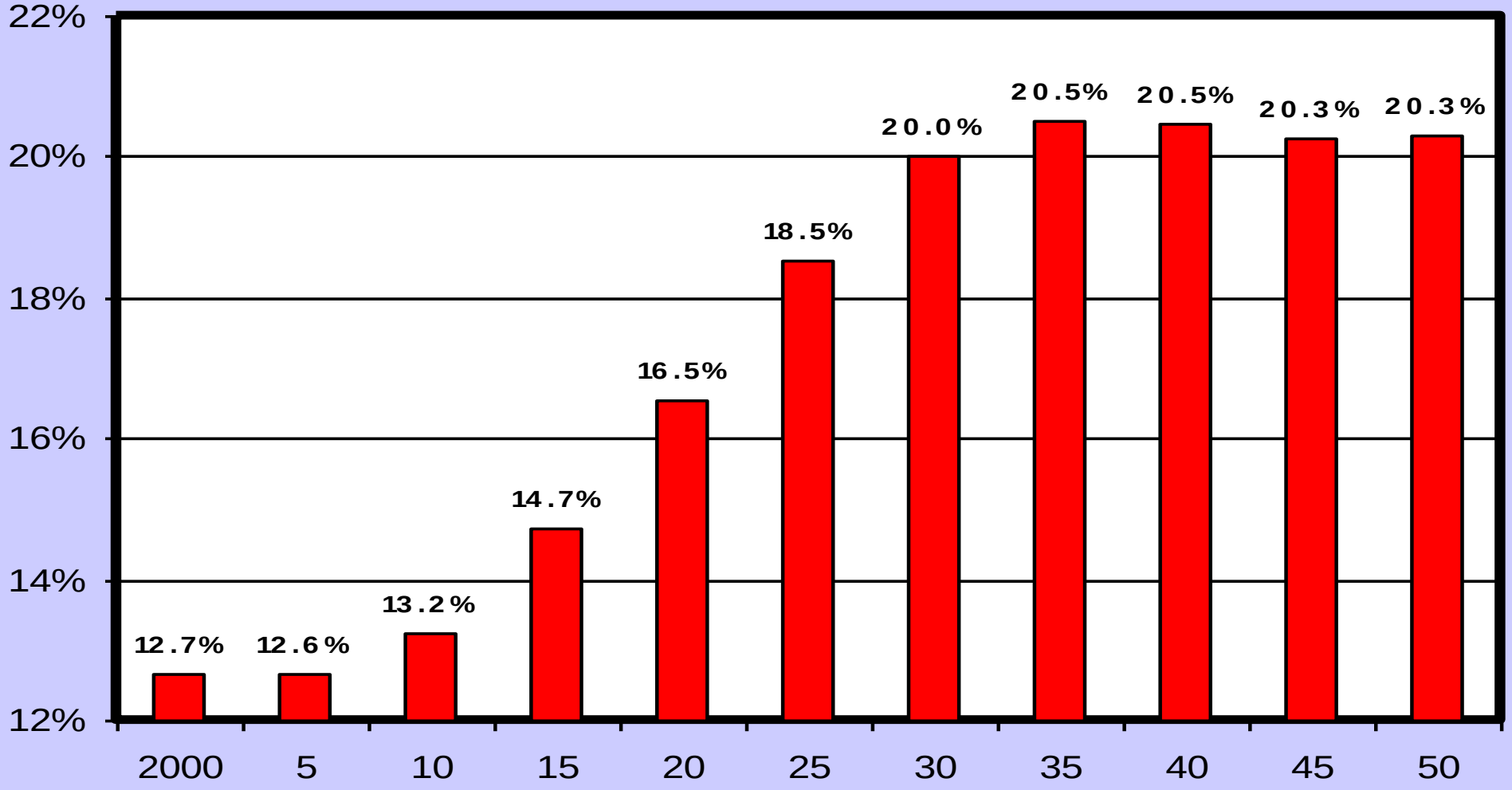
If at cocktail parties or at Congressional hearings one emits the idea that something is "not sustainable," one usually is taken for a deep thinker.

And so it has become fashionable at health-care conferences to opine that *"Medicare is not sustainable."*


Medicare's just not sustainable
Yep! Greedy geezers!

People say that because of the Baby Boom Tsunami.

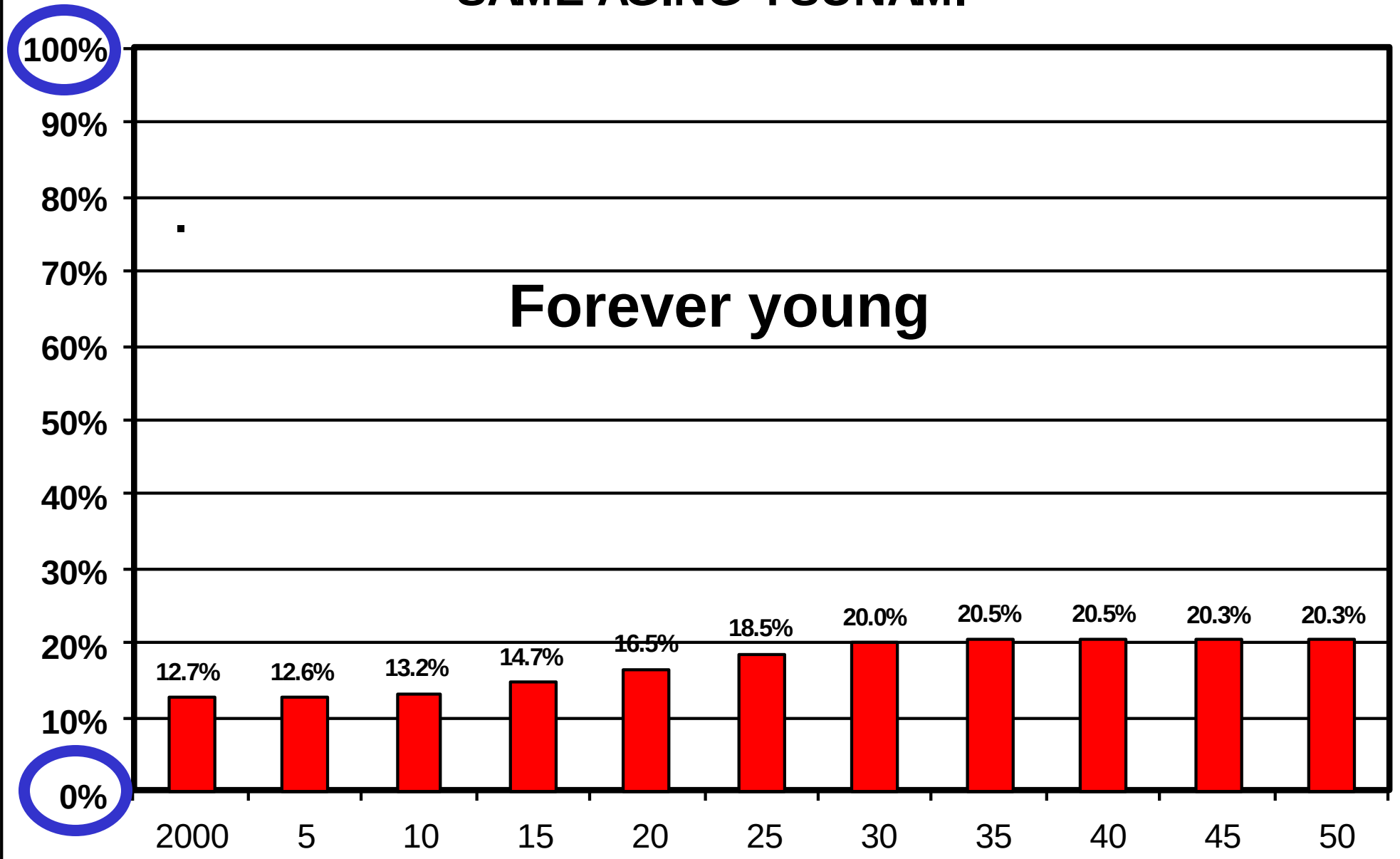
Projected Percentage Of The U.S. Population Aged 65 And Over



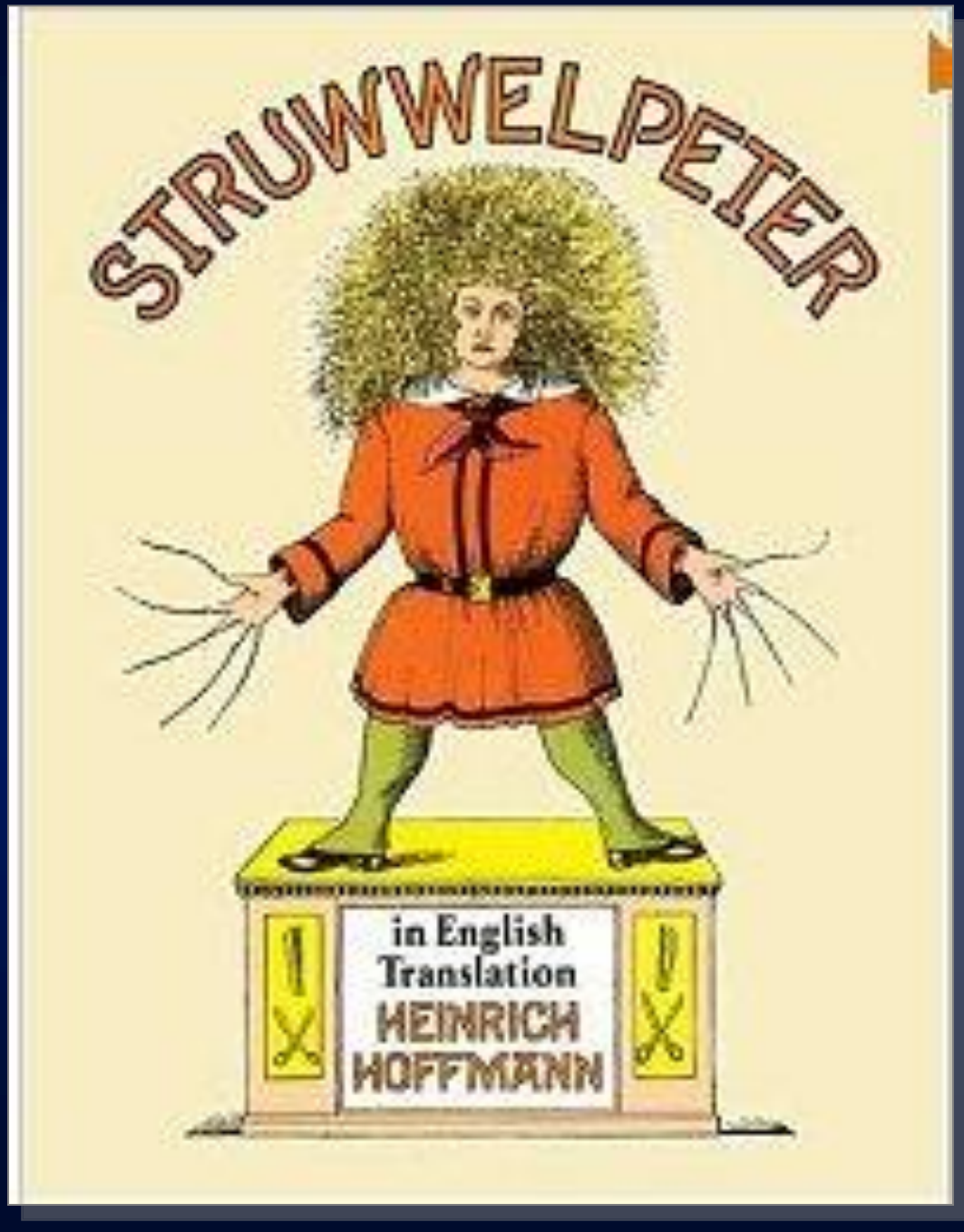
SOURCE: U.S. Bureau of the Census, Middle Series

At Princeton we are less daunted by the Baby Boom because we teach students to plot the data like this.

THE PRINCETON METHOD OF PLOTTING THE SAME AGING TSUNAMI

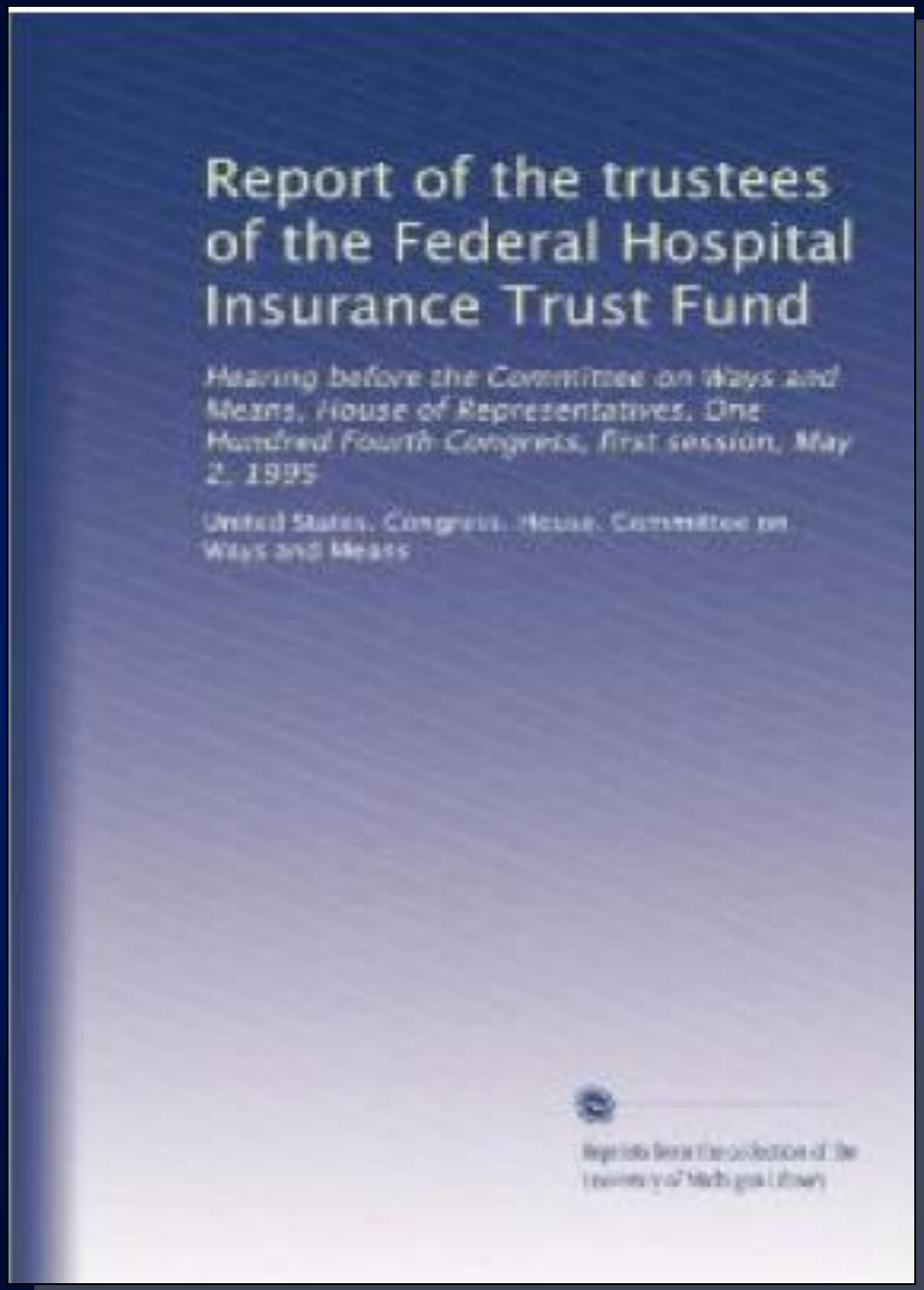


Germany, where I grew up, has the world's scariest children's books, which is why I left there.


STRUWWELPETER
in English
Translation
HEINRICH
HOFFMANN

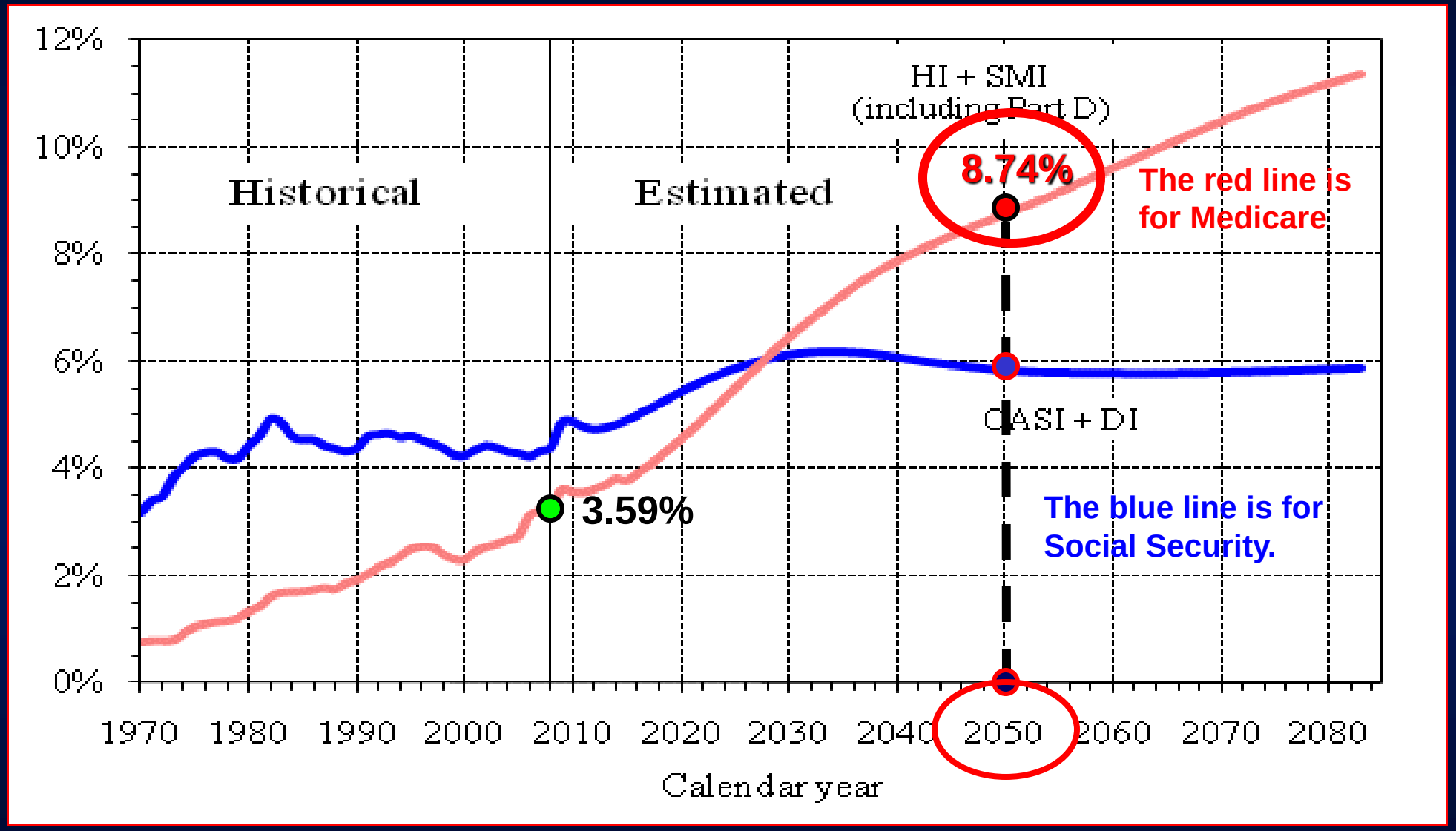
It has pictures like this in it.

Alas, America has some of the scariest adult books.


Report of the trustees of the Federal Hospital Insurance Trust Fund
Hearing before the Committee on Ways and Means, House of Representatives, One Hundred Fourth Congress, first session, May 2, 1995
United States. Congress. House. Committee on Ways and Means

It has pictures like this in it. This is from the 2009 report.

Chart B—Social Security and Medicare Cost as a Percentage of GDP



SOURCE: ***STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS, A SUMMARY OF THE 2009 ANNUAL REPORTS,*** **Social Security and Medicare Boards of Trustees,** http://www.ssa.gov/OACT/TRSUM/index.html

I ask you: Who wants to live through a time when close to 9% of our sacred U.S. GDP goes just for Medicare?

Propelled by that thought, I jumped into my car, drove up to the Verrazano Narrows Bridge on Staten Island and decided to jump off it.


I was
here.

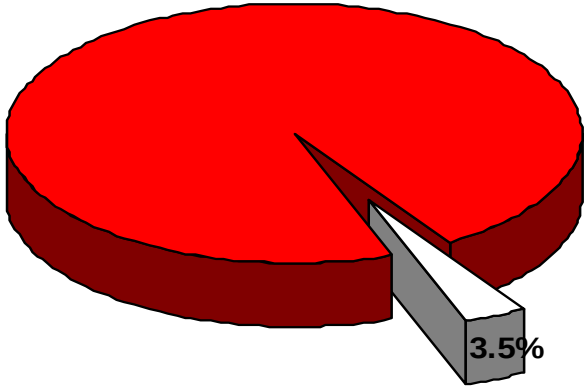
But just before jumping, this thought flashed through my mind:

“How big will be the GDP pie in 2050 out of which we’ll take that huge 8.74% slice just for the elderly?”

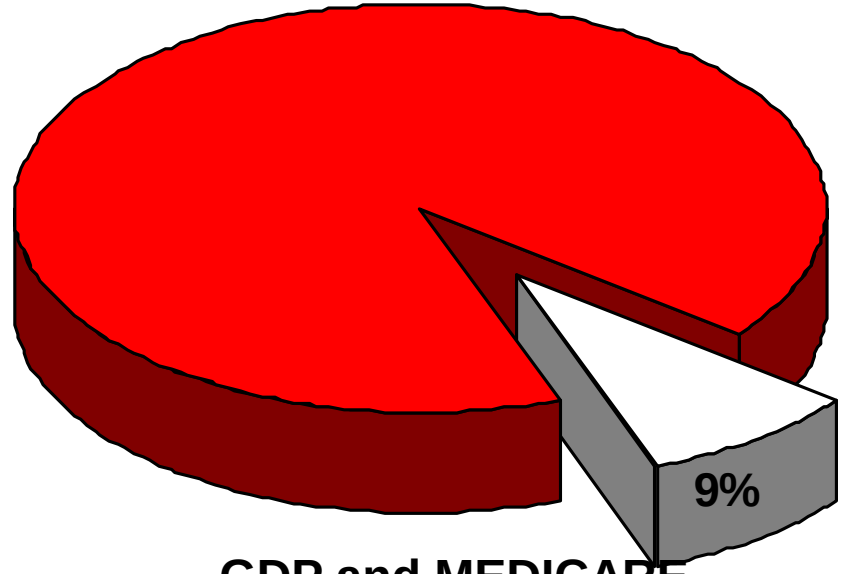
GROWTH OF MEDICARE SPENDING AND GROWTH OF GDP 2005-2050

Assumes real (inflation adjusted) GDP per capita grows at 1.5% per year

Like, Hm!



GDP and MEDICARE 2005



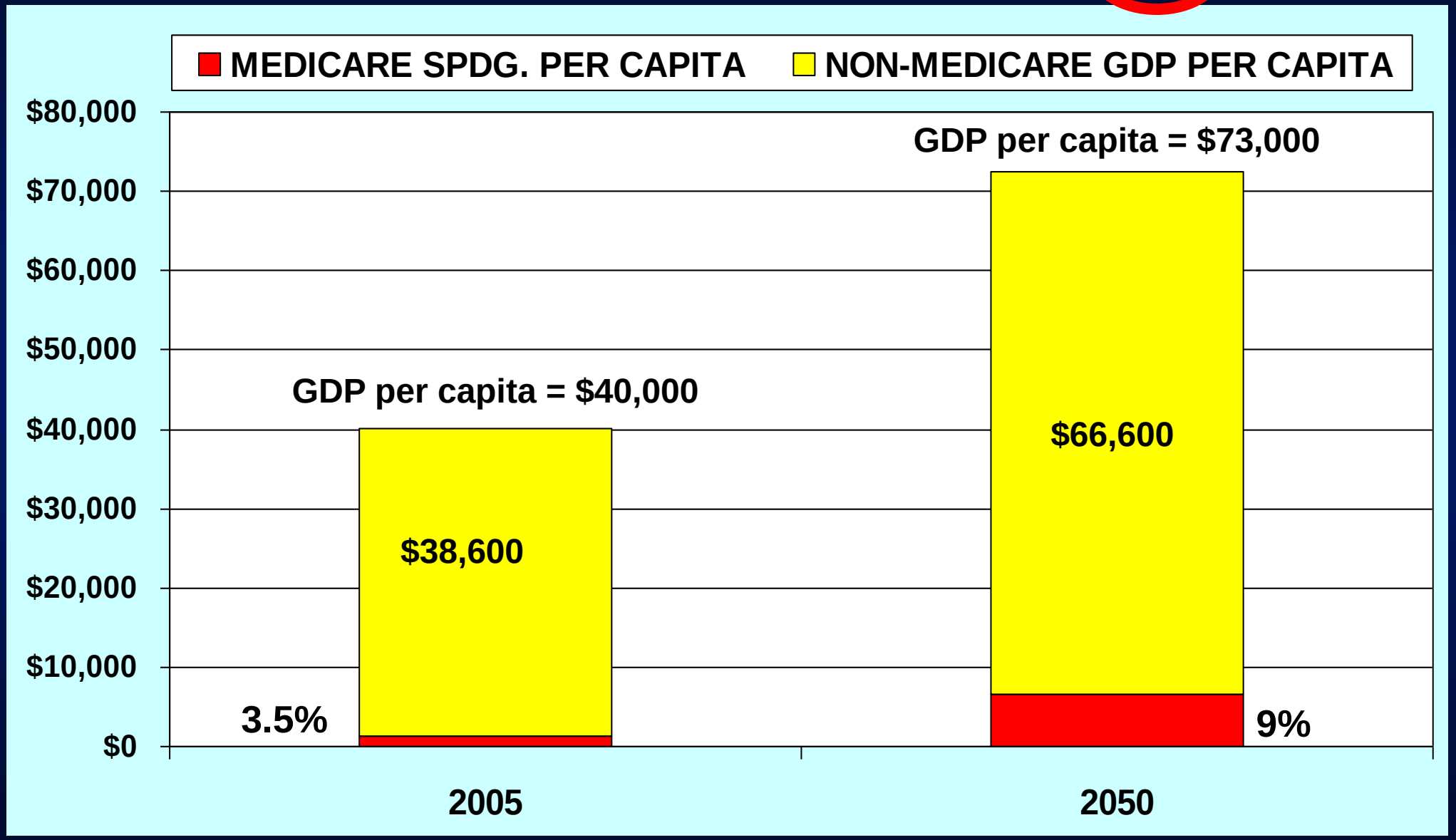
GDP and MEDICARE 2050

MEDICARE IN GDP

NON- MEDICARE GDP LEFT OVER

PROJECTED GDP PER CAPITA AND SHARE OF GDP GOING TO MEDICARE

Assuming GDP per Capita = $40,000 now and will grow at 1.5% per year

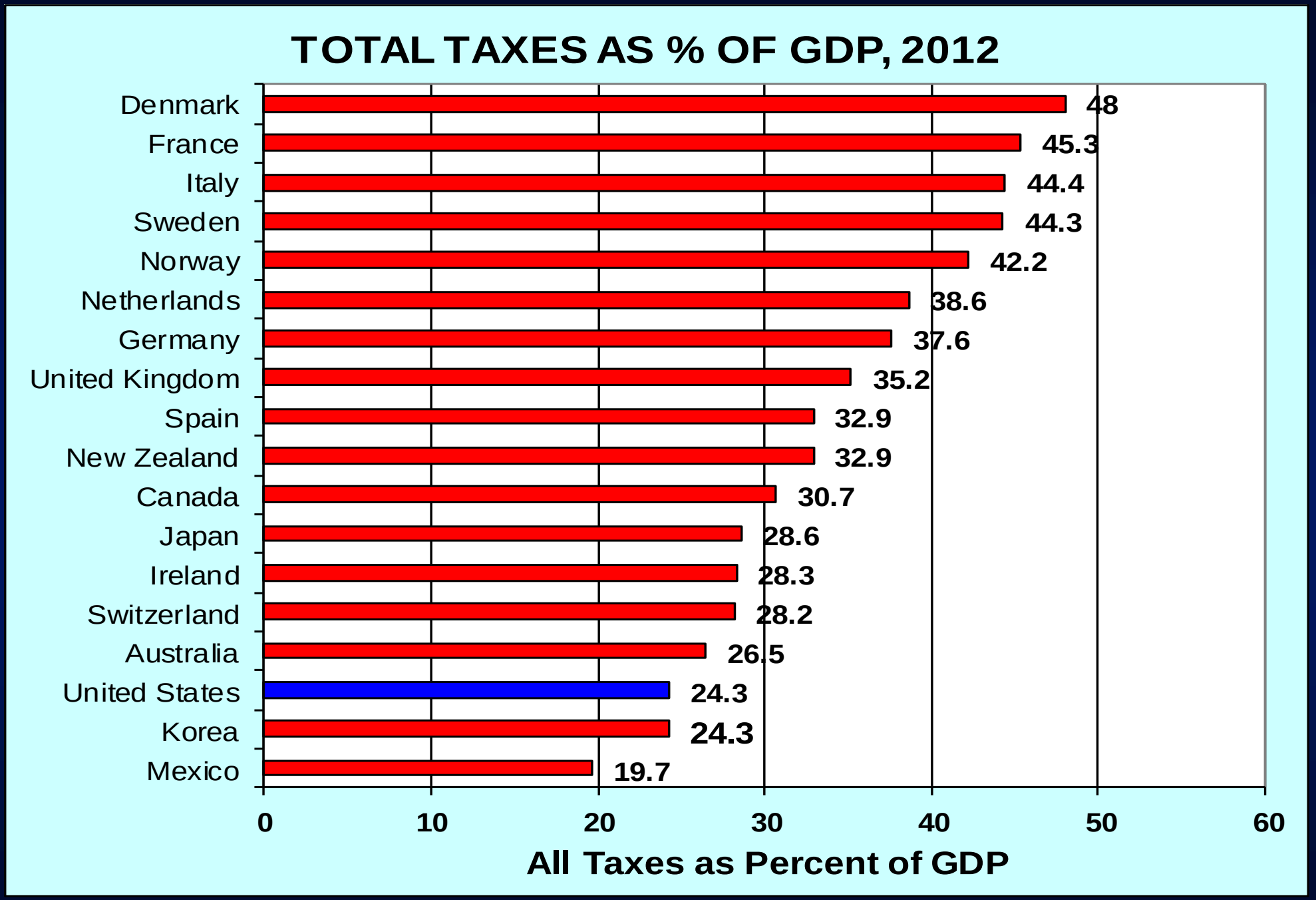


After beholding these visuals, I climbed down from the bridge span, drove home, had me brew and told myself:

> ***"Why should I now worry about the little bastards who'll be running the world in 2050, when they have so much more real GDP to play with than do we today?***
>
> ***If they want to put <u>their</u> aged on an ice floe and shove them into the ocean, that's their moral call, not mine.***

Of course, because of global warming there won't even be any ice floes then. So the young might as well get used to the idea that they are stuck with the future elderly.

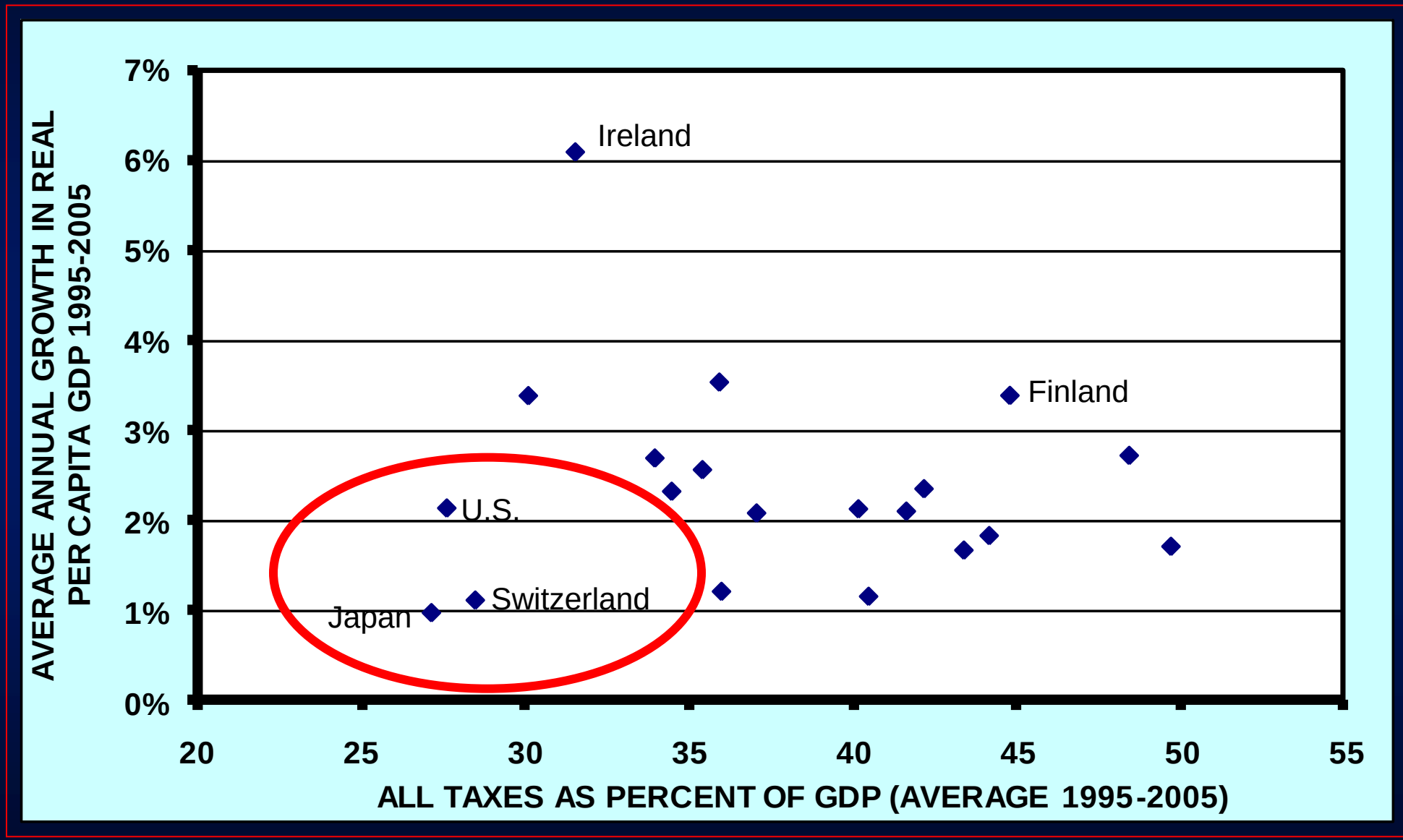
And lest you think that we already are an overtaxed nation and can’t raise them anymore, look at these data.



SOURCE: OECD DATA 2014, http``://stats.oecd.org/index.aspx?DataSetCode=REV

And lest you think that high taxes stifle economic growth, contemplate these data.

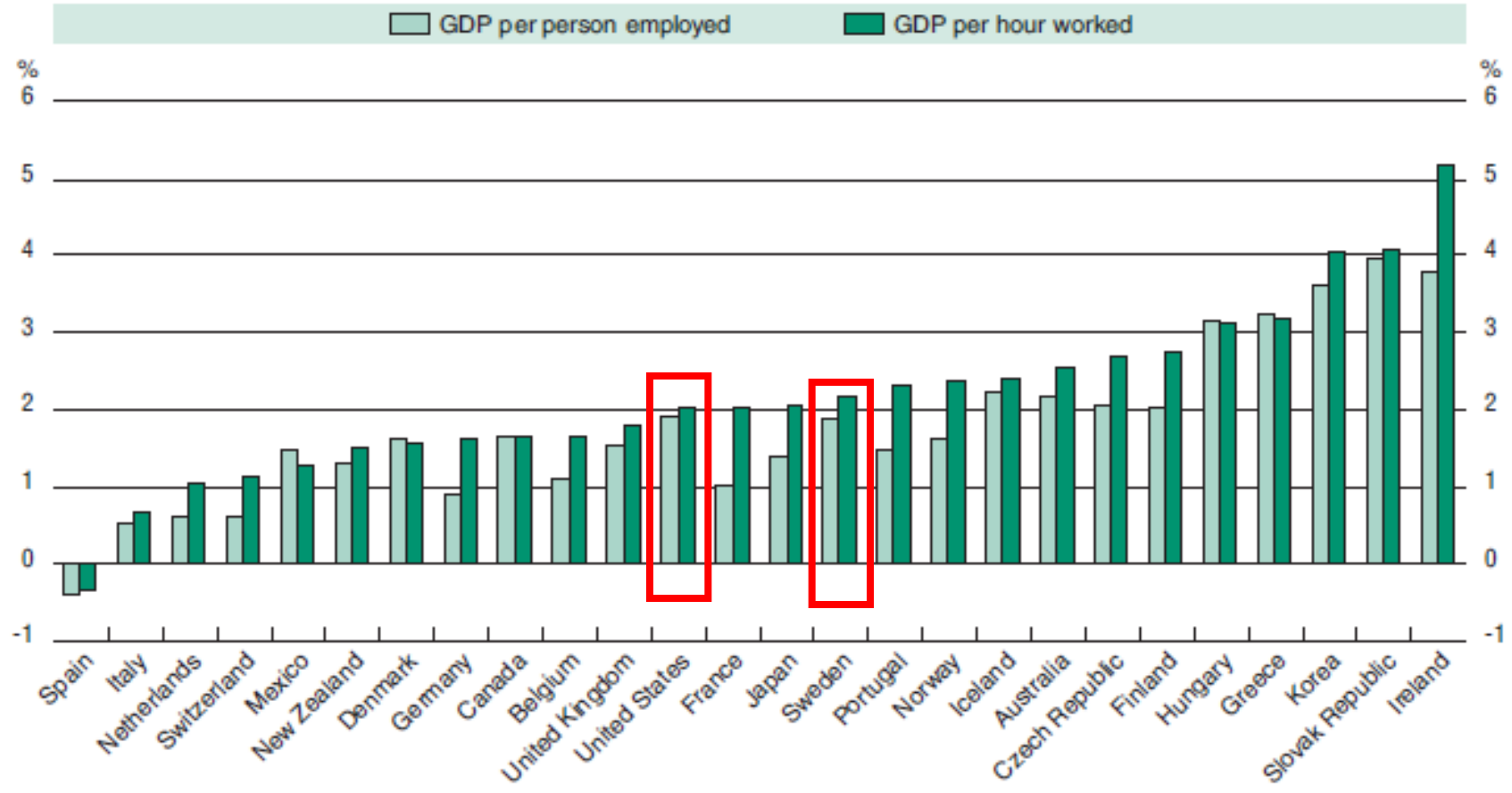
TAXES AND AVERAGE ECONOMIC GROWTH IN REAL GDP PER CAPITA 1995-2005



SOURCE: OECD Data Base

Chart 6. **Comparison of growth in GDP per hour worked and GDP per person employed, 1995-2002**

Annual compound growth rates



Source: OECD.

SOURCE: OECD, Statistics Brief No. 7, December 2003, http://www.oecd.org/dataoecd/5/11/22413472.pdf

Although everyone now chatters about “sustainability,” what does it actually mean?

According to the dictionary, something is sustainable if it is "able to continue for a long time."

Even though Medicare in its present guise cannot be said to be called an efficient program and could be improved – either in its traditional guise or in Medicare Advantage – the U.S. macro economy certainly could shoulder the burden of even the current Medicare for many years in the future.

But what is economically sustainable need not be politically sustainable in terms of this country's evolving social ethic.

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V. SOCIAL ETHIC vs ORNITHOLOGY IN THE FUTURE OF MEDICARE

For reasons that puzzle me greatly, most discussions on the future of Medicare – or of Social Security in– revolve around the financing of these programs.

The thought is that if the trust funds for these programs continue to have positive balances – or if people have adequate private pensions – everything will be hunky dory.

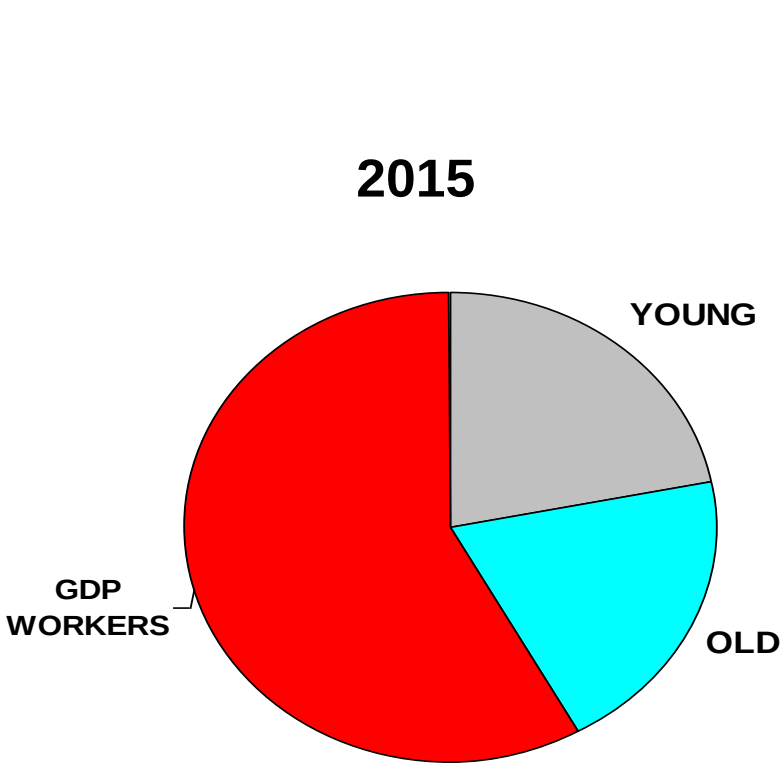
You can't eat money, nor can you put it on bleeding wounds.

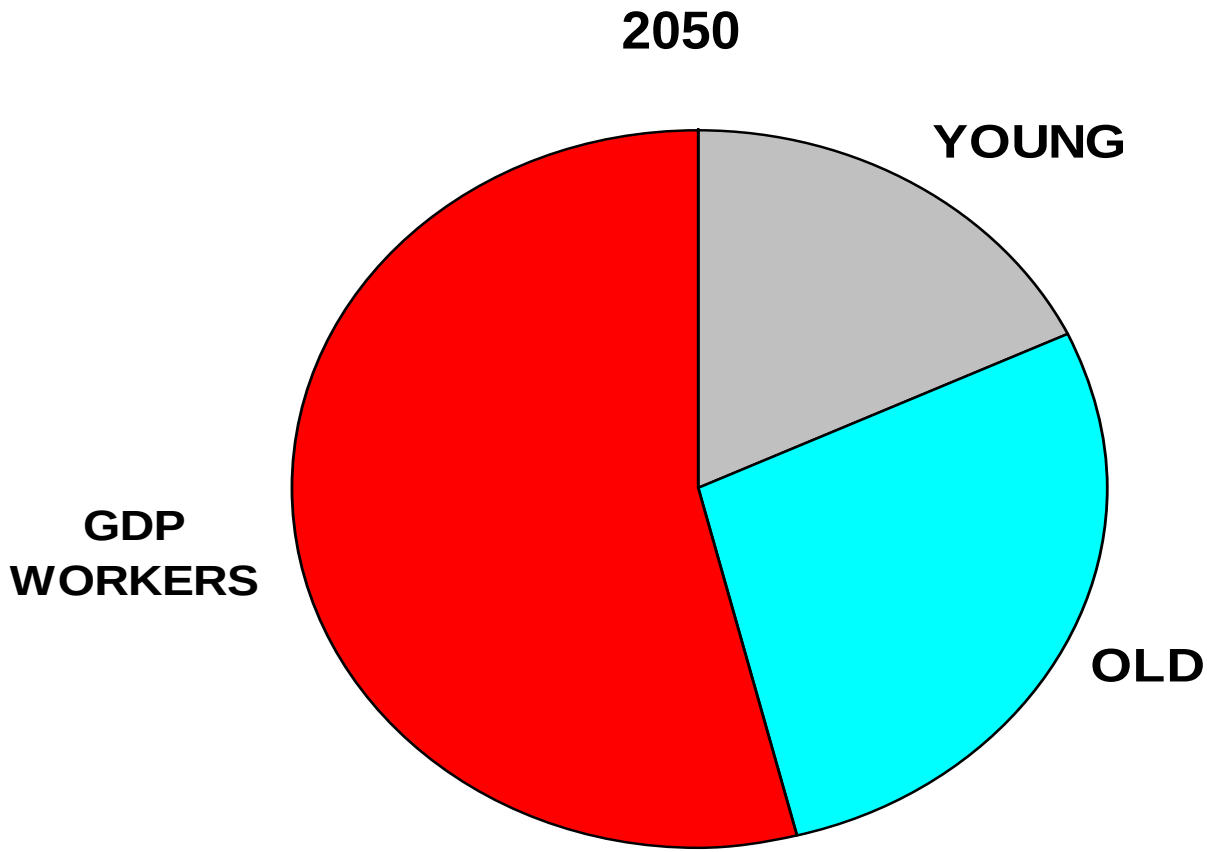
Besides, future generations can always easily steal from those funds to reduce their owners' claims on future GDP through:

- **general price inflation, which is a way to steal from people on fixed incomes;**
- **keeping interest rates on savings artificially low through Federal reserve policy, as is done now.**

The more important issue for future generations of elderly Americans is the prevailing social ethic that will guide the hand slicing up future GDP cake among future contemporaries.

HOW THE CONTEMPRARIES LIVING IN 2050 WILL SLICE UP THE GDP CAKE IN 2050 WILL DEPEND IN PART – BUT ONLY IN PART -- ON WHICH SOCIAL ETHIC WILL THEN CARRY THE DAY





But a more important perhaps even than social ethics will be lessons we can learn from ornithology.

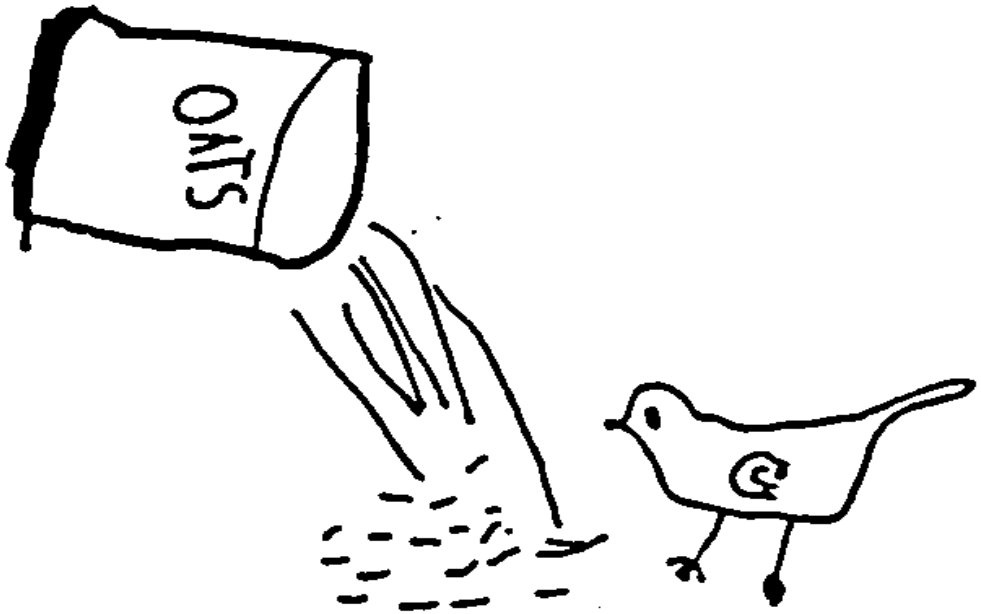
Lessons for Hospital Payment from Ornithology
Author(s): Hsiao Lien Reinhardt, Hsiao Nio Reinhardt and Uwe E. Reinhardt
Source: *Journal of Policy Analysis and Management*, Vol. 6, No. 3 (Spring, 1987), pp
Published by: Wiley on behalf of Association for Public Policy Analysis and Management
Stable URL: http://www.jstor.org/stable/3324857

In this paper we addressed the important question:

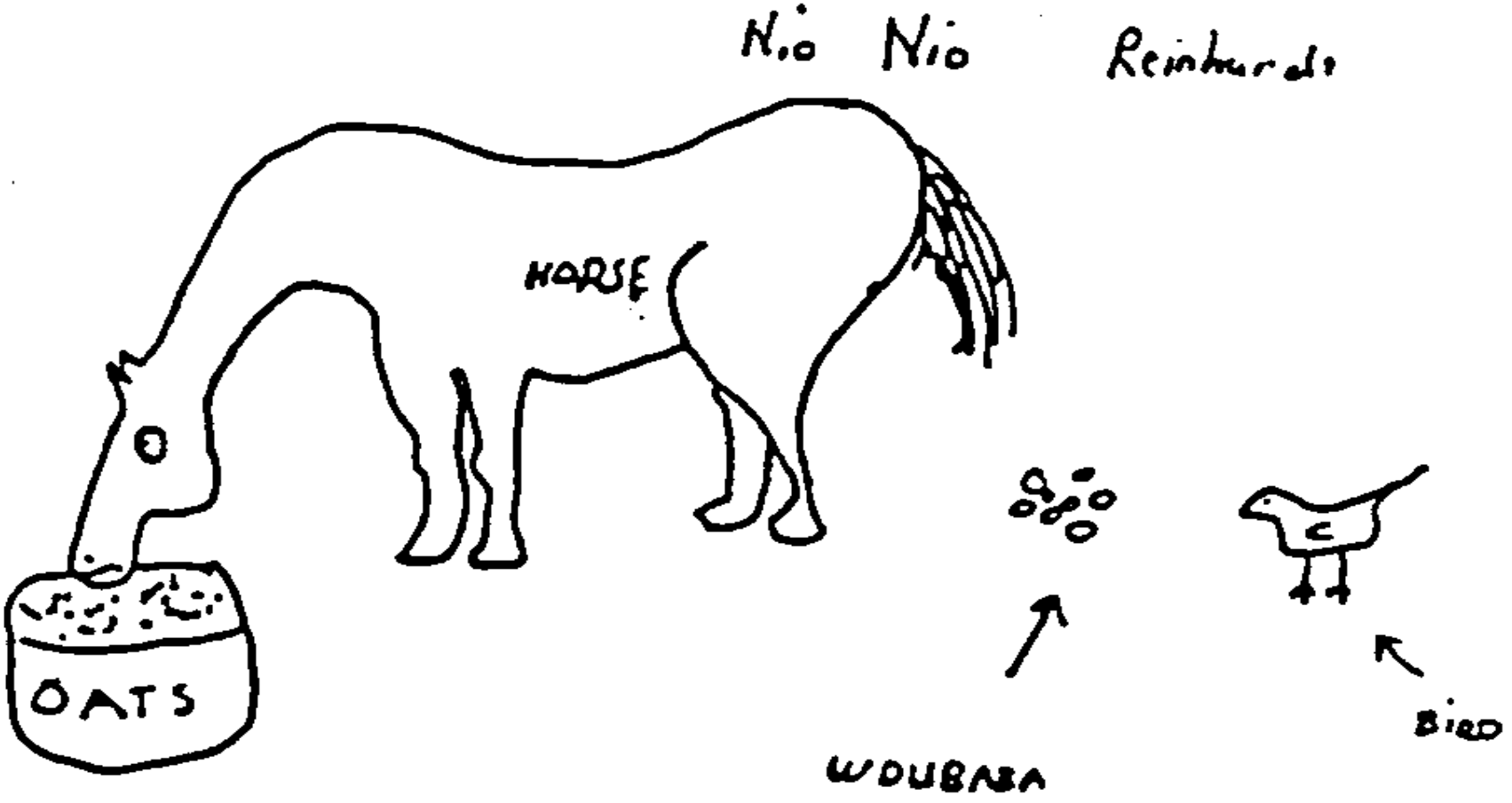
What is the most effective (not necessarily most efficient) way to feed a bird?

how TO Feed A bird : OPTION A [CASH OR VOUCHERS]

lion lion Rein



HOW TO FEED A BIRD: OPTION B [TRANSFERS IN KIND]



Leaning on this basic insight from ornithology, one could argue that the surest way to carve out for the poor – especially the elderly poor – a good slice of the GDP cake is to let the powerful, moneyed interest groups who own our government have a cut of the slice carved out for the elderly and the poor.

After all, isn't that how the *Medicare Modernization Act of 2003* and, yes, *ObamaCare* became law?

The Exchange

Yahoo_Finance.com

Here's Who's Getting Rich off Obamacare

By **Rick Newman**
November 15, 2013 11:02 AM

The Exchange


CNN Money
Video
Home | Business | Markets | Investing | Economy | Tech | Personal
The Buzz | Fear & Greed | Dow 30 | ETFs | Investing Guide | Mutual Funds | Tech30 | Interactive
NO NONSENSE LIFE INSURANCE
Get a Quick Quote on affordable, dependable life insurance.
GET STARTED TODAY
The Buzz
Thanks, Obamacare! Health insurer stocks soar
By Paul R. La Monica @lamonicabuzz January 21, 2015: 11:41 AM ET
Who says Barack Obama is bad for Corporate America?

We economists habitually think that crony capitalism is bad for the economy.

So if you sincerely want to help the poor in health care, it is smart to make crony capitalists your partners, cut them in a little on the deal, and have them help you lobby for the poor!

See, e.g., "Insurers, Hospitals, More Unite With Dem Lawmakers Against King Plaintiffs," http://insidehealthpolicy.com/login-redirect-no-cookie?n=81363&destination=node/81363

THANK YOU FOR LISTENING