Medicare Reform: Economics versus Politics

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No one familiar with the history of Medicare should be surprised that it remains at the center of an intense political debate. During the twenty years preceding the creation of the program in 1965, Democrats who sought to enact some version of national health insurance continuously battled Republicans who came up with one defensive move after another to keep the provision of medical care predominately in the private sector (Rettenmaier and Saving 1999, Helms 1999). Under the shrewd leadership of Wilbur Mills, the powerful Democratic chairman of the House Committee on Ways and Means, a series of last-minute legislative maneuvers in 1965 resulted in the addition of physician services to the package of hospital services previously proposed by the Johnson administration (for details, see Twight 1997 and Twight 1998, 375–80). The result was what many consider a confusing set of separate programs for hospital (Part A) and physician services (Part B) that remains to this day. As enacted, Medicare adopted what was regarded as "state-of-the-art" health insurance in 1965, designed for a market dominated by fee-for-service (FFS) medicine and cost-based payment schemes. Yet, as economist Ted Frech (1999) has recently written, the structure Congress adopted for Medicare in 1965 was already out of date when compared to the insurance benefits and payment methods beginning to be adopted in private insurance markets. The recent failure of the National Bipartisan Commission of the Future of Medicare to agree on a proposal for reform illustrates that the political infection injected into Medicare in 1965 is reaching a terminal stage. Faced with both an increasing number of eligible recipients and a relative decline in the number of workers paying payroll and income taxes, the program is in urgent need of reform.

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My focus in this article is on a related problem, the failure of economists to provide a convincing case for the use of private-market principles as the basis for efficient reform of Medicare. My criticism is not directed to the economists who have attempted for many years to apply market principles to health-care issues, but to the larger number of economists who have not. Moreover, my criticism pertains to the failure of economists to teach the fundamental principles of economics to educated Americans, rather than to the failure of "economics." This lack of education in economics is appallingly evident in Washington, D.C., especially on Capitol Hill. Any exposure to public-choice economics should convince anyone that politicians have a strong incentive to replace market activity with government regulation as a means to gain political power. Therefore, economics educators face a great challenge. Not only must we improve the basic understanding of economic principles, but we must continually provide convincing estimates of both the direct cost of regulation and the opportunity cost of the failure to achieve a higher level of economic efficiency.

The Current Medicare Debate

Medicare has continued to play a central role in partisan politics in the last several years. Following their congressional triumph in 1994, the Republicans, as part of their "Contract with America," proposed a number of changes in Medicare that would have reduced the projected rate of growth of the program's expense and would have provided the $270 billion in seven years needed to reach a balanced budget by 2002 (Kahn and Kuttner 1999). In an ironic coincidence, the proposed Medicare saving was almost identical in amount to the Republicans' proposed tax reduction, furnishing the Democrats with the rhetorical advantage of arguing that Medicare was being "cut" in order to give the wealthy a tax break. That attack put the Republicans on the defensive and was one of the reasons they failed in their efforts to reduce taxes. Many political analysts also identify the dispute over Medicare as one of the principle reasons for Democratic gains in the 1998 elections.

Having failed in their attempts to make substantial changes in Medicare, but needing savings in the program to meet budget targets, both parties agreed in the Balanced Budget Act of 1997 (BBA) to a more traditional means of controlling the cost of the program, cutting Medicare's payment rates for hospital and physician services.[1] As a gesture toward political responsibility, the act also established the National Bipartisan Commission on the Future of Medicare, which, after a year of effort, failed

1. The BBA also moved much of the home health-care benefit from Part A to Part B, which had the effect of improving the Part A trust fund while increasing the burden on general-fund financing (75 percent) and premiums paid by recipients (25 percent). The act also made numerous changes in the payment system and operation of the managed care portion of Medicare.

to reach agreement on a plan to establish financial solvency.[2] The debate among the members of the commission is indicative of the views of those opposed to market reforms in health policy and illustrates the challenge economists face in making the case for reforms that would restore consumer and provider incentives to achieve efficiency.

Briefly, the cochairs of the commission, Senator John Breaux and Congressman Bill Thomas, proposed to reform Medicare by using a premium-support system modeled after the Federal Employee Health Benefits Program (FEHBP) and a proposal by Henry Aaron and Robert Reischauer (Aaron and Reischauer 1995, Butler and Moffit 1995, Francis 1999). Abandoning both the terminology and the methodology of a pure voucher or defined-contribution approach, the premium-support plan would have paid a defined amount toward the purchase of an insurance plan that would have been required to provide a defined set of benefits. Although such a plan would have created new choices for Medicare recipients, it would also have allowed recipients to remain in traditional fee-for-service Medicare, as 84 percent of current enrollees now do.

Two of the main arguments against this proposal were that it would have subjected future enrollees to increased financial risk if the government's payments did not keep up with future increases in health-care costs, and that market competition would not have achieved the efficiency gains or budget savings claimed by the supporters of the proposal.

The first of these arguments reflects the familiar resistance of supporters of government entitlement programs to anything that would shift the risk of future cost increases from the general taxpayer to the individual beneficiary. This type of objection has been around since the passage of Social Security in 1935 and forms part of the rhetoric used to support Social Security and Medicare as social obligations to the elderly (Weaver 1996). Any reform proposal that includes any kind of means testing or attempts to restore individual incentives (in the name of economic efficiency) is opposed on the grounds that it would decrease the political support for these programs because it would make individuals less dependent on the government.

The second argument against the premium-support proposal was that competition was unlikely to be effective in medical markets and therefore could not be counted on to control the cost of medical care. Because Medicare recipients who elected to enroll in a competitive health plan would be liable for the marginal cost of additional benefits or cost increases, they would be exposed to additional out-of-pocket costs. Opponents argued that neither the adjustments to Medicare's fixed payments nor the special provisions to subsidize low-income recipients could be counted

2. The BBA specified that eleven of the seventeen commission members would have to agree in order to make a recommendation to Congress. Only ten members agreed on the chairman's premium-support proposal. The staff of the commission has now disbanded, and its office has closed, but its web site continues at http://thomas.loc.gov/medicare.

on to cover the additional costs. Within the commission, the debates on the probable effects of market reforms took place around a set of alternative estimates of future program costs prepared for the commission by its staff, the Office of the Actuary of the Health Care Financing Administration, the Congressional Budget Office, and the General Accounting Office. Although all economists and actuaries agree that such estimates are difficult to make, in this case they were simply rejected out of hand by the seven commissioners opposed to the premium-support proposal.[3] They argued that the effects of consumer choice and market competition assumed by the various experts were too optimistic and that the premium-support proposal would leave recipients who chose to participate exposed to unreasonable personal cost increases. Implicit in such arguments is the idea that health-care markets are not like other markets, and therefore only government regulation can be counted on to control costs, assure quality, and protect consumers.

As every economist knows, any prediction of future events rests on probabilities—in this case, the opponents' assumed probability that cost-increasing technological changes will dominate cost-saving ones, increasing the rate of growth of future medical costs. It is ironic that the supporters of status quo Medicare, who commonly castigate economists for their assumptions, achieve the rhetorical high ground in public debates by assuming the worst possible performance for market-based reform. Such debating tactics are not new, but this most recent chapter in the Medicare debate illustrates again the challenge that economists face in applying economic principles to health-policy issues.

Three Failures of Education and Research in Economics

Even the casual reader of newspapers can find statements almost every day that would make the professional economist cringe. In stories about health policy in the popular press, it is common to find statements that seem to deny the existence of scarcity, that disregard the concept of present value, and that fail to appreciate the relation between basic economic incentives and the efficiency of resource allocation. Out of a very large number of misunderstandings regarding economics, three specific issues play a significant role in confusing or diverting debates about health policies from what should be the main issues.

The Role of Health-Care Quality in Market Competition

All students of mainstream economics are taught the role of simplifying assumptions, and that one should not judge an economic theorem or model by its assumptions. In the typical principles course and in the textbooks assigned to students, instructors

3. Two of the seven members—Stuart Altman and Laura Tyson—were economists. Both were appointed by President Clinton.

carefully develop the concepts of supply and demand and illustrate them in the usual two-dimensional graph with price on the vertical axis and quantity on the horizontal axis. Teachers then apply the model to real-world situations in an effort to convince students that it is a powerful tool for understanding many interesting and useful things about history and the functioning of a modern economy. One of the most important applications shows how competitive markets adjust both prices and levels of output to a change in market conditions.

This elementary teaching is the only formal economic analysis to which most college students who go on to careers in law, medicine, business, journalism, and politics are exposed. Some of them become members of Congress. To the extent that they remember their economics course, they interpret any statement that health-care markets are competitive to mean that prices are lower and output levels greater than they otherwise would be. Although this condition may receive the approbation of most economists, in health-policy debates any assertion that prices will decline is usually combined with the assertion that price competition will reduce the *quality* of care and leave consumers worse off.

As UCLA's Armen Alchian used to say, some of the biggest disputes in economics are about "what is on the horizontal axis." Most economics textbooks, to the extent that they mention quality at all, point out that variations in the quality of the product are excluded from the analysis by the ceteris paribus condition. This approach, of course, is a useful way to teach economics, but it transmits the misleading message that market competition is mostly about price competition. Putting quality competition back into the model is left to more advanced courses. Most of the leading health-economics textbooks I have sampled do include an extensive discussion of the trade-off between quality and quantity, usually in the context of discussions of the market behavior of managed-care plans or hospitals (Folland, Goodman, and Stano 1993; Feldstein 1999).

What starts out as a convenient way to teach economics, however, ends up having a misleading effect on discussions of health policy, especially on discussions of the effects of a number of policy changes designed to increase market competition in health markets. In the real world of business, competitive strategies to improve the consumer's evaluation of the quality of the product or service are major concerns and receive much attention from management. Any health-care provider, be it a large hospital, a managed-care firm, or an individual physician, has to guard against getting a local reputation for bad quality. Considerable effort goes into adjusting the services and programs of the medical institution to meet the changing needs of consumers in order to gain market share. Competition also works to lower prices, but the process is not the one-dimensional cost cutting (substituting profits for quality) so often presumed in policy debates. For most politicians and many others engaged in health-policy discussions, the possibility that market competition in health markets could lead to improvements in both price and quality (and in the welfare of consumers) is

either not considered or dismissed out of hand. Yet the regulatory strategies promoted as substitutes for competition are routinely assumed to protect consumers from low-quality health care—an assumption with scant empirical justification.

The Meaning of Economic Efficiency in Competitive Health-Care Markets

This issue involves a variation on the preceding argument about the effects of competition on the quality of care in health markets. Here, the emphasis is on the lack of education about the process of economic competition and about the consequences of health policies that do not take advantage of the potential improvements in efficiency arising from competition.

In 1997, the Association for Health Services Research gave an award to Tom Rice for his book, *The Economics of Health Reconsidered* (1998), criticizing the application of economics to health-care markets and policy. His analysis was strongly criticized, however, by at least three health economists, one of whom asked, "Who was that straw man anyway?" (Pauly 1997; see also Dowd 1999, Gaynor and Vogt 1997). This debate illustrates the reluctance, even among some economists, to use economic theory as a guide to policy—a reluctance that arises from a misunderstanding of the methodology of scientific inquiry, especially the use of simplifying assumptions in modeling. What gets lost in the health-policy debate is analogous to the "gains from trade" in formal (highly simplified) exchange theory.

The description of economic activity in health markets has changed substantially in recent decades. In the 1970s, much of the analysis of those markets pertained to the lack of competition and the restrictive nature of state and federal laws that distorted both consumer and provider incentives (Pauly 1980, Olson 1981). In the 1990s, the literature still dealt with the distorting effects of both Medicare policies and the tax exclusion of employer-based health insurance (Arnett 1999), but analysts put much more emphasis on the changing nature of competition brought about by the movement of most private insurance coverage to some form of managed care (Frech 1996, Morrisey 1998).

The evidence shows that the changing nature of competition has had some effects that have probably improved economic efficiency. The rate of growth of health-care costs in both the public and the private sector has moderated in recent years; inefficient hospitals have closed or merged with more efficient organizations; numerous innovations have been introduced in the organization and delivery of health care and insurance; employers (but not their employees) have gained more choice of health plans; and an increase may have occurred in the rate of development, adoption, and evaluation of new medical technologies. Despite these improvements, the literature shows that many of the laws, regulations, and legal precedents responsible for the distorted incentives in health-care markets remain. In short, there is still room for much improvement.

But this potential for improvement in the efficiency of health markets is missing from the debate. The worst behavior of managed-care firms attempting to respond to employers' concerns about costs are held up as the results of economic competition. The attacks usually take the form of anecdotal reports on network news programs and in newspapers rather than of hard statistical data that can be subjected to careful review. Competent empirical studies of the performance of managed-care companies or for-profit hospitals usually reveal a different story (Feldstein 1999).

To improve the willingness of politicians to consider arguments based on market reforms, additional research is needed in the following areas:

- the ability of consumers to make informed medical decisions;
- the effects of increased consumer choice on the incentives of providers;
- the incentive of competing providers to supply more information to consumers when it is demanded;
- the incentive of competing health institutions to conduct additional research on medical outcomes and cost-effectiveness and to communicate such information to consumers;
- the incentive of health plans to compete on the basis of both price and quality;
- the measurement of the effects on costs and medical outcomes of the more rapid adoption of cost-effective technologies and the more rapid abandonment of cost-ineffective technologies;
- the more effective competition for and utilization of labor inputs when the use of employer-based health insurance is not distorted by the tax exclusion

Although the preceding list could be extended greatly, it is sufficient to suggest that present health-care markets fall far short of using competitive forces effectively to arrive at a more efficient allocation of health-care resources.

The Role of Multipart Pricing Strategies in Health-Care Markets

This topic may seem a more limited one, but the misunderstanding of sellers' incentives to charge different prices to different consumers (or groups of consumers) causes a great deal of policy confusion in Washington.[4] Health-policy discussions brim with accusations that providers are "guilty" of cost shifting—i.e., charging high prices to some consumers to make up for the loss of revenue when government price controls force providers to accept lower prices from certain beneficiaries (Morrisey 1994).

4. *Multipart pricing* is the term Armen Alchian (Alchian and Allen 1969) adopted to avoid the value-laden connotations of the more common term, *price discrimination*.

Numerous proposals are now emerging to mandate that Medicare beneficiaries be allowed to purchase drugs at their local pharmacy at the price drug manufacturers have negotiated with the Veterans Administration (VA) or the Department of Defense (this price is commonly called the Federal Supply Schedule price). Rarely in these discussions does anyone recognize that multipart pricing is a common practice in many markets and that sellers who can assure that one buyer cannot resell to another are able to gain additional revenue by charging on the basis of the price sensitivity (elasticity) of demand for the product. Charging lower prices to a purchaser such as the VA or a managed-care plan is a way to increase revenue, not an act of charity. Charging higher prices to some buyers is also a way to increase revenue and depends on the elasticity of demand, not on the fact that the firm is selling at lower prices to other buyers. Policy proposals that restrict the seller's ability to sell to some consumers at higher prices are a form of price control and, if adopted, will have the usual effects of price controls. Under price control, the excess demand gives sellers an incentive to use nonprice rationing to determine which consumers receive the product or service. At the same time, consumers have an incentive to make illegal payments or use clever contractual arrangements to obtain the product. Some, of course, just do without.

Policies that require suppliers to sell to everyone (or to a large class of consumers) at the lowest price charged any other buyer are guaranteed not to save the new buyers any money because such policies change the basic incentive that induced the lower prices in the first place. Consider the usual case of a drug manufacturer that sells most of its supply of a particular drug to wholesalers who then resell it to retail pharmacies. The manufacturer may also have contracts with several large buyers such as managed-care companies or the VA. In the usual case, the VA represents a relatively small market, but the company would rather sell to the agency at a low price rather than not have the sales.[5] A mandate that the lowest price must be given to the larger class of consumers changes the seller's expectations about the marginal revenue that could be obtained from the lower-price market. What was once a small market has been redefined by the legislation as a large market. Therefore, the seller will have no incentive to give the previously lower price to the VA the next time it negotiates a contract: the estimated savings based on a crude measure of the price difference never materialize. Several years ago a similar measure attempted to make the VA and military prices available to Medicaid recipients but ended up increasing the cost of drugs for the VA and the Department of Defense, so much so that Congress had to pass a special provision *not*

5. Because most of the total cost of the drug arises from the research and development (R&D) to discover it and from the fulfillment of Food and Drug Administration (FDA) requirements for marketing approval, the marginal cost of producing the additional supply is relatively low, hence not a significant barrier to selling the additional quantity. An additional reason to sell to the VA is that the agency trains many physicians who may become accustomed to using the company's product.

to base the Medicaid price on the military and VA rates. Ignoring the basic principles of economics can be hazardous to your budget, if not your health.

Conclusion

Several things seem certain regarding the future debate about Medicare. Regardless of what the actuaries say about the condition of the Part A trust fund, the program will remain at the center of presidential and congressional politics simply because it covers thirty-nine million people and because it continues to consume a growing proportion of the federal budget. Both the president and Congress want to add a drug benefit, but the government will not be able to afford it unless it imposes stringent price controls on drugs. If it does so, the industry will gradually walk away from the long and risky process of searching for new drugs, thereby denying many of us the benefits of new technologies. Meanwhile, Congress can be expected to avoid serious discussion of policies that would give recipients stronger incentives to seek cost-effective care. The easy course is to enact more controls on provider payment rates, controls that are sure to create excess demands. The response to any problem will likely be even more regulation to mandate various aspects of provider behavior. Eventually the quality of medicine and of provider service will deteriorate as medical scientists, investors, and all types of medical-care professionals seek alternative opportunities.

Such a result would not be pretty, but it might be precluded if we can somehow turn the debate back to fundamental concepts of economics and the beneficial effects of market competition. In making health-care policy, economics is anything but the dismal science.

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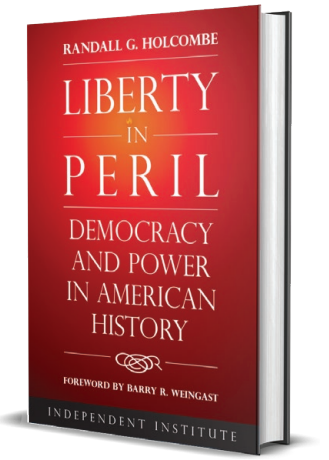

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