Is Obama Cooking the Medicare Books?

By John C. Goodman **April 28, 2012**

A new Obama administration report claims that health reform (ObamaCare) will save taxpayers $200 billion in the Medicare program through 2016. To what do we owe this good fortune? A good chunk of the savings, we are told, will be produced by lowering "excessive payments" to Medicare Advantage plans. These are plans operated by such private insurers as Aetna, Humana and WellPoint. They typically provide seniors with the kind of comprehensive coverage non-seniors have.

Another source of savings will be lower payments to doctors, hospitals and other providers to reflect their "improved productivity."

Finally, the administration expects efficiencies gained from "demonstration projects." These include experiments in paying more for better performance, paying package prices and encouraging a new type of HMO, called Accountable Care Organizations.

The administration's report was released on the eve of the release of this year's Medicare Trustees report, but whereas the Trustees report is a serious document, reflecting accepted accounting principles, the administration's document was clearly a piece of political propaganda — one that stretched the truth so much that the word "spin" would be a charitable description. For example, the administration's document failed to mention that:

• The Congressional Budget Office has studied the demonstration projects on three separate occasions (here, here and here) and each time has concluded that they are producing no serious savings and are unlikely to do so in the future.

• Medicare's Actuary has determined that reductions in payments to Medicare Advantage plans will not only result in lower benefits for the one in four seniors who are in these plans, but that about 7 ½ million enrollees will actually lose their coverage and have to seek more expensive Medigap insurance elsewhere.

• Medicare's Office of the Actuary also has concluded that the projected savings are unrealistic and will not materialize — since they will result in hospital closings and seniors' inability to find accessible health care — a judgment reaffirmed in the Chief Actuary's own statement in the latest Trustees report.

• Even if the $200 billion in savings did materialize, it would not be a saving to taxpayers; instead, these savings have already been pledged to create a new health insurance entitlement for young people — leaving taxpayers just as burdened as they were before.

• The administration's report also claimed that health reform has created $60 billion in new benefits for seniors, without mentioning that for every $1 of new spending beneficiaries will lose $10 of spending somewhere else.

On lower payments to providers, Chief Actuary Richard Foster produced a chart for the Trustees report, showing what "$200 billion in savings" actually means. The projection assumes that:

• Beginning in 2013, payments to physicians will drop by 31% to reach Medicaid levels.

• Going forward, Medicare payments will fall further and further below Medicaid fees, with each passing year.

Remember, the biggest problem for Medicaid patients is finding a doctor who will see them. As a result, they frequently must turn to community health centers and the emergency rooms of safety net hospitals, where rationing by waiting is common. What we can look forward to is a world in which seniors (from a financial point of view) will seem less desirable customers than welfare mothers.

What about the administration's preferred organizational form of health care delivery — Accountable Care Organizations? They have been rejected by the nation's leading health plans, including those that the administration points to as examples of high-quality, low-cost service. What about other demand-side reforms: forcing/inducing/coaxing providers to adopt electronic medical records, to coordinate care, to integrate care, to manage care, to emphasize preventive care, to adopt evidence-based medicine, and so on?

In theory, you can make a reasonable argument for each of these ideas. Who can deny that piecemeal medicine, with dozens of doctors making independent decisions about various aspects of a patient's care, is likely to be wasteful? Wouldn't it be better if the doctors all got together and coordinated their decisions? Doesn't integrated care make more sense than nonintegrated care? Wouldn't integrated care be easier if there were a medical home that kept all the patient records in one place? Wouldn't it all be more efficient if all the doctors could go to a computer screen and see what every other doctor has done to the patient and is planning to do?

I don't have a problem with any of this. In fact, I can point to examples where some of this actually works. My problem is that *wherever I find any of these techniques working, they originated on the supply side of the market, not the demand side*.

Whenever these ideas are foisted on physicians by a government pilot program or by some other third-party payer bureaucracy, they not only don't work, they often backfire. Electronic medical records and other electronic information systems seem to work, and work well, when they are adopted by doctors to solve their specific problems. (After all, isn't that how information systems get adopted in the rest of the economy?) They do not work well when they are designed and imposed by the buyers of care.

On the supply side, we have the islands of excellence (Mayo, Intermountain Healthcare, Cleveland Clinic, etc.). On the demand side, we have a whole slew of experiments with pay-for-performance and other pilot programs designed to see whether demand-side reforms can provoke supply-side behavioral improvements. And never the twain shall meet.

We cannot find a single institution providing high-quality, low-cost care that was created by any demand-side buyer of care. Not the Centers for Medicare and Medicaid Services (CMS), which runs Medicare and Medicaid. Not by any private insurer. Not any employer. Not any payer, anytime, anywhere. As for the pilot programs, their performance has been lackluster and disappointing.

What about grading hospitals based on the quality of care? One recent study finds that Medicare's reporting has had almost no impact on mortality. Another survey finds that quality report cards not only don't work, they may do more harm than good. What about paying for results? The latest study of pay-for-performance finds that doesn't work either. Accountable Care Organizations? The latest results show no reason to be hopeful. Electronic medical records? The latest survey of all the academic literature shows they new study in *Health Affairs* found that when doctors can easily order diagnostic tests online, they tend to order more tests — increasing costs.

The fundamental problem in health care is that people in the system face perverse incentives. If we want to change the perverse outcomes, we must change the incentives that lead to them. Nothing else is going to work.