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Medicare: Drifting Toward Disaster

The Honorable Michael O. Leavitt

GRACE-MARIE TURNER: Thank you all very much for joining us today for this special forum on the Medicare program, which now funds medical care for more than 42 million senior citizens and disabled Americans. The presence of so many of you here shows that you understand the need to focus on Medicare more than just once a year when the Medicare Trustees' report is issued.

I am Grace-Marie Turner, president of the Galen Institute, a public policy research organization that focuses on free-market ideas for health reform. We are co-sponsoring this event with our colleagues from The Heritage Foundation and the American Enterprise Institute. We also welcome the CMS Network as well as the Kaiser Network. They are broadcasting this event from the Newseum as a Webcast, which will be available later today on KaiserNetwork.org, as well as at Galen.org and Heritage.org.

We also are very pleased to welcome Senator John Breaux and Secretary Mike Leavitt, plus a distinguished panel of experts to discuss the future of Medicare. Secretary Leavitt titled his talk "Drifting Toward Disaster." He has been refining his address personally until the early hours of this morning, showing his dedication to this issue. Following his address, our distinguished panel will discuss solutions for Medicare's sustainability.¹

The Secretary will talk to us about the magnitude of the problem, and our panelists will be talking about big picture solutions. So to begin, I want to welcome my dear colleague and friend Bob Moffit, Director of

Talking Points

A Medicare system solvent through the 21st century would have three characteristics.

- **Value of care would replace volume of care as Medicare's best rewarded virtue.** The entire process rewards volume. We need to build incentives for high quality, efficient care directly into the Medicare payment structure.
- **Medicare Parts A and B would operate more like Medicare Part D.** The success of competition in the Medicare Drug Program demonstrates the power of personal choice. The cost of the benefit is transparent to consumers and they can choose the benefits that meet their needs.
- **Each generation would carry its share of the load.** Medicare is based on the cost of seniors' health care being borne primarily by younger workers. The demographic reality is there are diminishing numbers of workers per senior. Promises to today's and future beneficiaries must be kept, but not at the expense of future generations.

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/hl1088.cfm

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the Center for Health Policy Studies at The Heritage Foundation. Once again, thank you all very much for coming.

ROBERT E. MOFFIT, PH.D.: Ladies and gentlemen, on behalf of my colleagues at The Heritage Foundation, I also want to welcome you to this important forum.

Politicians think about the next election. Statesmen think about the next generation. Senator John Breaux, a Louisiana Democrat, is a statesman. He was elected to the House of Representatives in 1972 at the age of 28, then the youngest member of Congress. He was then elected in 1986 to fill the seat of Senator Russell Long of Louisiana and began a stellar career as a champion of bipartisanship in the United States Senate.

Senator Breaux rose to prominence as a member of the Senate Finance Committee and was a leader in welfare reform and tax reform. But it is in the area of entitlements where he made his greatest name. As Chairman of the Committee on Aging, Senator Breaux highlighted the importance of strengthening both Social Security and Medicare. In 1998, he was selected by President Clinton and House and Senate leaders to chair the National Bipartisan Commission on the Future of Medicare.

Since his retirement from the Senate in 2005, he has remained a steady voice of reason and a source of wise counsel for Republicans and Democrats alike. It is my honor to give you Senator John Breaux.

HON. JOHN BREAUX: Thank you very much Bob. Thank you for your contributions over the years and for your continued work in this area.

Good morning to all of you. What a great crowd. And we have a great panel. I am delighted to be here to present—not to introduce, but to present—to you the Secretary of HHS. We all know of his great work. He promised me that right after he fixed

Medicare, he was going to go out and fix Medicaid. And then right after that, he would fix the problem of the uninsured. And after that, he will fix the VA and then provide universal care for all of us. So it is going to be a busy day. But with his determination, I am sure it can get done.

What we really need in this area is truly not all that complicated. When I was on the Senate Finance Committee, we would have almost endless hearings with the Secretary on Medicare reform. Group after group would also come before the Finance Committee and say, “Senator, you have got to fix Medicare. Fix it, but do not cut my benefits. Fix it, but do not increase my premiums. Fix it, but make sure you do not increase the eligibility age. But, darn it, fix it!”

The problem obviously is that the things that you have to consider, the things that you have to look at, and the things that you have to do require not more books—except maybe books on political courage.

We should have a forum on political courage: how you get it, and how you keep it. It’s how you make reform work. Because the great challenges facing Congress reflect a great deal about the politics of our government and how we go about solving these challenges. There are great suggestions on how to fix Medicare. But the real issue is the political ability to make those very tough decisions by a political body that runs for office on a regular basis. It is very difficult.

We made recommendations on the Medicare Commission. Some of them were good. Some of them were enacted. The prescription drug program in Part D was part of that; it has been a great success. So I am really delighted to bring both Republicans and Democrats together to see if we can get this done. Everybody can take credit for getting it done. What Secretary Mike Leavitt brings to the table is an understanding that comes from being a Governor, from being a Cabinet Secretary, and from being a person who is really committed to health care in this country. His is the type of leadership that both sides

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1. Panelists included Robert Berenson, M.D., Senior Fellow at the Urban Institute (*urban.org*); Stuart M. Butler, Ph.D., Vice President for Domestic and Economic Policy Studies at The Heritage Foundation (*heritage.org*); Thomas P. Miller, Esq., Resident Fellow at the American Enterprise Institute (*aei.org*); Alice M. Rivlin, Ph.D., Senior Fellow at the Brookings Institution (*brookings.edu*); and Gail R. Wilensky, Ph.D., Senior Fellow at Project Hope (*projecthope.org*).

of the political aisle can appreciate. He is a man both sides can listen to, and can find the political courage necessary to accomplish that task.

He knows the subject. In addition, he brings the commitment and the political leadership. Ultimately, this is the greatest challenge as we look at reforming health care in this country. So, I am delighted to present to you the Honorable Michael Leavitt, Secretary of HHS.

HON. MICHAEL O. LEAVITT: I want to begin by explaining my motivation for giving this speech. Our nation has made a promise to provide health care to our seniors. I am going to speak critically of our current course. I don't want to see us fail. To keep this commitment requires change. Time is running out. Medicare is drifting toward disaster.

I am a Trustee of the Medicare Trust Fund. On March 26 I attended what will likely be my last annual spring meeting of the Trustees. Our primary business was to issue a report to the people on the condition of the Social Security and Medicare Trust Funds. The report is based on work by the government actuaries.

In the Treasury conference room we use there is a wall clock that has been there since 1873. At one time, the clock was actually hooked to the Western Union telegraph line which calibrated the exact time on a regular basis.

This year, Rick Foster, the chief Medicare actuary, sat in perfect alignment between me and the clock. As Rick gave his report that the Medicare Hospital Insurance Trust Fund was projected to be insolvent in 2019, I could see time passing with each swing of the clock's pendulum: ticktock, ticktock.

I'm not sure if that caused what I am going to describe to you, but as I listened I felt the weight of this responsibility pressing on me. When the report was finished, the final page of the report was passed around for our signatures.

It felt like the moment required more than just signing my name and moving on to the next appointment. This is serious business involving trillions of dollars and the lives of hundreds of millions of people.

As much as anything, the weight was a blend of responsibility and selfish panic. I realized that when the actuaries' forecast matures—and it will—somebody is going to say to me, "Weren't you a Trustee of the system for four years? What did you do to address the problem?" Somehow, the response "I signed the report each year" just doesn't feel adequate. Though the truth is, that's about all the authority the Trustees are given.

Just before the vote to accept the report, I asked the Secretary of the Treasury, Hank Paulson, the managing trustee, if he would keep the record of the meeting open because there were some things I just felt a need to say. He agreed.

My remarks today are a response to my discomfort, and I plan to submit them as part of the minutes of the March 26 Trustees' meeting.

"Scouting the Rapids"

I have constructed a metaphor in my mind that is useful in describing our dilemma with the Medicare entitlement program, which I will share with you today.

Whitewater canoeing at the championship level is high adventure and comes with serious dangers. My friend, Matt Knot, is an instructor and guide on the Gauley River in West Virginia.

There are treacherous places in whitewater country. Canoeers call them hydraulics. They are given descriptive names like "Hungry Mother" or "Lunch Counter" that dramatically communicate danger.

Hydraulics form when water pours over an obstacle like a rock. Unwary canoeists get sucked into them and can be trapped in one place by the force of the current. They are instantly overwhelmed and dragged under by the whirlpool effect created.

Matt says when you go into a hydraulic everything gets very dark as you are pulled deeper. Water circulates the boat back to the surface and then drags it down again, over and over. Survival depends on keeping your wits, waiting—and hoping—to be flushed out the bottom.

Some thrill-seeking river runners find the experience of navigating a hydraulic exhilarating. However, the worst hydraulics are known as "keepers." Boaters become victims when they get sucked down

into a hydraulic, and instead of being tossed about for a while and flushed out from the bottom, they get mired in a jungle of debris, which has also been sucked into the same hole.

This is an important point to remember: it is not just the hydraulic that brings fatal consequences; it is the combination of the hydraulic and debris that isn't evident.

Matt teaches students to anticipate. He calls it "scouting the river." Scouting is more than looking ahead. It's listening for the roar and sensing when the current is pulling you toward a dangerous place.

Here's the second important point. Safety comes only in foresight and avoidance. Matt says, "You have to start positioning your canoe well ahead of the danger, commit to a course that avoids the dangerous area, and then paddle hard."

I'm sure it is obvious to you that the river in my metaphor is the growing obligation our nation has to the pay for the health care of our senior and disabled citizens. Medicare's liabilities have grown from a mere trickle 40 years ago into what Matt Knot would call "Class 5 rapids." As new streamlets merge, it is becoming a raging torrent—more demanding and dangerous with each successive day.

The Medicare Trustees' Report does a good job of "scouting the rapids." But a nation that does not act on the warnings it contains is no different than a canoeist ignoring evidence of hydraulics in the river ahead.

The disaster is not inevitable. If we act now, we can change the outcome. In health care, the core problem is that costs are rising significantly faster than costs in the economy as a whole.

Rising Costs, Aging Population

Health care has done exactly that for my entire life. When I was born, it was 4 percent of the economy. When my son was born, it had doubled to 8 percent. When my first grandson was born two years ago, it had doubled again to 16 percent.

Every piece of evidence shows the trend continuing. The problem is beyond the fact that medical cost growth is faster than that of any other part of the economy. Our problem is also demographic. Our population is aging and as we age, medical expenses

grow. Today, 12 percent of the population is 65 or older. By 2030, nearly 20 percent of us will be seniors. There is nothing we can do to change that.

We have made a decision in our society that the cost of seniors' health care will be borne primarily by younger people who are still working. When that decision was made, it was assumed there would always be a fresh crop of earners to support the health care of their parents. That is not proving to be true. The demographic reality is there are diminishing numbers of workers per senior, and this ratio will decline rapidly once the "baby boom" generation reaches Medicare eligibility age starting in 2011.

In preparing to deliver this speech, I had economists, actuaries, and demographers developing detailed scenarios demonstrating how this will unfold. I then spent hours—writing draft after draft—looking for the right combination of facts to illustrate our dilemma. I've concluded today, that such a fact-filled analysis is unnecessary. Most of you have done the math yourself and know the simple truth: Higher and higher costs are being borne by fewer and fewer people. Sooner or later, this formula implodes.

The real pressure on this problem starts between now and 2019, when the Medicare Hospital Insurance Trust Fund is projected to become insolvent. There is no backup plan in the law to ensure that hospitals continue to be paid when the Trust Fund is depleted.

Congress will not be able to sit idly by and allow the Medicare program to become insolvent—they will be forced to take action. They will have the old familiar choices of raising taxes, cutting benefits to seniors, or imposing reduced payment rates on health care providers. Some of these choices represent the ugliest of political dilemmas, pitting a generation of workers against their parents and grandparents.

I have a son who is 30. He and his wife are just beginning their household. They have one young daughter and another baby on the way. They are in many ways becoming a typical American household. This is a wonderful thing to see as a parent, but I worry about our national economic future; I worry about our coming generational divide.

Let's consider what their generation's economic prospects look like over the next two decades. The typical household is going to see its health care spending basically double in the next twenty years—from 23 percent to 41 percent of total compensation. At the same time, we are going to nearly double the share of federal spending that goes to pay for Medicare, from 13 percent to more than 23 percent. And we are going to do this while the number of working people per Medicare beneficiary is sliced nearly in half, from 4 to 2 and a half.

That is clearly not a rosy scenario for growing young households like my son's. These working families will argue, "My generation did not agree to this arrangement. This is happening at a time when my own health care is unaffordable. I have children who need food and clothes. I'm struggling to make ends meet. Seniors need to either have lower benefits or pay more of the cost themselves." In fact, they will insist, "We are the ones with the heavy burden. Government needs to help us more so we can continue to work and enjoy what our parents did."

But their parents and grandparents will have legitimate worries too. They will argue, "I did my time. I paid into the system. I have a legal entitlement for health care, and the government has a moral obligation to provide it. I know the demographics have changed, but that isn't my problem." In fact, seniors will argue, "Health care costs are so high, my Medicare premiums, co-pays and deductibles are eating up almost half of my Social Security check. You need to help us more, not less."

The problem is: both will be right. The problems we see today with Medicare have the power to pit these parents and children against each other in an intergenerational economic struggle where each side will suffer.

Frighteningly, we will see that competition for resources play out much like another economic tension we are already experiencing. Our choices about social investment—in infrastructure, education, national defense—are being reduced as mandatory spending crowds out discretionary spending. In the last two decades, we've gone from half of our national spending being discretionary to only 38 percent. In four years, it is projected to be down to less than one-third.

We are seeing mandatory health care expenses crowd out other government spending—just as we are going to see health care spending crowd out non-health care spending in American households.

By now the current has grown so much that we are being sucked down into the hydraulic whirlpool again and again, with little surface time for air. The debris is piling up, and we may not have a way out.

Would it be a stretch to say 20 years hence, we would likely have accumulated a substantially larger national debt than we have now; and that a significant portion of that debt would be in the hands of foreign capital sources? Again, that's our current course.

Other nations, of course, have scouted out the river. What will the impact be of continued trade deficits, and new global competitors who spend a fraction of what we do on health care, yet produce similar or better big picture health results?

We factor continued growth into our scenario like it is certainty. Without continued investment from private and public sources, our prosperity would be taken away.

I was in Singapore the week before last. Their health care system consumes 4 percent of their gross domestic product. Rather than a Medicare-like government system, they require citizens to save. Incidentally, the Singaporean life expectancy is slightly longer than it is in the United States.

I would simply ask this question. If you were considering between an investment in two organizations and one spent 4 percent on health care with no future liability and the other spent 16 percent and had trillions of dollars of unfunded obligations, which one would you be most interested in?

In the late 1990s, I was Governor of Utah, and went to Argentina to develop trade relationships. I met various ministers of the Argentine government who, at the time, were proposing some aggressive and controversial changes. Among these was an attempt to transition their country away from a constitutionally protected pension system, their version of entitlements.

I remember thinking, "These are the most courageous political leaders I've ever met." I soon found it was not just courage. They were compelled.

Thinking the Impossible

At the beginning of the 20th century, Argentina was one of the wealthiest countries in the world—wealthier even than the United States. Over the next fifty years, successive governments constructed, and then expanded, an ever-generous system of social benefits, nationalized industries, and created a vast and bloated public administration. Yet protectionist policies and a failure to invest in innovation in agriculture and other key industries meant the world economy began to change while Argentina's didn't. Its productivity suffered. But the country kept on spending, content and confident it was better-off than its neighbors.

As it turns out, Argentina had been operating for many years on money borrowed from the financial markets and organizations like the World Bank and the International Monetary Fund. By the 1990s, the mortgage outstripped the country's ability to pay. Creditors told Argentina, "No more, unless you fix your entitlements."

Frankly, Argentina had started down the path of reform late, and once the government started, the political pain was too much—the nation could not sustain it. The government developed a solid monetary policy, but could not change its fiscal or spending practices.

A few years later, Argentina was in political turmoil, with a rapid succession of governments, a currency in free-fall, and a rapid spike in unemployment. The country teetered on the verge of civil unrest. Why? Because Argentines had put off hard choices for so long they were forced to make change too quickly, and they simply didn't have the political strength to do it.

It seems inconceivable that the United States of America, the strongest economic power in human history, the land of the free and the home of the brave, could ever be in a situation like the one Argentina faced a decade ago. But, is it?

Let's think on a horizon of twenty years.

Is it hard to conceive of a severe productivity dip in the United States as labor markets become more sophisticated in nations like China, Vietnam, India, and Brazil? They are increasingly competing not

only with our manufacturing sectors but also with our more dynamic knowledge sectors.

Is it really difficult to imagine world credit markets saying to the United States of America—as the world did to Argentina: "Given your lack of action in dealing with your deficit and the entitlements causing the problem, we are beginning to lack confidence in you"?

When we talk about the metaphoric torrent we are navigating, it is much more than just Medicare, of course. The massive burden we are feeling is created by a full 16 percent of our gross domestic product rushing through a single sector of the economy. We need changes that can affect this entire sector we call health care.

But there is a very close relationship between Medicare and the balance of the U.S. health sector. Medicare is such a powerful payer; the rest of the sector has based their billing and reimbursement mechanisms on Medicare.

I believe the key to health care reform in our nation is Medicare reform. Successfully changing Medicare will trigger the rest of the health care sector to follow. That would be better news if changing Medicare were not so politically and bureaucratically complicated.

Sounding the Alarm

Since I am speaking in my capacity as a Trustee of the Social Security and Medicare Trust Funds today, it is important to acknowledge that this job is about sounding the alarm. I hope I have made clear to you just how alarmed I am and how alarmed we should all be. There is serious danger here. It troubles me that this matter is not receiving more attention in the presidential candidates' discussions. The next President will have to deal with this in significant part. In fact, if they don't deal with it, our opportunity to apply Matt Knot's strategy of repositioning early and paddling hard is lost.

So, given the strong possibility this won't get fixed in the next 266 days, I would like to add some general advice on the creation of a political construct for action and a general strategy to solve the problem. I want to add, these are not being presented as Administration policies or proposals. I take

complete responsibility for them as a Trustee simply laying out my thoughts.

To get this done, we will have to do three things: separate the commitment from the pain, pick the right moment, and modernize the budget scoring conventions.

Separate Commitment from Pain. I believe there will need to be some trigger points built into legislation so members of Congress are not casting a vote to take specific measures but rather laying contingent plans if things go beyond a predetermined point. For example, if Medicare exceeds more than a defined percentage of the gross domestic product, some combination of actions would be automatically triggered and could be overridden only by a difficult to obtain super-majority.

Next, pick the right moment. It will be necessary for Congress to acknowledge that bi-partisan action is required. The usual legislative process won't ever produce enough bi-partisanship to deal with this problem. The way election cycles operate now, only a few months separate the time one election cycle ends and the next one begins.

Senators like Judd Gregg and Kent Conrad have offered bi-partisan legislation creating a special legislative process similar to those relating to military base closures. My sense is that such arrangements need to be put into place during windows of time when control of political power is sufficiently uncertain that both major parties feel at risk. To succeed, the rules of such a process would need to be the product of a larger consensus requiring both parties to operate under them regardless of whether they were in the majority or minority.

Finally, modernize scoring conventions. Many of the tools Congress will need to reform Medicare will involve significant behavioral changes and require investments that traditional scoring conventions would count solely as expenditures. In an age when the power of investment and productivity are the keys to success, the federal scoring conventions overvalue the status quo while undervaluing the investments that could transform it.

So far this morning, I have talked about the serious imperative our nation has to change the course of Medicare.

I also discussed several parts of a political construct that would allow political action.

Now I would like to frame up, at a high level, what a solution should look like from my perspective. I'm ready to break into song on this matter, but will restrain myself. However, if you find this preview interesting, I would enjoy sharing it in more detail with you at another time.

A Medicare system solvent through the 21st century would have three characteristics. First, value of care would replace volume of care as Medicare's best-rewarded virtue. Second, Medicare parts A and B would operate like Part D. Third, each generation would carry its share of the load.

1) Value of care would replace volume of care as Medicare's best rewarded virtue.

In Medicare, our most expensive patients are those with multiple chronic diseases. The combination of ailments compounds to magnify each other. The same is true with Medicare. Medicare has three chronic ailments that are defeating the system.

The first, I call *Silo Syndrome*: Each medical action is paid for separately. That provides little opportunity or incentive for coordination among providers and it often results in bad referral decisions, sloppy hand-offs, duplications, fraud, and poor quality of care. The result is inappropriate care and unnecessary cost.

Medicare needs to use its power as the nation's biggest payer to change this. It's not only wasteful but it encourages unnecessary care and expensive medical mistakes.

The second category is *Quality Indifference*: Doctors, hospitals, and other medical providers are paid at the same rates for low-quality or high-quality performance. Physicians who take measures that prevent acute flare-ups of chronic conditions are paid no more than those who don't. Skilled nursing facilities that prevent unnecessary re-hospitalizations are paid the same as those that don't. In fact, poor quality is often rewarded. When patients contract preventable hospital infections, costs skyrocket and in most settings, the hospital profits from it. Not only is our current system quality-indifferent, we reward poor quality!

Patients deserve to know the quality of the care they receive according to standards set by the experts. The information should be transparent, and most of all, we should reward quality.

This leads naturally to the third category: *Chronic More*. There are no mechanisms or incentives for controlling the volume and intensity of care. Not for the patient or the provider. The entire process rewards volume. Doctor and hospital incomes rise as more units of service are ordered. If those units are more costly, they generate even more revenue.

It is the same for a patient. Our current payment system provides no means for a patient to know the cost and little reason to care.

These volume incentives need to be treated with strong doses of information transparency and by building incentives for high quality, efficient care directly into our payment structure. A variety of policies would force these changes, and luckily the infrastructure of quality metrics and strategies for rewarding value are available. It just takes congressional action.

2) Make Medicare Parts A and B more like Medicare Part D.

In addition to changing the incentives from volume-rewarding to value-rewarding, the Medicare Part D Prescription Drug Program provides a good example of how better transparency and competition can drive change. It has not only ensured that seniors get the drugs they need, it has also demonstrated that seniors can use an organized marketplace to drive quality up and cost down.

Today, 90 percent of those who are eligible have drug coverage; satisfaction rates are high; and the cost is almost 40 percent below the original estimates. While there are several things that have contributed to the drop, a big one is the power of a competitive marketplace. Prices are determined through competition. The cost of the benefit is transparent to consumers and they can choose the benefits that meet their needs.

If the Medicare Part D structure were applied to Medicare Parts A and B, it would revolutionize the entire system. Imagine a physician practice invest-

ing resources to monitor and track patients with chronic conditions. They might if the program provided a beneficiary information on the quality of their care and dollar savings if they used more effective providers. It would drive quality up and cost down.

3) Each generation needs to do its share.

My father and mother are on Medicare. They worked hard all their lives and have done well. My dad likely earns more than the 30-year-old son I told you about earlier. He is struggling to buy a home, support his family, save for the children's college fund, and buy his health insurance. Yet, my son has taxes drawn from each paycheck to subsidize my parent's health insurance.

Medicare can be made more efficient by rewarding value and shifting to a PartD-like competitive model of delivery. However, what remains as the most important obstacle is rebalancing the generational obligation.

This is a classic public policy decision that has to be faced. It is simply unreasonable to think Medicare can be sustained unless this is changed. If we start now, the change can be made over time and with genuine fairness. We can avoid an intergenerational economic struggle from which both sides suffer. Promises to today's and future beneficiaries to provide coverage of health care must be kept, but not at the expense of future generations.

Conclusion

Medicare is indeed drifting toward disaster, but we know what to do. Matt Knot's river advice is the key: "Start positioning your boat well head of the danger, commit to a course that averts the problem, and paddle hard."

Every generation of Americans has overcome challenges to secure our nation's role as the world's economic leader. I believe solving the health care puzzle is this generation's challenge. It will require change.

In a global market there are three ways to approach change. You can fight it and fail; you can accept it and survive; or you can lead it and prosper.

We are the United States of America. Let us lead.