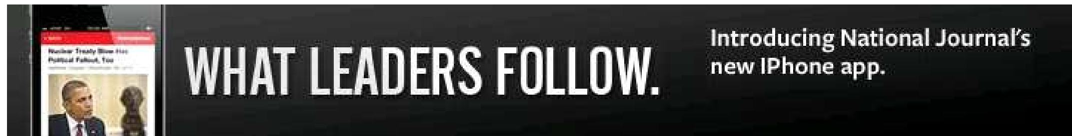

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POLITICAL CONNECTIONS

First, Do No Harm

Republicans and Democrats have competing visions for fixing Medicare. The plans carry contrasting risks.

by **Ronald Brownstein**

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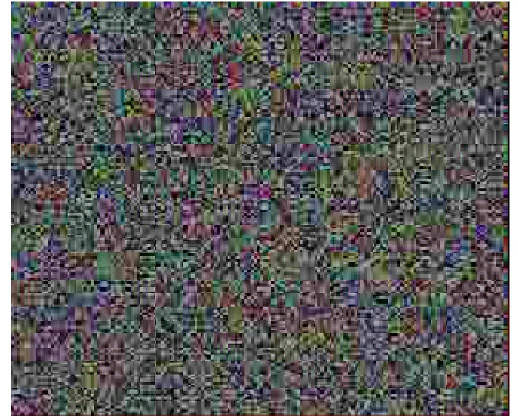

Washington won't stabilize its long-term debt unless it slows rising health care costs, especially for the elderly. That's one conviction that unites President Obama and congressional Republicans.

But the two sides offer divergent paths to that common destination. The differences revolve around three big questions: whether to change the incentives primarily for patients or for health care providers; whether centralized or decentralized action will best drive change; and whether government or individuals should principally bear the brunt and the risk of rising costs. The answers add up to radically different visions of America's social safety net.

Obama placed his bet with last year's health reform legislation. It aims to slow health care spending mostly by changing the calculus for providers, such as doctors and hospitals. The law advances an integrated strategy to nudge the medical system from today's fee-for-service approach toward a structure that more closely links compensation for providers to results for patients.

For instance, the legislation allows groups of providers to share in savings when they form "accountable care organizations" to better coordinate patient care. It ties hospitals' reimbursements to their quality ratings and penalizes them if too many of their patients must be readmitted. It creates mechanisms, including an independent Medicare board, to incubate further delivery-system changes.

This agenda rests on the belief that Medicare, with its colossal leverage as the health care purchaser for nearly 40 million seniors, can function as a battering ram to compel providers to accept reform. Once Medicare establishes the beachhead, the law's advocates believe, private insurers can also adopt these innovations, compounding savings. The ambitious partnership with business and provider groups to improve hospital quality that the administration announced this week captures how the process is supposed to work. "You need at least one large-enough buyer to lead and change the market," says Jonathan Gruber, a Massachusetts Institute of Technology health economist who advised the Obama effort.

Republicans rejected all of those arguments in the blueprint from House Budget Committee Chairman Paul Ryan, R-Wis., expected to

pass the House this week. His plan would not only repeal Obama's health care law but also end the existing Medicare program for Americans 55 or younger, replacing it with a voucher (or premium-support) system in which government would provide seniors a stipend to buy private insurance.

By dispersing the elderly among a multitude of private plans, Ryan would prevent Washington from encouraging reform by concentrating its buying power as Obama envisages. Instead, he's betting that the competition among private insurers for seniors' premium dollars would spur efficiencies—as it seems to have done among the insurers providing Medicare's prescription-drug benefit.

Ryan also departs from Obama by seeking to change behavior mostly among patients, not providers. His approach assumes that seniors will spend less if they must personally cover more health costs. "Seniors will choose more-economical health plans and put downward pressure on prices," argues the Cato Institute's Michael Cannon, a Ryan supporter.

But the nonpartisan Congressional Budget Office, in a stinging analysis, concluded that Ryan's plan would *increase* the elderly's total health spending, even while reducing government's share. CBO projected that total costs per-senior under Ryan's proposal would be about one-third *higher* than under conventional Medicare by 2022 and as much as *40 percent* greater by 2030, mostly because private insurers pay providers more than Medicare does. Seniors would shoulder that increased cost, paying more than twice as much out of pocket under the Republican's plan than under existing Medicare. Meanwhile, Ryan would save government only about 3 cents per dollar through 2030. As Gruber notes, that means seniors by then would spend $14 more for every $1 that government saves.

The government savings from vouchers would grow. But as Cannon forthrightly acknowledges, the GOP proposal likely won't reduce the elderly's overall health spending unless "seniors respond to the Ryan plan by purchasing less-comprehensive coverage and, therefore, consuming less medical care." Cannon argues that Medicare is so riddled with waste that seniors can cut back without harming their health. Yet—ironically, after Republicans (inaccurately) accused Obama of creating plug-pulling "death panels"—the CBO analysis suggests that Ryan's plan will reduce seniors' total health spending only if they self-ration their care.

That points to the two proposals' third big contrast. Obama aims to bolster the collective sharing of risk. His reform would vastly reduce the number of uninsured. It also requires government to bear the principal financial burden of rising medical costs. By contrast, tens of millions of Americans would remain uninsured under Ryan's approach (including, potentially, more seniors because it would not force them to buy private insurance). Although his Medicare restructuring would limit government's expense, it would expose the elderly more directly to escalating health costs.

The principal risk in Obama's proposal is that his health care reforms won't "bend the curve," and government costs will explode. The principal risk in Ryan's plan is that it could enormously increase the number of Americans without decent health insurance. That's a difference big enough to fight a presidential campaign around.

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