

OPINION

Medicare Reform: Obama vs. Ryan

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As the fallout over the Standard & Poor's downgrade makes clear, getting the country's future finances under control will require going beyond the spending-growth reductions in the Budget Control Act of 2011 and making fundamental changes to our entitlement programs, especially Medicare. To make the Medicare program fiscally sustainable, reform must: (1) place limits on spending growth and (2) change the program to hold actual spending growth to these limits.

There are two major approaches to achieve these ends. On April 6, House Budget Committee Chairman Paul Ryan put forth a plan that transforms Medicare into a marketplace of regulated, private-insurance policies with government-provided support for insurance premiums. On April 13, President Barack Obama proposed an alternative that retains the program's current structure with the overlay of a new, centralized bureaucracy.

Both plans place limits on spending growth that are far below that projected under the current Medicare law. The most important difference between the plans is their approach to containing spending within these limits.

The Ryan plan builds on the approach of the Medicare Part D prescription drug benefit, which has been widely recognized as a success. It encourages competition among private insurance plans and provides incentives for cost-conscious choices among plans by beneficiaries. The Obama plan would empower a new Independent Payment Advisory Board (IPAB) to analyze the drivers of excessive and unnecessary Medicare spending and recommend policies to Congress to limit it.

Mr. Ryan's approach would be more effective. It vests ultimate responsibility for cost containment with individuals and families, who have more limited ability to spend beyond their means than the government. It commits the government to spending a specific dollar amount, rather than an amorphous promise to eliminate unnecessary care—a promise that has been made and broken by politicians

many times before. Without a credible commitment to cost control, the incentives of doctors, hospitals and patients will be to spend more and more.

The Ryan plan has other advantages. It would result in better health services for each Medicare dollar because it uses market prices to allocate resources rather than a government-determined fee schedule. Politically-determined prices cause too much

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spending on some items and too little on others. For example, a study by Medicare Payment Advisory Commission (MedPAC) researchers published in the 2008 Health Affairs suggests that Medicare's overpayment for imaging services contributed to rapid spending growth. Although the new health-reform law seeks to address this problem with the IPAB, there is little reason to believe that it will succeed substantially better than MedPAC, which was created in 1997 in part to insulate Medicare policy from political meddling.

Finally, the Ryan approach would better protect older beneficiaries and those with poor health or low incomes. Such protections are implicit in the Obama plan, which simply promises not to harm access or quality of care. But they are explicit in the Ryan plan, which would give older and sicker beneficiaries a larger premium support payment and wealthier beneficiaries a smaller one.

Centralized, government-run insurance systems faced with resource constraints ration care by restricting eligibility for treatment. The Independent, a London newspaper, reported last month that cataract operations in Britain's National Health Service are being withheld until patients' sight problems "substantially" affect their ability to work. Hip and knee replacements are only being allowed when patients are in extreme pain.

In the U.S., as Medicare has re-

duced payment rates (the way that it has always tried to save money) physicians have begun requesting additional fees from beneficiaries to remain part of their practices. Although such "concierge" or "retainer" payments are still rare in some parts of the country, they have become more prevalent in Los Angeles, Miami, New York and Washington, according to a 2010 report by MedPAC. One of MedPAC's commissioners, Robert Berenson, has called concierge medicine "a canary in the coal mine."

There are also differences between the two plans in how they set limits on spending growth. The Obama plan starts limiting spending growth earlier, in 2014, rather than in 2022. It caps spending per beneficiary at the rate of growth of GDP per capita plus 0.5%, while Mr. Ryan's plan caps spending per beneficiary at the growth in the consumer price index.

As a result, in later years the Obama spending growth rate is likely to be slightly higher than the Ryan plan's, with the difference contingent on the growth rate of real GDP per capita. For example, if per capita income growth in the United States is 1%, then the Obama plan would increase Medicare spending by 1% more per year than the Ryan plan.

Here there are advantages to the Obama approach. By starting earlier, the Obama plan deals more effectively with the current debt problem. And by linking the spending growth to per capita income growth, it is contingent on the resources available to support the program.

No approach to reforming Medicare will be perfect or painless for everyone under all circumstances. The question is how best to commit the government to limit spending while promoting quality, protecting the poorest and sickest among us, and preserving the program for future generations. Mr. Ryan's plan is the better path forward and may work even better if the spending limits are set in the way President Obama proposed.

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