Preserving Medicare: A Practical Approach to Controlling Spending

Timely Analysis of Immediate Health Policy Issues

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Summary

Spending on the major entitlement programs, Social Security, Medicare and Medicaid, is a primary target of those seeking to reduce the federal deficit. In this paper, we focus on the debate over Medicare. Much of the discussion about the need for substantial reform in Medicare ignores the cuts in the Affordable Care Act (ACA) of about $500 billion over 10 years. This has reduced the projected growth rate in spending per beneficiary to about 3.5 percent, similar to the projected rate of growth in gross domestic product (GDP) per capita (3.8 percent).[1] However, increases in physician fees that are likely to occur will add $300 billion to Medicare spending over 10 years, adding about 0.7 percent to the growth rate. Nonetheless, significant steps to address Medicare spending growth have already been taken. In short, Medicare's projected fiscal problem is major one, but is now being driven more by growth in population served rather than program inefficiency as commonly asserted.

Recently, Congressman Paul Ryan introduced a major proposal that would privatize Medicare. The Congressional Budget Office (CBO) correctly argued that the Ryan plan would increase the overall spending on Medicare beneficiaries and shift large amounts of current spending to the beneficiaries themselves. A main problem with Ryan's proposal, as well as other Medicare privatization initiatives, is that private insurers simply do not have the leverage to negotiate with strong providers. In setting hospital rates and physician fees, Medicare exercises the demand-side market power that private insurers lack. As a result, private payment rates are substantially higher than Medicare's, and private plans are more expensive.

Moreover, spending by Medicare beneficiaries is skewed; the sickest Medicare beneficiaries account for about three-quarters of program spending. The expenditures of these beneficiaries exceed any plausible out-of-pocket caps in private insurance plans. Once these caps are exceeded, expenditures are not constrained by cost-sharing, which is the approach that the Ryan proposal essentially relies on.

We believe reforms to Medicare are needed, and that the program can be changed to achieve considerable savings without a major restructuring. The ACA has proposed experiments with large numbers of delivery system reforms. We need to let these pilot programs develop, learn from them and adopt successful approaches. In the short term, the CBO, the Medicare Payment Advisory Commission (MedPAC), deficit reduction commissions and others have made many proposals for achieving savings, such as increasing home health co-payments and extending Medicaid drug rebates to Medicare dual eligibles.

We make a number of other proposals for savings. It is possible to increase premiums for those with incomes above 300 percent of the federal poverty line (FPL) on an income-related basis, while at the same time reducing premiums for those with incomes below 300 percent of the FPL, much like the structure of ACA subsidies. This adjustment could be made in a way that provides net savings. The Medicare cost-sharing structure is enormously complicated and could be streamlined. The National Commission on Fiscal Responsibility and Reform offered a proposal that would save $110 billion, and also proposed increasing deductibles in Medigap plans to affect the level of utilization in Medicare. Once the ACA is in place, it will also be possible to phase in and increase the age of eligibility in Medicare; according to CBO estimates, this change could save Medicare $125 billion. There would, however, be shifts in spending to employers, states and higher-income Medicare beneficiaries; moreover, overall spending would be higher, though federal spending would be lower.

It is possible to improve Medicare governance to reduce spending, particularly with respect to making policy for covering and paying for new services. Increasing administrative resources could also more than pay for itself by reducing the fraud and abuse in the program. Finally, it is possible save a considerable amount by having Medicare take responsibility for management of acute care services used by dual eligibles. All told, these measures could provide substantial savings to Medicare without shifting potentially huge spending burdens onto beneficiaries. Our proposed changes to the Medicare program's governance and management, its cost-sharing provisions, income-related premium contributions and age of eligibility can be adopted without threatening the role of Medicare as an important institution of social insurance.

Urban Institute

Introduction

This paper examines alternatives for controlling Medicare spending growth within the structure of the current program. We begin by examining projections of Medicare spending growth over the next decade and show that the projections are significantly impacted by increases in Medicare enrollment due to retirement of baby boomers. On a per capita basis, Medicare spending growth is reasonably low, close to the growth in gross domestic product (GDP) per capita, largely because of the impact of policies adopted in the Affordable Care Act (ACA). But given the nation's fiscal straits, there is a clear need to examine all available savings from entitlement programs.

We examine the proposal introduced by Congressman Paul Ryan and conclude that the policy would be less effective compared with the current program. The overall cost of care provided to the Medicare population would increase, but government costs would fall simply because spending would be shifted to beneficiaries. Private insurers do not have Medicare's current negotiating power with providers; further, most of Medicare spending is on beneficiaries who would exceed plausible out-of-pocket caps in private plans, and thus most utilization would be unconstrained by cost sharing. We argue that Medicare's use of market power to set provider payment rates well below those of commercial payers has been reasonably successful in controlling Medicare costs. Given the high level of market concentration among providers, the exercise of demand-side power is simply essential to cost containment.

We conclude with suggesting a number of alternative ways to control Medicare spending growth: strengthening Medicare governance; increasing administrative resources, particularly related to fraud and coverage of new services; lowering Medicare premiums for low-income individuals, but increasing them for higher-income individuals in a way that provides new net revenues; restructuring Medicare cost sharing to make it more rational and cap out-of-pocket spending, thus reducing the need for Medigap policies that encourage high utilization; and finally, adopting a concerted effort within Medicare to control the acute care costs of dual eligibles.

The Medicare Spending Problem

Medicare spending is projected to grow at about 6.5 percent per year over the next decade, about two percentage points faster than the growth in the U.S. economy—4.7 percent per year.[2] (Medicare spending growth would increase by about 0.7 percentage points faster if physician fees were allowed to increase with the Medicare Economic Index (MEI) rather than face large cuts, as discussed below).[3] Medicare, along with Social Security and Medicaid, are targets for those seeking to rein in the federal deficit, and will certainly be examined by the newly appointed debt ceiling supercommittee. Congressman Paul Ryan has also recently made a proposal for a major restructuring of Medicare.[4] We fully agree with the need to address the broad range of spending and tax policies that have contributed to the large federal deficit, but have concerns about proposals such as Congressman Ryan's that would essentially replace Medicare with vouchers to purchase private health insurance.

The Centers for Medicare and Medicaid Services (CMS) Actuaries' project surprisingly slow growth in spending per enrollee, only 3.5 percent per year over the 2010–2019 period (Table 1). GDP per capita is projected to grow at about the same rate, 3.8 percent over the same period, which suggests that the Medicare problem—at least in the near term—may be overstated, and that doing better than the current trend could be difficult, though still possible. A principal reason for the projected 6.5 percent rate of growth in Medicare is the substantial increase in enrollment due to the retirement of baby boomers who start turning 65 this year—Medicare enrollment is projected to grow by almost 3 percent per year. The 6.5 percent annual growth clearly places a strong claim on nation's resources, but nonetheless much of this has been completely predictable since the increase in the elderly population has been well known for years.

Table 1: Medicare Spending Growth Per Capita Post-ACA

(Expenditures in billions, coverage in millions, per capita spending in thousands)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Average Annual Growth Rate 2011–2021
Medicare												
Medicare Expenditures	548.9	585.7	619.8	655.8	684.5	723.1	770.9	828	891.4	959.7	1033.1	
Annual Percent Change in Medicare		6.70%	5.80%	5.80%	4.40%	5.60%	6.60%	7.40%	7.70%	7.70%	7.70%	6.5%
Medicare Coverage	47.9	49.3	50.9	52.4	53.9	55.4	57.1	58.8	60.5	62.2	64.0	
Annual Percent Change in Medicare Enrollment		2.90%	3.20%	2.90%	2.90%	2.80%	3.10%	3.00%	2.90%	2.90%	2.90%	2.9%
Per Capita Medicare Spending	**11.5**	**11.9**	**12.2**	**12.5**	**12.7**	**13.1**	**13.5**	**14.1**	**14.7**	**15.4**	**16.1**	
Annual Percent Change in Per Capita Medicare		3.67%	2.50%	2.78%	1.47%	2.78%	3.44%	4.30%	4.63%	4.63%	4.63%	3.5%

Notes: Expenditure and coverage estimates from CMS Office of the Actuary September 2010. Estimates for 2020 and 2021 are projected using 2019 growth rates.

The projections of relatively slow rates of growth in spending per enrollee is partially due to changing composition of the elderly population; that is, there will be an influx of population in the lower-cost 65- to 75-year-old group. The shift in composition brings down the rate of growth in spending by lowering the average cost of the Medicare enrollee. However, most of the explanation for the relatively slow growth by historical standards in spending per enrollee is due to ACA provisions that have reduced Medicare spending. These provisions include reductions in payments to Medicare Advantage plans, hospitals, skilled nursing facilities and home health services. The CMS Actuaries estimate that these provisions have reduced the growth rate by a full percentage point.

There are two reasons why these spending projections could be understated. First, the CMS Actuaries have argued that the ACA-imposed cuts that are responsible for slowing Medicare growth, particularly those for hospitals, mean that Medicare payments will not keep up with growth in hospital costs and thus are not sustainable politically. However, this argument implies that hospitals have little choice but to incur these costs. The Medicare Payment Advisory Commission (MedPAC) and others have shown that hospitals with relatively small commercial insurance market share and less ability to charge higher private rates often constrain costs and therefore can generate profits on Medicare patients. In contrast, hospitals with strong market power that can obtain higher private payer and other revenues appear to have less pressure to constrain their costs, leading to higher costs per unit of service and losses on Medicare patients. There was no evidence that lower-cost hospitals had lower quality; indeed, MedPAC identified a sample of more than 200 hospitals that it considered efficient because the hospitals performed relatively well on cost and quality metrics, while serving a broad spectrum of patients.[5] In short, hospital costs are not exogenous; it is possible for hospitals to live within budget constraints while maintaining relatively high quality.

There is other recent evidence on the debate over whether hospitals will increase charges or cut costs in response to rate pressures. James Robinson showed that hospitals can cost-shift in concentrated markets—they have market power—but are more likely to cut costs in competitive markets.[6] In a recent comprehensive review of the cost-shifting literature, Austin Frakt concluded that cost-shifting can occur, but is limited.[7] A study by Wu found that on average, providers shift 21 cents for each dollar lost on Medicare; this implies that they cannot or do not shift the other 79 cents.[8] The bottom line is that rate reductions generally, but not always, lead hospitals to lower their costs.

The argument that the payment reductions are unsustainable also fails to recognize that any successful cost containment policy necessarily will reduce provider revenues. This would occur whether it comes from private sector payers having the leverage to reduce prices that providers now command, or using management tools to reduce the volume of services. It also could come from higher cost sharing faced by Medicare beneficiaries. In any case, provider revenues will be lower. One cannot call into question any cost containment policy simply because it would reduce provider revenues.

The second complicating factor in considering projections of Medicare spending growth is that they are likely to understate actual spending increases, because they reflect the deep cuts that are mandated by current law, but not the increases in physician fees that have occurred in recent years and are likely to occur in the future. Since the enactment of the Balanced Budget Act of 1997, annual Medicare physician payment updates have been determined by the Sustainable Growth Rate (SGR) formula. This formula sets a target for physician fees based on the annual growth in GDP per capita. To the extent that actual expenditures exceed the target, the SGR formula produces a reduction in the update. In recent years, actual expenditures have consistently exceeded the spending targets based on GDP per capita, but Congress has deferred the resulting cuts without changing the mechanism, resulting in a growing gap between actual spending and the SGR target. As a result, the SGR formula would produce a reduction in Medicare physician fees of about 29 percent in 2012. Although Congress understandably has not permitted the SGR-generated cuts to occur, the premise that these cuts will take place remains part of budget calculations, because it is in current law. To accommodate the political reality that cuts that cumulatively would represent about $300 billion over 10 years will not actually take place, the CMS Actuaries have developed an "alternative scenario," which assumes that Congress will continue to override the SGR formula.[9] We calculate, based on the Actuaries' analysis, that increasing Medicare fees by the MEI rather than impose the cuts that are assumed in the budget baseline over the projection period, would increase Medicare's growth rate by about 0.7 percent.

Congressman Ryan's Proposal

Paul Ryan, Chairman of the House Budget Committee, has made a major proposal to restructure the Medicare program—a proposal that was adopted by the Committee earlier this year.[10] Under the Ryan plan, the government would make payments directly to private health plans on behalf of Medicare-eligible enrollees, rather than pay hospitals, physicians and other medical providers directly for the services provided to their Medicare-eligible patients, as is currently the case. If the government payments were insufficient to cover premiums, beneficiaries would be responsible for additional costs. In other words, Medicare would no longer provide coverage for medical care, but instead would provide a subsidy (referred to as "premium support") toward the purchase of a private health insurance plan. None of the proposed changes would affect people who

currently are over age 55, who would continue in the current Medicare program with options to seek care from traditional, fee-for-service Medicare, or to enroll with a private health plan in the Medicare Advantage program.

Starting in 2022, the age of eligibility for Medicare would be gradually increased by two months per year until it reaches 67. Those who turn 65 in 2022 or later would not enroll in the traditional Medicare program; rather, they would be entitled to federal payments to help them purchase private health insurance policies. These payments would increase annually by the increase in the consumer price index. The intent is to make Medicare beneficiaries increasingly responsible for the cost for their insurance choices (e.g., more expensive plans would cost beneficiaries more).

Under the Ryan proposal, federal spending for Medicare is projected to decline, because the government contribution for spending would be strictly limited to the growth in inflation, regardless of the actual increase in spending. The problem, according the CBO estimates, is that the costs of providing insurance coverage to affected beneficiaries would not be less than currently projected.[11] In fact, CBO estimates that the total cost of providing Medicare benefits would actually rise under the proposal, primarily because the elimination of the traditional Medicare program would shift beneficiaries into more costly, private health plans.

CBO estimates that private plans are more costly than traditional Medicare for two basic reasons: the traditional Medicare program has lower administrative costs and obtains lower payment rates than private plans, advantages that are only partly offset by the health plans' greater ability to limit the volume of services paid for. Thus, for a typical 65-year-old in 2011, CBO estimates that the average spending in traditional Medicare would be 11 percent less than the spending in the same package of benefits purchased from a private insurer.[12] CBO estimates that the difference in costs would widen to 34 percent in 2022, mostly because of higher provider payment rates. Under this scenario, the Ryan plan would force Medicare beneficiaries to pay 68 percent of the cost of these higher premiums, as opposed to the 25 percent of the cost of physician services that beneficiaries currently pay under traditional Medicare.[13] In the more realistic alternative scenario discussed earlier, which assumes that the substantial cuts in payments to physicians from the implementation of the SGR formula would not actually take place, the difference in 2022 between those higher Medicare costs and the costs of private plans would be somewhat less—28 percent.

Other evidence on this issue is provided by MedPAC, which annually analyzes how much Medicare Advantage plans spend to provide the standard Part A and Part B Medicare services: when considering the fact that these private plans concentrate their business in geographic areas where traditional Medicare program spending is higher than average, these data also show that private plans are more expensive for taxpayers than traditional Medicare.[14]

More "Skin in the Game"

The Ryan approach reflects the view that competition among private insurers would create a market that currently does not exist and would over time produce market-driven efficiencies. The fundamental philosophy behind the Ryan approach and similar proposals is that individuals should pay a higher share of the cost of their care. Because beneficiaries will pay more of the cost of premiums, it is expected that they will choose plans with more cost sharing. When they face higher deductibles and cost sharing, beneficiaries will use care more prudently and shop for lower priced providers.

The Medicare program actually has a fair amount of cost sharing already. In 2011, Medicare Part A has one-day hospital deductible of $1,132, Medicare Part B has a $162 deductible and 20 percent cost sharing for medical services without limit,[15] and Medicare Part D for prescription drugs has a deductible of $310 followed by 25% co-insurance until expenditures reach $2,840. After this, there is no coverage until expenditures reach $5,448.[16] Some participating plans often help meet some of these expenses. The ACA gradually reduces the "doughnut hole" to 25 percent co-insurance. When expenditures exceed the doughnut hole, beneficiaries still pay 5 percent of expenditures. Thus, individuals even with extremely high Part B and Part D expenditures will still continue to face some costs.

Because of these Medicare provisions, individuals often buy Medigap policies that pay much of their out-of-pocket costs and protect them against "catastrophic" costs. Those with low incomes can enroll in Medicaid for supplementary coverage and again face little or no out-of-pocket costs. With so many beneficiaries effectively avoiding Medicare's cost-sharing requirements, the impact of the latter on utilization is mitigated. Some reforms of this structure may well be appropriate, but whether the impact on spending by increasing out-of-pocket costs would be significant is questionable.

Table 2 shows the distribution of health care spending. In 2006, 69 percent of Medicare beneficiaries spend less than $5,000 per year; they account for 12 percent of Medicare spending.[17] The $5,000 is roughly equivalent, in 2006 dollars, to the health savings account (HSA) out-of-pocket limit of $5,950 faced by the non-elderly in 2011. Any proposal for a private option would probably include out-of-pocket caps in this range. The fact that only 12 percent of the dollars are attributed to those who spend less than $5,000 and 23 percent to those with spending below $10,000 means essentially that the reach of additional cost sharing is likely to be limited. Those who are spending above $5,000 a year, and particularly those above $10,000, have serious illnesses and/or chronic conditions and are more

Table 2: Medicare Spending Patterns by Medicare Beneficiaries, 2006

Spending Level of Beneficiary	Beneficiaries (in thousands)	Percent Distribution	Total Medicare Spending (in billions)	Percent Distribution	Average Per Beneficiary ($)
0	4,675	10.65%	$0	0.00%	–
0–$2,000	16,831	38.36%	$14	4.06%	$826
$2,001–$5,000	8,673	19.77%	$28	8.21%	$3,240
$5,001–$10,000	5,181	11.81%	$36	10.60%	$7,006
> $10,000	8,518	19.41%	$264	77.13%	$30,993
Total	**43,877**		**$342**		**$7,801**

Source: Urban Institute analysis of MCBS 2006 Cost and Use file.
Note: Includes Puerto Rico.

likely to be affected by their physician's advice than by prices they would face.[18] More important, they will face little or no cost sharing above the stop loss caps. Since 77 percent of expenditures is on this small percentage of the Medicare population (19.4 percent), the likelihood of greater cost sharing affecting overall spending is relatively limited. For example, if those with expenditures below $10,000 reduce their spending by 10 percent in response to higher out-of-pocket costs, the result would be reduced Medicare spending by less than 3 percent. Even a 20 percent reduction in spending by this group—which seems unlikely—would reduce Medicare spending by only 5 percent.

Increasing the skin in the game may contribute, in a limited amount, to slowing Medicare spending growth but clearly more needs to be done. In the following section, we argue that Medicare's payment structure is necessary to deal with the growing market power of providers. There is room for competition between Medicare and private insurers, as exist now when more than 25 percent of Medicare beneficiaries choose a private Medicare Advantage plan in preference to traditional Medicare, but it would be extremely unwise to lose the strong market power that Medicare provides.

Market Power and Payment Rate Differentials

Recent years have seen substantial increases in consolidation in the hospital industry and increasingly among physicians.[19] Research has shown that market concentration leads to higher prices.[20] The higher provider payment rates generally used by insurers versus traditional Medicare is central to understanding the health spending performance of private plans compared with traditional Medicare. Private plans typically negotiate payment rates with providers, which increasingly have been able to gain the upper hand in these price negotiations. As hospital and physician consolidation increases, this seems only too likely to continue. In many markets, the private insurance industry is also highly concentrated,[21] weakening incentives to negotiate aggressively. In contrast, traditional Medicare sets prices based on systems developed for both hospital and physician payments, and uses its large market presence to set payment rates that most providers are willing to accept. The result is substantial payment differentials between the rates that Medicare pays providers and the average rates for private insurers for their various products in the commercial insurance market. Nationally private insurance rates are 25 percent higher for physician services[22] and about 40 percent higher for hospital services.[23]

An extensive literature documents the marked variation in provider prices both across markets and within markets, with suggestions that the disparities in prices have been increasing in recent years.[24] A recent survey found that in eight health care markets, average inpatient hospital payment rates of four large national insurers ranged from 147 percent of Medicare in Miami to 210 percent in San Francisco.[25] Variation within markets was even more dramatic. For example, the hospital with prices at the 25th percentile of Los Angeles received 84 percent of Medicare rates for inpatient care, while the hospital with prices at the 75th percentile received 184 percent of Medicare—more than twice as much. Particular hospitals with virtually unlimited market power commanded almost five times what Medicare pays for inpatient services and more than seven times what Medicare pays for outpatient care. Although not quite as pronounced, substantial variation in physician payment rates also exists across and within markets and by specialty.[26]

The recent growth in provider market power and negotiating leverage suggests that the payment differentials will continue to increase in the near future.[27] Recent analyses have found that hospital and physician payment rate increases have been a major contributor to rising health care costs in employer-sponsored insurance-based insurance products.[28] A PriceWaterhouseCoopers analysis of employer-sponsored health premium data found that price increases had overtaken service use increases as the leading determinant of health insurance premium increases beyond the underlying cost of doing business that providers face.[29] Indeed, studies exploring the reason why U.S. health care spending far exceeds that in other countries have found that substantially higher prices and more fragmented care delivery—not the overuse of services such as doctor visits

and hospitalizations—are the leading explanations.

We conclude that the market power that Medicare has is necessary to control cost growth. Most private insurers do not have the leverage necessary to restrain growth in payment rates. Given the central role of payment rates as a health care cost driver, and the market failure produced by growing provider consolidation that drives up prices, we think it is essential to maintain and even enhance the traditional Medicare program as we seek savings. This does not preclude encouraging private plans to compete with traditional Medicare program.

Medicare Reforms That Can Yield Savings

As part of this year's political discussions over deficit reduction, many have advocated the need for significant reforms in the Medicare program that go beyond reducing payment increases for providers. The ACA established a series of demonstration programs to be administered by CMS through the new Center for Medicare and Medicaid Innovation. The priority projects will test new payment approaches that move from volume-based payments, which have inherent incentives for providers to provide unneeded and sometimes inappropriate services that may harm patients, to "value-based payment" approaches designed to better reward care that demonstrably maintains or improves the quality of care, while trimming spending growth rates.

Pilots will also test promising models of innovative provider organization, including patient-centered medical homes and accountable care organizations, which attempt to break down current silos of care by giving separate health professionals and health care facilities aligned interests in coordinating their care to improve patient outcomes and reduce wasteful spending. CMS, state Medicaid agencies and private payers have started working together to find new, common approaches to payment, thereby giving providers consistency to support redesign in their mode of service delivery. To a significant extent, the major stakeholders in the health care system look to the traditional Medicare program as essential to these reform efforts.[30]

It is likely that multiple payers' adoption of fundamental changes in payment incentives will sustain long-term spending reductions for the system overall and for the Medicare program. However, although these initiatives offer great promise for reducing wasted spending, they will require trial-and-error implementation that could take years to achieve fruition. CBO reasonably has assumed only modest savings over a 10-year budget window from these initiatives pending research evidence on effectiveness of the numerous innovations that will be tested. Other cost-containment approaches will be needed in the short term to address Medicare spending.

Immediate Cost-Savings Opportunities

As pointed out earlier, reducing payment updates as part of the ACA has materially improved Medicare per capita spending projections. Over many years, MedPAC, the Government Accountability Office and the U.S. Department of Health and Human Services Office of the Inspector General (DHHS OIG) have made numerous cost-cutting recommendations correcting both policy and operational aspects of how current payments are made to providers, suppliers and health plans serving Medicare beneficiaries. These proposals go beyond payment reductions and are more targeted to achieve particular policy objectives that balance access, quality and cost.

CBO compiled a long list of budget options to reduce spending, some specific to Medicare.[31] Similarly, MedPAC has identified various technical payment adjustments that could produce substantial program savings without relying just on across-the-board payment reductions. For example, overdue rebasing of home health and skilled nursing facility payments could save about $40 billion over 10 years. MedPAC also proposed adding a small co-payment for home health episodes, an approach that would save about $4 billion over 10 years.[32] A more aggressive CBO cost-sharing option for home health services would reduce spending by nearly $50 billion over 10 years. In another example, the National Commission on Fiscal Responsibility and Reform recommended extending Medicaid drug rebates to Medicare dual eligibles and estimated savings of $49 billion over 10 years.[33] More savings are possible if the rebates were extended to all Medicare beneficiaries.

There are many other targeted proposals to reduce Medicare spending. As with the examples just reviewed, there are alternative approaches and considerations of access and quality in addition to spending that must be weighed, leading to different approaches to modify current programmatic policies. Yet because of political pressures, often applied by affected providers and suppliers, many options and recommendations have not been adopted in any form, whether by congressional legislation or CMS regulation and policy. In fact, in some cases, Congress in recent years has further narrowed the statutory authority that CMS had been using to accomplish even modest cost containment, such as with its instructions to CMS that it could no longer pay the same reference price for functionally equivalent drugs; Congress decided that Medicare had to pay substantially more for drugs providing no enhanced benefit.[34]

In short, there are many opportunities to reduce Medicare spending without changing the fundamental structure of Medicare or compromising its crucial role as a successful social insurance program for nearly 50 million citizens. Given this current lack of political will to take on stakeholders' interests, some have proposed changes to Medicare's governance—how policy decisions are made—and how program management is funded to even pick off this low-hanging fruit of excessive program spending. Other reforms would increase cost-containment

opportunities without the major program overhaul required under the Ryan proposal. The particular changes discussed here involve governance and management, income-related premium contributions, cost sharing and out-of-pocket limits and age of eligibility.

Medicare Governance

The ACA fundamentally restructured the governance of Medicare by creating the Independent Payment Advisory Commission (IPAB) with authority to issue recommendations to reduce the growth in Medicare spending, and provides for the Board's recommendations to be considered by Congress and implemented by the Administration on a fast-track basis. The IPAB, which will be constituted in 2012, will be an independent board housed in the executive branch and composed of 15 full-time members appointed by the President and confirmed by the Senate. As Senator Jay Rockefeller (D-WV), a principal architect of the IPAB model, noted, "It is long past time that Medicare payment policy is determined by experts using evidence, instead of by the undue influence of special interests."[35]

IPAB has become very controversial, with opposition from many in Congress, representatives of aging organizations and patient advocacy group and various health industry stakeholders, including the pharmaceutical industry and physician groups that would immediately be subject to IPAB cost-containment efforts, while certain other provider groups, most notably hospitals, would be exempt until the end of the decade. Most of the focus on the IPAB governance mechanism has focused on the merits of shifting decision-making authority away from elected officials to unelected, health care experts.

Mostly overlooked, however, is the companion ACA provision—namely, the setting of specific spending targets for Medicare program growth that requires achievement through congressional action.[36] Putting aside whether IPAB or Congress gets to make the recommendations, what is new and important is the requirement to reduce spending to stay within legislated spending targets. That mechanism can be the basis for forcing additional spending reductions that Congress otherwise would be unwilling to make. The supercommittee on deficit reduction could also propose spending reductions under the imposed discipline of a hard spending target. Successful congressional spending reductions by the end of the year would make the differences of opinion over the desirability of IPAB moot because the triggers that would generate the need for IPAB Medicare spending reduction proposals would not be pulled. In fact, even under current Medicare spending projections, which show significant moderation in Medicare per capita spending growth, as described earlier, IPAB spending proposals would probably not be needed.

Medicare Program Administration

There are currently fewer employees at CMS now than in 1980,[37] despite massive growth in the size of the main programs the agency is responsible for—Medicare and Medicaid—and a long list of additional operational responsibilities given to CMS. Further, CMS's role as administrator of the core programs is much more complex than in the past. In managing the Medicare program, Congress has mandated that CMS evolve from a "claims payer" to a "value-based purchaser" and given it many more responsibilities, which requires a workforce greater in size and expertise.

Although Congress has provided one-time supplemental funds for implementing specific legislated tasks—Part D created by the MMA of 2003 and the Center for Medicare and Medicaid Innovation set up by the ACA—the agency's core activities have been shortchanged. Many of these activities are directly related to program spending. Recent CMS administrators from both parties point to chronic underfunding of CMS, and suggest that CMS administrative resources are inadequate to carry out its administrative responsibilities, and may increase program spending, especially in the area of detecting and preventing fraud and abuse.[38]

Peter Budetti, director of the Center for Program Integrity at CMS, recently testified that the return on investment (ROI) for the center's activities is 14 to 1.[39] The Health Care Fraud and Abuse Control Program (HCFAC), a government-wide anti-Medicare-fraud program involving CMS, DHHS OIG and Department of Justice, has achieved a nearly seven to one ROI over the past three years. The ACA did provide additional resources, and there have already been successes, but many other opportunities for reducing program spending lost to fraud and abuse are unrealized because of insufficient resources.

Another important example of a lack of administrative resources producing wasted program spending in Medicare is in the area of coverage of new technologies and services. Without even getting into any of the controversial areas that have arisen in recent discussion of comparative effectiveness research and cost-effectiveness analysis, the current accepted role of Medicare in managing the coverage process also has been compromised because of the lack of resources and programmatic flexibility.

Determining whether to cover and pay for a new service requires sifting through the multifaceted evidence base, balancing benefits and risks and determining more finely when coverage is appropriate for which patients, under what conditions and in what settings, while considering the requisite clinician expertise and facility requirements. This approach is an accepted set of activities for CMS as it is for all payers, whether public or private. Most of the time, CMS renders nuanced judgments on coverage that places restrictions based on patient clinical characteristics and setting of care, referred to as "coverage with conditions," with the conditions specifying the clinical factors that affect whether an intervention using a particular technology or procedural technique is appropriate for payment.[40]

Table 3: Income Distribution for the Elderly Over 65

Singles				Couples			
		Frequency	Percent			Frequency	Percent
	<100 FPL	3,817,108	17.9		<100 FPL	816,375	4.7
	100–133	2,703,179	12.7		100–133	717,039	4.1
	134–300	8,069,222	37.9		134–300	6,785,198	39.2
	301–825	5,403,167	25.4		301–1,309	8,366,714	48.3
(85k +)	826+ FPL	1,294,596	6.1	(170k +)	1,310+ FPL	640,721	3.7

Source: Authors' calculations from the Current Population Survey.

However, placing conditions on Medicare coverage does not guarantee that clinicians will actually adhere to those guidelines. Often, these conditions are simply ignored,[41] such that patients may be receiving unapproved interventions that may not benefit them, but which come with a large cost. A recent study found that more than 20 percent of insertions of Implantable Cardioverter Defibrillators (ICDs) to prevent potentially fatal cardiac arrhythmias do not meet accepted clinical guidelines and likely deviate from the approved conditions on the Medicare coverage of ICDs, exposing patients to harmful complications, including avoidable deaths.[42] At $40,000 per insertion, that deviation from accepted practice results in $1 billion a year in likely inappropriate spending for this one service alone.[43]

A structural change in the funding of CMS, modeled after the approach used for the Social Security Administration, would allow CMS a direct draw on the Medicare trust funds, capped and overseen by the Congress. This draw could specify that the trust fund allocation be targeted specifically to activities like those mentioned here, which produce program savings.[44] Some portion of the savings could be retained by CMS to expand cost-containing efforts, as is done to a limited extent to support the HCFAC fraud program.

Income-Related Premiums

The premium structure in Medicare is quite complicated, with separate premiums for Part B and Part D. The Part B premium (Part D has similar problems) is equal to 25 percent of Medicare Part B spending. Those who are dually eligible for Medicare pay little or no premiums depending upon their incomes. Medicare beneficiaries with incomes above 133 percent of the federal poverty line (FPL) pay the full premium until income levels of $85,000 for individuals and $170,000 for couples (825% of FPL and 1,310% of FPL, respectively). At that point, Medicare premiums double. and for individuals and couples with higher income levels they increase further. Part D has similar income-related premium surcharges.

This structure places a very high burden on those with incomes below 300 percent of FPL,[45] in sharp contrast to the premium structure for coverage through the Health Insurance Exchanges created in the ACA. On the other hand, those with incomes above 300 percent of FPL up to the $85,000/$170,000 levels are paying much less as a percentage of income than those with similar incomes in the ACA. Part B and Part D premiums average about 5.8 percent of income for singles and 9.1 percent for couples at 300 percent FPL, with higher percentages of income required between 133 percent and 300 percent FPL and lower above 300 percent FPL. For example, Medicare premiums would average 15.4 percent of income for singles and 18.3 percent for couples at 150 percent FPL and 2.9 percent for singles and 4.6 percent for couples at 600 percent FPL. In the ACA, premiums would be capped at 4 percent of income at 150 percent FPL and 9.5 percent at 300 percent FPL and above, eventually falling naturally as a percent of income as incomes increase.

As shown in Table 3, a large number of Medicare beneficiaries over age 65 have incomes above 300 percent of the FPL but below the current threshold at which premiums increase sharply ($85,000/$170,000). Medicare premiums could be restructured in a way that lowered premiums for those with incomes below 300 percent of the FPL and gradually increased them for those with incomes above 300 percent of the FPL in a way that increased overall premium revenues.

Restructuring Cost Sharing and Providing an Out-of-Pocket Cap on Spending

To cover gaps in the current structure of Medicare benefits that was established in 1965, most beneficiaries have supplemental coverage through former employers or individually purchased Medigap policies, or have additional coverage through Medicaid, the Veterans Administration, or other sources. Medicare's benefits include substantial cost sharing in the form of hospital deductibles and routine co-insurance for physician and other outpatient services. As noted earlier, a particularly important gap in Medicare's benefits is the absence of an upper limit on the amount of Medicare cost-sharing expenses that a beneficiary can incur. In addition, there are limits to the number of days that Medicare will cover hospital and other institutionally based services such as care in skilled nursing facilities. Accordingly, beneficiaries often seek supplemental coverage not only because of the routine cost sharing associated with services, but also to obtain "catastrophic coverage" for long duration spells of illness.

An extensive literature demonstrates that when elderly beneficiaries are insured against Medicare's cost sharing they use more care and Medicare spends more on them, although as discussed earlier the impact of the greater cost sharing on overall spending can be relatively limited because supplemental coverage for individuals in poorer health has much less impact on their spending than for those in relatively good health.[46] Moreover, for particular services and patient populations (i.e. chronically ill patients), even modest cost sharing has been shown to create a barrier to

care that, when deferred, may result in greater program spending.[47]

The deductible and cost-sharing structure in Medicare could also be substantially changed and made more uniform across different benefit categories (e.g., home health and clinical laboratory currently have no cost sharing at all).[48] Part D could be integrated more into the overall structure. There could be one deductible across all services (say, $1,000) with 20 percent cost sharing up to an out-of-pocket cap at around current HSA levels (about $6,000 for individuals and $12,000 for couples). There could be greater cost-sharing protections for those with incomes below 250 percent of FPL, as in the ACA. The National Commission on Fiscal Responsibility and Reform proposed a similar approach and estimated savings of $110 billion over 10 years,[49] while providing better protection for those who need it most.

These changes should be accompanied by reforms of the Medigap market as proposed by the National Commission on Fiscal Responsibility and Reform, which recommended a prohibition on covering the first $500 of cost sharing and limits coverage to 50 percent of the next $5,000.[50] The notion is to restructure Medicare so that supplemental insurance becomes unnecessary; an additional objective would be to make Medigap less attractive by requiring a significant deductible. Rather than forbidding first-dollar coverage in supplemental insurance, a different approach would be to impose an excise tax on insurers that offer the most comprehensive plans, because of its known effect of increasing Medicare program spending.[51] Presumably, the first-dollar plans that fill in all Medicare benefit gaps would become relatively more expensive, encouraging beneficiaries to migrate to the less expensive Medigap plans that retain modest cost sharing.

Raise the Age of Eligibility to 67

Another option that would reduce Medicare services would be to gradually increase the age of eligibility from age 65 to age 67. This is not a policy change that can be done quickly; individuals need time to anticipate and prepare for the change. The option is now more feasible than in the past because of the ACA. The ACA includes provisions for 3:1 age rating, which will limit the variation in premiums among age groups, protecting those age 65–66. The ACA also provides for income-related premium and cost-sharing subsidies. Some individuals, particularly lower-income Medicare beneficiaries, would actually be better off because they could enroll in Medicaid if their incomes were less than 133 percent FPL. Others could obtain subsidies in the exchange, which would lower their cost of buying a private policy below the sum of their Medicare Part B and Part D premiums. A recent analysis concluded that nearly one in three beneficiaries—those with lower incomes—are projected to have lower out-of-pocket costs than they would have had if covered by Medicare.[52]

It is also true that many others with higher incomes would pay more. But as Steuerle and Rennane have shown,[53] most Medicare beneficiaries receive considerably more in benefits that they have paid in. Thus, for those for whom it is affordable, this is not unreasonable policy. Some of those who would no longer have Medicare would go into Medicaid, some would go into exchanges and receive subsidies, other would go into exchanges on a nonsubsidized basis and some would keep their employer plans. Medicare spending for the 65–66 age group would fall, although much of these savings would be offset by increased Medicaid costs and increases in exchange subsidies. The CBO has estimated that gradually raising the Medicare eligibility age to 67 beginning in 2014 would reduce federal outlays by $125 billion between 2012 and 2021, after accounting for offsetting Medicaid expenditures and exchange subsidies.[54] Employer costs would also increase, as would state outlays for their share of higher Medicaid expenditures. Although the policy could reduce federal government spending, it would increase the national health expenditures overall because private plans are more costly than traditional Medicare.[55]

This policy recommendation makes sense only if the ACA provisions, including the health insurance exchanges, elimination of person-specific insurance rating practices and the substantial subsidies to support the purchase of insurance for low-income individuals, go into effect on a national basis as planned in 2014. Phasing in the increase of the eligibility age should begin only once these provisions are in place and shown to be effective.

Dual Eligibles

One area that merits considerable policy focus is the care of dual eligibles, those who are eligible for both Medicaid and Medicare. This group spends an estimated $305 billion in 2010 between Medicare and Medicaid: $164.7 billion for Medicare and $140.3 billion for Medicaid.[56] These individuals are low-income and typically have multiple chronic conditions. Many go to several different providers with little coordination of their care. Moreover, the split of responsibility between Medicare and Medicaid also adds to inefficient and unnecessary spending. Many initial programs to improve disease and chronic care management were not successful, but several recent chronic care management programs have shown success in reducing costs with most of these savings accruing to Medicare.[57]

These programs have targeted services on those most likely to benefit from in-person contact, close interaction between care coordinators and primary care physicians and financial incentives and support for innovative care models. The successful demonstration programs have shown savings in reduced hospital admissions, readmissions, drug utilization, skilled nursing facility days and use of specialists. Most of these savings are in acute care services covered by Medicare. Even modest reductions in spending on these groups would result in considerable savings to the federal government both through Medicare and the federal share of Medicaid. In evidence presented

elsewhere, we showed that even small percentage reductions could yield savings of more than $200 billion over 10 years, simply because expenditures on dual eligibles are so large.[57] Most of the policy attention has focused on giving state Medicaid programs funding to develop new programs for dual eligibles. We believe this should be much more of a Medicare initiative than one organized and administered by state Medicaid programs, since Medicare will receive most of the benefits.

Conclusion

Medicare's projected fiscal problem is a major one, but is now being driven more by growth in population served rather than program inefficiency as commonly asserted. The Medicare Trustees currently estimate that on a per capita basis the Medicare program will grow at about the forecasted rate of GDP per capita (3.8 percent), well below historic rates. (Medicare growth over the next decade would be higher by about 0.7 percentage points if the cuts imposed by the SGR are not implemented.) The marked improvement in the per capita spending trajectory and the fact that anticipated pressure on program spending derives mostly from aging baby boomer–based population growth suggests that enhanced revenues to support the rapidly growing Medicare beneficiary population should be part of the solution to making Medicare sustainable.

Nevertheless, we have proposed a number of cost-containment opportunities under the current basic structure of Medicare, with additional savings achievable through targeted restructuring in the Medicare program's governance and management, cost-sharing provisions, income-related premium contributions and age of eligibility. These changes can be adopted without threatening the role of Medicare as an important institution of social insurance, as they build on the program's success in using its market power to address the growing problem of market concentration. The Ryan approach, as well as other proposals for privatization, would be highly disruptive and would not achieve the efficiencies they seek; moreover, they would likely increase overall spending and shift much of the burden of spending to beneficiaries.

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