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Medicare Reform: What's Happened and What's Next?

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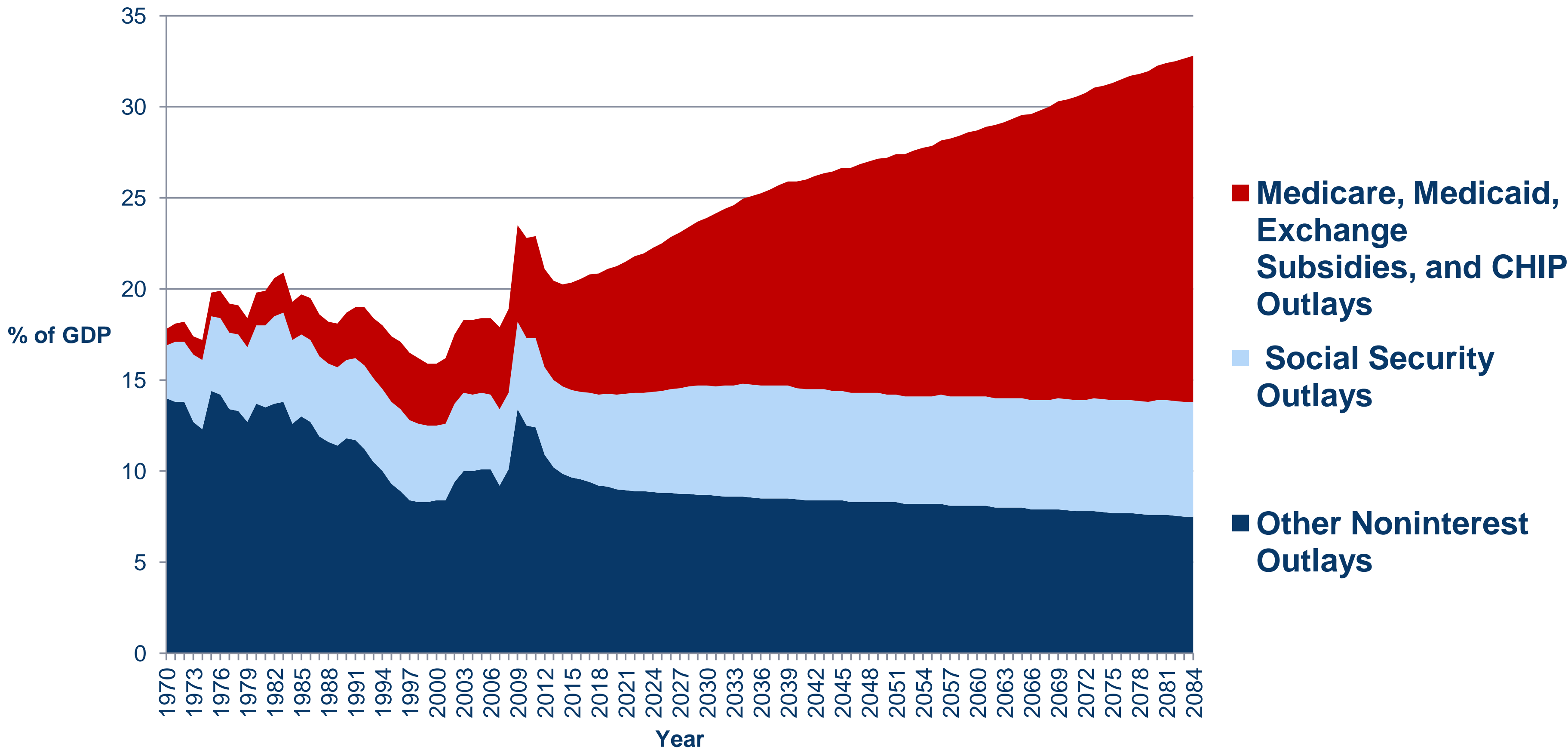
Spending on health care driving federal deficits



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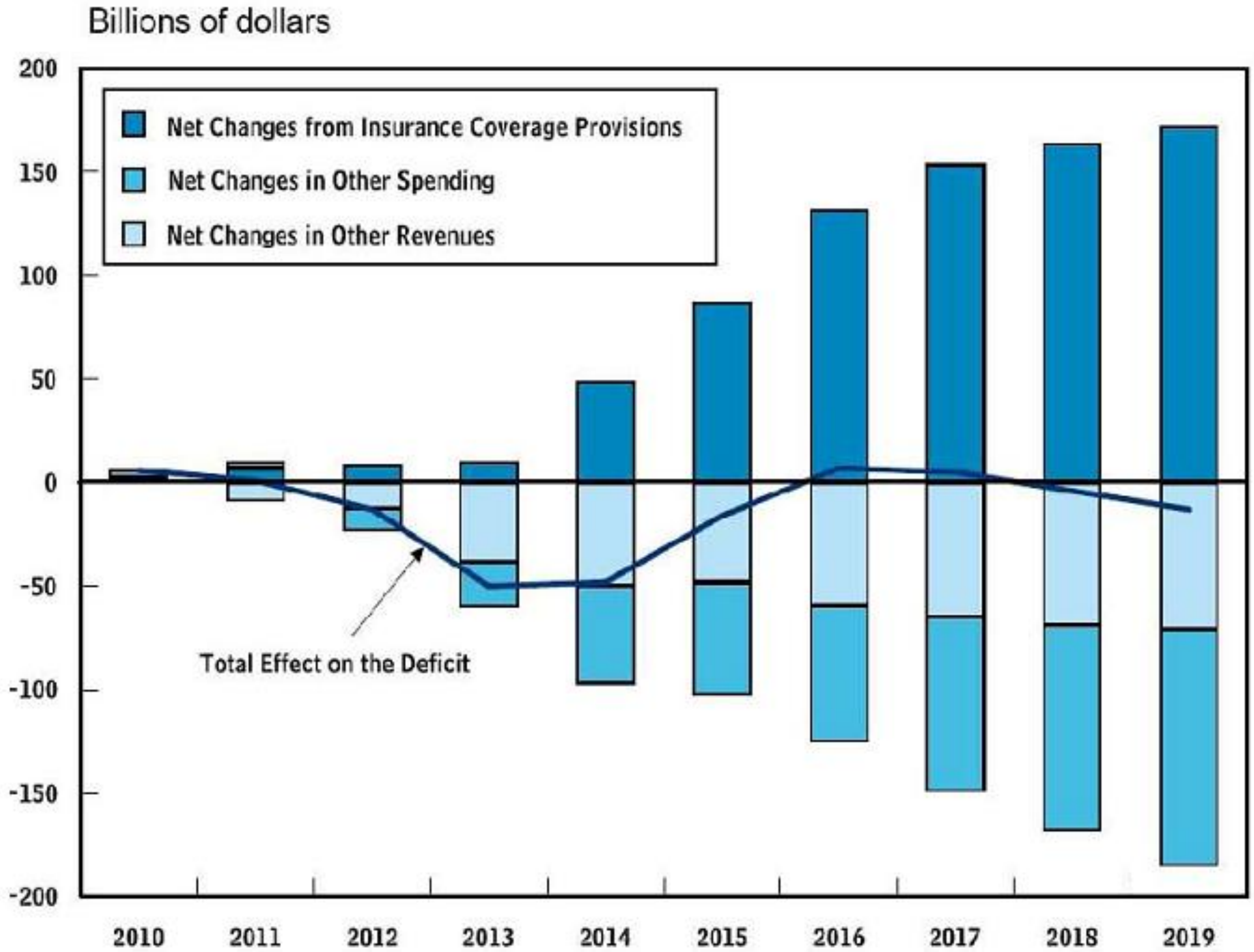
Source: 2011 CBO Long-Term Budget Outlook

Strategies for reducing Medicare costs

- **Reduce Costs:** Drive real health care reforms
  – Large, well-documented gaps in quality and efficiency
  – Generally requires system-wide focus and time
  – Difficult to achieve, with limits on evidence of how to affect system-wide costs and public mistrust of big steps that could reduce access to needed care
- **Shift Costs:** Change the distribution of costs
  – Providers: reduce payment rates that are "too high"- but may also shift costs to providers or other payers, increasing costs elsewhere
  – Beneficiaries: currently receive far more than pay in, but gaps in current coverage and many current (and future) beneficiaries have limited resources
- **Expect to See Both – How to Minimize Pressure for Cost Shifting**
  – Short term savings mainly through shifting
  – Behavioral responses and longer term impacts harder to project, especially since other things may change

Deficit consequences of Affordable Care Act



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Source: Congressional Budget Office Presentation to the Institute of Medicine, May 26, 2010

Unprecedented slowdown in Medicare spending growth required under current law (ACA+SGR)

Growth and Projected Growth in Per Capita Medicare Spending in Excess of Economic Growth*	
Period	Excess Rate of Spending Growth (% points)
1975-2007	2.4
1980-2007	2.2
1985-2007	1.4
1990-2007	1.6
2012-2021	**-0.4**
2020-2021	**0.8**

Never achieved before

- If current law is maintained, IPAB enforcement mechanism is not projected to be important
- Assumes SGR remains in effect, as in current law
- Does not include further savings proposals

*Source: M Chernew, NEJM, 2011. Data are derived from the CBO Long-Term Budget Outlook 2011. Excess rate of spending growth measures the amount by which health spending per person exceeds GDP per capita, with adjustment for demographic factors such as the aging of the population.

Past attempts at Medicare savings through price reductions have proven hard to maintain

BBA of 1997 initially projected Medicare savings of $393.8 billion over 10 year by:

- **Reducing Medicare payments to health care providers and health plans**
  - Limiting growth rates of FFS payments through creation of the SGR
  - Slowing the update factor for many providers, particularly hospitals
  - Restructuring methods of paying rehabilitation hospitals, home health agencies, skilled nursing facilities, and outpatient service agencies
  - Reductions in payments and slowing the growth rate of payments to Medicare managed care plans
- **Expanding the types of private plans that can participate in Medicare**
  - Created Medicare+Choice
  - Open enrollment with HMOs, POS, PPO, PSO, and private FFS plans eligible
- **Increasing beneficiary premiums**
  - Increasing Part B premiums
  - Better access to preventative services
  - Reduction in outpatient cost sharing

Difficult to sustain lower per-capita growth rates…

- Every year since 2003 Congress has intervened to override reductions in the SGR
  - *29.4% physician payment cut required in 2012*
- Multiple laws since 1997 have increased payments to providers and health plans, for example:
  - BBRA of 1999 restored approx. $13 billion over five years in provider payments
  - BIPA of 2000 restored approx. $35 billion over five years
  - MMA of 2003 increased funding for private MA plans
  - Many other examples of increases in provider payments

Source: The Commonwealth Fund, "An Examination of Key Medicare Provisions in the BBA of 1997"

Achieving Slower Medicare and Health Care Spending Growth for Long Term: "Bending the Curve"

1. Speed payment reforms away from traditional volume-based payment systems
   - E.g., ACOs, episode-based payments, and other payment reform efforts that focus directly on better care for patients at lower costs; pilots not sufficient
2. Assure Americans are rewarded with substantial savings when choosing plans offering higher quality care at lower premiums
   - E.g., Value-Based Insurance Design
3. Encourage more efficient competition among health plans in Medicare, aligned with competitive insurance choice outside Medicare
   - E.g., Medicare Part D

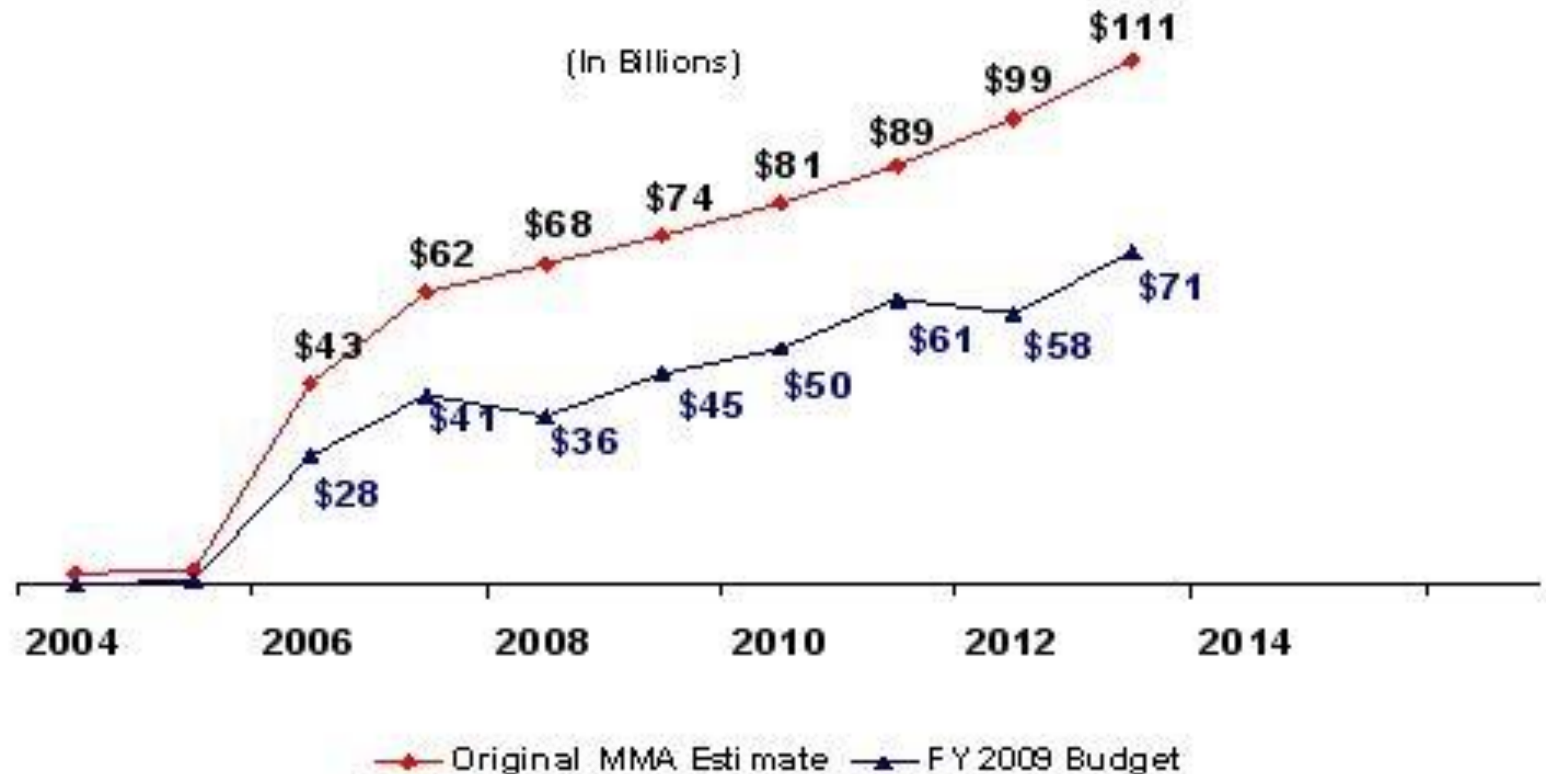
Source: Brookings Institution, "Bending the Curve Through Health Care Reform Implementation"

Can These Reforms Achieve Greater Savings?

- Promising Examples
  - Medicare Part D
  - Prospective Payments in BBA and other legislation

Total Projected Spending Under Part D, A Comparison of Original MMA and FY Budget 2009 Estimates

Total spending under Medicare Part D is projected to be 38.5 percent lower than previously estimated.



Data are from the original MMA estimate and FY 2009 President's Budget
Source: Office of the Actuary, CMS.

Potential reasons for lower than projected spending in Part D

- Setting a minimum standard of actuarial equivalence for eligible drug plans, instead of mandating a specific benefit package, provided insurers flexibility to experiment and develop innovative products
- Competitive design (fixed subsidy based on income and health status) provided strong incentives for beneficiaries to choose less costly plans
- This promoted benefit designs that gave much greater financial rewards to seniors who substituted generic equivalents for name brand drugs and who substituted similar drugs in a class, leading to lower costs while improving outcomes

Can These Reforms Achieve Greater Savings?

- Promising Examples
  - Medicare Part D
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- Cautions
  - Changes in Reporting vs Real Effects
  - Offsetting Behavioral Impacts

Difficult for CBO to score system-wide, long-term impacts on US health care costs – “real” health care reforms…

- Non-incremental reforms necessarily involve projections where evidence may be more limited, making scoring more difficult
- Robust evidence from published literature and other sources may not be available, making scoring difficult
- Scoring focus is on Federal spending, not system-wide effects and their “spillovers” to Medicare
- Current law provides very broad authority for Medicare to implement provider payment reforms on a pilot basis – so may need to look elsewhere for additional savings, including benefit reforms and reforms in health plan choice
- Immediate focus might include reforms that make current savings projections more secure – both CBO and the CMS Actuary have expressed doubt that current-law projections will be sustained

Can the Future Be Different? Achieving Slower Spending Growth Over Long-Term

- System-wide performance, not just short-term Medicare cost savings
- Achieve incremental progress toward system-wide goals where possible – for example, next upcoming SGR "fix"
- Use current authority on payment reform to drive more system-wide progress
  - Routine process for Medicare to participate in multi-payer reform efforts led by regions, states, and private collaborations (Advanced Medical Home Pilot; potential with ACO and bundled payment reforms)
  - Standard methods of timely Medicare data sharing with providers and performance measures reported from providers, so that pilots will be faster and more reinforcing
  - Evaluations that encourage maximum impact on care not maximum precision of analysis – encourage multiple, reinforcing reforms that have greater effects like medical homes, episode payments and ACOs that evolve over time, rather than trying to isolate effects of individual reforms
- **Focus must extend beyond Medicare provider payment reforms to benefit reforms and coverage choice, and to overall goal of lower cost growth and better quality, to have greater effects**