HEALTH POLICY REPORT

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Medicare at 50 — Moving Forward

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As Medicare enters its 50th year, this popular federal program faces profound challenges to its effectiveness and sustainability in future decades. In this report, we review these problems, building on the issues raised in our earlier article.[1] We also review several options to strengthen the program and enhance its viability.

CRITICAL CHANGES FACING MEDICARE

RISING EXPENDITURES

Perhaps the most important challenge facing Medicare is the prospect of increasing expenditures, driven in large part by demographic trends. As the U.S. population ages, the number of people who are eligible for Medicare benefits will grow, from 52.3 million in 2013 to 81.8 million in 2030.[2] From 2009 through 2013, Medicare spending per beneficiary increased at a historically low annual rate of 1.0% in nominal dollars and actually decreased in real terms (accounting for inflation). Over the next decade, slow growth in Medicare spending per beneficiary is expected to continue, but because of substantial increases in the number of beneficiaries, the growth in total program spending will outpace that in the overall economy (Fig. 1). Total Medicare spending is expected to increase from 3.0% of the nation's gross domestic product (GDP) in 2013 to 3.8% in 2030, and the program's share of the federal budget is expected to increase from 14.4% to 15.8%.[3] These fiscal trends will create continuing pressure to reform the program.

QUALITY IMPROVEMENT

Medicare beneficiaries are affected by the quality and safety problems that affect all patients in the U.S. health system.[4] Dramatic variability in the care received by Medicare beneficiaries for the same conditions around the United States has underscored concern about the quality of care delivered by the program.[5] In addition, the changing needs of beneficiaries as they become older, frailer, and sicker suggest that Medicare must improve its ability to coordinate and integrate services for the population it serves.[6]

Improving quality while containing costs requires changes at the front lines of care delivery, where health professionals and health systems meet the needs of individual Medicare beneficiaries. Since such patients use the same delivery system as all other Americans, improving the cost and quality of care for the elderly and disabled will require reforms in the U.S. health care delivery system as a whole.[7]

PROGRAM FRAGMENTATION

Medicare is a structurally complex and fragmented program that is confusing for beneficiaries and health care providers alike. Most insured nonelderly Americans enroll in a single health plan that pays for all their covered services — inpatient, physician, pharmaceutical, rehabilitation, and others — with a single system of premiums, copays and deductibles. In contrast, Medicare beneficiaries must wrestle with a variety of different plans to cover these same expenses, each with differing rules, regulations, premiums, copays, and deductibles.

Broadly speaking, Medicare beneficiaries can choose two options for securing coverage. The first is often called traditional Medicare. It consists of Parts A, B, and D. The second option is Medicare Advantage, or Part C, in which beneficiaries can enroll in a private plan to receive their Medicare benefits.

About 70% of Medicare beneficiaries currently choose traditional Medicare. They receive hospital coverage under Part A, which is automatically available to virtually all elderly Americans without any premium but with required deductibles and copays. Part B provides physician and outpatient coverage under traditional Medicare; if beneficiaries do not opt out of Part B, they pay an annual premium ($104.90 per

month in 2015) in addition to copays and deductibles. For prescription-drug coverage, beneficiaries can voluntarily enroll in Part D by choosing among many competing private drug plans with premiums and benefits that differ from plan to plan.

In addition, beneficiaries in traditional Medicare have the option to buy supplemental private coverage (so-called Medigap plans) or, if they are low-income, may qualify for Medicaid coverage; some have supplemental retiree coverage from former employers. Medigap plans offset all or part of patients' copays and deductibles under Parts A and B. Medicare beneficiaries who qualify for Medicaid have dual eligibility for the two programs. Medicaid will cover all or most premiums and copays, but income and asset requirements, as well as coverage (subject to a nationwide minimum), vary widely according to state.

Beneficiaries may choose private Medicare Advantage plans that are required to provide benefits at least equivalent to Parts A and B and can also offer Part D benefits; Medicare Advantage plans can offer additional benefits as well. The premiums, copays, and deductibles — as well as covered services and providers — in Medicare Advantage plans vary from plan to plan and from market to market. Beneficiaries with dual eligibility may also choose to enroll in a private Medicare Advantage plan for their Medicare benefits, or they may enroll in a Dual Eligible Special Needs Plan (one of several categories of Special Needs Plans for beneficiaries in specific circumstances) that is designed to coordinate Medicare and Medicaid benefits; these plans also may vary considerably from state to state.

The complexity and fragmentation of Medicare coverage options hinder the development of consistent policies to promote improved performance. Fragmentation also interferes with providers' efforts to coordinate inpatient, outpatient, drug, behavioral-health, and long-term care, since they must juggle the varying cost-sharing requirements, benefits, and participating providers in the array of plans in which their patients may be enrolled.

COVERAGE GAPS

Facing high deductibles for inpatient hospital care, copays for physician and outpatient care, no limits on out-of-pocket expenses, and no coverage for long-term care, Medicare beneficiaries with low or modest incomes may incur substantial financial burdens. Beneficiaries devote an average of 14% of their household budgets to health care spending. That percentage generally is higher for those who are older, poorer, and sicker.[8] Data from a recent survey of elderly residents of 11 industrialized countries show that seniors in the United States are almost twice as likely as those in any other surveyed country to report that they have had problems during the past year in accessing health care because of costs (Fig. 2).[9]

PROPOSALS TO IMPROVE MEDICARE

We review here three central approaches to addressing the challenges facing Medicare. The first approach, provider-payment and organizational reform, consists of a series of targeted incremental efforts to change the financing and organization of care provided to beneficiaries. The latter two approaches reflect more comprehensive attempts at reforming the Medicare program, one focused on increasing the role of private markets in Medicare and the other on strengthening traditional Medicare by simplifying it and making it more comprehensive. These strategies could be pursued in combination or separately.

INCREMENTAL PROVIDER-PAYMENT AND ORGANIZATIONAL REFORM

Medicare payment continues to be based predominantly on a fee-for-service model that rewards providers for the volume and complexity of services provided. Fee-for-service payment has not — until recently, at least — rewarded efficiency, nor has it encouraged the integration and coordination of services that have become increasingly important for the optimal care of Medicare patients. Options for addressing these shortcomings range from modifications to the current payment system to recognize quality and efficiency (value-based purchasing and blended or bundled payments) to broader attempts to design payment incentives and organizational arrangements across providers and settings (accountable care organizations and global payment) that encourage care coordination and integration.

VALUE-BASED PURCHASING

Value-based purchasing seeks to promote improved and more efficient care by rewarding providers for better performance or penalizing poor results. For more than a decade, Medicare has been experimenting with payment strategies that reward high quality. Beginning in 2003, the Hospital Quality Incentive Demonstration offered bonus payments to hospitals on the basis of a set of quality measures. The results of this experiment were mixed at best,[10-12] but the intuitive appeal of using payment to reward value rather than volume is strong, and experimentation with value-based purchasing has continued.

The Affordable Care Act (ACA) required Medicare to implement value-based purchasing across a broad set of providers, including physicians, hospitals, skilled nursing facilities, and home health. A value-based purchasing program for hospitals went into effect in October 2012. A similar program is beginning in January 2015 for a subset of physicians and is scheduled to include all physicians by January 2017.[13]

Targeted value-based purchasing programs have penalized hospitals that have higher-than-expected rates of Medicare readmissions within 30 days and hospital-acquired conditions. The former program has been associated with a drop in readmissions from 19.0% to 17.5% of patients since its implementation.[14]

Despite its intuitive appeal, value-based purchasing faces a number of challenges. It depends on the development of effective, and preferably outcome-based, measures. In addition, critics point out that value-based purchasing should more effectively utilize the power of nonfinancial incentives, such as professionalism and organizational culture, in motivating clinician behavior and improving performance.[15]

BLENDED PAYMENT

Blended payment is a combination of fee-for-service payment, a monthly care-management fee per patient for those served by an advanced primary care practice, bonuses for reaching quality targets, and shared savings.[16] The Center for Medicare and Medicaid Innovation is testing blended payment in several primary care initiatives.[17]

This payment model has been adopted by a number of private insurers and state Medicaid programs. It is designed to improve accessibility to primary care, coordination of care across sites of care, and assistance with management of complex conditions. Early results show improved quality and preventive care but mixed results on reducing hospitalization and emergency department use.[18]

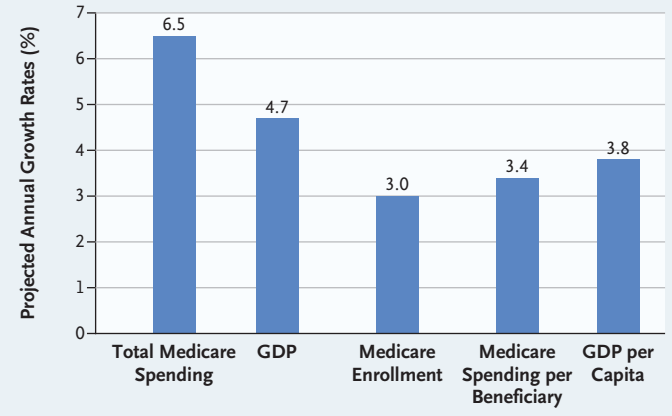

Figure 1. Projected Annual Growth Rates for Total Medicare Spending, as Compared with the Gross Domestic Product (GDP) and Medicare Enrollment, 2013–2023.

Although total Medicare spending is projected to grow much faster than the GDP, spending per beneficiary is expected to grow more slowly than the GDP per capita. Data are from the Centers for Medicare and Medicaid Services.

BUNDLED PAYMENT

Bundled payment is intended to support increased coordination and efficiency by setting a single prospective payment covering an inclusive set of services related to a specified medical condition. Beginning in April 2013, the Bundled Payments for Care Improvement Initiative began testing four different bundled-payment models that cover different combinations of hospital, physician, and postacute care.[19] The initiative currently involves almost 7000 participants, but it is too early to assess the cost or quality effect of the initiative.

On one hand, bundled payment has the potential to motivate providers within and across diverse settings to collaborate on ways to reduce costs and coordinate care for a particular condition. On the other hand, bundling could inhibit coordination across conditions by encouraging the development of siloed systems focused exclusively on one problem.[20]

ACCOUNTABLE CARE ORGANIZATIONS

The ACA launched an effort to improve health system performance by encouraging the creation of organizations of providers that are accountable for both the cost and quality of care. Medicare currently has two initiatives to promote such accountable care organizations (ACOs). In the Medicare Shared Savings Program (MSSP), groups of providers that meet certain organizational requirements can share in any savings they produce as compared with the predicted costs that would have been accrued by Medicare patients in the ACO if they were treated in the usual system.[21] The second model, known as the Pioneer ACO, is similar to the MSSP except that providers in these organizations agree to share not only gains from savings but risks for costs that exceed those in the regular care system. Both MSSP and Pioneer ACOs must meet numerous quality targets to share in any savings.

Of the 32 initial Pioneer ACOs, 19 remain, with most of the others joining the less demanding MSSP.[22] The MSSP currently has 337 participants. As of November 2014, a total of 118 of the 220 ACOs that joined the MSSP in 2012 or 2013 produced savings relative to their spending targets in their first performance year, with 52 receiving shared savings bonuses. Among Pioneer ACOs, 14 of 23 had savings and received shared savings bonuses in their second performance year, whereas 6 were required to repay a portion of excess spending.[23] Measures of quality of care and patient experience also have improved in the two groups.

GLOBAL PAYMENT

Global payment aims to improve quality and contain costs by increasing provider accountability for delivery-system performance even further. Providers receive a fixed payment in advance, covering all or most of the health care needs of a group of patients. The classic example of this approach is capitation of the type used by health maintenance organizations in which physicians are members of large affiliated groups or are employed by the organization.[24]

Global payment can offer strong support for preventive care to avoid the onset of costly illness, coordinated care to produce improved outcomes at a reduced cost, and the availability of nonmedical services to enhance population health. However, it also can put providers at risk for costs they may not be able to manage and encourage avoidance of sick and potentially costly patients. The use of capitated managed care grew rapidly in the early 1990s, but providers' inability to manage financial risk and patients' fears of restricted choice and access to care led to a subsequent decline.[25] With the spread of electronic information systems and the development of more sophisticated risk-adjustment methods, however, providers may be better able to implement global payment.[26]

Medicare already pays private Medicare Advantage plans a fixed annual payment to cover all Medicare benefits. Some observers view the ACO model as a mechanism for expanding the application of global-payment methods over time. The idea is that once providers and their patients get accustomed to participating in ACOs, which involve limited risk sharing by providers, some ACOs and their patients may be willing to go the next step to full capitation with more restricted choice of providers.[27] In response to ACO concerns, Medicare is slowing the required transition to full risk sharing in the MSSP,[28] but a similar arrangement for provider groups in private employer coverage in Massachusetts has shown increasing success over time both in reducing cost growth and increasing ACO participation.[29]

COMPREHENSIVE MEDICARE REFORM

PREMIUM SUPPORT

From the time of Medicare's inception, some observers have argued that the program would function better if the private sector had a larger role in its management and if beneficiaries had to choose among competing private plans with varying benefits and costs.[30] This philosophy has influenced the evolution of the program through the creation of the Medicare Advantage program and the structure of Part D.

In a logical extension of these previous initiatives, some policymakers have advocated that Medicare be structured as a premium-support program, in which beneficiaries would receive a defined subsidy that they could use to purchase either a private plan or traditional Medicare. Congressman Paul Ryan (R-WI), who chairs the House Ways and Means Committee, has been a leading advocate for the premium-support approach.[31]

The House of Representatives endorsed this approach in April 2014, when it passed a 2015 budget resolution that included Ryan's plan.[32] Under this proposal, persons who become eligible for Medicare beginning in 2024 would receive a subsidy to purchase a standard package of benefits from private plans or traditional Medicare competing in a newly created Medicare Exchange. If beneficiaries chose a plan that cost more than the subsidy amount, they would be responsible for paying the difference between that amount and the monthly premium of the chosen plan.

The Congressional Budget Office has estimated that projected federal spending on Medicare would be lower under such proposals. However, depending on the generosity of the subsidy, Medicare beneficiaries might spend substantially more than they currently do.[33]

The effects of a premium-support approach on the federal budget, Medicare beneficiaries, and the providers who treat them would depend greatly on the power of a private Medicare health insurance market to motivate health plans to meet beneficiaries' needs for high-quality, efficient services. This in turn requires consumers of insurance to make effective choices among competing plans and depends on the efforts of plans, spurred by consumer pressure, to find ways to reform the delivery system.

Critics of premium support are skeptical of several aspects of the proposal. They worry that beneficiaries lack the information to choose among plans, especially with respect to the quality of care they are likely to receive. Critics also note that many Medicare beneficiaries have cognitive impairments that make informed choice difficult. Finally, they note that private plans, as compared with traditional Medicare, have had modest ability in the past to force changes in provider behavior.[34]

Advocates of premium support note that the federal government now generates increasing data on plan performance in the Medicare Advantage program and on provider quality through the federal Medicare Compare website. Advocates also note that as members of the "baby boom" generation join Medicare, they are bringing the average age of beneficiaries down, and increasing numbers of them will have experience with managed care and plan choice. Proponents of premium support also note that Medicare was originally intended to offer beneficiaries coverage that is similar to employer-sponsored private insurance and that increasing numbers of employers are considering defined-contribution programs with similarities to the Ryan approach.[35]

REFORMING TRADITIONAL MEDICARE

Another comprehensive approach to Medicare reform would substantially restructure traditional Medicare to make it resemble current employer-sponsored insurance and to address problems of cost, quality, fragmentation, and coverage gaps. A revamped traditional Medicare might also compete much more effectively in a Ryan-style exchange.

Reform of traditional Medicare could begin by combining Parts A, B, and D into a single program with a single premium and a single system of deductibles and copays, administered by the federal government.[36] This would greatly simplify Medicare for both users and providers and lower administrative overhead.

Second, traditional Medicare could create incentives for consumers to utilize better performing providers and treatments that are clearly beneficial in preventing complications, such as effective medications to treat diabetes and hypertension. This could be done by reducing deductibles and copays for patients using these services and agents. Medicare would document provider performance levels through continued and enhanced collection of quality and cost data.

Third, traditional Medicare could aggressively employ the payment and organizational reforms that are outlined above — ACOs, value-based purchasing, and blended and bundled payments — to increase the quality, efficiency, and coordination of care provided to Medicare patients.

Fourth, to reduce coverage gaps, traditional Medicare could reduce out-of-pocket payments for Medicare beneficiaries, making Medigap plans unnecessary and eliminating the premium burdens and administrative costs (averaging 20%) associated with the purchase and management of these supplemental private plans. For low-income beneficiaries, Medicaid could be replaced with sliding-scale assistance with premiums and out-of-pocket expenses under the Medicare acute care benefit package, while retaining Medicaid coverage of long-term care.

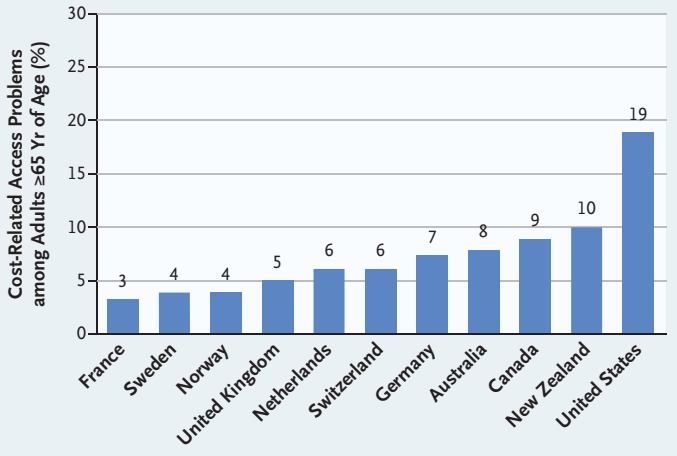

Figure 2. Cost-Related Problems in Accessing Health Care during the Past Year among Adults 65 Years of Age or Older in 11 Countries.

As examples of cost-related problems in accessing health care, respondents stated that they had a medical problem but did not visit a doctor, skipped a medical test or treatment recommended by a doctor, or did not fill a prescription or skipped doses because of the cost. Data are from the 2014 Commonwealth Fund International Health Policy Survey of Older Adults in Eleven Countries.

An important difference between the reform of traditional Medicare and the adoption of premium support is the underlying view of each plan regarding who should be held accountable and who should bear the costs and risks for ensuring needed improvements in the Medicare program and the health care delivery system. Premium support greatly increases the responsibility and potential risk borne by Medicare beneficiaries. It would make Medicare function more like the markets that allocate other goods and services. However, this particular group of consumers in the extraordinarily complex market for health care may not have the means — financial or otherwise — to drive needed improvements or tolerate added costs. Reforming traditional Medicare, in contrast, concentrates accountability and risk on the federal government and, through payment and organizational reforms, on the providers of health services. Medicare beneficiaries would retain traditional benefits with simplified and reduced out-of-pocket burdens. Anticipated savings would result from improvements in provider performance and reductions in administrative costs driven by federally managed payment and organizational reforms.

LONG-TERM SERVICES AND SUPPORTS

A notable gap in almost all proposed Medicare reforms is the absence of practical, affordable ideas for covering long-term services and supports that are increasingly important for the aging Medicare population. Although Medicaid pays for such care for impoverished beneficiaries, no similar support is available for older and disabled Americans who have incomes exceeding state-specific poverty levels. Furthermore, the fragmentation in the system makes it difficult to finance and deliver coordinated acute care and long-term services. A full discussion of the options in this area is beyond the scope of this report, but solutions will likely require new sources of revenue — and, as demonstrated by the passage and subsequent repeal of the Community Living Assistance Services and Support (CLASS) Act, approaches to this issue are difficult to enact under current political and economic circumstances.[37]

MOVING FORWARD

By 2030, more than 80 million Americans will rely on Medicare for access to needed health care services. Dealing with its pressing challenges is therefore a critical national priority that demands attention in national policy debate. The ideas for reform that are outlined here do not exhaust the options that have been and are likely to be considered. In particular, new approaches to supporting long-term services for our aging population are desperately needed. It should also be reiterated that these proposals are not mutually exclusive and that they are likely to be mixed and matched in any reform packages that gain the bipartisan support required for legislative enactment.

For health professionals, the outcome of these policy discussions will be crucial. For 50 years, physicians have been able to offer older and disabled patients much of the care they need without imposing prohibitive costs on the patients or their families. The daily work of clinical medicine will be infinitely more complicated, frustrating, and unsatisfying if Americans and their leaders cannot come to agreement on ways to make Medicare sustainable and effective for the next 50 years.

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