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Restoring Fiscal Sanity 2007

THE HEALTH SPENDING CHALLENGE

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The Challenge of Medicare

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The Medicare program is central to efforts to slow the rate of growth of health care spending. As discussed in chapter 1, the rate at which Medicare grows (along with Medicaid) will largely determine how fast total federal spending grows in the future and how prodigious an effort is required to keep the federal deficit under control. At the same time, as I shall discuss in this chapter, it is politically unlikely that the growth of Medicare spending will be allowed to fall behind the growth in total health care spending. Hence, the future growth in Medicare spending will attest to the success or failure of efforts to moderate the growth of total health spending.

Background on Medicare

The Medicare program was enacted in 1965 with the objective of providing seniors with health care that would be comparable to the health

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care available to the rest of the American population. Although most analysts believe that Medicare has succeeded in fulfilling this basic objective, there are important differences between Medicare and the health care available to the privately insured population in coverage and organizational structure of the delivery system.

Medicare as a Health Care Program

Medicare has four basic components. Part A, the Hospital Insurance program, covers inpatient hospital care and some home care, skilled nursing home care, and hospice care. It is financed by a portion of the Social Security wage tax—a 2.9 percent combined tax on employer and employee, although unlike the rest of the Social Security tax, the Medicare portion applies to all earned income. Part B, the Supplementary Medical Insurance program, covers outpatient hospital services, the remaining home health services, physician services, other services such as laboratory and diagnostic tests and durable medical equipment. Part C, also called Medicare Advantage, gives Medicare beneficiaries the option of enrolling in private plans—with at least the coverage of Parts A and B—that are paid on a capitated basis. Part D, which began in 2006, covers outpatient prescription drugs that are provided by private drug plans. The federal government contributions for Parts B and D come from general revenue. Medicare beneficiaries pay part of the cost of both Part B and Part D with premiums.

The Medicare benefit package contains more home care coverage than most plans for the under-65 population and, although limited, some nursing home coverage. However, except for the catastrophic coverage in the new outpatient prescription drug plan, there is not the usual "stop-loss" provision (limiting a person's financial liability) that is associated with most other insurance coverage. As a result, almost 90 percent of seniors have coverage in addition to Medicare, obtained from various sources such as employers, supplementary Medigap, Medicare Advantage, or Medicaid.[1] This supplementary coverage generally shields seniors from the deductibles associated with Parts A and B, as well as the 20 percent coinsurance associated with Part B expenditures. Nonetheless, even with Medicare and supplementary insurance, almost 20 percent of seniors' health care is financed out of pocket.[2]

The difference between the benefit packages for the Medicare population and the under-65 population primarily reflects differences in the expected use of benefits, particularly with the addition of outpatient prescription drug coverage to Medicare benefits. The difference in the financial orientation of the delivery system for each group reflects differences in financial incentives and funding liabilities between the two populations.

In the under-65 population, for whom most insurance is sponsored by employers, premiums are paid by employers and employees. Costs for managed care or network plans are usually less than those for indemnity plans. The more loosely organized networks, like Point of Service (POS) or Preferred Provider Organizations (PPOs), are more expensive than health maintenance organizations (HMOs), and network plans of all sorts cost less than old-fashioned indemnity plans, which have pretty much disappeared for the under-65 population.[3] Hence, most of the under-65 population is enrolled in some type of managed care or network plan. In contrast, most seniors are in the traditional fee-for-service indemnity program.

Private plan participation in Medicare has varied substantially during the last fifteen years but has never represented a very large portion of the senior population. Private plan participation reached a maximum of 17 percent of the Medicare population, but following the passage of the Balanced Budget Act of 1997, many plans withdrew from at least some areas of the country, and participation dropped to 12 percent by the end of 2003.[4] Following passage of the Medicare Modernization Act (MMA) in 2003, enrollment has started growing again. By December 2005, 14 percent of beneficiaries were enrolled in private plans.[5]

Private plan options increased in 2006, in part as a result of the requirement that seniors enroll in a private plan to receive the new drug benefit (although not necessarily to receive other Medicare benefits). It is too soon to know whether the growth experienced in 2005 will continue or whether private plans will show as much interest in participating in Medicare as they have in the past few years. If the capitation rate is reduced, perhaps to find funds for other purposes, future growth may be less robust.

Similar to spending throughout the health care sector, spending in the Medicare program is highly concentrated. In 2002, 5 percent of the program's population accounted for almost half of fee-for-service spending,

and 25 percent of the population accounted for almost 90 percent of spending.[6] Medicare spending is actually slightly less concentrated than spending for the under-65 population because the level of spending for all seniors is so much higher than that of the under-65 population. Over one-quarter of Medicare spending occurs during the last year of a beneficiary's life, a number that has held constant for several decades. Medicare beneficiaries use a disproportionate amount of health care relative to their numbers, reflecting both the greater prevalence of chronic conditions and the higher mortality among the elderly.[7]

Medicare versus the Rest of Health Care

In Medicare, the incentives to moderate spending or change behavior have been placed predominantly on the providers. Although beneficiaries spend substantial amounts of money out of pocket on health care, primarily for services not covered by Medicare, they tend to face small or no price increases for Medicare-covered services between what Medicare pays and what their supplementary insurance pays. With minimal pricing concerns at the point of use, most beneficiaries face few constraints in their use of, or access to, health services—except those who live in areas with limited health care capacity or where physicians are refusing Medicare patients.

Medicare's provider incentives vary according to the service covered. For hospital stays and nursing home and home care services, payments are made for a bundle of services under Medicare's prospective pricing systems. Under bundled payments, the incentive is to provide fewer and less costly services within the services covered by the payment—by being more efficient, by skimping on services, or by selecting patients healthier than the average. There is also an incentive to increase the number of bundled payments by readmitting patients to hospitals or providing multiple episodes of home care. In addition, although the reimbursement is nominally based on the diagnosis, it is also affected by the treatment. Thus bypass surgery is reimbursed differently than angioplasty, although both may be reflecting a similar disease state.

For services priced according to a fee schedule under Medicare, such as the relative value scale used for physician services, providers have an incentive to increase the volume of services, especially for those that are

highly compensated relative to their costs. Even though the sustainable growth rate ties total physician spending under Medicare to growth in the economy, thus providing an overall restraint on physician spending, the incentive for any individual physician remains to increase volume.

Medicare does not reward quality care or improved clinical outcomes. This is true for institutional providers who receive bundled payments and individual clinicians who are paid according to a fee schedule.

The incentives in the private sector are more diverse because of substantial variation in reimbursement and insurance used, although many insurance companies use Medicare-like reimbursement strategies for providers. Unlike Medicare, pressure to moderate spending is distributed more broadly in the private sector. Enrollees covered by private insurance frequently have a co-payment or coinsurance for at least some services; they may face different financial incentives toward in-network and out-of-network use; and a relatively small number are now enrolled in high-deductible plans that are often paired with a tax-favored medical savings account.

Providers also face a variety of incentives. Many plans use bundled payment systems, resembling those in Medicare, particularly for hospital payments. Some plans also use multiples of Medicare's relative value scale, while other plans use their own fee schedules. As in Medicare, there are frequently implicit incentives to increase the volume of services provided, few incentives for efficiency other than those associated with a bundled payment, and no rewards for quality care or clinical outcomes.

Innovative Strategies

Both private payers and Medicare understand the importance of changing some of the perverse incentives facing providers. There are more than 100 different pay-for-performance (P4P) experiments underway in the private sector and two large Medicare demonstrations in progress—with several others just beginning—that attempt to reward quality and encourage efficiency.[8]

The hospital pilot project of Premier Inc. focuses on rewarding quality. Hospitals in the top 10 percent on quality measures receive a 2 percent increase to their diagnosis-related group (DRG) reimbursement; those in the next 10 percent receive a 1 percent increase. In the third year of the

demonstration, penalties are being imposed on any hospital that has not exceeded the bottom 20 percent in quality from the baseline of the pilot's first year. Early reports indicate that participating hospitals had larger increases in quality improvement than did nonparticipating hospitals. Equally promising are reports indicating lower costs for at least some medical conditions.[9]

Medicare is also sponsoring a group practice demonstration that focuses on quality and efficiency by allowing practices whose patients show at least 2 percentage points slower growth in expenditures—compared with what other beneficiaries in their area spend—to keep 80 percent of the savings above the 2 percent threshold. This demonstration is still in its early stages, and thus relatively limited results are available.[10]

The Medicare Health Support pilot program, a care management demonstration, could help moderate spending for high-cost beneficiaries with complex needs. It is a chronic care improvement program for patients in fee-for-service Medicare with congestive heart failure or diabetes. Organizations providing care for these patients are paid a fee by the Centers for Medicare and Medicaid Services (CMS) for care coordination. Retaining the fee is contingent on demonstrating prespecified levels of savings.[11]

An additional demonstration scheduled to begin in 2007 allows for "gainsharing" between physicians and hospitals that are not part of integrated delivery systems. Various methodologies will be tested that allow hospitals to share savings with the physicians who produce them, thus providing for a better alignment of incentives between hospitals and physicians than exists under traditional Medicare. As in the other demonstrations, participants will be required to maintain or improve quality while demonstrating cost savings. Unlike current law, hospitals will be able to share up to 25 percent of the documented cost savings from quality improvements with physicians.[12]

These demonstrations may provide successfully tested strategies to improve performance that can be introduced into the full Medicare program. The inclusion of small and medium-sized physician practices, as well as demonstrations that focus on fee-for-service, is especially important because it is representative of most physicians' practices and how most beneficiaries receive care. Unfortunately, in the past many successful

demonstrations have proved difficult to implement at the national level, although the results of some demonstrations have affected changes in Medicare reimbursement structures. Because of the extraordinary importance of saving resources and improving quality in the Medicare program, it is possible that the experience of these demonstrations will be different. At the very least, they will provide important information about whether these types of changes would be desirable, information which would be available if and when the political will is found to introduce such changes.

Medicare versus the Private Sector: Who Has Been More Successful Moderating Spending?

There is ongoing debate about whether Medicare or the private sector has been more successful in restraining health care spending. When considering relatively small, discrete blocks of time, rates of growth in per capita spending can indeed differ between Medicare and private insurance. For example, from the early 1990s until the 1997 passage of the Balanced Budget Act, private insurance grew slower than Medicare. Since 1997, Medicare has been growing slower—sometimes substantially—than private insurance.

Some researchers claim that Medicare has been more successful over the last twenty years, beginning with the phase-in of bundled payments for hospitals.[13] The Medicare Payment Advisory Commission (MedPAC) reports that during the period from 1970 to 2002, Medicare spending has grown about 1 percentage point slower than private insurance (excluding outpatient prescription drugs so that the benefits are more comparable). However, during that same period private-sector benefits expanded and cost-sharing requirements declined, while Medicare benefits remained relatively unchanged.[14] Although it is difficult to make adequate adjustments to judge spending streams on a comparable benefits basis, an appropriate comparison of the spending streams cannot be made without such adjustments.[15]

Politically, the notion that Medicare could sustain lower rates of spending growth for any extended period relative to private insurance—implying less access to new technology, less or differential access to high-priced providers, or differential efficiencies by providers—seems totally

untenable. Medicare is currently the country's single largest payer of health care services. The impending retirement of the baby boomers will double the Medicare beneficiary population under current law. When baby boomer retirement is coupled with the increasing population share that those over 65 will represent, the likelihood that the Medicare growth rate can deviate from that of private insurance is even less tenable in the future than it is now. It is highly unlikely that middle-class seniors would tolerate sustained differences that produced what they perceived as inferior or undesirable results, assuming they continue not having to pay the full cost of the services.

This does not mean that Medicare or the private sector cannot each lead at different times regarding change. That can and does happen, but spending streams tend to converge over time. Thus sustaining a lower rate of spending growth per capita in Medicare will only happen if there is a comparable rate of spending growth in the private sector.

Objectives of Reform

The objectives for a reformed Medicare program may vary depending on one's political values and views on political feasibility. Here, four objectives are suggested to guide transformation of the program:

—Protect the most vulnerable among the aged and disabled.

—Begin reform as soon as politically possible to allow for as much transition time as possible.

—Move to substantially moderate the growth in spending.

—Find ways to improve the value of health care provided and received.

Menu of Options

Numerous analysts from across the political spectrum have estimated the budget effects of different strategies to slow Medicare spending. Some of these changes are attractive on policy grounds as well as for their budgetary effect, others primarily for their budgetary effects.

In reviewing the various options, this section follows the taxonomy used by MedPAC in their 2006 report, which includes the following:

—constraining payments

—limiting benefits and changing cost sharing, including increasing the age of eligibility

—increasing program financing

—increasing efficiency, including improving incentives within fee-for-service, using private plans to deliver Medicare benefits, and competing with traditional Medicare

—realigning incentives within Medicare, more broadly within health care including differential payments to providers, improved incentives for patients, and the development of comparative effectiveness information

Constraining payments is the most frequently used strategy to slow down Medicare spending. Each year, Congress decides whether and how much to update the various payments to providers. The Balanced Budget Act of 1997 aggressively slowed payments to providers for a short time, but as experience has shown, it is very difficult to sustain these slow-downs over time, especially if the drivers of spending are not addressed and spending in the private sector does not follow suit. After two years of unexpectedly slow spending growth, Congress "gave back" some of the savings, and Medicare spending is now projected to grow at a rate of 7.3 percent per year over the next decade.

It may be impossible to lower spending by constraining payments if volume or intensity of services or both are increasing. The importance of volume can be seen in Part B spending where, in 2005, physician fees increased at a rate of only 1.5 percent while Part B spending increased by 15 percent. The Congressional Budget Office (CBO) has estimated five-year savings for a variety of payment constraints (see appendix). Although they are modestly helpful in reducing Medicare expenditures in the short term, they have little appreciable effect on the problem. In addition, while some have argued that prices are a big part of the problem in the United States, reducing prices would represent more of a one-off saving than it would a reduction in the growth rate in spending, which is the larger challenge.[16] In addition, unless medical prices are reduced everywhere, it would be difficult to sustain the difference over time.

Limiting benefits—by increasing Medicare's age of eligibility, expanding beneficiary cost sharing, or limiting the benefit coverage—is not likely

to be politically popular, at least not among the Medicare beneficiary population, but it could have more sustained financial impact.

Increasing the eligibility age to 67 to make Medicare eligibility consistent with Social Security has been raised as a strategy for improving Medicare's financial position. Part of the appeal of this approach lies in the continuing increase in longevity being experienced by the American population. Current life expectancy in this country is 77.6 years. In 2003 American men could expect to live three years longer, and women more than one year longer, than they did in 1990.[17]

Increasing the eligibility age would reduce Medicare spending. However, the reduction may be less than presumed since the youngest beneficiaries tend to have lower than average medical expenditures.[18] The amount of savings will also depend on how quickly the age of eligibility is increased. If implementation follows Social Security and increases age eligibility by 2 months a year beginning in 2015, it would reduce spending only by 0.2 percent by 2075. If the eligibility age continued to increase by two months per year to age 70, the savings would be 0.8 percent of GDP by 2078.[19]A more rapid rise in eligibility age could occur if substantial advance warning were provided.

Increasing beneficiary cost sharing could provide significant revenues in the short term—CBO estimates that increasing the beneficiaries share of Part B from 25 to 35 percent would reduce spending by approximately $85 billion over the next decade.[20] However, concern has been raised that an across-the-board increase could impose financial hardships on lower-income beneficiaries and could also discourage the use of some medically necessary services.[21]

In addition, the Medicare Modernization Act will already substantially reduce the Part B subsidy for higher-income beneficiaries starting in 2007, with changes phased in over three years. Individuals with annual incomes of at least $80,000 will pay an income-based surcharge on the monthly premium. There is discussion on whether or not additional cost sharing would begin to result in fewer enrollees, but under current rules, Medicare continues to offer a substantial subsidy even for the highest-income individuals, and estimates of seniors dropping out of the program tend to be very small. For example, of the 1.8 million individuals who will be affected by the phased-in changes that start in 2007, it has been estimated

that only 30,000 will drop out of the program.[22] Thus, relating income to other parts of Medicare is likely to be raised in the future as Medicare expenditures place increasingly greater pressure on the Part A trust fund and on the general revenues used to finance Parts B and D.

MedPAC and others have suggested combining increased cost sharing with stop-loss or catastrophic coverage. This is an old idea, variants of which date back to proposals in the Reagan administration. It makes policy sense but gives back some of the savings. If combined with a prohibition on supplementary insurance, however, it could both alter behavior and save money. Banning supplementary insurance for Medicare to maintain financial incentives associated with cost sharing is a perennial favorite among economists and policy analysts but lacks political saliency in the extreme.

Limiting Medicare's coverage could also reduce spending, but this would have appeal only if done selectively or if combined with information on clinical effectiveness. "Tiering" coinsurance according to the appropriateness of use is a more attractive potential strategy. Limiting Medicare's coverage more generally and across the board is not very attractive given the substantial share of health care spending already not covered by Medicare.

Given the increasing share of GDP that will be going to Medicare, even if Medicare spending is able to grow at a level closer to 1 percent above GDP, enhancing program funding is likely to be a part of any long-term strategy to reform and bring into balance Medicare's funding and spending projections. However, increasing program funding alone does not address the imperative to slow Medicare spending as part of an overall strategy to restore fiscal sanity.

One option that may hold more promise is to moderate spending by increasing efficiency. While traditionally MedPAC has focused on whether the payments made to Medicare providers represent adequate reimbursement for efficient providers, MedPAC, CMS, and other payers and analysts increasingly have recognized that payments to providers under Medicare offer, at most, only limited incentives to achieving efficiency and no reward for producing quality or appropriate clinical outcomes.

As important as it is to change reimbursement systems to drive changes in provider behavior, it would also be helpful if beneficiaries were

rewarded or presented with incentives to use health care more efficiently. This latter objective underlies the movement towards consumer-directed health plans. It focuses not only on giving financial incentives to patients to be more cost conscious while using care but also on driving greater transparency in pricing and quality information. Another way to encourage seniors to be more cost conscious is to change the incentives they face when choosing their health plan. One of the frequently cited ways to do this is to adopt the model of the Federal Employees Health Benefits program of plan selection in which the government contribution does not vary with the cost of the plan. In Medicare, this strategy has also been called the premium support model.[23]

The increased use of bundled payments in reimbursing Medicare services—rather than paying for specific inputs of care—represented an important change that was first introduced by Medicare in the 1980s. It has been increasingly adopted by private-sector payers. Bundled payments are currently used for inpatient and outpatient hospital reimbursement, for home care, and to a lesser degree for nursing homes. Under bundled payments, institutions can capture the results of being efficient if they can provide care at less than the average cost represented by the bundled payment. However, there has been ongoing concern regarding potential gaming through "upcoding," that is, increasing the code to increase the complexity and therefore the payment.

The incentive for efficiency associated with bundled payments does not exist for physicians under Medicare. The use of a relative value–based fee schedule that ties updates to the aggregate level of spending on Part B provides no opportunity for efficient physicians to gain rewards.

However, neither the bundled payment method of reimbursement nor the disaggregated physician fee schedule provides any reward for quality or improved clinical outcomes. The lack of a reward for quality, the limited rewards for efficiency, and the recognition that there are very wide variations in spending levels that appear either to not be associated with different outcomes or to have a perverse association have led to calls for a fundamental revamping of reimbursement to providers under Medicare.

The systemically unhelpful incentives in Medicare reimbursements are generally present in the private sector and are driving much of the interest in implementing some type of pay-for-performance (P4P) reimbursement

system there as well. As discussed earlier, both CMS and the private sector are in the process of experimenting with different strategies that reward quality and improved outcomes, either independent of savings or as a result of the savings.

Pay-for-performance strategies attempt to realign incentives both to encourage ongoing improvement in the delivery of health care and to reward those who produce efficient, high quality care. These strategies pay for results instead of paying for the volume and intensity of specific services, regardless of the outcomes they produce or the appropriateness of the care delivered. However, many changes need to occur and many questions need to be addressed before a pay-for-performance system could be introduced into Medicare.

The first requirement is the development of a national performance measurement system that could be used as a basis for redesigning a payment system. The Institute of Medicine (IOM) has recently released a report entitled *Performance Measurement: Accelerating Improvement* that assesses the current state of performance measurement and recommends strategies to develop a usable performance measurement system for the future.[24]

The many decisions that need to be made to enable full implementation of P4P include how to reward improvement and attainment in some weighted manner, how to phase in a pay-for-performance system, how much of the reimbursement should or must reflect pay-for-performance to have an impact on behavior, whether to use new or existing Medicare funds, and how to adjust for differences in health status and compliance. The latter is particularly important to minimize the incentive to choose healthier patients or to further disadvantage safety net facilities that may have unusually high numbers of sicker or less compliant patients.

Moving to a payment system that encourages and rewards efficiency and quality improvement is an important part of any "spending smarter" strategy. However, it will take time to put in place because there is so much currently unknown and untested. During the phase-in of a new reimbursement system, it will be important to conduct ongoing assessment of the effects of changes to the reimbursement system. Recognizing the amount of change that needs to occur, IOM has recommended engaging in what it has termed "active learning," that is, adjusting and undertaking corrective actions in response to undesired or unintended consequences.[25]

Realigning incentives so that providers are encouraged to work collaboratively to improve the quality and efficiency of health care, and are rewarded for doing so, is the first component to "spending smarter." A second component is to develop good comparative clinical information on the effectiveness of medical procedures and technologies, so that providers, payers, and consumers can better understand the likely effects of using a particular therapeutic device or medical technology for a patient with a given set of symptoms and risk factors. To date, most of the interest in comparative effectiveness information has been directed toward pharmaceuticals and occasionally new devices. Although these are important areas of health care with many innovative and often expensive products that require coverage and reimbursement decisions, the potential payoff for better decision-making is even greater in other areas of health care, particularly the broader area of medical procedures.[26]

Determining the appropriate function, placement, structure, and financing of a comparative effectiveness center in the United States raises significant questions about the appropriate role of government. In most countries, information on comparative effectiveness and cost effectiveness has been used to make coverage and reimbursement decisions as part of the national health plan. In the United States, the more appropriate function of a comparative effectiveness center would be to provide credible, objective information that any payer could use. The expectation is that different payers would use the information differently, in terms of structuring differential reimbursement or co-payment rates based on comparative clinical effectiveness, but that the availability of the information is critical for payers, providers, and patients to make better decisions.[27]

What would happen if the United States invested in making credible clinical information available on comparative effectiveness for at least the highest-cost, highest-volume procedures and technologies—an investment that would likely require expenditures of at least $4 billion to $6 billion on an annualized basis for many years—and if it adopted a payment-for-results model of reimbursement that aligned incentives across various providers to encourage the delivery of coordinated, effective, and efficient health care? Such action would certainly improve the value of care received, but it is unclear whether spending growth rates would be modified. There would be many "one-off" savings that could

reduce the absolute level of spending per person and increase the value of health care spending. It seems reasonable that a realignment of incentives coupled with better information will also moderate spending growth rates, but it is not possible to know for certain whether and how much change in growth rates would result unless and until this approach is tried. However, given the other options available, which would either have little impact or seem politically infeasible, moving in the direction of providing credible clinical information and rewarding results seems very compelling.

Where Can Medicare and the Federal Government Lead and Where Must Medicare Follow?

The federal government can and should take the lead investing in the development and public availability of comparative effectiveness information. This type of information can be regarded as a traditional public good in the way economists use that term—once available, its use does not diminish its availability to other users; it is not excludable. This is clearly an important area for government leadership, regardless of whether or not there could be some joint financing with the private sector or placement in a quasi-government center to encourage the trust and buy-in of the private sector. Because the Medicare program will clearly be an important beneficiary of such information, Medicare could reasonably be regarded as a financial contributor to this activity, so long as the financing does not come exclusively out of general revenues.

It is more complicated to determine whether the government and Medicare can take the lead in realigning reimbursement to reward those who provide efficient, high quality care—that is, paying for results instead of paying for what is nominally the same service. Historically, Medicare has had great difficulty introducing concepts of selective contracting or competitive bidding in health care—both concepts that the private sector has used liberally since the 1980s. Even in areas with minimal service components, like durable medical equipment, competitive bidding has been difficult to introduce. Although it was first considered in 1992, competitive bidding for durable equipment is only now being phased in, from 2007 to 2009.

At the very least, Medicare can sponsor extensive experimentation involving different models of pay-for-performance, as it is now doing with the various current, or soon to be operating, demonstrations. These demonstrations include assessments of the sensitivity of various types of providers to differential payment strategies, the unintended consequences associated with different payment strategies, and implementation issues. Medicare could also help disseminate the knowledge produced by the demonstrations. CMS can and should also continue to be part of consortiums like NCQA (the National Committee for Quality Assurance) and NQF (the National Quality Forum).

It is possible that if the formulas used to calculate the pay-for-performance strategies appear "rigorous enough," or are at least objectively defined so that they appear more like diagnosis-related groups (DRGs) and the Resource-Based Relative Value Scale (RBRVS), Medicare may be able to take the lead in introducing payment realignment. Particularly in the current atmosphere, where there is significant interest in bailing out physicians from anticipated fee reductions over the next several years, it may be possible to phase in a pay-for-performance strategy that would begin with pay for reporting, as was done for hospitals following the Medicare Modernization Act. Other sectors in Medicare, such as hospitals, renal dialysis centers, and Medicare Advantage plans, are close to being ready to begin a phase-in of pay-for-performance, if the political will exists to move in this direction.

Even if the political will does exist, there are advantages and disadvantages to having Medicare take the lead. The advantage is that a large part of the health care sector would move toward paying for outcomes and results. The primary concern, however, is that the introduction of such a system and any subsequent changes will require new statutory language that would have to be implemented through the regulatory process. This whole area is very much in flux, and using the statutory and regulatory mechanisms of the federal government is a cumbersome, inflexible process.

Thus it is important to at least raise the question of whether it is too early in the evolution of a realigned reimbursement system for the government to take the lead in introducing it, even if it is politically possible to do so. The trade-off is balancing the use of government's power and ability to make things happen quickly and in a significant way versus the

ability of the private sector to be nimble, flexible, and "quicker on its feet." On balance, if Medicare can begin introducing pay-for-performance components into its reimbursement system, it should do so in a careful and phased process. The private sector should continue to follow suit, as it is doing sporadically now, and should pursue some of the innovations that appear necessary after early findings from the Medicare program.

Sensible Next Steps

Finding ways to slow the growth rate in Medicare spending, and thus in the rest of health care—given the historical ways in which they have trended together and the likelihood that this trending will become even more important in the future—is even more urgent following the introduction of the Part D drug benefit than it has been in the past.

Sensible next steps include the following:

—Move as quickly as politically and technically possible toward changing and realigning financial incentives for providers and, to the extent feasible, making patients more conscious of cost and quality.

—Improve the availability of comparative information on effectiveness.

—Introduce more competitive elements into Medicare.

—Provide full benefits for those with health-related disabilities and begin to gradually increase the age for full benefits for those without health-related disabilities.

—Extend the Medicare principle of relating incomes to premiums beyond Part B. How and how much will depend on whether the dominance of the fee-for-service system continues in the future and on how far relating incomes to premiums can go before people at the high end of the income scale start to rebel or push back.

Although there are no guarantees that these steps would actually reduce growth rates in spending, they represent a combination of reasonable next steps that could imaginably survive the test of political feasibility. Making more and better information available and realigning financial incentives seem to be among the few areas that have garnered both bipartisan and bicameral interest. That does not, however, mean their passage would be easy. As any former or current administrator of the Health Care Financing Administration or the Centers for Medicare and Medicaid Services can attest, nothing big in Medicare happens easily.

Appendix[a]

Budget options— Constraining payments	*Potential savings*	*Details of option*
Remove Medicare's payments for indirect medical education (IME) from the benchmarks for private plans.	$326 million in 2006 and $2.1 billion over 5 years	Remove payments for IME from the benchmarks for private plans, leaving the payment to teaching hospitals as the only compensation for IME.
Reduce Medicare's direct payments for graduate medical education (GME).	2004 costs totaled $2.2 billion; savings are $800 million in 2006 and $4.6 billion over 5 years	GME direct payments would be set at 120 percent of the national average salary paid to residents in 1987, updated annually for changes in consumer prices; option would reduce teaching and overhead payments while continuing to pay residents' compensation; would pay each hospital the same amount for the same type of resident.
Reduce Medicare's payments for the indirect costs of patient care related to hospitals' teaching programs.	$2.9 billion in 2006 and $17.2 billion over 5 years	Lower the IME adjustment to 2.7 percent from 5.5 percent for every increase of 0.1 in the ratio of full-time residents to number of beds.
Equalize Medicare's capital-related payments for teaching and nonteaching hospitals.	$400 million in 2006 and $2.4 billion over 5 years	Eliminate extra payments to teaching hospitals.
Convert Medicare's payments for GME into a block grant and slow their growth.	$600 million in 2006 and $3.3 billion over 5 years	Replaces current payment system with consolidated block grant to fund all GME activities at teaching hospitals (see three options above).

Budget options—Constraining payments	*Potential savings*	*Details of option*
Convert Medicare's disproportionate share of hospital (DSH) payments into a block grant.	$1.2 billion in 2006 and $10.5 billion over 5 years	Converts DSH payments into a block grant to the states. In 2006 each grant would be 10 percent less than the estimated sum of Medicare DSH payments made to hospitals in that state in 2005. In subsequent years, the grant would be indexed to the change in the consumer price index (CPI) for all urban consumers minus 1 percentage point. States would be given flexibility in how they used their DSH funds.
Reduce the update factor for hospital inpatient operating costs under Medicare.	$1.2 billion in 2008 and $55 billion through 2015 (over 10 years)	Reduces the Medicare prospective payment system (PPS) update factor to the annual change in the Medicaid Buy-In (MBI) minus 1 percentage point. Rate would take effect in 2008 and continue through at least 2015.
Reduce Medicare's payments for hospital inpatient capital-related costs.	$400 million in 2006 and $2.4 billion over 5 years	Would further reduce the prospective payment rate for hospitals' capital-related costs by 5 percentage points—bringing the total reduction to about 22 percent from the initial level.
Reduce Medicare's payments for home health care.	$240 million in 2006 and $6.3 billion over 5 years	Freeze the base payment for each home health episode at its calendar year 2005 level ($2,264) through 2009, with the goal of gradually narrowing the gap between payments and costs.

Budget options—Constraining payments	*Potential savings*	*Details of option*
Raise the eligibility age for Medicare.	0.2 percent to 0.8 percent of GDP by 2075	Two alternatives: increase eligibility age by 2 months every year beginning in 2015 until it reached 67 in 2026; increase eligibility age same as above but until it reached 70 in 2044.
Increase Medicare's premium for supplementary medical insurance (SMI) to 30 percent of benefit costs.	$4.7 billion in 2006 and $33.5 billion over 5 years	Set the SMI premium equal to 30 percent of the cost of Part B benefits; would raise the 2006 premium for enrollees to $95.70 per month versus $79.80.
Restructure Medicare's cost-sharing requirements.	$4.7 billion in 2006 and $34.3 billion over 5 years	Replace the current complicated mix of cost-sharing provisions with a single combined deductible covering all services in Parts A and B of Medicare, a uniform coinsurance rate of 20 percent for amounts above that deductible (including inpatient expenses), and an annual cap on each beneficiary's total cost-sharing liabilities. Combined deductible would be $500 in 2006, and the cap on total cost sharing would be $4,500 in later years. Those amounts would grow at the same rate as per capita Medicare costs.
Restrict Medigap coverage of Medicare's cost sharing.	$2.1 billion in 2006 and $15.8 billion over 5 years	Bar Medigap policies from paying any of the first $500 of an enrollee's cost-sharing liabilities for calendar year 2006 and limit coverage to 50 percent of the next $4,000 in Medicare cost sharing.

Budget options—Constraining payments	*Potential savings*	*Details of option*
Combine changes to Medicare's cost sharing with Medigap restrictions.	$7.1 billion in 2006 and $52.2 billion over 5 years	Medigap plans would be prohibited from covering any of the new $500 combined deductible that would be required by Medicare in 2006 and could cover only 50 percent of the program's remaining cost-sharing requirements.
Impose a co-payment requirement on home health episodes covered by Medicare.	$1.5 billion in 2006 and $11.8 billion over 5 years	Charge beneficiaries a co-payment amounting to 10 percent of the total cost of each home health "episode"—a 60-day period of services—covered by Medicare, starting on January 1, 2006.
Impose cost sharing for the first 20 days of a skilled nursing facility stay under Medicare.	$1.1 billion in 2006 and $8 billion over 5 years	Impose a co-payment for the first 20 days of care in a skilled nursing facility equal to 5 percent of the inpatient deductible, which would be $47.20 per day in 2006. Maximum additional liability for a beneficiary would thus equal the inpatient deductible and would rise at the same rate over time.
Impose a deductible and coinsurance amounts for clinical laboratory services under Medicare.	$800 million in 2006 and $5.9 billion over 5 years	Impose the SMI program's usual deductible and coinsurance requirements on laboratory services, beginning Jan 1, 2006.

a. Cost estimates based on Congressional Budget Office, "570: Medicare," in *Budget Options* (GPO: February 2005), pp. 191–215 (www.cbo.gov/showdoc.cfm?index=6075&sequence=13). Because of interactions among policies, the net savings that could be gained by adopting a combination of options is likely to be lower than the sum of the parts.

Notes

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