

### Key Points

- When evaluating proposals to improve Medicare's financial condition, it's important to recognize that improving the sustainability of the health system as a whole requires slowing the growth in overall health spending rather than shifting costs from one payer to another.
- New payment and delivery system models have the potential to control costs and improve quality by better aligning incentives to encourage integrated and coordinated care.

### Additional Resources

Medicare Advantage Payment Reform: [http://www.actuary.org/pdf/health/ma\\_oct09.pdf](http://www.actuary.org/pdf/health/ma_oct09.pdf)

Health Insurance Coverage and Reimbursement Decisions: Implications for Increased Comparative Effectiveness Research: <http://www.actuary.org/pdf/health/comparative.pdf>

Value-Based Insurance Design: [http://www.actuary.org/pdf/health/vbid\\_june09.pdf](http://www.actuary.org/pdf/health/vbid_june09.pdf)

## An Actuarial Perspective on Proposals to Improve Medicare's Financial Condition

Medicare plays a critically important role in ensuring access to health care among Americans age 65 and older and certain younger adults with permanent disabilities. Yet, rising health care spending threatens the sustainability of the Medicare program and the overall health system. Moreover, rising health spending threatens the nation's fiscal health.

Provisions in the Affordable Care Act (ACA) have improved Medicare's financial condition. Nevertheless, putting the country on a more sustainable fiscal path requires additional efforts to slow health spending growth. To this end, debt and deficit reduction proposals put forward by various groups, such as the National Commission on Fiscal Responsibility and Reform, include provisions to control health spending.<sup>1</sup> Related legislation has also been introduced.

The American Academy of Actuaries' Medicare Steering Committee supports continuing efforts by the president and Congress to address these challenges and urges further action to restore the long-term solvency and sustainability of Medicare. To assist in those efforts, this paper outlines many of the Medicare-related provisions in the various debt and deficit reduction proposals. For each proposal, a summary of the key cost, access, and quality issues from an actuarial perspective is provided. In future work, the

<sup>1</sup>See The Henry J. Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit-Reduction Proposals," (last modified April 4, 2011) for a side-by-side comparison of key Medicare changes recommended by various debt and deficit reduction proposals.

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committee plans to examine many of these options in more detail.

When evaluating proposals to improve Medicare's financial condition, it's important to recognize that improving the sustainability of the health system as a whole requires slowing the growth in overall health spending rather than shifting costs from one payer to another. So unless system-wide spending is addressed, implementing options to control Medicare spending will have limited long-term effectiveness.

### **Limit the Growth in Medicare Spending**

Some current proposals would set spending targets, either for Medicare in particular, or for federal health spending in total. Exceeding those targets could trigger specific actions, such as automatically reducing benefits or increasing revenues. The trigger, alternatively, could be structured to require the president or a commission to submit proposals that would be considered by Congress on an expedited basis. One approach, for instance, would set target spending for all federal health expenditures at the growth in gross domestic product (GDP) plus 1 percent. If the target is exceeded, the president would be required to submit proposals to reduce spending. Another approach automatically would reduce fee-for-service provider payments by 1 percent if general revenue contributions to Medicare exceed 45 percent of Medicare funding. (As discussed

below, the ACA created the Independent Payment Advisory Board, or IPAB, which focuses on reducing Medicare spending if it exceeds a targeted growth rate. As currently structured, the IPAB is somewhat restricted on what options it can recommend.)

**COST:** Medicare savings would depend on how aggressively the spending targets are set. Savings to the health system overall, however, would be offset to the extent that costs are instead shifted to Medicare beneficiaries or other payers.

**ACCESS/QUALITY:** The impact on the access to and quality of care would depend on the specific recommendations made. Depending on how the reductions are structured, reducing provider payment rates could reduce beneficiary access to care and/or the quality of care. Other specific options for reducing benefit costs or increasing revenues are examined in other sections of this paper.

### **Transition to a Premium Support or Voucher Program**

Some proposals would transition Medicare to a premium support or voucher program, while others offer such an approach as an option if certain measures to reduce Medicare spending growth are not deemed adequate. These approaches would change the Medicare program from a defined benefit plan to a defined contribution plan.

Under a premium support approach, the

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government would limit the amount it contributes toward Medicare coverage, with beneficiaries paying additional premiums to cover any difference between plan premiums and the government contribution. The growth in government contributions would be indexed by inflation or some other factor. Under a voucher-type approach, individuals would receive a voucher to purchase private health insurance. The voucher could be adjusted by various beneficiary characteristics—such as age, health status, geographic location, and/or income—and would be indexed by inflation or some other factor.

**COST:** Moving to a defined contribution approach would shift the risk of health spending growth away from the government and toward beneficiaries. Depending on how the government contribution is set, federal Medicare spending could be lower than currently projected. To the extent that health spending growth exceeds the increase in the government contribution, costs would be shifted to beneficiaries through higher premiums and/or higher cost sharing. As discussed below, increased cost-sharing requirements could lower spending growth due to reduced utilization. The impact of such an approach on overall health spending would also depend on how utilization management, administrative costs, and provider payment rates under private plans would compare to those under traditional Medicare.

**ACCESS/QUALITY:** Access to Medicare or private insurance would depend on the difference between the government contribution and the premium. The greater the share

of costs that are shifted from the government to beneficiary premiums, the more likely that beneficiaries will opt for less generous plans. Although this could encourage beneficiaries to seek more cost-effective care, some may forgo needed care. In addition, to bring costs down, care quality might be compromised. Such a system, for instance, might lead to a less-expensive second tier delivery system, which may be much more limited in the types of providers available.

### **Expand the Authority of the Independent Payment Advisory Board (IPAB)**

The ACA created the IPAB, which is similar to the Medicare Payment Advisory Commission (MedPAC).<sup>2</sup> The IPAB is charged with preparing recommendations to reduce the growth in Medicare per capita expenditures if spending exceeds a targeted growth rate. The targets are based on inflation until 2019, and on GDP plus 1 percent thereafter. Unlike MedPAC recommendations, IPAB recommendations would be implemented automatically unless the Congress passes legislation producing comparable reductions. The board is somewhat restricted in its recommendations—it cannot propose to ration health care, raise revenues, increase beneficiary premiums or cost sharing, or otherwise restrict benefits or modify eligibility criteria.<sup>3</sup> In addition, until 2020 most hospital services are excluded from the scope of payment changes that can be recommended.

Provisions included in various fiscal proposals would expand the scope of the IPAB, by eliminating the temporary carve-outs for hospital services, allowing options related to

<sup>2</sup>MedPAC would continue its role as advisor to Congress on issues affecting the Medicare program and would review any IPAB proposals.

<sup>3</sup>Section 3403 of the Affordable Care Act: <http://docs.house.gov/energycommerce/ppacacon.pdf>.

cost sharing and benefit design, and giving it authority over all federal health spending. The expansion of scope could be tied to directing IPAB to meet more ambitious spending growth targets.

**COST:** To the extent that the spending growth targets are tightened, additional Medicare cost savings could be achieved, compared to current law. However, total savings would be offset to the extent that costs are shifted to beneficiaries.

**ACCESS/QUALITY:** The impact on the access to and quality of care would depend on the specific recommendations made. Options to revise Medicare's plan design are examined in more detail below.

### Reform the Sustainable Growth Rate System

The sustainable growth rate (SGR) system was enacted as part of the Balanced Budget Act of 1997 to limit the growth in spending for Medicare physician services. The system compares actual cumulative spending for Medicare physician services to a specified spending target. If actual spending exceeds the target, then physician payment updates are adjusted downward. With the exception of 2002, the first year that physician fee cuts were called for under the SGR formula, the fee cuts have been temporarily overridden each year by Congress (i.e., the "doc fix"). As a result of the cumulative shortfall, physician payment rates will be reduced by nearly 30 percent in 2012, barring another override from Congress.

By putting pressure on physician payment

updates, the SGR system might have resulted in slower growth in physician payment updates than would have occurred otherwise. There are calls, nevertheless, to reform or eliminate the SGR system due to concerns regarding beneficiary access to care under large fee cuts, provider frustration regarding the short-term nature of payment fixes, the growing budgetary costs of further overrides, and the way the system's across-the-board fee cuts poorly target those providers with the highest volume increases.<sup>4,5</sup> One approach would eliminate the SGR, temporarily freeze physician payments, and develop a new physician payment system. The proposal would pay for the elimination of the SGR by other reductions in Medicare and Medicaid spending.

**COST:** Officially eliminating the SGR would increase Medicare spending over baseline projections including the SGR, unless offset by other spending reductions.

**ACCESS/QUALITY:** Eliminating the SGR could help maintain beneficiaries' access to care. Depending on how a new physician payment system would be developed, it could better align payments with the provision of high-value care.

### Reduce Spending for Prescription Drugs

Provisions included in various proposals would reduce payments for prescription drugs. One option would be to increase drug rebates by requiring Medicare to use its bargaining power to negotiate drug prices under the Part D program. Another option would extend drug rebates to those eligible

<sup>4</sup>Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy* (Chapter 4), March 2011.

<sup>5</sup>The Congressional Budget Office (CBO) estimates that replacing the SGR with a 10-year physician payment freeze would cost about \$250 billion; if payments were increased over time, the cost would be even greater. (*The Budget and Economic Outlook: Fiscal Years 2011 to 2021*, January 2011.)

for both Medicare and Medicaid.

Another approach would establish a government-run Part D option that would be offered alongside Part D private plans. The Centers for Medicare and Medicaid (CMS) would negotiate prices with prescription drug companies. However, as with Medicare Parts A and B, this ultimately could lead to CMS setting prescription drug prices.

**COST:** By reducing the prices paid for prescription drugs, these options would lower Part D spending and reduce its growth rate. To the extent that prescription drug companies can respond by increasing their prices in the private sector, costs would be shifted from Medicare to the private sector.

Lowering Part D spending would also reduce beneficiary premiums for Part D plans. In some cases the copayments for some prescription drugs could also be reduced.

**ACCESS/QUALITY:** Reducing the prices paid for prescription drugs potentially could reduce research and development in the pharmaceutical industry. Introducing a government-run Part D option could lead to some current Part D providers leaving the market, especially if the government-run plan sets drug prices—thereby reducing the choices available to enrollees.

### Revise Medicare's Fee-For-Service (FFS) Benefit Design and Cost-Sharing Requirements

Medicare, like most other health insurance plans, uses patient cost-sharing requirements (e.g., deductibles, copayments, coinsurance) to help balance plan affordability with the com-

prehensiveness of coverage. Patient cost sharing directly lowers Medicare spending by shifting a share of medical costs to the beneficiary. In addition, cost sharing can lower spending overall by reducing utilization. Patient cost-sharing requirements ideally align beneficiary incentives with program goals to provide quality and cost-effective care. However, Medicare's fee-for-service (FFS) cost-sharing requirements are not currently structured to meet these goals. In particular:

- The FFS cost-sharing requirements are skewed more toward less discretionary services, with high deductibles for Part A inpatient services and lower deductibles for Part B physician and outpatient services;
- Most beneficiaries have supplemental policies to fill in most or all FFS cost-sharing requirements, thereby reducing the incentives for beneficiaries to seek cost-effective care;<sup>6</sup>
- The lack of an out-of-pocket maximum under FFS leaves beneficiaries unprotected against catastrophic health costs.

Provisions in various proposals would increase and/or restructure Medicare's cost-sharing requirements. A number of proposals would combine or restructure the Part A and Part B cost-sharing requirements and add a new maximum out-of-pocket limit. (Medicare Advantage plans have some flexibility on how to structure cost-sharing requirements, and as of 2011, are required to cap out-of-pocket spending.) Some of these proposals would also eliminate first-dollar coverage in Medigap plans and/or prohibit supplemental insurance from covering any new or increased cost-shar-

<sup>6</sup>MedPAC reports that 89 percent of FFS beneficiaries in 2005 had supplemental coverage: 33 percent had individually purchased Medigap coverage, 37 percent had employer-sponsored coverage, 17 percent had Medicaid, and 2 percent had other public coverage. See *Report to the Congress: Improving Incentives in the Medicare Program* (Chapter 6), June 2009.

ing amounts. Taken together, these changes could help encourage Medicare beneficiaries to seek cost-effective care. A value-based insurance design (VBID) also could encourage the use of cost-effective care. A VBID approach would lower the cost sharing for high-value services and increase the cost sharing for low-value services. The ACA moved Medicare in this direction by covering certain preventive services with no cost sharing. Comparative effectiveness research can facilitate the identification of low- and high-value services.

**COST:** Increasing Medicare's cost-sharing requirements would reduce Medicare spending by shifting more of the costs to beneficiaries. Savings could also result by lowering utilization, especially if supplemental plans are prohibited from covering the difference. Adding an out-of-pocket cap would offset cost savings. Adjusting cost sharing to align incentives with effective use of services has shown promise in reducing spending in the non-Medicare market—most often for prescription drugs.<sup>7</sup>

**ACCESS/QUALITY:** A restructuring of Medicare's cost-sharing requirements could better align beneficiary incentives for high-quality and cost-effective care. In addition, incorporating a maximum out-of-pocket limit would provide the catastrophic protection that the FFS program currently lacks. Such a restructuring would increase out-of-pocket spending for many beneficiaries, but decrease it for those with the greatest health care needs.

Broad increases in cost sharing, rather than targeted increases, have been shown to reduce not only unnecessary care, but also necessary care, especially among the low income and chronically ill. For this reason, some propos-

als would exempt lower-income beneficiaries from cost sharing increases. In addition, a VBID approach could incorporate lower cost-sharing requirements for chronic treatments.

### **Raise the Medicare Eligibility Age**

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Since the program began in 1965, beneficiaries have been eligible for full Medicare benefits at age 65, consistent with Social Security's normal retirement age at that time. Since that time, the normal retirement age for Social Security has been increased to age 67 and there are currently proposals to increase it beyond 67. Similarly, there are proposals to gradually increase the Medicare eligibility age (e.g., to age 67 or 69), and some also would index the eligibility age for increased longevity.

**COST:** Raising the Medicare eligibility age would reduce the cost of the Medicare program and could increase payroll tax revenues by encouraging individuals to work beyond age 65. However, the increased revenues would be offset by increased federal spending to the extent that individuals between age 65 and the new eligibility age receive premium subsidies through the health insurance exchanges or coverage through Medicaid. In addition, some costs would be shifted to employers, states, and individuals.

**ACCESS/QUALITY:** People between age 65 and the new eligibility age would have to find a new source of health insurance—through employer coverage, the individual market or health insurance exchanges, or other public coverage such as Medicaid—or go uninsured. Provisions in the ACA increase the availability of other coverage sources. In particular,

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<sup>7</sup>See for instance, "Evidence That Value-Based Insurance Can Be Effective," Michael E. Chernew, et al. *Health Affairs* 29(3): 530-536, March 2010.

beginning in 2014, the ACA requires that private health insurance coverage be offered on a guaranteed-issue basis, prohibits preexisting condition exclusions, and limits premium variations by age. Low- and moderate-income individuals may be eligible for premium and cost-sharing subsidies or Medicaid coverage.

Shifting individuals between age 65 and the new eligibility age into private plans would increase average premiums for private plans. This could potentially reduce insurance coverage among younger individuals if their premiums increase as a result.

### **Increase Medicare Part B Premiums**

Medicare Part B premiums, initially set at 50 percent of Part B costs, currently are set at 25 percent of costs. Beginning in 2007, premiums for higher-income beneficiaries were raised to between 35 and 80 percent of costs, depending on income. The ACA temporarily freezes the index on income thresholds used to determine the premiums, which means more beneficiaries will be subject to higher premiums over time. Some proposals would increase the Part B premiums for those not already subject to higher premiums or raise them higher for those already subject to higher premiums.

**COST:** Increasing Medicare premiums would increase program revenues by shifting costs to beneficiaries. But it would not reduce Medicare spending (unless some beneficiaries decide to opt out of Medicare Part B due to the higher premiums).

**ACCESS/QUALITY:** Beneficiaries who are unwilling or unable to pay higher Part B premiums may face reduced access to care.

### **Next Steps**

This paper provides a brief overview of the various Medicare-related provisions put forward as part of proposals aimed at improving the nation's fiscal condition. In future work, the American Academy of Actuaries' Medicare Steering Committee plans to explore in more detail many of these and other options. The focus will be not only on whether an option helps improve Medicare's financial condition, but also on whether it improves the sustainability of the health system as a whole by slowing the growth in overall health spending.

In addition, the committee intends to examine new programs in the ACA that were included to jumpstart reforms to the health care delivery system. The Medicare Shared Savings Program, for instance, will facilitate the creation of Accountable Care Organizations (ACOs). The newly created Center for Medicare and Medicaid Innovation (CMI) will identify and test new models of health care delivery and payment and speed the expansion of successful models. By better aligning incentives to encourage integrated and coordinated care, ACOs and other new payment and delivery system models have the potential to control costs and improve quality.



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