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Examining the Health Care Equation

Actuarial perspectives on cost and quality

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Key Points

- Even though health care cost growth has slowed in recent years, Medicare still faces serious mid- and long-term financial challenges. Both the number of Americans enrolled in Medicare and the cost per enrollee are increasing.
- To reduce health care costs, any proposal for Medicare reform must accomplish one or more of the following: reduce the prices paid for services, reduce the utilization of services, shift to more cost-effective services, and/or keep high-risk patients healthier.
- To evaluate public policy proposals to reform Medicare, policymakers need to consider how they affect the cost of the program, how they affect beneficiaries' access to care, how they affect the quality of care, whether they slow the growth in health care spending rather than shifting costs from one payer to another, and whether they give providers and their patients incentives that encourage coordinated care to help control costs and improve quality.

Addressing Health Care Cost Growth in Medicare: A Framework

The federal Medicare program provides health insurance to most Americans aged 65 and over and to individuals under age 65 who have long-term disabilities. Medicare is a vital source of health coverage for millions of Americans, but it currently faces serious mid- and long-term financing challenges. Both the number of Americans enrolled in Medicare and the cost per enrollee are increasing. Even though health care cost growth has slowed in recent years, and this phenomenon is not certain going forward, long-term challenges remain.

Rising health care costs per beneficiary for Medicare is compounded by more enrollees due to the aging of the population and the retirement of the baby boomer generation. Medicare's current financing will not sustain the program for the long term, and over time it will place increasing financial demands on employers, workers, beneficiaries, and the federal budget. This pressure on the federal budget created by health care costs taking up an increasing portion can only worsen the fiscal challenges facing policymakers seeking to achieve a balanced federal budget.

This brief addresses a significant challenge facing Medicare—health care cost growth—by providing a framework for understanding and evaluating the primary options available for controlling costs and outlining a number of options to reform Medicare and the potential effects of those options on cost growth, care quality, and access to care.

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Recent efforts to address Medicare cost growth include provisions in the Affordable Care Act (ACA) designed to reduce Medicare spending, increase Medicare revenues, and develop new health care delivery systems and payment models to improve health care quality and cost efficiency. These measures have improved Medicare's financial condition, but problems remain. While these provisions in the ACA were important steps forward, they do not go far enough to put Medicare back on a sound financial footing.

The traditional Medicare program provides coverage for inpatient hospital services (Part A), which is financed largely through earmarked payroll taxes, and for physicians and outpatient care services (Part B), which is financed through beneficiary premiums and federal general tax revenues. Medicare Advantage (MA) plans are offered by private insurers. The plans must cover all of the services that the traditional program covers but may offer extra benefits not included in the traditional program either at no additional cost or for an additional premium. Medicare prescription drug benefits (Part D) are available through private insurers as a stand-alone plan to supplement traditional Medicare or as part of a Medicare Advantage plan.

Individuals opting for the traditional program (Parts A and B), also can purchase Medicare supplement insurance (Medigap). They also may have access to retiree health coverage and Medicaid (which are not discussed in this issue brief). Medigap coverage is sold through private insurers and may provide coverage and/or pay for some costs (i.e., copays, coinsurance, deductibles) that traditional Medicare does not. Medigap plans require a monthly premium in addition to the Part B premium, is guaranteed renewable, and only covers one individual. Medigap policies sold after Jan. 1, 2006, aren't allowed to include prescription drug coverage.

Major Medicare-related provisions of the ACA include:

- Reductions to provider payment updates. The annual updates for fee-for-service (FFS) provider payment rates will be adjusted downward to reflect productivity improvements.
- Basing Medicare Advantage (MA) plan payments on these reduced FFS rates. MA plan payments will be reduced gradually relative to FFS costs.
- Health care payment and delivery system improvements. Pilot programs, demonstration projects, and other reforms will be implemented to increase the focus on delivering high quality and cost-effective care. These include initiatives such as accountable care organizations, bundled payments, dual demonstrations, and value-based payments.
- Increases in Medicare revenues. Provisions to increase Medicare revenues include increasing the Hospital Insurance (HI) payroll tax for earnings above an unindexed threshold, temporarily freezing the income thresholds for Part B income-related premiums, and increasing Part D premiums for higher-income beneficiaries.
- Creation of the Independent Payment Advisory Board (IPAB). The board was created to submit recommendations for changes to provider payments if Medicare spending exceeded a target per capita growth rate.

Broad Categories of Policy Options

While the U.S. has experienced a recent slowdown in health spending growth, additional efforts will be required to put Medicare on a more sustainable path. Options for reducing Medicare spending, many included as part of debt and deficit reduction efforts, can be grouped into the following broad categories,

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which are discussed in more detail below.

- Reducing the cost of the traditional Medicare fee-for-service (FFS) program, including reforming the physician payment system, adopting managed care techniques, and revising the benefit design of traditional Medicare;
- Reducing the cost of the Medigap coverage through changes to the benefit design;
- Reducing the cost of the Medicare Advantage (MA) program by revising the payment system for competitive bidding;
- Reducing the cost of the Part D program by incorporating proposals to reduce spending for prescription drugs;
- Fundamentally restructuring Medicare through transitioning to a premium support program or mandatory participation in managed care; and
- Broader approaches to managing the cost of Medicare, which could include restructuring the benefit package to encourage more cost-effective care, focusing on payment reform (e.g., bundled payments, capitation) and delivery system reforms (e.g., accountable care organizations) that better align financial incentives.¹

While these approaches vary in significant ways, they have certain common themes, such as improving the alignment of financial incentives, using managed care techniques to better coordinate care, ensuring that benefits are structured to encourage the effective use of care, and mitigating cost-shifting from one program/payer to another. From an actuarial perspective, to produce real savings, any option to reduce spending must accomplish one or more of the following:

- Reduce the prices paid for services;
- Reduce the utilization of services and reduce waste;
- Shift to more cost-effective services; and
- Keep high-risk patients healthier.

Reducing the Cost of the Traditional Medicare Fee-For-Service (FFS) Program

Traditional Medicare is based on a FFS benefit design, often paying for volume rather than value. While allowing some flexibility for providers to deliver and beneficiaries to receive certain services, the FFS structure has limitations in terms of incorporating care management and utilization management techniques, which can lead to increased costs. A number of pilot and demonstration programs have led to alternate approaches to payment and delivery of care, including bundled payments and accountable care organizations. These types of programs, which are used in the private market, often offer the potential for shared savings if providers meet certain quality and financial performance metrics. In addition to these reforms, other approaches have been proposed to help reduce the cost of the traditional FFS program, many of which also focus on aligning financial incentives to encourage better quality of care.

REFORM THE PHYSICIAN PAYMENT SYSTEM

Physician payment rates historically were set by the Sustainable Growth Rate (SGR) system, which intended to limit the growth in Medicare spending for physician services. The SGR was enacted as part of the Balanced Budget Act of 1997. However, since 2003 Congress has overridden the physician fee cuts that the SGR formula would require (this override is known as the “doc fix”). In April 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which repealed the SGR and replaced it with a 0.5 percent annual payment update through 2019, followed by a five-year period of no updates. Beginning in 2026, payment updates will depend on performance-based measures. It is unclear the extent to which this new system may address Medicare spending growth, but it does provide incentives to better align payments with the

¹ For more information on general payment and delivery system reforms, see the Academy’s publications on health care costs: www.actuary.org/healthcosts.

provision of high-value care as compared to a FFS payment system.

REVISE THE BENEFIT DESIGN OF TRADITIONAL MEDICARE

The design of the benefits provided to individuals enrolling in traditional Medicare (as opposed to private MA plans) has several shortcomings: the lack of an out-of-pocket (OOP) maximum leaves beneficiaries unprotected against catastrophic costs; most beneficiaries have supplemental coverage (e.g., Medigap) with low cost-sharing requirements that reduce incentives to seek cost-effective care;² and the cost-sharing structure is not ideal for encouraging prudent use of health care. Updating the traditional cost-sharing features could help better align beneficiary incentives to seek cost-effective care. Meeting this goal, however, may require changes to supplemental coverage as well, because that coverage can reduce or eliminate the incentives for beneficiaries to seek cost-effective care. Proposals to update the traditional benefit design recommend changing or combining the Part A and B cost-sharing requirements and adding a maximum OOP limit.

The effect of a benefit redesign on overall program costs and beneficiary OOP spending would depend on the design specifics. Changes could be designed to raise, lower, or be neutral with respect to overall or average beneficiary spending. Even if average beneficiary spending remains unchanged, however, individual beneficiaries could be affected differently and could face higher or lower spending. For instance, adding a catastrophic cap but leaving average beneficiary spending unchanged would increase OOP 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 these reasons, policymakers often consider ways to shield lower-income beneficiaries from cost-sharing increases.

VALUE-BASED INSURANCE DESIGN

Value-based insurance design (VBID) is an approach intended to encourage cost-effective care. A VBID approach would lower cost sharing for high-value services and increase the cost sharing for low-value services.³ The ACA provided some movement in this direction by providing for Medicare coverage of certain preventive services with no cost sharing. Comparative effectiveness research, which includes head-to-head trials that compare new treatments and technologies to those already existing, can facilitate the identification of low- and high-value services. Adjusting cost sharing to align incentives with effective use of services, such as decreasing the cost share with higher compliance of treatment, has shown promise in reducing spending in the non-Medicare market—most often for prescription drugs.⁴

ADOPTION OF MANAGED CARE TECHNIQUES

By design, the original Medicare program does not incorporate utilization management techniques. However, use of quality metrics for provider incentive arrangements could lead to lower costs. One example, which has already been implemented under the ACA, is reducing payments for hospitals that are classified as having excess avoidable readmissions.

² Kaiser Family Foundation, Medigap Enrollment Among New Medicare Beneficiaries (April 2015): <http://kff.org/medicare/issue-brief/medigap-enrollment-among-new-medicare-beneficiaries/>.

³ High-value services can be defined as those that “provide substantial health benefit relative to the cost.” Generally, this means there is strong evidence of a clinical benefit. Low-value services would not provide substantial benefit relative to the cost, and there may not be strong evidence of a clinical benefit. See, for instance, “Applying Value-Based Insurance Design to Low-Value Health Services,” Mark Fendrick, et al., *Health Affairs* 29(11), November 2010.

⁴ See for instance, “Evidence That Value-Based Insurance Can Be Effective,” Michael E. Chernew, et al., *Health Affairs* 29(3): 530-536, March 2010.

Historically, the traditional Medicare benefit plan design does not include medical management provisions, such as preauthorization requirements for hospital admissions or other costly services. There often is no clear responsibility for coordinating all of the care a beneficiary receives. With fragmented information and benefits allowing self-referral, it is important that forms of care coordination are developed further. While a primary care physician (PCP) gatekeeper model could be difficult to implement in traditional Medicare due to its open network nature, ACOs and comprehensive primary care incentive initiatives are being tested through certain authorized pilot programs.

Some of the utilization management techniques that could be useful in traditional Medicare include elements of demand management. These techniques are designed to lower a member's need for health care services—nurse advice lines or targeted outreach, self-care and self-evaluation programs (www.healthfinder.gov, sponsored by the U.S. Department of Health and Human Services, which is not Medicare-specific), health risk appraisals, shared decision-making programs, and personal health records (PHR).

Utilization management techniques and reimbursement strategies that target lower utilization, higher-quality health care outcomes, and lower costs can be applied to traditional Medicare FFS, as well as MA and private sector plans.

Traditional Medicare has a potential advantage in this respect—a large amount of available claims data. Retrospective claim review and pattern review can help in identifying problem areas and developing solutions. Investment in data analysis and provider profiling may lead to savings in the future.

SUMMARY

To reduce the cost of traditional Medicare FFS program, a coordinated approach is necessary. Reforming the physician payment

system has the potential to reduce costs per service. And, changes to benefit design and cost sharing as well as some elements of utilization management could help to prevent large increases in utilization of services. Restructuring beneficiaries' cost sharing could be combined with VBID to encourage use of cost-effective care, and payment adjustments could incentivize efficient provider behavior. Both of these elements might result in a shift toward more quality and cost-effective services. With the Medicare population growing and beneficiary longevity increasing, it is in the long-term interest of the program to incorporate changes that will help balance cost, utilization, and quality of care.

Reducing the Cost of Medigap Policies Through Benefit Design Changes

Medicare Supplement insurance (Medigap) is obtained from insurance companies by Medicare beneficiaries to provide

Criteria for Evaluating Potential Options

Improving the sustainability of the health system requires slowing the growth in overall health spending, rather than just shifting the costs from one payer to another. Unless system-wide spending is addressed, implementing options to control Medicare spending will have limited long-term effectiveness. While controlling costs is vital to the sustainability of the program, it is not the only consideration. Slowing the growth in health spending, while maintaining or improving the quality of care, will require provider payment methods and health care delivery systems that encourage coordinated care.

How can and should effective proposals for improving Medicare's financial condition be evaluated? Some criteria include:

- How it affects the cost of the program;
- How it affects beneficiaries' access to care;
- How it affects the quality of care;
- Whether it slows the growth in health spending, rather than just shifting costs from one payer to another; and
- Whether it gives health care providers, and their patients, incentives that encourage the kind of coordinated care that could help both control costs and improve quality.

additional coverage and help pay for some of the significant cost-sharing requirements associated with traditional FFS Medicare. Currently, enrollment in Medigap is primarily concentrated in lower-cost plan options, specifically the lowest-cost plan options with first-dollar coverage.⁵ A Kaiser Family Foundation brief notes that it is unclear how enrollees choose among available Medigap plans (e.g., premium level, insurer, etc.).⁶ Currently, there are 14 allowable standard Medigap plans (policies A through N).

Many Medigap plans have provided first-dollar coverage for most services, insulating beneficiaries from the impact of the FFS program deductibles. One approach to addressing health care spending growth is to reduce the level of net benefits covered by Medigap policies so that there would exist some minimum level of patient cost sharing. With the passage of the MACRA, policymakers embraced this approach. Beginning in 2020, Medigap plans C and F, which covered Part B deductibles, will no longer cover the annual deductible for new enrollees. Individuals with existing Medigap plans and new enrollees up to 2020 will not be affected.

Better understanding of the needs of the Medigap population may help determine a way to restructure the entire program, including perhaps existing policies, into three generic policy types—a low-cost option, a medium-cost option, and a higher-cost option. This structure could still preserve standardized benefits across the three policy types, which would be similar to current options for Medigap policies A through N. It might also be feasible to consider two benefit levels (low-cost and high-cost) and a maximum OOP consideration.

Market forces and developing ACA environment could further diminish the need for a Medigap market. The landscape

for benefits for retirees (at least for the vast majority of retirees over age 65) is changing rapidly. The effect of private and public exchanges is uncertain. Dual eligible (people eligible for both Medicare and Medicaid) demonstration projects also may have an impact on strategic direction for that population. Medicare beneficiaries with Medicare plus Medigap coverage could change their coverage choices significantly in the next three years. Enrollment in MA plans continues to grow rapidly. As such, there could be two main dimensions that evolve for the future. One would be an increase in the number of beneficiaries moving to Medicare Advantage, in which 28 percent of all beneficiaries are already enrolled,⁷ networks have succeeded, and competition has kept premiums low. The second would be a decreased number of traditional Medicare beneficiaries with simplified Medigap options in locations with smaller populations and in which MA providers cannot create a viable network. A marketplace with public and private exchanges could further reduce the need for Medigap policies if other coverage is made available through the exchanges to Medicare eligibles, but the issue of affordable premiums might still exist for some.

Reducing the Cost of the Medicare Advantage Program

The MA program was created to offer a more cost-effective alternative to Medicare FFS by providing beneficiaries access to coordinated delivery systems and care management with enhanced benefits. Proponents of the MA program contend that a well-managed MA plan costs less than the FFS benefits and offers a comprehensive benefit package for a modest, or even no, premium. MA plans are reimbursed by the Centers for Medicare & Medicaid Services (CMS) based on a benchmark rate, which is the maximum amount paid to health plans and

⁵ Kaiser Family Foundation, “Medigap: Spotlight on Enrollment, Premiums, and Recent Trends” (August 2013): <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8412-2.pdf>.

⁶ Ibid.

⁷ Medicare Payment Advisory Commission (MedPAC), The Medicare Advantage program: Status report (March 2014): http://medpac.gov/documents/reports/mar14_ch13.pdf?sfvrsn=0.

is set by law. When the benchmark is higher than what it costs an MA plan to provide the FFS benefits, the MA plan receives a portion of the differential and is required to either enhance the benefits beyond FFS level or reduce the beneficiaries' Part B/Part D premiums. In most geographic areas,⁸ MA plans have provided comprehensive benefits that replace the combination of FFS and Medigap policies. Over time, due to policymaker objectives (e.g., to enable beneficiaries access to MA plans in all geographic areas) and the subsequently enacted payment policy changes (that set the mechanism by which the benchmark is determined), the MA benchmarks grew to be higher than the FFS costs in many geographic areas. An effort was made to address this in the ACA, which initiated a reduction in federal payments to MA plans over time, to bring them closer to the average costs of care under the traditional Medicare program. The ACA also provided for new bonus payments to plans based on quality ratings, beginning in 2012, and required plans beginning in 2014 to maintain a medical loss ratio of at least 85 percent, restricting the share of premiums that MA plans can use for administrative expenses and profits.

Various approaches have been proposed to reduce the cost of the MA program. Several recent trends may make the near future a key time to revamp the MA program. The enrollment in private health plans relative to traditional Medicare has increased to 30 percent of the Medicare participants in 2014. This shift to Medicare Advantage has continued since 2005, when private health plans first bid to enter Medicare Advantage with the new Part D program. However, participation across individual states ranges from a low of 1 percent to a high of 46 percent and is dependent on funding from CMS and the relative cost of care in the region. Those plans that can afford to add extra benefits based on payment levels

established by CMS for that region might have higher enrollment, which will, in turn, affect program costs. As ACO programs within FFS Medicare reduce cost growth, this will increase pressure on MA plans to be competitive.

REVISE PAYMENT SYSTEM TO ENCOURAGE GREATER PRICE COMPETITION

Competitive bidding is an approach in which payment rates would be set using an average of submitted bids. Under this approach, payment rates would not be directly linked to the FFS costs, although various versions of competitive bidding include capping the average bids at the FFS levels of costs or including the projected FFS costs as one of the "competitive bids."

An argument for implementing competitive bidding is that it would level the playing field among geographic regions within the MA program by paying plans based on a defined level of benefits (founded on actuarial equivalence relative to FFS benefits) and by using market forces to fund enhanced benefits. Competitive bidding can encourage plans to be more efficient and could result in lower benchmarks as higher-cost plans withdraw from the market. Most of the federal cost savings in competitive bidding would result from payment reductions in counties in which MA plans are more efficient than the FFS program. In counties in which plan bids currently exceed FFS cost, a pure competitive-bidding approach could result in maintaining payment levels above FFS. This may increase the likelihood of preserving access to MA plans in rural areas compared to the approach to reducing MA payments by phasing them down to 100 percent of FFS.

An argument against competitive bidding is that an immediate transition to such a system would be highly disruptive to beneficiaries due to the potential elimination of access to enhanced benefits or a significant increase in premiums for enhanced benefits. The resulting

⁸ According to MedPAC, a majority of Medicare beneficiaries have access to an MA plan (March 2014): http://medpac.gov/documents/reports/mar14_ch13.pdf?sfvrsn=0.

net migration out of MA plans into the FFS program and Medicare Supplement plans, especially in high-cost areas, could offset the savings to the government that would be gained by preserving membership in the MA program. It also could lead to fewer plans in the market.

SUMMARY

With approximately 30 percent of Medicare beneficiaries enrolled in an MA plan, the cost of Medicare Advantage is a key factor in the overall cost of the Medicare program. MA plans are paid based on benchmark rates that are set administratively. Congress has adjusted the payment rates to MA plans over time. More recently, Congress has provided bonus payments based on quality ratings. An alternative to this administrative pricing approach would be a competitive bidding system in which the payment rates would be set using an average of submitted bids. Competitive bidding would attempt to use market forces to ensure more equitable payment levels across different geographic regions and encourage plans to be more efficient. An immediate transition to a competitive bidding system, however, could have adverse effects on beneficiaries by reducing the number of plans available or increasing the cost of enhanced benefits.

Reducing the Cost of the Part D Program

Proposals to reduce spending for prescription drugs include requiring CMS to negotiate drug prices under Part D, extending drug rebates to individuals who are eligible for both Medicare and Medicaid, establishing a public Part D option, decreasing overutilization, lowering cost sharing for generics and raising cost sharing for brand names, and opening up preferred pharmacy networks.⁹

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 respond by increasing their prices in the private sector, costs would be shifted from Medicare to the private sector.

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

The major argument advanced by opponents of negotiation of drug prices under Part D is that reducing the prices paid for prescription drugs potentially could reduce research and development in the pharmaceutical industry. Introducing a public Part D option that would compete with private Part D plans could lead to some providers leaving the market. Some proponents believe a public plan could negotiate lower prices; opponents believe that it could reduce the choices available to enrollees.

SUMMARY

Most of the savings in the prescription drug reform proposals would come from reducing the prices paid for prescriptions. Some savings could result from benefit adjustments that support a shift to utilization of generic drugs or preferred brand drugs. However, it is unlikely that changes would reduce utilization materially. It would take a significant behavioral shift both on the part of providers and beneficiaries to slow utilization trend. In addition, taking into account the specific aspects of the Medicare population, it is not clear how the utilization adjustments (other than shift to generic or more appropriate medications usage) would impact cost of total medical care. Overutilization of prescription drugs is a significant challenge in controlling health care costs.

Fundamentally Restructuring the Medicare Program

Some policy experts have argued that a fundamental restructuring of the Medicare program could result in a more efficient

⁹ Other policy options that have been proposed would need to be evaluated, including reducing the number of protected classes and limiting the number of Part D plans an insurer could offer.

and cost-effective program. Many of these considerations would affect not only Medicare FFS but also MA plans.

TRANSITION TO A PREMIUM SUPPORT OR COMPETITIVE BIDDING MODEL

These two proposed approaches would change Medicare from a defined benefit plan to a defined contribution plan. Under a premium support approach, the government would limit the amount it contributes toward Medicare coverage relative to current levels, with beneficiaries paying additional premiums to cover any difference between plan premiums and the government contribution. The level of growth in government contributions would change over time, in accordance with inflation or average premium growth. Recent premium support proposals incorporate competitive bidding methods as a way of determining the government's contribution.

Moving to a defined contribution program would result in shifting 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. Those savings could result from a shift in costs from the government to Medicare beneficiaries, but that depends on how utilization management, administrative costs, and provider payment rates under private plans would compare to those under traditional Medicare over time. Additionally, the total growth in spending would depend on the proportion of the Medicare population that would drop health care coverage under a defined contribution approach if health care cost increases exceed the federal government's premium subsidy increases. Over time, the increase in the cost of insurance could cause premiums to become unaffordable for seniors who are on a fixed income.

Access to Medicare and 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 having less generous plans could encourage beneficiaries to seek more cost-effective care, some could forgo needed care. The pressure to reduce plan costs also could compromise the quality of care. Such a system, for instance, might lead to a less-expensive, second-tier delivery system, which may be much more limited in the types and/or quality of providers available.

Although it could result in an indirect tax on younger generations, one option would be to allow Medicare-eligible individuals to purchase health insurance through the exchanges at a limited cost. Raising the average age of enrollees in exchanges could increase exchange premiums. Because of the 3:1 limit in the ACA on rating variation by age, a portion of those higher costs would be passed on to younger adults. Allowing Medicare-eligible individuals to purchase coverage through an exchange would require another tier in the 3:1 limit on the ratio of the highest exchange premium to the lowest (other than juvenile) exchange premium.

INCREASE IN MANAGED HEALTH CARE PARTICIPATION

To supplement the existing managed care available through MA programs, CMS could add a primary care case management (PCCM) requirement and/or participation in an ACO. This approach is comparable to experience in some state Medicaid programs in which eligible individuals have the option of choosing from a menu of managed care options. A number of Medicare ACO demonstration programs also have indicated improvements in the quality of care for Medicare beneficiaries; however, it is important to note that these improvements have not always been at a lower short-term cost.¹⁰

¹⁰ CMS News Release: Medicare's delivery system reform initiatives achieve significant savings and quality improvements – off to a strong start, Jan. 30, 2014: <http://www.hhs.gov/news/press/2014pres/01/20140130a.html>. See also Evaluation of CMMI Accountable Care Organization Initiatives, L&M Policy Research (Nov. 3, 2013): <http://innovation.cms.gov/Files/reports/PioneerACOEvalReport1.pdf>.

SUMMARY

Much of the cost savings associated with the options in this section likely would be a result of either cost shifting or a reduction in overutilization. The premium support approach or allowing Medicare eligibles to purchase coverage through an exchange may simply shift costs from the Medicare program to a younger generation. The managed care option could help reduce or eliminate waste associated with overutilization of services. Any fundamental restructure of the Medicare program will need to take into account whether more costs are passed on to beneficiaries. As policymakers and regulators consider the various options for reform, it will be important to continue to examine the ACO demonstration projects and the early 2015 care management fee for Medicare eligibles with two or more chronic conditions to better understand their short- and long-term effects on Medicare costs.

Broader Approaches to Managing the Cost of Medicare

DELIVERY SYSTEM AND PAYMENT REFORM

A common focus in discussions about slowing the growth of health care spending in Medicare, as well as the health system as a whole, is the introduction of payment and delivery system reforms. Most of these types of proposals focus on realigning financial incentives to lower costs and improve health care quality and outcomes. Some of these models are highlighted below.¹¹

Accountable Care Organizations (ACOs).

With the Medicare Shared Savings Program (MSSP) and the Pioneer ACO program, ACOs are already being incorporated into the Medicare program. An ACO is essentially a group of health care providers that work together to manage and coordinate care for beneficiaries. In addition, under an ACO,

providers take financial responsibility for the cost and quality of care for their beneficiaries—they can share in cost savings if certain quality and cost metrics are met. ACOs represent both delivery system and payment reform.

Bundled and Capitated Payments.

Examples of specific payment reform options that can be used with ACOs or as stand-alone approaches include bundled payments and capitation models. Bundled payments, as the name suggests, offer providers a single, predetermined payment for all health care services a beneficiary might receive during the course of treatment for a specific condition over time. Specific to Medicare, in 2013, CMS announced a Bundled Payment of Care Improvement (BPCI) initiative in which organizations agree to accept bundled payments for defined episodes of care, including financial and quality-of-care requirements.

Capitation, or global payments, refers to the provision of a fixed, advance payment per beneficiary for a given time period. Capitation rates can vary by region and depend on the number of patients, the range of services provided, and the specified period of time during which the services are provided. In 2013, CMS engaged a Capitated Financial Alignment Model demonstration project under which a state, a health plan, and CMS work together to deliver and finance an integrated set of services for beneficiaries that are dually eligible for Medicare and Medicaid.

These are just representative examples of delivery system and payment reform models, including relevant pilot and demonstration programs in Medicare, that will test and explore the potential cost savings and quality improvements associated with approaches to align financial incentives.

¹¹ This is not an exhaustive list. For more information on these models and other approaches, see the Academy's website for current and forthcoming papers on health care costs: www.actuary.org/healthcosts.

Conclusion

Options to address Medicare spending include efforts to increase provider responsibility (often in combination with more alignment of financial incentives), eliminate waste, use managed care techniques to better coordinate care, and structure benefits to encourage more effective use of care. When evaluating approaches to slow spending growth in Medicare, it is important to recognize that improving the sustainability of Medicare also requires slowing the growth in overall health spending rather than shifting costs from one payer to another. As potential reforms to Medicare are considered, it is also important to evaluate the effect those reforms could have on the viability of the Medicare program, including cost, access, and quality of care.