

**PRESERVING AND STRENGTHENING MEDICARE FOR ITS
CURRENT AND FUTURE BENEFICIARIES**

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Thank you, Chairman Tiberi, Ranking Member McDermott, and Members of the Subcommittee, for this invitation to testify on policies to preserve and strengthen Medicare as it enters its second 50 years. I am Stuart Guterman, a Senior Scholar in Residence at AcademyHealth. AcademyHealth is an organization that works to improve health and the performance of the health system by supporting the production and use of evidence to inform policy and practice.

I am glad to be able to speak to you on this topic, because I have been working on Medicare issues for many years, at the Commonwealth Fund from 2005 to 2015, the Centers for Medicare and Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration, in the mid-1980s and again from 2002 to 2005, and at the Medicare Payment Advisory Commission (MedPAC) and its predecessor, the Prospective Payment Assessment Commission, from 1988 to 1999, as well as at the Congressional Budget Office (CBO). I have seen—and had the privilege of participating in—the innovative changes that the program has implemented over the years, and also been aware of the challenges faced by the program.

In addition, many of us with elderly parents or other loved ones know how they have been helped tremendously by Medicare’s coverage and the access to care it provides—

and also hindered by the program's shortcomings and the fragmented nature of health care provided in this country.

Medicare been a tremendous success in accomplishing its main goal: assuring the health and economic security of the nation's elderly and disabled. It has been influential in shaping the U.S. health system, improving the quality of care, and contributing to medical progress.

At the same time—like the rest of our health system—Medicare faces considerable challenges. Rising costs, affecting both the federal budget and beneficiaries, are an ongoing challenge. Medicare's benefit package, while rated highly by beneficiaries for enabling their access to care and protection from financial hardship and medical debts, falls short in providing financial protection for beneficiaries with low incomes and serious health problems. Fragmentation of coverage into different plans for hospital, physician, and prescription drug benefits is confusing for beneficiaries and undermines coordination of patient care; and because Medicare covers only a portion of medical expenses, most beneficiaries supplement Medicare with other coverage, adding to complexity and administrative cost. Better strategies are also needed to serve the growing number of beneficiaries with complex care needs with physical and cognitive functional limitations and multiple chronic conditions—symptoms of an aging population.

We have a historic imperative to continue to improve the program and ensure its viability into the future—but, at the same time, we must be careful not to hinder its effectiveness in carrying out its basic mission: providing access to needed health care for a vulnerable and growing number of aged and disabled Americans. In this testimony, I describe some of the issues that Medicare faces and offer some suggestions for improving its performance.

MEDICARE’S EVOLUTION

As we consider Medicare’s current state and the challenges it faces, we need to remember that it has evolved over time.

Expanded Coverage. While Medicare originally covered Americans age 65 and over, the Social Security Amendments of 1972 extended eligibility to persons under age 65 who qualify for Social Security benefits as permanently disabled (coverage begins 24 months after eligibility for disability benefits) and persons with end-stage renal disease (ESRD; coverage begins in the fourth month after dialysis treatments and extends for 36 months after a kidney transplant). In 2014, 8.9 million of the 53.8 million Medicare beneficiaries were eligible because of their disability status or ESRD.¹

The Medicare Modernization Act of 2003 made drug benefits available to Medicare beneficiaries beginning in 2006, under Medicare’s prescription drug coverage (Part D) program. Part D coverage is voluntary, and available only through private prescription

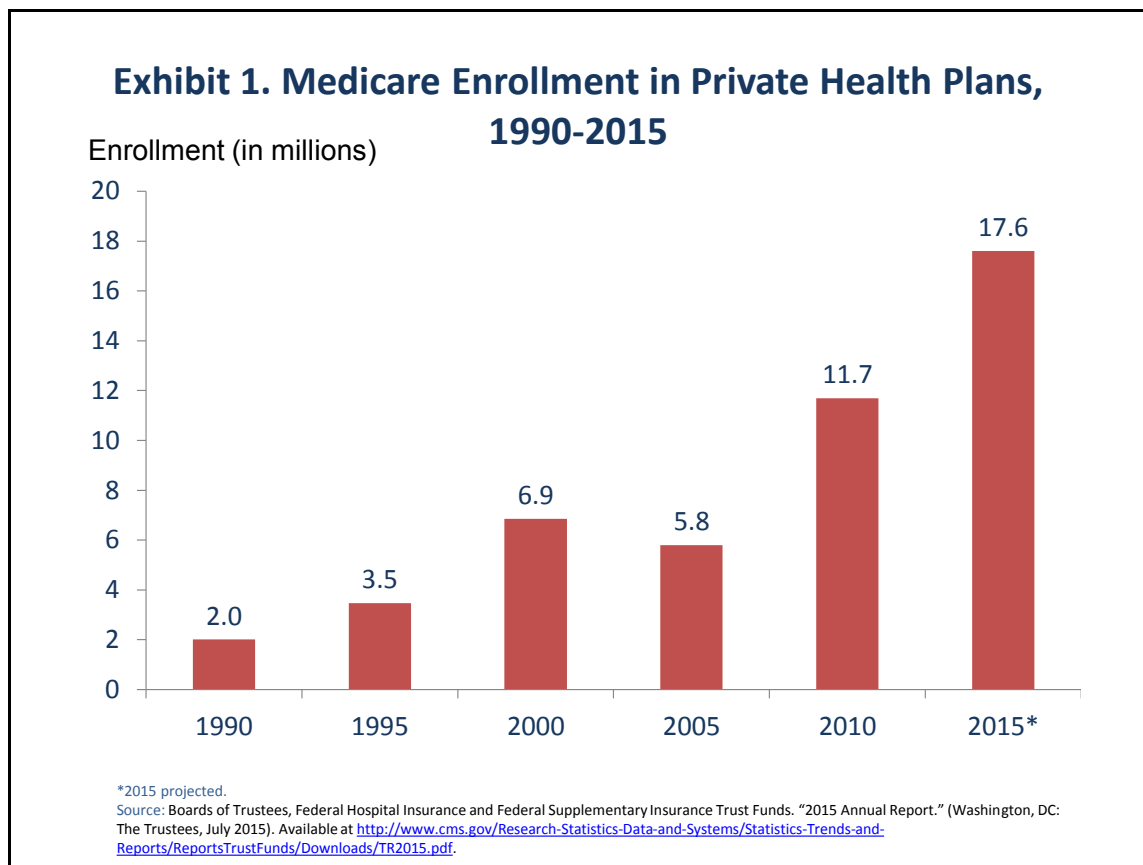
drug plans; premiums (heavily subsidized by Medicare) are paid directly to the plan, with additional subsidies available for beneficiaries with low incomes. In 2014, 37.8 million beneficiaries had prescription drug coverage through Medicare and another 2.7 million received retiree drug coverage under Part D.²

Expanded Choice. As an alternative to traditional Medicare, beneficiaries can obtain their Part A and Part B coverage (and Part D as well) through private health insurance plans. The Tax Equity and Fiscal Responsibility Act of 1982 created the Medicare Risk Program, making private health maintenance organizations (HMOs) and similar plans available to Medicare beneficiaries. Enrollment initially was small, but it grew rapidly in the mid-1980s as managed care became more popular in the private sector as well.

In 1997, the Balanced Budget Act created a new Medicare+Choice program to emphasize private plans as an option for beneficiaries. However, cuts in payment rates under traditional Medicare reduced private plan rates as well, causing many plans to leave the program. In addition, enrollment fell with the managed care backlash of the early 2000s.

The Medicare Modernization Act of 2003 created the current Medicare Advantage program, increasing plan payments and adding more types of plans. The sharply increased payment rates attracted more private plans, and the additional benefits that plans were able to offer because of the high payment rates attracted more beneficiaries. In 2015, an estimated 17.6 million beneficiaries—more than 30 percent of the Medicare

population—obtain their Medicare benefits through private Medicare Advantage plans (Exhibit 1).³



Payment Reform. When Medicare was enacted in 1965, it adopted payment methods modeled after prevailing private insurance practices at the time. Hospitals were reimbursed for their allowable costs, and physicians were paid based on local prevailing charges. There were no incentives for providers to control costs—the more providers spent, the more they were paid. Over the years, Medicare has implemented changes in how it pays providers, generally moving from cost-based reimbursement to prospective payment; but it still pays predominately on a fee-for-service basis—the more services that

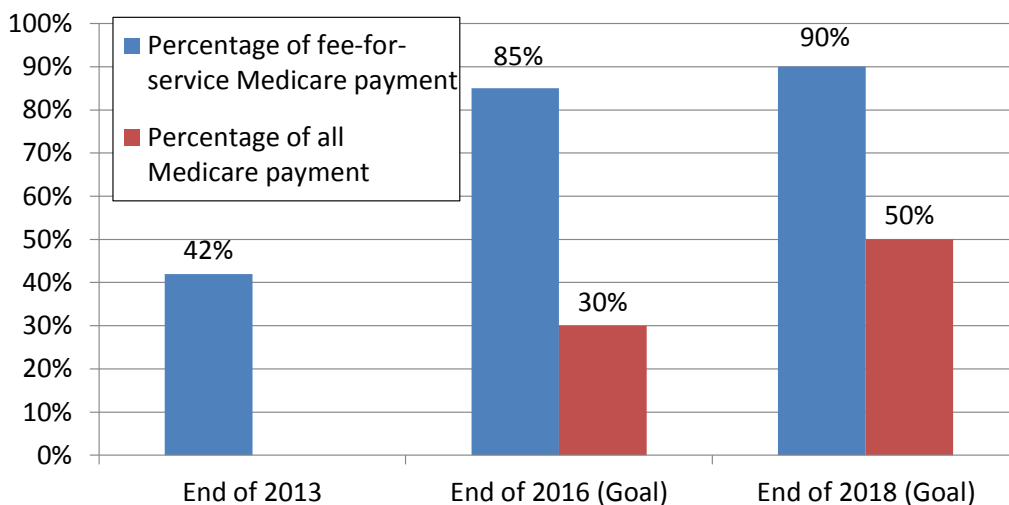
are provided and the more complex they are, the more the provider gets paid, regardless of how much those services contribute to the health of the patient.

More recently, Medicare has made significant improvements in the original payment methods modeled on the private insurance payment practices of the 1960s, and recent actions by Congress and the Department of Health and Human Services (HHS) have focused on accelerating that change.⁴ The Affordable Care Act of 2010 includes an array of provisions that are laying the foundation for fundamental Medicare payment reform, linking payment to patient outcomes and experiences of care, and giving providers an incentive to limit spending by rewarding reductions in the projected spending for their Medicare patients.⁵

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)—passed by this Congress—pushed Medicare payment reform further forward by repealing the sustainable growth rate formula (SGR), which was intended to counter the tendency of fee-for-service payment to reward volume and intensity rather than appropriateness, quality, and desirable outcomes, but was widely criticized because it produced large, across-the-board cuts in physician fees, hindered attempts to reform payments, and failed to control cost growth.⁶ MACRA put in place modest increases in physician fees, with strong rewards for high performance and incentives to participate in alternative payment models that reward value.

In addition, the Secretary of HHS has set a goal of linking 85 percent of traditional Medicare provider payment to quality or value by the end of 2016, and 90 percent by the end of 2018.⁷ A recent study indicates that, as of the end of 2013, 42 percent of provider payments in traditional Medicare are tied to the value of care. This represents significant progress, but much still remains to be done (Exhibit 2).⁸ Many initiatives that were not included in that study are in place now or will soon be implemented, supporting expectations that the percentage will increase considerably over the next few years—in fact, HHS recently announced that an estimated 30 percent of Medicare payments are tied to alternative payment models as of January 2016.⁹

Exhibit 2. Percentage of Medicare Payment Tied to Quality or Value, and Goals for the Future



Source: Catalyst for Payment Reform. "First-of-Its-Kind Scorecard on Medicare Payment Shows Widespread Payment Reform." Press release, May 5, 2015; available at http://www.catalyzepaymentreform.org/images/Press_Release_Scorecard_on_Medicare_Payment_Reform_final.pdf; Sylvia M. Burwell. "Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care." *The New England Journal of Medicine* March 5, 2015 372(10):897-99.

Also noteworthy is that Medicare Advantage plans are now financially rewarded for receiving a high rating based on their performance on measures of quality and patient experience.¹⁰ Although little is known about how Medicare Advantage plans actually pay their providers, the addition of rewards for plan performance to the existing incentive for efficiency in a per-enrollee per-month payment system can be expected to support the move from volume to value in Medicare.

Quality Improvement. Medicare has long had a mechanism in place to make sure that its funds were being used effectively and that its beneficiaries received care consistent with medical quality standards. The Social Security Amendments of 1972 created the Professional Standards Review Organization (PSRO) program to review the appropriateness of services reimbursed through Medicare—but the PSROs were viewed as primarily focused on utilization review rather than quality improvement.¹¹ Ten years later, the PSROs were replaced by Peer Review Organizations (PROs)—but the primary emphasis continued to be on utilization review.

In 1992, Medicare launched the Health Care Quality Improvement Program (HCQIP), shifting the focus of the PRO program to working with providers to improve health care.¹² In 2002, the HCQIP was expanded to include nursing homes and home health, and the PROs were renamed Quality Improvement Organizations (QIOs).

In the early 2000s, greater emphasis was put on the need to improve health care quality through measurement and payment.¹³ Medicare has implemented a series of initiatives aimed at providing information on quality measures to empower beneficiaries in choosing providers and enable providers to identify areas in which their performance could improve, including quality measures for hospitals, physicians, nursing homes, home health agencies, and dialysis facilities. Expanded use of health information technology was encouraged in 2004 by the issuance of an Executive Order by President George W. Bush, creating the Office of the National Coordinator for Health Information Technology; this effort was substantially enhanced by the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009.¹⁴

ONGOING CHALLENGES

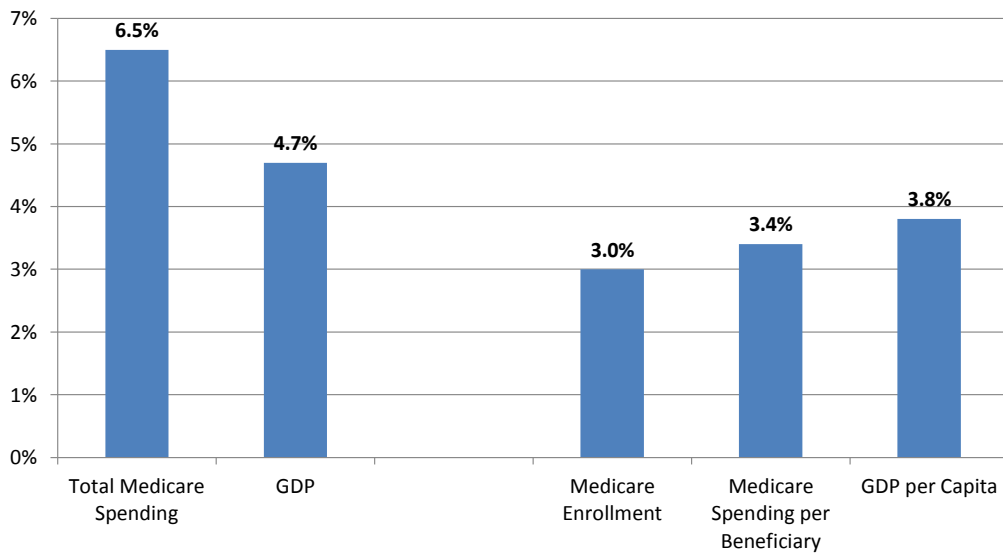
Despite its accomplishments, Medicare continues to face challenges, some of which are specific to Medicare and others—such as rising costs—that are faced by public programs and private payers alike. The future of the program and its ability to continue to provide access to high quality care to its beneficiaries will depend on how policymakers, health care providers, and beneficiaries themselves respond to these challenges—but success will require changes not only to Medicare, but across the health system.

Spending Growth. Medicare accounts for one-fifth of national health spending.¹⁵ Like the rest of the health system, it has over time been plagued by rapidly rising costs.

Medicare also is an important part of the federal budget, accounting for more than one-sixth of federal spending.¹⁶ In 2009, Medicare was spending an average of \$11,723 on 46.6 million beneficiaries, and the Medicare Hospital Insurance (HI) Trust Fund was projected to become insolvent by 2017.¹⁷ Spending per beneficiary has slowed dramatically in recent years, growing at only a 1.3 percent annual rate from 2009 to 2014, and the projected solvency of the HI Trust Fund has been extended to 2030.¹⁸

Still, Medicare faces a great challenge as the “boomer” generation born after World War II ages into coverage—by 2030, the number of beneficiaries is projected to rise more than 50 percent, from 53.8 million to 81.7 million, prompting concern about how to respond to the rising share of the federal budget and the nation’s resources that will be devoted to financing health care for the elderly and disabled. Although spending per beneficiary has been growing slowly in recent years, and is projected to grow slowly for the immediate future, the increasing number of beneficiaries will drive Medicare spending to grow faster than the economy as a whole (Exhibit 3).

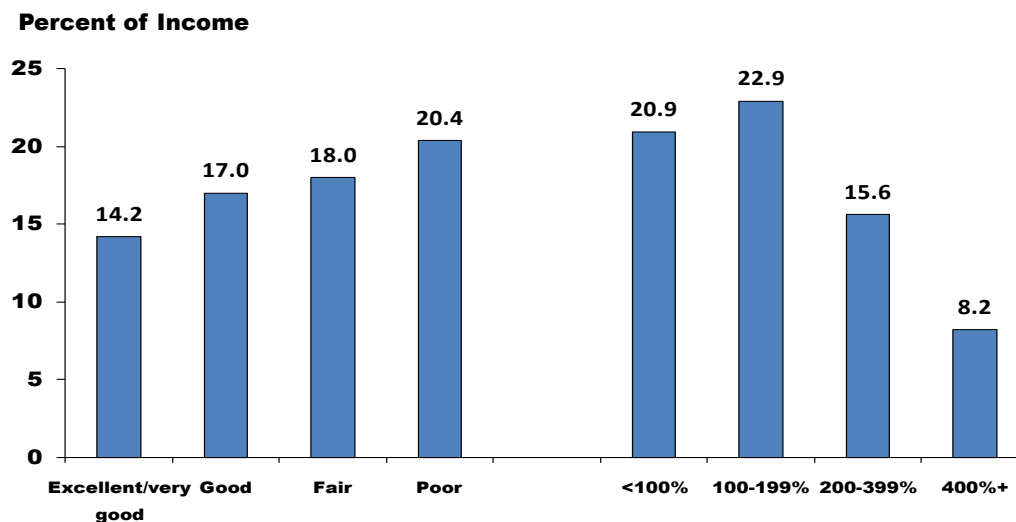
Exhibit 3. Projected Annual Growth Rates for Total Medicare Spending, GDP, Medicare Enrollment, Spending per Beneficiary, and GDP per Capita, 2013-2023



Source: Centers for Medicare & Medicaid Services, Office of the Actuary. National Health Expenditure Projections, 2013-2023.

Policymakers are confronted, therefore, with the question of how to continue to slow the growth of total Medicare spending when the spending per beneficiary already is increasing so slowly. Shifting more of the cost of meeting their health care needs onto beneficiaries themselves is problematic, however, since the aged and disabled include some of the poorest and sickest Americans, and they are least prepared to bear that additional burden (Exhibit 4).

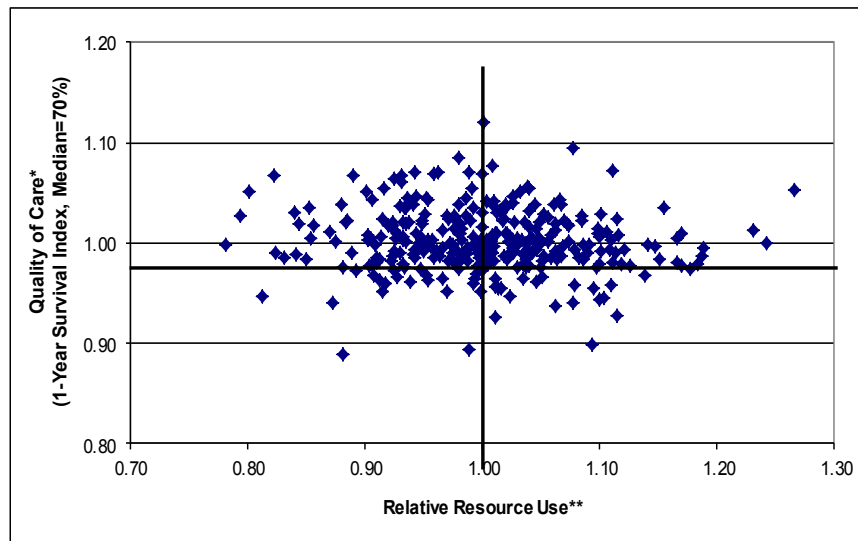
Exhibit 4. Median Out-of-Pocket Health Spending as a Percent of Income Among Medicare Beneficiaries, by Health Status and Income, 2006



SOURCE: T. Neuman, J. Cubanski, J. Huang, and A. Damico. "How Much Skin in the Game Is Enough? The Increasing Financial Burden of Health Spending for People on Medicare." Kaiser Family Foundation Data Spotlight, June 2011.

By now, the wide variation in both Medicare and private sector spending is well-documented.¹⁹ In Medicare, particularly, the lack of association between high spending and better quality and outcomes across the U.S. indicates that there should be ways to control spending while maintaining or even improving quality (Exhibit 5). Supporting comprehensive payment and delivery system changes that produce lower costs and better value, not just in Medicare, but across the entire health system, would go a long way to increasing value.

Exhibit 5. Quality and Costs of Care for Medicare Patients Hospitalized for Heart Attacks, Hip Fractures, or Colon Cancer, by Hospital Referral Regions, 2004



* Indexed to risk-adjusted 1-year survival rate (median=0.70).

** Risk-adjusted spending on hospital and physician services using standardized national prices.

Data: E. Fisher, J. Sutherland, and D. Radley, Dartmouth Medical School analysis of data from a 20% national sample of Medicare beneficiaries.

Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, (New York: The Commonwealth Fund, July 2008).

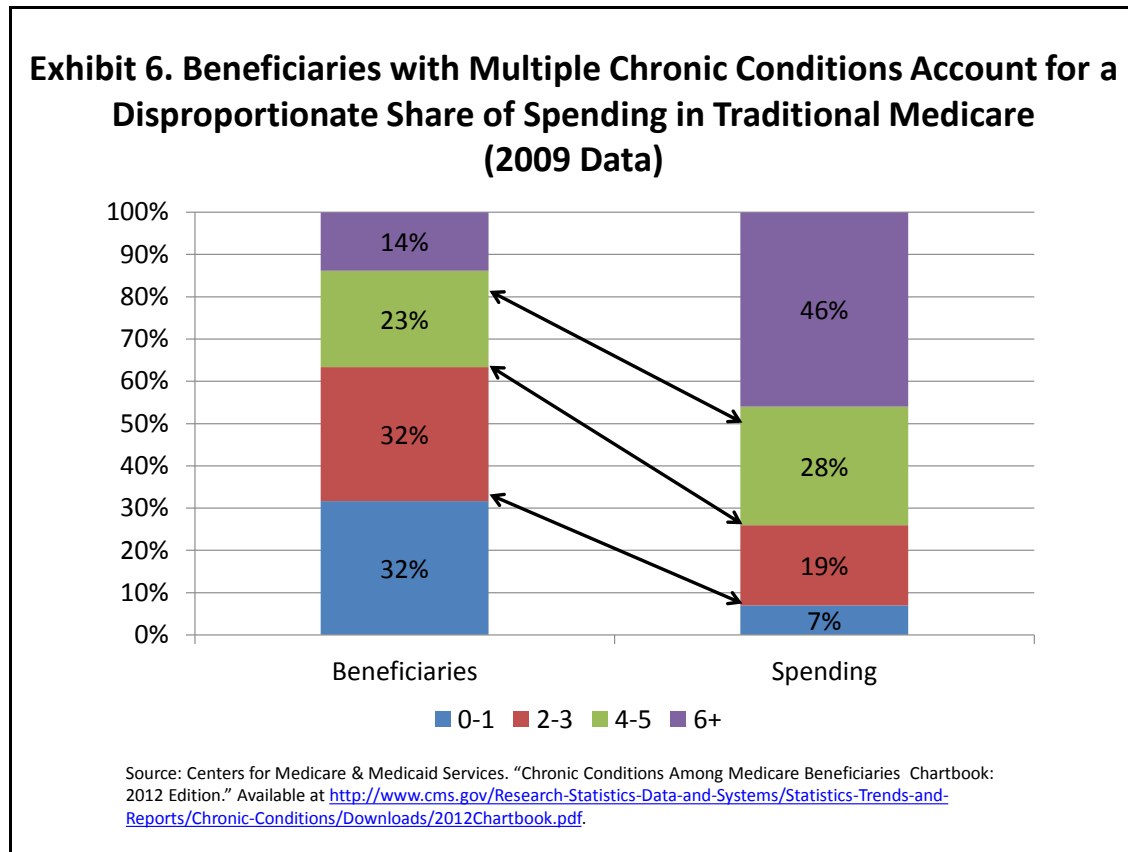
Benefit Design. Currently, Medicare beneficiaries who enroll in traditional Medicare must patch together multiple plans to receive adequate financial protection and prescription drug benefits. This creates complexity and confusion for beneficiaries and results in higher administrative expenses because of the multiple insurance carriers involved and the lack of integrated claims administration. The need to obtain coverage from multiple sources also makes it difficult for Medicare to incorporate value-based benefit designs that use patient cost-sharing to provide incentives to seek high-value care and compare alternative treatment choices. By offering separate medical and drug coverage, the current design creates a disincentive to achieve hospital and specialty care

savings through appropriate medication management. The availability of first-dollar supplemental coverage in the current Medigap market makes it difficult for Medicare to adopt incentives for beneficiaries to register and seek care from primary care practices and medical home teams or seek care from accountable health care systems with a track record of high quality and lower costs.

The combination of fragmented and first-dollar coverage thus raises total cost and confronts beneficiaries with complex choices at high administrative expense. And current benefits fail to protect beneficiaries from catastrophic out-of-pocket costs if they cannot afford private supplements. The only option available to beneficiaries who want integrated comprehensive coverage is to enroll in a private MA plan, with a more limited provider network. A more comprehensive Medicare benefit design that offered could simplify and strengthen beneficiary protection and complement the payment and system reforms that are needed to control costs and improve value.²⁰

Care for Beneficiaries With Complex Conditions. A related issue is that Medicare itself was created primarily to provide acute care—essentially short-term treatment for a specific illness, injury, or procedure, and to aid in recovery from that condition. In 1960, life expectancy at birth in the U.S. was 70; in 2010, it was 79.²¹ As both medical science and health care delivery have changed, so have the needs of Medicare beneficiaries. Now, 37 percent of Medicare beneficiaries have 4 or more chronic conditions—those beneficiaries account for 74 percent of total Medicare spending (Exhibit 6). Medicare

increasingly has focused on improving the coordination of care across providers and settings, and hopefully, proposals will be developed to address those issues and to serve the needs of these beneficiaries more effectively and more efficiently.²²



A notable gap in almost all proposed Medicare reforms is the absence of practical, affordable ideas for covering long term services and supports (LTSS) that are increasingly important for the aging Medicare population. While Medicaid pays for such care for impoverished beneficiaries, no comparable support is available for non-poor older and disabled Americans. Further, the fragmentation of acute care and LTSS makes it difficult to finance and deliver coordinated acute and LTSS. Solutions will likely

require new sources of revenue that are difficult to find from public sources, and private insurance has struggled to fill this gap.²³

Balancing the Roles of Traditional Medicare and Medicare Advantage. An ongoing issue is the appropriate balance between public traditional Medicare and private Medicare Advantage plans. A goal of the Medicare private plan program since its inception in 1982 has been to provide a more efficient model of care to beneficiaries than the unorganized fee-for-service-based payment system used by traditional Medicare. Expecting that private plans had the potential to be more flexible and efficient than FFS Medicare in meeting the needs of their enrollees, Medicare originally set payment rates for these plans at 95 percent of per beneficiary costs in traditional Medicare in each county, but the tendency for private plan enrollees to be less costly than other beneficiaries meant that plan payments were higher than the same enrollees would have been expected to cost in traditional Medicare.²⁴

The relationship between private plan payments and county-specific spending in traditional Medicare has been loosened somewhat, and payments to Medicare Advantage plans are now risk-adjusted to reflect the relative costliness of their enrollees. But Medicare Advantage plan payments overall still exceed traditional Medicare spending in much of the country, and that relationship varies not only by geographic area but also by type of plan. HMOs are the only type of MA plan with lower average costs per enrollee

nationwide than traditional Medicare, and there is wide variation in both efficiency and quality among individual plans.²⁵

A succession of policy changes over the past 30 years has resulted in substantial overpayment to Medicare Advantage plans relative to anticipated per beneficiary spending in traditional Medicare, and dilution and distortion of incentives to encourage the efficiency or effectiveness of which Medicare Advantage plans should be capable. The recent adjustments to payment policies has strengthened the relationship between plan payment and plan performance, and leveled the playing field between traditional Medicare and Medicare Advantage to some extent.²⁶ With more than 30 percent of Medicare beneficiaries enrolled in private plans—a growing number, but still a minority—it becomes increasingly important to determine the appropriate balance between traditional Medicare and Medicare Advantage, and to develop policies that bring out the best in both programs for the benefit of this and future generations of Medicare beneficiaries and to ensure the continued viability of the Medicare program.

CONCLUDING THOUGHTS

Medicare has been successful in achieving its basic mission—providing access to care and stable coverage to aged and disabled Americans. But, as the country's largest purchaser of health services, it can do more to improve quality, promote more coordinated care, and control costs—both its own and throughout the health system. Because of Medicare's unique position, it can be an important testing ground for cost and quality innovations. Policies have been put in place that encourage such development,

including expanding the power of the Secretary of Health and Human Services to put payment pilot programs on a "fast track" and to work with private payers and providers to establish multi-payer initiatives.

Medicare is a program that is extremely successful, popular, and important to its beneficiaries, but can be improved in several ways and, at the same time, fulfill its larger role as a key part of health care reform and a platform for improvements that can address the problems that it has in common with the rest of the health care system: the need for increased value for the dollars spent on care.

NOTES

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- ¹⁹ Institute of Medicine, Committee on Geographic variation in Health Care Spending and Promotion of High-Value Care. *Variation in Health Care Spending: Target Decision Making, Not Geography*. (Washington, DC: National Academies Press, 2013).
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