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MEDICARE

AT 50 YEARS



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Preface

In the same year we mark the Affordable Care Act's fifth anniversary, Medicare—the first major expansion of health insurance coverage in the United States—marks its 50th. And it is a milestone truly worth celebrating.

Medicare is more than just health insurance for older adults and people with long-term disabilities. An integral part of the nation's social fabric, it has helped to ensure health care access for the most vulnerable in society and protected them against crippling health care expenses; it has spurred broad changes in how health care is delivered and paid for nationwide; and it has at times been a force for racial and social equality.

It is also the case, however, that Medicare today faces serious challenges in fulfilling its mission for future beneficiaries.

In the six papers compiled in this volume, some of the nation's leading health policy thinkers discuss the past, present, and future of one of most significant pieces of legislation ever enacted in the United States. In the first two papers, readers will learn about Medicare's evolution and its major accomplishments (a few of which may surprise you) and what the Affordable Care Act does, and does not do, to address Medicare's major challenges. The next four papers are devoted to the big issues confronting Medicare and some potential policy solutions. The authors discuss the potential of value-based payment to improve care and achieve savings; options for modernizing Medicare's benefits and limiting costs for low-income beneficiaries; meeting the growing needs of seniors with complex health problems; and the potential dangers of basing major policy changes on long-term cost projections.

To be sure, this volume does not address every issue pertaining to Medicare's future. Still, we believe it offers insights and perspectives that can enrich readers' understanding of a program that is critical to the nation's health and well-being.



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MEDICARE: 50 Years of Ensuring Coverage and Care

Karen Davis, Cathy Schoen, and Farhan Bandeali

Before the Medicare program was enacted in 1965, 48 percent of Americans age 65 and older had no health insurance; today, just 2 percent lack coverage. Back then, older adults paid well 56 percent of their health care expenses directly out of pocket; today, that figure is down to 13 percent. In this first chapter, the authors discuss how Medicare has helped transform health care in the United States—and even stimulate broader social change. They describe the current state of the program, assess how beneficiaries are faring, and lay out some of the critical demographic, fiscal, and structural issues facing policymakers.

BACKGROUND

On July 30, 1965, President Lyndon Johnson signed into law the nation's first comprehensive government-sponsored program to provide health insurance for older Americans. Called Medicare, the program had been about 20 years in the making. After signing the Medicare bill into law, Johnson presented the first Medicare card to the former president who had first championed the idea: Harry S Truman, then 81 years old.

As Medicare prepares to mark its 50th anniversary, there is a lot to celebrate. In its first 50 years Medicare has unquestionably achieved its two basic goals: to ensure that Americans 65 and older have access to health care, and to protect them and their families from severe financial hardship from medical bills. In 1972, coverage was added for people with certain disabilities and those with end-stage renal disease. Along the way, Medicare also has helped to change medical technology and the health care delivery system. It has helped accelerate progress by indirectly financing medical education and teaching hospitals, and has ensured access for its beneficiaries to the latest medical advances.

MEDICARE: MEETING IMPORTANT NATIONAL GOALS

For five decades, Medicare has met a growing number of important goals for the nation. Today, it serves 55 million Americans in a number of important ways.

Providing Health Insurance Coverage

When Medicare was established, 48 percent of Americans 65 and older were uninsured.¹ Many people lost their health insurance when they retired, and private insurance companies, concerned about adverse risk, were reluctant to write comprehensive policies for older adults. Policies that were available often limited coverage, exempted pre-existing conditions, and offered inadequate protection (Exhibit 1).²

After Medicare was enacted, the number of uninsured Americans plummeted from 71 million in 1953 to 23 million in 1976. Today only 2 percent of adults 65 and older are uninsured.³

Exhibit 1. Medicare Coverage and Care, Then and Now

	1970	2012
Beneficiaries (millions)	20	55.7 (2015)
Percent disabled under age 65	7.4% (1973)	17%
Beneficiaries as share of U.S. population	9.8%	16%
Uninsured age 65 and older	48% (1963)	2%
Life expectancy at age 65		
Men	77.8 (1960)	82.7 (2010)
Women	80.8 (1960)	85.3 (2010)

Sources: Centers for Disease Control and Prevention, www.cdc.gov/nchs/data/hus/hus13.pdf; U.S. Social Security Administration, www.ssa.gov/history/lifeexpect.html; National Center for Health Statistics National Nursing Home Survey, 2004; and K. Davis and C. Schoen, *Health and the War on Poverty: A Ten-Year Appraisal* (Washington D.C.: Brookings Institution, 1978).

Reducing Financial Risk

Prior to Medicare, older people and their adult children faced a high risk of financial burden because of medical bills. In 1966, older Americans paid 56 percent of their medical expenses directly out-of-pocket.⁴ Medicare was designed to eliminate this financial pressure and ensure access to needed care.^{5,6} Today, older Americans pay just 13 percent of their health care expenses directly.⁷

Improving Access

The enactment of Medicare had an immediate and dramatic impact on access to health care services for beneficiaries.⁸ Reduced financial barriers resulted in increased demand and use of services. From 1963 to 1970, the hospital admission rate for older Americans increased from 18 percent to 21 percent. Additionally, the proportion of elderly Americans seeing a physician rose from 68 percent to 76 percent.⁹

Reducing Disparities

In its early years, Medicare was a major force for the racial desegregation of health care facilities, dramatically reducing disparities in access to care by making vigorous enforcement of the Civil Rights Act a condition of hospital participation in the program. Hospitals integrated their medical staffs, waiting rooms, and hospital floors in a period of less than four months.¹⁰ Between 1961 and 1968, hospitalization rates for whites age 65 and older rose 38 percent, while rates for blacks 65 and older jumped 61 percent.¹¹ As a result, disparities in access to hospital services for people of all ages narrowed, with the difference in hospitalization rates between whites and blacks falling from 30 percent in 1961 to 17 percent by 1968.¹²

SUPPORTING ADVANCES IN CARE AND DELIVERY

Medicare has given beneficiaries access to the latest advances in medical research and has helped finance medical progress through its indirect support of graduate medical education and payments to teaching hospitals.¹³ Gains in life expectancy at age 65 accelerated after enactment, increasing by 15 percent between 1965 and 1984, compared with 5 percent between 1950 and 1965.¹⁴ Life expectancy of Medicare beneficiaries is now five years longer than it was when Medicare started. Annual death rates of those age 85 and older dropped by 18 percent between 1960 and 1970, compared with just 2 percent between 1950 and 1960.¹⁵ While these gains undoubtedly owe much to advances in clinical care and medical research, Medicare ensured access to high-quality care for its beneficiaries.¹⁶ Medicare has been both a leader and an innovator, helping to set quality standards and supporting both medical advances and innovation in health services delivery.¹⁷

Providing Peace of Mind

Among voters of all ages, Medicare is one of the most widely supported government programs. Medicare beneficiaries are more satisfied with their Medicare coverage than adults under age 65 are with private health insurance.¹⁸

MEDICARE'S ENROLLMENT AND BENEFITS HAVE CONTINUOUSLY EXPANDED

When Medicare was launched, it covered 20 million people. In 2015, Medicare covers 55 million people, or 17 percent of the U.S. population.¹⁹ Eighty percent of beneficiaries are age 65 or older (and eligible for Social Security); the remaining 20 percent comprise individuals with serious disability (and covered by Social Security Disability Insurance) or end-stage renal disease.²⁰

Expanding Medicare's benefits over the years has been a challenge. In 1988, prescription drug coverage was added through the Medicare Catastrophic Coverage Act (MCCA), as well as limits on beneficiaries' out-of-pocket expenses. The higher premiums necessitated by these reforms, however, were unpopular, and in 1989 Congress repealed its actions. Nevertheless, the will to increase benefits persisted, and in 2003 a

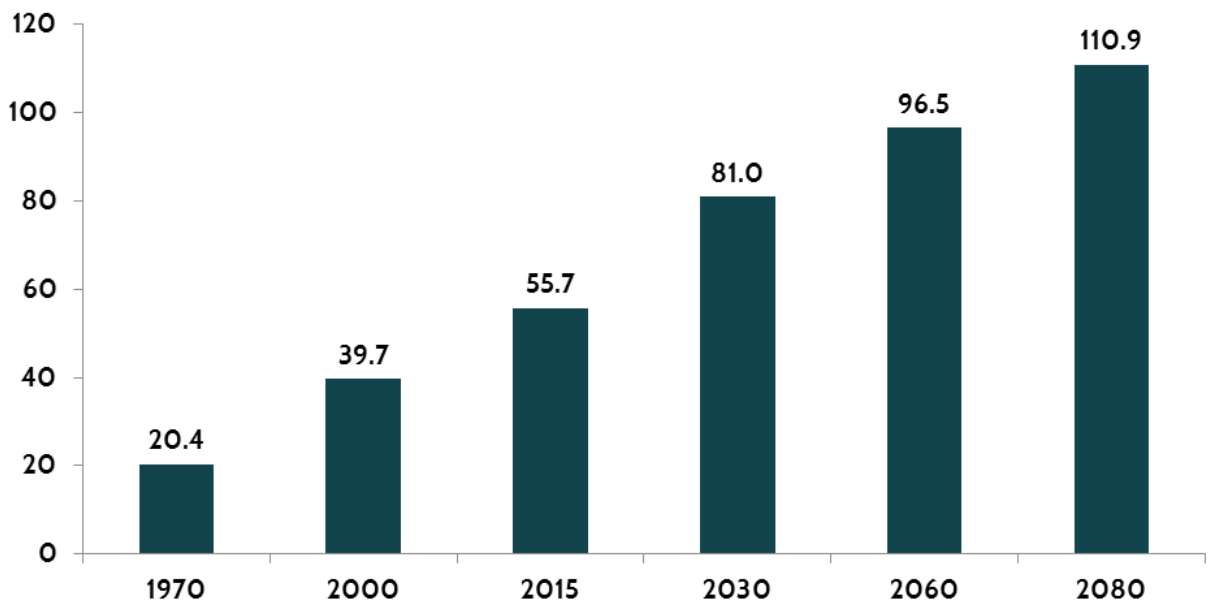
voluntary prescription drug benefit was introduced as part of the Medicare Modernization Act. In 2013, Medicare Part D drug coverage provided benefits to 39.1 million beneficiaries.²¹

In 1997, Medicare Part C—now called Medicare Advantage—was created to give beneficiaries the option of choosing an HMO-style Medicare plan instead of traditional Medicare. Currently, about 30 percent of beneficiaries have opted for this program.

Medicare enrollment is expected to grow rapidly as members of the baby boom generation, born after World War II, become eligible. An estimated 81 million people will be enrolled by 2030, after which enrollment is projected to increase more slowly, reaching 111 million by 2080 (Exhibit 2).

Exhibit 2. Medicare Enrollment, 1970–2080

Enrollment in millions



Source: Centers for Medicare and Medicaid Services, *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: CMS, 2013).

DEMOGRAPHICS OF THE MEDICARE POPULATION

Medicare covers the oldest and most disabled portion of the population. Today, 30 percent of beneficiaries are age 85 and older or disabled under age 65 (Exhibit 3). The majority of enrollees are women (55%). About one-fourth (23%) have less than a high school education, and less than half (47%) have some college or more. About half (49%) live with a spouse; 29 percent live alone; 5 percent live in institutions (primarily nursing homes); and 18 percent report other housing arrangements (such as living with a family member).

Incomes of Medicare beneficiaries are lower than those of working families. Social Security provides a base income that keeps most elderly out of poverty. Poverty rates for Medicare beneficiaries (14%) are lower than for children (22%). Forty-two percent of Medicare’s beneficiaries 65 and older have incomes at 200 percent of the poverty level or below. Only one-fourth (27%) have incomes over four times the poverty level.

Modest incomes combined with a greater need for medical care put beneficiaries at financial risk of burdensome medical bills. Even with Medicare, some beneficiaries are faced with substantial out-of-pocket costs.²²

Exhibit 3. Characteristics of Medicare Beneficiaries, 2010

Characteristic	Percent of the Medicare Population	Characteristic	Percent of the Medicare Population
Total population = 48.4 million	100%	Living arrangement	
Sex		Institution	5
Male	45	Alone	29
Female	55	Spouse	49
Race/ethnicity		Other	18
White, non-Hispanic	77	Education	
African American, non-Hispanic	10	No high school diploma	23
Hispanic	9	High school diploma only	29
Other	5	Some college or more	47
Age		Income status	
<65	16	Below poverty	14
65–74	44	100%–125% of poverty	9
75–84	27	125%–200% of poverty	19
85+	13	200%–400% of poverty	31
Health status		Over 400% of poverty	27
Excellent or very good	43	Supplemental insurance status	
Good or fair	48	Medicare only	10
Poor	8	Managed care	24
Residence		Employer-sponsored insurance	29
Urban	77	Medigap	18
Rural	23	Medigap with employer-sponsored insurance	4
		Medicaid	14
		Other	1

Sources: Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program* (Washington, D.C.: MedPAC, June 2014).

MEDICARE FINANCING: SHARING THE LOAD WITH BENEFICIARIES

At the heart of Medicare's design, and known as traditional Medicare, are Part A, Hospital Insurance, and Part B, Supplementary Medical Insurance. Part A includes coverage for hospital care, skilled nursing facility services, other institutional care, some home health care, and hospice care. It is financed primarily by a payroll tax of 1.45 percent each on employers and workers. Part B covers services from physicians and other professionals, ambulatory surgical centers, outpatient dialysis, home health, and other ambulatory services. It is financed approximately three-fourths from general tax revenue and one-fourth by beneficiary premiums. Higher-income beneficiaries now pay higher Part B premiums.

Part C, Medicare Advantage, enables beneficiaries to choose an integrated benefit package under private plans that contract with Medicare to deliver Part A and Part B health services. Enrollment in private plans has grown rapidly since 2003, when the Medicare Modernization Act, which covered prescription drugs, also liberalized payment to private Medicare managed care plans, allowing them to provide preventive health services and other added benefits at little or no extra cost to the patient (Exhibit 4).

Exhibit 4. Percent of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, 1999–2014



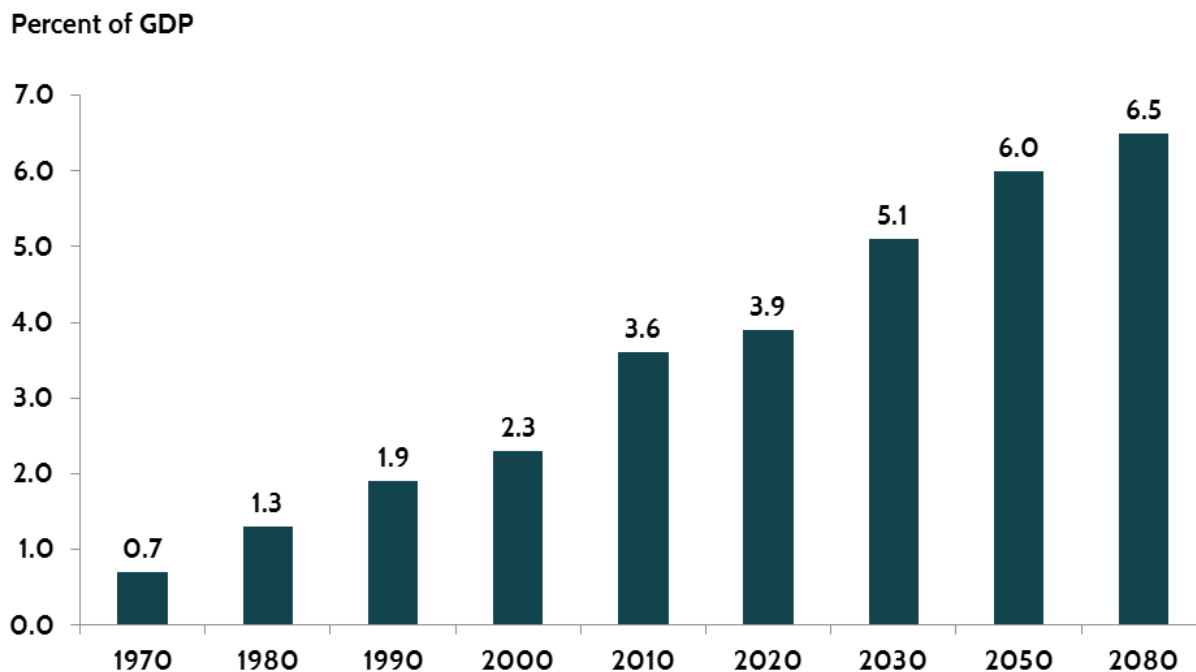
Source: Analysis of Medicare Advantage enrollment files by the Henry J. Kaiser Family Foundation.

Part D covers prescription drugs under private drug plans. It is financed approximately three-fourths from general tax revenues, with the remainder split between beneficiary premiums and state government contributions. Higher-income beneficiaries pay an additional premium. About 63 percent of Medicare beneficiaries have a private drug plan either as standalone coverage or in connection with Medicare Advantage plans. About 15 percent have retiree drug coverage. Eleven percent of Medicare beneficiaries had other sources of coverage (such as Medicaid, military, or veterans drug coverage). Twelve percent, or 6 million, continue to have no prescription drug coverage or coverage that is not on par with the Part D standard benefit.²³

Medicare Covers Two-Thirds of Beneficiaries' Costs

Spending per Medicare beneficiary increased 500 percent cumulatively between 1970 and 2013, from \$385 to \$12,210, or 0.7 to 3.5 percent of GDP.²⁴ Total Medicare spending in 2013 was \$583 billion, making Medicare one of the largest purchasers of health care in the U.S., accounting for nearly one-fourth (23%) of total personal health care expenditures. Current projections predict that Medicare spending will make up 5.1 percent of GDP by 2030 (Exhibit 5).

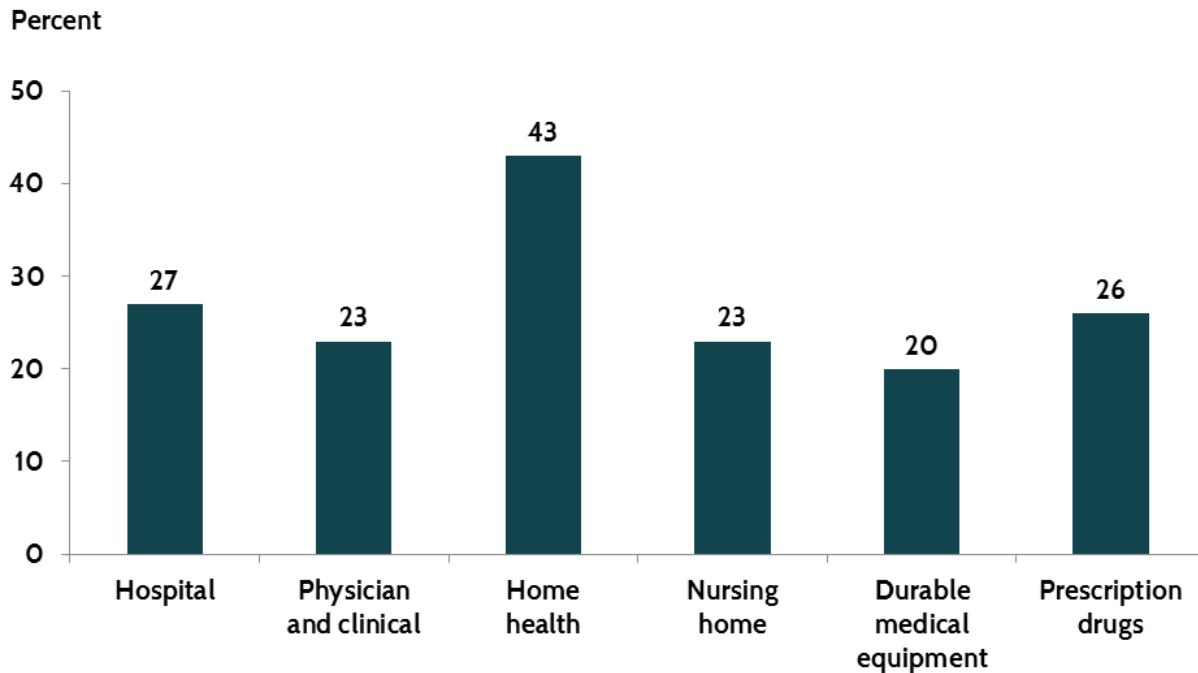
Exhibit 5. Medicare Spending as Percentage of U.S. Gross Domestic Product, 1970–2080



Source: Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program*, Data Book (Washington, D.C.: MedPAC, 2014).

Medicare accounts for 23 percent of spending on physician and clinical services; 23 percent of spending on nursing home care; 27 percent of hospital spending; 43 percent of home health spending; and 26 percent of spending on prescription drugs (Exhibit 6).

Exhibit 6. Medicare's Share of Spending by Type of Service, 2012



Source: Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program*, Data Book (Washington, D.C.: MedPAC, 2014).

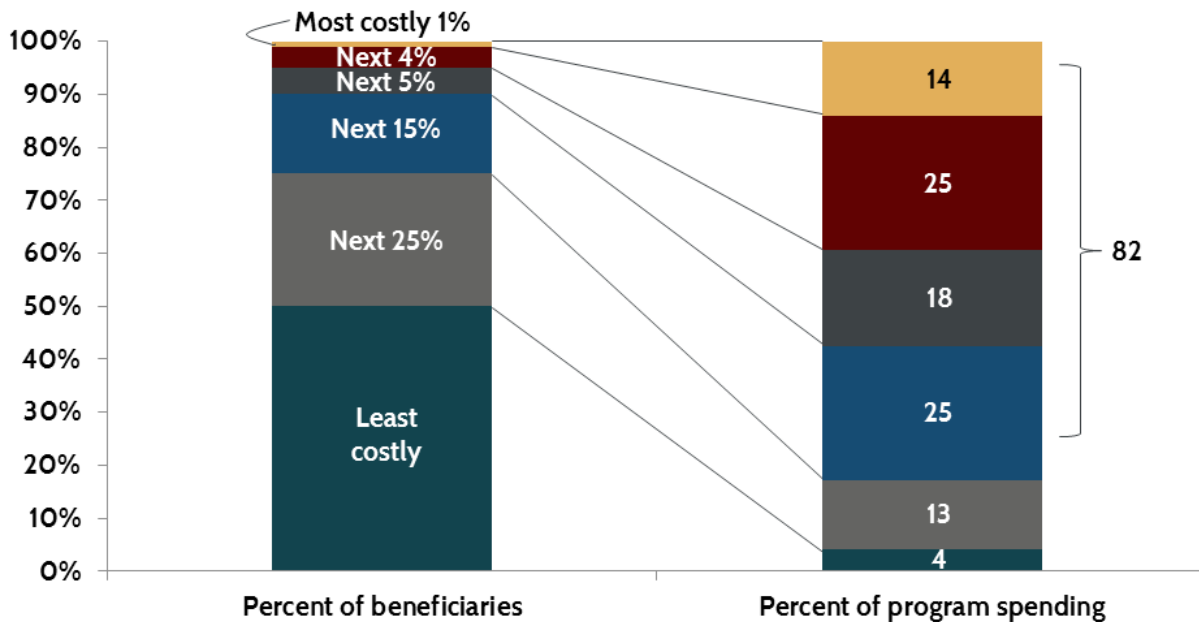
Older beneficiaries cost more because of their greater need for health services to address a higher number of chronic conditions. There is a twofold difference in spending between those ages 65 to 84 and those 85 and older. Per capita spending on women is nearly 25 percent higher than on men in 2010. However, spending levels between women and men ages 65 to 84 are virtually identical; the difference emerges primarily in adults age 85 and older.

In the aggregate, Medicare pays two-thirds of the health care costs of its beneficiaries. Patients pay 13 percent directly out-of-pocket, while private supplemental coverage, including employer-sponsored retiree plans and private MediGap plans, pay 15 percent. Medicaid and other public sources of coverage reimburse the remaining 5 percent of costs.²⁵

Not surprisingly, Medicare outlays are concentrated on those beneficiaries who are the sickest and have the most complex care needs. Five percent of beneficiaries account for 25 percent of Medicare spending, and

the quarter of beneficiaries with the highest costs account for 82 percent of all Medicare outlays (Exhibit 7). By contrast, the half of beneficiaries with the lowest expenditures account for only 4 percent of outlays.

Exhibit 7. Spending in Traditional Medicare Is Highly Concentrated in Small Group of Beneficiaries, 2010

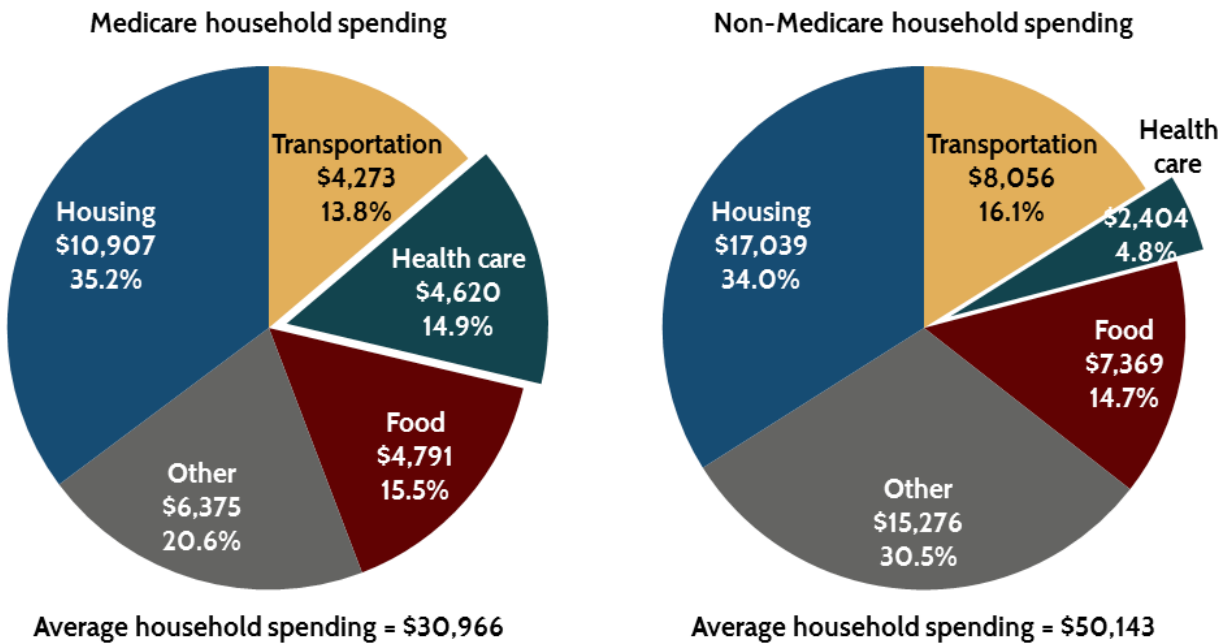


Note: All data are fee-for-service and for calendar year 2010. Analysis excludes beneficiaries with any group health enrollment during the year. "Percent of program spending" total may not sum to 100 percent because of rounding.
 Source: Medicare Payment Advisory Commission, analysis of 2010 Medicare Current Beneficiary Survey Cost and Use files (Washington, D.C.: MedPAC).

Beneficiaries Pay Out-of-Pocket for Deductibles, Supplemental Coverage

Even with Medicare, the cost to beneficiaries of premiums and cost-sharing can be quite significant, especially for those with extensive health care needs. Part A includes a deductible based on the average cost of one day of hospital care (\$1,260 in 2015) for a given benefit period. There is no further cost-sharing for the first 60 days. For hospital days 61 through 90 in a single benefit period, a coinsurance payment of \$315 per day is required; for days 91 and beyond, this rises to \$630 per each "lifetime reserve" day (up to 60 days over the beneficiary's lifetime). The Part B premium is typically \$104.90 in 2015, with a \$147 deductible. Part C and Part D plan premiums and cost-sharing vary by plan. These out-of-pocket costs, in addition to the cost of noncovered services, leave beneficiaries paying an average of 15 percent of income on health care, compared with 5 percent for those under age 65 (Exhibit 8).

Exhibit 8. Many Medicare Beneficiaries Do Not Have Sufficient Savings to Cover Health and Long-Term Care Expenditures as They Age, 2009

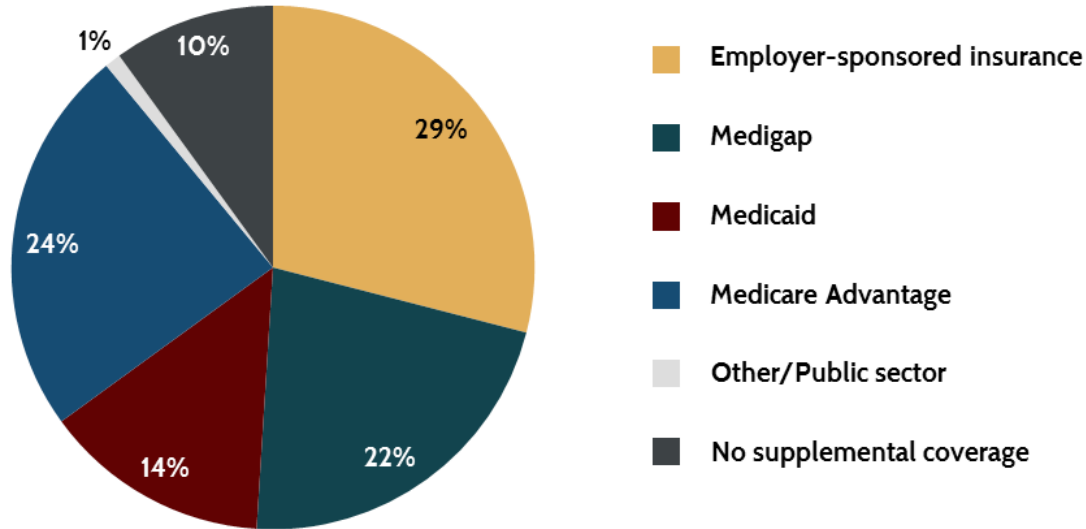


Source: J. Cubanski, C. Swoope, A. Damico et al., "Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households," analysis of the Bureau of Labor Statistics Consumer Expenditure Survey Interview and Expense Files, 2009 (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, June 2011).

Higher-income beneficiaries—those reporting more than \$85,000 on an individual tax return, or \$170,000 on a joint return—pay higher premiums under Part B and Part D. The amount of the premium corresponds with their income level. For example, an individual with income above \$214,000, the top tier, would pay a Part B premium of \$335.70 per month and an extra Part D premium of \$70.80 a month, over and above the Part D premium charged by their private drug plan.²⁶

The high out-of-pocket costs lead many beneficiaries to obtain supplemental coverage (Exhibit 9). In 2010, almost 30 percent of beneficiaries had employer-sponsored insurance, typically retiree health coverage from former employers; 24 percent had a private Medicare Advantage managed care plan; and 22 percent had a private Medicare supplemental insurance policy known as Medigap. Fourteen percent were covered by Medicaid; approximately 10 percent of Medicare beneficiaries had no supplemental coverage.

Exhibit 9. Sources of Supplemental Coverage Among Noninstitutionalized Medicare Beneficiaries



Source: Medicare Payment Advisory Commission, analysis of 2010 Medicare Current Beneficiary Survey Cost and Use files (Washington, D.C.: MedPAC).

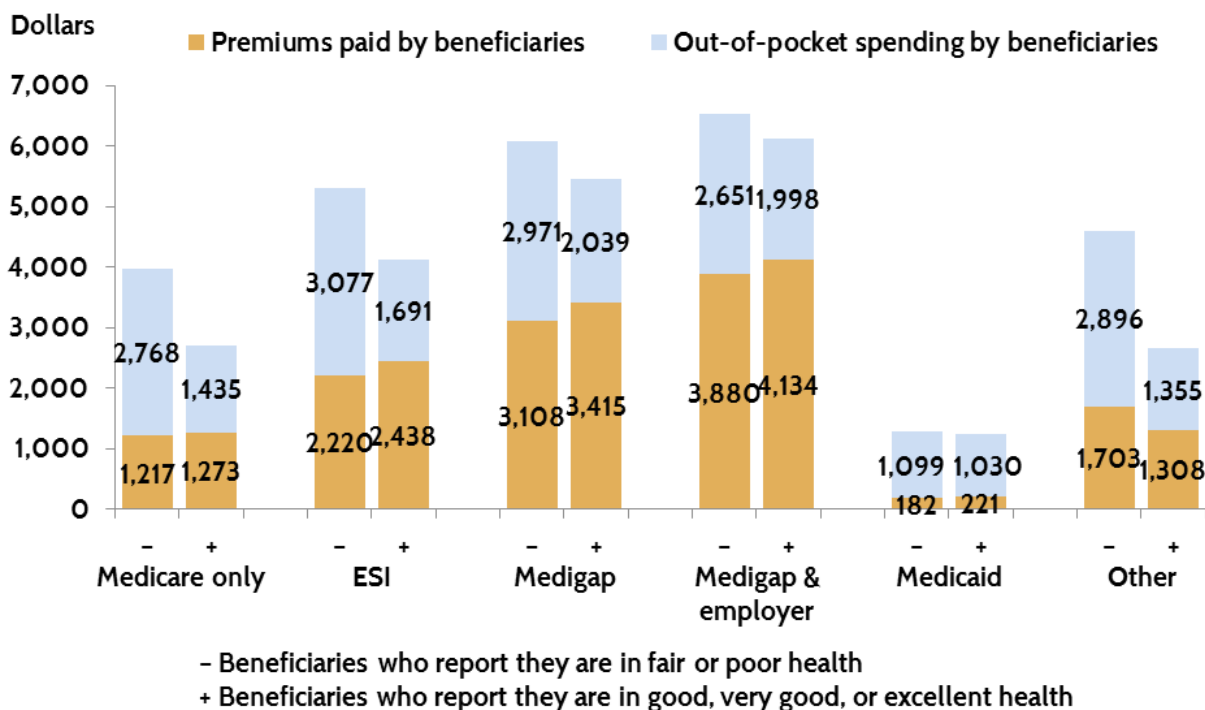
The extent and type of supplemental coverage varies by beneficiary income and health status. Medicaid is an important form of supplemental coverage for low-income Medicare beneficiaries, helping to pay for premiums and cost-sharing, as well as covering services not covered by Medicare, such as long-term nursing home care. For those with incomes under \$10,000, 57 percent receive supplemental coverage through Medicaid.

Nearly half of Medicare enrollees with incomes above \$80,000 receive coverage from employer-sponsored insurance; another quarter purchase Medigap coverage; and a fifth purchase Medicare Advantage private plan coverage. For those with modest incomes between \$10,000 and \$20,000, 15 percent have no supplemental coverage, while 21 percent are covered by Medicaid, and only 17 percent have employer-sponsored coverage.

Similarly, those who report their health as excellent or very good are more likely than those in poor health to have employer-sponsored coverage (34% vs. 18%), more likely to purchase Medigap coverage (24% vs. 16%), and more likely to be covered under private Medicare Advantage plans (25% vs. 18%). Those in poor health are more likely to have Medicaid (31%) than those in better health (7%), and also more likely to be without any form of supplemental insurance (15% vs. 10%).

Total out-of-pocket costs also vary by health status, with those self-reporting as being in fair or poor health paying almost 50 percent higher out-of-pocket payments than those reporting to be in better health (Exhibit 10). High out-of-pocket costs place a particular burden on Medicare beneficiaries whose income levels are less than 200 percent of the poverty level.

Exhibit 10. Out-of-Pocket Spending for Premiums and Health Services per Medicare Beneficiary, by Insurance and Health Status, 2010



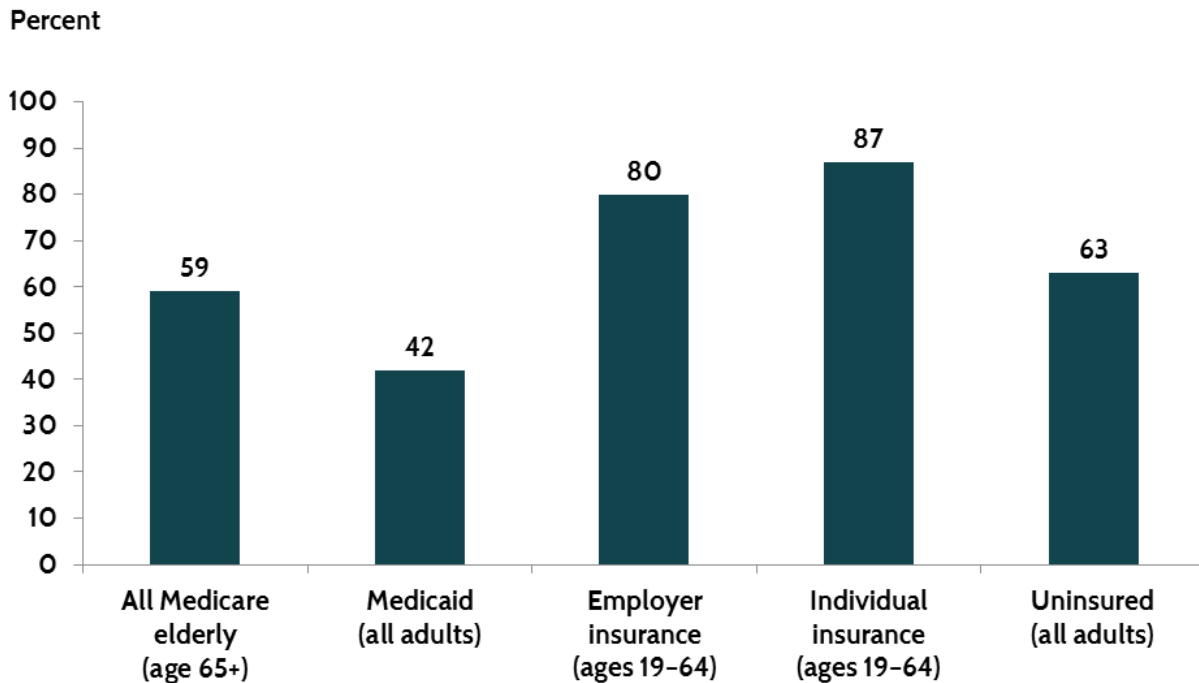
Note: ESI = employer-sponsored supplemental insurance.

Source: Medicare Payment Advisory Commission, analysis of 2010 Medicare Current Beneficiary Survey Cost and Use files (Washington, D.C.: MedPAC).

Financial Burdens Are Lightest for Medicare Beneficiaries

In 2012, about 60 percent of Medicare beneficiaries reported total family out-of-pocket costs and premiums in excess of \$1,000, compared with 80 percent or more for adults with employer-based insurance (Exhibit 11). This finding is especially striking given the lower income and poorer health reported by Medicare beneficiaries. Similar rates of out-of-pocket costs were reported by traditional Medicare and Medicare Advantage beneficiaries. Thirty-one percent of all Medicare elderly, 38 percent with employer insurance, and 49 percent with individually purchased insurance reported costs to be 10 percent or more of income.

Exhibit 11. Total Out-of-Pocket Costs of \$1,000 or More, 2012



Source: The Commonwealth Fund Biennial Health Insurance Survey (2012).

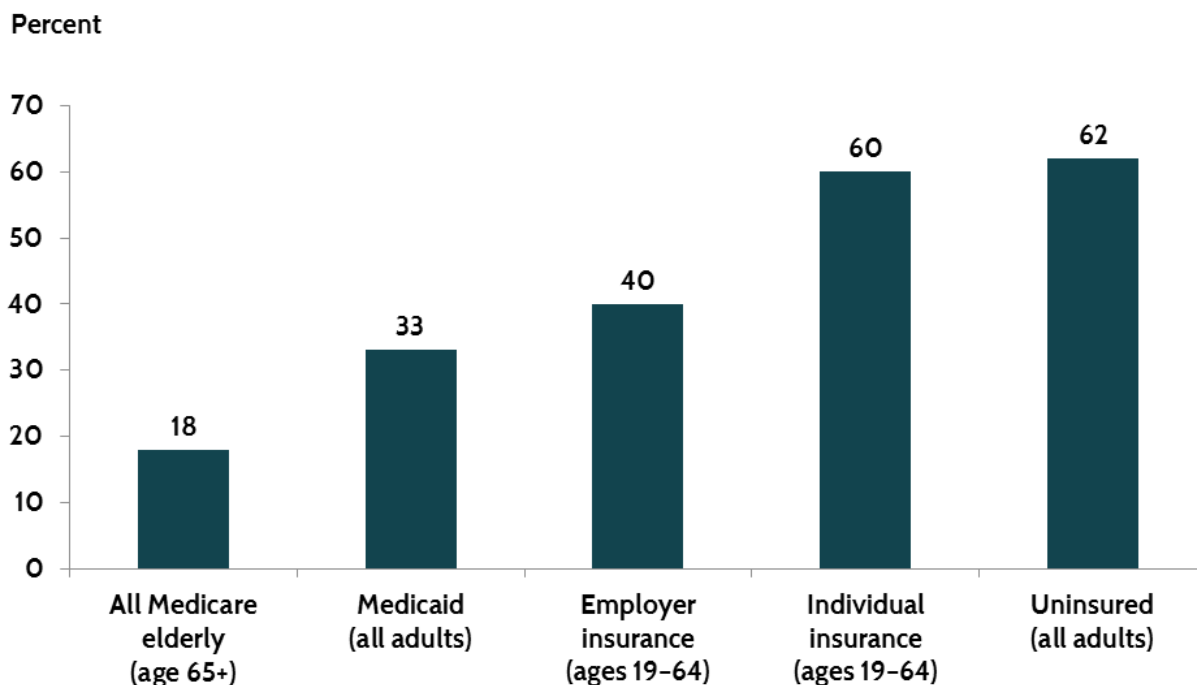
While Medicare requires substantial cost-sharing, elderly Medicare beneficiaries report fewer problems paying bills than those under age 65. The Commonwealth Fund's 2012 Biennial Health Insurance Survey found that only 14 percent of elderly Medicare beneficiaries reported problems paying medical bills, compared with 33 percent of individuals with employer-based insurance, 45 percent with individual coverage, and 50 percent of the uninsured. Among those with employer-based insurance, the share reporting financial problems caused by medical bills was double that for Medicare patients (34% and 16%, respectively).

ENSURING ACCESS AND PROMOTING QUALITY

Providing Access to Care

Medicare beneficiaries report having fewer cost-related barriers to care than people with other sources of coverage. Adjusted for race, poverty status, health status, and number of chronic conditions, findings from the Biennial Health Insurance Survey indicate only 18 percent of elderly Medicare beneficiaries had cost-related access problems, compared with 40 percent of adults with employer-sponsored insurance and 62 percent of the uninsured (Exhibit 12). Nonetheless, international comparisons show that adults 65 and older in the U.S. are much more likely to face problems with access to care than their counterparts in other countries.

Exhibit 12. Any Access Problem Because of Cost, 2012

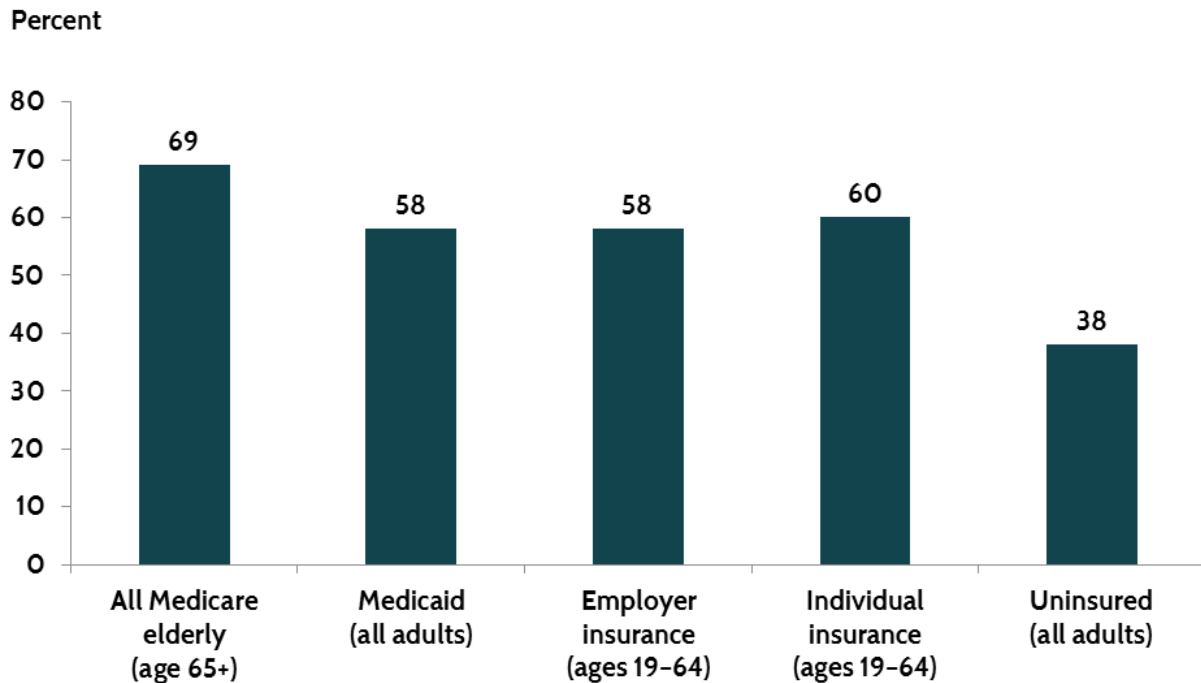


Source: The Commonwealth Fund Biennial Health Insurance Survey (2012).

Promoting the Medical Home Model, Preventive Care, Quality of Care

Medicare beneficiaries 65 and older report care experiences that are similar to or better than that of individuals under age 65. Nearly 70 percent of elderly Medicare beneficiaries report having a regular doctor or place of care that is accessible, knows them and coordinates their care (a medical home), compared to 58 percent of individuals with employer-based insurance (Exhibit 13). The uninsured were the least likely to have access to a medical home, with only 38 percent reporting such care experience. Concerning the ease of getting after-hours care without going to the emergency department, no significant differences were found between those with employer-based insurance and Medicare. Those most likely to report difficulty getting care had Medicaid or no insurance.

Exhibit 13. U.S. Adults Who Have a Medical Home, 2012



Source: The Commonwealth Fund Biennial Health Insurance Survey (2012).

More Medicare beneficiaries 65 and older with chronic conditions (65%) reported receiving all recommended preventive care services than those with employer-based insurance (43%), or those with no insurance (18%). Traditional Medicare and Medicare Advantage enrollees reported similar rates for all preventive care services.

Thirty-five percent of elderly Medicare beneficiaries rated their quality of care to be excellent or very good compared with 21 percent of people with employer-based insurance and 28 percent of adults with individual insurance. Medicaid patients were significantly more likely to rate their care excellent or very good than those in employer groups; the uninsured were less likely to report better care.

Traditional Medicare vs. Medicare Advantage

One of the key issues Medicare has faced throughout its history is whether market-based private insurance would yield greater value for the money spent. The pressure for privatization of Medicare has led to a gradual expansion of private Medicare Advantage plans offered through the program, and further steps toward private provision of insurance for Medicare beneficiaries promises to be a central question in future Medicare reforms.

Proponents of Medicare as social insurance make a number of points. Medicare, they note, covers the oldest, sickest, and most disabled individuals, as well as some of the poorest, while private insurers tend to

prefer those who are relatively younger, healthier, and financially more secure. Because of the highly skewed nature of health expenditures, with a few individuals accounting for a disproportionately large share of spending, natural market forces cause private insurers to avoid those at highest risk. And, in fact, research has shown that Medicare Advantage plan enrollees tend to be healthier.²⁷ The healthier enrollment of private plans can be explained in part by the imperfect risk adjustment mechanism used by the Centers for Medicare and Medicaid Services to set payment for Medicare Advantage plans—that is, plans continue to find that it pays for them to seek out the best risks.

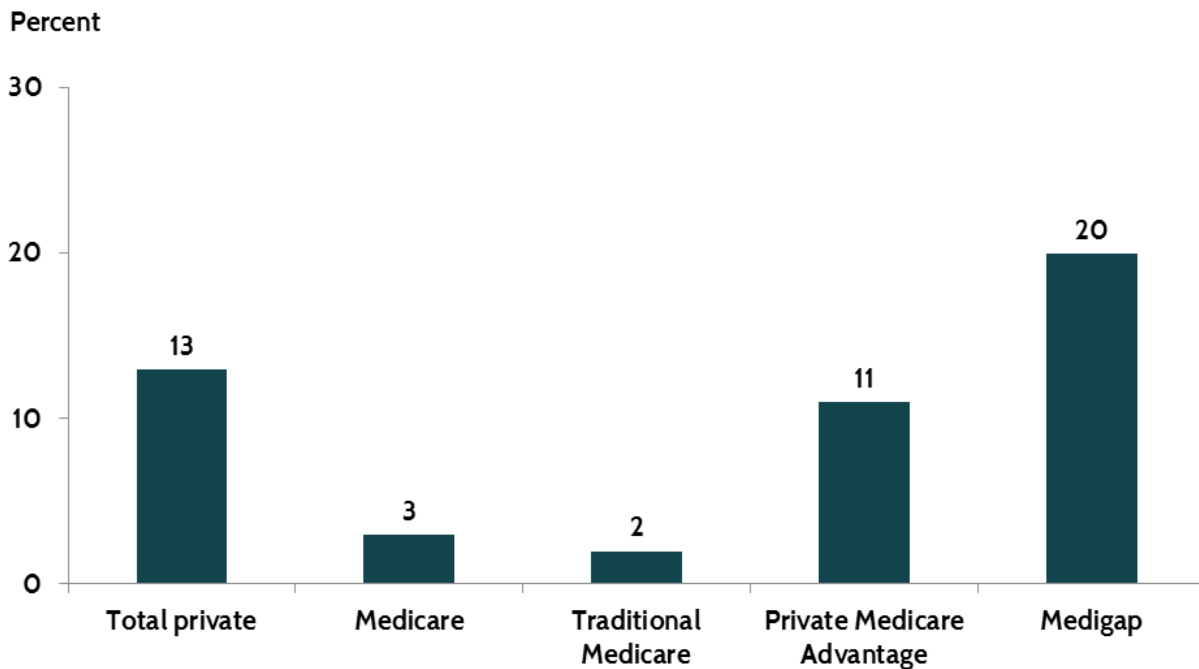
Some argue that private plans are more responsive to beneficiary preferences. Yet survey research shows Medicare compares favorably to private insurance on measures of performance such as access to care and protection from financial burdens, with no significant differences on these dimensions between Medicare Advantage and traditional Medicare.²⁸ Other research shows that disparities tend to be greater in Medicare Advantage than in traditional Medicare for those who have lower incomes, or are female, black, in fair or poor health, or less educated.²⁹

Medicare beneficiaries for the most part are pleased with their health insurance coverage. Elderly Medicare beneficiaries are significantly less likely than those with employer-based coverage to report having negative insurance experiences, such as receiving expensive medical bills for uncovered services, being charged more than insurance would pay, or not having their insurance accepted. Individually insured adults are more likely to have a negative experience. Forty-six percent of Medicare Advantage beneficiaries reported negative insurance experiences, compared with 33 percent of traditional Medicare beneficiaries.

Satisfaction with insurance coverage is significantly higher among Medicare beneficiaries. Only 7 percent of traditional Medicare beneficiaries and 11 percent of Medicare Advantage enrollees rate their insurance as fair or poor, compared with 21 percent of adults with employer-based insurance. Adults with individual coverage were the most dissatisfied, with 45 percent rating their insurance as fair or poor.

Finally, administrative costs in traditional Medicare, which average 2 percent to 3 percent, are much lower than those in Medicare Advantage (11%) or private supplemental Medigap plans (20%) (Exhibit 14).

Exhibit 14. Administrative Costs of Private Coverage Are High



Sources: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009); Congressional Budget Office, *Designing a Premium Support System for Medicare* (Washington, D.C.: CBO, 2006); and S. Sheingold, A. Shartzter, and D. Ly, *Variation and Trends in Medigap Premiums* (Washington, D.C.: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Dec. 2011).

The Affordable Care Act includes provisions designed to improve the value provided by Medicare Advantage plans. These include phasing out the federal government’s overpayments to Medicare Advantage plans, which have been reimbursed an average of 13 percent above the amount it would have cost to care for the same beneficiaries under traditional Medicare. The ACA also limits administrative overhead in Medicare Advantage plans to no more than 20 percent of premiums collected.³⁰ Moreover, enrollees now have access to plan quality “star ratings,” which appears to have led to some shift in enrollment toward 4- and 5-star plans.³¹

One of the major rationales for the Medicare Advantage program has been the belief that participating plans would use disease management and care coordination tools to reduce the need for hospitalization and to otherwise control use of health services.³² In fact, only a portion of Medicare Advantage plans are based on integrated delivery system models; others amount to no more than discounted fee-for-service plans, offering open access to all providers willing to participate. To ensure that Medicare, in all its forms, is providing good value to beneficiaries, it will be important to monitor the relative performance of traditional Medicare and the array of private plans available through the Medicare Advantage program.

CHALLENGES AHEAD: SERVING BOOMERS, CONTROLLING COSTS

Medicare faces enormous challenges as members of the baby boom generation, now in their late 50s and 60s, become eligible for coverage. Beginning in 2011, and continuing for the next 20 years, roughly 10,000 Americans will turn 65 every day.³³ As more and more reach the age of Medicare eligibility and enroll, total Medicare expenditures are projected to rise faster than growth in the overall economy. This accelerating rise in enrollment in coming years is fueling concerns about the future impact on the federal budget and the solvency of the Medicare Hospital Insurance Trust Fund.

There are other challenges as well. Medicare's insufficient benefit package compels many beneficiaries to seek supplementary private coverage. While the addition of prescription drug coverage in 2003 and elimination of cost-sharing for preventive care have had beneficial effects, Part B and Medigap premiums and the cost of noncovered services add to beneficiaries' financial burdens.³⁴ The aging of the population and the high prevalence of chronic disease among older adults also call for better strategies to serve beneficiaries with complex care needs and control the high costs associated with their care.

To date, policy leaders have followed a prudent course. Spurred by the Affordable Care Act, Medicare is currently testing promising innovations in health care delivery and payment, some of which have produced encouraging early results.³⁵ Over the coming years, it may even be possible to achieve significant savings by spreading the most successful of these new payment policies and delivery system models.

The ACA's reforms alone will not be enough, however, to address all of Medicare's challenges. In addition to addressing the stark fiscal realities that face the program, a future reform agenda also must seek to: improve financial protection for low- and modest-income beneficiaries; modernize Medicare's benefit package; reduce complexity in traditional Medicare's coverage; deliver more effective care to complex beneficiaries with high needs and high costs; and accelerate the program's move toward value-based payment.

There have been numerous proposals to transform Medicare. One of these, "Medicare Essential" (discussed in one of the forthcoming papers in our *Medicare at 50 Years* series) would create a comprehensive Medicare benefit financed by beneficiary premiums.³⁶ Because Medicare has substantially lower administrative costs than those in private supplemental insurance plans, beneficiaries would save on premiums. Beneficiaries would also have incentives to seek care from higher-value, lower-cost providers, such as patient-centered medical homes and accountable care organizations. Under another proposal, known as "premium support," beneficiaries would receive a payment that they would use to buy health insurance on their own, whether private coverage or traditional Medicare.³⁷ If the premium of the plan they choose exceeds the premium-support allowance, beneficiaries would pay the difference or enroll in a plan with lower premiums but higher deductibles and fewer benefits. But with so many beneficiaries already spending a sizable portion of their incomes on health services, it may not be possible to ask that they bear even greater out-of-pocket costs.

Perhaps the best course may involve building on the comparative advantages of both public and private insurance and promoting healthy competition between the two. Traditional Medicare has the advantage of lower administrative costs and participation by nearly all hospitals and physicians despite lower provider payment rates. Private plans have more flexibility to contract with lower-cost providers and to set restrictions on use of services (such as prior authorization of hospitalization). With its lower administration costs and

lower provider payment rates, traditional Medicare in particular may offer important advantages that can be used to improve coverage options for those under age 65, particularly those nearing retirement, by reducing costs to enrollees and improving the stability of coverage as older adults age into Medicare.

In the chapters that follow, we will examine the Affordable Care Act's reforms to Medicare and the challenges ahead and analyze policy options to ensure Medicare's viability and effectiveness for future beneficiaries.

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02

A MEDICARE TIMELINE: How Did We Get Here?

1935

The New Deal



Franklin D. Roosevelt's Social Security Act passes, but without a universal health insurance component because of opposition from Republicans, conservative Democrats, and organized medicine.

“ The greatest gap in our social security structure is the lack of adequate provision for the Nation’s health...This great Nation cannot afford to allow its citizens to suffer needlessly from the lack of proper medical care. ”

— *Harry Truman*

Health Care Reformer In Chief



Harry Truman, the first president to unreservedly advocate national health insurance, sees his proposal—targeted as socialized medicine—stall on Capitol Hill.

John F. Kennedy’s administration went on to pursue more modest plans to cover older Americans, but they failed to get traction in Congress.

1948

1965

Medicare Is Born



Lyndon Johnson champions and signs the Social Security Amendments of 1965, creating Medicare and Medicaid, in Harry Truman's hometown of Independence, Missouri. Medicare coverage includes hospital (Part A) and physician (Part B) services for people age 65 and older, and Medicaid covers low-income children and their caretaker relatives.

Medicare Eligibility Expanded

MEDICARE by the NUMBERS

52.3

million
Americans
covered by
Medicare in
2013

2%

Americans
65+ who do not
have health
coverage;

In 1962, 1/2 of elderly
were uninsured.

15%

Increase in life
expectancy at
age 65 between
1965-1984



8.8

million disabled
beneficiaries
under age 65

\$385

Spending per
beneficiary in
1970

\$12,210

Spending per
beneficiary in
2013

The Social Security Amendments of 1972 extend Medicare eligibility to people under age 65 with long-term disabilities and those with end-stage renal disease. They also establish the Professional Standards Review Organizations (PSROs) to review appropriateness of care.

1972

1982

Medicare Hospice Benefit Added, Private Plans Offered



The Tax Equity and Fiscal Responsibility Act adds a Medicare hospice benefit; establishes a program through which Medicare beneficiaries can choose to obtain their benefits from private health insurance plans; sets limits on Medicare hospital payments per case; and requires the development of a proposed prospective payment system for inpatient hospital services, under which hospitals would receive a fixed payment amount for each type of case. It also replaces the PSROs with Peer Review Organizations (PROs), which were given greater authority to review the appropriateness of hospital care and penalize hospitals for inappropriate care.

A New Payment System



The Social Security Amendments of 1983 establish the prospective payment system for inpatient hospital services, in which Medicare pays hospitals a fixed fee for each type of case, determined in advance and based on the relative average cost of treating that type of case in hospitals nationwide instead of the hospital's own costs.

1983

1987

Promoting Safe Nursing Homes



The Omnibus Budget Reconciliation Act of 1987 establishes quality standards for Medicare- and Medicaid-certified nursing homes.

New Benefits Added—And Repealed

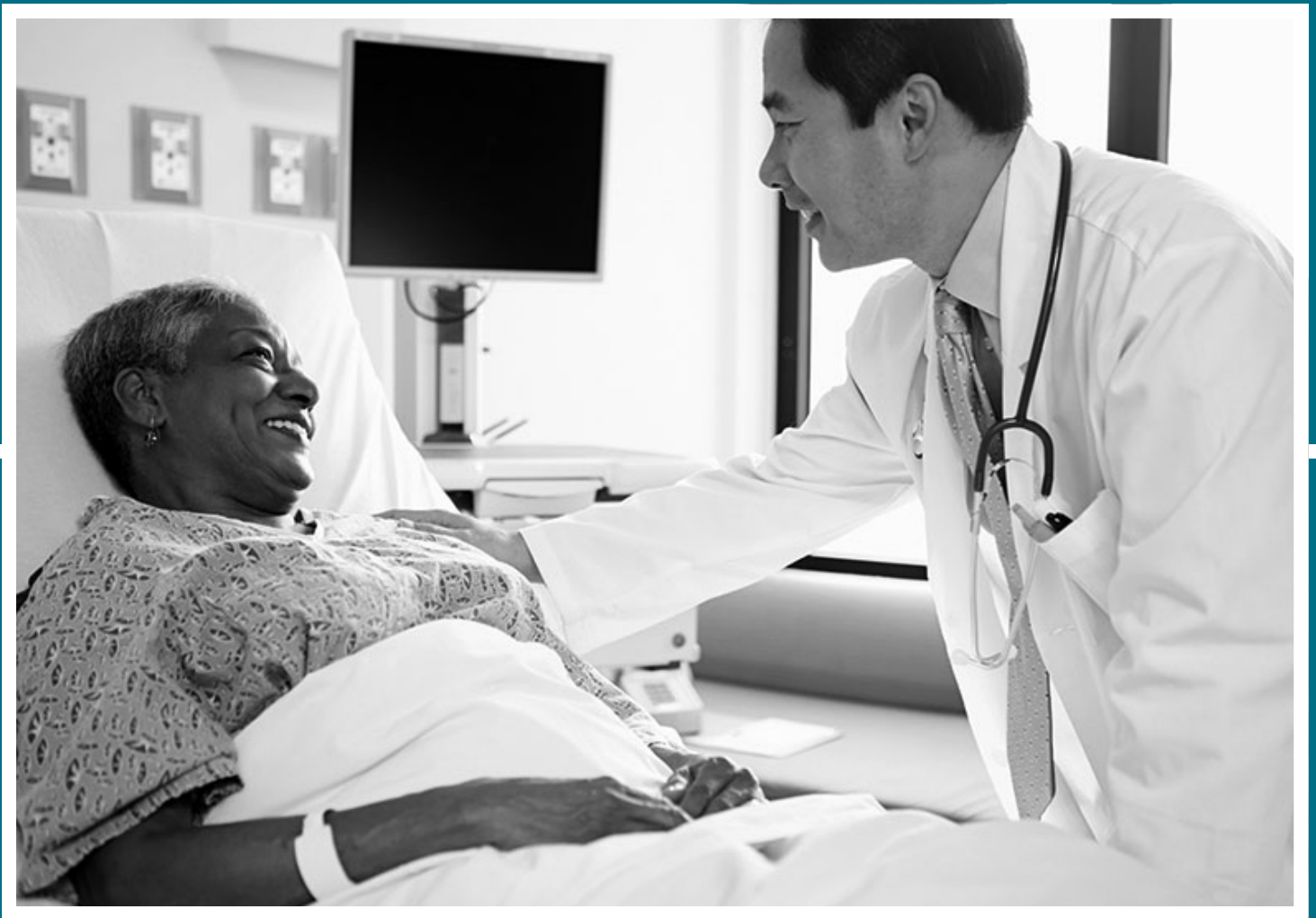


The Medicare Catastrophic Coverage Act of 1988 establishes an outpatient prescription drug benefit and a cap on beneficiaries' out-of-pocket costs. The major provisions of the law were repealed in 1989.

1988

1989

Cost Containment Efforts



The Omnibus Budget Reconciliation Act of 1989 changes the way physicians are paid by Medicare to encourage more efficient care. The Act replaces the previous system, under which physicians were reimbursed based on their usual charges, with one based on an estimate of the resources required to provide the services.

Expansion Of Payment Changes



The Medicare Catastrophic Coverage Act of 1988 establishes an outpatient prescription drug benefit and a cap on beneficiaries' out-of-pocket costs. The major provisions of the law were repealed in 1989.

1997

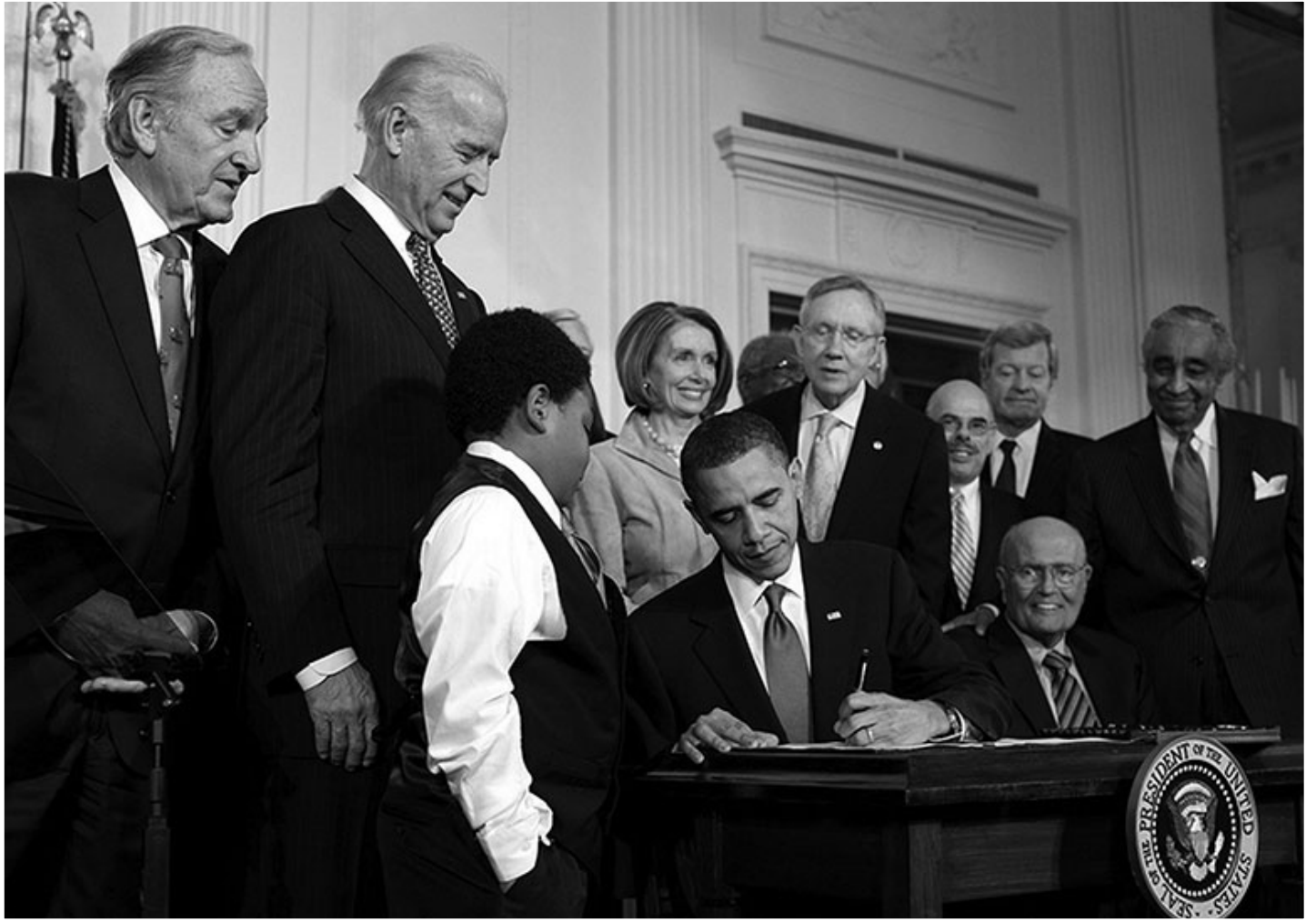
2003

A Lasting Drug Benefit



George W. Bush signs the Medicare Modernization Act, which establishes a prescription drug (Part D) benefit available to all Medicare beneficiaries (beginning in 2006) and replaces the Medicare+Choice program with the Medicare Advantage program, making additional types of private plans available and substantially increasing payments to those plans.

Better Coverage, Better Care, Lower Costs



Barack Obama signs the Affordable Care Act (ACA), which strengthens Medicare coverage of preventive care, reduces beneficiary liability for prescription drug costs, institutes reforms of many payment and delivery systems, and creates the Center for Medicare and Medicaid Innovation.

The ACA also adds many new health insurance protections, such as bans on preexisting condition exclusions; establishes health insurance marketplaces for small businesses and individuals to purchase affordable health insurance; and requires that states expand eligibility for Medicaid (a provision the Supreme Court later makes optional).

2010



03



THE AFFORDABLE CARE ACT AND MEDICARE: How the Law Is Changing the Program and the Challenges That Remain

Karen Davis, Stuart Guterman, and Farhan Bandeali

By moving Medicare away from fee-for-service payment and holding health care providers more accountable for both the quality and total cost of care, the Affordable Care Act has the potential to reshape not just the program but the entire U.S. health care system. But the rapid influx of new beneficiaries in coming years will necessitate further changes to Medicare, as total program outlays are likely to outpace growth in the economy.

BACKGROUND

When President Obama signed the Affordable Care Act (ACA) into law on March 23, 2010, his signature initiated the most significant overhaul of the U.S. health care system since the introduction of Medicare. While the ACA was intended primarily to extend health coverage to the uninsured and to make care more affordable, it also contained provisions designed to improve the health and health care of Medicare beneficiaries, lead the change toward paying health care providers based on quality rather than quantity of care, and shore up the long-term financial health of Medicare.¹

The ACA strengthens Medicare in a number of important ways. It:

- Improves coverage and care for beneficiaries by addressing gaps in preventive care and prescription drug benefits and strengthening chronic care management.
- Stimulates health care providers to innovate by emphasizing quality over quantity of care.
- Strengthens the structure and viability of the program by slowing the growth of future Medicare outlays and extending the solvency of the Medicare Health Insurance Trust Fund.

This paper discusses the gains created by the ACA as well as the problems that remain to be addressed.

IMPROVING COVERAGE AND CARE FOR BENEFICIARIES

The ACA includes provisions that directly improve benefits for all Medicare beneficiaries.² It adds preventive services without cost-sharing and improves Medicare prescription drug coverage. More broadly, the ACA emphasizes the importance of primary care in boosting the health of beneficiaries and in achieving cost savings through greater care coordination.

The ACA requires coverage without cost-sharing for all preventive services such as flu shots, tobacco cessation counseling, and screening for cancer, diabetes, and other chronic diseases. In addition, it adds coverage for an annual wellness visit to the previous one-time Welcome to Medicare visit. During 2013, an estimated 37 million Medicare beneficiaries received free preventive services. This not only improved access to such services but also increased the affordability of expensive screening such as colonoscopies.³

The Medicare Modernization Act of 2003 made coverage available for prescription drugs through private drug plans, but there was a gap in coverage once covered costs exceeded a threshold—the so-called “doughnut hole,” which required the beneficiary to pay the full covered cost until a much higher catastrophic coverage threshold was reached. The ACA reduces prescription drug prices for those who fall in the coverage gap and phases out the doughnut hole by 2020. In 2014, Medicare beneficiaries in the doughnut hole received a 52.5 percent discount on brand-name drugs and a 28 percent discount on generic drugs; as of July 2014, more than 8 million Medicare beneficiaries had saved over \$11.5 billion since 2010 as a result of the ACA’s prescription drug provisions.⁴

Easy access to basic medical care is key to both better patient outcomes and lower cost. Yet the U.S. health care system disproportionately rewards specialized care, contributing to a decline in the number of newly trained physicians electing primary care practice. The ACA provides a 10 percent boost in Medicare payments to primary care providers (and general surgeons) for five years (2011–15), and also raised Medicaid primary care services payment rates up to Medicare levels for two years (2013–14).⁵ Additionally, to address the shortage in the primary care workforce, the ACA creates new incentives such as funding for scholarships and loan repayments to expand the number of doctors, nurses, and physician assistants serving in underserved areas.

The ACA strengthens chronic care management by providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition. The Community-based Care Transitions Program (CCTP) is a new ACA initiative that funds community-based organizations to provide transition services to help reduce 30-day readmission rates.⁶ The organizations are paid on a per-eligible-discharge basis per 180-day period. The ACA also includes provisions for coordinating Medicare and Medicaid benefits for dual eligibles covered by both programs. The ACA created the CMS Medicare–Medicaid Coordination Office to fully integrate both care and payments for the dual-eligible population. Through more coordinated efforts, the dual-eligible population, which currently makes up the most expensive segment of the beneficiary population, could receive higher quality care at a cost savings.

Medicare does not cover long-term care. While the ACA initially included a Community Living Assistance and Supportive Services (CLASS) program with daily payments for long-term care services and supports in the home or in nursing facilities,⁷ that provision was subsequently repealed because the voluntary

premium funding with only a five-year vesting period was viewed as fiscally unviable. The ACA does provide states the opportunity to support community-based long-term services administered through Medicaid to keep beneficiaries at home or in the community for as long as possible. The ACA also extends funding for the Money Follows the Person program, which tries to reverse trends in institutionalization by boosting access to long-term services and supports at home, by five years.⁸

STIMULATING HEALTH CARE PROVIDERS TO INNOVATE

The fee-for-service provider payment system used by traditional Medicare and by many other payers has been subject to increasing criticism in recent years.⁹ It has not rewarded providers who deliver better patient outcomes or care experiences. It has imposed no penalty for duplicative or ineffective care, encouraging overutilization. In the case of Medicare, it has controlled prices but not expenditures, especially for physician services, which have continued to increase in volume over time.¹⁰ The ACA includes significant provisions that encourage movement away from fee-for-service payment and improvement in the quality of care provided to Medicare beneficiaries.

The Center for Medicare and Medicaid Innovation

Perhaps the ACA's most important Medicare reform initiative is the CMMI, also known as the Innovation Center. With \$10 billion in funding over 10 years, this new agency is tasked with developing, assessing, and disseminating innovations that contribute to improved outcomes, better patient care experiences, and lower costs, with authority for the Secretary of Health and Human Services (HHS) to spread successful innovations throughout the Medicare program.

These demonstrations and pilots are intended to lay the foundation for fundamental provider payment reform under Medicare by identifying and testing promising models of payment and health care delivery to replace fee-for-service payment. Among the most prominent innovations being tested are:

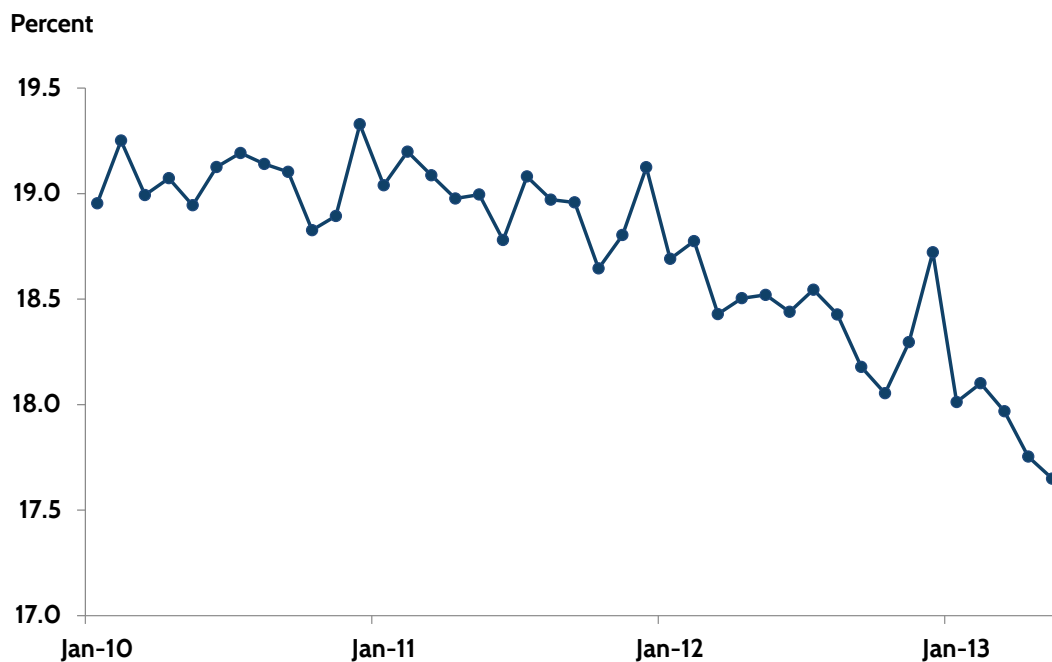
- A Comprehensive Primary Care Initiative, testing a blended payment method of fee-for-service, a per-Medicare-beneficiary-per-month payment for care management, and bonuses for quality performance.
- A Bundled Payments for Care Improvement initiative that provides an all-inclusive bundled payments for hospital, physician, and/or postacute care services for a specified condition and period of time for select hospital procedures and conditions.
- Variations on the accountable care organization (ACO) model, under which a group of providers takes responsibility for the total cost of care of beneficiaries who receive the plurality of their primary care from physicians in the organization. Those organizations receive a share of the Medicare savings they generate if they perform well on measures of quality and patient experience. Although most ACOs do not take risk for excess growth in Medicare spending for their patients, the objective is to move toward that type of arrangement over time.

To date, ACOs in the Medicare Shared Savings Program and in the Pioneer ACO pilot have demonstrated improvements in quality with modest cost savings.¹¹ A similar effort in the private sector by the Massachusetts Blue Cross Blue Shield plan has found 8.6 percent savings over a four-year time frame.¹²

Incentives to Encourage Quality and Value

The ACA created penalties designed to reduce hospital readmissions and hospital-acquired conditions (such as bed sores, falls, infections, and surgical complications). The hospital readmissions reduction program established a risk-adjusted methodology, endorsed by the National Quality Forum, to calculate benchmark levels of readmission rates for various health conditions including heart attacks, heart failure, pneumonia, and chronic obstructive pulmonary disease (COPD).¹³ If the readmission ratio for each condition is in excess of the national average given each hospital's risk profile, the hospital is penalized with a reduction in their Medicare payment. Early evidence indicates progress in reducing hospital readmissions—between January 2010 and January 2013, the readmission rate fell from almost 19 percent to just over 17.5 percent (Exhibit 1).

Exhibit 1. All-Cause, 30-Day Hospital Readmission Rate Steadily Declines



Source: Patrick Conway; Office of Information Products and Data Analytics, Centers for Medicare and Medicaid Services.

The ACA includes a Value-Based Purchasing program that provides extra payments to hospitals and other providers that have higher clinical quality and patient experiences of care.¹⁴ CMS has markedly expanded its public reporting of provider quality performance, making comparative data more readily available to beneficiaries, the public, and providers. In doing so, CMS hopes to help improve the responsiveness,

quality, effectiveness, and efficiency of the health system for all Americans. The enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) in April 2015 accelerates that process and increases coordination among multiple value-based purchasing initiatives now in place with a new Merit-Based Incentive Payment System (MIPS).¹⁵

STRENGTHENING THE STRUCTURE AND VIABILITY OF MEDICARE

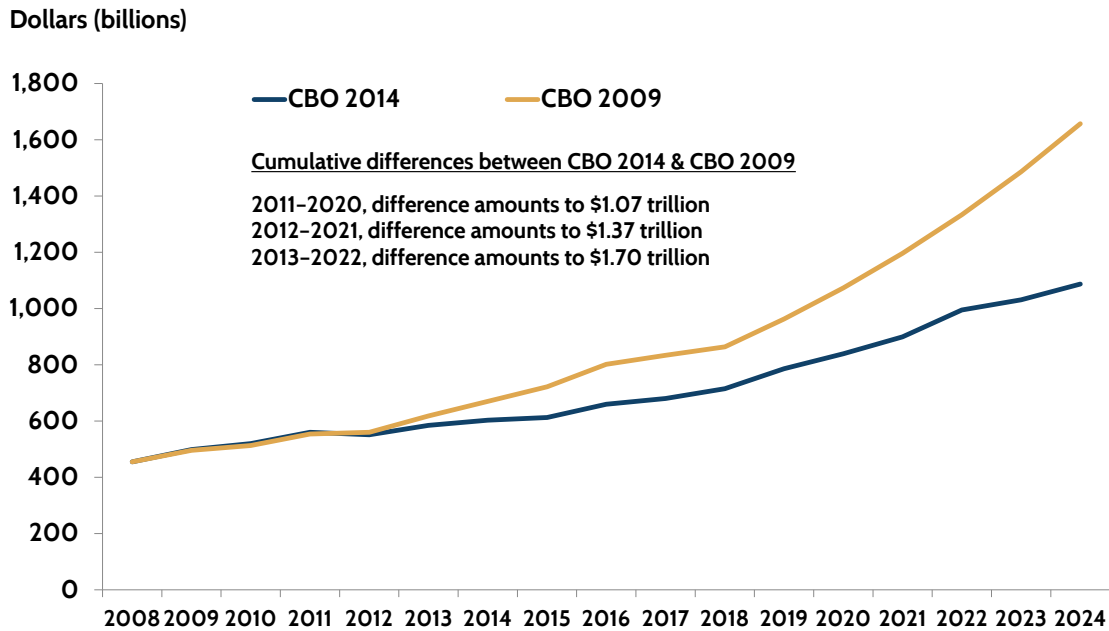
Perhaps the most controversial aspect of the ACA was how to finance improved coverage for the uninsured and underinsured. While the “carrots” of improved coverage and benefits are typically popular with those who stand to benefit, the “sticks” of funding improved coverage through reductions in spending for current programs or increased taxes always face opposition. The final legislation more than met the requirement that any added federal budget costs must be covered either by reductions in current federal outlays or by increased revenues. At the time, the 10-year net cost of the insurance coverage provisions was estimated by the Congressional Budget Office (CBO) at \$788 billion over the period 2010 to 2019, financed with \$492 billion in reduced direct government spending primarily in the Medicare program and \$420 billion in new revenue, for a net reduction to the federal deficit of \$124 billion over 10 years.¹⁶

Specifically, savings included \$186 billion in reductions to the annual updates of Medicare provider payment rates; \$118 billion from reduced governmental subsidies for MA plans; \$43 billion in reduced payments to hospitals serving a disproportionate share of low-income patients under both Medicare and Medicaid (to reflect the reduced amount of uncompensated care they would provide as many of the uninsured obtained coverage); and several other smaller provisions. The ACA also contained provisions to improve delivery system performance to enhance Medicare’s effectiveness, but these were “scored” by the CBO as achieving only minor savings (for example, \$5 billion over 10 years from ACOs and \$7 billion from reduced hospital readmissions). Revenues included fees on device manufacturers, pharmaceutical companies, and health insurers, plus increased payroll taxes on high-income Medicare beneficiaries dedicated to the Medicare Hospital Insurance Trust Fund (\$87 billion).

Downward Revisions to Projected Growth in Medicare Expenditures

Five years after enactment of the ACA, perhaps the most remarkable finding is that Medicare outlays have grown much more slowly than predicted. In each year since 2009, the Congressional Budget Office has lowered its projection of Medicare outlays over the following 10 years.¹⁷ The cumulative effect is stunning: projected Medicare spending from 2011 to 2020 is \$1 trillion lower than the CBO estimated prior to the ACA’s enactment (Exhibit 2). This contrasts with the less than \$400 billion in savings from the Medicare provisions of the ACA originally projected by the CBO. In fact, the slowdown in spending under Medicare would have been more than sufficient to finance the entire cost of the ACA as originally estimated (which itself has been subsequently reduced given the Supreme Court decision allowing states to opt out of participation in Medicaid expansion and the slower than anticipated enrollment of the uninsured in insurance exchanges).

Exhibit 2. Ten-Year Medicare Spending Projections Reduced by \$1 Trillion



Source: Karen Davis and Jeromie Ballreich, Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health, based on annual Congressional Budget Office (CBO) reports.

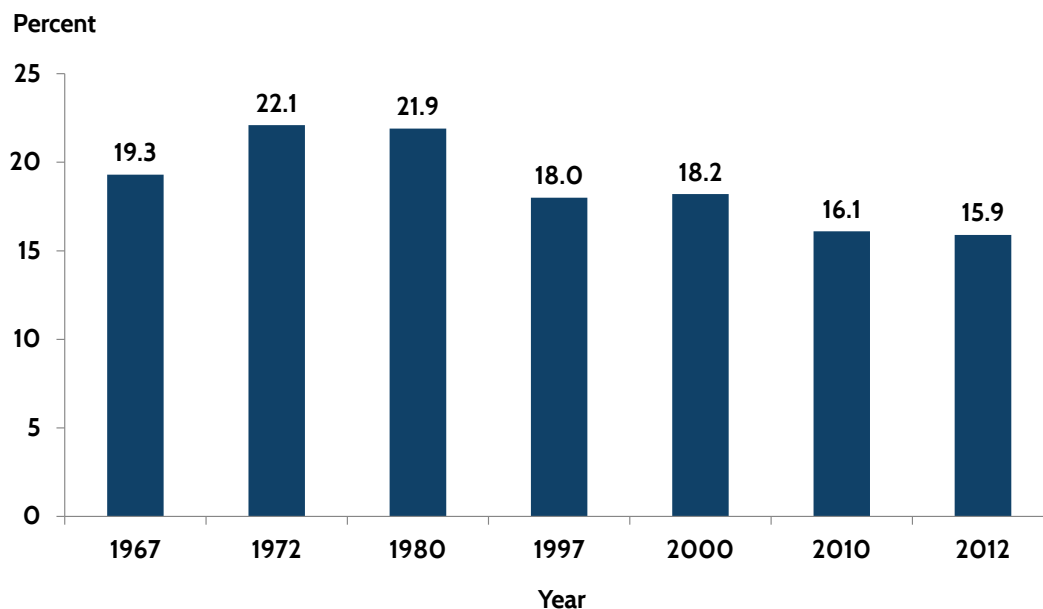
Controversy continues over how much of this slowdown in Medicare expenditure growth can be attributed to the ACA, how much was an overestimate of baseline spending resulting from an understandable failure to anticipate the full impact of the Great Recession, and how much was related to fundamental restructuring of the health care industry that predated ACA enactment. Undoubtedly, all three explanations played a role, and their effects most likely overlap. Further research will be required to shed more light on the issue.

At the time of the ACA's enactment, some experts suggested that the CBO estimates of Medicare savings were overly conservative, giving insufficient weight to the payment and delivery system reforms included in the ACA.¹⁸ For example, an analysis of Medicare savings in the ACA released by The Commonwealth Fund estimated 10-year Medicare savings at \$686 billion over the period 2011 to 2020, more than one-third greater than the savings estimated by the CBO.¹⁹

There is also some indication that increases in overall health care spending, including Medicare, began slowing down after 2005—a trend not obvious to CBO estimators in 2009–10, given lags in data availability—contributing to an overestimate of baseline Medicare spending. Experts have suggested that this slowdown could be a consequence of efforts that predated the ACA to improve patient safety and quality, or a number of leading prescription drugs going off patent protection, or the effect of Medicare prescription drug coverage on reduced hospitalization of Medicare beneficiaries. Most likely it was the result of a combination of these and other factors.²⁰

Certainly, throughout the decade following the release of the Institute of Medicine report *To Err is Human* in 1999, hospitals in particular mounted efforts to improve patient safety and reduce medical errors.^{21,22} The addition of prescription drugs to Medicare coverage in 2006 may have facilitated management of chronic conditions, reducing hospitalizations for conditions that are sensitive to primary care and medication adherence. Whatever the reason, annual hospitalization rates of those age 65 and older declined from 18.2 percent in 2000 to 16.1 percent in 2010, contributing to reduced Medicare outlays and slowing the overall trend in spending (Exhibit 3). Research will continue to explore the underlying causes of the trends in Medicare and total health care spending over the years predating and following enactment of the ACA. At this point, however, it seems clear that the changes set in motion by the ACA contributed to slowing the growth in Medicare outlays—and, in doing so, enhanced the financial viability of the program.

Exhibit 3. Decline in Annual Hospitalization Rate, Age 65 and Older, Helps to Slow Spending



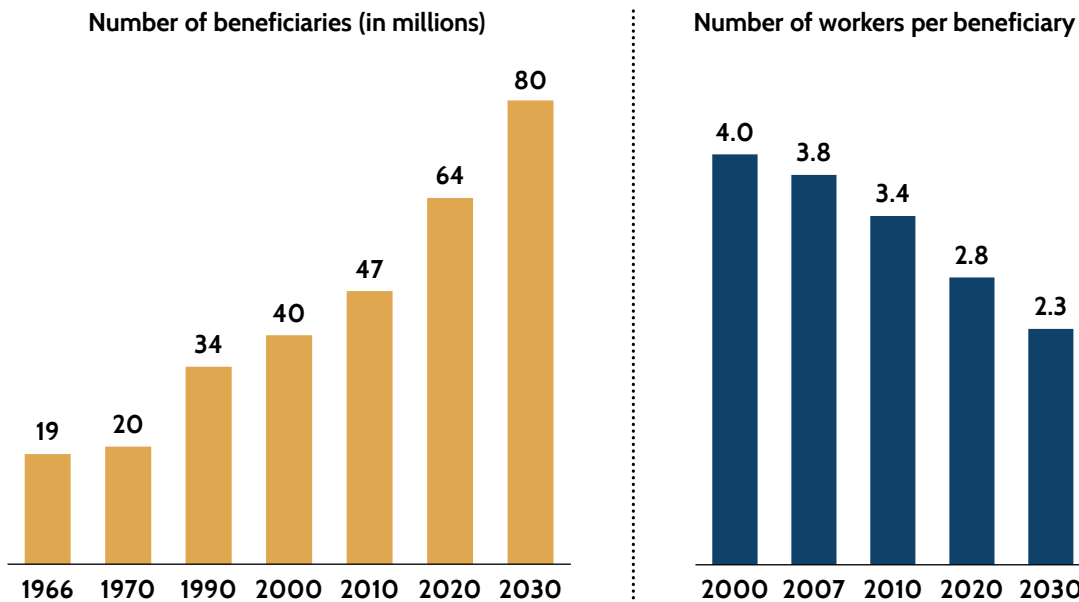
Note: Although the recent decline in hospital admissions for people age 65 and older is partly the result of an increase in the proportion of younger beneficiaries (ages 65–69), who have lower rates of hospitalization, hospitalization rates have in fact fallen for each age group in Medicare.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, family core and sample adult questionnaires, 2013.

Solvency of the Medicare Hospital Insurance Trust Fund

The Medicare Hospital Insurance Trust Fund, which pays for hospital and other facility-based services used by Medicare beneficiaries, is financed by an earmarked payroll tax of 1.45 percent on both employers and workers. Historically, outlays from the Trust Fund have increased faster than employee wages and therefore payroll tax revenues. And with the boom in population following World War II and the drop in fertility rates in the 1960s, the elderly population is projected to grow markedly faster than the working-age population for the next two decades (Exhibit 4). As more people draw benefits and relatively fewer people pay into the system, the gap between revenues and expenditures inevitably widens over time.

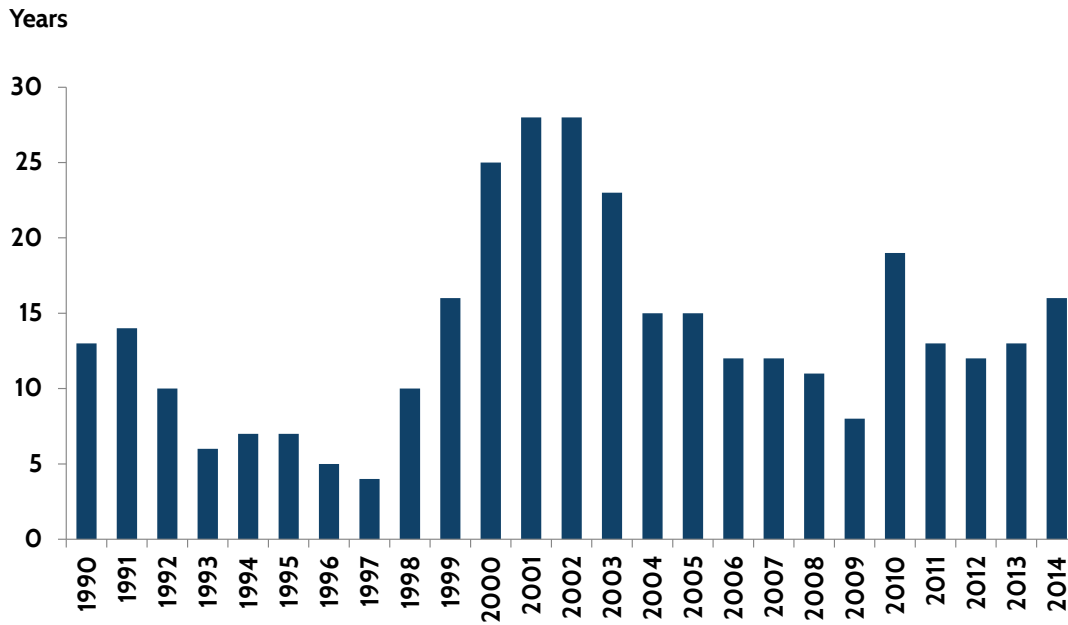
Exhibit 4. Federal Budgetary and Trust Fund Solvency Concerns as the U.S. Population Ages



Source: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

The date at which reserves in the Hospital Insurance Trust Fund are projected to be depleted is referred to as the “insolvency date.” Although in practice Congress has acted to modify revenues or expenditures to prevent predicted insolvency over time, and would undoubtedly dedicate additional revenues to the Trust Fund if necessary, the insolvency date has served to focus periodic political attention and corrective action (Exhibit 5).

Exhibit 5. Medicare Hospital Insurance Trust Fund: Years Remaining Until Projected Insolvency, 1990–2014



Source: P. A. Davis, "Medicare: Insolvency Projections," Congressional Research Service Report RS20946, Sept. 19, 2014.

Prior to enactment of the ACA, the Medicare Trustees projected that the Hospital Insurance Trust Fund would be depleted by 2017.²³ Immediately following enactment, the Trust Fund's solvency was extended by 12 years, to 2029.²⁴ Currently, the projected insolvency date is 2030—13 years later than at the time the ACA was enacted.²⁵ Rather than undermining the Medicare program, the ACA has strengthened its financing, reducing, at least for the near-term, pressure to cut benefits, shift costs to beneficiaries, tighten provider payment rates, or raise taxes to ensure the adequacy of financing. The fundamental imbalance in Medicare financing, however, remains unaddressed.

Independent Payment Advisory Board

The ACA authorized an Independent Payment Advisory Board to make provider payment recommendations aimed at holding Medicare expenditures to a given rate of growth relative to the economy over time. These recommendations would become binding if Congress does not substitute alternative mechanisms for achieving the same expenditure growth target in a timely fashion. The Board also would make recommendations on how to slow health spending across the public and private sectors. The CBO estimated the board would generate \$16 billion in savings over 2010–19, mostly in the out-years. This provision, however, has been politically controversial and has not been implemented to date.

Moving from Volume to Value

The ACA's provisions have signaled the direction for the future for Medicare provider payment reform. Traditional Medicare is moving to adopt new value-related alternative payment methods that encourage providers to be accountable for the quality and cost of care they deliver to beneficiaries. The Secretary of HHS has set a goal that 85 percent of all traditional Medicare payments will be tied to quality or value by the end of 2016, and 90 percent by the end of 2018.²⁶ A recent scorecard on Medicare payment reform found that, as of the end of 2013, that figure was 42 percent.²⁷ While progress has been made, considerable work remains to be done.

CHALLENGES REMAINING FOR MEDICARE

With its payment, quality, and delivery system reforms, the ACA is reshaping the Medicare program and addressing the need for improved performance throughout the entire health care system. The U.S. outspends other countries per capita on health care, yet lags on important dimensions of performance including access to care and health outcomes.²⁸ Innovative payment and delivery systems, along with other potent tools such as health information technology, comparative provider performance data, outcomes research, and a stronger primary care foundation, can generate significant savings and improved performance. Still, an array of remaining challenges will determine Medicare's course as it enters its second 50 years; several of these will be addressed in more detail in future papers in this series.

Provider Payment Reform

The recent enactment of the MACRA legislation modifying Medicare's physician payment system will accelerate the move toward paying for value.²⁹ Physicians participating in innovative alternative-payment methods such as accountable care organizations, bundled payment, or patient-centered medical homes will be eligible for 5 percent bonuses, and additional funding will be provided for value-based payments. The commitment by the Secretary of HHS that alternative payment models will constitute 50 percent of Medicare outlays by the end of 2018 indicates a push toward Medicare payment reform. Under the ACA, the Secretary has the authority to spread innovative payment methods tested by the CMMI that are found to either improve quality or lower cost without harming the other. But challenges remain in accomplishing the goals the Secretary has set out.

Improving Benefits for Low-Income Beneficiaries and Those with Complex Care Needs

Low- and modest-income beneficiaries are experiencing increasing financial difficulties in meeting uncovered costs.³⁰ As Medicare beneficiaries grow older and experience complex care needs, Medicare will have to identify innovative ways to help more beneficiaries continue to live at home and in the community as they face physical and cognitive impairments and need more personal care. Most challenging will be how to finance long-term care services and supports needed for a growing aging population.

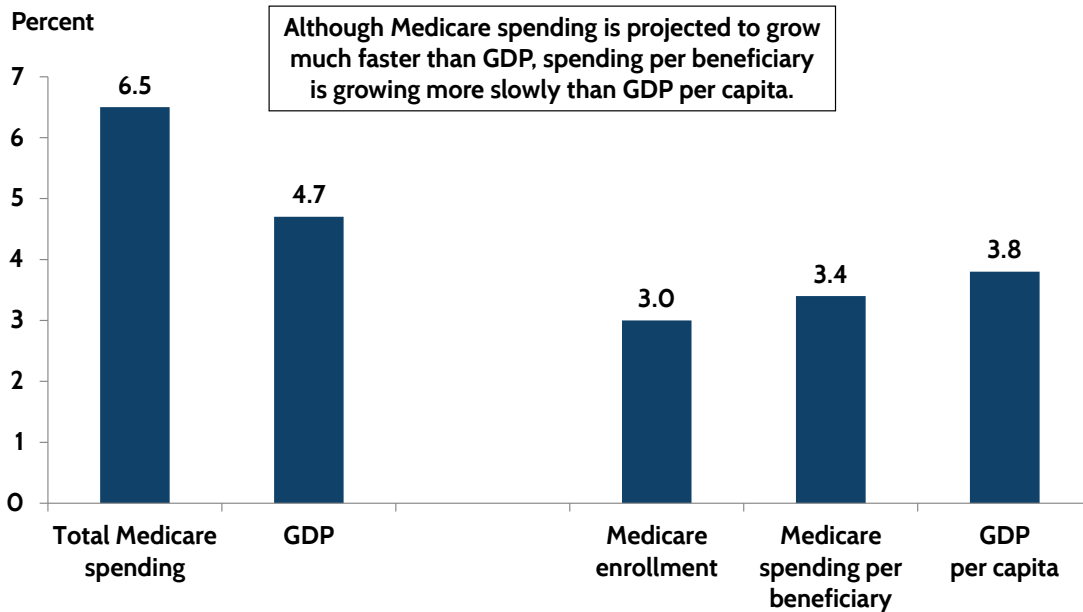
Medicare Program Complexity

While Medicare has been an innovative leader in methods of paying health care providers, its basic benefit structure is largely unchanged. The fragmentation of coverage into separate parts for hospital (Part A), physician (Part B), and prescription drugs (Part D) adds to administrative cost, complexity, and confusion for beneficiaries, and hinders coordination of care. Further, the high Part A deductible and absence of a ceiling on out-of-pocket costs leads most beneficiaries to supplement traditional Medicare with private coverage (from retiree plans or through individual purchase) or Medicaid. To obtain a single comprehensive integrated benefit package, Medicare beneficiaries must enroll in private MA plans that have higher administrative costs and more limited provider networks.³¹

Medicare Program Cost and Financing

The ACA bought time for policy officials to grapple with the best strategies for bringing Medicare revenue sources and expenditures into line. The Hospital Insurance Trust Fund's revenues will cover expenditures until 2030, and Part B and D rely on general revenue financing. Medicare expenditures per beneficiary are projected to grow more slowly than the gross domestic product per capita (Exhibit 6). However, total Medicare expenditures will place an increasing draw on general revenues and strain on the federal budget, and eventually the payroll tax revenues that support Part A will be inadequate. It also remains to be seen whether the slowdown in health care costs will continue, experience further improvement, or begin to rise again as a result of increased access to care for the previously uninsured, aging of the population, or technological change. All of these factors, and how they are addressed, have implications for Medicare's fiscal viability.

Exhibit 6. Projected Annual Growth Rates for Total Medicare Spending, GDP, Medicare Enrollment, Spending per Beneficiary, and GDP per Capita, 2013–2023



Note: GDP refers to gross domestic product.

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

Role of Private Plans

The appropriate role of private plans in the Medicare program continues to be the subject of intense debate. Medicare beneficiaries have a choice of traditional Medicare and private MA plans, in what effectively is a nationwide health insurance exchange. How best to balance the roles of the public traditional Medicare program and the private MA plans is an ongoing question. Historically, Medicare payment policy has advantaged private plans, preventing the program from realizing the anticipated gains these plans offer in flexibility and efficiency.³² As the ACA provisions to phase out those overpayments to MA plans are implemented, increased efficiencies may result from at least some of those plans.³³ Proposals to promote more direct price competition between traditional Medicare and Medicare Advantage plans also are getting attention.³⁴ How these issues are sorted out will be key to determining how beneficiaries receive their coverage and how Medicare—and beneficiary—dollars flow in the future.³⁵

CONCLUSION

In its 50 years, Medicare has successfully accomplished its two key goals—to ensure access to health care for its elderly and disabled beneficiaries and to protect them against the financial hardship of health care costs—and done so more effectively and efficiently than other sources of health insurance. Even with its coverage gaps and fragmentation of benefits, Medicare continues to be a positive force in shaping the U.S. health system.

The Affordable Care Act holds significant promise to improve Medicare's performance, strengthening it for a more viable and successful future. Challenges related to cost, complexity, and gaps in coverage remain, and their solutions will require collaborative and creative thinking.

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MEDICARE PAYMENT REFORM: Aligning Incentives for Better Care

Gerard F. Anderson, Karen Davis, and Stuart Guterman

The Affordable Care Act (ACA) has provided the Medicare program with an array of tools to improve the quality of care that beneficiaries receive and increase the efficiency with which that care is provided. These tools are expected to increase the proportion of traditional Medicare payments tied to quality or value to 85 percent by 2016 and 90 percent by 2018. This chapter explores the evolution of Medicare payment policy, the potential of value-based payment to improve care for beneficiaries and achieve savings, and strategies for accelerating its adoption.

BACKGROUND

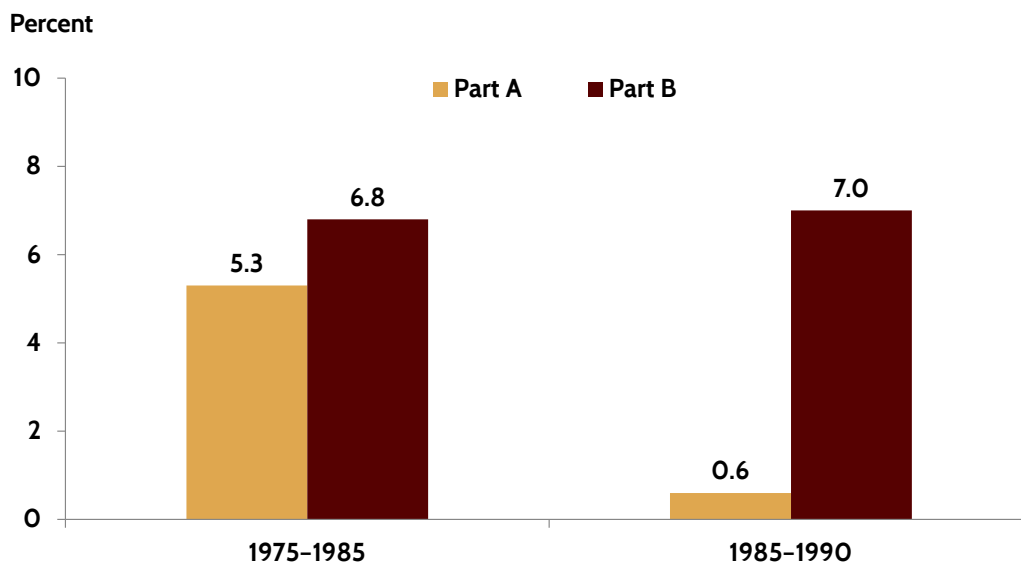
Medicare payment policy has evolved from the cost- and charge-reimbursement approach that predominated when the program was enacted to the prospective payment systems of the 1980s and 1990s and, more recently, to growing emphasis on value-based payment.¹ The enactment of the Affordable Care Act of 2010 (ACA) and the recent announcement of value-based payment goals for Medicare, along with the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), have accelerated that movement and provided Medicare with the means to accomplish the goals of better health care, smarter spending, and a healthier population.^{2,3} In this paper, we focus on the evolution of Medicare payment policy and the potential of payment reform to address the challenges discussed in the first two papers of this volume.^{4,5}

EVOLUTION OF MEDICARE PAYMENT POLICY

When Medicare was first established, it adopted the payment methods used by Blue Cross and Blue Shield plans at the time. Hospitals were paid on the basis of their own costs, and physicians were paid on the basis of the fees they charged. These payment systems provided no incentive to control costs—in effect rewarding higher hospital costs and physician fees—and did not take into account the quality or appropriateness of care or its contribution to patient outcomes. Between 1975 and 1985, annual Medicare spending per beneficiary rose from \$472 to \$1,579—a growth rate of 12.8 percent per year, or 5.3 percent when adjusted for economywide inflation.⁶

To counter this trend, Medicare in 1983 adopted a prospective payment system for hospital inpatient services, under which hospitals receive a fixed rate of payment per patient based on the average hospital cost nationwide for patients in the same diagnosis-related group (DRG). If the hospital's cost is less than the DRG payment rate, it retains the surplus payment, and if its cost exceeds the DRG payment rate, it bears the loss on that case. Hospitals responded by sharply reducing average length of stay. Spending per beneficiary by Medicare Hospital Insurance (Part A, which covers hospital inpatient and other facility-based care) subsequently declined sharply (Exhibit 1). Similar payment approaches subsequently were adopted by many private insurers and state Medicaid programs, as well as in more than 40 other countries. Medicare also has adopted prospective payment methods for postacute care, including home health and skilled nursing facility services.

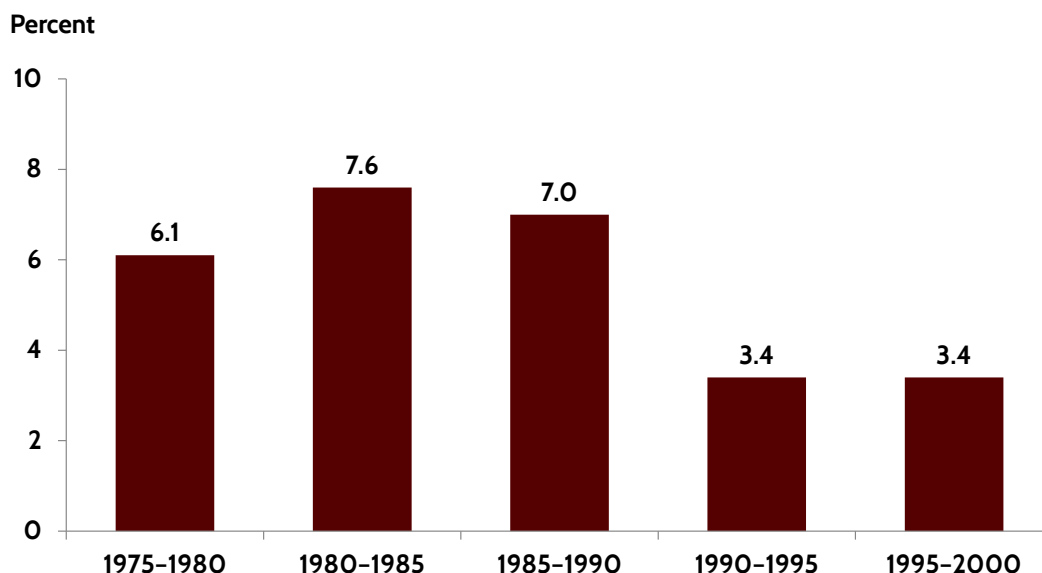
Exhibit 1. Real Annual Growth Rates for Medicare Part A and Part B Spending per Beneficiary, 1975–1985 and 1985–1990



Source: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds. *2014 Annual Report* (Washington, D.C.: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds, July 28, 2014), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf>. Spending figures deflated by Consumer Price Index for All Urban Consumers, U.S. City Average, All Items (1982–1984=100).

At the same time, Supplementary Medical Insurance (Part B, which covers physician and other ambulatory care) continued to rise rapidly, as physicians continued to receive payments based on usual, customary, and reasonable charges, which rewarded increased spending. In 1989, legislation was enacted to replace the old system. The Medicare fee schedule, implemented in January 1992, was based on an estimate of the resources required to provide each service, rather than having each provider set his or her own charges. Part B spending subsequently slowed dramatically (Exhibit 2). This resource-based relative value scale (RBRVS) has become the standard in the health insurance industry, with most private insurers using a form of RBRVS to set or negotiate rates.

Exhibit 2. Real Annual Growth Rate of Medicare Part B Spending per Beneficiary, Five-Year Intervals, 1975–2000



Source: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds. *2014 Annual Report* (Washington, D.C.: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds, July 28, 2014), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf>. Spending figures deflated by Consumer Price Index for All Urban Consumers, U.S. City Average, All Items (1982–1984=100).

Outpatient prescription drugs were not part of the initial Medicare benefit package. When Congress enacted Medicare prescription drug coverage in 2003, it was made available only through newly created private prescription drug plans. Those plans negotiate payment rates with pharmaceutical companies or contract with private pharmaceutical benefit managers. Unlike other countries, the U.S. does not negotiate pharmaceutical prices for the entire population—and it pays much higher prices for brand-name drugs.⁷

In 1982, Congress established the Medicare risk contracting program, which provided an alternative option for enrollees who chose to obtain their Medicare benefits from private managed care plans. In 1997 and again in 2003, Congress expanded the number and scope of private plans available through this program, now called Medicare Advantage. Medicare Advantage plans receive a monthly payment for each Medicare beneficiary enrolled in the plan, based on the location, age, and health status of the beneficiary. The fixed per-member per-month payment should give the plan a financial incentive to provide more coordinated, effective, and efficient care—but payments to Medicare Advantage plans historically have exceeded what their enrollees were expected to cost in

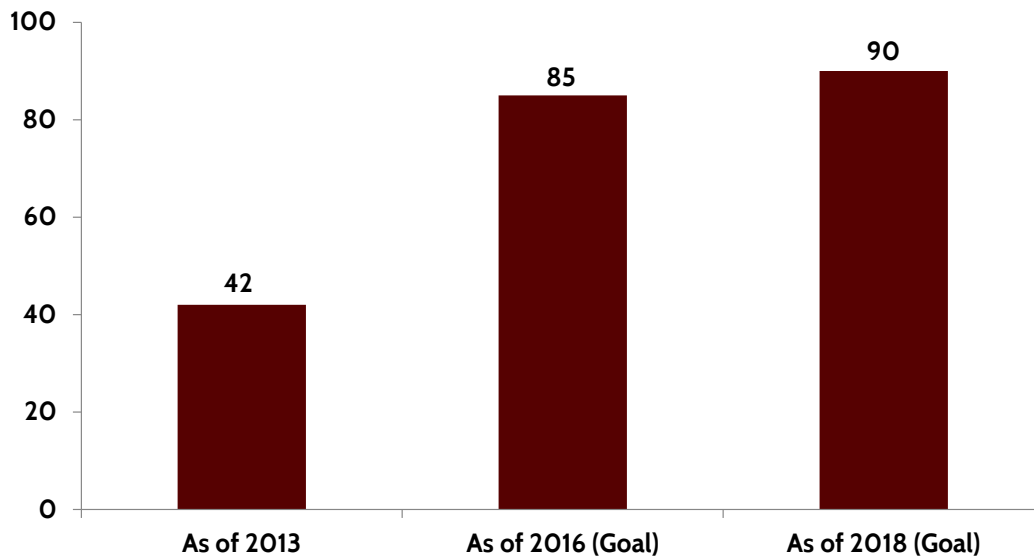
traditional Medicare, diluting the incentive for efficiency; moreover, although Medicare Advantage plans receive a fixed payment per enrollee, it is not clear how those incentives influence the way the plans actually pay their providers.⁸

MOVING THE FOCUS OF PAYMENT POLICY FROM VOLUME TO VALUE

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. The ACA 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.⁹

The HHS secretary 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 2018.¹⁰ 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 3).¹¹ 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.

Exhibit 3. Percentage of Traditional Medicare Payment Tied to Quality or Value, and Goals for the Future



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

In addition, Medicare Advantage plans, which cover 30 percent of Medicare beneficiaries as of 2014, are now financially rewarded under the ACA for receiving a high rating based on their performance on measures of quality and patient experience.¹² 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.

Payment Approaches That Reinforce Quality

Medicare provides bonuses to hospitals and other providers that achieve top-level scores on patient outcomes and care experiences. As of 2015, 1.5 percent of base payments for more than 3,500 hospitals is withheld and used to reward top-performing hospitals for the quality of their care and their patients' experiences of care; this amount increases to 2.0 percent by 2017.¹³ A similar program was initiated in 2015 for physicians in larger practices, and will expand to include all physicians by 2018.¹⁴

Several ongoing initiatives involve penalties for specific indicators of poor performance. One such program focuses on hospital readmissions; for several decades, almost 20 percent of Medicare beneficiaries who were hospitalized were readmitted within 30 days.^{15,16} The Medicare program began to target specific surgical procedures and medical conditions, with the expectation that the list would expand over the years; in just a few years, the overall rate of readmissions has dropped below 18 percent.¹⁷ Another initiative penalizes hospitals with higher-than-expected rates of hospital-acquired conditions; those conditions decreased across all hospitals by 17 percent between 2010 and 2013.¹⁸

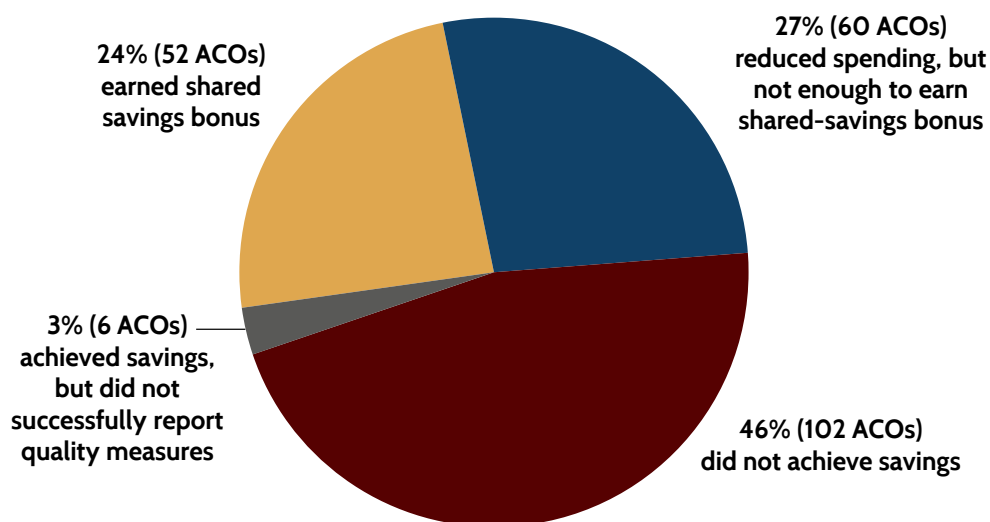
In the MACRA legislation, a merit-based incentive payment system (MIPS) will be established, beginning in 2019, that will combine several current value-based purchasing initiatives and will tie payment more closely to measures of performance.¹⁹ The success of these efforts will depend greatly on the ability to develop metrics that are viewed by a broad spectrum of stakeholders as accurate measures of performance—an endeavor that has made great progress but still faces substantial challenges.²⁰

Alternative Payment Models That Reward Value

The ACA created the Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs), which are groups of providers who accept joint responsibility for the quality and cost of the Medicare patients they treat and can share in the savings they generate as compared with a cost target.²¹ The ACA also created the Center for Medicare and Medicaid Innovation (CMMI) to develop and test value-based alternative payment methods.^{22,23} Many of those initiatives represent more far-reaching reforms, and put providers at financial risk for a portion or all of the cost of providing Medicare services. Among the most prominent activities being conducted by the CMMI are several aimed at transforming primary care, and several of its models involve a bundled payment for specified sets of hospital and/or postacute care related to specific procedures or conditions.²⁴

Accountable Care. The MSSP began in 2012; as of April 2015, there were more than 400 ACOs participating in the program, serving more than 7 million Medicare beneficiaries in 49 states, the District of Columbia, and Puerto Rico.²⁵ Early results from the MSSP participants indicate that, as a whole, they have achieved modest savings and generally improved the quality of care.²⁶ In the first year, 54 percent of the organizations for which results were available spent less than their targets, and 24 percent saved enough to earn shared-savings bonuses (Exhibit 4).²⁷

Exhibit 4. Medicare Shared Savings Program: Year 1 (2013) Performance of Participating ACOs



220 Medicare Shared Savings Program ACOs

Source: M. Abrams, R. Nuzum, M. Zezza, J. Ryan, J. Kiszla, and S. Guterman, *The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years* (New York: The Commonwealth Fund, May 2015).

The CMMI designed the Pioneer ACO Model for early adopters of coordinated care. It offers both upside shared savings and downside risk for losses in return for a larger share of achieved savings.²⁸ When it began in 2012 there were 32 participating organizations in 18 states; the number of Pioneer ACOs has fallen to 19 as of 2015, but most of the organizations that left the initiative switched to the MSSP. Over the first two years of the program, total Medicare expenditures increased more slowly for beneficiaries aligned with Pioneer ACOs than for beneficiaries in traditional Medicare, with little difference in patient experience.²⁹ These findings established the Pioneer ACO Model as the first CMMI initiative to meet the ACA criteria (proven potential to reduce Medicare spending while maintaining the quality of care) for expansion to other areas and organizations.

Primary Care Transformation. Since 2012, the Centers for Medicare and Medicaid Services (CMS) has been collaborating with commercial and state health insurance plans to offer population-based care management fees and shared-savings opportunities to participating primary care practices in order to support prevention, access to care, care coordination, chronic care management, and shared decision-making among patients and their providers. As of February 2015, the Comprehensive Primary Care (CPC) initiative includes 480 sites in seven regions, including more than 2,700 providers who serve 2.7 million patients, of which 400,000 are Medicare and Medicaid beneficiaries. Altogether, there are 38 public and private payers participating in this initiative.³⁰ Results from the first year are mixed: there was a statistically significant reduction in total Medicare expenditures per beneficiary, but not quite enough to offset the care management fees paid to the practices; several quality measures improved among participants, but none of the changes was statistically significant.³¹

Through the Multi-Payer Advanced Primary Care Practice demonstration, begun in 2011, CMS is participating in multi-payer reform initiatives currently under way in eight states to make advanced primary care practices more available.³² The demonstration, which was originally planned for three years, has been extended through 2018; it is anticipated that approximately 1,200 medical homes, serving more than 900,000 Medicare beneficiaries, will participate. In the first year, only two of the seven states for which data were available generated savings; no evidence is yet available on access to or quality of care.³³

Although the initial results have been mixed, these models do show some promise for providing vehicles for increasing the emphasis on primary care and facilitating more coordinated care. More time may be needed to overcome the adverse incentives and fragmented delivery and payment systems that still predominate in the U.S. health system.

Bundled Payment. Bundled payment is designed to provide financial incentives to improve the continuity and effectiveness of care, reduce the use of unnecessary services, and slow spending growth by creating financial incentives for providers to coordinate care across settings.³⁴ The CMMI has developed the Bundled Payments for Care Improvement (BPCI) initiative, which provides a single payment amount for a specified course of inpatient and/or post-hospital care. Four payment models cover different combinations of those services, with almost all of the approximately 7,000 participating providers opting for Model 2 (acute and postacute care episodes) or Model 3 (postacute care only).³⁵ Evaluation of first-year performance indicates that Model 2 may decrease variation in the use of postacute care, which has been a major factor in health spending differences across regions.^{36,37}

Progress, But a Long Way to Go

The testing of alternative payment models is still in an early stage. General evaluations have found gains in quality and modest savings, but the results so far have been mixed. There is some evidence that, as experience with alternative payment models accumulates, savings can increase.³⁸ Key requirements for success include setting incentive payments so that they align with potential savings; targeting interventions that help high-cost, high-need individuals avoid unnecessary hospitalization or emergency room use³⁹; and aligning policies among public and private insurers.

STRATEGIES FOR EXPANDING VALUE-BASED PAYMENT

One powerful tool that the HHS secretary possesses is the authority, granted by the ACA, to adopt innovations found to save money and improve quality for use throughout the Medicare program. In addition to continuing to test how well different incentives improve value, HHS is focused on improving the way care is delivered through learning networks such as the recently announced Health Care Payment Learning and Action Network.⁴⁰ It also aims to increase the availability of information to guide decision-making, by increasing the use of health information technology, enhancing transparency, and generating information through the Patient-Centered Outcomes Research Institute that can guide care decisions.

As described above, the MACRA legislation provides strong impetus to support Medicare's movement toward value-based payment: it provides 5 percent fee increases to physicians who receive a significant portion of their revenue from an alternative payment model, such as a blended, bundled, or global payment model, or from care provided through patient-centered medical homes or ACOs. In addition, MACRA provides funding to

increase the rewards for providers who achieve exceptionally high performance on measures of health care quality, patient experience, and efficiency. Further legislation may be necessary to fix the flawed fee-for-service physician payment system, since it is likely to remain a component of payment methods for some time.⁴¹

To accelerate movement away from fee-for-service payment with no link to value, it may be necessary to continue to widen the differential in payment rates for providers that participate in value-based payment models. Rewarding beneficiaries for seeking care from high-value providers would align provider and beneficiary incentives, and could go a long way toward supporting the success of those incentives.⁴² It would require that beneficiaries be given access to useful information on the prices and quality of participating providers.

Finally, the move to value-based payment will be much more effective if Medicare continues to actively seek partnerships with private insurers, state Medicaid, and other federal programs that adopt value-based payment methods. The ultimate goal is to transform the delivery of care for everyone, improving patient outcomes and care experiences, preventing avoidable hospitalization, and lowering costs. Reducing or eliminating avoidable, unnecessary, and ineffective care, and redeploying those savings to provide better financial protection and lower federal outlays, would be a major step toward improving the financial sustainability of the Medicare program in particular, and the U.S. health system in general.

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Modernizing Medicare's Benefit Design and Low-Income Subsidies to Ensure Access and Affordability

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Insurance coverage through the traditional Medicare program is complex, fragmented, and incomplete—a patchwork quilt that creates confusion for beneficiaries, generates high administrative costs, and undermines coverage and care coordination. Most important, Medicare does not limit out-of-pocket costs, nor does it ensure adequate financial protection for beneficiaries with low incomes and serious health problems. The integrated-benefit option proposed here aims to reduce cost burdens, strengthen Medicare, and enhance the program's role in stimulating health system innovation.

BACKGROUND

Over the past 50 years, Medicare has been meeting its goals of enhancing access to health care and providing financial protection against high health costs for its elderly and disabled beneficiaries.^{1,2} Still, Medicare's outdated benefit design fails to limit beneficiaries' out-of-pocket costs for covered benefits, and the financial protection provided to low-income beneficiaries falls far short of what the Affordable Care Act offers to the under-65 population. This brief examines illustrative policy options that would, in combination, modernize Medicare's benefits, improve health care access and affordability for low-income beneficiaries, and reduce coverage complexity.

There is a pressing need for reform. An estimated 20 million of Medicare's 52 million beneficiaries live on incomes below 200 percent of the federal poverty level. Nine million beneficiaries have complex care needs with serious functional limitations that hinder their ability to carry out daily activities.³ Although the poorest are eligible for Medicaid to supplement Medicare, under current policies beneficiaries with low or modest incomes are eligible for only limited help with paying for premiums or medical care expenses.

The absence of a ceiling on out-of-pocket costs can undermine the financial security and exhaust the resources of even higher-income beneficiaries. That's why most beneficiaries supplement Medicare's core benefits with coverage sold by private insurers, often purchasing multiple plans. This fragmented coverage is inefficient, generates high administrative costs, and undermines efforts to improve coordination of patient care and prevent avoidable hospitalizations. With many beneficiaries filling in Medicare's deductibles and coinsurance with supplemental coverage, there is also little opportunity to use financial incentives to encourage the use of higher-value, lower-cost care.

To modernize Medicare's core benefits and update policies related to low-income beneficiaries, the brief discusses two complementary options. The first would offer a new Medicare-sponsored plan choice. Available for an extra premium, it would provide an integrated design with prescription coverage, more-affordable cost-sharing, and a limit on out-of-pocket costs—making supplemental coverage unnecessary. The second option would expand subsidies for Medicare's premiums and reduce cost-sharing for beneficiaries with incomes up to 200 percent of the federal poverty level in ways that align with the Affordable Care Act's policies for the under-65 population.

We discuss how the two policies could reinforce each other and strengthen Medicare's ability to provide beneficiaries with greater security, while creating a platform for future program innovation. Modernizing Medicare's benefit design and expanding low-income policies together have the potential to lower administrative costs and smooth transitions as adults become eligible for Medicare.

CURRENT MEDICARE BENEFITS AND LOW-INCOME PROVISIONS

Medicare has separate deductibles and cost-sharing provisions for Part A hospital, skilled nursing facility, and home health services and for Part B physician, lab, and diagnostic benefits, with no limit on annual out-of-pocket spending for covered services. Part A includes a \$1,216 deductible per hospital episode and substantial cost-sharing for longer-term hospitalization or skilled nursing stays after a hospitalization. Part B has a \$104.90 monthly premium (\$1,259 per year per person), a separate \$147 annual deductible, and open-ended coinsurance of 20 percent for physician services (including surgeons and other hospital inpatient physicians), therapy, durable medical equipment, and outpatient services with no limit on out-of-pocket spending.

For prescription drug coverage, beneficiaries must buy a Part D plan with a separate premium that averages around \$440 a year plus a deductible and cost-sharing that varies across private plans. The Affordable Care Act (ACA) is phasing out Medicare's gap in drug coverage—the “doughnut hole”—but beneficiaries requiring specialty drugs or multiple medications can still face substantial costs.

Supplemental private coverage to fill in Medicare's deductibles and cost-sharing is costly, with Medigap premiums adding over \$2,000 a year, depending on geographic area. It is also inefficient, with 20 percent of the premium, on average, going toward administrative costs.⁴

Some low-income beneficiaries are eligible for assistance paying their Parts A and B cost-sharing and Part B premiums.⁵ Medicaid covers Medicare cost-sharing up to 100 percent of the poverty level and provides subsidies for Part B premiums up to 135 percent of poverty for those meeting income and asset tests.⁶ Personal asset limits for beneficiaries seeking extra help with Medicare premiums or cost-sharing are \$7,160 for an individual and \$10,750 for a couple (in 2014). The complexity of separate enrollment through Medicaid deters some poor Medicare beneficiaries from participating. Just half of beneficiaries with incomes below \$10,000 and only a fifth of

those with incomes up to \$20,000 have Medicaid supplements for Medicare coverage. (Appendix Table 1 shows the distribution of beneficiaries by income level.)

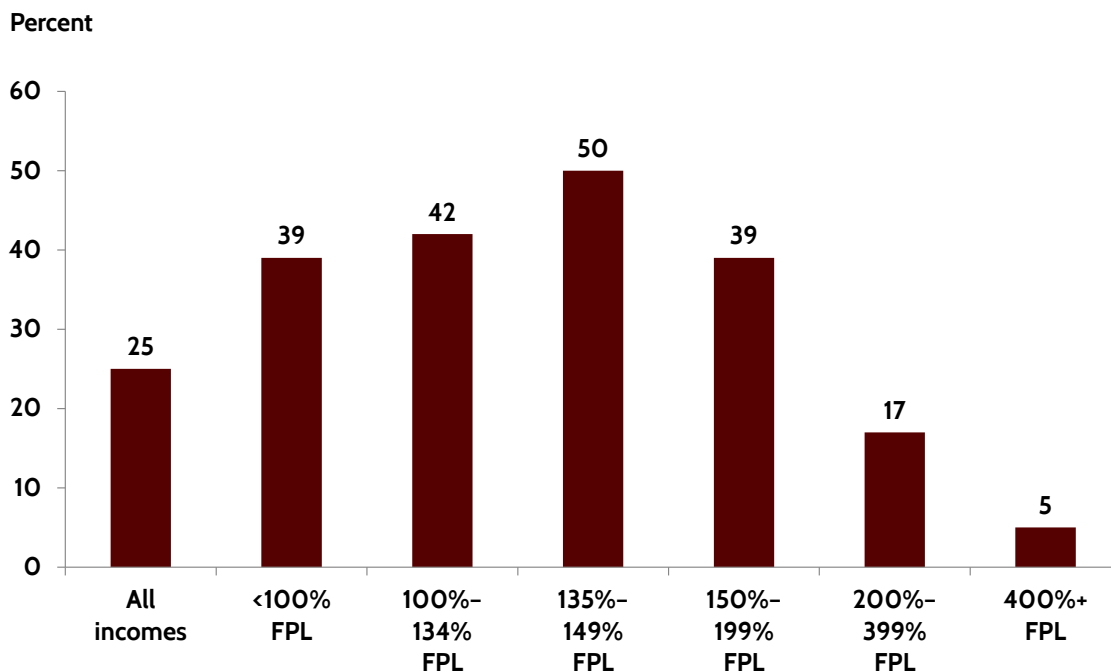
Low-income beneficiaries apply separately to Medicare for help with Part D. Medicare administers subsidies for Part D cost-sharing and premiums on a sliding scale up to 150 percent of poverty. The Part D asset limit is \$13,300 for individuals and \$26,580 for couples, with lower limits for full premium subsidies.

In contrast to Medicare, the ACA eliminates asset tests and provides substantial premium and cost-sharing subsidies up to 200 percent of poverty for the under-65 population and expands Medicaid to 138 percent of poverty for participating states.⁷ ACA provisions exclude Medicare beneficiaries. As a result, lower-income older adults who age into Medicare will face increased financial burdens for coverage and care.

UNDERPROTECTED AND UNDERINSURED MEDICARE BENEFICIARIES

Facing gaps in benefits and premium costs, an estimated 25 percent of all beneficiaries and 40 percent with incomes below twice the poverty level spent 20 percent or more of their income for premiums plus medical care costs in 2014.⁸ As Exhibit 1 illustrates, the percentage of beneficiaries with high cost burdens falls sharply for those with incomes above 200 percent of poverty—to less than half the levels experienced by low-income beneficiaries.⁹

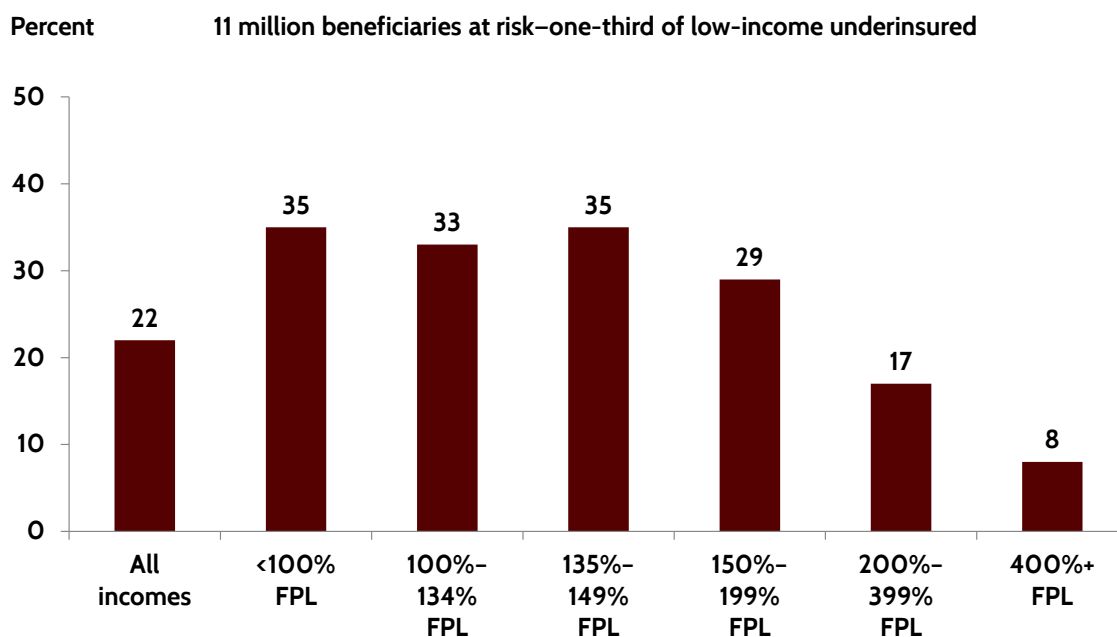
Exhibit 1. Proportion of Medicare Beneficiaries Spending 20 Percent or More of Income on Premiums and Medical Costs



Source: Analysis of 2010 Medicare Current Beneficiary Survey, projected to 2014.

An estimated one of five beneficiaries—11 million people—spent at least 10 percent of their income on medical care alone in 2014, not including premiums. Despite having Medicare, they were underinsured, spending a high share of their income on medical care.¹⁰ The risk of being underinsured was highest for low-income beneficiaries: an estimated one-third of those with incomes up to 150 percent of poverty, and 30 percent of those with incomes between 150 percent and 200 percent of poverty were underinsured, which is at least twice the rate for beneficiaries with higher incomes (Exhibit 2). On average, about half of low-income beneficiaries’ out-of-pocket costs were for Medicare covered benefits including prescription drugs; remaining costs were for dental, hearing, and long-term care services beyond those covered by Medicare.

Exhibit 2. One of Five Medicare Beneficiaries Underinsured—Spent 10 Percent or More of Income on Medical Care Alone (premiums excluded)



Source: Analysis of 2010 Medicare Current Beneficiary Survey, projected to 2014.

Such high financial burdens undermine access to care, deplete incomes, and drain resources. Notably, a recent study found that the elderly in the United States are far more likely to go without care because of the cost and face problems paying medical bills than their counterparts in 10 other high-income countries. Beneficiaries with complex care needs are particularly at risk.¹¹

POLICY OPTIONS TO MODERNIZE BENEFITS AND IMPROVE LOW-INCOME PROTECTIONS

To improve current Medicare benefits so that beneficiaries will not need to obtain supplemental coverage, and to expand low-income provisions under Medicare to provide adequate financial security for low- and modest-income beneficiaries, we suggest two related policies. The first policy, which we call “Medicare Essential,” would modernize Medicare’s benefit design by offering a new option for a supplemental premium sponsored by Medicare with integrated benefits, including prescription drugs. The second would protect low-income beneficiaries by expanding premium subsidies and reducing cost-sharing for beneficiaries up to 200 percent of poverty with the expanded assistance provided directly by Medicare.

Medicare Essential

Modernizing Medicare’s benefit design through the introduction of a new option, sponsored by Medicare, that features integrated benefits and an out-of-pocket-cost limit for all covered services would obviate the need for supplemental coverage. Such an option would reduce insurance complexity for beneficiaries, lower administrative costs now incurred by private plans, and enable Medicare to implement value-based incentives that reduce cost-sharing for beneficiaries seeking care from high-quality, lower-cost providers.¹² Such flexibility would complement federal payment policies to promote primary care, coordination, and care system innovations.

Exhibit 3 presents an illustrative benefit design for the Medicare Essential option and contrasts it with Medicare’s current core provisions. The illustrative design includes an overarching limit on annual out-of-pocket expenses and one deductible, with exemptions for preventive care, primary care, and prescription drugs. The design eliminates cost-sharing for hospital care after the deductible. For physician care, patients make copayments for primary care, specialists, and emergency department use. Cost-sharing for other Part B services with cost-sharing is reduced from the current 20 percent to 10 percent. A new overall limit on out-of-pocket costs for covered services includes prescription medications. To model the potential premium costs and impact on beneficiaries, we set the out-of-pocket limit at \$3,400 and the deductible at \$250.

Beneficiaries selecting this option would pay an extra premium set to fully finance the enhanced benefits. The extra premium would be added to the current Part B premium, in one monthly charge that would cover Parts A, B, and D benefits within an integrated insurance plan.

The extra premium for this new option, with drug benefits, comes to an estimated \$85 per month in 2014, in addition to Part B.¹³ At this level, the option would offer a lower-cost, simpler alternative to purchasing Medigap and Part D plans. Compared with Medigap plans that enroll the greatest number of beneficiaries (Plan F), beneficiaries would experience significant savings in premiums (about \$1,500 a year), although with somewhat higher cost-sharing.¹⁴

The combined Part B and Medicare Essential premium would likely be beyond the reach of low-income beneficiaries. Thus, expanded subsidies (described below) for low- and modest-income beneficiaries would be needed to work in tandem with Medicare Essential. If both policies were enacted, lower-income beneficiaries would be more likely to rely on the expanded low-income policies. Medicare Essential as a voluntary option would be more likely to appeal to those with incomes above 200 percent of poverty.

Exhibit 3. Illustrative Benefit Design to Offer New “Medicare Essential” Choice

	Medicare Essential	Current Medicare A, B, D
Benefit design	Integrated cost-sharing and incentives. Benefits include prescription drugs.	Parts A, B, and D (drugs) separate.
Deductible	Single \$250 annual deductible for all services. Exemptions for primary care (if registered with a primary care practice), preventive care, and prescriptions.	Hospital: \$1,216 per episode. Part B: \$147 per year.
Hospital cost-sharing	None.	\$304 per day for days 61 to 90.
Physician cost-sharing	\$20 primary care/\$40 specialist visit/\$50 emergency department (except for accidents and other urgent care).	20% open-ended; includes doctors for hospitalizations.
Other Part B services	10% coinsurance (therapy and durable medical equipment).	20% coinsurance.
Home health	None.	None.
Skilled nursing home	\$80 per day for days 21-100.	\$152 per day for days 21-100.
Prescription drugs	No deductible. Low/no cost-sharing for essential medications, low-cost for generics; 25% coinsurance for nonpreferred brand. Reference pricing.	Varies. Standard deductible \$310; cost-sharing 25% multiple tiers.
Out-of-pocket limit	\$3,400 annually for all covered services, including drugs.	None.
Illustrative value incentives*	No deductible for primary care if beneficiary is registered with a practice; \$10 per-visit cost-sharing for those enrolled in primary medical home practice. No deductible if referred by medical home or using high-value medical groups or networks. Out-of-pocket limit lowered to \$2,000 for patients using certified high-value accountable care network or care team.	None.
Monthly premium**	Estimated \$85 a month, including prescription drugs, plus Part B at \$104.90.	Part B: \$104.90 monthly. Part D: \$37 monthly average.

* For a discussion of Medicare Essential’s value-based design and value-incentives, see K. Davis, C. Schoen, and S. Guterman, “[Medicare Essential: An Option to Promote Better Care and Curb Spending Growth](#),” *Health Affairs*, May 2013 32(5):900-9.

** Premium estimate of Medicare Essential premium for 2014 assumes that all beneficiaries with Medigap and Medicare with incomes above 200 percent of poverty participate and that beneficiaries with employer-sponsored health insurance and Medicare Advantage remain with their current coverage.

New Protections for Low-Income Beneficiaries

Aligning Medicare's low-income protections with the ACA's reforms for people under 65 would require an expansion of premium subsidies on a sliding scale relative to income and a reduction of cost-sharing up to 200 percent of poverty. An illustrative option could include:

- Expansion in eligibility for Part B premium subsidies from 135 percent of the federal poverty level to 200 percent based on a sliding scale using ACA contribution rates.
- For those with incomes between 100 percent and 200 percent of poverty and not eligible for Medicaid, reduced cost-sharing for Medicare benefits and a new annual limit on out-of-pocket costs.
- For all beneficiaries with incomes below poverty, full Part B premium subsidies and minimal cost-sharing for Medicare services through Medicaid. (Those wishing to do so could opt to receive the more limited assistance available to beneficiaries just above poverty.)
- Elimination of the asset test for all beneficiaries. Following the ACA, annual income alone would determine eligibility for premium subsidies and reduced cost-sharing.

For illustrative purposes, we have specified the benefits to include: a unified deductible of \$250 a year, no separate deductible for hospital care, low copayments for visits, reduced coinsurance for other Part B benefits, and an out-of-pocket limit of \$2,000 for Parts A and B services. This design seeks to be in the actuarial value range for subsidized benefits for low-income adults in health plans offered in the ACA's insurance marketplaces.¹⁵

To streamline the application process, Medicare, rather than Medicaid, would administer and fund the expanded premium and cost-sharing subsidies for newly eligible beneficiaries who do not qualify for full Medicaid. There would be just a single application to fill out. The policies would use the same definition of income and draw on existing federal administrative systems.

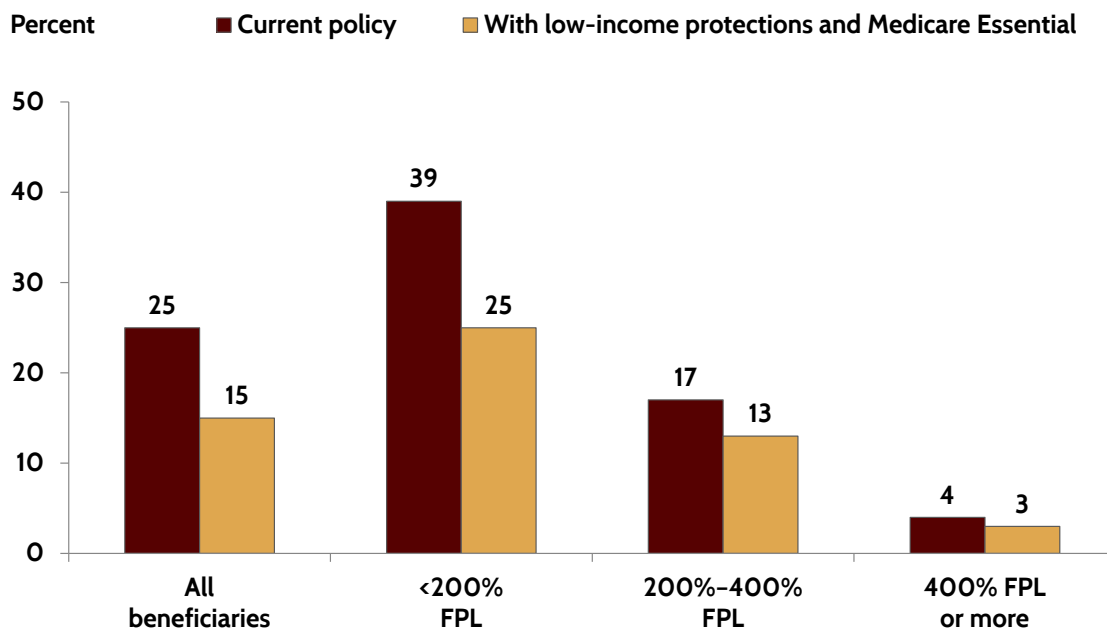
Impact of Illustrative Policies

The combination of Medicare Essential with expanded low-income provisions would represent an attractive new integrated option for beneficiaries with higher incomes and supplemental private coverage. The estimated monthly cost, including drugs, would be more affordable than what is currently available in the Medigap marketplace, largely as a result of lower administrative costs. If all current higher-income beneficiaries with Medigap, as well as all those with Medicare only, were to participate in such an option, an estimated 4 million of them would have lower costs.

If all beneficiaries who are income-eligible received the expanded low-income help, we estimate that the combination of Medicare Essential and the new low-income provisions would reduce from 25 percent to 15 percent the proportion of beneficiaries now paying 20 percent of their income or more on health care and premiums (Exhibit 4). Not surprisingly, those with incomes below 200 percent of poverty would experience the biggest difference: the proportion of these individuals spending at least a fifth of their income would drop from 39 percent to 25 percent. But even beneficiaries with incomes between 200 percent and 400 percent of poverty would benefit from Medicare Essential, with the proportion paying 20 percent or more dropping from 17 percent to 13 percent.

Exhibit 4. Impact of Two Policies (2014)

Proportion paying 20 percent or more of income on care and premiums



Source: Analysis of 2010 Medicare Current Beneficiary Survey, projected to 2014; modeled illustrative policies.

The share of beneficiaries who would remain underprotected reflects the limits of Medicare's benefit package, which excludes important high-cost services such as hearing aids, dental care, and long-term care services and supports.¹⁶

SUMMARY AND DISCUSSION

Medicare's current fragmented benefit design and inadequate subsidies for low-income beneficiaries result in particularly high out-of-pocket cost burdens for beneficiaries living below 200 percent of poverty. The cost burden puts their access to care at risk as well as their ability to afford care, causing many to forgo other necessities or go into debt.

Expanding eligibility for low-income subsidies well beyond the poverty level will be necessary to provide financial protection for those most at risk. Doing so would promote equity and mirror the ACA's provisions for the under-65 population, thereby smoothing transitions for people as they enter the Medicare program. To streamline enrollment and lower administrative costs, eligibility for premiums and cost-sharing help could be determined through a website with a single application.

As a companion policy, Medicare Essential could be designed so that the premium fully finances the enhanced benefits at no cost to the federal budget. Medigap policies currently incur high administrative costs, averaging 20 percent of premiums.¹⁷ Medicare Essential would likely be particularly attractive for beneficiaries currently buying Part D and Medigap policies, as they would realize substantial premium savings from lower overhead costs and having an integrated plan with prescription drugs. Since recent reforms prohibit Medigap policies from first-dollar coverage, Medicare Essential would be competitive with private supplemental policies, all of which include at least some cost-sharing.¹⁸

To the extent that a substantial share of beneficiaries now purchasing Part D plans opt for Medicare Essential, Part D pharmacy benefit managers (PBMs) would need to be selected by Medicare to administer the drug benefit to retain their markets. Some PBMs would likely be displaced. As this market is already highly concentrated and leading PBM groups now compete to participate in integrated plans for the under-65 population, this transition should be possible with only modest disruption in drug-pricing arrangements. By integrating the pharmacy benefit, Medicare would in the future be able to use its purchasing power, as well as follow value-based design principles, to ensure access to effective and essential medications.

Cost-sharing for all covered services could be structured to encourage beneficiaries to seek high-value care. Enabling such a flexible benefit design would strengthen Medicare's already significant role in providing a national platform to improve health system performance on behalf of the entire population. This leverage depends on Medicare being given the authority to adjust cost-sharing based on the value of services, as recommended by the Medicare Payment Advisory Commission (MedPAC) in a recent report.¹⁹ Over time, if the value-based approach spurred delivery system innovation, potential savings would accrue to families, public programs, and private employers.²⁰

In contrast to premium-support proposals, which would shift financial risk to beneficiaries if medical costs rise above some target rate, an approach like Medicare Essential would strengthen Medicare's ability to address costs over time.²¹ That's because it uses payment incentives for providers and incentives for patients to choose lower-cost, higher-quality care. By offering an integrated benefit option, traditional Medicare would provide new competition for the Medicare Advantage private plan market.

Enhancing traditional Medicare's core benefits in this way would begin to phase out Part A and Part B cost-sharing and revamp Medicare's core benefits with an out-of-pocket maximum. However, an additional monthly premium would be needed to avoid high cost-sharing. In contrast, MedPAC examined a more integrated design with an out-of-pocket maximum and the restriction that the Part B premium could not increase. This constraint resulted in a \$500 deductible, a \$750 per hospital admission copayment, and a \$5,000 annual out-of-pocket maximum.²² Faced with such cost-sharing, beneficiaries would likely continue to buy supplemental coverage for fear of incurring high costs if they become sick.

Federal Budget Costs

Although Medicare Essential could be designed to be self-financing, federal spending would be necessary to pay for expanded low-income premium and cost-sharing subsidies. We estimate an annual cost of over \$10 billion if all income-eligible beneficiaries participated.²³ To reduce federal budget outlays, low-income provisions could initially be limited to 150 percent of the poverty level. Policies could also be phased in, beginning with expanding premium

subsidies to 150 percent of poverty as recommended by MedPAC.²⁴ Or phasing could start with reduced cost-sharing up to 135 percent of poverty.

Some of the options listed by the Congressional Budget Office (CBO) or recommended by MedPAC could be adopted to finance federal costs. For example, CBO estimates that either expanding Part D rebates for low-income beneficiaries or increasing alcohol and cigarette taxes would yield more than \$100 billion in federal savings or revenues over a decade.²⁵ Simplifying enrollment and avoiding the need to supplement Medicare would also yield administrative savings that could be redeployed to improve benefits.

Together, the policy options we describe could offer the potential for future savings that would accrue not only to Medicare beneficiaries, but to the nation as a whole.

APPENDIX TABLE 1. DISTRIBUTION OF MEDICARE BENEFICIARIES BY POVERTY AND COVERAGE (ESTIMATED 2014)

	Medicare only	Medicaid	Employer	Medicare Advantage	Medigap	Total
People (millions)	5.2	8.9	20.0	10.7	7.9	52.7
Poverty distribution—Share of each group						
<100% poverty	15.1%	54.6%	2.2%	7.5%	5.2%	13.8%
100%–134% poverty	20.1%	27.3%	4.0%	10.4%	10.3%	11.8%
135%–149% poverty	5.0%	3.9%	2.0%	5.1%	3.5%	3.5%
150%–199% poverty	17.0%	9.1%	8.2%	15.3%	11.6%	11.2%
200%–399% poverty	30.3%	4.7%	38.1%	39.9%	38.5%	32.2%
400%+ poverty	12.5%	0.5%	45.3%	21.7%	30.9%	27.6%

Source: Based on Medicare Current Beneficiary Survey 2010 distribution inflated to 2014 Medicare beneficiary count.

STUDY METHODS AND DATA

We used the 2010 Medicare Current Beneficiary Survey (MCBS), inflated to 2014 and projected enrollment, to assess current financial burdens and the impact of the specified policy options. The 2010 Cost and Use files provide detailed information on out-of-pocket costs, including out-of-pocket spending on premiums and benefits not covered by Medicare and premiums paid for private plans. The nationally representative sample of beneficiaries has sufficiently robust sample sizes to examine subgroups by income.

In the analysis, we divided beneficiaries into poverty groups that correspond to current Medicare low-income policies and ACA thresholds for premium and cost-sharing subsidies. For married couples, the MCBS asks about costs only for the person interviewed but reports the couple's total income. Thus, estimates of out-of-pocket costs as a share of income understate burdens for married couples—the estimates miss premium and care costs for the spouse.

We used income reported in the MCBS compared with poverty thresholds to determine likely eligibility for expanded subsidies. In modeling the impact of expanding premium subsidies up to 200 percent of poverty, we assumed that all would be eligible except those with employer-based retiree coverage.

To assess the impact of provisions to reduce Medicare-related cost-sharing, we used information on total liability for Medicare-covered services and modeled the change in out-of-pocket costs with the specified change in benefit design for beneficiaries eligible to participate. We restricted participation to beneficiaries enrolled in traditional Medicare with Medicare only, Medigap, or Medicaid, excluding those with Medicare Advantage and employer-sponsored supplements. To simplify modeling, we assumed that all income-eligible beneficiaries with Medicare only, Medigap, and Medicaid above 100 percent to 200 percent of poverty would participate in the new low-income expansion for Medicare reduced cost-sharing. We modeled the impact of the specified reforms assuming full implementation and participation in 2014.

For Medicare Essential, we assumed only those with incomes above 200 percent of poverty would participate and pay the added premium. For simplicity, we assumed that all beneficiaries with incomes above 200 percent of poverty currently with Medicare only, Medigap, or Medicaid would participate. And beneficiaries with employer-sponsored insurance or Medicare Advantage would retain current coverage. We modeled just one year as if fully implemented in 2014. We did not model the potential dynamic longer-term impact on total spending if positive incentives succeeded in accelerating delivery system innovation to yield future cost savings.

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06



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SERVING OLDER ADULTS WITH COMPLEX CARE NEEDS: A New Benefit Option for Medicare

Marilyn Moon, Ilene L. Hollin, Lauren H. Nicholas, Cathy Schoen, and Karen Davis

A long-recognized shortcoming of Medicare is its lack of coverage for home- and community-based services. As lifespans lengthen, Medicare must adapt so that it can help more older adults avoid institutional care. In this chapter, the authors envision a new benefit option geared toward beneficiaries with multiple chronic illnesses or long-term physical or cognitive impairment. The new benefit would cover all nonmedical services that support independence, allow services to be tailored to each beneficiary's needs, and ensure that cost-sharing is affordable.

BACKGROUND

Analysts of the Medicare program have long noted that it does a poor job serving those with multiple chronic illnesses. Most conspicuous is its lack of coverage for home- and community-based services, which enable seniors with complex conditions to live independently.

While home- and community-based services are covered through state Medicaid programs, less than a third of Medicare beneficiaries with complex care needs are covered by Medicaid (the so-called dual eligibles). Low- and modest-income Medicare beneficiaries not covered by Medicaid face significant obstacles—financial and otherwise—to obtaining these services. Even beneficiaries who can afford to pay out of pocket for noncovered services can find it challenging to identify reliable, competent personal care providers. Physicians, nurses, and other traditional health care providers often cannot make knowledgeable recommendations about community services, such as senior day care centers, support for caregivers, or other personal care providers. This can even be true for individuals in Medicare Advantage Special Needs Plans (Medicare managed care plans that cover dual eligibles and facilitate coordination with Medicaid benefits), unless the contracting entity offers its enrollees a highly coordinated program.

Medicare has tried an array of approaches to delivering care more effectively to high-risk Medicare beneficiaries, with mixed results. Although the proportion of beneficiaries requiring complex care for multiple conditions is relatively small—an estimated 17 percent—care provided to this group accounts for 32 percent of Medicare spending on noninstitutionalized beneficiaries. Figuring out how to improve benefits for this population could have a positive impact on the entire Medicare program and on overall costs.

A new complex care benefit option for Medicare beneficiaries could improve patient and caregiver experience, help beneficiaries continue living at home, and reduce burdens on families who now try to patch together the resources needed to pay for care. One challenge is how to design a payment structure for a broader set of services that appropriately rewards providers of home and community care, thus helping to spread successful models of care more broadly.¹

This issue brief describes the characteristics and needs of Medicare beneficiaries who require complex care, the goals of a new benefit option that could be made available to this population, and a proposed structure that would both improve care and achieve savings.

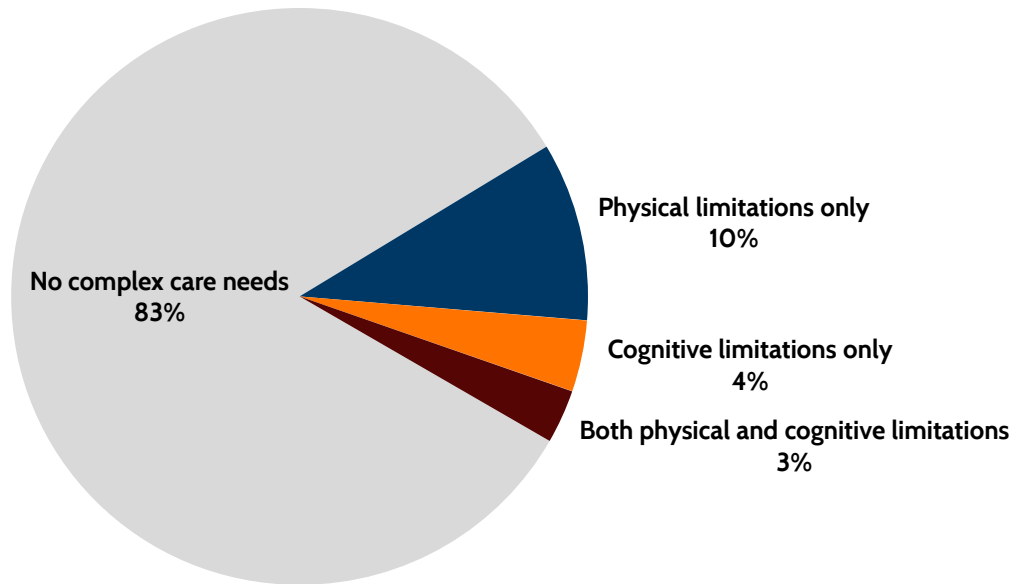
COMPLEX BENEFICIARIES AND THEIR NEEDS

Medicare beneficiaries meet our definition of “complex care beneficiaries” if they live at home or in the community, are not long-term residents of an institution such as a nursing, residential care, or assisted living facility, and have one or both of the following characteristics:

- Significant impairment in physical functioning—some difficulty with two or more activities of daily living, such as eating or bathing.
- Severe impairment in cognitive functioning (based on a summary cognitive impairment score covering immediate and delayed word recall, counting, naming, and vocabulary tasks), a self-reported diagnosis of Alzheimer’s or dementia, or the inability to complete the Health and Retirement Survey Questionnaire because of poor comprehension.

About 9 million Medicare beneficiaries meet this definition (Exhibit 1), of which 30 percent are eligible for Medicaid and about 32 percent are living below 200 percent of the federal poverty level but not covered by Medicaid (Exhibit 2).² This latter group is most at risk for being unable to pay for home and community services directly out-of-pocket, exhausting their limited savings, and entering a nursing home. where they can qualify for Medicaid after a short period.

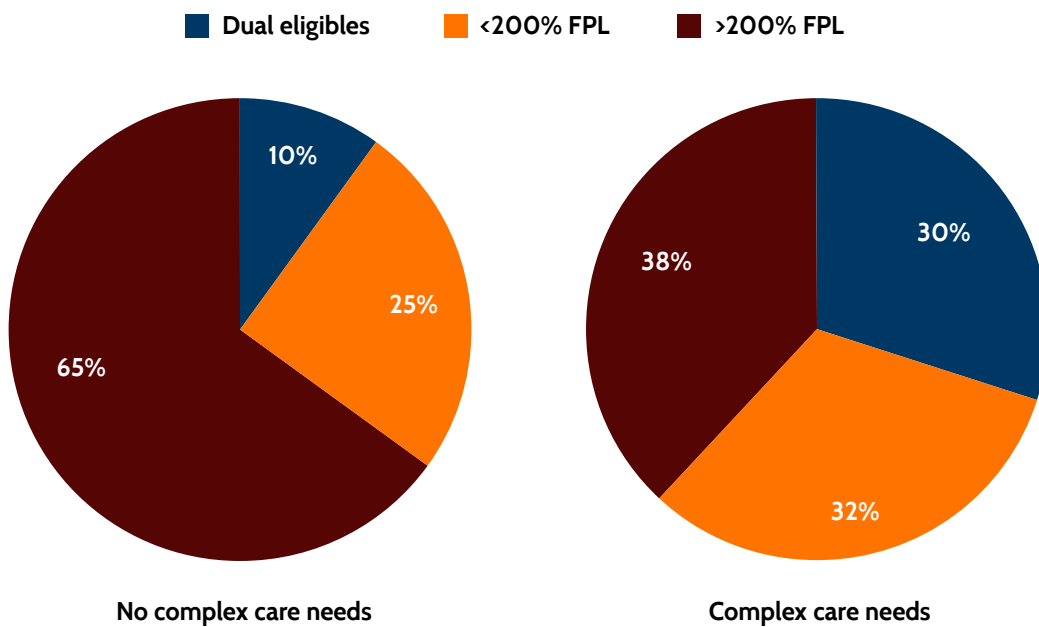
Exhibit 1. Beneficiaries with Complex Care Needs, Based on Eligibility Criteria



Note: n=12,549.

Source: Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health, based on Health and Retirement Survey, 2010.

Exhibit 2. Income Distribution of Beneficiaries with Complex Care Needs and Those Without, Across Income and Insurance Categories



Notes: FPL refers to federal poverty level. No complex care needs: n=9,279. Complex care needs: n=1,972.

Source: Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health, based on Health and Retirement Survey, 2010.

In 2010, Medicare’s mean payment for complex-needs beneficiaries was \$13,188, compared with the mean payment of \$5,754 for noncomplex beneficiaries (Exhibit 3). Out-of-pocket spending was also higher for the complex-needs group, with average annual spending at 17 percent of their income versus 7 percent for beneficiaries without complex needs. The spending gap between the two groups widens among beneficiaries who live below 200 percent of the federal poverty level but do not qualify for Medicaid.

Exhibit 3. Mean (Median) Annual Medicare and Out-of-Pocket Spending for Community-Dwelling Traditional Medicare Beneficiaries, 2010

Average annual Medicare spending

	All Medicare (n=10,638)	No complex care needs (n=8,836)	Complex care needs (n=1,802)
All Medicare	\$7,013 (\$1,140)	\$5,754 (\$978)	\$13,188 (\$3,137)
Dual eligibles	\$11,058 (\$2,491)	\$8,358 (\$1,706)	\$15,268 (\$5,097)
<200% FPL	\$5,360 (\$710)	\$4,404 (\$627)	\$8,965 (\$1,115)
>200% FPL	\$5,427 (\$1,010)	\$4,652 (\$940)	\$11,536 (\$2,280)

Average annual out-of-pocket spending as a percentage of household income

	All Medicare (n=7,989)	No complex care needs (n=6,767)	Complex care needs (n=1,222)
All Medicare	8.35% (2.15%)	6.73% (1.98%)	17.26% (3.73%)
Dual eligibles	6.52% (2.35%)	6.13% (2.19%)	7.31% (2.63%)
<200% FPL	21.06% (4.06%)	16.79% (3.86%)	38.62% (5.50%)
>200% FPL	3.60% (1.70%)	3.23% (1.59%)	6.70% (3.35%)

Note: Out-of-pockets costs are based on a two-year period and recalculated for annual average estimates. Household income includes respondent and spouse only. Dual eligibles qualify for Medicare and Medicaid. FPL refers to federal poverty level.

Source: Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health, based on Health and Retirement Survey, 2010, matched with Medicare records.

WHY MORE COMPREHENSIVE BENEFITS ARE NEEDED FOR COMPLEX CARE

Medicare provides better coverage (with less cost-sharing) for higher levels of care, and more restricted coverage for lower levels of care such as skilled nursing or outpatient therapy (which are subject to relatively low, arbitrary limits) and home health care (for which patients must meet criteria such as being homebound and requiring care of skilled nurses). In addition, some social services that might be essential for patient care, quality of patient experiences, and independent functioning are not covered by Medicare if they are not deemed medical in nature and intended to meet acute care needs.

Medicare does not provide an opportunity to substitute home and community care for more costly medical care, nor does it support models of delivery that employ both home care and acute care, such as the Hospital at Home model of care.³ Consequently, the handoff from one setting (such as a hospital) to another (like home health) is awkward at best. Medical records do not follow the patient between settings, so needs assessments must be repeated in each setting. In addition, professionals in one setting are generally poorly informed about care plans

in the next round of care. The patient and his or her caregiver face a bewildering array of choices at a time when the pressures of a health crisis can reduce the ability to make good decisions.

Given these realities, there is a threefold rationale for providing home and community care services such as personal care, senior day care, and caregiver training and support to a targeted group of beneficiaries with complex care needs:

- The cost of such services represents a major financial burden on beneficiaries with modest incomes.
- Without better support in the home, complex beneficiaries are more likely to require long-term institutional care, eventually qualifying for Medicaid and increasing long-run federal and state Medicaid expenditures.
- Even higher-income individuals often lack information about and assistance with obtaining high-quality, coordinated home and community services that are tailored to fit their needs and circumstances; such individuals could benefit from a new complex-care benefit even if they must pay the full actuarial cost.

The Long-Term Care Commission and numerous research studies have confirmed these observations.⁴ Moreover, the U.S. lags other countries in addressing the issue. Denmark, for example, made a major commitment to home care and preventing nursing home placement in 1987, leading to a major shift in long-term care expenditures away from institutional care.⁵ The Canadian province of Ontario just launched a major expansion of home care.⁶ And the Dutch have implemented innovative models of self-directed nursing care for home care residents that include both skilled nursing care and personal care services.⁷

PREVIOUS EFFORTS TO IMPROVE COMPLEX CARE

The needs of this vulnerable population are broad, and so is the range of approaches to meeting those needs. Past efforts have generally shared two primary goals: 1) to prevent or delay admission to a nursing home by improving care provided in the home or community, and 2) to improve coordination across acute and long-term care needs.⁸

Two major obstacles currently challenge these goals. One is the difficulty of paying for and coordinating nonmedical services and personnel.⁹ The other is the lack of financial incentives for all those participating to reduce use of services, including long-term nursing home care.

Past demonstration projects, such as Care Management for High-Cost Beneficiaries and the Medicare Coordinated Care Demonstration (MCCD), have focused on specific chronic conditions, disease management, and care coordination rather than on functional and cognitive limitations and in-home services.¹⁰ In fact, MCCD specifically excluded people with cognitive limitations. The same holds for states participating in the Center for Medicare and Medicaid Services' State Innovation Models (SIM) initiative.¹¹ While the Arkansas SIM program does target Medicaid beneficiaries with complex needs, it is designed to provide performance-based payments tied to the level of care coordination achieved. The Oregon model, meanwhile, creates "coordinated care organizations" to assist those with complex conditions.

ENVISIONING A NEW COMPLEX CARE NEED BENEFIT

Our approach to a complex care benefit is guided by the fact that most older adults with complex care needs have significant out-of-pocket costs for essential noncovered services and are often at risk of institutional placement. As envisioned, the benefit would target beneficiaries with physical or cognitive impairment or those who experience serious difficulty navigating multiple sources of acute care and social services.

Coordinate Complex Care. A new entity, which we call a complex care organization (CCO), would form the backbone of the new complex care benefit. Similar to accountable care organizations (ACOs), CCOs would have a strong primary care foundation. They would:

- deliver a comprehensive range of health care services, including in-home care;
- develop individualized care plans in consultation with each beneficiary;
- provide care management services;
- coordinate all care patients receive; and
- ensure that care is both appropriate and of high quality.

As with ACOs, participating providers would be eligible for a share of the health care savings generated from the expected reduction in nursing home placements. CCOs also would be eligible to receive the new chronic care coordination fees that Medicare began offering to primary care providers in January 2015.¹²

In addition, financial support would be made available to caregivers, whether they are family members or friends—who provide the lion’s share of personal services for patients at home—or hired professionals. While family and friends are likely to be preferred by the patient in most instances, many beneficiaries will not have access to a network of family caregivers. Further, caregiver burnout is a well-established phenomenon; at some point, paid support is likely to be needed to relieve the burden on family caregivers.

Cover Nonmedical Services That Support Independence. Additional nonmedical services would be offered to support independent living, including personal care assistance and respite care. Services such as meal support, medication reminders, and interventions to evaluate and address safety in the home could reduce falls or medication mishaps that often lead to preventable hospital admissions and expensive follow-up care. In some states, these and similar services are already available to dual eligibles through Medicaid, but not to those who are not impoverished enough to be covered by Medicaid.

Ensure Flexibility. Medicare benefits are very prescriptive and involve myriad regulations and limitations. Although these are intended to prevent coverage abuses, they also can be barriers to needed care, at times doing more harm than good. To serve the needs of the complex-care population effectively, flexibility is essential. Therefore, in our approach benefits would be creatively bundled and tailored to specific needs.

Base Cost-Sharing on Income. Cost-sharing would be affordable and based on the ability to pay, with larger subsidies provided to beneficiaries with low and moderate incomes. Affordable cost-sharing is particularly important for those with modest incomes, whose resources may be too high to qualify for Medicaid but are insufficient to pay for the additional services that support independent living.

All of the above goals must be developed within a realistic context: A broad expansion of services even for the most needy of Medicare beneficiaries is likely not feasible in the current fiscal and political climate. A

well-designed benefit with reasonable limits on spending for additional services, but with better coordination of care and more support for independent living, would lead to savings elsewhere in Medicare and Medicaid. As an example, the Maximizing Independence at Home model of care, which supports people with Alzheimer's and other forms of dementia, has reduced or delayed nursing home placement by an average of 110 days, yielding savings of \$26,000 over three years.¹³

Of course, even a careful and frugal approach to improving services for beneficiaries could lead to higher costs. Policymakers need to be assured that these changes are well managed and not simply opening Medicare to substantial new costs. Requiring higher-income beneficiaries to finance most of the cost of their services through premiums or copayments, and setting affordable copayments for modest-income beneficiaries, would further limit government outlays.

Advantages and Vulnerabilities

One advantage of covering home and community care through the complex care organizations we envision is that CCOs could relax the sometime arbitrary rules that currently govern the providers of these services. In place of these rules, more meaningful quality standards, such as achieving patient satisfaction goals and demonstrating the effectiveness of their care, could be created. For example, by combining outpatient rehabilitation and home health rehabilitation service, CCOs might be able to meet patients' needs better and eliminate some of the restrictions on providers of these services. What is not yet known is whether this would result in genuine cost savings—particularly to the extent that there are currently substantial unmet needs.

There is also the possibility that CCOs would have an incentive to skimp on care, or place undue burdens on family caregivers, if they were at risk for the full cost per person. One possible safeguard is to have the CCO share risk with Medicare, rather than bear full financial risk. Mandatory reporting on quality of care, including data on beneficiary and family caregiver experiences, also would help in this regard.

Another concern is that paid in-home care would substitute for family caregiving. But income-based cost-sharing would likely temper demand for in-home paid services. A reduced cash allowance also could be made available to families able and willing to directly provide services in lieu of formal paid in-home care.

DETERMINING ELIGIBILITY AND EXPANDING SERVICES

Clear and carefully considered eligibility requirements are a necessity. Policymakers would need to decide which functional limitations would qualify, which in-home and community services are needed in combination with more traditional medical care to optimize independence and health, and under what conditions beneficiaries could move in and out of the benefit. For instance, a transient illness may require a temporary enrollment in the CCO.

Just as CMS is now implementing and monitoring the impact of ACOs, it also could undertake demonstrations of CCOs. These pilots would generate evidence on: which beneficiaries stand to gain the most from a complex care benefit; the qualifications an organization needs to serve as a CCO; the types of services that CCOs should offer; the benefit's effects on quality of care and health outcomes; and cost impact.¹⁴

The structure of beneficiaries' financial incentives must be carefully considered as well. Two goals must be balanced: helping beneficiaries avoid the devastating financial burdens that complex illness or frailty often bring about, and preventing excessive reliance on paid services. Incentives should be geared to maintaining beneficiaries in a home setting at an affordable cost. In determining who should qualify for benefits and what the level of benefits should be for beneficiaries in different situations, the role of caregivers must be addressed. Beneficiaries

without a family support system are most likely to be at risk. But even when family members are available as caregivers, they should be supported in that role.

CONCLUSION

Cost, potential savings, financing, eligibility criteria, quality of care, and patient experience—these are some of the critical issues that must be explored and addressed to move forward with a Medicare complex care benefit. Accelerated testing of the CCO concept is important, however, and should begin soon. With more than 10,000 Americans turning 65 every day, the need for services to care for Medicare beneficiaries with complex needs will grow markedly over the coming decade. Devising affordable, high-quality programs that can allow these individuals to remain at home both raises overall quality of life and potentially reduces spending on institutional care. Each is a worthy goal; combined, they create a powerful incentive for progress.

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07



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PREDICTABLE UNPREDICTABILITY: The Problem with Basing Medicare Policy on Long-Term Financial Forecasting

Sherry Glied and Abigail Zaylor

While the aging of the population and rising health care costs are expected to expand the share of the economy devoted to Medicare, changes over the past decade—including those made by the Medicare Modernization Act and the Affordable Care Act—have helped stabilize the program's financial outlook even as benefits have been expanded. Given the inherent uncertainty of projecting Medicare's finances over the long term, it may be unwise to pursue desperate measures to avoid fiscal calamity that may well never materialize. Policymakers should instead focus on maintaining the Medicare's fiscal solvency while improving its ability to meet beneficiaries' needs.

BACKGROUND

Predictions about Medicare's financial future are often pessimistic, sometimes to the extreme. As some would have it, the program's future is a looming disaster toward which we are inexorably drawn by rising health care costs and the mass retirement of the baby boom generation.

Several observations suggest this dismal outlook is wrong. Changes in both policy and financial forecasts over the past 15 years provide reason for optimism about our nation's ability to afford the Medicare program into the future. Legislative changes enacted since 2000, primarily through the Medicare Modernization Act (MMA) in 2003 and the Affordable Care Act (ACA) in 2010, have substantially altered both the level and composition of current and forecasted program financing. Moreover, new information concerning the nature and pace of technological change in health care has altered actuaries' assessments of likely program costs for the near and long-term future. In fact, since 2003, the overall financial outlook for the program has improved considerably, even as the level of covered benefits has increased. More recently, there has been a marked slowdown in Medicare spending.

The ability to make significant programmatic changes in the short term—as demonstrated by the MMA and ACA—and the difficulty of forecasting costs over the long term suggest that policymaking can be most effective by addressing immediate needs.

This brief explores how the ACA and MMA have altered forecasts of future Medicare viability, details the limits of long-term forecasting, and reflects on the difficulty that tomorrow’s beneficiaries would have in determining their future needs and spending today.

MEDICARE FINANCING AT A GLANCE

Medicare is financed through a payroll tax that accumulates in a trust fund whose balances pay for expenses under Part A (which covers inpatient hospital care), through premiums paid by Medicare beneficiaries who choose to participate in Parts B (physician services) and D (prescription drugs), and through general revenues.

The Medicare trustees annually project future revenues and disbursements to ensure that Medicare trust fund balances are adequate to pay future costs; they also forecast total Medicare spending as a share of gross domestic product (GDP).

New Policies and Paradigms: Why Medicare Forecasts Change Over Time

Forecasts evolve because of both policy changes and modifications to forecasting methods and assumptions. In 2003, the Medicare program’s trustees projected that the program (then consisting only of Parts A and B) would account for 4.7 percent of the nation’s GDP in 2030, and 8.5 percent of GDP by 2070.¹ Since then, with the enactment of the MMA and the ACA, the Medicare program has changed substantially. These changes have had a significant impact on spending and are altering projections of future program costs as well as financing. The 2014 projections put Medicare costs, now including Part D, at 4.9 percent of GDP in 2030, and 6.6 percent in 2070.

By introducing income-related premiums for Medicare Part B, the MMA changed how the existing Medicare program is financed. It also created a new prescription drug insurance benefit (Part D), financed in part through premiums and in part through general revenues. At the outset, the income-related premiums for Part B affected only the top 5 percent of Medicare beneficiaries; the current thresholds start at about 735 percent of the federal poverty level (FPL). Medicare beneficiaries above the highest income threshold pay 80 percent of the average cost of Part B.²

The ACA expanded Medicare benefits by enhancing Part D drug benefits and by including Part B preventive care services with no cost-sharing.³ The ACA also adjusted reimbursement formulas for Medicare Part A, reducing payment growth to account for economy-wide productivity gains. Prior to the ACA, Medicare Advantage plans had received reimbursement at rates in excess of the cost of covering beneficiaries under the traditional fee-for-service program. The ACA reduced reimbursement rates for Medicare Advantage plans to eliminate these overpayments. The ACA also made a variety of other changes to Medicare spending.⁴

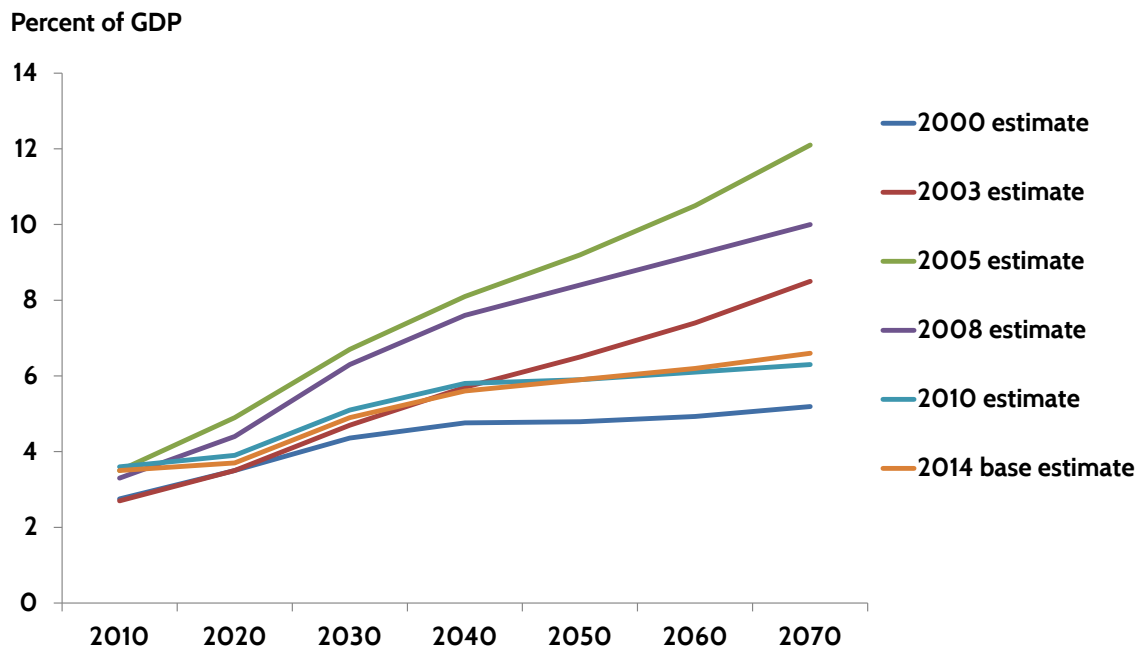
On the financing side, the ACA added an income-related Part D premium and froze the thresholds for the Part B and Part D income-related premiums from 2010 through 2019. By 2019, an estimated 9.6 percent of Medicare beneficiaries are expected to be subject to the high-income premiums.⁵ The ACA also raised payroll taxes for higher income beneficiaries. The 0.9 percent tax on high-income earners is expected to raise \$123 billion between 2010 and 2019 for the Hospital Insurance Trust Fund.⁶

The reported short- and long-term outlook for the program also changed because of changes in forecast methods and assumptions. These changes occurred as actuaries projected the impact of the legislative changes described above; as they learned more about the performance of different aspects of the program; and as they altered their forecast methodology. Most significantly, in 2003 the Medicare trustees substantially altered their assumptions about long-term cost growth. Before 2003, the trustees projected health care cost growth would be equal to wage growth (GDP+0); the predicted rise in spending reflected only the change in the number of elderly per worker.⁷ A technical review panel convened in 2000, however, recommended that the long-term projection should assume that health care costs would grow 1 percent faster than GDP (GDP+1), and the trustees incorporated this recommendation beginning in the 2003 report.

Changes in Forecasts of the Level of Medicare Spending, 2000 to 2014

The effects of these changes in policy and forecasting assumptions are apparent in the shifting projections made in the trustees' reports between 2000 and 2014 (Exhibit 1). (See [Appendix A](#) for an alternative 2014 projection and explanation.)

Exhibit 1. Forecasting Medicare Costs as a Share of GDP: Shifts in Policies and Paradigms Alter Predictions Over Time



Source: Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, Annual Report (2000–2014) (Washington, D.C.: United States Government Printing Office).

The first notable change in Exhibit 1—the shift between the 2000 trustees report estimate and the 2003 estimate for the period after 2025—occurred simply because of the change in the long-term growth assumption described above. This change alone suggested that by 2070 health care costs would consume 3.2 percent more of the GDP than was projected in 2000.

The second shift, between the 2003 and 2005 estimates, occurred because of the MMA. Part D added substantial costs to Medicare immediately, and the trustees projected that these high costs would grow rapidly in

the near future. The new program was expected to add 2 percent to the GDP share of Medicare by 2030 and 3.6 percent to that share by 2070. However, the rate of new drug development slowed appreciably in the early 2000s and blockbuster drugs such as Zocor and Zoloft went off patent. These developments led the trustees to revise their projections. The 2008 estimate, incorporating more of the realized Part D experience, was more than 2 percentage points of GDP below the 2005 estimate at the end of the forecast period.

The effects of the ACA can be seen in a comparison of the 2008 and 2010 forecast estimates. The ACA had a significant short-term effect on the Medicare forecast, extending the projected trust fund depletion date by 12 years. It also had a large effect on the long-term forecast by permanently changing the formula for increasing hospital payment rates from year to year. These changes reduced by 3.7 percent the anticipated share of Medicare in GDP by 2070.

Very short-run changes in health spending also contributed to changes in the forecast. No significant Medicare legislation passed between 2010 and 2014, and the Medicare technical review panel did not alter the trustees' long-term forecast projection. Instead, the 2014 estimate is about 0.2 percentage points of GDP below the 2010 estimates for 2030 and 2040 because of the unanticipated slowdown in health care spending that continues through today.

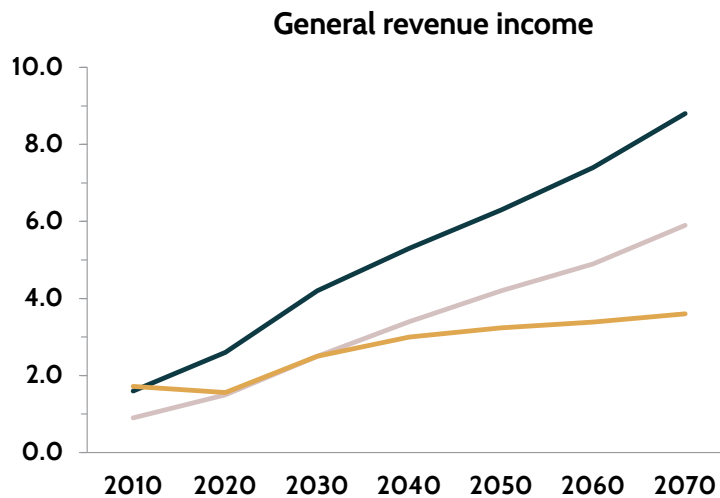
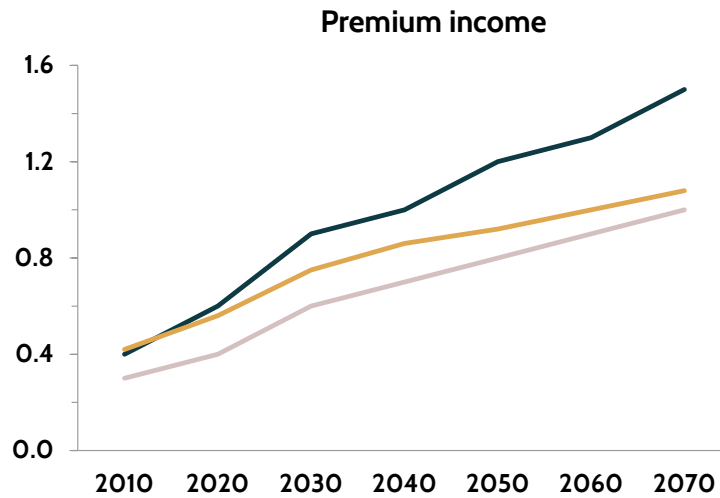
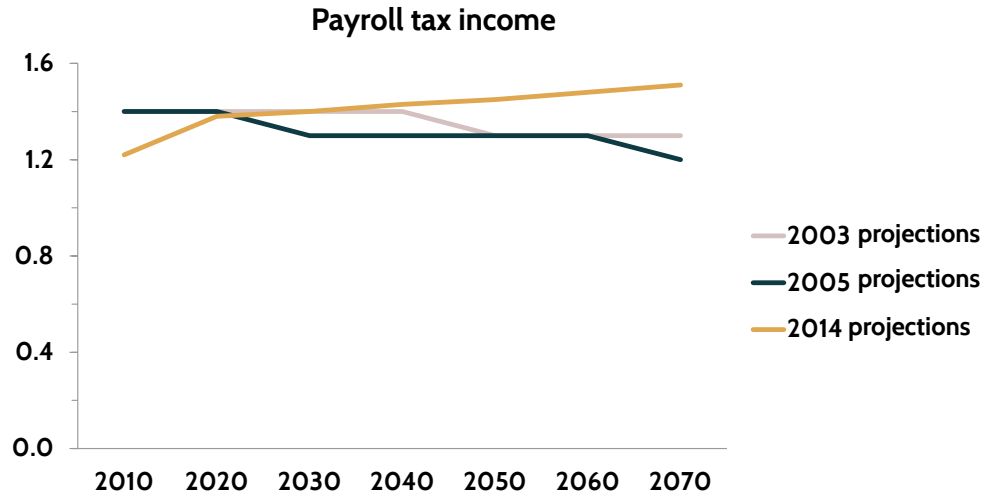
The current 25-year forecast for the total cost of Medicare as a share of GDP in 2040, after all the baby boomers have retired, is now just slightly below the level it was in 2003—before passage of the MMA and before the Great Recession. Put differently, faced with a deficit comparable to the one we see today, policymakers in 2003 assessed Medicare as a program ripe for expansion.

Changes in the Composition of Medicare Financing

The new policies and changes in assumptions described above also changed the expected composition of Medicare financing. Concerns currently focus on the program's expected draw on general revenue, financed primarily through income taxes.

Exhibit 2 breaks out the trajectory of financing from each of three revenue sources: payroll taxes, premium income, and general revenue. According to all projections, the share of total Medicare expenditures financed through the payroll tax is expected to decline over time, and the absolute share of GDP collected through the payroll tax is expected to be nearly flat.

Exhibit 2. Medicare Financing Projections as a Share of GDP



Source: Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, Annual Report (2003: Table II.A5—Medicare Sources of Income and Expenditures as percentage of GDP; 2005: Table III.A4—Medicare Sources of Income and Expenditures as a Percentage of the Gross Domestic Product; and 2014 Expanded and Supplemental Tables: HI and SMI Incurred Expenditures as a Percentage of the Gross Domestic Product).

Premium income grows as a share of GDP as a direct consequence of the expected increase in the cost of the overall program. The share of Medicare spending financed through premium income increased after passage of the MMA and the ACA because of the introduction of income-related premiums. Current estimates suggest that premium income financing for Medicare will rise from about 0.4 percent of GDP in 2010 to about 1.0 percent of GDP by 2070.⁸ For all but high-income beneficiaries, premiums for Part B and Part D are intended to finance a fixed share (25%) of program expenditures. The thresholds for high-income premium payments are indexed after 2019, so the overall share of total expenditures financed through premiums is largely fixed over time.

The decline in estimates of the future cost of Medicare, however, has substantially reduced the expected call on general revenues in the future. Under the trustees' baseline projections, the Medicare general revenue share of GDP is expected to double, from about 1.7 percent to about 3.6 percent of GDP between 2030 and 2070—less than half the level expected immediately after passage of the MMA. (The 2014 alternative projections are higher; see [Appendix A](#) for more information.)

CONCLUSION: UNCERTAINTY IS INHERENT IN MEDICARE POLICYMAKING

Predicting health care costs 20 or 30—let alone 50 or 75—years into the future is an inexact science, at best.⁹ The costs of providing care depend on future innovations in technology, the value of such innovations to beneficiaries and to taxpayers, and the supply of and demand for health care services. As the Part D experience and the recent cost slowdown suggest, projections of the rate of future technological change are hard to make even in the short run.

The aging of the baby boomers and rising health care costs will plausibly increase the share of GDP devoted to Medicare, but nothing is certain. As we have shown, changes made in the program over the past decade meant that despite substantial expansions of benefits, the financial outlook for the program remained quite stable. The experience of the past 15 years suggests that there is room for considerable optimism about the ability of our nation to afford the Medicare program into the future.

Long-term forecasting uncertainty should make policymakers and beneficiaries cautious about dramatic changes to the program in the near term. The range of error around forecasts of Medicare costs rises as the forecast window lengthens. This suggests that policymakers should focus on the immediate policy window, taking steps to reduce the current burden of Medicare costs by containing spending today. Medicare expenditure policy changes, such as changes in payment rates or methods, can and have taken effect very quickly. Similarly, revenue changes to pay these expenditures occur in real time. Future policymakers are likely to have as much opportunity and much more information than current policymakers to make optimal decisions about Medicare's future costs.

The challenges of forecasting Medicare costs provide an additional rationale for paying retiree costs through social insurance rather than a defined-contribution system.¹⁰ Individuals simply cannot anticipate what health care is likely to cost after they retire, and they cannot know how much to save against the prospect of these costs. If talented professional actuaries have difficulty making forecasts, then individuals will surely struggle to project what services they will need in the future. As a society, we can decide through the political process to alter policy or payment practices—and we have done so in the past—but such alterations are well beyond the power of any beneficiary.

STUDY METHODS AND DATA

This analysis uses the 2000, 2003, 2005, 2008, 2010, and 2014 annual reports of the Boards of Trustees for Medicare to assess how the financing of Medicare and projections of the program's future costs have changed over time.¹¹ It assesses the impact of legislative changes on the sources and levels of financing of the program and compares projections of the future costs and financing of the program made at different times to evaluate how both funding and forecasts have changed.

In keeping with the treatment of this issue in the trustees' reports, we assume that when the trust fund expiration date occurs, Medicare Part A spending that cannot be paid from trust fund revenues will be funded through general revenue. Thus, projected trust fund deficits, in years beyond 2012 in the 2003 report and in years beyond 2030 in 2014, were added to the general revenue financing bill.

Our projections use the trustees' official baseline, which assumed that the sustainable growth rate payment system for physicians would be overridden and that physician payments would increase at a rate of 0.6 percent from 2016 through 2023. It also assumes that the Medicare hospital payment system's productivity adjustments, enacted through the ACA, will continue to be upheld into the future. The trustees also provide an alternative scenario, which we discuss in [Appendix A](#).

APPENDIX A. AN ALTERNATIVE 2014 COST PROJECTION

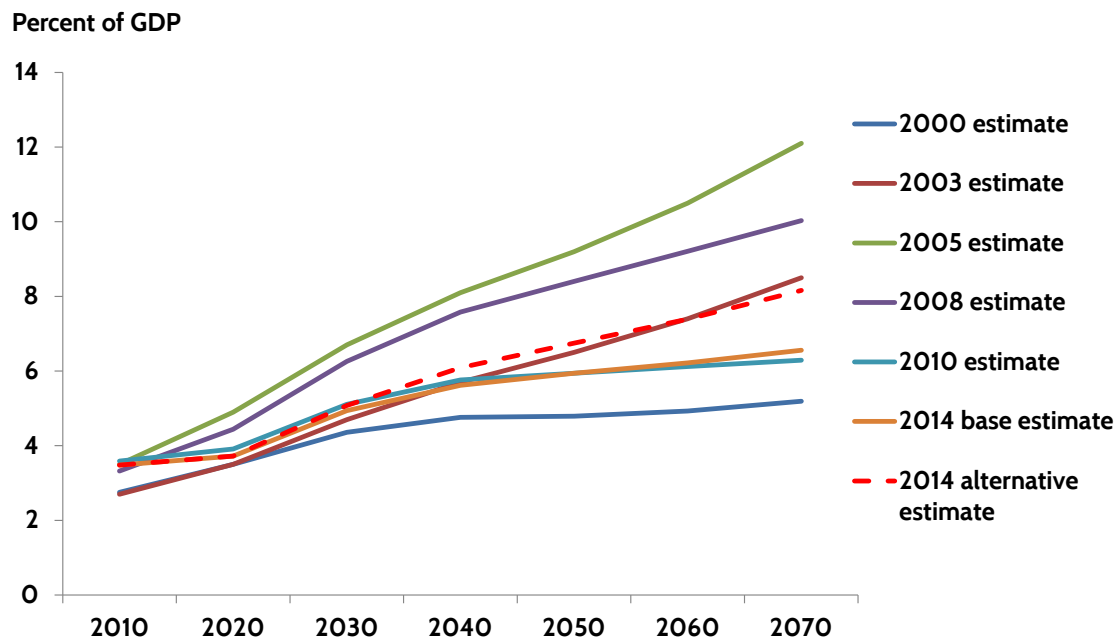
In recent years, the Medicare trustees' reports have included several alternative projections. The 2014 report included three sets of projections: current law projections, baseline projections that assumed that the sustainable growth rate (SGR) would be overridden, and a set of alternative projections that assumed the revised hospital payment updates phase out beginning in 2019. This brief reports results for the baseline projections.

Some evidence suggests that even the baseline projections may be too pessimistic. The Committee for a Responsible Federal Budget, for example, has shown that 98 percent of the overrides of the SGR between 2004 and 2014 were offset by other reductions in Medicare spending (Committee for a Responsible Federal Budget, blog post, March 13, 2014). The final "doc fix" bill passed this year will offset only a third of the cost of the fix through other Medicare changes (Committee for a Responsible Federal Budget, blog post, March 25, 2015), but this offset is not incorporated in the baseline scenario.

The alternative scenario assumption that the productivity adjustments will not be sustainable is based primarily on the argument that these adjustments will lead to a substantial deviation between Medicare payment rates and private insurer payment rates. Recent research, however, suggests that private payment rates are more likely to imitate Medicare rates than to deviate from them.¹²

Exhibit A-1 below includes the alternative scenario estimates in our assessment of Medicare forecasts over time. Even under the alternative scenario, 2014 Medicare long-term projections are below those made in 2003, 2005, or 2008. At the height of baby boomer retirement, in 2040, total Medicare expenditures under the alternative scenario would reach 6.09 percent of GDP, about 60 percent above their 2020 level.

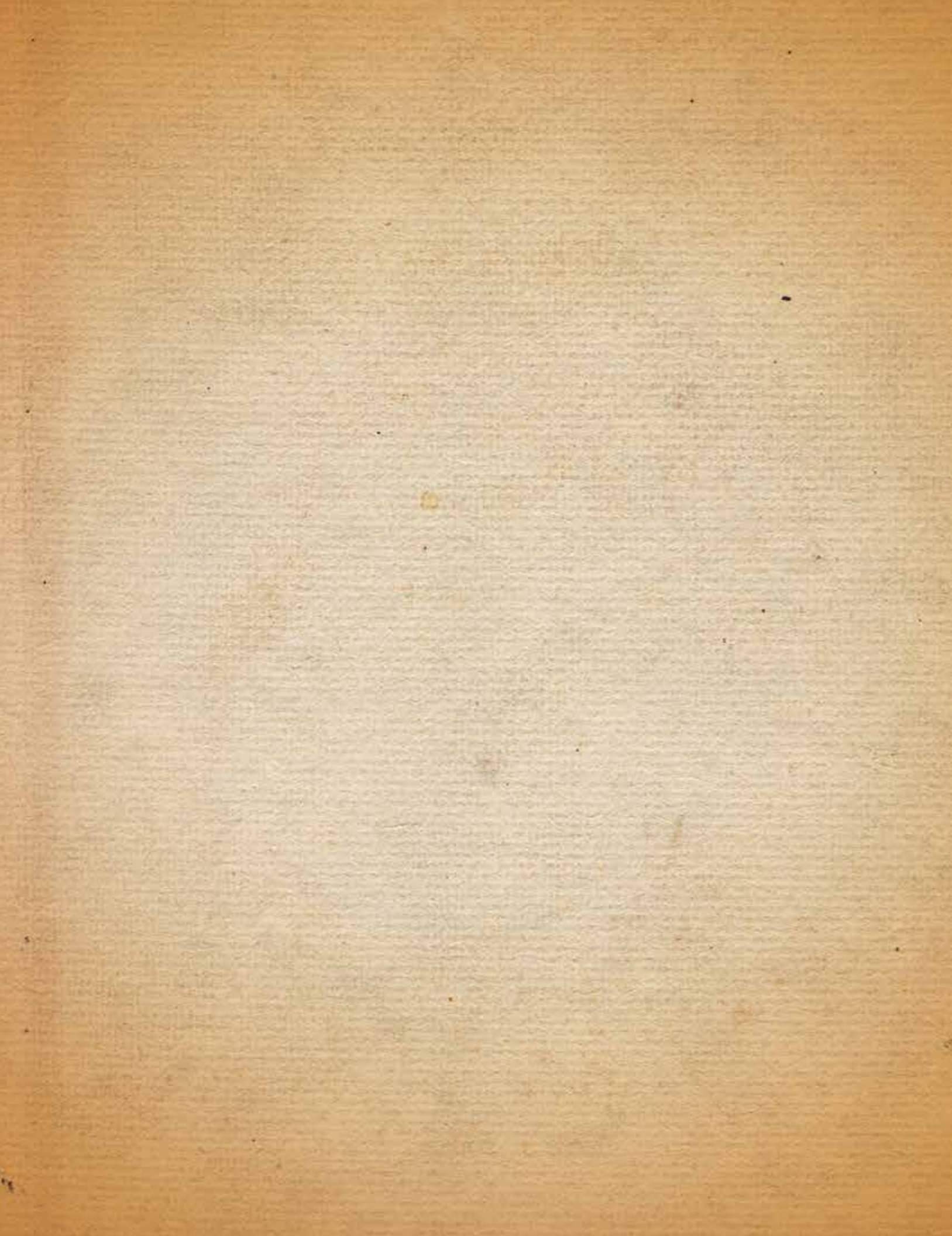
**Exhibit A-1. Medicare Costs as a Share of GDP:
Estimates Over Time, Including 2014 Alternative Estimate**



Source: Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, Annual Report (2000–2014) (Washington, D.C.: United States Government Printing Office).

NOTES

1. M. Moon, M. Segal, and R. Weiss, "A Moving Target: Financing Medicare for the Future," *Inquiry*, Winter 2000–01 37(4):338–47.
2. J. Cubanski, T. Neuman, G. Jacobson et al., *Raising Medicare Premiums for Higher-Income Beneficiaries: Assessing the Implications* (Washington, D.C.: Urban Institute, 2014).
3. K. Davis, S. Guterman, and F. Bandeali, *The Affordable Care Act and Medicare: How the Law Is Changing the Program and the Challenges That Remain* (New York: The Commonwealth Fund, June 2015).
4. Congressional Budget Office, Congressional Budget Office cost estimate: H.R. 4872: The Reconciliation Act of 2010 (Final Health Care Legislation) (Washington D.C.: CBO, 2010).
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6. P. A. Davis, J. Hahn, P. C. Morgan et al., Medicare Provisions in PPACA (P.L. 111-148): R41196, Congressional Research Service Report for Congress (April 21, 2010):1–89.
7. G. S. Wunderlich, *Improving Health Care Cost Projections for the Medicare Population:: Summary of a Workshop* (Washington, D.C.: National Academies Press, 2010).
8. State transfers and taxes on benefits will add a further 0.4 percent of GDP by 2070 (0.6% of GDP under the alternative scenario; see [Appendix A](#)).
9. K. Davis, "Shaping the Future of Medicare," *Health Services Research*, April 1999 34(1 Pt 2):295–306.
10. D. Shaviro, *Who Should Pay for Medicare?* (Chicago, Ill.: University of Chicago Press, 2004); and D. Shaviro, "Should Social Security and Medicare Be More Market-Based?" *Elder Law Journal*, 2013 21:87–148.
11. Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, Annual Report (2000–2014) (Washington, D.C.: United States Government Printing Office).
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Epilogue

For 50 years, Medicare has been instrumental in improving the health and economic security of some of the most vulnerable populations in society. During this time, the program has also reshaped the U.S. health system, fostering unprecedented access to specialized care, advancing the use of innovative medical technologies, and improving the quality of care.

As we have seen, however, Medicare today faces formidable challenges, both to its long-term fiscal viability and its capacity to meet the full range of needs of an older and more medically complex population. These include: rising costs, which affect beneficiaries as well as the federal budget; a benefit package that, while rated highly for the access to care and financial protection it affords, falls short in protecting beneficiaries with low incomes and serious, chronic health problems; fragmented coverage that is confusing for beneficiaries and undermines care coordination; and ensuring affordable access to quality home- and community-based services, demand for which will expand as a growing number of older adults face physical and cognitive impairments.

In this volume's review of Medicare's past accomplishments, ongoing challenges, and potential policy options, the authors collectively point to a path forward for current and future policymakers. It is one in which Medicare expands its role as leading health system innovator, spurring the nation to achieve better care, better outcomes, lower costs, and fewer disparities.

The Medicare program's capacity to drive health system reform has been apparent from the beginning and has continued unabated. By the late 1960s, just a few years after its inception, Medicare had effectively ended racial segregation in U.S. health care facilities. In the early 1970s, it began providing coverage to people of any age with long-term disability or end-stage renal disease—individuals who previously had been shut out of employer coverage. In the early 1980s, it introduced the hospital prospective payment system, followed by the Medicare physician fee schedule a decade later—changes that lowered Medicare spending growth and set a standard for the entire health insurance industry. And the program's most recent innovations in provider payment, designed to reward the delivery of high-value care, have influenced the approaches taken by private payers across the U.S., and even by health systems around the world.

This history of innovation—one of Medicare's greatest legacies—should serve the program and the nation well as it addresses an array of challenges, including those discussed here. With a continued openness to change and rigorous experimentation, there is no reason why this 50th anniversary of Medicare cannot simultaneously mark the beginning of a new era of achievement for our nation's health care system.

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