A ROADMAP TO MEDICARE SUSTAINABILITY

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Established in 1965, the Medicare program is the primary health insurance program for adults ages 65 and over and non-elderly people with permanent disabilities. Although Medicare has made a significant contribution to the lives of beneficiaries by improving their economic and health security, unfavorable demographic trends and rapidly increasing costs threaten its long term sustainability. Medicare is also a major contributor to the rise in U.S. federal debt, while the program’s complex rules and regulations stifle innovation, adversely affecting the cost and quality of care.

It is of interest to note that some of the problems we currently face, e.g., rapidly rising costs and overwhelming complexity, were already present in the first year of the Medicare program. Thus, we believe that we will not solve the problem by relying on continuing piece-meal “tinkering” with various program components. Medicare must be fundamentally reformed and made sustainable in a manner that is fair to seniors, to their children and their grandchildren, who are or will be paying the taxes for the Medicare program. If no action is taken, the costs of Medicare will burden the nation’s finances; the complexity of its rules will continue to stifle innovation; while the price-control approach to reimbursement will continue to decrease access and lead to poor outcomes for patients. As this book shows, bold action and consistent leadership on several fronts are required.

In this publication we highlight the pros and cons of the program and provide a set of recommendations that would allow our country to both contain the rapid growth in federal spending, as well as to ensure that the program remains affordable to individual citizens and is sustainable long term. Specifically, we propose to:

- Raise the age of Medicare eligibility to 69 years, with the option of entering the program at age 65.
- Move Medicare to a premium support model.
- Establish true Pay-for-Value for medical providers.
- Carry out tort reform.

We hope that this report will stimulate further public discussions around Medicare and the challenges it presents to our nation, and drive real legislative actions to help move us forward in a sustainable way. This publication is a follow up to our “A Roadmap to High Value Healthcare Delivery” report that focuses on improving the U.S. healthcare delivery system. You can view both publications online at: http://healthcare.asu.edu/.

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“If we solve our healthcare spending [Medicare], practically all of our fiscal problems go away. If we don’t? Then almost anything else we do will not solve our fiscal problems.”

– Dr. Victor Fuchs, Emeritus Professor of Economics, Stanford University

Medicare: a success...

President Lyndon B. Johnson at the signing ceremony July 30, 1965, at the Truman Library in Independence, Missouri.

“No longer will older Americans be denied the healing of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations.”


...and a problem: Medicare, as it currently exists is not sustainable

“The U.S. government is not going to be able to afford Medicare and Medicaid on its current trajectory.... The notion that somehow we can just keep on doing what we're doing and that's OK, that's just not true.”

– President Barack Obama¹

“We're going to have to recognize that Social Security and Medicare are unsustainable, not for the current group of retirees, but for coming generations. And we can't afford to avoid these entitlement challenges any longer.”

– Governor Mitt Romney²

“Absent a bipartisan effort to fix Medicare and protect this guarantee - if nothing is done - what the years ahead ensure is that seniors and health care providers will be getting a steady diet of cost-shifting and arbitrary cuts until the Medicare guarantee is kaput.”

– Senator Ron Wyden³

2) http://www.politicusilluminations.com/2013/02/morning-quote-mitt-romney-on-social-security-medicare.html
We are now eating away at our children's and grandchildren's futures.

This is why it is time to look at how to fix Medicare.

Some of the issues we face have been around since Medicare's inception

A Saturday Evening Post article from 1967 included a review of the first year of the Medicare program:

• First year cost significantly exceeded President Johnson’s forecast.
• Medicare was more complex and confusing to operate than its sponsors predicted.
• Medicare’s intricate billing procedures added millions to hospital overhead expenses.

It may be time for us to tackle Medicare with fundamental reforms.
Main Topics of This Book

• Medicare program overview.
• The pros and cons of Medicare.
• Solving the Medicare problem.
• Additional recommendations to ensure Medicare affordability.
• Reforming Medicare: Summary recommendations.
Medicare: What is it?

- A Federal social insurance program.
- Started in 1965.
- Provides government health insurance for all Americans age 65 and older, the disabled, and those with end-stage renal disease.

http://www.kff.org/medicare/reportingaboutmedicare/ataglance.cfm
The ABCs (and D) of Medicare

- Part A – Inpatient hospital care.
- Part B – Physician and outpatient care.
- Part C – Private insurance options.
- Part D – Prescription drug benefits.

Source: cms.gov.

Medicare Part A – Inpatient Hospital care

- Provides basic coverage to all who meet beneficiary criteria and includes:
  - Hospital stays in a semi-private room.
  - Brief nursing home stays (provided certain criteria are met).
  - Home health.
  - Hospice care.
- If you/your spouse have worked for at least 10 years and paid Medicare payroll taxes, you qualify for premium-free Part A coverage.
- If you are not entitled to premium-free Medicare Part A, you may still qualify for Part A but you will have to pay a monthly premium.

Medicare Part B – Physician and outpatient care

- Medicare Supplementary Medical Insurance.
- Provides optional coverage for all Medicare-eligible beneficiaries.
- Helps pay for:
  - Medically necessary outpatient services (e.g., lab tests, surgeries, physician visits) and supplies (e.g., wheelchairs, walkers).
  - Preventative services (e.g., annual wellness exam, screening for obesity, HIV, prostate cancer).

Source: cms.gov.

Medicare Part C – Private insurance options (Medicare Advantage)

- Since 1997, all Medicare-eligible beneficiaries can receive Medicare benefits through private insurance health plans (Medicare+Choice).
- With the passage of the Medicare Modernization Act in 2003, Medicare+Choice became Medicare Advantage Plan (MAP).
- These private insurance health plans must offer benefits equal to or greater than traditional Medicare.
- MAPs often combine parts A, B and D benefits into a single insurance offering.

Medicare Advantage plans have become more popular in recent years

- In return for limiting access to a more restrictive network of providers, MAP enrollees can benefit from:
  - Lower premiums.
  - Reduced cost sharing.
  - Additional benefits (e.g., dental, vision, health club memberships).
- One in four Medicare beneficiaries now belongs to a MAP, a proportion that has been steadily rising.


Medicare Part D – Prescription drug benefits

- Since 2006 anyone with Medicare Part A and Part B coverage is also eligible for drug coverage.
- Beneficiaries receive coverage by either enrolling in a stand-alone private prescription drug plan (PDP) or in a private MAP plan with prescription drug coverage.

Source: cms.gov.
Sources of Medicare funding

- Part A – Funded from payroll tax (Trust Fund model).
- Part B – Funded ~75% from Federal general tax revenue and ~25% from beneficiary premiums.
- Part C – Combination of funds that would have been used for parts A and B.
- Part D – Funded ~80% from Federal general tax revenues, ~10% from beneficiary premiums, and ~10% from state and other sources.


Status of the Medicare Part A Trust Fund

- The 2012 Medicare Trustees report states that the Hospital Insurance (HI) Trust Fund will be exhausted by 2024.
- Since there are currently no funds, only IOUs, in the HI Trust Fund, this is a hypothetical issue.

Part A Trust Fund is a “pay-as-you-go” system

- Money put into the trust fund is used to pay for current Medicare beneficiaries.
- Moreover, “Any cash generated when annual receipts exceed annual spending is not retained by a trust fund. Rather, the money is turned over to the Treasury, which gives the trust fund government bonds in exchange and uses the cash to finance the government’s ongoing activities…. The resources used to redeem a trust fund’s government bonds—and thus pay for benefits—in some future year will have to be generated from taxes, other government income, or government borrowing in that year.”


“Workers have been repeatedly told that their payroll taxes are being securely held in trust funds. But they are actually spent the very minute they arrive in the Treasury’s bank account. No money has been saved. No investments have been made. No cash has been stashed in bank vaults. Today’s payroll tax payments are being spent to pay medical bills for today’s retirees. And if any surplus materializes, it is spent on other government programs. As a result, when today’s workers reach the eligibility age of 65, they will be able to receive benefits only if future taxpayers pay (even higher) taxes to support them.”

Affordable Care Act (ACA) provisions are increasing payroll taxes for Part A

- A payroll tax of 2.9% is dedicated to the Part A trust fund.*
- As a result of the ACA, starting in 2013, this tax increased by 0.9% for couples making more than $250,000 (or individuals making more than $200,000) on any wages that exceed the above thresholds.**
- An additional Medicare tax of 3.8% will be levied against all taxpayer investment income (which has not been subject to Medicare payroll tax) for couples making more than $250,000 (or individuals making $200,000).**

* If the person is not self-employed, the tax is split between employee and employer.
** There is no employer match for this increase. This additional tax revenue is intended to be used to fund ACA provisions, and therefore, according to the Congressional Budget Office (CBO) would not be available to extend the solvency of the Medicare program.


Will these new taxes extend Medicare solvency?

- These new taxes were designed to support the viability of Medicare. But, government administrative accounting will in fact use them to offset the costs of subsidies to help non-Medicare citizens purchase health insurance.
- This has raised a debate over whether these new Medicare tax dollars can be counted on to both pay for the non-Medicare subsidies AND to reduce Medicare Trust Fund obligations.
- The Congressional Budget Office and the Medicare Actuary have indicated that using the new taxes in this way would not extend the solvency of Medicare.
The ACA provisions will not effectively extend the solvency of the Medicare Trust Fund

- Congressional Budget Office (CBO) Opinion, December 23, 2009
  - “The key point is that the savings to the HI [Medicare] Trust Fund under [ACA] would be received by the government only once, so they cannot be set aside to pay for future Medicare spending and, at the same time, pay for current spending on other parts of the legislation or on other programs.”

- Medicare Actuary, April 22, 2010
  - “In practice the improved HI [Medicare Trust Fund] financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.”


Medicare Governance

- U.S. Congress is a 535 member “governing board” for Medicare:
  - Allows for political logrolling, earmarks, and other political meddling.

- Centers for Medicare and Medicaid Services (CMS) manages and operates Medicare and Medicaid:
  - Federal agency with wide regulatory authority.
  - Functions as the insurance company that writes all the rules, sets the prices, regulates the providers, issues a myriad of advisories and updates, and pays the bills.
THE PROS AND CONS OF MEDICARE

Medicare Pros

- Guarantees some insurance coverage for the elderly and the disabled.
- Allows seniors with limited financial means to access health services.
- Helps protect the financial health of seniors.
Lack of insurance is a contributing factor to poor health outcomes

Mortality amenable to healthcare vs. uninsured population by state
(Mortality data, 2004-2005; Uninsured data, 2008-2009)


Being insured contributes to better management of chronic disease

Percentage of patients 18 years and older with these two chronic diseases under control by their insurance status (1999-2004)*

* Diabetes: HbA1C <9.0; Blood pressure: <140/90.

Seniors now have a higher rate of health insurance coverage than people under age 65 years

Prior to the Medicare program nearly half of the senior citizens were without health insurance; today this number is only 2%.

In contrast, while there has been an improvement in the percent of the under 65 population that is insured, the younger U.S. citizens are much more likely to be uninsured, with the most recent figure being 18% of the population. Even with the provisions of the ACA, the CBO estimates that 11% of the under 65 population will remain uninsured.
Medicare has increased seniors’ access to health services

Hospital discharges pre- and post-Medicare implementation
Per 1,000 elderly

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<tbody>
<tr>
<td>Hospital discharges</td>
<td>194</td>
<td>350</td>
<td>352</td>
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</table>


Older people use more healthcare services because they have more medical problems as they age

Share of population vs. healthcare spending by age group (2004)
Percent share of total

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Share of Population</th>
<th>Share of Healthcare Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-18</td>
<td>25%</td>
<td>13%</td>
</tr>
<tr>
<td>19-64</td>
<td>63%</td>
<td>53%</td>
</tr>
<tr>
<td>65+</td>
<td>12%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Source: Department of Health & Human Services, U.S. Census Bureau; Meeker, Mary. 2011. USA Inc.: A Basic Summary of America’s Financial Statements. KPCB.
Poverty rates in the 65+ population declined substantially since the introduction of Medicare

- In the mid-60s, before Medicare was enacted, senior citizens (people over age 65) had the highest poverty rate in the U.S. – nearly 30% – even though Social Security had been available to senior citizens for many years.
- Senior citizens now have the lowest poverty rate in the U.S., while poverty rates for people under age 65 are rising.
- In fact, those under the age of 18 have the highest poverty rate, with more than 1 of 5 living in poverty.
Medicare Cons

- Unfavorable demographic trends bring into question the sustainability of the current Medicare “pay-as-you-go” scheme.
- Rapidly increasing costs have contributed significantly to a higher than desired level of U.S. federal debt.
- Medicare is a bigger factor than Social Security in the future expected expansion of U.S. federal debt.
- Medicare is a complex program with rules that are hard for both patients and providers to understand.
- Medicare’s rigid regulations make it more difficult to introduce new models of more efficient healthcare delivery.
- Medicare’s past cost control efforts (through line item price controls) have not solved the problems of cost growth and quality; continuation of this cost cutting strategy will lead to decreased access and quality problems for Medicare beneficiaries.

The U.S. population will age rapidly over the next two decades

The aging of the U.S. population (1970-2030)
Age 65+ as percent of total U.S. population

By 2030, as more baby boomers enter the over age 65 population, that group will represent nearly 1 of 5 U.S. citizens.

The number of Medicare beneficiaries is projected to nearly double by 2030, but fewer workers will be paying in.

- The number of Medicare beneficiaries is expected to almost double between 2010 and 2030.
- Since Medicare has no cash in the Medicare trust fund, its expenses will need to be paid from taxes on the workforce.
- In 1970, when Medicare was a relatively new program, there were just under five workers for every Medicare beneficiary.
- By 2030, when the last baby boomers enter Medicare, there will only be slightly more than two workers per beneficiary. This will put a significant burden on our children and grandchildren.
To correct underfunding of just part A Medicare would require more than doubling the base Medicare payroll tax from 2.9% to 6.8%.

- To correct the underfunding of Medicare would require increasing the Medicare tax by 3.9% to 6.8% for all tax payers. Thus, a self employed person making $100,000 would see her or his Medicare tax increase from $2,900 to $6,800 – all in addition to federal income taxes. This increase in Medicare taxes would still be paying for someone else’s healthcare.

- Data presented here are limited to Medicare Part A Hospital Insurance Trust Fund. Medicare Part B Medical Insurance and Part D Prescription Drug Benefits are primarily funded via insurance premiums and general tax revenue transfers.

Note: These calculations are merely mechanical illustrations and are not meant to portray realistic solutions.

Medicare spending grew rapidly over the past decade; growth in spending is projected to continue.

Medicare spending as a % of gross domestic product (1970-2020E*)

Percent

5.0%
4.0%
3.0%
2.0%
1.0%
0.0%


* E = estimate.
Source: Congressional Budget Office, Budget and Economic Outlook, January 2010 (for 1970 data) and January 2011 (for 1980-2020 data); Kaiser Family Foundation Medicare Chartbook, 2010; Medicare Policy Project Publication Number: 8103.
Medicare costs are driven by two components, number of beneficiaries and cost per beneficiary.

Real annual Medicare payments per beneficiary and enrollment (1966-2009)*

- An increase in Medicare’s total costs has occurred as a result of both a rise in the number of beneficiaries, as well as an increase in the level of Medicare payments per beneficiary.
- However, the increase in cost per beneficiary (in constant 2005 dollars) has been much greater than the increase in enrollment.

* Data are inflation adjusted using BEA’s GDP price index. MM = million.
Source: Department of Health and Human Services, Meeker, Mary. 2011. USA Inc.: A Basic Summary of America’s Financial Statements. KPCB.
The average Medicare beneficiary receives benefits worth three times what he or she paid in taxes

A recent study by the Urban Institute has shown that Medicare benefits received greatly exceed taxes paid in.

The data shown on the previous slide are for a family of 2 where both individuals worked and both individuals did not retire until age 65 in the year 2030. With those assumptions, this couple would have paid $175,000 in Medicare taxes, but will receive over $500,000 in benefits.

This discrepancy is likely even greater because the model may overstate the amount of lifetime Medicare tax contributions. The model assumes that Medicare taxes had been invested at 2%+ inflation. However, in reality these taxes were spent by the government on Medicare or other expenses as soon as they came in. Moreover, many people are retiring before age 65 and thus would not contribute taxes for as many years.
• All of this leads to confusion for Medicare beneficiaries because most believe that since they paid Medicare taxes throughout their lifetime, they have already paid for the Medicare benefits they will receive upon retirement.

• The confusion is perpetuated further by specific interest groups that tend to imply that what the beneficiaries believe is true, when in fact it is not the case.

Social insurance programs (Medicare, Medicaid, Social Security) are major contributors to the rise in federal debt

U.S. real federal expenses, entitlement spending, real GDP (1965-2010)
Percent change from 1965

Data adjusted for inflation.
Source: White House Office of Management and Budget; Meeker, Mary. 2011. USA Inc.: A Basic Summary of America’s Financial Statements, KPCB.
“Over the next 20-30 years, the rising health costs and retirement of the baby boomers are projected to cause deficits that make the current one look puny. At the rate we are going, the U.S. would almost surely default on its debt one day.”

Dr. Christina Romer, former Chair of President Obama’s Council of Economic Advisers

Healthcare has become the largest component of Federal spending

Composition of Federal spending (1970-2010)
As a Percent of total Federal spending

• Another way of looking at the growth in social insurance expenditures is by comparing the distribution of federal spending in 1970 vs. 2010.

• Non-military discretionary spending has remained relatively the same, 20% vs. 19% of total federal spending.

• While overall defense spending increased between 1970 and 2010, its contribution as a percent of total federal spending has been cut in half.

• In contrast, federal healthcare spending grew from 5% of total federal expenditures to 23% over this time period.

* Healthcare spending includes Medicare, Medicaid + other health programs. Other mandatory spending includes, Income Security programs, Federal Civilian and Military Retirement, Veterans Programs, etc.; Other discretionary spending includes, Education, Training, Employment and Social Services, Transportation, Income Security programs, Veterans Benefits and Services, International Affairs, etc.

And the trend is projected to continue: Going forward, Medicare is a much bigger financial problem than Social Security

Of the major social insurance programs for the elderly population, Social Security and Medicare, the unfunded liability is much greater for Medicare than Social Security.

Both are important, but Medicare is a much bigger problem that needs to be resolved.
Medicare is a complex program with rules that are hard for both patients and providers to understand

According to a 2001 MedPac report, “…by one widely used estimate, over 125,000 pages of regulations – more than the Internal Revenue Service regulations for the entire tax system – control the program.”

“There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within the human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning and making any solid grasp of the matters addressed merely a passing phase.”

Chief Justice Samuel James Ervin, III, U.S. 4th Circuit Court Rehabilitation Association of Virginia v. Kozlowski

Further complexity is created by the fact that Medicare program rules are updated on a continuous basis

- The **Federal Register** provides new regulations affecting government healthcare programs almost weekly.
- In addition, CMS and its Medicare administrative contractors (private insurance companies who pay providers on behalf of Medicare), and the Office of Inspector General (OIG) issue documents, alerts, instructions, bulletins, educational materials, manual revisions, and other guidance almost every day.
- Open forums are also held regularly by CMS and contractors to present information and guidance in an informal manner which is not documented.
Just the annual pricing updates to providers are nearing the 20,000 page mark. How does anyone keep track?

<table>
<thead>
<tr>
<th>Publication</th>
<th>Number of Federal Register pages</th>
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<tr>
<td>Hospital</td>
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<tr>
<td>• Proposed 2012 Prospective Payment System rule</td>
<td>1,032</td>
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<tr>
<td>• Hospital Value-Based Purchasing Final Rule (7/1/11)</td>
<td>194</td>
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<tr>
<td>• Hospital Outpatient 2011 Final Rule</td>
<td>1,852</td>
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<tr>
<td>Physician</td>
<td></td>
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<tr>
<td>• Physician Fee Schedule 2011 Final</td>
<td>1,562</td>
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<tr>
<td>Subtotal</td>
<td>4,643</td>
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<tr>
<td>Other estimated pages from CMS and contractors (2010)</td>
<td></td>
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<tr>
<td>• Contractor bulletins</td>
<td>3,599</td>
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<tr>
<td>• CMS communications</td>
<td>11,177</td>
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<tr>
<td>Total</td>
<td>19,419</td>
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Source: Mayo Clinic, personal communication to authors.

Over regulation can lead to unintended consequences

“…the vast and confusing array of federal laws, rules, regulations, interpretive manuals, guidelines and audits…makes it much more difficult…for hospitals to respond to the concerns of patients of limited means who are unable to pay their hospital bills.”

“Fear of unfounded prosecution and the formidable array of enforcement tools available to the Medicare program have created fear among providers. Well-intentioned providers are cowed from appropriate behavior or even from participating in the program….”

• Park Nicollet, a large medical group based in St. Louis Park, Minnesota, carried out a “virtual” exercise to redesign primary care delivery.

• In the new concept clinic, patients with routine complaints (such as a sinus infection) would be treated by non-physician caregivers, sometimes remotely.

• Despite the need to expand office hours and hire additional clinical staff, Park Nicollet estimated that the model would lead to 10-15% cost savings.

• However, given that Medicare pays less or nothing for new delivery models, Park Nicollet discovered that the new concept clinic would run at a 40% loss.

Price controls do not result in lower total spending: Physician fees example

- Physician fees
- Physician expenditures per Medicare beneficiary

* Fee for service Medicare beneficiaries.

Why don’t price controls work in healthcare? The same reason they don’t work elsewhere in the economy.

Grayson’s maxim

“Add [price] controls and you will see ‘new’ services appear. Expect ‘unbundling’ of services with the price of individual units, when added together, totaling more than the original services.”

C. Jackson Grayson, Jr.
Chair, U.S. Price Commission (1971-1973)

Exhibit 1: The Medicare Price Control Cycle

- Cost too high
- Reduce line-item payment rate to providers
- Providers
- See more patients per day
- Order more tests, images
- Costs go up anyway
Providers are already paid below their cost by the government

U.S. community hospital profit and loss margins by payer class (2007)
Percent profit or loss

<table>
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<tr>
<th>Payer Class</th>
<th>Percent Profit or Loss</th>
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<tbody>
<tr>
<td>Employer Sponsored Insurance</td>
<td>32%</td>
</tr>
<tr>
<td>Medicare</td>
<td>-9%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>-12%</td>
</tr>
<tr>
<td>Uninsured and Self-Pay</td>
<td>-45%</td>
</tr>
<tr>
<td>Total</td>
<td>4.5%</td>
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</table>

Profit margins from patients with employer sponsored insurance are sufficient to leave the hospital industry with an overall positive margin, despite being only 36% of inpatient volume. Further reimbursement cuts by Medicare and/or Medicaid would pose significant challenges to hospitals.


- An indication of why across-the-board payment reductions by the Medicare and Medicaid programs are not a viable long term strategy is illustrated by the previous slide.
- In 2007, the Medicare and Medicaid government programs were already paying hospitals 9% below the actual cost of care delivery.
- This loss is offset by positive profit margins coming from employer sponsored insurance.
- In essence, individuals in the employer sponsored insurance category are paying an undeclared tax to fund the low reimbursement rates from government programs.
- With the laws that are in place now, the across-the-board payment reductions by Medicare and Medicaid will become even greater – likely leading to even more undeclared tax on individuals under age 65.
And stand to lose more if present legislation is not changed

- Providers face a 27-30% reduction in payment rates in 2014, if no changes are made to the current legislation.
- Thereafter, the rates are expected to have further cuts in each of the next six years. By 2021, the rate that Medicare pays physicians would be 35% less than it paid physicians 20 years earlier in 2001.


Low reimbursement and projected cuts are reducing physician access for Medicare patients

- In North Carolina, a team of “mystery shoppers” posing as Medicare beneficiaries looking for a new doctor, called 200 family physicians. Nearly half of the physicians contacted no longer accepted new Medicare patients.
- A 2010 survey of 9,000+ physicians by the American Medical Association (AMA) showed that 17% of all physicians (and 31% of primary care physicians) restrict the number of Medicare patients in their practice.
- Almost two-thirds (60%) of physicians surveyed by the AMA looked into opting out of Medicare and treating patients through a private contracting option (where neither the patient nor the provider can request payment from Medicare).
- Nearly 13% of physician respondents to a 2010 survey by the American Academy of Family Physicians would consider no longer seeing any Medicare patients; 62% said they may be forced to stop accepting new Medicare patients; and 73% said they would have to limit the number of Medicare appointments.

The impact of limited access as seen through the eyes of Medicare beneficiaries

• “I moved into this nice apartment complex, big medical complex across the street, I thought, ‘How lucky am I?’ And I went there and was told in the waiting room, well they just don’t take Medicare patients. One of the receptionists said to me, ‘Well honey, it’s just going to get worse.’”

• “His knee doctor no longer takes Medicare patients. And he has to pay two other doctors directly and wait for Medicare to reimburse him. He sees those doctors’ policies as warnings that Medicare’s reliability may be growing shakier.”


Medicare Actuary’s take

“…the prices paid by Medicare for health services are very likely to fall increasingly short of the costs of providing these services. By the end of the long-range projection period, Medicare prices for hospital, skilled nursing facility, home health, hospice, ambulatory surgical center, diagnostic laboratory, and many other services would be LESS THAN HALF of their level under the prior law. Medicare prices would be considerably below the current levels paid by private health insurance. Well before that point, Congress would have to intervene to prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result.”

The reliance of the Affordable Care Act on across-the-board reductions in Medicare payments has severe implications for providers in declining reimbursements and for patients in declining access.

The Congressional Budget Office’s take: Financial viability of the ACA is contingent on proposed Medicare pay cuts

- “The bill would put into effect a number of policies difficult to sustain…[and if sustained,] whether it would be accomplished through reductions in access to care or the quality of care.”
- “The long term budgeting could be quite different if key provisions were ultimately changed or not fully implemented.”

Conclusions about the current state of Medicare

• The costs of Medicare are unsustainable and will burden the nation’s finances.
• The complexity of its rules will continue to stifle innovation.
• The price-control approach to reimbursement will almost certainly lead to decreased access for patients.

As a country, we need to do something!
“Intractable problems are usually not intractable because there are not solutions, but because there are not solutions without side effects…. It is only when we demand a solution with no cost that there are no solutions.”

* Lester Thurow is the former dean of the MIT Sloan School of Management
## Medicare reform principles or what do the authors want Medicare to be

- Financially sound: Self-sustaining in the long term.
- Patient-centered: Empowers individuals to select providers and make healthcare decisions.
- Provides choice: Private market with multiple options.
- Promotes competition around quality and cost.
- Establishes government role: Coordinate competition and provide targeted financial support.

## Solving the Medicare problem: Summary Recommendations

1. Increase age of eligibility to 69 years, with the option to enter the program at 65 years, and link it to life expectancy thereafter.
2. Move to a premium support model with a national insurance exchange that includes a variety of insurance products.
The rise in Medicare costs is driven by two key factors

1. Number of eligible beneficiaries

2. Cost per beneficiary

We recommend raising the Medicare eligibility age to 69, with option to enter the program at 65

- Gradually raise the Medicare eligibility age to 69 years in the following manner: raise the age of eligibility by two months every six months beginning in 2014, until the eligibility age reaches 69 years.
- Eligibility thereafter should be indexed to life expectancy.
- We recognize that some individuals below age 69 may not be able to work for medical reasons or may not be eligible for healthcare benefits through their employers. To address this problem we propose to allow beneficiaries to enroll in the program at age 65, but at a reduced government contribution (actuarially equivalent to entering the program at age 69).
- Because Medicare and Social Security are interrelated, the most viable course of action would be to address the age of eligibility in both programs simultaneously.
Key point: while some will view this position as too harsh, we strongly feel that a country can only offer entitlement programs that it is willing to pay for with real dollars, rather than with Washington, D.C. smoke and mirrors. We do not feel the U.S. is willing to increase taxes to the point required by just part A of the present Medicare program (e.g., more than double the current tax rate, see slide 39). If that assessment is correct, raising the eligibility age to align with life expectancy gains is just common sense.

Increase the age of eligibility: Life expectancy at age 65 is increasing

<table>
<thead>
<tr>
<th>Life expectancy at age 65 (1960-2009)</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>14.3</td>
</tr>
<tr>
<td>2009</td>
<td>19.2</td>
</tr>
</tbody>
</table>

- When Medicare was started, life expectancy for an individual who reached age 65 was a little more than 14 years.
- By 2009, that life expectancy had grown to over 19 years.
- As a result of this rise in life expectancy, Medicare now needs to provide nearly an additional 5 years of medical coverage, compared with the 1960s when the program was first established.
- And now there are fewer workers per beneficiary to provide the taxes to fund the program.

In 2009 Americans exceeded the life expectancy at age 65 that Medicare projected for 2025.

- The actual gains in life expectancy have historically been greater than those projected by the Medicare Trustees.
- In 2005 Medicare Trustees made a projection of life expectancy at age 65 for 2025. But just 4 years later, the actual life expectancy had already exceeded the 2025 estimate.

Rising life expectancy and lower retirement age result in higher need for social support – Can we afford it?

<table>
<thead>
<tr>
<th>Year</th>
<th>Life expectancy at birth</th>
<th>Average retirement age*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950</td>
<td>68.2</td>
<td>68.3</td>
</tr>
<tr>
<td>2005</td>
<td>77.8</td>
<td>62.6</td>
</tr>
</tbody>
</table>

Gain/loss: +9.6  -5.7

15.3 year increase in living beyond retirement


There are multiple benefits to increasing the age of eligibility

- Encourages seniors to build up adequate retirement savings.
- Boosts overall GDP.
- Helps close Medicare funding gap.
Working longer is good for Boomers: It will help their financial security in retirement

The number of work years beyond age 65 necessary for a household to be sufficiently prepared for retirement by percentage of households (2007)

- At age 65 only about half of the households are financially prepared for retirement.
- Working an additional 1-3 years reduces the percentage of households that are not prepared for retirement almost in half.
- The idea of working longer before being eligible for Medicare benefits can potentially help households.

Working longer is good for the economy

- The McKinsey Global Institute estimates that the economic impact of Boomers retiring two years later is $12.9 Trillion in GDP over 2007-2025.
- If individuals work longer they also tend to spend more and the economy grows.


CBO estimates that raising the age of eligibility to 67 can generate $113B in savings over 10 years

A recent CBO report discussed the fiscal benefits of increasing the age of eligibility for Medicare:
- “This option would raise the age of eligibility for Medicare by two months every year beginning with people who were born in 1949 (who will turn 65 in 2014) until the eligibility age reached 67 for people born in 1960 (who will turn 67 in 2027).”
- CBO projects that net savings in the 2012-2021 time frame would be $113B.
- Raising the age of eligibility to 69 (in the same time frame) will produce additional savings, and is more in line with the financial reality of Medicare.

Source: Congressional Budget Office. 2012. “Raising the Ages of Eligibility for Medicare and Social Security.”
The rise in Medicare costs is driven by two key factors

1. Number of eligible beneficiaries
2. Cost per beneficiary

We recommend moving Medicare to a premium support model

- Individuals should own their insurance and have the freedom to chose their own insurance plan.
- Premium support provides a mechanism to achieve the above.
- Medicare would no longer be a government insurance company.
- Instead Medicare would function like the Federal Employee Health Benefits Plan (FEHBP) – coordinate private insurance options and provide a set dollar amount for each beneficiary to purchase insurance from a list of government approved insurance options.
- This is the approach recommended by the Clinton Medicare Bipartisan Commission in 1995 and by the Bipartisan Policy Committee Task Force in 2010.
We do not feel that the U.S. population is willing to increase taxes to the point where the present fee-for-service (FFS) Medicare program is sustainable.

Moving Medicare to a premium support model allows the government to change from an open-ended benefit to a program where the government can determine the contribution it can actually afford.

Individuals who recommend keeping the present FFS Medicare model should be honest about the tax increases required to do so. This is especially important because the alternative approach of just reducing Medicare payments will result in payment levels that are so low that both access and quality will be severely impacted.

The government’s primary approach to date, i.e., price controls, has been unsuccessful in containing Medicare costs...
Price controls do not result in lower total spending: Physician fees example

* Fee for service Medicare beneficiaries.

Price controls have been tackling the wrong part of the equation

- Medicare has also committed significant effort to figuring out the “ideal” price paid per unit of service to curb spending, when use rate is actually the more important variable.  

\[
\text{Total Cost} = \text{Price} \times \text{Use Rate}
\]

- The use rate is a direct function of the medical practice style in the delivery system.

It’s all about the use rate and it varies by region of the country

- "…utilization - not local price differences - drives Medicare regional payment variation…."\(^1\)

- “Most of this variation [in Medicare spending] was not due to differences in the price of care in different parts of the country, but rather to differences in the volume…."\(^2\)

- “…there is nearly a twofold difference between the MSA [Metropolitan Statistical Area] with the greatest service use (the Miami, FL, MSA) and the MSA with the least service use (the La Crosse, WI, MSA) [after adjusting for regional prices, added payments for Graduate Medical Education, demographics, beneficiary health status, etc.]."\(^3\)

Additional services provided in high-cost areas are those that depend most on individual physician practice style

Risk-adjusted ratio of high-spending vs. low-spending regions’ use rates by service
(>1 = use rates are higher in high-spending areas; <1 = use rates are lower in high-spending areas)

Services with existing clinical practice consensus
- Mammogram, women 65-69
- Pneumococcal immunization
- Total hip replacement
- Back surgery

Services where individual clinical practice style prevails
- Total inpatient days
- Inpatient days in ICU or CCU
- Evaluation and management (visits)
- Imaging
- Diagnostic tests


- Both high-spending areas and low-spending areas do mammograms, hip and back surgeries at the same rate per 1,000 population. Thus, these are not factors that make a high-spending area more costly.
- However, high-spending areas use about twice as many ICU days per 1,000 population – raising spending.
- Services where clinical judgment prevails (length of stay in the ICU and CCU, physician visits, imaging tests, diagnostic testing), are higher as well in high-costs areas – raising spending.
Private insurers may be better at controlling utilization, and therefore total costs (1/2)

Growth in healthcare expenditures vs. GDP in the United States (1990-2009)

Change in growth, percent

- From 1993 through 2000, healthcare expenditures in the U.S. grew roughly in line with GDP, which has been a goal for many economists.
- This time frame coincides with the “HMO” era – when managed healthcare plans were controlling medical utilization.

Source: OECD. Statistics from A to Z (accessed May 26, 2011), http://www.oecd.org/document/0,3746,en_2649_201185_46462759_1_1_1_1,00.html

Private insurers may be better at controlling utilization, and therefore total costs (2/2)

A 2009 report in The New Yorker by Atul Gawande reported that Medicare spending for the elderly in McAllen, Texas is much higher than in El Paso, Texas despite essentially the same demographics.

A follow up study on the non-Medicare commercially-insured population in the same communities painted a different picture…

Commercial payers in two Texas towns show better spending and utilization management than Medicare

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Medicare ratio McAllen to El Paso</th>
<th>Commercial ratio(^1) McAllen to El Paso</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient spending per enrollee</td>
<td>1.63</td>
<td>1.10</td>
</tr>
<tr>
<td>Outpatient spending per enrollee</td>
<td>1.32</td>
<td>0.69</td>
</tr>
<tr>
<td>Total spending per enrollee</td>
<td>1.86</td>
<td>0.93</td>
</tr>
<tr>
<td>Inpatient utilization(^2)</td>
<td>1.31</td>
<td>0.84</td>
</tr>
</tbody>
</table>

\(^1\) Blue Cross and Blue Shield of Texas; \(^2\) Per 1,000 enrollees, Medicare ratio calculated based on hospital discharges in the last 2 years of life.

http://www.dartmouthatlas.org/data/topic/

- The geographic areas of McAllen and El Paso, Texas have received considerable attention as a result of an initial report on the variability in Medicare costs and use rates across these demographically similar areas.
- A follow up report looking at the commercial payer population costs and use rates showed that although the Medicare use rate in McAllen was significantly higher than that in El Paso, the use rate for commercial patient population showed little difference. This shows that commercial insurers are likely better than traditional Medicare at controlling use of resources.
- Since the use rates of services are what differentiates a high-cost area from a low-cost area (see slides 99-100), it is likely that commercial insurers would be better positioned to help restrain future Medicare spending.
- A recent comparison of enrollees in Medicare Advantage health maintenance organization (HMO) plans with beneficiaries enrolled in traditional Medicare, showed that healthcare utilization rates were ~20–30% lower in the HMO population.\(^1\)


\(^1\) Blue Cross and Blue Shield of Texas; \(^2\) Per 1,000 enrollees, Medicare ratio calculated based on hospital discharges in the last 2 years of life.
Total healthcare spending for Medicare beneficiaries has grown at a faster rate than that of private plans

<table>
<thead>
<tr>
<th>Average annual growth in spending per beneficiary (1997-2005)</th>
<th>Percent¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Total spending for privately insured individuals, non-Medicare (including out of pocket, other sources)</td>
<td>7.7%</td>
</tr>
<tr>
<td>• Total spending for Medicare beneficiaries comprises the following sources:</td>
<td>10.6%</td>
</tr>
<tr>
<td>• Federal Medicare spending</td>
<td>5.8%</td>
</tr>
<tr>
<td>• Out of pocket</td>
<td>15.0%</td>
</tr>
<tr>
<td>• Private insurance*</td>
<td>18.7%</td>
</tr>
<tr>
<td>• Medicaid**</td>
<td>26.3%</td>
</tr>
</tbody>
</table>

PLUS private insurance in 2006-2007 absorbed a ~15% cost shift by providers who compensated for the underpayments from government run plans.²

¹ The proportion of Medicare enrollees with employer-sponsored primary insurance more than doubled.
² Medicare beneficiaries who also received funding under Medicaid.


• One of the arguments used by proponents of a “public” option based on Medicare, is that Medicare provides comparable access to healthcare at costs that grow more slowly than those of the private sector.
• Focusing only on Medicare’s federal per-beneficiary payments, Medicare costs appear to be growing more slowly than private plan costs.
• However, this apparent slower growth in Medicare spending is primarily the result of Medicare’s policy of rapidly shrinking its contribution to the beneficiaries’ total healthcare costs.
• Much of the growth in total costs for Medicare beneficiaries has been offset by cost shifting to Medicaid and increased reliance on out-of-pocket spending and other sources of private-sector funding.
• Therefore, if we look at total per beneficiary costs during that period, they are growing faster for Medicare than for private insurance.
A model like the Federal Employee Health Benefits Program offers patient choice and potential savings

- The Federal Employee Health Benefits Program (FEHBP), administered by the Office of Personnel Management (OPM), is a successful model of premium support:
  - FEHBP enrollees choose from a variety of health plans, including managed care, conventional insurance, high-deductible plans, etc.
  - Enrollees can buy a plan that is more expensive than the capped government contribution and pay the difference out of pocket.
  - OPM's regulatory role in FEHBP is light, focusing mainly on consumer protection and a level playing field for health plans.
  - FEHBP is exempt from state mandates.
- In 1999, a bipartisan commission estimated that the movement to premium support would slow the growth in Medicare spending by 1 to 1.5% annually.*


The FEHBP-like model has advantages for both patients and providers...

1. The government could focus limited resources on those who need help, an imperative as the baby boom generation reaches Medicare's current eligibility age.
2. Everyone could choose from among multiple insurance offerings. Individuals may buy coverage that exceeds the minimum if they wish.
3. Patients may be more fully engaged as purchasers and customers.
4. A dynamic private market could allow more freedom to provide innovation and productivity gains to reduce healthcare costs.
5. The model offers assurance of universal access to a basic level of affordable, market-based health insurance.

The FEHBP-like model has a lower regulatory burden

- In contrast to the light regulatory role in FEHBP offerings and administration, the Affordable Care Act (ACA) mandates that every qualified health plan offer an “essential benefits package” to be defined by the Department of Health & Human Services.¹

- As a national exchange exempt from state mandates, the FEHBP has fewer administrative burdens and costs. But the ACA leaves primary implementation to the states, so health insurers must comply with both the federal requirements and with the varying mandates of each state they operate in:
  - “As we have learned with Medicaid, the Health Insurance Portability and Accountability Act (HIPAA), and other programs, state implementation of federally directed programs is at best awkward and at worst ineffectual.”²


To ensure that Medicare is sustainable long-term under the premium support model, we recommend that the participating health plans take into consideration the following set of ideas when designing benefit plans for Medicare beneficiaries…
Although publicized as a great insurance program, Medicare has fewer benefits than typical private insurance plans.

A recent Kaiser Family Foundation study comparing fee-for-service Medicare benefits with a typical FEHBP insurance plan and a typical large employer plan showed that:

- Medicare has higher cost-sharing requirements for inpatient care.
- Medicare has less generous drug coverage.
- Medicare has **no out-of-pocket limit** on inpatient and outpatient services, and thus lacks **truly catastrophic insurance coverage**.


---

Due to lack of truly catastrophic coverage, nearly 90% of Medicare beneficiaries have supplemental coverage

Medicare beneficiaries by source of supplemental insurance coverage (2008)*

<table>
<thead>
<tr>
<th>Percent</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>43%</td>
</tr>
<tr>
<td>80%</td>
<td>22%</td>
</tr>
<tr>
<td>60%</td>
<td>20%</td>
</tr>
<tr>
<td>40%</td>
<td>13%</td>
</tr>
<tr>
<td>20%</td>
<td>1%</td>
</tr>
<tr>
<td>0%</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

- In the under 65 population it is uncommon to have supplemental insurance with privately insured plans.
- It’s been suggested that the presence of supplemental coverage leads to overutilization of services by Medicare beneficiaries.

* Excludes beneficiaries in MAPs.

Recommendations for health benefit design

- Eliminate co-pays and co-insurance for visits to coordinating, primary provider.
- Establish a High Deductible Health Plan option with preventive care covered at 100%.
- Vary patient premiums and/or deductibles based on uncontrolled medical conditions such as tobacco use, weight, blood pressure, and cholesterol. Or, provide rebates for following condition specific management programs such as back pain and diabetes.
- Provide a retrospective rebate on beneficiary drug costs for conditions such as congestive heart failure, hypertension, and diabetes, if patients fill all prescriptions.

Changing consumer incentives: Indiana’s experience with their employee health plan

- In 2006-2007, Indiana expanded its offerings to include two High-Deductible Health Plans (HDHPs) with individual Health Savings Accounts (HSAs):
  - The state funds employees’ HSA in the amount of 55% of the deductible.
  - Preventive services are covered 100%.
- Independent, actuarial review by Mercer confirmed that after adjusting for demographics (age, gender, family size) and health, HDHPs’ annual costs were 10.7% lower than costs of other plans:
  - Indiana’s savings in 2010 = $17 to $23M.
  - Employees’ savings in 2010 = $7 to $8M.

Transition to HDHPs in Indiana resulted in better utilization of healthcare resources

<table>
<thead>
<tr>
<th>2009 Healthcare utilization</th>
<th>PPO</th>
<th>HDHP2 (% change from PPO)</th>
<th>HDHP1 (% change from PPO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER visits (per 1,000)</td>
<td>308</td>
<td>-32%</td>
<td>-47%</td>
</tr>
<tr>
<td>Physician visits (per 1,000)</td>
<td>5,012</td>
<td>-28%</td>
<td>-46%</td>
</tr>
<tr>
<td>Hospital admissions (per 1,000)</td>
<td>114</td>
<td>-44%</td>
<td>-68%</td>
</tr>
<tr>
<td>Average length of stay (days)</td>
<td>4.9</td>
<td>-16%</td>
<td>-22%</td>
</tr>
<tr>
<td>Average cost per prescription</td>
<td>$65</td>
<td>-17%</td>
<td>-38%</td>
</tr>
</tbody>
</table>

Note: HDHP1 has a higher deductible and higher HSA funding than HDHP2.

• The reason the high deductible health plans yielded savings for both the payer and the beneficiary was because of reductions in overall utilization in emergency room visits, physician visits, and hospital use.
• In addition, the increased use of generic drugs reduced the cost of prescriptions.
ADDITIONAL RECOMMENDATIONS TO ENSURE MEDICARE AFFORDABILITY

Although the previous recommendations address Medicare affordability for the U.S. government, to guarantee affordability for individual citizens additional steps are required, namely,

– Establishment of true Pay-for-Value initiatives.
– Tort reform.
Since it will take some time to phase out Medicare as an insurer, it makes sense to establish true Pay-for-Value models that would encourage healthcare provider integration and the coordination of healthcare services for patients.

Establishing Pay-for-Value models in Medicare might also encourage private insurers to change their payment models, especially as they prepare to take care of the Medicare population.

There is significant variability in the cost of care across the U.S.

<table>
<thead>
<tr>
<th>Geographic region</th>
<th>Average standardized risk-adjusted per capita costs ($USD)*</th>
<th>Ratio to benchmark (national average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest cost 10% of providers</td>
<td>$6,194</td>
<td>0.8</td>
</tr>
<tr>
<td>Lowest cost 20% of providers</td>
<td>$6,613</td>
<td>0.9</td>
</tr>
<tr>
<td>National average**</td>
<td>$7,500</td>
<td>Benchmark</td>
</tr>
<tr>
<td>Highest cost 20% of providers</td>
<td>$8,301</td>
<td>1.1</td>
</tr>
<tr>
<td>Highest cost 10% of providers</td>
<td>$8,849</td>
<td>1.2</td>
</tr>
</tbody>
</table>

* Total = National average standardized risk-adjusted per capita cost x total Medicare beneficiaries in sample. Total Medicare beneficiaries n = 25,832,920. Standardization of Spending: To standardize payment rates, examined Medicare’s various FFS payment systems and identified the factors that lead to different payment rates for the same service (e.g., local wages, input prices, DSH, GME). Estimated what Medicare would have paid for each claim without those adjustments. Risk-Adjustment of Spending: Used total Hierarchical Condition Category (HCC) risk scores to risk-adjust spending data. Calculated standardized risk-adjusted costs by taking the standardized costs for each beneficiary in a region and dividing them by his/her actual individual risk score.

** Includes VI, PR, DC and unassigned data.

Higher spending does not correlate with better outcomes, suggesting system waste and room for improvement

Quality and costs of care for Medicare patients hospitalized for heart attacks, hip fractures, or colon cancer by hospital referral region (2004)

Move to true Pay-for-Value: Reward results and outcomes

Value = \frac{\text{Patient Outcomes}}{\text{Total Cost}}

**Patient Outcomes** may include mortality, safety, service, access, fewer complications, less rework, faster return to work or functionality. It may mean readiness or productivity for different groups, e.g., individual, employee, workforce, military, student.

**Total Cost** is spending per patient over a defined time for a particular patient, a condition, a population, or a payer.
Medicare has come up short with its Pay for Performance (P4P) initiatives

- Medicare’s current P4P initiatives reward providers mainly for compliance with process requirements.
- “These current [P4P] efforts…carry some risks. Most…are not actually about quality results, but processes. Most ‘pay for performance’ is really pay for compliance. Compliance to too many process standards…runs the risk of inhibiting innovation by the best providers.”

  Michael Porter and Elizabeth Teisberg

As Porter and Teisberg point out, we should concentrate on quality, not process

- So take the case of two California metropolitan teaching hospitals that treat similar Medicare populations.

- Assume both hospitals complete the P4P Medicare processes and receive a 5% P4P bonus for fully complying with the process requirements.
P4P bonus structure can pay more for lower efficiency… and worse outcomes

<table>
<thead>
<tr>
<th></th>
<th>Medical Center A</th>
<th>Medical Center B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care efficiency (utilization &amp; cost)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital days per patient</td>
<td>11.1</td>
<td>23.0</td>
</tr>
<tr>
<td>Physician visits per patient</td>
<td>35.5</td>
<td>81.8</td>
</tr>
<tr>
<td>Total Medicare reimbursement per patient ($000)</td>
<td>$37.0</td>
<td>$62.2</td>
</tr>
<tr>
<td><strong>Care effectiveness (outcomes)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality ratio (&gt;1 = better than expected)</td>
<td>1.43</td>
<td>0.88</td>
</tr>
<tr>
<td><strong>5% P4P bonus</strong></td>
<td>$1,851</td>
<td>$3,112</td>
</tr>
</tbody>
</table>


- The typical pay for performance bonus structure rewards medical centers for completing selected process items, such as, giving a heart attack patient an aspirin on admission.
- The example assumes that both medical centers (A and B) complete the required process items. The data shown are results for two actual teaching hospitals in California metropolitan areas.
- Looking at Medicare patient data and the care patients received in the last 6 months of life, medical center A uses half as many hospital days per patient and half as many physician visits per patient, as medical center B.
- Consequently, medical center A has significantly lower Medicare costs and its quality (as defined by case-mix adjusted mortality ratio) is also 43% better than expected.
- In contrast, the quality at the more expensive medical center B is 12% worse than would be expected.
- Most people would agree that Medicare should financially reward the medical center that has better outcomes while using fewer resources. However, under the payment schemes currently used by Medicare, center B, which is less efficient and has worse outcomes, will get the largest financial reward – the exact opposite of what is desired if we truly want to pursue high value healthcare.
P4P brings few – if any – gains in patient health outcomes

• “Among hospitals participating in a voluntary quality-improvement initiative, the pay-for-performance program was not associated with a significant incremental improvement in quality of care or outcomes for acute myocardial infarction.”¹

• “We are aware that improvements in process measures do not necessarily translate into improved clinical outcomes. As illustrated by our results, it is much easier to make sure a patient with diabetes received a [cholesterol] order each year, than it is to ensure that the [cholesterol] is controlled to appropriate levels.”²

• “Our analysis…demonstrates that the current generation of P4P measures based on process is inadequate. Hospital quality measures did not correlate with complications or mortality.”³


Other Medicare programs that focus on process, have not fared any better.

• A recent Congressional Budget Office report evaluated 10 major Medicare demonstration programs over the last twenty years.
• 9 of the 10 did not decrease total costs (and some actually increased total costs).
• Report conclusion: “The [one] bundled-payment demonstration achieved savings for the Medicare program, but the [remaining nine] demonstrations that paid bonuses to providers on the basis of their quality scores* produced little or no savings.”

*Quality was defined as compliance with specific care processes.

The current Medicare Value-Based Purchasing scheme will continue to benefit the least efficient providers

- Hospital payments remain on the traditional Medicare payment structure, with a 1% across-the-board reduction in payment to finance incentive payments.
- Incentive payments are set by a total performance score based on meeting specific process measures (70%) and patient satisfaction scores (30%).
- Since key components of the value equation – resource utilization and patient outcomes – are not truly factored into the score, the CMS approach will continue to benefit the least efficient or effective providers.


As a first step in the move toward true Pay-for-Value we propose to establish Expanded DRGs…
In 1984 Medicare introduced a new payment system to curb the growth of hospital-based healthcare costs called Diagnosis Related Groups (DRGs).

The DRG system is a patient classification system that relates the reason for a hospitalization with the costs that a hospital incurs for that hospitalization.

The system is a form of bundled payments by which the hospital receives a pre-determined lump sum for all services provided by the hospital for that admission. Physician services during that hospitalization are not included.

Over the years, and working with physicians, hospitals have found ways to manage hospital care within the lump sum payment.

First, some background on DRGs

- An EDRG is another form of a bundled payment.
- The bundled payment in this case would include the hospital payment as any DRG, plus all physician payments, and would cover related care for a period of time, such as 30 to 60 days, after hospitalization.
- The value of an EDRG lies in the fact that it takes a payment model providers are familiar with right now and puts both hospitals and physicians at risk for a patient’s health for an extended time after discharge (e.g., 30, 60, 90 days).
- EDRGs require that providers and hospitals work together while monitoring their outcomes and overall costs. The EDRG thus acts as a forcing function – forcing integration and collaboration among providers and forces a relentless focus on value.
Another advantage is that, as with all bundled payment models, providers are free to practice in whatever fashion gets the best results and lowest costs.

As providers succeed in lowering costs with better outcomes, they will be able to manage more and larger bundled payment programs for patients with more complex acute and chronic conditions.

A 2009 Commonwealth Fund survey of healthcare opinion leaders showed that provider payment reform, specifically the move toward bundled payments, was viewed as the primary option for controlling costs while maintaining quality (with 70% of leaders selecting bundled payments as an “extremely effective” or “very effective” option). ¹


“Imagine…a patient who comes to the hospital for a hip replacement. That patient and his insurer…will be billed separately for the X-rays, laboratory tests, the surgeon’s fee, the anesthesiologist’s fee, the rehabilitation services, the hospital bill and the visits to the doctor after he’s discharged. In a bundled payment system, all the bills are rolled into one standard hip-replacement charge. The idea is to force all of a patient’s care providers to work together. They have a strong incentive to eliminate unnecessary tests and treatments and use less expensive implants, drugs and devices that don’t compromise quality, and to prevent infections and other complications that could land the patient back in the hospital.”

Why EDRGs?

- The response to EDRG payments will require various providers (doctors, hospitals, nursing, home health services, pharmacists, scientists, engineers, financial planning officers, technologists, etc.) to work in a more integrated fashion.
- If these providers are successful they will be in a much better position to assume increasingly more responsibility, accountability, and authority in the care of patients required by larger bundled payments and full capitation.
- We recognize many experts strongly support full capitation as the best way to reward value. We concur. But most providers have to start on the path somehow and building upon the familiar model of Medicare’s current DRGs is a way to start.
- The integration and the infrastructure needed to succeed under EDRG payments will support the management of patients in more and larger models of bundled payments and full capitation.

Where to start with EDRGs

1. Start with expensive DRGs and create an EDRG for those conditions or procedures.
2. Use lump-sum (bundled) payments to establish EDRGs, and thus encourage judicious use rates.
3. Define outcomes, not process metrics.
4. Give providers two to three years to self-organize for EDRGs. Experience with standard DRGs over the past 25 years shows it can be done.
Start with expensive DRGs and create an EDRG for these conditions or procedures

In a given year, 10% of the population accounts for ~65% of the total healthcare spending

Concentration of healthcare spending in the U.S. population (2009)

- One of the ways to restrain overall healthcare costs is to concentrate efforts on the small percent of the population that drives the majority of the costs – rather than the vast majority of the population that accounts for a small share of the overall costs.
- Most of the highest cost Medicare patients are the sickest patients who end up being hospitalized.
- Payment approaches that provide incentives for more integrated and coordinated care of these sick patients, have the potential to reduce the resource use (and cost) for these patients.

Use lump-sum (bundled) payments to establish EDRGs, and thus encourage judicious use rates

Expanded DRG =
Current DRG + Post-discharge care + Physician services related to the medical condition for a specified period of time.

Define outcomes, not process metrics

• True pay-for-value means tying payments to outcomes and costs over time.
• Outcomes should be condition or DRG specific.
• Favor independent or private oversight of outcome measurements, because:
  • Government efforts are often subject to politics and lobbying.
  • Government defined outcomes tend to be watered down and turned into process measures.
Give providers two to three years to self-organize for EDRGs: Experience with current DRGs shows it can be done

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Average length of stay (days)</td>
<td>6.9</td>
<td>6.4</td>
<td>-8%</td>
</tr>
<tr>
<td>Hospital admissions (per 1,000 population)</td>
<td>163</td>
<td>125</td>
<td>-23%</td>
</tr>
<tr>
<td>Hospital days (per 1,000 population)</td>
<td>1,129</td>
<td>800</td>
<td>-29%</td>
</tr>
</tbody>
</table>


How to set the payment amount for EDRGs

- Don’t use complex formulas.
- Use reality-based pricing:
  - Base amount would be the cost of resources used by medical centers getting best risk-adjusted outcomes.*
  - The actual payment would then be the base amount plus 3% (without a small margin even a not-for-profit organization cannot stay in business).

The above slide represents an example of a given Expanded Diagnostic Related Group (EDRG), where each dot represents a hospital in a given peer group of hospitals – for instance teaching hospitals.

The providers who deliver care for that EDRG should determine what would be good outcomes to measure, for example, orthopedic surgeons would determine outcomes to track for total joint patients.

If the EDRG was total hips, the likely outcome measurements would be (risk-adjusted) mortality, complications, return to normal activity, and infection rates.

Each medical center can then be measured on these outcomes and an index developed.

In addition, the cost of the resources used to deliver this care could be determined for each medical center and plotted on a graph as shown above.

When such analyses are done, the distribution of the data typically follows a pattern seen in this hypothetical example.
Set base amount at the median cost of the top third of hospitals with the best outcomes

Each symbol represents a single medical center; EDRG = Expanded DRG

An important factor is how the payment amount that Medicare would pay for an EDRG would be determined.

In our view, it should not be done by complex formulas that are often incorrect and tend to reward medical centers that get the worst outcomes.

Instead, we feel the approach should be one suggested by Dr. Harold Luft* in 2008. That approach would determine the median cost of medical centers that get the best outcomes.

In our example we have taken the top 1/3 of hospitals on outcomes, then drawn a dotted line down that represents the median cost for the top 1/3 of hospitals on outcomes. Thus, the cost paid by the government would actually be less than the current median cost of all the hospitals.

Therefore, all medical centers that had costs to the right of the dotted line, would now have incentives to become more efficient.

While setting payment amount per above will encourage better efficiency, we run the risk of reducing care effectiveness. To ensure that we do not sacrifice quality, a withhold approach may be warranted.

* Dr. Luft is currently Director, Research Institute at the Palo Alto Medical Foundation (PAMF). He is a senior investigator for PAMF’s Department of Health Policy Research, as well as Caldwell B. Esselstyn Professor Emeritus of Health Policy and Health Economics and former director of the Institute for Health Policy Studies (IHPS) at the University of California, San Francisco (UCSF).
To ensure that we do not sacrifice quality for cost with EDRGs, a quality withhold approach may be warranted:

- A possible way to promote effectiveness is to introduce a “quality withhold”:
  - Instead of receiving 100% of the base payment amount, providers would initially receive 95% of the EDRG base payment amount.
  - Providers with outcomes in the top 1/3 would receive the full amount (95% + the 5% quality withhold).
  - Payment to providers with outcomes below the top 1/3 would remain at 95% of the EDRG base payment amount (they lose the 5% quality withhold).
- The quality withhold could be set at a higher percentage.

If implemented correctly, the move to true Pay-for-Value will provide incentives for the high cost providers to become more effective and efficient.

These savings will not happen overnight, but should be realizable and sustainable long term.

In addition to EDRGs we should consider additional Pay-for-Value approaches suggested by the AMA

<table>
<thead>
<tr>
<th>Payment model</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial capitation</td>
<td>An Accountable Care Organization (ACO*) receives a pre-defined, risk-adjusted monthly payment to cover all costs of services for a defined beneficiary group.</td>
</tr>
<tr>
<td>Condition-specific</td>
<td>A group of physicians receives a fixed amount to cover all services for a specific condition, such as congestive heart failure.</td>
</tr>
<tr>
<td>Accountable medical</td>
<td>A group of physicians receives up-front resources to restructure primary care delivery. It commits, in return, to reducing inappropriate healthcare utilization.</td>
</tr>
<tr>
<td>home</td>
<td></td>
</tr>
<tr>
<td>Inpatient care</td>
<td>Physicians and hospitals set Medicare payment rates and give warranties for inpatient treatment, agreeing not to charge more for infections and complications.</td>
</tr>
<tr>
<td>warranties</td>
<td></td>
</tr>
<tr>
<td>Mentoring programs</td>
<td>Medicare offers financial and technical support (e.g., patient utilization, cost, and quality analyses) to small or solo physician practices working with regional health improvement collaboratives.</td>
</tr>
<tr>
<td>Private contracting</td>
<td>Patients and physicians freely contract for services, allowing them to agree on rates for services without having to forgo Medicare payment.</td>
</tr>
</tbody>
</table>

* ACO = a healthcare delivery model that ties provider reimbursements to quality metrics and reductions in the total cost of care for a given population of patients.
The legal environment also contributes to higher use rate and inefficiency...

- Defensive medicine consists of procedures or tests that a doctor orders to avoid possible future malpractice lawsuits.
- The practice is prevalent among U.S. physicians. According to a survey of 824 physicians in 2005:
  - 93% said they had engaged in the practice of defensive medicine.
  - 59% said they often ordered more diagnostic tests than medically necessary.
  - 52% said they referred patients to other specialists in unnecessary circumstances.
  - 33% said they often prescribed more medications than medically necessary.

...and leads to higher healthcare delivery costs

- Estimates of annual healthcare costs caused by unnecessary care related to defensive medicine and associated legal costs range from ~$50 billion to $200 billion.¹,²
- “The legal environment also should be structured to encourage the sharing of information, perhaps through increased transparency and creation of a ‘safe harbor’ to report poor outcomes or errors.”³


Summary recommendations

• Key recommendations to make Medicare sustainable for the government:
  – Increase the age of eligibility to 69 years, with the option to enter the program at 65 years, and link it to life expectancy thereafter.
  – Move to a premium support model with a national insurance exchange that includes a variety of insurance products – a Medicare Exchange.
• Key recommendations to ensure Medicare affordability for individual citizens:
  – Establish true Pay-for-Value.
  – Carry out tort reform.
Conclusions: Detailed recommendations (1/3)

• Progressively increase the age of eligibility to 69 years starting in 2014 and link the future eligibility age to changes in future life expectancy:
  – We recognize that some individuals below age 69 may not be able to work for medical reasons or may not be eligible for healthcare benefits through their employers.
  – To address this problem we propose to allow beneficiaries to enroll in the program at age 65, but at a reduced government contribution (actuarially equivalent to entering the program at age 69).
• Beginning in 2016, all Medicare beneficiaries would be on premium support for a private health plan through a Medicare Exchange:
  – The amount of premium support for the individual beneficiary would be adjusted by income.
  – The Medicare Exchange model would be based on a Federal Employee Health Benefits Plan (FEHBP) approach with discretion given to an Office of Personnel Management (OPM)-like group to manage the Exchange.

Conclusions: Detailed recommendations (2/3)

– OPM-like group would have the following responsibilities:
  • Determine minimum performance standards for plans.
  • Each insurance company should have a basic low cost option.
  • There is at least one High Deductible Health Plan (HDHP) as an option.
  • Ensure that insurance plans are solvent.
  • Provide information on the plans and their past performance to the beneficiaries.
  • Enforce rules for consumer protection.
  • Initiate risk adjustment for plans with a disproportionate share of high cost patients.
– OPM-like group does not:
  • Standardize health benefits.
  • Set prices for either the plans or the providers.
Conclusions: Detailed recommendations (3/3)

- In year one, the basic government contribution would be determined on either what would have been paid per beneficiary under Fee For Service (FFS) or the 2nd least expensive plan, whichever is lower. Going forward limit the increase in government premium support to GDP +1% or the 2nd least expensive plan, whichever is lower. If per beneficiary costs increase by more than GDP + 1%, the beneficiary share of the Medicare premium will rise on a financial means tested basis.

- Provide a medical savings account for low-income beneficiaries from which they could pay co-pays, deductibles, etc. – thus assuring that low-income beneficiaries can obtain care.
  - Move to true Pay-for-Value: Start by changing how FFS Medicare pays for hospitalized patients by going to Expanded DRGs as described on slides 130-148.
  - Carry out tort reform.

Financial implications of the proposed Medicare reform

<table>
<thead>
<tr>
<th>Estimated savings (2013-2022)</th>
<th>$ Billions</th>
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<tbody>
<tr>
<td>Raising the age of eligibility to 69</td>
<td>~375⁴</td>
</tr>
<tr>
<td>Moving Medicare to premium support</td>
<td>~274²</td>
</tr>
<tr>
<td><strong>Total savings</strong></td>
<td>~618³</td>
</tr>
</tbody>
</table>

1) Assumes the same timeline as CBO projections of moving age of eligibility to 67 (2014-2027) and the same reduction in savings as a result of “federal spending on Medicaid, exchanges, federal retirees, and Social Security retirement.” Source: Congressional Budget Office. 2012. “Raising the Ages of Eligibility for Medicare and Social Security.” Issue Brief, January. 2) Senator Pete Domenici and Dr. Alice Rivlin. 2012. “Domenici-Rivlin Debt Reduction Task Force Plan 2.0.” Bipartisan Policy Center, December 3. 3) Savings are not directly additive since changing the age of eligibility reduces the number of beneficiaries that will be on premium support.
Conclusions: Medicare has to change to survive

- Medicare must be made sustainable in a manner that is fair to seniors, to their children and their grandchildren who are or will be paying the taxes for the Medicare program. As this book shows, bold action and consistent leadership on several fronts are required.
- If there is no action, Medicare in its current form:
  - Will burden the nation’s finances,
  - Will stifle innovation due to the complexity of its rules and regulations,
  - Will continue to decrease access for Medicare patients,
  - Will lead to worse outcomes and higher costs due to its continued use of price-controls, which have failed to control growth in overall Medicare spending.

As a country, we need to do something!
Established in 1965, the Medicare program is the primary health insurance program for adults aged 65 and older and people younger than 65 with permanent disabilities. Although Medicare has made a significant contribution to the lives of beneficiaries by improving their economic and health security, the program presents a number of challenges. It is of interest to note that some of the problems we currently face, e.g., rapidly rising costs and overwhelming complexity, were already present in the first year of the Medicare program. Thus, we believe that we will not solve the problem by relying on continuing piece-meal “tinkering” with various program components. Medicare must be fundamentally reformed and made sustainable in a manner that is fair to seniors, to their children and their grandchildren, who are or will be paying the taxes for the Medicare program.

Our key recommendations to make Medicare sustainable for the government include: Raising the age of Medicare eligibility to 69 years, with the option of entering the program at 65 years; Moving Medicare to a premium support model. Moreover, to ensure Medicare affordability for individual citizens, we also propose: Establishing true Pay-for-Value for medical providers; Carrying out tort reform.