CHAPTER 1

At a crossroads in Medicare: Assessing payment adequacy and moving toward value-based purchasing

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Health care spending has been a growing part of our economy for the past several decades, and all indications suggest it will continue to grow faster than national income. This chapter describes trends that are increasing spending by the Medicare program and other public and private payers. Analysts believe that technological change has been the dominant driver of growth in health care spending. Many advances have brought valuable improvements in the length and quality of beneficiaries' lives. Yet, at the same time, not all new technologies are worth their expense, and there is considerable evidence that, in general, we do not use health care resources very efficiently. Near-term budgetary pressures and concerns about Medicare's long-term financing could lead policymakers to consider more explicitly how much they value health care spending relative to other uses of resources.

MedPAC's predecessor agencies—the Physician Payment Review Commission and the Prospective Payment Assessment Commission—were created 20 years ago to advise the Congress on Medicare payment policy. MedPAC's continuing role is to evaluate the design and implementation of Medicare policy and make recommendations to the Congress on problems it identifies and opportunities it sees. To fulfill this mission, MedPAC examines whether Medicare's policies ensure that beneficiaries have access to medically necessary care of high quality and get the best value possible for beneficiaries and taxpayers.

As part of that process, the Commission evaluates the adequacy of payment rates for efficient providers under Medicare's payment systems. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directs MedPAC to conduct this analysis with efficient providers in mind to make the best use of Medicare's resources. (See Chapter 2 on MedPAC's framework for evaluating payment adequacy.) More recently, MedPAC has also begun to push for changes to Medicare's payment systems that could improve quality. This strategy pays providers based on their performance on a set of quality measures. Despite the difficulty involved in this approach, Medicare must begin to take that step to allocate program resources where beneficiaries receive the greatest value. Because of the program's size and influence, changes to Medicare's payment structure could lead to broader improvements in the delivery of health care.

The Commission formulates recommendations on payment updates and other Medicare policy issues within a broader political and economic context—one that has changed significantly over the past several years. For example, policymakers may feel pressure to limit growth in federal spending, including that for Medicare, to rein in the federal budget deficit. The Medicare program also sits on the cusp of the retirement of the baby boom population, which will bring substantial growth in the number of beneficiaries. Payment changes in the MMA as well as higher health expenditures and lower payroll taxes than expected led the Medicare trustees to project in their 2004 report that dedicated revenues will fall short of benefit obligations sooner than previously expected. With demographic pressures, continued advances in medical technology, and, beginning in 2006, Medicare's coverage of outpatient prescription drugs, the trustees also project that, in the future, program spending could require unprecedented shares of our country's economic output.

The Commission's goals are for Medicare to maintain good access to care for beneficiaries, improve quality, and limit growth in program spending. Past approaches to constraining Medicare spending have tended to treat broad categories of providers equally, without regard to the quality, appropriateness, or efficiency of their services. It is now time for decision makers to distinguish among providers on the basis of quality as they put policies in place to limit growth in spending. More broadly, the Commission concludes that Medicare is at an important crossroads: The program should move toward value-based purchasing by differentiating among providers on their quality and efficiency, thereby sending clearer signals to providers about what the program wants to pay for.

Who are Medicare beneficiaries?

Medicare's beneficiaries are a diverse group of 41 million individuals who vary by age, ethnicity, health status, and economic circumstances. The vast majority are age 65 or older, but in 2001, 14 percent were younger, disabled people (Table 1-1). Eleven percent were age 85 and above. Compared with the United States as a whole, the Medicare population has a higher proportion of females (because they tend to live longer), a larger share of white, non-Hispanic individuals, and more people who live in rural (nonmetropolitan) areas.

The living arrangements and incomes of Medicare beneficiaries vary substantially. In 2001, about half lived with their spouse, nearly a third lived alone, 16 percent had other arrangements (for example, living with adult children), and 6 percent lived in institutions such as nursing homes. In 2002, Social Security benefits made up just under 40 percent of total income of the noninstitutionalized elderly, with earnings, pensions, asset income, and other sources accounting for the remainder (Federal Interagency Forum on Aging Related Statistics 2004). The overall economic position of the elderly has improved over the past several decades. Nevertheless, many Medicare beneficiaries have limited incomes. In 2001, about 17 percent had incomes below the poverty level (defined then as $8,494 for people living alone and $10,715 for married couples) and about half had incomes of 200 percent of the poverty level or below.

On average, Medicare's benefits cover about half of all personal health care costs for its beneficiaries.[1] Several large categories of services, including outpatient prescription drugs and long-term care, are not currently

TABLE 1-1 **Characteristics of the Medicare population, 2001**

Characteristic	Percent of the Medicare population
Sex	
Male	44%
Female	56
Age	
Under 65	14
65–74	44
75–84	31
85+	11
Race/ethnicity	
White, non-Hispanic	80
African American, non-Hispanic	9
Hispanic	7
Other	4
Residence	
Urban	76
Rural	24
Living arrangement	
Institution	6
Alone	28
With spouse	49
Other	16
Income status	
Below poverty	17
100–125% of poverty	11
125–200% of poverty	22
200–400% of poverty	33
Over 400% of poverty	18
Type of supplemental insurance	
Medicare only	10
Managed care	16
Employer	31
Medigap or combination of medigap and employer	26
Medicaid	15
Other	2

Note: Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2001, poverty was defined as $8,494 for people living alone and as $10,715 for married couples. Sums may not add to 100 due to rounding.

Source: MedPAC analysis of the 2001 Medicare Current Beneficiary Survey, Cost and Use file.

covered by Medicare. Further, some of Medicare's cost-sharing requirements, such as a substantial inpatient deductible and high copays on long hospital stays, can lead to a considerable and open-ended financial obligation.

To reduce the risk of high cost sharing, over 90 percent of Medicare beneficiaries obtained supplemental coverage in 2001 through their former employers (31 percent), medigap policies (26 percent), Medicare Advantage plans (16 percent), or they enrolled in Medicaid (15 percent). In 2000, 12 percent of personal health care spending for Medicare beneficiaries was funded by Medicaid, while 12 percent was funded by private insurance (including medigap policies and employer-sponsored retiree coverage), and 4 percent by other sources (CMS 2003). About 19 percent of beneficiaries' personal health care spending was financed out of pocket.

For many Medicare beneficiaries, the premiums or cost-sharing requirements for supplemental policies are growing rapidly, as they have been for active workers. Some employers are reducing the availability of retiree coverage to their active workforce.

Background on Medicare and its financing

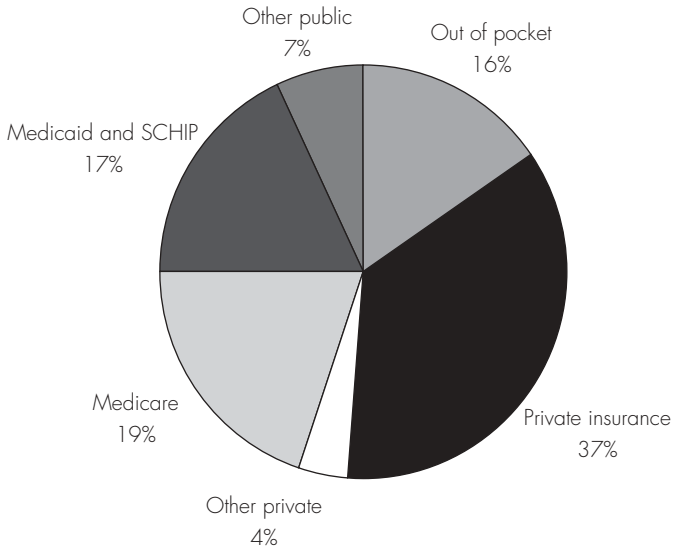
Although private insurance is the largest source of health care financing—making up 37 percent of the $1.44 trillion spent on U.S. personal health care in 2003—Medicare is the single largest payer for health care services (Figure 1-1, p. 6). Thus, through its coverage decisions and payment systems, the program can exert influence on how health care is organized and delivered in the United States.

The Medicare program has four parts. Hospital Insurance (HI, or Part A) is largely financed through a dedicated federal payroll tax. Supplementary Medical Insurance (SMI, or Part B) is funded primarily through transfers from general federal tax revenues and enrollee premiums. Part C is the Medicare Advantage program, in which private health plans provide care to beneficiaries, and Part D is the new outpatient drug benefit. Sources of funding for Part C are the same as for Parts A and B, while financing for Part D will be very similar to Part B.

Total Medicare spending was $281 billion in 2003, or about $7,000 per beneficiary (Table 1-2, p. 7). Federal taxes and interest pay for nearly 90 percent of Medicare spending. Payroll taxes provided the single largest source of funding for the combined Medicare program in 2003 (51 percent). Employees and their employers are each charged a mandatory 1.45 percent tax on earnings, with self-employed persons paying the full 2.9 percent. General tax revenues provided an additional 30 percent of all

FIGURE 1-1 **Medicare made up about one-fifth of spending on personal health care in 2003**

Total spending = $1.44 trillion



Note: SCHIP (State Children's Health Insurance Program). Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health care spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Premiums are included with each program (e.g., Medicare, private insurance) rather than in the out-of-pocket category. Other private includes industrial in-plant, privately funded construction, and nonpatient revenues, including philanthropy. Other public includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and state and local government hospital subsidies and school health.

Source: CMS, Office of the Actuary, 2004 National Health Accounts.

program income in 2003. Enrollees' premiums made up 10 percent of all Medicare income. These premiums include those for Part B, which CMS sets equal to 25 percent of average SMI expenditures for aged beneficiaries, as well as a small amount from enrollees who are not eligible for Part A but pay a premium for its coverage. Interest on current trust fund balances, a portion of income taxes on Social Security benefits, and other sources make up the remaining 9 percent of income.

The MMA created a system to warn policymakers as the Medicare program's financing becomes increasingly dependent upon general tax revenues relative to dedicated taxes and premiums. Each year, the Medicare trustees project the share of Medicare outlays that is financed with general revenues in the current year and six succeeding fiscal years. Under the warning system, if two consecutive annual reports from the trustees project that general revenues will fund 45 percent or more of Medicare outlays, then the President must propose and the Congress must consider legislation to address Medicare spending. General revenues currently make up 30 percent of program spending. However, the introduction of Part D in 2006 will mean that a larger proportion of the Medicare program's financing will come from general revenues. In their 2004 report, the Medicare trustees projected that general revenues would provide 45 percent of program financing in 2012—just outside the six-year projection window. Thus, policymakers may be called to consider changes to Medicare's benefits and financing in as few as three years from now. If policy changes increase program spending, the warning system could be activated in two years.

Although Medicare beneficiaries only made up about 15 percent of the U.S. population in 2000, they accounted for 37 percent of national personal health care expenditures (CMS 2003). The higher spending per person on personal health care services for Medicare beneficiaries than for the non-Medicare population reflects in part the much higher prevalence of chronic conditions among the elderly and disabled and their higher mortality. As estimated from Medicare claims data, about 78 percent of the Medicare population had at least one chronic condition in 1999, and 63 percent had two or more (Anderson 2002). Higher average personal health care spending for Medicare beneficiaries also reflects very concentrated use of services by individuals during their last year of life (Hogan et al. 2000).

Medicare program spending is highly concentrated among a few beneficiaries. In 2002, for example, the top 5 percent of beneficiaries ranked by spending accounted for nearly half of total fee-for-service (FFS) program spending, and the top quartile (25 percent) accounted for nearly 90 percent of spending (MedPAC 2004b). Concentration in spending is related directly to the cost of providing inpatient care, and people who experience an inpatient stay usually need more of all types of care during the year.

Hospital services are the largest component of Medicare spending. In 2003, 45 percent of Medicare expenditures covered inpatient and outpatient hospital services, followed by services paid on the physician fee schedule, other services (including hospice, lab, and durable medical

TABLE 1-2

Sources and uses of Medicare program financing, 2003

	Dollars (in billions)			
	Hospital Insurance	Supplementary Medical Insurance	Total	Percent of total
Total income	$175.8	$115.8	$291.6	100%
Payroll taxes	149.2	N/A	149.2	51
General revenue	0.5	86.4	86.9	30
Premiums	1.6	27.4	29.0	10
Interest, taxation on benefits, and other	24.4	2.0	26.4	9
Total expenditures	154.6	126.1	280.8	100
Hospital	109.4	17.9	127.3	45
Physician fee schedule services	N/A	48.3	48.3	17
Managed care	19.5	17.2	36.8	13
Skilled nursing facility	14.3	N/A	14.3	5
Home health care	2.6	7.1	9.7	3
Other	6.3	33.3	39.6	14
Administrative expenses	2.5	2.3	4.9	2

Note: N/A (not applicable). Other expenditures include hospice, durable medical equipment, and clinical laboratory services. Sums may not add to totals due to rounding.

Source: 2004 annual report of the Boards of Trustees of the Medicare trust funds.

equipment, among others), and payments to managed care plans (Table 1-2). This distribution of resources has changed over time as providers have moved more of their care to settings outside inpatient hospital facilities.

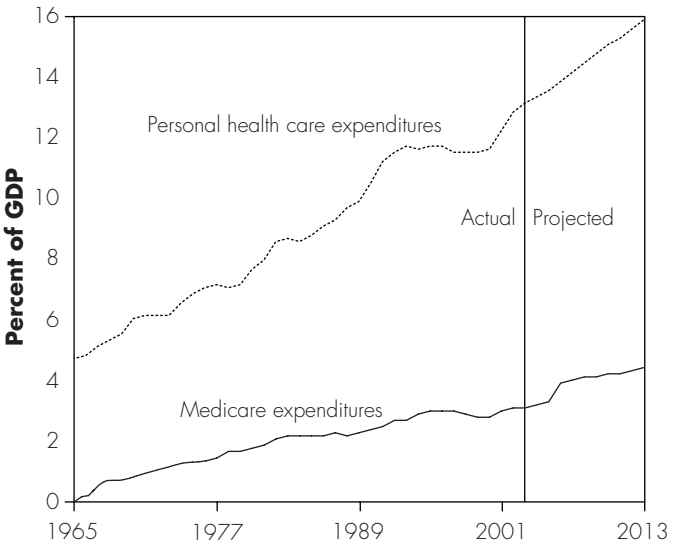
Trends in the growth of health care spending

National health care spending has been growing faster than the economy. Health care spending has brought with it medical innovations that make today's provision of care far more advanced than in the past. Nevertheless, growth in spending is striking: Personal health care expenditures accounted for more than 13 percent of gross domestic product (GDP) in 2004, up from 5 percent of GDP in 1965 (Figure 1-2).

Growth in spending has accelerated in recent years. During the 1990s, the share of GDP made up by personal health care was steady or even declining slightly at just under 12 percent (Glied 2003). Analysts attribute that

FIGURE 1-2

Personal health care expenditures account for a growing share of gross domestic product, 1965–2013



Note: GDP (gross domestic product).

Source: CMS, Office of the Actuary. Data for personal health care expenditures, GDP, and actual values of Medicare expenditures as a percentage of GDP are from the 2004 National Health Accounts. Projections of Medicare expenditures as a percentage of GDP are from the 2004 annual report of the Boards of Trustees of the Medicare trust funds.

period's slower growth to three factors: health plans' successful bargaining with providers over prices, managed care plans' use of strategies to control the volume of services, and competition among plans that restrained premium growth. The period after 1997 until 2001 was also a time marked by constraints on the growth of Medicare payment rates under the Balanced Budget Act of 1997 (BBA). Subsequently, however, health care spending has continued its upward climb. Consumers' demand for broader choice among providers and mergers among providers have given them greater negotiating power with insurers and health plans (Heffler et al. 2004).

Medicare's program spending for Parts A and B currently makes up about 2.6 percent of GDP. Once Medicare's benefit includes outpatient prescription drugs, CMS projects that the program's share will jump to 3.4 percent in 2006 and just under 4 percent by 2013. Medicare's share will climb upward on a steeper trajectory after 2010 as the baby boomers move into the ranks of Medicare beneficiaries.

Growth in spending for private health insurance

Trends in private health insurance premiums reflect spending growth in the health care sector. In the past year or two, increases in premiums slowed after about five years of steady acceleration (Strunk and Ginsburg 2004b, Kaiser Family Foundation and Health Research and Educational Trust 2004). Nevertheless, premiums for private health insurance still grew in excess of average growth in income. The same is true for most components of health care spending. For example, Strunk and Ginsburg estimate that in 2003, health care spending per privately insured person grew by 7.6 percent, while GDP per capita grew at 3.9 percent (Table 1-3). Data reflecting the first six months of 2004 show stable growth in per capita health spending, at an annual rate of 7.5 percent (Strunk and Ginsburg 2004a).

Given the large size of the hospital sector, its growth rate contributes heavily toward overall growth in spending across all health care services (Heffler et al. 2004). Declines in spending for inpatient services were largely responsible for the slowdown in overall spending growth in the mid-1990s. Hospital inpatient spending has grown more rapidly in recent years. Over the past two years, use of inpatient services grew relatively slowly, but prices grew rapidly as the ownership of hospitals consolidated and the more concentrated ownership exerted greater bargaining power in negotiations with payers. (See Section 2A for more discussion of this issue.) At the same time, spending for hospital outpatient services per privately insured person grew at the fastest rate among all sectors, even surpassing per capita growth in prescription drug spending. Still, many analysts expect that prescription drugs will continue to be among the fastest-growing sectors (Heffler et al. 2004).

Continued rapid growth in health premiums, a relatively weak labor market, and slow growth in the U.S. economy have led employers, insurers, and health plans to reconsider methods for controlling spending. One approach has been to shift a larger proportion of costs to enrollees through higher cost sharing, larger premium contributions, or consumer-directed health plans. Another approach involves reintroducing certain managed care techniques—such as prior authorization and utilization review—for services that are more likely to be overused, measuring providers' utilization and quality, tiering provider networks, and using disease management programs (Mays et al. 2004). (See Chapter 3 on possible use of similar tools by Medicare, such as measuring physicians' use of resources and managing the use of imaging services.)

Yet even with these approaches, some participants in the private health care market are worried about the pace of growth in health care spending and their inability to slow it down. For example, one coalition of employers, unions, and consumer groups has called for establishing an independent board that would restrict increases in insurance premiums for a core set of medical benefits and set constraints on payment rates to hospitals and physicians (Lueck 2004). Researchers with the Center for Studying Health System Change heard from a number of market participants that they could not take steps to contain costs (Nichols et al. 2004). They cited several forces, such as the current level of market power among providers, which has kept payers from being able to demand more efficient practice styles. At the same time, enrollee desire for broad choice has been strong, and physicians continue to organize themselves in small practices rather than in delivery structures that some respondents believed would provide better coordination of care—such as multispecialty group practices.

TABLE 1-3

Private spending on most types of health care services has grown faster than the gross domestic product, 1994–2004

		Change in private insurance spending on type of health care service per capita				
	Change in GDP per capita	All services	Hospital inpatient	Hospital outpatient	Physician	Prescription drugs
1994	4.9%	2.1%	–2.0%	8.7%	1.7%	5.2%
1995	3.4	2.2	–3.5	7.9	1.9	10.6
1996	4.4	2.0	–4.4	7.7	1.6	11.0
1997	5.0	3.3	–5.3	9.5	3.4	11.5
1998	4.1	5.3	–0.2	7.5	4.7	14.1
1999	4.8	7.1	1.6	10.2	5.0	18.4
2000	4.8	7.8	4.1	9.8	6.3	14.5
2001	2.1	10.0	8.7	14.6	6.7	13.8
2002	2.5	9.5	8.3	13.0	6.7	13.2
2003	3.9	7.6	6.2	11.1	5.5	9.1
January–June 2004	5.9	7.5	5.1	11.4	5.7	8.8

Note: GDP (gross domestic product). Estimates may differ from past reports because of data revisions by Milliman USA and the Bureau of Economic Analysis. Percent changes for January–June 2004 are growth compared with the same months in 2003.

Source: Strunk and Ginsburg 2004a, Strunk and Ginsburg 2004b. Health care spending data are from the Milliman USA Health Cost Index ($0 deductible) as of October 2004. GDP is from the U.S. Department of Commerce, Bureau of Economic Analysis.

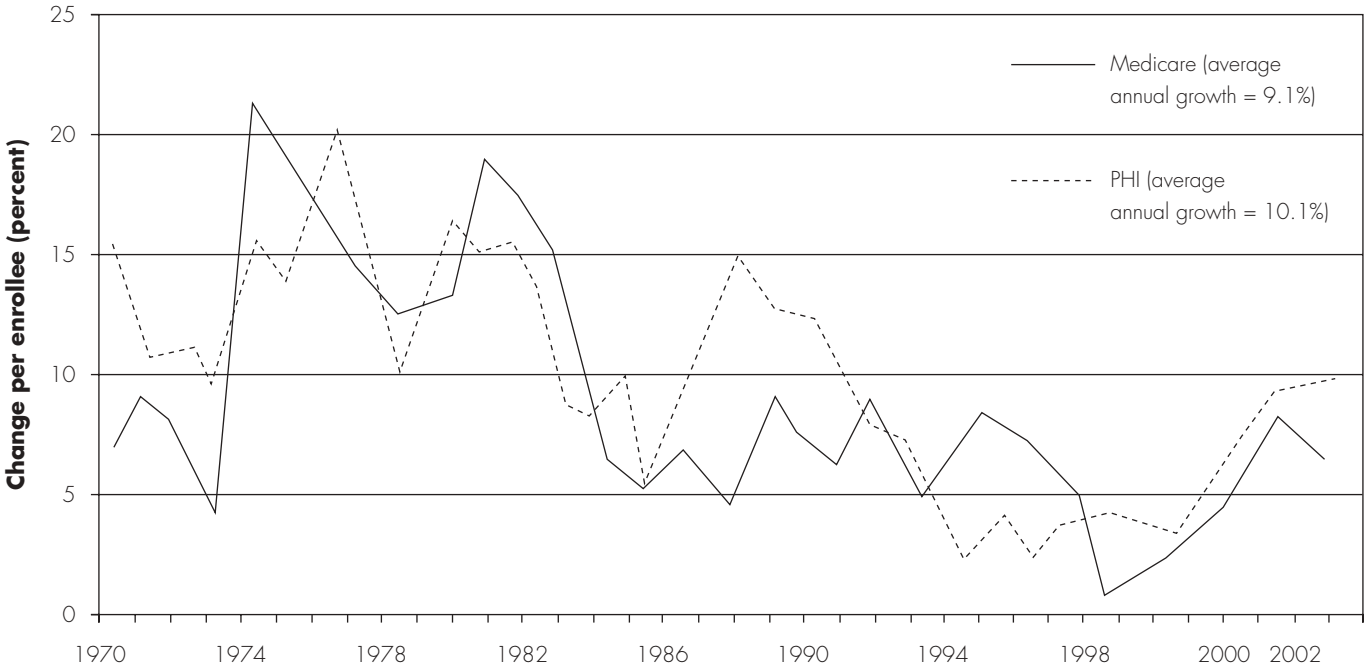
Growth in Medicare spending

Medicare's trustees project that total program spending will increase at an average annual rate of 7.5 percent over the 2004–2013 period, except for 2006 when the increase will be much higher because of the introduction of Part D (Boards of Trustees 2004). For 2004 and 2005, the trustees expect that HI spending will grow by 12 percent and 8 percent, respectively, in response to changes in payments under the MMA. After that, the actuaries project HI costs to grow by an average of 6 percent per year. By comparison, Part B expenditures are expected to grow by an annual average of 6.6 percent over the 2004–2013 period. However, the trustees note that 6.6 percent is likely too low, because it includes assumed cuts in physician updates under the sustainable growth rate (SGR) formula of 5 percent per year for seven consecutive years, beginning in 2006. Recent experience suggests that policymakers are unlikely to allow these cuts to be implemented.

Although rates of growth in per capita spending for Medicare and private insurance often differ from year to year, over the long term they have been quite similar (Pauly 2003). When comparing spending for benefits that private insurance and Medicare have in common—notably excluding prescription drugs—Medicare's per enrollee spending has grown at a rate that is about 1 percentage point lower than that for private insurance over the 1970–2002 period (Figure 1-3, p. 10). However, the comparison is sensitive to the end points of time one uses for calculating average growth rates. Differences have been more pronounced since 1985, when Medicare began introducing the prospective payment system for hospital inpatient services (Levit et al. 2004). Some analysts believe that, since the mid-1980s, Medicare has had greater success at containing cost growth than private payers by using its larger purchasing power (Boccuti and Moon 2003). Others maintain that benefits offered by private insurers have expanded as cost-sharing requirements declined over the entire period and enrollment in managed care plans grew during the 1990s. The comparison is thus problematic, since Medicare's benefits changed little over the same period (Antos and King 2003).

FIGURE 1-3

Changes in Medicare spending per enrollee have been similar to those for private health insurance over the long term



Note: PHI (private health insurance). Chart compares services covered by Medicare and private health insurance, including hospital services, physician and clinical services, other professional services, and durable medical products.

Source: Levit et al. 2004.

The financial horizon

The size of the federal budget deficit and concerns about Medicare's long-term financing are likely to shape perspectives of policymakers about the Medicare program during the upcoming year. This section reviews recent projections of the near- and longer-term financial landscape.

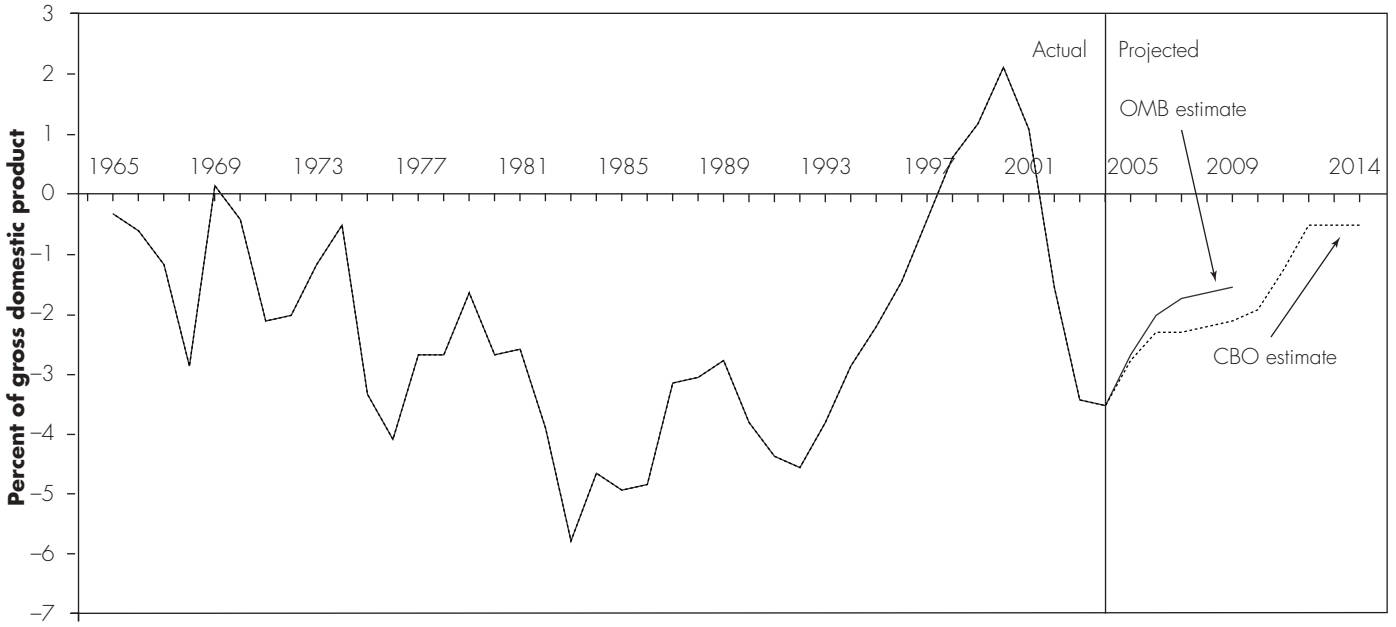
Near-term budgetary pressures

In the near term, the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) both project sizable federal budget deficits, which will heighten concern about growth in Medicare spending. For fiscal year 2004, the deficit was about $412 billion, or 3.6 percent of GDP. That figure makes up the highest share of the country's economic output since the early 1990s, a time when the Congress set limits on appropriated spending, raised taxes, and established procedural "pay-as-you-go" (PAYGO) rules under the Budget Enforcement Act for new laws affecting entitlement programs and taxes. More recently, the Congress has considered readopting PAYGO constraints on spending, but it has not yet done so formally. A few individual committees have used this approach informally.

CBO's September 2004 baseline projects that the budget deficit for 2005 will total $348 billion, or 2.8 percent of GDP, with deficits declining gradually until reaching $65 billion in 2014, or 0.4 percent of GDP (Figure 1-4). Those projections are based on current law, so they do not anticipate the effects of future legislative actions. They are probably conservative, because they assume implementation of substantial cuts in physician payments, which the Medicare trustees noted was unlikely (Boards of Trustees 2004). Further, CBO estimates that if all current tax provisions are made permanent, the federal deficit for 2014 will increase by $369 billion plus $100 billion in additional interest payments associated with debt service (CBO 2004b).

FIGURE 1-4

Near-term budgetary pressures may heighten concern about growth in Medicare spending



Note: OMB (Office of Management and Budget), CBO (Congressional Budget Office). Baselines are as of July and September 2004, respectively.

Source: Office of Management and Budget and Congressional Budget Office.

OMB's July 2004 baseline projects a deficit of $331 billion, or 2.7 percent of GDP, for 2005, and the administration has indicated that it would like to cut the deficit in half by 2009 by continuing its tax policies and restraining federal spending (OMB 2004). Some analysts argue that it will be difficult to achieve this goal without constraining growth in spending for the Medicare program. Medicare currently accounts for more than one-fifth of all entitlement spending and nearly 12 percent of total federal spending. Furthermore, Medicare will require a larger proportion of total federal spending as the new Part D outpatient drug benefit begins in 2006 and as the baby boomers begin to reach the age of eligibility (Newhouse 2004).

Longer-term projections of Medicare spending and financing

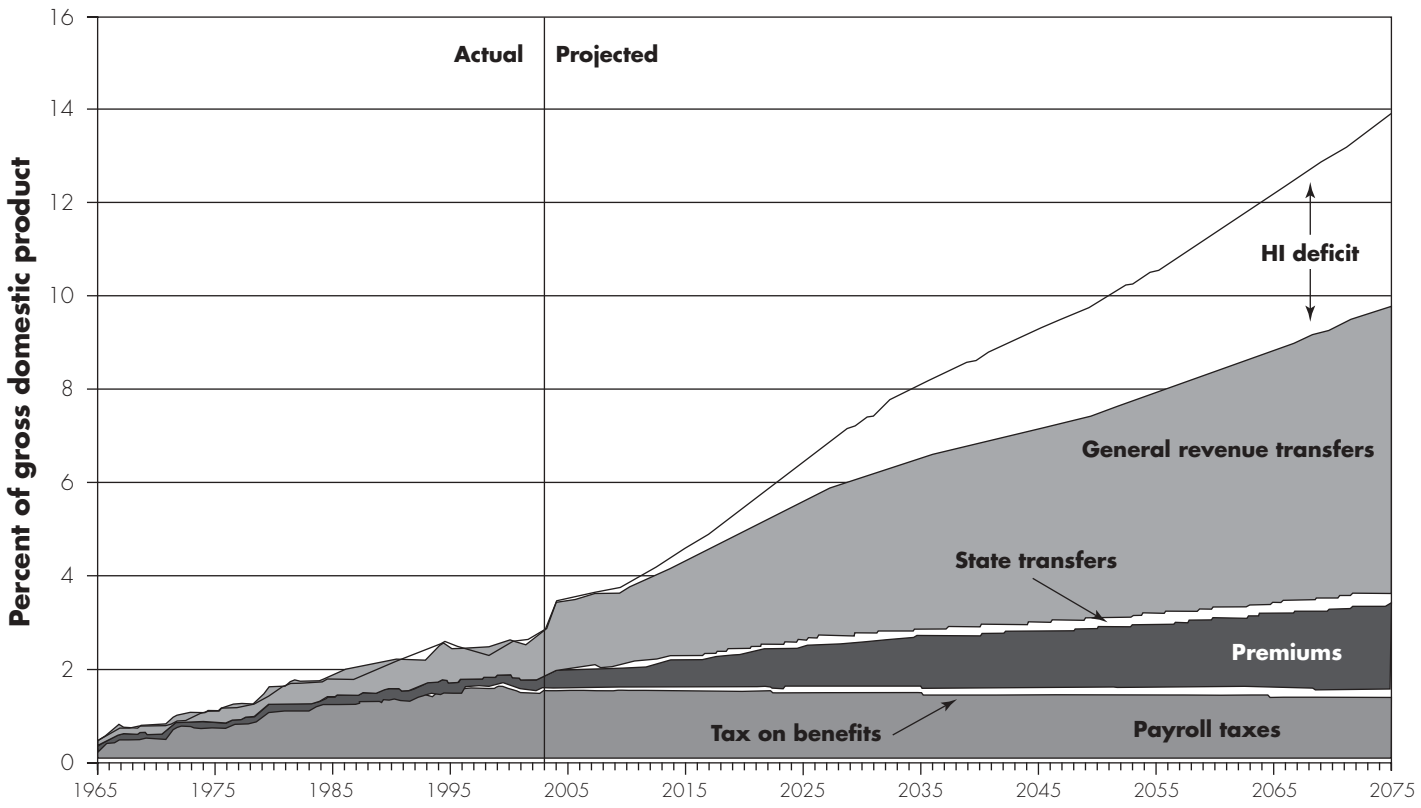
The Medicare Board of Trustees reported in March 2004 that Part A tax revenues would fall short of expenditures in 2004, although interest earned on surplus revenues from previous years would pay the difference. (Similar financing shortfalls occurred five to six years ago, providing some of the motivation—along with concerns about HI insolvency—for the Congress to enact sizable restraints on Medicare program spending in the BBA.) The trustees also moved up their projection of the date of exhaustion of Part A's trust fund by seven years to 2019.

A more complete metric of Medicare's financial condition is the share of the nation's economic resources that the entire program—including Parts A and B and the new prescription drug benefit under Part D—will require. The trustees estimate that Medicare expenditures will grow from 2.6 percent of GDP in 2003 to 7.7 percent by 2035 and 13.8 percent by 2078.

Figure 1-5 (p. 12) shows the trustees' intermediate projections of Medicare spending (top line) and sources of financing (layered areas). Some analysts consider these projections optimistic, because they assume that health care spending per person will grow only 1 percentage

FIGURE 1-5

Medicare expenditures are projected to exceed revenue and grow as a share of gross domestic product



Note: HI (Hospital Insurance). Excludes interest income.

Source: 2004 annual report of the Boards of Trustees of the Medicare trust funds.

point faster than growth in GDP per capita. Historically, it has grown even faster: Between 1970 and 2002, national spending for health care per capita grew 2.4 percentage points above the growth rate for the economy (Holtz-Eakin 2003a).

Future growth in Medicare spending will be fueled in part by the introduction of Medicare's prescription drug benefit. Although Part D addresses a major gap in Medicare's benefit package, the entitlement also implies substantial new requirements for federal spending. CMS's Office of the Actuary (OACT) projects that the introduction of a prescription drug benefit will boost Medicare program spending by about 30 percent between 2005 and 2007 and will cost more than $500 billion over the next 10 years. CBO's 10-year estimate is $400 billion, but CBO's director has suggested that the Part D benefit could cost between $1 trillion and $2 trillion from 2014 to 2023 (Holtz-Eakin 2003b). The differences between near-term estimates of the cost of Part D highlight the considerable uncertainty about how this new benefit will operate and how to project its effects on Medicare program spending.

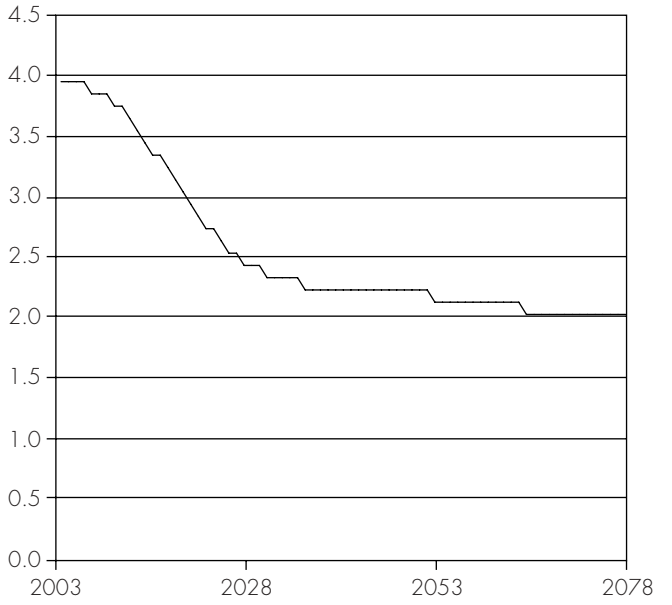
Rapid growth in the number of Medicare beneficiaries beginning at the end of this decade will also accelerate Medicare spending. As the baby boom generation retires between 2010 and 2030, the working-age population will grow by 10 million while the number of elderly will grow by 30 million (Holtz-Eakin 2003a). Moreover, life expectancy at age 65 is projected to increase by as much as 20 percent to 25 percent between now and 2075.

Demographic trends and the structure of Part A's financing mean that, in the future, relatively fewer active workers will be available to support each beneficiary. In 2003, each Medicare beneficiary had nearly four active workers paying payroll taxes to support his or her HI benefit (Figure 1-6). By 2030, this ratio is projected to decline to 2.4 workers, and then to 2.0 workers by 2078 (Boards of Trustees 2004). In the past, payroll taxes increased steadily as a share of GDP as the payroll tax rate and worker earnings increased over time. However, no further increases in the tax rate are scheduled in current law. As health care costs continue to grow rapidly for all payers in the U.S. economy, the trustees expect that fringe benefits—notably health insurance—will become a growing share of worker compensation and earnings will decline as a share of GDP.

It may be particularly important for policymakers to consider changes for the HI program, since the government will no longer have the authority to pay Part A claims once the HI trust fund is exhausted. The trustees estimate that if the Congress immediately enacted changes to address the projected shortfall in financing for Part A (the HI deficit in Figure 1-5), the payroll tax rate would need to rise from its current level of 2.9 percent to 6.02 percent. (Alternatively, HI expenditures would need to be reduced immediately by 48 percent.) If policymakers delay making changes, the magnitude of later changes would need to be more extreme. For example, balancing the HI deficit at the end of the 75-year projection period would require a payroll tax rate four times its current level, reductions in expenditures to one-fourth their projected amount, or some combination of the two.

By comparison, the SMI trust fund uses general tax revenues rather than dedicated payroll taxes for the bulk of its financing. Thus, if policymakers made no changes to Parts B and D (which both draw from the SMI trust fund) and income taxes remain a constant share of the economy, Medicare would by default make claim to a greater share of general revenues. For example, the trustees estimate that for 2003, general revenues devoted to SMI made up 8.7 percent of personal and corporate income taxes. That share will grow after 2006 with the introduction of Part D. If income taxes remained at their historical average share of the economy, the SMI program's general revenue financing would require 29 percent of all income tax revenue in 2030 and more than half by 2080.

FIGURE 1-6 **The ratio of active workers to Part A beneficiaries is projected to decline**



Note: Based on intermediate assumptions.

Source: 2004 annual report of the Boards of Trustees of the Medicare trust funds.

What drives growth in health care spending?

Growth in spending is affected by short-, medium- and long-term factors (Glied 2003). In the short term, the structure of contracts among beneficiaries, providers, and payers can influence spending growth. For example, health benefits and cost-sharing requirements have in some cases become the subject of negotiation between employers and active workers, and their relative bargaining power can affect how health benefits are structured within a firm's compensation package. At the same time, payers evaluate the numbers of providers within a market, their organizational structure and bargaining power, and the relative tolerance for managed care when deciding how to build networks and set payment rates. The underwriting cycle of insurers can explain a lot of the year-to-year variation in private health premiums over the medium term. A number of factors contribute to longer-term growth in health spending, including our lifestyles, the way in which we pay for health care services, and technological change.

Lifestyle and health care spending

Changes in personal behavior affect U.S. health care spending both for Medicare and other populations. The prevalence of obesity—which is thought to be associated with our more sedentary lifestyle and high-caloric diet—has doubled since 1980 to about 30 percent of the adult population today. One recent study calculated that obesity's rising prevalence and higher per capita spending on obese people accounted for a sizable portion of the growth in real per capita spending between 1987 and 2001 (Thorpe et al. 2004a). For the U.S. population age 65 and older, projections suggest that the prevalence of obesity will grow from 29 percent in 2000 to 36 percent by 2010 (Arterburn et al. 2004). Obesity in the elderly is associated with an increased risk of diabetes mellitus, cardiovascular disease, hypertension, stroke, lipid abnormalities, osteoarthritis, and some cancers. Other recent research finds that obesity during young adulthood and middle age is significantly associated with higher Medicare spending later in life (Daviglus et al. 2004).

More payments for more services

Medicare's FFS payment systems may contribute to the program's spending growth. These systems vary across provider types, with some systems more sophisticated than others. At one end of the spectrum is the per stay payment system for inpatient care: All services related to the patient's case are paid for as one bundle, which encourages hospitals to select the most efficient combination of services during a stay. A drawback of bundling is that it can create incentives for providers to select healthier patients or stint on care. At the other end of the spectrum are fee schedules that set prices for each individual service furnished. All of these systems fundamentally pay more to providers as they deliver more services; providers' ability to generate more volume varies with the service. And because each provider type has its own payment system, providers have little incentive to coordinate care.

Some policymakers contend that the Medicare Advantage (MA) program has the potential to slow rates of growth in Medicare program spending because capitated payments provide more incentive for plans to coordinate care. The MA program, however, has thus far used a system of payment rates with rates of increase that are linked to average FFS spending and with base county rates that in many areas exceed average FFS spending. Private plans have been unwilling to enter the markets in which about 40 percent of Medicare beneficiaries live despite payment rates substantially above FFS spending levels. This suggests that private plans may not reduce Medicare's costs in those areas (CBO 2004c). The MA program will move toward a system of competitive bidding in 2006, albeit with initial payment rates that still largely reflect average spending for FFS beneficiaries. Over time, analysts will watch growth in MA spending closely to see whether that program's incentive structure holds promise for constraining growth in spending.

The role of technological change

Many analysts believe that technology has been the biggest long-term driver of growth in health spending (Fuchs 2000, Fuchs 1996). Real per capita health spending has been on a fairly steady climb since 1929, as have advances in medical technologies. International comparisons show that levels of health spending per person in other countries are lower than those in the United States, raising the question of whether our care could be provided at lower cost. Nevertheless, rates of growth have been similar—even in countries with single-payer systems (Newhouse 2004). This similarity suggests that medical innovation is responsible for the bulk of growth in health spending (Newhouse 1992).

Although some medical technologies yield savings by, for example, reducing lengths of stays in hospitals, most tend to expand demand for health care. Why? First, as improved health outcomes that result from technology become more obvious, its broader applicability becomes more apparent to providers and consumers. For example, as surgical techniques for cardiac care improved, angioplasty was used more widely among patients who had not yet experienced a heart attack. Many technologies have also reduced the invasiveness, serious side effects, discomfort, or social stigma associated with therapies, thereby lowering nonmonetary obstacles to beneficiaries as they decide whether to seek treatment. The widespread use of selective serotonin reuptake inhibitors as therapy for depression is one example (Glied 2003).

The relative importance of specific factors in the growth of health care spending varies across conditions. Researchers found that for some conditions such as heart disease and hypertension, increases in the cost of therapy per treated case—that is, higher prices and more intensive services that are usually associated with new technologies—explain most of the spending increase (Thorpe et al. 2004b). For other conditions like cerebrovascular disease,

mental disorders, and kidney conditions, the dominant factor was an increase in the treated prevalence of the condition rather than increases in costs per case.

Other factors interact with medical technology to expand demand for health care. Private and public health insurance lessen the out-of-pocket financial liability of beneficiaries, thereby hiding the full cost of services from the consumer. This approach may lead individuals to use more health care than they would otherwise. Similarly, physicians, who direct beneficiaries' use of care, may be insensitive to the costs of care when they make treatment decisions. Sometimes providers' decisions about a treatment approach may be influenced by their own financial incentives. Further, expectations about health status are changing as beneficiaries age—most people expect to retain their health and mobility for longer periods than earlier generations. And perhaps most important, demand for health care tends to rise with increases in real income and wealth.

Consequences of growth in health spending

Rapid growth in health care spending has had wide-ranging effects. The U.S. health care sector has produced many of the world's medical innovations that lengthen life expectancies and improve quality of life. At the same time, however, employers argue that the rising cost of health premiums affects their ability to compete in the world marketplace. Many economists believe that growth in health premiums paid by employers has no effect on the competitive position of firms because they see health costs as merely offsetting cash compensation that firms would otherwise pay to workers (who could then purchase health coverage on their own). Nevertheless, health spending per person is substantially higher in the United States than in other industrialized countries (Anderson et al. 2003). The higher cost of health care, whether paid by employers or directly by workers, contributes to higher costs for labor in this country.

Clear distributional issues arise from the rapid growth in health spending. In response to double-digit increases in premiums, many employers have raised cost-sharing requirements for their employees, asked them to contribute a larger share of premiums or, particularly for smaller firms, reduced the availability of coverage. Since costs for private health insurance have risen faster than income, some workers may decide to forgo coverage (Ginsburg 2004). During 2003, approximately 45 million people, or 15.6 percent of the U.S. population, were uninsured at any one point in time. Increases in the numbers of people without private insurance coverage raise demand for public coverage, and may raise health care premiums for those who have insurance. The costs of caring for the uninsured do not fall equally on all providers, since the uninsured often postpone care until their condition becomes more serious. In turn, providers that bear more of those costs sometimes seek public subsidies or protectionist policies, which can reduce their incentives to deliver care efficiently. Rising costs put upward pressure on the financing needs of public and private health care programs for existing beneficiaries. And some analysts believe that higher health care costs may also lead to greater fragmentation in the health care market, as healthier people search for insurance alternatives that are less costly—which plans could accomplish by discouraging sicker individuals from enrolling (Glied 2003).

New insurance products have emerged in response to rapid growth in health spending. For example, some employers are beginning to offer consumer-directed health plans that combine a high-deductible plan (often including a health reimbursement or savings account) with catastrophic protection and decision-support tools to help members select among providers. Enrollees in these newer products generally accept higher cost sharing at the point of service. In return, members pay lower premiums (Tollen et al. 2004). The MMA allows employers to make nontaxable contributions to certain health savings accounts, and contributions by individual account holders are tax deductible.

Although enrollment in consumer-directed health plans has been low to date, these plans have attracted considerable attention. Supporters of these new products believe that higher cost sharing will lead members to lower their use of unnecessary services relative to other benefit designs, thereby slowing growth in health spending. Other analysts expect that this new type of product will encourage risk segmentation, since healthier enrollees might find lower premiums attractive, while sicker individuals would likely stay with more comprehensive coverage. At this early stage, studies on the consequences of consumer-directed health plans are mixed (Parente et al. 2004, Tollen et al. 2004).

The value of health care and national preferences for spending

Some analysts believe that, on the whole, the public is well served by devoting a growing share of its resources to health care and the Medicare program because of the value of those services (Cutler 2000). For example, one estimate suggests that growth in value associated with longer lives, improved quality of life, and declines in the pain and suffering that accompany medical treatment are larger than 1 percentage point above GDP growth—the assumption built into the trustees' long-term projections of Medicare spending (Glied 2003). Other analysts have evaluated the cost and benefits of new technologies for specific medical conditions such as heart attacks, depression, and cataracts, concluding that in most cases returns on medical innovations have been positive (Cutler and McClellan 2001).

But Medicare spending can be both wasteful and valuable at the same time. Evidence on unwarranted variation in Medicare spending suggests that a substantial share is misallocated. International comparisons showing much higher levels of spending in the United States without commensurate improvements in quality or outcomes also support this point (Anderson et al. 2003). At the same time, average returns on Medicare's spending for innovations have likely been positive: Improvements in life expectancy and reductions in morbidity have outweighed costs. The policy challenge is to promote the appropriate intensity of care and encourage the development of new technologies with benefits that, on the margin, are worth their cost.

However, not all new technologies have positive returns, and some spending that is currently devoted to new medical technologies might have similar or higher returns if used for other priorities. For example, one recent analysis suggests that while new drugs, devices, and procedures undoubtedly saved lives in the United States over the 1991–2000 period, an even greater number of deaths could have been averted if society's resources had, instead, been directed toward reducing disparities in care between whites and African Americans (Woolf et al. 2004). Other types of investments, such as in public health or health education, might also lead to significant returns for society.

How much should we spend on Medicare? The answer depends on how much value society places on the Medicare program (and health care generally) relative to the alternative uses of the program's resources. One approach to deciding how much the United States should spend is to hold nonhealth spending at current levels and to devote 100 percent of future growth in income to greater consumption of health care. Chernew and colleagues believe that under this approach, devoting 1 percentage point above growth of our national income to health care is affordable because no other types of spending would need to be cut. They estimate that growth of 2 percentage points above GDP growth would lead to declines in nonhealth consumption by the middle of the century (Chernew et al. 2003). Under either scenario, it is not clear that our society would be willing to devote all of its economic growth to health care rather than to other uses.

Could the federal government feasibly raise the resources needed to fund Medicare's growth? Newhouse argues that devoting ever-increasing shares of GDP to Medicare, Medicaid, and other federal programs will ultimately run into the "historical reluctance of American voters to allocate much more than 18 percent of the GDP to federal spending" (Newhouse 2004). On the one hand, Medicare beneficiaries may make up a growing share of voters, which could lead to changes from the historical pattern. On the other hand, under Medicare's current system of financing, beneficiaries will become increasingly dependent upon nonelderly workers for the program's funding; younger generations may not want to foot this bill.

Inefficiencies in the provision of care

Substantial evidence suggests that resources devoted to health care, including those of the Medicare program, have not been allocated efficiently. For the U.S. population as a whole, individuals receive too little of certain services, such as preventive care (McGlynn et al. 2003). Other services appear to be overused: Rapid growth in technologies such as medical imaging raises questions about the appropriateness of some use of these services (MedPAC 2004b).

The central piece of evidence analysts cite as proof of inefficiency is significant geographic variation in practice patterns and use of services within the United States. Despite variations in spending, people who live in higher-use areas do not have better health outcomes, and some indicators of quality, access, and satisfaction suggest that

they are worse off. The researchers estimate that if spending variations were reduced, the Medicare program could see substantial savings (Fisher et al. 2003). Subsequent research has demonstrated the feasibility of measuring the relative efficiency of individual hospitals and perhaps other types of providers.[2] One goal of this work is to help providers achieve longitudinal efficiency—that is, over time, reaching comparable outcomes for certain defined populations at lower cost (Fisher et al. 2004).

Some variation may be unwarranted, consisting of care that is "not consistent with a patient's preference or related to a patient's underlying illness" (Wennberg and Wennberg 2003). Unwarranted variation can be divided into three categories:

- Effective care—care that leads to the desired effect yet could be provided more efficiently with better coordination and improved patient adherence to treatment regimens.
- Preference-sensitive care—care that might result in different choices by beneficiaries if they better understood the implications of their options when they and their providers are making decisions about treatment.
- Supply-sensitive care—care in which service provision is driven by the capacity of the health care system to supply the services.

Supply-sensitive care has received the most attention from policymakers, but all types of unwarranted variation represent potentially costly inefficiencies.

One practical limitation of this typology is that it can be difficult to fit specific services into one of the three categories. For example, some supply-sensitive services—which could include such mainstays as physician visits and hospitalizations—seem as though they must include some care that is efficacious (Berenson 2004). Designing policy options to reduce unwarranted variation in health spending will require disentangling the services that fall into each category. Moreover, some of this variation reflects geographic differences in what physicians and other providers believe is appropriate care. In order to be effective, policy changes must incorporate authoritative guidelines and build consensus around them, or provide stronger incentives for those outcomes to emerge in the marketplace.

Evaluating policy changes to the Medicare program

Medicare faces extremely difficult and competing challenges: demand among beneficiaries and providers to expand benefits and payment rates, the continuing march of medical innovation, the resulting upward pressure on program spending, and the need to stem growth in federal spending because of concerns about financing. In this section, we review categories of proposals that policymakers may want to consider as they try to address Medicare's situation. They include approaches such as:

- Constraining payment rates
- Managing the use and provision of services
- Raising the age of eligibility
- Increasing premiums and cost sharing
- Increasing the program's financing

These categories are not mutually exclusive. In fact, given the magnitude of Medicare's long-term financing needs, policymakers will quite likely need to put in place options from many categories at the same time. All of these options are difficult, but in general, the longer policymakers wait to realign Medicare spending and financing, the more drastic changes will have to be.[3]

When considering proposals to constrain growth in Medicare spending, policymakers should look at their likely effects on quality of care and access, as well as on Medicare spending. Today, each of Medicare's payment systems treats broad categories of providers the same. The Commission concludes that as decision makers carry out policies to limit growth in spending, they need to draw greater distinctions among providers based on quality of care and value to beneficiaries. Last year, MedPAC recommended linking payment to quality for MA plans and providers that care for patients with end-stage renal disease (MedPAC 2004a). This report discusses additional ideas for moving Medicare toward a system of "pay for performance" in Chapter 4, and examines how broader use of information technology by providers could help that effort. Chapter 3 describes other policies that will allow the program to differentiate among providers by measuring resource use and managing the use of imaging services.

Constraining payment rates

Policymakers can constrain annual growth in Medicare spending by limiting the annual updates or increases in payment rates to health care providers. To some extent, this role is simply one aspect of being a prudent purchaser. This point of view underlies MedPAC's analysis of the adequacy of payment rates to the various health care sectors each year.

Under this approach, Medicare makes use of its status as the largest payer in the U.S. health care system to exert market power in setting administered prices. Constraining payment rates can have large effects on growth in spending. However, if such steps are carried out indiscriminately, they raise concerns about their effects on quality of and access to care.

The strategy of constraining growth in payment rates or using global budgets has been used extensively in Canada, Western Europe, and Japan (Glied 2003, Ikegami and Campbell 2004). U.S. policymakers have also used this approach on occasion, including constraints on payment rates that were built into the BBA. But constraining payments can be difficult to sustain over time. Why? A key reason is that changing prices alone does little to address the underlying factors that lead to spending growth (CBO 2003). In addition, limiting Medicare's payment rates too far below those of other payers could cause providers to be less willing to see Medicare beneficiaries. In the wake of the BBA, providers convinced policymakers that the law had tightened payment rates too restrictively and would ultimately reduce access to care. A subsequent bill, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, restored many of the payment cuts put in place by the BBA.

In addition, constraining payment rates alone will not lower spending if the volume of services furnished increases—which has been the case with Medicare's payment system for physician services (Hackbarth 2004). Nor has that payment system provided incentives for physicians to coordinate the care they provide to beneficiaries. Instead, the Medicare program may need more fundamental changes in how it pays physicians, such as a system that rewards them differently based on the quality and appropriateness of the services they provide, and the degree to which they coordinate care with other providers. Investments by physicians in information technology and electronic medical records could both help Medicare's ability to measure quality and make it easier for providers to coordinate with one another. This report discusses how Medicare might move toward such an approach in Chapter 4.

Other past changes to Medicare's payment systems were designed to affect underlying incentives more directly, and sometimes those have been more sustainable approaches. Although imperfect, the inpatient prospective payment system is one example. By paying hospitals for larger bundles of similar services rather than for each specific input to care, the payment system leaves decisions about how best to produce health care services to providers. And the prospective nature of the system puts providers at financial risk, thereby giving them incentive to deliver care efficiently (with outlier payments to protect sicker beneficiaries from incentives to stint on care). In the case of inpatient care, the combination of these features appears to have lowered spending and reduced lengths of stay without adversely affecting quality of care.

Nevertheless, reimbursement for inpatient hospital services makes up the largest share of Medicare spending, and thus it is important to ensure that the program encourages greater efficiency and reduction of excess capacity. Economic literature on the hospital industry suggests that providers who are under fiscal pressure generally have managed to slow their cost growth more than those facing less fiscal pressure (Gaskin and Hadley 1997). Section 2A compares hospitals with persistently negative margins with their market peers and finds that the less-profitable hospitals often have not taken steps to control costs and reduce excess capacity to the same extent as their counterparts.

Managing the use and provision of health care services

During the 1990s, many private plans tried a strategy of controlling how, when, and where health care services were used through administrative techniques such as prior authorizations and restrictive networks of providers. Although some of these techniques may have reduced the use of services, they were unpopular among consumers and providers, and many were discontinued during the subsequent backlash against managed care. More recently, private plans have reintroduced some of these approaches but applied them more judiciously to services that are prone to overuse.

One strategy for the Medicare program would aim to manage the use of services more closely than is the case today. Some might argue that private plans are best equipped to take on this role through the MA program and its system of capitated payments. In general, managed care plans may be able to constrain levels of health care spending relative to FFS by negotiating lower payment rates with preferred providers and applying management tools such as authorizing certain services in advance, giving providers feedback on their practice patterns, and offering financial incentives to reduce overuse of services. However, to achieve savings relative to FFS, private plans must more than offset their administrative costs and profits (CBO 2004c).

About 85 percent of Medicare beneficiaries are enrolled in traditional Medicare, accounting for the bulk of program spending. For this reason, analysts point out that FFS Medicare needs to become more of a strategic purchaser than a payer of claims, using many of the techniques of private plans to limit overuse of services and improve quality of care (Berenson 2003). For example, use of imaging services varies widely across geographic areas, and its volume has grown rapidly in recent years. MedPAC recommends that the program take steps that some private purchasers use, such as adopting safety standards for imaging equipment, using coding edits that detect unbundled imaging services, and setting standards for the training and education of physicians who bill for interpreting diagnostic imaging studies. Another recommendation is to use FFS claims data to compare physicians' resource use relative to peers. Chapter 3 of this report examines these strategies in greater detail.

Disease management programs for enrollees with chronic conditions are another management tool used by many private payers and plans. These programs rely heavily on educating beneficiaries about their condition so that they can monitor their own health, adhere to prescribed therapies, and avoid hospitalizations. Some programs also aim to better coordinate care among the patient's providers, thereby reducing unnecessary care. CMS has established a chronic care improvement program that will test disease management in FFS Medicare using a randomized controlled trial design (MedPAC 2004b). The wide use of disease management programs among private payers suggests promise in this approach. Nonetheless, there is no conclusive evidence that such programs generally lead to savings in the private sector, and there may be additional obstacles to implementing disease management for the Medicare population (CBO 2004a).

Promoting the use of information technology by health care providers is another strategy that could lead providers to better manage the use of services. Rapidly available and transferable information about a patient's medical history could help to reduce unnecessary care and medical errors, enhance Medicare's ability to evaluate the performance of providers, and thereby help to pay them differentially. Chapter 4 of this report discusses pay-for-performance strategies and information technology.

For the future, MedPAC will continue to research other policy approaches as well. For example, to what extent might the Medicare program consider information from cost-effectiveness analyses of new technologies when making coverage or payment decisions? Previous research by MedPAC shows that large purchasers other than Medicare use cost effectiveness and other strategies to purchase new technologies prudently (MedPAC 2003). Medicare may face some unique constraints that other payers do not. Nevertheless, the experiences of some private purchasers suggest that the Medicare program might pursue some elements of cost-effectiveness analysis and value-based purchasing.

Raising the age of eligibility

Policymakers could gradually raise the age of eligibility for Medicare from 65 to 67, making the program more consistent with eligibility rules for Social Security benefits. One could argue that as average life expectancy increases in the United States, it is reasonable to raise the age at which people qualify for Medicare coverage. If individuals work longer and delay retirement, they may also retain access to private health insurance at group rates—to the extent that their employers offer it.

By itself, the eligibility approach is unlikely to reduce Medicare's program spending by much. Moon notes that about 5 percent of today's Medicare beneficiaries are age 65 or 66, and those individuals have lower average Medicare spending because of their relative youth. Thus, she estimates that savings would be on the order of 2 percent to 3 percent (Moon 2000). Similarly, others estimate that raising the eligibility age to 70 would reduce program spending by about 9 percent a year (CBO 2003, Gluck and Moon 2000). By 2075, that amount would equate to about 0.7 percent of GDP.

A drawback of raising the age of eligibility is that it would not address the goals of improving quality of care or making more efficient use of the resources that finance Medicare. Further, the eligibility approach would affect access to care for some individuals in an age group for which it is typically more difficult and expensive to obtain other health insurance coverage. Even though many of the "younger elderly" would likely find alternative sources of health coverage, some would not. One estimate puts the number that would not find coverage at 9 percent of 65- and 66-year-olds, with another 11 percent underinsured (Davidoff and Johnson 2003). If policymakers chose this approach, they could permit individuals just under Medicare's eligibility age to buy into the program by paying the full premium for coverage at actuarially fair rates. Allowing people to buy in would help to reduce the numbers of uninsured, but premiums would likely be expensive and perhaps financially burdensome to those with no other coverage options.

Increasing cost sharing and premiums

Medicare might consider raising cost-sharing requirements and premiums, an approach now widely used in the private sector. After the backlash against managed care in the 1990s, health plans and employers loosened controls on the use of services. At the same time, however, they began emphasizing deductibles, coinsurance, and other incentives to encourage individuals to be more price conscious in their use of health care (Robinson 2002). Employers have also asked workers and retirees to shoulder a larger share of total premiums. If used in Medicare, the premium/cost-sharing approach would likely affect quality of and access to care, efficiency in the provision of care, and Medicare's long-term financing needs. Although these tools may hold promise for inducing patients to make more economical choices about care, in the near term they may not change the underlying forces that drive growth in spending (Nichols et al. 2004).

Specific options include raising Medicare's cost-sharing requirements, particularly for services that are subject to overuse. For example, CBO estimated that charging copayments for clinical lab services would lead to small reductions in use of services and Medicare spending (CBO 2003). Under the MMA, Medicare beneficiaries will begin paying a higher deductible for Part B services beginning in 2005. Medicare's Part B deductible has remained unchanged at $100 since 1991—too low a level, some might argue, to foster price sensitivity. The MMA increases the deductible to $110 in 2005 and, thereafter, raises it each year by an index of growth in spending per capita for Part B services. OACT estimates the deductible will reach $149 by 2013.

Another option could lower the federal subsidy of Part B premiums from the current 75 percent to 50 percent of average SMI expenditures for aged beneficiaries—the share that premiums were intended to cover when Medicare was first established. CBO estimates that increasing premiums across all Part B enrollees would reduce Medicare program spending by about 12 percent in 2075, or 1 percent of GDP (CBO 2003). The MMA introduced a variant of this approach: Beginning in 2007, the federal government will provide lower subsidies to Part B enrollees who have higher adjusted gross incomes. CBO estimated that this would lower Medicare program spending by less than half of 1 percent over the 2004–2013 period. Some analysts contend that lowering federal premium subsidies could reduce the numbers of individuals who choose to enroll in Medicare. Others argue that even with lower subsidies, Medicare's enrollment would remain high because it has advantages that private insurance may not—for example, a community-rated premium with unlimited access to most providers.

It is important to bear in mind that the effects of using this approach in Medicare would be tempered by supplemental coverage: medigap policies, employer-sponsored retiree plans, and Medicaid, each of which wraps around Medicare's benefit. Nearly 90 percent of enrollees supplement their Medicare benefit with other insurance that typically covers some or all of Medicare's deductibles and coinsurance. Thus, raising Medicare's cost sharing alone might simply translate into higher premiums for supplemental coverage with little effect on the use of care.

Although the premium/cost-sharing approach could lower Medicare spending, it would also raise demand for state and federal Medicaid spending. For example, beneficiaries who are dually eligible for Medicare and a state's full Medicaid benefit typically pay no Part B premium and low or no cost sharing on a package of medical services broader than Medicare's benefit. Eligibility requirements vary among states, but in general, individuals who qualify as full duals have very low incomes and assets, and they are a vulnerable and costly group of beneficiaries (MedPAC 2004b). Thus, if Medicare were to increase its

premium and cost-sharing requirements, the Medicaid program would pay for some of those changes on behalf of dually eligible beneficiaries.[4]

Supplemental coverage that shields beneficiaries from FFS cost-sharing requirements leads to greater use of services and higher Medicare spending—17 percent to 28 percent higher, by some estimates (Christensen and Shinogle 1997). For this reason, some analysts have suggested prohibiting supplemental insurance from providing first-dollar coverage. Such an approach could lead to sizable savings—some have estimated that they would be large enough to finance at least a portion of a catastrophic limit on out-of-pocket spending (MedPAC 2002).

Raising cost-sharing requirements could be effective for reining in use of discretionary services, but indiscriminate increases could impose financial barriers to essential care or cause hardship. Research has shown that many Medicare beneficiaries have limited incomes (Gluck and Moon 2000). In addition, the Medicare population faces increases in Medicare's current cost-sharing requirements, including the rise in the Part B premium and new premiums if they choose to enroll in Part D to receive outpatient prescription drug coverage.

Might higher cost sharing affect health outcomes? Although the RAND Health Insurance Experiment did not include elderly individuals, it did not find substantial differences in the health status of people who received free care versus those who faced higher cost sharing (Newhouse 1993). Although there are likely offsetting positive and negative effects, on average, higher cost sharing might not adversely affect health outcomes. RAND research also suggests that higher cost sharing discouraged the use of some necessary care as well as unnecessary care. Literature that focuses on the elderly suggests that higher cost sharing impedes the use of appropriate services, particularly the use of outpatient prescription drugs (Rice and Matsuoka 2004). For certain beneficiaries, higher out-of-pocket costs could undermine patient compliance with recommended care, coordination of services, or use of preventive care (Robinson 2002).

Increasing the program's financing

A final set of proposals for Medicare deals with finding sources of revenue to finance the program. Since this approach deals strictly with program financing, it would neither do much to affect quality of or access to care, nor improve efficiency in the provision of care.

Medicare's growth could be financed by more borrowing, at least for shorter periods of time. Under that scenario, the federal government would have to increase spending to cover larger interest payments on the federal debt. However, given the magnitude of resources required to finance projected Medicare spending, such an approach could put significant upward pressure on interest rates as the federal government competes with other borrowers for investment capital. Higher interest rates could, in turn, slow economic growth. Over the longer term, the federal government would need to choose between reducing federal spending or raising tax revenues to hold its borrowing to manageable levels.

Policymakers could reduce spending on other federal programs to finance the Medicare program with the current structure of tax revenues. This policy would mean looking at explicit trade-offs among federal programs—for example, among health care, education, homeland security, and defense—and devoting resources to Medicare up to the point where the marginal value society receives from program spending is worth the value of alternative programs it gives up. Even within the Medicare program, policymakers will likely have to make trade-offs.

A final financing approach is to raise federal taxes—payroll taxes on active workers or other sources of general revenue. Some analysts believe that relying on increases in payroll tax rates to meet at least some of Medicare's funding shortfall is a desirable policy approach, because the average income of future workers will be significantly higher. Others say that the dependence of the elderly on succeeding generations is both undesirable and unsustainable and that other approaches—such as encouraging individuals to work after age 65 and save a larger portion of their preretirement income for health care costs—may be more equitable (Fuchs 2000).

The chapters that follow reflect MedPAC's efforts to help policymakers get the best value possible for Medicare's beneficiaries and for taxpayers. Chapter 2 describes MedPAC's framework for updating Medicare payment rates and analyzes the adequacy of Medicare payments for each major FFS sector. Chapter 3 examines other strategies for applying value-based purchasing in Medicare. Chapter 4 looks at approaches for linking payments to the quality of providers' services. ■

Endnotes

1 Medicare's share of spending will grow after 2006, when the program will begin offering an outpatient prescription drug benefit.

2 Some analysts question whether Medicare can evaluate the performance of individual providers because many deliver too few of certain procedures to develop reliable measures. However, others believe it is possible to develop combinations of measures or average measures across time to assess performance more reliably.

3 One study quantifies the cost of delaying changes in the financing of Social Security and Medicare through a measure called fiscal imbalance (Gokhale and Smetters 2003). This measure is the difference between projected program expenditures and available resources under current policies. The authors calculate that restoring fiscal balance would require one of the following: a 16.6 percentage-point increase in payroll taxes, a two-thirds increase in federal income tax revenue, a 45 percent cut in Social Security and Medicare outlays, or elimination of the entire federal discretionary budget. Delaying policy changes until just 2008 makes necessary adjustments more difficult: an 18.2 percentage-point increase in payroll taxes or a 74 percent increase in income tax revenues.

4 Some states pay providers at lower rates than payment rates made by the Medicare program. As a result, the extent to which a state would pay for increases in Medicare cost sharing depends in part on its Medicaid payment rates.

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