


MI



# THREE REFORMS THAT CAN HELP BALANCE MEDICARE FINANCES

Yevgeniy Feyman  
Adjunct Fellow

## Contents

Executive Summary.....	3
Introduction.....	4
Reforms.....	5
Conclusion.....	8
Endnotes.....	9

## Executive Summary

Topping the health-care agenda of the Trump administration and Congress is the repeal and replacement of the Affordable Care Act. Still, it would be a mistake to ignore Medicare, the nation's single largest health-care entitlement. While the program is well liked by senior citizens,<sup>1</sup> Medicare's growing share of the federal budget,<sup>2</sup> growing reliance on general rather than dedicated revenue streams, and outdated benefits and cost-sharing structure make it ripe for changes that can deliver better value for beneficiaries and taxpayers.

While Medicare reform has traditionally been politically challenging, Republicans and Democrats have converged significantly in their support for market-oriented Medicare Part D (drug coverage) and Medicare Advantage plans. Understanding and leveraging lessons learned from these programs might enable Congress to shore up Medicare's overall finances while continuing to offer senior citizens coverage that best suits their needs and financial situation.

### Key reforms:

- **Combine Part A and Part B deductibles and cap an individual's annual out-of-pocket costs.** In contrast to private health insurance, senior citizens on Medicare face separate deductibles for inpatient hospital care (Medicare Part A: the 2017 deductible is \$1,316) and doctors' services (Part B: the 2017 deductible is \$183). To cover their Medicare coinsurance obligations—and health-care services that the program does not provide—many people also purchase supplemental insurance, called Medigap.<sup>3</sup> By obscuring the real cost of these services, however, Medigap plans often lead to higher health-care spending. A single deductible for physician and hospital services, as well as a provision to cap an individual's out-of-pocket health-care costs, would mitigate the need for costly Medigap policies (which cost, on average, over \$2,000 annually)<sup>4</sup> and the excessive spending that these policies induce. This reform would also limit what the sickest Medicare patients must pay to receive treatments.
- **Develop a premium support system for traditional Medicare (TM) and Medicare Advantage (MA) that would better encourage competition and choice between these plans.** MA plans, unlike TM, can vary deductibles and coinsurance; they also have different contractual agreements with providers that can incentivize higher-quality or lower-cost care. While traditional Medicare should remain an option, a premium support system in which senior citizens receive a voucher tied to a benchmark based on competition between MA and TM would encourage more informed choices between them and among MA plans. It also would ensure that taxpayers are not on the hook for overly expensive coverage.
- **Require 340b providers to pass through drug rebates.** Pharmaceutical companies that participate in Medicaid must offer deep discounts on certain drugs dispensed by facilities that serve low-income and other vulnerable patients. These discounts effectively apply to all outpatient drugs prescribed by 340b-covered providers, including to Medicare patients. While the intent of this program was to make it easier for patients to afford certain drugs, providers in many instances have pocketed the differences between discounts from drug manufacturers and what insurers (public and private) reimburse for the drugs. To save millions of taxpayer dollars and reduce out-of-pocket costs for patients, 340b providers should be required to pass through their discounts both to the Medicare program and to patients.

Most of the reforms suggested here enjoy, or have enjoyed, significant bipartisan support.<sup>5</sup> Individually, they are relatively modest changes. But taken together, they could save Medicare beneficiaries hundreds (and for some, thousands) of dollars in annual out-of-pocket costs and improve their health. They could also reduce federal spending by several hundred billion dollars over a 10-year budget window. The result would be to extend Medicare's long-term solvency and ensure that the program delivers more value to taxpayers and seniors.



## Introduction

Medicare has provided health insurance to elderly and disabled Americans over the past half-century. The program enjoys wide support among its 55 million (as of 2015) beneficiaries. Popularity, however, has made it politically difficult to address the gap between Medicare's expected revenues and expected costs. The program's structure—with separate funding for hospital and physician services and for prescription drug coverage, along with no restrictions on which participating providers seniors can see—also discourages care coordination for patients with chronic conditions and encourages the use of care that delivers marginal benefits at a high cost.

Political challenges notwithstanding, Medicare needs reforms—and sooner rather than later. Despite the well-reported slowdown in per-beneficiary cost growth beginning at least in 2008, Medicare spending is still projected to outpace growth in the overall economy.<sup>6</sup> In 2016, net Medicare outlays are expected to amount to about 3% of GDP. By 2026, they are expected to be about 4% of GDP, or just over \$1 trillion.<sup>7</sup>

Higher spending will be driven by an increase in per-beneficiary costs (Part A per-beneficiary costs are expected to grow 35% from 2015 to 2026) and enrollments (Part A enrollment is expected to grow 34% over the same period). Medicare's income from premiums and payroll taxes is expected to remain lower than expenditures, which is the primary reason that Part A's trust fund<sup>8</sup> will become insolvent in 2028.<sup>9</sup> Given that reducing the number of people with Medicare coverage is not a politically realistic option, reforms must focus on making the program deliver more efficient and better care.

## Reforms

The goal of the changes presented here is to provide a sustainable safety net against high-cost medical events (especially for low-income seniors) while building on successful strategies from the private sector and Medicare's pilot programs to drive more efficient health care in general. The changes are also designed in particular to foster the management and coordination of care for patients with chronic diseases or multiple conditions.

### ***Fix Medicare's Cobbled-Together Cost-Sharing Structure***

Medicare's age is perhaps nowhere more apparent than in its odd benefit and cost-sharing designs. Private health plans today do not separate the deductibles for hospital and outpatient services; plans also include an annual limit on a patient's out-of-pocket costs. But Medicare's benefit structure still retains its mid-20<sup>th</sup>-century character, when indemnity insurance was dominant and hospitals were paid retrospectively, based on cost.

Traditional Medicare patients who receive inpatient hospital care (through Part A) are responsible for a deductible (\$1,316 in 2017) before their coverage kicks in. Additionally, they pay a daily coinsurance rate for more than a certain number of days spent in the hospital, which is uncapped.

For doctors' services covered by Part B (including prescription drugs dispensed in a doctor's office), traditional Medicare patients face a deductible (\$183 in 2017) and then pay 20% of most physician services above that amount, and these copayments are also uncapped. To help deal with these deductibles, cost-sharing rules, and services that the program does not cover, Medicare patients often purchase supplemental insurance, called Medigap (in 2013, these plans cost over \$2,000 annually).<sup>10</sup> These supplemental plans, however, are associated with higher spending.<sup>11</sup>

There may be a better way. That is, to simplify traditional Medicare's cost-sharing structure and encourage providers to reduce unnecessary (and more costly) hospital services by coordinating care across inpatient and outpatient settings and, as well, to cap patients' out-of-pocket costs. Medicare patients would face a single deductible for Parts A and B with a single coinsurance rate, up to some cap, after which the program covers 100% of the costs. In scoring one version of such a proposal, the Congressional Budget Office (CBO) estimated a seven-year

savings of \$17.9 billion (extrapolating that to 10 years comes to \$25.6 billion).<sup>12</sup>

The savings would be driven by patients who would reduce their use of services because cost-sharing (deductibles and coinsurance) payments would increase for most beneficiaries. This may sound like a bad idea that would impose crushing financial burdens on Medicare beneficiaries—but it is important to recognize that the current distribution of cost-sharing among Medicare patients is highly skewed. While all seniors on average are expected to pay \$2,400 in cost-sharing in 2020, about three-quarters of Medicare patients will have cost-sharing of only \$750 on average. The remaining one-quarter will face cost-sharing of \$7,100 annually, and those with hospital stays of 60 days or more would face cost-sharing of \$23,000. Thanks to the cap on out-of-pocket spending, cost-sharing *reductions* for these groups of beneficiaries, which represent the sickest and costliest beneficiaries, would be substantial.<sup>13</sup>

Taken together, restructuring deductibles and coinsurance would save the federal government \$94.6 billion over 10 years<sup>14</sup> if paired with restrictions on supplemental coverage—which would expose beneficiaries to greater levels of cost-sharing by limiting the ability of supplemental plans to cover Medicare coinsurance—and would offer greater financial protection to Medicare beneficiaries who need it the most.

### ***Implement a Premium Support Program***

Medicare provides health coverage not only through a government-run insurance program; eligible seniors can instead enroll in privately administered plans, called Medicare Advantage or Part C. These plans currently enroll 17.6 million people, accounting for 31% of total Medicare enrollment (14.5 million are in individual plans, while the rest are in group plans).<sup>15</sup>

Unlike traditional Medicare, Medicare Advantage plans

have a variety of deductibles and coinsurance rates, and some add coverage for prescription drugs and dental and vision care. They also can have different contractual agreements with providers that might include incentives for higher-quality or lower-cost care. There are a wide variety of plans, including Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), all of which can have wide or narrow provider networks. (Traditional Medicare patients can see any physician or visit any hospital that participates in the program.) The premiums for some Medicare Advantage plans are no more than in traditional Medicare's Part B; other plans charge more.

Currently, the way government pays Medicare Advantage plans is inefficient. Plans submit bids to the government to offer coverage to Medicare beneficiaries. These bids represent the cost of covering an "average" beneficiary.

However, plans' payments are tied to an administrative benchmark that is closely related to traditional Medicare costs in the geographic area. When plans' bids are above this benchmark, enrollees are required to pay the difference in higher premiums. When bids fall below this benchmark, however, plans are paid the bid plus a rebate, which represents some share of the difference between the benchmark and the bid. These rebates are used to offer additional benefits or to reduce beneficiary cost-sharing. Because enrollees are not held accountable for choosing traditional Medicare when it is more expensive than Medicare Advantage plans, they are less incentivized to make more cost-effective decisions. And because Medicare Advantage plans are guaranteed a benchmark payment, they are somewhat insulated from the effects of competition—for instance, a beneficiary's premiums cannot fall below the standard Medicare premium, which reduces the incentive to bid below traditional Medicare costs. Additionally, if bids were competitively determined based on the overall costs of the marketplace, plans would have an incentive to bid more aggressively to ensure that they fall below the new (likely lower) benchmark.

To address these concerns, Congress should shift Medicare Advantage to a premium-support model. Seniors would receive a voucher tied to a competitively determined benchmark (based on some measure of plan bids, including the cost of traditional Medicare), which they could use to buy a Medicare Advantage plan or to enroll in traditional Medicare. Depending on the details, the Congressional Budget Office has estimated that this ap-

proach would save the federal government between \$69 billion and \$275 billion over a six-year-period.<sup>16</sup> (Importantly, any serious proposal should ensure that traditional Medicare remains an option.)

These estimates are driven primarily by the fact that when Medicare Advantage plans submit bids to provide coverage, these bids tend to be lower than traditional Medicare costs. A properly designed premium support system would encourage more patients to choose an MA plan where those plans cost less than TM.<sup>17</sup> Additionally, given the substantial literature finding positive spillovers from Medicare Advantage to traditional Medicare, these estimates are likely conservative, given that the CBO did not consider these effects in its analysis.

Medicare Advantage plans in the past have appeared to cost more for a given enrollee than traditional Medicare—primarily by enrolling healthier individuals. One study found that seniors switching into Medicare Advantage were healthier than those switching out.<sup>18</sup> Another found that plans offering fitness benefits succeeded in attracting healthier enrollees.<sup>19</sup>

However, more recent peer-reviewed studies suggest that Medicare Advantage is now helping to make traditional Medicare more sustainable overall and to deliver more value to seniors. For instance, Medicare Advantage enrollees tend to receive more appropriate screening for breast cancer, diabetes care, and cholesterol testing for cardiac care.<sup>20</sup> They also appear to have lower hospital readmission rates than similar patients enrolled in traditional Medicare.<sup>21</sup> Participants in one Medicare Advantage Special Needs Plan (plans for individuals with both Medicare and Medicaid, those with certain chronic conditions like HIV/AIDS or dementia, or those who live in nursing homes) had lower hospital use and higher physician use.<sup>22</sup> Moreover, increases in Medicare Advantage enrollment also consistently appear to lead to improved patient outcomes and lower costs for traditional Medicare—also known as spillovers (and may help explain a substantial share of the recent overall slowdown in Medicare costs).<sup>23</sup>

Better outcomes for patients in Medicare Advantage plans are likely driven by unique contractual arrangements—such as quality-based payments or capitated payments—between plans and providers, in addition to cost-sharing incentives (such as reduced coinsurance for using certain providers over others) and provider networks that encourage the use of lower-cost and high-

er-quality providers. The mechanisms for spillovers to traditional Medicare are likely to be the result of Medicare Advantage plans changing how providers practice when a greater share of their patients are covered by managed-care plans.<sup>24</sup>

Recent analysis has shown that Medicare Advantage plans today engage in relatively little selection of healthy patients<sup>25</sup> due to changes in payment methods adopted in 2004. Additionally, as noted previously, recent data from MedPAC indicate that payments to Medicare Advantage plans are, on average, no greater than traditional Medicare costs in 2017, while bids are now 10 percentage points below traditional Medicare costs.<sup>26</sup>

The experience with Medicare Advantage demonstrates that it is possible to deliver Medicare benefits at lower cost and with more value to seniors. Today, nearly 30% of seniors (more than 17 million people) are in privately administered plans. As the attractiveness of Medicare Advantage grows—more seniors are familiar with managed-care plan designs and with navigating network-based coverage—policymakers should find it more politically feasible to move the program closer to a true competitive framework, where plans are fully incentivized to keep costs low and beneficiaries are incentivized to choose the most efficient plans (including traditional Medicare).

It is important to remember that the further growth of Medicare Advantage would not represent privatization. In the first place, these private plans only administer what remains a public—i.e., a government—program. Moreover, an analysis by researchers at the University of Minnesota and Simmons College has suggested that some 50% of Medicare beneficiaries would be better off remaining in traditional Medicare due to lower premiums.<sup>27</sup> Traditional Medicare remains a vital element of the national safety net under better-structured competition between it and Medicare Advantage. But privately administered Medicare plans are proving themselves more efficient for taxpayers while giving seniors better value for their health-care dollars.

### ***Require 340b Providers to Pass Through Drug Rebates***

Last but not least, Congress should consider correcting a shortcoming of the current system that affects the price that Medicare (and Medicaid) patients pay for certain classes of prescription drugs dispensed in the outpatient setting in hospitals and clinics that participate in the 340b program.

Under section 340b of the Public Health Service Act, health-care providers that serve a large share of low-income and uninsured populations receive discounts on certain drugs from manufacturers that participate in the Medicaid drug rebate program. These discounts apply to all 340b covered drugs purchased by the provider, regardless of whether the patient is on Medicare or Medicaid. The intent of the program was ostensibly to make it easier for these providers to purchase expensive drugs and make it easier for patients to pay for them.

In recent years, the program has become somewhat controversial, as reports have found that many 340b providers profit on the difference between the statutory discounts from drug manufacturers and what insurers (both private and public) reimburse for the drugs. In one analysis, Medicare's inspector general found that a quarter of 340b providers in their sample did not pass through these discounts to the uninsured.<sup>28</sup> Pass-throughs are not legally required, but patients pay more when they are not required. Additionally, an analysis from the Government Accountability Office (GAO) found that 340b hospitals dispensed more expensive drugs than other hospitals, even when controlling for hospital characteristics and beneficiary health status.<sup>29</sup>

340b providers should be required to pass through their discounts both to the Medicare program and to patients (to reduce their cost-sharing). In 2013 alone, this approach (with partial pass-through) would have saved as much as \$1.1 billion, with \$213 million going toward reducing beneficiary cost-sharing.<sup>30</sup> Given the growth of 340b purchases, the savings are likely to be even more significant over a 10-year period.

## Conclusion

The proposals discussed here enjoy, or have enjoyed, bipartisan support, and would be mutually reinforcing. Each one offers enhanced savings and financial protection for senior citizens, strengthening one of Medicare's core purposes, reducing burdens on taxpayers, and improving the quality of care.

While President Trump hinted at avoiding Medicare reform during his campaign, the simple reality is that true reforms that protect the program and offer more value to beneficiaries will become more difficult to enact as budget pressures worsen. Indeed, this is exactly the time to advance bipartisan reforms. Embracing these “win-win” proposals for beneficiaries and taxpayers will reduce the need for more drastic changes, or tax increases, in the future, protecting Medicare for generations to come.



## Endnotes

- <sup>1</sup> Karen Davis et al., “Medicare Beneficiaries Less Likely to Experience Cost- and Access-Related Problems than Adults with Private Coverage,” *Health Affairs* 31, no. 8 (July 18, 2012): 1866–75.
- <sup>2</sup> Medicare is expected to grow from 15.26% of total federal outlays in 2016, to 17.34% by 2026. See Congressional Budget Office, January 2017 Economic and Budget Projections.
- <sup>3</sup> Note: Medicare Advantage (Part C) policies are sometimes grouped with Medigap policies; but for the purposes of this discussion, they are not included.
- <sup>4</sup> Jennifer T. Huang et al., *Medigap: Spotlight on Enrollment, Premiums, and Recent Trends*, Henry J. Kaiser Family Foundation, Apr. 2013.
- <sup>5</sup> Premium support has been widely advocated by MedPAC (Medicare Payment Advisory Commission, an independent congressional agency that advises Congress): see “Using Competitive Pricing to Set Beneficiary Premiums in Medicare,” MedPAC, June 2016. It was also a core proposal in the bipartisan Domenici-Rivlin Debt Reduction Task Force, and that commission also advocated reforming Medicare’s cost-sharing design; see Alice M. Rivlin, “A Bipartisan Approach to Reforming Medicare,” testimony before the House Ways and Means Subcommittee on Health, Apr. 27, 2012.  
  
While 340b reforms were not parts of the task force, reforms to the program were included in original drafts of the bipartisan 21st Century Cures Act, and in 2015, the Health Resources and Services Administration developed draft guidance to tighten qualifications for 340b-eligible providers.
- <sup>6</sup> The Centers for Medicare & Medicaid Services projects that by 2025, per-enrollee spending growth in Medicare will reach 4.8%, up from 2.4% in 2014. See Sean Keehan et al., “National Health Expenditure Projections, 2015–25: Economy, Prices, and Aging Expected to Shape Spending and Enrollment,” *Health Affairs* 35, no. 8 (Aug. 13, 2016): 1522–31.
- <sup>7</sup> Ibid.
- <sup>8</sup> Medicare’s Part A trust fund maintains assets that accrue primarily from payroll taxes and interest on the balance as well as taxation of some benefits; it uses these funds to pay out benefits on behalf of beneficiaries. When the fund is “insolvent,” it will no longer be able to pay full benefits but will only be able to pay out some share of benefits that are covered by a combination of existing assets and new income.
- <sup>9</sup> Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 22, 2016.
- <sup>10</sup> Ibid. at 4; and Juliette Cubanski et al., *A Primer on Medicare: Key Facts About the Medicare Program and the People It Covers*, Henry J. Kaiser Family Foundation, Mar. 20, 2015.
- <sup>11</sup> Ezra Golberstein et al., “Supplemental Coverage Associated with More Rapid Spending Growth for Medicare Beneficiaries,” *Health Affairs* 32, no. 5 (May 1, 2013): 873–81.
- <sup>12</sup> Congressional Budget Office, *Change the Cost-Sharing Rules for Medicare and Restrict Medigap Insurance*, Dec. 8, 2016.
- <sup>13</sup> Ibid.
- <sup>14</sup> Ibid.
- <sup>15</sup> Gretchen Jacobson et al., *Medicare Advantage 2016 Spotlight: Enrollment Market Update*, Henry J. Kaiser Family Foundation, May 2016.
- <sup>16</sup> Congressional Budget Office, *Convert Medicare to a Premium Support System*, Nov. 13, 2013.
- <sup>17</sup> Scott Harrison and Carlos Zarabozo, *Medicare Advantage Program: Status Report*, MedPAC, Dec. 8, 2016.
- <sup>18</sup> Michael A. Morrisey et al., “Favorable Selection, Risk Adjustment, and the Medicare Advantage Program,” *Health Services Research* 48, no. 3 (June 2013): 1039–56.
- <sup>19</sup> Alicia L. Cooper and Amal N. Trivedi, “Fitness Memberships and Favorable Selection in Medicare Advantage Plans,” *New England Journal of Medicine* 366, no. 2 (Jan. 12, 2012): 150–57.
- <sup>20</sup> John Z. Ayanian et al., “Medicare Beneficiaries More Likely to Receive Appropriate Ambulatory Services in HMOs than in Traditional Medicare,” *Health Affairs* 32, no. 7 (July 2013): 1228–35.

- <sup>21</sup> Jeff Lemieux et al., “Hospital Readmission Rates in Medicare Advantage Plans,” *American Journal of Managed Care* 18, no. 2 (Feb. 27, 2012): 96–104.
- <sup>22</sup> Robb Cohen et al., “Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients,” *Health Affairs* 31, no. 1 (Jan. 2012): 110–19.
- <sup>23</sup> See, e.g., Katherine Baicker and Jacob A. Robbins, “Medicare Payments and System-Level Health Care Use: The Spillover Effects of Medicare Managed Care,” *American Journal of Health Economics* 1, no. 4 (Oct. 16, 2015): 399–431; and Garret Johnson et al., “Recent Growth In Medicare Advantage Enrollment Associated with Decreased Fee-for-Service Spending in Certain US Counties,” *Health Affairs* 35, no. 9 (Sept. 2016): 1707–15.
- <sup>24</sup> One common criticism of traditional Medicare is that providers typically have little incentive to avoid overuse of care and little incentive to ensure that patients receive appropriate care in the appropriate setting. Medicare Advantage managed-care plans can affect these practice decisions by making payments to providers contingent on meeting quality and/or cost goals. In addition, the use of networks to include and exclude providers creates an incentive for some providers to alter the way they practice medicine in order to be included within networks. Because it is typically administratively difficult for providers to vary practice patterns among individuals with different types of insurance, changes in practice patterns are likely to affect *all* patients seen by the provider.
- <sup>25</sup> Joseph Newhouse et al., “How Much Favorable Selection Is Left in Medicare Advantage?” *American Journal of Health Economics* 1, no. 1 (Sept. 17, 2015): 1–26.
- <sup>26</sup> *Ibid.* at 16.
- <sup>27</sup> Cited in Joseph Antos, “Plan Competition and Consumer Choice in Medicare: The Case for Premium Support,” American Enterprise Institute and Robert Wood Johnson Foundation, Apr. 2013, p. 12.
- <sup>28</sup> Department of Health and Human Services Office of Inspector General, *Memorandum Report: Contract Pharmacy Arrangements in the 340B Program, OEI-05-13-00431*, Feb. 4, 2014.
- <sup>29</sup> Government Accountability Office, *Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals*, June 5, 2015.
- <sup>30</sup> Department of Health and Human Services Office of Inspector General, *Part B Payments for 340B-Purchased Drugs*, Nov. 2015.