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Medicare at 50

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Medicare: Beginnings

- **Universal National Health Insurance for all Americans**
  - Early Attempts
    - FDR – New Deal
    - Harry Truman - 1948
  - Failure resulted in more modest goals
- **Health insurance for elderly Americans**
  - Why did this make sense?
    - Health care bills for elderly were three times those of non-elderly
    - Retirees did not have access to employer provided insurance
    - Retirees were unattractive to private insurers in the individual health insurance market
    - Early 1960s – only ½ of age 65+ has health insurance
    - Seniors vote and their numbers were projected to increase

Medicare: Beginnings

- **In 1950s** – several attempts to provide health insurance for elderly
- JFK became a powerful Senate advocate
  - Medicare lost a close Senate vote in 1962
  - Medicare became part of the Kennedy legacy

- LBJ's landslide victory gave him majorities in Congress
- Wilbur Mills (D-AR) insisted that the program include Medicaid
- Signed into law by LBJ on July 30, 1965 at Independence, Missouri with Harry Truman looking on

Medicare at Birth

- **Original Medicare**:
  - Relatively modest insurance package
  - Deductibles, copayments and premium contributions were required from beneficiaries to limit costs
  - Did not include Long Term Care (LTC), prescription drugs or limits on out-of-pocket (OOP) costs
- **Structure of a separate Part A and Part B** imitated the prevailing status of private health insurance at the time - BCBS

Medicare at Birth

- **Payment of providers** in the same way that private insurers did at that time
  - Fee for service (FFS)
  - Physicians' payments based on local **usual and customary charges (UCR)**
  - Hospitals' payments were based on their 'reasonable costs' – **cost-based reimbursement**

Overall Impact on Coverage and Care

- **Improved protection against financial hardship** from medical expenses
  - Today, only 2% of elderly lack health insurance
  - In 1962, 48% lacked health insurance

- **Use of services** by elderly immediately increased
  - 1963-70, rate of hospital admissions per 100 elderly rose from 18 to 21 annually
  - Proportion of elderly who has contact with a physician each year increased from 68% to 76%
  - Rate of cataract procedures for seniors between 1965-75 doubled

Overall Impact on Coverage and Care

- **Life expectancy** at age 65 increased by 15% from 1965-84
- Medicare also did not reimburse **racially segregated health care facilities** in compliance with the Civil Rights Act of 1964
- In 2013, Medicare covered 52.3 million Americans
  - Annual cost of $583 billion
  - Nation's largest insurer
  - Medicare is very popular among users

Structure of Current Medicare – Part A

- **Part A – Hospital Insurance (HI)**
  - Inpatient hospitalization
  - Home Health Care
  - Skilled Nursing Facilities
  - Hospice Care

- **Part A Benefits**
  - 60 days for inpatient care after a **deductible** of $1288 (2016)
  - Days 61-90 provided with a **copay** of $322 per day
  - Days 91-150 (lifetime reserve days) provided with a **copay** of $644 per day

- **Automatically available** without any premium

Structure of Current Medicare – Part B

- **Part B – Physician and Outpatient Services**
  - Can opt-out, otherwise automatic enrollment
  - **Deductible** - $166 annual (2016)
  - After deductible, Medicare splits 80%/20% **coinsurance**
  - No out-of-pocket (OOP) maximum

Structure of Current Program – Part D

- **Part D – Rx Coverage**

- Private insurers offer Part D – beneficiaries voluntarily enroll
- Within certain parameters, they set many of the specifics of the policies they offer

- **Monthly Premium**
  - Standard premium
    - Individual < $85,000
    - Couples < $170,000
  - Higher income pay more

Structure of Current Program: Part D

- **Part D Standard Benefit**
- **Deductible Phase**
  - Deductible – maximum = $360
  - Some plans have no deductible
- **Initial Coverage Phase**
  - Coinsurance
  - Beneficiary and plan pay up to $3310
- **Coverage Gap Phase**
  - ‘Doughnut Hole’
  - Only discounts – no coverage
- **Catastrophic Coverage Phase**
  - OOP maximum for catastrophic coverage = $4850
  - 5% coinsurance

Evolution of Medicare – Covering New Populations

- **1972** – Medicare eligibility extended to persons:
  - **Under age 65** who qualified for **Social Security Disability payments** (with a two year waiting period) or
  - Those who had **End Stage Renal Disease (ESRD)**
- In 2013, 8.8 million of the 52.3 million Medicare beneficiaries were under 65 and disabled

Evolution of Medicare: Expanded Benefits

- Several efforts to **fill gaps** in original benefit structure

- **1988** – President Regan sponsored the **Medicare Catastrophic Coverage Act (the original Part C)**

  - Added coverage for Rx
  - Limitation on OOP expenses
  - In 1989, Congress repealed because of public opposition to premiums required to finance the expanded benefits

Evolution of Medicare: Expanded Benefits

- **2003** – President Bush sponsored the **Medicare Modernization Act (MMA)**
  - New coverage for Rx (Part D)
  - Private plans have larger role in Medicare
  - Coverage provided on a voluntary basis from private plans with a premium paid directly to the plan
- In **2013**, 39.1 million beneficiaries were enrolled in a Medicare Rx plan

Evolution of Medicare: Expanded Benefits

- The ACA filled in some gaps
- The program still has limitations in coverage
  - 90% of Medicare beneficiaries have supplemental insurance
  - Medigap
  - Medicaid

Evolution of Medicare: Choice, Competition and Private Plans

- **Rationale**:

- Private plans are inherently more efficient than government sponsored plans
- Government coverage for Medicare beneficiaries should be provided by private insurers
- Competition will increase the choices for beneficiaries and control costs as plans compete for business
- If private plans emphasize more managed care (like HMOs), they can better coordinate care than can traditional Medicare

Evolution of Medicare: Choice, Competition and Private Plans

- **1982** – **Medicare Risk-Contracting Program**
  - Increased access to HMOs
- **1997** – Medicare Part C
  - Additional types of plans available to beneficiaries
  - Less generous rates of payment lead to withdrawal of many plans and a drop in Part C enrollment
- **2003** – Congress increased payment to private plans and further expanded the types of plans eligible to participate
  - Now called **Medicare Advantage**
  - Payments set to a level higher than the costs of average beneficiaries under traditional Medicare
    - Enrollment grew substantially
- **2010** – ACA decreased payments, but enrollment is still about 15 million

Quality Improvement Initiatives

- **Quality and appropriateness of care** provided to Medicare beneficiaries and other Americans has increased overtime
- One area of concern – **geographic variation** in the use of services by Medicare beneficiaries
- **Medicare has responded** in several ways:
  - Requiring hospitals, nursing homes and home health agencies and dialysis facilities to **report data on processes and outcomes of care**
    - Publically available on Medicare Compare websites
  - Physician reporting requirements were implemented in 2007
  - The **Meaningful Use** program enacted in 2009 uses Medicare and Medicaid incentive payments to encourage the electronic reporting of quality data with the use of electronic health records
  - Other changes in payment system to reflect quality

The ACA and Medicare

Changes in Medicare Benefits under the ACA

- ACA covers all effective **preventive services** without cost sharing by patients

- Medicare Rx coverage is more affordable by **gradually closing the 'doughnut hole' in Part D**

The ACA and Medicare

Expanded on Past Reforms in Medicare payment of providers

- Medicare Shared Savings Program (MSSP)
- Providers can form ACOs within traditional Medicare to share responsibility for the quality and cost of care provided
- Other incentives to decrease hospital readmissions and hospital acquired conditions
- Expanded pay-for-value programs

The ACA and Medicare

- Developed a **quality rating system** for Medicare Advantage Plans to provide higher payments to plans earning higher ratings

- Creation of the **Center for Medicare and Medicaid Innovation**

  – Develop, assess and disseminate innovations that improve both Medicare and Medicaid

  – Secretary of Health and Human Services can adopt program-wide any innovation that is certified to decrease costs without decreasing quality OR increase quality without increasing costs

Financing

- **Part A – HI**

- **Payroll taxes** on earnings, paid by employers and employees
- Self-employed pay the equivalent of the combined tax rate
- Sources of Income
  - In 2014, 169.6 million paid HI taxes
    - 1.45% of payroll
    - ACA – additional 0.9% of income above 200K/250K
  - Taxation of Social Security Benefits
  - Income from interest of accumulated reserves

Financing

- **SMI**

- **General revenues** contribute 75% of Part B and D costs
- Remaining amount comes from **monthly premiums** charged to enrollees OR paid by Medicaid because of low income eligible
- Standard Premium
  - 2015 - $104.90
  - 2016 - $121.80
    - Hold-harmless provision - $104.90
- If income is greater than 85K/170K, higher premiums
  - In 2015, these ranged from $146.90 - $335.70

Financing

- **Part D - Rx**

- Base monthly premium - $33.13
- Actual premium depends on specific plan selected
- Higher income beneficiaries pay more in addition to the standard premium
  - 2015 - $12.30 - $70.80
- Payments from states to reflect Medicaid savings for dual-eligibles

Financing: Trust Funds

- Treasury credits Medicare taxes, premiums and other income to trust funds
  - HI – inpatient hospital and related care
  - SMI – two accounts
    - Part B – physicians and outpatient
    - Part D – Rx
- The only disbursements permitted from the funds are for benefit payments and administrative costs
- Excess funds are invested in interest-bearing securities
- Table 1 – Trust Fund Operations
- Table 2 – Program Cost
- Table 3 – Program Income
- In 2014, both HI and SMI had to dip into reserves

Trust Fund Operations

Table 1. Trust Fund Operations

(in billions)

	OASI	DI	HI	SMI
Reserves (end of 2013)	$2,674.0	$90.4	$205.4	$75.1
Income during 2014	769.4	114.9	261.2	338.0
Cost during 2014	714.2	145.1	269.3	344.0
Net change in Reserves	55.2	-30.2	-8.1	-6.0
Reserves (end of 2014)	2,729.2	60.2	197.3	69.1

Note: Totals do not necessarily equal the sum of rounded components.

Program Cost

Table 2. Program Cost

(in billions)

Category (*in billions*)	**OASI**	**DI**	**HI**	**SMI**
Benefit payments	$706.8	$141.7	$264.9	$339.6
Railroad Retirement financial interchange	4.3	0.4	—	—
Administrative expenses	3.1	2.9	4.5	4.4
Total	714.2	145.1	269.3	344.0

Note: Totals do not necessarily equal the sum of rounded components.

Program Income

Table 3. Program Income

(in billions)

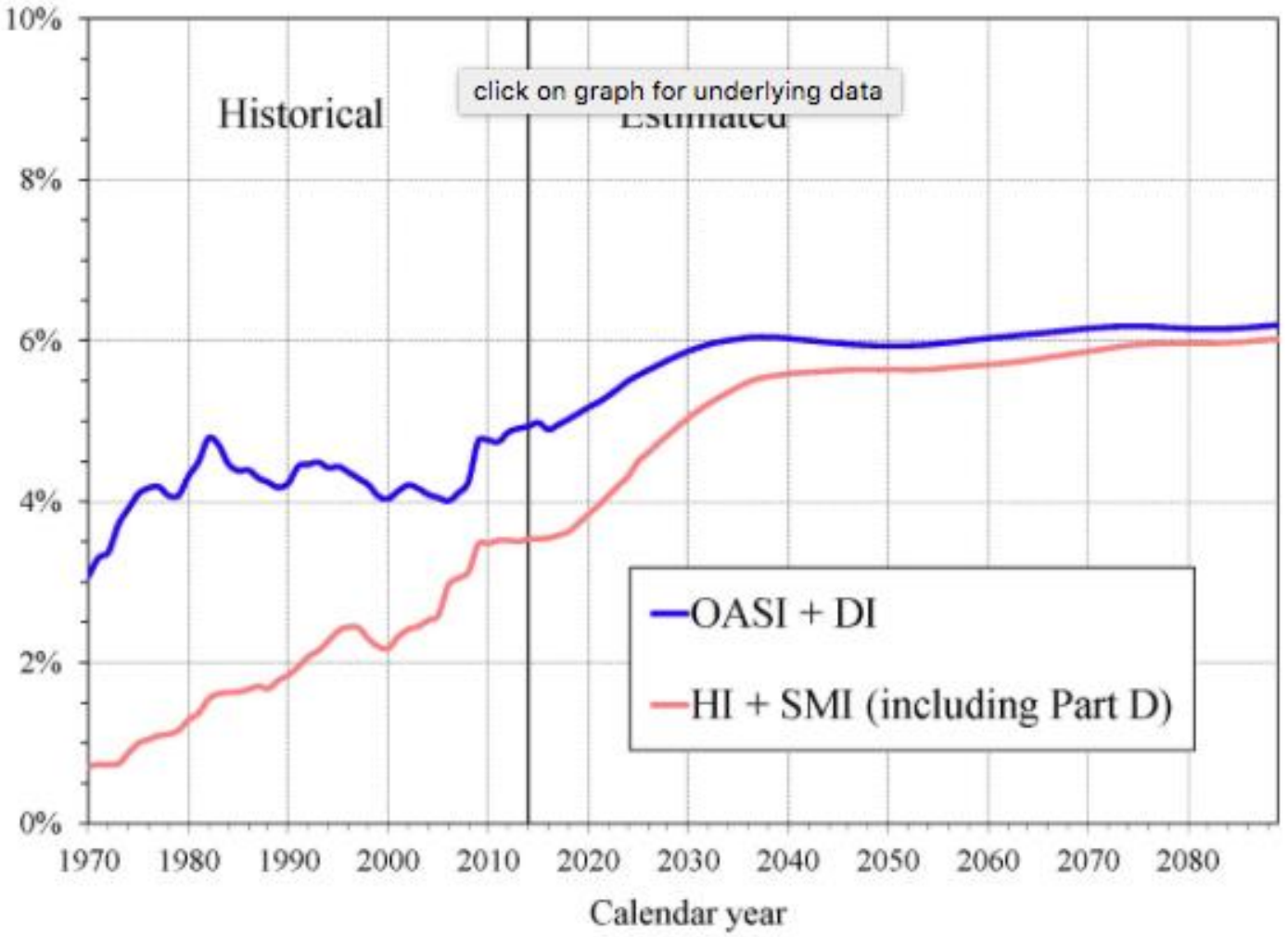
Source *(in billions)*	**OASI**	**DI**	**HI**	**SMI**
Payroll taxes	$646.2	$109.7	$227.4	—
Taxes on OASDI[a] benefits	28.0	1.7	18.1	—
Beneficiary premiums	—	—	3.3	$77.0
Transfers from States	—	—	—	8.7
General Fund reimbursements	0.4	0.1	2.0	3.0
General revenues	—	—	—	$243.7
Interest earnings	94.8	3.4	8.8	2.4
Other	[b]	—	1.6	3.3
Total	769.4	114.9	261.2	338.0

Financing: Trust Funds

- Projections under the '**intermediate assumptions**'
- Medicare costs increase to 5.4% of GDP in 2035 because of increase in the number of beneficiaries
  - 6.0% by 2089

- In 2014, 3.5% of GDP – **Chart A**
- Projections assume that:
  - Full realization of savings under the ACA
  - Physician payment rate updates specified in the MACRA of 2015
  - Sustained effectiveness of various current law cost savings measures
    - In particular, the lower increases in Medicare payment rates to most providers

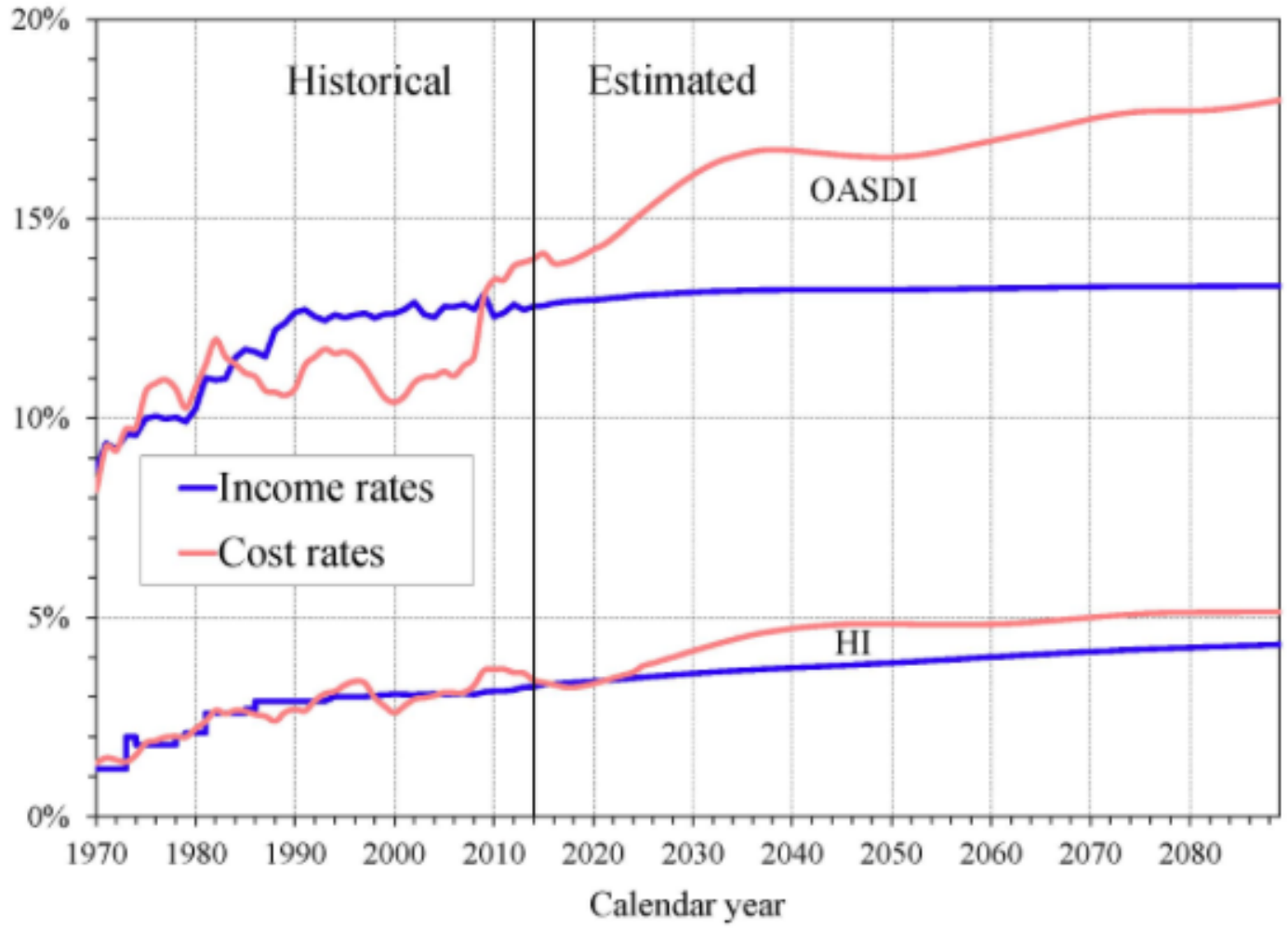
Chart A—Social Security and Medicare Cost as a Percentage of GDP



Financing: Trust Funds

- **Income Rate** and **Cost Rate**
- Since income is based on taxable payroll, we express the income and cost as a **% of taxable payroll**
- **Income Rate**
  - Payroll taxes and taxes on OASDI benefits (excludes interest)
  - Increases from 3.26% in 2014 to 4.32% in 2089
  - Due to increase in payroll tax rates for higher income under ACA
- **Cost Rate**
  - 3.42% in 2014
  - 4.84% in 2050
  - 5.14% in 2089
- **Chart B**

Chart B—OASDI and HI Income and Cost as a Percentage of Taxable Payroll



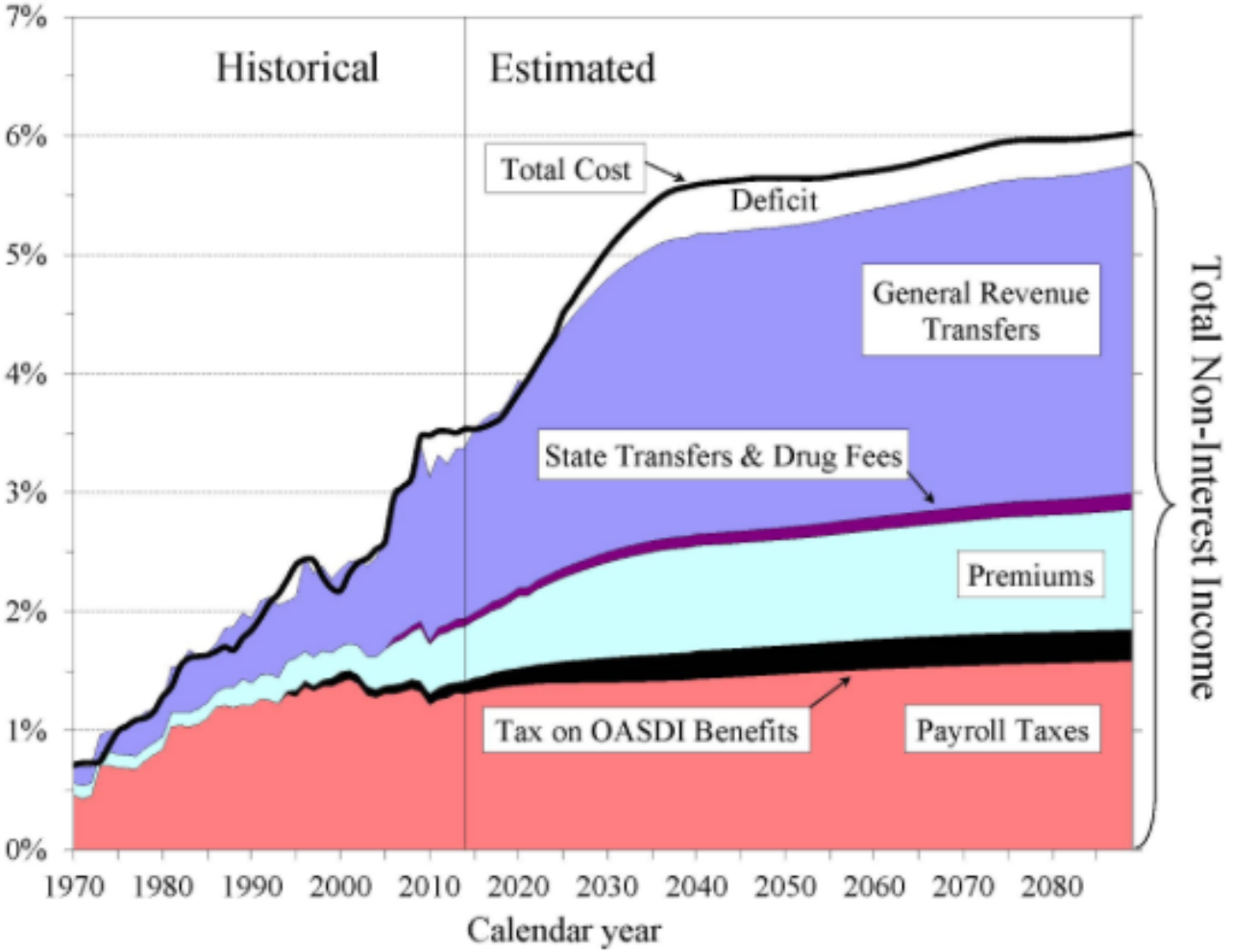
Financing: Trust Funds

- As Medicare costs grow overtime, **general revenues** and **premiums paid by beneficiaries** will play an increased role in financing the program

- **Chart C** – Medicare Cost and Non-Interest Income by Source as a Percentage of GDP

- Note that results are primarily because Parts B and D increase at a faster rate than Part A

Chart C—Medicare Cost and Non-Interest Income by Source as a Percentage of GDP

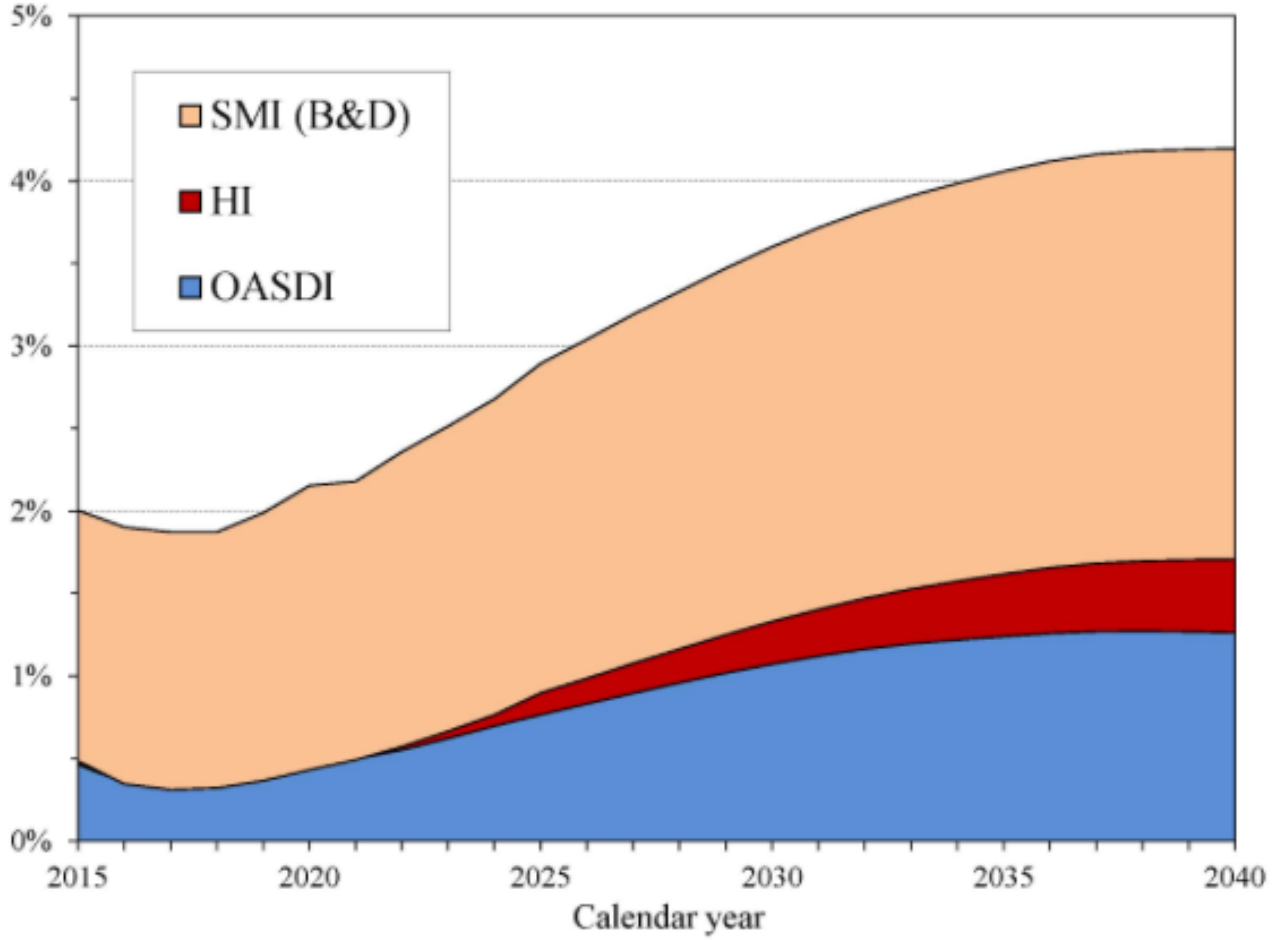


Financing: Trust Funds

- What are the **budgetary implications** of rising costs?
- **Chart D** – Projected SMI General Revenue Funding plus OASDI and HI Tax Shortfalls
- For HI
  - In 2015, projected difference between expenses and tax and premium income is $4 billion
- For SMI
  - Difference is $276 billion
- This assumes that scheduled benefits will be paid even in the absence of an increase in dedicated tax revenues

Chart D—Projected SMI General Revenue Funding plus OASDI and HI Tax Shorfalls

[Percentage of GDP]



Financing: Trust Funds

- Redemption of trust fund bonds, interest paid on those bonds and transfers from general revenues provide **no new net income** to the Treasury

- The payments must be financed by:
  - Increased taxation
  - Decreased government spending
  - Increased borrowing

Actuarial Status: Short-Run

HI - Trust Fund Ratio

- Compare asset reserves at the **beginning of the year** to **projected cost for the ensuring year**

- If ratio is at **least 100%**

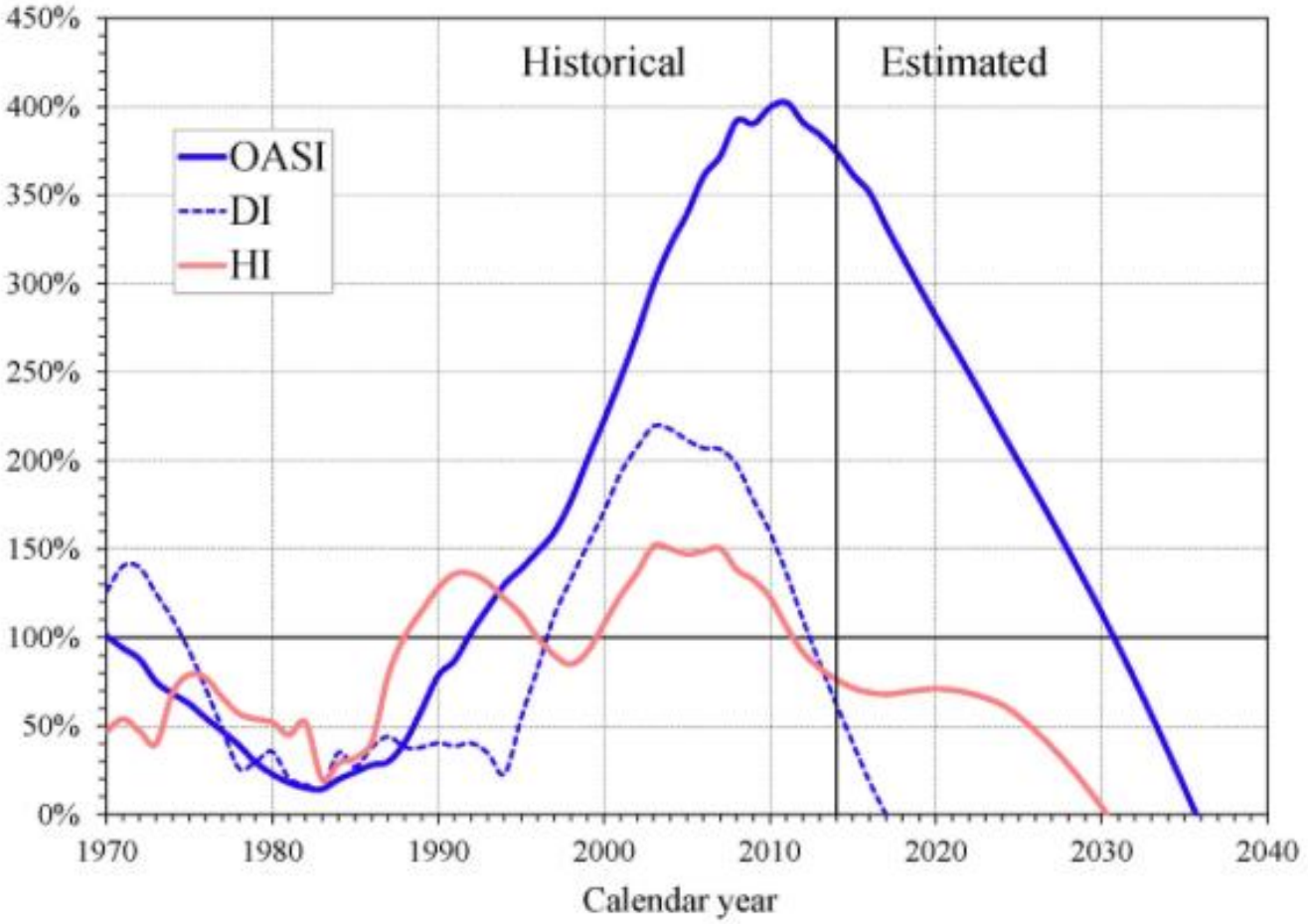
  – Good indicator of a fund's short-run adequacy
  – Even if cost > income
  – Trust funds reserves combined with tax revenue would be sufficient to pay benefits for several years

Actuarial Status: Short-Run

- HI trust fund does **not** meet the **short-range test** of financial adequacy
  - Ratio was 72% at beginning of 2015
  - Projected ratio does not rise to 100% within 5 years
  - Projected trust fun becomes fully depleted by 2030
- **Chart E** – intermediate assumptions

Chart E—OASI, DI, and HI Trust Fund Ratios

[Asset reserves as a percentage of annual cost]



Actuarial Status: Short-Run

- **SMI**
- Less stringent annual '**contingency reserve**' test for SMI
- Financing for that account is set each year to meet expected costs
- Overwhelming portion of financing consists of general revenues and beneficiary premiums (73%/25% in 2014) – Part B
- Part D – premiums paid by enrollees and the amounts appropriated from general revenues are determined each year

Actuarial Status: Key Dates

Key Dates in HI Financing

- 2003 – HI peek trust fund ratio
- 2021 – first year outgo exceeds income excluding interest
- 2023 – first year outgo exceeds income including interest
- 2030 – depleted

- In 2030, HI income would be sufficient to pay 86% of estimated HI cost
  - Decreases to 79% in 2039
  - Increases to 84% by 2089

Actuarial Status: Long-Run

- **Long Range Actuarial Balance**

- Actuarial balance for a **75 year valuation period**
- Balance measure includes:
  - The trust fund asset reserves at the beginning of the period
  - An ending fund balance equal to the 76th year's cost
  - Plus projected costs and income during the valuation period
- Expressed as a **percentage of taxable payroll** for the 75-year projection period

Actuarial Status: Long-Run

- **Actuarial Deficit**
- Represents the **average amount of change in income or cost** that is needed throughout the valuation period in order to **achieve actuarial balance**
- Actuarial balance is zero if costs for the period can be met for the period as a whole **and** the trust fund reserves at the end of the period are equal to the following year's costs (100% trust fund ratio)
- **HI – Intermediate assumptions**
  - Deficit 0.68
  - HI cost rate exceeds income rate in 2015 by 0.05% of taxable payroll
  - Long run deficit of .68% of taxable payroll under intermediate assumptions

Proposals to Improve Medicare

- Provider Payment and Organizational Reform
- Comprehensive Medicare Reform

Provider Payment Reform

Original Payment Methods

- Lacked incentives to control costs
- The more physicians charged, the more they were paid
- The more hospitals spent, the more they were paid

Provider Payment Reform

- **Hospitals** – Retrospective Cost-Based Reimbursement
- **1983 – Medicare Prospective Payment System (PPS)**
  - Pays hospitals on the basis of **Diagnostic Related Groups (DRGs)**
  - Hospital stay (by diagnosis) is the unit of payment
  - Suggested length of stay by diagnosis

Provider Payment Reform

- **Physicians** – Fee-for-Service (FFS) based on Usual, Customary and Reasonable Fee algorithm
  - Rewards providers for volume and complexity of services provided
  - Does not reward efficiency
  - Does not necessarily engage integration and coordination of services
- **1989 – Fee Schedule based on RBRVS**
  - Resource-Based Relative Value Scale
  - Reflects the resources required to perform procedures
  - Intended to correct perceived overcompensation of providers

Provider Payment Reform

- Controversial feature of RBRVS is the **Sustainable Growth Rate (SGR)** formula
  - Potential for increase in volume and intensity of services to push spending higher when fees were limited under RBRVS
  - Under SGR, fees are decreased if Medicare spending on physicians' services exceeds an aggregate target
- Formula has mandated a decrease each year since 2002
- Congress has deferred reduction because of concerns about access to care
- More on this later

Proposals to Improve Medicare: Provider Payment and Organizational Reform

- Modify **payment system** to recognize **quality** and **efficiency**
  - Value-based purchasing
  - Blended payment
  - Bundled payment
- Broader attempts to design **payment incentives and organizational arrangements** to encourage care coordination and integration
  - ACOs
  - Global Payment

Proposals to Improve Medicare: Provider Payment and Organizational Reform

Value Based Purchasing (VBP)

- Reward providers for better performance
- Penalize for poor results

Challenges with VBP

- Must develop effective, outcomes-based measures
- Should more effectively utilize the power of non-financial incentives such as professional and organizational culture to motivate behavior

Proposals to Improve Medicare: Provider Payment and Organizational Reform

- **2003 – Hospital Quality Incentive Demonstration**
  - Bonus payments to hospitals on basis of quality measures
  - Mixed results

- **ACA** – required Medicare to implement VBP across a broad set of providers
  - 2012 – Hospitals
  - 2015-17 – Physicians
    - **Medicare Access and CHIP Reauthorization Act (MACRA)**
    - Did away with SGR and Meaningful Use Program

Proposals to Improve Medicare: Provider Payment and Organizational Reform

Blended Payment

- Combination of **FFS**, **monthly care-management fees** per patient for those served by an advanced primary care physician and **bonuses** for reaching quality targets and shared savings
- Used by some private insurers and state Medicaid programs
- Designed to improve:
  - **Accessibility** to primary care
  - **Coordination** of care across sites of care
  - Assistance with **management of complex situations**
- Early results show:
  - Improved quality and preventive care
  - Mixed results on reducing hospitalization and ER use

Proposals to Improve Medicare: Provider Payment and Organizational Reform

Bundled Payment

- Supports increased coordination and efficiency
- Set a **single prospective payment** covering an inclusive set of services related to a **specific medical condition**
- **2013 – Bundled Payments for Care Improvement Initiative**
  - Testing four different bundled payment models
  - Too early to tell in terms of results
- Potential to motivate providers to collaborate on ways to reduce costs and coordinate care for a particular condition
- Could inhibit coordination across conditions by encouraging development of siloed systems focused exclusively on one problem

Proposals to Improve Medicare: Provider Payment and Organizational Reform

Accountable Care Organizations – ACOs

- Organizations of providers that are **accountable for both cost and quality of care**
- **MSSP – Medicare Shared Savings Program**
  - Groups of providers that meet certain organizational requirements can share in any savings they produce as compared to predicted costs that would have been accrued by Medicare patients in the ACO if they were treated in the usual system
- **Pioneer ACOs**
  - Share **gains from savings but risks for costs** exceeding those in the regular system
- Both must meet quality targets to share in any savings

Proposals to Improve Medicare: Provider Payment and Organizational Reform

Global Payment

- Providers receive **fixed payment in advance**
  - Covers all or most of the healthcare needs for a group of patients
  - Very similar to capitation
- **Pros/Advantages of Global Payment**
  - Strong support for preventive care to avoid the onset of costly illness
  - Coordinated care to produce improved outcomes at a reduced cost
  - Availability of non-medical services to enhance population health
- **Cons/Disadvantages of Global Payment**
  - Providers at risk and might avoid sick patients
  - Risk adjustment models are more refined now
  - Medicare Advantage Plans receive a fixed payment

Proposals to Improve Medicare: Comprehensive Medicare Reform

Premium Support Program (Ryan Plan)

- Medicare beneficiaries would receive a **defined subsidy** that would then be used to purchase either a private plan or traditional Medicare
- Purchase a **standard package of benefits** from **private plans** or **traditional Medicare** competing in a Medicare exchange
- If beneficiaries choose a plan exceeding the subsidy, they would be responsible for paying the difference

Proposals to Improve Medicare: Comprehensive Medicare Reform

- **Cons/Disadvantages of Premium Support**
  - Beneficiaries may lack information to choose among plans, especially with respect to quality of care
  - May have cognitive impairments that make informed decisions difficult

- **Pros/Advantages of Premium Support**
  - Federal government now generates an increasing amount of **data on plan performance** in Medicare Advantage Plans and on **provider quality** through the Medicare Compare website
  - Baby boomers will **lower the average age** of beneficiaries and many of them are used to managed care and plan choice
  - Defined contribution approaches are **widely used** in private employer sponsored plans

Proposals to Improve Medicare: Comprehensive Medicare Reform

Reforming Traditional Medicare

- Restructure to make it look more like employer-sponsored insurance
- Combine Part A, B and D into a **single program** with a single premium, deductible, copays
- Create incentives for consumers to utilize better performing providers and treatments by **reducing cost sharing** for patients using these providers
- Continue to use payment and organizational reforms
- Reduce OOP payments, making Medigap unnecessary

Proposals to Improve Medicare: Comprehensive Medicare Reform

Important Differences Between Two Approaches

- Underlying view of each plan with respect to **who should be held accountable** and **who should bear risk and costs**

- **Premium Support**
  - Increased responsibility and potential risk for **beneficiaries**
  - Functions like markets that allocate other goods and services

- **Reforming Traditional Medicare**
  - Concentrates accountability and risk on the **federal government** and on **providers** of healthcare

Continuing Issues

- Cost, cost, cost!
- Fragmentation of benefits
- Long-term care