Testimony before the U.S. Senate Special Committee on Aging
John Holahan
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Thank you for the opportunity to testify before the U.S. Senate Special Committee on Aging. The views I express are mine alone and should not be attributed to the Urban Institute or any of its sponsors. The testimony is based on a paper written with Dr. Robert Berenson, "Preserving Medicare: A Practical Approach to Controlling Spending."[1] In this testimony, I would like to make three basic points:

1) While in Medicare spending is projected to grow by about 7 percent per year over the next decade, spending growth on a per enrollee basis is now projected to be relatively modest, certainly lower than projected increases in private insurance premiums.
2) Proposals that would essentially privatize the Medicare system will not work as intended; they will increase overall expenditures and shift more spending onto Medicare beneficiaries.
3) Finally, there are a number of other reforms that while not restructuring Medicare would substantially lower its future expenditure path.

First, it is important to place Medicare spending growth in perspective. Medicare spending is projected to grow at about 6.5 percent per year over the next decade; about 2 percentage points faster than the growth in the U.S. economy – 4.7 percent per year.[2] Medicare spending growth would increase by about 0.7 percentage faster if physician fees were allowed to increase with the Medicare Economic Index (MEI) rather than face large cuts.[3] At the same time, however, the Center for Medicare and Medicaid Services (CMS) Actuaries project that spending per enrollee will increase only by 3.5 percent per year over the 2010-2019 period.[4] The gross domestic product (GDP) per capita is projected to grow at about the same rate – 3.8 percent – over the same period.

[1] Berenson RA and Holahan J. *Preserving Medicare: A Practical Approach to Controlling Spending*. Washington, DC: Urban Institute, Oct 2011. http://www.urban.org/health_policy/url.cfm?ID=412405
[2] Centers for Medicare and Medicaid Services, Office of the Actuary, September 2010.
[3] Centers for Medicare and Medicaid Services, Office of the Actuary. "Projected Medicare Expenditures Under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers." Baltimore, MD: CMS, 13 May 2011.
[4] Centers for Medicare and Medicaid Services, Office of the Actuary, September 2010.

A major reason for the projected 6.5 percent rate of growth in Medicare spending is the substantial increase in enrollment due to the retirement of the baby boomers who have started turning 65 this year. Medicare enrollment is projected to grow by almost 3 percent per year over the next decade. The influx of 65 to 75 year old group brings in a lower-cost group of individuals and lowers the rate of growth in the average cost of a Medicare beneficiary.

But much of the explanation of a relatively slow rate of growth by historical standards is due to the provisions in the Affordable Care Act (ACA) that will reduce Medicare spending increases. These include reductions in payments to Medicare Advantage plans, hospitals, skilled nursing facilities and home health services. According to the CMS Actuaries, these provisions will reduce the rate of spending growth by 1 percentage point. The CMS Actuaries have argued that these cuts are not sustainable, for example, that Medicare hospital payments will not keep up with the growth in hospital costs. However, this argument assumes that hospitals have little choice but to incur these costs. The reality is more complicated; there has been a growing research literature that shows that the ability to shift costs onto private payers is limited. Except in highly concentrated markets, the evidence is that hospitals will in fact restrain cost growth to live within available revenues.[5]

The 3.5 percent rate of growth also does not account for increases in Medicare physician fees. It is inconceivable that Medicare physician fees will be permitted to fall by 29 percent in 2012. CMS actuaries estimate that allowing Medicare physician fees to increase by MEI would increase Medicare spending by $300 billion over ten years and increase Medicare's projected growth rate by 0.7 percent.[6]

We conclude that while Medicare spending growth is relatively modest on a per enrollee basis, overall spending growth is still substantial and there is still room for savings and these should be pursued aggressively but carefully.

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[5] Robinson J. "Consolidation and the Transformation of Competition in Health Insurance." Health Affairs, 23(6): 11-24, 2004; Frakt AB. "How Much Do Hospitals Cost Shift? A Review of the Evidence." Milbank Quarterly, 89(1): 90–130, 2011; Wu V, "Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997." International Journal of Health Care Finance and Economics, 10(1): 61-83, 2009. DOI: 10.1007/s10754-009-9071-5.

[6] Centers for Medicare and Medicaid Services, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers."

Second, proposals such as that made by Congressman Paul Ryan, Chairman of the House Budget Committee, will not work as intended.[7] The plan would essentially turn Medicare over to private insurers, Medicare would provide subsidies towards the purchase of a private insurance plan, with beneficiaries responsible for additional costs over and above Medicare payments. While this would not begin until 2022, it is worth considering the fundamental approach. Medicare spending would clearly decline under this and other such proposals because Medicare's contributions would be limited to the growth of inflation regardless of the actual increase in health care spending. The Congressional Budget Office (CBO) has estimated that the total societal cost of providing Medicare benefits would actually increase under the proposal, primarily because the elimination of the traditional Medicare program would shift beneficiaries into more costly private plans. CBO estimates that private plans are more costly than traditional Medicare for two reasons: higher administrative costs and higher provider payment rates. CBO estimates that average spending in traditional Medicare would be 28 percent below spending for the same package of benefits from a private insurer in 2022 (even with a physician fee fix). Medicare beneficiaries would pay 68 percent of the cost of these higher premiums.[8]

The higher provider payment rates used by private insurers relative to traditional Medicare reflects the difficulty private plans have in negotiating payment rates with providers. Recent years have seen a substantial increase in consolidation in the hospital industry and increasingly among physicians. As hospital and physician consolidation increases, the difficulty the private plans have in negotiating provider payment rates has increased and will continue to do so. Traditional Medicare sets prices based on systems developed for both hospital and physician payments and uses its large market presence to set rates that most providers accept. We have concluded that the market power that Medicare has is necessary to control cost growth. Given the central role of payment rates as a health care cost driver and the market failure produced by growing provider consolidation that increases prices, it is essential to maintain and even enhance the traditional Medicare program as we seek savings. This of course does not preclude

[7] Congressional Budget Office. "Long Term Analysis of a Budget Proposal by Chairman Ryan." Washington, DC: CBO, 5 April 2011.
[8] Congressional Budget Office. "Long Term Analysis of a Budget Proposal by Chairman Ryan."

encouraging private plans to compete with the traditional Medicare plan, as now in the Medicare Advantage program.

The other problem with privatization approaches is that they ignore the skewness of the Medicare expenditure distribution; that is, a small percentage of Medicare beneficiaries account for the bulk of spending. Using data for 2006, we estimate that 69 percent of Medicare beneficiaries spend less than $5,000 per year.[9] They account for 12 percent of Medicare spending. $5,000 is roughly an equivalent in 2006 to the health savings account (HSA) out-of-pocket limit of $5,950 faced by the non-elderly in 2011. Any proposal for a private option would probably include out-of-pocket caps in this range. The fact that only 12 percent of the spending is attributed to those who spend less than $5,000 a year and 23 percent to those who spend bellow $10,000 means that the reach of higher cost-sharing levels is likely to be limited. In other words, 77 percent of expenditures is on roughly the 20 percent of Medicare population whose expenditures exceed $10,000 a year; they would face virtually no out-of-pocket costs for most of their expenditures. Thus, the impact of requiring Medicare beneficiaries to have more "skin in the game" would contribute only a limited amount to slowing Medicare spending growth.

Third, there are a number of other policies that could be implemented without a major restructuring. To begin with, we should build on a series of demonstration programs that have been part of the ACA. There are a number of options for testing new payment approaches that move away from volume-based payments and change current incentives that lead many providers to provide unneeded and sometimes inappropriate services. These new models include patient-centered medical homes and accountable care organizations. We do not know yet how well these reforms will work, but they represent changes in the delivery system that offer considerable promise.

We recognize that there is a need for savings in the near term while experimentation with these broader system reforms takes place. CBO and Medicare Payment Advisory Commission (MedPAC) have both identified a number of reforms. Proposals to consider include reducing home health and skilled nursing facility payment updates which could yield savings of about $40

[9] Urban Institute Analysis of the Medicare Current Beneficiary Survey, 2006 Cost and Use File.

billion over 10 years.[10] CBO has proposed increased cost-sharing for home health services which would reduce spending by nearly $50 billion over 10 years.[11] The National Commission of Fiscal Responsibility and Reform (Bowles-Simpson) recommended extending Medicaid drug rebates to Medicare dual eligibles, a policy which would provide an estimated savings of $49 billion over 10 years.[12]

There are several other possibilities that could provide near-term savings. The premium structure in Medicare is quite complicated with separate premiums for Part B and Part D; it is also unfair.[13] Using Part B as an example, those who are dually eligible for both Medicare and Medicaid pay little or no premiums depending on their incomes. Those with incomes above 134% of the federal poverty line (FPL) pay the full Part B premium (25 percent of expenditures) until income levels of $85,000 for individuals and $170,000 for couples (825 percent of FPL and 1,310 percent of FPL respectively). At that point Medicare premiums double; for individuals and couples with higher income levels they increase even further. Part D has similar income-related premium surcharges.

This means that those with incomes above 134 percent of FPL and below 300 percent of FPL pay extremely high premiums as a percentage of income, with premiums as a percentage of income declining until the $85,000/$170,000 levels are reached. This is in sharp contrast to the premium schedule in the ACA where premiums are 2 percent at an income level of 133 percent of FPL and increase to a maximum of 9.5 percent at an income level of 300 percent of FPL. It is possible to develop a premium schedule that is more like that in the ACA. This would lower premiums for those with incomes below 300 percent of poverty and increase them gradually up to the $85,000/$170,000 income levels. This could be done in a way that could provide increased revenues. CBO has estimated savings of $241 billion over ten years from increasing the Part B

[10] Congressional Budget Office, *Budget Options Volume I: Health Care*. Washington, DC: CBO, December 2008; Medicare Payment Advisory Commission, "Home Health Services," in *Report to Congress: Medicare Payment Policy*. Washington, DC: Medicare Payment Advisory Commission, March 2011.
[11] Congressional Budget Office. *Budget Options Volume I: Health Care*.
[12] The National Commission on Fiscal Responsibility and Reform. *The Moment of Truth*. Washington, DC: The National Commission on Fiscal Responsibility and Reform, December 2010.
[13] Zuckerman S, Shang B, Waidmann T. "Policy Options to Improve the Performance of Low Income Subsidy Programs for Medicare Beneficiaries." Washington, DC: The Urban Institute, forthcoming.

premium from 25 percent to 35 percent of program costs but this does not include the low-income protections we propose.

In addition, Medicare cost-sharing could be restructured with an out-of-pocket cap on all expenditures. Medicare benefits include substantial cost-sharing in the form of hospital deductibles and co-insurance for physician and out-patient services. There is no upper limit on the amount of Medicare cost-sharing expenses that beneficiaries occur. As a result, beneficiaries often seek supplemental Medigap coverage sometimes to pay for the routine cost-sharing associated with services, but also to obtain catastrophic coverage for long-duration spells of illness. There is research evidence that Medigap policies reduce the effective cost-sharing in Medicare, increasing utilization and Medicare spending.[14] The deductible and cost-sharing structure could be substantially changed and made more uniform across different benefit categories.[15] For example, there could be a single deductible of say $1,000 with 20 percent cost-sharing for Part A and Part B up to an out-of-pocket cap at around current HSA levels. The out-of-pocket cap could apply to Part D as well. There should be greater cost-sharing protections for those with incomes below 250 percent of FPL as in the ACA. The National Commission on Fiscal Responsibility and Reform proposed a similar approach and estimated savings of $110 billion over 10 years, while providing better protection for those who need it.[16] In principal, this would make the purchase of Medigap coverage much less necessary. The Bowles-Simpson Commission also recommended that Medigap policies not be permitted to cover the first $500 of cost-sharing and limit coverage to 50 percent of the next $5,000.[17] The notion is to restructure Medicare so that supplemental insurance is both unnecessary and financially unattractive.

Another option is to increase the age of eligibility to 67. This should be done gradually so that individuals can anticipate and prepare for the change. This option is only feasible when the ACA is fully implemented because many in this age group would have great difficulty getting coverage in the current health insurance market. ACA includes provision for 3:1 age rating

[14] Remler DK, Atherly AJ. "Health Status and Heterogeneity of Cost-Sharing Responsiveness: How Do Sick People Respond to Cost-Sharing?" Health Economics, 12(4):269-80, April 2003.
[15] Davis K, Moon M, Cooper B, Schoen C. "Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries." Health Affairs, Web Exclusive: w5-442-w5-454, 5 October 2005; Zuckerman S, Shang B, Waidmann T. "Reforming Beneficiary Cost Sharing to Improve Medicare Performance." Inquiry, 47: 215-225, Fall 2010.
[16] The National Commission on Fiscal Responsibility and Reform. *The Moment of Truth.*
[17] Ibid.

which will limit premiums for those age 65 to 66. The ACA also provides for income-related premium and cost-sharing subsidies, thus providing substantial protection for low-income individuals who would now purchase private plans through exchanges.[18] Those with higher incomes would pay more than they do today. Employers would also spend more as would states. Some of the savings to the federal government from phasing out Medicare for those 65-66 would be offset by subsidies in exchanges. But after accounting for these shifts, the CBO has estimated that gradually raising Medicare eligibility age to 67 beginning in 2014 would reduce federal outlays by $125 billion between 2012 and 2021.[19] It is important to note that national health expenditures oveall would be higher because private plans are more costly than traditional Medicare.[20]We emphasize again that the ACA provisions, including health insurance exchanges, age rating, and substantial subsidies to support the purchase of insurance for low income individuals are essential to making this kind of change in Medicare.

Medicare should also take greater responsibility for the acute care services provided to dual eligibles. We estimate that dual eligibles spent $305 billion in 2010 between Medicare and Medicaid.[21] Over the next decade, spending on dual eligibles will amount to over $4 trillion. Dual eligibles are primarily low-income individuals, and many have multiple chronic conditions. There is often little coordination of their care. The split of responsibility between Medicaid and Medicare adds to inefficient and unnecessary spending. There have been many efforts to develop programs that successfully coordinate care for these individuals. Not all have proven to be successful but many recent efforts have been. Successful demonstration programs have shown considerable savings from reduced hospital admissions, readmissions, drug utilization, skilled nursing facility days and use of specialists.[22] Most of the savings are on acute care services

[18] Neuman T, Cubanski J, Waldo D, Eppig F, Mays J. *Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform*. Henry J. Kaiser Family Foundation, March 2011.
[19] Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*. Washington, DC: CBO, March 2011. http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf.
[20] Congressional Budget Office. *Reducing the Deficit: Spending and Revenue Options*.
[21] Holahan J, Schoen C, McMorrow, S. "The Potential Savings from a Federal Chronic Care Management Policy." Washington, DC: The Urban Institute, forthcoming.
[22] Grumbach K, Bodeheimer T, Grundy P. "The Outcomes of Implementing the Patient Centered Medical Home Interventions." Washington, DC: Patient Centered Primary Care Collaborative, August 2009; Naylor MD, Brooten DA, Campbell RL, Maislin G, McCauley KM, Sanford Schwartz J. "Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized Clinical Trial." *Journal of the American Geriatrics Society*, 52: 675–84, 2004; Coleman EA, Parry C, Chalmers S, Min SJ. "The Care Transitions Intervention: Results of a Randomized Clinical Trial." *Archives of Internal Medicine*, 166: 1822–28, 2006; Wheeler JRC, Janz NK, Dodge JA. "Can a Disease Self-Management Program Reduce Health Care Costs? The Case of Older Women with Heart Disease." *Medical Care*, 41(6): 706–15, 2003; Brown R. "The Promise of Care Coordination: Models that

covered by Medicare. This strongly implies that Medicare not Medicaid should take the lead roel in developing policies and programs to manage the acute care services of dual eligibles.[23] Even small percentage reductions in spending could yield savings of more than $200 billion over 10 years simply because expenditures on dual eligibles are so large.[24]

Finally, we believe that Medicare would benefit from increased expenditures on Medicare administration. The Centers for Medicare and Medicaid Services have taken on many new responsibilities over the years but have had relatively little increase in staffing.[25] Considerable savings could be achieved, for example, from devoting more resources to detecting and preventing fraud within the Medicare program.[26]

Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses." Washington, DC: The National Coalition on Care Coordination, 2009.

[23] Feder J, Clemans-Cope L, Coughlin T, Holahan J, Waidmann T. "Refocusing Responsibility For Dual Eligibles: Why Medicare Should Take The Lead." Washington, DC: The Urban Institute, Oct 2011. http://author.urban.org/UploadedPDF/412418-Refocusing-Responsibility-For-Dual-Eligibles.pdf

[24] Holahan et al. "The Potential Savings from a Federal Chronic Care Management Policy."

[25] Stanton TS. "The Administration of Medicare: A Neglected Issue." *Washington and Lee Law Review*, 60(4): 1373-1416, Fall 2003.

[26] Budetti P. "Public and Private Sector Efforts to Detect Fraud in the Health Care System." Statement before United States House Committee on Ways and Means, Subcommittee on Oversight, 2 March, 2011.