CHAPTER 1

Context for Medicare payment policy

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Chapter summary

When Medicare was enacted in 1965, it was designed to help ensure access to medically necessary care for aged workers and their spouses and significantly lessen the financial liability for medical care. The program achieved those aims, and many analysts give Medicare credit for improving the economic position of the elderly.

Today, however, Medicare and other purchasers of health care in our nation face enormous challenges for the future. One challenge relates to the wide variation in the quality and use of services within our health care system, with quality often bearing no relationship or even a negative relationship to spending. Patient safety may be at risk if Medicare's payment systems create incentives for providers to furnish unnecessary care or provide no incentives for providers to coordinate their services. Analysts point to geographic variation in spending as evidence of inefficiency and waste. This raises the question of whether the resources entrusted to the Medicare program by taxpayers and beneficiaries are used wisely.

In this chapter

Another difficult challenge relates to financing. As is true for other purchasers of health care, Medicare's spending has been growing much faster than the economy. Our substantial national income and the interaction between broad use of newer medical technologies and health insurance are thought to account for much of this long-term growth, and some of those forces will likely push future spending higher. Medicare will have the additional challenge of higher levels of enrollment associated with retiring baby boomers, which will affect program spending levels as well as the demand for federal resources for other programs that benefit the elderly, such as Social Security and Medicaid.

Because of these forces, the Medicare trustees and others warn of a serious mismatch between the benefits and payments the program currently provides and the financial resources available for the future. If Medicare benefits and payment systems remain as they are today, the trustees note that over time the program would require major new sources of financing for Part A. Also, Medicare would automatically require increased shares of general tax revenues for Parts B and D, which would restrict the availability of resources for other federal priorities. Projected levels of spending could also impose a significant financial liability on Medicare beneficiaries, who must pay premiums and cost sharing.

Strategies to help ensure a more sustainable Medicare program include restructuring Medicare's benefits and supplemental coverage, increasing the program's financing, and using payment policy to obtain better value. Policymakers will need to use a combination of approaches to address Medicare's long-term financing. Since Medicare heavily influences many aspects of health care, policymakers should keep in mind that the program could play a leading role in initiating some types of change. At the same time, broad trends in the health care system affect the environment in which Medicare operates, and the program should work in collaboration with other payers who face similar pressures from growth in health care spending. ■

Medicare fills a critical role in our society—ensuring that the elderly and disabled have access to medically necessary care. Along with other payers in our health care system, the program has helped to finance important strides in medical technology. For the sake of its beneficiaries, we must preserve those aspects of the Medicare program. However, we should also use Medicare's considerable resources more wisely. The program rewards increases in the volume and specialized nature of services but not necessarily in the value of services in terms of health outcomes and efficiency. Practice patterns of care vary widely by geographic region, often with a poor relationship between quality and spending. Some stakeholders view the program as one in which all providers are entitled to payment, regardless of the quality, efficiency, or sometimes even the need for their services. Unless these aspects of Medicare change, the financial obligation of beneficiaries and future taxpayers will be onerous.

The program's shaky financial outlook is a strong impetus for change. As is true for other purchasers of health care services in the United States, Medicare's spending is growing much faster than the U.S. economy. Analysts often attribute this trend to the interaction of income, broad use of new medical technologies, and health insurance coverage. In addition, CMS began Medicare's new outpatient prescription drug program, Part D, in 2006. This program adds an important benefit to Medicare but greatly expands the program's need for resources. Finally, the leading edge of the baby boomers will become Medicare beneficiaries after 2010, which will also accelerate Medicare spending. These factors will lead Medicare to require an unprecedented share of our national income.

Moreover, because of the retirement of the baby boom generation, other federal programs such as Social Security and long-term care services financed through Medicaid will also require greater resources at the same time that Medicare spending expands. Some analysts point out that growth in our nation's economy has historically been large enough to finance expansion of both health and nonhealth spending (Chernew et al. 2003). Future growth in the economy may be able to support Medicare's financing needs, particularly if policymakers take steps to slow growth in health care spending or to reallocate federal revenues to health programs. Other analysts disagree, saying long-term economic growth alone will not be sufficient to bring the country's fiscal position into balance (Bernanke 2007). According to this point of view, fiscal stability will likely require a sizable slowdown in the growth rate of spending on health care and may also require a substantial increase in taxes as a share of our nation's economy (CBO 2005a).

Because the projected shortfall in Medicare's financing is so large, policymakers will need to use a variety of policy approaches. One strategy is to make changes that lead to efficient payments so that Medicare will pay no more than what is required to obtain quality services and good access to care for beneficiaries. However, Medicare faces constraints in making unilateral changes. Providers respond to the incentives of all their payers, not just Medicare's. The conflict between other payers' payment policies and Medicare's can undermine Medicare's incentives. Medicare takes the lead in initiating some changes. To be fully effective, however, Medicare must collaborate with other payers to create incentives for providers to improve their efficiency.

Understanding Medicare's initial design and financing

Policymakers created the Medicare program in 1965 at a time of great concern about the financial hardship that could result from illness and the difficulties the elderly had in obtaining health insurance. The number of elderly was growing at the time, as were medical costs, and older people were more likely to have difficulties obtaining private insurance coverage. Policymakers tied eligibility for Medicare's hospital insurance to an individual's eligibility for Social Security benefits because many retirees lost ties to their employers, who had helped to finance health care when they were active workers.

Policymakers designed Medicare's benefit structure and its payment methods to look like private insurance that was available at the time. An important provision within Medicare's statute precludes the program from "exercising any supervision or control over the practice of medicine." Medicare's sister program, Medicaid, was created at the same time to finance health care costs for low-income individuals, primarily those on public assistance who had few means with which to purchase private health insurance (Moore and Smith 2005).

Eligibility and financing for Part A and Part B

Medicare shifted much of the financial liability for health care spending from the elderly to taxpayers through a

hybrid system with two major parts—A and B—that had different eligibility requirements and different financing mechanisms.[1]

Part A, the Hospital Insurance (HI) program, covers stays in hospitals and skilled nursing facilities, hospice care, and some home health care. Policymakers designed Part A as a compulsory social insurance program tied to employment in work covered by Social Security, with dedicated payroll taxes held in the HI trust fund. The combined employer and employee amounts of HI taxes have increased gradually from an initial rate of 0.7 percent of earned income to 2.9 percent today.[2] Part A essentially finances health care expenses related to hospital and other care of current retirees through payroll taxes on current workers, with the promise of future benefits to those workers.

The Congress also established Part B, Supplementary Medical Insurance (SMI), covering services such as physician visits and outpatient hospital care. Part B is voluntary and became available in 1966 to anyone age 65 or older who enrolled and paid the $3 monthly premium. States could elect to pay the Part B premium for low-income individuals. Initially, Part B premiums were to finance 50 percent of covered benefits, with the remainder paid from general revenues (broad-based federal tax dollars made up of income and other taxes on individuals and corporations). Today, beneficiary premiums finance about 25 percent of SMI program spending, and general revenues finance the remainder, which currently requires about 10 percent of all personal and corporate income tax revenue. Beneficiaries must also pay cost-sharing requirements for a portion of their services, described next.

Benefit design and cost sharing

Part A and Part B were designed so that beneficiaries retained some financial responsibility for health spending through cost-sharing requirements at the point the patient receives medical services. Medicare's benefit package also left certain services uncovered, most notably outpatient prescription drugs. Over time, these factors led most Medicare beneficiaries to obtain supplemental coverage, primarily through individual medigap policies or employer-based retiree coverage. Medicaid provides supplemental coverage for lower income Medicare beneficiaries.

The proportion of spending for Medicare-covered services paid through cost sharing has remained fairly stable over time. Part A cost-sharing requirements generally increased at the same rate as payment updates for Part A services. Cost sharing for many Part B services is proportional to allowed charges (typically 20 percent coinsurance).[3] Lawmakers rarely increased Part B's annual deductible; for example, it remained at $100 from 1991 until 2004. As a result, beneficiary cost sharing for Part A and Part B combined made up a slightly smaller proportion of total spending for Medicare-covered services in 2003 than in earlier years (16 percent compared with 18 percent in 1977 (Table 1-1)). Beginning in 2005, the Part B deductible was raised to $110 and it now increases over time at the same rate as growth in Part B spending per person.

Outpatient prescription drugs were not covered until Part D began in 2006. One reason drugs were not included originally is that, at the time, it was not common for health insurance plans to cover prescription drugs. A further concern was cost. Medications have grown more important in treating many conditions. Meanwhile, prescription drugs have been one of the fastest growing sectors in health care, which puts considerable financial pressure on private employers, states, and beneficiaries. These forces, in turn, led to political pressure for Medicare to offer prescription drug benefits.

In 2002, Medicare's benefit package covered about 45 percent of the cost of all medical and long-term care services for Medicare beneficiaries (Kaiser Family Foundation 2005). This percentage increased for 2006 and future years because of the start of Part D, but estimates of the magnitude are not yet available. Most Medicare beneficiaries have supplemental coverage to fill in some or all of Medicare's gaps in cost sharing and coverage. About 90 percent of Medicare beneficiaries obtained supplemental coverage in 2003 through former employers (33 percent), medigap policies (25 percent), Medicare Advantage plans (13 percent), Medicaid (16 percent), or other programs (2 percent) (MedPAC 2006b). Supplemental coverage often gives enrollees greater predictability of their out-of-pocket spending. In return for paying an annual premium, beneficiaries receive supplemental coverage, such as medigap policies, that reduces their cost sharing to zero or nearly zero from the time they begin using health services each year. Some protection against high out-of-pocket spending is desirable, but such coverage may reduce beneficiaries' sensitivity to costs. Those with supplemental coverage tend to have higher use of services than individuals with similar health status and no supplemental coverage—17 percent to 28 percent higher by one estimate (Christensen and Shinogle 1997).

TABLE 1–1

The shares of total spending paid by Medicare program payments and beneficiaries' cost sharing have remained fairly stable over time

	1977			1983			2003		
	HI	SMI	Total	HI	SMI	Total	HI	SMI	Total
Total spending (in billions)	$15.8	$9.2	$25.0	$39.6	$25.3	$64.8	$141.4	$134.5	$275.7
Medicare program payments (in billions)	14.7	5.8	20.5	36.3	17.1	53.4	129.6	103.3	232.8
Beneficiary cost sharing (in billions)	1.1	3.4	4.5	3.3	8.2	11.4	11.8	31.2	42.9
Medicare program payments as a share of total spending	59%	23%	82%	56%	26%	82%	47%	37%	84%
Beneficiary cost sharing as a share of total spending	4	14	18	5	13	18	4	11	16

Note: HI (Hospital Insurance), SMI (Supplementary Medical Insurance). Total spending is the sum of Medicare program payments and beneficiary cost sharing for fee-for-service care. Payments and cost sharing for managed care plans are excluded. The estimates of beneficiary cost sharing for 2003 are significantly higher than they would have been using previous methodologies for calculating Part B cost sharing. Cost sharing excludes beneficiary premiums, which financed about one-third of SMI program spending in 1977 and less than one-quarter in 1983 and 2003. MedPAC estimates that the combination of beneficiary premiums and cost-sharing liability accounted for roughly 26 percent of total spending in 1977, 25 percent in 1983, and 24 percent in 2003.

Source: Percentages calculated by MedPAC from data in Table 19, Medicare & Medicaid statistical supplement for 2004. http://www.cms.hhs.gov/MedicareMedicaidStatSupp/LT/list.asp#TopOfPage.

Policymakers created the Medicaid program at the same time as Medicare to address the health care needs of low-income individuals. The federal government, along with the states, assumes nearly all the cost of health care for beneficiaries who meet means and asset tests, and the federal share is financed with general revenues (like Part B). Since 2003, policymakers introduced two measures to Medicare that also vary program subsidies based on financial need: variation in Part B's premium based on income and low-income subsidies for Part D.

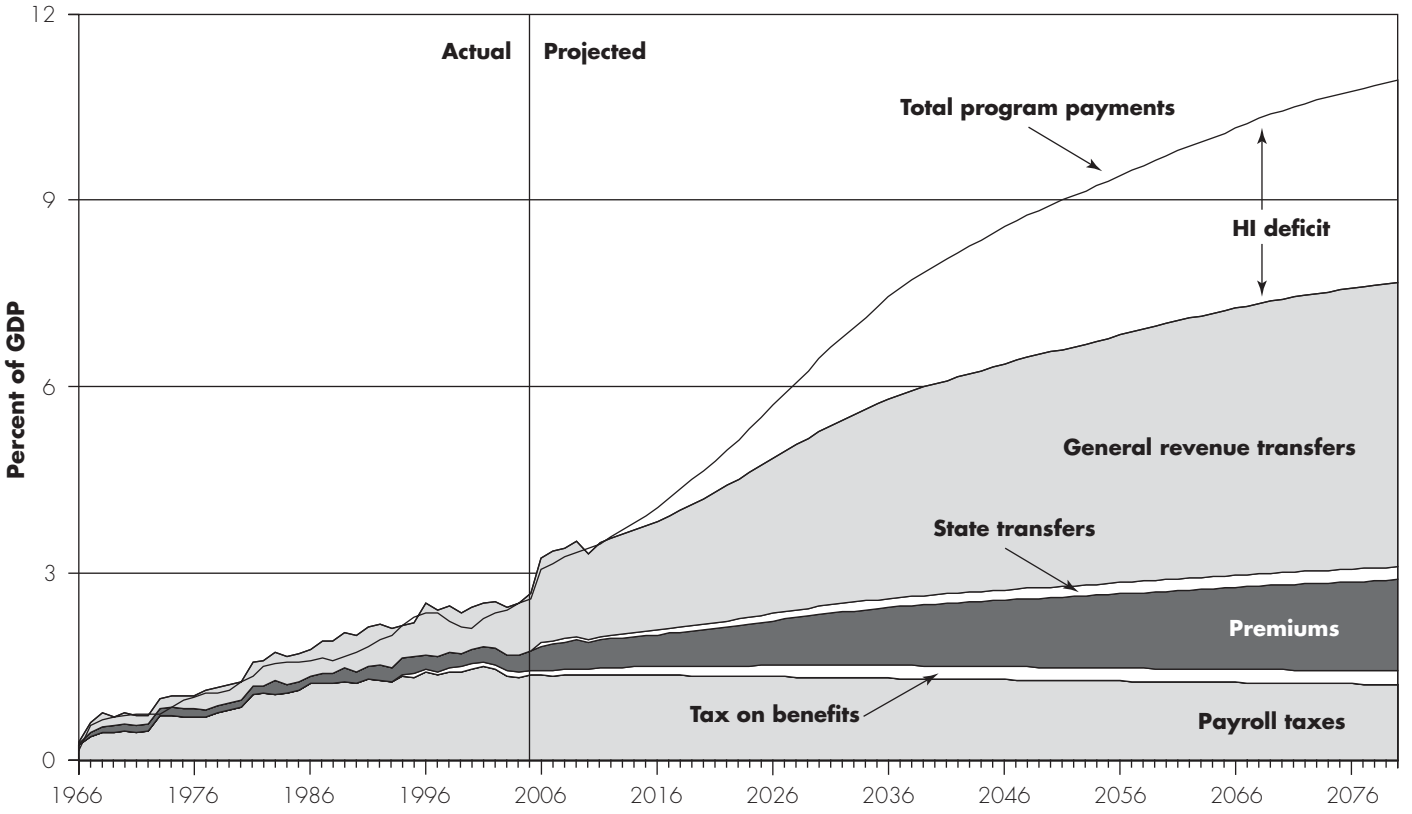
The presence of Medicare and Medicaid creates certain challenges for serving individuals eligible for both programs (called dual eligibles or duals). Federal and state policy goals for the programs sometimes conflict, and current policies toward dual eligibles create incentives to shift costs between payers, often hinder efforts to improve quality and coordinate care, and may reduce access to care (MedPAC 2004b). Medicaid has become the primary public payer for long-term care, with many beneficiaries gaining eligibility and qualifying for benefits through medical indigence (Moore and Smith 2005). The intersection of the two programs' payment policies has created particular problems related to shifting costs among payers for beneficiaries' post-acute and long-term care needs.

Shift from inpatient to outpatient services and post-acute care

Although Medicare relieved much of the financial liability associated with beneficiaries' health care, it quickly became apparent that the program's rising costs could become a significant concern for taxpayers and the economy. In the program's first few years, policymakers became concerned about increases in prices for medical care and any relationship between inflation and the introduction of Medicare (SSA 2006). Among all payers in the U.S. health care system, the main concern 40 years ago was the rise in inpatient hospital expenditures, which then constituted the bulk of spending on health care. This concern led to 1972 amendments to the Social Security Act that gave Medicare authority to conduct demonstrations (smaller scale experiments) of prospective payment methods, introduced the option of Medicare risk-sharing contracts, and constrained growth in reimbursement for physicians' practice costs to a

FIGURE 1–1

Medicare faces serious challenges with long-term financing



Note: GDP (gross domestic product), HI (Hospital Insurance). Tax on benefits refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

measure of such inflation (the Medicare Economic Index). Lawmakers thought these provisions had the potential to control program spending. At the same time, however, the amendments expanded Medicare eligibility to include the disabled and individuals with end-stage renal disease.

Implemented in 1983, the prospective payment system (PPS) for hospital inpatient care slowed growth in Part A spending but also had the foreseeable consequence of moving care to post-acute settings, funded through a mix of Part A and Part B, and outpatient settings, financed under Part B. On balance, growth in Part B spending has outpaced Part A. In 1977, Part A made up 63 percent of total spending (the sum of 59 percent Medicare program payments and 4 percent beneficiary cost-sharing liability), compared with about 51 percent in 2003 (Table 1-1, p. 7). Meanwhile Part B grew from 37 percent of total spending in 1977 to 49 percent in 2003. In turn, the movement toward certain types of post-acute care and outpatient care means that a greater proportion of program spending is financed with broader-based general revenues than dedicated payroll taxes on current workers.

Today's concerns about Medicare

Most of the initial concerns about Medicare's rising costs still hold today. As is true for other purchasers of health care, Medicare's spending is growing much faster than the economy. Projections of continued rapid growth in spending in the health care system combined with the

retirement of the baby boom population foreshadow accelerated growth in Medicare outlays in 2010 and beyond. At the same time, the Medicare program spends widely different amounts for beneficiaries across geographic regions, much of which can be attributed to differences in practice patterns rather than to differences in underlying health status. There are also wide geographic disparities in the quality of care beneficiaries receive, with no relationship or a negative relationship between quality of care and spending.

Projections of Medicare's long-term financing needs

Until recently, decision makers tended to focus on the financial status of the Medicare trust funds as the most important indicator of the program's sustainability. HI expenditures began to exceed HI tax income in 2004, with existing trust fund balances plus interest income keeping Part A in a solvent position. In their most recent report, the Medicare trustees project that, under intermediate assumptions, the HI trust fund will be exhausted in 2018. Under current law, Medicare does not have authority to pay for Part A services once the HI trust fund is exhausted. The SMI trust fund is financed automatically with general revenues and beneficiary premiums, but the trustees point out that SMI financing would have to increase sharply to match expected growth in spending.[4] Such rapid growth would have repercussions on beneficiaries as well as on the availability of funds for other federal priorities.

The status of Medicare trust funds does not give a complete picture. If Medicare benefits and payment systems remain as they are today, the trustees note that over time the program will require major new sources of financing for Part A and will automatically require increasing shares of general tax revenues for Part B and Part D (see text box, pp. 10–11). The trustees project that dedicated payroll taxes will make up a smaller share of Medicare's total revenue and that a large deficit between spending for Part A and revenue from dedicated payroll taxes will develop (Figure 1-1).

To finance the projected deficit through 2080, the trustees estimate that Medicare's payroll tax would need to increase immediately from 2.9 percent to 6.41 percent of earned income, or HI spending would need to be decreased immediately by 51 percent. Delays in addressing the HI deficit would eventually require even larger increases in the tax rate or even more dramatic cuts to spending. The premiums and general revenues required to finance projected spending for SMI services could impose a significant financial liability on Medicare beneficiaries and on resources for other priorities. If income taxes remain at their historical average share of the economy, the Medicare trustees estimate that the SMI program's share of personal and corporate income tax revenue would rise from 10 percent today to 24 percent by 2030 and to 40 percent by 2080. For beneficiaries, even though Part D now covers a portion of their spending on prescription drugs, growth over time in Medicare premiums and cost sharing for SMI services will require more of their incomes, which could lead to financial hardship for some; in 2002, roughly half of all noninstitutionalized Medicare beneficiaries had family incomes of $20,000 or less (Kaiser Family Foundation 2005).

The 45 percent trigger

Medicare's problems with long-term financing will become more visible to policymakers over the next few years because of a warning system established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) known as the 45 percent trigger. Lawmakers included this provision to spark debate on balancing national priorities between Medicare and other uses for general revenue financing. The implication of the funding warning is that the Medicare program should not impose too heavy an obligation on the general taxpayer.[5]

Each year, the Medicare trustees are required to project the share of Medicare outlays that is financed with general revenues in the current and six succeeding fiscal years. Under the warning system, if two consecutive annual reports project that general revenue will fund 45 percent or more of Medicare outlays in any year of the seven-year projection window, then the President must propose and the Congress must consider legislation to bring Medicare's spending below this threshold. However, the provision does not require the Congress to pass legislation. In their 2006 report, the Medicare trustees projected that the program would hit this 45 percent trigger in 2012, the last year of the seven-year window (Boards of Trustees 2006). Moreover, the trustees expect a similar finding for their 2007 report, so policymakers will likely need to consider changes to Medicare's benefits, payments, and financing by the spring of 2008.

Increasing financial liability for beneficiaries

Rapid growth in Medicare spending has implications for beneficiaries as well as taxpayers, since both groups finance the program. Although the premiums Medicare

Projecting growth in Medicare spending

In making long-term projections of Medicare's costs, a critical assumption is the growth rate in program spending per person, after adjusting for the age and gender mix of the population.[6] Before their 2001 report, the Medicare trustees assumed that long-range spending would grow at the same rate as gross domestic product (GDP) per person. Growth rates vary depending on the time period over which one calculates them. Nevertheless, on average, real rates of increase in our nation's health expenditures have risen faster than real growth in the economy over the past six decades—even during the 1990s when managed care techniques and expanded use of prospective payment methods slowed spending increases (2004 Technical Review Panel on the Medicare Trustees Report). In recognition of this, the Medicare trustees began assuming that long-range Medicare program spending per person would grow at a rate of GDP plus 1 percentage point, excluding effects resulting from the population's age and gender mix (which they model separately).[7]

A higher assumption would be more in keeping with experience. Between 1970 and 2003, for example, the inflation-adjusted growth rate in our nation's health spending per person was more than 2 percentage points higher than real GDP growth per person (CBO 2005a). Even an assumption that health care spending will grow 2 percentage points above GDP growth could be too low. One study combined projections of the health status of future Medicare cohorts with a look at 10 medical technologies that are likely to be adopted widely (Goldman et al. 2005).[8] Under one set of assumptions about the future prevalence of disease and disability, the study projects that, for example, widespread use of a compound that extends life span could lead to health care spending in 2030 that is as much as 70 percent higher than in a scenario without such technology.

For their 2006 report, the trustees refined their assumptions. Overall, the new approach is consistent with calculations of 75-year Hospital Insurance actuarial balances under an assumption of growth rates at GDP plus 1 percentage point. However, the trustees adopted a forecasting model that makes a more gradual transition from current rates of growth to an assumption that Medicare growth rates ultimately will equal GDP growth. For example, the model assumes that per capita growth rates in Medicare spending for 2030 will be 1.4 percentage points above GDP growth, declining gradually to GDP plus 0.75 percent in 2050 and to less than GDP plus 0.2 percent in 2080 (Boards of Trustees

(continued next page)

beneficiaries pay (primarily for Part B and Part D) are projected to make up a steady 12 percent to 13 percent of total program revenue, the dollar amounts of those premiums will require growing shares of beneficiaries' incomes. Part B premiums for 2007 are $93.50 per month (or $1,122 for the year), a $5 per month increase (5.6 percent) over the 2006 amount (CMS 2006). This is a much smaller increase than expected—the lowest since 2000. However, the 2007 premium increase was held down by an assumption that, under the sustainable growth rate system, Medicare's fees paid to physicians would decline by about 5 percent. Policymakers prevented cuts in physician fees for 2007 after CMS set the level of Part B premiums. CMS estimates that, with physician payment rates for 2007 held at their 2006 level, the 2007 monthly premium would have been $1.50 higher, or $95 (for a total increase of 7.3 percent over 2006). Beginning in 2007, Part B premiums will be higher for individuals with higher incomes because the federal government's premium subsidies will be related to income.[9] CMS estimates that about 4 percent of Part B enrollees will pay higher premiums based on income (CMS 2006).

Between 2000 and 2007, Medicare beneficiaries faced average annual increases in the Part B premium of nearly 11 percent—as high as 17 percent in 2005. Meanwhile, monthly Social Security benefits, which averaged around $900 per month in 2005, grew by about 3 percent annually over the same period.[10] Under current hold-harmless policies, Medicare Part B premiums cannot increase by a larger dollar amount than the cost-of-living increase in a beneficiary's Social Security benefit. The dollar amount of recent increases in Part B premiums has absorbed 30

Projecting growth in Medicare spending (continued)

2006). While providing somewhat more realistic nearer-term projections, the new approach still assumes that unknown policy changes or other unspecified forces will slow the rate of growth in future health spending.

The Medicare trustees are tasked with projecting the program's future costs based on how benefits are currently structured; that is, they do not forecast specific policy changes to Medicare benefits or payment rates. Nevertheless, one argument for assuming that Medicare's costs will grow somewhat more slowly than before is that past rates of growth are unsustainable. Projections based on higher assumptions about growth imply that future spending on health care will make up an unprecedented share of our nation's economy. One could argue that our nation will not be willing to devote, for example, nearly 40 percent of our national income to health care in 2075, because that would probably crowd out spending for other national priorities.[11]

How much Medicare spending is sustainable? Individual definitions of sustainability are subjective, but our society's answer depends on how much value our political and budget-setting processes place on the Medicare program relative to other spending priorities. One definition of affordability is an amount of health spending at which the United States would never reduce current levels of nonhealth spending and would devote 100 percent of future growth in income to greater consumption of health care. Chernew and colleagues believe that, under this definition, devoting 1 percentage point above GDP growth of our national income to health care is affordable because nonhealth spending would remain at current levels. 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).

A further question related to Medicare's financing is whether the federal government could feasibly raise the resources needed to fund the program's growth. One researcher 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). In the future, Medicare beneficiaries may make up a growing share of voters, which could lead to changes from the historical pattern. On the other hand, beneficiaries will depend even more on nonelderly workers for the program's funding and younger generations may not want to foot this bill. ■

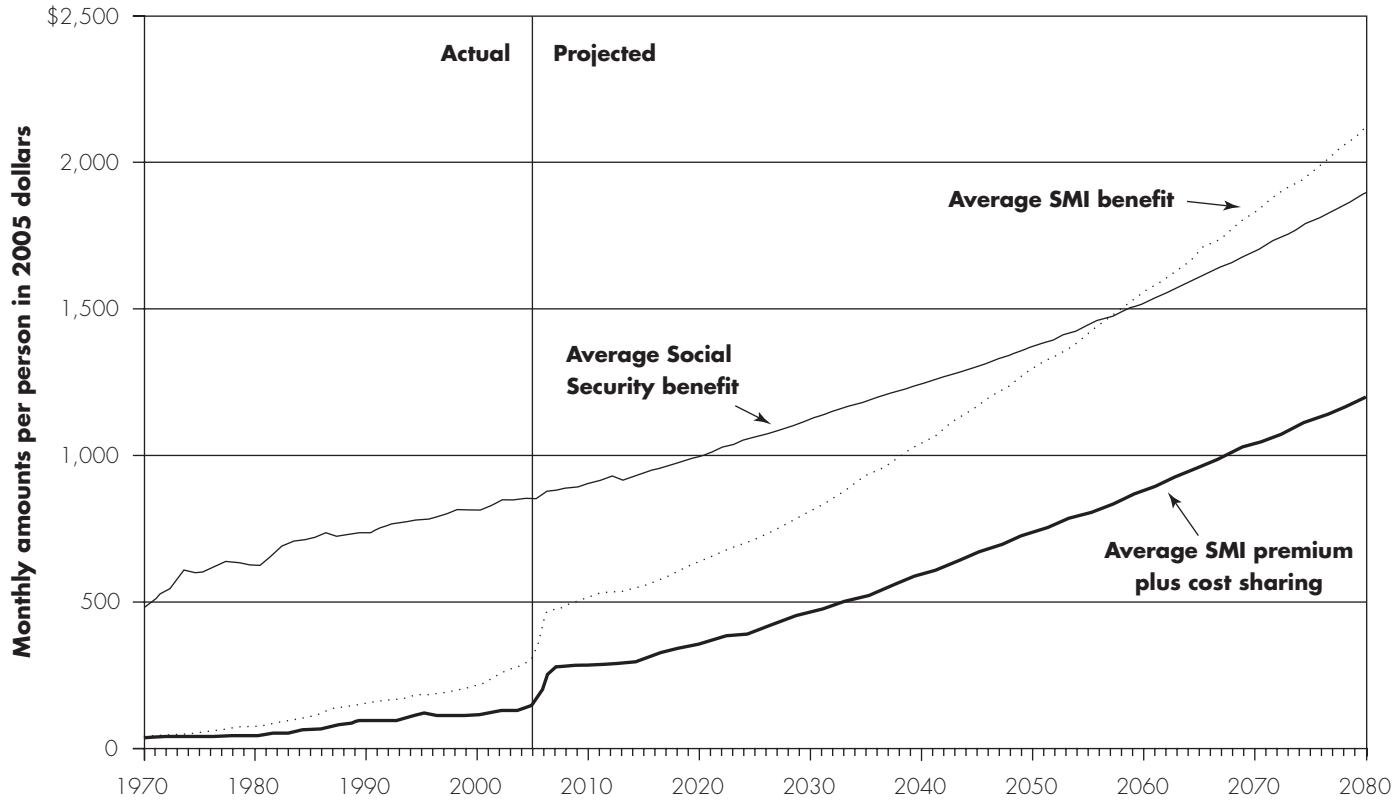
percent to 40 percent of the dollar increase in the average Social Security benefit. Part D premium increases are not subject to a hold-harmless provision.

The overall economic position of the elderly has improved over the past several decades. Still, most Medicare beneficiaries have limited incomes. In 2002, about half of noninstitutionalized beneficiaries had incomes of around $20,000 or less (Kaiser Family Foundation 2005). Seventeen percent had incomes less than the poverty level (defined then as $8,628 for people living alone and $10,885 for married couples), and 46 percent had incomes at 200 percent of the poverty level or below (MedPAC 2006b). In 2003, for 60 percent of the elderly, Social Security benefits made up 75 percent or more of their total income (Kaiser Family Foundation 2005).

Some beneficiaries who enrolled in Medicare's Part D benefit have better insurance coverage than before and many will see lower out-of-pocket spending. One estimate suggests that, in 2006, average out-of-pocket spending on drugs was 28 percent lower for Part D enrollees than it would have been without the new drug benefit, and it was 83 percent lower for recipients of Part D's low-income subsidies (Mays et al. 2004b). As a specific example, a beneficiary with no prescription drug coverage before enrolling in Part D and $3,000 in annual out-of-pocket drug spending paid an average of $1,500 in 2006 for cost sharing plus an additional $288 in premiums if she enrolled in a standard Part D plan.[12] The Medicare program paid for the remaining $1,212 of her drug spending. Her savings would have been even greater if she had qualified for and enrolled in Part D's low-income

FIGURE 1–2

Average monthly SMI benefits, premiums, and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Spending on prescription drugs prior to January 1, 2006 (the start of Part D), is not shown in this figure. SMI benefits and premiums include those for Part B and Part D.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

subsidy program, since the program would have covered much of her standard plan's premiums and cost sharing. However, other enrollees could pay higher out-of-pocket spending under Part D—one in four was projected to face increases in 2006 of up to $250 (Mays et al. 2004b). Beneficiaries tend to use more prescription drugs as they age; thus, some enrollees with initially higher out-of-pocket spending could benefit more over time from the insurance that Part D provides.

Yet even with the expansion of Medicare's benefits to include prescription drugs, over time growth in Medicare premiums and cost sharing will continue to absorb an increasing share of Social Security income. With the introduction of Part D, the average cost of SMI premiums and cost sharing for Part B and Part D absorbs more than 30 percent of Social Security benefits.[13] However, 30 percent is likely to be a smaller share of Social Security benefits than what those individuals spent on premiums and cost sharing for Part B and prescription drugs before 2006. On balance, even though most beneficiaries get relief from out-of-pocket spending because of Part D, over time, growth in health care spending will outpace growth in Social Security benefits (Figure 1-2). At the same time, Medicare's lack of a catastrophic cap on cost sharing under Part A and Part B means that some beneficiaries could face extremely high out-of-pocket expenses.

Projections such as these highlight the importance of finding ways to slow growth in Medicare spending. If policymakers do not take steps quickly, Medicare's need for financing will place an increasing liability on beneficiaries through their premiums and cost sharing, crowd out resources for other federal priorities, and potentially affect the federal budget deficit, the level of federal debt, and economic growth.

The broader U.S. health care system

Medicare is a very large program with total expenditures of $336 billion in 2005. Even so, it is just one part of an expansive and growing U.S. health care system. That system includes a broad array of private and public purchasers, insurers, providers, manufacturers, and suppliers. Combined expenditures on health care services in the United States totaled nearly $1.9 trillion in 2004, or 16 percent of our economy (Smith et al. 2006).

Private versus public financing in the U.S. health care system

Currently, public financing—federal, state, and local programs—makes up about 45 percent of all U.S. health care spending, with private sources providing the rest. The public share will rise by a few percentage points to nearly 50 percent by 2015 with Medicare's prescription drug benefit (Borger et al. 2006). In 2004, employers were the largest source of health insurance, covering about 60 percent of individuals residing in the United States (Fronstin and Collins 2005).

The United States uses private health insurance extensively because of our country's tax policies and economic history. During the World War II era, larger U.S. companies began offering health insurance to provide higher compensation to relatively scarce labor while avoiding wage and price controls. The federal government did not consider such fringe benefits subject to wage controls, and health insurance contributions paid by employers were not considered taxable income (Helms 2005). At the time, the health insurance industry was in its infancy. Since then, the use of employer-sponsored health insurance and the broader market for private insurance have grown substantially. For 2004, the exemption of employer-paid health insurance from payroll and individual income taxes reduced federal revenues by about $145 billion (CBO 2005b).

Some analysts believe that, if one considered the value of tax subsidies for employer-paid health insurance, the public share of health care spending would be closer to 60 percent (Woolhandler and Himmelstein 2002). A counterargument is that a wide variety of tax policies affect decisions about what mix of goods and services our country produces and consumes, yet generally we do not include the value of those tax subsidies in any of our national accounts.[14] In any event, the exemption of employer-paid health insurance from payroll and individual income taxes is one reason that our nation uses private health insurance so extensively.

Higher spending in the United States

Health care spending in the United States is far higher than in other countries—about $6,100 per person in 2004, or more than twice the median of member countries of the Organisation for Economic Co-operation and Development (OECD) (OECD 2006).[15] Nevertheless, rates of growth have been similar among industrialized countries—in other words, most are facing upward pressure on spending (Newhouse 2004).

Because the organizational structure of financing health care is more fragmented in the United States, providers may use their market power to negotiate more favorable payments than providers in other countries (Bodenheimer 2005b). By being more monopsonistic or exerting regulatory power to a greater degree, other governments may lower or restrain growth in payment rates for providers and prices for other services. The tactics of those governments include using a single purchaser approach, allowing multiple purchasers to bargain collectively, and using global budgets (Reinhardt et al. 2004).

The health care systems of other countries are not clearly preferable to ours. The drawbacks of other systems include longer waiting times for access to specialists and newer technologies—a cost not usually reflected in international comparisons—as well as inefficiency and issues concerning quality of care (Danzon 1992). For example, in recent years the United Kingdom and other countries that provide health care directly have introduced reforms that try to inject more competition by separating the roles of payer and provider (Docteur and Oxley 2003). Global budgets are only as successful as each country's ability to stick with its budget, even when providers and patients pressure it to spend more. Another issue is the system of price controls some countries use to limit profits: Manufacturers and other stakeholders claim that such policies stifle investment in research and development, thereby slowing the pace of medical innovation.

Some analysts believe that the high levels of spending in U.S. health care are largely attributable to paying higher prices for the same services than other countries do, including higher administrative costs. Data from the mid-1990s suggest that U.S. physicians had considerably higher incomes than physicians in other OECD countries (Reinhardt et al. 2002).[16] However, the United States has a wider distribution of compensation for all workers. For

skilled health professionals, labor costs are higher because they would otherwise enter other fields that offer high compensation. The organizational structure of providers and the regulation of health services in other countries also affect the level of salaries. Countries with public systems that provide care directly often contract with general practitioners (GPs) at salaries negotiated centrally with physicians' associations. Other countries make risk-adjusted, capitated payments to GPs for each patient they add to their list, thereby putting insurance risk on those physicians for the volume of care they provide. A few countries mix salary with capitated payments (Docteur and Oxley 2003).

Is higher spending worth it?

Advances in medical technology have led, on average, to improvements in our health and gains in life expectancy. Recently, Cutler and colleagues concluded that, on average across all ages, increases in medical spending between 1960 and 2000 (attributed largely to advances in medical care) provided reasonably good value, with an average cost per life-year gained of $19,900 (Cutler et al. 2006).

However, when focused on spending and life expectancy for individuals who are 65 and older, the same research found that the incremental cost of an additional year of life rose from $46,800 in the 1970s to $145,000 in the 1990s. These estimates suggest that the value of health care spending for the elderly has been decreasing over time, and the authors suggest that their estimates for the 1990s would fail many cost-benefit criteria.

Research on the wide geographic variation in health care spending suggests that we waste resources (Fisher et al. 2003). Some payment systems contribute to the problem of wasteful spending by rewarding inefficient or low-quality care as much as if not more than high-quality care delivered by efficient providers. Given questions about Medicare's sustainability, the Commission has called for distinguishing between high-quality care and care of more questionable value (MedPAC 2004a). Separate "siloed" reimbursements within payment systems also hinder providers from coordinating care for the same patient, which can lead to duplicative services.

Rapid growth in health care spending among all payers

For each of the past several decades, the United States has spent an expanding share of its resources on health care. In 1960, for example, national health expenditures made up about 5 percent of the gross domestic product (GDP). That share grew to 16 percent by 2004, and CMS projects that it will make up 20 percent by 2015 (Figure 1-3) (Borger et al. 2006). All payers in the U.S. health care system—public (including Medicare and Medicaid) and private—are facing similar upward pressures on spending.

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 grew at a rate about 1 percentage point lower than that for private insurance over the period from 1970 to 2002. However, the comparison is sensitive to the endpoints of time one uses for calculating average growth rates. Differences have been more pronounced since 1985, when Medicare began introducing the PPS for hospital inpatient services (Levit et al. 2004). Some analysts believe that, since the mid-1980s, Medicare, with its larger purchasing power, has had greater success than private payers at containing cost growth (Boccutti 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).

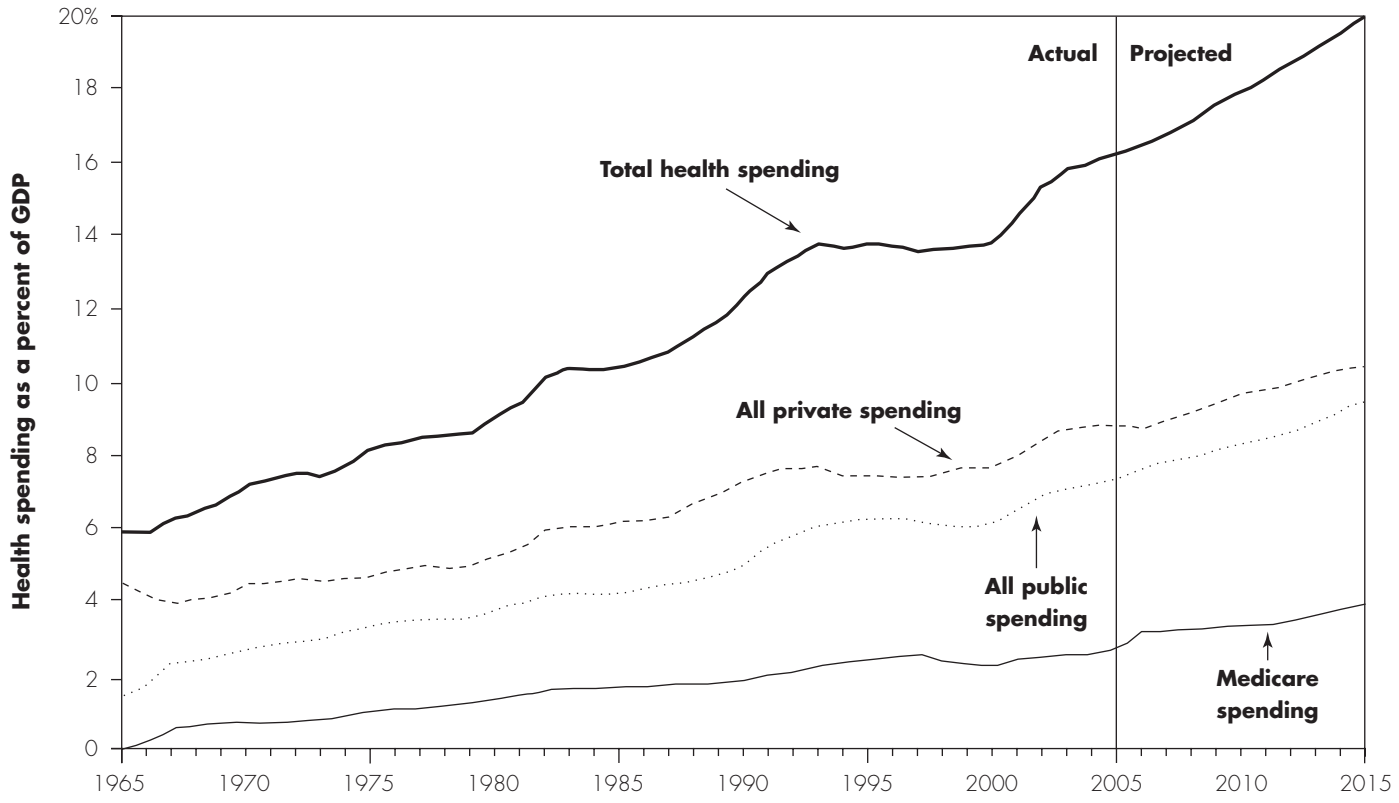
Although often disputed by economists, many analysts contend that certain health care sectors are able to shift costs by charging some payers higher prices to compensate for changes in the administered prices of other payers. Many hospital and other health industry executives are convinced that limits on Medicare and Medicaid payment rates lead to higher prices for private payers (Ginsburg 2003). Cost shifting could occur only in situations when providers have sufficient market power to raise their prices. If such a phenomenon occurs, it underscores the need for public and private payers to collaborate with one another on payment policy, since both sets of payers face similar upward pressures on spending over the long term.

Drivers of growth in health spending

One main driver of growth in spending is growth in income. Some analysts believe that, as our country's standard of living grows, we should expect to spend more on health care (Hall and Jones 2006). As individuals become better off and their consumption increases, the

FIGURE 1–3

Health care spending has grown more rapidly than GDP, with public financing making up nearly half of all funding



Note: GDP (gross domestic product). Total health spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2006.

incremental value of buying more commodities (e.g., another television or more clothing) falls. By contrast, the marginal value to them of an extended life span does not diminish as quickly. Similarly, the marginal value of procedures that are not life saving but that may improve the quality of life (e.g., joint replacements or cosmetic surgery) may increase relative to other goods. Hall and Jones suggest that, because of our underlying preferences, it is reasonable to expect health care spending to reach 30 percent of GDP by the middle of this century.

Many analysts point to the rates of development and diffusion of new technologies as another major driver of growth in health care spending (Fuchs 2005, Newhouse 1992). Many technologies reduce the invasiveness, serious side effects, discomfort, or recovery time associated with the therapies they replace, thereby lowering nonmonetary obstacles to beneficiaries as they decide whether to seek treatment. When procedures, drugs, or devices become available, a base of evidence may not exist to help providers decide how newer therapies compare with older ones. When providers recommend newer therapies that are covered by Medicare or other insurance, patients do not face the full cost of their care and may not be concerned about the comparative value of those therapies (see text box, p. 16). Although some medical technologies lead to savings by reducing lengths of hospital stays or avoiding hospitalizations, most technologies tend to expand demand for health care and increase spending. In some cases, providers may use new technologies inappropriately or more broadly than intended.

Recent research highlights the important role of health insurance in fueling growth in spending. Finkelstein finds

Challenges of appropriate pricing for health care

Most sectors of the U.S. economy rely on market forces to ensure the efficient allocation of resources. Consumers buy a good or service if, at its price, the item has greater value to them than other items they could purchase. We rely on competition among producers and service providers to keep prices in check while they make the goods and services that society wants. Within most sectors of the economy, this interaction of demand and supply leads to prices that act as signals of how much society values a good or service relative to other uses and thus determines how resources are allocated.

Economists have long argued that the provision of health care differs from providing goods or services in other sectors (Arrow 1963). Problems with information and uncertainty, the use of insurance, and institutional details lead to prices for health services that are not necessarily good signals of value (Chernew 2005). Some of the unique challenges with health care are:

- Patients often do not know what specific health services they need or the relative benefits and costs of treatment options. They rely on physicians and other providers, in a principal–agent relationship, who help make decisions on their behalf. While professional codes of conduct should guide providers toward furnishing appropriate care, providers do not necessarily have the same motivations and preferences as their patients.

- Unlike sectors of the economy that produce standard products, health care providers must individually evaluate the symptoms and conditions of patients to tailor plans of care, and they must do so in the face of uncertainty about the best course of action. As a result, it can be difficult to evaluate the quality (including appropriateness) and efficiency of a specific provider's care and build consensus among providers around standards of care.

- Most health care services are financed through insurance. In the event of a health crisis, insurance spares patients from a catastrophic financial liability. For lower income individuals, insurance may reduce barriers and lead to more timely care. However, insurance also shields patients from seeing the full cost of their care. This can lead individuals on the margin to use more and higher priced services than they would otherwise—particularly since they rely on providers to help decide what care they need.

- Lack of competition among certain types of suppliers can lead to relatively high prices for their products or services and little pressure to improve efficiency over time. Additionally, providers are increasingly organizing and marketing services for specific diseases, organ systems, and patient populations, and they are competing on the basis of these specialty services rather than on the basis of price (Berenson et al. 2006). This type of nonprice competition can raise health care costs.

These general characteristics of health care can affect how well prices act as signals of value in all types of delivery systems and payment arrangements. All types of payers confront these challenges—including public programs such as traditional Medicare that use administratively set prices as well as private payers that negotiate rates with providers and health plans.

Mispricing of services can lead to misallocation of investment resources, which can have large effects on the organizational structure and cost of health care delivery over time. For example, the process for reassessing relative value units for physician services in Medicare's fee schedule does not do a good job of identifying services that may be overvalued. As a result, payments for some services may be too high. Such inaccurate payment rates may encourage inappropriate growth in volume and, over time, may affect the supply of generalists and specialists by influencing physician decisions about whether to specialize (MedPAC 2006a). ■

that Medicare had a much more pronounced effect on hospital spending than estimates of insurance effects on an individual's behavior would suggest (Finkelstein 2007). She thinks the broad increase in demand for hospital services that occurred after the start of Medicare led to greater incentives for hospitals to enter markets, purchase new equipment and facilities, and adopt new practice styles. Extrapolating from her Medicare findings, she suggests that about half of the increase in per capita health spending between 1950 and 1990 could be attributable to the spread of health insurance. Other analysts have noted that small changes in assumptions behind Finkelstein's extrapolation to all health care spending would lead to much smaller effects (Ellis 2006).

Our nation's underlying health status and changes in clinical treatment thresholds also affect spending. Recent work by Thorpe and Howard suggests that, between 1987 and 2002, nearly all the growth in health care spending for Medicare beneficiaries can be attributed to patients being treated for five or more conditions (Thorpe and Howard 2006). In 2002, about 50 percent of all Medicare beneficiaries were under medical management for five or more conditions, compared with about 31 percent of beneficiaries in 1987. At the same time, a larger proportion of patients being treated for five or more conditions reported that they were in excellent or good health—60 percent in 2002, compared with 33 percent in 1987. The authors conclude that medical professionals are treating healthier patients, treatments are improving health outcomes, or both are occurring.

Thorpe and Howard also suggest that the rising prevalence of obesity plays a part, since many obese individuals have multiple comorbidities. Obesity in the elderly is associated with increased risk of diabetes mellitus, cardiovascular disease, hypertension, stroke, lipid abnormalities, osteoarthritis, and some cancers. The prevalence of obesity doubled among Medicare beneficiaries between 1987 and 2002 (reaching 23 percent), and the share of spending associated with obese individuals nearly tripled (reaching about 25 percent). A separate study estimates that Medicare will spend about 34 percent more on an obese 70-year-old than on a 70-year-old of normal weight over their remaining life spans (Lakdawalla et al. 2005). Widespread obesity could have important implications for Medicare, and policymakers may want to consider creating public health campaigns aimed at lowering its prevalence.[17]

Consequences of rapid growth in health spending

Rapid growth in health spending has wide-ranging effects. The U.S. health care sector has produced many medical innovations that lengthen or improve quality of life. At the same time, some employers argue that the rising cost of health care premiums affects their ability to compete in the world marketplace. However, most economists contend that growth in health premiums paid by employers has no long-term effect on the competitive position of firms (Fuchs 2005). Instead, a firm's costs for health premiums substitute for cash compensation that it would otherwise pay to workers, in the same way that retirement and other benefits substitute for higher wages. Longer term contracts with workers may prevent some firms from keeping their full compensation package in line with their productivity. As would be the case with any other cost, rapid growth in health premiums can make firms' need for greater productivity more apparent. To achieve productivity gains quickly, firms sometimes take disruptive steps and redistribute income and health coverage for workers and retirees.

Other distributional issues arise from rapid growth in spending on health care. In response to rapid increases in premiums, many employers have raised cost-sharing requirements for their employees, asked them to pay a larger share of premiums, or, particularly for smaller firms, reduced the availability of coverage. The percent of individuals with employer-based health insurance fell from 67 percent in 2000 to 62 percent in 2005, which analysts attribute to the rising cost of providing health benefits (Fronstin 2006). Since required premium contributions by enrollees have risen faster than income, some workers choose to forgo coverage (Ginsburg 2004). During 2005, nearly 47 million people, or 15.9 percent of the U.S. population, were uninsured at some point in time.

Increases in the numbers of people without private health insurance raise demand for public coverage and, to finance providers' uncompensated care, 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 limits on the competition they face. Rising costs put upward pressure on the financing needs of public and private health care programs for those beneficiaries who already have coverage. And some analysts believe

that higher health care costs may also lead to greater fragmentation of risk pools in the health care market, as healthier people search for insurance alternatives that are less costly (Glied 2003).

New insurance products have emerged in response to rapid growth in spending on health care. Employers are beginning to offer consumer-directed health plans that combine a high-deductible policy (often including a health reimbursement or savings account) with catastrophic protection.[18] Although larger numbers of employers are beginning to offer these products to their workers, thus far enrollment is low.[19] Enrollees in these newer products generally accept higher cost sharing at the point of service, making them more cost conscious when they seek care. In return, they pay lower premiums (Tollen et al. 2004). The law allows employers to make nontaxable contributions to certain health savings accounts (HSAs), and contributions by individual account holders are tax deductible. Current Medicare beneficiaries cannot establish HSAs, but as individuals enroll in Medicare, they may use tax-free distributions from existing HSAs to pay for Medicare premiums or the retiree share of premiums for employment-based retiree health insurance. As of 2007, Medicare beneficiaries may use a similar type of product if they choose: medical savings accounts, a type of high-deductible plan that is combined with a savings account offered by several private organizations within Medicare Advantage. (Chapter 4 provides more detail on these offerings.)

Changing Medicare policy within the broader U.S. health care system

Medicare faces powerful upward pressures on spending that will be difficult to staunch. The interaction between broad use of newer medical technologies and health insurance is thought to account for much of the long-term spending growth in the United States, and some of those forces will likely push future spending higher. Additionally, Medicare's outpatient prescription drug benefit places a substantial new financial responsibility on the program. As we near the end of this decade, Medicare will have to grapple with the additional challenge of higher enrollment levels associated with retiring baby boomers, which will affect program spending levels as well as the demand for federal resources for other programs that benefit the elderly such as Social Security and Medicaid.

To finance Medicare for the future as the program is now structured, policymakers would need to redirect an unprecedented share of our nation's resources to the program. Projections suggest that federal program spending for Medicare could grow from less than 3 percent of GDP today to nearly 8 percent by 2037 and about 11 percent by 2077 (Boards of Trustees 2006). Beneficiaries' premiums and cost sharing will also require growing shares of their income. The financial pressures on both beneficiaries and the federal budget are likely to spark more policy debate about Medicare's future. Under the MMA's warning system, this debate could begin officially in the spring of 2008.

Several strategies are available to Medicare policymakers, but none is easy. These include:

- restructuring benefits and supplemental coverage,
- increasing the program's financing by raising taxes, and
- using payment policy to obtain better value.

Policymakers will need to use a combination of approaches to address Medicare's long-term financing because no single strategy will be sufficient to address the problem. The ultimate goal of using payment policy to obtain better value is to do more with the Medicare program's given level of resources without adversely affecting access to or quality of care. Payment systems are tools that can be used to create incentives for desirable behavior. Much of MedPAC's work focuses on such options, but those steps alone may not be sufficient to address problems with Medicare's long-term financing.

The magnitude of savings from any of these approaches is difficult to characterize because it depends on the details of individual policy proposals. In particular, the outcome of policies that try to improve the efficiency of health care delivery can be highly uncertain. Where available, we provide specific estimates of savings.

Restructuring benefits and supplemental coverage

This general approach could involve measures such as raising Medicare's age of eligibility, expanding the portion of program spending financed with beneficiary premiums, increasing cost-sharing requirements and placing limits on supplemental coverage, or limiting Medicare's coverage for specific benefits.

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 full Social Security benefits.[20] As average life expectancy increases in the United States, encouraging longer participation in the labor force by raising the age at which people qualify for Medicare coverage is reasonable. If individuals work longer and delay retirement, they may also retain access to private health insurance at group rates—if their employers offer it.

By itself, the eligibility approach is unlikely to reduce Medicare's program spending by much. Fewer than 10 percent of today's Medicare beneficiaries are age 65 or 66, and those individuals have lower average Medicare spending because of their relative youth. One researcher estimates that if the eligibility age were raised to 67, the level of Medicare spending would fall by 4 percent to 5 percent, but Medicaid spending would increase somewhat (Johnson 2005). Others estimate that phasing in an increase in the eligibility age to 70 would equate to a 0.8 percent reduction in program spending relative to GDP (CBO 2005b). However, some of that reduced spending would be offset by higher spending under Medicaid and other programs.

A drawback of raising the eligibility age is that it 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 may find alternative sources of health coverage, one estimate suggests that 9 percent of 65- and 66-year-olds would not, and another 11 percent would be underinsured (Davidoff and Johnson 2003).[21] If policymakers chose this approach, they could allow those individuals just under Medicare's eligibility age to buy into the program by paying the full premium for coverage at actuarially fair rates.[22] Allowing people to buy into Medicare 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. For this reason, some proposals for this buy-in approach would also subsidize premiums for low-income individuals (Johnson 2005). That further step would reduce the number of near elderly who are uninsured but would also reduce federal program savings from raising the eligibility age.

Changing premiums, cost sharing, and supplemental coverage

Policymakers could change Medicare's premiums or cost-sharing requirements, approaches used widely in the private sector. Raising cost-sharing requirements could rein in spending for health care services that are more prone to overuse. Increasing the share of Medicare's costs borne by beneficiaries through premiums would also reduce the federal government's share of Medicare spending. However, since many Medicare beneficiaries have limited incomes, indiscriminate increases could impose financial barriers to essential care or cause hardship. Relatively few individuals account for the bulk of Medicare spending, and they may be relatively insensitive to levels of cost sharing in the face of serious health conditions. Policy changes should try to balance these two sets of concerns.

One specific option would lower the federal government's funding of Part B premiums from the current 75 percent to 70 percent of average SMI expenditures for elderly beneficiaries. The Congressional Budget Office (CBO) estimates that increasing Part B premiums in this manner would reduce Medicare program spending by about $85 billion over the 2006 to 2015 period (CBO 2005b). 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 policy would lower Medicare program spending by less than 0.5 percent over the 2004 to 2013 period. Some analysts contend that lowering federal premium subsidies could reduce the number of individuals who choose to enroll in Medicare. However, even at a level of 70 percent for most beneficiaries, federal subsidies would remain quite high. Moreover, others argue that enrollment would remain high because Medicare has advantages that private insurance may not—for example, a community-rated premium with unlimited access to most providers.

As structured today, Medicare's traditional benefit design does not protect against catastrophic levels of out-of-pocket spending. Medicare's cost-sharing requirements are also complex and vary depending on the type of service provided and the site of care. Supplemental coverage that shields beneficiaries from fee-for-service (FFS) cost-sharing requirements leads to greater use of services and would temper any savings from policies that raised Medicare's cost sharing.

Policymakers might want to combine increases in Medicare's cost-sharing requirements with catastrophic protection and limits on first-dollar coverage (CBO 2005b). A catastrophic cap on out-of-pocket spending could limit the financial liability on beneficiaries who need the most care. Restricting the ability of supplemental insurance to provide first-dollar coverage could lead to sizable savings for the Medicare program—large enough to finance some catastrophic protection (MedPAC 2002). As one specific example, CBO estimates that combining limits on first-dollar medigap coverage with a restructuring of Medicare's benefit for all services for Part A and Part B could save more than $130 billion between 2006 and 2015 (CBO 2005b). The proposed Medicare benefit for 2006 included a combined deductible of $500, 20 percent coinsurance for all services for Part A and Part B, and a catastrophic cap of $4,500. (Proposed amounts would grow over time at the same rate as Medicare costs per capita.)

Although approaches that increase cost sharing could lower Medicare spending, they could also raise 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 dual eligibles 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 dual eligibles.

The literature is mixed on the effects of cost sharing on health outcomes. The RAND Health Insurance Experiment, which did not include elderly individuals, found no substantial differences in the health status of people who received free care versus those who faced higher cost sharing (Newhouse 1993).[23] This body of work suggests that, although both positive and negative effects are likely to exist on average, higher cost sharing might not adversely affect health outcomes. However, RAND research also suggests that higher cost sharing discouraged the use of some necessary as well as unnecessary care. More recent literature that focuses on the elderly suggests that higher cost sharing decreases 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 the use of preventive services (Robinson 2002).

Limiting Medicare's coverage for specific benefits

Policymakers could set greater limits on the types of services or the share of costs that Medicare covers. For example, CMS could make national coverage decisions for new technologies to a greater degree than it does today, and the agency could base those decisions on analyses of both clinical and cost effectiveness. A variant of this approach would use information about clinical and cost effectiveness to set Medicare's payment rates and cost-sharing requirements.

The goal of such measures is to better target the use of new technologies toward patients for whom those innovations are most appropriate and of greatest value to the Medicare program. In this sense, better targeting the use of new technologies can increase efficiency even as it limits benefits.

To support Medicare's national coverage decisions, policymakers have tended to use information from clinical-effectiveness analyses rather than cost-effectiveness or comparative-effectiveness analyses. The Medicare Coverage Advisory Committee evaluates whether an innovation is "reasonable and necessary" for the diagnoses or treatment of Medicare beneficiaries, given available clinical evidence. In some cases, Medicare also considers clinical effectiveness when setting payment rates for new services. By focusing on clinical effectiveness, Medicare's process could lead to coverage of technologies that other countries might not find to be of sufficient value.[24]

Numerous stakeholders have raised concerns about incorporating cost-effectiveness analysis into Medicare's coverage decisions. For example, inconsistencies in cost-effectiveness methodologies can lead to results that vary from study to study (MedPAC 2005c). Some stakeholders question whether, under the Social Security Act that authorizes Medicare, the Secretary of Health and Human Services has the authority to consider cost effectiveness when deciding what to cover. Others fear that cost-effectiveness information would be used solely for cost containment and not for promoting appropriate care. Perhaps for similar reasons, private payers in the United States have been reluctant to incorporate cost-

effectiveness analysis in their coverage and payment policies. Under these circumstances another useful approach is comparative-effectiveness analysis: evaluating the costs and benefits of alternative treatments for the same condition.

In recent years, CMS has taken some steps to better target new technologies. For example, one recent review of Medicare's national coverage decisions from 1998 through August 2003 found that, in more than 60 percent of cases, CMS chose to cover the technology under certain circumstances (Neumann et al. 2005). Most frequently, the agency limited coverage to patients who had more severe conditions, who met certain diagnostic thresholds, or who failed first-line therapies. For other cases, the agency made coverage conditional on the site of care, in settings that had demonstrated experience. More recently, CMS began linking national coverage under Medicare with participation in comparative clinical trials and data registries to determine the effectiveness of new services for Medicare beneficiaries. Over time, this approach of providing coverage with certain conditions attached (e.g., participation in a registry) could provide information that would enable the agency to refine coverage decisions and payment policies to target technologies to the patients for whom they are most appropriate.

Increasing program financing

Under the Medicare trustees' projections, the program's need for resources would grow from less than 3 percent of GDP today to about 8 percent by 2037 and nearly 11 percent by 2077. Required resources would be even higher if future growth in health spending is closer to its historical average than the intermediate set of assumptions that the Medicare trustees used for their projections. To finance such growth in spending, decision makers face difficult choices.

Addressing how to finance Part A services is particularly important, since Medicare will no longer have the authority to pay for claims once the HI trust fund is depleted. Currently, the trustees project that program spending will exhaust the HI trust fund in 2018.

Growth in spending for Medicare could be financed with more borrowing. 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 spending, this approach could put significant upward pressure on interest rates as the federal government competes with other borrowers for investment capital. Higher interest rates, in turn, would slow economic growth.

For the longer term, the Congress could try to hold federal borrowing to manageable levels by allocating a greater share of resources to Medicare. This means that fewer resources would be available for other federal programs such as education and defense. If growth in health care spending does not slow and tax revenues remain at their historical share of GDP, reallocating federal spending alone may not be enough to address the problem. As the baby boom generation retires, the magnitude of resources needed for Medicare, Medicaid, and Social Security will reach unprecedented shares of GDP—even if some financing for those programs is offset with lower spending for other federal programs. Fiscal stability would require a sizable slowdown in growth rates in health spending and may also require a substantial increase in taxes as a share of our nation's economy (CBO 2005a).

A final financing approach is to raise federal taxes—payroll taxes on active workers, broader-based personal and corporate income taxes, or some new source of dedicated 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 after-tax wages of workers will grow more rapidly than benefits net of taxes and out-of-pocket health costs for Medicare enrollees (Thompson 2000). 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). Still other analysts caution that relying on tax increases to address Medicare's unfunded liabilities could lead to substantial job losses and lower growth in personal income and GDP (Foertsch and Antos 2005). The magnitude of tax increases needed depends on what priority policymakers give to financing Medicare relative to other priorities.

Using payment policy to obtain better value

Policymakers can better use Medicare's payment systems to create incentives for higher quality and greater efficiency. The list of approaches that policymakers might use is long: Building in incentives for providers to furnish high-quality care and to coordinate care, and setting payments for larger bundles of clinical services are just a few examples. The vast majority of beneficiaries

are in traditional Medicare, and thus the program needs to become more of a strategic purchaser than a payer of claims. At the same time, some analysts think expanding the use of private plans to deliver Medicare benefits could be a means of achieving greater efficiency.

Improving incentives within FFS payment systems

A past notion behind setting accurate administered prices was to identify the costs of care for Medicare beneficiaries and to reimburse at that level. However, such an approach can create the wrong incentives by giving the same payments to inefficient providers as to ones that deliver high-quality care at lower cost. A better goal in setting administered prices is to create incentives for providers to deliver high-quality care efficiently.

Keeping administered prices accurate is also challenging. Over time, inaccuracies and lags in the timeliness of data that CMS uses to set payment rates can accumulate into significant mispricing and unintended overpayment for certain services at the expense of others (Ginsburg and Grossman 2005). One example of a Medicare payment system with such biases is inpatient hospital care, where providing certain procedures (e.g., cardiac care) and caring for less severely ill patients are predictably more profitable than providing other care (e.g., basic medical services) or caring for more severely ill patients. The Commission's recommendations for improving the inpatient PPS would make payments more equitable among hospitals that provide different mixes of services and serve more- or less-complex patients (MedPAC 2005b). They also may lead to more efficient resource use if certain lucrative procedures are oversupplied under the current system.

Policymakers can constrain annual growth in Medicare spending by limiting the annual updates or increases in payment rates to health care providers. The Commission shapes its payment update recommendations with the goal of making enough resources available in the aggregate to cover the costs of efficient providers within each health care sector (see Chapter 2). To some extent, setting such limits is part of being a prudent purchaser, since limiting available resources to the amount needed for efficient providers puts appropriate financial pressure on less efficient providers to control their costs (Chapter 2A).

Two factors allow Medicare to limit payments to providers—government authority and the program's size. However, the existence of a large number of other payers or of a small number of dominant providers may, at times, limit the effectiveness of this approach, particularly if providers are able to shift costs from one set of payers to another. Even so, Medicare significantly influences how health care is organized and delivered in the United States through payment and coverage decisions. Medicare implicitly plays the role of market leader among private insurers that adopt the program's payment systems.

Constraining payment rates alone will not lower spending if the volume of services furnished increases. Medicare's payment system for physician services has been the most notable example of this phenomenon. Nor has the payment system provided incentives for physicians to coordinate the care that they provide to beneficiaries. Instead, the Medicare program may need more fundamental changes in how it pays physicians that reward them differently based on the quality of services they provide, including incentives to consider their use of resources and the degree to which they coordinate care with other providers. Investments by physicians in information technology (IT) and electronic medical records could help Medicare's ability to measure quality and make it easier for providers to coordinate with one another.

Medicare's payment systems are neutral and sometimes negative toward quality, paying the same or more for lower quality care as for higher quality care. In its March 2004 and 2005 reports, the Commission recommended policy changes that would differentiate among providers and lead Medicare to pay more for higher quality services (MedPAC 2005a, MedPAC 2004a). CMS has begun taking steps to move toward pay for performance and promote IT, but the agency has much more work ahead to build incentives into payment systems and ensure that they work as intended. Such a strategy may not reduce resource use; in fact, it could raise program spending. The aim, however, is that pay-for-performance measures would improve the value Medicare beneficiaries receive for the program's resources.

Medicare's FFS payment systems do not provide incentives to coordinate care, which can lead to unnecessary care and sometimes even iatrogenic illness. One tool many private payers and plans use to improve care coordination is disease management. 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. CMS established a chronic care improvement program called Medicare Health Support that is testing 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).

Reforms to FFS payment systems are not enough to ensure that Medicare does not waste or misdirect resources. Fundamentally, the incentives of traditional Medicare pay providers more for furnishing more services, even when the services are of limited value. Evidence for this is the literature on geographic variation in Medicare spending, which suggests that the nation could spend less on health care without sacrificing quality if physicians in regions with higher average use of resources reduced the intensity of their practices (Fisher et al. 2003). Traditional Medicare pays for certain services such as inpatient hospital care using payment systems that pay for larger bundles of services and, because of their prospective nature, put providers at financial risk. This combination of characteristics gives providers incentives to deliver care more efficiently. Even so, providers under these payment systems are still paid more for furnishing each additional bundle of services, and traditional Medicare pays for other types of services using fee schedules.

About 83 percent of Medicare beneficiaries are enrolled in traditional Medicare, accounting for the bulk of program spending. For this reason, FFS Medicare may need to adopt innovative purchasing strategies used in the private sector (MedPAC 2004b). In 2005, the Commission recommended that the Secretary measure the resource use of physicians using Medicare FFS claims and report that information back to physicians on a confidential basis. The objective of this policy is to provide physicians an opportunity to assess their practice style relative to their peers and determine whether they should make any changes. Today, some private payers draw on information about physicians' resource use to help them build networks, set payments under pay-for-performance programs, and design tiered cost sharing to steer beneficiaries toward more efficient providers. Another strategy of private payers is to set payment rates for certain services through a competitive bidding process. CMS is going to use this approach to set prices for durable medical equipment, prosthetics, and orthotics in certain parts of the country.

Observers from other industries, economists, and researchers assert that health care providers could use IT and systems-engineering methods to increase efficiency while improving the safety and quality of their services. Systems engineering refers to methods for analyzing and improving the performance of complex systems such as hospitals and ambulatory care (Reid et al. 2005). These methods often rely on IT to analyze detailed data on the process and outcomes of care delivery. Industries such as telecommunications, securities trading, retail, and general merchandising invested heavily in IT and systems engineering during the 1990s and reaped continued annual gains in productivity. Some analysts believe that if health care providers used IT-enabled systems-engineering methods, including interconnected electronic medical records, health care industries might also improve their efficiency (Hillestad et al. 2005). However, current use of systems engineering and health IT is low due to start-up costs, the difficulty of implementing unfamiliar systems, and the lack of return on investment to providers under FFS payment methods (MedPAC 2005a).

Using private plans to deliver Medicare benefits

Some analysts believe the best way to address high growth in Medicare spending is for competing private plans to manage the delivery of benefits while assuming some or all insurance risk for their members. For competition among private plans to work well, beneficiaries must make informed choices among plans and understand the consequences of the plans' benefits and management tools. Proponents suggest that private plans could help (1) stimulate price competition as plans compete for members, (2) lead to greater cost-consciousness among enrollees, and (3) improve quality of care. These reasons lie behind the Medicare Advantage program and the structure of Medicare's Part D, which relies on competing private plans to deliver outpatient prescription drug benefits.

Without good risk adjustment to payments, competing private plans have an incentive to enroll healthier individuals and avoid sicker ones. Researchers have improved risk adjusters by incorporating diagnosis information from claims data, and Medicare risk adjusts its payments to private plans in the Medicare Advantage and Part D programs (Pope et al. 2004). Nevertheless, the accuracy of risk adjusters is highly dependent on accurate coding in claims data. If too few conditions are coded or if they are miscoded, risk adjusters will not be accurate. If the accuracy of diagnoses in claims data improves over time, Medicare may need to recalibrate risk adjusters to reflect newer data.

In general, some types of 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. However, a plan's ability to negotiate discounts depends highly on the degree of negotiating leverage within each market. Moreover, to achieve savings relative to FFS, private plans must more than offset their administrative costs and profits (CBO 2004b). Certain aspects of managed care proved unpopular in the latter part of the 1990s, such as provider networks and requirements for prior authorization that some members considered too restrictive. Nevertheless, many plans have reintroduced managed care techniques and tailored them toward the services that are most likely to be overused. Some plans have also begun measuring providers' utilization and quality, then establishing tiers of providers that are subject to different cost-sharing requirements or payment rates depending on their track record of quality and resource use (Mays et al. 2004a).

Some Medicare Advantage plans improve care coordination for their enrollees. However, a wide variety of Medicare Advantage plans exist today, with different methods for promoting appropriate care and managing growth in cost. Plans run by multispecialty group practices largely require their members to seek care through their own physicians. Some of these plans have been successful at encouraging quality care by fostering consensus among their physicians and developing evidence-based practice guidelines. Other plans negotiate discounts from network providers, monitor provider quality and resource use, and then try to steer members toward preferred providers. Still other types use relatively few tools for managing care. A concern is that the Medicare program may pay plans that do not coordinate care or manage cost and quality for their enrollees more than plans that provide high-quality care more efficiently.

Setting payment levels for Medicare Advantage plans is a challenge. For years, the Congress sought to encourage expansion of plans to new areas and to try to reverse declining enrollment. Consistent with those goals, in recent years, policymakers have set Medicare Advantage payment rates higher than what it would have cost to provide services to plan enrollees in FFS Medicare. The Commission supports private plans in the Medicare program. Medicare beneficiaries should be able to have a choice between the FFS program and the alternative delivery systems that private plans can provide. At the same time, the Commission supports financial neutrality between payment rates for the FFS program and plan payment rates. Financial neutrality means that the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. Our analysis of recent Medicare Advantage data shows that plan payment rates continue to be well above FFS levels (see Chapter 4).

One policy approach that some researchers point to as a way to address Medicare's financial situation is called premium support (Dowd et al. 1992). Under some versions of premium support, beneficiaries could use an amount provided by the federal government to purchase their Medicare benefits through either a private plan or the FFS program. The subsidy could be based on a predetermined amount or on bids from private plans including a bid that represents average FFS spending. Beneficiaries who select a plan with premiums higher than the federal subsidy would pay the additional amount, while those in plans with lower premiums would receive additional benefits or rebates (CBO 2006). The magnitude of savings achievable under premium support is difficult to predict and depends on many details about how such competition would be carried out and how plans and beneficiaries would respond (CBO 2005b). The MMA includes a demonstration of one approach to premium support beginning in 2010.

Medicare within a multipayer health care system

Medicare is one large public program within an even larger health care system that includes many private payers and other public programs. Such a multipayer system has some distinct advantages. One advantage is that competitive pressure may lead some private payers to be innovative and better tailor their products to the populations in their "book of business." In geographic areas where they have bargaining leverage, private payers may be able to apply more pressure on providers to improve their performance than public payers because they can more credibly threaten to exclude providers from their networks. Private payers also need not hold political considerations in mind to the same degree as public payers, which could allow more room for experimentation and innovation.

A multipayer system has some liabilities as well. A more fragmented system of financing health care may mean that providers have a greater degree of bargaining leverage over prices than they would otherwise. Some analysts believe that certain providers are able to charge some payers higher prices to compensate for changes in the administered prices of other payers, perhaps allowing

providers to circumvent pressure to improve their performance. Because of the need for providers to interact with a variety of payers, each with different requirements for billing and performance measures, a multipayer system has higher administrative costs. Moreover, driving gains in efficiency can be difficult for any one payer because of each payer's differing sets of priorities and rewards.

There may be ways policymakers who are concerned about Medicare can enjoy some of the advantages of a multipayer system and reduce some of its liabilities. For some types of services, the Medicare program should take a leading role in carrying out policy changes. For others, Medicare will likely need to collaborate with other payers to carry out broader changes among health care providers. The following examples use different policy tools to improve efficiency and vary in their degree of collaboration with other payers.

- ***Tightening standards and making payment rates more accurate.*** Technological progress in imaging over the past years and its promise for improving diagnosis, treatment, and outcomes are impressive. At the same time, we have observed rapid and sustained growth in the volume of imaging services for Medicare beneficiaries, which has led to concerns about quality and patient safety, possible inaccuracies in Medicare payments, and potential overuse of imaging services. In 2005, the Commission recommended that CMS take steps to make coding edits that adjust payment amounts for multiple imaging services, set standards for physicians who bill Medicare for interpreting diagnostic imaging studies, and similarly set standards for all providers who bill Medicare for performing diagnostic imaging studies (MedPAC 2005a). The Commission also recommended taking steps to strengthen rules that restrict physician investment in imaging centers. Since many private and some other public payers use Medicare payment rates and policies as their own, by adopting such measures, the Medicare program could take a leading role in better ensuring that imaging services are provided safely and used appropriately.

- ***Using comparative-effectiveness analysis for new technologies.*** In collaboration with other public and private payers, Medicare could advance the use of comparative-effectiveness analysis and work to develop consensus about appropriate uses for new medical technologies. One example of a federal role in comparative-effectiveness analysis can be found in the MMA, which authorized the Agency for Healthcare Research and Quality to conduct and support research studying the outcomes, comparative clinical effectiveness, and appropriateness of health care items and services. Under a model of public–private collaboration, CMS could help facilitate greater consensus around methodologies and help build capacity for conducting analyses. For such analysis to be accepted and used widely, it would need to be authoritative and unbiased. In past national coverage decisions, CMS relied primarily on information about the clinical effectiveness of new technologies rather than on cost effectiveness. Given the widespread use of new technologies and medical practice patterns, policymakers may begin to incorporate comparative-effectiveness analysis in Medicare's coverage or payment policies if other payers are also doing so.

- ***Paying differentially among providers based on measures of quality and resource use.*** Last year, the Institute of Medicine issued a call for Medicare to phase in pay-for-performance measures to stimulate systemwide improvements in the quality of U.S. health care (IOM 2006b). Medicare could collaborate with other payers, providers, and interested parties to agree on measures of quality and resource use for pay-for-performance programs. CMS, along with accreditation and provider organizations, has begun to play a critical role in building the infrastructure to move to pay for performance. The agency identified and developed quality measures, collected standard data on quality, and published information on the performance of some providers. It also designed demonstration programs to test various aspects of paying for improved quality and efficiency. To ensure that a pay-for-performance strategy is successful for Medicare, CMS must continue to work with other payers and stakeholders so that the measures the agency uses are accepted widely. A common set of measures for quality and resource use across payers would also reduce the reporting burden on providers.

Medicare relies on providers who also deliver care to the broader set of payers in the health care system. In some health care sectors, Medicare can and should take the lead in initiating certain changes. In many situations, Medicare must often work in collaboration with other payers to make lasting changes. ■

Endnotes

1 As Robert Myers, the Social Security Administration's Chief Actuary in 1965 put it, designing a two-part program resulted from a "legislative process [that] was a matter of political compromise and was not by any means dictated by actuarial principles" (Myers 2000).

2 Aside from the direct method of increasing the payroll tax rate, a number of changes over the years have increased revenue to the HI trust fund. Certain employment groups were not included in the Social Security system and were added over the years, expanding the payroll tax base. For example, self-employed physicians were not covered under Social Security until 1965. State and local government employees and federal civil servants were also excluded from the set of workers covered under Social Security (and therefore were not paying HI payroll taxes) until the 1980s. While the Social Security portion of the payroll tax has an upper limit of yearly earnings that are taxable ($97,500 for 2007, having gradually increased from the 1966 level of $6,600), the upper limit on HI contributions was removed in 1994 so that all earnings are subject to the HI tax. The age of Medicare entitlement for the nondisabled remains 65, but raising the "normal retirement" for Social Security—the age at which beneficiaries can receive unreduced retirement benefits—also increases the pool of workers contributing to the HI trust fund to the extent that individuals 62 or older continue to work. Provisions that make Medicare the secondary payer in relation to other insurers have also reduced expenditures for Medicare. An additional source of funds for Medicare is the income tax on Social Security benefits that is designated for the HI trust fund.

3 There are some important exceptions to this. For example, Medicare patients seeking care at hospital outpatient departments must pay about 32 percent coinsurance (rates vary by service), and beneficiaries face 50 percent coinsurance for most outpatient mental health services.

4 In their projections, the trustees are required to assume what they consider unrealistically low physician payment updates (consecutive negative updates between 2007 and at least 2015). This fact, as well as the need to raise Part B assets in the SMI trust fund to more appropriate levels, puts even more upward pressure on SMI's financing needs.

5 Some analysts have criticized the trigger provision on several grounds. One can argue that the threshold of 45 percent arbitrarily caps general revenue financing (Moon 2005). If decision makers conclude that they must increase taxes to help ensure Medicare's sustainability, some may find raising general revenue more desirable than raising payroll taxes because income taxes are more progressive and may not discourage work effort as directly. Another criticism is that policymakers could carry out options to lower the general revenue funding share (by, for example, raising payroll taxes) without addressing concerns about the level of Medicare spending or program inefficiencies. Another critique of the 45 percent trigger is that, because of the way HI and SMI services are financed and the trigger measure is calculated, the mechanism favors certain policy options over others. The policy tools one chooses to use can have different effects. Specifically, payroll tax and premium increases lower the trigger measure by more than policies to lower Medicare spending.

6 The Medicare trustees make their projections in three phases. Short-range projections cover a 12-year period and reflect current Medicare policies by type of service as well as recent trends in growth of spending. For years 25 to 75 of the projection period, the trustees use projection models that apply assumptions about long-term growth rates in health spending to projections of growth in the economy, growth in numbers of beneficiaries and their demographic mix, and the relative cost of care for different demographic groups. For the intermediate period, the trustees gradually smooth the growth rate in per capita health spending between the short- and long-range assumptions (2004 Technical Review Panel on the Medicare Trustees Report).

7 The trustees characterize long-range growth rates in these terms to reflect the effects of technology on health spending. The GDP term reflects an income effect—broader use of technology as our nation's income increases. The 1 percentage point term reflects an increasing trend in the use of technology independent of income.

8 Even as the health status of people age 65 and older has been improving, the prevalence of chronic diseases and rates of disability among younger people have been rising. Researchers found that the combined effects of the changing health status of older and younger cohorts will lead to only modest upward pressure on aggregate health spending. However, the adoption rate of key technologies could affect spending levels more because some innovations are forecast to be very expensive. The 10 technologies considered include intraventricular cardioverter defibrillators, left ventricular assist devices, pacemakers to control atrial fibrillation, telomerase inhibitors, cancer vaccines, anti-angiogenesis, treatment of acute stroke, prevention of Alzheimer's disease, prevention of diabetes, and compounds that extend life span.

9 Individuals with modified adjusted gross incomes (MAGIs) of $80,000 or more and married couples with MAGIs of $160,000 or more will receive less than the 75 percent subsidy that all other Part B enrollees receive. CMS is phasing in higher premiums over a three-year period. By the end of that time, higher income individuals will pay monthly premiums equal to 35 percent, 50 percent, 65 percent, or 80 percent of Medicare's average Part B costs for aged beneficiaries, depending on income. All other individuals pay premiums equal to 25 percent of average costs for aged beneficiaries. For 2007, CMS estimates that 1.3 percent of Part B beneficiaries will pay $106 per month, 1.2 percent will pay $124.70 per month, 0.5 percent will pay $143.40 per month, and 0.8 percent will pay $162.10 per month, compared with a premium of $93.50 per month for the remaining 96 percent of Part B enrollees. In 2007, the additional premium amounts are one-third of the full higher amount that higher income beneficiaries will ultimately pay. If CMS had not phased in lower premium subsidies for higher income individuals, 2007 income-related premiums would have been about $131, $187, $243, and $299 per month. Whether higher premiums will affect beneficiaries' willingness to remain enrolled in Part B remains to be seen.

10 Social Security recipients received a 3.3 percent increase for 2007.

11 An implication of calculations made in the late 1990s for Medicare trustees' reports was that medical care services would make up 38 percent of GDP by 2075 (2004 Technical Review Panel on the Medicare Trustees Report).

12 For a beneficiary with a total of $3,000 in drug spending, this $1,500 out-of-pocket spending calculation is the sum of the $250 deductible, 25 percent coinsurance on the next $2,000 in drug spending ($500), and $750 of out-of-pocket spending in the standard benefit's coverage gap.

13 SMI premiums and cost sharing will make up a lower percentage—just under 20 percent—for those beneficiaries who do not enroll in Part D.

14 For example, we would not include the value of personal exemptions from individual income tax for dependent minors when calculating how much we spend on children.

15 Dollar amounts are adjusted for purchasing power parity—differences in the cost of living across countries—by comparing prices for a fixed basket of goods. OECD's adjustment is a broad-based basket, not one specific to health costs.

16 Analysts raise a similar argument about the higher price of acute hospital days in the United States, although inpatients receive more intensive care per bed day than in many other countries (Bodenheimer 2005b).

17 Reports document shortcomings in the evidence base about what works to address obesity and call for more programs and more evaluation. One recent report compared obesity rates across states and found that only one state had reduced the obesity rate; the report calls for development of strategies and a research program to evaluate them (Robert Wood Johnson Foundation 2006). Another recent report focusing on progress in preventing childhood obesity calls for multiple efforts from government, industry and media, communities, schools, and individuals. It also stresses the need to evaluate these programs and to disseminate the results of the programs that work (IOM 2006a).

18 Consumer-directed health plans are designed to make patients more sensitive to the price of their care. Some insurers that offer consumer-directed products provide decision-support tools to help individuals understand treatment options and locate price information about providers. This type of insurance product assumes that consumers can weigh the costs and benefits of their alternatives. One limitation of consumer-directed health plans stems from their benefit design combined with the concentration of health care spending among relatively few patients. Generally, about 10 percent of people account for about 70 percent of health care spending (Berk and Monheit 2001). Beneficiaries in fee-for-service Medicare exhibit only a slightly smaller concentration, with the top 10 percent of individuals accounting for 67 percent of program spending (MedPAC 2004b). A strategy of raising enrollees' sensitivity to the costs of their care may reduce spending for some discretionary services, but it may not be as successful at constraining spending for patients whose use of services quickly pushes them beyond both the deductible and the out-of-pocket spending limits.

19 In 2005, about 10 percent of privately insured, nonelderly adults were enrolled in high-deductible health plans (Fronstin and Collins 2005). Nevertheless, such plans have attracted considerable attention. Supporters believe that higher cost sharing will lead members to lower their use of unnecessary services, 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. A recent review of literature on these products suggests that, at this early stage, the evidence is not sufficient to draw firm conclusions. Nevertheless, early studies show modest favorable selection into consumer-directed health plans, some evidence that such plans may help lower costs and cost increases, and mixed effects on quality with evidence of both appropriate and inappropriate changes in use of services (Beeuwkes et al. 2006).

20 Retirees can obtain a reduced level of Social Security benefits beginning at age 62 but obtain full benefits only if they wait until age 65. Under current law, Social Security's normal retirement age will rise gradually from 65 to 67.

21 This study defines the underinsured as those individuals who, given their health status, would have purchased more extensive coverage but had insufficient income to do so. The authors used simulation models to predict the purchase of nongroup health insurance policies among the near elderly based on their health status and then constrained the type of insurance those individuals could purchase to policies that would cost no more than 20 percent of their income.

22 An alternative option would be to broaden the availability of disability coverage to the near elderly.

23 One should note that each of the Health Insurance Experiment's insurance alternatives included a cap on out-of-pocket spending, which could have affected behavior.

24 An increasing number of countries have public and private agencies that evaluate new technologies (Bodenheimer 2005a). Some explicitly use cost-effectiveness analysis—a methodology in which one quantifies both the health outcomes and the costs of new technologies (MedPAC 2005c). Organizations such as the United Kingdom's National Institute for Clinical Excellence (NICE) measure health outcomes in terms of quality-adjusted life years (QALYs), the arithmetic product of life expectancy and a measure of the quality of the remaining life years. U.K. policymakers use NICE's analyses to help decide which treatments should be funded publicly, based on whether a technology's resulting QALYs are at or below certain ranges of cost effectiveness (Reinhardt et al. 2004). If NICE's analyses conclude that a new technology is not cost-effective, patients in the United Kingdom must use their own funds or private supplemental insurance to pay for treatment.

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