

Slowing Medicare Spending Growth: Reaching for Common Ground

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Over the past half century, per-beneficiary real spending growth in Medicare has exceeded real per-capita gross domestic product (GDP) growth by more than 2 percentage points. It is widely agreed that this gap should not continue. In fact, the Patient Protection and Affordable Care Act (PPACA) is projected to close the gap completely, largely by reducing the rate of increase in fees paid to health plans and providers. Yet the ability to sustain the proposed fee cuts is highly uncertain. Moreover, even if the PPACA spending trajectory is realized, Medicare spending as a share of GDP will grow due to the aging of the population.

Policy makers from both parties have struggled to identify ways to reduce the fiscal burden of Medicare on the federal budget. The strategy most widely identified with the Republicans involves premium support. Details of such proposals vary (see Aaron and Frakt¹ for a critique of existing proposals), but the basic notion is that individuals would be given a fixed subsidy (voucher) that could be used to buy coverage. By setting the voucher rate, the government can define, and therefore control, the level of spending.

An alternative strategy that was incorporated into the PPACA (thus identified with the administration and Democratic efforts to reform Medicare) involves moving away from fee-for-service (FFS) payments to fixed payments per episode (bundled payment) or global payments per beneficiary. The global-payment model involves setting a fixed-payment rate to cover all of a beneficiary's care. Many variations of global payment are being explored. Perhaps the most prominent involves the global payment made to an Accountable Care Organization (ACO), which is a provider system capable of accepting and managing financial risk.

Although the parties may be far apart on a range of issues, and these 2 strategies at first blush appear divergent, they share a number of features. Both define a federal

budget contribution to Medicare. Both preserve beneficiary choice of provider, and both preserve physicians' auton-

omy (and responsibility) in making clinical decisions with their patients.

Yet the 2 approaches also have important differences. Identifying those differences and tracing their consequences can help clarify the relevant issues and contribute to defining common ground. There are 3 main differences between the 2 strategies for controlling spending growth. At the heart of the differences are preferences about how to divide the responsibility and risk associated with controlling Medicare spending.

1. How Should the Fixed Payment Be Set and Updated Over Time?

The current FFS Medicare system places responsibility for controlling spending on the government, and the taxpayers bear the cost if spending rises rapidly. However, the existing FFS system hampers the ability of the government to reduce spending growth because it does not encourage accountability for total spending, and our existing system has not been able to reduce fee updates enough to slow spending growth, despite the Sustainable Growth Rate (SGR) system. Under a voucher or global-payment approach, federal spending growth depends entirely on the method for updating the voucher level or the global budget. In Paul Ryan's original proposal, the voucher was essentially increased each year by the Consumer Price Index.² This increase is well below the historical rate of healthcare spending growth. In the more recent Ryan-Wyden plan, vouchers are updated based on competition, with a cap at 1 percentage point above GDP growth (which is greater than the forecasted spending growth under the PPACA). In existing global-payment models (such as the Pioneer ACO program), payment rates would be updated by the rate of spending growth in the FFS system. The use of FFS spending as a benchmark is problematic because (1) a policy aim is to shrink the FFS system and (2) the FFS system is viewed as a source of the spending problem in the first place.

In choosing a method of updating the value of a voucher or the level for global payments, one must balance fiscal concerns with the desire to promote development and adoption

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Policy makers have identified 2 systems for reducing the fiscal burden of Medicare on the federal budget: premium support and global payment.

- The alternatives have a lot in common, including placing the healthcare system on a budget.
- The systems differ in how they divide the responsibility and risk associated with controlling Medicare spending: premium support shifts risk to insurers and beneficiaries, and global payment shifts risk largely to providers.
- How to harness the power of consumers while minimizing market imperfections and income disparities is perhaps the central challenge facing reform.

It is likely that a fixed payment system designed for providers and a premium support system designed for health plans will coexist.

of new technology. This choice will be governed by values, the perceived potential for important medical breakthroughs, and demographic trends. Some stakeholders would like to limit total Medicare spending growth to the rate of GDP growth, thereby stabilizing the share of GDP consumed by Medicare. During a period of rapidly rising Medicare enrollment due to the aging of baby boomers, such a target would require per-beneficiary spending to grow at a rate below GDP growth. For example, holding Medicare growth to GDP growth rates would require an update in the per-beneficiary payment rate of GDP minus about 1.25 percentage points (the subtraction of 1.25 is required to offset demographic trends). Enacting such real cuts for older and disabled adults is viewed by many as undesirable. This issue highlights the fact that stabilizing the share of GDP devoted to Medicare is very challenging.

Because spending growth has historically been driven by new medical innovation, the reduction in payment increases would likely alter the nature or slow the rate of introduction of medical technology.³⁻⁵ This could imply a slowdown in the rate of improved medical treatment (as opposed to an absolute reduction in quality of care; providers would still be paid more, but considerably below historic trends). Yet because payment is bundled—at least in the global-payment model, and maybe in the premium-support model—introduction of new technology may not be as adversely affected as some fear. If there is considerable waste in the system, the clinical and administrative flexibility in the bundled-payment arrangements gives providers incentive to capture savings from increased practice efficiencies and elimination of low-value care. A new approach to payment may shift medical innovation toward cost-reducing technologies and processes. Such savings could help finance high-value medical innovation.

Ultimately, the choice of how rapidly to allow the fixed payment to rise depends on our willingness to support the system with taxes (and bear the economic costs associated with mildly higher tax rates). Views on this issue will vary, but it is important that the system be flexible enough to al-

low more rapid spending growth if we are blessed with medical discoveries (eg, a cure for Alzheimer disease or diabetes) that we are willing to finance. Strategies such as competitive bidding could allow markets to set update rates. However, because competition is imperfect, a bidding system might not sufficiently slow spending growth, so a cap on public spending seems reasonable under either the bundled-payment system or the premium support system.

2. Should Fixed Payments Go to Health Plans or Provider Systems?

When the government caps its liability for rapidly rising spending, the associated risks and responsibilities will be shifted. This means that insurers, providers, and/or beneficiaries will face new decisions and financial burdens. Vouchers and global payments vary in how they assign this risk and responsibility. Most voucher schemes assign new risk bearing to a mix of insurers and beneficiaries. Global payment places the new risks largely on providers. There are advantages and disadvantages to each strategy.

Insurers have developed competencies to manage data, support care management, and develop provider networks. Thus, they may be well suited to manage costs. One approach to managing costs is for insurers to use bundled- or global-payment strategies that force providers to share risk and responsibility. The ability of insurers to do so depends importantly on market conditions. However, the track record of insurers in this realm is poor. Therefore, failure to control costs means that beneficiaries will be liable for an increasing share of program spending over time.

In contrast, provider systems have more direct contact with patients, and thus are perhaps better positioned to alter patterns of care. If the Medicare program sets the payment rate to providers, it need not be so concerned with provider market power. However, while exceptions exist, a provider-oriented approach will require organizational changes and perhaps consolidation (which could have adverse consequences in the private insurance market because consolidated providers may increase market power and be able to raise prices to private payers). In many cases, providers will need to develop skills to manage risk and to coordinate care across different subgroups of providers. Providers need to perform better than they did in their last largely failed experiments in managing shared finances within 1970s and 1980s demonstration health maintenance organizations. Because of the constraints inherent in the bundled system, liability reform will likely be important.

Fortunately, the insurer and provider strategies are not mutually exclusive. In fact some innovative insurers in the commercial sector already accept a fixed premium and pay provider groups a global payment. Medicare could allow both approaches to coexist. Any organization willing to accept the fixed payment and be accountable for the patient outcomes should be able to participate in the program. It is important that the systems be designed on a level playing field, which would entail equalizing payments across systems. Equalization of payment will avoid favoring any particular organizational form and enable the most innovative organizations to succeed. For example, allowing providers in a global-payment system to have the same control over benefit design as health plans may be important.

Benefit design can be an important tool for aligning beneficiary and provider incentives, and a useful tool to support efforts to purge waste from the system. In premium-support systems, insurer control over benefit design is assumed (provided the coverage is not less generous than that mandated by Medicare). In a global-payment system, with payment going to provider entities, the locus of control is less clear. Yet, if provider systems are accountable for clinical and economic outcomes, some control over benefit design (within the same limits placed on plans) would be valuable. Benefit design can be used to encourage beneficiaries to seek care from the provider organization accountable for care and can be used to discourage use of low-value services. Moreover, patient cost sharing can mitigate conflicts between patients and providers who have incentives to practice conservatively. Ideally the organization accepting accountability would have at least some ability to control the details of benefit design within overall guidelines set by the Medicare program.

3. Should Plans or Providers Be Allowed to Charge Patients More Than the Fixed Payment?

Perhaps the most fundamental distinction between prototypical premium-support models and global-payment systems is whether providers (or plans) can charge patients above the amount of the voucher or global payment. In premium-support models it is assumed that insurers can charge an amount above the voucher. This feature allows beneficiaries to purchase more generous (or less managed) coverage if they desire, which might be very important if payment levels are tight. It also has the potential to create important new financial disadvantages for lower-income people. In typical global- or bundled-payment models, providers generally cannot charge an amount above the fixed payment. However, permitting providers to charge patients directly will allow beneficiaries who want access to more services to purchase them (or coverage for them). It may also

result in limited availability of certain providers and services to lower-income people.

Permitting plans or providers to charge an amount above the fixed payment shifts responsibility for controlling spending, and risk if spending is not controlled, to beneficiaries. Yet it is unclear whether beneficiaries have the tools necessary to bear the responsibility and risk associated with controlling spending growth. If insurance (or provider) markets are not very competitive, beneficiaries could be charged well above the economically efficient amount. If plans or providers are allowed to charge amounts above government rates, antitrust enforcement will be important, perhaps coupled with some price regulation, such as limits to plan or provider surcharges.

As noted earlier, although extra billing can allow the system to be more responsive to beneficiaries' preferences, it raises the possibility that disparities in access and quality related to income will develop, even if competition is perfect (though imperfect competition exacerbates concerns). To some extent, such income-related disparities exist now, and the Medicare Part D program already allows plans to charge amounts above the benchmark. Some of this disparity is attenuated by the availability of subsidies for low-income beneficiaries in Part D.

Today's political climate and budgetary concerns suggest that subsidies for lower-income populations may be strictly limited. Therefore, allowing plans or providers to charge an amount above the government payment could exacerbate disparities. Different observers will view such disparities with varying degrees of alarm, but it seems likely that in a fiscally constrained system, individuals with greater demand for care will need a mechanism to have that demand satisfied.

In any of the systems discussed here, efforts must be made to ensure that quality does not deteriorate. With voucher amounts or global-payment rates rising, albeit at slower than historical rates, quality of care for all beneficiaries could improve, perhaps significantly, relative to the status quo if waste can be eliminated and competition works well. Yet, there is great uncertainty because the evidence is scant. Specifically, even though current practice patterns appear to be financially feasible under altered payment arrangements with lower rates of spending *growth*, changes to the system may create incentives that lead to a reduction in quality. Low-income populations may be particularly vulnerable. Vigilance, and some regulation, may be needed under both regimes.

Nevertheless, we must recognize that even under ideal conditions, increasing the level of consumer risk and responsibility will likely result in access becoming more related to income than it already is. How to harness the power of consumers while minimizing market imperfections and income disparities is perhaps the central challenge facing reform. To

some extent, research can inform the policy process about issues related to market functioning and the degree of disparity associated with any given policy, but ultimately bridging the gap created by different values is necessary.

A final concern with allowing plans or providers to charge beneficiaries an amount above the fixed-payment rate is that allowing surcharges may encourage policy makers to underfund the Medicare program, shifting fiscal responsibility to beneficiaries. To guard against this possibility, a well-specified update system should be adopted.

Common Ground

Given the shared features of premium support and bundled payment, a path forward is discernible. First, Medicare spending should move away from the FFS system toward one that imposes some budgetary constraint. For example, the SGR must be repealed. However, the replacement for the SGR should encourage movement to more accountable systems, perhaps through a less onerous, but still declining, trajectory of fees for providers that remain in the FFS system. The transition to a new system will not be immediate, and intermediate steps such as episode-based bundling or shared-savings models may be important.

Future reforms should be designed to move us toward a more budgeted system. It is likely that a fixed-payment system designed for providers and a premium-support system designed for health plans will coexist. Payments for each system should create a level playing field, and payment rates should be designed to allow high-value care and to meet budget goals, as opposed to mimicking the FFS system. Regulation of health plans and regulation of accountable-provider systems should be comparable. For example, as we move toward an ACO system, we should consider allowing ACOs to have more control over benefit design.

The fundamental debate now must be around the details of the new system. We must discuss who should bear the responsibility for controlling spending growth and assume the risk if spending growth continues. Government (taxpayers) can absorb some of the risk by setting the trajectory of public spending growth, which touches on the core issue of our willingness to tax. Within any trajectory of government spending, we must decide what types of organizations should

receive the fixed payment (and under what terms). Allowing a broader set of organizations to participate on a level playing field seems wise, so this issue may not be particularly problematic. The distinction between assigning responsibility to plans or providers is less important than deciding the extent to which beneficiaries should bear risk and responsibility. Any sustainable trajectory may lead to perceptions of excessively diminished access. Thus, allowing beneficiaries to have some ability to “buy up” seems reasonable. Yet concerns about market imperfections and income-related disparities in access to care suggest that any attempts to shift costs to beneficiaries must be done with care and careful regulation.

Ultimately, we care about the efficiency and effectiveness of the entire healthcare system, not just the public spending. Many alternatives, including the PPACA, are just variations on the theme. Recognizing the commonalities may help us focus on, and resolve, the differences.

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REFERENCES

1. Aaron HJ, Frakt AB. Why now is not the time for premium support. *N Engl J Med*. 2012;366(10):877-879.
2. Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan*. http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf. Published April 5, 2011. Accessed March 6, 2012.
3. Chernew ME, Hirth RA, Sonnad SS, Ermann R, Fendrick AM. Managed care, medical technology, and health care cost growth: a review of the evidence. *Med Care Res Rev*. 1998;55(3):259-288.
4. Smith S, Newhouse JP, Freeland MS. Income, insurance, and technology: why does health spending outpace economic growth? *Health Aff (Millwood)*. 2009;28(5):1276-1284.
5. Chernew ME, Newhouse JP. Health care spending growth. In: Pauly MV, McGuire TG, Barros PP, eds. *Handbook of Health Economics*. Vol 2. Oxford, UK: North Holland, an imprint of Elsevier; 2012. ■