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Robert Wood Johnson Foundation

Preserving Medicare for Future Generations: Market-Based Approaches to Reform

America's fee-for-service Medicare program represents the third-largest category of federal spending and has been under scrutiny for decades for spending more on health care benefits for enrollees than taxes can generate to pay for them. The nonpartisan Congressional Budget Office (CBO) estimates that over the next 10 years, the number of Medicare enrollees will increase by one-third—approaching 67 million Americans.

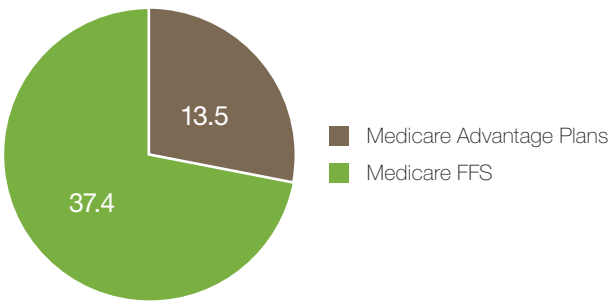
The CBO projects the cost of providing benefits to these enrollees will increase at an annual growth rate of 7 percent, reaching at least $1 trillion in fiscal year 2022. A combination of a higher volume of patients needing more care and the increasing costs of those services presents significant challenges for sustaining the Medicare program, particularly in an era of budget deficits.

The urgency of the situation may also offer a timely opportunity for reexamination of fee-for-service Medicare, including models that may support the overall goals of health system reform: better care and a healthier society at lower costs.

The Robert Wood Johnson Foundation asked scholars at the American Enterprise Institute to consider various approaches to reforming this "800-pound gorilla of American health care." Papers in this series include analyses of key market-based solutions that seek to address both Medicare's sustainability crisis and the inherent inefficiencies of the current system.

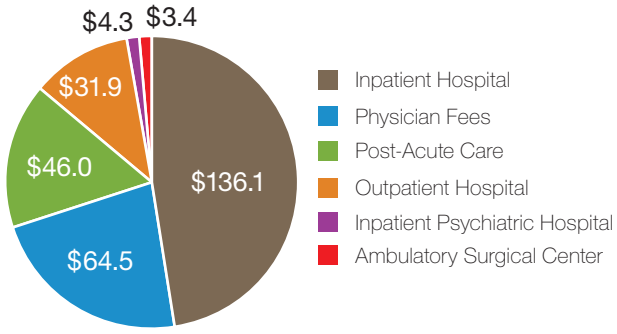
Where Is the Money Going?

Medicare Enrollment by Type of Coverage, 2012 (millions)



Source: 2012 Medicare Trustees' Report

Medicare Fee-for-Service Payments, 2010 ($ billions)



Source: MedPAC 2012 Data Book

The Role of Medicare Fee-for-Service in Inefficient Health Care Delivery

James C. Capretta

Medicare is the 800-pound gorilla of American health care. The misaligned incentives embedded in Medicare fee-for-service (FFS) have affected the entire health care delivery system, driving up costs without commensurate increases in quality.

Today, nearly 90 percent of beneficiaries in traditional Medicare have supplementary insurance that pays any costs not covered by the program. Because these beneficiaries pay close to nothing at the point of service, they have strong incentives to utilize as many services as their physicians recommend, even if the expected benefit is negligible or unproven. Those providing services in Medicare FFS are also able to increase their incomes when they perform more tests and procedures on patients. The predictable result has been steady growth in the volume of services—and hence costs—paid for by Medicare FFS.

Medicare's FFS, no-cost-sharing arrangement drives high costs not just in Medicare, but in the health sector as a whole. Medicare accounts for 23 percent of every dollar spent on health care in the United States, or up to 40 percent if you include Medicare claims paid by private supplemental insurance and the small amount of costs paid by the beneficiaries themselves. Because of Medicare's dominant size in the marketplace, the FFS model influences the entire health system's structure and costs. Most private insurers use Medicare FFS's payment approach to design their payment systems. Moreover, the advent of Medicare FFS, along with the spread of employer-sponsored insurance, was responsible for about half of the real cost increase in all health care spending in America from 1950 to 1990. Areas with more beneficiaries enrolled in Medicare Advantage (MA) experience lower costs for FFS Medicare, implying that the mere presence of (more efficient) MA plans lowers costs for all of Medicare in a given region.

Given Medicare's influence over all health costs, fixing the program should top the list of reform priorities. Regulatory approaches have failed in the past, largely because of a political dynamic that rewards volume, not quality. In the end, real improvement will almost certainly require a more fundamental change than has been enacted to date: a market-based reform that corrects the flawed incentives that drive unnecessary spending in the current program.

About the Author

James C. Capretta is a visiting fellow at the American Enterprise Institute. As an associate director at the White House's Office of Management and Budget from 2001 to 2004, he was responsible for all health care, Social Security, and welfare issues. Earlier, he served as a senior health policy analyst at the US Senate Budget Committee and at the US House Committee on Ways and Means. Capretta is also a senior fellow at the Ethics and Public Policy Center. At AEI, he researches how to replace the Patient Protection and Affordable Care Act with a less expensive and more effective reform plan.

A Competitive Bidding Approach to Medicare Reform

Roger Feldman, Bryan Dowd, and Robert Coulam

Competitive Bidding—Bids for a specific package of health services are submitted by competing health plans operating in a unique geographic area, which are then used as a reference point to determine the amount of federal contributions to premiums. An enrollee can pay extra if she chooses a more expensive plan whose bid is above the government's contribution.

In this paper, the authors advocate implementing a competitive bidding process for Medicare health plans. The authors assert that this type of bidding would serve simultaneously as both a defined-contribution and defined-benefit model and suggest that competitive bidding is a better, more efficient way to establish care pricing in Medicare plans than an administrative pricing system based on historic claims data. They argue that the system would not "crowd out" traditional Medicare and envision a future where both government and private health plans coexist.

Although the authors suggest that implementing competitive bidding would be relatively easy, they advocate close monitoring and regulation during a transitional period to ensure companies do not set prices artificially high and protect beneficiaries facing increases in costs and premiums.

The authors conclude that competitive bidding, as a vehicle for determining prices for Medicare health plans, holds the promise of substantial cost savings while protecting the health care needs of beneficiaries, regardless of the political question of determining the size of the entitlement.

About the Authors

Roger Feldman is the Blue Cross Professor of Health Insurance and Professor of Economics at the University of Minnesota. His experience in health care policy includes serving on the senior staff of the President's Council of Economic Advisers, where he was the lead author of a chapter in the 1985 Economic Report of the President. From 1988 to 1992, he directed one of the four national research centers sponsored by the Centers for Medicare and Medicaid Services. He is on the Panel of Health Advisers for the Congressional Budget Office and consults for various federal and state agencies on health care–related matters.

Bryan Dowd is Mayo Professor in the Division of Health Policy and Management (HPM), School of Public Health, and cochair of the Program in Human Rights and Health at the University of Minnesota. His research interests include Medicare policy, markets for health insurance and health care services, and application of econometric methods to health service research problems. He is the principal investigator for the division's CMS Master Research and Demonstration contract, MedPAC master contract, and AHRQ/NRSA training grant. He currently serves as chair of the Methods Council of AcademyHealth and is a senior associate editor of the journal *Health Services Research*.

Robert Coulam is senior lecturer and director of the Center for Health Policy Research at the Simmons College School of Management. He was formerly a principal associate at Abt Associates, where he managed large-scale research and evaluation projects on Medicare and Medicaid policy issues. Coulam led the technical support team for Medicare's demonstration of competitive pricing for health plans in the late 1990s; he also led the early Centers for Medicare and Medicaid Services efforts to design a competitive pricing demonstration for durable medical equipment and has been active in research efforts supporting recent federal initiatives to reform the Medicaid and Medicare programs. His most recent publications focus on the technical, legal, and political problems of applying competitive pricing to Medicare.

Plan Competition and Consumer Choice in Medicare: The Case for Premium Support

Joseph Antos

Premium Support—Replace Medicare's current defined-benefit system with a defined-contribution approach that provides a fixed subsidy to cover the cost of enrolling in an available health plan. Beneficiaries would receive a government contribution to purchase coverage and then be responsible for any extra premium. This reform incorporates competitive bidding and expands on it to include features such as a capped subsidy that is adjusted according to the health risk of the beneficiary.

The author maintains that traditional Medicare's uncapped subsidy and reliance on fee-for-service payment promotes more spending on health services, not better spending. Legislation to reduce program cost has focused on reducing the prices paid for services. However, Congress has overridden cuts in physician fees called for by the sustainable growth-rate formula and is unlikely to enforce large payment reductions called for in the Affordable Care Act. The author argues that market competition can reduce unnecessary spending and still allow beneficiaries to select more expensive plans if they choose.

The challenge is to follow a path to reform that "does not require unsustainable political discipline" to be implemented. The author suggests a phased-in approach to premium support that would allow health care providers to adapt to the new system. He also suggests other reforms for traditional Medicare, which likely would remain competitive as a low-cost option in many markets. He concludes that plan competition and consumer choice can be effective in promoting high-quality care at an affordable price.

About the Author

Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. He also is a member of the Panel of Health Advisers for the Congressional Budget Office and recently completed two terms as a commissioner of the Maryland Health Services Cost Review Commission. His research focuses on the economics of health policy, including Medicare and broader health system reform, health care financing and the budget, health insurance regulation, and the uninsured.

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