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Medicare spending—again in the spotlight

The Social Security trustees released their annual report in May, and the news was not good for Medicare.

The Medicare hospital insurance trust fund, which last year had been projected to remain solvent until 2029, is now expected to run out of money by 2024. The five-year reduction in solvency is primarily attributable to the slow economy and the resulting smaller contributions from the Medicare portion of the wage tax.

Although the trust fund insolvency date is sooner than was projected after the passage of the Affordable Care Act, it is still seven or eight years later than had been predicted before its passage. However, like last year, the trustees and the Medicare actuary warned that the spending projections are likely to be underestimates because of the assumptions on which these projections are based—namely, that current law will be carried out—which experience suggests is questionable. This dubious optimism is especially problematic in the “out-year projections,” given the payment reductions to providers built into the Affordable Care Act—reductions that the Medicare actuary has predicted would cause Medicare payments to be less than Medicaid payments, thereby creating access problems for seniors.

The Responses

In what may be seen as a move in the “right direction” or at least, a “better direction,” both political parties have been developing strategies that would slow Medicare spending. The less encouraging observation is that these strategies are fundamentally different from each other in their focus and direction.

The Democrats. As evidenced by the Affordable Care Act, Democrats are primarily relying on reductions in payments to providers of Medicare services to slow spending—the strategy that has been used for the past several decades to slow spending in Medicare. There also is a limited attempt in the act to change providers’ incentives somewhat so that they will shift their behavior away from a fee-for-service mentality, in which revenue increases with the increasing complexity of the service delivered. Most of the potential for change is embedded in the yet-to-be developed or funded projects to be sponsored by the Center for Medicare and Medicaid Innovation. The Affordable Care Act’s provisions for value-based purchasing and accountable care organizations (ACOs) also could produce a limited amount of change. But the future for ACOs, in particular, is at best uncertain, given the strongly negative reaction to the recently released proposed rule.

Because the reliance on legislated payment reductions has not historically produced the slower growth rates in Medicare spending that would be needed to make the program fiscally solvent, the Affordable Care Act included the Independent Payment Advisory Board (IPAB) as a “fail-safe” strategy. The IPAB, whose work is to begin in 2015, is a group of 15 individuals who are to be confirmed by the Senate and, once confirmed, will be independent of the Congress and the administration. This board will be responsible for making recommendations to the Congress that would produce the spending reductions needed to achieve the spending rates desired for Medicare. Their oversight is limited to changes in provider reimbursements, however, and does not extend to changes in benefits, eligibility, or copayments for Medicare.

Although Congress is not required to accept the IPAB's recommended changes in payment, it must pass legislation producing comparable savings unless an alternative is supported by a supermajority. If Congress fails to act, the HHS Secretary is required to implement the recommendations of the IPAB. For its first several years, the IPAB is unlikely to have much effect because hospitals are exempted from its oversight until after 2020 and physician payments will continue to be in a state of turmoil due to pressures related to the sustainable growth rate. If, however, the IPAB remains in place, it could have a significant impact on payment rates and ultimately Medicare spending. The potential of the IPAB to produce significant savings was highlighted when President Obama referenced it as the mechanism that could slow Medicare spending to GDP plus 0.75 percent—a key element in his deficit reduction proposal.

The Republicans. Republicans, or at least the House Republicans, have adopted a very different strategy. As outlined by Rep. Paul Ryan (R-Wis.), Medicare would be converted into a defined-contribution plan that is similar to the Federal Employees Health Benefit Plan. It has also been described as a “premium-support” program. Everyone who is currently 55 or older would be grandfathered into the old Medicare program. Going forward, seniors would be provided with a fixed dollar subsidy—initially set at \$8,000 for beneficiaries who turn 65 in 2022, the first participants in the new Medicare program. This is the amount the Congressional Budget Office estimates Medicare will spend on a 65-year-old in 2022. The subsidy would increase with age, illness, and low-income level. Seniors would be offered a choice of private-sector plans that would have to be approved by the government. The government would ensure that the plans offer an appropriate set of benefits and that they do not discriminate against seniors because of age or health status.

The main constraint on spending growth under the Ryan plan is the rate of increase in the subsidy, which Ryan has set to follow the Consumer Price Index (CPI). The CPI has seen substantially

lower growth than the historical growth in Medicare, but it is a measure that would dramatically affect the fiscal solvency of the program as well as future pressures on federal spending. The intent in the Ryan plan is to use the pressures produced by competition among the plans to produce plans that would spend less on providing Medicare benefits—by reorganizing how care is provided and reimbursed and by giving seniors a financial interest in choosing such plans. Ryan and others have pointed to the new Part D Medicare program, which has produced so much competition among the private drug plans offered to seniors that it has resulted in spending that is approximately 40 percent less than had been predicted.

Harsh criticisms have been raised against the Ryan plan as “altering Medicare as we now know it.” The plan's supporters could respond to some of the more serious critiques by a “tweaking of the specifics,” such as easing the rate of increase in the subsidy to GDP plus 0.5 or 0.75 percent or making traditional Medicare available on a defined-contribution basis. One also could argue that the use of IPAB-imposed payment reductions to achieve a preset Medicare spending level also changes the essential nature of the Medicare program as we have known it—that is, as an open-ended entitlement program.

The Public's View

It is not clear that the public is ready to take on the serious debate that would be needed to define Medicare for the future. In general, Americans are worried about the debt and deficit, but according to a recent *Washington Post* poll, they are not willing to consider reductions in spending on Medicare, Medicaid, Social Security, or defense. But they are also worried that underpayments by Medicare to their providers will reduce quality and access. Budget pressures will not allow these discussions to be postponed indefinitely. But they probably will not occur any time before the 2012 elections. ●

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