The Rising Cost of Medicare

As with other sectors of the health care system, the cost of Medicare continued to rise in 2005, but at a somewhat lower rate than previous years. The Centers for Medicare and Medicaid Services (CMS) reported that, for 2005, the cost of Medicare reached $342 billion, which was an increase of 9.3 percent over 2004 expenditures. Medicare spending in 2004 was 10.3 percent higher than 2003. Medicare experienced slower growth in the cost of hospital care, physicians services, other outpatient services, nursing home care, and home health care. Spending on prescription drugs increased faster than overall Medicare spending. (Recall that Medicare prescription drug coverage did not begin until January 1, 2006. These figures do not include the added costs of that plan.) A summary report of health care spending in 2005 is available at www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf. More comprehensive data are available either in a report made available by the Medicare Payment Advisory Commission at www.medpac.gov/publications/congressional_reports/Jun06DataBook_Entire_report.pdf or in the following article:


Medicare continues to look for new ways to keep rising costs under control. For a number of years, the Prospective Payment System (described on pp. 73–74 in the book) helped restrain hospital costs under Medicare Part A. However, in recent years, hospital costs have been going
up again. Two recent articles provide an excellent discussion of options under consideration for reducing hospital costs in the future.


In addition, CMS is looking at ways to constrain the cost of new technologies, the use of expensive pharmaceuticals such as erythropoietin (used for patients with kidney failure), and the cost of cardiac care in private (often physician-owned) cardiac hospitals.


**Medicare and Managed Care**

On pp. 138–39 of the book, I describe the effects of changing the formula by which the federal government pays managed care alternatives to the traditional, fee-for-service Medicare program. In response to reducing capitation rates to approximately 90 percent of the average per patient cost in the traditional program, large numbers of managed care plans left the Medicare market, with corresponding reductions in the number of beneficiaries covered under managed care options.
In response to this declining participation and enrollment, the Bush administration changed the rate at which these “Medicare + Choice” or “Medicare Advantage” plans were paid. In order to encourage these private plans either to remain in the market or reenter the market, CMS established payment rates that were about 10 percent higher than the average per patient cost in the traditional program. The Bush administration was willing to pay managed care plans more than it cost in the traditional program to entice them to stay in the market. In June 2006, the American Medical Association reported that Medicare Advantage plans now costs 11 percent more than traditional Medicare (www.ama-assn.org/amednews/2006/06/26/gvbf0626.htm#3).

In response to the higher payments to private health plans under Medicare Advantage, many more plans entered the Medicare market. In 2002, there were 240 Medicare Advantage plans; by February 2007 that number had grown to 604. In 2003 there were 5.3 million Medicare beneficiaries enrolled in Medicare Advantage plans; by February 2007 the number of enrollees had grown to 8.3 million. (These data are from a report published by the Kaiser Family Foundation, available at www.kff.org/medicare/upload/2052-09.pdf.)

As part of the effort to expand the Medicare Advantage program, CMS created incentives for private, for-profit PPOs to enter the market. (Recall that Part B of Medicare is quite similar to the PPO model, with a list of participating providers and financial incentives to use those providers.) The Kaiser Family Foundation report cited above found that Medicare was paying these private PPOs 17–19 percent higher than the average per patient cost in the traditional program. In a report by the Government Accountability Office (GAO) titled, “Financial and Other Advantages for Plans, Few Advantages for Beneficiaries,” analysts found that CMS had “exceeded its [statutory] authority” in offering these plans incentive payments that were nearly twice the incentives paid to other private Medicare Advantage plans.
A story in the *New York Times* reported this finding, suggesting that these actions by CMS were, “further evidence that the government is paying private industry to take Medicare off its hands.”


**Changes in the Way Medicare Pays Physicians**

On pp. 136–38 in the book, I describe the policies adopted by CMS to establish a “sustainable growth rate” (SGR) in payments to physicians under Medicare Part B. The concept of the SGR is quite similar to policies adopted by most Canadian provinces as part of Canadian Medicare. If the volume or intensity of services provided by physicians goes up faster than the growth in the population and the growth in the economy overall, then future payments to physicians will be reduced to take into account these increases. In Canada, this policy has led over time to declining reimbursement rates for doctors. The question for the U.S. policy was, would the outcome here be the same: declining payment rates to physicians.

As cited in a 2005 report by the GAO, the volume and intensity of services provided to Medicare beneficiaries rose every year from 2000 through 2003, by an average of about 5 percent ([www.gao.gov/new.items/d05326t.pdf](http://www.gao.gov/new.items/d05326t.pdf)). Accordingly, to keep with the SGR formula, CMS should have reduced payments to physicians by an average of 5 percent each year from 2001 through 2004. However, each year the medical profession has been successful in lobbying Congress to eliminate the called-for reduction in payments (often substituting an increase in payments instead). Often the legislation eliminating the SGR-mandated reduction in fees is passed at the last minute, often only weeks before the reduction is supposed to take effect.
By eliminating the called-for reductions on a year-by-year basis without changing the SGR law, Congress has only delayed a final reckoning. The SGR law continues to keep track of the continuing rise in the volume and intensity of services provided by America’s physicians to Medicare beneficiaries and has projected future fee reductions to make up for past excesses. If the mandates of the law were actually carried out, physicians would see major reductions in the amount they receive from Medicare, for a period of years. This realization has led the Medicare Payment Advisory Commission, the body charged with oversight of the Medicare payment system, to issue a report calling for either elimination or major restructuring of the SGR program (www.medpac.gov/publications/congressional_reports/Mar07_SGR_mandated_report.pdf).

The continuing problems with the SGR highlight a fundamental flaw in the Medicare system—a flaw that has always been part of systems that rely on fee-for-service (FFS) payment for services. Under FFS, there is no incentive or mechanism that encourages providers to make considered judgments about cost/benefit tradeoffs when deciding what care to apply at the margins. Such a system assumes an open-ended supply of funds. If, in fact, the system has a fixed pool of resources on which to draw, a decision to use more care by one provider will necessarily mean less care to the patients of other providers—either that or lower fees paid to the providers (as the SGR mandates). It appears that the American medical profession may need to take stock of this reality and identify a payment mechanism that will permit the Medicare program to meet its dual goals of providing high-quality care to its beneficiaries while keeping costs within a sustainable rate of growth.

Assuring High Quality of Care under the Medicare Program

While the cost of the Medicare program has been the focus of increasing attention, a
second strong focus has developed over the past several years: maintaining the quality of care provided under the Medicare system. The Bush administration and the CMS have adopted policies intended to tie the level of payment to providers to the quality of care provided. A series of recent articles has described this new “pay-for-performance” approach, suggesting that such an approach may have strengths as well as weaknesses:


For those interested in recent research on pay-for-performance, I list below a series of research articles that have recently been published.


The Financial Future of Medicare

In April 2007, the Trustees of the Medicare program issued their annual report (www.ssa.gov/OACT/TRSUM/trsummary.html). In it, they used the best available data on future population trends and future health care costs to predict future financial conditions for Medicare. A number of the findings in the report raise serious concerns about the fiscal stability of Medicare.

- Beginning in 2007, tax revenues will, for the first time, be insufficient to pay for care under Part A of Medicare (principally hospital care), necessitating that the Trustees use interest on the Part A Trust Fund (discussed on p. 116 of the book) to meet expenses.
- Beginning in 2011, Part A expenditures will exceed taxes and Trust Fund interest combined, necessitating the use of the principal in the Trust Fund to pay for care.
- In 2019, the Part A Trust Fund will be exhausted, necessitating the use of only tax funds to pay for care. Tax funds in that year are projected to be sufficient to pay for only 79 percent of care provided.
- In 2006, 12.3 percent of all federal tax revenues were required to pay the government’s
share of services provided under Part B of Medicare. In 15 years, this percentage of all federal tax revenues required to sustain Part B will nearly double.

The projections of future cost increases included in this year’s report have triggered what is referred to as a “funding warning”—a warning to the president, required by law, that the future financial stability of Medicare is at risk. Under the law, the president is required to propose legislation for Congress to consider to remedy this situation.

As part of the Trustees’ report, the two Public Trustees of the Medicare system—trustees who are not part of the current administration and whose task is to represent the broad public benefit—have issued the following warnings: “In the absence of reform that greatly restrains these cost increases, taxes on the working age population and out-of-pocket payments by beneficiaries will both have to rise far faster than incomes in the decades ahead . . . Our citizenry has demonstrated a strong propensity over the past half-century to increase the share of income spent on health care, and there is, as yet, no clear evidence of when, or even how, this trend might abate. But if it does not do so soon, then the bleak fiscal picture portrayed in these reports will be bleaker still.”