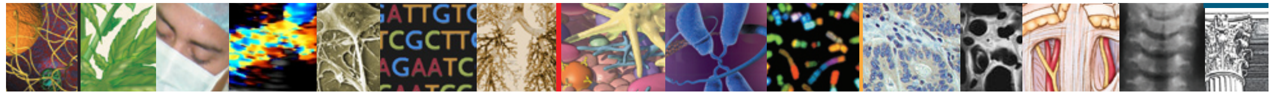

The NEW ENGLAND JOURNAL of MEDICINE

Perspective
JULY 8, 2010

Implementing Health Care Reform — Why Medicare Matters

Robert A. Berenson, M.D.

Despite the major achievements of the Patient Protection and Affordable Care Act in providing health insurance for more than 30 million Americans and regulating objectionable insurance-company practices, its opponents alleged throughout the health care reform debate that it would negatively affect Medicare beneficiaries. Although nothing in the law (now being referred to simply as the Affordable Care Act, or ACA) grants government the authority to ration care for these patients — to "pull the plug on Granny," as Senator Charles Grassley (R-IA) put it — Medicare is in fact central to the legislation. Indeed, more than half of the $938 billion price tag mostly for expanding coverage for low-income individuals will be paid from decreased Medicare spending,[1] which will also extend the solvency of the Medicare Part A trust fund by 12 years, to 2029.[2]

A new Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS) will develop, test, and implement new payment approaches supporting innovations in the organization of health care delivery, such as medical homes and accountable care organizations, to help contain Medicare and Medicaid spending and to serve as models for commercial insurers. But the currently projected savings come from two main sources: reduced payments to private Medicare Advantage plans and reduced payment updates for hospitals and most other providers. A phased elimination of the substantial overpayments to Medicare Advantage plans, which now enroll nearly 25% of Medicare beneficiaries, will produce an estimated $132 billion in savings over 10 years. Since health plans have used the extra payments to enhance benefits packages and entice beneficiaries to leave traditional Medicare, the reductions will not be painless; payment cuts in the Balanced Budget Act of 1997 led to health plans' withdrawing from Medicare and benefit cuts that made plan offerings less attractive, which together resulted in a 25% reduction in private-plan enrollment. CMS Chief Actuary Richard Foster projects that the ACA cuts will cause a decline in Medicare Advantage enrollment of one third by 2017.[2] The Medicare Payment Advisory Commission (MedPAC) has been calling for such fee reductions for years,[3] to keep Medicare Advantage from undermining traditional Medicare.

The ACA also produces nearly $200 billion in savings by assuming that providers can improve their productivity as firms in

The New England Journal of Medicine
Downloaded from nejm.org on February 13, 2012. For personal use only. No other uses without permission.
Copyright © 2010 Massachusetts Medical Society. All rights reserved.

other industries have done. On the basis of this presumed improvement, the law reduces Medicare's annual "market basket" updates for most types of providers — a provision that has generated controversy. Foster believes that many providers will not be able to improve their productivity to the required degree and questions whether the payment reductions will stick after providers plead their cases to Congress.[2] On the other hand, there is evidence that hospitals and physicians facing reduced Medicare payments can shift costs to commercial payers — a strategy that could negate the law's potential for reducing health care spending and increase scrutiny of Medicare as a poor payer because of the growing differential between Medicare and commercial-insurance payment rates.

During the reform debate, opponents of a Medicare-like public option frequently asserted that Medicare is a poor payer, covering only 80% of physicians' practice costs. But that argument assumes that generous physician incomes are "practice costs." A recent simulation of physician compensation showed that if all payers used the Medicare fee schedule, physicians would earn an average of $240,000, with cardiologists earning $450,000, and radiologists $390,000.[4] These compensation levels are poor only in comparison to what some physicians can get from commercial payers and directly from patients (current actual compensation for these physicians is $273,000, $483,000, and $488,000, respectively); the problem lies with providers' growing market power over the prices negotiated with commercial insurers. This problem suggests that we ought to consider setting all-payer rates for providers, but the country's antigovernment mood renders such a discussion unlikely, at least for now. Meanwhile, Medicare beneficiaries could experience problems obtaining important physician services, as physicians seek the greener pastures of the privately insured, turning away Medicare patients as they do Medicaid patients.

Concern that Congress seems incapable of making tough decisions to reduce Medicare spending inspired an extensive debate about creating a "super-MedPAC" — an independent panel with the authority to reduce Medicare spending. The ACA produced a compromise — the Independent Payment Advisory Board (IPAB) — which will start making recommendations in 2014. Initially, in any year in which the increase in Medicare's per capita spending rate exceeds the average of the growth in the Consumer Price Index (CPI) and that of the medical care CPI, the IPAB would be required to recommend spending reductions for Medicare. These recommendations would become law unless Congress passed an alternative proposal achieving the same savings.

The board's role is carefully circumscribed, however. Its jurisdiction is limited to payment — it is expressly prohibited from recommending increasing revenues; changing benefits, including patient cost sharing; or altering program eligibility. Furthermore, hospitals, the largest recipient of Medicare payments, are exempt from IPAB oversight until 2020. In short, the IPAB is not actually allowed to be a super-MedPAC, but its shackles might be loosened if Congress cannot address the mounting fiscal threat posed by unchecked growth of federal entitlement programs.

On another track, the suggestion that as much as 30% of Medicare spending is wasted figured prominently in the reform debate. Legislators from lower-spending U.S. regions invoked Dartmouth Atlas research on geographic variation in arguing that current payments are unfair because apparently inefficient providers receive more money than efficient ones. They sought payment penalties for high-spending areas and increases for low-spending areas. Representatives from high-spending areas objected, citing information suggesting that the Dartmouth data are insufficiently adjusted for differences in patients' underlying health and socioeconomic status and that they ignore needed price adjustments for providing graduate medical education or caring for a disproportionate share of Medicaid and uninsured patients.[5] Further complicating the policy analysis is the difference between absolute per capita spending and rates of increase in spending: a low-spending geographic area might well have a relatively high rate of increase — which might be reasonable, as it attempts to catch up.[5] For some policy purposes, the base spending differences might be relevant, but for purposes of bending the curve, rates of spending growth are probably more important.

The legislation does not settle this issue but seeks further analysis to help formulate policies to reward providers for value. In addition, Secretary of Health and Human Services Kathleen Sebelius is commissioning the Institute of Medicine to study geographic variation and to recommend ways to

The New England Journal of Medicine
Downloaded from nejm.org on February 13, 2012. For personal use only. No other uses without permission.
Copyright © 2010 Massachusetts Medical Society. All rights reserved.

incorporate quality and value metrics into the Medicare reimbursement system.

From yet another quarter have come complaints that current payment methods penalize efficient providers for offering high-value care and that more pilots and demonstrations, administered by the new CMS innovation center, represent unaffordable temporizing. In particular, some of the multispecialty group practices that have been held up as prototypes of the organizations that new payment models should encourage, including Mayo Clinic and Cleveland Clinic, have expressed frustration with the current volume-based payment approaches for hospitals and physicians. Although some consider the volume-generating incentives of current payment systems so perverse that they would not spend much time correcting existing mispriced values, these payment systems will probably be with us for some time. Moreover, some of the new payment approaches being promoted — for example, bundled payment for an episode of care — will probably build on the current prices. And it is unlikely that highly compensated physician specialties that are thriving under the fee-for-service system will voluntarily participate in the envisioned accountable care organizations that require multispecialty cooperation. Paradoxically, it will be necessary to correct mispricing and other flaws in existing fee-for-service payment systems in order to ultimately dismantle them.

Finally, there was hope that Congress would end the saga of the sustainable growth rate (SGR), the formula used to calculate Medicare's physician-fee updates, which has been consistently overridden and should now produce immediate 21% fee cuts to physicians, another 6% next January, and a few percent more after that. The House initially attempted to settle the SGR problem by taking all the past fictional savings off the budget books, but since a real fix would have added more than $200 billion to the cost of reform, the provision disappeared when President Obama limited the legislation's cost to $1 trillion. The SGR can continues to be kicked down the road. It seems that the more things change, the more they stay the same.

Dr. Berenson is vice-chair of the Medicare Payment Advisory Commission (MedPAC); the views expressed in this article represent his personal views and not necessarily those of MedPAC.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Urban Institute, Washington, DC.

This article (10.1056/NEJMp1005588) was published on May 26, 2010, at NEJM.org.

1. Elmendorf DW. Letter to Nancy Pelosi. March 20, 2010. (Accessed May 24, 2010, at http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf.)
2. Foster RS. Estimated financial effects of the "Patient Protection and Affordable Care Act," as amended. Baltimore: Centers for Medicare & Medicaid Services, April 22, 2010. (Accessed May 24, 2010, at http://thehill.com/images/stories/whitepapers/pdf/oact%20memorandum%20on%20financial%20impact%20of%20ppaca%20as%20enacted.pdf.)
3. The Medicare Advantage Program. In: Issues in a modernized Medicare program: report to the Congress. Washington, DC: Medicare Payment Advisory Commission, June 2005;59-83.
4. Berenson R, Zuckerman S, Stockley K, Nath R, Gans D, Hammons T. What if all physician services were paid under the Medicare fee schedule? An analysis using medical group management association data. Washington, DC: Medicare Payment Review Commission, March 2010. (Accessed May 24, 2010, at http://www.medpac.gov/documents/Mar10_Physician_FeeSchedule_CONTRACTOR_v2.pdf.)
5. Measuring regional variation in service use. Report to the Congress. Washington, DC: Medicare Payment Advisory Commission, December 2009.

Copyright © 2010 Massachusetts Medical Society.

The Independent Payment Advisory Board

Timothy Stoltzfus Jost, J.D.

A common theme in the health care reform debate in recent years has been the need for a board of impartial experts to oversee the health care system. Market forces alone, it is argued, cannot control health care costs, and Congress is too driven by special-interest politics and too limited in expertise and vision to control costs.

Provisions of the Patient Protection and Affordable Care Act (now being referred to as the Affordable Care Act, or ACA) create an Independent Payment Advisory Board (IPAB) to meet the need to oversee health care system costs.[1] The legislation establishes specific target growth rates for Medicare and charges the IPAB with ensuring that Medicare expenditures stay within these limits. The IPAB must also make recommendations to Congress as to how to control health care costs more generally.

The New England Journal of Medicine
Downloaded from nejm.org on February 13, 2012. For personal use only. No other uses without permission.
Copyright © 2010 Massachusetts Medical Society. All rights reserved.