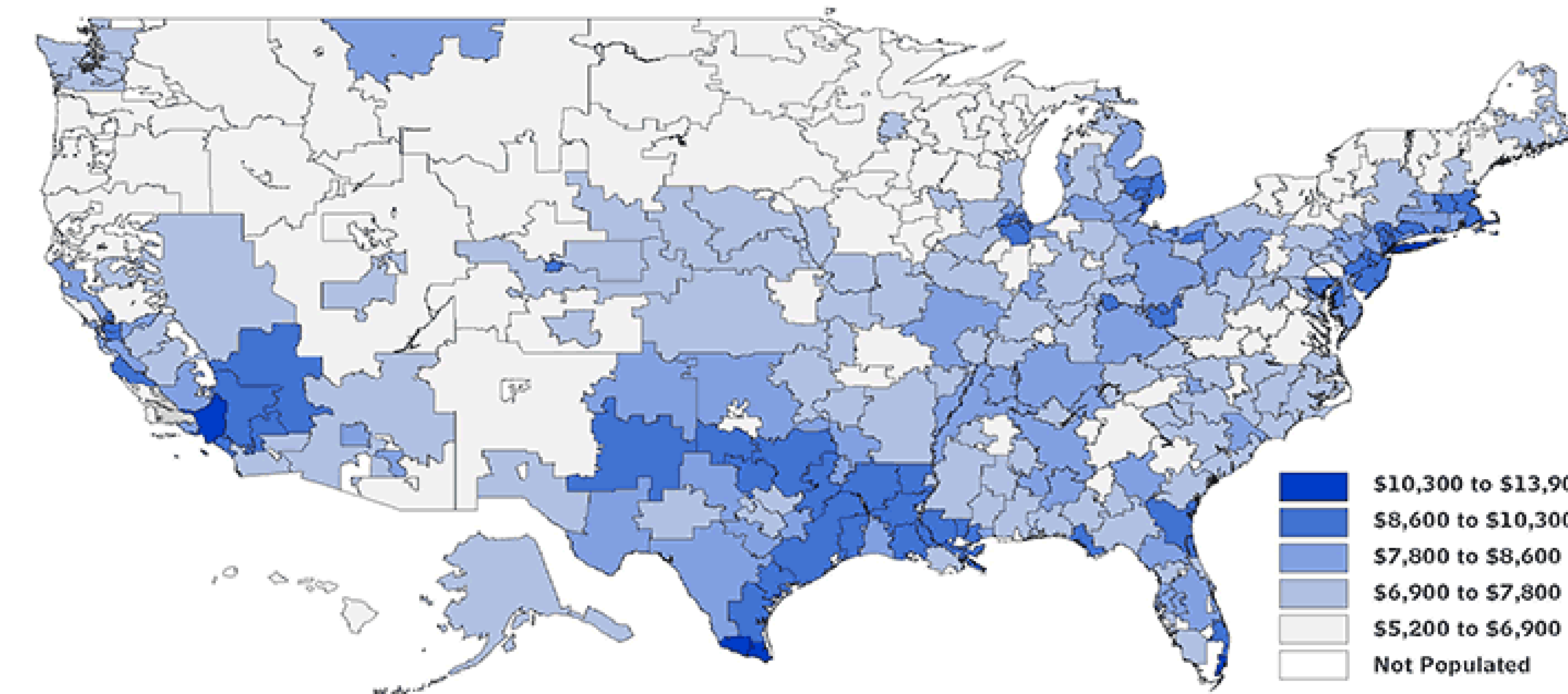


Medicare & Medicaid Reform: Ensuring Long-Term Solvency

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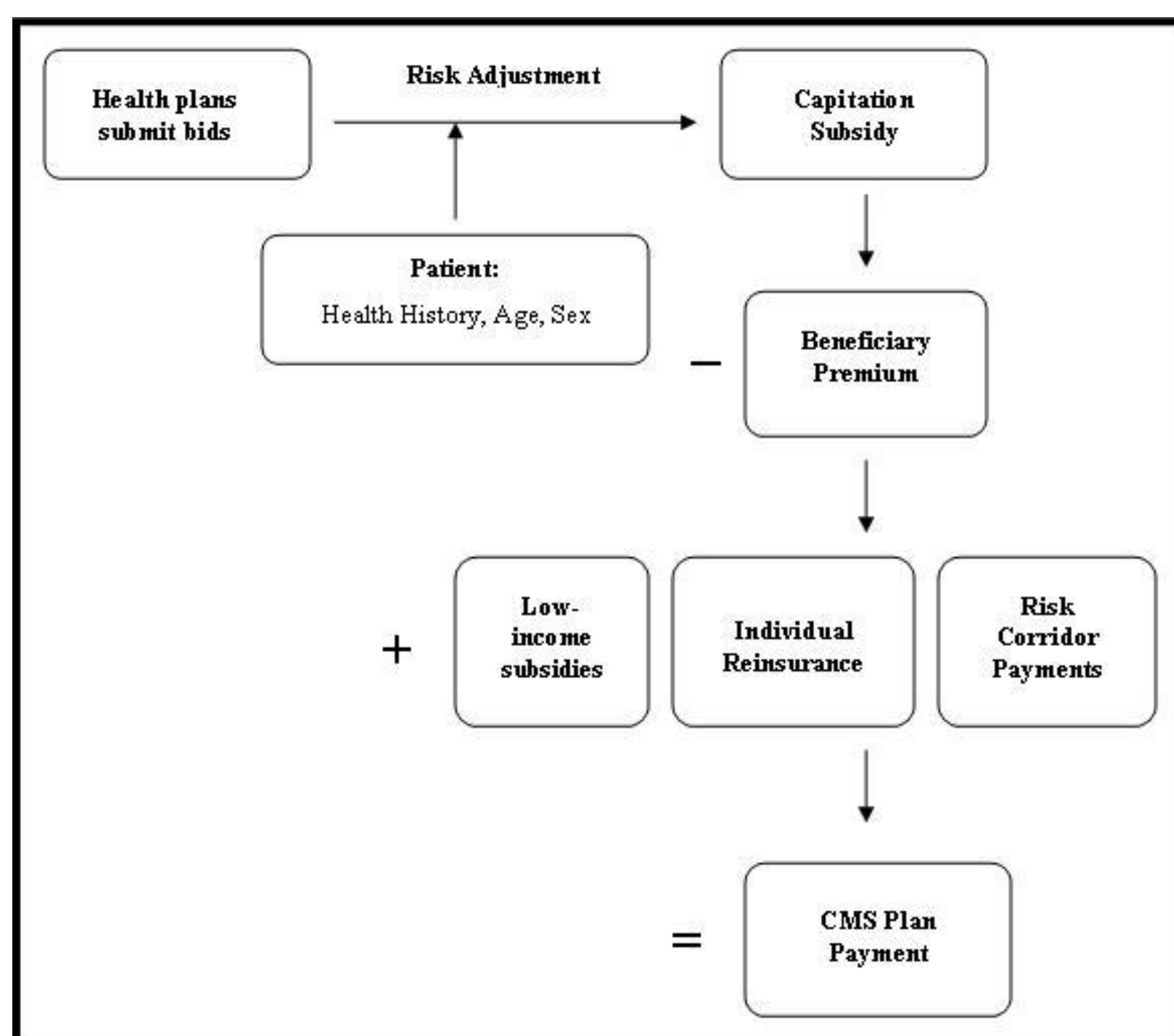
Across the United States, inefficiency in medical service delivery is underscored by the enormous geographic variation of per beneficiary Medicare spending. For example, Medicare spending on chronically ill patients – those suffering from diseases like cancer, heart disease, and diabetes – in the last two years of life ranges from an average of \$93,842 at U.C.L.A. Medical Center to \$53,432 at the Mayo Clinic’s Minnesota hospital. Most of the discrepancies in regional expenditures can be explained not by the price of the service but by the number of health care services consumed. Furthermore, the increases in hospitalizations and doctor’s visits in high-spending areas did not result in enhanced health outcomes. Many experts believe that without impairing health outcomes Medicare could save 30 percent if medical providers in high- and medium-spending areas were as efficient as those in low-cost regions.

Health care in the United States annually consumes over \$2 trillion, 16 percent of the nation’s gross domestic product. Medical spending is growing faster than the economy. These ballooning expenditures are compounded even further by a demographic wave as 78 million baby-boomers age, retire, and become eligible for Medicare. Medicare’s liabilities will exceed revenues by \$36 trillion over the next 75 years. In fact, spending on Medicare and Medicaid is expected to account for 13 percent of national income by 2040.

Moreover, the expenditures associated with Medicare and Medicaid do not necessarily achieve better health outcomes, demonstrating a lack of cost-effectiveness in America’s health care system. In 30 clinical categories which account for half of the reasons people seek care, only 55 percent of proven-effective therapies are administered to patients who need them. Health care providers did not perform the other procedures and failed to meet the rest of the evidence-based medical benchmarks. Medicare insures the recommended treatments, yet adherence to these quality indicators did not significantly vary between Medicare and non-Medicare patients. As the largest purchasers of health services in the United States, Medicare and Medicaid have the singular opportunity to use their substantial market clout to develop new cost and quality measures to leverage improvements in the entire medical delivery system.

Variable	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)*
Overall care	439	6712	98,649	54.9 (54.3–55.5)
Type of care				
Preventive	38	6711	55,268	54.9 (54.2–55.6)
Acute	153	2318	19,815	53.5 (52.0–55.0)
Chronic	248	3387	23,566	56.1 (55.0–57.3)
Function				
Screening	41	6711	39,486	52.2 (51.3–53.2)
Diagnosis	178	6217	29,679	55.7 (54.5–56.8)
Treatment	173	6707	23,019	57.5 (56.5–58.4)
Follow-up	47	2413	6,465	58.5 (56.6–60.4)

* CI denotes confidence interval.



Medicare and Medicaid should no longer remain an open-ended, fee-for-service program that entitles beneficiaries to health care services. This proposal incorporates a premium support model into Medicare and Medicaid; the government programs would no longer pay providers but instead make capped per person (capitation) payments to health plans. Every year, private plans would submit bids to the Centers for Medicare & Medicaid Services (CMS). Plans would project the expenses incurred for insuring a beneficiary of average health and then use that projection to make bids. The agency uses the bid amount to make modified payments based on the actual health status of each participant.

After aggregating the bids, the agency ascertains a nationwide average. A standard premium will be established as some percentage of the average bid. Beneficiaries will pay the calculated standard premium plus or minus any differential between their plan’s bid and the national mean. Low-income participants would receive subsidies to pay for plan premiums and other charges. Since consumers pay the differential between the plan’s bid and the national average, plans that submit bids below the nationwide mean can offer lower premiums and woo more beneficiaries. This would enable beneficiaries to keep more of the savings when they use a less costly plan that fulfills their medical needs. As cheaper plans gain market share, the weight of their bids will increase, restraining overall growth in the nationwide average bid. The bidding process is engineered to place perpetual downward pressure on health care expenditures, reducing CMS’ payments to health plans.

For each enrollee, CMS would reimburse the health plan to cover a certain percentage of the basic benefit. This reimbursement would be manifested in the form of capitation subsidies, individual reinsurance, and risk corridor payments.

Capitation Subsidy: In a capitation subsidy, the agency makes a risk-adjusted, prospective, fixed payment to plans as a share of the national average of plan bids. Insurance groups would be compensated on a risk-adjusted basis that takes into account a beneficiary’s age, sex, and health history. On balance, health plans would be reimbursed more if they provided coverage to sicker, elderly participants and less for younger, healthier ones.

Individual Reinsurance: With individual reinsurance, CMS provides an additional, retrospective payment by subsidizing the vast majority of spending above the catastrophic limit, giving insurers a stronger incentive to enroll high-cost patients.

Risk Corridors: Risk corridors would cap the losses or gains of each plan. If a plan’s actual benefits exceeded its bid, CMS would subsidize a portion of the losses. Conversely, if a plan’s expenditures were below the bid amount, the agency reserves the right to limit the plan’s profits. Proposed risk corridors could be broadened over time to make health plans gradually bear more of the risk.