

2006 Annual Report Medicare's Future

For more than 40 years, Medicare has helped the nation's elderly and disabled obtain the health care they need, while protecting the most vulnerable among them from financial hardship. Medicare faces many challenges as it begins its fifth decade, as program costs continue to rise and its beneficiaries' needs continue to evolve. Through its Program on Medicare's Future, The Commonwealth Fund works to:



Stuart Guterman
Senior Program Director

- enhance Medicare's ability to carry out its traditional mission of ensuring access and affordability.
- identify ways in which Medicare can become more effective and efficient, so that it can serve both as an example and a means of disseminating better performance throughout the health care system.



The Fund's Program on Medicare's Future is exploring how Medicare can encourage better performance throughout the health care system. Recently, the Fund and the Centers for Medicare and Medicaid Services brought together participants in the Medicare Physician Group Practice Demonstration to share strategies and refine approaches. The three-year demonstration offers practices the opportunity to earn performance payments for improving their efficiency and quality of care.

The Medicare Modernization Act of 2003 made major changes to the Medicare program, adding a new Part D prescription drug benefit and expanding the role of private plans through the new Medicare Advantage option. Many Medicare beneficiaries who previously lacked drug coverage were able to obtain it under Part D. But low-income beneficiaries who previously were

covered under Medicaid have had to cope with an abrupt transition to a very different Medicare program; others who were without drug coverage, meanwhile, have not yet enrolled in Part D.

Medicare drug coverage is available only through private plans—either standalone prescription drug plans, available for those enrolled in traditional Medicare, or Medicare Advantage drug plans, available for those enrolled in Medicare managed care. Medicare Advantage added several new features to Medicare, including regional preferred provider organizations, special-needs plans, and a bidding process intended to generate lower plan premiums and program savings.

Apart from these legislated changes, Medicare faces increasing pressure to increase the quality, appropriateness, and efficiency of the care provided to beneficiaries. Currently, officials are seeking to develop approaches that encourage these improvements through the program's payment and regulatory mechanisms. Over the past year, the Fund has been monitoring the impact of these changes on Medicare beneficiaries, identifying areas of concern, and developing appropriate policy options.

The Prescription Drug Benefit: Year One

The prescription drug benefit, launched in January 2006, fills a serious gap in essential coverage for beneficiaries, particularly those with low incomes or chronic illnesses. As of the end of the first open enrollment period, 22.5 million beneficiaries were enrolled in standalone prescription drug plans or in Medicare Advantage drug plans. The U.S. Department of Health and Human Services has estimated that another 15.8 million beneficiaries have comparable coverage through an employer plan or alternative source.¹ Still, more than 4 million beneficiaries—approximately 10 percent of the Medicare population—lack prescription drug coverage. Moreover, some three-quarters of those uncovered beneficiaries have low incomes and so are particularly vulnerable to the financial burden of high drug costs.

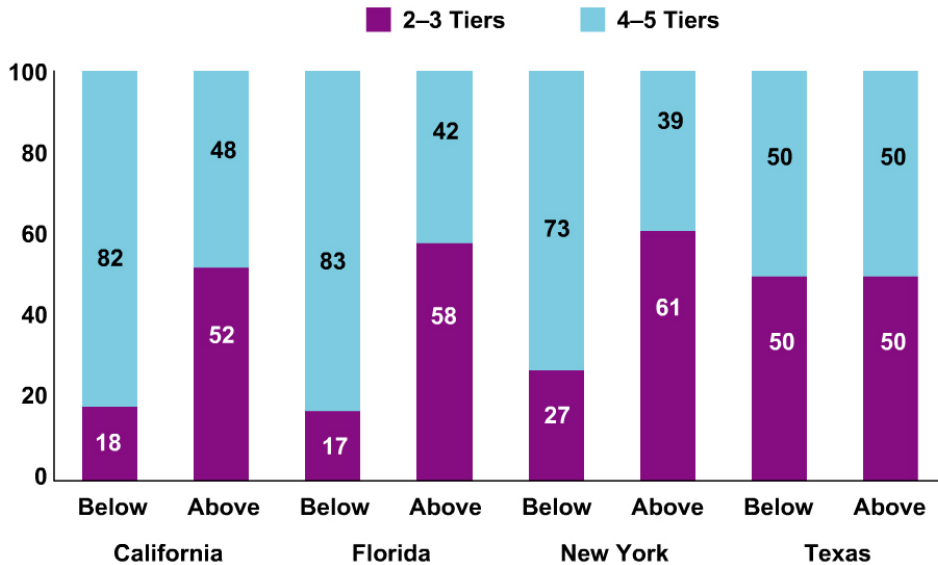
Several projects supported by The Commonwealth Fund have examined how the Part D benefit will affect beneficiaries' access to, and use of, medications prescribed by their doctors. A Fund-supported research team led by the University of Maryland's Bruce Stuart, Ph.D. examined prescription drug utilization and coverage prior to enactment of Part D among beneficiaries residing in nursing homes—a population with a high need for prescription medications. Of this group, 20 percent had no drug coverage, while another 60 percent had drug coverage through Medicaid (which no longer applies to Medicare beneficiaries beginning in 2006). These findings indicate that Part D will be extremely important to ensuring access to needed medications for this vulnerable group.²

An analysis of private drug plan benefit designs and formularies in the four most populous Medicare states, led by Tanisha Carino, Ph.D., of Avalere Health, revealed wide variation in rules requiring enrollees to obtain prior authorization for medications, as well as in the number of drugs covered. In particular, plans with lower premiums tended to have a greater number of formulary tiers. The researchers found that the high copayments in some of these tiers can hinder access to certain drugs—typically, those that are more expensive.

For plans with below-average premiums (into which Medicaid beneficiaries were automatically enrolled), average copayments in New York range from \$6 for tier 1 to \$69 for tier 4. Across the four states, 70 percent of plans with below-average premiums had more than three tiers, and 45 percent of plans with premiums above the benchmark had more than three tiers. The researchers recommend that indicators of beneficiary access to needed drugs be part of overall Part D performance measures.³

Private Medicare drug plans with more formulary tiers tend to charge lower premiums than plans with fewer tiers.

Percent of plans in state charging premiums below and above state benchmark



Source: N. Heaton, T. Carino, H. Dix, *Assessing Medicare Prescription Drug Plans in Four States: Balancing Cost and Access* (New York: The Commonwealth Fund, Aug. 2006).

Fund-supported researchers have been monitoring another trouble spot: the Part D subsidy designed to help low-income beneficiaries’ meet their share of drug expenses. A review conducted by the Social Security Administration in January 2006 showed that more than half of applicants who qualified for the subsidy on the basis of their income were denied because their financial assets were above the maximum threshold allowed.⁴ The most common sources of “excess” resources were modest bank accounts, in many cases opened in anticipation of health-related expenses later in life. But according to Fund-sponsored research conducted by Dennis Shea, Ph.D., of Pennsylvania State University, low-income beneficiaries who fail to meet the Part D’s asset test have similar rates of chronic conditions and out-of-pocket spending to those beneficiaries who qualify for extra help.⁵ Shea and colleagues noted that the similarities raise questions about the fairness of the means-testing and recommended that policymakers monitor these groups carefully.

Georgetown University’s Laura Summer and colleagues have been gathering data from people who work with beneficiaries across the country to identify additional problem areas and potential solutions.⁶ In addition to issues surrounding the low-income subsidy, Summer and her colleagues point out that Part D rules may make it too costly for many beneficiaries to continue

receiving long-term care in community settings rather than in nursing facilities, where residents are protected from copayments and other drug costs. Eliminating the copayment requirements for community-dwelling “dual eligibles” (low-income Medicare beneficiaries who were previously enrolled in Medicaid), as some in Congress have proposed, would be one way to allow such individuals to avoid institutionalization. Another serious issue—and one that affects all beneficiaries—is the general lack of assistance with using the new drug benefit, including accurate, easy-to-use information about private drug plan options, and help with applying for the low-income subsidy and enrolling in a plan.

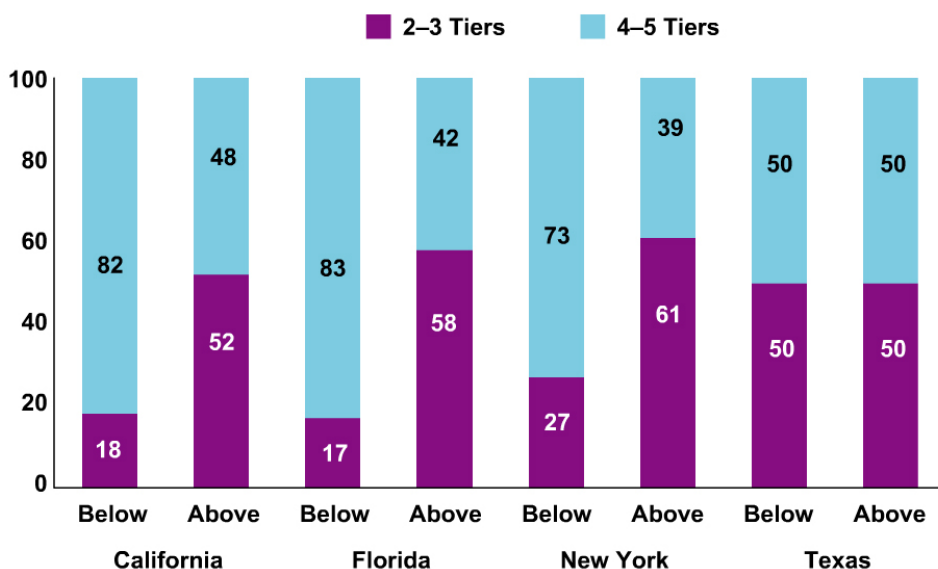


Laura Sumner
Georgetown University

Expanded Role of Private Plans

Through its grantmaking, The Commonwealth Fund has examined the impact of private plans on Medicare beneficiaries’ access to care and out-of-pocket costs. Fund-supported researchers have documented the enormous variation in out-of-pocket costs for beneficiaries who choose various private Medicare plans—information that has been cited by members of Congress in their communications with the Secretary of Health and Human Services.⁷ George Washington University’s Brian Biles, M.D., and colleagues estimated that annual out-of-pocket spending for Medicare Advantage enrollees in poor health range from less than \$1,400 to more than \$7,500.⁸ Speaking at a Fund-sponsored Alliance for Health Reform briefing, the study’s authors recommended permitting beneficiaries to switch plans with 30 days’ notice, making Medicare Advantage benefit packages more standardized, and better protecting enrollees from high out-of-pocket costs.

Payments to Medicare Advantage plans in 2005 averaged 12.4 percent more than costs in traditional Medicare, an extra \$922 per enrollee.



Source: B. Biles et al., *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised* (New York: The Commonwealth Fund, Nov. 2006).

Additional research by Biles and his team found that private Medicare Advantage plans received payments from the government in 2005 that exceeded expected fee-for-service payments for the same enrollees by an estimated \$5.2 billion.⁹ Armed with this evidence, both Democrats and Republicans have developed proposals to redirect some of this money to fund other policy initiatives, such as improvements in beneficiary coverage or deficit reduction. Already deep into the next phase of Fund-sponsored research, the research team is exploring geographic variations in Medicare Advantage benefit packages and their relationship to plan payment rates, with a focus on new special-needs plans, which target specific groups of enrollees (e.g., Medicare/Medicaid “dual eligibles” and beneficiaries with certain chronic conditions), and private fee-for-service plans, which provide the traditional Medicare benefit package through private plans.

Financial Aid for Low-Income Seniors

Through Medicare Savings Programs, states provide extra help to low-income beneficiaries by paying their Medicare premiums and, in one of the programs, cost-sharing. Fewer than one of three eligible individuals, however, is enrolled in them. Similarly, about three-quarters of Medicare beneficiaries without any drug coverage are believed to be eligible for the Part D low-income subsidy.¹⁰

Fund-supported researchers at the National Academy of Social Insurance examined ways to facilitate enrollment in these valuable programs. At an Alliance for Health Reform briefing, they presented a number of recommendations to congressional staffers—among them, simplifying and aligning programs for low-income beneficiaries, enhancing federal participation in the programs, and adopting uniform methods for counting income and resources.¹¹

Fund support also helped the State Solutions National Program Office at Rutgers University assist Minnesota in its efforts to increase enrollment in its Medicare Savings Program. The Rutgers staff conducted more than 1,800 education and enrollment sessions at community venues, many located in minority communities. These efforts yielded tangible results: enrollment of eligible Native Americans in Minnesota, for example, rose 11 percent.

Increasing Value and Efficiency

A wide and potentially confusing array of health plan options confronts Medicare beneficiaries. With Fund support, Jack Hoadley, Ph.D. of Georgetown University is addressing the issue. In December 2005, Dr. Hoadley and colleagues convened an expert panel—comprising industry members, advocates, researchers, and insurance regulators—to discuss greater standardization in Medicare Advantage. This discussion, together with another meeting held in September 2006, will be used as a basis for developing options for achieving this objective.



Jack Hoadley, Ph.D.
Georgetown University

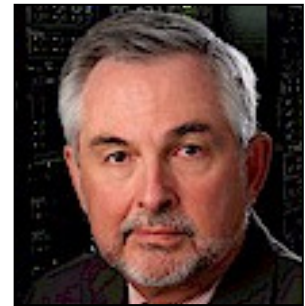
In an effort to reduce the fragmentation in seniors' health coverage, work on developing a comprehensive benefit option for Medicare—a new Part E—continues. As originally envisioned by Commonwealth Fund president Karen Davis and colleagues in an October 2005 *Health Affairs* article,¹² beneficiaries who would choose to enroll in the option—which they named “Medicare Extra”—would no longer need to purchase a private drug plan, in addition to Medigap supplemental coverage, to meet their coverage needs.

The Fund is also supporting efforts to improve the value Medicare gets for the money it spends. In April 2005, CMS launched the Physician Group Practice Demonstration, Medicare's first pay-for-performance initiative for physicians. Projected to run through March 2008, the program provides incentives for large, multi-specialty group practices to improve the coordination of care for their fee-for-service beneficiaries. Ten PGP sites serving upwards of 200,000 beneficiaries have projects under way to test improvements to data systems, care management programs, and coordination-of-care efforts, among other interventions that Medicare does not directly reimburse. In April 2006, leaders from each site met with CMS officials to share their experiences and strategies.¹³ Participants will be able to use information learned about what works, and what does not, to refine their approaches during the demonstration's remaining two years.

Fund grantees are also assessing the potential of value-based purchasing strategies to improve care and efficiency. For example, the Urban Institute's Robert Berenson, M.D., and his staff have been working with purchasers, providers, and federal and state regulators to see how the pay-for-performance approach might mesh with Medicare's system for compensating physicians. Many stakeholders agree that pay-for-performance should proceed in areas where there is underuse of recommended care, and where validated measures to profile and reward performance exist.

In invited testimony before the House Energy and Commerce Committee's Subcommittee on Health in July 2006, the Fund's Stuart Guterman emphasized that Medicare can use its role in financing health care to improve the performance of the Medicare program and the health care system as a whole.¹⁴ “Determining how much to pay physicians certainly is an important issue,” Guterman said, “but determining how to pay physicians so Medicare beneficiaries get the best care possible is of at least equal importance.” Noting the marked deficiencies in quality and coordination of care throughout health care, he argued for paying greater attention to what the nation receives for the money it devotes to health care.

In addition to financial incentives to support quality improvement in Medicare, there is a need for objective, reliable evidence of the benefits, risks, and costs of new medical procedures and technologies to support decision-making on the part of patients, clinicians, payers, and



Glenn Steele, Jr., M.D.
Member, Commission
on a High Performance
Health System
Dr. Steele is president
and CEO of Geisinger
Health System in
Pennsylvania. Geisinger
is one of 10 organizations
participating in Medicare's
Physician Group Practice
Demonstration.

policymakers. In a Fund-supported *Health Affairs* Web Exclusive, Gail Wilensky, Ph.D., called for the creation of an entity to generate, collect, and disseminate comparative information about the effectiveness of health care treatments.¹⁵ Wilensky will next examine the necessary policy conditions for realizing such a vision. The Fund will also support the development of a framework for identifying, disseminating, and applying better evidence for coverage, payment, and clinical decision-making.

Columbia University's William Sage, M.D., J.D., and Indiana University's Eleanor Kinney, J.D., M.P.H, meanwhile, argue for Medicare taking a leadership role in malpractice reform. In a Fund-supported article, they propose that malpractice disputes be adjudicated by Medicare's existing administrative appeals system, in conjunction with the program's quality improvement regulation and payment policy, to decrease errors and provide compensation for injured patients.¹⁶ Congress has taken note of this issue; Sage testified on the subject before the Senate's Committee on Health, Education, Labor, and Pensions in June 2006.¹⁷

The Fund will continue to conduct analyses and develop policy recommendations to ensure that Medicare beneficiaries receive appropriate, effective, and efficient health care. With rising health care costs, concerns about the quality and appropriateness of care, and a population increasingly dealing with multiple chronic conditions, Medicare faces considerable challenges. In coming years, the Program on Medicare's Future will focus on strengthening the program's effectiveness for its beneficiaries and building Medicare's role in achieving a high performing health system.

Notes

¹ Department of Health and Human Services News Release, "Over 38 Million People with Medicare Now Receiving Prescription Drug Coverage," June 14, 2006.

² B. Stuart, L. Simoni-Wastila, F. Baysac et al., "[Coverage and Use of Prescription Drugs in Nursing Homes: Implications for the Medicare Modernization Act](#)," *Medical Care*, March 2006 44(3): 243-49.

³ E. Heaton, T. Carino, and H. Dix, [Assessing Medicare Prescription Drug Plans in Four States: Balancing Cost and Access](#) (New York: The Commonwealth Fund, Aug. 2006).

⁴ Henry J. Kaiser Family Foundation, *Prescription Drug Coverage Among Medicare Beneficiaries*, June 2006.

⁵ D. Shea et al., "Close, But No Cigar. Medicare Beneficiaries Who Fail Asset and Income Testing for Subsidies in Medicare Part D," Presented at the Gerontological Society of America's 58th Scientific Meeting, Orlando, FL., November 2005.

⁶ L. Summer, P. Nemore, J. Finberg, "The Effect of Program Complexity on Access to Part D Drugs for Vulnerable Medicare Beneficiaries," report forthcoming from The Commonwealth Fund.

⁷ Letter to Health and Human Services Secretary Michael O. Leavitt from U.S. Senators Baucus and Rockefeller and U.S. Representatives Brown, Dingell, Rangel, and Stark, Oct. 25, 2006.

⁸ B. Biles, L. H. Nicholas, and S. Guterman, [Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?](#) (New York: The Commonwealth Fund, May 2006).

⁹ B. Biles, L. H. Nicholas, B. S. Cooper, E. Adrion, and S. Guterman, [The Cost of Privatization: Extra Payments to Medicare Advantage Plans—Updated and Revised](#) (New York: The Commonwealth Fund, revised Nov. 2006).

¹⁰ Henry J. Kaiser Family Foundation, *Prescription Drug Coverage Among Medicare Beneficiaries*, June 2006.

¹¹ J. Ebeler, P. N. Van de Water, and C. Demchak (eds.), “Improving the Medicare Savings Programs” (Washington, D.C.: National Academy of Social Insurance, 2006).

¹² K. Davis, M. Moon, B. S. Cooper, and C. Schoen, “[Medicare Extra: A Comprehensive Benefits Option for Medicare Beneficiaries](#),” *Health Affairs* Web Exclusive, Oct. 4, 2005.

¹³ M. Trisolini, G. Pope, J. Kautter, and J. Aggarwal, [Medicare Physician Group Practices: Innovations in Quality and Efficiency](#) (New York: The Commonwealth Fund, Dec. 2006).

¹⁴ S. Guterman, “Medicare Physician Payment: Are We Getting What We Pay For? Are We Paying for What We Want?” Invited Testimony, Energy and Commerce Committee, Subcommittee on Health Hearing, “Medicare Physician Payment: How to Build a Payment System That Provides Quality, Efficient Care for Medicare Beneficiaries,” July 25, 2006.

¹⁵ G. Wilensky, “[Developing a Center for Comparative Effectiveness Information](#),” *Health Affairs* Web Exclusive, Nov. 7, 2006.

¹⁶ E. D. Kinney and W. M. Sage, “Resolving Medical Malpractice Claims in the Medicare Program: Can It Be Done?” *Connecticut Insurance Law Journal*, 2005–06 12(1):79–136.

¹⁷ W. M. Sage, Testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate, June 22, 2006.