NATIONAL CENTER FOR POLICY ANALYSIS

Reforming Medicare with Personal Accounts, Incentives and Better Plan Design

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The long-term solvency of Medicare is the most serious domestic policy problem this country faces in the 21st century. Despite the rosy forecasts from politicians, the Medicare Trustees confirm that health care spending will consume an increasing proportion of the economy. As this occurs, Medicare spending will crowd out other government services.

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Executive Summary

Perverse incentives for patients and providers to squander resources are enormous. Medicare is an entitlement that places few limits on the services seniors consume. Beneficiaries bear little of the cost if they are wasteful and benefit little when they consume care prudently. In addition, Medicare providers have few financial incentives to control costs and keep beneficiaries out of the hospital.

Historically, a fundamental problem with efforts to contain Medicare expenditures is that Medicare follows a top-down model. Policymakers have tried to hold down spending with price controls and caps on the fees doctors and hospital earn, rather than empowering seniors to police their own consumption. One of the top-down cost-control methods involves paying hospitals a fixed fee per patient diagnosis. Another one (now modified) required automatically scaling back physician fees by a similar percentage if spending on physicians exceeded a specified growth rate. These efforts were largely unsuccessful. In 2010, the Affordable Care Act created a 15-member Independent Payment Advisory Board (IPAB) that has the power to cut reimbursements when the rate of spending growth exceeds a predetermined threshold. The five-year-old program has no members and Congress is debating repealing it.

Spending per beneficiary has risen over time as medical technology — and perverse incentives — have raised Medicare's costs. Per capita spending on Medicare beneficiaries has skyrocketed since its inception:

- In 1970, annual per capita Medicare spending was only $385.
- Today it is $12,430.
- It is projected to approach $19,000 a decade from now.

Medicare spending as a percentage of gross domestic product (GDP) was 1.3 percent in 1980, 2.2 percent in 2000 and now is about 3.5 percent. Spending is expected to surpass 4 percent by 2022, and under projections that are likely to occur, could reach 9.1 percent of GDP in 2089.

To affect consumer demand sufficiently to slow Medicare spending, policymakers must find ways to promote price sensitivity among beneficiaries long after they have met their deductibles. To reduce health expenditures from the supply side, policymakers have to find ways to

promote competition among providers caring for seniors. In addition, health plans and providers must be rewarded when they come up with cost-saving programs that provide high-quality care at a lower cost.

With the appropriate reforms, an increase in payroll taxes could fund a health spending account seniors themselves control — an idea known as prefunding. Putting seniors in charge of the funds in their account would make them more prudent consumers of health care because any unused funds would roll-over and accumulate for future health care expenses.

One way to prefund a portion of Medicare expenditures is to set up a Medicare Health Savings Account (HSA) for each worker. Working-age adults — and their employers — could jointly contribute a total 4 percent of payroll into a type of mutual fund that accumulates and grows at market rates. Upon reaching Medicare eligibility at age 65, the accumulated funds would be converted into an annuity that provides an annual payment into each senior's Medicare HSA. Upon reaching Medicare eligibility, seniors would also be covered by a high-deductible plan with potentially little-to-no cost sharing above a $5,000 annual deductible.

An actuarial analysis for the NCPA conducted by Milliman Inc., a national consultancy, found that prefunding personal accounts and coupling them with high-deductible plans would save Medicare an estimated $2.4 trillion annually by 2053 compared to the status quo. Of this amount:

- An estimated one-fifth ($434 billion) would come from better incentives that reduce the rate of health care inflation (that is, the medical trend rate).
- An estimated one-third of the savings ($787 billion) would come from reduced use of benefits by seniors.
- An estimated one-quarter ($651 billion) would come from increased cost-sharing by seniors.

A few health plans are experimenting with a concept that attempts to make enrollees care about the price of costly services even after their deductibles are met using a concept known as reference pricing. Reference pricing is an arrangement where enrollees face unlimited cost-sharing for all costs of a treatment or a procedure above a stated reference price set by the health plan, and close to some price available in the market. Because enrollees are very sensitive to prices higher than the reference price, providers have an incentive to charge the reference price to avoid losing business. Thus, high-deductibles and reference pricing will encourage doctors and hospitals to compete for seniors' business on the basis of price.

There are other methods Medicare plans could use to raise quality and reduce costs. Seniors' cost-sharing could be reduced or bonus deposits made to their Medicare HSA in return for working closely with a Medicare Advantage plan's care coordinator. Medicare Advantage plans are integrated health plans responsible for all medical care received. Copays could be reduced or possibly waived for seniors who first call their medical home to inquire about medical tests, prescription drugs or where to receive care in the event urgent care was needed.

Not long after Medicare was established in 1965, expenditures began to skyrocket. Rather than create a sustainable program where seniors shared some of the responsibility for controlling spending, politicians' preferred method to contain costs was to ratchet down reimbursements to Medicare providers. This was a mistake. Increasingly, Medicare needs to encourage workers to prefund more of their retiree medical needs and empower seniors to make more prudent spending decisions with the appropriate incentives. In addition, Medicare should explore other cost-sharing tools that could make beneficiaries price-sensitive above their deductibles.

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Introduction

The long-term solvency of Medicare is the most serious domestic policy problem this country faces in the 21st century. Despite the rosy forecasts from politicians, the Medicare Trustees report confirms health care spending will consume an increasing proportion of the economy. As this occurs, Medicare spending will crowd out other government services.

Perverse incentives for patients and providers to squander resources are enormous. Medicare is an entitlement that places few limits on the services consumed. Beneficiaries bear little of the cost if they are wasteful and benefit little when they consume care prudently. In addition, Medicare providers have few financial incentives to contain costs and keep beneficiaries out of the hospital. Poor quality and poorly coordinated care often boosts the revenue of providers rather than penalizing them.

Medicare Cost Containment. Historically, a fundamental problem with efforts to contain Medicare expenditures is that they followed a top-down model. Policymakers have tried to hold down spending with price controls and caps on the fees doctors and hospital earn, rather than empowering seniors to police their own consumption. For example, Medicare pays doctors and hospitals about 30 percent less than private insurers pay for the same services. In a major effort to control costs, in 1983 diagnosis related groups (DGRs) were implemented to pay hospitals fixed fees for each inpatient admission based on a diagnosis. DGRs may have somewhat slowed the growth of Medicare spending, but it is still rising at about two percentage points faster than the growth of gross domestic product (GDP).

After DRGs failed to adequately control the growth of Medicare spending, in 1997 a formula was created to automatically reduce physician payments by an automatic percentage to bring total spending in line the with the sustainable growth rate (SGR) — the rates of growth of the economy. This proved to be ineffective and was unpopular with physicians, and was finally modified by Congress in 2015.

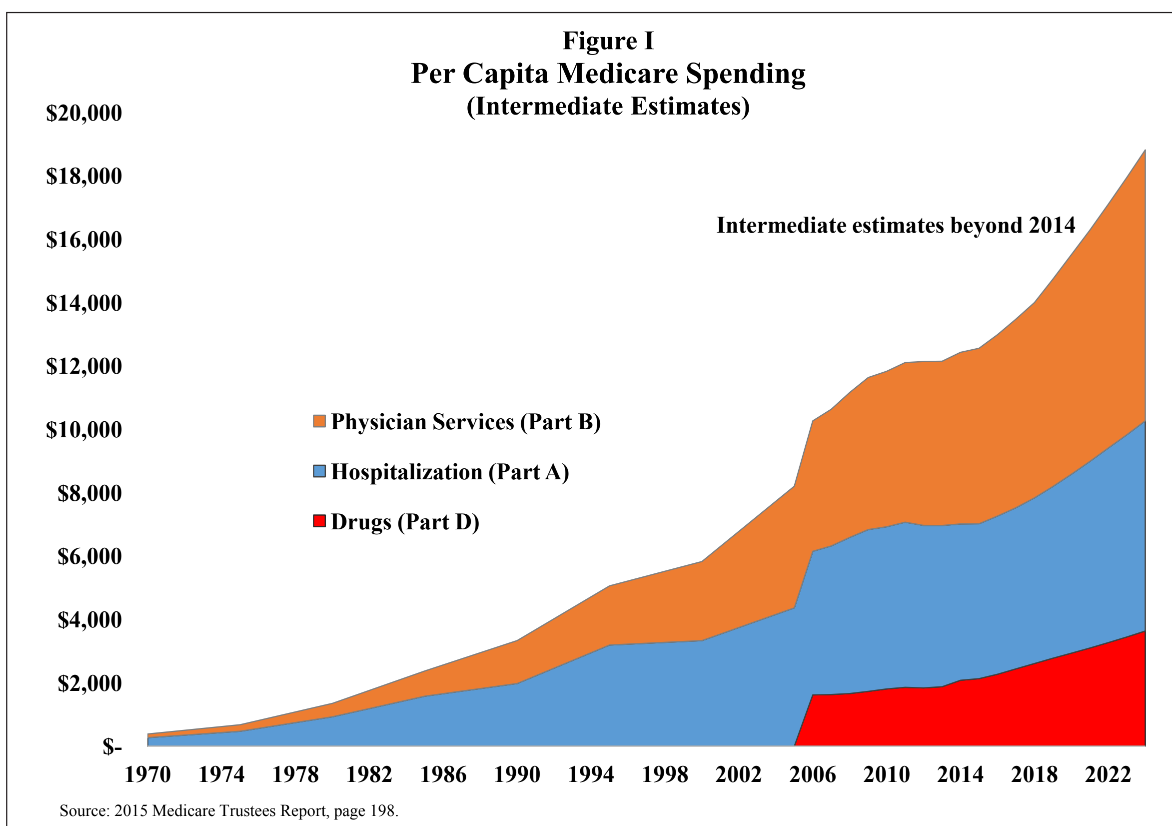
Finally, the 2010 Affordable Care Act created a 15-member Independent Payment Advisory Board (IPAB) that has the power to cut reimbursements when the rate of spending growth exceeds a predetermined threshold. In theory, IPAB's recommendations cannot be overridden unless Congress develops its own plan to reduce costs by a similar amount. IPAB is now 5 years old — but it has no sitting members and Congress is debating repeal of the ACA provisions that created it.

Other methods Medicare uses to control costs and discourage over-consumption include various types of cost-sharing. A common type of cost-sharing — used in all types of insurance — is an annual deductible that enrollees must meet before insurance coverage begins to pay claims. Currently, seniors enrolled in Medicare face a separate deductible for hospitalization (Part A) and physician services (Part B). Another common type of cost-sharing is co-insurance (often referred to as copays), where seniors have to pay a percent of the bill after meeting the deductible. Each time a senior is hospitalized in 2015, they face a deductible of $1,240 in addition to daily copays. For physician services, Medicare beneficiaries face an annual deductible of about $142 plus 20 percent cost-sharing.

Bad Idea: Insuring against Cost-Sharing. About 85 percent of seniors in fee-for-service Medicare have some type of supplemental coverage to reduce their cost-sharing. About 25 percent of seniors have Medigap supplemental plans that either reduce or eliminate all cost-sharing.[1] In other words, the Medicare program creates cost-sharing to encourage prudent utilization of care and then allows seniors to buy insurance to reduce their cost-sharing. If this sounds counterintuitive, it is. There is substantial evidence that generous supplemental plans increase medical spending even after controlling for health status.

The Medicare Payment Advisory Commission is an agency that provides Congress with nonpartisan advice on the Medicare program. It estimates Medicare spends one-third more on enrollees with Medigap coverage than on beneficiaries who don't have supplemental coverage. The Congressional Budget Office estimates that merely changing the design of Medigap policies to eliminate first-dollar coverage until seniors meet a threshold would save the Medicare program $58 billion over a 10-year period. Other changes to Medicare's cost-sharing rules could save an additional $52 billion over the same time period.[2]

The Need for Medicare Reform. If Medicare is to be sustainable, it must find a way to control spending.



To do this, seniors must have incentives to police their own behavior and that of their providers — much the way they do when purchasing other services. This suggests cost-sharing incentives must change in ways that allow enrollees to benefit from prudent decisions and financially penalize them for poor decisions. This also suggests providers must have an incentive to compete for seniors' business on the basis on cost or efficiency.

The Medicare Program Today

Medicare is funded on a pay-as-you-go basis. Each generation depends on the next to fund future benefits. As the program grows and medical technology advances, sustaining the program is possible only if younger workers and future generations are willing to pay high tax rates.

One problem is that spending per beneficiary has risen over time as medical technology — and perverse incentives — have raised Medicare's costs. Per capita spending on Medicare beneficiaries has skyrocketed since its inception:

- In 1970, annual per capita Medicare spending was only $385.
- Today it is $12,430; and it is projected to approach $19,000 a decade from now.
- Of the $12,430 spent per beneficiary in 2014, $5,400 was spent on physician care while $4,900 was spent on hospital care.
- About $2,100 was spent on drug therapy.

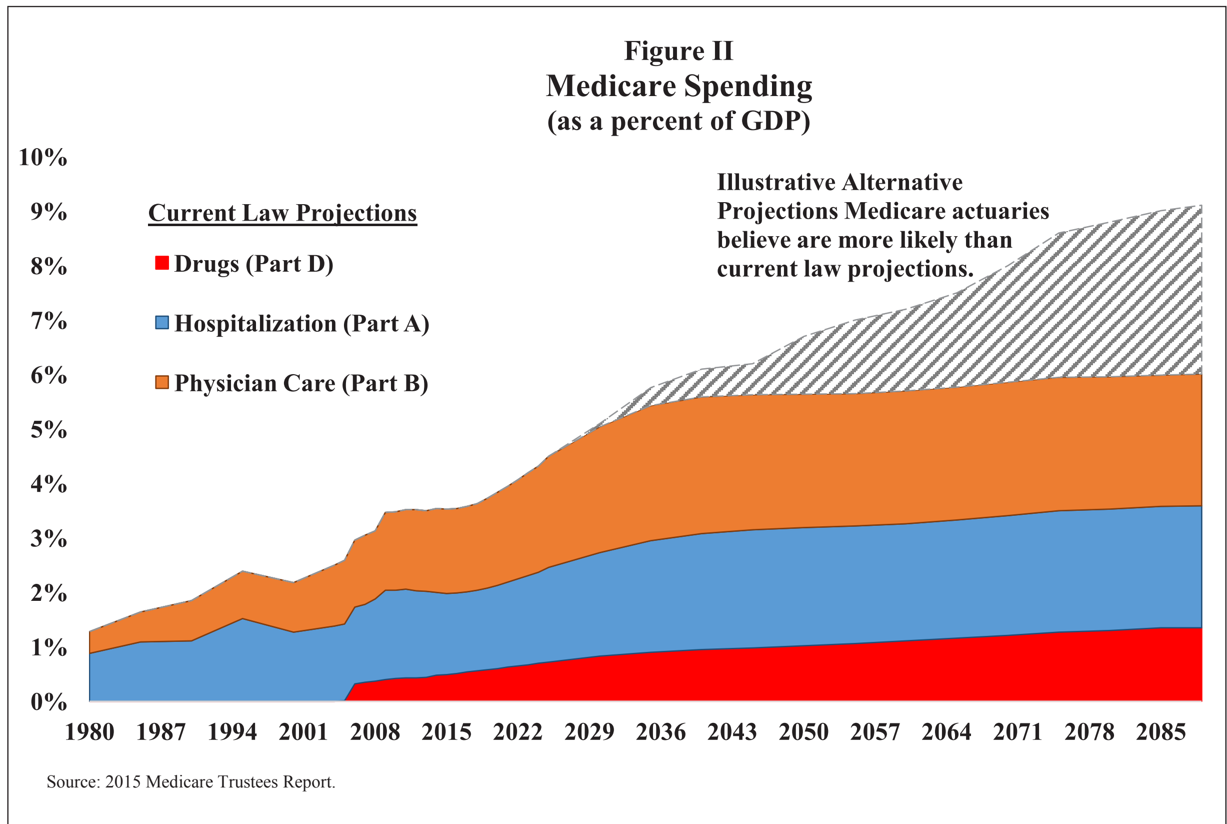
Spending on Medicare beneficiaries is on a course to grow another 58 percent over the next eight years. [See Figure I.]

Rising Medicare Spending. Medicare spending, and health care spending in general, has been rising for decades. Medicare spending as a percentage of gross domestic product (GDP) was 1.3 percent in 1980, 2.2 percent in 2000 and now is about 3.5 percent of GDP. Spending is expected to surpass 4 percent by 2022, but is projected to only approach 6 percent of GDP by 2089.

The problem is: These projections assume conditions under "current law." The Medicare actuaries also looked at spending under conditions the actuaries believe are more likely to occur in their *Illustrative Alternative* scenario. Under this more likely projections, Medicare spending could reach 9.1 percent of GDP in 2089 — about 50 percent higher than current law projections. [See Figure II.]

For instance, current law projections assume IPAB will remain in place, and planned reductions to physician fees will take place, as will other Medicare fee reductions. Thus, the Trustees assume reforms will be implemented to reduce the rate of growth in

Medicare spending to no more than the rate of economic growth. This would shrink the projected deficit in Medicare spending to manageable proportions. Moreover, current law assumes these provisions will be enforced, which is unlikely because Congress has consistently delayed implementation of cuts to Medicare providers fees for many years in a row.



It is no wonder the program is on shaky financial ground. The Urban Institute found Medicare beneficiaries tend to pay in far less than they receive in benefits. Seniors turning 65 in 1965, the year Medicare was created, had paid in nothing; they got a bargain. Although Medicare will be less generous to younger people, it is still quite lucrative. A two-income couple who turn 65 in 2015 will get back three times what they paid in, on average.[3]

Prefunding Medicare with Savings Accounts. Various methods have been proposed to address the financial sustainability of the current system. Price controls and ratcheting reimbursements down are old strategies that have been used for years and largely failed. Other proposals include increased cost-sharing, raising the age of eligibility, means-testing the premiums and cost-sharing of high-income beneficiaries, and raising payroll contributions.

Raising the age of eligibility sounds like an interesting idea. But it is unlikely to make much of a difference. Very little would be saved by raising eligibility to 67, for example. One-third of Medicare spending is on seniors in the last year of life. Seniors who have recently turned 65 or 66 don't require much health care compared to those turning 85 or 86.

Without fundamental reform, an increase in payroll contributions will only serve to push back the day of reckoning further into the future. Increasing the cost to high-income beneficiaries just adds trivial amounts of revenue without fundamentally addressing Medicare's problems.

The program's structure is rigid, both for seniors and providers. Although seniors bear some cost-sharing, it is not designed in a way that changes their incentive to over-consume. In addition, providers encounter bureaucracy and red tape that inhibit innovative ideas for improving quality and reducing costs.

To affect demand enough to reduce health expenditures, policymakers have to find ways to promote price sensitivity among beneficiaries long after they have met their deductibles. To reduce health expenditures from the supply side, policymakers have to find ways to promote competition among the providers caring for patients. Health plans and providers must be rewarded when they come up with cost-saving programs that provide high-quality care at a lower cost.

However, with the appropriate reforms, an increase in payroll taxes could fund a health spending account seniors themselves control — an idea known as

prefunding. Putting seniors in charge of the funds in their account would make them more prudent consumers of health care because any unused funds would roll-over and accumulate for future health care expenses. This could change the fundamental relationship between seniors and their providers and stimulate beneficial behaviors on the part of doctors and hospitals.

A way to achieve these goals:

- Workers (along with their employers) could put aside funds to prefund their out-of-pocket health care expenses when they retire, eventually reaching the point where each generation of retirees pays for the bulk of its own post-retirement medical care.
- Using a special type of Medicare Health Savings Account (or Medicare HSA), beneficiaries could manage some of their health care dollars — thus keeping each dollar of wasteful spending they avoid and bearing the full cost of each dollar of waste they generate.
- Physicians would be rewarded for keeping seniors healthy and would be allowed to profit from innovations that lower costs and raise the quality of care.

In return for making small changes today, simulations show that we can reach mid-century with a Medicare system no more burdensome (relative to national income) than the program is today. Moreover, these reforms would dramatically change incentives.

Medicare Prefunding

Today, Health Savings Accounts (HSAs) are a way workers and/or their employers can save pretax funds to pay out-of-pocket costs for preretirement health care. Similarly, a plan to prefund a portion of Medicare expenditures would require setting up a Medicare HSA for each worker. Working age adults — and their employers — could jointly contribute a total 4 percent of payroll into a type of mutual fund that accumulates and grows at market rates. Upon reaching Medicare eligibility, the accumulated funds would be converted into an annuity that provides an annual annuity payment into each seniors' Medicare HSA. To ensure no one has to forgo needed medical care, low-income workers who might otherwise not have sufficient lifetime earnings to adequately fund a Medicare HSA would be eligible for subsidies. Contributions from individuals who die before reaching age 65 would be used to subsidize low-income workers' accounts. As is typical with annuities, there would be no residual value at death to transfer to heirs.

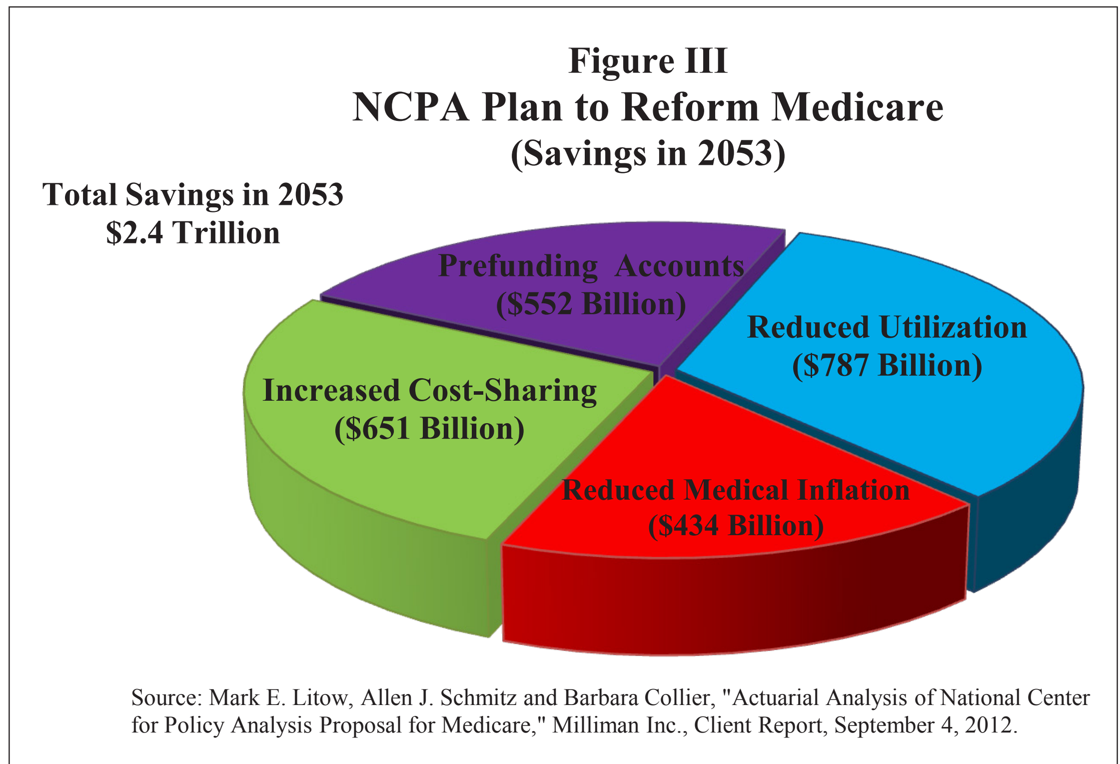
Upon reaching Medicare eligibility at age 65, seniors would be covered by a high-deductible plan with potentially little-to-no cost sharing above a $5,000 annual deductible, indexed for medical inflation. Deductibles at this level are increasingly common, even among individuals of modest means. A $5,000 deductible is less than many seniors currently spend on Medigap coverage and out-of-pocket medical care. On average, seniors spend more than $3,000 annually on medical care not covered by Medicare. Most seniors also purchase Medigap coverage — averaging about $2,000 annually — to pay for care not covered by Medicare.[4]

Besides the $5,000 deductible Medicare plan, seniors will also begin receiving an annual payment from their annuity into their Medicare HSA to fund medical care that occurs before they meet the deductible. Under some conditions, seniors may experience additional cost-sharing above their deductible if they fail to behave prudently and shop for value. [More

Economic Analysis of Prefunding Medicare HSAs

An analysis by the Private Enterprise Research Center (PERC) at Texas A&M University, based on data through 2007, found that private accounts could significantly reduce Medicare expenditures. PERC researchers used an economic model to analyze prefunding of a portion of Medicare beneficiaries' day-to-day medical care.[5] They also found proposals to couple high-deductible plans with 4 percent Medicare HSA accounts would hold the cost of Medicare to a proportion of GDP similar to what it is today. In addition, spending by seniors on premiums would take no greater share of their incomes than today. Seniors would also be protected against the cost of catastrophic medical problems over which they can exercise little control.

on this later.] Under this scenario, seniors will control most of the dollars that pay for their routine health care needs. As the sidebar on an economic analysis of prefunding Medicare shows, seniors could substantially lower Medicare program costs. [See the sidebar.]



Source: Mark E. Litow, Allen J. Schmitz and Barbara Collier, "Actuarial Analysis of National Center for Policy Analysis Proposal for Medicare," Milliman Inc., Client Report, September 4, 2012.

Actuarial Analysis. More recently, in 2012 the NCPA engaged Milliman Inc., a nationally recognized actuarial consulting firm, to model a Medicare reform plan that featured prefunding Medicare HSAs.[6] Actuaries modeled various scenarios, resulting in a range of estimates of the percent of gross domestic product (GDP) consumed by Medicare over a 40-year period under the reform proposal.[7]

Alternative scenarios took into account changes in Medicare expenditures in response to different proportions of seniors in high-deductible plans, changes in medical inflation, and differing levels of wage growth and interest rates.

Results of the Actuarial Analysis. Under the base estimates of annual savings, the Milliman analysis found that prefunding personal accounts and coupling them with high-deductible plans would save an estimated $2.4 trillion annually by 2053 compared to the status quo. [See Figure III.]

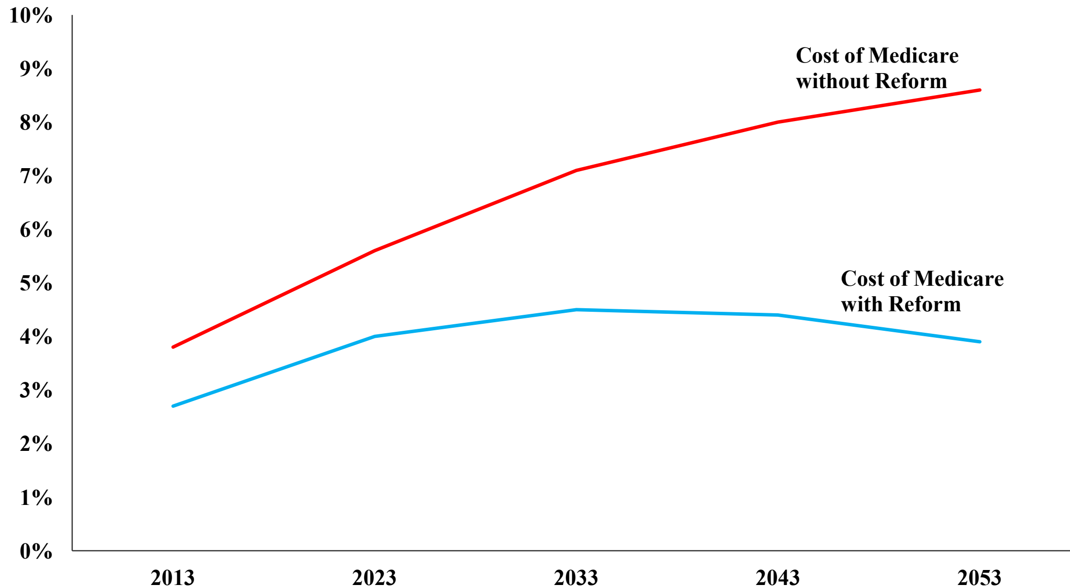
Of this amount:

- An estimated one-fifth ($434 billion) would come from better incentives that reduce the rate of healthcare inflation (that is, the medical trend rate).
- An estimated one-third of the savings ($787 billion) would come from reduced use of benefits by seniors.
- An estimated one-quarter ($651 billion) would come from increased cost-sharing by seniors.

What will it take to slow the growth of Medicare spending to the growth of the economy?

- Medicare consumes about 3.5 percent of GDP annually. Without reform, the proportion of our economy consumed by Medicare will double by 2053.
- Actuaries found that placing all (newly enrolled) seniors in $5,000-deductible plans would slow the growth of Medicare expenditures by 2053 to the same proportion of the economy as Medicare consumes today. [See Figure IV.]
- A 4 percent payroll tax would be sufficient to prefund Medicare HSAs and offset seniors' higher cost-sharing under a high-deductible plan.

For example, Figure IV shows the base scenario; if all seniors are placed in $5,000 deductible plans, medical inflation slows from an estimated 3.67 percent to 3.32 percent by 2053. As a result, the percent of GDP consumed by Medicare in 2053 would remain about 3.9 percent, slightly above what it is today. By contrast, if three-quarters of seniors opted for $2,500 deductible plans (as opposed to $5,000), both medical inflation and the share of GDP consumed by Medicare would be much higher by 2053. Substantially higher Medicare spending would require additional taxes or higher payroll contributions to sustain the program. For instance:



- If 75 percent of seniors opted for the $2,500 deductible plan, payroll contributions would have to more than double to 9 percent to keep Medicare spending to 3.8 percent of GDP. [See Table I, Alternative Scenario 2.]
- Thus, the payoff for having all seniors in a $5,000 deductible plan is that the Medicare program would require much smaller payroll contributions (about 4 percent of payroll), requiring no additional taxes to fund current expenditures by 2053.

The estimated savings, as shown in Figure V, would be due to a reduction in utilization of medical services, increased competition among providers (that is, reduced medical inflation), greater price sensitivity among patients, and prefunding Medicare through Medicare HSAs. Of the future reduction in taxes and premiums:

- An estimated 18 percent of savings would come from supply-side reforms.
- An estimated 27 percent would come from demand-side reforms.
- An estimated 23 percent would come from reducing financing costs due to the effects of prefunding; and
- An estimated 32 percent would come as a result of reductions in utilization.

The Demand-Side Solution to Reform Medicare

Economic studies — and common sense — confirm health care patients act more like consumers when they bear more of the costs for their medical care. Much of

Table I
Prefunded Plan Assumptions

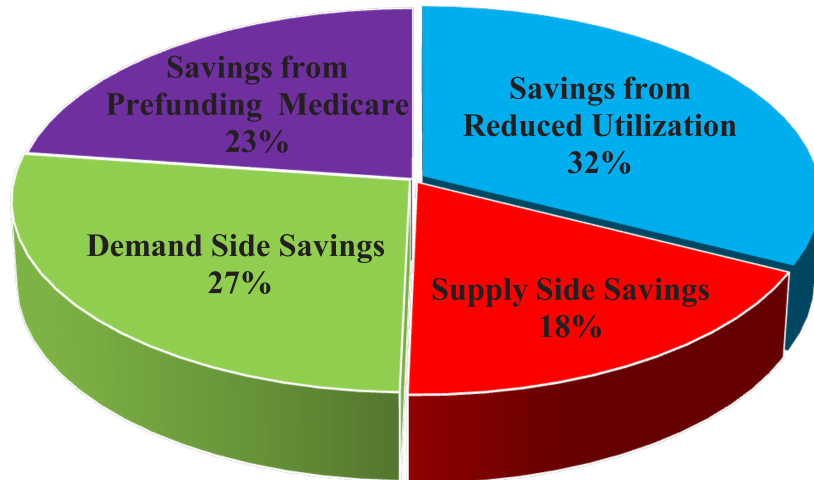
	Standard Medicare	Base Scenario	Alternative Scenario 1	Alternative Scenario 2
Medical Inflation (i.e. Medical Trend)	3.7%	3.3%	3.7%	3.7%
% of Seniors in $5,000 Deductible	N/A	100.0%	25.0%	25.0%
Payroll Contribution Rate	N/A	4.0%	4.0%	9.0%
Medicare Cost (%of GDP in 2053)	8.6%	3.9%	5.3%	3.8%

Source: Mark E. Litow, Allen J. Schmitz and Barbara Collier, "Actuarial Analysis of National Center for Policy Analysis Proposal for Medicare," Milliman Inc., Client Report, September 4, 2012.

what is wrong with the U.S. health care system is due to funding by third-party payers — that is, someone other than the patient footing the bill for health care services. Perverse incentives — incentives that reward consumption over conservation — are created when most medical expenses are paid for by third-party health insurance companies.

In the United States, patients pay approximately 11 percent of their medical bills "out-of-pocket." The remaining 89 percent of all medical bills are paid for by a third party. Economic theory suggests third-party arrangements result in consumers being considerably less price-sensitive than they would be if they had to pay for all of their medical expenses.

Figure V
Medicare Savings Health Insurance Retirement Accounts



Source: Mark E. Litow, Allen J. Schmitz and Barbara Collier, "Actuarial Analysis of National Center for Policy Analysis Proposal for Medicare," Milliman Inc., Client Report, September 4, 2012.

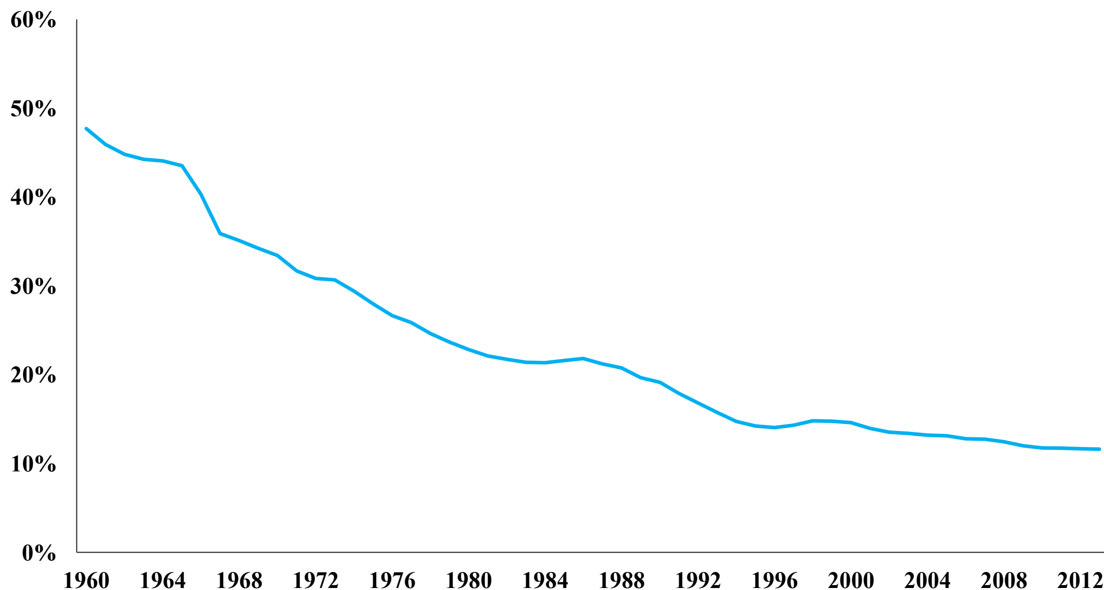
Academic research confirms this. The Rand Health Insurance Experiment (HIE) — which ran from 1974 to 1982 — demonstrated how cost-sharing affects consumer demand in the health care marketplace. In the experiment, participants experienced different levels of cost-sharing to see if cost-sharing incentives caused them to conserve on medical care.[8] The Rand Experiment confirmed patients became more price-sensitive in their health care choices. In fact, participants in the study consumed about 30 percent fewer medical services when faced with cost-sharing arrangements. Additionally, with the exception of only the poorest individuals, patients' health was not adversely effected by cost-sharing nor did they skimp on necessary medical care.[9]

Health Savings Accounts (HSAs), Health Reimbursement Arrangements and health insurance cost-sharing, such as annual deductibles and copayments, are all based on the lessons learned from the Rand Experiment. But aligning the incentives of health plan enrollees with health plan sponsors is only half of the battle. Another benefit of boosting the price-sensitivity of patients is how it positively affects the incentives of suppliers and providers.

When patients manage their own health care funds, they make prudent decisions — say, substituting generic drugs for brand name drugs, reducing unnecessary trips to physicians' offices and hospital emergency rooms, engaging in comparison shopping, seeking second opinions on surgery, questioning the necessity of certain diagnostic tests.

Under a Medicare plan that provides a patient-centered medical home coupled with financial incentives, seniors may call their care coordinator for help in locating medical imagining (such as an MRI) that offers the lowest cost-sharing or ask about hospitals that will honor a reference price. [More on reference pricing below.]

The Relationship of Health Care Demand and Supply. The portion of health care patients pay out of pocket has been falling for decades. Around 1960, patients paid about half of their medical bills out of pocket. Today that figure is only about 11 percent. [See Figure VI.] This imbalance is particularly pronounced when patients are hospitalized. Patient cost-sharing for hospital bills falls, on average, to a mere three cents on the dollar.



Source: "National Health Expenditures; Aggregate and Per Capital Amounts, Annual Percent Change and Percent Distributions: Selected Calendar Years 1960-2013," Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 2014.

As the proportion of medical bills paid out of pocket fell, patients increasingly cared less about the price (and quantity) of services consumed. As health care providers began to realize their patients no longer cared about price, doctors and hospitals lost any incentive to compete for patients on the basis of price. In other words, the perverse incentives that third-party payments have on the health care market not only reduces patients' price-sensitivity but also discourages price competition among providers. This partly explains why medical prices are rising at three times the rate of inflation and medical spending is increasing at twice the growth of national income.

Third-party payments are especially perverse in fee-for-service Medicare. Medicare is a rigid, bureaucratic program. Whereas self-insured employee health plans have the ability to innovate and try new incentives, changes in Medicare benefits are very slow by comparison.

As Figure V illustrates, only a portion of the savings to Medicare comes from seniors saving more of their own funds while working (that is, prefunding). Nearly one-third of the savings comes from reduced utilization when seniors police their own consumption. Nearly one-fifth of the savings would come from the supply side — the effect of beneficial incentives on suppliers. That is, doctors and hospital would change their behavior to compete for the patronage of seniors who are more price sensitive.

The Supply-Side Solution to Reform Medicare

There is little competition in health care. When economists talk about competition, they mean price competition. In health care, competition often takes the form of firms competing to maximize revenue against third-party reimbursement formulas.

No Price Competition in Health Care. Doctors' professional medical societies have historically discouraged price competition. To some degree physicians could avoid competing with each other on price because medical licensure is a competitive barrier to entry.[10] Nowadays, most physicians have signed agreements with preferred provider organizations (PPO) and large insurers that affiliate them with a variety of provider networks. Fees are not negotiated with patients' demand curve in mind. Rather, fees are a function of the respective market power of area insurers compared to that of area physician groups. In other words, individual doctors tend to be price takers; they can do little to raise or lower their prices. Physicians merely decide whether to accept or reject network contracts whose fees they perceive as inadequate. In an environment where physicians cannot raise or lower their prices, competition among doctors usually takes the form of competing on convenience or other amenities. This includes things such as where their office is located, which insurance they accept, waiting room amenities, how many hours a physician is willing to see patients and whether the doctor is willing to stay open late and work weekends.

Hospitals also sign network contracts (similar to physicians). Hospitals do not compete for patients on the basis of price either. Hospitals compete to attract patients covered by health insurance through public relations, convenience and by offering amenities reminiscent of a 5-star hotel. Although Medicare only pays doctors about 81 percent, and hospitals about 72 percent, of what private payers reimburse, Medicare beneficiaries are too numerous for most doctors and hospitals to ignore.

Boosting Competition among Providers with Reference Pricing. What can be done to encourage hospitals do to compete for seniors' business on the basis of price? One way is to make seniors care about price. Providing seniors with a $5,000 deductible health plan and an annuity payment into a Medicare HSAs is one way to make Medicare beneficiaries care about prices below their deductible. But seniors also need to care about expenditures after their deductible has been met. A few health plans are experimenting with a concept that attempts to make enrollees care about the price of costly services even after their deductibles are met. Using a concept known as *reference pricing*, a health plan establishes a reference price for high-cost procedures that is often slightly above the average or median prevailing price.[11]

Reference pricing is not currently used in Medicare plan design, but has been used in other retiree health plans run by pension plans. Reference pricing is an arrangement where enrollees face unlimited cost-sharing for all costs above a stated reference price. Because enrollees are very sensitive to prices higher than the reference price, providers have an incentive to maintain prices near the reference price to avoid losing business. The key to implementing reference pricing is education: enrollees must understand how the program works; they must possess the tools to compare prices among competing providers; and providers must understand their prices are being compared.

From 2008 to 2012, the California Public Employees' Retirement System (CalPERS) implemented a system of reference pricing for joint replacement surgery. CalPERS is a large retiree health plan with significant market power. Enrollees, area hospitals, physicians were all educated about the plan prior to its implementation. The reference price was $30,000; plan members were required to pay their typical cost-sharing (20 percent) plus 100 percent of all costs above the reference price. CalPERS members were provided with a list of 46 hospitals that would provide hip and knee replacement surgeries for $30,000, although enrollees were not required to use those hospitals. Surgeries on CalPERS enrollees at the lower-cost facilities jumped by more than 20 percent, while surgeries at high-cost providers fell by one-third the first year after implementation. Over time, many of the high-cost hospitals lowered their prices to CalPERS members by about one-third. Even the lower-cost hospitals lowered prices, by about 5 percent.[12] The savings to CalPERS and its members was more than $3 million in 2011 alone. CalPERS has since expanded the experiment to cataract removal at ambulatory surgery centers — saving $1.3 million over the course of two years.[13]

There are other ways providers could compete to raise quality and reduce costs. Seniors' cost-sharing could be reduced or bonus deposits made to the Medicare HSA in return for working closely with a Medicare Advantage plan's care coordinator. Copays could be reduced or possibly waived for seniors who first call their medical home to inquire about medical tests, prescription drugs or where to receive care in the event urgent care was needed.

Conclusion

Not long after Medicare was established in 1965, expenditures began to skyrocket. Rather than create a sustainable program where seniors shared some of the responsibility to control spending, politicians' preferred method to contain costs was to ratchet down reimbursements to Medicare providers. This was a mistake. Increasingly, however, Medicare needs to encourage workers to prefund more of their retiree medical funds and empower seniors to make more prudent spending decisions with the appropriate incentives. In addition, Medicare should explore other cost-sharing tools that could make Medicare beneficiaries price-sensitive above their deductibles.

Notes

1. "Change the Cost-Sharing Rules for Medicare and Restrict Medigap Insurance," Options for Reducing the Deficit: 2014 to 2023, Mandatory Spending, Option 7, Congressional Budget Office, November 13, 2013. Available at https://www.cbo.gov/budget-options/2013/44895.
2. Ibid.
3. C. Eugene Steuerle and Calab Quakenbush, "Social Security and Medicare Taxes and Benefits over a Lifetime: 2103 Update," Urban Institute, November 2013. Available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412945-Social-Security-and-Medicare-Taxes-and-Benefits-over-a-Lifetime.PDF.
4. Average out-of-pocket spending per Medicare beneficiary was $3,138 in 2007; 10% spent more than $7,861. See Claire Noel-Miller, "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care," AARP Public Policy Institute, Insight on the Issues 65, May 2012. Available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf. The Kaiser Family Foundation calculated that the monthly premiums for Medigap policies (in 2010) ranged in price from $16 per month for Plan N in a low-cost state to $317 for Plan H in a high-cost state. The most popular plan is Plan F, with about 44% of seniors choosing it. The average cost for Plan F across states is $172 per month, or about $2,064 per year. See Phil Moeller, "Include Medigap in Your 2012 Medicare Review," *U.S. News & World Report* (online), October 5, 2011. Available at http://money.usnews.com/money/blogs/the-best-life/2011/10/05/include-medigap-in-your-2012-medicare-review.
5. John C. Goodman, "A Framework for Medicare Reform," National Center for Policy Analysis, NCPA Policy Report No. 315, September 12, 2008. Available at: http://www.ncpa.org/pub/st315.
6. Mark E. Litow, Allen J. Schmitz, and Barbara Collier, "Actuarial Analysis of National Center for Policy Analysis Proposal for Medicare," Milliman Inc., Client Report, September 4, 2012. Available at http://www.ncpa.org/pub/actuarial-analysis-of-national-center-for-policy-analysis-proposal-for-medicare.
7. Actuaries modeled various scenarios for Medicare spending through 2053, using variables for medical expenditure trend growth, wage growth, projected interest rates, the proportion of seniors in high-deductible plans and differing payroll tax contributions. By 2053, about 85 million people are expected to be enrolled in Medicare. Wages are assumed to grow 1.2 percent annually, while the economy is projected to grow 3 percent annually. Interest rates and the rate at which the equity markets grow is assumed to be 5.2 percent. Although interest rates are currently much lower, historically they have been much higher. This estimate is consistent with average rates of return for long periods, such as the past 40 years.
8. Joseph P. Newhouse et al., *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).
9. Ibid.
10. Paul Starr, *The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry* (N.Y.: Basic Books, 1982).
11. Amanda E. Lechner, Rebecca Gourevitch and Paul B. Ginsburg, "The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer," Center for Studying Health System Change, HSC Research Brief No. 30, December 2013. Available at http://www.hschange.com/CONTENT/1397/.
12. James C. Robinson1 and Timothy T. Brown, "Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery," *Health Affairs*, Vol. 32, No. 8, August 2013, pages 1,392-1,397.
13. James C. Robinson, Timothy T. Brown and Christopher Whaley, "Reference-Based Benefit Design Changes Consumers' Choices and Employers' Payments for Ambulatory Surgery," *Health Affairs*, Vol. 34, No. 3, March 2015, pages 415-422.