Controlling Costs in Medicare: What Works and What Doesn’t

“Cost Containment in Medicare: A Review of What Works and What Doesn’t” examines the history of Medicare’s cost control initiatives. The authors from The Urban Institute and Health Policy Alternatives Inc. -- Robert Berenson, Michael Hash, Thomas Ault, Beth Fuchs, Stephanie Maxwell, Lisa Potetz and Stephen Zuckerman – wrote this report for the AARP Public Policy Institute.

Since 1965 when Medicare was signed into law, policy makers have been concerned about escalating costs and have examined various ways to contain costs without affecting beneficiaries’ access to quality health care.

The authors identify and describe nine approaches to Medicare cost containment since the mid-1980s. Overall, they found that Medicare has a mixed record of managing costs. But there is considerable evidence that modest cost containment has been achieved, especially compared to growth in private health spending.

**Key findings:**

*Prospective payment for hospitals and post-acute providers:* Prospective payment rates for hospitals have been in place for over 20 years. Studies confirm that changing the incentives from a cost-based system to an episode payment has resulted in measurable, ongoing savings and given Medicare greater control over program spending. However, the cost savings have been reduced somewhat because some costs have been shifted to post-hospital care and outpatient services.

Prospective rates for skilled nursing facilities (SNFs) were introduced in 1998. The results have been mixed. In the first two years, expenditures fell by three percent but returned to double digit increases since year 2000. These increases suggest the prospective payment for SNFs hasn’t been successful in controlling Medicare outlays.

On the home health side, Medicare spending for home health services grew at an annual rate of 30 percent between 1988 and 1996. Since prospective payments began in 2000, expenditure increases have been about seven percent. Home health agencies have responded to the payment system and together with other changes in eligibility have increased the efficiency of their operations.

*Physician fee schedules:* Studies and spending trends show that growth in Medicare physician expenditures were significantly lower through 2003 because of fee schedules and spending targets in place since 1992. There was a four percent savings in the 12-year period after 1991. However, for the years 1998 to 2005, total physician spending grew 7.4 percent annually, below the long term average of 8.9. One problem is that the fee-for-service payment system encourages increases in the volume of services. A second problem is that Congress has repeatedly over-ridden automatic reductions to the physician fee schedule that would otherwise have been imposed, allowing more rapid growth in expenditures above annual targets.
**Bundling fee-for-service payments and competitive bidding**: These two approaches to cost containment have been the focus of demonstration projects. In the 1990s, several hospitals were selected to bundle facility and physician payments for heart bypass surgery. Evaluation of seven sites showed a savings of 10 percent. Two competitive bidding demonstrations for durable medical equipment (DME) estimated savings of 20 percent. Ten urban areas were selected in 2007 for a phased-in competitive bidding program for selected DME items. While these approaches hold promise for cost containment, they require a large administrative effort.

**Benefit design and coverage of new technology**: Three features of Medicare benefit design examined from a cost containment perspective are increasing beneficiary cost-sharing – deductibles and coinsurance – on certain services and limiting the scope of benefits through the Medicare coverage process. Numerous studies show that use of medical services declines as prices paid by patients increase. Studies also show that limiting Medicare to a single deductible, 20 percent coinsurance and an annual out-of-pocket spending cap would generate substantial savings. Decisions to deny or limit Medicare coverage or impose conditions on coverage could be expected to produce savings in the short term. But the long term effect is less clear because it’s impossible to know how the use of a treatment would have evolved in the absence of coverage limitations or calculate the long run costs or savings of new treatments based on clinical trials.

**Chronic care management**: A disproportionate share of Medicare spending is for older adults, who are frail with multiple chronic conditions. Numerous Medicare demonstrations to coordinate care over two decades have not yet shown they reduce program costs significantly although they have shown positive impacts on quality and satisfaction. Care coordination approaches that better use primary physicians and establish a patient-centered medical home are promising and will be tested over the next few years.

**Private plan contracts**: Twenty-five years of experience with private plans contracts has shown no significant cost savings. In fact, studies show Medicare has paid private plans more than their costs and more than it would have paid for beneficiaries had they remained in the traditional Medicare program. Where private plans have excelled is in delivering enhanced benefits and lower out-of-pocket costs for beneficiaries compared with what they would get under traditional Medicare. Starting in 2010, Medicare will test a “premium support” approach in which private plans compete head-to-head with traditional Medicare for beneficiaries on the basis of bid premiums.

**Prevention of Fraud and Abuse**: Medicare has realized significant savings through recoveries, judgments and settlements using audits and prosecution of fraud and abuse cases brought under the False Claims Act. The Medicare Integrity Program has reduced the claims error rate and increased recoveries from private insurers who should have paid instead of Medicare. A published study shows that increasing funds for fraud prevention/detection initiatives could lower expenditures without adversely affecting health outcomes. Further savings could be available from investing in information technology, a more rigorous review of provider qualifications and greater oversight of Medicare contracts with private health plans.