Build on What Works: Medicare Cost Savers

Since 1965, Medicare has ensured guaranteed health care benefits for older adults and people with disabilities. Today, 50 million older adults and people with disabilities rely on Medicare for health coverage and most beneficiaries – 80% – report that Medicare is working well.[i]

This success aside, much can be done to spend Medicare dollars more wisely and to ensure that Medicare's promise of health security remains for generations to come. Towards this end, the Medicare Rights Center supports savings solutions that eliminate wasteful spending and promote the delivery of high value care – meaning better quality at a lower price.

Medicare Costs: Just the Facts

Medicare costs are slowing dramatically. Recent analysis by the S&P Dow Jones Indices illustrates that "health care costs have decelerated over the past few years, and Medicare costs have decelerated more than other health costs." A recent study finds that the majority of this slowdown is attributable to structural change, like increased provider efficiency.

The U.S. Department of Health and Human Services confirms that slowed growth over the last three years is "unprecedented in the history of the Medicare program." Since 2010, projected Medicare spending over the next 10 years dropped by **$590 billion** due to the noted spending slowdown.

Medicare is efficient. Medicare does a better job of controlling health care costs than private health plans. Medicare spending is expected to grow at rates of 3.9% per person per year over the next 10 years compared to 5% for private insurance.

Medicare Cost Savers:

Advance delivery and payment system innovations. The federal government should maximize its authority to test delivery system reforms designed to enhance health care quality while simultaneously driving down the cost of care. Kick started by the Affordable Care Act (ACA), these reforms are meant to improve care quality by promoting better coordination among providers, patients and caregivers to prevent harmful drug interactions, unnecessary hospitalizations and more.[ii] Congress should avoid dramatically altering Medicare benefits, so as to allow time for these advancements to yield results, meaning both improved care coordination and better cost-effectiveness.

Restore Medicare drug rebates. Passage of Medicare Part D rescinded prescription drug rebates – a critical tool that allows the federal government to secure lower drug prices – for beneficiaries dually eligible for Medicare and Medicaid. Restoring Medicaid-level drug rebates for low-income Medicare beneficiaries would save between $133.7 billion to $141.2 billion over 10 years.[iii]

Introduce a public Medicare drug benefit. Allowing the federal government to offer a drug plan and negotiate drug prices would eliminate the wasteful administrative expense of operating multiple private plans, ease the burden on beneficiaries of navigating a complex matrix of private drug plans,[iv] and could save up to $20 billion over 10 years.[v]

Maximize the use of generic drugs. Offering generic drugs for zero co-payments to Medicare beneficiaries with Extra Help would yield savings for both the federal government and for beneficiaries, while providing increased access to prescriptions and better health outcomes to the most vulnerable people with Medicare. Some versions of this proposal would simultaneously increase co-payments for brand name drugs, but this must be pursued with caution because it could limit access for people who must use a brand name drug out of medical necessity.[vi]

Create a Public Supplement. Introduce or pilot a voluntary publicly-administered supplement to traditional Medicare that includes a combined Medicare Part A and B deductible, a catastrophic cap, reduced coinsurances for Medicare Part B and a drug benefit with limited co-payments or coinsurance. Paid for through beneficiary premiums, this public supplement would achieve savings by building on the efficiencies of traditional Medicare, reducing administrative costs and diminishing the need for coordination among multiple sources of coverage.[vii]

Eliminate wasteful overpayments to Medicare Advantage (MA) plans. The ACA made strides to reduce overpayments to private Medicare health plans, but more could be done by expediting implementation of lowered benchmarks – the maximum cost that Medicare will pay MA plans per enrollee in a given area – mandated by the ACA or revisiting MA plan benchmarks to equalize spending between MA plans and traditional Medicare.[viii]

Risk scoring – the formula Medicare uses to determine MA plan payments based on estimated costs per beneficiary adjusted for health status – could also be adjusted to eliminate overpayments caused by differences in diagnostic coding between people with MA plans and people with traditional Medicare – saving $8.6 billion over 10 years.[ix]

Expand the competitive bidding program. Expansion of competitive bidding, which uses market principles to control costs for durable medical equipment, prosthetics, orthotics, and supplies,[x] to a national scale could be accelerated and extended to other types of medical equipment, such as lab tests and advanced imaging services – saving $7 billion over 10 years.[xi] Highly specialized or personalized types of medical equipment, such as prosthetic limbs and manual wheelchairs, should remain excluded from competitive bidding.[xii]

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[i] Kaiser Family Foundation, An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Services Use. (Statement by J. Cubanski before the Senate Special Committee on Aging, February 2013)
[ii] Medicare Rights Center. "The Affordable Care Act: Before and After." (March 2012)
[iii] "Rockefeller and 18 Other Senators Introduce Legislation to Protect Seniors and Reduce the Deficit." (April 2013); Congressional Budget Office (CBO). "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's 2014 Budget." (May 2013)
[iv] NCPSSM. "Hearing on Implementation of the Medicare Drug Benefit." (March 2006)
[v] Office of Senator Durbin. "Durbin, Schakowsky Introduce Bill Requiring HHS to Negotiate Drug Pricing in Medicare Part D." (March 2011)
[vi] Medpac. "Chapter 13: Status report on Part D, with focus on beneficiaries with high drug spending." (March 2012); National Coalition on Health Care. "Curbing Costs, Improving Care: The Path to an Affordable Health Care Future." (November 2012); Center for American Progress. "Senior Protection Plan." (December 2012)
[vii] Davis, K., Moon, M., Cooper, B., C. Schoen, "Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries." (Health Affairs: October 2005); Davis, K., Schoen, C., S. Guterman, "Medicare Essential: An Option to Promote Better Care and Curb Spending Growth." (Health Affairs: May 2013)
[viii] Kaiser Family Foundation, "Policy Options to Sustain Medicare for the Future." (February 2013)
[ix] GAO, "Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments." (January 2013); Congressional Budget Office (CBO). "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's 2014 Budget." (May 2013)
[x] CMS. "DMEPOS Competitive Bidding." (April 2012)
[xi] National Coalition on Health Care. "Curbing Costs, Improving Care: The Path to an Affordable Health Care Future." (November 2012); Center for American Progress. "Senior Protection Plan." (December 2012)
[xii] National Coalition on Health Care. "Curbing Costs, Improving Care: The Path to an Affordable Health Care Future." (November 2012)