Meeting Notes

Day 1, 5/3/2010: IPAB

**Outline of Presentations:**

A. Tasks of IPAB
   i. Develop and implement specific detailed proposals to reduce Medicare spending

   ii. These proposals must be implemented unless Congress acts following expedited procedures to implement alternative cost-cutting measures.

   iii. Develop and submit to Congress advisory reports matters related to the Medicare program

   iv. Submit to Congress and the President recommendations as to how to slow the growth in national health care expenditures

B. Procedures of IPAB
   i. Each year beginning with 2013, the CMS Chief Actuary makes a determination whether the projected per capita growth rate for the implementation year (the second year following the determination year) will exceed the per capita target growth rate for that year.

   ii. The Medicare per capita growth rate is the 5-year average rate of growth in per capita spending under Medicare ending in the implementation year

   iii. The target growth rate is the 5 year average ending in the implementation year which is:

      – prior to 2018, the average of the CPI and medical CPI
      – After 2017, nominal gross domestic product per capita growth plus 1 percentage point.

C. Expenditure Reduction Goals
   i. If Medicare growth rate will exceed the target rate, the Board shall make proposals that would reduce Medicare spending by the lesser of .5 percent in 2015, 1 percent in 2016, 1.25 percent in 2017, and 1.5 percent in 2018 and thereafter, or

   ii. the projected excess of the growth rate over the target rate.

D. Constraints on Proposals
   i. The proposal may not "ration health care," raise revenues or beneficiary premiums, increase the Part D based beneficiary premium percentage or reduce premium subsidies, increase beneficiary cost sharing, or restrict benefits or modify eligibility criteria.

   ii. Proposals for years before 2020 may not target inpatient or outpatient acute hospitals, long-term care hospitals, inpatient rehabilitation hospitals, psychiatric hospitals, and, possibly hospice care prior to 2020.

   iii. Proposals must take into account administrative expenditures HHS will incur to carrying them out.

   iv. Proposals may only include recommendations related to the Medicare program

v. Proposals must maintain or enhance beneficiary access to quality care

E. Deadlines
   i. By September 1, the IPAB must submit a draft proposal to HHS Secretary and to MedPAC.

   ii. On January 15 of the following year, the Board must submit a proposal to Congress and the President, on which HHS must comment by March 1.

   iii. HHS does not need to implement a Board proposal to cut Medicare spending in a year in which the five-year average in national health expenditures generally exceeds the growth rate in Medicare (as it often does), but this exception does not excuse the Board from making a proposal to Congress or Congress from considering it, and cannot be applied two years in a row.

   iv. If the Board fails to submit a proposal by deadline, HHS must itself submit a proposal meeting statutory requirements

F. Things that IPAB may want to tackle
   a. Impact of vast variation in prices paid by private insurers on access and prices paid for Medicare services
   b. Risk for providers: variation in the profitability of cases within DRGs
   c. Changes to risk adjustment: potentially adding less manipulable factors such as lab values

**Discussion:**

Questions about IPAB were discussed. To these questions, participants had several different answers.

1. Where will they find these 15 full-time experts, how will they keep them busy, and how will they retain them? How will they find and retain the staff necessary to deal with the large task at hand?
   - The expert positions would be unattractive to many top people because of the long duration (6 years), senate confirmation required, the large number of positions (15), full-time with no consulting allowed, and the relatively low salaries (approx $165,000).
   - The positions are modeled on the Fed, but salaries are a lot lower. Additionally, many Fed members leave before their term is up, which maybe likely in this context as well.
   - Six years may be close to the right amount of time if learning on the job is important. There is also a sense in which it is important to retain people long enough for them to care about affecting change.
   - If the board can really affect change, it will attract top talent. Many top people (nearing retirement and otherwise) would love to make a difference if they felt their efforts were productive.

- It is easily a full-time job to take on the more nuanced issues of targeted pricing and achieving cost cuts in the very short run.
- Fifteen full-time experts may be necessary to achieve the sort of diversity that Congress had in mind for the board.

2. Will the recommendations of IPAB be taken seriously by Congress?
    - Because members of Congress have spent so much political capital on the recent healthcare reform, it may be difficult to pass future Medicare cuts recommended by the board or otherwise.
    - The timeline outlined may be too tight for Congress to come up with reasonable alternative proposals given the Congressional divisions on health care policy. Although loop holes may exist or Congress could legislate them, there is some reason to believe that this may not happen. Any IPAB proposals are likely to be complicated. This would make it more difficult to come up with an alternative proposal within the specified timeline.
    - Just because IPAB is established, this doesn't mean that Congress will not pass its own Medicare reform unrelated to recommendations or even targets of IPAB.
    - Maybe IPAB can make recommendations to end special provisions for specific companies.
    - It may be difficult for IPAB to make the targeted cuts that would be optimal if these cuts involve regional winners and losers. Congress may tend to favor across the board cuts instead.
    - It is not surprising that IPAB is weak because members of Congress are reluctant to give up power. Hopefully this does not translate into them rejecting IPAB recommendations.
    - It is unclear how broad the "no judicial review" clause is in the creation of IPAB. This will probably only be determined by the courts.

3. If IPAB is effective and the targets are met, how will Medicare access and quality be affected by a potentially widening wedge between Medicare and private insurer payments?
    - There is a fear, maybe unfounded, that Medicare will turn into Medicaid (where beneficiaries in many places are known to have poor access to care).
    - Some hospital and provider groups could not survive if all patients were Medicare patients. The discrepancy in Medicare payments versus private insurance payments differs greatly by region.

4. If many providers are "off the table" with regard to reimbursement cuts before 2020, how will IPAB meet their targets?
    - They can make cuts to Part C.
    - They can provide incentives (potentially subsidies for using low-cost providers not cuts) to improve the overall average productivity level of the care sought by Medicare beneficiaries.

- They can promote accountable care groups and episode based payments to reduce hospital readmissions and complications. Episode based payments might work better for common diseases and events rather than rare illnesses.
- It is not obvious that an across the board reduction would be useful even if it was within the board's power. Targeting adjustments based on additional information (ie demographics, lab values, etc) could be useful in reducing the variance of reimbursements net costs faced by providers. To fully analyze the optimal adjustments, IPAB may need more data; collection of this data could be simplified with electronic medical records and the use of more broadly defined electronic standardized claims.
- Bundling of care recommendations from IPAB need to be defensible on the grounds of efficiency and synergies.
- IPABs success will depend on its ability to move delivery systems away from open-ended FFS.
- Tangible cost-savings maybe achievable if providers are forced to take a look at what works and doesn't work. This will involve a dramatic change of provider incentives.
- The interaction of technology and FFS drives a lot the unsustainable medical cost growth. IPAB would need to tackle this to achieve the aggressive short and long term goals.
- While IPAB can set an example of how to cut costs with Medicare reimbursements, it will be hard for private insurers to adopt some of the practices effectively if the innovations rely on beneficiaries remaining with the insurer for a long time (episode based payments, preventive care, etc). However, Kaiser is one of few examples of insurers that have overcome this problem because their plans are offered by almost all employers. The health insurance exchanges may also help individuals overcome the portability problem to some extent which could encourage private insurers to innovate in this direction.
- If it has the authority to do so, IPAB may consider taxing Medicare supplemental insurance policies to make up for the externality the supplemental polices put on the Medicare costs.

5. Would IPAB benefit from interaction with the Innovation Center?
    - IPAB may benefit from having joint staff with the innovation center. The innovation's centers mandate is to find innovative ways to pay for medical services; in particular, they have authority to test various ideas in pilots and extend the pilots if they are successful.
6. Is the focus of IPAB too much on short run cuts when long run cuts may be more feasible?
    - There is a sense in which IPAB may be on a "Wall Street" timeline because results are expected of the board in the very short run even though big change is more feasible in the long run.
7. Is the budget sufficient to accomplish the goals of IPAB?
    - IPAB differs from Medpac in many ways including the fact that it will be expected to produce implementation-ready recommendations. This will potentially require a staff of several hundred. The current budget does not seem like enough.

- If IPAB will be focused on drilling down and doing deep and timely analysis, they will need a sizable budget to hire highly skilled staff familiar with claims data.
- There is a reason why Medicare has low administration costs. Medicare claims are typically not adequately reviewed. Data collection is not as extensive as it should be. This may need to change to do timely analysis, and make the necessary cuts.

8. Some misc thoughts on reducing costs:
    - There is disagreement about whether available risk-adjustment methods are enough to prevent cream-skimming. However, there is agreement that risk-adjustment methods used for pricing MA are lacking and should be updated to include more risk factors. However, it may be that the primary reason why MA insurers are overpaid is political not technical.
    - Because uncompensated care may fall with the healthcare reform, this may leave more leverage for Medicare to reduce reimbursements without affecting hospital revenue.
    - Although it is easy to say that we should spend less on end-of-life care, it is actually not easy to identify and implement policy targeted at this group without hurting potential survivors. A workable solution seems illusive.
    - There is very little anti-trust regulation of hospitals and provider groups. Maybe the FTC and DOJ should be more active in governing competition in health care.

Day 2, 5/4/2010: Medicare Advantage

**Outline of Presentation**

A. History

i. Pre-history (1965-85)

- Group/Staff model plans (later HMOs) paid either FFS or cost based (80/20)
- Conflicted with prospective commercial payment methodology
- No opportunity for Medicare "savings"
- Late 70s "risk" pilots – KP Northwest

ii. TEFRA 1985

- Capitation based on 95% of county FFS
- Help KP, similar plans
- Save Medicare costs (5%)
- Provide for added benefits, especially for low income minorities
- Minimal risk adjustment

iii. Problems 1985-1997

- Geographic disparities in payments, added benefits
- Favorable risk profiles
- Evidence of overpayments (10-11%)
- Rapid growth starting in 1993; added benefits grew, including drugs

iv. BBA 1997

- Created "Medicare+Choice"
- Added new types of plans to promote greater geographic coverage
- Reduced growth of payments
- Plans quit or reduced geographic coverage; premiums rose; enrollment dropped; beneficiaries complained

v. BBRA-1999, BIBA-2000, MMA-2003

- Improved payments by adding floors, etc.
- Protections for newer plan types, especially PFFS plans
- MMA established Medicare Advantage with quasi-competitive bidding against county "benchmarks"
- Medicare Advantage ignited a new wave of growth again and a new wave of opposition

B. Current State of MA

i. Enrollment by types of MedAdv ( as of 4/10)
   - HMO ~ 7.3 million seniors
   - PPO ~ 2.1 million
   - PFFS ~ 1.7 million
   - MSA ~ 600

ii. Payments in 2010

   - Ratebook = 117%
   - Rebates = <4%>
   - Net = 113%

iii. More payment detail

   - By type (MedPAC March 2010 report)
     - HMOs ~ 112% of FFS Medicare
     - PPOs ~ 115%
     - PFFS ~ 117%
   - By region (approximate)
     - Highest (S.FL, S.CA) ~ 100%
     - Some urban ~ 110-115%
     - Rural ~ 115-130%
     - Puerto Rico ~ 170%

iv. Bids based on "benefit competition" Formula
   - Ratebook rate - Plan bid = Rebate
   - 75% of rebates used by plans, 25% back to CMS
   - Plan rebate portion can be used for:
     - Supplemental benefits (dental, vision, etc.)
     - Reduced cost-sharing (deductibles, copays, etc.)
     - Reduced Part B or Part B premiums
     - Increased payment to network providers
   - PFFS will probably disappear due to network requirement (or morph into PPOs)

C. Effect of PPACA

   - Froze ratebook for 2011, then multi-year transition
   - Base payment by quartiles of payment rate:
     - Highest ~ 95% of FFS
     - 2nd ~ 100%
     - 3rd ~ 107.5%
     - Lowest ~ 115%
     - In total, lower for each quartile than status quo
   - Rebate % used for beneficiaries reduced from current 75% to either 70%, 65%, or 50% based on quality "star" ratings
     (Rebate = Ratebook - Plan bid)
   - Quality bonus
     - Up to 5% more payment can be earned if plans reach certain quality scores on specified measures
   - "Qualifying counties" bonus

- For counties that have 250,000 people, 25% of seniors in MA and county FFS Medicare < National average, plans receive double bonus

– Minimum 85% Medical Loss Ratio (MLR) in 2014, with rebates if MLR is lower

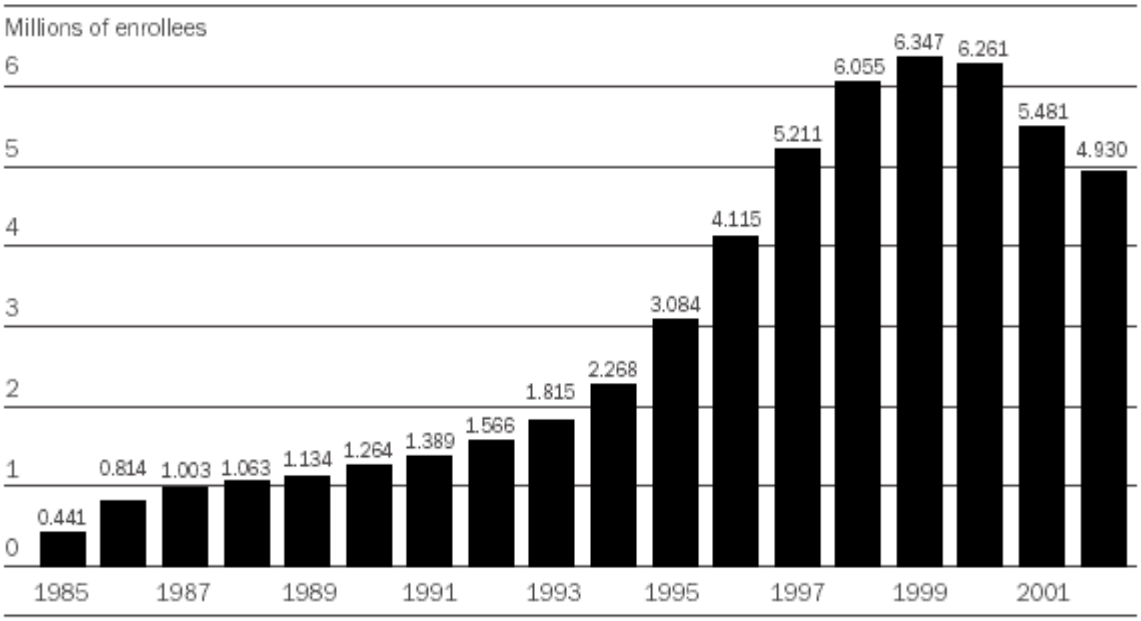
D. Why have private Medicare?

– Support capitated systems?
– Added benefits for low income beneficiaries?
– A venue for using managed care tools?
– "Halo effect" on FFS costs?
– A venue for care innovation and data?
– Get Congress off the hook?

E. What are the possible futures of MA?

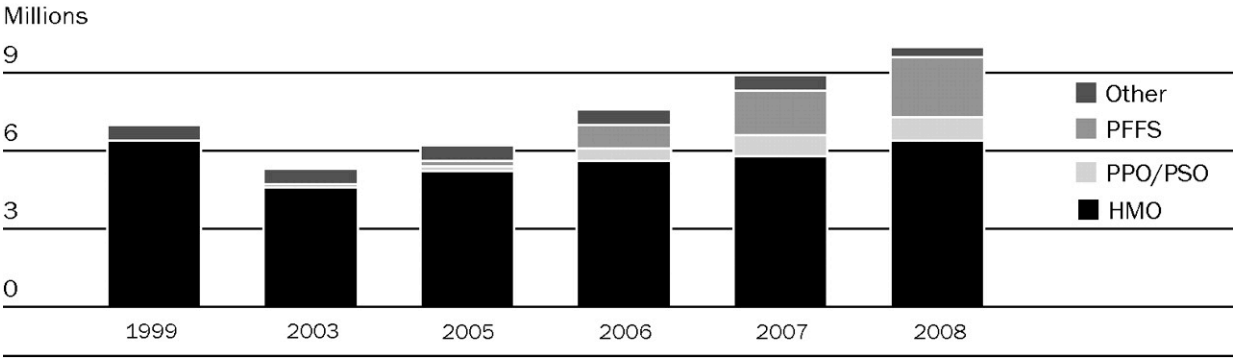
– Smaller "niche" program for high performance plans
– Move to real competitive bidding model
– Plans bow out; Medicare contracts with ACOs on shared risk basis
– Political change in 2012 reverses direction once again

**EXHIBIT 1**
**Enrollment in Medicare Risk/Medicare+Choice Plans, 1985–2002**




**SOURCE:** Mathematica Policy Research analysis of Centers for Medicare and Medicaid Services (CMS) Medicare Managed Care Contract Plans Monthly Summary Report, various years.
**NOTES:** Data for 1999–2002 are for enrollees in M+C coordinated care plans. Data for prior years are for enrollees in Medicare risk contracts. All data are for December of the given year.

**EXHIBIT 1**
**Medicare Private-Plan Enrollment, By Contract Type, Selected Years 1999–2008**




**SOURCE:** Centers for Medicare and Medicaid Services (CMS) Monthly Summary Report, various years (December), and June 2008.
**NOTES:** Totals exclude "pilots." Health maintenance organization (HMO) counts for 2003 and 2005 include a few enrollees in preferred provider organizations (PPOs) or provider-sponsored organizations (PSOs). "Other" includes Medicare 1876 Cost Plans, 1833 Cost Plans (HCPPs), Program of All-Inclusive Care for the Elderly (PACE), and demonstrations. HMO enrollment increased in 2008 as the CMS reclassified several demonstrations as HMO-SNPs (Special Needs Plans). PFFS is private fee-for-service.

**Discussion**

Questions about MA and related topics were discussed. Below are some different participant answers.

1. Has the fact that the goal of MA has changed so much over time affected its efficacy in achieving any specific goal: Efficiency, Assisting low-income people, Budgetary Savings?
    - It seems to be the consensus view that MA has not adequately met these goals and the evolving mission is a contributing factor.
    - In addition to affecting the effectiveness in achieving any goal, when the "outcome" of MA is analyzed people sometimes forget to take into account that the philosophy behind the program has varied so much over time.
2. What are some shortcomings of MA? Where there are shortcomings in MA, what might be an alternative approach to address these?
    - There is not enough emphasis on data collection and MA program evaluation. Medicare administrative costs are so low for a reason; there is not enough analysis of what they are getting for the money. It is possible that more analysis and auditing would more than pay for itself in savings to the Medicare program. Medicare doesn't invest enough in information gathering to be a good buyer.

- It is hard to compare the underlying cost structure directly so we don't really know if MA has a cost advantage in the provision of care. There should be more attention to gathering data on this issue.

3. What contributes to the regional variation in MA?
    - There are probably several sources of variation including: provider behavior, types of plans, and abuse or fraud. It is not clear how much each of these contributes to the overall observed variation.
4. What are alternative ways to structure MA payments? How do we compare these methods? When payment methods are not promising in their potential to boost productivity, what alternatives do we have?
    - Some payment alternatives proposed include:
        i. Set prices based on FFS prices and compete on services and quality
        ii. Competitive Bidding
        iii. Defined Contribution
    - Private plans are not particularly competitive in markets with monopoly power on the provider side. In these markets, traditional Medicare has more bargaining power and we should expect traditional Medicare to have a cost advantage.
    - In markets where providers have monopoly power, a better way to gain efficiency may be to incentivize providers to form ACOs. Bundling payments could help providers move toward the efficient provision of services.
    - On the other hand, providers have not taken the opportunity to organize themselves even though they have had this opportunity for some time. This experience highlights that Medicare will need to show providers there is an upside for them to organize <u>if</u> this organization is critical to improving productivity.
    - One way to promote organization of providers and more productive provision of care would be fundamental malpractice reform.
    - Regardless of the angle to reform the delivery system (whether through private insurance incentives or through direct provider incentives), there seems to be agreement that the delivery system will need to move in the direction of ACOs, bundled payments, and defined contribution.
    - There is disagreement on how "payment blind" physicians are or should be. If reforming the delivery system is done indirectly (through private insurance rather than provider reorganization), physicians will probably be more insulated from the value of the services they prescribe.
    - There was some discussion of the options for substitution into cheaper labor inputs (ie nurse practitioners). It seems like it is not particularly profitable to do this substitution at the primary care level (especially in CA), but may be more promising at the subspecialty level where the difference in pay is great between highly skilled nurses and specialists.
5. What role does MA serve?

- **One main role that participants acknowledged was that MA served as an opportunity for insurers to innovate and become more productive. Another main role is to provide consumers with choice, which may be particularly important for those that cannot afford supplemental coverage on traditional Medicare.**

6. Would it be desirable or feasible to extend a "Medicare Part D"-like system for public procurement in MA?
    - The Part D market seems to be functioning well according to most participants. Drug prices have seemed to decline after the introduction of Part D, although this is not true for monopoly drugs. Although, it should be pointed out that Part D has its shortcomings from the consumers point of view: 1. Ten percent of Medicare population still has no coverage, 2. Low income and disadvantaged populations are disproportionately represented in this uninsured group, and 3. There have been recent large increases in premiums charged by the largest insurers for the most popular plans.
    - The Part D design is not very easy to implement for private Medicare insurance more broadly. An advantage of Part D is the national nature of the drug market (as opposed to the regional markets associated with delivery of medical services).
7. What is the future of MA?
    - Some seem to believe that MA will not be around or will at least be not nearly as popular in the future in part due to the healthcare reform legislation.
    - The pressure on MA plans may not be as great as expected, however, because of the large wave of expected retirements of the baby boomer generation.
8. How does the mission of IPAB integrate with the experience and the future with MA?
    - One commonality is the lack of clarity of purpose of these two programs.
    - IPAB's success may depend on its ability to start out well. One way to get some quick savings would be to get control of the fraud and abuse in traditional Medicare. This would, in turn, lower the cost of MA since private insurers bid against FFS Medicare.
    - **Depending on how one interprets the exclusions in the IPAB mission, it looks like MA is the single biggest thing that IPAB is allowed to cut. IPAB may also have the authority to promote delivery system reform by incentivizing the creation of ACOs and creating bundled payments. Since the board cannot cut traditional reimbursement, the board may be constrained to offering weak incentives for voluntary provider reorganization that may disproportionately attract the most efficient not least efficient providers (the opposite of the target).**
    - Like the experience with MA, IPAB's mission may change in the next 10 years if there is legislation or judicial review which changes its mandate.