

---

# Cost Containment in Medicare: What Works and What Doesn't

Robert Berenson, Michael Hash, Thomas Ault, Beth Fuchs, Stephanie Maxwell, Lisa Potetz, and Stephen Zuckerman

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. There have been nine approaches to Medicare cost containment since the mid-1980s. Overall, 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.

## Prospective Payments

Prospective payment rates for hospitals have been in place for more than 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 2 years, expenditures fell by 3% 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% between 1988 and 1996. Since prospective payments began in 2000, expenditure increases have been about 7%. 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 was significantly lower through 2003 because of fee

schedules and spending targets in place since 1992. There was a 4% savings in the 12-year period after 1991. However, for the years 1998 to 2005, total physician spending grew 7.4% annually, below the long-term average of 8.9%. One problem is that the fee-for-service (FFS) payment system encourages increases in the volume of services. A second problem is that Congress has repeatedly overridden automatic reductions to the physician fee schedule that would otherwise have been imposed, allowing more rapid growth in expenditures above annual targets.

## Bundling FFS 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%. Two competitive bidding demonstrations for durable medical equipment (DME) estimated savings of 20%. 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 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% 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 pri-

## PROVIDER ACTION

### Impact to You

Because of the financial pressure that Medicare is under, CMS will continue to implement approaches for cost containment. And while overall Medicare has a mixed record of managing costs, there is considerable evidence that modest cost containment has been achieved, especially compared to growth in private health spending. This cost-containment effort will likely grow during the Obama administration.

### What You Need to Know

One of the nine methods Medicare has initiated to control expenditures is to change the incentives from a cost-based system to an episode payment. The other systems include physician fee schedules, bundling FFS payments, competitive bidding, benefit design, new technology, chronic care management, private plan contracts, and fraud and abuse prevention.

### What You Need to Do

Physicians will need to prepare to deliver cost-effective care. This will require practices to be able to handle all of the nine cost-reduction strategies that Medicare will likely expand.

mary 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 plan 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, judg-

ments, 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 and detection initiatives could lower expenditures without adversely affecting health outcomes. Further savings could be available from investing in information technology, more rigorous review of provider qualifications, and greater oversight of Medicare contracts with private health plans. *MPM*

Robert Berenson, Michael Hash, Thomas Ault, Beth Fuchs, Stephanie Maxwell, Lisa Potetz, and Stephen Zuckerman are from The Urban Institute and Health Policy Alternatives Inc. Project Manager was Sarah Thomas of the AARP Public Policy Institute.

Reprinted with permission of AARP ([www.aarp.org/ppi](http://www.aarp.org/ppi)).