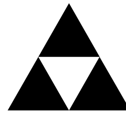

AMERICAN ACADEMY *of* ACTUARIES

May 29, 2009

The Honorable Max Baucus, Chairman
The Honorable Charles Grassley, Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Senators Baucus and Grassley,

On behalf of the Academy of Actuaries'[1] Medicare Steering Committee, I appreciate the opportunity to comment on the first in the Senate Finance Committee's series of policy options papers, *Transforming the Health Care Delivery System*, which was issued on April 29.

The Medicare system is in a serious financial crisis. The recently issued 2009 trustees report shows that by 2017 the Hospital Insurance (HI) trust fund will be depleted and tax revenues will only cover 81 percent of the cost of the program. By 2017 all health expenditures (public and private) are expected to exceed 20 percent of gross domestic product (GDP).

The Finance Committee has produced a number of excellent options to improve the Medicare program. Many of these options would help reduce the cost of the system and most of the proposed changes would enhance the quality of the program. We would note, however, that given the seriousness of Medicare's current financial challenges, even stronger action will likely be needed. The current focus on comprehensive health care reform provides an opportunity for policymakers to also reform Medicare in this Congress. Deferring action will only ensure that the changes necessary are more extreme and likely more burdensome to future generations.

The following comments concern proposals from the Committee's option paper where we believe an actuarial perspective may be useful.

Section I: Payment Reform—Options to Improve the Quality and Integrity of Medicare Payment Systems
The first proposal in Section I would "establish a hospital value-based purchasing program that moves beyond paying for reporting …to paying for hospitals' actual performance on those measures." Similarly, the second proposal in Section II would, among other things, require that certain services initiated within 30 days of discharge would be paid through a bundled payment beginning in 2015. One of the factors contributing to Medicare spending growth, and spending growth in the health care system as a whole, is that current provider-payment systems do not align financial incentives with the goal of maximizing the quality and value of health care provided. Moving to a value-based purchasing program for inpatient hospital care in Medicare, for example, would be a step toward better aligning financial reimbursement with improved health outcomes. The goal of paying for quality is an important one that has the potential to significantly improve the effectiveness of the health care system.

Section II: Long-Term Payment Reform—Options to Foster Care Coordination and Provider Collaboration
Sustainable Growth Rate
The third proposal in Section II offers two alternative solutions to a continuing problem with the method by which services of physicians and other providers are adjusted each year. The current adjustment is based on the Sustainable Growth Rate (SGR) index. Without legislation that would modify the SGR, a 21 percent reduction in payments would be required in 2010. Such a large reduction in physician payments is unrealistic and, without modification, will result in a severe disruption in the Medicare delivery system.

[1] The American Academy of Actuaries is a professional association with over 16,000 members, whose mission is to assist public policymakers by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

For some time, the index has provided for large reductions in physician fees, and each year, Congress has made annual ad hoc adjustments to avoid payment reductions, which may be disruptive. As a result, these reductions have increased with each ad hoc adjustment, and it is now not practically reasonable to return to that measure. Thus, it seems clear that the growth in provider payments has not been controlled by the SGR. As such, the SGR is no longer an appropriate index to use in determining annual changes in physician fees.

We believe that the immediate 21 percent reduction in fees called for by the current formula should not be implemented during the next three years, due to the potential disruption they would cause. Further, the Medicare Steering Committee believes it would be best to replace the current SGR index in the Medicare law with a more appropriate method for setting physician fees.

Recent legislative history suggests that immediate, large decreases in provider fees are unlikely to be implemented. While explicitly including this in statute could have a significant budgetary impact, adopting a solution that results in formula fee adjustments that Congress can reasonably expect to allow to go into effect each year would in turn make projected Medicare costs more realistic. Annual ad hoc increases are a poor mechanism for controlling long-term program costs, and subject critical funding decisions to short-term political pressures. And, there is always the chance that Congress will not be able to act in time to avoid a sharp decrease in some future year. Rather than simply reverting to current law at the end of three years, or current law with arbitrary floors, it is time to find a replacement for the current SGR system.

The Medicare Payment Advisory Commission (MedPAC) has studied this issue in detail, and the Academy would be pleased to assist policymakers in studying the issue as well. It is time to adopt a realistic plan for managing future payment increases that can be allowed to operate without annual ad hoc adjustments and that better aligns payments with the quality and efficiency of care.

Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform
We have no specific comments on the options provided in this section.

Section IV: Medicare Advantage—Options to Promote Quality, Efficiency and Care Management
Section IV of the paper addresses potential changes in the financing and structure of Medicare Advantage plans. Medicare Advantage plans have been in existence since 2003, and it is an appropriate time to take a close look at how the program has operated and to introduce any changes needed to improve the Advantage plans.

However, we would suggest the Committee carefully consider making changes in the design of the program that might result in the eventual decline of Medicare Advantage plans. Medicare+Choice plans became available in 1997 and were readily offered. Initially insurers were able to offer the Medicare+Choice plans at financially sound premium levels. However, a series of changes in the design and financial rules for Medicare+Choice plans removed the incentive for many insurers to continue to offer the plans. As a result, insurers began to pull out of the program leaving many enrollees who had been happy with the program without an alternative to traditional Medicare. Depending on their nature, changes to Medicare Advantage programs could result in a similar effect on such plans. The Medicare Steering Committee stands ready to assist the Senate Finance Committee in determining the actuarial impact of proposed changes to the Medicare Advantage benchmarks.

The Finance Committee presents two possible approaches to develop a more efficient payment structure. Approach 1, which would modify the current benchmarks, would directly reduce payment rates. In addition, it could be implemented without fundamentally changing the current Medicare Advantage bidding process. It would, however, continue to base prices on a complex administrative formula rather than market competition. The likely result is that benchmark payment rates would still be much more generous in some geographic areas than in others. In addition, if formula reductions are too deep or are implemented in an arbitrary fashion, they have the potential to disrupt the Medicare Advantage program and result in beneficiaries losing access to this coverage option.

Approach 2, which would set benchmarks based on a competitive bidding system similar to that used for Medicare Part D, would be a much more significant change. Competitive bidding has worked well in the Medicare Part D program, resulting in costs that are well below those originally projected. However, the Medicare Advantage program is significantly more complex than the Medicare Part D program, and any competitive bidding structure would have to be developed carefully to avoid unanticipated consequences. For instance, it would be important to

ensure that a competitive bidding system not discourage the entrance of new plans into the market. The transition would also have to be handled carefully to avoid disrupting the bidding process.

Whether approach 1 or 2 is ultimately taken, careful attention to the details of the system will be critical in making it work. The Academy would welcome the opportunity to provide the Committee with technical assistance in this area, as well as any of the other areas addressed in this comment letter.

As noted earlier, the seriousness of Medicare's current financial challenges requires strong and immediate reform to the program. If you have any questions or would like to discuss any of these comments further, please contact Heather Jerbi, the Academy's senior health policy analyst, at 202.785.7869 or Jerbi@actuary.org.

Sincerely,

Thomas F. Wildsmith, MAAA, FSA
Chairperson, Medicare Steering Committee
American Academy of Actuaries