

The Seniors' Choice Act

*A proposal keeping the promise to America's seniors
by building a stronger, more sustainable Medicare program*



U.S. Senator Richard Burr

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Summary of Key Policy Changes

Implementation of Common-Sense, Bipartisan Reforms Would Start in 2014

Give Seniors a New Benefit: Maximum Out-of-Pocket Protection

Under the current Medicare program, seniors do not have the peace of mind that they are protected against significant out-of-pocket medical expenses. By putting patients first, we strengthen Medicare for seniors by providing a new maximum out-of-pocket benefit for seniors. This policy proposal builds on the recommendations of the President's bipartisan Fiscal Commission and the bipartisan Lieberman-Coburn proposal:

- The unified deductible would streamline cost-sharing for inpatient visits and outpatient services (Medicare Parts A and B). Seniors would have a single annual deductible of \$550 for both Part A and B services.
- After paying the deductible, seniors would have unified cost-sharing for Part A and B services, visits, or treatments in the form of 20 percent co-insurance up to an annual total of \$5,500.
- For the seniors who might reach paying \$5,500 out-of-pocket over the course of a year, they would then only pay a 5 percent co-insurance for any service or treatment up to \$7,500.
- At \$7,500, a senior would reach the out-of-pocket maximum limit and would not have any additional expenses that year.

Increase Cost-Sharing for Wealthier Seniors

We suggest adopting a provision of the bipartisan Lieberman-Coburn Medicare reform plan which increased the new "annual maximum out-of-pocket cap to higher levels for those with significant monetary means."¹ Under this option, the new maximum out-of-pocket levels would be adjusted for income as follows:

- \$12,500 for individuals with income \$85,000 - \$107,000 (\$170,000-\$214,000 for married couples)
- \$17,500 for individuals with income \$107,000 - \$160,000 (\$214,000 - \$320,000 for married couples)
- \$22,500 for individuals with income \$160,000 - \$213,000 (\$320,000 for married couples)

Require Millionaires on Medicare to Pay Full Premiums

Our proposal would ensure millionaires on Medicare pay the full cost of their Parts B and D premiums, and have a higher unified deductible than other seniors. "Millionaires on Medicare" can afford to pay more: according to the independent Chief Actuary of the Social Security Administration, there are about 60,000 seniors enrolled in Medicare Part B who have annual incomes of more than \$1,000,000 or more.²

Modernize Requirements on Medigap Coverage, Save Seniors and Taxpayers Money

The President's Fiscal Commission noted, "the ability of Medicare cost-sharing to control costs – either under current law or as proposed above – is limited by the purchase of supplemental private insurance plans (Medigap plans) that piggyback on Medicare. Medigap plans cover much of the cost-sharing that could otherwise constrain over-utilization of care and reduce overall spending."³ Therefore, as part of a comprehensive effort to strengthen and modernize Medicare, we propose to prohibit Medigap plans from covering the first \$500 of a senior's cost-sharing and limit coverage above \$500 to 50 percent of the next \$5,000 of Medicare cost-sharing.⁴

¹ The Lieberman-Coburn Proposal: A Bipartisan Plan to Save Medicare, June 2011, page 3.

http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=1ea8e116-6d15-46ba-b2e0-731258583305

² This is modified adjusted gross income as outlined on page 8 of *Subsidies of the Rich and Famous*, an oversight report by Senator Tom Coburn, M.D., November 2011. http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=bb1c90bc-660c-477e-91e6-91c970fbee1f

³ http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf, page 38

⁴ http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf, page 38

Repeal Independent Payment Advisory Board

Putting 15 unelected bureaucrats in charge of the Medicare program is not the way we do things in America. Seniors deserve the ability to hold elected officials accountable for the decisions that affect their Medicare, but the Board created in the new health care law would put too much power in the hands of politically-appointed Washington bureaucrats. Therefore, we would immediately repeal the Independent Payment Advisory Board.

Incremental Premium Increases to Save Medicare

In 2011, the majority of Medicare enrollees paid a Part B premium of \$96.40 per month. The bipartisan Lieberman-Coburn Medicare plan proposed “increasing basic Part B premiums gradually for all enrollees by 2% of program costs every year for five years until the premium percentage paid by enrollees equals 35% of the program’s costs” so that the “dollar amount of the monthly premium increase per year would be, on average, approximately \$15-20 a month.”⁵

We propose increasing premiums on average, by three percent of overall program costs each year, beginning in 2013, so that a nine percent adjustment is accomplished before larger structural reforms we propose in 2016. Under our proposal, lower-income seniors would be held harmless from increased Part B premiums.

Gradually Increase the Age of Eligibility for Participating in Medicare

By adopting a provision of the bipartisan Lieberman-Coburn proposal, we propose a gradual increase in the age of eligibility for Medicare by two months each year, beginning with people who were born in 1949 (who will turn 65 in 2014) until the eligibility age reaches 67 for people born in 1960 (who will turn 67 in 2027).⁶ As the Congressional Budget Office (CBO) notes, these “increases are similar to those already under way for Social Security’s full retirement age—that is, the age at which workers become eligible for full retirement benefits—except that scheduled increases in the full retirement age include a 12-year period during which the full retirement age remains at 66.”⁷ CBO notes that an increased age threshold for Medicare eligibility would “reinforce the incentive to delay retirement created by increases in Social Security’s full retirement age.”⁸

Make SGR a “Bridge” to A New, Better Medicare

We would use a portion of the savings generated under our proposal to freeze the current physician payment rates for the near future to help ensure seniors will have access to their doctors. While freezing payments at current rates is not ideal, we must make hard choices to ensure increasingly scarce taxpayer dollars are utilized to put patients first. This would provide a “bridge” for SGR payments until the new Medicare premium support model we propose is implemented.

Offer a New Transitional, Voluntary Care Coordination Benefit to Seniors Who Need It

All Medicare beneficiaries that fit certain medical and clinical criteria would be eligible for a new, voluntary care coordination benefit. All seniors in the traditional Medicare program could select this care coordination benefit, but it would only be activated if they met certain medical criteria. This new benefit would be directed to higher-risk beneficiaries with the goal of better-managed health and decreased use of emergency rooms and avoidable hospitalizations. This voluntary benefit would be flexible enough to empower patients and providers to leverage the care coordination that will best meet their personal needs, such as targeted case management, transitional case management, patient support systems, bio-monitoring, or disease management.

⁵ http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=1ea8e116-6d15-46ba-b2e0-731258583305

⁶ Under this proposal there would be no change in the policy that Medicare is available to persons under age 65 who have been eligible for disability benefits under Social Security for at least 24 months and to those with end-stage renal disease or amyotrophic lateral sclerosis

⁷ <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>, page 45

⁸ <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>, page 45

To ensure appropriate and high-quality care coordination, providers and beneficiaries would be accountable for demonstrating results and achieving specific outcomes based on beneficiaries' health status and their care coordination needs. This would be an interim benefit before larger structural reforms were implemented in 2016.

Implementation of Premium Support Would Begin in 2016

Delivering Medicare Benefits through Premium Support

We propose adopting "premium support" to strengthen Medicare and give seniors the right to choose the Medicare plan that best meets their needs. This new system would provide each senior with a fixed government contribution for a Medicare plan of their choice.

First, we would define geographic areas within the country based on different regions that make sense for pricing goods and services covered by public and private health insurance plans. The idea of building on the Medicare Part D regions seems appropriate, but Congress could also decide to use states or a combination of states and new regional areas.

Second, we would require traditional Medicare Fee-For-Service (FFS) and private plans to compete with each other. In 2016, the first year of bidding, FFS Medicare and Medicare private plans would participate in competitive bidding at a regional level to offer a package of health care benefits actuarially equivalent to the previous year's Medicare benefit. While there would not be a specific, required benefit package required for new Medicare plans that would be spelled out in detail, all plans would be required to cover basic hospital, surgical, physician, and emergency care.

New plans would cover the basic categories offered by the current Medicare benefit, but would have a wide range of flexibility in plan design and plan administration. The government-administered plan would be required to be offered in every market area, but private plans would not have to bid in every region. Plan bids would be weighted by plan enrollment after the first year. First year bids could need some adjustment to prevent plans from offering an unreasonably low bid that could distort market share.⁹

Next, seniors would receive their Medicare benefit as a defined contribution. Key to making this proposal work is to give seniors in a region a fixed amount from the government for which to buy a Medicare plan. The government-administered plan and private plans would both bid to provide the Medicare benefit for a region. The Federal Government's contribution for the first year's bid would be the Government's share of spending (in Parts A and B) for the prior year. The Federal contribution for each senior would be tied to the weighted average bid. The defined governmental contribution would be adjusted for income levels, so the wealthiest seniors would pay more and the lower-income seniors would pay less. However, the contribution would not increase if a given senior simply picked a more expensive plan – the amount of the governmental contribution would be fixed, regardless of what plan a senior chose. The dollar amount of the defined contribution would increase each year based on the competitive bidding system that accounts for the prior year's expenses and enrollment.

To ensure a level playing field, a new Medicare Consumers' Protection Agency (MCPA) would oversee the bidding process. The Centers for Medicare and Medicaid Services (CMS) would still oversee the bids for the government plan, but overseeing private bids inside CMS would clearly be a conflict of interest. MCPA's management of the bidding process is modeled on the Office of Personnel Management's supervision of the bidding process for health benefits provided to Members of Congress and federal employees. MCPA would be led by Senate-confirmed appointees and would host a number of advisory boards to ensure broad, transparent stakeholder engagement.

As part of ensuring the system worked for every senior, the MCPA would oversee a risk-adjustment process to mitigate the problem when consumers with the highest costs (seniors who are the oldest and sickest) purchase a particular

⁹ Similar to CALPERS and when FEHBP was started, rate shock between FFS and private plans would be mitigated for the first three years by requiring premium thresholds to be no larger than a certain differential. This mechanism would be phased out over a three year period.

coverage product. Wealthier seniors would pay higher premiums, and lower-income seniors would pay reduced premiums, but all seniors would have a wide range of choices like the same kinds of choices Members of Congress currently receive. In our plan, stand-alone Prescription Drug Plans would continue, but FFS would be prohibited from adding a drug benefit, because the Medicare drug benefit is voluntary.

We would help encourage seniors' choices by using an open enrollment period each year, during which beneficiaries could choose a health plan that best meets their individual needs. This is similar to the approach used in Medicare's prescription drug benefit and in the Federal Employees' Health Benefits Program.

No senior currently on Medicare would be forced to leave the traditional Medicare option, but each year during the open enrollment period, newly-enrolling or currently-enrolled seniors could change their plan to one that best meets their needs. If a newly-enrolled beneficiary declined to select a plan, he or she would be auto-enrolled into the plan in his or her region that was the best fit for their budget and health status, but they would be allowed a one-time plan switch if they did not like their plan before the annual open enrollment period.

Introduction

Obligation for Reform and Opportunity for Renewal

For almost half a century, the Medicare program has provided health care to our nation's seniors. But, for some time, the Medicare program has faced increasingly serious financial troubles. The Medicare program is broken. It is facing increasingly grave challenges both in terms of costs and benefits. These challenges threaten the sustainability of the Medicare program for today's seniors and future beneficiaries.

While Medicare is very popular, seniors and their loved ones have not been immune to the current program's shortcomings. Unlike most commercial insurance, traditional Medicare still does not offer seniors maximum out-of-pocket protection. Too many seniors are exposed to unpredictably high costs when they get sick or feel forced to purchase costly supplemental plans. Nor does basic Medicare spend dollars effectively to coordinate patient care.

With respect to costs, the day of reckoning is near. As President Obama has noted, "With an aging population and rising health care costs, we are spending too fast to sustain the program." According to the most recent report from the Medicare actuaries, insolvency of Medicare's Hospital Insurance Trust Fund could hit as soon as 2016.¹⁰ The National Commission on Fiscal Responsibility and Reform and budget experts have warned that Medicare is the fastest growing part of the budget. Federal health care represents the nation's single largest fiscal challenge over the long run. The President is correct that if we do not reform Medicare, "it won't be there when future retirees need it." We cannot wait; we must reform Medicare to save it.

The new health care law acknowledged that the status quo is unsustainable, but instead of fixing what is broken, the new law put in place policies that will further strain an already overburdened system. In fact, the challenges facing the Medicare program have been made more acute by the new health care law, which failed to treat the underlying problems threatening Medicare's long-term sustainability. The new law changed Medicare as seniors know it, and not for the better. It took more than \$500 billion from the financially troubled Medicare program for new government spending not for seniors. Changes to Medicare Advantage will threaten millions of seniors' ability to keep the health care coverage they like, despite being promised that they could keep it. The new law established an independent board of unelected and unaccountable bureaucrats who can reduce reimbursements to health care providers who care for seniors. New Medicare enrollees are already experiencing difficulty in finding physicians taking new Medicare patients. If Congress does not save Medicare and repeal this board of politically-appointed bureaucrats, arbitrary cuts to health care providers will further jeopardize seniors' access to care.

Too often Washington's proposed solutions come in the form of patches that not only fail to fix underlying problems, but actually make them worse. While the new health care law failed to address the serious challenges facing Medicare, it is time for Congress to now have an honest discussion with the American people, not just about the financial challenges and severe shortcomings of the current program, but the important opportunity these challenges present to strengthen and improve Medicare for seniors. President Obama has said that "we have to reform Medicare to strengthen it."¹¹ We agree and believe that any serious Medicare reform must be patient-focused, and rooted in and leverage what is working well.

We are putting forward the reform proposal to show how the right set of common-sense reforms can allow us to keep our promises to seniors and provide seniors the choice of an even better benefit. Our vision for reform is guided by key principles: reform should provide seniors with better clinical outcomes. Reform should also lower costs and ensure that seniors can access appropriate care in the right setting, at the right time. Reform should offer a choice of a benefit that is as least as good as their current one. We believe that this blueprint for reforms lays a foundation from which to find

¹⁰ <https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>, page 25

¹¹ President Obama's Address to a Joint Session of Congress, September 8, 2011, <http://www.whitehouse.gov/the-press-office/2011/09/08/address-president-joint-session-congress>

agreement and bipartisan solutions. Medicare reform will not be easy, but if we are guided by these principles we will be headed in the right direction.

We applaud those who have put forward Medicare reform proposals over the years. This reform proposal is informed by and in many ways reflects this important body of work. Our reform blueprint is intended to build on bipartisan ideas that present the most viable path toward a better Medicare program, perhaps most notably the Breaux-Thomas Medicare Commission.¹² Our vision is informed by our own personal experiences with patients, loved ones, seniors, the health care system, and the Medicare program.

It is our hope that this Medicare reform blueprint will spark a respectful debate and robust discussion about how Congress can strengthen and improve the Medicare program, putting it on a sustainable path. Our blueprint defines the problems with the current program and outlines both immediate and longer-term reforms that will improve the program and put it on a much stronger fiscal footing. We cannot wait to address the serious problems facing Medicare today and in the coming years. We look forward to engaging with the full range of stakeholders, including Medicare thought leaders and our constituents, to refine these proposals and find solutions to the serious challenges confronting our nation's seniors, taxpayers, and health care system.

This is an opportunity to offer seniors the choice of a better benefit through increased choice and competition. Medicare's fiscal challenges cannot be ignored, so we must reform Medicare to benefit current and future seniors. We have the important opportunity to put patients first and give seniors a better Medicare benefit. We stand side-by-side, ready to work with seniors, stakeholders, industry, and our colleagues to strengthen Medicare, and by doing so, offer seniors the choice of a better benefit and greater peace of mind.

¹² Documents from The National Bipartisan Commission on the Future of Medicare are available online, <http://thomas.loc.gov/medicare/>

Chapter 1 – Medicare 101

Background: Medicare “101”

Congress established the Medicare program in 1965 –almost 50 years ago—as a federal entitlement program to provide health insurance to individuals 65 years of age and older.¹³ The Medicare program was later expanded to include permanently disabled individuals under 65. In 2010, Medicare provided federal health insurance to almost 48 million people who are elderly or disabled. In 2000, the program cost \$216 billion, but in 2011 that cost had grown to approximately \$550 billion.¹⁴

Today, instead of offering seniors a comprehensive and coordinated medical benefit, the Medicare program consists of bureaucratically-controlled silos: Medicare Parts A, B, C, and D. Too often, seniors are left on their own to navigate care through the program.

Part A, also commonly referred to as Hospital Insurance (HI), covers inpatient hospital services, skilled nursing care, home health, and hospice care. The Hospital Insurance Trust Fund is mainly funded by a dedicated payroll tax of 2.9 percent of earnings, split between employers and workers.

Part B, also referred to as Supplementary Medical Insurance (SMI), is voluntary and covers physicians’ services, outpatient services, and some home health services. Part B is funded by both beneficiaries (25 percent) and general revenues from the federal treasury (75 percent). In other words, three-fourths of Part B funding comes directly from taxpayers. Together, Parts A and B of Medicare comprise “original Medicare,” which covers benefits on a fee-for-service (FFS) basis.

Part C, which is also funded by the HI and SMI Trust Funds, is a private plan option for a beneficiary which offers coordinated care by covering Part A and B services. Lastly, Part D offers beneficiaries a voluntary prescription drug benefit, which is funded through beneficiary premiums (about 25 percent) and general revenues (about 75 percent).

Medicare’s prescription drug benefit provides coverage of outpatient prescription drugs to seniors who choose to enroll in this optional benefit, and in 2010, about 60 percent of eligible Medicare beneficiaries enrolled in Part D. Prescription drug coverage is provided through private prescription drug plans, or through Medicare Advantage prescription drug plans which offer prescription drug coverage that is integrated with the health care coverage they provide to Medicare beneficiaries under Part C.

The Shortcomings of Medicare’s Fee-For-Service Model

The popularity of the program may be because some of the program’s structural shortcomings – financing and demographics – are not always readily apparent. However, many seniors are painfully aware of other shortcomings found within the program. Many Americans with a family member or friend on Medicare have heard about a problem with the program: a senior who lacks coordinated care, has a hard time finding a doctor who will accept Medicare patients, and an unpredictable maze of confusing cost-sharing and coinsurance, an inexplicably high charge on a hospital stay or doctor’s office visit.

In too many ways, the Medicare benefit has been slow to keep pace with medical advances and improvements in the delivery of care. For example, a prescription drug benefit was not added to the program until 2003 – and even then Congress failed to create a sustained financing mechanism, instead adding more than \$16 trillion in unfunded liabilities to the federal balance sheet.¹⁵ Another shortcoming is that under basic Medicare there is no limit an individual senior’s

¹³ http://www.ssa.gov/OP_Home/ssact/title18/1800.htm

¹⁴ 2001 data accessed at <http://www.cbo.gov/doc.cfm?index=2727&type=0&sequence=5>, and 2011 estimate from the Congressional Research Service’s “Medicare Primer,” Patricia A. Davis, Coordinator, January 19, 2012 (R40425).

¹⁵ <http://www.crs.gov/Products/R/PDF/R41436.pdf#page=20>

cost-sharing or out of pocket cost. Moreover, many seniors are surprised to learn that basic Medicare does not cover dental care or eyeglasses, except in very limited circumstances.

As a result of these shortcomings, seniors clearly attempt to compensate for traditional Medicare benefits' shortcoming through supplemental coverage—the lack of comprehensive coverage in the bureaucrat-controlled FFS benefit design leads more than nine in 10 beneficiaries to take up some form of supplemental coverage.¹⁶

The Medicare Payment Advisory Commission explains the situation like this:

“The current fee-for-service (FFS) benefit design includes a relatively high deductible for inpatient stays, a relatively low deductible for physician and outpatient care, and a cost-sharing requirement of 20 percent of allowable charges for most physician care and outpatient services. Under this design, no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. If not supplemented with additional coverage, the FFS benefit design exposes Medicare beneficiaries to substantial financial risk and may discourage the use of high-value care. The lack of comprehensiveness in the FFS benefit design leads more than 90 percent of beneficiaries to take up supplemental coverage or have Medicaid, which mutes the effect of high out-of-pocket costs. Researchers agree that Medicare beneficiaries with supplemental coverage tend to have higher use of services and spending than those with no supplemental coverage.”¹⁷

Basic Medicare's benefit structure has also resulted in fragmented care. Seniors who are particularly at high risk because of their underlying health care needs or an episode of care fall victim to bouncing between providers and different access points, and not necessarily the most appropriate access points for care depending upon their needs. These beneficiaries, who are more vulnerable because of their health status, have suffered from the lack of coordinated care under Medicare's traditional “one-size-fits-all” FFS model.

Medicare's bureaucrat-controlled FFS model is more important than one might initially think. Just by virtue of its size and universality, the Medicare program has grown to exert undue influence over health care markets. Because Medicare is the largest payer of health claims in most market areas, often commercial health plans benchmark to Medicare's fixed prices and reimbursements for a range of medical services and treatments.

Jim Capretta, a former health care official at the White House Office of Management and Budget, recounts the statement of another Medicare official responding in an interview about reforming Medicare and our health system. The former Medicare official said:

“I don't think Medicare is broken....Health care is broken. The delivery system isn't working. That's the problem....We set up a delivery system which is fragmented, unsafe, not sufficiently patient-centered, full of waste, unreliable, despite . . . great efforts of the work force. We built it wrong. It isn't built for modern times....Medicare doesn't need fixing. Health care needs fixing.”¹⁸

However, as Capretta explained, trying to fix inefficiencies in health care without touching Medicare's current model is “exactly the wrong way to think about the problem,” because it ignores the silent, but powerful force Medicare plays as the largest payer in most geographic markets.¹⁹ It is true that health care in America definitely is too often “fragmented, uncoordinated, full of waste and excess, and not responsive enough to patient concerns and wishes.”²⁰ But Medicare's current structure is part of the reason for this – so fixing Medicare can help fix other problems in health care. As work by MIT economist Amy Finklestein has shown, one of the primary reasons for distortions and failings in our health care

¹⁶ Medicare Payment Advisory Commission (MedPAC) Report to the Congress: “Medicare and the Health Care Delivery System,” June 2011. Chapter 3, pg. 63.

http://www.medpac.gov/chapters/Jun11_Ch03.pdf

¹⁷ Medicare Payment Advisory Commission (MedPAC) Report to the Congress: “Medicare and the Health Care Delivery System,” June 2011. Executive Summary, pg. xiii. http://www.medpac.gov/documents/Jun11_EntireReport.pdf

¹⁸ National Review Online, “The Medicare Debate,” December 27, 2011. Capretta, James. <http://www.nationalreview.com/articles/286667/medicare-debate-james-c-capretta>; <http://www.kaiserhealthnews.org/Stories/2011/December/12/transcript-donald-berwick-interview.aspx>

¹⁹ National Review Online, “The Medicare Debate,” December 27, 2011. Capretta, James. <http://www.nationalreview.com/articles/286667/medicare-debate-james-c-capretta>

²⁰ National Review Online, “The Medicare Debate,” December 27, 2011. Capretta, James. <http://www.nationalreview.com/articles/286667/medicare-debate-james-c-capretta>

delivery system is Medicare's FFS model, especially in the broader context of a system of third-party payers.²¹ As Finklestein explained in 2007, "by 1970, the [Medicare] program caused a 37% increase in hospital spending." Finklestein says, "this is an enormous number," because she concludes that Medicare "is responsible for about half of the six-fold growth in real per capita health-care spending" over four decades.²²

Here's how Jim Capretta explains it:

"In Medicare fee-for-service, those providing the services get paid for every procedure or test that is performed, regardless of whether it helps the patient. And the government sends reimbursement for all claims submitted by any licensed provider, with no questions asked. In most markets, Medicare fee-for-service is the largest purchaser of medical care. The entire delivery system has been built up around the program's distorted incentives. Every type of provider has its own payment system. This fosters extreme fragmentation, as every lab, clinic, physician's office, and hospital can bill the Medicare program separately....The response of the political system to this inefficiency and high cost is counterproductive price controls. To hit budget targets (at least on paper), Congress and Medicare's regulatory apparatus have reduced the amounts that the program pays for medical procedures. This kind of cost cutting makes no distinction based on the quality or efficiency of care provided. Rather, it is across-the-board, hitting good actors and bad alike."²³

We have noted the healthy consensus among most experts as to the distortive effects of Medicare's FFS model. Here is yet another example. While Medicare makes adjustments to payments geographically with the intent to equitably cover variations in wages, rents, and other costs that occur regionally, an empirical analysis revealed that nearly 4 in 10 hospitals have been granted exceptions to how these adjustments are calculated – therefore *amplifying* the price-distorting effect of FFS even more.²⁴

In sum, Medicare's FFS distortions are a key reason the cost of medical services may vary inexplicably at times. Medicare is a price-fixing centralized bureaucracy, and when it is used as a benchmark for reimbursements, pricing distortions are then imported to the rest of the commercial market.

Unfortunately, this dynamic can encourage tremendous waste in our health care system. The business analytics firm Thomson Reuters examined published research and consulted experts, and they believe that an estimate of \$700 billion wasted in health care each year is "well supported by the available facts and research."²⁵ Peter Orzag, former director of the White House Office of Management and Budget, said in 2009 that, "as much as \$700 billion a year in healthcare costs do not improve health outcomes."²⁶ Jack Wennberg of the Dartmouth Center for the Evaluative Clinical Sciences has famously noted that "up to one-third of the over \$2 trillion that we now spend annually on healthcare is squandered on unnecessary hospitalizations; unneeded and often redundant tests; unproven treatments; over-priced, cutting-edge drugs; devices no better than the less expensive products they replaced; and end-of-life care that brings neither comfort care nor cure."²⁷

It is also concerning that the program is spending money in outdated delivery models that do not always make sense. The Medicare program should be structured to ensure that seniors are able to access timely and appropriate care in the most appropriate care setting. Unfortunately, Medicare's payment incentives are completely misaligned: the traditional fee-for-service model incentivizes providing services based solely on volume, rather than on value. In other words, instead of targeting Medicare dollars in a patient-focused manner to help seniors access the most appropriate care in

²¹ "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," Amy Finkelstein, April 2006. <http://econ-www.mit.edu/files/788>

²² "The Costs and Benefits of Universal Health Insurance," February 28, 2007 http://economistsview.typepad.com/economistsview/2007/02/amy_finkelstein.html

²³ Capretta, James, "The Medicare Debate," *National Review Online*, December 27, 2011. <http://www.nationalreview.com/articles/286667/medicare-debate-james-c-capretta?pg=2>

²⁴ National Academies, June 1, 2011. <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=13138>

²⁵ "Where Can \$700 Billion in Waste Be Cut Annually From the U.S. Healthcare System?" Thomson Reuters, Healthcare Analytics. October 2009, pg. 24. <http://www.factsforhealthcare.com/whitepaper/HealthcareWaste.pdf>

²⁶ "Where Can \$700 Billion in Waste Be Cut Annually From the U.S. Healthcare System?" Thomson Reuters, Healthcare Analytics. October 2009, pg. 3. <http://www.factsforhealthcare.com/whitepaper/HealthcareWaste.pdf>

²⁷ "The State of the Nation's Health," Dartmouth Medicine, Spring 2007, pg. 32. <http://dartmed.dartmouth.edu/spring07/pdf/atlas.pdf>; <http://www.factsforhealthcare.com/whitepaper/HealthcareWaste.pdf>

the most appropriate care setting to meet their individual needs, taxpayers and seniors are sometimes paying too much. Medicare pays for quantity of services, but is not always careful to gauge the quality of those services.

The Dartmouth Institute for Health Policy and Clinical Practice has well documented how volume based spending has resulted in significant Medicare spending variation by region, and that a higher volume of care does not necessarily produce more effective care or better outcomes for patients.²⁸ Congress' Medicare payment advisory group, MedPAC, largely agreed. They found that "regional variation in service use is not equivalent to regional variation in Medicare spending."²⁹ In other words, when Medicare payments are adjusted for regional variation in wages, cost-of-living, and other dynamics, the program still spends irrationally, paying hundreds of dollars more in some areas for a procedure than in others.

Federal Law Says Medicare Cannot Interfere With Medicine, But Reality is Quite Different
"Nothing in [Medicare law] shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

Sec. 1801. [42 U.S.C. 1395] ,
Prohibition Against Any Federal Interference.

None of this analysis of Medicare's FFS system is necessarily intended as finger-pointing. Rather, the key conclusion is that Medicare's FFS model is broken, and fixing it will not only help strengthen Medicare and restore a patient-focused approach to care, but should have a positive ripple effect throughout much of our health care system.

For example, the original Medicare law includes a "prohibition against any federal interference" in the practice of medicine, but as such a large purchaser of health care services Medicare has tremendous sway over the daily realities of how medicine is practiced. Today, the Medicare program has grown into a vast "one-size-fits-all" empire that too often effectively dictates to providers and seniors what services are covered and what costs will be reimbursed. Virtually every physician or nurse has experienced the sometimes arbitrary reimbursement structure of Medicare FFS. Seniors and health care providers would benefit from a system in which the distortions of Medicare's FFS program are mitigated by the forces of transparency and competition on cost, quality, and outcomes.

Another good example of the problems with Medicare FFS' reimbursement is its payment mechanism for physicians financed through the "sustainable growth rate" (SGR). However, the SGR is flawed because it basically is a global cap on all Medicare outpatient physician visits with no connection to cost, quality, or outcomes. Despite its name, the SGR underscores the unsustainable nature of the current Medicare program. The SGR's continued existence has contributed significantly to physicians' increasing frustrations with the program. In light of uncertain reimbursement and growing Medicare mandates on practicing medicine, some physicians have already begun dropping or limiting their participation in the program. Congress should repeal, redesign, and then replace the flawed SGR to ensure seniors' access to care with more sustainable reimbursement mechanisms that is more responsive to different physician practices and meaningful with regard to cost, quality, and outcomes.

In fact, frustrated with the unpredictability and disruption of continued patches to the SGR, some physicians have already stopped participating in Medicare. One survey found nearly half of physicians in one state were not accepting new Medicare patients, while a couple of hundred are withdrawing from the program altogether.³⁰ *USA Today* reported in 2010 that two times as many family doctors stopped participating in Medicare in 2010 compared with just six years prior to that.³¹

²⁸ "Health Care Spending, Quality, and Outcomes," the Dartmouth Atlas Project, February 27, 2009.

http://www.dartmouthatlas.org/downloads/reports/Spending_Brief_022709.pdf

²⁹ "Medicare Payment Advisory Commission (MedPAC), Report to the Congress: "Measuring Regional Variation in Service Use," December 2009, pg. vi.

http://www.medpac.gov/documents/Dec09_RegionalVariation_report.pdf

³⁰ Ackerman, Todd, "Texas doctors opting out of Medicare at alarming rates," *Houston Chronicle*, May 18, 2010.

<http://www.chron.com/disp/story.mpl/metropolitan/7009807.html>

³¹ Wolf, Richard, "Doctors limit new Medicare patients," *USA Today*, June 21, 2010. http://www.usatoday.com/news/washington/2010-06-20-medicare_N.htm

Medicare's Waste, Fraud, and Abuse Harms Seniors and Robs Taxpayers

We cannot allow waste, fraud, and abuse of the Medicare program to continue. The long-term Medicare spending projections are even more alarming when you consider the fact that each year tens of billions of taxpayer dollars are lost to waste, fraud, and abuse. While the exact amount of money lost to Medicare fraud each year is not known precisely, many estimate the total could be roughly \$60 billion dollars.³² That total would be more than 10 percent of the entire program cost. Some have estimated Medicare and Medicaid fraud is \$100 billion per year.³³

Regardless, Medicare's vulnerability to fraud is well-documented because the program is massive, complex, and bureaucratic. There have been repeated national high-profile cases about organized criminal elements perpetrating fraud schemes and ripping off seniors. For example, just from 2000-2007, nearly half a million claims were filled using the Medicare ID numbers of dead physicians.³⁴ It should not be a surprise that the Government Accountability Office (GAO) has designated Medicare as a high-risk program for more than two decades due to its vulnerability to improper payments and ongoing serious management challenges.

But taxpayers are not only being hit in their wallet or pocketbook by their money being siphoned out of Medicare through fraud – they are likely paying higher prices for commercial health coverage because of cost-shifting from Medicare. As retired health care actuary Mark Litow explains, “several studies have also shown that low Medicare reimbursements shift costs to private-sector health insurance, making premiums higher than they otherwise would be. The actuarial firm Milliman estimated that private insurers paid an additional \$89 billion in 2006 and 2007 due to Medicare and Medicaid cost-shifting.”³⁵ Many of these extra costs were passed on to patients in the form of higher premiums. As budget analyst Jim Capretta noted, “the truth is that private-insurance enrollees are paying *hundreds of billions of dollars in higher premiums* because the federal government forces doctors and hospitals to provide services to Medicare and Medicaid recipients at artificially low rates. This cost-shifting from private- to public-insurance enrollees is far greater than the frequently lamented cost-shifting from the uninsured to the insured.”³⁶ We must successfully tackle waste, fraud, and abuse from Medicare as part of strengthening Medicare for seniors.

Medicare's Serious Structural Challenges

In many ways, Medicare's current structure and benefit design still reflect a program established almost half a century ago when medicine consisted primarily of visits to the doctor or hospital. Just as medicine has advanced since then, many of the assumptions on which the Medicare program was established have changed over time. For example, in 1965 the average life expectancy was just above 70 years old. However, because of improvements in medical innovation and public health, today life expectancy is nearing 80 years old.³⁷ Moreover, the availability of advanced medical technology has spread dramatically, and surgeries that were once cutting edge for a middle-aged person, like heart surgery or cataract surgery, have become almost routine.

Since the program's inception, there has also been a significant decrease in the number of workers supporting retirees. When Medicare was created, roughly 4.6 workers supported each beneficiary receiving benefits. Today there is only an average of 3.8 workers per beneficiary.³⁸ With current trends and a wave of retiring baby boomers, in 2050 the program is only expected to have about 2.2 workers per beneficiary.³⁹

³² [CBS News](#) and [ABC News](#) both aired segments in 2010 that estimated Medicare fraud at about \$60 billion annually. DOJ Attorney General Eric Holder [said](#): “One estimate suggests that more than \$60 billion in public and private health care spending is lost each year to health care fraud.”

³³ Gingrich, Newt, and Barry Rand, “Stop Paying Crooks: Get Tough on Health-care Fraud,” *Orlando Sentinel*, September 29, 2010.

http://articles.orlandosentinel.com/2010-09-29/news/os-ed-medicare-fraud-gingrich-093010-20100929_1_health-care-fraud-home-health-medicare-and-medicaid

³⁴ “Medicare Vulnerabilities: Payments For Claims Tied to Deceased Doctors,” US Senate Committee on Homeland Security and Government Affairs Permanent Subcommittee on Investigations, Staff Report, July 9, 2008. <http://www.hsgac.senate.gov/download/psi-report-medicare-claims-tied-to-deceased-doctors>

³⁵ Litow, Mark, and Merrill Matthews, “Why Medicare Patients See the Doctor Too Much,” *The Wall Street Journal*, July 11, 2011.

<http://online.wsj.com/article/SB10001424052702304760604576428300875828790.html>

³⁶ Capretta, James, “The Medicare Debate,” *National Review Online*, December 27, 2011. <http://www.nationalreview.com/articles/286667/medicare-debate-james-c-capretta?pg=2>

³⁷ http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf

³⁸ “Economic Report to the President,” http://fraser.stlouisfed.org/docs/publications/ERP/pages/14147_2005-2009.pdf

³⁹ “Economic Report to the President,” http://fraser.stlouisfed.org/docs/publications/ERP/pages/14147_2005-2009.pdf

Not all change has been positive. In the past decades, medicine and science have grown rapidly, but so has the burden of costly, chronic conditions. Today 70 percent of deaths in America each year are due to chronic disease, and cancer, stroke, and heart disease account for more than half of all deaths each year.⁴⁰

The Baby Boomer generation's retirement will expand the number of people participating in Medicare by about a third over the next decade. In fact, according to the Pew Research Center, "As the year 2011 began on Jan. 1, the oldest members of the Baby Boom generation celebrated their 65th birthday [and] on that day, today, and for every day for the next 19 years, 10,000 baby boomers will reach age 65."⁴¹ Over the next decade 15 million more Baby Boomers will enroll in Medicare and the program's rolls will increase by about 30 percent.

A key contributor to Medicare's financial challenges lies in the fact that, while Americans do pay payroll taxes over the course of their career for the Medicare program, those contributions finance only a little more than one-third of the program's total costs. However, general tax revenues from current taxpayers finance the bulk of the program, constituting more than 40 percent of the program's funding stream, while premiums from current beneficiaries are only a little more than a tenth of all financing.

At the creation of the Medicare program, beneficiary premiums were envisioned to finance roughly half of the program. When making remarks during the signing ceremony of the Medicare bill in 1965, President Lyndon B. Johnson explained:
"And under a separate plan, when you are 65—that the Congress originated itself, in its own good judgment—you may be covered for medical and surgical fees whether you are in or out of the hospital. You will pay \$3 per month after you are 65 and your Government will contribute an equal amount."⁴²

However, today's seniors on Medicare receive more benefits from the program than they paid into Medicare with their payroll taxes. For example, a single woman who retired in 1980, after earning average wages throughout her career, could expect to receive medical care worth about \$74,800 over the rest of her lifetime. Today, that same woman retiring in 2010 can expect services worth \$181,000.⁴³ Consider the example of an average-wage, two-earner couple together earning \$87,000 a year. Upon retiring in 2011, they would have paid \$119,000 in Medicare payroll taxes during their careers. But they can expect to receive medical services – from prescriptions to hospital care – worth \$357,000, or about three times what they paid into the program during their career.⁴⁴

The following chart from the Congressional Research Service shows that a lifetime of payroll taxes funds roughly a third of the benefits that a senior receives. Beneficiary premiums cover relatively small amount of the cost of benefits provided, with roughly half of the benefits paid from general government revenues and interest payments.

⁴⁰ <http://www.cdc.gov/chronicdisease/overview/index.htm#1>

⁴¹ Pew Research Center, "Baby Boomers Approach Age 65 – Glumly," December 20, 2010. <http://pewresearch.org/databank/dailynumber/?NumberID=1150>

⁴² President Lydon B. Johnson's Remarks With President Truman at the Signing in Independence of the Medicare Bill. July 30, 1965. <http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp>

⁴³ These are in 2010 dollars, adjusted for inflation so can be compared. "What people pay into Medicare won't cover costs" Alonso-Zaldivar, Ricardo. Associated Press, 12/30/2010. http://www.msnbc.msn.com/id/40851739/ns/health-health_care/t/what-people-pay-medicare-wont-cover-costs/

⁴⁴ Urban Institute, "Social Security and Medicare Taxes and Benefits Over a Lifetime," June 2011. <http://www.urban.org/UploadedPDF/social-security-medicare-benefits-over-lifetime.pdf>

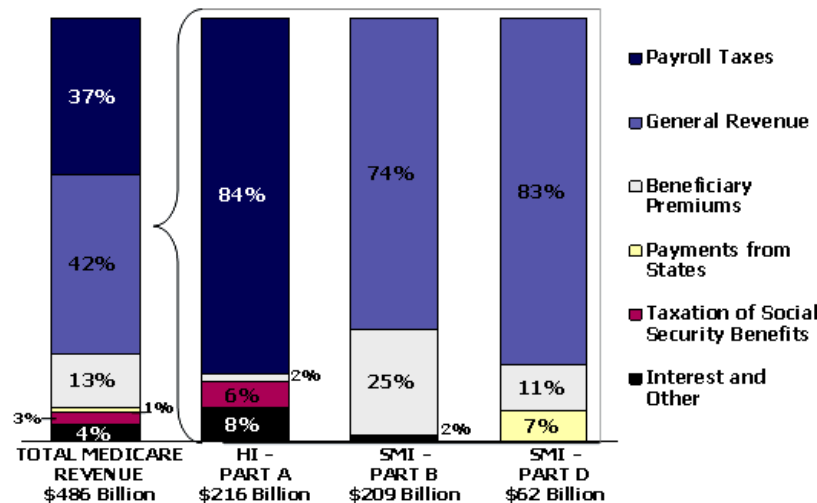


Table from the Congressional Research Service.⁴⁵

In response to those structural challenges, some Americans have suggested Congress should raise taxes to pay for current benefits. However, two respected economists, Kate Baicker from Harvard and Jonathan Skinner from Dartmouth, have examined the impact of raising taxes to pay for current benefits. Their conclusions were that tax rates would have to jump 28 percent for the wealthiest Americans just to keep Medicare solvent for another decade, and even the poorest Americans would see a tax increase.⁴⁶ These tax increases would slow economic growth dramatically. In fact, tax increases would slow GDP growth so much that by the time children today are on Medicare, the “per-household GDP is 11 percent lower than it would have been otherwise” when compared directly to today’s dollar. These projections mean that today’s children would have less economic opportunity and prosperity – just to pay for current benefits for today’s seniors. Tax increases will not paper over the problems of runaway Medicare spending. This is not an equitable solution, and no grandparent wants a smaller economic future for their grandchild.

All these dynamics – fewer workers per beneficiary, more benefits being paid out from the program, increased life expectancy – contribute to Medicare’s structural long-term challenges. What has not changed is our commitment to ensuring that seniors have access to high-quality care. For our country to keep its promise to seniors, Congress must take action now to build a stronger, more sustainable Medicare.

Federal Health Care Spending: Our Nation’s Single Largest Fiscal Challenge

Continuing on the current course for Medicare is not an option. The program’s independent, Medicare Actuary has warned that Medicare’s hospital care could face program insolvency in less than five years.⁴⁷ Unfortunately, the longer-term outlook is even worse. As the President’s National Commission on Fiscal Responsibility and Reform and budget experts have warned, “Federal health care spending represents our single largest fiscal challenge over the long-run.”⁴⁸ Under current law, Medicare spending is expected to jump from \$522.8 billion in 2010 to \$932 billion in 2020.⁴⁹

These projections have led the Congressional Budget Office (CBO) to warn that the skyrocketing rates of growth in health care spending cannot continue indefinitely because they would “eventually account for all of the country’s

⁴⁵ Congressional Research Service, “Medicare Financing,” June 1, 2011. Source: 2011 Report of the Medicare Trustees, Table II.B1, and the Kaiser Family Foundation. Note that totals may not add to 100% due to rounding.

⁴⁶ The National Bureau of Economic Research, “The Effects of Rising Health Care Costs on U.S. Tax Rates” <http://www.nber.org/aginghealth/2011no1/w16772.html>

⁴⁷ 2011 Medicare Board of Trustees Report, pg. 25. <https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>

⁴⁸ Report of the National Commission on Fiscal Responsibility and Reform, December 2010, pg. 36.

http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf

⁴⁹ Moffit, Robert, “The First Stage of Medicare Reform: Fixing the Current Program,” The Heritage Foundation, October 17, 2011.

http://www.heritage.org/research/reports/2011/10/the-first-stage-of-medicare-reform-fixing-the-current-program#_ftn4, See footnote 4.

economic output.”⁵⁰ Medicare’s unfunded liabilities, which total almost \$37 trillion, are about half of all federal, state, and local government unfunded liabilities.⁵¹

A Critical Look at Data on Future Medicare Spending

Despite the history of warnings, some believe that increased Medicare spending is not a concern. They usually cite one of two data points: recent national health care spending data, and projections of Medicare spending under the Patient Protection and Affordable Care Act.

First, let’s consider recent national health care spending data that is used to argue Medicare spending is not such a concern. It is true that the rate of Medicare spending has grown more slowly in recent years.⁵²

It is also certainly true that, due to the recent economic downturn, growth in national health spending overall has declined. As experts from the independent Medicare Actuary’s office have noted in *Health Affairs*, even though “medical goods and services are generally viewed as necessities,” the “recession had a dramatic effect on their utilization” to the point that “US health spending grew more slowly in 2009 and 2010—at rates of 3.8 percent and 3.9 percent, respectively—than in any other years during the fifty-one-year history of the National Health Expenditure Accounts.”⁵³ As part of that larger trend, “total Medicare spending, which accounted for 20 percent of all national health spending in 2010, grew 5.0 percent—more slowly than the increase of 7.0 percent in 2009.”⁵⁴ While this slower spending growth trend is good, the problem is that even this temporarily slower rate of growth was still faster than the economy.

Second, let’s examine the charge that the provisions of the new health care law have succeeded in restraining Medicare growth. It is true that the health care law projects a reduced growth rate in Medicare spending, but the reasons for that are unpopular and promise more than they can deliver. The controversial law took more than \$500 billion out of the Medicare program to spend on other programs and empowered a board of unelected bureaucrats to “reduce the per capita rate of growth in Medicare spending.”⁵⁵ The Independent Payment Advisory Board (IPAB) will be charged with developing proposals that cut Medicare – and because the panel is prohibited from suggesting more sensible changes like redesigning benefits, the panel will just cut reimbursements to physicians and other health care providers, resulting in delay and denial of care.

On paper, this reduction sounds appealing. The CBO has noted that “the growth in Medicare spending per beneficiary over the 2012–2022 period is projected to average just 1 percent a year more than the rate of inflation” while “in comparison, such real growth in Medicare spending per beneficiary averaged about 5 percent a year between 1985 and 2007.”⁵⁶

However, even with projected Medicare cuts, the program’s spending is set to explode in coming years. For example, the program is on target to grow by an average of six percent each year – far faster than our economy. The CBO has warned that “even with the constraining effect of the SGR [under current law] and other provisions, spending for Medicare under current law is anticipated to grow by an average of 6 percent per year.”⁵⁷ By 2022, taxpayers will be spending more than \$1 trillion on Medicare each year.⁵⁸

However, even this anticipated slowdown in the rate of Medicare spending is unrealistic. The IPAB and arbitrary across-the-board payment cuts to health providers mean some providers will not be able to see Medicare patients which may limit patient access to medical care. In fact, the independent Chief Actuary of the Medicare program has warned that

⁵⁰ Congressional Budget Office’s 2011 Long-Term Budget Outlook, June 2011. http://www.cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf

⁵¹ Moffit, Robert, “The First Stage of Medicare Reform: Fixing the Current Program,” The Heritage Foundation, October 17, 2011. http://www.heritage.org/research/reports/2011/10/the-first-stage-of-medicare-reform-fixing-the-current-program#_ftn6, See footnote 6.

⁵² Congressional Budget Office, The Budget and Economic Outlook: Fiscal Years 2012 to 2022, January 2012.

⁵³ <http://content.healthaffairs.org/content/31/1/208.full.pdf+html>

⁵⁴ <http://content.healthaffairs.org/content/31/1/208.full.pdf+html>

⁵⁵ Section 3403(b) of the Patient Protection and Affordable Care Act.

⁵⁶ Congressional Budget Office, The Budget and Economic Outlook: Fiscal Years 2012 to 2022, January 2012.

⁵⁷ Congressional Budget Office, The Budget and Economic Outlook: Fiscal Years 2012 to 2022, January 2012.

⁵⁸ Congressional Budget Office, The Budget and Economic Outlook: Fiscal Years 2012 to 2022, January 2012. Pg. 49

the provider cuts alone could effectively put 15 percent of hospitals out of business within a decade.⁵⁹ The Actuary also noted, if the projected cuts are allowed to take place, “Medicare beneficiaries would almost certainly face increasingly severe problems with access to care.”⁶⁰

The Actuary has warned lawmakers about the IPAB as well, saying that the board will have to hold Medicare spending to a growth level that would be “difficult to achieve in practice.”⁶¹ The Medicare Actuary also notes the IPAB is unlikely to succeed because the law includes assumptions that “are unlikely to be sustainable.”⁶²

In Order to Save Medicare, We Must Reform It

Unfortunately, despite the goal of improving health coverage, the President’s new health care law did not address many of the serious problems with the current Medicare program. Instead of fixing what is broken, the law took more than \$500 billion from Medicare to spend on new government programs not for seniors.⁶³ A June 2011 memo from the Office of the Chief Actuary for the Medicare program found that the Medicare program’s unfunded liabilities could increase as a result of the health care law – up to \$36.8 trillion, or more than twice the entire current national debt.⁶⁴

Sadly, the law fell short on other fronts. Instead of enacting reforms that will help strengthen the program, the new law put in place delivery system demonstration projects and pilots. Pilots and demos are no substitute for real reform, and unfortunately the Medicare program has a very poor track record of improving care and saving money through past pilots.⁶⁵

The new health care law’s creation of the Independent Payment Advisory Board is an admission that Medicare’s status quo is unsustainable. Instead of making the necessary structural reforms to save Medicare, this independent payment board of unelected, unaccountable bureaucrats can now reduce reimbursements to health care providers who care for seniors.

The new health care law changed Medicare as we know it, but not in the correct way. Federal health care spending represents our nation’s single largest fiscal challenge over the long-run and we cannot continue to ignore this problem. The good news is that with the right set of reforms, we will not only uphold our promise to save this program for millions of elderly and disabled Americans who depend on it, but we can offer them the choice of a better benefit than they currently are receiving. We simply cannot wait to put this important program on a sustainable path for seniors, health care providers, and taxpayers.

⁵⁹ http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf, page 10

⁶⁰ <http://www.cms.gov/ActuarialStudies/Downloads/2010TRAlternativeScenario.pdf> page 5

⁶¹ Memo on Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as amended by Richard Foster, April 22, 2010, http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf, page 20.

⁶² Memo on Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as amended by Richard Foster, April 22, 2010, http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf, page 20.

⁶³ Letter to Speaker Nancy Pelosi from Congressional Budget Office Director Douglas Elmendorf, March 18, 2010.

<http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf>

⁶⁴ Letter from CMS Office of the Actuary to the Senate Budget Committee, June 22, 2011. http://www.docstoc.com/docs/document-preview.aspx?doc_id=82292827;

<http://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf>

⁶⁵ <http://www.cbo.gov/ftpdocs/126xx/doc12663/01-18-12-MedicareDemoBrief.pdf>

Chapter 2 – Solutions for A Stronger Medicare Today

“But here’s the truth: Millions of Americans rely on Medicare in their retirement. And millions more will do so in the future.....But with an aging population and rising health care costs, we are spending too fast to sustain the program. And if we don’t gradually reform the system while protecting current [seniors], it won’t be there when future retirees need it. We have to reform Medicare to strengthen it.”

—President Barack Obama, September 8, 2011, Address to a Joint Session of Congress

While Congress must take action soon to save and strengthen Medicare, there are a range of common-sense reforms that can be adopted in the near term to make a fiscal improvement in the program’s long-term sustainability and give seniors a better benefit than they have today. Below we outline a range of policy proposals we believe should be implemented as soon as possible, which is likely 2014. These reforms will rationalize, improve, and modernize basic Medicare, strengthening it for seniors, and making it more sustainable for taxpayers.

Give Seniors A New Maximum Out-of-Pocket Protection

Unlike most commercial insurance, traditional Medicare still does not offer seniors maximum out-of-pocket protection. This means that seniors are exposed to unexpected high costs when they get sick. Even just one episode of hospitalization and rehab can leave seniors wading through thousands of dollars of co-pays and deductibles that are somewhat unpredictable and may feel arbitrary.

In a worst case scenario, a senior could face severe financial trouble because of unexpected hospital bills and medical costs. As the Congressional Budget Office explained, “if Medicare patients incur extremely high medical costs, they may face a significant amount of cost sharing because the program does not place a limit on those expenses.”⁶⁶

As a result of potential uneven exposure to high costs, many seniors feel forced to purchase costly supplemental plans that offer coverage against Medicare cost-sharing. Seniors like these private supplementary plans because they bring stability and security by making costs predictable, and cover services not covered by traditional Medicare. But these supplementary plans can encourage costly overutilization of unnecessary medical services, and their very existence is a symptom of an underlying problem: basic Medicare provides an insufficient benefit with illogical and inconsistent cost-sharing. As the President’s Fiscal Commission noted, “because cost-sharing for most medical services is low, the benefit structure encourages over-utilization of health care.”⁶⁷

“Potential improvements [in Medicare’s benefit design] could include, for example, adding a cap to beneficiaries’ out-of-pocket costs in the fee-for-service benefit and, at the same time, requiring supplemental policies to have fixed-dollar copayments for services such as office visits and emergency room use. Such restrictions on supplemental coverage could lead to reductions in use of Medicare services sufficient to help finance the addition of an out-of-pocket cap.....The strategies could also include cost-sharing protections for low-income beneficiaries so that they would not forgo needed care.”

MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2011, p. 64.

To modernize Medicare’s cost-sharing and protect seniors financially, we propose adopting a *unified-deductible* and *unified cost-sharing* with an annual *out-of-pocket maximum*. This policy proposal builds on the recommendations of the President’s bipartisan Fiscal Commission and the bipartisan Lieberman-Coburn proposal. Here’s how it would work:

- The unified deductible would streamline cost-sharing for inpatient visits and outpatient services (Medicare Parts A and B). Seniors would have a single annual deductible of \$550 for both Part A and B services combined.
- After paying the deductible, seniors would have unified cost-sharing for Part A and B services, visits, or treatments in the form of 20 percent coinsurance up to an annual total of \$5,500.

⁶⁶ Congressional Budget Office March 2011 Report, “Reducing the Deficit: Spending and Revenue Options,” pg. 49. <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁶⁷ Report of the National Commission on Fiscal Responsibility and Reform, December 2010, pg. 38 http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf

- For the seniors who might reach paying \$5,500 out-of-pocket over the course of a year, they would then only pay a 5 percent coinsurance for any service or treatment up to \$7,500.
- At \$7,500, a senior would reach the out-of-pocket maximum limit and not have any additional out-of-pocket expenses for that year.

These reforms would mean that, unless seniors are higher-income beneficiaries, they would never be forced to pay more than \$7,500 in a given year. Low-income seniors would receive “extra help” with their cost-sharing under this proposal on a sliding-scale just as these beneficiaries do today with cost-sharing under Medicare Parts B and D. This predictable system of financial cost-sharing structure should help protect seniors from financial hardship or bankruptcy in the event of a major illness or costly episode of care. As the Congressional Budget Office explained, the introduction of an out-of-pocket maximum limit “would provide greater protection against catastrophic costs” and “would especially help people who develop serious illnesses, require extended care, or undergo repeated hospitalizations but lack supplemental coverage for their cost sharing.”⁶⁸

Deductible: A deductible is an annual fixed dollar amount a beneficiary must pay before a health plan will cover the cost of expenses for medical treatments or services.

Co-Pay: A co-pay is a *fixed dollar amount* that a beneficiary pays each time he/she visits a physician or has a specific treatment or service covered by his/her health policy. For example, many beneficiaries have a health policy where visits to physicians’ office may have a \$20, \$30, or \$50 co-pay.

Co-insurance: Co-insurance is the *percentage* amount that a beneficiary will pay and a health plan will pay for a covered treatment or service. For example, if a beneficiary has 20% coinsurance for a covered item, the beneficiary will pay 20% of the cost and the health plan will cover 80%.

Out-of-pocket Maximum: An out-of-pocket maximum is a fixed dollar amount that represents the highest total amount a beneficiary would be required to pay for the cost of his/her health care. This does not include the costs of monthly premiums, but does include beneficiary expenditures toward the deductible, coinsurance, and copayments.

Increase Cost-Sharing for Wealthier Seniors

One area of emerging consensus for reforming Medicare is increasing wealthier seniors’ contributions to Medicare by increasing their deductibles, co-pays, or coinsurance levels. The Medicare program already charges wealthy seniors higher premiums for physician services (Part B) and drug coverage (Part D), so this policy largely builds on past precedents. The bipartisan Lieberman-Coburn Medicare reform plan increased the “annual maximum out-of-pocket cap to higher levels for those with significant monetary means.”⁶⁹ Our proposal adopts the Lieberman-Coburn plan’s new maximum out-of-pocket levels:

- \$12,500 for individuals with income \$85,000 - \$107,000 (\$170,000 - \$214,000 for married couples)
- \$17,500 for individuals with income \$107,000 - \$160,000 (\$214,000 - \$320,000 for married couples)
- \$22,500 for individuals with income \$160,000 - \$213,000 (\$320,000 for married couples)

While thoughtful individuals may differ about what levels of income-relating are appropriate and viable, the bipartisan Lieberman-Coburn plan’s suggestions are one way income-relating could be adjusted up the income scale. We believe increased premiums for Parts B and D for wealthier seniors based on their income levels makes sense.

Require Millionaires on Medicare to Pay Full Premiums, Have Higher Deductibles

In addition to the above reforms, we believe it is important to ensure millionaires on Medicare pay the full cost of their Parts B and D premiums, and have an even higher unified deductible. Plenty of seniors can afford to pay more: according to the Chief Actuary of the Social Security Administration, there are about 60,000 seniors enrolled in Medicare Part B who have annual incomes of more than \$1,000,000 or more.⁷⁰ As the President said in his State of the Union

⁶⁸ Congressional Budget Office March 2011 Report, “Reducing the Deficit: Spending and Revenue Options,” pg. 49. <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁶⁹ The Lieberman-Coburn Proposal: A Bipartisan Plan to Save Medicare and Reduce Debt, June 2011, pg. 3.

http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=1ea8e116-6d15-46ba-b2e0-731258583305

⁷⁰ This is modified adjusted gross income as outlined on page 8 of *Subsidies of the Rich and Famous*, an oversight report by Senator Tom Coburn, M.D., November 2011. http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=bb1c90bc-660c-477e-91e6-91c970fbee1f

address, “Washington should stop subsidizing millionaires.”⁷¹ However, this does not mean such “Medicare millionaires” would be forced to leave the program. Every American who paid Medicare payroll taxes for the appropriate duration would remain eligible for, and benefit from, participation in the Part A program. And some suggest that because wealthier seniors already pay more in payroll taxes and Medicare premiums, this policy is consistent with the principles of the traditional program.

Modify Requirements on Medigap Coverage, Save Seniors and Taxpayers Money

Because basic Medicare has not offered seniors protection against out-of-pocket costs, many seniors choose to purchase a supplemental policy that fills in many of the unpredictable “gaps” in Medicare’s cost-sharing. These private supplementary policies are known as “Medigap” policies.

Because our proposal would improve traditional Medicare, we also propose making changes to Medigap plans, because these plans can encourage overutilization of Medicare services in a manner that increases costs to the program, but does not necessarily improve medical outcomes.

As the Congressional Budget Office explained in March 2011, “studies have found that Medigap policyholders use about 25 percent more services than Medicare enrollees who have no supplemental coverage and about 10 percent more services than enrollees who have supplemental coverage from a former employer.”⁷² CBO notes that “because Medicare enrollees with supplemental coverage are liable for only a portion of the costs of those additional services, it is taxpayers (through Medicare) and not supplemental insurers or the policyholders themselves who bear most of the resulting costs.” As a result, CBO concludes, “Federal costs for Medicare could be reduced if Medigap plans were restructured so that policyholders faced some cost sharing for Medicare services but still had a limit on their out-of-pocket costs.”⁷³ Others, including the President’s National Commission on Fiscal Reform and Responsibility arrived at a similar conclusion.⁷⁴

Some have argued that it is inappropriate for Congress to regulate private commercial insurance under any circumstances. For roughly two decades—since the Omnibus Budget Reconciliation Act of 1990—Congress, with the assistance of the National Association of Insurance Commissioners, has required Medigap policies (that were sold after 1992) to conform to one of several uniform benefit packages outlined by Congress. In recent years, Congress has allowed new versions of the original plans, authorized several new plans, and discontinued some of the original or modified plans. Under our proposal, states would continue to have the regulatory authority to review and approve the rates of premiums, regulate rating and enrollment, approve policy forms, and other matters. But there certainly is precedent for Congressional intervention on this front, and we believe action is needed to improve basic Medicare.

Moreover, the existence of Medigap policies is a symptom of a flaw in the coverage basic Medicare offers: an unpredictable, uneven, and some might even say inequitable benefit design. If health analysts and economists were to design a new Medicare from scratch today, no one would replicate the current hodge-podge of deductibles and co-pays and fragmented care. We believe reforming Medigap is an important part of strengthening and modernizing Medicare.

As part of a comprehensive effort to strengthen Medicare, like the President’s bipartisan Fiscal Commission, we propose to prohibit Medigap plans from covering the first \$500 of a senior’s cost-sharing and limit coverage above \$500 to 50 percent of the next \$5,000 of Medicare cost-sharing.⁷⁵ If Congress implements our proposal, seniors who want to keep first-dollar coverage have good options with a Medicare Advantage (MA) plan. MA plans have a good record of helping

⁷¹ <http://www.whitehouse.gov/the-press-office/2012/01/24/remarks-president-state-union-address>

⁷² Congressional Budget Office March 2011 Report, “Reducing the Deficit: Spending and Revenue Options,” pg. 50. <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁷³ Congressional Budget Office March 2011 Report, “Reducing the Deficit: Spending and Revenue Options,” pg. 49. <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁷⁴ Report of the National Commission on Fiscal Responsibility and Reform, December 2010, pg. 38.

http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf

⁷⁵ Report of the National Commission on Fiscal Responsibility and Reform, December 2010, pg. 38.

http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf

provide meaningful coverage for those who need it the most. Low-income seniors find it a particularly attractive option. In fact, a higher percentage of low-income seniors are enrolled in MA than are not, and MA is most common among low-income seniors.⁷⁶

Currently, virtually every senior can enroll in a MA plan. According to MedPAC, “in 2011, virtually all Medicare beneficiaries have access to an MA plan...and 99 percent have access to a network-based coordinated care plan.”⁷⁷ Furthermore, nine in 10 seniors have “access to an MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium).”⁷⁸ Undoubtedly, the comprehensive coverage and care coordination offered by many MA plans is better than traditional Medicare.

Unfortunately, the health care law cut more than \$200 billion out of the Medicare Advantage program over the next decade.⁷⁹ These program cuts will inevitably reduce seniors’ choices. According to Doug Elmendorf, the Director of the independent Congressional Budget Office, “enrollment in the Medicare Advantage program in 2017 and later years will be about 60 percent of the enrollment that would have occurred in the absence of PPACA and the Reconciliation Act.”⁸⁰ According to the Actuary of the Medicare program, “when the MA provisions will be fully phased in, enrollment in MA plans will be lower by about 50 percent (from its projected level of 14.8 million under the prior law to 7.4 million under the new law).”⁸¹

It is short-sighted to make changes to MA without making changes to FFS. We believe both MA and FFS should compete head-to-head to provide seniors their Medicare benefits. But in the near term, before structural changes are implemented, our proposal would use some savings to reduce the reductions in MA that could harm seniors’ care and access.⁸²

Incremental Premium Increases to Save Medicare

A key reason that Medicare’s financing is currently so shaky is that seniors receive, on average, roughly three times the total dollar amount in services and benefits that they pay into the program by their Medicare payroll tax (Part A) and their monthly Medicare beneficiary premium (Part B).⁸³ In addition to strengthening the Medicare benefit and restructuring some elements, one obvious way to strengthen Medicare is to incrementally increase seniors’ premiums.

When President Lyndon B. Johnson announced the creation of the Medicare program in July 1965, he noted a senior would pay *half* of the Part B premium, and the government would pick up the other half. President Johnson: “And under a separate plan, when you are 65 you may be covered for medical and surgical fees whether you are in or out of the hospital. You will pay \$3 per month after you are 65 and your Government will contribute an equal amount.”⁸⁴ Since the creation of the program though, later Congresses have whittled down premiums for most seniors to just 25 percent of program costs, with the remaining 75 percent funded by current taxpayers.

In 2011, the majority of Medicare enrollees paid a Part B premium of \$96.40 per month. The bipartisan Lieberman-Coburn Medicare plan proposed “increasing basic Part B premiums gradually for all enrollees by 2% of program costs every year for five years until the premium percentage paid by enrollees equals 35% of the program’s costs” so that the

⁷⁶ “Low-Income & Minority Beneficiaries in Medicare Advantage Plans, 2009,” America’s Health Insurance Plans, Center for Policy and Research, September 2011, pg. 1 and 2. <http://www.ahipresearch.org/pdfs/MALowIncomeMinorityReport2011.pdf>

⁷⁷ Medicare Payment Advisory Commission (MedPAC), Report to the Congress: “Medicare Payment Policy,” March 2011, pg. 286.

http://www.medpac.gov/chapters/Mar11_Ch12.pdf

⁷⁸ Ibid. pg. 286.

⁷⁹ \$206.3 B in cuts to MA number by adding the -136 B reductions on Table 2 and the -70.3 B reductions from interactions on Table 5, from CBO, <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>

⁸⁰ Testimony of Douglas Elmendorf, Director of CBO before the Committee on Energy and Commerce, Subcommittee on Health, March 30, 2011, pg. 25.

<http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>

⁸¹ CMS Office of the Actuary, Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended, April 22, 2010.

https://www.cms.gov/ActuarialStudies/downloads/PPACA_2010-04-22.pdf

⁸² A more detailed explanation of the rationale for Medigap reform is available at www.coburn.senate.gov.

⁸³ Based on research by C. Eugene Steuerle, <http://taxpolicycenter.org/publications/url.cfm?ID=901397>

⁸⁴ President Lyndon B. Johnson’s Remarks with President Truman at the Signing in Independence of the Medicare Bill, July 30, 1965.

<http://www.lib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp>

“dollar amount of the monthly premium increase per year would be, on average, approximately \$15-20 a month.”⁸⁵ The Seniors’ Choice Act proposes a slight modification of that: increasing premiums on average, by three percent of overall program costs each year beginning in 2013, so that a nine percent adjustment is accomplished before larger structural reforms we propose in 2016. Under our proposal, lower-income seniors would be held harmless from increased Part B premiums.

In implementing this in detail, Congress should examine retaining the current “hold-harmless” policy that prevents a reduction of a beneficiary’s Social Security check if a senior’s Part B premium increases. Congress could also adopt a low-income subsidy on a sliding scale similar to the Low Income Subsidy in Medicare Part D. This would encourage seniors to spend their health care dollars wisely, but would hold harmless the truly low-income and most vulnerable.

While increasing premiums is never popular, Medicare’s generous benefits and runaway spending has not kept up with the financing needed to sustain the program. As the former White House Chief of Staff, Bill Daley, said earlier in 2011, “Medicare’s got to be strengthened; it will run out of money in five years if we don’t do something. Obviously there [have] to be improvements to it.”⁸⁶ We agree, and believe these modest adjustments along with our proposed improvements to the program are far more preferable to the draconian cuts that will be required if Congress does not act now to strengthen the program. We also believe that the vast majority of seniors today would rather pay a few dollars extra per month than see lawmakers raise taxes to levels that it reduces economic opportunity and prosperity for their grandchildren. If we kick the reform “can” down the road, the Medicare program and the seniors and disabled individuals depending upon it are likely to face even more severe choices in ensuring its future.

Gradually Increase the Age of Eligibility for Participating in Medicare

In 1965, the average life expectancy was just above 70 years old, so seniors were expected to be on the program an average of five years. In his White House remarks signing the Medicare law, President Johnson talked about the program being used by a man to “insure himself against the ravages of illness in his old age.”⁸⁷ Today however, thanks to improvements in medical innovation and technology, 70 years old is not necessarily “old age” and life expectancy is nearly 80 years old.⁸⁸ As the Congressional Budget Office noted in its analysis of the issue, “that trend [of increasing life expectancy], which increases the program’s costs, is expected to continue.”⁸⁹

We propose adopting the suggestion of the bipartisan Lieberman-Coburn proposal to strengthen Medicare and slowly increase the basic age of eligibility for Medicare. Adopting this policy would realign the program closer to its original purpose and help put the program on more solid footing. We propose gradually increasing the age of eligibility for Medicare by two months each year beginning with people who were born in 1949 until the eligibility age reaches 67 for people born in 1960.⁹⁰

As the Congressional Budget Office notes, these “increases are similar to those already under way for Social Security’s full retirement age—that is, the age at which workers become eligible for full retirement benefits—except that scheduled increases in the full retirement age include a 12-year period during which the full retirement age remains at 66 years old.”⁹¹

⁸⁵ The Lieberman-Coburn Proposal: A Bipartisan Plan to Save Medicare and Reduce Debt, June 2011, pg. 3.

http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=1ea8e116-6d15-46ba-b2e0-731258583305

⁸⁶ ABC’s ‘This Week’ Transcript of an interview with Bill Daley on July 10, 2011. <http://abcnews.go.com/ThisWeek/week-transcript-bill-daley/story?id=14039376&page=3>, <http://www.youtube.com/watch?v=70Bc6PJ4iKA>

⁸⁷ President Lyndon B. Johnson’s Remarks with President Truman at the Signing in Independence of the Medicare Bill, July 30, 1965. <http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp>

⁸⁸ Centers for Disease Control, National Vital Statistics Reports, Vol. 60, No. 4, January 11, 2012. http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf

⁸⁹ Congressional Budget Office March 2011 Report, “Reducing the Deficit: Spending and Revenue Options,” pg. 45. <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁹⁰ Under this proposal there would be no change in the policy that Medicare is available to persons under age 65 who have been eligible for disability benefits under Social Security for at least 24 months and to those with end-stage renal disease or amyotrophic lateral sclerosis.

⁹¹ The Congressional Budget Office’s *Reducing the Deficit: Revenue and Spending Options*, March 2011, <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf> page 25

Additionally, Medicare's basic eligibility age could be indexed to gains in longevity, as the President's bipartisan National Commission on Fiscal Responsibility and Reform recommended with Social Security. Under this approach, after the age of eligibility for Medicare reaches 67 in 2027, the age of eligibility would be indexed to increases in life expectancy, effectively increasing the age of eligibility for Medicare to 68 by about 2050 and to 69 by about 2075. Overall, this policy would increase the age of eligibility for Medicare by four years compared to current law, even though the average life expectancy age has grown by more than 10 years.

Though raising the age of eligibility no doubt sounds dramatic to some, we believe seniors and the American people deserve an honest conversation. This proposal is actually a measured, incremental policy because there would be no change for current beneficiaries, and seniors who are currently closest to qualifying for Medicare would be impacted the least. Consider the example of an individual who is 60 in 2011, who would only have to wait six more months for Medicare eligibility. It's worth noting that individuals eligible for Medicare as a result of a disability would not be subject to an increased eligibility requirement for seniors eligible for Medicare because of their age. We believe that increasing the eligibility age for Medicare is a way to modify the program while strengthening it for the millions of Americans who depend on it today and the future.

Make SGR a "Bridge" to A New, Better Medicare

As we have previously noted, it takes repeated Congressional intervention to prevent payment cuts to physicians who see Medicare patients. This consequence is unacceptable for physicians and patients. Allowing large reimbursement cuts would cause many physicians to drop their participation in the program, and thus jeopardize access to medical care for seniors on Medicare and military families with TRICARE. As the independent Chief Medicare Actuary warned in a memo to Congress, if reimbursement cuts are allowed to occur, many physicians "for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program possibly jeopardizing access to care for beneficiaries."⁹² It is unacceptable for Congress to allow this drastic cut to linger. The SGR represents real costs that must be paid to ensure seniors' access to care. Therefore, we propose using a portion of the savings generated under our plan to freeze reimbursement rates for the near future at their current levels. While this approach is not ideal, our nation remains in a precarious fiscal state, and we must make hard choices to ensure increasingly scarce taxpayer dollars are utilized to put patients first. We propose providing an immediate "bridge" for SGR payments until the new Medicare premium support model proposed in Chapter 3 is implemented. Congress could modify the timeline as needed during the transition to ensure a reasonable amount of predictability and stability for seniors and the health care professionals who provide them care. This ensures stability and predictability for physicians and enables seniors to continue to access the care they need.

Repeal Independent Payment Advisory Board

Since enactment of the President's health care law, the American people and seniors have learned about a new board of unelected bureaucrats that was created by the new law. The health care law created the Independent Payment Advisory Board (IPAB)—a panel of 15 unelected, politically-connected Medicare bureaucrats empowered with the ability to cut Medicare spending. Many of these unelected, unaccountable bureaucrats are likely to have political connections to powerful politicians, but not all of them are required to be physicians. Because the panel is prohibited from suggesting common-sense changes to Medicare like adjusting beneficiary premiums, cost-sharing, or benefit design, the panel will effectively just cut reimbursements to physicians and other health care providers. With Medicare reimbursements plummeting, some providers will not be able to see Medicare patients, which may limit patients' access to medical care. And, under the law, the Department of Health and Human Services is forced to implement the panel's proposals automatically unless Congress intervenes with similar cuts. There are virtually no checks on the panel because its members—who will be paid six figure salaries and can serve up to 12 years—are not accountable to voters and its recommendations cannot be challenged in court.⁹³ Seniors deserve the ability to hold elected officials accountable for

⁹² CMS Office of the Actuary, Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended, April 22, 2010, pg. 9-10. http://coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=f011f765-c229-4b33-8b95-6c30c8bfef0

⁹³ Section 3403(b) of the Patient Protection and Affordable Care Act.

the decisions that affect their Medicare, but this Board will put significant new power in the hands of politically-appointed Washington bureaucrats. Therefore, we would repeal the Independent Payment Advisory Board.

Offer a New Transitional, Voluntary Care Coordination Benefit to Seniors Who Need It

One of the greatest shortcomings of traditional Medicare's fee-for-service (FFS) model is the lack of coordinated care. In some ways, this is the essence of FFS: a payment model that pays for individual treatments and services, but does not pay anyone to manage or coordinate care. As a result, it's no surprise that traditional Medicare's payment silos can result in fragmented care, and too often, seniors and their families are left to navigate the health care system on their own – at a time when these patients are most vulnerable. Medicare's FFS care model is particularly inadequate when you consider that a small portion of the beneficiary population are the sickest, and as a result, are often the costliest to the health care system.⁹⁴ This subset of beneficiaries present the greatest risk of entering the costliest care settings because of their health status—complex health needs, multiple chronic conditions, acute episodes of care, or the transition after an acute episode of care. It is clear that such beneficiaries could benefit most from targeted help to provide an integrated, patient-centered approach to care when they need it. Ironically, sick patients not only cost the Medicare program the most, but they are actually the patients who have the most to gain from targeted care coordination offering better care and clinical outcomes.

Unfortunately, in a fee-for-service system, there is no one in charge of coordinating care, even for those seniors who clinically need it the most. Primary care physicians are probably best positioned to serve as a guide, helping direct patients through the health care system. But even with smart, proactive, engaged providers, beneficiaries may still move throughout the health care system getting more and more treatments and services, regardless of whether those treatments actually improve their health. Medicare beneficiaries would benefit from someone to help coordinate their care. This model of care could not only improve clinical outcomes for individual patients, it could help reduce costs for the Medicare program too if structured the right way.

A very small percentage of patients account for a disproportionate amount of health care spending. This is the nature of health care: sicker individuals consume more resources, and more resources cost more money. The sicker (and often older) a patient is, the more health care services and treatments they require, and the most that costs. The Agency for Healthcare Research and Quality recently affirmed this well-known fact that most health care costs are incurred by few Americans when they confirmed “only 10 percent of the U.S population accounted for nearly two-thirds of all health care costs in 2008.”⁹⁵

Furthermore, based on an examination of government data, Christopher Conover, a research scholar at Duke University's Center for Health Policy and Inequalities Research, has concluded that, “one percent of the population that has the highest annual health expenses accounts for one-fifth of health spending.”⁹⁶

Respected surgeon and health policy writer, Atul Gawande, wrote in the *New Yorker* magazine about the experience of Jeffrey Brenner. Brenner, a physician, lives in Camden, NJ and built a database of patients and their experience in the city's emergency rooms and hospitals. As Gawande explains, Brennan learned that “the people with the highest medical costs—the people cycling in and out of the hospital—were usually the people receiving the worst care.”⁹⁷ Brennan found “that between January of 2002 and June of 2008 some nine hundred people in the two buildings accounted for more than four thousand hospital visits and about two hundred million dollars in health-care bills.”⁹⁸ About one in four of the patients Brennan attempted to help (and study) suffered from catastrophic conditions. As Gawande explained:

“They are the patients who are in the top one per cent of costs because they were in a car crash that resulted in a hundred thousand dollars in surgery and intensive-care expenses, or had a cancer requiring seven thousand

⁹⁴ “Most Health Care Costs Incurred by a Few Americans,” AHRQ News and Numbers, January 12, 2012, <http://www.ahrq.gov/news/nn/nn011212.htm>

⁹⁵ “Most Health Care Costs Incurred by a Few Americans,” AHRQ News and Numbers, January 12, 2012, <http://www.ahrq.gov/news/nn/nn011212.htm>

⁹⁶ Conover, Christopher, “The health spending 1 percent,” American Enterprise Institute, November 22, 2011. <http://www.aei.org/article/health/healthcare-reform/the-health-spending-1-percent/>

⁹⁷ Gawande, Atul, “The Hot Spotters,” *The New Yorker*, January 24, 2011.

http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande#ixzz1ibp0wOuK

⁹⁸ Ibid.

dollars a week for chemo and radiation. There's nothing much to be done for those patients, you'd think. Yet they are also victims of poor and disjointed service. Improving the value of the services—rewarding better results per dollar spent—could lead to dramatic innovations in catastrophic care, too.”⁹⁹

Gawande's general conclusion is right: many of the sickest patients are also the costliest. Consider the experience of seniors who are often called “dual-eligibles”—the 9 million Americans enrolled in both Medicare and Medicaid. Duals represent a small percentage of these programs, but account for a disproportionate amount of costs across both programs. CMS estimates that total annual spending for dual-eligibles is \$300 billion across both programs.¹⁰⁰ In particular, these beneficiaries could greatly benefit from health coverage that offers care coordination.

The benefit of targeted care coordination for our sickest and most vulnerable seniors is coming into focus with the growing evidence and experiences of the benefits of effective care coordination. The President's Fiscal Commission highlighted the innovative example of Community Care of North Carolina, a provider-led medical home model, which has saved North Carolina more than \$1 billion by reducing hospitalizations and emergency room visits.¹⁰¹ There has been demonstrated success with care coordination in non-Medicare commercially-insured populations by employing innovative models of care designed to target the patients most at risk because of their health care needs. The success of these efforts in turn is leading to further adoption of innovative coordinated care models in the non-Medicare commercially-insured populations and calls by private insurers to advance care coordination in Medicare.¹⁰²

While successful care coordination models are data driven and many utilize cutting-edge health risk informatics, care coordination is not rocket science. For example, in recent years some employers have been incentivizing their employees and their employees' health care providers to encourage their adherence to evidence-based care and health behaviors that lower health care costs.¹⁰³ Studies have shown that targeted disease management can help lower costs by helping patients to avoid unnecessary hospitalizations.¹⁰⁴

Attempts to provide care coordination to Medicare beneficiaries over the years have been stymied by bureaucratic, top-down micro-managing or limited to demonstrations with mixed results. Unfortunately, the Accountable Care Organizations under the health care law are not targeted to any particular segment of the patient population, which is a missed opportunity in targeting improved health to the highest risk beneficiaries that hold the greatest potential for cost savings. We believe seniors enrolled in traditional FFS Medicare deserve *better care* than the current fragmented care they often receive. We believe any senior on Medicare should be able to benefit from innovative care coordination models, instead of the defacto fragmented care under traditional Medicare. In fact, we want to improve this component of traditional Medicare so that we provide some of the sickest, most clinically needy seniors with better health care and better outcomes.

Medicare Advantage's coordinated approach to care is one reason for the growing popularity of these plans among seniors, with more than one in four Medicare beneficiaries currently enrolled in an MA plan. While this integrated approach to care naturally lends itself to a more coordinated benefit, we believe that seniors in traditional FFS Medicare should have the opportunity to experience a new, targeted care coordination benefit. Our nation's seniors should not have to wait for micro-managed demonstrations to run their course before they are able to benefit from the proven, patient-centered care coordination non-Medicare patients enjoy.

Under our proposal, all Medicare beneficiaries that fit certain medical and clinical criteria would be eligible for a new care coordination benefit. All seniors in the traditional Medicare program could select that they want this care

⁹⁹ Ibid.

¹⁰⁰ Testimony of Melanie Bella, Director of CMS before the Senate Committee on Finance, August, 3, 2011. <http://www.hhs.gov/asl/testify/2011/08/t20110803a.html>

¹⁰¹ Report of the National Commission on Fiscal Responsibility and Reform, December 2010, pg. 41. http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf. “State saved nearly \$1B using medical homes,” *Fierce Health Finance*, January 3, 2012. <http://www.fiercehealthfinance.com/print/node/9706>

¹⁰² BlueCross BlueShield Association, “*Building Tomorrow's Healthcare System: The Pathway to High-Quality, Affordable Care in America.*” http://www.blueadvocacy.org/plans/view/do_what_works_-_what_the_government_should_do

¹⁰³ MedEncenive website, example of care coordination. http://medencenive.com/Mission_And_Vision.aspx

¹⁰⁴ Whellan et.al. “The Benefit of Implementing a Heart Failure Disease Management Program,” *Archives of Internal Medicine*, October 8, 2001, Arch Intern Med/Vol. 161:2223-2228. <http://archinte.ama-assn.org/cgi/reprint/161/18/2223.pdf>

coordination benefit, but it would only be activated if they met certain medical criteria. This way we ensure that the Medicare program is using its dollars in a cost-effective manner -- not just paying for more treatments and services for everyone, but really targeting the resources to those who need it the most. This new, voluntary benefit would be directed to higher-risk beneficiaries with the goal and expectation of better managed health and decreased use of expensive emergency room visits and avoidable hospitalizations. This benefit would be flexible enough to empower patients and providers to leverage the targeted care coordination that will meet their needs, such as targeted case management, transitional case management, patient support systems, bio-monitoring, or disease management. To ensure appropriate and high-quality care coordination, providers and beneficiaries would be accountable for demonstrating results and achieving specific outcomes based on beneficiaries' health status and their care coordination needs. The type and utilization of this benefit would be data driven and results oriented. The impact of this benefit will be carefully measured, and care coordination that does not meet the outcomes and requirements set forth in the benefit would not be reimbursed.

To save Medicare, we want to fix what is broken and build on what is working. Instead of arbitrary provider cuts that threaten beneficiary access to care, we believe effective care coordination targeted to Medicare's most at-risk seniors who account for disproportionate health care costs offers a better solution to addressing our nation's runaway health care costs. Targeted care coordination presents an important opportunity for beneficiaries to have a new, voluntary benefit that will improve the quality of care they receive, while helping taxpayers get a better return on their Medicare dollars.

Care coordination—if done the right way—can help bend the federal health care spending curve by reducing preventable hospitalizations and unnecessary emergency room visits. One in five Medicare patients are readmitted within a month of being discharged and a third are hospitalized again within 90 days.¹⁰⁵ The cost of these preventable episodes of care in the costliest delivery points is not limited to the billions of taxpayer dollars which these preventable visits to the emergency room and hospitalizations cost our nation every year—no patient enjoys going to the hospital. Care coordination done the right way could be a win-win for seniors and taxpayers: improved clinical outcomes that will decrease federal spending.

Care coordination should be designed by looking at what is working well. Proper care coordination can better ensure that beneficiaries access appropriate care, in the right setting, at the right time. As a senior's health care needs increase, it becomes increasingly important to have such an established relationship with a health care practice, and we believe care coordination helps to strengthen patient-doctor relationships.

A recent Congressional Budget Office analysis on Medicare's demonstration projects on disease management and care coordination underscores the challenges for realizing the full potential of care coordination within traditional Medicare's fragmented FFS model. As CBO explains:

“Demonstrations aimed at reducing spending and increasing quality of care face significant challenges in overcoming the incentives inherent in Medicare's fee-for-service payment system, which rewards providers for delivering more care but does not pay them for coordinating with other providers, and in the nation's decentralized health care delivery system, which does not facilitate communication or coordination among providers.”

However, providing the right patient and provider incentives will help maximize the potential of targeted care coordination, even within the FFS model until the larger reforms occur in 2016, which will naturally lend to greater care coordination. For example, a portion of the savings produced by other reforms outlined in this proposal could be provided as a monthly fee to cover the costs of care coordination when the benefit is triggered. If structured the right way, payment incentives could be aligned such that by lowering the costs for at-risk beneficiaries in need of care coordination, providers could be rewarded by sharing in the savings to the program. To further ensure effective use of taxpayer dollars, a portion of, or all of these payments, could be at-risk if benchmarks are not achieved and such fees could be limited to an amount smaller than the anticipated reductions in Medicare expenditures to ensure savings. As an

¹⁰⁵ Abelson, Reed, “Study Finds Many on Medicare Return to Hospital,” *The New York Times*, April, 2009.
http://www.nytimes.com/2009/04/02/health/02hospital.html?_r=2

incentive for participating in care coordination, a senior could be eligible for a reduced premium or reduced cost-sharing for demonstrating adherence to a disease management or treatment program. Regardless of the specific care coordination approach employed, beneficiaries participating in this benefit should provide feedback on their satisfaction with the quality of the care they receive.

The potential of care coordination to provide better health at lower costs will not be fully realized until the longer-term reforms are adopted, but we believe those with the greatest need for care coordination should not have to wait to receive the innovative care coordination many non-Medicare patients enjoy today. By providing a targeted care coordination benefit, we can and should immediately offer seniors a better benefit in the interim before larger structural reforms are implemented in 2016.

Chapter 3 – A More Sustainable Medicare to Come

“Premium support has bipartisan origins. The term was coined by two Democratic economists, Henry Aaron and Robert Reischauer, and premium support was the main recommendation of the bipartisan Commission on Medicare Reform, chaired by Senator John Breaux (D-LA) in the late 1990s. Subsidies and exchanges (called “alliances”) were proposed by President Clinton and are the basis of the expansion of coverage in President Obama’s Affordable Care Act (ACA).

Alice Rivlin, Former CBO Director, May 17, 2011¹⁰⁶

Building on a Bipartisan Solution

Our longer-term solution, premium support, has benefitted from longstanding bipartisan support and years of careful consideration by experts. Premium support received a lot of attention when center-left thinkers Henry Aaron and Robert Reischauer introduced the concept in the mid-1990s.¹⁰⁷ Aaron, who has served in a number of health policy roles in the federal government, is at the Brookings Institution. Reischauer, a former director of the Congressional Budget Office, is now president of the Urban Institute. In 1995, they wrote: “we propose converting Medicare from a ‘service reimbursement’ system to a ‘premium support’ system. These changes would resemble many that are now reshaping private employer-based insurance.”¹⁰⁸ They said that, “Medicare beneficiaries should have a degree of choice among health plans similar to that enjoyed by the rest of the population” and suggested how to accomplish that idea:

“Rather than paying for all services on a stipulated menu, Medicare would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services. As with private insurance for the working population, plans could reimburse any provider the patient choosesPlans could manage care in any of the ways now in use or that might arise in the future. All Medicare beneficiaries ultimately would receive a predetermined amount to be applied to the purchase of a health plan providing defined services.”¹⁰⁹

The concept of premium support received some of the greatest attention in the late 1990s when Congress created the “National Bipartisan Commission on the Future of Medicare” (“Medicare Commission”) in the Balanced Budget Act of 1997.¹¹⁰ Congress charged the Medicare Commission to examine the Medicare program and make recommendations to strengthen and improve the program before the Baby Boomers retired.¹¹¹ The Medicare Commission was jointly chaired by then-U.S. Senator John Breaux (D-Louisiana) and then-U.S. Representative Bill Thomas (R-California). The Medicare Commission met from late 1998 through 1999, and while the final framework failed to receive the votes needed to trigger automatic consideration of the proposal in Congress, the thoughtful, careful work of the Commission represented a definitive and respected contribution to moving the Medicare reform debate forward. In fact, much of the current discussion of “premium support” as a model for saving Medicare is modeled on the solid policy development accomplished by the bipartisan members and staff of the Medicare Commission.

¹⁰⁶ http://www.huffingtonpost.com/alice-m-rivlin/saving-chairman-ryan_b_863222.html

¹⁰⁷ Henry J. Aaron and Robert D. Reischauer, “The Medicare Reform Debate: What is the Next Step?” *Health Affairs*, 14, no. 4 (1995): 8-30. <http://content.healthaffairs.org/content/14/4/8.full.pdf>

¹⁰⁸ Henry J. Aaron and Robert D. Reischauer, “The Medicare Reform Debate: What is the Next Step?” *Health Affairs*, 14, no. 4 (1995): 8-30. <http://content.healthaffairs.org/content/14/4/8.full.pdf>

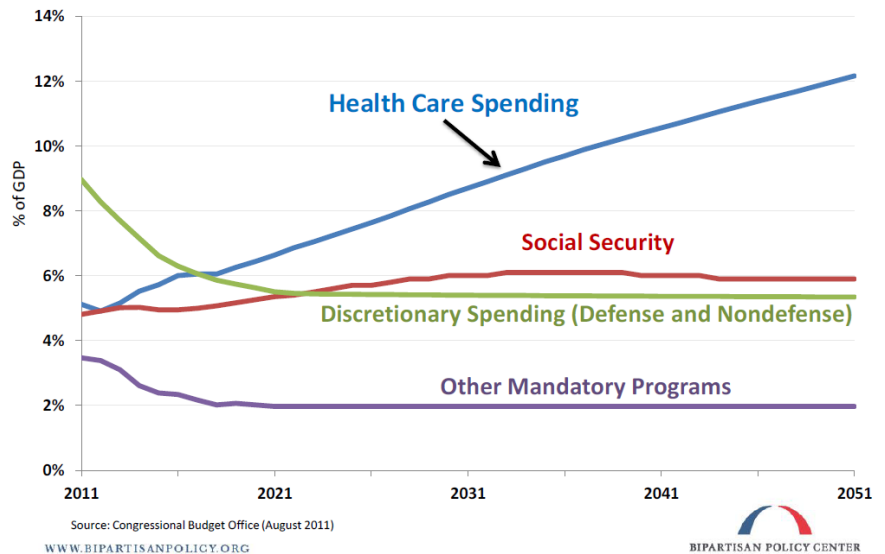
¹⁰⁹ Henry J. Aaron and Robert D. Reischauer, “The Medicare Reform Debate: What is the Next Step?” *Health Affairs*, 14, no. 4 (1995): 8-30. <http://content.healthaffairs.org/content/14/4/8.full.pdf>

¹¹⁰ Online archive of the National Bipartisan Commission for the Future of Medicare, <http://thomas.loc.gov/medicare/about.html>

¹¹¹ Online archive of the National Bipartisan Commission for the Future of Medicare, <http://thomas.loc.gov/medicare/index.html>

More recently, the idea of premium support has been revived by several thoughtful contributors to the debate. House Budget Chairman Paul Ryan (R-Wisconsin) has offered at least four versions of Medicare premium support.¹¹² And the former director of the independent Congressional Budget Office Alice Rivlin and former Senator Pete Domenici (R-New Mexico) are to be commended for their recent hard work on advancing premium support through the Bipartisan Policy Center. Their blueprint, while different than our framework, is a credible, thoughtful, and legitimate model that helps move the debate forward in a bipartisan way. They continue to help educate lawmakers and stakeholders that “the principal driver of future federal deficits is the rapidly mounting cost of Medicare” and “there can be no lasting solution to the U.S. debt crisis without structural changes in the Medicare program to slow its cost growth.”¹¹³

HEALTH CARE COSTS ARE THE PRIMARY DRIVER OF THE DEBT



The Big Idea: Delivering Medicare Benefits through Premium Support

The longer-term solution we propose adopting to save Medicare is usually called “premium support” because the new system would offer a defined contribution to each senior that would help support their Medicare coverage. Unlike today, in which prices for Medicare services and treatments are set in Washington, DC and offered as a defined benefit, our solution would use market competition between public and private plans to lower costs and increase choices for seniors. We would start these reforms in 2016 because the independent Medicare Actuary projected the Medicare Hospital Insurance Trust Fund could be insolvent as soon as that year.¹¹⁴ So, beginning in 2016, we would require the FFS Medicare to basically bid like a private health plan to cover a package of services.

Unsustainable Status Quo → 2014 Reforms → 2016 Reforms

Current path

Modernize cost-sharing

Structural reforms

First, we would define geographic areas based on different regions that make better sense for pricing goods and services covered by public and private health insurance plans. We like the idea of building on the Medicare Part D regions, but Congress could also use a combination of states and new regional areas. Congress should ensure the regions are small enough to ensure common insurance plans and prices, but large enough to use economies of scale.

Second, we would require Medicare’s FFS and private plans to compete. In 2016, the first year of bidding, FFS Medicare and private plans would participate in competitive bidding at a regional level to offer a package of health care benefits actuarially equivalent to the Medicare benefits provided in the year before. All plans would be required to cover basic hospital, surgical, physician, and emergency care – and would have to be actuarially equivalent to the 2015 Medicare

¹¹² Congressman Paul Ryan’s (R-WI) Roadmap for America’s Future, <http://www.roadmap.republicans.budget.house.gov/Issues/Issue/?IssueID=8520>; a plan with former CBO Director and Democrat Alice Rivlin, http://www.cbo.gov/ftpdocs/119xx/doc11966/11-17-Rivlin-Ryan_Preliminary_Analysis.pdf; The Path to Prosperity, Fiscal Year 2012 Budget Resolution, <http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf>; and a plan with Senator Ron Wyden (D-OR) <http://wyden.senate.gov/issues/issue/?id=ab82bb35-a617-4d66-b6e2-c9f9b4758c59>

¹¹³ Domenici-Rivlin Protect Medicare Act, <http://www.bipartisanpolicy.org/sites/default/files/Domenici-Rivlin%20Protect%20Medicare%20Act%20.pdf>

¹¹⁴ <https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>, page 25

benefit. The new independent Medicare Consumers' Protection Agency could also prescribe reasonable minimum standards for health benefit plans.

New plans would cover the basic categories offered by the current benefit, but would have a wide range of flexibility in plan design and plan administration. The government-administered plan would be required to be offered in every market area, but private plans would not have to bid in every region. CMS would administer the bids through regional offices in consultation with the independent Medicare Actuary. Plan bids would be weighted by plan enrollment after the first year. First year bids could need some adjustment to prevent plans from offering an unreasonably low bid that could distort market share.¹¹⁵

Next, after leveling the playing field and ensuring competition amongst plans, we would ensure seniors received their Medicare benefit as a defined contribution. A key to making the system work is that seniors would receive a fixed amount from the government for which to buy a Medicare plan directly tied to the percentage the federal government currently contributes toward seniors' Medicare benefits. (The Federal Government's contribution for the bid would be the prior year's actual government percentage contribution for Parts A and B spending, and the federal contribution would be tied to the weighted average bid.) The defined governmental contribution would vary based on income, so the wealthiest would pay more and the lower-income would pay less. But, the contribution would not increase if a given senior simply picked a more expensive plan – the amount of the governmental contribution would be fixed, regardless of what plan a senior choose. The dollar amount of the defined contribution would increase each year based on the competitive bidding system that accounts for the prior year's expenses and enrollment. The Medicare Consumers' Protection Agency would oversee a process (using what insurers call "risk adjustment") to mitigate adverse selection—the dynamic when consumers with the highest costs (seniors who are the oldest and sickest) purchase a particular coverage product. All seniors would have a wide range of choices like the kinds of choices Members of Congress currently enjoy. In our proposal, stand-alone Prescription Drug Plans would continue, but FFS would be prohibited from adding a drug benefit, because the Medicare drug benefit is voluntary.

To ensure that the government-administered plan fairly competes with the private plans, an independent organization would oversee the bids offered by the Centers for Medicare and Medicaid Services (CMS) and private plans. CMS would still oversee the bids for the government plan, but overseeing private bids inside CMS would clearly be a conflict of interest. The Medicare Consumers' Protection Agency would be modeled on the Office of Personnel Management and would be led by Senate-confirmed appointees. The MCPA would also ensure broad, transparent stakeholder engagement. MCPA would have explicit instructions to prohibit some activities (conflict of interest, etc.) and require certain others (administer solvency tests and reserves for all plans, require uniform explanation of benefits, certify marketing materials meet standards, ensure the accuracy of information, make sure consumer protections are adhered to, operate an ombudsman for complaints, etc.). The MCPA would also be required to conduct a nationwide education campaign – like was done for Medicare Part D – to ensure seniors are aware of their choices under the new system. The MCPA would perform a range of activities to protect seniors and ensure that competition is fair, transparent, and

Actuarial Value is “the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.” - From the U.S. Department of Health and Human Services, www.healthcare.gov

Actuarial equivalence is “a general term used to describe two or more benefit plan designs that have approximately the same value. In this context, ‘value’ could mean several things, but it is commonly either the dollar value of average expected benefits paid out by the plan or the average share of total health spending that is paid for by the plan. As long as the other methods and assumptions used are the same, the determination of whether two benefit plans are actuarially equivalent will be the same, regardless of which specific measure of actuarial value is used. If minimum benefit standards are imposed, actuarial equivalence comparisons could determine whether alternative plan designs meet or exceed these standards.” - American Academy of Actuary, www.actuary.org

¹¹⁵ Similar to CALPERS and when FEHBP was started, rate shock between FFS and private plans would be mitigated for the first three years by requiring premium thresholds to be no larger than a certain differential. This mechanism would be phased out over a three year period.

accountable. For example, the MCPA could ensure that bids are actuarially equivalent, ensure plans meet solvency standards, review marketing materials to ensure their accuracy, explain the new system to seniors, and provide seniors with timely information in order to select the plan that best meets their needs.

We would help encourage seniors' choices by using an open enrollment period each year, during which beneficiaries could opt out of their plan and choose another plan if it better met their medical needs. This approach is similar to what is used in Medicare's prescription drug benefit and in the Federal Employees' Health Benefits Program. No one currently on Medicare would be forced to leave the basic government-administered Medicare, but each year during the open enrollment period, newly-enrolling or currently-enrolled seniors could choose a plan that best meets their needs. If a newly-enrolled beneficiary declined to select a plan, he or she would be auto-enrolled into the plan in his or her region that was the best fit for their budget and health status, but they would be allowed a one-time plan switch if they did not like their plan before the annual open enrollment period.

Premium Support Is Proven, Fixes Key Problems

We believe premium support is the best way to protect beneficiaries, slow cost growth, and save Medicare. Premium support is not an academic endeavor, it is a demonstrated success. Premium support is a proven model that is effectively identical to the way Medicare's current prescription drug benefit is administered and delivered in Part D.

This model is also very similar to the way that Members of Congress and federal employees receive their health care coverage through the Federal Employees' Health Benefit Program. In fact, this approach is so workable that the Healthcare Leadership Council – a consortium of chief executives from a wide range of companies and non-profits in the health care industry – endorsed a version of Medicare premium support in 2011. The HLC's president, Mary Grealy, described premium support as a plan that “will contribute to deficit reduction without placing an unfair or disproportionate burden on patients, healthcare consumers or our most vulnerable citizens.”¹¹⁶

Premium support works by fixing two key problems in our health care system: Medicare's FFS system, and the disconnect consumers feel with third-party payers. First, there is general consensus that Medicare's FFS system encourages wasteful and often inexplicable variation and overspending because Medicare is a centralized, price-fixing bureaucracy that distorts actual local market costs. This inefficiency needlessly inflates the cost of health care. Premium support can help squeeze inefficiencies out of the system by making Medicare beneficiaries smarter health care consumers, and by ensuring Medicare prices are more reflective of actual regional costs. In fact, both FEHBP and Medicare Part D both have a better record of cost-control than traditional Medicare.¹¹⁷

Second, premium support would alleviate the disconnect many Americans with health insurance have between cost, quality, and outcome. Today, too many Americans families use more health care because they effectively believe someone else is paying for it. Our system of third party-payers has disconnected the purchaser of health care with the payer. Indeed, economists generally agree that, because health insurance costs are spread across a broader population and bills are paid by a third party, many Americans consume more health care than may be needed. It is common sense, when one thinks someone else is paying for his or her health care, there is little incentive to curb utilization or be prudent consumers. Moving to a fixed contribution (that would grow each year) will encourage seniors in Medicare to be more cost-conscious, while at the same time ensure they have their Medicare benefits.

We know that private plans can successfully deliver Medicare benefits. As the Congressional Research Service (CRS) noted, “Medicare has a long-standing history of offering its beneficiaries health insurance coverage through private

¹¹⁶ “Health Industry Leaders Recommend Over \$410 Billion in Healthcare Savings to Congressional ‘Super Committee,’” Healthcare Leadership Council, <http://www.hlc.org/newsroom/health-industry-leaders-recommend-over-410-billion-in-healthcare-savings-to-congressional-%e2%80%9csuper-committee-%e2%80%9d/>

¹¹⁷ Critics often point to increasing premiums in employer-provided health insurance as a weakness of premium support to control costs. However, the real reason premiums have grown so fast for individuals with employer-provided health insurance is due to the current federal tax treatment of that health insurance, which we suggested addressing through the Patients' Choice Act of 2009. Read more about that proposal here: <http://goo.gl/v49BK>

plans” that dates back to the 1970s.¹¹⁸ We have already discussed many of the successes of the Medicare Advantage program. More than 25 percent of seniors are enrolled in a MA plan that protects them against excessive out-of-pocket costs due to hospitalization. Furthermore, many MA plans offer care coordination – thus improving outcomes while reducing costs.

At the same time, Congress has instituted certain payment thresholds that have basically paid private plans to offer coverage in an area or locality that otherwise would not make good business sense. Efforts to ensure that private plans remain an option for seniors in areas where Medicare’s FFS system costs appear lower is a good desire. This has resulted in many seniors being able to benefit from high quality care in MA plans. One reasonable critique is that the establishment of certain MA payment thresholds cost taxpayers more to maintain in some areas than traditional Medicare. However, even the best current cost estimates of the cost of traditional Medicare may not be truly reflective of all of real costs and variables at work. Currently, there is hidden cross-subsidization between “high cost” and “low cost” areas because Medicare premiums are uniform across the nation. By virtue of being an open-ended entitlement in a fee-for-service system with a third-party payment model, Medicare spending is less directly connected to the real underlying costs than many think.

We do not want to overpay commercial plans or the government-run plan. As part of a level playing field, both should be forced to reflect the cost of providing Medicare benefits for seniors in a particular region. We want the government to be neutral with regard to where an individual senior chooses to get his or her Medicare plan. Seniors should have a system where they can choose a plan that best fits their budget and health needs. This will help dramatically lower costs.

Medicare Part D Shows Premium Support Can Work

Over the last decade, Congress passed some incremental reforms to Medicare, but none went far enough in actually strengthening the program. Congress created a new Medicare drug benefit; however, Congress erred in creating a benefit that was not designed to be self-funded. As a result, the creation of Part D significantly increased the deficit and added an estimated \$16 trillion of unfunded liabilities to Medicare. Moreover, today’s taxpayers are paying more than 80 cents of every Medicare drug benefit dollar –this will have to change.¹¹⁹

But, while Congress failed to ensure financing for the Part D program over the long run, the program has largely been a success in controlling costs and providing high quality and affordable private drug coverage to millions of beneficiaries. As former Secretary of Health and Human Services Mike Leavitt noted in 2011:

“The drug benefit, now in its sixth year, has outperformed all expectations. Seniors like it. Ninety percent of Medicare participants are in secure drug coverage and express strong satisfaction with the program in independent surveys. Scores of insurers participate in the program. In 2011, every senior in the country has access to a minimum of 28 drug plan options. Competition is working to hold down costs. Current projections by the Medicare actuaries show the 10-year costs of the drug legislation coming in 41 percent below estimates made when the bill passed.”¹²⁰

The program has been so successful in large part because Medicare has had a per capita defined contribution from taxpayers, and beneficiaries have been able to choose from a wide variety of private plans. Private plans have had the needed flexibility to be creative in designing benefit options, and taxpayers and patients both gain as a result. Leavitt noted that “plans are offering benefit designs that reward seniors for taking generics when they are available” and cites one study that shows “the average price per prescription for the most popular prescriptions for seniors participating in the drug program declined between 2006 and 2009 by 21 percent” because of the large migration into lower-cost generics.¹²¹

¹¹⁸ Congressional Research Service, “Medicare Advantage,” Paulette Morgan, March 3, 2009.

<http://www.crs.gov/pages/Reports.aspx?PRODCODE=R40374&Source=search>

¹¹⁹ Report of the Medicare Trustees, Table II.B1

¹²⁰ Leavitt, Michael, “A prescription to fix Medicare,” *The Washington Post*, May 19, 2011. http://www.washingtonpost.com/opinions/a-prescription-to-fix-medicare/2011/05/19/AFOsIP7G_story.html

¹²¹ Ibid.

Some critics of premium support may suggest that Part D is different because it is “just drug coverage,” insisting that seniors on Medicare cannot adequately choose a health coverage plan that best meets their health and budget needs. This approach contradicts the experience of millions of seniors who have made precisely such a decision in choosing their Part D drug coverage. As former HHS Secretary Mike Leavitt noted in the *Washington Post*:

“Critics said [Medicare Part D] would never work. They said that health care isn’t like electronics or cars, because consumers aren’t looking to save money when it comes to health services... Still others thought that the program would be too complex for seniors to navigate and that millions would opt out because of fear or confusion.”¹²²

Yet, roughly 90 percent of seniors have drug coverage, with the majority of them enrolled in Part D or enjoying private drug coverage through a MA plan.¹²³

The evidence that market competition has kept beneficiary premiums low through Part D cost control is undeniable. In 2011, officials from HHS announced that “premiums for private Part D benefits in 2012 will average about \$30 — down from \$30.76 in 2011.”¹²⁴ In fact, even the then-head of the Medicare program, Acting Administrator Dr. Don Berwick, admitted that a “competitive market and good competition among Part D plans’ played a huge role in cost control.” Dr. Berwick has explained a number of variables have combined to help reduce costs, including increased price transparency and the addition of more drug plan choices.¹²⁵ “You’re seeing intelligent behavior on the part of the beneficiary,” Berwick said. “They can make better choices for themselves.”¹²⁶ The cost savings are not just limited to prescription drugs: in the summer of 2011, the *Journal of the American Medical Association* published a report finding that Medicare Part D saves taxpayers “about \$1,200 per year in hospital, nursing home and other costs for seniors who previously did not have coverage.”¹²⁷

Part D is a good model for building a premium support system for all of Medicare. As Mike Leavitt said, “the basic features of a plan to use a Medicare Part D strategy in the rest of Medicare would be government oversight of an organized and competitive marketplace, annual choice of plan by the beneficiaries, and a fixed government contribution that is pegged to grow at a rate in line with expected revenue.”¹²⁸

Using the Model That Provides Members of Congress’ Health Coverage

A system of health plans competing to provide health coverage is very similar to the system used for the Federal Employees’ Health Benefits Program (FEHBP). Under FEHBP, the Office of Personnel Management (OPM) administers a system of private health plans that cover approximately 8 million people. For 2010, enrollees in FEHBP will have 235 different plan choices, including all regionally available options. Functionally, an enrollee can choose between five and 15 options, depending on where he or she resides.

The FEHBP program is administered by OPM, which is given the authority under law to contract with qualified carriers offering plans and to prescribe regulations necessary to carry out the statute. This proposal would establish a Medicare Consumers’ Protection Agency (MCPA) modeled after OPM’s management of FEHBP, to administer our new Medicare proposal.

¹²² Ibid.

¹²³ The most recent CMS analysis of the types of drug coverage of non-Part D enrollees was done in early 2010. Part D enrollment data (2 excel spreadsheets) in a zip folder at: <http://www.cms.gov/PrescriptionDrugCovGenIn/> (scroll down to 2010 Enrollment information link to zip folder). The Dec 2011 Monthly Contract Summary Data, MA and Part D is at: <http://goo.gl/DWwVl>. The retiree drug subsidy refers to those receiving retiree drug coverage through their former employers, and the employers are receiving a subsidy from Medicare for providing that coverage. The other main categories are military programs, and employer coverage for those still working. (Dual Medicare-Medicaid eligible are covered under Medicare Part D; the other excel spreadsheet shows LIS enrollment broken down by eligibility category in 2010, in case you need those figures.) About 10% were estimated to not have drug coverage.

¹²⁴ Nocera, Kate, “Medicare prescription drug costs go down,” *Politico*, August 4, 2011. <http://www.politico.com/news/stories/0811/60689.html>

¹²⁵ “Medicare success finds fans on the right,” *POLITICO*, Matt DoBias, August 4, 2011

¹²⁶ “Medicare success finds fans on the right,” *POLITICO*, Matt DoBias, August 4, 2011

¹²⁷ Medicare success finds fans on the right, By Matt DoBias, *Politico*, 8/4/11 4:29 PM EDT

¹²⁸ Leavitt, Michael, “A prescription to fix Medicare,” *The Washington Post*, May 19, 2011. http://www.washingtonpost.com/opinions/a-prescription-to-fix-medicare/2011/05/19/AFOslP7G_story.html

The proposal establishes the basic rules for benefits, enrollment, and participation in premium support under Medicare among other general requirements, while still allowing MCPA wide authority in implementing regulations, contracting with plans, establishing benefits, and administering the Medicare bidding system. MCPA would require the government-administered plan and private plans to allow eligible seniors to enroll during open season and other special election periods regardless of any pre-existing conditions. Neither the government-run nor private plans could discriminate against new enrollees on the basis of health status, race, sex, or age.

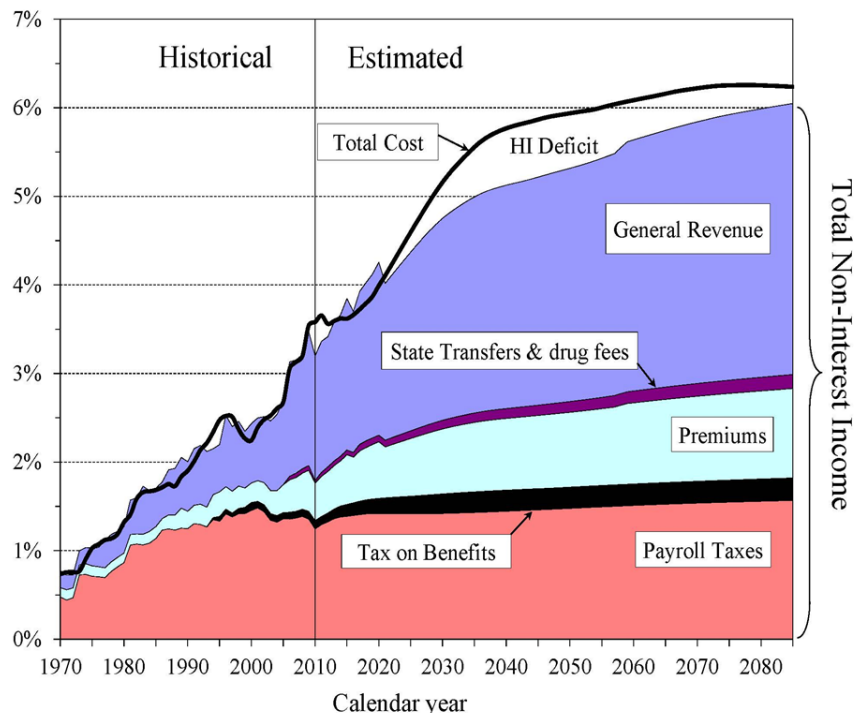
We believe that a carefully-designed, effectively administered Medicare premium support – informed by the OPM-FEHBP experience – can be a strong, stable, and successful model for seniors. Creating a new entity focused solely on protecting Medicare beneficiaries and administering the new Medicare plans allows MCPA to hire the best and the brightest staff from the Medicare program, but prevents CMS from serving in the role of being a regulator and competitor.

This new system will help effectively lower Medicare costs. FEHBP’s experience is instructive when it comes to premiums and costs. FEHBP has historically outperformed Medicare—over both the period from 1975 to 2009 and from 1975 to 2001.¹²⁹ Comparisons actually understate FEHBP’s superior cost control experience because figures are not adjusted for the aging of the federal workforce and the growth in the retiree population. Some critics may suggest that both private and total health care spending has grown faster than Medicare spending, but the reality is that excess cost growth for Medicare has far exceeded that of private health care and total health spending in the past. Our proposal is intended to save money by reining in health care cost growth in Medicare by creating robust competition among insurers and establishing a level of consumer choice that is routine in every aspect of our economy. Finally, with regard to premium increases, the Government Accountability Office (GAO) found that starting in 2003 FEHBP premium rate of growth was generally slower than for other purchasers.¹³⁰ And because our plan for seniors would not be subject to the distorting effect the tax code has on employer-provided health insurance, we expect cost-containment could be even more robust.

Critics or Defenders of the Status Quo?

Action is required to save Medicare for current and future seniors. The nearby chart shows the cost of the Medicare program and its funding sources as a percentage of our GDP.

Premium support is a tested, proven, effective model that will lower costs, slow the rate of growth in the Medicare program, protect Medicare for current and future retirees, and ensure seniors have the same kinds of choices as Members of Congress. There have been private plans in Medicare since the 1970s, and one in four seniors now enjoys receiving their Medicare through a private plan in MA. As for ending Medicare, the real threat to Medicare is not reform, but doing nothing. The most recent Medicare trustees’ report has warned that the Hospital Insurance Trust Fund could be insolvent just four years from now.



¹²⁹ More recent experience from 2002 to 2009 might appear to show Medicare with a slight performance edge, but if the aging of the federal workforce and the growth in the retiree population as a proportion of FEHBP enrollees were taken into account then Medicare’s slight performance edge would disappear.

¹³⁰ Government Accountability Office, *Federal Employees Benefits Program, Premiums Continue to Rise, but Rate of Growth Has Recently Slowed*, Statement of John E. Dicken, GAO-07-873T, May 18, 2007. <http://www.gao.gov/assets/120/116708.pdf>

We invite stakeholders and colleagues on both sides of the aisle to join us in advancing proven solutions to strengthen and save Medicare. The reality is that both Democrats and Republicans share blame in worsening Medicare's prognosis, and both have a responsibility to design a solution that fixes the problems, reduces costs, improves care, and ensures the program will be there for current and future retirees. We are offering our proposal as a reasonable and feasible approach to implementing premium support. Premium support is a model that works and we also know that insolvency is quickly approaching. It is time to strengthen Medicare.

Conclusion – We Can Build a Better Medicare

An abundance of data clearly shows that the Medicare program is facing challenges – both with respect to its fragmented benefit structure and its unsustainable financing. We must act now to strengthen and save it. There is no disputing that the Medicare Hospital Insurance Trust Fund is facing looming insolvency. Independent budget experts agree that the Medicare program’s runaway costs not only threaten the future of the program, but are compounding our nation’s serious fiscal challenges.

Millions of Americans have depended on Medicare for decades and millions more expect that this program will be there when they or their loved ones need it. If we are to fulfill the promise of a patient-centered Medicare for seniors today and in the future, we must make both immediate and longer-term reforms that build on what is working and fix what is broken.

The new health care law notionally acknowledged that the status quo is unsustainable, but instead of addressing the serious challenges facing Medicare, our nations’ seniors, and their doctors, this new law not only failed to fix what is broken, it took more than \$500 billion out of Medicare to spend on new programs not for seniors. This new law also empowered a board of unelected, unaccountable bureaucrats with the ability to reduce payments to health care providers who care for seniors, which will further threaten seniors’ access to care, and could ultimately result in care being denied.

Our nation and the Medicare program are at an important crossroads. The new health care law changed Medicare as we know it and not in the correct way. Without action, this is the course that our nation is on. We believe there is a better way, one that will put patients first. Our proposal offers both immediate and longer-term common-sense reforms that we believe will strengthen Medicare for seniors, put the program on a sustainable path for taxpayers, and ultimately save the program for future retirees.

Our proposal is guided by the goal of providing seniors with a better Medicare. We believe reforms should improve outcomes and ensure patients can access the most appropriate care that meets their individual needs, in the right setting, at the right time. Under our proposal, for the first time seniors would have the peace of mind that they are protected from catastrophic out-of-pocket medical costs and will have targeted care coordination when they need it. Under our premium support model, if a senior wants to keep their traditional Medicare, they can. However, because we believe that seniors should have the same kinds of choices as Members of Congress, we offer seniors the choice of a better benefit whether they are in the government-run or a privately-managed Medicare plan.

We hope to find common ground with seniors, our colleagues, and the full range of stakeholders that the common-sense and patient-focused reforms included in our proposal are a good place to find bipartisan consensus and spark a serious discussion on how we can protect the promise of Medicare for current and future retirees, while putting the program on a sustainable path for taxpayers.

Strengthening and saving Medicare is not about just “balancing the budget” or improving the quality of seniors’ care. Working to strengthen and save Medicare is about both providing seniors with a better Medicare, while simultaneously putting the program on a sustainable path for taxpayers. It is by strengthening Medicare that we save it and fulfill the promise that Medicare will be there when seniors need it, now and in the future.