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Statement to the House Committee on Ways and Means,
Subcommittee on Health

Premium Support Proposals for Medicare Reform

Joseph R. Antos, Ph.D.
Wilson H. Taylor Scholar in Health Care and Retirement Policy
American Enterprise Institute

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Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify today before the House Committee on Ways and Means, Subcommittee on Health.

Medicare reform based on the principle of premium support can responsibly slow the growth of program spending and help set this country on a sustainable fiscal path. Such a reform relies on market competition among health plans to achieve high-quality coverage at the lowest cost. That is essential if we are to protect the Medicare program for future beneficiaries.

The annual report of the Medicare trustees issued earlier this week reminds us once again that Medicare is living on borrowed time. Even if the substantial reductions in payments to health care providers included in the Affordable Care Act (ACA) are fully implemented and Congress allows the 32 percent reduction in physician payments required under current law to go through in January, Medicare spending will continue to grow at unsustainable rates. Medicare's Part A trust fund will be depleted in 2024, and the program faces $27 trillion in unfunded liabilities over the next 75 years. With the retirement of 76 million Baby Boomers over the next two decades, the program will consume an ever increasing share of the federal budget unless policies are adopted to bend Medicare's cost curve.

Traditional Medicare's uncapped entitlement and fee-for-service payment structure is a major cause of the rapid rise of program spending. Fee-for-service payment promotes the use of more, and more expensive, services in a fragmented and uncoordinated delivery system. That results in higher cost and poorer patient outcomes.

Premium support changes that incentive by giving consumers a subsidy to purchase insurance from a wide selection of competing health plans offering a core set of benefits. In each market area, the plans would submit bids to provide the basic benefits to a beneficiary with average health risk. The subsidy would be based on the low bid, which under many proposals is defined as the second-lowest bid offered in that market. To ensure affordability, subsidies would be higher for beneficiaries with lower incomes or higher health risks.

Beneficiaries could enroll in more expensive plans, but any extra premium would be paid solely by the beneficiary without additional subsidy. That gives an incentive to consumers to select lower-cost plans, and it gives an incentive to the plans to negotiate lower prices with providers and improve the delivery of care. Instead of increasing the volume of services to increase payment, health plans would have a strong interest in providing necessary services in a cost-effective manner. Under premium support, more efficient health care delivery is rewarded, not penalized.

A number of bipartisan Medicare reforms that incorporate premium support in their design have been advanced over the past 15 years—including the Breaux-Thomas proposal developed for the National Bipartisan Commission on the Future of Medicare, the Domenici-Rivlin proposal developed for the Bipartisan Policy Center's Debt Reduction Task Force and recent proposals by Rep. Paul Ryan (R-Wis.) and Sen. Ron Wyden (D-Ore).[1] Each of those proposals addresses long-standing problems that threaten to undermine Medicare and jeopardize the country's fiscal future.

My testimony addresses four key issues in designing a Medicare reform based on premium support. First, the role of traditional Medicare. There are political and practical reasons to retain traditional Medicare as a competing plan option under premium support. Properly structured, premium support would not favor any specific plan over another.

Second, cost shifting to beneficiaries. Concerns have been raised that premium support would impose dramatically higher costs on Medicare beneficiaries. That ignores the cost shifting that is already in place under the ACA, which requires large across-the-board cuts in provider payment that threaten access to care—a real cost to patients that is not reflected in higher premiums. It also ignores the clear incentives that health plans would have to keep costs low, and it takes no account of the availability of traditional Medicare as a safety valve for beneficiaries should private plans fail to perform.

Third, indexing the growth of Medicare's subsidy. Most proposals include an index to limit future Medicare spending, which produces "scoreable" budget savings. The choice of an index is important, but efficiency and innovation in health care delivery determine whether Medicare savings can be sustained in the long term.

Fourth, additional reforms. Premium support by itself will not save Medicare. More immediate reforms are needed to modernize traditional Medicare and produce additional cost savings as we transition to full premium support. Our fiscal crisis is too urgent and Medicare's problems are too complex to delay action.

Traditional Medicare as an Option

Should traditional Medicare be retained as a plan option under premium support, or should it be phased out? Last year's House budget resolution included a premium support proposal that closed new enrollment in traditional Medicare beginning in 2022.[2] Individuals turning 65 from that year on would have a choice of private plans, but traditional Medicare would not be available.

Responding to concerns, the House budget resolution passed this year includes traditional Medicare as a plan option under premium support for all beneficiaries, including those who become newly eligible for Medicare. Although there are problems with either approach, retaining traditional Medicare as an option is the most reasonable course.

Some conservatives criticize this change as backsliding. They correctly see the traditional Medicare program in its current form as inefficient and anticompetitive. But pretending that the program will disappear in 10 years makes it unlikely that Congress would make important but difficult decisions needed to set traditional Medicare on a fiscally sustainable path.

The reality is that traditional fee-for-service Medicare could have some 57 million enrollees in 2023, when premium support would begin under the proposal.[3] Even without the current automatic assignment of newly-eligible beneficiaries to traditional Medicare, that

program could remain a dominant force in the health sector for decades if seniors continue to enroll. Prudent reforms, discussed below, are needed to make traditional Medicare less wasteful in the near term as well as after premium support is in place.

Traditional Medicare is likely to retain a strong hold in rural locales and other markets that are dominated by a small number of providers. In such cases, health plans may have little bargaining power to negotiate lower prices with providers. However, private plans may be able to rein in their operating costs through care coordination and other efficiencies that are outside the reach of traditional fee-for-service Medicare. In other markets where there is less concentration and more competition among providers, private plans are likely to have a competitive advantage over traditional Medicare. They should be better able to contract selectively in such markets, allowing them to offer lower-cost options to seniors.

The objective of premium support should not be to drive out traditional Medicare. Instead, premium support should be designed to allow consumers to decide for themselves which plan provides the best value, and give them a clear financial stake in that decision.

Cost Shifting and the Market Test

Will premium support based on full competition among private plans and traditional Medicare work? Some critics argue that premium support simply shifts the cost of care to seniors without improving the efficiency of health care delivery. That would be true only if there were no room to improve health care efficiency or if plans ignored opportunities to cut costs, increase market share, and improve their bottom lines.

Under a premium-support system, an additional test or procedure would not generate additional reimbursement from the government. Most Medicare beneficiaries live on fixed incomes and are not in a position to pay substantially more. That reality will force health plans and providers to coordinate patient care and find other efficiencies rather than perpetuating the current fragmented system. In a well-organized market, beneficiaries will be attracted to health plans that provide the most effective care at the lowest price.

The alternative offered by the ACA is not appealing. The law imposes unprecedented cuts in provider payment rates to generate $850 billion in Medicare savings over the next decade. According to the Medicare actuary, those payment reductions mean that 15 percent of hospitals and other Part A providers would lose money on their Medicare patients by 2019.[4] That figure rises to 25 percent in 2030 and 40 percent in 2050.

Under those circumstances, providers will have to withdraw from the Medicare program, causing growing problems for seniors needing care. Impeding access to care imposes real costs on patients that are not reflected in higher premiums, but they represent a cost shift nevertheless.

Retaining fee-for-service Medicare as a plan option in premium support creates a safety valve if the private plans are unable to rein in costs. If the critics are correct, traditional Medicare would be the low-cost plan in every market. Beneficiaries would move back to the traditional plan when the cost differences became apparent.

We can be reasonably confident that even the health sector will respond to clear economic incentives. In the unlikely event that delivery system improvements fail to materialize, beneficiaries would not be forced into poor-performing plans.

Limiting Program Spending

Medicare reform proposals that rely on premium support include an external constraint on program spending, typically limiting the annual growth in the subsidy to some economic index such as the gross national product (GDP). The proposal in the House Budget Resolution for fiscal year 2013 sets the limit at the GDP growth rate plus 0.5 percent, which is identical to the fiscal target set in the President's 2013 budget for the Independent Payment Advisory Committee (IPAB). The Wyden-Ryan proposal and the Domenici-Rivlin proposal, as well as the IPAB under current law, use GDP plus 1 percent.

The difference between those two growth rates can be substantial from a budget scoring perspective. If the growth in Medicare outlays was limited using GDP plus 1 starting in 2013, spending for benefits through 2022 would total about $7.7 trillion.[5] That is equal to spending under CBO's current law baseline (which includes the IPAB growth target in its projections). The trajectory of spending is lower than under the baseline, however, which suggests that GDP plus 1 would yield net budget savings in subsequent years. Using GDP plus 0.5 results in about $180 billion in budget savings through 2022, and considerably more in later years.

The target can be ratcheted up or down to achieve any level of scoreable savings demanded by political circumstances. Indeed, this type of fiscal control is often included in reform proposals to ensure that CBO produces a "good" score. But that does not imply that future Congresses will enforce the outlay limit or that such a limit is appropriate under future circumstances that are difficult to predict. Deterioration in the underlying health status of the Medicare population, for example, could drive up necessary spending even when care delivery is efficient.

Despite that uncertainty, it is useful to include a spending target in Medicare reform proposals. The Sustainable Growth Rate (SGR), which is intended to limit Medicare physician spending, is an instructive example. Although Congress has overridden the SGR repeatedly over the past 9 years, payment rates have grown less rapidly than they would have with the inflation adjustment built into the formula. Without the SGR, it is possible that Congress would have allowed larger annual updates.

However, we should not fool ourselves into believing that spending targets by themselves will produce savings that can be maintained over the long term. What matters most are the economic incentives brought to bear by premium support, which encourage better decision-making on the part of both consumers and health care providers. If competition can keep program spending within the bounds set by the targets, then the targets are not necessary except as a budgetary mnemonic device that reminds us that resources are limited, even for the most urgent of programs. If not, then the targets would eventually have to be increased unless a public

consensus had been reached that other spending priorities took precedence over health care, at least at the margin.

The Rest of Medicare Reform

Additional reforms are necessary to modernize Medicare, make the program fairer, and reduce unnecessary spending. In addition, some changes in Medicare rules would greatly enhance the effectiveness of competition among health plans and make traditional Medicare more competitive in local markets.

To help slow Medicare spending growth while providing greater financial help to those who are most in need, we need better information, clearer financial incentives, and a reformed subsidy structure that reinforces rather than undercuts efforts to slow spending. Such reform proposals include:

- **Establish clear cost-sharing incentives for beneficiaries.** Separate Part A and Part B deductibles, coinsurance and copayment requirements that vary across different types of services, and arbitrary gaps in coverage (such as the limit on lifetime hospital days) make it impossible for beneficiaries to know what their costs will be. A single deductible covering all Part A and Part B services with a uniform coinsurance rate applied to all covered services, similar to the design of most private insurance, would help clarify for beneficiaries what they are likely to pay.
- **Make cost-sharing requirements income-sensitive.** Medicare currently relates the premiums that beneficiaries pay for Part B and Part D. In addition, dual eligibles and other low-income beneficiaries receive additional subsidies that have the effect of income-relating benefits. This principle should be extended by increasing cost-sharing requirements for higher-income beneficiaries. Any specific dollar amount of cost-sharing has a greater impact on low-income beneficiaries. Income-sensitive cost-sharing would more effectively promote cost awareness across the income distribution.
- **Introduce true insurance protection into Medicare benefits.** Eliminating limits on inpatient days and adding coverage for catastrophic expenses would provide protection against high and often unexpected costs.
- **Recover the cost of induced utilization from stand-alone Medigap insurers.** Supplemental coverage pays Medicare deductibles and coinsurance, which largely eliminates financial incentives for conservative care on the part of both patients and providers. Medigap plans do not absorb the cost of the additional use of services that results, which are paid by Medicare as primary insurer. (This is not an issue for Medicare Advantage plans, which provide primary coverage as well as any additional benefits for a fixed per-beneficiary government payment.) Requiring supplemental plans to defray higher program costs would transfer the additional cost from taxpayers back to those who purchase and benefit from Medigap plans. An alternative approach would exclude Medigap coverage for the first $500 of a senior's cost-sharing and limit coverage above that to less than full payment.[6] The objective of this proposal combined with the three preceding ones

is to improve traditional Medicare so that there would be little need for beneficiaries to purchase supplemental insurance, but not to dictate how Medicare beneficiaries decide to spend their own money.

- **Offer care coordination services to beneficiaries who need it.** Traditional Medicare could improve patient outcomes and potentially reduce cost by providing care coordination to high-risk beneficiaries being treated by multiple physicians and other providers.[7] If used by patients meeting appropriate medical criteria, such a service would help minimize unnecessary testing, emergency room use, and avoidable hospital admissions.
- **Reform Medicare's payment systems.** The ongoing threat of massive payment cuts to physicians under the Sustainable Growth Rate should be replaced with a sustainable payment policy based on the principle of shared sacrifice. New payment approaches should be tested that can promote effective and efficient care. It will be necessary to limit any payment increases until a new payment mechanism has been developed. Similarly, other payment reforms—including bundled payments and competitive bidding approaches for specific services—should be developed and tested for their potential impact on cost and patient outcomes.
- **Improve the beneficiary purchasing experience.** Although the Medicare program offers tools to help beneficiaries make their decisions about enrolling in traditional Medicare or in an MA plan, as well as the choice of a Part D plan for those who opt for traditional Medicare, those tools are limited. Better information is needed on all plan combinations available to beneficiaries, including actual premiums (rather than ranges) for Medigap plans. Information is also needed on the likely out-of-pocket cost that a beneficiary would incur in the event of an unexpected high-cost change in health status. Beneficiaries need to know what a plan choice will really cost them, including both predictable costs (premiums) and unpredictable costs (cost-sharing and out-of-network expenses). Improving the insurance "exchange" function is essential in a premium support system.

Such policy improvements will take time to implement, but Medicare will continue to exert increasing pressure on the federal budget. Other actions to offset those costs include:

- **Increase Medicare premiums.** The Part B premium currently covers 25 percent of the cost of the benefit. In the short term, the premium could be raised to 35 percent, with higher premiums paid by higher income beneficiaries. Once Part A and Part B benefits are combined to simplify the cost-sharing structure, a premium that pays for an appropriate share of the combined benefit would make sense.
- **Increase the eligibility age to 67.** This proposal provides an incentive for seniors to remain in the work force longer, which would increase the amount of payroll tax receipts and somewhat reduce Medicare spending.

Conclusion

The debate over Medicare reform is about means, not ends. There is broad agreement that Medicare spending is on an unsustainable trajectory that threatens to crowd out other priorities elsewhere in the budget. There is broad agreement that Medicare's performance in delivering services to older Americans can and should be improved. There is great controversy over how to ensure that seniors continue to receive high-value health care at a price that is affordable to them and to taxpayers.

If we ever hope to bend Medicare's cost curve, we must change the financial incentives that drive program spending to increasingly unaffordable levels. A well-designed premium support program can take full advantage of market competition to drive out unnecessary spending and increase Medicare's value to beneficiaries. In a properly structured market, beneficiaries would have incentives to seek services from cost-effective delivery systems and providers would have incentives to operate efficiently.

The alternative approach relies on tighter regulation and cuts in provider payment rates without changing the underlying fee-for-service incentives that have driven Medicare spending to unprecedented levels. That is ultimately self-defeating, stifling private sector creativity rather than channeling it toward system-wide improvement.

The need for Medicare reform has never been more urgent, or more clear. Premium support is not an academic theory. It has been effective in lowering costs and enhancing value for five decades in the Federal Employees Health Benefits Program and since the early 1990s in the California Public Employees Retirement System.[8] It can work in Medicare, but only if we take the time to get it right.

Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. He previously served as the Assistant Director for Health and Human Resources at the Congressional Budget Office, and he is currently a member of CBO's panel of health advisers.

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[1] Sen. John Breaux and Rep. Bill Thomas, "Building a Better Medicare for Today and Tomorrow," National Bipartisan Commission on the Future of Medicare, March 16, 1999, http://rs9.loc.gov/medicare/bbmtt31599.html; The Debt Reduction Task Force, "Restoring America's Future," Bipartisan Policy Center, November 2010, http://www.bipartisanpolicy.org/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf; Sen. Ron Wyden and Rep. Paul Ryan, "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future," December 15, 2011, http://budget.house.gov/UploadedFiles/WydenRyan.pdf; and House Committee on the Budget, "The Path to Prosperity: A Blueprint for American Renewal. Fiscal Year 2013 Budget Resolution," March 20, 2012, http://budget.house.gov/UploadedFiles/Pathtoprosperity2013.pdf.

[2] House Committee on the Budget, "The Path to Prosperity: Restoring America's Promise. Fiscal Year 2012 Budget Resolution," April 5, 2011, http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf .

[3] Author's calculations, based on 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 13, 2011, https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf.

[4] John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services, May 13, 2011, http://www.cms.gov/ReportsTrustFunds/downloads/2011TRAlternativeScenario.pdf.

[5] Author's calculation using CBO's estimated GDP growth rate of 4.7 percent between 2012 and 2022 and baseline spending estimates from CBO's March 2012 Medicare Baseline. CBO estimates that Medicare outlays for benefits in 2013 will equal $596.8 billion (net of the $4.6 billion dollar reduction due to the sequester called for in the Budget Control Act).

[6] See Sen. Joe Lieberman and Sen. Tom Coburn, "A Bipartisan Compromise to Save Medicare and Reduce the Debt," June 2011, http://lieberman.senate.gov/index.cfm/issues-legislation/health-and-social-policy/saving-medicare-the-liebermancoburn-plan.

[7] See Sen. Richard Burr and Sen. Tom Coburn, "The Seniors Choice Act," February 2012, http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=dd0753e9-e62b-4640-9659-75099f9bd1a9.

[8] Steven Findlay, "CalPERS: a model for health care reform?" *Business & Health*, June 1993, http://findarticles.com/p/articles/mi_m0903/is_n7_v11/ai_14046503/.