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A Bipartisan Approach to Reforming Medicare

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The Brookings Institution and Georgetown University

Subcommittee on Health

Committee on Ways and Means

U.S. House of Representatives

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Chairman Herger and Ranking Member Stark:

I am delighted to have the opportunity to testify on reforming Medicare through a premium support model. Medicare is a hugely successful program that has dramatically increased the availability of health care to seniors, increased the length and quality of life of older Americans, and greatly reduced their fear of being unable to afford care when they need it. We need to preserve Medicare's guarantee of affordable health care for older and disabled people and make sure that the program is sustainable as the number of beneficiaries explodes and upward pressure on health care costs continues.

Medicare reform is not just about Medicare. Medicare plays a crucial role in two of the most daunting challenges facing American policy makers: the relentless increase in the proportion of total spending that Americans collectively devote to health care (now about 18 percent of our gross domestic product (GDP) and rising); and the unsustainable projected increase in publicly held federal debt (now about 70 percent of GDP and rising). Medicare reform presents the opportunity to turn this large publicly-funded program into the leader in increasing the efficiency of health care delivery for all Americans – whether receiving care through public or private plans – improving the quality of health care services, slowing the growth of total health care spending at the

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[1] I am indebted to the staff of the Bipartisan Policy Center (BPC) and members of the BPC's Task Force on Debt Reduction for assistance with this Testimony. The views presented are my own and should not be attributed to any of the institutions with which I am affiliated.

national level, and (by slowing the projected growth of Medicare spending) reducing the growth of future debt.

I believe that a well-crafted bipartisan bill that introduces a premium support model while preserving traditional Medicare can help achieve these goals. Since there are several versions of premium support, I will focus my remarks on the proposal of the Bipartisan Policy Center's Task Force on Debt Reduction, which I co-chaired with former Senator Pete Domenici (see attachment). This plan is very similar to the bipartisan proposal presented by Chairman Paul Ryan and Senator Ron Wyden in December, 2011.

Features of the Domenici-Rivlin Proposal

Our proposal would preserve traditional Medicare as the default option for all seniors permanently. It also would offer seniors the opportunity to choose among comprehensive private health plans offered on a regulated exchange. These plans would be required to cover benefits with at least the same actuarial value as traditional Medicare (including a specified package of services), would have to accept all applicants (absolutely no cherry picking allowed), and would receive risk-adjusted annual payments based on the age and health status of their beneficiaries. The regional exchanges would collect and manage the prices and terms of competing plans within a designated region (a metropolitan area or a rural area) that would include traditional fee-for-service (FFS) Medicare as well as qualified private plans. The government's contribution would be set by the second-lowest-priced plan in the region (subject to the two lowest-priced plans having sufficient capacity). Beneficiaries who chose the lowest-priced plan would get money back and those who chose more expensive plans would have to pay the difference.

With more accessible information about costs and patient outcomes, cost-conscious consumer choice will enhance competition among plans (including FFS Medicare) and will lead providers to emphasize preventive measures, manage care coordination of patients with multiple chronic diseases, and adopt more cost-effective approaches to delivery of care. We are confident that this process will reduce the rate of growth of

Medicare spending, just as similar market competition works to improve quality and reduce cost for virtually every other good or service in our economy and others around the world.

However, we do not know in advance what consumer-driven competition will do in the next ten years to improve quality and reduce cost for ***any*** good or service – automobiles, computers, haircuts, or (under our proposal) health care. If you asked the Congressional Budget Office (CBO) to "score" the effect of market competition on the prices the government must pay over the next ten years to buy computers or automobiles, CBO would tell you that they could not do so. CBO's response to scoring the effects of competition on health care would be precisely the same, for precisely the same reason. Therefore, as a fail-safe, our proposal would cap the per enrollee government premium contribution over time at the rate of growth of the per capita GDP plus one percent. Although we consider this eventuality unlikely, should the plans' pricing process result in a higher rate of growth, the additional cost would be reflected in an income-tested premium, with full protection for low-income seniors against higher contributions. Congress could, of course, over-ride this premium increase, and decide to reduce provider payments or increase the government contribution instead.

Some questions about the Domenici-Rivlin approach

Can't Medicare beneficiaries already choose among private plans under Part C or Medicare Advantage (MA)? They can and about a quarter of them do. However, MA proved more expensive to the trust funds than FFS Medicare because it was not structured to provide incentives for competitive cost reduction and quality improvement. Our plan would subsume MA and provide transparent competition on regional exchanges, where beneficiaries could realize benefits of choosing more cost-effective plans. The government would no longer have to pay extra to private plans when FFS Medicare provided lower-cost coverage (as is often true under MA) and would not pay more to provide FFS Medicare when private plans offer the care for less (as it currently does under MA).

We believe that the effectiveness of competition in driving down costs and improving outcomes would be enhanced by the transparency of competing on an exchange and the structure of the bidding process in our proposal. Beneficiaries would pay more attention, especially in areas where they could save money, because FFS Medicare premiums exceeded the second lowest bid. Plans would also have more incentive to seek efficiency when the bidding mechanism resulted in lower payments from the government than under the present MA system of administratively pegging payments to the cost of FFS Medicare.

Is there evidence that competition leads to lower cost and better quality? Actually, despite its perverse features, MA provides considerable evidence that competition works. The impression that MA plans are more costly on average derives from the fact that Medicare often pays more to the plans than the cost of FFS Medicare and that many of them offer supplementary benefits. But recent MEDPAC analysis shows that private plans offer the Medicare entitlement package itself for the same cost as FFS Medicare and HMO's in MA cost less than FFS. Competition works best in more densely populated urban areas, but that is where most of the Medicare population lives. In fact, 88 percent of Medicare beneficiaries live in areas in which a bidding process like the one we propose would produce a second-lowest bid below the current cost of FFS Medicare. In rural areas where FFS Medicare might remain the only available plan, our proposal would avoid any dislocation for those residents, because it would retain traditional Medicare as a permanent option. Furthermore, although existing systems that follow our general model are too small to have the same leverage over the entire healthcare market as would Medicare, evidence thus far is promising. Systems organized along these lines include the state employee systems for California and Wisconsin, and some employers including Stanford University. The Netherlands has adopted a similar national system, and experience thus far is favorable.

Won't older and sicker seniors end up in traditional Medicare and raise its cost? This fear is based on the assumption that risk adjustment can't work, and that rules against

cherry picking will not be enforced, so that private insurers will find ways to shun the elderly with the most-expensive conditions. In fact, however, risk-adjustment techniques improved substantially as relevant data and experience accumulated in MA and other programs, and can be expected to improve more. Moreover, some health plans are developing effective techniques for managing chronic diseases, such as diabetes, and are now actively trying to attract patients with these risks. Finally, the Federal Employees Health Benefits Plan demonstrates that an intelligently managed enrollment process can give consumers free access to all plans, without plan underwriting or selection.

Won't efforts to squeeze costs in Medicare just shift them to the private sector? Under the current system, with Medicare savings achieved largely through simple reductions in reimbursement rates, cost shifting has been a major concern. However, our proposal is driven differently. If competition works to produce more cost-effective delivery, Medicare can be a leader here. Plans and providers that have incentives to serve their Medicare patients more cost-effectively will do the same for their other clients.

Why not see how the Patient Protection and Affordable Care Act (PPACA) works before changing Medicare further? I support the PPACA and assume most of its provisions will be implemented – even if the Supreme Court makes it necessary to replace the mandate with other ways of encouraging more people to buy health insurance. The Center for Medicare and Medicaid Innovation, the Patient-Centered Outcomes Research Institute, and Accountable Care Organizations – all features of the PPACA – can help to assemble solid evidence about cost-effective approaches to delivering health care. If the Independent Payment Advisory Board (IPAB) functions as intended, it will design regulations that encourage more cost-effective delivery of care in traditional Medicare. However, it remains to be seen how well these new institutions will perform. We think it only prudent to strengthen competition as an additional tool. Under our proposal, competing health plans all over the country would have strong incentives, not only to implement innovative ideas coming out of the federally-supported institutions created by the PPACA, but to seek every possible way to provide higher-quality care at a lower cost in their own local area. The PPACA attempts to reward Medicare providers that meet the

conditions set in regulations. Enhancing competitive incentives to achieve savings and improve outcomes could prove the more effective approach. Our proposal is to try both.

How does the Ryan-Wyden proposal differ from Domenici-Rivlin?

The bipartisan reform of Medicare proposed by Budget Committee Chairman Paul Ryan and Senator Ron Wyden is very similar to our proposal – and significantly different from Chairman Ryan's earlier proposal incorporated in the House Budget Resolution passed in 2011. Unlike the earlier Ryan proposal, Ryan-Wyden preserves traditional FFS Medicare permanently, proposes a bidding process on Medicare exchanges, sets the government contribution at the second-lowest bid, and has a failsafe provision that caps increases in the contribution at GDP plus one percent – all features of Domenici-Rivlin. Two differences are worth noting here. Ryan-Wyden would phase in more slowly starting in 2022 and would only apply to new beneficiaries, while we would start in 2018 or even sooner. Ryan-Wyden also is more flexible about what would happen if the cap were breached, suggesting that Congress might choose among various kinds of reductions in provider payments in addition to the means-tested premium increase in our proposal.

Why is a bipartisan approach necessary?

We believe that health care policy is far too important to be driven by a single party's ideology. Programs that affect people's lives so intimately must flow from a broad bipartisan consensus. The public's health insurance coverage should not bounce around unpredictably with each party transition in an election. No matter how the 2012 election turns out, the president and congressional leadership should strive to find common ground both on how to cover the uninsured and how to reform Medicaid and Medicare while stabilizing the debt. Furthermore, the American people and the financial markets will have the most confidence in our success, and in the outlook for policy stability, if a Medicare solution rests on broad principles that both parties can accept.

Moreover, the two parties' competing ideologies can both contribute to improving health care outcomes and reducing the growth of costs. Republicans tend to rely on market competition and consumer choice to produce results in the public interest; while Democrats tend to rely on regulation. Republicans tend to distrust government; while Democrats tend to distrust profit-seeking in the private sector. But none of us is certain what will work best to reduce the growth of health costs, while improving health outcomes. The premium support model embodied in Domenici-Rivlin and Ryan-Wyden seeks to combine the tools of market competition and cost-effective regulation in hopes of maximizing the chances of improving health care for seniors at a sustainable cost.

Thank you very much for this opportunity to testify.