

A Time for Solutions:
The Medicare Reform Debate

Testimony before the United States Senate
Special Committee on Aging

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Chairman Kohl, Ranking Member Corker, and Members of the Committee, thank you for the privilege of appearing today. In this written statement, I hope to make the following points:

- Medicare must be reformed. The Medicare *status quo* is dangerous to the fiscal health of the federal government, the U.S. economy, and especially Medicare beneficiaries. Medicare faces a projected 10-year cash flow deficit of \$4.14 trillion¹ In addition, the Independent Payment Advisory Board is a dramatic policy error that will exacerbate reimbursement problems and stifle innovation.
- The Joint Select Committee on Deficit Reduction has an important opportunity to undertake bipartisan reforms. I recommend:
 - Fix the Sustainable Growth Rate (SGR)
(10-Yr Deficit Increase= \$195.2 – \$388.5 billion)²
 - Repeal the CLASS Act
(10-Yr Deficit Increase = \$86.0 billion)³
 - Limit Medical Malpractice Torts
(10-Year Deficit Reduction = \$64.0 billion)⁴
 - Reduce Federal Payments for Graduate Medical Education Costs
(10-Year Deficit Reduction = \$69.4 billion)⁴
 - Raise the Eligibility Age for Medicare to 67
(10-Year Deficit Reduction = \$124.8 billion)⁴
 - Expand Cost Sharing Structures for Medicare and Medigap Insurance
(10-Year Deficit Reduction = \$32.2 billion – \$92.5 billion)⁴
 - Increase Basic Premiums for Medicare Part B
(10-Year Deficit Reduction = \$241.2 billion)⁴

The total 10-year deficit reduction would amount to as much as \$480 billion.

- Over the longer term, Congress should adopt a premium support approach to Medicare. Premium support models in varying forms and structures have been at the heart of every major bipartisan deficit reduction proposal.

¹ Authors Calculations. “2011 Medicare Trustees Report.”

<https://www.cms.gov/reportstrustfunds/downloads/tr2011.pdf>.

² Congressional Budget Office. “Medicare’s Payments to Physicians.”

http://www.cbo.gov/ftpdocs/122xx/doc12240/SGR_Menu_2011.pdf

³ Congressional Budget Office. “Analysis of the Major Health Care Legislation.”

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

⁴ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options”

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

The Need for Medicare Reform

Medicare as we know it is financially unsustainable. The reality is that the combination of payroll taxes and premiums do not come close to covering the outlays of the program. As shown in Table 1, in 2010, Medicare required nearly \$280 billion in general revenue transfers to meet its cash outlays of \$523 billion. Left unchanged, program costs will continue to escalate, leading to annual shortfalls and a projected cash-flow deficit of over \$600 billion in 2020.

These shortfalls lie at the heart of past deficits and projected future debt accumulation. As shown in Table 2, between 2001 and 2010, cumulative Medicare cash flow deficits totaled just over \$1.5 trillion, or almost 28 percent of the total federal debt accumulated in the hands of the public during the past decade.

Going forward, the situation is even worse. By 2020, the cumulative cash-flow deficits of \$6.2 trillion will constitute 35 percent of the nation's total debt accumulation. Including interest costs, accumulated Medicare's debt will be responsible for over 37 percent of the debt in the hands of the public.

Viewed in isolation, Medicare is a fiscal nightmare that must change course when combined with other budgetary stresses; it contributes to a dangerous fiscal future for the United States.

One of the most dangerous aspects of the *status quo* is the creation of the Independent Payment Advisory Board (IPAB). It should be repealed immediately.

This appointed panel has been tasked with cutting Medicare spending, but its poor design will prove ineffective in bending the cost curve, and instead will lead to restricted patients' access and stifled innovation.

By statute, IPAB cannot directly alter Medicare benefits. Instead, the more likely threat to patients is that the IPAB will be forced to limit payments for medical services. In effect, it will be able to decide which treatments are covered for patients and set price controls for each treatment.

This is especially troubling as IPAB may choose to focus on new treatments for conditions like Alzheimer's or Parkinson's, which will likely have rapid cost growth, particularly in the early stages of their market introduction. Because IPAB is directed to focus on areas of "excess cost growth," it will make these treatments a primary target.

Table 1: Annual Medicare Cash Flows

Annual Medicare Cash Flows	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Projected Total Income	273.2	284.8	291.6	317.7	357.5	437	461.9	480.8	508.2	486.1
Total Payroll Taxes Collected	152	152.7	149.2	156.7	171.4	181.3	191.9	198.7	190.9	182.0
Total Premiums Collected	24.2	26.7	29.0	33.4	40.0	48.9	53.5	58.2	65.2	61.80
Annual Cash Revenues	176.20	179.40	178.20	190.10	211.40	230.20	245.40	256.90	256.10	243.80
Annual Expenditures	-240.9	-265.7	-280.7	-308.9	-336.4	-408.3	-431.5	-468.2	-509	-522.8
Total Medicare Net Cash-Flow	\$ (64.70)	\$ (86.30)	\$ (102.50)	\$ (118.80)	\$ (125.00)	\$ (178.10)	\$ (186.10)	\$ (211.30)	\$ (252.90)	\$ (279.00)
Annual Medicare Cash Flows	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Projected Total Income	529.9	575.8	642	700.7	786.4	808.1	914	1000.6	1094.9	1205.5
Total Payroll Taxes Collected	202.95	217.47	239.10	257.34	284.80	288.59	321.88	347.48	374.95	401.43
Total Premiums Collected	71.01	78.08	88.11	97.32	110.53	114.95	131.58	145.77	161.43	182.03
Annual Cash Revenues	273.96	295.55	327.21	354.66	395.33	403.54	453.45	493.25	536.37	583.46
Annual Expenditures	-568.30	-597.90	-648.40	-703.40	-757.90	-826.40	-902.30	-985.10	-1078.80	-1192.60
Total Medicare Net Cash-Flow	\$ (294.34)	\$ (302.35)	\$ (321.19)	\$ (348.74)	\$ (362.57)	\$ (422.86)	\$ (448.85)	\$ (491.85)	\$ (542.43)	\$ (609.14)

Source: 1997-2011 CMS Medicare Trustees Reports and Authors Calculations

Table 2: Medicare and the Total Debt Held by Public

CBO & Author's Calculations	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Cummulative Medicare Cash Flow	\$ (472.50)	\$ (558.80)	\$ (661.30)	\$ (780.10)	\$ (905.10)	\$ (1,083.20)	\$ (1,269.30)	\$ (1,480.60)	\$ (1,733.50)	\$ (2,012.50)
Interest Paid on Medicare Shortfall	\$ (23.71)	\$ (25.77)	\$ (26.55)	\$ (33.34)	\$ (38.83)	\$ (51.90)	\$ (58.76)	\$ (54.29)	\$ (56.45)	\$ (64.11)
Total Medicare Debt Burden	\$ (496.21)	\$ (584.57)	\$ (687.85)	\$ (813.44)	\$ (943.93)	\$ (1,135.10)	\$ (1,328.06)	\$ (1,534.89)	\$ (1,789.95)	\$ (2,076.61)
Total Debt Held by Public	\$ 3,320	\$ 3,540	\$ 3,913	\$ 4,296	\$ 4,592	\$ 4,829	\$ 5,035	\$ 5,803	\$ 7,545	\$ 9,018
Total Medicare Cash Flow as % Debt	14.2%	15.8%	16.9%	18.2%	19.7%	22.4%	25.2%	25.5%	23.0%	22.3%
Total Medicare Burden as % Debt	14.9%	16.5%	17.6%	18.9%	20.6%	23.5%	26.4%	26.4%	23.7%	23.0%
CBO & Author's Calculations	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Cummulative Medicare Cash Flow	\$ (2,306.84)	\$ (2,609.19)	\$ (2,930.38)	\$ (3,279.12)	\$ (3,641.69)	\$ (4,064.55)	\$ (4,513.39)	\$ (5,005.24)	\$ (5,547.66)	\$ (6,156.80)
Interest Paid on Medicare Shortfall	\$ (77.28)	\$ (97.84)	\$ (121.61)	\$ (149.20)	\$ (180.26)	\$ (216.44)	\$ (243.72)	\$ (270.28)	\$ (299.57)	\$ (332.47)
Total Medicare Debt Burden	\$ (2,384.12)	\$ (2,707.03)	\$ (3,051.99)	\$ (3,428.32)	\$ (3,821.95)	\$ (4,280.98)	\$ (4,757.11)	\$ (5,275.52)	\$ (5,847.24)	\$ (6,489.27)
Total Debt Held by Public	\$ 10,430	\$ 11,598	\$ 12,386	\$ 12,996	\$ 13,625	\$ 14,358	\$ 15,064	\$ 15,767	\$ 16,557	\$ 17,392
Total Medicare Cash Flow as % Debt	22.1%	22.5%	23.7%	25.2%	26.7%	28.3%	30.0%	31.7%	33.5%	35.4%
Total Medicare Burden as % Debt	22.9%	23.3%	24.6%	26.4%	28.1%	29.8%	31.6%	33.5%	35.3%	37.3%

Source: 1997-2011 CMS Medicare Trustees Reports; Congressional Budget Office March 2011 Baseline; and Authors Calculations

Furthermore, about one-half of all healthcare spending is off limits until after 2020, which is likely to lead to disproportionate and uneven application of IPAB's scrutiny and payment initiatives.

As a result of the IPAB's cuts having to be achieved in one-year periods, there will be an enhanced focus on reimbursements, at the expense of longer-run quality improvements or preventative programs. In this way, IPAB could actually discourage rather than encourage a focus on quality improvement.

All of this suggests that IPAB is a potent mechanism for undesirable policy. Thus, it is particularly troubling that IPAB is unaccountable. Its decisions must be honored by the Secretary of HHS and it is structured to discourage Congress from making the important policy choices.

The IPAB is at best a band-aid on out-of-control Medicare spending and at worst a threat to physician autonomy and patient choice. Saving Medicare from ruin requires nothing short of total and comprehensive reform. Adding in more cuts to a broken system does not make it any less broken. The IPAB proposals will be short-term fixes and cuts. We need long-term thinking and long-term solutions. We need to move the focus from merely containing costs to focus on how to get the most value for our healthcare dollars.

If Medicare's provider reimbursements are drastically reduced, the market will react, and according to the basic laws of economics, providers will have three options: to close up shop, to refuse Medicare patients, or to shift the costs onto the other patients. None of these options help our healthcare system operate more effectively or more efficiently.

Recommendations for Immediate Reform

1. Fix the Sustainable Growth Rate (SGR) mechanism.

Medicare coverage no longer guarantees access to care. Increasingly, seniors enrolled in the Medicare program face barriers to accessing primary care physicians as well as medical and surgical specialists.

The physician access problem stems from Medicare's below-cost reimbursement rates and the uncertainty surrounding the Medicare sustainable growth rate (SGR) formula for physician payments. If the SGR were permitted to go into effect in 2012, physician services would face a reduction in payment of 29.4 percent.

While there is bipartisan agreement that the SGR formula needs to be fixed, the Patient Protection and Affordable Care Act (PPACA) failed to reset or restructure the fee schedule. As a result, physicians are now faced with difficult decisions regarding whether to accept new Medicare patients or leave the Medicare market altogether.

In June 2010, Congress failed to pass a timely update to the SGR, and physicians were forced to begin making Medicare practice decisions. Table 3 shows the impact on physician access for Medicare enrollees as a result of the uncertainty created by the June 1, 2010 Medicare Part B payment reduction of 21.3 percent, which was later reversed by Congress. During the delayed SGR update, 11.8 percent of physicians stopped accepting new Medicare patients, 29.5 percent reduced the number of appointments for new Medicare patients, 15.5 percent reduced the number of appointments for current Medicare patients, and 1.1 percent of physicians decided to stop treating Medicare patients altogether.

Table 3: Impact on Physician Access for Medicare Enrollees

As a result of the uncertainty created by the June 1, 2010 Medicare Part B payment reduction of 21.3 percent, later reversed by Congress, which decisions DID your practice implement in June?	
Stopped accepting new Medicare patients	11.8%
Reduced the number of appointments for new Medicare Patients	29.5%
Reduced the number of appointments for current Medicare patients	15.5%
Ceased treating all Medicare patients	1.1%

Which business considerations are currently under discussion by your practice due to this reimbursement uncertainty?	
Limit the number of new Medicare patients	67.2%
Refuse to accept new Medicare patients	49.5%
Cease treating all Medicare patients	27.5%
Reduce the number of appointments for current Medicare patients	56.1%

Source: September 2010 MGMA Sustainable Growth Rate Survey

Recognizing the payment uncertainty caused by Congress' failure to enact a permanent SGR fix in 2010, physician practices have started to reshape their practice patterns. Moving forward, 67.2 percent of physicians are considering limiting the number of new Medicare patients, 49.5 percent are considering the option of refusing new Medicare patients, 56.3 percent are contemplating whether to reduce the number of appointments for current Medicare patients, and 27.5 percent are debating whether to cease treating all Medicare patients.

The Fiscal Commission recognized the dire need for a meaningful fix to the SGR rate with its very first healthcare recommendation. Table 4 includes the commission's recommendation as well as other options scored by the Congressional Budget Office.

Beyond fixing the rate, Congress should also seek to develop an improved physician payment formula that rewards care coordination across multiple providers and settings. An effective fix would lead to a payment system that pays doctors based on quality instead of quantity of services.

Table 4: Options for Fixing the SGR

PROPOSAL	Plan Description	10-Year Score
CBO Specified Update Options	➤ 0% update through 2021	\$297.6 billion
	➤ MEI* update through 2021	\$358.1 billion
	➤ 1% update through 2021	\$342.1 billion
	➤ 2% update through 2021	\$388.5 billion
CBO Reset Options	➤ Reset SGR targets at 2010 spending level	\$195.2 billion
	➤ Reset SGR targets at 2010 spending level and use GDP+1% in target	\$247.0 billion
	➤ Reset SGR targets at 2010 spending level and use GDP+2% in target	\$301.0 billion
Fiscal Commission’s SGR Policy Recommendation	➤ Freeze update through 2013, -1%; update for 2014, reinstate the SGR in 2015 at 2014 spending level	\$261.7 billion

* MEI = Medicare Economic Index projections according to CBO

2. Repeal the CLASS Act.

In addition to an immediate fix to the SGR, the President’s Fiscal Commission recommended urgent reform, or outright repeal, of The Community Living Assistance Services and Supports Act (CLASS Act). This is because the CLASS ACT is certain to substantially increase the federal deficit due to an actuarial design that is structurally unsound. Healthy individuals who desire long-term care insurance are likely to find better quality products at lower prices in the private market, leaving the federal government on the hook for the most expensive and highest risk beneficiaries.

The Fiscal Commission highlighted the budgetary risk of creating a federal long-term care entitlement when it recommended a capped allotment be instituted for the federal share of Medicaid payments toward long-term care. Simply put implementing the CLASS Act undermines any serious effort at reducing the federal deficit.

In the current 10-year budget window, the CLASS Act is misleadingly scored as budgetary savings due to the fact that beneficiaries must pay premiums for five years before receiving any benefits. The initial excess revenue hides a sea of red ink to come in subsequent decades. Because the CLASS Act delivers phantom savings on paper, it will require \$86 billion in budgetary offsets over the next decade to repeal it.

Fortunately, there has been growing bipartisan support for repeal. Senate Budget Chairman Kent Conrad (D-ND) has called the CLASS Act “A Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of.” Chairman Conrad and six other Senators have sent a letter to Majority Leader Reid in which they state, “We have grave concerns that the real effect of the provision would be to create a new federal entitlement with large, long-term spending increases that far exceed revenues.”

3. Limit Medical Malpractice Torts.

This option would impose certain nationwide curbs on medical malpractice torts. Many states have enacted some or all of these limits, whereas others have very few restrictions on malpractice claims. Tort limits include caps on noneconomic damage (e.g. pain and suffering) and on punitive damages; a shortened statute of limitations; restrictions on the use of joint-and-several liability; and changes to rules regarding collateral sources of income.⁵

Malpractice tort limits would reduce total healthcare spending in two ways: First, by reducing the average size of malpractice awards, tort limits would reduce the cost of malpractice insurance premiums. This reduced cost of malpractice insurance paid by providers would flow through to health plans and patients in the form of lower prices for health care services. Second, as noted above, tort limits would also reduce utilization of healthcare services by a small amount as practitioners prescribing somewhat fewer services when faced with less pressure from potential malpractice claims.

In terms of federal healthcare spending, the CBO estimates the percentage decline in Medicare to be larger than the decline in spending for other federal healthcare programs or for national health spending. This estimate is based on empirical evidence showing that the impact of tort reform on the use of healthcare services is greater for Medicare than for the rest of the health system.⁶

This option would reduce mandatory spending for Medicare, Medicaid, Children’s Health Insurance Program (CHIP), subsidies for coverage purchased through health insurance exchanges, and the Federal Employees Health Benefits program by a total of roughly \$50 billion over the 10-year budget window.⁷

⁵ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁶ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁷ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

Both the Fiscal Commission and the Domenici-Rivlin taskforce strongly supported medical malpractice reform. Table 5 provides additional detail on each malpractice recommendation as well as a scored proposal by the Congressional Budget Office.

Table 5: Options for Malpractice Reform

PROPOSAL	Plan Description	10-Year Score
CBO Option: Limit Medical Malpractice Torts	<ul style="list-style-type: none"> ➤ A cap of \$250,000 on awards for noneconomic damages ➤ A cap on awards for punitive damages of \$500,000 or two times the value of awards for economic damages, whichever is greater ➤ A statute of limitations of one year from the date of discovery of the injury for adults, and three years for children ➤ A fair-share rule (replacing the rule of joint-and-several liability) under which a defendant in a lawsuit would be liable only for the final award that was equal to that defendant’s share of responsibility for the injury. ➤ Permission to introduce evidence of income from collateral sources (such as life insurance payouts and health insurance) at trial 	-\$49.5 billion
Fiscal Commission Option: Medical Malpractice Reform	<ul style="list-style-type: none"> ➤ Modify the “collateral source” rule to allow outside sources of income collected as a result of an injury ➤ Imposing a statute of limitations—perhaps to one to three years—on medical malpractice lawsuits ➤ Replacing joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury ➤ Creating specialized “health courts” for medical malpractice lawsuits ➤ Allowing “safe haven” rules for providers who follow best practices of care 	-\$17 billion
Domenici-Rivlin Option	<ul style="list-style-type: none"> ➤ Require states to cap awards for noneconomic and punitive damages for medical malpractice ➤ Start large-scale testing of systemic reforms, including safe harbors for practices that conform to accepted guidelines, specialized malpractice courts, and administrative proceedings to resolve disputes 	-\$48 billion

4. Reduce Federal Payments for Graduate Medical Education (GME) Costs.

Under Medicare’s prospective payment system for inpatient medical services, hospitals with teaching programs receive additional funds for costs related to graduate medical education (GME). For every increase of 0.1 in the ratio of full-time residents to the number of beds, indirect medical education (IME) adjustments provide hospitals with about 5.5 percent more in reimbursement payments.

Of concern, the Medicare Payment Advisory Commission (MedPAC) has consistently found that the IME calculation overstates the effect of teaching status on incurred costs. In its most recent report to Congress, MedPAC estimates that an IME adjustment of about 2 percent more closely reflects the indirect costs that teaching hospitals actually incur.⁸

Teaching hospitals also receive GME payments from both the federal government and the states through the Medicaid program. CBO estimates that total mandatory federal spending for hospital-based GME in 2010 was about \$10 billion -- \$9.5 billion through Medicare and \$500 million through Medicaid.⁹

Table 6 highlights a scored proposal completed by the CBO as well as the details of the Fiscal Commission’s proposed reduction toward graduate medical education (GME) payments.

Table 6: Proposals to Reduce GME Payments

PROPOSAL	Plan Description	10-Year Score
CBO Option: Consolidate and Reduce Federal Payments for GME at Teaching Hospitals	<ul style="list-style-type: none"> ➤ Consolidate all mandatory federal spending for GME into a grant program for teaching hospitals. ➤ Total funds available for distribution would be based on the 2011 aggregate payments for direct graduate medical education (DGME) and Medicaid GME plus 2011 aggregate payments for IME reduced to reflect a 2.2 percent IME adjustment ➤ Total funding for the grant program would grow with inflation as measured by the consumer price index for all urban consumers minus 1 percentage point per year. ➤ Payments would be apportioned according to the number of residents at a hospital and the portion of the hospital’s inpatient days accounted for by Medicare and Medicaid patients 	-\$69.4 billion
Fiscal Commission Option: Reduce excess payments to hospitals for medical education	<ul style="list-style-type: none"> ➤ Bring GME payments in line with the costs of medical education by limiting hospitals’ direct GME payments to 120 percent of the national average salary paid to residents in 2010 ➤ Updated annually thereafter by chained CPI and by reducing the IME adjustment from 5.5 percent to 2.2 percent, which MedPAC has estimated would more accurately reflect indirect costs. 	-\$60 billion

⁸ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

⁹ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

5. Raise the Age of Eligibility for Medicare to 67.

The usual age of eligibility for Medicare benefits is 65, although certain people qualify for coverage earlier. (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.) Because of increases in life expectancy, the average length of time that people are covered by Medicare has risen significantly since the program began in 1965. This trend, which increases the program's costs, is expected to continue.¹⁰

The issue of raising the age of eligibility for Medicare became a more politically viable possibility during the July 2011 debt ceiling negotiations when President Obama reportedly offered an increase in the Medicare age eligibility in exchange for Republican movement on increasing tax revenues.¹¹ The proposal was also discussed earlier in the year as part of the House Budget Resolution and prior to that as a provision in the Ryan-Rivlin Healthcare Plan which grew out of Fiscal Commission hearings. For additional information on the plan specifics see Table 7.

The Congressional Budget Office estimates that options outline in Table 7 would reduce federal spending by roughly \$125 billion over the next decade. The estimates primarily reflect a reduction in federal spending on Medicare and a slight reduction in outlays for Social Security retirement benefits. Those reductions would be partially offset by an increase in federal spending on Medicaid and an increase in federal subsidies to purchase health insurance through the new insurance exchanges that are scheduled to be established in 2014.

The option would reduce outlays for Social Security retirement benefits by inducing some people to delay their application for such benefits (some people apply for Social Security benefits at the same time they apply for Medicare) and by encouraging some people to delay retirement to maintain their employment-based health insurance coverage until they became eligible for Medicare. The option could also affect the number of people who apply for disability benefits; those effects are expected to be quite small and are not included in this estimate.¹²

The increase in Medicare's eligibility age would boost federal spending on Medicaid in two ways. First, some of the people who were no longer receiving Medicare benefits would have income below 138 percent of the federal poverty level and would therefore sign up for and receive Medicaid benefits instead. (Under current law, that income threshold applies only to people under age 65, but for this option CBO assumed that that age limit would increase in tandem with the Medicare eligibility age.) Second, people over 65 who would have been enrolled in both Medicare and Medicaid (those for whom Medicaid pays Medicare's premiums and cost sharing, and covers certain services not covered by Medicare) would

¹⁰ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

¹¹ Sam Stein. "Obama Offered to Raise Medicare Eligibility Age as Part of Grand Debt Deal." *The Huffington Post*. July 11, 2011.

¹² Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

instead have Medicaid as their primary source of coverage until they reached the new Medicare eligibility age.¹³

Subsidies for insurance coverage purchased in the new health insurance exchanges would also increase under this option because some of the people whose eligibility for Medicare was delayed would receive those subsidies instead.

Federal revenues under this option would decrease by a small amount over the 2012–2021 period; however, those effects are not included in this estimate. That decline in revenues would occur primarily because some employees and retirees whose eligibility for Medicare was delayed would accept coverage through their employer instead. (Active workers who are eligible for Medicare have the option of accepting or rejecting coverage from their employer; for those who accept such coverage, Medicare is the secondary payer.) Most of the resulting increase in employers' spending on health insurance would lead to reductions in taxable wages for active workers or would reduce employers' taxable profits; the remainder would probably be passed along to enrollees in the form of higher premiums. In addition, employers that provided retiree coverage to former workers before they became eligible for Medicare would incur higher costs to the extent that they provided such coverage over a longer period. Although the option could cause some employers to reduce or eliminate such retiree coverage, no changes of that sort are incorporated in this estimate. Federal revenues also would be reduced because a small portion of the subsidies provided through the health insurance exchanges are tax expenditures rather than outlays. CBO did not estimate any increase in tax revenues resulting from workers who delay retirement because total employment in the economy was assumed to remain unchanged that assumption is consistent with CBO's standard approach to cost estimates.

By 2035, Medicare's spending under this option is estimated to be about 7 percent below what it would be in the absence of this policy change—5.5 percent of gross domestic product rather than 5.9 percent. On the basis of estimates for the 2012–2021 period, CBO anticipates that about one-quarter of those Medicare savings would be offset by the increases in federal spending described above.¹⁴

¹³ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

¹⁴ Congressional Budget Office. "Reducing the Deficit: Spending & Revenue Options" <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

Table 7: Options for Raising the Medicare Eligibility Age

PROPOSAL	Plan Description	10-year score
CBO Option: Raise the Age of Eligibility for Medicare to 67	<ul style="list-style-type: none"> ➤ Raise the age of eligibility by two months every year beginning with people who were born in 1949 (who will turn 65 in 2014) until the eligibility age reached 67 for people born in 1960 (who will turn 67 in 2027) ➤ Thereafter, the eligibility age would remain at 67 ➤ Those increases are similar to those already under way for Social Security’s full retirement age (FRA) – that is, the age at which workers become eligible for full retirement benefits – except that scheduled increases in the FRA include a 12-year period during which the FRA remains at 66. ➤ The eligibility age for Medicare would remain below Social Security’s FRA until 2020, when both would be age 66 for people born in 1954; from that point on, the two would be identical. 	-\$124.8 billion
Ryan-Rivlin Plan:	<ul style="list-style-type: none"> ➤ Starting in 2021, the age of eligibility for Medicare would increase by two months per year until it reached 67 in 2032 ➤ Eligibility for the Medicare program would not change for people who are currently 55 or older; as a result, the average age and costs of enrollees remaining in the current Medicare program would increase over time. ➤ However, enrollee premiums under Medicare would be adjusted to equal what they would be under current law. 	<i>Proposal goes into effect outside of the 2021 budget window</i>
House Budget Resolution: The Path to Prosperity	<ul style="list-style-type: none"> ➤ Starting in 2022, the age of eligibility for Medicare would increase by two months per year until it reached 67 in 2033 	

6. Change Cost Sharing Structures for Medicare and Medigap

Cost sharing structures for traditional fee-for-service (FFS) Medicare plans vary significantly depending on the type of service provide – hospitalization, skilled nursing facility, home health care. These variations create inconsistent incentives for patients to weigh relative costs when choosing among options for treatment. Moreover, 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.¹⁵

Due to the fact that the cost sharing requirements in FFS can be substantial, about 90 percent of enrollees purchase supplemental coverage. About 15 percent of those FFS enrollees qualify for Medicaid, 40 percent obtain coverage through an employer,

¹⁵ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

and about 40 percent pay for a Medigap policy – an individual insurance policy that is designed to cover most or all of Medicare’s cost sharing requirements.

This means that Medicare enrollees with supplemental coverage are liable for only a fraction of the cost of additional care expenses, which places a heavy financial burden on the federal government. Consequently, 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.¹⁶

Table 8 outlines three proposals for changing the cost sharing structures for Medicare and Medigap as they were evaluated by the CBO. The table also covers alternative approaches proposed by the Coburn-Lieberman plan and the Fiscal Commission. There has been near universal agreement across all bipartisan deficit and healthcare reform plans that greater cost sharing is needed for supplemental insurance and Medigap.

The argument in favor of this option is that it would appreciably strengthen incentives for more prudent use of medical services—both by raising the initial threshold of health care costs that most Medicare beneficiaries face and by ensuring that more enrollees pay at least a portion of all subsequent costs up to the out-of-pocket limit. Because medigap plans would be barred from paying the first \$550 of an enrollee’s cost sharing liabilities (under the second and third alternatives), the costs borne by medigap plans would decrease, and therefore so would the premiums that the medigap plans charge. Another argument in support of this option is that it would provide greater protection against catastrophic costs. Capping enrollees’ out-of-pocket expenses would especially help people who develop serious illnesses, require extended care, or undergo repeated hospitalizations but lack supplemental coverage for their cost sharing.

Table 8: Options for Changing the Cost Sharing Structures of Medicare

PROPOSAL	Plan Description	10-Year Score
CBO Option 1: Establish Uniform Cost Sharing Only	<ul style="list-style-type: none"> • \$550 deductible covering all Part A and Part B • Uniform coinsurance rate of 20% between \$550 and \$5,500 • \$5,500 cap on enrollee cost sharing liabilities (medigap covers everything beyond) 	-32.2 billion
CBO Option 2: Restrict Medigap Plans Only	<ul style="list-style-type: none"> • Enrollee pays for first \$550 of expenses • Limit coverage to 50% between \$550 and \$5,500 in Medicare cost sharing • \$5,500 cap on enrollee cost sharing liabilities (medigap covers everything beyond) 	-\$53.4 billion

¹⁶ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

CBO Option 3: Establish Uniform Cost Sharing and Restrict Medigap Plans	<ul style="list-style-type: none"> • Enrollee pays for first \$550 of expenses • Uniform coinsurance rate of 10% between \$550 and cap if enrollee has another form of supplemental insurance • Uniform coinsurance rate of 20% between \$550 and cap if enrollee does not have another form of supplemental insurance 	-92.5 billion
Coburn-Lieberman Plan: Unified Annual Deductible & Annual Out-of-Pocket Limit	<ul style="list-style-type: none"> • Enrollee pays for first \$550 of expenses • Uniform coinsurance rate of 20% between \$550 and \$5,500 • Uniform coinsurance rate of 5% between \$5,500 and \$7,500 • \$7,500 cap on enrollee cost sharing liabilities (medigap covers everything beyond) 	-\$130 billion
Fiscal Commission Plan: Restrict first-dollar coverage in Medicare supplemental insurance	<ul style="list-style-type: none"> • Enrollee pays first \$500 • Limit coverage to 50% between \$500 and \$5,500 in Medicare cost sharing • \$5,500 cap on enrollee cost sharing liabilities (medigap covers everything beyond) 	-\$38 billion

7. Increase Basic Premiums for Medicare Part B

Medicare Part B allows beneficiaries to obtain coverage for physician and other outpatient services by paying a monthly premium. When the program began in 1966, the premium was intended to finance 50 percent of Part B costs per aged enrollee, with the remainder funded by general revenues. Subsequent legislation, however, reduced that share, and premium collections fell to less than 25 percent of program spending. The Balanced Budget Act of 1997 permanently set the Part B premium at about 25 percent of Part B spending per aged enrollee. General revenues still fund the remainder of Part B spending. (These calculations are based on costs for enrollees age 65 and older and do not include costs for people who qualify for Medicare before age 65 because of a disability.)¹⁷

The basic monthly Part B premium increased from \$96.40 in 2009 to \$110.50 in 2010. However, the majority of beneficiaries who enrolled prior to 2010 were not affected by that increase, because there was no cost-of-living adjustment (COLA) to Social Security benefits for 2010 and a “hold-harmless” provision protects beneficiaries from a drop in their monthly net Social Security payment if an increase in the Part B premium exceeds the Social Security COLA. Since January 2007, higher income enrollees have faced greater premiums for Part B than other enrollees, but the basic premium of 25 percent still applies to about 95 percent of enrollees. The Patient Protection and Affordable Care Act (Public Law 111-148) froze the thresholds at which income-related premiums begin at the 2010 levels of \$85,000 for single beneficiaries and \$170,000 for couples through 2019. Thus, the share of enrollees that will be subject to income-related premiums will increase over time, owing to growth in beneficiaries’ incomes.¹⁸

¹⁷ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

¹⁸ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

This option would gradually raise the basic Part B premium from 25 percent to 35 percent of the program’s costs for enrollees ages 65 and older over a five-year period, beginning in 2012. The premium share would increase by 2 percentage points per year through 2016 and then remain at 35 percent, preserving the thresholds at which income-related premiums begin as specified in current law. Also, the hold-harmless provision would be preserved; that provision would apply to more enrollees in 2012 because of the initial increase in premiums under this option. The Congressional Budget Office projects that this option would result in estimated savings of about \$71 billion over the 2012–2016 period and about \$241 billion over the 2012–2021 period. Table 9 also includes a proposal recommended by the Domenici-Rivlin Task Force.

One rationale for this option is that it would ease the budgetary pressures posed by rising costs in the Part B program, which will climb faster as members of the baby boom generation reach age 65. Even under this option, the public subsidy for most Part B enrollees—65 percent when fully phased in—would be greater than the 50 percent that was intended at the program’s outset. Also, because Medicaid pays the premiums for certain low income Part B enrollees with limited assets, about 18 percent of Medicare beneficiaries would be unaffected.¹⁹

Table 9: Ways to Increase the Basic Premium for Medicare Part B

PROPOSAL	Plan Description	10-year score
CBO Option	➤ Increase basic premium to 35 percent of the program’s costs	-\$241.2 billion
Domenici-Rivlin Option	➤ Gradually raise Medicare Part B premiums from 25 percent to 35 percent of program costs over five years	-\$123 billion

Premium Support

Medicare has long vexed policymakers. For at its budgetary heart is an inherent conflict. It promises beneficiaries the finest medical sciences – at low or no cost. Then when budgetary costs get out of hand, Medicare fixes prices or stops covering services. Both lead to less access for seniors – violating the programs original pledge.

A simple solution would be switching Medicare to a defined contribution program – as proposed by the House. Seniors would be budgeted an annual contribution, which could be adjusted to reflect costs associated with their health status and financial wherewithal. For the federal budget, the result is a capped exposure to Medicare – one that would adjust to reflect the number of seniors and inflation but not unlimited desires.

¹⁹ Congressional Budget Office. “Reducing the Deficit: Spending & Revenue Options” <http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf>

That would be great news for the spending outlook. It would be even better news for the exploding debt and the threat it carries to the nation's economic health. But it would be better news yet for Medicare and its beneficiaries.

Medicare now presents participants with two problems: It is bad medicine, and it is unsustainable. It is bad medicine because its fragmented structure facilitates payments to hospitals (Part A), doctors (Part B) and drug companies (Part D) but does nothing to make sure that those parts coordinate to provide quality care.

This is a microcosm of the broader problems with U.S. health care. Seniors do have the options of signing up for a coordinated benefit – the so-called Medicare Advantage. But PPACA gutted that program to pay for its unwise entitlement expansion. Doing a u-turn on Medicare Advantage is one path to moving to a defined contribution system.

With a fixed amount of money in the market, providers would have the best economic incentives. It would provide benefits more cheaply and introduce efficiencies to permit adding more benefits. The latter means coordination, health information technologies, preventative services and a litany of other well-recognized needs.

Thank you. I look forward to answering your questions.