

April 18, 2012

The Honorable Phil Gingrey, M.D.
U.S. House of Representatives
Washington, D.C. 202515

Dear Congressman:

We are pleased to respond to the letter of March 22 from you and your colleagues asking our views on how to improve the “strength and solvency of Medicare.”

We divide our response into three parts: some background information to clarify the discussion, specific suggestions for strengthening the Medicare program without imposing burdensome costs on its beneficiaries, and comments on recent budget proposals.

Background

Health-care cost growth is a system-wide problem, not one peculiar to Medicare. In fact, Medicare provides health coverage more inexpensively than private health insurance plans do. It has lower administrative costs and payment rates. In addition, Medicare has led — to a much greater degree than private health insurance — in advancing reforms in the health care payment system to improve efficiency and control fees. Medicare originated the prospective payment system, first for hospitals and then for other providers, a reform subsequently adopted by many private payers. Partly because of such innovations, Medicare has outperformed private insurance in holding down the growth of health costs. Between 1970 and 2010, Medicare spending per enrollee grew by an annual average of 1 percentage point less than comparable private health insurance premiums.¹ The health reform legislation has reduced the anticipated growth rate of nominal Medicare spending per beneficiary to about 3 percent a year over the next ten years, according to the Congressional Budget Office (CBO), well below its average of 7 percent a year during the previous decade and also below the projected rate of growth of private health care costs.²

The financial issues posed by Medicare Part A and by Parts B and D differ. Part A is managed through a trust fund that depends on earmarked revenues. Part A can run surpluses or deficits for a time, but it can reach a point where current revenues and accumulated reserves are insufficient to pay for all promised benefits. In contrast, Parts B and D, though financed in part by premium income, also receive general revenues. Under law, neither Part B nor Part D can run out of revenue.

¹ Centers for Medicare & Medicaid Services, *National Health Expenditure Web Tables*, January 2012, table 16, <https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf>.

² Centers for Medicare & Medicaid Services, *National Health Expenditure Projections 2010-2020: Forecast Summary and Selected Tables*, July 2011, table 17, <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>.

Of course, all parts of Medicare are components of the federal budget, but when people talk of the solvency of Medicare, they are talking only of Part A.

The 2011 report of Medicare’s trustees finds that Medicare’s Hospital Insurance (HI) trust fund will be able to pay for all hospital insurance coverage through 2024. At that point, earmarked revenues will cover 90 percent of costs.³ Over the next 75 years, revenue will cover an average of 83 percent of HI costs. This shortfall will need to be closed by raising revenue or lowering outlays, or most likely both. But the HI trust fund will not run out of all financial resources and cease to operate after 2024. It is not facing “bankruptcy,” as some have alleged.

Health reform (that is, the Affordable Care Act, or ACA) substantially improved Medicare’s long-term financial outlook. *Were the ACA not the law, the projected long-term difference between HI outlays and revenues would equal 3.89 percent of taxable payroll. With the ACA effectively enforced, the projected funding gap over the next 75 years is only one-fifth as large* — 0.79 percent of total earnings subject to the Medicare payroll tax. What this means is that Congress could, if it wished, close the projected funding gap with an increase in payroll tax rates of only 0.4 percentage points on both workers and employers. Even under the Medicare actuary’s alternative scenario, in which only about 60 percent of health reform’s Medicare savings are achieved, the long-run shortfall in HI is reduced by nearly one-half.⁴ These projections underscore the importance of resolutely implementing the Affordable Care Act.

The ACA begins to restructure the health care payment and delivery system to stop paying providers for more visits or procedures and begin rewarding effective, high-value health care. It reduces Medicare payments to hospitals with high readmission rates. It creates new payment models to encourage the creation of accountable care organizations (physician-led organizations that take responsibility for the cost and quality of care). It initiates pilot programs that bundle Medicare payments to hospitals and other medical facilities for services they provide during a single episode of care. It establishes a Center for Medicare and Medicaid Innovation to identify and foster new ways to increase the value of care and a Federal Coordinated Health Care Office to improve care for low-income Medicare beneficiaries who also are enrolled in Medicaid. It gives the Secretary of Health and Human Services (HHS) authority to implement approaches that prove successful in reducing costs and maintaining health-care quality without new legislation. It provides added support for research on which medical interventions work best so that private and public insurers alike can use such information in their coverage decisions. It sets up an Independent Payment Advisory Board (IPAB) to propose ways to hold down the growth of spending if projected outlays exceed targets that Congress has set, while reserving to Congress the right to meet those targets in other ways. The Congressional Budget Office (CBO) has not estimated savings from these provisions in the next ten years because their effects are not yet proven or because, in the case of the IPAB, it does not anticipate that spending growth will reach legislated targets in the coming decade. But taken together these reforms contain most of the ways of slowing the growth of health care spending that analysts have devised. More pointedly, they hold the potential to both “bend the cost curve” and improve the quality of care.

³ Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report*, May 13, 2011, <https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>.

⁴ Office of the Actuary, Centers for Medicare & Medicaid Services, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, May 13, 2011, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf>.

In the near term, however, a major slowdown in Medicare expenditures, beyond those that the ACA will achieve directly, will be hard to come by.

Additional steps to strengthen Medicare

Some additional savings can be achieved over the next ten years without jeopardizing the fundamental principles that have made Medicare one of the most successful and popular programs in our nation's history. The following changes would produce savings while preserving Medicare's defined benefit, and without raising the eligibility age or otherwise shifting costs onto beneficiaries.

The excess prices that Medicare pays for drugs prescribed for "dual eligibles" — those Medicare beneficiaries who are also enrolled in Medicaid — should be ended. Before the 2003 prescription drug law, *Medicaid* provided drug coverage for low-income elderly and disabled people also enrolled in Medicare. The 2003 law shifted that coverage to *Medicare*, thereby abandoning the features of Medicaid that secured low prices for those drugs by requiring drug manufacturers to pay rebates. The theory — now shown to have been mistaken — was that private insurance companies administering the Medicare drug program would negotiate still lower prices from drug manufacturers. In fact, as the HHS Office of Inspector General and others have found, Medicare is now paying substantially more to provide drugs to these beneficiaries than Medicaid used to pay.⁵ The President's budget proposes to secure for Medicare the same prices for low-income Part D enrollees that Medicaid continues to get for the same drugs when they are prescribed for Medicaid recipients who are *not* on Medicare. CBO estimates that this proposal would save \$137 billion over the next ten years. A similar proposal was included in the Bowles-Simpson plan.

Increasing the administrative budget of the Centers for Medicare & Medicaid Services (CMS) holds the potential for long-run program savings. As Robert Berenson and John Holahan of the Urban Institute have noted, "Recent CMS administrators from both parties point to chronic underfunding of CMS, and suggest that CMS administrative resources are inadequate to carry out its administrative responsibilities, and may increase program spending, especially in the area of detecting and preventing fraud and abuse." For each dollar CMS spends to detect and deter fraud, it realizes several dollars in saving. Boosting CMS's fraud detection resources is "low-hanging fruit" — a win-win way to reduce Medicare spending and improve care. Berenson and Holahan also find that Medicare's role in determining whether to cover and pay for new technologies and services has been compromised by a lack of resources.⁶

Care for dual eligibles is too fragmented, and financial incentives are not appropriately aligned between federal and state governments, since efforts by Medicaid that reduce hospitalizations will produce savings primarily for Medicare. Under the ACA, HHS has launched demonstration projects in the states to find ways to improve care coordination that can save money without reducing access to or quality of care. These demonstrations are essential. Experience to date with managed care for

⁵ Edwin Park, *Lower-Than-Expected Medicare Drug Costs Reflect Decline in Overall Drug Spending and Lower Enrollment, Not Private Plans*, Center on Budget and Policy Priorities, May 6, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3488>.

⁶ Robert A. Berenson and John Holahan, *Preserving Medicare: A Practical Approach to Controlling Spending*, Urban Institute, September 2011, <http://www.urban.org/UploadedPDF/412405-Preserving-Medicare-A-Practical-Approach-to-Controlling-Spending.pdf>.

the dual eligible population is mixed. Past results underscore the need for caution and careful testing, especially considering the vulnerable situation of dual eligibles, who tend to be in much poorer health and more likely to have multiple chronic illnesses and impairments than other Medicare beneficiaries. The goal of the demonstrations is to find out what works and what doesn't, to identify the best approaches and practices, and to show how successful models can be extended nationally. None of the promising approaches now being tested would take Medicare out of the picture. In fact, leading health policy experts from the Urban Institute have argued persuasively that Medicare, rather than Medicaid, should take the lead in reforming care for the dual eligibles.⁷

The Medicare Payment Advisory Commission (MedPAC) — Congress's nonpartisan advisory body on Medicare payment policy — recently sent Congress a long list of savings options that could be used as offsets for the cost of repealing Medicare's flawed sustainable growth rate (SGR) formula.⁸ The items on MedPAC's list deserve serious consideration. Additional savings can also be achieved through changes in Medicare's cost sharing and increases in income-related premiums, as discussed below.

Comments on recent proposals

The budget resolution recently passed in the House of Representatives would move Medicare in an unwise direction. It would shift costs to beneficiaries and drive up system-wide health costs. Most Medicare beneficiaries live on modest incomes and are not in a position to pay much more for their health care. The median income of Medicare households is about \$25,000 a year, and only about 15 percent of Medicare households have total household incomes over \$50,000. Medicare households also spend three times more than non-Medicare households do (as a percentage of their budgets) on out-of-pocket health expenses — 15 percent compared to 5 percent.

The House's budget plan would replace Medicare's current guarantee of coverage with a premium-support payment, raise the age of eligibility from 65 to 67, and reopen the "doughnut hole" in Medicare's coverage of prescription drugs. Together, these changes would shift substantial costs to Medicare beneficiaries. Since the budget resolution also assumes repeal of health reform, many 65- and 66-year olds would find themselves bereft of any health insurance coverage at all. Moreover, contracting traditional Medicare's share of the health insurance market would reduce its market power and weaken its ability to serve as a leader in controlling health care costs.⁹

The Bowles-Simpson proposal would restructure Medicare cost sharing by increasing the Part B deductible (and lowering the Part A deductible), capping a beneficiary's total annual out-of-pocket costs, and limiting the extent to which Medigap and other health plans can cover Medicare's cost-sharing. Although adding a catastrophic cap to Medicare would be desirable, any proposal of this sort must be carefully designed to provide appropriate incentives and protect vulnerable beneficiaries. It is a well-established principle of insurance design that certain services should be

⁷ Judy Feder and others, *Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead*, Urban Institute, October 2011, <http://www.urban.org/UploadedPDF/412418-Refocusing-Responsibility-For-Dual-Eligibles.pdf>.

⁸ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2012, p. 400, http://www.medpac.gov/documents/Mar12_EntireReport.pdf.

⁹ Paul N. Van de Water, *Medicare in the Ryan Budget*, Center on Budget and Policy Priorities, March 28, 2012, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3731>.

available with little or no cost sharing and low or no deductibles. These are services, such as maintenance drugs to arrest or control chronic illnesses, which actually save money in the long run by avoiding costly treatments and hospitalizations. Other services that are discretionary should carry higher cost sharing or be subject to deductibles. But even if these principles are overridden in the name of simplicity, any such proposal should be designed to protect low- and moderate-income beneficiaries. Without such protection, this change would likely increase costs for half or more of Medicare beneficiaries and cause some beneficiaries of limited means to fail to access needed care because they have difficulty affording it. For the majority of beneficiaries who do not end up in a hospital in a given year, most spending is for Part B. Beneficiaries with incomes below 100 percent of the poverty level would be generally protected by Medicaid, but low-income seniors with incomes just above the poverty line would face greater out-of-pocket costs than they might be able to afford. For example, a frail elderly widow with income of only \$12,000 — just above the poverty level — could be required to pay nearly \$400 more in cost sharing each year and could forgo needed care as a result. To shield the near-poor from these changes, cost-sharing protection should be extended on a sliding scale to people between 100 percent and 150 or 200 percent of the poverty level. Providing adequate low-income protection, of course, will reduce the amount of savings that can be achieved from changes in cost sharing.

Raising the basic Part B premium from 25 percent of program costs — the amount most beneficiaries pay — to 35 percent of program costs, as proposed by the Domenici-Rivlin panel, would be even more problematic. This step would increase Part B costs for *all* beneficiaries, *except* for the small proportion of high-income beneficiaries who now pay an income-related premium and for those with incomes up to 135 percent of the poverty line who are protected by Medicaid. As a result, the proposal would significantly raise premium costs for beneficiaries with incomes as low as \$15,100. It would also shift significant costs to states, as Medicaid programs would have to pay the full premium increase for Medicare beneficiaries with incomes below 120 percent of the poverty line. (Medicaid also pays premiums for beneficiaries between 120 percent and 135 percent of the poverty line but that assistance is fully federally funded.) Instead of increasing the basic premium, it would be far preferable to expand Medicare's income-related premiums, possibly along the lines proposed by the Administration and assumed in the House budget resolution.

Conclusion

Health reform has directly lowered the growth of Medicare spending. Its various pilots and demonstrations hold the potential to save much more in the future. Even then, Medicare will claim a growing share of gross domestic product (GDP) as baby boomers become eligible and longevity increases. That growth shows simply that there will be more beneficiaries and does not indicate inefficiencies in the program.

The key fiscal policy goal is to stabilize the federal debt relative to the size of the economy. The only way to accomplish this without severe cuts that would hit low- and middle-income Americans hard — including sharp cuts in Medicare — is through a balanced approach that includes revenue increases. The 2001-2003 tax cuts are a significant contributor to projected deficits, and letting some or all of those tax cuts expire would make a significant contribution to stabilizing the debt. In fact, CBO projects that if current laws remained in effect, the federal deficit would fall with time, and the deficits would be small enough that the debt burden — measured by the ratio of debt to

GDP — would shrink.¹⁰ That result would come about if all of the Bush-era tax cuts and the temporary payroll tax cut were allowed to expire, Medicare’s SGR formula were fixed in a deficit-neutral manner, and the automatic spending cuts triggered when the “supercommittee” failed to reach agreement are either allowed to take place or replaced by other deficit-reduction measures. Gradually phasing out the tax cuts and phasing in the spending cuts would reduce the risks to the economic recovery while having little adverse effect on the long-run budgetary picture. If deficits are brought down in a balanced way, making deep cuts in Medicare or fundamentally restructuring the program will be neither necessary nor desirable.

Sincerely,

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¹⁰ Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, March 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan_Specified_Paths_2.pdf.