Converting Medicare to a Defined Contribution Program

American College of Physicians–
American Society of Internal Medicine
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Written by Robert B. Doherty, MD

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Executive Summary

Before the enactment of Medicare in 1965, few elderly or nonworking disabled persons had reliable health insurance coverage, and the private coverage that was available to these groups was expensive and often inadequate, and renewal was not guaranteed. Medicare has provided affordable coverage to millions of Americans who otherwise would have been among the ranks of the uninsured or underinsured.

But Medicare's continued success is at risk. Budgetary, economic, and demographic trends threaten to undermine the financial viability of the program. Expenditures on Medicare have generally been growing at a faster rate than overall growth in federal expenditures. The impending retirement of the baby-boom generation will exacerbate the financial pressures on Medicare. Over the next several years, before the first of the baby boomers reaches age 65, increases in Medicare enrollment will account for a small fraction of the growth in Medicare. After about 2005, however, the ranks for Medicare beneficiaries will swell, adding pressure to the federal budget in the following decades.

Why does the continued growth in Medicare spending concern policy makers? For one thing, higher Medicare expenditures will, within a few years, exhaust the Part A trust fund. The Part A trust fund, which pays for hospital and other institutional expenses, is funded by a payroll tax on working Americans. As the population ages, the ratio of working Americans to retirees will decrease. As a result, Congress will have to either markedly increase the payroll tax on working Americans or to drastically curtail Medicare benefits and eligibility, or both.

Medicare Part B, which pays for physician services, durable medical equipment, and other nonhospital expenses, is funded by a combination of premiums paid by beneficiaries and general revenue. The projected rate of growth in Medicare expenditures will require that Congress devote an increasingly larger share of the general tax revenue to Medicare—at the expense of other desirable programs. Alternatively, Congress could require that beneficiaries pay substantially higher premiums, slash benefits and payments to providers, require higher beneficiary cost sharing, or restrict eligibility for the program (such as by limiting eligibility to individuals below certain income levels).

None of these measures—cutting benefits, raising taxes, reducing eligibility, or requiring that beneficiaries pay substantially more—are likely to enjoy the support of the public and their elected representatives in Congress. Consequently, Congress is exploring ways to gradually restrain the rate of growth in Medicare expenditures—thereby hoping to avoid the more drastic, and politically unpopular, measures that otherwise will be needed.

The Bipartisan Commission on the Future of Medicare, which was created by Congress as part of the Balanced Budget Act of 1997 (BBA '97), has been charged with developing recommendations to assure the continued viability of the Medicare program. Members of the Commission were jointly appointed by President Clinton, Senate Majority Leader Trent Lott, and then-Speaker of the House Newt Gingrich. It is co-chaired by Senator John Breaux (D-LA) and Representative Bill Thomas (R-CA). The BBA '97 requires that the Commission report back to Congress in March 1999 with its recommendations.

Converting Medicare from a defined benefit to a defined contribution (or premium contribution) program is one policy option that is getting serious consideration by the Commission. The Commission is also considering proposals to advance the age of Medicare eligibility and to require that higher income beneficiaries pay higher premiums.

The American College of Physicians–American Society of Internal Medicine (ACP-ASIM) represents physicians who specialize in internal medi-

cine and medical students who plan to become internists. With over 115,000 members, ACP-ASIM is the nation's largest medical specialty society. Because internists take care of more Medicare patients than any other specialty of physician, the members of ACP-ASIM—and their patients—have a particular interest in influencing the debate over the future of the Medicare program.

This is not the first time that the College has addressed the issue of Medicare reform. In 1997, the College released a policy paper titled "Reforming Medicare: Adapting a Successful Program to Meet New Challenges." The paper, which is available upon request, proposed measures to address structural and management reforms that will enable Medicare to become more cost effective. The recommendations addressed ways of improving care for patients, improving the fee-for-service program, ensuring appropriate use of technology, and improving the Medicare managed care program.

ACP-ASIM continues to advocate strongly for adopting the reforms recommended in the 1997 policy paper. We recognize, however, that additional savings will be needed and that a discussion of the future of Medicare must also address proposals for fundamental changes in the financing of the program.

This paper provides ACP-ASIM's *preliminary* recommendations on the issue of converting Medicare to a defined contribution program. It also provides recommendations on other related measures to ensure Medicare's continued solvency, including advancing the age of eligibility and basing premium contributions on income. ACP-ASIM will continue to evaluate the issue of Medicare reform, including review of any recommendations that may be forthcoming from the Bipartisan Commission.

ACP-ASIM opposes the conversion of Medicare from a defined benefit to a defined contribution program. Such a change would erode the guarantee that all elderly and disabled Americans, regardless of income, will have access to affordable coverage. ACP-ASIM believes that a defined benefit voucher program should be tested and evaluated on a demonstration project basis before a decision is made to implement it nationally. Too little is known now about the effect of such a program on access, administrative costs, and the ability of beneficiaries to choose the best plan for themselves. This paper provides recommendations for a demonstration project that would provide Congress with the information needed to make a decision on further implementation.

ACP-ASIM also opposes advancing the age of Medicare eligibility. Although ACP-ASIM understands the demographic argument for such a change, we are concerned that the impact will be to increase the ranks of uninsured Americans.

ACP-ASIM supports proposals to require higher income beneficiaries to pay higher premiums to support the program.

Finally, ACP-ASIM recommends that Congress consider increasing general revenues or payroll taxes to support the program rather than just rely on measures to reduce expenditures.

Background

Medicare has been a remarkably successful program.

Before the enactment of Medicare in 1965, few elderly or nonworking disabled persons had reliable health insurance coverage, and the private coverage that was available to these groups was expensive and often inadequate, and renewal was not guaranteed. The elderly and disabled feared bankruptcy from the costs of treatment for serious illness or the inability to receive treatment because they could not pay for it.[1]

Thirty-three years later, this is no longer the case. Medicare has provided elderly and disabled Americans with access to affordable health insurance coverage for medically necessary physician, hospital, and skill nursing services. It has opened the door to health care and greater economic security for the nation's elderly and disabled populations and has contributed to improved health and quality of life for millions of Americans.[2]

Budgetary and Demographic Pressures Threaten Medicare's Future

But Medicare's continued success is at risk. Budgetary, economic, and demographic trends threaten to undermine the financial viability of the program. According to the Congressional Budget Office (CBO), federal expenditures on Medicare will increase from $208 billion in 1997 to $277 billion in 2001. Spending will reach $448 billion in 2003, having risen at an average annual rate of 8.3 percent per year. The BBA '97 slowed Medicare spending, but even with this slowdown the CBO projects that Medicare outlays will continue to grow faster than overall federal outlays. Medicare's share of the federal budget will increase from under 12% in 1997 to 13% in 2002 and 16% by 2008.[3]

The impending retirement of the baby-boom generation will exacerbate the financial pressures on Medicare. Over the next several years, before the first of the baby boomers reaches age 65, increases in Medicare enrollment will account for a small fraction of the growth in Medicare. After about 2005, however, the ranks for Medicare beneficiaries will swell, adding pressure to the federal budget in the following decades.[4]

Potential Impact on Taxes, Benefits, Cost Sharing, and Eligibility

Why does the continued growth in Medicare spending concern policy makers? For one thing, higher Medicare expenditures will, within a few years, exhaust the Part A trust fund. The Part A trust fund, which pays for hospital and other institutional expenses, is funded by a payroll tax on working Americans. As the population ages, the ratio of working Americans to retirees will decrease. As a result, Congress will have to either markedly increase the payroll tax on working Americans or to drastically curtail Medicare benefits, eligibility, or both.

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[1] HJ Aaron and RD Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs*, Vol. 14, pp. 8–30.

[2] M Moon and K Davis, "Preserving and Strengthening Medicine," *Health Affairs*, Vol. 14, pp. 31–46.

[3] CBO, Economic and Budget Outlook, Fiscal Years 1999-2008.

[4] Ibid.

Medicare Part B, which pays for physician services, durable medical equipment, and other nonhospital expenses, is funded by a combination of premiums paid by beneficiaries and general revenue. The projected rate of growth in Medicare expenditures will require that Congress devote an increasingly larger share of the general tax revenue to Medicare—at the expense of other desirable programs. Alternatively, Congress could require that beneficiaries pay substantially higher premiums, slash benefits and payments to providers, require higher beneficiary cost sharing, or restrict eligibility for the program (such as by limiting eligibility to individuals below certain income levels).

None of these measures—cutting benefits, raising taxes, reducing eligibility, or requiring that beneficiaries pay substantially more—is likely to enjoy the support of the public and their elected representatives in Congress. Consequently, Congress is exploring ways to restrain gradually the rate of growth in Medicare expenditures—thereby hoping to avoid the more drastic, and politically unpopular, measures that otherwise will be needed.

Role of the Bipartisan Commission on the Future of Medicare

The Bipartisan Commission on the Future of Medicare, which was created by Congress as part of the BBA '97, has been charged with developing recommendations to ensure the continued viability of the Medicare program. Members of the Commission were jointly appointed by President Clinton, Senate Majority Leader Trent Lott, and then-Speaker of the House Newt Gingrich. It is co-chaired by Senator John Breaux (D-LA) and Representative Bill Thomas (R-CA). The BBA '97 requires that the Commission report back to Congress in March 1999 with its recommendations.

Converting Medicare from a defined benefit to a defined contribution (or premium contribution) program is one policy option that is getting serious consideration by the Commission. As explained later in this paper, a shift from a defined benefit to a defined contribution program offers the potential of putting Medicare on a sound fiscal basis for the foreseeable future. But it also has the potential of eroding the guarantee of affordable health insurance coverage for the elderly and disabled, especially those with low incomes. The Commission is also exploring other measures to restrain the rate of growth in Medicare, including raising premiums to higher income beneficiaries and advancing the age of eligibility.

ACP-ASIM's Interest in the Debate over Medicare

ACP-ASIM represents physicians who specialize in internal medicine and medical students who plan to become internists. With over 115,000 members, ACP-ASIM is the nation's largest medical specialty society. Because internists take care of more Medicare patients than any other specialty of physician, the members of ACP-ASIM—and their patients—have a particular interest in influencing the debate over the future of the Medicare program.

This paper provides the College's *preliminary* recommendations on the issue of converting Medicare to a defined contribution program. It also provides recommendations on other related measures to assure Medicare's continued solvency, including advancing the age of eligibility and basing premium contributions on income. ACP-ASIM will continue to evaluate the issue of Medicare reform, including review of any recommendations that may be forthcoming from the Bipartisan Commission.

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Medicare reform. In 1997, the College released a policy paper titled "Reforming Medicare: Adapting a Successful Program to Meet New Challenges." The paper, which is available upon request, proposed measures to address structural and management reforms that will enable Medicare to more cost effective. The recommendations addressed ways of improving care for patients, improving the fee-for-service program, ensuring appropriate use of technology, and improving the Medicare managed care program.[5] An executive summary of the 1997 paper is reprinted as Addendum I of this policy paper. The Lewin Group estimated that the recommendations in the 1997 policy paper, if adopted by Congress and instituted by the Health Care Financing Administration (HCFA), would save $65 billion over 5 years.[6]

ACP-ASIM continues to advocate strongly for adopting the reforms recommended in the 1997 policy paper. We recognize, however, that additional savings will be needed and that a discussion of the future of Medicare must also address proposals for fundamental changes in the financing of the program, such as the defined contribution model, income-related premiums, and advancing the age of eligibility. This new policy paper provides the College's recommendations on such additional policy measures.

In preparing this paper, ACP-ASIM also incorporated much of the analysis and recommendations from a 1995 policy paper by the American Society of Internal Medicine titled "Keeping Medicare Affordable," which addressed issues relating to defined contributions, income-related premiums, and advancing the age of Medicare eligibility.[7] (Note to readers: the American College of Physicians and the American Society of Internal Medicine merged in July 1998, forming ACP-ASIM).

This position paper does not address issues relating to the financing of graduate medical education (GME), although Medicare's role in financing GME is a major concern of the Bipartisan Commission. In 1997, ACP-ASIM issued a policy paper, "The Physician Workforce and Financing of Graduate Medical Education."[8] Its executive summary is reprinted as Addendum II of this paper. ACP-ASIM has provided its recommendations on the financing of GME to the Bipartisan Commission.

Defined Benefits versus Contributions

The existing Medicare program is a defined *benefit* program, meaning that beneficiaries have an open-ended entitlement to have Medicare pay for all covered benefits. There is no overall limit on how much of a financial contribution Medicare would make toward the care of any beneficiary. Under a defined *contribution* model, the federal government would give each beneficiary a set amount of dollars to purchase health insurance coverage through private sector plans, with the beneficiary paying the difference between the federal government's contribution and the cost of the plan.

[5] "Reforming Medicare: Adapting a Successful Program to Meet New Challenges," Policy paper, American College of Physicians, 1997.

[6] "Estimates of the Impact of Selected Medicare Changes," The Lewin Group, prepared for the American College of Physicians, May 6, 1997.

[7] "Keeping Medicare Affordable," Recommendations of the American Society of Internal Medicine, July, 1995.

[8] "The Physician Workforce and Financing of Graduate Medical Education," American College of Physicians, Reprinted from *Annals of Internal Medicine*, Vol. 128, No. 2, 15 January 1998.

A defined contribution program is also sometimes referred to as a voucher program, although this is a misnomer, because a voucher program can be either a defined benefit or defined contribution program. A recently released report prepared for the National Coalition on Health Care by the Lewin Group, titled "Comprehensive Medicare Reform: Defined Benefit vs. Defined Contribution," provides an excellent description and analysis of the different ways that a voucher program could be developed and implemented.

The report notes that under the defined contribution model, the federal government would issue a voucher to Medicare beneficiaries to help them purchase health insurance coverage. The amount of the voucher would be determined by Congress through the budgeting process based on the amount of funds available to Medicare rather than the projected cost of coverage. There would be no guarantee that the voucher amounts would be enough to purchase coverage comparable to the existing Medicare benefits package. If the voucher amount did not keep pace with cost of plans offering benefits comparable to the current Medicare benefits package, beneficiaries would have to supplement the voucher amount with their own funds to purchase comparable coverage. Some form of premium subsidy might be required to assist the poor and near-poor persons to protect them from becoming substantially underinsured.[9]

Not all voucher proposals would require that Medicare convert to a defined contribution model. The amount of the voucher could be set to the average bid price in each market area for the current Medicare benefits package. As long as beneficiaries are guaranteed that the voucher amount would be enough to purchase a plan in their area that offers at least the current Medicare benefits package, then this voucher model would still be a defined *benefits* plan. The voucher model becomes a defined contribution program only when Congress eliminates the guarantee that beneficiaries can obtain a minimum level of services when the voucher amount is exceeded.[10]

Some proposals also call for maintaining the traditional Medicare fee-for-service (FFS) program along with a voucher program. Beneficiaries could choose either to remain in the conventional Medicare program or purchase private coverage using a voucher. Even if the companion voucher program itself did not guarantee that the voucher amount would allow a beneficiary to purchase coverage through the private sector equal to the current Medicare benefits, the "defined benefit" guarantee under Medicare would be maintained through the option of enrolling in the conventional FFS program.

Specific Proposals under Consideration

The Bipartisan Commission has reviewed several specific proposals for a voucher program. Some would completely convert Medicare to a defined contribution model; others would maintain it as a defined benefit program.

[9] "Comprehensive Medicare Reform: Defined Contribution versus Defined Benefit," The Lewin Group, prepared for the National Coalition on Health Care, September 1998.
[10] Ibid.

Federal Employees Health Benefit Model

The Heritage Foundation has proposed that Medicare adopt the Federal Employees Health Benefit Program (FEHBP) as a model for reform. The Foundation proposes that the government invite bids from private plans meeting specified minimum requirements, then allow HCFA to negotiate premiums and packages, as well as service areas, with individual plans before agreeing on a final price-and-benefits package that is offered to Medicare beneficiaries in a particular area. Plans would have a basic core of benefits, as the FEHBP requires, but negotiators should be able to develop a variety of plan benefits and prices in any area. An annual open season would be instituted in which retirees can choose a plan for the following year. The conventional Medicare program would be maintained, but a semi-independent board would be created to operate the conventional program in all parts of the country. The board would have the power to make variations in the benefits, including deductibles and copayments, subject to an up-and-down vote in Congress. The traditional FFS program would be required to offer catastrophic coverage and full Part A and Part B benefits for a stated premium, to be negotiated each year.[11]

The FEHBP is not a defined benefits program. The FEHBP meets with plans to negotiate changes in benefits and cost sharing as well as premium increases, but there is no guarantee that the federal government's contribution will keep pace with premium costs. The federal government's contribution also varies for different groups of federal employees based on collective bargaining agreements. Over time, there can be a general increase in patient cost sharing, premium increases, and reductions in covered services.[12]

Similarly, the Heritage Foundation proposal for Medicare reform would also be a defined contribution plan. The voucher amount would be reduced proportionally, if necessary, to stay within the amounts budgeted by Congress. In these instances, individuals would be required to supplement the voucher amount with their own money. Furthermore, individuals who choose the conventional Medicare plan would be required to make additional payment to receive this coverage if costs under traditional Medicare exceed the voucher amount.[13]

Premium Support Proposal

Aaron and Reischauer propose that the existing Medicare program be converted to a premium contribution model. Rather than paying for all services on a stipulated menu, Medicare would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services. Key features of their proposal are listed on the following page.

[11] "Congress' Own Health Plan as a Model for Medicare Reform," Backgrounder #1123, Heritage Foundation, June 12, 1997.
[12] "Comprehensive Medicare Reform: Defined Contribution versus Defined Benefit," The Lewin Group, prepared for the National Coalition on Health Care, September 1998.
[13] Ibid.

- Plans would be required to offer defined services. Insurers would be permitted to sell coverage for additional services not covered under the basic plan, but only if marketing and delivery of those services were divorced from those of the basic plan.
- The defined services that each plan would offer would *not* be based on the current Medicare benefit package. Instead, the benefit package would combine the current Medicare benefits with coverage of prescription drugs and catastrophic protection.
- At least initially, cost-sharing requirements would be standardized. Aaron and Reischauer argue that standardized cost sharing and benefits are needed to reduce risk segmentation and help participants compare cost and quality.
- Payments to health plans would be based on a defined benefit package and adjusted for variations in actual costs and use among regions, not on the basis of actual bids or of the lowest bids within a region. Risk adjustment would be incorporated into payments to the plans. Plans would be invited to submit bids for providing the defined benefit package in a particular market for the "average" Medicare enrollee. If the enrollee chooses a plan that costs more than the federal Medicare payment, the participant would pay the balance. A beneficiary who chooses a plan that costs less than the federal contribution would be offered a "dividend" of supplemental coverage for services such as eyeglasses or routine dental care rather than cash rebates.
- During a phase-in period of 5 to 10 years, the federal payment would grow more slowly than projected baseline costs. If growth of plan expenses slows, costs to enrollees might not increase. An expert commission would recommend the size of the reduction; this recommendation would be re-evaluated every 2 or 3 years. In the long run, the federal payment would grow at the same rate as per capita spending on health care for the nonelderly.
- Local marketing organizations would be established to handle the sale of insurance. They would assist Medicare enrollees in buying insurance, discourage insurers from using marketing to attract superior risks, and keep marketing costs to a minimum. These entities, which could be public or private not-for-profit agencies, would receive information from insurers, ensure that it was provided to beneficiaries in an even-handed manner, and handle enrollment. They would counsel Medicare enrollees, some of whom are frail, to minimize sales abuses.
- Initially, the FFS Medicare program would run alongside the new system. The new system would be mandatory for everyone who turns 65 and becomes eligible for Medicare after a certain date. It would be optional for everyone in enrolled in Medicare before that date.[15]

[14] HJ Aaron and RD Reischauer, op. cit.
[15] Ibid.

Despite the requirement that plans offer a standardized benefit package, the Aaron and Reischauer proposal is a defined contribution program. By capping payments to stay within budgeted amounts, beneficiaries would be forced to supplement the voucher with their own funds to maintain at least the standard benefits package.[16]

A Defined Benefit Voucher Proposal

The Progressive Policy Institute (PPI) has proposed a defined benefit voucher program. Beneficiaries would choose from a selection of health plans providing coverage in their area. Plans would provide coverage at least equal to the current Medicare benefits package. There would be no mandated expansion of the Medicare benefits package to include prescription drugs or catastrophic coverage, but health plans could compete by offering more benefits. The traditional Medicare program would be maintained as a coverage option. However, if the average cost for the FFS program exceeded the average HMO bid, FFS enrollees would pay the difference through a higher premium or higher deductibles or copayments. Therefore, beneficiaries would pay the full incremental costs of remaining in FFS Medicare if the costs of conventional Medicare exceed the HMO bids in their community.[17]

What makes the PPI model a defined benefits program is a requirement that Medicare establish the voucher contribution at the average health maintenance organization (HMO) bid for the Medicare benefits package rather than the lowest bid submitted in an area. By using the average bid, most beneficiaries would be able to choose from two or more plans that accept the voucher amount as full payment. Because the PPI proposal does not limit expenditures to a predetermined budgeted amount, there is no guarantee that it will eliminate funding shortfalls. Additional savings would likely be needed to ensure the financial viability of Medicare through 2030.[18]

Potential Savings from the Voucher Proposal

One reason the Bipartisan Commission seems enamored with a defined contribution program is that it offers the promise of restraining expenditure growth in Medicare without having to explicitly curtail benefits or eligibility. A voucher program—-if set up as a defined contribution model—-could save enough money to eliminate the hospital trust fund deficit. (The trust fund is currently expected to be depleted by the year 2010.) As much as $3.6 trillion, or up to 27% of total program costs, could be saved between 2005 and 2030.

By comparison, the defined benefit voucher program could reduce the annual rate of growth by 1.5% per year from 2005 to 2030, saving $2.8 trillion. Even with this level of savings, a defined benefit voucher program would likely require that Congress impose additional measures to restrain spending—-such as delaying the age of eligibility or requiring higher income patients to pay more.[19]

[16] "Comprehensive Medicare Reform," op. cit.
[17] Ibid.
[18] Ibid.
[19] Ibid.

Analysis and Recommendations

1. ACP-ASIM opposes proposals to convert Medicare into a defined contribution program.

The College has strong practical and philosophical objections to converting Medicare to a defined contribution program.

ACP-ASIM has a long-standing history of support for universal coverage. Although Congress has been unable to agree on a program to provide coverage to all Americans, the existence of Medicare has provided coverage for *all elderly and disabled* Americans. A defined contribution program would price many lower-income, elderly disabled Americans out of the market for coverage. It would therefore represent a setback in the drive to expand coverage to all Americans. On this basis alone, ACP-ASIM, as a matter of principle, cannot support conversion of Medicare into a defined contribution program.

ACP-ASIM is particularly concerned about the impact a defined contribution program would have on less wealthy beneficiaries. One of the abiding strengths of the conventional Medicare program is that it provides the same coverage and benefits to beneficiaries regardless of income or acquired assets. The fact that Medicare is not viewed as a "welfare" program is one of the reasons that it has enjoyed consistent public support. A defined contribution program would create a two-tiered system, with the less wealthy being forced into plans with less coverage and fewer benefits than the plans available to the wealthy. This would be not only unjust but also politically unwise, because it would undermine public support for the program.

On a practical level, a defined contribution program places too much faith in the ability of frail beneficiaries to "shop" for coverage and make a wise choice among competing plans. The example of the FEHBP may not be illustrative of the impact of a similar program on the elderly and disabled, because the federal employee workforce is generally better educated, younger, and healthier than the Medicare population. The elderly and disabled would be far more vulnerable to abusive marketing practices. They would be at greater risk of purchasing plans that provide inadequate coverage for their medical conditions. The only plans that lower-income beneficiaries may be able to afford would be ones with high deductibles and copayments, imposing a harsh financial barrier on their access to care.

2. A defined *benefit* voucher program should be tested on a demonstration project basis before a decision is made to implement it on a national basis. The demonstration project should assess the impact of a defined benefit voucher system on adverse selection, continuity of care, fairness, access (especially for lower income beneficiaries), and administrative costs of care.

3. Effective risk adjustment methods should be developed and tested before a decision is made to implement a defined benefit voucher program on a national basis. Alternative risk adjustment methods should be tested and evaluated during the demonstration project.

4. A demonstration project on a defined benefit voucher program should evaluate the effectiveness of using local marketing organizations to handle the sale of insurance. They would assist Medicare enrollees in buying insurance, discourage insurers from using marketing to attract superior risks, and keep marketing costs to a minimum. These entities, which could be public or private not-for-

profit agencies, would receive information from insurers, ensure that it was provided to beneficiaries in an even-handed manner, and handle enrollment. They would counsel Medicare enrollees, some of whom are frail, to minimize sales abuses.

5. **Plans participating in the demonstration project should be required to offer benefits at least equal to those available under the conventional FFS program. Participating plans should be required to meet specific consumer protection standards comparable to those that Medicare+Choice plans must meet. Such standards should include internal and external appeals procedures, a prudent layperson standard for coverage of emergency services, access to specialty care, and requirements that physicians have a central role in developing utilization management and quality improvement protocols.**

6. **The demonstration project should evaluate alternative ways of establishing a premium contribution for a defined benefit voucher program. An acceptable method should reduce or eliminate geographic inequities in payments, not create incentives to over- or underbid, and not create disincentives for plans to participate in the program.**

ACP-ASIM believes that a demonstration project is needed before Congress decides to entrust the entire Medicare population to market forces, the effectiveness of which remains unproved for the mainstream Medicare population. Under a defined benefit voucher program, adverse selection would present a substantial risk. Plans participating in the program might attract healthier and younger beneficiaries, leaving older and sicker patients in the conventional Medicare program. Within the voucher program, plans would have an incentive to attract the lowest-risk patients, unless they knew that their payments would be increased if they enrolled a sicker pool of patients. Consequently, it will be imperative that an effective risk adjustment method be developed, tested, refined, and then applied to payments to providers under the voucher program *and* conventional Medicare.

Under a voucher program, beneficiaries may have a great deal of difficulty in choosing a health plan. Many beneficiaries currently have little understanding of the myriad of health insurance options that would be available to them. Using local marketing organizations may be one approach to helping beneficiaries make a wise and informed choice of plan, but the effectiveness and costs of such organizations will not be known until they are evaluated on a demonstration project basis.

The administrative costs of a voucher program also need to be evaluated. Can private sector plans truly deliver services to beneficiaries at lower cost than conventional Medicare, which traditionally has incurred lower administrative costs than private health insurers? Will the costs of administering a defined benefit voucher program exceed any savings that may occur from introducing more market competition into the program?

Too little is known about the impact of a defined benefit program on continuity of care and on the impact that it may have on access to care, especially for lower-income beneficiaries who likely would have a smaller number of health plans that they could afford. Too little is known about the best way of determining the premium contribution amount. Not enough is known about how to pay health plans and providers based in part on the risk of the patient population that they are serving. Too little is known about the ability of beneficiaries to exercise an informed choice of plans.

For all of these reasons, ACP-ASIM believes that it is premature for Congress to consider mandating a defined benefit voucher program. A rigorous evaluation of a such a program on a demonstration project basis is the only way to get the data needed for Congress to find out if and how such a program would work.

7. ACP-ASIM opposes advancing the age of eligibility for Medicare to be consistent with that of Social Security.

The argument for advancing the age of eligibility is an actuarial one. Proponents argue that when Medicare was enacted in 1965, it was not expected that the typical elderly beneficiary would live another 15 or 20 years past the age of eligibility. Now that it is not uncommon for beneficiaries to live into their mid-to-late 80s and even 90s, they suggest that it is logical to advance the age of eligibility for Medicare to reduce the number of years that beneficiaries rely on the program for coverage. The Social Security eligibility age will increase incrementally from 65 for persons born between 1938 and 1959. Those born in 1960 and subsequent years will reach eligibility at age 67. Accordingly, proponents argue that the Medicare eligibility age should be linked to the Social Security retirement eligibility.

What may make sense from an actuarial standpoint may not make sense from the standpoint of promoting good health policy, however. Advancing the age of Medicare eligibility is likely to increase the ranks of the uninsured. Retirees who do not have access to Medicare or coverage through their former employer could find themselves uninsured at a particularly vulnerable period in their lives. Without a guarantee that such individuals could obtain coverage through another source, more Americans are likely to find themselves uninsured. ACP-ASIM cannot support proposals that will add to the ranks of the uninsured.

8. ACP-ASIM supports requiring that higher income beneficiaries pay higher premiums to remain in conventional Medicare.

From the standpoint of fairness, ACP-ASIM believes that it is appropriate to ask higher income beneficiaries to contribute more to the Medicare program through a premium structure that is related to income. Although most estimates suggest that requiring higher income beneficiaries to pay higher premiums will produce only a modest increase in revenues, the College believes that it is appropriate to bring in more revenue to support the program from individuals who can afford to pay more.

9. If necessary, ACP-ASIM would support mandating a modest increase in the Medicare payroll tax *now* and/or an increase in general revenue contributions to ensure the viability of Medicare for future generations.

[20] Aaron and Reischauer, op. cit.

Finally, it may be necessary to ask taxpayers to contribute more revenue, through the payroll tax or general revenues, to maintain Medicare as a viable program. Relying solely on ways to reduce the costs of the program neglects the other side of the equation: the necessity of ensuring that revenues are sufficient. As Aaron and Reischauer argue, " . . . even if the rosiest plausible projections from savings from managed care are realized, benefits approximating those now provided by Medicare cannot be sustained unless revenues flowing into the system are increased. In plain English, that spells 'TAXES.' To sustain Medicare, payroll or other taxes earmarked for Medicare must be raised or general revenue subsidies will have to be increased."[20] Although increasing taxes and revenue is generally considered to be a politically unpopular option, broad public support for the program may translate into support for increased revenue if necessary to save the program from going bankrupt.

Conclusion

ACP-ASIM believes that strengthening and preserving Medicare should be the highest priority for Congress. Although universal coverage must be the ultimate goal, Congress must not place at risk the one program that has been an unqualified success in providing coverage to millions of Americans who otherwise would be among the ranks of the uninsured or underinsured.

Reforms that would convert Medicare from a defined benefits to a defined *contribution* program would weaken the program, not strengthen and preserve it. They would destroy the key feature that has made Medicare so successful: the promise that patients enrolled in the program will be covered for medically necessary medical care, without regard to their income or health status. This promise must not be withdrawn or undermined.

Too little is known about the effectiveness of a defined benefits voucher program for Congress to mandate implementation of such a program nationwide. A well-designed demonstration project that includes the elements described in this paper would provide Congress with the data needed to decide if a defined benefit program should be incorporated into Medicare and, if so, how it should be designed.

Even with a defined benefit voucher program, other reforms—including income-related premiums and modest increases in payroll tax rates and general revenue to support the program—would likely be needed. The improvements recommended in the 1997 ACP-ASIM policy paper "Reforming Medicare: Adapting a Successful Program to Meet New Challenges," should also be part of the solution. Shifting the responsibility of funding graduate medical education to all payers, not just Medicare—as the College recommends—will also help ensure the continued viability of the Medicare program.

Reform of Medicare will be controversial. Each of the options under consideration will require sacrifices. Though reform is clearly needed, Congress must exercise caution to ensure that a program that "has contributed to improved health and quality of life for millions" is not harmed by the same measures that are intended to keep it solvent.[21]

[21] Moon and Davis, op. cit.

Addendum I

Reforming Medicare

Adapting a Successful Program to Meet New Challenges

Written by Michael J. Werner, JD

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Executive Summary

In June of 1996, the reports issued by the Board of Trustees for the Medicare and Social Security trust funds described the dire financial condition of the Medicare program. The reports said that the Hospital Insurance trust fund would become insolvent by 2001 and that program expenditures for the Medicare Supplementary Medical Insurance program (which come primarily from general revenues) were growing more rapidly than the economy as a whole.

Although the Medicare program has achieved many successes over the past 30 years, its financial condition leaves no doubt that it requires restructuring. Many observers have noted that the Medicare program is out-of-date with health care delivery system changes. This reduces health plan options for beneficiaries and hurts access to potentially beneficial care. Others have charged that the program's management tools are ineffective and have led to high costs and quality problems. For all these reasons, the next Congress and Presidential Administration, regardless of party affiliation or ideology, are expected to explore ways to reform Medicare.

In this context, the American College of Physicians (ACP) presents its recommendations for Medicare reform and restructuring. The recommendations are based on the belief that Medicare must keep its commitment to program beneficiaries while maintaining its financial viability. There are no "quick fixes" to remedy Medicare's financial problems. Although policy makers and politicians may propose cutting reimbursements to physicians and other providers or increasing program beneficiaries' cost-sharing obligations, these proposals could have serious and lasting effects on the program. They do not address fundamental problems.

As the nation's largest medical specialty society, representing more than 100,000 physicians who practice internal medicine, the ACP's recommendations provide the internist's perspective on Medicare's ills and how to cure them. Internists are in a unique position to judge the quality and appropriateness of care provided to Medicare beneficiaries. Internal medicine requires its residents to undergo training in geriatrics. Physicians who practice internal medi-

cine and its many subspecialties have Medicare participation rates ranging from 80% to 90%. Moreover, general internists receive 38% of their revenue from Medicare, the highest among all primary care specialties.

The College's recommendations focus on providing care to older patients, describing the delivery systems that are most effective and the program changes needed to provide beneficiaries access to them. In addition, the recommendations address structural and management reforms that will enable Medicare to be more cost effective. They are grouped in four sections: 1) caring for patients, 2) improving the fee-for-service (FFS) program, 3) ensuring appropriate use of services and technology, and 4) improving the Medicare managed care program.

In the first section, the paper notes that Medicare beneficiaries, particularly those with chronic illnesses, will be well served by systems of coordinated care. Several models of coordinated care are described that could function in either capitated or FFS arrangements. Some of these approaches should be developed and implemented as demonstration projects, whereas others have already proven to be successful and should be replicated throughout the country. ACP's recommendations are as follows:

- The Health Care Financing Administration (HCFA) should contract directly with physicians who demonstrate the ability and willingness to provide a coordinated and comprehensive set of benefits for chronically ill Medicare beneficiaries.
- HCFA should develop demonstration programs that use case management to coordinate services for patients with complex conditions. Providing capitated payments for primary care services to physicians leading an interdisciplinary team is a worthwhile approach.
- The "bundled payment" demonstration program for heart bypass surgery (which creates a risk-sharing arrangement among providers by combining fee-for-service payments for specific services) should be expanded, either by HCFA or through the enactment of legislation.
- HCFA should develop demonstration projects to test the use of capitated financing schemes to pay for home health care.
- Medicare should establish delivery systems that provide coordinated and comprehensive care in the FFS sector for beneficiaries suffering from chronic illnesses.
- HCFA should reimburse case-management services under its fee schedule and develop demonstration programs to test various case-management models in FFS settings.
- Medicare should provide for hospice-type services (e.g., palliative care, pain relief, family counseling, and other psychosocial services) for terminally ill beneficiaries outside of a hospice.
- Medicare should provide for additional preventive care services, including appropriate screening services, for beneficiaries.

Although enrollment in managed care plans by Medicare beneficiaries is increasing, the vast majority of beneficiaries are enrolled in the FFS program. Consequently, the College advocates several changes that will help make the program more cost effective while ensuring that enrollees receive high quality care. Many of these proposals have been successfully implemented by private sector indemnity plans. In addition, HCFA is encouraged to evaluate the impact of modifying the FFS program's product design to increase efficiency and decrease costs. ACP's recommendations are as follows:

- HCFA should consider competitive bidding, negotiation, and other methods to purchase supplies and scrutinize payments. Legislation should be enacted to provide HCFA with the management authority

to implement these cost-saving techniques.

- Medicare should adopt the successful management techniques used by private sector indemnity plans (e.g., case management, physician profiling) to improve care and reduce costs. HCFA could begin this process by soliciting proposals from its carriers and fiscal intermediaries.
- HCFA should evaluate the impact of changing the Medicare FFS program's benefits package and cost-sharing requirements.

In its third section, the paper notes the cost and quality implications that stem from variations in the payment for and use of services in the Medicare program as well as the inappropriate use and supply of technology. Increased health services research and educational efforts to inform both doctors and patients of the effectiveness of treatment options are recommended. Moreover, HCFA is urged to change its coverage criteria and policies to place more emphasis on the cost effectiveness of technology. ACP's recommendations are as follows:

- Funding for outcomes research, the development of clinical practice guidelines, and the creation of regional Quality Improvement Foundations should be increased to help identify successful clinical practices and disseminate information to physicians and their patients.
- Medicare should use cost effectiveness as an explicit criterion in its decisions about coverage for a new technology.
- Medicare should increase its use of conditional or interim coverage rulings to help ensure the appropriate use of services and technology.
- Medicare should adopt more flexible pricing policies that cover the cost of the efficient use of technologies and provide incentives for the efficient use of resources.

Finally, recommendations are offered to improve Medicare's managed care program. These recommendations emphasize approaches to ensure that beneficiaries receive high-quality care. HCFA has initiated projects to address these concerns, but more needs to be done. The paper also proposes changes to the payment rate method for Medicare HMOs to help ensure that savings are achieved and that health plans receive fair compensation and have no incentives to avoid the chronically ill. ACP's recommendations are as follows:

- Federal quality standards should be developed to ensure that Medicare beneficiaries receive high-quality care in managed care environments. These standards should require health plans to adopt policies and procedures specifically designed for the elderly and to disclose all relevant information to beneficiaries about access to care, cost sharing, and other issues.
- Enrollees should have access to performance measures that rate the quality of care provided by the plan on issues specific to Medicare beneficiaries, such as functional status or treatment of chronic conditions.
- "Gag rules" or other actions designed to intrude improperly on the doctor–patient relationship should be prohibited.
- Legislation should be enacted that authorizes HCFA to contract directly with provider-sponsored organizations (PSOs) to give Medicare beneficiaries the Medicare benefits package for a capitated payment.
- HCFA should evaluate different approaches to fix the payment method. Competitive bidding, adding new risk stratification criteria, and establishing multicounty rates and payment thresholds all have the potential to improve the current system. In addition, payments for graduate medical education should be recaptured.

In sum, the ACP's recommendations address issues of program management and structure as well as necessary delivery system changes. These program improvements are an alternative to arbitrary funding cuts driven by budget needs rather than sound health policy. Although they will not solve all of Medicare's problems, by adopting these reforms policy makers will help ensure that the program 1) provides beneficiaries with high-quality and cost-effective care, 2) is financially viable, and 3) is adaptable to the modern health care delivery system.

Addendum II

The Physician Workforce and Financing of Graduate Medical Education

Written by Jack A. Ginsburg

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Executive Summary

This paper addresses key issues regarding the physician workforce and the financing of graduate medical education (GME). The American College of Physicians (ACP) recommends the establishment of a national advisory organization to develop a coherent and coordinated national policy on the health professions workforce. Given the increasing oversupply of physicians, the College recommends that no new medical schools be created, that total enrollment in U.S. medical schools not increase, and that the number of international medical graduates entering residency training in the United States be restricted. All health care payers should share the cost of GME; funding should be predictable and stable and should include ambulatory training sites. The number of first-year residents should be linked more closely to the annual number of medical graduates in the United States, and Medicare payments for medical education and training should be made only to the IIMOs that actually incur these costs. ACP advises that hospitals providing care primarily to underserved populations and indigent persons need stable funding with which to pay personnel to replace residents.

ACP calls for research to evaluate the feasibility of establishing a voucher system, in which each resident would receive payment authorization certificates to fund training at accredited residency sites. Additional research also is recommended to distinguish between the individual costs involved in GME and the other costs associated with GME and the care of indigent persons.

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