

Reforming Medicare in the Age of Deficit Reduction

Summary of Position Paper Approved by the ACP Board of Regents, April 2012

Why Is It Necessary to Reform Medicare?

Enrollment and spending in Medicare, the federal defined benefit system of health care insurance for people 65 and older (as well as certain groups of people with disabilities), has grown substantially over the past few decades. A heightened concern about government spending and the national debt have led policymakers to consider reforming the Medicare system.

Over the past 30 years, Medicare per capita spending has grown at a faster rate than the gross domestic product. Though certain estimates predict that Medicare spending growth will be slower than in the past decade, it is still expected to increase by 6 percent annually from 2010-2019. Further, though the Affordable Care Act will help to decrease Medicare spending, other factors—such as technological advancements, changes in health coverage, rising prices, reimbursement structures, and an influx of Baby Boomer enrollees—led to a report by the Medicare Trustees predicting that the hospital trust fund will run out of money by 2024 unless serious action is taken to address spending.

Context for Medicare Reform

Several important trends contribute to the growth in Medicare spending:

- ***Changing demographics and treatment needs.*** Almost half of the estimated spending growth for Medicare and other federal health care programs over the next 25 years is attributable to the aging of the population, and life expectancy at 65 has improved substantially over the past 70 years. Further, rising chronic disease rates hamper cost control efforts as conditions such as hypertension, diabetes, and hyperlipidemia replace inpatient hospital care as the most prevalent Medicare cost drivers.
- ***Medicare financing structure.*** Since Medicare is supported by payroll taxes, rising health care costs have led to increased Medicare premiums and/or taxes to meet the demand.
- ***Technological advancements and price growth issues.*** A significant share of health care cost growth can be attributed to advancements in technology. While new medical technologies produce substantial benefits to patients, some may inadvertently replace existing, less expensive technology of comparable clinical effectiveness. Medicare's administrative pricing system may overpay for medical equipment that may be purchased at a lower cost through other means, such as through competitive bidding.
- ***Coverage and benefit determinations.*** While Medicare beneficiaries are required to pay premiums, deductibles, and other forms of cost-sharing, 90% have some form of

supplemental coverage that greatly reduces their cost-sharing responsibility, potentially leading to greater spending.

- **Payment structure.** Medicare's fee-for-service structure inadvertently rewards physicians and other providers for delivering a high volume of services regardless of their value or cost-effectiveness.

Key Findings and Recommendations from the Paper

ACP recommends the following:

- To ensure solvency and maintain access to affordable care for beneficiaries, the Medicare program must lead a paradigm shift in the nation's health care system by testing and accelerating adoption of new care models, including:
 - Accelerating adoption of the patient centered medical home model
- Pilot-testing of a defined benefit premium support option, on a demonstration project basis, with strong protections to ensure that costs are not shifted to enrollees to the extent that it hinders their access to care.
- Eligibility and Premiums:
 - The Medicare eligibility age should only be increased to correspond with the Social Security eligibility age if affordable, comprehensive insurance is made available to those made ineligible for Medicare.
 - Medicare premiums should continue to be gradually increased for wealthier beneficiaries, and modest increases in the payroll tax cut to fund the Medicare program should be continued as well.
 - Congress should consider giving Medicare authority to redesign benefits, coverage and cost sharing to include consideration of the value of care being provided based on evidence of clinical effectiveness with consideration of cost.
- Medicare Parts A and B should be combined with a single deductible under the following circumstances:
 - Specified primary care and preventive services are not subject to the deductible
 - A limit is placed on total out-of-pocket expenses
 - The deductible is set at an actuarially appropriate level
 - Medicare payment levels to physicians for covered primary care and preventive benefits are adequate to assure that beneficiaries have access to such services
- Supplemental Medicare coverage – Medigap plans – should only be altered in a manner that encourages use of high quality, evidence-based care and does not lead Medicare beneficiaries to reduce use of such care because of cost.
- Medicare should provide for palliative and hospice services, including pain relief, patient and family counseling and other psychosocial services for patients living with terminal illness.
- The costs of the Medicare Part D prescription drug program should be reduced by the federal government acting as a prudent purchaser of prescription drugs.
- Congress should amend the authority for an Independent Payment Advisory Board (IPAB) in several respects order to achieve comprehensive, quality recommendations.

For More Information

This issue brief is a summary of *Reforming Medicare in the Age of Deficit Reduction*. The full paper is available at

http://www.acponline.org/advocacy/where_we_stand/policy/reforming_medicare.pdf.