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Reforming Medicare in the Age of Deficit Reduction

American College of Physicians

A Position Paper

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Reforming Medicare in the Age of Deficit Reduction

A Position Paper of the
American College of Physicians

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Executive Summary

A heightened concern about government spending and the national debt has led policymakers to consider reforming the Medicare system. By 2020, the Congressional Budget Office (CBO) predicts that 14% of federal spending will be devoted to Medicare. The 2010 Medicare's Board of Trustees estimates that while Medicare spending growth will be slower than in the last decade, it will still increase by 6% annually from 2010-2019.[1] The Affordable Care Act (ACA) will help slow Medicare spending. According to the CMS Office of the Actuary, the health care reform law will decrease spending by $575 billion over 10 years. Factors such as technological advancements, changes in health coverage, rising prices, and reimbursement structures contribute to the growth of health care expenditures.[2] Medicare will also face an influx of Baby Boomer generation enrollees, accounting for 45% of total spending growth over the next 25 years.[2] The 2011 Medicare Trustees report estimates that the hospital trust fund will run out of money by 2024 unless serious action is taken to address spending.

The Medicare program is a defined benefit, where enrollees receive guaranteed financial contributions for a package of health benefits. Some proposals to reform the Medicare system would transform the Medicare program to a defined contribution (or premium support) program, where beneficiaries would receive a finite amount of financial assistance to purchase health insurance.

It should be noted that many of the reforms proposed by members of Congress and the various deficit-reduction commissions would either directly or indirectly increase the financial burden for which Medicare beneficiaries are responsible. Increasing cost-sharing responsibilities on Medicare beneficiaries—many of whom are retired and have a fixed income—may encourage more cautious use of services; however, there is no guarantee that such changes will slow the nation's rising health care costs, which are driven by technological advancements, growth in prices for health care services, and other factors. The College is concerned that such efforts must ensure a balance between maintaining access to medically necessary care and reducing wasteful and limited value care.

The American College of Physicians has long supported efforts to ensure that Medicare beneficiaries have access to high-quality, coordinated care. In this time of mounting budget deficits, an aging population, and out-of-control health care costs, effective reform of the Medicare delivery system and benefit package must be initiated to emphasize prevention, wellness, and chronic care management.

This position paper considers the major benefit reform proposals that are of particular concern to internal medicine, including efforts to quell rising Medicare/health care costs, transform Medicare into a premium support program, increase the Medicare eligibility age, and apply income-based Medicare premiums. While Medicare delivery system and payment reform remains a major focus for the College, such important issues are outside of the scope of this position paper. The College's positions on Medicare payment reform are outlined in the 2009 position paper *Reforming Physician Payments to Achieve Greater Value in Health Care Spending*, among others.

Recommendations

1. **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 that improve population health, enhance the patient experience, and reduce per-beneficiary cost. Medicare must encourage patient-centered, coordinated, cost-conscious care (including access to a patient's primary care physician and specialists/subspecialists based on their health care needs); health information technology; collaboration across health care sectors; comparative effectiveness research; and other reforms that result in improved care for beneficiaries. Changes to the Medicare benefit structure should not increase the administrative burden on physicians and other health care professionals.**

2. **To improve the way health care is delivered and ensure the future of primary care, the College recommends that Medicare accelerate adoption of the patient-centered medical home model and provide severity-adjusted monthly bundled care coordination payments, prospective payments per eligible patient, fee-for-service payments for visits, and performance assessment–based payments tied to quality, patient satisfaction, and efficiency measures. Additionally, new payment models should avoid the volume-oriented fee-for-service system in favor of approaches that are aligned with quality and efficiency, such as episode of care payments and accountable care organizations.**

3. **ACP does not support conversion of the existing Medicare defined benefits program to a premium support model. However, ACP could support 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. Such a demonstration project would offer beneficiaries a choice between traditional Medicare and qualified premium support plans offered through the private sector, subject to Medicare requirements relating to benefits, cost-sharing, access to services, and premiums, while providing financial support to cover the Medicare benefit package. Such a demonstration project should:**
    a. **Utilize risk-adjustment mechanisms to protect against adverse selection.**
    b. **Provide a minimum benefit package equal to that of fee-for-service Medicare that includes preventive and primary care services without cost-sharing. Cost-sharing levels may vary but should reflect the actuarial value of traditional Medicare.**
    c. **Apply network adequacy standards that ensure beneficiaries have access to a sufficient network of physicians and other providers, including a means for beneficiaries to access out-of-network physicians and other providers at no additional cost if they are unable to receive medically necessary care though their existing network.**

d. Promote innovative delivery system models, such as the patient-centered medical home, among the participating fee-for-service Medicare and private plans.
e. Provide stringent oversight of health plan marketing activities to prevent cherry-picking and risk selection. A government entity or nonprofit organization should be authorized to provide outreach and objective educational assistance to beneficiaries.
f. The initial per capita federal contribution should be based on the average bid in a geographic area for a coordinated care plan providing the Medicare benefit package. The per capita Medicare expenditure level for that area may represent the fee-for-service bid. Subsequent federal contribution levels should rise with the average coordinated care plan premium (providing at least the Medicare benefit package) for that geographic area.
g. Dual-eligible beneficiaries should be exempt from participating in the demonstration project.

4. ACP supports policies to ensure that Medicare Advantage plans are funded at the level of the traditional Medicare program.

5. 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. Potential adverse impacts of prospectively increasing the age of eligibility could be mitigated by including a Medicare buy-in option (with income-based subsidies) for persons aged 55 to the age when they would become eligible for Medicare, by providing access and public income-based subsidies to buy coverage from qualified health plans offered through health exchanges, by providing access to Medicaid for persons up to 133% of the federal poverty level, and by reinsurance programs to encourage employer-based coverage.

6. ACP supports continuing to gradually increase Medicare premiums for wealthier beneficiaries as well as modest increases in the payroll tax to fund the Medicare program.

7. Congress should consider giving Medicare authority to redesign benefits, coverage, and cost-sharing to include consideration of the value of the care being provided based on evidence of clinical effectiveness and cost considerations.
a. ACP supports the concept of "value-based" insurance plans that vary the degree of patient cost-sharing based on the results of research on comparative effectiveness. Under such a proposal, patients would be encouraged to use health care resources wisely by varying patient cost-sharing levels so that services with greater value, based on a review of the evidence, have lower cost-sharing levels than those with less value. Although everyone should be guaranteed access to affordable, essential, and evidence-based benefits, persons should be able to obtain and purchase additional health care services and coverage at their own expense. However, physicians and other health care professionals should not be oblig-

ated to provide services that are unnecessary, inappropriate, harmful, and/or unproven even if the patient requests to pay for such services out-of-pocket.[3]

1). For such a program to be successful, stakeholders must work to educate physicians and other health professionals and their patients about high-value services, and encourage shared decision-making and use of patient decision aids to promote utilization of such services. Further, comparative effectiveness research should be pursued and given priority for federal funding to provide stakeholders with objective information on procedures and products of high or limited value.

b. A coordinated, independent, and evidence-based assessment process should be created to analyze the costs and clinical benefits of new medical technology before it enters the market, including comparisons with existing technologies. Such information should be incorporated into approval, coverage, payment, and plan benefit decisions by Medicare and other payers. The assessment process should balance the need to inform decisions on coverage and resource planning and allocation with the need to ensure that such research does not limit the development and diffusion of new technology of value to patients and clinicians or stifle innovation by making it too difficult for new technologies to gain approval. Coverage of tests and procedures should not be denied solely on the basis of cost-effectiveness ratios; coverage decisions should reflect evidence of appropriate utilization and clinical effectiveness. Useful information about the effectiveness and outcomes of technology and public education should be widely disseminated to reduce patient and physician demand for technologies of unproven benefit.[4]

c. Medicare should explore and pilot-test new ways to establish the pricing of physician services as part of new value-based payment models established with clear policy goals in mind, such as basing payment on evidence of value, so that high-value services would be paid more and lower-value services would be paid less.[5]

8. ACP supports combining Medicare Parts A and B with a single deductible under the following circumstances:

a. Specified primary care, preventive and screening procedures of high value based on evidence are not subject to the deductible, and no co-insurance or co-payments would apply;

b. A limit is placed on total out-of-pocket expenses that a beneficiary may incur in a calendar year (i.e., stop-loss coverage);

c. The deductible is set at an actuarially appropriate level that does not cause an undue financial burden on beneficiaries, especially lower-income beneficiaries; and

d. Medicare payment levels to physicians for covered primary care and preventive benefits are adequate to ensure that beneficiaries have access to such services, the payment rates cover physicians' resource costs (including annual increases in the costs of providing services due to inflation), and adequate annual updates are issued that are fair and predictable.

9. 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. Preventive procedures, such as those rated an A or B by the United States Preventive Services Task Force, should be exempt from cost-sharing. Any changes made to the structure of Medigap plans should be made prospectively and not affect existing beneficiaries.

10. 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.
- **a. Voluntary advanced care planning should be covered and reimbursed by Medicare to encourage patient-physician engagement and ensure that patients are informed of their palliative and hospice care options. Medicare should permit subsequent counseling sessions so patients and their physicians may adjust their advance care plans as needed to reflect changes in care preferences. Physicians and their patients should not be required to conduct such counseling.**
- **b. Palliative and hospice care services should be integrated across the health care spectrum, including such innovative delivery models as the patient-centered medical home.**
- **c. The federal government and other stakeholders must improve consumer knowledge about advanced care planning, palliative, and hospice care options.**
- **d. Racial and ethnic disparities related to palliative and hospice care must be addressed.**

11. 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.
- **a. Drug manufacturers should be required to provide a rebate to low-income Medicare patients enrolled in Part D.**
- **b. Congress should give Medicare the authority to negotiate the price of drugs offered under Part D, similar to the authority that the Veterans Administration has to negotiate the price of drugs for veterans.**

12. Congress should amend the authority for an Independent Payment Advisory Board (IPAB) to:
- **a. Allow Congress to override IPAB recommendations with a majority rather than a supermajority vote before they go into effect.**
- **b. Require that the IPAB include among its membership a physician who provides comprehensive and primary care services. The existing prohibition on members of the Commission having outside employment should be modified to create an exception for physicians involved in direct patient care.**
- **c. Eliminate the requirement that IPAB must produce recommendations for a specified level of savings if a target rate of allowable growth is exceeded. The board should have the discretion to recommend higher or lower savings targets**

based on its judgment of the best approach to reducing spending while ensuring continued access to care.

d. Ensure that savings obtained through IPAB recommendations and implementation either improve or at least maintain the quality of care provided. Budgetary savings founded on reduced quality is short-sighted and inappropriate.

e. Authorize that the IPAB consider all Medicare providers and suppliers when developing payment delivery and expenditures change proposals. The existing prohibition on IPAB making recommendations relating to certain providers (e.g., hospitals) through the end of this decade should be lifted. Payment delivery and reduction changes should not be the burden of a restricted number of Medicare clinicians, providers, and suppliers.

f. Broaden IPAB's scope of potential policy recommendations to include changes in benefits, cost-sharing, revenue, and payment and delivery system reforms, not limited to physicians.

Background

Context for Medicare Reform

Over the past 30 years, Medicare per capita spending has grown at a faster rate than the gross domestic product (GDP).[2] Medicare will see drastic changes in the coming decades, primarily driven by the aging of the population (e.g., more Baby Boomers entering the program) and rising per capita health care costs.[6] Without major changes to the delivery system and the financial structure, Medicare spending will continue to grow unabated. In FY2010, Medicare's total expenditures were $546 billion. The CBO estimates that expenditures will be $949 billion in 2020. Below is a brief outline of the primary challenges faced by the program and provides the context of why major reform is needed.

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.[7] Life expectancy at age 65 has improved substantially over the past 70 years. A 65-year-old in 1940 expected to live another 14 years whereas today's 65-year-old can expect to live an average of 20 years longer.[6] While this indicates great improvement in access to medical services and new technologies, it also means that Medicare must finance care for an exceedingly older population. As individuals age, they typically require more medical attention; in 2006, annual per capita Medicare spending for enrollees age 65 to 74 was about $6,000. For those age 80 and older, annual per capita spending was more than $12,000.[8] The Baby Boomer generation began enrolling in Medicare in 2011. As a result of this influx, total Medicare enrollment will reach 80 million in 2030, compared with half that number in 2000.[8]

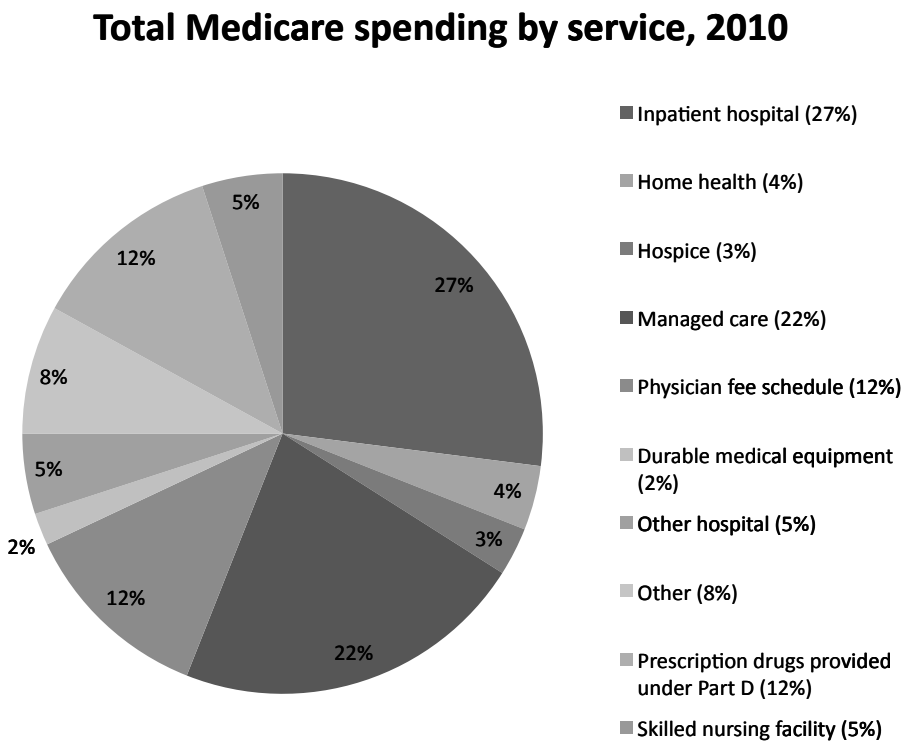
Rising chronic disease rates will continue to hamper Medicare cost control efforts. Over the past 20 years, Medicare spending growth was centered on inpatient hospital care; now, chronic conditions like hypertension, diabetes, and hyperlipidemia are prevalent cost drivers.[9] Half of Medicare enrollees with

multiple chronic diseases may account for up to 96% of annual Medicare spending.[10] Obesity is of particular concern as over 30% of current Medicare beneficiaries are obese.[11] Obese elderly individuals have fewer disability-free years of life than normal-weight elderly individuals, and Medicare spending for an obese individual is 35% higher than for a normal-weight beneficiary.[12]

Medicare financing structure

The aging population and their subsequent retirement create an additional problem, as fewer workers will be contributing to the Medicare program through worker payroll taxes. Medicare Part A (hospital insurance) is funded by payroll taxes; Part B is funded through enrollee premiums and the general federal tax revenue. Over the next 20 years, estimates show that payroll taxes will not keep pace with Medicare program spending, leading to inevitable shortfalls. According to the Kaiser Family Foundation, the ratio of workers per beneficiary will be 2.3 in 2030, down from 4.0 in 2000.[8] A slow economic recovery has also had a punitive effect on the trust fund, since fewer workers contribute payroll taxes.[13]

The Supplemental Medical Insurance (SMI) Trust Fund, which provides general revenue funding for Medicare Part B and D (along with beneficiary premium contributions), cannot become insolvent but is affected by growing medical costs. As health care costs rise, Medicare premiums and/or taxes would have to be increased to meet the demand. According to the Medicare Board of Trustees, the aging population and growing health care costs will push up SMI costs from 1.9% GDP in 2010 to about 3.4% GDP in 2035. Costs are



Source: MedPAC. A Data Book: Health Care Spending and the Medicare Program. MedPAC. June 2011.

estimated to balloon to about 4.1% of GDP by 2085.[9] Unless costs are curbed, Part B and D premiums will consume a greater share of beneficiary's Social Security payment, from 27% of the average monthly benefit in 2010 to 50% in 2080.[8] Alternatively, a greater share of federal general revenues would be devoted to offset the rising costs of Medicare Part B and D.

Technological advancements and price issues

According to the Medicare Payment Advisory Commission (MedPAC), a significant share of growth in health care costs can be attributed to advancements in technology and growth in prices. While new medical technologies often produce substantial benefits to patients (and in some instances may reduce costs), some may inadvertently replace existing, less expensive technology of comparable clinical effectiveness. Since health insurance insulates patients from the cost of expensive new technology, patients may not seek the most cost-effective, high-value intervention, potentially receiving an unnecessary or inefficient service. Further, new technology may be adopted by the medical community before its clinical effectiveness is fully realized. A literature review conducted by the CBO concluded that some new medical technologies could be used sparingly without undermining clinical value.[14] To help physicians and other health professionals decide which services and products would be most valuable to their patients, the ACA established the Patient-Centered Outcomes Research Institute to coordinate funding for comparative effectiveness research. The goal of comparative effectiveness research is to determine the benefits and potential downsides of similar procedures and products. With this research it is hoped that physicians and other health care providers will be better prepared to deliver high-value care that will improve patient health while slowing spending growth.

For certain services and products, Medicare's payment structure fails to reflect market value. For instance, Medicare pays for some durable medical equipment products using indexed administrative prices from 3 decades ago. Under this structure, Medicare pays over $3,600 for a mobility device that can be purchased for $1,300 from an Internet dealer.[15] Medicare has recently initiated competitive bidding for durable medical equipment in select areas in an effort to lower prices and alleviate price distortions created by the antiquated index payment structure.

Coverage and benefit determinations

Medicare's benefit structure may also accelerate growth in health care costs. While 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.[16] Seventeen percent of beneficiaries purchase Medigap supplemental insurance policies, and about 60% of those enrollees purchase a plan that nearly eliminates their cost-sharing for hospital, physician, hospice, and skilled nursing facility care.[60] This protection may encourage beneficiaries to receive unnecessary care; for instance, spending on elective admissions to inpatient hospitals is substantially higher for those with supplemental insurance than for those without it.[1]

Medicare's benefit design does little to encourage use of high-value services. The fee-for-service structure, which allows for unrestricted access to services covered under the Medicare statute, inadvertently incentivizes high-volume care rather than high-value care. Outside of the out-of-pocket

responsibilities (which are often reduced by supplemental coverage), beneficiaries have little financial reason to limit the volume or intensity of the care they receive or shop around for a high-quality provider.[17] The ACA seeks to change this by eliminating cost-sharing for certain primary care services that are deemed high-value by the United States Preventive Services Task Force.

Payment structure

Medicare's fee-for-service structure inadvertently rewards physicians and many other health care providers for delivering a high volume of services regardless of their value or cost-effectiveness.[1] As long as Medicare covers a procedure, the program will pay physicians and other providers for the services they deliver; therefore, it is financially beneficial for physicians and other providers to order a high volume of services. This has also led to an imbalance in the health care work force, where certain lucrative medical specialties attract physicians at the expense of primary care specialties. Similarly, crucial primary care cognitive services (such as physician office visits, home visits, skilled nursing facility visits) that strengthen the patient-physician relationship are undervalued compared with procedure-based care.[18] According to MedPAC, primary care services "do not lend themselves to efficiency gains" since patient examinations and counseling, care coordination efforts, and other patient evaluation and management activities take considerable time that is not adequately reflected in the Medicare physician fee schedule. It is difficult for a primary care physician to increase efficiency in delivering cognitive services; in contrast, many procedures can be made more efficient with improvements in technology or means of delivery. While many private insurers have integrated performance assessment-based payment into their reimbursement models, such methods are not widespread in traditional fee-for-service Medicare.[1] Limited information on provider performance is available to patients, hindering their ability to seek high-quality physicians and other health care providers.

Fee-for-service also fails to encourage care coordination among providers, further fragmenting the delivery of care and encouraging inefficiency.[19] This problem is aggravated in part because of the "silo" nature of Medicare financing that prevents physicians and hospitals from effectively working together, providing accountability and sharing savings. Medicare is implementing a number of demonstration projects and pilots that seek to improve coordination among providers across the health care spectrum, such as the Post Acute Care Payment Reform demonstration, the Accountable Care Organization pilot, and the Acute Care Episodes demonstration.[20]

Joint Select Committee on Deficit Reduction

With the recent emphasis on fiscal austerity, a range of commission and Congressional proposals have been circulated that recommend tightening Medicare benefits. Signed into law in August 2011, the Budget Control Act of 2011 established the Joint Select Committee on Deficit Reduction (also known as the "super committee"), a bipartisan and bicameral commission charged with finding ways to reduce the projected deficit by $1.2 trillion from FY2012 to FY2021. Although the Committee was required to draft and vote on a proposal by November 23, 2011, it failed to reach an agreement and thus did not approve and send a deficit-reduction plan to Congress. As a result, the Office of Personnel Management is required to reduce federal expenditures to an amount that will achieve the $1.2 trillion threshold. This will lead to auto-

matic, across-the-board cuts to the federal budget that will affect defense spending and nondefense programs, such as Medicare. These across-the-board cuts could slash Medicare spending by up to 2% per year beginning in 2013. Cuts to the Medicare program can only be made to provider and plan payments and cannot directly increase Medicare premiums or copay amounts, although they may indirectly lead to increases in out-of-pocket costs for beneficiaries.[5,21]

Prominent Medicare Reform Proposals

Bipartisan Policy Center (Domenici-Rivlin Plan)

The Debt Reduction Task Force of the Bipartisan Policy Center released the *Restoring America's Future* report.[22] The report, helmed by former Senator Pete Domenici (R-NM) and founding CBO director Dr. Alice Rivlin, seeks to fundamentally change the Medicare program in the interest of long-term fiscal solvency. For 2012, the proposal calls for an increase in Medicare Part B premiums from 25% to 35% of total program costs over 5 years; protections for low-income beneficiaries (e.g., dual eligibles) will remain intact. The plan recommends applying Medicaid rebate requirements on single-source drugs covered under Part D.

Regarding cost-sharing, the proposal suggests a combined Part A and B deductible of $560 in 2011, a coinsurance rate of 20% after the deductible is met, and an out-of-pocket cap of $5,250. The benefit structure would be reevaluated every 2 years by the IPAB created by the ACA. The IPAB would also make recommendations on benefit changes that would become law unless Congress intervenes. Savings would be garnered, for instance, by a reduced need for Medigap policies, since new catastrophic care protections would be established.

The report recommends a partial transformation of Medicare from a defined benefit system to a premium support model with the option for beneficiaries to remain in traditional Medicare. Beginning in 2018, the federal contribution towards benefits per beneficiary would be limited to the 2017 level and would be allowed to grow no faster than a 5-year moving average of GDP growth plus one percentage point. Beneficiaries would be able to choose to remain in fee-for-service Medicare; however, if federal spending per beneficiary "for the benefits specified in the legislation" increases beyond the rate of GDP + 1%, the beneficiary would have to pay additional cost-sharing to make up the difference. Like the Ryan plan, private coverage would be offered in a Medicare Exchange. The proposal predicts cost-savings from capping the allotment and potential increased competition among private and FFS insurance options. If private plans reduce costs, they would be able to direct a portion of the savings toward reducing premiums.

Additionally, the report proposes facilitating transfer of dual eligibles into Medicaid-managed care plans.

Heritage Foundation Premium Support Model

The Heritage Foundation think tank has proposed a defined contribution plan based on the Federal Employees Health Benefits Program (FEHBP). The proposal would unify Medicare's hospital, physician services, and pre-

scription drug benefits and add a catastrophic cap. The government's contribution to beneficiary premiums would be determined through a regional competitive bidding process among private and traditional Medicare plans. Plans could also be permitted to compete on a national level. Initially, the government would contribute 88% of the weighted average premium for the region. After 5 years, the government's contribution would be tied to the bid of the lowest-cost plan (the proposal also states that the contribution could be pinned at the average bid of numerous lower-cost plans in the area). Premiums could not vary by age or health status, similar to current Medicare Advantage rules. The government contribution would be income-adjusted; individuals with incomes of $55,000 and married couples with incomes of $110,000 would receive lower contributions while individuals with incomes of $110,000 and married couples with incomes of $165,000 would receive no contribution. Increases in the annual contribution would be capped at the rate of consumer price index (CPI) plus 1%. If Medicare program costs rose at a rate faster than the cap, the premium contribution would be proportionately reduced.

Rather than require plans to cover the Medicare benefit package, the Heritage proposal would create an entity to provide plan oversight and ensure that plans provide a range of benefit categories, such as hospitalization, physician services, and catastrophic protection. Further, plans would have to be actuarially equivalent to the combined Medicare A, B, and D package in the bidding process.[23]

National Commission on Fiscal Responsibility and Reform "Moment of Truth" Proposal

The White House's National Commission on Fiscal Responsibility and Reform (Fiscal Commission), co-chaired by former U.S. Senator Alan Simpson (R-WY) and former White House Chief of Staff Erskine Bowles, released a comprehensive deficit-reduction plan in December 2010.[24] The plan proposes a number of changes to Medicare's scope of coverage. The proposal calls for reform of the cost-sharing structure, particularly creating a single merged $550 deductible for Parts A and B and a 20% uniform coinsurance on health spending after the deductible is met. Out-of-pocket spending would be capped at $7,500 and the co-insurance rate would be lowered to 5% after cost-sharing exceeds the $5,500 threshold.

The Fiscal Commission also recommended that Medigap (private Medicare supplemental policies) eliminate first-dollar coverage, exposing Medigap policyholders to the first $500 of cost-sharing responsibilities. According to the Commission, cost-savings would be generated in part by reducing overutilization that may be encouraged by first-dollar coverage. The Commission also recommends extending Medicaid drug rebates to dual-eligibles in Part D.

The plan also proposes establishing global spending targets for federal health insurance programs of GDP + 1%. If spending rises at a faster rate, premium support or other changes will be considered.

Rep. Paul Ryan's Path to Prosperity/Ryan-Wyden Proposal

In April 2011, House Budget Committee Chairman Paul Ryan released the Path to Prosperity budget proposal, a deficit-reduction plan that sought to cut spending on everything from Social Security to defense. Following introduc-

tion, the House of Representatives approved the budget by a vote of 235-193. The proposal would dramatically transform the Medicare program from a defined benefit to a defined contribution (or premium support) system.

Starting in 2022, Medicare beneficiaries would choose among private insurance plans sold in a Medicare Health Insurance Exchange. The federal government would direct a capped allotment to the private insurance plan to offset the cost of providing coverage. According to CBO, the payment for 65-year-olds in 2022 would be $8,000, on average. In subsequent years the level of the allotment would increase at the rate of inflation (CPI-U). The individual amount would also potentially vary based on age, health status, and other factors. Allotment amounts also reflect beneficiaries' income. Wealthy beneficiaries would receive a smaller premium support payment than lower-income individuals.

Plans competing in the exchange would have to comply with benefit requirements established by the Office of Personnel Management. A risk-adjustment mechanism would be applied to shift payments from insurance plans with predominately healthy enrollees to those with less healthy enrollees. Medicare beneficiaries enrolled prior to 2022 would have the option of remaining in traditional Medicare or purchasing private insurance with aid of the premium support assistance.

Beginning in 2022, the proposal would gradually increase the Medicare eligibility age to 67. The proposal would establish a medical savings account (MSA) for low-income Medicare beneficiaries (e.g., those who would currently be eligible for both Medicare and Medicaid). In 2022, the federal government's contribution to the MSA would be $7,800 and would increase annually based on the CPI-U index.

Ryan-Wyden Proposal

On December 15, 2011, House Budget Committee Chairman Paul Ryan and Senator Ron Wyden (D-OR) released a modified version of the defined contribution proposal presented in the Path to Prosperity plan. Under the new model, future Medicare beneficiaries turning 65 in 2022 would be given a choice to enroll in private plans or the traditional Medicare plan offered in a regulated Medicare Exchange. Private and Medicare fee-for-service plans would submit bids to determine the benchmark. The second-least expensive plan or fee-for-service Medicare, whichever is cheaper, would be the benchmark plan for that area and represent the government's financial contribution. As with most premium support plans, the beneficiary would pay more for a plan priced above the benchmark and receive a rebate for plans priced below the benchmark. Insurance plans would be risk-adjusted and geographically rated. At a minimum, private plans would be required to offer the actuarial equivalent of the Medicare fee-for-service benefit package.

If competitive bidding among plans fails to produce significant cost savings, program growth after 2022 would be restricted to the level of GDP plus 1%. Should this occur, dual-eligibles would continue to have Medicaid pay for their cost-sharing and lower-income Medicare beneficiaries would be provided fully-funded accounts to assist with increased cost sharing. Additionally, Congress would be required to adjust provider reimbursements, program overhead, and means-tested premiums in the event that program cost exceeds GDP plus 1%.[25] According to a Center for Budget and Policy Priorities analysis, the federal contribution growth would be limited to GDP plus 1% per

capita, and contributions to beneficiaries would be reduced over time unless Congress took action to make other Medicare cuts.[26]

Proposed Recommendations

1. **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 that improve population health, enhance the patient experience, and reduce per-beneficiary cost. Medicare must encourage patient-centered, coordinated, cost-conscious care (including access to a patient's primary care physician and specialists/subspecialists based on their health care needs); health information technology; collaboration across health care sectors; comparative effectiveness research; and other reforms that result in improved care for beneficiaries. Changes to the Medicare benefit structure should not increase the administrative burden on physicians and other health care professionals.**

The College believes that the solvency of the Medicare program can only be achieved through a systemic change in the way health care is delivered and benefits are structured. According to MedPAC, the primary drivers of health care costs are technological advances, rising prices on health care goods and services, the enhanced generosity of health care benefits, certain provider payment incentives, and industry consolidation.[27] Future growth will be driven in part by changing demographics and rising income and wealth. In ACP's *Controlling Health Care Costs While Promoting the Best Possible Health Outcomes*, the College offers a number of recommendations on how to achieve cost-savings while promoting high-quality care, such as enhancing and coordinating technology assessments, enhancing use of health information technology, encouraging cost-consciousness and patient involvement through shared-decision making, appropriate payment for health care services, accurate pricing of services, controlling administrative costs, balancing the physician workforce mix, cost controls through tort reform, encouraging wellness, and prevention and chronic disease management.[4] While the complex issue of delivery system reform is largely outside of the scope of this paper, ACP supports reforming the health care system as a whole to promote innovations, such as the patient-centered medical home, a model that encourages preventive care, stronger provider coordination, and improved physician–patient relationships, resulting in higher patient satisfaction, better health outcomes and lower health care costs.

Changes made to the Medicare program should not increase the administrative burden of physicians and other health professionals. Physicians already face a wide range of administrative hurdles that divert financial resources and staff attention away from patient care. About 12% of physicians' net patient service revenue is directed toward administrative complexities.[28] Most of this loss is attributed to time spent by physicians and their staff communicating with payers over treatment plans, referrals, diagnoses, prescriptions, and other issues.[10] Another study determined that $82,975 is spent per physician per year on administrative costs, a figure that includes all payers, including Medicare.[29] Benefit management techniques, such as prior authorizations for prescription drugs provided under the Medicare benefit, may delay or restrict patient access to necessary drugs as well as add to the administrative burden incurred by

physicians and their staff. A survey conducted by the American Medical Association found that almost 70% of physicians had to wait several days to receive approval for services requiring prior authorization and that 10% of physicians reported having to wait over a week.[30] Existing ACP policy supports requesting that an entity, such as the Institute of Medicine, study the issue of administrative costs, paperwork documentation, and medical authorization rules across the health care system and make recommendations on how the amount of time spent on such activities can be reduced, particularly for primary care physicians.

The College has also endorsed the establishment of a national, multi-stakeholder initiative to reduce marginal and ineffective care and promote high-value health care. Such an initiative would involve stakeholders from medical societies, health plans, federal agencies such as CMS, consumer groups, experts on shared decision-making to design a comprehensive national strategy to promote use of high-value services and products while minimizing use of those determined to be low-value. In developing such a reform strategy ACP recommends a range of innovative ideas designed to accelerate the reform of our health care system into an efficient model that promotes high-quality, high-value care. One recommendation is to provide patients and clinicians with comparative effectiveness information. CBO estimates that technological advancements contribute to half of all health care spending growth.[31] Comparative effectiveness research will help physicians and other health care providers determine which goods and services meet the patient's needs, whether they are the latest clinical intervention or a time-tested service. This focus on evidence-based medicine may lead physicians and other health care providers to limit use of ineffective interventions, potentially leading to reduced costs and better outcomes. According to *the Economics of Smarter Health Care Spending*, "perhaps the most important contribution that public policy could make to system-wide efficiency would be to generate more information—for both patients and providers—about what care is in fact high value."[32] Further efforts to expand use of value-based insurance plans, improve the way health care is delivered, and reform the medical liability system, would also be developed in the stakeholder plan. Successful implementation of these and other initiatives to promote high-value care could lead to substantial cost-savings and great improvements in the health of the nation. By providing the right kind of incentives to clinicians, hospitals, and other providers, the United States could save up to 50% of total health care spending.[11] Medicare is at the core of this paradigm shift to improve the way health care is delivered for all patients. While cost-shifting and drastic provider payment cuts may achieve some savings, efforts to encourage high-quality care within Medicare will have a more positive effect on patient health and the fiscal health of the nation.

2. **To improve the way health care is delivered and ensure the future of primary care, the College recommends that Medicare accelerate adoption of the patient centered medical home model and provide severity-adjusted monthly bundled care coordination payments, prospective payments per eligible patient, fee-for-service payments for visits, and performance assessment–based payments tied to quality, patient satisfaction, and efficiency measures. Additionally, new payment models should avoid the volume-oriented fee-for-service system in favor of approaches that are aligned with quality and efficiency, such as episode of care payments and accountable care organizations.**

Medicare's payment system is in need of reform. According to MedPAC, the Medicare physician payment system "continues to call for unrealistically steep fee cuts, it inherently rewards volume over quality and efficiency, and it favors procedural services over primary care, which has serious implications for the nation's future primary care workforce."[33] The sustainable growth rate (SGR) formula, on which Medicare payment updates are based, is a deeply flawed mechanism that fails to control Medicare spending growth and has attracted critics from across the health care landscape. The SGR intends to provide lower payment updates when overall Medicare physician spending grows faster than the target growth rate. However, the SGR fails to incentivize physicians to limit superfluous services or reward those who provide high-value care. MedPAC has acknowledged the limitations of the SGR and has repeatedly called for its repeal. Congress has acted to counter SGR-initiated payment reductions, providing temporary funding patches to avoid drastic reductions in physician payments. Without Congressional intervention, the SGR would have automatically reduced physician fee schedule payments by 30% in 2012.[32] Repeal of the SGR is costly; without action the cost of repeal is estimated to reach $600 billion in 2016.[34]

The College has long advocated for efforts to reform the Medicare physician payment structure. In 2011, ACP called for a repeal of the SGR, stable updates for 5 years with higher updates for primary care services, implementation and evaluation of innovative payment models (such as the patient-centered medical home), and a set date to implement payment methods proven to encourage delivery of high-value care.[35] Substantial change will take time but the introduction of payments for services like phone and email consultations, non–face-to-face patient interactions, and transition of care activities, within the existing fee-for-service system will facilitate the movement toward high-value payment models. Payment reform, along with the delivery system reforms outlined in Recommendation 1, will help slow Medicare spending growth and improve the quality of care delivered to beneficiaries. The ACA established the Center for Medicare and Medicaid Innovation to test and evaluate new models of payment and care delivery. Demonstration projects initiated through the CMMI are not required to be budget neutral and can be implemented by CMS without further legislative approval if deemed effective. Among the payment reforms to be tested are salary-based payment for primary care practices and community-based health teams.

3. **ACP does not support conversion of the existing Medicare defined benefits program to a defined contribution model. However, ACP could support 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. Such a demonstration project would offer beneficiaries a choice between traditional Medicare and qualified premium support plans offered through the private sector, subject to Medicare requirements relating to benefits, cost-sharing, access to services, and premiums, while providing financial support to cover the Medicare benefit package. Such a demonstration project should:**
    a. **Utilize risk-adjustment mechanisms to protect against adverse selection.**
    b. **Provide a standard benefit package equal to that of fee-for-service Medicare that includes preventive and primary care**

services without cost-sharing. Cost-sharing levels may vary but should reflect the actuarial value of traditional Medicare.

c. Apply network adequacy standards that ensure beneficiaries have access to a sufficient network of providers, including a means for beneficiaries to access out-of-network providers at no additional cost if they are unable to receive medically necessary care though their existing network.

d. Promote innovative delivery system models, such as the patient-centered medical home, among the participating fee-for-service Medicare and private plans

e. Provide stringent oversight of health plan marketing activities to prevent cherry picking and risk selection. A government entity or non-profit organization should be authorized to provide outreach and objective educational assistance to beneficiaries.

f. The initial per capita federal contribution should be based on the average bid in a geographic area for a coordinated care plan providing the Medicare benefit package. The per capita Medicare expenditure level for that area may represent the fee-for-service bid. Subsequent federal contribution levels should rise with the average coordinated care plan premium (providing at least the Medicare benefit package) for that geographic area.

g. Dual eligible beneficiaries should be exempt from participating in the demonstration project.

The College recognizes the daunting problem of health care spending and has recommended a range of proposals to address health care costs in *Controlling Health Care Costs While Promoting the Best Possible Health Outcomes* and other policy papers. Numerous deficit-reduction plans have been presented by various commissions and members of Congress. A number of these recommend transforming Medicare into a *defined contribution* plan, where the government would provide a fixed financial subsidy toward the purchase of health insurance. This is a dramatic shift from Medicare's existing *defined benefit* structure, which ensures that beneficiaries will receive a statutorily established benefit package largely paid for by the government.

Some defined contribution plans are mislabeled as "premium support" proposals; however, the term "premium support" was coined by economists Henry Aaron and Robert Reischauer to describe a form of defined contribution for a defined benefit package where the federal contribution would rise with health care costs, as opposed to an unrelated inflation or economic index. Over the last 15 years, numerous proposals have suggested converting Medicare into a defined contribution program. Typical features of recent proposals include:

- A regulated marketplace established in a defined geographic area through which Medicare beneficiaries purchase private insurance (or if offered, traditional fee-for-service Medicare).
- A standard benefits package that all plans are required to provide beneficiaries. Some proposals would require the benefits package to be actuarially equivalent to that of fee-for-service Medicare.
- A public or private oversight authority to review insurance plan bids, monitor marketing practices, and assist enrollees in choosing an insurance plan.

- A formula to determine the initial contribution amount as well as a method of determining how this amount will be updated. This is a key difference among plans. Aaron and Reischauer's original premium support plan tied updates to health care costs. The Domenici/Rivlin plan uses an index related to the GDP, and the Ryan *Path to Prosperity* proposal would tie updates to the CPI. Since the latter two plans would peg updates to an index unrelated to health care costs, they are similar to defined contribution.
- A method for adjusting the contribution to reflect age, health status, and geographic differences, among other factors. Risk-adjustment methods that provide additional compensation to plans with a disproportionate number of sick enrollees are another important characteristic of premium support proposals.[36]

Medicare beneficiaries—the aged and the disabled—represent a vulnerable and complex demographic. A defined contribution model would cap the amount of financial assistance provided by the government, and if designed to maximize cost-savings, could potentially force seniors and the disabled to pay significantly more for their health care while doing little to slow the rise in health care sector costs. Under the *Path to Prosperity* proposal, a typical Medicare beneficiary with middle-income and average health care needs for their age would be responsible for an average of 68% of Medicare benchmark (a insurance plan that would provide the equivalent of Part A, B, and D benefits) by 2030.[37] Beneficiaries currently pay around 25% of the Medicare premium, part of an out-of-pocket responsibility that is significantly higher than a typical large employer health plan.[38] Most important, updates to the financial assistance level would probably be insufficient because health care costs would rise faster than the rates of inflation and GDP, economic indexes to which premium support adjustments are often pegged.

The College does not support transforming Medicare into a *defined contribution voucher* program, where the federal government would provide beneficiaries with a fixed voucher to purchase health insurance that is not required to provide a comprehensive benefit package. As ACP stated in 1999, "the College has strong practical and philosophical objections to converting Medicare to a defined contribution program." However, the College could support establishing a demonstration project to test a defined benefit premium support option, with sufficient funding for beneficiaries to purchase a plan in their area that covers a defined benefit package while encouraging prudent use of health care services. Most prominent defined contribution models would update the government contribution based on an index independent of health care costs. Such policy would undoubtedly reduce government expenditures but also shift an ever-increasing financial burden to beneficiaries. In creating a defined benefit voucher program, the government's financial contribution must grow at least as fast as the cost of premiums for plans providing the defined Medicare benefit package. A number of important safeguards must be ingrained in the demonstration project, including a financial contribution to cover a Medicare-equivalent benefit package for that geographic area, a minimum benefit package based on that of traditional Medicare, a robust risk-adjustment mechanism to mitigate adverse selection and protect vulnerable beneficiaries, culturally and linguistically competent outreach and education efforts to apprise all beneficiaries of their options, strong oversight of insurer marketing activities, and cost-sharing assistance to low-income beneficiaries, among others.

In testing a defined benefit premium support model, one approach would be to peg the federal contribution to the average coordinated care plan bid in

the area, such as a preferred provider organization, to establish a benchmark. This bid would represent the cost of providing the defined benefit package (e.g., Parts A, B, and D of Medicare). If the fee-for-service plan bid exceeded the cost of the average coordinated care plan, beneficiaries would pay the difference through cost-sharing or other means.[39] This approach differs from the existing Medicare Advantage payment structure in that the benchmarks are determined by competitive bidding, rather than an administratively set benchmark, and that traditional fee-for-service would place a bid along with private plans. This structure somewhat reflects the defined benefit voucher program proposed by the Progressive Policy Institute in the late 1990s, which was outlined in ACP's paper *Converting Medicare to a Defined Contribution Program.*[40,21] Such an approach may protect beneficiaries' ability to remain in fee-for-service Medicare, a plan that disproportionately attracts sicker and older individuals.[41] Other models, such as the Domenici-Rivlin approach, which would base the benchmark on the second-least expensive private plan or fee-for-service Medicare, whichever is lower, may achieve greater savings. Establishing competitive bids in distinct geographic areas would also ensure that premiums reflect the local market, a safeguard that would provide a sufficient financial contribution to beneficiaries living in areas where fee-for-service costs are historically high. Such a structure may also encourage insurers to offer plans in underserved urban and sparsely populated rural areas.[42] More important, these approaches would guarantee that beneficiaries would be able to purchase a plan that is equivalent to the Medicare defined benefit package without imposing a hefty cost-sharing burden.[43] Premiums for demonstration program enrollees should be community rated. This will help ensure that older, sicker Medicare beneficiaries are not forced to pay disproportionately high premiums because of their health status.

Over the last 25 years, the CPI has grown half as fast as annual Medicare spending per beneficiary. Other indices have grown at rates closer to that of Medicare (CPI-Medical at 5.1%, GDP+1 6.2%, national per capita health spending 6.3%) but would still result in shifting cost increases to Medicare beneficiaries.[37] Therefore, in a defined benefit voucher demonstration program, the government's contribution must rise to reflect medical costs and sufficiently cover the mandated benefit package in each area. Since medical costs rise at a faster rate than inflation, basing subsidy amounts on the CPI or the growth in GDP per capita plus one percentage point will aggressively reduce the deficit but fail to match the rate of health care cost growth, potentially leaving beneficiaries to finance a growing portion of the burden.[44] In a defined benefit premium support program, savings would be garnered though regulated competitive bidding among private plans and traditional fee-for-service, not by arbitrarily shifting costs to beneficiaries.

The current Medicare Advantage system provides insight into the potential for cherry-picking and adverse selection in the premium support model. The Government Accountability Office found that whether intentional or not, some Medicare Advantage plans with lower premiums, higher deductibles, and benefits like fitness center memberships, attracted lower-risk beneficiaries.[45,46] In designing a defined benefit premium support demonstration project, numerous regulations would need to be established to prevent adverse selection, leading to higher premiums for those who choose fee-for-service Medicare or other comprehensive plans. Plans should be prevented from offering benefits that attract healthier enrollees (conversely, such benefits, as long as they are evidence-based, may be integrated into the standard benefit package) and be subject to strong risk-adjustment mechanisms that support the viability of plans that enroll a disproportionate number of sick individuals, such

as traditional fee-for-service Medicare. This is no easy task, as risk-adjustment mechanisms for Medicare Advantage have been somewhat uneven in their effectiveness. The Medicare Modernization Act of 2003 established the Comparative Cost Demonstration project as a means to test competitive bidding among traditional and private Medicare plans. Opponents expressed concern that risk-adjustment tools would fail to protect vulnerable enrollees who would make up a disproportionate share of the less-restrictive traditional fee-for-service Medicare plan. Critics feared that the traditional Medicare option would fall victim to severe adverse selection and push sick patients into strict managed care plans. The ACA eliminated the demonstration, which was set to go into effect in 2010.[37]

The premium support model relies on an assumption that seniors will shift toward the most cost-effective plans, such as HMOs, leading to lower costs; however, this is speculative and little is known how low-income beneficiaries or those with complex health care needs would fare under such a system.[47] While HMOs and other managed care arrangements may be able to reduce costs compared to traditional Medicare, the limited provider networks and utilization restrictions may undermine access to providers for some beneficiaries.[48] Evidence shows that older people prefer health plans that cover a wide selection of providers. Within the Medicare Advantage program, HMO plans continue to have the highest share of enrollment, covering about 16% of all Medicare enrollees, but a growing number of Medicare enrollees are choosing preferred provider organization (PPO) plans, which have less restrictive networks and are more costly. From 2009 to 2010, local PPO enrollment increased by 42%, and enrollment in regional PPOs increased by 98%.[49] Similarly, older enrollees in the Federal Employee Health Benefit program tend to choose plans with open networks (and are willing to pay higher premiums for such coverage) rather than managed care plans that restrict choice of providers to improve cost-efficiency.[50] Therefore, health plans must be required to offer a sufficient choice or providers and establish a means for those who cannot access care (such as patients residing in a medically underserved area or long-term care facilities) to solicit care outside of their network, if applicable. A potential model on which to base the network adequacy standard would be the Managed Care Plan Network Adequacy Model Act developed by the National Association of Insurance Commissioners. Additionally, the traditional Medicare package must be integrated into a seamless benefit package so that hospital, physician, and prescription drug benefits are available in a single plan.

The College acknowledges that there are numerous technical and political challenges to initiating a premium support demonstration project. Potential hurdles include the likelihood that beneficiary participation would have to be mandatory to produce meaningful results, the possibility that Congress would prevent implementation of such a demonstration project, the potential for geographically adjusted bids to maintain spending disparities, and beneficiary dissatisfaction in the event that competitive bidding leads to reduced financial support for coverage. Despite these challenges, the College believes it is vitally important that a premium support model be tested to determine possible adverse effects or unintended consequences. Particular attention should be given to such issues as enrollee and provider reaction, plan participation, market effects, premium levels, and barriers to care. If done properly, a defined benefit voucher program may encourage beneficiaries to select coordinated care plans that may promote preventive care, wellness, and better cooperation among physicians and other health providers. However, caution should be

exercised prior to implementing such a significant change in Medicare financing that will affect millions of the nation's elderly and most vulnerable citizens.

4. ACP supports policies to ensure that Medicare Advantage plans are funded at the level of the traditional Medicare program.

Some claim that beneficiaries will have greater choice of coverage options under a Medicare defined contribution system. However, Medicare beneficiaries are already able to choose between traditional Medicare and a range of private Medicare Advantage plans. Some of these plans are able to provide Medicare services at a lower bid level; however, average Medicare Advantage payments are estimated to be 10% higher than traditional Medicare in 2011.[51] This inflated payment formula was established in 2003 in an effort to encourage enrollment in private plans. ACP supports giving Medicare beneficiaries choice in coverage (providing consumer protections, risk-adjustment mechanisms, and other protections are in place), but Medicare Advantage plans should be required to compete with traditional Medicare on an equal footing. The ACA seeks to provide parity between the two programs by lowering payment rates and creating bonus payments for high-quality plans.

The Medicare program must ensure that Medicare Advantage plans meet high quality standards and that patients have access to health plan quality performance information so informed choices can be made. The ACA establishes that Medicare Advantage plans can receive bonus payments if they meet various performance measures grouped in categories, such as preventive care or ability to manage chronic diseases.[52] While it is encouraging that these plans will be eligible for bonus payments for improving quality care to patients, the federal government must ensure that incentives are targeted to plans that achieve the highest level of quality. During the 2012-2014 period, plans that receive 3 stars ("average" rating) will receive a 3% bonus payment; the ACA law states that bonuses should be granted to plans scoring 4 stars or above.[53,54] The federal government should consider eliminating the bonus for plans that only receive 3 stars. This higher standard will ensure that underperforming plans work to enhance their efforts to deliver such crucial services as preventive care, better chronic disease management, and customer interaction.[55]

5. 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. Potential adverse impacts of prospectively increasing the age of eligibility could be mitigated by including a Medicare buy-in option (with income-based subsidies) for persons aged 55 to the age when they would become eligible for Medicare, by providing access and public income-based subsidies to buy coverage from qualified health plans offered through health exchanges, by providing access to Medicaid for persons up to 133% of the federal poverty level, and by reinsurance programs to encourage employer-based coverage.

Some policy makers propose increasing the eligibility age of Medicare to 67, the current age at which one is eligible for full Social Security benefits. Supporters claim that the Medicare eligibility age should be tied to rising life expectancy and that it would reduce spending. It should be noted that increased access to health coverage, such as Medicare, has a positive effect on life

expectancy by improving access to medical services.[56] When Medicare was introduced in 1965, total life expectancy at birth was 70.2 years; in 2006, that number had risen to 77.7 years.[57] While it is true that total life expectancy has risen considerably since Medicare's inception, there are still disparities in life expectancy. In 2006, white women had a life expectancy of 80.6 years, whereas African American women had a life expectancy of 76.5 years. The gulf between white men and African American men is wider, with white men expected to live to the age of 75.7 and African American men until the age of 69.7.[58] According to the CBO, gradually increasing the eligibility age to 67 by 2 months beginning in 2014 would lower federal spending by $124.8 billion from 2012 to 2021.[59] As a means to reduce costs and ensure the solvency of the Medicare program, the College gives qualified support to prospectively increasing the age of Medicare eligibility to 67; however, any changes in the eligibility age must be initiated with care, as was done by gradually phasing-in increases in the Social Security normal retirement age, to ensure that individuals currently approaching the age of Medicare eligibility (e.g., those currently age 55 and above) remain eligible for Medicare coverage beginning at age 65. This also assumes that the coverage and insurance reforms established in the ACA (such as requiring insurers to cover individuals with pre-existing conditions) remain intact or are strengthened. ACP does not support altering the eligibility standards for the under-65 population who are eligible for Medicare due to a disability.

ACP is concerned that increasing the Medicare eligibility age could have a detrimental effect on access to care for the aged and disabled population if improperly implemented, as some individuals would be forced to pay more for care than under traditional Medicare. Employers would be affected because they would have to continue to fund health insurance benefits for older employees, as some would likely delay retirement to maintain coverage. Older individuals have lower median incomes than people under the age of 65.[60] Further, the number of employers offering retiree health insurance has dwindled steadily, potentially forcing retired older adults to seek coverage through the Exchange or other means or to delay retirement altogether. From 1988 to 2006, the percentage of large employers (200 or more employees) offering retiree health insurance declined from 66% to about 35%.[61] Even fewer small businesses offer such benefits.

A Kaiser Family Foundation study estimated, assuming the eligibility age is increased in 2014 with no phase-in period and the ACA remains intact, that federal cost-savings would be muted since Medicaid and Exchange-based plans would have to absorb new enrollees.[62] Those aged 65 and 66 may have difficulty finding affordable insurance compared with Medicare, as two-thirds of beneficiaries would pay higher out-of-pocket costs for private coverage in 2014.[63] One-third would pay lower out-of-pocket cost because they would be eligible for Medicaid or significant income-related tax credits to purchase Exchange-based coverage. Medicare Part B and Exchange-based plan premiums would increase as well.[64] To reflect the needs of the older population, Exchange-based plans may have to expand the definition of "essential benefit package" to ensure that services needed by the elderly are available. Altering the Medicare eligibility age may force seniors to delay retirement, leading to higher costs for employer-based health plans. State Medicaid budgets will also be affected, as Medicaid enrollment would increase under this proposal. Further, removing relatively healthy individuals from the Medicare system may also create adverse selection for the over-67 population, pushing premiums higher for enrollees.

Absent a phased raising of the eligibility age coupled with programs and financial support to make Medicaid coverage available and Exchange-based

plans affordable and comprehensive, a policy increasing the eligibility age will result in a cost-shift to displaced Medicare beneficiaries. To ensure access to comprehensive coverage for older individuals made ineligible for Medicare, tax credits must be adjusted to ensure that Exchange-based coverage is affordable and meets the care needs of the older population. Under the ACA, individuals with incomes up to 400% of the federal poverty level (FPL) are eligible for tax credits to assist with premium costs, but only those with incomes up to 250% FPL will receive financial help to offset out-of-pocket costs. The median income of Medicare beneficiaries is just under 300% FPL; therefore, financial assistance should be enhanced to ensure that out-of-pocket costs are made affordable for the young elderly made ineligible for Medicare. The Kaiser Family Foundation analysis estimates that roughly half of individuals seeking Exchange-based plans will be eligible for financial assistance. This is particularly important for low-income beneficiaries, a disproportionate number of whom are racial and ethnic minorities and/or have multiple chronic illnesses.

Medicare may also establish a buy-in option permitting those aged 55 to 66 to purchase Medicare coverage. Such a program would accommodate those, who for various reasons—including loss of employer health insurance or ill health—have a pressing need for coverage before they would normally become eligible. This buy-in program should reflect the recommendations made in ACP's position paper *Developing a Medicare Buy-in Program*.[65] Also, employers may be incentivized to maintain or expand retiree health insurance by expanding the temporary reinsurance program for such coverage established in the ACA.

6. ACP supports continuing to gradually increase Medicare premiums for wealthier beneficiaries as well as modest increases in the payroll tax to fund the Medicare program.

As the Baby Boomer generation ages and transitions into the Medicare program, program costs are projected to outpace incoming revenue. For instance, the number of workers per beneficiary is expected to drop from 3.4 to 2.3 in 2030.[66] Medicare began charging higher premiums for upper-income Part B beneficiaries in 2007. The ACA also established a provision requiring higher-income beneficiaries to pay more for Medicare Part D.[67] In an effort to raise revenue while protecting benefits, ACP supports judicious increases in Medicare premiums for higher-income beneficiaries. As with any change in the Medicare cost-sharing structure, CMS must closely monitor the potential effect of such changes and how they may affect care for low and high-income beneficiaries.

The ACA also applied a number of changes to the tax system in an effort to increase Medicare revenue. The Medicare payroll tax was increased for individuals with incomes of at least $200,000 and couples with incomes of at least $250,000. The health reform law also established a Medicare tax on high-income people for investment income, such as dividends, capital gains, and royalties.[68,69] As noted, the number of workers per Medicare beneficiary will drop in the next 20 years. To ensure the solvency and continued viability of Medicare, the current workforce will probably need to increase the amount they pay into the Medicare system.

7. Congress should consider giving Medicare authority to redesign benefits, coverage, and cost-sharing to include consideration of the value of the care being provided based on evidence of clinical effectiveness and cost consideration.

a. ACP supports the concept of "value-based" insurance plans that vary the degree of patient cost-sharing based on the results of research on comparative effectiveness. Under such a proposal, patients would be encouraged to use health care resources wisely by varying patient cost-sharing levels so that services with greater value, based on a review of the evidence, have lower cost-sharing levels than those with less value. Although everyone should be guaranteed access to affordable, essential, and evidence-based benefits, persons should be able to obtain and purchase additional health care services and coverage at their own expense. However, physicians and other health care professionals should not be obligated to provide services that are unnecessary, inappropriate, harmful, and/or unproven even if the patient requests to pay for such services out-of-pocket.[70]

i. For such a program to be successful, stakeholders must work to educate physicians and other health professionals and their patients about high-value services, and encourage shared decision-making and use of patient decision aids to promote utilization of such services. Further, comparative effectiveness research should be pursued and given priority for federal funding to provide stakeholders with objective information on procedures and products of high or limited value.

b. A coordinated, independent, and evidence-based assessment process should be created to analyze the costs and clinical benefits of new medical technology before it enters the market, including comparisons with existing technologies. Such information should be incorporated into approval, coverage, payment, and plan benefit decisions by Medicare and other payers. The assessment process should balance the need to inform decisions on coverage and resource planning and allocation with the need to ensure that such research does not limit the development and diffusion of new technology of value to patients and clinicians or stifle innovation by making it too difficult for new technologies to gain approval. Coverage of tests and procedures should not be denied solely on the basis of cost-effectiveness ratios; coverage decisions should reflect evidence of appropriate utilization and clinical effectiveness.[4] Useful information about the effectiveness and outcomes of technology and public education should be widely disseminated to reduce patient and physician demand for technologies of unproven benefit.

c. Medicare should explore and pilot-test new ways to establish the pricing of physician services as part of new value-based payment models established with clear policy goals in mind, such as basing payment on evidence of value, so that high-value services would be paid more and lower-value services would be paid less.[5]

As expressed in the position paper *How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently?,* the College is a strong proponent of encouraging the use of high-value, cost-conscious care. Value-based insurance design (VBID), where cost-sharing requirements are adjusted to encour-

age or discourage use of certain services depending on their relative value, has shown promise as one way to incentivize use of evidence-based, high-value quality care. A value-based insurance design project initiated by Pitney Bowes reduced cost-sharing levels for drugs for certain chronic diseases and enrolled patients in disease management programs, leading to heightened adherence and reduced medical and pharmacy costs.[71] In a study of a VBID implemented by a large pharmaceutical company, employees and their dependents reduced cost-sharing for certain drugs used to treat diabetes, asthma, and cardiovascular conditions. As a result, aggregate drug use rates (and medication costs) increased while overall program costs remained neutral and the study recorded a significant increase in medication adherence and prescription fills for cardiovascular conditions.[44]

Congress has acknowledged the potential of the VBID concept by eliminating cost-sharing for certain high-quality services approved by the United States Preventive Services Task Force. Medicare should establish a demonstration project to test the concept in other realms of the Medicare program, such as the prescription drug benefit, where beneficiaries often pay different cost-sharing levels based on whether they're in a generic or a brand name drug "tier."[73] Lower drug costs may particularly benefit the Medicare population, a group that takes an average of five prescription drugs a day, 20% of whom skip or delay taking medications due to cost. As with any adjustment of the cost-sharing structure, protections must be integrated to ensure low-income patients and the chronically ill are not adversely affected by the increased burden. Options, such as reducing cost-sharing for certain drug classes (e.g., diabetes treatments), providing coverage to high-value medications in the Part D donut hole coverage gap, and lowering cost sharing for beneficiaries covered under chronic condition special needs plan arrangements, can all be implemented without any changes to existing law.[72] An expert panel convened by MedPAC suggested creating drug tiers based on clinical comparative effectiveness information.[73] In concert with VBID initiatives, stakeholders must aggressively pursue comparative effectiveness research to determine what products and services are most effective at achieving desired outcomes. Further, efforts must be made to encourage shared decision making between physicians and patients to ensure that patients are able to make informed care decisions.

8. **ACP supports combining Medicare Parts A and B with a single deductible under the following circumstances:**
    a. **Specified primary care, preventive and screening procedures of high value based on evidence are not subject to the deductible, and no co-insurance or co-payments would apply;**
    b. **A limit is placed on total out-of-pocket expenses that a beneficiary may incur in a calendar year (i.e., stop-loss coverage);**
    c. **The deductible is set at an actuarially appropriate level that does not cause an undue financial burden on beneficiaries, especially lower-income beneficiaries; and**
    d. **Medicare payment levels to physicians for covered primary care and preventive benefits are adequate to ensure that beneficiaries have access to such services, the payment rates cover physicians' resource costs (including annual increases in the costs of providing services due to inflation) and adequate annual updates are issued that are fair and predictable.**

The current Medicare benefit package is a complex array of deductibles, premiums, and coinsurance rates that fail to reflect the needs of future beneficiaries. The Part A inpatient hospital deductible, for instance, is excessive. Beneficiaries are forced to pay $1,132 before coverage begins and significant coinsurance after the deductible is met.[74] The Part B annual deductible is $162 with a 20% coinsurance for most services. On the other hand, home health and laboratory services require no coinsurance. With the exception of the prescription drug benefit, Medicare does not have a catastrophic care cap, and this exposes sick beneficiaries to high medical costs. Very low-income beneficiaries may be eligible for Medicaid benefits to assist with out-of-pocket payments, and many wealthier beneficiaries either purchase supplemental Medigap or use retiree health insurance to cover their cost-sharing.

The Medicare benefit package should be simplified to combine Part A and B deductibles and establish a single modest coinsurance and an out-of-pocket spending cap to protect against financially devastating illness. The Domenici-Rivlin debt reduction plan would create a combined Part A and B deductible of $560 with a coinsurance rate of 20% for all services in 2011. Out-of-pocket spending would be limited to $5,250.[75] While this may help sick seniors manage the cost of lengthy hospital stays, it raises the risks that patients will stint on physicians office visits since the combined deductible is higher than the current Part B deductible. In 2002, ACP expressed support for modest Medicare deductibles to ensure proper use of benefits, but such changes should not keep beneficiaries from seeking appropriate care due to cost. If the Medicare benefit is simplified, it should continue to reflect the actuarial value of the package it replaces and CMS must closely monitor how such changes affect beneficiary access, particularly related to physician services. Access to preventive procedures should be encouraged by exempting such services from cost-sharing. Additionally, an independent board of health policy experts could be organized to annually review the Medicare benefit package and make recommendations on changes needed to ensure beneficiary access to high-quality care.

9. 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. Preventive procedures, such as those rated an A or B by the United States Preventive Services Task Force, should be exempt from cost-sharing. Any changes made to the structure of Medigap plans should be made prospectively and not affect existing beneficiaries.

Medigap policies are supplemental insurance plans that typically cover Medicare co-payments and deductibles and some other benefits. About 15% of the Medicare population has Medigap coverage.[76] Some of the more generous Medigap plans reduce beneficiary cost-sharing to almost nothing, so-called "first-dollar" coverage. Medigap plans can be expensive. Plan F, the most popular Medigap product, costs about $2000 a year and the premium can vary in some states depending on the age of the beneficiary.[42] Plan F is one of two Medigap plans that cover all Part A and B deductibles and coinsurance, including cost-sharing for skilled nursing home and hospice care. Some evidence suggests that beneficiaries who have comprehensive Medigap plans tend to use more services than those without supplemental coverage.[77] A number of deficit-reduction proposals would alter the Medigap benefit structure, elimi-

nating first-dollar coverage to compel beneficiaries to use Medicare services more judiciously. The Obama Administration released a proposal that would require Medicare beneficiaries with generous Medigap plans to pay an additional Part B premium. Other proposals recommend that Part A and B deductibles be combined and set at $550 a year and that Medigap plans be prohibited from covering the deductible.[30]

While it is apparent that requiring all Medicare beneficiaries to share some cost would encourage more careful use of services and therefore reduce Medicare expenditures, it is less apparent that beneficiaries exposed to higher cost-sharing always avoid wasteful or minimal value services.[78,17] The National Association of Insurance Commissioners expressed concern that eliminating first-dollar Medigap coverage, which only covers services that Medicare deems "medically necessary," may cause beneficiaries to forgo needed treatment due to cost.[79] ACP policy states that health insurance benefits should be designed to encourage patient cost-consciousness and responsibility without deterring patients from receiving needed and appropriate services or participating in their care. It is crucial that any changes made to the Medicare cost-sharing structure preserve beneficiary's ability to access medically necessary services, particularly those aimed to prevent, screen, and diagnose illness.

10. 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.
   - **a. Voluntary advanced care planning should be covered and reimbursed by Medicare to encourage patient-physician engagement and ensure that patients are informed of their palliative and hospice care options. Medicare should permit subsequent counseling sessions so patients and their physicians may adjust their advance care plans as needed to reflect changes in care preferences. Physicians and their patients should not be required to conduct such counseling.**
   - **b. Palliative and hospice care services should be integrated across the health care spectrum, including such innovative delivery models as the patient-centered medical home.**
   - **c. The federal government and other stakeholders must improve consumer knowledge about advanced care planning, palliative, and hospice care options.**
   - **d. Racial and ethnic disparities related to palliative and hospice care must be addressed.**

All patients deserve access to palliative and end-of-life care that recognizes their individual's physical, psychological, social, religious, and cultural needs. Physicians serve a crucial role in making sure that care for the very ill is provided in a manner that is compassionate, respectful, and dignified. Palliative care focuses on relieving pain related to a chronic or terminal illness. Hospice care is focused on providing comfort to the patient in the last 6 months of life once standard treatment options have been exhausted. As identified by the Institute of Medicine and the Agency on Healthcare Research and Quality, key components of end-of-life care include care management; supportive services for individuals; pain and symptom management; family and caregiver support; communication among patients, families, and program staff; and assistance with advance care planning.[80]

Improving palliative and hospice care benefits

Among the many recommendations made by the National Priorities Partnership, an organization of payers, providers, and patient advocates devoted to health care system reform, is improving access to patient-centered, high-quality palliative and hospice care. The partnership recommends that palliative and hospice care be integrated across health care providers and into new delivery models, such as accountable care organizations and the patient-centered medical home.[81] Given that one of the primary goals of the patient-centered medical home is to strengthen the relationship between physician and patient, a palliative care model that facilitates shared decision making is crucial to promoting trust, communication, and mutual engagement. Further, better coordination of such services across the patient's care team will ensure that patients receive the care they prefer and that overly aggressive or duplicative care, which may result in poor outcomes, is avoided.

For almost 30 years, Medicare has covered hospice care services for patients estimated to have 6 months or less to live. Hospice is provided to patients who elect to forgo traditional treatment for a terminal illness. However, given the difficulty patients and their family members may have in deciding when to end curative treatment in favor of hospice care, the Medicare program should consider allowing patients to transition into hospice while receiving some potentially curative treatments. The ACA authorized a demonstration project to test the use of "concurrent care" as a means to ease the transition to hospice care and potentially improve patient's well-being and life expectancy.[82,83] Palliative care services should also be made available to those with chronic, advanced, and terminal illnesses, as the need for pain mitigation, counseling, and psychosocial services, among others, may present itself from the early stages of diagnosis.

Advance Care Planning

Annually, Medicare covers 80% of patients at the end of their lives, so ensuring patient-centered care during this sensitive period is particularly crucial.[84] However, many patients fail to receive the level of care they want. One way to ensure that the patient's preferences are carried out is through advance care planning, where a physician or other health care professional counsels the patient on issues such as living wills, durable power of attorney, and palliative and hospice care, among other options. Evidence shows that patients who complete advance directives such as living wills indicating their care preference toward the end of life are more likely to receive that care than those who did not complete an advance directive.[85] One study of elderly patients found that those with living wills were more likely to choose limited care (92.7% surveyed) or comfort care (96.2%), rather than an all care possible (1.9%).[42] Patients who have conversations involving end-of-life options express less fear and anxiety and report that their physician had a better understanding of their wishes following the discussion.[86]

Not only will end-of-life counseling strengthen the patient-physician relationship and give peace of mind to the patient and their loved ones, it is may also enhance the quality and value of the care received. A study of patients with advanced cancer found that those who had engaged in an end of life conversation with their physician had dramatically lower care costs during the last week of life than those who had not had such a conversation. The average cost of care for patients who had an end-of-life conversation with their physician

was 35% less than for patients who had not had a conversation regarding their end-of-life care preferences.[87] The study also concluded that higher costs of care yielded poorer outcomes during the patient's final week of life. Additionally, in areas with disproportionately high end-of-life costs, patients with advance directives indicating care limits had lower Medicare expenditures, higher rates of hospice use, and were less likely to die in a hospital.[88]

Unfortunately, only about 18-36% of adults complete an advance directive.[89] Since Medicare plays such an important role in financing care for patients at the end of life, it is crucial that the program encourage end-of-life conversations and advance care planning. Early drafts of the ACA included language that would reimburse physicians for discussing end-of-life options with their patients; however, this provision was removed from the final legislation. To raise awareness among the medical community and help incite physicians to conduct these important discussions, Medicare must educate about and provide payment for advance care planning between physicians and their patients. The program should also permit ongoing advance care planning discussions to give patients an opportunity to amend their advance directives or other related care plans as they evolve.

Addressing racial and ethnic disparities in the receipt of palliative care

Serious racial and ethnic disparities exist in the use of palliative and hospice care services. Eighty percent of hospice patients in 2009 were white, while just under 9% were African American and less that 2% were Asian, Hawaiian, or other Pacific Islander.[90] Studies have also found that African Americans are more often undertreated for pain than their white counterparts across numerous health care settings and are less likely to have a living will, do-not-resuscitate orders, and health care proxies.[91,92] Such disparities may be the result of different cultural backgrounds and spiritual beliefs, mistrust of the medical establishment, lack of education about palliative and hospice care, and language barriers.[51,93] To help educate patients, physicians must engage in cultural competency training to ensure that all patients are well-informed of their care options. Further, efforts should be made by stakeholders to engage community and religious organizations, such as chaplain services, to assist in educating patients and addressing their concerns.[94,55]

Physician education

Open communication is vital to the patient-physician relationship and becomes more crucial when the patient confronts end-of-life decisions. The ACP Ethics Manual states that to provide palliative care, physicians must be educated in the administration and regulation of pain-relieving medication, such as opioids; know how to refer patients to appropriate palliative care; and be familiar with home- and institution-based hospice care, among other aspects. Evidence suggests, however, that many physicians are ill-equipped to conduct end-of-life counseling or to provide palliative care to those in chronic and advanced stages of illness. According to a Government Accountability Office report, physicians may not recognize the need for pain and symptom management, may believe that referring a patient to such services means that they have "given up" on the patient, and often lack the necessary training to conduct compassionate discussion of end-of-life issues.[42] A survey of medical students, residents, and faculty found that only 18% of students reported tak-

ing a course in end-of-life care, 16% of residents had done a rotation in palliative or hospice care, and 17% of faculty had taught end-of-life care or a related aspect in the past year. The same study found many medical students and residents expressed that they were underprepared to address patient thoughts on dying and spiritual issues, help families cope with loss, or address cultural issues related to dying.[95]

11. 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.
   a. Drug manufacturers should be required to provide a rebate to low income Medicare patients enrolled in Part D.
   b. Congress should give Medicare the authority to negotiate the price of drugs offered under Part D, similar to the authority that the Veterans Administration has to negotiate the price of drugs for veterans.

In addition to integrating value-based insurance concepts into the Medicare prescription drug benefit (Part D), Congress should authorize the federal government to use its significant purchasing power to negotiate for lower Part D drug costs. However, the Medicare Modernization Act of 2003 explicitly forbids the federal government from negotiating with pharmaceutical companies over the price of drugs. Not only could such policy improve the fiscal solvency of the Medicare program, it could also reduce drug prices for Medicare beneficiaries.

The Veteran's Administration provides evidence of the federal government's ability to achieve lower drug costs through negotiation. The VA is able to purchase drugs at a rate that is up to 42% of the drug wholesaler suggested list price (known as the average wholesale price).[96] Like the VA, Medicare may be able to achieve additional savings by negotiating based on a formulary and by excluding certain drugs.[97] However, a Medicare formulary must not be developed solely to reduce costs, but to promote use of clinically effective, safe drugs. Reflecting ACP policy, "Formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically indicated cause) without cumbersome prior authorization requirements."[98] It should be noted that the CBO does not believe that significant savings would be achieved if Medicare was permitted to negotiate drug prices.[99] However, at least one study estimated that savings would be garnered if Medicare, rather than private plans, administered the drug benefit, because the traditional program has lower administrative costs and would be better positioned to negotiate with drug companies for lower prices.[100] The potential for Medicare savings is significant; one study determined that allowing Medicare the authority to negotiate would save $30 billion a year.[101]

Additionally, drug manufacturers should be required to provide lower-cost drugs to low-income Medicare beneficiaries by requiring substantial rebates on drug prices. A drug rebate mechanism is used to achieve low prices on drugs purchased by the Medicaid program. According to the HHS Inspector General, the Medicaid drug rebate program achieves significantly lower drug costs than the Medicare Part D program. Medicaid was able to retract 45% of drug costs through rebates, while the average Part D plan was able to achieve only 19% savings through rebates.

12. Congress should amend the authority for an Independent Payment Advisory Board (IPAB) to:

- **a. Allow Congress to override IPAB recommendations with a majority rather than a supermajority vote before they go into effect.**
- **b. Require that the IPAB include among its membership a physician who provides comprehensive and primary care services. The existing prohibition on members of the Commission having outside employment should be modified to create an exception for physicians involved in direct patient care.**
- **c. Eliminate the requirement that IPAB must produce recommendations for a specified level of savings if a target rate of allowable growth is exceeded. The board should have the discretion to recommend higher or lower savings targets based on its judgment of the best approach to reducing spending while ensuring continued access to care.**
- **d. Ensure that savings obtained through IPAB recommendations and implementation either improve or at least maintain the quality of care provided. Budgetary savings founded on reduced quality is short-sighted and inappropriate.**
- **e. Authorize that the IPAB consider all Medicare providers and suppliers when developing payment delivery and expenditures change proposals. The existing prohibition on IPAB making recommendations relating to certain providers (e.g., hospitals) through the end of this decade should be lifted. Payment delivery and reduction changes should not be the burden of a restricted number of Medicare clinicians, providers, and suppliers.**
- **f. Broaden IPAB's scope of potential policy recommendations to include changes in benefits, cost-sharing, and payment and delivery system reforms not limited to physicians.[102]**

The ACA establishes the IPAB, a 15-member body appointed by the President with the approval of the Senate composed of experts in health care finance, actuarial science, health plans, and integrated delivery systems, as well as physicians, third-party payers, and other disciplines. Beginning in 2014, if the rate of Medicare spending grows beyond a certain threshold, the IPAB is charged with initiating policies that would slow the rate of Medicare growth to meet a savings target determined by the Chief Actuary of Medicare. In determining ways to reduce spending, the IPAB is prohibited from trimming the Medicare benefit package, increasing premiums or other cost-sharing levels, or establishing policies that would ration care. The Board is allowed to implement incentives to promote more efficient care, reset payment of Medicare services deemed to be overvalued, and consider how its proposals would affect beneficiary access to services and quality of care.[103] Unless Congress intervenes to replace the IPAB's recommendations with its own policy to slow Medicare spending growth, the Secretary of Health and Human Services will be required to implement the IPAB's recommendations. Congress may alter the IPAB's recommendations if such actions are approved by supermajority.[104]

ACP has concerns with several aspects of the IPAB and has offered recommendations on how it may be improved to be more fair and effective. The College supports permitting Congress to override the recommendations of the IPAB by majority rather than supermajority. The College also requests that a primary care physician be included among the IPAB membership, that stronger safeguards be established to ensure that quality of care is strengthened or maintained and not diminished as a result of the IPAB's recommendations, and that the IPAB be required to consider all providers when determining delivery system changes or expenditure changes, among other provisions.

The College also believes that the authority of the IPAB be expanded to consider changes to Medicare benefits and coverage policy, noting that "It is important in order to efficiently use limited healthcare resources that decisions in these areas be based on a process that considers both clinical effectiveness and cost."[105] The Restoring America's Future proposal would authorize the IPAB to review the Medicare benefit structure every 2 years and make recommendations on how the package can be better aligned to the structure typical of private insurance plans.[7]

Conclusion

The Medicare program is a widely popular benefit that has undoubtedly enhanced the lives of seniors and the disabled; however, rising costs threaten the future of the Medicare program. Health care costs have risen significantly in the private and public sectors, reflecting the difficulty of managing spending in the face of popular and political opposition, technological advancements, increasing prices, and other factors. Difficult choices must be made to ensure the program's solvency, but not at the expense of patient health. The health care system itself must be reformed; arbitrary spending caps and cost-shifting will only undermine the financial well-being of the vulnerable. Whatever decisions are made, stakeholders across the health care spectrum, from patients to physicians to policymakers, must work together toward the goal of protecting Medicare for future generations.

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