



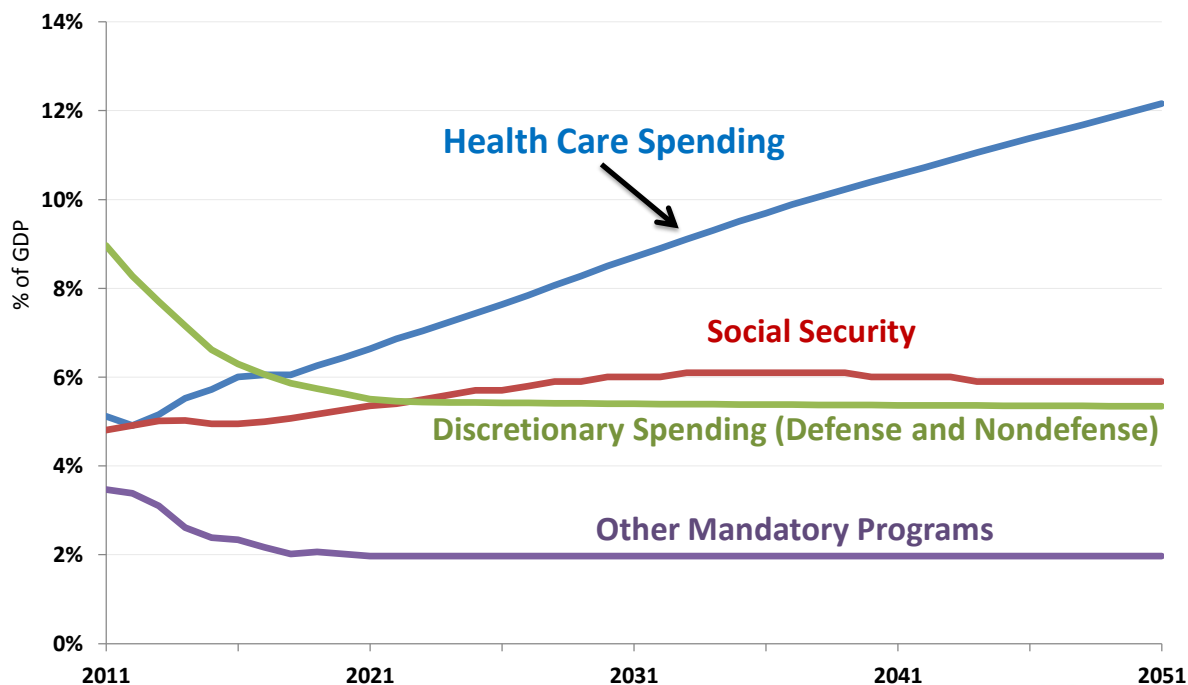
BIPARTISAN POLICY CENTER

Domenici-Rivlin Protect Medicare Act

The principal driver of future federal deficits is the rapidly mounting cost of Medicare. The huge growth in the number of eligible seniors over the coming years is due to both increasing longevity and the retirement of the baby boomers. Then, that beneficiary growth is multiplied by continuing increases in the cost of health care. Without a significant change in this trend, the cost of Medicare will continue to rise faster than the economy can possibly grow. Even if revenues are raised and other spending is restrained (both of which BPC supports), the exploding cost of Medicare is unsustainable.

Simply put, there can be no lasting solution to the U.S. debt crisis without structural changes in the Medicare program to slow its cost growth. This can be done through our proposal to transition Medicare to a “defined support” plan. Such a system will provide major incentives to increase the efficiency and effectiveness of health care delivery to seniors – without abolishing current Medicare, or forcing any beneficiary to move to a different system – and cap total Medicare spending while protecting low-income seniors.

HEALTH CARE COSTS ARE THE PRIMARY DRIVER OF THE DEBT



Source: Congressional Budget Office (August 2011)

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The Domenici-Rivlin defined support proposal will preserve Medicare for future generations. It will allow beneficiaries who wish to stay in traditional Medicare to do so, but also will present them with competing private plans as alternative options. It will restrain the growth in total Medicare spending, while protecting low-income beneficiaries from any increases in their cost above current law. In short, the Domenici-Rivlin plan both will preserve Medicare as a choice and also save money by flattening the now-steeply-rising Medicare cost curve.

The Domenici-Rivlin proposal restructures Medicare to achieve fiscal soundness in three ways:

- 1) A new federally-run Medicare Exchange will provide beneficiaries with a truly competitive marketplace in which they can choose among private healthcare plans and traditional fee-for-service Medicare (FFS). The private plans will be required to cover services with at least the same actuarial value as FFS Medicare, and their government subsidy will be adjusted up (or down) if they attract patients whose illnesses are more (or less) expensive than average. The Exchange will provide understandable information about the costs and health outcomes of plans so that beneficiaries can choose plans that are best for them, and will allow beneficiaries, if they are not satisfied, to change plans in an annual open season. This competition will incentivize healthcare plans to innovate in every facet of their operations and benefit designs to keep premiums down and quality of care up.
- 2) By using competitive bidding, this system will tie the federal contribution to the cost of the 2nd-cheapest approved plan or FFS Medicare in each area, whichever is cheaper (subject to that bidder having enough capacity to handle expected enrollment). Thus, the government will no longer have to pay extra to private healthcare plans in areas where the public FFS plan provides cheaper coverage, nor will they have to overpay to provide FFS Medicare in areas where approved private plans offer the same care at lower cost.
- 3) These two cost-control features should flatten the cost curve. However, an additional element will ensure substantial savings. The growth in per-beneficiary federal support will be limited to one percentage point faster than the growth of the economy – “GDP+1%” – compared to the current projection of growth that is 1.7 percentage points faster. If costs rise faster than the established limit, Medicare beneficiaries will have to pay higher premiums. However, individuals whose Part B premiums are paid by Medicaid programs will not be affected. Additionally, to smooth the transition to the defined support system, current beneficiaries with low incomes will be guaranteed access to traditional Medicare (or a plan of similar value) with no additional premiums. This subsidy will phase out at higher income levels.

How the Exchanges Work

In each regional market – be it a metropolitan area, or a large rural area where population density is low – all of the private healthcare plans and traditional FFS Medicare will submit bids (subject to strict quality and coverage standards) to provide a benefit package equal in value to that of FFS Medicare for Parts A and B to an average-risk beneficiary. The FFS "bid" will be based on average FFS costs for the same type of standardized beneficiary in the bidding area. The amount that the government contributes to premiums in that area will then be based on the 2nd-lowest private bid or FFS Medicare's bid, whichever is lower (subject to that bidder having enough capacity to handle expected enrollment). This will be referred to as the "benchmark" bid.

Beneficiaries who choose to enroll in a plan that is more expensive than the benchmark – even if that plan is FFS Medicare – will be required to pay the incremental additional cost. A beneficiary who enrolls in the plan with the lowest bid will be rebated the full difference in cost from the benchmark.

The Exchange will be federally run, presumably by the Centers for Medicare and Medicaid Services (CMS), require guaranteed issue and community rating (under which insurers must offer coverage to every senior for the same price, regardless of age, gender, health status, etc.), and enforce guidelines for the structure of the benefit package. The Exchange also will utilize the Medicare Advantage (MA) risk adjustment mechanism to distribute the government subsidy among insurers according to the health status of those whom they enroll.

The MA risk adjustment is the most sophisticated method in use, but it is not perfect. To further mitigate adverse selection by private plans, the Domenici-Rivlin proposal requires all plans on an exchange to have an actuarial value at least as high as traditional Medicare's. Moreover, the CMS will enforce rules on plans' reserves for solvency, accuracy of promotional materials, network adequacy, and will be able to block benefit designs that it deems are too likely to attract mostly healthy people – just as the OPM does for the FEHB program.

CMS also could require private plans to collect and provide more data so that independent research organizations can study plan selection (with all due protections for privacy). Such analysis is standard for FFS Medicare because the data are public. With access to the necessary data, independent researchers would serve as an important check against plans cherry-picking healthy enrollees. CMS could utilize this research to help determine if a plan's benefit design is disproportionately attracting healthier seniors.

Why is this proposal an improvement over the current Medicare system?

Medicare Advantage already offers private plans to Medicare beneficiaries. However, if a private healthcare plan currently has lower costs than FFS Medicare in its area, it cannot offer to rebate the entire cost difference to enrollees as an incentive to sign up. Instead, it must increase benefits – which in and of itself increases Medicare spending. Therefore, beneficiaries in areas with high FFS Medicare costs who enroll in private plans receive a host of free supplementary benefits, financed by the government. There is no policy justification for selectively offering free, government-financed supplementary benefits to beneficiaries in one geographic region but not another.

Instead, the new Medicare Exchange will provide strong incentives for plans to manage care-delivery efficiently and to offer the public evidence that their plans achieve quality outcomes at comparatively low cost – because low-bidding plans would be rewarded with increased enrollment.

The Domenici-Rivlin proposal also guarantees that the federal support per beneficiary will *not* grow faster than GDP+1%, thereby assuring the federal government of budgetary savings. The cap on the growth rate also should increase the pressure on plans to develop more efficient methods of care delivery, and might increase political support – by Medicare beneficiaries, their children, and those approaching Medicare eligibility – for federal policies that promote cost containment in health care. The Patient Protection and Affordable Care Act already established a cap on the growth of Medicare; moving to a competitive bidding model creates the incentives to make that cap stick.

In the event that Medicare spending per beneficiary rises at a faster rate, enrollees will have to pay higher premiums to cover the difference.¹ However, individuals whose Part B premiums are paid by Medicaid programs will not be affected. Additionally, to smooth the transition to the defined-support system, current beneficiaries with low incomes will be guaranteed access to traditional Medicare (or a plan of similar value) with no additional premiums. The new system also could be structured to provide a higher subsidy to those with lower incomes and a lower subsidy to those with higher incomes.

Estimated cumulative savings in billions of dollars, 2016 through:				
	<u>2021</u>	<u>2025</u>	<u>2030</u>	<u>2040</u>
Transition Medicare to a Defined Support Structure in 2016	\$170	\$440	\$1,100	\$4,300

¹ To promote stability, the proposal calls for employing a five-year historical trend of per-capita GDP rather than measuring the change over a single year.