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Domenici-Rivlin Protect Medicare Act

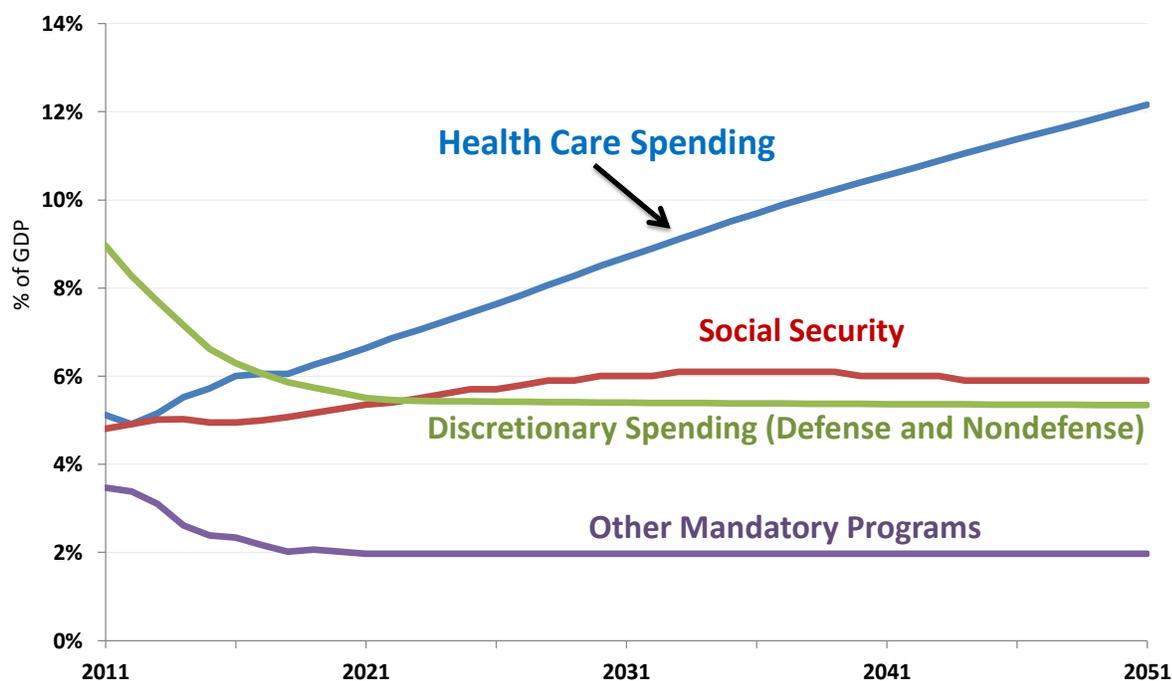
(Released November 1, 2011)

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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 life expectancies and the retirement of the baby boomers. Then, that beneficiary growth is multiplied by continuing increases in the cost of health care per enrollee. 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 we support), 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 accomplished through our proposal to transition Medicare to a “defined support” plan in 2016. Such a system would provide strong 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 plan.

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 would preserve Medicare for future generations. It would allow beneficiaries who wish to stay in traditional Medicare to do so, but also would present them with competing private plans as alternative options. It would 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 would preserve Medicare as a choice and also save money by flattening the steeply-rising projected Medicare cost curve.

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

- 1) New federally-run Medicare exchanges would provide beneficiaries with a truly competitive marketplace in which they can choose among private healthcare plans and traditional fee-for-service (FFS) Medicare. Participating private plans would be required to accept all applicants and would be prohibited from “cherry picking” the youngest or healthiest seniors. Every private plan would be required to provide benefits that have at least the same actuarial value as FFS Medicare. The plans would have to include a specific base set of services, and the federal support that each plan is provided with would be adjusted for the age and health status of its enrollees. The exchanges would provide understandable information about the costs and quality of plans so that beneficiaries could choose the options that would be best for them. Beneficiaries would have the opportunity to change plans in an annual open season. Increased competition would save money for seniors, people with disabilities, and the federal government.
- 2) Through competitive pricing by all plans, the federal contribution in each market area would be tied to the cost of the second-least expensive approved private plan or FFS Medicare, whichever is less expensive (subject to the two lowest-price plans combined having enough capacity to handle expected enrollment). Thus, the government would no longer have to pay extra to private healthcare plans in areas where FFS Medicare provides lower-cost coverage. Nor would the government have to overpay to provide FFS Medicare in areas where two or more approved private plans offer equivalent care at a lower cost.

These competitive enhancements would incentivize healthcare plans to innovate in every facet of their operations and benefit designs — subject to regulations – to keep premiums down and quality of care up.

These two features should significantly curb Medicare costs. We have every confidence that they, by themselves, would slow the growth of Medicare spending significantly – sufficiently, in fact, to achieve the targeted restraint proposed in the BPC debt-reduction plan.

As a backstop, however, the Protect Medicare Act would also strengthen the enforcement mechanism for the cap on per-beneficiary Medicare growth that was enacted in the Patient Protection and Affordable Care Act (PPACA). For Parts A, B, and D of Medicare combined, the cap would continue to limit the cumulative annual growth in per-beneficiary federal support to one percentage point faster than the per capita growth of the economy – “GDP+1%.” Under current law though, costs are projected to grow, on

average, more slowly than that rate for the next two decades, in which case the cap would not come into play.

If costs do rise faster than the established limit, however, and the Independent Payment Advisory Board's (IPAB) reforms are inadequate, Medicare beneficiaries with incomes above 150 percent of the federal poverty level (FPL) would pay higher premiums. (Those with incomes below 135 percent of the FPL would continue to receive zero-cost coverage paid for by Medicaid, and enrollees with incomes between 135 and 150 percent of the FPL would be protected from any premium increases.)

Additionally, to smooth the transition to the competitive pricing system, current beneficiaries with incomes below 150 percent of the FPL would be guaranteed access to either traditional Medicare or a private plan of the same cost – at their choice – with no additional premiums. This “hold harmless” provision would phase out at higher income levels.

How the Exchanges Work

In each regional market – be it a metropolitan area, or a multi-county rural area – each private healthcare plan and traditional FFS Medicare would submit its price to provide a benefit package equal in actuarial value to that of FFS Medicare for Parts A and B, including a specific base set of services, to a standard (average-risk) beneficiary for a year. The FFS “price” would be based on average FFS Medicare costs for the same standard beneficiary in the market area. The amount that the government contributes to premiums in that region would then be based on the second-lowest private plan price or FFS Medicare's price, whichever is lower (subject to the two lowest-price plans combined having enough capacity to handle expected enrollment). This would be referred to as the “benchmark” price.

Beneficiaries who choose to enroll in a plan that is more expensive than the benchmark – even if that plan is FFS Medicare – would be required to pay the incremental additional cost. A beneficiary who enrolls in the plan with the lowest price would be rebated the full difference in cost from the benchmark. Companies could also offer additional products with expanded benefits (as they do now), subject to review concerning the premiums for those products having an appropriate relationship to the benefits offered.

The exchanges would be federally run (either by the Centers for Medicare and Medicaid Services (CMS) or a separate entity), require guaranteed issue and community rating (under which insurers must offer coverage to every senior in the geographic area for the same price, regardless of age, gender, or health status), and enforce guidelines for the structure of the benefit package. The exchanges would also utilize a risk-adjustment mechanism to distribute the government subsidy among insurers according to the age and health status of those whom they enroll. Methods used in Medicare Advantage (MA) would be a starting point, but efforts to develop tools that do this more effectively should be ongoing.

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 would require all plans on an exchange

to offer a specific core set of benefits and have an actuarial value at least as high as traditional Medicare's. This would preclude the possibility of "bare-bones" plans attracting healthier people in ways not fully offset by the risk adjustment. Moreover, the federal government would enforce rules on plans' reserves for solvency, accuracy of promotional materials, and network adequacy. The administering agency would also be able to block benefit designs that it deems likely to disproportionately attract healthy people – just as the Office of Personnel Management (OPM) does for the Federal Employees Health Benefits (FEHB) program.

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

Currently, Medicare benefits are predominantly delivered through the traditional fee-for-service plan, which allows patients to see nearly any doctor they choose so long as that doctor accepts Medicare's payment rates. Because FFS pays separately for each service, providers have an incentive to provide more services, driving up program costs. This practice is a significant issue for traditional Medicare.

Medicare FFS has some promising pilots to reform provider payment under way, such as Accountable Care Organizations, per-episode payment, and patient-centered medical homes. Because the traditional program continues under the Protect Medicare Act, success from initiatives such as these will influence future market shares of FFS and private plans.

Medicare also offers private MA plans, which receive a fixed monthly payment from the government to care for each enrollee. These plans, therefore, have a strong incentive to work with doctors and hospitals to manage care efficiently. Although this incentive structure helps mitigate the overtreatment (i.e., "paying for quantity") problem faced by FFS, the current MA system has certain structural flaws.

Most significant is that MA uses administered pricing rather than competitive pricing to set the amount of government support in each region. Resulting from years of changes to this pricing formula, MA plans, in the aggregate, are paid more than FFS Medicare. When administered prices are high, incentives for plans to become more efficient are reduced. PPACA phased out much of this overpayment, but many private plans continue to be paid more than FFS Medicare. Another flaw is that MA plans that offer less-costly coverage than the administered price are currently taxed between 25 and 50 percent on any rebate that they offer to beneficiaries. Taxing low prices discourages plans from offering low premiums.

Instead, the new Medicare exchange would utilize a competitive pricing process, and would present information on the various plan offerings in a clear, concise manner. Setting the federal contribution at the cost of the second-least-expensive health plan or FFS, whichever is lower, in an area would also increase the connection between the price charged and enrollment. By increasing the reward for a low price, the Protect Medicare Act provides strong incentives for healthcare plans to manage care delivery efficiently, innovate in their benefit designs, and to offer evidence to the public that they achieve quality outcomes at low cost.

In a 2006 report, the Congressional Budget Office (CBO) hypothesized that competitive pricing as structured in the Protect Medicare Act could lead private health plans, on average, to lower their current prices by 5 percent, which would greatly increase the savings and effectiveness of this proposal.

The administered pricing system that currently exists is also inefficient for the federal government. MA plans are paid more than the cost of FFS in regions where the public plan offers the least expensive coverage. Similarly, even if multiple private healthcare plans are able to provide the same services as FFS for less money, the government must still contribute roughly the full cost of the public FFS plan. Moreover, in these areas where FFS Medicare is relatively costly, beneficiaries who enroll in private plans receive a host of free supplementary benefits or generous rebates financed by the government. There is no policy justification for selectively offering free, government-financed supplementary benefits to beneficiaries in some geographic regions but not others.

The Protect Medicare Act would change this. The government would no longer have to pay extra to private healthcare plans in areas where FFS Medicare provides lower-cost coverage, nor would they have to overpay to provide FFS Medicare in areas where approved private plans offer equivalent care at a lower cost. The new system would create a level playing field for competition between FFS Medicare and private plans. The efficiencies produced would save money and improve care for enrollees. This change alone, even after providing transitional support to many beneficiaries and without accounting for any dynamic effects such as those suggested by CBO, would save the government roughly \$20 billion in its first year of implementation and around \$300 billion over ten years.

Currently, in some parts of the country, at least two private healthcare plans are less expensive than FFS Medicare and the quality of care is as good.¹ In other parts of the country, FFS is cheaper. Despite the common refrain that traditional Medicare is significantly less expensive than private plans, according to MedPAC's [2011 Data Book](#), on average, the private plans serving Medicare patients provide the entitlement benefit package for exactly the same cost as the traditional program. More specifically, the HMOs participating in MA, which represent the majority of MA enrollment, provide equivalent coverage for 97 percent of the cost of traditional Medicare. Moreover, approximately 88 percent of beneficiaries live in regions where two or more private plans offer the Medicare benefit for less than FFS, according to a recent [analysis](#) by Robert Coulam, Roger Feldman, and Bryan Dowd based on CMS data.

While changes made to traditional Medicare in PPACA plus further reforms would likely make it even more competitive, the fact remains that private plans will be the least expensive in some geographic areas and FFS will be the least expensive in others. In such a hybrid public-private Medicare system, the Protect Medicare Act ensures that taxpayers get the best value per dollar.

¹ Robert H. Miller and Harold S. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997–2001," *Health Affairs* 21, no. 4 (July/August 2002): 63–86.

Estimated cumulative savings from CBO's <u>Current Law</u> baseline in billions of dollars, 2016 through:			
	<u>2022</u>	<u>2025</u>	<u>2032</u>
Transition Medicare to a Defined Support Structure in 2016	\$175	\$280	\$675