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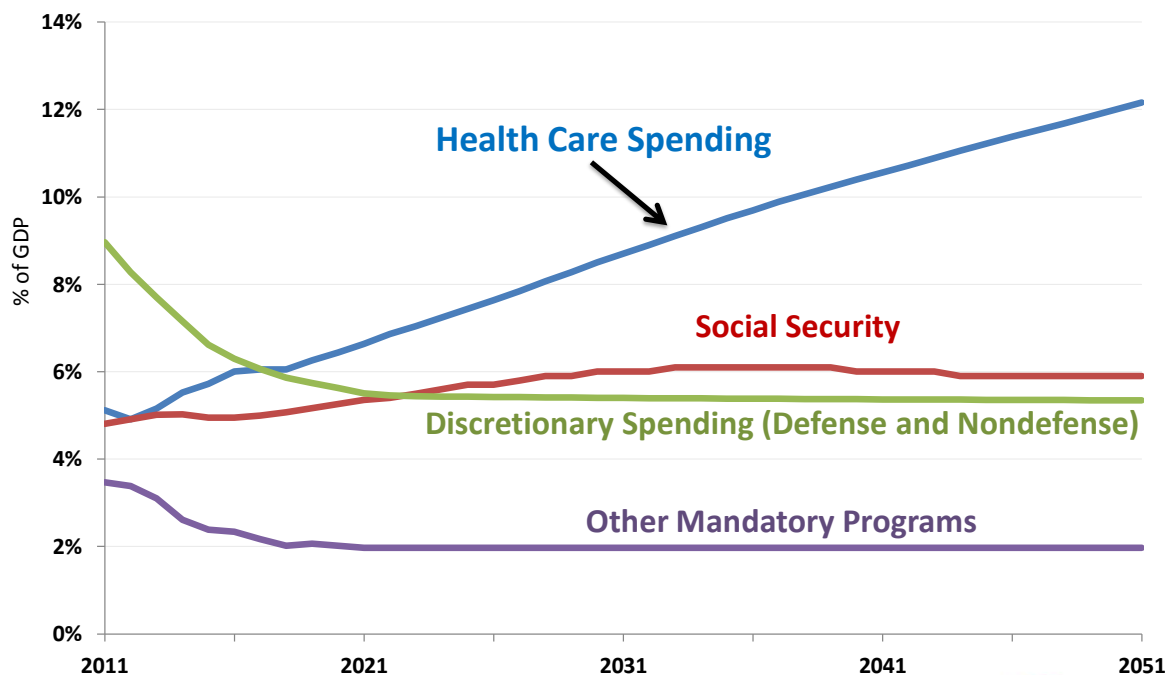
Domenici-Rivlin Protect Medicare Act

(Released November 1, 2011)

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. 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 the Bipartisan Policy Center 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 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 options that are best for them. Beneficiaries would have the opportunity to change plans in an annual open season.
- 2) Through a competitive bidding process, 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-bidding 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 the public FFS Medicare plan provides lower-cost coverage, nor would the government have to overpay to provide FFS Medicare in areas where 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. The Protect Medicare Act also would strengthen the enforcement mechanism for the modest cap on Medicare growth introduced 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 annual growth in per-beneficiary federal support to one percentage point faster than the growth of the economy – “GDP+1%.” However, if costs rose faster than the established limit and the Independent Payment Advisory Board’s (IPAB) reforms were inadequate, Medicare beneficiaries earning above 150 percent of the poverty level would pay higher premiums. Additionally, to smooth the transition to the defined support system, current beneficiaries with incomes below this threshold would be guaranteed access to the plan that they currently have 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 bids 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. The FFS "bid" would be based on average FFS Medicare costs for the same standard beneficiary in the bidding area. The amount that the government contributes to premiums in that region would then be based on the second-lowest private plan bid or FFS Medicare's bid, whichever is lower (subject to the two lowest-bidding plans combined having enough capacity to handle expected enrollment). This would 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 – would be required to pay the incremental additional cost. A beneficiary who enrolls in the plan with the lowest bid would be rebated the full difference in cost from the benchmark. Private plans also could offer additional products with expanded benefits (as they do now), subject to review concerning the premiums having an appropriate relationship to their bid for a plan with standard benefits.

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 also would 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. Moreover, the federal government would enforce rules on plans' reserves for solvency, accuracy of promotional materials, and network adequacy. The administering agency also would 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?

Medicare Advantage already offers private plans to Medicare beneficiaries. However, private healthcare plans that bid lower than FFS Medicare in their area are currently taxed between 25 and 50 percent on any rebate or increased benefits they offer. Taxing low bids, as with all taxes, discourages the taxed activity. Additionally, beneficiaries in areas with high FFS Medicare costs 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 one geographic region but not another.

Instead, the new Medicare Exchange would 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 would *not* grow faster than GDP+1% by strengthening the cap established in PPACA, 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. PPACA already established a cap on the growth of Medicare; moving to a competitive bidding model creates the incentives to make that cap stick.

If Medicare spending per beneficiary rose at a faster rate and IPAB's reforms were inadequate, enrollees would have to pay higher premiums to cover the difference.¹ However, individuals whose Part B premiums are paid by Medicaid programs would not be affected. Additionally, to smooth the transition to the defined-support system, current beneficiaries with low incomes would be guaranteed access to traditional Medicare 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.

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.

Estimated cumulative savings from CBO's <u>Alternative Fiscal Scenario</u> in billions of dollars, 2016 through:				
	<u>2022</u>	<u>2025</u>	<u>2032</u>	<u>2042</u>
Transition Medicare to a Defined Support Structure in 2016	\$191	\$408	\$1,475	\$5,378

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>	<u>2042</u>
Transition Medicare to a Defined Support Structure in 2016	\$187	\$369	\$875	\$2,936