Perspectives:
Options for Reforming Medicare

Experts and policymakers in Washington are considering a broad range of proposals for reforming Medicare. This paper presents perspectives from leading experts on some of the more frequently mentioned policy options.

Stuart Butler, Ph.D., is a Distinguished Fellow and Director of the Heritage Foundation’s Center for Policy Innovation.

Henry J. Aaron, Ph.D., is a Senior Fellow in Economic Studies and The Bruce and Virginia MacLaury Chair at The Brookings Institution.

Avalere Health, LLC is a leading advisory company focused on health care business strategy and public policy.

The views expressed herein are for information, debate and discussion, and do not necessarily represent official policies of AARP.
# Table of Contents

Raise the Medicare Eligibility Age................................................................................................. 1  
Raise Medicare Premiums for Higher-Income Beneficiaries.............................................................. 4  
Change Medicare to a Premium Support Plan .................................................................................... 7  
Require Drug Companies to Give Rebates or Discounts to Medicare ......................................... 10  
Increase Medicare Cost-Sharing for Home Health Care, Skilled Nursing Facility Care, and Laboratory Services........................................................................................................... 13  
Generate New Revenue by Increasing the Payroll Tax Rate ............................................................... 15  
Increase Supplemental Plan Costs and Reduce Coverage ............................................................... 18  
Raise Medicare Premiums for Everyone ............................................................................................ 21  
Strengthen the Independent Payment Advisory Board (IPAB) ..................................................... 24  
Redesign Medicare’s Copays and Deductibles .................................................................................... 27  
Address the Sustainable Growth Rate (Physician Payment) Formula ............................................ 29  
Increase Penalties for Health Care Fraud .......................................................................................... 32  
Allow Faster Market Access to Generic Versions of Biologic Drugs ............................................. 34  
Enroll All Beneficiaries Covered by Both Medicaid and Medicare in Managed Care .................. 36  
Prohibit Pay-for-Delay Agreements .................................................................................................. 38  
Medicare: Looking Ahead .................................................................................................................. 40  
A New Vision for Medicare .............................................................................................................. 42
Options for Reforming Medicare
Raise the Medicare Eligibility Age

Since Medicare’s creation in 1965, the eligibility age has been 65 for people without disabilities. Some proposals would gradually raise Medicare’s eligibility age from 65 to 67. So instead of receiving health coverage through Medicare, 65- and 66-year-olds would need to enroll in coverage through an employer plan or a government program (such as Medicaid) or purchase their own coverage on the individual market or through a health insurance exchange.

Argument for:
Stuart Butler, Ph.D.
The Heritage Foundation

Argument against:
Henry J. Aaron, Ph.D.
The Brookings Institution

Stuart Butler

Raising the Medicare eligibility age is a good idea, given the budget problems we face and the fact that Americans are living longer. But it must be done carefully, to make sure that older workers still have health insurance.

Both Medicare and Social Security were intended for retired Americans. So it would make sense to set the normal eligibility age of each program at the age where we have decided as a nation that retirement typically begins. And since working Americans generate the money to pay benefits, it’s also important for the eligibility age to be set where the number of years Americans work is enough to pay retirement benefits.

With Americans living longer, we have already slowly raised the normal age for Social Security benefits from the original 65 to age 67 (you can claim Social Security as early as 62, but the check is much smaller). Many argue for raising it to 70 over the next 20 years or so.

But the Medicare eligibility age has not kept up. Americans can sign up for that program at 65, despite the fact that an American reaching 65 these days can typically expect to live nearly another 20 years. With more Americans living longer, and health spending on older people rising, we just can’t afford Medicare at 65. It makes sense to increase the eligibility age slowly over 10 or 15 years to at least 67—the Social Security normal retirement age—and for the eligibility age of both programs to rise gradually after that as Americans live longer.
Medicare Reform Option: Raise the Medicare Eligibility Age

If we raised the Medicare eligibility age in this way, it would reduce Medicare’s costs by about 5 percent over the next 20 years. Not a magic bullet, but one important step to solving the Medicare cost problem.

What would this mean and how can raising the age be done fairly?

With Medicare’s eligibility age the same as for full Social Security, most Americans in the future would work a year or two longer. That would ease the burden on Medicare’s finances, and the wages or salaries for that extra time working would make retirement more financially secure for older people. It would also mean a more sensible balance between years in the workforce and years in retirement.

A concern for older workers would be whether they could get health insurance for an extra two years. If the new health law remains in place, or is repealed and replaced with another method of ensuring coverage, that would not be a problem. In any case, the vast majority could expect to continue, as today, to be covered by their employer’s plan, that of their spouse’s employer, or other coverage.

What about those who just couldn’t continue working for an extra couple of years because of ill health? Well, Medicare already provides health services for disabled Americans who qualify for Social Security disability payments. If we raise the Medicare eligibility age, we should make sure that older workers with such special needs, short of full disability, can get coverage through Medicare.

Henry Aaron

In order to slow the growth of Medicare spending, some people have suggested increasing the age of eligibility for Medicare from 65 to 67. That change would be unwise at this time. It would save the federal government little money. It would raise total health care spending. It would impose significant financial burdens on many financially vulnerable older people. And it would impose new costs on businesses and state governments.

When Medicare was created, the age of eligibility for benefits was set at 65. That was also the age at which full Social Security benefits were paid. Full Social Security benefits are now available only at age 66. For people born after 1961, full Social Security benefits will not be available until age 67. Given that background, increasing the age of eligibility for Medicare at first blush seems sensible.

It isn’t. Although “full” Social Security benefits are not payable until age 66, most people claim them earlier—60 percent of new Social Security retirement benefits in 2010 went to claimants younger than age 65. And employment based health insurance ends with retirement for most people. Millions who have retired or become unemployed for other reasons are without health insurance until they reach age 65 and become Medicare-eligible. Having to wait until age 65 for Medicare coverage is a serious problem even now. Raising the age of eligibility for Medicare makes the wait longer and the problem worse.

Even so, that step might be desirable if it helped lower the federal budget deficit. But the overall federal savings would be small and total health care spending would rise. The reason is that for every dollar the federal government would save from raising the
Medicare eligibility age to 67, other costs would go up by $1.10. The more-than-offsetting increases would go for increased federal and state Medicaid spending, higher subsidy payments under the new health care law, and added spending by businesses and older people themselves. Furthermore, raising the age of eligibility for Medicare would raise premiums for all other Medicare beneficiaries. The reason is that 65- and 66-year-olds are less costly than older Medicare enrollees, and premiums are based on average costs.

If the new health care law is rolled back, federal savings from raising the Medicare eligibility age would be larger, but more currently covered 65- and 66-year-olds would be uninsured or have to pay much more than now for health insurance.

Once the new health care law is up and running and helping people buy health insurance, it will be time to revisit the question of the age at which Medicare eligibility should start. People are living longer. The decades-long trend to earlier retirement has reversed. Those who can work longer should be encouraged to do so. But now is not the time to put at risk the health insurance coverage for millions of 65- and 66-year-olds, in the mistaken belief that doing so will contribute significantly to lowering the federal deficit.

Stuart Butler, Ph.D., is a Distinguished Fellow and Director of the Heritage Foundation’s Center for Policy Innovation.

Henry J. Aaron, Ph.D., is a Senior Fellow in Economic Studies and The Bruce and Virginia MacLaury Chair at The Brookings Institution.
**Options for Reforming Medicare**

**Raise Medicare Premiums for Higher-Income Beneficiaries**

Most Medicare beneficiaries pay a separate monthly premium for doctor visits (Part B) and prescription drug coverage (Part D) in Medicare. The premiums people pay for parts B and D cover about 25 percent of what Medicare spends on these services. Individuals with annual incomes of more than $85,000 and couples with annual incomes above $170,000 pay higher premiums, up to three times the standard premium depending on income level. Under several proposals, these higher-income beneficiaries would be required to pay as much as 15 percent more than they currently pay.

**Argument for:**

**Stuart Butler, Ph.D.**

The Heritage Foundation

**Argument against:**

**Avalere Health, LLC**

**Stuart Butler**

The best way to generate more premium revenue to help pay for Medicare Parts B and D is to raise premiums for higher-income beneficiaries. That would improve Medicare’s finances by bringing in more premium revenue, but without imposing burdens on modest-income beneficiaries.

Right now upper-income beneficiaries already pay higher premiums than others. Today a single beneficiary with an annual income of $85,000 or less ($170,000 for couples) pays $99.90 monthly for Part B coverage. Beneficiaries with incomes above those levels pay a premium that goes up according to their income, hitting a maximum of $319.70 a month for single people with incomes above $214,000. Yet even these higher premiums cover only about 80 percent of the actual cost of Part B services, with the rest coming from general taxes. Part D premiums are treated in a similar way.

Basing Medicare premiums on income makes a lot of sense. When Medicare was created in 1965, the vision was that the health benefits beneficiaries received should be adequate for all and should also be roughly the same for rich and poor alike. But even if that made sense at the time, the costs of Medicare are rising at a rapid clip, and we just cannot afford that vision any more. That’s why we’ve already accepted the principle that better-off beneficiaries should pay more for their Part B and D benefits. Still, while America’s Warren Buffets do pay higher premiums to cover a higher proportion of those benefits, about 20 percent of the cost of their benefits is still picked up by taxpayers.
So rather than focus on raising the standard premium for modest-income beneficiaries, we should instead raise them further on higher-income beneficiaries. Now some people claim that would be unfair. They say that because working Americans pay a flat Medicare payroll tax on their entire paycheck, richer beneficiaries have already paid much more into Medicare. But the payroll tax doesn’t actually go to pay Medicare B and D. It only goes toward the part of Medicare that pays for hospital services. Well-off beneficiaries enrolled in B and D still get large subsidies from other taxpayers, and that’s unfair.

But if we generate more revenue for Medicare through higher premiums on better-off beneficiaries, we need to do two things to make the result fair.

First, beneficiaries with very high incomes should pay the full cost of their taxpayer-subsidized Part B and D, not just a little more. The Warren Buffets can pay full freight. And second, to generate enough revenue from premium increases, we have to reexamine what “higher income” actually means. Many older couples with annual incomes below $170,000 ($85,000 for singles)—the current level for higher premiums—should pay more than a quarter of the actual cost of B and D (the proportion they cover today). It’s only fair that a couple with $100,000 of annual income should pay more for premiums than a couple living on $50,000. So the income threshold for higher premiums needs to come down, while protecting modest-income beneficiaries from unduly high premiums.

Avalere Health

On the surface, it may seem reasonable to charge Medicare beneficiaries with higher incomes more for the same Part B and D coverage. However, in reality, many of these proposals will also push costs onto more middle-class beneficiaries, particularly if the income level at which individuals are subject to the higher premium continues to be frozen, or even reduced. Higher-income beneficiaries already pay more money into the Medicare program before retirement through higher payroll and income taxes, and they already are required to pay up to three times more in premiums for Medicare Part B and D—so they should not have to pay even more for the same coverage as other beneficiaries. Higher-income Medicare beneficiaries are also required to pay higher premiums regardless of their expenses, which can vary substantially (for example, some may be supporting a spouse with expensive long-term care needs). In addition, raising Medicare premiums for higher-income beneficiaries could create a disincentive for individuals to work and save.

Some propose to keep the income level at which beneficiaries must pay the higher premiums, already frozen for 10 years, at the same threshold for even longer. Over time, this means that more Medicare beneficiaries will be required to pay the higher premiums each year. Others have proposed that thresholds be lowered. Under both proposals, more middle-class beneficiaries would hit the income level that triggers higher premiums. It is estimated that 25 percent of all Medicare beneficiaries may have to pay Part B income-related premiums by 2035. The number of Medicare beneficiaries subject to Part D income-related premiums will similarly increase.

Some higher-income beneficiaries may decide it is more advantageous to drop out of Parts B and D if they are able to buy less expensive private coverage or simply to self-pay for the physician visits and medications covered under Parts B and D. This will make
it more difficult for the federal government to manage risk within the Medicare program. Higher-income beneficiaries tend to be younger and healthier and are needed in the program to balance the costs of sicker and less wealthy enrollees. If enough higher-income beneficiaries drop out of Parts B and D, the premiums for Medicare Parts B and D will need to increase for beneficiaries who remain in the program, making Medicare participation more expensive for almost everyone.

Stuart Butler, Ph.D., is a Distinguished Fellow and Director of the Heritage Foundation’s Center for Policy Innovation.

Avalere Health, LLC is a leading advisory company focused on health care business strategy and public policy.
Options for Reforming Medicare
Change Medicare to a Premium Support Plan

Under this proposal, newly eligible Medicare beneficiaries would receive their health coverage through private insurance plans, not traditional Medicare. Beneficiaries would choose among competing plans and the federal government would contribute a fixed amount to pay the premiums for the private insurance plan. If the private insurance premiums prove to be higher than the federal contribution, seniors would be required to pay the difference. If the government’s annual contribution does not increase by the same amount as the annual cost increase in premiums, beneficiaries would pay the difference, which could get larger over time.

Argument for:
Stuart Butler, Ph.D.
The Heritage Foundation

Argument against:
Henry J. Aaron, Ph.D.
The Brookings Institution

Stuart Butler

It makes sense to put Medicare on a long-term budget that reduces the burden on our children and grandchildren while making health care affordable for older people. The best way to do that is through the idea called “premium support.”

The new health law does have a long-term budget for Medicare. But to keep within a budget, it uses an unelected board to set fees for your doctor and hospital, or payments to your private Medicare plan. So Washington ends up deciding what your doctor is worth. That’s bad.

A better way to stick to a budget is through the approach called “premium support,” which has a long and bipartisan history. This means older people would receive their own share of the Medicare budget to use toward a health insurance plan or with doctors. They would decide what is the best value for their money.

Nobody says this approach should start immediately. Some say not to start it for anyone who is now over 55. Others say to begin the approach 10 years from now.

If enacted, premium support would eventually work like this. If you have a private Medicare plan (known as Medicare Advantage), where you pay a premium to the plan, then not much would change. Medicare would just pay your share of Medicare spending to the plan. If you wanted a more expensive plan, you would pay the difference. For Medicare to keep to the budget, the difference you had to pay in the future might rise, or to avoid that you could switch to a less expensive plan.
Medicare Reform Option: Change Medicare to a Premium Support Plan

Say you wanted to stay in traditional fee-for-service Medicare. That’s where you get billed by doctors and hospitals and Medicare pays all or part of each charge. Premiums for Medicare Part B (physician services) and Part D (prescription coverage) would be combined with Medicare Part A hospital coverage into a simpler program with one premium and a wide range of doctors to choose from. But you could choose between different versions of traditional fee-for-service Medicare. You could agree to a more limited network of doctors, for instance, and pay less out of pocket after your premium support. Or you could have unlimited choice of doctors and pay more.

Premium support provides important protections for older people. First, unlike today, you would get “catastrophic” protection. That means Medicare would limit your out-of-pocket costs to a reasonable maximum level. Second, the amount of support each older person received would make sure sicker retirees paid no more than healthier ones for the same coverage. And third, modest or lower-income older people would receive more premium support for their Medicare costs than higher-income ones.

Medicare spending is growing rapidly and needs to be held to a budget to reduce the debt and deficits facing our children and grandchildren. That means, one way or another, older people will have to pay more for Medicare benefits. Premium support is the best way for Medicare to stay within a budget because it would give older people more control and choice over how that budget is actually spent.

Henry Aaron

Should Medicare be replaced with a system under which beneficiaries would be given a voucher for the purchase of health insurance? Under so-called premium support, the value of the voucher would be tied to some economic index, not health costs.

Fifteen years ago, I thought that such a change was promising. My hope and that of many others was that insurers would compete to hold down health care costs and improve the quality of care, thereby slowing the growth of government Medicare spending. For several reasons, I no longer do.

In the plan I supported, the value of the voucher would have been tied to average health care costs, not some outside index, ensuring that Medicare enrollees could always afford Medicare. But that is not what is being proposed today. Today’s plans would tie the value of the voucher to indexes that have grown and are expected to grow more slowly than health care costs. Under the plan I described many years ago, costs would not be more or less automatically shifted to beneficiaries. But under plans now under discussion, there is a high risk that with the passage of time, benefits will become increasingly inadequate or beneficiary costs will be much higher.

In addition, consumers can make informed choices among competing insurance plans only if the number of plans among which they are asked choose is limited to a few prototype plans. In addition, to minimize competition through ‘cream skimming,’ those plans should be marketed only through public or nonprofit organizations charged to provide clear and unbiased information. No current premium support plan provides these assurances.

There are other reasons why premium support should not be undertaken at this time. The nation has just enacted a major health insurance reform. A key step in that reform is the
creation of health insurance exchanges to regulate the sale of health insurance to people who are comparatively healthy—that is, not disabled—and are not elderly. Even for this population, the job of setting up these organizations is proving to be exceedingly difficult and controversial. The problems that such organizations would face in dealing with older and disabled people would be more challenging even than those they are now facing. The first job is to get these organizations up and running. Only then can one know whether they can handle the much harder task of administering insurance for the Medicare population.

Medicare has changed since the mid-1990s. It now offers competing private plans through Medicare Advantage and under the Part D drug program. The hoped-for savings have not yet materialized. In fact, Medicare Advantage plans on average cost more to provide standard Medicare services than does traditional Medicare. Growth of drug spending has slowed nationwide, but the competing Part D plans have not produced additional savings. In addition, the recently enacted health reform already contains measures that will slow the growth of Medicare spending nearly as much as would the various “premium support” plans, and further improvements to the current Medicare program, including greater use of Medicare’s market power, could go even further.

We cannot know whether some form of premium support may ultimately prove attractive until we know whether the health insurance exchanges that would administer the sale of insurance will work for the Medicare population. And we should not even think of exposing older people to that framework until we see how it works for the rest of the population.

Today’s job is to make health reform work. Tomorrow’s job will be to determine whether that framework should be extended to all Americans.

**Stuart Butler, Ph.D., is a Distinguished Fellow and Director of the Heritage Foundation’s Center for Policy Innovation.**

**Henry J. Aaron, Ph.D., is a Senior Fellow in Economic Studies and The Bruce and Virginia MacLaury Chair at The Brookings Institution.**

Perspectives 4, June, 2012

AARP Public Policy Institute, 601 E Street, NW, Washington, DC 20049

www.aarp.org/ppi

202-434-3890, ppi@aarp.org

© 2012, AARP.

Reprinting with permission only.

The views expressed herein are for information, debate and discussion, and do not necessarily represent official policies of AARP.
Under current law, drug manufacturers are required to give rebates or discounts to the Medicaid program for prescription drugs purchased by Medicaid beneficiaries. However, Medicare Part D — the optional prescription drug coverage — does not require similar manufacturer rebates or discounts. This proposal would require manufacturers to provide Medicare with the same rebates or discounts as those Medicaid receives for drugs purchased by certain low-income Part D enrollees.

Argument for:
Henry J. Aaron, Ph.D.
The Brookings Institution

Argument against:
Stuart Butler, Ph.D.
The Heritage Foundation

Henry Aaron

The Medicare Modernization Act (MMA), which took effect in 2006, provided an unintentional multibillion-dollar windfall for drug companies at the expense of the American taxpayer.

Here is how it happened. Before 2006, between 15 and 20 percent of Medicare enrollees received drug coverage under Medicaid (a different government program) because they are poor or disabled. Under federal rules, drug companies are required to give Medicaid sizable discounts below the price charged to others. (The Veterans Administration demands—and gets—similar discounts.) The MMA transferred those Medicare enrollees also covered by Medicaid—the so-called “dual eligibles”—to the new drug benefit for Medicare enrollees, Part D. But Part D is administered by private companies, rather than the government. These companies, in many cases, lacked the power to negotiate discounts as large as Medicaid received—or, for some drugs, much discount at all. As a result, the price of drugs for Medicare enrollees is higher than that under Medicaid and other government programs.

The cost is large. Dual eligibles are much heavier users of drugs than is the average Medicare enrollee, and they are particularly heavy users of some expensive drugs. As a result, they account for well over half of all spending under Medicare Part D. If drug companies were required to give the same discounts for drugs for dual eligibles and other low-income beneficiaries as they now provide for Medicaid enrollees, Medicare spending would be cut $112 billion over the next decade. These savings would spare the nation the need to raise taxes or cut other spending by similar amounts. That is why many groups
that have proposed ways to cut the overall deficit and Medicare spending have endorsed this change.

Nothing comes for free, however. Drug companies indisputably use the expectation of profits to guide research to find new drugs. Experts believe that the impact of restoring the discounts on drug sales for dual eligibles may somewhat discourage research. But not all new drugs are better than old ones. And drug companies are now spending more on marketing than research. If spending has to be cut somewhere—and it does—this is a good place to begin.

**Stuart Butler**

Some people think that requiring drug companies to reduce the prices they charge Medicare for low-income older people with Part D drug coverage would reduce Part D costs and be a good idea. It would not be—prices would just go up for other Americans, and there would be less research on cures for diseases like Alzheimer’s.

One reason it is a bad idea is that making drug firms cut their prices in one place just means they will tend to raise them somewhere else, just as squeezing one end of a balloon causes it to expand somewhere else. That’s why it turns out that when your bank is told to end a fee on one service, it just raises the fee on another service. So requiring a reduction—known as a “rebate”—on the cost of drugs for some or all older people in Medicare Part D just means someone else will pay more, such as working Americans who have to fill prescriptions for themselves or their children.

But let’s say the drug firms that were forced to give rebates in Medicare were somehow not able to recover the lost revenue from higher charges on other Americans. That would mean the total revenue they obtained from those drugs widely used by older people would fall. That might seem to be no problem for Medicare beneficiaries—just a problem for the companies and their investors. But there’s more to it. Knowing they would have to give the Medicare program rebates on future new drugs would make it less attractive for these firms to make the heavy and risky investments needed to find better drugs for diseases primarily afflicting older people, such as Alzheimer’s. That would be bad news for both today’s and tomorrow’s older Americans. The bigger the forced rebate, the greater the disincentive to invest in breakthrough drugs aimed at older people.

In addition, requiring a rebate would get in the way of existing negotiations over drug prices between the competing plans that offer Part D drug coverage and the drug companies. The tough competition and smart bargaining strategies they have used have enabled the Part D program to provide coverage at less total cost to Medicare than was expected. That’s why premiums in Part D have been lower than many expected. Having today’s negotiating flexibility leads to fewer of the bad side effects that I just described from government-required rebates. Part D is one of the areas of Medicare that actually works quite well.

That is not to say nothing is needed. Like other parts of Medicare, the revenue from Part D premiums covers only a small part of the actual cost. So today’s and tomorrow’s taxpayers will have to write bigger and bigger checks to the Internal Revenue Service if no action is taken. So while some very high-income seniors do pay a bigger proportion of their Part D cost today, it is reasonable to ask better-off seniors to pay more or even all of the cost of Part D.
Henry J. Aaron, Ph.D., is a Senior Fellow in Economic Studies and The Bruce and Virginia MacLaury Chair at The Brookings Institution.

Stuart Butler, Ph.D., is a Distinguished Fellow and Director of the Heritage Foundation’s Center for Policy Innovation.

The views expressed herein are for information, debate and discussion, and do not necessarily represent official policies of AARP.
Medicare does not charge a copay for patients whose doctors prescribe home health care or for the first 20 days in a skilled nursing facility. Several proposals would require a copay for home health care, including one that would require a payment of $100 for home health episodes with five or more home health visits and add copays for the first 20 days of care in a skilled nursing facility. Medicare does not currently require a copay for laboratory services (such as blood and diagnostic tests). A number of proposals would require beneficiaries to pay 20 percent of the cost of laboratory services.

Argument for:

Imposing a copayment for home health, skilled nursing facility (SNF), and laboratory services will discourage unnecessary use of these services. Since Medicare beneficiaries will be directly responsible for part of the cost, they will be more careful and deliberate about determining whether they need to use these services.

Studies have found that people use more health care services when there is little or no cost-sharing in place. For example, home health visits are one of the few services covered under Part B that do not require a copayment. Home health use has increased significantly in the past 10 years, which suggests that there may be overuse of these services. Use of laboratory services, which also does not require a copayment, has also increased. If cost-sharing were introduced, beneficiaries would have more of an incentive to talk to their provider about the necessity of the services being prescribed.

Shifting more of the cost for home health, SNF, and laboratory services to Medicare beneficiaries will also reduce Medicare costs and help to improve the long-term stability of the program. For example, adding a home health copayment could save the Medicare program as much as $40 billion over 10 years, depending on the copayment size and when it was implemented. Another study found Medicare savings of $21 billion over 10 years if SNF cost-sharing were increased. Savings estimates from adding laboratory test copayments are as high as $16 billion over 10 years, depending on the size of the copayment.

Most Medicare supplemental insurance (such as Medigap) would cover at least a portion of the cost-sharing, which would lessen the financial burden of these proposals on the majority of beneficiaries who have supplemental coverage.
Medicare Reform Option: Increase Medicare Cost-Sharing for Home Health Care, Skilled Nursing Facility Care, and Laboratory Services

Argument against:

Many Medicare beneficiaries will have trouble affording the copayment amounts, particularly those who are low income and do not qualify for any additional assistance (such as from Medicaid, a federal-state program that helps low-income people). These individuals may end up not getting needed care or services.

Studies have shown that Medicare beneficiaries using home health and skilled nursing facility services tend to be sicker and poorer than the average Medicare enrollee. Under some proposals, Medicare beneficiaries without other supplemental coverage could end up paying significantly more for these services. For instance, some could pay up to $1,180 more if they stayed in a SNF for 27 days, and some could pay up to $600 more for home health services. Not everyone can afford these higher costs, and some Medicare beneficiaries may avoid using these services, which may be medically necessary, or seek less appropriate care. This could lead to more emergency room visits or hospital admissions down the road, which could end up costing the program even more money.

Even Medicare beneficiaries with supplemental policies could face higher out-of-pocket costs, as premiums would likely rise to offset the higher copays. State governments would also pay more, as Medicaid would be responsible for the copayments of low-income Medicare beneficiaries who receive assistance from Medicaid.

Finally, patients are in no position to determine whether tests ordered by their health care provider are medically necessary. Patients generally follow the recommendation of their provider—thus, reducing unnecessary tests or services should be done at the provider level, not by limiting care to patients.

*Avalere Health, LLC* is a leading advisory company focused on health care business strategy and public policy.

Perspectives 10, June, 2012
AARP Public Policy Institute,
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3890, ppi@aarp.org
© 2012, AARP.
Reprinting with permission only.

The views expressed herein are for information, debate and discussion, and do not necessarily represent official policies of AARP.
The primary source of funding for Medicare hospital services (Part A) comes from the payroll tax. Workers and their employers each contribute 1.45 percent of earnings for a total contribution of 2.9 percent. Medicare also offers coverage for physician services (Part B) and prescription drugs (Part D), but these services are not funded by the payroll tax. It’s estimated that beginning in 2024 Medicare will not have enough money to pay for all of the expected hospital expenses. Increasing the payroll tax rate by 0.5 percent to 3.9 percent (or to 1.95 percent each for workers and employers) would raise additional revenue for Medicare’s inpatient hospital expenses. For an individual earning about $50,000 a year in wages, this increase would amount to an extra $250 in Medicare payroll taxes per year.

Argument for:

Henry J. Aaron, Ph.D.
The Brookings Institution

Argument against:

Stuart Butler, Ph.D.
The Heritage Foundation

Henry Aaron

Medicare Part A—covering hospital and skilled-nursing home stays—faces a modest projected long-term deficit: that is, the available funds will not pay for all services, but the gap is small. Based on current projections, a 1 percentage point increase in the payroll tax would more than completely close that deficit. In fact, it would provide a modest cushion should current projections prove to be unduly optimistic. Alternatively, this added revenue could be used to cover the cost of a new and important benefit—eliminating the current annual and lifetime maximums on Part A services. Such a payroll tax increase should be enacted promptly to take effect as soon as the economic recovery is well established and well advanced.

The news that Medicare Part A (also known as Hospital Insurance) faces so small a projected deficit may surprise many. The projected deficit was much larger before the recent health reform legislation was enacted. The public has not yet recognized how much that legislation did to improve the financial status of the Hospital Insurance program. Moreover, this improvement was achieved by scaling back future growth of payments to providers and without cutting benefits for Medicare beneficiaries in any way.

Hospital Insurance is financed through a special trust fund governed by strict rules, under which total benefit payments can never exceed total earmarked revenues. The revenues come principally from two sources. The largest is a payroll tax levied on all earnings. Most employed workers and their employers each pay 1.45 percent of workers’ earnings,
for a total of 2.9 percent. The other sources are a small portion of personal income tax collections and payments from states to cover the cost of drugs for beneficiaries who receive both Medicare and Medicaid (a separate program covering the poor).

The Hospital Insurance trust fund currently has a balance of about $200 billion, roughly what Hospital Insurance now spends each year. Because of the recession, revenues are down and do not cover all Hospital Insurance costs. As a result, the trust fund is shrinking. Looking ahead, the retirement of the Baby Boom Generation will keep spending above revenues. But the gap is small, and it is projected to get even smaller for two reasons.

First, the health reform legislation slowed the growth of future payments to hospitals and some other providers. Second, the health reform legislation increased the taxes earmarked for Hospital Insurance by raising payroll tax rates for high earners and imposing a new tax on investment income of high-income households. These increases and other smaller changes closed most, but not quite all, of the projected Hospital Insurance funding gap. Boosting payroll taxes by just ½ percentage point on workers and by the same amount on their employers—a total of 1 percentage point that would increase the total payroll tax from 2.9 percent to 3.9 percent—would take care of the rest of the problem, with a bit to spare.

There is no reason to perpetuate the myth that Medicare Hospital Insurance is in crisis. It isn’t. Vigorous enforcement of the recently enacted health reform legislation together with this modest tax increase will secure Hospital Insurance for current and future Medicare beneficiaries. The time to act is now.

Stuart Butler

Addressing Medicare’s long-term financial problems by raising payroll taxes on working Americans is not the answer. That will make the situation worse for the economy and for our children and grandchildren, and will erode the political will to undertake needed reforms.

Medicare is taking a bigger and bigger proportion of our national economy as the years go by. Right now over 3.6 percent of our entire economy is spent on Medicare. In just over 20 years that will rise to 5.6 percent, and by the time a college graduate today retires it will be over 6 percent. Moreover, Medicare will run huge deficits in the future, meaning large debt burdens for future generations.

So why not just raise the Medicare payroll taxes to try to keep up with the future rise in Medicare’s hospital spending? Several reasons.

First, raising the payroll tax means higher taxes for each dollar earned by working Americans. That would slow economic growth—further harming our ability to afford health care in the future.

Second, raising the payroll tax rate means the people who will pay most to reduce Medicare’s burden on our children and grandchildren would be our children, and especially our grandchildren. That’s because higher payroll taxes today imposes the biggest total burden on those who will have to work the longest before reaching
Medicare Reform Option: Generate New Revenue by Increasing the Payroll Tax Rate

retirement. Worse still, the payroll tax is imposed on every dollar earned, so even those workers not earning enough to pay income taxes would still be hit.

And third, raising taxes on someone in the future just takes the pressure off Congress to take sensible steps today so that we can ensure adequate and affordable health care now as well as in the future. Washington needs to make hard decisions about Medicare itself, which politicians want to avoid making—they’d rather pass a “small” tax increase on working-age Americans. But we need to make sure that programs like Medicare don’t take such a large share of the economy in the future that there is not enough for other critical goals like education, rebuilding our roads and bridges, and defending America. So we’ve got to get the future costs of Medicare down, not tax Americans more.

It’s true that tackling the rising costs of Medicare does mean addressing the cost growth of our whole health system. Part of Medicare’s cost problem is the whole health system’s cost problem. Whether you think the new health law is the right way to do that or another approach, we need to take action to get all health spending under control.

But it is also necessary to revisit the commitments we made in the Medicare program, and make decisions to encourage older people to seek better value for money and, where necessary, shoulder more of the cost of health care themselves. This will involve hard decisions. But we will never even start to make such hard decisions if we think we can just tax future generations.

Henry J. Aaron, Ph.D., is a Senior Fellow in Economic Studies and The Bruce and Virginia MacLaury Chair at The Brookings Institution.

Stuart Butler, Ph.D., is a Distinguished Fellow and Director of the Heritage Foundation’s Center for Policy Innovation.

The views expressed herein are for information, debate and discussion, and do not necessarily represent official policies of AARP.
Even with Medicare coverage, seniors are often left with significant health care costs, so many people purchase supplemental private insurance coverage (such as Medigap plans) to reduce their out-of-pocket expenses. One proposal would charge more for certain types of supplemental plans, such as those that cover all costs so seniors incur no out-of-pocket expenses themselves. Other proposals would limit what Medigap supplemental insurance plans will cover. For instance, they could prevent Medigap from covering the first $500 of a Medicare beneficiary’s out-of-pocket costs, and only cover 50 percent of the remaining charges. Some proposals may also include a cap to limit overall out-of-pocket expenses.

Options for Reforming Medicare
Increase Supplemental Plan Costs and Reduce Coverage

Henry Aaron

Most Medicare beneficiaries have health insurance coverage in addition to Medicare. Some coverage comes from previous employers and some from Medicaid. Roughly one Medicare beneficiary in six buys private insurance themselves, called Medigap. The reason people want such coverage is straightforward: There are gaps in Medicare coverage. The Hospital Insurance deductible is large. Medicare does not cover all of the cost of very long stays in a hospital or a nursing home, and beyond a certain point Medicare stops paying altogether. The cost of lengthy illnesses can be financially crushing, despite Medicare benefits.

So, what is the problem? The problem is not that people want to and are able to buy additional coverage. People should be free to use their own money to protect themselves from financial risk. But the price for such coverage should accurately reflect the expected cost of the added protection. At present it does not.

The additional insurance that Medicare enrollees buy increases the use of Medicare-covered services but covers only covers only part of the cost of this increased service use. Taxpayers pay the rest. For example, a person may stay a bit longer in a skilled nursing home if supplemental insurance covers the $144.50 daily copayment for stays longer than 20 days. Many supplemental insurance plans cover the copayment for the added days. But the copayments do not cover the full costs of the additional days, and Medicare covers the rest.
Medicare Reform Option: Increase Supplemental Plan Costs and Reduce Coverage

No one believes that people should be prevented from buying supplemental coverage altogether. But many are worried because current policies increase overall Medicare spending. Some reform proposals would change Medigap by raising the amount that Medicare enrollees must pay themselves and reducing what Medicare pays, especially at the beginning of an episode of illness. All such proposals would maintain or improve protection in one way—by placing a hard cap on total out-of-pocket expenses. This change would also reduce the price of Medigap insurance. Dual eligibles—those Medicare beneficiaries who also qualify for Medicaid (a government program for people with low incomes)—and those covered by supplemental insurance from previous employers would be unaffected. People who do not use many Medicare services would gain from such a shift, as they would save more from lowered Medigap premiums than the increase in what they would spend directly for medical services. But heavy users of Medicare services would see an increase in their total medical costs.

If some cuts in Medicare spending prove to be necessary in order to keep the Medicare program financially sound, limits on how Medigap insurance pays for services, in addition to those in current law, would have the side benefit of lowering Medigap premiums and might deter some people from using services that produce few benefits. But no reduction will be painless.

Avalere Health

It would be unwise to increase the premium amounts for Medicare supplemental insurance, such as Medigap, or to decrease the amount of coverage available to enrollees under these policies. There is no evidence that these reforms would deter Medicare beneficiaries from using unnecessary health care services. Further, Medigap reform proposals in particular have an unfair effect on lower-income Medicare enrollees and those in poor health.

About 20 percent of Medicare beneficiaries purchase some type of Medigap plan to help cover Medicare cost-sharing. A majority of these policies (59 percent) provide “first dollar” coverage, which protects enrollees from having to incur any out-of-pocket costs for Medicare services in exchange for a monthly premium. Supplemental insurance programs like Medigap make health care expenses more predictable and therefore easier to manage on a fixed income.

Critics say that generous Medicare supplemental policies, such as first dollar Medigap plans, encourage Medicare beneficiaries to use more and sometimes unnecessary health care services. Proposals to reform Medigap and other supplemental private insurance would require beneficiaries who purchase these plans to pay more for services, or tax the purchase of these first dollar plans.

There is, however, limited evidence to support the claim that first dollar coverage results in an increase in unnecessary use of services. In fact, there is some evidence that beneficiaries without supplemental coverage are more likely to postpone medically necessary services in order to avoid Medicare cost-sharing requirements. Furthermore, some studies found that when health plans increase cost-sharing, it particularly affects those who are sicker and poorer, as these are the individuals who are most likely to postpone or avoid seeking care. This delay of care could lead to more expensive health problems in the longer term, particularly for those with chronic conditions.
If the concern is overutilization and unnecessary use of health care services, there are less burdensome and more direct ways to address the problem. Many beneficiaries are not in a position to determine whether a service is necessary or not, and they should not be placed in a position of having to decide based on their ability to pay.

Finally, there is an equity issue inherent in proposals that target Medigap without reforming other forms of supplemental coverage. Beneficiaries who purchase Medigap coverage are less likely to have access to other forms of supplemental coverage, such as employer-sponsored insurance or Medicaid. Most Medigap reform proposals do not include similar premium and cost-sharing restrictions on these other types of supplemental coverage. This would place Medigap enrollees at an unfair financial disadvantage when it comes to affording supplemental insurance or covering Medicare out-of-pocket costs.

**Henry J. Aaron, Ph.D.,** is a Senior Fellow in Economic Studies and The Bruce and Virginia MacLaury Chair at The Brookings Institution.

**Avalere Health, LLC** is a leading advisory company focused on health care business strategy and public policy.

---

The views expressed herein are for information, debate and discussion, and do not necessarily represent official policies of AARP.
Most Medicare beneficiaries pay a monthly premium for doctor visits (Part B) and prescription drug coverage (Part D). The premiums people pay for parts B and D covers about 25 percent of what Medicare spends on these services. Individuals with annual incomes of more than $85,000 and couples with annual income above $170,000 pay higher premiums, which cover more than 25 percent of Medicare spending. Some proposals would increase premiums for everyone in Medicare to cover a larger portion of the program’s costs. Under one proposal, the standard Medicare premiums would go up from 25 to 35 percent of program costs. If that proposal were to go into effect in 2012, the current $99.90 monthly premium for Medicare Part B paid by the typical beneficiary would cost 40 percent more, or an additional $40 per month. Part D premiums, which vary widely by plan and region, would increase similarly.

Argument for:

Stuart Butler, Ph.D.
The Heritage Foundation

Argument against:

Henry J. Aaron, Ph.D.
The Brookings Institution

Stuart Butler

Increasing the basic premiums for Medicare Parts B and Part D makes sense. It would help Medicare’s finances and can be done while protecting lower-income older people.

Right now the premium that most older people pay is a basic premium that only covers about a quarter of the total cost of Part B or D services. The rest comes from general taxes paid by mainly by working-age Americans. Higher-income older people (couples with incomes of more than $170,000) do pay higher premiums, but even they do not pay the actual full cost.

Now it does make sense for many or even most seniors to pay more of their Medicare premium costs rather than expecting people like their working-age children to pay instead through taxes. These parts of Medicare are voluntary “add-ons” to the Medicare coverage they receive for hospital services (also know as Part A Medicare), which Americans pay for through the payroll tax. A retired couple with, say, $120,000 of annual income from investments is certainly better able to pay a higher proportion of B and D costs than their $50,000-a-year working-age neighbor can pay in taxes. So it would make sense to raise premiums for many older people with incomes below the level where Medicare currently charges higher premiums. But just raising the basic premium without any other changes would not be fair for all retirees.
One reason is that many modest-income older people already struggle to pay for their Part B and D premiums. These older people also have to buy extra insurance for costs not covered by Medicare, or else risk crippling medical bills or even bankruptcy. They cannot afford to pay higher premiums, and so if their basic premiums were raised, more of them would decide either not to enroll in Part B and D or to cut back on other necessities. So any general increase in premiums would need in some way to exempt modest-income older people.

Also, some very low-income older people have their Part B and D premiums paid by Medicaid—the federal-state program that pays for health care for poor people of all ages. States cover at least half the cost of Medicaid. So if Medicare raised the basic premium for all, states would have to pay more to Medicare. Many financially strapped states would probably respond by trying to cut back on medical care for low-income older people, such as by cutting the fees of doctors who treat older people or by being tougher in deciding whether older people can qualify for Medicaid. Even if they did not cut back on care for older people, states would likely try to save money by cutting health care for working-age poor families. So any premium increase would need to be combined with steps to avoid these results.

If we are going to avoid the future costs of Medicare imposing an unreasonable burden on our children and grandchildren, many older people will have to pay higher premiums. But simply raising the basic premium without other reforms is not the way to do it.

Henry Aaron

No across-the-board increase in Medicare premiums is justified. To be sure, the cost of medical care has been growing faster than incomes. So too has government spending on Medicare parts B and D. For that reason, these elements of Medicare impose a growing burden on the general taxpayer, just as they do on Medicare enrollees themselves, who must pay premiums, cost-sharing, and other out-of-pocket medical costs that are outpacing their incomes.

Nearly all participants in parts B and D receive insurance protection worth far more than the premiums they are now charged. Roughly three-fourths of the cost of Medicare parts B and D are shouldered by taxpayers. Some better-off enrollees could afford to pay a bit more than they now do without undue hardship. But for too many, even current premiums are burdensome.

Let’s look at the facts. The year 2010 is the most recent one for which the Census Bureau has reported data on incomes. In that year, one-fifth of single older women had incomes below $18,000. One-fifth of older couples had incomes of $27,000 a year or less. Total per person premiums for Medicare parts B and D average roughly $1,600 in 2012, and that does not include other Medicare expenses that people must pay, such as deductibles and other cost-sharing.

For those whose incomes are low enough, Medicaid pays Medicare premium deductibles and other cost-sharing. But few realize how very poor one must be to qualify for this help—$11,170 a year or less for single people and $15,130 or less for couples in 24 states. Some relief is available for some elderly single people with incomes up to a bit over $15,000 a year and for couples with incomes up to $22,695 a year. But older singles and couples with higher incomes must pay premiums themselves—roughly $1,600 a year.
Medicare Reform Option: Raise Medicare Premiums for Everyone

for singles and two sets of Part B and Part D premiums for couples—averaging $3,200 a year. Virtually everyone buys Medicare part B even so, because the coverage is so important and the taxpayer subsidy covers three-fourths of the total cost of services rendered.

Current law requires about 5 percent of Medicare beneficiaries to pay more than the normal premium, starting at incomes of $85,000 for single people and $170,000 for couples. No doubt these better-off older people can afford the added cost without hardship. But raising premiums across the board is a terrible idea.

Stuart Butler, Ph.D., is a Distinguished Fellow and Director of the Heritage Foundation’s Center for Policy Innovation.

Henry J. Aaron, Ph.D., is a Senior Fellow in Economic Studies and The Bruce and Virginia MacLaury Chair at The Brookings Institution.
The IPAB is a group of 15 health experts (generally appointed by the president and approved by the Senate) who are required to recommend ways to hold down Medicare spending growth if that growth exceeds a certain limit. The IPAB has the authority to reduce payments to some Medicare providers (e.g., hospitals, doctors), but it cannot raise beneficiary premiums or reduce their benefits. Some proposals would change the law to give the IPAB more authority so it could also reduce benefits, while other proposals would further limit the amount of Medicare spending growth, which could require the IPAB to further reduce spending on doctors, hospitals and other health care providers. Some would eliminate the IPAB altogether.

Argument for:
Henry J. Aaron, Ph.D.
The Brookings Institution

Argument against:
Stuart Butler, Ph.D.
The Heritage Foundation

Henry Aaron

A key provision of the recently enacted health reform legislation authorizes the establishment of the Independent Payment Advisory Board, or IPAB. Because excessively rapid growth of health care spending threatens the U.S. government budget, the IPAB should be retained and strengthened.

The health reform legislation contains many provisions—pilots, experiments, and other reforms—designed to improve quality of care and hold down the growth of spending. It encourages doctors and other providers to band together to deliver care cooperatively. If they can maintain or improve quality and slow spending growth, they can share in the savings. It funds research so that doctors and patients alike will have improved information on what interventions work best. If these provisions work as planned and growth of health care spending is contained, the IPAB will have nothing to do. But if they do not, and Medicare spending grows larger than a set limit, the IPAB will step in and propose ways to hold down growth of health care spending.

There are some things the IPAB can do, some things it may do, and some things it is prohibited from doing. It can propose changes in how some providers are paid or how care is organized. Congress may substitute other ways of reaching the spending targets, but if it does not, the IPAB recommendations take effect. The IPAB may suggest ways to change the health care system outside Medicare. But these recommendations have no binding legal force. The IPAB is prohibited from making any recommendations that
would result in health care rationing or that would change Medicare benefits, premiums, deductibles, or cost-sharing.

If the targets for Medicare spending growth are met, the long-term financing problems of Medicare will be largely solved. The number of enrollees will grow as baby boomers reach age 65, but costs per person will be well controlled. The success of the IPAB is therefore of critical importance.

Some members of Congress want to kill the IPAB even before it goes to work because of a mistaken belief that it usurps congressional authority. It does not. Congress remains free to reverse any recommendations that the IPAB makes. It could even kill the IPAB with new legislation. But the creation of the IPAB expresses a congressional commitment to an important goal—slowing the growth of health care spending.

Expanding what the IPAB is allowed to do could improve its effectiveness. It should be able to recommend changes in payments to all providers. It should be authorized to invest money in ways that will eventually save money, such as simplified billing systems or collection of data on treatment outcomes. It should be provided a larger staff than the legislation now authorizes. But the IPAB must be preserved as a key element, along with other cost-reducing, quality-improving provisions, to promote an increasingly cost-effective Medicare system.

**Stuart Butler**

The IPAB was created in the new health law to cap total Medicare spending so that it grows only a little more each year than the economy grows. To accomplish this, the 15 unelected board members will be able to cut payments each year to your physicians, hospitals, or Medicare plan provider by however much it takes to stay under the spending cap. If Congress cannot agree on its own package of cuts, then the IPAB’s cuts will go into place automatically, and nobody—not the courts or even Congress itself—can stop them. This IPAB should not be strengthened. It should be dismantled.

True, Congress can come up with different cuts to hit the same target, and that will overturn the IPAB’s plan. But if Congress can’t agree on its own package of cuts then the IPAB’s cuts will go into place automatically and nobody—not the courts or even Congress itself—can stop them.

This is a bad way to control Medicare spending. Physicians are already dropping out of Medicare in droves because the program shortchanges them compared with the payments they get for treating most other patients.

Yet some are now arguing that the IPAB should be able to make even deeper cuts in payments to doctors and hospitals. But lower payments will make it even less likely that your doctor will keep you as a patient, and less likely that hospitals will give you the tests or treatment you need. If you have enrolled in a private Medicare plan, expect fewer services and brand-name drugs.

Some also say to strengthen the IPAB’s cost-cutting powers by letting it change the actual Medicare benefits you can receive, rather than only cutting doctor and hospital payments. But that means allowing an unelected and uncontrollable board to change your basic Medicare benefits.
Others who support allowing the IPAB to change benefits say it should do so using research from a new government-created institute that is supposed to figure out which treatments are most effective. Right now the law says the IPAB mustn’t use such data. Why? Because lawmakers fear that giving the IPAB this option would lead to thinly disguised rationing. The British health system has a controversial board with exactly that kind of power. We all want effective care rather than ineffective care, of course. But older people would be unwise to allow a strong, unelected board to take the place of their doctor in deciding what the best treatment is.

Medicare will need to stick to a real budget, as federal education or transportation programs must do, if we are to avoid our children and grandchildren becoming overwhelmed by the future costs of the program. The question is who gets to decide how a reined-in Medicare budget will be spent. Using a Medicare board is a top-down vision of how to do that. It means the government decides what your doctor will be paid and, ultimately, what health care you will get. The alternative vision has no board because each older person would have the right to decide either which health plan, or which doctor and hospital, will get that person’s portion of the Medicare budget.

**Henry J. Aaron, Ph.D., is a Senior Fellow in Economic Studies and The Bruce and Virginia MacLaury Chair at The Brookings Institution.**

**Stuart Butler, Ph.D., is a Distinguished Fellow and Director of the Heritage Foundation’s Center for Policy Innovation.**

The views expressed herein are for information, debate and discussion, and do not necessarily represent official policies of AARP.
Options for Reforming Medicare

Redesign Medicare’s Copays and Deductibles

Medicare Part A pays for inpatient hospital, skilled nursing facility, hospice and home health care. Part B pays for physician and outpatient services (excluding prescription drugs). Part A and Part B have different cost-sharing and deductibles. Under Part A, beneficiaries who receive inpatient hospital services pay a deductible ($1,156 in 2012) in each benefit period, and there is no initial cost-sharing for hospital stays under 60 days. In contrast, the annual deductible for Part B services is $140, and beneficiaries must pay 20 percent of their costs after meeting their deductible. Some proposals would combine the Part A and Part B programs to have only one deductible (for example, $550) and one coinsurance (for example, 20 percent) for all Part A and Part B services. Currently, there is no annual upper limit on out-of-pocket expenses for Part A or Part B. Some proposals would set an out-of-pocket limit.

Prepared for the Public Policy Institute by: Avalere Health, LLC

Argument for:

Redesigning Medicare copayments and deductibles could simplify and streamline Medicare benefits for beneficiaries. It can be confusing to track the various deductibles and cost-sharing requirements across the different parts of the Medicare program. More uniform cost-sharing will give beneficiaries a coverage program that works more like the private health insurance plans that many had prior to enrolling in Medicare.

If an annual out-of-pocket spending cap were included in this redesign, Medicare beneficiaries—particularly those with high utilization—would have more financial protection from expenses caused by severe and often unexpected illnesses. This could also reduce the need for supplemental insurance, such as Medigap. While most beneficiaries likely will not reach the out-of-pocket limit in a given year, knowing that the limit exists could give them a greater sense of financial security.

Redesigning Medicare cost-sharing could also create savings for the federal government. One study estimated that the federal government could save up to $110 billion over a 10-year period if the Part A and Part B programs had a combined annual deductible of $550, a uniform 20 percent coinsurance rate for all services (reduced to 5 percent after beneficiary out-of-pocket costs exceeded $5,500), and an annual out-of-pocket cap of $7,500. In addition, increased cost-sharing could make beneficiaries more price-sensitive in using health care services, resulting in lower utilization and greater Medicare savings. These savings would improve the long-term stability of the Medicare program for both current and future beneficiaries.
Argument against:

Many Medicare beneficiaries would end up paying more out of their own pocket if Medicare cost-sharing were combined across Parts A and B. Beneficiaries who use few services or primarily physician services could be particularly affected by a combined deductible that is greater than the current Part B deductible and the new coinsurance requirements for certain services. Similarly, beneficiaries with higher hospital utilization could be adversely affected by proposals that apply coinsurance to the first 60 days of a hospital stay.

In addition, Medicare beneficiaries, especially those with modest incomes or no supplemental coverage, could find it difficult to afford these cost-sharing requirements. These beneficiaries may decide not to get the medical care that they need in order to avoid paying coinsurance or deductible amounts, which could lead to poorer health outcomes and higher Medicare costs in the long run. Providers, not patients, know what services and tests are appropriate—patients are in no position to second-guess their health care providers.

Supplemental plans are expected to help enrollees pay for the new cost-sharing requirements under the alternative benefit design. However, under some proposals, supplemental plans could pass some of these new expenses on to enrollees in the form of higher premiums, which would affect even the relatively few Medicare beneficiaries who do not use any Medicare-covered services in a given year.

Avalere Health, LLC is a leading advisory company focused on health care business strategy and public policy.
Ideas for reform:

**Stuart Butler, Ph.D.**
The Heritage Foundation

**Henry J. Aaron, Ph.D.**
The Brookings Institution

### Options for Reforming Medicare

**Address the Sustainable Growth Rate (Physician Payment) Formula**

In 1997, the law established a new formula for paying Medicare doctors. The goal of the “Sustainable Growth Rate” (or SGR) was to reduce health care costs by setting limits on how much doctors who treat Medicare patients could be paid. Fees have not been reduced in recent years, as the SGR formula calls for, because Congress has repeatedly intervened to prevent payment reductions. There are several proposals to reform the Medicare doctor payment system. Some proposals include freezing payments for primary care physicians while temporarily decreasing rates for specialists. Maintaining current payment rates for Medicare doctors would cost $316 billion over 10 years, according to the Congressional Budget Office.

### Stuart Butler

Doctors who take Medicare patients rightly complain bitterly about a government payment rule that is designed to cut their fees automatically every year to keep Medicare spending on doctors within a budget. This rule needs to be eliminated and other steps taken to prevent the future cost of Medicare from skyrocketing.

Almost everyone thinks the current rule, known as the SGR, makes no sense. Indeed, ever since it was passed by Congress in 1997 it has regularly been suspended for a year or so by lawmakers. If it were allowed to take full effect this year, physician fees would be cut by more than a quarter. That would be disastrous for doctors and for their older patients. A huge cut like that would cause doctors to leave Medicare in droves, and cause physicians who remained in the program to scale back care for their older Medicare patients and focus more on treating younger ones (non-Medicare) where the fees are better. SGR only remains in law because pretending it will be enforced in the future makes official projections of the future staggering cost of Medicare look a bit lower.

However, simply abandoning the rule without doing anything else is not the right solution. True, given that Congress routinely suspends the rule, eliminating it would force Congress to show Americans the real future cost of Medicare and the financial burden it will impose on our children and grandchildren. But the right approach is to combine the end of SGR with steps that will reform the way doctors are paid and deal with the long-term cost of Medicare.
Medicare Reform Option: Address the Sustainable Growth Rate (Physician Payment) Formula

At least two immediate steps are needed. First, the government should not be trying to set the wage of doctors. Right now, even if you think your doctor is worth more than the low government-set fee she gets from Medicare, it is illegal for you to agree with her on a higher fee for an office visit, say. If the set fee is not enough for your doctor to cover her own practice costs, her only choice is to pull out of Medicare completely and drop you as a Medicare patient. That law needs to change.

Second, to reduce the huge cost of Medicare that faces future generations, the premiums that older people pay for Part B of the program (the part that helps to pay physicians) must go up. That is needed so that physicians can receive fees for older patients that are closer to those from other patients. But premium changes need to be done carefully to avoid hardship for modest-income older people.

Other reforms are also needed throughout Medicare to make it affordable for future older people without burdening them and their families with heavy government debt and taxes. But the broad agreement that the SGR must end stresses the fact that the government trying to control wages and prices just doesn’t work. It results in fewer doctors serving older people and often worse service from those who do.

Henry Aaron

As part of its efforts to control Medicare spending, Congress in 1997 established the so-called sustainable growth rate formula. Under that formula, growth of total physician payments was tied rigidly to a broad economic index: If total payments to physicians grew faster than that index in one year, physician fees—what Medicare pays for each service—would be cut in the following year. The formula was expected to produce modest savings.

Like most rigid formulas, this one broke down. Total spending depends on both the number of services and the fee for each service. The number of services doctors prescribed and total spending for physicians services grew much faster than expected. As a result, the formula called for large cuts in fees that no one regarded as fair and that Congress has refused to enforce but was unwilling to abandon.

Year after year Congress postponed action. With each postponement, the backlog of delayed fee cuts grew. After years of such delays, the formula now calls for an unthinkable 27 percent cut in physician fees. So large a cut is unthinkable because it would cause many doctors to stop serving Medicare patients. But canceling the cuts would increase future budget deficits, because estimates of future budgets assume that the cut will be enforced. And increasing deficits is not something any elected official wants to do.

Furthermore, the cuts would apply equally to all doctors, general practitioners and specialists alike. The problem is that general practitioners, now in short supply, are paid less than specialists. So, letting the SGR formula take effect, cutting fees equally for all doctors, and canceling them are all unattractive options.

What should be done? Eventually, how the United States pays for health care and how care is delivered need to be changed. Multispecialty groups of physicians, nurse practitioners, and other providers should be paid to work in teams to provide a broad range of care to patients. In addition, doctors should be paid not for each narrowly defined service, but for the effective treatment of episodes of illness or chronic
conditions—for example, for all care a heart attack victim receives or the long-term treatment a diabetic requires. The new health law creates incentives to encourage such reforms, such as incentives for doctors to join with other providers to form so-called “accountable care” health organizations. Doctors are slow to change, however; so these reforms will take time. The best and fastest route to such a reformed health system is to mobilize Medicare’s enormous buying power to promote change.

Stuart Butler, Ph.D., is a Distinguished Fellow and Director of the Heritage Foundation’s Center for Policy Innovation.

Henry J. Aaron, Ph.D., is a Senior Fellow in Economic Studies and The Bruce and Virginia MacLaury Chair at The Brookings Institution.

© 2012, AARP. Reprinting with permission only.
Options for Reforming Medicare

Increase Penalties for Health Care Fraud

Estimates show that waste and fraud in the health care system cost taxpayers tens of billions of dollars every year. Proposals to reduce fraud include increasing the penalties for fraudulent activities, such as the illegal distribution of Medicare patient and provider information.

Prepared for the Public Policy Institute by: Avalere Health, LLC

Argument for:

Increasing penalties on providers and others who commit fraud can prevent and reduce fraud. Dollar for dollar, addressing fraud in this way is an effective strategy compared to other approaches. For every dollar spent on such activities over the past three years, the federal government has collected more than seven dollars in return. As funding has increased for antifraud efforts, the federal government is recovering more stolen health care dollars from fraudsters. In 2011, the Office of Inspector General, the primary watchdog for federal health care programs, expected to recover about $25 billion from its oversight and enforcement efforts. This money represents significant savings for taxpayers and is many times greater than the $311 million that was allocated to that office to recover them.

Undetected fraud continues to account for tens of billions of lost dollars in health care costs. Stricter penalties, such as higher fines and better conviction rates, could put more criminals out of business for longer and further discourage people from committing fraud.

Argument against:

Unfortunately, there is little evidence that fraud is deterred by harsher sanctions. People who commit fraud may not care about sanctions or may gamble that the payoff is worth the risk—even if the penalty for fraud is substantially increased.

As another matter, the threat of harsher sanctions may intimidate physicians and other providers who fear they may be prosecuted for innocent mistakes. As a result, some providers may drop out of health care programs that impose more severe sanctions. Such defections could limit access for some patients. For these reasons, increasing penalties may not have the desired effect of actually reducing health care fraud.

Finally, increased efforts to identify and penalize those who commit fraud include higher levels of scrutiny of provider claims through audits. Preparing for and going through an audit can be enormously time-consuming and expensive for providers who already feel
underpaid due to pressure from payers. Some providers may stop participating in Medicare or other health care programs to avoid the “hassle” and expense of an audit.

**Avalere Health, LLC** is a leading advisory company focused on health care business strategy and public policy.
Expensive biologic drugs (medications made from living organisms) are used to treat conditions like cancer, rheumatoid arthritis and multiple sclerosis. These types of drugs currently provide manufacturers with 12 years of exclusive market access before generic versions (known as biosimilars) can enter the market. This proposal would reduce the exclusivity period to seven years. Because generic medications have a lower retail cost, this would save money for Medicare and its beneficiaries.

Prepared for the Public Policy Institute by: Avalere Health, LLC

Biologics are drugs used to treat many complex and chronic diseases—such as cancer, multiple sclerosis, and rheumatoid arthritis—that often affect older populations. The U.S. Food and Drug Administration was only recently granted the authority to approve generic versions of biologic drugs as part of the new health law. There are currently no generic versions of biologic drugs on the market in the United States. In developing generic versions of the drug, one important issue is how long the brand-name biologic drug company is allowed to sell its product without any competition, known as market exclusivity. During the market exclusivity period, no competing generic drug can enter the market. Under the new health law, brand-name biologic drug manufacturers have 12 years of market exclusivity.

Argument for:

Generic versions of biologics—commonly known as biosimilars—will give consumers access to more affordable biologics. Biologics are some of the fastest-growing, and higher-priced, drugs in the market. A brand-name biologic drug can cost as much as $1.5 million annually. A generic version of that drug would be considerably less expensive.

Many support a reduction of the exclusivity period to no more than seven years. (Nonbiologic brand name drugs today generally have only a five-year exclusivity period). Reducing the market exclusivity period to seven years would allow biosimilars to enter the market much sooner, and the increased competition would likely lead to considerable savings for consumers. It would also mean savings for federal programs like Medicare and Medicaid (a federal-state program that provides assistance to low-income people). Allowing seven years of market exclusivity is more than enough time to give manufacturers a monopoly to recoup their development costs.
Argument against:

Drug companies have raised concerns that reducing the market exclusivity period could slow the development of new biologic drugs. Biologics are made from living organisms and are typically very expensive to test and develop. Shortening the period when the brand manufacturer is the only seller of the biologic will reduce the number of years that the manufacturer is able to make money from the product to recover its research and development costs. The concern is that drug companies would have less incentive to spend the money needed to research and develop new biologics if they do not believe they can recoup their costs. This could reduce the incentive to develop biologics that could be used to treat many of the diseases faced by Medicare enrollees.

Avalere Health, LLC is a leading advisory company focused on health care business strategy and public policy.

The views expressed herein are for information, debate and discussion, and do not necessarily represent official policies of AARP.
Approximately 9 million low-income older and disabled people are covered by both Medicaid (a federal-state program that provides assistance to low-income people) and Medicare. These people are referred to as “dual eligibles.” Because Medicare and Medicaid have different coverage rules and provider access, and dual eligibles are generally a less healthy population, there are higher costs and greater challenges in providing health care for this population. Proposals include requiring all low-income older people to enroll in a managed care plan, which means the care they receive would need to come from doctors and hospitals in the provider network for that managed care plan.

Argument for:

Enrolling people with both Medicaid and Medicare coverage (duals) into managed care plans is a good idea because it will reduce confusion for beneficiaries about what is covered, improve the care they receive through better coordination among their many doctors and providers, and lower costs for the Medicare and Medicaid programs.

Currently, people with both Medicare and Medicaid receive their health care through two different programs, with different rules and different networks of doctors and providers. This can be confusing to consumers who may not know what each program covers and whether doctors, specialists, or dentists they want to see participate in the program. If duals were enrolled into a managed care plan that combined their Medicare and Medicaid benefits, they would need to deal only with the managed care plan and not two separate programs. This would reduce confusion and make it easier for consumers to understand what health care services they have access to and find doctors who are part of their plan.

Having access to doctors and providers that work for the same plan would improve care for the patient. Doctors can more easily talk to each other and better coordinate the care and treatment of the patient. This is particularly important for duals because this group of Medicare beneficiaries tends to be sicker and need more health care services. Patients whose care is well coordinated usually feel better cared for and generally report fewer complications and improved quality of life.

Enrolling beneficiaries into managed care also has the added benefit of reducing Medicare and Medicaid costs. Better management of care could reduce wasteful or unnecessary use of health services and could reduce medical complications that can lead
Medicare Reform Option: Enroll All Beneficiaries Covered by Both Medicaid and Medicare in Managed Care

To more expensive care and treatment. By some estimates, these savings could amount to well over $100 billion for Medicare and Medicaid.

With these savings, some managed care plans may even be able to offer additional patient services and support, such as free dental services or access to nurse help telephone lines.

**Argument against:**

It is wrong to force low-income Medicare beneficiaries into managed care plans while those with higher incomes are allowed to keep their current doctors and other health care providers in the traditional Medicare program. If the rationale is to save money for the Medicare program, it is unlikely that mandatory managed care will produce these savings. If the rationale is to improve the coordination of care for sicker, lower-income beneficiaries—an important goal—then there are other options that could achieve the same result without having to force Medicare beneficiaries into a managed care plan.

Most managed care plans only allow their enrollees to see doctors who are part of their network. Duals who are required to enroll in a managed care plan would have to take the extra step of finding out whether their doctor is part of the plan’s network. Some beneficiaries may lose access to their current doctors and providers if those providers are not part of the managed care plan’s network, disrupting existing relationships and potentially leading to breaks in care.

The jury is still out on whether managed care will reduce costs. In fact, some studies even show that federal costs go up when Medicare beneficiaries are enrolled in managed care.

There are other ways to improve care and reduce costs for people with both Medicaid and Medicare that do not require enrollment into a managed care plan. For examples, some states allow beneficiaries to remain in traditional Medicare but pay a primary care physician an extra fee to coordinate and manage the patient’s care. These programs have demonstrated some success in improving care and reducing costs for individuals with Medicare and Medicaid. Such options—which do not require giving up one’s doctor—are better alternatives to mandatory enrollment into managed care.

*Avalere Health, LLC* is a leading advisory company focused on health care business strategy and public policy.
### Options for Reforming Medicare

#### Prohibit Pay-for-Delay Agreements

<table>
<thead>
<tr>
<th>Brand-name pharmaceutical companies can delay generic entry into the marketplace by compensating a generic competitor for holding its competing product off the market for a certain period of time. Some proposals would prohibit brand-name and generic pharmaceutical manufacturers from entering into these “pay-for-delay” agreements.</th>
</tr>
</thead>
</table>

**Argument for:**

Proposals to prohibit pay-for-delay agreements will help get less expensive generic drugs to the market more quickly. The U.S. Federal Trade Commission (FTC)—the government agency charged with protecting consumers from anticompetitive business practices—reports that patent settlement agreements between brand-name and generic manufacturers that involve some sort of compensation prohibit generic entry for nearly 17 months longer (on average) than agreements without such payments.

Eliminating pay-for-delay agreements would also result in substantial savings for consumers and government programs like Medicare and Medicaid, as generic drugs can cost up to 90 percent less than their brand-name counterparts. The FTC estimates that ending pay-for-delay agreements would save $3.5 billion each year for patients, insurers, and government programs.

Prohibiting pay-for-delay agreements could also improve patient health. Access to generic drugs has been shown to increase medication adherence, which is particularly important for individuals with chronic health problems who rely on multiple medications to help stabilize and manage their conditions. Medicare beneficiaries who fail to take their medications as prescribed are more likely to have costly health complications, creating additional costs for the beneficiaries and the Medicare program.

**Argument against:**

Pay-for-delay agreements are an efficient and cost-effective way for pharmaceutical companies to resolve expensive patent lawsuits. Patent challenges occur when generic drug manufacturers try to gain market entry before the patent on a brand-name drug has expired. If pay-for-delay agreements are prohibited, generic drugs could actually be kept off the market for a longer period of time, since it can take years to resolve patent litigation through the court system.
Prohibiting pay-for-delay agreements could also affect generic manufacturers’ willingness to challenge brand-name drug patents, reducing the number of generic drugs that become available before their brand-name counterparts go off patent. Generic manufacturers may be hesitant to engage in patent challenges if it is unclear whether the potential gains—including the possible settlement terms—outweigh the risk of recovering nothing.

Further, there is little proof that pay-for-delay agreements prevent generic competition. In fact, a majority of pay-for-delay agreements allow generic drugs to enter the market before the brand-name patent has expired. It is also important to ensure that the innovations of brand-name drug manufacturers are adequately protected by patents. Without this security, pharmaceutical companies may be less likely to invest money in the research and development of new drugs.

*Avalere Health, LLC* is a leading advisory company focused on health care business strategy and public policy.