Hearing before the Senate Committee on Aging
A Time for Solutions: Finding Consensus in the Medicare Reform Debate
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Committee for a Responsible Federal Budget at the New America Foundation

Chairman Kohl, Senator Corker, Members of the Committee, thank you for inviting me here today to discuss changes for Medicare and the health care system. The fiscal challenges we face as a nation are immense, and the single largest cause in the long-term is growing health care costs, so this is a very important hearing and we thank you for holding it.

I am Maya MacGuineas, president of the bipartisan Committee for a Responsible Federal Budget and the director of the Fiscal Policy Program at the New America Foundation. Our co-chairs are Bill Frenzel, Charlie Stenholm, Jim Nussle and Tim Penny, and the board is made up of past directors of the Office of Management and Budget, the Congressional Budget Office, the Federal Reserve System, the Treasury Department, and the Budget Committees.

The fiscal problems we face as a nation are severe. What was once a long-term problem has become far more immediate due to the huge run up in our debt from running deficits over the past ten years, the economic downturn, and the policies of responding to the downturn. What is even more worrying than the current high debt level, is the projections that it will grow as a share of the economy--*indefinitely*. The debt is already presumably a drag on economic growth, and without changes, it will at some point result in a fiscal crisis.

Going forward, the growth of deficits will be driven by the aging of society and growing health care costs. The Congressional Budget Office projects that federal spending is set to grow to unprecedented and unaffordable heights in coming years, with health care costs and aging driving increases in spending on our major entitlement programs: Medicare, Medicaid, and Social Security. By 2035, health care cost growth will account for 36 percent of the increases in major entitlement program spending, and 56 percent of the increases by 2085, with aging accounting for the remainder.[1]

Even under the optimistic scenario, where all the savings from the recent health care reforms stay in place through 2030 and reductions in Medicare payments to physicians, per the Sustainable Growth Rate, takes effect, Medicare costs will still grow to over 4 percent of GDP by 2021 and to over 6 percent of GDP in the 2030s.[2] According to the Congressional Budget Office's Alternative Fiscal Scenario, which assumes that various cost-controls put in place in the Affordable Care Act do not stick past 2021 and that lawmakers waive scheduled cuts to physician payments, Medicare costs are set to increase from about 3.7% of the economy in 2011, to 4.3 percent of GDP by 2021, and to over 7 percent of GDP in 2030s.[3]

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[1] See Congressional Budget Office's "Long-Term Budget Outlook," Box 1-1, June 2011. http://www.cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf

[2] Figures do not include Medicare offsetting receipts, which the Congressional Budget Office estimates will grow from about 0.5 percent of GDP today to roughly 1 percent of GDP in the 2030s.

[3] The Congressional Budget Office, the Medicare actuaries, and other experts have raised concerns about the provisions to slow the growth of Medicare payments to providers, referred to as "productivity adjustments." Over

I would like to make four main points in my remarks today:

- There are many areas of overlap between a variety of fiscal plans on ways to save money in health care, and as many of them as possible should be implemented as quickly as possible (see CRFB's table of overlapping polices at http://crfb.org/document/appendix-overlapping-policies-and-estimated-savings-across-fiscal-plans).

- No matter how large a package of health care reforms we manage to pass, in all likelihood, more will have to be done later.

- We should put in place policies likely to generate savings even if they don't "score" well, or don't generate large savings until beyond a ten-year window.

- We should end the open-ended nature of spending on health care and include it in a budget, as we do other parts of federal spending.

Reforming Medicare

At $555 billion (3.7 percent of GDP), Medicare is the costliest piece of the federal health care budget. Reducing costs, and more importantly, slowing the growth rate, will be a key to improving our fiscal future.

There have been many fiscal plans put forward over the past year to offer solutions on how to control health care costs and rising debt.[4] From these, a number of options have emerged as the lowest hanging fruit of health care reform. We should implement as many of them as possible. We have to be realistic here, we actually don't know how to completely fix our health care cost problems. Unlike Social Security, where there are just a few policy levers that need to be moved and it is a question of picking which ones, with health care it is highly unlikely that we could put in place one comprehensive fix and declare the problem solved. Instead, we will likely return to health care reform many, many times. Therefore, we should do as much as we possibly can to control costs each round, and then assess the results to inform the next inevitable round of changes.

I will touch upon three groups of possible reforms to Medicare that we need to consider in order to address rising health care costs and population aging. The first will be policy reforms that can generate savings. These may well be the easiest to implement, but will do the least to change the path of the program. The second group will be policies that could potentially bend the health care cost curve down. The last will be larger structural reforms to Medicare.

"Savers" – These policies would bring down the levels of health care spending, and though growth might be the same going forward, it would be off of a lower base.

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the long-term, public payments to health providers would differ markedly from private payments, and it is unclear whether lower public payments would be sustainable, and if so whether savings would come via greater efficiencies or reduced access or quality of care.

[4] See the Committee for a Responsible Federal Budget's *Deficit Reduction Plan Comparison Tool* at http://crfb.org/compare.

1. **The Sustainable Growth Rate (SGR).** One of the most pressing Medicare issues from year-to-year still is the Sustainable Growth Rate, or SGR, which ironically has become quite unsustainable. Congress has routinely waived scheduled cuts to Medicare payments to physicians since they were set to begin in the early 2000s. As a result of this "kick the can" approach, the system has built up a larger debt that requires unrealistically deep cuts. Simply freezing Medicare payment updates to physicians will cost the federal government almost $300 billion over the next ten years against a current law baseline, but reform can save us money compared to the costs of a ten-year freeze.

   We need a permanent solution to this problem that makes tough choices and asks for sacrifices instead of creating continued uncertainty for providers and beneficiaries and leaves in place large fiscal liabilities. The Fiscal Commission, MedPAC, and other experts have called for lawmakers to develop a new formula to control Medicare payments that both improves the delivery of care and costs less. The Fiscal Commission recommended a modest negative reduction in updates while CMS designs a new formula for physician updates, with a hammer taking effect if a new system is not implemented by 2015. MedPAC proposed a payment structure that would freeze updates for primary care doctors but provide a negative update for specialists, while also recommending changes to the payment formula to encourage physicians to move away from fee-for-service Medicare into more efficient systems, such as Accountable Care Organizations.

2. **The Medicare Eligibility Age.** Gradually raising the Medicare eligibility age would both reduce federal health care costs and increase incentives for workers to remain in the labor force, thereby, increasing economic growth. Asking the youngest, healthiest, and most able to work of Medicare's population to either continue to work to receive employer-sponsored health insurance or to enter into the new health care exchanges being set up by the Affordable Care Act to buy private insurance would better target limited public resources to those who need the support—not to mention the other benefits associated with a longer working life, including strengthened retirement security, a stronger labor market, and increased federal revenues.

3. **Reducing and Reforming Payment Rates.** Reducing Medicare payments to home health care providers; skilled nursing facilities; rural hospitals; and for hospital payments for bad debts, such as unpaid deductibles and copays could save up to $70 billion this decade. In addition, Medicare currently overpays hospitals for costs associated directly and indirectly with graduate medical education, and reducing these payments could save another $70 billion.

4. **Pharmaceutical Drug Payments.** While the Affordable Care Act reduced Medicare payments for most services, payments for prescription drugs under the Part D program were, for the most part, left unaffected and therefore remain an area with significant potential for savings. The Fiscal Commission recommended extending the discounts that drug companies are required to provide in the Medicaid program to people who are eligible for both Medicaid and Medicare and who receive drug coverage through Medicare Part D. The Domenici-Rivlin proposal recommended that drug companies be required to provide discounts for single source drugs where there is not competition among alternative drugs to control costs. Other reforms that could save money include changes to make generic drugs available to beneficiaries in a shorter time frame. Reforming these policies could lead to up to $160 billion in savings this decade, reducing costs for both the federal government and beneficiaries.

5. **Further means-test premiums.** Medicare Part B premiums could be means-tested further by asking wealthier individuals to pay more into the system, which could yield up to $40 billion in savings.

6. **Across the board premiums**. Going further than raising premiums on higher-income earners, raising the basic Part B premiums from 25 percent to 35 percent of program costs could save up $240 billion over ten years.

"Benders" – These policies would bend the health cost care curve by bringing down the growth of health care costs as well as the level.

1. **Cost-sharing requirements**. Medicare was designed to include types of cost sharing rules – in the form of deductibles and co-payments – to encourage beneficiaries to use their care wisely and keep costs down. Unfortunately, in reality Medicare is a hodge-podge of various different deductibles, co-pays, and co-insurance rates that are too complex and confusing to establish the correct incentives. On top of that, many seniors purchase Medigap or other supplemental insurance to cover most or all of their cost-sharing – meaning that for many beneficiaries there is no real "skin in the game."

   In addition to reforming cost-sharing rules where they already exist, lawmakers could look at imposing cost-sharing in areas of Medicare where there currently are none. For example, a 10% coinsurance rate for home health episodes could save $40 billion, and even more by imposing cost-sharing on clinical labs, skilled nursing facilities, and certain other areas of Medicare.

   As an alternative, you could overhaul the entire cost-sharing system, as was recommended by the Fiscal Commission, Domenici-Rivlin, and the Lieberman-Coburn bill. For example, replacing all the cost-sharing rules in Medicare Part A and Part B with a single $550 deductible and 20% co-insurance up to a $5,500 catastrophic cap saves more than $90 billion when combined with a restriction on Medigap plans. The Fiscal Commission and the Lieberman-Coburn proposal established an additional 5% co-insurance up to $7,500 in total cost sharing -- and saved nearly $130 billion.

2. **Restricting Medigap plans.** As I briefly touched on, restricting Medigap plans so that they cannot cover first-dollar expenses and limiting their other cost-sharing coverage provisions could save taxpayers more than $50 billion over a decade. The ability of Medicare cost-sharing to control costs – either under current law or as proposed above – is limited by the purchase of supplemental private insurance plans (known as Medigap plans) that piggyback on Medicare. Medigap plans cover much of the cost-sharing that could otherwise constrain over-utilization of care and reduce overall spending. Surveys have found that beneficiaries with first dollar Medigap policies use 25% more services than other beneficiaries. A recent study by the Kaiser Family Foundation found that restricting Medigap coverage would actually reduce costs for most seniors by lowering annual premiums.[5] Applying similar rules to TRICARE for Life – the Medigap plans for some former military personnel – would save another $40 billion.

[5] See Kaiser Family Foundation, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs." July 2011. http://www.kff.org/medicare/upload/8208.pdf.

3. **Cost-control pilot programs in the Affordable Care Act.** The 2010 health care reform law put in place numerous pilot programs and demonstration projects to better control health care costs. Cost-sharing reforms can better incentivize cost-conscious behavior for patients, but we also need payment reforms for Medicare providers and that is what many of the pilots and demonstrations seek to highlight. Giving CMS the authority to accelerate programs, without congressional action, that successfully control costs without harming the quality of care and doing more to improve incentives for providers could help control costs nationally. Successful pilots could require changes in behavior that are unpopular with some providers, and giving CMS the ability to do this on its own could help ensure savings materialize.

   To improve provider behaviors, most of the pilot programs focus on carrots to provide incentives for quality and cost improvements, such as higher payments for providers and bonuses, with fewer sticks for higher utilization or poor outcomes, such as penalties. Strengthening the sticks could help further incentivize improved outcomes and cost-controls.

4. **Medical malpractice laws.** Capping non-economic and punitive damages in medical malpractice cases, in addition to changing collateral source rules, could reduce medical costs throughout the health care industry.

5. **Coordination of dual eligible care.** Seniors who are eligible for both Medicare and Medicaid, often referred to as "dual eligibles," have some health care services covered by Medicare and some by Medicaid, but neither system takes responsibility for looking at their entire care. Dual eligibles are more likely to have complicated health conditions, which require coordination of care. Several proposals, including the Fiscal Commission's recommendations and Domenici-Rivlin, called for greater use of managed care.

"Structural Reforms" – These changes would change the basic structure of the Medicare system, by ending the basic design of open-ended health care spending.

1. **Independent Payment Advisory Board (IPAB).** Put in place by the Affordable Care Act, IPAB has been charged with limiting Medicare costs if per-beneficiary spending grows too quickly. However, IPAB is restricted from recommending reforms to certain elements of Medicare, such as taxes, Part B premiums, benefits, eligibility, and cost-sharing rules. Eliminating these special "carve outs" and giving IPAB the ability to make real, structural reforms could improve IPAB's chances of successfully limiting spending growth. A strengthened IPAB could make recommendations on cost-sharing rules, provider payment reforms, benefit designs, and other reforms to better align cost-consciousness and higher quality health outcomes. Strengthening IPAB could also be a direct method to set limits on overall spending if its scope were expanded and if given the authority to recommend changes to all elements of Medicare.

2. **Premium support or competitive bidding.** Under premium support, the federal government would provide subsidies to individuals—adjusted for age, health, and other factors—in order to help them purchase health insurance in private markets. It would be a direct way to control the growth of health care spending by setting the rate at which federal subsidies could grow each year, as was proposed in the Ryan-Rivlin plan and at even lower growth rates in Paul Ryan's budget proposal this spring.

A variation of pure premium support would be to introduce premium support alongside the traditional Medicare system, as was recommended in the bipartisan Domenici-Rivlin proposal. This plan would allow seniors to remain in the traditional Medicare program or to purchase private health insurance through a new Medicare Exchange, with a yearly limit on spending growth per beneficiary at the rate of GDP growth plus 1 percent. For people who choose to remain in traditional Medicare, if spending per beneficiary rises faster than the level specified, there would be an additional premium to cover the difference.

Finally, competitive bidding would offer an alternative to premium support, and would allow private plans to compete alongside Medicare in new health care exchanges, in which traditional fee-for-service Medicare would offer health plans in tandem with private bids. The idea is that added competition for Medicare would drive prices lower and help control cost growth over the long-term.

3. **A budget for Medicare.** The bottom line in restructuring health care spending is that we will probably not be able to keep an open-ended federally funded system for much longer. We should consider capping or limiting Medicare and other government health spending through a budget—just like we do for other areas of the government. As my colleague and CRFB board member Gene Steuerle has stated, "Simply put, you can't maximize benefits relative to costs if costs are excluded from the equation."[6] To directly control costs and budget for Medicare, lawmakers could take several different approaches, including strengthening IPAB, transitioning to premium support or competitive bidding, or establishing triggers and procedural hurdles if Medicare was set to exceed the amount budgeted for it..

Other Health Care Reforms

While Medicare can and must play a critical role in controlling health care costs going forward, Medicaid and other health spending will also need to be part of the solution.

Possible Medicaid reforms include reducing tax gaming by states to increase the amount the federal government pays to them. Lawmakers should also consider reforms to the Medicaid state-matching formula to better encourage cost-consciousness and ownership on behalf of states and the federal government.

The federal government could also save billions in the coming years by reforming co-payments, premiums, and cost-sharing in TRICARE and TRICARE for Life, and from reforming the Federal Employees Health Benefits Program (FEHB).

Lawmakers also need to consider reforms to the tax exclusion on employer-provided health care, which accounted for roughly $175 billion in forgone revenue last fiscal year – making it the largest federal tax expenditure of the more than $1 trillion in lost revenue each year from special credits, deductions, exclusions, and other tax preferences. This would be one of the most promising changes we could make to our tax code and our health care system.

[6] See Gene Steuerle Fiscal Times op-ed "Health Care Brawl: All or Nothing Doesn't Work," January 17, 2011. http://www.urban.org/publications/901401.html.

Medicare Reform in the Context of a Broader Fiscal Plan

While health care reforms, especially in Medicare, are a necessary component of solving our fiscal problems, they are not sufficient. To put the federal budget on a sustainable path, lawmakers will need to look at each area of the budget for savings, including from other mandatory programs, Social Security, and revenues.

Our country faces a fiscal gap in the trillions. Altogether, we need savings of $3 - $4 trillion this decade to put debt on a clear, downward path as a share of the economy. Many of the potential Medicare reforms I have discussed would take years to start yielding significant savings, given that beneficiaries would need time to adjust to changes. In the meantime, however, reforms to other mandatory programs and revenues can start yielding savings much more quickly than many reforms to health care and retirement programs.

Thank you to the Committee for all your work on this and the opportunity to appear here today, and I look forward to your questions.

Appendix: Overlapping Health Care Policies and Estimated Savings Across Fiscal Plans

Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions+	Lieberman-Coburn Health Proposal
Health Care						
Reform Medicaid Formula	**$15 billion** from introducing a reduced blended Medicaid rate in 2017	**$770 billion** from block granting Medicaid and indexing to CPI + population	Recommends consideration of block granting to meet long-term health cap	Replaces matching rates with reallocation of federal/state responsibilities beginning in 2018	**$100 billion** from unspecified FMAP changes (with possible increased state flexibility)	
Reduce State Medicaid Gaming	**$26 billion** from reducing Medicaid provider tax threshold		**$51 billion** from phasing out Medicaid provider tax threshold		Under discussion as part of Medicaid reform	
Improve Dual Eligible Care			**$15 billion** from mandating dual eligibles be placed in Medicaid managed care (with Medicare capitated payments)	**$8 billion** from removing barriers for states to place dual eligibles in managed care	**$0-$5 billion** from better care coordination	
Enact Tort Reform		**$62 billion** from aggressive reforms, including caps to non-economic and punitive damages	**$20 billion** from reforms such as collateral source rule changes and consideration of aggressive reforms	**$62 billion** from requiring states to cap non-economic and punitive damages		

Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions+	Lieberman-Coburn Health Proposal
Reduce Medicare Payments for Pharmaceutical Drugs	**$142 billion** from prohibiting pay for delay for generic drugs ($3b), shortening exclusivity for generics ($4b), and drug rebates ($135b)		**$55 billion** by applying Medicaid drug rebates to low income seniors covered by Medicaid and Medicare Part D	About **$160 billion** by expanding Medicaid drug rebates to Medicare Part D	Part D rebates proposed by Dems; other reforms, such as average wholesale price (AWP) rules for Part D drugs and drug reclassifications also considered	
Increase Medicare Cost-Sharing	More than **$1 billion** from increasing the Part B deductible and introducing a home health co-payment for new beneficiaries in 2017		**$65 to $75 billion** from a $550 deductible, 20% co-insurance up to $5,500, 5% co-insurance up to $7,500, and catastrophic cap above that	About **$30 billion** from a $560 deductible, 20% co-insurance up to $5,250 and catastrophic cap above that	Up to **$66 billion** from clinical lab and skilled nursing facilities (SNF) / Home Health co-pays (though money could also come from payment reduction)	**$65 to $75 billion** from a $550 deductible, 20% co-insurance up to $5,500, 5% co-insurance up to $7,500, and catastrophic cap above that
Increase Basic Medicare Premium				About **$240 billion** from raising basic Part B premiums from 25% to 35% of costs (5-year phase-in)		About **$240 billion** from raising basic Part B premiums from 25% to 35% of costs (5-year phase-in)
Increase Medicare Means-Testing	**$20 billion** from increasing means-testing premiums and freezing brackets beginning in 2017				**$38 billion** from freezing premium brackets after 2019 and increasing costs for high-earners	Increases catastrophic cap for high-earners and requires high-earners to pay 100% of premiums

Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions+	Lieberman-Coburn Health Proposal
Restrict Medigap Coverage	Over **$2 billion** from a Medicare Part B surcharge on beneficiaries who purchase Medigap policies with low cost-sharing requirements for new beneficiaries beginning in 2017		**$53 billion** from restricting first-dollar coverage of Medigap plans		Up to **$53 billion** from restricting first-dollar coverage of Medigap plans	**$53 billion** from restricting first-dollar coverage of Medigap plans
Enact Medicare Premium Support		Implements premium support for new retirees in 2022, with $8,000 yearly subsidy indexed to inflation	Pilots premium-support in FEHB and recommends consideration of premium support after 2020	Implements premium support in 2018 for current and new retirees, allowing traditional Medicare to compete, indexed to GDP+1%		
Reduce Post-Acute Care Payments	**$42 billion** from reducing payment updates for post-acute care providers and other reforms		**$9 billion** from accelerating home health cuts under PPACA		Up to **$50 billion** from cutting home health and SNF payments (though savings could come from cost-sharing)	**$9 billion** from accelerating home health cuts under PPACA
Raise Medicare Eligibility Age			Recommends consideration of eligibility age increase to meet long-term targets		Raising age from 65 to 67 under discussion by Obama and Boehner	**$124 billion** from raising the eligibility age to 67 between 2014 and 2025

Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions+	Lieberman-Coburn Health Proposal
Reform TRICARE and/or TRICARE for LIFE	**$22 billion** from a TRICARE for Life premium and higher TRICARE drug co-pays		**$43 billion** from applying Medigap restrictions on first dollar coverage to TRICARE for Life		Up to **$17 billion** from increasing drug co-pays under TRICARE	
Reform Federal Employees Health Benefits (FEHB) Program	**$2 billion** from reforming FEHB pharmacy benefit contracting		**$22 billion** from converting FEHB into premium support with fixed contribution amounts and having FEHBP subsidize Medicare premium instead of first dollar coverage		Up to **$11 billion** from allowing FEHB benefit to subsidize Medicare premium instead of first dollar coverage	
Reduce Medicare Bad Debt Payments	**$20** billion from reducing bad debts payment		About **$25 billion** from phasing out payments for bad debts		**$14-$26 billion** from phasing out payments for bad debts	**$25 billion** from phasing out payments for bad debts
Changes in Special Hospital Payment Policies	**$15 billion** from reducing Graduate Medical Education payments and payments to rural hospitals		**$70 billion** from reducing subsidies to hospitals for direct and indirect graduate medical education costs		**$28 billion**, half from graduate (direct and indirect) medical payments and half from rural hospitals	
Reduce Spending from the Affordable Care Act	**$18 billion** from correcting income definition rules for insurance subsidies and reducing spending on the Prevention and Public Health Fund	About **$590 billion** from repealing the coverage and tax provisions of the Affordable Care Act	Calls for reforming or repealing the CLASS Act, which could *cost* up to $87 billion in the first decade but reduce the deficit in future decades		**$10 billion** from not allowing the Prevention and Public Health Fund to grow and repealing Frontier State Adjustments	

Deficit-Reducing Policies	President's Super Committee Submission	House Republican Budget	Bowles-Simpson Fiscal Commission	Domenici-Rivlin (BPC)*	Under Consideration in Debt Limit Discussions+	Lieberman-Coburn Health Proposal
Reform the Sustainable Growth Rate (SGR)	Assumes a permanent freeze to reimbursement rates		**$36 billion** (compared to a 10-year freeze) from a -1% update in 2014 and directing CMS to develop an improved payment formula that encourages care coordination and quality over quantity			Provides 3-year SGR fix to give time for lawmakers to develop new Medicare reimbursement mechanism for physicians

Note: This list is not exhaustive of overlapping policies.

*Estimates for BPC proposals extrapolated out to 2021 and estimated without interaction from premium support or Medicaid overhaul by CRFB staff.