The Seniors' Choice Act

A proposal keeping the promise to America's seniors by building a stronger, more sustainable Medicare program

Questions & Answers

Q. How is this plan different than other Medicare premium support plans like Wyden-Ryan, or Rivlin-Domenici?

A. Wyden-Ryan and Rivlin-Domenici are both bipartisan plans designed to save and strengthen Medicare by adopting a premium support model, similar to the Medicare prescription drug benefit. Similar to those proposals, our proposal strengthens Medicare by adopting a premium support system in which private health insurers and the government bid to provide Medicare's health care coverage for individuals within a specified geographic region. The government contribution toward the cost of the plan would be a fixed amount per individual senior that is income-adjusted, similar to how Medicare covers a certain percentage of a beneficiary's costs today, so lower-income seniors would receive extra help and wealthier seniors would receive less of a contribution.

Our proposal varies from other proposals on some details, and one notable exception is that we would act immediately to strengthen and improve Medicare so the program is there for seniors today and in the future. We would require Medicare to provide a new maximum limit on the costs seniors' might incur because of a hospital stay or accident, and would force insurance companies and the government-run plan to compete with premium support starting in 2016.

We cannot wait to save Medicare. We believe now is the time to strengthen and improve Medicare so it is there when seniors need it. All seniors have the right to choose a Medicare plan that meets their needs, and our proposal would put patients first and help us keep our promise to seniors by adopting these reforms in the near future.

Q. Does this plan "end Medicare as we know it"?

A. No, but if the program is allowed to continue on its current course for just a few more years, Medicare as we know it *will* end. The biggest threat to Medicare as we know it today is the unsustainable status quo. In fact, the independent Actuary of the Medicare program has warned that the Medicare Hospital Insurance Trust Fund could be bankrupt in as soon as four years – by 2016. According to estimates from the non-partisan, independent Congressional Budget Office, the Medicare Hospital Insurance Trust Fund will be broke in a decade.

We believe that the responsible thing to do is to act now to strengthen and save the Medicare program, ensuring it is there when seniors need it. It is time for Congress to save Medicare, because Medicare is a critically important program for the millions of patients who depend on it. It is time to restore trust in America's patients and their doctors, instead of more "one-size-fits-all" approaches from Washington. We want a system that forces the government-run plan and insurance companies to compete for patients' so their quality choices increase while costs decrease.

Q. Some Medicare proposals have been criticized for appearing to reduce the deficit, but just shift costs to seniors. Does that worry you?

A. Our biggest worry is that we are in danger of losing the current Medicare program; action is needed to stabilize the program and prevent the insolvency of the Medicare Hospital Insurance Trust Fund. It is time to give seniors

the same kinds of choices that Members of Congress enjoy. The biggest reason to strengthen Medicare now is to make sure it is there for seniors today and in the future. We need to put patients in charge, so individual seniors can choose the care they need when they need it. Acting to save Medicare would help reduce the budget deficit, but we are concerned about the deficit of health care too many seniors face today. Under our proposal, seniors will have a new limit on their medical out-of-pocket costs, and we want to ensure that the sickest patients can benefit from targeted care coordination, which will help them improve their health. We can strengthen Medicare today so it will better cover major diseases and illnesses like strokes, cancer, Alzheimer's, or heart disease.

Fixing Medicare's financing is a necessary step toward putting the federal budget on a sustainable path, but fixing Medicare alone is insufficient to resolve our nation's fiscal and budgetary challenges. Stregthening and improving Medicare does not have to be mutually exclusive with putting Medicare on sound financial footing. Our plan does both and is a win-win for seniors and taxpayers.

Q. Will seniors receive less generous Medicare benefits under premium support?

A. No, the essence of premium support is that seniors all receive the same basic government contribution to choose a plan that meets their needs (allowing income-adjustment to give wealthier seniors a reduced subsidy). Under our proposal seniors could choose to stay in a private plan or government-run plan that provides their Medicare coverage, or they could switch plans. Either way, the Medicare benefit would be the same defined government contribution per individual senior.

To help deliver better care, our proposal allows some flexibility in benefit design and operation. For example, patients with a chronic condition like heart disease might choose to get their Medicare coverage from a private plan that specializes in helping heart patients. But if a patient chooses a plan that costs more than the government contribution, he or she would pay the difference. If a patient decided they wanted just a basic plan that was cheaper than the government contribution, they could pocket the difference. Regardless of what plan a senior chooses, our proposal requires participating plans to be actuarially equivalent to Medicare benefits in 2015.

To ensure the system works for every patient every time, our proposal creates a Medicare Consumers' Protection Agency to oversee the government-run and private health care plans to make sure they are offering actuarially equivalent benefits and are not cheating by only enrolling healthy individuals. Nothing in our proposal fundamentally changes the Medicare guarantee. Medicare remains a health coverage entitlement program available for the elderly and disabled.

Q. Does your proposal increase premiums for some seniors?

A. Our proposal would adjust Medicare premiums based on income. There currently are roughly 60,000 individual seniors on Medicare with annual incomes of $1 million or more, but taxpayers are forced to continue to subsidize these super-wealthy seniors like they do higher-income earning seniors in Medicare.

At the same time, lower-income seniors would receive extra help under our proposal so they could exercise their right to choose a health plan that best meets their needs. Our proposal would particularly help some of the lower-income seniors who currently feel forced to buy expensive supplemental plans because traditional Medicare does not even provide them a maximum annual out-of-pocket limit to protect them against catastrophe. As a result, too many seniors who receive a bad diagnosis or end up in the hospital worry about how they are going to pay their bills while they should be focusing on how to recover and get well.

The average individual on Medicare today receives three times the amount of benefits from the program as they paid into the system through payroll taxes during their working years. It's basic math to conclude that a system paying out three times the amount of money it receives in will face sustainability problems. To address this, our

proposal would increase some premiums for traditional Medicare, but seniors would enjoy a better benefit as a result. Seniors would also be able to choose a private plan for their Medicare coverage, and over the long term, we believe our proposed structural reforms will lower costs for seniors. At the same time, we would make some common-sense changes to expensive supplemental policies, which would actually allow most individual seniors to keep more of their own money. Additionally, our proposal simplifies the current maze of co-pays and deductibles so seniors have more peace of mind because they can better predict costs.

Q. What's the most important provision in your plan?

A. There are many important pieces of our proposal to strengthen and save Medicare and make it more sustainable. However, the crucial cornerstone of our reform proposal is to move Medicare from a defined-benefit to a defined contribution by adopting a premium support model. The key to premium support is that the government contribution to individual seniors is fixed (based on their income) and does not change whether they choose to receive their Medicare coverage through a basic plan or an expensive plan, or whether they choose a government-run plan or private plan.

The Medicare guarantee would remain intact, but instead of a bureaucrat-controlled, price-fixing system that distorts choices, individual patients on Medicare would benefit from lower costs and improved choices by forcing private health plans and the government-run plan to compete for their business. This is similar to how members of Congress and roughly eight million Americans in the Federal Employees' Health Benefit Program receive their health care. And this is similar to how the drug benefit works in Medicare. We believe premium support is a model than can strengthen Medicare so it is there now and in the future when Americans need it. Seniors should have the same kinds of choices Members of Congress enjoy.

Q. Some premium support plans cap overall growth, but your proposal does not include a cap. Why?

A. While there is no doubt that Congress must put Medicare spending on a sustainable path by restoring Medicare and putting patients in charge, a global cap on growth is not our preferred approach for restraining spending. We believe that recalibrating the incentives in the Medicare program, forcing better competition between private health plans and the government-run plan, and putting patients in charge will go a very long way toward not only improving Medicare for seniors, but lowering costs and slowing the rate of Medicare's growth. A global cap on expenditures may be a well-intended mechanism that some would require for purposes of achieving a favorable score from the Congressional Budget Office, but based in part on the experience with Medicare's prescription drug benefit, we believe patient-centered choice and competition between health plans can go a long way toward halting explosion of the federal government's spending in the Medicare program and helping taxpayers and seniors get a better deal for their dollar. Global caps may be useful budgetary tools in concept, but in practice, spending caps in Congress are routinely waived and undermined. For example, consider the past actions of Congress overriding the Sustainable Growth Rate which governs Medicare's reimbursements to physicians: for nearly the past decade Congress has routinely waived that statutory budget cap. If lawmakers found it necessary to achieve further savings in the Medicare program after our reforms were adopted, future Congresses would of course be able to act to add a cap or other measures.

Q. What happens to Medicare's prescription drug benefit?

A. Under our proposal, even with structural reform, the Medicare Part D program would continue functioning basically the same as it does today. Seniors could chose a private plan with integrated drug coverage (like MA provides) or they could chose the newly-competitive government-run plan to receive their Medicare benefit and separately purchase drug coverage. Under our proposal, Medicare's prescription drug benefit will continue to be voluntary.

Q. Some have suggested that the "premium support" approach does not include enough regulation and consumer protections to ensure seniors are treated fairly. How does your plan address this?

A. We absolutely believe that it is important to have adequate regulation and enforcement of rules to ensure there is a level playing field and individual patients on Medicare are protected. Our proposal creates a new Medicare Consumers' Protection Agency to oversee the competition between insurance plans in a manner similar to how the Office of Personnel Management oversees the Federal Employees' Health Benefits Program (FEHBP) that provides health coverage to Members of Congress and their staff, and all federal employees. Under FEHBP, the federal Office of Personnel Management administers a system of private health plans that cover approximately 8 million people. For 2010, enrollees in FEHBP functionally can choose between five and 15 options, depending on where he or she resides.

Q. So how the Medicare Consumers' Protection Agency (MCPA) work?

A. Here is an explanation.

General operations

MCPA would be authorized to contract with insurance carriers; approve health benefits plans for participation in the program based on established standards; determine the times and conditions for open seasons during which eligible individuals may elect coverage or change plans; make information available to seniors concerning plan options; apply administrative sanctions to health care providers who have committed certain violations; and advise Congress on the financing of the program.

Negotiations with plans

MCPA would also review proposals for rates (premiums) for the traditional Medicare plans and private plans in relation to many factors, including the cost of covered services, managed care initiatives, the plan's past experience, health care utilization patterns of the enrolled group, and health care cost inflation in general. Pursuant to the negotiations, MCPA and the plans would agree to specific terms and conditions each party is obligated to meet in the next contract year. MCPA would have a relatively small staff of actuaries and employees who negotiate with carriers, monitor plans and contracts, and generally oversee all aspects of program administration. Health plans would make contracts with MCPA for at least one year and may be made automatically renewable in the absence of notice by either party of intention to terminate.

Regulation of Plans

MCPA would ensure a participating health plan is licensed to sell group health insurance under state law in every area of a state in which it operates as an MCPA plan. Nationwide plans must be licensed in every state. HMOs must have an internal quality assurance program, and must credential and periodically re-credential participating providers.

Additional Consumer Protections

MCPA would oversee a range of quality reporting efforts. All plans must also complete quality assurance reports as well as fraud and abuse case reports. Additionally, HMOs with more than 500 enrollees must complete the Health Plan and Employer Data Information Set (HEDIS), which includes clinical performance measures based on information such as members' medical records. These measures help to compare how well plans prevent and treat illness. Each year MCPA plans with 500 or more subscribers must survey a portion of their members using the Consumers Assessment of Health Plan Survey (CAHPS) and report its results.

Q. Your proposal makes changes to Medigap plans. Do these types of supplemental plans really lead to increased costs?

A. The reality of overutilization is noticeable when one examines the data. According to the Kaiser Family Foundation's analysis of data from the Medical Expenditure Panel Survey (MEPS) and other sources, in 2009, "88 percent of people covered by standardized plans were in plans that covered 100 percent of Medicare's required deductibles and coinsurance, or all except the Part B deductible."[1] This means that more than 8 in 10 seniors with Medigap plans currently have plans that cover all deductibles and co-pays, or all except the Part B deductible.

In fact, because of the large numbers of seniors with Medigap coverage, it is almost impossible to adequately reform Medicare without addressing Medigap coverage. As the Kaiser Family Foundation noted, "in 2008, about one in six Medicare beneficiaries, over 7 million, had an individually purchased Medicare supplemental insurance policy, known as Medigap (and no other source of supplemental coverage)."[2] But the actual number is likely even higher. According to America's Health Insurance Plans, "in 2011, enrollment in Medigap coverage increased by about 300,000 policies to 9.7 million, up from 9.4 million Medigap policies in force in December 2010."[3]

There is also good reason to think that Medigap reform would actually reduce many seniors' costs. In fact, in a report, "Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," the Kaiser Family Foundation examined a policy option that would "prohibit Medigap policies from paying the first $550 of enrollees' cost sharing and requiring that they cover no more than half of Medicare's additional required cost sharing up to a fixed out-of-pocket limit."[4]

Under their modeling of this option, Kaiser found that the "majority of Medigap enrollees are projected to see a reduction in net out-of-pocket costs (including premiums)."[5] In fact, under this scenario, *four out of five seniors would save money, and some seniors could save more than $1,000 annually.*[6] Kaiser notes that "if premium reductions were fully proportionate to the drop in expenses, the savings for the *average* beneficiary would be sufficient to more than offset his or her new direct outlays for Medicare cost sharing."[7] This is a stunning admission that seniors are paying too much for costly supplemental coverage that encourages overutilization, unnecessarily costing the Medicare program.

Some have expressed concerns that simply prohibiting first-dollar coverage for Medigap could negatively impact some seniors by increasing their uncertainty or reducing their choices.[8] Others have expressed concern that making changes to Medigap insurance will lead to what insurance analysts call "adverse selection" – a market dynamic where individuals who are older and sicker (and costlier to insure), will be virtually the only ones buying the Medigap product. The thought is that if only older, sicker seniors buy Medigap policies, the price of Medigap policies will skyrocket and leave those most needing some supplementary coverage without unaffordable coverage.

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[1] "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," Kaiser Family Foundation, July 2011, pg. 3. http://www.kff.org/medicare/upload/8208.pdf
[2] "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," Kaiser Family Foundation, July 2011, pg. i. http://www.kff.org/medicare/upload/8208.pdf
[3] "Trends in Medigap Coverage and Enrollment, 2010-2011," America's Health Insurance Plans, Center for Policy and Research, July 2011, pg. 1. http://www.ahipresearch.org/pdfs/Medigap2011.pdf
[4] "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," Kaiser Family Foundation, July 2011, pg. i. http://www.kff.org/medicare/upload/8208.pdf
[5] Ibid. pg. iii.
[6] "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," Kaiser Family Foundation, July 2011, pg. i. http://www.kff.org/medicare/upload/8208.pdf
[7] Ibid. pg. ii.
[8] Ibid. pg. iv.

Both of these concerns are well-intended, but we believe such concerns are misplaced for two important reasons. First, such concerns appear contradicted by a number of experts and a wide range of empirical analysis. It's worth considering a few more data points:

- In one study, even when researchers controlled for "health status, chronic conditions, functional limitations, and other factors that explain spending variations across supplemental insurance categories," they found that supplemental insurance resulted in a higher probability and greater level of Medicare spending, particularly for Part B services. [9]
- Another study found that "models indicate that Medigap and employer-provided enrollees spend approximately $1,000 and $1,500 more annually, respectively, than those without supplemental coverage" and "Medicare supplemental coverage appears to add $5.5 billion annually to the federal budget."[10]
- And yet another study found that there was little chance of adverse selection in Medigap, but "on average individuals with Medigap insurance coverage spend about $2,119 more on health care than similar individuals without Medigap. This is a 32% increase…."[11]

Q. The new health care law cut more than $200 billion out of the Medicare Advantage program. Why have I not seen more seniors impacted by these cuts?

A. Most of these cuts have not yet gone into effect. In fact, in 2011, less than one percent of the total MA cuts (more than $200 billion) were actually implemented.[12] The impact of the cuts were partially mitigated by an unprecedented nationwide $8.3 billion "demonstration" in MA that we suspect had more to do with the political calendar and electioneering than preventing seniors from losing their high quality private Medicare plans.[13] But once the cuts are fully phased in, both the independent Congressional Budget Office and the independent Chief Actuary of the Medicare program warn that MA participation will be severely reduced.

Q. Most seniors already have the choice of a private plan in Medicare Advantage, so why do you think your approach will offer better choices and competition?

A. It is true that more than one in four seniors receives their Medicare benefits from a commercial plan under the Medicare Advantage (MA) program, but the problem today is that MA and traditional Medicare do not compete against each other. We believe we should transition to a system in which the government is neutral about what plan a senior chooses, a system in which money follows the senior, not the system.

Moreover, as former director of the Congressional Budget Office Alice Rivlin explains:

> "Medicare Advantage already offers private plans to Medicare beneficiaries. However, if a private healthcare plan currently has lower costs than FFS Medicare in its area, it cannot offer to rebate the entire cost difference to enrollees as an incentive to sign up. Instead, it must increase benefits – which in and of itself increases Medicare spending. Therefore, beneficiaries in areas with high FFS Medicare costs who enroll in private plans receive a host of free supplementary benefits, financed by the government. There is no policy justification for selectively offering free, government-financed supplementary benefits to beneficiaries in one geographic region but not another."[14]

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[9] "Medicare Spending by Beneficiaries with Various Types of Supplemental Insurance," Rezaul K. Khandker, SmithKline Beecham Pharmaceuticals and Lauren A. McCormack, Research Triangle Institute, Medical Care Research and Review, Vol. 56 No. 2, (June 1999) 137-155.

[10] "The Relationship between Medicare Supplemental Insurance and Health-Care Spending: Selection Across Multiple Dimensions," David M. Zimmer, Western Kentucky University, Eastern Economic Journal, Vol. 38, Issue 1, pp. 118-133, 2012. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1971452

[11] "Adverse Selection, Moral Hazard and the Demand for Medigap Insurance," Michael Keane, University of New South Wales and Olena Stavrunova, University of Technology, Sydney, Working Paper No. 167, School of Finance and Economics, University of Technology Sydney, Australia, November 2011, pg. 54. http://www.finance.uts.edu.au/research/wpapers/wp167.pdf

[12] Letter from the Congressional Budget Office to Speaker Nancy Pelosi, March 20, 2010. http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

[13] http://finance.senate.gov/newsroom/ranking/release/?id=5b4fee8c-3e8f-49d9-913b-71cc0f569904

[14] http://www.bipartisanpolicy.org/sites/default/files/Domenici-Rivlin%20Protect%20Medicare%20Act%20Backgrounder%20(12-8-11).pdf , page 4

Q. Your proposal would repeal the Independent Payment Advisory Board. Doesn't this mean that costs will just increase under your proposal?

A. We realize that the nonpartisan Congressional Budget Office has estimated the Independent Payment Advisory Board (IPAB) will reduce Medicare expenditures in the long run. However, we do not believe the IPAB is a tenable way to manage the Medicare program's spending growth. Instead, we believe that empowering seniors with more meaningful, transparent choices will go a long way towards achieving meaningful savings and putting Medicare spending on a more sustainable path over the long-term. Moreover, we believe our proposal, if fleshed out in legislative language and scored by the Congressional Budget Office, would save more than the IPAB over a 10 to 20 year period. We believe our approach is more preferable to across the board provider cuts (IPAB's basic expenditure reduction mechanism) which would effectively delay and deny seniors' access to care.

Q. Some critics of premium support have suggested Medicare actually has a *better* record than the private sector in controlling health care costs. Is this true, and wouldn't this mean your proposal is headed in the wrong direction?

A. Excess cost growth for Medicare has far exceeded that of private health care and total health spending in the past. According to CBO, that holds true over the 1975 to 2008 period. Recent declines in the rate of Medicare's spending growth are a historical anomaly that many analysts attribute to the frail economic situation. Our premium support proposal is designed to save money by reining in health care cost growth in Medicare, in large part by creating robust competition among private insurers and the government-run plan and establishing a level of consumer choice that is routine in every aspect of our economy.

Furthermore, our structural changes to Medicare over the longer-term are modeled on the competitive bidding structure of the Federal Employees' Health Benefits Program (FEHBP), and FEHBP has historically outperformed Medicare (over both the period from 1975 to 2009 and from 1975 to 2001). Comparisons often understate FEHBP's superior cost control experience because figures are not adjusted for the aging of the federal workforce and the growth in the retiree population as a proportion of FEHBP enrollees.

Q. Currently waste, fraud, and abuse are a significant challenge to the integrity of the Medicare program. Does your proposal make a dent in this problem?

A. Absolutely. Our proposal would dramatically reduce the incredible waste and fraud in traditional Medicare. Currently, the traditional Medicare program is vulnerable in several significant ways.

First, let's look at how it works now. Currently, traditional bureaucrat controlled Medicare's billing system is often described as a "pay and chase" payment system where claims are paid, then overpayments and fraudulent payments are "chased" after the fact. The Medicare program is required by law to pay claims within weeks, which is designed to ensure that providers and suppliers receive reimbursement in a timely manner. But this very predictability also can be abused by fraudsters who may bill Medicare using stolen provider and beneficiary numbers.

There is also effectively no financial incentive in the traditional Medicare plan to prevent the payment of inaccurate or fraudulent claims. The only structural incentives to ensure integrity in the program are operative *after* bills have already been paid.

Another problem is that, the Medicare program effectively has had to take all providers and suppliers into its ranks of participants who can bill Medicare. When it was created, this rationale was well-intended and designed to ensure no provider or supplier was unduly discriminated against. However, this has had the effect of tilting the balance in favor of allowing providers and suppliers to participate in the program and bill Medicare, and it is

harder to police participants once they are in the program. As the Deputy Inspector General for the U.S. Department of Health and Human Services explained, "since its inception, Medicare has been a program that allows "any willing provider" to provide services for beneficiaries. In other words, we have treated participation in our programs as a right, instead of a privilege."[15]

Additionally, the Medicare program is a web of complex, detailed, and often confusing payment rules. This makes program management and oversight a challenge. The net effect, as health care analyst Michael Cannon explains, is a huge challenge policing the program: "For providers, Medicare is like an ATM: So long as they punch in the right numbers, out comes the cash. To get an idea of the potential for fraud, imagine 1.2 million providers punching 1,000 codes each into their own personal ATMs. Now imagine trying to monitor all those ATMs."[16]

Our proposal would realign incentives and increase program integrity in several ways. First, by transitioning to a defined benefit to a defined contribution, seniors in Medicare will have an incentive to be smarter consumers of health care dollars.

Second, by transitioning to a competitive system where private health plans and the government-run plan are forced to compete for seniors choosing their plans, plans would have a strong incentive to self-police and look inward to root out waste, fraud and abuse. As private plans reduce internal exposure to fraud, they can reduce their overhead costs and fraud loss, and be more competitive relative to other plans.

Third, operating a program with more uniform (and fewer) transactions from the federal perspective could help reduce taxpayer exposure to fraud or improper payments. Critics may point out that current private plans in Medicare – Medicare Advantage and Part D drug plans – still have fraud and vulnerabilities to waste and abuse. These critics would be right. No system will eliminate fraud, waste, and abuse. When the federal government spends billions of dollars on millions of people, there will always unfortunately be some level of overpayment and fraud and waste. However, forcing private plans to compete against traditional Medicare would help realign incentives and allow seniors to choose a plan they believe best meets their needs based on cost, quality, and outcomes.

Q. Curbing runaway Medicare spending seems to be important to you. So how much does your proposal save?

A. We do not yet have a concrete, specific amount of "savings" outlined, but we believe our proposal could save between $200 billion and $500 billion over a decade. This broad range estimate falls between the estimated savings from the bipartisan Rivlin-Domenici and Lieberman-Coburn proposals.[17] In coming months we will be further developing our core legislative principles and filling in some details of this proposal, and we welcome our colleagues and stakeholders to participate in that process.

Q. How is your proposal different than choices of private plans through Medicare Advantage?

A. There are three key differences.

1. Currently, Medicare Advantage plans whose bids come in lower than the benchmark established in the bidding process effectively have to offer more benefits to beneficiaries, rather than lower costs. Under our proposal, plans would be able to pass savings on to seniors.

[15] http://oig.hhs.gov/testimony/docs/2011/Roy_Testimony_04052011.pdf, page 7
[16] http://www.cato.org/pub_display.php?pub_id=13235
[17] http://www.bipartisanpolicy.org/sites/default/files/Domenici-Rivlin%20Protect%20Medicare%20Act.pdf, and http://www.coburn.senate.gov/public/index.cfm/pressreleases?ContentRecord_id=ae711529-741a-4f52-89eb-4e6ef1c861a7

2. Medicare Advantage plans bids are made with reference to Medicare fee-for-service. This imports all the cost distortions and inefficiencies of basic Medicare's fee-for-service system. Our proposal requires real competition between private plans and the government-administered plan so seniors can benefit from lower costs.

3. Our proposal preserves choice in the Medicare program, compared to the Patient Protection and Affordable Care Act which included reductions to Medicare Advantage plans so large that the Actuary of the program projects enrollment in MA plans will be cut in half by 2017.

Q. The Congressional Budget Office recently released an analysis showing that a wide range of efforts in the Medicare program to offer care coordination did not necessarily save money. How does this square with your care coordination proposal?

Our proposal envisions a care coordination benefit that is:

1. Transitional – Offered before premium support starts in 2016.
2. Targeted – Directed toward the highest cost, highest risk seniors based on their clinical profile and medical need. These are the seniors who cost the Medicare program the most and would benefit the most from care coordination.
3. Voluntary – No senior would be forced to participate, but any senior meeting certain standards-of-need would be eligible to participate.
4. Offset – While it is designed to be budget-neutral, any associated costs would be offset by savings from other reforms.

Q. How is asking wealthier seniors on Medicare to pay more in premiums *different* than asking wealthier Americans to pay <u>more in taxes</u>?

A. There are five key differences.

1. Individual payroll taxes only fund roughly 40 cents of every dollar in Medicare benefits. So merely increasing payroll taxes does not solve Medicare's significant funding shortfall for all beneficiaries.
2. Because money is fungible, increasing payroll or others taxes does not mean that those taxes would actually will fund Medicare. In fact, there is no guarantee that Congress would use increased revenue to fund Medicare, instead of waste it on new bureaucratic programs.
3. Beneficiary premiums, rather than payroll taxes, are more likely to have an impact on helping curb overutilization. Therefore, increasing premiums for wealthier seniors is more likely to restrain overutilization than hiking their taxes. We cannot tax our way out of the financing challenges facing the Medicare program, but we can put in place common sense Medicare reforms, like income-adjusted premiums, which will help ensure patients are seeking appropriate care.
4. Depending on the type of tax envisioned, wealthier Americans who might be subject to a tax also are the ones who are most able to hire accountants to find loopholes, move around income, and reduce their tax liability.
5. Tax hikes can have a negative effect on economic growth.