Can Medicare Be Preserved While Reducing the Deficit?

Timely Analysis of Immediate Health Policy Issues

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Summary

The politically polarized debate over the role of Medicare in deficit and debt reduction often ignores the accumulating evidence that the program can achieve significant spending reductions without sacrificing Medicare's essential protections. The caricature of Medicare as a program out of control and in need of fundamental restructuring is wrong. Equally wrong are views that any significant changes to Medicare's current benefit design and payment policies would compromise beneficiary access and quality. Instead of joining this nonproductive clash of ideological and political positions, we identify policies that correct long-standing gaps in financial protections that Medicare beneficiaries face, promote greater efficiency within payment systems, and recognize the need for additional revenues to pay for the impending surge in the number of beneficiaries in the program.

We are not suggesting that the policies we identify be implemented immediately or how Medicare should fit into a broader plan for debt reduction. We are also not seeking to assemble a set of policies designed to achieve an arbitrary savings or revenue target, although we recognize that comparisons between our savings estimates and others are inevitable. Our goal is to illustrate, with a package of reasonable Medicare policy options, that policy-makers can produce substantial budgetary savings, while preserving and, in some cases, enhancing the program for current and future beneficiaries. This analysis demonstrates that Medicare reforms can be consistent with preservation of Medicare's social insurance protections if the costs are shared among beneficiaries, providers and taxpayers. The options we discuss are not intended to be an exhaustive list. Instead, they represent the types of responsible changes that could be implemented in the near future.

Although Medicare spending growth drives deficit projections, action to reduce spending growth does not require compromises to Medicare's insurance protections. We start by establishing a few facts about Medicare to correct the caricature of the program that is often espoused.

1. Although Medicare spending is estimated to grow at 6 percent a year, the problem is not program inefficiency. Rather, it is the combined effect of annual enrollment growth of about 3 percent and a similar rate of growth in spending per enrollee—the latter is lower than commercial health insurance.
2. There is no evidence that competition among private health plans, alongside or replacing Medicare, would decrease costs. Medicare Advantage plans have lower costs than traditional Medicare in only about 15 percent of counties, representing 30 percent of Medicare Advantage spending. In all other counties, Medicare Advantage plans have costs equal to or greater than traditional Medicare.
3. Medicare has led payment reform in the past and continues to do so. From the implementation of the inpatient prospective payment system in 1984 to the myriad of prospective payment systems for other services, Medicare has created payment systems that have been adopted by other payers and hold the potential for further spending reductions.

Meanwhile, serious benefit design flaws that were created in 1965 when Medicare was enacted have never been addressed. These include high premiums and cost-sharing for low-income beneficiaries and the lack of a cap on out-of-pocket spending. Also central to the budget discussions is the sustainable growth rate (SGR) policy that requires major reductions in physician fees absent congressional action. Each year, Congress has overridden this policy, but the unpopular and counterproductive formula has not been permanently repealed because of its projected impact of budgetary scoring.

Since the problems of Medicare are complex, there are limits to what any single policy can do. We suggest a range of policies, affecting current and future beneficiaries, providers and taxpayers that can improve beneficiary protection, while providing enough savings and new revenues to finance substantial deficit reduction and offset the costs of repealing the SGR.

Although we understand the rationale for raising the eligibility age for Medicare to 67 over time, simply doing so by relying on the current mix of private and public programs would leave many 65- and 66-year-olds with

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limited or no coverage options. The Affordable Care Act's (ACA) health insurance exchanges will take a significant amount of time to be developed and to work efficiently in many states. Moreover, absent legislative change, the ACA Medicaid expansion is not available to those age 65 and older, and several states have indicated that they will not adopt the Medicaid expansion at all. Thus, many low-income 65- and 66-year-olds would be left lacking affordable coverage without Medicare. Adding 65- and 66-year-olds to the exchanges would also affect risk pools, increasing premiums for everyone buying health insurance through exchanges.

However, allowing 65- and 66- year-olds to buy into Medicare, but requiring them to pay more than they do today (with income protections) would mitigate many of the problems of simply raising the age of eligibility. A buy-in option would still provide program savings. Middle- and high-income individuals would pay the full actuarially fair premium for their age cohort, not the significantly lower Part B and Part D premiums of today. Unlike today, the lowest-income individuals would have access to Medicare at no cost with full cost-sharing subsidies. In addition, the ACA subsidy schedule would be used to limit premiums as a percentage of income for others with incomes below 400 percent of the federal poverty level (FPL). We also recognize that additional financial protections may be needed for those above 400 percent of FPL.

Next, restructuring of Medicare's current beneficiary obligations would provide better financial protection as well as program savings. This would mean increasing premiums and deductibles for middle- and high-income individuals, and lowering them for those with incomes below 300 percent of FPL. Medicare would also introduce an income-related cap on out-of-pocket spending; for those with significant health needs, this is a valuable protection that is currently unavailable. The program would also improve low-income subsidies for those with incomes below 300 percent of FPL, a badly needed reform. These benefit improvements would make Medicare beneficiaries less reliant on Medigap supplemental insurance, permitting adoption of policies to reduce the first-dollar Medigap coverage that contributes to higher Medicare spending.

Although the ACA included major reductions in plan and provider payments, additional opportunities remain. These include:

- Adjusting the overpayments to Medicare Advantage plans by reducing ACA benchmarks to a maximum of 95 percent of traditional Medicare per-beneficiary costs in the highest cost areas and to 100 percent everywhere else.
- Legislating that Medicare Part D obtain the same drug rebates for dual eligibles that Medicaid had received and encouraging generic substitution of drugs by eliminating cost-sharing completely for generic medications, along with copayments on substitutable brand-name drugs.
- Reducing indirect medical education payments to teaching hospitals to be more consistent with the empirical evidence on the cost of teaching functions. Some of the savings would be used to promote more rapid graduate medical education (GME) reform—toward providing physicians with the requisite skills to manage delivery system reform.
- Reducing the overpayments to skilled nursing facilities and home health agencies, significantly reducing current high profit margins.
- Eliminating the SGR formula, thus permanently ending the annual crises over physician fee reductions. But at the same time, reducing fees where payment rates far exceed the underlying cost of production (for example, many tests, imaging, and procedures) and eliminating site-of-service differentials that pay hospitals as much as two times more for services provided by hospital-employed physicians as for the same services provided by independent physicians.

Others have proposed dozens of additional policy options for producing substantially greater spending reductions than in our package. Particular opportunities include even greater attention to reducing overly generous payment levels for various providers and suppliers of Medicare services; improving care management and coordination for Medicare patients with functional disabilities, including the dual-eligible populations served by Medicare and Medicaid; and building on recent successes in attacking fraud and abuse by giving the Centers for Medicare and Medicaid Services (CMS) additional administrative resources to broaden its activities.

Finally, to help pay for the inevitable growth in the number of enrollees, there would be an increase in the Medicare payroll tax of 0.5 percent. This would begin to address the problem that expected benefits considerably exceed expected contributions to Part A of Medicare. We suggest implementing the increase in 2017, after the economy has had time to recover.

Together, these policies would provide savings or new revenues of about $730 billion (Table ES-1 summarizes these results). This would permit paying for permanent repeal of the SGR and still provide savings of about $600 billion. The plan and provider payment reforms alone would achieve savings of over $300 billion during the next 10 years. If implemented in 2017, the payroll tax increase would yield about $200 billion through 2022.

Actual savings would depend on how quickly certain policies are phased in, an important consideration given

continued slow economic growth. The estimates (except for the Medicare buy-in and the payroll tax) assume immediate implementation, so should be regarded as upper-bound numbers. Savings also depend on exactly how policies are designed. For example, savings from restructuring premiums and cost-sharing could vary greatly depending on how various parameters are set: premiums and deductibles, out-of-pocket caps, low-income subsidies, and the Medigap structure. The specific estimates, which should be considered preliminary, are derived from the Congressional Budget Office (CBO) and Medicare Payment Advisory Commission (MedPAC) analyses and are adjusted as appropriate to reflect our proposals when they vary from those estimated by CBO or MedPAC.

Table ES-1. Savings and New Revenue from Medicare Reforms, 2013–22 (in billions)

Create Medicare buy-in option with ACA subsidies for 65–66-year-olds[a]	$90
Restructure premiums, cost-sharing and Medigap	150
Reform Medicare Advantage payments	30
Restore drug rebates for dual eligibles and promote use of generics	154
Reduce teaching hospital payments and provide targeted incentives	50
Eliminate excessive skilled nursing facility and home health payments	35
Reprice overpriced services and promote primary care in physician fee schedule	15
Reduce overpayments for clinical laboratory services	10
Increase payroll tax by 0.5%, beginning in 2017	200
Total savings and new revenues	**734**
Less SGR repeal	**-138**
Net total savings and new revenues	**$596**

Notes: All estimates are based on CBO and MedPAC estimates of similar proposals and are adjusted as appropriate. Estimates, except where noted, assume that policies are implemented in 2013 or 2014. This is unlikely, so 10-year savings and revenue estimates are somewhat overstated. Numbers are 10-year estimates and do not account for a delayed phase-in of some policies.
[a]Assumes, following CBO, that policy is phased in two months a year beginning in 2014.

Introduction

The politically polarized debate over the role of Medicare in deficit and debt reduction often ignores the accumulating evidence that the program can achieve significant spending reductions without sacrificing Medicare's essential protections. The caricature of Medicare as a program out of control and needing fundamental restructuring is wrong. Equally wrong are views that any significant changes to Medicare's current benefit design and payment policies would compromise beneficiary access and quality. Instead of joining this non-productive clash of ideological and political positions, we identify policies that correct long-standing gaps in financial protections that Medicare beneficiaries face, promote greater efficiency within payment systems, and recognize the need for additional revenues to pay for the impending surge in the number of beneficiaries in the program.

Although Medicare spending growth drives deficit projections, action to reduce spending growth does not require compromises to Medicare's insurance protections. We start by establishing a few facts about Medicare to correct the caricature of the program that is often espoused.

Medicare's primary budget challenge is enrollment, not inefficiency. Actually, half the projected 6 percent annual growth in Medicare spending over the next decade reflects dramatic growth in the number of beneficiaries in the program.[1] As baby boomers age onto Medicare, enrollment will grow from the 49.5 million Americans in Medicare in 2012 to a projected 64.3 million in 2021, an average annual growth rate of close to 3 percent.[2] Medicare expenditures *per beneficiary* are expected to increase by only about 3 percent a year, which is roughly the same rate as anticipated growth in the GDP per capita and 2 percentage points below the projected per capita growth rate for commercial health insurance (which has historically risen somewhat faster than Medicare). Medicare spending per beneficiary actually grew just 0.4 percent per beneficiary in fiscal year 2012, continuing a pattern of very low growth—1.9 percent annually—between 2010 and 2012.[3] These low growth rates per beneficiary reflect in part the reductions in Medicare payments to providers already implemented as part of the Affordable Care Act. Such slow growth in spending per beneficiary does not mean we can cease efforts to improve program efficiency, but covering the costs of increasing numbers of beneficiaries will also require additional revenue devoted to the program.

There is no evidence that competition among private health plans, alongside or replacing Medicare, would decrease costs. Currently, 27 percent of Medicare beneficiaries choose a private Medicare Advantage health plan as their insurer, opting out of traditional Medicare. Health plans compete with each other and with traditional Medicare by competitive bidding to try to attract enrollees. In short, competitive bidding among health plans is already a core element of Medicare. Unfortunately, this market competition has not produced lower costs. Medicare Advantage plans have lower costs than traditional Medicare in only about 15 percent of counties

(these account for about 30 percent of Medicare Advantage spending).[4] Despite this negative experience, premium support proposals assume savings from competition.[5] To the contrary, premium support's main effect would not be to reduce health care spending, but to shift responsibility for high costs to beneficiaries, unlike the current Medicare program that retains collective public responsibility for cost growth while allowing beneficiaries a choice of private plans.

Medicare has led payment reform in the past and continues to do so. It is sometimes suggested that Medicare is mired in 1960s payment policy. For example, a recent *Washington Post* editorial criticized "the program's design, often tweaked but left fundamentally intact since its creation in 1965, which basically pays doctors and hospitals fixed fees for whatever they do."[6]

In truth, however, since 1984, hospitals have been paid a fixed hospital discharge rate regardless of "whatever they do," providing an incentive for efficiency. This approach, based on "diagnosis-related groups," has since been adopted by many private insurers in the United States and more than a dozen countries around the world. Prospective payment systems have been adapted for other providers as well. Medicare payment approaches continue to evolve.

The notable exception is physician payments, which do rely on a fee schedule that rewards overprovision of services, especially tests and minor procedures. Physician payment policy does need to change. To this end, the ACA created a range of pilot programs that will test new delivery and payment approaches for virtually all providers, to be replicated widely within Medicare if successful. Private insurers and state Medicaid programs are assessing and building on these pilots, facilitating health systemwide adoption of successful payment reforms. Alongside these innovations are a myriad of Medicare payment changes within Medicare's traditional structure with the potential to reduce spending. These measures reflect expert judgment by MedPAC, the Government Accountability Office (GAO), the Office of the Inspector General (OIG), and other respected bodies.

This brief draws on others' work as well as our own to demonstrate that, contrary to widespread claims, a combination of reductions in some provider payments, along with modest changes in beneficiary obligations, can significantly reduce projected Medicare spending per beneficiary—even below historically low projected levels—within Medicare's traditional structure. Combined with moderate increases in payroll tax revenues, which are necessary to accommodate 1.5 million new beneficiaries per year for each of the next 30 years, these measures simultaneously preserve Medicare's insurance protections and enhance the nation's fiscal well-being. We are not suggesting that these policies should be implemented immediately or how savings from Medicare should fit into a broader debt-reduction plan. Our goal is simply to offer reasonable Medicare policy options that, as a group, will produce budgetary savings and preserve and, in some cases, enhance the program for current and future beneficiaries.

Restructuring Beneficiary Obligations

Premium support—or replacement of Medicare's guaranteed health insurance benefit with a voucher toward the purchase of private (or, in some proposals, public) insurance—is a prime example of policy reform designed to achieve budgetary objectives that can have serious adverse consequences for beneficiaries. Premium support could easily reduce federal spending, simply by letting the voucher grow more slowly than expected growth in Medicare costs. These spending reductions would come from shifting, not reducing, beneficiaries' health care costs.[7]

Private health insurance would cost more than Medicare for equivalent benefits and beneficiaries, and, under the premium support arrangement, beneficiaries—not the program—would pay the difference between vouchers and actual insurance costs. As is true in the current Medicare Advantage market, imperfect risk adjustment in premium support would create incentives for risk selection. Beneficiaries with the greatest health needs would likely gravitate to more comprehensive plans and face higher premiums. To avoid this, a considerable amount of regulation would be necessary, a critical feature that premium support advocates rarely acknowledge.[8]

In the face of growing criticism of premium support, a proposal to increase the age of Medicare eligibility emerged. This would bring the age of eligibility for Medicare coverage in line with the current rules for receiving full benefits from Social Security. From a budgetary perspective, the proposal's attractiveness reflects CBO estimates that raising the eligibility age from 65 to 67 in increments of two months a year beginning in 2014 would reduce federal spending by $113 billion between 2014 and 2021 and more in the 2013–2022 window.[9] (Medicare savings of $148 billion are offset by $35 billion in new spending on premium subsidies and Medicaid expenditures.) This does not count the extra income and payroll tax revenue collected from those who choose to work longer as a consequence.

Savings would come not by reducing health care costs, but by expecting employers, beneficiaries, and the Medicaid program to pay more and by potentially reducing coverage. If precluded from Medicare participation, some 65- and 66-year-olds with access to employer coverage would likely work longer to retain that coverage.[10] The lowest-income 65- and 66-year-olds would likely seek Medicaid coverage, at a cost to both state and

federal budgets. Young elderly with incomes between Medicaid eligibility and 400 percent of the federal poverty level would be eligible for premium subsidies in the ACA's insurance exchanges—which would actually reduce out-of-pocket costs, relative to Medicare, for people with incomes below 300 percent of FPL.[11]

Yet many beneficiaries excluded from Medicare would not have these options. The Medicaid expansion that is part of the ACA does not provide coverage for people age 65 or older, so Medicaid eligibility would be limited to only the poorest seniors. And even if the ACA was modified to extend the Medicaid expansion to people age 65 and 66, several states have indicated an unwillingness to adopt even the currently defined expansion, leaving most low-income people age 65 and 66 in these states without access to affordable coverage.

Further, health insurance exchanges are not likely to be working smoothly and efficiently for several years in many states. And for people with incomes above 400 percent of FPL without access to an employer plan, premiums in the exchange could be very high relative to income. Yet, despite these high premiums, the decision by 65- and 66-year-olds to participate in exchanges would raise premiums for all exchange participants, because the ACA sets limits on premium variation based on age. This could decrease participation among the healthy nonelderly, precisely the population most necessary to creating sustainable and affordable coverage in the exchanges. Although there are sound reasons for raising the age of eligibility for Medicare, they do not offset the problems that would be created within the present policy structure.

A Medicare Buy-In Option. There is a viable alternative approach to simply increasing the age of eligibility for Medicare coverage that would mitigate some of the problems faced by 65- and 66-year-olds who would no longer be eligible. In addition, program savings could be significant, while providing financial protections for low-income individuals. Individuals turning 65 would be allowed to buy into Medicare by paying actuarially fair premiums (reflecting expected costs for this age group) for Parts A, B and D (including Medicare Advantage) until they turn 67. That premium would represent the actuarially fair cost of Medicare, not simply the 25 percent of the premium for Parts B and D that current Medicare beneficiaries pay. Deductibles and coinsurance would be structured similar to current Medicare benefits or, preferably, similar to the policy option discussed in the following section.

In sum, phasing in a Medicare buy-in would mitigate some of the adverse consequences of raising the age of eligibility in the current policy environment by giving individuals continued access to Medicare, while recognizing increases in life expectancy (as Social Security has) and still providing federal savings.

People with incomes between 138 percent and 400 percent of FPL would be eligible for income-related premium subsidies under the same schedule as in the ACA (Table 1). There may also be a need for additional financial protections for people with incomes above 400 percent of FPL who do not have access to an employer health plan, if premiums are too high relative to income for this group. (A measure of wealth might be a better indicator of affordability of the Medicare buy-in for retired individuals. But it would be extremely difficult to implement, so income serves well, though imperfectly, as a proxy.) At the same time, people in this age group with incomes below 138 percent of FPL would be allowed to enroll in Medicare with zero premiums and no (or very limited) cost-sharing. There would be no Medicaid obligation and, consequently, no problem with access in states not opting for the ACA Medicaid expansion. People now eligible for Medicaid under current state eligibility rules would retain those benefits.

Table 1. Premium Caps in the ACA

Up to 133% of FPL	2% of income
133–150% of FPL	3–4% of income
150–200% of FPL	4–6.3% of income
200–250% of FPL	6.3–8.0% of income
250–300% of FPL	8.0–9.5% of income
300–400% of FPL	9.5% of income

Estimating savings from this Medicare buy-in option relative to the CBO's estimates of $113 billion from simply raising the age of eligibility is not straightforward. CBO assumed that some 65- and 66-year-olds would enroll in Medicaid, some would get exchange subsidies, and some would get other coverage or stay in employer plans.[12] In our formulation, because of the higher federal costs for the poor and expenditures to provide subsidies to some of those with incomes above 400 percent of FPL, the Medicare buy-in option will not achieve the same level of savings as simply raising the Medicare eligibility age. Our ballpark estimate is that savings would be in the neighborhood of $90 billion over the 2013–2022 period.[13] In sum, phasing in a Medicare buy-in would mitigate some of the adverse consequences of raising the age of eligibility in the current policy environment by giving individuals continued access to Medicare, while recognizing increases in life expectancy (as Social Security has) and still providing federal savings.

Restructuring Premiums, Cost-Sharing and Medigap. Medicare's serious benefit design flaws related to premiums and cost-sharing can be revised to generate federal savings by raising contributions from some beneficiaries, reducing contributions for others, and enhancing Medicare's value to all. Currently, Medicare lacks a cap on out-of-pocket spending, exposing beneficiaries to risk for catastrophic expense and encouraging the purchase of supplemental Medigap insurance.

These Medigap policies drive up beneficiary costs as well as overall Medicare costs by lowering all out-of-pocket exposure, not only high-end costs.[14] In addition, Medicare's cost-sharing is inconsistent across services—high on hospital admissions, significant on many Part B services, and nothing on other services.

Finally, although the Medicare Modernization Act required high-income beneficiaries to pay higher Part B premiums (a requirement the ACA extended to Part D), the overall premium structure places a disproportionate burden (as a share of income) on many other beneficiaries.

Currently, individuals with incomes at 150 percent of FPL and above are not eligible for premium subsidies from the Medicare Savings Programs. They therefore pay in full the premium equal to 25 percent of Part B and Part D costs. For beneficiaries with incomes at 150 percent of FPL, this premium constitutes about 10 percent of income; cost-sharing responsibilities increase that financial burden further. Premiums decline as a share of income as incomes rise, since they are constant in dollar terms until much higher income levels. Premiums for both Part B and D do not increase until beneficiary income surpasses $85,000 for individuals and $170,000 for families.

The following reforms provide a four-part approach to restructuring Medicare premiums and cost-sharing responsibilities. First, we propose to institute a unified deductible for Parts A and B, retaining a separate deductible for Part D. Deductibles would vary with income, the way cost-sharing varies for the nonelderly buying nongroup exchange-based coverage in the ACA. For beneficiaries with incomes above 400 percent of FPL, deductibles would be higher than current average deductibles; deductibles would be roughly the same as today, on average, for beneficiaries with incomes between 300 percent and 400 percent of FPL; and deductibles for lower-income adults would be lower than today's average. Coinsurance would apply to all services but could also vary by income.

Second, Part B and Part D premiums would increase to 40 percent (or higher) of Part B and Part D costs, while applying rules similar to those used in the ACA to limit premium contributions as a share of income for lower-income beneficiaries. (When Medicare started, premiums were intended to cover 50 percent of Part B.) Beneficiaries would be required to pay the lower of the premium contribution set as a share of income based on ACA rules or 40 percent of Part B and Part D costs. This restructuring would reduce premium contributions from current levels for individuals with incomes greater than 150 percent and below 300 percent of FPL and increase premiums for middle-income beneficiaries. We estimate that beneficiaries with incomes at 400 percent of FPL would still pay no more than about 6 percent of their incomes as Medicare premiums.

Third, new out-of-pocket caps on combined Part A, B and D cost-sharing would be implemented. Currently, individuals are exposed to potentially very large amounts of out-of-pocket expenses, primarily through Part B but also, to a lesser degree, through Parts A and D. The reform would introduce an out-of-pocket cap of, say, $6,000 for those with incomes above 400 percent of FPL, with lower out-of-pocket caps for those with lower incomes. Individuals with incomes below 133 percent of FPL would have no out-of-pocket expenses. These out-of-pocket maximums would provide substantially more financial protection than Medicare provides today, particularly for those with serious medical needs.

The fourth component would impose limits on Medigap coverage. Supplemental coverage would become less necessary once an out-of-pocket cap is in place. Research has shown that people with Medigap coverage tend to impose higher costs on the Medicare program, but estimates vary. One way to limit Medigap coverage would be to prohibit policies covering the first $500 of expenses and no more than 50 percent of the next $4,950 in medical expenses, an approach consistent with the Bowles-Simpson recommendation. These Medigap limits could be set lower for low-income beneficiaries. Alternatively, a premium surcharge could be imposed on first-dollar coverage Medigap plans, a more direct approach that could be designed to yield comparable savings in Medicare. The surcharge would discourage the purchase of the lowest-value Medigap plans, while the new out-of-pocket caps would make Medigap much less necessary. The result would be to free up funds for middle- and high-income individuals to pay higher Parts B and D premiums.

All these policies are interrelated and should be considered as a package. The uniform deductible and Parts B and D premiums that are set at a higher level than middle- and high-income people face today would help finance lower premiums and cost-sharing for low-income beneficiaries, finance the new out-of-pocket caps, and provide savings. The out-of-pocket caps reduce the incentive to purchase Medigap policies, reducing the costs these policies impose on the Medicare program. The savings that individuals achieve by not buying Medigap policies could be used to pay for higher deductibles and higher Part B and D premiums.

There are no direct estimates of this proposed package of policies, but we can project the potential savings for components of the package from

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estimates produced by CBO for related policies.[15] First, CBO projected that a 35 percent premium in Part B would yield $241 billion in savings between 2012 and 2021. An increase in premiums on Part D to 35 percent would yield another roughly $100 billion. Savings would be greater if premiums covered 40 percent of Part B and Part D costs. Second, CBO estimates that a policy with a uniform deductible for Parts A and B of $500 coupled with an out-of-pocket cap of $5,500 would yield savings of $32.2 billion. We propose somewhat higher deductibles for Part A and B and a slightly higher out-of-pocket cap, which would yield even more savings. Similarly, the higher deductible for Part D would generate additional savings. Third, CBO estimates that savings from limits on first-dollar Medigap coverage, such as those proposed by Bowles-Simpson, would yield savings of $53.3 billion. As a group, these reforms could yield over $400 billion in savings between 2012 and 2021.

In our proposal, however, these savings would be offset by enhanced subsidies for beneficiaries with incomes below 300 percent of FPL that would reduce both their premiums and deductibles. Based on earlier analysis, adequate low-income subsidies could cost over $200 billion a year when fully phased in.[16] These subsidies could offset more than half the savings from the other policy changes. We therefore expect this package of policies to yield savings of about $150 billion.

As a result of the enhanced protections, people with incomes above Medicaid levels, but below 300 percent of FPL, would spend less than they do today. Similarly, the limit on out-of-pocket spending would mean that beneficiaries with very high expenses would also be better protected. However, those with incomes above 400 percent of FPL would pay more in Medicare premiums, although they could save on Medigap premiums if they forgo that coverage as a result of the benefits from the proposed Medicare out-of-pocket cap.

Given fiscal pressure to reduce Medicare spending, and no evidence of better quality in MA plans, further revisions of MA payment should be adopted to generate savings and encourage competition among plans based on efficiency, not guarantees of favorable payment rates.

Adjusting Payments to Plans and Providers

Although often given short shrift, the ACA's Medicare cost-containment initiatives are significant and varied.[17] Under the ACA, providers will be increasingly subject to a range of performance penalties and bonuses, aimed at minimizing inappropriate or maximizing appropriate care. More fundamentally, CMS has embarked on the development of new payment and organizational innovations—exemplified by accountable care organizations, medical homes, and bundled payments—aimed at shifting provider financial rewards away from volume and toward efficiently delivered, high-quality care. It will be several years before experience can be evaluated and success more broadly implemented, as the law encourages.

Alongside these longer-term payment innovations, however, are underappreciated and sometimes criticized rate reductions under Medicare's current payment methods; these approaches are having an immediate and substantial positive impact on Medicare spending. When compared to major program restructuring (e.g., premium support), these initiatives are frequently dismissed as arbitrary payment cuts, without policy justification. Critics further argue that such payment reductions backfire because providers increase volume to offset price reductions or shift costs to other payers. While there may be some basis for each of these assertions, they are exaggerated. For example, MedPAC finds that the majority of hospitals, which are able to negotiate high prices from commercial insurers and self-insured employers, can afford to be relatively inefficient and, thus, have negative Medicare margins. MedPAC concludes that Medicare's policy of applying financial pressure to hospitals is warranted to try to promote greater hospital efficiency, which would benefit all payers, not only Medicare.[18]

Although the ACA has required a number of payment changes that are already generating substantial spending reductions, research by CMS and MedPAC reveals many more opportunities for additional savings. We focus here on policy-justified refinements to current Medicare payment methods in three categories: Medicare Advantage, Medicare Part D, and Medicare Part A and Part B payment systems.

Reforms to Medicare Advantage (MA) Payments. Medicare Advantage plans have paid above–per capita costs for equivalent beneficiaries in traditional Medicare and have used these payments to provide extra benefits to attract more than a quarter of Medicare beneficiaries into private health plans. Measures taken by the ACA significantly reduce these extra payments, but employ a lengthy transition period that for many MA plans will take six years. Further, these measures reduce, but do not eliminate the long-standing bias that provides health plans with payment above traditional Medicare costs, a policy designed to attract enrollment in private plans rather than encourage efficiency and Medicare cost savings. Given fiscal pressure to reduce Medicare spending, and no evidence of better quality in MA plans, further revisions of MA payment should be adopted to generate savings and encourage competition among plans based on efficiency, not guarantees of favorable payment rates.[19]

Immediately, policy-makers could speed up and ultimately eliminate current overpayments to MA plans relative to traditional Medicare. Since 2006, MA plan payments have been based on bids for the cost of delivering Part A and

Part B benefits (including profit).[20] Plan bids are compared with a benchmark that is often above per capita costs in traditional Medicare. Before the ACA, plans with bids below the benchmark were paid their bids plus 75 percent of the difference between the bid and the benchmark, all of which had to be reinvested in enhanced benefits or lower premiums. The remaining 25 percent of the difference was retained as Medicare's share. In response to long-standing criticism by many, including MedPAC, that these extra payments to plans are wasteful and inefficient, the ACA will, over time, narrow the degree to which benchmarks exceed traditional Medicare costs and increase Medicare's share of any difference between bids and benchmarks.

Even with the ACA, health plan payments in excess of traditional Medicare costs will persist. Indeed, at least initially, savings from benchmark reductions have been partly offset by broad application of MA quality bonuses, further boosting MA payments above costs in traditional Medicare. The net result, according to MedPAC estimates, is that payments to MA plans in 2012 were more than 7 percent above what costs would have been for those enrollees in traditional Medicare.[21] Favorable selection—albeit reduced relative to earlier years—continues to boost MA payments compared to traditional Medicare, in essence providing MA plans an undeserved windfall resulting not from better management of risk, but rather rewarding them for avoiding risk.[22]

Although MA payments in excess of payments for similar beneficiaries in traditional Medicare currently finance enhanced benefits or reduced premiums and cost-sharing for MA participants, improving Medicare's protection is better addressed by the addition of limits on out-of-pocket payments, as proposed above. With this protection in place, remaining MA overpayments can be eliminated by speeding up the transition to the ACA's lower benchmarks, now scheduled for 2017; further reducing benchmarks, either to a maximum of 95 percent of traditional Medicare's per beneficiary costs in the highest cost areas and 100 percent everywhere else, or by reducing the current varying benchmarks proportionately across geographic areas to achieve equivalent Medicare savings;[23] and restructuring the MA quality bonus system to be budget neutral—with financial rewards to high-performing plans paid for by penalties to low performers. Using data from an earlier Urban Institute study, we estimate these actions would generate $30 billion in savings over 10 years.[24]

Reforms to Medicare Part D. The Medicare Modernization Act of 2003 established Part D to provide Medicare beneficiaries with prescription drug coverage and to replace Medicaid with Medicare drug coverage for beneficiaries enrolled in both programs (dual eligibles). Two elements of current policy, affecting providers and beneficiaries, respectively, could be modified to generate savings from more efficient purchasing.

Restoration of the Medicaid Rebate for Dual Eligibles. Drug manufacturers are required to pay specified rebates for prescription drugs purchased by Medicaid programs. Although these rebates continue to apply to most Medicaid beneficiaries, they were eliminated for dual eligibles with the implementation of Part D, assuming that private drug plans would negotiate similarly low prices for prescription drugs now paid for by Medicare. In fact, private Part D drug plans have received far smaller discounts under Medicare than Medicaid rebates would represent.[25] As a result, CBO estimates that simply *restoring* the required rebates Medicaid had previously received for these beneficiaries would save the Medicare program $137 billion over the decade 2013–2022 with modest, if any, cost-shift to other payers.[26] In essence, this policy simply represents a return to the same level of rebates for these beneficiaries when they were receiving drug benefits through Medicaid.

Modification of Cost-Sharing to Better Promote Generic Substitution. Substitution of generic for brand-name prescription drugs has contributed significantly to a slowdown in both national and Medicare spending on prescription drugs. However, dual eligibles and other Medicare beneficiaries with incomes below 135 percent of FPL receiving low-income subsidies (LIS) toward cost-sharing face a far more limited incentive for generic substitution than do other Medicare beneficiaries. MedPAC posits that the smaller price gap between the two types of drugs faced by low-income beneficiaries contributes to LIS beneficiaries' lower substitution rate—especially for commonly used drugs like those that lower cholesterol and prevent heartburn (esophageal reflux). Accordingly, MedPAC recommends reconsideration of the current copayments facing the LIS-eligible population, to increase the differential in cost-sharing between generic and brand-name medications.

Mindful of sustaining affordable access for the low-income population, we endorse MedPAC's recommendation that generic substitution be encouraged by eliminating cost-sharing completely for generic medications while at the same time setting the copayment on the substitutable brand-name drug at $6.00.[27] The change would be limited to therapeutic categories in which generic substitutes exist, and the policy would defer to physician preferences, based on patients'

Alongside such elements of the ACA as accountable care organizations (ACOs) and other payment reform pilots, refinements to existing payment mechanisms have the potential to better tie payments to appropriate costs, eliminating both unintended excess payments and rewards for inefficiency.

specific needs. MedPAC estimates savings at $17 billion over 10 years.[28]

Refinements to Current Payment Mechanisms in Parts A and B of Traditional Medicare. Alongside such elements of the ACA as accountable care organizations (ACOs) and other payment reform pilots, refinements to existing payment mechanisms have the potential to better tie payments to appropriate costs, eliminating both unintended excess payments and rewards for inefficiency. The ACA already includes a range of provider payment limits, but other options remain. Specific additional payment refinements include:

- Reduction in indirect medical education (IME) payments to teaching hospitals;
- Revisions to skilled nursing facilities (SNF) and home health payment methods;
- Revisions to the physician fee schedule to reduce rates for overpriced services and increase rates for primary care providers; and
- Reductions in payments for clinical laboratory services.

Reduction in Indirect Medical Education Payments to Teaching Hospitals. Medicare invests about $9.5 billion in graduate medical education (GME), while Medicaid contributes another $0.5 billion. Of this, about $3 billion supports Medicare's share of the direct costs of running GME training programs. But the lion's share of spending constitutes Medicare's estimated share of the indirect clinical costs associated with providing GME, such as longer lengths of stay associated with hospitals' educational mission. MedPAC analysis finds that these indirect GME costs (roughly $6.5 billion) exceed the empirically calculated costs associated with teaching functions by about $3.5 billion a year.[29]

CBO has calculated that eliminating these non-empirically justified indirect payments to teaching hospitals and establishing grants for medical education costs that grow at a rate equal to inflation (measured by CPI-U) minus 1 percentage point would produce savings of approximately $70 billion over 10 years.[30] Rather than eliminating the complete IME excess, MedPAC has proposed using it as financial leverage to catalyze more rapid GME reform—specifically, tying hospital payments to investment in providing physicians with the requisite skills to manage delivery system reform, hopefully achieving higher-value care in the long run.[31] Specifically, MedPAC calls for assessing GME programs based on measuring programs' performance in developing new physician perspectives and training in evidence-based medical practice, effective use of information technology, quality measurement and improvement, cost awareness and prudent practices, care coordination, participation on and leadership of interdisciplinary teams, and shared decision-making. MedPAC also would use financial carrots for academic health centers to provide increased emphasis on specialty training in ambulatory care and in primary care.[32]

To simultaneously reduce excess spending yet support MedPAC's objectives, a portion of current IME spending—in this proposal, we assume $1 billion a year—could be retained to support development and implementation of an incentive grant program for GME, with the recognition that future payments could be higher if, as MedPAC believes, the investment actually begins a move toward delivery of lower-cost, higher-value care. To preserve MedPAC's incentive program, but funded at a lower level, GME funding would be reduced by $2.5 billion initially, and would yield 10-year savings of roughly $50 billion rather than CBO's $70 billion.

Revisions to Skilled Nursing Facilities and Home Health Payment Methods. In 2011, post-acute care, primarily by SNFs and home health agencies (HHAs), represented the third-largest category of Medicare spending (at 15 percent), following hospital and physician services. These providers' relatively high profit margins—in 2010, 18.5 percent for SNFs and 19.4 percent for freestanding HHAs—indicate that current prospective payment rates are unnecessarily generous. Margins for the top-quarter of SNFs and HHAs exceeded 27 percent in 2010, or more than 40 percent greater than the average.[33] Two factors other than relative efficiency likely explain these high margins. First, patient classification is not capturing variation in patient costs within categories, thereby producing overpayments to providers serving patients whose care needs are less than average for the category (or underpayments to providers serving patients with above-average care needs).[34] Second, norms and quality standards are weaker for post-acute than for acute care, allowing providers to reduce their costs by simply delivering less care, without regard to patient needs.

To reduce overpayments, MedPAC and the Obama administration have recommended immediate reductions to SNF and HHA prospectively set rates, in order to better align payments with actual costs. In response to the evidence of very high margins in March 2012, MedPAC recommended that Congress eliminate its update to provider payments in 2013 and rebase payments beginning in 2014, with an initial reduction of 4 percent followed by greater reductions until Medicare payments were closer to costs. MedPAC also proposed rebasing of payments for home health services beginning in 2013 along with changes in payments for therapy services. Using the midpoint of MedPAC five-year estimates and projecting them forward over the 2013–2022 period, we estimate that MedPAC recommendations result in about $35 billion in savings.[35]

The Obama administration's FY 2013 budget also proposed reductions in post-acute care provider payments. It proposes reducing payment updates for SNFs and HHAs, as well as inpatient rehabilitation facilities and long-term care hospitals, by 1.1 percentage points for 2014–2021. CBO estimates savings of $45 billion over 10 years (2013–2022).[36]

Across-the-board reductions, however, would not address incentives to favor low-cost patients or to underserve patients who need extensive care. To eliminate overpayments and address perverse incentives, payment reductions could be accompanied by a payment reform that would add a shared savings component to prospectively set rates.[37] Although rates would still be set in advance, providers' experience would be assessed at year's end to determine the difference between prospective payments and actual costs (including a reasonable profit). Providers would receive a share, rather than the full amount, of any excess payment above costs, and Medicare would pay a share of provider costs that exceeded prospective rates.

Rates could be set to achieve the same savings achieved in MedPAC's proposals. But rather than affecting all providers equally, it would recapture excessive payments appropriately from each provider, depending on its actual patient mix and service costs. Although risk-sharing rather than full risk would somewhat reduce incentives for efficiency, profit incentives would remain strong and patients would be better protected. The risk-sharing policy could be designed to achieve the $35 billion MedPAC estimates for its recommendation.

Performance could be further improved and further savings generated with additional refinements to SNF and HHA payments, not only to address specific MedPAC concerns with current payment formulas (most prominently, incorporating therapy services into prospective payment rates), but also to introduce penalties, like those that now apply to hospitals, for excessive hospital readmissions. Penalties could apply more broadly—to inappropriate hospital admissions of any nursing home patient—in order to counter incentives nursing homes currently face that encourage hospitalization in order to qualify for the higher Medicare SNF rate of a post-hospital nursing home stay.

Even after fixing the SGR, the Medicare fee schedule (MFS), which theoretically values services based on their relative production costs, still needs substantial refinement to correct evident payment distortions that have accrued over the 20 years the MFS has been in place.

Revisions of the Physician Fee Schedule to Reduce Rates for Overpriced Services and Increase Rates for Primary Care Providers. As noted at the outset, how Medicare (along with other payers) pays physicians for their services is one of the last vestiges of true fee-for-service. And many of the ACA's payment demonstrations (e.g., medical homes and bundled payments) specifically target physicians for new delivery and payment approaches. But the success of these pilots will be hampered by the mispricing that overpays for tests and many procedures under the current Medicare fee schedule and, in essence, rewards provision of unnecessary services while skimping on primary care payment. While pilot tests proceed, it is important to correct two of the major flaws in current physician payment policy. The result would be a better functioning Medicare fee schedule, smoothing the transition to new payment methods, while also producing modest Medicare budget savings.

The policy proposals intended to correct these physician payment flaws and the budget numbers associated with them assume a permanent fix to the SGR.The SGR is a complex formula established in the Balanced Budget Act of 1997, which sets annual expenditure targets for Medicare physician spending and requires payment rate adjustments to keep spending from exceeding the rate of GDP growth. Since 2002, Congress has intervened to delay scheduled physician reimbursement cuts that would result from the SGR's application. Every time Congress has implemented a temporary "doc fix" to prevent cuts to physician fees, it has funded the offsets via reductions elsewhere in Medicare and Medicaid, pushing the problem off for another year.

The recently enacted fiscal cliff legislation—The American Taxpayer Relief Act of 2012—delays for one year an almost 27 percent cut in doctor fees under the Medicare SGR formula. The Act reduces Medicare and Medicaid spending by approximately $30 billion, to pay for this one-year freeze in Medicare physician payment rates. Currently, CBO estimates that eliminating the SGR formula and replacing it with a 10-year fee freeze would cost about $138 billion between 2013 and 2022.[38] This number may seem large, but is dramatically lower than the previous estimate of $244 billion that CBO released as recently November 2012. The $244 billion CBO estimate took into account expected increases in the number of Medicare beneficiaries remaining in traditional Medicare over the next 10 years and growth in the volume of services provided per beneficiary. Based on the most recent data, those are both projected to be much lower than had been previously assumed. This means that policy-makers are now facing a much lower cost of complete SGR repeal than they have in years and can take this opportunity to repeal this flawed policy once and for all.

Even after fixing the SGR, the Medicare fee schedule (MFS), which theoretically values services based on their relative production costs, still needs substantial refinement to correct evident payment distortions that have accrued over the 20 years the MFS has been in place. First, there are overvaluations of services—that is, payment rates that far exceed the underlying relative costs of production—that result in overpayment for tests, imaging, and many procedures, with corresponding relative underpayment for "evaluation and management" services—that is, office visits and the associated activities physicians and their care teams spend managing and coordinating

patient care. Misvaluations, which also are incorporated into fee schedules administered by commercial health plans and Medicaid programs, result in large income disparities across the specialties and contribute to an inadequate supply of primary care physicians in many parts of the country.[39]

Second, the misvaluations are not confined to physician payment rates. Medicare and most other payers pay hospitals as much as two times more for outpatient services provided by hospital-employed physicians as they pay for the same services provided by independent physicians.[40] This is because the physician's professional service is paid under the MFS, and the hospital is paid separately for its facility costs. This MFS difference is referred to as the "site of service" differential and is meant to recognize that hospitals have certain costly obligations that independent practices do not have, including 24/7 standby capacity and the obligation to serve anyone with medical needs regardless of health insurance status. Nevertheless, the site of service differential is excessive and leads to higher cost-sharing for patients, while encouraging many hospitals to employ physicians in order to take advantage of the much higher payment rates. Hospitals receive the higher payments even if the employed physicians continue to practice in their original setting and have little or nothing to do with the hospital's commitment to 24/7 access for the community.[41]

The interaction of these physician and site of service payment problems produces perverse results for Medicare. When Medicare reduced overpayments under the MFS for various cardiac imaging services in 2010, many cardiologists decided to accept offers to become hospital employees, producing relatively more "provider-based payments"—and higher Medicare spending. As a result, reducing payment rates for overpriced physician services under the MFS can increase Medicare payments even more—now to hospitals employing the physicians.

An aggressive program of revaluing the MFS over the next few years can correct pricing distortions—and needs to be accompanied by a reduction in or elimination of the site of service differential. The additional costs hospitals uniquely bear could be allocated only into those services that hospitals uniquely provide—that is, emergency department and inpatient services.

Currently, any payment rate changes within the MFS are implemented to be budget neutral. That means that if a service's payment rate is reduced, the payment rates for all other MFS services are increased marginally to balance the reduction. However, payment rate corrections can also be used to achieve budget savings. In 2011 in the context of proposing an elimination of the SGR, MedPAC proposed a nearly 18 percent reduction in all MFS fees except for designated primary care services, to be achieved over three years, and then flat payments for the rest of a 10-year period.[42] A current rough projection of the MedPAC proposal is that it would save about $46 billion.[43]

A less aggressive alternative, but one still yielding substantial savings, would be a 2 percent per-year reduction in services not designated as primary care for three years, and then flat payment for another seven years for all services, accompanied by an aggressive, budget-neutral redistribution of fees that normally results from reducing overvalued services to better support primary care. This modification of MedPAC's proposal would cumulatively reduce non–primary care fees by 6 percent, about a third as much as MedPAC's proposal. Budget savings for these physician payment changes would be about $15 billion over 10 years.

At the same time, to prevent further hospital employment of physicians to take advantage of what would be even greater site of service differentials, we would reduce combined hospital and physician payments for hospital outpatient services close to or at MFS levels while initially fully offsetting these reductions by increasing payments for hospital-only services (e.g., emergency department care and inpatient care) to have this component of the policy change be budget neutral.[44] Further analysis is needed to assess whether hospitals' unique obligations justify the level of additional costs that have produced such higher site of service payment differentials.

Payment Reductions for Clinical Laboratory Services. Medicare currently spends about $9 billion a year on clinical laboratory services, representing 1.6 percent of total program spending in 2011. The average annual growth rate for these services was 5.5 percent over the past decade. The growth was driven by rising volume, as there were only two increases in lab payment rates during that decade (1.1 percent in 2003 and 4.5 percent in 2009).[45] Payment rates were reduced by 1.75 percent in 2011, and legislation enacted in 2012 imposed an additional 2 percent reduction. Although there are substantial fixed costs in running clinical labs, the marginal costs for an additional test is small, such that the substantial volume growth in lab services represents mostly profits for clinical labs. A number of health plan and provider representatives have suggested that Medicare's de facto national fee schedule for lab services pays substantially more than do large commercial insurers in their contracts with national laboratories.[46]

Given that aggregate Medicare spending growth is driven as much by increases in the number of program beneficiaries as it is by increases in spending per beneficiary, any balanced policy approach needs to recognize that modifying payments to providers or extracting a greater contribution from beneficiaries will not solve the program's financial problems on their own.

CMS should conduct formal surveys of lab fees paid by large payers for clinical lab services in order to systematically assess the appropriateness of fees in Medicare. The agency could then correct any evident overpayments for lab services, relying on "inherent reasonableness" authority that specifies a process for correcting Medicare payments found unreasonable because they are either grossly excessive or insufficient. Even absent formal studies, MedPAC determined that a 10 percent reduction in the clinical lab fees could be one provision used to offset the costs of repealing the SGR.[47] Subsequent to that suggestion, Congress enacted the 2 percent payment reduction as part of last year's "doc fix."[48] Another 8 percent reduction in the clinical lab fee schedule would save another $10 billion over 10 years. At the same time, CMS should exercise its inherent reasonableness authority to conduct the data acquisition necessary to determine whether even greater fee reductions would be appropriate to bring Medicare's lab fees in line with other large payers. Limited exceptions should be granted for small clinical laboratories, such as those in rural areas housed in small hospitals, which lack the economies of scale to absorb such cuts, and where there are no other labs to provide practical alternatives for patients and clinicians.

Increasing Revenues

Given that aggregate Medicare spending growth is driven as much by increases in the number of program beneficiaries as it is by increases in spending per beneficiary, any balanced policy approach needs to recognize that modifying payments to providers or extracting a greater contribution from beneficiaries will not solve the program's financial problems on their own. The third leg of this policy solution needs to come in the form of greater revenues to support the program. In addition to general tax revenues, given that Medicare Part A is set up to be funded by payroll taxes future beneficiaries pay during their working years, it is reasonable to include an enhanced payroll tax in any comprehensive and balanced approach to addressing Medicare's fiscal dilemma.

Table 2. Savings and New Revenue from Medicare Reforms, 2013–22 (in billions)

Create Medicare buy-in option with ACA subsidies for 65–66-year-olds[a]	$90
Restructure premiums, cost-sharing and Medigap	150
Reform Medicare Advantage payments	30
Restore drug rebates for dual eligibles and promote use of generics	154
Reduce teaching hospital payments and provide targeted incentives	50
Eliminate excessive skilled nursing facility and home health payments	35
Reprice overpriced services and promote primary care in physician fee schedule	15
Reduce overpayments for clinical laboratory services	10
Increase payroll tax by 0.5%, beginning in 2017	200
Total savings and new revenues	**734**
Less SGR repeal	**-138**
Net total savings and new revenues	**$596**

Notes: All estimates are based on CBO and MedPAC estimates of similar proposals and are adjusted as appropriate. Estimates, except where noted, assume that policies are implemented in 2013 or 2014. This is unlikely, so 10-year savings and revenue estimates are somewhat overstated. Numbers are 10-year estimates and do not account for a delayed phase-in of some policies.
[a]Assumes, following CBO, that policy is phased in two months a year beginning in 2014.

The current hospital insurance tax is 2.9 percent of earnings divided equally between employers and employees. Unlike the Social Security tax, which applies only to earnings up to a maximum $113,700 in 2013, this tax applies to all earnings. In 2013, there is an additional tax of 0.9 percent on earnings over $200,000 for an individual (over $250,000 for a couple). The ACA also imposed a 3.8 percent Medicare tax on unearned income for individuals with incomes above $200,000 and married couples above $250,000, effective January 1, 2013. CBO estimates that replacing the 0.9 percent surtax with a 1 percentage point increase in the payroll tax paid by all workers would yield $651 billion between 2012 and 2021.

Raising payroll tax revenues by less than the CBO example—we suggest 0.5 percent—would yield savings of about $300 billion. It would also help Medicare accommodate the growing elderly population and specifically (though not fully) address the inadequacy of Part A's payroll tax funding base—estimated to leave a gap between expected spending and expected revenues of 2.4 percent of taxable payroll over the next 75 years. The higher tax would mean that baby boomers would be contributing more to the cost of their own benefits. However, the payroll tax has the disadvantage of being a tax on labor at a time of high unemployment, so implementation should probably be delayed. We suggest the 0.5 percent increase in the payroll tax be implemented in 2017; this would produce about $200 billion in new revenues.

Conclusion: Reducing Medicare Costs and Securing its Insurance Protections

The proposals laid out in this paper achieve a number of objectives, including providing about $600 billion in savings or new revenues for the Medicare program over 10 years, after allowing for the costs of a $138 billion SGR fix (see Table 2). In all, there are savings or new revenues of about $730 billion. The actual savings from these policy options depend on how they are implemented, including the rate at

which some are phased in. To be clear, we did not assemble a set of policies designed to achieve an arbitrary savings or revenue target, although we recognize that comparisons between our savings estimates and others are inevitable.

We do not believe that simply increasing the age of eligibility for Medicare for those age 65 and 66 is workable, because of the lack of coverage options for those with the lowest incomes. However, given that there is a rationale for raising the age of eligibility, allowing those 65 and 66 years of age to buy into Medicare at an actuarially fair premium—with income protections—would yield program savings and avoid the many negative impacts of simply raising the age of eligibility in the current policy environment. Our estimated savings would be lower than simply increasing the age of eligibility as analyzed by the CBO without a Medicare buy-in option.

We dramatically improve protections for low-income Medicare beneficiaries and introduce an income-related out-of-pocket cap for all of them. We also introduce income-related premiums and deductibles that are higher for middle-income beneficiaries than they are today. Further, we rationalize physician payment by calling for permanent repeal of the SGR policy and altering physician fees to favor primary care services. We also make a number of other reforms in payments to MA plans and providers, including prescription drugs, skilled nursing facilities, home health agencies and clinical laboratories. Finally, we raise new revenues through a small 0.5 percent increase in the payroll tax beginning in 2017—increasing contributions of future beneficiaries to be more in line with their future costs and to help pay for the costs of a growing elderly population. Even with an SGR fix, net savings and new revenues remain about $600 billion.

There are dozens of other possible benefits and provider payment reform opportunities that we have not included here, partly because they require more detailed analysis than we could provide at this time to assess their likely impacts. A few examples include reducing overly generous payment levels for various providers and suppliers of Medicare services; lowering the extra payments made to rural hospitals—critical access hospitals, sole community hospitals, and Medicare-dependent hospitals; improving care management and coordination for dual-eligibles; and reducing fraud through increasing the CMS administrative budget.

Our goal is to illustrate with a package of reasonable Medicare policy options, policy-makers can produce substantial budgetary savings, while preserving and, in some cases, enhancing the program for current and future beneficiaries. This analysis demonstrates that Medicare reforms can be consistent with preservation of Medicare's social insurance protections if the costs are shared among beneficiaries, providers and taxpayers. The options we discuss are not intended to be an exhaustive list. Instead, they represent the types of responsible changes that could be implemented in the near future.

Our analysis demonstrates that Medicare reforms can be consistent with preservation of Medicare's insurance protection if the costs are shared among beneficiaries, providers and general taxpayers; savings need not be achieved at the expense of insurance protection. We do not argue that these policies should be implemented immediately or that Medicare savings should dominate a plan for debt reduction. This paper simply offers Medicare policy options that, together, produce budgetary savings and preserve and, in some cases, improve the program for current and future beneficiaries.

Many, if not all, of the proposals we put forth will be politically difficult to achieve. But the proposal is intended as a package that would reform Medicare by requiring shared sacrifices from beneficiaries, health plans, providers and taxpayers. Modifications to provider payments should be pursued along with increases in obligations from middle- and high-income beneficiaries and increased payroll taxes. Likewise, changes in premiums, cost-sharing, or Medigap policies would not be equitable, and should not be considered, without inclusion of catastrophic protection in the Medicare benefit package and improved low-income subsidies.

Finally, despite the importance of eliminating excessive and inefficient provider payment from Medicare, attention to a growing gap between Medicare payments and payments by private insurers is essential. Medicare already pays physicians 20 percent less and hospitals 30 percent less than commercial insurers.[49] It is true that Medicare's substantial market power allows the program to considerably constrain payment without endangering access to care, but its market power is not infinite. Payment reductions can threaten access if the gap between Medicare and private rates grows too large. In light of this risk—and providers' growing market power—some experts have called for public and private payer collaboration in designing and constraining rates to providers or in setting overall health care budgets. System-wide cost containment along these lines will therefore be critical to the future fiscal health not only of Medicare but of the nation's health care system.

Endnotes

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For those with incomes between 138 and 400 percent of FPL, the federal government will pay the difference between individuals' income-related premiums and the cost of the second-lowest cost silver plan in exchanges. The premiums for those age 65 and 66 who have incomes between 138 percent and 400 percent of FPL will be lower than the full cost within this age group because of age rating. But while the federal government will see lower subsidy costs for older adults, it will have higher subsidy costs for younger ones. In other words, the federal government will pay subsidy costs not just for those age 65 and 66 but somewhat higher subsidy costs for all exchange participants in this income range. As a result, the federal subsidy costs will really depend on the cost of private premiums, specifically for the second-lowest cost plans in each exchange market.

For those with incomes above 400 percent of FPL, there are no federal expenditures. The existence of age rating, however, does lower premiums for those age 65 to 66 but increases them for younger age groups, introducing a cross-subsidy.

13 Under our formulation of a Medicare buy-in, federal savings would be less than under the CBO approach. Spending on the poor will be higher because those with incomes below 138 percent of FPL would be enrolled in Medicare rather than in Medicaid, at no cost to states. This would result in higher federal expenditures. The federal costs of subsidies in exchanges for those with incomes between 138 percent and 400 percent of FPL should be lower than the CBO estimates to the extent that Medicare costs are lower than private premiums but much of this depends on the cost of the second-lowest cost silver plan in exchanges. The cost of these plans is hard to predict, but it seems unlikely that federal subsidies will be higher under the Medicare buy-in, more likely they will be lower. Also, adding the 65- and 66-year-olds to the HIX will increase all premiums, thus increasing subsidy costs in total even for younger people.

Under the Medicare buy-in option, the cross-subsidies from age rating for those with incomes above 400 percent of FPL would not exist. But we suggest that Medicare should extend some form of financial protection for those above 400 percent of FPL who do not have access to an employer-sponsored plan.

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[35] MedPAC, "The Medicare Advantage Program."

[36] *Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies Relative to CBO's March 2012 Baseline.* Washington: CBO, 2012. http://www.cbo.gov/sites/default/files/cbofiles/attachments/43502-SGR%20Options2012.pdf.

[37] This section draws on material Judy Feder prepared for "Policy Options to Sustain Medicare for the Future," Kaiser Family Foundation, January 2013.

[38] "Update to Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies Relative to CBO's March 2012 Baseline." Washington: CBO, November 2012.

[39] "Improving Incentives in the Medicare Program." In *Report to the Congress: Medicare Payment Policy.* Washington: MedPAC, June 2009.

[40] Fitch Ratings. "2011 Median Ratios for Nonprofit Hospitals and Health Care Systems." August 2011; Moody's Investors Service. "Not-for-profit Healthcare Medians Show Resiliency against Industry Headwinds but Challenges Still Support Negative Outlook." August 2011.

[41] MedPAC, "The Medicare Advantage Program."

[42] "Re: Moving Forward from the Sustainable Growth Rate (SGR) System." Letter to Congress, October 14. Washington: MedPAC, 2011.

[43] The originally reported budget effect was a 10-year savings of $100 billion relative to an earlier CBO projection of $300 billion to eliminate the SGR completely. Given that current information from CBO suggests the cost of eliminating the SGR would be only $138 billion (or, about 46 percent of $300 billion), a current projection of the MedPAC proposal is that it would save $46 billion.

[44] Exceptions to the reductions could be made for hospitals with extraordinary reliance on outpatient revenues or serving particular patient populations that produce higher costs.

[45] "Health Care Spending and the Medicare Program." In *A Data Book: Medicare Payment Policy.* Washington: MedPAC, 2012.

[46] Lab fee schedules were established in 1985 based on local area charges. However, because national payment limits apply to each test, as a practical matter, most tests are paid at the national limits, resulting effectively in a national fee schedule.

[47] MedPAC, "Re: Moving Forward from the Sustainable Growth Rate (SGR) System."

[48] Emergency March 2012 Update, Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) to the CY 2012 Medicare Physician Fee Schedule (MPFS) Database. March 2012. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7767.pdf.

[49] "Chart 6-22: Change in Medicare Hospital Inpatient Costs per Discharge and Private Payer Payment-to-Cost Ratio 1987–2010." In *A Data Book: Health Care Spending and the Medicare Program.* Washington: MedPAC, 2012; "Figure B-2: Ratio of Medicare to Private Payer Physician Fees Is Stable." In *Report to the Congress: Medicare Payment Policy.* Washington: MedPAC, 2010.

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