

REPORT 10 OF THE COUNCIL ON MEDICAL SERVICE (A-07)
Strategies to Strengthen the Medicare Program
(Reference Committee A)

EXECUTIVE SUMMARY

For over 20 years, the Council on Medical Service has studied ways of strengthening and reforming the Medicare program. Current AMA policy on Medicare reform is articulated in Policy H-330.898 (AMA Policy Database). In part, this policy calls for the current Medicare program to ultimately be replaced with a self-funded, private sector approach to financing health care for the elderly, with equitable means-testing provisions. Specifically, the AMA supports shifting the funding of Medicare to a system of mandatory individually owned savings, with a required minimum contribution, accumulated tax-free and dedicated to funding post-retirement medical care. The government would provide a contribution to the health care retirement accounts of economically disadvantaged individuals.

However, in light of the ongoing, annual advocacy efforts to seek both temporary and permanent changes to the Medicare physician payment system, as well as the ongoing threat of insolvency of the Medicare Trust Fund, the timing appears right for the AMA to shift the focus from long-term Medicare reform strategy to clearly articulating a series of interim steps that could help stabilize and modernize the Medicare program.

In 2007, the AMA is once again engaged in an aggressive campaign to reverse imminent Medicare physician pay cuts and to remove the constant threat of negative payment updates by achieving a permanent replacement for the Sustainable Growth Rate (SGR) formula. SGR-driven pay cuts are a symptom of larger disease, however, which is a Medicare financing system that is unable to deliver the benefits promised to either the current generation of seniors or the baby-boom and future generations.

Medicare's ultimate financial sustainability has been the subject of concern for many years. The so-called "45% trigger," established by the Medicare Modernization Act of 2003, has made explicit the imperative to stabilize the program by mandating that the Administration present a financing plan to Congress if two consecutive reports of the Medicare Trustees predict that, within seven years, 45% or more of Medicare funding will come from general revenues. The 2006 Medicare Trustees report projected that this would occur in 2012. The 2007 report, released in April 2007, projects that this would occur in 2013. Thus, the President will be required to present a long-term Medicare financing strategy to Congress in early 2008.

Although existing Policy H-330.898 presents both short and long-term strategies for Medicare reform, the Council sees an opportunity for the AMA to articulate an updated set of alternatives, and to position itself as a resource for ideas that will help move Medicare beyond annual budget battles. Accordingly, this Council report recommends adoption of a set of five alternatives that policy makers could consider when seeking ways to modernize and fiscally strengthen the Medicare program. Although the Council remains committed to AMA policy that would ultimately move Medicare to a system of pre-funded financing, the changes presented in this report represent a politically viable set of alternatives that could be implemented in the near-term.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 10 - A-07

Subject: Strategies to Strengthen the Medicare Program

Presented by: William A. Dolan, MD, Chair

Referred to: Reference Committee A
(Virginia E. Hall, MD, Chair)

1 For over 20 years, the Council on Medical Service has studied ways of strengthening and
2 reforming the Medicare program. In light of the ongoing, annual advocacy efforts to seek both
3 temporary and permanent changes to the Medicare physician payment system, as well as the
4 ongoing threat of insolvency of the Medicare Trust Fund, the timing appears right for the AMA to
5 shift its focus from its long-term Medicare reform strategy to clearly articulating a series of interim
6 steps that could help stabilize and modernize the Medicare program.

7
8 In 2007, the AMA is once again engaged in an aggressive campaign to reverse imminent Medicare
9 physician pay cuts and to remove the constant threat of negative payment updates by achieving a
10 permanent replacement for the Sustainable Growth Rate (SGR) formula. The Board of Trustees is
11 presenting a report to the House of Delegates at this meeting that discusses Medicine's current
12 effort to eliminate the SGR, secure payment updates that reflect annual practice cost increases, and
13 assume a leadership role in efforts to promote health care quality and appropriateness.

14
15 SGR-driven pay cuts are a symptom of larger disease, however, which is a Medicare financing
16 system that is unable to deliver the benefits promised to either the current generation of seniors or
17 the baby-boom and future generations. The Council and the Board agree the best way to achieve
18 adequate funding for Medicare physician services, therefore, is through broader Medicare reforms
19 that will strengthen the entire Medicare program. In addition to the Board report on the SGR and
20 this Council report on ways to bolster the Medicare program's fiscal solvency and efficiency,
21 Council on Medical Service Report 8, which is also before the House at this meeting, analyzes
22 strategies to address rising health care costs.

23 24 BACKGROUND

25
26 The Medicare program is supported by two separate trust funds -- the Hospital Insurance (HI) Trust
27 Fund, and the Supplementary Medical Insurance (SMI) Trust Fund. Under current law, there is no
28 provision for sharing or transferring revenues between the two funds. The Federal HI Trust Fund
29 finances Medicare Part A, which covers inpatient hospital, some home health, skilled nursing
30 facility, psychiatric hospital, and hospice care services. The primary source of income for the HI
31 Trust Fund is a 2.9% payroll tax paid by employers and employees (1.45% each). The Federal
32 SMI Trust Fund finances Medicare Part B, which covers physician services, hospital outpatient
33 services, some mental health services, durable medical equipment, ambulatory surgical center
34 services, physician-administered drugs, some lab tests, and home health visits not covered under
35 Part A. The SMI Trust Fund also finances Part D, which offers prescription drug coverage.

1 Income to the SMI Trust Fund comes from federal general revenues (75%) and beneficiary
2 premiums (25%).

3
4 The long-term financing and benefits structure of the current Medicare program is unsustainable.
5 The current system relies on taxes (both the Medicare payroll tax and general tax revenues) paid by
6 current workers to fund the benefits provided to current retirees. The ratio of workers contributing
7 payroll taxes to the number of beneficiaries is expected to decline steadily as “baby boomers”
8 become eligible for Medicare, life expectancy continues to improve, and future birth rates stay at
9 levels similar to that of the last two decades. Compounding the demographics problem is the
10 continual increase in health care costs across all segments of the population. In their 2007 report to
11 Congress, the Medicare Trustees noted that HI tax revenues currently cover approximately 99% of
12 HI costs. The Trustees project that taxes will cover only 79% of costs in 2019, the same year in
13 which the Trustees project exhaustion of HI Trust Fund assets. Without politically challenging tax
14 and/or premium increases, revenues will not keep pace with program obligations, leading to
15 insolvency (in the case of the HI Trust Fund) and a steadily increasing demand on the federal
16 budget.

17
18 AMA POLICY

19
20 Current AMA policy on Medicare reform is articulated in Policy H-330.898 (AMA Policy
21 Database). In part, this policy calls for the current Medicare program to ultimately be replaced
22 with a self-funded, private sector approach to financing health care for the elderly, with equitable
23 means testing provisions. Specifically, the AMA supports shifting the funding of Medicare to a
24 system of mandatory individually-owned savings, with a required minimum contribution,
25 accumulated tax-free and dedicated to funding post-retirement medical care. The government
26 would provide a contribution to the health care retirement accounts of economically disadvantaged
27 individuals.

28
29 Policy H-330.898 also identifies ways in which the existing Medicare program could be modified
30 to help improve its sustainability in the short-term, including combining the cost-sharing
31 requirements of Parts A and B into a single deductible, and using the Federal Employees Health
32 Benefit Program (FEHBP) as a model for restructuring Medicare so that seniors could choose the
33 plan that best meets their needs from among competing plans.

34
35 THE CURRENT MEDICARE ENVIRONMENT

36
37 The Medicare program has experienced several changes since the Council last considered the issue
38 of Medicare reform in 2003, and Policy H-330.898 was amended. The Medicare Prescription Drug
39 Improvement and Modernization Act of 2003 (MMA) created the Prescription Drug Benefit (Part
40 D). The MMA also increased Medicare’s reliance on insurance companies by using them to
41 deliver the Part D drug benefits, as well as through the revamping of Medicare+Choice into
42 Medicare Advantage. The structure of the Part D benefit has led to increased price competition in
43 Medicare both among drug manufacturers seeking to have their drugs be the preferred choice on
44 Part D formularies and among drug plans seeking to enroll new subscribers. At the same time,
45 average per capita payment rates for Medicare Advantage plans have risen well above average per
46 capita Medicare fee-for-service spending, which impedes progress towards meaningful competition
47 in Medicare. In addition to the MMA, efforts to control costs and increase efficiency throughout
48 the health care system have given rise to new paradigms designed to transform the way health care
49 is delivered and paid for.

1 Medicare’s ultimate financial sustainability has been the subject of concern for many years. The
2 so-called “45% trigger,” established by the MMA, has made the imperative to stabilize the program
3 explicit, by mandating that the Administration present a financing plan to Congress if two
4 consecutive reports of the Medicare Trustees predict that, within seven years, 45% or more of
5 Medicare funding will come from general revenues. The 2006 Medicare Trustees report projected
6 that this would occur in 2012. The 2007 report, released in April 2007, projects that this would
7 occur in 2013. Thus, the President will be required to present a long-term Medicare financing
8 strategy to Congress in early 2008. The President’s 2008 budget already includes across-the-board
9 cuts to Medicare that would be implemented if the 45% threshold is reached again in 2007.

10
11 Although Policy H-330.898 continues to present both short and long-term strategies for reform, the
12 Council sees an opportunity for the AMA to articulate an updated set of alternatives, and to
13 position itself as a resource for ideas that will help move Medicare beyond annual budget battles.

14 15 STRENGTHENING THE MEDICARE PROGRAM

16
17 The Council has identified several changes that could be implemented together or separately, and
18 would improve the financial structure and longevity of the Medicare program. The Council
19 envisions that several of these suggestions would be implemented incrementally over a period of
20 several years, so that current and near beneficiaries would experience minimal or no changes. This
21 will allow future generations of beneficiaries adequate time to understand and plan for the changes
22 that will be introduced into the program.

- 23
24 1. Combine the Medicare Trust Funds into a single unit, so that revenues for the Medicare
25 program can be administered more efficiently and be better targeted toward the services used
26 by beneficiaries.

27
28 Technological advances have resulted in an increased number of procedures and treatments
29 being delivered in non-hospital settings, and new drugs and improved chronic care
30 management have reduced the need for hospital treatments. As previously noted, the current
31 financing structure limits flexibility in reallocating funds according to different service
32 patterns, such as increased volume of office-based treatments and technologies (Part B) that
33 has resulted in fewer hospital days (Part A).

34 35 Benefits of Strategy

- 36
37 • Would accommodate changes in practice trends and technologies, allowing resources to
38 follow most appropriate modes of care.
39 • Would reduce administrative complexities in the long-term.
40 • Would facilitate restructuring beneficiary cost-sharing to provide more rational coverage.
41 • Could facilitate increased collaboration between physicians and hospitals.

42 43 Challenges of Strategy

- 44
45 • Would stimulate opposition from those entities that potentially stand to lose.
46 • Could escalate tensions between physicians and hospitals.
47 • May necessitate changes in data tracking processes for different service categories.
• Could encourage payment policies based on bundled payments to hospitals and
physicians.

1 Current AMA Policy

- 2 • Policy H-330.898 supports combining the cost-sharing requirements of Parts A and B into
- 3 a single deductible.
- 4 • Several AMA policies support being able to shift funds to recognize savings accrued from
- 5 changes in site of service or improved outpatient care that results in fewer hospitalizations
- 6 (D-390.977, H-390.979, H-390.980).
- 7 • Policies H-385.992[2] and H-185.996 support provision of care in the most appropriate
- 8 and/or effective setting.

- 9
- 10 2. Restructure beneficiary cost-sharing so that patients have a single premium and deductible for
- 11 all Medicare services, with means-tested subsidies and out-of-pocket spending limits that
- 12 protect against catastrophic expenses. The cost-sharing structure should be developed to
- 13 provide incentives for appropriate utilization while discouraging unnecessary or inappropriate
- 14 patterns of care. The use of preventive services such as those recommended by the US
- 15 Preventive Health Task Force should also be encouraged. Simultaneously, policymakers will
- 16 need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit
- 17 design standards to ensure that policies complement, rather than duplicate or undermine,
- 18 Medicare’s new cost-sharing structure.

19

20 The current Medicare cost-sharing structure involves several levels of Part A and D deductibles

21 and copayments/coinsurance, including a significant “donut hole” in Part D, and provides

22 limited protection against unforeseen catastrophic costs. These factors encourage most

23 Medicare enrollees to purchase supplemental insurance that provides “first-dollar” coverage,

24 which facilitates demand for increased volume of services, and insulates patients from the true

25 cost of services.

26

27 Benefits of Strategy

- 28 • Would establish predictable out-of-pocket limits for beneficiaries, and may discourage
- 29 individuals from seeking supplemental “first-dollar” coverage.
- 30 • Would encourage price-consciousness in seeking routine care, but provide sufficient
- 31 protection against unaffordable health events through the use of means-tested subsidies
- 32 and catastrophic limits.
- 33 • Could save beneficiaries money on overall out-of-pocket liabilities for combined Medicare
- 34 and Medigap or other supplemental coverage.
- 35 • Per Congressional Budget Office cost estimates, could yield cost savings.

36

37 Challenges of Strategy

- 38 • Could impose additional costs on some beneficiaries.
- 39 • Patient education would need to be increased regarding new cost-sharing structure and
- 40 “appropriate” use of Medicare services.
- 41 • Patients could delay or forgo necessary care.

1 Current AMA Policy

- 2 • Policy H-330.898 supports combining the cost-sharing requirements of Parts A and B into
- 3 a single deductible.
- 4 • Policies related to health system reform support providing means-tested subsidies or
- 5 similar assistance to help low-income individuals obtain insurance (e.g., H-330.898, H-
- 6 165.865, H-165.920).
- 7 • Policies support encouraging the use of preventive services by providing first dollar
- 8 coverage (D-330.935, H-290.972).
- 9

- 10 3. Phase-in a single high annual deductible for all Medicare services, to be indexed for inflation
- 11 and subsidized for low-income beneficiaries. Preventive services such as those recommended
- 12 by the US Preventive Health Task Force would be exempt from the deductible. Establish
- 13 policies to encourage workers to pre-fund savings to meet the deductibles.
- 14

15 The intent of the high deductible is to increase patient responsibility and cost-consciousness

16 when seeking medical care. Such a policy would require a lengthy phase-in, initially focusing

17 on individuals who are much younger than Medicare age so that they would have time during

18 their working years to pre-fund savings accounts that could be used to pay high deductibles

19 once they become eligible for Medicare. Policies would need to be implemented that would

20 encourage the public to fund Health Savings Accounts or other savings accounts that could be

21 used in retirement to meet the Medicare deductible. Equity for low income beneficiaries could

22 be achieved either through establishing deductibles on a sliding scale based on income, or by

23 providing means-tested subsidies to assist low-income beneficiaries in meeting a single

24 deductible level established for all beneficiaries.

25

26 Benefits of Strategy

- 27 • Could yield significant program cost savings from reduced utilization and increased
- 28 individual responsibility for health care costs. Analysts have identified potential for
- 29 significant program cost savings with a \$5,000 deductible.
- 30 • Could encourage increased price consciousness in seeking routine care, but provide
- 31 sufficient protection against catastrophic health events.
- 32 • Would give individuals a predictable and fixed annual out-of-pocket liability, which they
- 33 could finance through accumulated savings.
- 34

35 Challenges of Strategy

- 36 • Would increase costs of beneficiaries who have the ability to pay more.
- 37 • Would require the development of mechanisms to assist low-income beneficiaries.
- 38 • Patients could delay or forgo necessary care.
- 39

40 Current AMA Policy

- 41 • Several policies support the use of Health Savings Accounts to fund health care expenses,
- 42 including post-retirement expenses (H-330.898, H-165.852, H-180.957, D-165.962)
- 43 • Policies related to health system reform support providing means-tested subsidies or
- 44 similar assistance to help low-income individuals obtain insurance (e.g., H-330.898, H-
- 45 165.865, H-165.920).
- 46 • Policies support encouraging the use of preventive services by providing first dollar
- 47 coverage (D-330.935, H-290.972).

- 1 4. Offer beneficiaries a choice of plans for which the federal government would contribute a
2 standard amount toward the purchase of traditional fee-for-service Medicare or another health
3 insurance plan approved by Medicare. All plans would be subject to the same fixed
4 contribution amounts and regulatory requirements. Policies would need to be developed, and
5 sufficient resources allocated, to ensure appropriate government standard-setting and
6 regulatory oversight of plans.

7
8 Alternative plans could be offered through employers, associations, private insurers, or other
9 entities, but all plans would be subject to federal regulatory requirements and meaningful
10 government oversight of their participation. Plans could vary in benefit offerings and patient
11 cost-sharing, provided that plans are actuarially equivalent, and meet standards identified by
12 the Centers for Medicare and Medicaid Services. The government contribution could be based
13 on competitive bidding. Alternatively, the contribution amount could be set at some
14 predetermined rate (e.g., current spending levels, with annual adjustments). In either case,
15 individuals would be responsible for paying the difference between the government
16 contribution and plan premiums. Individuals potentially would be able to retain at least a
17 portion of the contribution amount that exceeds actual premiums. Subsidies would be available
18 to assist low-income individuals in purchasing some “standard” plan.

19
20 Benefits of Strategy

- 21 • Would facilitate continuity of coverage for those newly eligible for Medicare.
22 • Would allow beneficiaries to match coverage levels to their anticipated needs or levels of
23 concern.
24 • Could increase predictability of Medicare costs paid by the government (i.e., limiting them
25 to the defined contribution).
26 • Could increase beneficiary cost-consciousness by making individuals responsible for
27 paying for richer benefit choices.
28 • Would help to ensure more than a single plan operated in any region and would promote
29 competition between health plans.

30
31 Challenges of Strategy

- 32 • Could lead to adverse selection problems for plans.
33 • Would require an enhanced “information market” to help beneficiaries choose from
34 among plans.
35 • Could expose beneficiaries to higher levels of financial risk.
36 • Would require that the regulatory structure and agency funding be able to accommodate
37 plan oversight.
38 • Would necessitate the development of a mechanism for making means-tested subsidies
39 available and allowing low-income individuals access to a range of plans.

40
41 Current AMA Policy

- 42 • Key pillars of the AMA’s strategy to expand health care coverage for the uninsured
43 include fostering the availability of individually selected and owned health insurance, and
44 allowing health insurance markets the flexibility to create valuable and efficient coverage
45 options (H-165.920, H-165.856).
46 • Policies H-330.898, H-330.912 and H-330.933 support moving Medicare in the direction
47 of free market choice of plans.

- 1 • Policy H-160.966 supports resisting health plans’ efforts to acquire significant market
2 power.

3
4 5. Restructure age-eligibility requirements and incentives to match Social Security schedule of
5 benefits.

6
7 Medicare and Social Security are intended primarily to provide support to retirees. Medical
8 technology, along with increased scientific knowledge about maintaining good health, has
9 extended life expectancy rates, and concurrently, the number of productive working years.
10 Medicare eligibility should transition to a tiered system, similar to Social Security, in which
11 penalties and incentives are awarded based on the age at which benefit collection begins (i.e.,
12 between ages 62 and 70).

13
14 Benefits of Strategy

- 15 • Would produce modest cost savings for the program.
- 16 • Could encourage individuals to stay in the workforce longer, during which time they could
17 still be contributing to Medicare funding and to personal savings to cover post-retirement
18 medical needs.
- 19 • Younger retirees would have access to some level of Medicare benefit at age 62.
- 20 • Older retirees would have access to enhanced benefits if enrollment were delayed beyond
21 Normal Retirement Age (65–67), up to age 70.

22
23 Challenge of Strategy

- 24 • Could be perceived as taking something away from younger seniors.

25
26 Current AMA Policy

- 27 • None.

28
29 DISCUSSION

30
31 Consistent with changes that have recently been introduced through the Medicare Modernization
32 Act and with paradigm shifts in the way health care is delivered and financed, the Council believes
33 there is an opportunity for the AMA to take a lead role in discussions related to Medicare reform.
34 The reforms described in this report would facilitate program efficiencies and encourage
35 beneficiaries to assume increased responsibility based on ability to pay for their health care, while
36 at the same time maintaining many of the core features of the current Medicare program.

37
38 Absent these types of reforms, it is likely that Medicare will cease to exist as a reliable source of
39 insurance for retirees. The projections for Medicare, under current law, manifest mounting
40 pressure on the federal budget, trust fund exhaustion that would not permit full payment of
41 currently scheduled benefits, and unsustainable long-term growth in costs. The sooner these
42 problems are addressed, the more varied and less disruptive will be their solutions. With the
43 recommendations presented in this report, the AMA has an opportunity to demonstrate leadership
44 on an issue that is a high priority for physicians and their patients.

1 In presenting these five alternatives, the Council’s intent was to offer a set of strategies that policy
2 makers could consider when seeking ways to modernize and fiscally strengthen the Medicare
3 program. Although the Council remains committed to AMA policy that would ultimately move
4 Medicare to a system of pre-funded financing, the changes presented in this report represent a
5 politically viable set of alternatives that could be implemented in the near-term.

6
7 RECOMMENDATIONS

8
9 The Council recommends that the following be adopted and the remainder of this report be filed:

- 10
11 1. That our American Medical Association (AMA) support the following reforms to strengthen
12 the Medicare program, to be implemented together or separately, and phased-in as appropriate:
13
- 14 (a) Restructure beneficiary cost-sharing so that patients have a single premium and
15 deductible for all Medicare services, with means-tested subsidies and out-of-pocket
16 spending limits that protect against catastrophic expenses. The cost-sharing structure
17 should be developed to provide incentives for appropriate utilization while
18 discouraging unnecessary or inappropriate patterns of care. The use of preventive
19 services such as those recommended by the US Preventive Health Task Force should
20 also be encouraged. Simultaneously, policymakers will need to consider modifications
21 to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure
22 that policies complement, rather than duplicate or undermine, Medicare’s new cost-
23 sharing structure.
24
 - 25 (b) Offer beneficiaries a choice of plans for which the federal government would
26 contribute a standard amount toward the purchase of traditional fee-for-service
27 Medicare or another health insurance plan approved by Medicare. All plans would be
28 subject to the same fixed contribution amounts and regulatory requirements. Policies
29 would need to be developed, and sufficient resources allocated, to ensure appropriate
30 government standard-setting and regulatory oversight of plans.
31
 - 32 (c) Restructure age-eligibility requirements and incentives to match the Social Security
33 schedule of benefits. (New HOD Policy)

References for this report are available from the AMA Division of Socioeconomic Policy
Development.

Fiscal Note: No Significant Fiscal Impact