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Medicare: Structural Reform

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Congressional Research Service

July 24, 2013

Why Reform Medicare?

- Common reasons:
  - Program created in 1965
  - No beneficiary out-of-pocket limit
  - Complicated cost-sharing structure
  - Demographics
  - Long-term sustainability
- Incremental or structural reforms?

Context for Reform

- Beneficiaries are generally happy with Medicare

Context for Reform continued

- Changes to Medicare may also impact:
  - Health care providers and suppliers
  - Insurance companies
  - Specialty contractors (e.g., systems, claims processing, etc.)
  - Other public and private health programs
  - Families of beneficiaries
  - Employers
  - Taxpayers

Benefit Redesign

- Most proposals focus on cost-sharing

- Example 1: Simpson/Bowles
  - Single A & B deductible
  - Uniform co-insurance
  - Out-of-pocket limit
  - Deductible and out-of-pocket limit vary by income
  - Medigap near-first-dollar coverage restricted

Benefit Redesign continued

- Example 2: Commonwealth Fund Proposal
  - Alternative benefit package (*Medicare Essential*) that would integrate Parts A, B & D benefits, and supplemental coverage
  - One premium
  - A single $250 deductible
  - A $3,400 annual limit on out-of-pocket costs
  - Reduced cost-sharing for those receiving care from "high-value" medical providers

Limit Federal Spending

- Increase beneficiary cost-sharing
- Spend less on services (e.g., reduce provider payments)
- Across the board reductions (e.g., sequestration)
- Set growth targets & establish mechanisms to enforce limits
  - Current mechanisms
    - Physician Sustainable Growth Rate (SGR) System
    - Medicare "Trigger"
  - New mechanism
    - Independent Payment Advisory Board (IPAB)

Independent Payment Advisory Board (IPAB)

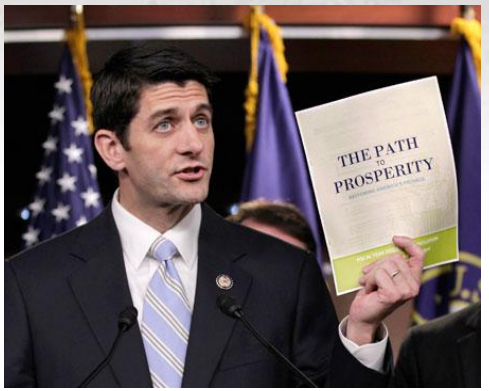
- Created by the Affordable Care Act
- Required to make recommendations to slow spending growth if per capita Medicare expenditures over a 5-year period are expected to exceed the target growth rate
  - Target growth rate for determination years through 2018, based on average of CPI for all items and CPI medical; after 2018 based on GDP+1
  - CBO projects that per capita spending growth will be below the target rates through 2023
- Prohibited from making recommendations that would: ration care, raise premiums, increase cost sharing, restrict benefits, or modify eligibility
- IPAB recommendations automatically go into effect unless Congress takes affirmative action
- Variety of proposals/bills would repeal IPAB, expand authority, and/or change growth targets

Premium Support Model

- Models vary, but most include the following elements:
  - Budget for Medicare distributed in the form of a defined contribution
  - Beneficiaries receive a predetermined level of financial (premium) support to pay for all or part of the cost of coverage
  - Health insurance plans bid competitively to cover a designated benefit package
  - Beneficiaries choose among participating plans

Premium Support - Example

- Chairman Ryan's FY2014 budget proposal
  - Those eligible prior to 2024 would enroll in current system; those eligible after 2024 would enroll in the new system



  - Federal payments to plans, including traditional fee-for-service Medicare, would be determined through competitive bidding and tied to second lowest approved bid in an area
  - Payments would be geographically rated and adjusted for enrollees' heath status
  - Growth in premium support limited to GDP+ 0.5%
  - Medicaid would provide assistance to dual eligibles
  - Less support for high-income beneficiaries

Considerations

- One time structural change or evolution?
- Who/what is at risk?
- Do the changes reduce or shift costs? To whom?
- How to ensure access and quality of care?
- Would economies of scale be affected?
- What will the practice of medicine look like in 40-45 years?
- Medicare costs depend on costs and delivery of care in wider health care system