

# A Bipartisan Plan to Save Medicare & Reduce Debt

## *The Lieberman/Coburn Proposal*

- The Lieberman/Coburn proposal would save more than \$600 billion over 10 years, based on past reviews of Congressional Budget Office (CBO) estimates, proposals from the President’s Bipartisan Fiscal Commission and internal Senate estimates.
- Extends the solvency of Medicare’s Hospital Insurance Trust Fund by allocating some of the savings from the proposal to the trust fund.
- Reduces Medicare’s 75-year unfunded liabilities by an estimated \$10 trillion and significantly reduces the fiscal impact of Medicare on the federal budget. The proposal strengthens Medicare and makes it more sustainable for taxpayers.
- For the first time in the history of the Medicare program, seniors will have an annual out-of-pocket-maximum within the Medicare program to protect them from bankruptcy in the event of a major illness or long term health condition.
- Contains a three year fix to the Medicare physician reimbursement formula that is paid for and will bring stability and payments to Medicare’s providers, ensuring access for seniors.
- Preserves Medicare as a government program for current and future enrollees.

## BACKGROUND

According to the 2011 Medicare Trustees’ Report, Medicare HI Trust Fund will be insolvent in 2024 unless structural changes are made to the program, and under the worst-case scenario, it could be insolvent as early as 2016. In fact, Medicare Part A will face the largest financial shortfall in the history of the program in 2011 – running a deficit of \$34.1 billion. Under the current Medicare structure, the Medicare Part A Program is expected to pay out more in hospital benefits than it receives in income in all future years. Similarly, Medicare Part B is expected to grow significantly faster than the economy in all future years, averaging 7.5% growth over the next 10 years.

As a result of an aging population and this cost growth, Medicare has become an enormous driver of our unsustainable federal debt and deficits. In 2010, 47.5 million Americans were covered by Medicare at a total cost of \$523 billion. The total cost of Medicare is expected to reach \$1 trillion in just over a decade. This situation is unsustainable. We are at a tipping point that requires immediate action by Congress and the President – both to preserve Medicare for seniors who overwhelmingly rely on it and to reduce our staggering \$14 trillion federal debt.

The Lieberman/Coburn Medicare proposal builds on past bipartisan proposals to preserve Medicare by aiming to save the program at least \$500 billion over the next 10 years. These savings will be used to shore up the Medicare trust fund, provide a three year “doc fix”, reduce the financial pressure that the program places on the federal budget, and preserve Medicare as a government program.

## SUMMARY OF LEGISLATIVE PROPOSAL

### Replace Medicare's Current Complicated Cost-Sharing Requirements with a Unified Annual Deductible and a Maximum Out-of-Pocket Limit for All Enrollees

The Medicare benefit structure has long been criticized for being too complex and for promoting overutilization, which wastes taxpayers' money. Within the current Medicare system, cost sharing such as copays and deductibles vary significantly depending on the type of service provided. The Lieberman/Coburn proposal would streamline Medicare into a single combined annual deductible of \$550 for both Part A and B services. Streamlining the deductibles will make it easier for seniors to navigate Medicare while also directly addressing overutilization.

The Lieberman/Coburn proposal would also add an annual "out-of-pocket maximum" of \$7,500 so that each Medicare recipient would now have a cap on annual medical costs to protect them from financial hardship or bankruptcy in the event of a major illness. Medicare enrollees do not have this protection now. The Fiscal Commission estimates that the benefit restructure along with Medigap reform (discussed below) will save \$130 billion over 10 years.

### Adjust the Eligibility Age for Medicare to Reflect Gains in Life Expectancy

The eligibility age for Medicare benefits is 65, although certain people qualify for coverage earlier because of disability. Since the creation of the Medicare program in 1965, life expectancy and the average length of time that people are covered by Medicare has risen dramatically. According to the Centers for Disease Control, when Medicare was passed in 1965, the average lifespan for Americans was 70.2. In 2006, the average lifespan for Americans was 77.7 – an increase of 10.6%. This increase in the length of time an enrollee may be covered by Medicare has significantly raised the costs of the overall program.

The Lieberman/Coburn proposal would bring Medicare more in-line with its original structure by raising the age of eligibility for Medicare by two months every year beginning with people who were born in 1949 (who will turn 65 in 2014) until the eligibility age reaches 67 in 2025. Thereafter, the eligibility age would remain at 67.

With the passage of the Affordable Care Act (ACA) and the insurance options that will be made available to those approaching retirement via the newly created insurance exchanges, it makes sense to adjust the Medicare eligibility age. The Lieberman/Coburn proposal also provides the caveat that if the ACA is repealed, the eligibility age increase to Medicare would be rolled back to its original age of 65. CBO estimates that increasing the eligibility age could save Medicare in excess of \$124 billion over the next 10 years while bringing the eligibility of the program more in line with its original structure.

### Increase Savings in Home Health Industry

The CBO projects that the use of home health services, and the resulting costs to the Medicare program, will grow rapidly over the next 10 years, rising from about \$23 billion in 2012 to \$52 billion in 2021. The ACA included several policies that altered reimbursements for home health providers. The Lieberman/Coburn proposal accelerates these changes to incorporate productivity adjustments beginning in 2013 and directing the Department of Health and Human Services to phase in rebasing the home health prospective payment system by 2015 instead of 2017. Based on the recommendation of the President's bipartisan Fiscal Commission, this change saves an estimated \$9 billion over 10 years.

## Require Higher Income Americans to Pay More Out of Pocket for Medicare

The Lieberman/Coburn proposal will ask wealthier Americans to pay for more of their Medicare. The proposal will do this by increasing the newly created annual maximum out-of-pocket cap to higher levels for those with significant monetary means. This policy is consistent with our principal that wealthier Americans are going to need to pay more if Medicare is to become solvent. The new maximum out-of-pocket levels would be as follows:

- \$12,500 for individuals with income \$85,000 - \$107,000  
(\$170,000-\$214,000 for married couples)
- \$17,500 for individuals with income \$107,000 - \$160,000  
(\$214,000 - \$320,000 for married couples)
- \$22,500 for individuals with income \$160,000 - \$213,000  
(\$320,000 for married couples)

## Limit Medigap Coverage of Medicare's Cost Sharing

According to America's Health Insurance Plans, 20% of Medicare enrollees obtain supplemental coverage known as a Medigap policy to pay deductibles and copays. Because Medigap plans cover all of the "gaps" in an enrollee's Medicare coverage, policyholders use up to 25% more services than Medicare participants who have no supplemental coverage, even though numerous studies have indicated that this increase in utilization does not lead to better health care outcomes. And because enrollees are only liable for a small portion of this increase in utilization, it is taxpayers – through Medicare costs – and not Medigap insurers who bear most of the costs that result from the increased utilization. Federal costs for Medicare could be reduced significantly if Medigap plans were restructured so that policyholders faced minimal cost-sharing for all Medicare services.

The Lieberman/Coburn proposal would bar Medigap policies from paying any of the first \$550 of an enrollee's cost-sharing liabilities and would limit coverage to half of the remaining coinsurance up to the newly created \$7,500 max out-of-pocket. As stated above, CBO estimates the Medigap reform and benefit restructuring will save \$130 billion over 10 years. If both the Medigap reform and the benefit restructuring described earlier in the proposal were put in place, the bipartisan Fiscal Commission estimates that the savings would be \$130 billion over 10 years.

## Phase Out Medicare Payments for Bad Hospital Debts

Currently, Medicare reimburses hospitals and other providers for unpaid deductibles and copays owed by beneficiaries. In order for hospitals to be paid for unpaid deductibles and copays, the hospital must be able to establish that reasonable collection efforts were made, and there was no likelihood of recovery at any time in the future. This practice is not mirrored by the private sector, and is fiscally unsound while the Medicare program faces enormous shortfalls.

This proposal's establishment of an annual maximum-out-of-pocket coverage within Medicare should drastically reduce the need to reimburse hospitals for bad debt. Accordingly, and based on the recommendation of the President's bipartisan Fiscal Commission and a policy proposal by the CBO, the Lieberman/Coburn proposal phases out this subsidy for uncollected hospital debts by taxpayers, saving an estimated \$23 billion over 10 years.

## **Require Higher Income Americans to Pay More for Their Share of Medicare Part B**

To the surprise of many Americans, Medicare Part B is not funded by the payroll taxes that are deducted from their paychecks. Medicare Part B is supported by premiums (25%) and general tax revenue (75%). This means that many wealthy Americans effectively have their Medicare Part B coverage subsidized through general revenue tax dollars. We think this is a tremendous waste of taxpayer money.

The Lieberman/Coburn proposal will require those 65 and older who are making more than \$150,000 annually (\$300,000 for couples) to pay the full cost of their Medicare Part B coverage. We believe that in a time of massive federal debt and long term deficit projections, using federal tax dollars to subsidize the health insurance of high income retirees is unwise. Warren Buffett can afford to pay the full cost of his Medicare Part B insurance coverage and thousands of other wealthy seniors can as well. The Lieberman/Coburn proposal will require those well-off seniors in higher income brackets to pay the full \$400+ premium for their Medicare Part B coverage. Formal savings estimates for this policy are forthcoming, but we estimate it will save \$5 to \$10 billion over 10 years.

## **Increase the Minimum Premium to 35% of the Program's Costs for Enrollees**

Medicare Part B allows retirees and other specified groups to purchase insurance coverage for physicians' and other outpatient services for a set monthly premium. In 2011, the majority of Medicare enrollees paid a premium of \$96.40 per month. When the program began in 1966, the premium was intended to finance 50% of Part B costs per aged enrollee with the remainder funded by the federal government. President Lyndon Johnson noted this 50/50 cost share in his speech when he signed Medicare into law saying, "And under a separate plan, when you are 65 you may be covered for medical and surgical fees whether you are in or out of the hospital. You will pay \$3 per month after you are 65 and your Government will contribute an equal amount."

Subsequent legislation has reduced that share and premium collections fell to less than 25% of program revenues in the early 1990s. The Balanced Budget Act of 1997 permanently set the Part B premium at about 25% of Part B costs per aged enrollee. General revenues still fund the remaining 75% of Medicare Part B, which puts enormous pressure on the federal budget year over year.

The Lieberman/Coburn proposal would raise the basic Part B premium for all enrollees by 2% of program costs every year for five years until the premium level enrollees paid reached a minimum level of 35% of the program's cost in 2019. The dollar amount of the monthly premium increase per year would be, on average, approximately \$15-20 a month.

Additionally, Congress will continue with the "hold-harmless" policy that prevents a reduction of a beneficiary's Social Security check due to a Part B premium increase. If the Medicare Part B premium increase exceeds the Social Security recipient's cost-of-living adjustment, the total Medicare Part B increase would not be more than their total cost of living adjustment. CBO projections estimate that this policy proposal would save Medicare \$241 billion over a 10 year period.

## **Require Higher Income Americans to Pay More for Their Share of Medicare Part D**

The Medicare drug program (Part D) was created in 2003 and began in 2006. In 2010, 83% of total program costs were paid by general revenues, with just 11% of the program costs covered by beneficiary premiums. This means that many wealthy Americans effectively have their Medicare Part D health insurance subsidized through general revenue tax dollars. We believe that this is an inefficient use of taxpayer dollars.

The Lieberman/Coburn proposal will require those 65 and older who are making more than \$150,000 annually (\$300,000 for couples) to pay the full premium costs for their Medicare Part D drug coverage. Formal savings estimates for this policy are forthcoming, but we estimate it will save \$5 to 10 billion over 10 years.

### **Three Year SGR Fix Designed to Bring Stability to the Medicare Provider System**

The Medicare program reimburses 96,000 physicians who provide care for roughly 40 million seniors by using a payment mechanism known as the Sustainable Growth Rate (SGR). Congress established the SGR in 1997 as a funding formula designed to adhere to overall spending targets. The SGR works by effectively decreasing reimbursement levels one year if Medicare reimbursements to physicians another year were higher than a set target. Congress was well-intentioned when it passed the SGR, but it has proven to be extremely vulnerable to political influences and many have rendered it a failure. In fact, since 2004, Congress has intervened on an almost annual basis to prevent reimbursement reductions to doctors who accept Medicare enrollees.

Unless Congress intervenes again at the end of the year, beginning January 1, 2012, physicians (that are paid under Part B) who accept Medicare will face an incredible 30% reduction in their reimbursements. This is unacceptable for physicians and patients, as dramatic reductions could prevent physicians from being able to provide medical care to seniors on Medicare without taking a financial loss. It is unacceptable for Congress to allow this drastic cut that could threaten seniors' access to care to linger – it must be addressed.

The systemic flaws with the SGR mechanism have led lawmakers and leaders in the health care community to call for its redesign. Therefore, the Lieberman/Coburn proposal provides for a three year "bridge" so that Congress can develop a new funding mechanism to reimburse Medicare providers. CBO estimates that extending the SGR for three years costs \$37.7 billion over 10 years. This cost will be fully offset by savings within the overall proposal.

### **Improve Medicare's Ability to Combat Waste, Fraud, and Abuse**

Medicare loses tens of billions of taxpayer dollars each year from waste, fraud, and abuse. To strengthen and save the Medicare program, the Lieberman/Coburn plan also includes provisions from a bill authored by Senators Carper and Coburn – the Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayer Dollars (FAST) Act (S.1251). The FAST Act would enact stronger penalties for Medicare fraud; curb improper payments and establish stronger fraud and waste prevention strategies to help phase out the practice of "pay and chase"; curb the theft of physician identities; expand the fraud identification and reporting work of the Senior Medicare Patrol; take steps to help states identify and prevent Medicaid overpayments; improve the sharing of fraud data across agencies and programs; and deploy cutting-edge technology to better identify and prevent fraud.