



The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Directions for Bipartisan Medicare Reform

Gail R. Wilensky, Ph.D.

Before Senator Ron Wyden (D-OR) and Representative Paul Ryan (R-WI) introduced their “Bipartisan Options for the Future” on December 15, 2011, the notion that Democrats and Republicans

agreed about certain aspects of Medicare might have seemed unthinkable.¹ But the pairing of a liberal Democrat who has long worked on health care reforms and a fiscally conservative Republican primarily known for work on budget issues suggests that it might be possible for the parties to reach a compromise on Medicare reform. Of course, meaningful reform is not likely to occur in 2012: any significant reform probably won't happen until the public sends a clearer signal about the kinds of change it will tolerate, which won't be possible until after the fall elections. Yet some Republicans and Democrats appear to be in substantial agreement about some changes that

might make Medicare more efficient, effective, and fiscally sustainable — even if none of these changes are universally accepted by either party as desirable or even tolerable.

First, there has long been discussion about raising Medicare's eligibility age from 65 to 67, as is happening with Social Security. Though still controversial among some Democrats, this policy change was put on the table by President Barack Obama as part of a compromise package. With 78 million baby boomers becoming Medicare-eligible over the next 18 years, eventually doubling the number of beneficiaries, increased spending due to population aging and greater longevity is mak-

ing such a change seem more compelling.

As opponents note, however, the savings from increasing the eligibility age by 2 years probably wouldn't be large, since the youngest seniors tend to be the healthiest. Moreover, if Medicare doesn't cover them, 65- and 66-year-olds will need to continue working to get coverage from employers (which, it could be argued, would be better for them and for the economy, assuming that the economy improves enough to generate the jobs needed) or they will get subsidized coverage from the health insurance exchanges being created by the Affordable Care Act (ACA). The effect of such a change on overall spending has been debated, but the effect on federal spending is likely to be favorable.

Second, despite past controversy over the approach, Medicare has increasingly adopted policies tying benefits to income, without

generating much pushback. Medicare funding is already income-related, since the program is funded by a combination of a wage tax on earned income, which as of 2013 will be levied on all other income as well, and a general-revenue contribution dominated by receipts from personal income taxes.

Over time, benefits have also become related to income. For years, low-income seniors who aren't poor enough to qualify for Medicaid have had some portion of their premiums, deductibles, and copayments covered. Both the Medicare Modernization Act and the ACA reduced subsidies for higher-income seniors.² Since 2007, high-income seniors have received only a 25% subsidy for Part B premiums (which primarily cover physician services), rather than the 75% subsidy that other seniors receive. High-income seniors will also receive smaller subsidies for Part D, the prescription-drug benefit. Under the Wyden–Ryan proposal, the subsidy for seniors purchasing private plans or traditional Medicare would vary with income.³ This portion of the proposal has not seemed to generate much controversy.

Third, the goal of slowing Medicare's growth to achieve fiscal sustainability is driving much of the discussion about the need for reform. Because Medicare is an open-ended entitlement program, total program spending each year is the sum of spending for all covered services, rather than a set amount that Congress appropriates annually. With periodic additions to benefits, increasing costs per person, and a growing population, it's hardly surprising that Medicare spending — like the rest of health care

spending — has grown much faster than the economy. But both political parties agree that this gap is unsustainable.

Medicare spending, like all health care spending, is currently growing unusually slowly, in part because of the sluggish economy and the decline in insurance coverage associated with substantial job losses since 2008. Medicare spending is projected to continue to grow slowly through 2020, owing to the ACA's reductions in reimbursement to Medicare providers. As a result, per capita Medicare spending is projected to grow by approximately 3.5% per year, about the same rate that the economy grows (a projected 3.6% per year) over the course of the decade, although total Medicare expenditures are projected to grow by 6.6% per year because of the ongoing retirement of the baby boomers.⁴ The Medicare actuary and others have questioned whether the reimbursement reductions will be enforced, however, given concerns about impairing access to care, and spending rates are expected to increase after the current budget period unless additional reductions in payment are implemented.

Various experts and policy-makers have been converging around a targeted growth rate for Medicare spending of growth in the gross domestic product (GDP) plus 1%. The proposal from the Obama administration, the proposal from former Clinton budget director Alice Rivlin and former Senator Pete Domenici (R-NM), and now Wyden–Ryan all reference GDP plus 1% as their target growth rate.⁵ The question of how to achieve that rate is another story, but the occurrence of discussions among both Democrats and Republicans about

strategies for ensuring a specified spending growth rate represents a fundamental move away from Medicare as an open-ended entitlement.

The Obama administration and many Democrats see the Independent Payment Advisory Board (IPAB) created by the ACA as the appropriate enforcing mechanism for Medicare. Like most previous attempts to control Medicare spending, the IPAB has been given authority to change how and how much providers are reimbursed, but the new board has unprecedented power to implement changes. The Rivlin–Domenici and Wyden–Ryan proposals use premium-support-type models that provide government subsidies to seniors for purchasing any of various health plans. Under this strategy, Medicare spending growth would be achieved by controlling subsidy growth. Whether that could be done without increasing the share of premiums that seniors must pay is hotly debated. The answer depends at least partly on whether motivating seniors to seek the best value and giving plans flexibility in organizing and delivering services can slow the growth in plan costs. By including traditional Medicare (which would be subject to the IPAB's decisions) as one of the choices offered, both Rivlin–Domenici and Wyden–Ryan may provide the elements of a future compromise.

Finally, the need to reform care delivery in Medicare may be the area of greatest agreement across the political spectrum. Even those who most celebrate Medicare's success in expanding seniors' access to care generally agree that the program provides too much uncoordinated, fragmented care to a population pri-

marily characterized by chronic disease. There are important differences of perspective regarding how best to transform the delivery system and who should lead that transformation, but the disillusionment and frustration with the current reimbursement system could not be stronger.

There's also growing agreement that a fee-for-service system like Medicare's, which reimburses physicians for some 7000 discrete services, is inconsistent with achieving the care coordination needed by seniors with multiple chronic conditions or complex acute care needs. To me, this growing disillusionment with the incentives and rewards of fee-for-service medicine is the most sur-

prising evolution in thinking of the past quarter century and offers the greatest promise for success in developing a replacement, whatever its parameters.

I would not minimize the challenges of reaching agreement on the appropriate design of the future delivery system, ways to achieve that design, and strategies for producing fiscal sustainability. But despite the parties' profound philosophical differences, areas of agreement are developing, even in these most partisan of times. Sometimes it's important to celebrate even these small, interim successes.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From Project HOPE, Bethesda, MD.

This article (10.1056/NEJMp1200914) was published on March 7, 2012, at NEJM.org.

1. Wyden R, Ryan P. Guaranteed choices to strengthen Medicare and health security for all: bipartisan options for the future (<http://budget.house.gov/uploadedfiles/wydenryan.pdf>).
2. Summary of Medicare Act of 2003 — Public Law 111-148-March 23, 2010 (<http://www.nis.org/conf2004/summary-medicare-act-2003.htm>).
3. GOP.gov. The path to prosperity: restoring America's promise—fiscal year 2012 budget resolution (<http://budget.house.gov/fy2012budget>).
4. Change in projected Medicare spending, 2010–2019. Washington, DC: Henry J. Kaiser Family Foundation (<http://www.facts.kff.org/chart.aspx?cb=58&sctn=169&ch=1805>).
5. Debt Reduction Task Force. Restoring America's future. Washington, DC: Bipartisan Policy Center (<http://www.bipartisanpolicy.org/projects/debt-initiative/about>).

Copyright © 2012 Massachusetts Medical Society.