

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - I-07

Subject: Strategies to Strengthen the Medicare Program
(Council on Medical Service Report 10, A-07)

Presented by: Georgia A. Tuttle, MD, Chair

Referred to: Reference Committee J
(Liana Puscas, MD, Chair)

1 At the 2007 Annual Meeting, the House of Delegates referred two of five strategies proposed in
2 Council on Medical Service Report 10 (A-07) for strengthening the Medicare program.
3 Specifically, the House requested referral of the following proposed strategies:

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- 5 • Combine the Medicare Trust Funds into a single unit, so that revenues for the
6 Medicare program can be administered more efficiently and be better targeted toward
7 the services used by beneficiaries.
8
 - 9 • Phase-in a single high annual deductible for all Medicare services, to be indexed for
10 inflation and subsidized for low-income beneficiaries. Preventive services such as
11 those recommended by the U.S. Preventive Health Task Force would be exempt from
12 the deductible. Establish policies to encourage workers to pre-fund savings to meet the
13 deductibles.

14

15 Although testimony before the Reference Committee at the 2007 Annual Meeting was generally
16 supportive of the Council's report and recommendations, concerns were raised regarding the
17 implementation of these two proposed strategies. As noted in the Reference Committee report:

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19 Some felt that combining the Medicare funding would antagonize collaborative efforts
20 with the hospital community. Others were concerned that combining the entitlement of
21 Part A and the voluntary Part B program may be unworkable. In addition, concerns were
22 also raised regarding Recommendation (c) for the implementation of a high deductible for
23 all Medicare services, as some studies have shown that higher cost-sharing requirements
24 may prolong the time that patients initiate seeking care.
25

26 As described in Council on Medical Service Report 10 (A-07), the long-term financing and benefits
27 structure of the current Medicare program is unsustainable. In the absence of significant reforms,
28 Medicare will be unable to deliver the benefits promised to either the current or future generations
29 of beneficiaries. The recommendations in Council Report 10 (A-07) offered a series of options to
30 strengthen Medicare's long-term fiscal solvency and efficiency. This report explores two of these
31 options further, and presents updated recommendations for consideration by the House.

1 BACKGROUND

2
3 Long-standing AMA Policy H-330.898 (AMA Policy Database) presents both short- and long-term
4 strategies for Medicare reform, and reflects the AMA's commitment to supporting the transition of
5 Medicare to a system of pre-funded financing. However, in light of the ongoing, annual need for
6 advocacy efforts to seek both temporary and permanent changes in the Medicare physician
7 payment system, as well as the ongoing threat of insolvency of the Medicare Trust Fund, the
8 Council recognized an opportunity for the AMA to articulate an updated set of alternatives, and to
9 position itself as a resource for ideas that will help move Medicare beyond annual budget battles.
10 Accordingly, Council on Medical Service Report 10 (A-07) presented several changes that could
11 be implemented together or separately, and would improve the financial structure and longevity of
12 the Medicare program.

13
14 The House of Delegates voted to support the following strategies presented in Council on Medical
15 Service Report 10 (A-07):

- 16
17 1. Restructure beneficiary cost-sharing so that patients have a single premium and deductible
18 for all Medicare services, with means-tested subsidies and out-of-pocket spending limits
19 that protect against catastrophic expenses. The cost-sharing structure should be developed
20 to provide incentives for appropriate utilization while discouraging unnecessary or
21 inappropriate patterns of care. The use of preventive services such as those recommended
22 by the US Preventive Health Task Force should also be encouraged. Simultaneously,
23 policymakers will need to consider modifications to Medicare supplemental insurance (i.e.,
24 Medigap) benefit design standards to ensure that policies complement, rather than
25 duplicate or undermine, Medicare's new cost-sharing structure.
26
27 2. Offer beneficiaries a choice of plans for which the federal government would contribute a
28 standard amount toward the purchase of traditional fee-for-service Medicare or another
29 health insurance plan approved by Medicare. All plans would be subject to the same fixed
30 contribution amounts and regulatory requirements. Policies would need to be developed,
31 and sufficient resources allocated, to ensure appropriate government standard-setting and
32 regulatory oversight of plans.
33
34 3. Restructure age-eligibility requirements and incentives to match the Social Security
35 schedule of benefits. (H-330.896)
36

37 The Council believes that these reforms, if implemented, would facilitate program efficiencies and
38 encourage beneficiaries to become more actively involved in their health care decisions, while at
39 the same time maintaining many of the core features of the current Medicare program.
40

41 COMBINING THE MEDICARE TRUST FUNDS

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43 Council on Medical Service Report 10 (A-07) also had recommended support for combining the
44 Medicare Trust Funds into a single unit so that revenues for the Medicare program can be
45 administered more efficiently and be better targeted toward the services used by beneficiaries. As
46 noted in the report, the Medicare program is supported by two separate trust funds--the Hospital
47 Insurance (HI) Trust Fund, financed through fixed payroll taxes of 2.9%, and the Supplementary
48 Medical Insurance (SMI) Trust Fund, which is financed through a combination of general tax

1 revenues and beneficiary premiums that are adjusted each year based on program costs. The
2 Federal HI Trust Fund finances Medicare Part A, which covers inpatient hospital, some home
3 health, skilled nursing facility, psychiatric hospital, and hospice care services. The Federal SMI
4 Trust Fund finances Medicare Part B, which covers physician services, hospital outpatient services,
5 some mental health services, durable medical equipment, ambulatory surgical center services,
6 physician-administered drugs, some lab tests, and home health visits not covered under Part A.
7 The SMI Trust Fund also finances Part D, which offers prescription drug coverage. Eligible
8 beneficiaries (based on work history) are automatically enrolled in Part A; enrollment in Part B and
9 Part D is voluntary, and beneficiaries are responsible for paying premiums.

10
11 When Medicare was enacted in 1965, it was common for insurance to cover only hospital services,
12 since incidents of hospitalization tended to represent the greatest financial risk for individuals
13 seeking medical care. Thus, Medicare's structure mirrored the private insurance market at the
14 time, offering hospital insurance (Part A) as an entitlement, and coverage for physician services
15 (Part B) for those individuals who were willing to pay a premium and separate deductibles and co-
16 payments.

17
18 Medical practice has changed dramatically in the 40 years since Medicare was enacted, as has the
19 private insurance industry. The vast majority of private health insurance plans now provide
20 coverage automatically for both hospital and physician services, in recognition of the technological
21 and cultural changes that have resulted in an increased number of procedures and treatments being
22 delivered in non-hospital settings. Many highly effective and complex intensive services are now
23 provided outside the hospital in the outpatient setting. As the number and complexity of these
24 services have increased, so has their cost, necessitating a higher level of insurance to cover the
25 expense. Over the years, private insurance companies have responded to these changes by
26 realigning their coverage and cost-sharing structures, adapting their benefits to changes in medical
27 practice.

28
29 Unlike private industry, Medicare has maintained essentially the same bifurcated structure of
30 coverage and benefits since its enactment. The Council believes that combining the Medicare
31 Funds would help lay essential groundwork for critical reforms that could help strengthen the
32 Medicare program overall. Combining the HI and SMI Trust Funds would be an appropriate
33 acknowledgement of changes in medical practice patterns since Medicare's inception. As noted,
34 technological advances and societal expectations have resulted in a blurring of the line between
35 hospital and outpatient services, and new drugs and improved chronic care management have
36 created more options for patients and their physicians. The Council believes that maintaining the
37 historical distinction between "hospital services" and "physician services" is inconsistent with new
38 paradigms in the current health care environment that emphasize a more flexible approach to the
39 provision and delivery of patient care.

40
41 The existence of separate Trust Funds to finance Part A services and Part B services discourages
42 flexibility and may create disincentives for various partners in the health care system to work
43 together to improve the efficiency of the Medicare program. Because the Trust Funds operate and
44 are financed separately, each with a different set of rules depending primarily on site of service,
45 shifting services from one category to another is often seen as advantageous (or, conversely,
46 disadvantageous) from the perspective of providers or entities. There is also the illusion that
47 placing more services in one category (generally Part B) will help strengthen the financial outlook
48 for the entire Medicare program. Although it may appear that one Trust Fund is more "robust"

1 than the other, the Funds are highly interdependent, and, as a whole, the Medicare program is on a
2 trajectory that cannot be sustained. Unifying the Trust Funds would be a critical first step in
3 breaking down the barriers between providers and sites of service that exist under the current
4 Medicare system, and would provide the basis for the development of a uniform set of
5 administrative and payment rules that would govern all Medicare providers. Several AMA
6 directives already support being able to shift funds to recognize savings accrued from changes in
7 site of service or improved outpatient care that results in fewer hospitalizations (D-390.977, D-
8 390.979, D-390.980). Rather than perpetuating tensions among service providers, unifying the
9 Medicare Trust Funds could encourage all groups to work together to ensure adequate and
10 sustainable financing mechanisms for the program as a whole.

11
12 In general, combining the trust funds would allow for a more comprehensive measure of
13 Medicare's financial status. As noted above, there is an illusion that the SMI Trust Fund is more
14 robust than the HI Trust Fund, since revenues to the SMI Trust Fund are automatically increased to
15 meet expenditures. Under the current system, Medicare "insolvency" will occur when Part A costs
16 exceed HI Fund assets (currently projected to occur in 2019). However, policy experts are
17 increasingly concerned about the sustainability of the Medicare program as indicated by the
18 increasing portion of general revenues being consumed by the SMI Trust Fund. The fact is, neither
19 Trust Fund represents a fiscally efficient or sustainable program, and shifting services and
20 expenditures between the two will not affect Medicare's long-term viability. Combining the HI
21 and SMI Funds into a single Medicare fund would be a more rational way to measure the fiscal
22 strength of the Medicare program overall, which could facilitate the development of realistic
23 solutions for all areas of the program.

24
25 Finally, on a practical level, merging the Trust Funds could expedite a restructuring of beneficiary
26 cost-sharing, which experts agree is critical to helping improve the longevity of the program. As
27 outlined in Council on Medical Service Report 10 (A-07), the current Medicare cost-sharing
28 structure is fragmented, involving several levels of Part A, B, and D deductibles and co-
29 payments/coinsurance, and provides only limited protection against catastrophic costs. This
30 fragmentation has increased over the years, and the development of any rational cost-sharing
31 design has been precluded by the need to maintain a separation between the different Trust Fund
32 programs. AMA policy already supports the development of a Medicare cost-sharing structure that
33 provides incentives for appropriate utilization while discouraging unnecessary or inappropriate
34 patterns of care. Specifically, AMA policy supports combining the cost-sharing requirements of
35 Parts A and B into a single deductible (H-330.898 and H-330.896), and restructuring beneficiary
36 cost-sharing so that patients also have a single premium for all Medicare services (H-330.896).
37 Merging the Trust Funds would ensure that beneficiary cost-sharing applies to a single program
38 that offers a comprehensive and integrated set of services that facilitate efficient and appropriate
39 use of care.

40
41 PHASING IN A SINGLE HIGH ANNUAL DEDUCTIBLE
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43 Council on Medical Service Report 10 (A-07) also had recommended support for phasing in a
44 single high annual deductible for all Medicare services, to be indexed for inflation and subsidized
45 for low-income beneficiaries. Analysts have identified potential for significant cost savings for the
46 Medicare program resulting from the implementation of a high deductible. The intent of a high
47 deductible would be to increase patient responsibility and cost-consciousness in seeking medical
48 care. To the extent that this would yield cost savings, the primary impact to the Medicare program

1 would not result from shifting Medicare costs to patients, but from discouraging unnecessary or
2 over-use of services, which can result from the illusion that care is “free” when patients have
3 limited cost-sharing responsibility.

4 As noted, under the current system, Medicare has a complex set of beneficiary cost-sharing rules
5 that apply separately to Part A, B, and D services. Medicare offers limited protection against
6 catastrophic costs, which can be especially threatening to seniors and others with limited financial
7 resources. The lack of catastrophic coverage has led the majority of Medicare beneficiaries to
8 purchase Medigap policies, which in addition to insuring against catastrophic costs, often cover
9 Medicare’s standard annual deductibles, effectively eliminating any cost-sharing obligations for
10 most beneficiaries. Lack of cost-sharing, or so-called “first dollar coverage,” has been shown to
11 result in an increase in spending on health care services.

12
13 One of the adopted recommendations in Council on Medical Service Report 10 (A-07) addressed
14 the obsolete cost-sharing and limited benefit structure of the Medicare program by supporting
15 implementation of a single premium and deductible for all Medicare services, and the
16 establishment of out-of-pocket spending limits to protect against catastrophic costs (H-330.896).
17 In recommending a high deductible, the intent of the Council had been to further strengthen this
18 reform by encouraging that the deductible be high enough so that patients would be compelled to
19 carefully consider the necessity and appropriateness of seeking medical care. However, the
20 Council agrees with concerns expressed by the House of Delegates that imposing a high deductible
21 at this time may not be the most effective way of encouraging greater patient discretion and
22 responsibility.

23
24 VALUE-BASED DECISION-MAKING AND TARGETED BENEFIT DESIGN

25
26 While some evidence suggests that increasing patient cost-sharing does lower health care costs,
27 there is significant concern that some patients delay or forgo necessary care because they are
28 unable or unwilling to pay the out-of-pocket costs. A more comprehensive strategy for ensuring
29 that health care costs reflect necessary and appropriate care would be to promote “value-based
30 decision-making” within the Medicare program. As described in Council on Medical Service
31 Report 8 (A-07), “Strategies to Address Rising Health Care Costs,” there is an opportunity across
32 the health care system to improve the processes by which decisions are made, so that they take into
33 consideration both cost and benefit – particularly clinical outcomes. Value-based decision-making
34 can be thought of as an extension of evidence-based medicine, in which a host of private and public
35 decisions are improved through greater availability of information and through incentives. This
36 framework could be applied in numerous situations, including when physicians and patients are
37 choosing among alternative drug therapies; when insurers are designing health plan cost-sharing
38 features; or when legislators are determining public health budgets or considering mandating
39 insurance coverage of particular benefits.

40
41 One example of “value-based decision-making” that would be consistent with encouraging
42 Medicare beneficiaries to take more responsibility for their health care choices is “targeted benefit
43 design.” This benefit design strategy uses varying levels of out-of-pocket cost-sharing to reward
44 compliance by patients with chronic conditions, thereby averting costly adverse outcomes. An
45 example of this type of insurance design is being piloted at the University of Michigan with its
46 MHealthy: Focus on Diabetes Program, which targets University employees and their dependents
47 who have been diagnosed with diabetes. Under the program, diabetic patients receive co-payment
48 reductions for specific medical interventions that have been shown to be clinically effective in the

1 treatment or management of diabetes. Reduced co-payments are applied to drugs to help control
2 blood sugar, blood pressure and cholesterol, and to annual eye exams for diabetic patients.
3 According to the University's human resources Web site, the goal of the MHealthy: Focus on
4 Diabetes Program is to "encourage the proper and sustained use of specific drugs...and help
5 prevent or reduce the long-term complications of diabetes." The program has been well received,
6 and the university hopes that it can serve as a model for more cost-effective delivery of health care.

7
8 Targeted benefit design, a more individualized approach to cost-sharing, is emerging as a
9 mechanism to ensure that patients seek and receive effective and necessary care, while at the same
10 time minimizing incentives to seek unnecessary care. At the 2007 Annual Meeting, the House
11 voted to support the use of targeted benefit design, noting that consideration should be given to
12 tailoring cost-sharing requirements to patient income and other factors known to impact
13 compliance (H-155.960).

14
15 DISCUSSION

16
17 Council on Medical Service Report 10 (A-07) presented a series of strategies for reforming
18 Medicare in ways that could strengthen the financial structure and longevity of the program. In
19 developing the report, the Council was careful to propose individual strategies that were not
20 necessarily dependent upon one another for success of implementation. However, each of the
21 recommendations did address an aspect of the current Medicare program that could benefit from
22 reform.

23
24 Combining the Medicare Trust Funds into a single unit in and of itself is unlikely to result in any
25 significant changes to the financial stability of the program. However, the Council shares the
26 opinion of many policy analysts who propose that the structure of the Medicare program is best
27 conceptualized as a single entity, rather than separate silos reflecting different modes of care. The
28 Council is aware that the Reference Committee report at the 2007 Annual Meeting reflected
29 concern that combining the Medicare Trust Funds "would antagonize collaborative efforts with the
30 hospital community." The Council believes that combining the trust funds is an important first step
31 toward encouraging a more equitable and collaborative relationship between all Medicare
32 providers, regardless of site of service.

33
34 The Council recognizes, however, that combining the Trust Funds would necessitate several
35 significant administrative changes, including developing new rules for how funds are allocated,
36 services are paid for, and service delivery is tracked. It is critical that the current artificial
37 distinctions and differential rules based on site of service not be perpetuated under a unified
38 Medicare. The AMA will need to be actively engaged in policymaking discussions regarding the
39 creation and implementation of financing, payment, and other rules under a combined Medicare
40 structure.

41
42 Regarding concerns that "combining the entitlement of Part A and the voluntary Part B program
43 may be unworkable," the Council does not believe that this represents a significant operational
44 barrier to combining the Medicare Trust Funds. The relatively low premiums and generous
45 benefits package offered under Part B has resulted in very high levels of voluntary enrollment since
46 Medicare's inception. Since approximately 95% of eligible seniors choose to enroll in Medicare
47 Part B, unifying the programs is unlikely to cause a disruption to the vast majority of beneficiaries.

1 Regardless of how the trust funds are organized, the Council believes that changes to the cost-
2 sharing and benefit structure of the Medicare program are critical components of any meaningful
3 reform efforts. The Council is compelled by the concern that simply advocating for a high-
4 deductible for all Medicare services as originally recommended in Council Report 10 (A-07) could
5 inadvertently discourage some seniors from receiving necessary care. As an alternative, the
6 Council recommends that the AMA encourage Medicare to explore the use of a “value-based,
7 targeted benefit design” structure, where cost-sharing obligations are developed based on a careful
8 analysis of clinical effectiveness and associated costs and benefits of a given treatment. The
9 Council believes, however, that if targeted benefit design structure is developed and successfully
10 implemented, reconsideration of a high-deductible for some services might be in order.

11

12 Absent these types of reforms, it is likely that Medicare will cease to exist as a reliable source of
13 insurance for seniors. The projections for Medicare, under current law, manifest mounting
14 pressure on the federal budget, Trust Fund exhaustion that would not permit full payment of
15 currently scheduled benefits, and unsustainable long-term growth in costs. The sooner these
16 problems are addressed, the more varied and less disruptive will be their solutions.

17

18 RECOMMENDATIONS

19

20 The Council recommends that the following be adopted in lieu of Recommendations 1 and 3 of
21 Council on Medical Service Report 10 (A-07), and the remainder of this report be filed:

22

- 23 1. That our American Medical Association continue to study combining Parts A and B of the
24 Medicare Trust Funds into a single program, and report back, clearly delineating the
25 advantages and disadvantages of this action, including the effect on Graduate Medical
26 Education (GME) funding, and of adding a means test to Medicare Part A.
- 27 2. That our AMA encourage the Centers for Medicare and Medicaid Services to explore the
28 use of value-based, targeted benefit design to facilitate a more efficient and meaningful
29 cost-sharing structure that will help align incentives for patients to seek appropriate and
30 effective care. (Directive to Take Action)
- 31

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

Fiscal Note: No Significant Fiscal Impact