

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-12)  
Strengthening Medicare for Current and Future Generations  
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2012 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Substitute Resolution 126, which directed the AMA to refine its policy regarding Medicare financing reform, including a defined contribution program that would allow beneficiaries to purchase private health insurance coverage (Policy D-330.916). Policy D-330.916 also directed the AMA to consider mechanisms to adjust contribution amounts to ensure that health insurance coverage remains affordable for all Medicare beneficiaries. The Board of Trustees assigned Policy D-330.916 to the Council on Medical Service for a report back at the 2012 Interim Meeting.

The AMA has advocated for many years that the Medicare program needs to be strengthened in order to ensure that it remains a viable mechanism for providing health insurance coverage for America's seniors and disabled. Policy H-330.896, established in 2007, provides a strong foundation for the development of a comprehensive alternative to the current Medicare system. The policy identifies changes that must be made to strengthen the traditional Medicare program (i.e., restructuring beneficiary cost-sharing, including modifying Medigap rules, and changing the eligibility age to match Social Security), and expresses support for giving beneficiaries a choice of plans for which the federal government would contribute a standard amount (i.e., a "defined contribution") toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. The Council firmly believes that implementing a defined contribution system, with strong regulatory protections for patients, is a responsible and feasible approach to strengthening the Medicare program.

The Council recommends that the AMA support transitioning Medicare to a defined contribution program that would enable beneficiaries to purchase coverage of their choice through a Medicare exchange of competing health insurance plans. The following report proposes a set of nine principles that should be included in a defined contribution system, which are designed to ensure that Medicare remains a viable program for current and future generations, and that health insurance coverage remains affordable and accessible for the poorest and sickest beneficiaries.

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-12

Subject: Strengthening Medicare for Current and Future Generations

Presented by: Donna E. Sweet, MD, Chair

Referred to: Reference Committee J  
(Veronica K. Dowling, MD, Chair)

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1 The American Medical Association (AMA) has advocated for many years that the Medicare  
2 program needs to be strengthened in order to ensure that it remains a viable mechanism for  
3 providing health insurance coverage for America's seniors and the beneficiaries who are eligible  
4 for Medicare because of disability or end-stage renal disease. Absent thoughtful efforts to  
5 strengthen and preserve Medicare, current and future generations are likely to find themselves  
6 increasingly vulnerable to eroding benefits and rising out-of-pocket costs.

7  
8 At the 2012 Annual Meeting, the House of Delegates adopted Substitute Resolution 126, which  
9 directed the AMA to refine its policy regarding Medicare financing reform, including a defined  
10 contribution program that would allow beneficiaries to purchase private health insurance coverage  
11 (Policy D-330.916). Policy D-330.916 also directed the AMA to consider mechanisms to adjust  
12 contribution amounts to ensure that health insurance coverage remains affordable for all Medicare  
13 beneficiaries. The Board of Trustees assigned Policy D-330.916 to the Council on Medical Service  
14 for a report back at the 2012 Interim Meeting.

15  
16 The Council on Medical Service began a process of re-evaluating the AMA's Medicare reform  
17 policies prior to the 2012 Annual Meeting. At the 2011 Interim Meeting the House of Delegates  
18 adopted the recommendations in Council on Medical Service Report 4-I-11, which called for  
19 members of the House of Delegates and the Federation to provide comments to the Council  
20 regarding the development of policy options for long-term Medicare financing reform. The report  
21 described the financial challenges facing the Medicare program, reviewed current AMA policy  
22 related to Medicare reform, and solicited input from members of the House and the Federation  
23 regarding ways to strengthen health insurance options for current and future Medicare  
24 beneficiaries. Comments received on Council Report 4-I-11 emphasized the need to advocate for  
25 Medicare reforms that would allow patient choice, support the patient-physician relationship, and  
26 preserve an efficient, affordable traditional Medicare coverage option for those who want it.

27  
28 Following adoption of Policy D-330.916, the Council solicited additional feedback from the  
29 Federation on issues directly related to the creation of a defined contribution program within  
30 Medicare. The Council also met with Alice M. Rivlin, PhD, who co-chaired the Bipartisan Policy  
31 Center's Debt Reduction Task Force with former Senator Pete Domenici (R-NM), and served on  
32 the National Commission on Fiscal Responsibility and Reform, co-chaired by Erskine Bowles and  
33 former Senator Alan Simpson (R-WY), both of which proposed transitioning Medicare to a defined  
34 contribution system. The majority of comments from the Federation and Dr. Rivlin emphasized  
35 that defined contribution amounts should be sufficient to ensure that all Medicare beneficiaries  
36 could afford to purchase health insurance coverage, and that private health insurance plans should

1 be subject to regulations that protect patients and ensure the availability of coverage for even the  
2 sickest patients.

3  
4 The Council greatly appreciates the efforts of the individuals, state medical associations, and  
5 national medical specialty societies that provided thoughtful testimony and written comments on  
6 Council on Medical Service Report 4-I-11 and the development of a defined contribution program,  
7 per Policy D-330.916.

8  
9 THE URGENT NEED FOR CHANGE

10  
11 The long-term viability of the Medicare program has been a significant and growing public policy  
12 concern for many years. The spending projections for Medicare under current law manifest  
13 mounting pressure on the federal budget with insufficient financing that will make it difficult to  
14 fund full payment of currently scheduled benefits and growth in costs that is unsustainable in the  
15 long-term. In addition, the repeated failure of Congress to repeal the Sustainable Growth Rate  
16 (SGR) formula compounds federal budget problems, and perpetuates a state of instability in the  
17 Medicare program that could ultimately jeopardize beneficiaries' access to care. Appendix A  
18 provides background on the structure and financing of the Medicare Trust Funds, and describes the  
19 relationship between Medicare's financial outlook and the national debt.

20  
21 Heightened concerns about the federal deficit and the national debt limit have resulted in even  
22 greater scrutiny of the Medicare program. Medicare expenditures currently account for 3.7 percent  
23 of gross domestic product (GDP), and the Medicare Trustees project that Medicare spending will  
24 reach 5.7 percent of GDP by 2030 (2012 Medicare Trustees Report). Key policymakers  
25 acknowledge that any serious fiscal reform effort needs to confront the impact that Medicare's  
26 financing and benefit structure has on the federal budget.

27  
28 In addition to Medicare's fiscal troubles, there are weaknesses inherent in the program's benefit  
29 design. Accordingly, changes are necessary to strengthen the program for the current generation of  
30 beneficiaries as well. Although Medicare is a popular program, its shortcomings are evidenced by  
31 the fact that nearly 90 percent of Medicare beneficiaries have some form of supplemental health  
32 insurance (e.g., a Medigap policy or retiree coverage through a former employer), or are enrolled in  
33 a Medicare Advantage (Part C) plan. Unlike most commercial health insurance plans, traditional  
34 Medicare (i.e., Parts A and B) has no out-of-pocket spending limits, exposing beneficiaries to  
35 unlimited financial risk unless they purchase a supplemental policy.

36  
37 According to a 2012 analysis by the Kaiser Family Foundation, the benefit value of traditional  
38 Medicare is less generous than what is typically offered under a large employer PPO program, or  
39 under the most popular plan selected by Federal Employees Health Benefits Program (FEHBP)  
40 enrollees, the Blue Cross/Blue Shield Standard Option. Furthermore, the current Medicare cost-  
41 sharing structure involves several levels of deductibles and copayments across the various parts of  
42 the Medicare program (i.e., Parts A, B and D), which makes it difficult for beneficiaries to predict  
43 or even understand what their out-of-pocket obligations might be. As a result, most beneficiaries  
44 purchase supplemental coverage that not only limits their out-of-pocket liability for catastrophic  
45 costs, but also often eliminates all cost-sharing. Supplemental insurance provides beneficiaries  
46 with "first dollar" coverage, which insulates them from the true cost of services, and facilitates  
47 demand for increased volume of services, thus increasing federal government spending on the  
48 Medicare program.

49  
50 Twenty-five percent of Medicare beneficiaries choose to enroll in a Medicare Advantage (Part C)  
51 plan. Medicare Advantage plans are offered by private insurers, and include HMOs, PPOs, and

1 private fee-for-service plans that provide all Medicare covered services in exchange for a per  
2 enrollee capitated payment from the federal government. Unlike traditional Medicare, Medicare  
3 Advantage plans cap out-of-pocket spending, and many offer enhanced benefits such as reduced  
4 cost-sharing or vision or dental benefits. Enrollment in Medicare Advantage plans has increased  
5 steadily since 2004, suggesting that beneficiaries value having the ability to choose coverage  
6 options and benefit designs offered by private insurers. However, true choice under Medicare  
7 Advantage remains limited. In particular, if plans are able to provide Medicare services less  
8 expensively than the capitated amount set by the federal government, they are required to provide  
9 enhanced benefits to beneficiaries (e.g., more generous cost-sharing), rather than lowering the  
10 overall cost of the insurance plan. In effect, beneficiaries are forced to pay for additional services  
11 regardless of whether they value those services.

12  
13 The number of beneficiaries with supplemental insurance also includes the approximately 20  
14 percent of Medicare beneficiaries who are eligible to receive assistance through the Medicaid  
15 program (i.e., dual-eligibles). For many low-income Medicare beneficiaries, Medicaid plays an  
16 important role in protecting them against unaffordable and potentially catastrophic out-of-pocket  
17 costs. For these beneficiaries, Medicaid provides premium and cost-sharing assistance, and most  
18 (77 percent) receive full Medicaid benefits (Kaiser Family Foundation, April 2012). However, not  
19 all low-income Medicare beneficiaries are eligible for Medicaid assistance. Nearly 60 percent of  
20 seniors with incomes below the federal poverty level (FPL), and 87 percent of seniors with  
21 incomes between 100 and 200 percent of FPL are not covered by Medicaid (Kaiser Family  
22 Foundation, March 2012). These individuals are likely unable to afford supplemental coverage,  
23 and yet are among the beneficiaries most in need of financial assistance under the traditional  
24 Medicare program design.

## 25 26 AMA POLICY

27  
28 Over the years the AMA has developed policy that articulates specific reforms that are necessary to  
29 ensure that Medicare remains a viable mechanism for providing meaningful health insurance  
30 coverage. Policy H-330.896 supports several important modifications:

### 31 32 Policy H-330.896 – Strategies to Strengthen the Medicare Program

33  
34 Our AMA supports the following reforms to strengthen the Medicare program, to be  
35 implemented together or separately, and phased-in as appropriate:

- 36  
37 1. Restructuring beneficiary cost-sharing so that patients have a single premium and  
38 deductible for all Medicare services, with means-tested subsidies and out-of-pocket  
39 spending limits that protect against catastrophic expenses. The cost-sharing structure  
40 should be developed to provide incentives for appropriate utilization while  
41 discouraging unnecessary or inappropriate patterns of care. The use of preventive  
42 services such as those recommended by the US Preventive Health Task Force should  
43 also be encouraged. Simultaneously, policymakers will need to consider modifications  
44 to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure  
45 that policies complement, rather than duplicate or undermine, Medicare's new cost-  
46 sharing structure.
- 47  
48 2. Offering beneficiaries a choice of plans for which the federal government would  
49 contribute a standard amount toward the purchase of traditional fee-for-service  
50 Medicare or another health insurance plan approved by Medicare. All plans would be  
51 subject to the same fixed contribution amounts and regulatory requirements. Policies

1 would need to be developed, and sufficient resources allocated, to ensure appropriate  
2 government standard-setting and regulatory oversight of plans.  
3

- 4 3. Restructuring age-eligibility requirements and incentives to match the Social Security  
5 schedule of benefits.  
6

7 Several bipartisan deficit reduction and Medicare reform proposals include elements that are  
8 consistent with the reforms outlined in Policy H-330.896, including proposals developed by the  
9 Bipartisan Policy Center Debt Reduction Task Force (Domenici-Rivlin) and the National  
10 Commission on Fiscal Responsibility and Reform (Simpson-Bowles).  
11

12 Policy H-330.896 calls for reforms that will better protect beneficiaries in the current Medicare  
13 program and allow for a more rational cost-sharing structure that simultaneously provides  
14 beneficiaries with financial security and encourages the efficient use of health care services. Policy  
15 H-330.896 also supports adjusting the Medicare eligibility age to more closely mirror current  
16 demographic trends. Like Social Security, Medicare was designed primarily to provide support to  
17 retirees. Medicare's eligibility age should be adjusted to reflect technological and scientific  
18 advances that have extended life expectancy, and concurrently, the number of productive working  
19 years. At a minimum, Medicare eligibility should transition to a tiered system, similar to Social  
20 Security, in which penalties and incentives are awarded based on the age at which benefit  
21 collection begins.  
22

23 The reforms detailed in Policy H-330.896 must be addressed in order to repair fundamental flaws  
24 in the traditional Medicare program. Beneficiaries, particularly those with low incomes or high  
25 anticipated medical expenses, would be better served by a Medicare program that more closely  
26 resembles commercial insurance, with a single premium, deductible and copayment structure for  
27 all covered services. Yet there is a growing recognition that the magnitude of the financing and  
28 budgeting issues associated with meeting Medicare's obligation will require more substantial  
29 reforms. The challenge for any serious Medicare entitlement reform proposal is to identify ways to  
30 balance the nation's fiscal responsibilities with its social responsibility to ensure access to high  
31 quality health care for seniors and the disabled.  
32

33 Longstanding Policy H-330.898 articulates the AMA's current vision for long-term Medicare  
34 reform. It calls for the Medicare program to be phased out and replaced by a self-funded, private  
35 sector approach that would require individuals to make minimum contributions into individually  
36 owned savings accounts dedicated to funding post-retirement medical care. Subsidies would be  
37 available for low-income individuals to ensure that their accounts receive minimum contributions  
38 annually. Council on Medical Service Report 4-I-11 included a detailed discussion of Policy  
39 H-330.898 and invited the House to use the policy as a starting point for considering the  
40 development of updated policy to address ways to strengthen the Medicare program over the long-  
41 term.  
42

#### 43 STRENGTHENING MEDICARE THROUGH DEFINED CONTRIBUTIONS 44

45 Policy H-330.896, which was established by the AMA in 2007, provides a strong foundation for  
46 the development of a comprehensive alternative to the current Medicare system or the self-funded  
47 approach called for in Policy H-330.898. Policy H-330.896 identifies changes that must be made  
48 to strengthen the traditional Medicare program (i.e., restructuring beneficiary cost-sharing,  
49 including modifying Medigap rules, and changing the eligibility age to match Social Security), and  
50 also expresses support for giving beneficiaries a choice of plans for which the federal government

1 would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or  
2 another health insurance plan approved by Medicare.

3  
4 Consistent with Policy H-330.896, Policy D-330.937 supports giving patients more control over  
5 and responsibility for their health care spending by making Medicare a defined contribution  
6 program. Traditional Medicare is a “defined benefit” program, under which the federal  
7 government pays for a specific set of health care benefits, regardless of cost. However, unless  
8 beneficiaries purchase supplemental coverage (or a Medicare Advantage plan), they are limited to  
9 the single benefit package that the federal government has selected. Medicare’s defined benefit  
10 structure restricts patient choice, and in so doing, removes incentives that could help limit spending  
11 growth by leveraging private market innovation. Moving Medicare to a defined contribution  
12 program would expand patient choice by giving beneficiaries an amount of money to be applied  
13 toward the purchase of health insurance coverage provided under the traditional Medicare program,  
14 or by a private insurer. Although insurers would be subject to certain regulatory requirements to  
15 ensure beneficiaries are protected, a defined contribution system would allow private insurers the  
16 freedom to design a range of plans that meet patient demand. The popularity of supplemental plans  
17 in the current Medicare system – including Medicare Advantage plans – suggests that most  
18 Medicare beneficiaries want benefit options that are not offered under traditional Medicare,  
19 particularly related to cost-sharing and out-of-pocket spending limits.

20  
21 A defined contribution system is likely to result in lower rates of health care spending growth,  
22 since insurers would be competing on price as well as benefit design, and would be directly  
23 accountable to patient demand for high-value, high-quality services. Under a defined contribution  
24 arrangement, private insurers competing with traditional Medicare could offer plans with a wide  
25 variation in premium charges. Beneficiaries would be responsible for paying the difference  
26 between the defined contribution amount and the full premium of the plan they selected. In the  
27 event that beneficiaries select a lower price plan, beneficiaries could keep the difference, possibly  
28 in the form of a contribution to a health savings account. Giving beneficiaries a defined  
29 contribution and allowing them to select the coverage of their choice creates an incentive for  
30 patients to be cost-conscious when purchasing coverage, which, in turn creates an incentive for  
31 insurers to find ways to improve the value of their plans.

32  
33 The FEHBP, which covers federal employees, including members of Congress, is an example of a  
34 defined contribution system that works very effectively for plan enrollees, while also effectively  
35 managing program spending growth. Under the FEHBP, federal employees receive a defined  
36 contribution to apply toward the purchase of a health insurance plan approved by the Office of  
37 Personnel Management. Participating insurers offer a wide range of plan types, including preferred  
38 provider and health maintenance organization options, point of service plans, high deductible plans,  
39 and consumer-directed plans that offer health savings accounts.

40  
41 A defined contribution system could offer a more predictable and sustainable way for the federal  
42 government to continue providing assistance to Medicare beneficiaries. The transition from  
43 defined benefit to defined contribution programs has been widely publicized with respect to  
44 employment-based retirement programs. Some analysts anticipate that employers will soon begin  
45 transitioning to defined contribution programs for employee health benefits as well, especially if  
46 the health insurance exchanges created by the Affordable Care Act (ACA) are successful in  
47 stimulating innovations in the private health insurance market.

48

1 DISCUSSION

2  
 3 Comments received on Council Report 4-I-11 indicated a preference for maintaining the traditional  
 4 Medicare program as an option for current and future beneficiaries, while also expanding coverage  
 5 options available to Medicare enrollees. Although the Council explicitly encouraged the House to  
 6 comment on the concept of phasing out Medicare in favor of a system of individually owned,  
 7 private savings accounts (as described in Policy H-330.898), the majority of comments focused on  
 8 expanding the options available under Medicare, rather than replacing the program altogether. The  
 9 Council believes that the AMA should build on existing policies (e.g., Policy H-330.896[2]) that  
 10 support making Medicare a defined contribution program, as suggested by Policy D-330.916.

11  
 12 Expanding health insurance choice and pluralism have been long-standing goals of the AMA.  
 13 Conceptually consistent with defined contributions, the AMA’s health system reform proposal,  
 14 which was established in 1998 and has been refined since, advocates for the promotion of  
 15 individually selected and owned health insurance in a robust health insurance marketplace, using  
 16 refundable and advanceable tax credits that are inversely related to income so that patients with the  
 17 lowest incomes will receive the largest credits. In 2007, the AMA formally established policy  
 18 supporting a standard (defined) contribution system for the Medicare program (Policy H-  
 19 330.896[2]).

20  
 21 The Council firmly believes that implementing a defined contribution system, with strong  
 22 regulatory protections for patients, is a responsible and feasible approach to strengthening the  
 23 Medicare program. As noted, recent bipartisan proposals from Pete Domenici and Alice Rivlin,  
 24 and Erskine Bowles and Alan Simpson advocate for Medicare reforms that include giving  
 25 beneficiaries a defined contribution. Previously, the National Bipartisan Commission on the Future  
 26 of Medicare, led by Senator John Breaux (D-LA) and Representative Bill Thomas (R-CA) during  
 27 the Clinton administration, recommended implementing a defined contribution system.

28  
 29 The Council recommends that the AMA support transitioning Medicare to a defined contribution  
 30 program that would enable beneficiaries to purchase coverage of their choice through a Medicare  
 31 exchange of competing health insurance plans. Traditional Medicare would be an option in the  
 32 Medicare exchange. However, as noted, the traditional Medicare program has significant design  
 33 flaws, particularly with respect to cost-sharing obligations and out-of-pocket spending limits. The  
 34 AMA should continue to advocate for improvements to the traditional Medicare benefit design as  
 35 Medicare transitions to a defined contribution program, and traditional Medicare begins to compete  
 36 with private plans for enrollees.

37  
 38 Private health insurance plans participating in the Medicare exchange must be subject to  
 39 regulations and standards that help protect enrollees and ensure plan availability for all  
 40 beneficiaries. Specifically, plans should be required to meet guaranteed issue and guaranteed  
 41 renewability requirements, prohibited from rescinding coverage except in cases of fraudulent  
 42 representation, follow uniform marketing standards, and be subject to solvency requirements.

43  
 44 In addition, safeguards should be in place to ensure some minimum level of coverage is provided  
 45 by every plan. Although traditional Medicare’s specific benefit design exposes beneficiaries to  
 46 unpredictable and potentially unlimited out-of-pocket costs, the Council believes that traditional  
 47 Medicare should be used as the reference point for acceptable levels of coverage. Specifically, the  
 48 Council suggests requiring plans to cover the “actuarial equivalent” of the benefit package  
 49 provided by Medicare. The actuarial value of a health insurance policy is the percentage of the  
 50 total covered expenses that the plan would cover for the average enrollee. Linking private plan  
 51 minimum coverage requirements to the actuarial value of traditional Medicare ensures that

1 Medicare beneficiaries are receiving at least the same level of insurance coverage, on average, as  
2 they would in traditional Medicare. Importantly, plans can be actuarially equivalent and include  
3 different benefit options and plan designs, so private plans would have the flexibility to develop  
4 innovative coverage options for Medicare beneficiaries.

5  
6 Transitioning Medicare to a defined contribution program requires that safeguards be in place to  
7 ensure that coverage remains affordable to all Medicare beneficiaries, and that all beneficiaries  
8 have a range of private options from which to choose. Risk adjustment methodologies must be  
9 developed and implemented to ensure that private health plans can afford and are willing to provide  
10 coverage for sicker beneficiaries and those with higher projected health care costs.

11  
12 The Council is aware that determining the value of the defined contribution will be critical to  
13 ensuring that it provides viable coverage alternatives for beneficiaries and a sustainable option for  
14 the federal government. The Council concurs with feedback it received suggesting that the amount  
15 of the defined contribution be based on the value of the government's contribution under traditional  
16 Medicare. To ensure that health insurance coverage is affordable for all beneficiaries, adjustments  
17 should be allowed to the defined contribution amount. Specifically, individual defined contribution  
18 amounts should vary based on beneficiary age, income and health status, with older, lower income  
19 and sicker beneficiaries receiving larger contributions. Through adjustments to the defined  
20 contribution amounts, all Medicare beneficiaries will be able to afford to purchase health insurance  
21 coverage through at least one of the plans in the Medicare exchange.

22  
23 The Council agrees with feedback it received that the baseline defined contribution amount should  
24 be adjusted annually to ensure that health insurance coverage remains affordable for all  
25 beneficiaries over time. Annual adjustments should be based on changes in health care costs and  
26 the cost of obtaining health insurance, rather than on gross domestic product (GDP) or other  
27 indexes that are not directly tied to health care costs.

28  
29 The Council is aware that implementing a Medicare defined contribution program should be done  
30 gradually, using a phased-in approach. A complete transition will involve significant, coordinated  
31 efforts by all stakeholders, including the federal government, private insurers, patient advocacy  
32 groups, and the AMA.

33  
34 In addition to supporting transitioning Medicare to a defined contribution program, the AMA  
35 should continue to strongly advocate for related Medicare reforms. Policies related to balance  
36 billing, private contracting, and the repeal of the Medicare Independent Payment Advisory Board  
37 remain particularly relevant and should be reaffirmed. Similarly, the AMA should continue to  
38 support incentives to encourage people to contribute to health savings accounts, and to promote  
39 their use as a means to ensure access to high quality medical care. It is also critical that the AMA  
40 continue to advocate for the other Medicare reforms articulated in Policy H-330.896, particularly  
41 restructuring beneficiary cost-sharing in order to provide incentives for appropriate utilization  
42 while discouraging unnecessary or inappropriate care, and increasing the Medicare eligibility age  
43 to reflect increases in the average life expectancy in the United States.

44  
45 Conversely, the Council believes that Policy H-330.898, which proposes replacing the Medicare  
46 program with a self-funded, private sector approach to health insurance funding, should be  
47 rescinded. The lack of feedback on Policy H-330.898 may suggest reluctance on the part of the  
48 House of Delegates for the AMA to advocate this strategy, and the Council agrees that promoting  
49 the elimination of the Medicare program is not appropriate in the current political or economic  
50 environment. The Council notes that while the emphasis of Policy H-330.898 is on phasing out the



1 Medicare program, there are other components of the policy that remain relevant, all of which are  
2 articulated elsewhere in AMA policy. Appendix B provides a crosswalk of these policies.

3  
4 The Council notes that funding for graduate medical education (GME) is currently tied to the  
5 Medicare program, and believes that safeguards should be in place to ensure that a transition to a  
6 defined contribution program does not adversely affect GME financing. A robust and stable  
7 funding stream for GME is necessary to train a well-educated and diverse physician workforce that  
8 is sufficient to provide care for all Americans, including Medicare beneficiaries. Any efforts to  
9 strengthen the Medicare program should ensure that mechanisms are in place for financing  
10 graduate medical education at a level that will provide workforce stability and an adequate supply  
11 of physicians to care for all Americans.

12  
13 The AMA has long advocated for moving to an all-payer (i.e., federal, state and private payers)  
14 system to help strengthen the funding stream for GME (e.g., Policies H-310.917, H-305.929, D-  
15 305.967). At the 2012 Annual Meeting the House of Delegates referred Resolution 329, “Going  
16 Forward with Reforming GME Financing,” which asked the AMA to craft a new model for  
17 sustainable GME funding that would include funding from Centers for Medicare and Medicaid  
18 Services and private funding sources. The Board of Trustees assigned this item to the Council on  
19 Medical Education, which will be presenting a report to the House at the 2013 Annual Meeting.

20  
21 The Council also notes that reforms that address rising health care costs need to be pursued in  
22 tandem with other Medicare reforms. Several policies (e.g., Policies H-155.960, H-450.938, and  
23 H-165.838) support efforts to contain rising health care costs by reducing the burden of preventable  
24 disease, reducing administrative costs, making health care delivery more efficient, and  
25 implementing medical liability reforms to reduce the cost of defensive medicine. The ACA  
26 provides for a range of new pilot programs that are expected to result in major payment and  
27 delivery reforms in Medicare and, ultimately, the private sector. The AMA supports physician-led  
28 efforts to pursue payment and delivery reforms that promote improved patient access to high-  
29 quality, cost-effective care (Policy H-390.849), and supports local innovation and funding of  
30 demonstration projects that allow physicians to pursue practice changes that best fit local needs  
31 (Policy D-390.961). AMA resources are available at [www.ama-assn.org/go/paymentpathways](http://www.ama-assn.org/go/paymentpathways) to  
32 help physicians understand options available under emerging payment and delivery models.

33  
34 Finally, the Council recommends rescinding Policy D-330.917, which called for the Federation and  
35 members of the House of Delegates to provide comments on Medicare financing reform to the  
36 Council by January 6, 2012, for consideration in this follow-up report, and D-330.916, which  
37 called for the AMA to refine its policy regarding Medicare financing reform, including a defined  
38 contribution program.

#### 39 40 RECOMMENDATIONS

41  
42 The Council on Medical Service recommends that the following be adopted and the remainder of  
43 the report be filed:

- 44  
45 1. That it be the policy of our American Medical Association that a Medicare defined  
46 contribution program should include the following:  
47  
48 a. Enable beneficiaries to purchase coverage of their choice from among competing  
49 health insurance plans, which would be subject to appropriate regulation and  
50 oversight to ensure strong patient and physician protections.

51

- 1           b. Preserve traditional Medicare as an option.
- 2
- 3           c. Offer a wide range of plans (e.g., HMOs, PPOs, high-deductible plans paired with
- 4           health savings accounts), as well as traditional Medicare.
- 5
- 6           d. Require that competing private health insurance plans meet guaranteed issue and
- 7           guaranteed renewability requirements, be prohibited from rescinding coverage
- 8           except in cases of intentional fraud, follow uniform marketing standards, meet plan
- 9           solvency requirements, and cover at least the actuarial equivalent of the benefit
- 10          package provided by traditional Medicare.
- 11
- 12          e. Apply risk-adjustment methodologies to ensure that affordable private health
- 13          insurance coverage options are available for sicker beneficiaries and those with
- 14          higher projected health care costs.
- 15
- 16          f. Set the amount of the baseline defined contribution at the value of the
- 17          government's contribution under traditional Medicare.
- 18
- 19          g. Ensure that health insurance coverage is affordable for all beneficiaries by
- 20          allowing for adjustments to the baseline defined contribution amount. In
- 21          particular, individual defined contribution amounts should vary based on
- 22          beneficiary age, income and health status. Lower income and sicker beneficiaries
- 23          would receive larger defined contributions.
- 24
- 25          h. Adjust baseline defined contribution amounts annually to ensure that health
- 26          insurance coverage remains affordable for all beneficiaries. Annual adjustments
- 27          should reflect changes in health care costs and the cost of obtaining health
- 28          insurance.
- 29
- 30          i. Include implementation time frames that ensure a phased-in approach. (New HOD
- 31          Policy)
- 32
- 33      2. That our AMA advocate that any efforts to strengthen the Medicare program ensure that
- 34      mechanisms are in place for financing graduate medical education at a level that will
- 35      provide workforce stability and an adequate supply of physicians to care for all Americans.
- 36      (New HOD Policy)
- 37
- 38      3. That our AMA reaffirm Policies H-330.896, "Strategies to Strengthen the Medicare
- 39      Program," H-385.961, "Medicare Private Contracting," D-390.986, "Medicare Balance
- 40      Billing," H-165.833, "Amend the Patient Protection and Affordable Care Act (PPACA),"
- 41      H-165.852, "Health Savings Accounts," and H-185.974, "Parity for Mental Illness,
- 42      Alcoholism, and Related Disorders in Medical Benefits Programs." (Reaffirm HOD
- 43      Policy)
- 44
- 45      4. That our AMA rescind Policy H-330.898, "Long-Term Funding of Medicare," Policy D-
- 46      330.917, "Medicare Reform Financing," and Policy D-330.916, "Medicare Financing
- 47      Reform." (Rescind HOD Policy)
- 48
- 49      5. That our AMA continue to explore the effects of transitioning Medicare to a defined
- 50      contribution program on cost and access to care. (Directive to Take Action)

Fiscal Note: Less than \$500.

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

Appendix A: Medicare and the Federal Budget

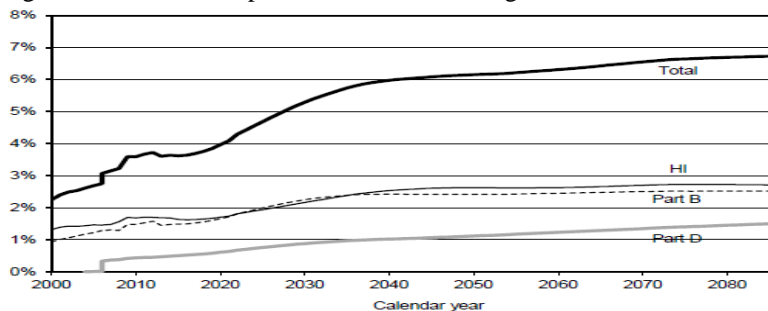
The Medicare Trust Funds

The Medicare program is supported by two separate trust funds. The Federal Hospital Insurance (HI) Trust Fund finances Medicare Part A, which covers hospital, home health, skilled nursing facility, and hospice care services. The primary source of income for the HI Trust Fund is a 2.9 percent payroll tax paid by employers and employees (1.45 percent each). Beginning in 2013, higher income workers will pay an additional 0.9 percent tax on their earnings into the HI Trust Fund. The Federal Supplementary Medical Insurance (SMI) Trust Fund finances Medicare Part B, which covers physician services, hospital outpatient services, some mental health services, durable medical equipment, ambulatory surgical center services, physician-administered drugs, some lab tests, and home health visits not covered under Part A. The SMI Trust Fund also finances Part D, which offers prescription drug coverage. Income to the SMI Trust Fund comes from federal general revenues (76 percent) and beneficiary premiums (24 percent).

The concept of Medicare “solvency” refers to the income and assets available in the HI Trust Fund. Payroll taxes paid by current workers are used to fund the benefits provided to current retirees. The declining ratio of workers contributing payroll taxes to the number of beneficiaries results in a decline in the amount of income available to fund program expenditures. The strain on available resources is exacerbated by the continual increase in health care costs throughout the health care system. A recent analysis by the Urban Institute shows that the cost of Medicare benefits received far exceeds the amount of Medicare taxes collected. For example, an average two-earner couple turning 65 in 2011 is expected to use \$357,000 in lifetime Medicare benefits, but only paid \$119,000 in Medicare taxes during their working years (Steuerle and Rennane, June 2011). As a result, HI expenditures have exceeded income annually since 2008, and funds have been drawn from the HI Trust Fund to cover the shortfall. Projections in the 2012 Medicare Trustees Report to Congress indicate that annual HI revenues will continue to fall below projected expenditures, necessitating annual payouts from the Trust Fund. Under current law, the Medicare Trustees project that the HI Trust Fund will be completely exhausted in 2024, leaving no contingency for financing benefit obligations that exceed annual dedicated sources of revenue.

In contrast to the HI Trust Fund, the SMI Trust Fund is always fully funded. By law, federal funds are allocated each year to ensure that projected Part B and Part D expenditures (less beneficiary premiums) are covered. As more people become eligible for Medicare, and as program costs increase, a greater portion of the federal budget must be diverted to the Medicare program. In 2011, SMI transfers from the Federal budget equaled 1.5 percent of GDP; transfers are projected to grow to 3.0 percent of GDP by 2086 (2012 Medicare Trustees Report). Figure 1 shows projected Medicare expenditures for all components as a percentage of GDP.

Figure 1: Medicare Expenditures as a Percentage of GDP

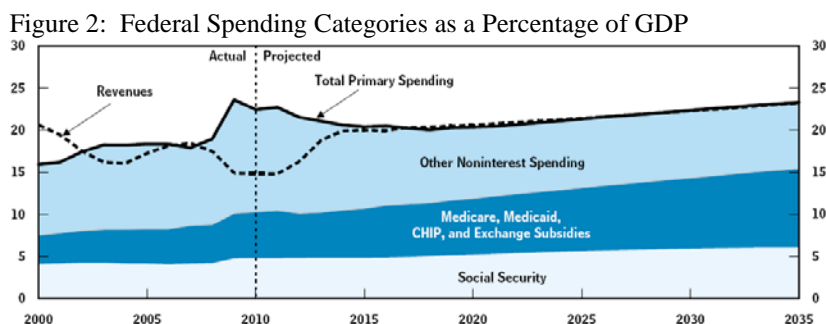


Source: 2012 Medicare Trustees Report

It should be noted that spending projections for the Medicare program are based on current law, which under the SGR formula requires an approximately 30 percent cut in physician payments in January 2013. Since Congress is unlikely to allow physician payments to be cut by nearly one-third, Medicare’s future funding obligations are severely understated in the projections. Without significant tax and/or premium increases, revenues will not keep pace with program obligations, leading to insolvency (in the case of the HI Trust Fund) and an increasing demand on the federal budget.

### Medicare and the Federal Budget

As Figure 2 from the Congressional Budget Office shows, health care spending is one of the largest portions of the federal budget.



Source: Congressional Budget Office 2011 Long-Term Budget Outlook, June 22, 2011

There is a direct relationship between expenditures for Medicare Part B and D services and the federal tax revenues that are allocated to the program on an annual basis. However, from a federal budget perspective, there is also a cost to drawing assets from the HI Trust Fund to provide Part A services. A trust fund typically holds assets to meet some future contingency, yet most government trust funds do not contain real assets. Instead, they represent a record of promises by the government to use future tax revenues to pay for future obligations as necessary. In the case of the HI Trust Fund, the earmarked revenues from payroll taxes are credited to the fund, but are effectively spent on current government activities. Until recently, annual income from payroll taxes has been sufficient to cover Medicare Part A expenditures, and the actuarial value of the HI Trust Fund has remained stable. As previously noted, however, since 2008 income from the Medicare payroll tax has been insufficient to cover current expenditures, and it has been necessary to redeem Trust Fund assets to meet the obligations to beneficiaries. Because the federal government has used the HI Trust Fund assets to fund ongoing consumption of other federal programs, Medicare expenditures that are scheduled to come from the trust fund must actually come out of the current budget resources. As policymakers struggle with budget deficits and the national debt level, they are acutely aware of growing costs associated with financing Medicare Part B and Part D services, and with “repaying” the loans that have been made from the HI Trust Fund over the past several decades.

Lawmakers also need to confront the \$325 billion funding deficit caused by their repeated failure to permanently replace the SGR. It is widely acknowledged that the SGR formula is fundamentally flawed and that it is based on assumptions about growth rates and spending baselines that are unrealistic in today’s health care environment. Since 2002, Congress has intervened on 13 separate occasions to stop cuts in physician payment rates, and with a few exceptions has paid for the intervention by assuming even larger cuts in future years. The cost of funding the accumulated

cuts that have been deferred has been a major factor in the rising price of repealing the SGR, which has grown from about \$48 billion in 2005 to nearly \$325 billion today.

Appendix B: Policy H-330.898 Crosswalk

As described in the Discussion section of Council on Medical Service Report 5-I-12, the Council is recommending that Policy H-330.898, “Long-Term Funding of Medicare,” be rescinded. Portions of Policy H-330.898 that remain relevant to the proposed defined contribution option are expressed elsewhere in AMA policy, as described in this policy crosswalk.

<b>Components of Policy H-330.898</b>	<b>Remaining Relevant AMA Policy</b>
(1) Our AMA supports proposals to shift the funding of Medicare from the current tax financed pay-as-you-go system to a system of mandatory individually owned private savings, with a required minimum contribution, accumulated tax-free and dedicated to funding post-retirement medical care. The government would provide a contribution to economically disadvantaged individuals making smaller than average contributions to their retirement accounts.	Council on Medical Service Report 5-I-12 articulates support for transitioning to a defined contribution program as a more viable Medicare reform option.
(2) Supports establishing incentives to encourage the use of accumulated balances in health savings accounts for the funding of post-retirement medical care.	Policy H-165.852 supports the use of health savings accounts, and is recommended for reaffirmation in Council on Medical Service Report 5-I-12.
(3) Recognizes that while private sector solutions can address a large portion of the long-term funding of Medicare, there will still be a need and responsibility for support from government or charitable organizations for the economically disadvantaged.	The defined contribution program articulated in Council on Medical Service Report 5-I-12 includes additional support for economically disadvantaged individuals.
(4) Continues to support modernization of the traditional Medicare program by combining the cost-sharing requirements of Parts A and B into a single deductible.	Policy H-330.896 supports restructuring beneficiary cost-sharing, and is recommended for reaffirmation in Council on Medical Service Report 5-I-12.
(5) Continues to support replacing Medicare’s systems of price controls with a system of price competition.	Policy H-165.985 supports price competition over price controls, and is recommended for reaffirmation in Council on Medical Service Report 5-I-12.
(6) Supports the premise that the FEHBP should be used as a model for restructuring Medicare. This type of program would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program, for the plan that best meets their needs. Private retiree health insurance also should be integrated into any FEHBP-modeled system.	Council Report 5-I-12 articulates support for a transitioning Medicare to a defined contribution program, which would allow seniors to choose among competing private plans.  This concept is also included in Policy H-330.896, which is recommended for reaffirmation in Council on Medical Service Report 5-I-12.

<b>Components of Policy H-330.898</b>	<b>Remaining Relevant AMA Policy</b>
<p>(7) Supports the premise that during the transition from the current Medicare program to a system of pre-funding, workers would not only establish private savings accounts for their retirement expenses, but would also continue to support current and soon-to-be retirees through some level of taxation.</p>	<p>Council on Medical Service Report 5-I-12 articulates support for transitioning to a defined contribution program as a more viable Medicare reform option.</p>
<p>(8) Reaffirms that the fundamental goal of transforming Medicare should be to assure the health of the elderly and disabled populations. Patients must have access to high quality medical services. The best value in medical care can be achieved by ensuring that the medical profession has a central role in the design and implementation of a new Medicare program. Patients must also receive timely and accurate information on the necessity and important aspects of Medicare transformation.</p>	<p>The recommendations presented in Council on Medical Service Report 5-I-12 reflect a commitment to assuring the health of the elderly and disabled populations.</p>