



**THE FUTURE OF MEDICARE:  
CONVERTING TO PREMIUM SUPPORT OR  
CONTINUING AS A GUARANTEED BENEFIT PROGRAM**

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**Oral Statement**

Today, Medicare works to provide access to care and financial protection for 50 million seniors and disabled beneficiaries. These men and women contributed to the program throughout their working lives and continue to contribute substantially to their own medical expenses through premiums for supplemental coverage and out-of-pocket expenses. Although Medicare covers people who are poorer, sicker, and more expensive to care for than private insurance plans do, it is a better buy than private coverage. Medical and administrative costs are lower than those in private coverage because of administrative efficiencies and the leverage Medicare exercises as the largest purchaser of health care in our country.

The Affordable Care Act is projected to achieve estimated Medicare savings of \$716 billion between 2013 and 2022. This will be achieved by phasing out the overpayments to private Medicare Advantage plans, reducing provider payment productivity updates (which has been accepted by the hospital industry in large part because covering the uninsured will reduce hospitals' bad debts), and various provider payment changes and improvements. The Affordable Care Act's major payment and delivery system reforms are projected to slow Medicare spending per beneficiary to 3.1 percent annually over 2012–2021, extending the solvency of the Medicare Hospital Insurance (Part A) Trust Fund to 2024.

A major concern, however, is that the retirement of the post-World War II generation will increase the numbers of beneficiaries at the same time that the decline in fertility rates in the 1970s and 1980s has lowered the number of active workers in the labor force. As a result, expenses are projected to grow faster than payroll tax revenues.

To bring the Trust Fund into balance, more revenues will be needed, spending growth will need to be further restrained, or beneficiaries will need to pay more of their own health care expenses either directly or through premiums.

Given this dilemma, a national debate on the future of Medicare, with careful consideration of the consequences of alternative strategies, is appropriate. Converting Medicare to a fixed sum of money capped at the growth of the economy, without effective health care cost control, would shift costs to beneficiaries who already struggle with out-of-pocket medical expenses and limited incomes. An alternative approach of continuing guaranteed benefits and rewarding hospitals and physicians for providing

high-quality care in an efficient manner has the potential to achieve needed budgetary savings while reducing, not increasing, financial risk to beneficiaries.

### **Premium Support and Repeal of the Affordable Care Act**

The philosophy behind premium support holds that patients are best positioned to eliminate overuse of services, shop for lower-cost care, and pick lower-cost health plans. Rather than guaranteeing that Medicare will pay the cost of a defined set of benefits, under the most recent Medicare premium proposal advanced by vice presidential candidate Rep. Paul Ryan, chair of the House budget committee, beneficiaries would receive an allowance based on their age, health status, and income to be applied toward the purchase of a health plan. Over time, the dollar allowance would be capped at the rate of gross domestic product (GDP) growth per person plus 0.5 percent.

Governor Mitt Romney endorses this Medicare premium support strategy. Because the federal government would cap future allowances by the rate of economic growth rather than the rising costs of health insurance premiums or medical care cost, this approach would result in the federal government spending less over time as beneficiaries spent more, assuming health care costs continued to rise at current rates. The value of the allowance or defined contribution for private insurance would erode over time, resulting in higher premiums for beneficiaries and/or reductions in benefits.

The Congressional Budget Office (CBO), in fact, estimated that the latest Ryan premium support proposal, which shaped the 2012 House Budget Resolution, will raise costs for beneficiaries, with beneficiary cost rising over time. Our estimate is that average private health insurance premiums would exceed the allowance by \$4,250 in 2030.

It is also important to weigh the merits of choosing among competing private plans. As previously noted, private health insurance is more costly than public coverage given its larger administrative costs, higher provider payments, and less-efficient risk pooling. CBO estimates that utilizing private coverage for a set of benefits similar to what is currently covered by traditional Medicare would be 12 percent more expensive than traditional Medicare in 2022. By 2030, private coverage of the same benefits would be about 40 percent more expensive than traditional Medicare.

The nation's experience with the Medicare Advantage program suggests that beneficiaries would be less satisfied and more likely to experience access problems when opting for a private plan. Thirty-two percent of Medicare Advantage beneficiaries report at least one access problem because of cost, compared with 23 percent of those with traditional coverage.

The widespread use of competing private plans under a premium support scenario has the potential to undermine the stability and effectiveness of Medicare by fragmenting the risk pool. Even if Medicare beneficiaries retained a choice of enrolling in traditional

Medicare as called for in the latest Ryan proposal, physicians and hospitals could receive substantially higher payment from private plans and would be likely to opt out of participation in traditional Medicare, nullifying it as a genuine choice for beneficiaries. Dividing Medicare beneficiaries across multiple private plans would undermine the leverage the program currently has to drive efficiency among providers and widespread change across the entire U.S. health system.

Moreover, while the premium support proposal contained in the latest House budget resolution included some protections against risk selection (or “cream-skimming”) by private insurance companies, officials would need to be particularly vigilant about plans covering a relatively low number of beneficiaries with complex health care needs.

Along with premium support, Governor Romney endorses increasing the age of eligibility for Medicare by two months per year starting in 2022 until it reached 67 in 2033. Romney also calls for the full repeal of the Affordable Care Act, including the coverage and Medicare benefit improvement provisions as well as repeal of the Medicare savings provisions. Repeal of the ACA would increase the federal budget deficit by \$109 billion over the next decade and shorten the time until the Medicare Part A Trust Fund becomes insolvent from 2024 to 2016. Romney would also replace Medicaid with a block grant to states, which could put long-term care benefits for Medicare and Medicaid beneficiaries at risk, and sharply restrict the growth in the federal budgetary commitment to Medicare and Medicaid over time.

### **Continuing Medicare as an Essential Benefit by Building on the Affordable Care Act**

A different approach to preserve Medicare’s guaranteed benefits would be to retain and build on the innovations in the Affordable Care Act. Instead of shifting financial costs onto beneficiaries, this approach would hold health care providers accountable for achieving high-quality care, excellent outcomes for patients, and ensuring that the total cost of health care is in line with what the nation can afford. It puts the accountability in the hands of those directly responsible for providing care.

The Affordable Care Act permits physician-led accountable care organizations to share in savings if they hold costs below a target rate of growth. The Center for Medicare and Medicaid Innovation is testing a variety of pilot payment innovations to reward providers for lowering cost while improving quality. It also gives the Secretary of Health and Human Services authority to spread successful innovation throughout the Medicare program if innovations lower cost, improve quality, or both, without being to the detriment of either.

President Obama, in continuing to implement the Affordable Care Act, would expand Medicare beneficiaries’ access to preventive care, reduce the cost of prescription

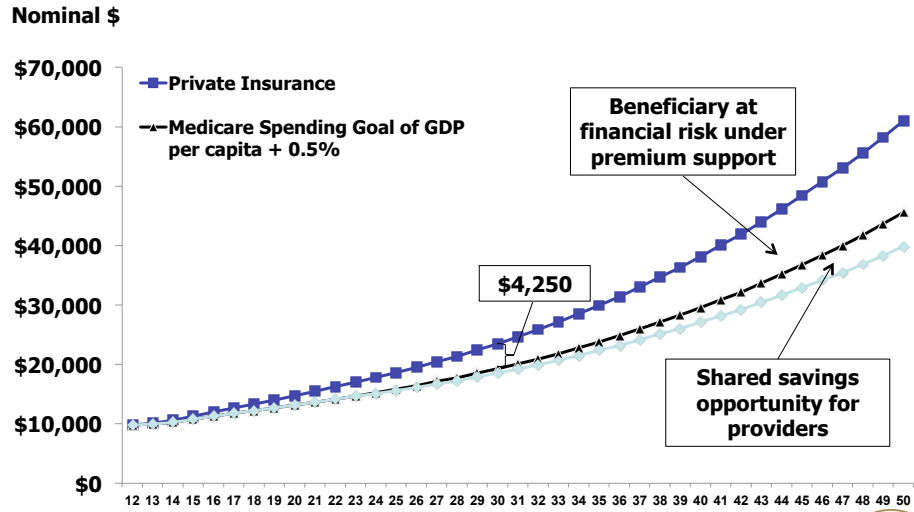
drugs, provide more help for low-income beneficiaries, provide better information for beneficiaries to make more informed health care choices, and encourage more coordinated care. The Affordable Care Act also places payments to private Medicare Advantage plans on an equal footing with traditional Medicare, slows the increase in provider charges, and raises premiums for high-income beneficiaries, extending the solvency of the Medicare Hospital Insurance Trust Fund.

President Obama's continued implementation of the Affordable Care Act would change how care is organized, delivered, and paid for. Many of the law's provisions are focused on Medicare, as well as Medicaid and the Children's Health Insurance Program, but it encourages the participation of multipayer initiatives that include both the public and private sectors. Models that emphasize the role of primary care and the need to coordinate care across providers and settings, like the patient-centered medical home and the accountable care organization, are being developed to improve care and stabilize costs.

The Affordable Care Act would give physicians, hospitals, and other health care providers an incentive to reduce the rate of growth in Medicare outlays by creating opportunities for them to share in savings. President Obama has further stated that through these reforms he would attempt to hold the rate of growth in health care spending to GDP plus 0.5 percent, the same goal as under the premium support proposal. However, under the premium support strategy, the beneficiary is at financial risk when private insurance premiums exceed the Medicare spending target (Exhibit ES-1). Under the shared savings strategy, providers have the opportunity to reap benefits when costs are below the target for Medicare spending. Beneficiaries also gain from lower Medicare costs, as their premiums and out-of-pocket expenses are reduced by the slower growth in Medicare spending.

As policymakers and the nation confront the urgent need to control health spending while continuing to improve the quality and efficiency of care delivered, these activities provide a foundation on which to build, with the potential to control health spending while moving toward a high performance health system.

### Exhibit ES-1. Medicare Spending per Beneficiary Under Premium Support and Shared Savings Scenarios, 2012–2050



Source: Commonwealth Fund calculations based on Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, (Washington: Congressional Budget Office, March 2012), and Congressional Budget Office, *The 2012 Long-Term Budget Outlook* (Washington, D.C.: Congressional Budget Office, June 2012).



# **THE FUTURE OF MEDICARE: CONVERTING TO PREMIUM SUPPORT OR CONTINUING AS A GUARANTEED BENEFIT PROGRAM**

**Karen Davis**

For almost 50 years, Medicare has provided access to health care and protection against ruinous medical bills to millions of elderly and disabled beneficiaries. Medicare was enacted in 1965 because half of seniors lost their private insurance when they retired at age 65. Middle-class families were at great financial risk when an elderly parent needed life-saving care. Guaranteeing that Medicare continues to meet its basic goal of providing health and economic security to 50 million current beneficiaries, as well as the post-World War II generation as it reaches retirement, is an essential priority for the nation. Starkly different choices have been proposed for the future of the program: namely, converting it to a fixed dollar premium support system or continuing Medicare as a guaranteed benefit program.

As it is currently structured, Medicare works to provide access to care and financial protection for millions of vulnerable seniors and disabled individuals who have contributed to the program throughout their working lives and continue to contribute substantially to their own medical expenses through premiums for supplemental coverage and out-of-pocket expenses for noncovered services. Medicare is a good buy: medical and administrative costs are lower than those in private insurance plans because of administrative efficiencies and the leverage Medicare exercises as the largest purchaser of health care in our country.

Converting Medicare to a fixed sum of money capped at the growth of the economy without effective health care cost control would shift cost to beneficiaries who already struggle with out-of-pocket medical expenses and limited incomes. An alternative approach of continuing guaranteed benefits and rewarding hospitals and physicians for providing high-quality care in an efficient manner has the potential to achieve needed budgetary savings while reducing, not increasing, financial risk to beneficiaries.

## **Medicare Works**

Medicare is a critical public program that works for beneficiaries far poorer, sicker, and more expensive to care for than those typically covered by private insurance (Exhibit 1).<sup>1</sup> Nearly half of all Medicare beneficiaries report incomes of less than 200 percent of the

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<sup>1</sup> Henry J. Kaiser Family Foundation, *Medicare at a Glance* (Washington, D.C.: Henry J. Kaiser Family Foundation, Nov. 2011).

federal poverty level—\$21,780 in 2011. Forty-five percent report living with three or more chronic conditions, and more than a quarter of all beneficiaries have a cognitive or mental impairment (29%) or consider themselves in fair or poor health (28%). A significant proportion of the Medicare population has functional impairments—this includes disabled individuals under age 65 (17%) or those reporting two or more limitations in daily living (15%).

Despite these challenges, decades of research demonstrate that Medicare is working to fulfill the two main purposes of health insurance—ensuring access to needed care and providing adequate financial protection from burdensome medical expenses. Medicare achieves these goals better than employer coverage and particularly better than individual coverage sold on the private insurance market. Elderly Americans are significantly more likely to report better outcomes on a host of questions related to affordability, access, and coordination relative to the under-65 insured population in the United States (Exhibit 2).

A recent Commonwealth Fund study found that only 8 percent of elderly Medicare beneficiaries rated their insurance as fair or poor, compared with 20 percent of adults with employer insurance and 33 percent of those who purchased insurance on their own (Exhibit 3).<sup>2</sup> Adults with employer-based insurance or individual insurance reported medical bill problems at almost twice the rate of Medicare beneficiaries. And about 37 percent of adults with employer coverage and 39 percent of those with individual coverage went without needed care because of costs, compared with less than one-fourth of Medicare beneficiaries.

Within the Medicare program, traditional Medicare outperforms private Medicare Advantage plans. Six percent of beneficiaries enrolled in traditional Medicare rate the coverage as fair or poor, compared with 15 percent in Medicare Advantage plans (Exhibit 4). Further, those beneficiaries enrolled in Medicare Advantage plans were more likely to report access problems because of cost (32% vs. 23% in traditional Medicare).

Medicare is a good buy for beneficiaries and taxpayers. Costs in Medicare are lower than those in private coverage because of administrative efficiencies and leverage the program exercises as the largest purchaser of health care in our country. Administrative costs in Medicare average less than 3 percent of expenditures, compared with 5 percent to 15 percent of premiums in large employer plans and 25 percent to 35 percent of premiums in the pre-reform, small-group market, and 41 percent in the

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<sup>2</sup> K. Davis, K. Stremikis, M. M. Doty, and M. A. Zezza, “Medicare Beneficiaries Less Likely to Experience Cost- and Access-Related Problems than Adults with Private Coverage,” *Health Affairs Web First*, published online July 18, 2012.



individual market (Exhibit 5).<sup>3</sup> Traditional Medicare administrative expenses are 2 percent, compared with 11 percent in Medicare Advantage, and 20 percent in Medigap (Exhibit 6).

Costs are also lower in Medicare because the program pays hospitals, physicians, and other health care providers lower prices than those offered by private insurance (Exhibit 7). Even so, Medicare continues to experience high provider participation rates. According to a recent survey of physicians, almost three-quarters (74%) of providers are accepting all or most new patients with Medicare.<sup>4</sup>

While beneficiaries are highly satisfied with Medicare, many elderly and disabled Americans still report significant financial burdens related to health care. The Medicare benefit package contains substantial cost-sharing, inducing many enrollees to purchase costly supplemental Medigap coverage. On average, Medicare picks up 74 percent of the medical expenses of beneficiaries, compared with 85 percent in large employer preferred provider organization (PPO) plans and 83 percent in the Federal Employees Health Benefit Program Standard Option (Exhibit 8).

In fact, Medicare households devote a much larger share of their more limited incomes to health care. Median health expenses in 2009 accounted for almost 15 percent of the average Medicare household's income, three times the rate of non-Medicare households (Exhibit 9).<sup>5</sup> This is projected to rise to 26 percent in 2020 (Exhibit 10). Beneficiaries with serious health problems or low incomes often report significant out-of-pocket spending burdens.<sup>6</sup> In 2006, beneficiaries in poor health reported out-of-pocket health care spending at 20 percent of income (Exhibit 11).

Even premiums are a major expense for Medicare beneficiaries. The elements—\$177 a month for Medigap supplemental coverage, \$33 a month for Part D premiums, and \$100 a month for Part B premiums—add up to \$3,720 a year.<sup>7</sup> That does not include out-of-pocket costs for prescription drugs and uncovered services such as dental care, eye care, and hearing aids. These are major expenses for a household living on Social Security income, which averaged \$14,760 in 2012.

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<sup>3</sup> The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

<sup>4</sup> Center for Studying Health Systems Change, *HSC 2008 Health Tracking Physician Survey*, Sept. 2009.

<sup>5</sup> J. Cubanski, A. Damico, L. Dawson et al., *Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households*, Kaiser Family Foundation Program on Medicare Policy Data Spotlight, June 2011.

<sup>6</sup> D. Yamamoto, T. Neuman, and M. K. Strollo, *How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Sept. 2008).

<sup>7</sup> R. Rabin, "Grappling with Details of Medicare Proposals," *The New York Times*, Sept. 17, 2012.

## **Medicare and the Federal Budget**

In many ways, Medicare is a low-cost program. Its actuarial value is less than typical employer plans and the Federal Employees Health Benefits Program standard option plan, it has lower administrative costs, and it uses its leverage as a major purchaser to get good rates from hospitals and physicians while still enjoying widespread provider participation.

Further, the Affordable Care Act of 2010 (ACA) is projected to achieve savings estimated at \$716 billion between 2013 and 2022. This will include \$156 billion in savings from phasing out the overpayments to private Medicare Advantage plans, \$415 billion in savings from provider payment productivity updates (which have been accepted by the hospital industry because covering the uninsured will reduce hospitals' bad debts), and the remaining from various provider payment changes and improvements.<sup>8</sup>

As a result of these provisions, Medicare is now projected to grow more slowly on a per capita basis than the gross domestic product (GDP) per capita (Exhibit 12). Between 2012 and 2021, per capita Medicare spending will grow at an annual rate of 3.1 percent, below that of GDP per capita at 4.1 percent. Even if Medicare physician fees grow with inflation, Medicare spending will grow at 3.8 percent over the decade, and between 3.1 percent and 3.8 percent if fees are frozen or offsetting savings to modifying the sustainable growth rate formula is achieved.<sup>9</sup>

Medicare is the largest payer for health care. The program will spend almost \$600 billion in 2012 for its more than 50 million beneficiaries, accounting for more than 20 percent of U.S. national health expenditures.<sup>10</sup> Like the rest of the health care system, Medicare faces rising health care costs. Private health spending per person is projected to increase 5.0 percent annually over the period 2012 to 2021, well in excess of projected Medicare spending.

There is encouraging early evidence that overall health system spending is slowing and that Medicare spending in particular is slowing. CBO and the HHS Office of the Actuary substantially overestimated growth in health spending and Medicare spending pre-reform. In 2020, Medicare spending is now projected to be \$935 billion, 12.7 percent below pre-reform estimates of \$1.1 trillion for a cumulative reduction of \$689 billion over 2011–2020 (Exhibit 13).

This lower spending rate has improved the fiscal outlook for Medicare. Prior to the enactment of ACA, the Medicare Hospital Insurance (Part A) Trust Fund, which pays

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<sup>8</sup> Congressional Budget Office, "Letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act" (Washington, D.C.: Congressional Budget Office, July 2012).

<sup>9</sup> J. Holahan and S. McMorrow, "Medicare and Medicaid Spending Trends and the Deficit Debate," *New England Journal of Medicine*, Aug. 2, 2012 367(5):393–95.

<sup>10</sup> Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditure Data, accessed July 2012 at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>.

for hospital and other facility-based services and is financed by an earmarked payroll tax, was projected to become insolvent by 2017.<sup>11</sup> Immediately after enactment, it was estimated to be solvent to 2029. Now—even with the economic contraction in 2008 that reduced payroll tax revenues—it is projected to be solvent until 2024.

One major reason for this improved outlook is the ACA itself—particularly the freeze on Medicare Advantage plan payments and the productivity update adjustment in provider payments. But it also may reflect more fundamental changes in the health care delivery system as a result of a decade-long focus on quality improvement and efforts by the industry to position itself to take advantage of new payment and delivery system innovations. David Cutler of Harvard University and I argued, at the time of ACA enactment, that CBO was not giving sufficient weight to the impact of provider payment and delivery system innovations.<sup>12</sup> Projected trends in our report suggest that the ACA will achieve Medicare savings of \$686 billion over 2011-2020, compared to \$510 billion estimated by CBO (Exhibit 14). Now CMS projections for Medicare spending over this period are \$689 billion lower than their pre-reform estimate—in large part attributable to ACA as well as savings occurring as a result of changes in the pharmaceutical and health care services industry and positioning of the industry to take advantage of future changes in Medicare.

There is concern, however, that the retirement of the post-World War II generation will increase the numbers of beneficiaries at the same time that the decline in fertility rates in the 1970s and 1980s has lowered the number of active workers in the labor force. The number of Medicare beneficiaries is projected to grow to 80 million in 2030 while the number of workers per beneficiary has dropped from 4:1 in 2000 to 3.4:1 in 2010 and is projected to drop further to 2.3:1 in 2030 (Exhibit 15). As a result, expenses—or outflow from the Part A Trust Fund—is projected to grow faster than payroll tax revenues, or inflow to the Part A Trust Fund.

To bring the Trust Fund into balance, more revenues will be needed, spending growth will need to be further restrained, or beneficiaries will need to pay more of their own health care expenses either directly or through premiums. Requiring current beneficiaries to pay more premiums or out-of-pocket costs is a difficult choice, given that beneficiaries are already paying significant shares of their incomes on health care and have limited retirement savings.

Very few beneficiaries have high incomes. Only 3 percent have incomes over \$100,000 in 2006, and only one-fifth have incomes over \$40,000 (Exhibit 16). Higher-

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<sup>11</sup> Both Supplementary Medical Insurance (Part B), which pays for physician and other ambulatory care and medical supplies, and Prescription Drug Coverage (Part D) are financed by beneficiaries' monthly premiums and open-ended draws on general revenues, so they are fully financed by definition, but they represent a progressively greater burden on both beneficiaries' resources and the federal government's budget.

<sup>12</sup> D. M. Cutler, K. Davis, and K. Stremikis, *The Impact of Health Reform on Health System Spending* (Washington, D.C. and New York: Center for American Progress and The Commonwealth Fund, May 2010).

income beneficiaries already pay higher income-related Part D and Part B premiums. Since the early 1990s, workers with higher incomes have paid Medicare payroll taxes on their entire incomes, which are not subject to an earnings ceiling like Social Security. So high-income beneficiaries have contributed significantly to Medicare over their working lifetimes and continue to do so in retirement.

Additional revenues may well need to be part of the solution. The Medicare trustees estimate that increasing the payroll tax 1.35 percentage points from 2.90 to 4.35 percent would balance the Part A Trust Fund for the next 75 years.<sup>13</sup> Alternatively, immediately reducing expenditures by 26 percent would achieve long-run stability, but would do so only at the risk of suppressing spending faster than hospitals and other providers can innovate to improve productivity and efficiency.

Given this dilemma, it is appropriate to have a national debate on the future of Medicare with careful consideration of the consequences of alternative strategies. One strategy would limit the government's fiscal liability by converting Medicare to a premium support program and capping the rate of growth of government contributions. Another strategy is to transform the health care delivery system, providing significant incentives for physicians, nurses, hospitals, and other health care providers to deliver high-quality care while holding total expenditures on health care to the same growth as the rest of the economy and stabilizing the share of the economy devoted to health care. This directly attacks the overall health care cost problem, rather than assuming the elderly and disabled beneficiaries can achieve significant economies in their care.

### **Converting Medicare to “Premium Support”**

Guaranteeing that Medicare continues to meet its basic goal of providing health and economic security to 50 million current beneficiaries—as well as the post-World War II generation as it reaches retirement—is an essential priority for the nation. Starkly different choices have been proposed for the future of the program: converting it to a fixed dollar premium support system or continuing Medicare as a guaranteed benefit program. Despite the successful track record of Medicare and that fact that its projected spending growth over the coming decade is below the growth in the economy, some policymakers have proposed major restructuring of the program in an effort to lower federal spending on health and reduce the federal budget deficit further.

The philosophy behind premium support proposals holds that patients are best positioned to eliminate overuse of services, shop for lower cost care, and pick lower-cost health plans. Rather than guaranteeing that Medicare will pay the cost of a defined set of benefits, beneficiaries would receive an allowance based on their age, health status, and

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<sup>13</sup> Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2012 Annual Report* (Washington: CMS, April 2012).

income to be applied toward the purchase of a health plan. Over time, the dollar allowance would be capped at the GDP growth rate per capita plus 0.5 percent (in the 2012 House Budget version). If the premium exceeded the dollar allowance, the enrollee would be financially responsible for the excess. If the premium is less than the dollar allowance, the enrollee could keep the savings.

A number of different premium support proposals have been advanced, with variations in whether the enrollee would have the option of using the allowance to buy traditional Medicare and how growth in the allowance would be capped over time. Three versions are particularly relevant:

- The 2011 House of Representatives Medicare premium support proposal put forward by Rep. Paul Ryan, chairman of the House budget committee, along with the repeal of the ACA coverage and Medicare benefit improvement provisions but retention of the Medicare savings provisions, which was passed by the House but not acted upon by the Senate.
- The 2012 House of Representatives Medicare premium support proposal, also put forward by Rep. Ryan, and passed by the House in 2012 along with the repeal of the ACA coverage and Medicare benefit improvement provisions, but retention of the Medicare savings provisions.
- Governor Romney's Medicare position which endorses the premium support strategy and the full repeal of the ACA including the coverage and Medicare benefit improvement provisions as well as repeal of the Medicare savings provisions.

### **2011 House of Representatives Budget Resolution—Medicare Premium Support Provisions**

Budget Chairman Paul Ryan included a Medicare premium support plan in a budget proposal that passed the U.S. House of Representatives in April 2011.<sup>14</sup> It was part of a budget resolution to cut the top rate on taxes for individuals and corporations, exempt military spending from cuts, and make deep cuts in domestic spending. It would have repealed the health insurance expansion provisions and capped growth in federal budget outlays for Medicare and Medicaid. The plan was estimated to reduce federal spending by \$5.8 trillion over 10 years, \$4.2 trillion of which would have been used to finance tax cuts, leaving \$1.65 trillion for deficit reduction.

The House proposal would have converted Medicare to a fixed dollar contribution toward the purchase of private health insurance when individuals now under age 55

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<sup>14</sup> K. Davis, "Stark Choices: The Health Care Budget Proposals from the President and the House of Representatives," *The Commonwealth Fund Blog*, April 29, 2011.

qualified for Medicare, and would have repealed the health reform provisions expanding health insurance coverage, restored the doughnut hole in Medicare prescription drug coverage, replaced Medicaid with a block grant to states, and sharply restricted the growth in the federal budgetary commitment to Medicare and Medicaid over time.

For those under age 55, the House budget resolution would have replaced Medicare benefits with a fixed dollar premium support allowance toward the purchase of private insurance. All beneficiaries becoming eligible for Medicare on or after January 1, 2022 would have been given a voucher equal to \$8,000 on average, or the projected amount of the government's contribution for traditional Medicare in that year. This payment would have been used by beneficiaries to purchase coverage from competing private plans offered in a newly established Medicare exchange.

Starting in 2022, the allowance would have been capped and risen each year with the consumer price index, estimated by the Congressional Budget Office to increase 3 percentage points less than the rise in health care costs each year. The premium support allowance would have varied with health status, age, and income. In particular, people in the top 2 percent of the income distribution would have received 30 percent of the allowance, and the next 6 percent would have received 50 percent of the allowance. Beginning in 2022, the age of eligibility for Medicare would have increased by two months per year until it reached 67 in 2033.

Under the 2011 House resolution, the federal government would lose its leverage as a major purchaser of health care and therefore, its ability to lower the rising health care costs that are at the center of the budget deficit problem. Without effective measures to control costs, such as incentives to reduce hospitalizations, the cuts in Medicare and Medicaid would translate into considerably higher costs for vulnerable low-income, elderly, and disabled individuals, as well as working families.

Some specific consequences of the 2011 House budget resolution included:

- **Tight limits on growth in federal budget outlays for Medicare and Medicaid**  
The House resolution would have indexed the Medicare voucher and Medicaid per capita outlays with the consumer price index, which is projected to grow at 2.5 percent annually. Private health spending per capita, by contrast, is projected by the Centers for Medicare and Medicaid Services to grow almost 3 percentage points faster—5.1 percent annually—over the coming decade. As a result, Medicare and Medicaid would have covered a lower portion of health care spending over time under the House resolution. According to the Congressional Budget Office (CBO), federal spending on Medicare, Medicaid, the Children's Health Insurance Program, and subsidies for health insurance premiums would be reduced by 63 to 66 percent in 2050 relative to current baseline projections.

- **Higher cost of private coverage for Medicare beneficiaries**

The CBO estimated that privatizing Medicare would cost, rather than save, money. Initially, private coverage for similar benefits as currently covered by Medicare would be 12 percent more expensive than Medicare because of higher administrative costs and higher provider payment rates. By 2030, private coverage would be about 40 percent more expensive than Medicare for the same benefits.<sup>15</sup> Simply put, at the outset, federal costs could go up and less federal dollars would go to providing benefits and more would go to insurance profits and higher payments to providers.

- **Higher costs for Medicare beneficiaries**

Since the federal government would have tied future vouchers to the consumer price index, rather than the rising costs of health insurance or medical care, the federal government would spend less over time as beneficiaries spend more. By replacing Medicare with an allowance or defined contribution for private insurance that buys less for the premium dollar, the value of the voucher would erode over time, resulting in higher premiums for beneficiaries and/or reductions in benefits. CBO estimated that by 2022, new enrollees would have to pay at least \$6,400 more out-of-pocket to buy coverage comparable to traditional Medicare. By 2030, out-of-pocket costs would triple, and the portion of a typical 65-year-old's health care expenses paid for by the beneficiary would increase from 30 percent currently to 68 percent under the House of Representatives budget resolution. High-income beneficiaries would pay nearly all of their own health care costs. CBO also indicated that some beneficiaries would simply be unable to purchase any plan and would become uninsured.

The Kaiser Family Foundation illustrated the implications for a typical beneficiary turning 65 in 2022. 65-year old beneficiaries would pay \$5,630 including both their out-of-pocket costs and Part B and D premiums in 2022 (Exhibit 17). Under the alternative fiscal scenario which assumes that the sustainable growth rate formula for Medicare physician fees would be changed, beneficiary cost would increase to \$6,260. Under the Ryan Premium Support proposal, it would be \$12,500 with based on the extended baseline projection scenario. Beneficiary spending for a typical 65-year old would increase from one-fourth of average Social Security income in 2022 to almost half of their Social

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<sup>15</sup> Commonwealth Fund calculation based on Figure 1, Page 22 in CBO letter to the Honorable Paul Ryan, April 5, 2011, available at [http://www.cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan\\_Letter.pdf](http://www.cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf).

Security checks (\$12,500 or 49% of average Social Security income of \$25,560) (Exhibit 18).

The higher cost to beneficiaries results in large part because private insurance is more costly than Medicare. Total spending for a 65-year old in 2022 would be \$13,530 under the extended baseline scenario, \$14,760 under the alternative fiscal scenario, and \$20,500 under the Path to Prosperity scenario.

## **2012 House of Representatives Budget Resolution—Medicare Premium Support Provisions**

In the most recent Ryan proposal,<sup>16</sup> reflected in the Budget Resolution passed by the House of Representatives in March 2012,<sup>17</sup> individuals becoming eligible for Medicare beginning in 2023 would be given a choice of private plans competing with traditional Medicare in a newly-created Medicare Exchange. In addition, the age of eligibility would be increased gradually to age 67 by 2034. Each beneficiary would be provided with a premium support subsidy equal to the lesser of the premium charged by the second-least expensive private plan available in their area or local per capita costs in traditional Medicare. The per capita allowance would be limited to the rate of growth in the nation's GDP per capita, plus 0.5 percentage points.

If a beneficiary chooses a costlier plan, he or she would be responsible for paying the difference between the premium support subsidy amount and the chosen plan's monthly premium. Conversely, if the beneficiary chooses a less costly plan, he or she would receive a rebate for the difference. Private health plans participating in the exchange would be required to cover at least the actuarial equivalent of the traditional Medicare benefit package and to offer coverage to all beneficiaries. In addition, the federal contribution to beneficiaries' health plans would be adjusted to account for their age and health status. Lower-income beneficiaries would be eligible for subsidies.

The CBO has estimated the impact on the federal budget using assumptions based on Chairman Ryan's proposal and his report, *Path to Prosperity*.<sup>18</sup> As expected, projected federal spending on Medicare would be significantly lower in the long run under the Ryan proposal than under current law. By 2050, spending for new enrollees under the Ryan proposal would be 35 percent lower than under current law, but Medicare beneficiaries could bear substantial additional costs.

The latest Ryan premium support allowance is capped at the growth of GDP per capita plus 0.5 percent rather than the CPI. CBO estimated it will also raise costs for

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<sup>16</sup> Congressman Paul Ryan's Web site, <http://paulryan.house.gov/issues/issue/?IssueID=9969>.

<sup>17</sup> U.S. House of Representatives, Committee on the Budget, [Concurrent Resolution on the Budget—Fiscal Year 2013, Report 112–421](#) (Washington, D.C.: Government Printing Office, March 23, 2012).

<sup>18</sup> Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, March 2012, available at [http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan\\_Specified\\_Paths\\_2.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan_Specified_Paths_2.pdf).



beneficiaries, with beneficiary cost rising over time (Exhibit 19). Our estimate is that average private health insurance premiums would exceed the allowance by \$4,250 in 2030 (Exhibit 20).

This reduced government spending would come with consequences—increasing beneficiary cost substantially and increasing total cost of care for beneficiaries as a result of higher payments to physicians, hospitals, and other providers. Beneficiaries would bear the full fiscal brunt of rising costs, while insurance companies and providers would experience increased revenues.

It is important to consider several facts when weighing the merits of any proposal that places the onus for cost control on beneficiaries choosing among competing private plans. First, as previously noted, private health insurance is more costly than public coverage given its larger administrative costs, higher provider payments, and less efficient risk pooling. The Congressional Budget Office estimates that utilizing private coverage for a set of benefits similar to what is currently covered by Medicare would be 12 percent more expensive in 2022.<sup>19</sup> By 2030, private coverage would be about 40 percent more expensive than Medicare for the same benefits.

The nation’s experience with Medicare Advantage program suggests that beneficiaries would be less satisfied and more likely to experience access problems when opting for a private plan. Thirty-two percent of Medicare Advantage beneficiaries reported at least one access problem due to cost, compared with 23 percent of those with traditional coverage. This may, in part, reflect Medicare Advantage beneficiaries’ experiences with private health maintenance organization (HMO) plans that offer lower premiums in return for limited access to a smaller network of providers.

The widespread use of competing private plans under a premium support scenario has the potential to undermine the stability and effectiveness of Medicare by fragmenting the risk pool. Even if Medicare beneficiaries retained a choice of enrolling in traditional Medicare, physicians and hospitals that could receive substantially higher payment from private plans would be likely to opt-out of participation in Medicare nullifying it as a genuine choice for beneficiaries.

Dividing Medicare beneficiaries across multiple private plans would undermine the leverage the program currently has to drive efficiency among providers and widespread change across the entire U.S. health system. Moreover, while the premium support proposal contained in the latest House budget resolution included some protections against risk selection (or “cream skimming”) by private insurance companies, officials would need to be particularly vigilant about plans covering a relatively low number of beneficiaries with complex health care needs.

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<sup>19</sup> Congressional Budget Office, *Long-Term Analysis of a Budget Proposal by Chairman Ryan* (Washington, D.C.: Congressional Budget Office, April 2011).

## **Romney–Ryan Medicare Policy Position**

Governor Romney has embraced the Medicare premium support strategy capped at the rate of growth of GDP per capita plus 0.5 percent (although other specifics are not available), and supports repealing the ACA, including its Medicare savings provisions. Doing so would restore the higher levels of payments to providers and private plans. Under this proposal, beneficiaries would have a choice between traditional Medicare and private plans—using a “premium support” contribution from the government, adjusted for the beneficiary’s income and health status, toward the premium payment with any additional cost borne by the beneficiary. He otherwise vows not to change the program for those nearing retirement, but would gradually raise the age of eligibility for Medicare to age 67 between 2023 and 2034.

Repeal of the ACA would increase the federal budget deficit by \$109 billion over the next decade and shorten the time until the Medicare Part A Trust Fund becomes insolvent from 2024 to 2016.<sup>20</sup> CBO recently estimated that repealing the Affordable Care Act would increase Medicare program spending by \$716 billion over the 10-year period from 2013 through 2022.<sup>21</sup> The largest portion of that increase would come from undoing changes to provider payments reflecting increases in productivity and restoring the gradual elimination of overpayments to Medicare managed care plans that benefit insurance companies and a minority of beneficiaries at the expense of all Medicare beneficiaries.<sup>22</sup> A majority of these savings come from trimming payment increases to hospitals by 1 percentage point annually, reducing overpayments to Medicare managed care plans, and instituting various provider payment reform initiatives. Repealing the law entirely would increase the federal deficit.

Repeal of the Affordable Care Act would also eliminate provisions that improve benefits for beneficiaries. These include provisions intended to help reduce costs for prescription drugs, expand coverage for preventive care, provide more help for low-income beneficiaries, provide information for beneficiaries to make more informed health care choices, deter fraud and abuse, and support high-quality, coordinated, and comprehensive care.<sup>23</sup> Starting in 2010, Medicare beneficiaries who reached the coverage gap—or “doughnut hole”—in prescription drug coverage (\$2,830) automatically received \$250 rebates. In 2011, a new Medicare coverage gap discount program provided a 50

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<sup>20</sup> Centers for Medicare and Medicaid Services, *Medicare Stable, But Requires Strengthening* (Washington, D.C.: CMS Office of Public Affairs, April 2012).

<sup>21</sup> D. Elmendorf, *Letter to John Boehner, Speaker, U.S. House of Representatives on the Direct Spending and Revenue Effects of H.R. 6079, the Repeal of Obamacare Act* (Washington, D.C.: Congressional Budget Office, July 24, 2012).

<sup>22</sup> *Ibid.*

<sup>23</sup> S. Guterman, K. Davis, and K. Stremikis, *How Health Reform Legislation Will Affect Medicare Beneficiaries* (New York: The Commonwealth Fund, March 2010).

percent discount on brand-name drugs to Medicare Part D enrollees who spend enough on prescription drugs to enter the doughnut hole. Under the program, manufacturers provide discounts to eligible beneficiaries at the point-of-sale in the pharmacy or by mail order. Additional discounts on brand-name and generic drugs are phased in to completely close the doughnut hole for all Part D enrollees by 2020.

Millions of beneficiaries have already benefitted from these new provisions in the law:

- **Closing the Medicare prescription drug benefit doughnut hole.** An estimated 5.1 million people with Medicare saved over \$3.1 billion through rebates and the 50 percent discount over 2010 and 2011. In 2012, 70,000 people with Medicare benefitted from the discount, saving approximately \$65 million.
- **New preventive care services without cost sharing and annual wellness visit with no copay.** More than 32.5 million seniors have already received one or more free preventive services, including the new annual wellness visit.

Repeal of the Affordable Care Act would also eliminate provisions supporting delivery system innovation, including models like the patient-centered medical home and the accountable care organization. Both models emphasize the role of primary care and the need to coordinate care across providers and settings, are being developed to improve care and stabilize costs, and encourage meaningful use of health information technology. A major set of ACA reforms also changes the way hospitals and other health care providers are paid to focus more on the quality and effectiveness of care patients receive, rather than solely rewarding providers for the volume and intensity of their services regardless of the value to patients. Repealing the law would also eliminate provisions to provide information for beneficiaries to make more informed health care choices, deter fraud and abuse, and support safe, accessible, coordinated, and comprehensive care that effectively responds to patients' needs.

### **Continuing Medicare as an Essential Benefit by Building on the Affordable Care Act**

A different approach to preserve Medicare's guaranteed benefits as the post-World War II population reaches retirement is retaining and building on the innovations contained in the Affordable Care Act. This strategy is based on the philosophy that doctors, nurses, and other health professionals are best positioned to eliminate waste, duplication, overuse of services, and costly and harmful medical errors. Instead of shifting financial costs onto beneficiaries, it would hold health care providers accountable for achieving high-quality care, excellent outcomes for patients, and ensuring that the total cost of health care is in line with what the nation can afford. It puts the accountability in the hands of those directly responsible for providing care.

It permits physician-led accountable care organizations to share in savings if they hold costs below a target rate of growth (Exhibit 21). The Center for Medicare and Medicaid Innovation is testing a variety of pilot payment innovations to reward providers for lowering cost while improving quality. The Affordable Care Act invests in rapid and systematic testing of innovative models of health care delivery and payment to learn what works best. It also gives the Secretary of Health and Human Services authority to spread successful innovation throughout the Medicare program. It contains many provisions that improve benefits for beneficiaries, allow providers to be rewarded for delivering high-quality care, and place the program on more stable financial footing.

Moving the U.S. health system toward a higher level of performance, with sustainable access to affordable care, improved quality and patient-centeredness, greater accountability for health outcomes and treatment costs, and enhanced population health cannot be accomplished by the federal government alone. State and local governments, businesses, providers, and households are under increasing pressure due to the unsustainable rate of cost growth and all must play a role. A high performance health system is not only consistent with, but also necessary for, controlling health care spending into the future. Policies to slow health spending growth must address factors across the health system so that the immediate problems facing governments at all levels—as well as businesses and households—can be ameliorated while at the same time achieving long-term stability (Exhibit 22, 23).

### **The Future of Medicare: Converting to Premium Support or Continuing as a Guaranteed Benefit Program**

President Obama, in continuing to implement the Affordable Care Act, would expand Medicare beneficiaries' access to preventive care, reduce the cost of prescription drugs, provide more help for low-income beneficiaries, provide better information for beneficiaries to make more informed health care choices, and encourage more coordinated care. The Affordable Care Act also slows the growth of payments to private Medicare Advantage plans and providers and raises premiums for high-income beneficiaries, extending the solvency of the Medicare Hospital Insurance Trust Fund.

Governor Romney, in repealing the Affordable Care Act, would shorten the life of the Trust Fund, increase the federal budget deficit, and eliminate improved prescription drug and preventive services for Medicare beneficiaries. Over time, he would reduce Medicare program spending by increasing the eligibility age for Medicare coverage and converting Medicare into a defined contribution program. Under this program, beneficiaries would have a choice between traditional Medicare and private plans—using a “premium support” contribution from the government, adjusted for the beneficiary's income and

health status, toward the premium payment with any additional cost borne by the beneficiary. This would increase the typical beneficiary's out of pocket burden for health care.

President Obama's continued implementation of the Affordable Care Act also would move forward with changes in how care is organized, delivered, and paid for. Many of the law's provisions are focused on Medicare, as well as Medicaid and the Children's Health Insurance Program, but the law also encourages multipayer initiatives that include both the public and private sectors. Models like the patient-centered medical home and the accountable care organization, which emphasize the role of primary care and the need to coordinate care across providers and settings, are being developed to improve care and stabilize costs. Both models encourage meaningful use of health information technology.

It permits physician-led accountable care organizations to share in savings if they hold costs below a target rate of growth. The Center for Medicare and Medicaid Innovation is testing a variety of pilot payment innovations to reward providers for lowering cost while improving quality.

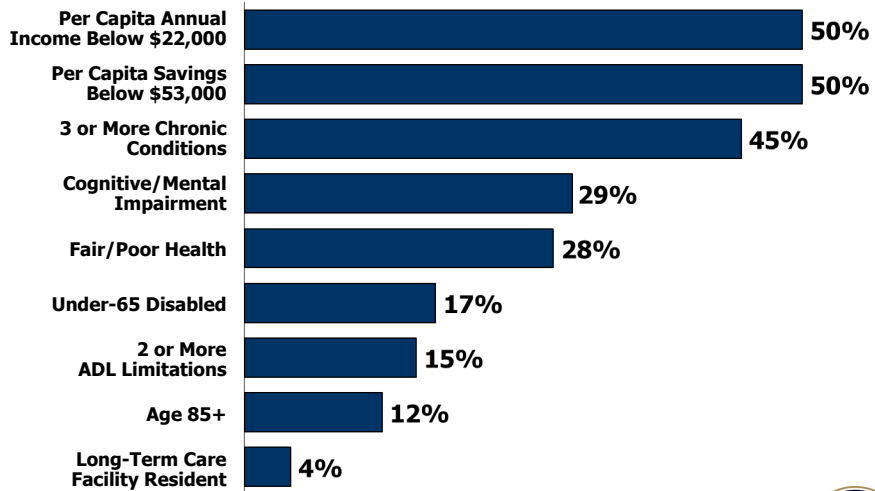
The Affordable Care Act invests in rapid and systematic testing of innovative models of health care delivery and payment to learn what works best. It also gives the Secretary of Health and Human Services authority to spread successful innovation throughout the Medicare program if innovations lower cost, improve quality, or both, without being to the detriment of either. It contains many provisions that improve benefits for beneficiaries, allow providers to be rewarded for delivering high-quality care, and place the program on more stable financial footing.

The Affordable Care Act would give physicians, hospitals, and other health care providers an incentive to reduce the rate of growth in Medicare outlays by creating opportunities to share in savings. President Obama has further stated that through these reforms he would attempt to hold the rate of growth in health care spending to GDP plus 0.5 percent, the same goal as under the premium support proposal. However, under the premium support strategy, the beneficiary is at financial risk when private insurance premiums exceed the Medicare spending target. Under the shared savings strategy, providers have the opportunity to reap benefits when costs are below the target for Medicare spending. Beneficiaries also benefit from lower Medicare costs as their premiums and out-of-pocket expenses are reduced by the slower growth in Medicare spending (Exhibit 24).

As policymakers and the nation confront the urgent need to control health spending, while continuing to improve the quality and efficiency of care delivered, these activities provide a foundation on which to build, with the potential to control health spending while moving toward a high performance health system.

### Exhibit 1. Characteristics of the Medicare Population

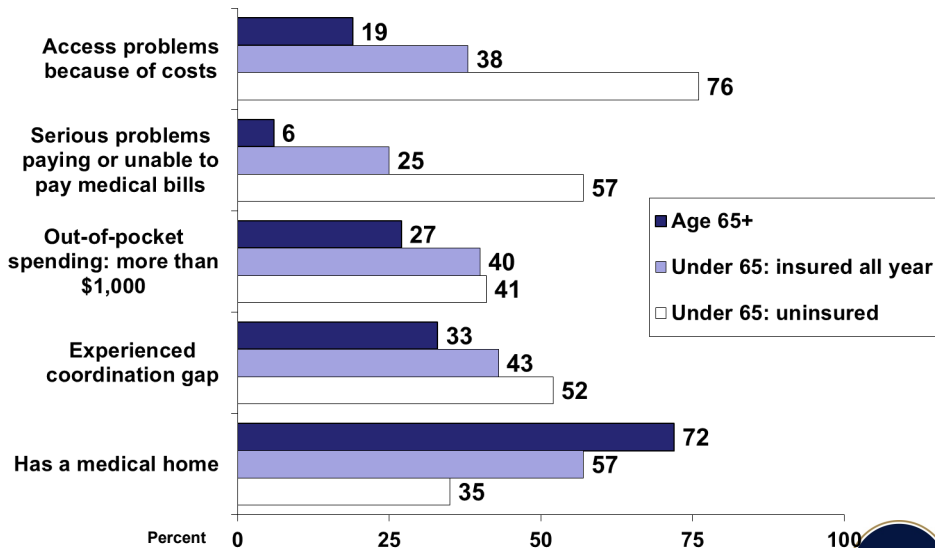
Percent of total Medicare population:



Note: ADL is activity of daily living.  
 Sources: Income and savings data from Urban Institute/Kaiser Family Foundation analysis, 2011. All other data from Kaiser Family Foundation analysis of the Centers for Medicare and Medicaid Services Medicare Current Beneficiary 2008 Access to Care file.



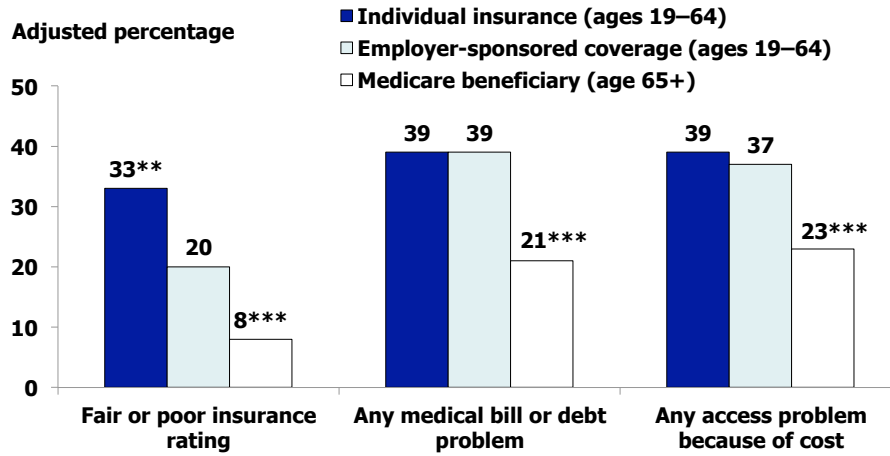
### Exhibit 2. Affordability, Access, and Coordination Experiences in the Past Year, by Age and Insurance Among U.S. Adults



Source: C. Schoen, R. Osborn, D. Squires et al., "New 2011 Survey of Patients with Complex Care Needs in 11 Countries Finds That Care Is Often Poorly Coordinated," *Health Affairs* Web First, published online Nov. 9, 2011.



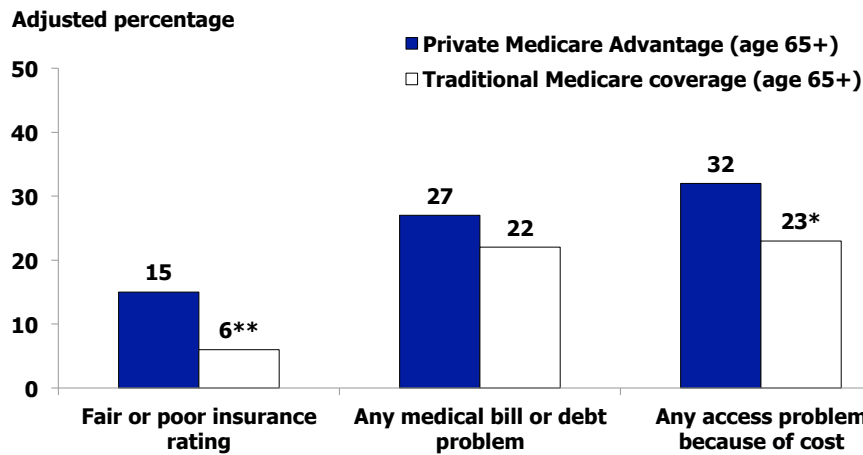
### Exhibit 3. Elderly Medicare Beneficiaries More Satisfied with Insurance, Less Likely to Experience Cost- or Access-Related Problems than Those Covered by Employer or Individual Health Plans



Notes: Medical bill problems include: not able to pay bills, contacted by a collection agency for unpaid medical bills only, had to change way of life because of medical bills, or have medical bills or debt being paid off over time. Access problems include: did not fill prescription, did not get needed specialist care, skipped recommended test or follow-up, had medical problems but did not visit doctor. Indicates significant difference from employer insurance: \*\* p<0.01, \*\*\* p<0.001.  
 Source: K. Davis, K. Stremikis, M. M. Doty, and M. A. Zezza, "Medicare Beneficiaries Less Likely to Experience Cost- and Access-Related Problems than Adults with Private Coverage," *Health Affairs* Web First, published online July 18, 2012.



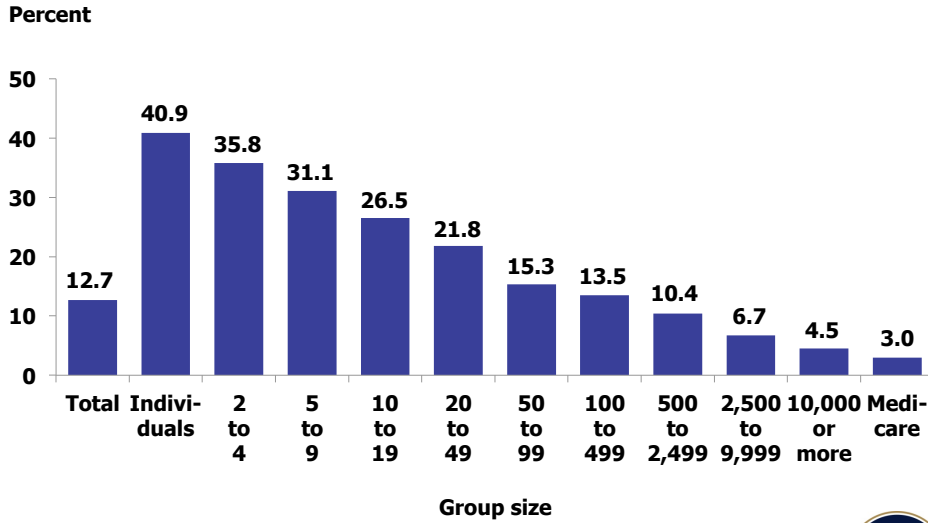
### Exhibit 4. Beneficiaries with Traditional Coverage More Satisfied, Less Likely to Experience Access Problems than Those with Medicare Advantage



Notes: Medical bill problems include: not able to pay bills, contacted by a collection agency for unpaid medical bills only, had to change way of life because of medical bills, or have medical bills or debt being paid off over time. Access problems include: did not fill prescription, did not get needed specialist care, skipped recommended test or follow-up, had medical problems but did not visit doctor. Indicates significant difference from Medicare Advantage: \* p<0.05, \*\* p<0.01.  
 Source: K. Davis, K. Stremikis, M. M. Doty, and M. A. Zezza, "Medicare Beneficiaries Less Likely to Experience Cost- and Access-Related Problems than Adults with Private Coverage," *Health Affairs* Web First, published online July 18, 2012.



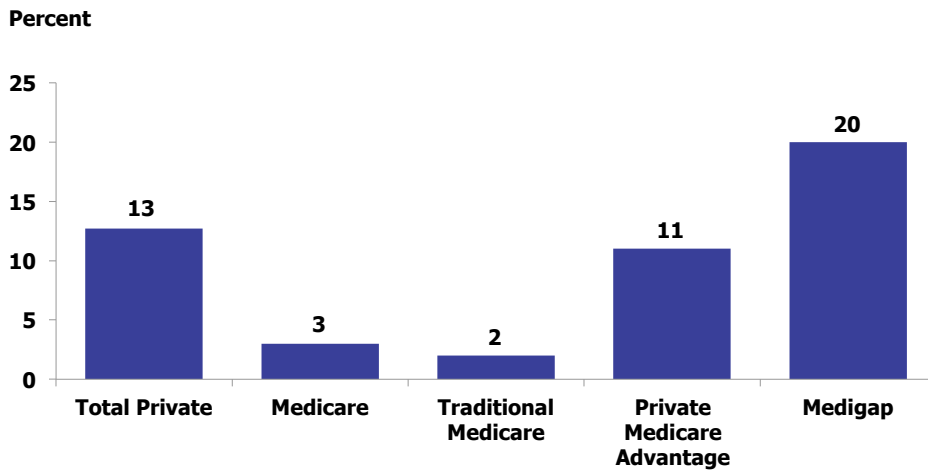
**Exhibit 5. Administrative Costs in Medicare Are Lower than Those in Private Coverage Because of Efficiencies**



Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009); Congressional Budget Office, *Designing a Premium Support System for Medicare*, (Washington: Congressional Budget Office, Dec. 2006).



**Exhibit 6. Administrative Costs in Private Medicare Advantage Coverage Are Five Times Higher than Traditional Medicare**

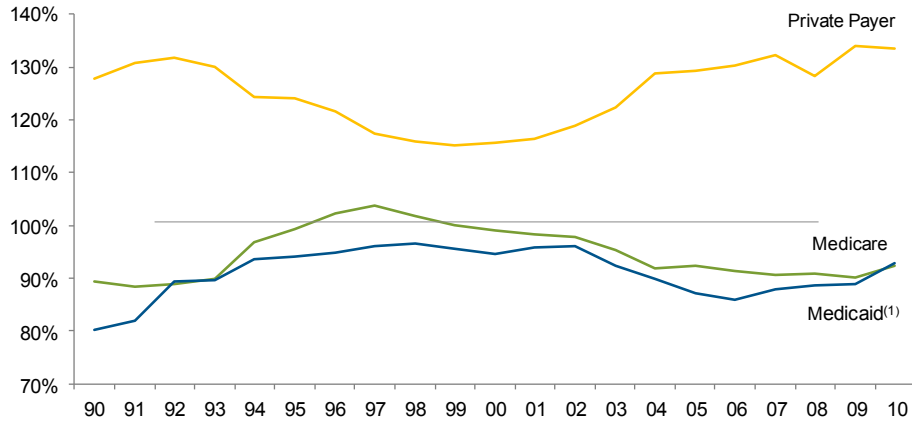


Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009); Congressional Budget Office, *Designing a Premium Support System for Medicare*, (Washington: Congressional Budget Office, Dec. 2006); and S. Sheingold, A. Shartzter, and D. Ly, Steven Sheingold, Adele Shartzter, and Dan Ly, *Variation and Trends in Medigap Premiums*, (Washington: HHS Assistant Secretary for Planning and Evaluation, Dec. 2011).





### Exhibit 7. Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare, and Medicaid, 1990–2010



Note: <sup>(1)</sup> Includes Medicaid Disproportionate Share payments.

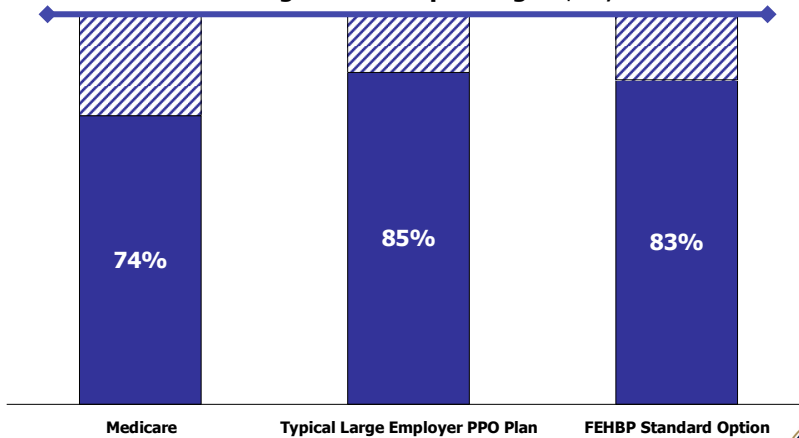
Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2010, for community hospitals.



### Exhibit 8. Medicare Is Less Generous than FEHBP and Other Large Employer Plans

■ Share of Total Spending Paid by Plan in 2007

Total Average Medical Spending = \$14,270

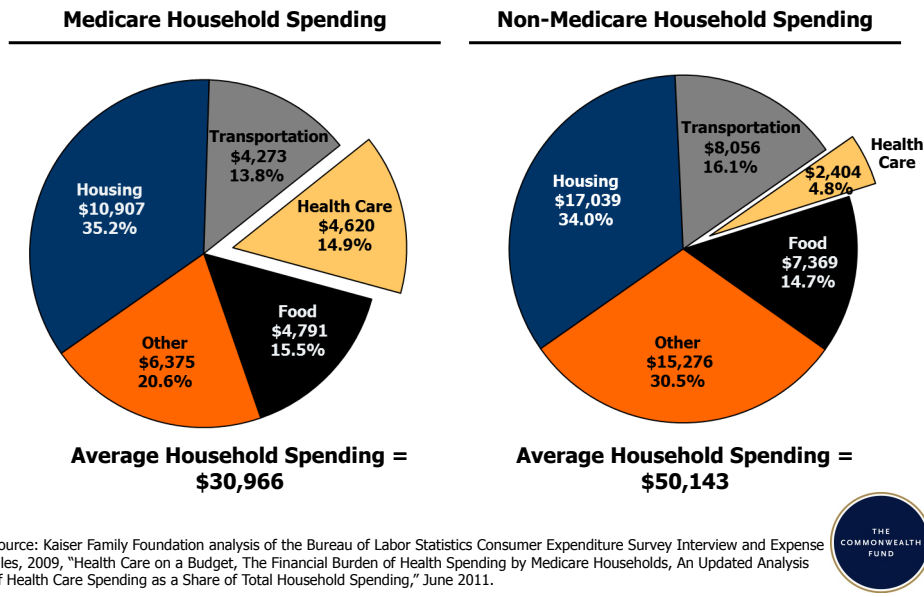


Note: The FEHBP (Federal Employees Health Benefits Program) standard option is offered through Blue Cross Blue Shield. Employer plans include dental benefits.

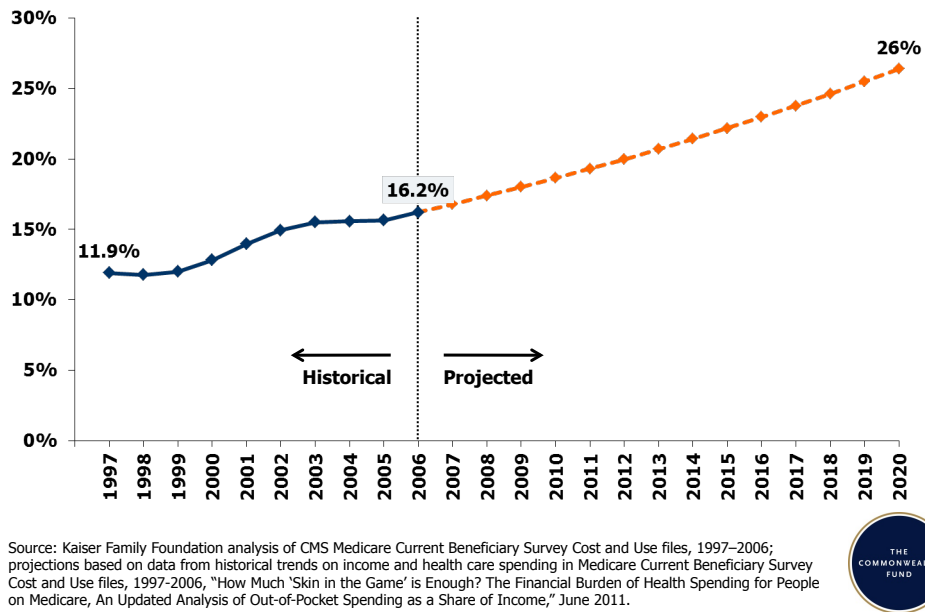
Source: Hewitt Associates analysis for the Kaiser Family Foundation, 2008.



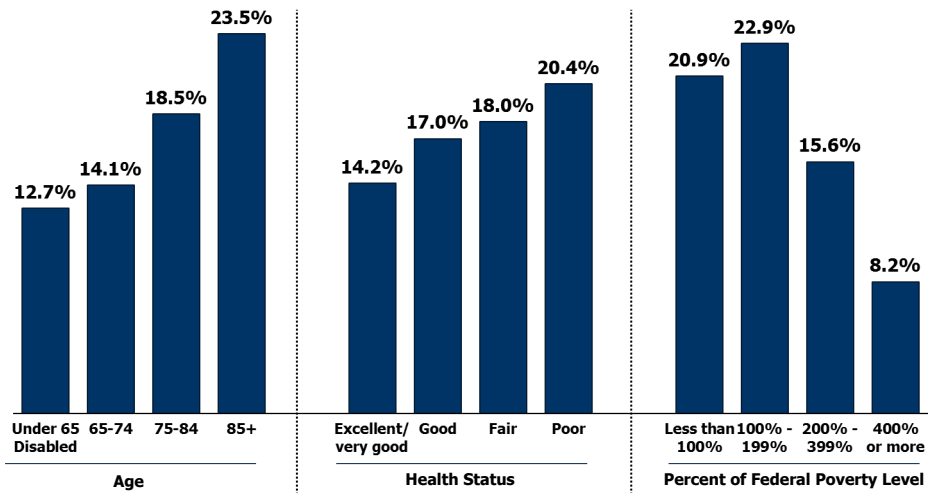
### Exhibit 9. Distribution of Average Household Spending by Medicare and Non-Medicare Households, 2009



### Exhibit 10. Historical and Projected Healthcare Spending Burden Among Medicare Beneficiaries, 1997–2020



### Exhibit 11. Median Out-of-Pocket Health Care Spending as a Percent of Income Among Medicare Beneficiaries, by Demographic Characteristics, 2006

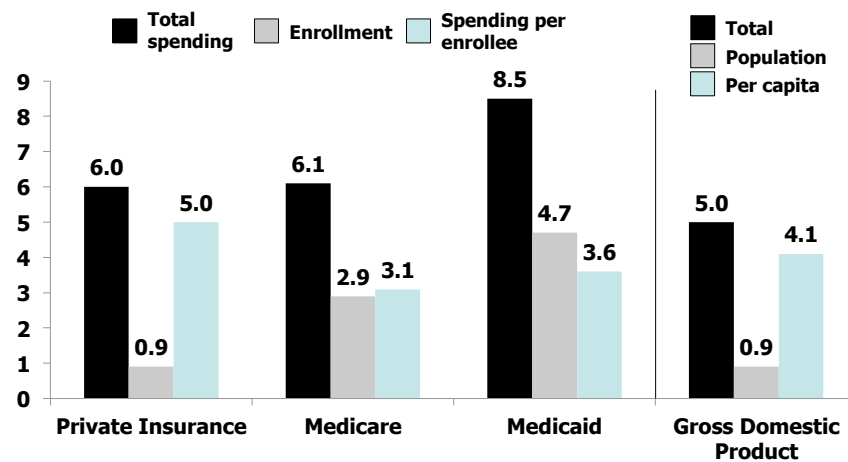


Notes: Includes Medicare Advantage enrollees; and includes institutionalized and non-institutionalized beneficiaries. In 2006, the federal poverty level was \$9,800 for an individual, and \$13,200 for a couple.  
 Source: Kaiser Family Foundation analysis of CMS Medicare Current Beneficiary Survey Cost and Use File, 2006, "How Much 'Skin in the Game' is Enough? The Financial Burden of Health Spending For People on Medicare, An Updated Analysis of Out-of-Pocket Spending as a Share of Income," June 2011.



### Exhibit 12. Health Care Spending and Economic Growth, 2012–2021

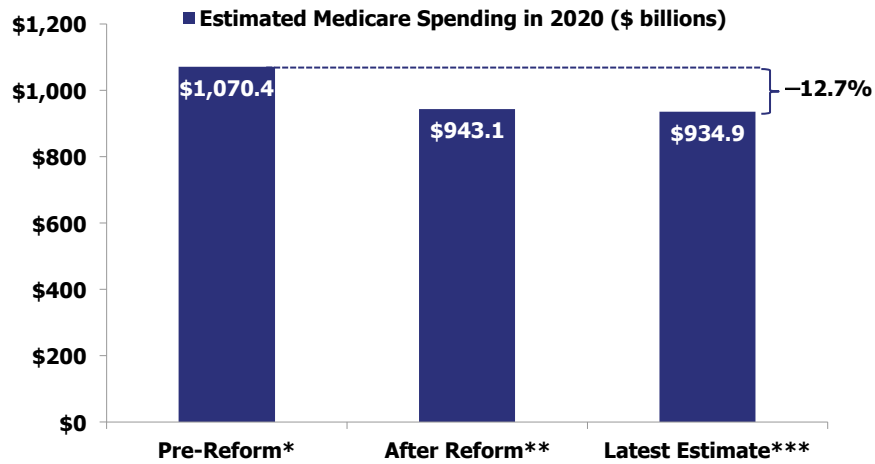
Average annual growth rate (%)



Note: Medicare spending projections will be slightly higher without the physician-fee cut included in current law.  
 Source: J. Holahan and S. McMorrow, "Medicare and Medicaid Spending Trends and the Deficit Debate," *New England Journal of Medicine*, Aug. 2, 2012 367(5):393–95.



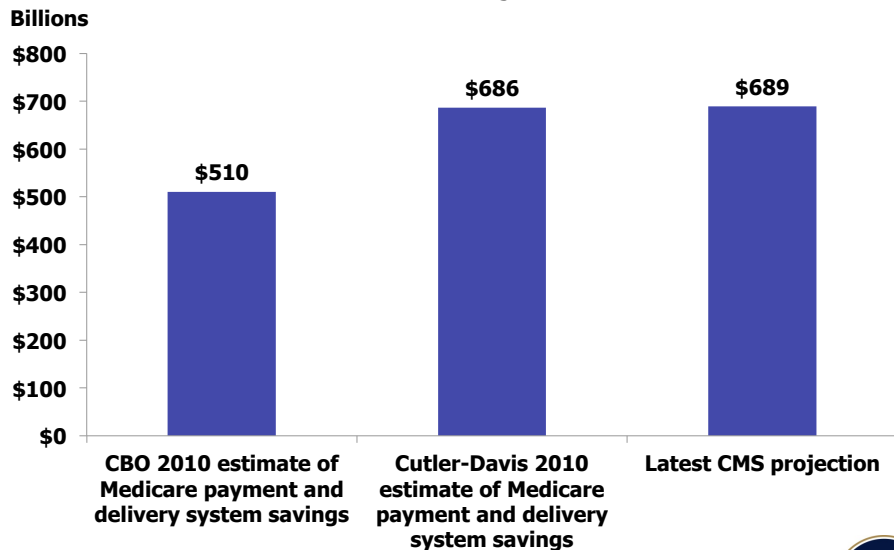
**Exhibit 13. Projected Medicare Spending in 2020  
\$136 Billion Lower Than Pre-Reform Predictions  
Cumulative Reduction of \$689 Billion over 2011–2020**



\* CMS projection as of February 2009 assuming no reform; \*\* CMS projection as of September 2010 after enactment of reform; \*\*\* CMS projection as of July 2012 after enactment of reform.  
Source: CMS spending projections from 2009, 2010, and 2012; Commonwealth Fund estimates extrapolating trends in past one to two years assuming continuation of compounded annual growth rate.



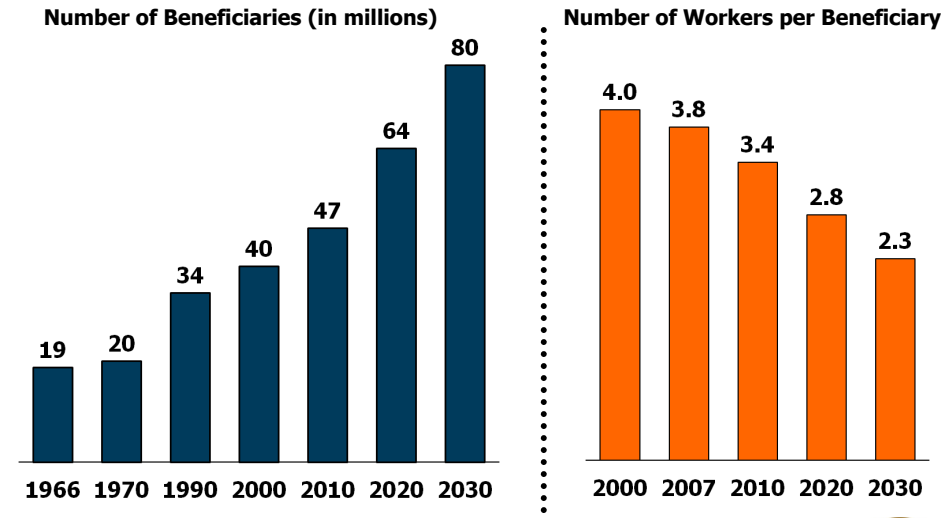
**Exhibit 14. Total 10-Year Medicare Savings  
Relative to Pre-Reform Projections, 2011–2020**



Data: Authors' estimates based on trends in: The Congressional Budget Office, Analysis of H.R. 4872, Reconciliation Act of 2010, Mar. 20, 2010, <http://www.cbo.gov/doc.cfm?index=113798&type=1>; CMS Spending projections from 2009 and 2012; and D. M. Cutler, K. Davis, and K. Stremikis, *The Impact of Health Reform on Health System Spending*, Center for American Progress and The Commonwealth Fund, May 2010.



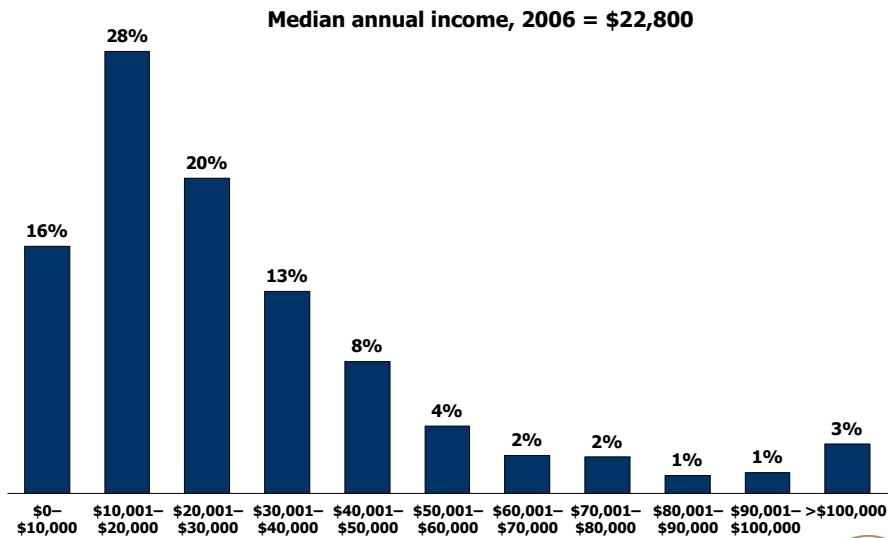
**Exhibit 15. Historical and Projected Number of Medicare Beneficiaries and Number of Workers Per Beneficiary**



Source: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.



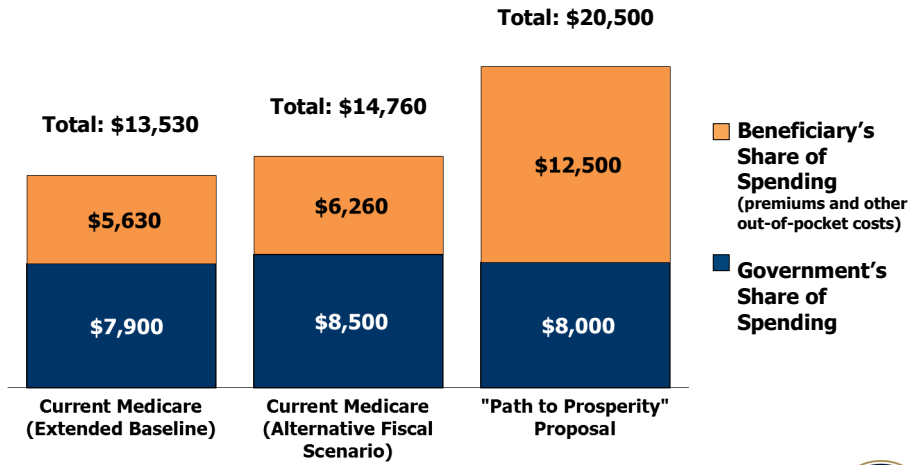
**Exhibit 16. Annual Income of Medicare Beneficiaries, 2006**



Notes: Annual income includes that of individual respondents and their spouses, if applicable. Estimates do not sum to totals in text because of rounding.  
Source: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006.



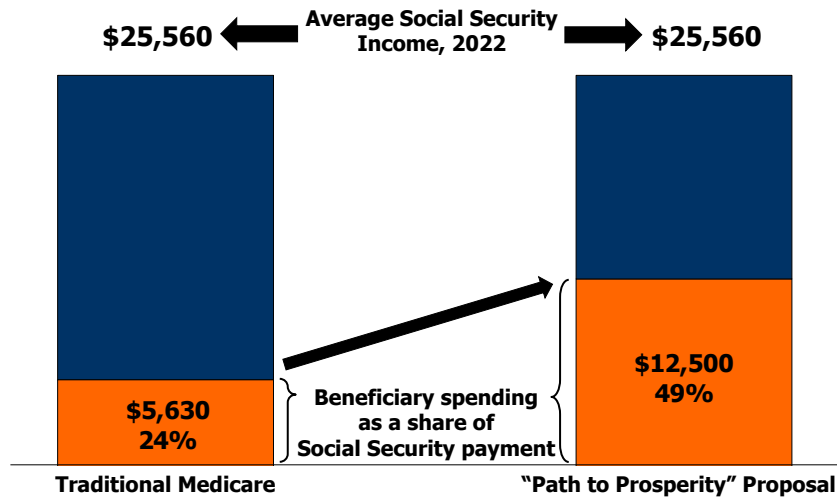
**Exhibit 17. Federal and Medicare Beneficiary Contributions to Total Health Care Spending for a Typical 65-Year-Old, 2022**  
**Current Medicare vs. "Path to Prosperity" Proposal**



Note: Numbers are rounded.  
 Sources: Kaiser Family Foundation analysis. Beneficiary health care spending under Medicare (extended baseline scenario and alternative fiscal scenario) and Chairman Ryan's proposal is calculated based on data in the CBO letter to Chairman Paul Ryan dated April 5, 2011, "Proposed Changes to Medicare in the 'Path to Prosperity'; Overview and Key Questions," April 2011.



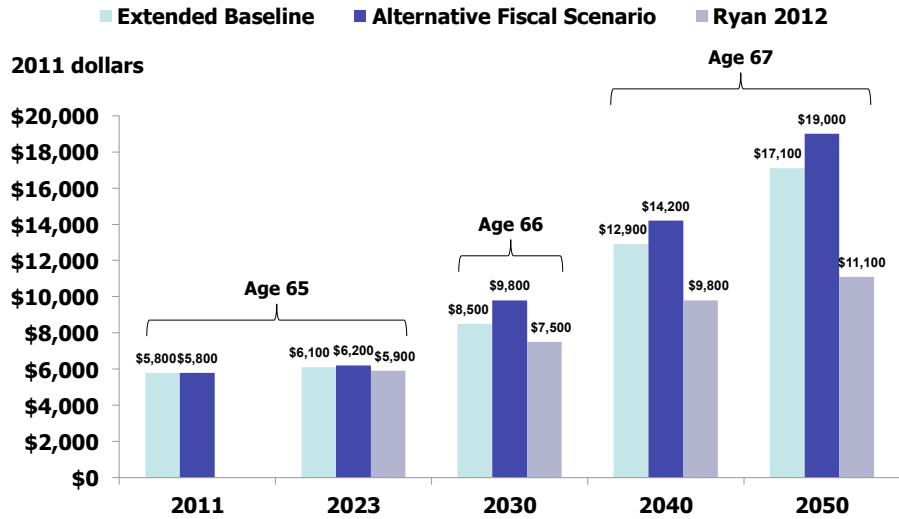
**Exhibit 18. Health Care Spending as a Share of Social Security Income for a Typical 65-Year-Old Medicare Beneficiary, 2022**



Source: Kaiser Family Foundation analysis. Beneficiary health care spending under Medicare (extended baseline scenario) and Mr. Ryan's proposal is calculated based on data in the CBO letter to Chairman Paul Ryan dated April 5, 2011. Social Security income for an average wage 65-year old retiring at age 65 is based on Social Security Administration data (Table VI.F10 of the 2010 Trustees Report) adjusted to current dollars (based on annual CPI projections in Table VI.F6. See <http://www.ssa.gov/OACT/TR/2010/lr6f6.html> factors).



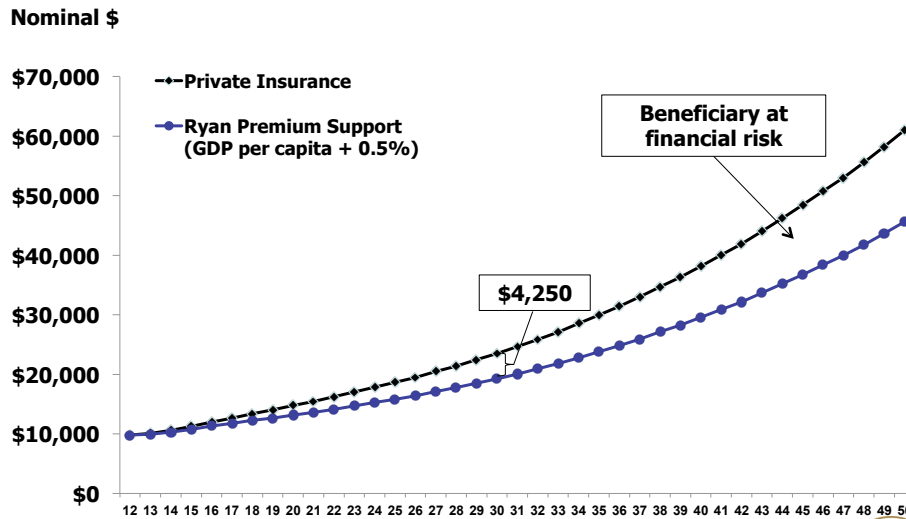
### Exhibit 19. Approximate Average Inflation-Adjusted Medicare Spending for Beneficiaries of Certain Ages



Source: Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan* (Washington, D.C.: Congressional Budget Office, March 2012).



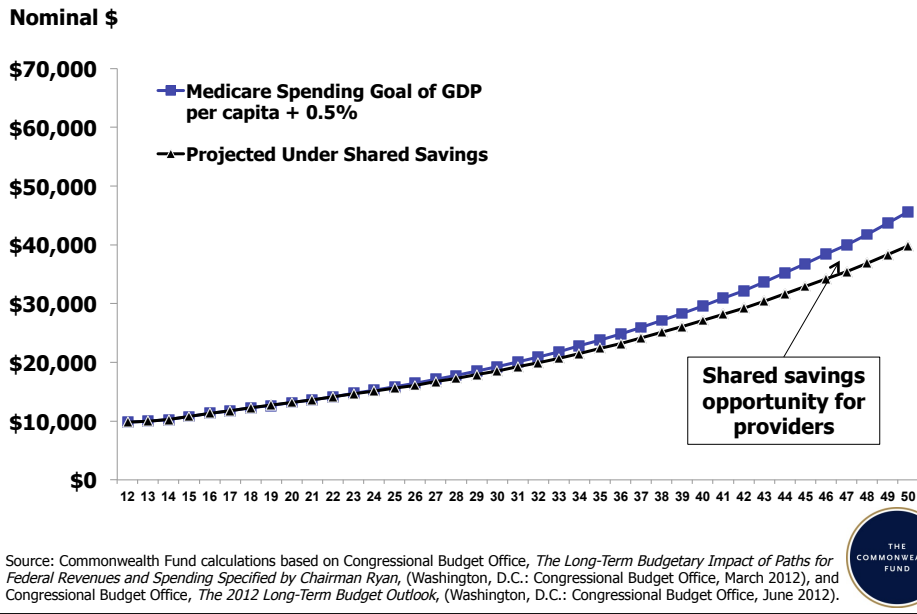
### Exhibit 20. Medicare Spending per Beneficiary Under Premium Support Scenario, 2012–2050



Source: Commonwealth Fund calculations based on Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, (Washington, D.C.: Congressional Budget Office, March 2012), and Congressional Budget Office, *The 2012 Long-Term Budget Outlook*, (Washington, D.C.: Congressional Budget Office, June 2012).



### Exhibit 21. Medicare Spending per Beneficiary Under Shared Savings Scenario, 2012–2050



### Exhibit 22. System Improvement Provisions of the Affordable Care Act

<b>Supporting primary care, prevention, and wellness</b>	Primary care 10% bonus for five years; Medicaid payment rates to primary care physicians no less than 100% of Medicare rates in 2013 and 2014; annual wellness visit and/or health risk assessment for Medicare beneficiaries; preventive services without cost-sharing; local and employer wellness programs; medical home initiatives
<b>Payment reforms to encourage and support improved system performance</b>	Value-based purchasing programs; reduced payment for hospital-acquired conditions and potentially preventable readmissions; bundled payment for acute and postacute care
<b>Accountable care organizations</b>	Accountable care organizations to share savings in Medicare
<b>Controlling health spending</b>	Independent Payment Advisory Board recommendations to meet Medicare expenditure target as well as total system spending nonbinding recommendations; productivity improvement update factor
<b>Resources to promote system improvement</b>	Center for Medicare and Medicaid Innovation; Patient-Centered Outcomes Research Institute; Medicare–Medicaid Coordination Office
<b>Quality improvement and public reporting</b>	Directs the U.S. Department of Health and Human Services to develop national quality strategy, public reporting
<b>Accelerating the adoption of health information technology</b>	Incentives to providers that encourage them to adopt and meaningfully use health information technology
<b>Medicare private plan competition</b>	Levels the playing field between Medicare Advantage and traditional Medicare fee-for-service plans

Source: Commonwealth Fund analysis.





## Exhibit 23. Overview of Center for Medicare and Medicaid Innovation–Sponsored Initiatives

**Bundled Payments for Care Improvement.** Tests four different payment models to encourage improved care coordination and efficiency related to hospital admissions. Currently selecting participants.

**Pioneer ACO Model.** Tests advanced ACO models. 32 organizations are participating.

**ACO Advance Payment Model.** Tests whether advance payments will assist participation in the Medicare ACO programs for physician-led and rural organizations with limited access to start-up capital. 20 organizations are currently participating.

**Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration.** Supports 500 FQHCs' transformation to medical homes through \$6 per member per month payment for each eligible Medicare beneficiary.

**Comprehensive Primary Care Initiative.** Public and private payer collaborative to strengthen primary care, involving risk-adjusted, monthly care management fees, as well shared savings payments. 7 states and 500 primary care practices are currently participating.

**Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents.** Seeks to improve quality of care for people in nursing facilities by reducing preventable inpatient hospitalizations. Currently selecting participants.

**Partnership for Patients.** Nationwide public–private partnership to support safer care and more effective transitions of patients from hospitals to other settings. \$218 million was awarded to 26 organizations to be Hospital Engagement Networks, which help identify and spread solutions already working to reduce health care–acquired conditions. An additional \$500 million is available for models improving care transitions and reducing readmissions for high-risk Medicare beneficiaries. Already, 47 participants have been selected for that program.

**Independence at Home Demonstration.** Tests effectiveness of delivering comprehensive primary care at home, focusing on patients with multiple chronic conditions. 15 independent practices and 3 consortia participating.

**Medicaid Emergency Psychiatric Demonstration.** Tests whether Medicaid can support higher-quality care at a lower total cost by reimbursing private psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically been unavailable. 11 states and D.C. are participating.

**Medicaid Incentives for the Prevention of Chronic Diseases.** Provides incentives to Medicaid beneficiaries participating in prevention programs and demonstrate changes in health risk. 10 states are participating.

**Financial Alignment Initiative.** Aligns financial incentives of Medicare and Medicaid to provide Medicare–Medicaid enrollees with a better care experience. This opportunity is open to all states. Currently, one state is participating.

**State Innovation Models Initiative.** A competitive funding opportunity for states to design and test multipayer payment and delivery models that deliver high-quality health care and improve health system performance. Up to \$275 million will be made available for up to 30 grants.

**Health Care Innovation Awards.** Provides grants up to \$30 million to participants who are implementing innovative ideas to deliver better health, improved care, and lower costs. 107 grants totaling \$894 were awarded. Nearly \$2 billion in savings is expected over three years from these initiatives.

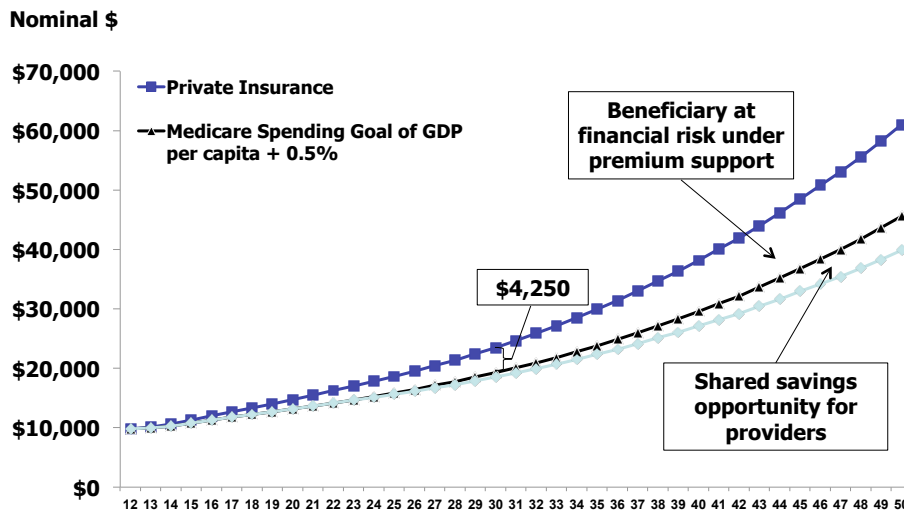
**Strong Start for Mothers and Newborns.** Supports reducing the risk of significant complications and long-term health problems for both expectant mothers and newborns.

**Graduate Nurse Education Demonstration.** Provides hospitals with funds for clinical training of advanced practice registered nursing (APRN) students. 5 hospitals are participating.

**Innovation Advisors Program.** Creates a network of delivery system reform experts. 73 advisors have been selected.



## Exhibit 24. Medicare Spending per Beneficiary Under Premium Support and Shared Savings Scenarios, 2012–2050



Source: Commonwealth Fund calculations based on Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, (Washington: Congressional Budget Office, March 2012), and Congressional Budget Office, *The 2012 Long-Term Budget Outlook* (Washington, D.C.: Congressional Budget Office, June 2012).

