

**GUARANTEED
CHOICES
TO
STRENGTHEN
MEDICARE AND
HEALTH SECURITY
FOR ALL**

BIPARTISAN OPTIONS FOR THE FUTURE

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GUARANTEED CHOICES TO STRENGTHEN MEDICARE AND HEALTH SECURITY FOR ALL: BIPARTISAN OPTIONS FOR THE FUTURE

Senator Ron Wyden (D-OR) and Representative Paul Ryan (R-WI)

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Executive Summary

Few issues draw more heated partisan rhetoric than the future of Medicare. Seniors are a reliable and powerful voting bloc, and both Republicans and Democrats are guilty of exploiting Medicare concerns to frighten and entice voters. Regrettably, this discussion has taken our collective eyes off the importance of protecting, strengthening, and preserving the Medicare guarantee.

But turning discussions of Medicare's future into the third rail of American politics not only does a disservice to the more than 48 million Americans who currently rely on Medicare as their primary source of health insurance, but also does nothing to guarantee that Medicare will continue to be a lifeline for America's seniors.

In fact, the more the national conversation about the future of Medicare deteriorates into partisan attacks that our opponents will "cut Medicare" versus superficial campaign pledges to "make no changes" to a 45-year-old program, the harder it gets to have a serious debate about the best way to ensure that seniors can rely on a strengthened Medicare program for decades to come.

Before the partisan attacks begin to escalate and the 2012 election ads start to air, we are outlining a plan for how Democrats and Republicans can work together to ensure that American retirees – now and forever – have quality, affordable health insurance.

Our plan would strengthen traditional Medicare by permanently maintaining it as a guaranteed and viable option for all of our nation's retirees. At the same time, our plan would expand choice for seniors by allowing the private sector to compete with Medicare in an effort to offer seniors better-quality and more-affordable health care choices.

We are a Democrat and Republican; a Senator and a Representative; senior members of our respective Budget Committees; and members of the committees that have jurisdiction over Medicare and health care costs. As budgeteers, we understand the difficulty presented by demographic changes over the next several decades. As members with policy oversight, we recognize and encourage the potential for innovation to improve care and hold down costs. And most important, as representatives of hard-working Americans in Oregon and Southern Wisconsin, we realize our absolute responsibility to preserve the Medicare guarantee of affordable, accessible health care for every one of the nation's seniors for decades to come.

Our Plan includes the following parts:

Choice: Starting in 2022, a new Medicare program will begin offering seniors a choice among Medicare-approved private plans and the traditional Medicare plan – much like the choice of plans Members of Congress have. Any private plan that wishes to participate in this new program must provide *at least* as comprehensive a benefit as traditional fee-for-service Medicare, and the traditional program will be strengthened so that it can effectively compete in this new marketplace. This marketplace will supplant Medicare Advantage. Any senior at or above age 55 today will see no changes in the Medicare program.

Affordability: Coverage will be guaranteed through a new “premium support” system that encourages plans to provide high-quality care more efficiently. Private plans will compete directly with traditional Medicare based on their ability to provide quality coverage at an affordable lower cost. Premium-support levels will be determined by the cost of the second-lowest-cost plan, as well as traditional Medicare. For the first time, seniors will be protected from catastrophic health care costs with a new limit on out-of-pocket costs for all seniors. Seniors who are eligible for Medicaid or other income assistance will be guaranteed ongoing coverage without any additional costs.

Protecting the Guarantee: In the event that these efforts do not stem the rising tide of Medicare spending, beginning in 2023 there will be a cap on cost growth of 1 percent over Gross Domestic Product, plus inflation. Any increase over that cap will be reflected in reduced support for the sectors most responsible for cost growth, including providers, drug companies, and means-tested premiums.

Protecting Seniors: This reformed Medicare program will include the toughest consumer protections in American government. The history of seniors’ programs has shown that whenever a new program is created, fraudulent schemes spring up to exploit its participants. To ensure ample protection from scam-artists and bad actors, the program will not only require insurance coverage protections such as guaranteed issue and risk adjustment, but it will also require the Centers for Medicare and Medicaid Services (CMS) to actively review marketing practices and benefit adequacy. For new private plans, CMS will retain the authority it currently possesses to assess bids in order to weed out junk plans and unqualified insurers. Seniors will be provided with simple, easy-to-understand information about the plans that are available in their areas during their annual open-enrollment period, explaining options and prices, and they will be told exactly how their current plan compares to the next-lowest-cost option. Traditional Medicare will always be offered as a viable and robust choice.

Protecting The Safety Net: The creation of the Medicare program in 1965 came as the result of a call to action on behalf of seniors. This age group – 65 and older – was seemingly uninsurable (only half of this population had any form of health insurance). Yet seniors required more services than other group. Since the creation of Medicare, the trend has changed, and now 98 percent of America’s seniors are enrolled in Medicare and ensured health security. Looking at the history and progression of the Medicare program, however, there is a glaring gap in the success story: care delivery to low-income seniors. As of 2010, there were 9 million of these so-called “dual eligibles” (those who qualify for both Medicare and Medicaid). Because of their low-income status, these individuals have been forced into a fragmented system of care delivery, and yet they are the most likely to require medical attention and

to benefit from integration and coordination. We acknowledge that a number of efforts are underway in both the public and private sectors that seek to change that. Our proposal aims to support those efforts by encouraging plans that specialize in the quality-care management of high-cost seniors to participate in the new Medicare program.

Finally, we do not believe that income should determine how many choices a senior has. For that reason, we hold dual eligibles harmless from any premium increases, guarantee them the same options in the new program as any other Medicare beneficiary, adjust their premium-support payments to reflect their health needs, and ensure that this vulnerable population receives additional support in the form of fully-funded accounts for their out-of-pocket costs.

Lifelong Choices: The consistent theme of our proposal emphasizes that “choice” and “reform” do not have to mean “adverse selection” and “beneficiary cuts.” Instead, we draw from an ideal that Americans should be able to choose from a variety of health care options just as Members of Congress do, and that when people have control over their health care choices they begin to make different decisions about how to spend their health care dollars.

Currently, however, when Americans turn 65, they often must relinquish any health insurance they may have had and subsequently enroll in Medicare. Allowing individuals to keep one insurance product as they transition from their working years to retirement would help ensure a smooth transition into the Medicare program. In order to maximize the choices that individuals have prior to retirement, we present a “free choice option” that would allow employers with 100 workers or fewer to offer their employees the value of the employer contribution to health care – tax-free to the employee and deductible to the employer – so that individuals may purchase health insurance that is not tied to their workplace if they choose to do so.

Giving workers employed by small businesses the ability to shop for less-costly health coverage will have a profound impact on the marketplace. By allowing an employee to take his or her employer’s contribution and use it to purchase the best plan for his or her individual or family’s needs, market forces will pressure plans to keep their premiums as low as possible in order to gain market share. Furthermore, by allowing the employee to keep any remainder of the “free choice option,” subject to tax, there will be an inherent incentive to choose the plan that provides the best value – i.e., the highest quality coverage at the lowest cost.

Taken together, these reforms will ensure that Medicare will remain the guaranteed, affordable lifeline that its creators envisioned, both for older Americans and for young families paying into the system. The reforms make certain that a program created in the 20th Century is strengthened, modernized, and can deliver on its promise in the 21st Century. We hope that the following pages begin a different kind of discourse. We are two Members of Congress who firmly believe in the iron-clad guarantee of the Medicare program, and this belief has informed our understanding of the unacceptable risk posed to our seniors’ health and retirement security if we do not come together as a country and take action to save and strengthen Medicare.

Through this new law... every citizen will be able, in his productive years, to ensure himself against the ravages of illness in his old age. ...no longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, to their uncles, and to their aunts.

– President Lyndon B. Johnson, July 1965

GUARANTEED CHOICES TO STRENGTHEN MEDICARE AND HEALTH SECURITY FOR ALL: BIPARTISAN OPTIONS FOR THE FUTURE

Proposal

“The rising cost of medical care, and particularly of hospital care, over the past decade has been felt by persons of all ages. Older persons have larger than average medical care needs. As a group they use about two-and-a-half times as much general hospital care as the average for persons under age 65, and they have special need for long-term institutional care. Their incomes are generally considerably lower than those of the rest of the population, and in many cases are either fixed or declining in amount. They have less opportunity than employed persons to spread the cost burden through health insurance. A larger proportion of the aged than of other persons must turn to public assistance for payment of their medical bills or rely on ‘free’ care from hospitals and physicians. Because both the number and proportion of older persons in the population are increasing, a satisfactory solution to the problem of paying for adequate medical care for the aged will become more rather than less important.”¹

– Report submitted by the Department of Health, Education and Welfare to the House Ways and Means Committee, April 1959

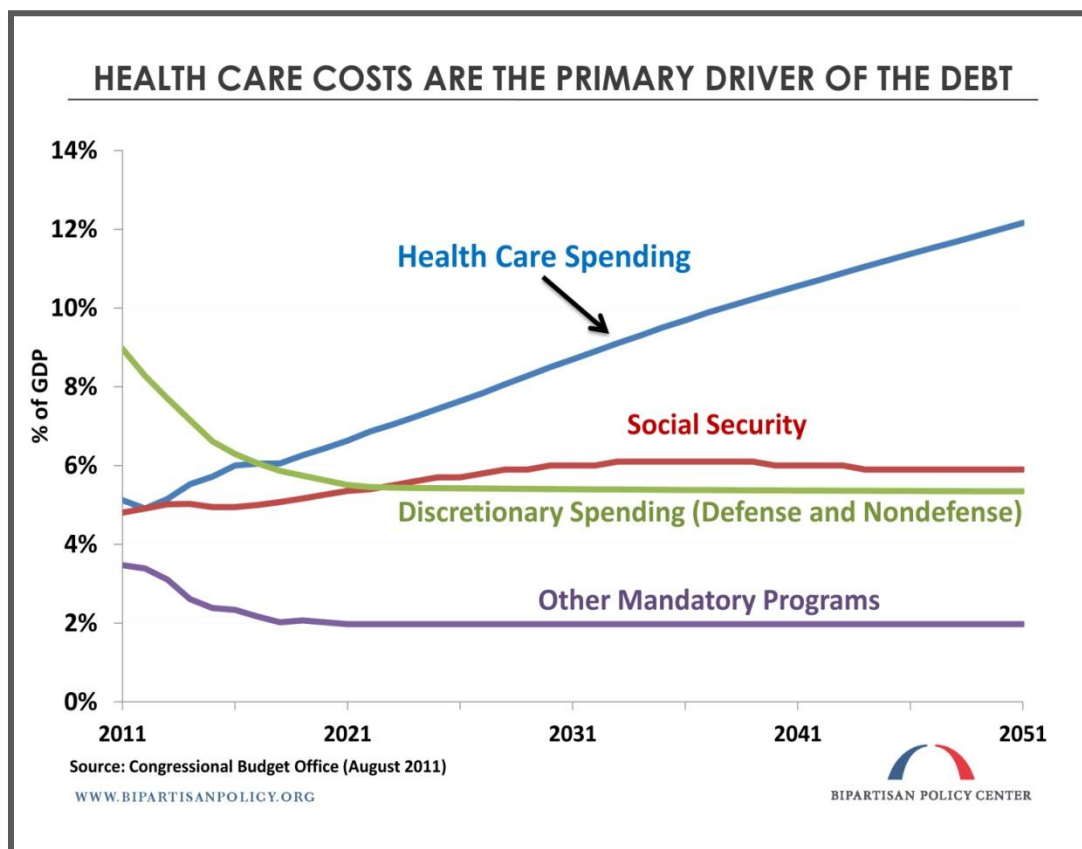
GUARANTEED CHOICES IN THE MEDICARE PROGRAM

Medicare has been a lifeline to millions of seniors since its inception in 1965, and although much has changed since its passage, the needs of those who value and depend on this “Social Contract” have not changed. Providing services for these seniors is what the Medicare program was created to do. That commitment has not changed. With more than 10,000 baby boomers turning 65 every day for the next two decades, and with health costs increasing at unsustainable rates, reform is now essential to ensure that Medicare will remain a guaranteed, affordable lifeline for seniors and taxpayers for decades to come.

Forty-eight million Americans currently rely on Medicare for their health security. Over the next several decades, that number will rise rapidly due to increasing longevity and the retirement of the baby boomers. That increase in enrollment, coupled with the escalating cost of health care, creates a spending path for Medicare that presents severe budget challenges for the future. Over the long-term, Medicare spending is growing more than twice as fast as the economy. Left unchecked, the growth of health care costs not only threatens the government’s ability to guarantee Medicare’s promise to millions of seniors, but also puts the solvency of the federal government and the health of the U.S. economy at risk.

¹ <http://www.ssa.gov/history/corningchap4.html>

Of the projected increase in government's health spending, the Congressional Budget Office (CBO) estimates that Medicare occupies the largest share.²



These challenges are news to few, and the concerns of seniors about the future of Medicare are reaching fever-pitch levels. Seniors fear that the benefits they rely on are going to be taken from them, or that their doctors are going to leave the program just as the sheer number of Americans who require their services is set to increase. Together, we propose a bipartisan path forward, with options that guarantee choice and affordable coverage for those whom we have pledged to protect.

One of the traits that is most revered about Americans is our ability to innovate. Yet, for years, American politicians have acted as if the structure of the Medicare program is without flaws and requires no examination, despite strong evidence to the contrary. Whatever political benefits accrue from this attitude come at the expense of both current and future generations of retirees. We can no longer ignore the obvious truth that change within Medicare could actually result in a stronger program. It is time to build upon and improve the groundbreaking Medicare program created in 1965 and thereby improve our nation's fiscal *and* physical health.

² http://cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf, p 46.

Our Goal

We believe there is a bipartisan path forward on Medicare reform. Over the years, both political parties have failed to be honest with the American people about Medicare's future. Both political parties have exploited this issue, scoring political points at the expense of our seniors' health and retirement security. Americans deserve better.

Both sides can – *and must* – work together to put an end to empty promises and promote a strengthened Medicare program that can deliver on its promise to current seniors and future generations. This proposal represents our good-faith effort to do just that.

Our Principles

- **No disruptions for those in or near retirement.** Seniors should not be forced to reorganize their lives because of government's mistakes.
- **Preserve a guaranteed safety net for seniors.** Lower-income seniors and those with greater health care risks should receive greater support, and assistance for wealthier seniors should be reduced.
- **Ensure a sustainable future for Medicare.** Gradual, sensible reforms must be made to address the root drivers of the program's explosive cost growth.
- **Build a strengthened program around the needs of patients, not bureaucrats.** True choice and competition – with traditional Medicare always remaining a guaranteed and competitive option – will help lower costs, root out waste and improve the quality of care by forcing providers to compete against each other for the patient's business.

A Bipartisan Proposal to Strengthen the Medicare Guarantee

For those currently enrolled or near retirement (55 or older), we propose no structural Medicare changes that will affect their benefits. For future seniors (those now 54 or younger,) we propose to strengthen Medicare by transitioning the current program toward a coverage-support plan with the choice of guaranteed coverage options – including traditional Medicare – on a Medicare exchange. The coverage-support value would be adjusted to provide additional support for the poor and sick, and reflect a reduced subsidy for the wealthy.

Create a Sustainable Medicare Program for the 21st Century

The Medicare program should be strengthened to serve the needs of retirees – both current and future. As put forward by this proposal, the reformed Medicare program would allow future retirees (those who first become eligible by turning 65 on or after January 1, 2022) who choose the traditional fee-for-service Medicare plan to do so. Beginning in 2022, these seniors would also be given a choice of private plans competing alongside the traditional fee-for-service option on a newly created Medicare

Exchange. Medicare would provide a coverage-support payment either to pay for or offset the premium of the plan chosen by the senior, depending on the plan's cost.

The Medicare Exchange would provide seniors with a competitive marketplace where they could choose a plan the same way Members of Congress do. All plans, including the traditional fee-for-service option, would participate in an annual competitive bidding process to determine the dollar amount of the federal contribution seniors would use to purchase the coverage that best serves their medical needs. The second-least expensive approved plan *or* fee-for-service Medicare, whichever is least expensive, would establish the benchmark that determines the coverage-support amount for the plan chosen by the senior. If a senior chose a costlier plan than the benchmark, he or she would be responsible for paying the difference. Conversely, if that senior chose a plan that cost less than the benchmark, he or she would be given a rebate for the difference. Payments to plans would be risk-adjusted and geographically rated. Private health plans would be required to cover *at least* the actuarial equivalent of the benefit package provided by fee-for-service Medicare.

Program growth would be determined by the competitive bidding process – with choice and competition forcing providers to reduce costs and improve quality for seniors. The competitive market for Medicare choices would foster innovation and quality, while ensuring that the program is financially stable. As a backup, program growth after 2022 could not exceed nominal Gross Domestic Product growth plus 1 percent.³ If costs per beneficiary rose faster than this established limit, those low-income individuals who qualify for both Medicare and Medicaid (also known as “dual-eligibles”) would continue to have Medicaid pay for their out-of-pocket expenses. Other lower-income seniors (those who do not qualify for Medicaid but are still under a certain income threshold) would receive fully-funded accounts to help offset any increased out-of-pocket costs. To offset an increase in the cost of Medicare beyond the growth limit, Congress would be required to intervene and could implement policies that change provider reimbursements, program overhead, and means-tested premiums.

The cap on the growth rate is intended to: (1) act as a fallback to assure the federal government budgetary savings and protect the future of Medicare; and (2) foster the proper incentives for providers and plans to develop more efficient methods of quality care delivery and attract seniors to those plans that succeed.

Guarantee Affordable Choices for All Seniors

Seniors would be guaranteed a plan that is at least the value of the traditional fee-for-service Medicare option. Health plans that participate alongside traditional Medicare in the Medicare Exchange would be required to offer insurance to *all* seniors – regardless of age and health status – thereby preventing insurers from cherry-picking only the healthiest seniors for coverage under their plans. These protections ensure that Medicare's sickest and highest-cost beneficiaries have access to affordable and quality coverage choices. The regulations governing the Exchange would include guaranteed issue (i.e., the inability to deny coverage based on pre-existing conditions) and community rating (i.e., the

³ The growth rate would use nominal GDP to ensure that inflation would be factored in and to protect seniors from premium increases in the event inflation spikes in the future.

inability to impose prohibitively disparate costs on seniors) requirements for all health plans to ensure that seniors are able to choose an affordable health plan that works best for them – without fear of denial or discrimination.

Stronger Protections for Those with Greater Needs

The federal contribution to seniors' health plans would be risk-adjusted so that the sickest seniors are protected from high premiums as well as adverse selection from insurers. Building on the risk-adjustment tools currently used by the Centers for Medicare and Medicaid Services (CMS), proper risk adjustment would ensure that seniors with the highest health costs would still be able to find an affordable plan. Federal contributions would be increased to account for a senior's health status and age.

CMS would also conduct an annual risk review audit of all insurance plans participating in the Medicare Exchange. Insurance plans covering a higher-than-average number of *low-risk* seniors would pay a fee. Conversely, insurance plans covering a higher-than-average number of *high-risk* seniors would receive an incentive payment. The fees and incentive payments would flow internally through the same fund, so that payments to plans that cover high-cost patients would be funded wholly by the fees from plans that cover low-cost patients.

More Support for Low-Income Seniors and a Reduced Subsidy for High-Income Seniors

Low-income seniors shopping for coverage would be offered the same range of high-quality options offered to all other seniors. They would be guaranteed the ability to choose a traditional fee-for-service Medicare plan, or they could choose a private plan on the Medicare Exchange with a fully-funded account from which to pay premiums, co-pays and other out-of-pocket costs.

Special consideration would be given to the 9 million Americans who qualify for both Medicare and Medicaid. These “dual eligibles” are disproportionately sicker than other seniors. They are often suffering from multiple chronic conditions that require persistent medical attention, as well as physical and cognitive impairments. Despite their greater needs, dual eligibles are forced to contend with a fragmented benefit system and care delivery that is both inefficient and outrageously expensive.⁴ Efforts both public and private are underway to better integrate and coordinate the care and services deemed necessary for these individuals. This proposal should complement those efforts by encouraging plans that specialize in care management for complex patients to compete in the Medicare Exchange based on their ability to provide affordable, quality coverage to a specialized population.

The high-income means-testing thresholds that exist in current law for the Parts B and D programs would apply to the new Medicare program, such that certain high-income seniors would pay an increased share of their premiums.

⁴ <http://www.kff.org/medicaid/upload/4091-08.pdf>, <http://www.kff.org/medicare/upload/8138.pdf>

Increased Consumer Protections

Enhanced transparency initiatives, overseen by CMS, would ensure that all plans operating in the Medicare Exchange provide seniors with bona fide coverage and honest information to help them make informed choices. Plans that fail to comply with established standards of participation would have their contracts terminated. Building upon Medicare's current marketing rules, all plans would also be required to have their marketing materials approved annually by CMS.

Given that many seniors elect to stay in the same plan year after year, it will be increasingly important to ensure that seniors are notified of any changes to their area's plan offerings and costs. Therefore, during the annual open-enrollment period, seniors would also receive clear and easy-to-understand information on what plan they are currently enrolled in and how it compares to the lowest-cost options available to that senior. This will include what the projected cost of that plan will be for the upcoming plan year, specifics on what other plans in their area will be offered, and what the federal coverage-support contribution will be. Individual assistance would also be available to ensure that all questions can be answered during open enrollment and that each senior has ample information and assistance in determining which plan works for them. This assistance program will incorporate the lessons learned from marketing abuses by Medicare Advantage and Medigap plans in the past.

Modernize and Improve Medicare Advantage

Medicare Advantage brought a new concept of health care delivery to the Medicare program: coordinated care. Traditional Medicare pays health providers on a service-by-service basis rather than based upon outcomes or the quality of their treatments. Medicare Advantage HMOs, on the other hand, have taken a different approach. Every year, plans negotiate a set, risk-adjusted rate that CMS pays for these plans to manage and oversee care for these enrollees. With this fixed amount paid every month, plans have developed innovative bundling services that have succeeded at providing advanced, integrated care for over 11.5 million seniors. This is one example of the type of innovation that can result from introducing choice and competition.

Medicare Advantage is not without flaws. The program has been plagued by payment issues and access problems. Furthermore, because of geographic disparities in the cost of health care, seniors are often limited in their choices of plans and options. Moreover, while Medicare Advantage currently offers seniors a choice of private Medicare coverage, plans are limited in their ability to compete directly with traditional fee-for-service Medicare. Namely, if a private Medicare Advantage plan has *lower* costs than traditional Medicare, then by law, the plan may *not* offer a rebate to the senior. Instead, the plan must compete by offering additional benefits, which in some circumstances increases the use of services – and therefore costs.

This proposal builds on the coordinated-care model of the Medicare Advantage system while ensuring that those who are currently in the program see no disruptions in services. Future Medicare enrollees would have access to plans that provide access to care similar to the way that Medicare Advantage plans do now, but they would benefit from a more efficient, competitive marketplace.

Common-sense Reforms to Traditional Fee-for-Service Medicare

To strengthen the current fee-for-service program and ensure that it remains competitive amongst plans offered on the new Medicare Exchange, it should undergo a number of updates to its cost-sharing rules, including – but not necessarily limited to – combining the Parts A and B deductibles and creating a new catastrophic cap to limit out-of-pocket spending. These reforms are aimed at addressing health inflation, and they would help improve Medicare’s sustainability.

The outdated physician payment formula should also be reformed so that doctors do not experience massive across-the-board reductions in payments for serving Medicare patients. Medicare’s reimbursement status quo threatens to drive Medicare providers out of business, jeopardizing access for seniors. A new reimbursement system that fairly compensates physicians who treat seniors is necessary to create incentives that improve quality and efficiency.

GUARANTEED CHOICES FOR SMALL BUSINESSES AND THEIR WORKERS

Seniors are not the only health care consumers who can be empowered to lower costs by strengthening choice and competition in the health care marketplace. Small businesses and their workers can also benefit. Small businesses currently have a hard time providing affordable health care coverage for their workers and typically only offer one choice of health plan if they can afford to offer health coverage at all.

Our Goal

We believe there is a bipartisan path forward on addressing the discrimination and distortions that result from the current tax treatment of health insurance. Small businesses and individuals should be freed from restrictions that inhibit choice and control in health coverage. We are offering a positive first step toward reforming the broken third-party payment system by promoting greater choice and competition.

Our Principles

- **No disruptions for those who enjoy the coverage they currently have.** Reforms aimed at expanding choice should not come at the expense of those who enjoy their current plans.
- **Greater equality for small businesses.** The larger the business, the greater the power they have in the current third-party payment system. Small businesses should have the ability to empower their employees with access to the widest range of quality, affordable coverage options.
- **Greater access and power for workers.** Workers should not be limited only to the coverage options offered by their employers. Reforms should maximize choices for individuals to purchase portable, affordable health coverage without forgoing its current preferred tax treatment.

A Proposal to Strengthen the Health Care Marketplace

To give small businesses and their workers more choices, any small business with up to 100 workers would be able to offer its employees a “free choice option” so they could use the amount that their employer contributes toward their health coverage to purchase their own health insurance. The cost of the free choice option would be fully tax deductible to the employer, just like employer-provided health coverage. Small businesses that don’t currently offer health coverage would also be able to opt to help pay for health coverage for their workers through the free choice option.

Maximizing Options for Workers

The cost to the employer – and the tax-free benefit to the worker – would remain the same. The difference is that the employee would now have more choices for how to use the employer-provided benefit. The employee could use the free choice option to purchase any qualified health plan available in the state. A worker seeking additional coverage or benefits could purchase a more comprehensive plan. A worker seeking a lower-cost plan, such as a consumer-driven health plan, would be able to choose that type of plan.

If the worker chooses a plan whose cost is equal to or greater than the amount of the free choice option his or her employer provides, the free choice option would be fully tax-free to the worker. If the worker chooses a health plan that costs less than the amount of the employer contribution, the cost of the health plan would also be excluded from the employee’s income. The worker choosing a plan that costs less than the employer contribution amount would also get a cash refund for the amount the contribution exceeded the cost of the health plan, but the employee would have to pay tax on the cash refund.

By giving workers employed by small businesses the ability to shop for less-costly health coverage, the free choice option would help hold down health care costs, not only for the workers who buy the lowest-cost plans, but also for all workers by putting pressure on all participating qualified health plans to keep costs low in order to compete with the lower-cost plans.

Ensuring a Smooth Transition into the Medicare Program

Currently, when seniors become Medicare-eligible, they often relinquish any health insurance they may have had and subsequently enroll in Medicare. Allowing individuals to keep one insurance product as they transition from their working years to retirement would help ensure a smooth transition into the Medicare program. In order to maximize choices individuals have prior to retirement, the free choice option would allow certain employers to offer their employees the value of the employer contribution to health care so that individuals may purchase health insurance that is not tied to their workplace if they choose to do so.