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Hatch Outlines Structural Medicare, Medicaid Reforms That Should Be Part of Deficit Reduction Package

Five Bipartisan Entitlement Reforms, Include Adjusting Medicare Eligibility Age, Modernizing the Medigap Program, Simplifying Medicare Beneficiary Cost-Sharing, Competitive Bidding in Medicare, & Medicaid Per Capita Caps

WASHINGTON –With the nation's debt headed toward $16.5 trillion, U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, reiterated today the need for structural reforms to the Medicare and Medicaid programs as a means of reducing the debt and laid out five bipartisan ideas that he believes should be included in any deficit reduction package.

"If we're serious about addressing our nation's debt, Medicare and Medicaid need structural reforms," **said Hatch in a speech on the Senate floor.** "Today, I want to lay out five specific reform proposals that can help to rein in entitlement spending and put our nation on a better fiscal course. These are reasonable, rational ideas that have all enjoyed bipartisan support over the years. I believe they should be included in any deficit reduction package."

Below are the bipartisan entitlement reform policies Senator Hatch believes must be considered:

1. **ADJUST THE MEDICARE ELIGIBILITY AGE FOR SENIORS FROM 65 TO 67 YEARS OF AGE.** The eligibility age would gradually increase each year by two months until it reaches the new eligibility age of 67 years within a decade. This common-sense proposal would reflect increases in longevity and simply align Medicare eligibility with Social Security eligibility at 67 years of age over time.

   RATIONALE: The total number of seniors enrolled in Medicare will increase from 47 million in 2010 to 81 million in 2030. An additional 10,000 seniors are added to the program each day, while the number of workers paying into the program per beneficiary has declined by 18 percent over the last decade. When Medicare was created in 1965, the average life expectancy was 70 years. In 2009 it stood at 78 years. Currently, 41 percent of Medicare beneficiaries are 75 years and older and account for 50 percent of total spending in the program.

BIPARTISAN SUPPORT: This policy was supported by the bipartisan Simpson-Bowles National Commission on Fiscal Responsibility and Reform. It was also included in the bipartisan Biden-Cantor deficit reduction negotiation, the bipartisan Obama-Boehner negotiations, and the Coburn-Lieberman Medicare proposal from last Congress. Prominent Democrats, such as Budget Committee Chairman Kent Conrad (D-N.D.) and House Budget Committee Ranking Member Chris Van Hollen (D-Md.), suggested that this policy should be part of the discussion to reform entitlements. The nonpartisan Congressional Budget Office (CBO) has provided this as an entitlement reform option.

2. **MODERNIZE THE MEDIGAP PROGRAM.** Empower seniors to make better healthcare choices and reduce costs for Medicare that stem from over-utilization of services by limiting supplemental Medicare Insurance plans called Medigap plans, from covering initial out-of-pocket expenses for seniors when they receive care. Lowering unnecessary utilization will reduce Medicare costs over time.

RATIONALE: In 2010, Medicare on average paid $9,765 per beneficiary. The average out-of-pocket expense (because of co-payments, co-insurance and deductibles) per recipient was $1,679. Nearly 90 percent of all Medicare beneficiaries have some supplemental insurance coverage to offset their cost-sharing costs. Almost 30 percent of them have Medigap policies that provide coverage for initial out-of-pocket expenses. Multiple studies have found the Medigap policyholders use about 25 percent more services than Medicare enrollees who have no supplemental coverage, and about 10 percent more services than enrollees who have employer-sponsored retiree coverage. This over-utilization of services directly contributes to higher costs for all seniors in Medicare. Limiting first-dollar coverage will ensure that seniors make the right choices to ensure the highest-quality outcome while keeping costs low for the entire Medicare population.

BIPARTISAN SUPPORT: This policy was supported by the bipartisan Simpson-Bowles National Commission on Fiscal Responsibility and Reform. It was also included in the bipartisan Biden-Cantor deficit reduction negotiations. The House Democratic Ways and Means Committee included this as part of broader cost-sharing reforms in their 2011 deficit reduction proposal. The President's own deficit reduction proposal in September 2011 included a policy to achieve a similar result by applying a 15 percent surcharge on Part B premiums for those seniors who purchase Medigap plans with low cost-sharing.

3. **SIMPLIFY MEDICARE BENEFICIARY COST-SHARING AND ESTABLISH A CATASTROPHIC LIMIT.** Streamline complicated Medicare cost-sharing into a single combined annual deductible for both Medicare Part A and B services, establish a uniform coinsurance rate for amounts above the deductible, and institute an annual catastrophic cap to financially protect seniors in cases of serious health events.

RATIONALE: Under Medicare, cost-sharing, such as copays and deductibles, vary significantly depending on the type of service provided. Currently, Medicare has a deductible for inpatient care under Part A ($1,132 in 2011) for hospital services. With a separate deductible charged for physician and other outpatient services under Part B ($162 in 2011), there are no limits on how much seniors pay in out-of-pocket costs.

This benefit structure has long been criticized for being too complex, and for promoting overutilization of care which, in turn, translates into higher costs for seniors. Streamlining the cost-sharing will make it easier for seniors to navigate Medicare more efficiently while also reducing costs. Most importantly, it will give seniors financial security in cases of high out-of-pocket costs.

BIPARTISAN SUPPORT: This policy was supported by the bipartisan Simpson-Bowles National Commission on Fiscal Responsibility and Reform. It was also included in the bipartisan Coburn-Lieberman Medicare proposal last Congress. The nonpartisan Congressional Budget Office (CBO) has provided this as an option to reduce costs.

4. INCREASE QUALITY AND LOWER COSTS: MEDICARE COMPETITIVE BIDDING. Allowing health plans to compete with traditional fee-for-service Medicare would provide seniors their guaranteed comprehensive Medicare benefit, while reducing costs and preserving the quality of care. The federal government would continue to define a package of required benefits that would constitute comprehensive Medicare coverage, as it does today. Each year, private insurers and traditional Medicare would submit bids to provide guaranteed Medicare benefits. The government would then provide, on behalf of each senior, a risk-adjusted payment based on those competitive bids in their area of the country. Seniors who choose plans that cost less than the government payment would get the difference back through lower premiums or additional health benefits.

RATIONALE: Reforms should be drawn from bipartisan, market-oriented solutions such as a competitive system of bidding among traditional Medicare and carefully-regulated private plans. Robust competition empowers seniors, rather than Washington, to choose — based on transparent cost and quality information — if they prefer support for traditional Medicare or a private health plan. Sustainable Medicare reform would build on the success of Medicare Advantage by holding private health plans to a higher level of accountability through competitive bidding. Seniors already benefit from this type of structure in the Medicare prescription drug benefit (Part D), which has controlled costs and is very popular with beneficiaries.

BIPARTISAN SUPPORT: In 1999, the bipartisan Breaux-Thomas Medicare Commission recommended a defined support model much like the system used by Members of Congress. That same year, President Clinton proposed a major set of Medicare reforms with his own version of premium support, which he called a “competitive defined benefit proposal.” Alice Rivlin, Director of the Office of Management and Budget for President Clinton, recently worked with former Senator Pete Domenici (R-N.M.) on the Protect Medicare Act, which included a defined support plan for Medicare. Another bipartisan team, U.S. Senator Ron Wyden (D-Ore.) and U.S. House Budget Committee Chairman Paul Ryan (R-Wis.), developed a defined support plan.

5. STRENGTHEN MEDICAID WHILE IMPROVING PATIENT CARE: PER CAPITA CAPS. There are many ways to implement fiscal discipline in the Medicaid program, such as block grants that cap the amount of spending the federal government sends to states and also bipartisan proposals that limit the amount of federal dollars spent for each Medicaid beneficiary (per capita caps). Per capita caps are similar to a proposal put forward by President Clinton in 1995. Spending limits would be set by beneficiary eligibility categories and adjusted for patient health condition. This approach would put the Medicaid program on a sustainable budget, and it would be combined with new tools for states to implement patient-centered reforms. Along with these defined funding streams, the federal government would also work with the states to set clear, transparent goals and then monitor specific metrics on quality, access, and coverage.

RATIONALE: The federal share of Medicaid spending as a share of the economy is set to grow by 37 percent over the next 10 years, with total federal spending during that time reaching $4.4 trillion. According to CMS’s actuary, the Medicaid program is “the largest source of general revenue-based spending on health services…a larger source of such Federal expenditures than Medicare.” Meanwhile, Medicaid represents the single largest portion of state budgets (estimated at 23.6 percent in FY2011). Currently, federal taxpayers have an open-ended liability to match state Medicaid spending, which is a significant factor in Medicaid’s budgetary challenges. Bipartisan per capita cap reforms would implement desperately needed fiscal discipline in Medicaid while preserving access to care for beneficiaries.

BIPARTISAN SUPPORT: In 1995, President Clinton proposed a Medicaid reform plan including a provision to establish a per capita cap on federal Medicaid spending. All 46 Members of the Democratic Caucus of the Senate signed a letter to President Clinton expressing their “strong support for the Medicaid per-capita cap structure” including several currently serving Senators and then-Senator Joe Biden. More recently, in October 2012, former Senate Majority Leader Tom Daschle expressed his support for Medicaid per capita caps as a way of “guaranteeing benefits on the Medicaid program.”

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