REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-11)
Medicare Financing Reform
(Reference Committee J)

EXECUTIVE SUMMARY

The long-term viability of the Medicare program has been a significant public policy concern for many years. The spending projections for Medicare under current law manifest mounting pressure on the federal budget, exhaustion of the trust fund that permits full payment of currently scheduled benefits, and growth in costs that is unsustainable in the long-term. In addition, the repeated failure of Congress to repeal the Sustainable Growth Rate (SGR) formula compounds federal budget problems, and perpetuates a state of instability that further jeopardizes the integrity of the Medicare program.

Recently, Medicare has come under even greater scrutiny due to heightened concerns about the federal deficit and the national debt limit. Medicare expenditures account for nearly 15 percent of total federal spending, and the Medicare Trustees project that Medicare spending will continue to grow more than six percent annually through 2020. Key policymakers acknowledge that any serious fiscal reform effort needs to confront the impact that Medicare's financing and benefit structure has on the federal budget.

The Council on Medical Service believes that the American Medical Association (AMA) needs to take a leadership role in articulating strategies to promote a more sustainable way of financing health care for retirees. The AMA has clear policy outlining steps that must be taken immediately to strengthen the traditional Medicare program, including repealing the SGR; restructuring beneficiary cost-sharing and modifying Medigap benefit designs; expanding beneficiary choice of coverage options; and aligning the eligibility age with Social Security. These reforms are crucial to modernizing the traditional Medicare program. In addition, the Council also believes that it is urgent that the country begin to consider additional ways to strengthen the financing of Medicare that could be implemented in the long term.

Accordingly, the Council on Medical Service is developing recommendations for the House of Delegates as to how to address critical issues related to Medicare financing and the financing of health care for seniors. Medicare reform has proven to be a contentious issue, and it may be challenging to develop new policy that adequately addresses the concerns of all stakeholders. This report has been prepared to give members of the House of Delegates and the Federation the opportunity to discuss and express their views on long-term Medicare reform options before the Council formally brings recommendations to the House of Delegates. The Council will present a report at the 2012 Annual Meeting that contains a series of recommendations regarding potential Medicare financing reforms, based on input received.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-11

Subject: Medicare Financing Reform

Presented by: Thomas E. Sullivan, MD, Chair

Referred to: Reference Committee J
(Barbara J. Arnold, MD, Chair)

The long-term viability of the Medicare program has been a significant public policy concern for many years. The spending projections for Medicare under current law manifest mounting pressure on the federal budget, exhaustion of the trust fund that permits full payment of currently scheduled benefits, and growth in costs that is unsustainable in the long term. In addition, the repeated failure of Congress to repeal the Sustainable Growth Rate (SGR) formula compounds federal budget problems, and perpetuates a state of instability that further jeopardizes the integrity of the Medicare program.

Recently, Medicare has come under even greater scrutiny due to heightened concerns about the federal deficit and the national debt limit. Medicare expenditures account for nearly 15 percent of total federal spending, and the Medicare Trustees project that Medicare spending will continue to grow more than six percent annually through 2020 (2011 Medicare Trustees Report). Key policymakers acknowledge that any serious fiscal reform effort needs to confront the impact of Medicare's financing and benefit structure on the federal budget. The newly formed Joint Select Committee on Deficit Reduction will present recommendations to Congress in November 2011, which may include some changes to the Medicare program. However, major entitlement reforms are likely to be considered in the months following the 2012 elections. This creates a potential window of opportunity in 2013 to advocate a new vision for insuring America's seniors that will move the country beyond the perennial fiscal challenges that threaten the Medicare program.

The Council on Medical Service believes that the AMA needs to take a leadership role in articulating strategies to promote a more sustainable way of financing health care for America's seniors. The AMA has clear policy outlining steps that must be taken immediately to strengthen the traditional Medicare program, including repealing the SGR (e.g., Policy H-390.855, AMA Policy Database); restructuring beneficiary cost-sharing and modifying Medigap benefit designs (Policy H-330.896); expanding beneficiary choice of coverage options (Policy H-330.896); and aligning the eligibility age with Social Security (Policy H-330.896). These reforms are crucial to modernizing the traditional Medicare program. In addition, the Council also believes that it is urgent that the country begin to consider additional ways to strengthen the financing of Medicare that could be implemented in the long term.

Accordingly, the Council on Medical Service is developing recommendations for the House of Delegates as to how to address critical issues related to Medicare financing and the financing of health care for seniors. The Council is aware that reforms that address rising health care costs need to be pursued in tandem with financing reforms. However, the scope of this report is limited to exploring alternative financing options for ensuring that seniors have access to high quality health care.

Medicare reform has proven to be a contentious issue, and it may be challenging to develop new policy that adequately addresses the concerns of all stakeholders. For that reason, the Council believes that members of the House of Delegates and the Federation should have the opportunity to discuss and express their views on how to improve health insurance coverage options for seniors before the Council brings formal recommendations to the House of Delegates. The Council is addressing the issue of potential Medicare reforms in two steps, as follows:

1. This report identifies concerns associated with the current Medicare program, and summarizes alternatives that are being discussed by relevant stakeholders. It then reviews AMA policy addressing long-term Medicare reform, and includes an appendix of questions for discussion and comment before the Reference Committee at the 2011 Interim Meeting. The Council asks that members of the House, as well as state medical associations and national medical specialty societies, convey additional comments to the Council by January 6, 2012.

2. The Council will present a report at the 2012 Annual Meeting that contains recommendations regarding potential Medicare reforms, based on input received.

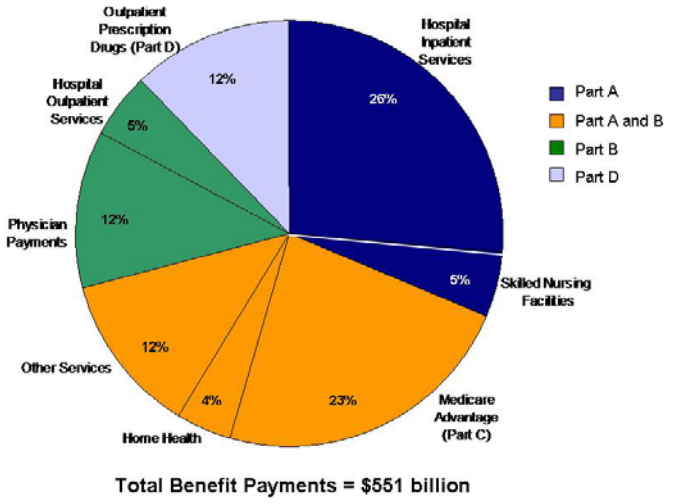
The Council has previously used a two-report approach with other significant topics with potentially controversial recommendations. Most recently, the Council used this strategy when it developed policy recommendations for emerging physician payment and health care delivery reforms (Council on Medical Service Reports 4-I-08 and 6-A-09). The Council is also using a two-report approach to address the issue of Medicaid reform. The first of these reports, Council on Medical Service Report 5, is also before the House at this meeting.

BACKGROUND

The Medicare program is supported by two separate trust funds – the Federal Hospital Insurance (HI) Trust Fund, and the Federal Supplementary Medical Insurance (SMI) Trust Fund. The HI Trust Fund finances Medicare Part A, which covers hospital, home health, skilled nursing facility, and hospice care services. The primary source of income for the HI Trust Fund is a 2.9 percent payroll tax paid by employers and employees (1.45 percent each). Beginning in 2013, higher income workers will pay an additional 0.9 percent tax on their earnings. The SMI Trust Fund finances Medicare Part B, which covers physician services, hospital outpatient services, some mental health services, durable medical equipment, ambulatory surgical center services, physician-administered drugs, some lab tests, and home health visits not covered under Part A. The SMI Trust Fund also finances Part D, which offers prescription drug coverage. Income to the SMI Trust Fund comes from federal general revenues (75 percent) and beneficiary premiums (25 percent). Figure 1 shows the distribution of Medicare expenditures by service category.

The concept of Medicare "solvency" refers specifically to the income and assets available in the HI Trust Fund. The current system relies on taxes paid by current workers to fund the benefits provided to current retirees. The declining ratio of workers contributing payroll taxes to the number of beneficiaries results in a decline in the amount of income available to fund program expenditures. The strain on available resources is exacerbated by the continual increase in health care costs throughout the health care system. As a result, HI expenditures have exceeded income annually since 2008, and funds have been drawn from the HI Trust Fund to cover the shortfall. Projections in the 2011 Medicare Trustees Report to Congress indicate that annual HI

Figure 1: Medicare Benefits By Type of Service, 2011



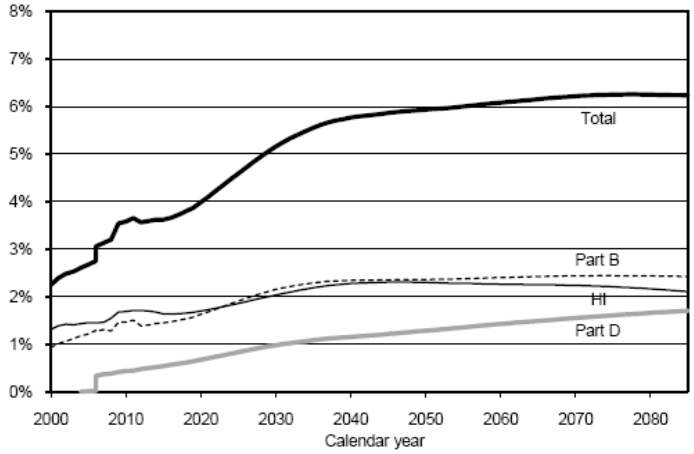
NOTE: Numbers do not sum to 100% due to rounding. Total does not include administrative expenses and is net of recoveries

Source: Kaiser Family Foundation, Medicare Spending and Financing Fact Sheet, August 2010

revenues will continue to fall below projected expenditures, necessitating annual payouts from the Trust Fund. Under current law, the Medicare Trustees project that the Medicare HI Trust Fund will be completely exhausted in 2024, leaving no contingency for financing scheduled benefit obligations that exceed annual dedicated sources of revenue.

In contrast to the HI Trust Fund, the SMI Trust Fund is always fully funded. By law, federal funds are allocated each year to ensure that projected Part B and Part D expenditures (less beneficiary premiums) are covered. As more people become eligible for Medicare, and as program costs increase, a greater portion of the federal budget must be diverted to the Medicare program. SMI revenues from the Federal budget are projected to grow about 5.3 percent annually through 2085, exceeding the projected annual GDP growth of 4.6 percent, which means that SMI financing will continue to consume a greater share of the federal budget (2011 Medicare Trustees Report). Figure 2 shows projected Medicare expenditures for all components as a percentage of GDP.

Figure 2: Medicare Expenditures as a Percentage of GDP



Source: 2011 Medicare Trustees Report

It should be noted that spending projections for the Medicare program are based on current law, which under the SGR formula requires a 29.5 percent cut in physician payments in January 2012. Since Congress is unlikely to allow physician payments to be cut by nearly one-third, Medicare's future funding obligations are severely understated in the projections. Without significant tax and/or premium increases, revenues will not keep pace with program obligations, leading to insolvency (in the case of the HI Trust Fund) and a steadily increasing demand on the federal budget.

MEDICARE AND THE FEDERAL BUDGET

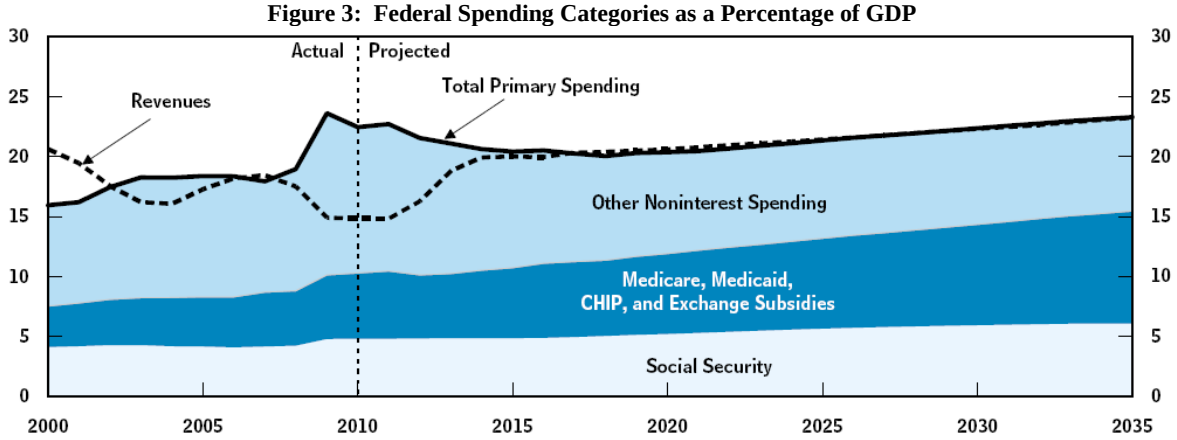
As noted, there is a direct relationship between expenditures for Medicare Part B and D services and the federal tax revenues that are allocated to the program on an annual basis. However, from a federal budget perspective, there is also a cost to drawing assets from the HI Trust Fund to provide Part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

Lawmakers also need to confront the $300 billion funding deficit caused by their repeated failure to permanently replace the SGR. It is widely acknowledged that the SGR formula is fundamentally flawed and that it is based on assumptions about growth rates and spending baselines that are unrealistic in today's health care environment. Since 2002, Congress has intervened on 12 separate occasions to stop cuts in physician payment rates, and with a few exceptions has paid for the intervention by assuming even larger cuts in future years. The cost of funding the accumulated cuts that have been deferred has been a major factor in the rising price of repealing the SGR, which has grown from about $48 billion in 2005 to nearly $300 billion today.

In May 2011, the US hit its "debt ceiling," the limit on the amount of money the government can borrow to pay for federal programs. In largely partisan battles, lawmakers struggled for months to reach an agreement that would raise the debt ceiling and prevent the country from defaulting on its outstanding loans. In August 2011 Congress passed and the Administration signed legislation that raises the US debt ceiling and promises cuts in federal spending over the next ten years. As Figure 3 from the Congressional Budget Office (CBO) shows, health care spending is one of the largest portions of the federal budget.

As part of the August 2011 budget agreement, Congressional leaders formed the Joint Select Committee on Deficit Reduction, which is tasked with making recommendations to further reduce the deficit by $1.5 trillion. This Committee is authorized to consider entitlement reforms, including changes in the SGR, and will make recommendations to the Congress no later than

Figure 3: Federal Spending Categories as a Percentage of GDP



Source: CBO's 2011 Long-Term Budget Outlook, June 22, 2011.

November 23, 2011. If the committee fails to report savings or if the Congress fails to enact them by December 23, 2011, automatic across-the-board cuts in federal mandatory and discretionary spending would be triggered. Although some spending would be exempted from the automatic cuts (e.g., Social Security, Medicaid, and Medicare benefits), payments to Medicare providers would be subject to reductions.

MODIFICATIONS TO THE CURRENT MEDICARE PROGRAM

Over the years the AMA has developed policy that articulates specific reforms that are necessary to ensure that Medicare remains a viable mechanism for providing meaningful health insurance coverage for seniors. Policy H-330.896 calls for three key reforms: 1) restructuring beneficiary cost-sharing; 2) offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare; and 3) restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits. The policy calls for Medicare cost-sharing that would give patients a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The AMA also supports modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, a new cost-sharing structure under Medicare. Under a system in which beneficiaries would have a choice of traditional Medicare or another plan, the AMA calls for all plans to be subject to the same fixed contribution amounts and regulatory requirements, and encourages the development of policies to ensure appropriate government standard-setting and regulatory oversight of plans.

Several bipartisan deficit reduction and Medicare reform proposals have elements that are consistent with the reforms articulated in Policy H-330.896. For example, the Bipartisan Policy Center Debt Reduction Task Force, chaired by Alice Rivlin, PhD, and former Senator Pete Domenici (R-NM), and the National Commission on Fiscal Responsibility and Reform, chaired by Erskine Bowles and former Senator Alan Simpson (R-WY) propose combining cost-sharing requirements for Parts A and B, with a single coinsurance rate and maximum out-of-pocket spending limits. The Bowles-Simpson plan and the Bipartisan Plan to Save Medicare and Reduce Debt, introduced by Senators Joseph Lieberman (I-CT) and Tom Coburn, MD (R-OK), propose limiting Medigap coverage to ensure beneficiaries are responsible for at least some level of first-

dollar coverage. The Lieberman-Coburn plan also includes a recommendation that the Medicare eligibility age be raised from 65 to 67, consistent with changes in life expectancy.

Another reform concept being discussed is the possibility of transitioning Medicare to a "premium support" program, which would allow beneficiaries to use Medicare funding to purchase a health insurance plans of their choice. Variations of this concept are included in the Dominici-Rivlin proposal, the Bowles-Simpson proposal, and the House Concurrent Budget Committee Resolution, which was passed by the House of Representatives in April 2011. Medicare is currently a "defined benefit" program, where the federal government pays for a specific set of health care benefits, regardless of cost. Under a premium support program, the government would provide a "defined contribution" to eligible seniors to enable them to purchase their own coverage based on what insurance benefits they would value most. The amount of the government contribution is not directly dependent on the benefits received. The general concept of a premium support system is consistent with AMA Policy H-330.896, which advocates offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. However, there are important implementation questions associated with this financing mechanism, including how premium support amounts will be determined; whether and how means-testing mechanisms might be applied; and what regulations would govern health plans offering alternatives to traditional Medicare coverage.

SUPPLEMENTING MEDICARE – BUILDING ON AMA POLICY

The reforms proposed in Policy H-330.896 were designed to be implemented within the scope of the current Medicare program. The AMA must continue to advocate strongly for structural reforms to modernize the cost-sharing and benefits structure, and introduce more patient choice into the program. The reforms outlined in Policy H-330.896 remain relevant in the current environment.

In the long-term, however, it seems unlikely that the traditional Medicare program can continue to serve as the primary source of health care coverage and services for seniors. Money from the HI Trust Fund is already being spent faster than it is being replenished; the SMI Trust Fund is projected to consume steadily increasing amounts of federal tax revenues, effectively squeezing out other federal budget priorities; and the inability of Congress to face the budget realities associated with continued reliance on the SGR formula all place Medicare in an extremely vulnerable position. The concept of Medicare as a pre-funded benefit – where workers pay into a system during their working years, and draw from the system upon retirement – is illusory. A recent analysis by the Urban Institute shows that the cost of Medicare benefits received far exceeds the amount of Medicare taxes collected. For example, an average two-earner couple turning 65 in 2011 is expected to use $357,000 in lifetime Medicare benefits, but only paid $119,000 in Medicare taxes during their working years (Steuerle and Rennane, June 2011). Even with significant improvements in the efficiency of the Medicare program, it is clear that the current Medicare financing structure and design are insufficient to provide the resources necessary to adequately and affordably provide insurance coverage to seniors.

AMA policy on long-term Medicare reform is articulated in Policy H-330.898, which calls for the current Medicare program to transition to a self-funded, private sector approach to financing health care for the elderly. Individuals would be required to make a minimum contribution into individually owned savings accounts, which would grow tax-free, and be dedicated to funding post-retirement medical care. Subsidies would be available for low-income individuals to ensure that their accounts receive minimum contributions annually. The policy also recommends using the Federal Employees Health Benefit Program (FEHBP) as a model for restructuring Medicare so

that seniors could choose the plan that best meets their needs from among competing plans. Policy H-330.898 envisions eliminating the need for the traditional Medicare program by creating mechanisms to allow seniors to purchase private coverage.

The Council and the House of Delegates last revisited the adequacy of Policy H-330.898 in 2003 (Council on Medical Service Report 5, I-03). Below are the components of Policy H-330.898, followed by a brief Council discussion.

(1) Our AMA supports proposals to shift the funding of Medicare from the current tax financed pay-as-you-go system to a system of mandatory individually owned private savings, with a required minimum contribution, accumulated tax-free and dedicated to funding post-retirement medical care. The government would provide a contribution to economically disadvantaged individuals making smaller than average contributions to their retirement accounts.

Individually owned private savings

Under Policy H-330.898, individuals would be required to save money to enable them to purchase health insurance coverage in retirement. These individual savings could supplement funds available from a premium support system or a defined contribution system, or could take the place of the federal government's obligation to contribute to the cost of health care coverage for all seniors, regardless of income.

Required minimum contribution

Policy H-330.898 suggests requiring individuals to contribute a minimum amount annually to their retirement health care savings accounts, to ensure that the accumulated funds are sufficient to purchase an appropriate coverage policy at retirement.

Contributions for economically disadvantaged individuals

Policy H-330.898 recognizes that not all individuals will be able to afford to make minimum contributions to their retirement health care savings account. The policy provides for government subsidies to enable eligible individuals to accumulate sufficient balances in their savings accounts.

(2) Supports establishing incentives to encourage the use of accumulated balances in health savings accounts for the funding of post-retirement medical care.

The Council notes the AMA has strong policy on the value of health savings accounts (e.g., Policies H-180.857 and H-165.852).

(3) Recognizes that while private sector solutions can address a large portion of the long-term funding of Medicare, there will still be a need and responsibility for support from government or charitable organizations for the economically disadvantaged.

Similar to the first component of Policy H-330.898, this component articulates the principle of providing contributions to subsidize the retirement health savings accounts of economically disadvantaged individuals. The Council firmly believes that the government, rather than charitable organizations, should have the primary responsibility to provide support for the economically disadvantaged.

(4) Continues to support modernization of the traditional Medicare program by combining the cost-sharing requirements of Parts A and B into a single deductible.

As previously discussed, this concept is expressed in Policy H-330.896, which advocates short-term modifications to strengthen the existing Medicare program.

(5) Continues to support replacing Medicare's systems of price controls with a system of price competition.

The AMA has strong policy promoting price competition over price controls (e.g., Policy H-165.985). Several policies (e.g., Policies H-380.989, H-383.991 and H-385.961) support allowing patients to privately contract with their choice of physicians.

(6) Supports the premise that the FEHBP should be used as a model for restructuring Medicare. This type of program would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program, for the plan that best meets their needs. Private retiree health insurance also should be integrated into any FEHBP-modeled system.

The core feature of this component of the policy is the importance of allowing seniors to choose from among competing plans to identify the plan that best meets their needs, which is a strong theme in AMA policy (e.g., Policy H-330.912). AMA policy supports using FEHBP regulations as a reference when considering if a given plan would provide meaningful coverage (Policy H-165.846).

(7) Supports the premise that during the transition from the current Medicare program to a system of pre-funding, workers would not only establish private savings accounts for their retirement expenses, but would also continue to support current and soon-to-be retirees through some level of taxation.

It is important to ensure a fair transition from the traditional financing of Medicare to a new way of financing health insurance for seniors. The Council recognizes that the expectations and obligations of younger and older Americans must be fairly balanced, and any transition will likely need to be phased in over several years.

(8) Reaffirms that the fundamental goal of transforming Medicare should be to assure the health of the elderly and disabled populations. Patients must have access to high quality medical services. The best value in medical care can be achieved by ensuring that the medical profession has a central role in the design and implementation of a new Medicare program. Patients must also receive timely and accurate information on the necessity and important aspects of Medicare transformation.

This final component of Policy H-330.898 articulates the overall goals of moving from the current, unstable Medicare program to a new model for insuring America's seniors.

The Council suggests the House use these eight components of Policy H-330.898 as a starting point for considering the development of updated policy to address transitioning the Medicare program over the long-term so that it moves beyond annual crises. The Appendix of this report includes a list of questions that the Council hopes will generate comments and information to help guide the development of future AMA policy on how to strengthen Medicare and health insurance coverage for seniors.

DISCUSSION

While the forthcoming recommendations of the Congressional Joint Select Committee on Deficit Reduction may include some recommendations for reforming Medicare, it is likely that major policy discussions about entitlement reform will take place in 2013, following the 2012 elections. The Council believes that by developing a long-term vision for reforming Medicare at this time, the AMA will be able to actively help shape the future of the program.

In light of the ongoing efforts to stabilize the Medicare program, and the growing realization that even under the best of circumstances, these efforts will be insufficient to address the significant financing and budgeting issues associated with meeting Medicare's obligations, the Council believes there is an opportunity for the AMA to take a lead role in discussions related to Medicare reform. The AMA should continue to advocate for the short-term reforms to the traditional Medicare program that are articulated in Policy H-330.896, while simultaneously positioning itself to present a vision for moving beyond traditional Medicare, to a stable, equitable system that promotes shared responsibility and patient choice to ensure that America's seniors have access to the health care they want and need.

The purpose of this report has been to examine the myriad concerns associated with the current Medicare program, and to re-examine AMA Policy H-330.898, which proposes transitioning from the current Medicare program to a private sector approach in which the government provides subsidies to those most in need.

For purposes of clarity, this report focuses on the role of the Medicare program in providing health insurance coverage to seniors, who make up 83 percent of the program enrollees. In addition, at this time the Council is not attempting to address the other parts of the health care system that are supported by the current Medicare program, such as providing funding for graduate medical education at teaching hospitals, or additional payments to support rural hospitals. The Council acknowledges that policy decisions will ultimately need to be made to address those services and supports provided by Medicare that do not include seniors.

The Council is seeking the advice and suggestions of members of the House of Delegates, state medical associations, and national medical specialty societies in refining AMA policy for transitioning beyond the current Medicare program. The Council has included a list of questions as an appendix to this report, which are intended to help stimulate discussion and feedback. At this time it is critical that the AMA continue to build its reputation as a partner in identifying ways to create a more robust and secure way of ensuring access to high-quality, cost effective care for America's seniors.

RECOMMENDATIONS

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

1. That our American Medical Association forward the testimony and comments from Reference Committee and House of Delegates discussions regarding the Medicare financing reform strategies outlined in this report to the Council on Medical Service for consideration in developing its recommendations for a follow-up report at the 2012 Annual Meeting. (Directive to Take Action)

2. That our AMA encourage members of the House of Delegates, state medical associations, and national medical specialty societies to forward any additional comments on the Medicare financing reform strategies outlined in this report to the Council on Medical Service by January 6, 2012. (Directive to Take Action).

3. That our AMA make the comments submitted to the Council on Medical Service for its 2012 Annual Meeting report on Medicare financing reform strategies available to AMA members via the AMA website or other appropriate mechanism. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500.

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

APPENDIX
Suggested Questions Regarding Long-Term Medicare Financing Reform

These questions are intended to stimulate thought and discussion. The questions are not intended to be mutually exclusive, nor are they all- encompassing. The Council encourages Delegates and the Federation to share comments on these questions and other issues related to the subject of long-term Medicare reform.

1. In the long term, should the federal government continue to guarantee access to a minimum level of health insurance coverage for seniors? If so, should this be accomplished by the government acting as an insurer (e.g., traditional fee-for-service Medicare), or by the government providing vouchers, tax credits, or similar resources to enable seniors to purchase coverage from a private insurer? How should this be financed (e.g., dedicated tax, general revenues)?

2. Assuming delivery and physician payment reforms, should traditional fee-for-service Medicare (i.e., the federal government acts as the insurer) remain an option for seniors choosing a health insurance plan?

3. AMA Policy H-330.896, "Strategies to Strengthen the Medicare Program," supports allowing beneficiaries to use Medicare dollars to purchase a health insurance plan approved by Medicare (i.e., not necessarily traditional fee-for-service Medicare). How should the amount of money beneficiaries receive be determined? Should the amounts be means-tested? What, if any, restrictions should there be on beneficiary choice of plans?

4. Eligibility for the current Medicare program is based on age, rather than need. Medicare Part B and D premiums are means-tested, but cost-sharing remains relatively low even for the wealthiest seniors. In 2013, higher income workers will pay an additional 0.9% Medicare payroll tax. Should additional means-testing mechanisms be applied for Medicare beneficiaries? To what extent should Medicare participation be means-tested? Should Medicare eligibility be phased out at higher income levels?

5. Policy H-330.898, "Long-Term Funding of Medicare," proposes requiring individuals to establish private savings accounts to fund health care retirement expenses in. Should individuals be required to save for future health care needs? Should such savings be held individually, or should they be pooled and managed by a third-party (public or private)? What regulatory restrictions should be placed on health care savings accounts?

6. What are the most important issues that should be considered when thinking about a transition from the current financing and design of Medicare to a new or modified system of financing Medicare? What are the implications of reforms on various generations (e.g., current young adults vs. those nearer retirement age vs. current retirees)?

Please send comments to:

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