February 24, 1999

Hon. John Breaux
Chair
National Bipartisan Commission on the Future of Medicare

Dear Senator Breaux:

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) is pleased to share with you the attached preliminary position paper on converting Medicare to a defined contribution program. The paper also addresses other proposals under consideration by the Commission, including proposals to institute a defined *benefit* voucher system, to advance the age of Medicare eligibility, to require higher income beneficiaries to pay more into the program, and to increase payroll taxes or general revenues to support the program.

ACP-ASIM is the largest medical specialty society, representing over 115,000 physicians who specialize in internal medicine and medical students. Internists are specialists in adult medical care, and as such, provide primary and subspecialty care to more Medicare beneficiaries than any other physician specialty. We therefore have a particular interest in how proposals to change Medicare will affect the quality, availability, and cost of care to elderly and disabled patients.

Based on a review of the evidence that is now available on several of the options for restructuring Medicare that are under consideration by the Commission, the position paper concludes with several preliminary recommendations. (Once the Commission issues its final report, we will review our preliminary recommendations in the context of the Commission's own conclusions and findings). The paper concludes that:

1. **Medicare should *not* be converted to a defined contribution program**. A defined contribution program would break the federal government's promise to make affordable health insurance coverage available to elderly and disabled patients. Instead of contributing whatever is required to make affordable care available to beneficiaries, the government's contribution would be limited to whatever a given Congress decided to spend on the program. This would inevitably erode the very feature—the guarantee that all beneficiaries will have access to affordable coverage, regardless of income or health status—that has made the current program so successful.

2. **A defined *benefit* voucher (or premium support) program should be tested on a demonstration project basis before a decision is made to implement it on a national basis.** There currently is insufficient evidence on the potential impact of a premium support model on access, quality, administrative costs, and other potential outcomes for the Commission—or Congress—to conclude that this model should be adopted now. Our paper proposes several specific features—such as how the voucher contribution should be determined—that should be evaluated during a demonstration project. We believe that a demonstration project would allow a future Congress to make a more informed decision on the advisability of a premium support program than could possibly be made now based on the limited information that is available.

3. **Congress should *not* delay the age of eligibility for enrollment in Medicare.** Although we acknowledge the demographic argument that is made for advancing the age of eligibility—which is that people are living longer than when Medicare was first enacted—we cannot support this proposal until and unless steps are taken to achieve universal coverage. A delay in the age of eligibility will force millions of retired Americans--those who no longer will have coverage through their employers or Medicare--to join the ranks of the uninsured, which is not an acceptable outcome. In addition, the second half of the

seventh decade of life is a time when many people, especially those with many risk factors for heart disease, require a great deal of costly care.

4. **Congress *should* consider requiring that higher income beneficiaries pay more into the program through income-related premiums.** As a matter of fairness, we believe that it is reasonable to ask those who can afford to do so to pay more into the program.

5. **Congress *should* consider increasing payroll taxes and/or general revenues to support the Medicare program.** Improved but costly tests and treatments account for a substantial part of the increase in the costs of the Medicare program. These real benefits cost money. We believe that a balanced approach requires that Congress not just look at ways of reducing the costs of the program, but also at measures to increase funding for Medicare.

6. **As ACP-ASIM advocated in a policy paper issued in 1997, Congress *should* institute changes in Medicare that will improve care of patients, improve the fee-for-service program, ensure appropriate use of medical technology, and improve the Medicare managed care program.** The recommendations proposed in that paper should save tens of billions of dollars over a five year period.

ACP-ASIM recognizes that Medicare reform is needed. But we also believe strongly that Congress must exercise caution to assure that a program that has improved care and quality of life for millions is not harmed by measures that are designed to preserve it. The recommendations in this paper provide an informed basis for deciding how to change the Medicare program without the need to institute "reforms" that run a considerable risk of harming elderly and disabled patients.

Sincerely,

Harold C. Sox, MD, FACP
President