



Implementation Considerations for Universal Coverage

Federal Law Considerations and Medicare

California State Assembly Select Committee on Health Care Delivery Systems and Universal Coverage

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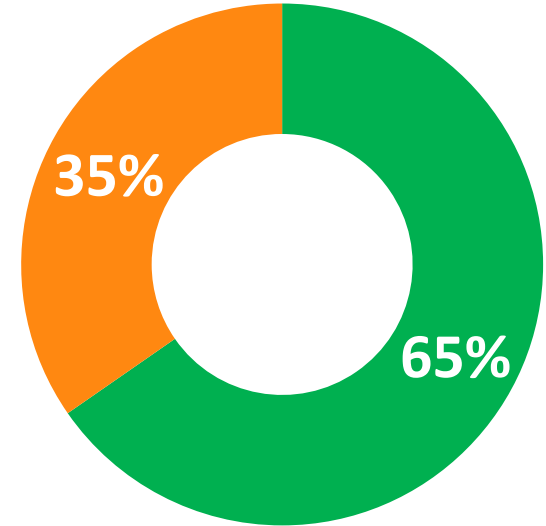
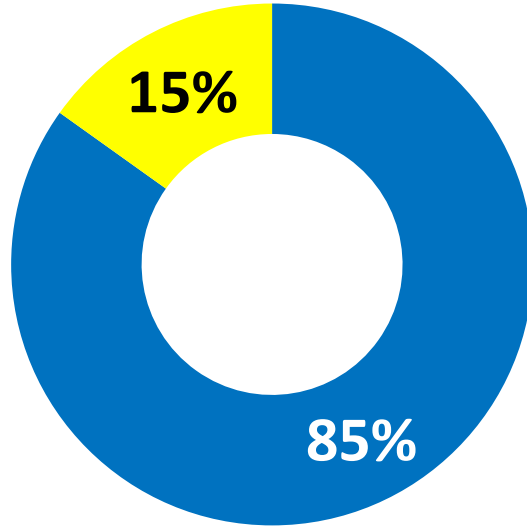
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Figure 1

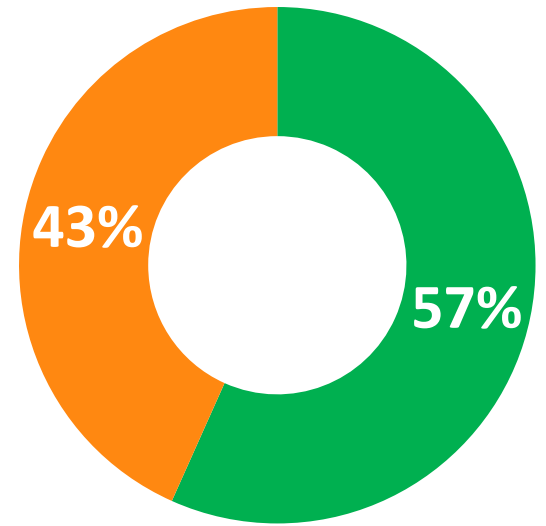
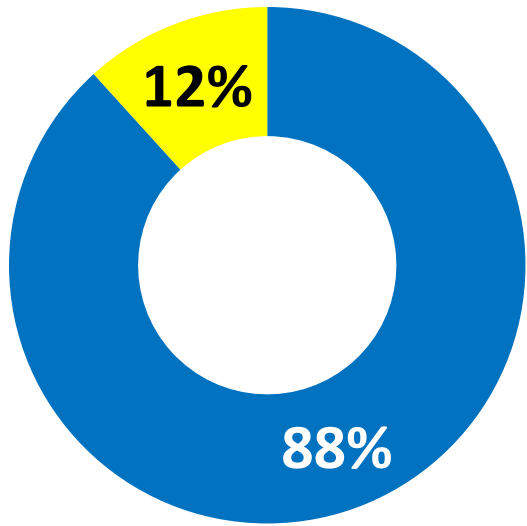
Overview of Medicare eligibility and enrollment

■ Age 65 and over ■ Under age 65 with disabilities ■ Traditional Medicare ■ Medicare Advantage (MA)

U.S.
Medicare Beneficiaries:
58.9 million
1 in 5 US residents



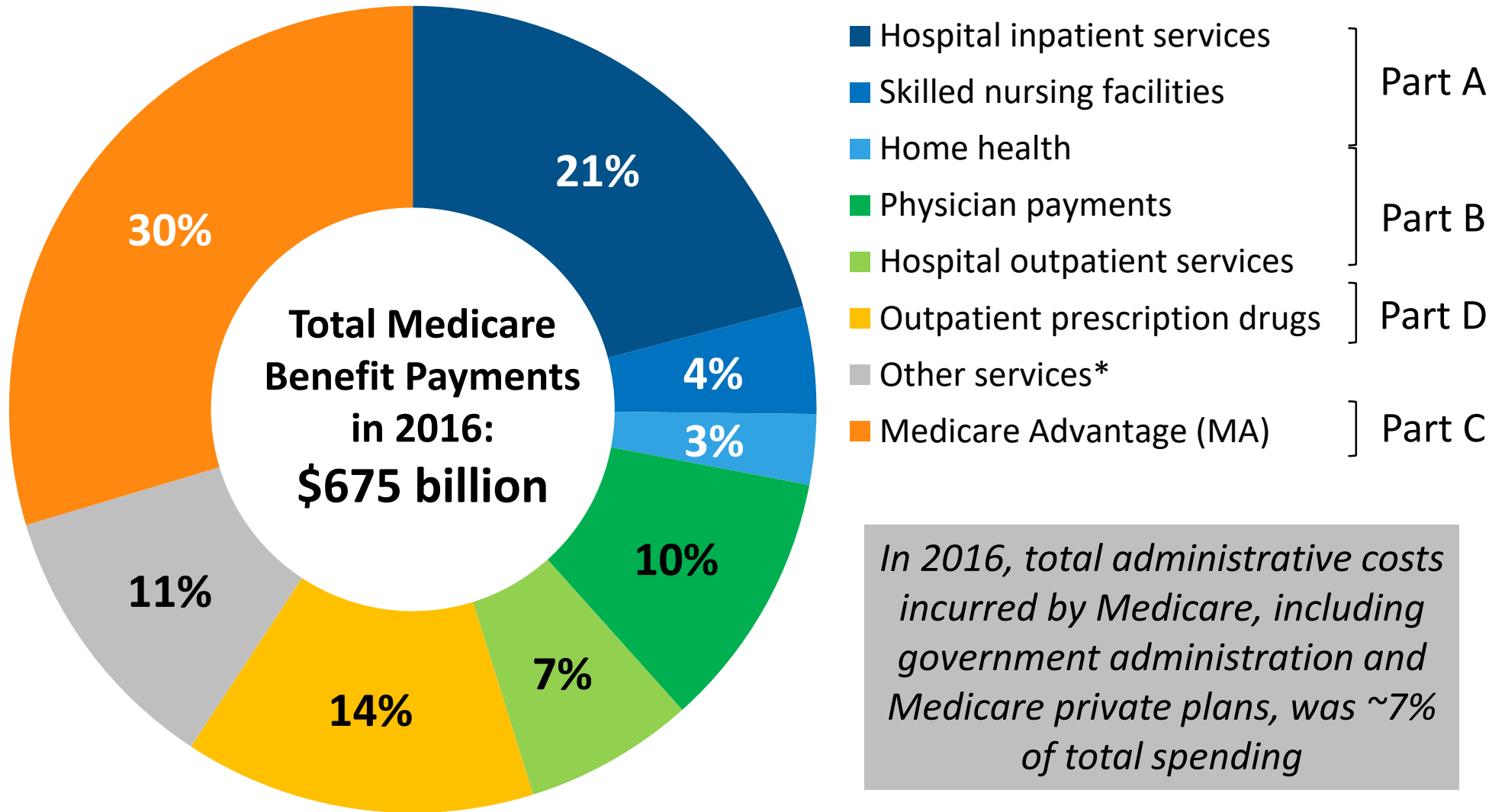
CA
Medicare Beneficiaries:
6.0 million
1 in 6 CA residents



SOURCE: Kaiser Family Foundation analysis of Centers for Medicare & Medicaid Services, Medicare Enrollment data, November 2017.

Figure 2

Where do Medicare benefit payments go?



NOTE: *"Other services" consists of hospice, durable medical equipment, Part B drugs, outpatient dialysis, ambulance, lab services, and other Part B services; also includes the effect of sequestration on spending for Medicare benefits and amounts paid to providers and recovered.

SOURCE: Data on benefit payments from Congressional Budget Office, June 2017 Medicare Baseline; data on administrative expenses from CMS, 2016 National Health Expenditure data.

Figure 3

How is Medicare financed?

- **Part A:** funded mainly by a **2.9% payroll tax** on earnings paid by employers and employees (**1.45% each**) deposited into the Hospital Insurance Trust Fund
 - Higher-income taxpayers (>\$200,000/individual and >\$250,000/married couple) pay an additional 0.9% Medicare payroll tax
- **Part B:** funded by **general revenues** covering 75% of program costs each year and **beneficiary premiums** covering the other 25%
 - Higher-income beneficiaries (>\$85,000/individual and >\$170,000/married couple) pay a higher share of program costs
- **Part D:** funded like Part B, with **general revenues** covering ~75% of program costs each year, and **beneficiary premiums** and **state transfers** covering the rest
 - Higher-income beneficiaries (>\$85,000/individual and >\$170,000/married couple) pay a higher share of program costs

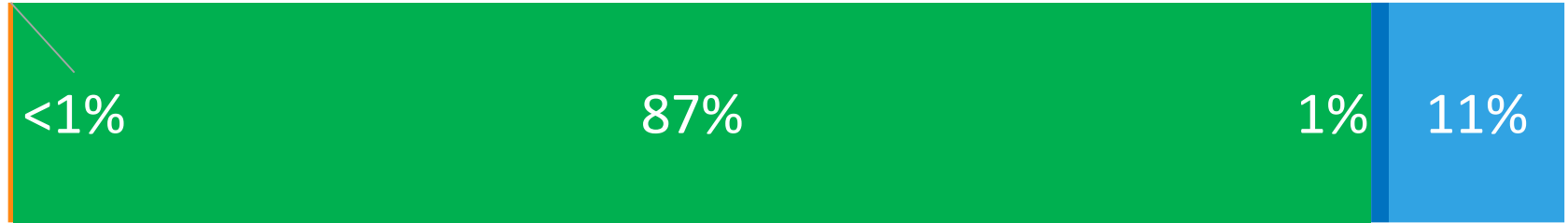
Figure 4

How is Medicare financed?

*Revenues
in 2016:*

■ General revenue ■ Payroll taxes ■ Premiums ■ Other

Part A
\$291
billion



Part B
\$313
billion



Part D
\$106
billion



NOTE: Data are for the calendar year. "Other" includes transfers from states, taxation of Social Security benefits, interest, and other.

SOURCE: 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1.

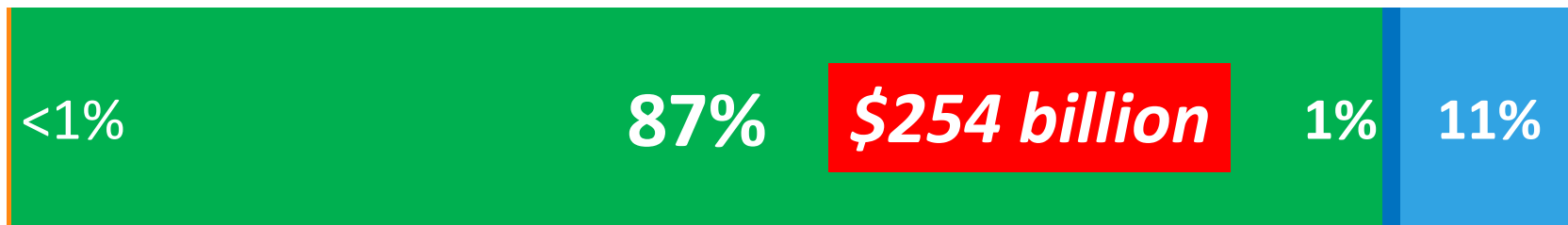
Figure 5

How is Medicare financed?

Revenues
in 2016:

■ General revenue ■ Payroll taxes ■ Premiums ■ Other

Part A
\$291
billion



Part B
\$313
billion



Part D
\$106
billion



NOTE: Data are for the calendar year. "Other" includes transfers from states, taxation of Social Security benefits, interest, and other.

SOURCE: 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1.

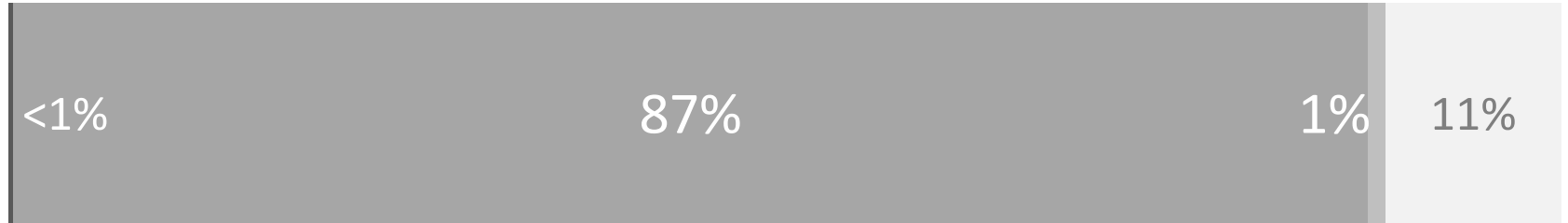
Figure 6

How is Medicare financed?

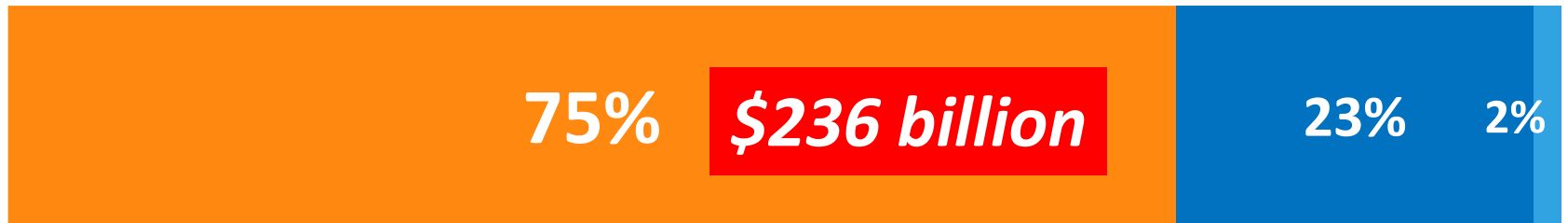
Revenues
in 2016:

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Part A
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NOTE: Data are for the calendar year. "Other" includes transfers from states, taxation of Social Security benefits, interest, and other.

SOURCE: 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1.

Figure 7

Overview of Medicare law and waiver authority

- **Title XVIII of the Social Security Act** covers Medicare eligibility, benefits, provider payments, & financing
- Federal law permits the Secretary of HHS to waive certain provisions of Medicare law to conduct demonstration projects and test models of payment & delivery system reforms related to Medicare
 - **Section 3021 of the ACA (SSA §1115A)**: Established the **Center for Medicare and Medicaid Innovation** with broad authority to test innovative models for service delivery and payment methods in Medicare, Medicaid, and CHIP
- Congress can also require specific Medicare demonstrations through legislation
- Medicare waivers/demonstrations are different from Medicaid & ACA waivers

Figure 8

Overview of the Center for Medicare and Medicaid Innovation

- Innovation Center solicits ideas for new models, develops models, and selects “partners” to test models through a competitive process (usually)
- Models require rigorous monitoring, testing, & independent evaluation
- Duration & scope of models can be expanded through formal rule-making process
- Models can be terminated (or modified) unless HHS Secretary determines that the modification is expected to improve quality w/out increasing spending, reduce spending w/out reducing quality, or improve quality & reduce spending

Figure 9

Categories for Innovation Center models

- Accountable care
 - *e.g., Next Generation ACOs, Vermont All-Payer ACO Model*
- Episode-based payment incentives
 - *e.g., Comprehensive Care for Joint Replacement Model (hip/knee replacements)*
- Primary care transformation
 - *e.g., Independence at Home Demonstration*
- Initiatives focused on Medicaid and CHIP populations
 - *e.g., Strong Start for Mothers and Newborns Initiative*
- Initiatives focused on Medicare-Medicaid enrollees
 - *e.g., Financial Alignment Initiative*
- Initiatives to speed the adoption of best practices
 - *e.g., Health Care Payment Learning and Action Network*
- **Initiatives to accelerate the development and testing of new payment and service delivery models**
 - *e.g., Maryland All-Payer Model, Pennsylvania Rural Health Model, State Innovation Models*

Can California use existing CMMI authority in the implementation of a single-payer system?

- Existing CMMI authority allows for models testing changes to Medicare payment and service delivery to improve quality and, ideally, achieve program savings
- But broader changes would be needed for implementation of a single-payer system
- Medicare changes likely to be needed would depart from previous applications of the waiver/demonstration and model testing process
 - Waivers/demonstrations typically test new payment & delivery models, not permanent changes to a state's entire health care delivery system
 - Time-limited
 - Oriented around improving quality and/or reducing spending in Medicare
 - Typically federally-guided or controlled efforts, or state-federal partnerships

Figure 11

Using CMMI authority to implement a single-payer system: necessary but not sufficient

- Beyond seeking permission from HHS for changes that can be made under existing authority, federal statutory changes would be needed
- Perhaps most importantly, there is no authority granted the HHS Secretary to redirect Medicare's funding streams or trust fund dollars to states to oversee and manage these funds on behalf of a state's entire Medicare population
- Incorporating Medicare in a single-payer system would require a high degree of collaboration between the federal government and the state to make it work, and would require the state to address many statutory, regulatory, and administrative issues related to Medicare