E LEGE OF S
INTERNAL

REFORMING MEDICARE IN THE

Reforming Medicare in the Age of Deficit Reduction

A Position Paper of the
American College of Physicians

This paper, written by Ryan Crowley, was developed for the Health and Public Policy Committee of the American College of Physicians: Robert M. Centor, MD, FACP, Chair; Robert McLean, MD, FACP, Vice Chair; Vineet Arora, MD, FACP; Charles Cutler, MD, FACP; Thomas D. DuBose, Jr. MD, MACP; Jacqueline W. Fincher, MD, MACP; Luke O. Hansen, MD; Richard P. Holm, MD, FACP; Ali Kahn, MD; Lindsey S. Merritt; Mary Newman, MD, FACP; P. Preston Reynolds, MD, FACP; and Wayne Riley, MD, MBA, MACP with contributions from Virginia L. Hood, MBBS MPH FACP (ACP President); Yul Ejnes, MD, FACP (Chair, ACP Board of Regents), and Donald W. Hatton, MD, FACP (Chair, Medical Practice and Quality Committee).
It was approved by the Board of Regents on 16 April 2012.

Reforming Medicare in the Ag e of Deficit Reduction

Summary of Position Paper Approved by the ACP Board of Regents, April 2012

Why Is It Necessary to Reform Medicare?

Enrollment and spending in Medicare, the federal defined benefit system of health care insurance for people 65 and older (as well as certain groups of people with disabilities), has grown substantially over the past few decades. A heightened concern about government

supplemental coverage that greatly reduces their cost-sharing responsibility, potentially leading to greater spending.

- Payment structure. Medicare's fee-for-service structure inadvertently rewards physicians and other providers for delivering a high volume of services regardless of their value or cost-effectiveness.

Key Findings and Recommendations from the Paper

ACP recommends the following:

- To ensure solvency and maintain access to affordable care for beneficiaries, the Medicare program must lead a paradigm shift in the nation's health care system by testing and accelerating adoption of new care models, including:
  - Accelerating adoption of the patient centered medical home model
- Pilot-testing of a defined benefit premium support option, on a demonstration project basis, with strong protections to ensure that costs are not shifted to enrollees to the extent that it hinders their access to care.
- Eligibility and Premiums:
  - The Medicare eligibility age should only be increased to correspond with the Social Security eligibility age if affordable, comprehensive insurance is made available to those made ineligible for Medicare.
  - Medicare premiums should continue to be gradually increased for wealthier beneficiaries, and modest increases in the payroll tax cut to fund the Medicare program should be continued as well.
  - Congress should consider giving Medicare authority to redesign benefits, coverage and cost sharing to include consideration of the value of care being provided based on evidence of clinical effectiveness with consideration of cost.
- Medicare Parts A and B should be combined with a single deductible under the following circumstances:
  - Specified primary care and preventive services are not subject to the deductible
  - A limit is placed on total out-of-pocket expenses
  - The deductible is set at an actuarially appropriate level
  - Medicare payment levels to physicians for covered primary care and preventive benefits are adequate to assure that beneficiaries have access to such services
- Supplemental Medicare coverage – Medigap plans – should only be altered in a manner that encourages use of high quality, evidence-based care and does not lead Medicare beneficiaries to reduce use of such care because of cost.
- Medicare should provide for palliative and hospice services, including pain relief, patient and family counseling and other psychosocial services for patients living with terminal illness.
- The costs of the Medicare Part D prescription drug program should be reduced by the federal government acting as a prudent purchaser of prescription drugs.
- Congress should amend the authority for an Independent Payment Advisory Board (IPAB) in several respects order to achieve comprehensive, quality recommendations.

For More Information

This issue brief is a summary of Reforming Medicare in the Age of Deficit Reduction. The full paper is available at

How to cite this paper:

American College of Physicians. Reforming Medicare in the Age of Deficit Reduction. Philadelphia: American College of Physicians; 2012: Policy Paper. (Available from American Col[e]

A heightened concern about government spending and the national debt has led policymakers to consider reforming the Medicare system. By 2020, the Congressional Budget Office (CBO) predicts that 14% of federal spending will be devoted to Medicare. The 2010 Medicare's Board of Trustees estimates that while Medicare spending growth will be slower than in the last decade, it will still increase by 6% annually from 2010-2019.[1] The Affordable Care Act (ACA) will help slow Medicare spending. According to the CMS Office of the Actuary, the health care reform law will decrease spending by $575 billion over 10 years. Factors such as technological advancements, changes in health coverage, rising prices, and reimbursement structures contribute to the growth of health care expenditures.[2] Medicare will also face an influx of Baby Boomer generation enrollees, accounting for 45% of total spending growth over the next 25 years.[2] The 2011 Medicare Trustees report estimates that the hospital trust fund will run out of money by 2024 unless serious action is taken to address spending.

The Medicare program is a defined benefit, where enrollees receive guaranteed financial contributions for a package of health benefits. Some proposals to reform the Medicare system would transform the Medicare program to a defined contribution (or premium support) program, where beneficiaries would receive a finite amount of financial assistance to purchase health insurance.

It should be noted that many of the reforms proposed by members of Congress and the various deficit-reduction commissions would

/ 4) &) ; :'" ') ? ;'"? : %? 4B:5B5; & : &) %5 : 5> : 5:;
+ ;" ' ;! ' ; 4 :& " %) & : &) ' :; :+ 4;" "+ ;'" : !
) 4!5 4?" : " 4 : ' :+4"? ; :+%' 5/:
/ 4) ?" :5;4" ' ;:) ? 45" ;:) : %:+%' :& 4$;'" : ;"?"!
;" 5:;) :+4 ? ' ;: 44B!+" $'" : ' :4"5$:5 % ;") ' /: :) ? 4' !
& ' ;: ' ;"; B:) 4:') ' +4) ";:) 4 ' "C ;") ' :5) >%: : >;) 4"C
;) :+4) ?" :) >;4 : ' :) # ;"? : > ;") ' %55"5; ' :;)
' " " 4" 5/:
/ :'" ";" %+ 4: +"; : 4 %) ' ;4" >;") ' :5) >%: : 5 :) '
; : ? 4 : " :'" : :) 4 + " : 4 :) 4: :)) 4 '" ; : 4
+%' :+4) ?" '" :; : " 4 : ' ";:+ $ /: :+ 4: +"!
; : " 4 : A+ ' ";>4 :%? %) 4:; ;: 4 :& B:4 +4 5 ' ;
; : !) 4!5 4?" : " /: > 5 0> ' ;: 4 %) ' ;4" >;") ' :%?!
%5) >%:4"5 :@"; :; : ? 4 :)) 4 '" ; : 4 :+%' :+4 !
& ">& :,+4) ?" '" : ;:% 5;:; : " 4 : ' ";:+ $ -:) 4
; ;:) 4 + " : 4 /
/ > %% " %: ' " " 4" 5:5) >%: : A & +;: 4) & :+ 4;" "!
+ ;'" :'" :; : &) ' 5;4 ;") ' :+4) # ;/:

/: :5>++) 4;5:+) %" 5:;) : ' 5>4 :; ;: " 4 : ? ' ; :+%' 5: 4
>' : ;:; :%? %) :; ::;4 ";") ' % " 4 :+4) 4 & /

/: : " 4 : %" "%B: :5) >%:) ' %B: :'" 4 5 :;) :) 44 5+) '
@"; :; :) " % >4";B: %" "%B: :" :) 4 % :) & +4 ' 5"?
'" 5>4 ' :"5:& : ? "% %:;) :;) 5 :& :'" %" %:) 4: " 4 /
) ; ' ;" % ? 45 :"& + ;5:) :+4) 5+ ;"? %B:'" 4 5" :; : :) : %%
" "%B:) >%: :& ";" ; : B:'" %% '" : : " 4 : >B!'" :) +;") '
,@"; :'") & ! 5 :5> 5" " 5-:) 4:+ 45) ' 5: : :;) :; : :@ '
; B:@) >%:) & : %" %:) 4: " 4 : B:+4) ?" '" : 55: '
+> % ()")"11]TJ 0.56287 0 Td [0.5"6286 0 Td [(>)11]TJ 0. 0 Td [<13>18]TJ 0.55559 0 85J 0.d [("

; :;) :+4) ?" :5 4?" 5:; ;: 4 :>' ' 55 4B:'" ++4) +4" ;
4& >% ' 9) 4:>' +4) ? ' : ? ' :" :; :+ ;" ' ;:4 0> 5;5:;) :+ B
) 4:5> :5 4?" 5:) >;!) !+) $;/<
* -/:) 4:5> : :+4) 4 & :;) : :5> 55 >%5; $) % 45:& >5;
@) 4$: ;) : > ; :+ B5" " ' 5: ' :) ; 4: %; :+4) 5!
5") ' %& ' :; "4:+ ;" ' ;5:) >;: " !? %& :5 4?" 5 : '
') >4 :5 4 : "5") ' !& $'" : ' :>5 :) :+ ;" ' ;
"5") ' : " 5: ;) 55 'TJ+0.5)84+2)>2d [<17>9]TJ 0.5.25977 0 Td [(+)6]TJ]TJ 0.573

(/: >++%& ' ; % " 4 :) ? 4 " +:+%' 5 5) >%:) ' %B:
%; 4 :'" : :& ' ' 4:; ;: ') >4 5:>5 :) : " !0> %;B: ?" ' !
5 : 4 : ' :) 5:') ;:% : " 4 : ' " " 4" 5:;) :4 > :>5
) :5> : 4 : >5 :) :) 5;/: 4 ? ' ;"? :+4) >4 5:5> : 5:;) 5
4 ; : ' : :) 4: :

multiple chronic diseases may account for up to 96% of annual Medicare spending.[10] Obesity is of particular concern as over 30% of current Medicare beneficiaries are obese.[11] Obese elderly individuals have fewer disability-free years of life than normal-weight elderly individuals, and Medicare spending for an obese individual is 35% higher than for a normal-weight beneficiary.[12]

Medicare financing structure

The aging population and their subsequent retirement create an additional problem, as fewer workers will be contributing to the Medicare program through worker payroll taxes. Medicare Part A (hospital insurance) is funded by payroll taxes; Part B is funded through enrollee premiums and the general federal tax revenue. Over the next 20 years, estimates show that payroll taxes will not keep pace with Medicare program spending, leading to inevitable shortfa

estimated to balloon to about 4.1% of GDP by 2085.[9] Unless costs are curbed, Part B and D premiums will consume a greater share of beneficiary's Social Security payment, from 27% of the average monthly benefit in 2010 to 50% in 2080.[8] Alternatively, a greater share of federal general revenues would be devoted to offset the rising costs of Medicare Part B and D.

Technological advancements and price issues

According to the Medicare Payment Advisory Commission (MedPAC), a significant share of growth in health care costs can be attributed to advancements in technology and growth in prices. While new medical technologies often produce substantial benefits to patients (and in some instances may reduce costs), some may inadvertently replace existing, less expensive technology of comparable clinical effectiveness. Since health insurance insulates patients from the cost of expensive new technology, patients may not seek the most cost-effective, high-value intervention, potentially receiving an unnecessary or inefficient service. Further, new technology may be adopted by the medical community before its clinical effectiveness is fully realized. A literature review conducted by the CBO concluded that some new medical technologies could be used sparingly without undermining clinical value.[14] To help physicians and other health professionals decide which services and products would be most valuable to their patients, the ACA established the Patient-Centered Outcomes Research Institute to coordinate funding for comparative effec

responsibilities (which are often reduced by supplemental coverage), beneficiaries have little financial reason to limit the volume or intensity of the care they receive or shop around for a high-quality provider.[17] The ACA seeks to change this by eliminating cost-sharing for certain primary care services that are deemed high-value by the United States Preventive Services Task Force.

Payment structure

Medicare's fee-for-service structure inadvertently rewards physicians and many other health care providers for delivering a high volume of services regardless of their value or cost-effectiveness.[1] As long as Medicare covers a procedure, the program will pay physicians and other providers for the services they deliver; therefore, it is financially be

matic, across-the-board cuts to the federal budget that w

tion, the House of Representatives approved the c[illegible]

capita, and contributions to beneficiaries would be reduced over time un e ud

physicians and their staff. A survey conducted by the American Medical Association found that almost 70% of physicians had to wait several days to receive approval for services requiring prior authorization and that 10% of physicians reported having to wait over a week.[30] Existing ACP policy supports requesting that an entity, such as the Institute of Medicine, study the issue of administrative costs, paperwork documentation, and medical authorization rules across the health care system and make recommendations on how the amount of time spent on such activities can be reduced, particularly for primary care physicians.

The College has also endorsed the establishment of a national, multi-stakeholder initiative to reduce marginal and ineffective care and prod

Medicare's payment system is in need of reform. According to MedPAC, the Medicare physician payment system "continues to call for unrealistically steep fee cuts, it inherently rewards volume over quality and efficiency, and it favors procedural services over primary care, which has serious implications for the nation's future primary care workforce."[33] The sustainable growth rate (SGR) formula, on which Medicare payment updates are based, is a deeply flawed mechanism that fails to control Medicare spending growth and has attracted critics from across the health care landscape. The SGR intends to provide lower payment updates when overall Medicare physician spending grows faster than the target growth rate. However, the SGR fails to incentivize physicians to limit superfluous services or reward those who provide high-value care. MedPAC has acknowledged the limitations of the SGR and has repeatedly called for its repeal. Congress has acted to counter SGR-initiated payment reductions, providing temporary funding patches to avoid drastic reductions in physician payments. Without Congressional intervention, the SGR would have automatically reduced physician fee schedule payments by 30% in 2012.[32] Repeal of the SGR is costly; without action the cost of repeal is estimated to reach $600 billion in 2016.[34]

The College has long advocated for efforts to reform the Medicare physician payment structure. In 2011, ACP called for a repeal of the SGR, stable updates for 5 years with higher updates for primary care services, implementation and evaluation of innovative payment models (such as the patient-centered medical home), and a set date to implement payment methods proven to encourage delivery of high-value care.[35] Substantial change will take time but the introduction of payments for services like phone and email consultations, non–face-to-face patient interactions, and transition of care activities, within the existing fee-for-service system will fte

- A formula to determine the initial contribution amount as well as a method of determining how this amount will be updated. This is a key difference among plans. Aaron and Reischauer's original premium support plan tied updates to health care costs. The Domenici/Rivlin plan uses an index related to the GDP, and the Ryan *Path to Prosperity* proposal would tie updates to the CPI. Since the latter two plans would peg the

the area, such as a preferred provider organization, to establish a benchmark. This bid would represent the cost of providing the defined benefit package (e.g., Parts A, B, and D of Medicare). If the fee-for-service plan bid exceeded thehm oJ/Kj-99dno,j,yd[f

as traditional fee-for-service Medicare. This is no easy task, as risk-adjustment mechanisms for Medicare Advantage have been somewhat uneven in their effectiveness. The Medicare Modernization Act of 2%kr+hlk1-lop9n,j,yd=2%kr+hlk1-lo##9,j,yd=2%

exercised prior to implementing such a significant change in Medicare financing that will affect millions of the nation's elderly and most vulnerable citizens.

/: :5>++) 4;5:+) %" 5:;) : ' 5>4 :; ;: " 4 : ? ' ; :+%' 5: 4
>' : ;:; :%? %) :; :;4 ";") ' % " 4 :+4) 4 & /

Some claim that beneficiaries will have greater choice of coverage options under a Medicare defined contribution system. However, Medicare beneficiaries are already able to choose between traditional Medicare and a range of private Medicare Advantage plans. Some of these plans are able to provide Medicare services at a lower bid level; however, average Medicare Advantage payments are estimated to be 10% higher than traditional Medicare in 2011.[51] This inflated payment formula was established in 2003 in an effort to encourage enrollment in private plans. ACP supports giving Medicare beneficiaries choice in coverage (providing consumer protections, risk-adjustment mechanisms, and other protections are in place), but Medicare Advantage plans should be required to compete with traditional Medicare on an equal footing. The ACA seeks to provide po,ykK[rfjy/Kj-m11pl,j,ykK[ofjy/Kj-9m#1#,j,ykK[vfjy/Kj-n#l1p,mkk#-m11k1,j,yk

expectancy by improving access to medical services.[56] When Medicare was introduced in 1965, total life expectancy at birth was 70.2 years; in 2006, that number had risen to 77.7 years.[57] While it is true that total life expectancy has risen considerably since ,j,ac s kn9,mE fhkoj/Kj-lo#lk,j,yd KE tf9j/Ky/Kj-99jol,j,yd KE fhKj-99jol,j,yd KE %kr+

Refo

age or discourage use of certain services depending on their relative value, has shown promise as one way to incentivize use of evidence-based, high-value quality care. A value-based insurance design project initiated by Pitney Bowes reduced cost-sharing levels for drugs for certain chronic diseases and enrolled patients in disease management programs, leading to heightened adherence and reduced medical and pharmacy costs.[71] In a study of a VBID implemented by a large pharmaceutical company, employees and their dependents reduced cost-sharing for certain drugs used to treat diabetes, asthma, and cardiovascular conditions. As a result, aggregate drug use rates (and medication costs) increased while overall program costs remained neutral and the study recorded a significant increase in medication adherence and prescription fills for cardiovascular conditions.[44]

Congress has acknowledged the potential of the VBID concept by eliminating cost-sharing for certain high-quality services approved by the United States Preventive Services Task Force. Medicare should establish a demonstration project to test the concept in other realms of the Medicare program, such as the prescription drug benefit, where beneficiaries often pay different cost-sharing levels based on whether they're in a generic or a brand name drug "tier."[73] Lower drug costs may particularly benefit the Medicare population, a group that takes an average of five prescription drugs a day, 20% of whom skip or delay taking medications due to cost. As with any adjustment of the cost-sharing structure, protections must be integrated to ensure low-income patients and the chronically ill are not adversely affected by the increased burden. Options, such as reducing cost-sharing for certain drug classes (e.g., diabetes treatments), providing coverage to high-value medications in the Part D donut hole coverage gap, and lowering cost sharing for beneficiaries covered under chronic condition special needs plan arrangements, can all be implemented without any changes to existing law.[72] An expert panel convened by MedPAC suggested creating drug tiers based on clinical comparative effectiveness information.[73] In concert with VBID initiatives, stakeholders must aggressively pursue comparative effectiveness research to determine what products and services are most effective at achieving desired outcomes. Further, efforts must be made to encourage shared decision making between physicians and patients to ensure that patients are able to make informed care decisions.

/: L

The current Medicare benefit package is a complex array of deductibles, premiums, and coinsurance rates that fail to reflect the needs of future beneficiaries. The Part A inpatient hospital deductible, for instance, is excessive. Beneficiaries are forced to pay $1,132 before coverage begins and significant coinsurance after the deductible is met.[74] The Part B annual deductible is $162 with a 20% coinsurance for most services. On the other hand, home health and laboratory services require no coinsurance. With the exception of the prescription drug benefit, Medicare does not have a catastrophic care cap, and this exposes sick beneficiaries to high medical costs. Very low-income beneficiaries may be eligible for Medicaid benefits to assist

j-mlpmy/Kj-mmlo#,j,ypo,j,ydK[efy]‘Kj-loo1K[efy]/Kj-99ln

R

was 35% less than for patients who had not had a conversation regarding their end-of-life care preferences.[87] The study also concluded that higher costs of care yielded poorer outcomes during the patient's final week of life. Additionally, in areas with disproportionately high end-of-life costs, patients with advance directives indicating care limits had lower Medicare expenditures, higher rates of hospice use, and were less likely to die in a hospital.[88]

Unfortunately, only about 18-36% of adults complete an advance directive.[89] Since Medicare plays such an important role in financing care for patients at the end of life, it is crucial that the program encourage end-of-life conversations and a

ing a course in end-of-life care, 16% of residents had done a rotation in palliative or hospice care, and 17% of faculty had taught end-of-life care or a related aspect in the past year. The same study found many medical students and residents expressed that they were underprepared to address patient thoughts on dying and spiritual issues, help families cope with loss, or address cultural issues related to dying.[95]

**/: :) 5;5:) : ; : " 4 : 4;: :+4 5 4"+;") ' : 4> :+4) 4 &
5) >%: :4 > : B:; : 4 %) ? 4' & ' ;: ;'" : 5: :+4> ' ;
+>4 5 4:) :+4 5 4"+;") ' : 4> F(
/ 4> :]TJ 0.51657 0 Td [<17>2]TJ 0.57174 0 T0 Td [(O095 0 Td [(5) [(2)]TJJ 0.27783 0

ACP has concerns with several aspects of the IPAB and has offered recommendations on how it ma

[1] Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy. Washington DC:MedPAC; 2011.
[2] MedPAC. Report to Congress: Medicare Payment Policy. MedPAC. March 2011.
[3] American College of Physicians. How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently? Philadelphia: American College of Physicians; 2011: Policy Paper.
[4] American College of Physicians. Controlling Health Care Costs While Promoting The Best Possible Health Outcomes. Philadelphia: American College of Physicians; 2009.
[5] Hood, V. Letter to Joint Select Committee on Deficit Reduction. American College of Physicians. September 12, 2011.
[6] Congressional Budget Office. CBO's 2011 Long-Term Budget Outlook. Congressional Budget Office. June 2011. Accessed at http://www.cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf on January 12, 2012.
[7] Congressional Budget Office. Raising the Ages of Eligibility for Medicare and Medicaid. Congressional Budget Office. December 2005. Accessed at http://www.cbo.gov/ftpdocs/69xx/doc6971/12-15-AgeEligibility.pdf on January 12, 2012.

http://www.bipartisanpolicy.org/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf on October 13, 2011

[23] Moffit R. The Second Stage of Medicare Reform: Moving to a Premium-Support Program. The Heritage Foundation. November 28, 2011.

[24] The National Commission on Fiscal Responsibility and Reform. The Moment of Truth: Report of the National Commission on Fiscal Responsibility and Reform. The White House. December 2010. Accessed at http://tinyurl.com/29eexln

[25] Wyden R and Ryan P. Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future. December 15, 2011.

[26] Van de Water. Ryan-Wyden Premium Support Proposal Not What It May Seem. Center on Budget and Policy Priorities. December 16, 2011.

[27] Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy. Washington DC: MedPAC; 2011.

[28] Blanchfield BB et al. Saving Billions of Dollars—And Physicians' Time—By Streamlining Billing Practices. Healta

[43] Sheils JF and Fishman A. Comprehensive Medicare Reform: Defined Benefit vs. Defined Contribution. National Coalition on Health Care. September 1, 1998.

[44] CBO. Letter to Congressman Paul Ryan: Preliminary Analysis of Ryan-Rivlin Proposal. Congressional Budget Office. November 10, 2011. Accessed at http://www.cbo.gov/ftp-docs/119xx/doc11966/11-17-Rivlin-Ryan_Preliminary_Analysis.pdf on October 12, 2011.

[45] Postal AD. GAO: Medicare Advantage Insurers Cherry-Picked. National Underwriter. June 7, 2010. Accessed at http://www.lifeandhealthinsurancenews.com/Issues/2010/June-7-2010/Pages/GAO-Medicare-Advantage-Insurers-CherryPicked.aspx

[46] GAO. Medicare Advantage: Relationship between Benefit Package Designs and Plans' Average Beneficiary Health Status. GAO. April 2010.

[47] Rosenthal MB. Hard Choices—Alternatives for Reining In Medicare and Medicaid Spending. NEJM. 2011;364(20):1887-1890.

[48] Horney JR, Van de Water PN, Greenstein R. Rivlin-Domenici Deficit Reduction Plan Is Superior to Bowr M Kef9]yn/Kj-n9ook,j,yK=of9]y/Kj-9mk#1,j,yK[=wrf9]y/Kj-m1mom,j,yKjp-p1k,j,yK[%j

[63] Neuman T, Cubanski J, and Waldo D. Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform. Kaiser Family Foundation. March 2011. Accessed at http://www.kff.org/medicare/upload/8169.pdf on May 17, 2011.

[64] Neuman T, Cubanski J, and Waldo D. Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform. Kaiser Family Foundation. March 2011. Accessed at http://www.kff.org/medicare/upload/8169.pdf on May 17, 2011.

[65] American College of Physicians. Developing a Medicare Buy-in Program. Philadelphia: American College of Physicians; 2005: Position Paper.

[66] Wolf R. Medicare to swell with Baby Boomer onslaught. USA Today. December 13, 2010. Accessed at http://www.usatoday.com/news/washington/2010-12-30-medicare30_ST_N.htm on May 17, 2011.

[67] AARP. Policy Guide. http://www.aarp.org/content/dam/aarp/about_aarp/aarp_policies/2011_04/pdf/Chapter7.pdf

[68] Marr C. Changes in Medicare Tax on High-Income People Represent Sound Additions to Health Reform. CBPP

[82] Andrews M. Medicare Will experiment With Expansion of Hospice Coverage. Kaiser Health News. September 7, 2010. Accessed at http:/

[101] The Commonwealth Fund. Washington Health Policy Week in Review: Medicare Drug Negotiation Could Save Billions, Study Says. The Commonwealth Fund. April 4, 2007. Accessed at http://tinyurl.com/6jrmr3f on October 13, 2011.

[92] American College of Physicians. Testimony of the American College of Physicians to the House Energy and Commerce Committee Subcommittee on Health, "IPAB: The Controversial Consequences for Medicare and Seniors." July 13, 2011. Accessed at http://www.acponline.org/advocacy/where_we_stand/medicare/ipab.pdf on February 13, 2012.

[102] Newman D and Davis CM. The Independent Payment Advisory Board. Congressional Research Service. November 30, 2010. Accessed at http://assets.opencrs.com/rpts/R41511_20101130.pdf on October 13, 2011.

[103] Vaida B. The IPAB: How Could It Change Medicare? Kaiser Health News. May 8, 2011. Accessed at http://www.kaiserhealthnews.org/Stories/2011/May/09/ipab-faq.aspx on October 13, 2011.

[104] American College of Physicians. Testimony of the American College of Physicians to the House Energy and Commerce Committee Subcommittee on Health, "IPAB: The Controversial Consequences for Medicare and Seniors." July 13, 2011.

A