# MEDICARE REFORM: RHETORIC VERSUS SUBSTANCE

by
Henry J. Aaron[a]

"When I use a word," Humpty Dumpty said, in a rather scornful tone,
"it means just what I choose it to mean - neither more nor less."

"The question is," said Alice, "whether you can make words mean so many different things."

"The question is," said Humpty Dumpty, "which is to be master - that's all."
Lewis Carroll, *Through the Looking Glass*

"May I have your attention please?
May I have your attention please?
Will the real Slim Shady please stand up?
I repeat, will the real Slim Shady please stand up?
We're gonna have a problem here..."
Eminem, *The Real Slim Shady*

It seems a shame to spend our time discussing whether a particular plan *replaces* Medicare or *reforms* it; or whether or not that plan is genuine, honest-to-goodness 'premium support.' But names help frame debates; and in politics framing is, if not everything, then a very big deal. Whatever else it may be, Medicare is high-stakes politics.

When Bob Reischauer and I coined the term 'premium support,' we did it precisely to distinguish the plan we described from 'vouchers.'[1] Many people were suggesting that Congress should replace 'Medicare' with 'vouchers.' Medicare was—and is—a *defined-benefit* program. The benefit is access to defined services at a pre-specified cost. The value of that benefit automatically rises with the cost of covered services. The value of vouchers, in contrast, is linked to an index independent of health care costs. In practice, the index is chosen because it is expected to grow less rapidly than the cost of health care. If the elderly and disabled had a voucher they could choose the insurance plan that suited them best. And if they had to pay all of any cost above the voucher, enrollees, it was hoped, would have increased incentives to enforce efficient production of health care services.

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Initial voucher proposals were silent or vague on regulation. This gap signaled that sponsors didn't think that regulation was very important. It also suggested that the resulting market would be regulated no more aggressively than were the insurance markets of the day, which is to say 'not much.'

In short order, the term "voucher " got a rather bad 'rep.' In some measure, the stigma was elicited by Medicare advocates leery of any fundamental changes. But critics raised substantive concerns. As some voucher opponents put it, the elderly and disabled would be cut off from a program—Medicare—replete with rights and protections, handed checks that would cover an ever-smaller share of their health costs, and placed at the mercy of insurers and providers who were not altogether to be trusted.

As economists, Bob Reischauer and I understood the advantages of market-based competition. We recognized that vouchers might, under the right conditions, produce important advantages. The reasoning, straight out of principles-of-economics text books, is that people have different preferences regarding the risks against which they want to protect themselves. By switching from insensitive or high-cost vendors to responsive and low-cost vendors, cost- and quality-conscious consumers goad suppliers in many markets to improve quality and hold down price, and they might do so in insurance markets as well. Insurers, in turn, would have incentives to police physicians, hospitals, and other care-givers into providing improved care at lower prices.

We were convinced, however, that plain-vanilla vouchers would not deliver these benefits. We also feared that the voucher plans then on the table were more likely to harm Medicare enrollees than to help them. We saw three changes in standard voucher plans as essential.

- First, the cash payment should be indexed to average health care costs, not to some extraneous index. For decades, advancing medical technology had been pushing up health care spending faster than prices or incomes.[b] It seemed

[b] There is a widespread view that health care is unusual in this respect. This view is false. Technological advance almost invariably increases spending, even as it lowers price. Spending on ground transportation (the automobile and railroads), air transportation, computation (the computer), entertainment (movies, recordings, television) all rose

likely to continue doing so. Hence, linking a voucher to a non-health index virtually guaranteed benefit cuts that we believed the old and disabled could ill afford. To be sure, competition or some other development might conceivably drive down the cost of health care for everyone. But the fundamental purpose of Medicare was—and is—to assure that the elderly and disabled receive health care not materially different from that provided to the rest of the population. If general medical cost growth did not slow, Medicare beneficiaries should not be cut off from services available to others by some mechanical formula. Either way, the right index to use was the cost of health care, not a general index of GDP or prices.

- Second, competition could not work in unregulated markets. Enthoven, Stiglitz and Rothschild, and others had laid out the various reasons why unregulated insurance markets, in general, and health insurance markets, in particular, can and do fail. To avoid these problems, plan offerings should be limited and standardized so that people could understand their choices. Sales information and marketing should be managed by disinterested third parties—public or private—both to help consumers understand their choices and to minimize socially wasteful competition among insurers to enroll the healthy.
- Third, we saw as imperative the development of risk-adjusted payment algorithms to further reduce incentives to compete based on risk selection. Regulation could not entirely eliminate such incentives, as insurers can always take steps to push out enrollees who turn out to be high-cost users. Joseph Newhouse years ago suggested that the best approach might blend (*ex ante*) risk-adjusted capitation and (*ex post*) adjustments based on incurred costs. Bob

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sharply with technological advance. Prices of transportation, computation, and entertainment fell. Official price indices show health care prices rising. But whether health prices have, in fact, risen or fallen remains unclear, as proper adjustment for quality change is extremely difficult. In at least two cases–the treatment of heart disease and mental illness–careful analyses of quality change suggest that prices actually fell, although official indices show prices to have risen.

and I didn't know whether adequate risk adjustment was possible, but believed that it is a precondition for successful premium support.

Against this background, it seems clear to me that all of the recent proposals for modifying Medicare that advocates call 'premium support' differ *fundamentally* from the plan Bob and I called premium support. To be sure, the term 'premium support' is

**HOW LANGUAGE EVOLVES: ONE EXAMPLE:**

The word 'gender' originally applied to words, not people. According to Fowler's *Modern English Usage*, 1965 edition:

> **gender**, n., is a grammatical term only. To talk of *persons* or *creatures of the masculine* or *feminine g.*, meaning *of the male* or *female sex*, is either a jocularity (permissible or not according to context) or a blunder.

According to *Dictionary.com*, 2011:

> **gender,** noun
> 1. a. a set of classes that together include all nouns, membership in a particular class being shown by the form of the noun itself... . The number of genders in different languages varies from 2 to more than 20....
> b. one class of such a set
> c. such classes or sets collectively or in general
> d. membership of a word...in such a class
> 2. sex: the feminine gender

What seems to have happened is that English speakers, perhaps from a desire to avoid talking about 'sex,' euphemistically extended the use of a word that applied to language to spare themselves from using a term with connotations they wished to avoid. Perhaps there is some parallel with the use of premium support.

nobody's personal property. Language evolves and changes depending on usage [see box]. Just as those squeamish about using the word 'sex' might prefer the word 'gender,' supporters of voucher plans might out a similar discomfort prefer the term 'premium support.'

The central issues, however, are ones of substance, not terminology. And there are two such issues. The overriding question is whether the recently advanced voucher proposals are good ideas. The secondary question, if the answer to the first question is—as I believe— 'no,' is whether there is a good alternative.

## WHY RECENT VOUCHER PROPOSALS ARE BAD IDEAS

I shall focus on two of the recent voucher proposals: the one advanced by Paul Ryan in his 2011 budget proposal[2] and the one contained in the budget plan of the Bipartisan Policy Center.[3] These plans differ from the voucher proposals of the 1990s in certain respects and resemble them in others.

Current Voucher Plans

Under the Ryan plan the age of eligibility for Medicare would be increased two months a year, starting in 2022, until it reaches age 67 in 2033. People turning age 65 in 2022 would no longer be eligible for Medicare (parts A, B, or C). They would receive, instead, a voucher and a Medical Savings Account ($7,800 in 2022). The value of the voucher for 65 year olds in 2022 would be the same as the estimated net value of Medicare benefits (after premiums and cost sharing) for 65 year olds in that year—$8,000—but would subsequently be age- and risk-adjusted. The voucher could be used only to buy private insurance. People who turn age 65 or who qualify for Medicare through Disability Insurance before 2022 could remain in traditional Medicare or switch to the new system after 2022. Each year, the value of vouchers and the amount deposited in the MSA would be increased at the same rate as the consumer price index. People in the top 8 percent of the annual income distribution for the Medicare-eligible population would receive less than the full voucher payment.

Under the proposal of the Bipartisan Policy Center, a voucher alternative to Medicare would be launched in 2018. The per-person cost of Medicare in 2017 would thereafter be raised at a rate equal to the growth of per capita GDP, plus 1 percentage point. Medicare enrollees could opt to take the voucher and buy insurance privately or they could remain in traditional Medicare, provided that they paid a premium to cover any growth the cost of traditional Medicare beyond GDP plus 1 percentage point.[c] Private plans that cut costs

[c] What would be done if the price of traditional Medicare was pushed up by adverse selection is unclear.

below the voucher amount could either offer added services (as they are required to do under current law) or rebate premiums to enrollees. Although the plan description does not address the topic, I assume that private plans would either be required to offer a community rate or the voucher would be adjusted for age and health status, as in the Ryan plan.

Are Current Proposals Premium Support?

As noted above, what words mean evolves. It is clear, however, that both plans fail, in varying degrees, to include the safeguards that Reischauer and I described to meet the three shortcomings with voucher proposals. In their initial forms, both plans link vouchers to non-health price indexes. Neither plan presents adequate information on whether or how the market for private insurance plans would be regulated.

Indexing

The Ryan plan would tie its voucher to an index that historically has grown far more slowly than health costs. The Bipartisan Policy Center's index has grown more rapidly than consumer prices, but less rapidly than Medicare costs. From 1990 through 2010 the CPI rose cumulatively by 67 percent. A sum that grew at the same rate as nominal per capita GDP plus 1 percentage point would have grown 150 percent. Over the same period, per capita Medicare spending rose 224 percent.

These numbers express the health-care cost problem. They also indicate the risks of linking the value of health insurance for a vulnerable population to an independent index. Benefits under the Ryan plan would have been cut by 48 percent over the last two decades. Benefits would have been cut 23 percent under the Bipartisan Policy Center plan.

Voucher advocates claim that if Medicare beneficiaries are constrained by the insurance that vouchers would support, cost-conscious buying would slow the growth of spending. Perhaps. But, as CBO has pointed out, voucher recipients would have been denied the Medicare discounts called for under current law. They would also have been exposed to the higher selling and administrative costs characteristic of private insurance.

The Congressional Budget Office estimates that under the Ryan plan the cost-increasing effects would swamp the cost-reducing effects, so much so that by 2030 the overall cost of care for the Medicare population would be at least 41 percent higher than it would be under Medicare and the amount that enrollees would have to pay directly would more than double. If one looks back rather than ahead, the health services covered by a Ryan-type voucher plan that began in 1990 would have been about half of what they actually are and those under current law by 2009.

Looking ahead, the differences between voucher plan spending and Medicare spending depend sensitively on whether one believes that the savings called for under the Affordable Care Act are realized. That depends, in turn, on whether the key provisions of the Affordable Care Act survive court challenge, whether state resistance undermines the law's effectiveness, whether the law is repealed, and whether the targets for reductions in reimbursements are sustainable. If the law survives and is enforced, the gap between GDP plus 1 percentage point and projected Medicare spending could be modest. Should the ACA be repealed or weakened, however, the differences could be quite large. Furthermore, one cannot be sure whether new medical technology will make GDP plus 1 percentage point quite generous or severely restrictive. This uncertainty underscores the fact that Medicare spreads the risk of surprisingly rapid increases in health care costs across the population as a whole through taxes, while vouchers focus them on the elderly and disabled.

Not only do voucher advocates claim savings, they do so with quite remarkable certitude. Now, I freely acknowledge that vouchers may conceivably have the transformative effect on health care costs and efficiency claimed for them. Anything is possible. But large savings are far from certain. All other nations spend dramatically less per person on health care than does the United States. Most have achieved those results by other means. My own current view is that the risks to the Medicare population of linking a voucher to an index other than that for health care are sufficiently serious that any plan with such a linkage should, for reasons set forth below, be deferred.

Regulation

Neither the Ryan plan nor the Bipartisan Policy Center proposal speak in detail to the regulation of private insurance offerings and marketing. *The Path to Prosperity: Restoring America's Promise* references an earlier release that describes a plan purportedly endorsed by both Representative Ryan and Alice Rivlin. The full reference to regulation in the earlier document reads:

> "In order to receive the Medicare payment, a beneficiary would select a plan from a newly created Medicare Exchange. Health plans which choose to participate in the Medicare Exchange must agree to offer insurance to *all* Medicare beneficiaries, thereby preventing cherry picking and ensuring that Medicare's sickest and highest cost beneficiaries receive coverage."[4]

This passage states clearly that marketing of insurance would be controlled by a central authority, but is silent on how the regulation would be done. As it happens, Congressman Ryan was more forthcoming in draft legislation he had previously sponsored. That proposed legislation would have required states to offer an unlimited menu of insurance options:

> "A State shall not restrict or otherwise limit the ability of a health insurance plan to participate in, and offer health insurance coverage through, the State Exchange, so long as the health insurance issuers involved are duly licensed under State insurance laws applicable to all health insurance issuers in the State and otherwise comply with the requirements of this part."[5]

This statement means that controls exercised by the exchanges would <u>not</u> include the number of vendors, the number of plans, or the nature of plans. Given the capacity to insurers to segment the market by plan design, this provision is a veritable license to engage in competition based on risk selection. I do not know whether Representative Ryan—or, for that matter, the Bipartisan Policy Center—now holds other views. But the whole question of how sale of health insurance would be regulated is too important for ambiguity.

Regardless of what voucher sponsors intend, it would be irresponsible to ignore the limits of what likely would be done to regulate health insurance given the prevailing hostile

mood toward government regulation. That mood makes highly improbable the serious regulation of insurance offering and marketing that would be necessary to enable Medicare enrollees to make informed choices based on objective and neutral sales materials. More likely, Congress either would follow Representative Ryan's stated preference to require the 'any willing insurer' policy contained in his 2010 proposal or would delegate to states the power to regulate exchanges, as was done in the Affordable Care Act. The first course would virtually invite competition based on risk selection nationwide. Under the second course, many states would likely succumb to lobbying by insurers with the same unfortunate result in much of the nation.

Are ACA Subsidies the Same as Vouchers?

Some voucher advocates counter that those who defend the Affordable Care Act have no reasoned basis for opposing vouchers for the Medicare population because, they assert, the ACA subsidies are the same as vouchers.[6] This claim was also made at a previous meeting of this group.

This assertion is false. First, while the ACA subsidy formula does not provide complete protection from unexpected increases in health care costs, it does provide some, particularly to lower-income enrollees. The Ryan and Bipartisan Policy Center plans provide none.

During the earlier discussion here, I realized that I did not fully understand the operation of the ACA formula. Because of my uncertainty, I asked the Congressional Budget Office how the ACA subsidy would vary with changes in the cost of health care. As it happened, they had received the same question from journalists, who were likewise confused. Because misstatements were being made in public, they prepared an analysis, which I attach to this paper as an appendix.

In brief, as health insurance premiums increase, ACA subsidies also increase, but by less than the full added premium cost. The protection afforded by the ACA is higher for

low- than for higher-income enrollees. In contrast, the Ryan and Bipartisan Policy Center subsidies do not vary with premiums.

The second difference between the ADA subsidies and the two voucher plans described above is how they would affect the different populations to which they would apply. Most of those who will qualify for subsidies under the ACA will receive a net benefit. They would previously have been uninsured or would have borne premium costs unaided. In contrast, the voucher plans would be worth less than the Medicare coverage they replace. Not only are vouchers and ACA subsidies different in form; quite simply, ACA subsidies increase benefits, while vouchers cut them.

Exchanges: For Whom

Well-regulated health insurance exchanges may conceivably improve the individual and small-group insurance markets. After all, those markets now operate execrably. Furthermore, exchanges under the ACA would apply only to the non-elderly, non-disabled. Even for this population, the hurdles to setting up successful exchanges have yet to be cleared. Creating well-functioning exchanges for the Medicare population will be much harder.

- The variance in health care spending is higher for the elderly and disabled than for the non-elderly and non-disabled. The reward for socially wasteful competition through risk selection is correspondingly higher for the Medicare population than for those whom the ACA exchanges will serve.
- Second, the Medicare population includes large numbers of people with mental or physical impairments or who are undergoing age-related mental decline.

Both considerations mean that operating exchanges successfully to serve the Medicare population would be more challenging than operating exchanges to serve the current individual and small group markets. I believe that it would be more prudent to learn how to operate exchanges with the easier population. Only after the challenges of serving the non-elderly and non-disabled are met would it make sense to take on the far more difficult

task of serving the elderly and disabled. What makes no sense at all is to call for repeal of the Affordable Care Act provisions regarding exchanges for the non-Medicare population and simultaneously propose creating exchanges for Medicare enrollees. Nor can I comprehend why any serious legislator would propose that the 'dual eligibles'—those who receive both Medicare and Medicaid—be asked to manage health savings accounts.

I now think that the type of plan that Bob Reischauer and I called premium has little or no chance of being passed or, if passed, implemented with the safeguards that we envisaged. The proposals now under discussion are all fatally flawed. The vouchers are linked to wrong indexes. In the current political atmosphere, the regulation required to make them work reasonably well is a fantasy. And it remains unclear, more than fifteen years after we wrote, whether adequate risk adjustment is feasible. More fundamentally, I am less persuaded now than I was when Bob and I wrote that even the well-run voucher systems that we called 'premium support' are desirable for the Medicare population. Medicare enrollees are an enormously heterogeneous group. Many are physically and mentally capable of handling the demands of shopping for insurance and managing health savings accounts. But the physical and mental tolls of aging and impairment mean that a larger proportion of the elderly and disabled than of the rest of the population are not able to meet those challenges.

In addition, major legislative developments have occurred since the mid-1990s. Congress has significantly improved Medicare coverage. Much of Medicare now operates under prospective payment. And, of course, the Affordable Care Act is now law and includes aggressive regulation of Medicare spending and the creation of health insurance exchanges (as well as the myriad other provisions). The immediate challenge is to make health exchanges work for the population that will qualify for subsidies under the Affordable Care Act. As do many others, I hope that Congress, the executive, and the fifty states will successfully meet that challenge.

If they do, then I believe that the health insurance exchanges are likely to expand to include groups not now eligible to buy insurance through them. Eventually, it may make sense to open them up to the Medicare population or some members of it. But that time, in my view, is many years in the future.

## APPENDIX

*Letter from Phil Ellis, Congressional Budget Office*, 13 January 2011

The bottom line answer to your questions is that you have it right for the period through 2018 – subsidies and enrollee premiums will grow at the same rate, so the enrollee and the government will each bear some of the cost of premium growth and the shares of the premium paid by each will hold steady (with the enrollee share being lowest, of course, for the lower-income enrollees).

The effect of the additional indexing that will probably apply in later years is harder to characterize. The short-hand answer that subsidies are indexed to CPI after 2018 is NOT correct, but what is correct? The only way I could think of to illustrate what will happen is to construct some numerical examples – see the attached tables, which try to show what happens from one year to the next if only "regular" (pre-2019) indexing applies, and what happens if "additional" (post-2018) indexing applies. (Note that I've tried to make the example realistic and am applying the PPACA subsidy schedule but am using rough approximations for many of the numbers involved.)

The first table shows the relatively straightforward case in which income grows at the same rate as CPI, so that folks' income as a share of the FPL stays the same (assuming the FPL levels grow at CPI). In that case, the share of income that folks have to pay grows faster when the additional (post-2018) indexing applies – but because that share starts out smaller for lower-income folks, their premiums increase by a smaller amount (in dollar terms).

The second table shows the more complex case in which income growth exceeds CPI, which has the added effect of moving folks up the subsidy phase-out schedule a bit in "Year 2." The slope of that phase-out schedule varies by income in a complex way.

In either case, the upshot is that the subsidies will indeed grow more slowly after 2018, but the degree of the slowdown varies with income. For the lowest-income folks in the exchanges, the subsidy will grow nearly as fast as premiums, whereas for the higher-income subsidy recipients, the growth in subsidies will be much slower – but may still exceed CPI. (I've done some similar calculations for higher-income single enrollees, and the subsidy growth rate for them could be below CPI.) The reduction in the subsidy growth is thus progressive, in a sense; if instead the subsidies at all income levels grew only with CPI, all enrollees would have the same dollar increase in their premiums which would of course be a much larger share of income for the lower-income enrollees.

One additional caveat is that the additional indexing provisions will apply only if exchange subsidy payments exceed a specified share of GDP (which by sheer coincidence equals 90% of CBO's original estimate of subsidy payments for 2018 divided by CBO's projected GDP for that year); thus, there is some probability they will not apply. I have seen the projections of the CMS actuaries which indicate that exchange subsidies will thus be fixed as a share of GDP after 2019, and I don't think that is a correct interpretation – but have not yet had a chance to make that point to Rick Foster.

As for comparing the PPACA subsidies to the Rivlin/Domenici plan – indexing gov't payments to GDP + 1 – the comparison depends to some extent on who you decide is an "average" exchange enrollee, given that the indexing effects vary among enrollees. (Under PPACA, the effects probably vary by ago too given that age-rating is allowed in the exchanges but I have not looked at that dimension.) By contrast, in R/D -- and under Rivlin-Ryan, with which I'm more familiar -- premiums are, I think, community rated, so the subsidies are effectively equivalent for all enrollees.

Having said that, these examples indicate that – after 2018 – the subsidies would grow noticeably faster than GDP+1 for the lower income group (150% of FPL), around GDP+1 or a tad faster for those around 250% of FPL, and slower than GDP+1 for the folks around 350% of FPL. But the difference depends on what the income growth rate is. If premiums grow faster than the 6% rate we project (which is roughly GDP per capita + 2), then the PPACA subsidies would grow more quickly too while the R/D subsidies would not, so in that sense there is more risk for enrollees under R/D.

I hope this is helpful – and not a case of information overload. Given the widespread confusion on these points, we hope we will be able to put out an issue brief discussing the indexation of exchange subsidies – but the timing of that will depend on the press of other events. Let us know if you have further questions.

CBO then published this explanation, which may be found at www.cbo.gov under the title "Additional Information About CBO's Baseline Projections of Federal Subsidies for Health Insurance Provided Through Exchanges, May 12, 2011.

**ILLUSTR** **ILLUSTRATIVE SUBSIDY EXAMPLES -- FAMILY POLICY**
Scenario Scenario: Income Growth Rate = CPI

**ASSUMP** **ASSUMPTIONS -- ALL ARE ROUGH APPROXIMATIONS**

| | | | | |
|---|---|---|---|---|
| CPI | CPI | 2% | Family Premium | 15000 |
| Income | Income Growth | 2% | FPL in Year 1 | 20000 |
| Premium | Premium Growth | 6% | FPL in Year 2 | 20400 |

| EXAMPL | EXAMPLES | Year 1 | Year 2 Regular Indexing | Year 2 Add'l Indexing | Year 1 | Year 2 Regular Indexing | Year 2 Add'l Indexing | Year 1 | Year 2 Regular Indexing | Year 2 Add'l Indexing |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Lower-Income Family | | | Middle-Income Family | | | Higher-Income Family | | |
| | Income | 30000 | 30600 | 30600 | 50000 | 51000 | 51000 | 70000 | 71400 | 71400 |
| Income | Income / FPL | 150% | 150% | 150% | 250% | 250% | 250% | 350% | 350% | 350% |
| Income / | Req'd Premium Share | 4.00% | 4.16% | 4.32% | 8.05% | 8.37% | 8.69% | 9.50% | 9.87% | 10.26% |
| | *Growth Rate* | | *3.9%* | *8.0%* | | *3.9%* | *8.0%* | | *3.9%* | *8.0%* |
| Req'd Pr | Total Premium | 15000 | 15900 | 15900 | 15000 | 15900 | 15900 | 15000 | 15900 | 15900 |
| *Growth* | | | | | | | | | | |
| Total Pre | Enrollee Premium | 1200 | 1272 | 1322 | 4025 | 4267 | 4434 | 6650 | 7049 | 7325 |
| | *Enrollee Share* | *8.0%* | *8.0%* | *8.3%* | *26.8%* | *26.8%* | *27.9%* | *44.3%* | *44.3%* | *46.1%* |
| Enrollee | Federal Subsidy | 13800 | 14628 | 14578 | 10975 | 11634 | 11466 | 8350 | 8851 | 8575 |
| *Enrolle* | *Federal Share* | *92.0%* | *92.0%* | *91.7%* | *73.2%* | *73.2%* | *72.1%* | *55.7%* | *55.7%* | *53.9%* |
| Federal | | | | | | | | | | |
| *Federal* | Subsidy Growth Rate | | 6.0% | 5.6% | | 6.0% | 4.5% | | 6.0% | 2.7% |
| | Enrollee Premium GR | | 6.0% | 10.2% | | 6.0% | 10.2% | | 6.0% | 10.2% |
| Subsidy | | | | | | | | | | |
| Enrollee Premium GR | | 7.8% | 12.0% | | 6.9% | 11.1% | | 6.0% | 10.2% | |

**ILLUSTRATIVE SUBSIDY EXAMPLES -- FAMILY POLICY**
Scenario: Income Growth Rate = CPI + 1

**ASSUMPTIONS -- ALL ARE ROUGH APPROXIMATIONS**

| | | | |
|---|---|---|---|
| CPI | 2% | Family Premium | 15000 |
| Income Growth | 3% | FPL in Year 1 | 20000 |
| Premium Growth | 6% | FPL in Year 2 | 20400 |

| EXAMPLES | Year 1 | Year 2 Regular Indexing | Year 2 Add'l Indexing | Year 1 | Year 2 Regular Indexing | Year 2 Add'l Indexing | Year 1 | Year 2 Regular Indexing | Year 2 Add'l Indexing |
|---|---|---|---|---|---|---|---|---|---|
| | Lower-Income Family | | | Middle-Income Family | | | Higher-Income Family | | |
| Income | 30000 | 30900 | 30900 | 50000 | 51500 | 51500 | 70000 | 72100 | 72100 |
| Income / FPL | 150% | 151% | 151% | 250% | 252% | 252% | 350% | 353% | 353% |
| Req'd Premium Share | 4.00% | 4.19% | 4.35% | 8.05% | 8.36% | 8.69% | 9.50% | 9.78% | 10.16% |
| *Growth Rate* | | *4.7%* | *8.8%* | | *3.8%* | *7.9%* | | *2.9%* | *6.9%* |
| Total Premium | 15000 | 15900 | 15900 | 15000 | 15900 | 15900 | 15000 | 15900 | 15900 |
| Enrollee Premium | 1200 | 1294 | 1344 | 4025 | 4304 | 4473 | 6650 | 7049 | 7325 |
| *Enrollee Share* | *8.0%* | *8.1%* | *8.5%* | *26.8%* | *27.1%* | *28.1%* | *44.3%* | *44.3%* | *46.1%* |
| Federal Subsidy | 13800 | 14606 | 14556 | 10975 | 11596 | 11427 | 8350 | 8851 | 8575 |
| *Federal Share* | *92.0%* | *91.9%* | *91.5%* | *73.2%* | *72.9%* | *71.9%* | *55.7%* | *55.7%* | *53.9%* |
| Subsidy Growth Rate | | 5.8% | 5.5% | | 5.7% | 4.1% | | 6.0% | 2.7% |
| Enrollee Premium GR | | 7.8% | 12.0% | | 6.9% | 11.1% | | 6.0% | 10.2% |

## ENDNOTES

1. Henry J. Aaron and Robert D. Reischauer, "The Medicare reform debate: what is the next step?" *Health Affairs,* Winter 1995, pp. 8-30.

2. Congressional Budget Office, *Long-Term Analysis of a Budget Proposal by Chairman Ryan,"* 5 April 2011.

3. Bipartisan Policy Center, *Restoring America's Future: Reviving the Economy, Cutting Spending and Debt, and Creating a Simple, Pro-Growth Tax System,"* The Debt Reduction Task Force, Senator Pete Domenici and Dr. Alice Rivlin, Co-Chairs, November 2010.

4. A Long-Term Plan for Medicare and Medicaid*Alice Rivlin and Paul Ryan*, November 17, 2010 http://budget.house.gov/news/documentsingle.aspx?documentID=225826

5. H.R. 4529, Section 102(a)(3), 111th Congress, 2nd Sess.

6. One example is James Capretta, "Obamacare's Cruel and Inhumane Inflation-Indexed Vouchers: The president's real alternative to Ryan's plan is rationing," *The National Journal Online*, 21 April 2011. The author subsequently published two clarifications in *The National Journal Online*, "A Clarification on the Indexation of Obamacare's Vouchers, on 25 April 2011 and a second, "Medicare's Actuaries Say Obamacare Vouchers Could Be Tied to the CPI," on 26 April 2011. These clarifications blame the error in the first paper on poor legislative drafting and point out that if health care spending in fact rises no faster than the CPI, then the ACA would increase aid only at the growth of the CPI, a point that was never in dispute.