

Premium Support: A Primer

December 2011

This paper was developed as part of the work of the Budgeting for National Priorities project with support from the Annie E. Casey Foundation and the Charles Stewart Mott Foundation whose assistance is gratefully acknowledged. Also, thanks to the Bipartisan Policy Center for their many contributions to the paper.

The authors thank members of the Brookings-Heritage Fiscal Seminar for many discussions of the issues covered in this report. The paper is being released to the public in the interest of exploring one possible solution to exploding health care costs which in turn are playing a major role in the growth of the budget deficit. Members of the Fiscal Seminar do not necessarily endorse premium support but we believe that the debate over premium support, which has often been confusing, is a vital part of the deficit debate about which the public needs to be better informed.

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The major cause of the federal budget crisis, which is still in its early stages, is the relentless growth of Medicare spending. The two biggest causes of Medicare growth are the retirement of the baby boom generation, thus increasing the number of people on the rolls, and the persistent increase in the per person cost of medical care. The retirement of the baby boom generation is just beginning and the per person growth of Medicare, even though it has moderated slightly in recent years, tends to be well above economic growth, the growth of wages, and overall inflation.¹ Unless something is done, Medicare will continue to consume an increasing percentage of the federal budget. According to the Medicare Actuary, Medicare will grow from 3.6 percent of the nation's GDP in 2010 to 10.4 percent by 2080.² Moreover, the interest on the money borrowed to pay for our programs, one of the most rapidly growing of which is Medicare, will greatly exceed even our spending on Medicare. Unchecked, growth in spending on Medicare and interest on the federal debt will bankrupt the country.

A special feature of health care that makes it difficult to control is that many Americans think the entire population has a right to the best medical care available including sophisticated tests, quality routine care, the best medicines, and expensive surgical procedures. For most other categories of spending in the federal budget, policymakers can make cuts without necessarily incurring the wrath of the American people. Not so with Medicare. A recent Washington Post-ABC News poll found that nearly 80 percent of Americans oppose Medicare cuts.³ The politics of dealing rationally with Medicare are further complicated by the fact that both parties have accused the other of trying to undermine the Medicare program. Republican presidential candidates, for example, are strongly criticizing President Obama for taking money from Medicare to finance the Affordable Care Act (ACA).⁴ Similarly, in the pending 2012 elections, Democrats are planning to excoriate Republicans for trying to destroy Medicare by endorsing the version of premium support incorporated in the House budget for 2012 (see below).⁵

If the reluctance of politicians to incur the wrath of voters can be overcome, and if the internecine fighting between the parties can be quelled, analysts and policymakers have developed two broad choices for constraining the growth of Medicare costs. The first is to call on health professionals and other experts to identify reforms that would contain costs by adopting measures such as reducing the use of redundant or unnecessary tests, reducing the use of treatments that evidence shows are not effective, increasing the use of generic drugs, and increasing the effectiveness and use of preventive care. Given that approximately 25 percent of Medicare spending occurs in the last year of life, there could be significant savings in end-of-life care as well.⁶ The repeated observation that there is little or no correlation between the cost of health care spending and quality of care in a geographical area within the United States and that the U.S. spends far more on health care than any other nation but scores relatively poorly as compared with many other countries on measures of health and of quality of care strongly suggest that we are spending too much money on health care.⁷ The ACA, passed in 2010, contains several mechanisms of top-down reforms to control health care costs, most notably the Independent Payment Advisory Board (IPAB) composed of health experts who will review current research and practice and then submit reform proposals to Congress, although Congress placed limits on the types of reforms the IPAB can recommend.⁸ The proposals would then be considered under special rules in which the legislation would

be considered as enacted unless Congress amended the IPAB recommendation with legislation that achieved the same level of saving.

The second way to contain Medicare growth is to adopt policies that harness market forces to control costs. Although controversial, premium support is perhaps the most credible approach of this type developed so far. The purpose of this primer is to explain premium support, to present the best arguments for and against its use to control health care spending in general and Medicare spending in particular, and to outline a premium support plan that is responsive to most of the valid criticisms. The paper was written as a background document for the Brookings-Heritage Fiscal Seminar. This paper contains an initial section explaining what premium support is (written by Ron Haskins of Brookings), a section presenting arguments against premium support (written by Henry Aaron of Brookings), a section presenting arguments in favor of premium support (written by James Capretta of the Ethics and Public Policy Center), and a section outlining a specific premium support plan—the Domenici-Rivlin plan—that many (but not all) members of our Fiscal Seminar would endorse.

The primary audience for our premium support paper is policymakers who must soon take bold steps to contain Medicare costs, but we also hope this primer will promote understanding of premium support and the arguments for and against it by reporters, students, lobbyists, and the public.

Section A

Premium Support: An Overview By Ron Haskins

The fundamental idea of premium support, developed originally by Henry Aaron and Robert Reischauer,⁹ is to give recipients a capped amount of money to enter the market and purchase an insurance plan that provides the coverage they think they need. Here is a succinct summary of how a premium support plan could work:

- The country would be divided into service areas, usually metropolitan areas, that would serve as the geographic region for common insurance plans and prices;
- The government would specify a set of health care services that had to be covered by every insurance plan that wanted to qualify for federal premium support funds; plans could provide additional coverage, presumably at higher prices which would be paid by beneficiaries;
- Any public or private entity wishing to provide insurance or services within each service area could submit a bid that specified the features and cost of its plan;
- A special organization would serve as a central clearing house for bids and would also: ensure that bids covered the mandatory services; produce lists of the bids and their features for beneficiaries to review; explain the operation of the system to beneficiaries; and provide beneficiaries with additional information and counseling if they want it in order to select the plan that best suits their needs;
- A formula would be used to determine how much money government would be given to beneficiaries as premium support and how much the amount of money would increase each year; and
- The amount of premium support for individuals within service areas could be adjusted for factors such as regional differences in prices, health status, and age.

There are many proposals about how premium support would work in practice. However, we are going to adopt the approach taken by the Congressional Budget Office (CBO) in its thorough 2006 comprehensive report on premium support and focus attention on two characteristics of premium support plans: the government's contribution to paying the premium support benefit and the contents of the mandatory benefit package.¹⁰

Government Payments

From a spending control perspective, the key and most controversial feature of premium support is determining the amount of money the federal government would provide beneficiaries each year to purchase an insurance plan.¹¹ Here it is helpful to distinguish between two broad types of insurance plans—defined-benefit and defined-contribution plans. The main difference between the two is that defined-benefit plans specify a guaranteed basket of health care services that will be covered by the government payment. By contrast, defined-contribution plans specify a guaranteed dollar amount to pay for health care or health care insurance. All premium support plans are defined-contribution plans, although many of the premium support plans proposed so far specify a minimum set of services and procedures that must be covered. Beneficiaries can have a wide array of insurance plans from which to choose, but the government's premium support payment would not vary regardless of the plan selected by the

beneficiary. If beneficiaries selected a plan that cost more than the premium support amount, they would have to pay the difference. However, if beneficiaries selected a plan that was less than the premium support amount, they could keep the cost savings. This feature of premium support may have the effect of both increasing the incentive for beneficiaries to select less expensive plans and the effect of providing insurance companies with incentive to provide such plans. Selecting a less expensive plan would increase the risk to beneficiaries that they could incur costs for procedures that are not covered by their plan but might be covered by more expensive plans. This risk could be reduced by requiring all plans that can participate in the premium support program to cover a specified set of services, as most premium support plans do.

Medicare is now primarily a defined-benefit program—most recipients are in a fee-for-service program that pays for a specified set of services. Recipients must pay for part of their care by meeting deductibles and paying premiums and co-insurance, but almost all beneficiaries have supplemental insurance that pays most of the costs not covered by Medicare.¹² The important point is that as health care costs grow, the government's Medicare payments grow as well. And therein lies the problem. The government has little control over the growth in annual health care costs. This is especially the case because neither beneficiaries nor providers have much incentive to control the number of tests or procedures received by beneficiaries. On the other hand, the defined-benefit feature of Medicare reduces the risk of increased out-of-pocket expenditures on health care by recipients, many of whom have limited financial resources.¹³

Thus, premium support incentivizes cost control at the price of increased cost risks to beneficiaries. By contrast, Medicare has the benefit of minimizing the risk of increased costs to beneficiaries but at the price of reduced incentives for efficiency and cost containment.

How the annual rate of increase in the premium is determined is the central and most controversial feature of the premium support concept. Consider three formulas for determining the rate of increase. The 1999 Bipartisan Commission on Medicare, headed by then-Senator John Breaux and then-Representative Bill Thomas, tied the premium support amount to the market costs of health care.¹⁴ More specifically, as in the premium support outline above, organizations in each geographical region that wished to sponsor insurance plans would submit their annual bids to the oversight entity. The premium support amount in each region would then be set at around 88 percent of the average bid. Thus, as in the current Medicare program, the Breaux-Thomas approach to setting the premium amount was related to the market cost of health care.

Additional approaches to defined contribution premium support are now being proposed by Paul Ryan, the Chairman of the House of Representatives Budget Committee, by the Heritage Foundation, and by former Senator Pete Domenici and former CBO Director and OMB Director Alice Rivlin, first as part of their overall deficit reduction plan and then in a revised version that responds to some criticisms of their original proposal (see below). All the plans proposed a premium support formula external to the cost of market care. Ryan, in the resolution on the 2012 budget which passed the House, proposed to increase the annual premium support payment to

Medicare beneficiaries by the rate of increase in the Consumer Price Index (CPI). Given that the growth of consumer prices trails the growth of per person health care spending by around 4 percentage points a year, the Ryan plan would achieve dramatic savings that would amount to trillions of dollars over the years and would thereby greatly reduce the projected federal deficit. But critics, including CBO, argue that the savings would be achieved by transferring a major portion of the annual medical care cost increase onto recipients.¹⁵ The Heritage plan would index the payment to CPI plus 1 percentage point.¹⁶

A more generous formula for determining the annual rate of increase in premium support was proposed as part of the Domenici-Rivlin comprehensive deficit reduction package.¹⁷ Domenici and Rivlin would allow the premium to increase at the rate of GDP growth plus 1 percentage point. If this growth formula had been in place between 1985 and 2009, the average annual growth of spending per enrollee allowed by the Domenici-Rivlin formula would have been 0.8 percentage points lower than its actual level.¹⁸ Savings of a little less than 1 percentage point may seem minor, but cumulated over many years annual savings of this modest level would accumulate and be enormous, especially in the out years.

Both the Ryan and Domenici-Rivlin premium support plans would result in a reduction of costs to the federal government. Two comments about these savings are in order. First, although some savings could result from increased efficiency, in all likelihood beneficiaries would have to absorb at least part of the reduced government costs. Thus, if a given politician holds the view that Medicare reforms must not impose additional costs on beneficiaries (above those already projected under the current Medicare program), she will not favor premium support. Second, as shown by the comparison between the Ryan plan and the Domenici-Rivlin plan, some approaches would impose lower costs on beneficiaries, likely resulting in more support by politicians. Another provision of premium support that might broaden its appeal would be to either confine increased costs to more wealthy beneficiaries (or at least limit the exposure of low-income beneficiaries), or to initially index the level of the premium to actual Medicare cost and then transition to GDP+1 or some other formula which would achieve greater savings in the out years.

A central question about premium support is whether it would provide incentives for insurance companies, providers, and beneficiaries to take actions that would slow the growth of health care costs. A standard critique of the nation's health care system is that people who use health care the most do not bear the true cost of their care. Most Americans get most of their care covered by employer or union-sponsored private insurance plans or by Medicare or Medicaid. Even most of the Medicare deductibles and co-payments are usually covered by Medigap or other supplemental insurance plans, insulating consumers even further from the impact of the cost of care. But if recipients had to pay more money out of pocket, they might be more likely to purchase the level of insurance they anticipate needing instead of the maximum amount they can afford.¹⁹ And if out-of-pocket expenditures were also linked to incentives for consumers to understand which treatments and tests are effective for certain costly conditions, they might start questioning whether they really need the tests and treatments recommended

by doctors. And better still, consumers might reduce smoking, control their weight, get more exercise, and take advantage of preventive care in order to improve their health and reduce consumption of and personal expenditures on health care. These effects of higher out-of-pocket spending are plausible, but there is little solid evidence to support their actual occurrence under the cost pressure imposed on beneficiaries by a premium support plan.

Similarly, advocates of premium support believe that greater economizing by beneficiaries would be accompanied by greater cost consciousness by insurance companies. If beneficiaries are looking for less expensive insurance plans in order to minimize their out-of-pocket expenditures, insurance companies would have incentive to offer lower-cost plans. In fact, insurance companies might achieve lower prices for the basic coverage required by Medicare by negotiating with doctors, clinics, and hospitals for favorable rates based on volume. It is not beyond imagination that insurance companies and doctors could use recommendations by the IPAB to achieve better health care at lower prices by reducing redundant tests and ineffective procedures.

A common characteristic of both the top-down recommendations in the ACA and the premium support approach favored by Republicans and at least some prominent Democrats is that there is no way to know how well they will work until they are implemented and evaluated.

Benefits Package

The Medicare program currently covers a specific set of benefits.²⁰ Under premium support plans, to ensure that beneficiaries are not able to use their government support to buy an insurance plan with risks for inadequate coverage, almost all the premium support programs developed so far require insurers to offer, at a minimum, a pre-determined set of benefits.²¹ The decision to build premium support around a guaranteed set of benefits reflects the fear of many analysts that plans could compete to attract consumers by offering coverage that is inferior to current Medicare benefits or that coverage would decline over time. In most proposals, the set of required benefits is similar to those now offered by Medicare. Given that beneficiaries must select among providers or health insurance plans, having a standardized set of mandatory benefits would also facilitate price comparisons across plans.

Any organization wishing to provide insurance coverage for the mandatory set of benefits would submit a bid giving details about how each type of coverage would be provided and the cost of their plan or plans. An agency with the authority to decide whether plans meet all the required benefits would validate acceptable plans which would then be eligible for the federal Medicare premium. Similarly, organizations responsible for helping beneficiaries select an appropriate plan to meet their needs would, if asked by recipients, be better able to explain the plans and their differences so that beneficiaries could make an informed selection.²² Another advantage of standardized benefits is that they would make it more difficult for plans to offer a package of benefits that permitted risk selection (the tendency of insurance companies to avoid customers who are likely to be at high risk of contracting conditions that

require expensive treatments or who already have such conditions).²³ If plans had unlimited flexibility in covering health care services, they might be able to reduce the number of beneficiaries with medical conditions requiring expensive treatments by the simple expedient of either not covering or offering minimal coverage for those conditions.

There are, however, some disadvantages to the standardization of benefits.²⁴ If all plans offer the same benefits package, insurance providers might be handicapped in developing plans that result in more efficient delivery of care. CBO uses the examples that plans may be unable to use innovative cost-sharing methods or flexible methods for managing care. A second potential disadvantage of standardization is that insurers would not be able to offer plans that are tailored to the specific needs and desires of beneficiaries. Of course, ability to offer plans tailored to the needs and desires of some groups of beneficiaries can promote risk selection. As the Kaiser Family Foundation observes: “the less constraint on benefit variation, the more potential for risk selection.”²⁵

Given this brief overview of how premium support could work, and keeping in mind the many differences between specific premium support plans now being discussed, we turn to a review of the arguments against and in favor of premium support. Our goal in the next two sections is to help readers understand why some knowledgeable experts oppose premium support while others support some version of premium support. Following these two sections, we propose a specific plan for premium support that addresses some, though not all, of the criticisms presented next.

Section B

Why Premium Support Is a Bad Idea: Rhetoric versus Substance By Henry Aaron

"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.'²⁶ 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.

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 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.²⁷ It seemed 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. If it did, the savings would be realized. 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.²⁸ 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 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 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 of a similar discomfort prefer the term ‘premium support.’

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 jocularly (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.

The central issues, however, are ones of substance, not terminology. And there are three 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. Third, hovering over this entire discussion is the nagging need to slow the growth of Medicare spending and the question of whether premium support should be on the menu of tools to fix this problem.

[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 proposal²⁹ and the one contained in the budget plan of the Bipartisan Policy Center.³⁰ 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 sixty-seven in 2033. People turning sixty-five 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 (MSA; \$7,800 in 2022). The value of the voucher for sixty-five year-olds in 2022 would be the same as the estimated net value of Medicare benefits (after premiums and cost-sharing) for sixty-five 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 sixty-five 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 in the cost of traditional Medicare beyond GDP plus 1 percentage point.³¹ Private plans that cut costs 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. Both refer to risk adjustment, but are as vague as (I must confess) Reischauer and I were.

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. CBO 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 under current law in 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 ACA are realized. That depends, in turn, on whether the key provisions of the ACA 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.”³²

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.”³³

This statement means that controls exercised by the exchanges would not include the number of vendors, the number of plans, or the nature of plans. Given the capacity of 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 ACA. 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 ACA have no reasoned basis for opposing vouchers for the Medicare population because, they assert, the ACA subsidies are the same as vouchers.³⁴ 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.

Because of my own uncertainty about the operation of the ACA formula, I asked CBO 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, CBO prepared an analysis.³⁵

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 ACA 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 because:

- 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; and
- 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 ACA 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.

[Slowing the Growth of Medicare Spending: Should Vouchers or Premium Support Be on the Menu?](#)

I now think that the type of plan that Bob and I called premium support has little chance of being passed and that, if passed, no chance of being implemented with the safeguards that we envisaged. The proposals now under discussion are all fatally flawed. The vouchers are linked to the 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 system that we called 'premium support' is 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.

Nor are vouchers (or even premium support) the best way, under current conditions, to meet the urgent challenge to control the growth of health care spending. Major legislative developments have occurred since the mid-1990s. Congress has significantly improved Medicare coverage. Much of Medicare now operates under prospective payment. Analysts have developed a well-defined agenda for Medicare reform, including complete redesign of Medigap coverage, reform of the obsolete division of Medicare into multiple 'parts' in nostalgic mimicry of the BlueCross BlueShield model on which Medicare was initially designed (and which reified the bipartisan contributions of Republicans and Democrats to the initial design), and other steps endorsed by various study groups.

Most importantly, of course, ACA is now law. It includes aggressive regulation of Medicare spending and creates health insurance exchanges (as well as myriad other provisions). The immediate challenge is to make health exchanges work for the population that will qualify for subsidies under ACA. 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.

Section C

The Advantages of Reforming Medicare with Premium Support **By James C. Capretta**

In coming years, the United States must take steps to address the serious challenges of a large and growing fiscal gap as well as rapidly rising costs for both public and private purchasers of medical services. These problems are of course inter-related, as rapid cost growth in federal health entitlement programs is the most important reason that budget estimates show long-term deficits and debt soaring to levels that would be crippling for the American economy.

At the center of these twin challenges is the Medicare program. It is the largest federal health entitlement program, and Medicare spending is already putting tremendous pressure on federal finances due to many years of rapid cost growth. In the coming two decades, federal spending on Medicare is set to soar even more rapidly as the baby boom generation heads into its retirement years. Medicare is also the single largest insurance plan in the United States, and thus central to solving the problem of rapidly rising costs in the nation's broader health system.

While a political consensus has emerged that Medicare must be modified and reformed for both fiscal and health policy reasons, there is not yet a consensus around what are the key elements of an effective reform plan.

One prominent reform concept—so-called “premium support”—has been discussed for more than fifteen years as a possible organizing principle for modernizing Medicare.³⁶ In previous debates, including one that occurred during deliberations of the 1998-99 National Bipartisan Commission on the Future of Medicare, premium support was advanced but ultimately not adopted by policymakers due to vigorous opposition from factions committed to preserving Medicare's current design.³⁷

And yet, despite the setbacks and continued opposition, premium support is the idea that just won't go away—and for good reason. That's because it's the most promising reform concept available, with the potential to bring about serious and continuous cost discipline without eroding the quality of care provided to Medicare's participants.

Medicare Fee-for-Service's Role in the Cost Problem

To see the value of premium support as a reform concept, it is necessary to understand how Medicare works today, and especially the role that Medicare plays in today's inefficient arrangements for delivering health care services.

Health care in the United States has many virtues. We have the world's most skilled physician workforce, as well as the world's most advanced hospitals and outpatient clinics. Most Americans have fairly ready access to the care that can be provided by the nation's sophisticated network of hospitals and physician offices through third-party insurance arrangements. U.S. health care also remains open to innovation in ways that other systems around the world are not.

But there's no question that U.S. health care also suffers from serious deficiencies. The primary problem is that health care in this country is highly fragmented and uncoordinated. In the main, physicians, hospitals, clinics, labs, and pharmacies are autonomous, financially independent units. They bill separately for the services they render to patients, with very little need to coordinate with anyone else in the system. The result is an incredible level of duplication and waste, overemphasis on procedure-based medicine, as well as burdensome paperwork, excessive bureaucracy, and a lack of accountability for the all-too-frequent cases of low-quality care.

Why does health care delivery in this country suffer from these deficiencies? There are a number of reasons, but by far the most important one is the dominant role played by Medicare's traditional fee-for-service (FFS) insurance arrangements.

Medicare FFS is the largest and most influential payer in most markets. As the name implies, FFS pays any licensed health care provider when a Medicare patient uses services—no questions asked. Nearly 75 percent of Medicare's 49 million enrollees are in the FFS program.³⁸ Physicians, hospitals, clinics, and other care organizations most often set up their operations to maximize revenue from Medicare FFS payments.

For FFS insurance to make any economic sense at all, the patients need to pay some of the cost when they receive health care services. Otherwise, there is no financial check against the understandable inclination to agree to all of the tests, consultations, and procedures that could be possible, but not guaranteed, steps to better health.

But Medicare FFS does not have effective cost-sharing at the point of service. Yes, the program requires cost-sharing, including 20 percent co-insurance to see a physician, but more than 90 percent of FFS beneficiaries have additional insurance in the form of Medigap coverage, retiree wrap-around plans, or Medicaid that pays for nearly all costs not covered by FFS.³⁹ Further, Medicare's rules require providers to accept Medicare's reimbursement rates as payment in full, effectively precluding any additional billing to the patient.

In the vast majority of cases, then, FFS enrollees incur no additional cost when they use more services, and health care providers earn more only when service use rises. It is therefore not at all surprising that Medicare's costs have risen rapidly over the years due a relentless rise in the volume of services used by FFS participants. For instance, CBO reports that the average beneficiary used 40 percent more physician services in 2005 than just eight years earlier.⁴⁰ Spending for physician-administered imaging and other tests was up approximately 40 percent from 2002 to 2007.⁴¹

Medicare's dominant FFS design also stifles much needed innovation in service delivery. As Mark McClellan, former Administrator of the Centers for Medicare and Medicaid Services (CMS), put it:

In traditional FFS Medicare, benefits are determined by statute and cannot easily include many innovative approaches to benefit design, provider payment, care coordination services, and personalized support for beneficiaries.... When

providers are paid more when patients have more duplicative tests and more preventable complications—as is the case in FFS payment systems—it is more challenging to take steps like adopting health IT [information technology] or reorganizing practices in other ways to deliver care more effectively.⁴²

Moreover, many of the payment regulations reward higher use of last year's services, offered by last year's list of qualified providers. New service delivery organizations, pricing approaches, and ways of caring for a patient—such as over the Internet and phone—are simply not accommodated by payment rules, many of which were written decades ago. Even marginal changes can take years to implement, often after a multi-year test. Providers are thus understandably reluctant to invest in new approaches, no matter how promising, which will pay off only if Medicare accommodates the change. The result is that today's fragmented and dysfunctional system is virtually frozen in place for all users of U.S. health care, not just Medicare beneficiaries.

Medicare's Administrators Can't Engineer Delivery System Reform

The antidote to a fragmented and uncoordinated delivery system is a high value, low cost network of the best providers of medical care. The architects of the 2010 health care law recognized this need and set in motion a number of initiatives that they hoped would bring about this transformation under the heading of “delivery system reform.”

Unfortunately, these efforts are doomed to fall well short of the high expectations set for them. The reason is that the federal government has no capacity to build a higher value network of providers in the Medicare program. The private-sector delivery models that are so admired by federal Medicare officials—such as the Geisinger health plan, the Cleveland Clinic, and Intermountain Health Care—operate on a principle of provider exclusivity. They do not take just any licensed provider into their fold. They operate highly selective, data-driven networks. Low-quality performers are dropped or avoided altogether, and tight processes are established to streamline care and eliminate unnecessary steps.

The federal government has never shown any capacity to enforce rules on providers that are even remotely similar to those achieved by model programs such as Geisinger, the Cleveland Clinic, and Intermountain. Indeed, the whole point of the Medicare FFS model that Congress has protected so jealously over the years is that beneficiaries may see any licensed provider of their choosing, to whom Medicare pays a fixed reimbursement rate, irrespective of quality. Past attempts to steer patients toward preferred physicians or hospitals, such as the Centers of Excellence demonstration in the 1990's, have failed miserably because politicians and regulators find it impossible to make distinctions among hospitals and physician groups based on quality measures that are inevitably subject to dispute.

Congress and Medicare's regulators have found it much easier to cut costs with across-the-board payment rate reductions that apply to every licensed provider without regard to any measures of quality or efficient performance. Tellingly, the 2010 health law uses this approach to achieve most of its Medicare savings. The big reductions come from arbitrary cuts in payment updates for institutional providers of care. That pattern is

unlikely to change so long as Medicare FFS remains the dominant option. To cut spending fast and with certainty, the preferred solution of the American political system will always be deeper reductions in payment rates.

The danger is that these cuts will erode the quality of medical care provided to the nation's seniors. Already, the Chief Actuary for the program is warning that the cuts imposed in the new health law will drive average payment rates for the Medicare program below that provided in Medicaid, and Medicaid is notorious for having such a constrained network of willing suppliers that enrollees have serious access to care problems.⁴³

The Premium Support Prototype: Medicare Part D

Premium support provides an alternative vision for how to bring about delivery system reform. Instead of relying on the government's capacity to re-engineer how doctors and hospitals are organized and provide care, premium support relies on a decentralized process of consumer choice and vigorous price and quality competition among the plans providing coverage as well as among those providing services directly to patients. The idea is to give the program's participants strong financial incentives to gravitate toward arrangements that can deliver high-quality care at the lowest possible premium.

The drug benefit in Medicare provides a prototype of how premium support could work in the larger program. The key design feature of the drug benefit is that the government's contribution toward the coverage does not vary based on the plans selected by the beneficiaries. The participating private plans offering the insurance submit bids to the federal government based on the premium amounts they will charge for providing the drug benefit. The government then calculates what it will pay on a regional basis, based on a weighted average of the bids. The government's contribution toward drug coverage is the same for high cost and low cost plans. Beneficiaries selecting plans that cost more than the weighted average pay the additional premium entirely out of their own pockets. Conversely, beneficiaries choosing less expensive plans reduce their premium expenses commensurately.

At the time of enactment, this competitive design had many critics. Some argued that the program would not work because private plans would decline to participate without a guaranteed share of the market. Others said that beneficiaries would not sign up for the program because the competitive structure was too complex to navigate. Still others said that program costs would explode without government-regulated price controls.

All of these predictions proved to be wrong. Now in its sixth year of implementation, the program has exceeded all expectations. Some 90 percent of Medicare participants are in secure drug coverage of some sort, and public opinion surveys show that they are very satisfied with what they have. Most importantly, the program is coming in way under budget, with ten-year costs now expected to come in 42 percent below the estimates done at the time of enactment.

The Department of Health and Human Services recently announced that the average beneficiary's premium for the program will be about \$30 in 2012, down from \$30.76 in

2011.⁴⁴ Remarkably, that is just \$4 more per month than the average premium in 2006. Over the first six years of the program, the average premium increase has been just 2.5 percent per year—well below cost growth in the rest of Medicare.

The drug benefit is working because it engages the consumer in cost cutting. Seniors want the best value for their Part D premium, which means looking for plans that keep their branded drug prices low and offer favorable terms for using low-cost generics. The result has been a record of cost control that government micromanagement cannot match. Indeed, if the federal government had tried to mandate the kind of cost cutting that the private part D plans are now enforcing, it almost certainly would have backfired. For instance, manufacturers and patient groups would have lobbied against blanket generic substitution requirements for a variety of reasons, thus slowing down the movement in that direction.

Broadening Support for the Concept

A number of objections have been raised about premium support over the years by opponents. These objections can be addressed without violating the fundamental design principles necessary to make the concept work.

The first objection is that some versions of premium support assume the only plans available to Medicare beneficiaries would be sponsored by private insurers, and that the traditional Medicare FFS program would be phased out with no new entrants beyond a certain cut off year. It is certainly the case that the Medicare drug benefit has no public option competing with the private drug coverage plans, and the absence of a government-run competitor has made it easier to ensure a fair competition among the plans that are presented to the beneficiaries.

But because of Medicare's long history with a government-run FFS system, it is not unreasonable to consider retaining traditional FFS as one option from which seniors could elect to get their coverage in the future. That was a feature of the premium support proposal developed by the National Bipartisan Commission in 1998-99 (the Breaux-Thomas proposal), as well as the version advanced by the Bipartisan Policy Center in 2010.⁴⁵

The only condition that should be attached to continuing a FFS option is that the playing field for the competition must truly be level. Today, Medicare FFS essentially dictates payment rates to the provider community. That is not the case with private plans. They must negotiate contracts with networks of willing providers of services. In a premium support program with FFS retained as an option, FFS should be required to submit bids on a region-by-region basis consistent with the market area required to be covered by private plans, and the reimbursement rates paid by FFS to hospital, physician, and other providers of services and supplies in those markets must be reasonable by local standards.

A second objection is that the government's premium support payments should be set in a way that does not unduly push cost risk onto the beneficiaries. For instance, if premium support payments were scheduled to rise with inflation or even economic

growth rather than health costs, then it is possible that the out-of-pocket costs seniors would face in a reformed Medicare program would rise much faster than their incomes.

But this objection can be addressed rather easily by setting the government's contribution for premium support payments using the same methodology employed in the drug benefit. There, the government's contribution is based on the enrollment-weighted average of the bids from the competing private plans. This ensures that the government's contribution never strays from the actual cost structure faced by the beneficiaries. The premium support plan advanced by a majority of the National Bipartisan Commission was based on a similar competitive bidding approach.

The downside of setting the government's contribution based on competitive bidding is that the official scorekeeper of Congressional legislation— CBO—does not believe that competition of this sort will substantially “bend the cost curve” downward in future years. Thus, competitive bidding may not be scored as actually solving Medicare's long-term cost problem.

This should be not an insurmountable obstacle to advancing the premium support concept, however. One way around the problem would be to establish a back up budgetary mechanism that kicks in depending on the robustness of the savings from competition in premium support. If it turns out that more savings is needed to hit budgetary targets beyond what is produced by premium support, then other adjustments could automatically kick in as necessary. However, if premium support works as well as the drug benefit has, with costs rising at a moderate and affordable pace, then no additional adjustments would be necessary to achieve the desired level of budgetary savings.

Conclusion

Medicare was designed in 1965 to be compatible with the prevailing BlueCross BlueShield-type insurance that was prevalent in the marketplace at that time. Quite a lot has changed in last forty-six years, so it should not be surprising that the program is due for an update.

Medicare is valuable to seniors because it provides secure access to needed medical care at the most vulnerable stage of life. That wouldn't change with premium support. What would change is that Medicare would benefit from the same competitive pressures that deliver continuous quality and productivity improvements in most sectors of the American economy.

Section D

The Domenici-Rivlin Premium Support Plan **By Pete Domenici and Alice Rivlin**

Since the release of the Task Force Report last year, Dr. Rivlin, Senator Domenici, and the Bipartisan Policy Center have continued to refine their plan, incorporating feedback and adding detail. The proposed plan below has significant differences from the one proposed in the original Domenici-Rivlin Plan, which Henry Aaron discusses in his section of the paper.

The Domenici-Rivlin premium support proposal will preserve Medicare for future generations. It will allow beneficiaries who wish to stay in traditional Medicare to do so, but also will present them with competing private plans as alternative options. It will restrain the growth in total Medicare spending, while protecting low-income beneficiaries from any increases in their cost above current law. In short, the Domenici-Rivlin plan both will preserve Medicare as a choice and also save money by flattening the now-steeply-rising Medicare cost curve.

The Domenici-Rivlin plan restructures Medicare to achieve fiscal soundness in three ways:

1. A new federally-run Medicare Exchange will provide beneficiaries with a competitive marketplace in which they can choose among private healthcare plans and traditional fee-for-service Medicare. The private plans will be required to cover services with at least the same actuarial value as FFS Medicare, and their premium revenue will be adjusted up (or down) if they attract patients whose illnesses are more (or less) expensive than average. The Exchange will provide understandable information about the costs and health outcomes of plans so that beneficiaries can choose plans that are best for them, and will allow beneficiaries, if they are not satisfied, to change plans in an annual open season. This competition will incentivize healthcare plans to innovate in every facet of their operations and benefit designs to keep premiums down and quality of care up.
2. By using competitive bidding, this system will tie the federal contribution to the cost of the second-cheapest approved plan or FFS Medicare in each area, whichever is cheaper (subject to capacity constraints). Thus, the government will no longer have to pay extra to private healthcare plans in areas where the public FFS plan provides cheaper coverage, nor will they have to overpay to provide FFS Medicare in areas where approved private plans offer the same care at lower cost.
3. These two cost-control features should flatten the cost curve. However, an additional element will ensure substantial savings. The growth in per-beneficiary federal support will be limited to one percentage point faster than the growth of the economy—GDP+1—compared to the current projection of growth that is 1.7 percentage points faster. If costs rise faster than the established limit, Medicare beneficiaries will have to pay higher premiums. However, individuals whose Part B premiums are paid by Medicaid programs will not be affected. Additionally, to smooth the transition to the defined-support system, current beneficiaries with low incomes will be guaranteed access to traditional Medicare with no additional premiums. This subsidy will phase out at higher income levels.

How the Exchanges Work

In each regional market—be it a metropolitan area, or a large rural area where population density is low—all of the private healthcare plans and traditional FFS Medicare will submit bids (subject to strict quality and coverage standards) to provide the standard Medicare benefit package for Parts A and B to an average-risk beneficiary. The FFS "bid" will be based on average FFS costs for the same type of standardized beneficiary in the bidding area. The amount that the government contributes to premiums in that area will then be based on the second-lowest private bid or FFS Medicare's bid, whichever is lower. This will be referred to as the "benchmark" bid.

Beneficiaries who choose to enroll in a plan that is more expensive than the benchmark—even if that plan is FFS Medicare—will be required to pay the incremental additional cost. A beneficiary who enrolls in the plan with the lowest bid will be rebated the full difference in cost from the benchmark.

The Exchange will be federally run, presumably by the Centers for Medicare and Medicaid Services (CMS), require guaranteed coverage (under which insurers may not decline any applicant), and enforce guidelines for the structure of the benefit package. CMS also will utilize risk adjustment by placing all premiums into a single pool, and then redistributing them among insurers according to the health status of those whom they enroll.

Why is This Proposal an Improvement over the Current Medicare System?

Medicare Advantage already offers private plans to Medicare beneficiaries. However, if a private healthcare plan currently has lower costs than FFS Medicare in its area, it cannot offer a rebate to enrollees as an incentive to sign up. Instead, it must increase benefits—which in and of itself increases Medicare spending. Therefore, beneficiaries in areas with high FFS Medicare costs who enroll in private plans receive a host of free supplementary benefits, financed by the government. There is no policy justification for selectively offering free, government-financed supplementary benefits to beneficiaries in one geographic region but not another.

Instead, the new Medicare Exchange will provide strong incentives for plans to manage care delivery efficiently and to offer the public evidence that their plans achieve quality outcomes at comparatively low cost—because low-bidding plans would be rewarded with increased enrollment.

The Domenici-Rivlin proposal also guarantees that the federal support per beneficiary will not grow faster than GDP+1, thereby assuring the federal government of budgetary savings. The cap on the growth rate also should increase the pressure on plans to develop more efficient methods of care delivery, and might increase political support—by Medicare beneficiaries, their children, and those approaching Medicare eligibility—for federal policies that promote cost containment in health care. The ACA already established a cap on the growth of Medicare; moving to a competitive bidding model creates the incentives to make that cap stick.

In the event that Medicare spending per beneficiary rises at a faster rate, enrollees will have to pay higher premiums to cover the difference. However, individuals whose Part B

premiums are now paid by Medicaid programs will not be affected.⁴⁶ Additionally, to smooth the transition to the defined-support system, current beneficiaries with low incomes will be guaranteed access to traditional Medicare with no additional premiums. The new system also could be structured to provide a higher subsidy to those with lower incomes and a lower subsidy to those with higher incomes.

Savings

According to calculations by the Bipartisan Policy Center, the cumulative savings between 2016 and several future dates would be \$162 billion by 2021, \$409 billion by 2025, \$1.025 trillion by 2030, and \$4.05 trillion by 2040. Clearly, the Domenici-Rivlin approach would dramatically reduce the future costs of Medicare, one of its primary goals.

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¹⁶ Stuart Butler, Alison Fraser and William Beach, *Saving the American Dream* (Washington: The Heritage Foundation, 2010) pp. 17-23, <http://savingthedream.org/about-the-plan/plan-details/SavAmerDream.pdf>; Robert Moffit, *The Second Stage of Medicare Reform: Moving to a Premium Support Program* (Washington: The Heritage Foundation, 2011), <http://www.heritage.org/research/reports/2011/11/the-second-stage-of-medicare-reform-moving-to-a-premium-support-program>.

¹⁷ The Debt Reduction Task Force, "Restoring America's Future" (Washington: Bipartisan Policy Center, November 2010), <http://www.bipartisanpolicy.org/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf>.

¹⁸ According to personal communication with staff at the Bipartisan Policy Center, which sponsored the Domenici-Rivlin commission, the estimates of the levels of the growth of both Medicare and the Domenici-Rivlin plan differ across several sources. The difference of 0.8 percentage points between the actual increase in annual Medicare costs and the increase that would have been allowed by the Domenici-Rivlin premium support formula is taken from Lisa Potetz, "Exhibit 4: Average Annual Growth in Medicare Spending, 1985-2009," from *Medicare Spending and Financing: A Primer* (Menlo Park, CA: Kaiser Family Foundation, 2011), p. 2, <http://www.kff.org/medicare/upload/7731-03.pdf>.

¹⁹ Joseph P. Newhouse, "Consumer-Directed Health Plans and the RAND Insurance Experiment," *Health Affairs* 23, no. 6 (2004): 107-113.

²⁰ These benefits are: under part A, inpatient care at hospitals, short stays in skilled nursing facilities, hospice care, post-acute home health care, and pints of blood; under part B, outpatient hospital care, physician visits, preventative services like mammography and colorectal screening, ambulance services, clinical laboratory service, durable medical equipment, kidney supplies and services, outpatient mental health care, and diagnostic tests; under part D, outpatient prescription drugs.

²¹ The original premium support plan offered by Chairman Ryan, often called a "voucher" proposal by those who didn't like the plan, would allow beneficiaries to enter the market and use their premium support money to buy any plan that suits their needs. The issue of whether government should prevent individuals from making decisions that are against their long-term interests is at the heart of the difference between liberals and conservatives on government responsibility. In the case of premium support, Chairman Ryan elected to move away from a model of complete individual choice and require that government premium support money be spent on plans that meet government stipulated requirements. See Ezra Klein, "Creator of Premium Support says Ryan has 'Vouchers, Not Premium Support,'" *The Washington Post*, April 11, 2011, http://www.washingtonpost.com/blogs/ezra-klein/post/creator-of-premium-support-says-ryan-has-vouchers-not-premium-support/2011/04/08/AFAVsILD_blog.html.

²² The organization in each geographical region that accepts the bids ensures that the bids are for health care plans that meet the required services, provides materials that explain the various plans, and provides help to beneficiaries, similar to the exchanges envisioned by ACA.

²³ A way for insurance companies to increase their profits is to increase the share of healthy people on their rolls. They can do this both by attracting people who are healthy and by refusing to cover people who are not healthy because they already have a health problem (often called a pre-existing condition). One way to keep unhealthy people off the rolls is to offer plans that do not cover conditions that are expensive such as asthma.

²⁴ Congressional Budget Office, *Designing a Premium Support System for Medicare*, p. 21.

²⁵ Program on Medicare Policy, "The Nuts and Bolts of Medicare Premium Support Proposals," p. 8.

²⁶ Aaron and Reischauer, "The Medicare Reform Debate: What Is The Next Step?"

²⁷ 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 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.

²⁸ Alain Enthoven, *Health Plan: The Practical Solution to the Soaring Cost of Medical Care* (New York: Beard Books, 2002); Michael Rothschild and Joseph Stiglitz, “Equilibrium in Competitive Markets: An Essay on the Economics of Imperfect Information,” *Quarterly Journal of Economics* 90, no. 4 (1976): 629-649.

²⁹ Congressional Budget Office, *Long-Term Analysis of a Budget Proposal by Chairman Ryan*.

³⁰ The Debt Reduction Task Force, *Restoring America's Future*.

³¹ What would be done if the price of traditional Medicare was pushed up by adverse selection is unclear.

³² Alice Rivlin and Paul Ryan, *A Long-Term Plan for Medicare and Medicaid* (Washington: House of Representatives Committee on the Budget, 2010),

<http://budget.house.gov/news/documentsingle.aspx?documentID=225826>.

³³ *Roadmap for America's Future Act of 2010*, HR 4529, 111th Cong., 2nd sess., H 10.

³⁴ 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*, April 21, 2011. The author subsequently published two clarifications in *The National Journal Online*, “A Clarification on the Indexation of Obamacare’s Vouchers,” on April 25, 2011 and a second, “Medicare’s Actuaries Say Obamacare Vouchers Could Be Tied to the CPI,” on April 26, 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.

³⁵ This analysis was first prepared as a personal letter to myself and later as an analysis publically available on the CBO website. For the latter, see Congressional Budget Office, *Additional Information about CBO's Baseline Projections of Federal Subsidies for Health Insurance Provided Through Exchanges* (Washington: Author, May 12, 2011), http://www.cbo.gov/ftpdocs/121xx/doc12188/05-12-Subsidies_in_Exchanges.pdf.

³⁶ The term “premium support” was first used by Henry Aaron and Robert Reischauer in 1995 in an article promoting the reform concept. See Aaron and Reischauer, “The Medicare Reform Debate.”

³⁷ See <http://thomas.loc.gov/medicare> for a historical record of the Commission’s work, including cost estimates produced for a premium support reform plan.

³⁸ Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds* (Baltimore: Centers for Medicare and Medicaid Services, 2011), Table IV.C1, <http://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf>.

³⁹ Joan Sokolovsky, Julie Lee, and Scott Harrison, “Reforming Medicare’s Fee-For-Service Benefit Design,” (presentation, Medicare Payment Advisory Commission, Washington, February 23, 2011), <http://www.medpac.gov/transcripts/benefit%20design%20jsjl.pdf>.

⁴⁰ Congressional Budget Office, *Factors Underlying the Growth in Medicare's Spending for Physician Services* (Washington: Author, 2007), Table 3, <http://www.cbo.gov/ftpdocs/81xx/doc8193/06-06-MedicareSpending.pdf>.

⁴¹ Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program* (Washington: Author, 2009) p. 102, <http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf>.

⁴² *Testimony on the Medicare Advantage Program, Before the House of Representatives Committee on the Budget*, 110th Cong. (2007) (statement of Mark McClellan, Visiting Senior Fellow at AEI-Brookings Joint Center for Regulatory Studies), <http://www.allhealth.org/briefingmaterials/mcclellantestimony-818.pdf>.

⁴³ See John Shatto and M. Kent Clemens, “Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers” (Baltimore: Centers for Medicare and

Medicaid Services, 2011),

<https://www.cms.gov/ReportsTrustFunds/downloads/2011TRAlternativeScenario.pdf>.

⁴⁴ U.S. Department of Health and Human Services, “Medicare Prescription Drug Premiums Will Not Increase, More Seniors Receiving Free Preventive Care, Discounts in the Donut Hole,” Press Release, August 4, 2011, <http://www.hhs.gov/news/press/2011pres/08/20110804a.html>.

⁴⁵ See The Debt Reduction Task Force, *Restoring America's Future*.

⁴⁶ To promote stability, the proposal calls for employing a five-year historical trend of per-capita GDP rather than measuring the change over a single year.