Backgrounder

Published by The Heritage Foundation

No. 2500
December 13, 2010

# How to Fix Medicare: A New Vision for a Better Program

*Robert E. Moffit, Ph.D., and James C. Capretta*

**Abstract:** *Medicare is the government health insurance program on which the vast majority of America's senior and disabled citizens rely. The program has no spending limits—despite its price controls and central planning—and, as currently designed, is simply unsustainable. All future taxpayers and retirees deserve to have good and reliable health insurance (federal employees already do). Medicare can be saved—but not by ever more burdensome government bureaucracy and micromanagement, such as prescribed by the misnamed Patient Protection and Affordable Care Act. Patient choice and market competition, along with strong budget controls, are the keys to reforming Medicare so that it will be available to future generations. And for those looking for guarantees—this paper details five principles on which future Medicare enrollees should be able to count.*

Medicare is an entitlement program intended to secure health care for senior and disabled citizens. But its current design, based on government central planning and price controls, falls far short of guaranteeing access to high-quality care for current and future retirees. With no budgetary limit, program costs have soared and will become unaffordable for future taxpayers. The Patient Protection and Affordable Care Act (PPACA) reinforces bureaucratic micromanagement and price regulation and makes the program's current problems even worse.

In the 21st century, a renewed Medicare should be firmly based on patient choice and market competi-

## Talking Points

- Today's Medicare—based on government central planning and price controls—falls far short of guaranteeing access to quality care for current and future retirees.
- With no spending limit, program costs have soared and will become unaffordable. The Patient Protection and Affordable Care Act reinforces bureaucratic micromanagement and makes current problems worse. Including budgetary controls to reformed Medicare will ensure that the program is affordable for current and future taxpayers.
- A renewed Medicare should be based on patient choice and market competition. "Premium support," where the government makes direct contributions to the health plans chosen by enrollees, and health plans and providers compete for beneficiaries' health care dollars, could achieve higher quality and affordable cost.
- Premium support would give future Medicare patients choice of affordable, quality health plans.
- Federal workers already enjoy such freedom and quality of care—it is time for all American taxpayers to have the same opportunity.

This paper, in its entirety, can be found at:
*http://report.heritage.org/bg2500*

Produced by the Center for Policy Innovation

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

tion. Such reform could be achieved through the creation of a new system of "premium support," where the government makes a direct and generous contribution to the health plan of an enrollee's choice, and health plans and providers compete directly for beneficiaries' health care dollars. Premium support would give future Medicare patients control over the flow of Medicare dollars and decisions, guarantee personal choice of health plans, and let them secure the best value for the money. This is the kind of consumer choice model that federal workers and retirees in the Federal Employees Health Benefits Program (FEHBP) enjoy. It is a popular and successful approach because it emphasizes personal choice among plans, and government oversight ensures consumer protection and transparency.

A reformed and sustainable Medicare program should be based on five key guarantees:

**(1) Predictable and Stable Financing.** Congress should guarantee definite and stable funding for Medicare that simultaneously assures solid coverage for beneficiaries while protecting future taxpayers from unaffordable obligations. A new Medicare program would be based on competition and consumer choice in every region of the nation, delivering high value for Medicare dollars, and replacing the inefficient central planning and price regulation that either overpays or underpays providers around the country. Building on policy initiatives already proposed by the Administration or adopted by Congress, the new Medicare premium support program would replace today's program design during a transition of five or 10 years. The amount of premium support provided to beneficiaries would be determined with a three-step process.

First, building on President Barack Obama's original proposal for Medicare Advantage competitive bidding,[1] Congress would allow health insurance companies to offer the Medicare benefits package regionally, with premiums for the coverage set by the insurers themselves. Government-administered fee-for-service would also be one of the plans offering coverage in each region. Premiums would be set to cover expected costs. In each regional market, the government would determine the weighted average premium of all participating insurance plans, including government-administered fee-for-service. Under the premium support program, the government's contribution to any of the competing health plans on behalf of a Medicare beneficiary would be set, on a default basis, at 90 percent of the weighted average premium in any given region.

Second, Congress would establish an overall long-term budget for Medicare premium support payments in a new budget process aimed at bolstering control of entitlement spending beyond the normal 10-year budget window. A budgeted amount for Medicare would be established over a long-term period, such as 30 years, after weighing this spending against other priorities, such as overall levels of taxation and spending for other entitlements like Social Security and Medicaid. Changes to this previously established Medicare budget would require additional congressional action.

In the PPACA, Congress capped the growth of per capita Medicare spending (in the years after 2018) at per capita GDP growth plus one percentage point, and established a board to enforce this limit with provider-payment reductions.[2] Congress should move away from the PPACA model and instead apply a spending limit to the overall level of Medicare premium support payments, which would be allowed to grow from an initial target by a blend of the general consumer price index (CPI) and the Medical CPI, plus expected growth in the number of program enrollees. If Medicare premium-support payments, derived from the weighted average of submitted premiums from insurers, were to exceed the spending limit established for the program, the government contribu-

1. The President's original budget proposal for competitive bidding was based on market bids, separate from the Medicare payment benchmarks that govern Medicare Advantage today.
2. During the transition, the Medicare budget rules would apply to the entire Medicare program. Section 3403 of Title III of the PPACA states that, beginning in 2014, Congress initially limits Medicare per capita spending growth at a blend of CPI and Medical CPI. Beginning in 2018, Medicare spending growth is to match the growth of per capita GDP plus 1 percentage point.

tion percentage would be adjusted downward from 90 percent as necessary, say to 88 percent, to bring spending in line with the Medicare budget. The combination of competitive bidding with a limit on the government's contribution should provide powerful incentives for cost-cutting throughout the health sector.

Finally, the government contribution should be provided to beneficiaries on the basis of need. Medicare would remain valuable to all seniors because of the access it would provide to insurance plans that have a broad and stable risk pool. But those with earnings and savings sufficient to pay more of the premiums themselves should be asked to do so—thus lessening the burden on workers who pay Medicare taxes. This would move the Medicare program toward a genuine safety net role, even as all seniors would retain stable coverage.

**(2) Broad Personal Choice of Plans and Options.** The key feature of a functioning, competitive marketplace is informed consumer choice. Medicare beneficiaries would be given the opportunity to select coverage that best suits their needs. In the transition to the new Medicare program, certain options would automatically be grandfathered in as acceptable options for beneficiaries, including Medicare Advantage plans, FEHBP plans, state employee retiree plans, employer plans regulated by the Employee Retirement Income Security Act (ERISA), and plans licensed by the states, including small-employer group plans, Taft–Hartley plans for certain union employees, and individual, high-deductible plans or health savings accounts. In every case, however, the health plans offered to Medicare enrollees must provide protection from catastrophic illness.

**(3) Standards that Meet or Exceed the FEHBP's**. A Medicare Patient Protection Commission, modeled on the Consumer Product Safety Commission, would enforce a common set of insurance and consumer protection rules.[3] For insurance, the commission would certify that health plans offer the basic categories of health benefits modeled on the statutory requirements of the FEHBP. While the community rating and guaranteed-issue rules of the FEHBP would be retained, the reformed Medicare program would also provide premium discounts for enrollment in wellness or prevention programs. Medicare enrollees would be permitted to switch plans in an annual open season (as they do today in the FEHBP), and they would also have the option of signing up for two-year, three-year, and five-year health insurance contracts. Thus, health plans could offer wellness bonuses (either year by year or at the end of the contract) for those who participate in preventive health care programs. The program would also include a risk-adjustment or reinsurance mechanism to offset any adverse selection—a major improvement over the FEHBP. For consumer protection, the commission would enforce FEHBP-style rules, such as fair marketing, plain-English requirements for presentation of plan information, and fiscal-solvency requirements.[4]

**(4) Freedom of Choice for Medicare Enrollees.** Americans enrolled in Medicare would be able to buy the health plan that best suits their personal needs and is affordable to taxpayers now and in the future. The new Medicare program would only be available for new retirees during a transition period of perhaps five or 10 years; no current Medicare patients would be affected by this structural change. Unlike today, however, new retirees would be able to bring private health plans into retirement with them and secure a government contribution, in the form of premium support, to offset their costs. Once enrolled in the new Medicare program, they would be able to choose from a wide variety of health plans during an "open season," just as federal workers and retirees do today.

**(5) Medicare Savings for Medicare Alone**. Congress should also pursue additional Medicare reforms, beyond the creation of a new premium-support program, that would result in savings that

3. Members of the Consumer Product Safety Commission are nominated by the President and confirmed by the Senate.
4. For an excellent account of the FEHBP's clear superiority over traditional Medicare in controlling cost and delivering high-quality care within a light and rational regulatory framework, see Walton J. Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, D.C.: AEI Press, 2009).

would be plowed back into the Medicare trust fund to enhance the program's fiscal solvency. Such reforms could include adjustments to supplemental Medigap policies to ensure some level of cost-sharing by fee-for-service Medicare enrollees, raising or refining co-insurance or co-payments for certain Medicare services (such as home health care), increased premiums, or gradually raising the retirement age.

## A Better Deal

A better Medicare program, with a range of personal choice and a system of governance broadly similar to the FEHBP, will give Medicare patients control over the flow of dollars and freedom to make decisions about how they access medical services. This will stimulate intense market competition among plans and providers, control costs, and promote rapid innovation and higher productivity through the efficient delivery of quality care, thus guaranteeing value in return for retiree premiums and taxpayer dollars. Strong budgetary controls will back up the competitive structure, ensuring that the Medicare program remains affordable. Most important, these reforms will promote personal freedom of choice as well as stable and reliable health insurance.

*—**Robert E. Moffit, Ph.D.**, is Senior Fellow in the Center for Policy Innovation at The Heritage Foundation; **James C. Capretta** is a Fellow at the Ethics and Public Policy Center.*