The Heritage Foundation
LEADERSHIP FOR AMERICA

EXECUTIVE SUMMARY
BACKGROUNDER

No. 2626 | NOVEMBER 28, 2011

The Second Stage of Medicare Reform: Moving to a Premium-Support Program

Robert E. Moffit, Ph.D.

Medicare is in deep financial trouble. The right way to make it available and affordable for future generations is not through price controls and regulation, but through a bipartisan approach, as outlined in The Heritage Foundation's *Saving the American Dream,* that achieves prudent budget targets while protecting seniors from financial risk. Properly designed, premium support can do that.

A Bipartisan Tradition

Of all Medicare changes advanced over the past three decades, only premium support—a variant of defined-contribution financing—has inspired bipartisan leadership for comprehensive structural reform. Building on the successful experience of existing premium-support systems, such as Medicare Part D and the Federal Employees Health Benefits Program (FEHBP), Congress therefore should:

1. **Simplify traditional Medicare.** Congress should create a uniform Medicare fee-for-service (FFS) plan, combining the benefits of Parts A, B, and D with a catastrophic benefit. For beneficiaries choosing traditional Medicare, the cost for a single stated premium sufficient to finance the combined FFS benefits would be offset by the government's premium support. Beneficiaries would pay one premium, minus the government contribution, and one set of co-payments for a traditional FFS plan.

2. **Establish a defined-contribution payment system.** The government's contribution to enrollee coverage would be based on regional competitive bidding among health plans, including Medicare FFS. Regional bidding (using existing Medicare Advantage or Part D regions) would be based on the provision of Medicare Parts A, B, and D benefits, or an actuarial equivalent, plus catastrophic coverage. After an initial five-year period, during which it would pay each health plan an amount equal to 88 percent of the total cost based on the weighted *average* premium for competing plans in that region, the government would pay its contribution based on the bid of the lowest-cost plan or the average of the three *lowest*-cost plans.

3. **Allow wide-open competition.** During an initial two- or three-year transition period, Congress should allow new retirees to keep their current health plans (assuming that they provide *catastrophic* protection) as "deemed automatically eligible" for participation in Medicare premium support. The new market would be open to employment-based, individual, small-group, large-group, managed-care, Medicare Advantage, FEHBP, and state-employee health plans. Retirees with health saving accounts would also be able to bring them into retirement.

4. **Reduce the government's defined contribution for upper-income Americans and**

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eliminate it for the wealthiest enrollees. Congress should tighten current income thresholds for future government premium-support contributions, index these thresholds to inflation, and phase out subsidies for the wealthiest cohort of retirees (about 3.5 percent of the Medicare population). All retirees should be able to enroll in Medicare, pay premiums at competitive rates, and take advantage of guaranteed-issue, community-rated health insurance in large national and regional pools.

5. **Put Medicare on a true budget.** Congress should put Medicare on a long-term budget, like most government programs. It should cap annual Medicare spending at the rate of inflation, measured by the CPI, plus 1 percent and, if needed to stay under this cap, adjust plan payments accordingly to restrain medical inflation.

6. **Establish fair administration and a level playing field.** Medicare premium support should be administered by Medicare's Center for Drug and Health Plan Choice to ensure a level playing field for market competition among diverse health plans while enforcing rules for consumer protection, just as the Office of Personnel Management does in administering the FEHBP. To prevent any conflict of interest, Congress must also separate supervision of the competitive system from administration of traditional Medicare.

7. **Retain Medicare insurance rules.** Congress should retain Medicare's community rating (the same premiums for all enrollees based on the characteristics of the entire pool rather than separate premiums based on individual characteristics); guaranteed issue (policies are available to enrollees regardless of health status or pre-existing conditions); and guaranteed renewability (enrollees have the right to continue the policy as long as they make premium payments). Seniors' right to keep their current plans or enroll in a better one would be guaranteed through an annual open season, just as it is today in Medicare Advantage.

8. **Establish an effective risk adjustment for insurance.** Congress should allow private plans a high degree of freedom in managing health risks while providing a generous government contribution. Improving on the FEHBP model, Congress could keep the *prospective* risk-adjustment models already in place for Medicare Advantage and Part D and improve upon them. Alternatively, it could establish a national risk-transfer pool and require plan membership in the pool.

A Better Medicare Future

Medicare premium support offers many advantages. As in the FEHBP, patients would have better choices and broader access to quality care through a variety of health plans, benefit options, physicians, and specialists on both the regional and national levels. It would foster greater innovation in health care delivery, harness technology more efficiently and safely, and secure higher value at lower cost—an estimated savings of $702 billion over the initial 10 years. It would also reduce the bureaucracy, red tape, waste, fraud, and politicization that characterize today's program and compromise care for retirees.

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A part of the Heritage plan

Abstract

Medicare is in deep trouble. Major change is inevitable. But major Medicare reform must address the needs of a huge and diverse generation of new retirees, not merely enhance the power of the federal bureaucracy or protect the narrow interests of politically connected providers. The Heritage Foundation has developed such a reform—a variant of defined-contribution financing commonly called "premium support"—in its comprehensive budget proposal, Saving the American Dream. *The Heritage proposal not only restores Medicare solvency, it also achieves a balanced budget in 10 years, and maintains it, without raising taxes. good luck*

> We all agree that the Medicare benefits package could and should be better than it is. The 1965 model we're running Medicare under today needs to be updated and modernized for the 21st century and adapted to conform to modern notions of health care delivery. I believe that a premium-support approach is the best way to do that.
>
> —Senator John Breaux (D–LA), 1999, former co-chairman of the National Bipartisan Commission on the Future of Medicare

One thing is certain: Regardless of congressional action or inaction, Medicare beneficiaries, especially baby boomers, will pay more for their benefits and government will pay less.[1] Under the Patient Protection and Affordable Care Act of 2010 (PPACA), for example, Medicare beneficiaries face major premium increases, higher drug costs, and guaranteed reductions in access to care resulting from payment reductions to hospitals, home health agencies, nursing homes, even hospice care.[2] Deeply flawed Medicare payment systems are also on automatic pilot to cut reimbursements to physicians. Medicare provider payments are on a downward slope toward Medicaid reimbursement levels, meaning that many Medicare patients, just like Medicaid patients

TALKING POINTS

- Premium support for Medicare—a variant of the defined-contribution system—has a long history of bipartisan support. The successful Federal Employees Health Benefits Program (FEHBP) is a premium-support program—and offers the best model for Medicare reform.
- To establish a premium-support system, Congress would have to allow Medicare's fee-for-service plan to compete with private alternatives, creating a formula for government contribution, establishing a level playing field for plan competition, and enforcing uniform rules for patient protection.
- With premium support, Medicare patients would enjoy personal choice, better access to care, and more innovation in health care delivery as a result of market competition.
- Beginning in 2016, a Medicare premium support program would yield an initial 10-year savings of $702 billion.
- Patients and taxpayers would benefit from superior cost control, a radical reduction in red tape, fraud, and abuse, as well as a long-overdue de-politicization of crucial health care decisions.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2626**

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today, will have serious trouble finding providers who will take care of them.[3]

Concentrated Power. More ominously, the PPACA created a powerful 15-member Independent Payment Advisory Board (IPAB) charged with making "detailed and specific" recommendations, subject to neither administrative nor judicial review, for further Medicare payment cuts to doctors and other medical professionals to meet hard spending targets.[4] Unless Congress enacts alternative and equal savings, IPAB's recommendations are automatically executed. Remarkably, President Obama wants to enhance IPAB's power. Some of the President's allies in the health policy community even want to extend that power over doctors and hospitals in the private sector.[5] This is tantamount to rationing through price regulation.

Outdated Structure. Medicare was originally designed as the foundation of national health insurance.[6] Even though it is based on central planning and price controls, the program is run by private contractors, doctors, and hospitals. This arrangement spawned a massive and growing federal regulatory regime.[7]

With the Balanced Budget Act of 1997, the Medicare Modernization Act of 2003, and the PPACA of 2010—all three adding hundreds of provisions to the Medicare statute—the Medicare bureaucracy has become a regulatory gusher, compounding the transactional costs of doctors and hospitals and other medical providers already struggling with reams of government red tape and paperwork. Patients suffer as a result. Says Douglas Perednia, M.D., formerly a principal investigator on computer imaging for the National Cancer Institute,

> A wide range of state and federal rules suck up enormous amounts of provider time and overhead. As time is the only inventory clinicians have, more time spent on administration means that less time will be spent on providing services to patients. Less time with patients yields fewer services and lower total bills. The de facto result is a rationing of care.[8]

Medicare, which processes 4.5 million claims per day, is also plagued by the triple threat of waste, fraud, and abuse. While honest medical professionals try to abide by the voluminous rules and avoid audits, investigations, and fines and penalties, the sheer complexity of the system and its regulatory regime creates a cluttered environment in which clever and dishonest providers flourish at taxpayers' expense.[9]

Meanwhile, Medicare's decisions are subject not only to intense bureaucratic infighting, but also to detailed congressional

1. "Medicare is going to be cut. That is inevitable. There is no way to solve the nation's long-term debt problem without reducing the growth rate of federal health spending. The only question is whether the cuts will be smart ones." Ezekiel J. Emanuel and Jeffrey B. Liebman, "Cut Medicare, Help Patients," *The New York Times*, August 22, 2011, at *http://www.nytimes.com/2011/08/23/opinion/cut-medicare-help-patients.html* (October 27, 2011).
2. Robert E. Moffit, "Obamacare and Medicare Provider Cuts: Jeopardizing Seniors' Access," Heritage Foundation *WebMemo* No. 3105, January 19, 2011, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Medicare-Provider-Cuts-Jeopardizing-Seniors-Access*.
3. According to Mark Pauly, an economist at the University of Pennsylvania, "Most Medicaid rationing is implicit. For instance, unusually low provider payment rates restrict the supply of higher quality care that embodies new technology. Such indirect rationing by (low) price is more politically acceptable than explicit rationing by clinical, demographic or social criteria." Mark Pauly, "What If Technology Never Stops Improving?" *Washington and Lee Law Review*, Vol. 60, No. 4 (Fall 2003), p. 1246.
4. Robert E. Moffit, "Obamacare and the Independent Payment Advisory Board: Falling Short of Real Medicare Reform," Heritage Foundation *WebMemo* No. 3102, January 18, 2001, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-the-Independent-Payment-Advisory-Board-Falling-Short-of-Real-Medicare-Reform*.
5. Henry J. Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals," Program on Medicare Policy, July 22, 2011.
6. "The original hope was that Medicare would grow into a universal health insurance, not coverage only for the elderly, the disabled and those suffering from renal failure." Theodore Marmor, Spencer Martin, and Jonathan Oberlander, "Medicare and Political Analysis: Omissions, Understandings and Misunderstandings," *Washington and Lee Law Review*, Vol. 60, No. 4 (Fall 2003), p. 1151.
7. In 1998, the Mayo Foundation for Medical Education and Research presented its findings on Medicare paperwork to the National Bipartisan Commission on the Future of Medicare. Bruce M. Kelly, director of government relations for the Mayo Foundation, shared the information with The Heritage Foundation on March 4, 1999. Mayo then estimated Medicare's paperwork burden at 110,758 pages, with the total volume of federal health care regulation, including Medicaid rules, amounting to 132,720 pages. With the enactment of the PPACA, the page count will explode.
8. Douglas A. Perednia, *Overhauling America's Healthcare Machine* (Upper Saddle River, New Jersey: FT Press, 2011), p. 93.
9. For an account of federal efforts to combat Medicare fraud and abuse, see Cliff Binder, "Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse," Congressional Research Service, *Report for Congress*, June 23, 2011. Senators Tom Coburn (R–OK) and Thomas Carper (D–DE) have co-sponsored remedial legislation: the Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayer Dollars Act (S. 1251).

micromanagement. The result: Medicare has evolved into a great arena for special-interest politics and income redistribution, the battleground of the "Medicare Industrial Complex," as described by Bruce Vladeck.[10] Armies of lawyers, lobbyists, and consultants for medical specialty organizations, providers, and beneficiary groups engage in an annual fight to increase federal payments; change reimbursement rules; add benefits or medical treatments to Medicare coverage; and obstruct new ideas and innovations, even promising demonstration projects.

A Better Program. Congress should reform Medicare with a focus on improving the program's financial condition.[11] But this initial reform should be undertaken as preparation for restructuring Medicare and changing it into a premium-support program, where the federal government would make a defined contribution to the cost of enrollees' chosen coverage. A Medicare premium-support program would provide comprehensive coverage and increase patient satisfaction, while controlling costs and securing better value for patients. For more than five decades, the Federal Employees Health Benefits Program (FEHBP), serving federal workers and retirees, has been a popular and successful premium-support program. Based on competitive bidding among private health plans, the government makes a defined contribution to the health plan of the enrollee's choice. There are a wide variety of plans and benefit options at local and national levels. All plans must meet standards for fiscal solvency and consumer protection; no plans may exclude enrollees for pre-existing medical conditions. Congress should build upon the best features of the FEHBP as a working model for Medicare reform.[12]

Walton Francis, a former official at the Department of Health and Human Services (HHS) and a prominent Washington-based health care economist, has examined decades of comparative data and concluded that

> For over most of its fifty years, the FEHBP has outperformed original Medicare in every dimension of performance. It has better benefits, better service, catastrophic limits on what enrollees must pay, and far better premium cost control, despite covering a federal workforce that rapidly aged throughout this period and a retiree population that rapidly grew—both major causes of higher health care costs. Fraud is rampant in Medicare and almost non-existent in the FEHBP. Medicare is low hanging fruit for "rent seeking" private interests who leverage billions of dollars through their lobbying activities and the congressional bounty they obtain; the FEHBP has been virtually immune to such assaults.[13]

Premium Support: A Bipartisan Remedy for Medicare's Ills

The phrase "premium support" was initially coined by Henry Aaron of the Brookings Institution and Robert Reischauer of the Urban Institute as a description of their 1995 proposal for Medicare reform,[14] but the basic approach has had a long and distinguished history of bipartisan support. While there are crucial differences in the details among different proposals, premium support is a variant of defined-contribution funding for health insurance: The government makes a direct contribution, in an amount determined by

10. Bruce C. Vladeck, "The Political Economy of Medicare," *Health Affairs*, Vol. 18, No. 1 (January/February 1999), pp. 22–36. Dr. Vladeck is a former administrator of the Health Care Financing Administration (HCFA), the initial name of the Centers for Medicare and Medicaid Services (CMS). Vladeck's essay is a classic account of the political dynamics of the program.
11. For a description of the steps needed for such a change, see Robert E. Moffit, "The First Stage of Medicare Reform: Fixing the Current Program," Heritage Foundation *Backgrounder* No. 2611, October 17, 2011, at *http://www.heritage.org/research/reports/2011/10/the-first-stage-of-medicare-reform-fixing-the-current-program*.
12. Walton J. Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, D.C.: AEI Press, 2009). See also Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (Winter 1995), pp. 47–61; Harry P. Cain, "Moving Medicare to the FEHBP Model, or, How to Make an Elephant Fly," *Health Affairs*, Vol. 18, No. 4 (July/August 1999), pp. 25–39; and Walton Francis, "The FEHBP as a Model for Reform," in Robert B. Helms, ed., *Medicare in the 21st Century: Seeking Fair and Efficient Reform* (Washington, D.C.: AEI Press, 1999), pp. 147–168.
13. Francis, *Putting Medicare Consumers in Charge*, p. 8.
14. Aaron and Reischauer have recently disavowed premium support as the best way to reform Medicare. Nonetheless, their original proposal remains compelling: Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What Is The Next Step?" *Health Affairs*, Vol. 14, No. 4 (Winter 1995), pp. 8–30.
15. While "premium support" proposals are sometimes referred to as "voucher" proposals—often by proponents and opponents alike—they are not the same. A voucher is a certificate given directly to a beneficiary that is redeemable for cash value for the purchase of a good or service—in this case a health plan. Aaron and Reischauer distinguish their proposal from that of a "pure" voucher, "in which the elderly and disabled receive a voucher and are told to fend for themselves in an unregulated and lightly regulated marketplace." *Ibid.*, p. 27.

a formula, to an enrollee's chosen health plan.[15]

In 1980, Representatives Richard Gephardt (D–MO) and David Stockman (R–MI) proposed the National Health Reform Act, which contained a defined contribution for Medicare, and President Ronald Reagan also offered a defined contribution for Medicare in his fiscal year (FY) 1981 budget proposal.[16] In 1983, Gephardt and Stockman re-introduced their comprehensive National Health Reform Act (H.R. 850), which would have provided Medicare beneficiaries with a defined contribution equal to "the average health care expenditure" in a geographic area.[17] In 1995, Congress enacted the Balanced Budget Act of 1995, which also contained a premium-support provision, with a government contribution based on competitive bidding; it would have enabled beneficiaries to remain in traditional Medicare or enroll in a private plan of their choice.[18] President Bill Clinton vetoed the bill.

The Balanced Budget Act of 1997 created the 17-member National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Representative Bill Thomas (R–CA). The commission's majority supported a premium-support proposal, but fell one vote shy of meeting the statutory condition for a formal recommendation to Congress. The product of more than 18 months of detailed analysis and deliberations, the Breaux–Thomas proposal, modeled after the FEHBP, provided a generous government contribution to health plans, adjusted for age and income, and was based on geographic competitive bidding; a unification of Parts A and B into one plan with one trust fund, run by the government with new managerial flexibility; an increase in the normal retirement age from 65 to 67; the addition of catastrophic and drug coverage; and an independent board to administer the competitive system. The Breaux–Thomas proposal was a template for subsequent legislation.[19]

Premium support, in various forms, has also been endorsed by some of the nation's most prominent health policy specialists, including Alice Rivlin of the Brookings Institution, Alain Enthoven of Stanford University, Mark Pauly of the University of Pennsylvania, Bryan Dowd and Roger Feldman of the University of Minnesota, and former Medicare administrators Gail Wilensky and Mark McClellan. Analysts with the American Medical Association, the American Enterprise Institute, the Cato Institute, the National Center for Policy Analysis, the Progressive Policy Institute, as well as The Heritage Foundation, have promoted or developed premium-support reforms.

More recently, the House Budget Resolution of 2011 authorized premium support, based on the proposal of Representative Paul Ryan (R–WI).[20] Premium support is also embodied in recommendations by the Bipartisan Policy Center's Debt Reduction Task Force, and the Committee for a Responsible Federal Budget. Premium support is even offered as a potential cost-control option by the President's National Commission

16. Groundwork for the Medicare defined-contribution proposals that emerged in the 1980s and 1990s had been plowed by a number of economists and health policy specialists, including Ralph Saul of Ina Corporation, Walter McClure of the University of Minnesota, and Alain Enthoven of Stanford University. Brian Dowd, Roger Feldman, and Jon Christianson, *Competitive Pricing for Medicare* (Washington, D.C.: AEI Press, 1996), pp. 9–10.

17. The National Health Reform Act of 1983, "Findings," Section 4 (C). The bill would have authorized a direct contribution to beneficiaries, making it a voucher, and the sponsors called it a voucher.

18. The ill-fated Balanced Budget Act of 1995 did not, however, provide a direct competition between private plans and traditional Medicare. The Henry J. Kaiser Family Foundation, "The Nuts and Bolts of Medicare Premium Support Proposals," Program on Medicare Policy, June 2011, p. 20.

19. For example, the Medicare Preservation and Improvement Act of 1999 (S. 1895), sponsored by Senators John Breaux (D–LA) and Bill Frist (R–TN); the Medicare Preservation and Improvement Act of 2001 (S. 357); and the Medicare Prescription Drug and Modernization Act (H.R. 1), Section 241. In the House–Senate conference on the Medicare Modernization Act of 2003, the House-passed premium-support proposal was struck from the bill in favor of a premium-support "demonstration project" in six geographic areas in 2010. The Patient Protection and Affordable Care Act of 2010 abolished that demonstration project.

20. House Budget Committee Fiscal Year 2012 Budget Resolution, "The Path to Prosperity: Restoring America's Promise," April 5, 2011, at *http://budget.house.gov/uploadedfiles/PathtoProsperityFY2012.pdf* (October 27, 2011). For a Heritage discussion of Ryan's budget proposal, see Robert E. Moffit and Kathryn Nix, "Transforming Medicare into a Modern Premium Support System: What Americans Should Know," Heritage Foundation *WebMemo* No. 3227, April 15, 2011, at *http://www.heritage.org/Research/Reports/2011/04/How-to-Transform-Medicare-into-a-Modern-Premium-Support-System*. For an analysis of Ryan's original "Roadmap," see Moffit and Nix, "The Future of Health Care Reform: Paul Ryan's 'Roadmap' and its Critics," Heritage Foundation *Backgrounder* No. 2495, December 3, 2010, at *http://www.heritage.org/Research/Reports/2010/12/The-Future-of-Health-Care-Reform-Paul-Ryan-s-Roadmap-and-Its-Critics*.

21. Kaiser Family Foundation, "The Nuts and Bolts of Medicare Premium Support Proposals," p. 23.

on Fiscal Responsibility and Reform (the Bowles–Simpson Commission).[21]

Steps to Premium Support

Building on this large body of policy work, Congress can take decisive steps to create a premium-support program:

1. Simplify Traditional Medicare. As outlined in *Saving the American Dream*,[22] Congress should create a uniform Medicare fee-for-service (FFS) plan, combining the benefits of Parts A, B, and D, with the addition of a catastrophic benefit.[23] In other words, beneficiaries would pay a single stated premium, at an amount that would finance the combined FFS benefits, and the cost of that premium would be offset by the government's premium support. So, beneficiaries would pay one premium and one set of co-payments for one plan. Beneficiary and taxpayer funds would be deposited in one Medicare FFS trust fund. By unifying Medicare this way, Congress would take a big step toward premium support, allowing a modernized Medicare FFS plan to compete on a level playing field with private health plans.[24]

Medicare today is organized into four parts, each with different sources and methods of financing. Part A, the Hospitalization Insurance (HI) program, is funded by a federal payroll tax on today's workers and deposited in a trust fund that finances today's retirees. Part B, the Supplementary Medical Insurance (SMI) program, pays doctors, funds outpatient medical services, covers payment for a certain class of drugs, and is financed by a combination of beneficiary premiums and automatic draw downs on general revenues from federal income and business taxes. Part C, Medicare Advantage, is a system of private health plans financed by a combination of premiums and federal payments, though payment to these plans is "benchmarked" to Medicare's existing administrative payment. Part D, the prescription drug program, is also financed by a combination of beneficiary premiums and taxpayer subsidies. Part D, however, operates on a premium-support basis similar to that of the FEHBP.

The division of Medicare into different parts with radically different funding streams is mostly a reflection of short-term political responses rather than a product of deliberate policy,[25] and it contributes to unnecessary complexity. As Aaron and Reischauer observed in 1995, "Whatever rationale may once have existed for the distinction between services in Parts A and B, medical technology, the development of new forms of service delivery, and new payment structures have rendered it obsolete."[26] The policy to unify traditional Medicare has also been suggested by the Bipartisan Policy Center, the National Commission on Fiscal Responsibility and Reform, and the American Enterprise Institute. The idea is also embodied in the Coburn–Lieberman proposal.[27]

2. Establish a Defined-Contribution Payment System. As outlined in *Saving the American Dream*, the government's contribution to enrollee health coverage would be based on a regional competitive bidding process among health plans, including Medicare FFS. The bidding process would take place in geographically defined regions throughout the country.[28] Regional bidding would be based on the provision of Medicare Parts A, B, and D benefits, plus catastrophic coverage.[29] Congress should also allow health plans to compete on a nationwide as well as a regional basis.

22. Stuart M. Butler, Alison Acosta Fraser, and William W. Beach, eds., *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, The Heritage Foundation, 2011, at *http://savingthedream.org/*.
23. *Ibid.*, p. 21.
24. In discussing modifications to Representative Paul Ryan's proposal for premium support, Gail Wilensky, former Medicare administrator, notes: "Since traditional Medicare will be available anyway as long as Americans who are currently 55 years old are alive, continuing Medicare as a choice, as a defined contribution plan, might be a politically important compromise." Wilensky, "Reforming Medicare—Toward a Modified Ryan Plan," *The New England Journal of Medicine*, Vol. 364, No. 2 (May 19, 2011), pp. 1890–1892.
25. Marilyn Moon, "Modernizing Medicare's Benefit Structure," *Washington and Lee Law Review*, Vol. 60, No. 4 (Fall 2003), p. 1207.
26. Aaron and Reischauer, "The Medicare Reform Debate: What Is the Next Step?", p. 14.
27. Henry J. Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals," Program on Medicare Policy, July 22, 2011.
28. Congress may wish to retain the existing regional organization of Medicare Part C or adopt that of Medicare Part D. In Medicare Part C, there are 26 regions. For the administration of Medicare Part D, the prescription drug program, there are 34 regions. Part D is also a premium support system.
29. Butler *et al.*, *Saving the American Dream*, p. 21.

On the basis of these regional market bids, the government would annually calculate the weighted average premium in any given region. During the first five years of the new premium-support system, the government would pay each health plan an amount equal to 88 percent of the total cost, based on the weighted *average* premium for competing plans in that region.[30] After that initial five-year period, the government would then pay 88 percent of the contribution based on the bid of the *lowest*-cost plan.[31] The Congressional Budget Office reports that in using the lowest-cost-plan bid as the payment benchmark, Medicare spending could be reduced by 8 percent to 11 percent.[32]

Using the lowest-cost-plan bid to secure consequential program savings should be compatible with the goal of assuring adequate coverage for beneficiaries. But there is more than one way to accomplish that objective. Picking just one low-cost plan is the simplest way to achieve savings, but it might give too much weight to an outlier, a plan with a stringent or very small network of providers. Another approach might be to base the government payment on the average of the three or five lowest-plan bids in a region. This could also achieve the objective of a low-cost benchmark for government payment.

The contribution amount of 88 percent was embodied in the Breaux–Thomas proposal, and endorsed in 1999 by the majority of the National Bipartisan Commission on the Future of Medicare. Though varying slightly from year to year, Medicare beneficiaries' share of Part B premiums have historically averaged about 12 percent of the total program costs.[33] While the percentage contribution would be the same in each region, the actual dollar amounts would vary depending on the diverse market conditions in different parts of the country. In Miami, for example, the dollar amount might be larger than that of geographically less expensive service delivery in, say, Minneapolis. Given a fixed-dollar contribution, regardless of the plan that the beneficiary chooses, the beneficiary would pay the full amount above that government contribution. In other words, if a Medicare beneficiary wished to buy a regional or national plan that is more expensive than the defined contribution, he could do so, and pay extra out of pocket.[34] If a beneficiary wished to buy coverage that is less expensive than that amount, he would pocket the savings.

As noted, the FEHBP is a working model of a premium-support program. With the FEHBP, the government contribution is to be 72 percent of the weighted average premium of plans competing nationally. While the proposed Medicare contribution in the Heritage proposal would be larger, it is more precise in reflecting the impact of costs on persons at different income levels, as well as real differences in health care costs and delivery in different parts of the United States.

Congress should also encourage personal savings for Medicare beneficiaries wherever possible. In Medicare Part C, the government payment to Medicare Advantage plans is "benchmarked" at the cost of traditional Medicare FFS and capped at a level equal to the average amount in a local area. In Part D, the Medicare prescription drug program, the payment is capped on a national average of competing plans only. There is no Medicare FFS "benchmark" for the government payment in the drug program. Today, the beneficiary who buys a Part D plan receives 100 percent of

30. In accord with the comprehensive federal tax reform recommendations in *Saving the American Dream*, the government contribution would remain tax free.
31. A persuasive case for using the lowest-cost bid, while answering common objections to that approach, is made by Robert F. Coulam, Roger Feldman, and Bryan E. Dowd, *Bring Market Prices to Medicare: Essential Reform at a Time of Fiscal Crisis* (Washington, D.C.: AEI Press, 2009).
32. Congressional Budget Office, "Designing a Premium Support System for Medicare," December 2006, p. 40. This range of CBO estimates was based on 2004 county-level data.
33. The National Bipartisan Commission on the Future of Medicare, "Preliminary Staff Estimate: Senator Breaux's Medicare Proposal," February 16, 1999, p. 6. A standard 88 percent contribution rate is generous, and reflects the general level of taxpayer subsidies for Medicare, which may vary slightly from year to year. Aaron and Reischauer proposed an initial defined contribution at 95 percent in every "market area," envisioning a slower rate of future payment growth, and adjusted to "remove indirect medical education, direct medical education and disproportionate share payments." Aaron and Reischauer, "The Medicare Reform Debate," p. 23.
34. In their own premium-support proposal, Aaron and Reischauer likewise proposed a variation in the Medicare payments to plans based on "market areas" bidding. "The federal Medicare payment in each market area would be the same regardless of which plan the enrollee chose. If the enrollee chose a plan that cost more than the federal Medicare payment in the area, the participant would pay the balance. This supplementary payment can be thought of as a replacement for the cost of retiree and Medigap insurance." Aaron and Reischauer, "The Medicare Reform Debate," p. 21.

the savings. But a Medicare beneficiary secures only 75 percent of the savings in Medicare Advantage program. By law, if a plan's bid is under the government benchmark payment, the plan must rebate 75 percent of the savings to the beneficiary in the form of lower premiums or richer benefits; the remaining 25 percent of the savings is retained by the federal government.

More Savings. An even more intense market competition among plans holds the promise of ever greater savings and even better value for beneficiaries. It would be ideal if consumers could secure 100 percent of the savings resulting from their personal choices. One way to achieve that, and secure even greater savings for taxpayers and beneficiaries alike, is for Congress to authorize payment of 100 percent instead of 88 percent of the premium of the lowest-cost health plan. By removing the 88 percent cap on the lowest-cost plan, it might initially appear that taxpayer costs would be higher. But the removal of the cap would give competing plans even stronger incentives to offer benefit options—within the statutory benefit requirements—that are *at* or *below* the government's defined contribution. This would intensify price competition in the Medicare market, which would, in turn, help to restrain overall premium increases on which the government's payment is based.[35]

3. Allow Wide Open Competition. During the first two or three years of transition to the new premium-support program, Congress should allow new retirees to keep their current health plans as "deemed automatically eligible" for participation—assuming they provide *catastrophic* protection. Premium support would thus be available to employment-based plans, individual plans, small and large group plans, managed-care plans, FEHBP plans, and state-employee health plans. The new system would also be open to Medicare Advantage plans as well as to new health care delivery options. Those with health saving accounts would also be able to bring them into retirement, and likewise secure the standard government contribution.

After this initial grace period, health plans would be subject to certification for participation in the new Medicare premium-support program, assuming their compliance with basic benefit requirements, most importantly the provision for protection from the financial devastation of catastrophic illness.

4. Reduce and Eliminate the Government's Defined Contribution for the Wealthiest Enrollees. The allocation of limited Medicare dollars should be focused on the security of retirees, particularly those of limited means, and guarantee their protection from the financial devastation of catastrophic illness. Congress should tighten the current income thresholds for future government contributions—in the form of taxpayer subsidies for premiums—that already exist in Medicare Parts B and D, index these thresholds to inflation, and phase out taxpayer subsidies for the wealthiest cohort of retirees entirely.[36] This relatively small number of unsubsidized wealthy individuals and couples—about 3.5 percent of the Medicare population—would nonetheless be able to enroll in the Medicare program, pay competitive premiums, and retain existing guaranteed-issue, community-rated health insurance in a large pool.[37]

Under current law, most beneficiaries pay only 25 percent of the premium costs of Medicare Parts B and D; the remaining 75 percent of the premium cost is subsidized by the taxpayers. For upper-income beneficiaries, the income thresholds for reduced taxpayer subsidies

35. Aaron and Reischauer, for example, opposed using the lowest-cost-plan bid as the benchmark for a "premium free" option. They expressed an understandable concern that it would attract enrollees into a plan that might be efficient but would be characterized by a "Spartan delivery system"; such a plan, they feared, might not be able to absorb the influx of large enrollment of low-income persons without compromising quality of care. Aaron and Reischauer, "The Medicare Reform Debate," p. 23. But this problem could be alleviated, as noted, by using an average of the three or five lowest-cost bids in a region. In either case, lifting the cap on the government contribution to the lowest-cost plan (or the average of the lowest-cost plans setting the government payment) could generate even greater savings. In the FEHBP, for example, there is a 75 percent cap on the government contribution to employees' choice of health plan under the existing payment formula. As a practical matter, this means that federal workers and their families must pick up 25 percent of the cost of any plan, no matter how efficient that lower-cost plan is in delivering benefits. An effective consumer-choice system would encourage consumers to secure 100 percent of the costs for picking less expensive plans. Thus, The Heritage Foundation recommended the removal of the 75 percent cap on the defined contribution in the FEHBP. See Angela M. Antonelli and Peter B. Sperry, eds., *A Budget for America: A Mandate for Leadership Project* (Washington, D.C.: The Heritage Foundation, 2001), pp. 331–332.
36. Butler *et al.*, *Saving the American Dream*, pp. 19–20.
37. *Ibid.*, p. 20.

Percent of Defined-Benefit Contribution for Medicare Beneficiaries, by Income

SINGLES	% of Contribution
$0–$55,000	100%
$56,000–$57,000	98%
$75,000–$76,000	64%
$82,000–$83,000	49%
$100,000–$101,000	18%
$109,000–$110,000	2%
More than $110,000	0%

MARRIED COUPLES	% of Contribution
$0–$110,000	100%
$111,000–$112,000	98%
$130,000–$131,000	64%
$137,000–$138,000	49%
$155,000–$156,000	18%
$164,000–$165,000	2%
More than $165,000	0%

Sources: Calculations by the Center for Data Analysis, The Heritage Foundation.

Table 1 • B2626 heritage.org

begin at $85,000 for an individual and $170,000 for a couple. This creates big "cliff effects" in government subsidies for those upper-income beneficiaries enrolled in Medicare Parts B and D. For these and higher-income beneficiaries, premium payments are increased (thus cutting taxpayers' subsidies) on an income scale that would require them to pay 35 percent, 50 percent, 65 percent, or 80 percent of the full premium.[38] Moreover, under the PPACA, these "high income" thresholds are locked into place over the next 10 years, meaning that they will encompass an ever-larger population of Medicare beneficiaries and generate additional savings to the federal government.

Alternatively, under the Heritage proposal in *Saving the American Dream*, the premium support for a beneficiary's chosen plan would start to be reduced for an individual with an annual income of $55,000. This is roughly $12,000 above the average annual income for an American worker. The phase-out of the government contribution would be gradual, reduced at 1.8 percent per year for every additional $1,000 in income above the threshold. The government contribution would be phased out entirely for a single beneficiary with an annual income of above $110,000. For couples, the income range would be $110,000 to $165,000. Couples with annual incomes in excess of $165,000 would thus receive no government contribution in a Medicare premium-support program. Unlike current law, however, the income thresholds over the next 10 years and beyond would be indexed to inflation.

The proposed income-based subsidy system improves on current law. While the income thresholds are lowered, affecting about 9 percent of beneficiaries, the reduction in taxpayer subsidies for upper-income enrollees is not nearly as disruptive as current law; the phase-out of the government contributions is far more gradual. The new thresholds for phasing out the taxpayer subsidies are also indexed to inflation, as measured by the Consumer Price Index (CPI). Unlike the PPACA, this is a genuine structural reform, not merely a mechanism to secure "savings" for other entitlement expansions outside of program.

Income testing has been a regular feature of the Medicare program for many years. Part A hospital costs and Part B premiums and co-payments for low-income enrollees are financed through the Medicaid program. Among premium-support reforms, Senator Breaux's 1999 proposal for the National Bipartisan Commission

38. For 2011, this means that a person paying 80 percent of the full monthly premium would pay $369.10 for Part B, and an additional $69.10 in premium for Part D.

on the Future of Medicare included an income-related premium; low-income persons would continue to be subsidized through Medicaid, and high-income persons (with annual incomes in excess of 500 percent of the federal poverty level) would have paid a modest, additional 15 percent premium to cover health plan costs.[39] In 2011, Representative Paul Ryan, chairman of the House Budget Committee, proposed full premium support to 92 percent of Medicare beneficiaries, but would have reduced the government contributions to enrollees in the top 2 percent of income by 70 percent, and those in the next 6 percent by 50 percent.[40]

As outlined in *Saving the American Dream*, low-income seniors would continue to secure Medicaid subsidies, as they do today; and if they chose a private plan in the premium-support system, states would be able to use Medicaid funds to add to the federal contribution to seniors' chosen coverage.[41]

5. Put Medicare on a Budget. As outlined in *Saving the American Dream*, Congress should establish a Medicare budget and cap annual Medicare spending at the rate of inflation, measured by the CPI plus 1 percent and enrollee population growth.[42]

Under the Heritage proposal, the Medicare spending cap would, of course, directly impact the share of the government contribution to health plans, including the traditional FFS option. In other words, the government share of the premium would be adjusted to ensure compliance with the spending cap. Under the Heritage proposal, the standard government contribution would be 88 percent of the plan's premium cost. If that amount were to exceed the Medicare budget cap, the result would be a reduction of the government contribution to, say, 87 percent or 86 percent of the beneficiary's premium cost. The payment adjustments would apply to all plans equally and all across the regions. They would also apply to national plans.

If health plan bids came in *below* the Medicare budget target, Congress could allow rebates to beneficiaries as direct deposits to their savings accounts, or authorize more generous benefits or premium reductions for beneficiaries, as is the case today with Medicare Advantage. Aaron and Reischauer suggested a variant of this approach in 1995, by allowing the difference between the amount of the government contribution and the cost of the plan to be "rebated to participants as nontaxable income or split between government and participants."[43]

In the early 1990s, Medicare reformers, especially premium-support proponents, largely eschewed the employment of hard caps.[44] The tacit assumption was that big budget savings would follow the creation of a consumer-driven, highly competitive, market-based system: Get the structure right, get the economic incentives right, then the market forces will work, and the savings will follow. While those assumptions remain valid, the circumstances have changed. Record spending, dangerous deficits, and a national debt that is projected to surpass the size of the national economy threatens the economic safety and security of the public. Market reform requires a fallback, an external discipline that will guarantee a limitation on already unacceptably high levels of federal spending and debt.

The PPACA marks a major turning point in Medicare history by imposing a hard cap on Medicare spending. Surveying previous Medicare debates before 2003, Professor Jonathan Oberlander of the University of North Carolina notes that "Democrats widely viewed such a cap as threatening the ability of seniors to access quality

39. The National Bipartisan Commission on the Future of Medicare, "A Preliminary Staff Estimate: Senator Breaux's Medicare Proposal," February 16, 1999, p. 6.

40. Representative Ryan proposed an extra annual government subsidy worth $7,800 for low-income earners; by any standard, this is generous additional assistance.

41. Butler *et al.*, *Saving the American Dream*, p. 21.

42. *Ibid.*, p. 20.

43. Aaron and Reischauer, "The Medicare Reform Debate," p. 24. Under the Heritage tax-reform proposal, all savings would be tax free; so there would be no need to establish a separate health savings account to capture non-taxable income. However, seniors would be able to use their existing health savings accounts for medical expenses in retirement. Butler *et al.*, *Saving the American Dream*, pp. 35–40.

44. For example, there was no such budget cap in the original 1995 Heritage Foundation proposal, as outlined in *Health Affairs*, nor in the 1999 Breaux–Thomas proposal, which was based explicitly on the FEHBP model that Heritage endorsed. During debate on the Balanced Budget Act of 1997, congressional Republican efforts to impose a hard cap on Medicare spending failed.

medical care, and as incompatible with Medicare's social contract and American conceptions of entitlement."[45] In 2010, congressional Democrats reversed course and made sure that Medicare would no longer be an *open-ended* federal entitlement.

Even though Aaron and Reischauer did not endorse a hard external cap on Medicare spending in 1995, using indices of inflation or economic growth, they clearly outlined their goal for Medicare spending:

> In the long run, the federal Medicare payment should grow at the same rate as per capita spending on health care for the non-elderly. This formula is mechanical and may require periodic adjustment, because the per capita cost of care depends on the average age of the population, the age specific gradient in health care costs, and the age bias of new medical technology. If Congress found it necessary to reduce federal support for Medicare, it could slow payment increases, thus shifting the costs to Medicare enrollees.[46]

Today, regardless of policy differences, there is a powerful bipartisan consensus that Medicare should, in some way or other, be a budgeted program.[47] Two years before the enactment of the PPACA, a variety of analysts with diverse views from the American Enterprise Institute, the Brookings Institution, the Concord Coalition, the New America Foundation, and the Urban Institute had concluded that "The first step toward establishing budget responsibility is to reform the budget decision process so that the major drivers of escalating deficits—Social Security, Medicare, and Medicaid—are no longer on autopilot." They further recommended that "Congress and the president enact explicit long-term budgets for Medicare, Medicaid and Social Security that are sustainable, set limits on automatic spending growth, and reduce the relatively favorable budgetary treatment of these programs compared with other types of expenditures."[48]

All caps are controversial because they set Medicare spending levels below the historical pattern of rising health care costs, but they vary in impact and timing. Holding Medicare spending growth to GDP plus 1 percent is currently the most favored option among many top health policy analysts.[49] It is embodied in the PPACA, beginning in 2018; it is endorsed by the Bipartisan Policy Center, also beginning in 2018; and the National Commission on Fiscal Responsibility and Reform, beginning in 2020. It is also a feature of the 2010 Ryan–Rivlin proposal. Analysts at the Center for American Progress are extreme; they want to limit all federal health spending, including Medicare spending, to flat GDP growth beginning in 2020. They would even extend the cost-control enforcement of the IPAB beyond Medicare to the private sector.[50]

But all caps are not the same, neither in their goals nor their functions. The PPACA cap on Medicare spending is the primary instrument to control Medicare costs. The cap is to be enforced through IPAB, which would make "detailed and specific" recommendations for provider payment cuts, i.e., price controls. This centralized process of elite decision making is the means by which scarce resources are to be allocated for officially sanctioned service reimbursements or favored care-delivery models.

The PPACA cap would function as the Medicare equivalent of a "global budget." Such an approach has long been championed by the Left. A variant of the idea was embodied in the 1994 Clinton health plan and it has been a key feature of the British and Canadian health systems. Over time, the PPACA's budgetary objectives would be secured through even tougher provider payment cuts, inviting rationing through reimbursement restrictions, much like national health insurance.

President Obama's proposed cap is GDP plus one-half percent. Not only is the President's cap tighter

45. Jonathan Oberlander, "The Politics of Medicare Reform," *Washington and Lee Law Review*, Vol. 60, No. 4 (Fall 2003), p. 1122.
46. Aaron and Reischauer, "The Medicare Reform Debate," pp. 23–24.
47. The broad policy is no longer an issue, only the details of its implementation. For further discussion, see Robert E. Moffit, Gail Wilensky, and James C. Capretta, "How Should Washington Control Medicare Spending?" Heritage Foundation *Lecture* No. 1192, August 30, 2011, at *http://www.heritage.org/research/lecture/2011/08/how-should-washington-control-medicare-spending*.
48. The Brookings–Heritage Fiscal Seminar, "Taking Back Our Fiscal Future," April 2008, p. 2, at *http://s3.amazonaws.com/thf_media/2008/pdf/wp0408.pdf* (October 27, 2011).
49. See, for example, Wilensky, "Reforming Medicare—Toward a Modified Ryan Plan."
50. The Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals."

than current law, he is also offering it amidst a slow growth economy. Unlike the Ryan budget proposal, Obama's stricter IPAB enforcement would, however, intensify the pressure of Medicare payment cuts already enacted under current law.[51]

In the case of the Heritage proposal, much like the Ryan proposal, the cap functions as a "fall-back" to control spending. The front line of cost control is personal choice in an intensely competitive market. This decentralized decision making among millions of beneficiaries interacting with numerous plans (and more than a million providers) in a new environment of plan and provider competition would drive plan and provider innovation and productivity and lower costs.

By capping Medicare spending at CPI plus 1 percent and enrollee population growth, the Heritage proposal would be a serious restraint on future Medicare spending. The cap would be slightly more generous than Representative Ryan's budget proposal, which would cap the growth of Medicare spending at the CPI. Indexing spending growth to general price increases (using CPI), rather than normally higher medical prices, would serve to restrain rather than merely accommodate medical inflation.

The Heritage Foundation's premium-support system, combined with safety valves for expanded access to care and more direct congressional control over the spending levels than under IPAB, is much more flexible and a far better option than either the President's proposal or current law.[52]

6. Establish Fair Administration and a Level Playing Field. Medicare will remain a public program, notwithstanding overblown "privatization" rhetoric, and will require sound public administration. Medicare's administration of a premium-support program should be vested in a federal agency or office with authority to ensure a level playing field for market competition among diverse health plans while fairly enforcing uniform rules for consumer protection. As noted in *Saving the American Dream*, the best candidate for such an agency already exists: Medicare's Center for Drug and Health Plan Choice, the agency that today administers Medicare Advantage and the Part D drug program—the competitive portion of the Medicare program. Today, the Center for Drug and Health Plan Choice enforces marketing rules, and protects enrollees from marketing abuses.[53]

With Medicare premium support, the center would continue many of its current functions: enforcing a common set of rules for market competition and protecting consumers. In a new system, the center would have to certify that new plans entering into regional or national competition are duly licensed for insurance business by a state, meet federal solvency rules and reserve requirements for the payment of claims, meet the basic benefit standards established by law, and abide by the consumer-protection requirements.

The center's role and responsibility would be similar to, but not identical to, that of the Office of Personnel Management (OPM). OPM, for example, administers the FEHBP as an *employer*, not just as an umpire enforcing the uniform rules of market competition. As an employer, OPM contracts with health plans and negotiates rates and benefits on behalf of federal workers and retirees. These negotiations are confidential and largely confined to national plans, while state and local plans are more or less automatically certified for FEHBP competition if they meet the basic benefit and insurance requirements. (Benefit categories for the FEHBP are a statutory requirement, and specified by Title V, Chapter 89.) OPM is to ensure there is a "reasonable" relationship between the plans' rates and its benefits. While OPM enforces statutory requirements, it does not *standardize* benefits packages. There are thus a wide variety of plans and benefit options, with very different levels of premiums and cost-sharing arrangements. Only occasionally does OPM, as an employer, get into the business of dictating detailed and specific medical treatments or procedures.[54] If the director of OPM is dissatisfied with a plan's offerings, or if

51. On a per capita basis, federal spending on Medicare beneficiaries who will be 65 in 2022 will be $100 higher under the Ryan 2011 budget proposal than under current law ($8,000 to $7,900). Congressional Budget Office, "Additional Information on CBO's Longterm Analysis of a Budget Proposal by Chairman Ryan," April 8, 2011, p. 3.

52. Some prominent Democrats oppose IPAB because it subverts congressional authority and poses a danger to patient care. Says Representative Pete Stark (D–CA), "In theory at least, you could set the vouchers at an adequate level. But, in its effort to limit the growth of Medicare spending, the board is likely to set inadequate payment rates for health care providers, which could endanger patient care." Cited by Robert Pear, "Obama Panel to Curb Medicare Finds Foes in Both Parties," *The New York Times*, April 19, 2011, at *http://www.nytimes.com/2011/04/20/us/politics/20health.html* (October 27, 2011).

53. Butler *et al.*, *Saving the American Dream*, p. 19.

54. Congress, as a matter of historical fact, also rarely interferes with the OPM negotiating process, and only occasionally has it mandated benefits or forbidden federal payment for certain procedures, such as abortion.

the director deems a plan too costly, regardless of whether the plan meets other criteria, he can exclude that plan from competition with other plans. The director of OPM, acting as employer, has enormous residual authority, confirmed by the courts, over the FEHBP.

In Medicare premium support, the Center for Drug and Health Plan Choice would be solely an umpire. The center would therefore continue to admit plans that meet specified standards to compete, as it does today with Medicare Advantage and Medicare Part D. But it would have no authority to negotiate rates and benefits, nor should it standardize health benefit packages among competing plans.[55] But, like OPM, the center should have authority to certify that health plans provide certain *categories* of benefits—such as hospitalization, physicians services, emergency and ambulatory services, drugs, and catastrophic protection—and make sure that the basic offerings are actuarially equivalent to the Medicare benefit provisions of Parts A, B, and D in the bidding process. Plan benefits and premiums are to be fully transparent. If the plans do not meet either the benefit criteria or the insurance standards, the center should have the authority to exclude them from the program.

For administering Medicare premium support, Congress should further specify that the agency could not interfere with private contracting between health plans and medical service providers or with private contracting between beneficiaries and medical professionals, and should not impose premium caps on health plans, or price controls on doctors, hospitals, or other medical institutions, goods, or services. It should reaffirm Medicare's original statutory prohibition against federal officials' interference with, or supervision of, medical practice.[56] It should make these prohibitions explicit.

In almost all respects, then, the governance envisioned for the new Medicare premium-support program would be similar to the administration of the FEHBP: imposing uniform insurance rules on all participating health plans, especially rules for consumer protection (including fair marketing rules, protection against fraud and misleading advertising, and plain-English requirements in sales and contracts), conducting an open season for plan enrollment, establishing a grievance process for the expeditious resolution of claims or disputes, and enforcing strong fiscal solvency and reserve requirements. As Walton Francis observes, "Despite many millions of person-years of enrollment by retired federal employees and their aged surviving spouses, there has been no documented pattern of abuse of any kind by plans in the FEHBP."[57]

In designing a new Medicare premium-support program, the economics of a level playing field are simple enough: no subsidy or regulatory advantage for any participant in the competition; no artificial obstacles to consumer demand or provider supply; free and equal access to and exit from the market. But the political science is more complicated. Congress must protect the taxpayers and the beneficiaries from any conflict of interest: The agency that administers a competitive system cannot have a relationship, even the appearance of one, with one of the competitors; the umpire cannot have a team on the playing field.[58] The problem is that the center is part of the Centers for Medicare and Medicaid Services (CMS), and the director reports to the administrator of CMS, the agency that runs the Medicare FFS plan, which would remain a competitor in the new premium-support system.

Congress could choose a number of options to resolve this problem. None is perfect. First, Congress could require the director of the center

55. The Heritage proposal differs from the 1999 Breaux–Thomas premium support plan, which would have created a national board to negotiate rates and benefits, as well as enforcing financial and quality standards and insurance and consumer-protection rules.

56. Section 1801 of Title XVIII reads: "Nothing in this Title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or compensation of any officer or employee of any institution, agency, or person, providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person."

57. Francis, *Putting Medicare Consumers in Charge*, p. 35.

58. "It is a basic principle of economic organization in a market that those responsible for setting the rules of competition, and providing consumers with information on rival products, should have neither an interest in promoting a particular product nor even a close relationship with one of the competitors. That is why the Securities and Exchange Commission maintains a wall of separation between itself and individual companies." Stuart M. Butler, "Reorganizing the Medicare System to Ensure a Better Program for Seniors," Heritage Foundation *Backgrounder* No. 1294, June 14, 1999, at *http://www.heritage.org/Research/Reports/1999/06/Reorganizing-Medicare-to-Ensure-a-Better-Program-for-Seniors*.

to report directly to the Secretary of HHS rather than the director of CMS. Second, Congress could move the center out of HHS entirely and make it an independent agency that reports directly to Congress, such as the Medicare Payment Advisory Commission (MedPAC). Third, Congress could transform the center into an independent commission, say, a new Medicare Patient Protection Commission, modeled after the Consumer Product Safety Commission (CPSC), with a board appointed by the President and confirmed by the Senate and serving staggered terms. In any case, it is absolutely critical to break the institutional connection between the Center for Drug and Health Plan Choice and CMS, which runs traditional Medicare. Otherwise, taxpayers will be faced with the inherent conflict created by a "public option": a government agency sponsoring a government plan to expand its market share against private plans in a rigged competition. Indeed, under the PPACA, this problem already exists.[59]

7. Retain Medicare Insurance Rules. As recommended in *Saving the American Dream*, Medicare's traditional insurance rules would remain the same: community rating, which means that premiums would be the same for all enrollees based on the characteristics of the entire pool, rather than separate premiums based on individual characteristics; guaranteed issue, meaning that policies would be available to enrollees regardless of health status or pre-existing conditions; and guaranteed renewability, meaning that enrollees would have the right to continue the policy, as long as they make premium payments. In practice, the right to renew the health insurance policy would be guaranteed annually through an annual open season, where beneficiaries could keep their current plans or change to a better one. This, too, is the practice of the FEHBP.

Medicare's population, non-working and disabled citizens, differs from the FEHBP and employment-based pools: They are older, sicker, and live on fixed incomes. The highest concentration of Medicare costs is, of course, incurred by the oldest and sickest beneficiaries. While some have proposed age-adjusted premiums, it is unnecessary. The Medicare Advantage program has prospered under the traditional rules but, unlike the FEHBP, has improved its operations through a risk-adjustment mechanism; Medicare Advantage and Part D plan premiums do not vary by age or health status.[60] Likewise, under premium-support, potential problems can also best be handled through a sound risk-adjustment mechanism.

Improving on the FEHBP's annual open-season process, Congress may wish to allow Medicare beneficiaries to enroll in plans for two or even three years. With longer-term contracts, plans would have even stronger economic incentives to promote wellness and preventative care programs. For beneficiaries who enroll in such programs, improve their health and reduce insurance claims, insurers would be able to provide premium discounts or even bonuses.[61]

8. Establish an Effective Risk Adjustment for Insurance. Any insurance market, even if it included just two health plans, faces adverse selection; a process of risk segmentation that can destabilize and destroy it. Any one of a number of plans will attract a disproportionate share of older and sicker beneficiaries. This drives up the premium costs of the plan and encourages younger and healthier beneficiaries to drop out of the plan, driving up the costs even further and causing the plan to fail. In a pluralistic market, especially if there are liberalized rules like guaranteed issue and community rating, the process repeats itself. Plans fail, and the destabilized market collapses—a "death spiral."

However, at least one example is incompatible with the general theory. Since its inception in 1960, the FEHBP, the oldest, the largest, and

59. In the FEHBP, OPM does not sponsor a government plan to compete with private insurers. Under Section 1334 of the PPACA, however, OPM's role is radically changed. Beginning in 2014, it will sponsor two national health plans to compete directly against private health insurance plans in the state-based health insurance exchanges. See Robert E. Moffit, "Obamacare and the Hidden Public Option: Crowding Out Private Coverage," Heritage Foundation *WebMemo* No. 3101, January 18, 2011, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-the-Hidden-Public-Option-Crowding-Out-Private-Coverage*.

60. This differs from Representative Ryan's proposal, in which plans would be permitted to vary their premiums by age, while the government contribution would likewise be adjusted by age and health status as well as by income. Representatives Richard Gephardt (D–MO) and David Stockman (R–MI) also authorized the Secretary of HHS to establish actuarial categories and adjust government-contribution and premium charges by the age of the Medicare beneficiaries, male and female, over and under age 75, as well as disability status. The National Health Reform Act of 1983, Section 6, Establishment of Actuarial Categories.

61. In Switzerland, for example, some health plans provide premium reductions over five years—bonuses—for those who do not file insurance claims. See Regina Herzlinger, *Who Killed Health Care?* (New York: McGraw Hill, 2007), p. 195.

the most pluralistic consumer-driven health insurance market in the world, has never experienced anything that could be fairly described as a death spiral.[62] While adverse selection has been a persistent problem, it has been a relatively minor one. Because the FEHBP is flexible, private plans enjoy a high degree of freedom in managing health risks. But the generosity of the government contribution is also an incentive for younger enrollees to purchase more expensive plans as well as less expensive plans, since the marginal costs of doing so are relatively modest. Thus, there is a broad distribution of younger and older enrollees among all of the plans competing in the program; indeed very little risk segmentation.[63] With the even more generous government contribution in the Heritage proposal, it is reasonable to expect similar dynamics in a new Medicare program.

Nonetheless, Congress should provide added protection against market instability. Risk adjustment would accomplish that objective; in particular, it would ameliorate the problems that naturally arise from the retention of Medicare's community rating and guarantee-issue provisions—such as higher costs for younger (generally healthier) enrollees, encouraging them to drop out of a plan increasingly populated with older (generally sicker) members paying the same premiums as younger enrollees while incurring higher expenses. There are a few options. Congress could, for example, keep the risk-adjustment mechanisms already in place for the Medicare Advantage program and Medicare Part D, and improve them if necessary.[64]

Alternatively, Congress could establish a national risk-transfer pool, and require plan enrollment as a precondition of plan participation in Medicare. This is a *retrospective* system of cross-subsidization of health plans. It would have some special advantages. It would be neater and cleaner; the assignment of additional subsidies or premiums would be based on hard data, and not the best guesswork of projected outcomes or costs. While all plans would be required to participate, the governance of the national risk pool, its risk-premium setting, would remain in the hands of the private insurers. At the end of the enrollment year, if any given plan ended up with the largest concentration of risks, say, an inordinate enrollment of costly diabetics or cancer patients, that plan would be made whole by the common pool.[65] At the very least, it would be worth a demonstration project.

Advantages of Premium Support

For Medicare beneficiaries and taxpayers alike, a premium-support program would offer numerous advantages:

Better Choices and Access to Care. Premium support will guarantee beneficiaries a rich menu of plan choices, as well as access to a wide range of medical specialties at competitive rates. In the FEHBP, all enrollees, including those in rural areas, have a choice of a dozen or more national plans, as well as state-based health plans. Patients have access to a broad array of physicians and medical specialists, as well as a variety of benefits and services. FEHBP plans also provide coverage for those traveling abroad.[66] This level of choice and access could be duplicated for Medicare enrollees.

While it is true that an estimated 95 percent of physicians accept Medicare patients, there are dramatic provider payment cuts already underway, and access to

62. In his 1997 testimony before the Senate Finance Committee, former CBO director Robert D. Reischauer remarked, "The FEHBP shows that it is possible to create a smoothly functioning market system of national scope in which a number of different types of plans compete for enrollment." Reischauer added that the "FEHBP's experience also suggests that an effective competitive market can function without a sophisticated mechanism for risk adjusting payments to plans." Robert D. Reischauer, "Medicare Reform and the Federal Employees Health Benefits Program," testimony before the Committee on Finance, U.S. Senate, 105th Congress, 2nd Session, May 21, 1997.

63. Curtis S. Florence and Kenneth E. Thorpe, "How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection?" *Health Affairs*, Vol. 22, No. 2 (2003), pp. 211–218.

64. The formula for each program is complex, but similar to each other. In both programs, the base per capita payment is a standard payment, and that payment is further adjusted for risk. In Medicare Advantage, for example, risk calculations are based on demographic information (such as an enrollee's age, sex, institutional, and Medicaid status) and medical conditions, including those diagnosed in the previous year. For Medicare Part D, monthly payments are also adjusted for enrollees' "risk scores" and medical conditions, including enrollees' diagnoses from the previous year and ranked disease categories.

65. For a more detailed description of a risk-transfer pool, see Edmund F. Haislmaier, "State Health Care Reform: A Brief Guide to Risk Adjustment in Consumer-Driven Health Insurance Markets," Heritage Foundation *Backgrounder* No. 2166, August 1, 2008, at *http:/www.heritage.org/research/reports/2008/07/state-health-care-reform-a-brief-guide-to-risk-adjustment-in-consumerdriven-health-insurance-markets*.

66. Francis, *Putting Medicare Consumers in Charge*, pp. 167–169. See also, Walton J. Francis, "The FEHBP as a Model for Medicare Reform: Separating Fact from Fiction," Heritage Foundation *Backgrounder* No. 1674, August 7, 2003, at *http://www.heritage.org/research/healthcare/bg1674.cfm*.

care for newly retired persons has been a growing concern. In 2008, for instance, 45 percent of medical providers in Oregon decided against taking new Medicare patients, even as the American College of Physicians says that rapidly aging Americans will need a 40 percent increase in primary care physicians by 2020.[67] Under the PPACA, as noted, Part A Medicare reimbursements will be relentlessly reduced, even to Medicaid levels. This guarantees reduced access to care, a problem aggravated by the rapidly emerging physician shortage.

Greater Innovation in Care Delivery. CMS actuary Richard Foster says that a premium-support program, where providers compete for market share on the basis of price, could encourage medical technology companies, among others, to pursue major, market-driven improvements in care delivery, instead of minor tinkering, that would deliver patients higher value at lower cost.[68]

Historically, the Medicare program has been notoriously slow. Says Marilyn Moon, "Despite general agreement since the 1970s that the benefit structure should be improved to reflect changes in the needs of Medicare beneficiaries and the evolution of private insurance over time, a major overhaul of the benefit package did not take place until December of 2003."[69] The main reason: Benefit decisions are legislative and regulatory decisions, which are ultimately political decisions. Thus, as Francis notes, "Public programs like Medicare require years (not months, not weeks, not days) to make decisions that in the private sector can be and are often made in hours."[70]

Payment and delivery-system changes are not only slow, but also contentious. Much Medicare decision making focuses on tinkering with flawed administrative payment formulas, like the resource-based relative value scale (RBRVS) or the sustainable growth rate (SGR). Inadvertent testimony to the sluggishness of Medicare change is the recent creation of the Centers for Medicare and Medicaid Innovation (CMI), a new agency authorized under the PPACA to pursue breakthroughs in Medicare payment and delivery reforms.

Competition would be a tonic for traditional Medicare and the CMS staff. The Obama Administration's vaunted delivery reforms would have a better chance of working in a bracing competitive environment. With a robust premium-support system, CMI could succeed in head-to-head competition with private-sector innovators in securing greater patient satisfaction at lower cost; something far more rewarding than merely experimenting on a captive audience.

Superior Cost Control. Medicare premium support would secure superior cost control. Based on the estimates of the Heritage Center for Data Analysis (CDA), a Medicare premium-support program would yield $702 billion in savings over ten years beginning in 2016.[71]

Competition is a powerful engine of cost control, and its impact, better value for the dollars spent, would be felt throughout the health care delivery system.[72] Medicare actuary Foster says that premium support could encourage medical technology companies to produce goods and services at a lower cost, while reducing adverse events.[73]

During the deliberations of the National Bipartisan Commission on the Future of Medicare in 1999, Senator Breaux offered an initial premium-support proposal. Then-CBO director Dan Crippen observed, "We believe that introducing competition into the Medicare program could help to reduce costs

67. Perednia, *Overhauling America's Healthcare Machine*, p. 66.

68. John Wilkerson, "CMS Actuary: Premium Support Could Lead to More Efficient Health Care," *Inside Health Policy*, July 13, 2011.

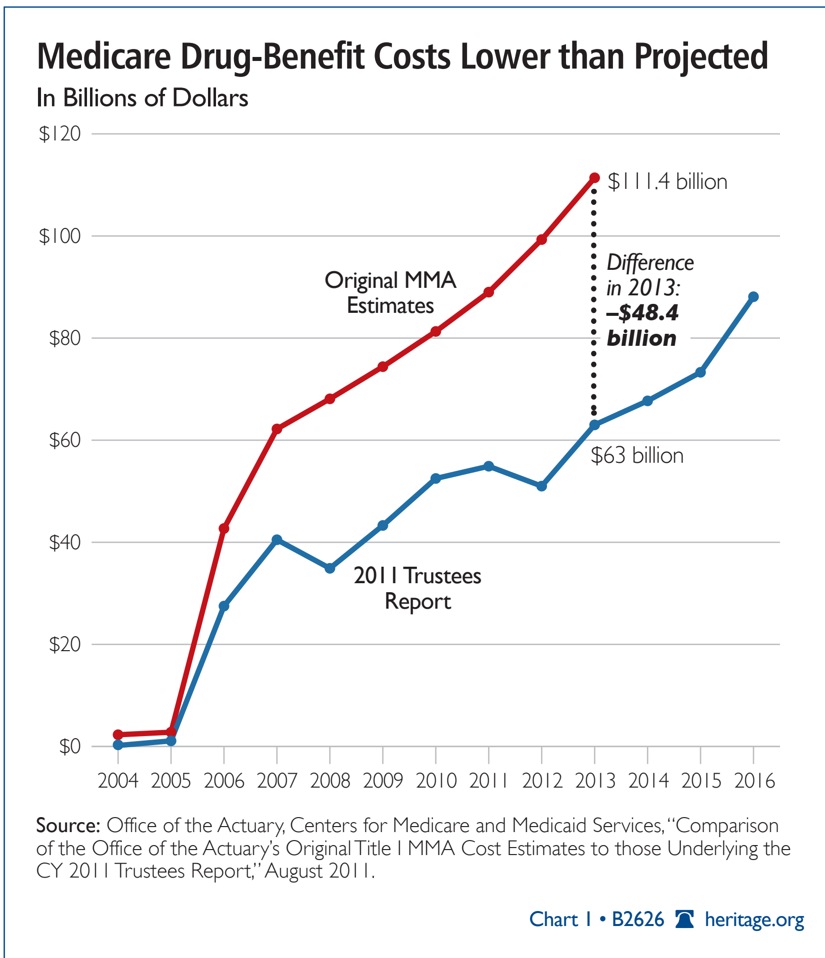
69. Moon, "Modernizing Medicare's Benefit Structure," p. 1209.

70. Francis, *Putting Medicare Patients in Charge*, p. 190.

71. This Heritage CDA estimate is based on the Medicare premium-support outline in *Saving The American Dream*: setting the government contribution on the weighted average bid of competing plans in the first five years of the program beginning in 2016, and switching to a government contribution based on the lowest bid in the second five years. The estimate also assumes the repeal of the PPACA.

72. For an excellent discussion of the role of competition, see James C. Capretta, "The Case for Competition in Medicare," Heritage Foundation *Backgrounder* No. 2605, September 12, 2011, at *http://www.heritage.org/research/reports/2011/09/the-case-for-competition-in-medicare*.

73. Wilkerson, "CMS Actuary: Premium Support Could Lead to More Efficient Health Care."



Source: Office of the Actuary, Centers for Medicare and Medicaid Services, "Comparison of the Office of the Actuary's Original Title I MMA Cost Estimates to those Underlying the CY 2011 Trustees Report," August 2011.

in both the short and the long run. A premium-support system that resulted in effective price competition among plans would most likely lower Medicare costs."[74] Medicare's Office of the Actuary concurred with CBO's expectations of long-term cost reductions.[75] With a slower growth in program costs, commission staff projected that the original Breaux proposal would mean that beneficiary premiums would be 15 percent to 25 percent lower than projections under what was then current law.[76]

In their final 1999 report, the commission staff produced an analysis of the proposal developed by Senator Breaux and Representative Bill Thomas. In that analysis, the commission staff projected a slowing of Medicare spending by an estimated 1 percent per year, and accumulating significant savings over time.[77] This annual percentage reduction was in line with a 1998 Lewin Group finding that a competitive program, accompanied by a growth in managed care enrollment, would result in long-term Medicare spending reductions between 0.5 percent and 1.5 percent annually.[78] Beneficiaries would no longer have to rely on costly supplemental insurance, but be able to take advantage of integrated, comprehensive coverage.

According to commission staff, beneficiaries would also have stronger incentives to secure better value from sharing savings by choosing more efficient and less expensive plans. Health plans, likewise, would have powerful economic incentives to compete on price by offering coordinated and integrated health coverage.

Congress today has the benefit of examining historical patterns of

74. Letter from Dan L.Crippen, director, Congressional Budget Office, to Senator John Breaux, February 18, 1999.

75. The Office of the Actuary estimates were reported on February 23, 1999; the Commission staff report was released on February 17, 1999; and the Lewin Group estimates, based on the potential of a "defined benefit voucher program," were calculated by John Shiels and Andrea Fishman in a report for the National Coalition on Health Care and released in September of 1998. These estimates and related data are summarized in a Commission staff report, "Fiscal Analysis of Senator Breaux's Premium Support Proposal," The National Bipartisan Commission on the Future of Medicare, February 24, 1999, at *http://thomas.loc.gov/medicare/fiscal.html* (October 31, 2011).

76. Memo to Medicare Commission from Jeff Lemieux, Commission Staff, The National Bipartisan Commission on the Future of Medicare, February 17, 1999, at *http://medicare.commission.gov/medicare/jeff.html* (October 31, 2011).

77. "Cost Estimate of the Breaux–Thomas Proposal," National Bipartisan Commission on the Future of Medicare, March 14, 1999, at *http://medicare.commission.gov/medicare/cost31499.html* (October 31, 2011).

78. "Fiscal Analysis of Senator Breaux's Premium Support Proposal," The National Bipartisan Commission on the Future of Medicare.

performance for premium-support programs.[79] In the case of Part D,[80] the program's cost growth has come in well below the official projections. Over the period 2004 to 2013, based on the Medicare Actuary's projections, Medicare Part D is 41.8 percent *below* the original cost estimate, yielding a total savings projected at $264.6 billion.[81] No other program, public or private, has shown such a dramatic performance in the health sector of the economy.

With FEHBP, the program has historically outperformed private health insurance.[82] Examining performance over a 20-year period, and adjusting for benefit improvements, notably the provision of prescription drugs, the Joint Economic Committee staff found that, in terms of average cost growth, the FEHBP also outperformed traditional Medicare on average 5.8 percent to 6.7 percent.[83]

Less Bureaucracy, Red Tape, and Politics. Traditional Medicare is a massive edifice of central planning. It is a sclerotic system governed by tens of thousands of pages of rules and regulations and guidelines, staffed by thousands of employees and thousands more contract workers. Medicare's complex payment formulas (the RBRVS, the SGR, and diagnosis-related groups) for thousands of payments, invariably controversial in their application, also encourage routine congressional micromanagement. Because Medicare decisions are centralized, they are flashpoints in Congress and the federal bureaucracy. As Heritage Distinguished Fellow Stuart Butler has observed,

> Providers included in the [benefits] package fight diligently—and usually effectively—to block serious attempts to scale back outdated coverage for their specialties. Meanwhile, talk of upgrading the Medicare benefits package unleashes an intense lobbying battle among other specialties that seek to be included in the Medicare benefits package. Invariably, the result depends as much (if not more) on shrewd lobbying than on good medical practice.[84]

The politics engendered by the outdated structure of traditional Medicare contributes directly to waste. As former Medicare administrator Bruce Vladeck observed in 1999, "There are plenty of $400 toilet seats in the Medicare program, because Medicare cannot deliver services to its beneficiaries without providers and because providers are major sources of employment, political activity and campaign contributions in every congressional district in the nation."[85]

With a new Medicare premium-support system, the government would make one payment on behalf of a beneficiary or a couple to one plan. Its regulatory responsibilities would be confined to enforcing marketing and insurance rules, certifying plan participation, and consumer protection. Much of today's bureaucracy and red tape would be rendered unnecessary. With a new managerial flexibility, CMS could be unleashed as an agent of innovation and patient satisfaction, experimenting with new payment and delivery reforms, while undertaking a long overdue "bottom up" review of its managerial needs. In the crucible of competition, it could enter the market and keep private health plans "honest," while offering

79. Medicare Advantage is different. While plan payment is based on bids for Medicare benefits, it is also coupled with a mandatory rebate of 75 percent of any amount below the Medicare benchmark in the form of more generous benefits or premium reductions. Payment for these additional benefits does indeed cost taxpayers, but Medicare patients' reduced reliance on Medicaid and Medigap also saves taxpayers' money. It is worth noting that President Obama proposed severing Medicare Advantage plan bidding from traditional Medicare payment, thus making it more like Part D and FEHBP. Francis, *Putting Medicare Consumers in Charge*, p. 195.

80. The Heritage Foundation and many other fiscal conservatives opposed the creation of a universal Medicare entitlement for prescription drugs, but always supported a competitive system in private health care delivery.

81. The data are from the Office of the Actuary, CMS, "Comparison of the Office of the Actuary's Original Title I MMA Cost Estimates to those Underlying the CY 2011 Trustees Report," August 2011.

82. During the 1980s, for example, FEHBP premiums rose an average 12 percent, while private-employer-based plans rose by 14 percent. Congressional Research Service, "The Federal Employees Health Benefits Program: Possible Strategies for Reform," May 24, 1989, p. 255. The CRS report remains the most comprehensive analysis of the FEHBP ever published.

83. Michael J. O'Grady, "Health Insurance Spending Growth: How Does Medicare Compare," a report for the Joint Economic Committee, June 10, 2003. Since private health insurance is, and has been, far more generous than Medicare, adjustment for benefit improvements is crucial. Traditional Medicare, as noted, only covers roughly half of the total health costs of the beneficiaries. Nine out of 10 are enrolled in supplemental, mostly private, coverage.

84. Stuart M. Butler, "Principles for a Bipartisan Reform of Medicare," Heritage Foundation *Backgrounder* No. 1247, January 29, 1999, at *http://www.heritage.org/Research/Reports/1999/01/Principles-for-a-Bipartisan-Reform-of-Medicare*.

85. Vladeck, "The Political Economy of Medicare," pp. 30-31.

Medicare patients a better FFS product at a competitive price. The market share of Medicare FFS, with its combinations of premiums, co-payments, and benefits, would be determined solely by beneficiary choice.

In a consumer-driven market, with the diffusion of decision-making power among millions of enrollees, there would be a sharp decline in the influence of rent-seeking special interests, and a long overdue de-politicization of Medicare's financing and delivery decisions. The program would function more like the market-driven FEHBP, and less like the rough political playground of the "Medicare Industrial Complex." The FEHBP covers more than 8 million people and is administered by an OPM staff of approximately 150 civil servants, enforcing a spare statute and just 87 pages of rules published in the *Code of Federal Regulations*.[86]

Less Fraud and Abuse. Medicare, as noted, is plagued by scandalous levels of waste, fraud, and abuse. According to the Government Accountability Office, the annual loss amounts to $48 billion.[87] With Medicare FFS, the sheer number of transactions—government payments for roughly a billion claims annually submitted by hundreds of thousands of providers—the opportunities for this triple threat to the taxpayers are legendary.

With premium support, the government's transactions are radically reduced to fixed and transparent annual payments to competing regional and national health plans; these plans have powerful economic incentives to police their contracts with medical providers and reduce the cost of fraud or improper payments. Losses from fraudulent or wasteful transactions directly affect their premium charges and undermine their competitive position in an intensely competitive market. Once again, Congress should carefully examine the comparative performance of the FEHBP and Medicare. As Francis has noted, "In only a relatively handful of instances in the past dozen years has the federal government lost substantial sums of money to actual fraud in or by private health plans participating in the FEHBP or Medicare Advantage…."[88]

Conclusion

In *Saving the American Dream*, The Heritage Foundation provides an outline of a new Medicare premium-support program. There are differences in detail compared to other proposals. But, as a policy for Medicare reform, premium support has a long history of bipartisan sponsorship. It has recently been embraced in one form or another by a wide range of analysts and institutions, including the American Enterprise Institute and the Bipartisan Policy Center Debt Reduction Task Force, and it is offered as a potential budget option by the National Commission on Fiscal Responsibility and Reform.[89]

Today, there are two working models of premium support: the FEHBP and Medicare Part D. Both have a great record of serious cost control, rich and varied benefit offerings, and high levels of patient satisfaction. Congress can replicate the success of these popular programs by transforming Medicare into an integrated plan ready to compete with private plans; establishing a defined-contribution payment system; focusing taxpayer subsidies on beneficiaries who need the most help; putting Medicare on a budget like other government programs; establishing a level playing field for open competition under uniform rules enforced by a neutral agency; and establishing an effective risk-adjustment system to cope with adverse selection.

Such a reform would improve Medicare for future retirees. It would expand their access to high quality care, and make Medicare practice far more attractive to physicians and other medical professionals. It would spur greater innovation in benefit design and care delivery, and it would reduce bureaucracy and red tape, as well as waste, fraud, and abuse. It would also end the paralyzing and unproductive politicization of crucial decision making over the provision of medical care for tens of millions of Americans. It would secure a superior and more cost-effective Medicare program for the next generation of retirees and taxpayers alike.

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86. *5 Code of Federal Regulations*, Chap. 1, Part 890, Federal Employees Health Benefits Program, pp. 447–534.
87. This estimate is based on FY 2010 data, and represents about 38 percent of total improper payments by the federal government. Government Accountability Office, "Improper Payments: Reported Medicare Estimates and Key Remediation Strategies," GAO–11–842T, testimony before the Subcommittee on Government Organization, Efficiency and Financial Management, Committee on Oversight and Government Reform, U.S. House of Representatives, July 28, 2011, at *http://gao.gov/products/GAO-11-842T* (October 31, 2011).
88. Francis, *Putting Medicare Consumers in Charge*, p. 170.
89. The Henry J. Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals," Program on Medicare Policy, July 22, 2011.