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Transforming Medicare into a Modern Premium Support System: What Americans Should Know

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House Budget Committee Chairman Paul Ryan's (R–WI) budget proposal for fiscal year 2012 would transform the Medicare program into a "premium support" system. Under the Ryan approach, the federal government would make a direct financial contribution to Medicare enrollees' health care coverage, just as it does today for federal workers and retirees in the popular Federal Employees Health Benefits Program (FEHBP), the nation's largest and most successful example of a premium support system.

The advantage of a premium support system is that it enables enrollees to apply the government's contribution to the health plan of their choice, providing them a broad range of integrated health care options. This is in sharp contrast to the gap-ridden and inflexible benefit standardization of traditional Medicare, which encourages nine out of 10 seniors to seek costly supplemental coverage. Premium support would introduce intense competition in a consumer-driven market, which has historically slowed the growth of health care costs and increased patient satisfaction.

Moving Toward a Defined Contribution. Premium support, like a voucher, is a variant of defined-contribution health care financing. This general approach, though differing in details, is neither novel nor partisan. In 1983, former Representatives Richard Gephardt (D–MO) and David Stockman (R–MI) introduced the National Health Care Reform Act. It included comprehensive Medicare reform based on a defined contribution to enrollees' choice of plan in the form of a "direct contribution" toward payment of a plan's premium: a "voucher." In that plan, the contribution would have been drawn from Part A and Part B Trust funds, but when fully phased in, the amount would be based on the weighted average of premiums in a geographical area and indexed to the Gross National Product (GNP) deflator.[1]

The term "premium support" was coined by Henry Aaron, a senior fellow at the Brookings Institution, and Robert Reischauer, president of the Urban Institute. Both are prominent liberal public policy institutions. In a 1995 edition of *Health Affairs*, Aaron and Reischauer described their vision:

> Medicare would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services. As with private insurance for the working population, plans could reimburse any provider the patient chooses on a fee-for-service basis (the current method Medicare uses for most beneficiaries), contract with a PPO, or operate through an HMO. Plans could manage care in any of the ways now in use or that might arise in the future. All Medicare beneficiaries ultimately

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would receive a predetermined amount to be applied to the purchase of a health plan providing defined services.[2]

Aaron and Reischauer's government contribution would have been based on average health care costs,[3] not an economic index. Eventually, the contribution would grow at the same rate as per capita health care spending for the non-elderly.[4]Aaron recently re-emphasized that his version of Medicare premium support contained certain features: a regulatory restriction on the number of plans; an agency providing assistance and neutral information to enrollees; and a retrospective risk-adjustment mechanism to make plan risk selection "unprofitable." [5]

In 1999, premium support was the centerpiece of the majority recommendation of the National Bipartisan Commission on the Future of Medicare, chaired by former Senator John Breaux (D–LA) and former Representative William Thomas (R–CA). Under the Breaux–Thomas proposal, the federal government would have paid 88 percent of the average cost of the premiums of competing plans offering the standard Medicare benefits package, adjusted annually for benefit and technology costs. Commission staff estimated that premium support would slow annual growth in Medicare outlays by 1 percent to 1.5 percent annually, yielding $100 billion in savings in the first seven years.[6] The Congressional Budget Office also concluded that the competition would have reduced costs.[7]

Since the 1990s, America's debt and deficits have severely worsened.[8] Not surprisingly, Democrats and Republicans alike have proposed budgetary caps to control Medicare spending growth, a major shift from the earlier premium support proposals offered by the Bipartisan Commission, The Heritage Foundation, and the original Aaron–Reischauer proposal. In 2008, analysts from a broad range of think tanks, including Brookings and Heritage, proposed to put Medicare (and other entitlements) on a long-term budget, reviewable every five years.[9] In 2010, Congress enacted record-breaking Medicare provider payment reductions and put an unprecedented hard cap on the growth of future Medicare spending, tying it to measures of inflation and economic growth. Further specific payment reductions

1. The National Health Care Reform Act of 1983, (H.R. 850), Section 104. Reps. Gephardt and Stockman described their version of the government contribution as a "voucher" to offset premium costs. In their legislative findings, they declared, "The present system of financing and regulation prevents health care deliverers from competing with each other on the basis of efficiency and price as well as quality."
2. Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What is the Next Step?" *Health Affairs*, Vol. 14, no.4 (1995), pp. 8–30. In the aftermath of the release of Ryan's budget proposal, Aaron clarified his differences with the Ryan approach. See Henry J. Aaron, "How Not to Reform Medicare," *The New England Journal of Medicine*, April 6, 2011, at *http://healthpolicyandreform.nejm.org/?p=14134* (April 12, 2011).
3. Aaron, "How Not to Reform Medicare."
4. "In the long run, the federal Medicare payment should grow at the same rate as per capita spending on healthcare for the nonelderly. 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 costs to Medicare enrollees." Aaron and Reischauer, "The Medicare Reform Debate: What Is The Next Step?" p. 23.
5. Aaron, "How Not to Reform Medicare."
6. National Bipartisan Commission on the Future of Medicare, "Building a Better Medicare for Today and Tomorrow," March 16, 1999, at *http://medicare.commission.gov/medicare/bbmtt31599.html* (April 14, 2011).
7. Letter from Dan Crippen, Director, Congressional Budget Office, to the Honorable John Breaux (D–LA), February 18, 1999, p. 1.
8. Today, America's national debt is $14 trillion and taxpayers face an annual deficit of $1.4 trillion. By 2020, the Medicare Hospital Insurance (HI) Trust will be insolvent, meaning that Congress will have to increase taxes substantially or cut seniors' Medicare benefits. With the passage of time, the financial risks to younger working families become progressively larger.
9. See Stuart M. Butler and Alison Fraser *et al.*, *Taking Back Our Fiscal Future*, The Brookings–Heritage Fiscal Seminar, April 2008, at *http://www.heritage.org/research/reports/2008/03/taking-back-our-fiscal-future*.

can be recommended by the Independent Payment Advisory Board.[10]

With such broad agreement that Medicare's costs are unsustainable, it is time for Congress to look seriously at the ways a premium support system could serve patients and reduce the crushing entitlement burdens that face America's younger working families and their children.

FEHBP: Premium Support in Action. The Federal Employees Health Benefits Program (FEHBP), administered by the U.S. Office of Personnel Management (OPM), is a working model of a premium support system. The FEHBP provides coverage for active and retired federal employees, including members of Congress and their staffs. This popular program serves approximately 8 million individuals. Enrollees choose from a wide variety of health plans, including conventional insurance, managed care, plans sponsored by employee or union organizations, and high-deductible plans.

In the FEHBP, the capped amount of the government's contribution to employees' health plans is based on 72 percent of the weighted average premium of health plans competing in the program. This formula, allowing for changes in the market, also provides that the government's contribution cannot exceed 75 percent of the cost of any given plan. If federal workers or retirees buy a plan that is more expensive than the government contribution, they pay the extra costs. OPM determines "reasonable minimal standards" for plans, ensures that the health plans are fiscally solvent, and enforces rules for consumer protection. It does not set prices, standardize health benefit packages, or apply detailed guidelines for doctors or hospitals. Compared to Medicare's rules, OPM's regulatory role in FEHBP is light, and it is focused on providing a level playing field for health plans to compete. Walton Francis, a prominent Washington-based health care economist, writes that "the FEHBP has outperformed original Medicare in every dimension of its performance. It has better benefits, better service, catastrophic limits on what enrollees must pay, and far better premium cost control."[11]

How the Ryan Proposal Improves upon the FEHBP. Chairman Ryan's proposal would convert Medicare to a new premium support system starting in 2022.[12] The average government contribution would be based on the federal spending per capita in traditional Medicare.[13] Contributions would increase based on the consumer price index for urban consumers and would reflect the increasing age of the Medicare enrollee, taking into account the higher costs incurred by older retirees.[14] Like the Breaux–Thomas proposal, Ryan's proposed contributions are much higher than those in the FEHBP. Also in contrast to the FEHBP, the contributions reflect the need for greater assistance to lower-income enrollees. While all seniors in the bottom 92 percent of all earners would receive the full contribution, those in the top 2 percent would receive 30 percent, and those within the top 6 percent would receive 50 percent. Low-income beneficiaries would receive contributions to a medical savings account estimated to be worth approximately $7,800 in 2022 as additional assistance.

10. Beginning in 2015, Medicare per capita spending is limited to a fixed growth rate—initially a blend of general and medical inflation—and in 2018, growth in GDP plus 1 percent. Patient Protection and Affordable Care Act, Public Law 111-148, Section 3403.
11. 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 (1995), pp. 47–61.
12. Chairman Paul Ryan of Wisconsin and the House Committee on the Budget, "The Path to Prosperity: Restoring America's Promise," Fiscal Year 2012 Budget Resolution, at *http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf* (April 12, 2011).
13. According to the CBO, the average contribution for a 65-year-old in 2022 would be about $8,000, based on the estimated net federal spending per capita in Medicare. Douglas W. Elmendorf, Director of the Congressional Budget Office, "Long-term Analysis of a Budget Proposal by Chairman Ryan," April 2011, at *http://www.cbo.gov/doc.cfm?index=12128* (April 12, 2011).
14. In the FEHBP, there is no variation in the government contribution based on age.

Americans who turn 65 before 2022 would have the choice of remaining in traditional Medicare or participating in the new program.[15] Participants in the new program would receive a payment that could be applied to any health plan meeting the government standards through a Medicare insurance exchange. Plans would have to offer coverage to any Medicare beneficiary, regardless of pre-existing medical conditions.

One weakness of the FEHBP is that there is no risk adjustment to account for disparities among enrollees and plan costs. Ryan would add a risk-adjustment mechanism for health plans that have a disproportionate number of high-cost, high-risk enrollees. The Centers for Medicare and Medicaid Services (CMS), the agency that runs Medicare, would administer the risk adjustment to ensure that plans were appropriately compensated for their enrollees' health risks.

Making the Details Work for Patients. The Ryan proposal is the latest version of premium support. In the give and take of the legislative process, provisions will be hammered out in detail. In these complex transactions, the purpose of reform can be undermined. Thus, lawmakers should focus on key goals. Specifically:

1. ***Maximize choice.*** Under premium support, Medicare would become a real insurance program, not merely an outdated mechanism to reimburse specific services. Receiving fixed financial assistance to offset the cost of health insurance would permit seniors to choose the health plan that works best for them, rather than being locked into a federally defined benefits package and forced to pay a second premium for supplemental private insurance to cover Medicare's gaps. Under most versions of premium support, Medicare would contribute to any number of acceptable, yet vastly different, grandfathered options, including existing Medicare Advantage plans, plans approved to participate in the Federal Employees Health Benefits Program (FEHBP), and employer plans. If a person wanted to bring the health plan he had during his working life into retirement with him, he would be able to secure premium support to offset its cost. Moreover, individuals should have the opportunity to choose plans that covered specific services uniquely important to them.
2. ***Ensure consumer protection without excessive bureaucracy.*** In a reformed system, doctors and patients would no longer be at the mercy of the Medicare bureaucracy, which has an unenviable record of denying claims more often than private insurance. The federal government would exercise oversight and play a strong role in consumer protection, but it would not interfere in medical practice or increase the "hassle factor" for doctors; plans that did so would incur customer disapproval and surely lose market share.
3. ***Ensure that financing is fair.*** Giving people purchasing power and options would pressure insurers to offer plans of better value that respond to popular demand, and intense competition among insurers would control costs. As a result, the Medicare program would see serious savings. Giving seniors a defined contribution adjusted by income and health status as Ryan proposes would allow Congress to fashion a rational budget. Seniors would have a vested interest in ensuring health dollars were spent wisely, and they would seek out the best value in health plans and medical services. Seniors and taxpayers would thus become partners—not opponents—in efforts to control Medicare costs. Financed in a predictable manner, the new system would also create stability for participating physicians and superior patient access to the care they provide.[16]

Medicare Is Changing, For Better or For Worse. Medicare reform is imperative if the program is to have a viable future. The traditional Medicare fee-for-service design of the 1960s has proven

15. Also beginning in 2022, the eligibility age for Medicare would increase each year by two months, until it reached 67 in 2033.
16. For further discussion, see also Robert E. Moffit and James C. Capretta, "How to Fix Medicare: A New Vision for a Better Program," Heritage Foundation *Backgrounder* No. 2500, December 12, 2010, at *http://www.heritage.org/Research/Reports/2010/12/How-to-Fix-Medicare-A-New-Vision-for-a-Better-Program*.

ineffective in controlling costs and delivering value to individual patients, who must buy supplemental policies to fill in coverage gaps. This outdated structure of central planning and price fixing has also turned the program into a frenzied arena of special interest lobbying, and it has become a relentless engine of mounting debt. With the retirement of 77 million baby boomers beginning this year, Congress has two broad options.

It can reduce payments to providers and expand the power of the Medicare bureaucracy over reimbursement of medical treatments and procedures. In fact, Congress has already embarked on that path with enactment of the Patient Protection and Affordable Care Act (PPACA), reducing provider payments and creating new reimbursement regimes and tougher rules to guide medical practice. By placing a hard cap on Medicare spending and voting to move away from traditional fee-for-service medicine, Congress has already decided to end Medicare "as we know it."[17] Remarkably, the President wants to tighten Medicare payment restrictions even more.

A better option is to adopt a premium support program of financing, giving patients direct control over the flow of dollars in the program and forcing health plans and providers to compete to deliver value for those dollars. The demonstrable success of the FEHBP shows that such an approach is compatible with Americans' personal freedom of choice and their desire to secure high-quality care at competitive prices. Premium support remains the best solution for serious Medicare reform.

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17. Robert E. Moffit and Kathryn Nix, "The Future of Health Care Reform: Paul Ryan's 'Roadmap' and Its Critics," Heritage Foundation *Backgrounder* No. 2495, December 3, 2010, pp. 4–6, at *http://www.heritage.org/Research/Reports/2010/12/The-Future-of-Health-Care-Reform-Paul-Ryan-s-Roadmap-and-Its-Critics?query=The+Future+of+Health+Care+Reform:+Paul+Ryan's+"Roadmap"+and+Its+Critics*.