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A Recipe for Reform: Success of Consumer-Driven Principles in Medicare Programs

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Medicare is in crisis. Already generating tens of billions of dollars annually in deficits, its financial challenges threaten taxpayers and enrollees alike. Moving to a premium-support model would reverse the program's deterioration by using the dynamics of the free market to contain costs and improve consumer satisfaction.

Critics claim that this approach is radical and would allow insurers to discriminate against people with pre-existing conditions. They assume that health care spending would continue to follow its current upward trajectory, despite changes in economic incentives. Finally, they argue that seniors would not be effective consumers. None of these claims is supported by the evidence.

The Federal Employees Health Benefits Program (FEHBP), which provides health care benefits for approximately 8 million federal employees, retirees, and their families, has long been the gold standard for a premium-support financing system.[1] But examples also exist within Medicare itself and are proving successful. Applying their successes to the rest of Medicare can restore permanent solvency to the program, preserve robust access to high-quality care, encourage continued physician participation, and strengthen Medicare as *real* insurance for tomorrow's seniors.

Elements of Premium Support in the Medicare Prescription Drug Benefit. Medicare Part D offers a voluntary prescription drug benefit delivered exclusively through private health plans. Seniors choose from qualified drug plans that offer at least a minimum level of benefits set by the government. Low-income participants receive additional assistance, and beginning in 2011, high-earning beneficiaries pay an additional income-related premium. The Centers for Medicare and Medicaid Services (CMS) provides oversight, ensuring plans are sufficient and insurers do not eliminate certain benefits to discourage enrollment by those with chronic illnesses. The results have been striking.

Bang for the buck. Medicare covers 74.5 percent of the average weighted premium for a standard plan, determined through a bidding process that reflects the true market value of participating plans. Due largely in part to the market-based structure of Medicare Part D, the cost of the program has been lower than expected: CMS originally projected the program's 10-year cost would be $634 billion; instead, it now is expected to be $373 billion—41 percent below the original estimate.[2] Some say this is a result of system-wide reduction in spending on prescription drugs, but in fact spending by the elderly has fallen by a greater percentage than the rest of the population. In other words, competition and incentives have driven consumers to higher-value products.

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Consistent, affordable options. Costs for Part D enrollees have remained stable as well. As former Office of Management and Budget (OMB) official James Capretta explains, "[T]he whole point of Part D's consumer choice structure is that it allows enrollees to migrate out of plans with high costs to those with low costs. And, not surprisingly, that has happened every year of the program's operation." [3] In 2011, average premiums increased by just $1, which has been the average increase for the past two years.[4]

Popular and user-friendly. Finally, Part D has achieved a high level of popularity among participants. In 2011, at least 28 stand-alone drug plans are available to all beneficiaries.[5] Last year, 84 percent of enrollees reported feeling satisfied with their coverage, and 94 percent said that their plan worked well and they understood how it worked.[6]

Elements of Premium Support in Medicare Advantage. Medicare Advantage, or Part C, offers seniors the benefits otherwise available under traditional Medicare from a broad range of private plans. Because it gives seniors access to richer benefits packages, lower and simpler premiums, and high-quality care, the program is an appealing alternative to traditional fee-for-service Medicare. Since 2005, enrollment has grown from 5.3 million to 11.1 million, 24 percent of today's entire Medicare population.[7] There are several reasons seniors are choosing Advantage.

Comprehensive insurance options. Seniors choose from a variety of health plans, several of which offer benefits *not* included in traditional Medicare, such as dental or vision care. The availability of comprehensive plans eliminates the need for additional coverage, enabling enrollees to pay a single, integrated premium—unlike the separate premiums paid by enrollees in traditional Medicare for coverage by Part B, Part D, and supplemental policies.

Quality care. Medicare Advantage beneficiaries not only receive better benefits, but emerging evidence indicates they also experience higher quality of care than their counterparts in fee-for-service (FFS). Comparisons show double-digit reductions in emergency room visits, hospital readmissions, length of inpatient stays, and avoidable admissions.[8] Plans have used payment incentives and evidence-based practices to improve the quality of care. Better care coordination and disease management

1. See Walton 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/Reports/2003/08/The-FEHBP-as-a-Model-for-Medicare-Reform-Separating-Fact-from-Fiction*.
2. Pharmaceutical Care Management Organization, "CMS: Part D Costs $261 Billion Lower than Expected," August 19, 2010, at *http://pcmanet.org/2010-press-releases/cms-part-d-costs-261-billion-lower-than-expected* (August 8, 2011).
3. James Capretta, "Ezra Klein's F on Part D," Heritage Foundation *Foundry*, June 16, 2011, at *http://blog.heritage.org/2011/06/16/ezra-kleins-f-on-medicare-part-d/*.
4. Amy Hall, "CMS Announces the 2011 Average Part D Premium Estimate and the 2011 Part D Benchmarks," Centers for Medicare and Medicaid Services, August 18, 2010, at *http://www.cms.gov/officeoflegislation/downloads/2011PartDBenchmarks.pdf* (August 8, 2011).
5. "Medicare: The Medicare Prescription Drug Benefit," Kaiser Family Foundation Fact Sheet, October 2010, at *http://www.kff.org/medicare/upload/7044-11.pdf* (August 8, 2011).
6. "Seniors' Opinions About Medicare Rx: Fifth Year Update," KRC Research for Medicare Today Survey, September 2010, at *http://www.medicaretoday.org/pdfs/KRC%20Medicare%20Today%20Survey%20of%20Seniors%20with%20Medicare%20Rx%202010%20FINAL.pdf* (August 8, 2011).
7. "Medicare: Medicare Advantage," Kaiser Family Foundation Fact Sheet, September 2010, at *http://www.kff.org/medicare/upload/2052-14.pdf* (August 8, 2011).
8. "America's Health Insurance Plans," Statement for the Record, Committee on Ways and Means, U.S. House of Representatives, February 10, 2011, at *http://waysandmeans.house.gov/News/DocumentSingle.aspx?DocumentID=230519* (August 8, 2011). See also "Using AHRQ's 'Revisit' Data to Estimate 30-Day Readmission Rates in Medicare Advantage and the Traditional Fee-for-Service Program," AHIP's Center for Policy and Research, October 12, 2010, at *http://www.ahipresearch.org/pdfs/AHRQ_revisit_readmission_rates_10-12-10.pdf* (August 8, 2011).

make certain plans especially appealing for seniors with chronic conditions. In contrast, according to AHIP, "the Medicare FFS program lacks the infrastructure and coordination that are needed across providers to address the specific needs of each individual patient."[9]

Better value. Critics claim that Medicare Advantage is ineffective at controlling costs because spending per beneficiary is 109 percent that of traditional Medicare.[10] However, it is important to note what is being paid *for*; Medicare Advantage enrollees receive more generous benefits than those offered by traditional Medicare. Moreover, several Medicare Advantage plans have succeeded at offering traditional Medicare benefits at lower cost. According to the Government Accountability Office, in 2010, "[Advantage] plans projected that they could cover their costs for providing Medicare's standard benefits for about 98 percent of the amount that would be spent under the FFS program."[11] A more sensible payment system would create even stronger incentives for insurers to bring down this average even further.

The Heritage Plan: Building on Success. Heritage's *Saving the American Dream* proposal builds on the most successful of these principles already guiding portions of seniors' care today.[12] Individuals could still choose premium-based Medicare fee-for-service. They would have a new menu of options, however, of private plans including fee-for-service, managed care, Medicare Advantage, association plans, employer-based plans, and more.

Contributions would be income-adjusted (like in Part D), restoring Medicare to its original function as a genuine social insurance program. Very wealthy seniors would continue to benefit from access to an insurance marketplace where they could not be denied coverage, but they would no longer receive taxpayer subsidies to purchase coverage. Low-income seniors would continue to receive additional aid under Medicaid if they remain in traditional Medicare; if enrolled in a private plan, states could "top off" the federal contribution with further financial assistance.

Costs would be controlled in part through competition. The federal contribution for premium support would be based on bids submitted by participating plans to cover traditional Medicare benefits, as well as a new catastrophic care benefit. Bids would be weighted based on enrollment, like in FEHBP and Part D, and once fully implemented, the government contribution would equal 88 percent of the lowest premium bid. This would put pressure on insurers to bring costs below their competitors'.

As in Medicare Part D, risk adjustment would protect against one plan taking on all the sickest patients—a problem called adverse selection. Medicare's new role would be similar to that of the Office of Personnel Management in administering the FEHBP, providing oversight to guarantee that plans are financially solvent and consumer protections to guard against fraud and misleading contractual agreements.

Medicare Will Not Survive under Any Other Plan. As Medicare enrollment grows, increasing demand for medical services cannot be fulfilled through the program's current, outdated fee-for-service structure that rewards volume—not quality care—and exacerbates rising costs. The Obama Administration's plan thus far is to allow an unelected board to tinker with the program, most likely by reducing payments to providers, which would guarantee reduced access to care. Medicare can be made affordable—and its quality improved for patients—by transforming it into a premium-support system.

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9. "America's Health Insurance Plans," Committee on Ways and Means.
10. "Medicare: Medicare Advantage," Kaiser Family Foundation Fact Sheet.
11. "Medicare Advantage: Comparison of Plan Bids to Fee-for-Service Spending by Plan and Market Characteristics," U.S. Government Accountability Office, February 4, 2011, at *http://www.gao.gov/new.items/d11247r.pdf* (August 8, 2011).
12. See 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.*