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Six Key Elements of Medicare Premium Support Proposals

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Abstract: *"Premium support" proposals to reform the Medicare program have a long and bipartisan history. The basic idea, which would provide beneficiaries with a financial contribution to purchase Medicare coverage, has been developed and refined over more than 15 years. While versions differ in detail, they contain several core elements.*

The idea of premium support has a long bipartisan history. Henry Aaron and Robert Reischauer coined the term in 1995,[1] and in the 1990s, there was considerable discussion of the idea. A majority of the 1999 National Bipartisan Commission on the Future of Medicare turned the idea into a formal proposal, and it was introduced as legislation by commission co-chairs Senator John Breaux (D–LA) and Representative William Thomas (R–CA).

More recently, we've seen such premium support proposals as the Domenici–Rivlin plan, developed by former Senator Pete Domenici (R–NM) and Brookings Institution scholar Alice Rivlin. Recently, another version was proposed by Senator Ron Wyden (D–OR) and Representative Paul Ryan (R–WI). In addition, The Heritage Foundation has for many years supported the idea, with a major proposal included in our long-term budget plan, together with a more detailed premium support proposal released in December.[2]

So the bipartisan premium support idea has developed and been refined over many years. And when you look at these various versions, you will see its themes becoming clearer and the range of remaining issues becoming narrower, with a consensus gradually emerging.

That said, I acknowledge that the concerns raised in my co-panelist Henry Aaron's paper—many of which have been raised generally over that whole period—have

1. Henry J. Aaron and Robert D. Reischauer, "The Medicare Debate: What Is the Next Step?" *Health Affairs*, Vol. 14, No. 4 (1995), pp. 8–30.

2. 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://www.savingthedream.org/about-the-plan/plan-details/SavAmerDream.pdf*; Robert E. Moffit, "The Second Stage of Medicare Reform: Moving to a Premium-Support Program," Heritage Foundation *Backgrounder* No. 2626, November 28, 2011, at *http://www.heritage.org/research/reports/2011/11/the-second-stage-of-medicare-reform-moving-to-a-premium-support-program*.

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a degree of validity to them.[3] He raises points that need to be addressed or clarified, and that I believe can be. So it is helpful to engage in what I would call an engineering discussion about precisely how to design and improve premium support. I see this as an iterative process, improving the basic design.

When you look at different premium support proposals, a number of themes and elements are evident.

A LONG-TERM BUDGET FOR MEDICARE

The idea of setting a long-term spending cap in some form for the Medicare program to help address our budget and debt situation has gained support from a wide range of people in recent years.[4]

A real budget for Medicare is also critical if we are to balance Medicare's goals alongside other national goals on a level budgeting playing field so that we can use our resources appropriately. A real, capped long-term budget for Medicare would allow us to avoid programs—the so-called entitlements, like Medicare—automatically taking precedence over so-called discretionary programs, such as those dedicated to educating our children or defending the nation.

Setting and implementing a real budget is one of the key features of premium support.

WHO ULTIMATELY CONTROLS SPENDING ON MEDICARE?

The second theme, which flows from the first, is the method used to distribute a long-term Medicare budget. That is an issue of control: Who ultimately should decide which beneficiary gets what services?

In Canada or in the United Kingdom, where I came from, essentially the government distributes budgeted amounts of money to providers, hospitals, or regional health authorities and allows them to distribute resources. The Patient Protection and Affordable Care Act's Independent Payment Advisory Board (IPAB) will operate in a similar way, though it will give less discretion to health providers, keeping to a capped budget by cutting provider and hospital payments.

Premium support proposals distribute funds in a very different manner. Premium support distributes the capped budget to individuals to pay for a plan or services. There's a strong theme in premium support of putting control and choice into the hands of individual Americans.

HOW FAST SHOULD A MEDICARE BUDGET GROW?

An important theme among advocates of premium support is a debate over how to set the baseline amount of support as a benchmark and how fast the Medicare budget should grow over time. There seems to be a general agreement that some kind of competitive bidding process should be used to set the initial amount of money so that it is related to actual health costs in the region. Should it be the lowest-cost plan or the second-lowest, as in the Domenici–Rivlin proposal, or some market basket of below-average, below-median plans? That's open to debate, but any option would be just a refinement of the basic mechanism.

There is more disagreement among premium support advocates over the method of increasing the budget over time. There are two broad approaches. One is to let it grow in a way that is connected to growth in the economy. The Domenici–Rivlin plan, for instance, indexes the budget at the underlying growth rate in the economy plus one percentage point (and also by the growth in the eligible population). That would link the growth of Medicare spending to our economic capacity to finance the program rather than to the costs of medical care. But that also means that in a slow or recessionary economy, as we have been experiencing, Medicare funding could be well below the rate of health cost increases.

The other broad approach is to index spending by a formula related in some way to health costs rather than economic growth. In the Heritage proposal, for instance,

3. See Henry Aaron, "Why Premium Support Is a Bad Idea," in *Premium Support: A Primer,* The Brookings Institution, 2011, at *http://www.brookings.edu/~/media/Files/rc/papers/2011/1216_premium_support_primer/1216_premium_support_primer.pdf.*
4. Joseph Antos *et al.*, "Taking Back Our Fiscal Future," The Heritage Foundation and The Brookings Institution, April 2008, at *http://s3.amazonaws.com/thf_media/2008/pdf/wp0408.pdf.*

we index growth to CPI plus 1 percent (and also by the growth in the eligible population). While this (like Domenici–Rivlin or Ryan–Wyden) would be slower than the historical trend of health costs, it would tend to be closer to those costs during periods of slow economic growth. The budget typically would be tighter during periods of faster growth, when it might be easier to make adjustments in the structure and costs of medical care.

The original Reischauer–Aaron proposal indexed the growth in Medicare fully to health costs, so the index was more generous (since medical costs have generally risen faster than CPI, or even CPI plus 1 percent), but their 1995 plan did allow for a tighter index if Congress decided the Medicare budget needed to be constrained (as most would argue is needed today).

What do these different methods of indexing try to achieve?

When you look at the objective of indexing the rate of growth, policymakers are really trying to balance three goals or considerations. One is reaching a budget objective, which in these days of high deficits and growing debt is a very important objective. At the same time, another is to achieve a reasonable balance of financial risk between beneficiaries and taxpayers today and between today's beneficiaries and taxpayers and those in the future. A third consideration is to strike a balance between the interests of low-income beneficiaries and those of middle- and high-income beneficiaries.

Policymakers are trying to juggle these usually competing goals while constructing an index. That's why you see income adjustments built in to good premium support systems, to help make sure people at the low-income end are insulated as best we can insulate them from financial risk, while the Warren Buffetts—and many who are not that affluent but quite comfortable—need to shoulder a little bit more financial risk and pay for more of their benefits. That important element is in the Heritage proposal, for instance. Indeed, at Heritage we would phase out premium support funding entirely for very affluent seniors.

WHEN SHOULD PREMIUM SUPPORT TAKE EFFECT?

There is a discussion over when a premium support system should be introduced. Some proposals would exempt today's Medicare recipients and even those over 55 from any change. But at Heritage we don't think we should exempt baby boomers from having to shoulder some of the risk and cost of meeting our budget and Medicare goals. Just because Bill Gates happens to be 57 years old, why should he and other baby boomers be exempt from change?

That's why Heritage supports introducing the core features of premium support for baby boomers. Politically, it would be safer to grandfather them in, but that would grandfather in a large part of the financial problem—and doing that would make it even harder to deal with our fiscal problems.

INFORMATION AND CONSUMER PROTECTION

An important theme in most designs of premium support is that there does have to be an infrastructure of information and appropriate consumer protection. Exactly how best to do that can be debated. We can build on existing structures in the Medicare program. We can create a national exchange system, as Rivlin–Domenici does. Or we can use other approaches. But it is generally agreed by premium support advocates that an infrastructure of some kind needs to be included.

INCORPORATING FEE-FOR-SERVICE

In the view of most advocates of premium support, fee-for-service should not be artificially protected, but neither should it be artificially penalized or closed down. The Heritage proposal addresses this issue by making fee-for-service essentially like an open network insurance system fully financed with a premium that is eligible for premium support. Fee-for service would then compete on a level playing field with private plans.

If, as some proponents of the existing system maintain, fee-for service is the most efficient method of providing health care to seniors, then it will prevail in that competition. If not, then over time, seniors will find plans that are more attractive, and they will receive a larger share of Medicare funds.

CONCLUSION

Premium support has a long and bipartisan history. It has important themes and objectives. But its design is a constant iterative engineering process of refinement to deal with legitimate issues that have been raised.

The most recent iteration, the Wyden–Ryan proposal, is an excellent example of a stage in this process. So are the proposals put forward in the past year by Heritage and by Alice Rivlin and former Senator Domenici. Each of these proposals moves us forward towards achieving an affordable, acceptable system of health care for seniors—and one that is also affordable for our children and grandchildren.

—Stuart M. Butler, Ph.D.*, is Director of the Center for Policy Innovation at The Heritage Foundation. This lecture is adapted from remarks delivered at a panel discussion on "Controlling Medicare Costs: Is Premium Support the Answer?" held at the Brookings Institution in Washington, D.C.*