Backgrounder

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The Top Five Flawed Arguments Against Premium Support

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Abstract: *The introduction of the bipartisan Wyden–Ryan premium support plan for Medicare ensures that reform of the government's largest health entitlement program will continue to be a major topic of debate in 2012. With premium support, the federal government moves away from running a health plan and instead provides fixed levels of support for private insurance plans selected by the beneficiaries themselves. Opponents have made a number of flawed arguments against the concept that do not stand up to careful scrutiny. Political momentum continues to build for premium support because of its potential to control health care costs through the power of consumer choice.*

With a high-profile, bipartisan proposal for "premium support" on the table for discussion, this year will likely be marked by as much intense debate about Medicare as was 2011.

In April 2011, House Budget Committee Chairman Paul Ryan (R–WI) released a budget plan that would have put the nation's fiscal house in order by imposing spending discipline in every corner of the federal budget.[1] Importantly, the Ryan budget plan, which passed the House but not the Senate, included significant entitlement reforms. For Medicare, the plan called for converting the program for future program entrants (those under the age of 55) into a premium support model. In a premium support program, the government would move away from run-

Talking Points

- The introduction of the bipartisan Wyden–Ryan premium support plan for Medicare ensures that this issue will continue to be as hotly debated in 2012 as it was in 2011.
- In most markets, Medicare FFS is the largest purchaser of medical care, and the entire health care delivery system has been built up around the program's distorted incentives.
- The primary arguments of the opponents of premium support are fundamentally flawed and provide no grounds for opposing the initiative.
- Contrary to opponents' claims, Medicare has a poor record of cost control, while the prototype for premium support—the Medicare drug benefit—has a strong record of success.
- Premium support has enjoyed a long history of bipartisan support. Even *The New York Times* editorial page has expressed limited support for a premium support solution to Medicare's problems.

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ning a health plan and instead provide fixed levels of support for private insurance plans selected by the beneficiaries themselves.

Even though premium support has enjoyed a long history of bipartisan support, President Barack Obama immediately attacked the Ryan proposal in a highly publicized speech, setting the stage for an intense, months-long debate over how best to ensure that Medicare will be solvent and stable for future generations.[2] The debate gained new life in December when Senator Ron Wyden (D–OR) joined with Ryan in offering an updated version of premium support for discussion and debate in 2012.[3]

Flawed Arguments

Regrettably, not all of the debate over premium support has been edifying. Indeed, opponents of premium support have used many seriously flawed and biased arguments. The following are the five arguments most commonly cited by premium support opponents and the reasons why these arguments are seriously flawed and provide no real basis for opposing a premium support plan.

Flawed Argument #1: Premium support would simply shift costs to the beneficiaries. Opponents have repeatedly suggested that moving to premium support would achieve budgetary savings only by shifting massive costs onto the beneficiaries.[4] To support their argument, they cite a Congressional Budget Office (CBO) analysis of the Ryan proposal in which the CBO estimated that beneficiaries would pay $6,400 more in premiums under premium support than under the current Medicare program. However, this analysis relies on two highly implausible assumptions. First, it assumes that the deep payment rate reductions imposed under Obamacare are sustainable. That is evident from the CBO's assumption that, because of government-imposed price controls, current Medicare could provide the standard package of health coverage in 2022 for just 72 *percent* of what it would cost a private plan to provide the same coverage.

Yet this massive gap will exist only if the price controls are sustainable, which they clearly are not. The chief actuary for Medicare has repeatedly warned Congress since Obamacare was enacted that the steep payment rate reductions imposed by that law will drive providers out of the Medicare program and thus severely restrict access to care for seniors.[5] That is not a basis for reliably controlling costs.

The second implausible assumption is that competition in Medicare will not affect the efficiency or cost of the options offered to Medicare participants. The whole point of premium support is to build a functioning marketplace in which plans must compete for the business of cost-conscious consumers. Ryan and other proponents of premium support rightly believe that this is the key to genuine "delivery-system reform," which will incentivize service providers to find new, better, more efficient, and less costly ways of providing needed services. The CBO's assessment assumes nothing will change, which is simply not credible.

Flawed Argument #2: Government-run Medicare is more efficient than private plans. Opponents of premium support frequently assert that private plans have long been more costly than tra-

1. See Committee on the Budget, U.S. House of Representatives, "Path to Prosperity: Restoring America's Promise," April 2011, at *http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf* (January 19, 2012).
2. Barack Obama, "Remarks by the President on Fiscal Policy," The White House, April 13, 2011, at *http://www.whitehouse.gov/the-press-office/2011/04/13/remarks-president-fiscal-policy* (January 19, 2012).
3. Ron Wyden and Paul Ryan, "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future," December 2011, at *http://budget.house.gov/UploadedFiles/WydenRyan.pdf* (January 19, 2012).
4. See Ezekiel J. Emanuel, "For Medicare, We Must Cut Costs, Not Shift Them," *The New York Times*, December 19, 2011, at *http://opinionator.blogs.nytimes.com/2011/12/19/for-medicare-we-must-cut-costs-not-shift-them/* (January 19, 2012).
5. See John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures Under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Centers for Medicare and Medicaid Services, Office of the Actuary, August 5, 2010, at *https://www.cms.gov/ReportsTrustFunds/downloads/2010TRAlternativeScenario.pdf* (January 19, 2012).

ditional Medicare.[6] Indeed, this assertion has been repeated so often that it has become part of the conventional wisdom. The only problem is that it is false.

According to data provided by the Medicare Payment Advisory Commission, on an apples-to-apples basis, the private plans serving Medicare patients provide Medicare-covered benefits for exactly the same cost as the traditional program. Moreover, the HMOs participating in Medicare Advantage (MA), which have by far the highest MA enrollment, provide Medicare benefits for 97 percent of the cost of the traditional program.[7]

Furthermore, the MA plans accomplish this despite the huge advantages enjoyed by the traditional fee-for-service (FFS) program. Under the FFS program, the government can essentially dictate the prices it will pay for services through the regulated payment systems that apply to all hospitals, doctors, clinics, labs, and other providers. In contrast, Medicare Advantage plans must negotiate contracts with those same providers to ensure access to care for their enrollees. The result is that the FFS program shifts huge costs onto the private plans to the detriment of a fully functioning health care marketplace.

Flawed Argument #3: Medicare spending has grown more slowly than private health care spending. Opponents also argue that Medicare costs have grown more slowly than private plan costs over the years because of Medicare's strong cost control mechanisms. This is also false. First, the studies that allegedly show that Medicare controls costs better than private plans fail to control for changes in coverage. Since the early 1970s, Medicare's statutorily required benefit package has not kept up with changes in medical practice. In contrast, private plans cover many more services and products today than they did 40 years ago. When the changes in coverage by private plans are taken into account, private plans have performed better on cost than traditional Medicare.[8]

Further, characterizing Medicare practices as "cost control" is misleading. By fiat, Medicare imposes archaic, outdated, and completely arbitrary fee schedules on service providers. These regulated payment systems shift costs onto other insurance plans and have done nothing to improve the efficiency of the health care sector.

Flawed Argument #4: Medicare's drug benefit, the prototype for premium support, is not a success story. For a long time, opponents of markets in health care argued that no evidence shows that competition controls cost growth. This was before Congress enacted the Medicare drug benefit (Medicare Part D), which is designed as a premium support program for prescription drug coverage. At the time of enactment, opponents said it would never work.[9] Some said it would fail because private plans would decline to participate without a guaranteed share of the market. Others said the beneficiaries would not sign up for the voluntary benefit because the competitive structure would be too complex to navigate. Still others said that program costs would explode without government-imposed price controls.

All these predictions were dead wrong. The program has achieved widespread coverage, scores of plans participate and compete against each other, and costs have grown at a very moderate pace.

Opponents have since resorted to trying to discredit the clear evidence that the competitive design

6. See editorial, "What About Premium Support?" *The New York Times*, December 3, 2011, at *http://www.nytimes.com/2011/12/04/opinion/sunday/what-about-premium-support.html* (January 19, 2012).

7. See Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book*, June 2011, p. 150, at *http://www.medpac.gov/documents/Jun11DataBookEntireReport.pdf* (January 19, 2012).

8. See The *2003 Joint Economic Report*, S. Rep. 108–206, 108th Cong., 1st Sess., pp. 103–113, at *http://www.gpo.gov/fdsys/pkg/CRPT-108srpt206/pdf/CRPT-108srpt206.pdf* (January 19, 2012).

9. See Ezra Klein, "Does Medicare Part D Make the Case for Paul Ryan's Plan?" *The Washington Post*, June 8, 2011, at *http://www.washingtonpost.com/blogs/ezra-klein/post/does-medicart-part-d-make-the-case-for-paul-ryans-plan/2011/05/19/AGfPbyLH_blog.html* (January 19, 2012). The Heritage Foundation and other conservative institutions and analysts opposed drug benefit on other grounds, mainly because the benefit was universal and unpaid for.

of the drug benefit has worked incredibly well. Their arguments still do not hold water.

For instance, some have suggested that the moderate rise in drug costs in Medicare is unrelated to the benefit's design, but simply a reflection of moderating spending growth systemwide. While cost growth has moderated across the board for prescription drugs, the slowdown has been more pronounced in Medicare. Today, the actuaries at the Centers for Medicare and Medicaid Services project that Medicare prescription drug spending over the first decade of the program will come in about 40 percent below the projections at the time of enactment.[10] At the time of the drug benefit's enactment, the actuaries issued projections of national health expenditures indicating that total retail spending on prescription drugs for the ensuing decade would reach about $3.5 trillion.[11] In early 2010, the actuaries released new projections for the same 10-year period and put total drug spending at about $2.4 trillion—31 percent below the previous projection.[12] Of course, these projections of total national spending on drugs also include prescription drug spending for the elderly. When the elderly, who account for about one-third of all spending, are removed from the estimate, the drop in projected spending for everyone else was less pronounced, only about 27 percent, well below the 40 percent reduction for the Medicare drug benefit.

Moreover, the real question is what precipitated the fall in projected systemwide spending. Obamacare apologists are constantly arguing that changes in Medicare have the potential to influence the entire health care market. If this is the case, Medicare Part D should also affect the entire market. For instance, Part D plans have aggressively pushed generic substitution as a way to lower premiums with considerable success. This trend among the elderly has also likely influenced how physicians and pharmacists behave with the rest of their patients.

Flawed Argument #5: The government can engineer "delivery system reform" more effectively than a functioning marketplace. Opponents of premium support offer up improvements in a government-led "delivery system" as an alternative vision for cost control and Medicare reform. The idea is that the federal government, using the leverage that comes with Medicare program spending, is nimble enough to implement payment changes and other regulatory reforms that will lead to more productivity and efficiency in the health sector. Among the most prominently mentioned reforms are Accountable Care Organizations and payments for full episodes of care that bundle reimbursements for the various providers of medical services into a single, larger payment.

Dr. Donald Berwick, former administrator of the Centers for Medicare and Medicaid Services, is a leading proponent of this point of view. In a revealing interview after his departure from the CMS, he said:

> I don't think Medicare is broken. I don't think Medicaid is broken. They're very important social programs of good intent that are accomplishing largely what they intend to accomplish. Health care is broken. The delivery system isn't working. That's the problem.
>
> We set up a delivery system which is fragmented, unsafe, not sufficiently patient-centered, full of waste, unreliable, despite…great efforts of the work force. We built it wrong. It isn't built for modern times.

10. Centers for Medicare and Medicaid Services, Office of the Actuary, "Comparison of the Office of the Actuary's Original Title I MMA Estimates to Those Underlying the CY 2011 Trustees Report," 2011.
11. Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditures Projections: 2003–2013," February 2004, at *http://www.cms.gov/NationalHealthExpendData/downloads/nheprojections2003-2013.pdf* (January 19, 2012).
12. Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditures Projections 2009–2019," January 2010, at *http://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf* (January 19, 2012).

Medicare doesn't need fixing. Health care needs fixing.[13]

Regrettably, this perspective completely ignores the history of Medicare and the long and mostly futile history of federal efforts to control Medicare's escalating costs.

Yes, health care delivery in the United States is too fragmented, uncoordinated, wasteful, and unresponsive to patient concerns and wishes. However, the primary cause of all of these problems is Medicare, especially Medicare's dominant fee-for-service insurance model.[14] In Medicare FFS, service providers are paid for every procedure or test that they perform, regardless of whether it helps the patient. The government reimburses all claims submitted by a licensed provider, no questions asked.

In most markets, Medicare FFS is the largest purchaser of medical care. The entire delivery system has been built up around the program's distorted incentives. Every type of provider has its own payment system. This fosters extreme fragmentation as every lab, clinic, physician's office, and hospital can bill Medicare separately. Moreover, 90 percent of Medicare FFS enrollees have supplemental insurance that pays for all of the costs that Medicare does not cover. This means these beneficiaries pay nothing at the point of service and therefore have no incentive to limit the amount of care they receive, regardless of how questionable the potential benefits. Of course, those providing the services can increase their incomes from Medicare only by increasing the volume of services consumed by their Medicare patients. The result is a quite predictable and longstanding trend of rapidly increasing use of services.

The response of the political system to this inefficiency and high cost is counterproductive price controls. To meet budget targets, Congress and Medicare's regulatory apparatus have reduced the amounts that the program pays for medical procedures. This kind of cost cutting makes no distinction based on the quality or efficiency of care provided. Rather, it is across-the-board, hitting good actors and bad alike. Some advocates of price controls say that the government is merely using its market leverage, but the truth is that private-insurance enrollees are paying hundreds of billions of dollars in higher premiums because the federal government forces doctors and hospitals to provide services to Medicare and Medicaid recipients at artificially low rates. This cost-shifting from public insurance to private insurance enrollees is far greater than the frequently lamented cost-shifting from the uninsured to the insured.

Dr. Berwick and his allies now downplay Medicare's role in creating the current mess because future cost cutting will become more rational through such ideas as Accountable Care Organizations (ACOs), which are essentially government-organized HMOs. This is just more wishful thinking. For ACOs or any other model to work, the government must build a high-quality, low-cost network of providers—something the federal government has demonstrated absolutely no capacity for doing in 30 years of trying.[15]

Conclusion

The arguments used by opponents of premium support are weak and flawed. This might explain why *The New York Times* recently endorsed the concept of premium support as worth pursuing in an editorial that otherwise rehashed many of the same flawed arguments put forth by opponents. It is no small matter when *The New York Times* editorial page, which is not known for being friendly to market-based approaches to health reform, nods in the direction of market-based reform for Medicare:

13. Kaiser Health News, "Transcript: Donald Berwick on Medicare, Medicaid, 'Rationing' and Who Decides," December 12, 2011, at *http://www.kaiserhealthnews.org/Stories/2011/December/12/transcript-donald-berwick-interview.aspx* (January 19, 2012).
14. Amy Finkelstein, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," April 2006, at *http://econ-www.mit.edu/files/788* (January 19, 2012).
15. Congressional Budget Office, "Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment," *Issue Brief*, January 2012, at *http://www.cbo.gov/ftpdocs/126xx/doc12663/01-18-12-MedicareDemoBrief.pdf* (January 24, 2012).

> The best proposal for premium support is one that gives beneficiaries choice while protecting them from any added costs if competition does not keep prices down. Enrollees would be given a set amount of money to buy a plan comparable to what Medicare now provides. If they chose a plan that cost less, they could pocket the difference. If they wanted better benefits, they would have to pay the added premium themselves. But if market competition failed to restrain costs, the federal government would increase the support given.[16]

The editorial went on to suggest that the primary advocates of premium support do not support the version that the editorial page could support, thus implying that premium support stands no chance of being adopted any time soon. Yet this is not true. The premium support plan advanced by the Debt Reduction Task Force of the Bipartisan Policy Center,[17] led by former Senator Pete Domenici (R–NM) and former Clinton Administration Budget Director Alice Rivlin, is very similar to the plan *The New York Times* suggests, as is the Wyden–Ryan plan, which was introduced after the editorial was published.

When *The New York Times* and Representative Ryan are calling for essentially the same type of reform, political momentum is clearly building for the change. This is very good news for those who are counting on Medicare to be there for them in the coming years and decades.

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16. See editorial, "What About Premium Support?"
17. See Pete Domenici and Alice Rivlin, "The Domenici–Rivlin Premium Support Plan," in The Brookings Institution, "Premium Support: A Primer," December 2011, pp. 24–30, at *http://www.brookings.edu/~/media/Files/rc/papers/2011/1216_premium_support_primer/1216_premium_support_primer.pdf* (January 19, 2012).