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Premium Support: Medicare's Future and Its Critics

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Abstract

Medicare patients today face reduced access to care, which will inevitably be rationed through the Affordable Care Act's relentless payment cuts. On paper, Medicare will continue to appear as a model of administrative cost control, but real administrative costs—borne by doctors, hospitals, and clinics—will continue to soar, and medical professionals will struggle to comply with the numerous rules and reporting requirements governing care delivery. Medicare premium support, long a bipartisan proposal, is the best alternative to this unhappy scenario. It would guarantee better choices and broader access to quality care, faster innovation in care delivery, and less waste and fraud in medical transactions. It would also deliver superior cost control. For the next generation of taxpayers and retirees alike, there is no better future.

This paper, in its entirety, can be found at **http://report.heritage.org/hl1212**

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Certain Congressmen keep telling seniors that they will keep "Medicare as we know it." They are talking nonsense. In fact, the Affordable Care Act of 2010 (ACA)—with 165 provisions amending or affecting the program—has already ended Medicare "as we know it."[1] Nostalgia for the 1960s notwithstanding, change is inevitable. The need for change is confirmed by expert testimony. Just consider three propositions.

1. **Medicare reform is not an option; it is a necessity.** In his September 8, 2011, address to Congress, almost 18 months *after* enactment of the ACA, President Obama said: "[H]ere's the truth: Millions of Americans rely on Medicare in their retirement. And millions more will do so in the future.... But with an aging population and rising health care costs, we are spending too fast to sustain the program. And if we don't gradually reform the system while protecting current beneficiaries, it won't be there when future retirees need it. We have to reform Medicare to strengthen it."[2] Correct.

Key Points

- Premium support, with a fixed dollar payment and enrollee freedom to purchase above or below that amount in an intensely competitive environment, would create a sustainable Medicare program for seniors and taxpayers.
- Beneficiaries could keep the plans they have today and get better plans if they wish tomorrow with a wide range of benefits and providers.
- Such a reform would slow the growth of Medicare spending, securing savings for beneficiaries and taxpayers rather than merely shifting those costs to seniors in reduced access and to the private insured through higher premiums.
- Premium support would be much less disruptive for doctors and patients than the pending payment cuts to medical professionals under the Affordable Care Act, the President's budget proposal, and the sequestration mandated by the Budget Control Act.

2. **No possible scenario—particularly the enforcement of the Affordable Care Act—protects seniors from Medicare cuts.** Writing in the August 22, 2011, edition of *The New York Times*, former Obama presidential adviser Ezekiel Emmanuel and his colleague Jeff Liebman declare, "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."[3] Exactly.

3. **The phrase "Medicare benefit guarantee" is oxymoronic.** Guaranteed benefits? Congressmen can not only change benefits at any time; they can also set Medicare payments and fix the conditions of provider reimbursement at artificially low levels. The result: They can render access to those benefits a dead letter for millions of Americans.

Senator Ron Wyden (D–OR) put it neatly: "Absent a bipartisan effort to fix Medicare and protect this guarantee—if nothing is done—what the years ahead ensure is that seniors and health care providers will be getting a steady diet of cost-shifting and arbitrary cuts until the Medicare guarantee is kaput."[4] Bet on it.

As early as 2019, courtesy of the ACA, Medicare payment for Part A benefits is already on track to dip into the nether regions of Medicaid reimbursement. The result: a progressively larger number of Medicare providers running into the red and thus unable to deliver benefits and services at the scheduled reimbursement levels. The Medicare actuary says 15 percent by 2019, 25 percent by 2030, and 40 percent by 2050.[5]

Physicians, under current law, also face Medicare payment cuts that are so draconian—31 percent in 2013—that Congress once again will likely stop them from going into effect. Yet the prospects remain profoundly unfavorable for physicians. More seniors plus fewer providers does not—and cannot—equal "guaranteed" benefits.

Those who disagree with Senator Wyden must pine for an alternative universe. In Lewis Carroll's *Through the Looking Glass*, Alice, finding herself in such a state, declares plaintively that she simply cannot believe impossible things. Irritated, the White Queen insists on persistent practice: "Why, sometimes I've believed as many as six impossible things before breakfast." Faith in congressionally "guaranteed benefits," based on politicians' promises just takes practice.

Premium Support: A Better Medicare Future

The Heritage Foundation has developed a detailed prescription for Medicare "premium support" in *Saving the American Dream*,[6] a comprehensive program of fiscal and budgetary reform. There are several other major premium-support proposals.[7]

The core concept is simple: The government makes a defined contribution (premium support) to the

1. The new law ends Medicare as an open-ended entitlement, imposes record-breaking payment reductions on providers, and starts a phaseout of fee-for-service (FFS) payment, the very essence of traditional Medicare financing.
2. President Barack Obama, "Address by the President to a Joint Session of Congress," September 8, 2011, http://www.whitehouse.gov/the-press-office/2011/09/08/address-president-joint-session-congress (accessed July 19, 2012).
3. Ezekiel J. Emmanuel and Jeffrey B. Liebman, "Cut Medicare, Help Patients," *The New York Times*, August 22, 2011, http://www.nytimes.com/2011/08/23/opinion/cut-medicare-help-patients.html (accessed July 19, 2012).
4. Matt Dobias, "Wyden: Time to End the Medicare 'Street Fight'," *Politico Pro*, March 6, 2012.
5. *2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplemental Medical Insurance Trust Funds*, April 23, 2012, p. 217, http://cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and Reports-/ReportsTrustFunds/ Downloads/TR2012.pdf (accessed July 19, 2012); hereafter cited as *2012 Medicare Trustees Report*.
6. 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, http://savingthedream.org/. For the details of the Heritage premium-support proposal, see Robert E. Moffit, "The Second Stage of Medicare Reform: Moving to a Premium Support Program," Heritage Foundation *Backgrounder* No. 2626, November 28, 2011, http://report.heritage.org/bg2626.
7. These include the Burr–Coburn plan, the Domenici–Rivlin plan, the Ryan FY 2013 budget proposal, and the Wyden–Ryan plan. To compare and contrast these proposals with the Heritage plan, see Robert E. Moffit, "Saving the American Dream: Comparing Medicare Reform Plans," Heritage Foundation *Backgrounder* No. 2675, April 4, 2012, http://report.heritage.org/bg2675.

health plan of a beneficiary's choice.[8] The per capita contribution, a fixed dollar amount, is based on a process of competitive bidding among insurers to provide Medicare benefits.[9] The beneficiary may buy richer coverage by paying more or may buy less expensive coverage by paying less and pocket the savings. Insurance plans would compete directly for enrollees' dollars and market share. This approach reflects a broad bipartisan tradition.[10]

Decentralized Decision-Making. While current payment centralizes control over provider reimbursement on a fee-for-service (FFS) basis, premium support would decentralize financial decision-making through the personal preferences of enrollees. Dollars would go directly to the plans that enrollees decide, and plans and providers would compete to deliver what enrollees want, need, and value. Intense plan competition for market share, with plans and doctors and hospitals working cooperatively together to provide the best product for the lowest price, would drive innovation in benefit design, encourage superior productivity in care delivery, and enhance patient satisfaction.

WHILE CURRENT PAYMENT CENTRALIZES CONTROL OVER PROVIDER REIMBURSEMENT ON A FEE-FOR-SERVICE BASIS, PREMIUM SUPPORT WOULD DECENTRALIZE FINANCIAL DECISION-MAKING THROUGH THE PERSONAL PREFERENCES OF ENROLLEES.

Defined-contribution financing, however it is characterized by its critics, is already operable in funding benefits for the vast majority of Medicare enrollees. About 60 percent of Medicare's population is enrolled in private drug plans (PDPs) in Medicare Part D, the drug program, which is a working model of premium support. Also, 27 percent of all seniors are enrolled in private plans offered under Medicare Part C, Medicare Advantage (MA). MA, however, is hobbled by a flawed payment formula that increases Medicare costs.[11]

While some critics see this approach as radical and disruptive,[12] in fact, it would largely import Medicare Part C and D financing—vital parts of Medicare as we *do* know it—into the provision of benefits in Parts A and B. There would, of course, be some crucial modifications, but the result would be much better than the *status quo*: All enrollees would have integrated insurance products, competitively priced, that would provide an array of medical services plus guaranteed catastrophic protection.

The federal government also uses this defined-contribution approach in health coverage of its own employees and retirees through the popular and successful Federal Employees Health Benefits Program (FEHBP).

8. Many critics of this approach to health care financing describe it as a voucher program. Today, "voucher" has a negative connotation, conjuring up images of hapless seniors at the mercy of unregulated health insurance companies. It is perhaps noteworthy that defined contribution pension arrangements, where companies contribute directly to stock, bond, or equity funds chosen by employees, are usually not described as voucher programs. In fact, a voucher is a certificate given directly to a consumer that is redeemable for cash value for the purchase of a good or service of that person's choice, often without restriction. While such a voucher is a form of defined contribution, no major Medicare reform proposal today is designed to operate in such a fashion.
9. Conservatives and centrists are not alone in thinking that competitive pricing is a superior system of Medicare payment. Analysts with the Century Foundation, a "progressive" public policy organization based in New York, observe, "Replacing the current system of payments to plans, which is linked to fee-for-service rates, with one based on competitive pricing, under which a plan's premiums would reflect its bid to cover a basic Medicare benefit package, might result in fairer payments." Lisa Potetz and Thomas Rice, eds., *Medicare Tomorrow: The Report of The Century Foundation Task Force on Medicare Reform* (New York: The Century Foundation Press, 2001), p. 11.
10. While the Wyden–Ryan proposal has attracted the most media attention, Senators Tom Coburn (R–OK) and Richard Burr (R–NC) are also champions of a well-fleshed-out premium support plan. On Capitol Hill, the basic idea of a defined contribution for Medicare financing goes back to the 1980s, when Representatives Richard Gephardt (D–MO) and David Stockman (R–MI) offered a Medicare voucher program. Their proposal was supported by the Reagan Administration. During the 1990s, Senator John Breaux (D–LA) and Representative Bill Thomas (R–CA), co-chairmen of the National Bipartisan Commission on the Future of Medicare, unveiled a comprehensive Medicare premium support proposal modeled after the FEHBP, but it was opposed by the Clinton Administration. Today, top analysts from a variety of institutions—the Brookings Institution, American Enterprise Institute, National Center for Policy Analysis, and Progressive Policy Institute—have endorsed this approach.
11. The payment formula for Medicare Advantage increases Medicare spending. It sets a benchmark based on traditional Medicare payment and mandates that 75 percent of the difference between the benchmark and plan bids must be realized in lower premiums or richer benefits for enrollees, not cash rebates.
12. According to Henry Aaron, a senior fellow at the Brooking Institution, for example, "To move ahead now to commit or enroll the Medicare population in entities that do not yet exist and whose capabilities have not yet been tested and proved would be a rash legislative act carrying the threat of hardship and disruption." Henry J. Aaron, Bruce and Virginia MacLaury Senior Fellow, The Brookings Institution, "The Current State of Medicare," statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, April 27, 2012, p. 9, http://www.brookings.edu/research/testimony/2012/04/27-medicare-aaron (accessed July 19, 2012).

Between 1960 and 1983, before federal annuitants were eligible for Medicare, it was the main form of health care financing for all government retirees.

All Medicare reform proposals differ in details. While details are vitally important, they are less important than the economic incentives at the core of the reform: a fixed dollar payment with enrollee freedom to purchase above or below that amount in an intensely competitive environment. This would create a program that is sustainable for seniors and taxpayers.

Points of Progress. Such a reform would secure progress in many areas, but three are worth noting.

First, beneficiaries could keep the plans they have today and get a better plan if they wish tomorrow, securing them a wide range of benefits and providers. Historically, Americans have been highly satisfied with their health insurance options, including seniors enrolled in traditional Medicare, Medicare private plans, or employer-sponsored plans that provide Medicare-subsidized drug coverage.[13] Under the Heritage proposal, for example, persons satisfied with employer coverage could have the option of taking it with them into retirement.[14]

No one on traditional Medicare today will be worse off. The reason: All major premium-support proposals continue traditional Medicare as an option and also require private plans to offer a benefits package that is the same as or at least actuarially equivalent to that provided by traditional Medicare. It's hard to imagine how any enrollee would not be better off. Most reform proposals, such as that offered by Heritage, require offering benefits *richer* than traditional Medicare, including drugs and catastrophic coverage. Experience with Medicare Parts C and D, as well as the FEHBP, shows that continual benefit improvements are a regular feature of these programs.

Second, it would slow the growth of Medicare spending, securing savings for both beneficiaries and taxpayers rather than merely shifting those costs to seniors in reduced access and to the private insured through higher premiums.[15] Former Senator John Breaux (D–LA) recalls that the 1999 proposal endorsed by the majority of the National Bipartisan Commission on the Future of Medicare, which he co-chaired with former Representative Bill Thomas (R–CA), would have reduced Medicare spending growth by 12 percent.[16]

Third, it would reduce the politicization and the costly micromanagement that today burden the program. The politicization of health care decisions, fueled by powerful special interests, undercuts efficiency, stops innovation, and kills even worthwhile demonstration projects.

PREMIUM SUPPORT WOULD BE LESS ONEROUS THAN AN EVEN DEEPER SET OF MEDICARE PAYMENT REDUCTIONS PRESCRIBED BY PRESIDENT OBAMA, REINFORCED BY HIS EVEN STERNER BUDGETARY TARGETS.

Premium support offers a way out. Because health care decision-making is radically decentralized among millions of enrollees and thousands of plans and providers, the impact of special-interest lobbying is thus limited. Traditional FEHBP governance in particular is an excellent model and demonstrates how federal officials can avoid costly micromanagement and sideline special interests that can block or hinder improvements in benefit design and patient care.

Premium support, its critics notwithstanding, would indeed be much less disruptive and wrenching than the pending impositions on patients and medical professionals under the Affordable Care Act plus the

13. While government subsidies for drug coverage in employer-based plans are a feature of the Medicare Modernization Act of 2003, signed into law by President George W. Bush, House and Senate Democrats, in their Medicare Prescription Drug Act of 2000, also proposed federal subsidies to employer plans.
14. This was also a feature of the Breaux–Thomas proposal. "Part of the attractiveness of premium support is its ability to better integrate with employer-provided retiree coverage; similar to the way employer-provided pensions and Social Security benefits are currently integrated. By easing the integration of the two systems employers will be under less pressure to further reduce or drop retiree coverage." National Bipartisan Commission on the Future of Medicare, "Impact of the Commission Premium Support Proposal on Different Types of Beneficiaries," 1999, p. 5, http://medicare.commission.gov/medicare/impact.htm (accessed July 19, 2012).
15. An often overlooked cost of the Medicare *status quo* is the price all Americans pay in higher premiums for their private insurance because of price controls and the resultant cost shifting from Medicare.
16. The Honorable John Breaux, statement on Medicare premium support before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, April 27, 2012, p. 4.

additional Medicare payment cuts (the sequestration) mandated by the Budget Control Act.[17] It would also be less onerous than an even deeper set of Medicare payment reductions prescribed by President Obama, reinforced by his even sterner budgetary targets. Obama's harsh prescription invites demoralization among medical professionals and guarantees access problems for Medicare patients.

Because there is no other serious alternative to this unhappy scenario, former Medicare Administrator Thomas Scully says that premium support is inevitable.[18] Though strongly critical of Representative Paul Ryan's (R–WI) budget proposal, which he deems "deeply flawed," Matt Miller, senior fellow at the Center for American Progress, nonetheless writes, "Even so, Democrats should want the flexibility after 2012 to include ideas like premium support in their own agenda. It was invented by Democratic economists, after all."[19]

Missing the Mark: Where the Critics Go Wrong

Various Members of Congress, as well as certain prominent policy analysts, strongly oppose Medicare premium support. Some analysts who once favored it have even switched sides.[20] Among the critics, certain themes have emerged.

1. Premium support would destroy traditional Medicare. In response to the Wyden–Ryan proposal, for example, the White House declared, "The Wyden–Ryan scheme could, over time, cause the traditional Medicare program to 'wither on the vine' because it would raise premiums, forcing many seniors to leave traditional Medicare and join private plans. And it would shift costs from the government to seniors."[21]

As noted, changes enforced by the Affordable Care Act would indeed "end" traditional Medicare FFS as enrollees have known it. Under *all* major premium-support reform proposals, however, Medicare FFS would be offered as a readily available alternative to private health plans.[22] Any beneficiary who wanted to remain in traditional Medicare FFS would be able to do so.

In some markets, reflecting regional health care costs, FFS may be the low bidder with premiums economically attractive to beneficiaries, and in others, it may not be. Just as every beneficiary would have the right to stay in the plan in which he or she is enrolled, every beneficiary would also have the right to get a better plan. Consumer choice would tell the tale.[23] As Joseph Antos of the American Enterprise Institute notes, "Indeed, the point of the proposal is to give seniors a good deal through competition, not to drive out traditional Medicare and not to dictate what plan seniors must choose."[24]

If champions of traditional Medicare believe that the fee-for-service option can survive the competition, then they should have no problem putting their faith to the market test. A "doomsday scenario" for FFS must otherwise tacitly assume its inability to compete on a level playing field with private plans. Curiously,

17. For an excellent discussion of this simple truth, see J. D. Foster, "Premium Support Is Incremental, Not Radical Medicare Reform," Heritage Foundation *Backgrounder* No. 2649, February 7, 2012, http://report.heritage.org/bg2649.
18. Marilyn Werber Serafini, "Ex-Medicare Administrator: Premium Support 'Is Going to Have to Happen'," *Kaiser Health News*, May 31, 2012, http://www.kaiserhealthnews.org/Stories/2012/June/01/scully-medicare-premium-support.aspx (accessed July 19, 2012).
19. Matt Miller, "Wait! Paul Ryan Has a Point," *Washington Post Opinions*, May 25, 2011, http://www.washingtonpost.com/opinions/wait-paul-ryan-has-a-point/2011/05/25/AGeH5GBH_story.html (accessed July 19, 2012).
20. For example, Henry Aaron of the Brookings Institution and Robert Reischauer of the Urban Institute originally coined the term "premium support" in 1995, but they no longer support it. Aaron says that an acceptable Medicare premium support program must have three characteristics: a government contribution linked to health care costs, a restricted market with a limited number of "prototype" health plans, and an effective risk-adjustment system to combat adverse selection. Aaron says that none of the major proposals meets all of these conditions. See Aaron, "The Current State of Medicare," pp. 6–7.
21. Jed Lewison, "White House Rejects Ryan-Wyden: 'This Plan Would End Medicare as We Know It,'" *The Daily Kos*, December 15, 2011, http://www.dailykos.com/story/2011/12/15/1045680/-whitehouse-rejects-wyden-ryan-this-plan-would-end-Medicare-as-we-know-it (accessed July 19, 2012).
22. Even a top adviser to President Obama commented favorably on this approach in a recent Senate Budget Committee hearing: "David Cutler, a professor of economics at Harvard University, praised the idea of a marketplace that maintains the traditional fee-for-service Medicare program and gives seniors a guaranteed benefit that they can rely on." Emily Ethridge, "Conrad 'Really Encouraged' About Options for Reducing Medicare Spending," *CQ Today*, March 1, 2012.
23. In examining this question in 1999, the National Bipartisan Commission on the Future of Medicare reported that, based on CBO projections, beneficiary enrollment in private plans would account for half of all Medicare enrollment. National Bipartisan Commission on the Future of Medicare, "Impact of the Commission Premium Support Proposal on Different Types of Beneficiaries," p. 2.
24. Joseph R. Antos, "Fact Checking the Fact Checker on Paul Ryan's Medicare Reform Plan," American Enterprise Institute, April 6, 2012, http://blog.american.com/2012/04/fact-checking-the-fact-checker-on-paul-ryans-medicare-reform-plan (accessed July 19, 2012).

this is a reversal of so-called progressives' vehement insistence that a "robust public option" was essential to health reform in 2010, keeping private health plans "honest" while emerging triumphant.[25]

2. Premium support would "privatize" Medicare. In response to the Ryan 2013 budget proposal, Senator Richard Durbin (D–IL) charged that "Paul Ryan wants to privatize Medicare."[26] In fact, the critics' privatization charge is meaningless. Medicare's entire delivery system—doctors, hospitals, home health agencies, hospice care, and skilled nursing facilities—is almost entirely composed of private agents or institutions. The small number of exceptions would be public hospitals that are reimbursed for treating Medicare patients. Nine out of 10 Medicare beneficiaries are enrolled in supplemental insurance, mostly private and employer-sponsored plans. So Medicare is already heavily "privatized."

Since the 1980s, private health plans have served as an alternative to traditional Medicare. Medicare Advantage plans now enroll more than one out of four beneficiaries, and Medicare drug plans enroll roughly six out of 10 beneficiaries. Even the Medicare bureaucracy, as powerful as it is, does not directly administer Medicare: It is administered through private contractors, usually large private insurance carriers like the Blues, who process Medicare claims. In all cases, the financing of care provided by these agencies and institutions is public financing. In all cases, the rules governing these agencies and institutions are public rules.

3. Premium support would leave Medicare patients at the mercy of rapacious insurance companies. In an interview on CBS's *Face the Nation*, Representative Debbie Wasserman Schultz (D–FL) insisted that Ryan's FY 2012 Medicare proposal would "allow insurance companies to deny you coverage and drop you for pre-existing conditions."[27] While *Politifact* flatly declared Wasserman Schultz's statement false, she has left a vivid impression of hapless seniors cast adrift on wild, open "free market" seas, fending off insurance industry sharks. It's a recurrent theme among opponents of reform.

In fact, every major premium-support proposal would retain or reinforce insurance rules that prevent "cherry picking" or coverage denials based on health status.[28] Every such proposal would also authorize a federal agency to ensure a level playing field for market competition among diverse health plans and enforce uniform rules for health insurance and consumer protection, such as marketing rules and fiscal solvency requirements.[29]

4. Premium support would increase beneficiary premiums. In response to the Ryan budget and the Wyden–Ryan proposals, critics often assert that premium support would raise beneficiary premiums to unacceptably high levels. But Medicare premiums are already scheduled to increase substantially under current law.[30] A transition from a defined benefit to a defined contribution would not necessarily increase premiums over current projections. Indeed, with premium support, premiums could increase at a slower rate than current-law projections or even decline.

Under premium support, the government's contribution would be based on an annual process of regional or national competitive bidding among health plans; a market-based contribution, whether set at an average or a low-cost bid, would thus be tied to real *health* spending trends.

This market-based bidding process, designed to yield a real market payment, could reduce initial costs for enrollees and taxpayers alike. Whatever the market-based contribution, enrollees would be free to

25. The issue of the level playing field was the central point of contention during the 2009–2010 health care debate. Proponents of the "public plan" usually designed it with special funding, regulatory, or risk advantages while fixing payments to doctors and hospitals below private market rates. The objective: the "crowding out" of private coverage and the triumph of a government monopoly.

26. "Durbin Slams Paul Ryan Budget Plan," *CBS News*, March 21, 2012, http://www.cbsnews.com/8301-505267_162-57401429/durbin-slams-paul-ryan-budget-plan/ (accessed May 31, 2012).

27. "Debbie Wasserman Shultz Says Ryan Medicare Plan Would Allow Insurers to Use Pre-existing Conditions as Barrier to Coverage," *Tampa Bay Times* Politifact.com, June 1, 2011, http://www.politifact.com/truth-o-meter/statements/2011/jun/01/debbie-wasserman-schultz/debbie-wasserman-schultz-says-ryan-medicare-plan-w/ (accessed July 19, 2012).

28. Moffit, "Saving the American Dream," pp. 2–3.

29. Ibid.

30. Under current *law*, the standard Medicare Part B premiums are projected to increase from $99.90 in 2012 to $161.20 in 2021. *2012 Medicare Trustees Report*, p. 229, Table V.E2. For seniors, the continuation of current *policies* will guarantee even higher premiums. If Congress overrides the scheduled physician payment reductions in 2013, which it almost certainly will do, Part B premiums will be significantly higher than projected by the Medicare Trustees.

buy plans above or below the government's specified amount, paying more if they wish or paying less and securing the savings.

INTENSE COMPETITION AMONG PLANS WOULD ALSO GREATLY CONTRIBUTE TO A DOWNWARD PRESSURE ON PREMIUMS.

Unlike Medicare premium support, not all competitive bidding programs encompass consumer choice, such as market bidding for goods and services in government contracts or procurement programs. Even so, the process of competitive bidding itself yields a market payment and savings. In the initial round of Medicare's competitive bidding for durable medical equipment, for example, Topher Spiro of the Center for American Progress reports, "Not surprisingly, the benefits to seniors and taxpayers were substantial; the average price savings was 35 percent. The program is now projected to save $17 billion for taxpayers and $11 billion for beneficiaries through lower coinsurance and monthly premiums over ten years."[31]

Intense competition among plans would also greatly contribute to a downward pressure on premiums. In Medicare Part C, average monthly premiums for Medicare Advantage plans declined from $39 in 2011 to $35 in 2012, with the lowest premiums in HMOs and regional PPO plans.[32]

In Medicare Part D, plan premiums have been impressively stable. The monthly average premium was approximately $31 in 2011 and fell to $30 in 2012. From the inception of the program, beneficiaries have enjoyed a positive experience with drug plan premiums. In 2006, the average premium was $23; in 2007, it fell to $22; in 2008, it increased to $24; in 2009, it rose to $28; and in 2010, it increased to $30.[33] As the Medicare Trustees report, the patent expiration of popular brand-name drugs and generic substitution contributed to this downward pressure on premiums, but as Antos has also noted, seniors' price sensitivity plus the health plan marketing of generics also encouraged seniors' choice of lower-cost drugs.[34]

The most extensive empirical analysis of premium support was conducted in 1999 by the National Bipartisan Commission on the Future of Medicare, the special panel created by the Balanced Budget Act of 1997. The commission concluded that Medicare beneficiaries' premiums would decline by 20 percent after 10 years as Medicare patients were able to share in the projected savings of the commission's premium-support proposal.[35]

5. Traditional Medicare does a better job of controlling costs than Medicare Advantage. Paul Krugman, a professor of economics at Princeton University, writes, "Privatizing and voucherizing Medicare does nothing whatsoever to control costs. We've seen that from the sorry history of Medicare Advantage."[36]

In fact, Medicare Advantage has no such "sorry" history. MA has a broader range of benefits than FFS, including care coordination, disease management, and specialized care for patients with chronic illnesses and disabilities, as well as preventive care. Preliminary evidence shows that MA enrollees also receive higher-quality care than those enrolled in traditional Medicare.[37]

The MA payment system is indeed flawed because it is tied to traditional Medicare's administrative payment system, but the additional costs of the program largely reflect the richer benefits. Overwhelmingly,

31. Topher Spiro, "The Independent Payment Advisory Board: Protecting Medicare Beneficiaries and Taxpayers from Special Interests," Center for American Progress *Issue Brief*, March 5, 2012, http://www.americanprogress.org/issues/2012/03/aca_ipab.html (accessed July 19, 2012). So that there is no misunderstanding, neither Mr. Spiro nor the Center for American Progress has endorsed competitive bidding for Medicare premium support or any other variant of a defined contribution for Medicare.
32. Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, "Medicare Advantage 2012 Data Spotlight: Enrollment Market Update," Henry J. Kaiser Family Foundation *Data Spotlight*, June 2012, p. 1, http://www.kff.org/medicare/upload/8323.pdf (accessed July 19, 2012).
33. *2012 Medicare Trustees Report*, p. 231.
34. Joseph R. Antos, "What Does Medicare Part D Say About the Ryan Plan?" American Enterprise Institute, June 15, 2011, http://www.aei.org/article/health/entitlements/medicare/what-does-medicare-part-d-say-about-the-ryan-plan/ (accessed July 19, 2012).
35. National Bipartisan Commission on the Future of Medicare, "Impact of the Commission Premium Support Proposal on Different Types of Beneficiaries," p. 1.
36. Paul Krugman, "Privatizing Medicare," *The New York Times*, April 4, 2011, http://krugman.blogs.nytimes.com/2011/04/04/privatizing-medicare?/pagemode=print (July 19, 2012).
37. See Jeet S. Guram and Robert E. Moffit, "The Medicare Advantage Success Story—Looking Beyond the Cost Difference," *The New England Journal of Medicine*, Vol. 366 (March 29, 2012), pp. 1177–1179, http://www.nejm.org/doi/full/10.1056/NEJMp1114019?/viewType=Print&viewClass=Print (accessed July 19, 2012).

MA plan bids to provide the standard Medicare benefits come in at or below the government's benchmark for plan payment,[38] and slightly more than half of enrollees pay no premium.

Current law requires that 75 percent of the difference between the lower MA bids and the government benchmark be rebated to enrollees in the form of richer benefits or lower premiums. This increases Medicare spending. Not one of the major premium-support proposals, however, replicates the Medicare Advantage payment formula.

6. Premium support would end Medicare's guaranteed benefits. Writing in *The New Republic*, Jonathan Cohn emphasizes the risk: "Remember, Medicare is a guarantee—a compact, really. In exchange for paying into the system during their working years, all Americans receive a promise of comprehensive health benefits once they turn 65."[39]

One imagines a "guarantee" as something rock solid, but a politician's "promise"—which is essentially what an entitlement "guarantee" is—can range from the merely aspirational to the downright deceptive. Cohn elides the distinction. If a political guarantee is to be the standard, for the sake of argument, then *all* major versions of premium support guarantee beneficiaries at least the Medicare benefits or the level of benefits they get today with access to new plans with even higher levels of coverage at competitive prices tomorrow. In the Heritage proposal, for example, market bidding would be based on the provision of Medicare benefits in Parts A, B, and D, or their actuarial equivalent, plus catastrophic coverage.[40]

IN THE FACE OF AN ONCOMING FISCAL CATASTROPHE, THE OLD '60S MODEL OF UNIVERSAL ENTITLEMENTS IS AN EXTRAVAGANT ANTIQUE.

As for the wealthiest Americans, the Heritage proposal would build upon today's legal requirement that upper-income beneficiaries pay more for their benefits. Such retirees today must pay between 35 percent and 80 percent of their Part B and D premiums. Under the Heritage proposal, these upper-income Americans would continue to have guaranteed access to Medicare's benefits under Medicare's insurance rules, but the highest-income beneficiaries—about 3.5 percent of all Medicare enrollees—would not get taxpayer subsidies for their coverage.

By insisting on current policies, the Congressional Budget Office (CBO) projects that the level of federal debt could reach 200 percent of America's gross domestic product (GDP) as early as 2037.[41] Because America is seriously threatened with dangerous debt, all federal spending must be reduced, and continued taxpayer subsidies for the wealthiest recipients are no longer sound policy. In the face of an oncoming fiscal catastrophe, the old '60s model of universal entitlements is an extravagant antique.

Often, critics of "privatization" conveniently overlook another salient fact: Traditional Medicare does not provide anything close to "comprehensive" benefits. There are big gaps in coverage. In fact, traditional Medicare has been eroding as the primary payer of seniors' medical bills as private payment, mostly through supplemental insurance, progressively picks up the growing tab. To illustrate, traditional Medicare's share of total spending for seniors declined from 72.2 percent in 1997 to just 50.8 percent in 2005.[42]

38. For 2012, the bids from all MA plans averaged 98 percent of Medicare FFS for the standard Medicare benefits, while HMO plans bid an average of 95 percent of Medicare FFS spending. Medicare Payment Advisory Commission, *A Data Book: Health Spending and the Medicare Program*, June 2012, p. 146, http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf (accessed July 16, 2012).
39. Jonathan Cohn, "Ron Wyden, Paul Ryan, and the Future of Medicare," *The New Republic*, December 15, 2011, p. 2, http://www.tnr.com/blog/jonathan-cohn/98588/wyden-ryan-medicare-voucher-premium-support-reform (accessed July 20, 2012).
40. The actuarial equivalence standard would encourage plans to develop new and different combinations of benefits, stimulating innovation in delivery options. Among the many drawbacks of '60s-style Medicare has been its historic sluggishness. From 1965 to 2003, there was relatively little change in the Medicare defined benefit structure. This inertia was compounded by the fact that almost every serious benefit decision, like the addition of Medicare drug coverage, was accompanied by a major political fight.
41. Congressional Budget Office, *The 2012 Long-Term Budget Outlook*, June 2012, p. 11, http://cbo.gov/sites/default/files/cbofiles/attachments/LTBO_One-Col_2.pdf (accessed July 20, 2012). This level of debt would be based on CBO's "extended alternative fiscal scenario," which refers to an extension of current *policies* as opposed to current *laws*. Because higher debt and government borrowing "crowds out" private capital investment, the continuation of current policies would have catastrophic economic consequences for the American people.
42. Robert A. Book, "Illusions of Cost Control in Public Health Care Plans," Heritage Foundation *Backgrounder* No. 2301, July 24, 2009, p. 7, www.heritage.org/Research/Healthcare/bg2301.cfm.

7. Lower-income seniors would be vulnerable to higher out-of-pocket costs. In reference to Ryan's FY 2013 budget proposal, for example, Paul Van de Water, a Senior Fellow with the Center on Budget and Policy Priorities, says, "The Ryan budget thus would significantly raise the out-of-pocket health costs that Medicare beneficiaries with modest incomes face, even as it proposes tax cuts for the wealthiest Americans."[43]

In fact, *all* of the major premium-support proposals, including the Heritage plan, would establish limits on out-of-pocket expenses and retain or enhance current income-based protections for low-income beneficiaries.[44] The Ryan budget proposal is explicit in its protection of low-income persons from higher out-of-pocket costs:

> If costs rose faster than this established limit, those low income individuals who qualify for both Medicare and Medicaid (also known as "dual-eligible") would continue to have Medicaid pay for their out of pocket expenses. Other lower income seniors (those who don't qualify for Medicaid but are still under a certain income threshold) would receive fully funded accounts to help offset any increased out-of-pocket costs.[45]

8. Seniors would be confused and unable to choose health insurance policies. Complaining of Ryan's Medicare proposal, economist Paul Krugman, for example, insists that "patients are not consumers."[46] Paul Abrams warns:

> Imagine ... the attraction to scam artists of people in their declining years having to select among a variety of plans—assuming, of course, that any such plans were available in the first place, and assuming that millions of senior citizens will [pore] over competing plans and be able to choose the one best suited to themselves.[47]

Henry Aaron of the Brookings Institution doubts most Americans are very good at making health insurance choices for themselves:

> "Considerable research suggests that most people, to say nothing of a population that includes the frail elderly and the disabled, are not very good at evaluating insurance plans and choosing the one that is in their best interest."[48]

MILLIONS OF SENIORS MAKE ALL KINDS OF HEALTH CARE CHOICES, RANGING FROM THE KINDS OF PHYSICIANS AND SPECIALISTS THEY ENGAGE TO TREAT THEM TO THE KIND AND LEVEL OF INSURANCE COVERAGE THEY ENJOY.

In fact, today millions of seniors make all kinds of health care choices, ranging from the kinds of physicians and specialists they engage to treat them to the kind and level of insurance coverage they enjoy. Roughly 90 percent of seniors in traditional Medicare enroll in supplemental health insurance to close gaps in coverage, including private plans sponsored by AARP.

Retirees enroll in Medicare in their mid–60s, and fewer than one

43. Paul N. Van de Water, "What You Need to Know About Premium Support," Center on Budget and Policy Priorities, March 19, 2012, pp. 1–2, http://www.cbpp.org/cms/index.cfm?fa=view&id=3704 (accessed July 20, 2012).
44. Current Medicaid funding for those who are eligible continues under all major proposals, or additional assistance is made available for low-income persons who are not eligible for Medicaid. See Moffit, "Saving the American Dream," pp. 2–3.
45. "The Path to Prosperity: A Blueprint for American Renewal," The Fiscal Year 2013 Budget Resolution, House Budget Committee, March 20, 2012, p. 53, http://paulryan.house.gov/UploadedFiles/Pathtoprosperity2013.pdf (accessed July 20, 2012).
46. Choosing a medical service and a health insurance policy involves very different sets of choices. In his condemnation of "consumer-based" health care as a failure, Krugman says, "Medical care, after all, is an area in which crucial decisions—life and death decisions—must be made. Yet making such decisions requires a vast amount of specialized knowledge. Furthermore, those decisions often must be made under conditions in which the patient is incapacitated, under severe stress, or needs action immediately, with no time for discussion, let alone comparison shopping." Paul Krugman, "Patients Are Not Consumers," *Economist's View*, April 22, 2011, http://economistsview.typepad.com/economistsview/2011/04/paul-krugman-patients-are-not-consumers.html (accessed July 20, 2012).
47. Paul Abrams, "Saving Medicare from 'Private-izing' Ryan," *Huffington Post*, Blog, April 16, 2011, http://www.huffingtonpost.com/paul-abrams/saving-medicare-from-priv_b_850004.html (accessed July 20, 2012).
48. Henry Aaron, "Vouchers or Premium Support: What's in a Name?" *Health Affairs*, Blog, April 6, 2011, http://healthaffairs.org/blog/2011/04/06/vouchers-or-premium-support-whats-in-a-name/ (accessed July 20, 2012).

out of 10 of all Medicare beneficiaries report poor health.[49] Millions of baby boomers starting to enroll in the program are often tech-savvy, many of them retiring from jobs in an information-driven work environment. Compared to previous generations of retirees, they have enjoyed a broader range of health options and a wider range of experience with managed care arrangements in their employment-based insurance.

During 2011, in Medicare Part D, seniors chose among more than 1,100 prescription drug plans nationwide in 34 market regions. Likewise, roughly one out of four Medicare beneficiaries were able to choose from among almost two dozen Medicare Advantage plans on average in 26 market regions throughout the country. Their choices included HMOs, PPOs, and private fee-for-service plans (PFFSs). Seniors can also enroll in special-needs plans (SNPs), targeted to "dual eligible" seniors and those institutionalized or suffering from chronic medical conditions: in other words, the very old, the frail, and disabled.

Individuals like their choices. Survey research sponsored by the Commonwealth Fund and the Kaiser Family Foundation established the strong relationship between plan choice and enrollee satisfaction.[50] In Medicare Parts C and D, research replicates these findings. In the case of Medicare's drug program, according to one recent survey, more than nine out of 10 enrollees said they were satisfied, and the highest rate of satisfaction (95 percent) was among those with disabilities.[51]

In a government program without choice, there is only official direction. While there may indeed be "considerable research" that indicates that individuals are not good at determining what plan is best for them, there is no evidence that government officials can make wiser choices to meet individual wants and needs.

9. Premium support will not work because risk-adjustment mechanisms are imperfect. After years of experiment, Aaron, for example, says it is unclear "whether adequate risk adjustment is feasible."[52] Van de Water agrees, notes that the process is "imperfect" and argues that it "still leaves insurers with a financial incentive to attract healthier people and discourage sicker ones from signing up; and the resulting overpayments to some plans inflate Medicare's overall costs."[53]

In fact, risk adjustment is clearly improving.[54] As former CBO Director Alice Rivlin reports:

> [R]isk adjustment techniques improved substantially as relevant data and experience accumulated in MA and other programs, and can be expected to improve more. Moreover, some health plans are developing effective techniques for managing chronic diseases, such as diabetes, and are now actively trying to attract patients with these risks.[55]

Domenici–Rivlin and Wyden–Ryan, for example, have proposed a "back end" risk adjustment that would negate plans' efforts at "creaming" of healthy enrollees and

49. Based on 2008 data, 8.4 percent report poor health, while 41 percent report excellent or very good health and 51 percent report good or fair health. The largest cohort of Medicare beneficiaries, of course, are those aged 65 to 74, or 43.4 percent of the total. See Medicare Payment Advisory Commission, *Data Book: Health Care Spending and the Medicare Program*, pp. 22–23.
50. Karen Davis and Cathy Schoen, "Managed Care, Choice, and Patient Satisfaction," The Commonwealth Fund, August 1997, p. 5, http://www.commonwealthfund.org/Publications/Fund-Reports/1997/Aug/Managed-Care--Choice--and-Patient-Satisfaction.aspx (accessed July 20, 2012).
51. See KRC Research, "Seniors Opinions About Medicare RX: Sixth Year Update," PowerPoint presentation, October 2011, http://hlc.org/blog/wp-content/uploads/2011/10/Oct-2011-KRC-Medicare-Today-Survey-of-Seniors-with-Medicare-Rx-10-14-11-FINAL1.pdf (accessed July 20, 2012).
52. Henry J. Aaron, "Medicare Reform: Rhetoric Versus Substance," The Brookings Institution, October 11, 2011, p. 11, http://www.brookings.edu/~/media/research/files/papers/2011/10/11%20premium%20support%20aaron/1011_premium_support_aaron (accessed July 26, 2012).
53. Paul N. Van de Water, "Converting Medicare to Premium Support Would Likely Lead to Two Tier Health Care System," Center on Budget and Policy Priorities, September 26, 2011, http://www.cbpp.org/files/9-26-11health.pdf (accessed July 20, 2012).
54. The CMS model for risk adjustment uses demographic data and medical conditions to adjust per capita plan payment. Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission, says the current model is "a much better predictor" of a patient's costs than previous models. For further improvements in the CMS model, MedPAC recommends an increase in the number of medical conditions and two years worth of diagnostic data to improve payment accuracy. Glenn Hackbarth, "Report to the Congress: Medicare and the Health Care Delivery System," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, June 19, 2012, pp. 15–16.
55. Alice M. Rivlin, "A Bipartisan Approach to Reforming Medicare," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, April 27, 2012, p. 5.

would redistribute common risk pool funding to "make whole" plans that enrolled disproportionately high risks.[56] Heritage has endorsed *both* prospective and retrospective risk-adjustment measures to guarantee market stability.

An Uncommon Consensus: A Medicare Spending Cap

Intense competition will control costs. Experience with premium-support programs, such as the FEHBP and Medicare Part D, does show significant savings.[57] It is impossible to predict with certainty the dynamics of a new competitive market. As former CBO Director Rivlin observes:

> If you asked the Congressional Budget Office to "score" the effect of market competition on the prices the government must pay over the next ten years to buy computers or automobiles, CBO would tell you that they could not do so. CBO's response to scoring the effects of competition on health care would be precisely the same, for precisely the same reason.[58]

So Rivlin (like Ryan and Wyden and Heritage) proposes that Congress adopt some form of a Medicare spending cap to guarantee savings if competition falls short, with the added advantage of securing a CBO score. The cap would thus operate as a *fallback*.[59] Such caps would indeed lock in big reductions in the growth of Medicare spending and would restrain rather than accommodate medical inflation. In all such proposals, Congress would, of course, retain the authority to adjust Medicare spending to accommodate changing circumstances.

Looking Backwards. Our vision of the future is blurry, but looking backwards, we have a pretty clear picture.[60] In hindsight, all spending caps would significantly reduce the growth in Medicare spending. Over the period 2002–2010, Medicare's average annual growth rate was 8.79 percent. If we applied the fully implemented ACA's spending cap of GDP plus 1 percent, over the 2002–2010 period, Medicare's average annual growth rate would have been reduced to slightly more than 2.4 percent. Over the period 2005–2010, it would have been 3.3 percent.

If one were to retrofit Medicare with President Obama's recently proposed budget cap (GDP plus 0.5 percent), Medicare's average annual spending growth would have fallen to 1.94 percent over the 2002–2010 period. If one compressed that cap over the period 2005–2010, the results would have been an even more draconian Medicare reduction: an average annual growth rate of 1.7 percent.

Using the Heritage spending cap of Consumer Price Index (CPI) plus 1 percent over the period 2002–2010, Medicare's average annual growth rate would have been slightly more than 3.4 percent. Over the period 2005–2010, the Heritage cap would have yielded an average annual growth of 3.7 percent.

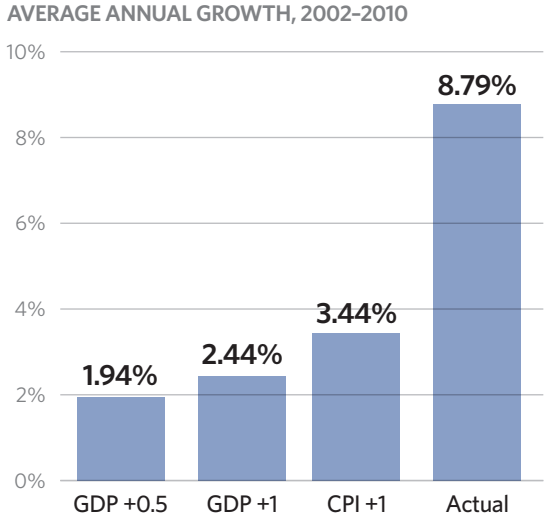
Future projections are perilous. Whether tying Medicare spending growth to price changes or economic growth works best would only be revealed by the unfolding of events. One can expect different impacts under different conditions. A raging inflation combined with slow economic growth—a replay of the terrible state of the economy in the late '70s—would obviously make the Heritage proposal far more attractive than the others. Based on trends of the recent past, the Heritage proposal would have been much more generous in providing Medicare dollars to America's retirees than President Obama's prescriptions.

If, as a matter of policy, a Medicare spending cap is undesirable under premium support, then the caps in the Affordable Care Act or the President's stricter budget proposal are even more objectionable. In fact, a cap in premium support would impose fewer problems for beneficiaries than the Independent Payment Advisory Board's colder and more distant decision-making; it gives them options that rigid administrative pricing does not. Notes Heritage Distinguished Fellow Stuart Butler, "Seniors ultimately get to decide which plans or providers

56. See Moffit, "Saving The American Dream," pp. 12–15.
57. Moffit, "The Second Stage of Medicare Reform," pp. 15–17.
58. Rivlin, "A Bipartisan Approach to Reforming Medicare," p. 3.
59. Premium support does not, of course, logically entail an external budget cap. Some champions of this reform, such as Senators Coburn and Burr, oppose such caps and others, such as former Senator Breaux, vehemently so.
60. Calculations by Drew Gonshorowski, policy analyst with The Heritage Foundation's Center for Data Analysis, based on Centers for Medicare and Medicaid Services (CMS) national health expenditure data.

CHART 1

Medicare Spending Had Caps Been in Place Beginning in 2002



Source: Heritage Foundation calculations based on data from CMS National Health Expenditures, Congressional Budget Office, and U.S. Department of Labor, Bureau of Labor Statistics.

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will get their money and how much, as opposed to an IPAB determining what their providers will be paid."[61]

Representative Pete Stark (D–CA), no fan of market-based reform, perhaps summarized it best: "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."[62]

Conclusion

Medicare patients today face reduced access to care, which will inevitably be rationed through the Affordable Care Act's relentless payment cuts. Despite advertisements to the contrary, IPAB deliberations will surely evolve into a highly politicized process of Medicare payment redistribution fueled by special-interest lobbying.

On paper, Medicare will continue to appear as a model of administrative cost control. The reality will be different. Real administrative costs—borne by doctors, hospitals, and clinics—will continue to soar. The *Federal Register* will fatten, and medical professionals will struggle to comply with the numerous rules and reporting requirements governing care delivery.

Medicare premium support, long a bipartisan proposal, is the best alternative to this unhappy scenario. It would improve the environment for medical practice, guarantee retirees better choices and broader access to quality care, encourage faster innovation in care delivery, and discourage waste and fraud in medical transactions. It would also deliver superior cost control. For the next generation of taxpayers and retirees alike, there is no better future.

*—**Robert E. Moffit, PhD,** is a Senior Fellow in the Center for Policy Innovation at The Heritage Foundation. This lecture is based on his presentation to a meeting of the Association of Health Care Journalists in Atlanta, Georgia.*

61. Stuart M. Butler, "The Debate Over How to Rein in Medicare Costs," *The JAMA Forum*, April 13, 2012, http://newsatjama.jama.com/2012/04/13/jama-forum-the-debate-over-how-to-rein-in-medicare-costs/ (accessed July 20, 2012).
62. Cited in Robert Pear, "Obama Panel to Curb Medicare Finds Foes in Both Parties," *The New York Times*, April 19, 2011, http://www.nytimes.com/2011/04/20/us/politics/20health.html (accessed July 20, 2012).