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Real Medicare Reform: Why Seniors Will Fare Better

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Abstract

Medicare reform based on a defined-contribution system of financing—commonly referred to as a "premium support" system—could slow or even reverse the growth in seniors' annual premium costs. Medicare Advantage, a system of private, competing plans, and Medicare Part D are, in effect, premium support programs. In basic structure, they have features that are similar to the successful Federal Employees Health Benefits Program (FEHBP). In these programs, the government allocates a fixed payment to a health plan chosen by enrollees. The government per capita payment to health plans on behalf of the beneficiaries—premium support—is based on marketplace bidding among competing plans to provide a specified set of health benefits. This payment arrangement allows broad consumer choice, and thus compels health plans to compete directly for enrollees' dollars—or lose market share.

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Medicare Advantage (Part C), a system of private, competing plans, and Medicare Part D, the drug program, are, in effect, premium support programs. In basic structure, they have features that are similar to the successful Federal Employees Health Benefits Program (FEHBP). In these programs, the government allocates a fixed payment to a health plan chosen by enrollees. The government per capita payment to health plans on behalf of the

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Key Points

- Without Medicare reform, seniors will be subject to significant increases in premiums each year. The structural Medicare reform proposal for premium support has the potential to slow and even reverse premium growth for beneficiaries, while also generating savings for taxpayers.
- Premium support would realign economic incentives of enrollees, plans, and providers. By stimulating intense competition, market forces would control costs and thus slow the growth in Medicare spending. These market forces would thus have a positive impact on future seniors' premiums.
- Successful programs with competitive, defined-contribution models of financing, similar to that of premium support, already exist today with the FEHBP, Medicare Part D, and Medicare Advantage. Premiums have remained stable in these existing models, while maintaining patient satisfaction.
- Research by many independent economists shows that competition among plans and providers has the ability to lower costs.

beneficiaries—premium support—is based on marketplace bidding among competing plans to provide a specified set of health benefits. This payment arrangement allows broad consumer choice, and thus compels health plans to compete directly for enrollees' dollars—or lose market share.

Premium performance in all three of these programs has been positive. Enrollees routinely report high levels of satisfaction with their plan choices, and financially they have benefited from the intense competition among health plans in the form of slower premium growth, and, in some cases, even premium reductions.

This financing approach is at the heart of Medicare reform proposals developed by The Heritage Foundation, Representative Paul Ryan (R–WI), and many others. As noted, this type of financing already governs the purchase of Medicare private plans and prescription drugs for the vast majority of seniors today. In effect, real Medicare reform would expand this defined-contribution financing to the entire Medicare program.

Current Law. Under current law, as amended by the Patient Protection and Affordable Care Act (PPACA), current seniors' Medicare premiums—as well as other out-of-pocket costs—are scheduled to rise steeply. That is certain. Standard Medicare Part B premiums, for example, are projected to jump from $99.90 in 2012 to $161.20 in 2021.[1] This rising premium cost trend—combined with greater difficulties securing access to care among physicians and other medical professionals—is likely to continue if Congress insists on maintaining Medicare's status quo.

A Better Future. Premium support uses a system of market-based bidding among competing health plans to determine the defined contribution (the per capita premium support) for the plans' enrollee coverage.[2] The basis of the contributions in virtually all of these proposals would be market-based bids on the plans' provision of Medicare benefits. Government payments would thus reflect *real* health care costs.

Members of Congress should have confidence that such a competitive system will provide the advantages of high-quality care at competitive premium prices. This confidence is well grounded in the reliable premium performance of existing government-sponsored defined-contribution (premium support) programs,[3] as well as the academic analyses of independent economists who have carefully examined various competitive proposals for Medicare reform.

Competition and Premiums: What Experience Shows

Members of Congress should re-examine the ample record of major government health programs that are based on defined-contribution systems of financing: the FEHBP, Medicare Part D, and Medicare Advantage.

FEHBP. Compared to conventional private health insurance, the FEHBP has historically enjoyed a strong record of cost control.[4] The FEHBP was established in 1960 to provide health benefits to federal employees and retirees and their families, and is administered by the Office of Personnel Management (OPM), the federal agency that oversees the enforcement of civil service laws and the payment of federal salaries and benefits. Unlike most private employor-sponsored health insurance, the FEHBP also covers retirees, an older pool of more expensive enrollees with a much greater demand for medical services than active employees. Government payment to private health plans is based on market bidding among

1. Centers for Medicare and Medicaid Services, *2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April 23, 2012, p. 229, Table V.E2, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf (accessed November 16, 2012).
2. For a description of the Heritage Medicare reform plan, 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. See also, Robert E. Moffit and Rea S. Hederman Jr., "Medicare Premium Support: The Best Reform Option," Heritage Foundation *WebMemo* No. 3483, February 2, 2012, http://report.heritage.org/wm3483.
3. For an overview of the performance of the government's defined-contribution programs, including cost control, see Robert E. Moffit, "Expanding Choice Through Defined Contributions: Overcoming a Non-Participatory Health Care Economy," *Journal of Law, Medicine and Ethics* (Fall 2012), pp. 558–573.
4. For the best summary of this issue, see Walton J. Francis, *Putting Medicare Patients in Charge: Lessons from the FEHBP* (Washington, DC: AEI Press, 2009), pp. 111–143.

competing health plans nationwide, and the government provides a direct payment to the health plans representing 72 percent of the average premium bid.[5] There is no standardization of benefits in the FEHBP, a wide variety of plans are offered, and individuals are able to pick a plan that best suits their needs.

Due to the explosive growth in health care inflation in the 1980s and 1990s, the Reagan Administration focused on changing economic incentives in the FEHBP. The Reagan agenda pioneered the expansion of co-payments and deductibles in health coverage to control FEHBP costs, while expanding the health plan choices available to federal workers and their families. During the 1980s, while conventional employment-based health insurance experienced a premium growth of 14 percent, FEHBP premiums rose by 12 percent.[6] From the 1990s onward, the FEHBP's general pattern of success continued into the 21st century. In 2012, for example, FEHBP premiums were projected to increase by 3.8 percent, while private employer-based insurance was projected to increase by 5.4 percent.[7]

Official FEHBP projections, however, do not themselves reveal the true premium performance. In the crucible of intense plan competition, when federal employees and enrollees weighed the price and benefit comparisons in choosing their health plans, the premium increases were often *less* than the official projections. In 1994, for example, the FEHBP's projected average premium increase was 3 percent, but the real increase was 2.7 percent.[8]

Medicare Part D. Medicare Part D provides drug coverage through numerous competing private plans in 34 regions of the country. The Part D program provides an array of affordable choices, including the provision of drugs through standalone prescription drug plans (PDPs), employer-sponsored plans, and Medicare Advantage plans. On average, Medicare enrollees have access to 12 plans in their geographical areas, and a stunning 88 percent of Medicare enrollees have access to at least one Medicare Advantage plan that includes drug coverage with *no additional premium* beyond their standard Part B premium.[9]

It is noteworthy that seniors escaped well-intentioned, but economically incompetent, congressional attempts to impose price controls and undercut plan premium competition for Medicare prescription drugs. During the bitter 2003 debate on Medicare Part D,[10] liberals in Congress attempted to fix the monthly drug premium to "protect" Medicare enrollees through government premium caps. One such proposal, offered by then-Representative Ted Strickland (D–OH) would have fixed the initial monthly drug premiums at $35, and would have steadily increased that amount by indexing it annually to inflation.[11] Luckily for seniors, Strickland's ill-conceived attempt to second-guess the market and create a $35 monthly "floor" for Part D premiums failed enactment. The market reality: In 2006, the first full year of the program, seniors' average monthly premium was actually $23. It fell to $22 in 2007. By 2008, it rose to $24, and increased again to $28 in 2009. In 2010, it reached $30.[12] Between 2011

5. Under the FEHBP formula, no plan can get a government contribution on behalf of a beneficiary that exceeds 75 percent of the plan's total premium cost. In other words, by limiting the savings that enrollees can secure, current law undercuts the greater potential of FEHBP to achieve an even better performance in cost control.
6. Moffit, "Expanding Choice Through Defined Contributions," p. 565, and Congressional Research Service, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*, May 24, 1989, p. 255.
7. Deborah Brunswick, "Health Insurance Costs to Rise Again Next Year," *CNN Money*, September 22, 2011.
8. Jeff Lemieux, Memorandum to the Medicare Commission, The National Bipartisan Commission on the Future of Medicare, February 17, 1999, http://medicare.commission.gov/medicare/jeff.html (accessed May 15, 2013).
9. Roger Feldman, Bryan Dowd, and Robert Coulam, "A Competitive Bidding Approach to Medicare Reform," *Preserving Medicare for Future Generations: Market-Based Approaches to Health Care Reform*, The Robert Wood Johnson–American Enterprise Series (April 2013), p. 10.
10. The Heritage Foundation was opposed to adding a universal prescription drug entitlement to Medicare, but has always favored a competitive system of private plans offering seniors drug coverage.
11. In 2003, there were several Democratic proposals to have the government cap monthly premiums. See "Medicare Overhaul Continues in Congress," Coalition on Human Needs, June 23, 2003, p. 3.
12. Centers for Medicare and Medicaid Services, *2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April 23, 2012, p. 231.

and 2012, the average monthly premium *declined* from $30.76 to $30.[13] The average monthly premium is expected to remain constant in 2013, at $30.[14]

For Medicare beneficiaries, this premium performance in a working model of a Medicare premium support program is impressively stable. It is also quite unlike anything that is happening either in traditional Medicare or in conventional private insurance, where insurance premiums have been higher, and are likely to increase significantly, especially with the full implementation of the PPACA in 2014.

In an extensive evaluation of Medicare Part D consumer behavior published in the *American Economic Review*, researchers found that seniors exercising choice over drug plans reduced their overspending on drugs by an average of $298 annually.[15] The researchers define "overspending" as the amount of the annual cost of insurance and out-of-pocket costs for drugs above the cost of the "cheapest" alternatives on the market. Examining seniors' behavior in choosing among the array of drug plan choices, researchers concluded:

> The results from our sample provide robust evidence of large reductions in overspending from 2006 to 2007, with average reductions in overspending of $298, which is 55 percent of the 2006 level. In addition to those large average effects, we find substantial heterogeneity, with 81 percent of the study sample lowering their overspending.[16]

Curiously, these researchers also found that the best results in individual cost reductions were found among the oldest and potentially sickest Medicare enrollees.[17]

In short, Medicare Part D's overall costs have defied official expectations. The program's total costs from 2006 to 2011 were 48 percent *lower* than the Medicare Trustees' original projections for the same time period.[18] This level of cost containment has no parallel in the rest of America's health care sector and exemplifies the magnitude of possible savings if the powerful forces of market competition were unleashed throughout the entire Medicare program.

Medicare Advantage (MA). Medicare Advantage is the system of private health plans that today provides comprehensive coverage to 27 percent of all Medicare beneficiaries. While the efficiency of MA's system of competitive bidding is compromised by tying government payments for private plans to traditional Medicare's system of administrative pricing, MA nonetheless has an impressive record for restraining seniors' premium costs. In 2011, the average monthly premium was approximately $31, and in 2012 fell to $30.[19]

Medicare Advantage plans must submit annual bids in offering traditional (or "guaranteed") Medicare benefits. One of the features of the Medicare Advantage program is that seniors can receive a rebate in either richer benefits or lower premiums and out-of-pocket costs if they choose a health plan that bids under the traditional Medicare benchmark payment. If seniors enroll in a plan that is more expensive than the benchmark payment, of course, they pay more to make up the difference. But the vast majority of Medicare Advantage plans

13. Sarah Kliff, "What a 76 Cent Premium Decrease Says About Medicare's Future," *The Washington Post*, August 9, 2011.
14. News release, "Medicare Prescription Drug Premiums to Remain Steady for Third Straight Year," U.S. Department of Health and Human Services, August 6, 2012, http://www.hhs.gov/news/press/2012pres/08/20120806b.html (accessed May 15, 2013).
15. Jonathan D. Ketcham, Claudio Lucarelli, Eugenio J. Miravette, and M. Christopher Roebuck, "Sinking, Swimming, or Learning to Swim in Medicare Part D," *American Economic Review*, Vol. 102 (October 2012), pp. 2639–2673. The researchers used data for the years 2006 and 2007.
16. Ibid., p. 2642.
17. Ibid.
18. Centers for Medicare and Medicaid Services, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table II.C18, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/tr2004.pdf (accessed May 15, 2013), and *2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table III.D3, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf (accessed May 15, 2013).
19. Marsha Gold, Gretchen Jacobson, Anthony Damico, and Tricia Neuman, "Medicare Advantage 2012 Data Spotlight: Enrollment Market Update," The Henry J. Kaiser Family Foundation, *Data Spotlight*, June 2012, p. 1, http://kff.org/health-costs/report/medicare-advantage-2012-enrollment-market-update/ (accessed May 15, 2013).

bid *below* the Medicare benchmark payment.[20] So, enrollees in those plans get the MA program's rebate, often in the form of reduced premiums.[21] Since 2007, between 85 percent and 94 percent of participating seniors have had plans available to them with *no premium payments* other than the standard Medicare Part B premium.[22]

These three government programs—all financed through defined contributions—strongly suggest the enormous potential for low and stable premiums in a future Medicare premium support system.

Medicare Reform and Seniors' Premiums: What the Research Shows

Experience with defined-contribution financing, consumer choice, and competition, has already demonstrated positive results in controlling health care costs. That is the conclusion reached by many independent analysts who have prescribed such a remedy for reforming Medicare.

Premium support would clearly realign economic incentives of enrollees, plans, and providers in a rational fashion. By stimulating intense competition, market forces would control costs and thus slow the growth in Medicare spending. These market forces would thus have a positive impact on future seniors' premiums.

The question of whether any given Medicare beneficiary would see an increase or decrease or a measure of stability in his premium costs would depend on several variables. The market would offer many answers. Much would depend on how health plans respond to new competitive pressures in designing offerings and cost sharing. Whether the plan is a private plan or traditional Medicare, whether a managed care plan or a fee-for-service plan, whether it is a high-deductible or low-deductible plan, all of these factors would largely determine seniors' premium payments. Individual seniors will have very different experiences depending on their choices; some will pay more, some will pay less, and some may experience no premium increases at all.

The Breaux–Thomas Proposal. Based on conventional economic theory and careful analysis, credible projections for premium savings do exist. In 1999, for instance, Senator John Breaux (D–LA), Representative Bill Thomas (R–CA), and the majority of the National Bipartisan Commission on the Future of Medicare developed a comprehensive Medicare premium support proposal. The commission staff estimated that Medicare beneficiaries' premiums would decline by 20 percent after 10 years of implementation, reflecting their share of the projected overall savings from the market dynamics of the proposed competitive program.[23] In addition, the director of the Congressional Budget Office (CBO) then made favorable comments regarding the commission's proposal, writing that "introducing competition into the Medicare program could help to reduce costs in both the short and the long run. A premium support system that resulted in effective price competition among plans would most likely lower Medicare costs."[24]

More recently, however, current CBO Director Douglas Elmendorf has stated that the CBO does not have the methodological tools to score the impact of market competition.[25] The CBO can, and does, measure the impact of static budget caps and price regulations. The fact that the CBO does not have the capacity to measure the dynamics of market competition is one reason why many advocates of Medicare reform based on defined-contribution financing, or

20. In fact, the average bid for all Medicare Advantage plans is 98 percent of the costs of traditional Medicare in the geographic bidding regions, and for HMOs the bids are 95 percent of those traditional Medicare costs. See James C. Capretta, "The Role of Medicare Fee-for-Service in Inefficient Health Care Delivery," in *Preserving Medicare for Future Generations: Market-Based Approaches to Reform,* The Robert Wood Johnson-American Enterprise Series, (April 2013), p. 7.
21. The law does not allow seniors to receive cash rebates for choosing plans that provide coverage below the Medicare benchmark payments.
22. Most Medicare Advantage plans come under the Medicare payment benchmark, and are thus legally required to rebate 75 percent of the difference to enrollees in richer benefits or lower premiums. The remaining 25 percent is retained as savings to the federal government. See Medicare Payment Advisory Commission, "A Data Book: Health Care Spending and the Medicare Program," 2012, p. 142.
23. National Bipartisan Commission on the Future of Medicare, "Impact of the Commission Premium Support Proposal on Different Types of Beneficiaries," p. 1., http://medicare.commission.gov/medicare/impact.htm (accessed May 20, 2013).
24. Letter from Dan Crippen, CBO director, to Senator John Breaux (D–LA), co-chair, National Bipartisan Commission on the Future of Medicare, February 18, 1999, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/10xx/doc1092/breaux.pdf (accessed May 13, 2013).
25. Douglas W. Elmendorf, "CBO's 2011 Long-Term Budget Outlook," testimony before the Committee on the Budget, U.S. House of Representatives, June 23, 2011, http://budget.house.gov/uploadedfiles/623elmendorftestimony.pdf (accessed May 13, 2013).

premium support financing, have included Medicare budget or spending caps; a hard cap guarantees measurable savings under conventional CBO scoring.[26]

Independent Economists' Estimates. Conversely, many private-sector economists are able to model the impact of market competition. For example, Professors Roger Feldman and Bryan Dowd at the University of Minnesota, and Robert Coulam of the Simmons School of Management of Boston analyzed the competitive-bidding approach in the recent Ryan proposal coauthored by Senator Ron Wyden (D–OR).[27] They conclude: "Under competitive bidding, beneficiaries who are willing to change plans will face no increase in monthly premiums." But Feldman et al. found that even *without switching* into a more competitive plan, 43 percent would still face *no change in premiums at all*; 22 percent would face premium increases of less than $40 per month; 18 percent would face additional costs between $40 and $70; 16 percent would face extra costs in the range of $70 to $125; and only the remaining 1 percent would have increases ranging up to $352.[28]

Recent research published in the *Journal of the American Medical Association* by economists Zirui Song, David Cutler, and Michael Chernew also shows that competitive bidding could reduce Medicare's costs by 9 percent annually.[29] Applying the benchmark for plan payment used in Representative Ryan's most recent Medicare premium support proposal (either the second-lowest bid or traditional Medicare, whichever costs less), and using 2006–2009 data on Medicare Advantage plan bids and traditional Medicare's costs, the researchers found that nationally, the second-lowest-cost plan bid would be 9 percent lower than traditional Medicare's costs. If millions of seniors migrated to lower-cost plans, the Medicare program would thus enjoy significant savings, in sharp contrast to the continuing pattern of rising costs and a deepening long-term debt. Commenting on the study, James Capretta and Yuval Levin observe that

> because the *JAMA* study is based on the existing Medicare Advantage program, which is dominated by a regulated payment system instead of true competition, it likely understates the potential savings. Under premium support, the competition (in terms of price and quality) would be significantly more intense, which would drive costs down further. Thus, taxpayers and the program's beneficiaries would almost certainly save even more than the significant amount the JAMA study unwittingly implies.[30]

Consensus on Competition. The idea for a broader application of market-based payment for medical goods and services in Medicare, using competitive bidding among plans and providers, spans the ideological spectrum. While it is at the heart of Medicare per capita payment in Medicare premium support proposals, progressives as well as conservatives and moderates have called for the expansion of competitive bidding in particular areas of Medicare.

To improve private-plan payment in Medicare, in 1999 President Bill Clinton proposed a process for establishing a real marketplace based on a government contribution to health plans outside Medicare's traditional administrative pricing system. Thus, the Clinton Administration endorsed

> a new "competitive defined benefit" program that, for the first time, would inject price and quality

26. A Medicare spending cap is no longer just a policy proposal; it is current law. As a policy matter, a Medicare spending cap has been embraced by the Obama Administration (a key feature of the PPACA) and congressional Republicans. In the case of centrist and conservative proponents of Medicare premium support, however, any such cap would function as a "backstop" to ensure savings that are guaranteed and thus measurable by the Congressional Budget Office. For conservatives and centrists, competition, not global Medicare budgets or price controls, is to be the mechanism to control cost and slow the growth in Medicare spending.
27. Roger Feldman, Robert Coulam, and Bryan Dowd, "Competitive Bidding Can Help Solve Medicare's Fiscal Crisis," American Enterprise Institute *Health Policy Outlook*, February 2012, http://www.aei.org/files/2012/02/16/-competitive-bidding-can-help-solve-medicares-fiscal-crisis_081704430956.pdf (accessed May 13, 2013).
28. Ibid.
29. Zirui Song, David M. Cutler, and Michael E. Chernew, "Potential Effects of Reforming Medicare Into a Competitive Bidding System," *Journal of the American Medical Association*, Vol. 308, No. 5 (August 1, 2012), http://jama.jamanetwork.com/article.aspx?articleid=1273025 (accessed April 15, 2013).
30. James C. Capretta and Yuval Levin, "More Mediscare," *The Weekly Standard*, August 20, 2012, http://www.weeklystandard.com/articles/more-mediscare_649725.html (accessed May 15, 2013).

> competition among health plans in Medicare.... Such price competition would make it easier for beneficiaries to make informed choices about their health plan options. It also would provide incentives for beneficiaries to choose private plans offering high-quality health care while also saving them money by reducing their Part B premium costs. This saves the government money as well.[31]

The Clinton initiative for Medicare bidding among private plans did not, however, get past the budgetary planning stage. Unfortunately, when Congress enacted the Medicare Advantage program in 2003, it retained payment to private health plans based on Medicare's administrative payment benchmarks for traditional Medicare benefits. This was a deliberate policy decision, even though it resulted in a flawed payment process that ensured unnecessary spending.[32]

More recently, the Center for American Progress (CAP), a progressive think tank, supported pure competitive bidding in Medicare Advantage. CAP would change the benchmark payment from traditional Medicare to the average cost of competing private plans, pointing to the potential for additional savings.[33] The Obama Administration supported a similar reform to Medicare Advantage in its initial fiscal year 2010 budget proposal, estimating an impressive 10-year savings of $175 billion.[34] The Obama Administration subsequently dropped its original Medicare competitive bidding proposal.

Why the Critics Are Wrong

Despite the existing positive experiences with defined-contribution financing and private plans in Medicare, during the 2012 presidential campaign, President Obama's allies in Congress and the media insisted that the initial premium support reform proposal, principally authored by Representative Ryan, would shift and increase costs on future seniors. The now-infamous claim is that future seniors would have to pay $6,400 in additional out-of-pocket costs per year under the Ryan proposal.[35]

In fact, that estimate was based on an outdated analysis of CBO projections of an earlier version of the Ryan plan that was substantially different from the one that Ryan has recently proposed.[36] Examining the Obama team's clumsy attempt to pull a "fast one" on the public, many independent analysts dismissed it, with *The Washington Post* fact checker, for instance, giving Ryan's critics two "Pinocchios" for the erroneous charge.[37]

Scary Speculations. During the 2012 presidential campaign, speculative projections of the negative impact of a competitive system on seniors' premiums had also become a cottage industry among Washington health policy analysts. In October 2012, for example, the Kaiser Family Foundation released a study purporting to show how the Ryan proposal would increase seniors' premiums. Media reports highlighted a sensational Kaiser finding

31. National Economic and Domestic Policy Councils, "The President's Plan to Modernize and Strengthen Medicare for the 21st Century," detailed description, July 2, 1999, p. 8, http://clinton2.nara.gov/WH/New/html/medicare.pdf (accessed April 15, 2013).
32. For a description of the Medicare Advantage payment system and its flaws, as well as the program's strengths in delivering high quality care, 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/10.1056NEJMp1114019?viewType=Print&viewClass=Print (accessed May 15, 2013).
33. The Center for American Progress Health Policy Team, "The Senior Protection Plan," November 2012, p. 6, http://www.americanprogress.org/wp-content/uploads/2012/11/SeniorProtectionPlan-3.pdf (accessed April 15, 2013). It is unclear whether a senior could choose a plan that bids above or below the benchmark under CAP's proposal.
34. Office of Management and Budget, "A New Era of Responsibility: Renewing America's Promise," February 2009, p. 28, http://www.gpo.gov/fdsys/pkg/BUDGET-2010-BUD/pdf/BUDGET-2010-BUD.pdf (accessed April 15, 2013).
35. Obama for America, "Promises," television ad, August 25, 2012, http://www.youtube.com/watch?feature=player_embedded&v=b9XkVonSIxk (accessed May 13, 2013).
36. For a more detailed discussion of this controversy, see Rea S. Hederman Jr., "Why Medicare Premium Support Would Not Cost Future Beneficiaries $6,400 More," Heritage Foundation *Issue Brief* No. 3745, September 28, 2012, http://www.heritage.org/research/reports/2012/09/why-medicare-premium-support-would-not-cost-future-beneficiaries-$6400-more.
37. Glenn Kessler, "Health Care's $6,400 Question—Fast Fact Check," *The Washington Post*, September 4, 2012, http://www.washingtonpost.com/politics/health-cares-6400-question--fast-fact-check/2012/09/04/086b1046-f6d9-11e1-8398-0327ab83ab91_video.html (accessed October 19, 2012).

that 59 percent of current seniors would have significantly higher premiums under a premium support model for Medicare reform.[38] But underlying that Kaiser-generated headline was the remarkable assumption that *no* seniors would switch from traditional Medicare to cheaper, more efficient, private plans, despite paying higher premiums in traditional Medicare. In an assessment of the Kaiser study, Joseph Antos, a research fellow with the American Enteprise Institute and a former Assistant Director of the CBO, observed:

> The Kaiser study reports that when the cost of health plans falls, more beneficiaries have to pay *more*, not less. They [*sic*] assume that plans under premium support will find a way to save 5 percent, a modest amount compared to the 30 percent of health spending that the Institute of Medicine says is squandered every year. But the study shows that if costs drop 25 percent, then 93 percent of medicare beneficiaries would pay more—and the extra payment would be much greater than before. Yes, you read that right. Lower health plan costs would increase what Medicare beneficiaries have to pay—but only if they insist on paying more for the same benefits that are offered less expensively elsewhere.[39]

The very idea that people who turn age 65 would somehow lose their price sensitivity was strange. Beneath the media headlines that seniors remaining in traditional Medicare would pay higher premiums, the Kaiser research actually reinforced previous research that competitive private plans in Medicare would in fact be less expensive than traditional Medicare. In any case, the Kaiser study was mostly irrelevant to the real debate on the Ryan proposal. The Kaiser researchers had modeled the proposal's alleged effect on *current* seniors; in fact, Ryan's proposal, if enacted, would have affected future seniors and would not have been operational until 2023 at the earliest.

A working assumption of seniors' price insensitivity is, of course, nonsense. The true experience of consumers, including retirees, in an intensely competitive health insurance market in the *real* world tells a very different story.

As previously noted, a team of researchers writing in the *American Economic Review* found that seniors enrolled in Medicare Part D who realized that they were spending far more than necessary on prescriptions were among the most decisive consumers in changing plans, particularly the very old and the frail:

> The greatest reductions were achieved by those who overspent in 2006, and this cannot be explained by changes in observed health. Interestingly, improvements were greatest among those age 85 and above, and those initiating medications for Alzheimer's disease in 2007 improved by more than average. Although we cannot observe the choice process itself, these two results suggest that populations with greater prevalence of cognitive limitations are helped by various sources including family members, health care providers and other private organizations, and decision support tools such as online plan finders.[40]

In the real world, perhaps the best example of consumer price sensitivity is the experience of the FEHBP, where consumers, including retirees, change health plans to save money on premiums. In 1981, the FEHBP had a budget shortfall of $440 million and beneficiaries stood to face a stunning increase in premiums of 24 percent for the contract year 1982.[41] President Ronald Reagan's Director of the Office of Personnel Management, Donald J. Devine, addressed the crisis head on by introducing

38. Gretchen Jacobsin, Tricia Neuman, Anthony Damico, "Transforming Medicare into a Premium Support System: Implications for Beneficiary Premiums," Kaiser Family Foundation, October 2012, http://www.kff.org/medicare/upload/8373.pdf (accessed October 23, 2012).
39. Joseph R. Antos, "The Problem with Kaiser's Premium Support Study? Seniors are Smarter than That—and So Are Health Plans," AEIdeas blog, October 15, 2012, http://www.aei-ideas.org/2012/10/the-problem-with-kaisers-study-on-premium-support-seniors-are-smarter-than-that-and-so-are-health-plans/ (accessed May 15, 2013).
40. Ketcham et al., "Sinking, Swimming, or Learning to Swim in Medicare Part D," p. 2642.
41. News release, "Feds Health Benefits Changes Save Taxpayers and Employees Nearly $2 billion," U.S. Office of Personnel Management, October 17, 1983.

cost-sharing requirements in the form of deductibles and co-pays in health insurance. Devine's decisive action would dramatically lower beneficiary and taxpayer premium costs. In two years, over 800,000 enrollees switched into the lower-cost plans. According to OPM's 1983 Compensation Report, "This effort...saved the Federal Government and enrollees approximately $600.3 million for 1982 and $811.7 million in 1983. This savings, plus those due to enrollees migrating to lower-cost plans, equal approximately $2 billion in total health benefits premiums avoided in calendar years 1982 and 1983."[42] Average employees' premiums increased by only 4 percent in 1983, well below the double-digit increase in medical care costs generally.[43] In 1983, federal retirees (annuitants) accounted for 38 percent of total enrollees, proving that retirees are also sensitive to cost.[44] On an aggregate basis, the savings for both taxpayers and beneficiaries were dramatic, amounting to $2 billion by 1983. In 2012 dollars, that would be equivalent to $4.6 billion.[45]

Premium Support: The Best Option for Seniors

Conventional economic theory is sound, and independent economists have demonstrated the superiority of consumer-driven market competition in controlling health care costs. Beyond theory, there is real-world practice. Policymakers have had enough positive experience with existing defined-contribution programs to know that intense competitive pressures and real consumer choice, as proposed in Medicare premium support reforms, could slow or even reverse the premium cost growth for Medicare beneficiaries.

The Heritage Foundation, Representative Ryan, and other analysts representing a variety of public policy institutions have offered Medicare premium support proposals. Virtually all such proposals operate on improved systems of competitive bidding for determining market-based payments for the provision of traditional Medicare benefits.[46]

With such a reform, the Medicare beneficiary, as a consumer, would be the key decision maker in the system. The beneficiary would direct the flow of the Medicare dollars. Satisfaction of the beneficiaries' wants and needs, as expressed in their choices, would drive the system and shape the responses of both health plans and medical professionals. It would stimulate innovation and productivity in health care delivery, and encourage care coordination and management, as it does today in Medicare Advantage. Intense competition would encourage health plans to offer the best benefits and the highest quality of service at the lowest possible price.

Finally, such a reform would encourage seniors to choose health plans that are competitively priced. This would enable seniors to experience slow and stable premium growth, or even a reduction in their premium costs. When competitive health plans, seeking greater market share, manage to price their benefits below the specified government payment, seniors would get government payment for the full cost of their Medicare benefits; in other words, "premium free" health plans. For beneficiaries and taxpayers alike, it is hard to imagine a better outcome.

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42. U.S. Office of Personnel Management, *Compensation Report: U.S. Civil Service Retirement System, Federal Employees Health Benefits Program, Federal Employees' Group Life Insurance Program, Pay Programs*, fiscal year 1983, p. 2, http://babel.hathitrust.org/cgi/pt?id=uiug.30112105073313#page/n2/mode/1up (accessed January 18, 2013).
43. News release, "Feds Health Benefits Changes Save Taxpayers and Employees Nearly $2 billion."
44. U.S. Office of Personnel Management, *Compensation Report: U.S. Civil Service Retirement System, Federal Employees Health Benefits Program, Federal Employees' Group Life Insurance Program, Pay Programs*, p. 55.
45. Determined using a Consumer Price Index calculator: Federal Reserve Bank of Minneapolis.
46. For a comparative description of the leading Medicare premium support proposals, 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.