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JUNE 2011



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For the
The Henry J. Kaiser Family Foundation

This paper was commissioned by the Kaiser Family Foundation.
Conclusions or opinions expressed in this report are those of the authors
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Introduction

Current Medicare can be understood as a “defined benefit” program. The federal government has an open-ended obligation to pay for the program’s statutorily promised benefits. With an increasing focus on persistently high federal deficits and accumulating national debt, proposals are being debated in Congress to reduce the federal government’s expenditures on the program. One option is a defined contribution model such as premium support whereby the government’s fiscal commitment to the program would become more limited and predictable.

The most prominent of the proposals described as premium support¹ that are presently being discussed are the plan for Medicare restructuring sponsored by House Budget Committee Chair, Paul Ryan (R-WI), which was approved by the House of Representatives in April 2011 as part of the House Fiscal Year 2012 budget resolution,² and the Medicare recommendations made by recent deficit reduction commissions, including the commission led by Pete Domenici and Alice Rivlin.³ Elements of Medicare premium support also can be seen in the existing Medicare Advantage (MA or Part C) and Prescription Drug (Part D) programs. Similar “managed competition” concepts upon which premium support was developed are reflected in the coverage expansions and insurance reforms included in the Patient Protection and Affordable Care Act (ACA) enacted in 2010.

This report provides an overview of key features of Medicare premium support proposals, discusses issues that may arise in designing a premium support system, and discusses the implications for beneficiaries and program spending. The Appendix describes the history of proposals to transform Medicare into a system of premium supports, beginning in the early 1980s and includes a description of proposals that have been introduced more recently in the context of deficit and debt reduction discussions.

What is Premium Support?

Under Medicare premium support proposals, private health insurance plans that meet certain standards would compete head-to-head for the enrollment of Medicare beneficiaries. Some proposals would guarantee coverage for at least a common benefit package; others would leave benefit decisions to the plans. In some proposals, fee-for-service Medicare (“traditional Medicare”) would compete under the same rules as the private insurance plans.⁴ In other proposals, traditional Medicare would be phased out. The federal government would manage the competition between the private insurance plans by: 1) setting certain plan standards and 2) providing a fixed contribution (i.e., subsidy) towards the plan premium. Beneficiaries would actively participate in the selection of their own insurance and would be required to pay extra for plans costing more than the government’s contribution. The contribution amount might be increased for lower-income and sicker beneficiaries to help cover the cost of their premiums (and possibly cost-sharing requirements). Any Medicare program savings would depend on the

government's contribution level and the extent to which market competition constrained health care spending, either by driving down pricing, reducing utilization, or a combination of both.

Advocates of Medicare premium support say that it will promote a more cost-effective Medicare program than today's model which relies on government price setting and other regulation to constrain program costs. In their view, giving beneficiaries financial incentives to select the least costly insurance plans will, in turn, encourage the plans to compete for enrollment on price, quality of care and service. They argue that this will enable Medicare to be sustained through the coming years when an expanding population of Americans becomes eligible for the program.

Opponents of Medicare premium support say that it will end Medicare's guaranteed benefit and shift significant health care costs from the government to beneficiaries, reducing coverage and access to services, most particularly for the poor and frail elderly and disabled individuals. Questions are raised about whether the new private insurance market would drive down health care costs or merely redistribute premium dollars to cover private insurers' administrative costs which are higher than those incurred by traditional Medicare. Opponents also say that premium support could do harm to the health care system as a whole by cutting back on funds now used to support graduate medical education, improve access to care for rural and other underserved communities, and finance new medical technology.

Are Premium Support and Vouchers the Same Thing?

Premium support and vouchers are similar defined contribution approaches to restructuring Medicare, and while important technical distinctions may be drawn between them, of late the terms are frequently used interchangeably. (In this paper, we use the term premium support to encompass all current proposals, including some that may technically be voucher plans.) The major distinction is that proposals for premium support would base the government's contribution on the cost of private coverage for a defined set of services while under voucher proposals the government contribution could be established based on other factors, such as federal budgetary goals. Additionally, voucher proposals often do not specifically define a benefit package and would allow beneficiaries to apply their government voucher or premium contribution toward the cost of any private plan offered to them by a licensed insurer in an open marketplace. By contrast, premium support proposals rely on a structured marketplace in which beneficiaries would choose among plans meeting federal standards. Premium support proposals differ, however, on the structure of the marketplace and stringency in federal requirements.

The origins for both Medicare vouchers and premium support, as well as other defined contribution approaches, are rooted in a philosophical perspective that a market is a more effective way to drive down costs of medical care than government regulation. Alain Enthoven, for example, advocated in the 1970s a voucher-based, national health insurance program in which relatively unfettered market forces would encourage private insurers to compete for

enrollees on the basis of price and benefits. In the early 1980s, when Medicare's long-term sustainability was in jeopardy due to projected shortfalls in the Hospital Insurance Trust Fund, some economists called for spending on the program to be constrained by replacing it with voucher payments to beneficiaries, the amounts for which would be allowed to grow more slowly than medical inflation. Beneficiaries would then use the vouchers to purchase private insurance. Medicare voucher proposals were considered in Congress during this period although none were enacted during that period.

Henry Aaron and Robert Reischauer are considered the fathers of Medicare "premium support," proposing this approach in the mid-1990s to constrain Medicare expenditures and modernize the program.⁵ (Aaron has since said that he no longer supports moving Medicare to a premium support system.⁶) These economists distinguished their approach from vouchers by providing that the amount of government contribution (i.e., "support") be tied to average health care costs, not an economic index, thus ensuring some level of benefit adequacy over time. In Aaron's words, "This difference is crucial. Voucher plans are virtually guaranteed to become increasingly inadequate; premium support plans will not."⁷

The Aaron and Reischauer approach has since inspired numerous proposals by policy think tanks and commissions as well as legislation considered in Congress. More detail on the evolution of these proposals and a description of the leading premium support plans being debated today is provided in the Appendix. In the pages that immediately follow, the core features of premium support are identified and the potential implications for different stakeholders and the health care system as a whole are discussed.

What are the Features of Premium Support?

Restructuring Medicare using a premium support approach requires policy makers to decide on a number of key program features. The following describes the major features and the implications of different design decisions. Information on the specific premium support proposals that are referenced here is included in the Appendix.

What will be the initial level of the government's contribution? This is one of the most critical components of a premium support plan. The level of government contribution affects the level of beneficiary out-of-pocket costs, the number of plan choices available to beneficiaries, the number of plans from which beneficiaries with limited incomes may choose, the offering of benefits above and beyond the required benefit package, if any, and the long-term stability of plan offerings.

If the Medicare program no longer directly pays for the cost of health care services provided to Medicare beneficiaries, some means of setting the government's contribution toward the cost of private insurance coverage must be chosen. The government's contribution could be tied to the premiums of the private health insurance plans available to Medicare beneficiaries in their communities, determined for example, through a competitive bidding process. Under a bidding system, the actual government subsidy amount might be tied to a specific percentage of the

average bid premiums (or the lowest or median bid) or a specific dollar amount. The premium support proposal developed in the late 1990s by the National Bipartisan Commission on Medicare, for example, would have tied the government contribution's amount to the enrollment-weighted average of plan premiums for a core set of benefits, adjusted for geography and risk. A recent proposal by the Heritage Foundation adopts a similar approach, tying the contribution at first to the weighted average premium in an area and then later tying it to the lowest cost plan. Alternatively, the government contribution could be based solely on federal budget goals, an approach more technically characterized as a voucher approach. For example, the initial amount could be set at the average federal cost of Medicare benefits in a base year and indexed to an economic measure, as discussed next.

Will the government's contribution vary by the beneficiary's geographic location? Health care costs vary around the country reflecting local differences in medical practice patterns as well as economic factors such as wages and the cost of living. Some proposals would adjust premium support payments to reflect geographic variation in costs, while others do not. The Ryan 2012 budget proposal does not mention a geographic adjustment, although his earlier Roadmap proposal would have included one and phased it out over time. Geographic variation would be built into proposals where premiums would be determined by competitive bids by insurers in local markets, such as proposed in 1999 by the National Bipartisan Commission on the Future of Medicare, for example. In other proposals, such as the recent Domenici-Rivlin plan, a national government contribution amount would be adjusted for geographic variation.

One goal of constraining geographic variation would be to reduce the portion of Medicare spending that seems to be largely due to geographic differences in the way medicine is practiced rather than beneficiary risk factors. But if the government contribution does not vary by geography, beneficiaries in high cost areas could pay substantially more out of pocket than beneficiaries in other areas. The experience of the Medicare Advantage program suggests some of the challenges in designing such adjustments so that they achieve their intended results without disrupting the coverage of beneficiaries, as private plans respond to increasing or decreasing payments from the government. Attracting these plans to locate and remain in some core urban and remote rural areas that have disproportionately high-risk populations or are already experiencing a shortage of health care providers and facilities may be especially difficult.

Will the government's contribution vary by beneficiary age or health status? Under current law, all Medicare beneficiaries are guaranteed the same set of benefits, but the cost to the government of paying for those benefits differs for a variety of reasons. Individual health needs differ, and in any given year 10% of beneficiaries account for 58% of Medicare program expenditures.⁸

Under premium support, insurers have an incentive to avoid enrolling those individuals who are higher than average in terms of their potential for using covered services, that is, the older and sicker beneficiaries. Insurers will be more likely to engage in risk selection behaviors, including medical underwriting and selective marketing, in the absence of regulations such as guaranteed

issue of coverage to all applicants, regardless of age or health status, limits on the use of pre-existing condition exclusions, and rules relating to market conduct. As a result, most premium support proposals, including the Ryan 2012 budget plan, would require participating plans to accept any beneficiary who applied, regardless of their health status. Most also call for some form of risk adjustment system (as discussed below) to help mitigate the risk that the insurer's premiums will not cover expected claims. Opponents question, however, whether such rules and risk mitigation mechanisms can fully offset the economic incentives for plans to engage in such risk selection behaviors.

Risk Adjustment. Risk selection among health insurers can be addressed through some form of risk adjustment system. Risk adjustment redistributes dollars from plans that enroll on average healthier (less costly) beneficiaries to those that enroll on average older and sicker (more costly) beneficiaries. Risk adjustment tools often also account for differences in costs due to geography and other factors. The latter may include income (Medicaid being a potential proxy measure) and institutional status (e.g., whether a beneficiary resides in a nursing home). The need for effective risk adjustment becomes greater as the rules of competition become less constrained because insurers will have incentives to design benefit packages, price premiums, and selectively market with an eye to drawing the most favorable risks compared with the risk of enrollees in their competitors' plans. Ideally, risk adjustment will compensate plans fairly for enrolling higher cost enrollees.

Although most experts agree on the need for risk adjustment under a premium support system, opinions differ on whether existing risk adjustment methodologies are sufficiently adequate to discourage insurers from competing on the basis of selecting the best risks. Existing systems, including the CMS–HCC model used as the basis for risk adjusting payments to Medicare Advantage plans, have been found to over-predict the costs for beneficiaries who are in good health (and thus overpay for them) and under-predict (and thus underpay) for those who are in poor health.⁹ This results in the government overpaying Medicare Advantage plans with better risks, unnecessarily inflating program costs. Based on the current state of risk adjustment, it is at least plausible that any risk adjustment system will be unable to mitigate all of the effects of risk selection.

How will the government contribution grow over time? In some versions of premium support, like the recent Heritage Foundation proposal, the government contribution would grow at the same rate as the premium benchmark (the lowest cost plan, for example), so that over time the government contribution would remain at a fixed percentage of that benchmark. Proponents believe that under this approach, competition among plans for enrollees would slow the rate of growth in Medicare expenditures relative to the current program.

Many of the proposals under current debate, however, delink the government contribution from underlying health plan costs. They would instead set the initial government contribution to equal what Medicare currently spends on average per beneficiary, with annual adjustments thereafter indexed to an economic measure. The Domenici-Rivlin proposal, for example, indexes the government contributions per Medicare beneficiary to the growth in the economy

(GDP) + 1 percentage point (GDP+1) whereas Rep. Ryan's 2012 budget plan indexes payments to general inflation. Another option might be to index the growth in the contribution to medical inflation (CPI-Medical).

Based on historical trends and generally accepted projections, these measures will not keep pace with the rising costs of health care. From 1985 through 2009, for example, average annual growth in both Medicare spending per beneficiary (7.0%) and overall national per capita health spending (6.3%) outpaced that of GDP+1 (6.2%), the CPI (2.9%) and the CPI-Medical (5.1%).¹⁰ Limiting growth in government contributions in this way is intentional, however, as premium support proponents want to ensure that beneficiaries have financial incentives to seek efficient plans and that competing plans are encouraged to seek efficiencies that lower health care costs in order to attract beneficiaries.¹¹

Whether or not competition among plans would achieve these intended efficiencies or simply shift costs to beneficiaries is the heart of the debate about recreating Medicare as a premium support program. If making plan premiums transparent and competitive and encouraging beneficiaries to act as prudent purchasers has the effect of slowing overall health spending, the premium support approach would have achieved its goal. If the proponents are wrong, however, beneficiaries would face steadily rising plan premiums and/or rising cost-sharing responsibilities imposed through their plan deductibles, coinsurance and copayments.

In its preliminary analysis of the Ryan 2012 budget, the CBO estimates that federal savings would be achieved, especially in the long run, but only because beneficiaries would pay more, not because Medicare coverage would be less expensive than under current law.¹² Specifically, CBO estimates that even though private plans would impose more utilization controls, the total cost of private plans in a premium support system would be both higher and faster-growing than traditional Medicare because of their higher administrative costs and higher provider payments. Federal savings would result from the limitations on how much the government contribution would grow. Savings would accrue gradually because the premium support option would initially involve only a small proportion of beneficiaries, in particular those who are younger and less costly. In its analysis, CBO notes the substantial uncertainty in making long-run estimates, and in predicting how well private insurers might restrain health care costs relative to the provider payment constraints assumed under current law, which may be difficult or impossible to maintain.

How much will beneficiaries pay for Medicare? Whichever method for determining the level of government contribution, premium support proposals would require beneficiaries to pay any premium amounts in excess of the government's contribution.¹³ These amounts, which will likely vary depending on the age of the beneficiaries and where they live, could be significantly higher than beneficiaries would pay under current law. Thus, some lower-income beneficiaries may become uninsured while some higher-income beneficiaries may elect to self-insure or seek alternative insurance options, if any, in the private insurance market.

For example, according to the recent CBO analysis of the Ryan budget proposal for premium support, Medicare beneficiaries would spend more for health care under the proposal than they would under the existing program. As a result, some Medicare-eligible individuals would choose not to purchase health insurance, and would become uninsured. A typical 65-year-old would pay more than twice as much under this version of premium support as they would have paid under traditional Medicare. (For this proposal, in 2022, the government contribution for a 65 year old would be \$8,000 and the beneficiary would pay \$12,500, compared with what would have been a beneficiary cost of \$5,630 for traditional Medicare that year.¹⁴) This estimate reflects the net effect of slower-growing government contributions and higher plan costs.

Unlike the current Medicare program, where the same standard Part B premium applies to all beneficiaries, some premium support proposals would vary beneficiary contributions based on geography and age. Beneficiary contributions by income also could differ from current Medicare. With respect to geography, if the government contribution is the same around the country but plan premiums vary locally, beneficiaries in high-cost areas would pay more than others for similar Medicare benefits. As discussed earlier, some proposals would vary the government contribution to reflect geographic variation in health care costs, while others would not.

Premiums could also be higher for older beneficiaries because, unless prohibited from doing so, insurers are likely to charge them more based on their expected higher use of covered services. Some proposals would prohibit insurers from charging more by age, while others would not. The Heritage Foundation plan, for example, is built on the existing Medicare Advantage system and beneficiary premiums could not vary by age or health status. Under the Ryan budget, the government contribution would be adjusted for age; however, private plans would be allowed to vary premiums by beneficiary age that could potentially result in significantly higher premiums for older than for younger beneficiaries. How much higher the premiums ultimately charged to older beneficiaries would be is uncertain, although the Ryan plan does not propose any limits on these charges.

Under the existing program, Medicare subsidies vary based on beneficiary income. This design could be continued under premium support proposals, with varying details. Currently some lower-income beneficiaries receive assistance through Medicaid coverage or direct federal subsidies to help pay their obligations for Medicare premiums and cost-sharing amounts. Those subsidies are tied to the existing Medicare premium and cost-sharing amounts, and would therefore need to be changed in a premium support model. Because premium support could require greater beneficiary contributions, maintaining the same level of support for low-income beneficiaries could require additional federal investments in subsidies for these individuals. (More on premium support and lower-income beneficiaries appears below.)

Under premium support, the extra contributions required of higher-income beneficiaries could vary from current law, depending on the proposal. Currently, Medicare limits the government subsidies provided to higher-income beneficiaries under Medicare Part B (physician and other

outpatient services) and Part D (prescription drugs) by increasing the beneficiary premium contribution for these Medicare benefits. Premium support proposals generally would require higher income beneficiaries to pay more for their entire Medicare benefit package. The Heritage Foundation plan goes so far as to eliminate the government contribution for Medicare entirely for individuals above an income threshold (\$110,000 for individuals/\$165,000 for couples). That is, if these individuals chose to participate in Medicare, they would be required pay the full premium for the private coverage available to them under the premium support system.

What benefits would be covered by plans under a premium support system? Premium support proposals vary in the extent to which benefits are specified. While strict voucher plans, like that offered by Rep. Ryan in his earlier Roadmap plan, would allow beneficiaries to use their government contribution for any insurance available to them in the market, premium support plans generally specify a defined set of benefits for which insurers would set premiums and compete for enrollees in a managed market place. Without specific guidelines and requirements, the concern would be that coverage for beneficiaries would be less generous than under traditional Medicare, could erode over time, and vary widely across plans.

A defined set of benefits could, like the Federal Employees Health Benefits Plan (FEHBP), consist of broad categories of services, such as inpatient and outpatient hospital care, physician services, and prescription drugs, with plans free to determine the specific benefits within these categories. A mid-range option would be to adopt the approach used by Medicare Advantage, requiring the private plan's benefit package to equal the actuarial value of the benefits offered under traditional Medicare. Defined benefits could also be the same as the traditional Medicare benefit package, consisting of both categories of services as well as specific definitions of the scope and cost-sharing for those services.

Allowing for variations in benefits raises an additional concern as to whether safeguards are sufficient to discourage competitors in the market from using benefit design to deter sick people from enrolling in their plans. As a general rule, the less constraint on benefit variation, the more potential for risk selection.

The ongoing debate about the number of Medicare Advantage and Part D plan choices and whether plan differences are sufficiently meaningful for beneficiaries to make informed and prudent choices suggests the challenges of reaching consensus on what constitutes the optimal number of plan choices and component features in a multiple choice environment.¹⁵

Which requirements would be imposed on plans that enroll Medicare beneficiaries? Under premium support, the government would establish rules for plan participation in Medicare and then would contract with qualifying plans and provide information to beneficiaries about their plan options. A more highly regulated marketplace would generally provide greater protections for consumers (e.g. solvency requirements, age bands, appeals processes) while imposing what some might consider excess constraints on insurers.

The government would also collect and disseminate comparative information on quality (process and outcomes data) and costs of the participating plans. This appears to be the approach adopted in the Ryan 2012 budget plan. It calls for a “tightly regulated Medicare exchange for health plans” where plans would have to agree to offer insurance to all Medicare beneficiaries, avoid cherry-picking of the best risks and “ensure that Medicare’s sickest and highest-cost beneficiaries receive coverage.”¹⁶ Proposals are likely to vary in the extent to which such an exchange or similar entity sets rules and provides oversight relating to plan benefit packages, underwriting and rating practices, marketing and other plan operations.

A related design issue is whether all plans that meet program qualifications will be allowed to participate or should the program have the authority to contract more selectively? Currently, the MA and Part D programs allow any plan that meets specified standards to participate. The requirements for plan participation under FEHBP are more complex but OPM must contract with any qualified HMO. Enrollees “vote with their feet” which plans are the best; those that fail to meet beneficiary preferences lose enrollment. Such an approach also means that the administering agency is not put in the awkward political position of choosing among plans. The other possibility would be for Medicare to selectively contract with a limited number of plans in each area. This is the approach taken by many employment-based health benefit plans. Selective contracting would give program officials considerable leverage over plans seeking access to the Medicare market. Priority could be given to those plans, for example, meeting certain quality standards. Such an approach, with fewer plans, could raise the bar in terms of the quality of plans permitted to enroll beneficiaries. Further, there is some evidence that individuals make more informed choices when presented with fewer options. On the other hand, this approach would limit the choices available to beneficiaries. Moreover, some analysts doubt that a program as large as Medicare could negotiate effectively with multiple plans in each market area. Restricting participation might also create barriers to the entry of new plans into the market. This could, over time, undermine the development of efficient markets.¹⁷

Will the traditional Medicare program continue? Leading proposals differ in their approach with respect to the traditional Medicare program. Some premium support proposals envision the fee-for-service Medicare program continuing as one plan option competing with private plans for Medicare beneficiaries. This was the design of the premium support proposals advanced in the 1990s (e.g., the National Bipartisan Commission on the Future of Medicare), and was embraced in the Rivlin-Domenici proposal and adopted in the Heritage Foundation’s recent proposal. Other proposals, such as the Ryan 2012 budget plan, would maintain the existing fee-for-service program only for current beneficiaries. That is, after a certain date, new enrollees would no longer be allowed to enroll in the traditional program.

If traditional Medicare were to be closed to newly eligible beneficiaries as of a certain date, the government would have to manage the fee-for-service Medicare program for a shrinking, aging, and increasingly expensive population of beneficiaries. This would be particularly challenging if beneficiaries remaining in traditional Medicare were protected from paying more in premiums as a result of the deteriorating risk pool. Such a protection is included in the Ryan 2012 budget plan, although not specified is whether beneficiaries remaining in the traditional program

would also be protected from cost-sharing increases (e.g., the Part A deductible and coinsurance for physician visits under Part B).

If traditional Medicare were instead treated as just another competing plan under the new premium support program, a number of questions may arise, depending on how the program was structured. One such question is what would be the effect on premiums and cost-sharing under the traditional Medicare program. In particular, if under premium support, plans competed in an environment where government payments grew more slowly than health care costs, then beneficiaries in traditional Medicare would also be expected to experience a significant rise in premiums or erosion in benefits.

A second question is whether private insurers would participate. At least historically, insurers have opposed a program design in which they would have to compete head-to-head with traditional Medicare for Medicare enrollees because of the fee-for-service program's relatively lower administrative costs and lower costs for paying providers (since it sets reimbursement rates administratively instead of having to negotiate payment rates). Insurers have also raised concerns in the past debates about being disadvantaged relative to traditional Medicare because the same governmental agency that administers the competition among private plans and traditional Medicare (e.g., reviewing premium bids and otherwise setting the rules for the competition) would be setting provider rates and other rules for the traditional program. This latter concern might be addressed by making changes to Medicare's administrative structure. For example, under some past proposals,¹⁸ an independent board would have been established to administer the premium support program, paring back responsibilities of the existing Medicare agency (now the Centers for Medicare and Medicaid Services) to running the traditional program (and administering Medicaid). Issues arose, however, about the accountability of such a board.

Where beneficiaries have a choice between traditional Medicare and competing private plans, beneficiaries currently enrolled in traditional Medicare may not want to make a change if it would mean losing access to their current physicians. This is not just a convenience issue since discontinuities in care are associated with poorer health outcomes. Concerns arise too as to whether older and frailer beneficiaries are capable of making such plan decisions on their own, particularly if they lack the support of family or friends to help them with this process.

How would low-income Medicare beneficiaries be affected? Under premium support proposals, special measures may be needed to assure affordable plan options for lower-income beneficiaries. Proposals vary on whether such beneficiaries continue to have their plan premiums (and cost-sharing) subsidized through their state Medicaid programs, as under the Heritage and Domenici-Ryan proposals, or through additional federal plan payments and enriched benefits, the approach of the 1999 Bipartisan Commission and legislation which emerged from the Commission's recommendations.

For lower-income beneficiaries, especially, the smaller the government subsidy, the less choice they will have of plans. For example, if the government contribution for these low-income

beneficiaries is set to equal the value of the lowest cost plan in the area, the average cost plan in the area, or is tied to a fixed dollar amount that does not keep pace with premium growth, then they will not be able to afford to enroll in more expensive plans. It is possible that the lower-cost plans are the most efficient, cost-effective, highest quality plans. Alternatively, such plans may hold down their premiums through the use of inappropriate controls on utilization (e.g., denying coverage for medically necessary services) or through favorable risk selection.

The Ryan 2012 budget plan addresses lower-income beneficiaries in a very different way. It would provide for increased government help for low-income beneficiaries by depositing money for them in Medical Savings Accounts (MSAs) from which they could draw to pay plan cost-sharing amounts such as deductibles and coinsurance.¹⁹ Like the government's premium contributions for beneficiaries in general, the amount deposited into low-income beneficiaries' MSAs would increase each year by the CPI-U. The adequacy of the MSAs to cover premium and cost-sharing amounts would depend on both the level of the initial contribution and how well plan competition constrained health care costs. In the case of the Ryan 2012 proposal, the \$7,800 MSA contribution that would be provided to beneficiaries with incomes below 100 percent of poverty in 2022 is substantially less than the \$12,500 that CBO estimates as the average out-of-pocket spending for a beneficiary in the premium support program that year. This differential would widen over time.²⁰ Adequacy of the MSA contribution could be an even greater concern for low-income beneficiaries with high health care needs who use more than the average amount of services.

Those who support MSAs as a way to assist lower income beneficiaries to afford premiums and cost-sharing amounts may argue that MSAs gives beneficiaries more ownership of their health care budgets and encourages beneficiaries to shop prudently for their medical care. Critics may respond that MSAs may not be adequately funded to cover the costs of low-income beneficiaries with relatively high costs, which could result in beneficiaries going without needed medical care. Even if the accounts are adequately funded, the MSAs may impose hardships, particularly on frail and disabled individuals and make it difficult for them to transact with their health care providers, particularly if they fail to draw on their accounts to pay their medical bills.²¹

Will Medicare contributions toward the costs of medical education, urban safety net hospitals and rural health care continue? Over the years, policy makers have chosen to reach beyond Medicare's pure insurance function to support other missions, such as the training of medical interns and residents and provision of care in rural areas and by hospitals that serve a predominantly low-income population. These missions have generally been accomplished through various adjustments in Medicare fee-for-service payments to hospitals. For example, in fiscal year 2010, the Medicare program made \$9.5 billion in payments to hospitals for graduate medical education, \$10.8 billion for hospitals serving a disproportionate share of low-income people, while the vast majority of rural hospitals receive some type of special payment adjustment. Whether and how to continue to provide federal support for these missions through Medicare or a substitute funding stream would need to be addressed in developing a premium support approach to restructuring the program.

Is premium support the same as the FEHBP? Proponents of premium support options also often suggest as a model the Federal Employees Health Benefits Program (FEHBP), which offers multiple plans to federal employees (including Members of Congress) and annuitants.²² In the emerging debate, premium support proponents are using “FEHBP-like” to describe their proposals.²³ They vary, however, in the extent to which they adopt FEHBP’s major design features and the differences can often be significant.²⁴ Most important is that under FEHBP, the government’s premium contribution for any qualified plan keeps up with health care costs by being tied to a specific percentage (72%) of the average plan premium. The average FEHBP premium is a program-wide average of the enrollment charges for all individuals who are eligible to receive a government contribution, with separate determinations for self only and for self and family enrollments. Under some premium support proposals, the government contribution would be tied to a specific base dollar amount and then allowed to grow for some measure of inflation rather than grow with the cost of care, thus shifting costs onto beneficiaries.²⁵

Potential Implications

Restructuring Medicare from a defined benefit program to a defined contribution program such as premium support has significant implications for the federal budget, Medicare beneficiaries, and the health care system as a whole.

Implications for the Federal Budget

When looked at solely from a budgeting perspective, converting Medicare to a premium support program offers substantial advantages. In particular, it could make federal Medicare expenditures predictable and easy to control, which is not a strength of the current program. Medicare is a large and fast-growing part of the federal budget, comprising 15% of expenditures in 2010 and projected to grow to 17% by 2021 and more in the years beyond.²⁶ The growing enrollment resulting from retirement of the baby boom generation coupled with the long-standing national trend of rapid growth in health care costs contribute to projected Medicare expenditure growth.

Controlling growth in Medicare expenditures is a major challenge, technically as well as politically. The health care system is complex, and efforts to change the behavior of participants within it can produce unintended consequences. In particular, the traditional fee-for-service program is vulnerable to increases in the volume and intensity of services provided per beneficiary, whether or not the services improve health outcomes. The ACA includes a number of changes to address this by linking Medicare payment to quality of care measures, aligning incentives across providers to promote more efficient use of services, and improving information about the comparative effectiveness of health care interventions. For the most part, savings from these delivery system changes are not easily predicted until they are put into effect; thus, these approaches may not satisfy those looking for certainty of large and immediate budget savings.

By contrast, replacing Medicare with a premium support plan could make expenditures predictable because the government's contribution toward the cost of health care for each Medicare beneficiary would be known in advance. Moreover, the amount could be adjusted to keep within specified federal budgetary goals. This is particularly true of proposals that do not link the government contribution to underlying plan premiums. Under these models, federal savings could occur regardless of whether total Medicare costs were kept under control. For example, as described earlier, CBO estimates in its analysis of the Ryan budget plan that the total cost of providing the same benefits would be higher under premium support than under fee-for-service Medicare.

A potential threat to achieving budget savings is if, as has occurred in the past under the Medicare Advantage program, relatively high government payments are required in order to attract sufficient participation by private plans. When cuts to private plan payments were enacted in the 1990s, many plans ceased participation with Medicare. If, when combined with beneficiary contributions, premium support payments are deemed insufficient by plans, plan choices could become too limited to sustain the type of competitive system envisioned by premium support advocates. This is a particular concern for plans like the Ryan budget, under which the traditional Medicare program would not be available as a "safety net" plan choice.

Although budget predictability is a potential advantage of a premium support system, the potential effects of this predictability on the availability and affordability of health services to Medicare beneficiaries are controversial. That is, would beneficiaries, private plans and providers adapt to ensure that beneficiaries can afford needed services within the constraints of a premium support plan as proponents expect, or would the cost of health care coverage become burdensome for all but the most well-off beneficiaries as opponents fear?

Implications for Medicare Beneficiaries

Replacing Medicare with a premium support system would completely change the Medicare entitlement that has been provided to the elderly and disabled for nearly 50 years. Under current law, beneficiaries are entitled to a defined set of benefits which are subsidized by the federal government. Under any of the premium support proposals under discussion, beneficiaries would instead be guaranteed a government subsidy, which may or may not be sufficient to provide the current Medicare benefits and premium contributions would be required as a condition of receiving any Medicare benefits, although proposals generally make some type of accommodation for low-income beneficiaries. Under variants of premium support, such as the Heritage Foundation's proposal, Medicare government contributions would be eliminated entirely for higher-income Medicare beneficiaries. So, even though they contributed Medicare payroll taxes during their working life in expectation of receiving Medicare, they would no longer be eligible for benefits from the program.

Under the premium support proposals being currently debated, beneficiaries would likely initially experience increased out-of-pocket costs for services covered under Medicare

compared with what they would experience under current law. Over time, if market competition among private insurance options failed to hold down the growth in premiums and health care costs more generally, the share of Medicare costs borne by beneficiaries would steadily rise, eroding with each year the generosity of Medicare's coverage. As detailed above, the extent of such cost shifting to beneficiaries would depend on how government contributions were determined, and would be greatest under those proposals that would delink the contributions from the cost of Medicare benefits. In terms of increased burdens on beneficiaries, the most dramatic option would be to tie the growth in government contributions to a measure of inflation such as CPI that has historically been far lower than per beneficiary increases in Medicare costs.

Lower-income beneficiaries would be particularly vulnerable under a premium support system unless the proposal included significant premium and cost sharing subsidies. High levels of subsidies are unlikely to the extent that premium support is used as a means to achieve reductions in Medicare program spending. Currently, low-income beneficiaries are guaranteed the same standard benefits as any Medicare beneficiary, with the freedom to choose health care providers. Premium and cost sharing assistance and Part D subsidies are available in some form for those with incomes up to 150% of the federal poverty line.²⁷ Even if similar premium and cost sharing assistance is provided under a premium support system, depending on the details of the plan, these beneficiaries might have fewer plan options available to them, and the lower-cost plans may provide less generous Medicare benefits than other plans, meaning higher out of pocket burdens for enrollees. Of critical importance would be the interaction between proposed Medicare and Medicaid reforms, which would affect as many as nine million dually-eligible beneficiaries if a premium support plan were to be implemented this year.

As cost-sharing rises for beneficiaries, utilization of health care would be expected to decline. This could mean a sharp reduction in both unnecessary as well as necessary services, the effects disproportionately experienced by lower-income beneficiaries if adequate subsidies are not provided to cover the gaps. To the extent that beneficiaries forego or delay necessary care, poorer health outcomes can be expected. Increased Medicare program costs could also result if delayed care results in increased severity of illness and the need for more expensive medical interventions.

Under the current program, virtually all people ages 65 and older are entitled to and covered by Medicare unless they have another source of health insurance coverage, such as an employer plan. Such universal coverage is not a given under a premium support system – in the absence of strong financial incentives to enroll in a plan. Some individuals could choose to forgo health insurance coverage if they consider the required premium contribution to be unaffordable, as noted by the CBO with respect to the Ryan 2012 budget proposal. As described above, the extent to which a growing share of seniors could become uninsured in the future would depend on key design features, such as how the government contribution is calculated, adjusted for beneficiaries' age, health status, and locale and then increased over time and the permissible variation in benefits offered by private plans.

Implications for Health Plans and Health Care Providers

Private insurers and health plans would be directly affected by a plan to convert Medicare to a premium support system. Implications for insurers would depend on the level of the government's contribution per enrolled beneficiary, the standards for plan participation and enrollment rules and the extent to which they regarded the government as a reliable business partner.

Under the current Medicare Advantage program, private insurers cover about 26 percent of Medicare beneficiaries, the highest rate since private plan options first became available to most beneficiaries beginning in the 1980s. An opportunity to significantly expand that market under premium support has the potential to be very attractive to private insurers. The Medicare Advantage experience, as well as that of Medicare Part D, suggests that private plans will be most responsive to participation if they believe that the government will be a good business partner in terms of predictable requirements, including plan standards and oversight, provides for sufficient flexibility for them to build off their existing operations and provider networks and, most importantly, whether they believe that they can effectively compete with other participating plans given the level of government support (contribution amounts, low-income subsidy payments and ability to attract beneficiaries by offering more attractive benefits).

The level of government contribution has been a critical variable in determining the status of the Medicare Advantage and predecessor private plan programs. Plan participation has been highest (as has beneficiary enrollment) when government payments have, on average, been higher than the costs to those plans for providing Medicare's covered benefits. Participation has been lowest in periods when the government's payments per beneficiary have, on average, been closer to underlying plan costs.²⁸ As noted above, when plan payments were limited in the 1990s, many insurers pulled out of Medicare, leaving their enrollees to find new plans or return to traditional Medicare. Thus, if payments to plans are constrained and plans are subject to requirements that they perceive to be too restrictive, then plans tend to react by limiting their service areas or pulling out of the Medicare program altogether.

The Medicare Part D experience showed the attractiveness to private insurers of expanding their Medicare business under a program structure that shares elements of premium support. Initial concerns about the ability of the program to attract sufficient plan participation throughout the U.S. have not borne out. Regardless of where they live, Medicare beneficiaries can choose among a large number of different stand alone-Part D plans with varying benefit designs. For the low-income subsidy population, however, available plan options have been less predictable and stable as plans have responded to adverse selection by increasing their premiums and changing their benefit designs.²⁹

One of the most critical design issues for insurers with respect to a premium support restructuring is that traditional fee-for-service Medicare be treated as one of many competing plans under the same set of rules and not operated as a parallel program. This stems from their

concern that traditional Medicare would otherwise be at a competitive advantage because of its lower administrative costs and greater leverage over provider reimbursement. (A contrary perspective is that traditional Medicare would likely experience significant adverse selection because it would likely attract the sickest beneficiaries.)

Health care providers also could be significantly affected by the change to a premium support system. Rates paid by private plans are generally higher than those set by the government under the traditional Medicare program, and CBO believes this would continue to be the case under premium support system. Even so, if government contributions are limited, beneficiaries may seek to enroll in lower-premium plans that offer less generous provider reimbursement rates, impose stronger utilization controls or require higher beneficiary cost sharing, all of which have implications for provider revenue. Plans with higher cost sharing require providers to collect a larger proportion of their reimbursement directly from beneficiaries. Moreover, providers would face lost revenue and increased uncompensated care if/when, as noted above, some Medicare-eligible individuals chose to forgo health insurance due to the cost and become uninsured.

Some providers could be disadvantaged if they are not sufficiently included in the provider networks of the private plans available to Medicare beneficiaries in their area, depending on whether or not there are requirements on participating plans with respect to the scope of provider networks. Finally, providers that have relied upon additional Medicare payments, such as teaching hospitals, those serving a disproportionate share of low-income individuals and those in rural areas, could be disadvantaged depending on what decisions were made as to how these payments are handled under a premium support approach.

Implications for the Health Care System

Medicare is the single largest purchaser of health services, financing one in five dollars spent on health care services nationally, and as a result, the program's policies influence the broader health system in many ways. For example, since the mid-1980s when Medicare shifted its method of paying for inpatient hospital care from a per-day system to a per-discharge system, hospital stays have shortened and the proportion of national health expenditures for hospitals has declined from about 39 percent to 30 percent.³⁰ While changes in health care technology allowing for greater use of outpatient surgery were also a factor, the delivery system was quick to react to incentives offered by Medicare payment policies because the program is a larger source of revenue. In addition, private payers sometimes use Medicare policy as a benchmark in negotiating payment rates, particularly for physician fees. Thus, a complete restructuring of Medicare into a premium support or voucher program has implications for changes beyond the boundaries of the Medicare program itself.

Recent efforts to use Medicare's leverage as a very large purchaser to encourage health care delivery system changes that would reduce costs for all payers, not just Medicare, could be undermined if Medicare expenditures were diffused among a large number of private plans. For example, efforts at encouraging provider cooperation such as the creation of accountable care

organizations or the introduction of bundled payments across providers for an episode of care would have to be adopted and perhaps coordinated among multiple competing private plans in order to have the same impact. The premium support system could be designed to limit choice of plans to those involving integrated care networks or those that use certain cost control tools, but typically premium support proposals would rely on market competition rather than federal regulation to lower health care costs. Indeed proponents of premium support believe that this market competition will prove more effective than changes in Medicare fee-for-service payment policy in reducing costs. If so, Medicare's fee-for-service leverage would not be required to promote cost-saving delivery system changes.

A conversion to premium support would also require decisions about whether to continue federal support for medical training and sustaining hospitals serving low-income populations and those located in rural areas. If such support were to be continued in the absence or diminished condition of the Medicare fee-for-service payment system, to what degree and through what mechanism would this occur? If the federal government's substantial support for medical education and rural and safety net hospitals were eliminated or severely reduced, some of the costs would probably be shifted to private payers, local governments and other potential funding sources, but in some situations services would likely be reduced, medical training opportunities might become more limited, and some hospitals may not be able to continue operating with a reduction in this funding.

In its 1999 report, the National Bipartisan Commission on the Future of Medicare recognized the need to address these roles, and recommended that the Congress examine all of Medicare's non-insurance functions, special payments and subsidies to determine whether they should continue to be funded by Medicare or from another source. It offered that payments for direct medical education would be financed and distributed independent of a Medicare premium support system, either as a mandatory entitlement or multi-year discretionary appropriation program.

Concluding Observations

A comprehensive restructuring of Medicare as envisioned under a defined contribution approach like premium support or vouchers would rearrange billions of dollars and affect tens of millions of beneficiaries, hundreds of thousands of health care providers, and numerous others who have a stake in the Medicare program, such as suppliers and financial investors. Its success at ensuring that the Medicare program continues to meet the health care needs of its beneficiaries would depend on the details of the premium support or voucher systems and how all of these interests respond to changing incentives. One small turn of a policy knob (e.g., the nature of the benefit package or the amount of the premium contribution paid by the government) could have a dramatic effect on beneficiaries' access to services, their out-of-pocket costs, and whether the program ultimately increases or decreases federal expenditures for Medicare.

Ambitious reform in any realm presents challenges but the hurdles faced by policymakers seeking major changes for a popular program like Medicare may be especially high given the age, disability, and health care needs of the population it serves. That said, the long-term sustainability of Medicare is likely to require major changes, which could include program restructuring along the lines discussed in this brief or alternative measures including delivery system changes that build upon those enacted in the ACA, increasing payroll taxes, finding new sources of revenues for the Medicare trust funds, or modifications to eligibility based on age or other criteria.

APPENDIX – MAJOR PROPOSALS: PAST AND PRESENT

The emerging themes of today's debate over the future of Medicare are similar to those that emerged in previous periods, beginning in the 1980s. The basic structure of the proposals and the arguments for and against, as well as the makeup of the groups likely to support and oppose, remain much the same. Although previous major efforts to fully remake Medicare into a voucher or premium support program were not successful, Congress had vouchers in mind when it addressed Medicare restructuring as part of the 1995 Balanced Budget Act, which was vetoed by President Clinton, and premium support when it redesigned the private plan options for Medicare both in 1997 as part of the Balanced Budget Act and in 2003 as part of the Medicare Modernization Act.

Past Proposals

Against the background of a prolonged recession and rising deficits, escalating Medicare program costs and impending shortfalls in its Hospital Insurance (HI) Trust Fund spurred interest in Medicare reform throughout much of President Reagan's first term. A Medicare voucher program was included in Reagan's FY 1981 budget proposal, followed by the introduction in 1982 by Representatives Gephardt (D-MO) and Stockman (R-MI) of a Medicare voucher proposal as part of a deficit reduction package. The measure was ultimately dropped by a House-Senate conference committee.³¹ The enactment in 1983 of major changes to Medicare's hospital payment system, as well as other changes to increase HI Trust Fund revenues, helped to abate the most immediate concerns about Medicare's financial status.

Throughout the remainder of the 1980s and early 1990s, Medicare voucher proposals were introduced in Congress but given little serious attention. In 1995, the new Republican-led Congress adopted legislation that was influenced by proponents of Medicare vouchers as part of the Balanced Budget Act (BBA) of 1995.³² An impetus again for Medicare restructuring was concern with rising federal deficits and projections that the HI Trust Fund faced insolvency within seven years. Another contributing factor was interest on the part of many Congressional Republicans in privatizing federal social insurance programs.

The BBA of 1995 would have transformed the then relatively small Medicare managed care program, which operated parallel to traditional Medicare in many but not all parts of the country, into "MedicarePlus," a program in which all Medicare beneficiaries would be given a choice between the traditional program and an array of private plan options.³³ For each beneficiary, the government would contribute monthly a predetermined amount of money, adjusted for the beneficiary's age, gender, and other factors. If the contribution amount was higher than needed to cover the anticipated costs of the average Medicare beneficiary, the plan would either have to provide additional benefits, a cash rebate or combination of both. If the plan cost more than the government's contribution, the beneficiary would have to pay the difference.³⁴

President Clinton vetoed the BBA of 1995.³⁵ As an alternative, his administration developed a proposal to give traditional Medicare more tools and flexibility to manage program costs and improve quality of care, while at the same time changing the payment methodology for Medicare's private plan options. The proposal, not acted on by Congress, included a number of key ingredients of premium support, including introduction of a competitive bidding process for determining payments to the private plans. One significant departure from premium support, however, was retaining a separate, traditional Medicare program and not placing it in direct competition with the private plan options.³⁶

The Balanced Budget Act (BBA) of 1997, which was negotiated by the Republican-led Congress with the Clinton White House, redesigned Medicare's private plan options (Medicare+Choice) but did not adopt basic elements of vouchers or premium support. Congress did include in the law authorization for the Medicare program to conduct a Competitive Pricing Demonstration under which government payments to participating private plans in a few areas of the country would have been based on different competitive bidding designs and not on the existing administrative pricing system. The demonstration never got off the ground, however, due to the lack of interest on the part of plans in the demonstration states. One of their major concerns was that traditional Medicare would not have been part of the bidding, potentially leaving the plans at a competitive disadvantage.³⁷

The next major debate over vouchers and premium support came as part of the work of the National Bipartisan Commission on the Future of Medicare, authorized by the BBA of 1997. A Commission report, due by March 1, 1999, was to identify problems that threatened the financial integrity of the HI Trust Fund and analyze potential solutions. Of particular concern was long-term program sustainability once the baby boom generation attained Medicare eligibility, beginning in 2011.

While the 17-member Commission fell short by one vote of achieving the super majority required to officially recommend a plan to Congress for solving Medicare's long-term financing problems, its Chairman, Senator Breaux (D-LA) along with Senator Frist (R-TN) introduced legislation in the 106th Congress based on the Commission's work. Commissioners voting against the plan raised a variety of concerns, including its potentially adverse implications for beneficiaries in terms of costs and access to care. The bill called for a new "FEHBP-like" approach to reforming Medicare, building upon the premium support conceptual framework promoted by Aaron and Reischauer.³⁸ Under this and successor legislation introduced by Senators Breaux, Frist and Representative Thomas (R-CA), Medicare was to be changed into a program in which private health plans competed on an equal footing with traditional Medicare. To control program expenditures, Medicare would provide a fixed contribution to the plan chosen by the beneficiary. Options would include private plans meeting certain criteria and the government-administered traditional Medicare plan. The government's contribution amount would be tied to the enrollment-weighted average of plan premiums for a core set of benefits, adjusted for geography and risk. (Weighting for enrollment would ease the effect of the transition on traditional Medicare where the majority of beneficiaries would likely remain for the first few years.) Beneficiaries who elected a plan charging a higher premium than the

government's contribution would pay the difference out-of-pocket.³⁹ Low-income beneficiaries would enroll in the lowest-cost, high-option plan available to them (which would include coverage of prescription drugs).

Although premium support proposals based on the Bipartisan Commission's work were debated through the later years of the Clinton and early years of the Bush Administrations, none were enacted. George W. Bush endorsed premium support as a presidential candidate in 2000 and promoted it as President. In the lead-up to enactment of the Medicare Modernization Act of 2003 (MMA), which added an outpatient prescription drug benefit to Medicare, the Republican-majority House passed a provision to transform Medicare into a premium-support system by 2010. The provision was later replaced by a "Comparative Cost Demonstration,"⁴⁰ to test over a six-year period (beginning in 2010) in up to six areas whether direct competition between private plans and traditional Medicare would "enhance competition, improve health care delivery for all Medicare beneficiaries, and provide for greater beneficiary savings and reductions in government costs."⁴¹ As was the case for previous premium support proposals, opponents took issue with the provision's treatment of traditional Medicare, arguing that it would lose out to private plans in the enrollment of healthier (less costly) beneficiaries because only the sicker beneficiaries, with long established relationships with their physicians, would fail to enroll in the private, mostly managed care, plans.⁴² In a head-to-head competition on premiums, traditional Medicare would experience the effects of ever worsening risk selection. The Demonstration authority was repealed in 2010 as part of the ACA.⁴³

In the MMA of 2003, Congress also revamped Medicare+Choice (M+C) into the Medicare Advantage (MA) program. Some would argue that the MA program, which gives beneficiaries a choice of private plan options as an alternative to traditional FFS Medicare, shares some key features of the FEHBP and premium support proposals. There are major differences, however, between the way current Medicare works, with traditional Medicare and MA plans operating under different rules, and the vision of premium support in which traditional Medicare is treated as one of many competing plans under the same set of rules. Important to note too is that the MA program and its predecessor M+C and risk-contract programs have never achieved the program savings that were expected as a result of giving beneficiaries an option of enrolling in private plans.⁴⁴

Current Proposals

Driven by concerns about federal deficits and long-term program sustainability, some in Congress have called for Medicare to be restructured into a defined contribution program along the lines of premium support or vouchers. In addition, a number of bipartisan commissions have issued recommendations for restructuring Medicare as part of their blueprints for reducing the federal deficit and national debt.⁴⁵ At this writing, some of these proposals tend to be more conceptual than specific, giving only outlines of the recommended policy changes.

Ryan 2012 Budget. Chairman Ryan proposed a Medicare restructuring plan in April 2011 as part of his fiscal year 2012 federal budget proposal.⁴⁶ He first proposed a Medicare voucher

proposal in the “Roadmap to America’s Future Act,” a comprehensive proposal for reform of federal entitlement programs and the tax code, initially offered in 2008.⁴⁷ Joined by Dr. Alice Rivlin, in 2010 he proposed Medicare restructuring as part of a plan to limit federal spending on the Medicare and Medicaid programs.⁴⁸ The 2012 budget plan, described as being built on the Rivlin-Ryan proposal, is labeled by Rep. Ryan as premium support and he distinguishes it from his Roadmap voucher proposal because federal payments would go directly to private health plans and not to beneficiaries. The 2012 budget plan, passed by the House of Representatives on April 15, 2011, assumes enactment of the Ryan Medicare approach.⁴⁹

The Ryan proposal is not fully specified, and may continue to evolve, but as described to date, the core of the plan is that future Medicare beneficiaries, specifically those who become eligible for Medicare in 2022 or later would not be enrolled in the traditional Medicare program. (The age of Medicare eligibility would be increased by 2 months each year beginning in 2022, reaching age 67 in 2033.) Instead, a federal payment would be made on their behalf toward the cost of a private health insurance plan chosen by them from among those available on a new “Medicare exchange.” Beneficiaries would be liable for any additional premium and might receive some or all of the difference if their chosen plan premium was less than the amount of the federal payment.

The Medicare payment amount under the Ryan 2012 budget would be determined based on an estimate of the average annual per-capita cost of traditional Medicare in 2022 (net of beneficiary premium contributions) for a 65-year old beneficiary, increased annually thereafter by growth in the all-urban consumer price index (CPI-U) and adjusted for enrollee age. The Congressional Budget Office (CBO) estimates that the 2022 amount for a 65-year old would be \$8,000, in contrast to an average spending of \$15,000 for those older beneficiaries remaining in traditional Medicare. No payment adjustment is indicated for geographic differences, a feature of the earlier Ryan Roadmap and Rivlin-Ryan proposals.

Also under the Ryan 2012 budget proposal, higher-income beneficiaries would receive a reduced federal payment, while lower-income beneficiaries would be given additional support. The additional assistance for low-income beneficiaries would be in the form of a medical savings account (MSA) from which they could draw to cover out-of-pocket expenditures, including both premiums and cost sharing. MSA amounts, valued at \$7,800 in 2022 and indexed to grow by the CPI-U, would be provided to beneficiaries with incomes below the federal poverty level, according to the CBO. The premium support reductions for higher-income beneficiaries would apply so that beneficiaries with incomes in the top 2% of income for the Medicare-eligible population would receive amounts equal to 30% of the premium support payment, while those in the next 6% of the income distribution would receive 50% of the payment amount.

The Ryan budget plan indicates Medicare payments would vary with the health status of the beneficiary, but the mechanism is not described. In addition, the Centers for Medicare and Medicaid Services would manage a “risk review audit” system under which fees would be

collected from plans that, on average, have healthier enrollees and redistributed to plans with less healthy enrollees.

The Ryan budget describes the plan choices available on the Medicare exchange as “tightly regulated,” indicating that plans would be required to accept any beneficiary. No other health plan requirements are specified in the budget plan, but according to the CBO analysis of the Ryan budget, premiums would be allowed to vary by age of beneficiary, and a benefit standard would be established by the Office of Personnel Management. By contrast, the original Ryan Roadmap voucher plan describes the creation of a list of “Medicare-certified” plans, yet indicates that beneficiaries would not be restricted to this list in choosing a private plan.

The current Medicare program would be maintained for individuals who became eligible for benefits prior to 2022, although these beneficiaries would have the option of switching into the premium support program. Adjustments would be made to protect beneficiaries staying in the original Medicare program from premium increases that would otherwise occur as a result of the shift of all new beneficiaries into private plans.

Simpson-Bowles. Most prominent among the commissions with Medicare recommendations is the National Commission on Fiscal Responsibility and Reform, created through Executive Order by President Obama and chaired by Alan Simpson and Erskine Bowles.⁵⁰ Although the Commission did not endorse premium support for Medicare, it did recommend that a “defined contribution premium support” approach be applied to FEHBP, noting though that such an approach “holds significant promise of controlling costs, but also carries serious potential risks.” In addition, the Commission said that redesigning FEHBP in this manner would afford an opportunity to assess the effects of premium support on costs, health care utilization and outcomes, helping to inform considerations about whether premium support is appropriate for restructuring Medicare. It also recommended that if the aggregate average cost growth of our health care system exceeded a specified target over a five year period, then structural reforms such as Medicare premium support should be pursued.⁵¹

Domenici-Rivlin. A strong endorsement for Medicare premium support was included in the recommendations of the Bipartisan Policy Center’s Debt Reduction Task Force, chaired by Pete Domenici and Alice Rivlin. Under its plan, Medicare would be transitioned to a premium support program, beginning in 2018.⁵² Growth in per-beneficiary Medicare spending would be limited to a five-year moving average of the growth in GDP plus 1 percentage point.⁵³ Medicare beneficiaries who elected traditional Medicare would have to pay an additional premium if the per capita costs of that program rose faster than this limit. Beneficiaries who elected a private plan option would not have to pay the extra premium. Competition among private plans for the enrollment of beneficiaries would be encouraged by the creation of a “Medicare Exchange,” through which participating plans would be given incentives to develop products that save beneficiaries money, including rebates of premiums. However, Medicaid would continue to subsidize Medicare premiums for low-income beneficiaries.

Committee for a Responsible Budget. In late 2010, the Committee for a Responsible Federal Budget published a set of proposals to focus the national discussion on the need for and options to reduce the deficit.⁵⁴ To achieve control of health care costs over the long-run, the Committee identified two options: (1) putting Medicare on a predetermined fixed budget or (2) transforming it into a premium support program. The elements for Medicare premium support largely track those described above for the Domenici-Rivlin proposal but do not include a “Medicare Exchange.”

Heritage Foundation. The Heritage Foundation has proposed converting Medicare to a premium support system as part of its broad budget package, *Saving the American Dream*, released in May 2011.⁵⁵ Similar in design to the Breaux-Thomas plan of 1999, the Heritage proposal would build on the existing Medicare Advantage and Part D plan structure, and would maintain a modified fee-for-service Medicare plan as a competing plan option that any Medicare beneficiary could choose. To begin, the government contribution would be set at 88 percent of the weighted average premium of competing plan bids for an area, and after 5 years it would equal 88 percent of the lowest plan bid in the area. Benefits under the premium support proposal would combine coverage under Medicare Parts A, B and D, plus add a new catastrophic benefit.

The government contribution would be reduced or eliminated for higher income beneficiaries. Reduced contributions would be made for individuals and couples with incomes between \$55,000 and \$110,000 respectively (amounts indexed to inflation). For those with incomes above \$110,000/\$165,000 the Medicare benefit would be eliminated entirely. Heritage estimates that at this level 3.5% of individuals otherwise eligible for Medicare would receive no government benefits, while 90% would have no reduction in their government contribution. The fee-for-service Medicare program would be modified to introduce a Part A premium and increase the premiums for Parts B and D to match the income contribution scale established for private plan contributions. A catastrophic cap would be added to the fee-for-service program, and cost sharing would be adjusted to keep the actuarial value of Medicare benefits at its present level.

Under the Heritage proposal, dual eligibles may not have the same plan choices as other beneficiaries. For dual eligibles remaining enrolled in the Medicare fee-for-service program, the Heritage proposal would provide Medicaid coverage for premiums and cost sharing, although the extent of this coverage is not clear. If, however, a dual eligible beneficiary chose to enroll in a private plan, they would only receive Medicaid benefits to cover premiums and cost sharing if the state opted to provide this coverage.

This report is a product of the Kaiser Family Foundation’s Project on Medicare’s Future, a major initiative of the Foundation’s Program on Medicare Policy. The Project is supported in part by a grant from Atlantic Philanthropies. The Kaiser Family Foundation is solely responsible for the work of the Project.

¹As discussed in the Appendix to this paper, Rep. Ryan proposed earlier versions of Medicare restructuring that he described as a voucher plan. This latest version is referenced by him and by the Congressional Budget Office as premium support.

²The House of Representatives approved H.Con. Res. 34, establishing the budget for fiscal year 2012 and setting forth budgetary levels for fiscal years 2013 through 2021, on April 15, 2011, by a vote of 235-193. The budget resolution is pending in the Senate.

³Alice Rivlin was the Director of the Office of Management and Budget under President Bill Clinton; Pete Domenici is a former Senator from New Mexico and was Chair of the Senate Budget Committee.

⁴Traditional Medicare refers to Medicare Parts A and B. Beneficiaries enrolled in traditional Medicare have an option to enroll in a free-standing Part D, prescription drug plan for coverage of outpatient prescription drugs. Many beneficiaries enrolled in traditional Medicare may also have supplemental coverage through a retiree health plan or a Medigap plan which helps pay for the Part B premium and Part A and B cost-sharing requirements. Alternatively, a beneficiary may elect to enroll in a Part C, Medicare Advantage plan. Such plans must cover all Part A and Part B services and may offer coverage of non-Medicare covered services, such as vision care. Medicare Advantage organizations offered benefit packages with and without Part D prescription drug coverage.

⁵Aaron, Henry J. and Robert D. Reischauer, *The Medicare Reform Debate: What is the Next Step?* *Health Affairs*, vol. 14, no. 4, Winter 1995, p. 8-30; Reischauer, Robert D.; Medicare: Beyond 2002, in Altman, Stuart et al, eds., *Policy Options for Reforming the Medicare Program: Papers from the Princeton Conference on Medicare Reform*, Robert Wood Johnson Foundation, July 1997, p. 97-111. Alain Enthoven is credited with articulating early versions of premium support for the fee market. Enthoven's original proposal, presented in the late 1970s, envisioned an array of private plans competing for enrollees on the basis of price and quality. Consumers would spur competition by choosing their preferred plans with their feet. They would weigh factors such as quality and access to providers against the cost of the different options and choose the plan that best met their medical and financial needs. Premium support would encourage plans to be efficient so that they could offer coverage with competitive premiums. Enthoven, Alain, Consumer Choice Health Plan." *New England Journal of Medicine* 298, 1978; Enthoven, A. and Kronick, Rick, A Consumer-Choice Health Plan for the 1990s. *New England Journal of Medicine* 320 (1): 29-37, 1989; Enthoven, Alain, Reforming Medicare by Reforming Incentives, *New England Journal of Medicine*, May 11, 2011. <http://healthpolicyandreform.nejm.org/?p=14437&query=home>

⁶Aaron, Henry, "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/>. See also Aaron, Henry, How *Not* to Reform Medicare, *New England Journal of Medicine*, April 6, 2011.

⁷Aaron, Henry, 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/>

⁸Kaiser Family Foundation, analysis of fee-for-service expenditures in the CMS Medicare Current Beneficiary Survey Cost and Use file, 2006.

⁹Frogner, B.K., et al., Incorporating New Research into Medicare Risk Adjustment, *Medical Care*, 2011 Vo. 49, No. 3: 295-300; Congressional Budget Office, *Designing a Premium Support System for Medicare*, December 2006; Jason Brown et al., *Does Risk Adjustment Reduce Selection in the Private Health Insurance Market? New Evidence from the Medicare Advantage Program*, (preliminary and incomplete paper), September 2010, available at www.econ.wisc.edu/workshop/ma-sept28.pdf

¹⁰Medicare spending per beneficiary from *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, August 2010, Table V-B1; GDP and CPI data from *The Economic Report of the President, 2011*, Tables B-1 and B-60.

¹¹Linking government contributions to an alternative measure such as the per capita growth in program premiums, would keep contribution levels in line with plan premium trends but may not achieve desired budgetary savings.

¹²Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan," Letter to Rep. Paul Ryan, April 5, 2011, www.cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf.

¹³Plans with premiums below the government's contribution might be required to rebate the difference or "savings" in the form of a reduced premium, provide the beneficiary with extra benefits, or return some or all of the difference to the government. This is the basic design under the existing Medicare Advantage program. Another possibility would be to permit the insurance plan to retain all or some of the amount, either to be used in any way the plan wants (e.g., for profit) or to build its reserves as a cushion in the event that the plan's actual costs for paying claims

exceeds their projected revenues collected from premiums. The latter appears to be what is envisioned under the Ryan 2012 budget proposal, although this is a detail that has not yet been provided.

¹⁴ Kaiser Family Foundation, *Proposed Changes to Medicare in the "Path to Prosperity," Overview and Key Questions*, April 2011, www.kff.org/medicare/upload/8179.pdf.

¹⁵ Gold, Marsha, *Strategies for Simplifying the Medicare Advantage Market*, Kaiser Family Foundation, July 2009, www.kff.org/medicare/upload/7935.pdf; Hoadley, Jack, Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries, Commonwealth Fund, May 30, 2008, www.commonwealthfund.org/Content/Publications/Issue-Briefs/2008/May/Medicare-Part-D--Simplifying-the-Program-and-Improving-the-Value-of-Information-for-Beneficiaries.aspx

¹⁶ U.S. House of Representatives, Committee on the Budget, *Pathway to Prosperity*, Fiscal Year 2012 Budget Resolution. 2012, <http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf>

¹⁷ National Academy of Social Insurance, April, 1998, p. 20

¹⁸ See, for example, the proposal developed by the Bipartisan Commission on the Future of Medicare in 1999, <http://thomas.loc.gov/medicare/bbmtt31599.html>.

¹⁹ State Medicaid programs could continue to help eligible low-income beneficiaries pay for services (e.g., nursing home care) not covered by Medicare as they do today, but their capacity to do so might be considerably reduced under the Ryan plan's block granting of federal Medicaid dollars.

²⁰ Kaiser Family Foundation, *Proposed Changes to Medicare in the "Path to Prosperity," Overview and Key Questions*, April 2011, www.kff.org/medicare/upload/8179.pdf.

²¹ Indiana and Florida have adopted forms of health savings accounts for their Medicaid beneficiaries. For a critical perspective, see Utah Health Policy Project, *Health Savings Accounts: Poor Choice for Medicaid & the Low-Income Uninsured*, updated September 15, 2008;

www.healthpolicyproject.org/Publications_files/Medicaid/2008/MedicaidHOAHSAFactsheet9-15-08.pdf. The challenges in educating Medicaid beneficiaries in the use of such savings accounts is discussed in Barth, John and Jessica Greene, *Encouraging Healthy Behaviors in Medicaid: Early Lessons from Florida and Idaho*, Center for Health Care Strategies, July 2007; www.chcs.org/usr_doc/Encouraging_Healthy_Behaviors_in_Medicaid.pdf

²² The California Public Employees' Retirement System also is frequently described as a premium support program.

²³ Moffit, Robert E. and James C. Capretta, *How to Fix Medicare: A New Vision for a Better Program*, Heritage Foundation Backgrounder No. 2500, December 13, 2010, www.heritage.org/research/reports/2010/12/how-to-fix-medicare-a-new-vision-for-a-better-program.

²⁴ For the details on the government's contribution under FEHBP, see: Office of Personnel Management, *Frequently Asked Questions About FEHBP Premiums*, www.opm.gov/insure/health/faq/premiums.asp#2

²⁵ Reinhardt, Uwe, Comparing Ryan's Medicare Plan to What Congress Gets, *New York Times*, April 18, 2011, <http://economix.blogs.nytimes.com/2011/04/18/comparing-ryans-medicare-plan-to-what-congress-gets/>

²⁶ Congressional Budget Office, *Preliminary Analysis of the President's Budget for 2012*, March 18, 2011 and accompanying March 2011 Medicare baseline.

²⁷ Kaiser Family Foundation, *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid*, January 2011.

²⁸ In 2010, Medicare paid on average 9% more for every beneficiary that enrolled in MA than if they remained in traditional Medicare. Medicare Payment Advisory Commission, *A Data Book: Healthcare Spending and the Medicare Program*, June 2010. See also Berenson, Robert et al., *Cost Containment in Medicare: A Review of What Works and What Doesn't*, AARP Public Policy Institute, December 2008, http://assets.aarp.org/rgcenter/health/2008_18_medicare.pdf

²⁹ As a result of a combination of plan decisions about the lack of attractiveness of the low-income subsidy population and the bidding process, many beneficiaries receiving the low-income subsidy (an extra amount from the government to pay their Part D premium and most of their cost-sharing amounts), have had to annually switch plans or have been reassigned plans so as to avoid incurring a premium.

³⁰ Centers for Medicare and Medicaid Services, *National Health Expenditures by type of service and source of fund, CY1960-2009.*, https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

³¹ Congressional Research Service, *Health Insurance: The Medicare Voucher Proposals*, by Glenn Markus, December 14, 1982.

³² Balanced Budget Act of 1995.

³³ These private plan options included high deductible health plans combined with Medical Savings Accounts as well as union, Taft-Hartley or association-sponsored plans. Other options included private managed care organizations, fee-for-service arrangements and provider sponsored organizations (PSOs).

³⁴ Under this proposal, expenditures for the traditional fee-for-service program would have been limited to health sector-specific amounts; spending in excess of these amounts would have triggered reductions in provider payments.

³⁵ H.R.2491 December 6, 1995, Seven-Year Balanced Budget Reconciliation Act of 1995, Veto Message of the President of the United States, *Congressional Record*, December 6, 1995.

³⁶ See S. 2342, Medicare Modernization Act, introduced on behalf of the Clinton Administration by Senator Patrick Moynihan on April 4, 2000. It also included an outpatient prescription drug benefit.

³⁷ While the details of the Demonstration were planned, implementation was ultimately blocked by Congress. Berenson, Robert et al., *Cost Containment in Medicare: A Review of What Works and What Doesn't*, AARP Public Policy Institute, December 2008, http://assets.aarp.org/rgcenter/health/2008_18_medicare.pdf

³⁸ Aaron, Henry J. and Robert D. Reischauer, The Medicare Reform Debate: What is the Next Step? *Health Affairs*, Winter 1995, v. 14, No. 4, www.healthaffairs.org.

³⁹ The proposal details varied with respect to the calculation of the government's contribution and the beneficiaries' premium obligations. See, for example, S. 1895 (Breau), Medicare Preservation Act, S. 2807 (Breau), Medicare Prescription Drug and Modernization Act, introduced in 106th Congress.

⁴⁰ Section 241(a) of the Medicare Modernization Act (MMA, P.L. 108-173).

⁴¹ U.S. House of Representatives, *Conference Report for H.R. 1, the Medicare Prescription Drug, Improvement and Modernization Act*, 108th Congress, 1st Session, House Report 108-391, November 21, 2003, p. 563.

⁴² To address this concern, the Demonstration called for a phase-in of the competition over four years but the provision was still generally opposed by beneficiary advocates.

⁴³ See section 1102(f) of the Health Care and Education Reconciliation Act (P.L. 111-152).

⁴⁴ Berenson, Robert et al, 2008.

⁴⁵ See also Kaiser Family Foundation, *Comparison of Medicare Provisions in Deficit-Reduction Proposals*, regularly updated, www.kff.org/medicare/upload/8124.pdf

⁴⁶ House Committee on the Budget, "Pathway to Prosperity, Fiscal Year 2012 Budget Resolution," and Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan," April 5, 2011.

⁴⁷ www.roadmap.republicans.budget.house.gov/News/DocumentSingle.aspx?DocumentID=167112

⁴⁸ Rivlin, Alice and Paul Ryan "A Long-Term Plan for Medicare and Medicaid," November 17, 2010 and Congressional Budget Office, *Preliminary Analysis of the Rivlin-Ryan Health Care Proposal*, Letter to Rep. Ryan, November 17, 2010.

⁴⁹ The House approved H.Con. Res. 34, establishing the budget for fiscal year 2012 and setting forth budgetary levels for fiscal years 2013 through 2021. on April 15, 2011, by a vote of 235-193. The budget resolution is pending in the Senate.

⁵⁰ Alan Simpson is a former Republican Senator from Wyoming; Erskine Bowles was a Chief of Staff to President Clinton.

⁵¹ The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, The White House, Washington, December 2010,

www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.

⁵² Bipartisan Policy Center, Deficit Reduction Task Force, *Restoring America's Future*, Washington, D.C. November 2010, <http://bipartisanpolicy.org>.

⁵³ According to the report, this compares with GDP plus 1.7 percentage point under current law. Bipartisan Policy Center, 2010.

⁵⁴ Committee for a Responsible Budget, *Let's Get Specific: Health Care*, Washington, D.C. September, 2010. <http://crfb.org/document/lets-get-specific-health-care>

⁵⁵ Heritage Foundation, *Saving the American Dream, The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, SR-91, May 10, 2011, www.heritage.org



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This report (#8191) is available on the Kaiser Family Foundation's website at www.kff.org.

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