



Health Policy Brief

MARCH 22, 2012

Premium Support in Medicare. The nation's fiscal crisis has renewed the focus on structural reform. Can a market-oriented solution cut costs and improve care?

WHAT'S THE ISSUE?

Medicare, the federal health program for the aged and disabled, has been at the center of the ongoing debate over how to reduce the federal budget deficit and improve the nation's long-term fiscal prospects. Medicare spending has slowed in recent years for various reasons, but is expected to accelerate as the economy recovers and more baby boomers enroll.

Over the years, various proposals have been weighed to achieve greater control over Medicare's cost growth by moving away from traditional fee-for-service payment and strengthening private plans' role in the program. "Premium support" is one option. Under this approach, Medicare enrollees would choose a private health plan and the federal government would pay a predetermined contribution to that plan.

This brief explains the concept further and examines the debate between proponents—who say premium support would slow Medicare's growth, foster innovation, and give beneficiaries new choices—and critics, who mainly fear that beneficiaries would pay a steadily rising share of their health costs.

WHAT'S THE BACKGROUND?

With eligibility of the baby boom generation, Medicare enrollment is projected to grow to 80 million by 2030, double that in 2000 (Exhibit 1). The current discussion over reshaping

Medicare is part of an ongoing debate about the sustainability of the program and the best way of reining in growth in costs.

Currently, Medicare beneficiaries are automatically enrolled in the fee-for-service program, under which the federal government pays hospitals, doctors, and other providers directly for covered services. About one in four beneficiaries have chosen to enroll in a Medicare Advantage plan—a private insurance plan that provides Medicare-covered services in exchange for a monthly payment from the government and, in some cases, a premium paid by beneficiaries. (See the [Health Policy Brief](#) published June 15, 2011, for more information on Medicare Advantage plans.)

THE ROLE OF PRIVATE PLANS: The concept of premium support builds on this notion of beneficiaries picking private plans to deliver their Medicare benefits, but with an additional feature of limiting the government subsidy and not permitting it to vary with plan features. The phrase was first used in a November 1995 *Health Affairs* article by Brookings Institution economists Henry Aaron and Robert Reischauer. Under the approach that they described, beneficiaries would receive a government contribution toward the premium charged by a private plan of their choice. If the premium exceeded the contribution, beneficiaries would pay the difference.

Aaron and Reischauer's plan, in turn, drew on the notion of "managed competition"

2%

Annual Medicare cut

The failure of the Super Committee to agree on a deficit reduction plan could trigger a 2 percent annual cut in Medicare payments to providers starting fiscal year 2013.

popularized by Stanford economist Alain Enthoven. The underlying premise was that health plans would compete for enrollees by offering attractive features and prices. The competition would prompt private plans to find innovative ways of delivering cost-effective care, gradually bringing Medicare spending under control.

Since then, various versions of premium support have been proposed. Most recently, the concept has been a centerpiece of several deficit reduction plans, including those offered by House Budget Committee Chair Rep. Paul Ryan (R-WI) and Sen. Ron Wyden (D-OR), and included in the House Budget Committee's fiscal year 2013 budget proposal released on March 20, 2012; and by former White House budget director Alice Rivlin and former Senate Budget Committee Chair Pete Domenici (R-NM) under the auspices of the Bipartisan Policy Center.

Sens. Richard Burr (R-NC) and Tom Coburn (R-OK) have also introduced legislation to create a premium support model. Their proposal includes other changes, including raising the eligibility age and significantly increasing Medicare premiums.

HOW WOULD PREMIUM SUPPORT WORK?

The various proposals now being debated all focus on the potential of slowing the growth of Medicare spending by having private plans compete on price to provide care to beneficiaries. Beyond that, several key design elements and other details differ.

ROLE OF TRADITIONAL MEDICARE: A question in all premium support plans is what role, if

any, the traditional Medicare program would play in a system of premium support. Some proposals would keep the traditional program intact and make it available in addition to private plans.

Proponents maintain that it may not be feasible to offer a choice of plans to all Medicare beneficiaries, especially those living in areas where few plans operate. Moreover, continuing to offer traditional Medicare would allow beneficiaries the choice of staying in the program out of personal preference, such as loyalty to a particular physician, even if they might have to pay more to do so.

Other premium support proposals would do away with traditional Medicare over time. The objective of this approach is to end the traditional fee-for-service payment structure, which inherently creates incentives to increase the volume of services provided to beneficiaries and ultimately to increase costs.

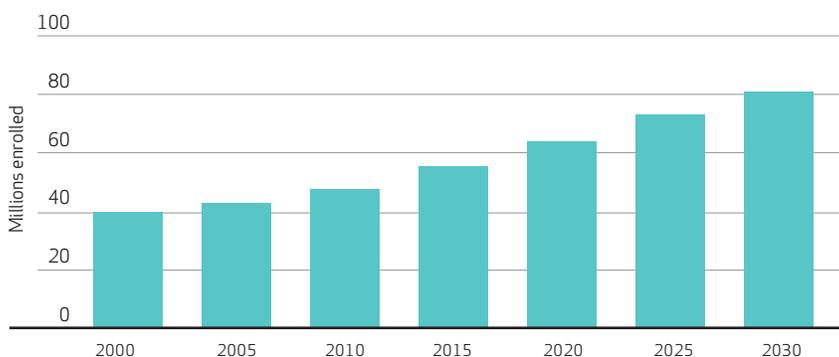
Under a previous plan that Ryan proposed in 2011, traditional Medicare would remain an option only for those beneficiaries who become eligible for Medicare for the first time before 2022. As of 2022 all those becoming eligible for Medicare for the first time would have to choose a private plan. However, that aspect of the initial Ryan plan proved unpopular. The plan now being advanced by Ryan and Wyden maintains traditional Medicare as an option for all beneficiaries in the future.

FIXED FEDERAL CONTRIBUTION: All premium support models are based on the notion that the government would set a fixed contribution that would be paid directly to participating health plans. This approach differs from the way that the government pays plans participating in the current Medicare Advantage plan.

Currently, Medicare Advantage plans “bid,” much as in an auction, to provide services to Medicare beneficiaries under Medicare Parts A and B, which cover hospital and physician services, respectively. The government then compares the bids to a “benchmark” level that varies from county to county and that is linked to Medicare spending under the traditional fee-for-service program. Plans that bid higher than the benchmark charge enrollees a supplemental premium. Those bidding below the benchmark return a portion of the difference to enrollees in the form of additional benefits.

EXHIBIT 1

Projected Medicare Enrollment, 2000–30



SOURCE 2011 Medicare Trustees Report.

5.6%

Medicare spending reduction
Competitive bidding would reduce federal spending on Medicare by about 5.6 percent through 2020, according to the American Enterprise Institute.

“The various proposals now being debated all focus on the potential of slowing the growth of Medicare spending by having private plans compete on price to provide care to beneficiaries.”

Because the county-by-county benchmarks are linked to traditional fee-for-service spending, the entire bidding system for Medicare Advantage is still tied to the traditional program. By contrast, premium support proposals would typically create a bidding process in which the federal contribution is tied more directly to the bids submitted by the plans.

The Domenici-Rivlin and Wyden-Ryan proposals, in fact, call for setting the government’s contribution at either the second-lowest bid from health plans or at the price for the traditional fee-for-service Medicare program, whichever is lower. Those beneficiaries choosing more expensive plans would pay the additional costs out of pocket. Payments to plans would be adjusted for the health risk profile of the enrollees, as they are in Medicare Advantage. There would also be additional financial support, as there is now, for low-income beneficiaries who need assistance paying their share of Medicare expenses.

“MARKET-BASED” APPROACH: A “pure” premium support proposal would mean that the level of the government’s annual payment to plans would be determined entirely through the bidding process, and thus be wholly “market based.” However, the premium support models now under discussion insert some additional regulation into this market model. Under these proposals, Congress would set a limit on how fast the government contribution could grow over time. This cap on the rate of growth would reinforce a constraint on spending over and above what could be achieved in a market model.

The original Ryan plan unveiled in 2011 would have allowed the federal contribution to grow at the rate of general inflation (about 1.5 percent in 2012). Because health care spending has consistently outpaced inflation, that cap is widely considered too tight. The newer Ryan-Wyden proposal features a more generous allowance for growth, equal to the rate of the increase in GDP plus 0.5 percent. Domenici and Rivlin have championed the target of GDP plus 1 percent.

WHAT ARE THE IMPLICATIONS?

Any form of premium support would affect spending by both the federal government and by Medicare beneficiaries.

EFFECT ON FEDERAL SPENDING: The impact on federal spending would depend on several factors, including the initial government con-

tribution level in the first year of the restructured system and the allowed rate of growth in that contribution over time. The Congressional Budget Office (CBO), for example, estimated that the 2011 Ryan proposal would probably reduce federal spending by 2030 by 8 to 11 percent.

A more recent analysis by Roger Feldman and colleagues at the American Enterprise Institute suggests that a fully implemented competitive bidding system would reduce federal spending on Medicare by about 5.6 percent, or \$339 billion, through 2020. Together with provisions in the Affordable Care Act that are projected to slow Medicare’s growth rate and save 4.2 percent over the same period when fully in place, total Medicare spending by 2020 would be reduced by 9.5 percent.

EFFECT ON BENEFICIARIES: How premium support would affect Medicare beneficiaries has been widely debated, and a number of concerns voiced. Foremost is how much more, if any, Medicare beneficiaries might have to pay for coverage. If the constraints on government contributions prove too tight and health costs continue to escalate, Medicare enrollees would pay ever-growing amounts for coverage.

The analysis mentioned above by Feldman and colleagues examined the likely effects on beneficiaries of competitive bidding by health plans, finding that 43 percent of beneficiaries would see no change in their costs; 22 percent would face higher payments of less than \$40 per month; and about 1 percent would experience higher costs, as much as \$352 per month.

There are also concerns about what would happen if the traditional Medicare program were allowed to coexist in the future alongside private plans. Some experts warn that costs in the traditional Medicare program would probably rise inexorably. They say that the sickest beneficiaries would be likely to stay in the fee-for-service program to retain access to their preferred providers or to have open-ended access to health care services. If the costs of the traditional program rose steeply, it’s possible that many Medicare enrollees would find the program unaffordable.

Research has shown that many people—for example, Medicare enrollees picking Part D prescription drug plans—have difficulty making choices that are in their best interest when they confront a broad array of options. Henry Aaron, the early proponent of premium support, now voices concern over the ability of the

frail, elderly, and disabled to evaluate a large number of private insurance plans and choose the best option for themselves.

HIGHER PROVIDER PAYMENTS?: CBO's 2011 estimates of Ryan's premium support proposal assumed that premiums for a private plan comparable to Medicare in 2022 would be higher than the cost of coverage under Medicare fee-for-service. The assumption stemmed from the fact that private insurers typically pay doctors and hospitals more than Medicare. Private plans historically also have had higher administrative costs, although these have declined lately. What's more, for-profit plans must provide a return to shareholders. For these and other reasons, the CBO projected that private plans would not be able to hold the rate of growth of premiums to the consumer price index, as Ryan had proposed.

All of these factors contributed to reinforcing the projection that Medicare beneficiaries would shoulder a growing share of Medicare spending as the years went on. Some observers contend that CBO's assumptions and resulting estimates of the costs of premium support may have been too pessimistic. For instance, bids offered by private Medicare Advantage Plans were just about equal to fee-for-service costs in 2010. Supporters of premium support maintain that more vigorous price competition would force plans to restrain their costs, and that private plans are better positioned than Medicare fee-for-service to find innova-

tive ways of delivering services or controlling utilization.

WHAT'S NEXT?

Medicare is likely to remain a focal point of ongoing efforts to address the federal deficit. The failure of the Joint Select Committee on Deficit Reduction, or so-called Super Committee, to agree on a deficit reduction plan in late 2011 could trigger a 2 percent annual reduction in Medicare payments to providers set to begin in fiscal year 2013. It remains to be seen whether Congress will allow those cuts to go forward or turn to other approaches, such as premium support, in its search for budget savings.

Some policy makers would prefer to see Medicare reforms authorized under the Affordable Care Act play out before moving onto an additional wave of system redesign. These changes include the creation in 2013 of a new Independent Payment Advisory Board, pilots of accountable care organizations as a mechanism to both boost quality and rein in costs, and a number of other payment innovations. It may be several years at least before evidence of any cost savings emerge, however.

Broad-scale Medicare reform remains a highly politicized issue and, as a result, is unlikely to be divorced from national politics. The outcome of the 2012 elections is likely to have considerable bearing on the direction of the Medicare program. ■

About Health Policy Briefs

Written by
Anne Schwartz
Deputy Editor
Health Affairs
with assistance from
Mark Merlis
Health Policy Consultant

Editorial review by
Marilyn Moon
Senior Vice President and Director
Health Program
American Institutes for Research

Gail R. Wilensky
Senior Fellow
Project HOPE

Ted Agres
Senior Editor for Special Content
Health Affairs

Susan Dentzer
Editor-in-Chief
Health Affairs

Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:
"Health Policy Brief: Premium Support in Medicare," *Health Affairs*, March 22, 2012.

Sign up for free policy briefs at:
www.healthaffairs.org/healthpolicybriefs

RESOURCES

Aaron, Henry, "[Vouchers or Premium Support: What's in a Name?](#)" *Health Affairs* Blog, April 6, 2011.

Aaron, Henry and Robert D. Reischauer, "[The Medicare Reform Debate: What Is the Next Step?](#)" *Health Affairs* 14, no. 4 (1995): 8–30.

Feldman, Roger, Robert Coulam, and Bryan Dowd, "[Competitive Bidding Can Help Solve Medicare's Fiscal Crisis.](#)" American Enterprise Institute, February 2012.

Fuchs, Beth and Lisa Potetz, "[The Nuts and Bolts of Medicare Premium Support Proposals.](#)" Henry J. Kaiser Family Foundation, June 2011.

House Budget Committee, "[Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future.](#)" December 15, 2011.

Wilensky, Gail R., "[Reforming Medicare—Toward a Modified Ryan Plan.](#)" *New England Journal of Medicine* 364 (2011): 1890–92.