



# The Inherent Flaws in Medicare Premium Support

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## Introduction

Proposals to restructure Medicare by providing “premium support” or vouchers to beneficiaries have garnered a great deal of attention recently. In April Rep. Paul Ryan (R-WI), the chairman of the House Budget Committee, proposed a plan that would ultimately eliminate traditional Medicare. According to an analysis by the nonpartisan Congressional Budget Office, beneficiaries would pay *more than double* for their health care under Rep. Ryan’s original plan than under the current system.

In an attempt to address these fatal flaws, proponents of premium support have since developed variations on the design. But upon close examination these designs fail to address the deficiencies that are inherent in premium support.

No version of premium support achieves savings without adverse consequences for beneficiaries. Some versions impose an arbitrary cap on the amount of the voucher, significantly shifting costs to beneficiaries, regardless of their choice of plan. Other versions make many of those who wish to remain in traditional Medicare pay sharply higher premiums. For these beneficiaries the choice of traditional Medicare would be a false one in reality.

Moreover, no version of premium support fully prevents private health insurance plans from attracting healthier beneficiaries, driving up premiums for those who remain in traditional Medicare. In addition, no version of premium support creates a level playing field between private plans and traditional Medicare. As a result of these two factors, more and more beneficiaries would gradually shift to private plans over time.

These risks are too great. Medicare coverage costs less than comparable private coverage and Medicare is more successful at containing costs per enrollee than private plans. While diluting traditional Medicare would sacrifice these advantages, premium support

would provide little benefit in savings because the Affordable Care Act already created a mechanism to limit the growth in Medicare costs. This issue brief will discuss the risks of premium support and argue for a better approach.

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## Design variations

Premium support proposals have been around since the late 1970s. At the most basic level Medicare spending would be converted into “premium support”—or vouchers—to purchase an insurance plan. If beneficiaries choose a plan that costs more than the voucher, they must pay the difference.

Beginning in 2022 for new beneficiaries, Rep. Ryan’s original plan would replace traditional Medicare with vouchers to purchase private insurance. The value of the voucher would grow over time at the rate of inflation. Because this rate is slower than the projected growth in health care costs, the voucher would leave beneficiaries to pay increasingly more over time.<sup>1</sup>

To moderate this plan, former budget director Alice Rivlin and former Sen. Pete Domenici (R-NM) proposed a variation.<sup>2</sup> Their plan would allow future beneficiaries to use the voucher to purchase either a private insurance plan or the traditional Medicare plan. Using competitive bidding, the voucher would be based on the second-lowest cost private plan or the cost of traditional Medicare—whichever is lower. But growth in the value of the voucher would be capped at growth in the economy plus 1 percentage point. Rivlin and Domenici acknowledge that “if costs rise faster than the established limit, Medicare beneficiaries will have to pay higher premiums.”<sup>3</sup>

On December 15 Sen. Ron Wyden (D-OR) and Rep. Ryan released another variation.<sup>4</sup> Their plan is similar to the Rivlin-Domenici plan but removes the cap on the voucher. Instead, if Medicare spending growth exceeds growth in the economy plus 1 percentage point, then Congress must reduce payments to health care providers, reduce program overhead, or increase premiums for higher-income beneficiaries. Importantly, while the Rivlin-Domenici plan would require private plans to cover the same services as traditional Medicare, the Wyden-Ryan plan would only require private plans to cover any package of benefits that provides the same “actuarial value”—pays the same percentage of costs—as traditional Medicare.

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## Projected cost containment in Medicare

All of the proponents of premium support assume that major structural reforms are needed to contain Medicare costs. But this premise is too simplistic.

Over the next 10 years Medicare costs are projected to grow at an average rate of 5.8 percent per year.<sup>5</sup> That growth rate primarily reflects an increase in enrollment as the baby boomers become eligible for Medicare. But strikingly, the growth in *costs per beneficiary* is projected to average only 2.8 percent per year—compared to growth in GDP per capita of 3.9 percent and growth in total health care costs per capita of 5.1 percent.<sup>6</sup> In the coming decade at least, Medicare will be very successful in containing costs.

Moreover, the Affordable Care Act contributes significantly to this cost containment.<sup>7</sup> Without the new law, Medicare would grow at an average rate of 6.9 percent per year—more than 1 percentage point faster than under current law.<sup>8</sup> By the end of the projection period in 2020, Medicare is still projected to grow at a slower rate than it would without the Affordable Care Act.

In particular, the law’s Independent Payment Advisory Board, or IPAB, is a critical mechanism that will limit the growth in Medicare costs. If growth exceeds a target rate—growth in the economy plus 1 percentage point after 2017—then the IPAB must propose savings that either reduce growth to the target rate or reduce spending by 1.5 percent after 2017—whichever is less. In this way the IPAB *guarantees* that Medicare will not grow too fast.

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## Medicare and private plans

What’s more, choice already exists in the Medicare program. For more than 30 years, private plans have operated in Medicare. Since 2006, 100 percent of Medicare beneficiaries have had a choice of a private insurance plan—and they currently have a choice of 12 plans on average.<sup>9</sup> In fact, 24 percent of beneficiaries are enrolled in private plans through Medicare Advantage.<sup>10</sup>

Enrollment in private plans has been growing primarily because they do not compete with traditional Medicare on a level playing field—payments to private plans are on average 10 percent higher than payments under traditional Medicare.<sup>11</sup> However, the Affordable Care Act will gradually reduce—but not eliminate—these overpayments over the next five years.

There is no evidence that private plans provide better quality than traditional Medicare, and the quality of private plans is highly uneven, according to the independent Medicare Payment Advisory Commission.<sup>12</sup> But there is evidence that all else being equal private plans would cost more than comparable coverage under traditional Medicare, for two reasons.

First, private plans pay higher rates to health care providers—20 percent higher for physicians and 30 percent higher for hospitals, on average.<sup>13</sup> Second, private plans have

significantly higher administrative costs, mostly because they incur significant marketing costs and keep about 4 percent to 5 percent of premiums as profits.<sup>14</sup> Administrative costs average 12 percent of premium revenues for private plans (7 percent for large employers),<sup>15</sup> but are only 1.5 percent of spending for Medicare.<sup>16</sup>

To be as efficient as Medicare, then, private plans must offset these higher costs through aggressive management to lower utilization of services.

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## Savings from premium support

In general, premium support proposals achieve much of their federal savings through “increases in the premiums paid by beneficiaries, not from increases in the efficiency of health care delivery,”<sup>17</sup> as the nonpartisan Congressional Budget Office concluded in one analysis. And what savings these proposals do achieve is likely to be limited because the IPAB already caps growth in Medicare costs.

In fact, Rep. Ryan’s original plan only achieves significant savings by capping the voucher at the rate of inflation—significantly less than the IPAB’s target growth rate. By contrast, the voucher cap under the Rivlin-Domenici plan and the overall cap under the Wyden-Ryan plan are the same as the IPAB’s target growth rate over the long term, and would therefore achieve little savings.

Either a voucher cap must be so severe that costs to beneficiaries would more than double—as under Rep. Ryan’s plan—or it would shift costs to beneficiaries without achieving much savings—as under the Rivlin-Domenici plan. Of course a voucher cap could theoretically grow with health care costs or the voucher could be left uncapped—as under the Wyden-Ryan plan. But these variations would achieve no savings at all.

Moreover, it is instructive to compare a voucher cap with the cap under the IPAB. While a voucher cap would in effect put beneficiaries on a budget—shifting risk to beneficiaries—the IPAB will put all of Medicare on a budget. The IPAB is specifically prohibited by law from:

- Rationing care
- Raising taxes or premiums
- Increasing cost-sharing
- Restricting benefits or modifying eligibility<sup>18</sup>

Instead, it must “improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement.”<sup>19</sup>

Some premium support proposals—such as the Rivlin-Domenici plan and the Wyden-Ryan plan—could potentially achieve savings through competitive bidding, in which the voucher is tied to a low bid. In areas where a private plan can make a bid that is lower than the cost of traditional Medicare, the voucher would be based on the bid of the private plan. As a result, many beneficiaries who wish to remain in traditional Medicare would be required to pay sharply higher premiums.

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## The problem of adverse selection

Many studies show that private plans attract healthier, less costly beneficiaries than beneficiaries in traditional Medicare<sup>20</sup>—a phenomenon known as “adverse selection.” Private plans, for example, can design benefit packages that are attractive to healthier beneficiaries. Premium support proposals that do not standardize benefits across private plans and traditional Medicare—such as the Wyden-Ryan plan—would be especially susceptible to adverse selection.

If less healthy, more costly enrollees are left behind in traditional Medicare, then premiums for traditional Medicare would rise. In turn, more beneficiaries would leave traditional Medicare, causing premiums to rise further, and so on—creating a so-called “death spiral.”

This is not a theoretical concern. Death spirals have occurred in the real world, for instance when universities started providing a fixed-amount contribution similar to premium support to their health care plans.<sup>21</sup>

Premium support proposals generally adjust the voucher for health status—redistributing payments from plans with healthier enrollees to plans with less healthy enrollees. This “risk adjustment” mechanism would certainly help, but current risk adjustment methods are still far from perfect.<sup>22</sup> According to some studies risk adjustment accounts for less than half of the variation in predictable health care spending.<sup>23</sup> Current methods tend to overpay plans with healthier enrollees and underpay plans with less healthy enrollees.

Even if risk adjustment were highly successful, premiums for traditional Medicare could still rise and enrollment could still decline over time.<sup>24</sup> In a simulation of one premium support proposal—which assumed that risk adjustment would remove 75 percent of variation in costs—participation in traditional Medicare declined by 24 percentage points over a 20-year period.<sup>25</sup> Highly effective risk adjustment, then, may only slow down a death spiral.

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## Unfair competition against traditional Medicare

Under premium support proposals that preserve traditional Medicare as an option, traditional Medicare would not be able to compete on a level playing field. Currently,

traditional Medicare cannot provide an integrated benefit package that includes prescription drug coverage, modify benefit designs, or offer provider network options. In addition, traditional Medicare must provide financing that private plans do not provide, such as financing for graduate medical education, rural hospitals, and hospitals that disproportionately serve low-income people.

These unfair advantages make premium support different from the competition that would have occurred through the forthcoming health insurance exchanges under the Affordable Care Act if the new law had included a public plan. That public plan could have operated like a private plan, under the same set of rules. More fundamentally, the Affordable Care Act will fill a void of coverage whereas premium support would dilute traditional Medicare.

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### Conclusion: A better way

If private plans are able to use their artificial advantages and risk selection to underprice traditional Medicare, then more and more beneficiaries would gradually shift to private plans over time. This result would sacrifice the advantages of Medicare: its pricing power, low administrative costs, and ability to drive system-wide efficiencies in health care delivery.

A much better approach would be to retain those advantages while achieving savings through payment- and delivery-system reforms. The Affordable Care Act took far-reaching steps on such reforms, which will contain costs across the health care system, not merely shift costs to others—especially to beneficiaries.

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## Endnotes

- 1 Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan" (2011), p. 23.
- 2 The Bipartisan Policy Center, "Domenici-Rivlin Protect Medicare Act" (2011), available at <http://www.bipartisanpolicy.org/sites/default/files/Domenici-Rivlin%20Protect%20Medicare%20Act%20.pdf>
- 3 Ibid
- 4 Sen. Ron Wyden (D-OR) and Rep. Paul Ryan (R-WI), "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future," December 15, 2011, available at <http://wyden.senate.gov/imo/media/doc/wyden-ryan.pdf>
- 5 Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditures 2010-2020," available at <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>.
- 6 Ibid
- 7 See, for example, Andrea M. Sisko and others, "National Health Spending Projections: The Estimated Impact of Reform Through 2019," *Health Affairs*, October 2010, p. 1940; "The Medicare provisions in the Affordable Care Act... are anticipated to result, on net, in much slower Medicare spending growth over the projection period."
- 8 CMS, *supra* note 5.
- 9 Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (2011), p. 292.
- 10 MedPAC, "Report to the Congress: Medicare Payment Policy," p. 291.
- 11 MedPAC, "Report to the Congress: Medicare Payment Policy," p. 293.
- 12 MedPAC, "Report to the Congress: Medicare Payment Policy," pp. 294-307.
- 13 Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals" (2008), p. 93.
- 14 Ibid, p. 93.
- 15 Ibid, p. 70.
- 16 Ibid, p. 93.
- 17 Congressional Budget Office, "Budget Options Volume I: Health Care" (2008), p. 121.
- 18 Patient Protection and Affordable Care Act, Section 3403(c)(2)(A)(ii).
- 19 PPACA, Section 3403(c)(2)(B)(ii).
- 20 Thomas Rice and Katherine Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," *Journal of Health Politics, Policy and Law* 29 (6) (2004): 1196; Medicare Payment Advisory Commission, "Report to the Congress: Promoting Greater Efficiency in Medicare" (2007), p. 63.
- 21 Rice and Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," p. 1197.
- 22 Congressional Budget Office, "Designing a Premium Support System for Medicare" (2006), p. 27; Brian K. Frogner and others, "Incorporating New Research Into Medicare Risk Adjustment," *Medical Care* 49 (3) (2011): 295-300.
- 23 CBO, "Key Issues," p. 89.
- 24 Rice and Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," p. 1202.
- 25 Rice and Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," p. 1202.