REFORMING MEDICARE

Option: Change Medicare to a Premium Support Plan

Under this proposal, newly eligible Medicare beneficiaries would receive their health coverage through private insurance plans, not traditional Medicare. Beneficiaries would choose among competing plans and the federal government would contribute a fixed amount to pay the premiums for the private insurance plan. If the private insurance premiums prove to be higher than the federal contribution, seniors would be required to pay the difference. If the government’s annual contribution does not increase by the same amount as the annual cost increase in premiums, beneficiaries would pay the difference, which could get larger over time.

Argument for:
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Argument against:
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Stuart Butler

It makes sense to put Medicare on a long-term budget that reduces the burden on our children and grandchildren while making health care affordable for older people. The best way to do that is through the idea called “premium support.”

The new health law does have a long-term budget for Medicare. But to keep within a budget, it uses an unelected board to set fees for your doctor and hospital, or payments to your private Medicare plan. So Washington ends up deciding what your doctor is worth. That’s bad.

A better way to stick to a budget is through the approach called “premium support,” which has a long and bipartisan history. This means older people would receive their own share of the Medicare budget to use toward a health insurance plan or with doctors. They would decide what is the best value for their money.

Nobody says this approach should start immediately. Some say not to start it for anyone who is now over 55. Others say to begin the approach 10 years from now.

If enacted, premium support would eventually work like this. If you have a private Medicare plan (known as Medicare Advantage), where you pay a premium to the plan, then not much would change. Medicare would just pay your share of Medicare spending to the plan. If you wanted a more expensive plan, you would pay the difference. For Medicare to keep to the budget, the difference you had to pay in the future might rise, or to avoid that you could switch to a less expensive plan.
Say you wanted to stay in traditional fee-for-service Medicare. That’s where you get billed by doctors and hospitals and Medicare pays all or part of each charge. Premiums for Medicare Part B (physician services) and Part D (prescription coverage) would be combined with Medicare Part A hospital coverage into a simpler program with one premium and a wide range of doctors to choose from. But you could choose between different versions of traditional fee-for-service Medicare. You could agree to a more limited network of doctors, for instance, and pay less out of pocket after your premium support. Or you could have unlimited choice of doctors and pay more.

Premium support provides important protections for older people. First, unlike today, you would get “catastrophic” protection. That means Medicare would limit your out-of-pocket costs to a reasonable maximum level. Second, the amount of support each older person received would make sure sicker retirees paid no more than healthier ones for the same coverage. And third, modest or lower-income older people would receive more premium support for their Medicare costs than higher-income ones.

Medicare spending is growing rapidly and needs to be held to a budget to reduce the debt and deficits facing our children and grandchildren. That means, one way or another, older people will have to pay more for Medicare benefits. Premium support is the best way for Medicare to stay within a budget because it would give older people more control and choice over how that budget is actually spent.

Henry Aaron

Should Medicare be replaced with a system under which beneficiaries would be given a voucher for the purchase of health insurance? Under so-called premium support, the value of the voucher would be tied to some economic index, not health costs.

Fifteen years ago, I thought that such a change was promising. My hope and that of many others was that insurers would compete to hold down health care costs and improve the quality of care, thereby slowing the growth of government Medicare spending. For several reasons, I no longer do.

In the plan I supported, the value of the voucher would have been tied to average health care costs, not some outside index, ensuring that Medicare enrollees could always afford Medicare. But that is not what is being proposed today. Today’s plans would tie the value of the voucher to indexes that have grown and are expected to grow more slowly than health care costs. Under the plan I described many years ago, costs would not be more or less automatically shifted to beneficiaries. But under plans now under discussion, there is a high risk that with the passage of time, benefits will become increasingly inadequate or beneficiary costs will be much higher.

In addition, consumers can make informed choices among competing insurance plans only if the number of plans among which they are asked choose is limited to a few prototype plans. In addition, to minimize competition through ‘cream skimming,’ those plans should be marketed only through public or nonprofit organizations charged to provide clear and unbiased information. No current premium support plan provides these assurances.

There are other reasons why premium support should not be undertaken at this time. The nation has just enacted a major health insurance reform. A key step in that reform is the
creation of health insurance exchanges to regulate the sale of health insurance to people who are comparatively healthy—that is, not disabled—and are not elderly. Even for this population, the job of setting up these organizations is proving to be exceedingly difficult and controversial. The problems that such organizations would face in dealing with older and disabled people would be more challenging even than those they are now facing. The first job is to get these organizations up and running. Only then can one know whether they can handle the much harder task of administering insurance for the Medicare population.

Medicare has changed since the mid-1990s. It now offers competing private plans through Medicare Advantage and under the Part D drug program. The hoped-for savings have not yet materialized. In fact, Medicare Advantage plans on average cost more to provide standard Medicare services than does traditional Medicare. Growth of drug spending has slowed nationwide, but the competing Part D plans have not produced additional savings. In addition, the recently enacted health reform already contains measures that will slow the growth of Medicare spending nearly as much as would the various “premium support” plans, and further improvements to the current Medicare program, including greater use of Medicare’s market power, could go even further.

We cannot know whether some form of premium support may ultimately prove attractive until we know whether the health insurance exchanges that would administer the sale of insurance will work for the Medicare population. And we should not even think of exposing older people to that framework until we see how it works for the rest of the population.

Today’s job is to make health reform work. Tomorrow’s job will be to determine whether that framework should be extended to all Americans.

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