CED
Committee for Economic Development

Modernizing Medicare

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Access to high-quality, affordable health care goes to the core of what we want for ourselves and our families. At some point in their lives, most people will experience the vulnerability that comes with serious illness or injury—either to oneself or a loved one—and the subsequent feeling of gratitude for access to modern medicine.

Americans can be justifiably proud of our health care system, including its quality and innovative treatments. In particular, the creation of the federal Medicare program in 1965 meant that those 65 and older no longer needed to worry about access to high-quality, affordable care during their retirement years.

The aggregate cost of US health care has been growing dramatically for decades—from 5 percent of GDP in 1960 to 17 percent in 2014.

Yet, while programs like Medicare, Medicaid, and more recently, the Affordable Care Act (ACA) extended health care coverage to particular populations, the aggregate cost of US health care has been growing dramatically for decades—from 5 percent of GDP in 1960 to 17 percent in 2014.

The health care industry is highly inefficient—perhaps one of the most inefficient sectors of our economy.

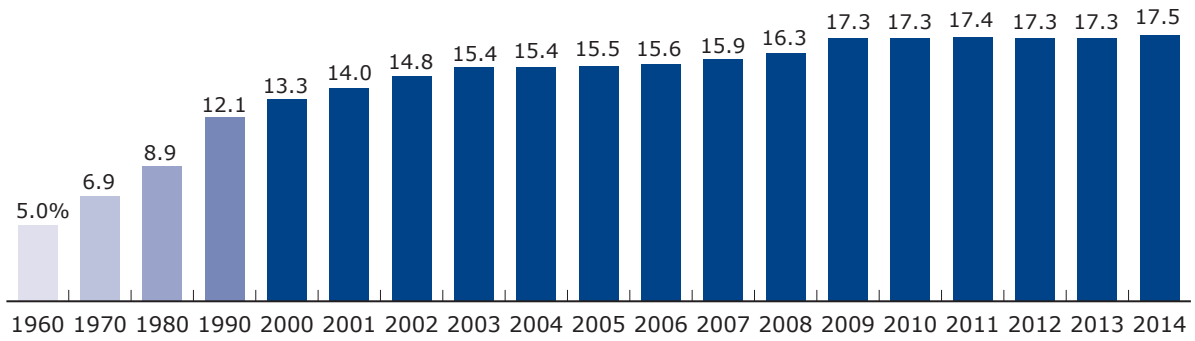
The US Health Care System

The United States has a mixed health care system, with both private and public elements. The majority of the working-age population is covered by private insurance through their employers with the cost divided between employer and employee. The federal government (and therefore all taxpayers) shares in the cost of health care in a less than transparent way through tax subsidies for the portion of health insurance premiums paid by employers as an employee benefit. The very low-income working-age population is covered by the joint federal-state Medicaid program, with details of eligibility and benefits determined by each state within broad federal guidelines. In addition, in some states the federal Affordable Care Act (ACA) provides premium subsidies for private insurance to individuals whose income falls just above the Medicaid eligibility threshold.

Chart 1

National health expenditures are a growing share of the economy

Percent of GDP



Source: Centers for Medicare and Medicaid Services

Some of that increased health care spending clearly results from the overall aging of the US population. For example, the large baby boomer generation requires greater health care as it approaches and enters retirement than it did 50 years ago. Some of the incremental spending results from new and valuable medical technology. But part of the increase arises from waste embedded in our health care system. The health care industry is highly inefficient—perhaps one of the most inefficient sectors of our economy.

- A 2013 Institute of Medicine review of previous studies estimated that 30 percent of health care spending, or $750 billion annually, is wasted.[1]
- The Dartmouth Institute for Health Policy has estimated that 20 to 30 percent of all Medicare clinical care spending is unnecessary or harmful and could be avoided without worsening health outcomes.[2]

Medicare's mission—to provide seniors with high-quality, affordable care—is complicated by the elderly's increased vulnerability to age-related medical conditions and the consequent challenges to their insurability. Growth in overall US health care spending is worrisome, but the challenges with regard to Medicare are even greater.

Modernizing the program remains politically challenging, if not positively perilous.

One source of cost growth is the retirement of baby boomers, which is increasing pressure on Medicare. A second is that Medicare's per-beneficiary costs have been growing faster than the United States' collective income for decades. Despite recent slowing in the growth of Medicare costs, the program remains the single most powerful driver of projected growth in the US public debt. For example, a recent Congressional Budget Office (CBO) report projected that Medicare would increase the US budget deficit by 2.5 percent of GDP by 2046, even after accounting for the recent slowdown in Medicare costs.

By contrast, the CBO estimates that all nonhealth components of noninterest spending will actually reduce the deficit by 0.6 percent of GDP over this same time frame.[3] Thus, all of the projected unsustainable increase in the public debt—including the cost of interest on that debt, can be assigned to the growing cost of Medicare and other health care.

Even with the recent cost slowdown, the question is not *whether* Medicare will overflow the banks of the federal budget, but *when*. The CBO projects the growth of Medicare spending and the resulting growth in interest on the national debt to be so rapid that it will crowd out available funding for other public priorities—including national security, infrastructure, scientific research, and education.

The ABCs (and Ds) of Medicare

Most seniors receive most of their health care coverage through the federal Medicare program. Medicare consists of four parts: Parts A, B, C, and D.

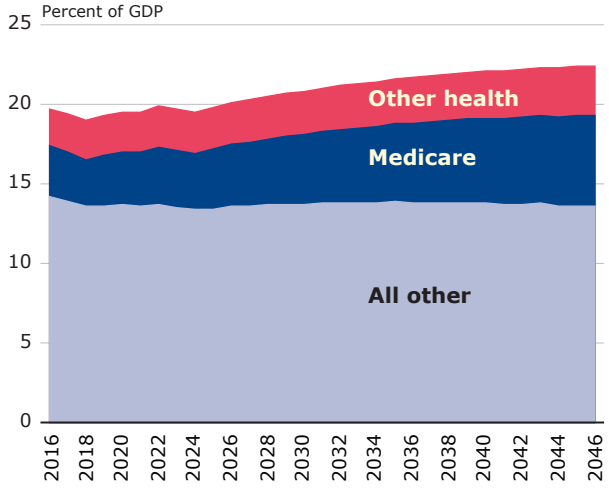
- Medicare Part A covers hospital bills. Current workers and employers pay a payroll tax to cover the cost of Medicare Part A for Medicare-eligible seniors.
- Medicare Part B covers physicians' services. Medicare Part B is paid for through a combination of general federal tax revenues and premiums paid by seniors.
- Medicare Part C provides seniors the option of enrolling in private health insurance through the Medicare Advantage program. (See *Medicare Advantage* on page 5.) Funding for Medicare Part C comes from payroll taxes, general federal tax revenues, and premiums paid by seniors.
- Medicare Part D covers prescription drugs. Its cost is paid through a combination of general federal tax revenues and premiums paid by seniors.

Medicare cost growth threatens both the quality of and access to the Medicare program itself.[4] Access to high-quality care for our nation's seniors cannot possibly be maintained indefinitely if Medicare costs continue to outpace growth in our nation's income.

Despite the urgency of addressing these threats to Medicare, modernizing the program remains politically challenging, if not positively perilous. The received wisdom is that Medicare (and Social Security) must be reformed for their own sake—not changed for budget purposes—lest policymakers be accused of "balancing the budget on the backs of the elderly." But given Medicare's cost and its centrality to the United States' long-term budget problems, modernizing Medicare is imperative. If the United States does not address Medicare cost growth, no other steps—no matter how draconian—can possibly prevent an eventual debt explosion. Ignoring the problem is not an option. To the contrary, the inevitable emergency program cuts will be more harmful to seniors than well-designed, purposeful reform undertaken now.

Chart 2

Health care accounts for all net spending growth



Source: 2016 Long-Term Budget Outlook, Congressional Budget Office.

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Despite these political challenges, modernizing Medicare provides opportunities to improve both the quality and affordability of care. Thanks in part to the modest slowing of Medicare's own cost growth in the wake of the financial crisis, the current brief respite from budgetary pressure provides an opportunity to allow market forces and consumer choice to improve quality, affordability, and access.

Modernizing Medicare through Medicare Advantage

CED's policy statement, *Adjusting the Prescription*, presents detailed policy proposals to reform the US health care system for the working-age population and its dependents. The need to address the system for seniors is no less urgent.

Fundamentally, we believe that value-conscious consumers of all ages choosing among competing health insurance plans will drive the entire health care system toward greater quality and affordability. Consumers will choose the plans that best meet their particular needs and preferences. And plans and providers, subjected to value-conscious consumers, will need to seek every opportunity to reduce cost while providing the highest possible quality.

This same approach can apply to Medicare. However, given Medicare's unique mission and characteristics, our approach must be specifically tailored to this application. CED proposes modernizing Medicare by modifying the Medicare Advantage program so that Medicare enrollees can save money if they make efficient choices.

Seniors' market-driven choices, in turn, will drive high-quality, affordable care over the long run. Specifically, we propose:

1. **Eliminating the Medicare Advantage price benchmark based on traditional Medicare's fee-for-service cost and providing enrollees with a premium subsidy**

   Currently, a formula based on the cost of traditional fee-for-service Medicare in the beneficiary's geographic area determines the amount the Medicare program pays for Medicare Advantage premiums—the "benchmark."

Medicare Advantage

Medicare Advantage, sometimes called "Part C," is a substitute for traditional Medicare. It is chosen voluntarily by many seniors who find Medicare Advantage plans that they prefer over traditional fee-for-service Medicare. Medicare Advantage premiums are paid in full or in part by the Medicare program, according to a formula based on the cost of traditional Medicare in the beneficiary's geographic area. If the premium is higher than the formula-based payment from Medicare, then the beneficiary is responsible for paying the difference. Most Medicare Advantage plans substitute for all of Part A (hospital coverage), Part B (physician coverage) and Part D (prescription drug coverage), and also eliminate the need for seniors to buy an add-on "Medigap" plan.

Most Medicare Advantage plans use "managed care" in the form of either integrated delivery systems (IDSs) or the use of restricted networks of cooperating but independent physicians (like Preferred Provider Organizations, or PPOs). As a result, Medicare Advantage plans generally serve specific geographic areas, with many different Medicare Advantage plans across the country. In 2016, 2,001 plans are available in at least one geographic area. Virtually all (99 percent) of Medicare beneficiaries have access to at least one plan.[5]

If the cost of the Medicare Advantage premium exceeds the benchmark, the beneficiary is responsible for paying the difference.

However, Medicare Advantage plans that have lower costs than the benchmark rate are not allowed to pass all of those savings on to seniors in the form of lower premiums. Instead, these efficient insurance plans can provide their beneficiaries only from 50 to 70 percent of the efficiency savings. (The percentage that may be given to enrollees depends upon the "star" quality rating of the plan. The balance of the efficiency savings, from 30 to 50 percent of the total, is paid to the federal government as its share.) The enrollee "rebate" of 50 to 70 percent of the "underbid" may be delivered by buying down Part B or Part D premiums, copays or deductibles. However, the plan, if it so chooses, can also provide additional coverages or benefits that might attract more enrollees, such as free eyeglasses, health club memberships, or some other benefit that it believes will increase its enrollment and thereby add to its operating surplus (or profit). This "bells and whistles" strategy might add to the satisfaction or wellbeing of the enrollees, but it does not go as far as it could to motivate enrollees to seek out more efficient plans or to motivate plans to pursue operating efficiencies.

In short, the "haircut" on rebates blunts the incentive for Medicare Advantage plans to pursue operating efficiencies and, therefore, for beneficiaries to consider Medicare Advantage in the first place.

To maximize these incentives, CED recommends that private Medicare Advantage plans be allowed to bid simply to replace Part A and Part B Medicare coverage, and that Medicare beneficiaries in the region would receive a premium subsidy equal to the premium of the second-lowest-priced Medicare Advantage plan in the region.[6] Each beneficiary would be able to choose any available plan using that subsidy.[7]

Beneficiaries would be responsible for paying the balance of any premium that exceeded the subsidy. Medicare Advantage providers could offer alternative plans with "bells and whistles" that broaden their coverage, but beneficiaries would remain responsible for any premium cost above the subsidy.

And that requirement for beneficiaries to pay any excess premium cost above the premium subsidy could apply to traditional Medicare as well.[8] If traditional Medicare is more expensive than Medicare Advantage plans available in the region, then beneficiaries should have the option of saving money by enrolling in a private Medicare Advantage plan.

2. **Increasing the income-conditioning of Part B and Part D premiums, including a temporary Part B premium reduction for lower-middle income seniors**

Seniors, as a group, are both wealthier and poorer than working-age families: that is, there are proportionally more seniors at both extremes of the income and wealth distributions. Very-low-income seniors are protected through their eligibility for Medicaid. Very high-income seniors benefit from subsidized Medicare premiums (even after taking into account the current income conditioning of Part B premiums). It would be fair and appropriate to charge them more for traditional fee-for-service Medicare if its costs proved higher than those of available private plans, and if they had choices of plans that could offer higher quality and greater efficiency.

The challenge is how to handle lower-middle-income seniors—those who are not eligible for Medicaid, but for whom the existing Medicare Part B premium already is expensive. Our proposal aims to reduce Part B premiums for comparatively low-income seniors so that they can continue in traditional fee-for-service Medicare, should they need to do so, at limited additional cost relative to the current system. However, our proposal also aims to give seniors of modest means an incentive to save money by choosing a more efficient Medicare Advantage plan should such a choice be feasible.

Redirecting some of our proposal's overall savings into a temporary reduction of the current Part B premium for those with incomes modestly above the threshold for Medicaid eligibility is the best way to reduce or eliminate the additional cost *relative to the current system* of staying with traditional Medicare while simultaneously maintaining the price advantage *under the new system* of Medicare Advantage plans we propose. The temporary premium reduction could be administered through the individual income tax. It should not apply to new retirees after the enactment of our proposal, and it should phase down with income so as not to impose a "notch" that would adversely affect seniors in the event of small increases of income.

The Part B premium already is income-conditioned through higher-than-standard charges for those with higher incomes. This proposal would extend that to include lower-than-standard premiums for those with lower incomes. It could elicit additional contributions only from more affluent seniors, leaving those with modest incomes better off or unaffected.

Greater competition among Medicare plans will drive providers and plans to hold costs down and deliver high-quality care.

Another question is whether to allow *current* Medicare enrollees to stay in traditional fee-for-service Medicare at no additional cost—so-called "grandfathering." This would be politically attractive but also very costly economically considering that the life expectancy of a new 65-year-old Medicare enrollee is about 20 years.[9] So not only would full grandfathering of existing Medicare beneficiaries greatly delay the achievement of budget savings, it also would so reduce the population of value-conscious enrollees that it would make the revised Medicare Advantage less attractive to innovative plans.[10]

3. **Risk-adjusting premium revenue for plans**

   One challenge associated with health insurance is that insurers have an incentive to seek out healthy enrollees who incur fewer costs and shun people who are sick. Such cherry picking can be outlawed; indeed, Medicare has prohibited insurers from rejecting applicants, yet subtle variations of such behavior have been alleged.[11] Premium revenue of plans should be risk adjusted, meaning the regulatory authority should hold back some portion of premium revenue for later distribution among the plans according to how their patients' diagnoses relate to the average diagnoses for the entire population.

   Risk adjustment rewards—and thereby incentivizes—plans that find ways to treat the sick more efficiently. Risk adjustment compensates plans that develop a reputation for providing exceptional treatment of expensive and serious conditions.

   Manipulation of risk adjustment remains a potential danger. Even in current fee-for-service Medicare, providers can search for the most expensive diagnoses on which to bill the system. Likewise, private plans that participate in Medicare Advantage can benefit from documenting a sicker-than-average enrollment, which some plans in the current Medicare Advantage have attempted, evidence suggests.[12] However, risk adjustment processes have improved over time. The same improvements that will be necessary to protect current fee-for-service Medicare will contribute to making a modernized Medicare Advantage more cost efficient as well.

4. **In rural areas, allowing Medicare beneficiaries to enroll in traditional Medicare at no additional out-of-pocket cost, until Medicare Advantage plans meet a minimum threshold of availability in the area and are generally accepted by health care providers**

Our proposal will yield estimated savings equal to approximately 9 percent of current program cost.

In some parts of the country, and especially in rural areas, Medicare Advantage alternatives to traditional Medicare are available on paper, but health care providers are few and geographically dispersed. Many do not participate in the available Medicare Advantage plans.

Nationwide, on average, a Medicare beneficiary can choose among 19 plans, with the average rising to 21 plans in metropolitan areas. In contrast, in nonmetropolitan areas, 3 percent of beneficiaries lack access to *any* plan except traditional Medicare, and another 4 percent of beneficiaries in 445 counties spread across 28 states have access to only one Medicare Advantage plan.[13]

The calculation of the premium subsidy described in Recommendation 1 must be based on Medicare Advantage plans that are truly available, if any are. If none exist, then the premium subsidy available to seniors in those areas must be sufficient to purchase traditional fee-for-service Medicare.

Why Modernizing Medicare through Medicare Advantage Will Work

Seniors have already shown themselves willing to enroll in Medicare Advantage plans. Medicare Advantage enrollment has increased from about 6 percent of seniors in 1992, when the plans were first introduced, to about 31 percent in 2016. Even more revealing, Medicare Advantage enrollment has continued to climb after 2010, when changes included in the Affordable Care Act essentially raised the prices of Medicare Advantage plans for seniors.[14]

Table 1

Modernizing Medicare through Medicare Advantage

Recommendation	Effect
1a. Eliminate Medicare Advantage (MA) price "benchmark" based on traditional Medicare fee-for-service cost.	Remove influence of inflation-prone, inefficient fee-for-service medicine on Medicare costs.
1b. Require MA plans to submit prices competitively, unconstrained by Medicare "benchmark." Allow plans to bid as low as their efficiency allows. Plans may offer variations with greater coverages and services at higher premium prices if they so choose.	Give plans the incentive to achieve efficiencies while maintaining quality, enabling them to bid lower to attract customers.
1c. Provide enrollees with a nonrefundable, single-purpose, advanceable credit that they can use to buy the lowest or the second-lowest-price plan (either MA or traditional Medicare) at no out-of-pocket cost. Allow enrollees to purchase more-expensive plans by paying the incremental cost above the second-lowest-price plans. (Enrollees pay an equivalent of the current-law Part B and Part D premiums subject to changes specified below.)	Enrollees choose plans based on their own preferences, quality, and price. Plans are driven by competition to achieve efficiencies to satisfy consumers, leading to pressure for continuous improvement and innovation.
2a. Increase the income conditioning of enrollee Part B and Part D premiums.	Upper-income beneficiaries pay higher premiums. Net program cost and the federal budget deficit and public debt are reduced accordingly.
2b. Temporarily reduce Part B premiums for current low-income beneficiaries who face increased costs if they choose to continue to use traditional Medicare. (New enrollees pay current-law Part B premiums, as modified above. Current enrollees who switch to lower-cost MA plans keep part of the savings.)	Allow low-income enrollees who have ongoing programs of care and relationships with current Medicare providers to continue that care with little or no out-of-pocket cost. Allow new low-income enrollees to obtain coverage at no out-of-pocket cost if they choose the low-priced plans but without any reduction in their current Part B and Part D premium-equivalents.
3. Risk-adjust plan premium revenue.	Reward plans that take on sick patients; discourage plans from seeking out only healthy patients.
4. Identify a minimum threshold for availability of MA plans in rural areas. Until MA plans are generally available and accepted by providers, allow beneficiaries to enroll in traditional Medicare at no additional out-of-pocket cost.	Protect rural enrollees who do not have access to true MA options from premium increases for traditional Medicare.

Modernizing Medicare through Medicare Advantage offers four sources of cost savings:

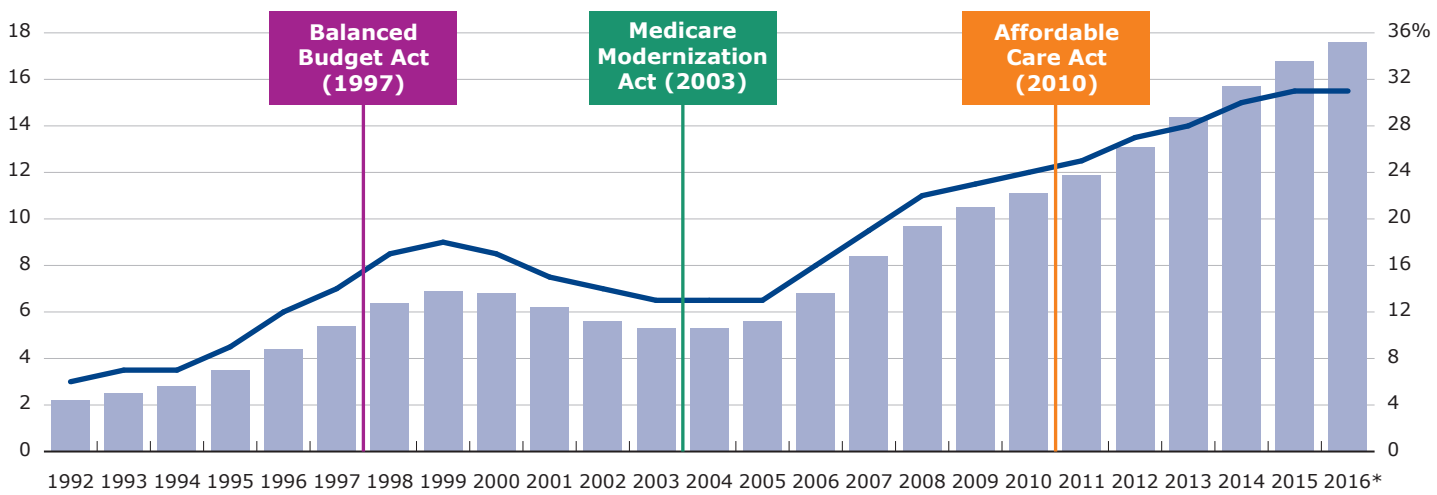
1. Some current Medicare beneficiaries will choose to switch to Medicare Advantage plans with lower premium costs. Some of those switching plans will be switching from traditional fee-for-service Medicare, and others will be seniors who are already enrolled in Medicare Advantage plans but choose to switch to a lower-cost Medicare Advantage plan with fewer "bells and whistles," which we expect will be more widely available under the reforms we propose. Because these individuals will be switching to more efficient plans, the Medicare payments on their behalf will fall accordingly and the overall benchmark in the region will tend to decline. Medicare will save money as a result.

2. Over time, growing familiarity with and acceptance of lower-cost Medicare Advantage plans may lead to increasing sign-up rates among *new* Medicare enrollees. Most Medicare Advantage plans use some form of "managed care," such as integrated delivery systems or preferred provider organizations (PPOs) that have become increasingly common for the working-age population. The greater exposure of recent retirees to managed care plans during their working lives may make them more receptive to coordinated Medicare Advantage plans than are older generations of retirees for whom traditional fee-for-service medicine was the norm.

3. Initially, CED's proposals will lead to lower Medicare pricing in low-cost regions (where efficient plans already exist) and to higher Medicare pricing in high-cost regions, *with little or no change in the overall average*. Over time, however, the higher benchmark payment by Medicare in higher-cost regions will increase the incentive for efficient plans to enter those markets. That will help move patterns of medical practice in high-cost regions towards those in low-cost regions, thereby saving money for Medicare.

Chart 3

Total Medicare private health plan enrollment, 1992–2016



* As of April 2016

Source: Kaiser Family Foundation, CED calculations

4. Over the long term, greater competition among Medicare plans—including traditional fee-for-service Medicare—will drive providers and plans to find ways to hold costs down while delivering high-quality care that Medicare enrollees want to choose. A wide variety of process improvements—including but not limited to practice patterns, back-office support, and cost-saving innovations in treatments and pharmaceuticals—are likely to be involved. The scope for efficiency improvement is quite broad, just as it is today in virtually every market other than health care.

The nonpartisan Congressional Budget Office (CBO) has estimated the potential cost savings of changes to Medicare that are broadly similar to CED's proposals.[15] CBO estimates that switching to such an approach would reduce total Medicare spending by approximately 6 percent. Increasing income conditioning for Part B (physicians' services) and Part D (pharmaceuticals) would add almost another 6 percent reduction in Medicare spending according to CBO's estimate.

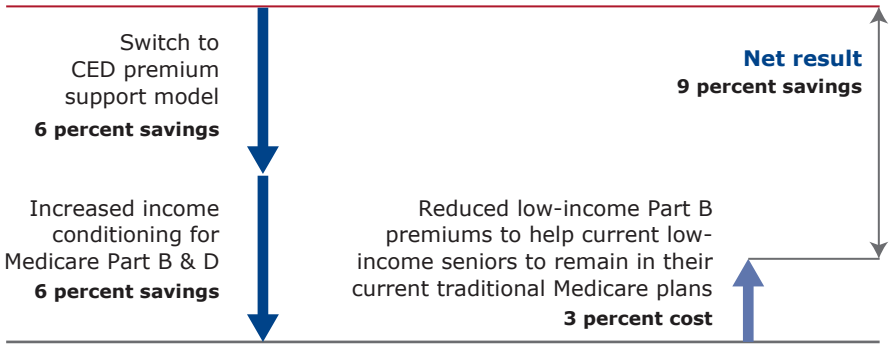
However, CED proposes using some of these savings to allow *current* low-income enrollees to remain in their current fee-for-service Medicare plans at no additional out-of-pocket cost. On net, we estimate that CED's proposal will yield savings equal to approximately 9 percent of current program cost.

CBO's estimates in this case generally exclude potential savings over the longer term from process or productivity improvements in health care delivery induced by greater competition. CED believes these market-driven advances will prove vitally important. We see plans with open-ended incentives to improve quality and reduce costs as among the most important drivers of better long-term outcomes, not only across Medicare Advantage plans, but within the fee-for-service world as well. For this reason, we expect that our proposed changes will yield even greater cost savings and quality improvement over the long run than the 9 percent we estimate in the short run.

Existing market-based health care systems for the working-age population that are similar to what we propose for Medicare have shown enormous promise in terms of both efficiency and quality. They do so because competition to attract cost-responsible enrollees forces plans to seek every means to deliver the highest possible quality at the lowest possible cost. For example, in Dane County, Wisconsin, more than 20 percent of residents are eligible for the state employee health insurance program, which encourages cost-conscious choices.

Chart 4

Estimated savings from CED Medicare Advantage proposals



Source: Congressional Budget Office and CED estimates

The presence of so many cost-conscious consumers has motivated the creation of a number of low-cost, high-quality integrated health care delivery systems, which may explain why Dane County had lower premiums and experienced lower premium increases in recent years than other similar Wisconsin counties.[16]

There is also clear evidence that Medicare Advantage plans can deliver high-quality health care to seniors at lower cost—i.e., more cost-efficiency—than traditional fee-for-service Medicare. About four-fifths (81 percent) of all Medicare beneficiaries have access to a plan that charges no additional premium above the cost of traditional Medicare, implying that many private plans can provide the same services as traditional Medicare at the same or lower cost.[17]

In 2015, premium reduction rebates—that is, reduced out-of-pocket costs (e.g., copays, deductibles) for the enrollee or additional services from Medicare Advantage plans—that were effectively able to operate at lower cost than traditional fee-for-service Medicare were available to 27 percent of the Medicare population. Across all plans, beneficiaries received an average of $76 per month in total rebates, including additional services and lower cost sharing.[18]

Clearly Medicare Advantage plans are capable of providing high-quality care while still underbidding traditional Medicare even today. They simply need sharper incentives to do so.

Conclusion

The longer our elected policymakers delay in modernizing Medicare, the larger its looming cost challenges grow. Fortunately, the tools for modernizing the program lie at hand, in the form of the existing and successful Medicare Advantage program. Enhancing the scope and power of consumers to pursue value through choice in the health care market will drive providers to find ways to increase quality while reducing cost. In this lies an enormous opportunity not just to lower but actually to bend the cost curve downward, while still providing every American access to the high-quality care that we as a society have promised, and that they have rightfully come to expect.

Endnotes

1 Mark Smith, Robert Saunders, Leigh Stuckhardt, and J. Michael McGinnis, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (Washington, D.C.: National Academies Press, 2013) (www.nap.edu/catalog/13444/best-care-at-lower-cost-the-path-to-continuously-learning).

2 Jonathan Skinner, PhD and Elliot S. Fisher, MD, MPH, *Reflections on Geographic Variations in U.S. Health Care*, The Dartmouth Institute for Health Policy & Clinical Practice, March 31, 2010 (www.dartmouthatlas.org/downloads/press/Skinner_Fisher_DA_05_10.pdf).

3 *The 2016 Long-Term Budget Outlook*, Congressional Budget Office, July 12, 2016 (www.cbo.gov/publication/51580). The figures quoted in the text ignore Medicare offsetting receipts, which would not affect the conclusion.

4 *2015 Long-Term Budget Outlook* , Congressional Budget Office.

5 Gretchen Jacobson, Marsha Gold, Anthony Damico, Tricia Neuman, and Giselle Casillas, *Medicare Advantage 2016 Data Spotlight: Overview of Plan Changes*, The Henry J. Kaiser Family Foundation, December 2015 (http://kff.org/medicare/issue-brief/medicare-advantage-2016-data-spotlight-overview-of-plan-changes/).

6 In other words, in return for paying the Part B premium according to current law, the beneficiary would receive the lowest or second-lowest plan at no additional charge. Setting the subsidy at the second-lowest bid both increases the plan capacity and provides choice at the zero out-of-pocket price point.

7 Many current MA plans offer drug coverage (the equivalent of Part D) as well. There need be no change in that coverage and cost. Similarly, Medicare Advantage plans typically reduce copays and deductibles and always include an out-of-pocket spending cap (thereby obviating the need for Medigap coverage), which could continue.

8 The Centers for Medicare and Medicaid Services, which administers Medicare, could be charged with computing the price of a Medicare premium on a comparable basis, including all of the cost elements that would be borne by private MA plans, and using risk adjustment to compensate if traditional Medicare has an enrolled population that is more or less costly to cover than private MA plans.

9 Life expectancy at age 65, of course, is much greater than life expectancy at birth. The latter is subject to many contingencies that already are passed by age 65.

10 CBO estimates that with grandfathering of current beneficiaries, after five years only 25 percent of beneficiaries would be covered by a new system, and those 25 percent, being younger and on average healthier, would account for only 15 percent of Medicare spending. After 10 years, only 45 percent of beneficiaries, responsible for only 30 percent of total spending, would be under the new system.

See *A Premium Support System for Medicare: Analysis of Illustrative Options*, Congressional Budget Office, September 2013 (www.cbo.gov/publication/44581).

11 Douglas B. Jacobs, Sc.B. and Benjamin D. Sommers, M.D., Ph.D., "Using Drugs to Discriminate—Adverse Selection in the Insurance Marketplace," *New England Journal of Medicine* 372, January 29, 2015, pp 399-402 (doi:10.1056/nejmp1411376).

12 Alice M. Rivlin and Willem Daniel, "Could Improving Choice and Competition in Medicare Advantage Be the Future of Medicare?," *Forum for Health Economics and Policy*, De Gruyter, vol. 18, issue 2, December 2015, pp 151–68 (doi:10.1515/fhep-2015-0046).

13 Jacobson, Gold, Damico, Neuman, and Casillas, *Medicare Advantage 2016 Data Spotlight*.

14 Approximately 24 percent of seniors were enrolled in MA plans in 2010 when the Affordable Care Act was enacted. See Tricia Neuman, Giselle Casillas, and Gretchen Jacobson, *Medicare Advantage and Traditional Medicare: Is the Balance Tipping?* The Henry J. Kaiser Family Foundation, October 20, 2015 (http://kff.org/medicare/issue-brief/medicare-advantage-and-traditional-medicare-is-the-balance-tipping/).

15 *A Premium Support System for Medicare*, CBO. The approaches considered by CBO (modeled after the plan proposed by Senator Ron Wyden and Representative Paul Ryan in 2011 (www.budget.house.gov/bipartisanhealthoptions)) differ from what we propose in several respects. So, for example, CBO assumes that MA would be abolished and new plans would be created to replace it, whereas we would modify MA instead. CBO also assumes that each issuer of insurance plans would be limited to offering two plans, in the interest of simplifying the choices available to consumers. We would allow insurers to offer more than two plans, in the interest of providing more choices and facilitating more innovation and competition. And unlike Wyden-Ryan, we would set the amount of the enrollee subsidy by competitive bid, not by an inflation-indexed cap.

16 Mike Bare, Erik Bakken, John Mullahy, and David Riemer, "The Dane Difference: Why Are Dane County's Exchange Premiums Lower?," *Health Affairs Blog*, December 18, 2014 (http://healthaffairs.org/blog/2014/12/18/the-dane-difference-why-are-dane-countys-exchange-premiums-lower/).

Adjusting the Prescription: Committee for Economic Development Recommendations for Health Care Reform, Committee for Economic Development, April 2015 (www.ced.org/reports/single/adjusting-the-prescription-ced-recommendations-for-health-care-reform).

17 Jacobson, Gold, Damico, Neuman, and Casillas, *Medicare Advantage 2016 Data Spotlight*.

18 "The Medicare Advantage program: Status report," Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 13, 2015 (www.medpac.gov/documents/reports/chapter-13-the-medicare-advantage-program-status-report-%28march-2015-report%29.pdf?sfvrsn=0).

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