Modernizing Medicare

A Report by the Committee for Economic Development of The Conference Board
Modernizing Medicare

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Executive Summary

In our policy statement *Adjusting the Prescription*, the Committee for Economic Development of The Conference Board (CED), presented 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. In this policy statement, we turn to that task.

Fundamentally, we believe that value-conscious consumers of whatever age 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 needs, and preferences differ. Plans and providers, subjected to value-conscious consumers, will need to seek every opportunity to reduce cost while providing the highest possible quality. To mobilize fully the beneficial forces of competition and to achieve universal coverage, we would provide beneficiaries with refundable and advanceable tax credits that could be used only to purchase health insurance coverage. The credit would cover the cost of a low-priced plan, fully meeting standards of coverage and quality, available in the market area of the recipient. The recipient may choose a more expensive plan, but if so, he or she is responsible for the difference in cost.

This fundamental approach can apply to Medicare. However, given the program’s unique mission and characteristics, our approach must be specifically tailored to Medicare. In particular, we believe that many Medicare beneficiaries will want to use alternatives to the traditional program, but others will resist any perceived change in the current system. To provide more and better alternatives, we therefore recommend building on the existing voluntary Medicare Advantage program, rather than imposing mandatory change on all.

Medicare Advantage has some of the characteristics of the system that we recommend, but from our perspective it has some specific flaws. In particular, the incentive in the current system is for Medicare Advantage plans that can achieve greater efficiency than the traditional system to spend the money that they save on additional services—“bells and whistles”—rather than to reduce prices they charge consumers. Therefore, we propose changing the Medicare Advantage pricing system. Beneficiaries would be able to choose between the two lowest-cost plans in their particular market areas at no additional cost. (As under current law, all beneficiaries would pay the equivalent of the Part B and Part D premiums. We choose two plans to ensure capacity and choice at that zero price point.) Beneficiaries will be free to choose more expensive plans, but those beneficiaries will be responsible for the incremental cost. Plans will have an inducement to hold their prices down to be more attractive to prospective enrollees—much more so than under current Medicare Advantage.

Meanwhile, we would maintain an equivalent of the current Medicare Part B and Part D premiums charged to enrollees but with modifications. Changes would include increasing modestly the income-adjusted premium amount for the more affluent enrollees and temporarily reducing the Part B premium for the lowest-income current enrollees (those who do not have their Part B premiums paid by Medicaid). Reducing these premiums would help those who must continue their programs of care that cannot be moved from providers under the existing traditional Medicare program. Thus, we would achieve quality, affordability and access—the three objectives of the US health care system.

We believe that our approach provides the greatest incentive both to maintain quality and to “bend the cost curve” and reduce the current unsustainable growth of costs under traditional Medicare. We believe that our proposal would have the greatest prospect of maintaining the quality of and access to Medicare coverage that our taxpayers need and deserve for decades and generations to come.
Introduction

The US health care system has accomplished many wonderful things. Its treatments for many acute and chronic conditions are world-class and widely emulated. Its pharmaceutical development leads the world. It has evolved innovative care delivery models as well. US health care professionals are well-trained and dedicated. They serve our population from gestation through old age with passion and patience.

And in the last six years, the Patient Protection and Affordable Care Act (ACA) took some important strides forward in terms of access to coverage for the nation’s workers and children—notably for low-income working families and for those with preexisting conditions—and took some positive steps on quality.

And yet, the US health care system must change. It can and must do better.

This is true of the private health care system even after the ACA—as we explained in April of 2015 in our policy statement, Adjusting the Prescription. But it also is true of Medicare—perhaps to an even greater degree.

Despite all of our nation's efforts in the delivery of care, we can do much more to keep seniors healthy, even as we continue to provide state-of-the-art treatments when they become sick. This is what we would call the quality of care: the timely delivery of the services, often simple and everyday in nature, that people need to remain well—thereby postponing or avoiding entirely the necessity of heroic, complex treatments that entail risk and their own ill effects. That especially includes avoiding the chronic conditions such as diabetes and heart disease that can erode the quality of life. And we must do all of this at a lower cost. Despite the recent slowdown in Medicare cost growth—which may have resulted to some degree from consumer reluctance to incur medical bills following the financial crisis—health care costs continue to grow unsustainably.

This would be true if only because of the inevitable demographic crush of aging baby boomers, coupled with lengthening life spans and falling birth rates (which reduce the number of taxpaying workers). Rising per-person health care costs compound the problem. This erodes seniors’ spendable incomes through higher out-of-pocket obligations and threatens their longer-term access to care.

There could be important synergies if the federal government were to restructure its Medicare program as well as to improve the ACA. Improvements to either the private or the public segments of the health care system would influence positively the evolution of the entire system. However, the two segments do operate largely independently, especially in the short run. And Medicare, in particular, has its own rules of pricing and the practice of medicine, which are sorely in need of modernization. So this CED policy statement focuses on how to make Medicare responsive to market forces, along the same lines as our recommendations to improve the ACA.

CED’s Overall Approach to Health Care Reform

Today, in Washington, health care policy is at a standoff. The nub of the dispute over health care is the relative roles of government and the market. And that philosophical distinction is nowhere stronger than in the operation of the federal Medicare program. In Adjusting the Prescription, the Committee for Economic Development (CED) put forward a proposal that we believe strikes the best balance between these roles—that takes the best of both perspectives and builds a system that achieves the objectives of both—in the context of the private health care system for the working-age population and their dependents. Here we discuss briefly the broad principles behind this approach, which we believe would apply equally to Medicare.
CED favors a fundamentally market-driven approach to increase access, control costs, and improve quality—in other words, to provide every consumer with value, which is the highest possible quality of health care per dollar spent. This is the same as our original vision, as expressed in 2007, but with some refinements, based on the experience of the ACA’s enactment and implementation. We see a role for the federal government that is more focused toward ensuring healthy private-sector competition as fertile ground for quality and efficiency to grow.

As we explained in our detailed 2015 policy statement:

- We believe that consumers can help to reduce the cost of care. In particular, consumers should be able to save money if they choose health-insurance plans that are more efficient and can deliver quality care at lower cost. We believe that consumer value-consciousness in turn will motivate value- and efficiency-consciousness on the part of plans and providers. In particular, plans will respond to consumers seeking value by demanding value from providers; thus, insurance reform will become delivery-system reform.

- For consumer value-consciousness to have impact, consumers must have choices among a broad variety of insurance plans. One size does not fit all; consumers have different preferences for care depending on their needs and where they live, and they deserve to have plans that meet their individual expectations. Government’s role is to prevent a “race to the bottom” by maintaining appropriate standards of coverage and quality of care, encouraging all existing and new plan business models through a level playing field, with sound consumer protection, full information, and true competition through anti-trust enforcement and other safeguards. We must recognize that the diversity of consumer preferences and needs likely will lead to a corresponding diversity of plans and providers in the marketplace, and that innovation and disruption of the traditional plan and provider business models will be essential to increase quality and slow the growth of costs.

- In particular, we should challenge fee-for-service medicine. The perverse incentives of this model are widely recognized. They shackle process improvement and competition and encourage overuse, leading to higher costs. We hope and even expect that innovation will someday improve upon and change current models of care beyond recognition, but today’s state of the art strongly indicates that we need sharper incentives for more integration and coordination of care.

- Just as consumers have varying preferences for care, so too do they have varying needs for communication to explain their options and to obtain coverage. We should offer consumers multiple access points through which to choose and purchase insurance. Private exchanges or individual insurance brokers should be able to offer service to those consumers who would prefer to build such relationships. The market should determine the kinds of information and guidance that consumers want (with protection against price discrimination based on health status) through genuine competition.

- Our health-insurance system needs to be mindful of differences in geography. Choices that are available in large metropolitan areas likely do not exist in sparsely populated rural settings. We must pursue the best delivery modes of care in both settings—even though they will be somewhat different.

- We should emphasize providing information for, rather than injecting remote government judgment into, the physician-patient relationship. We should expand data gathering and research to inform physicians and patients in their own decision-making. We should avoid pseudo-market devices that substitute government command and control for consumer and provider choices of what constitutes quality care at a lower cost.
• The health-insurance system should risk-adjust premium revenue. Plans should accept consumers at uniform premiums regardless of preexisting conditions, and those plans that care for more costly risks, on average, should be rewarded for doing so, through premium dollars held back and distributed among such plans based on their actual experience.

Compliance with these principles would, in our judgment, much improve the health care and health insurance systems for both the working-age population and their dependents and seniors. It would put our entire health care system on a long-term path toward quality improvement, greater and assured access, and affordability.

**Why Medicare Must Be Modernized**

Even with our recommended improvements of the ACA, restructuring the Medicare program would be an essential remaining step. We believe that CED’s recommendations to improve the ACA provide a sound general approach to improve health care in the United States, and also a foundation for the essential next step of modernizing Medicare. The nation’s current health care system for seniors, anchored by Medicare, presents its own problems and requires specific solutions.

**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 whose cost is divided between employer and employee, with the federal government (and therefore all taxpayers) sharing the cost in a less than transparent way, through tax subsidies for employer contributions toward the cost of that private insurance. The very low-income working-aged population is covered by the joint federal-state Medicaid program (depending on state participation for some persons), and now with the ACA the federal government provides subsidies for the premium payments for private insurance of those just higher in income than the Medicaid eligibility threshold in some states.

**Compliance with these principles would put our entire health care system on a long-term path toward quality improvement, greater and assured access, and affordability.**

**How Medicare Works.** Coverage for seniors is more heavily public than private. Although there remain some retiree health plans funded by employers, the great bulk of coverage is provided under Medicare. Coverage of low-income seniors, particularly the permanently disabled who need long-term care, is in larger part the responsibility of Medicaid. Military veterans have their own system under the Veterans Administration.

The cost of Medicare coverage is distributed across multiple funding sources. Current workers and employers pay a payroll tax to fund Medicare Part A, which covers hospital bills. The cost of Medicare Part B, which covers physicians’ services, is shared between general tax revenues and beneficiary premiums. Those premiums are income conditioned, with general revenues covering the lowest-income beneficiaries, premiums paid out of pocket by the middle-income seniors (through deductions from Social Security benefits for those who receive benefits), and still higher premiums charged to the upper-income seniors (again collected through deductions from Social Security payments).

Most Medicare enrollees accept the default program, known as “traditional” or “fee-for-service” Medicare. Enrollees can go to any provider or hospital that accepts Medicare. Some physicians are “participating” Medicare providers, who have agreed to “assignment”—that is, they will accept the Medicare reimbursement formula as payment in full (beyond Medicare’s own copays and deductibles, which are the responsibility of the patient; many enrollees purchase add-on private insurance, or “Medigap” coverage, to pay for those copays and deductibles). Other providers may charge fees in excess of the Medicare reimbursement.
There is considerable controversy over whether Medicare attracts a sufficient number of providers to be “participating” providers—or to accept Medicare patients at all—and whether willingness to serve Medicare patients is declining over time. This could complicate the transition to traditional Medicare coverage for many newly eligible enrollees.

Medicare’s costs have been growing more rapidly than the nation’s collective income—out of which those costs must be paid.

The alternative for Medicare enrollees is to choose private plans under Medicare Advantage, sometimes called “Part C.” Medicare Advantage plans sometimes impose provider network constraints, like those imposed by many private plans for the working-age-population and their dependents. Some Medicare Advantage plans are available at no additional cost over traditional Medicare or even offer additional coverage or small cash rebates. Other Medicare Advantage plans might charge more than traditional Medicare. Medicare Advantage has itself been controversial over recent years and has been the subject of several major legislative changes. We will argue below that Medicare Advantage, with some focused changes, could significantly improve the workings of Medicare in terms of quality, affordability, and access.

The Problem. For decades, the United States has spent an ever-increasing share of its collective income on health (see Chart 1). At the simplest level, this may or may not be a problem. The world’s most affluent (and increasingly affluent) nation might rationally decide to devote a disproportionate share of the increment to its affluence on health, as opposed to other potential uses. And we arguably have enjoyed a return on that investment. However, many would ask whether we have received full value from that growing spending. The health care industry may be one of the most (if not the most) inefficient sectors of our economy. And it is not clear whether our nation has the power to arrest the growth of spending on health care by limiting it to the amount that truly adds value.

![Chart 1](Image)

**National health expenditures are a growing share of the economy**

Percent of GDP

Source: Centers for Medicare and Medicaid Services
The rising cost of health care is an increasing drag on every budget in the nation. Businesses trying to maintain a constant level of coverage for their employees and their families have faced rising costs that have impinged upon research and development (R&D), investment, and in the long run, increases in cash wages (and in other forms of employee compensation). Households have had their spendable incomes pinched by rising premium payments, higher copays and deductibles, cutbacks in coverage, and ultimately by reduced growth of take-home pay because of rising employer premiums. CED’s recommendations for ACA improvement have addressed the growth of those private costs.

Medicare faces all of the same issues as private-sector health care, but its challenges are even greater. The quality of care will be under increasing pressure as the large baby boomer generation ages and retires. But further, cost is a major concern—and inevitably following on cost, access. CED’s recommendations to improve the ACA are directed at the private-sector drain of rising costs. But because care for seniors is borne more heavily by the public sector, Medicare’s cost growth has been felt more by government budgets (as well as the seniors themselves), and the burden there may soon attract even more attention among policy makers in Washington than have the ills of private health care.

Medicare’s costs have been growing more rapidly than the nation’s collective income—out of which those costs must be paid. The gap between costs and revenues is so large that the accumulated public debt is projected to grow enormously—crossing 100 percent by 2039.

Medicare is the single most powerful force behind the projected future growth of the public debt (despite the recent cost slowdown). This is made clear by the relative rates of growth of spending on Medicare and of all other noninterest federal programs.

If the nation does not address the long-run Medicare cost problem, no other steps—no matter how draconian—can possibly prevent an eventual debt explosion.

In fact, the Congressional Budget Office (CBO) projects in their baseline that, by the year 2046, taking account of all savings claimed by the ACA and all of the recent good news regarding slower-than-anticipated growth in health care costs, spending on Medicare will have increased by 2.5 percent of GDP, while other federal health care spending will have increased by another 0.8 percent of GDP. But taken together, all other components of noninterest spending are projected on net to reduce the deficit by 0.6 percent of GDP. Thus, all of the increase in debt and deficits, and all of the resulting increase in interest on the debt, can fairly be attributed to the increase in Medicare plus other health care spending (see Chart 2).
In their 2014 long-run baseline projections, CBO assumed that revenues would follow the current law, and thus would increase well above their current level (which is approximately their post-World War II average) of about 18 percent of GDP, reaching almost 24 percent of GDP by the end of the long-term projection in 2090. Even so, the growth of Medicare spending and the resulting debt-service cost is so rapid that the rising deficit will crowd out almost all available funding for all other public priorities—including national security, infrastructure, scientific research, education, food safety, and all the rest (see Chart 3). If revenues were constrained to current levels, debt service growth would be even faster, and room for nonhealth, noninterest spending within available revenues will be essentially exhausted much faster, by 2054—at which point the debt load and deficits would be so high that the CBO mathematical macroeconomic model fails to solve (see Chart 4).7

The current Medicare system has not proven amenable to cost control. Until recently, the law included mandatory physician reimbursement cuts if cost growth exceeded set thresholds, but the policymaking system proved incapable of allowing those reimbursement cuts to occur. In the last decade or so, there has been some relief from Medicare cost growth. Some of this relief is likely because of the recent deep economic recession, and eventually will dissipate. Some of the cost saving is likely driven by less consumer use because of higher copays. Yet even with the recent cost slowdown, Medicare eventually will overflow the banks of the budget—the question is when, not if.

The problem of cost growth threatens both the quality of and access to the program. If large cuts in physician reimbursements were to take place, there is little doubt that some physicians would choose to cease serving Medicare beneficiaries, while those remaining would attempt to shift costs from Medicare to beneficiaries or the private sector. Many beneficiaries could lose access altogether, while a growing sense (and reality) of Medicare as a “second-tier” health care system would emerge for others.

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Medicare and resulting debt service crowd out all other federal priorities

% of GDP

![Chart 3](chart3)

![Chart 4](chart4)

**Source:** 2014 Long-Term Budget Outlook, Congressional Budget Office.
Current law also empowers the Independent Payment Advisory Board (IPAB) to identify and mandate cost-saving measures for Medicare, but we are skeptical that the IPAB’s recommendations are likely to marry quality and savings. We believe that market forces could induce a number of competing insurance plans to identify potential cost savings better than a single independent and remote board. Market forces could be unleashed if private plans and the traditional Medicare system competed on a level playing field and allowed individual beneficiaries to choose the best value. Such a “premium support” model may emerge as a frequently chosen alternative to the current single-payer Medicare system. It has been advocated by, among others, the Bipartisan Policy Center’s Debt Reduction (the “Domenici-Rivlin”) Task Force.

**If the nation does not address the long-run Medicare cost problem, no other steps—no matter how draconian—can possibly prevent an eventual debt explosion.**

Considering the demographic pressures of baby-boomer retirements and longer-term increases in longevity and reductions in fertility, fundamental modernization is essential. CED recommends that our model for improvement of the ACA be applied to the Medicare Advantage program.

Seniors are particularly concerned about their health care. Many have medical conditions, and are in programs of care with providers they know and trust. Therefore, those seniors are understandably wary of potential disruptions in their health care system. Elected officials are apt to use health care as a political issue rather than to make the necessary choices. That creates important problems for public policy.

In particular, the received wisdom is that Medicare (and Social Security) must be reformed for their own sake; they must not be changed for budget purposes, lest the policymakers be accused of “balancing the budget on the backs of the elderly.” This is particularly awkward, given the central role of Medicare costs in the long-run budget problem. In summary, if the nation does not address the long-run Medicare cost problem, no other steps—no matter how draconian—possibly can prevent an eventual debt explosion. A slowing of Medicare cost growth relative to the current projections is necessary and inevitable. But given the politics, all changes in Medicare must be done with extreme sensitivity to the fears of seniors that they will lose their providers and programs of care, or that their care will become unaffordable within their fixed incomes, or both. Not only must program reform be chosen to avoid those eventualities, but it must also be communicated in a fashion that makes this absolutely clear.

The politics of reform are perilous, and yet much can be gained from improvements in both the quality and the affordability of care. There can be no guarantee of the continuity of care even if the current Medicare program is left untouched in perpetuity—if only for the obvious reason that individual providers come and go. Furthermore, if the current Medicare program is left to the projected escalation of costs, the eventual emergency program cuts will be far more harmful to seniors than well-designed purposeful reform now. Success in achieving a better and a sustainable Medicare depends on the imperative of improving the quality of care, the creation of the best transition mechanisms, and the communication of those policies to the public. Past efforts at major reforms in this space have failed, and we are under no illusions that future efforts, however well meaning, will be easy.
Modernizing Medicare—The Current Limits and Potential Role of Medicare Advantage

We believe that the best vehicle for modernizing Medicare is the current Medicare Advantage program. Medicare Advantage is a substitute for traditional Medicare. It is chosen voluntarily by many beneficiaries who find Medicare Advantage plans that they prefer to 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 fee-for-service Medicare in the beneficiary’s geographic area. Some plans are more expensive than the formula-based payment from Medicare, and if so, the beneficiary is responsible for the difference. Plans most often are some form of “managed care,” with a pharmacy benefit; and so most Medicare Advantage plans (sometimes called Part C) substitute for all of Part A (hospital coverage), Part B (physician coverage) and Part D (prescription drug coverage), while also obviating the need for an add-on private “Medigap” plan.

Because most Medicare Advantage plans use “managed care,” in the sense that they either are integrated delivery systems (IDSs) or they use restricted networks of cooperating but independent physicians (like Preferred Provider Organizations, or PPOs), they generally serve specific geographic areas. As a result, there are many Medicare Advantage plans across the country. This year, 2,001 plans are available in at least one geographic area. On average, beneficiaries can choose from among 19 plans offered by six different firms as alternatives to traditional fee-for-service Medicare. (In other words, many firms offer multiple plans from which enrollees may choose.) Virtually all (99 percent) of Medicare beneficiaries have access to at least one plan.9

To a limited degree, the current Medicare Advantage program is similar to CED’s vision: Each beneficiary may choose among alternative plans, and, if the beneficiary chooses an expensive plan, he or she is responsible for the incremental cost. However, in a fundamental difference, the minimum cost of Medicare Advantage plans is effectively fixed at approximately the cost of delivering traditional Medicare services.

Even with its current blunted incentives, Medicare Advantage performs quite well.

That is, a Medicare Advantage plan that achieves greater operating efficiency is not free to charge a lower premium such that its enrollees can save all of those additional dollars. Rather, an efficient Medicare Advantage plan can provide its beneficiaries only from 50 to 70 percent of the efficiency savings. (The percentage of this “rebate” 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 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).

These “bells and whistles” might add to the satisfaction or well-being of the enrollees, but they do not motivate enrollees to seek out more efficient plans or to motivate plans to pursue operating efficiencies. And because these plans must return 30 to 50 percent of any such cost reduction or service, but can use the full savings for advertising, marketing, or any other such enhancement within the standard Medicare package, the incentive to underbid traditional Medicare is attenuated. Under the system that we envision, all plans would be induced to control costs and reduce their bids simply to attract enrollees.
In other words, Medicare Advantage as it is now designed does not truly fulfill CED’s objective of driving higher quality at lower cost; our proposed alternative would.

And we believe the potential of a freed, more competitive Medicare Advantage to be substantial. Even with its current blunted incentives, Medicare Advantage performs quite well.

The standard of comparison is traditional Medicare. Even after the payment of the Part B premium, traditional Medicare provides no limit on out-of-pocket costs, specifically copays and deductibles on the delivery of care. That is why many of the elderly choose to protect themselves from potentially catastrophic loss by paying still more for private, add-on “Medigap” policies. However, since 2011, all Medicare Advantage plans have been required to limit beneficiaries’ out-of-pocket spending for services covered under Medicare Parts A and B to no more than $6,700— with no additional charge for a Medigap policy. But Medicare Advantage plans are permitted to provide still lower out-of-pocket limits, and in 2016, Medicare Advantage enrollees’ average out-of-pocket limit was $5,235. Thus, in this respect, Medicare Advantage plans offer more robust coverage than does traditional Medicare.

One more source of out-of-pocket cost for Medicare enrollees is prescription drug coverage; and again, Medicare Advantage plans offer stronger coverage than does traditional Medicare Part D. In 2016, Medicare Part D imposes a $4,850 out-of-pocket limit (which includes a $360 deductible plus the so-called “donut hole” or “gap” without coverage) in addition to a 5-percent deductible, without limit, on additional pharmaceutical purchases. So again, enrollee out-of-pocket costs are in theory potentially infinite but can be limited and reduced through the purchase of an additional private Medigap policy.

Yet here, too, Medicare Advantage plans provide more robust coverage. Medicare Advantage coverage is required to be of at least equal value to traditional Part D, and so Medicare Advantage plans are invariably at least as good. Only 16 percent of Medicare Advantage plans include the full $360 deductible; 55 percent have no such deductible at all. And as to the “donut hole,” 44 percent of Medicare Advantage plans offer at least some additional coverage in that range of pharmaceutical expenses.

And despite these lower limits on out-of-pocket cost, Medicare Advantage plans’ premiums are competitive with traditional Medicare. About four-fifths (81 percent) of all beneficiaries have access to a plan that costs the same as the traditional Medicare Part B premium (typically called a “zero premium plan”). We believe that this performance in terms of pricing and coverage is only a first indicator of what could be accomplished if Medicare Advantage plans were truly free to compete.

As noted above, seniors are—with some good reason—very cautious about changes in traditional Medicare. They fear that ill-considered change might cause them to lose their current providers or programs of care or might raise the cost of their coverage beyond their ability to pay. This has created politically motivated inertia that has caused some budget analysts to despair of ever solving Medicare’s long-run budget problem. It is somewhat surprising, therefore, that a growing proportion of seniors have chosen to overcome that inertia on their own—by leaving traditional fee-for-service Medicare to move to private Medicare Advantage plans.
History of Medicare Advantage

In 1992, 2.2 million Medicare beneficiaries were enrolled in Medicare Advantage (then called “Medicare+Choice”) plans. Enrollment grew steadily until about the time of the enactment of the Balanced Budget Act (BBA) of 1997. Prior to the BBA, the federal-government-paid Medicare Advantage plan premiums were set above the average cost of traditional Medicare in each geographic area, to encourage the growth of the program. That above-average premium to Medicare Advantage plans caused concern for its effect on the overall Federal budget. It also caused some to fear that Medicare Advantage would displace traditional Medicare solely because of those additional resources—which, of course, could not be sustained in the long run.

Accordingly, the BBA cut Medicare Advantage reimbursements to amounts closer to traditional Medicare. That was expected to reduce Medicare Advantage enrollment, and it did. Enrollment fell from a peak of 6.9 million in 1999 to 5.3 million in 2003 (see Chart 5).

In that year, the Medicare Modernization Act (MMA—whose major purpose was to provide prescription drug coverage under Medicare) renamed the program “Medicare Advantage” and revised the payment formula. MMA provided a temporary increase in the payment, superseded by a more fundamental revision of the benchmark for costs used to set Medicare Advantage premiums. This new benchmark formula was still tied to Medicare fee-for-service (FFS) spending in the region. The MMA also eased entry into the program for PPO-type plans. As a result of these changes, Medicare Advantage enrollment surged, from 5.3 million in 2003 to 11.1 million in 2010.

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**Chart 5**

**Total Medicare private health plan enrollment, 1992–2016**

- Millions of persons (left scale)
- Percent of all Medicare beneficiaries (right scale)

- **Balanced Budget Act (1997)**
- **Medicare Modernization Act (2003)**
- **Affordable Care Act (2010)**

* As of April 2016

Source: Kaiser Family Foundation, CED calculations
In the debate over the legislation that would become the ACA in 2010, however, concerns again arose about the growing costs in Medicare. Reducing Medicare Advantage premiums was seen as a way of saving federal budget dollars—and therefore, of paying for the ACA. Furthermore, advocates of traditional Medicare also remained concerned that the growth of Medicare Advantage enrollment would gradually erode support for the old-fashioned program. Accordingly, the ACA reduced premium reimbursements for Medicare Advantage significantly. The Congressional Budget Office (CBO), the nonpartisan official scorekeeper of the Congress, estimated that these provisions would reduce total Medicare spending by $117 billion over 10 years (2010–2019).

These changes in reimbursement were expected to make Medicare Advantage much less attractive to both providers and prospective enrollees. At the time of the consideration of the ACA, CBO estimated 2009 Medicare Advantage enrollment at 10.6 million. With no change in law, projected 2019 enrollment was 13.9 million. With the changes in the ACA, CBO estimated that Medicare Advantage enrollment would drop to 9.1 million in 2019—less than 2009 enrollment—and 35 percent lower than the projected 2019 level.

The remarkable development was that this projection turned out to be wrong, not just in amount but in direction. Medicare Advantage enrollment not only has refused to drop, it has increased substantially. Enrollment in 2014 was 15.7 million, or about 30 percent of seniors—up from about 6 percent in 1992 and about 24 percent as of the enactment of the ACA in 2010.

Lessons of Medicare Advantage

We at CED take two lessons from this experience. The first is that seniors clearly are willing and able to make sophisticated choices. To the extent that news and chatter told a story of declining attractiveness of Medicare Advantage plans, millions of seniors reviewed the facts and their own circumstances and made their own decisions. This is a confirmation of the experience with respect to Medicare prescription drug (Part D) coverage. At the time of creation of Part D in 2003, the conventional wisdom was that many if not most seniors could not handle the volumes of information and the multiple choices involved, and that the system would collapse under the weight of mass confusion and indecision. In practice, providers and support organizations have used everything from Internet tools to one-on-one counseling to help seniors find the plans that are best for them individually. The evidence says that beneficiaries have found their way to good plans and are highly satisfied with the program and with their choices. Moreover, the cost of the program has come in well below estimates. Thus, we would by no means sell short the capability of the Medicare beneficiary population to make intelligent choices.

Many of the arguments in defense of traditional Medicare exhibit a similar factual disconnect, which commonly are based on the notion that seniors are not capable of making choices among alternative health care plans. The conclusion of this argument is that Medicare should preserve the traditional fee-for-service program as a simple option, or should even restrict seniors to traditional Medicare, so as to protect them from making mistakes in any choices among alternative plans—such as are afforded by Medicare Advantage. The successful experience of seniors in navigating Medicare Part D (prescription drug coverage) belies that concern.

But the true logical disconnect and irony is that once the non-Medicare Advantage seniors are enrolled in traditional Medicare, they can be confronted with far more complex choices among alternative providers, including most notably choices among specialists in several disciplines to deal with their multiple chronic conditions. This raises many potential pitfalls. For example, patients seeking multiple specialists might be stymied if some candidates do not participate in Medicare (that is, do not accept Medicare reimbursement at Medicare’s typically low rates).
Patients might choose particular specialists who have no history of collaborating with one another, potentially leading to failures of coordination that can yield inferior care. Given that defenders of fee-for-service plans often cite as an advantage access to a broader menu of providers, which is inherently complex for enrollees, it is ironic that defenders of fee-for-service Medicare often cite simplicity as an advantage of that program.

**Unlike virtually any other enterprises in the economy, Medicare Advantage plans can deliver only a part of any price reduction to their customers.**

Our second lesson, more specifically, is that plans like those offered by Medicare Advantage appeal greatly to seniors. In part, this is because seniors recognize the value of coordinated care. One can theorize about the advantages of a fee-for-service plan reimbursing all physicians, and therefore allowing the enrollee to choose the one very best physician in every specialty. But given the frequency among seniors of having multiple interacting conditions, and the benefits in such circumstances of the specialty physicians working as a team with a sophisticated central knowledge base, the alleged advantages of broad-access, fee-for-service medicine probably remain theoretical in most cases. And the cost savings and simplicity afforded by coordinated care likely mean that more Medicare Advantage enrollees actually receive the specialty attention they need. Evidence shows that much of recent Medicare Advantage enrollment comes from current Medicare enrollees switching from traditional Medicare, rather than signups by newly eligible Medicare enrollees.\(^\text{13}\) It might be that a period of enrollment in traditional Medicare leads some beneficiaries to conclude that Medicare Advantage would be superior.

Here again, we see a logical disconnect in common arguments against private Medicare Advantage plans. Defenders of traditional Medicare sometimes argue that private plans will engage in a “race to the bottom” by skimping on coverage to reduce costs and increase profits. Apart from the fact that some of the leading private plans are organized as not-for-profits, this argument misses much crucial reality. Private plans do best when enrollees stay healthy and continue paying premiums with the fewest possible health problems. And traditional Medicare is not provided by government employees with somehow higher motives. The federal government and Medicare do not deliver health care, only health care coverage and administration. Most fee-for-service Medicare providers (other than not-for-profit hospitals or other institutions) are private individuals who are motivated to earn incomes. Without impugning their integrity, they easily can respond to the incentive that fee-for-service medicine presents: the more services, the more fees. Numerous accounts of excesses—both legal and illegal—by providers under fee-for-service Medicare have been documented.\(^\text{14}\) Physicians who practice under Medicare and private Medicare Advantage plans have taken the same oath to care for their patients. No black-and-white interpretation of care under traditional Medicare versus Medicare Advantage is justified.

Furthermore, traditional fee-for-service Medicare for decades has pursued cost savings through reductions in administered reimbursement rates and prices, rather than avoiding excessive and wasteful procedures and pursuing greater efficiency. In its practical effect, this enduring pursuit of savings by quite possibly reimbursing providers below costs and motivating many to leave the Medicare program might well be described as a “race to the bottom” all on its own.

Another reason for Medicare Advantage’s attraction for seniors might well be the greater exposure of the working-age population to various forms of coordinated care. As those persons become eligible for Medicare, they likely would be much more receptive to coordinated Medicare Advantage plans than new enrollees were one or two generations ago, to whom traditional fee-for-service medicine was the norm, if not their only experience.
The administrators of Medicare should continue to expand and refine their current bundling and accountable care organization (ACO) initiatives (though we see such initiatives as an endless and only partially effective “cat and mouse” competition between providers and regulators). But considering the weakness of such halfway measures and the almost certain political resistance to more fundamental changes in traditional Medicare, we see revisions in Medicare Advantage that motivate greater competition as the best way forward. We propose to allow Medicare enrollees to save money if they make an efficient choice, and for those market-driven choices to yield quality, affordable care.

From the perspective of long-term health care system improvement, the shortcoming of the current Medicare Advantage program is that it provides insufficient incentive for efficiency. This is because competing plans can spend 100 percent of any efficiency savings on any advertising, marketing, or amenities that might attract enrollees (or merely keep the savings in their own coffers), but alternatively may rebate only 50 to 70 percent of such savings in reduced out-of-pocket costs (or additional coverages). So competing plans are relatively less likely to pursue customers by reducing price. Unlike virtually any other enterprises in the economy, Medicare Advantage plans can deliver only a part of any price reduction to their customers.

Many seniors—both new enrollees just turning 65, and older continuing beneficiaries—clearly prefer to be able to choose programs of care other than the traditional fee-for-service system. Unleashing the current Medicare Advantage program to achieve even greater efficiency and draw additional enrollees voluntarily should be far more politically acceptable than forcing unwilling seniors out of the traditional program. And from that enhanced competition in Medicare Advantage will flow the quality improvement and cost reduction that seniors and the nation at large so desperately need.

Modernizing Medicare—How It Might Be Done

In our proposal to improve the ACA, we would provide a universal, fixed-dollar, single-purpose refundable tax credit that would pay for the low-priced plan in the region. We believe that the same general approach would drive competition, quality improvement, and greater efficiency in Medicare Advantage, in exactly the same fundamental way.

We believe that the best outcome would be achieved if the process began with enactment of CED’s vision for the improvement of the ACA for the working-age population and their dependents. The current popularity of the Medicare Advantage program is driven to a considerable degree, we believe, by the expansion of choice of health care plans among working-age consumers over the last decade or two—notably, the growth of systems closer to the model of managed care. If consumers continue to exercise such choice while they are working, they will be better prepared in their Medicare years to make the more-informed choices that our proposal would seek. Thus, CED’s proposal with respect to the ACA would be a most helpful foundation for Medicare reform.

For many, reform of the Medicare system may offer more stability and continuity, not less.

Furthermore, many seniors will be resistant to any significant change in policy with respect to Medicare, because many are on fixed incomes (and have, of course, no or limited employment prospects) and might want or need the traditional fee-for-service Medicare program, perhaps to keep particular providers who already participate in their programs of care.15 Seniors are rightfully sensitive to potential changes in expected premium costs as well, because their incomes are typically fixed, and they often have no option to resume work, increase their work hours, or make career changes.
Transition to a fundamentally restructured Medicare program will not be simple, and it must be gradual. Current Medicare beneficiaries, especially those who are older, already have medical conditions and relationships with physicians who treat them. Packing up and moving to a new health care plan may not be an attractive—or even a feasible—option for those people.

**The vast majority of new Medicare beneficiaries must change their health care arrangements upon enrollment.**

Beyond the issue of continuity of care is the matter of finance. If Medicare is not to overwhelm the federal budget—which, by current trends, it will do, even with the recent cost-growth slowdown—the federal government must spend less. Some consider Medicare spending to be a zero-sum game. To them, if the federal government spends less, beneficiaries must spend more (or suffer deteriorations of care). To seniors living on social security plus small, eroding retirement nest eggs, who have no realistic options for supplementing their incomes, this prospect is terrifying. Some with political agendas exploit these preconceptions and fears and make a serious national conversation about solidifying Medicare’s finances almost impossible.

The path forward must respect the financial vulnerability of the current seniors and their need for continuity of care. This means that budgetary savings from Medicare reform necessarily will flow more slowly (which also means that beginning the reform process is urgent). Some argue that, to maintain the stability of care for the current senior population, who already have medical conditions and programs of care with physicians they know and trust, Medicare must remain unchanged in perpetuity. That is a formula for fiscal disaster and it misjudges reality. It misses the fundamental point: the vast majority of new Medicare beneficiaries must change their health care arrangements upon enrollment. Obviously, very few newly minted 65-year-olds have any prior experience with Medicare. An intelligent modernization program would take advantage of that reality and see to it that new enrollees (and any older beneficiaries who can consider changing plans) have an array of higher-quality, higher-value plans from which to choose. And if the Medicare Advantage market becomes attractive to enrollees, it will likewise become attractive to insurers and integrated plans, which may offer new 65-year-olds the option of continuing with the same kinds of plans that they chose while in their working years. Thus, for many, reform of the Medicare system may offer more stability and continuity, not less. But as Medicare Advantage expands, the federal government must use risk adjustment and other tools to ensure that care of the current seniors through traditional Medicare remains stable as well.

Upon that basis, we envision a Medicare Advantage program that is changed only with respect to regulation of pricing. As noted above, under the current system, Medicare Advantage plans are required to offer a base bid for provision of Medicare Part A and Part B services. If the plan believes that it can achieve efficiencies such that it can underbid the benchmark price in its region, then it can provide a rebate in cost abatement or services to the enrollee equal to only part of its underbid. Many plans surely conclude that keeping the full amount of efficiency savings, or spending it on advertising or marketing, is more appealing than providing potential enrollees with only partial cost abatement or services and turning over the rest to the federal government. Crucially, this mitigates the competitive pressure to reduce premiums. (See the explanation in Figure 1 on page 18.)
Figure 1

Current Enrollee Choices

Plan W
- Traditional Medicare
- $$$$$
- "Any willing provider"
- Fee for service
- No MEDIGAP needed

Plan X
- Medicare Advantage
- $$$$$
- Efficient selected-provider network
- No additional services
- Small cost rebate
- No MEDIGAP needed

Plan Y
- Medicare Advantage
- $$$$$
- Efficient selected-provider network
- Additional services
- No cost rebate
- No MEDIGAP needed
Instead, we foresee allowing plans to bid simply to replace Part A and Part B coverage. In return for paying the equivalent of the current Part B premium, beneficiaries could purchase the lowest- or the second lowest-priced plan in the region.\textsuperscript{17} We recommend the use of the second-lowest bid to 1) allow enrollees to have a choice of at least two plans (more if bids should be equal) at zero additional cost; and 2) to ensure that there will be adequate capacity of the plans with zero additional cost to take on the enrollees who want them. The second-lowest-bid method also has the property of eliciting bids that more accurately reflect the perceived value to the bidder.\textsuperscript{18}

Each beneficiary would be able to choose any other available plan (which by definition would be more expensive), paying only the incremental cost above the second-lowest priced plan. That is to say, plans could offer alternatives that broaden or enrich their coverage at correspondingly higher prices; beneficiaries would remain responsible for the excess. (As noted above, the vast majority of current Medicare Advantage plans offer drug coverage (the equivalent of Part D) as well. There need be no change in that coverage and cost. And likewise, Medicare Advantage plans typically reduce copays and deductibles, and obviate the need for private Medigap add-on coverage. That can continue.)

Because of the current superior cost and coverage performance of Medicare Advantage, we anticipate that the lowest bids will be rendered by Medicare Advantage plans. Even under the current system, most Medicare enrollees can choose from among numerous Medicare Advantage plans. The average number of plans available in metropolitan counties in 2016 is 21; even in nonmetropolitan counties, the average is 11. With such competition in most markets, we think it reasonable to expect the lowest bids to come from among these several Medicare Advantage plans.

This also means that traditional Medicare is likely to be among the plans that are priced more highly. The Medicare administrators (the Centers for Medicare and Medicaid Services, or CMS) would be responsible for computing a price of a Medicare premium on a basis comparable to the Medicare Advantage plans, including all of the elements of cost that would be borne by private Medicare Advantage plans, and using risk adjustment to compensate should traditional Medicare have an enrolled population that is more or less costly to cover than private Medicare Advantage plans. If traditional Medicare is more expensive, then beneficiaries should have the option of saving money by enrolling in a private plan. (See the explanation in Figure 2 on page 20.)
**CED Enrollee Choices**

- **Plan W**: Traditional Medicare
  - **$$$$$$$**
  - **PART A**
  - **PART B**
  - **PART D**
  - MEDIGAP
  - "Any willing provider"
  - Fee for service

- **Plan X**: Low-Price Medicare Advantage
  - **$$$$$$$**
  - **PART A, B, and D**
  - No MEDIGAP
  - Efficient selected-provider network
  - No additional services

- **Plan Y**: Medicare Advantage
  - **$$$$$$$**
  - **PART A, B, and D**
  - No MEDIGAP
  - Efficient selected-provider network
  - Some additional services

- **Plan Z**: Upscale Medicare Advantage
  - **$$$$$$$**
  - **PART A, B, and D**
  - No MEDIGAP
  - Efficient selected-provider network
  - Some additional services and amenities
The Congressional Budget Office (CBO) has produced the following schematic (see Figure 3) to explain how the bidding process would determine the “benchmark” amount of the implicit credit available to Medicare enrollees under an approach very similar to ours (CBO modeled its description after the plan proposed by Senator Ron Wyden and Representative Paul Ryan in 2011. Other similar proposals have been offered by Senator John Breaux and Representative Bill Thomas in 1999, and by Alice Rivlin and Representative Paul Ryan in 2010. A key difference between our proposal and these others is that in every year we would set the amount of the enrollee subsidy by competitive bid, not by an inflation-indexed cap. Our approach would ensure that plans would be available to all enrollees at zero out-of-pocket cost.)

### Figure 3

**Key operations under the illustrative second-lowest-bid option for premium support**

**Operation in each region:** The federal government divides the country into regions that reflect health care markets within states. Any insurer that submits a bid for a region would be required to serve the entire region.

<table>
<thead>
<tr>
<th>Bidding</th>
<th>Benchmark</th>
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<tbody>
<tr>
<td>Insurer A { Plan A-1, Plan A-2 }</td>
<td>Plan Z-2, Plan B-1</td>
</tr>
<tr>
<td>Insurer B { Plan B-1, Plan B-2 }</td>
<td>FFS, Plan A-2</td>
</tr>
<tr>
<td>Insurer Z { Plan Z-1, Plan Z-2 }</td>
<td>Plan Z-1, Plan B-2</td>
</tr>
<tr>
<td>Medicare { FFS }</td>
<td>Plan Z-1, Plan A-1</td>
</tr>
</tbody>
</table>

The FFS program is a competing plan with a bid equal to the projected cost of care for a beneficiary of average health within the region.

*Source: Congressional Budget Office*
The following charts contrast the workings of the current Medicare pricing system with the alternative that we propose. Chart 6 illustrates in an impressionistic way the current roughly 10 percent efficiency advantage of Medicare Advantage plans relative to traditional Medicare. In this hypothetical situation, traditional fee-for-service Medicare operates at a per-enrollee cost that we set at an arbitrarily scaled 100. Medicare Advantage programs, which are more efficient, can cover enrollees at a cost of only 90. However, the current system does not allow Medicare Advantage plans to underbid traditional Medicare by that full amount. At best, as depicted in Chart 7, Medicare Advantage can offer enrollees a rebate in cost abatement or services equal to seven (as little as five for plans with low “star” quality ratings), and must therefore charge 93 (and return three to the Treasury—as illustrated in the center of the chart). This dulls the competitive incentive, and so instead of using their 10 of efficiency to offer cost abatement or additional coverages, many plans either retain the savings themselves or spend them on other ways to attract enrollees. Clearly, the current system does not fully mobilize the efficiency advantages of Medicare Advantage to reduce costs and create a competitive dynamic.

In contrast, as illustrated in Chart 8, we propose to allow Medicare Advantage plans to reduce their premium prices to their enrollees to their lower cost of delivery of 90 (as illustrated in the bar in the center), making full use of their efficiency advantage to attract additional enrollees. Alternatively, plans can offer additional services with their efficiency savings, but enrollees must pay the cost (as represented in the bar on the right). This competitive dynamic would create the strongest possible incentives for all Medicare Advantage plans—and even traditional Medicare providers—to reduce cost while improving quality, and thereby to attract the maximum number of enrollees. Without such a competitive dynamic, Medicare costs will continue to grow at unsustainable rates. With it, there is the greatest possible prospect of achieving quality, affordable care for all of our seniors.

**Note:** This is a hypothetical illustration using an arbitrary scale.

**Source:** Committee for Economic Development
Premium revenue of plans would be “risk adjusted.” The objective of risk adjustment in the broadest terms is to blunt the incentives for insurers to seek out healthy enrollees and to shun people who are sick. Instead, risk adjustment would reward plans that find ways to treat the sick more efficiently. Although simple “cherry picking” has been outlawed in the sense that Medicare has prohibited insurers from rejecting applicants, subtle variations of such behavior have been alleged.  

“Grandfathering” of current Medicare enrollees—allowing them to stay in traditional fee-for-service Medicare at no additional cost—would be politically attractive, but it would also be very costly. 

Instead, risk adjustment seeks to compensate plans that in some way develop a reputation for providing exceptional treatment of expensive and serious conditions. In the past, risk adjustment mechanisms have identified expensive patients by the pharmaceuticals that they have been prescribed; more recently, risk adjustment has been based on diagnostic codes assigned by their providers. Some portion of premium revenue is held back by the regulatory authorities, and later is distributed among the plans according to how their patients’ eventual diagnoses related to the average for the entire population.

Manipulation of risk adjustment is a potential danger. Even in the current traditional 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 documentation of a sicker-than-average enrollment, and there is evidence in the current Medicare Advantage that plans attempt to do just that. Still, risk adjustment processes have improved over time, and the same further improvement that is necessary to protect the current traditional Medicare would contribute to making a modernized Medicare Advantage more cost-efficient. We see associated benefits from an expansion of plans based on capitated prepayment—such as many Medicare Advantage plans are—with a broader impact of risk adjustment. Some expensive conditions present choices between costly up-front treatments that can solve the problem or slightly less costly maintenance treatments that can be even more expensive over just a few years. The recent discovery of a pharmaceutical for hepatitis C attracted much attention for its eye-popping price tag, but lost in the sticker shock was the reality that it could more than recover that cost over time. Under current health insurance arrangements, plans can make self-rewarding decisions to avoid such expensive up-front remedies in the anticipation that the patient is likely to move on to another plan soon enough that the expensive care will be some other plan’s problem. Providing an incentive for plans to undertake the cure and avoid the need for continuing high maintenance costs might be cost-effective for the health care system overall in the long run.  

“Grandfathering” of current Medicare enrollees—allowing them to stay in traditional fee-for-service Medicare at no additional cost—would be politically attractive, but it would also be very costly. The life expectancy of a new 65-year-old Medicare enrollee is about 20 years. 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. In addition, such grandfathering would be excessively generous to many seniors. Seniors as a population are both wealthier and poorer than are working-age families; their income and wealth distributions are flatter, with proportionately more at both extremes. The very-low-income seniors are and will remain protected through their eligibility for Medicaid; these are the so-called “dual eligibles,” or “duals.” The very-high-income seniors are subsidized for their Medicare coverage, even considering the income conditioning of the Part B premium.
It could be fair and appropriate to charge wealthy seniors 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 difficult issue is the appropriate treatment of the lower-middle-income seniors—those who are not eligible for Medicaid, but whose well-being already is tested by the existing Medicare Part B premium.

The objective of our policy is to provide relief to these 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 policy also should give seniors with incomes just above the threshold for Medicaid eligibility a real 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 seniors is the most efficient and well-targeted way to reduce or eliminate the additional cost of staying with traditional Medicare. The cost savings would be relative to the current system while maintaining the price advantage under the new system of more efficient Medicare Advantage plans. This reduction 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. It could be administered through the individual income tax. 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. The revised Medicare Part B premium also can be made more income sensitive than the current structure, as is often proposed even independently of fundamental reform. It could elicit additional contributions only from the more affluent seniors, leaving those with modest incomes as nearly unaffected as possible.

Such a price incentive would drive all plans and providers—including individual providers under fee-for-service Medicare and integrated care systems, including ACOs—to achieve cost savings that plans can use to attract senior enrollees. Under this approach, efficiency improvements in the practice of medicine—not higher premiums imposed upon seniors with modest incomes—will drive the federal budget’s cost savings.

Some might argue that traditional fee-for-service Medicare would be under a disadvantage in such a competitive environment. Integrated plans and all of their providers would have a strong incentive to control costs so that they could hold premiums down and therefore attract enrollees, whereas individual fee-for-service Medicare providers would feel less inducement to sacrifice some of their own incomes to have a highly diluted effect on the overall cost of Medicare. This phenomenon probably would be real. However, rather than suggesting some compensation in favor of fee-for-service Medicare in this competitive environment, it probably should merely reinforce our understanding that traditional Medicare is inherently inflationary and not amenable to efficiency improvement or cost control. If it loses out in such a competitive environment, it will be for good reason.

Looking forward, we note that the actuarial value (the percentage of the insured’s expected total medical cost) of Medicare today is quite low—much less generous than the coverage offered by most employer plans. This is part of the reason why many Medicare beneficiaries are driven to enroll in private “Medigap” plans. This is not a felicitous time to consider expansion of Medicare’s coverage given the impending budget squeeze, but this issue should not be forgotten if competition should bring Medicare’s costs under better control in the future.
How Low-Income Seniors Would Fare

Obviously, low-income seniors are potentially the most vulnerable to any change in Medicare. After all, it was the many seniors who could not afford insurance premiums that had increased to cover the health risks attendant on all older persons who motivated the creation of Medicare in the first place. So it is not surprising that protection of low-income seniors is an immediate concern of many upon considering any proposal for change.

We believe that our proposed approach to Medicare would leave low-income seniors better off than they would be under continuation of the current system. We say this for the following reasons:

1. As the discussion of budget implications below will show, we began seeking no budget savings from the coverage of the low-income population as currently defined: the dual-eligible Medicare and Medicaid beneficiaries, or the so-called “duals.” Coverage of the current duals varies by state, but many have their Medicare Part B premiums and their copays and deductibles paid by Medicaid, so that they have cost-free coverage. We anticipate that such cost-free coverage will continue to be available to that group (although the exact nature of that coverage is ultimately in the purview of the states). If any of the duals should choose to enroll in a more-efficient, less-expensive Medicare Advantage plan, the savings could even be shared with the enrollee at a net budget reduction relative to what we anticipate.

2. As noted earlier, we would temporarily reduce Part B premiums to hold harmless currently enrolled seniors with incomes just above the cutoff for the “dual” population who choose to remain with the less-efficient, higher-cost traditional Medicare program. Some enrollees might do so to avoid interrupting existing programs of care by moving to new plans and providers, despite potential cost savings.

3. On a continuing basis, we would provide zero-additional-cost enrollment in traditional Medicare for residents of rural areas (who are generally of lower income than the rest of the nation) unless more-efficient Medicare Advantage plans are genuinely available in their locations, with sufficient numbers of participating providers to offer access to quality care.

We do believe that once our approach takes root, new enrollees will enjoy better choices of health plans. Providers will face stronger competitive pressure to offer plans that provide the care that our diverse population wants, at an affordable cost. Future enrollees above Medicaid eligibility incomes will have quality options at no more cost than their current Part B and Part D premiums.

Some defend current-law traditional Medicare on the ground that low-income seniors cannot make good choices among alternative health care plans. We believe that this argument sells our seniors short, and that the experience of Medicare Part D prescription drug coverage documents that. The elderly themselves have proved fully competent to find plans that meet their needs, and other individuals and organizations in their communities have proved eager to help if needed. Computer search tools have been developed to aid in the process, and they surely will be improved even further.

Beyond having plans and providers compete on quality, we believe that our approach yields the very best prospect of access to affordable Medicare coverage for decades to come. On Medicare’s current path, its promise to seniors will inexcvably erode, and again obviously, low-income seniors will be hurt the most. Medicare needs a new path. We believe that our proposal is the best in sight.
Issues of Geography

In addition, any reform should take explicit account of regional differences in the availability of care, especially with respect to rural areas with few alternative providers and insurance and care plans. Medicare Advantage alternatives to traditional Medicare are available in parts of the country on paper but have very few providers, are widely geographically separated, and many of those do not participate in the Medicare Advantage plans. Thus, for example, while the average Medicare beneficiary can choose among 19 plans, the average in metropolitan areas is 21, whereas in nonmetropolitan areas the average is 11. Three percent of beneficiaries in nonmetropolitan areas have access to no plan, and 445 counties in 28 states (accounting for 4 percent of Medicare beneficiaries) have Medicare Advantage plans offered by only one firm. Reform must be sensitive to the natural concerns that arise from this situation. Senior enrollees in traditional Medicare cannot be assessed with additional costs above the current law because of the lower costs of plans that are not truly available to them. Political resistance to change that is insensitive to such geographic issues would prevent improvement that benefits the nation as a whole. Therefore, although it will add complexity and increase cost, we believe that the calculation of fixed-dollar credits for Medicare beneficiaries in rural areas to purchase insurance must be set based on Medicare Advantage plans that truly are available—if any are. If there are none, then the credit must be sufficient to purchase traditional fee-for-service Medicare. We would note that this policy would create a strong incentive for more efficient Medicare Advantage plans to find ways to serve rural senior enrollees.
Proposal Summary

Table 1 provides an overview of CED’s Medicare reform proposal:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Effect</th>
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<tbody>
<tr>
<td><strong>1.</strong> Eliminate Medicare Advantage (MA) price “benchmark” based on traditional Medicare fee-for-service cost.</td>
<td>Remove influence of inflation-prone, inefficient fee-for-service medicine on Medicare costs.</td>
</tr>
<tr>
<td><strong>2.</strong> 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.</td>
<td>Give plans the incentive to achieve efficiencies while maintaining quality, enabling them to bid lower to attract customers.</td>
</tr>
<tr>
<td><strong>3.</strong> 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.)</td>
<td>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.</td>
</tr>
<tr>
<td><strong>4.</strong> Increase the income conditioning of enrollee Part B and Part D premiums.</td>
<td>Upper-income beneficiaries pay higher premiums. Net program cost and the federal budget deficit and public debt are reduced accordingly.</td>
</tr>
<tr>
<td><strong>5.</strong> 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.)</td>
<td>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.</td>
</tr>
<tr>
<td><strong>6.</strong> Risk-adjust plan premium revenue.</td>
<td>Reward plans that take on sick patients; discourage plans from seeking out only healthy patients.</td>
</tr>
<tr>
<td><strong>7.</strong> 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.</td>
<td>Protect rural enrollees who do not have access to true MA options from premium increases under traditional Medicare.</td>
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Modernizing Medicare

Budgetary Implications

Medicare’s mission is to provide seniors with high-quality, affordable care—a task that is complicated by their vulnerability to medical conditions, increasing with age, and the consequent challenges to their insurability.

The current system falls short on that undeniably essential goal. We believe that the system we envision would do far better. We also agree with all of the major fiscal authorities that in the long run, without fundamental reform, the current system will threaten not only the quality of care, but also seniors’ access to it, because its costs will become unaffordable.28

Some hope the growth of costs will slow merely because looming unaffordability will become clear, and individual providers will alter their behavior unilaterally. We fear that the current system gives every individual provider the incentive to carry on with past behavior and look to others to trim their incomes to solve the problem. If this fear proves well-founded, then the longer we wait, the more challenging the cost problem will become.

Others believe or hope that the cost savings in the ACA—which were designed to achieve only budget neutrality relative to health care’s prior unsustainable path, not to save money—will change provider behavior and overproduce on the estimated cost savings.29 We are skeptical, but again fear that choosing inaction on the basis of this hope would prove imprudent and would leave the problem more intractable than it is today.

We believe the course we are recommending would be more successful at ensuring long-term access to quality care. We note that estimating future health care spending is perilous and believe that all claims regarding the effects of health care programs, including our own, deserve careful scrutiny. We will provide here our best explanation of the potential savings from our approach.

Conceptually, we would identify five separate sources of savings from our proposed program:

1. Some seniors who now are enrollees of existing Medicare Advantage plans will choose revised versions of those plans that forgo the “bells and whistles” that are now used to bulk up the benefits (and costs) of those plans to the current benchmark payment. The Medicare payments on behalf of those individuals will fall accordingly (and the overall benchmark in the market region will tend to decline), and Medicare will save money as a result.

2. Some current enrollees of traditional fee-for-service Medicare will switch to cheaper Medicare Advantage plans that are revised for success under the new system. The Medicare payments on behalf of those individuals will fall accordingly (and the overall benchmark in the market region will tend to decline), and Medicare will save money as a result.

3. Over time, we believe that growing familiarity with and acceptance of lower-cost Medicare Advantage plans will lead to increasing sign-up rates among new Medicare enrollees. That will reduce Medicare spending.

4. Improved regional pricing under our proposal will lead in the first instance to lower Medicare pricing in low-cost market regions, and higher Medicare pricing in high-cost regions, with little or no change in the overall average. However, over time, the higher benchmark in higher-cost regions will accentuate the incentive for efficient plans to find ways to enter those markets, to take advantage of the higher benchmark rates. That should help to pull patterns of medical practice in high-cost regions toward those in low-cost regions and thereby save money for Medicare.
5. Over the long term, greater competition among Medicare plans—including traditional fee-for-service Medicare—would drive providers and plans to find ways to hold costs down while delivering quality care that Medicare enrollees want to choose. All manner of process improvement—including but not limited to practice patterns, back-office support, and cost-saving innovations in treatments and pharmaceuticals—would be involved. The scope for efficiency improvement would be all-encompassing, just as it is today in virtually every market other than health care.30

Broadly speaking, sources one to four correspond to near-term savings, which we illustrate in Figure 4. Source item five is exclusively a long-term prospect, which we illustrate in Figure 5.
The nonpartisan Congressional Budget Office (CBO) has evaluated broad specifications of systems establishing choice in Medicare that are generally similar to what we propose. In the third year of implementation, CBO estimates savings (from sources more or less equivalent to our specified sources of savings numbered one through three above) equal to about 6 percent of total net Medicare spending, as shown in Table 2.

Table 2
Change in net federal spending for Medicare under illustrative premium support options, relative to that under current law, 2020

<table>
<thead>
<tr>
<th></th>
<th>Second-lowest-bid option</th>
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<tbody>
<tr>
<td>In billions of dollars(^a)</td>
<td>-45</td>
</tr>
<tr>
<td>As a percentage of net federal spending for Medicare</td>
<td>-6</td>
</tr>
<tr>
<td>As a percentage of net federal spending for Parts A and B for affected beneficiaries(^b)</td>
<td>-45</td>
</tr>
</tbody>
</table>

Note: Although estimates of percentage changes are based on CBO’s March 2012 baseline projections (which are the projections underlying the analysis in this report), the dollar savings are based on applying those percentages to CBO’s most recent projections (see Updated Budget Projections: Fiscal Years 2013 to 2023, May 2013, www.cbo.gov/publication/44172).

\(^a\) Rounded to the nearest $5 billion.

\(^b\) Affected beneficiaries include everyone who would have enrolled in Medicare under current law, except dual-eligible beneficiaries (people who are simultaneously enrolled in Medicare and Medicaid). Spending for affected beneficiaries includes all spending for Part A (Hospital Insurance) and Part B (Medical Insurance) except spending that was excluded because it is not covered by the bids that Medicare Advantage plans submit under current law—namely, the additional payments to disproportionate-share hospitals (whose share of low-income patients exceeds a specified threshold) and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. Spending for Part D prescription drug insurance is excluded.

Source: Congressional Budget Office
In addition, CED would increase the income conditioning of the enrollee premiums for Part B and Part D. In the first instance, this would have a positive impact on revenues as indicated in Table 3.

As we noted above, we would reallocate some of the additional revenues from this additional income conditioning of premiums to providing Part B premium relief only for the current low-income enrollees, to help those who wish to remain in traditional Medicare to maintain their programs of care. Without that temporary relief, the fundamental restructuring of the Medicare and Medicare Advantage systems, according to CBO, would reduce total Medicare spending by about 6 percent, and the additional income conditioning of the Part B and Part D premiums would produce almost as much additional savings. So assuming that less than half of the additional revenues from income conditioning the enrollee premiums would be retained, we anticipate total Medicare savings equal to about 9 percent of current program cost.

To explain its general approach to evaluating the budgetary savings of the restructuring of Medicare Advantage—which we believe is by far the more important savings component of our proposal—CBO says that it...

...would create more competitive pressure than the Medicare Advantage program, encouraging insurers to reduce their costs (primarily by constraining the volume and intensity of health care services provided and to a lesser extent by reducing administrative costs and profits) and thus to be able to lower their bids. The greater competition relative to the current Medicare program would arise because insurers with lower bids would expect to achieve larger increases in enrollment, because more Medicare beneficiaries would choose plans affirmatively and those beneficiaries would face larger differences in premiums among different plans.32

Table 3

<table>
<thead>
<tr>
<th>Increase premiums for Parts B and D of Medicare</th>
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<tr>
<td>(Billions of dollars)</td>
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<tr>
<td></td>
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<tr>
<td>Change in mandatory outlays</td>
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<td></td>
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<td></td>
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<tr>
<td>Freeze income thresholds for income-related premiums</td>
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<tr>
<td>Both of the above policies\a</td>
</tr>
</tbody>
</table>

Note: The first and third alternatives would take effect in January 2016; the second alternative would take effect in January 2020. Estimates are relative to CBO's August 2014 baseline projections.

a. If both policies were enacted together, the total effects would be less than the sum of the effects for each policy because of interactions between the approaches.

Source: Congressional Budget Office
CBO further lays out its view of the policy option in Chart 9.

**Chart 9**

**Factors that would affect bids under illustrative premium support options, relative to current-law bids for Medicare Advantage plans, 2020**

<table>
<thead>
<tr>
<th>Downward Pressure on Bids</th>
<th>Current-Law Bids for Medicare Advantage Plans</th>
<th>Upward Pressure on Bids</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Second-Lowest-Bid Option</strong></td>
<td>-7 percent</td>
<td>-4 percent net effect</td>
</tr>
<tr>
<td><strong>Average-Bid Option</strong></td>
<td>-6 percent</td>
<td>+2 percent</td>
</tr>
</tbody>
</table>

**Increased Competition**
Medicare beneficiaries would face premiums reflecting the full difference in plans’ bids, which is a stronger incentive to choose a low-bidding plan than under Medicare Advantage. Beneficiaries who did not make an active enrollment choice would be assigned to a low-bidding plan.

**Reducing the Importance of FFS Rates**
A reduction in the share of beneficiaries enrolled in the FFS program would tend to reduce the importance of rates from that program in determining how much private insurers would pay providers to treat Medicare enrollees.

**Favorable Selection**
The enrollees in private plans would be healthier on average than enrollees in the fee-for-service (FFS) program (even after the adjustment to federal payments to account for the health status of enrollees), and that difference would be greater under the premium support options than under the Medicare Advantage program.

**Broader Provider Networks**
Increased enrollment in private plans, and in lower-bidding private plans in particular, would require some insurers to expand their provider networks and, in so doing, to pay higher rates or contract with providers who have higher-cost practice styles.

**Source:** Congressional Budget Office

Note: CBO assumed covered services under current law and under the illustrative premium support options would be the same. CBO used its projection of current-law bids for Medicare Advantage’s private plans as a starting point and excluded three types of Medicare Advantage plans that are likely to differ substantially from plans that would be offered under a premium support system: private FFS plans, special needs plans, and employment-based group plans.
CBO’s estimate is, by its own admission, rough and is highly dependent on detailed specifications of the proposals. So, for example, CBO assumes no transition relief, no relief for beneficiaries in rural areas, and no savings from low-income Medicare beneficiaries who also are eligible for Medicaid.

CBO is less specific with respect to the longer term (generally equivalent to our source five above), venturing that savings would be roughly constant as a percentage of total Medicare spending for about a decade but would expand thereafter. However, CBO does not estimate a specific figure, saying that

…the heightened price competition would probably reduce the growth of Medicare spending over the long term relative to that under current law… However, the longer-term effects are even more uncertain than are the short-term effects of a premium support system on Medicare spending. 33

For the most part, CBO cites specifically the care-management capabilities of private plans:

The increased competition created by either option would tend to restrain growth in Medicare spending by reducing demand for costly new technologies and treatments and by increasing demand for cost-reducing technologies. A crucial factor underlying the rise in spending for health care in recent decades has been the emergence, adoption, and widespread diffusion of new medical technologies and services… Although such advances can sometimes reduce costs, in medicine they and the accompanying changes in clinical practice have generally had the opposite effect. By strengthening price-based competition in Medicare, a premium support system could change that dynamic within the program and perhaps in the broader health care system. Moreover, relative to outcomes under current law, the potential for cost savings from managing utilization and limiting provider networks would be greater under a premium support system with a larger share of Medicare beneficiaries enrolled in private plans that have the flexibility to manage care. The magnitude of that effect is highly uncertain, however, and it would take a number of years before it became fully apparent. 34

At the same time, CBO expresses some caution about the attainability of additional longer-term savings:

On the other hand, reductions in the share of Medicare beneficiaries enrolled in the FFS program would cause private insurers participating in a premium support system to pay higher rates to health care providers. Two main mechanisms would be at work. First, although the rates private insurers pay now under the Medicare Advantage program are similar to those for Medicare's FFS program, CBO expects that a lower FFS market share would reduce the importance of the FFS program's rates in determining how much private insurers would pay providers for treating Medicare enrollees. Second, to accommodate an influx of enrollees, some private plans might need to expand their networks to include health care providers who would be more costly, on average.

That is, CBO essentially denies or ignores any potential for process and productivity improvement, and confines all potential for future savings to either the restriction of treatments (much of which likely would be better medicine, using effective but cheaper and conservative existing techniques) or the enforcement of reimbursement restrictions on providers.
To us, that amounts to a death sentence on the US health care system in general, and Medicare in particular. We would note that a one-time 6 percent reduction of Medicare costs would amount to not a bending of the cost curve, but a mere lowering of it. That is, starting from a slightly lower base, Medicare costs would continue to grow at an exponential rate greater than that of our GDP. The gap between Medicare costs and society’s income—out of which those costs must be paid—would continue to grow to infinity. An infinite price tag with a 6 percent discount still leaves infinity. This view says that the Medicare cost problem is unsolvable because price controls for Medicare cannot viably continue forever to diverge more and more from private-sector prices.

We believe consumers empowered by choice to pursue value will drive producers to find ways to increase quality while reducing price.

So looking at the big picture, CBO does not mention broader opportunities for process improvement, which CED believes 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 results not only across Medicare Advantage plans, but within the FFS world as well. For this reason, we are far more optimistic about cost savings and quality improvement in the long run than we are in the near term.

We believe that a market-based system, under which value-conscious consumers choose their own plans, can induce process and productivity improvement that will truly bend the cost curve—that is, reduce its rate of growth, not just its level. Only that degree of progress can achieve affordable, quality care over the long term, and we believe that only a market-based system such as we recommend can provide it.

We believe that existing systems that approximate our recommendations have shown enormous promise in private plans for the working-age population, and that putting those systems to broader use and thereby expanding the reach of competition across the health care system will, in turn, expand the benefits in terms of efficiency and quality.

It is impossible to assign a precise value to such future savings. No one can know the future. And CBO has always refused to “score” the benefits of future market competition—and that is understandable. After all, injecting competition into a market is making use of Adam Smith’s “invisible hand”—and the invisible hand cannot be measured, precisely because it is invisible.

So no one can measure the benefits of future competition in health care, just as no one can measure the benefits of future competition in the manufacture of automobiles or the provision of haircuts. But some guideposts exist. In a 2005 report, a committee of the Institute of Medicine and the National Academy of Engineering reported “an estimated 30 to 40 cents of every dollar spent on health care, or more than a half-trillion dollars per year, is spent on costs associated with overuse, underuse, misuse, duplication, system failures, unnecessary repetition, poor communication, and inefficiency.” A 2013 IOM report estimated that $750 billion is wasted annually in the health care system (about 30 cents of every health care dollar). The Dartmouth Institute for Health Policy estimates that 30 percent of all Medicare clinical care spending is unnecessary or harmful and could be avoided without worsening health outcomes. (At the same time, of course, many important health care services go undelivered.) So considerable reductions could be achieved, conceivably, in the level of health care spending—and such savings would be most welcome.
There is further evidence of the potential for budgetary savings from the existing Medicare Advantage program, even though we believe that its incentives for pursuing value could be much improved. In 2015, according to the Medicare Payment Advisory Commission (MedPAC), Medicare Advantage premium-reduction rebates (applying to the Part B premium) were available to 27 percent of the Medicare population in 346 counties in 11 states.\(^3\) And across all plans, beneficiaries received an average of $76 per month of total rebates, including additional services and lower cost sharing as well as cash.\(^4\) About four-fifths—81 percent—of all Medicare beneficiaries have access to a plan that charges no additional premium on top of the cost of traditional Medicare. Meanwhile, unlike traditional Medicare, which has no limit on out-of-pocket spending (which is a main selling point for add-on private “Medigap” plans), Medicare Advantage plans are required to include an out-of-pocket limit of $6,700 (for 2016), and 61 percent of Medicare Advantage plans with prescription drug coverage (most do include prescriptions) offer limits lower than that legal maximum.\(^5\) So clearly Medicare Advantage plans are capable of underbidding traditional Medicare even today, but need sharper incentives to do so.

Again, we believe that ongoing productivity and process improvements are essential for future access to quality care. A fiscally sustainable overall federal budget and Medicare program are out of reach without such progress. That is what we believe improved incentives alone can provide. No one can know how much future productivity improvement is attainable in health care. But we do know that productivity growth is obtained in other markets, which are driven by competition, and so we are confident that productivity growth will be forthcoming once health care is driven by competition as well. Slowing the rate of growth of Medicare costs by just one percentage point (or even less) of productivity growth per year could prove to be the margin between a program that is affordable in the long run and one that is not.\(^6\)

Therefore, we believe that the estimated 9 percent savings relative to current total Medicare spending is just the beginning. We are confident that competition will provide greater improvement in Medicare affordability through innovation and process improvement, while maintaining and even improving quality. We believe that such progress is the only way to ensure continued access to quality care for America’s seniors.

**Conclusion**

Although the ACA was a politically perilous enterprise, Medicare modernization will be far more dangerous. CED seeks to provide the ideas needed to improve the ACA and to make Medicare reform both substantively possible and politically viable.

The political environment surrounding Medicare today is so fraught that many policymakers would prefer not even to mention program reform, much less discuss it actively. By that scale, most Washington insiders surely would label our proposal as politically unrealistic.

We persist because, by the scale of today’s Washington, realistic proposals are totally inadequate. From Medicare through every other major federal program in the budget, change well beyond the current pale will be needed to stave off dangerous and possibly irreversible accumulation of debt.

CED sees its role in these times as expanding the scope of the debate—to include sound policies of a scale to match the size of the nation’s problems. We ask others to look beyond accepted political bounds to survey the full extent of the challenges our nation faces. We welcome a vigorous but respectful debate among people with different political perspectives but the same unbending commitment to the future of the nation.
Although our approach to Medicare modernization differs in detail from that for improvement of the ACA, the thrust of the proposals is exactly the same. We believe that consumers empowered by choice to pursue value will drive producers to find ways to increase quality while reducing price. Both Medicare and private health care must be efficiency-driven, because otherwise providers will migrate to the uncompetitive sector to profit comfortably from its more generous compensation.

Health care is deeply personal. Those with existing medical conditions fear the loss of their existing care relationships. Everyone fears some development that will lead to a loss of good insurance or of coverage entirely and, with it, the ability to pay for his or her family’s care. The ACA has eased those fears in some respects, but it has exacerbated them in others; and the American people surely do not relish the prospect of going through such an uncertainty- and anxiety-inducing legislative process again to address the even-more-perilous problems of Medicare.

Still, even some of the ACA’s strongest advocates recognize that there is far more to be done—with respect to the ACA itself and Medicare. If the cost of Medicare continues to outpace the growth of our nation’s income, out of which it must be paid, then the access of our nation’s seniors to quality care cannot possibly be maintained indefinitely. The US health care system is so large (larger than the total economy of France, for example) and so dependent upon long-lived assets (even human skills and training), that regardless of the “health care fatigue” American citizens and their elected policymakers may feel, there is no time to waste in seeking a sustainable course for both the private and public segments of our health care system.

As always, the temptation is to take political advantage of a crisis—to paint the other side as somehow ill-willed or uncaring and to refuse compromise. But health care is critical to the well-being of every citizen—especially seniors—and to the financial health of the entire nation. Changing the law will require bipartisan leadership. Compromise is essential.

We at CED call on our elected policymakers to recognize the urgency of reform and take advantage of the current brief respite from budgetary pressure to allow market forces and consumer choice to begin to reshape our health care industry. We stand ready to work with others in the public and private sectors to set our health care system—and all that depends on it—on sound footing for the nation’s future.


3 Medicare hospital coverage is Part A; optional physician coverage is Part B; and optional prescription drug coverage is Part D.


5 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.

6 Some might argue that the fault should be assigned to a shortfall of revenue. That argument could be made over a short period of time. But in the long run, Medicare costs are projected to grow faster than the GDP. Tax revenue cannot possibly keep pace with these costs indefinitely.

7 Under this alternative scenario, CBO also assumes that annual agency appropriations grow more rapidly than in the baseline, which in turn would increase debt service costs still further. Beyond that, the effects of all of these policies are subject to “dynamic scoring”—that is, the economy suffers because of the large deficits that raise interest rates and crowd out private investment.

8 Social Security’s costs also grow faster than the GDP, but by a smaller margin; and spending in all of the rest of the budget’s components is expected to grow more slowly than the GDP by more than enough to neutralize the impact of Social Security’s spending. This solves the budgetary effect of Social Security in aggregate, assuming that actual budget performance matches projections. It does not resolve the conflict arising because of the nation, and the nation’s workers in particular, expected Social Security, taken by itself, to be self-financing—in other words, that Social Security (and Medicare) should be an “earned benefit” rather than an “entitlement.”


10 Medicare Advantage 2016 Data Spotlight: Overview of Plan Changes, Kaiser Family Foundation, December 2015, Table A1 (http://files.kff.org/attachment/issue-brief-medicare-advantage-2016-data-spotlight-overview-of-plan-changes). Virtually all (87 percent) Medicare Advantage plans include prescription drug coverage; the remainders are essentially specialty products for select groups of people (such as military veterans) who already have prescription drug coverage from other sources. The universe of plans considered in the footnoted statement above is only those plans that offer drug coverage.

11 Under the Affordable Care Act, the donut hole will be eliminated by 2020.


14 For example, the Government Accountability Office estimated that improper payments under Medicare were almost $50 billion in fiscal year 2013. Medicare Fraud: Progress Made, but More Action Needed to Address Medicare Fraud, Waste and Abuse, Government Accountability Office, 2014 (www.gao.gov/assets/670/662845.pdf).

15 The Affordable Care Act imposed several changes in the functioning of traditional Medicare, including the creation of an Independent Payment Advisory Board (IPAB) and Accountable Care Organizations (ACOs), cuts in reimbursement rates, and other changes. We see such structures as artificial market-clone devices within a fundamentally command-and-control-driven Medicare system, and we remain skeptical about their long-term prospects for success. We would not recommend that these experiments be abandoned in the traditional system, but we believe that allowing our strategy of true market forces to drive decisions in Medicare Advantage is far more promising.

16 The few with prior Medicare experiences would have been categorically eligible while receiving Social Security Disability Insurance (SSDI) benefits or suffering end-stage renal disease.

17 The Part B premium, which currently is 20 percent of the cost of the Part B program, would change over time as the plan’s competitive bids changed. Reductions or slower growth of the competitive bids would reduce the federal government’s 80 percent share of the cost to run the Part B Medicare program and would be a source of budgetary savings.


Modernizing Medicare


23 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.

24 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. A Premium Support System for Medicare, Congressional Budget Office.

25 Some “duals” are eligible for Medicaid because they suffer from particularly costly medical conditions.

26 Medicare Advantage 2016 Data Spotlight, Kaiser Family Foundation.

27 We propose to protect rural Medicare enrollees who find themselves without competitive choices of efficient plans. We do not propose to protect current providers from the development of competitive, efficient plans. Under admittedly different circumstances and with different opportunities and constraints, rural medicine—like metropolitan-area medicine—must be driven by competition to become as efficient as possible at delivering quality care. We anticipate improvements to health care financing, including different forms of reimbursement for essential services such as emergency room care, that will make providers more cost-sensitive and will reduce monopoly power that encourages providers to resist joining in more-efficient coordinated care. We also anticipate technological advancement such as telemedicine to facilitate the delivery of care from efficient but remote providers. Christopher Pope, “Assuring Hospital Emergency Care Without Crippling Competition,” (www.healthaffairs.org/blog/2015/07/06/assuring-hospital-emergency-care-without-crippling-competition/); Medicare Payment Advisory Commission, Medicare in Rural America, June 2001, especially pp. 139-ff, (http://www.medpac.gov/documents/reports/Jun01_Whole_report.pdf#page=139).

28 For example, The 2015 Long-Term Budget Outlook, Congressional Budget Office, (www.cbo.gov/publication/50250).

29 The ACA was estimated to generate savings in Medicare to offset costs elsewhere—in subsidies for purchases of private insurance and costs for Medicaid coverage for the low-income working-age population and their dependents.

30 The cost of Medicare Part B (physician) services is divided between the general fund (that is, all taxpayers) and participating seniors (who pay premiums equal to 25 percent of the cost of the program). Therefore, all savings in the cost of Part B services will benefit all participating seniors, and all taxpayers generally.

31 A Premium Support System for Medicare: Analysis of Illustrative Options, Congressional Budget Office, September 2013 (www.cbo.gov/publication/44581). The approaches considered by CBO differ from what we propose in several respects. So, for example, CBO assumes that Medicare Advantage would be abolished and new plans would be created to replace it, whereas we would modify Medicare Advantage 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.

32 A Premium Support System for Medicare, Congressional Budget Office, p. 17.


35 For example, Mike Bare, Erik Bakken, John Mullaby, and David Riemer, “The Dane Difference: Why Are Dane County’s Exchange Premiums Lower?” Health Affairs Blog, December 18, 2014 (www.healthaffairs.org/blog/2014/12/18/the-dane-difference-why-are-dane-county-exchange-premiums-lower/).


42 A further issue is the joint federal–state Medicaid program. Medicaid serves both the low-income population broadly and the indigent disabled (including many institutionalized elderly). We believe that the improved efficiency that our reform program will achieve in the care of the working-age population is the most productive step that could be taken to control the cost of caring for the nondisabled Medicaid population. States should be able to enroll Medicaid beneficiaries in the same efficient systems that we contemplate for all working-age Americans and their dependents. Long-term care for the indigent disabled is a topic beyond the scope of this project. However, we recognize the importance of this issue—for both patient quality of life and the ability of governments to meet the cost of care and fulfill other priority obligations. We look forward to research that will provide guidance on the best ways to achieve quality, affordable care for the long-term disabled.
Modernizing Medicare

October 2016