An Idea for Cutting Medicare Costs Could Mean Higher Premiums for Some

By AUSTIN FRAKT

Last month, as Republican leaders were preoccupied with another unsuccessful attempt to replace Obamacare, a senior Trump administration official warned about a different major medical program, Medicare.

The official, Seema Verma, administrator of the Centers for Medicare and Medicaid Services, wrote in The Wall Street Journal that Medicare was facing a fiscal crisis. She announced that she was asking the agency's innovation center for ideas to address it and that part of the answer was to give consumers "incentives to be cost-conscious." This has some Democrats worried that she's trying to move Medicare toward something called premium support, which would be a huge change for consumers.

What's the fiscal crisis? According to projections from this year's Medicare Trustees Report, the fund that pays for Medicare-financed hospital care will be depleted in 12 years, and care for other services will consume an ever-larger share of the economy and federal revenue. Citing trends like those, Republicans put the outlines of a Medicare premium support plan in the House of Representatives' 2018 fiscal year budget resolution, as they did in several prior ones.

In broad terms, "premium support" means the government pays a contribution toward premiums, and beneficiaries pay the rest. In a sense, today's Medicare program already has such a structure. For either the traditional program or a private Medicare Advantage plan, the government pays a preset premium stipend (alternatively called a subsidy, credit or voucher) that varies across these two parts of the program. In all cases, stipends grow at the rate of health care costs.

If Medicare already has a form of a premium support model, what's all the fuss about?

The important difference is in how stipend levels are set. Today's stipends are not driven by the market, but are set according to legislatively established formulas. But the type of premium support Medicare reformers usually advocate — what people generally mean when they use this term — would use market signals to set stipend levels.

"Premium support could result in increased efficiency in the Medicare program," said Bryan Dowd, a health economist and co-author of a book that analyzed premium support options. That efficiency could push the hospital trust fund depletion date further into the future and reduce "the financial burden on future generations."

Premium support models take many forms, but there are two crucial variables. One is how stipend levels are set, which determines how much of beneficiaries' own money they need to contribute. The other key feature of premium support is how much the stipend grows over time. Both aspects are hotly debated.

In some versions of premium support, the stipend level would grow more slowly than health care costs, forcing people to pay more out of pocket over time to purchase coverage. In other versions, the stipend level would grow at the same rate as health care costs, so beneficiaries would continue to pay about the same share of their own money.

Most premium support approaches would retain traditional Medicare, though its fate would be uncertain, a source of controversy. "A lot rides on how the government's support level differentially impacts the cost to beneficiaries of private plans versus traditional Medicare," said Timothy McBride, a health economist with Washington University in St. Louis. Geography also plays a role. "If traditional Medicare is disadvantaged, that would hit rural beneficiaries harder, because a larger share of rural America relies on the traditional program than do urban Americans."

As a report this month from the Congressional Budget Office reveals, how much premium support could save the government varies considerably depending on how stipend levels are established. Across the variations the C.B.O. examined, Medicare spending could fall by as much as 9 percent or as little as about 0.5 percent. But premiums could rise, including the premium for traditional Medicare. Under one projection, the C.B.O. estimates, traditional Medicare's premium could double.

In all the possibilities the C.B.O. analyzed, stipend levels would be based on bids from Medicare Advantage plans and traditional Medicare that reflect the cost to cover a person for standard Medicare services. Stipend levels would keep pace with overall health care costs, but they could still be lower than what many Medicare beneficiaries receive today.

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For example, tying the stipend to the second-lowest bid and requiring all Medicare beneficiaries to be subject to that new, lower level would save $419 billion over 2022-26, the C.B.O. estimated.

Tying it to the average bid or requiring only new beneficiaries to be subject to the new stipend would save less. In either case, people would have access to plans that don't cost more than today's. But those who chose more expensive plans because they offer more benefits, or the traditional plan because it covers any doctor willing to accept Medicare patients, would pay more out of pocket. As a result, more people would pick cheaper, private plans, and fewer would choose traditional Medicare.

This worries some health policy experts. "Traditional Medicare has been the leader in reforming the health care payment and delivery system to improve efficiency," said Paul Van de Water, senior fellow with the Center on Budget and Policy Priorities. "It has outperformed private insurance in holding down the growth of health costs, but its ability to continue to do that would shrink significantly if premium support caused its enrollment to dwindle."

Exactly how much more people would pay depends not only on the plans they select, but also on where they live. In some markets, many plans, including the traditional program, might charge premiums close to the second-lowest bid. In others, plans that many beneficiaries may want might cost a lot more.

In the premium support debate, there's a fundamental lesson: It's conceptually simple to reduce federal spending on health care, but it's very hard to do so in a way that doesn't increase costs for at least some consumers. To actually reduce total (not just federal) health care spending for everyone, one has to overhaul how care is delivered, not just how it is paid for. That's much harder.

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