



Perspective

Reforming Medicare — Toward a Modified Ryan Plan

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Medicare reform, an issue that is rarely out of the political spotlight for long, has once again achieved a position of prominence. The current focus is primarily on the role that Medicare

and other entitlement programs play in driving up the deficit, but the need to reform Medicare long predates the economic collapse of 2008.

The most basic problem is that since the 1960s, health care spending (and Medicare along with it) has been growing 2 to 2.5 percentage points faster than the economy as a whole. The retirement of the baby boomers, which officially began in January 2011 and will increase the Medicare population from its current level of 44 million to about 78 million by 2030, will exacerbate the problem, but the primary issue all along has been excess spending. From time to time, we have seen reductions in this

rapid rate of growth — for instance, during the 3 years after the Balanced Budget Act (BBA) was passed in 1997, when almost all providers of services to Medicare beneficiaries saw their reimbursements substantially reduced.¹ The first year after the BBA's passage, spending on Medicare slowed dramatically; the second year, spending actually decreased by a small amount (which had never happened previously); the third year, spending grew at a moderate rate; and after that, spending increases were back up in the 7% range. The return to large increases occurred partly because Congress passed legislation that gave back some reimbursement that had previously

been cut, in response to vigorous lobbying by the health care provider community, and partly because providers learned how to respond more effectively to the BBA's changes — that is, how to game the system.

We are currently in the midst of a period similar to 1998, the year after the enactment of the BBA. Reductions in reimbursements to Medicare providers authorized by the Affordable Care Act (ACA) are beginning to take effect, and if the legislated reductions actually occur, they will reduce spending on Medicare by more than \$500 billion over a decade. The question is whether a Medicare program that relies on reductions to provider reimbursements without fundamentally altering the incentives that providers face will be sustainable. Indeed, the actuary of the Centers for Medicare and Medicaid Services (CMS) has repeatedly ques-

tioned whether the ACA's reductions will be sustainable without producing major problems of access.² Although the ACA also includes various pilot programs that could ultimately change providers' incentives, the legislated changes primarily involve the same fee-for-service approach that has characterized Medicare in the past. The recently released proposed rule for accountable care organizations (ACOs) was a discouraging first effort at fostering a different dynamic: it sets a minimum savings requirement that far exceeds what long-standing large-group practices were able to achieve in an earlier CMS demonstration project³ — though perhaps the final regulation will create an environment that is more amenable to ACOs or similar organizations.

Congressman Paul Ryan (R-WI), chairman of the House Budget Committee, has proposed a very different strategy for slowing Medicare spending.⁴ It has variously been called a “defined contribution” plan (as opposed to the current Medicare program, which is a defined benefit plan), a premium support program, and a voucher plan, among other terms. It would operate in a fashion very similar to that of the Federal Employees Health Benefit Plan (FEHBP), in which a wide range of private plans are available with varied benefits and types of networks, the subsidy doesn't vary according to the plan the individual chooses, and every November, individuals can continue in their plan or choose another one.

Under Ryan's plan, Americans who will turn 65 in 2022 or later would receive a fixed subsidy from the government (the defined contribution). The subsidy for 65-year-olds would be \$8,000 —

equivalent to the estimated average per-beneficiary spending by traditional Medicare in 2022. The subsidy would grow by a measure of inflation — specifically, the Consumer Price Index — and would increase for people who are older and sicker. Low-income beneficiaries would also receive a substantial amount of money in a medical savings account. A wide variety of private plans would be available. These plans could not discriminate on the basis of age or health status, and many other rules would need to be developed. Americans who are currently 55 or older would be allowed to continue in the current Medicare program if they wished to do so.

There has been no lack of criticism of Ryan's proposal. I agree with some concerns that have been raised about it, but rather than dismiss it in its entirety, I would relax some of the harsher provisions, recognizing that by doing so, I would diminish some of the savings it would create.

First, the rate of increase Ryan chose for the subsidy is too stringent, especially for the new program's first decade. A rate of increase of the gross domestic product (GDP) plus 1% or 0.75% might be more achievable and is consistent with other proposed goals for Medicare growth.⁵ Proposing increases that are too much of a stretch is unhelpful, as has been demonstrated repeatedly over the past 8 years, when Congress ignored the sustainable-growth-rate measure that theoretically determines increases in Medicare's physician fees.

Second, the subsidy must be sufficient for purchasing at least one available health plan in each geographic area at whatever percentage of premium coverage is assumed to be appropriate at the

outset. Although an important policy decision must be made regarding subsidy levels, let us assume that the subsidy would be expected to cover 75% of the cost of a premium for coverage of the benefits currently available to seniors. Today, Medicare has premium charges for Part B (physician and outpatient hospital care) and Part D (outpatient drugs), deductible and coinsurance charges, and no catastrophic coverage, and the intent would be to continue the financial equivalent of current practice. Thus, at least one plan would have to be available in each geographic area for which the Medicare subsidy would cover 75% of the premium, or whatever amount was chosen for 2022. Otherwise, the subsidy would need to be modified. I assume that, as in the FEHBP, plans would vary widely in terms of their premiums, reflecting various benefits and various arrangements with provider networks.

Third, consideration should be given to making traditional Medicare available on a premium basis, so that the subsidy could be used to buy it as well as private plans. Since traditional Medicare will be available anyway as long as Americans who are currently 55 years old are alive, continuing Medicare as a choice, as a defined-contribution plan, might be a politically important compromise.

This approach, in my view, is much more attractive than the ACA's strategy, which focuses exclusively on reducing provider reimbursements and perhaps changing some provider incentives if the pilot programs are successful and are implemented nationally (of which we have no assurance). The ACA gives the real power to the new Independent

Payment Advisory Board, which can reduce reimbursements if spending grows too fast. A modified Ryan plan would allow private plans to introduce many of these changed incentives without permission from the government and would, for the first time, give seniors a reason to care about these alternative plans. That's a very powerful difference.

The views expressed in this article are those of the author and do not reflect the

views of Project HOPE, Congressman Ryan, or any other person or entity.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From Project HOPE, Bethesda, MD.

This article (10.1056/NEJMp1104425) was published on April 27, 2011, at NEJM.org.

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