Comparison of Medicare Premium Support Proposals

In response to concern about increases in the federal debt and deficit, prominent policymakers and commissions have proposed reducing federal spending on entitlement programs, including Medicare. One of the most frequently discussed proposals would transform Medicare from a defined benefit program, in which beneficiaries are guaranteed coverage for a fixed set of benefits, to a defined contribution or "premium support" program, in which beneficiaries are guaranteed a fixed federal payment to help cover their health care expenses.

The idea of transforming Medicare into a system of premium supports, establishing fixed contributions per Medicare beneficiary, has been raised intermittently since the early 1980s, and more recently, a number of proposals have been advanced in the context of reducing the federal deficit and debt. Premium support proposals differ in a number of ways, including how federal payments on behalf of beneficiaries would be determined; whether Medicare fee-for-service would remain an option; what protections would be provided for low-income beneficiaries; and the extent to which the proposal would rely on a federal cap on Medicare spending to help constrain the growth in program spending. These differences have important implications for beneficiaries, Medicare spending, health care providers, and health plans.

This document provides a side-by-side comparison of proposals for transforming Medicare into a premium support program that have been put forth by policymakers and commissions as part of broad-based deficit- and debt-reduction packages, including:

- **Representative Paul Ryan**'s proposal "The Path to Prosperity: A Blueprint for American Renewal," as released on March 20, 2012;
- **S. 2196**, the "Congressional Health Care for Seniors Act of 2012," as introduced by Senator Rand Paul, and co-sponsored by Senators Lindsey Graham, Mike Lee, and Jim DeMint, on March 15, 2012;
- **Senator Richard Burr and Senator Tom Coburn**, as proposed in the report "The Seniors' Choice Act," released on February 16, 2012;
- **Senator Ron Wyden and Representative Paul Ryan**, as proposed in the report "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future," released on December 15, 2011; and
- **Former Senator Pete Domenici and Dr. Alice Rivlin**, as described in "The Domenici-Rivlin Protect Medicare Act," initially released on November 1, 2011 and updated on June 15, 2012.

All proposals are compared to the current Medicare program, including changes to the program enacted as part of the Patient Protection and Affordable Care Act (ACA) of 2010. With the exception of S. 2196, the descriptions included in this side-by-side comparison are based on summaries released by the proposals' sponsors; legislative language, with more detailed specifications, is not available at this time for those proposals. While some of the proposals also include other Medicare savings proposals, such as raising the age of Medicare eligibility or prohibiting Medigap plans from providing first-dollar coverage, this document focuses on provisions of each proposal that would convert Medicare to a system of premium supports.

Republican Presidential candidate, former Gov. Mitt Romney, has described his approach to premium support as a system under which future generations of seniors would be entitled to a government payment that would be applied toward either traditional Medicare or a private health plan, allowing individuals to keep the savings if they choose a plan that costs less than the government payment, or pay more if they enroll in a more expensive plan. Lower income seniors would receive higher support payments while higher income seniors would receive lower support payments. President Obama has indicated his opposition to such proposals.[1]

The appendix provides a short description of premium support proposals released by others including: Dr. Alice Rivlin and Rep. Paul Ryan (November 17, 2010); CATO Institute (April 1, 2011); Republican Study Committee (April 8, 2011); Heritage Foundation (May 10, 2011); and the American Enterprise Institute (May 25, 2011).

[1] Office of Management and Budget, The President's Budget for Fiscal Year 2013, The Budget Message of the President, February 13, 2012; available at www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/message.pdf

	Current Medicare, including changes enacted in the ACA	Domenici-Rivlin[1]	Wyden-Ryan[2]	Burr-Coburn "Seniors' Choice Act"[3]	S. 2196, "Congressional Health Care for Seniors Act"[4]	Chairman Ryan's "Path to Prosperity"[5]
Date	**Current**	**June 15, 2012**	**December 15, 2011**	**February 16, 2012**	**March 15, 2012**	**March 20, 2012**
General approach for premium support	Not a premium support system. Individuals ages 65 and older, and younger adults with permanent disabilities who are entitled to Part A and enrolled in Part B (Medicare beneficiaries) are entitled to a defined benefit package, with option for coverage of Part A and B benefits under either traditional fee-for-service (FFS) Medicare or a private Medicare Advantage plan. Beneficiaries may also receive Part D prescription drug benefits under private plans, including either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug plans (MA-PDs).	Beneficiaries would be entitled to a defined federal contribution to be used towards the purchase of a plan that is actuarially equivalent to the services offered under FFS Medicare; plans would be available through a new Medicare Exchange.	Beneficiaries would be entitled to a defined federal contribution to be used towards the purchase of a plan that is actuarially equivalent to the services offered under FFS Medicare; plans would be available through a new Medicare Exchange.	Beneficiaries would be entitled to a defined federal contribution to be used towards the purchase of a plan that is actuarially equivalent to the services offered under FFS Medicare.	Beneficiaries would be entitled to a defined federal contribution to be used either towards the purchase of a plan offered as part of the Federal Employee Health Benefits Plan (FEHBP) or, for beneficiaries with employer-sponsored insurance, towards the purchase of an employer-sponsored health plan.	Beneficiaries would be entitled to a defined federal contribution to be used towards the purchase of a plan that is actuarially equivalent to the services offered under FFS Medicare; plans would be available through a new Medicare Exchange.
Covered population	All Medicare beneficiaries.	All Medicare beneficiaries.	All individuals who become eligible for Medicare on or after January 1, 2022.	All Medicare beneficiaries.	All Medicare beneficiaries.	All individuals who become eligible for Medicare on or after January 1, 2023.
First year of premium support payments	Not applicable.	2016	2022	2016	2014	2023
Role of traditional fee-for-service (FFS) Medicare program	All beneficiaries who are entitled to Part A and enrolled in Part B have the option of receiving Medicare-covered services under the FFS Medicare program, or a private Medicare Advantage plan.	FFS Medicare would be offered through the Medicare Exchange along with other private plans, and available to all Medicare beneficiaries.	FFS Medicare would be offered through the Medicare Exchange along with other private plans, and available to all Medicare beneficiaries.	FFS Medicare would be offered along with other private plans, and available to all Medicare beneficiaries.	FFS Medicare, including Part D prescription drug plans, would no longer be an option.	FFS Medicare would be offered through the Medicare Exchange along with other private plans, and available to all Medicare beneficiaries.

	Current Medicare, including changes enacted in the ACA	Domenici-Rivlin[1]	Wyden-Ryan[2]	Burr-Coburn "Seniors' Choice Act"[3]	S. 2196, "Congressional Health Care for Seniors Act"[4]	Chairman Ryan's "Path to Prosperity"[5]
Date	**Current**	**June 15, 2012**	**December 15, 2011**	**February 16, 2012**	**March 15, 2012**	**March 20, 2012**
Oversight and administration	The Centers for Medicare and Medicaid Services (CMS) oversees the operation of traditional Medicare, and regulates the operation of Medicare Advantage and Part D private plans.	CMS would oversee the operation of traditional Medicare, and regulate the operation of private plans, including rules on plans' reserves for solvency, accuracy of promotional materials, and network adequacy. The agency could block benefit designs that it deems likely to disproportionately attract healthy people.	CMS would oversee the operation of traditional Medicare, and regulate the operation of private plans.	CMS would oversee the bids for FFS Medicare. The new Medicare Consumers' Protection Agency (MCPA) would oversee the bids and regulation of private plans.	Office of Personnel and Management (OPM) would oversee and regulate plans participating in FEHBP, as under current law. OPM would be prevented from placing new mandates on health insurance plans offered under FEHBP.	CMS would oversee the operation of traditional Medicare, and regulate the operation of private plans.
Benefit package and cost sharing	FFS Medicare: Beneficiaries who are entitled to Part A and enrolled in Part B receive a defined set of benefits, with separate deductibles for Part A and Part B, and cost-sharing that varies across services. Deductibles and other cost-sharing do not vary by income. Medicare Advantage: Beneficiaries enrolled in plan entitled to Medicare benefits, and actuarially equivalent cost-sharing. Some plans are required to use federal rebate payments to provide benefits not covered by FFS Medicare and/or lower cost-sharing. Part D: Enrollees entitled to standard benefit, or one that is actuarially equivalent.	Private plans would be required to cover at least the actuarial equivalent of the FFS Medicare benefit package, including a specific base set of services (although not necessarily the same benefits). Private plans could offer expanded benefits for an additional premium. Plans would be "subject to strict quality and coverage standards." Changes with respect to prescription drug coverage not specified.	Private plans would be required to cover at least the actuarial equivalent of the FFS Medicare benefit package (although not necessarily the same benefits). FFS Medicare would have a unified deductible for Part A and Part B. Changes with respect to prescription drug coverage not specified.	Private plans would be required to cover at least the actuarial equivalent of the FFS Medicare benefit package (although not necessarily the same benefits). Plans would be required to cover basic hospital, surgical, physician, and emergency care, as well as any other services mandated by the new MCPA. FFS Medicare would have a unified deductible and cost-sharing; millionaires would have a higher unified deductible. FFS Medicare would be prohibited from covering prescription drugs; stand-alone PDPs would continue to be an option for beneficiaries in FFS Medicare.	As under the current FEHBP, plans would not be required to offer a standardized set of benefits. All plans would cover basic hospital, surgical, physician, and emergency care, as well as prescription drugs and mental health care with parity. New private plans would be required to provide equivalent or superior benefits relative to an existing plan in FEHBP.	Private plans would be required to cover at least the actuarial equivalent of the FFS Medicare benefit package (although not necessarily the same benefits). Changes with respect to prescription drug coverage not specified.

	Current Medicare, including changes enacted in the ACA	Domenici-Rivlin[1]	Wyden-Ryan[2]	Burr-Coburn "Seniors' Choice Act"[3]	S. 2196, "Congressional Health Care for Seniors Act"[4]	Chairman Ryan's "Path to Prosperity"[5]
Date	**Current**	**June 15, 2012**	**December 15, 2011**	**February 16, 2012**	**March 15, 2012**	**March 20, 2012**
Out-of-pocket limits	FFS Medicare: No limit on out-of-pocket spending. Medicare Advantage: All plans are required to limit out-of-pocket spending to levels specified annually by CMS. Part D: Includes a catastrophic threshold that limits beneficiaries' liability.	No limit on out-of-pocket spending under FFS Medicare.	FFS Medicare would have a limit on out-of-pocket spending.	FFS Medicare would have a limit on out-of-pocket spending, and higher income beneficiaries would have a higher limit on out-of-pocket expenses.	Plans would have a limit on out-of-pocket spending, with the limit varying by plan.	No limit on out-of-pocket spending under FFS Medicare.
Federal payments to plans	Medicare Advantage plans are paid based on their bids, which are plans' estimated costs of providing Medicare Parts A and B benefits to the average Medicare beneficiary. Plan bids are compared to federally established county and regional benchmarks (the maximum amount Medicare will pay plans). As of 2018, the benchmarks will range from 95 percent to 115 percent of the costs of FFS Medicare in the county. Payments to plans are adjusted based on enrollees' risk profiles (health and certain demographics). Part D plans are paid 74.5 percent of the nationwide average plan bid for the cost of providing the standard Part D benefit to the average beneficiary. Federal govern-ment also pays 80 percent of spending for drugs above the "catastrophic threshold." Payments to plans are adjusted based on enrollees' risk profiles and incomes.	Federal payments to plans ("defined benefit amount") would be tied to either the second-least expensive approved plan or FFS Medicare, whichever is least expensive (subject to the two lowest-price plans combined having enough capacity to handle expected enrollment). Plan bids would be based on a benefit package equal in actuarial value to FFS Medicare Part A and Part B, and standardized to an average risk beneficiary. Price of FFS Medicare would be based on the average FFS Medicare costs for an average risk beneficiary in the same market area. Premium support payments would be adjusted for health status, and geography.	Federal payments to plans ("defined benefit amount") would be based on the benchmark bid, which would be defined as either the second-least expensive approved plan or FFS Medicare, whichever is least expensive. Premium support payments would be adjusted for health status, geography, and income.	In the first year, the federal payment to plans would be the "government's share of spending (in Parts A and B) for the prior year." In all other years, the federal payment to plans would be "tied" to the average bid, weighted by plan enrollment. Payments would be adjusted for health status and income.	Federal payments to plans ("defined benefit amount") would be same as current FEHBP contributions, which are approximately 75 percent of the cost of the "average plan." Federal payments for beneficiaries in employer-sponsored plans would be capped at the plan's premium. Not specified as to whether federal payments for employer-sponsored plan premiums would be available to both active workers and retirees who are Medicare beneficiaries. Not specified as to whether payments would be adjusted for enrollees' health status.	Federal payments to plans ("defined benefit amount") would be based on the benchmark bid, which would be defined as either the second-least expensive approved plan or FFS Medicare, whichever is least expensive. Premium support payments would be adjusted for health status and geography.

	Current Medicare, including changes enacted in the ACA	Domenici-Rivlin[1]	Wyden-Ryan[2]	Burr-Coburn "Seniors' Choice Act"[3]	S. 2196, "Congressional Health Care for Seniors Act"[4]	Chairman Ryan's "Path to Prosperity"[5]
Date	**Current**	**June 15, 2012**	**December 15, 2011**	**February 16, 2012**	**March 15, 2012**	**March 20, 2012**
Marketplace design	Medicare Advantage and Part D plan information (e.g., benefits, cost-sharing, premiums and quality ratings) is available on Medicare Compare website.	Would establish new Medicare Exchanges.	Would establish new Medicare Exchanges.	No specific provision, but the MCPA would be required to conduct a nationwide education campaign to ensure beneficiaries are aware of choices.	Would use the existing structure under FEHBP.	Would establish new Medicare Exchanges.
Service areas	FFS Medicare: A defined set of covered benefits are guaranteed.[6] Medicare Advantage: Most plans guarantee coverage of services across a county, although some provide coverage across a larger geographic area (e.g., regional PPOs, which serve areas consisting of one or more states). Part D: Plans are required to provide drug coverage to all beneficiaries in the same region; no region is smaller than one state.	Area not specified. Proposal suggests metropolitan areas or a large rural area where population density is low.	Area not specified.	Plans would be required to cover regions, such as the Part D regions or a combination of states and new regional areas.	Would use the existing service areas under FEHBP.	Area not specified.
Guaranteed issue	FFS Medicare and Part D: All beneficiaries are eligible for enrollment without regard to income, health status, age or other factors. Medicare Advantage: Generally, all beneficiaries are eligible to enroll in any Medicare Advantage plan, with exceptions for Special Needs Plans which are only available to beneficiaries with specific characteristics.	Would be required. All beneficiaries would be eligible to enroll in a plan without regard to health status or age.	Similar to Domenici-Rivlin proposal.	Similar to Domenici-Rivlin proposal.	Similar to Domenici-Rivlin proposal.	Similar to Domenici-Rivlin proposal.

	Current Medicare, including changes enacted in the ACA	Domenici-Rivlin[1]	Wyden-Ryan[2]	Burr-Coburn "Seniors' Choice Act"[3]	S. 2196, "Congressional Health Care for Seniors Act"[4]	Chairman Ryan's "Path to Prosperity"[5]
Date	**Current**	**June 15, 2012**	**December 15, 2011**	**February 16, 2012**	**March 15, 2012**	**March 20, 2012**
Premiums/ rebate	Part A: Most beneficiaries do not pay a Part A premium; they are entitled to Part A if they or their spouse contributed to payroll taxes during their working years. Part B: In general, premiums are set to cover 25 percent of program costs. Low-income beneficiaries are entitled to premium assistance, and higher income beneficiaries pay higher premiums. Medicare Advantage: In addition to the uniform Part B premium, beneficiaries in Medicare Advantage plans may pay a premium that may vary by plan and county. Part D: Part D premiums generally set to cover 25.5 percent of program costs, but vary by plan and region. Low-income beneficiaries are entitled to premium assistance, and higher income beneficiaries are subject to higher premiums.	Beneficiaries who chose to enroll in a plan that was more expensive than the benchmark would be required to pay the incremental additional cost. Beneficiaries who enrolled in a plan with the lowest bid would be rebated the full difference in cost from the benchmark. Unclear if current Part B and Part D formulas would be retained.	Beneficiaries who chose to enroll in a plan that was more expensive than the benchmark would be required to pay the incremental additional cost. Beneficiaries who enrolled in a plan that costs less than the benchmark would be rebated the full difference in cost from the benchmark. Unclear if current Part B and Part D formulas would be retained.	Part B premiums would be increased by 3 percent of Part A and B program costs each year, beginning in 2013, to achieve a 9 percent increase prior to implementation of premium support in 2016. Beneficiaries would pay the difference between the defined federal contribution and the bid for the plan in which they chose to enroll. Unclear how the Part B and Part D formulas would be calculated or applied beginning in 2016.	Beneficiaries would pay the difference between the defined federal contribution and the bid for the plan in which they chose to enroll.	Beneficiaries who chose to enroll in a plan that was more expensive than the benchmark would be required to pay the incremental additional cost. Beneficiaries who enrolled in a plan with the lowest bid would be rebated the full difference in cost from the benchmark. Unclear if current Part B and Part D formulas would be retained.
Community rating	Medicare Advantage and Part D plans are community rated; premiums charged by plans do not vary by risk profile.	Would be required. Premiums could not vary by age or health status.	Would be required. Premiums could not vary by age or health status.	Not specified.	Would be required. Premiums could not vary by age or health status.	Would be required. Premiums could not vary by age or health status.

	Current Medicare, including changes enacted in the ACA	Domenici-Rivlin[1]	Wyden-Ryan[2]	Burr-Coburn "Seniors' Choice Act"[3]	S. 2196, "Congressional Health Care for Seniors Act"[4]	Chairman Ryan's "Path to Prosperity"[5]
Date	**Current**	**June 15, 2012**	**December 15, 2011**	**February 16, 2012**	**March 15, 2012**	**March 20, 2012**
Protections against selection through benefit design	CMS reviews plan bids to prevent discriminatory benefit designs. Medicare Advantage plans are prohibited from charging high cost sharing for services that may discourage sicker beneficiaries from enrolling in the plan. Part D plans are subject to non-discrimination requirements with respect to formularies and cost-sharing.	CMS would be required to enforce rules on plans' benefit designs deemed likely to disproportionately attract healthy people.	CMS would review plans' benefit adequacy. Plans covering a higher-than-average number of low-risk seniors would pay a fee. Plans covering a higher-than-average number of high-risk seniors would receive an incentive payment.	No specific provision, but MCPA would oversee the plan bids and risk adjustment process (see oversight and administration).	A new "high-risk pool" for the highest-cost beneficiaries would be created for the costliest 5 percent of all people enrolled in FEHBP; health care plans would be reimbursed for 90 percent of the total medical expenses of high-cost people.	CMS would conduct an annual risk review audit of all plans participating in the Medicare Exchanges. Plans covering a higher-than-average number of low-risk seniors would pay a fee. Plans covering a higher-than-average number of high-risk seniors would receive an incentive payment.
People who are dually eligible for Medicare and Medicaid ("dual eligibles")	Medicaid pays the Part B premiums for beneficiaries dually eligible for Medicare and Medicaid, up to 135 percent of the federal poverty level (FPL). Medicaid also helps pay Part A and B cost sharing for full dual eligibles, and in some cases for individuals eligible for partial benefits. Medicare limits the cost-sharing Part D plans can charge dual eligibles, and guarantees dual eligibles can enroll in at least one Part D plan for no premium. Medicare limits the cost sharing Part D plans can charge dual eligibles and Medicare guarantees that these beneficiaries can enroll in at least one Part D plan for no premium.	Premium and cost-sharing assistance for dual eligibles, defined as beneficiaries with incomes below 135 percent of the federal poverty level (FPL), would be provided under Medicaid. Unclear if eligibility would also be based on assets. Dual eligibles would be held harmless from premium increases if the growth in per-beneficiary federal support exceeds the cap on payments (GDP+1 percent). Current beneficiaries with incomes below 135 percent of the FPL would retain a choice between FFS Medicare and a private plan of similar value for no additional premium. Unclear if eligibility would also be based on assets. Unspecified as to whether future beneficiaries with incomes below 135 percent of the FPL would retain the same choice.	Premium and cost-sharing assistance for dual eligibles would be provided, either under Medicaid or MSAs. Details unspecified. Dual eligibles would continue to have Medicaid pay their out-of-pocket expenses if costs per beneficiary rise faster than the cap on payments (nominal GDP+1 percent). Unspecified as to whether dual eligibles would be required to pay the incremental additional cost if they chose to enroll in a plan that was more expensive than the benchmark.	Not specified.	Beneficiaries who could not afford to pay plan premiums would receive additional premium assistance and cost-sharing through Medicaid. Eligibility levels and level of government support for Medicaid assistance are not specified. Unspecified as to whether dual eligibles would be required to pay the incremental additional cost if they chose to enroll in a plan that was more expensive than the average plan.	Premium and cost-sharing assistance for people eligible for both Medicare and Medicaid ("dual eligibles") would be provided under Medicaid. Details unspecified. Dual eligibles would continue to have Medicaid pay their out-of-pocket expenses if costs per beneficiary rise faster than the cap on payments (GDP+0.5 percent). Federal Medicaid payments, including payments for dual eligibles, would be provided in a block grant. Unspecified as to whether dual eligibles would be required to pay the incremental additional cost if they chose to enroll in a plan that was more expensive than the benchmark.

	Current Medicare, including changes enacted in the ACA	Domenici-Rivlin[1]	Wyden-Ryan[2]	Burr-Coburn "Seniors' Choice Act"[3]	S. 2196, "Congressional Health Care for Seniors Act"[4]	Chairman Ryan's "Path to Prosperity"[5]
Date	**Current**	**June 15, 2012**	**December 15, 2011**	**February 16, 2012**	**March 15, 2012**	**March 20, 2012**
Other low-income beneficiaries	For beneficiaries with incomes up to 150 percent of the FPL, Medicare limits the premiums and cost sharing Part D plans can charge beneficiaries qualifying for low-income subsidies; Medicare guarantees that these beneficiaries can enroll in at least one Part D plan for no premium.	Current low-income beneficiaries, including dual eligibles as well as beneficiaries with incomes between 135 percent and 150 percent of the FPL, would retain a choice between traditional Medicare or a private plan of similar value for no additional premium. Unclear if eligibility would also be based on assets. Unspecified as to whether future low-income beneficiaries would retain the same choice. Beneficiaries with incomes between 135 percent and 150 percent of the FPL would be protected from any premium increases. Unclear if eligibility would also be based on assets.	Low-income beneficiaries who are not dual eligibles would receive a MSA from which to pay premiums, co-pays, and other out-of-pocket costs. Low-income seniors would be offered the same range of plan options offered to other seniors. Eligibility levels for low income beneficiaries are not specified.	Low-income beneficiaries would pay reduced premiums. Eligibility levels for low income beneficiaries are not specified.	Low-income beneficiaries, for whom monthly plan premiums would exceed monthly Social Security benefits or Railroad Retiree benefits, could pay to OPM the amount the beneficiary desires. Details unspecified.	Low-income beneficiaries who are not eligible for both Medicare and Medicaid ("dual eligibles") would receive a medical savings account (MSA) from which to pay premiums, co-pays, and other out-of-pocket costs. Low-income seniors would be offered the same range of plan options offered to other seniors. Eligibility levels for low income beneficiaries are not specified.
Higher-income beneficiaries	Part B and Part D enrollees with incomes greater than $85,000 per individual/$170,000 per couple pay an income-related monthly premium for Part B and Part D; premium amounts range from 35 percent to 80 percent of the average program cost, depending on income; income thresholds frozen at current levels through 2019. Deductibles and cost-sharing do not vary by income.	Higher-income beneficiaries (above 150% FPL) could receive a lower federal subsidy, if the growth in Medicare payments per beneficiary exceeds GDP+1 percent.	Would apply the same income-related premium thresholds as under current law.	Higher-income Medicare beneficiaries would continue to pay higher premiums, and would have a higher limit on out-of-pocket expenses under FFS Medicare. Millionaires would pay the full cost of Part B and Part D premiums and have a higher unified deductible than other beneficiaries.	Beneficiaries with incomes between $85,000 and $1,000,000 per individual would receive smaller federal contributions, phasing down from 80 percent to 15 percent of the defined federal contribution towards plan premiums; millionaires would receive no federal subsidy and would pay the full cost of premiums.	Would apply the same income-related premium thresholds as under current law.

	Current Medicare, including changes enacted in the ACA	Domenici-Rivlin[1]	Wyden-Ryan[2]	Burr-Coburn "Seniors' Choice Act"[3]	S. 2196, "Congressional Health Care for Seniors Act"[4]	Chairman Ryan's "Path to Prosperity"[5]
Date	**Current**	**June 15, 2012**	**December 15, 2011**	**February 16, 2012**	**March 15, 2012**	**March 20, 2012**
Primary mechanism for achieving savings	Several avenues to achieve savings included in the ACA, including reducing annual payment updates for hospitals and other providers; reducing payments to Medicare Advantage plans; payment and delivery system reforms and innovations (e.g., accountable care organizations; value-based purchasing; establishing the Center for Medicare and Medicaid Innovation); and the Independent Payment Advisory Board (IPAB).	Assumes competition between plans and FFS Medicare would reduce growth in future spending, with stopgap cap on per capita spending (see below).	Assumes competition between plans would reduce growth in future spending, and "Congressional action" would be required if growth in costs per beneficiary exceeded stopgap cap (see below).	Assumes competition between plans and FFS Medicare would reduce the growth in future spending. Would include a voluntary care coordination program for beneficiaries in FFS Medicare who met certain medical and clinical criteria; assumes this program would reduce the growth in future spending.	Assumes competition between plans, and continued enrollment of federal employees in FEHBP, would reduce the growth in future spending.	Assumes competition between plans and FFS Medicare would reduce growth in future spending, with stopgap cap on per capita spending (see below).
Cap on Medicare spending	Beginning in 2014, a 15-member Independent Payment Advisory Board (IPAB) will recommend ways to reduce Medicare spending by an applicable percentage defined in law if the five-year average rate of growth in Medicare per capita spending exceeds certain target growth rates based on the CPI-U and the CPI-M prior to 2018, and the nominal per capita GDP plus 1.0 percentage point in 2018 and future years. If spending exceeds the target, the IPAB would recommend proposals to achieve savings of the lesser of either the amount by which projected spending exceeds the target, or the applicable percentage.	No change to IPAB specified. If the growth in Medicare payments per beneficiary for Parts A, B, and D combined exceeded GDP + 1 percent, then Medicare beneficiaries with incomes above 150 percent of the FPL would pay a larger share of plan bids.	No change to IPAB specified. If the growth in Medicare payments per beneficiary exceeded nominal GDP + 1 percent, then Congress would be required to intervene, and could implement policies that change provider reimbursements, drug companies, program overhead, and means-tested premiums.	IPAB would be repealed. Would not cap federal spending.	Would not cap federal spending.	IPAB would be repealed. The growth in Medicare payments per beneficiary could not exceed GDP + 0.5 percent.

	Current Medicare, including changes enacted in the ACA	Domenici-Rivlin[1]	Wyden-Ryan[2]	Burr-Coburn "Seniors' Choice Act"[3]	S. 2196, "Congressional Health Care for Seniors Act"[4]	Chairman Ryan's "Path to Prosperity"[5]
Date	**Current**	**June 15, 2012**	**December 15, 2011**	**February 16, 2012**	**March 15, 2012**	**March 20, 2012**
Medicare's role in other health-related activities	Medicare supports other health-related activities such as graduate medical education, rural health, and urban safety net hospitals.	Not specified.	Not specified.	Not specified.	No Medicare bonus or incentive payments, and no payments for graduate medical education would be made after January 1, 2014. Medicare supplemental (Medigap) policies and demonstration projects would be terminated, as of January 1, 2014.	Not specified.

[1] Former Senator Pete Domenici and Dr. Alice Rivlin, "The Domenici-Rivlin Protect Medicare Act," November 1, 2011. See also Bipartisan Policy Center, "Domenici-Rivlin Protect Medicare Act," Updated June 15, 2012.

[2] Senator Ron Wyden and Representative Paul Ryan, "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future," December 15, 2011; available at www.wyden.senate.gov/bipartisanhealthoptions

[3] Senator Richard Burr and Senator Tom Coburn, "The Seniors' Choice Act," February 16, 2012.

[4] S. 2196, "Congressional Health Care for Seniors Act of 2012," as introduced by Senator Rand Paul on March 15, 2012, 112th Congress; and Senator Rand Paul, "Congressional Health Care for Seniors Act," released March 15, 2012.

[5] Chairman Paul Ryan, "The Path to Prosperity: A Blueprint for American Renewal," March 20, 2012.

[6] Some services and procedures are subject to local coverage determinations; such determinations may vary across the country.

APPENDIX: Summary of Additional Premium Support Proposals

RIVLIN-RYAN (November 17, 2010)

Would provide premium support payments to purchase private health insurance in a Medicare Exchange for people who turn 65 on or after 2021; would set premium support amount at the average federal cost per Medicare enrollee in 2021, indexed to per capita GDP+1%; would adjust premium support payments by income, geography, and health risk; would allow enrollees eligible for Medicare before 2021 to continue on traditional fee-for-service; premiums would be held harmless from effects of the Medicare Exchange.

Source: Dr. Alice Rivlin and Rep. Paul Ryan, "A Long-Term Plan for Medicare and Medicaid," November 17, 2010. Congressional Budget Office, "Preliminary Analysis of the Rivlin-Ryan Health Care Proposal," November 17, 2010.

CATO INSTITUTE (April 1, 2011)

Would convert Medicare to a premium support system, with subsidies to beneficiaries adjusted for health status and lifetime income; enrollees could save their voucher if they do not spend the entire amount; phase-out vouchers with Medicare beneficiaries relying entirely on HSAs over the long-term.

Source: CATO Institute, "A Plan to Cut Spending and Balance the Federal Budget," April 1, 2011.

REPUBLICAN STUDY COMMITTEE (April 8, 2011)

Would create optional private health insurance plans for beneficiaries; would transition to premium support system; would adjust subsidies for beneficiaries' income, health status, and geographic differences in medical costs; would require plans to offer catastrophic coverage. Starting in 2021, dual eligible individuals would receive fully funded account from which to pay out-of-pocket expenses.

Source: Republican Study Committee, "Honest Solutions: Fiscal Year 2012 Budget," April 8, 2011.

HERITAGE FOUNDATION (May 10, 2011)

Starting in 2016, would transition Medicare to a "premium support" program; would set premium support amount to 88% of the weighted average premium of regional bids of competing health plans for the first 5 years; starting in 2021, would limit Medicare payment amount to 88% of the lowest bid of competing plans in a region; would adjust premium support payments by income; in 2021, would allow traditional Medicare to compete directly with private plans; would cap total Medicare spending, and index spending cap to chained CPI and Medicare population growth.

Source: The Heritage Foundation, "Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity," May 10, 2011.

AMERICAN ENTERPRISE INSTITUTE (May 25, 2011)

Would convert Medicare to a premium support system over 10 or more years, with subsidies adjusted by health status and income.

Source: American Enterprise Institute, "A Balanced Plan for Fiscal Stability and Economic Growth," May 25, 2011.

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