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BACKGROUNDER

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Medicare: How Timely Reforms Can Prevent Painful Consequences

Robert E. Moffit, PhD

Abstract

Most Americans recognize that there is a problem with the growth of federal entitlements, including Medicare. Americans must understand their real policy choices, and the consequences of their choices, including the profoundly consequential choice to do absolutely nothing. Doing nothing may be the most politically palatable option for the moment, but would prove painful for taxpayers, beneficiaries, and the country. The President and Congress will have to address Medicare, sooner rather than later. The Medicare Hospital Insurance Trust Fund will run out of the money to pay all of Medicare's promised benefits in 2026—three years earlier than the Medicare Trustees projected in 2017. Congress and the President should start to educate the public, explaining the real alternatives, now.

The President and Congress will have to address Medicare, sooner rather than later. The Medicare Hospital Insurance (HI) Trust Fund, plagued by a continuous string of annual cash deficits, will run out of the money to pay all of Medicare's promised benefits in 2026—three years earlier than the Medicare Trustees projected last year.[1]

The Fiscal Challenge

The deteriorating condition of the Medicare program, including the HI Trust Fund (for Medicare Part A), is caused by the relentless growth of Medicare spending, further fueled by the accelerating enrollment of retiring baby boomers and the rising per capita cost of caring for them. Medicare Part B, the part of Medicare that pays doctors and outpatient services, is not threatened with insolvency

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The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

Key Points

- The Medicare Hospital Insurance (HI) Trust Fund will run out of the money to pay *all* of Medicare's promised benefits in 2026.
- The driver of the Medicare's deteriorating financial condition (including the HI Trust Fund) is the relentless growth of Medicare spending, fueled by the per capita costs and the accelerating enrollment of retiring baby boomers.
- Of all of the federal entitlements, Medicare is the biggest challenge. Congress and the President should start to educate the public, explaining the real alternatives, including potentially large tax increases or painful cuts in benefits or Medicare payments.
- The President and Congress should secure popular support for carefully calibrated Medicare reform, phasing in far-reaching changes gradually, while protecting current beneficiaries, particularly low-income enrollees.
- Doing nothing would prove painful for beneficiaries, taxpayers, and the country as a whole.

because transfers from the general fund automatically fund rising Part B spending.[2] Medicare spending, averaging 7 percent over the next 10 years,[3] will outpace the growth of wages, inflation, the general economy, and all other health care spending.

The Medicare Trustees estimate that Medicare will consume larger chunks of the American economy and will increase from 3.7 percent of gross domestic product (GDP) to 5.9 percent of GDP by 2042, or even 6.2 percent, depending on a more pessimistic set of assumptions.[4] Meanwhile, Medicare funding for Part B alone will consume progressively larger portions of Americans' personal and business income taxes, rising from a little more than 14 percent today to an estimated 25 percent by 2040.[5]

The Fiscal Warning. During the 2016 presidential campaign, candidate Donald Trump promised that he would not touch Medicare. Thus far, his budget proposals reflect that campaign promise. With the notable exception of Chairman Steve Womack (R–AR) and his colleagues on the House Budget Committee,[6] there is little discernible appetite for comprehensive Medicare reform on Capitol Hill.

Policy alternatives are narrowing. Pursuant to federal law, the Medicare Trustees this year also issued a formal warning to Congress and the President that the Medicare program faces an "excessive" reliance on general revenues, reaching an amount in excess of 45 percent of total Medicare spending. Under current law, the President is required to submit remedial legislation within 15 days of the transmission of his fiscal year (FY) 2020 budget to Congress, and Congress is required to act on legislation in an expeditious fashion.[7] In other words, ready or not, the President and the Congress are required to act next year.

Once again, the Medicare Trustees have issued another urgent call for action:

> The sooner solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations and behavior. The Trustees recommend that Congress and the executive branch work closely together with a sense of urgency to address the depletion of the HI trust fund and the projected growth in HI (Part A) and SMI (Parts B and D) expenditures.[8]

Medicare Spending, Federal Deficits, and Debt

Mandatory spending, including federal entitlement spending, accounts for about 70 percent of all federal spending.[9] Manhattan Institute analyst Brian Reidl observes, "Since 2008—when the first Baby Boomers qualified for early retirement—Social Security and Medicare have accounted for 72 percent of all inflation-adjusted federal spending growth (with other health entitlements responsible for the

1. 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 7, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf (accessed July 24, 2018), hereafter cited as 2018 Medicare Trustees' Report. For a discussion of the implications of the report, see Joseph Antos and Robert E. Moffit, "The 2018 Medicare Trustees Report: Fiscal and Policy Challenges," American Enterprise Institute, *AEI Economic Perspectives*, July 9, 2018, https://www.aei.org/publication/the-2018-medicare-trustees-report-fiscal-and-policy-challenges/ (accessed July 30, 2018).
2. Former Medicare Trustees Charles Blahous and Robert Reischauer observe, however, that this "does not mean that SMI lacks financing stresses, but they are manifested as growing pressures on the general federal budget rather than in the threat of program insolvency." Charles P. Blahous and Robert D. Reischauer, "A Letter to the Public from the Former Public Trustees of Social Security and Medicare," Bipartisan Policy Center, June 14, 2018, p. 2, https://bipartisanpolicy.org/library/a-letter-to-the-public-from-the-former-public-trustees/ (accessed July 24, 2018).
3. Congressional Budget Office, *The Budget and Economic Outlook: 2018 to 2028*, April 9, 2018, p. 51, https://www.cbo.gov/publication/53651 (accessed July 24, 2018).
4. 2018 Medicare Trustees Report, p. 19.
5. Ibid., p. 39.
6. News release, "House Budget Committee Unveils 'Budget for a Brighter American Future,'" House Budget Committee, June 19, 2018, https://budget.house.gov/press-release/house-budget-committee-unveils-budget-brighter-american-future/ (accessed July 24, 2018).
7. 2018 Medicare Trustees Report, p. 8.
8. Ibid., p. 10.
9. House Budget Committee, "A Brighter American Furture: A Balanced Budget for FY 2019," 2018, p. 7, https://budget.house.gov/wp-content/uploads/2018/06/FY19_Budget-Blueprint-Final.pdf (accsessed July 24, 2018).

rest)."[10] Over the next 10 years, according to the Government Accountability Office, Medicare, Social Security, and net interest on the debt will consume about two-thirds of the projected $3 trillion increase in total federal spending.[11]

These federal entitlements are the biggest drivers of federal spending, future deficits, and debt. As the Medicare Payment Advisory Commission, the panel that advises Congress on Medicare reimbursement, warns:

> In fact—assuming no other policy or legislative interventions—spending on Medicare, Medicaid, the other major health programs, Social Security, and net interest payments are projected to reach almost 20 percent of the nation's economy by 2039 and, by themselves, will exceed total federal revenues.[12]

Medicare is the biggest challenge. The Congressional Budget Office (CBO) details Medicare's relentless fiscal pressures: Medicare's gross outlays will grow from $707 billion to over $1.5 trillion from 2018 to 2028.[13] It is the biggest driver of federal health care spending, dwarfing Medicaid, the Affordable Care Act subsidies, and the Children's Health Insurance Program. Under current law estimates, federal health spending, led by Medicare, will grow faster than any other federal spending category.[14]

Deficits. In 2009, President Barack Obama had warned that "Medicare and Medicaid are the single biggest drivers of the federal deficit and the federal debt by a huge margin."[15] Today, the Medicare Payment Advisory Commission observes that "[w]ith their reliance on general tax dollars and federal deficit spending, Medicare and the other major federal health care programs have a substantial effect on the federal debt."[16]

The CBO projects that federal deficits will average $1.2 trillion annually and total $12.4 trillion from 2019 to 2028.[17] Meanwhile, over the same period, gross federal debt, fueled by these annual deficits, will grow from an estimated $21.3 trillion to $33.8 trillion.[18]

Debt. Since 1946, the CBO reports, the average debt-to-GDP ratio was 45 percent. This year, the CBO announced that debt is equal to 76.5 percent of GDP, and that projected debt amounts to 96 percent of GDP by 2028. Under an alternative scenario, based on a more pessimistic set of assumptions, the CBO estimates that the debt could reach 105 percent of GDP by 2028, a level that has been exceeded, the agency notes, "only one time" in American history.[19] In a classic understatement, the CBO reported last year, the accumulation of such levels of debt, compared to the size of the American economy, would have "serious budgetary and economic consequences."[20]

Beyond the conventional estimates of the federal debt, there are also the unfunded obligations of the growing federal entitlement programs. These obligations refer to the estimated long-term cost of the promised Medicare benefits, minus the dedicated

10. Brian Riedl, "The Entitlement Crisis Ignored," *National Review*, March 1, 2018, https://www.nationalreview.com/magazine/2018/03/01/ (accessed July 24, 2018).
11. Government Accountability Office, "The Nation's Fiscal Health: Action is Needed to Address the Federal Government's Fiscal Future," *Report to Congress*, June 2018, p. 19, https://www.gao.gov/assets/700/692666.pdf (accessed July 24, 2018).
12. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2018, p. 20, http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0 (accessed July 24, 2018).
13. Congressional Budget Office, *The Budget and Economic Outlook: 2018 to 2028*, Table 2-1, p. 44.
14. Jessica Banthin, "Health Spending Today and in the Future: Impacts on Federal Deficits and Debt," Congressional Budget Office, July 18, 2017, p. 14, https://www.cbo.gov/system/files/115th-congress-2017-2018/presentation/52913-presentation.pdf (accessed July 24, 2018).
15. Angie Drobnic Holan, "Obama Says Medicare and Medicaid Are the Largest Deficit Drivers. Yes, Over the Long Term," Politifact, June 25, 2009, http://www.politifact.com/truth-o-meter/statements/2009/jun/25/barack-obama/obama-says-medicare-and-medicaid-are-largest-defic/ (accessed July 24, 2018).
16. MedPAC, *Report to the Congress: Medicare Payment Policy*, p. 21.
17. Congressional Budget Office, *The Budget and Economic Outlook: 2018 to 2028*, p. 79. The CBO estimates that the 2017 Tax Cuts and Jobs Act will be responsible for $1.9 trillion of that "total projected deficit" (including debt service) over the next 10 years.
18. Ibid., p. 87.
19. Ibid., p. 79.
20. Congressional Budget Office, *The 2017 Long-Term Budget Outlook*, March 2017, p. 1, https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/52480-ltbo.pdf (accessed July 24, 2018).

revenues to fund those benefits. The trustees project that Medicare faces an unfunded obligation of $37.7 trillion over 75 years,[21] meaning that the program will have to draw down that amount in general revenues to sustain the Medicare benefit payments. The Centers for Medicare and Medicaid Services' Office of the Actuary posits an alternative scenario, estimating that the Medicare unfunded obligations could amount to $47.3 trillion over the next 75 years.[22]

Of all federal entitlements, Medicare today poses the greatest, single fiscal challenge.

Medicare for All? Medicare's growing fiscal problems should put the emerging congressional "Medicare for all" proposals into proper perspective—if not to rest altogether. Beyond the impact on America's complex system of health care delivery, the financing of the current federal entitlements is tough enough without forcing taxpayers to take on another major tax increase coupled with a massive new addition to the nation's already staggering public debt. Indeed, Senator Bernie Sanders' bill (S. 1804), which attracted strong support among prominent Senate Democrats, would rely on a variety of specialized tax increases, plus a set of employer-based taxes and income taxes, amounting to a new tax of 11.5 percent of payroll.[23]

Champions of "single payer" health care often claim that replacing private health insurance and its premium costs with a government monopoly will save money for enrollees and taxpayers alike. In the case of the Sanders bill, however, independent analysts do not buy it. Given the bill's array of comprehensive benefits and its abolition of cost sharing, Professor Kenneth Thorpe of Emory University, a nationally prominent health care economist, estimates that the real tax burden would amount to 20 percent of payroll and that 70 percent of all working families would be paying more than they do today for health care.[24] Likewise, analysts at the Urban Institute, a prominent liberal think tank based in Washington, DC, estimate that the true cost of the Sanders proposal would be much higher than advertised, equaling $32 trillion over 10 years, and burdened with a short-fall of $16.6 trillion.[25] More recently, former Medicare Trustee Charles Blahous estimated that the full costs of the Sanders bill would be about $32.6 trillion between 2022 and 2031.[26] Closing such a gap would require broad-based taxation, hitting the middle class particularly hard.

In the meantime, Congress and the President need to address Medicare as well as the relentless growth in other federal entitlement spending. Responsible public officials can no longer ignore this spending, which is generating a surge in future deficits and unprecedented levels of debt. America, as the CBO clearly and repeatedly warns, could very well end up in a fiscal crisis. This would entail explosive interest rates, even higher federal spending to fund interest on the debt, federal borrowing that would crowd out private capital, and a precipitous decline in business borrowing, wages, and productivity.[27] The nation would, in other words, experience a major economic contraction.

Medicare as an Evolving Social Program

Those opposed to Medicare reform insist that they are defending "Medicare, as we know it." Medicare "as we know it" is, however, a protean thing. In fact, Medicare has been changing, often in major ways, since its inception in 1966. The shift in benefit spending, particularly from inpatient to outpatient and other medical services, has been steady and dramatic. In 1977, almost three-quarters of total benefit spending (then just $21.8 billion) was for inpatient hospitalization; in 1997, inpatient hospitalization spending shrunk to almost half of total benefit spending (then $208.1 billion); and by 2017, inpatient hospitalization spending had shrunk further to roughly one-fourth of total benefit spending ($696.7 billion).[28]

Although Congress and successive presidential Administrations have periodically enacted big programmatic reforms, each effort has fallen short of the goal of putting Medicare on a long-term, stable footing. In 1983, during the Reagan Administration, Congress overhauled hospital payment. In 1989, during the first

21. Ibid.
22. Susan Codesport, Office of the Actuary, "Memo on the Unfunded Obligations of the Medicare Program," provided to the staff of the Senate Budget Committee, June 5, 2018, p. 1.
23. For a more detailed description of the financing and other provisions of the Sanders bill, see Robert E. Moffit, "Government Monopoly: Senator Sanders' 'Single Payer' Health Care Prescription," Heritage Foundation *Backgrounder* No. 3261, October 31, 2017, https://www.heritage.org/sites/default/files/2017-10/BG3261.pdf.

Bush Administration, Congress created a new physician payment system. In 1997, during the Clinton Administration, Congress enacted across-the-board cuts in Medicare spending as part of its efforts to secure a balanced budget. In 2003, during the second Bush Administration, Congress created the large and growing system of private Medicare Advantage plans in addition to adding prescription drug coverage delivered almost exclusively through private insurance plans. Today, Medicare Advantage plans enroll 36 percent of all beneficiaries.[29]

In 2010, during the Obama Administration, Congress enacted the Affordable Care Act, which included an estimated 165 provisions of law affecting the Medicare program, including the imposition of an unprecedented hard cap on the annual growth of Medicare spending and the authorization of various payment and delivery reforms. In 2015, during the Obama Administration, Congress again overhauled Medicare physician payment through bipartisan legislation.

These congressional and administrative changes had only limited success. Epic problems have plagued congressional physician payment reforms since their inception in 1989. Congressional attempts to create private health plan alternatives have also been uneven, notably the failed "Medicare + Choice" program enacted in 1997. Likewise, the Obama Administration experiments in care delivery reforms, such as accountable care organizations (ACOs), initially got off to a rocky start, and their performance in generating net savings has fallen short of the initial CBO projections by more than $2 billion.[30] The tacit assumption was that Washington would secure higher quality care at lower cost through better administrative pricing.

In fact, the relatively modest performance of Medicare payment and delivery reforms in controlling costs was hardly surprising. In 2010, the CBO estimated that Obamacare payment or delivery reforms would not have much, if any, significant effect on Medicare spending.[31] Later CBO evaluations of Medicare payment reform demonstrations likewise showed little or no savings.[32]

The lesson is clear—without a strong injection of market forces, health care will not achieve the value proposition of better care at lower costs. To achieve these goals, Congress still needs to make major legislative changes.

The Politically Tough Task of Reform

Washington politicians find themselves in a major dilemma.

On the one hand, the Medicare Trustees, plus a broad range of public officials, policy analysts, and economists, rightly fear the consequences of the program's mounting fiscal problems and insist that Medicare must adapt to the rapidly changing conditions of the 21st century.[33]

24. Kenneth E. Thorpe, "An Analysis of Senator Sanders [sic] Single Payer Plan," Emory University, January 27, 2016, https://www.scribd.com/doc/296831690/Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal (accessed July 24, 2018).
25. John Holahan et al., "The Sanders Single-Payer Health Plan," Urban Institute *Research Report*, May 2016, https://www.urban.org/sites/default/files/publication/80486/200785-The-Sanders-Single-Payer-Health-Care-Plan.pdf (accessed July 24, 2018).
26. Charles Blahous, "The Costs of a National Single-Payer Healthcare System," Mercatus Center at George Mason University, July 30, 2018, https://www.mercatus.org/publications/federal-fiscal-policy/costs-national-single-payer-healthcare-system (accessed July 30, 2018).
27. Congresstional Budget Office, *The Budget and Economic Outlook: 2018 to 2028*, p. 6.
28. Paul Spitalnic, CMS Chief Actuary, "The Financial Status of Medicare," presentation to the American Enterprise Institute, June 6, 2018, Slide 3.
29. 2018 Medicare Trustees Report, p. 21.
30. Josh Seidman, John Feore, and Neil Rosacker, "Medicare Accountable Care Organizations Have Increased Federal Spending Contrary to Projections that They Would Produce Net Savings," Avalere, March 29, 2018, http://avalere.com/expertise/managed-care/insights/medicare-accountable-care-organizations-have-increased-federal-spending-con (accessed July 24, 2018).
31. Letter from Douglas W. Elmendorf, Director, Congressional Budget Office to the Honorable Nancy Pelosi, Speaker of the United States House of Representatives, March 18, 2010, Table 5. Preliminary Estimate, https://www.politico.com/pdf/PPM110_hr4872.pdf (accessed July 24, 2018).
32. Most of these demonstration projects, according to the CBO, produced little or no savings. See Congressional Budget Office, "Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination and Value-Based Payment," January 18, 2012, http://www.cbo.gov/publication/42860 (accessed July 24, 2018).
33. Though they disagree on policy or specific reform proposals, the bipartisan list of officials and analysts is impressive: former President Barack Obama, House Speaker Paul Ryan, the House Budget Committee, former CBO Director and Brookings scholar Alice Rivlin, former Federal Reserve Chairman Alan Greenspan, former Comptroller General Robert Walker, the 1999 Breaux–Thomas Commission, the Bowles–Simpson Commission, as well as the editorial boards of *The Washington Post* and *The Wall Street Journal*. The Medicare Trustees, who report annually on the program's financial condition, routinely plea for consequential reforms that would further slow the growth of Medicare spending.

On the other hand, the public, based on the best survey research, wants to keep Medicare "as it is" today. For example, on the 50th anniversary of the program, the Kaiser Family Foundation reported that 77 percent of Americans stated that Medicare is a very important program, second only to Social Security (with 83 percent). Nine of 10 seniors report positive experiences with the program, and 92 percent had no problems in paying for their medical expenses.[34]

Strong support for the program among seniors is understandable. The overwhelming majority of seniors have paid Medicare taxes during their working lives. Many are also under the erroneous impression, however, that the payroll taxes of their working lives are financing the Medicare coverage they are getting today. In fact, Medicare is a pay-as-you-go financing system; the payroll taxes that seniors paid during their working lives have long ago been spent on the previous generation of Medicare beneficiaries. The reality: The increasingly generous funding of the health benefits they enjoy today is almost entirely financed by today's workers paying today's payroll and income taxes. As analysts at the Urban Institute have proven conclusively, Medicare beneficiaries in virtually every income category receive far more in benefits than they ever paid in taxes during their working lives.[35] In short, the vast majority of today's senior citizens are recipients of a major federal benefit program they did not pay for; and most could not pay for, even if they wanted to do so.

Anxiety. Nonetheless, even with the lopsided polling in favor of the status quo, surveys also reveal an underlying concern about the future of the program; a vague sense that Medicare cannot somehow continue with business as usual. For example, Kaiser Family Foundation polling also found that more than half of the public was not confident in Medicare's ability to provide the level of today's benefits for future retirees; only 12 percent said that they were "very" confident.[36]

Even though Medicare's future is uncertain, no consensus has yet gelled on the path forward. There is no evidence of a broad-based consensus on significant Medicare proposals, such as the big tax increases that will be necessary to cover the growing costs or substantial cuts in retirees' benefits to render the program fiscally stable. In fact, recent polling reveals that Americans, regardless of party affiliation, overwhelmingly want to "maintain" or "increase" Medicare spending.[37]

An Agenda for Responsible Reform

According to the Medicare Payment Advisory Commission, "There is strong evidence that a sizeable share of current health care spending—both overall and by Medicare—is inefficient or unnecessary, providing an opportunity for policymakers to reduce spending, extend the life of the program, and reduce pressure on the federal budget."[38] Moreover, even small reductions in program growth can have serious and positive budgetary and economic consequences. Future federal debt, as the Medicare Payment Advisory Commission reports, is very sensitive to even the slightest changes in Medicare and Medicaid per capita spending.[39]

Among the best remedies available, Congress can simplify the program, gradually and modestly reduce taxpayer subsidies for Medicare's voluntary programs (Parts B and D), recalibrate the Medicare subsidy system to those who need the most help, and expand and intensify the competition among health plans and providers. As detailed below, The Heritage Foundation's Center for Data Analysis has completed estimates for FY 2019 that demonstrate the potential savings of these measures.

First, Simplify the Traditional Program. As the Medicare Payment Advisory Commission reports,

> The Medicare program is a complex and fragmented system, consisting of multiple paths to entitle-

34. Nira Norton, Bianca DiJulio, and Mollyann Brodie, "Medicare and Medicaid at 50," The Henry J. Kaiser Family Foundation, July 17, 2015, https://www.kff.org/medicaid/poll-finding/medicare-and-medicaid-at-50/ (accessed July 24, 2018).
35. C. Eugene Stuerle and Caleb Quakenbush, "Social Security and Medicare Lifetime Benefits and Taxes," Urban Institute, September 16, 2015, https://www.urban.org/research/publication/social-security-and-medicare-lifetime-benefits-and-taxes (accessed July 24, 2018).
36. Norton, DiJulio, and Brodie, "Medicare and Medicaid at 50."
37. John Gramlich, "Few Americans Support Cuts to Most Government Programs, Including Medicaid," Pew Research Center, May 26, 2017, http://www.pewresearch.org/fact-tank/2017/05/26/few-americans-support-cuts-to-most-government-programs-including-medicaid/ (accessed July 24, 2018).
38. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, p. 39.
39. Ibid., p. 22.

ment, multiple types of coverage (Part A, Part B, Part C and Part D), multiple payment systems, and different rules for each setting. The Medicare program must set prices for thousands of discrete services at different levels of aggregation (e.g., inpatient hospital payments are paid based on the stay, while physician payments are based on the service) and in different labor markets across the country. The Medicare program statute and rule making include a substantial number of exceptions, adjustments and modifications to its general policies.[40]

Today, seniors are often unclear about what is, or is not, covered under Medicare. Most choose to pay a second premium for supplemental health insurance to close coverage gaps and to help them navigate Medicare's complex and cumbersome system of separate Part A and Part B deductibles, co-payments, and coinsurance requirements. By paying an additional premium for private coverage, they avoid this complexity in most cases because these plans play a dual role of handling all of the paperwork as well as covering the gaps and the out-of-pocket costs incurred under the traditional program. For seniors, simplifying traditional Medicare could eliminate this needless hassle; and for seniors and taxpayers alike, it would eliminate the extra expense of this current arrangement.

To simplify the program, Congress could start by combining Medicare Parts A and B, creating a single deductible and uniform cost sharing, while adding a catastrophic benefit. By doing so, Congress could save the taxpayers $5.9 billion in FY 2019.[41]

This change would transform the complex Medicare entitlement program into an integrated health insurance plan, similar to the kind of coverage used by most people enrolled in private commercial insurance. The change, especially the provision of a catastrophic benefit, would provide seniors with peace of mind while also substantially reducing their additional cost and dependence on supplemental insurance.

Second, Gradually Raise the Age of Eligibility. Congress could implement such a change over 10 years and raise the age of Medicare eligibility from 65 to at least the age of normal retirement for Social Security—67. Congress could secure a rational relationship between ages and benefit eligibility well into the future by indexing the age of eligibility to longevity. The Heritage Center for Data Analysis estimates that this change would yield $23 billion for FY 2019.[42] Such a change would slow down the growth of spending and encourage even more people to work longer, which would tap into a rich reservoir of professional talent and work experience among older Americans and help to stimulate economic growth and productivity while alleviating pressure on the Medicare trust funds.

Third, Gradually Reduce Taxpayer Subsidies for Parts B and D and Further Reduce These Subsidies for Wealthy Retirees. Medicare Parts B and D are voluntary programs, and no person is compelled to enroll in them. During the Johnson Administration, beginning in 1966, Medicare beneficiaries paid 50 percent of the Part B premium costs. During the Clinton Administration, in 1994, that beneficiary share was 33.3 percent. During the Bush Administration, in 2004, it was set at 25 percent.[43]

Congress should gradually raise the beneficiary share of Parts B and D premium costs from 25 percent to 35 percent. Congress could implement such a change over five years (at 2 percent per annum) or 10 years (at 1 percent per annum). This change would save $26 billion in FY 2019.[44]

Effective in 2007, Congress required "means testing" for Medicare Part B premiums, reducing the taxpayers' Part B subsidies for wealthier retirees. Today, this provision affects 3.5 million beneficiaries.[45] Effective in 2011, Congress applied the taxpayer-subsidy reduction to Part D, the Medicare drug program, currently affecting 2.5 million beneficiaries.[46] Under current law, single persons with an income in excess

40. Ibid., p. 40.
41. The Heritage Foundation, *Blueprint for Balance: A Federal Budget for Fiscal Year 2019*, June 2018, p. 182, https://www.heritage.org/blueprint-balance.
42. Ibid., p. 185.
43. 2018 Medicare Trustees Report, Table III.C2, p. 81.
44. The Heritage Foundation, *Blueprint for Balance*, p. 183. The $26 billion estimate is based on a 2 percent per annum premium increase.
45. 2018 Medicare Trustees Report, p. 199.
46. Ibid., p. 201.

of $85,000, and couples with an annual income in excess of $170,000 pay higher Parts B and D premiums on a progressive scale, ranging from 35 percent to 85 percent of the total premium costs.

Congress should expand the number of Medicare recipients getting reduced taxpayer subsidies. Single Medicare recipients with an annual income of $55,000, and couples with an annual income of $110,000, should start gradually paying higher premiums on a progressive income scale. For the wealthiest Medicare recipients, Congress should end taxpayer subsidies for Parts B and D entirely.[47] This change would yield savings of $28 billion in FY 2019 alone.[48]

Expanding and Improving Medicare Premium Support. Premium support is a financing arrangement whereby the government makes a defined contribution to the health plan of a beneficiary's choice. The government contribution is a fixed-dollar amount based on a payment formula, including adjustments for health risk and income.[49] With such a per capita contribution, the beneficiary may choose any type of health plan, including traditional Medicare, a health savings account plan, an employer-sponsored plan, or any individual or group health plan meeting basic Medicare standards. A person can purchase richer coverage by paying more in premium dollars than the amount of the annual government contribution or enroll in a less expensive health plan, pay less than the government payment, and pocket the difference in personal savings or deposit the money in a health savings account.

In contrast to this system of choice and competition, the current Medicare fee-for-service system centralizes reimbursement of providers for delivering care through a complex system of administrative payment run by the Medicare bureaucracy, a process subject to both congressional micromanagement and intense special interest group lobbying. Medicare premium support would decentralize medical payment in a highly competitive, market-based system, reimbursing doctors and other medical professionals through private contracts. Endowed with broad choice, Medicare beneficiaries would personally control the flow of dollars to the health plans. Intense competition among health plans and providers to deliver benefits and services at competitive prices would secure major savings, drive innovation in health care delivery, and increase patient satisfaction.

Ample evidence supports the success of such an approach. The reason: Defined contribution ("premium support") programs already cover the vast majority of seniors for all or part of their health care coverage. Of the 58 million Medicare beneficiaries, 44.5 million are enrolled in the Medicare drug program (Part D), a system of competing private plans to deliver prescription drug coverage, and 21.3 million are enrolled in Medicare Advantage (Part C), today's system of competing major medical private health plans.[50] Both programs provide seniors with solid catastrophic protection, which traditional Medicare does not. Moreover, since 1960, the federal government has been using this financing approach to provide health coverage for millions of its own employees and retirees in the Federal Employees Health Benefits Program. Historically, enrollees in these defined contribution programs are highly satisfied with their health coverage, including the richness of their benefits, the quality of their coverage, and the broad range of their choices.

Heritage analysts project that moving Medicare to a premium support system would yield serious savings: $61 billion in savings in FY 2019 alone.[51]

Conclusion

Medicare, along with other federal entitlements, faces major fiscal and programmatic challenges. If official Washington allows these entitlement problems to fester without serious attention, as they

47. Congressional champions of raising taxes on "the rich" should have no logical objection to such a proposal. Indeed, reducing the dependence of upper-income persons on federal entitlements is clearly a more sensible fiscal remedy.
48. The Heritage Foundation, *Blueprint for Balance*, p. 184.
49. For a detailed discussion of the components of a Medicare premium support program, see Robert E. Moffit, "The Second Stage of Medicare Reform: Moving Toward a Premium Support Program," Heritage Foundation *Backgrounder* No. 2626, November 28, 2011, http://thf_media.s3.amazonaws.com/2011/pdf/bg2626.pdf.
50. 2018 Medicare Trustees Report, Table IV.C1, p. 151.
51. The Heritage Foundation, *Blueprint for Balance*, p. 187. Medicare Advantage pays plans on the basis of Medicare's fee-for-service cost and a process of competitive bidding among private health plans at the county level. The Heritage savings estimate in this instance was calculated on a government benchmark payment based on the second-lowest-cost plan in a competitive region.

already have for far too long, America will generate dangerous deficits and levels of debt.

Of all of the federal entitlements, Medicare is the biggest challenge. Medicare has undergone major changes over the past half century, and despite these changes, traditional (fee-for-service) Medicare, which covers the vast bulk of Medicare beneficiaries, has been preserved. Congress and successive Presidents made these changes to protect and stabilize Medicare, while improving its range of patient choice and modernizing its benefits.

Congress and the President should do so again. They should start to educate the public, outlining and explaining the real alternatives, including potentially large tax increases or painful benefit or Medicare-payment cuts. They should also explain the bounteous benefits of robust choice and competition as forces to control cost and improve medical outcomes. Working together, the President and Congress could secure popular support for carefully calibrated Medicare reform, phasing in far-reaching changes gradually, while protecting low-income enrollees. This will require a judicious combination of leadership and salesmanship.

Most Americans do recognize that there is indeed a problem with the growth of federal entitlements, including Medicare. Americans must understand their real policy choices and the consequences of their choices, including the profoundly consequential choice to do absolutely nothing. Doing nothing may be the most politically palatable option for the moment, but that studied indecisiveness would surely prove painful for taxpayers and beneficiaries, and bad for the country.

*—**Robert E. Moffit, PhD,** is Senior Fellow in Domestic Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation. This* Backgrounder *is based on his presentation at the national conference of the Association of Health Care Journalists in Phoenix, Arizona, on April 14, 2018. Statistical information has been updated to reflect the 2018 Medicare Trustees Report.*