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Make Medicare Budget Options Compatible with Comprehensive Reform

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Taxpayers will find out this year whether Congress is serious about grappling with entitlement spending, the single most important domestic policy issue facing the nation. Medicare, with 44 million enrollees, poses the most serious challenge. The program is burdened with gigantic debt: $34 trillion in unfunded liabilities—the benefits promised to current and future Medicare enrollees but not yet financed by current and future taxpayers.

A trigger in Medicare law requires the President and Congress to consider budgetary changes in the program this year. Rather than tweaking the status quo, Congress should focus on proposals that move the program toward a new system based on free-market principles.

The Trigger. Former Congressional Budget Office (CBO) staffers Joseph R. Antos and Tracy Foertsch, in an econometric analysis of the impact of the Medicare debt, concluded that honest funding of the promised Medicare benefits would require the current Medicare payroll tax to increase from today's 2.9 percent to 13.4 percent.[1]

The President has recently submitted his Medicare budget proposals to Congress, outlining $178 billion in savings over five years.[2] As they have in the past, senior congressional leaders are already dismissing these proposals as unrealistic or "dead on arrival."

Meanwhile, current Medicare law requires the President and Congress to act on Medicare spending because the Medicare Trustees have made a formal determination that the program is relying on excessive draw-downs from general revenues, meaning that outlays are not being sufficiently financed by dedicated revenues for Medicare. The Trustees are required to issue a warning when they find in two consecutive determinations that general revenue financing of the program would exceed 45 percent of total Medicare outlays within seven years. The Medicare Trustees made such a determination in their 2006 report and issued a "funding warning" in their 2007 report. The law requires the President to submit remedial legislation to Congress, and Congress must consider it or an alternative on an expedited basis.[3]

The budgetary changes needed to meet the statutory requirement that general revenues not exceed 45 percent of Medicare outlays are not in themselves particularly onerous. The issue is Medicare policy underlying the budget changes, not the budgetary adjustments themselves. Medicare is not simply about dollars and cents. Rather, the problem is the structure of the program as a centralized bureaucracy that will be unable to absorb efficiently the wants and needs of the large and diverse baby boom generation within the boundaries of fiscal responsibility.

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When making budgetary changes in Medicare, Congress can choose between two broad directions: reinforcing the current structure of traditional Medicare or moving toward comprehensive Medicare reform.

Reinforcing the Current Structure. Medicare is currently a defined-benefit, open-ended entitlement program governed by central planning and price controls, with virtually every aspect of the financing and delivery of medical goods and services under the regulatory control of the Medicare bureaucracy.

It is not difficult to fashion budgetary changes to accommodate the existing structure. The traditional methods are simple: tighten up the existing system of Medicare price controls on doctors, hospitals, and other medical providers; add a new system of price controls to prescription drugs under the guise of "negotiation"; impose new standards or requirements on doctors, hospitals, or other medical providers as a condition of reimbursement (e.g., "pay for performance" schemes); reviser payment formulas to exclude payment for the delivery of care under new or unapproved circumstances; slow or restrict access to new medical technologies or medical procedures; or reduce payments to private health plans serving Medicare enrollees, which are routinely described as "overpayments" (compared to traditional Medicare's supposedly "right" administrative payment).

Of course, Medicare's administrative pricing is notoriously arbitrary and does not reflect real economic conditions of supply and demand for medical services. The normal result is overpayment for some services and underpayment for others. Nonetheless, if the policy objective is to preserve the basic structure of central planning and price regulation, then traditional methods would be effective: The Medicare bureaucracy's power would increase, and its regulatory reach would expand.

The modification of Medicare's administrative payment formulas may appear complex, but the underlying principle is simple. Without the interaction of supply and demand in a normal, functioning market, cost-control options are severely limited. Government officials cannot control the demand for medical services (or anything else, for that matter). They can only control the supply. In a centralized system like traditional Medicare, the most efficient way to control supply without appearing to cut benefits for enrollees directly is to cut the payments for those benefits. That is the main function of price controls as a cost-control mechanism. It is an undesirable policy for senior and disabled citizens enrolled in Medicare because, at the end of the day, it simply shifts costs onto them in distinctly unpleasant ways.

Reform-Based Budgeting. The alternative to reinforcing the traditional Medicare structure is to make budgetary changes that advance or are compatible with a movement toward comprehensive Medicare reform. Such reform would consist of restructuring the entire program around the free-market principles of consumer choice and competition.

Though there are a number of variations on the theme of comprehensive Medicare reform, the central component is a transition from a defined-benefit system to a defined-contribution system. Medicare would become a system of competing health plans, including plans that workers choose to bring with them into retirement. Government would continue to subsidize the health care of seniors and the disabled, but the government contribution would be specific (not open-ended) and could be adjusted for income, age, or health status. Retirees with incomes higher than 400 percent of

1. Tracy L. Foertsch, Ph.D., and Joseph R. Antos, Ph.D., "The Economic and Fiscal Effects of Financing Medicare's Unfunded Liabilities," Heritage Foundation *Center for Data Analysis Report* Noi. CDA05-06, October 11, 2005, at *www.heritage.org/research/healthcare/cda05-06.cfm.*
2. Robert E. Moffit, Ph.D., "The President's Medicare Budget: A First Step Toward Entitlement Reform," Heritage Foundation *WebMemo* No. 1797, February 5, 2008, at *www.heritage.org/research/healthcare/wm1797.cfm.*
3. For a discussion of the Medicare "trigger," see Robert E. Moffit, Ph.D., and Alison Acosta Fraser, "Washington Must Pull the Trigger to Contain Medicare Spending," Heritage Foundation *WebMemo* No. 1796, February 4, 2008, at *www.heritage.org/research/budget/wm1796.cfm.*

the federal poverty level are affected much less by health care costs than lower-income retirees are. Also, 10 percent of beneficiaries—the oldest and sickest—account for more than two-thirds of Medicare expenditures.[4]

In pursuing comprehensive reform, Congress could incorporate the best features of competitive models that are already in operation. For example, the most prominent model for Medicare reform has been the Federal Employees Health Benefits Program. Originally proposed by analysts at The Heritage Foundation,[5] this model has been adopted by the House Republican Study Committee (RSC) as part of its budget proposal.[6]

Congress should also closely examine the impressive work of the National Bipartisan Commission on the Future of Medicare of 1999, particularly the Breaux–Thomas "premium support" proposal. With this proposal, government and private health plans would compete on a level playing field, enrollees would get "premium support" toward the purchase of a plan of their choice, and government contributions would be income-related. The proposal would reduce the cost growth of Medicare by 1 to 1.5 percentage points per year, based on the original 1999 estimates.

Congress should also take notice of the well-performing parts of the existing Medicare program, particularly the health plan competition in Medicare Part D, the prescription drug program, and the new Medicare Advantage program. Competition works, and patients are more satisfied when they can exercise personal choice. In Medicare Part D, the projected average monthly premium has dropped by a stunning 38 percent since the inception of the program. Additional cost savings of $117 billion are projected from 2008 to 2017.[7] In Medicare Advantage, the new system of competitive private plans created under the Medicare Modernization Act of 2003, almost 20 percent of Medicare enrollees have chosen private health plans with superior benefits, including preventive care, care management programs, and prescription drug coverage.

The following budgetary options would be compatible with comprehensive Medicare reform:

- *Expand income-related subsidies.* All Medicare subsidies should be income-related. More help should go to enrollees with lower incomes or higher health care costs. To a limited extent, Congress followed this principle with changes in Medicare Part B, requiring individual seniors with incomes of $80,000 per year or couples with annual incomes of $160,000 per year to pay higher premiums.

  Under current law, the income thresholds are indexed annually, thus limiting the number of enrollees subject to the higher premiums in later years. Congress could eliminate this indexing feature for Part B and apply the same new income rules to Part D, the prescription drug program. In both Part B and Part D, the taxpayer today pays 75 percent of the costs of benefits. It is not unreasonable for wealthy seniors to pay slightly more. President Bush submitted these proposals, which would have saved $10.3 billion over a five year period, last year.[8]
- *Raise enrollees' share of the Part B premium from 25 percent to 30 percent.* When Medicare was enacted in 1965, the law provided that taxpayers would pay 50 percent of Part B premiums for physicians and outpatient medical services. This was based on the Great Society understanding of the social contract. In the 1960s, the senior pop-

4. Henry J. Kaiser Family Foundation, "Medicare: A Primer," Washington, D.C., 2007, p. 14.
5. See Stuart M. Butler and Robert E. Moffit, "The FEHBP As a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (Winter 1995), pp. 47–61.
6. See Brian M. Riedl, "RSC Budget Provides Serious Blueprint for Spending Restraint," Heritage Foundation *WebMemo* No. 1011, March 10, 2006, at *www.heritage.org/research/budget/wm1011.cfm.*
7. Peter Pitts, "Part D: Enrollment Up, Costs Down," Center for Medicine in the Public Interest, February 1, 2008, at *http://drugwonks.com/cgi-bin/mtcontges.cgi/1745.*
8. See Robert E. Moffit, Ph.D., "The President's Medicare Budget Proposal: A Step Forward on Entitlement Spending," Heritage Foundation *WebMemo* No. 1344, February 6, 2007, at *www.heritage.org/research/healthcare/wm1344.cfm.*

ulation was comparatively less well-off financially than it is today. Congress eroded this mutual obligation over time and in the Balanced Budget Act of 1997 permanently limited the seniors' share of the Part B premium to 25 percent of the total premium.

Ideally, Congress should restore the original arrangement of a direct 50-50 split in Medicare Part B premium payments; in the short term, Congress should at least raise the basic premium from 25 percent to 30 percent. This change would not negatively affect the poorest seniors—roughly 7 million enrollees—because Medicaid pays their Medicare premiums under current law. According to the CBO, raising the basic Part B premium from 25 percent to 30 percent of total premium costs would save $6.8 billion this year and $42.2 billion over five years.[9]

- *Restructure traditional Medicare cost-sharing for Part A, Part B, and Medigap.* Medicare has a variety of cost-sharing requirements for benefits under Parts A and B.

  In 2007, under Part A (the part of Medicare that pays hospital bills), the basic deductible was $992, and there was a schedule of cost-sharing, depending on the length of the hospital stay. The daily amount of Medicare hospital coinsurance rises with the length of hospital stay, going from no coinsurance at all for the first 60 days to as much as $496 per day after 91 days. Instead of the traditional protection from progressively rising out-of-pocket costs that one normally finds with private health insurance, Medicare Part A schedules the reverse: The sicker one is, the higher one's out-of-pocket payment. Traditional Medicare, of course, has no catastrophic benefit, which is why the vast majority of its beneficiaries must purchase or secure supplemental coverage.

  Home health care is also covered under Medicare Part A, but the home health benefit has no coinsurance and unlimited home health care visits. With Part B (the part of Medicare that pays physicians' services and outpatient benefits), the basic deductible is $131, and the coinsurance requirement for most medical services, treatments, or procedures is 20 percent. The exception is outpatient mental health benefits, which have a hefty 50 percent coinsurance requirement.

  Meanwhile, Medigap supplemental insurance is used not only to supply the necessary catastrophic coverage, but also to cover the costs of deductibles and coinsurance in traditional Medicare.

  One way to improve this situation is to abolish this complex set of cost-sharing requirements for traditional Medicare and replace it with a uniform deductible for both Part A and Part B, a standardized coinsurance rate, and an annual cap on out-of-pocket costs. In one scenario, cost-sharing for Part A and Part B would be replaced with a combined deductible of $500 and a cap on out-of-pocket expenses of $5,000, indexed to Medicare's per capita costs. According to the CBO, this proposal would reduce costs by $11.6 billion over five years.[10]

  In a variant of this proposal, the Republican Study Committee offered a budget proposal in 2006 that would have provided a uniform deductible of $500, a standardized coinsurance requirement of 20 percent, and an annual cap on out-of-pocket expenses for each beneficiary at $2,500. The RSC proposal would also have prohibited any Medigap policy from covering the standard $500 deductible while permitting Medigap policies to cover 50 percent of the Medicare beneficiary's total coinsurance payments.

  In another variant of this proposal, Medigap policies would be prohibited from paying the first $500 of a Medicare beneficiary's cost-sharing in the first year (2008) and half of any additional cost-sharing up to $4,500. Medigap would cover Medicare cost-sharing above that amount. According to the CBO, the proposal would save $1.9 billion in 2008 and $14.4 billion over five years.[11]

9. Congressional Budget Office, *Budget Options*, 2007, p. 183.
10. *Ibid.*, p. 187.
11. *Ibid.*, p. 188. In this proposal, future dollar limits would be indexed to the growth in average Medicare costs.

- *Establish a co-payment for home health benefits.* Home health benefits are broadly used, and Medicare alone accounts for 38 percent of all home health care spending in the country.[12] As noted, there are no limits on home health visits, and there is no coinsurance requirement.

  With the rapid growth of the Medicare population over the next several years, beneficiaries' use of home health benefits will grow. Since there is no cost-sharing requirement for these services, the best option for Congress would be to establish some sort of co-payment. For every episode of home health care usage—60 days—Congress could impose a co-payment of 10 percent of the costs of the benefit. According to the CBO, this would reduce Medicare spending by $12.9 billion over five years.[13]

Conclusion. The President has submitted a series of budget proposals to cope with the immediate and long-term problems confronting Medicare, but congressional leaders have dismissed the President's proposals out of hand. They have yet to offer anything substantive to cope with the enormous challenge of entitlements, notably the $34 trillion Medicare problem. In any case, the law requires the President and Congress to act this year on Medicare spending.

Some Members of Congress will doubtless attempt to offer serious proposals to cope with the long-term challenges facing Medicare, as well as to fulfill the immediate requirements of the Medicare funding warning. Members should make proposals that are logically compatible with real reform: the transformation of Medicare into a system that is governed by consumer choice, competition, personal freedom, and a plentitude of health care options. They should avoid making budgetary changes that only entrench the status quo and enhance the power of the Medicare bureaucracy.

The budget cycle of 2008 will be another test of congressional seriousness in the face of America's top domestic challenge: entitlement spending.

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12. Henry J. Kaiser Family Foundation, "Medicare: A Primer," p. 14.
13. Congressional Budget Office, *Budget Options*, p. 190.