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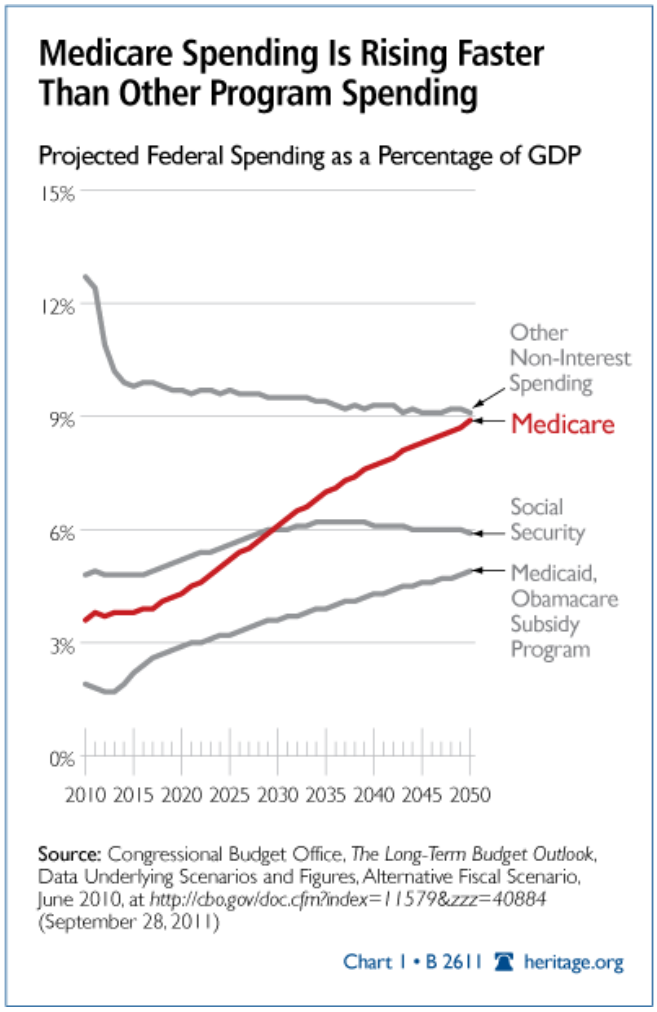
First Stage of Medicare Reform: Fixing the Current Program

Saturday, 22 October 2011 00:00 Robert Moffit, Ph.D.

Abstract: *Medicare spending, a major driver of the federal debt, is expected to jump from $522.8 billion in 2010 to $932 billion in 2020. Instead of resorting to the traditional "solutions" of raising taxes, cutting benefits, or cutting payments to health care providers, Congress should begin a two-stage structural reform of Medicare to transform the program into a robust system of consumer choice and competition. Such a system would serve beneficiaries better while restraining Medicare spending to protect current and future taxpayers.*

[T]he growth of Medicare outlays has continued to outstrip the growth of the rest of the federal budget, and we've been able to avert a full blown financial crisis only through a series of marginal adjustments to the program. As you all well know, the pressures will become increasingly intense as the baby boomers start to retire around the end of the next decade.- Alan Greenspan



Faced with dangerous debt, Congress must soon decide the future of federal entitlements, including Medicare.

The recently enacted Budget Control Act[2] not only raised the debt ceiling, but also created the Joint Select Committee on Deficit Reduction, the bipartisan "super committee," to identify $1.5 trillion in savings over 10 years. This committee is to report its recommendations by November 23, 2011, and Congress must vote up or down, without any amendments, on the recommendations by December 23, 2011. If the committee cannot or will not produce budget recommendations, the Budget Control Act authorizes across-the-board cuts in federal spending, including Medicare.

On Medicare, Members of Congress can pursue a careful, two-stage structural reform of the current program and transition to a better one. If they do not, they must either double down on flawed provider payment reductions and tax increases or unleash yet another round of counterproductive Medicare provider payment cuts as provided by the Budget Control Act.

The Urgency of Reform

Medicare is growing faster than federal spending and the general economy.[3] Under current law, Medicare spending—the largest health care purchaser and largest driver of federal entitlement costs and the federal debt—is expected to jump from $522.8 billion in 2010 to $932 billion in 2020.[4] Today, Medicare spending equals 3.6 percent of the national economy as measured by gross domestic product (GDP). By 2030, it will account for between 5.2 percent and 5.9 percent of GDP.[5] The program's long-term unfunded liabilities—the total cost of the benefits promised but not paid for—amount to a breathtaking $36.8 trillion.[6]

The urgency of reform is incontestable. With the first wave of the massive baby-boom generation retiring in 2011, the number of beneficiaries is projected to grow from 47.4 million in 2010 to almost 81 million in 2030.[7] With more retirees living longer—average life span is projected to reach 80.7 years by 2030[8]—and fewer workers supporting them, Medicare costs will crush current and future taxpayers. Because general revenues from the Treasury will account for an increasingly larger share of Medicare spending,[9] it is unclear how current and future taxpayers can possibly cope with these enormous obligations.

A Two-Stage Approach. Congress should reform Medicare in two stages as outlined in the Heritage Foundation's *Saving the American Dream*, a comprehensive plan to reduce the federal debt, cut federal spending, and stimulate economic growth.[10]

During the first stage, a five-year transition period, Congress should make changes to the current program. It should add a catastrophic benefit and restructure the role of supplemental insurance, gradually increase the beneficiary share of Medicare premiums, restructure the existing taxpayer subsidies for upper-income retirees, and gradually phase out the subsidies for the wealthiest Americans. In accordance with the Heritage plan,

Congress could also earmark all savings exclusively for Medicare, secure the solvency of the Medicare Hospital Insurance (HI) trust fund, permanently fix the Medicare physician payment system, gradually raise the age of eligibility to 68 over 10 years, and remove restrictions on the ability of doctors and patients to contract privately for medical services.

In the second stage, after a five-year transition, Congress should unify all of the parts of Medicare into a single plan financed with a single premium and a unified trust fund, create a new system of insurance rules and consumer protections similar to those in the popular and successful Federal Employees Health Benefits Program (FEHBP), and establish a uniform "premium support" system to finance the entire system.

Serious Savings. Compared with the Congressional Budget Office (CBO) budget baseline, the two-stage Heritage Medicare reform plan would result in $9.4 trillion in Medicare savings by 2035.[11] In sharp contrast to the Patient Protection and Affordable Care Act of 2010 (PPACA),[12] every penny of Medicare savings is earmarked exclusively for Medicare. This would enhance Medicare solvency and allow, for example, a permanent "fix" to the broken Medicare physician payment formula. Moreover, the Heritage plan would reverse the program's rush toward ruinous debt.

First Steps Toward Comprehensive Reform

Medicare's fee-for-service (FFS) financing is cumbersome, counterproductive, and wasteful. It generates patient access problems and dissatisfaction among doctors, and it rewards volume rather than quality. Even with price controls, Medicare spending accelerates, thus fuelling larger deficits. Congress can make real progress with specific policy changes.

Step 1: Protect Medicare patients from the costs of catastrophic illness.

Traditional Medicare has serious gaps in coverage, most notably an absence of protection against the financial devastation of catastrophic illness. Marilyn Moon, a former Medicare public trustee, identifies this as one of the program's "greatest weaknesses."[13]

To cover these program gaps, more than nine out of 10 Medicare beneficiaries have enrolled in supplemental coverage. The supplemental policies, which provide "wraparound" coverage, are usually private employer plans, Medigap plans, Medicaid, or other public-sector coverage.

While supplemental insurance may provide catastrophic protection, it also provides "first dollar" coverage and thus fuels overutilization and higher Medicare costs. This is especially true of Medigap insurance, which is a costly product.[14] As Walton Francis, a prominent Washington health care economist, writes:

The literature on the effects of Medigap on Medicare spending generally agrees that excess utilization of medical care is on the order of 15 to 25 percent, or at today's per capita spending levels, from $1500 to perhaps over $2500 a year per enrollee in costs to

original Medicare, and (as a "ballpark" estimate) in the range of $45 billion to $75 billion a year in total original Medicare spending.[15]

A growing bipartisan consensus supports adding a catastrophic benefit, especially in tandem with reform of Medicare cost-sharing arrangements. Congress has been presented with a variety of reasonable options. For example, the Bipartisan Policy Center has proposed an annual out-of-pocket cap of $5,250, and the National Commission on Fiscal Responsibility and Reform (Bowles–Simpson Commission) has recommended an annual catastrophic cap of $7,500.[16] Of course, the higher the catastrophic threshold, the less the benefit's premium would cost.

In any case, Congress should add a Medicare catastrophic benefit. At the inception of a universal premium support program five years hence, catastrophic coverage would be a mandatory feature of all health insurance. In a new premium support program, the initial value of the mandatory catastrophic benefit for all plans would equal the weighted average of such benefits provided in the Medicare Advantage program, reflecting the market-driven demand for such coverage in the first year.[17] Thereafter, the cap would reflect the market as it does today in the FEHBP and the Medicare Advantage program. For traditional Medicare FFS, after the first year of premium support implementation, the cap would be adjusted annually by the Secretary of the Department of Health and Human Services (HHS).[18]

The Best Policy: Add a catastrophic benefit to traditional Medicare and require catastrophic coverage in all current and future private plans participating in Medicare.

In the short term, adding a benefit normally increases program costs, but that is not necessarily true in this case. For example, Walton Francis proposes a catastrophic benefit in Medicare FFS only for those who either do not have such coverage or are willing to forgo or drop their existing wraparound coverage. Enrollees and employers (who could pay the catastrophic premium) would have incentives to switch from expensive supplemental coverage to less expensive catastrophic coverage. If structured properly, a catastrophic benefit could reverse harmful incentives and yield savings. Francis adds:

For example, a modestly subsidized benefit for catastrophic expense protection could be added to original Medicare. This could be done at a level and in an amount that would make it always a better buy than the equivalent protection in any Medigap plan, and made available only to those who did not have benefit supplementation for inpatient or outpatient costs.[19]

In 1986, President Ronald Reagan tried unsuccessfully to add a fiscally responsible Medicare catastrophic benefit and give peace of mind to millions of seniors.[20] Since then, several prominent analysts have proposed a catastrophic benefit combined with rationalizing Medicare's complex and perverse co-payment arrangements.

In adding catastrophic coverage and reforming supplemental coverage, the common alternatives to a choice option, such as that proposed by Francis, would be a restriction on

supplemental coverage or some kind of premium tax. For example, the CBO estimates that a $5,500 annual catastrophic cap in addition to a single Medicare deductible and uniform coinsurance would save $32.2 billion over 10 years (2012–2021). The savings would be greater ($92.5 billion) if Congress combined a uniform cost sharing for Medicare with a statutory restriction on Medigap plans covering the first $550 of a beneficiary's cost sharing.[21] Beginning in 2017, President Barack Obama would impose a Medicare Part B premium "surcharge" for new enrollees who buy "near first dollar" Medigap coverage. This is, in effect, a premium tax. It would yield a modest 10-year savings of approximately $2.5 billion.[22]

The Center for Data Analysis (CDA) at The Heritage Foundation estimates that adding a catastrophic benefit to Medicare during a five-year transition to a Medicare premium support program would cost $42.1 billion.[23] (See Appendix A.)

Step 2: Eliminate hospitalization trust fund deficits.

Medicare Part A, the Hospitalization Insurance program, finances premium-free hospitalization, skilled nursing care, home health care services, and hospice care.[24] It is financed by a special federal payroll tax on employers and employees, which is deposited in the HI trust fund.

When implemented in 1966, the payroll tax was 0.7 percent of the first $6,000 of earned annual income. Since then, Congress has increased the tax 10 times. Today, American workers and their employers pay a 2.9 percent payroll tax on earned income with no maximum limit.[25] Retirees are exempt from the tax, and there is no direct relationship between the tax and the benefits that retirees will collect.[26]

Nonetheless, Congress has already agreed to a new Medicare tax increase. Beginning in 2013, under the PPACA, individuals with an annual income of $200,000 and couples with an annual income of $250,000 will pay a Medicare payroll tax of 3.8 percent of earned income and "unearned" income, including income from stocks, bonds, dividends, rental income, and even the sale of a home under certain circumstances. Because the income thresholds are not indexed to inflation or economic growth, the new 3.8 percent payroll tax will rapidly apply to an ever larger number of upper-income workers.[27]

While Medicare Part B automatically draws revenues from the Treasury to cover costs, when Part A runs out of funds, it cannot pay benefits. Throughout Medicare's history, cost increases have outstripped official HI projections. As early as 1966, the government's actuaries grossly underestimated the real HI costs.[28] Since then, the Medicare Trustees have issued more than two dozen warnings of HI insolvency.

In 2008, HI spending exceeded HI revenues, and the program has run large annual deficits ever since. By 2010, the HI deficit had reached $32.3 billion, and it is projected to reach $34.1 billion for 2011.[29] The future promises endless annual HI deficits. The CBO projects HI insolvency in 2020.

Under the Medicare Trustees' "intermediate" estimate, the trust fund will be exhausted by 2024, five years earlier than their previous estimate. Medicare Part A accounts for $8.3 trillion of the 75-year unfunded Medicare obligation.[30] In sheer size, this is a financial burden that approaches the total unfunded liabilities of the Social Security program, which amount to $9.1 trillion.

Medicare's standard response is more restrictive payment formulas and ever tighter regulation. For example, in 1983, Congress adopted a Prospective Payment System (PPS) for hospital reimbursement: a fixed standardized payment for medical services based on the categorical diagnosis of the patient's medical condition. The fee schedule applies to hospital treatment of patients in more than 500 diagnostic-related groups (DRGs). While federal officials had initially hoped that the PPS would create strong disincentives to deliver unnecessary care, it led instead to major cost-shifting to outpatient medical facilities under Medicare Part B.

The PPACA further modified the payment formulas for Part A providers to reduce Medicare payments progressively by $156 billion over the first 10 years.[31] The CMS Office of the Actuary says that these initial PPACA 10-year payment reductions, if sustained, would cause an estimated 15 percent of Part A providers to operate at a loss, thereby jeopardizing Medicare patients' access to care. If sustained beyond 10 years, they would cause 25 percent of providers to operate at a loss by 2030 and 40 percent to operate at a loss by 2050.[32] Payment rates would dip below Medicaid payment levels. In other words, current law guarantees that Medicare patients will face serious problems with access to care.

The Best Policy: Eliminate the HI deficits by creating a temporary Medicare Part A premium for the next five years to cover the transition to a new premium support program.

An annual supplemental premium would be flexible, rising or falling to cover the projected annual HI deficits. Based on Medicare Trustees' projections, it would also be modest. For the first five years (2012–2017), the average annual HI deficit would be approximately $17 billion, and the standard premium for all enrollees to cover that deficit would be about $30 per month. If Congress were to "means-test" the premium for the income range ($55,000 to $110,000 for individuals and $110,000 to $165,000 for couples) prescribed by The Heritage Foundation, about 90 percent of enrollees would pay only $8 per month.[33]

In contrast to an increase in the payroll tax or another raid on general revenues, adding a premium is compatible with the principle that Medicare beneficiaries should pay for their hospitalization benefits. Many of them believe, firmly but erroneously, that they already have. While many beneficiaries sincerely believe that they paid for their Part A benefits, however, most did not pay nearly enough to cover the actual costs. In fact, most receive two or three times more in Medicare benefits than they paid in Medicare taxes.[34]

The Heritage CDA estimates that adding a premium for Part A would save $97.0 billion over five years. (See Appendix A.)

The alternative options are conventional, inadequate, or more painful. Congress could increase workers' payroll taxes again, extend that tax to beneficiaries' retirement income, cut benefits, cut payments for the benefits, or some combination of these options.

A supplemental premium is clearly superior to the status quo of endless annual trust fund deficits, another payroll tax hike, or a raid on the general funds in a deficit-ridden Treasury. The Medicare Trustees estimate, under current law, that covering the actuarial deficit with a payroll tax would require increasing the standard 2.9 percent payroll tax to 3.69 percent or reducing Part A spending by an equivalent amount.[35]

Payroll taxes are especially burdensome to low-income workers and families trying to finance their own health insurance, while an income-related supplemental premium is more equitable. Payroll taxes increase labor costs, reduce job growth, and compromise business expansion, hitting small businesses especially hard. In contrast, the impact of the supplemental premium would be entirely within the Medicare program.

When reforming entitlement programs, Congress needs to consider the impact of reform on the broader economy.[36] During an economic downturn with high unemployment, raising payroll taxes on workers and businesses is particularly undesirable.

Step 3: Reduce the taxpayer burdens of Medicare Part B.

Medicare Part B, the Supplemental Medical Insurance (SMI) program, is voluntary. It covers physicians' services, outpatient hospital services, and related services, including certain classes of drugs. Congress has sought unsuccessfully to control costs through a complex administrative payment system and price controls that are either technically flawed or politically ineffective, such as the Medicare physician payment system and the impossible Sustainable Growth Rate (SGR) for updating physician reimbursement.[37]

Unlike Part A, Medicare Part B does not have a trust fund that can be exhausted. Rather, it is financed automatically each year by a rising combination of beneficiary premiums and taxpayer subsidies drawn from the federal Treasury. As a percentage of income taxes, general revenues for SMI jumped from 5.4 percent in 2000 to 19.2 percent in 2010.[38] Part B contributes an estimated $21 trillion to Medicare's long-range (75-year) unfunded obligation.[39]

Today, Medicare enrollees pay 25 percent of the premium, and 75 percent of the cost is financed by general revenues. This proportion of beneficiary and taxpayer premium contributions was set by the Balanced Budget Act of 1997, but this was not always the case. In 1966, when Medicare was implemented as part of President Lyndon B. Johnson's Great Society program, beneficiaries paid 50 percent of the Part B premiums even though they were generally less well off in the 1960s than beneficiaries are today. Beneficiary

obligations declined to 32.5 percent in 1980 and 25 percent in 1985 and then rose to 33.3 percent in 1994.[40]

The Best Policy: Gradually raise the beneficiary's contribution to Medicare Part B premiums from 25 percent to 35 percent.

This increased contribution should be phased in over five years at the rate of 2 percentage points per year as the CBO and others have suggested.

While this proposed premium share would be far below the original arrangement, it is compatible with the social insurance principle that beneficiaries should pay for their benefits. It would also restore some measure of balance between beneficiary and taxpayer obligations. Young working families today must buy their own insurance and also cross-subsidize the coverage of more expensive older co-workers in employment-based risk pools. Younger working families not only are paying the Medicare payroll tax to subsidize the hospitalization of current retirees, as well as funding the bulk of seniors' Part B and Part D costs through their federal income taxes, but also are required to pick up the growing costs of a rapidly expanding Medicaid program, which finances the bulk of rising long-term care costs.

Taxpayers' pockets are not infinitely deep. Indeed, limited taxpayer funding should be concentrated on those beneficiaries who need the most help. Certain features of current law should be retained.

First, the income-based premium structure would remain for wealthy retirees who do not pay the standard Part B premium, although the income range would be changed so that taxpayer subsidies would be phased out altogether for individuals with annual incomes above $110,000 and couples with annual incomes above $165,000.

Second, the existing "hold harmless" protections of current law would be preserved. Under that provision, Medicare enrollees are protected from Part B premium increases if the dollar amount of the increase exceeds the dollar amount of their Social Security cost-of-living adjustment (COLA).[41]

The CBO estimates that increasing the beneficiary's contribution for the standard Part B premium from 25 percent to 35 percent would save $71 billion over five years (2012–2016) and $241 billion over 10 years (2012–2021).[42] The CDA estimates that increasing the beneficiary's contribution for Part B to 35 percent would save $71.1 billion over five years. (See Appendix A.)

Alternatively, beginning in 2017, President Obama would increase the Part B deductible by $25 and increase Part B and Part D premiums for upper-income enrollees by 15 percent until 25 percent of all beneficiaries are subject to the higher premiums. The President's proposed increase in the deductible would save $1 billion over 10 years, and the upper-income premium increase would save $20 billion in 10 years.[43]

In addition to the Heritage Foundation, Senators Joseph Lieberman (I–CT) and Tom Coburn (R–OK), the Bipartisan Policy Center, and the Cato Institute have included this policy recommendation in their major Medicare proposals.[44]

Step 4: Reduce the taxpayer burdens of Part D.

Medicare Part D provides beneficiaries with subsidized insurance coverage for prescription drugs and biologics.[45] Beneficiaries can secure drug coverage from stand-alone prescription drug plans, Medicare Advantage plans, or employer-based health plans.[46]

Under the PPACA, Congress further liberalized the drug benefit. The new law provides for a $250 rebate in 2010 for every Medicare beneficiary in the "donut hole"—the oddity in the benefit design that requires patients to pay 100 percent of their drug costs up to a catastrophic threshold. It also mandates a 50 percent discount on brand-name drugs and imposes a 25 percent cap on beneficiary costs in the donut hole.

These recently enacted changes, combined with the baby boomers' high utilization of prescription drugs, will increase beneficiary and taxpayer costs. While prescription drugs account for only 12 percent of Medicare spending, Part D spending is projected to grow faster than every other component of Medicare.[47] Total Part D spending is projected to jump from $62 billion in 2010 to $156.6 billion by 2020[48] and to contribute $7.5 trillion to Medicare's long-range unfunded liability.[49]

The Best Policy: Increase the Medicare beneficiary's contribution to the premium from 25 percent to 35 percent. Similar to Part B, the premium increase should be phased in by increments of 2 percentage points per year over five years while maintaining the "hold harmless" provisions that protect low-income persons in Medicare Part B.

Like the financing of Medicare Part B, beneficiaries pay roughly one-fourth of the total Medicare Part D premium cost. Taxpayers pay for the remainder, mostly through drawdowns of general federal revenues, but also partly through state government transfers.

The Heritage Foundation CDA estimates that raising the Medicare beneficiary's Part D contribution to 35 percent would save $8.0 billion over five years.

Perhaps the leading policy alternative is to give the Secretary of HHS the power to "negotiate" directly with drug companies or, in other words, to fix Medicare prices for drugs in much the same way Medicare sets prices for benefits under Part A and Part B. However, this would not secure lower drug prices unless accompanied by restrictive formularies that deny Medicare patients access to the current range of drugs.

Such a policy is as unnecessary as it is undesirable. While Medicare Part D spending is going to increase substantially, particularly with the acceleration of the baby boomers' retirement, a competitive system of private delivery has controlled premium costs. In a

stunning reversal of health spending trends, intense competition in the private delivery of drug benefits has reduced the projected premium increases for 2012. Altogether, Part D has experienced a 44 percent reduction in projected premium costs since the inception of the program.[50]

In addition to the Heritage plan for Medicare reform, the Medicare recommendations of the Coburn–Lieberman proposal, the Bipartisan Policy Center, and the CATO Institute offer similar approaches to Medicare Part D.

Step 5: Cut taxpayer subsidies for the wealthiest beneficiaries.

Medicare does not impose uniformity, either in financial obligations or in the provision of benefits, but it does allow for special or more generous assistance for low-income beneficiaries or persons with special needs. For example, the program provides for Medicaid funding of benefits for "dual-eligibles," who comprise 18 percent of the Medicare population. It preserves the "hold harmless" provisions in Medicare Part B and provides additional taxpayer subsidies for low-income persons in Part D.

In the Medicare Modernization Act of 2003 and the PPACA, Congress enacted income-based premium payments. Under current law, individuals with annual incomes above $85,000 and couples with incomes above $170,000 must pay higher premiums. Depending upon the income level above these thresholds, enrollees will pay 35 percent, 50 percent, 65 percent, or 80 percent more than enrollees who pay the standard premiums.

In 2011, for example, the standard monthly Part B premium is $115.40, but an upper-income enrollee in the 35 percent income category pays $161.50, and an enrollee in the 80 percent category pays $369.10. For the drug benefit, the standard premium is $30.76, but an upper-income enrollee in the 35 percent income category pays an additional $12 premium, and one in the 80 percent category pays an additional $69.10.[51]

The Best Policy: Tighten the current income thresholds, index them to inflation, and completely phase out taxpayer subsidies for the wealthiest retirees.

Rather than pursue an old-fashioned "soak the rich" tax policy, Congress could gradually reduce Medicare subsidies beginning at an annual income of $55,000 for individual retirees—roughly $12,000 above the average annual income for an American worker—and $110,000 for couples. Subsidies would be phased out gradually at 1.8 percent per year for every additional $1,000 in income above the threshold. Taxpayer subsidies would be phased out entirely at $110,000 for single retirees and $165,000 for couples. Unsubsidized wealthy individuals and couples—about 3 percent of the Medicare population—could still enroll in Medicare, pay premiums, and secure the pooling advantages of guaranteed-issue, community-rated health insurance.

The Heritage Foundation CDA estimates that reducing and phasing out taxpayer subsidies for the wealthiest retirees would save $204.1 billion over five years. (See Appendix A.)

The proposed income range for reduced taxpayer subsidies is an improvement over current law. In sharp contrast to the "cliff" effects of current law, in which retiree costs increase over four income categories, the income thresholds for the phaseout of taxpayer subsidies are far more gradual and less disruptive and would be indexed to inflation as measured by the Consumer Price Index. Under current law, the existing income thresholds ($85,000 for an individual and $170,000 for a couple) are locked in place without any indexing until 2019, guaranteeing that they will capture a progressively larger numbers of beneficiaries.

In the past, eliminating a federal entitlement for any class of Americans would have been unthinkable, but conditions have changed. While predicting the shape of any future entitlement reform is impossible, a bipartisan consensus, with recent support from President Obama, is already emerging on expanding Medicare "means testing."[52] In the face of exploding entitlement costs and mounting debt, Congress should not force struggling taxpayers to continue to subsidize the wealthiest retirees.

Step 6: Preserve patient access to physician care.

For many physicians, the conditions of their medical practices are deteriorating. Not only have they received little or no relief from flawed medical liability laws in many states, but they are also increasingly dependent on unstable and inequitable government payment schemes. In Medicare, their payment is determined by a bizarre and complex fee system (the Resource-Based Relative Value Scale) that is reinforced by price controls on medical services and updated by the unworkable Sustainable Growth Rate formula, which annually prescribes draconian cuts.[53] In 2012, implementing the SGR formula would cut payments to physicians treating Medicare patients by 29.4 percent.

While Congress usually blocks its own payment update formula from going into effect, the SGR remains on the books. Meanwhile, American doctors, already faced with declining incomes, are trying to serve Medicare patients while dealing with the aggravation of Medicare's lower reimbursement and the heavier burdens of an increasingly oppressive regulatory regime. The PPACA made the bureaucracy even more top-heavy by imposing new compliance rules and financial penalties and creating a powerful board to recommend even more cuts in provider payments.[54] Not surprisingly, demoralized American physicians are declaring their intention to change or reduce their Medicare practices.[55]

The Best Policy: Freeze physician payment for five years, end the SGR entirely, and transition to a premium support model.

Ideally, Congress should establish a new standardized payment, indexed to the general level of inflation. However, because of the enormity of the out-year costs and the high price of repeated congressional failure to fix the payment system, freezing physician payment for five years is the most practical among a variety of painful options.

For 2012 through 2016, CBO estimates the cost of such a freeze at $108.9 billion.[56] Congress should sunset the SGR system entirely in five years as part of a transition to a new Medicare premium support program.

In the meantime, if certain medical specialties or services merit an increase or a decrease in any given year, the Medicare Payment Advisory Commission could recommend changes to Congress based on a market survey of physician services, and Congress could enact them on an expedited basis. With a full transition to a premium support system, Medicare fee for service would compete with other plan options, and the newly created Centers for Medicare and Medicaid Innovation (CMI) could devise an appropriate physician fee schedule and payment update system for doctors who wish to participate, thus enabling traditional FFS Medicare to respond effectively in a competitive system.[57]

Most of the conventional SGR fixes are costly. For example, using the Medicare Economic Index to update the fee schedule, an index of the costs of providing a medical service, would cost an estimated $116.4 billion over five years and $358 billion over 10 years. A mere 2 percent update would cost $388.5 billion over 10 years.[58]

The Heritage Foundation CDA estimates that a zero percent update to the SGR would cost $109.0 billion over five years. (See Appendix A.)

If Congress decides to freeze or slow physician payment growth below the historical rate of growth in health spending, that payment decision should be combined with two key policy changes.

First, doctors should be allowed to charge more than the capped amount of physician reimbursement, as they were before Congress changed the law in 1989.

Second, if physicians decide to charge more than the government reimbursement, they should be required to disclose their prices and fees for medical services beforehand. Price transparency, which facilitates robust price competition among doctors and specialists, would be the legal precondition for balanced billing of Medicare patients.

In expanding patient access, Congress should also defy special-interest hospital lobbying by repealing the current restrictions on Medicare payments to physician-owned specialty hospitals. As Professors Michael Porter of Harvard University and Elizabeth Teisberg of the University of Virginia note, “Specialty hospitals that track and report their outcomes, demonstrate good results, and use evidence-based standards will drive significant value improvements in health care delivery.”[59]

Another key change in Medicare physician payment policy would be the repeal of Section 4507 of the Balanced Budget Act of 1997. Under this provision, a doctor may contract privately with a Medicare patient only if the doctor signs an affidavit to that effect, transmits the affidavit to the Secretary of HHS within 10 days of the agreement, and agrees to refrain from treating and submitting claims for all other Medicare patients for a period of two years.[60]

At the time of its enactment, Clinton Administration officials absurdly claimed that Section 4507 liberalized private contracting in Medicare. In fact, it imposed an unprecedented and unique restriction on the right of Medicare patients to spend their own money on lawful medical services provided by a doctor of their choice. Mark Pauly, a prominent health care economist at the University of Pennsylvania, has observed: "In contrast to people with private insurance, people on Medicare cannot pay with their own money for something that is more medically valuable to them than it is to the Medicare bureaucracy."[61]

Even British physicians can treat patients either privately or through the British National Health Service without any similar restrictions. American physicians should be able to do so as well. A policy that stabilizes Medicare payments and maximizes the freedom of doctors and patients would guarantee access to care for Medicare patients.

Step 7: Raise the age of eligibility to 68.

When Social Security was enacted in 1935, the average life span was 62, and Congress and the Roosevelt Administration set the normal retirement age at 65. When Congress and the Johnson Administration enacted the Medicare program in 1965, they retained the normal retirement age of 65 as the age of eligibility for Medicare, but the average life span in 1965 had increased to 70.2 years. By 2009, the average life span was 78.2 years, and it is expected to reach 80.7 years in 2030.[62]

Under current law, the normal retirement age for Social Security is already being raised to 67. During discussions with congressional leaders on raising the debt ceiling, President Obama briefly joined a growing consensus of independent analysts who support raising Medicare's age of eligibility to 67.[63] This was a key feature of the 1999 Breaux–Thomas Medicare reform. The American Enterprise Institute, Representative Paul Ryan (R–WI) and Alice Rivlin, William Galston and Maya MacGuineas, and Senators Tom Coburn and Joseph Lieberman also have proposed this reform.

The CBO estimates that raising Medicare's age of eligibility to 67, increasing the age of retirement by two months every year starting in 2014, would save $18.2 billion over five years (2012–2016) and $124 billion over 10 years (2012–2021).[64]

The Best Policy: Raise the normal age of eligibility for both Medicare and Social Security to 68 over 10 years and thereafter index the eligibility age to longevity.[65] The Heritage CDA estimates that raising the Medicare eligibility age to 68 at the rate of two months per year beginning in 2012 would save $52.8 billion over five years and $243.6 billion over 10 years. (See Appendix A.)

Given the gravity of America's fiscal challenge, increasing life spans, and the opportunities that demographic changes present to retain the talents of older workers, Congress should address the normal age of retirement more aggressively. Congress should also provide significant tax advantages to those who work beyond the normal retirement age. Under the Heritage tax reform proposal, any person working beyond the

normal retirement age, regardless of income, would automatically qualify for an annual $10,000 tax deduction.[66]

Beyond Heritage's tax deduction proposal, Congress could consider other ways to encourage older workers to remain active and productive in the labor force and stay in employer-based insurance. One way would be to repeal the 10 percent penalty for late enrollment in Medicare Part B for otherwise Medicare-eligible persons who remain in employment-based health plans. As Walton Francis has observed:

This penalty is imposed even if the enrollee is covered by comprehensive insurance and the possibility of adverse selection is remote. Lifting this restriction for those covered by comprehensive plans would induce more elderly to remain in employer-sponsored retirement plans, thereby directly reducing Medicare costs.[67]

Another approach is to eliminate the Medicare and Social Security payroll taxes entirely, for both employers and employees, for workers who work beyond normal retirement age. The federal retirement benefits for workers who work beyond retirement age would be based only on their earnings before normal retirement age.

Along with the payroll tax cut, the employer offering health insurance should receive a fiscally responsible government contribution to partially offset the cost of the employer's health plan or the plan chosen by the worker. Of course, with a transition to full premium support, any retired or employed worker would receive a standard government contribution to the plan of his or her choice. In sharp contrast to current law, Congress should encourage persons to keep their current health plans or purchase coverage that they determine better serves their needs.

Step 8. Introduce a co-payment to Medicare home health care.

Medicare pays home health agencies to provide services for beneficiaries in their homes, such as skilled nursing services, certain rehabilitation therapies, and the services of home health aides. There is no cost-sharing requirement for this benefit. While less than 10 percent of Medicare beneficiaries use these services, usage and the number of staff visits have sharply increased in recent years. Understandably, oversight of these agencies has intensified in search of fraud. Between 2001 and 2009, home health care spending rose about 10 percent per year, reflecting a heavier reliance on skilled nursing and therapy services.[68]

The Best Policy: Add a co-payment for Medicare home health services.

The CBO has estimated that enacting a 10 percent co-payment for the total cost of each home health care episode (the provision of services for 60 days) would save $14 billion over the first five years and more than $40 billion over 10 years (2012–2021).[69] This a better policy than current law, with the $39 billion in 10-year savings from the PPACA's reductions in home health care payments.[70]

The Heritage CDA estimates that enacting a 10 percent co-payment would save $16.7 billion over five years. (See Appendix A.)

Promoting beneficiary cost-consciousness is far better than enforcing punitive payment reductions. Under the PPACA, these agencies face new payment caps, tighter payment formulas, and a 1 percent reduction in their market basket updates each year for four years.[71] The Congressional Research Service estimates that current law could slow the growth in Medicare home health payments to zero.[72]

Conclusion

Medicare reform is not an option; it is a necessity. Americans face an unfunded Medicare liability of almost $37 trillion because politicians have made promises to beneficiaries that they cannot keep. Without reform, taxpayers will be saddled with crushing taxes or Medicare patients will suffer savage reductions in access to care as the Medicare bureaucracy relentlessly ratchets down payments to doctors and hospitals to control costs.

Real reform is a test of leadership. It should be done carefully, correctly, and in stages. For example, during the five-year transition to premium support, Congress should change the existing Medicare program by adding a catastrophic benefit, gradually and modestly increasing beneficiary premium payments, expanding Medicare's policy of tying taxpayer subsidies to income, raising the age of eligibility, and taking steps to preserve patient access to physician care.

After the five-year transition period, the second stage of reform should preserve the fee-for-service option while transforming Medicare into a robust system of consumer choice and competition, broadly using the premium support financing that characterizes the popular and successful Medicare Part D and the FEHBP.

Whether or not the Joint Committee on Deficit Reduction fulfills its obligation to rescue America from dangerous levels of spending and debt remains to be seen, but the financial condition of the current Medicare program is deteriorating, and current policy is threatening seniors' access to care. The serious Medicare reform required to reverse this course will be difficult and painful, but a congressional failure to act will only make the task harder and even more painful.

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Source: The Heritage Foundation

Appendix A

Projected Five-Year and 10-Year Medicare Savings

Medicare Reform Projections

Change in Net Outlays, in Billions of Dollars

	2012	2013	2014	2015	2016	2012–2016
Add Catastrophic Plan, New Spending	8.0	8.2	8.4	8.6	8.8	42.1
Enhanced Means Testing*	–36.3	–38.5	–40.9	–42.9	–45.5	–204.1
SGR 0% Update	12.1	19.1	22.9	26.1	28.8	109.0
Increase Elgibility Age to 68 (2 Months per Year Starting 2012)**	–3.1	–6.6	–10.4	–14.2	–18.4	–52.8
10% Home Health Co-Payment	–2.6	–2.6	–3.6	–3.8	–4.1	–16.7
Premium for Part A	18.2	18.8	19.4	20.0	20.5	97.0
Increase Minimum Part B Premium to 35% of Program Costs	3.5	8.3	13.4	19.5	26.4	71.1
Increase Minimum Part D Premium to 35% of Program Costs	1.0	1.0	1.0	2.0	3.0	8.0
Total Change in Net Outlays	**–44.6**	**–48.6**	**–57.4**	**–67.7**	**–80.3**	**–298.6**

Note: Projections shown are based on repealing the Patient Protection and Affordable Care Act of 2010 (PPACA), and thus are based on the Medicare baseline prior to passage of PPACA.

* The premium support payment is phased out at a rate of 1.8 percent for every additional $1,000 for singles beginning at $55,000 and couples beginning at $110,000. The premium support payment is completely phased out by $110,000 for singles and $165,000 for couples.
** Does not include changes in spending for Medicaid or the premium tax credits.

Source: Calculations by the Center for Data Analysis, The Heritage Foundation.

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Appendix B

Methodology

When available, the Center for Data Analysis used and updated analyses of reform proposals prepared by the Congressional Budget Office, such as projections on the effects of some policy changes in Medicare. For analysis of the impact of tax changes, the CDA used its tax and health care models.

In December 2006, the CBO estimated that a premium support program with competitive bidding could reduce Medicare expenditures by 8 percent to 11 percent, although it would not significantly affect underlying spending growth.[73] Another study on the benefits of consumer choice through such approaches found that Medicare spending would fall by 8 percent as a result of choice and competition.[74]

Wealthier seniors contribute more toward their health care under this plan. The CDA used the March 2011 Current Population Survey to estimate how many seniors have adjusted gross income in excess of the phaseout thresholds. Under the plan, the value of the premium contribution is reduced by 1.8 percent for each $1,000 in excess of the phaseout level. The CDA estimates that more than 9 percent of seniors have income in excess of the phaseout threshold.

Revenues from the new Part A premium were determined by multiplying the number of Part A beneficiaries by the premium. The new premium was set so that the total revenue generated would offset the average deficit for Part A during the five-year transition

window (2012–2016), while the number of estimated beneficiaries during the same period is from the 2011 Medicare Trustees Report.

The net new spending required to reform Medicare's Sustainable Growth Rate mechanism is from a CBO scoring of a 0 percent update of the SGR through 2021.[75]

Other changes in Medicare, including the increase in the eligibility age and higher Part B and Part D premiums, have scoring estimates based on the CBO. Savings in raising the retirement age would be higher with other changes in public policy, such as Medicaid reforms and repeal of Obamacare. Where possible, the CDA scores of these changes closely match CBO estimates.[76]