The Heritage Foundation

CONGRESSIONAL TESTIMONY

Preserving and Protecting Medicare

Testimony before
Committee on Ways and Means Subcommittee on Health

United States House of Representatives

March 16, 2016

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My name is Robert E. Moffit. I am Senior Fellow at The Heritage Foundation. The views I express in this testimony are my own and should not be construed as representing any official position of The Heritage Foundation.

The Congressional Budget Office (CBO) has recently issued a rather somber warning about the state of America's fiscal health. We are faced with the return of large annual deficits and a sharp upward trajectory of federal debt, particularly as a percentage of our entire national economy, reaching 76 percent of GDP by the end of this year. It is, of course, impossible to tackle our growing fiscal problems without addressing federal entitlement spending, including Medicare.

Of federal entitlements, Medicare presents the most difficult challenge. Medicare's Hospital Insurance Trust Fund faces insolvency in 2026. But trust fund insolvency is only one indicator of Medicare's fiscal well-being. The more important issue is Medicare spending. CBO noted that from 2010 to 2015, reflecting the relatively slow growth in Medicare spending, Medicare increased from just 3.5 to 3.6 percent of GDP. [1]

To all appearances, however, the recent slowdown in Medicare spending is over. For this past year, CBO estimated a spending increase of about 7 percent, the "fastest rate of growth" since 2007. [2] Going forward, Medicare is projected to grow from 3.6 percent of GDP in 2015 to 4.7 percent of GDP in 2026. [3]

Looking ahead, CBO reports, "Projected deficits and debt for the coming decade reflect the significant long-term budgetary challenges facing the nation. In particular, although revenues are projected to remain steady as a percentage of GDP over the coming decade, the aging of the population and the rising costs of health care are

[1] Congressional Budget Office , " The Budget and Economic Outlook: 2016 to 2026," (January 2016), Table F-5, p. 153, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51129-2016Outlook.pdf
[2] Congressional Budget Office, "An Update to the Budget and Economic Outlook: 2025 to 2025," (August 2015), p. 13., https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50724-BudEconOutlook-3.pdf
[3] Congressional Budget Office, "The Budget and Economic Outlook: 2016 to 2026," Table 3-1, p. 64.

projected to substantially boost federal spending on Social Security and the government's major health programs over the next ten years and beyond," [4]

The policy challenge is difficult, but not impossible. Congress and the Administration will need to balance the burdens to be imposed on the taxpayers, including the tens of trillions of dollars in the program's long-term unfunded obligations, with the needs of the growing millions of enrollees who depend upon Medicare. To accomplish this objective, policymakers should undertake specific structural changes to alleviate the taxpayers' fiscal burdens, while assuring seniors financial security and improving their medical care; in short, the job is to get better value for the ever larger expenditure of Medicare dollars.

Congress should thus consider four structural changes to the Medicare program: the simplification of the traditional Medicare Program by combining Medicare Parts A and B; expanding the existing policy of limiting taxpayer subsidies to the wealthiest classes of enrollees; gradually raising the normal age of eligibility for Medicare enrollment; and expanding the defined contribution financing of the Medicare program from prescription drug coverage to hospitals and physicians services.

These are broad policy proposals, and they can be achieved in different ways. The fiscal impact of these proposals would vary, of course, and would be scored differently by the Congressional Budget Office based on technical changes or programmatic details, such as changes in age eligibility, risk adjustment or payment formulas or contribution levels, or the various modifications in the ways in which these proposals would be implemented.

Finally, I would add that none of these proposals are novel; they have been offered before in other contexts. But they also have one thing in common. At different times, under different circumstances, they have generated genuine bipartisan support. Congress can, and should, improve the program in a bipartisan spirit.

SIMPLIFY THE TRADITIONAL MEDICARE PROGRAM.

A recurrent theme among health policy analysts, regardless of their political persuasion, is that American health care is overly complex and confusing, as well as unnecessarily costly. This is true in the private sector, but equally true in the public sector and no more so than in traditional Medicare. Karen Davis and her colleagues at the Commonwealth Fund, a prominent progressive think tank, captures the current problem accurately: " The fragmentation of coverage into separate parts for hospital (Part A) and physician (Part B) and prescription drugs (Part D) adds to the administrative cost, complexity, and confusion for beneficiaries, and hinders coordination of care."[5]

Congress can start reducing Medicare's complexity by combining Medicare Parts A and B into a single plan, complete with catastrophic coverage, a single deductible and uniform coinsurance.

The provision of catastrophic protection, the protection of persons from the financial devastation of a serious illness, is the very purpose of any insurance arrangement. President Reagan tried to secure that protection in 1988,

[4] CBO, "The Budget and Economic Outlook: 2016 to 2026," (January 2016), p. 10.
[5] Karen Davis, Stuart Guterman, and Faran Bandeali, "The Affordable Care Act and Medicare: How The Law Is Changing the Program and the Challenges That Remain," The Commonwealth Fund, (June 2015), p. 18.

but certain flaws in that particular legislative product, ancillary to the provision of catastrophic coverage, undercut its noble purpose: to provide security and peace of mind to the nation's seniors.

In combining Medicare Parts A and B, Congress should also include Medigap reform. Today, Medigap plans can and do provide first dollar coverage, which stimulates excessive utilization, and thus generates ever higher Part B costs for seniors enrolled in the program. [6]

I hasten to add that pursuing such a set of changes has the potential for generating consensus. I would remind the Committee that broadly similar proposals were offered by Senator John Breaux (D-LA) and Chairman Bill Thomas (R-CA) in 1999, as one of the key recommendations of the National Bipartisan Commission on the Reform of Medicare. Versions of more simplified cost sharing have also been endorsed by the Bipartisan Policy Center and the National Commission on Fiscal Responsibility and Reform (Bowles- Simpson Commission).

RETARGET MEDICARE SUBSIDIES TO THOSE MOST IN NEED

When Medicare was created in 1965, senior citizens were among the poorest of the general population and roughly half did not have access to private health insurance coverage. The program thus fulfilled a specific need, assisting those who did not have coverage with guaranteed and continuous coverage and improving the financial security of America's elderly population. The program clearly succeeded in solving those problems. All seniors today have insurance coverage, and, while the population has been aging rapidly, the Census Bureau reports that the poverty rate among senior citizens has shrunken dramatically, from 35 percent in 1960 to just 10 percent today.[7]

Taxpayers, through general revenue transfers, finance 75 percent of the funding for Medicare physicians services (part B) and drug coverage (Part D). Beneficiary premiums finance the remaining 25 percent of these medical costs. In sharp contrast to Medicare Part A, Medicare Parts B and D are *voluntary* programs. No person is forced to enroll and pay the taxpayer- subsidized premiums.

Today, working families are supporting an ever larger senior population, including upper income recipients, many of whom are financially better off than the working families that support them. As economist Robert Samuelson observed, "Today, younger and poorer workers increasingly support (through payroll taxes) older and wealthier retirees."[8] Urban Institute analysts note, for example, that a married couple retiring in 2015 that earned an average annual income ($47,800) will have paid an estimated $683,000 in lifetime Medicare and Social Security taxes, and will have secured $1,038,000 in lifetime benefits in retirement.[9]

Congress has already adopted a policy of targeting taxpayers' subsidies to those who need help the most. In the Medicare Modernization Act of 2003 and in the Affordable Care Act of 2010, Congress has already reduced the

[6] Based on an analysis of MedPAC data, seniors' total extra Part B premium payments would amount to $70.1 billion over the period 2012 to 2023, See Robert E. Moffit and Drew Gonshorowski, " Double Coverage: How it Drives Up Medicare Costs for Patients and Taxpayers," Heritage Foundation *Backgrounder* No. 2505, June 4, 2013, http://thf_media.s3.amazonaws.com/2013/pdf/bg2805.pdf

[7] See Carmen DeNavas-Walt and Bernadette D. Proctor, "Income and Poverty in the United States:2014" (United States Census Bureau: September 2015), http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf

[8] Robert J. Samuelson, *The Good Life and Its Discontents: The American Dream in the Age of Entitlement* (New York: Vintage Books, 1997), p. 222.

[9] C. Eugene Steurle and Caleb Quackenbush, " Social Security and Medicare Lifetime Benefits and Taxes: 2015 Update," The Urban Institute, (September 2015), p.2, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000378-Social-Security-and-Medicare-Lifetime-Benefits-and-Taxes.pdf

generosity of taxpayer subsidies for upper income retirees. Moreover, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires upper income enrollees to pay higher premiums; a policy that affects approximately 6 percent of the total Medicare population. I would add, in this context, that income-testing of Medicare premium payments has not, as some critics fear, resulted in an exodus from the program.[10] Even with less generous taxpayer subsidies for Medicare Part B and Medicare Part D, Medicare's large pooling of risks and guaranteed issue coverage is a major financial advantage to all enrollees, including very wealthy beneficiaries

In this area as well, there is a potential for consensus. In his recent Budget submission, President Obama has proposed, as he has done previously, raising Medicare premiums for higher income enrollees, such that 25 percent of all seniors would eventually pay higher Medicare premiums. But Congress could secure major savings and reduce taxpayers' burdens by increasing the number of Medicare beneficiaries who pay higher Medicare premiums from 6 to just 10 percent of the total Medicare population. This could be down by re-setting the income threshold for higher Medicare premium payment at $55,000 for individuals, which is, as noted, well above a single person's average annual income (in 2015 dollars) estimated by Urban Institute analysts at $47, 800. For couples, the beginning threshold could be lowered to $110,000, well above the average annual income of a two earner couple at $95, 600. [11] Below those income levels, the beneficiaries would be entitled, as they are today, to 100 percent of the standard taxpayer subsidies. Above those levels, premiums would gradually increase. Instead of the sharp, cliff-like increases that characterize current law, Medicare premiums would rise gradually with incremental increases in annual income. Part B and D premiums would increase 1.8 percent for every $1000 increase in income above the initial income thresholds for individuals and couples.

Medicare Part B and D are *voluntary* programs, with three quarters of total funding coming from taxpayers' general revenues; and the share of general revenues as a source of Medicare funding is steadily increasing. As Samuelson also observes, "The central question is an enduring one: How do we help those who can't help themselves without also tempting those who could help themselves from becoming dependent on government?" [12]

While the Congress must make wise judgments about what is "due" to beneficiaries, the Congress must also determine what is fair for taxpayers. It is clearly unjust for one generation to saddle generations yet unborn with mountainous debt that undermines their own economic future. If entitlement spending is not restrained, the consequence will be shrinkage of economic opportunities and a lower standard of living for young Americans.

Congress must therefore address the consequences of current policy on younger persons who are working, raising families, and saving and trying to provide for their own retirement. In this context, a secondary, but nonetheless important, consideration is this: Should taxpayers subsidize, through entitlement spending, the wealthiest cohort of America's retired population at all, say, those with annual incomes above $165,000? My own view is that they should *not* be required to do so.

[10] "There is some concern that proposals to raise premiums for higher income beneficiaries could lead some to drop out of Medicare Part B and/or Part D, which could result in higher premiums for others who remain in Medicare, assuming the higher income beneficiaries who disenrollment is relatively healthy. However, so far, there is no evidence that higher income beneficiaries are dropping out of Part B and Part D in response to existing income-related premiums." Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future*, January 29, 2013, p. 24, http://kff.org/medicare/report/policy-options-to-sustain-medicare-for-the-future/

[11] Steurle and Quackenbush, "Social Security and Medicare Lifetime Benefits and Taxes: 2015 Update," p. 17.

[12] Samuelson, *The Good Life and Its Discontents*, pp. 253-254.

RESET MEDICARE'S ELIGIBILITY AGE FOR THE TWENTY FIRST CENTURY

Medicare's normal age eligibility--65 years— has been historically tied to Social Security eligibility, which was fixed by law in 1935 amidst the Great Depression. Social Security has since changed its normal age of eligibility to 67. There have been no changes in Medicare, even though the economic, demographic and social conditions of the United States have changed dramatically since Medicare was enacted in 1965.

There are sound reasons for reconsidering the current age of Medicare eligibility. First, as noted, Americans' life expectancy and our demographics have changed dramatically. President Franklin D. Roosevelt and Congress enacted Social Security in 1935, and set the age of eligibility at 65. This was a safety net program, and that age eligibility was set when the average American life span was roughly 62 years. By 1965, however, American life expectancy had increased to 70.2 years. By 2030, it will reach approximately 81 years of age.

America is rapidly aging. In 1965 when Medicare was enacted, there were roughly 4.5 workers for each beneficiary. Today, that ratio is slightly more than 3 to 1. But the Medicare Trustees project that enrollment will rise sharply from over 55 million today to more than 82 million in 2030. And by that time, there will be slightly more than just two workers for every Medicare beneficiary. This will inevitably impose serious pressures on taxpayers, encourage even tougher Medicare payment reductions affecting seniors, or some unhappy combination of both.

Second, Congress should consider the positive potential of Americans working longer, and the immense social benefits of tapping into the knowledge, skills and talents of older workers. This is particularly appropriate in light of the decline in workforce participation, projected to reach a low of 62.1 percent in 2019.[13] According to a CBO analysis, gradually raising the Medicare age of eligibility to 67—and thereby tracking the policy already adopted for Social Security—will increase workforce participation among those 65 and older.[14] Among baby boomer professionals especially, more and more of them are already choosing to work longer, and enjoy doing so.[15]

Raising the age of eligibility to 67, thus tracking Social Security, is the most prominent proposal for resetting the normal age of Medicare eligibility. But Congress should also explore the option of gradually raising the normal age of eligibility for both Medicare and Social Security to age 68 over 10 years and thereafter indexing the normal age of eligibility to longevity. If Congress were to pursue this idea, it might be worthwhile considering a tax policy to encourage continued participation in the labor force: Any person, regardless of income, who works beyond the normal retirement age, could automatically qualify for a special annual deduction or tax break. The Congressional Budget Office should be able to provide some valuable insights on the potential impact of such a set of combined policies, particularly in scoring them for their macroeconomic effects.

[13] Ibid. p. 44.
[14] Joyce Manchester, " How Will Older People's Participation in the Labor Force Be Affected by The Coming Increase in Full Retirement Age for Social Security?" Congressional Budget Office, (January 9, 2013), https://www.cbo.gov/publication/43834
[15] See " A Billion Shades of Grey," *The Economist*, April 26, 2014, http://www.economist.com/news/leaders/21601253-ageing-economy-will-be-slower-and-more-unequal-oneunless-policy-starts-changing-now

Once again, Congress has the potential for reaching consensus on this issue. During his 2011 discussions with congressional leaders on the debt ceiling, President Obama agreed, at least briefly, with raising the age of Medicare eligibility to 67. I note that Alice Rivlin, a senior fellow at the liberal Brookings Institution and former Director of the Congressional Budget Office (CBO), as well as William Galston, a former domestic policy advisor to President Bill Clinton, and the Committee for a Responsible Federal Budget, have also endorsed raising it to 67.

INTEGRATE TRADITIONAL AND COMPETITIVE MEDICARE INTO A SINGLE PROGRAM.

The vast majority of today's seniors are enrolled in a Medicare defined contribution program, either through Medicare Advantage or Medicare Part D. While defined contribution funding in other almost identical contexts (such as plan payment in the FEHBP) is not normally referred to as "premium support," for all practical purposes that is what it is. Congress should expand this financing system for hospitalization and physician services, establish a level playing field among Medicare's third party payers, and intensify competition for all plans and providers. Congress should require a simplified traditional Medicare plan to compete, head to head, with Medicare Advantage plans, and other private options as well as employment based plans.[16]

Under such a proposal, the government contribution to an enrollee's premium could be based on regional competitive bidding among all health plans, including traditional Medicare, to offer a basic health benefits package consisting of the standard benefits of Parts A, B and D, or their actuarial equivalent. In 2013, CBO found that private plans could deliver the same level of benefits at a lower price than traditional Medicare, and estimated the wide range of savings (over just six years) from a low of $69 to a high of $275 billion, depending upon specific assumptions.[17]

All plans would be required to offer catastrophic coverage, just as all Medicare Advantage and Part D plans do today. If a Medicare recipient purchases a plan that is less than the amount of the government contribution, the recipient could keep that money as cash rebate or roll the funds over into a tax free health savings account. If the recipient purchases a plan that exceeds the government contribution, the recipient would pay the additional amount in premium.

The Congress should adjust the government contribution for income, just as it adjusts Medicare Parts B and D premiums today and continue to improve upon the Medicare Advantage risk adjustment mechanisms.[18] Because of the pre-existing infrastructure of such a competitive market is already embodied in Medicare Parts C and D, including the process for dissemination of comparative plan information and risk adjustment mechanisms, the transition would be much easier today than it would have been when the majority of the National Bipartisan Commission proposed such a change in 1999.

[16] Today, employer-sponsored plans already participate in Medicare Part D, and about 3 million Medicare Advantage enrollees are also in employer-sponsored health plans. Medicare Payment Advisory Commission, *MedPAC Data Book*, p. 141.

[17] Basing payment on an average bid would yield $69 billion; basing payment on the second-lowest plan option would yield $275 billion. Congressional Budget Office, *Options for Reducing the Deficit: 2014-2023*, (November 2013), p. 204. https://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-3.pdf

[18] Recent academic research shows progress in the reduction of adverse selection in the Medicare Advantage program. See, in particular, Joseph P. Newhouse, Mary Price, J. Michael McWilliams, John Hsu, and Thomas G. McGuire, How Much Favorable Selection is Left in Medicare Advantage?," The National Bureau of Economic Research, *Working Paper* 200021, *NBER Working Paper Series*, (March 2014) , http://www.nber.org/papers/w20021

Compelling health plans and providers to compete for customers on a single level playing field would have several advantages. Personal choice, clarity in pricing, transparency in performance, combined with intense competition among plans and providers would ensure more direct accountability to patients and control costs. CBO has reported that it could generate serious savings for seniors and taxpayers alike.[19]

The proposal would reduce government bureaucracy and regulation.[20] Competing health plans, not the Medicare bureaucracy or its agents, would contract with doctors and hospitals, determine their employment or conditions of participation, establish provider rates and conditions of reimbursement, collect premiums and pay claims, and more quickly and easily incorporate new benefits, medical treatments or procedures, and oversee the quality of medical services.

The proposal would stimulate greater clinical innovation, and progressive improvements in care delivery. While traditional Medicare is struggling to promote innovation through administrative payment manipulations, the Medicare Advantage program has already pioneered case management, care coordination, and the expansion of preventive care, while Medicare Part D has provided Medicare patients with a broad array of drug therapies that rivals the generous levels available to federal workers and retirees in the Federal Employees Health Benefits Program.[21]

The proposal would discourage the routine congressional micromanagement and sharply reduce or eliminate the special interest group politicization of pricing and procedures that plagues Medicare today. Under such a proposal, decision-making would be radically decentralized - diffused among millions of enrollees seeking the best value for their Medicare dollars - and market pricing would reward the most efficient medical plans and providers. Competing plans would also be directly accountable to patients and would have powerful incentives to make fair and rational payments to doctors and other medical professionals, while avoiding wasteful spending. Plans would have powerful new market incentives to combat fraud and abuse simply because any failure to do so would directly detract from their bottom line and undercut their market share.

These four options for Medicare structural reform are not exhaustive. But they have been previously proposed by very different analysts of often sharply differing political perspectives. Various versions of these general proposals have also been scored, at one time or another by the Congressional Budget Office, or other independent analysts, and in each case they show promise of delivering significant savings for the Medicare program, seniors and the taxpayers. But the most important reason why these proposals deserve your consideration is that they hold promise of making Medicare an even better program for current and future retirees.

Thank you, Mr. Chairman and Members of the Committee. I would be happy to answer any of your questions.

[19] See Congressional Budget Office, "A Premium Support System for Medicare: Analysis of Illustrative Options," September 18, 2013, https://www.cbo.gov/sites/default/files/09-18-PremiumSupport.pdf.

[20] As Rand Corporation researchers concluded, "Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance physicians' ability to focus on patient care." Mark W. Friedberg, et al., *Factors Affecting Physician Professional Satisfaction*, The Rand Corporation, (2013), p. 3. http://www.rand.org/pubs/research_reports/RR439.html

[21] For a comparative overview of the performance of these programs, see Robert Emmet Moffit, PhD., "Expanding Choice Through Defined Contributions: Overcoming A Non-Participatory Health Care Economy", *Journal of Law, Medicine and Ethics, Volume* 40, No. 3, (Fall 2012), pp. 563-568.

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