Backgrounder

No. 2649
February 7, 2012

Published by The Heritage Foundation

# Premium Support Is Incremental, Not Radical Medicare Reform

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**Abstract:** *Medicare reform is inevitable because its demands on the federal budget are unsustainable. The question is whether Congress will extend the premium support model to the rest of Medicare or pursue a radical approach that either ignores the existing problems until the program collapses or forces all Americans, seniors and non-seniors alike, into a national, government-run, European-style health care system. The premium support approach would incrementally build on the program as it operates today to provide seniors with more choice, leading to a more rational health care market for all Americans.*

Medicare reform is coming soon, perhaps very soon. The federal program providing health insurance to America's seniors works reasonably well today, but it could perform much better by offering more choices at lower cost to seniors, ensuring that at-risk seniors have the financial protection they need, reducing costs to taxpayers, and working as a tool for restraining the growth in health care costs nationally. However, Medicare is wildly unaffordable as currently configured, and thus substantial reform is inevitable.

The budgetary resources claimed by Medicare are enormous. In 2010, Medicare spending exceeded $500 billion, of which $204.7 billion was funded by individual and corporate income taxes. This burden is projected to grow rapidly in the coming years under the twin accelerants of rising health care costs and baby-boom generation retirements. Medicare reform

## Talking Points

- Fundamental Medicare reform is inevitable. The traditional, radical approach to pretend it is essentially sound denies reality.
- A second radical approach, as followed in Obamacare, would destroy Medicare from the inside by slashing payments to doctors and hospitals, forcing providers out, and denying seniors access to quality health care.
- The familiar, incremental approach builds on Medicare's existing structure. Medicare today mostly follows a premium support model in which government and beneficiaries share the costs of insurance. Reform should produce a unified, coherent premium support system.
- Seniors today pick among health care plans in Medicare Advantage, the drug benefit, and in purchasing Medigap policies. Seniors can and should be allowed to choose among plans in a consolidated premium support program.
- Premium support cannot privatize Medicare because it is already almost entirely run by the private sector from the companies that manage accounts to private plans offered under Medicare Advantage and Part D to the providers themselves.

This paper, in its entirety, can be found at:
*http://report.heritage.org/bg2649*

Produced by the Thomas A. Roe Institute for Economic Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
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is coming soon, and it can take one of two radical paths or one sensible, incremental path.[1]

One radical path is to pretend the program is fine as it is. Many traditional Medicare supporters adopt this unsustainable do-nothing, non-reform approach. Another radical path is effectively to force all Americans, seniors and non-seniors alike, into a national, government-run, European-style health care system. President Barack Obama's health care reform (Obamacare) was the latest step on this path.

The main alternative to these radical approaches is to rationalize Medicare's existing structures through familiar incremental reforms. The result, known as "premium support," is reflected in The Heritage Foundation's *Saving the American Dream* plan as well as in the bipartisan legislation introduced by House Budget Committee Chairman Paul Ryan (R–WI) and Senator Ron Wyden (D–OR).[2] Premium support is readily recognizable to seniors today. It could be implemented in stages as described elsewhere and would remedy the major failings of Medicare, making it effective and affordable for seniors and taxpayers alike.[3]

## The Need for Medicare Reform

Finding a solution to a problem starts with agreeing that there is a problem. Few dispute Medicare poses big problems today. Medicare's troubles are ultimately distinguishable as a financial problem, a structural problem, and an economic problem—what it costs, what it offers, and the total economic resources that Medicare will absorb in the years ahead.

The financial problem is well established. According to the latest Medicare Trustees' report, Medicare imposed a drain on the Treasury's general fund in 2010 of $204.7 billion— about 16 percent of the total 2010 budget deficit.[4] In other words, taxpayers as a group provided more than $200 billion to subsidize seniors' health insurance. This drain will only grow larger as the price of health care rises and the baby-boom generation retires, presenting the nation with Medicare's unfunded promises in the tens of trillions of dollars.

The structural problem is nearly as plain as the financial problem. Essentially, Medicare is a massive health insurance company owned and operated by the government for seniors, who are collectively the most medically complex members of society. To make matters worse, Medicare's basic structure was laid down decades ago, and Congress has repeatedly meddled in its operations to address political or budgetary issues. Medicare's patchwork coverage has forced most seniors to buy additional coverage to fill in the gaps.

Yet each of these aspects is but an addendum to Medicare's larger structural shortcoming, which is reminiscent of Henry Ford's famous quip, "Any customer can have a car painted any color that he wants as long as it is black."[5] For most seniors, traditional Medicare provides one choice of coverage.

1. For a wealth of information on Obamacare from The Heritage Foundation, See "Our Research & Offerings on Obamacare," at *http://www.heritage.org/issues/health-care/health-care-reform/federal-health-care-proposals/obamacare* (January 25, 2012).
2. See Stuart M. Butler, Alison Acosta Fraser, and William W. Beach, eds., *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, The Heritage Foundation, 2011, at *http://savingthedream.org/about-the-plan/plan-details/*, and Ron Wyden and Paul Ryan, "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future," December 2011, at *http://budget.house.gov/UploadedFiles/WydenRyan.pdf* (January 25, 2012).
3. See Robert E. Moffit, "The First Stage of Medicare Reform: Fixing the Current Program," Heritage Foundation *Backgrounder* No. 2611, October 17, 2011, at *http://www.heritage.org/research/reports/2011/10/the-first-stage-of-medicare-reform-fixing-the-current-program*, and "The Second Stage of Medicare Reform: Moving to Premium Support," Heritage Foundation *Backgrounder* No. 2626, November 28, 2011, at *http://www.heritage.org/research/reports/2011/11/the-second-stage-of-medicare-reform-moving-to-a-premium-support-program*.
4. Centers for Medicare and Medicaid Services, *2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, May 13, 2011, at *https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf* (January 26, 2012).
5. See Henry Ford, *My Life and Work* (New York: Doubleday Page and Company, 1922).

Medicare does not provide real insurance as most Americans likely conceive of insurance. It is an outdated government mockup of what insurance should be, a pale imitation of the real insurance that seniors need and expect.

***Medicare's larger structural shortcoming…is reminiscent of Henry Ford's famous quip, "Any customer can have a car painted any color that he wants as long as it is black." For most seniors, Medicare provides one choice of coverage.***

Medicare's economic dimension is similarly straightforward and may remain even after the financial and structural problems are addressed. As with health care generally, seniors' health care spending through Medicare and otherwise absorbs a very large and rapidly growing portion of the nation's productive resources. Whether this is a problem or only a consequence depends on whether this reflects the nation's preferred allocation of its resources and its money. Depending on the approach, correcting Medicare's financing may not alter the economic picture materially or restructure Medicare. However, when the federal government can use a single program to control and direct a significant chunk of the nation's annual income and output and that chunk is expected to grow steadily, these developments ought not pass without notice.

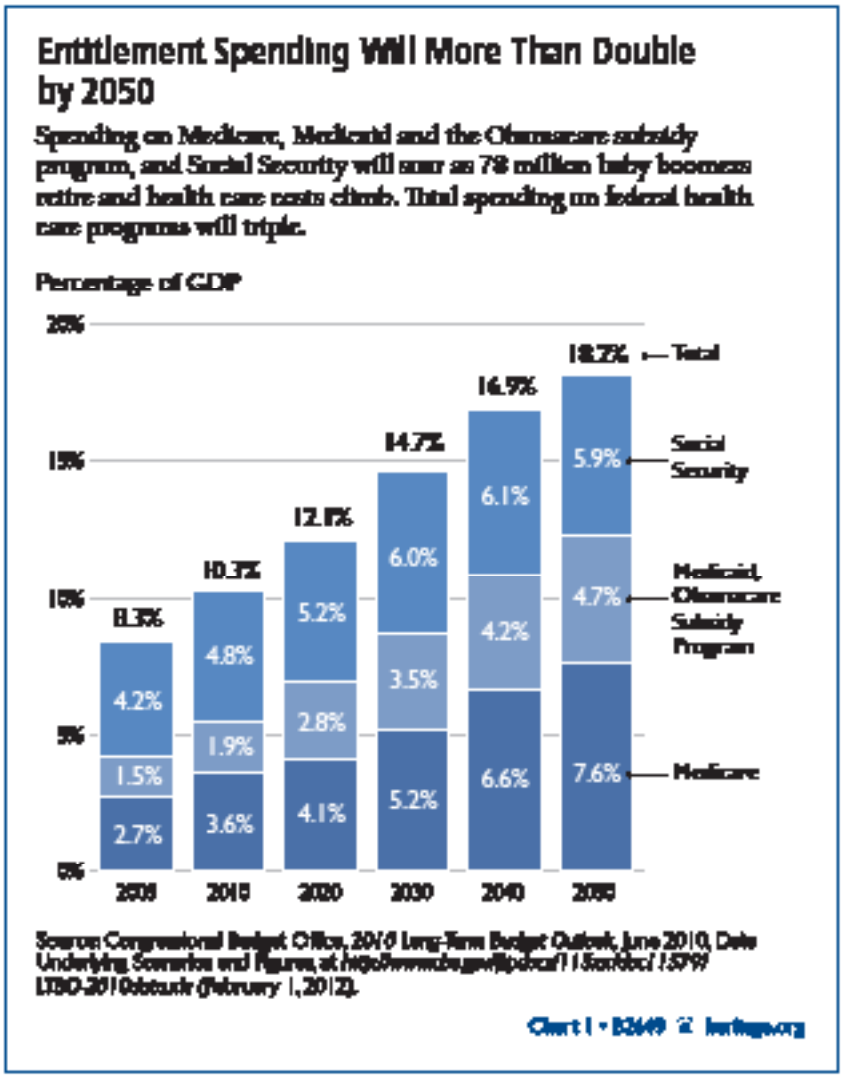
At least since the Clinton Administration the nation has been wrangling with fundamental reforms to Medicare's financing to make the program affordable and to modernize its structure to ensure that seniors can afford and receive appropriate quality care, while reducing the portion of the nation's resources devoted to Medicare.

Today, three basic approaches to Medicare reform are on the table. Two of them are truly radical and would take Medicare in wholly new and truly uncertain directions, while the third option is fundamentally incremental and familiar, building on the program as it operates today. The first radical option is to do nothing and allow the entire operation to collapse financially. Surprisingly, this approach still has a few supporters among Medicare traditionalists, including the seniors lobby AARP, which insists on the absurdity that Medicare's problems can all be solved by cutting government waste.[6] The second radical option is moving toward a national single-payer system, or total government-run health care. The Patient Protection and Affordable Care Act (PPACA), President Obama's massive health care legislation also known as Obamacare, was a major next step in this direction.[7]

Contrary to the strong assertions of some, including many who prefer one of the two radical approaches, the familiar and incremental approach is to adopt a premium support model for Medicare. Far from a new idea, the premium support model can be traced back to the Clinton-era National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Representative Bill Thomas (R–CA).[8] This approach was also outlined in a joint effort by Chairman Ryan and former Clinton Administration Office of Management and Budget Director Alice Rivlin,[9] and it was included in the more recent "Path to Prosperity" budget proposal offered by Chairman Ryan that was passed by the House of Representatives in 2010.[10] It

6. See Emily Goff and Alyene Senger, "The Video AARP Hasn't Made: Medicare's Need for Structural Reform," The Heritage Foundation, *The Foundry*, October 20, 2011, at *http://blog.heritage.org/2011/10/20/the-video-aarp-hasnt-made-medicares-need-for-structural-reform/*.
7. Patient Protection and Affordable Care Act, Public Law 111–148.
8. See National Bipartisan Commission on the Future of Medicare, "Building a Better Medicare for Today and Tomorrow," March 16, 1999, at *http://thomas.loc.gov/medicare/bbmtt31599.html* (January 26, 2012).
9. See Paul Ryan and Alice Rivlin, "A Long-Term Plan for Medicare and Medicaid," November 17, 2010, at *http://paulryan.house.gov/UploadedFiles/rivlinryan.pdf* (January 26, 2012).
10. Committee on the Budget, U.S. House of Representatives, "Path to Prosperity: Restoring America's Promise," April 5, 2011, at *http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf* (January 26, 2012).

has been described most completely in The Heritage Foundation's *Saving the American Dream* plan and the Wyden–Ryan plan noted above.[11] Far from a radical approach, every aspect of the Medicare premium support model builds on elements that are common, indeed fundamental to the existing Medicare system. Premium support simply takes these elements to their logical conclusion while tying them together in a cohesive, coherent program.




## Radical Proposal #1: Do nothing (or very little).

Despite the mounting evidence of Medicare's financial troubles, a number of policymakers and major institutional voices maintain that Medicare is fundamentally sound despite its current drain on general revenues. Indeed, these defenders of the status quo are so enamored with Medicare as it operates today that they often argue its current design should be extended to the rest of the U.S. population—the "Medicare-for-all" concept.

In truth, leaving Medicare as is would be the most radical of all paths because it is the path of sure fiscal catastrophe. Medicare spending, which has risen from 0.7 percent of gross domestic product (GDP) in 1971 to 3.6 percent in 2010, is already putting a severe strain on the federal budget. This means the nation is devoting more than 3 percent of GDP to a single federal program, and Medicare's growth is on track to accelerate over the next two decades as health care costs continue to rise and baby boomers age into the program. Medicare combined with Social Security and Medicaid spending threatens to drive up the federal debt above 100 percent of GDP.

Worldwide experience shows that rapid debt growth at this extreme is very dangerous because countries with such excessive debt burdens tend to experience slow economic growth and high debt service costs, both of which make digging out from under this burden much more difficult. In short, doing nothing—leaving Medicare as it is but for a tweak or two—is radical in that it is destined to fail. Such a policy of inertia will lead inexorably to a burst of ever-more radical, painful changes compelled by collapsing Medicare and federal government finances and imposed on a population of seniors unprepared for the shock of restricted health care access and much higher costs. The sooner reform is enacted, the longer seniors and seniors-to-be will have to prepare, the sooner they can avail themselves of

11. Butler *et al.*, *Saving the American Dream*.

the expanded health insurance choices, and the less damage Medicare's resource demands will do to the nation's finances and economy.

***Far from a radical approach, every aspect of the Medicare premium support model builds on elements that are common, indeed fundamental to the existing Medicare system.***

Closely related to those advocating doing nothing are those who advocate doing as little as possible. In their view, Medicare's structure is fundamentally sound. It just needs better management. Better management is always desirable, but Medicare's financial problems are not due to bad management, but to bad design. Medicare's financial problems are structural and fundamental.

## Misguided Management Reform #1: Super HMOs.

The recently enacted Obamacare health law is filled with the next generation of management tweaks, a multitude of ideas to give the Department of Health and Human Services (HHS) the authority to manage Medicare differently. The top idea is Accountable Care Organizations (ACOs), an updated version of the well-known health maintenance organizations (HMOs). The idea is to give doctors and hospitals financial incentives to develop new organizations for delivering care that would be more cost-efficient, and then the taxpayers share in the savings through Medicare.

This sounds great in an academic setting, but as usual, in practice a top-down approach to building these new organizations will not work.[12] Moreover, HHS is planning to place Medicare beneficiaries into ACOs without necessarily obtaining the beneficiaries' consent to do so. The result is a fatally flawed concept with little prospect of making a real difference. Even the Congressional Budget Office (CBO) and the actuaries who evaluate these programs for the Administration do not expect these efforts to amount to much.[13]

## Misguided Management Reform #2: The Independent Payment Advisory Board (IPAB) and more top-down control.

The second radical management proposal is to cap total Medicare spending and then allow an unaccountable board to enforce the cap by cutting payments to service providers. President Obama has advocated this approach, and unbeknownst to many Americans, it was included in Obamacare in the form of the Independent Payment Advisory Board.[14]

The IPAB was born out of the belief that Congress lacks the expertise and determination to oversee Medicare properly. In a sense, this is correct. Medicare is effectively a massive, government-owned and government-run health insurance company that must establish reimbursement rates for hundreds of thousands of services, goods, and procedures.

No Congress can effectively perform the role of chief executive officer or board of directors of such

12. For more information on ACOs, see John S. Hoff, "Accountable Care Organizations: Obama's Magic Bullet Misfires," Heritage Foundation *Backgrounder* No. 2592, August 10, 2011, at *http://www.heritage.org/research/reports/2011/08/accountable-care-organizations-obamacares-magic-bullet-misfires*, and Rita Numeroff, "Why Accountable Care Organizations Won't Deliver Better Health Care—and Market Innovation Will," Heritage Foundation *Backgrounder* No. 2546, April 18, 2011, at *http://www.heritage.org/research/reports/2011/04/why-accountable-care-organizations-wont-deliver-better-health-care-and-market-innovation-will*.
13. See CBO Director Douglas Elmendorf's comments in Merrill Goozner, "Rising Health Care Curve Won't Bend, Even for Obama," Kaiser Health News, July 13, 2011, at *http://www.kaiserhealthnews.org/Stories/2011/July/13/Rising-Health-Care-Curve-Obama-fiscal-times.aspx* (January 26, 2012).
14. For a favorable general overview of the IPAB, its genesis, and related further policy questions, see Jack Ebeler, Tricia Neuman, and Juliette Cubanski, "The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending," Henry J. Kaiser Family Foundation, April 2011, at *http://www.kff.org/medicare/upload/8150.pdf* (January 26, 2012).

a complex entity. Thus, Obamacare outsources the authority to change what Medicare pays for medical services to the IPAB, a 15-member body appointed by the President with bipartisan congressional input. After 2014, the IPAB is charged with keeping total Medicare spending below a cap defined in law at slightly faster than the economy's growth rate.[15]

To hit the target, the IPAB can only make recommendations to reduce payments to service providers. The IPAB is not allowed to change how beneficiaries interact with Medicare. This means the IPAB will surely resort to the same arbitrary price-cutting that has been used in Medicare for the past half century to the detriment of patients, physicians, and the health care market. Instead of identifying waste, unnecessary expenses, and systemic inefficiencies that arise in any organization, the IPAB will likely follow Congress's practice in recent years of cutting reimbursement rates for everyone, an approach that has proven ineffective in restraining Medicare costs and harmful to seniors' access to needed health care services.

Across-the-board cuts, especially if applied repeatedly, appear to affect providers primarily, but these cuts inevitably lead to serious consequences for beneficiaries. In some cases these cuts bring prices in line with costs, but in other cases the indiscriminate cuts mean underpaying providers for services. Under normal conditions market forces would drive up the prices of some services to signal the need to employ more cost-effective practices or to reflect increases in underlying costs. Artificially holding down prices jumbles the market signal that would otherwise encourage more doctors to apply more effective practices and search for less-costly alternatives.

According to Richard Foster, chief actuary of the Centers for Medicare and Medicaid Services, the rate cuts already enacted in PPACA will drive Medicare's reimbursement rates below Medicaid rates by the end of the decade, and Medicaid's rates are so low that many of the program's participants have great difficulty securing ready access to care. "Unless providers could reduce their cost per service accordingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries."[16] The IPAB is then charged with cutting rates further, which will compel even more medical professionals to stop seeing Medicare patients. Medicare's health insurance for seniors is of little value if seniors have limited or no access to the care they need.

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Advocates for the IPAB approach try to portray the idea as a noncontroversial, good-government management support system for Medicare. The truth is that it is a radical and counterproductive plan to hand over immense power to an unelected board to reduce payment rates by fiat and implicitly to ration services for seniors. The net effect will be to diminish seniors' access to care. America's seniors were promised a viable, effective Medicare program. While substantial changes are necessary, these changes should not imperil seniors' access to care.[17]

## Effective, Incremental Medicare Reform: Premium Support

A brief review of Medicare is necessary to show how reforms based on premium support build on Medicare's existing foundations. Medicare is the federal government's health insurance program for all Americans age 65 and older and for the disabled.

15. The cap's growth rate is set at the GDP growth rate plus 1 percentage point, although the President has recently proposed to lower the annual cap to GDP plus 0.5 percentage point.
16. See Richard S. Foster, "The Financial Outlook for Medicare," testimony before the Committee on the Budget, U.S. House of Representatives, July 13, 2011, at *http://budget.house.gov/UploadedFiles/Foster_Testimony.pdf* (January 26, 2012).
17. For more information on the IPAB's flaws, see James C. Capretta, "The Independent Payment Advisory Board and Price Controls," Kaiser Health News, May 6, 2010, at *http://www.kaiserhealthnews.org/Columns/2010/May/050610Capretta.aspx* (January 26, 2012).

In 2010, the program covered 47 million enrollees, almost half of whom had annual incomes below 200 percent of the federal poverty level ($21,600 for individuals and $29,140 for couples).

Medicare has four parts:

- Part A is available to all seniors with sufficient work history, generally at no additional cost. It covers in-patient hospitalization, hospice care, and some home health care and is funded by a 2.9 percent payroll tax.
- Part B covers physician services, outpatient hospital services, preventive care, and some home health services. Seniors voluntarily sign up for Part B and pay a premium equal to 25 percent of the program's costs, the balance of 75 percent is funded by a taxpayer-paid subsidy. The premium increases for married seniors with incomes between $170,000 and $428,000 so that at the upper limit the subsidy rate falls from 75 percent to 20 percent.[18]
- Part C, Medicare Advantage, consists of private health insurance plans that have been vetted by the government to assure compliance with program guidelines on costs, service, and offerings. These plans compete for beneficiaries within the Medicare program. Seniors may choose to participate in Part C in lieu of participating in the other parts of Medicare. Benefits are funded through a combination of plan-set premiums, taxpayer subsidies, and a portion of funds that would otherwise go to Part A.
- Part D is another voluntary program offering coverage for prescription drug expenses through privately offered plans. Beneficiary premiums cover about 10 percent of Part D financing, 8 percent of the funding comes from states and other sources, and 82 percent of the program's funding comes from taxpayer subsidies. As with Part B, the Part D premium is income-related, so subsidies decline as the beneficiary's income rises.

Even a quick overview shows some important features of the Medicare geography:

1. Many seniors have the understandable but mistaken belief that they earned all of their Medicare benefits by paying into Medicare all their working lives, when in fact this is true for only Part A.
2. Although Medicare is a government program, significant portions already operate through the private sector, namely the Part D drug benefit and the Medicare Advantage option.
3. Seniors must navigate the marketplace to find suitable providers whether the senior is enrolled in the traditional Medicare fee-for-service or a privately offered plan.
4. Seniors who participate in Medicare Advantage or the Part D drug benefit already sift through various private plan options to sign up for their preferred choice, affirming that both private companies and seniors are able to participate in the health insurance market.
5. The premiums associated with three out of four of Medicare's elements are income-related, which means seniors with higher incomes receive smaller subsidies.
6. The premiums that seniors pay for three out of four parts of Medicare cover a relatively small portion of the program's total costs, and taxpayers pay for the balance of the costs.

Another vital feature is what Medicare does not cover, an aspect that distinguishes Medicare from what most Americans would consider real insurance. Most especially, Medicare's benefits for individuals are capped, thus exposing seniors to financial destitution, even though Medicare was intended to guarantee seniors adequate access to affordable health care and to prevent health care costs from driving seniors into poverty. Seniors with very high costs or chronic illnesses requiring prolonged and expensive treatments can exhaust their coverage by hitting the cap and thus running out of benefits. Consequently, around 10 million seniors choose to supplement Medicare coverage by buying Medigap at market rates from private insurance companies.[19]

18. The income thresholds are half these amounts for non-married seniors.
19. See America's Health Insurance Plans, Center for Policy and Research, "Trends in Medigap Coverage and Enrollment, 2010–2011" July 2011, at *http://www.ahipresearch.org/pdfs/Medigap2011.pdf* (January 26, 2012).

## The Premium Support Model

Under the premium support model as described in *Saving the American Dream*, the Wyden–Ryan plan, and elsewhere, seniors would enroll in the health plans of their choice. Medicare would then cover a portion of the premiums (the premium support, also sometimes called a defined contribution) associated with a senior's chosen plan. This approach is similar to the federal contribution that millions of federal employees and retirees receive through the Federal Employees Health Benefits Program (FEHBP) and is typical of most health plans purchased today by non-seniors in the private sector. Most importantly, it is very similar to the structure for Medicare Advantage and Medicare Part B and Part D. Essentially, the current structure for the rest of Medicare would be extended to Part A, the sole holdout and the oldest element of Medicare. Further, as with the Part B and Part D premiums, the amount of premium support would decline once the senior's income exceeds a certain threshold.

***The choice of moving toward a premium support model is about improving the options for seniors to buy the insurance that best fits their needs and circumstances, in part by fostering a stronger private health insurance market.***

In some premium support plans, such as the Heritage plan, seniors would still have the option of buying traditional Medicare fee-for-service, or they could purchase their insurance from private insurers. However, in designing their plans, private insurers would remain subject to Medicare's basic insurance rules, much as the FEHBP provides rules and oversight for federal employees. Additional mechanisms to ensure proper oversight would also be needed. For example, the new system could preserve and strengthen Medicare's Center for Drug and Health Care Plan Choice, which is tasked with identifying abuse and overseeing marketing rules for Medicare Advantage and Medicare drug plans under Part D.

Finally, the premium support model does not inherently presuppose a specific level of overall Medicare spending. The choice of moving toward a premium support model is about improving the options for seniors to buy the insurance that best fits their needs and circumstances, in part by fostering a stronger private health insurance market. As a matter of budget policy, Medicare spending may increase, remain on its current trajectory, or decline under a premium support model depending on the level of support provided to low-income, middle-income, and upper-income seniors. There are good reasons to believe Medicare spending would decline under a premium support model even without changing the subsidy structure while providing seniors as good or better health care coverage and health care services, but the level of resources committed to Medicare through the budget is ultimately a separate policy issue.[20] The distinction is between how much to spend and what to buy.

## Evolution, Not Revolution

Laying out the current Medicare model and a full premium support model in this fashion shows how the premium support model is an incremental, evolutionary approach to ensuring Medicare remains an affordable program that ensures adequate access to health care services for America's seniors.

**Seniors Already Choose Among Private Plans.** Many Americans and many policymakers imagine Medicare as a one-stop shop for all seniors' health insurance needs. Thus, they have difficulty imagining seniors sorting through the complexities of buying their own health insurance. In fact, today, tens of millions of seniors independently buy some form of health insurance in the private market:

- Nearly 12 million seniors (about 25 percent of all Medicare beneficiaries) were on Medicare Advantage in 2011 and choose their own health care plan according to their own needs.[21]
- 34.5 million subscribed to Medicare Part D in 2011, choosing their own drug coverage from

20. Many premium support proposals, including the Heritage plan, include an explicit budget cap as a backstop to ensure that Medicare spending is constrained.
21. See Centers for Medicare and Medicaid Services, *2011 Annual Report of the Boards of Trustees*, p. 195, Table IV.C.1.

among private plans according to their own needs.[22]

- In 2008, about one in six Medicare beneficiaries (about 7 million seniors) purchased extra Medigap insurance in the private market.[23]

**Medicare Is Already Almost Entirely "Private."** Critics often suggest that the premium support model would "privatize" Medicare. In reality, the vast bulk of the Medicare-financed health care delivery system is already private. The shortcoming with Medicare's design lies not in the elements that are in the hands of private citizens and businesses, but in many of the elements that remain firmly under government control.

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In the Medicare system itself, about 25 percent (12 million) Medicare participants already buy the main components of their insurance coverage from private companies through the Medicare Advantage program. In many respects, the premium support model is simply an elaboration of and completion of what Medicare Advantage started.

Nearly two-thirds (22.5 million) of seniors not on Medicare Advantage purchase private health insurance against drug expenses. Under Medicare Part D, seniors purchase drug coverage from private insurers vetted by Medicare. Seniors pay a premium for this coverage that covers less than 10 percent of the average cost, and taxpayers pay the balance. The portion paid by taxpayers is premium support. Thus, Part D is a classic premium support program.

As noted, about 7 million seniors also buy supplemental health care coverage. They do not buy this coverage from Medicare or some other government agency. They buy it from private insurance companies regulated by the states and the federal government.

Medicare Part A (Hospital Insurance) and Part B (Medical Insurance, mostly doctors' services), which are administered by the traditional Medicare program, are not administered on a daily basis by government bureaucrats in Washington, D.C., but by private contractors, usually large private insurance carriers that process Medicare claims.

Continuing on the progression from insurance to health care services, outside the Indian Health Service, the Veterans Administration system, and military medicine in general, the federal government employs very few doctors, nurses, technicians, or hospital administrators. It owns no hospitals, although municipal governments own some facilities. The most critical aspect of the health care system—the actual delivery of care to the nation's seniors—is performed almost entirely by the private sector. Doctors, nurses, home health care providers, nursing homes, clinics, hospice care facilities, and hospitals are almost all private agents or institutions.

Seen in this light, the health care delivery and financing system for seniors is already overwhelmingly in private hands, administered by private firms. It cannot be privatized because it has always been privately run. Only the portions of the insurance system that remain in government hands—although much of this work is contracted out—and those portions under government control are precisely those demonstrating Henry Ford's dictum of offering seniors only one option.

## Seniors' Options Fully Vetted

Many seniors are fully capable of making their own choices about financial matters, including health insurance. They have demonstrated that competence by enrolling in Medicare Advantage, the Medicare drug benefit, and Medigap supplemental coverage, not to mention making the other financial decisions on life insurance, investments, estate planning, and reverse mortgages, among others. Nevertheless, many seniors have a reasonable concern that as they grow older, their willingness or

22. See *ibid.*, p. 181, Table IV.B8.
23. See Henry J. Kaiser Family Foundation, "Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs," July 2011, at *http://www.kff.org/medicare/upload/8208.pdf* (January 26, 2012).

ability to make financial decisions could diminish. Many take comfort that traditional Medicare run by a presumably benevolent and competent government will offer them reliable insurance against high health care costs without having to wrangle with private health insurance companies.

***Under a premium support model, government will still play a major role in determining which companies are strong enough financially and responsible enough in their customer service to participate in the program, just as the federal government does today.***

Whether seniors should be more concerned about a government bureaucracy handling their insurance issues or a private company subject to market pressures and vigilant government oversight is a separate question. The fact remains that this is a concern for many. Yet under a premium support model, government will still play a major role in determining which companies are strong enough financially and responsible enough in their customer service to participate in the program, just as the federal government does today with Medicare Advantage and the Part D drug benefit and as it does for federal workers participating in the FEHBP. Because federal monies pay some of the premium costs for these plans, the federal role remains entirely appropriate and central to the operation of a premium support plan. However, the federal role shifts away from offering and managing what is effectively a government-run insurance company offering inadequate insurance coverage, to the more traditional and proper governmental role of regulation and oversight.

## Seniors Paying Rising Premiums for Health Insurance

Another misconception that may lead to discomfort with the premium support model is the element that seniors would henceforth need to pay premiums for health insurance. Many people not already on Medicare mistakenly believe that their payroll taxes paid during their working lives pay for all of their Medicare benefits. This is incorrect.

As discussed above, the payroll tax essentially prepays for Medicare Part A. Seniors pay premiums for a portion of the premiums for Parts B, C, and D coverage. Under the premium support model, the government contributes a defined amount to the cost of the policy and the beneficiary picks up the rest, precisely the arrangement currently in place for most of Medicare.

Further, under most premium support proposals such as the Heritage plan, the level of premium support decreases as a seniors' income rises above a threshold. Likewise, most seniors who today purchase Medicare Parts B, C, or D pay premiums that are adjusted according to their reported income.

When they pay Medicare premiums, many seniors today may believe they are paying the full cost of the benefits that they receive or that these costs were somehow offset by the payroll taxes they paid while working. Again, these beliefs are mistaken. In point of fact, the payroll tax paid while working applies only to Part A, and taxpayer subsidies cover most of the costs of providing coverage for the rest of Medicare. These subsidies are paid out of the general fund of the U.S. Treasury into which are deposited individual and corporate federal income taxes and a variety of lesser revenue sources.

A strong argument can be made for subsidizing the health insurance of low-income seniors as part of the nation's basic safety net. An equally strong argument can be made against subsidizing the health insurance or any other expense incurred by wealthy seniors. Somewhere between these two end points—supporting low-income seniors so that they are not impoverished by health care costs and requiring wealthy seniors to cover their own expenses—lies an income threshold at which the subsidy should begin to decline and another, higher-income level at which the subsidy should disappear.

In 2011, the Part B and Part D subsidies began to phase out at $85,000 for individuals and $170,000 for married seniors. These are moderately high levels of retirement income. Indeed, less than 5 percent

of seniors pay more than the standard premium amount.[24] To put these figures into context, a senior making $170,000 in annual income from savings earning 5 percent has an estate worth at least $3.4 million, not including the value of his or her home.

While a phasedown of the subsidy is not an inherent element of the premium support model, most premium support plans such as the Heritage *Saving the American Dream* plan follow Medicare's current pattern and include a phasedown so that subsidies are directed where they are most needed. These subsidies are paid out of the taxes levied on everyone. There is no justification for subsidizing wealthy retired seniors' health insurance with taxes levied on middle-class working families.

## Conclusion

Fundamental Medicare reform is both inevitable and imminent. The natural evolution for Medicare is to build on its existing strengths. Efforts to reform a program of such complexity and such importance to a large and often vulnerable population should be incremental and familiar. The premium support model for Medicare fits this prescription perfectly. It builds directly on the existing elements of three of the four parts of Medicare. It would offer seniors the ability to choose the plans that fit their needs and circumstances while ensuring that the offered policies are well-vetted and carefully monitored by the federal government already charged with that task. Ultimately, it would help lead to a more rational health care market for all Americans.

Those who would call premium support "radical" or who suggest that it would "privatize" or otherwise destroy Medicare in some sense are either unfamiliar with how Medicare works today, or perhaps in their ardor to advance a truly radical alternative they have not taken the time to study how the premium support model would actually work. Every senior on Medicare today would easily recognize and relate to a fully implemented Medicare reform built on the premium support model, which would provide seniors with more choice and a system that would be vastly easier to navigate than the current system.

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24. See Social Security Administration, "Medicare Premiums: Rules for Higher-Income Beneficiaries," December 2011, at *http://www.socialsecurity.gov/pubs/10536.pdf* (January 26, 2012).