CHAPTER FIVE

Reform #4: Modernize Medicare for the Twenty-First Century

Principal Features of Reform #4: Modernize Medicare for the Twenty-First Century

- Introduce competitive bidding to add private insurance options for all Medicare enrollees
  - Define the benefit as premium support, calculated from a regional benchmark average price of three lowest-priced approved plans
  - Include the premium for LMCC high-deductible coverage as one of the three plans determining the benchmark average
  - Require all plans defining the calculated benchmark to include prescription drug benefits
  - Provide cash rebates to individual HSAs if the beneficiary chooses a plan with a premium less than benchmark; require payment from enrollees if premiums exceed benchmark
- Include catastrophic coverage in all plans eligible for Medicare program (that is, annual out-of-pocket limits)
- Combine old Parts A, B, and D to simplify deductibles, payments
- Establish expanded HSAs for all Medicare enrollees
  - Automatically open account for every Medicare enrollee; have limits and uses match other HSAs
  - Convert current HSA variants under Medicare to universal HSAs
  - Permit tax-free rollovers of all HSAs to surviving family
- Phase out taxpayer subsidies for high-income-earning seniors
- Modernize eligibility with gradual phase-in to age seventy
- Repeal the Independent Payment Advisory Board

Medicare is a tax expenditure targeted at the elderly who have already at least partially paid tax contributions over the years for their future health care insurance. Originally, Medicare was put forward as a safety net for protecting senior citizens from financial ruin by catastrophic illness. A key rationale for Medicare was that the program would enable seniors to avoid financial dependence, as evidenced by their lower incomes. This thinking ignored the fact that senior citizens had more substantial assets than younger adult populations during the years of the passage of the Medicare bill.[1] Even more ironic, original Medicare never had and, even today, traditional Medicare still does not include catastrophic insurance for asset protection.

Regardless of its origins, today's Medicare is highly fragmented, almost undecipherable in its complexity, flawed in its coverage, and inadequate in its benefits. After decades of coverage additions and patchwork remedies, today's Medicare is a confusing amalgam of four relatively separate insurance programs, each with complicated and diverse funding sources. Part A (hospital insurance) covers inpatient services, some home care, skilled nursing services, and hospice care. It is funded through the federal payroll tax by today's working population and employers. Most people do not pay a premium for Part A because they (or a spouse) have already paid via their payroll taxes while employed, although they do pay deductibles and copayments. Part B (medical insurance) covers doctor bills, outpatient treatment, screening and lab tests, and certain medical supplies, subject to deductibles and copayments. It is funded partly by beneficiaries via income-adjusted monthly premiums and partly by general tax revenues. Part C (Medicare Advantage, or MA) is a private insurance system that includes Part A and Part B benefits (i.e., it replaces Parts A and B, so-called traditional Medicare coverage), as well as some prescription drug coverage, for regional beneficiaries. As opposed to traditional Medicare, MA plans must have annual out-of-pocket limits (i.e., catastrophic coverage). In MA, Medicare contracts with private

insurers to offer health services through a variety of provider networks, most commonly health maintenance organizations. MA is funded partly by member premiums and partly by capitated payments from taxpayer funds (note that since 2006, Medicare has paid plans under a bidding process, whereby Medicare receives bids from private insurers for coverage equal to Parts A and B and then pays the insurer for coverage relative to formulaic benchmarks by county or region). Part D (prescription drug coverage) is funded by income-adjusted enrollee premiums and taxpayer funds, as is Part B; copayments and deductibles vary by plan. In Part D, private insurance companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. In addition to this enormous programmatic complexity, Medicare administrators process nearly 4.9 million Medicare claims each business day, according to CMS. Unsurprisingly, the Medicare program is fraught with errors, fraud, and waste estimated by the Government Accountability Office to have totaled $60 billion in 2014.[2]

Medicare not only is a disjointed and antiquated system designed for decades long past; even more critical, it is in serious financial trouble. As noted in chapter 1, the Medicare trustees report projects that the Hospitalization Insurance fund will be depleted in 2030. Meanwhile, the population of seniors is dramatically expanding, and the taxpayer base financing the program is dramatically shrinking. In its first year, Medicare spent under $1 billion for 250,000 senior citizens, but in 2014 it spent over $615 billion for more than fifty-two million enrollees. Nearly four million Americans now reach age sixty-five every year. In 2050, the sixty-five-and-over population is projected to reach 83.7 million, almost double the 43.1 million in 2012. And the future health care needs for seniors have dramatically increased. The already high health expenses for a sixty-five-year-old (Figure 5.1) will triple by 2030.[3] Americans live 25 percent longer after age sixty-five now than in 1972,[4] with an average life expectancy of about eighty-five years, approximately five years longer than at the inception of

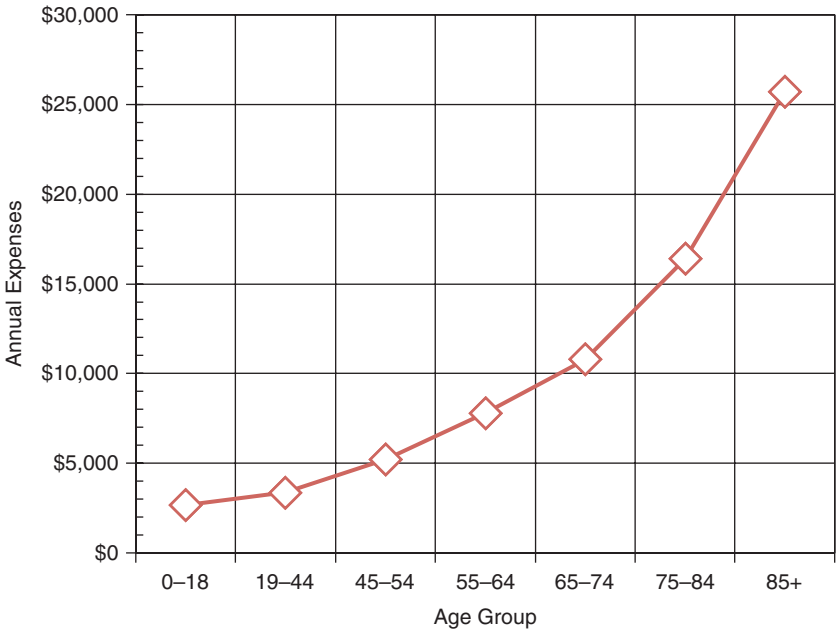

FIGURE 5.1. Per Capita Health Care Expenses, by Age, 2004.
Age is a clear predictor of health care utilization and health care costs per person.
Source: Centers for Medicare and Medicaid Services.

Medicare (Figure 5.2). Today's seniors need to save money for decades, not just years, of future health care.

Despite expanding needs from demographics, Obamacare imposed a new obstacle to health care access for seniors. Its Independent Payment Advisory Board (IPAB), a group of political appointees, is specifically given the task of formulaically reducing payments to doctors and hospitals. As Howard Dean, former chair of the Democratic National Committee, warned, "The IPAB is essentially a health-care rationing body. By setting doctor reimbursement rates for Medicare and determining which procedures and drugs will be covered and at what price, the IPAB will be able to stop certain treatments its members do not favor by simply setting rates to levels where no doctor or hospital will perform them."[5] The IPAB adds to Medicare's already significant access constraints; contrary to the

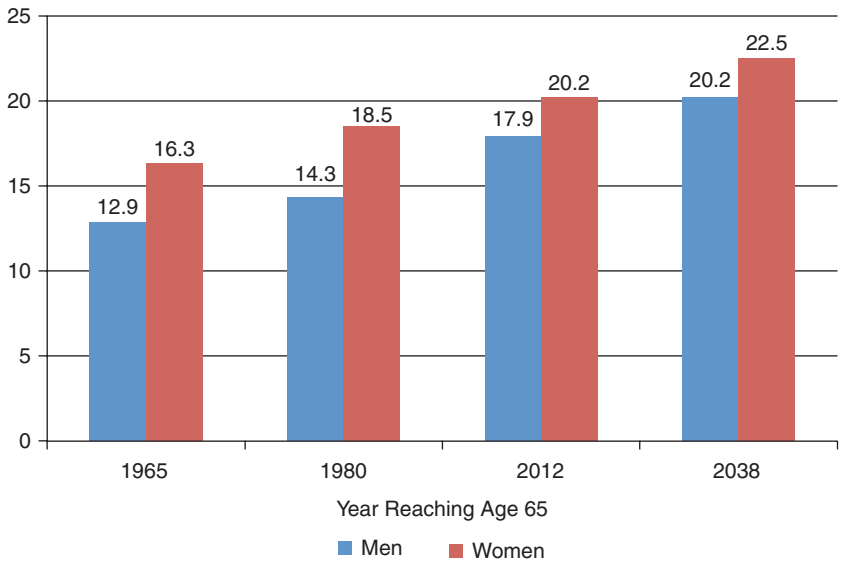

FIGURE 5.2. Additional Years of Life Expectancy in United States for Sixty-Five-Year-Olds, 1965–2038.
The additional life expectancy for those already reaching sixty-five years of age has increased greatly since 1965, when Medicare began.
Source: CDC/National Center for Health Statistics, *National Vital Statistics Reports* 62, no. 7 (January 2014).

administration's demonization of private insurers, *Medicare already ranks at the top of the charts for the highest rates of claim refusals—more than nearly all comparison private insurers every year.*[6]

Traditional Medicare often obstructs the delivery of health care and limits choices of doctors by virtue of its complex restrictions and rules about accepting "assignment" of Medicare insurance. "Assignment" means that a doctor has agreed to accept the Medicare-approved amount as full payment for services. Other doctors have not agreed to accept assignment, but they can choose to on a case-by-case basis. For these "non-participating" doctors, Medicare pays 5 percent less than their usual fees. Regardless of how much the health care provider charges non-Medicare patients for the same service, a Medicare patient cannot be charged more than 15 percent over the amount Medicare approves, that is, the

"limiting charge." Doctors who formally "opt out" can charge patients whatever they want, but they must forgo filing Medicare claims for two years, and their Medicare-eligible patients must pay out of pocket to see them. By law, seniors are not allowed to use their Medicare benefits to pay doctors privately via their own arrangement.

The resulting trend is clear—doctors are increasingly refusing traditional Medicare and opting out of Medicare entirely. This trend promises to accelerate.[7] To prevent the escalation of two-tiered access to quality medical care, available only to affluent seniors, we need to empower all seniors to become value-seeking health care consumers. This empowerment also promises to be particularly effective for reducing inflated expenditures systemwide because seniors are the heaviest users of health care.

Seniors have shown the path toward Medicare reform—and that path is private insurance. In fact, more than 70 percent of Medicare beneficiaries already purchase private insurance to supplement or replace traditional Medicare.[8] About 23 percent of beneficiaries buy Medigap plans. These state-based private insurance plans that supplement nondrug Medicare benefits are available only to those enrolled in traditional Medicare (A and B) and not to MA enrollees. Voluntary enrollment in alternative Medicare Advantage private health plans, with the catastrophic coverage that is missing from traditional Medicare, has expanded to 31 percent of all Medicare beneficiaries, tripling since 2004 to 16.8 million in 2015.[9] Private prescription drug coverage in Part D, also with catastrophic caps, has also been highly favored by beneficiaries. Nevertheless, even in these private plans, Medicare ultimately defines the prices for medical care via complex and rather arbitrary capitated payments and other benchmarks,[10] thereby controlling access while, in some cases, wasting money.

Some elements of the fifty-year-old Federal Employees Health Benefits Program (FEHBP),[11] Congress' successful health insurance benefit program based on competition and consumer choice, serve as a model for reforming Medicare. In fact, the FEHBP served as the model for successful parts of current Medicare that rely

on competition, that is, MA and Medicare Part D. Instead of government-directed traditional Medicare, the FEHBP contains almost three hundred plans from almost one hundred different companies that compete for business. The government provides money toward the premium of the plan chosen by the enrollee. Plan design, covered services, and costs emerge from competition and the value-seeking decisions of the individual consumer. In direct contrast to traditional Medicare, FEHBP's oversight agency, the Office of Personnel Management, does not establish payment rates to providers. Prior to Obamacare's mandates, each plan was free to offer benefits within very broad limits, including deductibles, covered services, limits on services, and copays. Other Medicare reform proposals, particularly the "Saving the American Dream" plan from Butler,[12] also serve as models for the reforms proposed herein.

Modernizing Medicare for the twenty-first century centers on a three-pronged strategy. This strategy will empower seniors to move to affordable private health insurance and HSAs, keys to improving benefits and reducing costs. The three elements of the strategy—a defined-contribution model, markedly expanded HSAs, and modernization of eligibility—are discussed in detail as follows.

Element #1: A Defined-Contribution Model

The first element of Medicare reform is implementing a defined-contribution model that offers private insurance options for beneficiaries with competition-based premiums and simplified benefits, as well as consumer incentives to seek value. The basic concept of this model is that the government would make a defined, fixed contribution, that is, a "premium support," to the private health plan of a Medicare enrollee's choice. Medicare will make market-based payments to competing insurance plans, not arbitrarily set prices and then pay health care providers. This way, the government's role changes from being a direct insurer to helping beneficiaries buy insurance. Similar to a number of previous reform

proposals, the amount of the government's defined-contribution benefit will be based on the average of the three lowest-priced plans put forth to Medicare. This index group forming the calculated benchmark would include one limited-mandate high-deductible plan. All Medicare-eligible plans would be required to have annual out-of-pocket limits, that is, the catastrophic coverage that is missing from current traditional Medicare. All plans would also be required to offer prescription drug benefits.

If a beneficiary chooses a plan with a premium less than the benchmark, then a rebate payment of the entire difference would be made into that individual's HSA; if payment was due from the enrollee because of higher cost than the benchmark, the enrollee would be responsible. This would save more than the $15 billion per year the CBO estimates based on using higher benchmarks.[13] In this plan, the taxpayer premium subsidies for the highest-income earners would be lower but completely phased out at the highest levels. Medicare enrollees would be able to purchase more coverage by paying more in addition to the fixed government contribution.

Coverage would simplify the current separation of inpatient and outpatient expenses, unifying deductibles and payments fragmented into Medicare Part A and Part B. Ultimately, the goal is to eliminate the confusing and unnecessary separation of all inpatient and outpatient coverage, including MA plans and prescription drug coverage. In the long run, traditional Medicare will have been moved to private health insurance to improve access to doctors, hospitals, and modern medical technology and drugs; to improve benefits; and to reduce costs for all enrollees. For those over age thirty-five today, traditional Medicare will still remain an option; for those under age thirty-five, traditional Medicare coverage will no longer be provided.

Element #2: Expanded Eligibility and Uses of Health Savings Accounts

The second important element of modernized Medicare is new access to broadly expanded HSAs for all beneficiaries. Presently,

HSAs are quite limited in their allowed role for seniors. In fact, as noted earlier, the current laws prohibit Medicare enrollees from HSA eligibility. Seniors who have applied for or accepted Social Security cannot contribute to an HSA. Restricted accounts called "Medicare Advantage MSAs" are currently available but require enrollment in a high-deductible MA health plan. Among other restrictions (see "Key Questions and Answers on the Atlas Plan"), deposits into these MSAs are prohibited except from Medicare itself and are limited in amount to typically less than half of the required deductible of the accompanying coverage. On the death of the owner, HSAs are deemed taxable unless the beneficiary is the spouse.

Given that future health care needs for today's seniors now last decades, expanded HSAs will be of great importance to a modernized Medicare. HSA holders also participate more in wellness programs that focus on obesity and other major risks associated with chronic disease, increasingly relevant to senior care. New Medicare HSAs will be transformed into highly flexible vehicles for seniors to seek the best value for their health care spending (see "Key Questions and Answers on the Atlas Plan"). Under this plan, Medicare enrollees will automatically open HSAs if they had none before entering Medicare eligibility. Also under this plan, all Medicare enrollees will be fully eligible for HSAs regardless of enrollment into any specific coverage or program and without any specified level of deductible on insurance. The only requirement for making contributions to the HSA will be that the enrollee has catastrophic coverage. HSAs under new Medicare will have far higher maximum contribution limits (approximately double those for 2016), matching all other HSAs in the newly reformed system; likewise, they will have the same broadened uses of non-Medicare HSAs, including nonprescription medications and home health care devices. All current Medicare MSA limits and rules for uses will be updated to match universal HSA regulations, including removing the requirement to enroll in coverage with arbitrarily defined deductibles and eliminating Medicare MSA's restrictions

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on deposits. Because seniors typically incur greater health care costs, they will be allowed to roll over, tax free, money from retirement accounts into their HSAs. Seniors, their families, and their employers will all be allowed to contribute to the new HSAs up to the annual maximum. People will also be permitted to use their own HSA dollars for the health expenditures of their elderly parents regardless of tax dependency status. Even if Social Security benefits have begun, seniors will still be allowed to fund their HSAs. In new Medicare HSAs, a 20 percent penalty will be in place for nonqualified HSA withdrawals once the owner of the HSA becomes seventy years old. On the death of an enrollee, new Medicare HSA balances will be allowed to be rolled over to the tax-free HSA of the surviving spouse or other family members. This feature will also enhance HSA balances of younger family members and perpetuate increased consumer leverage on pricing.

Element #3: The Modernization of Eligibility

The third element of Medicare reform is the updating of eligibility from obsolete criteria of fifty years ago to reflect the demographics and health needs of today's seniors. The rationale to change these archaic eligibility criteria is straightforward. Modern medical care in the United States has increased life expectancy from birth by 1.6 years per decade for a half-century. Life expectancy from age sixty-five has increased about five years since program inception, equating to about one year longer from age sixty-five per decade that passes. Thus those individuals currently thirty-five years old will add another three years to their post-age-sixty-five life span. Moreover, older people now remain in the workforce longer. Retirement age has increased by five years since the early 1990s.[14] Under the proposed new Medicare, the age of eligibility would increase by two months per year until the individual reaches age seventy; after that, the eligibility age would be indexed to life expectancy. From CBO estimates, savings of about $65 billion over the decade would result from slowly phasing in this change.[15]