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A Special Report to the House Ways and Means Committee

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MEDICARE PART B REFORM

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The American people sent the powerful message last November that they want Congress to undertake a radical overhaul of government. They want Congress to review the activities of the federal government to determine how to move functions closer to the people. They want Congress to curb the growth of government and its intrusion into their lives. And they want Congress to look at how to reform those programs within the domain of the federal government so that they can better achieve their stated purposes.

Congress has an unprecedented opportunity to undertake such a fundamental reform of the Medicare program. It must do so in the context of the immediate need to take steps to balance the books of the federal government and to rein in the huge growth in federal spending over the last several years, which has pushed the country into debt while raising the burden of taxes on Americans. More specifically, Congress must consider Medicare reform in the context of a general reform of entitlement spending. None of the entitlement programs can be considered "off the table" as Congress grapples with the deficit—especially programs that provide large subsidies to one generation by passing the tab to the next.

The Medicare system thus should come under careful review to see whether sensible savings can be achieved while reforms are undertaken. As I will point out in this testimony, among the many possible reforms to achieve a reduction in the growth of net outlays of Medicare, Congress should consider an increase in the heavily subsidized Medicare Part B premium. As I will explain, this can be justified whether or not the objective of the reform is to reduce net outlays.

Still, any changes in the Medicare Part B premium should be taken in tandem with steps toward structural reform of the entire Medicare program. That structural reform should move Medicare away from the current highly regulated system, characterized by complex price and volume controls and Washington-specified services, toward a system which seeks to protect the health of eligible Americans as economically as possible. In this latter, reformed Medicare system, retirees would have the widest possible discretion to enroll in plans of their own choosing, with the benefits they and their doctors feel are right for the retiree, and with the government making an appropriate contribution toward the cost of the chosen plan.

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1 Substantial portions of this were delivered in testimony before the Health Subcommittee, House Committee on Ways and Means, on February 7, 1995.

With the government making a fixed contribution for each retiree, Medicare beneficiaries not only would have the freedom to choose the benefits and type of plan they preferred (such as fee-for-service or managed care), but also would have the incentive to seek out the best value for money among plans. This reform would give retirees in Part B choices and incentives very similar to those applying to Members of Congress under the Federal Employee Health Benefits Program. It is no coincidence that the FEHBP has managed to keep increases in enrollee costs well below those of Medicare and, more significantly, those of corporate health plans while maintaining a high level of satisfaction.

The possible changes in the Part B premium I will review are compatible with this structural reform.

THE CASE FOR RAISING PART B PREMIUMS

The Medicare Supplementary Medical Insurance (SMI) program, known as Part B, pays for physician services, outpatient hospital services, and other medical expenses for Americans aged 65 and over and for the long-term disabled. Unlike the hospital portion of Medicare (HI, or Part A), enrollment in Part B is voluntary. And unlike the HI program, Part B services are paid for through a system of premiums (supplemented with general revenues) rather than payroll taxes. According to the most recent report of the Board of Trustees, SMI disbursements in 1993 were $57.8 billion ($54.0 in benefits). The program received $41.5 billion in general revenue contributions in 1993 (71.9 percent of income).[2]

This subsidized, voluntary program is very popular. At the time of its enactment on July 1, 1966, 17.7 million aged persons enrolled in Medicare Part B. This population has steadily increased over time. In 1990, 32.6 million aged persons were enrolled in Medicare Part B. In 1995, 35.7 million persons are enrolled in Part B, or 97 percent of the total Medicare population. In 1990, 3.2 million enrollees were covered under both the Medicare and Medicaid programs (the state paid for premiums and required cost-sharing expenses).

There are several reasons for making changes in the Part B program, and in particular for requiring some beneficiaries to shoulder a higher proportion of program costs. Among them:

❶ Part B is a heavily subsidized entitlement without regard to income or any past contributions.

Unlike the HI program (Part A), the benefits available from Part B are not even in theory based on contributions made by recipients during their working years. Instead, it is a government-sponsored health insurance program that is heavily subsidized by taxpayers (including many elderly Americans who have chosen not to enroll).

The subsidy is roughly three dollars for every dollar of premium paid. More precisely, beneficiaries in 1993 contributed just 24.6 percent of program income.[3]

When Part B was established, it was Congress's intention to provide a subsidy, but at a much lower rate than today. Until 1973, SMI premiums were set by law to finance one half the benefit and administrative costs of the program plus a small contingency amount to go into a separate trust fund. However, in 1972, Congress amended the Social Security Act and drastically altered that arrangement. Beginning in July 1973, SMI premiums could be increased only if monthly Social Security cash benefits were increased. Premiums are permitted to rise no more than the percentage increase in cash benefits. Since the 1972 amendments, the proportion of Part B income contributed by

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2 Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1994 Annual Report of The Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Washington D.C.: U.S. Government Printing Office, April 1994), p. 1.

3 *1994 Annual Report*, p. 1.

enrollees has declined, and so the degree of subsidy has increased. Enrollees in 1995 pay a premium of just $46.10 for insurance that covers 80 percent of allowable charges with a deductible of only $100. Had the original deductible been allowed to rise in line with outlays, it would be over $1,000 today. With such inexpensive and generous coverage, subsidized by the taxpayer, it is little wonder that almost all eligible Americans decide to enroll in Part B.

When working Americans are facing up to the need to tighten their belts and accept reductions in federal programs, it is hard to see why, at the very least, more affluent retirees should not contribute a larger share of the cost of Part B. While Medicare Part B requires the payment of premiums, it is actually an income transfer program, taking away income from one segment of the population and redirecting it to another without regard to the latter's income.[4]

❷ Part B costs are growing at an alarming rate.

In the 1994 trustees' report to the Congress, the financial outlook for Medicare Part B is not encouraging. While the trustees believe the SMI program currently is actuarially sound, they "[n]ote with great concern the past and projected rapid growth in the cost of the program....Growth rates have been so rapid that outlays of the program have increased 59 percent in aggregate and 45 percent per enrollee in the last five years. For the same time period, the program grew 23 percent faster than the economy despite recent efforts to control the cost of the program."[5] While the trustees do not make any long-range projections as they do in the HI (Part A) program, they point out that the SMI program will be affected by many of the same factors that are projected to increase Part A's costs (medical inflation, a rapidly aging society, etc.).

Part B outlays are growing at such a rapid rate that they are consuming an ever-larger share of the gross domestic product (GDP), as are HI expenditures. In 1993, Part B spending constituted 0.88 percent of GDP. This year the proportion is projected to be 0.99 percent, and in just 10 years' time the proportion is projected to be 1.17 percent.[6]

Such an alarming rate of increase in a program, particularly a voluntary enrollment program, demands congressional action to curb the growth of future outlays by benefit reductions and/or by requiring at least some beneficiaries to shoulder a greater share of costs.

❸ The generosity of Part B subsidies is a barrier to finding more economical and efficient ways of providing health care services to the elderly.

Since enrollees pay only 25 percent of the costs of Medicare Part B, insurance alternatives to the program generally are very unattractive even if they are actually much more efficient in delivering services—unless the proportion of the premium paid by the private sector enrollee is close to 25 percent. Some corporate retiree plans require low cost sharing from beneficiaries, and so are competitive with Part B. But if, say, a retiree had to pay the full cost of equivalent insurance coverage, Part B could be almost three times as costly in delivering services (including overhead) and would still be more attractive to the retiree. There are good reasons to believe that because of this wide price differential, made possible by the heavy subsidy, Part B is under less pressure to realize true efficiencies. Its payment schedule is a highly complex price control system, for instance, and is very inflexible, and only nine percent of enrollees are in managed care. In the competitive private sector,

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4 David Koitz, *Medicare Taxes, Premiums, and Government Contributions for 1995*, CRS Report for Congress, December 20, 1994, p. 2.

5 *1994 Annual Report*, p. 3.

6 Guy King, "Health Care Reform and the Medicare Program," *Health Affairs*, Vol. 13, No. 5 (Winter 1994), p. 41. Projections based on Trustees Report.

by contrast, there is continuous adjustment of pricing and benefit levels as plans seek greater efficiency, and there has been a quite dramatic shift in recent years to managed care.

Reducing the subsidy level in Part B would encourage many retirees to compare the costs and benefits of private alternatives with those of the Part B program. The further the subsidy was reduced, and hence the more level the playing field, the greater would be the inducement to pick more efficient private plans. That would lead to a reduction in the outlays of the program.

Whether or not the subsidy level is reduced, the desire to introduce greater incentives for efficiency has led many analysts to favor reforms that would reconstitute Medicare Part B (and Part A) into the equivalent of a voucher program to give the elderly the opportunity and incentive to choose plans and benefits that are very different from Part B. This reform would not, in itself, change the government's contribution to retirees, but it would give them far more freedom of choice and a strong incentive to seek the best value for their money among private-sector plans competing on an equal footing with the Part B program.

OPTIONS FOR RAISING PART B PREMIUMS

Not a Tax Increase. If this subcommittee gives serious consideration to reducing the level of subsidy by raising the Part B premium, members no doubt will be accused by some critics of favoring a tax increase.

An increase in the Part B premium is *not* a tax increase.

Members of this subcommittee can feel very confident that as a senior official of The Heritage Foundation, I would not come before you and advocate a tax increase. On the other hand, while opposing tax increases, we at Heritage have argued consistently that individuals or corporations receiving an explicit service from government—especially one which also could be provided by the private sector—should pay the full cost of that service unless there is some pressing reason for a subsidy (such as poverty). And such a subsidy should be explicit, rather than hidden in the price of the service. This is why scholars from The Heritage Foundation have testified before various committees and published studies advocating full-cost user fees for commercial services available from the federal government.

Part B is a "commercial" service provided by the federal government. If there is to be a subsidy for enrollees in the program, it should be restricted to those whom Congress has determined cannot reasonably afford an acceptable level of physician services and other services available under Part B. There is a strong case for ending the subsidy available to other Americans.

While a case can be made for greater cost sharing in Part A, the case is much stronger for Part B. Americans contribute to their Part A benefits throughout their working life. Those contributions are mandatory and are income-related. Thus, there is reasonable argument against means-testing Part A or reducing benefits if they fall below the equivalent value of payroll contributions. No such argument applies to Part B. Part B is voluntary—retirees and the long-term disabled examine the cost of coverage under the subsidized Part B program and under private alternatives and choose whether or not to enroll.

Under current law, according to the Congressional Budget Office, the federal government is projected to spend $485.9 billion over the next five years in Part B payments (of which premium payments cover just 25 percent).[7]

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7 Congressional Budget Office, "CBO December 1994 Baseline, Outlays by fiscal year, in billions of dollars," January 9, 1995.

OUTLAYS
(in billions of dollars)

1996	1997	1998	1999	2000
75.3	85.3	96.1	108.0	121.2

There are several options available for raising Part B premiums.

OPTION 1: Raise the beneficiary premium to 100 percent of costs.

While obviously the most difficult option politically, this change could achieve net savings to the program of as much as $364 billion over five years, depending on the assumptions made.[8] Even if this sharp increase had applied in 1995, beneficiaries still would pay just $184.40 per month for good coverage.

But, needless to say, this change would be a great hardship for many lower-income Americans. It would also be a new burden to states unless states chose to maintain their current level of financial support for individuals also on Medicaid—in which case these low-income Americans would face relatively large premium costs.

OPTION 2: Raise the premium contribution level to 50 percent of costs.

Congress originally set the premium for Part B at 50 percent of costs, so this option would merely reinstate that premium percentage. This would still retain a heavy subsidy to enrollees, regardless of income. Had this change been in effect in 1995, premiums would be $92.20 per month. The net savings to the government from this change would be as much as $121.5 billion over five years.

While lower-income enrollees would not be affected by this change as much as under option 1, many would still face hardship—while upper-income enrollees would continue to be heavily subsidized.

OPTION 3: Means-test premiums for upper-income beneficiaries.

A compromise change would be to reduce the subsidy as income rises. The savings achievable from such a change would vary widely, depending on what method of means-testing was introduced.

A general concern about any means-testing system is that it has the equivalent effect of raising marginal tax rates for individuals enrolled in the program, since premiums rise with income. Still, this effect could be kept quite small. Consider the following change:

> Gradually reduce the Medicare Part B premium subsidy for "high retirement income" beneficiaries. The threshold begins at $65,000 in adjusted gross income for individuals and $85,000 for couples. The subsidy is phased out in increments of 3 percent per $1,000 of income above the threshold. The full premium would be paid by individuals above $98,000 in AGI and couples above $118,000 in AGI.

8 A change of this magnitude would have large behavioral effects which are beyond the scope of this analysis. Clearly one effect would be that the number of persons enrolled in Part B would decline as individuals comparing premium costs chose more competitive private plans. That would reduce outlays and the net savings to the deficit.

The increase in the equivalent effective marginal tax rate in this case would be approximately 5 percentage points.

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While these reductions in the subsidies in Part B would yield savings to taxpayers, I must emphasize again, in conclusion, that such changes should be instituted in tandem with initial steps toward a restructuring of the Medicare program. The aim of the structural changes should be a Medicare system in which retirees receive a contribution toward the cost of coverage (perhaps inversely related to income) which they may use to enroll in a plan of their choice. Such a system would have to be introduced gradually and would require certain changes in insurance rules for plans serving the Medicare population. But if the long-run expenditures of Medicare are to be brought under control while assuring the widest choice and value-for-money for retirees, structural reform is essential.