NATIONAL CENTER FOR POLICY ANALYSIS

How to Pay for Medicare [1]

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Medicare, the health care program for the elderly, now provides insurance coverage for over 50 million Americans, and accounts for 20 percent of the $3 trillion spent annually on health care. Its share of the nation's output and total health care spending has grown significantly over its first 50 years. Over the next 75 years, from 2016 to 2089, Medicare is projected to grow from 3.53 percent to 6.02 percent of gross domestic product (GDP).

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Executive Summary

Historically, per-capita health care expenditures have risen faster than per-capita GDP; this is referred to as Medicare's excess cost growth. The difference between per-capita output and per-capita health spending has been ascribed to several factors: a smaller share of health care paid for directly by users, increasing demand for more and better care as citizens become wealthier, and technological advances that have increased the cost of and demand for procedures that improve the quality of life.

One of the goals of the Affordable Care Act and of the majority of Medicare reform proposals has been to reduce or eliminate excess cost growth as it applies to federal spending. Without significant changes in the current program, it is not realistic to think that federal Medicare spending per capita can be constrained to grow at the same rate as per-capita GDP.

Estimating Lifetime Medicare Benefits after Taxes. After paying premiums, taxes on Social Security benefits *and* federal income taxes in support of Parts B and D, do Medicare recipients receive more benefits — measured by the value of their medical care — than they pay into the program in their lifetimes? Estimates based on the Trustees' baseline forecast indicate that, on average:

- For medium earning men and women born in 1950 and retiring in 2015, Medicare net benefits at retirement are equal to $77,000 and $98,000, respectively.
- In contrast, very high earning workers pay over $200,000 more in taxes and premiums in support of Medicare than they receive in benefits over their lifetimes.

Baseline and Alternative Estimates for People Born in 1990. Workers born in 1990 will retire in 2055. For these workers, under both the baseline and alternative forecasts, lifetime taxes grow more rapidly than benefits when compared to today's retirees, but their net benefits

remain positive. However:

- The 1990 birth cohort's very high earners' total taxes and premiums under the baseline forecasts are almost three times greater than the benefits they will receive in their lifetimes.
- In contrast, the very high earners born in 1950 had lifetime taxes and premiums that are less than two times their benefit payments.

For these very higher earners, much of the increase in the ratio of lifetime taxes and premiums to benefits received is due to the means testing of premiums.

How Much Is Medicare Worth? Medicare's value as a percent of average lifetime earnings (based on the medium earning profile) has grown by birth year. If the average net value of Medicare benefits, net of premiums, were "annuitized" as an income payment:

- For medium earning workers born in 1930, the value of annuitized Medicare benefits would be about 27 percent of their average annual earnings.
- For today's retirees, they would be worth about 35 percent of average earnings.
- For today's new labor force entrants, Medicare's annuity value is still 40 percent, if derived from the baseline forecast, but rises to 53 percent, if based on the alternative forecast.

Options to Reform Medicare. Reforming Medicare's financing requires the younger population to provide funding for some part of their own retirement health care. But if seniors' individual demand for health care continues growing at a rate faster than the ACA's implicit spending cap of per-capita GDP growth, then retirees must gradually bear a greater share of their health care consumption. There are four broad options for Medicare reform:

Option I. Raise Beneficiary Premiums to Cover Excess Cost Growth. Reducing federal per-capita Medicare spending growth in the alternative forecast to the baseline estimates from the 2015 Trustees Report could be accomplished by raising seniors' premiums.

Option II. Raise Deductibles and Copays to Limit Spending to the Baseline Forecast. Retirees would then be responsible for the rising cost sharing this option requires. Means-tested contributions to Health Savings Accounts (HSAs) by the federal government could complement the reformed insurance. Option II holds promise in expanding the role of prices in the health care market.

Option III. Constrain the Federal Payment Rate by Procedure and Service. Rather than paying the CMS-determined reimbursement to each provider, Medicare would give those amounts to the participants. If the participant chose a provider whose charges were higher than the Medicare reimbursement, the participants would be responsible for the difference. As a result of the expected excess cost growth, the share of total costs borne by participants could be expected to rise over time. However, over time a real market would emerge for health care due to seniors' demand for lower prices.

Option IV. Premium Support Payments that Rise at the Same Rate as Per-capita GDP. Option IV would offer a significant level of both individual choice and individual payment responsibility while limiting the role of CMS in the Medicare market. In its simplest form this option provides average premium support payments that in aggregate follow the Trustees' baseline forecast.

These proposals all are designed to bring the per-capita federal cost growth of Medicare, the taxpayer burden, in line with the per-capita growth of GDP and all can incorporate retiree premium payments, deductibles, copayments and contributions that vary inversely with lifetime income.

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Introduction

Medicare, the health care program for the elderly, celebrated its golden anniversary last year. The program now provides insurance coverage for over 50 million Americans, and accounts for 20 percent of the nation's $3.8 trillion spent on health care. Its share of the nation's output and total health care spending have grown significantly over its first 50 years. Over the period from 2016 to 2089 (75 years), Medicare is projected to grow from 3.53 percent of gross domestic product (GDP) to 6.02 percent of GDP.[2]

Across generations the program has, up to now, provided benefits that have grown relative to workers' preretirement earnings. Accounting for all lifetime taxes and premium payments in support of the program, it is estimated that net benefits (benefits after payroll taxes, premiums and federal income taxes are paid that finance the program) for medium earning workers will remain positive even for today's new labor force entrants. Though the program is progressive within each generation, in that higher earning workers pay more in Medicare taxes and have lower net benefits over their lifetimes, each generation's retirement benefits are paid in part by higher taxes on succeeding generations.

Moving toward making the tax burden more equal across generations so that future generations of workers are not burdened with an increasing taxpayer share can be accomplished by constraining the taxpayer-funded portion of Medicare so that per capita spending grows at the same rate as per capita GDP. There are four possible options to recast the program's financing and insurance structure so as to constrain the tax-financed portion of retiree health care spending.

How Medicare is Funded. Medicare is funded by a 2.9 percent payroll tax on workers (half paid by the employer, half paid by the worker). The Affordable Care Act increased the payroll tax by another 0.9 percent on earnings above $200,000 for single workers and above $250,000 for married couples. This is combined with taxes on Social Security benefits, federal general revenues, premium payments from retirees, state transfers and a few other sources to fund the program.

Medicare's Hospital Insurance (HI), or Part A, primarily covers health care spending associated with hospital stays; but it also covers home health care, payments to skilled nursing facilities and hospice care. It is funded by the payroll tax described above and federal income taxes on Social Security benefits.

Since 2005, the HI portion of the program has run deficits that contribute to the overall deficits of the federal government. Based on the 2015 Medicare Trustees Report, the HI portion of the program is expected to run a slight surplus between 2016 and 2021 as revenues collected from the payroll tax are more than expenditures, but in years 2022 and beyond the program is expected to run deficits even with the optimistic current law forecast.

Medicare Supplementary Medical Insurance (SMI) includes Parts B and D. Part B covers doctors' visits, payments for outpatient procedures and some home health expenses. Part D covers prescription drugs. These two programs are voluntary in the sense that individuals must pay a premium to enroll. Part B premiums are set at approximately 25 percent of the average beneficiary's expenses; they covered 25 percent of the $281 billion Part B expenditures in 2015. Part D premiums covered 14 percent of this part of the program's 2015 expenses of $93 billion, while state transfers pay another 9 percent and general revenues (federal income taxes) pay the remainder.

Altogether, Medicare spending was about $650 billion in 2015. The two largest revenue sources were general revenues, 45 percent, and payroll taxes, 37 percent. Premiums accounted for 13 percent of total spending; taxes on benefits and state transfers make up the remainder.[3]

Medicare's Growth

Historically, per-capita health care expenditures have risen faster than per-capita gross domestic product — referred to as excess cost growth. This difference between the two has been ascribed to several factors:

- The share of health care expenditures paid by users directly has fallen over the last 30 years, from 25 percent to just over 10 percent.
- As the nation becomes wealthier, citizens have demanded and received more and better health care.
- Technological advances have decreased the cost and increased demand for body part replacements and other procedures that improve quality of life.

One of the goals of the Affordable Care Act and of the

majority of Medicare reform proposals on both sides of the aisle has been to reduce or eliminate excess cost growth as it applies to federal spending.

Medicare Cost Estimates. The annual Medicare Trustees report produced by the Centers for Medicare and Medicaid Services (CMS) details the future revenue and expenditure forecasts for the program. The report's *baseline* forecast assumes that current laws, such as certain provisions and requirements found in the Affordable Care Act that will affect the financing and operation of Medicare, will come to fruition. It also uses a variety of assumptions about population growth, GDP growth and health care utilization to estimate the costs of the program over time. The Trustees also produce an *alternative* forecast that estimates cost growth in the event that Congress overrides provisions of current laws that affect the financing and operations of Medicare. In addition, the Congressional Budget Office (CBO) also produces a report that estimates the growth of Medicare into the future. The Medicare Trustees' baseline forecast assumes that measures to reduce Medicare costs in the ACA will happen. Specifically the Act requires that hospital reimbursements and other Part A reimbursements from Medicare be reduced to reflect the increase in economy-wide productivity (producing more or better products at less cost), assuming that health care productivity increases at the same rate.

The Trustees' *alternative* forecast recognizes that productivity growth in health care — in this case improving health care quality at lower cost — has always been below economy-wide productivity increases and that adjustments based on improved efficiency will occur, but only for the first years of the forecast. Then, the Trustees assume that, beginning in 2020, the ACA imposed economy-wide productivity adjustment to Medicare physician reimbursements will be eventually be phased out by 2034, when the Medicare price updates reach the rate of increase assumed for privately paid health insurance plans. Without these changes, the payment rates to providers that are currently about 67 percent of private insurance payments would fall to 40 percent, resulting in fewer providers accepting Medicare patients.

The CBO report allows for the limits included in the ACA to be effective for the next decade, implying a modest growth in excess cost beginning with 0.4 percent and reaching 0.8 percent by the end of the decade. After 2025, the CBO assumes that long-run excess cost growth gradually rises and ultimately reaches 1.3 percent above GDP growth in 2040. The CBO forecast then combines these cost growth assumptions with the demographics of increasing life expectancy and the number of baby boom retirements — an estimated 78 million — to reach their ultimate forecast: federal Medicare expenditures will be more than double the Trustees' baseline forecast and almost 40 percent greater than the Trustees' alternative forecast by the end of 2040.

Without significant changes in the current program, it is not realistic to think that federal Medicare spending per capita can be constrained to grow at the same rate as per-capita GDP.

Estimating Lifetime Benefits

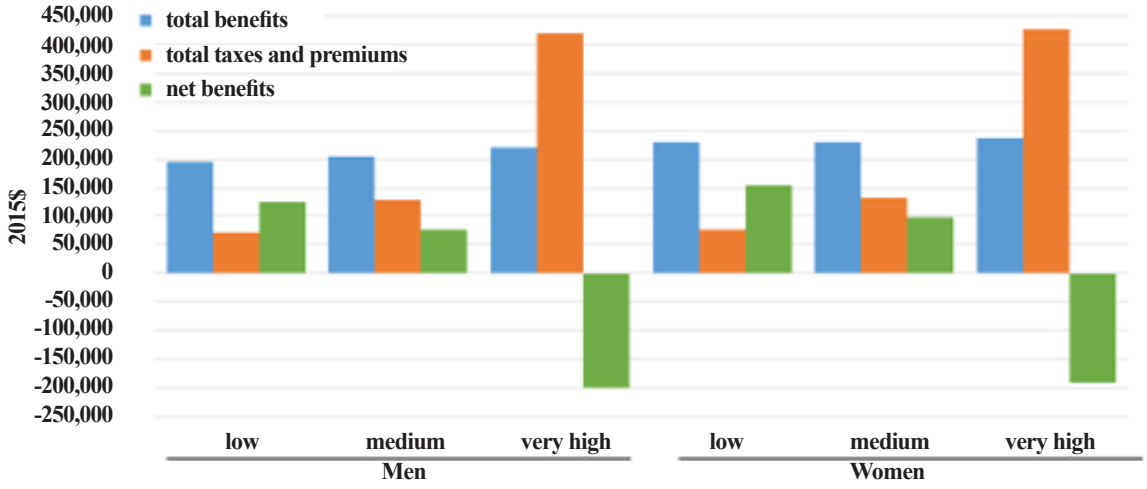
After paying premium payments, taxes on Social Security benefits *and* federal income taxes in support of Parts B and D, do Medicare recipients receive more in benefits than they pay into the program in their lifetimes? For the purposes of this exercise, assume that individuals live with certainty to the age of 65 and then, at retirement, life expectancy is contingent on lifetime income and on sex.[4] Higher income workers have longer life expectancies than lower income workers; women have higher life expectancies at retirement than do men; and income differences in longevity (based on lifetime earnings) are more distinct among men than among women. Medicare benefits, premium payments, taxes on Social Security benefits and federal income taxes in support of Parts B and D are adjusted by income-adjusted probabilities of survival to each age above 65.

The four figures below represent estimates of lifetime Medicare benefits, taxes and premiums for workers born in 1950 and 1990. Figures I to IV present the estimates for men and women earning low, moderate and high incomes, who are new retirees and new labor force entrants as of 2015, under the Trustees' baseline and alternative forecasts.

1950 Baseline Estimates. The estimates in Figure I are for men and women born in 1950 who reached 65 years of age in 2015:

- For medium earning men and women, Medicare benefits at retirement are equal to $77,000 and

Figure I. Lifetime Medicare Benefits, Revenues, and Net Benefits, Men and Women Born in 1950 (2015 Retirees) - Baseline Estimates
2015$, 2.9% real discount rate, estimates at age 65



Source: Authors' estimates. Hypothetical earnings from Social Security Administration. Individuals work with certainty at ages 21 to 64 and retire at age 65. Income-adjusted mortality rates by sex begin at age 65. Medicare spending from 2015 baseline estimates. Future payroll and income taxes increase to fund annual spending. See text and appendix for details.

$98,000 in net benefits, respectively.

- This means for medium earners retiring in 2015, Medicare will provide benefits over and above the taxes and premiums they paid (payroll taxes and federal income taxes during their work years) and will pay (premiums and federal income taxes during retirement) in support of the program.
- The net benefits for low earning workers are over $100,000. In contrast, the very high earning workers pay over $200,000 more in taxes and premiums in support of the Medicare program than they receive in benefits over their lifetimes.

1950 Alternative Estimates. Figure II again presents estimates for new retirees in 2015, but in this case Medicare benefits are based on the Trustees' alternative forecast. Recall that the alternative forecast assumes that the Medicare cost reduction measures put forth in the Affordable Care Act will not materialize, so Medicare costs will be greater than in the baseline forecast. Compared to Figure I, the results are only slightly different. Since most of the taxes in support of the program have already been paid for members of this birth year, the Trustees' baseline and alternative forecasts are the same over the first decade of the forecast and then only gradually diverge up until the mid-2030s. Thus, the higher benefits, and the taxes and premiums necessary to fund them, are largely paid by future workers. However, for this group the timing of benefit growth and the taxes are staggered. For example:

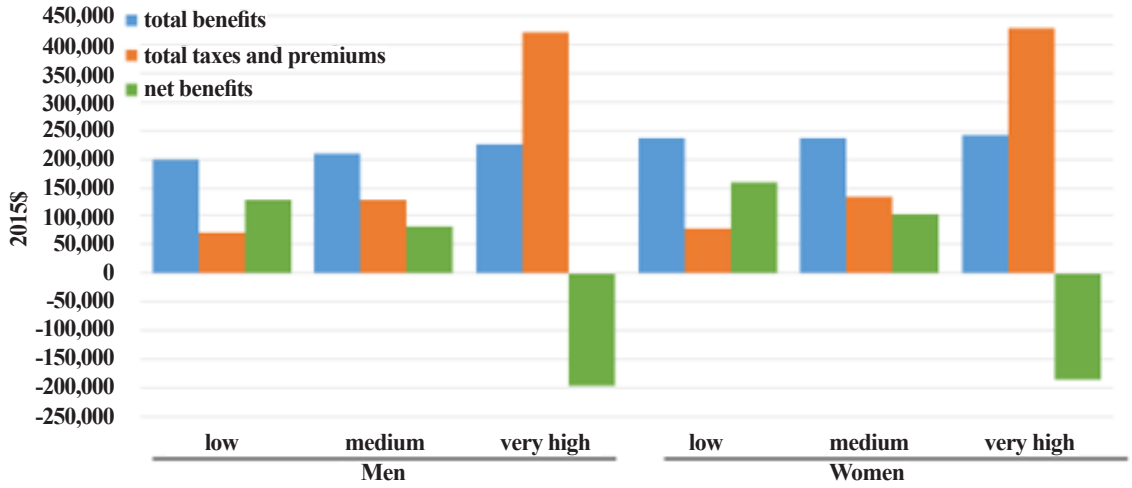
- Medium earning men's lifetime benefits will increase to over $209,000 if the alternative forecast prevails compared to $205,000 with the baseline forecast.
- Their taxes and premiums will rise only modestly resulting in higher net benefits of almost $81,000 under the alternative.

1990 Baseline and Alternative Estimates. Figures III and IV present the baseline and alternative results for workers born in 1990 who are basically new entrants to the labor force in 2015. The estimates in Figure III assume the baseline forecast holds in the future. These workers will retire in 2055, which is well into the years in which the baseline and the alternative forecasts diverge. Several things are of note in these figures.

- First, medium earning workers continue to receive net transfers from Medicare. Under both forecasts, compared to today's retirees, their lifetime taxes grow more rapidly than benefits, but their net benefits remain positive.
- The 1990 birth cohort's very high earners' total taxes and premiums under the baseline forecasts

Figure II. Lifetime Medicare Benefits, Revenues, and Net Benefits, Men and Women Born in 1950 (2015 Retirees) - Alternative Estimates

2015$, 2.9% real discount rate, estimates at age 65



Source: Authors' estimates. Hypothetical earnings from Social Security Administration. Individuals work with certainty at ages 21 to 64 and retire at age 65. Income-adjusted mortality rates by sex begin at age 65. Medicare spending from 2015 alternative estimates. Future payroll and income taxes increase to fund annual spending. See text and appendix for details.

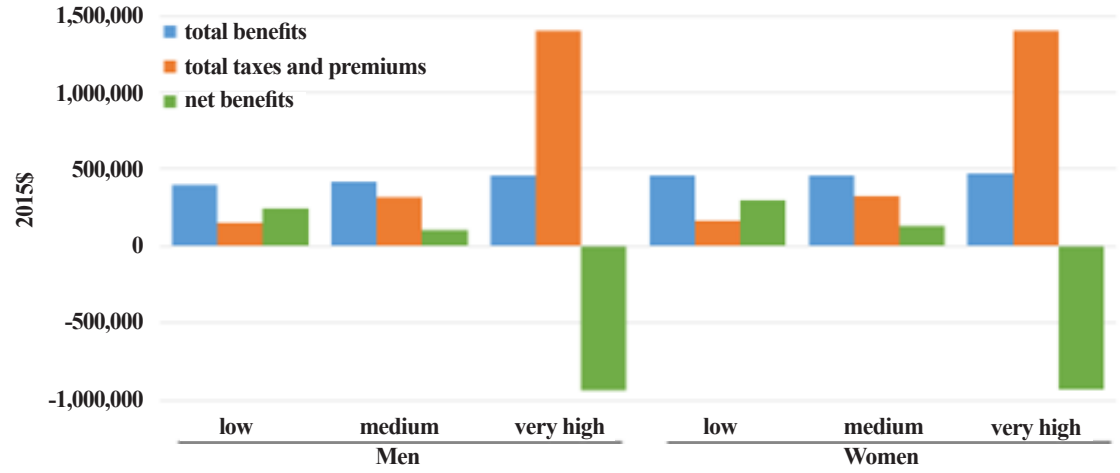
are almost three times greater than the benefits they will receive in their lifetimes. In contrast, those born in 1950 had lifetime taxes and premiums that are less than two times their benefit payments. Much of this is due to the means testing of premiums.

Comparing Figures III and IV also shows that the net *benefits* for the medium workers are again higher under the Trustees' alternative forecast than under the Trustees' baseline forecast. However, Figure IV shows that the net *taxes* for the very high earning workers are higher under the alternative forecast. How is it possible that the higher spending under the alternative appears to produce higher net benefits for most earners, except those with very high earnings, and can such an intergenerational program persist?

Medicare's so-called good deal is a direct result of excess cost growth. During future retirees' work years they are paying taxes to support a smaller Medicare program than they will be part of upon retirement. As the previous section showed with progressive taxation, except for the highest income earners, where the progressivity of the income tax component of Medicare financing dominates future Medicare benefits, all others find Medicare a good lifetime deal. But there are no "free" lunches. Why is this the case?

Figure III. Lifetime Medicare Benefits, Revenues, and Net Benefits, Men and Women Born in 1990 (2055 Retirees) - Baseline Estimates

2015$, 2.9% real discount rate, estimates at age 65



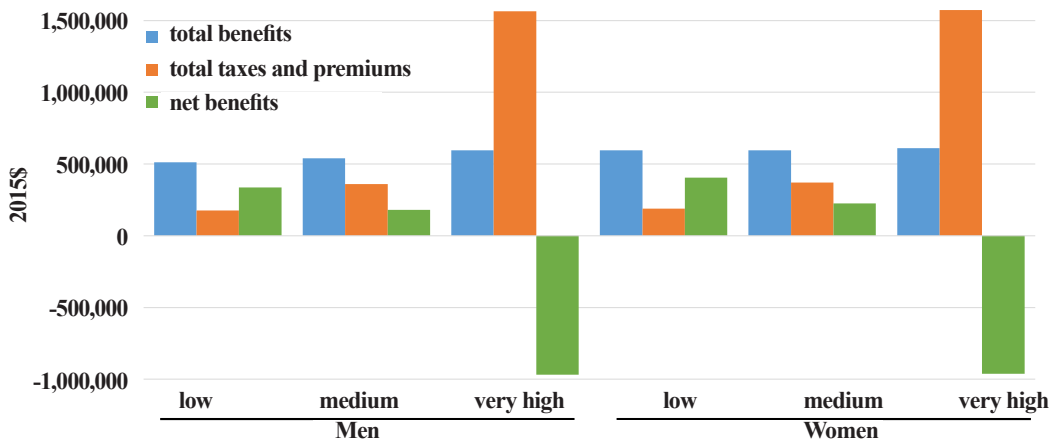
Source: Authors' estimates. Hypothetical earnings from Social Security Administration. Individuals work with certainty at ages 21 to 64 and retire at age 65. Income-adjusted mortality rates by sex begin at age 65. Medicare spending from 2015 alternative estimates. Future payroll and income taxes increase to fund annual spending. See text and appendix for details.

First, per capita retiree health care consumption growth in excess of per capita GDP growth means that the share of retirement health care consumption is rising. With generational transfer financing in place, this increasing share of retirement health care means that workers can expect a greater and greater share of their retirement

expenses will be paid by the next generation. However, since current taxpayers will be responsible for less of their retirement consumption they will save less for their future and the equilibrium capital stock will be lower.

Figure IV. Lifetime Medicare Benefits, Revenues, and Net Benefits, Men and Women Born in 1990 (2055 Retirees) - Alternative Estimates

2015$, 2.9% real discount rate, estimates at age 65



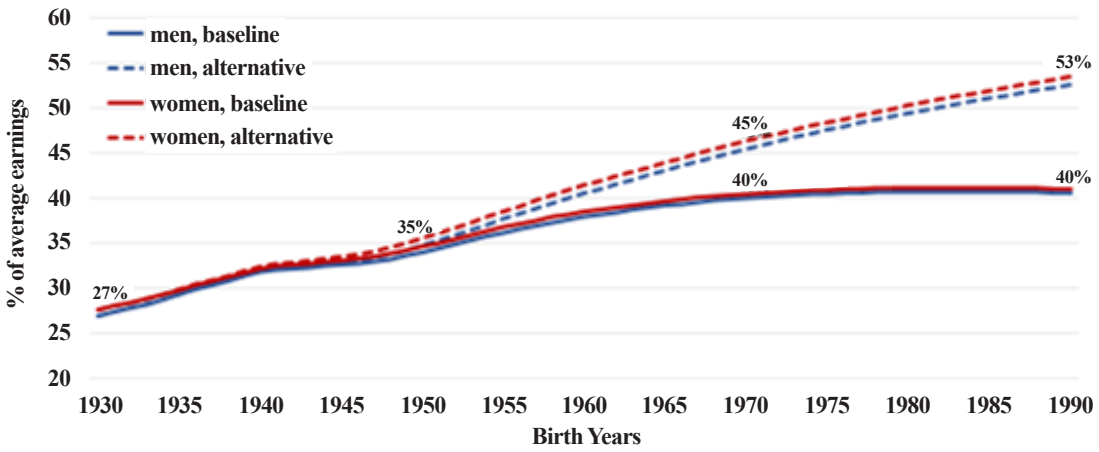
Source: Authors' estimates. Hypothetical earnings from Social Security Administration. Individuals work with certainty at ages 21 to 64 and retire at age 65. Income-adjusted mortality rates by sex begin at age 65. Medicare spending from 2015 alternative estimates. Future payroll and income taxes increase to fund annual spending. See text and appendix for details.

The Annuitized Value of Medicare Benefits. Figure V illustrates how Medicare's value as a percent of average lifetime earnings (based on the medium earning profile) has grown by birth year. To do this, consider the value of Medicare benefits, net of premiums, as an annuity that pays an amount in the form of periodic payments over time:

- For medium earning workers born in 1930, if Medicare benefits were "annuitized" as an income payment they could be worth about 27 percent of their average annual earnings.
- For today's retirees, it is worth about 35 percent of average earnings and, as shown in Figure V, the annuity based on the higher alternative forecast is slightly higher than the annuity from the baseline forecast.
- Women's annuity values are higher than men's due to longer life expectancy.
- For the 1970 birth cohort, Medicare's annuity value is 40 percent of average earnings if based on the baseline forecast, but is 45 percent if based on the alternative.
- For today's new labor force entrants, Medicare's annuity value remains at 40 percent if derived from the baseline forecast but rises to 53 percent if based on the alternative.

The important points from this figure are: (1) Medicare's annuity value stabilizes at 40 percent when Medicare per-capita grows at the same rate as per-capita GDP as seen in the series derived from the baseline forecast and (2) the alternative forecast produces an

Figure V. Annuitized Value of Medicare Benefits as a Percent of Average Lifetime Earnings, Medium Earnings, Baseline and Alternative Forecasts



Source: Authors' estimates. Hypothetical earnings from Social Security Administration. Individuals work with certainty at ages 21 to 64 and retire at age 65. See text and appendix for details.

annuitized value that grows as a percent of average lifetime income. A third point, not seen in the figure, but implied by it, is that under both forecasts Medicare's cumulative total spending on behalf of each successive birth cohort will rise relative to their cumulative lifetime earnings if the eligibility age remains fixed at 65, given that conditional life expectancy at age 65 is anticipated to rise. Thus, even with the baseline forecast growth assumption, indexing the eligibility age to gains in life expectancy would be necessary to stabilize Medicare's share of individuals' lifetime consumption.

The second catch, as illustrated in the alternative forecast, is that the excess cost growth implies an ever rising tax rate on the working population. This rising tax and resultant falling return to work indicates a disincentive for people to work, as may already be evidenced by the falling labor force participation rate over time.

Options to Reform Medicare

While Medicare reforms may reduce some health care expenditures, the goal of the reforms outlined below are to control the extent to which future taxpayers must pay for the health care of their elders.

For any reform to be viable, two conditions must be met:

- First, reforms must not rely on the hope of new technology or new federal bail-out legislation.
- Second, any reform that limits the federal government's role in paying for retiree health must not restrict seniors' access to health care.

All reforms require the younger population to provide funding for some part of their own retirement health care. As the United States becomes richer and Americans live longer, health care consumption has and will continue to increase in importance. As a result excess cost growth should be expected to continue for the foreseeable future.

Any reform that achieves a per-capita federal Medicare expenditure growth equal to the per-capita growth of GDP, so that the Medicare burden on taxpayers as a share of GDP remains constant, must be done in a way that does not impede the development of new health care solutions to problems arising from aging. Further, such reforms must be done in a way that minimizes the effect on recipients, both current and future retirees.

If seniors' individual demand for health care continues growing at a rate faster than the ACA's implicit spending cap of per-capita GDP growth, then retirees must gradually bear a greater share of their health care consumption. The question is how this growing retiree burden is distributed across retirees. The analysis presented here concerns the reconciliation of the per-capita growth in senior health care and per-capita GDP growth no matter the size of the Medicare population.[5] There are four options to consider:

Option I. Raise Beneficiary Premiums to Cover Excess Cost Growth. Reducing federal per-capita Medicare spending growth in the alternative forecast to the baseline estimates from the 2015 Trustees Report could be accomplished by raising premiums. In effect, Medicare stays essentially as it is, but premiums paid by participants rise each year to account for the per capita excess cost growth.

Recall that the Trustees' alternative forecast excess cost growth was 50 percent higher than the Trustees' baseline. Thus, if the taxpayers' burden is limited to the baseline, but retirees desire to spend commensurate with the alternative forecast, premiums would have to cover the additional 50 percent. Naturally, the distribution of those additional premiums across retirees would be the subject of debate.

Such a reform basically changes how Medicare is financed, but its implementation is easier to conceptualize if considered along with a reformed insurance structure in which all of Medicare's three parts are combined. With this option, as currently is the case, retirees can choose Medicare Advantage plans or can stay in fee-for-service Medicare.[6] The Centers for Medicare and Medicaid Services (CMS) would retain its role in setting provider reimbursement rates and managing the program.

Effective implementation of this reform would require a well-defined premium schedule and, if means-tested, the distribution of the premiums by income would also have to be announced well in advance and adaptable to effectively limit spending to the baseline. Past reforms have already established means testing for Parts B (doctors' visits, outpatient services etc.) and D (prescription drug) premiums. However, to constrain taxpayer-financed Medicare to the levels in the baseline forecast requires lower income thresholds and premiums that apply to all parts of the program.

Option II. Raise Deductibles and Copays to Limit Spending to the Baseline Forecast. This option changes Medicare's insurance package such that increasing deductibles and copayment rates accomplish the goal of constraining aggregate spending to the Trustees' baseline forecast. As with Option I, it is simplest to conceive of this reform with all of Medicare's parts combined and with the insurance covering catastrophic events.

The reform could include uniform deductibles, copayment rates and maximum dollar expenditures across all beneficiaries. Retirees would then be responsible for the rising, required cost sharing. Means-tested contributions to Health Savings Accounts (HSAs) by the federal government could complement the reformed insurance. Option II holds promise in expanding the role of prices in the health care market.

However, several questions arise. For example, how would taxpayer contributions to lower income retirees' HSAs be financed and how much of the unspent portion would these retirees retain? Deposits into the HSAs for lower income retirees could come from redirected Medicaid payments that have historically been directed toward premium payments, implicit Medigap insurance and state contributions.

The HSAs for lower income retirees could be implemented in a way similar to the debit cards used in the Supplemental Nutrition Assistance Program (SNAP). A Supplemental Medical Assistance Program debit card or "SMAP" card could be used to cover deductibles and copayments, with some portion of the remaining balance retained by these retirees.

Several other issues arise with this option. For example, are the contributions to retirement HSAs tax preferred? Will deductibles and copayment rates increase with lifetime earnings? Behavioral responses will result from the imposition of higher cost sharing requirements, unless a new form of Medigap insurance emerges. This possibility raises the ongoing issue of whether to tax Medigap to the degree that it induces more use of the taxpayer-provided insurance. These are all important issues, but are smaller obstacles than the alternative, the expected consequences of the full implementation of the ACA's productivity adjustment.

Option III. Constrain the Federal Payment Rate by Procedure and Service. While the previous two reforms make structural adjustments to Medicare financing and insurance coverage, this reform and the following reform bring a large amount of individual freedom to Medicare participants. Here Medicare gives participants the level of the CMS-determined reimbursement. Participants are responsible for the difference. Moreover, as a result of the expected excess cost growth, the share of total costs borne by participants can be expected to rise over time. Consider the case of a knee replacement. In this Medicare reform the patient knows how much Medicare will pay. If the patient can find a facility that performs the knee replacement for the Medicare amount or less, the procedure is totally paid by Medicare. However, because of the expected excess cost growth, the difference between the market price of knee replacements and the Medicare reimbursement will be rising over time. This difference makes it worthwhile for the patient to shop for the replacement just as they would for a new car.

This form of coverage allows a real market for medical services to emerge as patients are in charge. As a result, the suppliers will have to compete on price with the potential of reducing the level of excess cost growth, at least during the adjustment period. Incentivizing users to care what health care costs are will affect demand and as a result the level of health care expenditures may fall. During the adjustment to a new lower rate of growth in taxpayer-financed spending, it will appear the excess cost growth has slowed. However, seniors may supplement the CMS provided payments and per-retiree health care spending may continue to rise faster than per-capita GDP, but the rate will be more a function of market influences. Importantly, the growth in the taxpayer portion of spending can be lessened.

A final issue with this reform is dealing with that part of the retired population that has insufficient funds to pay for their health care. As with Option II, these retirees would have a debit card (SMAP card). But for those who are chronically ill, paying the growing difference between market prices and Medicare reimbursements will be an increasing burden. Also, health status shocks may result in random large increases in health care requirements.

The first of these issues is handled by setting the level of funding in SMAP cards issued to the lower income retired population using something similar to the current way by which CMS determines the risk-adjusted payments to Medicare Advantage plans. The chronically ill would receive a greater SMAP allocation. The second of these issues is resolved through the establishment

of a real insurance market against catastrophic health status changes. The premiums for such insurance would come wholly from CMS but would lower the level of reimbursements across the board.

This reform has great potential. Over time a real market would emerge for health care. Ads for physicians and hospitals would focus on price and convenience, and an insurance market for catastrophic health status changes could develop. The evolution of supplemental private market insurance products purchased by the non-poor population would be similar to those that emerge under Option II; but in this case, like current Medigap coverage, they would first provide some form of catastrophic coverage.

Option IV. Premium Support Payments that Rise at the Same Rate as Per-capita GDP. Option IV would offer a significant level of both individual choice and individual payment responsibility while limiting the role of CMS in the Medicare market. In its simplest form this option provides average premium support payments that in aggregate follow the Trustees' baseline forecast. The relative size of federal support for participants and the level of premium support would be determined using a methodology similar to that currently used for Medicare Advantage's risk-adjusted payments.

With this option, the only role of the federal government and, hence, CMS, would be to determine the level of individual federal support based on the beneficiaries' health conditions. Importantly, CMS controls over prices, reimbursements to providers and allowable procedures would be completely absent. Each enrollee would receive a level of premium support that is based on current health status and cost risk. Further, no enrollee would be allowed to cash out their premium support payment.

Currently, only Medicare Advantage plans are similar to private markets for beneficiaries. In the relatively unregulated world envisioned for Option IV, Medicare Advantage plans could still exist but would see much more competition. Importantly, all plans must include catastrophic coverage, even for healthier enrollees.

Thus, while a plan offering minimum benefits for a minimum premium may well attract healthier and perhaps wealthier enrollees, they must still pay for any significant change in their health status. Furthermore, the enrollees' premium support payments would be based on expected health care costs, adjusted so that less healthy individuals are not at a disadvantage vis-à-vis providers. Each beneficiary would know his or her risk-adjusted stipend each year. These would be estimated based on the value of the evolving insurance coverage. The means-tested component would augment the support for lower income retirees in a magnitude similar to the other options.

Conclusion

Due to the rising number of retirees and excess cost growth it is important and indeed almost imperative to change how the Medicare cost burden is taxpayer-financed. Indeed most reforms either passed or suggested have exactly that goal. These proposals all are geared toward bringing the per-capita federal cost growth of Medicare, the taxpayer burden, in line with the per-capita growth of GDP. In addition, all seem to agree that this goal will not be accomplished by reducing payments to providers. Thus, any real solution must entail an increase in the share of senior health care that is paid for by the senior population.

From the perspective of the working population, changes in the benefit structure of Medicare is a two-sided coin. On one side is the fact in their future that Medicare will cover less and less of their senior health care. Thus, Medicare spending will be shifting to greater reliance on beneficiaries and less reliance on taxpayers. Reform is about finding feasible options to shift Medicare spending from taxpayers to beneficiaries while ensuring access to improving technology. The other side of future lower taxpayer-funded Medicare is that the tax burden for current workers will be lower.

These four reforms options can accomplish the goal of bringing the more realistic Trustees' alternative forecast of federal Medicare expenditure down to the level of the Trustees' baseline forecast. In all four reforms, beneficiaries are increasingly responsible for funding their retirement health care expenditures. As illustrated by our analysis of lifetime benefits, taxes and premiums, the current financing arrangement puts much of the program's financing burden on higher earning workers and on subsequent generations. The program's generational equity can be improved if future beneficiaries – current workers – prepay some of their retirement health care through new savings options.

Notes

1. Adapted from Andrew Rettenmaier and Thomas R. Saving, "Paying for Medicare Now and in the Future," Private Enterprise Research Center, Texas A&M University, March 2016.

2. Board of Trustees, *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Washington, D.C., 2015.

3. The Medicare Modernization Act of 2003 requires the issuance of a funding warning if Medicare required 45% or more of its funding from nondedicated funding sources within a designated forecast window. Between 2006 and 2013 the funding warning was issued. The funding warning has not been issued with the 2014 and 2015 Medicare Trustees Report. One of the dedicated funding sources is interest on the HI Trust Fund bonds. However, that interest is ultimately paid through general revenues.

4. The methodology for adjusting the Social Security Administration's life tables used in producing the 2007 Trustees reports by lifetime income is described in Andrew J. Rettenmaier, "Is Social Security Wealth?" 2016, Private Enterprise Research Center, Working Paper 1602. The differential mortality was derived by comparing two public use Social Security Administration data files, the 2006 Earnings Public Use File (EPUF) and the 2004 Benefit and Earnings Public Use File (BEPUF). Both files include annual earnings for individuals beginning as early as 1951. The EPUF is a 1% sample of all individuals who had been issued a Social Security number as of 2006. However, for this, EPUF does not include date of death so as not to reveal the identity of the individuals in the file. The BEPUF is restricted to individuals who received Social Security benefits in 2004 and are thus survivors to 2004. Select birth years from the BEPUF sample of survivor is compared to the sample of all individuals in the EPUF to estimates survival rates by income class birth year and sex. These survival rates are then used to produce differential life tables by income class.

5. This does not mean that changes in the Medicare population size are not important, but their impact is of a second order of importance to the size of the difference between the future per-capita cost growth and per-capita GDP growth. Since the Balanced Budget Amendment of 1995, Medicare has been the secondary payer for employed citizens of Medicare eligibility age with firm-supplied health insurance. As a result, total expenditures are reduced as more and more 65-year-olds delay retirement.

6. Medicare Advantage is a managed health care plan (HMO or PPO) that provides Medicare benefits, Parts A and B and sometimes D, in a lower monthly premium. Medicare Advantage plans are more popular among lower income seniors and the federal subsidies for the plan are paid to insurers.

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