An Examination of Medicare's Current Design and an Alternative

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ABSTRACT

Approaches to Medicare reform have generally avoided addressing the structural aspects of the program and have largely focused on adjustments to improve program efficiency. Medicare's central features, such as its operation as a publicly run, community-rated insurance plan and its financing via tax transfers from working-age households to retirees and disabled individuals, have left the long-term solvency of the program vulnerable to demographic pressures. This paper examines how these basic characteristics of Medicare have resulted in alarming unfunded liabilities and proposes reforms that would substantially restructure the program. These proposed reforms include combining the various Medicare benefit programs into one rationalized insurance product entirely funded by a Medicare payroll tax, allowing premiums to vary based on lifetime earnings and coverage preference, and facilitating savings for healthcare premiums and costs in retirement. While reforms of this nature are politically ambitious and will require an extended timetable for implementation, such changes would transform Medicare into a program that is more sustainable, more consistent with stronger economic growth, less burdensome on workers, and less distorting of the US healthcare system than it is today.

JEL codes: I13, H51, H68, I14

Keywords: Medicare, payroll taxes, unfunded liability, Medicare HI trust fund, means testing, competition, premiums, Health Savings Accounts

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Medicare was enacted half a century ago, and it has been at the forefront of prominent political debates from the moment the program first began paying hospital and physician bills for enrollees. Medicare's rapid spending growth and its position as the dominant regulator of the nation's vast network of hospitals, clinics, and private physician practices have made it the focal point of both fiscal and health-care policy debates.

Proposals to reform Medicare have tended to focus on changes that proponents believe will improve the program's operational efficiency and cost-effectiveness. For example, in the Affordable Care Act, Congress changed Medicare's payment rules to discourage hospitals from readmitting previously discharged Medicare patients at excessive rates. Similarly, in the Medicare Access and CHIP Reauthorization Act of 2015, Congress laid the foundation for a new system for paying physicians under the program. The goal of these reforms was not to change how Medicare works in any fundamental way; rather, they were intended to make adjustments within the program's existing structure to promote better and more effective health services based on the resources that are devoted to Medicare as a consequence of its basic design. That is an understandable perspective, but it is not the only way to think about Medicare reform. It is also possible to take a step back and consider whether Medicare's original structure ought to remain in place indefinitely—and what an alternative design might look like.

Much of Medicare's financial challenge is directly related to the program's basic architecture. Medicare is a publicly run, community-rated insurance plan for persons age 65 and older and for disabled individuals, in which participants' health status does not figure into what they must pay in premiums for the coverage they receive. This aspect of the program does not involve any federal taxation or spending. But the program is also a pay-as-you-go social insurance system; much like Social Security, it was designed to partially finance the health insurance premiums for retired and disabled workers and their

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spouses. Further, Medicare is a social welfare program that depends on large transfers from working-age households to retirees and disabled individuals. It is these latter two features of the program that involve federal taxation and spending and that open the program up to demographic and other pressures that make financing the program such a challenge.

It is possible to conceptualize a different kind of Medicare, one that retains all of the protections of a community-rated insurance product but reduces the tax-and-transfer aspects associated with its current design. Disentangling the different aspects of the current program would be complex and certainly a very difficult political project. But the current program design is a source of endless fiscal strife, and that will remain the case so long as the program works as it does today.

WHY MEDICARE LOOKS AS IT DOES

Lyndon Johnson signed the legislation that created Medicare in 1965, but its roots can be traced to the 1940s. During that time, most of the world's democratic governments were expanding social welfare programs. In the immediate postwar period in the United Kingdom, a newly elected Labour government pushed through the creation of the National Health Service, a single-payer program of universal, tax-financed healthcare provision.[1] President Harry Truman, a Democrat, sought to do something similar in the United States. He proposed a series of measures in 1945 to improve access to health care. Among his proposals was a voluntary, federally administered national health insurance plan.[2]

1. For a brief history and description of the National Health Service, see Peter Greengross, Ken Grant, and Elizabeth Collini, *The History and Development of the UK National Health Service, 1948–1999*, 2nd ed. (London: DFID Health Systems Resource Centre, 1999).
2. Harry S. Truman Library and Museum, "President Truman's Proposed Health Program," National Archives and Records Administration, accessed May 3, 2017, http://www.trumanlibrary.org/anniversaries/healthprogram.htm.

But it was difficult for Truman to convince Congress to adopt his plan. A major impediment was strong opposition from the American Medical Association, along with widespread public skepticism about the role of government in health care. The commencement of armed conflict in the Korean War also diverted national attention and forced the Truman administration to scale back some of its ambitions on domestic matters.

When the national Democratic Party was next in a position to push for broader health insurance enrollment, they looked to their success in creating Social Security during the 1930s for their model. At enactment in 1935, Social Security was controversial.[3] But President Franklin Roosevelt was confident its design—a pay-as-you-go social insurance program—would eventually make the program very popular and politically untouchable. He was right.

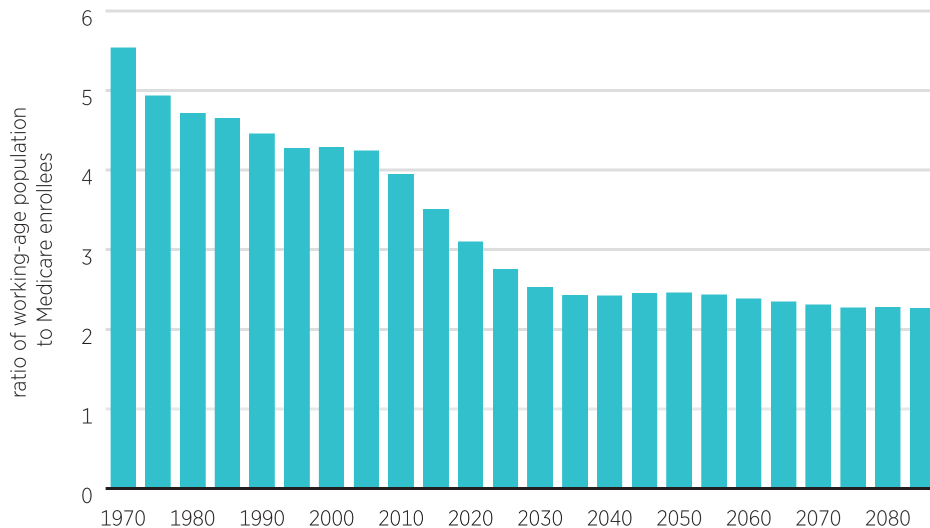
The key to Social Security's political success is, ironically, the payroll tax. Workers pay the tax during their working years and then receive a benefit in retirement, based in part on the wages that were taxed while they were working. This connection between taxed earnings and benefits paid in retirement is the core of Social Security. Most Americans believe they have "earned" their Social Security benefits when they reach retirement because the federal government takes taxes out of every one of their paychecks to pay for it. Proposals from politicians to adjust Social Security payouts are thus viewed with extreme skepticism.

The architects of Medicare borrowed liberally from the Social Security playbook. Medicare was built in part on an intergenerational social insurance model. Current workers pay a payroll tax, which in turn determines their eligibility for some of the program's benefits—namely, hospital insurance (HI) or Part A of Medicare—when they retire. And the taxes they pay are deposited into a dedicated federal trust fund, from which the benefits for current retirees are paid. As with Social Security, retirees believe they have earned their Medicare benefits with their payroll taxes, and thus they also view attempts to alter those benefits as reneging on an implicit contractual agreement between citizens and the government.

Using the Social Security template—namely, collecting payroll taxes from current workers to finance benefits for current retirees—to design Medicare has meant importing into Medicare the same demographic pressures now pushing Social Security toward insolvency. As shown in figure 1, the combination of falling birth rates and rising life expectancy has dramatically reduced the ratio of workers paying into the Medicare HI trust fund to those drawing

3. Alfred M. Landon, "I Will Not Promise the Moon," *Vital Speeches of the Day* 3, no. 1 (1936): 26–27.

FIGURE 1. RATIO OF THE WORKING-AGE POPULATION TO MEDICARE ENROLLEES, 1970–2085



Sources: Social Security Administration, *The 2016 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*, June 22, 2016; Centers for Medicare and Medicaid Services, *The 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 22, 2016.

benefits from it. In 1970, there were 5.5 workers for every Medicare beneficiary. Today, there are just 3.5 workers for every person on Medicare, and by 2050, the ratio will have fallen to just 2.4 workers.

Medicare has a second part—Part B, for physician and other outpatient services—that exacerbates the fiscal problems associated with Part A, hospital insurance. As originally conceived, Medicare Part B expenditures were to be financed partly from premiums paid by the beneficiaries themselves and partly from the federal treasury. Working-age Americans were asked to directly subsidize the health insurance premiums for older Americans, irrespective of the Medicaid enrollees' ability to pay.

Initially, the policy was to have the program financed in equal amounts by the beneficiaries and by the federal treasury. That policy held until 1976, when Congress, in response to rising costs (and thus also rising premiums for the beneficiaries), limited the annual increases in beneficiary premiums to the percentage increase in their Social Security benefits. This policy had the result of rapidly reducing the proportion of the program paid for by the enrollees themselves. In 1984, during the Reagan administration, Congress established a new policy that

keeps the beneficiary premiums at about 25 percent of Part B costs. That policy, with some exceptions, has basically held for the past three decades.[4]

In 2003, Congress added a new prescription drug benefit, Medicare Part D, and modeled its financing on the Part B program.[5] Beneficiary premiums were required for enrollment, but they would not cover the full cost of the benefit. Once again, federal taxpayers would pay for whatever drug benefit costs were incurred but not covered by beneficiary premiums. The law was written to limit what program enrollees must pay to roughly 25 percent of the cost of the standard drug benefit, with federal taxpayers picking up the other 75 percent.[6]

The burden on federal taxpayers from the Medicare Part B and D programs is enormous, largely hidden from view, and seldom noted in public debates. According to the 2016 Medicare Trustees Report, taxpayers will be providing an astonishing $4.2 trillion in subsidies for these parts of the program between 2016 and 2025.[7] These amounts exceed what will be spent during that same period on all of the federal programs providing direct support to low-income households.[8]

Figure 2 shows that, as recently as 2000, total general fund payments to Part B amounted to just over 5 percent of federal income tax collections (both personal and corporate). With the enactment of the drug benefit in 2003 and the retirement of the baby boomer generation, taxpayer subsidies for Medicare are set to soar. They are already well above 15 percent of all income tax receipts and will exceed 25 percent by 2050.

For the average Medicare beneficiary, the amount of the subsidization of their health insurance in retirement is substantial. As shown in figure 3, a single-earner couple in which both people reach age 65 in 2015 can expect to receive Medicare benefits that exceed what they pay in taxes by $357,000 (the amounts shown are in constant 2013 dollars). And the net subsidy for these couples will only go up in the years ahead.

In recent years, as Medicare's costs have mounted and many people have recognized that Medicare's financing rules are seriously unfair to working-age Americans, Congress has partially pulled back from the previous policy

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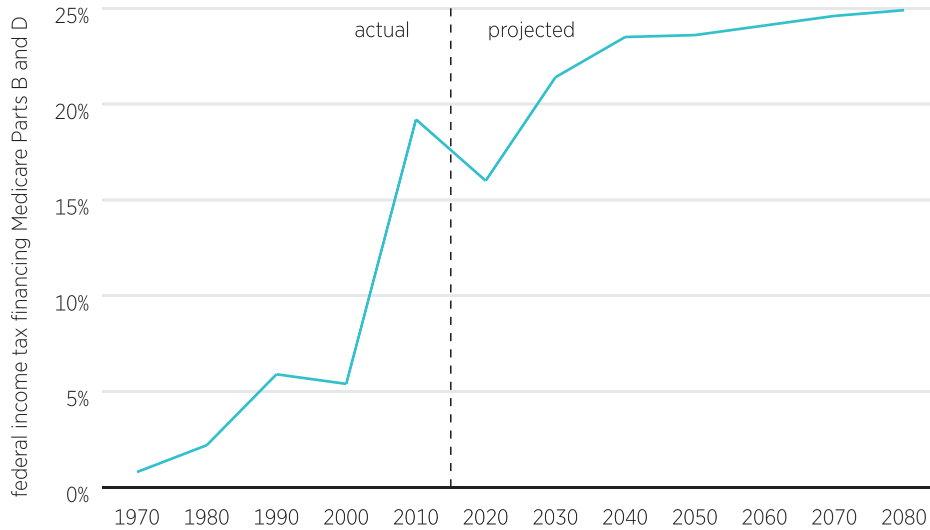
4. Margaret H. Davis and Sally T. Burner, "Three Decades of Medicare: What the Numbers Tell Us," *Health Affairs* 14, no.4 (1995): 231–43.
5. Medicare beneficiaries also have the option to take their full entitlement in the form of enrollment in a private insurance plan. This feature of the program is called Medicare Advantage or Part C.
6. "The Medicare Part D Prescription Drug Benefit" (Fact Sheet, The Henry J. Kaiser Family Foundation, Menlo Park, CA, October 2015).
7. Centers for Medicare and Medicaid Services, *The 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 22, 2016, tables III.C4 and III.D3 (hereafter, 2016 Medicare Trustees Report).
8. Congressional Budget Office, *Updated Budget Projections: 2016 to 2026,* March 2016, table 4.

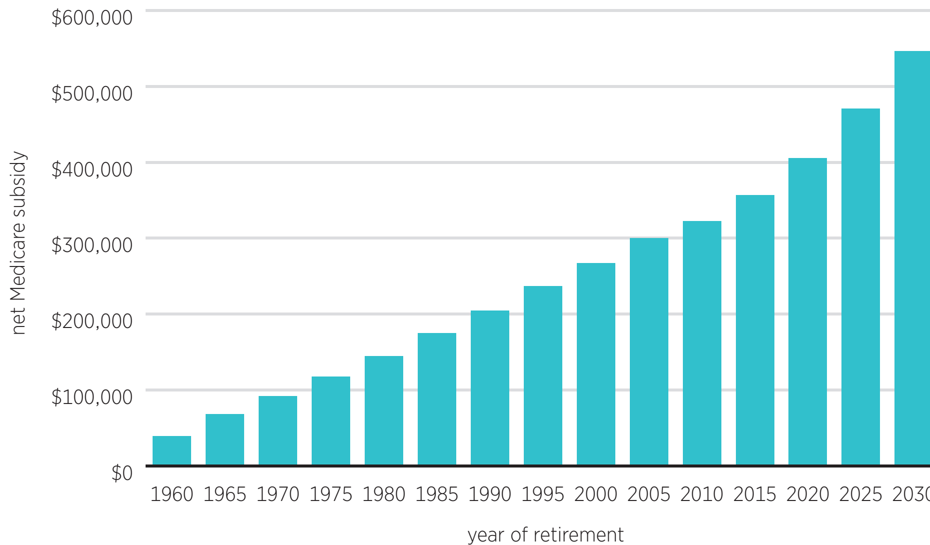
FIGURE 2. FINANCING MEDICARE PARTS B AND D, GENERAL REVENUES AS A PERCENTAGE OF FEDERAL INCOME TAXES



Note: Federal income taxes include both personal and corporate.

Source: 2016 Medicare Trustees Report, table II.F2.

FIGURE 3. NET MEDICARE SUBSIDY BY YEAR OF RETIREMENT (IN CONSTANT 2013 DOLLARS)



Note: Calculations assume a single-earner couple earning the average wage and retiring at age 65 in the year indicated.

Source: C. Eugene Steuerle and Caleb Quackenbush, “Social Security and Medicare Taxes and Benefits over a Lifetime—2013 Update,” Urban Institute, November 2013.

of providing substantial taxpayer assistance to all seniors regardless of their ability to pay for their own health care. Both Part B and Part D now charge higher-income seniors more for enrollment in the program. Under Part B, seniors with incomes above $85,000 (or $170,000 for couples) pay a higher premium than the 25 percent of program cost that is charged to everyone else. The premium can go as high as 80 percent of program costs for seniors with the highest incomes. Part D utilizes the same income thresholds to increase premiums for these seniors from the base rate, 35 percent of total costs, to 80 percent of costs. About 10 percent of all Medicare beneficiaries will pay these income-tested premiums in 2019, which means 90 percent of all Medicare beneficiaries will continue to receive the maximum amount of taxpayer subsidies for their health care.[9] It is also noteworthy that even those seniors paying the highest possible premiums for Parts B and D still receive a subsidy equal to 20 percent of the value of this insurance.

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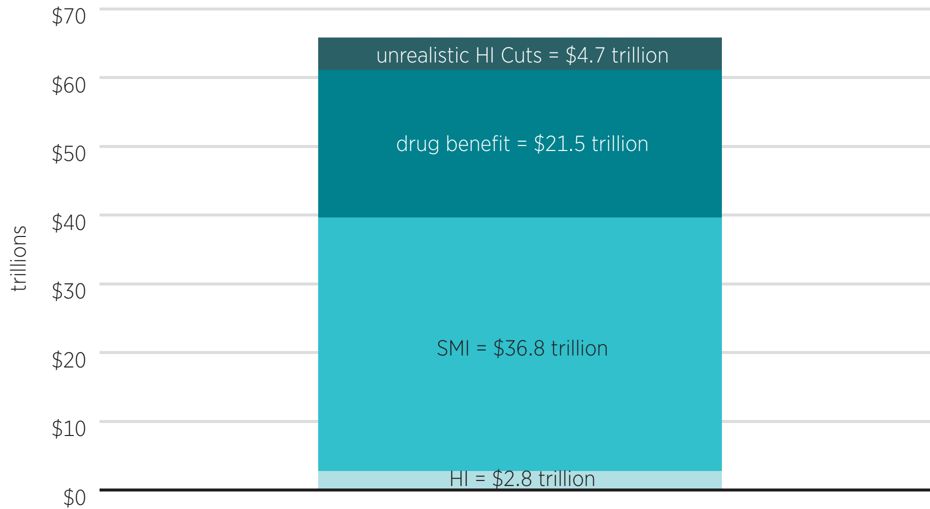
MEDICARE'S UNFUNDED LIABILITIES

Medicare was never intended to be entirely financed by dedicated taxes and premiums from beneficiaries. Still, it is useful to calculate how much program expenditures are expected to exceed resources specifically dedicated to paying its costs. The annual Medicare trustees' reports estimate that the Medicare HI trust fund has an unfunded liability of $2.8 trillion.[10] That estimate assumes that the deep cuts in hospital and other facility payments included in the Affordable Care Act will occur without interruption indefinitely

9. Juliette Cubanski, Tricia Neuman, Gretchen Jacobson, and Karen E. Smith, "Raising Medicare Premiums for Higher-Income Beneficiaries: Assessing the Implications" (Issue Brief, Henry J. Kaiser Family Foundation, Menlo Park, CA, January 2014).
10. This calculation is based on subtracting an estimate of all future spending, measured in present value terms by discounting the amounts, from an estimate of all future income, also discounted. 2016 Medicare Trustees Report, table V.G1.

FIGURE 4. MEDICARE'S UNFUNDED LIABILITIES OVER THE INFINITE TIME HORIZON



Sources: 2016 Medicare Trustees Report; "Medicare Unfunded Obligation for 2015 Trustees Report," memorandum from Suzanne Codespote, Office of the Actuary, Centers for Medicare and Medicaid Services, July 22, 2015.

into the future, which is unlikely. The actuaries therefore also make a calculation of the program's unfunded liabilities assuming these cuts are eventually moderated. Under this alternative calculation, the unfunded liability of Part A of Medicare is about $4.7 trillion higher, or $7.5 trillion.[11]

For Parts B and D of Medicare, the unfunded liabilities are essentially the cost of the program not covered by beneficiary premiums (which thus must be paid from the federal treasury). As shown in figure 4, the present value of all future general fund payments to Medicare for Parts B and D of the program will reach $58.3 trillion.

Adding this present value to the official unfunded liability of HI of $2.8 trillion, plus $4.7 trillion for removing unrealistic cuts in payment rates, results in a total unfunded liability for the Medicare program that exceeds $65 trillion.

11. The calculation of the additional unfunded liability associated with this questionable reduction in hospital spending is based on the 2015 Medicare Trustees Report projections. See Suzanne Codespote, Office of the Actuary, Centers for Medicare and Medicaid Services, "Medicare Unfunded Obligation for 2015 Trustees Report" (memorandum, July 22, 2015).

A BROAD REDESIGN CONCEPT

Rethinking how Medicare might work in the future should begin with disentangling the program's two main features.

- Medicare provides guaranteed inclusion in a nationwide, community-rated risk pool of all persons age 65 and older, plus eligible disabled workers. Medicare implicitly charges everyone in the risk pool the same premium for coverage, regardless of health status. Moreover, no one can be denied access to the pool based on a prior history of illness. Inclusion in the Medicare risk pool is thus a highly valuable benefit, irrespective of the program's tax and subsidy system.
- Medicare is also a tax-and-transfer program. In a sense, the HI program can be thought of as a social insurance program aimed at securing an annuity for health insurance coverage in retirement. Workers pay the HI payroll tax while working and, in return, get an insurance benefit that has value equivalent to a monthly insurance premium paid for by the government. While the implicit premium annuity is the same for all beneficiaries, higher-income workers pay much more in taxes to receive it.[12] Medicare also collects premiums from beneficiaries and taps into the federal treasury to pay for additional health insurance benefits for this population. Medicare's tax and spending provisions have caused the program to be in a state of near-constant financial distress.

Even if Medicare did not have its tax-and-transfer features, it would still be a highly valued program for its beneficiaries. That's because beneficiaries would know that, at age 65, they would be guaranteed access to a health insurance plan with predictable premiums based on overall costs for the entire enrolled population.

Conceptualizing Medicare in this way is useful because it immediately makes clear that a redesigned Medicare could de-emphasize its current tax-and-spending features—especially for those who could reasonably save enough to cover most of their health insurance premiums in retirement on their own—while retaining and promoting its value as a source of guaranteed, affordable health insurance in retirement and during a disability. Reworking the program in

12. The combined employer-employee Medicare payroll tax rate is 2.9 percent on covered wages for workers with incomes below $200,000 annually ($250,000 for couples filing taxes jointly). Above these income thresholds, the tax rate rises to a combined 3.8 percent. Internal Revenue Service, "Social Security and Medicare Withholding Rates," Tax Topic 751, last updated April 14, 2017.

this way would reduce the financial risks to federal taxpayers while still providing an important safety net to retirees.

The starting point for a deep and far-reaching reform of Medicare should be a vision for how the program would work after the reform is fully implemented (following a lengthy transition period). The following are the key features of a hypothetical reworked Medicare program.

A Rationalized Medicare Insurance Product

Instead of separate insurance products for hospitalization, outpatient services, and drugs, Medicare would provide to enrollees a combined insurance product covering all of these essential medical services. A single premium would cover the cost of enrolling in Medicare insurance. Further, there would be a single, unified deductible; sensible cost sharing; and catastrophic protection providing an upper limit on annual enrollee costs.

Community-Rated Premiums

Medicare should treat all enrollees equally, regardless of their health status, just as is the case today. In practice, this means that insurance premiums for enrolling in Medicare would not vary based on the age or health status of enrollees. However, premiums should vary based on the lifetime earnings of enrollees, as well as on their own choices about the kind of coverage they prefer.

A Smaller Universal Entitlement Funded Entirely by a Medicare Payroll Tax and from a Single Medicare Trust Fund

As noted previously, Medicare would remain an attractive program because of the security of the insurance it would offer. Nonetheless, to ensure maximum enrollment, the program should continue to provide a small, universal entitlement benefit to all enrollees, perhaps set to cover 20 percent or so of the value of today's benefit. According to the Congressional Budget Office (CBO), Medicare spent about $12,300 per beneficiary in 2016.[13] A benefit set at 20 percent of that amount would equal about $2,500 in today's terms. All Medicare enrollees in the future would be entitled to receive a premium subsidy of this amount (adjusted to reflect the value of the insurance plan at the time they are enrolled).

13. Congressional Budget Office, *January 2017 Medicare Baseline*, January 24, 2017.

In 2016, total Medicare spending was $699 billion, and total tax receipts (mainly payroll taxes) were $287 billion. A Medicare program that cost 20 percent of today's program would equal $140 billion. It would be possible to finance a universal entitlement at roughly 20 percent of today's benefit with a payroll tax that is set at roughly 60 percent of today's rate. However, with the US population aging, both Medicare enrollment and Medicare spending are projected to swell in coming years. By 2040, there will be 60 percent more enrollees in the program than there were in 2015. Therefore, a benefit set at 20 percent of the per-person value of Medicare under current law might require a payroll tax roughly equivalent to a combined employer-employee rate of 2.3 percent.

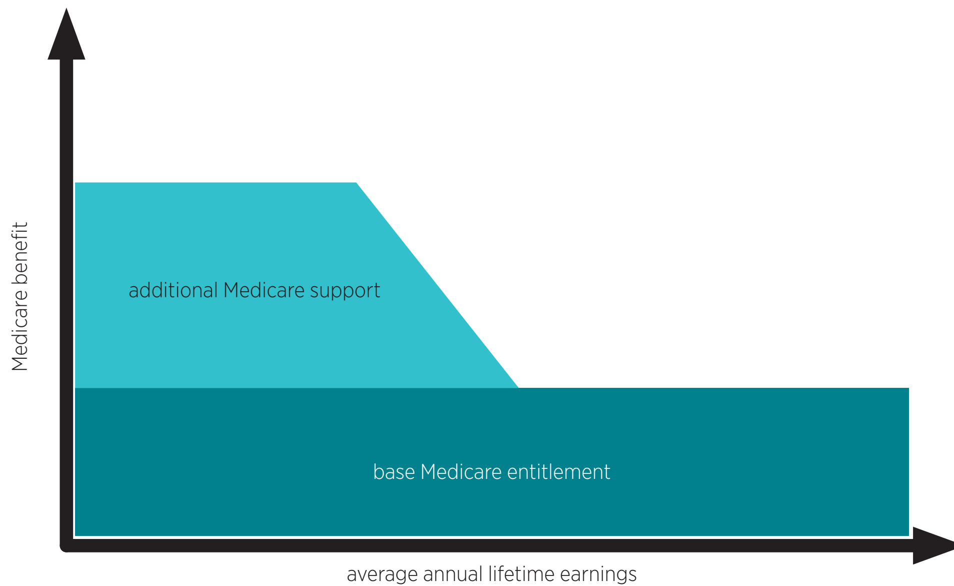
This new, universal, and smaller entitlement should be paid from a single Medicare trust fund, and the long-term financing goal should be to finance the program entirely from payroll tax collections. In other words, when fully phased in, a redesign of Medicare should seek to eliminate entirely the general fund subsidies that now dominate the program and impose an enormous financial burden on working-age Americans. Like Social Security, Medicare should provide a benefit that is self-sustaining over time with the payroll taxes dedicated to paying for it. There would be no need for two different trust funds under this kind of reform; Parts A and B could be merged together into a single Medicare trust fund.

Eligibility for this universal entitlement should also be calibrated so that as the population lives longer, program enrollment is adjusted accordingly. At a minimum, the age of eligibility for Medicare should be increase from 65 to 67 in the coming years.

Additional Financial Support Tied to Lifetime Earnings

Medicare should provide additional support to elderly and disabled individuals without the means to pay premiums on their own. This added benefit above the base level of entitlement would be calibrated to the lifetime earnings of the Medicare enrollee. Lifetime earnings is the appropriate measure because it avoids the disincentive effects and administrative complexity of measuring the actual savings and wealth of program enrollees. A means test of that nature would be intrusive and costly, and it would discourage enrollees from saving their earnings while working because of the resulting reduction in their Medicare benefits. Lifetime earnings are readily available from payroll tax records, and they can be used to assess how much a person should have been reasonably able to set aside to pay premiums for health care in retirement, regardless of the actual state of their savings and wealth.

FIGURE 5. MEDICARE'S ADDITIONAL SUPPORT TIED TO LIFETIME EARNINGS



As depicted in figure 5, the enrollees in roughly the lowest quartile of lifetime earnings would be eligible for substantial additional support, on a sliding scale. That support would then be phased out so that middle-class and upper-middle-class beneficiaries would get only the universal entitlement benefit.

The amount of support provided to enrollees with low lifetime earnings would be based on what it would cost to provide a Medicare product with low cost-sharing and a low premium. That cost could be ascertained by looking at the average actuarial cost of providing such a product through the traditional government-managed fee-for-service program, as well as through the private insurance offerings available to enrollees (called Medicare Advantage plans).

Defined Contributions and Beneficiary Choice

Medicare beneficiaries would be entitled to receive either a base level of support or, if they have relatively low lifetime earnings, a larger benefit. Either way, the benefit would be in the form of a defined contribution payment. Beneficiaries would have a number of competing options for their Medicare coverage, and they could use the defined contribution to reduce the cost of enrollment in the

plan that they find most suitable and attractive. Importantly, the level of support provided by the federal government would not vary based on choices made by the beneficiaries. Consequently, beneficiaries would be responsible for all of the additional premiums associated with more expensive options, and they would keep all of the savings associated with enrollment in the less expensive choices.

Both the base level of support and the added support for retirees with low lifetime earnings would be pegged to the average cost of a plan in the region. The traditional Medicare program, run by the federal government, would be one of the options available to beneficiaries, but there would be private plan offerings as well. The government's defined contribution payment to beneficiaries would be tied to a weighted average of the premiums charged for the various plans available (based on a standardized benefit). Those with the lowest lifetime earnings would get a defined contribution payment close to the full premium cost of the average plan. That payment would be reduced gradually, based on higher lifetime earnings, until it reached about 20 percent of the total average premium for those whose lifetime earnings placed them in the middle class or higher.

While the government's defined contribution payments would be pegged to a standard Medicare insurance plan, the private plans would be allowed to offer varying levels of deductibles and cost sharing. In particular, the private plan offerings could be in the form of high-deductible insurance (with a relatively low premium) combined with a health savings account (HSA). HSAs allow enrollees to accumulate assets tax-free for use in paying medical expenses not covered by insurance. Beneficiaries with HSAs and with defined contribution payments in excess of the premium for the plan they select could deposit the excess in their HSAs. And beneficiaries with HSA balances from their working years would be allowed to combine those accounts with a high-deductible Medicare offering.

Competition among the plans offered to beneficiaries would help to hold down overall premiums. CBO analyzed a reform plan built on defined contribution payments and consumer choice—often called "premium support"—and concluded that a reform plan that pegged the government contribution to the average cost of a plan would reduce overall costs by 4 percent compared to current law, and beneficiaries would see a 6 percent reduction in their premium costs.[14]

14. Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options*, September 2013.

Other reforms, such as modernizing the program's Medigap rules and improving management of the government-run fee-for-service option, could supplement premium support and further reduce Medicare's long-term costs.[15]

Savings for Healthcare Premiums and Costs in Retirement

This conceptual framework for Medicare is premised on the view that most (but not all) workers, with the right incentives, could and would save enough to finance their own health insurance premiums in retirement, if given the opportunity to do so. After all, most middle-class and upper-middle-class Americans pay for most of their private health insurance premiums today out of their own resources while they are working. In competitive labor markets, employer-paid premiums on behalf of workers come out of the total compensation the employers are willing to pay them. So it is the workers who are really paying for job-based health care, not the employers. Employer-paid premiums are not subject to federal income or payroll taxes, so there is an implicit subsidy of this coverage from the federal government, but it covers only about 40 percent of the cost of job-based health insurance.[16] The average employer contributed about $5,200 toward health insurance per worker in 2015, which means workers paid for about $3,100 of that premium in lower wages, in addition to the $1,200 they had to pay directly in premiums themselves. Overall, then, the average worker is already paying about $4,300 annually toward health care, and that amount grows every year with the rise in health expenses.[17]

Most middle-class and upper-middle-class workers are already paying for much of their health insurance expenses while working. Therefore, it is not unreasonable to expect that they would have the wherewithal to set aside enough resources to cover more of their health insurance premiums when they retire.

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15. For a longer discussion of these additional Medicare reforms, see Joseph Antos et al., *Improving Health and Health Care: An Agenda for Reform* (Washington, DC: American Enterprise Institute, December 2015).
16. The Office of Management and Budget estimates the tax expenditure for excluding employer-paid premiums from taxation at $339 billion in 2016. See Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2017*, February 2016, table 14-1. Employer-provided health coverage constitutes about 85 percent of private health insurance in the United States, and total private health insurance spending in 2014 was $991 billion. See Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2012* (Washington, DC: US Census Bureau, September 2013); Centers for Medicare and Medicaid Services, "National Health Expenditure Data: Historical," December 6, 2016; Gary Claxton et al., *Employer Health Benefits 2015: Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation; Chicago: Health Research & Educational Trust, 2015).
17. Claxton et al., *Employer Health Benefits 2015*.

It is not, however, necessary to mandate that these households set aside more of their income for their Medicare premiums. Doing so would only encourage them to offset this required savings by using other means of setting resources aside and building wealth. Rather, what is needed is transparent information about what they can expect to receive in Medicare benefits in retirement, and the ability to set aside resources in tax-preferred savings vehicles that could be used to pay for their Medicare premiums in retirement. Many studies have documented that the presence of the Social Security program results in a corresponding reduction in retirement savings among workers.[18] Scaling that program back would automatically encourage higher savings among middle-class and upper-middle-class workers. The same would be true with Medicare.

To accommodate additional savings for health premiums, workers would need adjustments in the allowable, tax-preferred savings vehicles. The following are two such examples.

Health savings accounts. HSAs should be a primary means by which a household sets aside resources for premium expenses in retirement. Under current law, the maximum annual contribution allowed is $6,750 for a worker with health insurance covering himself and his family, and a contribution can only be made if the health insurance has a high deductible. Moreover, HSAs are poorly integrated with Medicare today. Withdrawals are permitted for Medicare premiums, but Medicare beneficiaries are not allowed to continue making contributions to their HSA. These restrictions should be relaxed: Contributions should be permitted regardless of enrollment in a high-deductible plan; the contribution limit should be raised substantially; and contributions should be permitted for those age 65 and older.

401(k)s and IRAs. Tens of millions of workers set aside substantial amounts in tax-preferred 401k and IRA savings vehicles. The contribution limits for these accounts could also be gradually increased for cohorts of workers expected to cover more of their Medicare premium in retirement. In addition, withdrawals from these accounts for the payment of Medicare premiums could be exempt from federal taxation, thus putting these accounts on the same footing as HSAs and making them attractive vehicles for setting aside resources to finance higher premiums in retirement.

18. For a discussion of the relationship between social insurance and personal savings, see Andrew G. Biggs, "A New Vision for Social Security," *National Affairs* 16 (2013).

TRANSITION

Restructuring Medicare in such a dramatic and fundamental way cannot happen quickly. The changes recommended above represent such a sharp break from the current program that it would take many years to transition from the way the program runs today to an entirely different program design. Moreover, a gradual transition is necessary to ease the burden on the generation of workers who will be asked to finance Medicare as it exists—with its expensive subsidization from working-age Americans—even as they also must set aside enough resources to pay for more of their own premium payments when they reach retirement age. A longer transition can ease the financial burden on any one cohort of workers.

It is useful to conceptualize the Medicare reform outlined above as fundamentally a plan to substitute, in time, higher premiums from the middle and upper classes for the large general fund subsidies that taxpayers now provide to finance the cost of a large share of Medicare Part B and Part D. The end goal is a self-financing Medicare program, paid for entirely from the receipts generated by the Medicare payroll tax (perhaps with a tax rate that is modestly below today's 2.9 percent rate). At that point, there would be no general fund subsidies for Medicare burdening working-age Americans.

Viewed this way, it is possible to see how a transition from the current to the reformed program could proceed. Over time, as younger cohorts of workers began paying their Medicare payroll taxes, they would be advised of the expected premium they would owe when they became eligible for benefits in retirement. At the same time, older workers who are closer to retirement would be advised of a gradual reduction in the income thresholds used in the current program in order to establish a higher premium requirement on enrollees with incomes above the thresholds. A gradual lowering of these thresholds would also mean a gradual lowering of the required general fund subsidies necessary to keep the program afloat. After a number of years, the income thresholds used for the income-tested premiums would begin to approach the income parameters of the redesigned Medicare benefit. At that point, the program could move toward lifetime earnings as the basis for determining the required premium from beneficiaries.

As the years pass, there would be a gradual and steady increase in personal savings among younger workers in response to the expectation of a reduced Medicare benefit in retirement. At the same time, as retirees are subjected to gradually higher premiums based on their incomes, the general fund subsidy for the program would decline, thus easing the implicit tax burden on working-age households. Although there is not a direct relationship between today's general fund subsidies and the income tax burdens placed on working Americans,

a reduction in the subsidies would dramatically ease overall fiscal pressures. Certainly a tax reduction would be one possibility, thus perhaps offsetting to a degree the additional savings these households would need to set aside in order to pay for a higher proportion of their premiums in retirement.

Ultimately, there would come a time, perhaps in 30 years or so, when it would be possible to move fully to the redesigned Medicare program because both workers and those entering Medicare coverage would have fully adjusted to their expectations based on the new reality of the program's changed entitlement structure.

Other aspects of the redesigned program could proceed on a different, more accelerated schedule. It should be possible to move quickly to a unified Medicare trust fund, combining all existing financing sources and program spending into one account. That change would make the transition away from general fund subsidy of the program more transparent, and it would set the stage for moving toward a program entirely financed from payroll tax receipts.

It should also be possible to move relatively quickly toward a unified insurance product for new beneficiaries and to implement a version of the premium support model of beneficiary choice and plan competition. These changes would bring immediate program improvements and reduce costs, thus paving the way to rebalance the relative shares of the federal government and beneficiaries in terms of premium payments.

CONCLUSION

It is not possible to turn back the clock to 1965 and start over on Medicare. The program is deeply embedded in American culture, making any kind of abrupt change unlikely. But there should be no doubt that Medicare, as currently constructed, creates immense fiscal problems for the United States—problems that will need to be addressed one way or another in the coming years.

Recently, many policymakers have advanced reforms to make Medicare operate more efficiently.[19] One prominent reform plan is the premium support concept, which is described and advocated in this paper. But premium support won't be sufficient to solve Medicare's long-term fiscal challenge. The basic problem with Medicare is structural, and it goes beyond the program's overemphasis on government management of health insurance. Put simply, the program provides

19. In June 2016, House Republican leaders released a healthcare reform plan that included the recommendation to move to premium support in Medicare—along with many other recommendations. See Office of the Speaker of the House, *A Better Way: Our Vision for a Confident America*, June 22, 2016.

far too much subsidization to households that earned middle- and upper-middle-class incomes while working. Today, all working-age taxpayers are subsidizing the insurance premiums of these households, which is the primary reason the program is an immense fiscal burden.

However improbable it may be politically, it is possible to envision a different kind of Medicare structure, with less of its financing run through the federal budget but still having tangible benefits that will be attractive for all seniors. That kind of program would be more sustainable, less burdensome on workers, and less distorting of US health care.

A reform of this kind will not happen quickly. It will be necessary to provide a lengthy transition in order to allow current program enrollees to continue in the program as it is currently constituted and to give plenty of time for both younger workers and those close to retirement to make adjustments in response to gradual changes.

But after a time, it is important to move Medicare away from the current approach of fully subsidizing nearly all retirees and toward a structure that asks workers with sufficient lifetime earnings to pay for a much larger share of their healthcare premiums in retirement.

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