Medicare

A New Medicare Program. As the long-term fiscal burden of Medicare becomes more unsustainable, it is clear that – to fulfill the mission of Medicare – small and gradual changes to the program will not suffice. The entire methodology of the program must be converted away from a program that shelters beneficiaries from prices – and is therefore inefficient in restraining rising costs and proficient at sheltering prices from beneficiaries – into one in which Medicare beneficiaries choose the most affordable coverage that best suits their needs.

Just as the Medicare Program requires a new methodology, so too does its structure of financing. The Part A and Part B trust funds are combined to create one unified trust fund. The new Medicare Program and the existing program continue to be financed by trust fund revenues, Medicare payroll taxes, and general revenue contributions. The measure of solvency is converted away from one based on the unfunded liability of the Part A trust fund and into one in which the program's solvency is measured as a percentage of GDP.

Medicare Payment. For future Medicare beneficiaries who are now 55 or younger (those who first become eligible on or after 1 January 2019), the proposal creates a standard Medicare payment to be used for the purchase of private health coverage. For current beneficiaries, and those older than 55, the plan preserves the existing Medicare Program, as further described below. The payment will be made directly to the health plan designated by the beneficiary (similar to the administration of the refundable health care tax credit), with the beneficiary receiving any leftover amount as a payment from the health plan, or assuming financial responsibility for any difference in the payment and the total cost of the premium. Additionally, this allows the Medicare beneficiary to invest the leftover amount in a Medical Savings Account [MSA] to pay for other medical expenses, or to purchase long-term care insurance.

Each Medicare beneficiary becomes eligible for the payment by enrolling in a health insurance plan. Medicare will publish an annual list of plans that are "Medicare certified." Medicare enrollees are able to use their payment to pay for one of the Medicare certified plans, or any other plan, such as those offered by former employers or available from the private market.

The standard payment is $9,500 (the average amount Medicare currently spends per beneficiary), and is indexed for inflation by a blended rate of the CPI and the medical care component of the CPI. For affected beneficiaries, the payment replaces all components of the current Medicare program (Medicare fee-for-service, Medicare Part B, Medicare Advantage, and Medicare Part D). Payment amounts are risk-adjusted. They also are partially geographically adjusted, with the geographic adjustment phasing out over time.

Risk Adjustment. Medicare beneficiaries receive the standard amount – $9,500 – once they enroll for the benefit, with the flexibility to receive a positive adjustment of that amount based on a risk-assessment from their chosen health plan. Once enrolled in a plan, Medicare beneficiaries may complete initial health exams through their health insurance plan to determine whether they are eligible to receive a higher risk-adjusted

payment. The health plan must submit to the Medicare program any necessary results of the exam in order for Medicare to determine an adjusted risk-assessment.

Under the current system, Medicare frequently overpays for some services and beneficiaries and underpays for others. This reform targets support to those who truly need additional help by risk-adjusting their payments based on their health condition.

Income-Relating. The payment amount is modified based on income, in a manner similar to that for current Medicare Part B premiums subsidies. Specifically: beneficiaries with incomes below $80,000 ($160,000 for couples) receive the full standard payment amount; beneficiaries with annual incomes between $80,000 and $200,000 ($160,000 to $400,000 for couples) receive 50 percent of the standard amount; beneficiaries with incomes above $200,000 ($400,000 for couples) receive 30 percent.

Enhanced Support for Low-Income Beneficiaries. While any Medicare beneficiary, regardless of income level, is able to set up a tax-free MSA if he or she desires, the new Medicare Program establishes and funds an MSA for low-income beneficiaries. Specifically, for those who are fully "dual eligible" (eligible under current policies for both Medicare and Medicaid), and beneficiaries with incomes below 100 percent of the poverty level, the plan provides an MSA payment. Those with incomes between 100 percent and 150 percent of poverty receive 75 percent of the full deposit.

Retention of Medicare for Those Over 55. Clearly, the transition to this restructured Medicare Program must protect those at or near retirement – people who have long planned on the existing Medicare Program for their retired years. That is why the transition to the individual purchase of private health insurance applies to those eligible starting on 1 January 2019. For those eligible prior to that date (those over 55), the existing Medicare Program remains, and is strengthened with changes, such as income-relating of drug benefit premiums, to ensure its long-term sustainability.

Premiums continue to be based on an all-beneficiary average, so the phasing of the younger population into the new program will not increase premiums for the population continuing in the existing program.

The proposal also retains the Medicare payroll tax of 2.9 percent of the Federal Insurance Contributions Act [FICA] and Self-Employed Contributions Act [SECA] payroll tax, as is the case now. According to the Office of the Chief Actuary of the Centers for Medicaid and Medicare Services, this reform plan will assure the solvency of the overall Medicare Program for the long term.