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Expanding and Improving Medicare

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Medicare is a social insurance program that provides health insurance coverage. And like private health insurance, premiums are calculated by actuarial methods. The purpose of this paper is to show how Medicare can be expanded and improved without changing its administrative and funding structure.

Background
Medicare consists of four parts: Hospital Insurance for the Aged and Disabled (Part A), Supplementary Medical Insurance for the Aged and Disabled (Part B), Medicare Advantage Programs (Part C), and the Voluntary Prescription Drug Benefit Program (Part D).

Medicare has two separate trust funds. The Hospital Insurance Trust Fund (Part A) and the Supplementary Medical Insurance Trust Fund consisting of Part B and Part D accounts. The Medicare Advantage Programs (Part C) receive capitated payments for enrolled beneficiaries from the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund. The four Medicare parts, two trust funds, and administration by the Centers for Medicare & Medicaid Services are authorized by Title XVIII of the Social Security Act.

Hospital Insurance
The primary source of funding for the Hospital Insurance Trust Fund is payroll taxes. Other sources consist of Part A premiums from people who do not qualify for premium-free Part A, a portion of the dedicated income taxes paid on Social Security benefits, and interest earned on the trust fund investments. The Hospital Insurance Trust Fund does not receive funding from congressional appropriations.

Payroll taxes (aka FICA) are imposed under the Federal Insurance Contributions Act found in the Internal Revenue Code. FICA is levied on employees, employers, and self-employed for Medicare Hospital Insurance and Old-Age, Survivors, and Disability Insurance (aka Social Security). The U.S. Supreme Court ruling on the constitutionality of the Social Security Act of 1935 quotes from the Act that these payments are "annual premiums to be determined on a reserve basis in accordance with accepted actuarial principles and based upon such tables of mortality as the Secretary of the Treasury shall from time to time adopt."[1]

The Office of the Actuary at the Centers for Medicare & Medicaid Services prepares an annual report for Congress which includes short-range and long-range tests of financial adequacy for the Hospital Insurance Trust Fund. This allows Congress to close any projected funding gap by raising the Medicare portion of FICA or an equivalent mix of program cuts and contributions increases. The Medicare portion of FICA pays for Hospital Insurance benefits for individuals having at least 40 quarters of covered employment. Individuals not meeting this requirement must pay an insurance premium while receiving Part A benefits. The premium is set each year by the Office of the Actuary. The premium rate is calculated by projecting the number of Part A enrollees without 40 quarters of covered employment along with the benefits and administrative costs that will be incurred on their behalf.

Supplementary Medical Insurance Trust Fund

An annual budget request is sent to Congress in the "Justification of Estimates for Appropriations Committees" report.[2] Part B and Part D accounts of the Supplementary Medical Insurance Trust Fund receive funding from beneficiary premiums and general revenue. The Office of the Actuary sets the actuarial income-related premium rate for Part B and Part D at levels that cover approximately 25 percent of estimated benefits and related administrative costs. Congressional mandatory appropriations from general revenues pay the remaining 75 percent.[3] Both accounts remain in financial balance for all future years because beneficiary premiums and general revenue transfers are annually set at a level to meet expected costs for the following year.

Medicare Administration

The Centers for Medicare & Medicaid Services has ten regional offices. The regional field staff work closely with beneficiaries, health care providers, state governments, Medicare contractors, community groups and others to provide education and address questions. The regional offices put into practice the protective regulations, policy and program guidance developed in the central office.

The fee-for-service claims are sent to Medicare and processed by a Medicare Administrative Contractor (MAC). There are 12 A/B MACs with a defined geographic area that process Part A and Part B claims for institutional providers, physicians, practitioners, and suppliers. Four A/B MACs also process home health and hospice claims in addition to their typical Medicare Part A and Part B claims. There are four DME MACs, each with a defined geographic area that processes Medicare durable medical equipment, orthotics, and prosthetics claims.

The Centers for Medicare & Medicaid Services pays a monthly capitation rate to Part C Medicare Advantage plans and Part D prescription drug plans. In addition to the fee-for-service and capitation payment models, the Medicare & Medicaid Innovation Center is developing and testing innovative health care payment and service delivery models including global budgeting.

The Centers for Medicare & Medicaid Services relies on quality improvement organizations to improve the quality of health care for all Medicare beneficiaries. These organizations are composed of a group of health quality experts, clinicians, and consumers whose mission is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

The Centers for Medicare & Medicaid Services has contractors that perform specific functions. These contractors include fee-for-service recovery auditors and contractors who combat fraud, waste and abuse. Other contractors monitor the accuracy of claim payments in the fee-for-service program. A/B MACs and DME MACs are responsible for handling redeterminations, the first level of appeals for a fee-for-service claim. The first level of appeals in a Medicare Advantage plan claim is reconsideration by the plan. The second level of appeals is conducted by Medicare appeals contractors.

Expanding and Improving Medicare

Using the current Medicare law, expanding Medicare clearly means extending coverage to those under 65 years of age and eliminating the medical assistance programs in Medicaid. Improving Medicare means eliminating Medicare supplement plans and limiting cost sharing.

The new under age 65 coverage is funded by beneficiary premiums and appropriations from general revenue. Instead of the Affordable Care Act premium tax credits, sliding scale premium rates are based on the poverty level of each taxpayer. The full premium is paid if the taxpayer's modified adjusted gross income is above a set federal poverty level. The premiums are collected as an earmarked income tax under the Internal Revenue Code and reconciled on the U.S. Individual Income Tax Return. In the Social Security Act of 1935, the worker's portion of Social Security is collected as an income tax. The amount collected is not deducted from the taxpayer's income.[4]

The current Hospital Insurance Trust Fund (Part A) and the Supplementary Medical Insurance Trust Fund with medical services (Part B) and prescription drug coverage (Part D) accounts are kept separate from a new trust fund for those under 65 years of age. The new trust fund is composed of hospital, medical services, and prescription drug coverage accounts.

Hospital stays and medical services in all three trust funds are provided without copays, deductibles, and coinsurance. Outpatient prescription drug coverage for all Medicare beneficiaries is provided with nominal copays and coinsurance only for those who choose more expensive drugs over their generic equivalents. Beneficiary premiums and appropriations are set to cover these costs.

Changes to Federal and State Revenue

Expanding Medicare increases individual income tax revenue and FICA for the Social Security and Medicare Hospital Insurance trust funds. It also eliminates spending on government subsidized health coverage programs.

Based on fiscal year 2017 data, the increase in federal revenue due to the elimination of federal tax allowances for work-related health coverage is about $284 billion. Included are the small business health care tax credits of $1B and the self-employed income tax deduction for health insurance of $7B. Health insurance coverage for workers that is paid by the employer is currently treated as non-taxable wages. Employee contributions to a cafeteria plan or various health plans are also excluded from taxation. Removing these tax exclusions results in additional federal income tax revenue and FICA of $279B.[5] Utilizing the average effective federal tax rates, the $279B can be separated into individual income taxes of $163B and FICA of $116B.[6] The

removed tax allowances are offset by the Affordable Care Act penalty payments of $3B for those who fail to acquire health insurance coverage.[5] These estimated amounts apply only if people do not adjust their behavior to reduce the new tax liability created by these changes.

Federal spending in 2017 for Medicaid medical assistance programs for people under age 65 and the Children's Health Insurance Program is estimated to be $296B. The Affordable Care Act premium tax credits, cost-sharing reduction subsidies, spending and revenues related to risk adjustment and reinsurance, and the Basic Health Program payments total $45B.[5]

State funding for Medicaid medical assistance programs for people under age 65 and the Children's Health Insurance Program is roughly $148B.[5] The states paid $17B for Medicare Part A and Part B insurance premiums for those who qualify for both Medicare & Medicaid.[7] The states also made Part D transfers of $10B to Medicare.[3] Federal law requires that state Medicaid programs make Disproportionate Share Hospital payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. The states paid $9B and the Federal Government paid $12B for this program.[8]

In summary, federal general revenue is increased by $494B. The Social Security Trust Fund and Medicare Hospital Trust Fund have a combined increase of $116B. The states see an increase in general revenue of $184B. See Exhibit 1. Note: The states with an income tax have an even larger increase in revenue due to the increase in adjusted gross income.

Exhibit 1

Revenue Changes (Billions of Dollars)

	Federal General Revenue	**SS/HI Trust Fund**	**State General Revenue**
Elimination of Federal Tax Allowance for Work-Related Coverage			
Federal Income Tax	163		
FICA		116	
Self-Employment Tax Deduction	7		
Small Business Tax Credits	1		
Federal Spending			
Medicaid/CHIP	296		148
ACA	45		
Transfer from States			
Part A / Part B	(17)		17
Part D	(10)		10
Disproportionate Share Hospital	12		9
Coverage Penalties	(3)		
TOTAL	**494**	**116**	**184**

Discussion and Conclusion

Expanding and improving Medicare as a social health insurance program creates equity in the finance and delivery of health care. The current Medicare law is expanded to include those under 65 years of age. It is improved and made more efficient by incorporating health insurance cost sharing as part of the beneficiary premiums which are based on income and family size.

Extending coverage to those under age 65 requires a new trust fund consisting of hospital, medical services, and prescription drug coverage accounts. The new trust fund accounts become part of the annual budget request sent to Congress in the "Justification of Estimates for Appropriations Committees" report. The Office of the Actuary sets a single sliding scale premium rate based on the poverty level of each family by combining the premium rates of the three accounts. The full premium is paid if the taxpayer's modified adjusted gross income is above a set federal poverty level.

The new trust fund accounts remain in financial balance for all future years because beneficiary premiums and general revenue transfers are annually set at a level to meet expected costs for the following year. The premium is collected as an earmarked income tax under the Internal Revenue Code and reconciled on the U.S. Individual Income Tax Return.

Medicare currently provides reinsurance to Part D plan sponsors in addition to capitation payments. Most Part D plans change their premiums, deductibles, copays, the drugs they cover and whether they offer any coverage in the doughnut hole on a yearly basis. This is wasteful complexity for both the Federal Government and Medicare beneficiaries. Part D is improved by Medicare becoming the sole provider of outpatient prescription drug coverage with nominal copays and coinsurance only for those who choose more expensive drugs over their generic equivalents. And by eliminating Medicare supplement plans and Medicaid medical assistance programs, hospital stays and medical services are covered with no deductions, copays, and coinsurance for all Medicare beneficiaries.

With the expansion of Medicare, federal general revenue increases by $494B. The Social Security Trust Fund and Medicare Hospital Trust Fund have a combined revenue increase of $116B. The new federal general revenue and the FICA Medicare contributions for hospital insurance can help pay for the expansion and improvement of Medicare. In addition, the new FICA Social Security contributions increase the Social Security fund.

The states see an increase in general revenue of $184B. States that have an income tax have an even larger increase in revenue due to the increase in adjusted gross income. The increase helps pay for the state portion of Medicaid long-term services and supports needs of those with low-income and other state budgetary items.

ENDNOTES

1. Helvering v. Davis, 301 U.S. 619 (1937).

2. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2019, https://www.cms.gov/About-CMS/Agency-information/PerformanceBudget/Downloads/FY2019-CJ-Final.pdf.

3. Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, July 13, 2017, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf.

4. Social Security Act of 1935, https://www.ssa.gov/history/35act.html.

5. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 To 2026*, March 2016, https://www.cbo.gov/publication/53091.

6. The Urban-Brookings Tax Policy Center, Tax Policy Center Model Estimates, *T17-0041 - Average Effective Federal Tax Rates - All Tax Units, By Expanded Cash Income Level,* March 17, 2017, https://www.taxpolicycenter.org/model-estimates/baseline-average-effective-tax-rates-march-2017/t17-0041-average-effective-federal.

7. The Henry J. Kaiser Family Foundation (KFF), Distribution of Medicaid Spending by Service, Timeframe: FY 2016, https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/?currentTimeframe=0&selectedDistributions=payments-to-medicare&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

8. The Medicare Payment Advisory Commission (MedPAC), Medicaid DSH Allotments: How Could Funding for Safety-Net Hospitals Change in 2018?, Issue Brief June 2017, https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-DSH-Allotments-How-Could-Funding-for-Safety-Net-Hospitals-Change-in-2018.pdf.