

THE SOCIAL SECURITY AND MEDICARE PROGRAMS: ISSUES AND POSSIBLE SOLUTIONS

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PREFACE

This paper examines financial and other issues facing the Social Security and Medicare programs. It discusses a wide range of options that have been proposed by numerous organizations across the political spectrum to resolve the issues. An evaluation of the proposals is not included, but an estimate of the financial impact is provided when available.

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SUMMARY

The Social Security and Medicare programs are the nation's largest contributory entitlement programs, each primarily benefitting those of retirement age and those with disabilities. Social Security and Medicare together accounted for 41 percent of federal program expenditures in fiscal year 2015. Each program largely is supported through two trust funds.

Depletion of each of Social Security's trust funds is projected in less than two decades, by 2034 (or earlier) for the two trust funds combined. At that time, income is projected to be sufficient to pay 79 percent of the scheduled Social Security benefits. This share is expected to drop to 74 percent in 2090.

One of Medicare's trust funds also is facing a negative balance — by 2028. At that time, dedicated revenues are predicted to be sufficient to pay 87 percent of the costs. This share is expected to decline gradually to 79 percent in 2043, then to rise slowly to 86 percent in 2090.

The deterioration in the finances of Social Security are largely due to two demographic factors: lengthening life expectancy and the large number of people in the baby-boom generation becoming eligible for benefits. These demographic factors also have greatly affected Medicare's finances, but Medicare also has been impacted by rapidly rising health care costs per beneficiary.

Without congressional action, those who have paid into the Social Security and Medicare trust funds through payroll taxes will receive lesser benefits than scheduled. For example, a 21 percent drop in the size of the monthly Social Security check would have to occur in less than two decades.

A number of options are available to resolve the financial imbalances. Delays in taking action will reduce the number of options and reduce the time period during which modifications can be phased in. Earlier action will also help minimize adverse impacts on vulnerable populations, including lower-income workers and people already dependent on program benefits.

For the Social Security program, achieving a long-term balance in program finances will require revenue enhancements and/or benefit reductions. If action is taken soon, benefit reductions can be limited to those who are still some years away from becoming eligible for benefits. For the Medicare program, changes to revenues and benefits also are part of the mix of possible solutions to achieving long-term solvency; various means of reducing costs also are possibilities.

A number of options to resolve the financial difficulties are presented in this paper. Most of the options are designed to modify the programs while maintaining their basic characteristics; a few options would fundamentally change these programs. An evaluation of the options is not within the scope of this paper.

BACKGROUND

The federal government offers a number of “entitlement” programs. These programs consist of two types:

- Noncontributory: Fourteen federal programs fall into this category, including Medicaid and Supplemental Social Security.
- Contributory: Social Security and Medicare are programs in which individuals who have contributed to the programs through the payment of payroll taxes are eligible for benefits.

This paper focuses on Social Security and Medicare, particularly on the trust funds that support these programs.

Social Security

The Social Security program provides workers who have paid into the system through the payroll tax with retirement, disability, and survivors insurance benefits. The law authorizing Social Security was passed in 1935; the first benefit check was issued in 1940.

Revenue

Eighty-five percent of the funding for Social Security benefits in 2015 came from payroll taxes paid by workers and employers. Workers and employers contribute equal amounts; a self-employed individual pays twice the rate of a wage and salary worker. Interest earnings accounted for 10 percent of the income in 2015. A third source of income for Social Security is the income taxes paid on Social Security benefits, which accounted for 3 percent of the Social Security income in 2015.

Social Security revenue is deposited into two trust funds:

- Old Age and Survivors Insurance (OASI) Trust Fund. The current payroll tax rate is 5.015 percent for employees and employers. This rate is applied to a maximum taxable earnings figure of \$127,200 in 2017 (\$118,500 in 2016).
- Disability Insurance (DI) Trust Fund. The current payroll tax rate is 1.185 percent for employees and employers, with the same maximum taxable earnings figure as OASI.

While legally separate entities, the two Social Security trust funds often are combined to summarize the finances of the Social Security program (OASDI). The combined payroll tax rate is 6.2 percent for employees and employers (see Table 1). The original tax rate in 1937 was 1.0 percent for employees and employers. The rate was increased multiple times over the next five decades, but has not been increased since 1990.

From 1937 to 1975, Congress increased the maximum taxable earnings figure on an ad-hoc basis, rising from \$3,000 in 1937 to \$14,100 in 1975. Increases were made to improve system financing and to reflect increases in the average wage due to inflation and productivity gains. Since 1975, the maximum taxable earnings figure has generally increased annually at the same rate as the average wage. (The large increase in 2017, coupled with no change in 2016, reflects the gain in the average wage between 2013 and 2015.)

Approximately 169 million workers paid payroll taxes in 2015. The change in the number of covered workers subject to the payroll tax varies with the economic cycle but the increase frequently has exceeded 2 million per year. Since 2012, the per year increase has been at least 2

**TABLE 1
PAYROLL TAX RATES IN 2016**

	OASI*	DI*	OASDI*	HI	Total
Employees	5.015%	1.185%	6.20%	1.45%**	7.65%
Employers	5.015	1.185	6.20	1.45	7.65
Total	10.030	2.370	12.40	2.90	15.30

* These taxes are applied only up to a maximum earnings figure (\$118,500 in 2016; this figure is adjusted annually).

** An additional 0.9 percent is levied on individual earnings exceeding \$200,000 and joint return tax filers with earnings exceeding \$250,000. These dollar figures are not indexed for inflation.

Source: "A Summary of the 2016 Annual Social Security and Medicare Trust Fund Reports," Social Security and Medicare Boards of Trustees, <https://www.ssa.gov/oact/trsum/>.

million; this is expected to continue through 2019. After 2022, however, the increase in the number of covered workers is expected to be much lower at less than 1,200,000 in every year through 2090, including less than 700,000 per year from 2029 through 2033. The number of covered workers is predicted to be 197 million in 2040 and 250 million in 2090.

Those Social Security beneficiaries with modified adjusted gross income¹ of less than \$25,000 (single filer) or less than \$32,000 (married couples filing jointly) do not pay any tax on Social Security benefits. Beneficiaries with incomes from \$25,000 to \$34,000 (individuals) or \$32,000 to \$44,000 (married couples filing jointly) pay the lesser of 50 percent of their benefit income or modified AGI in excess of \$25,000 (single filer) or \$32,000 (married couples filing jointly). Beneficiaries with incomes of more than \$34,000 (individuals) or more than \$44,000 (married couples filing jointly) pay the lesser of 85 percent of their benefit income or modified AGI in excess of \$34,000 (single filer) or \$44,000 (married couples filing jointly).

Benefits

In 2016, 60.9 million people received some form of benefit from the Social Security program. The annual change in the total number of OASDI beneficiaries has varied significantly over time. Since 2009, the annual change has been at least 1 million. The annual change is predicted to continue to exceed 1 million through 2033, reaching as high as 1.9 million. It is then projected to drop sharply, to less than 500,000 in each year from 2040 through 2050. After 2050, the change in number is projected to vary from 500,000 to 850,000 per year. The number of OASDI beneficiaries is predicted to be 92 million in 2040 and 125 million in 2090.

OASI benefits were received by 50.3 million people in 2016: 44.3 million retirees and dependents and 6.0 million survivors. From 1971 through 1981, the number of retired and dependent enrollees rose by an average of 660,000 per year. The rate of growth slowed over the next decade and averaged 300,000 per year from 1994 through 2003. The number of retired and dependent enrollees increased sharply over the next several years and has averaged more than 1.1 million per year since 2009. In contrast, the number of survivors receiving benefits has

¹ Modified AGI is AGI plus nontaxable interest income plus income from foreign sources plus one-half of Social Security benefits.

declined in each year since 1996. The number of OASI beneficiaries is predicted to be 79 million in 2040 and 107 million in 2090.

There was a rapid increase in the number of disabled enrollees from 1990 through 2013, with the number reaching 11.0 million in 2013. It dropped to 10.6 million in 2016. The number is expected to begin to rise again in the near term, reaching nearly 13 million in 2040 and 18 million by 2090.

The amount of the Social Security benefit depends on the earnings record of an individual and the age at which the individual starts to collect benefits. In order to qualify for Social Security benefits, an individual has to have earned at least 40 credits. Before 1978, a credit was earned for each calendar quarter in which an individual earned at least \$50. Since 1978, a credit is earned for each \$x of earnings during a calendar year (with x rising to \$1,260 in 2016), up to a maximum of four credits in a calendar year.

For those born before 1938, the normal retirement age (NRA) was 65. The NRA gradually increases for those born between 1938 and 1960, reaching 67 for those born after 1959. The earliest that an individual can receive a retirement benefit is age 62 (early eligibility age: EEA), but the monthly benefit is reduced for those who retire before normal retirement age. The reduction is as much as 30 percent for those whose NRA is 67 but elect to start drawing benefits at age 62. If an individual waits until after the NRA to begin drawing benefits, the benefit payment rises 8 percent per year, but everyone must start to receive benefits at age 70.

The size of the benefit payment — the “primary insurance amount” (PIA) — at normal retirement age is based on the average earnings of the highest 35 years of an individual’s earnings. The amount in each year is indexed — adjusted — for the change in the average wage since then. If an individual worked for fewer than 35 years, the calculation includes a zero for each year not worked. The annual average is converted to the “average indexed monthly earnings” (AIME). The PIA is the sum of: (a) 90 percent of the first \$885 of the AIME, plus (b) 32 percent of the AIME over \$885 and through \$5,336, plus (c) 15 percent of the AIME over \$5,336. The dollar amounts at which the shares change are known as the “bend points.”

Medicare

Medicare is a single-payer social insurance program that uses private insurance companies that are under contract to the federal government. The Medicare program, which began in 1966, is administered by the Centers for Medicare and Medicaid Services (CMS). Medicare provides health insurance for Americans aged 65 and older. It also provides health insurance to younger people with disabilities or terminal illnesses. Those with disabilities become eligible for Medicare 24 months after qualifying for Social Security’s disability insurance; 15 percent of Medicare enrollees are younger than 65.

Medicare has various parts:

- Part A (hospital insurance) helps pay for hospital stays, home health services following hospital stays, skilled nursing facilities, and hospice care. If an individual or their spouse paid Medicare taxes for at least 10 years, no premium is charged for Part A. Those 65 and

older who are citizens or permanent residents and are not eligible for premium-free Part A can elect to pay a premium to enroll; these individuals also must be enrolled in Part B.

- Part B (medical insurance) helps pay for physicians, outpatient hospital services, home health services, and other services for the aged and disabled. It is a voluntary program in which all participants must pay a monthly premium.
- Part D provides subsidized access to drug insurance coverage. Anyone eligible for Part A or enrolled in Part B may enroll in Part D. All participants pay a premium.

Parts A and B are considered traditional, fee-for-service Medicare, in which the federal government pays directly for each covered medical service used. Alternatively, a participant who is enrolled in both Parts A and B can choose to enroll in the Medicare Advantage (MA) program (Part C). In Medicare Advantage, beneficiaries enroll in a private health plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO), and receive all Medicare-covered Part A and Part B benefits and typically Part D benefits. Additional benefits may also be offered. Unlike traditional Medicare, those enrolled in MA have a maximum out-of-pocket limit. The insurer receives a set annual amount from the government for each enrollee.

Revenue

Like Social Security, the Medicare program has two trust funds. However, just one of these funds receives revenue from payroll taxes.

Hospital Insurance (HI) Trust Fund. This fund pays for Medicare Part A. Revenue comes primarily (87.5 percent in 2015) from the payroll tax. The current rate is 1.45 percent, paid both by employers and by employees. Unlike Social Security, the tax is applied to all earnings. Self-employed individuals pay 2.9 percent. Beginning in 2013, individuals with income greater than \$200,000 (\$250,000 for married couples) pay a higher tax rate of 2.35 percent. The employer is not subject to this additional 0.9 percent tax. The \$200,000/\$250,000 limit is not indexed for inflation or wage growth.

The HI payroll tax rate initially — in 1966 — was 0.35 percent, but it quickly rose to 0.6 percent in 1968. It was increased several more times through 1986, but has not been modified since then. Initially, taxable earnings were subject to the same cap as Social Security. The cap for Medicare was raised relative to the Social Security cap from 1991 through 1993 and was eliminated in 1994.

Other sources of revenue for the trust fund include income taxes paid on Social Security benefits (7 percent of total revenue in 2015), interest earned on the trust fund investments (3 percent), and Medicare Part A premiums from people who are not eligible for premium-free Part A.

Most beneficiaries do not pay a premium for Part A, but are subject to a deductible (\$1,316 in 2017). For hospital stays exceeding 60 days, a substantial copayment is charged.

Supplementary Medical Insurance (SMI) Trust Fund. Medicare Parts B and D are covered by this trust fund. The SMI is not funded from payroll taxes. Instead, the funding largely comes from general revenue of the federal government (about 75 percent of the total) and premiums paid by enrollees of the Medicare program. A small amount of funding comes from special

payments by states and from fees on manufacturers and importers of brand-name prescription drugs.

Part B covers 80 percent of the health provider charges after the enrollee pays a small deductible (\$183 in 2017). The standard monthly premium for Part B is \$134 in 2017 for individuals earning less than \$85,000 and joint filers earning less than \$170,000. The monthly premium rises with income to \$428.60 for individuals earning more than \$214,000 (\$428,000 for joint filers). The Part D premium varies by the plan selected by enrollees, with the base monthly amount of \$35.63 in 2017. As in Part B, those with higher incomes pay additional amounts, up to \$76.20 per month.

Benefits

The number enrolled in Medicare — in the HI program and/or the SMI program — was 55.3 million in 2015. Nine million were disabled and 46.3 million were “aged” (age 65 and older). The number of Medicare enrollees in 2015 was 8 percent less than the number of Social Security beneficiaries. The differentials were 6 percent for those 65 and older and 17 percent for those disabled. Before 1980, the number of Medicare beneficiaries was less than 80 percent of the number of Social Security beneficiaries, but the share has gradually increased over time. Enrollment in Medicare has followed the same general trends discussed earlier for Social Security.

The number enrolled varies across the various parts of Medicare. In 2015, 54.9 million were enrolled in Part A, of which 46.0 million were age 65 and older. Enrollment in Part B was 50.7 million, of which 42.5 million were age 65 and older. Part D enrollment was 41.8 million. The average benefit in 2015 was \$12,559 overall: \$4,978 in Part A, \$5,441 in Part B, and \$2,141 in Part D.

Part C enrollment — which is dependent on enrollment in Parts A and B — was 17.5 million in 2015. Enrollment in Medicare Advantage plans has grown disproportionately over time.

Most enrollees in traditional Medicare have Medicare supplemental insurance independent from Medicare to help cover the charges not covered by Medicare. Some enrollees are covered by former employers; others purchase coverage directly from private insurance companies (“Medigap” coverage). The Medigap policies are standardized by law to provide identical benefits. Prescription drugs are not included in Medigap policies; additional insurance can be purchased for drugs.

According to a 2016 report that cited 2012 data,² 14 percent of Medicare beneficiaries had traditional Medicare only, 25 percent had employer-sponsored health plans, 17 percent had purchased a Medigap plan, 12 percent also qualified for Medicaid, and 33 percent had enrolled in Medicare Advantage. It is illegal to have both a Medigap policy and Medicare Advantage.

² Medicare Payment Advisory Commission, <http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-3-medicare-beneficiary-and-other-payer-financial-liability.pdf?sfvrsn=0>.

Trust Fund Finances in 2015

The four trust funds are summarized in Table 2. Costs exceeded income in the DI and HI funds. If interest earnings (see Table 3) were excluded from the OASI income, the reserve balance would have experienced a decrease of \$40 billion instead of an increase of \$51 billion. Excluding interest income, the two Social Security funds had an annual deficit of \$70 billion. In each fund, benefit payments represent more than 97.5 percent of the total costs (see Table 4).

**TABLE 2
TRUST FUND OPERATIONS IN 2015, IN BILLIONS**

	OASI	DI	HI	SMI
Income During 2015	\$801.6	\$118.6	\$275.4	\$369.1
Cost During 2015	750.5	146.6	278.9	368.8
Net Change in Reserves	51.0	-28.0	-3.5	0.3
Reserve Balance at the End of 2015	2,780.3	32.3	193.8	69.5

Source: "A Summary of the 2016 Annual Social Security and Medicare Trust Fund Reports," Social Security and Medicare Boards of Trustees, <https://www.ssa.gov/oact/trsum/>.

**TABLE 3
PROGRAM INCOME IN 2015, IN BILLIONS**

	OASI	DI	HI	SMI
Payroll Taxes	\$679.5	\$115.4	\$241.1	-
Taxes on OASDI Benefits	30.6	1.1	20.2	-
Interest Earnings	91.2	2.1	8.2	\$2.3
General Fund Reimbursement	0.3	0.0	1.0	1.6
General Revenue	-	-	-	270.7
Beneficiary Premiums	-	-	3.2	82.2
Transfers From States	-	-	-	8.9
Other	0.0	-	1.6	3.4
Total	801.6	118.6	275.4	369.1

Source: "A Summary of the 2016 Annual Social Security and Medicare Trust Fund Reports," Social Security and Medicare Boards of Trustees, <https://www.ssa.gov/oact/trsum/>.

**TABLE 4
PROGRAM COST IN 2015, IN BILLIONS**

	OASI	DI	HI	SMI
Benefit Payments	\$742.9	\$143.4	\$273.4	\$365.3
Railroad Retirement Interchange	4.3	0.4	-	-
Administrative Expenses	3.4	2.8	5.5	3.5
Total	750.5	146.6	278.9	368.8

Source: "A Summary of the 2016 Annual Social Security and Medicare Trust Fund Reports," Social Security and Medicare Boards of Trustees, <https://www.ssa.gov/oact/trsum/>.

FINANCIAL ISSUES

The Social Security and Medicare Boards of Trustees annually report on the status of the Social Security and Medicare programs.³ The reports include a 75-year forecast, with the 2016 reports including projections through 2090. Projections are made under each of three sets of assumptions, labeled as low cost, intermediate, and high cost. The intermediate assumptions are used in the Trustees’ summary report. The projections depend on numerous demographic, economic, and program-specific assumptions.

These annual reports from the Boards of Trustees are the primary source of information used in this section. The Congressional Budget Office (CBO) also makes 75-year projections of the Social Security system.⁴ Their projections are compared to those of the Trustees in this section.

Social Security and Medicare together accounted for 41 percent of federal program expenditures in fiscal year 2015.⁵ Each program faces financing shortfalls under currently scheduled benefits and financing (see Table 5). Social Security and Medicare each will experience cost growth substantially in excess of gross domestic product (GDP) growth through the mid-2030s. After the mid-2030s, the situation nearly stabilizes, as projected costs as a share of GDP are nearly flat for Social Security and rise only slowly for Medicare.

Two demographic factors are largely responsible for the deterioration in the finances of the two Social Security trust funds and are major contributors to the financial issues with the HI trust fund. First, life expectancy has increased since the programs began; it is predicted to continue to rise through the 21st century. Chart 1 displays life expectancy by sex at age 65: the number of years on average that a beneficiary of Social Security and Medicare would draw benefits based on the original normal retirement age. Between 1940 and 2015, life expectancy at age 65 rose by 6.2 years for males and 7.2 years for females, each an increase of more than 50 percent. In contrast, the NRA has been increased by only 2 years. Between 1965, when Medicare was

**TABLE 5
KEY DATES FOR THE TRUST FUNDS**

	OASI	DI	OASDI	HI
Year That Costs Exceed Income Excluding Interest	2010	2019	2010	2015
Year That Costs Exceed Total Income	2022	2019	2020	2021
Year the Trust Fund is Depleted	2035	2023	2034	2028

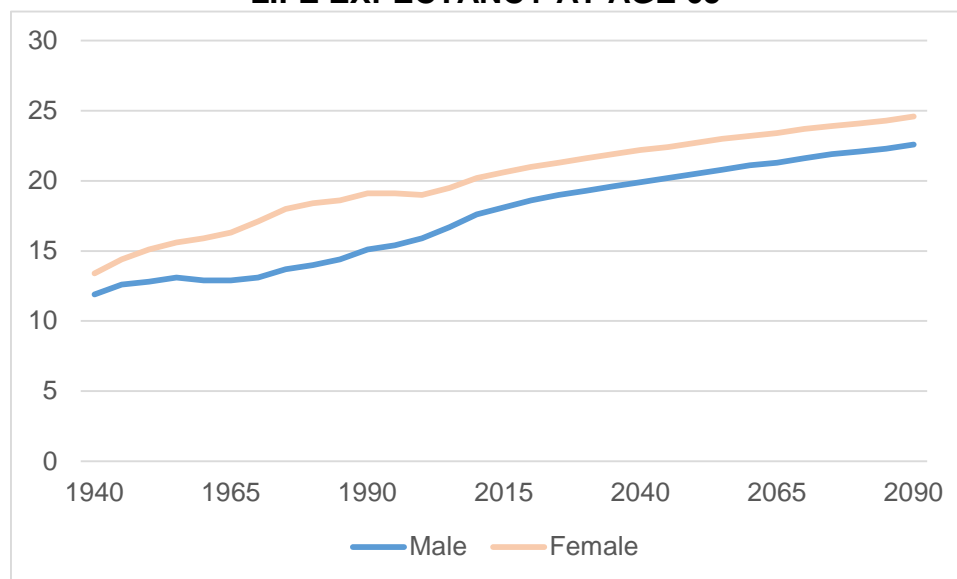
Source: “A Summary of the 2016 Annual Social Security and Medicare Trust Fund Reports,” Social Security and Medicare Boards of Trustees, <https://www.ssa.gov/oact/trsum/>.

³ Each Board issues a lengthy report. A combined summary report also is prepared: *A Summary of the 2016 Annual Social Security and Medicare Trust Fund Reports*, Social Security and Medicare Boards of Trustees, <https://www.ssa.gov/oact/trsum/>.

⁴ For a comparison of the CBO projections to those of the Social Security Board of Trustees, see Congressional Budget Office, *Testimony on Comparing CBO’s Long-Term Projections With Those of the Social Security Trustees*, September 21, 2016, <https://www.cbo.gov/publication/51988>.

⁵ The federal government’s fiscal year runs from October 1 through September 30. Fiscal year 2015 ended on September 30, 2015. Subsequent references to years refer to the federal fiscal year.

**CHART 1
LIFE EXPECTANCY AT AGE 65***



* The projections are based on the intermediate set of assumptions.

Source: 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 2016, <https://www.ssa.gov/oact/tr/2016/index.html>.

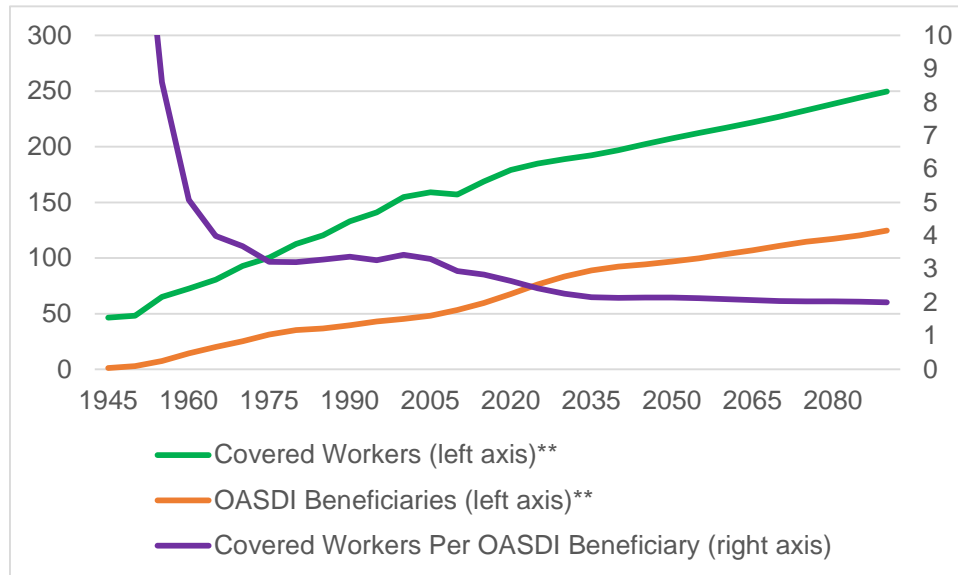
passed by Congress, and 2015, life expectancy at age 65 rose by 5.2 years for males and 4.3 years for females.

Second, the large baby-boom generation is becoming eligible for Social Security and Medicare benefits. The succeeding baby-bust generation is smaller in number. Thus, the number of workers paying into the programs has begun to fall relative to the number of beneficiaries; this ratio had been nearly stable from the mid-1970s through 2007 (see the purple line in Chart 2). The number of covered workers per OASDI beneficiary is expected to fall further, particularly through the mid-2030s. A similar decline is projected in the number of covered workers per Medicare HI enrollee. In 2015, enrollment in Medicare part A was 92.3 percent of the OASDI number; the ratio is projected to rise to 96.5 percent by 2090.

In addition to the demographic factors, Medicare has experienced increases in expenditures per beneficiary in excess of the inflation rate and in excess of per capita GDP growth, as seen in Chart 3.⁶ Costs per beneficiary increased rapidly both on an inflation-adjusted basis and relative to per capita GDP from 1970 through 2005. These cost increases slowed substantially in recent years, with gains not much different from the overall inflation rate from 2009 through 2015 and less than the gain in per capita GDP (see Chart 4). However, costs per beneficiary are projected

⁶ The projected cost increases are based on current-law benefits and do not consider whether the trust funds will have sufficient resources to meet these obligations. By law, the trust funds cannot borrow money or pay benefits in excess of annual income and trust fund reserves.

**CHART 2
NUMBER OF COVERED WORKERS AND
NUMBER OF SOCIAL SECURITY BENEFICIARIES***



* The projections are based on the intermediate set of assumptions.

** Number in millions.

Source: 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 2016, <https://www.ssa.gov/oact/tr/2016/index.html>.

to again rise in excess of the overall inflation rate and the rate of growth in per capita GDP after 2017.

Social Security Old-Age and Survivors Insurance Trust Fund

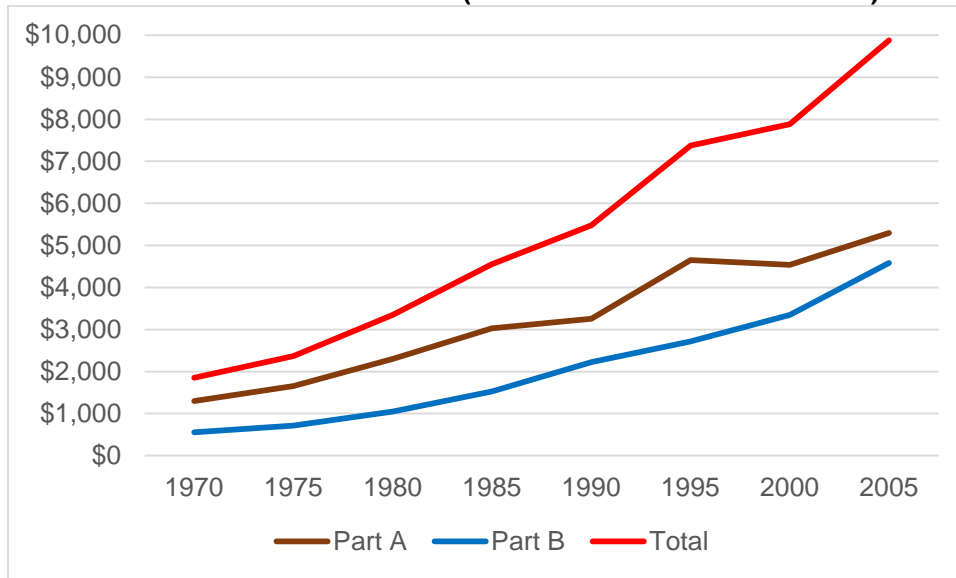
Excluding interest income, OASI costs began to exceed income in 2010. Including interest income, an annual deficit is projected to begin in 2022. Because of this deficit, the reserves will be drawn down, with depletion expected in 2035. At that time, income would be sufficient to pay 77 percent of the scheduled benefits. The projected 75-year actuarial deficit is 2.39 percent of taxable payroll.⁷

Social Security Disability Insurance Trust Fund

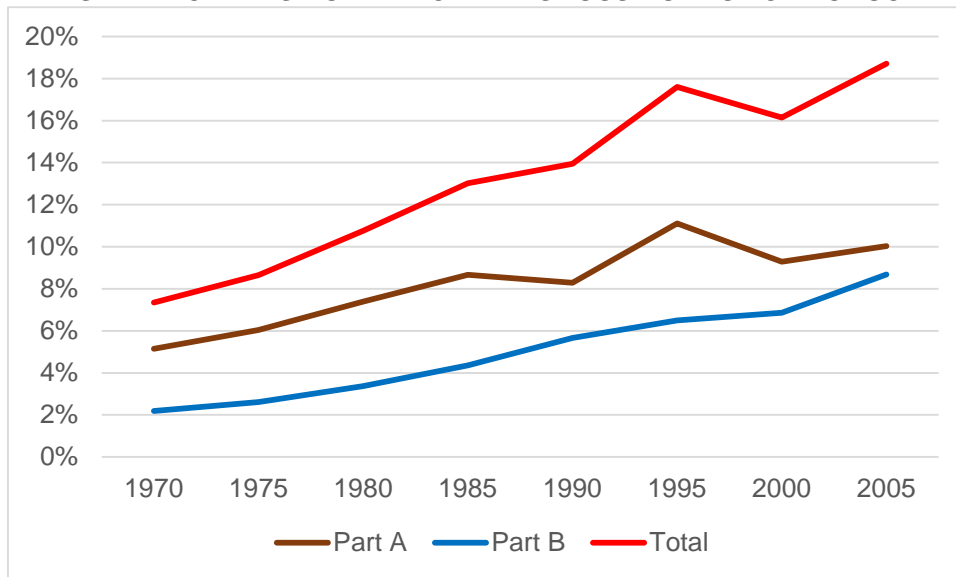
Since depletion of the DI trust fund was predicted to occur in 2016, Congress acted in 2015 to postpone its depletion, primarily by temporarily reallocating a portion of the OASI payroll tax to

⁷ The actuarial deficit represents the average amount of change in income or costs that is needed throughout the period in order to achieve actuarial balance. The actuarial balance is defined as the difference between future Social Security obligations and the income rate of the Social Security Trust Fund, commonly referred to as "solvency." Actuarial balance is calculated for 66 different valuation periods, beginning with the upcoming 10-year period and continuing with each successive year up to the full 75-year projection. If at any point over the 75-year projection the anticipated costs of Social Security exceed the future value of the trust fund's income, that period would be deemed to be out of actuarial balance. (This definition is from Investopedia.com.)

CHART 3
HISTORICAL COSTS PER MEDICARE BENEFICIARY
ADJUSTED FOR INFLATION (EXPRESSED IN 2015 DOLLARS)

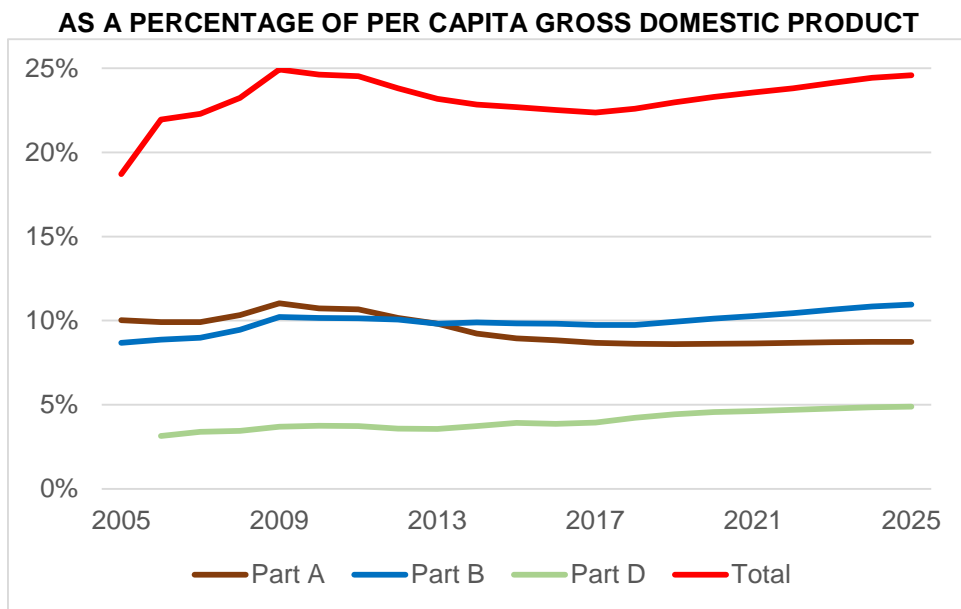
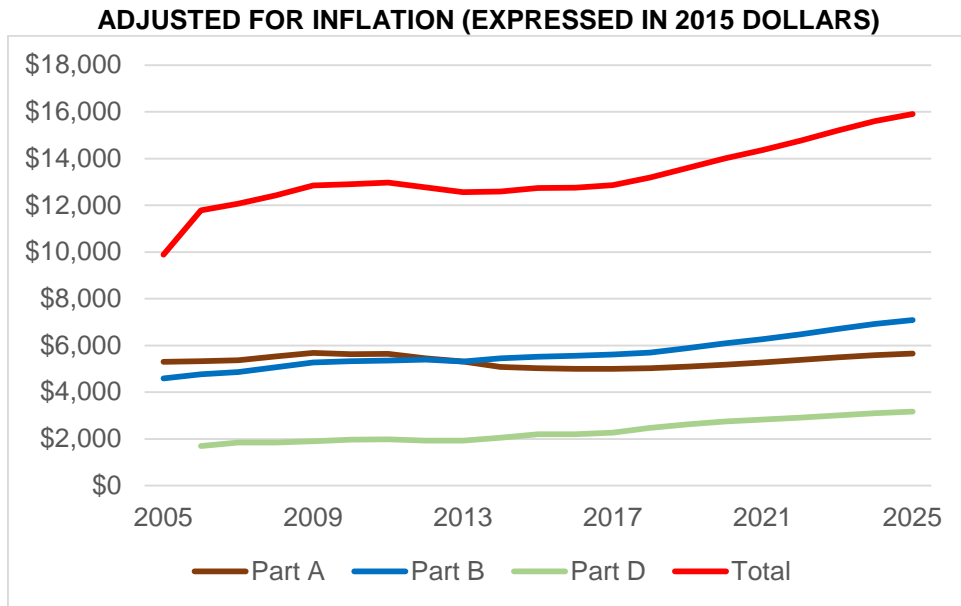


AS A PERCENTAGE OF PER CAPITA GROSS DOMESTIC PRODUCT



Sources: 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 2016, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf> (unadjusted costs per beneficiary) and U.S. Department of Commerce, Bureau of Economic Analysis (per capita gross domestic product and gross domestic product implicit price deflator).

CHART 4 RECENT AND PROJECTED COSTS PER MEDICARE BENEFICIARY



Sources: 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 2016, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf> (unadjusted costs per beneficiary); U.S. Department of Commerce, Bureau of Economic Analysis (per capita gross domestic product and gross domestic product implicit price deflator through 2016); and IHS Markit (projections of per capita GDP and GDP deflator).

the DI fund. From 2016 through 2018, 0.57 percentage points of the payroll tax is shifted from OASI to DI.

Costs are expected to exceed income in 2019, with depletion of the DI fund in 2023. At that time, income would cover 89 percent of scheduled benefits. The projected 75-year actuarial deficit is 0.26 percent of taxable payroll.

Combined Social Security Trust Funds

Income growth in the Social Security trust funds has been above trend in recent years due to the economic recovery but the growth rate is expected to slow to the trend rate. The number of beneficiaries is expected to continue to increase at a rate substantially greater than the rate of growth in the number of workers.

Combined, the two trust funds had reserves of \$2.8 trillion at the end of 2015. They meet the test of short-term (10-year) close actuarial balance, since combined fund assets are projected to exceed costs through 2028. However, the funds fail the test of long-range close actuarial balance.

Including interest income, income to the two funds combined currently exceeds costs. However, this annual surplus is expected to last only through 2019. Excluding interest income, OASDI costs began to exceed income in 2010; an annual deficit is predicted to continue throughout the projection period. The annual deficit is expected to average \$69 billion through 2019 (about 1.1 percent of taxable income). After 2019, the annual deficit is expected to rise steeply to 3.38 percent of taxable income in 2038. The annual deficit is projected to lower to 3.13 percent in 2050, then again rise, reaching 4.35 percent in 2090.

The Trustees project that the combined OASDI trust funds will be depleted in 2034. At that time, income is projected to be sufficient to pay 79 percent of the scheduled benefits. This share is projected to drop to 74 percent in 2090. The projected 75-year actuarial deficit is 2.66 percent of taxable payroll, 1.0 percent of GDP, 20 percent of program noninterest income, and 16 percent of program cost.

As a share of workers' taxable earnings, Social Security benefits were a little more than 10 percent in 2000. The cost rate climbed to 14.1 percent in 2015. The rate is expected to reach 16.6 percent in 2038, decline slightly through 2050 to 16.4 percent, then rise slowly thereafter, reaching 17.7 percent in 2090. In contrast, the OASDI income rate is expected to hold steady at 13 percent; it has been near this figure since 1990. The income rate is calculated as the payroll tax rate of 12.4 percent plus taxes on OASDI benefits.

Social Security program costs rose substantially during the 1970s and early 1980s, rising from a little more than 3 percent to nearly 5 percent of GDP. The cost share gradually dropped back to 4 percent in the mid-2000s before starting to rise. Program costs equaled 5.0 percent of GDP in 2015. Further increases are expected, particularly through 2030, and costs are predicted to reach 6.0 percent of GDP in 2035. Following a marginal decrease through 2050, program costs as a share of GDP are expected to reach 6.1 percent.

The CBO's predictions are more pessimistic than those of the Social Security Board of Trustees. For example, the CBO forecasts that the combined trust funds will be depleted in 2029, five years earlier than the projection of the Trustees. As a percentage of taxable payroll, the 75-year actuarial balance is -4.68 according to the CBO compared to -2.66 according to the Trustees. As a percentage of GDP, the 75-year actuarial balance is -1.55 as projected by the CBO compared to -0.95 as forecast by the Trustees.

The two forecasts differ for numerous reasons. According to the CBO, nearly two-thirds of the difference as a percentage of GDP would be eliminated if the CBO used the projections of the Trustees for four major inputs:

- Earnings subject to the payroll tax: The Trustees' projection is higher.
- GDP growth: The Trustees expect higher labor force participation rates, higher productivity growth, and higher inflation.
- Demographics: The Trustees forecast higher fertility rates and lesser increases in life expectancy.
- Real interest rates: The Trustees' projection is higher.

Overall, the CBO projects higher outlays and lesser revenue than the Trustees.

Medicare Health Insurance Trust Fund

Expenditures from the HI trust fund have exceeded noninterest income since 2008. The annual deficit currently is small, but is expected to rise considerably starting in 2020, with an annual deficit of nearly \$40 billion in 2025, the last year for which dollar figures are provided. Expenditures are forecast to continue to exceed noninterest income through 2090. Including interest income, costs are projected to exceed total income beginning in 2021. Thus, the HI fund fails the tests of both short-term and long-term financial adequacy.

Depletion of the HI trust fund is projected to occur in 2028. At that time, dedicated revenues are predicted to be sufficient to pay 87 percent of the costs. This percentage is expected to decline gradually to 79 percent in 2043, then to rise slowly to 86 percent in 2090.

The projected 75-year actuarial deficit is 0.73 percent of taxable payroll, 0.3 percent of GDP, 19 percent of noninterest income, and 16 percent of program cost. These deficits are somewhat larger than had been predicted in the prior year and the depletion of the trust fund is expected to occur two years earlier than previously projected.

The Part A costs amounted to 1.5 percent of GDP in 2015. This percentage is expected to rise to 2.1 in 2040 and to 2.2 in 2090.

Relative to taxable payroll, the HI program costs were 3.44 percent in 2015. The cost rate gradually increased over the last 45 years. It is expected to continue to rise to almost 5 percent in 2040 and to 5.08 percent in 2090. In contrast, the income rate rises from 3.35 percent in 2015 to 4.37 percent in 2090. The increase in the income rate results from the higher payroll tax rate for high earners that was implemented in 2013. Since the dollar figure at which the higher rate is effective is not indexed for inflation or wage growth, most workers will pay the higher rate by 2090.

In 2015, the HI cost rate exceeded the income rate by 0.09 percent of taxable income. A small annual deficit is expected through 2021, but the annual deficit rises rapidly thereafter to 1.04 percent in 2045. After that, the annual deficit recedes, dropping to 0.71 percent in 2090.

Medicare Supplementary Medical Insurance Trust Fund

Since the SMI trust fund receives financing from the federal government's general fund and from beneficiary premiums, both Part B and Part D are projected to remain adequately financed into the indefinite future. However, due to the aging population and rising health care costs, projected costs are expected to rise from 2.1 percent of GDP in 2015 to 3.5 percent in 2037. By 2090, the share of GDP is forecast to be 3.8 percent. Premiums from beneficiaries are expected to cover nearly one-fourth of the costs, with nearly all of the rest financed by general revenues.

Combined Medicare Costs

The combined Medicare costs were less than 1 percent of GDP in 1970. The percentage has climbed almost continuously since then, reaching 3.6 percent in 2015. Thus, the rate of increase over the last 45 years was much greater than for Social Security. The rate of increase is expected to continue to be greater than Social Security into the late 2030s, reaching 5.6 percent of GDP in 2040, only slightly less than the share from Social Security. By 2090, the cost share is projected to be 6.0 percent of GDP, just 0.1 percentage point less than Social Security. The projected cost increase per beneficiary becomes the largest factor driving the share higher after 2040.

Budgetary Implications of Social Security and Medicare

In 2016, projected general fund payments to Medicare Parts B and D (SMI) are \$319 billion. The projected difference between Social Security's expenditures and dedicated tax income is \$73 billion. For HI, the projected difference between expenditures and noninterest income is \$9 billion. Thus, Social Security and Medicare place a \$401 billion demand on the general fund, equivalent to 2.1 percent. The demand of these programs on the general fund as a share of GDP steadily rises into the mid-2030s and reaches 4.2 percent in 2040. Contrary to current law, this analysis assumes that full benefits will be paid after the depletion of the trust funds.

A Comparison of Lifetime Benefits to Lifetime Taxes Paid

The Urban Institute estimated the lifetime benefits and lifetime taxes paid for the Social Security program and for the Medicare program for various household types and various earnings levels.⁸ The analysis was done for the year in which the cohort turned 65, stretching from 1960 through 2060.

A summary is shown in Table 6, presenting the ratio of lifetime taxes paid to lifetime benefits received. The earnings figures represent constant "average" earnings over a career beginning at age 22 and ending on the 65th birthday. The benefits and taxes are expressed as the expected present value at age 65, using a discount rate of 2 percent plus inflation. Average longevity is assumed for each cohort. The benefits reflect those scheduled under current law, regardless of the status of the trust funds. Given the projected shortfalls in the trust funds, future benefits likely are overstated and/or future taxes likely are understated.

⁸ Urban Institute, *Social Security and Medicare Lifetime Benefits and Taxes*, September 2015, <http://www.urban.org/research/publication/social-security-and-medicare-lifetime-benefits-and-taxes>.

For those turning 65 in 2015, only single people with high earnings had paid enough in taxes to cover the Social Security benefits that individual will receive. Except for the highest earners, the ratios decline between 2015 and 2060. The ratios in Table 6 are much lower for Medicare than for Social Security since Parts B and D are not funded from payroll taxes. Instead, the general fund covers most of the expense.

TABLE 6
RATIO OF LIFETIME TAXES PAID TO LIFETIME BENEFITS RECEIVED,
SOCIAL SECURITY AND MEDICARE PROGRAMS

Earnings	1960		2015			2060			2060 Versus 2015		
	SS	Total	SS	Med	Total	SS	Med	Total	SS	Med	Total
Single Male											
\$22,500	0.101	0.085	0.685	0.164	0.413	0.654	0.103	0.305	-0.031	-0.061	-0.108
\$47,800	0.160	0.142	0.925	0.359	0.699	0.878	0.232	0.548	-0.048	-0.127	-0.152
\$76,500	0.189	0.170	1.108	0.574	0.930	1.064	0.384	0.764	-0.044	-0.191	-0.166
\$119,100	0.212	0.190	1.298	0.821	1.158	1.336	0.614	1.051	0.038	-0.206	-0.107
Single Female											
\$22,500	0.078	0.063	0.626	0.141	0.365	0.609	0.091	0.275	-0.017	-0.050	-0.090
\$47,800	0.123	0.106	0.845	0.308	0.623	0.819	0.206	0.498	-0.026	-0.102	-0.125
\$76,500	0.144	0.126	1.009	0.493	0.830	0.992	0.341	0.696	-0.017	-0.153	-0.134
\$119,100	0.161	0.141	1.182	0.705	1.036	1.245	0.546	0.961	0.063	-0.159	-0.075
Married Couple With One Earner											
\$22,500	0.054	0.043	0.407	0.076	0.213	0.395	0.048	0.156	-0.011	-0.028	-0.057
\$47,800	0.086	0.073	0.549	0.166	0.373	0.531	0.108	0.289	-0.018	-0.057	-0.084
\$76,500	0.101	0.087	0.657	0.265	0.504	0.644	0.177	0.408	-0.013	-0.088	-0.095
\$119,100	0.113	0.098	0.770	0.379	0.634	0.808	0.281	0.568	0.038	-0.098	-0.066
Married Couple With Two Earners											
\$45,000	0.096	0.078	0.657	0.149	0.387	0.631	0.097	0.290	-0.026	-0.052	-0.098
\$70,300	0.114	0.098	0.756	0.242	0.526	0.732	0.160	0.411	-0.025	-0.082	-0.115
\$95,600	0.138	0.120	0.881	0.332	0.658	0.847	0.227	0.526	-0.034	-0.105	-0.132
\$124,300	0.149	0.131	0.951	0.431	0.762	0.925	0.308	0.633	-0.026	-0.123	-0.129

SS: Social Security.

Med: Medicare; benefits are net of premiums.

Source: Urban Institute, *Social Security and Medicare Lifetime Benefits and Taxes*, September 2015,
<http://www.urban.org/research/publication/social-security-and-medicare-lifetime-benefits-and-taxes>.

SOCIAL SECURITY OPTIONS

In their 2016 annual report, the Social Security and Medicare Boards of Trustees state “Lawmakers have a broad continuum of policy options that would close or reduce the long-term financing shortfall of both programs.” They go on to state that “The Trustees recommend that lawmakers take action sooner rather than later to address these shortfalls, so that a broader range of solutions can be considered and more time will be available to phase in changes while giving the public adequate time to prepare. Earlier action will also help elected officials minimize adverse impacts on vulnerable populations, including lower-income workers and people already dependent on program benefits.”

The Boards of Trustees do not discuss options to prevent the depletion of the trust funds in their annual report. However, many individuals and organizations have written extensively for years about possible solutions to the finances of the Social Security program, as well as other possible modifications to the program. Various bills have been introduced in Congress over the years.

Among the possible alternatives are a number of options to reduce benefits, several options to increase revenue, and various other modifications, some of which would worsen the finances of the program. Some organizations have proposed comprehensive plans to resolve the projected imbalances. In addition, a few fundamental overhauls to the program have been proposed.

After placing the options into categories, the list of options to improve the finances of the Social Security trust funds is not long. However, a wide range of possibilities exist within most of the categories, based on timing and the magnitude of the proposed change. Timing refers to the year in which a change takes effect and whether the change is phased in and the number of years of the phase-in period. The magnitude of the proposed change also creates many possibilities. For example, if the desire is to increase the payroll tax from its current 12.4 percent, over what time period does the rate increase phase in and to what rate does the tax rise?

The effects of many of the options listed below have been estimated by the Social Security Administration, often using various phase-in periods and varying degrees of change.⁹ The effects are measured in four ways:

- The change in the 75-year actuarial balance as a percentage of payroll.
- The change in the 75-year actuarial balance as a percentage of the shortfall eliminated.
- The change in the annual balance in the 75th year as a percentage of payroll.
- The change in the annual balance in the 75th year as a percentage of the shortfall eliminated.

The Congressional Budget Office also has estimated the effects of a number of policy options.¹⁰ It estimates the change in the 75-year actuarial balance as a percentage of GDP and as a percentage of the shortfall eliminated. It also estimates the year in which the reserves will be

⁹ Social Security Administration, Actuarial Publications, October 12, 2016, *Summary of Provisions That Would Change the Social Security Program*, <https://www.ssa.gov/oact/solvency/provisions/>.

¹⁰ Congressional Budget Office, *Social Security Policy Options, 2015*, December 2015, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51011-SSOptions_OneCol.pdf.

depleted and estimates the effects as of the year 2040. The CBO examines a subset of these options in more detail in another publication.¹¹

Most of the options apply either to the Old Age and Survivors Insurance program or to both programs. Options specific to the Disability Insurance program are specified later in this section.

Options to Raise Revenue

- Raise or eliminate the cap on earnings to which the Social Security payroll tax applies. Due to rising earnings inequality, the proportion of aggregate earnings subject to the payroll tax has dropped to 82 percent from 90 percent in 1983. Increasing the cap would raise revenue but would subsequently also increase benefits for high earners. Thus, under some proposals, the current taxable maximum would still be used to calculate benefits, though the payroll tax would be applied to higher amounts. Alternatively, some proposals link the increase in the cap to changes in the PIA formula, such as lowering the percentage applied to earnings above the second bend point from 15 to 5. Depending on how quickly and to what level the cap is raised and whether the benefit calculation is changed to limit benefits based on the higher earnings, this proposal could have a moderate-to-very-large effect on the trust fund shortfall.
- Raise the payroll tax rate. Depending on how quickly and to what level the rate is raised, this proposal could have a moderate-to-very-large effect on the trust fund shortfall.
- Expand the definition of earnings to which the payroll tax applies. Possible targets include employer-sponsored group health insurance, voluntary spending reduction plans (such as flexible spending accounts), 401(k) plans (retirement savings plans sponsored by employers), and investment income. The effect on the trust fund shortfall could range from small to large.
- Expand Social Security coverage to include all newly hired state and local government employees.¹² This option would raise revenue in the early years, but this would be offset in later years once these newly covered employees retire and start drawing benefits. The 75-year actuarial balance improves slightly, but the balance in the 75th year worsens slightly.
- Invest trust fund reserves in marketable securities, such as corporate bonds. Currently, the reserves are invested in special-issue government bonds only. According to the Social Security Administration, as a percent of payroll, this option could have between no effect and a moderate effect on the 75-year actuarial balance but would have no effect on the balance in the 75th year; the effects of this option on the trust fund shortfall were not calculated.
- Increase the tax on Social Security benefits. This might be done by treating Social Security benefits in the same manner as private pension income, which is taxable at the ordinary income rate. Alternatively, the minimum dollar amount subject to the tax could be lowered and/or the percentage of the benefits that are taxed could be increased. Only a small reduction in the trust fund shortfall would be realized.

¹¹ Congressional Budget Office, *Options for Reducing the Deficit: 2017 to 2026*, December 2016, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52142-budgetoptions2.pdf>.

¹² State and local governments that do not offer their own retirement plan must enroll their employees in Social Security. However, if a retirement plan is offered, the state or local government can choose whether to enroll its workers in Social Security.

Options to Reduce Benefits

- Change the annual cost-of-living adjustment (COLA) for benefits from the unchained Consumer Price Index for urban wage earners and clerical workers (CPI-W) to a chained CPI; most suggestions are to use the chained CPI for all urban consumers (chained CPI-U). The CPI-W, the only CPI originally available, does not reflect changes in spending patterns and has several types of statistical biases. A chained CPI on average registers a slightly lower inflation rate than a nonchained measure. This option will have a moderate effect on reducing the projected shortfall. Alternatively, a few have proposed reducing the COLA by an arbitrary amount, which could result in a greater improvement in trust fund finances. Some have suggested reducing the COLA by a set amount only for those with an above-average PIA.
- Raise the normal retirement age and/or the early eligibility age. In some suggestions, the ages rise to a certain level (e.g. a NRA of 69) by one formula, then is adjusted in later years in conjunction with changes in life expectancy. The delayed retirement age also might be increased. Depending on how quickly the ages are increased and to what level, this option could have a moderate-to-large effect on reducing the trust fund shortfall.
- Change the means of calculating the benefit for those retiring in the future. Numerous suggestions have been made; the following list is representative:
 - Apply across-the-board adjustment to the 90/32/15 PIA factors. Depending on how quickly this is phased in and the degree to which the factors decline, this could have a large-to-very-large effect on the projected deficit.
 - Increase the number of years of earnings on which the average monthly benefit is calculated. Currently, the highest 35 years of earnings are used. Suggestions have been made to increase the number to 38 or 40. This would have a small-to-moderate effect on the projected deficit.
 - Use price indexing rather than the average wage index to determine the initial benefit. Currently, the historical earnings of a worker are adjusted to today's dollars by increasing each year's earnings by a factor based on the difference in the average wage index between the historical year and the current year. Gains in the average wage index have exceeded inflation due to productivity increases. This option would not affect the PIA formula. It would have a moderate effect on the projected deficit.
 - Adjust the 90/32/15 factors in the PIA formula to reflect the difference between growth in the average wage and growth in inflation. This is an alternative means to adopt price indexing. If applied to all future retirees ("pure price indexing"), this would have a very large effect on the projected deficit.
 - Apply the benefit formula to individual years of earnings. In this option, a PIA would be calculated for each year of earnings, with the overall PIA calculated as the average of the annual PIAs. Currently, average earnings is calculated first, then the PIA formula is applied. This option would have a small effect on the projected deficit.
 - Replace the current PIA formula with a two-part formula. The first part would provide a fixed benefit for the number of years worked. The second part would provide an additional benefit based on average earnings. This option would have a small effect on reducing the projected deficit.

- Index the bend points in the PIA formula to prices. This would have a moderate effect on the projected deficit.
- Index initial benefits to future changes in longevity. This option would involve adjusting the PIA factors and would have a moderate effect on reducing the projected deficit.
- Replace the windfall elimination provision and the government pension offset with a revised reduction. This would have a slight positive effect on the projected deficit.
- Reduce the number of drop-out years. This would have a small positive effect on the projected deficit.
- Change the means of calculating the benefit for those retiring in the future with the intention of increasing the progressivity of the benefit structure. Numerous suggestions have been made; the following list is representative:
 - Change the 90/32/15 PIA factors, by some combination of raising the first percentage and/or lowering the other two percentages. This option could have a large effect on the projected deficit.
 - Add an additional bend point and lower the PIA factors. In one proposal, the new bend point would be about half-way between the existing first and second bend points. The factors would change to 90/30/10/5. This option would have a moderate effect on reducing the projected deficit.
 - Implement “progressive price indexing” as an alternative to pure price indexing: wage indexing will continue to be used for lower-earnings workers while price indexing will be used for those with higher earnings. This alternative would include adding another bend point to the formula. It could have a large impact on the deficit.
- Create a two-component system for calculating the PIA in conjunction with raising the taxable maximum. For earnings up to the current maximum, the existing PIA formula would be used. For earnings above the current maximum, calculate a surplus benefit using a 5 percent factor.
- Reduce family member benefits — particularly to spouses, though the survivors’ benefit also could be reduced. The current spouse benefit is based on 50 percent of the PIA of the other spouse. This percentage could be gradually lowered. Alternatively, any reduction could be limited to those receiving above-average benefits. These options would have only small effects on the trust fund shortfall.

Other Suggested Modifications

- Shift to the experimental CPI-E (CPI for the elderly). This CPI typically measures slightly higher inflation than the current measure. This proposal is in sharp contrast to most proposals to change to a CPI measure that will result in slightly smaller COLAs. An alternative is to raise the COLA for those of an advanced age; this suggestion is most often made in conjunction with a change to a chained CPI. Such measures would increase the projected shortfall in the trust fund.
- Update the actuarial adjustments that determine the differences in the benefit amount based on the age at which a person begins to receive benefits. These adjustments are made so that over a lifetime, the average individual will receive the same amount of benefits regardless of the age at which benefits are first claimed. However, these

adjustments were set more than 50 years ago when life expectancy was shorter. In addition, the adjustments do not reflect the longer longevity of females than males.

- Introduce a new poverty-related minimum benefit, replacing the current special minimum PIA. This would increase the projected shortfall in the trust fund.
- Increase benefits for those with at least 20 years of Social Security eligibility. This would increase the projected shortfall in the trust fund.
- Add flexibility to the claiming of benefits and introduce a hardship exemption.
- Drop the payroll tax requirement for those reaching age 62. This would increase the projected shortfall in the trust fund.
- Enhance survivors benefits and reinstate benefits for certain beneficiaries. This would increase the projected shortfall in the trust fund.
- Eliminate gradually the taxation of benefits. This would increase the projected shortfall in the trust fund.
- Change the disability requirements for widow(er)s.
- Change the requirements for divorced spouses.
- Enhance the information provided to future beneficiaries regarding retirement options.
- Begin a dialogue on the importance of personal retirement savings.
- Earmark other taxes for Social Security, transferring monies from the general fund to the Social Security trust funds.

Fundamental Changes to the Program

Two more extensive changes to the Social Security system have been proposed; each elevates the importance of individual savings accounts. One proposal is to transition to a flat benefit structure, creating a minimum benefit that will keep all retirees out of poverty. Gradually, all future beneficiaries with a greater benefit will experience a reduction in benefits until they receive the same amount as the minimum benefit. Payroll taxes also will be gradually lowered. Most beneficiaries thus will need to boost their investment in accounts such as 401(k).

The other fundamental change is to gradually end the Social Security system by having all earners contribute to a private retirement account rather than pay payroll taxes. Those with inadequate retirement savings will be compensated from the general fund, as in other noncontributory entitlement programs.

Options Specific to the Disability Insurance Program

Many authors have mentioned the desirability of making changes to the DI program, but few have offered many details.

Some proposals have focused on reducing the number of DI beneficiaries:

- Require DI applicants to have worked more in recent years. Currently, applicants must have worked in five of the last 10 years; a proposal has been made to change this to four of the last six years.
- Eliminate eligibility for starting disability benefits after age 61, instead requiring the applicant to begin receiving OASI benefits. Those claiming DI benefits at age 62 are not subject to the reduced benefits that someone claiming retirement benefits at age 62 is subject to.

- Tighten eligibility rules, for example by eliminating nonmedical factors in the determination process.
- Encourage DI beneficiaries to return to work; emphasize recovery over dependency. This might be accomplished by improving assistance on recovery and returning to work, removing any work disincentives that exist, improving continuing disability reviews, and emphasizing prevention of fraud and abuse.

The goal of other DI proposals is to decrease spending per beneficiary. The rationale is to emphasize poverty prevention rather than income replacement. One way to do this is to adopt a flat benefit that keeps the recipients out of poverty. Other proposals include increasing the DI portion of the payroll tax and shifting to the private provision of disability insurance.

The Committee for a Responsible Federal Budget asked the Social Security Administration's Office of the Chief Actuary to estimate the financial effects of some 75 potential proposals affecting the DI program as part of their "Social Security Disability Insurance Solutions Initiative." This effort was led by Jim McCrery and Earl Pomeroy. The response was issued in April 2016.¹³

The 75 proposals were organized into a number of categories, including revenue, benefit offset, and eligibility. The estimated effects were measured in terms of the change in the 75-year actuarial balance and the change in the balance in the 75th year, of the DI trust fund alone and the combined OASDI trust funds. The proposals with the greatest impact on the trust fund balances were:

- Raising the DI payroll tax by 0.35 percent.
- Eliminating the taxable maximum for the DI payroll tax.
- Ending DI benefits at age 62 and older.
- Eliminating the DI COLAs for those between the early eligibility age and the normal retirement age.
- Paying DI benefits with a reduced percentage of PIA for those retiring before the NRA.

Bills Recently Introduced in Congress

Numerous bills related to Social Security have been introduced to Congress since mid-2016. This subsection discusses three bills that propose substantial reform that extends the period of solvency of the Social Security trust funds.

Save Our Social Security Act of 2016

On July 13, 2016, Representative Reid Ribble (R-Wis.) introduced the Save Our Social Security (SOS) Act (H.R. 5747). The bill had six cosponsors, including one Democrat.¹⁴ The bill was assigned to the House Committee on Ways and Means, then to the Subcommittee on Social Security.

¹³ Social Security Administration, Actuarial Response to "SSDI Solutions Initiative," April 2016, https://www.ssa.gov/oact/solvency/McCreryPomeroySSDI_20160404.pdf.

¹⁴ Representative Ribble did not run for re-election in 2016. Of the six cosponsors, four did not run for re-election. The cosponsors remaining in the House of Representatives are James Cooper (D-Tenn.) and Todd Rokita (R-Ind.).

The Office of the Chief Actuary at the Social Security Administration provided estimates of the bill's financial effects on Social Security.¹⁵ The overall assessment by the Chief Actuary was that "... the combined OASI and DI Trust Funds would be fully solvent through the 75-year projection period, under the intermediate assumptions of the 2015 Trustees Report. The proposal, however, would not meet the definition of 'sustainable solvency' beyond the 75th year for the foreseeable future, because projected combined trust fund reserves would be declining as a percentage of the annual program cost at the end of the 75-year long-range period."

In 2015, the trust fund ratio — the ratio of reserves in the combined OASI and DI trust funds at the beginning of the year to the cost of the program for the year — was 308. Without corrective action, the ratio is projected to reach zero in 2034. Under the SOS Act, the ratio would decrease to 128 in the mid-2040s, rise to 148 in the mid-2060s, then decline to 126 in 2090. The 75-year actuarial balance would improve from -2.68 percent of payroll — as estimated in the Trustee's 2015 report — to 0.03 of payroll. The balance in the 75th year would improve from -4.65 percent of payroll to -0.46 percent of payroll.¹⁶

The Act has seven basic provisions with direct effects on the OASDI program:

- Increase the OASDI taxable maximum such that 90 percent of covered earnings are taxable in 2022 and later. The maximum would be \$346,800 in 2022. This provision alone would reduce the 75-year actuarial deficit by 0.99 percent of payroll and the annual deficit for the 75th year by 1.06 percent of payroll.
- Reduce the 15 percent PIA formula factor to 5 percent for workers who die or become newly eligible for retirement or disability benefits in 2021 or later. This provision alone would reduce the 75-year actuarial deficit by 0.30 percent of payroll and the annual deficit for the 75th year by 0.45 percent of payroll.
- Increase the normal retirement age. After the NRA reaches 67 for those attaining 62 in 2022, increase it by two months per year until the NRA reaches 69 for those attaining 62 in 2034. Thereafter, index the NRA to longevity (increasing about 1 month every two years). This provision alone would reduce the 75-year actuarial deficit by 1.01 percent of payroll and the annual deficit for the 75th year by 2.21 percent of payroll.
- Use the chain-weighted version of the CPI for all urban consumers to calculate the cost-of-living adjustment, beginning with the December 2017 COLA. This provision alone would reduce the 75-year actuarial deficit by 0.54 percent of payroll and the annual deficit for the 75th year by 0.76 percent of payroll.
- Increase the special minimum PIA for workers who die or become newly eligible for retirement or disability benefits in 2017 or later. This provision alone would *increase* the 75-year actuarial deficit by 0.16 percent of payroll and the annual deficit for the 75th year by 0.27 percent of payroll.
- Provide a PIA increase after 20 years of benefit eligibility (that is, to those in their 80s) equal to the PIA of a hypothetical worker with the same birth year who earns the average wage index every year through the year prior to initial benefit eligibility. This would be applied to all beneficiaries in years 2017 and later. This provision alone would *increase*

¹⁵ See https://www.ssa.gov/oact/solvency/RRibble_20160713.pdf.

¹⁶ The overall effect of this and other plans does not equal the sum of the effects of the individual provisions of the plan since some provisions interact with other provisions.

the 75-year actuarial deficit by 0.15 percent of payroll and the annual deficit for the 75th year by 0.21 percent of payroll.

- Reduce the maximum number of dropout years for retired and disabled workers to 4 for newly eligible workers in 2017, to 3 for newly eligible workers in 2018, and to 2 for newly eligible workers in 2019 and later. This provision alone would reduce the 75-year actuarial deficit by 0.37 percent of payroll and the annual deficit for the 75th year by 0.55 percent of payroll.

Thus, two provisions — increasing the maximum taxable payroll and increasing the retirement age — one of which enhances revenue and the other cuts benefits, are responsible for most of the improvement in the trust fund reserves. Changing the COLA (a reduction in benefits) would have a moderate effect. The other provisions are a mix of increasing and reducing benefits, with low-income individuals benefitting relative to high-income individuals.

Strengthening Social Security Act of 2016

On September 9, 2016, Representative Linda Sanchez (D-Calif.) introduced the Strengthening Social Security Act of 2016 (H.R. 5952). The bill was assigned to the House Committee on Ways and Means, then to the Subcommittee on Social Security.

Estimates of the bill's financial effects on Social Security are available from the Office of the Chief Actuary at the Social Security Administration.¹⁷ The overall assessment by the Chief Actuary was that "... the combined OASI and DI Trust Funds would be sufficient to extend the projected year of reserve depletion from 2034 to 2048, under the intermediate assumptions of the 2016 Trustees Report."

The 75-year actuarial balance would improve from -2.66 percent of payroll to -1.77 percent of payroll. The balance in the 75th year would improve from -4.35 percent of payroll to -4.10 percent of payroll.

The Act has five basic provisions with direct effects on the OASDI program:

- Eliminate the OASDI taxable maximum amount starting in 2017. This provision alone would reduce the 75-year actuarial deficit by 2.13 percent of payroll and the annual deficit for the 75th year by 2.15 percent of payroll.
- Increase the 90 percent PIA formula factor to 91 percent for beneficiaries newly eligible in 2021, 92 percent for those newly eligible in 2022, reaching 95 percent for those newly eligible in 2025 and later. This provision alone would *increase* the 75-year actuarial deficit by 0.28 percent of payroll and the annual deficit for the 75th year by 0.41 percent of payroll.
- Increase the first PIA bend point above the level it would be in current law by 1 percent for beneficiaries newly eligible in 2021, 2 percent for those newly eligible in 2022, reaching 15 percent higher for those newly eligible in 2035 and later. This provision alone would *increase* the 75-year actuarial deficit by 0.39 percent of payroll and the annual deficit for the 75th year by 0.71 percent of payroll.

¹⁷ See https://www.ssa.gov/oact/solvency/LSanchez_20160909.pdf.

- Use the Consumer Price Index for the Elderly (CPI-E) starting with the December 2016 COLA. This provision alone would *increase* the 75-year actuarial deficit by 0.39 percent of payroll and the annual deficit for the 75th year by 0.52 percent of payroll.
- Establish an alternative benefit for a surviving spouse. This provision alone would *increase* the 75-year actuarial deficit by 0.12 percent of payroll and the annual deficit for the 75th year by 0.12 percent of payroll.

Thus, the first provision to eliminate the cap on taxable payroll would substantially increase revenue. The other four provisions each would increase benefits, with low-income individuals particularly benefitting.

Social Security Reform Act of 2016

On December 8, 2016, Representative Sam Johnson (R-Tex.) introduced the Social Security Reform Act of 2016 (H.R. 6489). He is the Social Security Subcommittee Chairman of the House Ways and Means Committee. The bill was assigned to the House Committee on Ways and Means.

Estimates of the bill’s financial effects on Social Security are available from the Office of the Chief Actuary at the Social Security Administration.¹⁸ The overall assessment by the Chief Actuary was that “... the combined OASI and DI Trust Funds would be fully solvent (able to pay all scheduled benefits in full on a timely basis) throughout the 75-year projection period, under the intermediate assumptions of the 2016 Trustees Report. In addition, under this plan the OASDI program would meet the further conditions for sustainable solvency, because projected combined trust fund reserves would be growing as a percentage of the annual cost of the program at the end of the long-range period.”

Under this Act, the trust fund ratio would decline to 10 during the mid-2040s, then steadily rise to 115 in 2090. The 75-year actuarial balance would improve from -2.66 percent of payroll to 0.02 percent of payroll. The balance in the 75th year would improve from -4.35 percent of payroll to 0.21 percent of payroll.

The Act has 15 basic provisions with direct effects on the OASDI program:

- Phase in a new benefit formula from 2023 to 2032 for retired worker and disabled worker beneficiaries becoming initially eligible in January 2023 or later. Replace the existing two PIA bend points with three new bend points and modified benefit formula factors. This provision alone would reduce the 75-year actuarial deficit by 0.85 percent of payroll and the annual deficit for the 75th year by 1.53 percent of payroll.
- Use an annualized “mini-PIA” formula beginning with retired and disabled worker beneficiaries becoming newly eligible in 2023, phased in over 10 years. The mini-PIA calculation would use a single year’s average monthly indexed earnings (mini-AIME) and primary insurance amount (mini-PIA) for each year with taxable earnings. This provision alone would reduce the 75-year actuarial deficit by 0.34 percent of payroll and the annual deficit for the 75th year by 0.59 percent of payroll.

¹⁸ See https://www.ssa.gov/oact/solvency/SJohnson_20161208.pdf.

- Replace the current-law windfall elimination provision with a new calculation for most OASI and DI benefits based on covered and non-covered earnings, phased in for beneficiaries becoming newly eligible in 2023 through 2032. This provision alone would reduce the 75-year actuarial deficit by 0.03 percent of payroll and the annual deficit for the 75th year by 0.05 percent of payroll.
- Increase the retirement age. After the normal retirement age reaches 67 for those attaining age 62 in 2022, increase the NRA by 3 months per year starting for those attaining age 62 in 2023 until it reaches 69 for those attaining age 62 in 2030. Increase the age up to which delayed retirement credits may be earned from 70 to 72 on the same schedule. This provision alone would reduce the 75-year actuarial deficit by 0.84 percent of payroll and the annual deficit for the 75th year by 1.33 percent of payroll.
- Provide no COLA for those with modified adjusted gross income above specific thresholds and compute the COLA using the chain-weighted version of the CPI-U for all other beneficiaries, beginning with the December 2018 COLA. This provision alone would reduce the 75-year actuarial deficit by 1.25 percent of payroll and the annual deficit for the 75th year by 2.31 percent of payroll.
- Limit the auxiliary benefit for spouses and children of retired workers and disabled workers becoming newly eligible beginning in 2023, and phased in for 2023 through 2032, to the amount based on one-half of the PIA of a hypothetical worker with earnings equal to the national average wage index each year up to his or her eligibility year, and who has the same eligibility year as the worker. This provision alone would reduce the 75-year actuarial deficit by 0.07 percent of payroll and the annual deficit for the 75th year by 0.11 percent of payroll.
- Require full-time school enrollment as a condition of eligibility for child benefits at age 15 up to 18, beginning in January 2019. This provision alone would reduce the 75-year actuarial deficit by 0.01 percent of payroll and the annual deficit for the 75th year by 0.01 percent of payroll.
- Provide a new minimum benefit for workers with more than 10 years of covered earnings above a specified level, phased in for retired and disabled worker beneficiaries becoming newly eligible in 2023 through 2032. This provision alone would *increase* the 75-year actuarial deficit by 0.23 percent of payroll and the annual deficit for the 75th year by 0.41 percent of payroll.
- Eliminate the retirement earnings test for all beneficiaries under the NRA, beginning in January 2019. This provision alone would reduce the 75-year actuarial deficit by 0.01 percent of payroll and the annual deficit for the 75th year by 0.12 percent of payroll.
- Eliminate federal income taxation of OASDI benefits that is credited to the OASI and DI Trust Funds for 2054 and later, phased in from 2045 to 2053. This provision alone would *increase* the 75-year actuarial deficit by 0.40 percent of payroll and the annual deficit for the 75th year by 0.96 percent of payroll.
- Provide an option to split the 8 percent delayed retirement credit (DRC) to offer a lump sum benefit at initial entitlement equivalent to 2 of the 8 percent DRC earned, and a 6 percent DRC on subsequent monthly benefits, effective for workers attaining age 62 in 2023 and later. This provision alone would have a negligible effect on the 75-year actuarial deficit and the annual deficit for the 75th year.
- Provide an addition to monthly benefits for all beneficiaries who have been eligible for at least 20 years, beginning in January 2023. The additional amount is calculated based on 5

percent of the PIA for a hypothetical worker with earnings equal to the national average wage index each year. This provision alone would *increase* the 75-year actuarial deficit by 0.07 percent of payroll and the annual deficit for the 75th year by 0.07 percent of payroll.

- Change the requirement for new and current disabled widow(er) beneficiaries that disability must occur no later than 7 years after the worker’s death, or after surviving spouse with child-in-care benefits were last payable, to no later than 10 years, beginning in January 2023. This provision alone would have a negligible effect on the 75-year actuarial deficit and the annual deficit for the 75th year.
- Eliminate the requirement for new and current disabled surviving spouse beneficiaries to be age 50 or older for receipt of benefits, beginning in January 2023. This provision alone would have a negligible effect on the 75-year actuarial deficit and the annual deficit for the 75th year.
- Waive the two-year duration of divorce requirement for divorced spouse benefit eligibility in cases where the worker (former spouse) remarries someone other than the claimant before the two-year period has elapsed, for new and current beneficiaries beginning in January 2023. This provision alone would have a negligible effect on the 75-year actuarial deficit and the annual deficit for the 75th year.

Thus, all of the provisions affect benefits directly or indirectly; one of the provisions consists of a *reduction* in revenue. Three provisions — modification to the benefit formula, increasing the retirement age, and changing the cost-of-living adjustment — are responsible for all of the improvement in the fund reserves. The other provisions are a mix of increasing and reducing benefits, with a net effect of slightly reducing the fund reserves, primarily due to the elimination of income taxation of OASDI benefits.

Other Comprehensive Plans

The Committee for a Responsible Federal Budget has recommended considering four plans, including the SOS Act described above.¹⁹ The other plans were developed by

- The National Commission on Fiscal Responsibility (the “Simpson-Bowles” plan)²⁰
- The Bipartisan Policy Center (the “Conrad-Lockhart” plan)²¹
- The American Enterprise Institute²²

In addition to these four plans, the Committee for a Responsible Federal Budget urges consideration of establishing a commission, as was used in 1983 to reform Social Security at a

¹⁹ Committee for a Responsible Federal Budget, Mark Goldwein, *Five Social Security Plans That Really Would Help Make America Great Again*, August 2016, <http://crfb.org/blogs/marc-goldwein-five-social-security-plans-really-would-help-make-america-great-again>.

²⁰ The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, http://momentoftruthproject.org/sites/default/files/TheMomentofTruth12_1_2010.pdf.

²¹ Bipartisan Policy Center, *Securing Our Financial Future: Report of the Commission on Retirement Security and Personal Savings*, “Chapter VI: Strengthen Social Security’s Finances and Modernize the Program,” June 2016, <http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/06/BPC-Retirement-Security-Report.pdf>.

²² American Enterprise Institute, *Increasing the Effectiveness and Sustainability of the Nation’s Entitlement Programs*, June 2016, <https://www.aei.org/wp-content/uploads/2016/06/Increasing-the-Effectiveness.pdf>.

time when it was facing depletion of its reserves. A bill to create such a commission has been introduced in recent years by Rep. John Delaney (D-Md.) and Rep. Tom Cole (R-Okla). They suggest a commission of 13 members, with three appointed by each party leader in the House and Senate and a chair appointed by the president. The commission would be given one year to pass a plan with at least nine votes that would be expedited by Congress, which would be restricted to an up-or-down vote.

“Simpson-Bowles” Plan

This plan was released in December 2010. It addresses a number of aspects of the federal fiscal situation, not just Social Security, but only the Social Security proposals are discussed here. Of the 10 Social Security recommendations, five reduce the magnitude of the projected deficit. As projected in 2010 by the Office of the Chief Actuary at the Social Security Commission, this plan resulted in solvency in the Social Security trust funds throughout the 75-year period. In addition, the OASDI program would meet the further conditions for sustainable solvency, because projected combined trust fund reserves would be growing as a percentage of the annual cost of the program at the end of the long-range period.²³

According to the Chief Actuary and based on the 2010 Trustees report, under this plan the trust fund ratio would decline to 140 during the mid-2040s, then steadily rise to 290 in 2090. The 75-year actuarial balance would improve from -1.92 percent of payroll to 0.23 percent of payroll. The balance in the 75th year would improve from -4.12 percent of payroll to 0.08 percent of payroll.

The deficit-reducing recommendations follow:

- Phase in changes to the benefit formula gradually through 2050, adding a bend point about halfway between the existing first and second bend points and modifying the factors from the current 90/32/15 to 90/30/10/5. This would result in the benefit structure becoming more progressive. This provision alone would reduce the 75-year actuarial deficit by 0.86 percent of payroll and the annual deficit for the 75th year by 2.12 percent of payroll.
- Increase the taxable maximum gradually, covering 90 percent of earnings by 2050. This provision alone would reduce the 75-year actuarial deficit by 0.67 percent of taxable payroll and the annual deficit for the 75th year by 0.90 percent of payroll.
- Use the chained CPI for the COLA. This provision alone would reduce the 75-year actuarial deficit by 0.50 percent of payroll and the annual deficit for the 75th year by 0.70 percent of payroll.
- Index the NRA and the EEA to longevity so that they grow about one month every two years. The NRA would reach 69 and the EEA 64 in about 2075. This provision alone would reduce the 75-year actuarial deficit by 0.34 percent of payroll and the annual deficit for the 75th year by 1.22 percent of payroll.
- Cover newly hired state and local government workers after 2020. This provision alone would reduce the 75-year actuarial deficit by 0.16 percent of payroll but would *increase* the annual deficit for the 75th year by 0.12 percent of payroll.

²³ Social Security Administration, Actuarial Response to Simpson-Bowles Plan, December 2010, https://www.ssa.gov/oact/solvency/FiscalCommission_20101201.pdf.

Other than putting Social Security on a sustainable financial path, the other goal of the plan is to reduce poverty among the very poor and the very old. The other five recommendations have either no effect on the projected deficit or are expected to increase the size of the deficit:

- Create a minimum benefit equal to 125 percent of the poverty level and index this benefit to wage growth, for individuals who have worked at least 25 years. The minimum benefit would phase down proportionately for those with fewer years of work (down to the existing minimum of 10 years). This provision alone would *increase* the 75-year actuarial deficit by 0.15 percent of payroll and the annual deficit for the 75th year by 0.26 percent of payroll.
- Provide a benefit enhancement equal to 5 percent of the average benefit, phased in over five years, for individuals who have been eligible for benefits for 20 years. This proposal is intended to ensure that the very old and those who have been disabled for at least 20 years do not outlive their personal retirement resources. This provision alone would *increase* the 75-year actuarial deficit by 0.15 percent of payroll and the annual deficit for the 75th year by 0.23 percent of payroll.
- Add flexibility in claiming retirement benefits by allowing retirees to claim half of their benefits at one time, as early as age 62, with applicable actuarial reduction. Also add a hardship exemption for those unable to work beyond 62 but who do not qualify for disability benefits.
- Direct the Social Security Administration to improve information on retirement choices, better inform future beneficiaries on the implications of early retirement, and promote greater retirement savings.
- Begin a broad dialogue on the importance of personal retirement savings.

Each of four recommendations would have a moderate effect on the solvency of the trust funds; combined, they account for all of the improvement: changing the benefit formula, increasing the taxable maximum, using the chained CPI for the COLA, and indexing the NRA and the EEA to longevity.

While the plan does not address the DI program, the Commission recommends a comprehensive redesign of the program to modernize the program objectives and the eligibility criteria.

“Conrad-Lockhart” Plan

The focus of this report, which was issued in June 2016, was broader than Social Security, encompassing retirement security and personal savings. One chapter was specific to Social Security. It includes 13 recommendations to improve Social Security.

The overall assessment by the Chief Actuary was that “... the combined OASI and DI Trust Funds would be fully solvent throughout the 75-year projection period, under the intermediate assumptions of the 2016 Trustees Report. In addition, under this plan the OASDI program would meet the further conditions for sustainable solvency, because projected combined trust fund reserves would be growing as a percentage of the annual cost of the program at the end of the long-range period.”²⁴

²⁴ Social Security Administration, Actuarial Response to Conrad-Lockhart Plan, October 2016, https://www.ssa.gov/oact/solvency/BPCCRSPS_20161011.pdf.

Based on the 2016 Trustees report, the trust fund ratio would decline to 156 between 2046 and 2051, then rise to 181 in 2090 under this plan. The 75-year actuarial balance would improve from -2.66 percent of payroll to 0.11 percent of payroll. The balance in the 75th year would improve from -4.35 percent of payroll to -0.20 percent of payroll.

Nine of the recommendations have the effect of reducing the projected deficit:

- Increase the progressivity of the benefit formula. Over 10 years, phase in changes to the benefit formula, adding a bend point about halfway between the existing first and second bend points and modifying the factors from the current 90/32/15 to 95/32/15/5. This provision alone would reduce the 75-year actuarial deficit by 0.04 percent of payroll and the annual deficit for the 75th year by 0.10 percent of payroll.
- Apply the benefit formula annually to earnings to more evenly reward continued work. In this option, a PIA would be calculated for each year of earnings, with the overall PIA calculated as the average of the annual PIAs. Currently, average earnings is calculated first, then the PIA formula is applied. This provision alone would reduce the 75-year actuarial deficit by 0.23 percent of payroll and the annual deficit for the 75th year by 0.38 percent of payroll.
- Index the retirement age to longevity to reflect ongoing increases in life expectancy. Starting in 2022, the NRA would increase by one month every two years for 48 years until it reached age 69. The maximum benefit age would rise to 72. The EEA would remain unchanged, but the benefit reduction for early retirement would increase. This provision alone would reduce the 75-year actuarial deficit by 0.50 percent of payroll and the annual deficit for the 75th year by 1.34 percent of payroll.
- Change the COLA to use the chained CPI-U starting in 2017. This provision alone would reduce the 75-year actuarial deficit by 0.47 percent of payroll and the annual deficit for the 75th year by 0.61 percent of payroll.
- Cap and reindex the spousal benefit. With most women now working, the current provisions largely benefit affluent households who could afford to have only one earner. This provision alone would reduce the 75-year actuarial deficit by 0.11 percent of payroll and the annual deficit for the 75th year by 0.21 percent of payroll.
- Raise the maximum taxable earnings level to \$195,000 in 2020, covering about 85.6 percent of aggregate earnings. Thereafter, the maximum would rise by average wage growth plus 0.5 percentage points. This provision alone would reduce the 75-year actuarial deficit by 0.56 percent of payroll and the annual deficit for the 75th year by 0.63 percent of payroll.
- Raise the payroll tax rate from 12.4 percent to 13.4 percent in 2026. This provision alone would reduce the 75-year actuarial deficit by 0.88 percent of payroll and the annual deficit for the 75th year by 1.00 percent of payroll.
- Increase taxes on benefits for high-income beneficiaries. Starting in 2022, all benefits received by those with adjusted gross incomes of \$250,000 (\$500,000 for couples) would be taxed. This provision alone would reduce the 75-year actuarial deficit by 0.01 percent of payroll and the annual deficit for the 75th year by 0.01 percent of payroll.
- Replace the windfall elimination provision and government pension offset with a prorated benefit for workers with noncovered earnings based on the share of lifetime total earnings that were covered by Social Security. This provision alone would reduce the 75-

year actuarial deficit by 0.06 percent of payroll and the annual deficit for the 75th year by 0.09 percent of payroll.

Other than putting Social Security on a sustainable financial path, the other goal of the plan is to improve retirement security for lower-income beneficiaries. The other four recommendations follow:

- Establish a basic minimum benefit to enhance Social Security for beneficiaries with low incomes. This provision would effectively replace Supplemental Security income. This provision alone would *increase* the 75-year actuarial deficit by 0.19 percent of payroll and the annual deficit for the 75th year by 0.24 percent of payroll, but reduce general fund costs.
- Enhance the survivors' benefit to help widows and widowers maintain their standard of living. Two-earner couples can experience a decline in benefits of up to half when one of them dies, a greater loss of income than for spouses in one-earner families. This provision alone would reduce the 75-year actuarial deficit by 0.02 percent of payroll but would *increase* the annual deficit for the 75th year by 0.21 percent of payroll.
- Reinstate benefits for college-aged children of deceased beneficiaries and certain other beneficiaries. This provision alone would *increase* the 75-year actuarial deficit by 0.06 percent of payroll and the annual deficit for the 75th year by 0.06 percent of payroll.
- Improve the DI program and address the depletion of its trust fund.

Most of the improvement in the solvency of the trust funds results from four recommendations: raising the payroll tax rate, increasing the taxable maximum, using the chained CPI for the COLA, and raising the NRA and the maximum retirement age.

American Enterprise Institute Plan

As with the two prior plans, the AEI plan, released in June 2016, is broader than the Social Security program. Its recommendations related to Social Security are substantially different from those of the other plans. Estimates of the effect on the projected deficit are not provided.

The main feature of the AEI plan is to transition to a flat benefit structure, setting the benefit high enough to eliminate old-age poverty. The plan would immediately provide every new retiree who has legally lived in the country for at least 40 years a guaranteed benefit at the normal retirement age that is set equal to the poverty threshold of a single person 65 or older (about \$950 per month). Those who have been legal residents for between 10 and 40 years would receive a benefit on a graduated scale. This is similar to Canada's system.

Unlike the current Social Security requirement for an individual to have worked for at least 10 years in order to receive benefits, under the AEI plan the benefits would be provided regardless of how much time a person worked. In future years, the minimum benefit would rise with wage growth; over time, this likely would raise the minimum benefit to above the poverty level, which is adjusted for inflation, not wage growth.

This higher and rising minimum benefit would be offset by declining benefits for all other retirees. This would be accomplished by gradually reducing the 90/32/15 PIA factors to zero by 2075. According to the AEI, "The phase-out of the traditional formula would be calibrated so

that, to an approximation at least, Social Security would honor the benefits that participants have already accrued under the current benefit formula. The goal is for this reform to not cut benefits that participants already have earned and paid for, but instead alter the terms under which participants earn new benefits.”

After a period of several decades, all beneficiaries would receive the same benefit. Thus, the importance of private retirement savings would increase substantially.

The AEI’s plan includes several other provisions:

- Make workers no longer subject to the 12.4 percent payroll tax once they reach age 62. This would encourage individuals to delay retirement and would make older workers more attractive to employers.
- Progressively boost benefits for current retirees. Since current retirees would not receive the guaranteed minimum benefit, current retirees with benefits below the poverty level would be switched to a COLA based on the experimental CPI for the elderly, which is based on purchasing habits of those over 65; the CPI-E tends to measure a slightly higher inflation rate than the CPI-W. Those with relatively low, but above poverty, benefits would continue to have a COLA based on the CPI-W measure, while those with higher benefits would be switched to a chained CPI that on average measures slightly less inflation.
- Raise the early retirement age gradually to 65. The normal retirement age would not be changed.
- Enroll newly hired state and local government workers.
- Reform disability benefits. The reforms should tighten eligibility criteria, increase incentives for employers to accommodate workers with disabilities, and raise the earned income tax credit.

Summary of the Plans

The provisions of each of the four plans cited by the Committee for A Responsible Federal Budget plus the more-recent Social Security Reform Act introduced in Congress are shown in Table 7. The “other provisions” section of the table lists proposals that would either worsen the finances of the trust funds or have an unclear, mixed, or minor effect on finances.

Five provisions that would narrow the deficit have widespread support (proposed in at least three of the five plans):

- Raise the maximum taxable earnings figure.
- Alter the annual cost-of-living adjustment to use a chained CPI.
- Increase the normal retirement age and/or early eligibility age and link further adjustments of the ages to changes in longevity.
- Increase the progressivity of the benefits by changing the 90/32/15 PIA factors and/or the bend points.
- Redesign the disability insurance program.

In addition, there is widespread support to boost the benefits of those with the lowest earnings and those of advanced age, proposals that would increase program costs.

Of the five plans, four (excluding the American Enterprise Institute plan) were evaluated by the Office of the Chief Actuary of the Social Security Administration. Each of the four provides for the OASDI trust funds to be fully solvent throughout the 75-year projection period. Three of the plans (excluding the SOS plan) would be sustainably solvent after the 75-year period.

**TABLE 7
PROVISIONS OF FIVE PLANS TO REFORM SOCIAL SECURITY**

	SOS*	S-B**	C-L^	AEI^^	SJ~
REVENUE PROVISIONS THAT WOULD NARROW THE DEFICIT					
Raise the Maximum Taxable Earnings Level	x	x	x		
Increase the Payroll Tax Rate			x		
Increase Taxes on Benefits for High-Income Earners			x		
BENEFIT PROVISIONS THAT WOULD NARROW THE DEFICIT					
Change the Cost-of-Living Adjustment to Use a Chained CPI	x	x	x		x
Increase the Normal Retirement Age and/or Early Eligibility Age and Link the Ages to Longevity	x	x	x	x	x
Increase the Progressivity of the Benefits by Changing the PIA Factors and/or the Bend Points	x	x	x		x
Apply the Benefit Formula to Annual Earnings			x		x
Cap and Reindex Spousal Benefits			x		x
Reduce the Number of Drop-Out Years	x				
Adopt a Flat Benefit Plan				x	
Require Full-Time School Enrollment for Those 15-to-18 Years of Age to Receive Benefits					x
Redesign the Disability Insurance Program		x	x	x	
OTHER PROVISIONS					
Increase the Benefits for Retirees With Low Incomes	x	x	x	x	x
Increase the PIA for Those With at Least 20 Years of Membership Eligibility	x	x			x
Add Flexibility to the Claiming of Benefits and Provide a Hardship Exemption		x			x
Drop the Payroll Tax at Age 62				x	
Enhance Survivors Benefits			x		
Reinstate Benefits for Certain Beneficiaries			x		
Replace the Windfall Elimination Provision and the Government Pension Offset			x		x
Cover Newly Hired State and Local Government Employees		x		x	
Eliminate Retirement Earnings Test					x
Gradually Eliminate Taxation of Benefits					x
Change Disability Requirements for Widow(er)s					x
Change Requirement for Divorced Spouse					x
Better Inform Future Beneficiaries on Options		x			
Begin a Dialogue on the Importance of Personal Retirement Savings		x			

* SOS: Save Our Social Security, https://www.ssa.gov/oact/solvency/RRibble_20160713.pdf.

** S-B: Simpson-Bowles, http://momentoftruthproject.org/sites/default/files/TheMomentofTruth12_1_2010.pdf.

^ C-L: Conrad-Lockhart, <http://cdn.bipartisanpolicy.org/wp-content/uploads/2016/06/BPC-Retirement-Security-Report.pdf>.

^^ AEI: American Enterprise Institute, <https://www.aei.org/wp-content/uploads/2016/06/Increasing-the-Effectiveness.pdf>.

~ SJ: Social Security Reform Act of 2016 introduced by Rep. Sam Johnson, https://www.ssa.gov/oact/solvency/SJohnson_20161208.pdf.

MEDICARE OPTIONS

Medicare's issues are more complex than those of Social Security due to rapid changes in health care, including substantial increases in health care costs at rates faster than GDP growth.²⁵ Whereas the solution to the Social Security deficit essentially is some combination of increasing revenues and decreasing benefits, controlling costs per beneficiary is an important component of the financial sustainability of Medicare.

Moreover, many of Medicare's issues are intertwined with those of other federal health care functions. While Medicare is the largest portion of the federal government's involvement in health care, the federal government also provides Medicaid and the Children's Health Insurance Program (CHIP), and subsidizes insurance purchased under the Patient Protection and Affordable Care Act (PPACA) — commonly called the Affordable Care Act (ACA) and nicknamed "Obamacare." The ACA is a federal statute enacted on March 23, 2010. It has numerous provisions that affect the operation of Medicare. The changes were designed to improve benefits, slow the growth in spending, and improve the quality and delivery of care.

Another difficulty in summarizing Medicare options is that most of the literature, particularly comprehensive plans to modify Medicare, date from 2013 or earlier. Provisions of the ACA continued to be phased in after 2013 and other statutory changes to Medicare and other federal healthcare programs have been made since then — in particular, the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2), which became law on April 16, 2015. Thus, some of the options discussed in this section may be partially or wholly out of date.

H.R. 2 can be divided into four pieces:

- The Sustainable Growth Rate (SGR) formula that was designed for Medicare to pay physicians was replaced. Instead of a payment decrease as scheduled under the SGR, the new law would increase payments by small annual percentages. Over the first 11 years, CMS estimated that this provision would increase Medicare costs by \$150.5 billion (by \$20.7 billion in 2025).
- The CHIP program was temporarily extended.
- Premiums for Medicare Parts B and D were increased for those with income above a certain level. More beneficiaries will pay the higher premium amounts.
- Numerous other changes were made to Medicare and Medicaid. In particular, payment rate increases for various providers would be limited. The CMS estimated that the combined effect of the changes to Medicare, including the increase in premiums discussed in the prior bullet, was a savings of \$62.2 billion over 11 years (\$10.5 billion in 2025).

The CMS estimated the long-range impacts of H.R. 2 on Medicare, using the 2014 report of the Board of Trustees. It found that H.R. 2 would extend by one year the period before which the HI trust fund would be depleted. The 75-year actuarial deficit would be reduced from 0.87 to 0.84.

²⁵ In 2013, health care expenditures by all parties in the United States amounted to 16.4 percent of GDP. The next-highest share was 11.1 percent in the Netherlands and Switzerland.

In order to understand some of the options, various terms need to be understood. Payments for health care made by beneficiaries — for those with Medicare or other health insurance coverage — fall into two categories:

- Premiums: a fixed, recurring amount paid in advance for an insurance policy.
- Cost sharing: out-of-pocket payments made when health care is received. Three elements determine the cost-sharing obligations of enrollees:
 - Deductible: an initial amount of spending paid entirely by the enrollee, typically per year.
 - Catastrophic cap: a limit on out-of-pocket spending, typically per year.
 - The share of costs paid between the deductible and the cap. The portion of the cost borne by the enrollee may be determined as a percentage of the total cost (called coinsurance) or as a fixed amount for each service (called a copayment).

Unlike Social Security, in which options to reduce the financial imbalances can easily be classified as either revenue raising or benefit reducing, many of the Medicare proposals are difficult to classify as revenue raising, benefit reducing, or cost saving. For example, should an increase in the premium paid by an enrollee be classified as an increase in revenue or as a reduction in benefits? Similarly, is raising a copayment only a means to increase revenue, or does it have the effect of reducing demand and thereby controlling costs?

Due to the complexities in the health care system, there is little certainty about the magnitude of budget savings that could be realized from the many possible reforms in Medicare. According to the Chief Actuary of the CMS, “Projections of health care spending are necessarily uncertain. Reasonable estimates can vary significantly from each other, especially when applied over many years.”²⁶

In general, neither the CBO nor the CMS have made long-term projections of the financial effects of various proposals to modify Medicare — the H.R. 2 analysis was an exception. Projections of the short-term effects also are limited. The CBO has made 10-year projections for certain proposals, primarily those to raise revenue.²⁷ In general, it is a challenge to estimate effects on the HI trust fund (Part A) since so many of the proposals apply to Medicare in general and some proposals combine Parts A and B (and perhaps D).

Options to Reduce Financial Imbalances

- Increase the payroll tax rate for Medicare. If the current rate of 2.9 percent was raised to 3.9 percent in January 2017, the CBO estimates that the revenue gain over 10 years would be \$823.2 billion, including an increase of \$100.5 billion in the 10th year (2026).
- Raise the Medicare eligibility age. Most proposals link the Medicare eligibility age to that of Social Security’s normal retirement age. This age is 67 for those born in 1960 and later. As discussed earlier, there are various proposals to raise the NRA and/or tie it to changes in longevity. Most proposals would change the Medicare eligibility age in step

²⁶ CMS Office of the Actuary, *Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2)*, April 9, 2015, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/2015-HR2.html>.

²⁷ Congressional Budget Office, *Options for Reducing the Deficit: 2017 to 2026*, December 2016, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/52142-budgetoptions2.pdf>.

with Social Security. If the eligibility age started to increase in January 2020 by two months per year, it would reach 67 for those born in 1966 and becoming eligible for benefits in 2033. The CBO estimates a savings of \$55.2 billion through 2026 (\$15.2 billion in 2026).

- Raise premiums paid by Medicare beneficiaries. Currently, the premiums for Parts B and D each cover about one-fourth of the costs of those programs. The CBO estimates that raising the premiums so that they would cover 35 percent of the costs, phased in over five years beginning in January 2018, would reduce Medicare outlays by \$318 billion through 2026 (by \$59 billion in 2026). When Part B began in 1966, the premium was intended to cover 50 percent of the costs.
- Raise premiums only for those with higher incomes. This would be an extension of the means testing that is already used for premiums.
- Establish a temporary Part A premium, to be applied in any year in which an annual deficit is projected in the HI trust fund.
- Combine Parts A and B to increase efficiency and realize cost savings. Currently, the deductible and copayment schedule is different in the two parts; these would be standardized in this option. The new structure could be set so that beneficiaries paid more of the total cost of services. Some proposals include Part D in the new combined structure.
- Require drug companies to give rebates or discounts for low-income Part D enrollees. This provision currently applies to Medicaid beneficiaries. The CBO estimates that if implemented in January 2019, this would reduce federal outlays by \$145 billion through 2026 (by \$26 billion in 2026).
- Allow faster market access to generic versions of biologic drugs. Manufacturers currently receive 12 years of exclusive market access for medications made from living organisms. Proposals have been made to lower this to seven years.
- Prohibit pay-for-delay agreements between brand-name pharmaceutical companies and generic competitors.
- Negotiate drug prices with pharmaceutical companies, which is currently prohibited.
- Institute cost sharing for such services as home health care, the first 20 days in a skilled nursing facility, and laboratory services.
- Reduce Medicare payments for medical education, e.g. teaching hospitals.
- Reduce Medicare payments for a variety of services, including skilled nursing facilities, home health care, laboratory services, and some physician fees.
- Stop paying more for Medicare Advantage plans than traditional Medicare.
- Increase the cost to beneficiaries of supplemental private health insurance. According to the CBO, establishing uniform cost sharing for Medicare in January 2020 would reduce federal outlays by \$18.6 billion through 2026 (by \$2.4 billion in 2026).
- Increase the cost to beneficiaries of Medigap plans that cover all costs so that beneficiaries have no out-of-pocket costs (“first-dollar coverage”). According to the CBO, if implemented in January 2020, this would reduce federal outlays by \$44.5 billion through 2026 (by \$6.7 billion in 2026).
- Introduce minimum out-of-pocket requirements under TRICARE for Life, a supplement to Medicare for military retirees and their Medicare-eligible family members. According to the CBO, if implemented in January 2020, this would reduce federal outlays by \$8.7 billion through 2026 (by \$1.5 billion in 2026).

- Increase penalties for fraud, which may amount to tens of billions of dollars per year.
- Reduce coverage of bad debt, defined as uncollected out-of-pocket payments from patients. Currently, Medicare reimburses eligible facilities, such as hospitals and skilled nursing facilities, for 65 percent of the allowable bad debt. The CBO estimates that reducing this percentage to 45, beginning in October 2017, would reduce federal outlays by \$15.3 billion through 2026 (by \$2.5 billion in 2026). A reduction to 25 percent would have twice the effect.
- Reduce the use of medical procedures and tests by implementing tort reform.
- Enroll beneficiaries covered by both Medicare and Medicaid in managed care. The two programs have different coverage rules and provider access, contributing to higher costs and to challenges providing health care to this group of “dual eligible” beneficiaries.
- Accelerate the ACA’s payment and delivery system reforms.

Among the eight Medicare options for which the CBO provided 10-year estimates of cost savings or revenue increases in 2016, by far the largest effect comes from raising the HI payroll tax by 1 percentage point (employee and employer combined). Increasing premiums for Parts B and D also has a large effect. The next-largest effect comes from requiring drug companies to give rebates to low-income Part D beneficiaries.

Other Suggested Modifications

- Change the fee-for-service system of paying providers to a system that incorporates the quality of care, as promoted in the ACA. This comprehensive care includes “patient-centered medical homes” (PCMH) and “accountable care organizations” (ACO) in which comprehensive care is provided by teams of professionals from different medical disciplines. ACOs are included in the ACA. Groups of hospitals, physicians, and other care providers currently can voluntarily create an ACO to treat Medicare patients. The ACO can share in any cost savings realized by Medicare.
- Ensure that all enrollees have catastrophic coverage — that is, a cap on out-of-pocket expenditures.
- Modify the Independent Payment Advisory Board (IPAB). This board consists of 15 health experts, largely appointed by the President with Senate approval, who are to recommend ways to hold down Medicare spending growth if the growth exceeds a certain limit. It has the authority to reduce payments to some Medicare providers, including hospitals and doctors, but cannot raise beneficiary premiums or reduce benefits. Some proposals would give the IPAB authority to reduce benefits, others would lower the limit on spending growth, while other proposals would eliminate the IPAB.
- Reduce the age of Medicare eligibility. Under this proposal, the average per enrollee need and cost of those with Medicare coverage would decrease.
- Allow enrollees to contract with any physician without financial punishment to the physician.

A number of other specific suggestions have been made. See the section on “Selected Plans to Modify Medicare” for examples.

Fundamental Changes to the Program

The primary suggestion to change fundamentally the Medicare program is to transition it to a premium support plan. Newly eligible Medicare beneficiaries would receive their health

coverage through private insurance plans. Beneficiaries would choose among competing plans, likely including traditional fee-for-service Medicare, with the federal government contributing a fixed amount toward the premium cost of the plan.

Numerous proposals to establish a premium support system have been made over the last two decades. The proposals have differed in many respects, including the means by which the federal distribution would be set and how the federal contribution would change over time.

In 2013, the CBO analyzed two premium support alternatives.²⁸ These options differ largely in terms of the formula by which the federal contribution would be determined. In each alternative, the nation would be divided into regions within which private insurers would submit bids to provide Part A and Part B Medicare benefits to a beneficiary of average health. The fee-for-service program would be part of the system as a competing plan. The cost to the beneficiary would vary with the cost of the plan they selected.

In both alternatives, combined spending by the federal government and beneficiaries would be less than if the current law remained in place. Under the “second-lowest-bid option,” the benchmark used to set the federal contribution would be the lower of a pair of bids: the region’s second-lowest bid submitted by a private insurer and Medicare’s fee-for-service bid. Net federal spending would decline 11 percent, but payments by beneficiaries would increase 11 percent. The total cost borne by the federal government and the beneficiaries combined would decrease 5 percent.

Under the “average-bid option,” the benchmark in a region would be the weighted average of all bids, including the fee-for-service bid. Each bid would be weighted by the proportion of the beneficiaries enrolled in that plan in the preceding year. Net federal spending would decline 4 percent and payments by beneficiaries would decrease 6 percent. The total cost borne by the federal government and the beneficiaries combined would drop 4 percent.

Under both options, effects on premiums and total payments for some beneficiaries would differ greatly from the national average. In particular, in most regions, the premiums and total payments of beneficiaries enrolled in the fee-for-service program would be higher than under current law.

The CBO assumed that the premium support system would be implemented in 2018. They estimated that in 2020, the second-lowest-bid option would save the federal government \$45 billion (6 percent) and the average-bid option would save \$15 billion (2 percent). During the 2020s, the rate of growth in Medicare spending would be similar under the two premium support options to the rate under current law. Thus, the savings in percentage terms would remain the same as in 2020, though the CBO notes that this estimate is subject to considerable uncertainty. After the 2020s, the CBO estimates that the percentage savings from the two premium support options would rise slightly, but the CBO made no effort to quantify the amounts due to the even larger uncertainties. Thus, the CBO’s analysis did not attempt to evaluate the premium-support

²⁸ Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options*, September 2013, <https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/09-18-PremiumSupport.pdf>.

options on a long-term, actuarial basis. However, savings of the magnitude projected by the CBO would not preclude the depletion of the HI trust fund in the foreseeable future.

Selected Plans to Modify Medicare

Plans to address the Medicare program typically come within broader healthcare plans. Medicare-specific recommendations from six plans are summarized below. Since five of these plans were released in 2013 or earlier, they are out of date in some ways. For example, modifications to the Medicare Sustainable Growth Rate (SGR) were adopted in 2015 (H.R. 2) and some of the reforms phased in through the ACA have now been essentially completed (relative to earlier proposals to accelerate the phase-in period). Moreover, the dollar estimates of the effects of the proposals that are included in three of the plans need to be updated.

Simpson-Bowles Plan

The comprehensive 2010 plan from the National Commission on Fiscal Responsibility and Reform included a chapter on health care. The 10-year cost savings cited below were included in the Commission's report, but no information was provided as to how these figures were estimated.

There were six major health care recommendations; those related to Medicare follow:

- Reform the Medicare Sustainable Growth Rate.
- Reduce the costs of Medicare. Seven methods were proposed:
 - Reduce Medicare fraud by providing the CMS greater statutory authority and increased resources. Savings in the first 10 years were estimated at \$9 billion.
 - Reform Medicare cost-sharing rules. Establish a combined deductible for Parts A and B along with uniform 20 percent coinsurance on amounts above the deductible. Reduce the coinsurance rates to 5 percent after costs exceed \$5,500 and cap total cost sharing at \$7,500. Savings in the first 10 years were estimated at \$110 billion.
 - Restrict first-dollar coverage in Medicare supplementary insurance. Prohibit Medigap plans from covering the first \$500 of an enrollee's cost sharing and limit coverage to 50 percent of the next \$5,000 in cost sharing. Without such out-of-pocket charges, enrollees tend to overuse health services. This recommendation includes TRICARE for Life. Savings in the first 10 years were estimated at \$38 billion.
 - Extend the Medicaid drug rebate to dual eligible beneficiaries who receive prescriptions through Part D. Savings in the first 10 years were estimated at \$49 billion.
 - Reduce excess payments to hospitals for medical education provided by Medicare. Savings in the first 10 years were estimated at \$60 billion.
 - Reduce Medicare payments for bad debt. A gradual end to this practice is recommended. Savings in the first 10 years were estimated at \$23 billion.
 - Accelerate the changes included in the ACA regarding reimbursements to home health providers. Savings in the first 10 years were estimated at \$9 billion.
- Aggressively implement and expand payment reform pilots. The ACA requires the CMS to conduct a variety of pilot and demonstration projects in Medicare.

- Eliminate provider carve-outs from the IPAB. The ACA exempted certain provider groups, particularly hospitals, from short-term changes from IPAB's authority.

Of the various planks of this plan, cost-sharing reform was estimated as producing the greatest cost savings. Reducing payments to hospitals for medical education ranked second.

Bipartisan Policy Center Plan

This 2013 plan also was broader than Medicare.²⁹ A number of Medicare proposals were included in three categories:

- Preserve and Improve Medicare Care Delivery and Payment Systems
 - Develop an improved version of Accountable Care Organizations. In doing so, replace the SGR formula and offer all Medicare providers financial incentives to participate in new payment models.
 - Implement modifications to Medicare Advantage plans. Establish a standardized minimum benefit, a cost-sharing limit to protect against catastrophic expenses, and slightly lower cost sharing. Require all plans to include prescription drug coverage.
 - Expand the voluntary bundled payments demonstration into a standard Medicare payment method.
 - Implement a fallback spending limit no sooner than 2020 that would restrain annual age-adjusted per beneficiary spending growth to per capita GDP growth plus 0.5 percent, calculated as a five-year moving average.
- Strengthen and Modernize the Medicare Benefit
 - Implement a new benefit structure for Parts A and B that maintains current aggregate cost sharing for beneficiaries and provides a cost-sharing limit (to protect from catastrophic medical costs). The existing deductibles would be combined; coinsurance for most services would be replaced by a copayment; preventive care would be maintained with no cost sharing; and physician visits would be exempted from the combined deductible.
 - Require all supplemental coverage from Medigap and employer-provided plans to include a deductible of at least \$250 and an out-of-pocket maximum no lower than \$2,500. These policies could cover no more than half of beneficiary copayments and coinsurance.
 - Expand assistance to low-income beneficiaries up to 150 percent of the federal poverty level.
 - Establish lower thresholds so that about 17 percent of beneficiaries would pay income-related premiums.
- Make Medicare and Related System Reforms That Improve Care and Lower Cost Growth
 - Implement durable medical equipment competitive bidding program.
 - Equalize payment rates for office visits to the rate in the lowest-cost setting.
 - End the CMS demonstration related to Medicare Advantage star ratings.
 - Encourage use of high-quality, low-cost drugs, in part by addressing anticompetitive settlements between brand and generic manufacturers.

²⁹ Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, April 2013, <http://bipartisanpolicy.org/library/health-care-cost-containment/>.

- Limit the in-office exception to the physician self-referral law, which precludes a physician from referring a patient to a medical facility in which he has a financial interest, be it ownership, investment, or a structured compensation arrangement.
- Institute changes to graduate medical education.
- Prioritize electronic sharing of information among providers.

Engelberg Center Plan

In 2013, the Engelberg Center released a plan for reforming health care.³⁰ The Medicare portion of the plan had four main planks:

- Transition to Comprehensive Care. Collaborations of providers would receive a globally capitated, comprehensive payment for their attributed beneficiaries. They would have to meet a set of care quality and outcome performance measures for full payment. The organization of providers could consist of an integrated system or networks of providers working together. The comprehensive payment initially would be set to current beneficiary spending; this would increase over time at the rate of per capita GDP.
- Reform Benefits to Support Comprehensive Care and Lower Costs. A maximum would be set for out-of-pocket costs, with reforms to copayments and deductibles. First-dollar coverage would be eliminated from Medigap coverage.
- Reform Medicare Advantage to Promote High-Value Health Plan Competition. Payment updates also would be limited to the rate of growth of per capita GDP.
- Use the savings from reforms to support the transition to comprehensive care. As part of this, the SGR would be replaced by an alternative payment system.

Urban Institute

The Urban Institute proposed a plan specific to Medicare in March 2013 that they estimated would have produced about \$600 billion in net savings over a 10-year period.³¹ Their estimates of the dollar impacts generally were based on estimated savings of similar reforms that had been made by the CBO or the Medicare Payment Advisory Commission, or from estimates made in earlier Urban Institute studies, but in some cases information on which to base the estimates were limited. Thus, the estimated savings should be considered to be rough estimates.

The plan had multiple parts, grouped into three categories:

- Restructure Beneficiary Obligations
 - Raise Medicare eligibility to age 67 but create a Medicare buy-in option for those 65 or 66 years old. The buy in would consist of actuarially fair premiums. Low-income individuals would receive a subsidy through the ACA. The 10-year savings was estimated at \$90 billion, based on a CBO estimate of the savings from increasing the age and a “ballpark estimate” of the cost of the buy-in.

³⁰ Engelberg Center for Health Care Reform at Brookings, *Bending the Curve: Person-Centered Health Care Reform – A Framework for Improving Care and Slowing Health Care Cost Growth*, April 2013, <https://www.brookings.edu/research/bending-the-curve-person-centered-health-care-reform-a-framework-for-improving-care-and-slowing-health-care-cost-growth/>.

³¹ Urban Institute, *Can Medicare Be Preserved While Reducing the Deficit?*, March 2013, <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412759-Can-Medicare-Be-Preserved-While-Reducing-the-Deficit-.PDF>.

- Restructure premiums, cost sharing, and Medigap. There are four interrelated components: (1) institute a unified deductible for Parts A and B that varies with income; (2) raise premiums so that they cover 40 percent of expenses while limiting premium contributions for those with lower incomes; (3) institute an out-of-pocket cap for combined Parts A, B and D cost sharing; and (4) limit Medigap coverage by requiring deductibles and copayments, again making provisions for those with low incomes. The 10-year savings was estimated at \$150 billion, based on a CBO estimate of the savings from applying a uniform deductible with a cap on out-of-pocket expenses, a CBO estimate of the savings from increasing the premiums to cover 35 percent of the costs, a CBO estimate on limits to first-dollar coverage, and an earlier Urban Institute estimate of the cost of subsidies for those with low incomes.
- Adjusting Payments to Plans and Providers
 - Reform Medicare Advantage payments. According to the Urban Institute, “Medicare Advantage plans have paid above-per capita costs for equivalent beneficiaries in traditional Medicare and have used these payments to provide extra benefits to attract more than a quarter of Medicare beneficiaries into private health plans.” This policy attracts enrollment in private plans rather than encourages efficiency and Medicare cost savings. The proposal is to accelerate the reduction of overpayment to Medicare Advantage plans that is in the ACA and to further reduce benchmarks used in plan bids. The 10-year savings was estimated at \$30 billion, based on an earlier Urban Institute estimate.
 - Restore drug rebates for dual eligible beneficiaries. The 10-year savings was estimated by the CBO at \$137 billion.
 - Promote the use of generics by dual eligible beneficiaries by changing the cost sharing. The 10-year savings was estimated by the CBO at \$17 billion, from a MedPAC estimate.
 - Reduce teaching hospital payments and provide targeted incentives. The 10-year savings was estimated at \$50 billion, based on an adjustment to a CBO estimate.
 - Eliminate excessive skilled nursing facility and home health payments. The 10-year savings was estimated at \$35 billion, based on an extension of a five-year MedPAC estimate.
 - Reduce overpayments for clinical laboratory services. The 10-year savings was estimated at \$10 billion; no formal study has been made.
 - Revise the physician fee schedule to reduce rates for overpriced tests and procedures and to increase rates for primary care providers. This proposal assumed a permanent fix to the SGR. The net 10-year savings was estimated at \$15 billion, based on an adjustment to a MedPAC estimate.
 - Repeal the SGR. The 10-year cost was estimated at \$138 billion based on a CBO estimate to eliminate the SGR and institute a 10-year freeze on rates.
- Increase revenue. The payroll tax would rise by 0.5 percent, starting in fifth year of the plan. This was expected to raise \$200 billion, based on a CBO estimate of a 1 percentage-point increase.

Four of the proposals provide significant cost savings or additional revenue: increasing the payroll tax, restoring drug rebates, restructuring premiums, and raising the eligibility age.

A Roadmap to Medicare Sustainability

The authors of this publication — Denis Cortese, Natalie Landman, and Robert Smoldt — specifically focused on Medicare.³² Their plan has two provisions to reduce federal costs — by an estimated net \$618 billion over 10 years — achieved by reducing the number of beneficiaries and reducing the cost per beneficiary:

- Raise Medicare eligibility to age 69 but create a Medicare buy-in option for those between 65 and 68 years old. The buy in would consist of actuarially fair premiums. The age would increase by two months every six months until age 69. Thereafter, the age would be indexed to life expectancy. The 10-year savings was estimated at \$375 billion, based on a CBO analysis of the effect of raising the eligibility age to 67.
- Transition to a premium support model with a national insurance exchange that includes a variety of insurance products. This would be similar to the approach used in the Federal Employees Health Benefits Plan. The amount of premium support would be adjusted by income. The 10-year savings was estimated at \$274 billion, based on a Bipartisan Policy Center estimate.

The plan consists of two additional provisions intended to ensure affordability:

- Establish true pay-for-value reforms. This would start by changing how fee-for-service Medicare pays for hospitalization by expanded Diagnosis Related Groups (DRGs). This proposal would encourage healthcare provider integration and improve the coordination of healthcare services for patients. It is included in the plan since it will take time to phase out Medicare.
- Reduce the use of medical procedures and tests by implementing tort reform.

A Better Way

In June 2016, Republicans in the U.S. House of Representatives, led by Speaker Paul Ryan, released a document on health care, including a section on Medicare.³³

The 13 recommendations related to Medicare are organized into three categories:

- Immediate Relief From “Obamacare”
 - Strengthen Medicare Advantage. Three changes are proposed: (1) repeal the benchmark cap on payments to providers; (2) limit the ability to negatively adjust MA payments based on accurate coding; and (3) restore an open enrollment period.
 - Repeal the IPAB.
 - Repeal the Center for Medicare and Medicaid Innovation on January 1, 2020.
 - Repeal the ban on physician-owned hospitals.
 - Repeal the changes to the hospital wage-index system.
- Structural Reforms
 - Allow for value-based insurance design through Medicare Advantage. This would give insurers more flexibility in designing plans.

³² Arizona State University, Healthcare Delivery and Policy Program, *A Roadmap to Medicare Sustainability*, February 2013,

http://healthcaretransformationinstitute.org/sites/default/files/RMS_022713.pdf.

³³ *A Better Way*, June 22, 2016, <http://abetterway.speaker.gov/assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf>.

- Restrict Medigap plans, beginning in 2020.
- Combine Medicare Parts A and B. There are four parts to this proposal: (1) create a single deductible; (2) institute an annual out-of-pocket maximum; (3) implement a standard 20 percent cost-sharing requirement for all services; and (4) streamline the three assistance programs known as Medicare Savings Programs into one program, requiring states to use one uniform asset test for qualification in the program.
- Protect the doctor-patient relationship by easing the regulatory requirements on doctors.
- Reform the disproportionate share hospital (DSH) payments. These payments — through Medicare and Medicaid — support care for low-income patients. This proposal has two parts: (1) repeal the fiscal year 2018 and 2019 Medicare DSH cuts (and Medicaid cuts); and (2) beginning in FY 2021, create one combined national pool of uncompensated care funds and make the distribution of funds based on certain federally collected data.
- Create a website that compares the performance of Medicare Advantage and traditional fee-for-service plans. The website would provide data on a core set of quality measures by metropolitan statistical area beginning in 2020.
- Increase the Medicare eligibility age. The age would be gradually raised to correspond with Social Security.
- Preserving Medicare for Future Generations
 - Implement Premium Support. Beginning in 2024, Medicare beneficiaries would be given a choice of private plans competing with traditional fee-for-service Medicare. The premium support payment would be paid by Medicare directly to the plan or fee-for-service program. The premium support program would operate similarly to the Federal Employees Health Benefits program. The support payment would be greater for those with low incomes and those who are very sick. The private plans would be required to provide insurance to all Medicare beneficiaries.

Summary of the Plans

The provisions of each of the six plans are shown in Table 8. Five proposals to control costs were mentioned in at least three of the plans: combining Medicare Parts A and B; increasing the age of Medicare eligibility; placing limitations on Medigap policies, particularly those providing first-dollar coverage; reforming Medicare Advantage, including reducing payments; and reducing payments for medical education. In addition, there was support for creating out-of-pocket caps for all enrollees.

Unlike the plans to address issues with Social Security, none of the plans to address Medicare issues have been evaluated to determine whether the HI trust fund will remain solvent over the long term. Three of the six plans provide no financial estimates and the other three plans estimate cost savings only over a 10-year period.

TABLE 8
PROVISIONS OF SIX PLANS TO REFORM MEDICARE

	S-B*	BPC**	EC^	UI^^	CLS#	GOP~
PROVISIONS TO NARROW THE DEFICIT						
Increase the Payroll Tax Rate				X		
Raise the Eligibility Age				X	X	X
Increase Premiums, but Limit the Premiums for Those With Low Incomes				X		
Raise Premiums Only for Those With High Incomes		X				
Combine Parts A and B	X	X		X		X
Place Limits on Medigap Policies, Particularly on First-Dollar Coverage	X	X	X	X		X
Reform Medicare Advantage, Including Payment Reductions		X	X	X		
Restore Drug Rebates for Dual Eligible Beneficiaries	X			X		
Change Cost Sharing to Promote the Use of Generic Drugs				X		
Disallow Anticompetitive Settlements Between Drug Companies		X				
Reduce Payments for Medical Education	X	X		X		
Decrease Payments for Skilled Nursing and Home Health	X			X		
Reduce Payments for Laboratory Services				X		
Decrease Payments for Certain Physician Fees		X		X		
Combat Medicare Fraud	X					
Reduce Payments for Bad Debt	X					
Require Durable Medical Equipment to be Competitively Bid		X				
Eliminate the Provider Carve-Out From IPAB	X					
Transition to a Premium Support Plan					X	X
Repeal the Center for Medicare and Medicaid Innovation						X
Implement Tort Reform					X	
OTHER PROVISIONS INCLUDED IN MORE THAN ONE PLAN						
Implement an Out-of-Pocket Cap for All Enrollees		X	X	X		
Expand Comprehensive Care/Accountable Care Organizations		X	X			

* S-B: Simpson-Bowles, http://momentoftruthproject.org/sites/default/files/TheMomentofTruth12_1_2010.pdf.

** BPC: Bipartisan Policy Center, <http://bipartisanpolicy.org/library/health-care-cost-containment/>.

^ EC: Engelberg Center, <https://www.brookings.edu/research/bending-the-curve-person-centered-health-care-reform-a-framework-for-improving-care-and-slowng-health-care-cost-growth/>.

^^ UI: Urban Institute, <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412759-Can-Medicare-Be-Preserved-While-Reducing-the-Deficit-.PDF>.

CLS: Cortese-Landman-Smoltdt,

~ GOP: A Better Way, <http://abetterway.speaker.gov/assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf>.