Statement before the House Committee on Energy and Commerce

Subcommittee on Health Hearing

A 21st Century Medicare:

Bipartisan Proposals to Redesign the Program's Outdated Benefit Structure

Bigger Steps Needed for Medicare Cost-Sharing Reform

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Summary Points

- Slowing the future rate of Medicare spending to below its currently projected baseline level should be the primary reason for reforming the structure of cost sharing in the traditional Medicare program.
- A major-risk approach to cost sharing, with higher coinsurance and annual stop-loss caps tied to income level, could provide the fairest and most effective avenue toward the best results.
- Taxes on Medigap coverage just complicate the tax code more without much precision in retargeting Medicare spending incentives; instead, higher-income seniors should be subsidized less and low-income seniors subsidized more.
- Modernization of Medicare cost sharing could improve integration of health care delivery, realign incentives to improve value-based health care, protect beneficiaries against catastrophic health risks, and facilitate more effective competition between traditional Medicare and private Medicare Advantage plans
- Changes in cost sharing must continue to protect vulnerable low-income beneficiaries and remain administratively feasible.

Thank you Chairman Pitts, Ranking member Pallone, and members of the Subcommittee on Health for the opportunity to testify today on redesigning Medicare's outdated benefit structure, particularly its provisions for cost sharing.

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based research organizations.

Finding economically feasible and politically tenable options for slowing the rate of spending growth in Medicare through restructured cost sharing -- without harming the quality of care delivered or jeopardizing vulnerable beneficiaries -- has proven to be no easy task. A variety of government organizations, including the Congressional Budget Office and Medicare Payment Advisory Commission, and academic health policy researchers have put forth recent plans to improve the program, but they often diminish potential savings by playing it too safe. The best option for sustainable reform that balances a number of competing policy considerations appears to be a major-risk approach toward restructuring

cost-sharing requirements for the traditional Medicare program. It involves a higher coinsurance rate and a stop-loss income-related cap on participants' annual cost-sharing liabilities. An additional key to subsidizing high-income seniors less is by restricting their use of supplemental insurance such as Medigap for early-dollar spending, rather than taxing the coverage itself.

When health policy analysts join forces with budget-deficit hawks to search for remaining targets of belt-tightening in the Medicare program, they usually find that the policy reform shelves are relatively bare of politically "safe" options that can deliver early and significant cost savings.

Most premium support proposals generally would delay their implementation for at least a decade, and they stop short of seriously threatening the longevity of the traditional Medicare fee-for-service (FFS) program. Although the Affordable Care Act (ACA) relies heavily on annual, across-the-board reimbursement cuts for health care providers, the sustainability of its budgetary formulas that would eventually drive some Medicare payments down to below-cost Medicaid levels remains dubious. Raising the eligibility age for Medicare benefits in the near term also seems ahead of its time.

Repeatable and scalable results from a host of fiscal-science-fair demonstration projects in the ACA are always somewhere over the budget

window's horizon. And the ability of pioneering accountable care organizations to breed in the regulatory captivity of Obamacare will require heroic assumptions about either asexual reproduction or politically assisted artificial insemination.

However, restructuring the splintered cost-sharing requirements of the traditional Medicare FFS program's separate silos for parts A and B (if not part D)[1] provides another potential policy reform tool that could achieve the twin goals of saving taxpayer dollars while improving risk-protection benefits for elderly beneficiaries. By increasing Medicare enrollees' cost consciousness regarding more discretionary, first-dollar health care choices,[2] a coordinated set of changes in the traditional program's deductible and coinsurance provisions could help reduce current and future levels of Medicare spending. At least some of those savings from greater sharing of health care costs between Medicare insurance benefits and enrollee's out-of-pocket payments at the front end could be used to provide better "stop-loss" protection against larger catastrophic risks.

My testimony today is going to focus primarily on *how* policymakers might restructure traditional Medicare cost sharing to achieve these goals, and less on the lively debate that continues over *whether* they should do so. Regarding the latter issue, the arguments for cost sharing reform within the

traditional menu of benefits within Medicare FFS usually first point to the higher discretionary spending that its relatively low deductibles produce, particularly when augmented by additional layers of supplemental insurance coverage (such as individual Medigap insurance, employer-sponsored retiree coverage, and Medicaid). Past research studies differ in the magnitude of this effect, but they generally agree on its direction.[3] Most recently, a MedPAC-sponsored study concluded that total Medicare spending was 33 percent higher for beneficiaries with Medigap policies than for those with no supplemental coverage. For beneficiaries with employer-sponsored supplemental coverage, Medicare spending was 17 percent higher.[4]

Although such potential budgetary savings generally provide the strongest political rationale for Medicare cost-sharing reform, they must compete with and complement other policy considerations. Modernization of Medicare cost sharing could improve integration of health care delivery, realign incentives to improve value-based health care, protect beneficiaries against catastrophic health risks, and facilitate more effective competition between traditional Medicare and private Medicare Advantage plans. At the same time, changes in cost sharing must continue to protect vulnerable low-income beneficiaries and remain administratively feasible.

Past Proposals to Restructure Medicare Cost Sharing

Proposals for reform of Medicare cost sharing are far from virgin territory in health policy circles. The historical legacy of Medicare's original division between hospital-based care and other outpatient care (with two separate trust funds and sources of financing) has produced substantial initial cost sharing for the first day of hospital care in the form of a high deductible ($1,184 in 2013) in Part A, but a much lower deductible ($147 in 2013) for outpatient services spending in Part B.

However, coinsurance cost sharing of 20 percent for each additional dollar of Part B outpatient care above that program's initial deductible amount is not capped, and it could potentially amount to even greater out-of-pocket liabilities for beneficiaries. For example, 6 percent of Medicare fee-for-service beneficiaries who enrolled in Part A and Part B for 12 months in 2009 had a cost-sharing liability of $5,000 or more (assuming no additional insurance coverage, such as an individual Medigap plan, employer-sponsored retiree coverage, or Medicaid supplemental benefits for low-income retirees).[5] Moreover, the probability of catastrophic health spending over time is higher than the probability within a single year would indicate.[6]

Hence, a majority of the members of the National Bipartisan Commission on the Future of Medicare in 1999 recommended that the

separate deductibles for Part A and Part B be replaced with a single deductible of $400, which then would be indexed to growth in Medicare costs.[7]

In March 2011, the Congressional Budget Office (CBO) analyzed the effects of replacing Medicare's mix of cost-sharing requirements with a single combined deductible of $550 (covering all Part A and Part B services), a uniform coinsurance rate of 20 percent for amounts above that deductible, and an annual cap of $5,500 on each enrollee's total cost-sharing liabilities. CBO estimated that if this option took effect on January 1, 2013, with the various thresholds indexed to growth in per capita Medicare costs in later years, federal spending for Medicare would fall by about $32 billion over the 2012–21 period.[8]

Limiting the Spillover Spending Effects of Supplemental Coverage

If Medigap plans—private plans designed to supplement basic Medicare coverage and sold to individuals—were barred from paying the first $550 of an enrollee's cost-sharing liabilities for calendar year 2013 and could cover only half of other Medicare cost sharing (equivalent to changing Part B's 20-percent coinsurance rate to only 10 percent) up to the annual $5,500 cap on total cost sharing (and if the various thresholds were indexed to growth in per-capita Medicare costs for later years), CBO estimated that,

under this reform option, projected federal outlays would be reduced by roughly $93 billion over the 2012–21 period.[9]

MedPAC Leaves More Restructuring Discretion to HHS Secretary

In June 2012, the Medicare Payment Advisory Commission (MedPAC) proposed a slightly different approach to reform Medicare's benefit design. It recommended an annual deductible for Part A and Part B services equaling $500 (while leaving open whether it would be combined or separate for those categories). However, MedPAC suggested that copayments (fixed dollar amounts), rather than coinsurance (a percentage of costs), should apply for cost sharing above the deductible amount and until a total annual, out-of-pocket $5,000 maximum is reached.[10] It further complicated and diluted the effects of this restructuring by insisting that beneficiaries' cost-sharing liabilities in the aggregate should not increase in the redesign of the traditional Medicare fee-for-service program. MedPAC also proposed that copayment amounts may vary by type of service and provider, with the secretary of health and human services altering or eliminating cost sharing based on evidence of the value of particular services.[11]

MedPAC took a sizable leap of faith that the likely evidence base will be sufficiently robust for the secretary to tailor cost sharing in an accurate

and consistent manner. The Medicare advisory body then urged a different "tax" approach to discourage, or at least recoup, some of the added costs imposed on the basic Medicare program when supplemental Medigap coverage encourages greater spending. Instead of relying solely on barring Medigap insurers from paying any of the initial costs falling within the unified deductible and then limiting reductions in coinsurance liabilities above that amount to no more than half the standard 20-percent rate for Part B spending, MedPAC would allow beneficiaries the option to add costs to this (newly restructured) basic Medicare coverage through additional Medigap insurance. But they then would be charged for exercising this privilege with an extra 20-percent "excise tax" on the value of that supplemental coverage.[12]

The actual effects of this change in the treatment of supplemental Medicare coverage[13] would vary depending on the degree to which beneficiaries choose to retain their additional coverage and pay the tax (producing new revenue to offset some of the higher Medicare spending), as opposed to dropping that coverage and creating more budget savings through lower Medicare spending.

Adjusting Cost Sharing for the Income Levels and Health Risks of Beneficiaries?

Earlier this year, MIT economist Jonathan Gruber proposed a plan for restructuring cost sharing and supplemental insurance for Medicare, as part of the Brookings Institution's *15 Ways to Rethink the Federal Budget.* He expressed concern with the affordability of revisions to cost sharing among seniors under some of the previous reform proposals, as well how proposed stringent regulation on supplemental Medicare plans would not allow the plans to "reflect diversity of elders' tastes for supplemental coverage."[14]

Gruber proposed an alternative to previous CBO proposals, based instead on an "income-related" out-of-pocket maximum. Gruber divides those stop-loss limits into just four income categories and then sets their maximums as respective fractions (1/3, 1/2, 2/3, and all) of the current-law health savings account stop-loss limit ($5,950) that also is used under the Affordable Care Act's rules for qualified insurance coverage. He also recommends reducing the unified deductible by half (to $250) for seniors below 200 percent of the federal poverty level.[15]

Gruber concedes that computing the amounts of such out-of-pocket protections will be administratively difficult and could raise privacy concerns if private insurers must know the incomes of individual Medicare

beneficiaries. The greater irony is that Gruber admits that his plan to protect low-income seniors by lowering their income-related, out-of-pocket maximums "by itself is unlikely to produce any budget savings."[16]

To retrieve those dollars for the federal Treasury. Gruber proposes a tax on supplemental Medicare coverage—even higher than the one envisioned by MedPAC—to offset the higher Medicare spending that supplemental coverage causes. Subject to political negotiations, he estimates that a tax rate of up to 45 percent on Medigap plan premiums and on the cost of employer-sponsored retiree coverage would be justified.[17] Gruber concludes that the budgetary implications of this proposal are "difficult to infer."[18]

In an earlier *American Economic Review* study in 2010 with coauthors Amitabh Chandra and Robin McKnight,[19] Gruber recommended that increased cost sharing should be tied to a patient's underlying health status (rather than just income), with chronically ill patients facing lower cost sharing. The authors found that higher copayments for office visits and prescription drugs reduced Medicare medical spending, with elasticities of demand similar to those reported in the RAND Health Insurance Experiment[20] for the nonelderly. However, Chandra, McKnight, and Gruber also noted a significant offsetting rise in use of hospital care visits and

overall hospital-based spending (reducing net budget savings from higher copayments on other services by about 20 percent) because of the higher copayments for outpatient care and prescription drugs. Moreover, they found large offsets for the sickest Medicare populations with chronic diseases, suggesting that higher copayments for that cohort of beneficiaries produced little net budgetary savings for the Medicare program.[21]

Hence, Gruber and his coauthors concluded that because the "mirror effect" of this relationship suggests that an *increase* in physician and drug spending arising from supplemental Medicare coverage is substantially offset (within the traditional Medicare program) by the *fall* in hospital costs, income-related out-of-pocket limits alone provide far-from-optimal health insurance (and Medicare cost savings). They recommend further specific targeting of copayments related to the underlying health status of chronically ill patients.[22]

Keeping Cost-Sharing Reform Simpler and More Effective

In any case, there is a better way to handle income-related limits on more unified Medicare cost sharing, again courtesy of a younger but wiser Jonathan Gruber. In 1994, Gruber and coauthor Martin Feldstein proposed "A Major Risk Approach to Health Insurance Reform."[23] To reduce the economic dead-weight loss produced when low coinsurance rates (and low

marginal costs of insured care) induce excessive consumption of health care and inefficient resource allocation, Gruber and Feldstein modeled a different type of health insurance plan. It would have a 50-percent coinsurance rate but limit out-of-pocket health spending to 10 percent of income.

They estimated that aggregate welfare gains (which also include reduced risk bearing for large health care costs) by switching to major-risk insurance for both private and public (Medicare and Medicaid) health coverage would range from $34 billion to $110 billion—*in 1995 dollars*.[24] Those estimates varied depending on the degree of risk aversion and price elasticity of demand, respectively, by health care consumers. For example, a higher degree of risk aversion and higher demand elasticity would produce a larger welfare gain.

An attractive dimension of the major-risk approach is its relative progressivity. Average out-of-pocket spending under the plan rises sharply as income rises because the stop-loss maximum rises with income. The major-risk plan reduces the total consumption of health care much more for high-income individuals. It also alters the risk distribution individuals face by increasing the risk of modest spending but limiting the maximum risk.

Gruber and Feldstein noted that relying on 50-percent coinsurance, rather than the equivalent amount of cost sharing (up to 10 percent of

income) solely through a first-dollar deductible, extends the ability of the plan's cost-sharing incentives to reduce dead-weight losses across a wider range of health spending. But it also limits the value of the increased risk to individuals through greater cost sharing. Of course, the various specific projections of welfare-gain effects in the 1994 study would need to be updated to align with current levels of health spending, and they remain sensitive to relative assumptions about the levels of demand elasticity and risk aversion for health care consumers.

Policy Priorities for Reform

The larger lesson from these analyses of Medicare cost-sharing restructuring involves the importance of setting clear policy priorities, avoiding trying to accomplish conflicting goals with the same policy instrument, and carrying out first what matters most.

Slowing the future rate of Medicare spending to below its currently projected baseline level should be the primary reason for reforming the structure of cost sharing in the traditional Medicare program. That means most beneficiaries (except for those provided separate special protection from this reform) will actually end up receiving lower levels of taxpayer subsidies and either pay more for the Medicare services they want or get fewer (or less expensive) services. The most appropriate area of Medicare

spending to face those new cost-sharing incentives involves early-dollar, discretionary spending, rather than the costs facing beneficiaries with much more expensive or chronic medical conditions.

The major-risk approach to Medicare reform makes the most sense for most beneficiaries. It balances protecting them more effectively against catastrophic financial risks with increasing their cost consciousness for decisions involving health care costs they can manage better within the limits of their income. By relying on a higher percentage of coinsurance (rather than a large front-end deductible), this approach also produces the best mix of stop-loss protection and greater sensitivity to the non-catastrophic costs of covered services.

Maneuvering through Exceptions and Implementation

Trying to overcompensate and dilute the tension between most beneficiaries' income constraints (including the opportunity cost of spending for other non-health-care wants and needs) and their initial layers of health care need is likely to undermine the main purpose for taking on the difficult political challenge of increasing cost sharing for the traditional Medicare program. Nevertheless, it would prove to be too economically harsh and politically disastrous to ignore the need for at least some enhanced

protection of many lower-income Medicare beneficiaries within a higher cost-sharing approach.

Implementing a Medicare policy change of this magnitude also poses significant challenges. A new cost-sharing structure must remain understandable and workable in practice. It has to be sensitive to differences among beneficiaries but avoid trying to be customized to such a granular level that it cannot provide predictable incentives or support everyday billing and payment operations. Focusing cost-sharing reform on Medicare FFS also must account for keeping the future playing field as level as possible in the traditional program's competition with Medicare Advantage plans in attracting and retaining enrollees.

The administrative complexities of income-related cost sharing can be managed through setting a reasonable range of annual income bands linked to proportionately related mixes of out-of-pocket maximum levels (rather than calculating them dollar for dollar at every level of reported income).[25] This should be supplemented with a narrow set of opportunities to appeal for exceptions based on unexpected hardship.

The cleaner and less complicated way to deal with the distortions of supplemental insurance for traditional Medicare enrollees is to set regulatory boundaries on what either individual Medigap plans or employer-sponsored

retiree plans can cover.[26] The current tax code already produces enough distortions in economic decision making without adding a new excise tax on supplemental insurance premiums to that list.[27] Instead of taxing a small slice of affluent seniors *more* and then recycling some of that revenue back to other lower-income seniors (with all the inefficient processing and extraction charges this political spin cycle entails), it would be far better simply to subsidize nonpoor seniors *less*.

We should acknowledge the relationship between personal income and the ability to handle much greater cost sharing for health care services,[28] but respond by developing a separate program of cash subsidies to lower-income Medicare beneficiaries facing more chronic health conditions. Such financial assistance could be distributed directly to their (new) individual Medicare savings accounts based on a combination of their income and health risk scores. An alternative option would restructure and streamline current Medicare Savings Programs for low-income Medicare beneficiaries to match a more unified set of cost-sharing provisions in Medicare FFS.[29]

Although such subsidies should be carefully targeted to be most generous to beneficiaries with the lowest incomes and the greatest health risks, their exact size and scope also should be related to the budget savings and cost-conscious economizing incentives that policymakers seek. Pushing

back on one end of the cost-sharing continuum would need to be balanced by increased cost sharing for higher-income and lower-risk beneficiaries. Although using an income-related stop loss limit on Medicare FFS cost sharing helps keep a beneficiary's out-of-pocket financial burden proportional to his or her income, it may be necessary to extend some additional, lesser amounts of cost sharing subsidies even to some beneficiaries with incomes somewhat above the dual-eligibility level for Medicaid.

The distortions of supplemental insurance coverage primarily harm the traditional Medicare FFS program, whether they originate from individual Medigap plans or employer-sponsored retiree coverage. These cost-sharing reforms are not needed for private plans in Medicare Advantage because the coverage scheme in those plans is integrated within a single insurer rather than spread across a taxpayer-financed primary insurer (traditional Medicare) and a secondary private insurer. To the extent that some further adjustments in cost-sharing rules for Medicare Advantage plans still may be needed for their annual competitive bidding process, they could be handled by using an actuarial equivalence standard that allows them to offer different cost-sharing packages (similar to how past and present Part D

prescription drug plans have varied so widely from the original statutory benefit defined in the Medicare Modernization Act).

Any remaining problems of mixed cost-sharing incentives and competitive effects could be corrected in two ways: (1) Require private insurers to offer only integrated coverage (current-law Medicare benefits plus any supplemental ones), with a separate price and taxpayer subsidies for the basic Medicare coverage, or its actuarial equivalent, determined through premium-support-style competitive bidding,[30] and (2) Authorize the traditional Medicare program greater administrative flexibility needed to compete in such a bidding regime, such as by offering more enhanced catastrophic stop-loss protection and changing other cost-sharing provisions to offset its budgetary costs.[31]

Given the future budgetary stresses and broader sustainability challenges facing the Medicare program, this more aggressive approach to reform its cost sharing is long overdue. But taking two modest, but important, steps forward—a unified deductible and a stop-loss limit for traditional Medicare—will provide little progress if we then take two steps backward—diluting such cost sharing for most Medicare beneficiaries on the unbounded assumption that very few may be able to afford it (or that too many then would refrain from seeking necessary health care services), and

instead adding a new tax at a fill-in-the-blank rate on supplemental insurance plan coverage.

The 1984 Walter Mondale presidential campaign once was tagged with an uninspiring, but telling, slogan for such tactics: “Dares to be cautious.”[32]

The cost-saving juice must be worth the political squeeze in undertaking reform of Medicare cost sharing. A major-risk approach to reform of cost-sharing and taxpayer subsidies for coverage offers more future reward, whether for just Medicare or also the rest of the private health insurance market (as Feldstein and Gruber originally proposed).

The particular parameters for restructured cost sharing suggested in my testimony, of course, are merely suggestive markers rather than fixed points. They can be adjusted higher or lower, depending on the full mix of competing policy priorities and budgetary saving score that is desired. But they all will operate within a reformed Medicare FFS program that relies more on income-related cost-consciousness, enhances insurance protection against catastrophic risks, and reduces the likelihood of rising premiums and steeper taxes.

Notes

[1] Part A for Medicare covers the costs of inpatient care (primarily hospital spending). Part B covers physicians' services and other outpatient care. Part D covers prescription drug expenses. Each part of the traditional Medicare program has its own sources of financing (a payroll tax for Part A, separate enrollee premiums plus general revenue support for Parts B and D).
[2] Such discretionary spending decisions may involve either purchases within the scope and scale of first-dollar deductibles or other purchases subject to cost-sharing (either coinsurance or copayments) before any stop-loss limit on out-of-pocket spending is reached.
[3] See, for example, Adam Atherly, "Supplemental Insurance: Medicare's Accidental Stepchild," *Medical Care Research and Review* 58, no. 2 (2001): 131-161; Sandra Christensen and Judith Shinogle, "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," *Health Care Financing Review* 19, no. 1 (1997): 5-17.
[4] Christopher Hogan, "Exploring the Effects of Secondary Insurance on Medicare Spending for the Elderly," A Study Conducted by Staff from Direct Research, LLC, for MedPAC, 2009.
[5] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, DC, June 2012), 5.
[6] Ibid., 10.
[7] National Bipartisan Commission on the Future of Medicare, *Building a Better Medicare for Today and Tomorrow* (Washington, DC, March 16, 1999).
[8] Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options* (Washington, DC, March 10, 2011): 49.
[9] Ibid., 49-50.
[10] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System,* 20.
[11] Ibid., 19.
[12] Ibid., 21.
[13] MedPAC would also apply the same reform to employer-sponsored retiree coverage.
[14] Jonathan Gruber, "Proposal 3: Restructuring Cost Sharing and Supplemental Insurance for Medicare," in *15 Ways to Rethink the Federal Budget,* ed. Michael Greenstone et al. (Washington, DC: Brookings Institution, February 2013), 25.
[15] Ibid., 25.
[16] Ibid.
[17] Ibid., 25–26.
[18] Ibid., 26.
[19] Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *The American Economic Review* 100, no. 1 (2010): 193–213.
[20] The RAND Health Insurance Experiment (HIE) remains the most extensive and important experimental study of the effects of cost-sharing and the design of health insurance benefits. Its results demonstrated that higher patient payments (cost sharing) significantly reduced use of medical care, without any adverse health outcomes for the average person. See, for example, Joseph Newhouse. *Free for All: Lessons from the RAND Health Insurance Experiment*. (Cambridge, MA: Harvard University Press, 1993).
[21] Amitabh Chandra, Johnathan Gruber, and Robin McKnight, "*Patient Cost-Sharing and Hospitalization Offsets in the Elderly*," 209–11.
[22] Ibid., 212.
[23] Martin Feldstein and Jonathan Gruber, "A Major Risk Approach to Health Insurance Reform" (working paper 4852, National Bureau of Economic Research, Cambridge, MA, September 1994).
[24] Ibid., 26. A full and accurate update, in terms of current (2013) dollars is not readily available, because it involves more variables than simply the effects of health care spending inflation over time.
[25] This involves balancing the unworkability of administering customized "personal" cost sharing limits for literally millions of Medicare beneficiaries against dilution of relatively income-sensitive variations in cost sharing, as well as treating seniors with significantly different incomes too similarly. The issue comes down to how wide a dollar-income range needs to be maintained between changes in stop-loss limits for different cohorts of Medicare seniors. Those cost-sharing brackets certainly should be narrower than those used for the federal income tax's rate brackets, but at least wider than every ten-thousand dollar interval in

additional reported income. Congress has a good deal of experience in making similar judgments for the phase-out of income-related tax subsidies or phase-in of higher income-related taxes.

[26] For example, certain preventive health benefits that pass an evidence-based test for cost-saving or health-enhancing effectiveness could be exempted from the new Medicare FFS cost sharing provisions, somewhat similar to how they already are treated in HSA-qualified plans in the private insurance market today.

[27] See, for example, Tom Miller, "Rethinking the 'Other' Payroll Tax," Real Clear Politics, January 11, 2012.

[28] For example, about half of all Medicare beneficiaries had annual incomes (as individuals, not households) below $22,500 in 2012, and one-quarter of them had incomes below $14,000. Kaiser Family Foundation, "Income-Relating Medicare Part B and Part D Premiums under Current Law and Recent Proposals: What Are the Implications for Beneficiaries**?"** February 2012**.** About 35 percent of Americans age 65 and older had incomes below 200 percent of the federal poverty level.

[29] See, for example, Stephen Zuckerman, Baoping Shang, and Timothy Waldmann, "Policy Options to Improve the Performance of Low-Income Subsidy Programs for Medicare Beneficiaries," Urban Institute, January 2012.

[30] See, for example, note 7.

[31] See note 7; Thomas Miller, *When Obamacare Fails: The Playbook for Market-Based Reform* (Washington, DC: American Enterprise Institute, December 2012), 20.

[32] Mondale's media director, Roy Spence, infamously praised his boss because he "dares to be cautious." Richard Cohen, "Jackson Shows Mondale's Caution," *Boca Raton News*, January 6, 1984,