Department of Health and Human Services

Sunset Head Start to Make Way for State, Local, and Private Alternatives

RECOMMENDATION

Congress should reduce funding for Head Start by 10 percent in fiscal year (FY) 2019, and by an additional 10 percent every year thereafter until the program is sunset in 2028.

RATIONALE

In addition to its questionable status as a function of the federal government under the Constitution, the federal Head Start program has failed to live up to its stated mission of improving kindergarten readiness for children from low-income families. In December 2012, the Department of Health and Human Services (HHS), the agency that administers Head Start, released a scientifically rigorous evaluation of more than 5,000 children participating in the program. It found that Head Start had little to no impact on the cognitive skills, social-emotional well-being, health, or parenting practices of participants. Low-income families should not have to depend on distant, ineffective federal preschool programs.

As such, Congress should sunset the federal Head Start program over a period of 10 years. The sunset provision will provide states with adequate time to determine whether they need to provide additional state funding to subsidize day care for low-income families. To begin phasing out the program, Congress should reduce Head Start funding by 10 percent in FY 2019, completely restoring revenue responsibility for the program to the states within 10 years.

ADDITIONAL READING

- Lindsey M. Burke and David B. Muhlhausen, "Head Start Impact Evaluation Report Finally Released," Heritage Foundation *Issue Brief* No. 3823, January 10, 2013
- David B. Muhlhausen, "The Head Start CARES Demonstration: Another Failed Federal Early Childhood Education Program," Heritage Foundation *Backgrounder* No. 3040, August 6, 2015.
- David B. Muhlhausen, "Head Start Program: Fraudulent and Ineffective," Heritage Foundation *WebMemo* No. 2919, May 28, 2010.

Medicare Reform: Slow Down the Rate of Spending and Preserve the Program for Future Retirees

RECOMMENDATION

Undertaking a comprehensive reform of Medicare is a major policy challenge. Meeting that challenge is a national necessity. It will require the President, working with Congress, to adopt and carefully implement several inter-related policy recommendations:

- **Unify Medicare Part A and Part B.** The Medicare program is divided into four programs: Part A (hospitalization); Part B (physician services); Part C (comprehensive private Medicare plans); and Part D (prescription drug coverage). Congress should combine Medicare Part A and Part B into a single plan and streamline Medicare's cost sharing with one premium, one deductible, uniform cost sharing, and add a catastrophic limit. This would remove Medicare's outdated silo structure and provide seniors with a more coherent program that integrates both hospital and physician services, reduces its array of confusing cost-sharing requirements, and secures protection against the financial devastation of catastrophic illness.
- **Gradually raise the standard age of Medicare eligibility.** The average life expectancy has increased greatly since Medicare was created in 1965, but the program's age of eligibility (age 65) has remained the same. Congress should gradually increase the age of eligibility to 68 years of age and then index it to life expectancy. This change better reflects today's life expectancy, and better aligns Medicare eligibility with Social Security eligibility.
- **Gradually increase Medicare enrollee premiums based on income.** Medicare Parts B and D are voluntary programs, and they are financed by beneficiary premiums and taxpayer subsidies drawn from the Treasury. For the vast majority of Medicare enrollees, these taxpayer subsidies for Parts B and D premiums amount to 75 percent of their total Part B and Part D premiums. Under current law, wealthy Medicare recipients are required to pay more for these Medicare benefits: Single individuals with an annual income of $85,000 and couples with an annual income of $170,000 are thus required to pay higher premiums for physician and outpatient services and drugs.[1] About 6 percent of the total Medicare population thus receives fewer taxpayer subsidies for their Parts B and D benefits. Congress should expand the income thresholds for these premium subsidies so that approximately 10 percent of the total Medicare population would pay higher income- related premiums. Medicare premiums should increase gradually with incremental increases in annual income. This would ensure that limited taxpayer resources are distributed more evenly based on income, and would target subsidies to those who need them most.
- **Allow private contracting in Medicare.** In 1997, Congress, working with the Clinton Administration, imposed an unprecedented restriction on the right of doctors and patients to privately contract for medical services outside the Medicare program. Congress should eliminate the statutory and regulatory restrictions or penalties on the right and ability of Medicare enrollees and their physicians to contract privately outside the Medicare program for Medicare-covered services. Restoration of this freedom would improve seniors' access to medical care.
- **Allow specialty hospitals to participate in Medicare.** Under the Affordable Care Act of 2010, Congress restricted payment to emerging specialty hospitals, even though they had an outstanding record of performance in delivering highly specialized quality care. Congress should eliminate statutory restrictions on Medicare payment to specialty hospitals, including physician-owned hospitals. Eliminating these barriers would intensify much-needed competition in the hospital sector and stimulate innovation in the delivery of high-quality care to seniors.

RATIONALE

All Americans ages 65 and older who have paid into Social Security, as well as some Americans classified as disabled, are entitled to enroll in Medicare, the giant government health program for senior and disabled citizens. Medicare spending will rise from an estimated $716.8 billion in 2017 to almost $1.3 trillion by 2025.[2] Yet its long-term unfunded obligations—the benefits promised but not paid for out of dedicated revenues over the next 75 years—range from $32.4 trillion to $43.5 trillion, depending upon the assumptions used; in other words, an enormous programmatic debt.[3]

Meanwhile, Medicare spending growth will outpace that of all other health care programs, as well as inflation and the general economy. At the same time, a rapidly aging population will require more intensive medical services, and the quality and efficiency of care delivery will be of paramount concern.

The rapid aging of the American population is the main driver of rising Medicare spending. Members of the baby boom generation—the 77 million Americans born between 1946 and 1964— are retiring at the rate of roughly 10,000 per day. While there are roughly 58 million persons enrolled in Medicare today, by 2030, approximately 81 million will be enrolled in the program.[4] The President and Congress must cope with Medicare's rising spending, which threatens the fiscal welfare of the country, as well as preserve the program for current and future generations. To accomplish these goals, Congress, working with the President, should take the steps detailed above to change federal law.

Medicare Advantage Reform: Expand Premium Support Financing

RECOMMENDATION

Replace the Medicare Advantage payment system with a new market-based payment system. Congress should replace the current Medicare Advantage (Part C) payment system with a new benchmark based on regional market-based bids from competing private health plans to provide traditional Medicare benefits.

Extend the new Medicare Advantage payment system to all of Medicare. Under this new defined contribution ("premium support") system, a beneficiary who chose a plan that was more expensive than the market-based benchmark would pay the difference. If a beneficiary chose a less expensive plan, he or she would receive the difference in a cash rebate that could be used to offset other health costs.

RATIONALE

Medicare Advantage (Medicare Part C) is a large and growing system of competing private health plans, with comprehensive benefits and protection from catastrophic illness. Financed on a defined contribution basis, it is an alternative to enrollment in traditional Medicare, sometimes called Medicare Fee for Service (FFS). Between 2006 and 2016, enrollment in these private Medicare plans jumped from 6.9 million to 17.2 million beneficiaries, 31 percent of all Medicare enrollees.[5] Both the Congressional Budget Office and the Medicare Trustees project Medicare Advantage to continue to grow. Nonetheless, the program's payment system is not as economically as efficient as it could be. The reason: Government payment to these plans is still tied to the relatively inflexible administrative payment system of traditional Medicare instead of being based on pure market competition among these plans. Extending a defined contribution payment system to all of Medicare would intensify competition among plans and providers, spur innovation in care delivery, and control costs.

ADDITIONAL READING

- Walton Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, DC: AEI Press, 2009).
- Robert E. Moffit, "Medicare's Next 50 Years; Preserving the Program for Future Retirees," Heritage Foundation *Special Report* No. 185, July 29, 2016.

Eliminate the Teen Pregnancy Prevention Grants

RECOMMENDATION

Congress should eliminate funding for the Teen Pregnancy Prevention (TPP) grants.

RATIONALE

HHS's Office of Adolescent Health operates Teen Pregnancy Prevention (TPP) grants. TPP is an "evidence-based" grant program that rigorously evaluates the effectiveness of the programs it funds.

TPP has two funding streams: Tier I and Tier II grants. According to HHS, Tier I grants are awarded to grantees replicating programs that "have been shown, in at least one program evaluation, to have a positive impact on preventing teen pregnancies, sexually transmitted infections, or sexual risk behaviors."[6] Thus, Tier I grants are supposed to be evidence-based. The belief is that these grants will be effective because they are replicating programs labeled evidence-based. Is this assumption correct?

Each of the Tier I grantees is supposed to evaluate the impact of the evidence-based model it is replicating. So far, from 2015 to May 2017, 13 experimental evaluations of nine evidence-based models have been published by HHS or in the *American Journal of Public Health*.[7] Overwhelmingly, these evaluations demonstrated that replicating evidence-based models failed to affect the sexual behavior of participants. Clearly, replicating an evidenced-based program model does not guarantee similar results.

The reason for this failure may be the inconsistent evidence used to label the program models as evidence-based. For example, HHS used contradictory evidence of the effectiveness of the Becoming a Responsible Teen (BART) program to label this model evidence-based. Of the three randomized experiments that were classified with a "high ranking" for scientific rigor, two of the studies found the model to be ineffective.[8] How can the body of research on BART that leans strongly toward the program being ineffective be used to promote it as an evidence-based model?

Just because an evidence-based program appears to have worked in one location, does not mean that the program can be effectively implemented on a larger scale or in a different location. Proponents of evidence-based policymaking should not automatically assume that pumping taxpayer dollars toward programs attempting to replicate previously successful findings will yield the same results.

The other set of TPP grants (Tier II) fund demonstration programs that do not meet HHS's evidence-based definition, but are considered by HHS to be innovative programs worthy of funding. The majority of experimental evaluations of the Tier II grants find more failures than benefits.

ADDITIONAL READING

- Evelyn Kappeler, "Building the Evidence to Prevent Adolescent Pregnancy: Office of Adolescent Health Impact Studies (2010–2014)," *American Journal of Public Health*, Vol. 106, No. S1 (September 2016).
- David B. Muhlhausen, "Evidence-Based Fiscal Discipline: The Case for PART 2.0," Heritage Foundation *Backgrounder* No. 3158, September 27, 2016.
- U.S. Department of Health and Human Services, Office of Adolescent Health, "Grantees FY 2010–2014."

Transfer Low-Income Housing Assistance to the States and Relevant Departments

RECOMMENDATION

In order to better coordinate services, the President and Congress should eliminate the major functions or transfer responsibility of the major subsidized-housing assistance programs from the Department of Housing and Urban Development (HUD) to the state governments and the Departments of Health and Human Services (HHS), Veterans Affairs (VA), and the Interior. Specifically:

1. **Transfer financial responsibility to the states for subsidized housing programs that support the non-elderly:** the Housing Choice Voucher Program ("Section 8 vouchers"); the Project-Based Voucher Program; the Public Housing Capital Fund; the Public Housing Operating Fund; Choice Neighborhoods; HOPE VI; the Family Self-Sufficiency Program; Homeownership Voucher Program; Public Housing Homeownership (Section 32); the Section 8 Moderate Rehabilitation Program; the Public Housing/ Section 8 Moving to Work Demonstration Program; the Neighborhood Networks Program; the Resident Opportunity and Self-Sufficiency program; and the HOME Investment Partnerships program;
2. **Eliminate or transfer to the Department of the Interior Native American housing programs:** the Tribal Housing Activities Loan Guarantee program (Title VI); the Indian Community Development Block Grant program; the Indian Housing Block Grant program; Loan Guarantees for Indian Housing (Section 184); Loan Guarantees for Native Hawaiian Housing (Section 184A); and the Native Hawaiian Housing Block Grant program;
3. **Transfer to HHS programs for homeless assistance and Housing Opportunities for Persons with AIDS;** and
4. **Transfer to the VA the HUD-Veterans Affairs Supportive Housing Vouchers,** a veteran's assistance program that operates in conjunction with the Housing Choice Voucher program.

RATIONALE

Transferring programs and functions to the appropriate responsible agency can help people who need housing by better coordinating services while reducing duplication of services.

Eliminating offices such as the Federal Housing Authority is appropriate because they have had minimal impact on homeownership rates in return for substantial costs to the taxpayer.

Returning financial responsibility for subsidized housing programs to the states is appropriate because housing needs, availability, and costs vary significantly across states and localities, as do the levels of needed and available assistance. Instead of primarily federally funded programs that often provide substantial benefits for some while leaving others in similar circumstances with nothing, the federal government should begin transferring the responsibility for both the administration and costs of low-income housing programs to the states. States are better equipped to assess and meet the needs of their populations, given their unique economic climates and housing situations. With the fiscal responsibility of paying for their housing programs, states will have the incentive to run them much more efficiently and effectively.

Eliminate the Community Development Block Grant

RECOMMENDATION

Congress should eliminate the Community Development Block Grant (CDBG), which provides money to state and local governments for low-income housing, infrastructure development, public services, and other activities.

RATIONALE

This program has been in place since 1974 and has cost taxpayers more than $100 billion during the course of its lifetime. The CDBG is not well-targeted to low-income communities, and due to a lack of transparency in the data, it is difficult to assess whether the program is meeting its stated goals of, among others, creating jobs for low-income individuals and eliminating "slums and blight."

ENDNOTES

1. For a more detailed description of this proposal, see Robert E. Moffit, "Medicare's Next 50 Years: Preserving the Program for Future Retirees," Heritage Foundation *Special Report* No. 185, July 29, 2016, p. 22, http://www.heritage.org/health-care-reform/report/medicares-next-50-years-preserving-the-program-future-retirees.
2. Centers for Medicare and Medicaid Services, *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, June 22, 2016, https://www.cms.goviresearch-statistics-data-and-systems/statistics-trends-and-rgportstreportstrustfundgdownloadsitr2016.pdf (accessed May 31, 2017).
3. For a discussion of Medicare's long-term obligations over the years, see Moffit, "Medicare's Next 50 Years," p. 11.
4. Ibid., p. 3.
5. Medicare Payment Advisory Committee, *A Data Book: Health Care Spending and the Medicare Program* (Washington, DC: MedPac, June 2016), p. 131, http://www.medpac.govidocsidefault-source/data-bookhune-2016-data-book-health-care-spending-and-the-medicare-program.pdf (accessed May 31, 2017).
6. U.S. Department of Health and Human Services, Office of Adolescent Health, "Evidence-Based TPP Programs," http://www.hhs.gov/ash/oah/oah-initiatives/tpp_program/db/ (accessed July 22, 2016).
7. U.S. Department of Health and Human Services, Office of Adolescent Health, "Grantees FY 2010–2014," http://www.hhs.gov/ash/oah/oah-initiatives/evaluation/grantee-led-evaluation/grantees-2010-2014.html (accessed September 26, 2016), and "Building the Evidence to Prevent Adolescent Pregnancy: Office of Adolescent Health Impact Studies (2010–2014)," *American Journal of Public Health*, Vol. 106, No. S1 (September 2016).
8. The two studies that found BART to be ineffective are Angela R. Robertson et al., "The Healthy Teen Girls Project: Comparison of Health Education and STD Risk Reduction Intervention for Incarcerated Adolescents Females," *Health Education & Behavior*, Vol. 38, No. 3 (2011), pp. 241–250, and Janet S. St. Lawrence et al., "Sexual Risk Reduction and Anger Management Interventions for Incarcerated Male Adolescents: A Randomized Controlled Trial of Two Interventions," *Journal of Sex Education and Therapy*, Vol. 24, No. 1–2 (1999), pp. 9–17. The study that found at least one beneficial effect is Janet S. St. Lawrence et al., "Cognitive-Behavioral Intervention to Reduce African American Adolescents' Risks for HIV Infection," *Journal of Consulting and Clinical Psychology*, Vol. 63, No. 2 (1995), pp. 221–237.