Pursuing Medicare Reform in the Context of a Financing Crisis

Medicare faces a looming financing crisis, which has only grown more urgent due to the economic damage wrought by the COVID-19 pandemic. Federal lawmakers will have no choice but to act soon to shore up Medicare's solvency, whether by slowing the growth of program costs, raising eligibility ages, increasing taxes, or a combination of all three. All decisions about the future design and scope of Medicare will be made in the context of this overriding financial challenge.

Even before the pandemic hit, Medicare was heading into trouble. Medicare's hospital insurance (HI) program—the one part of Medicare that can experience a depletion of its financial resources—entered calendar year 2020 with a trust fund balance sufficient only to fund less than seven months' worth of benefit payments.[1] This meant that its near-term financial stability depended largely on whether incoming payroll tax revenues would be nearly sufficient by themselves to fund outgoing benefit payments. The Medicare trustees' report released in June 2022 projected that this delicate balancing act would be sustained only until 2028, at which point the hospital insurance program would become insolvent. Insolvency, in this context, means that the HI trust

fund will not be able to provide all of the promised hospital benefits at the projected level of dedicated financing under current law.

Impending Medicare HI insolvency is a sizable enough problem by itself, but it actually represents less than half of the larger Medicare financing challenge. The greater part of Medicare, which covers physician services, prescription drugs, and all other benefits routed through its supplementary medical insurance (SMI) trust fund, faces an even more severe cost growth problem. Medicare SMI is statutorily constructed so that technically it cannot become insolvent; premium assessments on SMI beneficiaries, and contributions of federal general revenues, are automatically increased each year in the amounts necessary to fund benefit payments. However, the absence of insolvency within SMI doesn't mean that it lacks financing strains. It simply means that the pain of its uncontrolled cost growth is felt in different ways by different people (e.g., premium-paying beneficiaries and federal taxpayers).

The rising costs of Medicare SMI could well be considered the most daunting Medicare-related challenge facing lawmakers, greater even than Medicare HI's impending insolvency. The trustees had estimated that Medicare SMI would require $377 billion in general revenue funding in 2020 alone.[2] This draw on general government revenues exists above and beyond all other Medicare financing sources, including the payroll taxes collected for Medicare HI, and premiums paid by and on behalf of Medicare beneficiaries. Going forward, these pressures on the federal budget will only intensify (as illustrated in fig. 3.1). Medicare SMI costs are growing so rapidly that by 2035 they are projected to absorb a share of US gross domestic product (GDP) that is more than 50 percent larger than they do today.[3]

This cost growth will also drain the pocketbooks of Medicare's aged beneficiaries by reducing the effective purchasing power of their monthly Social Security checks. Under current law, average Medicare Part B and Part D premiums are projected to soar from 13 percent of the average Social Security benefit today to 19 percent by the end of the trustees' 75-year valuation window.[4]

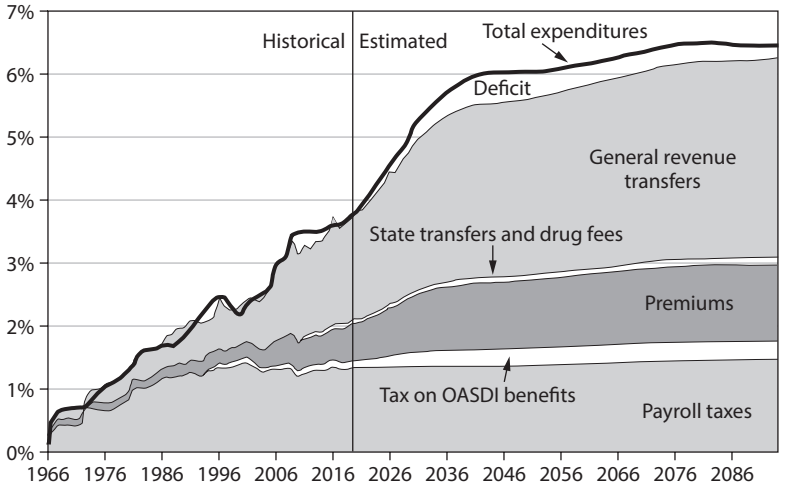

FIGURE 3.1. Medicare Costs and Revenue Sources as a Percentage of Gross Domestic Product. Projected Medicare obligations will swamp the federal budget. *Source*: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2020 Annual Report of the Boards of Trustees* (Washington, DC: Centers for Medicare and Medicaid Services, April 22, 2020), figure I.1, https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf (prepandemic projections).

Sobering though these numbers are, they reflect a relatively optimistic take on Medicare's future. Specifically, they assume that certain ambitious cost-containment provisions of the 2010 Affordable Care Act (ACA) are successful and remain in force. The ACA instated gradual reductions in Medicare provider payment growth, which subtract roughly 1 percent each year from annual payment updates.[5] The compounding effects of these annual adjustments will widen an already large differential between Medicare and private insurance payment rates. For example, Medicare payment rates for inpatient hospital care are currently only about 60 percent of what they are under private insurance. The Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), the agency that administers the program, projects that due to the ACA, Medicare payment rates for inpatient hospital care will eventually decline to roughly 40 percent of what private insurance pays on average.[6]

No one knows the consequences of such a vast divergence between future Medicare and private payment rates, a situation that subjects program participants to tremendous uncertainty. For example, Medicare's actuaries have expressed concern that pushing Medicare provider payment rates so far below private insurance rates—which would also be well below providers' reported costs of operation—could result in "access and quality-of-care issues for Medicare beneficiaries."[7] This in turn could drive mounting political pressure to eventually repeal these provisions of the ACA. If that happens, Medicare costs will be even higher than current projections show, accelerating HI insolvency and requiring still greater sacrifices from beneficiaries and taxpayers. Fortunately, from the perspective of Medicare finances, if not from the perspective of providers, the ACA's payment adjustments have thus far been sustained.

Medicare's enormous financial challenge is made more urgent and immediate by the COVID-afflicted American economy. The downturn triggered by the pandemic affected Medicare finances in several ways, the most significant being a reduction in payroll tax collections. The Congressional Budget Office (CBO) indicated in 2022 that there were fewer than five months' worth of benefit payments in Medicare's HI trust fund.[8] Instead of indulging in fanciful debates about whether to expand Medicare, lower its age of eligibility, or, even more grandiosely, enact "Medicare for All" (the name commonly applied to current proposals to have the federal government provide comprehensive health insurance for all Americans), federal lawmakers will likely need to enact legislation merely to prevent the current Medicare program from becoming insolvent during the late 2020s.

Impact on Beneficiaries

This blizzard of data must not blind us to the reality that Medicare finances are not simply a matter of abstract lines plotted on graphs. There are real people behind all these numbers, and they suffer real hardship so long as Medicare finances remain uncorrected.

It's obvious that Medicare beneficiaries would suffer greatly if lawmakers were ever to permit Medicare HI to become insolvent. Under federal law, if this were to happen, then payments to health providers would be suddenly interrupted, precipitating immediate disruptions of health care access. According to the Medicare trustees' latest projections, 10 percent of Medicare HI obligations would go unpaid in the year following trust fund depletion.[9] Such a sudden disruption of access to hospital care could have unimaginably severe health consequences for American seniors.

But far beyond the solvency of this one Medicare trust fund, Americans are generally made poorer by the larger federal policy failure to contain the growth of Medicare costs. Excess health price inflation, which is exacerbated by a wide range of US government policies, inevitably limits the quantity and quality of care that Americans can receive for every dollar they spend. Rising health costs place American households under worsening financial stress, irrespective of whether these costs are borne out of pocket, deducted from take-home wages, or reflected in tax burdens. The increasing share of federal spending absorbed by health programs gradually stifles government's ability to meet other national needs and to serve the public in other ways. Simply put, we are losing control of our financial future due to these health policy failures, both at the household level and at the government level.

A lasting solution to these problems requires that federal policies be reformed to slow the growth of Medicare costs specifically, and health care costs more generally. These objectives dovetail with widespread desire among the American public to sustain the Medicare program on which tens of millions have come to depend. The irony is that Medicare as we know it cannot be preserved unless it is significantly changed.

The Successes of Medicare Advantage

Amid the daunting numbers that have proliferated throughout annual Medicare trustees' reports in recent years, there have been pockets of

good news—areas where Medicare has outperformed expectations. One of them is the Medicare Advantage (MA) program.

MA is a feature of Medicare through which beneficiaries can receive Medicare coverage from private insurance plans. Medicare pays a fixed amount to cover each beneficiary enrolled in an MA plan, which in turn provides the participating individual with Part A (hospital insurance) coverage, Part B (physician and other medical insurance) coverage, and often Part D (prescription drug) coverage as well, in addition to other benefits such as vision, hearing, and dental care.[10] Growing numbers of American seniors are concluding that the private health plans offering coverage under MA meet their needs more effectively than does traditional Medicare.

Medicare has offered private plan enrollment options since its inception, but the MA program as it operates today really took shape because of the 2003 Medicare Modernization Act (MMA).[11] When the 2003 MMA was passed, private plan enrollment in Medicare stood at just over 5 million, or roughly 13 percent of participants. After the enactment of the MMA, Medicare Advantage enrollment took off dramatically, surpassing 11 million, or 24 percent of participants, by the time the Congress debated the ACA in 2009 and 2010.[12]

Some analysts attributed the post-MMA increases in Medicare Advantage enrollment to Medicare's then paying MA plans a larger amount per beneficiary than was provided under traditional fee-for-service (FFS) Medicare.[13] The ACA's sponsors sought to end this imbalance by enacting reductions, beginning in 2012, in MA benchmark payments so that MA payments per capita would no longer exceed the amounts spent in the publicly administered Medicare FFS program.

Government forecasters expected that once MA plans' perceived subsidy advantage was eliminated, the plans would become less attractive and enrollment would therefore decline. Specifically, the 2010 Medicare trustees' report, published immediately after the ACA's enactment, anticipated that MA enrollment would decline from a peak of about 12 million in 2012 (24 percent of Medicare beneficiaries) to about 8 million in 2020 (13 percent of beneficiaries).[14]

This expected decline in MA enrollment never happened. Despite the ACA's cuts in federal payments to MA plans, enrollment continued to grow dramatically. In 2020 it stood at roughly 25 million, or approximately 40 percent of all Medicare beneficiaries—over three times the enrollment projected in the wake of the ACA (as shown in fig. 3.2).[15] Medicare beneficiaries have increasingly voted with their feet and are walking away from traditional Medicare as they find that for the same amount of money, private plans under MA are better able to meet their coverage needs.

Annual Medicare trustees' reports throughout the last decade have repeatedly expressed surprise over MA plans' rising popularity. The 2010 trustees' report, released immediately after the ACA, noted that "the Affordable Care Act reduces Medicare payments to private plans" and predicted that this would "result in less-generous plan benefit packages and/or higher premiums." Consequently, "enrollment in MA plans is expected to decline in the future, both in number and as a percent of total beneficiaries."[16] But just four years later, the trustees' 2014 report noted, "the Trustees previously estimated that plan enrollment would decrease, starting in 2011, as a result of the benchmark and rebate changes in the Affordable Care Act." Instead, "between 2004 and 2013,

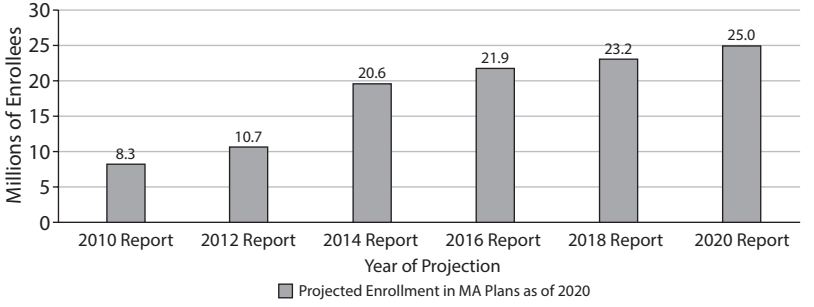

FIGURE 3.2. Medicare Advantage Enrollment Repeatedly Surpassing Trustees' Projections. *Source*: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2020 Annual Report of the Boards of Trustees* (Washington, DC: Centers for Medicare and Medicaid Services, April 22, 2020), 150, table IV.C1, https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf.

private plan enrollment grew by 9.5 million or 176 percent, which compares to growth in the overall Medicare population of 25 percent for the same period."[17] Since that 2014 report, enrollment in MA has only continued to exceed prior trustees' projections. MA's enrollment in 2021 of nearly 28 million was substantially greater than the 2014 report's revised projection of 20.6 million.[18]

Annual trustees' reports offer various explanations for Medicare Advantage enrollments surpassing previous estimates, but while explanations have evolved and projections have been updated, the phenomenon of higher-than-projected numbers has persisted with remarkable consistency. The inescapable conclusion is that Medicare Advantage has simply been able to offer more value than government experts had forecast. As a result, as the 2014 trustees' report notes, "the effect of the ACA benchmark reductions [MA payment rate on MA enrollment] was less than previously assumed."[19] Evidence of MA's unexpected performance is scattered throughout the trustees' reports, for example in 2013 it states, "in this year's report, the Medicare Advantage plan bid assumptions were lowered to reflect recent data suggesting that certain provisions of the Affordable Care Act will reduce growth in these costs by more than was previously projected."[20]

This all raises the question as to whether the surprising success of Medicare Advantage in cutting costs has been achieved by shifting burdens to beneficiaries. Thus far, this does not appear to be the case. First, if it were, it's doubtful that so many more Medicare beneficiaries would voluntarily choose to enroll in MA. Other data support the view that MA is providing real value to beneficiaries. The Kaiser Family Foundation finds that "premiums paid by Medicare Advantage enrollees have slowly declined since 2015," even as premiums in traditional Medicare have steadily grown.[21] Researchers writing in the *American Journal of Managed Care* also find that "although MA payment cuts were expected to reduce the attractiveness of the MA program to both plans and enrollees, the program's enrollment grew steadily from 2009 to 2017. Over this period, plans reduced their costs for providing Part A and Part B benefits to their enrollees, thereby preserving room for

rebates. Our findings show that plans made such cost reductions without significantly affecting enrollees' access to or affordability of care compared with TM [traditional Medicare] beneficiaries."[22]

While Medicare as a whole faces mounting challenges, the market competition occurring within Medicare Advantage among private health plans is producing results that have repeatedly surpassed government forecasters' expectations. As policymakers wrestle with the difficult choices for stabilizing Medicare, they will need to derive lessons from where Medicare is working well, as much as from those aspects of Medicare that need to change.

Looking Ahead

The primary focus here is on the financial challenges facing Medicare, which will require lawmakers to enact legislation in the near-term to preserve Medicare HI solvency and, at least at some point, to slow the growth of broader program costs. Lawmakers will need to make a number of inherently subjective value judgements in the course of fulfilling this responsibility. However, a wide range of philosophical preferences would be served by policy choices that render Medicare's financial challenges more manageable.

Medicare beneficiaries and federal taxpayers are benefiting from the efficiencies achieved through the competitive processes in Medicare Advantage. To the extent that MA has presented financial incentives to competing health insurers, these insurers have responded by finding ways to lower their costs, while reducing premiums and out-of-pocket expenses facing program beneficiaries. Individual participants have also responded to these incentives by enrolling in MA plans in escalating numbers. Trends to date suggest that additional savings might be achieved by making the financial incentives facing participants and insurance providers more robust and transparent, as well as by increasing the flexibility afforded to competing health insurers, specifically by widening their latitude to offer insurance coverage of varying design.

In recent decades, bipartisan proposals to constrain Medicare cost growth while limiting adverse impacts on beneficiaries have typically included some variant of a defined contribution or premium support financing model. Under a premium support approach, Medicare would provide a specified amount of funding for each individual beneficiary, irrespective of whether the individual enrolls in traditional Medicare FFS or a private plan.[23] Among the notable premium support proposals debated in recent decades are those developed by the Breaux-Thomas Medicare Commission in 1999, by Rep. Paul Ryan (R-WI) and Sen. Ron Wyden (D-OR) in 2011, and by the Bipartisan Policy Center (Rivlin-Domenici). The Congressional Budget Office has projected that reforms based on premium support could slow the growth of Medicare costs considerably, although the amount saved would vary widely depending on how payment levels are set as a function of private insurer bids, and on whether current participants in traditional Medicare are moved into the premium support system or grandfathered into their current form of coverage.[24]

Regardless of the policy direction lawmakers choose, repairing Medicare finances will require tough choices that even the most well-designed reforms cannot wholly eliminate. This is because Medicare, as a program for the aged, is being buffeted by powerful demographic forces. As Americans live longer lives, and as more members of the historically large baby boom generation enter the ranks of retired beneficiaries, we cannot avoid the necessity of striking difficult balances between how much support beneficiaries receive during their retirement years, how many years of life these benefits cover, and how high tax burdens should be set. Consider, for example, that baby boomer retirements are driving growth in Social Security costs that far exceed growth in US economic output, increasing from 4.2 percent of GDP at the start of 2008 to a projected 5.9 percent of GDP in the mid-2030s, even without Social Security outlays being affected nearly as much as Medicare's by the rising cost of health care.[25] Hence, even if reforms succeeded perfectly in taming excess health cost inflation, rising

Medicare costs would still need to be managed and ameliorated in other ways.

In addition, as is often noted in financial markets, "past performance is no guarantee of future results." The fact that MA has managed to produce so many efficiency gains over the past decade does not necessarily mean it will continue to do so at the same rate going forward. Waste that has already been wrung out of the system cannot be re-eliminated. Lawmakers therefore cannot take it for granted that expanding MA would empower private insurers to generate cost savings even more successfully than they have done during the past several years. In addition, the potential for savings would depend, in part, on the scope, design, and details of any such expansion. Still, any cost savings achieved relative to current projections would somewhat relax the necessity of making other difficult choices to stabilize Medicare finances.

Medicare currently faces a future of unaffordable cost growth and a looming financial shortfall, which is quickly becoming more urgent due to the economy being weakened by COVID-19. To repair program finances with least harm to beneficiaries, lawmakers will need to find ways to build upon those parts of Medicare that are providing the greatest value for the money.

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