HEALTH MANAGEMENT ASSOCIATES

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Addressing Medicare Trust Fund Solvency

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Executive Summary

The Medicare Part A Trust Fund is projected to become insolvent by 2028. The Medicare Supplementary Medical Insurance Trust Fund, which includes Part B and Part D, has been and is projected to continue to experience spending growth in excess of Gross Domestic Product growth. To extend solvency of the Part A Trust Fund, Congress will be called on to choose between reducing provider or Medicare Advantage plan payments, increasing dedicated income, modifying beneficiary cost sharing, or some combination of these options. One option for gathering informed input on these choices would be for Congress to determine the mix of revenue increases and spending reductions they prefer to maintain solvency of the Part A Trust Fund and to mandate that the Medicare Payment Advisory Commission or MedPAC issue a report with recommendations for the spending reductions portion. Congress may also wish to include the other parts of Medicare in these deliberations as this growing spending increases the federal budget and contributes to deficit spending. In addition, beneficiaries' experience and potential reforms to the Medicare program are best considered holistically, regardless of the division of the program into various parts.

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Issue

The Medicare Trustees expect that Medicare's Hospital Insurance (HI) Trust Fund, which covers Part A, will become insolvent by 2028, due to income from dedicated payroll taxes not keeping pace with expenditure growth.[1] This reflects an improvement in projected outlook with the HI Trust Fund remaining solvent for two additional years beyond last year's projection. However, even this time frame presents a challenge for deciding how to modify the program in time to implement policies designed to maintain solvency. Total Medicare expenditures are projected to nearly double over the next decade while the number of workers per Medicare beneficiary who pay HI Trust Fund taxes continues to decline. As a result, the difference between Part A expenditures and income is expected to exceed $390 billion over the next decade.[2]

Given the size of the funding gap and the limited time left, options for keeping the HI Trust Fund solvent will require that significant policy changes be implemented quickly. For example, the Medicare Trustees state that to extend the insolvency date to 2046 either the Medicare payroll tax would need to be raised immediately from the current rate of 2.90% to 3.66% or Part A

[1] 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Boards of Trustees (June 2022)
[2] Ibid.

spending would need to be permanently reduced by about 17%.[3] Even hybrid approaches that combine policies to increase income and reduce expenditures are likely to raise significant concerns among stakeholders and face political obstacles.

If the imbalance between HI Trust Fund expenditures and income is not addressed, then once the Fund tips into insolvency Medicare will not have the resources to fully pay Part A claims. The program could continue to partially pay Part A obligations, including the Part A portion of Medicare Advantage (MA) plan payments, using concurrent tax income. However, there is no precedent for how this would work as Congress has never allowed the HI Trust Fund to become depleted to zero. One plausible scenario—Medicare paying a reduced rate for Part A claims as they are submitted, similar to the effects of a sequester—provides a useful strawman against which to compare alternatives. For example, if the year in which the HI Trust Fund becomes insolvent, tax receipts are sufficient to fund only 90% of Part A obligations, then options for reforming Part A payment policy that result in cuts for providers of less than 10% would represent a negative change relative to previous payment rates and an improvement relative to the new reality of payment rates under insolvency.

Congress has passed several bills that directly or indirectly reduce Medicare Part A spending that could help to inform additional policies to address the Trust Fund's solvency. Some of these key payment policies include:

- **2% sequester:** The Budget Control Act (BCA) of 2011 established the Joint Select Committee on Deficit Reduction, which was tasked with developing a proposal that would reduce the deficit by at least $1.5 trillion over fiscal years 2012 to 2021.[4] Because the Joint Committee was unable to achieve that goal, the automatic spending reductions, known as sequestration, were triggered.[5] Subsequent actions by Congress, most recently to pause the sequester during the COVID-19 emergency, have extended the BCA mandatory sequester to FY 2030. The Protecting Medicare and American Farmers from Sequester Cuts Act scheduled the sequester to resume with a 1% payment reduction effective April 1 – June 30, 2022 and the full 2% payment reduction effective July 1, 2022.[6]

  While some criticize the BCA sequester as a blunt instrument and would prefer to target reductions to specific high-cost areas of Medicare, policies like a sequester that require across-the-board cuts avoid the political tradeoffs of appearing to favor some groups over others. In addition, designing across-the-board sequesters does not require detailed policy analyses to inform how best to tailor more complex spending reduction efforts.

[3] The HI Trust Fund's primary income source is the dedicated 2.90% payroll tax on covered earnings. Employers and employees each pay 1.45% and self-employed workers pay 2.90% percent of their net earnings. Since 2013, high-income workers pay an additional 0.9% on their earnings above an unindexed threshold ($200,000 for single taxpayers and $250,000 for married couples).

[4] The Budget Control Act: Frequently Asked Questions, Congressional Research Service (October 2019)

[5] Ibid.

[6] Protecting Medicare and American Farmers from Sequester Cuts Act (December 2021)

Despite its relative simplicity, the BCA sequester has successfully reduced Medicare expenditures over the last decade.

- **4% PAYGO sequester:** The Statutory Pay-As-You-Go (PAYGO) Act of 2010 is designed to ensure that legislation affecting direct spending or revenues does not increase projected deficits through automatic spending reductions if needed. Statutory PAYGO sequestration has never occurred – when automatic reductions would have been triggered, Congress has always waived or delayed them from taking effect.[7] The Protecting Medicare and American Farmers from Sequester Cuts Act delays any statutory PAYGO debits for a year.[8]

  The PAYGO sequester faces similar criticism as the BCA sequester and has similar advantages. If the PAYGO sequester is ever triggered along with the BCA sequester, Medicare providers would face significant payment cuts. Yet, if policymakers opt to ensure Medicare Trust Fund solvency through spending reductions alone, then resulting pay cuts could be even larger.[9]

- **Balanced Budget Act (BBA) of 1997**: The 1997 BBA included the most significant spending reductions introduced in the history of the Medicare program, more than $393 billion over 10 years.[10] As a result, HI Trust Fund expenditures and income were balanced so that the Fund's insolvency date, which had been projected to occur in 4 years was extended, eventually by 28 years.[11] The BBA achieved these savings through reducing payments to managed care plans and limiting their payment growth rates, limiting hospitals' payment growth rates, restructuring the way other Part A providers were paid, and requiring beneficiaries to pay more in cost sharing.[12]

  The Medicare payment reductions included in the 1997 BBA were in some ways the antithesis of sequester cuts. While they broadly affected Part A providers, managed care plans, and Medicare beneficiaries, the specific policy changes for each of these groups varied. If similar tailored policies were pursued in the future, they would ideally be informed by careful policy analyses and expert stakeholder input. Such a path could provide the opportunity to pair Trust Fund solvency action with reforms designed to address other existing Medicare program issues, such as limiting payment reductions (or even increasing payment rates) for providers in under-served areas or who serve a greater

[7] FAQs on Sequester: An Update for 2020, House Committee on the Budget (March 2020)
[8] Protecting Medicare and American Farmers from Sequester Cuts Act (December 2021)
[9] 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Boards of Trustees (June 2022)
[10] An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997, The Commonwealth Fund (September 1997)
[11] FAQs on Medicare Financing and Trust Fund Solvency, Kaiser Family Foundation (June 2022)
[12] An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997, The Commonwealth Fund (September 1997)

share of disadvantaged Medicare beneficiaries and increasing payment reductions for services that have been identified as low-value or potentially harmful for beneficiaries.

- **Affordable Care Act (ACA)**: Among numerous provisions affecting Medicare, the ACA changed the way payments for most types of healthcare providers are updated each year by requiring a productivity adjustment.[13] The Medicare Trustees have observed that the reduced payment updates that have resulted from the productivity adjustment have kept growth in Medicare payment rates lower than commercial insurance payment rate growth.[14] The ACA also established the Centers for Medicare & Medicaid Services Innovation Center and the Medicare Shared Savings Program (MSSP). The Innovation Center is tasked with testing various models to determine if they could result in savings, quality improvements, or both for Medicare and Medicaid. MSSP allows healthcare providers to join together to form accountable care organizations (ACOs) to manage the delivery of care for Medicare beneficiaries, in pursuit of savings and improved quality.

  Some of the Medicare policy changes included in the ACA are similar to across-the-board sequesters and some are similar to the tailored policies of the 1997 BBA. The productivity adjustment reduces payments for most types of Medicare providers and comes with some of the same advantages and disadvantages of sequesters. While the MSSP and various Innovation Center models have sought to expand their reach to a wider array of Medicare providers, they remain exclusive to qualified participants, who in choosing to participate are subject to different payment and other policies than Medicare providers in the traditional program. It should be noted that the MSSP and some Innovation Center models have produced savings for the Medicare program, but many other models have not. Pursuing additional models or expanding existing ones should be viewed as a medium- or longer-term investment in reforming the Medicare program. The total Medicare program savings achieved to date by MSSP and successful Innovation Center models is much less than the nearly $400 billion in savings (or new revenue) that will be needed to address the Part A Trust Fund shortfall over the next decade.[15,16] Furthermore, the extent to which successful models result in savings, these savings may be achieved outside the time frame required to maintain Trust Fund solvency.

Congress will soon need to consider new legislation to extend Medicare HI Trust Fund solvency. Following the significant effects of the COVID-19 pandemic, healthcare workforce shortages, inflation, and other stressors, Congress faces difficult choices between asking providers or Medicare Advantage plans to accept reduced payments, beneficiaries to pay more in cost

[13] The ACA productivity adjustment requires that annual provider Medicare payment updates reflect a market basket (which measures the price increase of the goods and services those providers buy), reduced by the current 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity.
[14] 2022 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Boards of Trustees (June 2022)
[15] 2020 Report to Congress, Center for Medicare and Medicaid Innovation (August 2021)
[16] Affordable Care Act's Shared Savings Program Continues to Improve Quality of Care While Saving Medicare Money During the COVID-19 Pandemic, CMS (August 2021)

sharing, and/or workers to pay additional taxes. Congress had anticipated a need for informed input on weighing these choices and included a mechanism in the ACA to serve this purpose—the Independent Payment Advisory Board (IPAB). If the IPAB had been implemented, it would have been charged with enforcing limits on Medicare spending growth based on broad authority to propose and execute Medicare payment policies by using a spending target system and accelerated legislative approval process. The IPAB faced significant bipartisan pushback, in part because it was seen as inappropriately assuming some of Congress's legislating authority. As a result, board members were never appointed, and IPAB was officially repealed in the Bipartisan Budget Act of 2018.[17]

Proposed Policy

Although IPAB was not the right tool for the job, Congress still has a need for informed input so that members can weigh the choices available to maintain HI Trust Fund solvency. Fortunately, Congress has an existing tool that is highly regarded for the quality of its input on how the Medicare program should pay providers and innovate for the future—the Medicare Payment Advisory Commission or MedPAC. Every year MedPAC issues a report to Congress that includes recommendations on how to update payments to Medicare providers. MedPAC also routinely makes recommendations for how the Medicare program can be changed to improve quality, access, and affordability. For example, MedPAC has recommended:

- Implementing a unified payment system for post-acute care, with aggregate payments reduced by 5%
- Replacing the MA benchmark policy, which they project would save more than $10 billion over five years
- Reforming Medicare's benefit design to give beneficiaries better protection against high out-of-pocket costs and to create incentives for them to make better decisions about their use of discretionary care

Many of MedPAC's recommendations have been the result of studies the Commission has undertaken in response to mandates included in legislation. Congress could similarly call upon MedPAC to make recommendations on how to reduce provider payments and modify beneficiary cost sharing to extend HI Trust Fund solvency. Such a mandate could task MedPAC with making payment update recommendations for each provider group, as they do each year, but this time designed so that total savings across all providers and beneficiary cost sharing adds up to a total dollar amount specified by Congress. Specifically, Congress could pass legislation specifying the ratio of revenue increases and spending reductions that they prefer for addressing HI Trust Fund insolvency and pair this with a mandate for MedPAC to release a report on the spending reductions portion. As noted earlier, MedPAC's analyses could begin with the strawman alternative of a straight cut across all types of providers, similar to a sequester. Combined with the total savings amount specified in the legislation, this would direct MedPAC

[17] Bipartisan Budget Act of 2018 (February 2018)

to consider whether the effects of this reduction should be equal across different types of providers and if any changes to beneficiary cost sharing should be included.

Proposed Policy

Congress could extend Medicare HI Trust Fund solvency through a combination of revenue increases and spending reductions and could determine how to best achieve these spending reductions through cuts to provider payments and modifications to beneficiary cost sharing based on recommendations issued by MedPAC as part of a mandated report.

Congress could then consider MedPAC's recommendations that are included in the Trust Fund solvency mandated report like any of the Commission's other recommendations. Legislative decision-making and action would still be entirely within Congress's charge. Congress could implement different or additional changes to those recommended by MedPAC. Congress could also choose to not act on the MedPAC recommendations, which would leave the exact combination of revenue increases, spending reductions, and any other policies specified in the original legislation in effect, including across-the-board, sequester-style cuts if these were included.

Potential Savings

The amount of savings that would result from Congress extending the Medicare HI Trust Fund solvency through reducing provider payments, increasing dedicated income, and/or modifying beneficiary cost sharing based in part on recommendations issued by MedPAC as part of a mandated report would depend on the combination of choices that Congress selected.

Congress may also wish to mandate that MedPAC make recommendations for the Supplementary Medical Insurance (SMI) Trust Fund that covers Part B and Part D in addition to the HI Trust Fund. While the impending insolvency of the Medicare Part A Trust Fund receives more attention, the SMI Trust Fund is also experiencing high expenditure growth. The SMI Trust Fund will not become insolvent as by design income increases to meet expenditures. Yet this automatic increase in income through increases in general revenue taxes, federal borrowing, and premiums is a growing strain on taxpayers and beneficiaries. Perhaps more importantly, the division of the Trust Funds is an artifact of the state of health insurance at the time that the Medicare program was designed decades ago. All parts of Medicare contribute to how beneficiaries experience healthcare and are best considered holistically.

The scale of payment reductions and beneficiary cost sharing increases that would be necessary to ensure that the Medicare HI Trust Fund remains solvent and the SMI Trust Fund requires less general tax revenue (and deficit spending) than currently projected are likely to have significant consequences for beneficiaries' access to and quality of care. MedPAC is well-suited to exploring these concerns and including in a Congressionally mandated report recommendations for mitigating the effects of the payment reductions and beneficiary cost sharing increases on quality of care, especially highlighting the opportunities for designing policies to have a more equitable impact for disadvantaged beneficiaries.

Potential Quality of Care Improvements

The effects on quality of care that would result from Congress extending the Medicare Trust Fund solvency through reducing provider payments, increasing dedicated income, and/or modifying beneficiary cost sharing based in part on recommendations issued by MedPAC as part of a mandated report would depend on the combination choices that Congress selected.