

Testimony Submitted to the Senate Budget Committee:

“Medicare Forever: Protecting Seniors By Making the Wealthy Pay Their Fair Share”

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Chairman Whitehouse, Ranking Member Grassley, and distinguished members of the committee, thank you for the invitation to participate in this hearing.

The Medicare HI Signal

The headline focus of today’s session is the impending depletion of reserves in the Medicare Hospital Insurance (HI) trust fund, which is of course a pressing concern requiring the attention of Congress.

The Medicare trustees projected in their latest annual report that the HI trust fund would run through its reserves in 2031.¹ If that were allowed to happen, incoming revenue could continue to pay for a portion of the costs of submitted claims for services, but it would not be sufficient to fully cover those expenses.

While Congress has never allowed the Social Security and Medicare trust funds to become fully depleted before stepping in with a fix, if it happened in the coming years it is possible that the remedy would be for the Centers for Medicare and Medicaid Services (CMS) to apply across-the-board cuts to prevent Medicare HI spending from exceeding incoming revenue. Hospitals would be certain to see such a step as a serious threat to their ability to provide high-quality care to the program’s beneficiaries.

Given the potential harm trust fund exhaustion might cause, addressing the HI shortfall expeditiously is, of course, very important, but it would be a mistake to see fixing this problem as all that needs to be done to make Medicare sustainable.

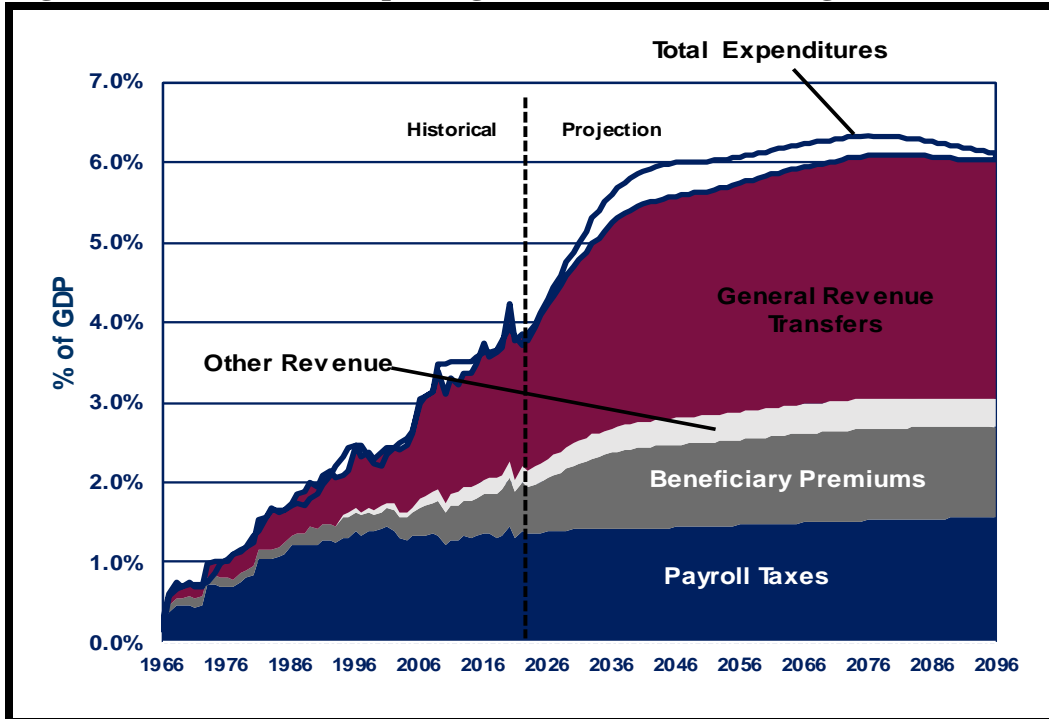
The imbalance between HI spending and outgo is actually a manifestation of a larger problem, which is the widening gap between Medicare’s *total* costs, for both HI (also called part A) *and* Supplementary Medical Insurance (also called part B), and the receipts (taxes and premiums) collected to pay for both trust funds’ expenses. Moreover, it no longer makes sense to treat Medicare as two separate insurance plans (or three with

¹ “2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds,” The Boards of Trustees of Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, March 31, 2023, <https://www.cms.gov/oact/tr/2023>.

inclusion of the drug benefit), as that is not how most Americans experience health coverage outside of the Medicare context.

Figure 1 replicates the key projection data for all of Medicare’s costs and receipts from the 2023 trustees’ report, shown as a percentage of Gross Domestic Product (GDP), from the program’s inception in the mid-1960s through the projection period covering the next 75 years. The core problem is the rapid growth of total Medicare spending, driven by an aging population and escalating costs for services.²

Figure 1. Total Medicare Spending and Sources of Financing



Source: Medicare Trustees (2023)

In 1990, total program spending equaled 1.9 percent of GDP; three decades later, it had reached 4.0 percent of GDP. Medicare’s trustees expect costs will reach 4.9 percent of GDP in 2030 and 6.0 percent in 2050.³

What is most striking about this figure is the increase in general revenue transfer to Medicare over time.

² These projections may be too optimistic, according to the actuaries who produce estimates of future Medicare spending and receipts, because they assume a perpetual widening between what is paid for services by Medicare relative to commercial insurance, driven by payment limits enacted by Congress in 2010 and 2015. See “Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers,” John D. Shatto and M. Kent Clemens, Centers for Medicare and Medicaid Services, March 31, 2023, <https://www.cms.gov/files/document/illustrative-alternative-scenario-2023.pdf>.

³ 2023 Trustees’ Report.

The initial versions of Medicare legislation focused on HI, which was modeled on Social Security, with a trust fund and a payroll tax on workers to cover its costs. The addition of Supplementary Medical Insurance (SMI) came late in the legislative process and was offered as a way of covering physician fees through a voluntary program (participation in HI is mandatory in the same way it is for Social Security as nearly all workers are required to pay the payroll tax).

At enactment, the intention was to finance half of SMI spending from beneficiary premiums, with the other half covered by transfers from the general fund of the Treasury. Over time, the share covered by premiums was allowed to fall to 25 percent, which is where it remains. The other 75 percent of expenses paid from SMI -- for physician services, prescription drugs, and other ambulatory care -- comes from the general fund of the Treasury, which is just another way of saying other sources of revenue for the federal government, including other taxes and the proceeds from selling debt instruments.

The transfers from the Treasury to Medicare SMI are not capped; they occur automatically and are set at levels which ensure the SMI trust fund is perpetually solvent. Thus, Congress is never asked to “rescue” SMI because the trust fund is never in danger of being depleted.

But that does not mean it imposes no economic burden on taxpayers. As shown in Figure 1, the transfers to SMI are substantial, and escalating rapidly. The 2023 Trustees’ report estimates the transfers to SMI will total \$6.6 trillion over the next decade alone. By 2050, the annual transfer will equal 2.8 percent of GDP, up from about 0.5 percent in 1990.

Again, these funds must come from taxpayers at some point, either immediately in the form of current taxes, or in the future as tax collections to pay off the debt that was incurred to keep paying benefits in previous years.

Spending Not Covered by Taxes or Premiums

The Department of the Treasury releases an annual statement assessing the financial status of the entire federal government which relies on accrual accounting to present as much of the data as is practical. The accrual method is useful when comparing long-term benefit obligations with the expected revenue to pay for them because it converts future streams of spending and taxes into present values. The difference between the totals is the unfunded liability.

For Medicare, the trend is what is most alarming. As shown in Table 1, in the most recent report from February 2023 reveals Medicare has unfunded liabilities of \$52.5 trillion as of 2022 when the general fund transfer to SMI are removed as sources of funding (because there is no dedicated taxes behind them). As of 2016, the unfunded liability estimate was \$20.0 trillion less.⁴ The implication is that Medicare is adding new benefit

⁴ “Financial Report of the United States Government: Fiscal Year 2022,” Department of the Treasury, February 16, 2023, <https://www.fiscal.treasury.gov/files/reports-statements/financial-report/2022/02-16->

commitments at a rate that far exceeds its funding sources. It should be noted that it is unrealistic to entirely displace the general fund transfers with new taxes, so Medicare’s unfunded liabilities using this definition will always be substantial. The concern is that the trend shows the burden is growing rapidly.

Table 1. Medicare’s Accrued Unfunded Liabilities (\$ Trillions)

	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2020</u>	<u>2022</u>
Open Group Method	32.5	33.5	37.7	45.7	52.5

Source: Department of the Treasury (2023 and 2021)

The growing gap is a major reason the full federal budget has a deteriorating outlook, as reflected in data published by the Congressional Budget Office (CBO) and summarized in Table 2.⁵ With the revenue dedicated to Social Security and Medicare falling behind spending growth, federal debt is forecast to rise to nearly 170 percent of GDP in 2050. At the end of 2008, it was 40 percent of GDP.

Table 2. Overview of Key Federal Budget Aggregates (Historical and Projected)

	% of GDP				
	<u>1980</u>	<u>2000</u>	<u>2022</u>	<u>2030</u>	<u>2050</u>
Social Security	4.2	4.0	4.8	5.8	6.2
Medicare (Gross)	1.3	2.2	3.9	4.5	6.9
Defense	4.8	2.9	3.0	--	--
Rest of Gov’t	9.0	6.8	11.5	10.2	9.1
Net Interest	<u>1.9</u>	<u>2.2</u>	<u>1.9</u>	<u>3.2</u>	<u>6.1</u>
Total Spending	21.2	17.7	25.1	23.7	28.3
Total Revenues	18.5	20.0	19.6	18.1	18.9
Annual Surplus (+) or Deficit (-)	-2.6	+2.3	-5.5	-5.6	-9.4
Federal Debt	25.5	33.7	97.0	108.3	168.7

Source: CBO (Historical Tables and Long-Term Projections)

[2023-FR-\(Final\).pdf](#) and “Financial Report of the United States Government: Fiscal Year 2020,” Department of the Treasury, March 25, 2021, [https://fiscal.treasury.gov/files/reports-statements/financial-report/2020/fr-03-25-2021-\(final\).pdf](https://fiscal.treasury.gov/files/reports-statements/financial-report/2020/fr-03-25-2021-(final).pdf). The unfunded liability calculation presented here is based on the open group method, which includes all current and future participants in the Medicare program.

⁵ See “Historical Tables” and “Long-Term Budget Projections,” Congressional Budget Office, <https://www.cbo.gov/data/budget-economic-data#2>.

Reforms

Congress should view HI's challenges as an indication that the broader program needs to be updated and reformed. After all, hospital care does not occur without the patient also getting attention from a physician. Many other services and treatments are also usually provided to the patient both before and after an admission occurs. A narrow focus on hospital and other institutional costs risks perpetuating a fragmentation within Medicare that is outdated.

The following are broad recommendations for proceeding with changes to Medicare to address the program's financial challenges.

1. *Address Both the Revenue and Spending Sides of the Equation (and Seek Bipartisan Support).* Medicare's finances will be improved most by updating both sides of the financial equation. With an aging population, it is appropriate for Congress to revisit the taxes used to pay for the program. At the same time, there is also room for making Medicare more efficient in the coming years. Finding the right balance also might help build a bipartisan coalition in support of the legislation, which would foster public acceptance and strengthen long-term program stability.
2. *Define a Standardized and Less Fragmented Benefit.* When Medicare was enacted, in 1965, it was modeled on the prevailing private insurance plans of that time, which often provided separate coverage for hospitalizations and physician services. Medicare did so too, and Congress also established separate cost-sharing rules for its two parts. It also paid for HI with payroll taxes and B with premiums and general fund transfers. Initially, Medicare did not cover prescription drugs, nor did it limit what beneficiaries must pay out-of-pocket on an annual basis (a so-called "catastrophic cap").

In the intervening decades, the basic structure of Medicare did not change, but workarounds were created to address the program's limitations. Seniors bought supplemental plans, and HMOs were introduced to provide a more integrated plan (with less cost-sharing) for the beneficiaries. In 2003, Congress added a new part to the program -- D -- for prescription drugs.

It is time to bring Medicare's benefit design into line with the standards of today's insurance plans. There should be one cost-sharing structure and a limit on out-of-pocket costs. Drugs can be covered separately for the time being, but, in time, part D should be folded into the larger plan too. This redesign would lessen the need for supplemental coverage and can be accomplished on a budget-neutral basis.

3. *Improve the Choice Structure for Beneficiaries.* Medicare's original two-part structure and the program's evolution since enactment have made it difficult for the beneficiaries to accurately assess their options. When eligible persons enroll in part A, typically at age 65, they also can voluntarily enroll in parts B (for physician and ambulatory care) and D (for prescriptions) by agreeing to pay monthly premiums

covering a portion of the costs. They also can enroll in a Medicare Advantage (MA) plan or buy a supplemental policy (Medigap) wrapped around the traditional fee-for-service (FFS) benefit.

Adding to the complexity is the lack of a single, coordinated enrollment system. Under current processes, it is not a simple matter to compare the all-in financial implications of the various combinations of coverage. Many beneficiaries end up relying on brokers even though they are paid most often by private insurance plans seeking to gain an advantage in the market.

Improving the program and lowering its costs should include simplification of the enrollment process so that beneficiaries can readily identify low-cost and high-value options.

Beneficiaries should be presented with the full range of their benefit options through one government-administered enrollment portal that makes it less necessary for beneficiaries to rely on outside parties to help them make their choices. Through it, they should be able to compare competing approaches for delivering covered services on an apples-to-apples across the three main benefit components, as shown in Figure 2. Standardization of the benefits is crucial (including for the supplemental options) to ensure ready premium comparisons.

Figure 2. Restructured Choices for Medicare Beneficiaries

Required Medicare-Covered Services	Prescription Drug Coverage	Supplemental Coverage
Traditional FFS	Stand-Alone Part D Plans	Reformed Medigap Options
ACOs	Stand-Alone Part D Plans	ACO-Affiliated Medigap
Medicare Advantage Plans	MA-Affiliated Part D Coverage (MA-PD)	MA-Sponsored Optional Supplements

Source: Author

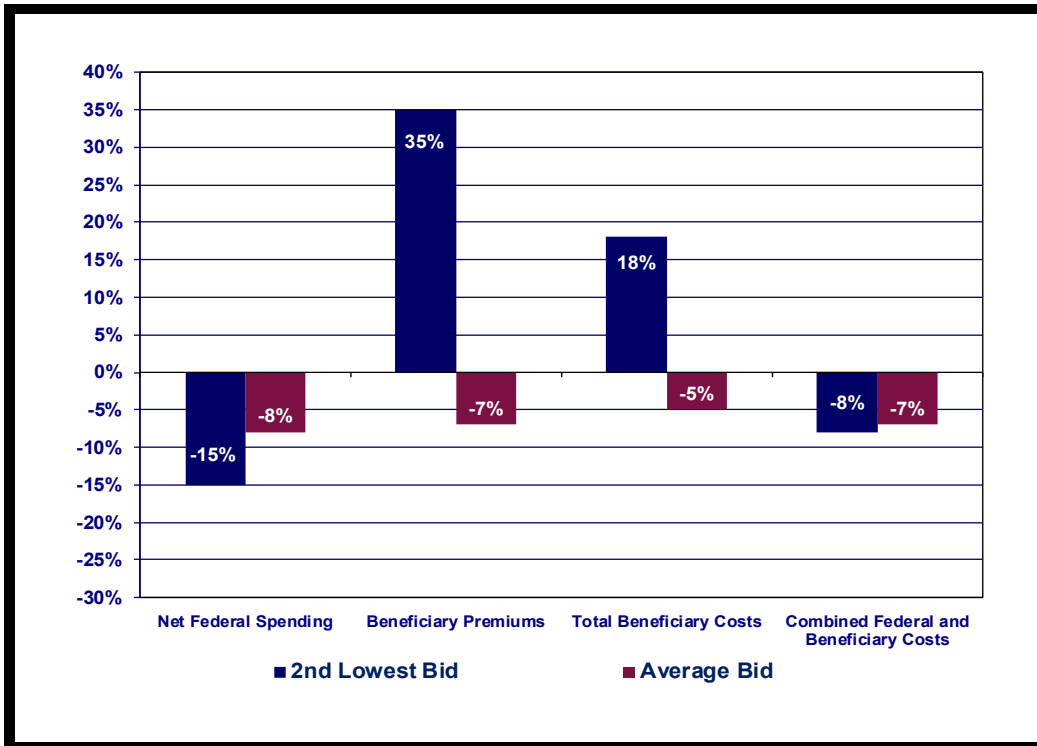
Accountable Care Organizations (ACOs) -- now a subpart of FFS -- should become a coverage option that is distinct from both FFS and MA. ACOs differ from MA plans in that they are organized and run by the hospitals and physician groups providing care to patients, not insurance companies. Some Medicare beneficiaries may be

comforted by this distinction. ACOs also are not traditional FFS because they need to have systems in place for coordinating care across settings and disciplines.

4. *Promote Premium Competition.* CBO has confirmed that strong competition among the coverage options can lower costs for the government and the beneficiaries, but reform of the payment system is required to achieve these results.

MA plans already submit competitive bids under current law, but those bids are considered in relation to benchmarks tied in part to historical cost rates that may not accurately reflect what spending would be with efficient care provision. Further, FFS does not participate in the bidding process in that its enrollees pay the same premium irrespective of the relative cost of FFS to other plans.

Figure 3. Premium Support Effects on Program and Enrollee Costs



Source: CBO (2017)

Fair competition requires the submission of bids from MA plans, ACOs, and FFS for the same set of *standardized* benefits, as defined in law for a reformed Medicare benefit package. FFS’s bid would be calculated by the government based on the cost per-beneficiary in each market. The government should also reform its risk adjustment methodology to ensure the competition is based on efficient care delivery and not differences in the ability of plans to identify risk factors.

The government’s contribution toward coverage (its “premium support”) would be based on the submitted bids. CBO has estimated that if the government set its contribution based on the average bid, there would be savings both for the

government and the beneficiaries, as shown in Figure 3. The government's costs would fall by 8 percent, and the beneficiaries would pay 5 percent less in out-of-pocket costs and premiums.

CBO's assessment confirms that competition would lower costs by encouraging migration toward more efficient coverage options. It also suggests that the competition likely would slow cost growth in future years by encouraging the development and adoption of cost-reducing technologies that improve the efficiency of care delivery.⁶

5. *Promote Provider Price Competition in FFS.* Premium support is not the only means by which stronger market discipline can be introduced into Medicare. Enrollees in FFS can be encouraged to select low-cost and high-quality service providers too.

For this to occur, Medicare will need to become a leader in using transparent pricing for standardized services to foster strong competition among providers. Not all medical care is amenable to such a system, but some is (perhaps 40 percent).⁷

Hospitals and physicians today have weak incentives to post clear pricing for their services, and the complexity of medical care makes price comparisons difficult for patients when multiple line items are billed for a full episode of care.

Medicare could promote strong provider competition by requiring participating facilities and practitioners to disclose their prices for standardized interventions including common procedures, diagnostics, and management of chronic diseases.⁸ Further, this requirement should force those providing services to work with each other to provide one, all-in price. It is essential that what is being priced be standardized and encompass all that is needed to properly take care of the affected patients.

An additional requirement is an incentive for the program's enrollees to select lower-priced options. Medicare could do this by calculating benchmarks based on prevailing FFS rates for the list of standardized interventions. Beneficiaries opting for lower-priced providers should get to keep some of the savings (perhaps 50 percent). In some cases, the financial benefit could be substantial, which would create strong incentives for the providers to compete aggressively.

⁶ "A Premium Support System for Medicare: Updated Analysis of Illustrative Options," Congressional Budget Office, October 2017. <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53077-premiumsupport.pdf>.

⁷ "Estimating the Potential Savings Health Care Savings of Reference Pricing," American Academy of Actuaries, November 2018, https://www.actuary.org/sites/default/files/files/publications/ReferencePricing_11.2018.pdf.

⁸ For an explanation of the benefits of reference pricing, see "Reference Pricing Changes the 'Choice Architecture' of Health Care for Consumers," James C. Robinson, Timothy T. Brown, and Christopher Whaley, *Health Affairs*, March 2017, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1256>.

6. *Reform the Trust Funds.* Medicare's trust funds need updating too. With a combined HI and SMI benefit package, the trust funds should be assessed as a unified whole rather than separately. That could be done in several ways.

A crucial first step should be to recalibrate the basis for general fund support of the program's spending obligations, with a view to limiting the amounts to what Congress deems to be affordable. Trust funds only work as political signals if their receipts are limited in some way and are defined to ensure affordability over time. That is most definitely not the case currently with SMI, with the government's contribution to SMI expected to rise to levels that will push federal debt well above what would be sustainable or advisable.

One option would be to tie the government's contribution to what was paid in a reference year and then index that amount to the rate of growth in the national economy when determining future transfers. This change would ensure that current and future taxpayers contribute the same amount of their combined incomes each year toward ensuring adequate health services for the nation's elderly and disabled citizens.

There are a number of ways to combine HI and SMI into a combined measure of financial sustainability. The objective should be to ensure that shortfalls in SMI are combined with those projected for HI so that reductions in spending or increases in taxes for either part would bolster the finances of the entire program.

7. *Authorize Automatic Adjustments to Ensure Permanent Stability.* As part of a plan to improve Medicare's financial outlook, Congress should build into the program provisions, which will automatically ensure stability even if the projections used when calibrating the initial reforms prove to be too optimistic. Future gaps in funding could be closed by authorizing the executive branch to gradually make adjustments in key program parameters to ensure spending stays even with receipts over the long term. The adjustments could adhere to a framework that Congress approves, with a split between new revenue and spending restraint that conforms to the wishes of the legislature.

Building automatic adjustments into Medicare (and also Social Security) would transform the federal government's long-term budget outlook by making it far less likely that a debt crisis will ever occur. If a gap were to emerge in either of the major programs, pre-determined changes could restore balance and prevent benefit obligations from ever outrunning the revenue needed to pay for them.

Conclusion

Medicare is one of the federal government's most important programs because of the access to medical services it provides to its participants. The program's financial status should be improved to ensure those benefits are secure for both current beneficiaries and

future generations. As the needed changes will take time to implement, Congress should begin to develop and consider the necessary legislation as soon as possible.

Related Material:

US Health Policy and Market Reforms: An Introduction, James C. Capretta, AEI Press (2022), <https://www.aei.org/research-products/book/us-health-policy-and-market-reforms-an-introduction/>.

“Medicare’s Supplementary Medical Insurance Fund: A Growing Burden on Taxpayers,” James C. Capretta, *Health Affairs Forefront*, June 6, 2023, <https://www.healthaffairs.org/content/forefront/medicare-s-supplementary-medical-insurance-fund-growing-burden-taxpayers>.

“Medicare’s Price Regulations: How the Government Determines What It Pays for Medicare Care,” James C. Capretta and David N. Bernstein, *Economic Perspectives*, American Enterprise Institute, September 2023, <https://www.aei.org/wp-content/uploads/2023/09/Medicares-Price-Regulations-How-the-Government-Determines-What-It-Pays-for-Medical-Care.pdf>.

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“Medicare as a Catalyst for Competitive Reforms,” James C. Capretta, in *American Renewal: A Conservative Plan to Strengthen the Social Contract and Save the Country’s Finances*, Paul Ryan and Angela Rachidi, eds., AEI Press (2022), <https://americanrenpr.wpengine.com/wp-content/uploads/2022/11/AR-final.pdf>.

“Fiscal Rules for Social Security and Medicare: Would Accrual Accounting Help?,” James C. Capretta, in *Public Debt Sustainability: International Perspectives*, Barry W. Paulson, John Merrifield, and Steven H. Hanke, eds., Lexington Books, 2022.