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INSURANCE

Strengthening Medicare's Finances

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Since 1965, the United States has pledged to provide health security in retirement to all Americans who have contributed to Medicare throughout their working lives. In 1972, Congress extended Medicare coverage to recipients of Social Security Disability Insurance.¹ The Medicare program embodies a solemn commitment to assure the elderly and disabled access to affordable health care of a quality available to the general population. In 2016, Medicare covered over 57 million people across the United States, the majority of them seniors.² It serves as a critical protection for vulnerable millions who would otherwise be uninsured and unable to afford even basic health care, despite having much greater health care needs. Even so, Medicare could do more to reduce the burden of high out-of-pocket costs on many beneficiaries, in order to maintain its commitment to provide health care coverage for the elderly and the disabled.

In addition to providing high-quality, affordable health insurance to otherwise vulnerable populations, Medicare has also outperformed private health insurance in holding down the growth of health care costs, an important policy concern. Between 1989 and 2014, Medicare spending per enrollee grew at an average annual rate of 5.5 percent, somewhat slower than the 6.3 percent average annual growth rate in private insurance spending per enrollee over these years.³ Although

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Background

What is Medicare and How is It Financed?

Medicare has four major components. Medicare Part A, also known as Hospital Insurance, covers inpatient hospital care, hospice care, skilled

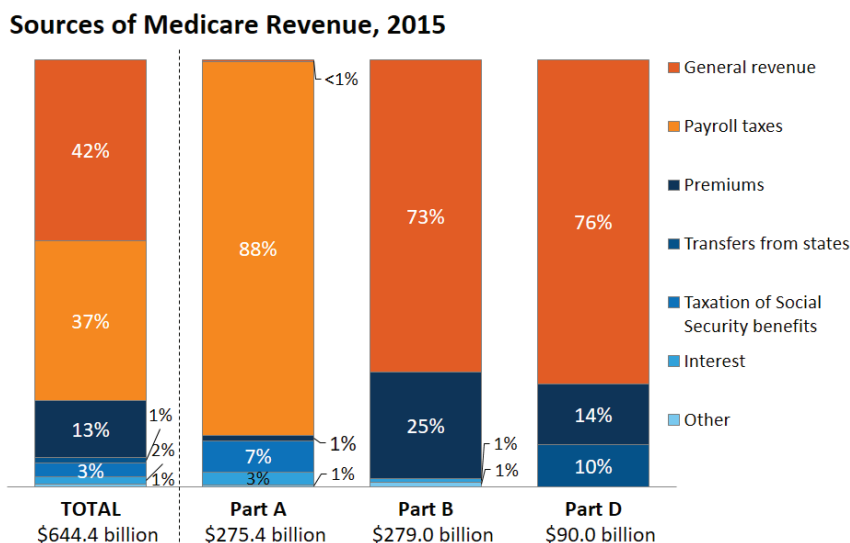
¹ Eligibility begins after a two-year waiting period, except in certain cases.

² Centers for Medicare & Medicaid Services, 2016, CMS Financial Report: FY 2016, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2016_CMS_Financial_Report.pdf.

³ Juliette Cubanski and Tricia Neuman, 2016, The Facts on Medicare Spending and Financing, The Henry J. Kaiser Family Foundation, <http://kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>.

nursing facility care, and some home-based care. Medicare Part B (Supplementary Medical Insurance) covers doctors' services and outpatient care, medical devices, and preventive care. Medicare Part D covers prescription drugs. Medicare Part C, more commonly known as Medicare Advantage, is an alternate source of Medicare coverage for Parts A and B – and often also Part D – that beneficiaries can opt to purchase from a private insurance company.⁴

Medicare Part A is financed primarily through a 2.9 percent payroll tax on earnings paid by employers and employees (1.45 percent each). Unlike the payroll tax for Social Security, which applies to earnings up to an annual maximum (\$127,200 in 2017), the 2.9 percent Hospital Insurance tax is levied on total earnings. The Affordable Care Act increased revenue for Medicare Part A through an additional 0.9 percent Medicare tax on earnings above certain thresholds (\$200,000/individual and \$250,000/couple). Payroll taxes account for 88 percent of Part A revenue (see figure below). Since 1993, Medicare Part A also receives revenue from income taxation of Social Security benefits (7 percent of Part A revenue).⁵ The Affordable Care Act also added a tax on the investment income of households with high earnings, termed the “unearned income Medicare contribution,” although this revenue does not flow to the Medicare program. Thus, Medicare taxes have increased on those with higher incomes, but remained steady for most workers.



NOTE: Data are for the calendar year.
 SOURCE: 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1.



⁴ Medicare.gov, n.d., What's Medicare?, <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html>.
⁵ The trust fund receives revenue from taxes on up to 85 percent of Social Security benefits for single taxpayers with incomes over \$34,000 and for taxpayers filing jointly with incomes over \$44,000. Social Security Administration, n.d., Taxation of Social Security Benefits, <https://www.ssa.gov/oact/progdata/taxbenefits.html>.

Medicare Parts B and D have a different financing model: roughly three-quarters of their funding comes from general federal revenues, and most of the remaining one-quarter comes from beneficiary premiums. Higher-income enrollees (more than \$85,000 for individuals and \$170,000 for couples) pay higher premiums, ranging from 35 percent to 80 percent of per capita costs, depending on their income.⁶

What is Medicare's Financial Outlook?

Medicare Part A (Hospital Insurance)

The 2016 report of Medicare's trustees projects that Medicare's Hospital Insurance (HI) trust fund will be able to pay 100 percent of costs through 2028, given current revenue sources. In 2028, when the HI trust fund is projected to be depleted, incoming payroll taxes and other revenue will be sufficient to pay 87 percent of Medicare hospital insurance costs.⁷ The shortfall will need to be closed through raising revenues, slowing the growth in spending, or both.

Medicare's Hospital Insurance (HI) trust fund will be able to pay 100 percent of costs through 2028.

These projections are highly uncertain and not a cause for alarm. Since 1970, the projected date of HI insolvency has been as near as two years away or as far as 28 years in the future.⁸ The latest projection falls in the middle of that range.

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⁶ Cubanski and Neuman, 2016.

⁷ Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, June 22, 2016, 2016 Annual Report, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf>.

⁸ Patricia A. Davis, Medicare: Insolvency Projections, Congressional Research Service, October 5, 2016, <https://www.fas.org/sgp/crs/misc/RS20946.pdf>.

the projected HI 75-year shortfall from 3.88 percent of payroll subject to the Medicare tax, as estimated in 2009, to 0.73 percent, as estimated in 2016.

Medicare Part B (Supplementary Medical Insurance) and Part D (Prescription Drug Benefit)

Medicare Parts B and D can't run short of funds because they have a permanent appropriation to cover outlays in excess of beneficiary premiums. But they will impose growing costs on enrollees and taxpayers as a result of the growth of per-person medical spending and by population aging. Growth of prescription drug spending, because of expensive new drugs and price increases for older products, has become a particular concern for both Medicare and the entire U.S. health care system.⁹

Medicare Part C (Medicare Advantage)

The Medicare Advantage program is financed predominately by the other parts of Medicare. Medicare Advantage plans cover all of Part A, Part B, and (typically) Part D benefits. Enrollees typically pay monthly premiums for additional benefits covered by their plan, in addition to the Part B premium. Enrollment in Medicare Advantage has grown over the years, and now nearly one-third of Medicare beneficiaries (31 percent) are enrolled in an MA plan.¹⁰ Data on enrollment rates in Medicare Advantage over time suggest that as seniors age and become sicker, they tend to drop Medicare Advantage plans in favor of traditional Medicare.^{11,12}

Policy Challenges

Long-term revenue shortfall

As discussed above, the Medicare HI trust fund is projected to become insolvent in 2028. Even with strong economic growth and potential cost-savings through greater efficiencies in the health care delivery system, Medicare will require substantially more revenues over the coming decades than under current law.¹³

Growth of prescription drug and other spending

Medicare has been a leader in reforming the health care payment system to improve efficiency. Efforts should continue to focus on slowing health care

⁹ Aaron S. Kesselheim, Jerry Avorn, and Ameet Sarpatwari, 2016, The High Cost of Prescription Drugs in the United States, JAMA, 316(8):858-871, <http://jamanetwork.com/journals/jama/article-abstract/2545691>.

¹⁰ Cubanski and Neuman, 2016.

¹¹ Momotazur Rahman, Laura Keohane, Amal N. Trivedi, and Vincent Mor, 2015, High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare, Health Affairs, 34(10), 1675-1681, <http://content.healthaffairs.org/content/34/10/1675.abstract?sid=225f9167-0749-445a-a660-80241597bc7d>.

¹² Cubanski and Neuman, 2016.

¹³ Final Report of the Study Panel on Medicare's Long-Term Financing, September 2000, "Financing Medicare's Future," National Academy of Social Insurance, https://www.nasi.org/sites/default/files/research/med__report_financing_NO.pdf.

cost growth, while improving the quality of care.¹⁴ Spending on prescription drugs is projected to grow especially quickly over the coming decade, with per capita spending expected to rise by 5.8 percent annually for Part D, versus 3.2 percent for Part A and 4.6 percent for Part B.¹⁵

The aging of the Boomer generation

With the retirement of the Boomer generation, Medicare enrollment is rising. The number of beneficiaries is projected to grow from 57 million in 2016 to nearly 90 million by 2040. More beneficiaries means increased program spending. At the same time, as Boomers retire, the workforce that pays Medicare Part A payroll taxes – and that contributes through income taxes to the general revenues which fund three-quarters of Medicare Parts B and D – is growing more slowly than it has in the past.



High and rising out-of-pocket costs

For many seniors and people with disabilities on Medicare, out-of-pocket health care spending is burdensome. Out-of-pocket spending includes premiums, deductibles, and co-payments, as well as spending on things that Medicare does not cover like dental, vision, hearing, and long-term care costs. Vulnerable populations – the near-poor, those in poor health, and the oldest beneficiaries – face the highest out-of-pocket cost burdens. In 2011, even with programs like Medicaid aimed at helping the low-income population, the poorest Medicare beneficiaries spent an average of 23 percent of their income on health care.¹⁶

¹⁴ Karen Davis, Stuart Guterman, and Farhan Bandeali, 2015, The Affordable Care Act and Medicare: How the Law Is Changing the Program and the Challenges That Remain, The Commonwealth Fund, http://www.commonwealthfund.org/~media/files/publications/fund-report/2015/jun/1821_davis_aca_and_medicare_v2.pdf.

¹⁵ Cubanski and Neuman, 2016.

¹⁶ Claire Noel-Miller, 2015, Medicare Beneficiaries' Out-of-Pocket Spending for Health Care, AARP Public Policy Institute: Insight on the Issues, <http://www.aarp.org/content/dam/aarp/ppi/2015/medicare-beneficiaries-out-of-pocket-spending-for-health-care.pdf>.

Policy Options

Increase the payroll tax rate for Medicare Hospital Insurance

Raising the Hospital Insurance payroll tax by 0.8 percentage points would eliminate the entire currently-projected shortfall in the Part A trust fund. This option would raise the Medicare Part A payroll tax from its current level of 2.9 percent to 3.7 percent, split between employer and employee (1.85 percent paid by each). Workers with earnings above \$200,000 (\$250,000 for married couples filing jointly), who owe the 0.9 percent additional Medicare payroll tax on earnings above the threshold, would see their Part A payroll taxes rise from 1.45 to 1.85 percent on their earnings below the threshold, and from 2.35 to 2.75 on their earnings above the threshold (their employers would pay 1.85 percent both below and above the threshold). Alternatively, the tax could be increased by a smaller amount starting now and gradually ramped up, so that the net present value was the same as that of an immediate increase by 0.8 percentage points.

Premium support

Medicare now provides a specified, largely uniform set of health benefits, which beneficiaries can receive either through traditional Medicare or a private Medicare Advantage plan. Under premium support, in contrast, Medicare would make a fixed dollar payment (often called a “voucher”) on behalf of each beneficiary toward the cost of health insurance — either a private plan or a form of traditional Medicare. The beneficiary would pay an additional premium if his or her plan cost more than the amount of the voucher.

Premium support would represent a major restructuring of Medicare and would have disparate effects on beneficiaries, depending on their place of residence and choice of plan. Proponents contend that it would reduce overall Medicare spending by increasing competition among health plans and making beneficiaries more cost-conscious. Opponents argue that it would largely shift costs to beneficiaries, particularly those who wanted to remain in traditional Medicare. Most premium-support proposals have not been fleshed out in detail, however, and these details would have important implications for beneficiaries and the Medicare program.¹⁷

Control health care spending growth

Policymakers should continue to seek new ways of slowing the growth in Medicare and other health care spending without shifting costs to vulnerable beneficiaries or harming the quality of care. Objectives could include

¹⁷ See: Gretchen Jacobson and Tricia Neuman, 2016, Turning Medicare Into a Premium Support System: Frequently Asked Questions, The Henry J. Kaiser Family Foundation, <http://kff.org/medicare/issue-brief/turning-medicare-into-a-premium-support-system-frequently-asked-questions/>.

reducing costs by increasing competition among health care providers and reducing financial incentives to deliver unnecessarily costly services. Specific policies could entail eliminating or reducing differences in payments across sites of service, ending overpayments to pharmaceutical companies for drugs prescribed to low-income beneficiaries, expanding the use of competitive bidding, reducing payments for medical education, and reducing coverage of bad debts. (For a discussion of policy options for reducing prescription drug spending, see Section 2.d of this *Report*.) Also, the Medicare Payment Advisory Commission (MedPAC), Congress' nonpartisan advisory body, issues two annual reports with recommendations on Medicare payment policies.¹⁸

Limit out-of-pocket spending

Unlike most private health insurance plans, Medicare does not have a cap on out-of-pocket spending for beneficiaries of Parts A and B, nor does it have a cap on Part D prescription drug spending. As a result, between premiums, cost sharing, and high prescription drug costs, Medicare beneficiaries pay a significant amount in out-of-pocket costs for their health care coverage, and that burden will only increase as health care costs continue to rise.¹⁹ One solution would be to add an out-of-pocket cap to spending on benefits received under Medicare Parts A and B and prescription drug costs under Part D. An alternative or companion option would be to offer tax credits that would kick in when an individual exceeds a certain spending threshold or be linked proportionally to the individual's out-of-pocket spending burden.²⁰ Another option would be to extend the availability of premium and cost-sharing assistance to more low-income beneficiaries through the Medicare Savings Programs and low-income drug subsidy.

Restore adequate administrative funding

Administrative funding has not kept up with the growing demands on the Medicare program. There are about the same number of employees at Centers for Medicare & Medicaid Services (CMS) now as in 1980, despite tremendous growth in the size of the Medicare and Medicaid programs, and growth in the operational responsibilities of CMS.²¹ At the same time as its employee base has stagnated, CMS's role as the administrator of Medicare and Medicaid is much more complex than in the past. In managing the Medicare program, Congress has mandated that CMS

¹⁸ Available at medpac.gov. See also Kaiser Family Foundation: Medicare Policy, 2013, Policy Options to Sustain Medicare for the Future, Section 2, <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8402-section-two.pdf>. Although this latter report is somewhat dated, there are comparable, current opportunities.

¹⁹ Marilyn Moon and Yan Wang, 2016, Who Pays for Medicare?, Center on Aging at American Institutes for Research, <http://www.air.org/system/files/downloads/report/Center-on-Aging-Who-Pays-for-Medicare-1-May-2016.pdf>.

²⁰ Yevgeniy Feyman, 2016, Out-of-Pocket Caps: The Wrong Way to Tackle High Drug Prices, Manhattan Institute, Issue Brief: Health Policy, <http://www.manhattan-institute.org/sites/default/files/IB-YF-0316.pdf>.

²¹ CMS is requesting funding for 4,112 direct Full-Time Equivalent (FTE) employees in Fiscal Year 2017. This number is less than the 4,961 FTE employees the agency had in 1980. CMS, n.d., "FY2017 CMS Congressional Justification of Estimates for Appropriations Committees," p. 6, <https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2017-CJ-Final.pdf>; Thomas H. Stanton, 2003, "The Administration of Medicare: A Neglected Issue," *Washington and Lee Law Review*, 60(4): 1373-1416, p. 1380. <http://scholarlycommons.law.wlu.edu/cgi/viewcontent.cgi?article=1256&context=wlulr>

evolve from a “claims payer” to a “value-based purchaser” and has given it additional responsibilities, which require a larger workforce with greater expertise. And in addition to Medicare and Medicaid, CMS has a number of new responsibilities – such as administering the Children’s Health Insurance Program (CHIP), the health insurance Marketplaces created by the Affordable Care Act, Medicare Advantage, the Center for Medicare and Medicaid Innovation (CMMI), and much more. In addition to improving the administrative efficiency of the programs it manages, increasing administrative resources would partly pay for itself by enabling the CMS to reduce fraud and abuse.²²

Conclusion

Congress has taken action at every point in Medicare’s history to ensure that the program remains solvent, and that the nation’s promise of health security to those in retirement and those with severe disabilities is kept. The program is not in crisis, and not going bankrupt; rather, it requires modest measures to shore up its long-term finances, as has been done on numerous occasions throughout the program’s history. The conclusion of the Academy’s bipartisan study panel on the future of Medicare’s finances from over a decade ago remains true today: to sustain the commitment to provide standard health care to the elderly and to people with disabilities, significant increases in tax revenue will be required. Economic growth, increased cost-sharing, and efficiency gains alone will not suffice. The policy options discussed here should be considered in terms of their effects on both the solvency of Medicare and the health and financial security of seniors and people with disabilities.



²² Robert A. Berenson and John Holahan, 2011, “Preserving Medicare: A Practical Approach to Controlling Spending Timely Analysis of Immediate Health Policy Issues,” <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412405-Preserving-Medicare-A-Practical-Approach-to-Controlling-Spending.pdf>.