Medicare Solvency Roundtable

Insights from Leading Experts to Keep Medicare on Solid Financial Ground

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Executive Summary

The Congressional Budget Office (CBO) projects the Hospital Insurance (HI) Trust Fund, which pays for hospital and most institutional services under Medicare Part A, will be depleted in 2027. Should this occur, full payments to providers for services covered under Part A would be delayed, which could ultimately harm the level of care patients receive. From 2022 to 2031, HI Trust Fund revenues are projected to fall $494 billion short of spending. In addition, the attention the COVID-19 pandemic has placed on health disparities has raised questions about how Medicare should be structured to support equitable outcomes by race and ethnicity. The Urban Institute convened a panel of national experts in March 2021 to discuss policy options to address the solvency of Medicare's Part A trust fund. This brief summarizes findings from that discussion, followed by some of the panelists' comments for each of the options considered.

Several areas of agreement about potential pathways emerged. These included addressing service areas, such as post-acute care (PAC) and Medicare Advantage (MA), where Medicare payments have historically been relatively high compared with providers' costs. In addition, reforming the way in which Medicare supports graduate medical education and reducing the level of support to more justifiable levels could help address solvency issues and achieve other policy objectives, such as supporting the development of a more adequate primary care workforce. Panelists also discussed several options with varying levels of support that would generate savings from prescription drugs along with several other options involving transferring savings from other components of Medicare or from the broader budget into the Part A trust fund.

The panel surfaced several compelling comments on options to address Medicare solvency. Medicare enjoys broad public support, and there is a reluctance to make changes to features that have

built that support. Panelists voiced concerns about policy options that would harm beneficiaries, such as reductions in benefits or increased cost sharing. In addition, the panel recognized the importance of Medicare to patients and providers. Health care providers rely on Medicare for financing a significant portion of the services they deliver, and these providers have been instrumental in treating patients during the COVID-19 pandemic. Some panelists supported broader structural reforms to Medicare, but there was a general recognition that major reforms are unlikely in the near term, given competing priorities and political feasibility. As a result, addressing solvency as an essential policy outcome is not likely to involve broad-based structural reform to Medicare. Instead, a combination of accounting, spending, and revenue measures to postpone insolvency is the likely path forward to address financial pressures on Medicare, particularly those focused on areas of overpayment to providers, which are unlikely to have direct impacts on beneficiaries.

Introduction

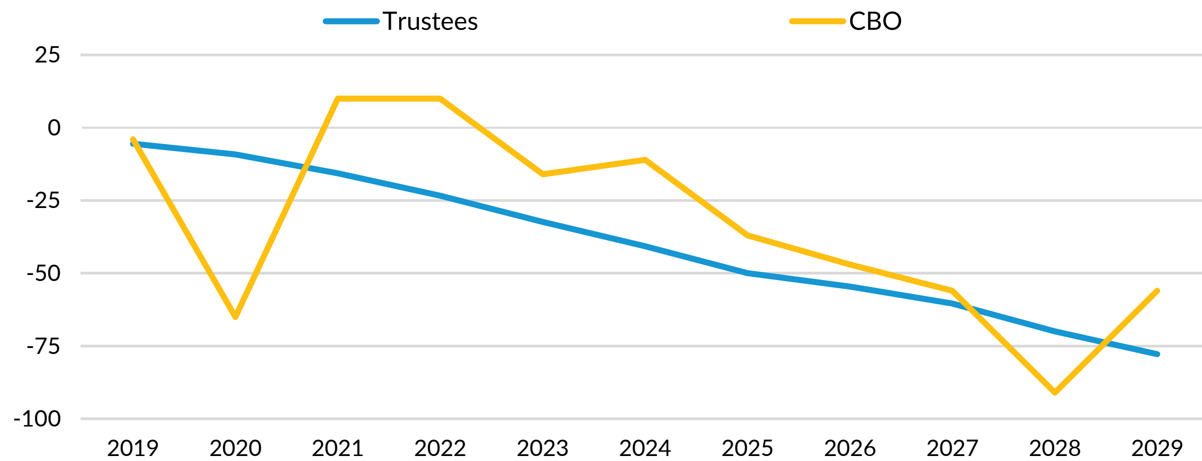
CBO projects the HI Trust Fund, which pays for inpatient hospital and most institutional services under Medicare Part A and is funded mainly by payroll taxes, will be depleted in 2027.[1] Continued instability caused by COVID-19 and its variants contributes to uncertainty about the financial picture for Medicare, in addition to various provisions of pandemic-related aid and stimulus packages, specifically the Coronavirus Aid, Relief, and Economic Security, or CARES, Act and the American Rescue Plan Act. If the HI Trust Fund were depleted, full payments to providers for services covered under Part A would be delayed, which could ultimately harm the level of care patients receive (Komisar 2020).[2] From 2022 to 2031, CBO projects spending for the HI Trust Fund to exceed revenues by $494 billion.[3] Physician services, hospital outpatient departments, and medical supplies (covered under Part B) and prescription drugs (covered under Part D) are paid from the Supplementary Medical Insurance Trust Fund, which cannot be depleted because its funds are automatically replenished. Enrollee premiums finance roughly 25 percent of these services, and general revenues finance 75 percent.

Both CBO and Medicare Trustees project that the size of the HI Trust Fund deficit will grow over time, as shown in figure 1. Both projections show deterioration in the HI Trust Fund's fiscal position. The estimates differ primarily because CBO's projections are more recent and incorporate data on how the economic downturn in 2020 due to the pandemic affected program revenues and spending.

FIGURE 1

CBO and Medicare Trustees HI Trust Fund Surplus and Deficit Projections

Billions of dollars



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Sources: Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: Centers for Medicare & Medicaid Services, 2020); and CBO, *The Budget and Economic Outlook: 2021 to 2031* (Washington, DC: CBO, 2021).

Notes: CBO = Congressional Budget Office. HI = Hospital Insurance. The spike in the HI Trust Fund deficit in 2020 in the CBO figures reflects the effect of the pandemic. Released in early 2020, the Trustees' report reflects prepandemic forecasts for 2020, whereas the CBO figures reflect actual 2020 information. Updated Trustees' data and forecasts are expected to be released soon.

Though there are fiscal pressures on Medicare Part A, growth in Part B spending is projected to outpace the growth of Part A spending. As shown in table 1, spending for Part A services is forecast to grow 6.0 percent annually from 2021 to 2030. Over the same period, Parts B and D services are forecast to grow 7.4 and 7.2 percent, respectively. Also, on a per enrollee basis, spending on Parts B and D (5.1 and 4.9 percent annually) will grow faster than spending on Part A (3.9 percent). MA spending will grow by 9.4 percent over the period because of both increased enrollment (4.4 percent annually) and increased spending per enrollee (4.5 percent annually). Part C does not have its own dedicated financing but instead draws in set ratios from the HI and Supplementary Medical Insurance Trust Funds, thus a high rate of growth in Part C is reflected in projections of growth in HI spending. All of these spending growth rates are significantly higher than the projected growth in consumer and economy-wide prices of around 2 percent (CBO 2021).

While the looming insolvency of the HI Trust Fund poses an urgent problem for policymakers, the broader financing challenges for the Medicare program also need to be addressed.

TABLE 1

Medicare Spending and Enrollment, by Program Part

	Part A	Part B	Part D	Medicare Advantage/ group plans
Spending				
2021 ($billions)	365	422	96	343
2030 ($billions)	654	865	192	820
Annual growth (%)	6.0	7.4	7.2	9.1
Enrollment				
2021 (millions)	64	58	50	26
2030 (millions)	78	72	62	40
Annual growth (%)	2.0	2.2	2.2	4.4
Spending per enrollee				
2021 ($)	5,700	7,280	1,920	13,190
2030 ($)	8,390	12,010	3,100	20,500
Annual growth (%)	3.9	5.1	4.9	4.5

Source: "Medicare—CBO's Baseline as of March 6, 2020," Congressional Budget Office, March 19, 2020, https://www.cbo.gov/system/files/2020-03/51302-2020-03-medicare.pdf.

Notes: Medicare Advantage/group plan spending is also contained within the reported Parts A and B amounts; Medicare Advantage/group plan estimates do not include Part D spending for plan enrollees. The table relies on the Congressional Budget Office's (CBO's) March 2020 baseline projections because its 2021 baseline did not report projections for Medicare Advantage/group plan spending. Using CBO's 2021 projections, spending per enrollee growth was similar for Parts A and B (4.0 and 5.4 percent), and per enrollee spending growth for Part D was a percentage point higher (5.9 percent).

Considering these fiscal challenges, the Urban Institute convened a panel of national experts in March 2021 to discuss policy options to address the solvency of Medicare's Part A trust fund. Panelists included 17 experts from various sectors, including government, academia, foundations, policy and actuarial research institutions, and industry:

- Joe Antos, American Enterprise Institute
- Robert Berenson, Urban Institute
- Shawn Bishop, US Senate Finance Committee
- James Capretta, American Enterprise Institute
- Dan Crippen, Board, Center for Health Care Strategies; former CBO director
- Matt Fiedler, USC-Brookings Schaeffer Initiative for Health Policy
- Richard Frank, Department of Health Care Policy, Harvard Medical School
- Marc Goldwein, Committee for a Responsible Federal Budget
- Gretchen Jacobson, Commonwealth Fund
- Cara James, Grantmakers in Health

- Mark Miller, Arnold Ventures
- Tricia Neuman, Kaiser Family Foundation
- Robert Reischauer, Urban Institute; former CBO director
- Erica Socker, Arnold Ventures
- Andrew Swire, Amgen
- Erin Trish, USC Schaeffer Center
- Cori Uccello, American Academy of Actuaries

This brief presents background material on Medicare spending and proposals to address Medicare program solvency and summarizes panelists' comments about the policy options considered. We present the views of multiple experts who attended the meeting, while providing a synthesis of the discussion.

Framing Considerations for Medicare Solvency Policy Options

Robert Reischauer, a former Medicare HI trustee, former CBO director, former vice chair of the Medicare Payment Advisory Commission (MedPAC), and Urban Institute president emeritus, provided opening remarks to frame the roundtable discussion. In the near future, he explained, Congress and the administration will have to come together to enact legislation. At a minimum, this legislation must address Medicare HI Trust Fund solvency and, at a maximum, could make profound changes in health insurance options available for elderly and disabled beneficiaries that could have ramifications for the health insurance of the general population as well.

In considering the various policy options to address Medicare solvency, Reischauer emphasized the need to try to develop a consensus around three "big questions":

1. Which available policy path is most desirable from the standpoint of the policy on its merits, and which would be best from the standpoint of enactment in a timely fashion?
2. What are the distributional effects of the unavoidable burden of shoring up the HI Trust Fund?
3. To what extent should policy proposals include "sweeteners"—policies that would be popular among beneficiaries but costly to the program—to make other changes politically palatable?

On the first question, Reischauer described several potential paths. The first would use the looming exhaustion of the HI Trust Fund to motivate consideration of significant structural reforms that both address the shortcomings of the current Medicare program and rationalize the fragmented and convoluted financing system that supports the HI and Supplementary Medical Insurance Trust Funds. The original authors of the Medicare program were insistent on a trust fund financed by a

payroll tax; though some viewed the reliance on an earmarked payroll tax as expansionary, Wilbur Mills and other budget guardians viewed this approach as limiting growth in the benefit (Patashnik and Zelizer 2001). The shortcomings of the current program include its complexity; its inadequate benefit system that causes most fee-for-service beneficiaries to rely on supplemental coverage from Medigap, Medicaid, or retiree plans; its "irrational pattern of cost sharing"; and its inability to constrain cost growth. Structural reform would need to be phased in gradually to be viable, which would diminish the immediate financial benefit to the HI Trust Fund. Ideally, though, such reforms could resolve Medicare financing for the intermediate (20 years) or long run. In addition, Reischauer suggested broad structural reform could potentially help with more widespread efforts to address national health care cost growth. Enacting fundamental change is challenging because it threatens several powerful stakeholders, but such opportunities come along very rarely. In this instance, it may be more viable because the opportunity does not arise from partisan considerations.

A second path is to cobble together a set of "usual suspects," that is, modest proposals to cut spending and raise revenues that would preserve the current Medicare structure but might move things around in the "alphabet soup" of Medicare. Such an approach would probably be the most viable politically, according to Reischauer, and be capable of extending the life of the HI Trust Fund for another decade or so. But these policies might lack coherence or a vision of what the Medicare program could be and would probably only add to the system's complexity.

A third possible path is to craft a hybrid response combining a set of modest structural reforms and a handful of the usual-suspect proposals to cut spending and raise revenues. This could include reforms to MA that, over time, facilitate the transition of MA to a "purer" form of premium support.

The second question asks who should bear the burdens associated with shoring up the HI Trust Fund. Should taxpayers, beneficiaries, health care providers, or the broader public bear the burdens? Beneath each of these categories is another layer of equally important if not more challenging detailed questions about which taxpayers, which beneficiaries, and which providers should bear the burdens. The answers to these questions are often unclear, in part because behavioral responses and other interactions can mean that the ultimate burden is a far cry from the initial incidence.

On the third question about potential sweeteners, Reischauer suggested an obvious candidate would be adding an out-of-pocket maximum to traditional fee-for-service Medicare. The danger, he warned, is that if one sweetener is allowed into the policy package, others may storm the gates.

In concluding his remarks, Reischauer noted that no matter the path, no matter how the burden is distributed, and no matter the sweeteners that are allowed to be wrapped up in the policy package, reaching a solution that has bipartisan support, which is essential, will be much more difficult this time around. Some will demand that President Biden's Medicare campaign promises be included in the package, such as reducing Medicare's age of eligibility and Biden's commitment to include a public option in the health insurance Marketplaces. In addition, policies will be evaluated on potentially divisive dimensions that have received little attention in the past, thanks to the availability of more detailed data, sophisticated analytic techniques, and changed national priorities. Policymakers will be

interested in the differential effects of policies by race, gender, ethnicity, income, life expectancy, and geographic location. All these considerations will make addressing Medicare HI Trust Fund solvency a complicated task.

Key Takeaways

Following the robust panel discussion of policies, several areas of broad if not universal agreement emerged that convey potential policy pathways for addressing Medicare solvency.

- Despite the desire of some panelists to pursue broad-scale structural reforms, panelists suggested that broad reforms to Medicare were unlikely, and an approach combining increased revenues with targeted spending reductions that minimize impact on beneficiaries is more feasible.
- An accounting-based approach, such as redirecting revenue from the net investment income tax (NIIT) from general revenues to the HI Trust Fund would be insufficient to close the financing gap on its own. Although it could be part of a package of reforms, the reallocation would not reduce the overall federal deficit.
- Though additional revenues would likely need to be part of a package to forestall HI insolvency, no clear preferred approach emerged in the discussion. Some proposals would target people with higher incomes and/or close tax loopholes, some would broaden the types of income subject to tax, and others would raise the payroll tax and affect more people. Each proposal has pros and cons.
- Panelists generally agreed that focusing on Medicare service areas with traditionally high Medicare payments relative to provider costs, such as PAC and MA, are likely to be part of an effective strategy. The panel showed little enthusiasm for reducing payment rates for inpatient hospital services—by far the largest component of Part A spending. MedPAC considers Medicare inpatient hospital payments to be roughly in line with relatively efficient hospitals' costs (MedPAC 2021a).
- Reducing the amount Medicare spends on graduate medical education to more justifiable levels and reassessing the way the funds are allocated is desirable both for addressing Medicare solvency and achieving other policy goals, like a renewed focus on supporting the development of the primary care workforce.
- Though most Medicare spending on prescription drugs falls under Parts D (primarily) and B and is not financed through the HI Trust Fund, curbing spending on prescription drugs was another area where panelists generally felt legislative progress could be made. There are several existing legislative savings proposals with varying levels of bipartisan support; some proposals face strong opposition.

The Urban Institute team requested the panel of experts to comment on several different dimensions of proposed policies, including political feasibility. With many other pressing matters facing

Congress, including ongoing effects of the COVID-19 pandemic, panelists suggested there is not much willingness to take on debate about major health care reforms. However, packages of reforms that address Medicare solvency but also include some sweeteners could be appealing to legislators. In addition, packages that have a rescue framing, such as relief and reform for PAC providers that include financing changes to alleviate strain on the HI Trust Fund, could gain traction.

In discussing policy options, panelists also identified several broad considerations for Medicare solvency. First, policy options that are progressive in nature and place more financing burden on beneficiaries with higher incomes may be appealing, but they also have the consequence of shifting away from Medicare's shared social insurance model. In addition, these reforms may weaken the widespread public support for Medicare that currently exists. Several legislative proposals that have nothing to do with health broadly or Medicare more narrowly and would raise revenue from people with higher incomes are already under consideration, but there is inevitably some limit to raising resources from any single revenue source.

Several policy options, such as reforms to MA and competitive bidding approaches, also raise the question about the role of private plans and companies in Medicare. There is some concern among experts that overpayment to private MA plans may be contributing to the exhaustion of Medicare funding.[4]

Panelists pointed out the challenge that beneficiaries do not fully appreciate how expensive their Medicare benefits are relative to the amount they have paid toward the program over their working years. With substantial gaps in Medicare's benefits, like exposure to out-of-pocket costs and lack of coverage for long-term care, and a perception that beneficiaries have already paid for their benefits, it may be difficult for beneficiaries to bear or accept higher levels of cost sharing or higher premium contributions to help finance their Medicare spending. This suggests that approaches to address solvency would need to raise further Medicare revenues from the broader population and pursue reductions in program spending that do not directly reduce benefits.

Finally, one challenge that panelists emphasized is that the HI Trust Fund solvency issue is only part of the broader fiscal pressure on Medicare. The insolvency date for the HI Trust Fund is most immediate, but other parts of Medicare are experiencing cost growth that strains general government resources. Some of the policy options discussed during the panel would improve the financial footing of the Medicare program broadly but would not directly benefit the HI Trust Fund. Some mechanism would need to be identified to shift resources to the HI Trust Fund, ideally without worsening the financial outlook for other Medicare components or causing Medicare to further burden general fund revenues.

Policies to Address Medicare Solvency

This section provides brief descriptions of the policies presented at the meeting and some of the comments panelists provided about the policies. Our list of policy approaches was compiled from a review of current literature and proposals to address Medicare solvency; we provide sources in the

endnotes and references to the discussion below. We grouped the policies into four conceptual categories for consideration: accounting policies that redirect existing revenue sources to the HI Trust Fund; revenue-oriented policies that create new funding streams to support Medicare; spending policies that adjust benefits, payments, and other elements within the existing Medicare program; and policies that could address solvency as part of broader Medicare reforms. Some policies fit into more than one category, and some panelists would categorize the policies differently than we have. Also, the set of policies we highlight is not exhaustive of all the ways Medicare solvency could be addressed. We requested panelists to consider the merits of the proposed reforms, including their financial impacts, equity implications, and political feasibility.

TABLE 2

Potential Policy Approaches to Address Medicare Solvency

	Estimated savings/revenue
Accounting-based policy options	
Dedicate net investment income tax to Part A	$270 to $350B over 10 years
Shift Part A home health services to Part B	$6B annually
Revenue-oriented policy options	
Increase the dedicated payroll tax rate	$400B over 10 years
Increase the Medicare high-income add-on tax for the highest earners	$7.7B annually
Subject all personal income to Federal Insurance Contributions Act taxes	$210B over 10 years
Limit payroll tax deductions for employer health insurance contributions	$260B over 10 years
Tax excessive profits during the pandemic	
Return savings related to the decline in MA claims during the pandemic	$8.4B+ one time
Spending policies within the current Medicare program	
Reduce payments to post-acute care providers	$80B over 10 years
Increase beneficiary cost sharing for Part A services	
Implement site-neutral hospital outpatient and physician payments	$40B over 10 years
Expand competitive bidding for medical equipment and labs	Up to $10B over 10 years
Reform and reduce graduate medical education payments	$30B over 10 years
Increase the coding-intensity adjustment to lower excess MA payments	$47B over 10 years overall ($25B for HI Trust Fund)
Base MA benchmarks on local MA bids rather than traditional Medicare costs	$44B over 10 years
Implement a unified payment system for post-acute care	$102B over 10 years
Restrict Medigap cost sharing to bar first-dollar coverage	$72B over 10 years
Spending policies as part of broader Medicare reform	
Integrate Parts A and B with a unified cost-sharing structure	
Implement a premium support plan	$419B over 5 years
Deploy navigators and expand tools for high-need patients to manage their conditions	
Lower prescription drug costs in Medicare	$100 to $450B over 10 years
Raise the age of Medicare eligibility incrementally to 67	$80B over 10 years

Source: Urban Institute synthesis of Medicare financing reform proposals and spending effect estimates from various sources; source documents are cited in each proposal description in the text below. The list of proposals is not exhaustive, and proposals may fit in more than one category.

Note: MA = Medicare Advantage.

Accounting-Based Policy Options

1. DEDICATE PROCEEDS OF THE NIIT TO THE HI TRUST FUND

The NIIT is a 3.8 percent surtax on a portion of income above certain thresholds that was implemented by the Health Care and Education Reconciliation Act of 2010, following the passage of (and which amended) the Affordable Care Act (ACA). It is paid by high earners with significant investment income and was intended to offset the net costs of the ACA. Net investment income includes interest, dividends, capital gains, rental and royalty income, and other sources of income not subject to the HI tax on earnings. Capital gains on the sale of a personal residence are not subject to the NIIT to the extent they are excluded from the regular income tax. Subject to eligibility requirements, $250,000 is excluded from capital gains for single filers ($500,000 for married couples filing jointly).[5] Business incomes of active participants in S corporations and limited partnerships are also exempt from the NIIT.[6]

Under this proposal, future proceeds from the NIIT, which President Biden has included in his fiscal year 2022 budget proposal, would be credited to the HI Trust Fund instead of general revenues, adding an estimated $270 to $350 billion to the trust fund over the 2021–30 period. This revenue would potentially close nearly half of the 10-year shortfall. While this proposal would strengthen the HI Trust Fund, it would simply be a reallocation of the tax's revenue and would not decrease the overall federal deficit (Van de Water 2020).

There was some concern among panelists that the NIIT was originally passed to help finance coverage expansions of the ACA, and that allowed the legislation to be scored by CBO as reducing the long-term federal deficit. Shifting proceeds of this tax to the HI Trust Fund would mean that the single revenue source would in effect (or notionally) be used to pay for two different types of spending. A panelist pointed out that reallocating NIIT revenue from general funds to the HI Trust Fund amounts to more than merely an accounting change, because it would modify the spending constraint that the HI Trust Fund imposes. At the same time, the spending constraint is now more binding than when Medicare was enacted. Earned income as a share of personal income fell from 78 percent in 1965 to 59 percent in 2020.[7]

One panelist also suggested that raising the NIIT would lead to lower realization of capital gains and thereby reduce capital gains tax revenues. In addition, there is interplay between the proposed changes to the NIIT and other potential tax policies being discussed by the Biden administration to generate revenue, such as raising the long-term capital gains tax rate for households with incomes greater than $1 million per year.[8] If passed, the capital gains tax increase could reduce NIIT revenue and the potential benefit to the HI Trust Fund.

2. SHIFT ALL HOME HEALTH SERVICES TO PART B

Under current Medicare rules, about one-third of home health care spending is financed under Part A. Some experts have proposed unifying the home health benefit by shifting all home health services to Part B.[9] Such a policy change would move nearly $6 billion in annual spending away from the HI Trust Fund. But panelists noted that here, too, such a shift is more than just an accounting change. The shift

would put upward pressure on the Part B premium (unless there were some provision to shield beneficiaries from an increase, such as by limiting premium increases for enrollees with lower incomes) and add to the amount of general fund revenue needed for Part B spending.

Revenue-Based Policy Options

Multiple Medicare policy experts have argued that raising additional revenues should be part of the solution to putting the program on more solid financial footing. In addition to comments on specific policies that would raise new revenues, as we describe below, panelists shared some general comments regarding revenue-based options. One noted that based on their experience, implementing these types of taxes can be difficult; the panelist pointed to the Cadillac tax, a 40 percent excise tax on high-cost employer health plans enacted as part of the ACA. Raising revenue through taxes could be challenging considering President Biden's promise of no additional taxes for those with incomes under $400,000.

Others commented that adding more financing complexity would move the program farther away from the original concept of Medicare as a self-financing program, and that pushing hard on higher earners would potentially lessen Medicare's broad public support and undermine the concept of social insurance. At the same time, we should be examining sources of income that are potentially falling through the cracks under the current tax code. One panelist also pointed out that there could be a tremendous increase in taxes for people with high incomes when the Trump administration individual tax cuts expire. However, other panelists noted that policymakers should be taking a closer look at what sources of income are not being used to support the existing system.

3. INCREASE THE PAYROLL TAX DEDICATED TO MEDICARE FROM 1.45 TO 1.95 PERCENT EACH FOR EMPLOYEES AND EMPLOYERS

The payroll tax that funds Medicare Part A is 2.9 percent, with the employee and employer each responsible for half (1.45 percent). A modest payroll tax rate increase, phased in to give workers time to recover from the COVID-19 recession, would provide a meaningful increase in contributions over time. Phasing in the tax increase gradually would avoid large and sudden increases in tax burdens and would create long-term revenue support for the HI Trust Fund. Experts estimate that about $400 billion could be raised over the next 10 years with a gradual increase of about 1 percentage point (from 1.45 percent to 1.95 percent each for employees and employers) over several years.[10]

One panelist noted that a related possibility for raising payroll tax revenue would be to count employer health insurance contributions as taxable compensation subject to the payroll tax. Another panelist noted that based on their experience working with the Treasury to try to implement the ACA's Cadillac tax, implementing these kinds of fixes is extremely difficult (implementation of the Cadillac tax was delayed, and the tax was subsequently repealed). As mentioned above, another panelist noted that President Biden's promise of no new taxes for families with incomes below $400,000 per year makes some of these options difficult. One offered the possibility of raising the payroll tax only for high earners (i.e., those earning more than $400,000 per year).

4. INCREASE THE ADDITIONAL MEDICARE TAX FOR THE HIGHEST EARNERS

The ACA added a 0.9 percent payroll surcharge tax for people earning more than $200,000 and families earning more than $250,000, with revenue directed at the HI Trust Fund, called the additional Medicare tax. This is also called the Medicare "high-income add-on" tax. This tax generated revenue of about $10 billion in 2018. The add-on tax could be expanded, for example by increasing it to 2 percent for those earning more than $1 million per year. This is estimated to add approximately $7.7 billion per year to the HI Trust Fund.[11]

5. SUBJECT ALL PERSONAL INCOME TO FEDERAL INSURANCE CONTRIBUTIONS ACT TAXES

Many experts have proposed variations on the idea that existing taxes can be expanded to make more sources of income subject to taxes directed toward Medicare. One idea is that all personal income, as defined by the Internal Revenue Code, would be subject to Federal Insurance Contributions Act (FICA) taxes, including self-employment taxes (i.e., Self-Employment Contributions Act [SECA] taxes). Using 2019 figures, this policy would immediately increase Part A trust fund revenues by more than $100 billion a year.[12] This policy would broaden the scope of the FICA taxes to apply not only to wage earnings and self-employment income as they do now, but to other sources of personal income, including partnership and S corporation net income, business net income, interest, royalties, rent, and dividends.

Panelists pointed out there are a few variations on proposals that would broaden the tax base for some existing taxes to benefit Medicare. CBO estimates that expanding the base of the NIIT to include the incomes of active participants in S corporations and limited partnerships would raise $210 billion over 10 years.[13] Revenues of an expanded NIIT could then be redirected to the HI Trust Fund.[14]

6. LIMIT PAYROLL TAX DEDUCTIONS FOR EMPLOYER HEALTH INSURANCE CONTRIBUTIONS

Currently, an employer's contribution for health insurance coverage for its employees is not counted as earnings and is exempt from federal income and payroll taxes for both the employer and employee. It has been estimated that the payroll tax exclusion of employer health premiums reduces Treasury revenue by $106 billion per year; capping or eliminating employers' payroll tax exclusion for health insurance contributions would increase revenue that could be directed to the Medicare program. Reducing an employer's deductibility of employer health insurance by half amounts to increased revenues equal to roughly one-fourth of the total costs of deductibility, because the employer pays only 50 percent of the payroll tax. This would amount to approximately $26 billion per year in new revenues for the trust fund (Gruber 2010).[15]

As mentioned earlier, one panelist who had worked with the Treasury to implement the Cadillac tax said implementing these kinds of tax-oriented fixes is extremely difficult.

7. TAXING EXCESSIVE PROFITS DURING THE PANDEMIC

Despite the widespread economic distress it caused, the COVID-19 pandemic generated windfall profits for some businesses and corporations across a range of industries. An excess-profits tax could place a higher tax rate on income earned in 2020 and 2021 that exceeds 2019 income by a certain percentage. This temporary tax increase for some could be directed to bolster the Part A trust fund.[16]

8. RETURN SAVINGS RELATED TO THE SUBSTANTIAL DECLINE IN MEDICARE ADVANTAGE CLAIMS DURING THE PANDEMIC

Health care utilization dropped dramatically during the second quarter of 2020, with stay-at-home orders and patients reducing or delaying their visits to health care providers to avoid potential coronavirus exposure. In the second quarter of 2020, insurers with large MA enrollment reported declines in utilization of 30 percent in March and April. By late 2020, utilization had returned to prepandemic levels,[17] but the dip earlier in the year reduced Part A trust fund spending in traditional Medicare by an estimated $8.4 billion. MA plans continued to receive the predetermined per beneficiary amounts, so the reduced utilization constituted an unexpected windfall. Some experts have proposed remanding some of these profits back to the Medicare Trust Fund and using *ex post* limits on MA plan profits.[18]

Panelists noted that this policy approach could accomplish claw-back on MA profits though the MA medical loss ratio requirements, which stipulate those insurers must spend at least 85 percent of their revenue on patient care. The ACA requires MA plans (and Part D plans) to report their medical loss ratios annually. Failure to meet the minimum medical loss ratio can result in remittance of funds to the Centers for Medicare & Medicaid Services, a prohibition on enrolling new members, or ultimately contract termination.

Spending Policies within the Current Medicare Program

9. REDUCE PAYMENTS TO POST-ACUTE CARE PROVIDERS

Medicare payments to PAC providers, including skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health agencies, have generally had a high payment-to-cost ratio, with Medicare margins of at least 10 percent most years despite changes to PAC payments. This proposal would lower or eliminate payment updates to PAC providers, consistent with previous MedPAC recommendations (MedPAC 2020) and budget proposals from the Obama and Trump administrations. Reducing payments to PAC providers could generate up to $80 billion over 10 years.[19]

This policy was identified by panelists as one that could potentially reduce excessive spending without harming Medicare beneficiaries. In addition, panelists suggested this policy may be politically feasible because of the sense that PAC reform will be necessary in the wake of the pandemic.

10. INCREASE BENEFICIARY COST SHARING FOR PART A SERVICES

Most Medicare beneficiaries do not pay premiums for Part A enrollment, but using Part A services may require out-of-pocket payments or payments by beneficiaries' supplemental coverage plans (e.g., Medigap). For example, in 2021, traditional Medicare beneficiaries (or their supplemental insurers) are responsible for a $1,484 deductible for a hospital stay. The Medicare program would reduce its spending by shifting a portion of what it now pays for hospital and other Part A services to beneficiaries.

Many panelists, however, held that the burden of measures aimed at improving Medicare program solvency should not fall substantially on beneficiaries, particularly those with the highest health care needs. In addition, this policy raised potential equity concerns, because it has a disproportionate impact on beneficiaries with low incomes (but not those dually eligible). Panelists also noted the distinction between policy proposals that would raise enrollee premiums (i.e., on Part B), which distribute costs broadly across beneficiaries and are less politically attractive, and those that would increase cost sharing at the point of service, which focuses the burden on those using services. In addition, increased cost sharing at the point of service also raises potential equity concerns, as the burden disproportionately falls on the sickest patients, who also are disproportionately people of color.

11. IMPLEMENT SITE-NEUTRAL HOSPITAL OUTPATIENT AND PHYSICIAN PAYMENTS

Medicare pays for care delivered in hospital outpatient departments using the Outpatient Prospective Payment System and for care delivered in independent physician offices using the Medicare Physician Fee Schedule. Having two separate payment systems can lead to different payment rates for essentially the same services. It also creates a financial incentive for hospitals to purchase physician practices so they can bill at the higher Outpatient Prospective Payment System rates. In response, Medicare has implemented some site-neutral payments; new hospital-owned physician practices cannot bill at the hospital outpatient rate. However, many hospital-owned practices were grandfathered in and can continue to bill through the Outpatient Prospective Payment System. Expanding site-neutral payments to the grandfathered practices could save the Medicare program about $40 billion over 10 years. Further expanding site neutrality to require hospital outpatient departments to bill at the physician fee schedule rates for certain services would potentially generate $100 billion in savings over 10 years.[20]

Like with the PAC proposal, panelists noted that this policy could potentially reduce spending without affecting beneficiaries. However, this policy presents the challenge of transferring the savings from Part B to the Part A trust fund.

12. EXPAND COMPETITIVE BIDDING FOR MEDICAL EQUIPMENT AND LABS

Medicare demonstrations of competitive bidding approaches for durable medical equipment and labs have yielded savings while maintaining access to high-quality vendors for beneficiaries. However, Medicare still primarily uses a fee schedule to pay for these items. These demonstrations could be applied more broadly for durable medical equipment and labs to achieve savings.[21] One panelist

cautioned that expanded competitive bidding could restrict access to certain goods and services, which might reduce access to care for people with certain disabilities. Another suggestion was to reduce durable medical equipment and clinical lab fee schedule rates based on prices obtained by private plans rather than relying on competitive bidding only, which would be easier to administer and potentially yield larger savings.

13. REFORM AND REDUCE GRADUATE MEDICAL EDUCATION PAYMENTS

Medicare provides about $10 billion annually to hospitals to support graduate medical education and offset the direct and indirect costs of training medical residents. Medicare is the major source of funding support for physician training programs. The funding formulas for direct and indirect costs differ. MedPAC analysis suggests the funding formula for indirect costs, which reflect the higher patient care costs related to teaching activities, is too generous by $3 billion annually compared with the level justified by data (Miller 2015). Proposals to reform Medicare's support of graduate medical education include converting payments into direct grants to institutions; allowing ambulatory settings like physician groups to receive payments for training residents; and reducing the total funding to align more closely with rates supported by data, which is estimated to save $30 billion or more over 10 years.[22] CBO also describes budget options that would limit growth in graduate medical education spending over time (CBO 2018). Efforts to reduce these payments are likely to face substantial political resistance from the hospital industry and particularly large teaching hospitals. Teaching hospitals are often large employers and economic anchors in their communities. They train doctors and other health care professionals and serve as safety net institutions delivering health care to underserved populations.[23]

14. INCREASE THE CODING-INTENSITY ADJUSTMENT TO LOWER EXCESSIVE MA PAYMENTS

Medicare pays MA plans more for beneficiaries with higher estimated health risks, which are associated with higher health expenditures. Diagnoses coded on health care claims help determine the level of a beneficiary's health risk. This creates an incentive for MA plans to increase coding intensity to maximize payments. Medicare already makes across-the-board downward adjustments to its payments to MA plans through its coding-intensity adjustment to adjust for overall differences in coding practices between MA and traditional Medicare. But MedPAC and others estimate that payments to MA plans are still 8 to 11 percent higher than for traditional Medicare beneficiaries of similar risk. The magnitude of the downward coding-intensity adjustment could be increased (and better targeted) to better account for differential coding practices. In 2019, CBO estimated that increasing the adjustment to reduce overpayments by 8 percent would yield $47 billion in savings over 10 years, with $21 billion accruing to the Part A HI Trust Fund.[24] This change could be made under existing administrative authority; it would require neither legislation nor new rule making.

Panelists discussed whether a coding-intensity adjustment would fully capture the favorable selection into MA plans, noting there is some dispute about the level of favorable selection. An alternative suggestion was raised that would reduce fee-for-service benchmarks by 10 to 12 percent, though this would likely not be feasible.

15. BASE MA BENCHMARKS ON LOCAL MA BIDS RATHER THAN TRADITIONAL MEDICARE COSTS

Medicare pays MA plans based on the plan's bid relative to a benchmark, which is determined by the local risk-adjusted spending for fee-for-service Medicare beneficiaries. An alternative would determine local benchmarks based on plan bids, similarly to the approach used to determine subsidies in the ACA Marketplaces. For example, the benchmark might be the second-lowest-cost bid among MA plans. This would induce greater price competition among MA plans. CBO estimates that this approach could potentially save about $44 billion over 10 years.[25] Efforts to extract program savings from the MA side of the ledger should consider the equity implications of any changes, as racial and ethnic minorities comprise a disproportionately high share of MA enrollment (Meyers et al. 2021).

Panelists felt this was another policy option that would reduce Medicare spending without harming beneficiaries. Another alternative mentioned was to reform how MA plan quality bonus payments are made to generate program savings (or at least be budget neutral) by evaluating quality and distributing payments and penalties at the local market level along the lines of MedPAC recommendations (Tabor et al. 2020).

16. IMPLEMENT A UNIFIED PAYMENT SYSTEM FOR POST-ACUTE CARE

The Improving Medicare Post-Acute Care Transformation, or IMPACT, Act of 2014 directed the health and human services secretary to develop a single prospective payment system for PAC in skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health agencies. Medicare currently uses separate prospective payment systems for each of these care settings, despite substantial overlap in the types of patients they treat. The result is that Medicare can pay different amounts to treat similar patients, depending on their treatment settings. MedPAC has assisted in proposing the design features of a unified PAC prospective payment system; the prototype bases reimbursement on patient characteristics rather than site of service (though it continues to recognize inherent cost differences between institutional settings and home health). For several years, MedPAC has concluded that the unified PAC prospective payment system is feasible and has recommended that it be implemented beginning in 2021, with a three-year transition and alignment of setting-specific regulatory requirements (MedPAC 2018).[26] The IMPACT Act did not require implementation of the PAC prospective payment system, and the Centers for Medicare & Medicaid Services continues to consider its design.

17. RESTRICT MEDIGAP COST SHARING TO BAR FIRST-DOLLAR COVERAGE

In traditional fee-for-service Medicare, beneficiaries can face high copayments for medical services, leading many beneficiaries to purchase supplemental Medigap coverage to reduce out-of-pocket costs. Beneficiaries may also have supplemental coverage through other sources, such as an employer retiree plan or Medicaid dual eligibility. Some Medigap policies cover the Medicare Part B deductible and all a beneficiaries' out-of-pocket costs, called first-dollar coverage; it can increase overall Medicare spending because beneficiaries are not exposed to any cost at the point of service. In a blog post, one panelist proposed a policy that would ban first-dollar coverage in both Medigap and employer-sponsored supplemental plans.[27] CBO modeled a similar policy that would prohibit Medigap from

providing first-dollar coverage and estimated it would save $72 billion over 10 years.[28] As precedent for addressing Medigap cost sharing, the Medicare Access and CHIP Reauthorization Act prohibited selling Medigap policies that cover the Part B deductible to new Medicare beneficiaries beginning in 2020.

In considering this policy, one panelist suggested that a surcharge could be imposed on Medigap plans based on the impact they have on Medicare program spending and the value of the wraparound services they provide. This would effectively increase the cost of Medigap, particularly first-dollar coverage, and make these policies less desirable.

Spending Policies as Part of Broader Medicare Reform

18. INTEGRATE PARTS A AND B WITH A UNIFIED COST-SHARING STRUCTURE

Medicare is structured as separate parts; Part A covers hospital and institutional services and Part B covers physician and other professional services, and each has separate cost-sharing and benefits rules for beneficiaries and programmatic financing mechanisms. Prescription drug coverage under Part D and coverage through MA plans under Part C add to the complexity. As health care has grown more integrated over time, this structure has led to confusion, complexity, and perverse incentives. Some have proposed integrating the benefits for beneficiaries (Davis et al. 2013, Garrett et al. 2019); the financing structure could also be streamlined, such as by combining the two trust funds.[29] Unified cost-sharing schedules could be designed to generate program savings or to increase financial protection for beneficiaries, for example, by adding an out-of-pocket maximum to traditional Medicare.

19. IMPLEMENT A PREMIUM SUPPORT PLAN

Medicare beneficiaries currently can elect to enroll in coverage through MA plans or remain in fee-for-service Medicare. Some beneficiaries are assigned to accountable care organizations, which bear some similarities to a provider-run managed-care plan. In a premium support model, the government would pay the same risk-adjusted amount for each beneficiary's coverage regardless of the coverage choice. Beneficiaries would pay premiums that equal the difference between the cost of the Medicare benefits package and the government contribution (MedPAC 2017). An expansion of premium support in Medicare, including for fee-for-service enrollees, could be implemented in multiple ways. One proposal would introduce competition between MA plans, accountable care organizations, and unmanaged fee-for-service plans, with the government contributing a fixed amount for coverage based on bids by the offerors.[30] The benchmark would not be defined by area-specific fee-for-service spending but could instead be determined by the second-lowest bid.[31] CBO estimates that a premium support plan would save $419 billion over five years (CBO 2017). Others have discussed the operational challenges that could arise under a premium support policy (Berenson, Skopec, and Zuckerman 2017). An appropriate transition, a reasonable inflation factor, and accurate risk adjustment could help address the proposal's long-term impact on access to care.[32]

Based on experience and conversations with MA plan representatives, one panelist commented that MA plans would prefer to have benchmarks reduced than to absorb more fundamental restructuring of the program's payment mechanism.

20. DEPLOY NAVIGATORS AND EXPAND TOOLS FOR HIGH-NEED PATIENTS TO MANAGE THEIR CONDITIONS

Medicare spending is concentrated among beneficiaries with significant health needs. Recent initiatives like alternative payment models have targeted care delivery for those with significant needs to reduce costs while maintaining quality, but these efforts have not yielded significant savings. The expansion of tools for patients with chronic conditions could help them manage their own conditions. For example, providing better patient screening and patient activation assessments as well as web-based tools, workshops, and guides for these patients and their providers could help avoid more costly care. Patient navigators, such as nurses, social workers, or other nonclinical staff, could work with high-need patients to reduce complications and avoid emergency department visits and hospital stays.[33]

Panelists noted that these patient-oriented care management tools could potentially work in a capitated setting but are difficult to implement and may not work in a fee-for-service environment. Also, it is difficult to estimate the potential savings of this policy, which limits the appeal of this policy as part of Medicare solvency solutions.

21. LOWER PRESCRIPTION DRUG COSTS IN MEDICARE

Although most Medicare drug spending is through Part D (as well as Part B) and savings would not automatically accrue to the HI Trust Fund, several participants discussed the possibility of enacting policies that would lower drug costs in Medicare. Any savings to Part D generated by such policies would not address HI financing challenges unless statutory language directed the savings to be for that purpose. Controlling the costs of high-cost hospital-administered drugs under Part A would accrue savings directly to the HI Trust Fund. Spending on prescription drugs is one of the drivers of Medicare spending growth, a function, in part, of the increase in participants, many with chronic conditions, which increases utilization. MedPAC's index of drug prices declined in 2019, but changes are uneven across therapeutic classes; the changes reflect increased competition for some classes in contrast to a growth in specialty drugs, such as autoimmune and oncologic treatments. According to a recent IQVIA report, net prices for brand-name medicines (accounting for the level of rebates) declined 2.9 percent in 2020. For the last five years, net price growth for brand-name medicines has been in line with or below inflation (IQVIA 2021). However, the role of manufacturer rebates to pharmacy benefit managers, and potential variation in those rebates, complicates policy proposals with respect to Medicare drug pricing.

Trends in drug spending combined with changes in the Part D benefit design have resulted in a reduction in cost-containment incentives for Part D plans (IQVIA 2021; MedPAC 2021b). As a result, MedPAC has recommended major changes to the Part D benefit design and Medicare subsidies (MedPAC 2020c).

A few proposals exist that aim to lower prescription drug spending.[34] While some proposals are more controversial, some have been introduced in legislation in the prior Congress and had varying degrees of bipartisan support. These include modifying the design of the Part D benefit to increase pressure on plans to more aggressively manage drug spending, including in the catastrophic phase, and implementing a requirement for drug companies to pay rebates to Medicare if their list prices rise faster than inflation (which could apply to Parts B and D).

In addition, the Part D low-income subsidy benefit design could be adjusted to create greater incentives for generic medication use (e.g., by eliminating copayments for generic drugs while preserving very modest copayments for brand-name drugs). Modifications to the way physicians are paid for administered Part B drugs, such as a fixed fees for administering drugs, could also reduce spending; providers currently receive payments that are a percentage of the drug's cost, which may encourage the use of higher-cost drugs.[35] Shifting more of the costs of reinsurance from the federal government to drug manufacturers and health plans could also reduce Medicare spending.

Another proposal, more controversial on Capitol Hill, would require the secretary of health and human services to negotiate prices for a subset of drugs, such as drugs that account for substantial spending and do not have competition.[36]

Prescription drugs are the primary form of managing chronic conditions. So, as one panelist noted, shifting drug costs to beneficiaries who need them could reduce abilities to treat these conditions and widen disparities.

22. RAISE THE AGE OF MEDICARE ELIGIBILITY INCREMENTALLY TO 67

Medicare's age of eligibility has remained at 65 for years, despite longer life spans and extended working years. One proposal would gradually increase the age of eligibility to 67, consistent with changes in full retirement benefit eligibility in Social Security. This proposal could reduce Medicare expenditures by about $80 billion over 10 years, according to one estimate, but would be substantially offset by increased federal spending on ACA Marketplace subsides and increased Medicaid spending.[37] However, one panelist noted that eligibility changes would likely be implemented on a generational basis, so this policy would not likely address short-term solvency issues.

Conclusion

In considering potential approaches to addressing Medicare's solvency, panelists were not optimistic about the potential for addressing solvency as a component of long-term, broad Medicare reform. Medicare has broad public support, and there is reluctance to make changes to the factors that have built that support. It also has powerful stakeholders who resist change. The panel generally suggested that a combination of accounting, revenue, and spending measures will be necessary to address solvency.

Feasibility considerations make it easier to pursue policies focused on overpayments to select providers rather than address program aspects that affect beneficiary care or costs. This means that a

combination of savings and accounting measures is a likely path forward. Further, the feasibility of various options to address solvency may depend on when Congress considers the topic; some proposals may be more appealing to the public in the wake of the pandemic. The challenge of addressing solvency may limit the appetite among both political parties and spur a desire to punt on major reforms as much as possible. Several options for Medicare savings would not directly benefit Part A's financial situation, and so decisions would remain about whether to direct savings to Part A, shore up other parts of Medicare, or divert savings to other policy objectives. One additional consideration is the time horizon for which Congress seeks to address solvency, specifically, whether it seeks a shorter-term solution or policies that address longer-term financial pressures on Medicare.

Notes

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