Testimony Submitted to
the Senate Finance Committee
Subcommittee on Fiscal Responsibility and Economic Growth

"The Hospital Insurance Trust Fund and the Future of Medicare Financing"

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The HI Trust Fund's Shortfall Points to Much Larger Fiscal Challenges

This subcommittee is to be commended for holding this hearing because the subject matter it will address -- the financial outlook for Medicare generally, and status of the program's Hospital Insurance (HI) trust fund specifically -- will require Congress' attention in the near term. Last year, the Board of Trustees charged with overseeing, and reporting on, the program's financial status projected that HI would be depleted of reserves in 2026.[1] It is not known at this time if this year's report to Congress (due by April 1 according to the Medicare title of the Social Security Act) will alter the projected year of HI depletion.[2]

The decline of HI's reserves is of course, on its own, a problem that should concern Congress because of the importance of ensuring continuity in the provision of medical services. If HI were to have insufficient funds to pay fully for all of the claims it receives, it is likely that providers would get paid a fraction of what current regulations would allow, which might then jeopardize access to care for some beneficiaries. Congress has never allowed such a scenario to occur, and it is unlikely to do so in this instance either. There is every reason to expect corrective legislation will be passed in time to prevent an interruption of benefit payments.

However, even if near-term depletion of HI is averted, that will not resolve the fundamental problem because HI's issues really are symptoms of a larger fiscal challenge.

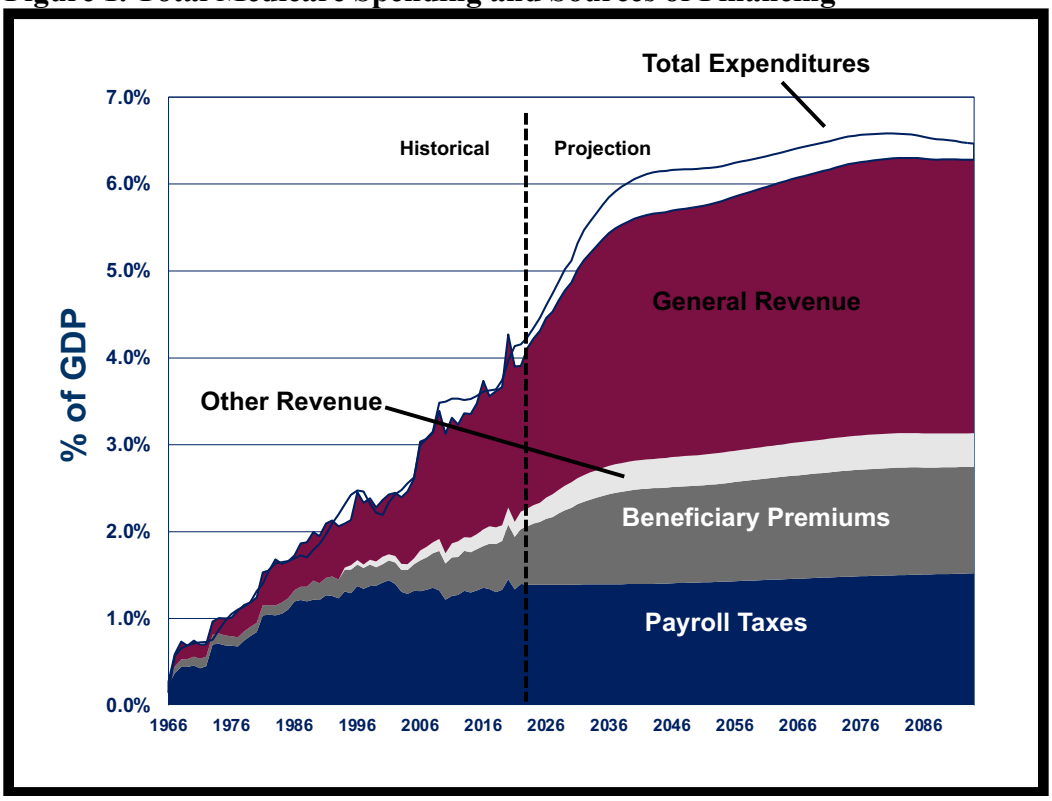
The imbalance between HI spending and outgo is a manifestation of the widening gap between Medicare's *total* costs, for both HI *and* Supplementary Medical Insurance

[1] "2021 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, August 31, 2021, https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf. Hereafter, the report is referenced as the 2021 Trustees' report.
[2] See section 1817(b)(2) of the Social Security Act, https://www.ssa.gov/OP_Home/ssact/title18/1817.htm.

(SMI), and the receipts (taxes and premiums) collected to pay for both trust funds' expenses.

Figure 1 replicates the key projection data for all of Medicare's costs and receipts from the 2021 trustees' report, shown as a percentage of Gross Domestic Product (GDP), from the program's inception 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, not strictly (or even primarily) an imbalance in HI-only income and outgo.[3]

Figure 1. Total Medicare Spending and Sources of Financing



Source: Medicare Trustees (2021)

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 exceed 5.0 percent of GDP in 2030 and 6.0 percent in 2050.[4]

[3] 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, August 31, 2021, https://www.cms.gov/files/document/illustrative-alternative-scenario-2021.pdf.

[4] The 2021 Trustees' Report, https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf.

What is striking about this figure is what it reveals about the general revenue financing of Medicare. At enactment, SMI was supposed to be financed from beneficiary premiums covering half of its expenses, with the remainder 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 Treasury, which is just another way of saying other taxes the federal government collects, and funds that the Treasury borrows to cover annual budget deficits.

The transfers from the Treasury are not subject to limitation; they occur automatically and are set at levels that 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, because it does. As shown in Figure 1, the transfers to SMI are very substantial, and escalating rapidly. The 2021 Trustees' report estimates the transfers to SMI will total $5.3 trillion over the next decade alone. By 2050, the annual transfer will equal 2.8 percent of GDP, up from 0.7 percent in 2000.

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.

The Department of the Treasury releases an annual statement covering the financial status of the entire federal government, and uses accrual accounting to present as much of the data as is practical. Accrual accounting attempts to take into account new benefit obligations earned under the rules of various entitlement programs in relation to the expected revenue to pay for them, and uses discounting to present the streams in present value terms. The difference between the cumulative totals for spending and receipts can be presented as the unfunded liability that will need to be closed in some fashion.

For Medicare, the trend line of the estimated unfunded liabilities is what is most alarming. As shown in Table 1, in the most recent report, released in March 2021, Medicare had a combined unfunded liability of $45.7 trillion as of 2020, up from $32.5 trillion in 2016.[5]

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

	2016	2017	2018	2019	2020
Open Group Method	**32.5**	**33.5**	**37.7**	**42.2**	**45.7**

Source: Department of the Treasury (2021)

[5] "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. The unfunded liability calculation presented here is based on the open group method, which includes all current and future participants in the Medicare program.

The growing gap between Medicare's total expenditures and the receipts dedicated to paying for them also is central to the adverse fiscal outlook for the federal budget as a whole, as reflected in data published by the Congressional Budget Office (CBO) and summarized in Table 2.

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

	% of GDP				
	1980	**2000**	**2021**	**2030**	**2050**
Social Security	**4.2**	**4.0**	**5.0**	**5.9**	**6.3**
Medicare (Gross)	**1.3**	**2.2**	**3.7**	**5.1**	**7.7**
Other Health	**0.4**	**1.0**	**2.7**	**2.5**	**3.1**
Defense	**4.8**	**2.9**	**3.3**	**2.8**	**3.3**
Rest of Gov't	**8.6**	**5.4**	**14.4**	**4.1**	**2.7**
Net Interest	**1.9**	**2.2**	**1.5**	**2.5**	**8.2**
Total Spending	**21.2**	**17.7**	**30.6**	**22.9**	**31.3**
Total Revenues	**18.5**	**20.0**	**17.2**	**17.7**	**18.4**
Annual Surplus (+) or Deficit (-)	**-2.6**	**+2.3**	**-13.4**	**-5.1**	**-12.8**
Federal Debt	**25.5**	**33.7**	**102.7**	**104.5**	**195.3**

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

The same demographic and health-specific factors pushing up Medicare's expenses are also increasing costs in Social Security and Medicaid. The combined expense of these programs is the principal reason the federal government is running large deficits today and will run sustained and widening deficits over the next three decades.

As is shown in the table, spending on Medicare, along with Social Security, Medicaid, and other health entitlements, has grown steadily for decades. In 2050, CBO expects the combined spending on these programs will be equal to 17.1 percent of GDP, up from 5.9 percent of GDP in 1980. In 2050, obligations for just these programs will consume nearly all expected federal revenue.

Rising expenses for the major entitlement programs, without a commensurate increase in revenues, will push federal borrowing up very rapidly. In 2050, CBO projects the annual budget deficit will reach 12.8 percent of GDP, and cumulative federal debt will have grown to nearly 200 percent of GDP, up from 25.5 percent in 1980.

Borrowing at such a pace is outside of all historical experience for the United States, and almost certainly would lead to a crisis. One possibility is that the U.S. dollar would gradually lose its position as the world's reserve currency, which would then precipitate a

substantial rise in the cost of borrowing funds in public markets. If net interest payments spike, there will be less funding available for other public priorities, which might then force policymakers to enact painful austerity measures.

Using the Same Tax for Two Purposes Undermines Fiscal Discipline

The administration has proposed several tax policies to extend the solvency of the HI trust fund, but the implications of these policies are not well understood.

A major problem, as explained by the Committee for a Responsible Federal Budget (CRFB), is that the administration's plan would use federal tax receipts twice: the taxes would be deposited into the HI trust fund, thus slowing the depletion of its reserves. At the same time, the taxes also are dedicated to offsetting new spending plans outside of Medicare.[6] Put another way, one tax is planned to be used to pay for two streams of federal expenditures.

One of the administration's proposals for HI solvency is to transfer the receipts from a tax created in the Affordable Care Act (ACA) -- the net investment income tax, or NIIT -- from the Treasury's general fund to HI. CRFB estimates that this transfer would increase HI receipts by $430 billion over ten years, and by $2.15 trillion over 30 years. There would be no additional federal revenue generated by this policy, however. Rather, it would divert the revenue from the existing tax, which was instrumental in 2010 in ensuring the ACA was estimated by CBO as not increasing federal deficits. In other words, this tax paved the way for ACA's enactment, and now would be used to extend HI solvency.

The administration also proposes to tighten the rules around the implementation of the NIIT, along with the Self-Employment Contributions Act (SECA), which would generate new revenue of $235 billion over ten years and $1.2 trillion over 30 years. However, as proposed, this revenue also would go paying for the Build Back Better legislation in addition to shoring up HI. Again, using the same source of revenue for two purposes actually increases federal borrowing relative to what would occur if the new tax were to be devoted solely to delaying the exhaustion date of the HI trust fund.

Broader Reforms

While it is important to ensure the HI fund is not depleted of all reserves, and that full benefits are paid on a continuous basis, Congress should view HI's challenges as signals 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 also are usually provided to the patient both before and after an admission occurs. A narrow focus on hospital costs risks perpetuating a fragmentation within Medicare that is outdated.

[6] "How Much Would the President's Budget Extend Medicare Solvency," Committee for a Responsible Federal Budget, June 10, 2021, https://www.crfb.org/blogs/how-much-would-presidents-budget-extend-medicare-solvency.

The following are six aspects of current Medicare that are in need of reform and could be addressed in a plan to improve the program's overall financial outlook.

1. *A 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 established separate cost-sharing rules for its two parts (A and B). It also paid for A with payroll taxes and B with premiums and general fund transfers. Medicare also 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 supplement coverage, and can be accomplished on a budget neutral basis.

2. *The Choice Structure*. Medicare's origin and evolution have made the program difficult for beneficiaries to navigate. 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 (prescriptions) by agreeing to monthly premiums covering a portion of their total costs. They also have the option to enroll in Medicare Advantage, or buy a supplemental policy wrapped around the traditional fee-for-service (FFS) benefit.

   Adding to the complexity is the lack of a single coordinated system of enrollment across these components and coverage options. Under current processes, it is not a simple matter for beneficiaries to compare the all-in financial implications of the various combinations of coverage available to them. Many beneficiaries end up relying on brokers to sign up for coverage, even though brokers are often paid by plans seeking to boost enrollment.

   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 basis (with standardized benefits) and across the three main benefit components, as shown in Figure 2.

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.

3. *Premium Competition*. CBO has confirmed that strong competition among the coverage options can lower Medicare's costs, and those imposed on the beneficiaries, but reform in the payment system is needed to achieve these results.

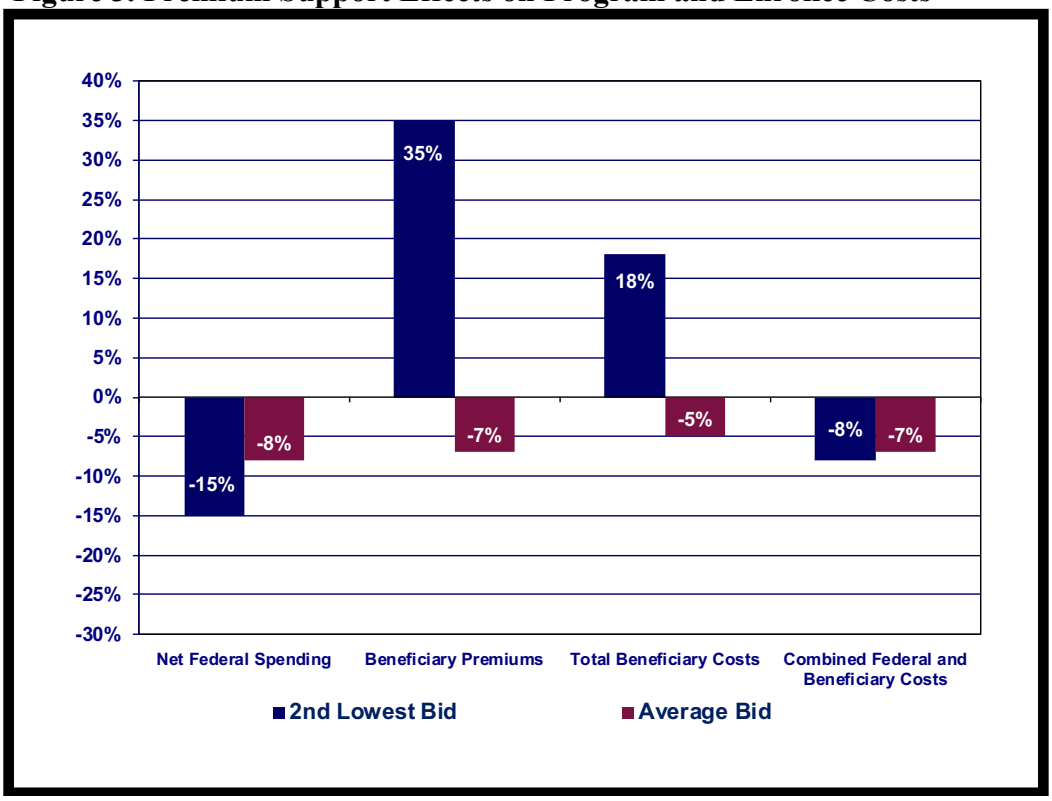
   MA plans already submit competitive bids under current law, but those bids are considered in relation to benchmarks tied in part to historical cost rates that may not accurately reflect what spending would be with efficient care provision. Further, FFS does not participate in the bidding process, in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

   Fair competition requires submission of bids from FFS, ACOs, and MA plans for the

same set of standardized benefits, as defined in a reformed Medicare benefit package. FFS's bid would be a calculation by the government based on the per beneficiary costs in each market. The government could refine its risk adjustment methodology to ensure the competition is based on efficient care delivery and not differences in the underlying health status of the enrollees.

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.

Figure 3. Premium Support Effects on Program and Enrollee Costs



Source: CBO (2017)

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.[7]

[7] "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.

5. *Competition and Price Shopping 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, in managed care plans or FFS.

   For this to occur, Medicare will need to become a leader in using standardized pricing to foster strong competition among service providers. Not all medical care is amenable to consumer discretion, but some is (perhaps 40 to 50 percent). 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 services covering common procedures and services.[8] Further, this requirement should force those providing services to work with each other to provide one, all-in price covering a full episode of care. It is essential that what is being priced be standardized, and cover the full range of services required to properly take care of what the patient needs.

   An essential added step is an incentive for the Medicare enrollees to want to use lower-priced options. Medicare could do this by calculating benchmarks in every market (based on prevailing FFS rates) for the list of standardized interventions. Beneficiaries opting for providers who post prices below the benchmarks should get to keep some of the savings (perhaps 50 percent). In some cases, for expensive care (such as common surgeries), the payment to the Medicare beneficiary could be substantial, which would create strong incentives for the providers to price their services more aggressively and for the beneficiaries to migrate to the lowest-priced options.

6. *Consolidated Trust Fund*. Medicare's trust funds need updating to mirror the changes recommended for Medicare's insurance design, with parts A and B combined into one insurance plan. With the benefits combined, the trust funds should be merged too (into a singular Medicare trust fund), with all receipts and expenses of the existing HI and SMI trust funds redirected to the combined account.

   A crucial additional reform is the recalibration of the basis for general fund support of the program's spending obligations. It should not be unlimited, as it is today for SMI. 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 distinctly not the case currently, 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.

[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.

One option would be to tie the government's contribution to the new Medicare trust fund to what was paid in a reference year, and then index that amount for subsequent years to the rate of growth in the national economy. This adjustment 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.

Changing the basis of general fund support for Medicare will not by itself ensure an appropriate political response when trust fund depletion becomes imminent. In a sense, that is the intent -- to force elected leaders to grapple with the uncomfortable reality that there is a limit to how much can be borrowed to pay for Medicare benefits. A single trust fund with a limited tap on general revenue would ensure the trust fund was an instrument of fiscal discipline, which is the purpose of such accounting devices.

Conclusion

Medicare is one of the federal government's most important programs because of the access to medical care it provides to its enrollees. Its financial status should be improved to ensure its benefits are secure for both current and future participants. That will require looking at the financial outlook for all of Medicare and not just HI.

The right reforms have the potential to improve and strengthen Medicare by making the program more efficient rather than cutting benefits. As these changes will take time to implement, Congress should begin to consider and develop the necessary legislation as soon as possible.

Related Papers and Book Chapters:

"Market-Driven Medicare Would Set US Health Care on a Better Course," James C. Capretta, Economic Perspectives, American Enterprise Institute, July 2021, https://www.aei.org/wp-content/uploads/2021/07/Market-Driven-Medicare-Would-Set-US-Health-Care-on-a-Better-Course.pdf.

"Toward Meaningful Price Transparency in Health Care," James C. Capretta, Economic Perspectives, American Enterprise Institute, July 2019, https://www.aei.org/wp-content/uploads/2019/06/Toward-meaningful-price-transparency-in-health-care.pdf.

"Structured Markets: Disciplining Medical Care with Regulated Competition," James C. Capretta, American Enterprise Institute, March 2021, https://www.aei.org/wp-content/uploads/2021/03/Structured-Markets.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.