MEDPAC Medicare Payment Advisory Commission

TESTIMONY

The Hospital Insurance Trust Fund and the Future of Medicare Financing

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Statement of
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The Medicare Payment Advisory Commission (MedPAC) is a small congressional support agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to pursue Medicare policies that ensure beneficiary access to high-quality care, pay health care providers and plans fairly by rewarding efficiency and quality, and spend tax dollars responsibly. The Commission would like to thank Chair Warren and Ranking Member Cassidy for the opportunity to testify at this hearing today.

Introduction

The Medicare program faces a very challenging financial future. In 2021, the Congressional Budget Office (CBO) projected that annual Medicare spending would more than double in the 10-year period between 2021 and 2031, rising from $839 billion to $1.8 trillion (Congressional Budget Office 2021a). During this period, Medicare's share of total federal spending is expected to rise from 10.1 percent to 18.8 percent (Congressional Budget Office 2021b).[1] CBO also projected that Medicare's Hospital Insurance (HI) trust fund—which is largely financed by payroll taxes and funds Medicare's payments to hospitals and post-acute care providers, as well as a portion of payments to Medicare Advantage (MA) plans—will become insolvent in 2027. The Medicare Trustees project that the HI trust fund will become insolvent a year earlier, in 2026. Without changes to current law or policy, the Trustees have estimated that ensuring the solvency of the trust fund for an additional 25 years would require the Medicare payroll tax to be raised from 2.9 percent to 3.7 percent. Alternatively, without revenue increases, Part A spending would need to immediately be reduced by 18 percent (about $70 billion in 2022), an amount that will grow over time if action is delayed (Boards of Trustees 2021).

The continued growth in spending also affects the Supplementary Medical Insurance (SMI) trust fund, which funds payments to physicians and ambulatory care providers, outpatient prescription drug benefits, and a portion of payments to MA plans. The SMI trust fund accounts for a larger share of total Medicare spending than the HI trust fund (60 percent vs. 40 percent). The SMI share is also growing over time; CBO projects that SMI spending will increase to 64 percent of total spending in 2031. The SMI trust fund is financed by a combination of general revenues and beneficiary premiums, so it cannot become insolvent like the HI trust fund. However, the continued growth in SMI spending consumes a growing share of general tax revenues and reduces the funding available for other parts of the budget.

Increasing Medicare spending also strains beneficiaries' household budgets. In 2020, Medicare premiums and cost sharing were estimated to consume 24 percent of the average Social Security benefit, up from 14 percent in 2000. The Medicare Trustees estimate that in another 20 years, these costs will consume 31 percent of the average Social Security benefit.

The projected insolvency of the HI trust fund and the need to make spending from the SMI trust fund more sustainable will motivate changes in Medicare spending—at a minimum reducing the rate of spending growth over time. In this spirit, though all policy changes involve tradeoffs, the

[1] The 2021 figure is artificially low due to temporary increases in federal spending related to the coronavirus pandemic. In 2019, the last full year before the pandemic, Medicare accounted for 14.6 percent of federal spending.

Commission believes there are policies that will reduce spending without significant deleterious consequences. Spending is only one side of the solvency/sustainability equation; revenues are equally important. However, my comments will be limited to policy changes that would affect Medicare spending. The financing of the Medicare program lies outside the Commission's statutory purview.

The Commission has identified a number of aspects of Medicare payment systems that hamper the program's ability to achieve fiscal sustainability. We have made—and will continue to make—recommendations that, if implemented, could address these challenges and allow Medicare to improve payment accuracy and equity without sacrificing the quality of or access to care for the program's beneficiaries. For today's hearing, I would like to highlight our work in three areas: annual updates to Medicare's fee-for-service (FFS) payment systems, the MA program, and the prescription drug benefit (Part D).

Annual updates to FFS payment rates

As required by law, the Commission annually makes payment update recommendations for providers paid under Medicare's traditional FFS payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment rate for all providers in a payment system is changed relative to the prior year. In making our update recommendations, we first assess the adequacy of Medicare payments in the current year by considering beneficiaries' access to care, providers' access to capital, and how Medicare payments compare with providers' costs. As part of that process, we examine whether payments will support the efficient delivery of services, consistent with our statutory mandate. We then assess how those providers' costs are likely to change in the year the update will take effect and make a judgment about what, if any, update is needed for the year in question. Next month, we will release our latest March report, which will have recommendations on payment updates for 2023.

I would like to note that our work on payment updates over the past two years has focused heavily on the effects of the coronavirus pandemic, which has had catastrophic consequences for many Medicare beneficiaries and affected the entire health care delivery system. We have been careful to consider the impacts of the pandemic and pandemic-related policies on our measures of payment adequacy in both the short and long term. To the extent that the effects of the pandemic are temporary or vary significantly across providers in a sector, they are best addressed through targeted, temporary funding policies rather than a permanent change to payment rates.

Our assessments of payment adequacy change from year to year based on new data and any underlying changes in a particular payment system, but I would like to highlight that over the last four years (spanning our March 2019, March 2020, and March 2021 reports, plus the recommendations that we approved last month and will appear in our March 2022 report), we have consistently found that payment rates for four types of providers—largely in the post-acute care sector, and largely funded through the HI trust fund—are unnecessarily high and could be reduced without compromising beneficiaries' access to care:

- ***Skilled nursing facilities*** have had Medicare profit margins that exceed 10 percent, continuing a two decades–long trend. Over the last four years, we have recommended that their annual update for the upcoming year be eliminated (i.e., keeping payment rates

the same as in the prior year) and, most recently, that current payment rates also be lowered by 5 percent. CBO estimates that these changes would reduce program spending by more than $10 billion over five years.

- ***Home health agencies*** have had Medicare profit margins that exceed 15 percent, also continuing a long-running trend. Over the last four years, we have recommended that their annual update for the upcoming year be eliminated and current payment rates be lowered, most recently by 5 percent. CBO estimates that these changes would reduce spending by between $5 billion and $10 billion over five years.

- ***Inpatient rehabilitation facilities*** have had Medicare profit margins of between 13 percent and 15 percent. Over the last four years, we have recommended that the annual update be eliminated and current payment rates be lowered by 5 percent. CBO estimates that these changes would reduce spending by between $5 billion and $10 billion over five years.

- ***Hospices*** have had Medicare profit margins that exceed 10 percent. Over the last four years, we have recommended eliminating their annual update and, for the last three years, also reducing the annual cap on payments to individual hospices by 20 percent. (The reduction in the cap would apply additional financial pressure to hospices that have very long lengths of stay and relatively high profits.) CBO estimates that these changes would reduce spending by between $5 billion and $10 billion over five years.

These recommendations would affect providers of Part A–covered services, so any reductions in their payment rates would lower Part A spending and improve the solvency of the HI trust fund. (Home health is a partial exception because some of its services are covered by Part B.) In addition to their direct effects on providers and FFS spending, these recommendations would have the added benefit of applying a modicum of appropriate financial pressure on MA plans by reducing the spending benchmarks that help determine plan payment rates.

Medicare Advantage

The MA program allows beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional FFS Medicare program. (Since MA plans provide both Part A and Part B services, roughly 40 percent of their funding comes from the HI trust fund and 60 percent comes from the SMI trust fund. They receive separate payments from the SMI trust fund for providing drug benefits.) The Commission strongly supports the inclusion of private plans in the Medicare program because they have the potential to offer more affordable care for beneficiaries while spending less than FFS. Thus, the Commission contends that under the right payment mechanisms, MA plans could serve as vehicles to manage overall spending and quality of care more effectively than the fragmented FFS system. Although MA plans have the potential to provide good value for the program, the methodology that Medicare uses to pay MA plans has several features that prevent that value from materializing and that contribute to the program's solvency and sustainability problems.

The MA program is now quite robust. Enrollment has grown by about 10 percent annually in recent years, and last year 46 percent of eligible Medicare beneficiaries (about 27 million people)

were enrolled in plans. If this trend continues, the majority of eligible Medicare beneficiaries will be enrolled in MA in the next few years. Almost all beneficiaries (99 percent) have access to at least one plan, and the average beneficiary has more than 30 plans available in their county. The payments that plans use to provide extra benefits, known as rebates, have also grown rapidly, and this year average nearly $2,000 annually per enrollee, an all-time high.

However, the expansion of MA is also a cause for concern. Private plans that accept full risk have been available in Medicare since the mid-1980s, but our review suggests that they have never yielded aggregate savings for the program. That remains true today. We estimate that in 2022 Medicare payments to MA plans equal about 104 percent of what Medicare would have spent on those same beneficiaries in traditional FFS.

The gap between MA payments and FFS spending primarily reflects three factors. First, policymakers set MA payments above FFS spending levels in low-FFS-spending counties to ensure access to MA plans and the extra benefits offered to MA enrollees in those counties. Specifically, the benchmark for each county equals a percentage of the projected average per capita FFS spending for the county's beneficiaries. Counties are ranked based on their per capita FFS spending and then divided into four quartiles. Benchmarks are set at 115 percent of county FFS spending for the quartile of counties with the lowest FFS spending, 107.5 percent and 100 percent for counties in the next two quartiles of FFS spending, and 95 percent for counties in the quartile with the highest FFS spending. In addition to increasing Medicare payments, this quartile system creates cliffs between counties that result in inequitable benchmarks, where counties with similar FFS spending levels can have very different MA payment rates. Second, MA plans are paid more if they serve sicker beneficiaries, but aggressive coding by MA plans and a lack of incentives for providers to similarly code under traditional FFS has led to a poorly calibrated risk adjustment system that leads to higher Medicare spending. Third, MA plans are rewarded for achieving a higher star rating through the quality bonus system, but the Commission has found that the MA quality bonus program boosts plan payments for most MA enrollees, does not meaningfully reflect plan quality in local areas, and should be reformed to better achieve its goals while reducing Medicare spending.

Overall, beneficiaries clearly find MA an attractive option through which to receive their Medicare benefits, as evidenced by the program's strong enrollment growth. However, since Medicare spends more to cover beneficiaries in MA than it does in FFS, the shift toward MA worsens Medicare's sustainability and makes the need for structural improvements to MA more urgent. To encourage efficiency and innovation, MA plans need to face appropriate financial pressure similar to what the Commission recommends for health care providers in the traditional FFS program.

To that end, over the past few years the Commission has made three recommendations that would eliminate or reduce what we consider to be the most significant policy flaws in the current program:

Account for coding differences between MA and FFS. Medicare's payments to MA plans are risk adjusted to account for differences in enrollees' health status, so that plans are paid less for their healthier enrollees and more for their sicker enrollees. The adjustment for each enrollee is partly based on the diagnoses that providers code, which gives MA plans an incentive to record

more diagnoses that is largely absent in FFS. To some extent, these structural differences mean that diagnostic coding may be more complete in MA than in FFS (and in some MA plans relative to others). The payment incentive to code more intensely creates risk adjustments that are not comparable between MA and FFS. Furthermore, some plan sponsors put a disproportionate effort into documenting more diagnoses, giving them an unwarranted competitive advantage over other plans in their market. Without rendering a judgment on the accuracy of MA coding (though some plans likely push the bounds of accuracy and the Commission strongly supports efforts to promote program integrity), the key issue is that coding in FFS and MA is not comparable. By law, CMS lowers payments to MA plans in recognition of these coding differences, but these reductions have never accounted for the full extent of the coding differences between MA and FFS.

As a result, the more intense coding in MA relative to FFS leads to higher payments to plans and raises program spending. This year, we found that coding differences mean that payments to MA plans are about 3.6 percent higher than they would have been if MA enrollees were treated in FFS Medicare. In 2020, coding differences boosted payments to plans by about $12 billion. This coding intensity undermines the incentives for plans to improve quality or reduce costs, and the variation in coding intensity across plans generates inequity by giving an advantage to plans that code more extensively.

In 2016, the Commission recommended a three-pronged approach to fully account for the impact of coding differences: (1) develop a risk-adjustment model that uses two years of diagnostic data instead of just one year (this would make the FFS diagnostic data more complete and reduce the marginal benefit for MA plans of coding additional diagnoses), (2) exclude any diagnoses that are documented only on a health risk assessment, and (3) apply a coding adjustment that eliminates any remaining differences in coding between FFS Medicare and MA plans (Medicare Payment Advisory Commission 2016). At the time, CBO estimated that these recommendations would reduce Medicare spending by between $1 billion and $5 billion over five years.

Replace the quality bonus program. The MA quality bonus program (QBP) provides higher payments to plans that have a rating of 4 stars or better on a 5-star scale. Over the years, the Commission has identified several flaws in the QBP. First, the QBP uses too many quality measures, and many of them are process measures rather than measures that focus on outcomes and patient/enrollee experience. Second, the star ratings are determined at the MA contract level, which may cover very large geographic areas and thus may not be a reliable indicator of the quality of care provided in an individual's local area and may not sufficiently capture variation in quality among subgroups of beneficiaries. This problem has been exacerbated by plan sponsors consolidating contracts to artificially improve their star ratings, an issue that has been partially addressed by legislation. Third, the QBP is financed with additional dollars above and beyond the cost of providing the Medicare benefit, in contrast to FFS quality payment. Lastly, an evaluation of quality in MA would ideally be based in part on a comparison with the quality of care in FFS, but the data needed to compare MA with FFS is lacking.

The Commission has concluded that the current state of quality reporting no longer provides an accurate description of the quality of care in MA, either over time, among MA plans, or relative to FFS Medicare. With almost half of eligible beneficiaries now enrolled in MA plans, it is imperative that beneficiaries be able to compare MA and FFS quality, including alternative

payment models in FFS such as accountable care organizations (ACOs), and to compare the performance of the plans available in their area. Policymakers also need better information on the quality of care to monitor MA and FFS performance, evaluate MA payment policy, and assess other elements of the MA program such as network adequacy.

In 2020, the Commission recommended replacing the QBP with a value incentive program that would:

- Use a small set of population-based outcome and patient/enrollee experience measures that, where practical, aligns across MA plans and ACOs. To avoid undue burden on providers, measures should be calculated or administered largely by CMS, preferably with data that are already being reported, such as claims or encounter data.

- Evaluate quality at the local market level to provide beneficiaries with information about the quality of care in their local area and provide MA plans with incentives to improve the quality of care provided in every geographic area.

- Account for differences in enrollees' social risk factors so plans with higher shares of enrollees with social risk factors are not disadvantaged in their ability to receive quality-based payments.

- Finance the MA quality system in a budget-neutral manner to be more consistent with Medicare's FFS quality payment programs, which are either budget neutral (financed by reducing payments per unit of service) or produce program savings because they involve penalties (Medicare Payment Advisory Commission 2020).

Quality bonuses account for about 3 percent of overall Medicare payments to MA plans in 2022, so replacing the QBP with a budget-neutral program would generate substantial program savings. In 2020, CBO estimated at the time that these recommendations would reduce Medicare spending by more than $10 billion over five years.

Establish benchmarks that allow the Medicare program to share in the efficiencies generated by Medicare Advantage. In contrast to the traditional FFS program, where Medicare pays providers fixed rates per service, Medicare pays MA plans a fixed rate for each enrolled beneficiary. Plan payment rates are determined by plan bids and benchmarks that are based on local FFS spending. Plans that bid below the benchmark (which nearly all do) receive some of the difference as a rebate that plans must use to provide extra benefits in the form of lower cost sharing, lower premiums, or supplemental benefits. Those benchmarks are increased (usually by 5 percentage points) for plans that receive the quality bonus.

This year, MA plans are able to provide the Part A and Part B benefit package at a lower cost than the FFS program; the average bid equals 85 percent of FFS costs. Medicare customarily has mechanisms that allow it to benefit from the savings that providers or plans generate when they become more efficient. For example, the ACOs that operate in FFS have shared-savings arrangements with Medicare. In MA, Medicare benefits from plans operating more efficiently by keeping some of the difference between plan bids and benchmarks. However, the savings generated by this mechanism are more than offset by the combined effect of high benchmarks

and quality bonuses. As a result, the Commission contends that the benchmark system should be revised to allow the Medicare program, its beneficiaries, and taxpayers to share in the savings that MA plans are able to achieve.

Specifically, last year the Commission recommended that the Congress enact a new policy that calculates benchmarks using a relatively equal blend of local area FFS spending and national FFS spending, makes rebates a fixed percentage of the difference between the benchmark and a plan's bid (this percentage would be at least 75 percent; under the current system, the percentage varies based on a plan's star rating), and incorporates a discount rate that reduces all benchmarks by at least 2 percent. This approach would allow the Medicare program to capture some MA efficiencies, while not being overly disruptive to MA plans' ability to earn rebates and offer supplemental benefits to their enrollees (Medicare Payment Advisory Commission 2021). At the time, CBO estimated that this recommendation would reduce program spending by more than $10 billion over five years.

The prescription drug benefit (Part D)

Under Part D, Medicare subsidizes about three-quarters of the cost of a basic outpatient drug benefit and provides a low-income subsidy (LIS) that covers much of the cost sharing and premiums for low-income beneficiaries. About 75 percent of Medicare beneficiaries are currently enrolled in Part D. Unlike Part A and Part B, all Part D benefits are delivered through private plans—stand-alone prescription drug plans (PDPs) and Medicare Advantage–Prescription Drug (MA–PD) plans that provide combined medical and drug coverage. Consistent with the growth in MA enrollment, the share of Part D beneficiaries enrolled in MA–PDs has risen steadily over time.

Part D has a complicated, three-part benefit design. In the first part of the benefit, beneficiaries may face a deductible and pay cost sharing that equals 25 percent, on average. Part D plans receive capitated payments that largely finance coverage in this stage of the benefit. Beneficiaries with drug costs that exceed the initial part of the benefit then enter a second part known as the coverage gap, where they still face cost sharing of 25 percent but coverage is largely financed by manufacturer discounts on brand-name drugs or the LIS. The third part is a catastrophic benefit for beneficiaries with very high drug spending. In this stage, beneficiaries pay cost sharing of 5 percent (those who receive the LIS pay nothing) and coverage is largely financed by Medicare through cost-based reinsurance.

When Part D started in 2006, most spending was attributable to brand prescriptions for widely prevalent conditions such as high cholesterol and depression. Blockbuster drugs for such conditions lost patent protection toward the end of that decade, and many Part D enrollees switched to generic versions of their medicines. As this occurred, manufacturers turned to developing orphan drugs, biologics, and other high-priced specialty drugs for smaller patient populations. These broader changes to the prescription drug market, combined with Part D's unusual structure, have led us to raise several concerns about the program:

- Part D plans bear little liability for spending after the initial stage of the benefit. In the coverage gap, plans are responsible for just 5 percent of brand spending for enrollees without the LIS and bear no liability for LIS enrollees. In the catastrophic stage, plans

cover only 15 percent of spending. When post-sale rebates and discounts that plans collect on some brand-name drugs are taken into account, plan sponsors may actually reduce their costs by covering a more expensive medication over a generic.

- The manufacturer discounts on brand-name drugs in the coverage gap have lowered out-of-pocket costs for some beneficiaries, but they also artificially lower the prices for brand-name drugs relative to generics, which reduces incentives to use generics.

- The shift toward high-cost drugs has effectively turned Part D from a program that relies on capitated, risk-bearing plans to one that largely relies on cost-based payment. In 2007, Medicare's capitated payments to Part D plans were more than twice as large as its cost-based reinsurance payments ($17.6 billion vs. $8.0 billion). By 2020, reinsurance payments were nearly five times larger ($47.8 billion vs. $10.2 billion).

- The growth in spending on high-cost drugs has also increased the number of beneficiaries who reach the catastrophic stage of the benefit. Beneficiaries who reach this stage and do not receive the LIS may still incur substantial out-of-pocket costs.

In 2020, the Commission addressed these concerns by recommending major changes to the Part D program (Medicare Payment Advisory Commission 2020). These changes would substantially redesign the program's benefit structure, restore the role of risk-based, capitated payments that was present at the start of the program, and provide some resistance on drug price increases. This redesign would:

- Eliminate the coverage gap and the discounts that manufacturers provide on brand-name drugs during that part of the benefit. These changes would create a benefit where plans would be responsible for 75 percent of spending for benefits between the deductible and the catastrophic threshold, with enrollees responsible for the remaining 25 percent through cost sharing. (The Medicare program would continue to pay most of the cost sharing for enrollees who receive the LIS.)

- Provide enrollees with greater financial protection by eliminating cost sharing in the catastrophic part of the benefit, thus creating an annual cap on out-of-pocket costs.

- Reduce Medicare's reinsurance in the catastrophic part from 80 percent to 20 percent and require manufacturers to provide a discount of at least 30 percent on high-priced medicines. Plans would be responsible for the remaining 50 percent. These changes would shift insurance risk from Medicare to plan sponsors and drug manufacturers.

- Improve the ability of plans to manage drug spending more effectively by establishing a higher copayment amount under the LIS for nonpreferred drugs and by giving plans greater flexibility in covering drugs in the protected classes.

In tandem with these changes, CMS would need to recalibrate its risk adjustment system for Part D payments to ensure that they adequately account for differences in enrollees' health status. Since plans would bear more insurance risk in the catastrophic stage of the benefit under

these reforms, policymakers could also consider modifying the Part D risk corridors to temporarily provide plans with greater protection during a transition to the new benefit structure.

In 2020, CBO estimated that this package of recommendations would reduce program spending by more than $10 billion over 5 years.

Conclusion

Medicare spending is expected to more than double over the next decade due to a combination of higher enrollment driven by the retirement of the baby boomers and continued growth in per capita spending in all parts of the program. This spending growth will strain the solvency of the HI trust fund and the sustainability of the general revenue–financed SMI trust fund. By design, consistent with the Commission's statutory charge, I have discussed only the spending side of Medicare's sustainability problem. The recommendations I have discussed today touch on some key areas where the Commission contends that reforms are both urgently needed and could be implemented in a way that reduces program spending, continues to pay providers and health plans adequately for delivering services, and ensures that beneficiaries have good access to care.

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