VIEWPOINT

HEALTH POLICY

Addressing the Risk of Medicare Trust Fund Insolvency

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Medicare solvency is among the many time-sensitive health care challenges awaiting action by the Biden administration and Congress. The Congressional Budget Office (CBO) projects[1] that the Medicare Hospital Insurance (HI) Trust Fund, which pays for hospital, nursing facility, home health, and hospice services provided under traditional Medicare and Medicare Advantage plans, will become insolvent in 2024. This date is 2 years sooner than predicted by the Medicare trustees before accounting for the effects of the coronavirus disease 2019 (COVID-19) pandemic. The Medicare HI Trust Fund is funded mainly by payroll taxes and taxation of Social Security benefits. The CBO projects that the trust fund's obligations will outpace revenues by 1% per year over the next decade, resulting in a 10-year deficit of $758 billion. Without an increase in funds, Medicare will be unable to fulfill its obligations to more than 68 million individuals and will only able to pay 83% of bills for hospital, nursing home, and home health care covered under Part A in 2024. Congress has addressed insolvency in the past but never on such a tight deadline.

Medicare HI Trust Fund solvency projections account for changes in spending, an aging population, increases in health care costs, and underlying economic trends affecting payroll taxes and other revenues. These projections also allow for the expected effects of legislation on the trust fund. In some years, legislation has improved the financial status of the Medicare HI Trust Fund by cutting the growth in spending for hospitals, postacute care, and other health care entities, including Medicare Advantage plans, and also by increasing revenues, such as with the Affordable Care Act. In other years, legislation such as the Tax Cut and Jobs Act of 2017, has weakened its financial status, which decreased revenue into the trust fund. The economic fallout from the pandemic has accelerated the depletion of the trust fund due to payroll tax revenue losses from increased unemployment, shifts from full-time to part-time work, furloughs, and lower salaries. The unemployment rate, down from 14.7% in April, remains at 6.7%, nearly double the 2019 rate.

> Eliminating the shortfall over the next 10 years to extend the solvency of the Medicare HI Trust Fund could require savings or new revenues totaling as much as an estimated $750 billion.

Policy Options

Given the magnitude of the Medicare HI Trust Fund shortfall, a combination of revenue increases and spending reductions may be necessary to avoid policies that would increase the financial burden on beneficiaries or have an adverse effect on financially fragile health care institutions such as rural hospitals.

One way to address the shortfall would be to shift revenues from the existing Net Investment Income Tax (NIIT [which taxes certain forms of unearned income at a rate of 3.8%]) into the Medicare HI Trust Fund. Revenues raised by the NIIT, included in the Health Care and Education Reconciliation Act of 2010 (specifically in the unearned income Medicare contribution section) are now paid into the general fund. Depositing NIIT revenues into the trust fund recognizes that sources of personal income have changed since the creation of Medicare, when wages and salaries accounted for more than 75% of personal income compared with approximately 50% today.[2,3] Because the Medicare HI Trust Fund is funded primarily by payroll tax revenue, it does not capture unearned income that is more prevalent among higher-income households. In 2018, the NIIT generated roughly $27 billion. Depositing these revenues into the trust fund would strengthen its financial status without affecting overall tax burdens. Congress could also broaden the NIIT taxable base by including subchapter S corporations and limited partnerships, raising approximately $200 billion in new revenues over 10 years.[4]

Another way to raise revenues would be to increase the Medicare payroll tax for high earners. Currently, individuals and employers each contribute 1.45 percent of payroll to the Medicare HI Trust Fund. Individuals with higher earnings pay an additional 0.9% of payroll. Increasing the rate on high earners to 2% would yield $7.7 billion per year, according to the CBO, but also impose a greater burden on wage income, which is a shrinking income source for the trust fund. Increasing payroll taxes above 1.45% for everyone could add decades of solvency but would disproportionately affect lower- and middle-income taxpayers, including people in communities of color.

Policy makers could bolster the Medicare HI Trust Fund by reducing Medicare payments to hospitals, nursing facilities and Medicare Advantage plans. However, since the pandemic took hold in the spring of 2020, Congress has been more inclined to increase spending to ease the financial burden of COVID-19 on organizations delivering health care services. For example, Congress authorized funding for hospitals, skilled nursing facilities, and other facilities through the Provider Relief Fund to compensate them for unanticipated revenue losses and expenses due to the pandemic. Some

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of these recent changes weaken the trust fund, such as the 20% increase in Medicare payments for COVID-19 hospitalizations.

While policy makers may be reluctant to adopt significant reductions in payments to hospitals during the pandemic, they could consider reducing payments to postacute service entities that have relatively high Medicare margins, such as skilled nursing facilities, as proposed by President Trump and the Medicare Payment Advisory Commission. This would save an estimated $100 billion over 10 years, but doing so would be difficult to justify given the toll of the pandemic on nursing homes. Congress might revert to so-called budget gimmicks, such as shifting spending obligations for graduate medical education from the Medicare HI Trust Fund to a grant funded by general revenues, as was proposed by the Trump administration. This approach does not address underlying cost drivers.

Another strategy would reduce payments to Medicare Advantage plans, which have experienced strong growth and relatively large margins, especially during the pandemic.[5] The Medicare Advantage program is growing quickly and is projected to account for nearly half of all Medicare spending within the decade. Approximately 43% of Medicare Advantage spending comes from the Medicare HI Trust Fund. The Affordable Care Act helped reduce overpayments to Medicare Advantage plans to equalize payments between traditional Medicare and Medicare Advantage, but Medicare Advantage payments still exceed traditional Medicare costs due to coding intensity, bonus payments, and benchmarks that are set above traditional Medicare costs in many parts of the United States.

Congress could address one source of overpayments to Medicare Advantage plans, known as coding intensity. Medicare pays plans more for enrollees with underlying illnesses than it does for healthier enrollees to encourage plans to serve beneficiaries with existing health conditions. Doing so creates an incentive for plans to code their enrollees' diagnoses in a fashion that increases plan revenues. Each year, the Centers for Medicare & Medicaid Services adjusts Medicare payments to plans to align with traditional Medicare coding, with a minimum adjustment of 5.91% set by law. However coding intensity costs have been consistently above the statutory minimum, with estimates ranging from 8% to 11%.[6,7] Increasing the coding adjustment to at least 8% would yield $47 billion in Medicare savings, which translates to approximately $21 billion in savings to the Medicare HI Trust Fund.[4]

Congressional action might impose across-the-board reductions in benchmarks—the maximum amount Medicare pays in a given county. Congress could also reduce bonus payments to plans that are projected by the CBO to cost $94 billion over 10 years (approximately $40 billion in Part A spending).

Congress might seek a more fundamental change in how it pays Medicare Advantage plans. One approach would be to decouple Medicare Advantage bids and the benchmark from traditional Medicare spending rather than have plans bid against a benchmark based on local traditional Medicare spending, as they now do. Under this approach, Medicare Advantage plans would submit bids in local markets based on their cost of providing a standardized benefit package. The benchmark level for Medicare payments could be based on the second-lowest bid or the average bid. While this policy would be expected to reduce total Medicare spending and reduce Medicare HI Trust Fund outlays, it could also result in some plans exiting if they are unable to compete profitably or offering fewer extra benefits. Proposals that reduce Medicare outlays by cutting benefits are often raised, but this approach seems unlikely under the Biden administration.

Eliminating the shortfall over the next 10 years to extend the solvency of the Medicare HI Trust Fund could require savings or new revenues totaling as much as an estimated $750 billion. Reaching this target with spending reductions alone would be difficult, particularly during the pandemic and also because many constituencies (eg, hospitals) will oppose any such reductions. In all likelihood, new revenues will also be required but always be politically challenging. The most modest revenue increase discussed could generate more than $270 billion over 10 years without increasing the tax burden on US households, but it would not be enough to avoid insolvency within the decade. Any change that affects revenues and many changes that reduce Medicare spending will require congressional action—a challenging prospect even with the Democrats having a 1-vote majority the (vice president). Difficult as these choices may be, trust fund insolvency would put beneficiaries and health care institutions at risk and undermine confidence in the program.

ARTICLE INFORMATION

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