Medicare’s Fiscal Crisis and Options for Reform

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April 30, 2012

Medicare is living on borrowed time. According to the Medicare Trustees’ latest report, the program’s Hospital Insurance (HI) trust fund will be depleted in 2024.\(^1\) Outlays for the Supplementary Medical Insurance (SMI) trust fund, which pays for physician and outpatient services as well as prescription drugs, are growing even faster than spending for inpatient care. Over the next 75 years, Medicare faces $27 trillion in unfunded liabilities. With the retirement of 76 million Baby Boomers over the next two decades, the program will consume an ever increasing share of the federal budget unless policies are adopted to bend Medicare’s cost curve.

Concerned that this critical program faces a funding shortfall that could threaten seniors’ access to needed medical care, 16 health professionals who were elected to the U.S. House of Representatives or the U.S. Senate jointly requested an analysis of Medicare’s fiscal crisis and reform options that could make the program sustainable for future generations. This report is a response to that request.

**Assessing Medicare’s Fiscal Status**

The annual report of the Medicare Trustees provides an accounting of the program’s finances over the past year and projects the likely financial flows in and out of the trust funds over the next 75 years. However, because Medicare’s three major components (Part A, Part B, and Part D) are not funded in identical ways, the Trustees’ analysis does not provide an easily-understood measure of the overall financial health of the program.\(^2\)

Part A is funded primarily from payroll tax receipts and taxes on the benefits provided to high income enrollees. The 2012 Trustees’ report shows that Medicare’s Part A trust fund began to sell off assets to cover its operating cost beginning in 2008, and the trust fund will be exhausted in 2024. After that date, hospitals and other Part A providers can only be paid up to the amount of new revenue paid into the trust fund during the year.

In contrast, Part B and Part D are funded by a combination of beneficiary premiums and automatic payments from general tax revenue. Because enough general revenues are added each year to balance the books, the Part B and Part D trust funds can never be exhausted. Although those funds are “adequately financed,” Part B and Part D costs have been increasingly rapidly, averaging 5.9 percent and 7.2 percent annual growth over the last five years.\(^3\) Part B and Part D spending are projected to continue to grow in coming years at rates that exceed growth in the economy.

One frequently-cited measure of Medicare’s overall fiscal condition is the amount by which the HI trust fund is projected to be in deficit over the next 75 years plus the amount of general revenues projected to be added to the SMI trust fund over that same period. That total, referred to as the program’s unfunded liabilities, amounted to $27 trillion (in present value terms) according to the 2012 Trustees’ report.
In other words, if we could deposit $27 trillion into Medicare’s trust fund accounts today, the program would be able to pay benefits in full over the next 75 years. In the 76th year, Medicare would again be in deficit.

That amount of underfunding is staggering. By comparison, the Bureau of Economic Analysis reports that first quarter 2012 gross domestic product (GDP) came in at $15.5 trillion. Medicare’s underfunding is equivalent to nearly two years of our nation’s total output.

It is true that Congress could take actions that would phase in more gradual spending reductions and revenue increases over time to fill the gap. If that were not possible, then Medicare truly would be out of time. Nonetheless, the unfunded liability estimate does convey the urgency of Medicare’s fiscal situation.

As worrisome as these numbers are, they are unrealistically optimistic measures of Medicare’s future. In making their projections, the Trustees assume that all provisions of current law will be carried out without change. They assume that Medicare’s physician payments will be cut 30.9 percent as of January 2013 and the “productivity” reductions in payments to hospitals and other cuts will be carried out without modification.

That flies in the face of past experience. Every year since 2003, the Congress has overridden the cuts in physician payment required under the sustainable growth rate (SGR) formula. It is no longer conceivable that Congress would allow Medicare to cut physician payments by a third or more in the coming years.

It is similarly not conceivable that Congress would allow the payment reductions for hospitals and other Part A providers required by the Affordable Care Act (ACA) to be implemented as scheduled. The Trustees report that such reductions would result in operating losses for 15 percent of Part A providers in 2019, rising to 25 percent by 2030. Under those circumstances, providers will have to withdraw from the Medicare program, reducing seniors’ access to needed care.

Richard Foster, chief actuary for the Centers for Medicare and Medicaid Services (CMS), has indicated that such payment reductions are unlikely. For that reason, he points out that “the financial projections shown in [the Trustees report] for Medicare do not represent a reasonable expectation for actual program operations in either the short range (as a result of the unsustainable reductions in physician payment rates) or the long range (because of the strong likelihood that the statutory reductions in price updates for most categories of Medicare provider services will not be viable).”

The Trustees’ alternative projection assumes that physician payment would be held to a 1 percent annual increase instead of next year’s 31 percent cut, and that the “productivity” cuts in other providers’ payments would be phased down starting in 2020. Under those more realistic
assumptions, Medicare’s unfunded liabilities over the next 75 years would increase from $27 trillion to $37 trillion, or 2 ½ times the size of the nation’s economy.\textsuperscript{7}

Two other observations are worth noting. First, even if the current law payment reductions are implemented fully, Medicare’s spending could be higher than expected under the Trustees’ “intermediate cost” assumption. Under the “high-cost” assumption, the Part A trust fund is exhausted in 2017 instead of 2024.\textsuperscript{8}

Second, trust fund accounting ignores the impact of Medicare on the rest of the budget. From a trust fund perspective, the SMI trust fund had a $900 million surplus in 2011.\textsuperscript{9} The HI trust fund had a $33 billion deficit. In contrast, HI and SMI each required a net draw on the federal budget: $47 billion and $228 billion respectively. In fact, SMI will continue to draw increasingly large amounts from the budget even though by law the SMI trust fund will always remain in balance—and will, in fact, run a small surplus thanks to conservative actuarial practices.

This difference in accounting treatments is the source of the controversy over the impact of the ACA on Medicare and the budget. Although it is mechanically true that legislation that cuts $850 billion (over 10 years) from Medicare’s outlays extends the solvency of the trust funds, using that same money to expand health insurance subsidies leaves the budget in worse shape than it was before.\textsuperscript{10} In addition to the long-term obligation to pay Medicare benefits, the law added a new entitlement, in effect counting the same money twice.\textsuperscript{11}

It is clear that Medicare is on an unsustainable fiscal path. The Medicare Trustees called for Congress and the executive branch to “work closely together with a sense of urgency” to resolve Medicare’s financing crisis.\textsuperscript{12} Without real and lasting reform, Medicare’s promise will not be kept for future generations—or for the baby boomers, who are just now beginning to move from the labor force and into retirement with the expectation that Medicare will be there for them.

**Premium Support as the Basis for Medicare Reform**

Demographics will be a major driver of Medicare spending over the next two decades as the baby boomers enter the program. Medicare enrollment is projected to increase by 70 percent through 2035, after which enrollment will continue to grow but at a much slower pace.\textsuperscript{13} In the face of this surge of new beneficiaries, it is imperative that we find more efficient ways to deliver health care.

Medicare reform based on the principle of premium support can responsibly slow the growth of program spending and help set this country on a sustainable fiscal path. Such a reform relies on market competition among health plans to achieve high-quality coverage at the lowest cost. That is essential if we are to protect the Medicare program for future beneficiaries.

Traditional Medicare’s uncapped entitlement and fee-for-service payment structure is a major cause of the rapid rise of program spending. Fee-for-service payment promotes the use of more,
and more expensive, services in a fragmented and uncoordinated delivery system. That results in higher cost and poorer patient outcomes.

Premium support changes that incentive by giving consumers a subsidy to purchase insurance from a wide selection of competing health plans offering a core set of benefits. In each market area, the plans would submit bids to provide the basic benefits to a beneficiary with average health risk.

The government subsidy, paid directly to the plan chosen by the beneficiary, would be based on the low bid or, under some proposals, the second-lowest bid offered in that market. To ensure affordability, subsidies would be higher for beneficiaries with lower incomes or higher health risks.

Beneficiaries could enroll in more expensive plans, but any extra premium would be paid solely by the beneficiary without additional subsidy. That gives an incentive to consumers to select lower-cost plans, and it gives an incentive to the plans to negotiate lower prices with providers and improve the delivery of care.

Instead of increasing the volume of services to increase payment, health plans would have a strong interest in providing necessary services in a cost-effective manner. Under premium support, more efficient health care delivery is rewarded, not penalized.

Premium support is the key to creating a sustainable Medicare program, but other reforms are necessary. Medicare was created in 1965 and in many ways it remains trapped in the past. Comprehensive reform is needed if the program is to provide full value to beneficiaries at a cost that taxpayers can bear.

Recent Reform Proposals

Policymakers across the political spectrum recognize the need to address long-standing problems that threaten to undermine Medicare and jeopardize the country’s future. Bipartisan proposals for reforms based on premium support include the Bipartisan Policy Center’s Debt Reduction Task Force proposal developed by former Republican Senator Pete Domenici and Alice Rivlin of the Brookings Institution and the proposal by Sen. Ron Wyden (D-Ore.) and Rep. Paul Ryan (R-Wis.). A reform proposal by Sen. Richard Burr (R-N.C.) and Sen. Tom Coburn (R-Okla.) and the 2013 House budget resolution (which is based on Wyden-Ryan) also recommended premium support. In addition, Sen. Joe Lieberman (D-Conn.) and Sen. Coburn offered a plan to modernize and improve certain aspects of Medicare that impede efforts to slow the growth of unnecessary spending.

A consensus seems to have emerged about the central features of comprehensive Medicare reform based on premium support.
First, traditional fee-for-service Medicare should be retained as a competing plan option available to any beneficiary who chooses it. The inclusion of traditional Medicare recognizes that it is likely to have well more than the 37 million people who are currently enrolled when the premium support system is put into operation. Even if newly-eligible beneficiaries are not allowed to enroll in traditional Medicare, the program will continue to be a major force in the health care market and cannot be ignored.

Premium support does not need to exclude traditional Medicare. Premium support lets consumers decide for themselves which plan provides the best value, and gives them a clear financial stake in that decision. Although there is plenty of room to improve efficiency in health care, there is a possibility that private plans may fail to find those efficiencies. If that occurs, beneficiaries will move to traditional Medicare, providing an important safety valve that ensures they will be protected.

The Domenici-Rivlin proposal makes traditional Medicare the default plan under their version of premium support. This follows the current procedure of automatically enrolling newly-eligible beneficiaries in traditional Medicare unless they opt for a Medicare Advantage plan. Other proposals are silent on the issue.

Default enrollment may be the price of political support (or at least, minimal opposition) for Medicare reform from the moderate left. It minimizes the concern that premium support would end Medicare, but it also slows the evolution of the program toward greater efficiency. Under default enrollment, the path of least resistance—at least in terms of deciding which plan to pick—is traditional Medicare even if there are better options available.

Some default is necessary to ensure that everyone who is eligible actually enrolls. Random assignment, perhaps to plans that charge no more than the standard premium, would satisfy that requirement. In rural locales and other markets dominated by a small number of providers, traditional Medicare is likely to be the low-cost choice.

Second, to safeguard against the threat of runaway spending, a fiscal target should be established that limits the growth of the federal subsidy. Wyden-Ryan and Domenici-Rivlin each set the upper limit on annual growth in Medicare’s subsidy at GDP plus 1 percent, which is identical to the fiscal target set for the Independent Payment Advisory Board (IPAB) in the Affordable Care Act. The House budget resolution uses the same target as the President’s 2013 budget, GDP plus ½ percent. Burr-Coburn does not specify a spending limit.

Whether to include an external control on Medicare spending and if so, how stringent that limit should be, have been controversial issues. If the fiscal target is enforced, an overly restrictive limit could threaten access to care and impede medical progress—a problem common to all formula-driven spending controls, including the ACA’s “productivity” cuts, the IPAB target, and the sustainable growth rate for Medicare physician payment. A formal requirement that
Congress review the appropriateness of the fiscal target in Medicare premium support is one way to reduce the risk.¹⁹

However, we should not place undue faith in spending limits. The targets provide some fiscal discipline but they do not produce savings that can be maintained over the long term. What matters most are the economic incentives brought to bear by premium support, which encourage better decision-making on the part of both consumers and health care providers.

If competition can keep program spending within the bounds set by the targets, then the targets are not necessary except as a budgetary mnemonic device that reminds us that resources are limited, even for the most urgent of programs. If not, then the targets would eventually have to be increased unless a public consensus had been reached that other spending priorities took precedence over health care, at least at the margin.

Third, additional reforms are necessary to modernize Medicare, make the program fairer, and reduce unnecessary spending. Four of the recent proposals (Burr-Coburn, Lieberman-Coburn, Wyden-Ryan, and Domenici-Rivlin) include specific improvements in traditional Medicare, but they vary considerably on the additional reforms they support. The 2013 House budget resolution is modeled after Wyden-Ryan but is silent on most aspects of Medicare that could be reformed outside of premium support. That reflects its objective of establishing a framework for the budget and not prescribing detailed policy provisions. The Burr-Coburn proposal offers the most detail about its provisions.

The four proposals that advance specific reforms to traditional Medicare agree that the program should offer true insurance protection to beneficiaries in the form of catastrophic coverage. In addition, Medicare’s complex system of cost-sharing requirements would be simplified. A single deductible covering all Part A and Part B services with a uniform coinsurance rate applied to all covered services, similar to the design of most private insurance, would help clarify for beneficiaries what they are likely to pay.

Cost-sharing is supposed to make patients more sensitive to the cost of care, but that will not work if the cost-sharing rules are incomprehensible as they are today with separate deductibles for Part A and Part B and a bewildering array of coinsurance and copayments for other services. Lieberman-Coburn specifically suggests a single annual deductible of $550 for both Part A and Part B services. Burr-Coburn adds to that a proposal to replace the complicated system of copayments and coinsurance with a 20 percent coinsurance applied to all Part A and Part B services.

Lieberman-Coburn and Burr-Coburn also tie cost-sharing to beneficiary incomes. This is done by income-relating the catastrophic cap. The highest-income beneficiaries making more than $160,000 a year could pay as much as $22,500 a year in cost-sharing before catastrophic coverage takes over. Those with incomes below $85,000 would have their cost-sharing capped at $7,500 a year.
At first glance, such a proposal may seem to violate the tradition of Medicare offering the same benefits to everyone who is enrolled. However, that tradition is more myth than reality. Medicare already charges higher premiums to those with higher incomes, and low-income beneficiaries already get additional subsidies through Medicare and Medicaid. Making cost-sharing requirements sensitive to income extends what is in fact Medicare’s long-standing policy to favor those with low income.

All four proposals also agree that the SGR formula, which calls for a reduction in Medicare physician payment of 30.9 percent in January, should be permanently replaced with an alternative funding mechanism. Although Congress has habitually overridden the SGR cut and is expected to do so again, the budget cost of a permanent “fix” is scored by the Congressional Budget Office as exceeding $300 billion. Lieberman-Coburn and Burr-Coburn propose to freeze physician payments for three years to allow time to replace the SGR.

Fourth, there remains ample room to negotiate the specific details of Medicare reform. Beyond the provisions just discussed, the proposals have specified few details about how premium support would be implemented and what else would be changed in traditional Medicare.

Domenici-Rivlin and Burr-Coburn agree that competitive bidding under premium support should begin in 2016, reflecting both the seriousness of Medicare’s financing crisis and optimism that the technical aspects of the reform can be implemented fairly quickly. Wyden-Ryan and the 2013 House budget resolution propose to begin premium support 10 years hence (2022 and 2023, respectively), outside CBO’s budget scoring window but also allowing more time to develop the details. Burr-Coburn is alone in specifying a new independent agency to oversee plan competition, perhaps similar to the role played by the U.S. Office of Personnel Management for the Federal Employees Health Benefits Program.

A similar diversity of opinion exists with regard to reforms of traditional Medicare. Three proposals (Domenici-Rivlin, Burr-Coburn, and Lieberman-Coburn) would raise the Part B premium from its current 25 percent of program cost to 35 percent; Wyden-Ryan is silent on this provision. Burr-Coburn would require millionaires to pay the full cost of Part B and Part D as premiums; Lieberman-Coburn would require seniors making $150,000 or more to pay the full cost of Part B. Two proposals (Burr-Coburn and Lieberman-Coburn) would raise the age of eligibility to 67.

Before comprehensive Medicare reform can be fully considered by policymakers, considerable work must be done to develop the details which can determine the political and technical success or failure of legislation. The proposals discussed here demonstrate that serious thinking has gone into Medicare reform, and that much more thinking on all sides will be needed to develop a proposal that can be successfully enacted and implemented.
Key Elements of Market-Based Medicare Reform

1. Convert Medicare into modern health insurance.
   - Provide protection against catastrophic health expenses for all beneficiaries.
   - Simplify cost-sharing in traditional Medicare. Replace the current confusing structure with a single deductible that applies to all services under Part A and Part B, and impose a uniform 20% coinsurance on all services.
   - Increase cost-sharing for high-income beneficiaries.
   - Reduce the cost of extra service use resulting from Medigap. Options include excluding Medigap coverage for the first $500 of a beneficiary’s cost-sharing responsibility or limiting all Medigap payments to less than 100 percent coverage of cost-sharing amounts.
   - Make traditional Medicare a comprehensive health plan by combining Part A and Part B, with a single premium that covers both parts.
   - Establish a health savings account as part of traditional Medicare.
   - Increase the eligibility age for Medicare to 67. Allow seniors between 62 and 67 to buy into the program.

2. Improve health care delivery in traditional Medicare.
   - Provide case management services for high-cost patients with multiple chronic conditions. Such services would coordinate across multiple providers to minimize duplicate or conflicting tests and procedures.
   - Enroll dual eligibles to enroll in organized health plans equipped to meet their needs, coordinate their care, and coordinate funding from Medicare and Medicaid. The range of plan options for dual eligibles should not be arbitrarily limited.
   - Establish Medicare Prime, a smarter plan alternative for enrollees in traditional Medicare. Unlike traditional Medicare which pays “any willing provider,” Medicare Prime would operate as a network plan, selecting high-quality providers willing to take a discount from standard Medicare payment rates.
   - Enhance traditional Medicare’s authority to adopt innovative benefit designs and management practices. To be competitive, Medicare must be able to respond to changing conditions in local markets.

3. Reform Medicare payment policies.
   - Permanently fix the physician payment problem. Eliminating the SGR will require budget savings based on the principle of shared sacrifice among physicians, other health care providers, and beneficiaries.
Reform Medicare’s payment systems. A new physician payment methodology that rewards quality and conservative medical practice would replace the current fee schedule mechanism. Other models, including bundled payment and competitive bidding for specific services, would be developed.

Shift Medicare payments for medical education and other spending not directly tied to medical services out of the entitlement and into discretionary spending.

4. Create effective plan competition in Medicare.

Convert Medicare to a defined contribution/premium support system. Traditional Medicare would be available as a plan option. Beneficiaries not making an affirmative choice of plans would be randomly assigned, with the option to change enrollment within 60 days.

Replace current bidding system that is tied to traditional Medicare to full competitive bidding in each local market. The subsidy would be tied to the lowest (or second) lowest bid in each market. Subsidies would be adjusted for income and health risk. In addition, a reinsurance mechanism would further reduce the incentive to “cherry pick” low-risk patients.

Improve the beneficiary’s purchasing experience. Better decision-support tools would provide beneficiaries with more specific information about their plans options, including the cost of Medigap insurance and the likely cost that a beneficiary could expect to pay out of pocket for typical kinds of medical care.

Permit seniors to use their Medicare subsidy in the private insurance market. This allows individuals to opt for less-generous coverage or other combinations of benefits without forcing private insurers to meet every requirement in the program.
The Way Forward

Medicare is facing an unprecedented fiscal crisis that will undermine the health security of older Americans unless decisive action is taken to reform the program. Some point to the recent slowdown in the growth of Medicare spending as evidence that the program can get along with business as usual. That is simply not the case. The Medicare trustees have taken those changes in spending trends into account and conclude that action is urgently needed to ensure that Medicare will continue to meet the health needs of our seniors.

The bipartisan proposals for Medicare reform that have been advanced recently reflect the growing consensus that the danger is real but solutions are possible. If we hope to bend Medicare’s cost curve, we must change the financial incentives that drive program spending to increasingly unaffordable levels. A well-designed premium support program can take full advantage of market competition to drive out unnecessary spending and increase Medicare’s value to beneficiaries. In a properly structured market, beneficiaries would have incentives to seek services from cost-effective delivery systems and providers would have incentives to operate efficiently.

The alternative approach relies on tighter regulation and cuts in provider payment rates without changing the underlying fee-for-service incentives that have driven Medicare spending to unprecedented levels. That is ultimately self-defeating, stifling private sector creativity rather than channeling it toward system-wide improvement.

Comprehensive Medicare reform should combine premium support with other changes to ensure that seniors continue to receive high-value health care at a price that is affordable to them and to taxpayers. The major elements of such a reform are summarized in the text box.

The broad themes—modernize Medicare, improve health care delivery, reform payment policies, and create effective plan competition—are common to the bipartisan proposals discussed in this report. Unlike earlier proposals, the reform outlined here recognizes that traditional Medicare itself must be given the ability to innovate if we expect it to compete in the open market. The current program is unable to respond in a timely and appropriate manner to changes in medical science and the business of health care. That can be remedied while maintaining basic consumer protections.

The need for Medicare reform has never been more urgent, or more clear. Medicare is at the center of the unrelenting increase in overall health spending, which consumes 18 percent of our GDP now and is expected to continue its rise into the future. Medicare is also a key driver of the explosion of federal debt, which is now about 70 percent of GDP and rising.

These challenges transcend party lines. Taking Medicare reform off the table will not protect seniors. Responsible reform that introduces premium support and preserves traditional Medicare
as an option is the best way forward. There is reason to be optimistic that bipartisan agreement
can be reached in time to avoid the dire consequences of inaction.

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panel of health advisers.

1 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary
2 Part A covers hospital and post-hospital services and operates through the HI trust fund. Part B covers physician
and outpatient services and Part D covers prescription drugs, and they each have subaccounts within the SMI trust
fund. Medicare Advantage, or Part C, does not have its own trust fund. Its operations are included as part of the HI
and SMI trust funds.
4 Bureau of Economic Analysis, “Gross Domestic Product: First Quarter 2012 (Advance Estimate),” press release,
6 2012 Trustees report, p. 278.
7 Suzanne Codespote, Letter to Senate Budget Committee, Medicare Unfunded Obligation for 2012 Trustees Report,
April 23, 2012.
8 2012 Trustees report, p. 64.
9 2012 Trustees report, p. 236.
10 See Charles Blahous, “The Fiscal Consequences of the Affordable Care Act,” Mercatus Center, April 10, 2012,
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14 A useful comparison of several reform proposals is available. See Robert E. Moffit, “Saving the American
Dream: Comparing Medicare Reform Plans,” Heritage Foundation, April 4, 2012,
15 The Debt Reduction Task Force, “Restoring America’s Future,” Bipartisan Policy Center, November 2010,
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Fiscal Year 2013 Budget Resolution,” March 20, 2012,
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18 These issues are also discussed in Joseph Antos, “Premium Support Proposals for Medicare Reform,” testimony
before the House Committee on Ways and Means, Subcommittee on Health, April 27, 2012,