The Future of the Medicare Trust Fund

For the Montana Chapter of HFMA – October 27, 2021

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Background: Medicare Financing

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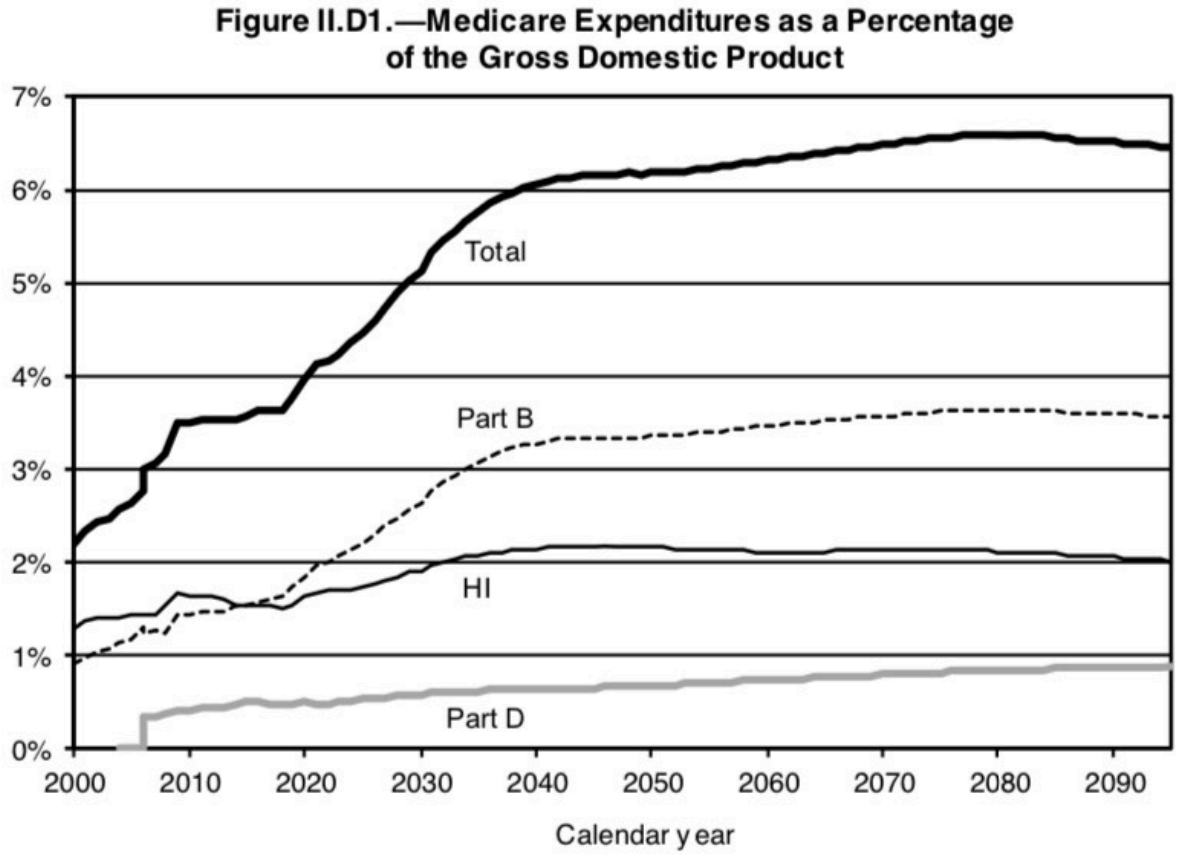
Health Care Expenditures

- National health expenditures
  - $3.8 trillion in 2019
    - $11,582 per person
  - Growing at average annual rate of 4.6 percent
  - 17.7 percent in 2019 of the Gross Domestic Product (GDP)
  - Projected to grow 19.7 percent by 2028

IMPACT OF COVID-19

- ***Source: CMS NHE Fact Sheet, 2019***

Spending as Percent of GDP



Note: Percentages are affected by economic cycles.

How Is Medicare Financed?

- Part A: Hospital Insurance
  - 1.45% payroll tax on both employer and employee
- Part B: Supplemental Medical Insurance
  - Beneficiary premium
    - Required to cover 25% of total Part B spending
    - Increased in 2007 for higher income levels
  - General revenues
- Part C: Medicare Advantage
  - Not separately financed
- Part D: Prescription Drug Benefit
  - Beneficiary premium – varies by geographic area
  - General revenues

Workers per Beneficiary

FIGURE 1–4 **Medicare enrollment is rising while number of workers per beneficiary is declining**

Figure 1-4a. Medicare enrollment

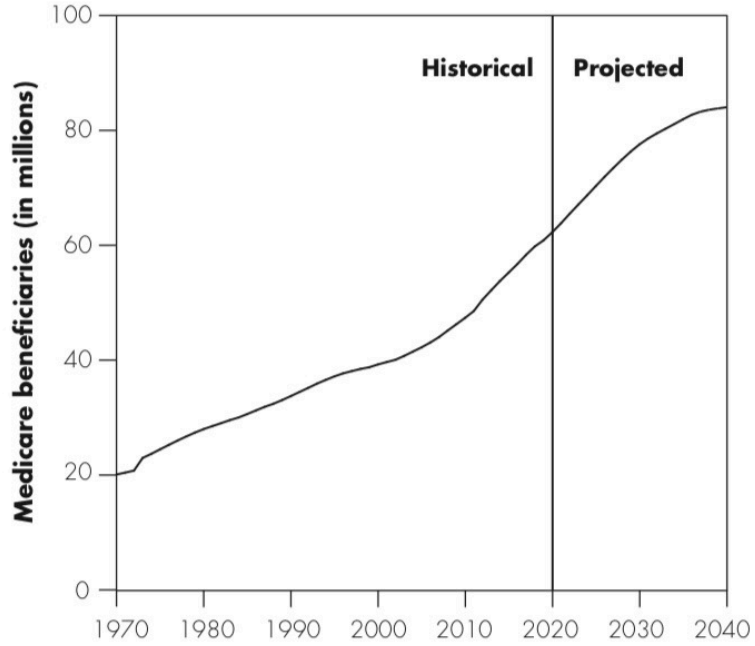
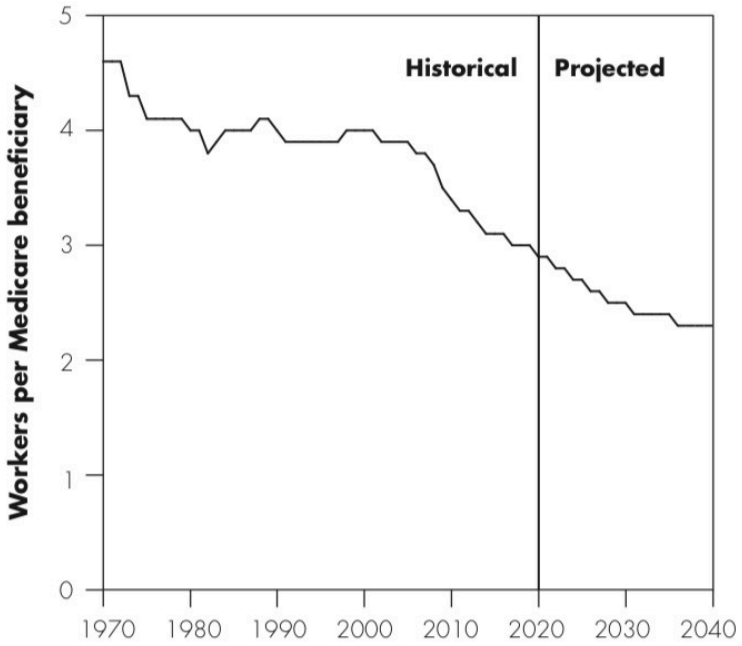


Figure 1-4b. Workers per beneficiary

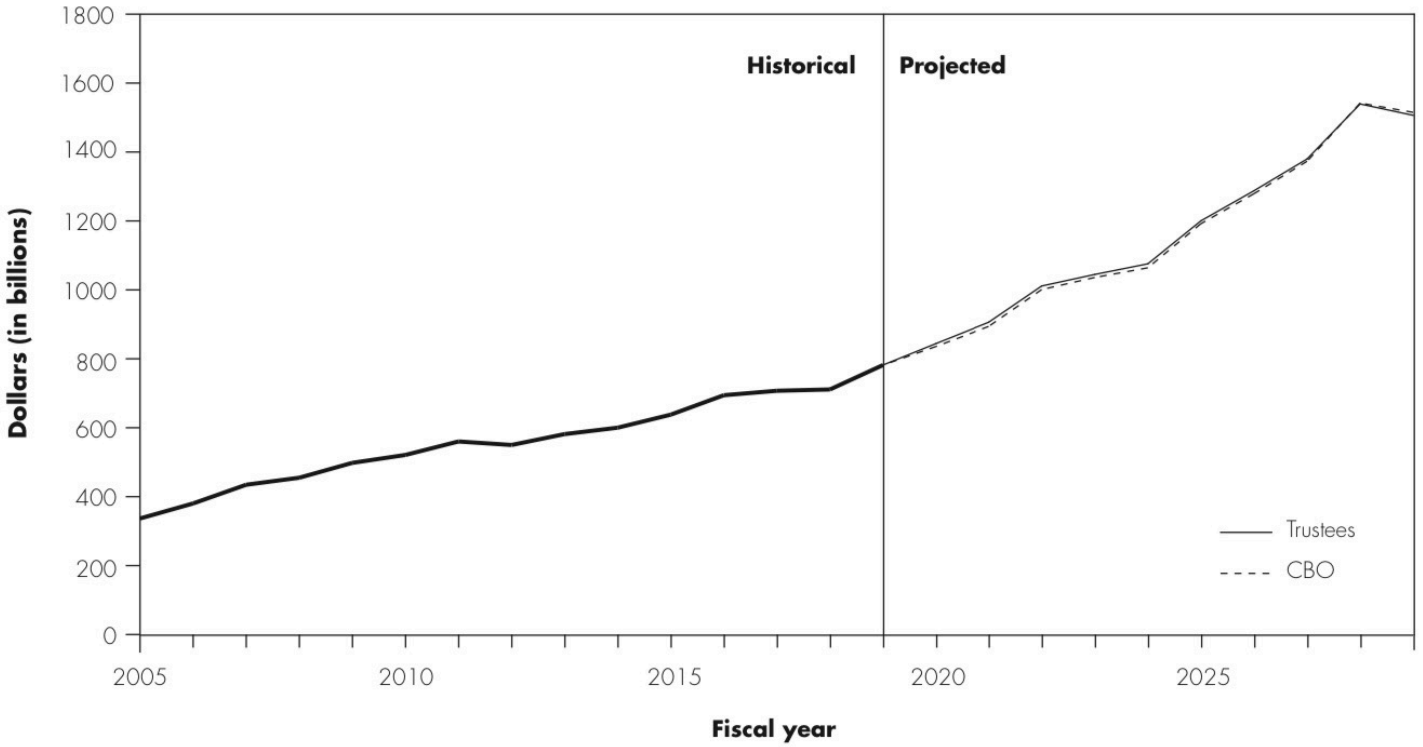


Note: "Beneficiaries" referenced in these graphs are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). Part A is financed by Medicare's Hospital Insurance Trust Fund. The potential effects of the coronavirus pandemic are not included in these projections.

Spending Projections

FIGURE 1–2

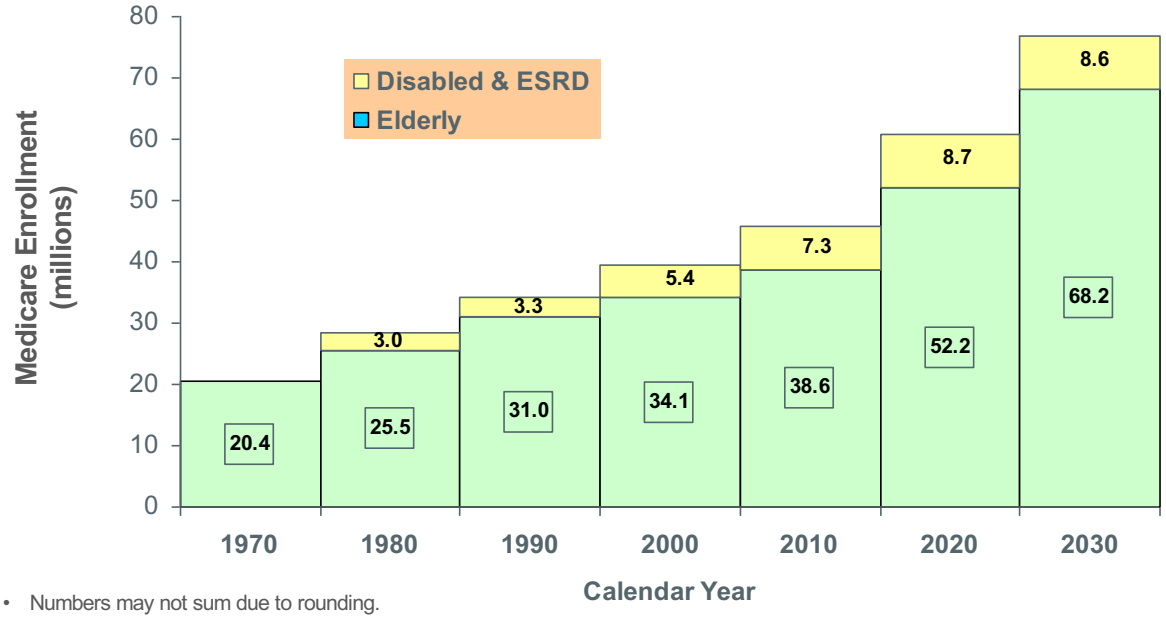
Medicare Trustees and CBO project Medicare spending to nearly double over the next decade



Note: CBO (Congressional Budget Office). Figure shows spending per fiscal year (as opposed to calendar year). The potential effects of the coronavirus pandemic are not reflected in these projections. At the time these projections were developed, a statutorily required sequestration was scheduled to increase in size in 2029 (growing from the current 2 percent reduction to benefit payments to a 4 percent reduction for the period from April 1, 2029, through September 30,

Aging of the ‘Baby-boomers’

The number of people Medicare serves will nearly double by 2030.



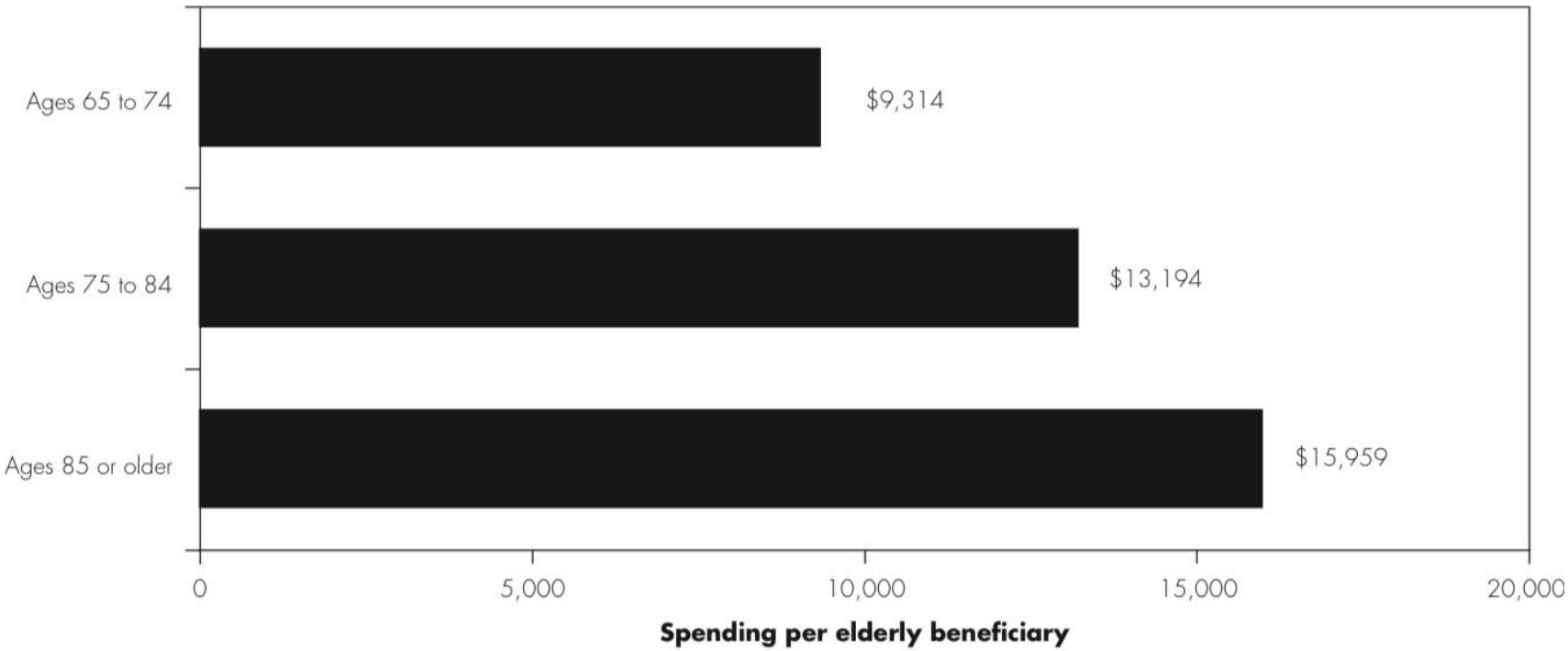
- Numbers may not sum due to rounding.

Source: CMS, Office of the Actuary

Spending Varies with Age

FIGURE 1–5

Spending per elderly beneficiary varied by age, 2017



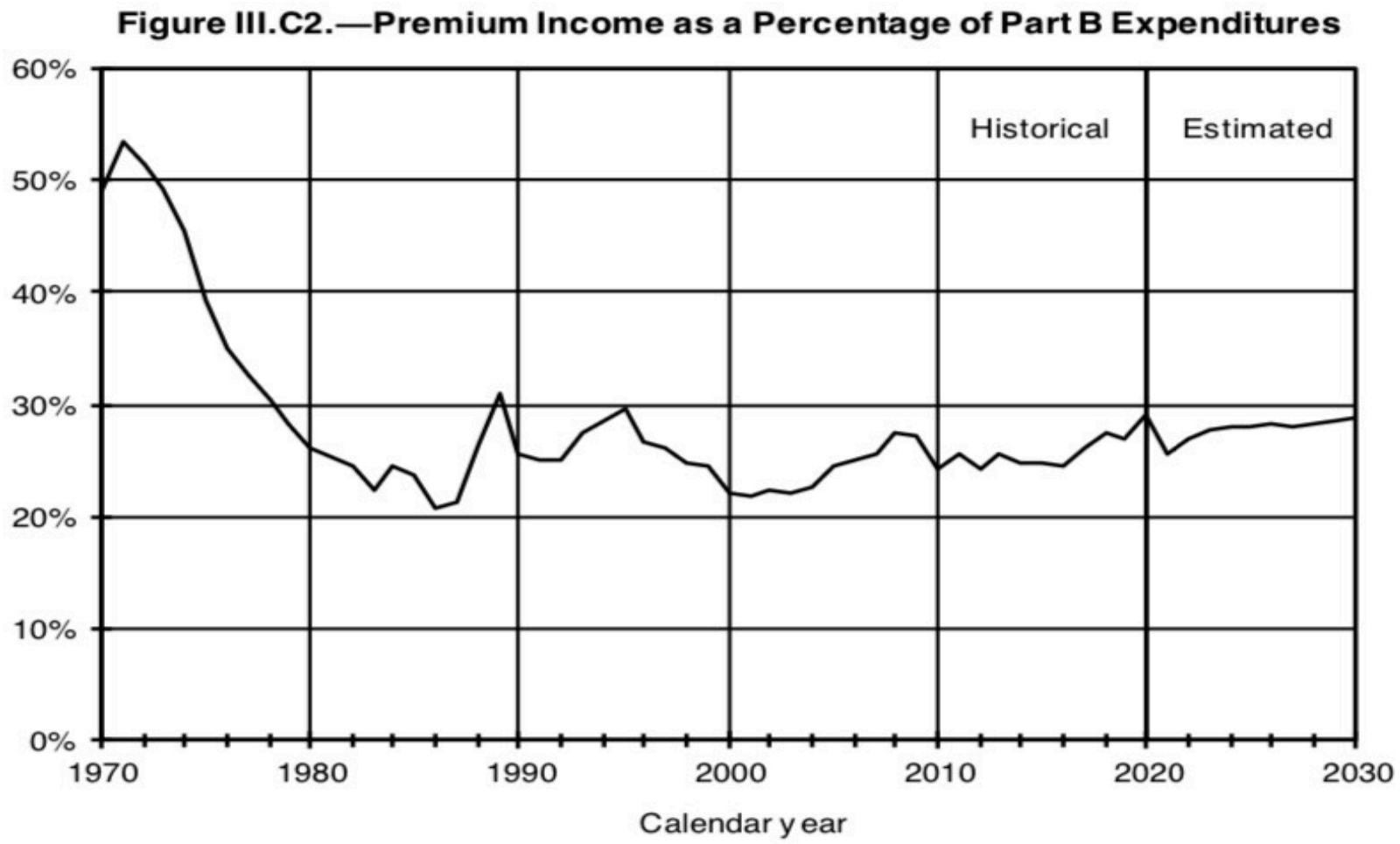
Note: Includes beneficiaries in traditional Medicare and Medicare Advantage dwelling in the community and in institutions. Spending per beneficiary for non-elderly enrollees (who are eligible for Medicare due to end-stage renal disease or disability) was $15,879 (not shown above).

Forecast: The Supplemental Medical Insurance Trust Fund

SMI Solvency Projections 2021

- Adequately financed over the next decade and beyond
  - Premiums paid by enrollees plus government funding
  - Reset annually
    - Does not require Congressional approval
- Part B costs have averaged annual growth rate of 8.5 percent over the last five years
  - Compared to GDP growth of 2.8 percent
  - Growth expected to average 7.2 percent over next five years (GDP = 5.3 percent)
- Higher spending results in increased general revenue funding and higher beneficiary premiums

Part B Premium to Expense



Proposals Impacting Providers

Outpatient site neutral

- Non-grandfathered off-campus
- On campus clinics

340B drug program

- Modify payment rate
- User fee
- Revise distribution methodology

Reduce bad debt reimbursement from 65% to 25%

Reduce payment to critical access hospitals

- From 101% of cost to 100% of cost

Forecast: The Hospital Insurance Trust Fund

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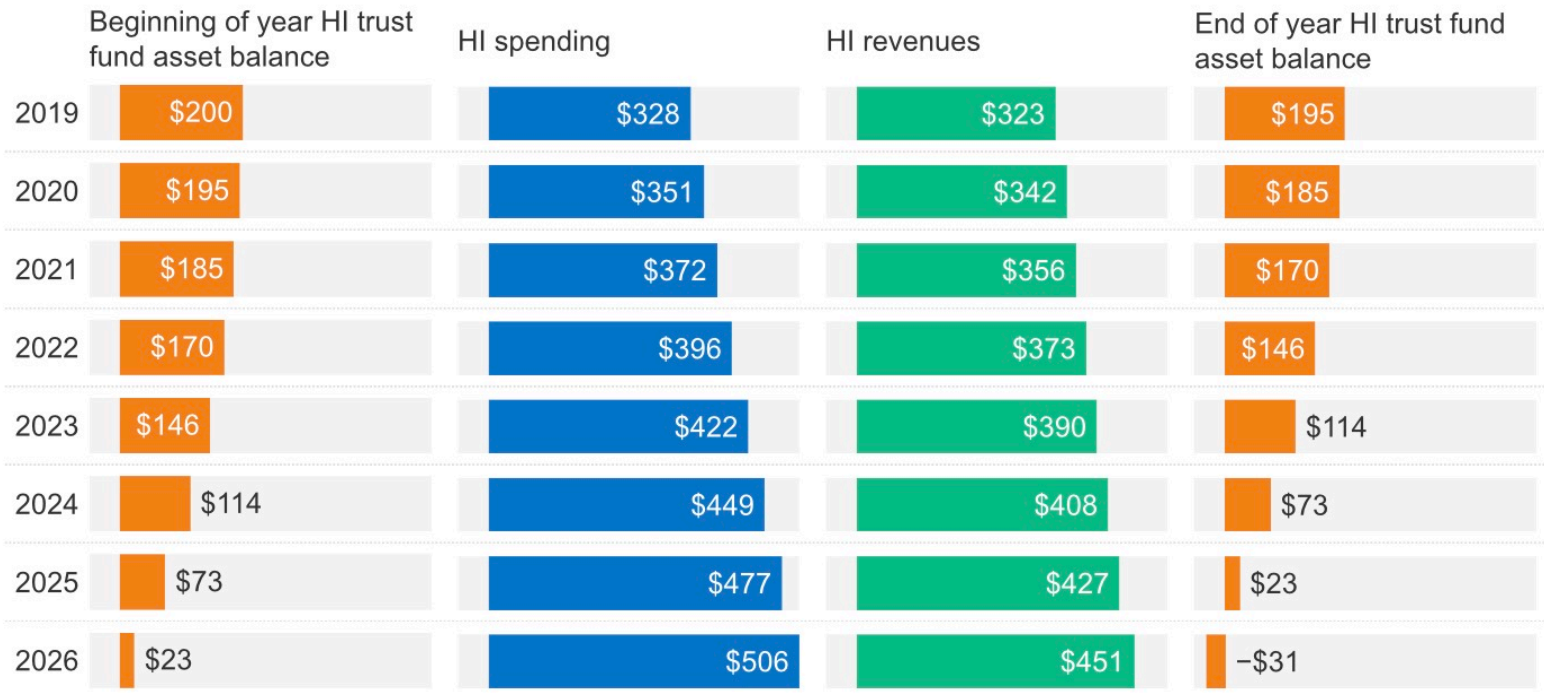
Current Status

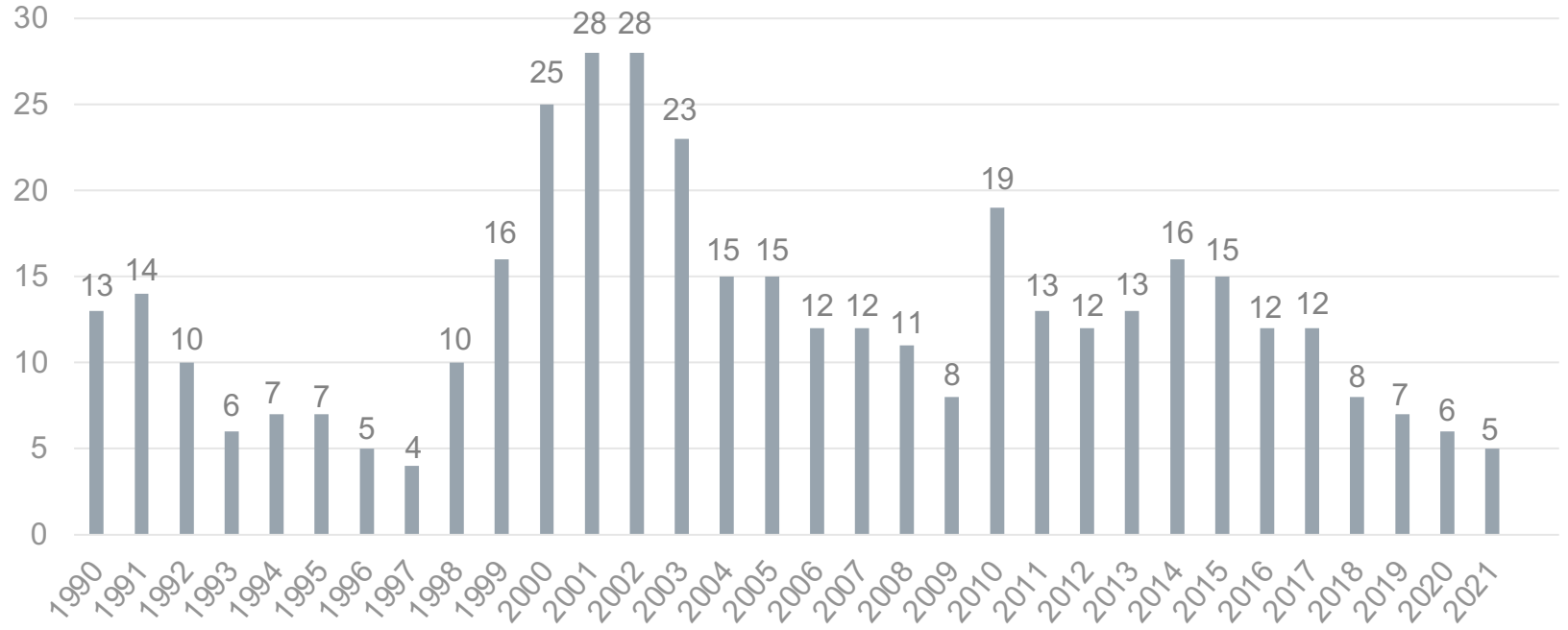
Assets in the Medicare Hospital Insurance Trust Fund are Gradually Being Depleted



NOTE: HI is Hospital Insurance. Amounts in billions.
SOURCE: KFF analysis of data from the 2020 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Trust Funds, April 2020.
• PNG

KFF

Insolvency: The Past & the Future



Exhausted?

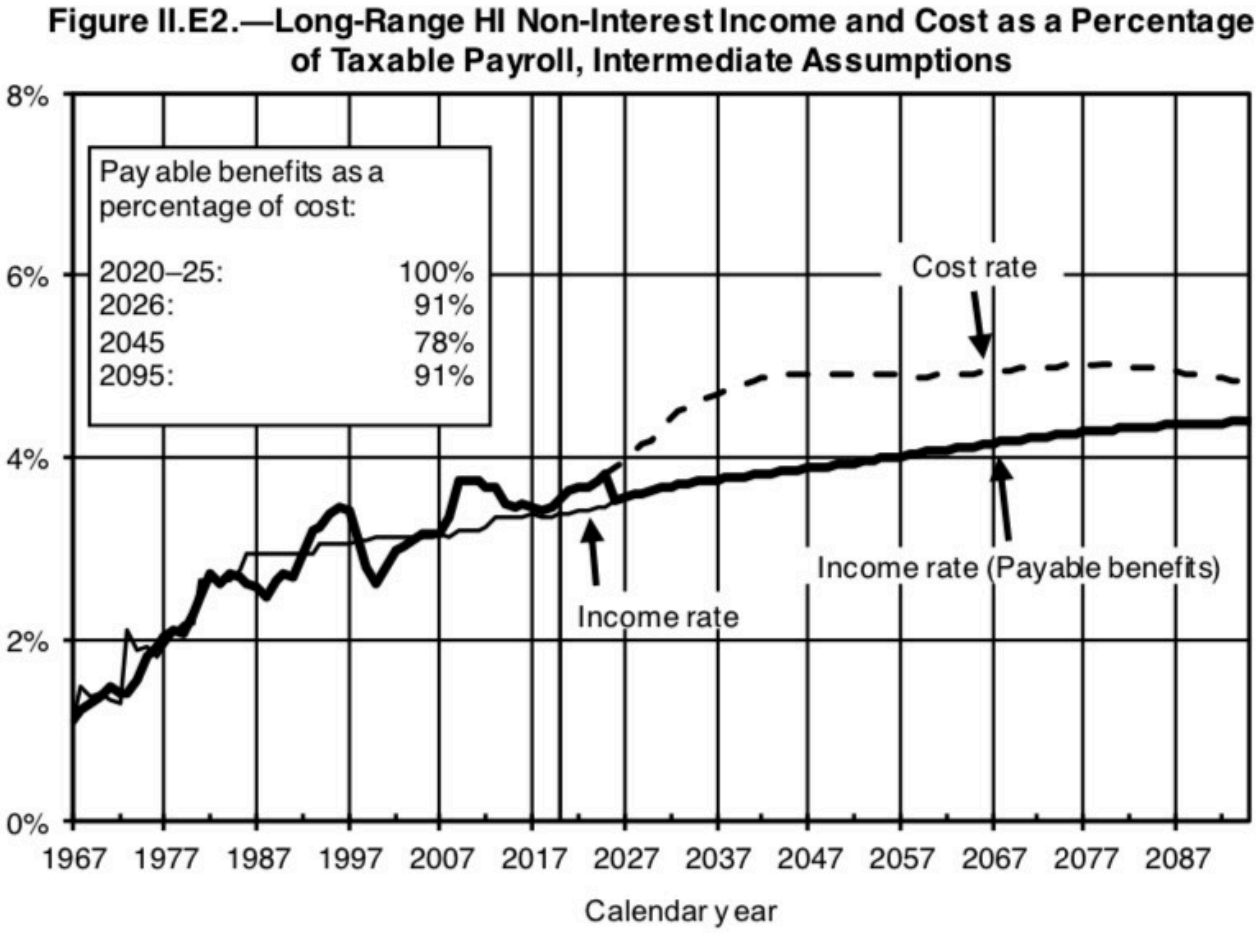


Figure II.E2.—Long-Range HI Non-Interest Income and Cost as a Percentage of Taxable Payroll, Intermediate Assumptions
8%
6%
4%
2%
0%
Pay able benefits as a percentage of cost:
2020–25: 100%
2026: 91%
2045 78%
2095: 91%
Cost rate
Income rate (Payable benefits)
Income rate
1967 1977 1987 1997 2007 2017 2027 2037 2047 2057 2067 2077 2087
Calendar y ear

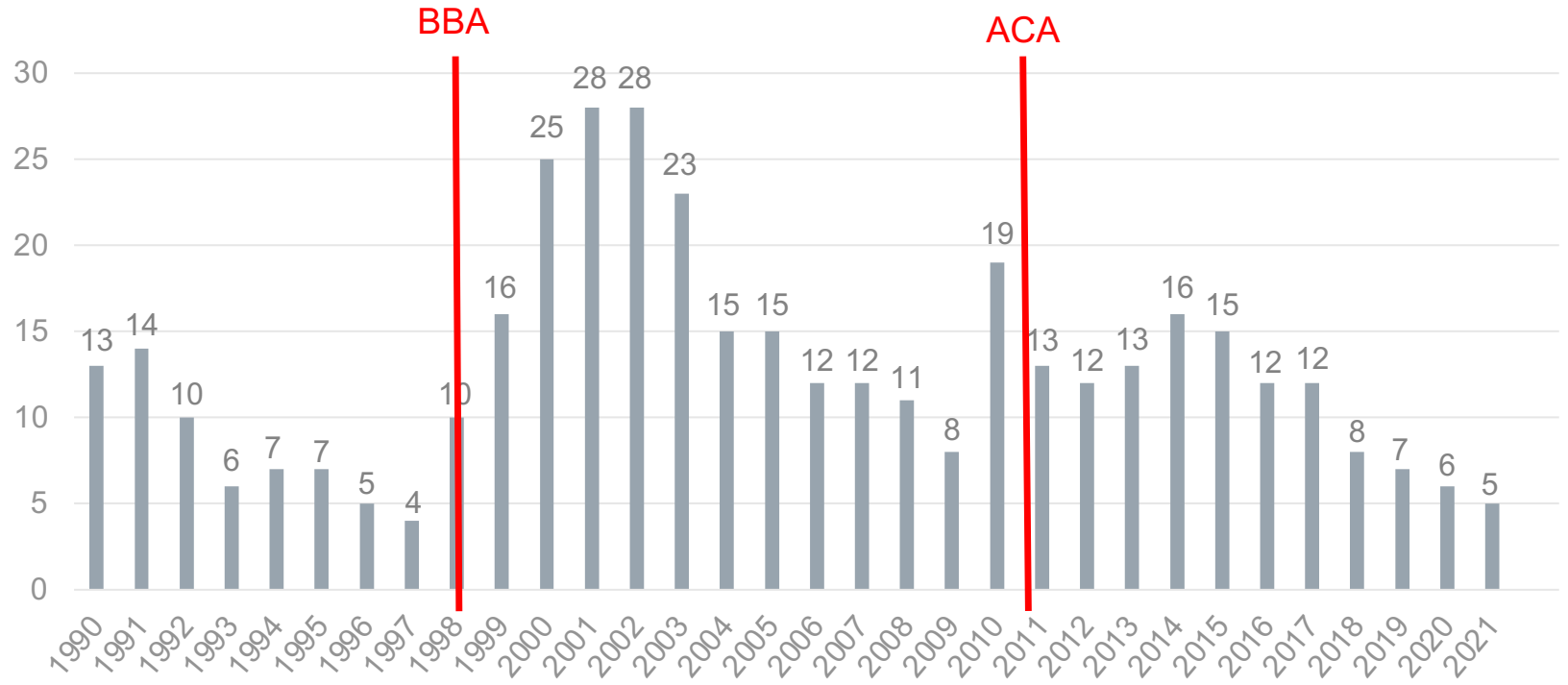
2021 Trustee's Report

- *The projected trust fund depletion date is 2026, the same as estimated in last year's report. HI income is projected to be lower than last year's estimates due to lower payroll taxes. HI expenditures are projected to be lower than last year's estimates because of lower projected provider payment updates and certain methodological improvements…*
- *HI revenues would cover only 91 percent of estimated expenditures in 2026 …*

Medicare Trust Fund

- Modern Health Care, April 22, 2020
  - *The 2020 assessment has an elephant in the room…*
  - *The global pandemic will 'no question' have a negative effect on the reserve funds of both Medicare and Social Security*
  - *In a high-cost environment, that reserve would run out by 2023*
    - *It is possible that experience could be even worse than that*
    - *It is too early to say exactly what the impacts are. But…they are generally going to be worse than presented under the intermediate assumptions in this report.*
  - *Once the trustees incorporate the effects of COVID-19 on payroll tax revenue and other factors in next year's report, 'the situation will go from bad to worse'*

Insolvency: Past Responses



Proposals Impacting Providers

Medical education
- Move GME and IME to national pool

Remove disproportionate share from IPPS
- Index to inflation

Reduce bad debt reimbursement from 65% to 25%

Post-acute care
- Reduce payments for post-acute care services
- Unified post-acute care payment system
- Shifting more payment for home health from Part A to Part B

Critical Access Hospitals
- Eliminate program
- Reduce payment from 101% of cost to 100% of cost
- Reduce swing bed program reimbursement

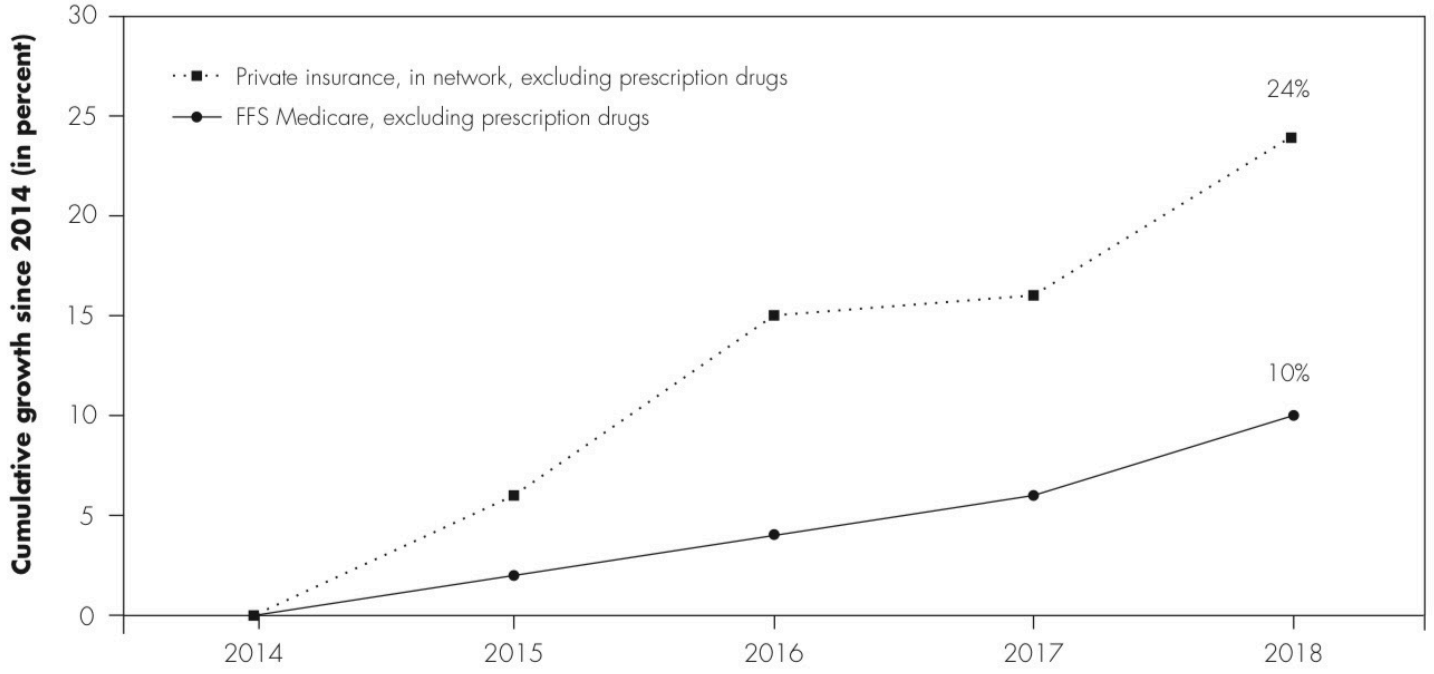
Eliminate sole community hospital program

How does this tie to expansion of Medicare to include dental, hearing, and vision coverage? Lowering the eligibility age?

Medicare Advantage

- MedPAC: impact of MA plans on federal spending
  - Part of 2021-2022 workplan
  - Issue of plan profits
  - Revise MA payment methodology
    - Recent OIG report on suspicious payments to MA plans

Impact of Medicare Advantage



Note: FFS (fee-for-service). The figure shows cumulative growth since 2014. It reflects payments to providers from health insurers and patients (i.e., cost sharing) but not payments from other sources (e.g., worker's compensation or auto insurance). Spending on retail prescription drugs is not available for the privately insured, so it is excluded from both lines in this graph. Spending on out-of-network services for the privately insured is not available for that group and thus is not included in this graph. The figure reflects spending for individuals with full-year insurance coverage (including individuals with $0 of health care spending). "Private insurance" reflects spending for individuals ages 18 to 64 in fully insured and self-insured plans (i.e., employer self-funded plans) contributed by national and regional plans and third-party administrators nationwide; it includes claims from individual and group plans as well as marketplace plans and Medicare Advantage plans for non-elderly disabled individuals.

Source: MedPAC analysis of Medicare's Master Beneficiary Summary File; FAIR Health analysis of its National Private Insurance Claims database (which reflects

Questions:

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