STATEMENT OF

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ON

MEDICARE AND SOCIAL SECURITY: EXAMINING SOLVENCY AND IMPACTS TO THE FEDERAL BUDGET

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Medicare and Social Security: Examining Solvency and the Impacts to the Federal Budget
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Chairman Arrington, Ranking Member Boyle, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medicare program. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's most critical program to promote the health and income security of our senior and disabled populations.

In this testimony, I will provide an overview of the key results and discussions from the 2024 Medicare Trustees Report[1] and summarize certain important limitations of the current-law projections included in the report. Although the Trustees Report comprises three different sets of assumptions—intermediate, low-cost, and high-cost—my testimony will discuss the results of the intermediate assumptions only.

Medicare Overview

I will begin with an overview of the Medicare program. Medicare helps pay for health care services for the aged, disabled, and individuals with end-stage renal disease (ESRD). It has two separate trust funds: the Hospital Insurance trust fund (HI) and the Supplementary Medical Insurance trust fund (SMI). HI, otherwise known as Medicare Part A, helps pay for inpatient hospital services, hospice care, and skilled nursing facility (SNF) and home health services following hospital stays. SMI consists of Medicare Part B and Part D. Part B helps pay for physician, outpatient hospital, home health, and other services for individuals who have voluntarily enrolled. Part D provides subsidized access to drug insurance coverage on a voluntary basis for all beneficiaries and premium and cost-sharing subsidies for low-income enrollees. Medicare also has a Part C, which serves as an alternative to traditional Part A and Part B coverage. Under this option, beneficiaries can choose to enroll in, and receive care from, private Medicare Advantage and certain other health insurance plans, with payments being made from both the HI and SMI Part B trust fund accounts.

In 2023, Medicare covered 66.7 million people: 59.1 million aged 65 and older, and 7.6 million disabled. About 48 percent of these beneficiaries have chosen to enroll in Part C private health plans that contract with Medicare to provide Part A and Part B health services. Total Medicare expenditures in 2023 were $1,037.0 billion, and total income was $1,024.6 billion. Assets held in special issue U.S. Treasury securities decreased by $12.4 billion to $396.7 billion at the end of 2023.

[1] https://www.cms.gov/oact/tr/2024. This testimony cites language directly from the report.

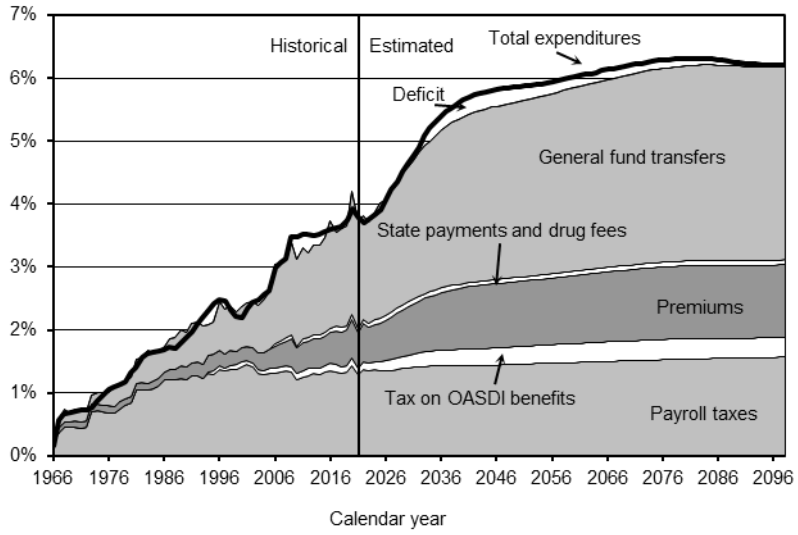
The Trustees Report evaluates the financial status of the HI and SMI trust funds. For HI, the Trustees apply formal tests of financial status for both the short range and the long range; for SMI, the Trustees assess the ability of the trust fund to meet incurred costs over the period for which financing has been set.

HI and SMI are financed in very different ways. Within SMI, current law provides for the annual determination of Part B and Part D beneficiary premiums and government contributions to cover expected costs for the following year. In contrast, HI is subject to substantially greater variation in asset growth, since employee and employer tax rates under current law do not change or adjust to meet expenditures except through enacted legislation.

Despite the significant differences in benefit provisions and financing, the two components of Medicare are closely related. HI and SMI operate in an interdependent health care system. Most Medicare beneficiaries are enrolled in HI and SMI Parts B and D, and many receive services from all three. Accordingly, efforts to improve and reform either component must necessarily have repercussions for the other components. In view of the anticipated growth in Medicare expenditures, it is also important to consider the distribution among the various sources of revenues for financing Medicare and the manner in which this distribution will change over time.

Figure I shows the past and projected amounts of Medicare revenues under current law excluding interest income, which will not be a significant part of program financing in the long range as trust fund assets decline. The figure compares total Medicare expenditures to Medicare non-interest income—from HI payroll taxes, HI income from the taxation of Social Security benefits, HI and SMI premiums, SMI Part D State payments for certain Medicaid beneficiaries, fees on manufacturers and importers of brand-name prescription drugs (allocated to Part B), and HI and SMI general fund transfers. The Trustees expect total Medicare expenditures to exceed non-interest revenue for all future years.

Figure I—Medicare Sources of Non-Interest Income and Expenditures as a Percentage of the Gross Domestic Product



As shown in figure I, for most of the historical period, payroll tax revenues increased steadily as a percentage of Gross Domestic Product (GDP) due to increases in the HI payroll tax rate and in the limit on taxable earnings, the latter of which lawmakers eliminated in 1994. Beginning in 2013, the HI trust fund receives an additional 0.9-percent tax on earnings in excess of a threshold amount.[2] The Trustees project that, as a result of this provision, payroll taxes will grow slightly faster than GDP.[3] Beginning in 2022, HI revenue from income taxes on Social Security benefits is expected to gradually increase as a share of GDP as the share of benefits subject to such taxes increases.[4]

The Trustees expect growth in SMI Part B and Part D premiums and transfers from the general fund of the Treasury to continue to outpace GDP growth and HI payroll tax growth in the future. This phenomenon occurs primarily because SMI revenue increases at the same rate as expenditures, whereas HI revenue does not. Accordingly, as the HI sources of revenue become increasingly inadequate to cover HI costs, SMI revenues will represent a growing share of total Medicare revenues. Government contributions are projected to gradually increase from 43 percent of Medicare financing in 2023 to about 50 percent in 2045, stabilizing thereafter. Growth in these contributions as a share of GDP adds significantly to the Federal budget pressures. SMI premiums will also increase at the same rate as SMI expenditure growth, placing a growing burden on

[2]Current law also specifies that individuals with incomes greater than $200,000 per year and couples above $250,000 pay an additional Medicare contribution of 3.8 percent on some or all of their non-work income (such as investment earnings). However, the revenues from this tax are not allocated to the Medicare trust funds.

[3]Although the Trustees expect total worker compensation to grow at the same rate as GDP after the first 10 years of the projection, wages and salaries are projected to increase more slowly than fringe benefits (health insurance costs in particular). Thus, projected taxable earnings (wages and salaries) gradually decline as a percentage of GDP. Absent any change to the tax rate scheduled under current law, HI payroll tax revenue would similarly decrease as a percentage of GDP. Over time, however, a growing proportion of workers will have earnings that exceed the fixed earnings thresholds specified in the law ($200,000 for single workers and $250,000 for married couples filing joint returns), and an increasing portion of taxable earnings will therefore become subject to the additional 0.9-percent HI payroll tax. The net effect of these factors is an increasing trend in payroll taxes as a percentage of GDP.

[4]See section V.C7 of the 2024 Old-Age and Survivors Insurance and Disability Insurance (OASDI) Trustees Report for more detailed information on the projection of income from taxation of Social Security benefits.

beneficiaries. High-income beneficiaries have paid an income-related premium for Part B since 2007 and for Part D since 2011.

The interrelationship between the Medicare program and the Federal budget is an important topic—one that will become increasingly critical over time as the general fund requirements for SMI continue to grow. Transfers from the general fund of the Treasury are the major source of financing for the SMI trust fund and are central to the automatic financial balance of the fund's two accounts, while representing a large and growing requirement for the Federal budget. SMI government contributions equaled 1.6 percent of GDP in 2023 and will increase to an estimated 3.1 percent in 2098 under current law. Moreover, in the absence of legislation to address the HI financial imbalance, interest earnings on trust fund assets and redemption of those assets will cover the difference between dedicated revenues and expenditures until 2036.[5] In 2035, this funding shortfall for the HI trust fund represents 0.2 percent of GDP.

The preceding discussion summarized the total financial obligation posed by Medicare and the manner in which it is financed. However, the HI and SMI components of Medicare have separate and distinct trust funds, each with its own sources of revenues and mandated expenditures. Accordingly, it is necessary to assess the financial status of each Medicare trust fund separately.

Financial Status of the Hospital Insurance Trust Fund

Expenditures from the HI trust fund exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018, 2019, and 2020, expenditures again exceeded income, with trust fund deficits of $1.6 billion, $5.8 billion, and $60.4 billion, respectively. The large deficit in 2020 was mostly due to accelerated and advance payments to providers from the trust fund. In 2021, there was a small surplus of $8.5 billion as these payments began to be repaid to the trust fund, and this continued repayment resulted in a larger surplus in 2022 of $53.9 billion. There was another small surplus of $12.2 billion in 2023, and fund surpluses will continue through 2029. Deficits are projected to return beginning in 2030 and to persist for the remainder of the projection period, requiring redemption of trust fund assets until the trust fund's depletion in 2036.

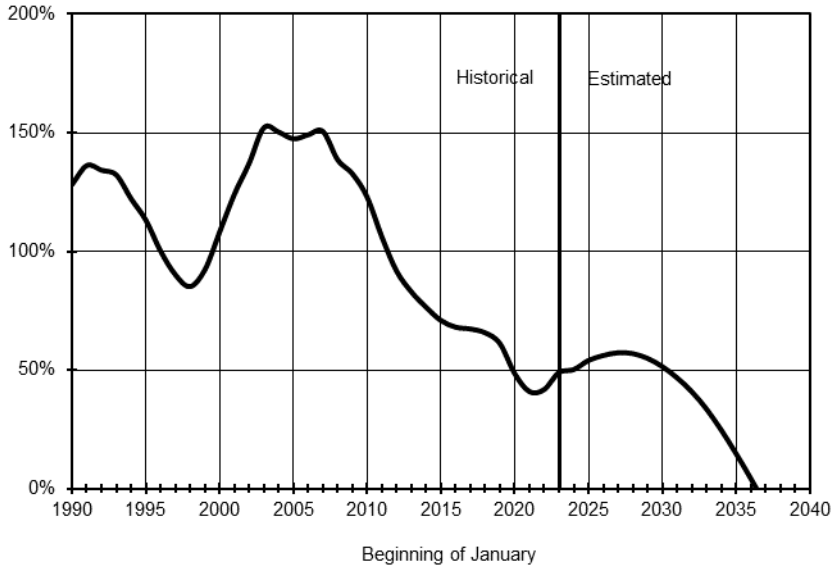
The Trustees apply an explicit test of short-range financial adequacy and, based on the 10-year projections, the HI trust fund does not meet this test because estimated assets are below 100 percent of annual expenditures and are not projected to attain this level under the intermediate assumptions. This outlook indicates the need for prompt legislative action to achieve financial adequacy for the HI trust fund throughout the short-range period.

Under the intermediate assumptions and excluding the effects of interest income, the assets of the HI trust fund would increase until 2027 and then steadily decrease as a percentage of annual

[5]After asset depletion in 2036, no provision exists to use transfers from the general fund of the Treasury or any other means to cover the HI deficit.

expenditures throughout the remainder of the short-range projection period, as illustrated in figure II. The ratio declines until the fund is depleted in 2036. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services could rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

Figure II—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures



There is substantial uncertainty in the economic, demographic, and health care projection factors for HI trust fund expenditures and revenues. Accordingly, the date of HI trust fund depletion could differ substantially in either direction from the 2036 intermediate estimate. For example, assets would increase throughout the entire projection period under the set of low-cost assumptions while asset depletion would occur in 2030 under the set of high-cost assumptions included the report.

The Trustees prepare 75-year estimates of the financial and actuarial status of the HI trust fund. Although financial outcomes are inherently uncertain, particularly over periods as long as 75 years, such estimates are helpful for assessing the trust fund's long-term financial condition.

Due to the difficulty in comparing dollar values for different periods without some type of relative scale, the Trustees show income and expenditure amounts relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll). The ratio of HI income (including payroll taxes, income from taxation of Social Security benefits, premiums, general fund transfers for uninsured beneficiaries, and monies from fraud and abuse control activities, but excluding interest income) to taxable payroll is called the *income rate*, and the ratio of expenditures to taxable payroll is the *cost rate*.[6]

[6]The Trustees estimate these costs based on when they are incurred rather than when they are paid.

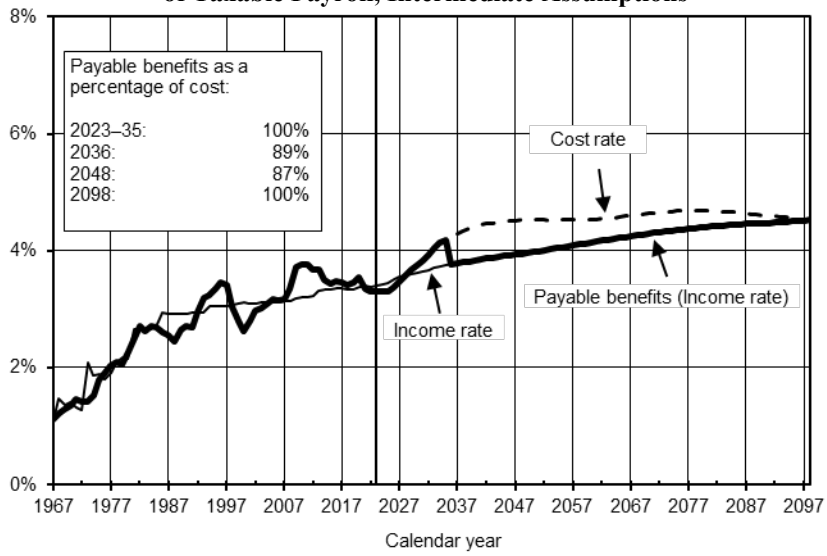
The standard HI payroll tax rate is scheduled to remain constant at 2.90 percent (for employees and employers, combined). In addition, starting in 2013, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Since income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers and their earnings will become subject to a higher HI tax rate. (By the end of the long-range projection period, an estimated 80 percent of workers would be subject to this additional tax.) Thus, HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Similarly, HI income from taxation of Social Security benefits will also increase faster than taxable payroll because the income thresholds determining taxable benefits are not indexed for inflation and because the income tax brackets are indexed to the chained Consumer Price Index (C-CPI-U), which increases at a slower rate than average wages. After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the C-CPI-U as specified in the Internal Revenue Code. As a result of this assumption, income from the taxation of Social Security benefits increases at a similar rate as, rather than significantly faster than, taxable payroll.

The cost rate has mostly been declining over the last decade largely due to expenditure growth that was constrained in part by low utilization and low payment updates. The cost rate increased in 2019, as taxable payroll growth slowed, and in 2020, as taxable payroll growth slowed because of the pandemic, but then it declined again in 2021 and 2022 as a result of a decrease in expenditures attributable to the impact of the pandemic. After remaining steady in 2023 through 2025, the cost rate is projected to rise in 2026 and beyond primarily due to an acceleration of health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.5 percent through 2033 and 1.0 percent thereafter. After 25, 50, and 75 years, for example, the prices paid to HI providers under current law would be 17 percent, 36 percent, and 50 percent lower, respectively, than prices absent the productivity reductions.

Figure III shows projected income and cost rates under the intermediate assumptions. As indicated, estimated HI incurred expenditures continue to exceed non-interest income for all projected years. (The projected excess of costs over non-interest income until 2036 is covered by interest earnings and the redemption of trust fund assets.)

The HI cost rate increases more rapidly than the income rate for most years through about 2044. The projected annual deficits expressed as a share of taxable payroll increase from 0.07 percent in 2029 to a high of 0.60 percent in 2044 and then gradually decrease and become a surplus of 0.01 percent by the end of the projection period. The convergence of growth rates for income and costs reflects the continuing effects of slower payment rate updates, assumed decelerating growth in the volume and intensity of services, and the increasing portion of earnings that are subjected to the additional 0.9-percent payroll tax. The percentage of expenditures covered by non-interest income is projected to decrease from 89 percent in 2036 to 87 percent in 2048 and then to increase to about 100 percent by the end of the projection period.

Figure III—Long-Range HI Non-Interest Income and Cost as a Percentage of Taxable Payroll, Intermediate Assumptions



It is possible to summarize the year-by-year cost rates and income rates shown in figure III into single values representing, in effect, the average value over a given period. Based on the intermediate assumptions, the Trustees project an HI actuarial deficit of 0.35 percent of taxable payroll for the 75-year period under current law, which represents the difference between the summarized income rate of 4.09 percent and the corresponding cost rate of 4.44 percent. As a result, the HI trust fund fails the Trustees' test for long-range financial balance, as it has every year since 1991 when this test was first applied.

The following two examples illustrate the magnitude of the changes needed to eliminate the deficit. For the HI trust fund to remain solvent throughout the 75-year projection period, (i) the standard 2.90-percent payroll tax could be immediately increased by the amount of the actuarial deficit to 3.25 percent, or (ii) expenditures could be reduced immediately by 8 percent.[7] More realistically, the tax and/or benefit changes could occur gradually but would require ultimate adjustments that would be higher than adjustments that were done immediately. Lawmakers have many options to address the long-range financial imbalance.

Financial Status of the Supplementary Medical Insurance Trust Fund

SMI comprises two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The Trustees determine the financial status of the SMI trust fund by evaluating the financial status of each account separately, since there is no provision in the law for transferring assets or income between the Part B and Part D accounts. The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general fund transfers for each part, are

[7]Under the two examples for addressing the actuarial deficit, tax income would initially be substantially greater than expenditures, and trust fund assets would accumulate rapidly. Subsequently, however, tax income would be inadequate, and assets would be drawn down to cover the difference. This example illustrates that if lawmakers designed legislative solutions to eliminate only the 75-year actuarial deficit, without consideration of such year-by-year patterns, then a substantial financial imbalance could still remain at the end of the period, and the long-range sustainability of the program could still be in doubt.

sufficient to cover the following year's estimated expenditures. Accordingly, each account within SMI is automatically in financial balance under current law. In contrast, HI and Old-Age and Survivors Insurance and Disability Insurance (OASDI) are primarily financed from payroll taxes. The financial assessment of the SMI program therefore differs in important ways from that for OASDI or HI.

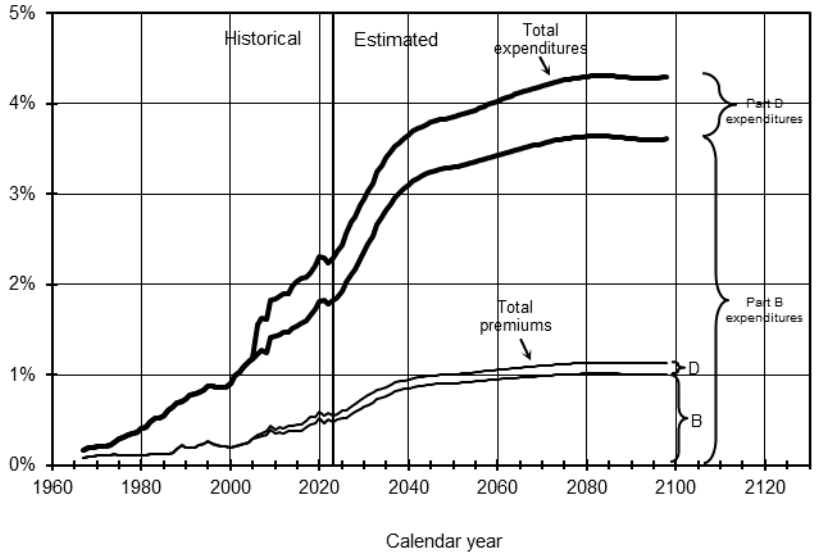
Financing for the SMI trust fund is generally adequate because beneficiary premiums and government contributions, for both Part B and Part D, are established annually to cover the expected costs for the upcoming year. Should actual costs exceed those anticipated when the financing is determined, future financing rates can include adjustments to recover the shortfall. Likewise, should actual costs be less than those anticipated, the savings would result in lower future financing rates. As long as the future financing rates continue to cover the following year's estimated costs, both parts of the SMI trust fund will remain financially solvent.

The primary test of financial adequacy for Parts B and D pertains to the level of the financing established for a given period (normally, through the end of the current calendar year). The financing for each part of SMI is considered satisfactory if it is sufficient to fund all services, including benefits and administrative expenses, provided through a given period. In addition, to protect against the possibility that cost increases under either part of SMI will be higher than expected, the accounts of the trust fund would normally need assets adequate to cover a reasonable degree of variation between actual and projected costs. For Part B, the Trustees estimate that the financing established through December 2024 will be sufficient to cover benefits and administrative costs incurred through that time period, and they estimate that assets will be adequate to cover potential variations in costs as a result of new legislation or cost growth factors that exceed expectations. The estimated financing established for Part D, together with the flexible appropriation authority for this trust fund account, would be sufficient to cover benefits and administrative costs incurred through 2024.

The amount of the contingency reserve needed in Part B is normally much smaller (both in absolute dollars and as a fraction of annual costs) than in HI or OASDI. A smaller reserve is adequate because the premium rate and corresponding general fund transfers for Part B are determined annually based on estimated future costs, while the HI and OASDI payroll tax rates are fixed under law and are therefore much more difficult to adjust should circumstances change. A statutory competitive bidding process establishes Part D revenues annually to cover estimated costs. Moreover, the flexible appropriation authority established by lawmakers for Part D allows additional general fund financing if costs are higher than anticipated.

While the SMI program is in financial balance, a critical issue is the impact of growth in SMI costs, which places greater demands on beneficiaries and taxpayers. Figure IV shows past and projected total SMI expenditures and premium income as a percentage of GDP. Total SMI expenditures amounted to 2.3 percent of GDP in 2023 and are projected to grow to about 4.1 percent of GDP within 40 years and to 4.3 percent by the end of the projection period under current law.

Figure IV—SMI Expenditures and Premiums as a Percentage of the Gross Domestic Product

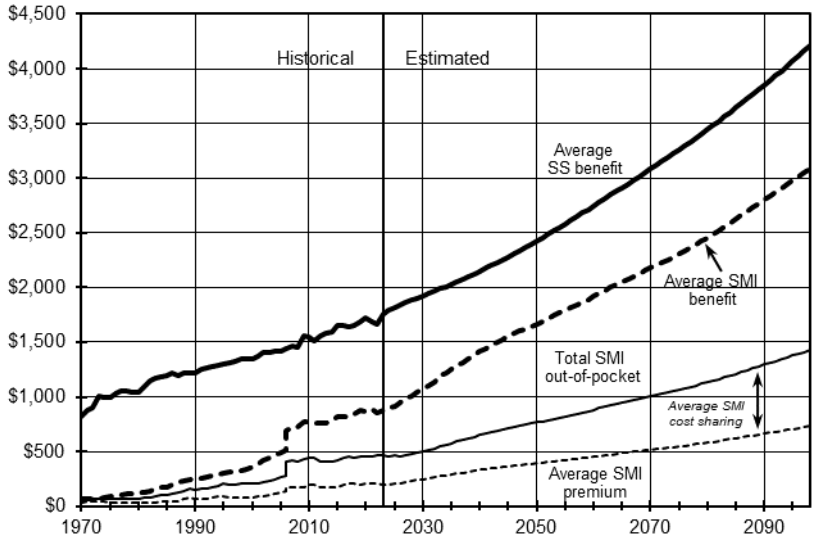


As SMI per capita benefits grow faster than average income or per capita GDP, the premiums and coinsurance amounts paid by beneficiaries represent a growing share of their total income. Figure V compares past and projected growth in average benefits for SMI versus Social Security. The figure also shows amounts for the average SMI premium payments and average cost-sharing payments. To facilitate comparison across long time periods, all values are in constant 2023 dollars.

Over time, the average Social Security benefit tends to increase at about the rate of growth in average earnings. Health care costs generally reflect increases in the earnings of health care professionals, growth in the utilization and intensity of services, and other medical cost inflation. As indicated in figure V, average SMI benefits in 1970 were only about one-twelfth the level of average Social Security benefits but had grown to more than one-third by 2005. With the introduction of the Part D prescription drug benefit in 2006, this ratio grew to almost one-half. Under the intermediate projections, SMI benefits would continue increasing at a faster rate and would represent nearly three-quarters of the average Social Security retired-worker benefit in 2098.

Figure V.—Comparison of Average Monthly SMI Benefits, Premiums, and Cost Sharing to the Average Monthly Social Security Benefit

[Amounts in constant 2023 dollars]



Average beneficiary premiums and cost-sharing payments for SMI will increase at about the same rate as average SMI benefits.[8] Thus, a growing proportion of most beneficiaries' Social Security and other income would be necessary over time to pay total out-of-pocket costs for SMI, including both premiums and cost-sharing amounts. Most SMI enrollees have other income in addition to Social Security benefits. Other possible sources include earnings from employment, employer-sponsored pension benefits, and investment earnings. In addition, most draw down their accumulated assets to supplement their income in retirement. For simplicity, the comparisons in figure V apply to Social Security benefits only; a comparison of average SMI premiums and cost-sharing amounts to average total beneficiary income would likely lead to similar conclusions. For illustration, the Trustees estimate that the average Part B plus Part D premium in 2024 would equal about 11 percent of the average Social Security benefit but would increase to an estimated 17 percent in 2098. Similarly, an average cost-sharing amount in 2024 would be equivalent to about 14 percent of the Social Security benefit but would increase to about 17 percent in 2098. The combination of premium and cost-sharing amounts for Parts B and D would equal about 26 percent of the average Social Security benefit in 2024 and would increase to an estimated 34 percent in 2098.

The availability of SMI Part B and Part D benefits greatly reduces the costs that beneficiaries would otherwise pay for health care services. The introduction of the prescription drug benefit increased beneficiaries' costs for SMI premiums and cost sharing, but it reduced their costs for previously uncovered services by substantially more. Figure V highlights the impact of rapid cost growth for a given SMI benefit package.

The average Old-Age and Survivors Insurance (OASI) benefit amount for all retired workers is the basis for the Social Security benefits shown in figure V; individual retirees may receive significantly more or less than the average, depending on their past earnings and other factors. For

[8]As a result, the projected ratio of average SMI out-of-pocket payments to average SMI benefits is nearly constant over time.

purposes of illustration, figure V shows the average SMI benefit value and cost-sharing liability for all beneficiaries. The value of SMI benefits to individual enrollees and their cost-sharing payments vary even more substantially than OASI benefits, depending on their income, assets, and use of covered health services in a given year. In particular, Medicaid pays Part B premiums and cost-sharing amounts for beneficiaries with very low incomes, and the Medicare low-income drug subsidy pays the corresponding Part D amounts (except for nominal copayments). Moreover, high-income beneficiaries have paid an income-related premium for Part B since 2007 and for Part D since 2011. Further information on the nature of this comparison, and on the variations from the average results, is available in a memorandum by the CMS Office of the Actuary at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Beneficiaryoop.html.

Another way to evaluate the implications of rapid SMI cost growth is to compare transfers from the general fund of the Treasury to the SMI trust fund with total Federal income taxes (personal and corporate income taxes). Table I shows SMI government contributions as a percentage of total Federal income taxes. Should such taxes in the future maintain their historical average level of the last 50 years relative to the national economy, then, based on the intermediate assumptions, SMI government contributions in 2098 would represent about 31.2 percent of total income taxes.

Table I—SMI Government Contributions as a Percentage of Personal and Corporate Federal Income Taxes

Fiscal year	Percentage of income taxes[1]
Historical data:	
1970	0.8%
1980	2.2
1990	5.9
2000	5.4
2010	19.6
2015	14.0
2016	16.2
2017	16.4
2018	16.8
2019	17.0
2020	19.6
2021	18.5
2022	13.3
2023	16.9
Intermediate estimates:	
2030	21.6
2040	26.7
2050	28.1
2060	29.4
2070	30.5
2080	31.3
2090	31.2
2098	31.2

[1]Includes the Part D prescription drug benefit beginning in 2006.

These examples illustrate the significant impact of SMI expenditure growth on beneficiaries, taxpayers, and the Federal budget. The projected SMI expenditure increases associated with the cost of providing health care, plus the impact of the baby boom generation reaching eligibility age,

would continue to require a growing share of the economic resources available to finance these costs. This outlook reinforces the Trustees' recommendation for development and enactment of further reforms to address the rate of growth in SMI expenditures.

Current Law Limitations

The Social Security Act requires the Trustees to evaluate the financial status of the Medicare trust funds. To comply with this mandate, the Trustees assess whether the financing provided under current law is adequate to cover the benefit payments and other expenditures required under current law. Accordingly, the estimates shown in the Trustees report are based on all of the current statutory requirements, including (i) the reductions in payment updates by the increase in economy-wide productivity for most non-physician provider categories; (ii) the physician payment updates specified by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for all future years; and (iii) the expiration of the bonuses for qualified physicians in advanced alternative payment models (advanced APMs) and in 2025 of the $500-million payments for physicians in the merit-based incentive payment system (MIPS).

There is substantial uncertainty regarding the adequacy of future Medicare payment rates under current law. The Trustees present an illustrative alternative scenario that reflects higher Medicare outlays that would result if certain statutory Medicare payment provisions were not fully implemented in all future years.

For all Part A services and some (most non-physician) Part B services, payment updates will be reduced in all future years by the increase in economy-wide productivity.[9] By the end of the long-range projection period, payment rates for affected providers would be significantly lower than their level in the absence of these reductions. In 2018, the Medicare payment rates for inpatient hospital services declined to about 60 percent of those paid by private health insurance.[10] If future improvements in productivity were to remain similar to what providers have achieved in the recent past (about 0.4 percent annually), then Medicare payment levels for inpatient hospital services at the end of the long-range projection period would be less than 40 percent of the corresponding level paid by private health insurance. This comparison assumes that private payer rate increases would continue to be set through the same negotiation process used to date, independent of the Medicare reductions or other health system changes. Specifically, private payer rates would grow by 2.8 percent per year, or the increase in the price of inputs to the provision of health care (3.2 percent) less the assumed growth in hospital productivity (0.4 percent). By comparison, Medicare payment rates would grow by 2.2 percent per year, or 3.2 percent less the assumed growth in economy-wide productivity (1.0 percent).

Physician payment updates similarly raise important long-range concerns that will almost certainly need to be addressed by future legislation. In particular, additional payments totaling $500 million per year and annual bonuses are scheduled to expire, resulting in a payment reduction for most physicians. In addition, current law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they

[9]In addition to the productivity adjustments, Medicare payments to providers will be affected by the sequestration of outlays in April 2013 through November 2032.

[10]See https://www.aha.org/system/files/media/file/2020/10/TrendwatchChartbook-2020-Appendix.pdf. Private payer hospital payments are roughly 45 percent above costs while Medicare hospital payments are roughly 13 percent below costs.

expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term.

In view of these issues, it is important to note that the actual future costs for Medicare may exceed the projections shown in the Trustees Report, possibly by substantial amounts. Use of an alternative projection can illustrate the potential magnitude of this difference.

It is conceivable that health care providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

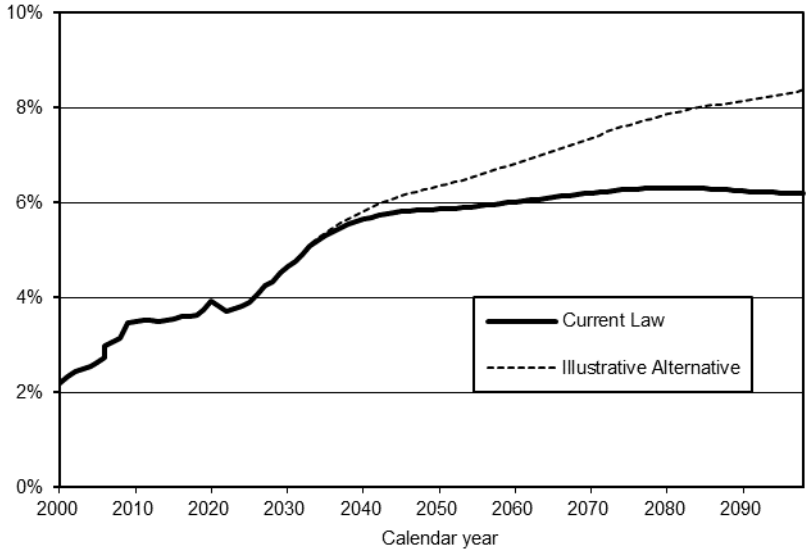
A transformation of health care in the U.S., affecting both the means of delivery and the method of paying for care, is also a possibility. Private health insurance and Medicare are taking important steps in this direction by initiating programs of research into innovative payment and service delivery models, such as accountable care organizations, patient-centered medical homes, improvement in care coordination for individuals with multiple chronic health conditions, better coordination of post-acute care, payment bundling, pay for performance, and assistance for individuals in making informed health choices. Such changes have the potential to reduce health care costs and cost growth rates and could, as a result, help lower health care spending to levels compatible with the lower price updates payable under current law.

The ability of new delivery and payment methods to lower cost growth rates is uncertain at this time. Preliminary indications are that some of these delivery reforms have had modest levels of success in lowering costs. It is too early to tell if these reductions in spending will continue or if they will grow to the magnitude needed to align with the statutory Medicare price updates. Given these uncertainties, it will be important for policymakers to monitor the adequacy of Medicare payment rates over time to ensure beneficiary access to high-quality care.

To help illustrate and quantify the potential magnitude of the cost understatement, a set of illustrative Medicare projections has been prepared under a hypothetical alternative in which Medicare spending reflects less than full implementation of the payment updates to providers specified under current law.

There are multiple ways in which the law could be changed if these provider updates prove unsustainable. The illustrative scenario presents just one possibility among many that demonstrates the degree to which the current-law projections may be understated. While a particular set of illustrative alternative update assumptions for specific years is used, the transition from current law to the illustrative alternative ultimate assumptions over time is intended to reflect an increasing likelihood of modifications to current law rather than a specific forecast of when current law will cease to be fully implemented. Figure VI compares the illustrative alternative projection with the projections under current law.

Figure VI—Medicare Expenditures as a Percentage of the Gross Domestic Product under Current Law and Illustrative Alternative Projections



The top curve in figure VI shows the cost levels under the illustrative alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028–2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period. Finally, the scenario assumes the continuation of the bonuses for qualified physicians in advanced alternative payment models (advanced APMs), which are expected to end after 2026, and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire after 2024. Under this alternative, the average long-range per beneficiary growth rate for all Medicare services would be similar to the long-range growth rate assumed for the overall health sector.

Under the illustrative alternative scenario, Medicare costs as a percentage of GDP continue to increase rapidly throughout the projection period, reaching 6.4 percent of GDP in 2050 and 8.4 percent in 2098—considerably higher than under current law (5.9 percent of GDP in 2050 and 6.2 percent of GDP in 2098).

Conclusion

The 2024 Medicare Trustees Report presents the financial pressures facing Medicare and notes that the earlier the reforms to address these pressures are enacted, the more flexible and gradual they can be. I concur with the Trustees' assessment and offer my assurance that the Office of the Actuary will continue to assist in evaluating potential legislation to address the financial challenges facing the Medicare program.