Op-Ed

Let's Not Forget About Medicare

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WITH SO MUCH ATTENTION FOCUSED ON THE Affordable Care Act (ACA) and its potential replacements or reforms, it is easy to forget about other looming health care challenges—but Medicare is the most serious among them. The slowdown in health care spending recently reported for 2016 may also make it even easier to put aside concerns over Medicare. Indeed, health care spending for 2016 grew at a rate of only 4.8%, a reduction of a full percentage point over the spending growth of 5.8% from 2015.¹ Centers for Medicare and Medicaid Services (CMS) projections for the next decade indicate that 2016 and 2017 are expected to have the slowest periods of growth—5.4% growth between 2016 and 2017—and will then accelerate. The higher growth in the previous year (2014–2015) was attributed primarily to the expansion in coverage from the ACA while the slower growth for 2016 is because coverage had generally stabilized for 2016.

CMS expects that this acceleration in health care spending during the decade after 2017 will be particularly sharp for Medicare and Medicaid. Individuals on Medicaid will become older over the decade and are more likely to be sicker and more costly. Medicare enrollment will only grow as the baby boomers (people born between 1946 and 1964) continue to age into Medicare. This will continue until the end of the next decade. By 2030, all of the baby boomers will have reached retirement age. The early waves of baby boomers who began to retire in 2011 will reach the age of 70 or older during this next decade, which will also increase the amount of health care they are expected to use.

The projections, like all government projections, assume current law continues. For the private sector of health care and for Medicaid, this is a more precarious assumption than usual since Congress and the Trump administration are in the throes of making decisions about the next round of health care reform. What is done, how it is done, and how soon

the changes occur will obviously affect projections about health care spending and coverage. Under current law, the insured rate is expected to remain at about 91% and should increase slightly to 91.5% by 2025. Of course, this number is extremely sensitive to the types of changes that may occur under any health care reform revisions.

What is unlikely to be affected is Medicare. This is so for two reasons: (1) President Trump has said he does not intend to change Medicare or Social Security, and (2) Medicare payments to the provider community were already substantially reduced when the ACA was adopted. And, of course, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will change how physicians are reimbursed under Medicare. But this law is only now beginning to go into effect. Changes may well be introduced in response to unanticipated outcomes associated with MACRA, but that will probably not happen until at least several years from now.

While projected spending levels for 1 to 2 decades are always subject to change and frequently wrong, the directional challenges awaiting Medicare are indisputable, even if the precise year when some of the event-forcing changes—like which year the Part A: Hospital Insurance Trust Fund becomes insolvent—may not be certain.

Medicare spending is currently projected to grow at 5.9% in 2017 and by 7.6% in 2025. Such growth is more rapid than Medicare spending has been increasing in past years and more rapidly than private sector spending is projected to rise.

Some of the growth in Medicare spending is because of enrollment growth. The annual growth in Medicare enrollment in 2017 is expected to be 2.8% and CMS is projecting the same growth for 2025. According to the actuaries, in the decade after 2030, Medicare will grow at a much slower pace of slightly under 1% per year. The growth in enrollment would be enough to stress Medicare financing even without a growth in spending per enrollee, but that, too, is expected to grow—3% this year and by 4.7% in 2025. This is in contrast to the last 2 years of unusually slow Medicare spending growth per enrollee of 1.7% and 1.6%, respectively, but not as rapidly as it grew a decade ago, when it grew by 6.8% in 2007.

Why is this a problem?

First, the Part A Trust Fund is projected to be depleted by 2028.² The threat of depletion has happened before and is an event-forcing occurrence since payments from Part A cannot be made for Medicare

inpatient hospital stays or other Part A benefits if the revenue plus any residual balances is less than the projected Part A costs. One remedy in the past has been to reduce pressure on the Part A Trust Fund by reducing reimbursement to some or all providers paid by Medicare from Part A. This happened under the Balanced Budget Act in 1997 and again as part of the ACA legislation in 2010. Alternatively, the financing of the Trust Fund, which comes from a portion of the FICA or Social Security tax, could be increased as it was under the ACA legislation.

The greater pressure, however, may well come more indirectly, such as from the growth in spending on Medicare Part B, which pays for physicians, outpatient hospital visits, etc., and Part D, which pays for outpatient drugs. Both of these are funded in part by premium payments and in substantial part by general revenue. They are a larger expenditure taken together than Part A and are each growing at a faster rate than Part A.³ While there is not an event-forcing moment comparable to the Part A insolvency, their growth will make other general revenue-funded expenditures of the federal government more challenging.

There are a variety of ways to improve the financial status of Medicare, including (1) increasing the age of eligibility, (2) reducing the benefits for some or all seniors, and (3) changing the structure and increasing the financing. The Speaker of the House, Representative Paul Ryan (R-WI), has favored “premium support” as a Medicare strategy, which he argues would produce better incentives, lead to better choices by seniors, and ultimately lower spending in Medicare. Premium support provides for a choice of plans, including traditional Medicare, with a subsidy for seniors set according to the cost of the lowest or second-lowest plan in an area, allowing seniors to choose the plan that suits their needs—a structure similar to the exchanges in the ACA.

However, even if there is a triple-crown strategy that includes a change in Medicare’s structure, an increase in eligibility age, and a change in benefits that is modified or related to income, the increased enrollment from baby boomer retirement combined with the increased spending per senior is likely to increase the need for more revenue. But increasing revenue should be the last change made—not the first. Otherwise, the challenge of making Medicare viable for the post-baby boom period is likely to be kicked down the road yet again.

References

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