

THE FUTURE OF MEDICARE



ADAPTED FROM:

The Alliance for Health Policy's Future of Medicare Series, a three-part series covering the basics of the Medicare program. *April – May 2022.*

BACKGROUND

Medicare is a federal health insurance program for people aged 65 and older, certain younger people with disabilities, and those with End-Stage Renal Disease or Amyotrophic Lateral Sclerosis. Medicare covers over 64 million lives and is projected to cover over 75 million individuals by [2030](#).

In recent years, policymakers have raised concerns around the program's future as Medicare's hospital insurance trust fund is projected to be depleted by [2028](#). To understand how to innovate within the program, a fundamental understanding of the program's structure is necessary.

4 PARTS OF MEDICARE

Part A: Covers inpatient hospital stays, skilled nursing facilities, hospice care, and some home health care. Most people pay no premium, but do face deductibles and coinsurance.

Part C: Known as Medicare Advantage, Part C combines the traditional Medicare benefits of Parts A and B, usually with Part D, in a single plan offered by private insurers, often including additional benefits.

Part B: Covers certain doctors' services, outpatient care, medical supplies, and preventive services with 20 percent cost sharing for most services, a deductible, and monthly premiums.

Part D: Covers prescription drugs. Offered by private insurers with cost sharing and monthly premiums that vary by plan.

Payment rates for each distinct part of Medicare are governed by an annual Centers for Medicare and Medicaid Services (CMS) rulemaking process and by corresponding payment systems. This includes the Inpatient Prospective Payment System for hospitals (Part A), the Skilled Nursing Facility Prospective Payment System (Part A), the Outpatient Prospective Payment System for outpatient care (Part B), and the Physician Fee Schedule (Part B). Other major Medicare payment systems include those for home health, hospice, ambulance services, Part B drugs, and durable medical equipment.

Medicare has traditionally followed a fee-for-services (FFS) system of payment where a provider performs a service and is paid for that service. To increase quality within the Medicare system, CMS has additionally implemented several new models of delivering health care services in recent years, known as value-based care models. Value-based programs reward health care providers with incentive payments for the quality and cost of care they give to people with Medicare. These value-based models are commonly tested under the Center for Medicare and Medicaid Innovation (CMMI) through a waiver authority instituted

through the passage of the Affordable Care Act. Under this authority, CMMI can test value-based payment models and expand them based on their success at reducing costs while improving or maintaining quality. This aligns with CMS' strategic vision of putting most Medicare beneficiaries into an accountable care arrangement by [2030](#).

Medicare Advantage (MA) functions as a managed care alternative to traditional Medicare, where private insurers administer the benefits. MA plans combine coverage for Parts A and B covered services, and frequently Part D drug coverage, and may include additional supplemental benefits. The beneficiary cost-sharing obligations may be above or below FFS but must be actuarially equivalent overall. MA plans are paid a monthly capitated amount per beneficiary by CMS that is risk adjusted to account for beneficiary differences in health status and other characteristics.

Medicare Part D is administered through private plans approved by the federal government. Medicare enrollees have 2 options for obtaining Part D coverage including 1) stand-alone prescription drug plans (PDPs) for enrollees in traditional FFS; or 2) Medicare Advantage Prescription Drug Plans (MA-PDs), covering all Medicare benefits including drugs. Medicare subsidizes nearly 75 percent of the cost of basic benefits for Part D enrollees. Funding of the Part D benefit is secured through transfers from general revenues and beneficiary premiums.

Although Medicare covers many health care services, traditional Medicare has relatively high deductibles and cost-sharing requirements, and places no annual limit on beneficiaries' out-of-pocket costs for services covered under [Parts A and B](#). Traditional Medicare also does not cover some health care services that many beneficiaries may need, such as dental care,

eye exams, eyeglasses, and hearing aids, or long-term care services and supports. These gaps in coverage may exacerbate health challenges, particularly for vulnerable beneficiaries. Health disparities among Medicare beneficiaries are in part driven by the unequal distribution of resources based on factors such as race and ethnicity, as well as [socioeconomic status](#).

Medicare beneficiaries face challenges in understanding the Medicare enrollment process and when to enroll. Individuals delaying taking Social Security do not receive information from the government about their initial Medicare eligibility at age 65, resulting in potentially delayed enrollment. Individuals who miss enrollment deadlines can face lifelong penalties and fees. Moreover, the enrollment process for Medicare is a complicated process. Medicare beneficiaries face complex choices with deciding between traditional Medicare, alone or with Medigap, and the range of Medicare Advantage plans and Part D plans.

Additionally, low-income Medicare beneficiaries must often navigate a fragmented set of coverage sources and financial assistance programs, including Medicaid, the Medicare Savings Programs, and the Part D Low-Income Subsidy (LIS) Program. These programs have enrollment processes and eligibility thresholds that vary by state. Medicare beneficiaries with chronic and cognitive conditions face additional challenges in navigating this patchwork of programs. Individuals dually eligible for Medicare and Medicaid often navigate separate administration of the Medicare and Medicaid programs, which have different benefits, provider networks, and administration processes.

Congress, the administration, and stakeholders are analyzing and proposing changes to the Medicare program to improve the program for beneficiaries, reduce costs to taxpayers, and improve

program administration. Such policy proposals include, but are not limited to, expansion of benefits, prescription drug reform, Medicare Advantage changes, addressing Medicare insolvency, and addressing the Medicare sequester.

Policy options to address Medicare insolvency are generally focused on the Part A Trust Fund (hospital spending) and not the entire program, because of the design of the Medicare trust funds. However, policy proposals focused on addressing Medicare's fiscal challenges more broadly

often focus on reforms in other parts of the Medicare program as well. Sustainability reforms run the full spectrum of more minimalist to more comprehensive and structural in nature. Additionally, Medicare enrollment growth and growth in spending per person are increasing spending across the Medicare program. Congress will need to decide who within the Medicare stakeholder sphere bears the burden of improving Medicare finances – beneficiaries, providers, high-income individuals, or unspecified future taxpayers.

RESOURCES

[Health Policy Handbook: Chapter 6](#)
Dual Eligible Beneficiaries

[Understanding the Future of COVID-Related Medicare and Medicaid Flexibilities](#)
Overview of COVID-Era Program Flexibilities

[Recent Trends in Coverage Enrollment and Affordability](#)
Current trends in enrollment, premiums, and out-of-pocket costs

[Medicare Payment Reform: Lessons Learned and Considerations for the Future](#)
Overview of federal value-based payment models

[Medicare Part D Basics and Policy Options for Redesign](#)
Defining characteristics of Medicare Part D



MEDICARE 101

This webinar highlighted Medicare's role in providing access to health care coverage for older adults, as well as people with disabilities or other qualifying health conditions. The program has a complex benefit design and uses varying mechanisms to determine payments to providers and health plans under each program. While Medicare provides comprehensive health coverage, many beneficiaries do not have access to certain services, including dental, vision, and hearing services. Out-of-pocket

cost sharing requirements also pose challenges for beneficiaries. The program's funding outlook is also troubling. The Medicare Hospital Insurance Trust Fund is projected to become insolvent within the next six years, meaning there will not be sufficient funds to cover the full expected cost of promised Part A benefits. The Hospital Insurance Trust Fund finances hospital care and other services for Medicare beneficiaries.

KEY TAKEAWAYS

- There are many complex factors within each prospective payment system, used to determine payment rates for various health care providers and services.
- The Inpatient Prospective Payment System determines payment rates for inpatient hospital services while the Outpatient Prospective Payment System covers a broader range of outpatient services. There are additional payment systems for home health, hospice, ambulance services, Part B drugs, and durable medical equipment.
- The Centers for Medicare and Medicaid Innovation (CMMI) was created to test new models of payment, quality, and care delivery. CMMI has tested many models, centering on value-based care where providers take responsibility for the quality and cost.
- Medicare Part C, or Medicare Advantage, is a managed care alternative to traditional Fee-For-Service Medicare, where the plan is administered by private insurers rather than the government. The plans are paid by CMS through a per member per month, payment structure.



"Payment policy is an extremely powerful tool to motivate desired changes in provider behavior."

– James E. Mathews, Ph.D., Executive Director, MedPAC

Content adapted from the April 22, 2022 webinar, "The Future of Medicare" View additional resources & expert lists [here](#).

UNDERSTANDING THE MEDICARE POPULATION AND CONSUMER AFFORDABILITY

This webinar provided an overview of Medicare coverage, and discussed gaps in traditional Medicare coverage, including dental, vision, hearing, and long-term services and supports. The panel also discussed disparities that exist in the Medicare program and among Medicare

beneficiaries. It also highlighted the fragmented system of coverage for dually eligible beneficiaries, and the confusing Medicare enrollment process. Panelists presented policy options to address these challenges in the Medicare program.

KEY TAKEAWAYS

- There are a number of services, including vision, dental, and hearing, that are not covered by traditional Medicare, and traditional Medicare also carries relatively high deductible and cost-sharing requirements.
- Racial and ethnic disparities exist in the Medicare program.
- Dually eligible beneficiaries have to navigate a complex and fragmented coverage system.
- Medicare enrollment processes are often complex and misunderstood which can have negative, long-term impacts on Medicare beneficiaries.



“There is increased attention to leveraging the Medicare program to advance health equity and reduce health disparities.”

– Loren Saulsberry, Ph.D., The University of Chicago Department of Public Health Sciences

“Low-income Medicare beneficiaries navigate a fragmented and often confusing set of coverage sources and financial assistance programs.”

– Eric T. Roberts, M.D., Ph.D., University of Pittsburgh School of Public Health



*Content adapted from the May 6, 2022 webinar, "Understanding the Medicare Population and Consumer Affordability"
View additional resources & expert lists [here](#).*

POLICY OPTIONS TO IMPROVE MEDICARE SUSTAINABILITY

The Medicare Hospital Insurance Trust Fund is projected to become insolvent within the next six years, meaning there will not be sufficient funds to cover the full cost of promised Part A benefits. The Hospital Insurance Trust Fund finances hospital care and other services for Medicare beneficiaries

This session focuses on the implications of policy options to promote Medicare sustainability. Panelists explored trends in Medicare spending; introduced key concepts related to Medicare financing and solvency; and explored the implications of policy options to promote Medicare sustainability.

KEY TAKEAWAYS

- Some 64 million elderly and disabled Americans rely on Medicare for their health insurance, but the program faces serious short and long-term financial pressures.
- Current estimates show that the HI Trust Fund will be insolvent by 2028.
- The program is composed of two parts – the Hospital Insurance Fund (HI or Part A Trust Fund) which pays for hospitals and institutional services and the Supplemental Medical Insurance (SMI or Part B Trust Fund) which pays for physician’s outpatients services and Part D drugs.
- The HI Trust Fund’s structure places a constraint on its spending, such that when there is insufficient funds, payments to providers must be reduced. The SMI Trust Fund has no such constraint.
- Panelists thought that an approach combining increasing revenues with targeted spending reductions would be most effective. All emphasized the need to reduce impact on beneficiaries.



“The different approaches we would take for solving Medicare insolvency will have different implications for who will bear the burden of improving Medicare finances.”

– Bowen Garrett, Ph.D., Urban Institute

Content adapted from the May 20, 2022 webinar, "Policy Options to Improve Medicare Sustainability." View additional resources & expert lists [here](#).