



Bipartisan Policy Center

# Sustaining and Improving Medicare

---

**THE PATH FORWARD**

**December 2023**

---

## STAFF

### Tara Hartnett

Policy Analyst

### Marilyn Serafini

Executive Director

### G. William Hoagland

Senior Vice President

### Hanna Vohra, J.D.

Policy Analyst

### Aidan Kennedy

Project Associate

---

## CONSULTANTS

### ATI Advisory (Technical and Estimating Support)

---

## HEALTH PROGRAM

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., the Bipartisan Policy Center's Health Program develops bipartisan policy recommendations that will improve health care, lower costs, and enhance coverage and delivery. The program focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

## ACKNOWLEDGMENTS

BPC would like to thank Arnold Ventures for its generous support of this project. We would also like to thank the members of BPC's Medicare Sustainability Advisory Group, who shared their expertise on the challenges and opportunities in the Medicare program:

- Sheila Burke, MPA, RN, Strategic Advisor, Chair, Government Relations & Public Policy, Baker Donelson and Faculty, Research Fellow, JFK School of Government, Harvard University
- Kathleen Buto, Principal, Kathleen Buto Consultants, LLC
- James Capretta, Senior Fellow and Milton Friedman Chair, American Enterprise Institute
- Juliette Cubanski, Deputy Director, Program on Medicare Policy, KFF
- Matthew Fiedler, Ph.D., Brookings Schaeffer Initiative on Health Policy, Brookings Institution
- Chris Jennings, President, Jennings Policy Strategies
- Mark E. Miller, Executive Vice President of Health Care, Arnold Ventures
- Tricia Neuman, Sc.D., Executive Director, Program on Medicare Policy, KFF
- Dean Rosen, Partner, Mehlman Consulting
- Cori Uccello, Senior Health Fellow, American Academy of Actuaries

We also want to thank the federal health policy experts, national organizations, providers, payers, beneficiary representatives, and academicians, who all provided insights into this policy area. BPC also thanks Lee Fleisher and Richard Hirth for advising BPC's Health Program and sharing their expertise for this report.

## DISCLAIMER

BPC had complete editorial control of this report. The findings and recommendations expressed herein do not necessarily represent the views or opinions of any of BPC's Medicare Sustainability Advisory Group members, their employer, institution, or organization, or of BPC's founders, funders, advisers, or board of directors.

# Table of Contents

---

**4 EXECUTIVE SUMMARY**

---

**10 OVERVIEW**

---

**17 POLICY RECOMMENDATIONS**

**17 Phase 1: Strengthen Medicare Through Immediate Reforms**

*18 Restructure the Traditional Medicare Benefit*

*27 Reduce Costs and Increase Revenues to Address Trust Fund and Financial Challenges*

*41 Adopt Changes in Medicare Advantage*

*53 Enforce a Workable Trigger Mechanism*

**58 Phase 2: Ensure Fair Competition Between Traditional Medicare and Medicare Advantage**

---

**61 CONCLUSION**

---

**62 APPENDIX A: SAVINGS ESTIMATES**

---

**63 APPENDIX B: COMPARISON OF THE TRADITIONAL MEDICARE BENEFIT UNDER CURRENT LAW AND THE PROPOSED RESTRUCTURED MEDICARE BENEFIT**

---

**65 GLOSSARY OF ACRONYMS**

---

**66 ENDNOTES**

# Executive Summary

---

More than 65 million older Americans and those with disabilities rely on Medicare for health care, but as the population rapidly ages, the program faces increasingly urgent financial challenges. Indeed, expenditures in recent years have consistently outpaced dedicated revenue streams. With Medicare's Hospital Insurance (HI) Trust Fund facing insolvency by 2031, and with beneficiaries and taxpayers frustrated by the lack of progress in ensuring greater affordability, policymakers must overcome their political fears of addressing the problems and focus on reforms that will sustain and improve Medicare in the coming years.

Central to ensuring Medicare's long-term survival is for Congress to address the program's core financial issue—the gap between rising spending and lagging revenue. Medicare now covers nearly 20% of the U.S. population, and total expenditures for benefits are projected to exceed \$1 trillion this year, up from \$580 billion only 10 years ago.<sup>1,2,3,a</sup> The number of workers who help finance the program through payroll taxes relative to the number of beneficiaries is declining. There were about four workers for every beneficiary from 1980-2008; by 2022, the number had dropped to about 2.9, and by 2030 it is expected to be 2.5.<sup>4</sup>

Congress also needs to examine a second significant problem: how Medicare can better meet the needs of enrollees. Beneficiaries, many of whom are retirees on fixed incomes, are struggling to pay their share of expenses and navigate a complex Medicare system to find the right coverage and benefits. Health care advocates question the program's fairness, too, as some enrollees get benefits that others do not, depending on which coverage options they select.

In this report, the Bipartisan Policy Center issues recommendations for Congress to improve the program—both its financing and the benefits it provides. BPC's 2021 report, [The Cost of Waiting to Act on Medicare's Hospital Insurance Trust Fund](#), points to recurring examples of policymakers' hesitancy to address reform, analyzes various reform proposals, and demonstrates that waiting only increases the price of action.<sup>5</sup>

Congress has been reluctant to address Medicare's long-term solvency, due largely to the scale of the financial adjustments required and aversion to the political risks involved. Reforming Medicare undoubtedly will invite political opposition: Older Americans turn out for key elections in disproportionately high numbers.<sup>6</sup> Earlier in 2023, when some in Congress suggested restraining

---

<sup>a</sup> These are gross amounts that do not account for offset by premium payments. In 2023, offset-by-premium amounts are projected to be \$835 billion, up from \$502 billion 10 years ago, a 5.2% annual rate of increase over this period.

Medicare spending as part of a deal to raise the debt ceiling limit, others strongly opposed the move. In his State of the Union address in February 2023, President Biden urged both parties to commit to keeping Medicare benefits unchanged.<sup>7</sup> In a rare demonstration of unity, both Democrats and Republicans stood and applauded. Without a politically viable path toward bipartisan compromise, Congress took Medicare changes off the table and raised the debt ceiling in May without addressing the challenges facing the program when it passed the [Fiscal Responsibility Act of 2023](#).<sup>8</sup>

That said, a politically viable path forward is possible, and this report outlines how. It is not without precedent for Congress to act on a bipartisan basis to address Medicare's cost and solvency issues. Examples include but are not limited to the Social Security Act Amendments of 1983, which established a new prospective payment system for inpatient hospital services, and the Balanced Budget Act of 1997, which established both a prospective payment system for outpatient services and Medicare Part C.<sup>9</sup> Both examples occurred when divided government existed, which is to say different parties held the White House and at least one chamber of Congress. Indeed, the political divide is virtually a prerequisite to avoid the temptation to politicize any effort to improve Medicare. These previous accomplishments demonstrate policymakers' ability to come together when the need arises and leaders of the two parties lead.

This report creates a road map for bipartisan action that Congress should pursue in a two-step process. The changes in the first step would secure meaningful improvements that would make Medicare more affordable for the federal government, taxpayers, and beneficiaries. It also lays the foundation for a second set of fundamental reforms that build upon the first step's goals by ensuring further simplification for beneficiaries and promoting competition within the program.

The road map's first step, outlined in Phase 1 below, calls on Congress to immediately address the HI Trust Fund's impending insolvency and affordability challenges for beneficiaries by slowing spending increases and raising revenues. At the same time, policymakers would enhance Traditional Medicare (TM) by improving benefits, reducing costs, and simplifying the program for easier access.

Phase 1 also addresses enforcement of past triggers that Congress has instituted—but ignored—to force action when federal spending on Medicare dangerously exceeds revenues. To be sure, important new prescription drugs and devices are contributing to Medicare's increased spending, and that should be a factor for policymakers to consider as they make decisions about appropriate levels of spending. Nevertheless, it will be important to fix the current general revenue trigger so that it more effectively pressures Congress and the administration to take corrective steps as appropriate to ensure the program's financial sustainability.

The recommendations in the second step, outlined in Phase 2, would create apples-to-apples competition between Traditional Medicare and Medicare Advantage (MA), allowing beneficiaries to easily compare these coverage options based on a standard set of benefits.

It is crucial for Congress to embrace both parts of this road map; rationalizing and improving how MA plans and TM fairly compete within an improved competitive policy will not in and of itself address all solvency and affordability issues facing the program. Because of demographics, Medicare's costs will increase regardless of how efficient the program becomes; enhanced revenues and payment reforms, as a result, will have to be part of any bipartisan compromise that thoughtfully deals with solvency.

BPC also encourages the Senate to swiftly engage in full, fair, and prompt consideration of the Social Security and Medicare public trustees. The Senate Finance Committee approved two nominees on November 2, 2023, but a full Senate vote is required, and at the time of publication, the Senate had not moved forward. In addition to the four trustees who are members of the administration, the two public trustees serve as objective experts who report on the status of the trust funds to Congress and the American people; they also provide credibility for the annual reports. Since 2015, these two positions have been vacant due to Senate inaction. Congress should ensure that these positions are consistently filled moving forward.

## **BPC'S ROAD MAP INCLUDES THE FOLLOWING MAJOR PROPOSALS:**

---

### **1. Phase 1: Strengthen Medicare Through Immediate Reforms**

#### **A. Restructure the Traditional Medicare Benefit**

##### **i. Restructured Benefit Elements**

- Congress should establish an annual out-of-pocket limit for beneficiaries enrolled in Traditional Medicare set at the weighted average of the benefit currently provided by Medicare Advantage plans (and indexed to inflation) to protect beneficiaries from catastrophic expenses.
- Congress should establish a single, annual deductible for beneficiaries enrolled in Parts A and B.

##### **ii. Medigap: Options for Congressional Consideration**

- Congress could restructure Medigap plans by restricting first dollar coverage for Medicare-covered services.

- Congress could impose an additional charge on Medigap plans based on the coverage offered.

### **iii. Beneficiary Protections**

- Congress and the Centers for Medicare & Medicaid Services (CMS) should take steps to streamline the eligibility requirements and enrollment processes of the Medicare Savings Programs to align them more with the Part D Low-Income Subsidy program.

### **iv. Enrollment Processes**

- CMS should work with the Social Security Administration to streamline the beneficiary enrollment processes for all parts of Medicare. CMS should also update the Medicare Plan Finder tool to allow beneficiaries to see all their costs in one place, including the catastrophic limit in TM; the single, annual deductible for Parts A and B; the cost and benefits of Part D; and a standardized comparison of provider networks.
- Congress should increase support for the State Health Insurance Assistance Program and reauthorize and increase support for the Medicare Improvements for Patients and Providers Act programs.

## **B. Reduce Costs and Increase Revenues to Address Trust Fund and Financial Challenges**

### **i. Post-acute and Hospice Care Provider Payments**

- Congress should reduce base payments to skilled nursing facilities by 3 percentage points, home health care agencies by 3 percentage points, and inpatient rehabilitation facilities by 7 percentage points.
- Congress and CMS should pursue value-based initiatives in the post-acute care setting, including implementing value-based purchasing programs for inpatient rehabilitation facilities and long-term care hospitals and encouraging the integration of post-acute care providers in innovative payment models.
- Congress should wage adjust and reduce the hospice aggregate cap by 20%.

### **ii. Site-neutral Payments**

- As an element of comprehensive Medicare reform, Congress should align payments for outpatient services commonly performed in physician offices at a site-neutral rate across ambulatory settings.

### **iii. Tools for Better Fee-for-service Management**

- Congress should require CMS to initiate a selective contracting

program, after an initial test period, for certain high-volume services, including diagnostic laboratory tests, imaging services, and others, as appropriate.

#### **iv. Increased Revenues: Congress Must Raise Revenues; Options for Consideration**

- Congress could increase the payroll tax rate on total earnings.
- Congress could increase revenues from the Net Investment Income Tax by expanding its base and dedicating the added receipts (above what is collected under current law) to the HI Trust Fund.
- Congress could establish lower income thresholds for the Part B and D premium surcharges that beneficiaries pay due to the income-related monthly adjustment amount (IRMAA).

### **C. Adopt Changes in Medicare Advantage**

#### **i. Risk Adjustment**

- CMS should modify risk adjustment methodology to use two years of diagnostic data.
- Congress and CMS should exclude diagnoses identified through health risk assessments from risk score calculations.
- For any difference in coding intensity still remaining, CMS should increase the across-the-board coding intensity adjustment to Medicare Advantage plan payments.
- Congress should expand the scope of the risk adjustment data validation audit program or conduct prepayment reviews and impose a financial penalty for Medicare Advantage Organizations that are found to be submitting unverified diagnoses beginning in 2025.

#### **ii. Quality Bonus Program**

- Congress and CMS should alter the MA Quality Bonus Program by removing the benchmark quality bonuses associated with it and replacing it with a budget-neutral quality incentive that utilizes a smaller set of meaningful performance metrics.

#### **iii. Competition in Medicare Advantage**

- Congress should direct CMS to design a competitive bidding system for Medicare Advantage Organizations. The bidding system should include a standard benefit with a higher actuarial value than fee-for-service (FFS) that all plans must offer, a benchmark based on the enrollment-weighted average of the bids submitted, and tiered packages to include supplemental benefits.



#### **D. Enforce a Workable Trigger Mechanism**

- As a stopgap until Medicare is reformed, the executive branch and Congress should enforce the current Medicare trigger warning established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- Congress should review, reconsider, and modify the Medicare funding warning in current law.

#### **2. Phase 2: Ensure Fair Competition Between Traditional Medicare and Medicare Advantage**

- Congress should strengthen Medicare by promoting fair competition between Traditional Medicare and Medicare Advantage plans, with the intent of simplifying and improving choices while also constraining cost growth to ensure the program's long-term sustainability. The steps required for this reform are a natural extension of the changes proposed in Phase 1. The combined changes are proposed in two steps because it will take somewhat longer to prepare TM for fair competition than is the case with MA plans, and there is urgency for moving the existing MA program into a better system of payment because of the challenges of fair risk adjustment.
- This recommendation creates a standard set of benefits that enrollees would be able to compare across TM and MA. These reforms provide a unique opportunity to thoughtfully improve the structural design, benefits, and financing of the program.



# Overview

Medicare, which Congress created in 1965, is a federal health insurance program for Americans ages 65 and older, those under 65 with certain long-term disabilities, and people of all ages with End-Stage Renal Disease.<sup>10</sup> The following overview identifies key trends and persistent challenges that are stressing the Medicare program for both beneficiaries and the federal government.

## WHAT'S DRIVING MEDICARE SPENDING INCREASES?

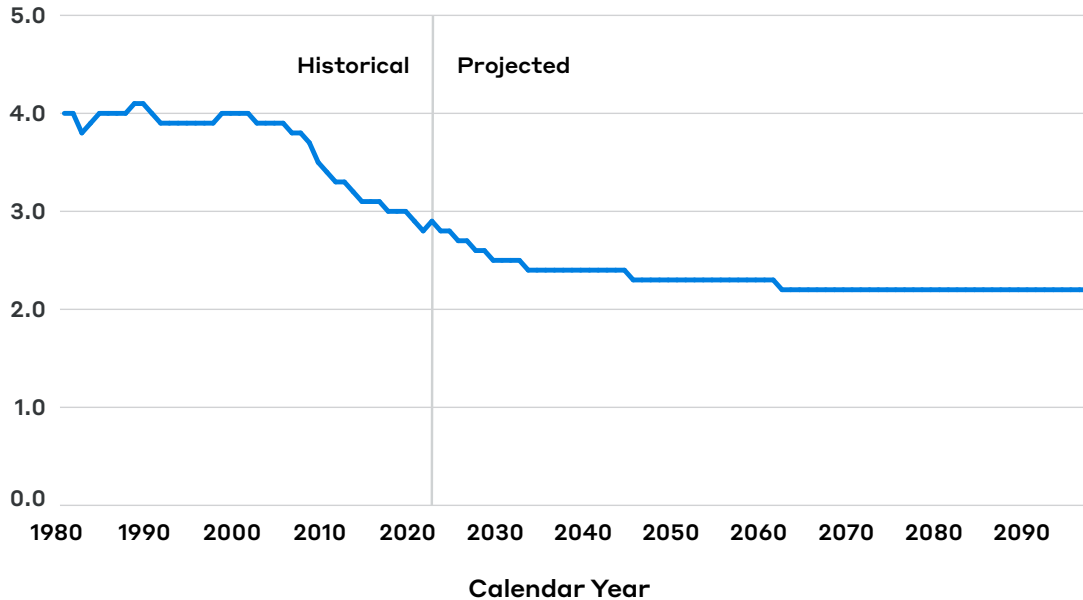
---

Today, Medicare covers more than 65 million people—almost 20% of the U.S. population—the share of which will continue to rise as the baby boom generation ages and life expectancy increases.<sup>11</sup> In 2060, Medicare is projected to cover more than 90 million beneficiaries, nearly a quarter of the U.S. population.<sup>12</sup>

Additionally, with the first baby boomers having reached the age of 75 in 2021, the rapidly expanding aging population necessitates increased care and greater associated expenditures per person. In contrast, the number of workers who help finance the program through payroll taxes relative to the number of beneficiaries is expected to continue to decline.<sup>13</sup> There were about 4 workers for every beneficiary from 1980-2008; by 2022, the number had dropped to about 2.9, and by 2030 it is expected to fall to 2.5.<sup>14</sup>

### Figure 1. Workers per Beneficiary<sup>15</sup>

The number of workers per Medicare beneficiary decreased from 4 in 1980 to about 2.9 in 2022 and is expected to be 2.5 in 2030.

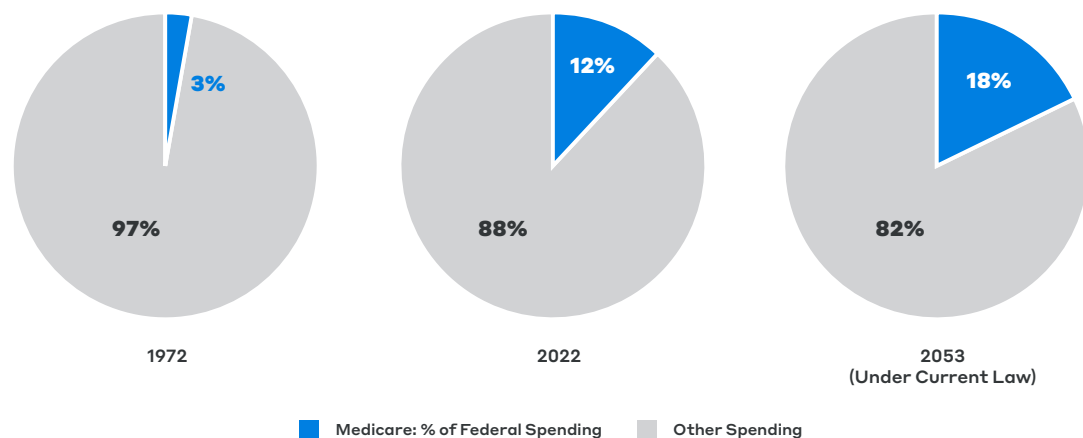


Adapted from 2023 Medicare Trustees Report.

In 2023, total expenditures for Medicare benefits, offset by premium payments, are projected to reach \$834 billion, up from \$502 billion 10 years ago—a 5.2% annual rate of increase over this period.<sup>16,17</sup> Representing the second-largest federal spending program after Social Security, Medicare accounted for 12% of total federal spending and about 3% of the gross domestic product (GDP) in 2022 and is projected to account for 18% of federal spending in 2053 (see Figure 2).

### Figure 2. Medicare's Share of the Federal Budget<sup>18</sup>

In 1972, Medicare spending accounted for only 3% of the federal budget. That figure reached 12% in 2022. By 2053, Medicare is projected to account for 18% of the federal budget.

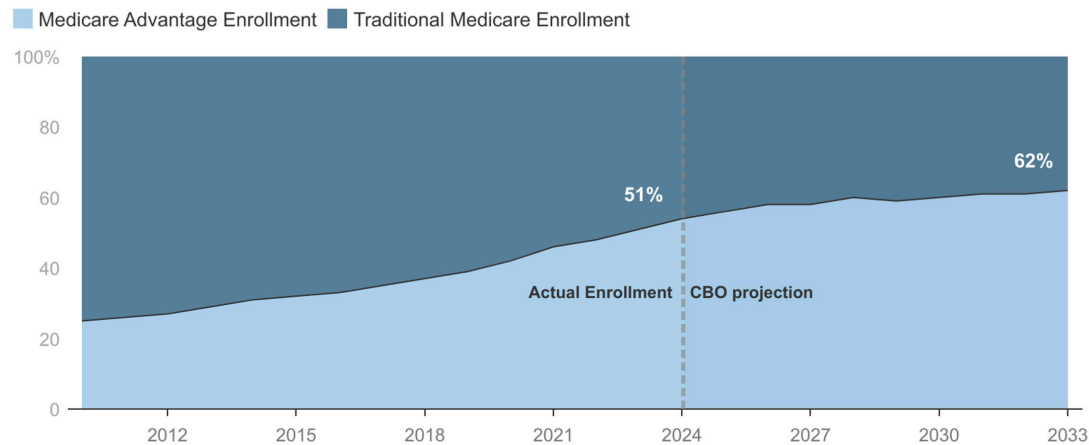


Adapted from Peter G. Peterson Foundation.

In addition to the growing number of beneficiaries, including older enrollees who need a greater level of care, other cost drivers include the introduction of expensive new technologies, rising prescription drug prices, and a shift to Medicare Advantage (MA). MA is a private plan alternative to Traditional Medicare (TM). More than half of all Medicare enrollees now choose Medicare Advantage over Traditional Medicare, and that number is increasing. It is important to note that according to a [2023 MedPAC report](#), the federal government is paying about 6% more per beneficiary for those in MA in 2023 than for those in TM.<sup>19</sup> Thus, as the percentage of enrollees in MA increases, so too does overall federal Medicare spending.

**Figure 3. Medicare Advantage and Traditional Medicare Enrollment, Past and Projected<sup>20</sup>**

More than half of Medicare beneficiaries (51%) have moved into Medicare Advantage, and the Congressional Budget Office (CBO) projects that 62% will choose MA over TM by 2033.



Adapted from KFF.

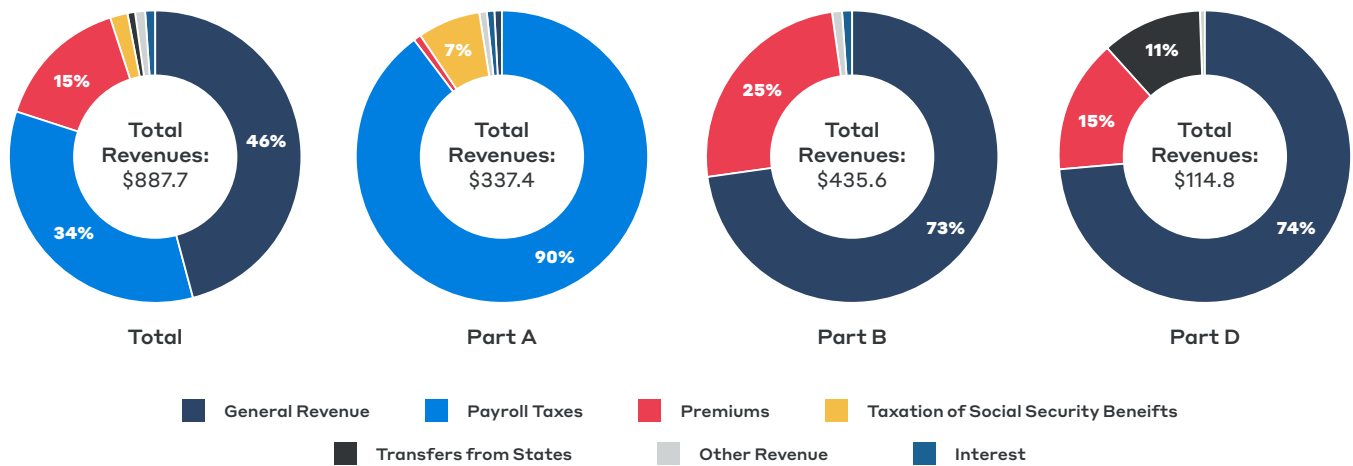
## MEDICARE FINANCING AND TRUST FUNDS

Medicare is composed of four parts—Part A (inpatient services), Part B (outpatient services), Part C (private MA plans), and Part D (private prescription drug benefit). Parts A and B make up Traditional Medicare, also known as Original Medicare or Medicare fee-for-service (FFS). Part C, more commonly known as Medicare Advantage, is made up of private health plans that provide all Medicare-covered services, as well as additional benefits not covered in TM, such as reduced cost sharing and dental, vision, and hearing services.<sup>21</sup> Most beneficiaries also enroll in Part D prescription drug plans, either through stand-alone prescription drug plans, MA plans with prescription drug coverage, or plans for certain beneficiary populations, such as retirees and MA special needs plans (SNPs).<sup>22</sup>

Medicare has two distinct trust funds—the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds, which handle Medicare’s revenues and expenditures.<sup>23</sup> The HI Trust Fund pays for Medicare benefits covered under Part A and some program administration costs.<sup>24</sup> The SMI Trust Fund pays for Medicare benefits covered under Parts B and D, as well as some program administration costs.<sup>25</sup> Both trust funds contribute to Part C, or MA, through a prospective, capitated payment system.<sup>26</sup>

**Figure 4. Medicare Revenue Sources, in Billions, for Calendar Year 2021<sup>27</sup>**

Medicare is primarily financed through payroll taxes, general revenues, and beneficiary premiums. Each part of Medicare is financed differently.



Adapted from KFF.

Each year, the Board of Trustees for Medicare reports to Congress on the financial operations and actuarial status of the program, specifically on the financial future of the HI and SMI trust funds.<sup>28</sup> According to the 2023 Medicare Trustees Report, the HI Trust Fund will become insolvent in 2031.<sup>29</sup> This is a three-year reprieve from the trustees’ projections in 2022, which predicted insolvency by 2028.<sup>30</sup>

Total HI Trust Fund spending is projected to exceed revenue by \$333 billion over the next decade.<sup>31</sup> The [2023 Medicare Trustees Report](#) highlighted a growing need for general revenues to meet enrollee benefits throughout the program. “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,” the report said. “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.”<sup>32</sup>

Overall, the trustees projected federal contributions to increase from 43% of Medicare spending in 2022 to about 49% by 2040. They predicted that SMI premiums will rise on track with SMI spending growth, requiring increased contributions from beneficiaries. SMI expenditures accounted for 1.8% of GDP in 2022, up from 0.9% in 2000. By 2097, they are expected to reach 3% of GDP, according to the trustees.<sup>33</sup>

## Medicare Part A (Hospital Insurance)

Part A has been a persistent focus of attention from policymakers as the HI Trust Fund insolvency date approaches and is now projected to occur in 2031. The HI Trust Fund's depletion could mean that providers such as hospitals, nursing facilities, and hospices would suffer, which would undermine access to and possibly quality of care for many beneficiaries.<sup>34</sup> The trustees project that once the funds are depleted in 2031, the program could only then pay 89% of benefits, indicating an 11% reduction.<sup>35</sup>

Part A covers inpatient care in hospitals, skilled nursing facilities (SNFs), hospice care, and some home health care.<sup>36</sup> In 2024, the inpatient hospital deductible will be \$1,632, which covers the first 60 days of care.<sup>37</sup> For extended inpatient stays, beneficiaries have a daily coinsurance amount of \$408 for days 61 through 90, \$816 for lifetime reserve days, and \$204 for SNF stays for days 21 through 100.<sup>38</sup>

Part A benefits are primarily financed through a 2.9% payroll tax on earnings paid by employers and employees, or 1.45% each.<sup>39</sup> In 2021, payroll taxes accounted for 90% of Part A's revenue.<sup>40</sup> The remaining sources of revenue include taxes on Social Security benefits, interest on federal securities, and beneficiary premiums.<sup>41</sup> Notably, virtually all beneficiaries do not pay a Part A premium because they or their spouse meet a requirement for a minimum number of quarters worked.<sup>42</sup>

## Medicare Part B (Supplementary Medical Insurance)

Part B covers outpatient services from physicians and other health care providers, some home health care, durable medical equipment, and many preventive services.<sup>43</sup> Unlike Part A, enrollment in Part B is voluntary; however, the majority of beneficiaries enroll in both Parts A and B—or, alternatively, in MA plans. For Part B benefits, enrollees must pay a standard monthly premium, an annual deductible of \$240, and a coinsurance rate of 20% for most physician visits, excluding annual wellness visits and preventive services.<sup>44</sup>

Part B benefits are primarily financed through a combination of general revenues and beneficiary premiums. In 2024, the standard monthly premium will be \$174.70. Higher-income beneficiaries also pay income-related monthly adjustment amounts if they earn more than \$103,000 annually for individuals or more than \$206,000 for couples.<sup>45</sup>

## Medicare Part C (Medicare Advantage)

MA plans are private health plans that contract with the federal government to provide all Part A and Part B services as an alternative to Traditional Medicare. In addition, MA plans must meet certain federal requirements, such as providing beneficiaries with a maximum out-of-pocket limit. In 2023, this limit for in-network services may not exceed \$8,300.<sup>46</sup>

Although private Medicare plans have existed since the late 1960s, enrollment in MA increased significantly after the passage of the Medicare Modernization Act of 2003 and the Patient Protection and Affordable Care Act of 2010 (ACA).<sup>47</sup> Over the past decade, enrollment in MA plans has nearly doubled, and in 2023, just over half (51%) of all Medicare-eligible beneficiaries are enrolled in Medicare Advantage.<sup>48</sup> CBO projects that by 2033, 62% of all Medicare beneficiaries will choose MA over TM (see Figure 3).<sup>49</sup>

Like beneficiaries enrolled in Traditional Medicare, those in Medicare Advantage pay the standard Part B monthly premium (\$174.70 in 2024) and can pay a supplemental premium for additional benefits, such as coverage for prescription drugs, hearing, dental, vision, or fitness. (MA plans frequently offer these benefits, although little data is available on their utilization.) In 2023, nearly three-quarters of beneficiaries enrolled in MA plans with prescription drug coverage pay no monthly premium other than the standard monthly Part B premium.<sup>50</sup> MA beneficiaries are subject to the same income-related monthly adjustment as TM enrollees.

In 2023, the number of MA plans available to beneficiaries in their county averaged 43 nationally.<sup>51</sup> However, the number varies greatly by geographic region. Beneficiaries living in metropolitan counties can choose from an average of 46 plans, compared with an average of 29 plans for those in nonmetropolitan areas.<sup>52</sup> In 85 counties with less than 1% of total beneficiaries, only one MA issuer—also called a Medicare Advantage Organization (MAO)—offers MA plans, and in 40 counties, no plans are available.<sup>53</sup> In contrast, in 27 U.S. counties, beneficiaries can choose from 75 to 87 plans.

A variety of factors are behind the growth in MA enrollment. The out-of-pocket limit, additional benefits not covered by Traditional Medicare, potentially lower premiums, and coordinated care are attractive to beneficiaries and can address disparities.

The bidding process by which MAOs receive payments is imperfect and produces excessive payments in the program. It also results in inflated benchmarks, risk scores, and quality bonuses. MAOs often receive larger payments for each covered enrollee than Medicare spends on beneficiaries in Traditional Medicare (about 6% more in 2023).<sup>54</sup> Addressing risk adjustment and quality measures, and promoting greater competition in MA, would produce higher-value care for beneficiaries and save money for the federal government.

## Medicare Part D (Prescription Drug Coverage)

Part D covers outpatient prescription drugs through private plans—including stand-alone prescription drug plans and Medicare Advantage plans with prescription drug coverage—that contract with Medicare. Part D is optional for beneficiaries enrolled in Traditional Medicare, and a majority of MA plans (89%) include prescription drug coverage.<sup>55</sup> Forty-eight million people with Medicare are currently enrolled in plans that provide the Medicare Part D drug benefit, which represents more than three-quarters (77%) of all Medicare beneficiaries.<sup>56</sup>

[The Inflation Reduction Act of 2022 \(IRA\)](#) recently addressed some of the high costs that beneficiaries face when they are accessing prescription drug coverage.<sup>57</sup> Even before the IRA, Part D provided some catastrophic coverage for certain high out-of-pocket costs, but there was no annual out-of-pocket limit for beneficiaries. Starting in 2025, the IRA will impose a hard cap on Part D out-of-pocket spending at \$2,000 annually.<sup>58</sup>

The IRA also increased assistance through Part D's Low-Income Subsidy (LIS) program. Under the new law, beneficiaries with incomes below 135% of the federal poverty level (\$19,683 for an individual in 2023) continue to receive full coverage of the cost of Part D premiums, deductibles, and cost sharing.<sup>59</sup> This means they pay no Part D premium or deductible and only modest copayments.<sup>60</sup> For beneficiaries whose annual incomes fall below 150% of the federal poverty level (\$21,870 for an individual in 2023), the IRA increased their assistance from partial to full coverage.<sup>61,62</sup>

## BPC's Approach

BPC developed this road map with help from a Medicare Sustainability Advisory Group of 10 ideologically diverse health policy experts who assisted us in identifying the challenges facing the program and the opportunities for policymakers to eliminate waste, reduce costs, increase competition, and improve the beneficiary experience by simplifying processes and benefits. BPC also conducted numerous interviews with providers, payers, beneficiary representatives, and academicians to help inform these proposals and ensure that they are actionable. In addition, BPC contracted with ATI Advisory to provide a range of cost estimates on certain proposals (see Appendix A for more information).



# Policy Recommendations

---

This report aims to strengthen Medicare through improved benefits, increased competition, prudent program management, and sound financing that, taken together, enhance affordability for beneficiaries and taxpayers, as it substantially extends the trust funds' solvency. Specifically, reforms should provide improved defined benefits that ensure all Medicare beneficiaries have affordable care and access to the health services they need; simplify the program so that it is easier for beneficiaries to use; reduce program and premium costs by instituting fair and equal competition between private and public health coverage choices; eliminate excessive payments and waste from various elements of the program while also ensuring that health care providers are adequately compensated to ensure high quality care; and improve financing of the program by increasing revenues within the context of instituting broader Medicare reforms that strengthen and improve the program.

This report's policy recommendations are separated into two phases:

- Phase 1 addresses recommendations to extend the solvency of the Hospital Insurance Trust Fund, simplify the Traditional Medicare benefit, and adopt changes for Medicare Advantage. It also addresses enforcement of past triggers Congress has instituted—but ignored—to force action when federal spending on Medicare dangerously exceeds revenues.
- Phase 2 is a compilation of recommendations that would create apples-to-apples competition between Traditional Medicare and Medicare Advantage, allowing beneficiaries to easily compare these two coverage options based on a standard set of benefits.

## **PHASE 1: STRENGTHEN MEDICARE THROUGH IMMEDIATE REFORMS**

---

Congress should make the changes in Phase 1 immediately to improve program benefits and reduce spending. This would accomplish meaningful progress now and lay the groundwork for changes outlined in Phase 2.

The policy changes in Phase 1 would:

- simplify the Traditional Medicare program for beneficiaries by enhancing benefits, reducing costs, and making it easier to navigate;
- reduce costs and increase revenues to address worsening trust fund and financial challenges;
- reduce excessive MA payments and promote competition; and
- enforce a trigger mechanism for policymakers to act when Medicare spending dangerously exceeds revenues.

## A. Restructure the Traditional Medicare Benefit

Although the number of beneficiaries who choose to enroll in Medicare Advantage is increasing rapidly, almost half still choose to receive TM coverage. As of 2023, about 34 million beneficiaries are enrolled in Traditional Medicare.<sup>63</sup> Still, TM enrollees do not receive some benefits, such as an annual maximum out-of-pocket cap, more coordinated care, and supplemental benefits—all of which are provided through MA.<sup>64</sup>

BPC recommends that Congress restructure Traditional Medicare to make the benefit simpler, more streamlined, and affordable for beneficiaries. Congress should also consider fully integrating Parts A and B into one benefit, which we explore in Phase 2 (see Appendix B for a comparison of the TM benefit under current law and the proposed restructuring of benefits).

### Restructured Benefit Elements

Currently, Parts A and B lack coordination and, therefore, so does their cost sharing. No catastrophic cap on cost sharing exists, meaning that no limits are set on beneficiaries' out-of-pocket expenses.<sup>65</sup> Further, beneficiaries must meet separate deductibles for Parts A and B, and they have to pay a certain percentage of coinsurance on care for which they may not know the cost; this causes uncertainty regarding how much they will have to pay. Implementing an out-of-pocket limit and a single, annual deductible could occur in a variety of ways, and Congress will have to carefully consider the implications for beneficiaries' finances, as well as the program's finances.

---

**CONGRESS SHOULD ESTABLISH AN ANNUAL OUT-OF-POCKET LIMIT FOR BENEFICIARIES ENROLLED IN TRADITIONAL MEDICARE SET AT THE WEIGHTED AVERAGE OF THE BENEFIT CURRENTLY PROVIDED BY MEDICARE ADVANTAGE PLANS (AND INDEXED TO INFLATION) TO PROTECT BENEFICIARIES FROM CATASTROPHIC EXPENSES.**

---

To provide beneficiaries with more predictability and protection from high out-of-pocket costs, particularly for those who lack or are unable to purchase supplemental coverage, the Traditional Medicare benefit should include an annual catastrophic limit for Parts A and B services. In 2023, the annual catastrophic limit for MA plans may not exceed \$8,300 for in-network services, although that is notably lower in many MA plan offerings, as the weighted-average catastrophic limit is \$4,835 for in-network services.<sup>66</sup>

The annual catastrophic limit in TM should align with cost-sharing limits in Medicare Advantage and be set as the same amount provided in MA plans.

Setting the limit at the weighted average of the benefit currently provided by MA plans (and indexed to inflation) would shield beneficiaries from significant out-of-pocket costs and would make it easier for consumers to compare plans while promoting competition across the program. If members of Congress wanted this reform to be budget neutral under current law during its implementation, they could offset the annual catastrophic limit by adjusting beneficiaries' cost-sharing requirements, such as the annual deductible amount they pay, or limiting Medigap coverage.

---

**CONGRESS SHOULD ESTABLISH A SINGLE, ANNUAL DEDUCTIBLE FOR BENEFICIARIES ENROLLED IN PARTS A AND B.**

---

In 2024, the annual deductible for Part B will be \$240.<sup>67</sup> The annual deductible for Part A will be \$1,632, which covers beneficiaries' share of costs for the first 60 days of Medicare-covered inpatient hospital care.<sup>68</sup> For days 61 through 90 day of hospitalization, beneficiaries must pay a coinsurance amount of \$408 and \$816 per day for lifetime reserve days.<sup>69</sup> These are high amounts that can burden beneficiaries who seek hospital care often.

Instead of separate deductibles for Parts A and B services, Congress should allow beneficiaries to pay a single, annual deductible for all Medicare-covered services. The goal of the deductible is generally to reduce the costs of other aspects of the benefit package, such as premiums, copayments, and coinsurance. Although beneficiaries could view a deductible as financially burdensome, their overall cost might be lower due to a lower premium and to cost sharing.<sup>70</sup> The deductible might also reduce unnecessary utilization of services, and therefore spending for the program. To mitigate an increase in the deductible amount for beneficiaries who primarily use Part B services, physician office visits should be exempt from meeting the combined deductible, and beneficiaries would be only required to pay copayments for these visits. A combined deductible would simplify the TM benefit design and cost-sharing structure for beneficiaries, making it easier for them to understand and track their services altogether, rather than separately.<sup>71</sup>

Congress would have to address what a combined, annual deductible means for those beneficiaries who have only Part A coverage. As of 2019, about 7.5% of beneficiaries were enrolled in Part A only, likely because they receive coverage for physician services from an existing employer, and Part A coverage is automatic if one also receives Social Security.<sup>72</sup> These beneficiaries are not subject to a deductible for Part B services under current law, and making them subject to a single deductible for both Parts A and B would not make sense and could potentially cause financial burdens. Congress could consider applying the single deductible only to beneficiaries who have both Parts A and B, and allow

Part A-only beneficiaries to maintain their Part A deductible under current law. For lower-income beneficiaries, these changes could also pose a burden if the Part B deductible increases, which would likely be the case. Congress could consider establishing an income-related deductible for low-income beneficiaries who do not qualify for cost-sharing assistance.

## **Medigap**

Most Traditional Medicare enrollees supplement Parts A and B through other sources.<sup>73</sup> This additional protection typically covers some or all of beneficiaries' cost sharing and might provide additional benefits not covered by TM.<sup>74</sup> The three major sources of supplemental coverage are Medigap, employer-sponsored retiree health coverage, and Medicaid.<sup>75</sup> In 2020, 36% of TM beneficiaries had a Medigap policy.<sup>76</sup>

Medigap policies are private insurance plans that Medicare beneficiaries may choose to purchase to supplement their TM coverage. These plans partially or fully cover beneficiaries' Parts A and B cost-sharing requirements, including copayments, coinsurance, and deductibles, and they can also offer extra benefits.<sup>77</sup>

Beneficiaries may need protections to mitigate the high out-of-pocket costs they could face for their Medicare coverage, but the Medigap premiums can pose a financial burden. Estimated premiums range from \$150 to \$200 per month, and TM beneficiaries pay these premiums in addition to the Part B premium and any additional cost-sharing requirements that the Medigap plan may not cover.<sup>78</sup> Moreover, while the purchasing of Medigap plans can assist beneficiaries financially, the plans also cover all or almost all copayments. This benefit disincentivizes enrollees to consider the cost of services, and they could seek care that may be unnecessary, therefore leading to higher costs for the Medicare program.<sup>79</sup> According to 2020 KFF data that compared all TM beneficiaries, those who had Medigap were more likely to be white and have annual incomes of \$40,000 or more per person.<sup>80</sup>

Federal law requires Medigap insurers to offer "guaranteed issue" policies to beneficiaries ages 65 and older during a one-time period of the first six months of their enrollment in Part B. During this period, Medigap insurers cannot vary premiums based on someone's preexisting medical conditions (also called medical underwriting), nor can they deny anyone a policy based on factors such as age, gender, or health status.<sup>81</sup>

However, after the initial six-month period, beneficiaries could be subject to medical underwriting and denied a Medigap policy or charged a higher premium for having a preexisting condition. For beneficiaries under age 65 who have disabilities or End-Stage Renal Disease, states can enact their own laws guaranteeing access to coverage, but no federal laws exist to ensure that these beneficiaries can receive Medigap.<sup>82</sup> In addition, in many cases, beneficiaries of any age who want to switch from an MA plan to TM and purchase a Medigap policy after one year of enrollment may be subject to denial or underwriting.<sup>83</sup>

Although any expansion of Medicare benefits increases costs for the program, Congress can mitigate these by implementing changes to Medigap. While the reforms to the benefit in the section above are intended to make the purchasing of Medigap policies less necessary, some beneficiaries are still likely to purchase a policy, especially if they tend to be more risk averse. BPC presents two options for improving Medigap that Congress should choose from.

---

**CONGRESS COULD RESTRUCTURE MEDIGAP PLANS BY RESTRICTING FIRST DOLLAR COVERAGE FOR MEDICARE-COVERED SERVICES.**

---

Congress could restrict Medigap policies from paying a set amount of beneficiaries' cost-sharing requirements for Parts A and B services (which should be equal to the amount of the single, annual deductible) and limit coverage to 50% of the next set amount of beneficiaries' cost sharing (which would be equal to half of the amount of the single, annual deductible). The Medicare Payment Advisory Commission (MedPAC) has proposed a variety of changes to reform the TM benefit design, and CBO has put forward budget options that would lower program costs and Medigap premiums for beneficiaries by rationalizing cost sharing and supplemental coverage.<sup>84,85</sup>

CBO evaluated Medigap changes that would restrict the private policies from paying any of the first \$700 of an enrollee's cost-sharing obligations for Part A and B services and would limit coverage to 50% of the next \$6,300 of an enrollee's cost sharing. Medigap policies would cover all further cost-sharing obligations, so beneficiaries would not pay more than \$3,850 in a given year. The option also included a \$700 annual deductible for Parts A and B services and an annual catastrophic limit of \$7,000. The CBO option acts as an example, but Congress would have to determine what these dollar amounts should be when redesigning the benefits, as they all have to align. CBO notes that the dollar amounts would be indexed to the rate of growth of average fee-for-service (FFS) spending per enrollee.

Under current law, the [Medicare Access and CHIP Reauthorization Act of 2015 \(MACRA\)](#) prohibits Medigap policies from covering beneficiaries' Part B deductibles, effective January 1, 2020.<sup>86</sup> BPC's proposal would remain consistent with the goal of MACRA, as Medigap policies would be restricted from providing the amount equal to a combined deductible that covers both Part A and Part B services, thereby restricting coverage of any deductible related to Part B.

In many cases, beneficiaries will spend through the deductible whether they have supplemental coverage or not, and the insurer will charge an overhead rate to essentially transmit the deductible payment back to the beneficiary. Limiting

Medigap coverage of the deductible could actually lower the cost burden on beneficiaries rather than increase it.

---

**CONGRESS COULD IMPOSE AN ADDITIONAL CHARGE ON MEDIGAP PLANS BASED ON THE COVERAGE OFFERED.**

---

Another option, which MedPAC has proposed, would impose a surcharge on Medigap plans.<sup>87</sup> If this change were to happen along with implementation of an out-of-pocket maximum for Traditional Medicare, beneficiaries might weigh the pros and cons of the new cost-sharing limit with the potentially higher cost of supplemental coverage and decide that it is no longer necessary to purchase such a generous plan.<sup>88</sup> In response to this additional charge, implementation should be combined with a process through which beneficiaries could decide to drop their supplemental policies without penalties.<sup>89</sup>

In his 2013 budget proposal, President Obama also included this surcharge, which would have been equivalent to about 15% of the average Medigap premium, or about 30% of the Part B premium, for new beneficiaries who purchased Medigap policies with particularly low cost-sharing requirements (other policies would have been exempt).<sup>90</sup> Obama's proposal estimated a savings of \$2.5 billion over 10 years.<sup>91</sup>

**Beneficiary Protections**

Although BPC's recommendations in aggregate aim to decrease costs for beneficiaries, those with lower incomes are still vulnerable to higher costs and would require additional assistance. Overall, 17% of Medicare beneficiaries have incomes at or below 100% of the federal poverty level (\$14,580 for an individual in 2023).<sup>92</sup> In a recent survey, more than 1 in 5 of beneficiaries over 65 reported that they struggled to afford their premiums.<sup>93</sup> Two programs currently assist lower-income Medicare beneficiaries, and these programs disproportionately serve beneficiaries in communities of color, beneficiaries under 65 with disabilities, and women, who tend to have lower incomes and modest savings.<sup>94</sup> Improving the enrollment process for these assistance programs would help to protect underserved beneficiaries from the difficulties of affording care.

The Medicare Savings Programs (MSPs) are Medicaid-administered programs for people on Medicare who have limited income and resources. In 2019, 10.3 million Medicare beneficiaries, or 16% of all beneficiaries, were enrolled in one of the four MSPs: the Qualified Medicare Beneficiary (QMB), the Specified Low-Income Beneficiary (SLMB), the Qualifying Individual (QI), and the Qualified Disabled Working Individual (QDWI). Each has different income and resource eligibility limits.<sup>95,96</sup> The QMB and SLMB programs are the largest in terms of

enrollment and offer the most benefits.<sup>97</sup> Most low-income beneficiaries must apply to their state Medicaid programs to enroll in MSPs; states determine eligibility, and redetermine that eligibility at least every 12 months.<sup>98</sup>

The Part D Low-Income Subsidy (LIS) program helps pay for a portion of Part D plan costs, including premiums, deductibles, and copayments.<sup>99</sup> In 2023, LIS is available to beneficiaries with incomes less than 150% of the federal poverty level and modest assets.<sup>100</sup> The government determines eligibility through data from the Social Security Administration (SSA).<sup>101</sup> In 2019, 22% of beneficiaries were enrolled in the program, with the vast majority receiving full LIS benefits.<sup>102</sup> Before [The Inflation Reduction Act of 2022 \(IRA\)](#) only beneficiaries with incomes up to 135% of the federal poverty level were eligible for full benefits, but the law expanded eligibility for beneficiaries with incomes up to 150% of the federal poverty level to allow them to receive full coverage of the cost of Part D premiums, deductibles, and cost sharing.

Each Medicare beneficiary who may not qualify for full Medicaid might still be able to enroll in the MSPs, and enrollment in these automatically deems a person eligible to receive benefits through LIS. The opposite is not true, however, partly because the income threshold for LIS is lower.<sup>103,104</sup> Enrollment in MSPs has historically been low. In 2019, nearly 1.6 million Medicare beneficiaries (11%) were enrolled in LIS but not in the MSPs, which includes a little over 1.1 million who were eligible but not enrolled and nearly half a million whose incomes and/or assets were too high.<sup>105</sup> Some likely reasons for low enrollment are a lack of outreach and messaging to those who are eligible; conflicting enrollment and eligibility requirements among the MSPs and other programs; and various program rules and administration, including confusing enrollment processes.<sup>106</sup> In addition, the asset test that determines eligibility for both the MSPs and LIS requires beneficiaries to have countable resources (e.g., money in savings and checking accounts, stocks, and bonds) below a certain limit, but this differs from the eligibility requirements to determine Medicaid expansion or marketplace coverage established under the ACA.<sup>107</sup>

---

**CONGRESS AND CMS SHOULD TAKE STEPS TO  
STREAMLINE ELIGIBILITY REQUIREMENTS AND  
ENROLLMENT PROCESSES OF THE MEDICARE  
SAVINGS PROGRAMS TO ALIGN MORE WITH THE  
PART D LOW-INCOME SUBSIDY PROGRAM.**

---

[The Medicare Improvements for Patients and Providers Act of 2008 \(MIPPA\)](#) included provisions to promote enrollment of LIS applicants into Medicare Savings Programs, including requiring the Social Security Administration to transmit data from LIS applications to state Medicaid agencies, requiring that

states initiate Medicare Savings Programs applications using that data, and making eligibility requirements more generous.<sup>108,109</sup>

States have authority under MIPPA to make further changes to increase enrollment in MSPs, and SSA sent them information in May 2021 identifying individuals who were likely newly eligible for an MSP but had not enrolled.<sup>110</sup> The Centers for Medicare & Medicaid Services finalized a rule in September 2023 making some of these changes required under MIPPA, as well as additional changes to ease administrative burden for states and reduce enrollment barriers for beneficiaries to bring an estimated 860,000 more individuals into the MSPs.<sup>111</sup> These changes included eliminating duplicative paperwork and leveraging eligibility data from other programs; emphasizing that states should accept electronic sources—as opposed to paperwork—and self-attestation for beneficiary verification; automatically enrolling SSI recipients eligible for Medicare into the QMB MSP program; and requiring states to use LIS information both as an application for an MSP and for MSP eligibility determination.<sup>112</sup> CMS could provide further technical assistance to states to maximize their existing authority.

Building on recent modest programmatic improvements, Congress should also extend the cost-sharing protections provided in the QMB program (for beneficiaries with incomes up to 100% of the federal poverty level) to the SLMB and QI programs, which provide benefits to beneficiaries with incomes up to 135% of the federal poverty level.

### **Enrollment Processes**

Beneficiaries face many challenges when enrolling in Medicare. Each of the four parts of Medicare has its own enrollment process, with some of the parts having auto-enrollment processes and exceptions to the enrollment requirement altogether. People who are already receiving Social Security are automatically signed up for Parts A and B when they first become eligible for Medicare, and they can choose to keep or decline Part B, usually if they are still receiving insurance coverage from an employer.<sup>113,114</sup> But people who are not yet receiving Social Security are not automatically enrolled in Medicare; they must sign up for Part A either with CMS or the Social Security Administration, and they can sign up for Part B only through CMS.<sup>115</sup> Traditional Medicare beneficiaries must also separately enroll in Part D to receive prescription drug coverage, which carries its own premium separate from the monthly Part B premium.

This complex web of enrollment rules can be difficult for beneficiaries to understand and navigate, particularly since enrollment is not integrated when beneficiaries are choosing plans. Beneficiaries, as a result, could be unaware of the total monthly premium amount they will be paying.



Beneficiaries also face challenges navigating the Medicare Plan Finder (MPF) on the Medicare.gov website. This tool allows beneficiaries to shop for plans and compare prices between Traditional Medicare, Part D plans, MA plans, and Medigap policies. CMS upgraded the tool in 2019, but beneficiaries still face issues navigating the website, particularly when they try to learn which plans are available in their area and also up-to-date information about plans' providers networks.<sup>116,117</sup>

---

**CMS SHOULD WORK WITH THE SOCIAL SECURITY ADMINISTRATION TO STREAMLINE THE BENEFICIARY ENROLLMENT PROCESSES FOR ALL PARTS OF MEDICARE. CMS SHOULD ALSO UPDATE THE MPF TOOL TO ALLOW BENEFICIARIES TO SEE ALL THEIR COSTS IN ONE PLACE, INCLUDING THE CATASTROPHIC LIMIT IN TRADITIONAL MEDICARE; THE SINGLE, ANNUAL DEDUCTIBLE FOR PARTS A AND B; THE COSTS AND BENEFITS OF PART D; AND A STANDARDIZED COMPARISON OF PROVIDER NETWORKS.**

---

No single government entity is responsible for the entire Medicare enrollment process: CMS administers the Medicare program, but many individuals must apply through the Social Security Administration.<sup>118</sup> This is increasingly becoming an issue as more and more individuals delay retirement past 65—many waiting until age 70. This situation means that people who are not yet receiving Social Security do not have the benefit of automatic Medicare enrollment and have to enroll themselves in the program. This can create confusion, as beneficiaries have to navigate both government entities to answer their questions.<sup>119</sup> Both Medicare and Social Security should work together to develop a system that would make the enrollment process simpler.

CMS should also improve the Medicare Plan Finder on the Medicare.gov website. The tool should allow beneficiaries to view all their costs in one place, including the out-of-pocket limit and the combined deductible, as well as the total monthly premium amount they will pay as one premium, which includes both the Part B and D premiums. This change would not integrate Parts B and D but would simplify the shopping process for beneficiaries by allowing them to consider all their Medicare options in one place. The MPF should also include a standardized comparison of provider networks to allow beneficiaries to more easily understand which providers will be available to them.

---

**CONGRESS SHOULD INCREASE SUPPORT FOR THE STATE HEALTH INSURANCE ASSISTANCE PROGRAM AND REAUTHORIZE AND INCREASE SUPPORT FOR THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT PROGRAMS.**

---

The confusing and disjointed process for enrolling in Medicare and choosing coverage makes it difficult for beneficiaries to understand what they are receiving. Beneficiaries report wanting more help making coverage decisions.<sup>120</sup> The State Health Insurance Assistance Program (SHIP) is a national program, administered by the Administration for Community Living, that provides grants to states to provide counseling, education, and assistance to Medicare beneficiaries. Beneficiaries and their families and caregivers can access SHIP services to help make informed decisions about Medicare coverage and benefits. The Medicare Improvements for Patients and Providers Act (MIPPA) programs, also administered by the Administration for Community Living, provide grants to states to assist older adults and individuals with disabilities in applying for special assistance through SHIPs, Area Agencies on Aging, and the Aging and Disability Resource Centers/No Wrong Door System.<sup>121</sup>

These programs provide education on programs that may save beneficiaries money, such as the Medicare Part D Low-Income Subsidy (LIS) program, the Medicare Savings Programs, and Medicare Preventive Services. Other proposals in this report seek to enhance and simplify Medicare options, and the SHIP and MIPPA programs could help explain programmatic changes and assist beneficiaries in understanding their options and gaining access to benefits.

However, given the projected growth in the Medicare-eligible population, these programs will need additional funding to adequately support beneficiaries and further simplify their experiences. In 2021, SHIP served 2.7 million people out of approximately 63 million Medicare beneficiaries.<sup>122,123</sup> The Medicare Trustees project that 75 million beneficiaries will have Part A coverage by 2029, a more than 15% increase from the 65 million in 2022.<sup>124</sup> If SHIPs continue to serve a similar share of the Medicare population, funding to serve 3.2 million beneficiaries would be needed.

Funding for SHIP has increased slightly in recent years, from \$53.1 million in fiscal year 2022 to \$55.2 million in FY2023, after a flat funding trend from FY2020-FY2022.<sup>125</sup> MIPPA is currently authorized through FY2024 at a \$50 million annual funding level.<sup>126</sup> Congress should provide additional funding; alternatively, a per-member, per-month assessment fee on Medicare Advantage plans could fund program expansion.

## **B. Reduce Costs and Increase Revenues to Address Trust Fund and Financial Challenges**

Congress should both reduce costs and increase revenues to delay the Hospital Insurance Trust Fund's insolvency and ensure greater affordability for beneficiaries and sustainability for the program. To help achieve these goals, it should reduce excessive post-acute and hospice care payments, institute site-neutral payments, and increase revenues. Although this report does not provide recommendations on promoting participation in value-based models, BPC acknowledges the efforts that Congress and CMS have made to shift to value-based care over the past decade. CMS' vision is that by 2030, 100% of Traditional Medicare beneficiaries will be in accountable care relationships, but there is much work to be done to achieve that goal, and BPC will pursue this in future work.<sup>127,128</sup>

### **Post-acute and Hospice Care Provider Payments**

Post-acute care is one of the largest categories of Traditional Medicare spending, and evidence suggests that payments to these providers are excessive and inflate profits. Medicare beneficiaries receive post-acute care in four types of settings after an inpatient hospitalization. In 2021, the TM program spent \$56.8 billion on care provided in skilled nursing facilities (SNFs), home health care agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs).<sup>129</sup> This accounted for approximately 11% of total spending in Traditional Medicare.<sup>130</sup> That year, average Medicare margins, or the amount by which payments exceeded costs for post-acute care providers, were high and increasing (17.2% for SNFs, 24.9% for HHAs, 17% for IRFs, and 6.7% for LTCHs).<sup>131,132</sup>

---

**CONGRESS SHOULD MODIFY PAYMENTS TO SKILLED NURSING FACILITIES, HOME HEALTH CARE AGENCIES, AND INPATIENT REHABILITATION FACILITIES BY REDUCING THE BASE PAYMENT RATES BY:**

- 3 PERCENTAGE POINTS FOR SNFS;**
- 3 PERCENTAGE POINTS FOR IRFS;**
- 7 PERCENTAGE POINTS FOR HHAS.**

---

Post-acute care providers are paid under separate prospective payment systems (PPS), which CMS updates annually. Recent updates to the SNF, home health, and LTCH payment systems have made them more reflective of patient characteristics and less sensitive to volume of services provided or the setting of care. However, MedPAC, which advises Congress on Medicare policy, has concluded that Medicare payments still substantially exceed costs for SNFs, IRFs, and HHAs.<sup>133</sup>

Congress and CMS recently made substantial changes to the SNF and home health payment systems, removing incentives to provide a higher volume of services, particularly therapy services, and instituting systems that tie payment to patient characteristics and needs. Congress required reforms to the home health payment system in the Bipartisan Budget Act of 2018, and CMS acted accordingly to implement the Patient-Driven Groupings Model (PDGM) for home health care agencies in January 2020.<sup>134</sup> Additionally, CMS finalized a new payment methodology for skilled nursing facilities in its FY2019 rule, the Patient-Driven Payment Model (PDPM), which went into effect in October 2019.<sup>135</sup> These changes are budget neutral, but they have still introduced payment fluctuations and uncertainty for these providers in recent years.

Separate from these reforms, policymakers have focused on reducing post-acute care payments as a way to reduce excessive payments and achieve savings in the Medicare program. Democratic and Republican presidents' budget proposals and MedPAC have all proposed a variety of policy options to reform post-acute care payments to reflect more appropriate benefit costs and services.<sup>136,137</sup> These options would subsequently reduce Part A spending.

One option for change that has surfaced recently in research and legislation is a unified post-acute care payment system. This would create one PPS for services provided in all four post-acute settings, and it could be structured to reduce aggregate payments or be budget neutral. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) required several reports and prototypes for a unified payment system, along with standardized patient assessment data reporting, to enable better comparisons of patients and care across settings.<sup>138</sup> The president's 2021 budget proposal also included a unified payment system proposal that it estimated would save \$101.5 billion over 10 years.<sup>139</sup> Under the IMPACT Act requirements, MedPAC and RTI International—contracted by the Office of the Assistant Secretary for Planning and Evaluation—have published reports and prototypes that determined such a system to be feasible.<sup>140,141</sup>

Transitioning to this system would substantially redistribute payments between post-acute care providers and could reduce overall spending on post-acute care if policymakers decided to implement the system in a non budget-neutral manner. However, MedPAC and others have noted difficulties associated with implementing such a system and the potential for disruption to providers and beneficiaries. For example, benefits and cost sharing, as well as conditions of participation, would have to be standardized across settings. Additionally, the shifts to the PDPM and PDGM payment systems have begun to resolve some of the concerns, such as volume-based payments, that motivated interest in a unified system.

Other proposals retain the existing payment systems but achieve savings by reducing the applicable payment rates in each of the PPSs, either by reducing the amount of the annual payment update or reducing the base payment

rate. Reducing the otherwise applicable annual payment update has received bipartisan support. The 2017 budget from President Obama and 2021 budget from President Trump both proposed reductions in the annual update factors applied to post-acute providers' payments.<sup>142</sup> Alternatively, MedPAC has recommended reducing providers' base rates. In its March 2023 report, MedPAC recommended decreasing base payment rates by 3% for SNFs, 3% for IRFs, and 7% for HHAs.<sup>143</sup> Relative to a unified payment system, reductions within the current payment systems reflect a more feasible policy option with less potential disruption for beneficiaries.

In 2023, MedPAC stopped issuing annual payment recommendations for long-term care hospitals. In its latest recommendation (March 2022), the commission did not recommend a base rate reduction but proposed that the payment increase for LTCHs proceed as it otherwise would under current law, with a market basket increase minus the applicable productivity adjustment.<sup>144</sup> However, some studies show that care provided in long-term care hospitals could be handled at a lower cost in other post-acute settings without affecting quality of care.<sup>145</sup> Congress should monitor the value of care provided in LTCHs and adjust payments accordingly.

Although average Medicare margins are high, there is significant diversity among providers in the post-acute care sector. For example, in 2021 providers in the 25<sup>th</sup> percentile of Medicare margins had margins of 3.8%, and nonprofit providers had margins of 2.8%.<sup>146</sup> An important dynamic influencing the overall profitability of post-acute care providers, particularly skilled nursing facilities, is the relationship between Medicare and Medicaid payment rates. The Medicaid program covers the majority of nursing facility residents' care. When factoring in Medicaid and other non-Medicare payers, facilities' margins vary considerably from the Medicare margin. In 2021, the median all-payer total margin was 3%.<sup>147</sup> Twenty-five percent of nursing homes had total margins of -5.7% or lower, and 25% of nursing homes had total margins of 10.6% or higher.<sup>148</sup>

Additionally, the recently proposed minimum staffing requirements for SNFs would increase the cost of care in these facilities by \$40.6 billion over 10 years.<sup>149</sup> However, CMS estimates the majority of these increased costs, \$26.9 billion, would be due to caring for residents utilizing Medicaid.<sup>150</sup> If policymakers determine that an increase in payments is necessary, they should explore alternative mechanisms rather than relying on Medicare payments as the avenue for this increase.

Given evidence that Medicare rates significantly exceed the cost of providing care, policymakers should reduce providers' base rates to get better value for Medicare's post-acute care spending. Congress should reduce the base payment rate for SNFs, IRFs, and HHAs by 3%, 3%, and 7%, respectively. These recommendations align with MedPAC's most recent recommendations and could be phased in over two years. MedPAC estimates that these changes would reduce SNF spending by \$2 billion in 2024 and more than \$10 billion over five

years, and home health spending by \$750 million to \$2 billion in 2024 and by more than \$10 billion over five years.<sup>151</sup> If implemented in 2025, this policy would likely result in savings of \$50 billion to \$60 billion in the 2024-2033 budget window.

If reductions are implemented, Congress and CMS should closely monitor the impact of these payment adjustments on quality of care, staffing levels, and margins of small and nonprofit post-acute care facilities and agencies.

---

**CONGRESS AND CMS SHOULD PURSUE VALUE-BASED INITIATIVES IN THE POST-ACUTE CARE SETTING, INCLUDING IMPLEMENTING VALUE-BASED PURCHASING PROGRAMS FOR IRFS AND LTCHS AND ENCOURAGING THE INTEGRATION OF POST-ACUTE CARE PROVIDERS IN INNOVATIVE PAYMENT MODELS.**

---

Opportunities exist to expand the role of value-based payment in the post-acute care setting. Already, the post-acute prospective payment systems for skilled nursing facilities and home health care agencies include value-based purchasing programs—the SNF Value-Based Purchasing (VBP) program and the Home Health VBP program—that incentivize providers to improve the quality of care they provide by withholding a percentage of payments and redistributing a share or all of the withholding based on quality measure performance.<sup>152,153</sup> However, the PPSs for long-term care hospitals and inpatient rehabilitation facilities only utilize quality reporting programs that incentivize reporting of quality measures; they do not adjust payment based on performance.

Additionally, the incorporation of post-acute care providers in the Center for Medicare and Medicaid Innovation’s (CMMI) value-based care initiatives to date has been inconsistent. CMMI has involved post-acute care providers in episode-based payment models, such as the Bundled Payments for Care Improvement (BPCI), BPCI Advanced, Comprehensive Care for Joint Replacement, and Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents.<sup>154,155,156</sup> However, in some instances, limited financial incentives have made participation challenging for providers.<sup>157,158</sup> Overall, few post-acute care providers have focused risk-based models that go beyond quality incentives and reductions. CMS should strengthen incentives for post-acute care providers to participate in more comprehensive value-based payments.

Congress and CMS have demonstrated interest in further including post-acute care providers in value-based models. The Consolidated Appropriations Act of 2021 contained a provision that required MedPAC to develop an additional prototype for a value-based payment program that could be incorporated into

a unified PAC payment system.<sup>159</sup> In its white paper, CMMI noted an interest in additional episode-based payment models, for which medical and surgical episodes may often include the post-acute care setting.<sup>160</sup> CMS recently finalized changes to incorporate staffing adequacy, resident experience, and staff retention in the SNF VBP program.<sup>161</sup> In July 2023, CMMI released a request for information to inform a future episode-based payment model. The request included questions relating to how best to incentivize coordination with post-acute care providers and align with existing post-acute care value-based payment programs.<sup>162</sup>

Improving the quality of post-acute care has the potential to affect spending on other services funded by the HI Trust Fund. For example, the SNF VBP program currently rewards facilities for lower rates of all-cause hospital readmissions.<sup>163</sup> Inpatient hospital spending also comes from the HI Trust Fund, so achieving reductions in these rates could lead to cost savings for the program attributed to hospital care.<sup>164</sup>

CMS and Congress have structured another post-acute care value-based payment program with the aim of generating direct savings to the Medicare program. The Protecting Access to Medicare Act of 2014 required CMS to create the SNF VBP in a way that resulted in savings.<sup>165</sup> Under the SNF VBP, CMS withholds 2% of payments to skilled nursing facilities and pays out a portion of the withholding in incentives, retaining the remaining 40% of the withholding as savings to the program.<sup>166</sup> If Congress and CMS enacted IRF and LTCH VBPs in 2025 with similar structures, the change would likely result in estimated savings of just under \$5 billion in the 2024-2033 budget window.

---

### **CONGRESS SHOULD WAGE ADJUST AND REDUCE THE HOSPICE AGGREGATE CAP BY 20%.**

---

The Medicare hospice benefit provides comprehensive care and support for terminally ill patients and their families with a focus on palliative care. Medicare beneficiaries are eligible for hospice care if they have a terminal illness with a prognosis of six months or less to live; to receive Medicare-covered hospice care, beneficiaries must waive their rights to Medicare payment for curative care for the condition.<sup>167</sup> Medicare's FFS spending on hospice benefits has grown substantially in recent years, outpacing the growth rate of total Medicare spending; expenditures nearly doubled from 2010-2021, growing from \$12.9 billion to \$23.1 billion.<sup>168,169,170</sup> Greater use of the benefit and larger provider margins have driven the spending growth. Medicare payments to hospices in 2020 exceeded their marginal costs by 18%.<sup>171</sup>

The hospice PPS pays providers a set rate for each day a patient is enrolled in the benefit, regardless of the services provided. The Health and Human

Services' Office of Inspector General (OIG) has identified several integrity concerns relating to the incentives created by the hospice care payment structure, including improper payments.<sup>172</sup> The system can incentivize providers to pursue long lengths of stay and to provide less care per patient per week, given that providers are paid by the day and not by services provided—both trends have been observed in recent years.<sup>173,174</sup> Additionally, hospices might bill for more expensive levels of hospice care than are necessary, which has substantial spending implications, given that the payment for different levels of care varies by hundreds of dollars per day.<sup>175</sup>

One program integrity concern that MedPAC and the OIG have identified relates to a cap that limits the aggregate Medicare payments an individual hospice can receive in a year. Congress created this cap, along with a cap on inpatient care relative to total hospice care days, to limit hospice care costs to less than the cost of conventional curative medical care.<sup>176</sup> In recent years, 18% to 19% of hospices have exceeded the cap, which results in reductions to their FFS Medicare payments.<sup>177</sup> The amount by which hospices exceed the aggregate cap has increased from \$384,000 in 2019 to \$422,000 in 2020.<sup>178</sup> Hospices that exceed the cap have disproportionately long stays and high rates of discharging patients.<sup>179</sup> This could be an indication that these hospice providers are selecting patients who may not be eligible for the hospice benefit.<sup>180</sup> These hospices also have disproportionately high margins.

Another factor behind increased spending might be the shift from nonprofit to for-profit and equity-owned hospice providers. The OIG has found that for-profit hospices were more likely to bill inappropriately for general inpatient care, and the median stay for beneficiaries served by for-profit hospices was longer than the median stay for beneficiaries served by nonprofit hospices.<sup>181</sup> In recent years, the hospice industry has shifted from almost entirely nonprofit providers to a majority of for-profit providers. According to the OIG, hospice payments to for-profit hospices totaled \$12.7 billion in 2019, an increase of 87% since 2010; payments to nonprofit hospices rose just 34% in that period, totaling \$8 billion in 2019.<sup>182</sup> Private equity also represents a growing share of hospice ownership. The number of hospice agencies owned by private equity firms increased from 106 in 2011 to 409 in 2019 (the total number of hospices in these two years was 3,162 and 5,615, respectively).<sup>183</sup>

Although the aggregate cap is currently functioning as a limit on an individual hospice's total Medicare payments, policymakers could better leverage this tool to reduce unnecessary spending from the HI Trust Fund. Reducing the aggregate cap would reduce total hospice spending while preserving program integrity and improving quality of care. Importantly, a 20% reduction would target payment decreases to hospices with long stays, high live-discharge rates, and high margins, while leaving the majority of providers unaffected. For example, hospices in the lowest two quintiles for share of stays greater than six months would see no reduction in payments, while those in the highest quintile would see a 17.2% reduction in payments.<sup>184</sup> Therefore, BPC



recommends reducing the aggregate cap by 20% and wage adjusting it to better reflect local market conditions.

In its March 2023 report, MedPAC estimated that this proposal would save \$5 billion to \$10 billion over five years, which reflects a reduction of approximately 3% to 6% in hospice spending.<sup>185</sup> If this policy were implemented in 2025, it would likely result in an estimated savings in the \$5 billion to \$25 billion range over 10 years.

### **Site-neutral Payments**

Medicare Part B covers services received in outpatient settings, including hospital outpatient departments (HOPDs), physician offices, and ambulatory surgical centers (ASCs). In 2022, Medicare FFS spent \$60 billion on hospital outpatient services.<sup>186</sup> Medicare payment rates often differ for the same services provided across these ambulatory settings. Medicare generally pays HOPDs the highest rates under the Outpatient Prospective Payment System (OPPS) and substantially more than a physician office would receive for the same service under the Physician Fee Schedule (PFS). For example, in 2018 the Medicare payment rate for the most common evaluation and management (E&M) visit in a hospital outpatient department was 2.25 times higher than the rate in a physician's office.<sup>187</sup>

These payment differentials have a direct impact on Medicare spending, with costs for the same care higher in certain settings. Additionally, these payment differences affect beneficiary cost sharing. For services covered by Medicare Part B, beneficiaries typically pay 20% of the cost for each service or item after they meet the deductible. When the rate for a service is higher, this results in higher costs for the beneficiary. Finally, these payment differences can incentivize certain arrangements among providers, such as consolidating physician offices with hospitals or increasing hospital employment of physicians. This has the effect of shifting more billing from the PFS to the OPPS, further increasing total program spending and beneficiary cost sharing.<sup>188</sup> Research shows that patients treated in HOPDs and other ambulatory settings have similar levels of acuity, and some services are commonly provided in all three settings.<sup>189</sup>

---

**AS AN ELEMENT OF COMPREHENSIVE MEDICARE REFORM, CONGRESS SHOULD ALIGN PAYMENTS FOR OUTPATIENT SERVICES COMMONLY PERFORMED IN PHYSICIAN OFFICES AT A SITE-NEUTRAL RATE ACROSS AMBULATORY SETTINGS.**

---

Policymakers have considered and implemented changes in recent years that have made some Medicare payments for outpatient care site neutral, meaning they are equivalent regardless of the setting of care delivery. In the Bipartisan Budget Act of 2015, Congress required CMS to pay PFS-equivalent rates for applicable items and services to off-campus sites that had not offered services and billed Medicare before 2015.<sup>190</sup> CMS interpreted this to mean items and services not furnished in a dedicated emergency department.<sup>191</sup> CBO estimated that this would save \$9.3 billion from 2016-2025.<sup>192</sup> Although this applied site-neutral payments to a subset of HOPDs and services, the change exempted existing or under-construction off-campus HOPDs and it excluded on-campus HOPDs. Presidential budgets from the Obama and Trump administrations have proposed expanded site-neutral payment policies.<sup>193</sup> Additionally, CMS has implemented an expanded policy applying site-neutral rates for evaluation and management services to those off-campus HOPD sites that had previously been exempted.<sup>194</sup> This policy has faced legal challenges, but ultimately a federal appeals court ruled the federal government has the authority to more closely align Medicare payments across settings for these services.<sup>195</sup>

Additionally, policymakers, agencies, and organizations have supported a further expansion of site-neutral payments for a broader set of clinical services and settings. Members of Congress have recently put forward several proposals to make payment rates equivalent across sites of care. In May 2023, the House Energy and Commerce Committee voted to advance the PATIENT Act of 2023, which would expand site-neutral payments to off-campus outpatient departments for drug administration services.<sup>196</sup> CBO estimates that this policy would save \$3.8 billion over the 10-year budget window.<sup>197</sup> The Energy and Commerce Committee has considered, but not advanced, broader proposals as well, such as expanding site-neutral payment for non-E&M services furnished in grandfathered off-campus hospital outpatient departments and paying for certain services furnished at on- and off-campus HOPDs at a site-neutral rate.<sup>198</sup>

In July 2023, the House Ways and Means Committee voted to advance the [Health Care Price Transparency Act of 2023](#), which would similarly expand the services furnished in an off-campus outpatient department that would be subject to PFS-equivalent payment to include drug administration services.<sup>199</sup>

In its June 2023 report, MedPAC proposed a site-neutral policy that would align payments across outpatient settings, including on- and off-campus HOPDs and ambulatory surgical centers, for 66 ambulatory payment classifications, which are categories of outpatient services. Its recommendation for 57 ambulatory payment classifications was to align the OPPS and ASC payment rates with PFS rates. For nine other ambulatory payment classifications, the recommendation was to align OPPS rates with ASC rates. MedPAC recommends that this policy be implemented on a budget-neutral basis.<sup>200</sup>

The potential savings associated with site-neutral payments depend on the number and nature of services for which payments are revised and the settings to which the payment reductions apply. MedPAC designed its 2023 site-neutral proposal in a budget-neutral manner, meaning equivalent increases in payments to HOPDs would be made to offset savings. CBO, president's budgets under Obama, Trump, and Biden, and the Committee for a Responsible Federal Budget have estimated that other proposals implemented without budget neutrality would result in substantial savings, as described below.

In this report, BPC seeks solutions to improve Medicare and extend its sustainability, and we recommend a site-neutral policy similar to MedPAC's 2023 proposal. This would entail aligning payment rates across on- and off-campus HOPDs, ASCs, and physician offices for a subset of services that can be provided in all settings appropriately and safely. BPC previously recommended moving in a similar direction in a 2013 report.<sup>201</sup> Policymakers should consider supporting emergency and standby capacity by providing supplemental payments for services when they are provided as part of an emergency department visit. Additionally, the alignment in rates could be phased in to minimize disruption to providers, as CMS did when it expanded site-neutral payments in the 2019 OPSS and ASC payment system rule.<sup>202</sup>

Although hospital outpatient departments fulfill certain functions such as emergency care that might justify higher reimbursement in certain instances, the cost of this care is more appropriately reflected in rates for inpatient services than for services that are typically provided in other settings. The following policy proposal would maintain the current, higher OPSS and ASC payment rates for outpatient services that cannot in most cases be appropriately or safely provided in clinician offices. Moreover, certain hospitals require additional support to continue providing care to geographic areas and populations that are associated with high costs or low payments. These providers should be subsidized directly rather than through differential payment rates that are unrelated to the direct cost of care.<sup>203</sup> Congress should redistribute a portion of the savings from the proposed site-neutral policy to these hospitals.

Recent estimates of policies similar to MedPAC's recommendation have reflected potential savings of \$102 billion to \$153 billion over 10 years.<sup>204,205</sup> The American Hospital Association projects that MedPAC's recommendation would decrease payments by \$181 billion over 10 years. Based on the ambulatory payment classifications identified by Medicare for site-neutral payment and these existing estimates, such a proposal if enacted in 2025 would likely achieve savings in the \$100 billion to \$200 billion range over the 2024-2033 budget window. This policy would also substantially reduce costs for Medicare beneficiaries. Increasing rates for emergency services and phasing in the policy would reduce the savings achieved under this proposal.

Hospitals provide important community services, such as standby and emergency capacity, as well as providing access to services that are uncompensated or paid at relatively low rates. However, BPC recommends that Medicare adopt changes to payment rates to minimize or eliminate reimbursement differentials across settings, retaining only those variations that reflect true differences in the characteristics of patients and the associated cost of serving them. This proposal to equalize payments across sites for some services would provide immediate benefits to beneficiaries (through reduced cost sharing and premiums) and taxpayers (through lower Medicare spending).

Still, Congress should reinvest a portion of the savings from implementing site-neutral payments to support vulnerable hospitals. In 2000, the Institute of Medicine defined safety-net providers as “those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients.”<sup>206</sup> Federal and state programs and researchers have since used various definitions of safety-net hospitals for purposes of targeting additional funds to support continued access to care for these facilities. Some use geographic indicators, such as rural or medically underserved communities, while others measure the share of patients with certain income levels or who are covered by Medicaid, Medicare, or other programs.<sup>207,208,209</sup> Serving these populations can be financially challenging for hospitals, and they typically operate at a lower margin than other hospitals.<sup>210</sup>

In tandem with the recommended site-neutral policy, Congress should reinvest a portion of the savings into additional payments to safety-net hospitals. This could occur through existing mechanisms and safety-net definitions used in Medicare and Medicaid, such as disproportionate share hospital, uncompensated care, or rural hospital payments. Alternatively, policymakers could consider establishing a new definition of safety-net hospitals that is based on a different set of criteria. For example, MedPAC has recommended establishing a Safety-Net Index, which would capture hospitals with a high volume of Medicare services, those that serve many low-income Medicare patients, or those that devote a high portion of their revenue to uncompensated care.<sup>211</sup>

## Tools for Better Fee-for-Service Management

---

**CONGRESS SHOULD REQUIRE CMS TO INITIATE A SELECTIVE CONTRACTING PROGRAM, AFTER AN INITIAL TEST PERIOD, FOR CERTAIN HIGH-VOLUME SERVICES, INCLUDING DIAGNOSTIC LABORATORY TESTS, IMAGING SERVICES, AND OTHERS, AS APPROPRIATE.**

---

To help Traditional Medicare compete with Medicare Advantage, CMS should more actively manage TM's operations to lower its costs and improve its value. A primary tool should be the greater use of selective contracting for nonphysician, nonhospital services, such as diagnostic laboratory tests, imaging services, and others, as appropriate. These services can be provided in a variety of venues and lend themselves to price competition because of the relative standardization of their offerings. Selective contracting would allow CMS to steer Traditional Medicare patients to providers of these services that offer the best value and avoid having to pay all licensed providers regardless of their relative quality or efficiency.

In moving toward selective contracting, CMS would be required to emphasize assurance of ready access to care for beneficiaries from potential service providers. Indeed, through selective contracting, CMS might be able to improve access to care by requiring winning bidders to make their services more available in communities that are underserved.

CMS could create standards and criteria for providers of these services to submit bids and compete based on price and quality. The process could work similarly to the current Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).<sup>212</sup> Under that program, suppliers of this equipment compete against other suppliers in their area by submitting bids, and contracts go to the suppliers that offer the best price and meet applicable quality and financial standards.<sup>213</sup>

The DMEPOS program, however, only pertains to health care equipment. This recommendation would extend the concept of relying on a bidding system to create a network of preferred providers beyond devices and equipment to certain services that lend themselves to standardization (in terms of what is being provided to the patient) and to a competitive bidding process. The program should be designed with considerations for beneficiary access to laboratories and quality assurance to avoid repeats of imaging services.

The competitive bidding system for durable medical equipment has been shown to achieve savings without reducing access or quality for beneficiaries.<sup>214</sup> Promoting competition among certain services could help lower costs for the program and allow beneficiaries to receive high-quality care. The potential to reduce costs, which could also lower premiums and out-of-pocket spending for beneficiaries, is significant because of Medicare's size. Instead of buying these services from all participating providers, Medicare would begin selecting the best suppliers of these services using objective metrics of quality and efficiency, which should allow CMS to secure a lower unit price for most of the specified items.

### **Revenue Increases**

Slowing the rate of spending in the Medicare program is necessary to achieve sustainability, but those changes must be balanced with increases in revenues. Raising taxes in some way is inevitable to support the trust funds, but there are a variety of pathways that Congress could take to get there, each having advantages and disadvantages. Congress must come together to decide on the most sensible proposal and should consider the following menu of options.

---

### **CONGRESS COULD INCREASE THE PAYROLL TAX RATE ON TOTAL EARNINGS.**

---

In 2021, payroll taxes on earnings accounted for 90% of Part A revenue, which primarily funds the HI Trust Fund.<sup>215</sup> Contributions to the trust fund come from a 2.9% tax on earnings paid by employees and employers, who contribute 1.45% each.<sup>216</sup> Individual taxpayers making more than \$200,000 per year (\$250,000 for married couples) must pay an additional 0.9% payroll tax on wage and self-employment income above these thresholds, equaling a total of 2.35%.<sup>217</sup> Raising the payroll tax rate could generate resources for the HI Trust Fund and would extend solvency.

CBO estimated in its [Options to Reduce the Deficit: 2021–2030](#) that raising the payroll tax rate by 1 percentage point would generate \$878 billion over 10 years and raising it by 2 percentage points would generate \$1.7 trillion over 10 years.<sup>218</sup> These increases would be evenly split between employers and employees, and individuals who earn over \$200,000 annually would still be subject to higher

tax increases. It is important to note that while these increases would generate more money for the Medicare program, the percentage-point increases could have sizable effects on lower-income individuals and families and could widen income inequality. Congress could also consider phasing in the increase.

---

**CONGRESS COULD INCREASE REVENUES FROM THE NET INVESTMENT INCOME TAX BY EXPANDING ITS BASE AND DEDICATING THE ADDED RECEIPTS (ABOVE WHAT IS COLLECTED UNDER CURRENT LAW) TO THE HI TRUST FUND.**

---

The Net Investment Income Tax (NIIT) applies a rate of 3.8% to certain net investment income of individuals, estates, and trusts that have income above a statutory threshold amount.<sup>219</sup> The threshold amount is a modified adjusted gross income in excess of \$200,000 for a single filer and \$250,000 for married couples filing jointly.<sup>220</sup> The NIIT does not apply to income such as wages, unemployment compensation, or distribution from certain retirement accounts; rather, it applies to other sources of income such as interest, dividends, and passive income from businesses not subject to the corporate income tax.<sup>221,222</sup> The NIIT is an existing tax that funds general revenues.

The NIIT may be avoidable for certain types of businesses—limited partnerships and S corporations—that are not subject to the corporate income tax under certain circumstances.<sup>223</sup> CBO scored a proposal to expand the base of the NIIT to impose it on the income of active participants in limited partnerships and S corporations, and estimated that it would generate \$249 billion over 10 years.<sup>224</sup> Further, the president’s 2024 budget proposes closing the loophole for these certain types of businesses, and it increases the NIIT rate from 3.8% to 5% on earned and unearned income for those making over \$400,000 a year.<sup>225</sup> The budget estimated that these changes alone would increase revenues to the HI Trust Fund by nearly \$650 billion over the next decade.<sup>226</sup>

---

**CONGRESS COULD ESTABLISH LOWER INCOME THRESHOLDS FOR THE PARTS B AND D PREMIUM SURCHARGES THAT BENEFICIARIES PAY DUE TO THE INCOME-RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA).**

---

The 2003 Medicare Modernization Act created the income-related monthly adjustment amount, which went into effect in 2007, to require a surcharge on Part B premiums, and in 2011 to require Part D premium surcharges for beneficiaries' who earn more than a certain amount annually.<sup>227,228</sup> Currently, the Part B premium is \$174.70 monthly, and the Part D premium is dependent on the plan chosen. The Part B premium covers about 25% of total program costs, but beneficiaries with higher incomes pay a higher percentage of program costs, depending on the range in which they fall. If an individual beneficiary has an income of more than \$103,000 annually (\$206,000 for a couple filing jointly), they are subject to IRMAA. See Figure 5 for each dollar amount pertaining to income.

**Figure 5. Income-Related Monthly Adjustment Amount for Part B Beneficiary Premiums<sup>229</sup>**

<b>Beneficiaries who file individual tax returns with modified adjusted gross income</b>	<b>Beneficiaries who file joint tax returns with modified adjusted gross income</b>	<b>Income-related monthly adjustment amount</b>	<b>Total monthly premium amount</b>
<b>Less than or equal to \$103,000</b>	Less than or equal to \$206,000	\$0.00	\$174.70
<b>Greater than \$103,000 and less than or equal to \$129,000</b>	Greater than \$206,000 and less than or equal to \$258,000	\$69.90	\$244.60
<b>Greater than \$129,000 and less than or equal to \$161,000</b>	Greater than \$258,000 and less than or equal to \$322,000	\$174.70	\$349.40
<b>Greater than \$161,000 and less than or equal to \$193,000</b>	Greater than \$322,000 and less than or equal to \$386,000	\$279.50	\$454.20
<b>Greater than \$193,000 and less than \$500,000</b>	Greater than \$386,000 and less than \$750,000	\$384.30	\$559.00
<b>Greater than or equal to \$500,000</b>	Greater than or equal to \$750,000	\$419.30	\$594.00

The income thresholds for determining which beneficiaries would pay a higher premium had remained at a fixed amount since 2011 after passage of the Affordable Care Act and were set to stay at those amounts until 2019.<sup>230</sup> 2020 was the first year that the income thresholds for IRMAA surcharges were adjusted for inflation, and the threshold has increased since then from \$87,000 for an individual to \$103,000 in 2024, and modification will continue to account for inflation.<sup>231</sup>

In 2013, about 5% of beneficiaries were paying the IRMAA, and the expectation was that by the time the income thresholds started growing again, the percentage of beneficiaries having to pay higher premiums would be about 7% in 2020.<sup>232</sup> However, still only about 8% of Part B beneficiaries pay a higher premium due to IRMAA today in 2023.<sup>233</sup> The number of beneficiaries paying the premium surcharges has not grown exponentially, but lowering the income thresholds could bring more revenue for the program.



The income threshold ratios for individual beneficiaries to beneficiaries who file jointly currently is 1:2, but the ratio could be updated to 1:1.5, which would lower the thresholds for both individuals and couples and would subject more beneficiaries to the IRMAA. This would not necessarily increase the percentage of beneficiaries paying the IRMAA, but the amount they would be paying above the standard premium amounts could increase. President Obama's 2013 budget proposal included an alternative, proposing instead to increase income-related premiums by 15% starting in 2017, and to maintain the income thresholds until 25% of beneficiaries under Parts B and D were subject to these premiums.<sup>234</sup> The Obama administration estimated that this change would generate about \$28 billion over 10 years.<sup>235</sup>

### C. Adopt Changes in Medicare Advantage

The share of beneficiaries enrolled in Medicare Advantage is increasing, and this is contributing to rising Medicare spending. In 2023, just over half (51%) of all Medicare-eligible beneficiaries are enrolled in Medicare Advantage and that number is projected to grow to 62% in 2033.<sup>236</sup>

MedPAC estimates that enrollment in MA results in disproportionately higher spending for Medicare than if beneficiaries were enrolled in TM; capitated payments to MA plans are \$27 billion, or 6%, higher than FFS payments would be if these beneficiaries were enrolled in Traditional Medicare.<sup>237,238</sup> In contrast, the average MA plan's bid to provide Part A and B benefits is 17% lower than FFS would be projected to spend for these enrollees. The Medicare program does not fully benefit from these lower costs reflected in MA bids, because Traditional Medicare enrollees help to finance Medicare Advantage through their payroll taxes and Part B premiums, but do not receive benefits from MA, while taxpayers and TM beneficiaries are subsidizing excess payments to MA.<sup>239</sup> Beneficiaries choose MA plans to benefit from such perks as lower costs, care coordination, and simpler navigation, but the federal government can reduce excessive payments that plans receive while still maintaining advantages for beneficiaries.

Medicare pays MA plans a monthly capitated rate per beneficiary to deliver Medicare Parts A and B, excluding hospice. Every year, MA plans submit bids estimating the cost to cover an average beneficiary. The bids must also include administrative expenses and profit, but plans must meet a minimum medical loss ratio that ensures that those amounts do not exceed 15% and that 85% of revenue is dedicated to benefits for the beneficiary.<sup>240</sup> These bids are compared to county-level benchmarks in the plan's service area that are set at 95%-115% of FFS-county spending, depending on the county's spending quartile. The lower of the plan's bid or the county-level benchmark becomes the "base rate" or "capitated payment."

The capitated payments are then adjusted up or down using a risk score that reflects the enrollee's health status relative to the national average. This process

is known as risk adjustment. In addition to the risk-adjusted payment, plans can also receive a rebate if their bid is below the county-level benchmark. The rebate is calculated as 50%-70% of the difference between the plan's risk-adjusted bid and the risk-adjusted county benchmark, and the rebate must be used to offer supplemental benefits or to lower premiums.<sup>241</sup> Under the Quality Bonus Program (QBP), the bids of plans achieving a quality rating of four stars are compared to a higher benchmark, and high-quality plans can also receive a higher rebate amount.<sup>242</sup>

Two drivers of higher Medicare Advantage payments are 1) inflated Medicare benchmarks relative to the actual cost of care for the average MA beneficiary, and 2) inflated risk scores relative to the actual risk profile of the average MA beneficiary, according to MedPAC.<sup>243</sup> Further, a MedPAC report and a research article published in *Health Affairs* show that the QBP adds to Medicare Advantage spending without realizing the intended levels of quality increases, plan efficiency, or provision of additional benefits.<sup>244,245</sup>

BPC recommends pursuing policies that modify risk adjustment practices and create a competitive bidding system to address inflated risk scores and benchmarks, respectively. This report also recommends transitioning the Quality Bonus Program to a budget-neutral program to reduce program spending by collecting and redistributing existing funds, similar to other value-based payment programs, and by better aligning incentives to achieve lower bids.

### **Risk Adjustment**

Risk scores are beneficiary-level values that indicate the expected costs for an enrollee, relative to an average beneficiary enrolled in Traditional Medicare. The scores are calculated using the hierarchical condition category (HCC) model, which assigns scores based on demographic and diagnosis information. These scores are applied as an adjustment to plans' payments, with the goal of removing disincentives for MA plans to cover sicker beneficiaries, and it remains essential to ensuring plans do not avoid risk due to sicker-than-average beneficiaries.<sup>246</sup>

However, the system creates financial incentives for plans to record all possible diagnoses for their enrollees, as more thorough documentation of beneficiaries' diagnoses results in increases to their risk scores. This contrasts with providers serving TM patients, whose payments are not typically tied to risk scores and therefore who have less incentive to capture diagnoses. Higher diagnosis coding intensity among MA plans is well documented, and it results in higher risk scores for beneficiaries enrolled in MA than if they were covered in TM.<sup>247</sup> MedPAC estimates that excessive payments to MA organizations due to coding intensity will be \$23 billion in 2023, representing nearly all the estimated excessive payments. These higher payments undermine incentives for plans to engage in quality improvement and cost reduction.<sup>248</sup>

Under current law, to reduce excessive payments, CMS applies a mandatory minimum coding intensity adjustment to risk scores. This policy, however, does not account for the full difference between MA and FFS risk scores, leading to the remaining excessive payment. Policymakers and advisers have proposed and implemented several policy approaches to further account for MA coding intensity and to reduce the amount of these excessive payments. In contract year 2022, CMS began relying exclusively on encounter data for the calculation of HCC scores, a shift from utilizing both encounter data and information from the Risk Adjustment Processing System.<sup>249</sup>

This change is expected to narrow differences in coding intensity, but there are remaining opportunities to ensure this data is complete and accurate and that it is truly reflective of resource use.<sup>250,251,252</sup> CMS and MedPAC, under Democratic and Republican administrations, have put forward proposals to address the magnitude of the coding intensity differential between MA and FFS. Proposals include increasing the coding intensity adjustment, modifying or validating the diagnoses inputs in the risk adjustment methodology, and expanding the scope of the risk adjustment data validation (RADV) audit program.<sup>253,254</sup>

BPC's recommendations build on this work and support a package of policies that would make two refinements to the risk adjustment methodology and increase the coding intensity adjustment. BPC also recommends increasing retrospective adjustments on MA payments where audits find insufficient evidence for coding. The following proposals seek to make risk adjustment more accurate and equivalent between MA and FFS and to reduce coding intensity that is not associated with care that treats identified conditions.

---

### **CMS SHOULD MODIFY RISK ADJUSTMENT METHODOLOGY TO USE TWO YEARS OF DIAGNOSTIC DATA.**

---

Currently, risk adjustment under the HCC model uses diagnoses recorded during the previous calendar year. Given the difference in incentives under MA and FFS to capture all diagnoses described above, it may be less likely that a one-year lookback period captures Traditional Medicare beneficiaries' diagnoses in the claims data when compared with diagnoses captured during a one-year period for MA beneficiaries. This contributes to risk scores reflecting a greater differential in MA and TM beneficiaries than actually exist, which leads to higher relative payments for MA plans.<sup>255</sup>

To address this issue, MedPAC has proposed, and CBO has put forward, a budget option utilizing two years of diagnoses data for risk scores rather than one, and the 21<sup>st</sup> Century Cures Act gave CMS the authority to do so

beginning in 2019.<sup>256,257</sup> CMS has never utilized this authority, however. BPC recommends using two years of data, which would increase the number of diagnoses captured for FFS beneficiaries by allowing more time for claims data to reflect care provided to a beneficiary for such diagnoses. This is likely to have minimal impact on the number of diagnoses captured for MA beneficiaries, given that plans already have incentive to capture all diagnoses in a one-year period and an additional year of data would be unlikely to capture additional diagnoses. The impact of increasing the FFS risk scores while maintaining Medicare Advantage risk scores would better align risk scores among the two populations. A MedPAC analysis confirmed this argument when it showed that utilizing two years of diagnosis data decreases the difference in coding intensity between MA and FFS.<sup>258</sup> Using two years of data would reduce MA risk scores relative to FFS risk scores by 1%-2%.<sup>259</sup>

---

**CONGRESS AND CMS SHOULD EXCLUDE DIAGNOSES IDENTIFIED THROUGH HEALTH RISK ASSESSMENTS FROM RISK SCORE CALCULATIONS.**

---

Under both Traditional Medicare and Medicare Advantage, providers conduct health risk assessments (HRAs) as a way to collect information about a beneficiary's health status and risk. As noted above, because risk scores directly affect MA plans' payments but not TM's payments, Medicare Advantage plans have a greater incentive to utilize these assessments to document diagnosis codes. MedPAC found that nearly two-thirds of MA coding intensity is attributable to diagnoses from chart reviews and HRAs. Specifically, diagnoses under HRAs (where no treatment was provided) accounted for about 1-2 percentage points of overall MA coding intensity impact.<sup>260</sup> MedPAC found that 37% of HRA diagnoses are not documented on any other encounter data.<sup>261</sup> This is a concern because it means that MA plans are receiving higher payments for diagnoses that they are not incurring any costs to treat. Alternatively, other encounters documenting diagnoses demonstrate that providers are treating the condition.

MedPAC and presidential administrations have proposed options to reduce the impact of HRA-only diagnoses on MA risk scores. The administration's budget proposals for 2021 and 2024 included recommendations to conduct a prospective prepayment review confirming diagnoses and set a threshold for requiring medical record documentation.<sup>262,263</sup> MedPAC has recommended excluding diagnoses identified only from health risk assessments, finding that diagnoses that are identified only on an HRA and not acted on through a care plan or through other medical encounters should not be included for purposes of risk adjustment.<sup>264</sup> Therefore, BPC recommends excluding HRA-only diagnoses from risk adjustment calculations for both MA and TM beneficiaries.

---

**FOR ANY DIFFERENCE IN CODING INTENSITY STILL REMAINING, CMS SHOULD INCREASE THE ACROSS-THE-BOARD CODING INTENSITY ADJUSTMENT REDUCTION TO MEDICARE ADVANTAGE PLAN PAYMENTS.**

---

Current law requires CMS to apply an across-the-board coding intensity adjustment to account for MA enrollees having higher average risk scores than otherwise similar TM beneficiaries. The minimum adjustment required in statute is 5.9%.<sup>265</sup> Reductions larger than 5.9% are allowed under current law. CMS, however, has not utilized [this](#) authority, instead continuing to implement the minimum 5.9% reduction. In 2021, MedPAC identified the difference in risk scores between MA and TM enrollees to be 10.8%.<sup>266</sup>

The recommended policies to utilize two years of diagnostic data and exclude HRA-only diagnoses would reduce the delta between MA and FFS risk scores. However, there is likely to be some remaining difference not addressed by these two policies.<sup>267</sup> Therefore, CMS should increase the across-the-board coding intensity adjustment to account for this remaining difference.

An across-the-board coding intensity adjustment reduces payments to all plans, including those that do not code as intensively, while maintaining incentives for plans to increase coding intensity. CMS should monitor the impact of these adjustments to ensure that plans have the appropriate incentives to enroll sicker beneficiaries and that favorable risk selection does not occur.

In 2018, CBO estimated that together the first two policy changes (utilizing two years of diagnosis data and excluding HRA diagnoses) would reduce spending by \$67 billion over 10 years (2019-2028) if implemented in 2021.<sup>268</sup> CBO also estimated in 2018 that changing the reduction in risk scores from the current 5.9% to 8% to better reflect coding differences would lower spending by \$47 billion between 2021 and 2028.

These scores reflect savings if the policies were implemented independent of one another. If implemented together in 2025, the three policy changes would likely result in estimated savings between \$200 billion and \$300 billion over the 2024-2033 budget window. This assumes the full 10.8% reduction in risk scores estimated by MedPAC beginning in 2025. The potential savings associated with these proposals might be lower or greater if the contribution of risk score growth and coding intensity to MA spending changes in future years. Additionally, this does not reflect recently finalized changes to the risk adjustment methodology, which would lower the savings.<sup>269</sup>

---

**CONGRESS SHOULD EXPAND THE SCOPE OF THE RISK ADJUSTMENT DATA VALIDATION AUDIT PROGRAM OR CONDUCT PREPAYMENT REVIEWS AND IMPOSE A FINANCIAL PENALTY FOR MAOS THAT ARE FOUND TO BE SUBMITTING UNVERIFIED DIAGNOSES BEGINNING IN 2025.**

---

To support diagnoses reported for risk adjustment and to recoup identified overpayments, CMS annually conducts risk adjustment data validation (RADV) audits to verify documentation in medical records. Although CMS recently finalized changes to the program that will likely increase the amount recouped through these audits, opportunities remain to account for a larger share of overpayments resulting from unverified diagnoses.<sup>270</sup>

Currently, more than 700 Medicare Advantage contracts exist. However, CMS has historically conducted RADV audits on only 30 MA contracts per year. From 2011-2013, approximately 80% of audited contracts contained improper payments. CMS estimates the audits would recoup \$479 million per year beginning in 2025.<sup>271</sup> Auditing a larger share of contracts would undoubtedly result in additional recoupments. CMS should meaningfully increase the share of MA contracts subject to RADV audits annually, and it should recoup identified overpayments due to unsubstantiated diagnoses factored into risk scores. In addition, CMS should impose a financial penalty for Medicare Advantage Organizations (MAOs) that are found to be submitting unverified diagnoses for purposes of risk adjustment to provide a further disincentive for coding that leads to improper payments; this would also have a deterrent effect for contracts that are not audited.

Another way to address improper payments resulting from unverified diagnoses is to conduct a prospective review of risk score data. President Biden included this approach in his 2024 budget proposal, which suggested a targeted risk-adjustment prepayment review.<sup>272</sup> Such a review would ideally prevent improper payments by requiring documentation of medical records in some instances before CMS makes risk-adjusted payments to MA organizations. This would also lessen the need for RADV audits.

CMS would need additional funds to administer an expanded RADV program or prepayment reviews. However, this increase would be minimal; current annual expenditures for these reviews are \$51 million.<sup>273</sup> BPC estimates that expanding the RADV audit program would likely produce additional savings; the amount would depend on the scope of the expanded audits. Imposing penalties for contracts with identified overpayments would result in a small increase in revenues in addition to the recoupment amounts.

## Quality Bonus Program

The Quality Bonus Program (QBP) has not had the intended effect of improving overall MA plan quality. Studies have shown that it generally does not drive MA plans to be more efficient, may not result in additional benefits for enrollees, and it increases Part B premiums for all enrollees, including those in Traditional Medicare.<sup>274,275</sup> Additionally, numerous studies, including ones by MedPAC and CBO, have found that the current QBP is flawed as geographic variation, plan enrollment, and plans' activities unrelated to quality improvement can influence measurement.<sup>276,277,278,279,b</sup>

---

**CONGRESS AND CMS SHOULD ALTER THE MA QUALITY BONUS PROGRAM BY REMOVING THE BENCHMARK QUALITY BONUSES ASSOCIATED WITH IT AND REPLACING IT WITH A BUDGET-NEUTRAL QUALITY INCENTIVE THAT UTILIZES A SMALLER SET OF MEANINGFUL PERFORMANCE METRICS.**

---

The ACA established the Quality Bonus Program to encourage plans to compete for enrollment based on their quality. More specifically, the ACA required that a five-star rating system be used to inform enrollees on the quality of MA plans and to determine plans' eligibility for bonus payments.<sup>280</sup> In 2023, MA plans are rated on up to 40 clinical quality, patient experience, and administrative measures under the star ratings system, the composite score of which and ratings for individual measures are published on the Medicare Plan Finder to assist enrollees in making informed coverage decisions.<sup>281,282</sup>

Achieving higher star ratings under the QBP gives MA plans considerable advantages, including receiving a 5% adjustment in the county benchmark, retaining a greater percentage of the rebate, and offering beneficiaries in lower-rated plans the flexibility to enroll in higher-rated plans at any time of the year (as opposed to the open-enrollment period limitation).<sup>283,284,285</sup> KFF projects that in 2023, Medicare Advantage plans will receive \$12.8 billion in bonus payments under the QBP, more than four times the amount in 2015.<sup>286</sup> In 2023, 51% of Medicare Advantage Part D contracts were rated as four stars or above, and these contracts represent a disproportionate share of enrollment; 72% of enrollees are in a contract rated four stars or above.<sup>287,288</sup>

The star rating system determines two parts of a plan's payment: first, whether the plan is eligible for a bonus payment and second, the percentage of the

---

<sup>b</sup> Bonuses have "historically been lowest for special needs plans and highest for group sponsored employer/union plans." See: <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-payments-will-reach-at-least-12-8-billion-in-2023/>.

difference between a plan's bid and the county benchmark that the plan retains as rebates and must use to reduce enrollees' premiums, cost sharing, and/or offer supplemental benefits.<sup>289</sup> Under the QBP, plans rated four stars or higher are referred to as "bonus plans" and can submit their bids against a higher FFS benchmark—typically 5% higher than the standard county benchmark. While being compared to a higher benchmark gives plans the ability to offer additional benefits to enrollees, plans are not required to use the funds for this purpose. In certain counties, plans are also eligible for double bonuses, which can increase the standard benchmark by 10%. "Double bonus" counties are defined as urban counties with low Medicare FFS spending and historically high MA enrollment.<sup>290</sup>

Congress should modify the QBP to eliminate the current benchmark increases but retain an incentive for performance through the existing enhanced rebate payments. The funding for such an incentive would be taken from spending that would otherwise happen under the MA rebate bonuses. This change could be accomplished by withholding payments for the year in which performance is being assessed and then redistributing the money according to performance or adjusting future payments upward or downward based on performance.<sup>291</sup>

Reforming the QBP should also include utilizing a simplified and smaller set of more meaningful, quality measures assessed at the local market level.<sup>292,293</sup> In 2023, ratings for MA plans with prescription drug coverage are calculated using 38 different measures.<sup>294</sup> This expansive set of measures may dilute the results, and many of these measures may be challenging for beneficiaries to interpret or are not correlated with health outcomes. Seventy-five percent of MA enrollees are in a plan with four or more stars, demonstrating that some measures are "topped out," or no longer reflecting a meaningful distinction between plans.<sup>295</sup> This inhibits beneficiaries' ability to find truly high-performing plans. Additionally, the measures do not capture key issues that CMS and GAO have identified in the MA program, such as utilization management, network adequacy, and high rates of seriously ill beneficiaries switching to Traditional Medicare.<sup>296</sup> More meaningful measures could better reflect clinical outcomes, enrollee experience, and plan administration.

In its 2018 Budget Options document, CBO estimated that eliminating benchmark increases on the basis of quality bonuses in the QBP would reduce mandatory spending by \$94 billion between 2021 and 2028.<sup>297</sup> This spending reduction is due to direct reductions in benchmarks as well as an assumed reduction in plan bids. CBO finds that for every additional dollar in reduced benchmarks, plans would reduce their bids by 50 cents in order to partially shield beneficiaries from benefit cuts. Any changes in enrollment in response to the QBP changes would have minimal budgetary effects, according to CBO, given evidence that plans largely shield beneficiaries from reductions in benefits by reducing their bids when benchmarks are reduced.



Total MA spending and QBP spending have increased since this estimate. Assuming that the trend in the share of MA spending (2%-3%) reflected in the QBP remains over the budget window, this policy change if enacted in 2025 would likely produce savings in the \$100 billion to \$200 billion range in the 2024-2033 budget window.

### **Competition in Medicare Advantage**

The current MA bidding system creates competition based on the attractiveness of a plan rather than the cost of a plan. Medicare Advantage Organizations (MAOs) use the rebate they incur through the bidding process to offer benefits to enrollees, usually in the form of reduced cost sharing, lower or zero-cost Part D premiums, sometimes lower Part B premiums, and supplemental benefits. In 2023, 66% of MA plans with prescription drug coverage charged no Part D premium.<sup>298</sup>

MAOs typically offer supplemental benefits as part of a plan package. In 2023, over 99% of Medicare beneficiaries live in a county where at least one MA plan offers supplemental benefits not covered by Traditional Medicare.<sup>299</sup> The most common supplemental benefits include hearing, dental, and vision, as well as fitness benefits.<sup>300,301</sup> Payments to MAOs to cover a beneficiary remain higher than what the cost would be to cover a beneficiary in TM, and these additional payments to MAOs result in an excess of rebate dollars.<sup>302</sup>

In 2022, rebates for Medicare Advantage Organizations averaged almost \$2,000 annually per enrollee and were the highest in the program's history. Some MAOs also retain some of the rebate for themselves, even though it is intended for the beneficiary.<sup>303,304</sup> The extra money also sometimes goes to other supplemental benefits that may have lower beneficiary value and are underutilized, creating waste in the program.

Medicare Advantage Organizations can also offer as many plan variations as they want in a county to attract certain groups. The number of plans available nationwide has increased by 6% between 2022 and 2023, and a little over half of all Medicare beneficiaries can choose from more than 40 MA plans where they live.<sup>305</sup> This makes it extremely challenging for beneficiaries to compare plans and choose one that is best for them, especially when the variability is coupled with difficulties navigating the Medicare Plan Finder tool.

The benchmark under current law is set at 95%-115% of FFS spending in a county.<sup>c</sup> With the increasing number of beneficiaries enrolling in MA rather than Traditional Medicare, this approach may no longer accurately reflect the

---

<sup>c</sup> The MA benchmarks under current law are determined by the FFS spending in a county, which establishes a certain percentage of FFS that their bids will be set against. These percentages range from 95%-115% of FFS spending. Counties with the lowest FFS Medicare spending receive the highest percentage of FFS spending as their benchmark, which is 115%. The third-highest costing counties receive 107.5% of FFS, the second highest receives 100%, and the highest receives 95%. See: [https://www.bettermedicarealliance.org/wp-content/uploads/2020/03/BMA\\_WhitePaper\\_MA\\_Bidding\\_and\\_Payment\\_2018\\_09\\_19-1.pdf](https://www.bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_WhitePaper_MA_Bidding_and_Payment_2018_09_19-1.pdf).

market in many counties.<sup>306</sup> Currently, an MAO knows what the benchmark in the county will be, which allows them to alter their bids and predict the rebate they will receive to lower cost sharing and premiums for their enrollees. If an MAO submits its bids and does not know what the average is, it might submit a bid that only reflects the cost of covering Parts A and B with no potential to receive a rebate, resulting in higher costs for enrollees.

Competitive bidding solely for Medicare Advantage plans is not a novel idea and has been proposed a few times in the past decade, most notably by the USC-Brookings Schaeffer Initiative for Health Policy in 2018 and in President Obama's FY2017 budget proposal, as well as by BPC in a 2013 report, [A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment](#).<sup>307,308,309</sup> Increasing competition in the Medicare program has been a long-standing consideration, and policymakers have also considered proposals that would utilize bidding beyond MA only.

---

**CONGRESS SHOULD DIRECT CMS TO DESIGN A COMPETITIVE BIDDING SYSTEM FOR MEDICARE ADVANTAGE ORGANIZATIONS. THE BIDDING SYSTEM SHOULD INCLUDE A STANDARD BENEFIT WITH A HIGHER ACTUARIAL VALUE THAN FFS THAT ALL PLANS MUST OFFER, A BENCHMARK BASED ON THE ENROLLMENT-WEIGHTED AVERAGE OF THE BIDS SUBMITTED, AND TIERED PACKAGES TO INCLUDE SUPPLEMENTAL BENEFITS.**

---

BPC recommends that in addition to the TM changes stated above, Congress should implement a system in which Medicare Advantage benchmarks are determined based on the weighted average of MA plans' bids to reduce excessive payments and in which MA plans are partially standardized so that beneficiaries can more easily compare plans. Moving to a system where the benchmark is based on the enrollment-weighted average of the bids submitted could result in benchmarks that more accurately reflect the MAOs' cost of covering a beneficiary. This proposal is stand-alone and would function largely as an alternative to the recommendations on risk adjustment above. Congress could consider combining this proposal with the Quality Bonus Program proposal laid out above.

- If the system began in 2027, MAOs would be required to submit their bids in 2026 projecting the cost of covering the standard benefit for a beneficiary with average health. MAOs would bid on a standard benefit that would include coverage of Parts A and B services, a maximum out-of-pocket cap, and a slightly higher actuarial value than FFS (e.g., 105%).

A slightly more generous benefit package guarantees that MAOs would utilize those additional 5 percentage points to continue to offer lower cost sharing or additional benefits to beneficiaries, even within a more competitive structure. MAOs would have the ability to vary their specific cost-sharing structures, provided that they are actuarially equivalent and nondiscriminatory.

- The system would take place at the county level, and in the first year the benchmark would be determined by calculating the weighted average of all the bids submitted in the county in the prior year. These prior-year bids will have been based on the old calculation of the benchmark, which is a certain percentage of FFS spending in the county. There would also be a certain percentage added onto these bids to reflect the higher actuarial value of the standard benefit and would include a certain growth factor to reflect the growth cost year over year.
- Once the system is in place in the second year and beyond, CMS would continue to calculate the benchmark based on the average of the bids submitted in the prior year. This allows the MAOs to have more certainty for what the benchmark will be, and they can calculate their bids accordingly. Although this system would repeal the FFS county-level benchmark, this benchmark would instead function as a cap. In counties where the weighted average MA bid would be higher than the otherwise applicable FFS county-level benchmark, this benchmark would apply to ensure that spending did not increase in any counties. Both the bids and the benchmark would be risk adjusted under current law.
- CMS would set the bids against the newly calculated average benchmark to determine the rebate that MAOs would receive. If the bid turned out to be above the benchmark, MAOs would charge the beneficiary that amount in the form of a premium. If the bid turned out to be lower than the benchmark, Congress could consider allowing MAOs to retain a certain percentage of the rebate to use toward lowering cost sharing or to offering supplemental benefits. Under current law, plans can receive 50%-70% of their rebates—typically 65% or 70%—depending on their star ratings, and the government retains the remainder.<sup>310</sup> Since this proposal is stand-alone from the other MA reforms in this report, the quality measures for plans would remain as is under current law, allowing plans with higher star ratings to have their bids set against a higher benchmark, and a plan's star rating would determine the percentage of the rebate that it retains.
- MAOs would be required to offer beneficiaries the option of enrolling in a basic plan that only includes the standard benefit package, plus a certain actuarial value that can be used to reduce beneficiary cost sharing and premiums, which serves as the basis for plan bids. If the MAO has a remaining rebate to offer supplemental benefits, Congress should require various tiers of supplemental benefit packages with increasingly higher actuarial values than the standard benefit package. This would

not standardize the specific benefits that MAOs offer within their plans, although Congress could consider going further and standardizing the benefit packages beyond increased actuarial value. In 2023, almost all beneficiaries have access to at least one or more plans with hearing, dental, and vision benefits, although the scope of coverage varies greatly from plan to plan.<sup>311</sup> If an MAO decides to offer dental, hearing, and vision as supplemental benefits, Congress should standardize them to make it easier for beneficiaries to compare the offerings.

Congress would also need to address other factors as considerations for this proposal. For the purposes of estimating the proposal's cost, BPC made the assumption that this system would be implemented nationally all at one time, but CMS and MAOs would both require lead time for development and planning. Congress could phase in the system. The phase-in could be based on the number of plans or cost of care in a particular area, or CMS could test the system in a few areas before it was implemented nationally. Congress could also consider limiting the number of plan options that an MAO can offer in a county. On average, according to data from ATI Advisory, about five plans are offered per MAO per county, but some MAOs offer up to ten plans per county.<sup>312</sup> Given this variability, Congress could consider limiting the number to five standardized plans per MAO, which would still allow the MAOs to innovate and offer a variety of plans. Such standardization would reduce variation among counties that have substantially higher numbers of plans per MAO, but it is estimated that it would not affect MAOs in about 55% of counties.<sup>313</sup>

Implementing this system would require Congress to consider a pathway for Special Needs Plans (SNPs), which are specialized MA plans tailored to specific populations—beneficiaries who are dually eligible for Medicare and Medicaid, have certain chronic conditions, or require institutional-level care.<sup>314</sup> A little more than 5 million beneficiaries are enrolled in a SNP in 2023, and enrollment has increased exponentially since 2015 and accounts for 17% of total MA enrollment.<sup>315</sup> For purposes of estimating the cost of this proposal, we did not consider SNPs, but due to the continual increase in enrollment and the unique challenges that these beneficiaries face, the HHS secretary should have the authority to consider a pathway appropriate for payment while also protecting special-needs populations.

Previous estimates of savings associated with competitive bidding proposals have ranged from \$30 billion to \$100 billion over 10 years.<sup>316,317,318</sup> In 2018, the Brookings Institution published a paper that modeled the potential policy parameters and associated savings from a competitively bid system and projected bids would decrease by 5% in counties where bids are not greater than the benchmark. This resulted in projected savings of \$10 billion per year, or nearly a 6% reduction in MA spending.<sup>319</sup> The 2017 president's budget also proposed a competitive bidding system that estimated savings of \$77.2 billion over 10 years.<sup>320</sup> These proposals shared several commonalities with the policy contemplated in this report, including utilizing the average bid to determine

the new benchmark and increasing the actuarial value of the base benefit package to protect benefit generosity for enrollees. However, these proposals differed in that they provided for 100% of the rebate to be retained by the plan or used to reduce beneficiaries' cost sharing, unlike this proposal, which retains the current law rebate structure.

Since these proposals were written and scored, MA spending and the difference between bids and benchmarks have increased substantially. For example, in 2015 (the year the Brookings Institution used for its data), MA spending was \$170 billion, and the bid-to-benchmark ratio was 88%.<sup>321,322</sup> In 2023, MA spending is projected to be \$454 billion, and the bid-to-benchmark ratio is 76%.<sup>323,324</sup> This indicates that a similar proposal would generate greater savings than was earlier projected. This is because setting the benchmark at the average bid would lead to a greater relative reduction in spending than when the average bid was closer to the average benchmark. Reductions in bids then follow as a result of the lower benchmark, and rebate payments decrease with the lower bid to benchmark ratio.

Another existing competitive bidding policy proposal and score that is instructive in determining potential savings would direct reductions to MA benchmarks. CBO considered this as part of its December 2022 policy options document in which it analyzed a direct 10% reduction in MA benchmarks applied uniformly across counties. CBO assumed that plans would reduce their bids by 50% of the benchmark reduction. Additionally, CBO asserted that reducing benchmarks by more than 10% would not result in a proportional increase in savings. This is because very large reductions would be more likely to cause plans to exit the MA market and lead more beneficiaries to enroll in Traditional Medicare rather than Medicare Advantage.<sup>325</sup>

Under BPC's proposal, we assume that benchmarks would decrease by about 20%, to equal the average bid plus 5% additional actuarial value. Accordingly, we assume that bids would be 7% lower. Accounting for some shift in enrollment from MA to TM and associated reduced savings, this proposal if implemented in 2027 would likely result in savings in the \$400 billion to \$500 billion range for the 2024-2033 budget window.

#### **D. Enforce a Workable Trigger Mechanism**

In response to policymakers' concerns over the growth of general revenue funding contributions to total Medicare expenditures, Congress created the Medicare trigger in [the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 \(MMA\)](#). However, Congress has repeatedly ignored the process even though the trustees have activated the trigger regularly since 2006 and again in their 2023 Trustees Report. Not only should Congress enforce this trigger mechanism, but it should also revise it to ensure members of Congress have incentives to comply.

As required by the Social Security Act, the Medicare Board of Trustees oversees the financial operations of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds and reports annually to Congress on the trust funds' financial and actuarial status. The HI Trust Fund is financed by payroll taxes, federal taxes on Social Security benefits, and premiums for beneficiaries who are not otherwise eligible for Medicare Part A.

The SMI Trust Fund is financed primarily by general revenue transfers and beneficiary premiums for Parts B and D services. Congress originally intended a 50/50 split between Part B premiums and general revenue transfers to serve as a check on the SMI Trust Fund. However, as program costs greatly increased, Congress allowed beneficiaries' premiums to grow more slowly than total Part B spending. In 2022, premiums for Parts B and D accounted for only about 25% of revenues for the SMI Trust Fund, whereas the remaining 75% came from general revenue transfers.<sup>326</sup>

Most of policymakers' focus, however, has been on the HI Trust Fund because of the urgency related to its projected insolvency. Medicare's trustees estimated recently that the HI Trust Fund will become insolvent in 2031. Insolvency does not mean that Medicare would no longer be able to pay Part A claims, but rather the trust fund would not have any assets. When annual spending exceeds the trust fund's income, the asset level decreases, but Medicare draws down on these assets to cover the difference.<sup>327</sup> Since 2018, annual shortfalls have produced declining assets.

Once the trust fund is depleted, annual program revenues will cover only a portion of annual program outlays starting in 2032. At or before that point, Congress would have to act to close the funding gap. If Congress does not act, Medicare payments would be reduced, as the Medicare Board of Trustees has pointed out, "to levels that could be covered by incoming tax and premium revenues." No statutory provision allows for an automatic transfer from general revenues or any other mechanism to fill the difference absent congressional action.

With annual deficits projected to continue for the foreseeable future, the HI Trust Fund is unlikely to regain a positive balance on its own, and any changes to the program would require time to have a meaningful effect. A higher positive balance, within reason, is desirable, as it shows that Medicare Part A is operating on stable financial footing.<sup>328</sup>

---

**AS A STOPGAP UNTIL MEDICARE IS REFORMED,  
THE EXECUTIVE BRANCH AND CONGRESS SHOULD  
ENFORCE THE CURRENT MEDICARE TRIGGER  
WARNING ESTABLISHED IN THE MEDICARE  
PRESCRIPTION DRUG, IMPROVEMENT, AND  
MODERNIZATION ACT OF 2003.**

---

The formula for calculating general revenue funding is distinct from the general revenue transfers directed to the SMI Trust Fund, which under current law covers almost 75% of Part B expenditures. The MMA also created the Medicare Part D drug benefit, which increased the amount of general revenues needed to finance the Medicare program. Currently, 74% of Part D revenue comes from general revenues, while 15% comes from beneficiary contributions.<sup>329</sup>

Beginning in 2005, the MMA required the Medicare trustees to decide each year whether general revenue funding would exceed 45% of Medicare's total outlays for the current fiscal year or any of the next six fiscal years. While the HI and SMI trust funds have different sources of revenue and are statutorily independent, the formula to calculate excess general revenue funding combines their respective funding streams (see Figure 6).

**Figure 6. Medicare Trigger Formula<sup>330</sup>**

The numerator in the formula is the general revenue funding amount and is calculated by subtracting total Medicare outlays from HI and SMI by dedicated revenues (e.g., HI payroll taxes, beneficiary premiums, and more). The general revenue Medicare funding is divided by total Medicare outlays (the denominator) to equal a general revenue funding percentage.

**Medicare Trigger Formula**

$$\text{General Revenue Funding Percentage} = \frac{\text{Total Medicare Outlays} - \text{Dedicated Revenues}}{\text{Total Medicare Outlays}}$$

Adapted from 2023 Medicare Trustees Report.

---

**CONGRESS SHOULD REVIEW, RECONSIDER, AND  
MODIFY THE MEDICARE FUNDING WARNING IN  
CURRENT LAW.**

---

A Medicare funding warning is officially triggered when two consecutive Medicare trustees' reports project that general revenues will exceed 45% of total program outlays within the next seven fiscal years of the projection. Once the Medicare funding warning is triggered, the president is required to submit proposed legislation responding to such a warning to Congress within 15 days of submitting the administration's budget for the upcoming fiscal year.<sup>331</sup> Congress is then required to promptly introduce legislation to respond to the Medicare funding warning. Under the MMA, within three days of the session in which the proposal is received, the two floor leaders in each chamber must introduce a bill to respond to the funding warning. However, Congress is not required to consider the president's specific proposed legislation, nor is it required to enact legislation to lower the percentage of general revenue funding below the trigger threshold (i.e., 45% of total program outlays).

While the trustees have consistently sounded the alarm, policymakers have neglected to follow the statutory process. The ratio exceeded 45% at the end of calendar years 2009 through 2012 and in calendar year 2020. Although the ratio dropped to 43.2% in 2022, nonetheless it is expected to again exceed 45% at the end of calendar year 2025, the third year of the projection, which is within seven years of 2022. Because the 2023 report also projected over 45% of revenues, a funding warning once again has been issued, which is the trustees' sixth consecutive year warning. Submission of the president's 2025 budget proposal next year, in an election year and with political promises that "Medicare is off the table," likely guarantees that Congress will once again ignore the funding warning.



**Figure 7. Past and Projected Amounts of Medicare Revenues as a Percentage of Total Non-interest Medicare Income<sup>332</sup>**

Payroll taxes and premiums have been the largest revenue contributors to Medicare in the past several decades. Revenues exceeded or almost exceeded 45% of program outlays every year since 2010 and are projected to continue exceeding that threshold.

Calendar year	Payroll taxes	Tax on benefits	Premiums <sup>1</sup>	Brand-name drug fees	State payments	Government contribution <sup>2</sup>
<b>Historical Data</b>						
<b>1970</b>	61.8%	---	13.7%	---	---	24.6%
<b>1980</b>	68.0	---	8.6	---	---	23.4
<b>1990</b>	62.2	---	9.8	---	---	27.9
<b>2000</b>	59.8	3.6%	9.1	---	---	27.6
<b>2010</b>	38.9	2.9	13.3	---	0.9%	44.0
<b>2015</b>	38.1	3.2	13.6	0.5%	1.4	43.2
<b>2016</b>	36.3	3.3	12.8	0.4	1.4	45.7
<b>2017</b>	37.7	3.5	14.6	0.6	1.6	42.0
<b>2018</b>	36.0	3.2	15.2	0.5	1.6	43.4
<b>2019</b>	36.4	3.0	15.3	0.4	1.6	43.4
<b>2020</b>	34.0	3.0	14.8	0.3	1.3	46.6
<b>2021</b>	34.4	2.8	15.1	0.3	1.4	46.1
<b>2022</b>	36.1	3.3	15.7	0.3	1.4	43.2
<b>Intermediate Estimates</b>						
<b>2030</b>	29.9	4.4	17.2	0.2	1.2	47.1
<b>2040</b>	26.1	4.7	18.5	0.1	1.0	49.6
<b>2050</b>	25.7	4.9	18.6	0.1	1.0	49.8
<b>2060</b>	25.3	5.0	18.7	0.0	1.0	50.0
<b>2070</b>	25.0	5.1	18.8	0.0	1.1	50.0
<b>2080</b>	25.1	5.1	18.8	0.0	1.1	49.9
<b>2090</b>	25.6	4.9	18.7	0.0	1.1	49.6
<b>2097</b>	25.9	4.9	18.6	0.0	1.1	49.5

<sup>1</sup>Includes premium revenue from HI and both accounts in the SMI trust fund.

<sup>2</sup>Includes Part B repayment amounts in 2016-2025.

**Note:** Row sums may not exactly equal 100 percent due to rounding.

Adapted from 2023 Medicare Trustees Report.

Administrations have only once—under President George W. Bush in 2008—submitted a legislative proposal as required.<sup>333</sup> Congress, however, did not act on his proposal. Administrations of both parties have routinely ignored the Medicare trigger and the MMA requirement. Administrations have generally taken the position that the recommendations clause of the Constitution (Article 2, Section 3) provides that the president “shall from time to time ... recommend to [Congress’s] Consideration such Measures as he shall judge necessary and expedient.” This is an arguable position, given the repeated warnings from the program’s trustees and the clear depletion of the HI Trust Fund in 2031.

Congress should consider how to appropriately incentivize policymakers to address the financial health and long-term stability of the program along with its impact on the federal budget. To be sure, no triggering mechanism designed to force legislators to act will be successful without the political will to do so. Avoiding a real and calamitous trigger—the depletion of the HI Trust Fund in 2031 that could delay providers’ payments and reduce beneficiaries’ access to services—should focus policymakers on reforms.

Congress could build on the MMA trigger calculation to enforce a limit on general revenue funding of Medicare. Specifically, Congress could require the HI Trust Fund to transfer revenue to the SMI Trust Fund when general revenue funding outlays are projected to exceed the 45% threshold when the process required in the MMA does not yield a solution. This would increase the HI Trust Fund’s liability, expedite its depletion—and force the executive branch and Congress to act promptly to comply with the Medicare trigger.

## **PHASE 2: ENSURE FAIR COMPETITION BETWEEN TRADITIONAL MEDICARE AND MEDICARE ADVANTAGE**

---

Congress should strengthen Medicare to promote fair competition between Traditional Medicare and Medicare Advantage, with the intent of simplifying and improving choices for beneficiaries while ensuring the program’s long-term sustainability by constraining cost growth. The reforms in Phase 1 would set up the Medicare program to achieve the overall reforms proposed in Phase 2, and it is critically important for policymakers to implement both sets of recommendations to improve the program for beneficiaries and achieve lasting financial sustainability. These reforms provide a unique opportunity for policymakers to thoughtfully improve Medicare’s structural design, benefits, and financing.

Key to enabling fair and informed competition, the reforms must empower Medicare beneficiaries by giving them the information they need to make apples-to-apples comparisons between TM and MA plans. Achieving this goal will require an improved defined benefit and an enhanced standard cost-sharing limit for all coverage options. The presence of an improved and more equivalent TM benefit in the competition would add an incentive to provide lower-cost, higher-quality care. It would also include and apply a more rigorous and accurate risk adjustment system for the program, which would ensure that plan payment rates reflect the health status of the patients they serve (and protect Traditional Medicare from being unfairly burdened by adverse selection). However, to successfully implement a system like this and ensure a level playing field, the risk adjustment system would require Congress to make substantial changes, but more research and analyses are needed to fully understand the issues involved.

The competition established between Traditional Medicare and Medicare Advantage would determine the monthly premiums for beneficiaries and would be driven by the bids submitted by MA plans and TM for the cost of providing a new standard benefit, measured against an enrollment-weighted average benchmark. The calculated benchmark in each market, as determined by the submitted bids, would be used to calculate the set amount paid by Medicare each year, as well as the amount of the total premium paid by the beneficiary.

Importantly, all plans would offer the same benefit package, but at different costs, and all beneficiaries would have access to a plan with the standard Part B premium. Still, plans might have coverage differences, such as in the extensiveness of provider networks. Some plans, for example, might include a broad network of clinicians and hospitals, while others could be more limited.

Beneficiaries selecting coverage with premiums equal to the benchmarks would pay the same premium that would be required under current law. However, those selecting plans with bids below the benchmark would pay lower premium amounts, while those selecting more expensive plans would pay higher premium amounts. This design is intended to incentivize cost reduction by rewarding plans that offer lower premiums while still covering the standard benefit.

As an illustrative example, in a given year, the weighted average benchmark in a market is \$13,000. The regular Part B premium would be equal to \$1,000. Medicare would calculate a set payment of \$12,000 for enrollment into whatever plan a beneficiary selected. If the chosen plan costs \$13,000, then the beneficiary would pay the standard \$1,000 premium, which is the regular Part B premium. If the chosen plan was \$12,500, then the beneficiary would pay \$500 instead of \$1,000 (or get \$500 back as a rebate). If the beneficiary picked a plan costing \$13,500, that individual would pay \$1,500 because the Medicare program would pay \$12,000.

To ensure that Traditional Medicare can compete with MA plans on a level playing field, the standard, defined benefit offered would need to be strengthened, simplified, and more closely aligned with plan offerings and improved to meet unmet health needs of beneficiaries. Like MA, the TM benefit would be integrated into one benefit to include both Parts A and B services. The integrated Traditional Medicare benefit would include the improvements recommended in Phase 1: an annual catastrophic limit set at the same amount required in MA, a combined deductible for Parts A and B services, and cost-sharing incentives to drive beneficiaries to seek efficient, necessary care. The benefit would also be updated to contain an improved benefit package that would include additional benefits, such as hearing, dental, and vision, that both MA and TM would offer. The transition from the Phase 1 standard benefit with a higher actuarial value than FFS that Medicare Advantage plans must offer would have to be well planned out as it moves to this system with an enhanced benefit that would include such offerings as hearing, dental, or vision.

To help Traditional Medicare be more cost effective and competitive, CMS should have new purchasing and anti-fraud and waste prevention authority to administer the program more prudently. Redesigning the Traditional Medicare benefit to align more closely with MA benefit packages would simplify the program for beneficiaries and empower them to make more informed and comparable coverage decisions, while protecting all beneficiaries from high out-of-pocket costs.

One element to simplify the decision process for beneficiaries and promote competition would be to provide more transparency into the available plans. If Traditional Medicare or a MA plan's bid fell below the benchmark, the difference would be made known to beneficiaries, who would receive a rebate to purchase supplemental benefits or lower their premium. If a MA plan's bid or the TM calculation was above the benchmark, the difference would be used to increase the beneficiary's monthly premium. When shopping for plans, beneficiaries would also have more transparency into the availability of in-network providers. Under current law, beneficiaries enrolled in Traditional Medicare have access to virtually any provider they wish to see, while beneficiaries in MA have a narrower, in-network pool of providers, and provider information is not always easily accessible. Under the new system, CMS would institute more oversight to ensure that provider networks are routinely audited and updated to provide the most accurate information to beneficiaries choosing to enroll in Medicare Advantage, which would ensure that beneficiaries are making more-informed choices.

Ensuring fair competition among more standardized offerings would provide more control to beneficiaries and better understanding of the coverage they are receiving. This would also dispense with the current rebate system for MA plans that allows them to largely compete on the extra supplemental benefits they offer. Competition, in turn, would be based more on cost, which would be reflected in beneficiaries' premiums.

If a beneficiary chose to use a rebate to purchase supplemental benefits (any benefits that go beyond the standard set of benefits), CMS would standardize the additional benefit offerings to make it easier for beneficiaries to compare plans, understand the actuarial value of the additional benefits, and secure additional benefits that meet their needs. Standardizing supplemental benefits could also result in the ability to compare TM and MA more fairly.

The Medicare Plan Finder would require updating to reflect the elements of the competition system by depicting a side-by-side comparison of TM/Medigap policies and the MA plans available to beneficiaries in their area. It would clearly identify the components of each plan, allow beneficiaries to distinguish among the differences, and simplify the decision-making process, resulting in better-informed choices by beneficiaries. Additional protections for low-income beneficiaries beyond Phase 1 would also be needed to supplement any new competitive model.

This section has laid out a broad vision for Medicare reform, and BPC acknowledges that questions remain for how certain elements would function. Policymakers will need to undertake necessary considerations during the transition from Phase 1 to Phase 2 to maintain reduced spending for the program and improved experiences for beneficiaries.

## Conclusion

---

Insolvency looms for Medicare's Hospital Insurance Trust Fund, driven by unprecedented growth in the aging population, a shift in enrollment to Medicare Advantage, and ongoing inefficiencies in both Traditional Medicare and Medicare Advantage. Unless Congress acts quickly, the program's financial difficulties will accelerate. Many beneficiaries already face high costs, in addition to having to navigate a complex program that needs simplification.

It is imperative that members of Congress focus on these challenges and work together to fundamentally reform the nearly 60-year-old Medicare program in a way that will meet the needs of beneficiaries and taxpayers alike. By acting promptly and decisively, policymakers will sustain Medicare for generations of Americans to come.

# Appendix A: Savings Estimates

The ranges of estimated savings in this report were developed utilizing publicly available data and scores. They are intended to provide a sense of magnitude for potential savings achievable through the policies proposed. Score ranges are not interacted across proposals. Where an existing score was referenced, it was updated to reflect projected spending for the 2024-2033 budget window utilizing the Congressional Budget Office's (CBO) May 2023 baseline. Most policies are assumed to be implemented beginning in 2025, with the exception of competitive bidding, which is assumed to be implemented in 2026. Sources include CBO, the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance trust funds, MedPAC, the Brookings Institution, and the Committee for a Responsible Federal Budget.

Policy	Estimated Range of Potential Savings, 2024-2033
Modifying payments to skilled nursing facilities, home health care agencies, and inpatient rehabilitation facilities by reducing the base payment rates	\$50 billion-\$60 billion
Implementing value-based purchasing programs for inpatient rehabilitation facilities and long-term care hospitals	Less than \$5 billion
Modifying payments to hospices by wage-adjusting and reducing the aggregate cap by 20%	\$5 billion-\$25 billion
Paying for hospital outpatient department services commonly performed in physician offices at a site-neutral rate	\$50 billion-\$100 billion (based on Committee for a Responsible Federal Budget's 2020 proposal and estimate), \$100 billion-\$200 billion (estimated from MedPAC's June 2023 recommendation)
Using two years of diagnoses data, excluding health risk assessment diagnoses for MA risk adjustment, and increasing the across-the-board coding intensity adjustment reduction to MA plan payments	\$200 billion-\$300 billion
Replacing the MA Quality Bonus Program with a budget-neutral quality incentive utilizing a smaller set of meaningful performance metrics	\$100 billion-\$200 billion
Expanding the scope of the risk adjustment data validation audit program	Less than \$5 billion
Design a competitive bidding system for MA	\$400 billion-\$500 billion

# Appendix B: Comparison of the Traditional Medicare Benefit under Current Law and the Proposed Restructured Medicare Benefit<sup>334</sup>

Medicare TM Benefit Design Features	Current law		Proposed restructured benefit
<b>Deductible</b>	<b>Part A:</b> Inpatient hospital deductible: \$1,632 (covers the first 60 days)	<b>Annual Part B deductible:</b> \$240	Single, annual deductible for Parts A and B services
<b>Coinsurance/ Copayments</b>	<b>Part A:</b> Daily copayments for days 61-90: \$408  Daily copayments for lifetime reserve days: \$816  SNF Daily copayments for days 21-100: \$204	<b>Part B:</b> 20% coinsurance for most Part B services	As is under current law: 20% coinsurance for most Part B services
<b>Cost-sharing limit</b>	Unlike Medicare Advantage, there is no annual cost-sharing limit in traditional Medicare for Parts A and B services.  <b>Note:</b> Under the IRA, there will be a \$2,000 limit on beneficiaries' Part D out-of-pocket spending, indexed annually to the rate of increase in per capita Part D costs (beginning in 2025).		Annual catastrophic limit set at the weighted average of the benefit currently provided by MA plans (and indexed to inflation)
<b>Preventive Services/Annual wellness visits</b>	No cost sharing for most Part B preventive services; the secretary maintains administrative authority to modify and/or eliminate coverage for preventive services		Maintain no cost-sharing obligations for preventive services and annual wellness visits.
<b>Supplemental Coverage (Medigap-only)</b>	Medicare Access and CHIP Reauthorization Act ( <b>MACRA</b> ) prohibits Medigap from selling plan types that cover new enrollees' Part B deductibles.		Option: Limit Medigap from covering the first set amount of cost sharing for Parts A and B services and limit coverage to 50% of the next set amount; Medigap would then cover all further cost-sharing obligations  To be consistent with MACRA, the limit on first dollar coverage could equal the amount of the combined A/B deductible.  Option: Charge an additional premium on certain Medigap policies

Medicare TM Benefit Design Features	Current law		Proposed restructured benefit	
	Part A	Part B	Part A	Part B
<b>Monthly Premiums (2023)</b>	<p>Most beneficiaries (99%) do not have to pay a Part A premium since they have at least 40 quarters of Medicare-covered employment.</p> <p>Individuals aged 65 and older who have fewer than 40 quarters of coverage and certain individuals with disabilities pay a monthly premium to voluntarily enroll in Part A. For those with at least 30 quarters of coverage (or their spouse), the monthly premium is \$278. Those with less than 30 quarters pay a monthly premium of \$505.</p>	\$174.70	Same as current law	Based on a % of Part B spending (current law)
<b>Income-Related Monthly Adjustment Amount (IRMAA)</b>	Higher-income beneficiaries pay Part B income-related monthly adjustment amounts in addition to the standard Part B premium.		Maintain IRMAA for high-income beneficiaries under current law. Congress could consider lowering the income threshold to generate revenue for the HI Trust Fund.	



# Glossary of Acronyms

---

<b>ACA</b>	Patient Protection and Affordable Care Act of 2010	<b>MedPAC</b>	Medicare Payment Advisory Commission
<b>ASC</b>	Ambulatory surgical center	<b>MIPPA</b>	Medicare Improvements for Patients and Providers Act of 2008
<b>CBO</b>	Congressional Budget Office	<b>MMA</b>	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
<b>CMMI</b>	Center for Medicare and Medicaid Innovation	<b>MPF</b>	Medicare Plan Finder
<b>CMS</b>	Centers for Medicare & Medicaid Services	<b>MSP</b>	Medicare Savings Program
<b>FFS</b>	Fee-for-service	<b>NIIT</b>	Net Investment Income Tax
<b>GDP</b>	Gross domestic product	<b>OIG</b>	Office of Inspector General
<b>HCC</b>	Hierarchical condition category	<b>OPPS</b>	Outpatient Prospective Payment System
<b>HHA</b>	Home health agency	<b>PFS</b>	Physician Fee Schedule
<b>HI</b>	Hospital Insurance	<b>PPS</b>	Prospective payment system
<b>HOPD</b>	Hospital outpatient department	<b>QBP</b>	Quality Bonus Program
<b>HRA</b>	Health risk assessment	<b>RADV</b>	Risk adjustment data validation
<b>IRA</b>	Inflation Reduction Act of 2022	<b>SHIP</b>	State Health Insurance Program
<b>IRF</b>	Inpatient rehabilitation facility	<b>SMI</b>	Supplementary Medical Insurance
<b>IRMAA</b>	Income-related monthly adjustment amount	<b>SNF</b>	Skilled nursing facility
<b>LIS</b>	Part D Low-Income Subsidy program	<b>SNP</b>	Special Needs Plan
<b>LTCH</b>	Long-term care hospital	<b>SSA</b>	Social Security Administration
<b>MA</b>	Medicare Advantage	<b>TM</b>	Traditional Medicare
<b>MACRA</b>	Medicare Access and CHIP Reauthorization Act of 2015	<b>VBP</b>	Value-based purchasing
<b>MAO</b>	Medicare Advantage Organization		

# Endnotes

---

- 1 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 2 Centers for Medicare & Medicaid Services, *National Health Expenditures Projections 2022 – 2031: Forecast Summary*. Available at: <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>.
- 3 KFF, *National Health Expenditures Projections 2012 – 2022: Forecast Summary*. Available at: <https://www.kff.org/wp-content/uploads/sites/3/2016/01/proj2012.pdf>.
- 4 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 5 Bipartisan Policy Center, *The Cost of Waiting to Act on Medicare’s Hospital Insurance Trust Fund*, June 2021. Available at: <https://bipartisanpolicy.org/report/hospital-insurance-trust-fund/>.
- 6 Emily Brandon, “Why Older Citizens are More Likely to Vote,” *U.S. News*, October 5, 2020. Available at: <https://money.usnews.com/money/retirement/aging/articles/why-older-citizens-are-more-likely-to-vote>.
- 7 Hannah Grabenstein, “WATCH: ‘We all apparently agree’ on saving Medicare and Social Security, Biden teases during State of the Union,” *PBS News Hour*, February 7, 2023. Available at: <https://www.pbs.org/newshour/politics/watch-we-all-apparently-agree-on-saving-medicare-and-social-security-biden-teases-during-state-of-the-union>.
- 8 Public Law 118-5, Fiscal Responsibility Act of 2023. Available at: <https://www.congress.gov/bill/118th-congress/house-bill/3746>.
- 9 The Commonwealth Fund, “50 Years of Medicare: How Did We Get Here?” 2015. Available at: <https://interactives.commonwealthfund.org/medicare-timeline/>.
- 10 Centers for Medicare & Medicaid Services, “Medicare Program – General Information,” 2023. Available at: <https://www.cms.gov/about-cms/what-we-do/medicare>.
- 11 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 12 Ibid.
- 13 Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2022. Available at: [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).
- 14 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 15 Ibid.
- 16 Centers for Medicare & Medicaid Services, *National Health Expenditures Projections 2022 – 2031: Forecast Summary*. Available at: <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>.
- 17 KFF, *National Health Expenditures Projections 2012 – 2022: Forecast Summary*. Available at: <https://www.kff.org/wp-content/uploads/sites/3/2016/01/proj2012.pdf>.
- 18 Peter G. Peterson Foundation, *Budget Basics: Medicare*, April 2023. Available at: <https://www.pgpf.org/budget-basics/medicare>.
- 19 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).

- 20 KFF, “Medicare Advantage in 2023: Enrollment Update and Key Trends,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>.
- 21 Centers for Medicare & Medicaid Services, *Understanding Medicare Advantage Plans*, July 2022. Available at: <https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf>.
- 22 KFF, “Key Facts About Medicare Part D Enrollment and Costs in 2023,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-and-costs-in-2023/>.
- 23 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 24 Ibid.
- 25 Ibid.
- 26 Ibid.
- 27 KFF, “What to Know about Medicare Spending and Financing,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/>.
- 28 Centers for Medicare & Medicaid Services, “Trustees Report & Trust Funds,” 2023. Available at: <https://www.cms.gov/data-research/statistics-trends-and-reports/trustees-report-trust-funds?redirect=/reportstrustfunds/>.
- 29 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 30 Centers for Medicare & Medicaid Services, *The 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 2022. Available at: <https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf>.
- 31 Committee for a Responsible Federal Budget, “Analysis of the 2023 Medicare Trustees’ Report,” 2023. Available at: <https://www.crfb.org/papers/analysis-2023-medicare-trustees-report>.
- 32 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 33 Ibid.
- 34 Howard Gleckman, “A Two-Year Reprieve For Medicare Insolvency Sounds Like Good News. But It Isn’t,” *Forbes*, June 8, 2022. Available at: <https://www.forbes.com/sites/howardgleckman/2022/06/08/a-two-year-reprieve-for-medicare-insolvency-sounds-like-good-news-but-it-isnt/?sh=ded7e392000e>.
- 35 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 36 Medicare.gov, “Parts of Medicare.” Available at: <https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare>.
- 37 Centers for Medicare & Medicaid Services, “2024 Medicare Parts A & B Premiums and Deductibles,” 2023. Available at: <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles>.
- 38 Ibid.
- 39 Internal Revenue Service, “Topic No. 751, Social Security and Medicare Withholding Rates,” 2023. Available at: <https://www.irs.gov/taxtopics/tc751>.
- 40 KFF, “FAQs on Medicare Financing and Trust Fund Solvency,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/>.
- 41 KFF, “What to Know about Medicare Spending and Financing,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/>.

- 42 Centers for Medicare & Medicaid Services, *Medicare General Information, Eligibility, and Entitlement: Chapter 2 - Hospital Insurance and Supplementary Medical Insurance*, May 2023. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c02.pdf>.
- 43 Medicare.gov, “Parts of Medicare.” Available at: <https://www.medicare.gov/basics/get-started-with-medicare/medicare-basics/parts-of-medicare>.
- 44 Centers for Medicare & Medicaid Services, *Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update*, October 2023. Available at: <https://www.cms.gov/files/document/mm13365-cy-2024-update-medicare-deductible-coinsurance-premium-rates.pdf>.
- 45 Centers for Medicare & Medicaid Services, “2024 Medicare Parts A & B Premiums and Deductibles,” 2023. Available at: <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles>.
- 46 KFF, “Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/>.
- 47 The Commonwealth Fund, *The Evolution of Private Plans in Medicare*, December 2017. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare>.
- 48 KFF, “Medicare Advantage in 2023: Enrollment Update and Key Trends,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>.
- 49 Ibid.
- 50 KFF, “Medicare Advantage 2023 Spotlight: First Look,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/>.
- 51 Ibid.
- 52 Ibid.
- 53 Ibid.
- 54 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 55 KFF, “Medicare Advantage 2023 Spotlight: First Look,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/>.
- 56 KFF, “Key Facts About Medicare Part D Enrollment, Premiums, and Cost Sharing in 2021,” 2021. Available at: <https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-premiums-and-cost-sharing-in-2021/>.
- 57 Public Law 117-169, Inflation Reduction Act of 2022. Available at: <https://www.congress.gov/bill/117th-congress/house-bill/5376>.
- 58 KFF, “Explaining the Prescription Drug Provisions in the Inflation Reduction Act,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/#bullet03>.
- 59 Office of the Assistant Secretary for Planning and Evaluation, *2023 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)*, January 2022. Available at: <https://aspe.hhs.gov/sites/default/files/documents/1c92a9207f3ed5915ca020d58fe77696/detailed-guidelines-2023.pdf>.
- 60 KFF, “Explaining the Prescription Drug Provisions in the Inflation Reduction Act,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/#bullet03>.
- 61 Assistant Secretary for Planning and Evaluation, *2023 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)*, January 2022. Available at: <https://aspe.hhs.gov/sites/default/files/documents/1c92a9207f3ed5915ca020d58fe77696/detailed-guidelines-2023.pdf>.
- 62 KFF, “Explaining the Prescription Drug Provisions in the Inflation Reduction Act,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/#bullet03>.

- 63 Center for Medicare Advocacy, “Medicare Enrollment Numbers,” 2023. Available at: <https://medicareadvocacy.org/medicare-enrollment-numbers/>.
- 64 Sachin H. Jain, “Before Rushing To Criticize Medicare Advantage, Let’s Take A Close Look At The Alternative,” *Forbes*, December 5, 2022. Available at: <https://www.forbes.com/sites/sachinjain/2022/12/05/before-rushing-to-criticize-medicare-advantage-lets-take-a-close-look-at-the-alternative/?sh=2682791f52e2>.
- 65 Congressional Budget Office, *Change the Cost-Sharing Rules for Medicare and Restrict Medigap Insurance*, December 2022. Available at: <https://www.cbo.gov/budget-options/58647>.
- 66 KFF, “Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/>.
- 67 Centers for Medicare & Medicaid Services, “2024 Medicare Parts A & B Premiums and Deductibles,” 2023. Available at: <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles>.
- 68 Ibid.
- 69 Ibid.
- 70 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 1: Reforming Medicare’s Benefit Design*, June 2012. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun12\\_ch01.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun12_ch01.pdf).
- 71 Ibid.
- 72 Assistant Secretary for Planning and Evaluation, *Medicare Beneficiary Enrollment Trends and Demographic Characteristics*, March 2022. Available at: <https://aspe.hhs.gov/sites/default/files/documents/f81aafbba0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf>.
- 73 KFF, “A Snapshot of Sources of Coverage Among Medicare Beneficiaries,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>.
- 74 Ibid.
- 75 Assistant Secretary for Planning and Evaluation, *Medicare Beneficiary Enrollment Trends and Demographic Characteristics*, March 2022. Available at: <https://aspe.hhs.gov/sites/default/files/documents/f81aafbba0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf>.
- 76 KFF, “A Snapshot of Sources of Coverage Among Medicare Beneficiaries,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>.
- 77 Medicare.gov, “What’s Medicare Supplement Insurance (Medigap)?” Available at: <https://www.medicare.gov/health-drug-plans/medigap>.
- 78 KFF, “A Snapshot of Sources of Coverage Among Medicare Beneficiaries,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>.
- 79 J. Norman, Medigap Surcharges: They’re Back, *The Commonwealth Fund*, April 11, 2013. Available at: <https://www.commonwealthfund.org/publications/newsletter-article/medigap-surcharges-theyre-back>.
- 80 KFF, “A Snapshot of Sources of Coverage Among Medicare Beneficiaries,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>.
- 81 KFF, “Medigap Enrollment and Consumer Protections Vary Across States,” 2018. Available at: <https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/>.
- 82 MedicareResources.org, “Medigap eligibility rules for Americans under age 65 vary by state,” 2023. Available at: <https://www.medicareresources.org/medicare-eligibility-and-enrollment/medigap-eligibility-for-americans-under-age-65-varies-by-state/#federal>.

- 83 KFF, “Medigap Enrollment and Consumer Protections Vary Across States,” 2018. Available at: <https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/>.
- 84 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 1: Reforming Medicare’s Benefit Design*, June 2012. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun12\\_ch01.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun12_ch01.pdf).
- 85 Congressional Budget Office, *Options for Reducing the Deficit: 2021 to 2030*, December 2020. Available at: <https://www.cbo.gov/system/files/2020-12/56783-budget-options.pdf>.
- 86 Public Law 114-10, Medicare Access and CHIP Reauthorization Act of 2015. Available at: <https://www.congress.gov/114/plaws/publ10/PLAW-114publ10.pdf>.
- 87 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 1: Reforming Medicare’s Benefit Design*, June 2012. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun12\\_ch01.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun12_ch01.pdf).
- 88 Ibid.
- 89 Ibid.
- 90 Office of Management and Budget, *Fiscal Year 2013 Budget of the U.S. Government*. Available at: <https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf>.
- 91 Ibid.
- 92 Urban Institute, *Analysis of Alternative Approaches to Increasing Part B Financial Assistance to Medicare Beneficiaries with Low Incomes*, December 2022. Available at: <https://www.urban.org/research/publication/analysis-alternative-approaches-increasing-part-b-financial-assistance>.
- 93 The Commonwealth Fund, *Medicare’s Affordability Problem: A Look at the Cost Burdens Faced by Older Enrollees*, September 2023. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/medicare-affordability-problem-cost-burdens-biennial>.
- 94 KFF, “Help with Medicare Premium and Cost-Sharing Assistance Varies by State,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/help-with-medicare-premium-and-cost-sharing-assistance-varies-by-state/>.
- 95 National Council on Aging, “Medicaid and Medicare Savings Programs,” 2023. Available at: <https://www.ncoa.org/article/medicaid-medicare-savings-programs>.
- 96 KFF, “Help with Medicare Premium and Cost-Sharing Assistance Varies by State,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/help-with-medicare-premium-and-cost-sharing-assistance-varies-by-state/>.
- 97 Medicaid and CHIP Payment and Access Commission, *Medicare Savings Programs: Eligibility and Enrollment*, September 2023. Available at: [https://www.macpac.gov/wp-content/uploads/2023/09/09\\_Slides-for-MSP\\_September-2023\\_FINAL.pdf](https://www.macpac.gov/wp-content/uploads/2023/09/09_Slides-for-MSP_September-2023_FINAL.pdf).
- 98 Medicaid and CHIP Payment and Access Commission, *Medicare Savings Programs: Policy Options*, December 2019. Available at: <https://www.macpac.gov/wp-content/uploads/2019/12/Medicare-Savings-Programs-Policy-Options.pdf>.
- 99 National Council on Aging, “Understanding Medicare’s Part D Low Income Subsidy (LIS/Extra Help),” 2023. Available at: <https://www.ncoa.org/article/understanding-medicare-part-d-low-income-subsidy-extra-help>.
- 100 Section 1860D-14 of the Social Security Act. See also 20 CFR § 418.3101.
- 101 Medicaid and CHIP Payment and Access Commission, *Medicare Savings Programs: Policy Options*, December 2019. Available at: <https://www.macpac.gov/wp-content/uploads/2019/12/Medicare-Savings-Programs-Policy-Options.pdf>.
- 102 KFF, “Help with Medicare Premium and Cost-Sharing Assistance Varies by State,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/help-with-medicare-premium-and-cost-sharing-assistance-varies-by-state/>.
- 103 National Council on Aging, “Medicaid and Medicare Savings Programs,” 2023. Available at: <https://www.ncoa.org/article/medicaid-medicare-savings-programs>.

- 104 KFF, “Help with Medicare Premium and Cost-Sharing Assistance Varies by State,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/help-with-medicare-premium-and-cost-sharing-assistance-varies-by-state/>.
- 105 Ibid.
- 106 Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP - Chapter 3: Improving Participation in the Medicare Savings Programs*, June 2020. Available at: <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-3-Improving-Participation-in-the-Medicare-Savings-Programs.pdf>.
- 107 KFF, “Help with Medicare Premium and Cost-Sharing Assistance Varies by State,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/help-with-medicare-premium-and-cost-sharing-assistance-varies-by-state/>.
- 108 Centers for Medicaid & CHIP Services, *Opportunities to Increase Enrollment in Medicare Savings Programs*, November 1, 2021. Available at: <https://www.medicaid.gov/sites/default/files/2021-11/cib11012021-updated.pdf>.
- 109 Public Law 110-275, Medicare Improvements for Patients and Providers Act of 2008. Available at: <https://www.congress.gov/110/plaws/publ275/PLAW-110publ275.pdf>.
- 110 Centers for Medicaid & CHIP Services, *Opportunities to Increase Enrollment in Medicare Savings Programs*, November 1, 2021. Available at: <https://www.medicaid.gov/sites/default/files/2021-11/cib11012021-updated.pdf>.
- 111 Federal Register, *Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment*, September 2023. Available at: <https://www.federalregister.gov/documents/2023/09/21/2023-20382/streamlining-medicaid-medicare-savings-program-eligibility-determination-and-enrollment>.
- 112 Centers for Medicare & Medicaid Services, “Streamlining Medicaid and CHIP, Final Rule, Fact Sheet,” 2023. Available at: <https://www.cms.gov/newsroom/fact-sheets/streamlining-medicaid-and-chip-final-rule-fact-sheet>.
- 113 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2019. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun19\\_medpac\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf).
- 114 Centers for Medicare & Medicaid Services, “5 things you need to know about signing up for Medicare,” 2023. Available at: <https://www.cms.gov/training-education/find-provider-type/employers-unions/top-five-medicare-enrollment>.
- 115 Ibid.
- 116 Centers for Medicare & Medicaid Services, “Medicare Plan Finder Gets an Upgrade for the First Time in a Decade,” 2019. Available at: <https://www.cms.gov/newsroom/press-releases/medicare-plan-finder-gets-upgrade-first-time-decade>.
- 117 National Council on Aging, “Helping the Medicare.gov Medicare Plan Finder Live up to Its Name,” 2022. Available at: <https://www.ncoa.org/article/helping-the-medicare-gov-medicare-plan-finder-live-up-to-its-name>.
- 118 Better Medicare Alliance, *Empowering Beneficiaries and Modernizing Medicare Enrollment*, September 2020. Available at: <https://www.bettermedicarealliance.org/wp-content/uploads/2020/09/Empower-Beneficiaries-and-Modernize-Medicare-Enrollment-10.1.20-3.pdf>.
- 119 Ibid.
- 120 The Commonwealth Fund, *The Private Plan Pitch: Seniors’ Experiences with Medicare Marketing and Advertising*, September 2023. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/private-plan-pitch-seniors-experiences-medicare-marketing-advertising>.
- 121 Administration for Community Living, “Medicare Improvements for Patients and Providers (MIPPA),” 2023. Available at: <https://acl.gov/programs/connecting-people-services/medicare-improvements-patients-and>.
- 122 Administration for Community Living, “State Health Insurance Assistance Program (SHIP),” 2023. Available at: <https://acl.gov/programs/connecting-people-services/state-health-insurance-assistance-program-ship>.

- 123 Assistant Secretary for Planning and Evaluation, *Medicare Beneficiary Enrollment Trends and Demographic Characteristics*, March 2022. Available at: <https://aspe.hhs.gov/sites/default/files/documents/f81aafbba0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf>.
- 124 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 125 U.S. Department of Health and Human Services, *Fiscal Year 2024 Budget in Brief*. Available at: <https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf>.
- 126 National Council on Aging, “Medicare Improvements for Patients and Providers Act (MIPPA),” 2021. Available at: <https://www.ncoa.org/article/mippa>.
- 127 P. Rawal, D. Jacobs, et al., “Building On CMS’s Accountable Care Vision To Improve Care For Medicare Beneficiaries,” *Health Affairs Forefront*, July 31, 2023. Available at: <https://www.healthaffairs.org/content/forefront/building-cms-s-accountable-care-vision-improve-care-medicare-beneficiaries>.
- 128 U.S. Department of Health and Human Services, “Medicare Shared Savings Program Saves Medicare More Than \$1.8 Billion in 2022 and Continues to Deliver High-quality Care,” August 24, 2023. Available at: <https://www.hhs.gov/about/news/2023/08/24/medicare-shared-savings-program-saves-medicare-more-1-8-billion-2022-continues-deliver-high-quality-care.html>.
- 129 Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, July 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/07/July2023\\_MedPAC\\_DataBook\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf).
- 130 Ibid.
- 131 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 132 Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program*, July 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/07/July2023\\_MedPAC\\_DataBook\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf).
- 133 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 134 Centers for Medicare & Medicaid Services, “Home Health Patient-Driven Groupings Model,” 2023. Available at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health/home-health-patient-driven-groupings-model>.
- 135 Federal Register, *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program*, August 2018. Available at: <https://www.govinfo.gov/content/pkg/FR-2018-08-08/pdf/2018-16570.pdf>.
- 136 Office of Management and Budget, *Budget of the U.S. Government Fiscal Year 2017*. Available at: <https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf>.
- 137 Office of Management and Budget, *Budget of the U.S. Government Fiscal Year 2021*. Available at: <https://www.govinfo.gov/content/pkg/BUDGET-2021-BUD/pdf/BUDGET-2021-BUD.pdf>.
- 138 Public Law 113-185, *Improving Medicare Post-Acute Care Transformation Act of 2014*. Available at: <https://www.congress.gov/113/plaws/publ185/PLAW-113publ185.pdf>.
- 139 U.S. Department of Health and Human Services, *FY2021 President’s Budget for HHS*. Available at: <https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf>.
- 140 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 10: Mandated report: Evaluation of a Prototype Design for a Post-Acute Care Prospective Payment System*, June 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/06/Jun23\\_Ch10\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch10_MedPAC_Report_To_Congress_SEC.pdf).



- 141 RTI International, *Report to Congress: Unified Payment for Medicare-Covered Post-Acute Care*, July 2022. Available at: <https://www.cms.gov/files/document/unifiedpacreporttocongress.pdf>.
- 142 Budgets of the United States Government. Available at: <https://www.govinfo.gov/app/collection/budget/>.
- 143 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 144 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 10: Long-term Care Hospital Services*, March 2022. Available at: [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_Ch10\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch10_SEC.pdf).
- 145 National Bureau of Economic Research, *Long-Term Care Hospitals: A Case Study in Waste*, April 2019. Available at: <https://www.nber.org/papers/w24946>.
- 146 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 147 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 7: Skilled Nursing Facility Services*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Ch7\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch7_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 148 Ibid.
- 149 Federal Register, *Medicare and Medicaid Programs; Minimum Staffing Standards for Long-term Care Facilities and Medicaid Institutional Payment Transparency Reporting*, September 2023. Available at: <https://www.govinfo.gov/content/pkg/FR-2023-09-06/pdf/2023-18781.pdf>.
- 150 Ibid.
- 151 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 152 Centers for Medicare & Medicaid Services, “The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program,” 2023. Available at: <https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing>.
- 153 Centers for Medicare & Medicaid Services, “Expanded Home Health Value-Based Purchasing Model,” 2023. Available at: <https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model>.
- 154 Centers for Medicare & Medicaid Services, “Bundled Payments for Care Improvement (BPCI) Initiative: General Information,” 2023. Available at: <https://www.cms.gov/priorities/innovation/innovation-models/bundled-payments>.
- 155 Centers for Medicare & Medicaid Services, “BPCI Advanced,” 2023. Available at: <https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced>.
- 156 Centers for Medicare & Medicaid Services, “Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (NFI),” 2023. Available at: <https://www.cms.gov/medicaid-chip/medicare-coordination/avoidable-hospitalizations>.
- 157 Jacqueline LaPointe, “Orgs Troubled by Post-Acute Care’s Role in New Bundled Payments,” *RevCycleIntelligence*, March 15, 2018. Available at: <https://revcycleintelligence.com/news/orgs-troubled-by-post-acute-cares-role-in-new-bundled-payments>.
- 158 Baker Donelson, *Post-Acute Care Providers Ponder Role in BPCI Advanced*, February 2018. Available at: <https://www.bakerdonelson.com/post-acute-care-providers-ponder-role-in-bpci-advanced>.
- 159 Public Law 116-260, Consolidated Appropriations Act of 2021. Available at: <https://www.congress.gov/bill/116th-congress/house-bill/133/text>.
- 160 Centers for Medicare & Medicaid Services, *Innovation Center Strategy Refresh*. Available at: <https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper>.

- 161 Federal Register, *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2024*, August 2023. Available at: <https://www.federalregister.gov/documents/2023/08/07/2023-16249/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>.
- 162 Federal Register, *Request for Information; Episode-Based Payment Model*, July 2023. Available at: <https://www.federalregister.gov/documents/2023/07/18/2023-15169/request-for-information-episode-based-payment-model>.
- 163 Centers for Medicare & Medicaid Services, “The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program,” 2023. Available at: <https://www.cms.gov/medicare/quality/nursing-home-improvement/value-based-purchasing>.
- 164 Medicare Payment Advisory Commission, “The Hospital Readmissions Reduction Program has succeeded for beneficiaries and the Medicare program,” June 15, 2018. Available at: <https://www.medpac.gov/the-hospital-readmissions-reduction-program-has-succeeded-for-beneficiaries-and-the-medicare-program/>.
- 165 Public Law 113-93, *Protecting Access to Medicare Act of 2014*. Available at: <https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf>.
- 166 Centers for Medicare & Medicaid Services, *Skilled Nursing Facility Value-Based Purchasing Program FY 2024 Program Year Fact Sheet*, August 2023. Available at: <https://www.cms.gov/sites/default/files/2023-08/FY2024-SNF-VBP-Fact-Sheet.pdf>.
- 167 Centers for Medicare & Medicaid Services, *Medicare Hospice Benefits*, March 2023. Available at: <https://www.medicare.gov/Pubs/pdf/02154-medicare-hospice-benefits.pdf>.
- 168 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 169 Ibid.
- 170 Office of Inspector General, *Medicare Payments of \$6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight*, February 2022. Available at: <https://oig.hhs.gov/oas/reports/region9/92003015.pdf>.
- 171 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 172 Office of Inspector General, “Hospice,” 2023. Available at: <https://oig.hhs.gov/reports-and-publications/featured-topics/hospice/>.
- 173 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 10: Hospice Services*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Ch10\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch10_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 174 Office of Inspector General, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio*, July 2018. Available at: <https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf>.
- 175 Medicare Payment Advisory Commission, *Hospice Services Payment System*, October 2022. Available at: [https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC\\_Payment\\_Basics\\_22\\_hospice\\_FINAL\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_hospice_FINAL_SEC.pdf).
- 176 Section 1814(i)(2)(A) of the Social Security Act.
- 177 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 10: Hospice Services*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Ch10\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch10_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 178 Ibid.
- 179 Ibid.
- 180 Centers for Medicare & Medicaid Services, *Medicare Hospice Benefits*, March 2023. Available at: <https://www.medicare.gov/Pubs/pdf/02154-medicare-hospice-benefits.pdf>.

- 181 Office of Inspector General, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio*, July 2018. Available at: <https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf>.
- 182 Office of Inspector General, *Medicare Payments of \$6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight*, February 2022. Available at: <https://oig.hhs.gov/oas/reports/region9/92003015.pdf>.
- 183 R. T. Braun, D. G. Stevenson, et al., “Acquisitions of Hospice Agencies by Private Equity Firms and Publicly Traded Corporations,” *Jama Internal Medicine*, 181(8): 1113-1114, 2021. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2779069>.
- 184 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 10: Hospice Services*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Ch10\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch10_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 185 Ibid.
- 186 Congressional Budget Office, *Baseline Projections*, May 2023. Available at: <https://www.cbo.gov/system/files/2023-05/51302-2023-05-medicare.pdf>.
- 187 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 4: Physician and Other Health Professional Services*, March 2019. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/mar19\\_medpac\\_ch4\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_ch4_sec.pdf).
- 188 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2022. Available at: [https://www.medpac.gov/wp-content/uploads/2022/06/Jun22\\_MedPAC\\_Report\\_to\\_Congress\\_v2\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v2_SEC.pdf).
- 189 Ibid.
- 190 Public Law 114-74, Bipartisan Budget Act of 2015. Available at: <https://www.congress.gov/114/plaws/publ74/PLAW-114publ74.pdf>.
- 191 Federal Register, *Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Certain Off-Campus Outpatient Departments of a Provider; Hospital Value-Based Purchasing (VBP) Program*, July 2016. Available at: <https://www.govinfo.gov/content/pkg/FR-2016-07-14/pdf/2016-16098.pdf>.
- 192 Congressional Budget Office, *Estimate of the Budgetary Effects of H.R. 1314, the Bipartisan Budget Act of 2015*, October 2015. Available at: <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr1314.pdf>.
- 193 Budgets of the United States Government. Available at: <https://www.govinfo.gov/app/collection/budget/>.
- 194 Federal Register, *Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children’s Hospitals-Within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots*, November 2019. Available at: <https://www.federalregister.gov/documents/2019/11/12/2019-24138/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center>.
- 195 Committee for a Responsible Federal Budget, “Equalizing Medicare Payments Regardless of Site-of-Care,” 2021. Available at: <https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care>.
- 196 H.R. 3561 – PATIENT Act of 2023. Available at: <https://www.congress.gov/bill/118th-congress/house-bill/3561/all-actions?overview=closed#tabs>.
- 197 Congressional Budget Office, *Estimated Direct Spending and Revenue Effects of H.R. 3561, the PATIENT Act of 2023*, July 2023. Available at: <https://www.cbo.gov/system/files/2023-07/hr3561.pdf>.

- 198 Energy & Commerce, “Health Subcommittee Legislative Hearing: ‘Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care,’” April 26, 2023. Available at: <https://energycommerce.house.gov/events/health-subcommittee-legislative-hearing-1>.
- 199 H.R. 4822 – Health Care Price Transparency Act of 2023. Available at: <https://www.congress.gov/bill/118th-congress/house-bill/4822/text>.
- 200 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/06/Jun23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf).
- 201 Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, April 2013. Available at: <https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/BPC-Cost-Containment-Report.pdf>.
- 202 Federal Register, *Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs*, November 2018. Available at: <https://www.govinfo.gov/content/pkg/FR-2018-11-21/pdf/2018-24243.pdf>.
- 203 Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, April 2013. Available at: <https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/BPC-Cost-Containment-Report.pdf>.
- 204 Congressional Budget Office, *Proposals Affecting Medicare - CBO’s Estimate of the President’s Fiscal Year 2021 Budget*, March 2020. Available at: <https://www.cbo.gov/system/files?file=2020-03/56245-2020-03-medicare.pdf>.
- 205 Committee for a Responsible Federal Budget, “Equalizing Medicare Payments Regardless of Site-of-Care,” 2021. Available at: <https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care>.
- 206 Institute of Medicine, *America’s Health Care Safety Net: Intact but Endangered*, 2000. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK224523/>.
- 207 U.S. Government Accountability Office, *Medicare: Information on Medicare-Dependent Hospitals*, February 2020. Available at: <https://www.gao.gov/products/gao-20-300>.
- 208 Centers for Medicare & Medicaid Services, “Disproportionate Share Hospital (DSH),” 2023. Available at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/disproportionate-share-hospital-dsh>.
- 209 Medicaid.gov, “Medicaid Disproportionate Share Hospital (DSH) Payments,” 2023. Available at: <https://www.medicaid.gov/medicaid/financial-management/medicaid-disproportionate-share-hospital-dsh-payments/index.html>.
- 210 America’s Essential Hospitals, *Essential Hospitals: How We Build a Healthy Country for All*, February 2023. Available at: <https://essentialhospitals.org/wp-content/uploads/2023/02/AboutEssentialHospitalsFebruary2023.pdf>.
- 211 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 3: Supporting Safety-net Providers*, June 2022. Available at: [Jun22\\_Ch3\\_MedPAC\\_Report\\_to\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch3_MedPAC_Report_to_Congress_SEC.pdf).
- 212 Centers for Medicare & Medicaid Services, “DMEPOS Competitive Bidding,” 2023. Available at: <https://www.cms.gov/medicare/payment/fee-schedules/dmepos-competitive-bidding>.
- 213 Ibid.
- 214 D. Newman, E. Barrette, and K. McGraves-Lloyd, “Medicare Competitive Bidding Program Realized Price Savings For Durable Medical Equipment Purchases,” *Health Affairs*, 36(8), 2017. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1323#>.
- 215 KFF, “FAQs on Medicare Financing and Trust Fund Solvency,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/>.
- 216 Ibid.
- 217 Ibid.
- 218 Congressional Budget Office, *Options for Reducing the Deficit: 2021 to 2030*, December 2020. Available at: <https://www.cbo.gov/system/files/2020-12/56783-budget-options.pdf>.

- 219 Internal Revenue Service, “Questions and Answers on the Net Investment Income Tax,” 2023. Available at: <https://www.irs.gov/newsroom/questions-and-answers-on-the-net-investment-income-tax>.
- 220 Ibid.
- 221 Ibid.
- 222 Congressional Budget Office, *Options for Reducing the Deficit, 2023 to 2032 – Volume II: Smaller Reductions*, December 2022. Available at: <https://www.cbo.gov/system/files/2022-12/58163-budget-options-small-effects.pdf>.
- 223 Congressional Research Service, *The 3.8% Net Investment Income Tax: Overview, Data, and Policy Options*, June 2023. Available at: <https://crsreports.congress.gov/product/pdf/IF/IF11820>.
- 224 Congressional Budget Office, *Options for Reducing the Deficit, 2023 to 2032 – Volume II: Smaller Reductions*, December 2022. Available at: <https://www.cbo.gov/system/files/2022-12/58163-budget-options-small-effects.pdf>.
- 225 Office of Management and Budget, *Budget of the U.S. Government Fiscal Year 2024*. Available at: [https://www.whitehouse.gov/wp-content/uploads/2023/03/budget\\_fy2024.pdf](https://www.whitehouse.gov/wp-content/uploads/2023/03/budget_fy2024.pdf).
- 226 Ibid.
- 227 MedicareResources.org, “A Brief History of Medicare in America.” Available at: <https://www.medicareresources.org/basic-medicare-information/brief-history-of-medicare/>.
- 228 Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, April 2013. Available at: <https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/BPC-Cost-Containment-Report.pdf>.
- 229 Centers for Medicare & Medicaid Services, “2024 Medicare Parts A & B Premiums and Deductibles,” 2023. Available at: <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles>.
- 230 KFF, “Medicare’s Income-Related Premiums: A Data Note,” 2015. Available at: <https://www.kff.org/medicare/issue-brief/medicares-income-related-premiums-a-data-note/>.
- 231 MedicareResources.org, “What is the income-related monthly adjustment amount (IRMAA)?,” 2023. Available at: <https://www.medicareresources.org/medicare-eligibility-and-enrollment/what-is-the-income-related-monthly-adjusted-amount-irmaa/>.
- 232 Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, April 2013. Available at: <https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/BPC-Cost-Containment-Report.pdf>.
- 233 Centers for Medicare & Medicaid Services, “2024 Medicare Parts A & B Premiums and Deductibles,” 2023. Available at: <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles>.
- 234 Office of Management and Budget, *Fiscal Year 2013 Budget of the U.S. Government*. Available at: <https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2013/assets/budget.pdf>.
- 235 Ibid.
- 236 KFF, “Medicare Advantage in 2023: Enrollment Update and Key Trends,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>.
- 237 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 4: Favorable Selection and Future Directions for Medicare Advantage Payment Policy*, June 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/06/Jun23\\_Ch4\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch4_MedPAC_Report_To_Congress_SEC.pdf).
- 238 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 11: The Medicare Advantage Program: Status Report*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Ch11\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 239 Ibid.
- 240 Better Medicare Alliance, *Understanding Medicare Advantage Payment & Policy Recommendations*, September 2018. Available at: [https://www.bettermedicarealliance.org/wp-content/uploads/2020/03/BMA\\_WhitePaper\\_MA\\_Bidding\\_and\\_Payment\\_2018\\_09\\_19-1.pdf](https://www.bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_WhitePaper_MA_Bidding_and_Payment_2018_09_19-1.pdf).

- 241 Medicare Payment Advisory Commission, *Medicare Advantage Program Payment System*, October 2022. Available at: [https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC\\_Payment\\_Basics\\_22\\_MA\\_FINAL\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_MA_FINAL_SEC.pdf).
- 242 KFF, “Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \$12.8 Billion in 2023,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-payments-will-reach-at-least-12-8-billion-in-2023/>.
- 243 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 4: Favorable Selection and Future Directions for Medicare Advantage Payment Policy*, June 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/06/Jun23\\_Ch4\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch4_MedPAC_Report_To_Congress_SEC.pdf).
- 244 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 8: Redesigning the Medicare Advantage Quality Bonus Program*, June 2019. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun19\\_ch8\\_medpac\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch8_medpac_reporttocongress_sec.pdf).
- 245 A. A. Markovitz, J. Z. Ayanian, et al., “The Medicare Advantage Quality Bonus Program Has Not Improved Plan Quality,” *Health Affairs*, 40(12), 2021. Available at: <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.00606>.
- 246 Centers for Medicare & Medicaid Services, *Report to Congress: Risk Adjustment in Medicare Advantage*, December 2021. Available at: <https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf>.
- 247 Urban Institute, *Understanding Medicare Advantage Payment: How the Program Allows and Obscures Overspending*, September 2022. Available at: <https://www.urban.org/research/publication/understanding-medicare-advantage-payment>.
- 248 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 11: The Medicare Advantage Program: Status Report*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Ch11\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 249 Centers for Medicare & Medicaid Services, *Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies*, April 4, 2022. Available at: <https://www.cms.gov/files/document/2023-announcement.pdf>.
- 250 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery Systems – Chapter 7: Ensuring the Accuracy and Completeness of Medicare Advantage Encounter Data*, June 2019. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun19\\_ch7\\_medpac\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch7_medpac_reporttocongress_sec.pdf).
- 251 J. Jung, C. Carlin, and R. Feldman, “Measuring Resource Use in Medicare Advantage Using Encounter Data,” *Health Services Research*, 57: 172-181, 2022. Available at: <https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.13879>.
- 252 J. Jung, R. Feldman, and C. Carlin, “Coding Intensity Through Health Risk Assessments and Chart Reviews in Medicare Advantage: Does It Explain Resource Use?,” *Medical Care Research and Review*, 2023. Available at: <https://journals.sagepub.com/doi/10.1177/10775587231191169>.
- 253 Centers for Medicare & Medicaid Services, “Medicare Advantage Risk Adjustment Data Validation Final Rule (CMS-4185-F2) Fact Sheet,” 2023. Available at: <https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-risk-adjustment-data-validation-final-rule-cms-4185-f2-fact-sheet>.
- 254 Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy*, March 2016. Available at: <https://www.medpac.gov/wp-content/uploads/2021/10/march-2016-report-to-the-congress-medicare-payment-policy.pdf>.
- 255 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 4: Mandated Report: Impact of Changes in the 21st Century Cures Act to Risk Adjustment for Medicare Advantage Enrollees*, June 2020. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun20\\_ch4\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch4_reporttocongress_sec.pdf).

- 256 Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy*, March 2016. Available at: <https://www.medpac.gov/wp-content/uploads/2021/10/march-2016-report-to-the-congress-medicare-payment-policy.pdf>.
- 257 Congressional Budget Office, *Modify Payments to Medicare Advantage Plans for Health Risk*, December 2018. Available at: <https://www.cbo.gov/budget-options/2018/54736>.
- 258 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 4: Mandated Report: Impact of Changes in the 21st Century Cures Act to Risk Adjustment for Medicare Advantage Enrollees*, June 2020. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun20\\_ch4\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch4_reporttocongress_sec.pdf).
- 259 Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy – Chapter 12: The Medicare Advantage Program: Status Report*, March 2016. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/chapter-12-the-medicare-advantage-program-status-report-march-2016-report.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/chapter-12-the-medicare-advantage-program-status-report-march-2016-report.pdf).
- 260 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 11: The Medicare Advantage Program: Status Report*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Ch11\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 261 Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy*, March 2016. Available at: <https://www.medpac.gov/wp-content/uploads/2021/10/march-2016-report-to-the-congress-medicare-payment-policy.pdf>.
- 262 U.S. Department of Health and Human Services, *Fiscal Year 2024 Budget in Brief*. Available at: <https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf>.
- 263 U.S. Department of Health and Human Services, *FY2021 President’s Budget for HHS*. Available at: <https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf>.
- 264 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 11: The Medicare Advantage Program: Status Report*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Ch11\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 265 Section 1853(a)(1)(C)(II)(iii) of the Social Security Act.
- 266 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 11: The Medicare Advantage Program: Status Report*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Ch11\\_Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf).
- 267 Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy*, March 2016. Available at: <https://www.medpac.gov/wp-content/uploads/2021/10/march-2016-report-to-the-congress-medicare-payment-policy.pdf>.
- 268 Congressional Budget Office, *Modify Payments to Medicare Advantage Plans for Health Risk*, December 2018. Available at: <https://www.cbo.gov/budget-options/2018/54736>.
- 269 Centers for Medicare & Medicaid Services, *Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies*, March 31, 2023. Available at: <https://www.cms.gov/files/document/2024-announcement-pdf.pdf>.
- 270 Federal Register, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, February 2023. Available at: <https://www.govinfo.gov/content/pkg/FR-2023-02-01/pdf/2023-01942.pdf>.
- 271 Ibid.
- 272 U.S. Department of Health and Human Services, *Fiscal Year 2024 Budget in Brief*. Available at: <https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf>.

- 273 Federal Register, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, February 2023. Available at: <https://www.govinfo.gov/content/pkg/FR-2023-02-01/pdf/2023-01942.pdf>.
- 274 A. A. Markovitz, J. Z. Ayanian, et al., “The Medicare Advantage Quality Bonus Program Has Not Improved Plan Quality,” *Health Affairs*, 40(12), 2021. Available at: <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.00606>.
- 275 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 8: Redesigning the Medicare Advantage Quality Bonus Program*, June 2019. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun19\\_ch8\\_medpac\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch8_medpac_reporttocongress_sec.pdf).
- 276 A. A. Markovitz, J. Z. Ayanian, et al., “The Medicare Advantage Quality Bonus Program Has Not Improved Plan Quality,” *Health Affairs*, 40(12), 2021. Available at: <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2021.00606>.
- 277 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 3: Replacing the Medicare Advantage Quality Bonus Program*, June 2020. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun20\\_ch3\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf).
- 278 Congressional Budget Office, *Options for Reducing the Deficit: 2019 to 2028*, December 2018. Available at: <https://www.cbo.gov/system/files/2019-06/54667-budgetoptions-2.pdf>.
- 279 KFF, “Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \$12.8 Billion in 2023,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-payments-will-reach-at-least-12-8-billion-in-2023/>.
- 280 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 8: Redesigning the Medicare Advantage Quality Bonus Program*, June 2019. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun19\\_ch8\\_medpac\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch8_medpac_reporttocongress_sec.pdf).
- 281 Centers for Medicare & Medicaid Services, *Fact Sheet: 2023 Medicare Advantage and Part D Star Ratings*, October 2022. Available at: <https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf>.
- 282 The Commonwealth Fund, “Taking Stock of Medicare Advantage: Quality Reporting and Quality Bonuses,” March 3 2022. Available at: <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-quality-reporting-and-quality-bonuses>.
- 283 Congressional Budget Office, *Options for Reducing the Deficit: 2019 to 2028*, December 2018. Available at: <https://www.cbo.gov/system/files/2019-06/54667-budgetoptions-2.pdf>.
- 284 Ibid.
- 285 National Council on Aging, “What Are the Medicare Star Ratings?,” 2023. Available at: <https://www.ncoa.org/article/medicare-star-ratings>.
- 286 KFF, “Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \$12.8 Billion in 2023,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-payments-will-reach-at-least-12-8-billion-in-2023/>.
- 287 Ibid.
- 288 Centers for Medicare & Medicaid Services, *Fact Sheet: 2023 Medicare Advantage and Part D Star Ratings*, October 2022. Available at: <https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf>.
- 289 KFF, “Spending on Medicare Advantage Quality Bonus Payments Will Reach at Least \$12.8 Billion in 2023,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-payments-will-reach-at-least-12-8-billion-in-2023/>.
- 290 Congressional Budget Office, *Options for Reducing the Deficit: 2019 to 2028*, December 2018. Available at: <https://www.cbo.gov/system/files/2019-06/54667-budgetoptions-2.pdf>.



- 291 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 3: Replacing the Medicare Advantage Quality Bonus Program*, June 2020. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun20\\_ch3\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf).
- 292 Ibid.
- 293 Urban Institute, *The Medicare Advantage Quality Bonus Program: High Cost for Uncertain Gain*, June 2023. Available at: <https://www.urban.org/research/publication/medicare-advantage-quality-bonus-program>.
- 294 Centers for Medicare & Medicaid Services, *Medicare 2023 Part C & D Star Ratings Technical Notes*, January 2023. Available at: <https://www.cms.gov/files/document/2023-star-ratings-technical-notes.pdf>.
- 295 Alliance of Community Health Plans, *MA for Tomorrow: Raising the Bar on Quality*, 2023. Available at: <https://mafortomorrow.org/wp-content/uploads/2023/06/MAFT-Raising-the-Quality-Bar-FINAL.pdf>.
- 296 Urban Institute, *The Medicare Advantage Quality Bonus Program: High Cost for Uncertain Gain*, June 2023. Available at: <https://www.urban.org/research/publication/medicare-advantage-quality-bonus-program>.
- 297 Congressional Budget Office, *Options for Reducing the Deficit: 2019 to 2028*, December 2018. Available at: <https://www.cbo.gov/system/files/2019-06/54667-budgetoptions-2.pdf>.
- 298 KFF, “Medicare Advantage 2023 Spotlight: First Look,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/>.
- 299 Ibid.
- 300 Ibid.
- 301 KFF, “Extra Benefits Offered by Medicare Advantage Firms Vary,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/extra-benefits-offered-by-medicare-advantage-firms-varies/>.
- 302 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 12: The Medicare Advantage Program: Status Report and Mandated Report on Dual-eligible Special Needs Plans*, March 2022. Available at: [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_Ch12\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf).
- 303 Ibid.
- 304 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System – Chapter 8: Redesigning the Medicare Advantage Quality Bonus Program*, June 2019. Available at: [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun19\\_ch8\\_medpac\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch8_medpac_reporttocongress_sec.pdf).
- 305 KFF, “Medicare Advantage 2023 Spotlight: First Look,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/>.
- 306 Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/06/Jun23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf).
- 307 USC-Brookings Schaeffer Initiative for Health Policy, *A Proposal to Enhance Competition and Reform Bidding in the Medicare Advantage Program*, May 2018. Available at: <https://www.brookings.edu/wp-content/uploads/2018/05/ma-bidding-paper.pdf>.
- 308 Office of Management and Budget, *Budget of the U.S. Government Fiscal Year 2017*. Available at: <https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf>.
- 309 Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, April 2013. Available at: <https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/BPC-Cost-Containment-Report.pdf>.
- 310 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2023. Available at: [https://www.medpac.gov/wp-content/uploads/2023/03/Mar23\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).

- 311 KFF, “Medicare Advantage 2023 Spotlight: First Look,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/>.
- 312 ATI Advisory, *Medicare Advantage Plan Analysis by County*, November 2023. Available at: [https://bipartisanpolicy.org/wp-content/uploads/2023/11/202311\\_ATI\\_BPC\\_County-MA-Plan-Analysis.xlsx](https://bipartisanpolicy.org/wp-content/uploads/2023/11/202311_ATI_BPC_County-MA-Plan-Analysis.xlsx).
- 313 Ibid.
- 314 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy – Chapter 12: The Medicare Advantage Program: Status Report and Mandated Report on Dual-eligible Special Needs Plans*, March 2022. Available at: [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_Ch12\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf).
- 315 ATI Advisory, *Medicare Advantage Enrollment Trends*, February 2023. Available at: <https://atiadvisory.com/resources/wp-content/uploads/2023/03/Medicare-Advantage-Enrollment-Trends-February-2023.pdf>.
- 316 Committee for a Responsible Federal Budget, “Budget Offsets Bank.” Available at: <https://www.crfb.org/budget-offsets-bank>.
- 317 Office of Management and Budget, *Budget of the U.S. Government Fiscal Year 2017*. Available at: <https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf>.
- 318 USC-Brookings Schaeffer Initiative for Health Policy, *A Proposal to Enhance Competition and Reform Bidding in the Medicare Advantage Program*, May 2018. Available at: <https://www.brookings.edu/wp-content/uploads/2018/05/ma-bidding-paper.pdf>.
- 319 Ibid.
- 320 Office of Management and Budget, *Budget of the U.S. Government Fiscal Year 2017*. Available at: <https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf>.
- 321 Congressional Budget Office, *March 2016 Medicare Baseline*. Available at: <https://www.cbo.gov/sites/default/files/recurringdata/51302-2016-03-medicare.pdf>.
- 322 Assistant Secretary for Planning and Evaluation, *Medicare Advantage Overview: A Primer on Enrollment and Spending*, May 2023. Available at: <https://aspe.hhs.gov/sites/default/files/documents/9b42ffbf2341726d5b63a9647b0aad15/medicare-advantage-overview.pdf>.
- 323 Congressional Budget Office, *Baseline Projections*, May 2023. Available at: <https://www.cbo.gov/system/files/2023-05/51302-2023-05-medicare.pdf>.
- 324 Assistant Secretary for Planning and Evaluation, *Medicare Advantage Overview: A Primer on Enrollment and Spending*, May 2023. Available at: <https://aspe.hhs.gov/sites/default/files/documents/9b42ffbf2341726d5b63a9647b0aad15/medicare-advantage-overview.pdf>.
- 325 Congressional Budget Office, *Options for Reducing the Deficit, 2023 to 2032 – Volume 1: Larger Reductions*, December 2022. Available at: <https://www.cbo.gov/system/files/2022-12/58164-budget-options-large-effects.pdf>.
- 326 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 327 KFF, “FAQs on Medicare Financing and Trust Fund Solvency,” 2022. Available at: <https://www.kff.org/medicare/issue-brief/faqs-on-medicare-financing-and-trust-fund-solvency/>.
- 328 Bipartisan Policy Center, *The Cost of Waiting to Act on Medicare’s Hospital Insurance Trust Fund*, June 2021. Available at: <https://bipartisanpolicy.org/report/hospital-insurance-trust-fund/>.
- 329 KFF, “What to Know about Medicare Spending and Financing,” 2023. Available at: <https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/>.
- 330 Congressional Research Service, *Medicare Trigger*, April 2022. Available at: <https://crsreports.congress.gov/product/pdf/RS/RS22796>.
- 331 Congressional Research Service, *Medicare Trigger*, April 2012. Available at: [https://www2.law.umaryland.edu/marshall/crsreports/crsdocuments/RS22796\\_04092012.pdf](https://www2.law.umaryland.edu/marshall/crsreports/crsdocuments/RS22796_04092012.pdf).

- 332 Centers for Medicare & Medicaid Services, *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 2023. Available at: <https://www.cms.gov/oact/tr/2023>.
- 333 Congressional Research Service, *Medicare Trigger*, April 2012. Available at: [https://www2.law.umaryland.edu/marshall/crsreports/crsdocuments/RS22796\\_04092012.pdf](https://www2.law.umaryland.edu/marshall/crsreports/crsdocuments/RS22796_04092012.pdf).
- 334 Centers for Medicare & Medicaid Services, *Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update*, October 2023. Available at: <https://www.cms.gov/files/document/mm13365-cy-2024-update-medicare-deductible-coinsurance-premium-rates.pdf>.



## Bipartisan Policy Center

1225 Eye St NW, Suite 1000  
Washington, DC 20005

[bipartisanpolicy.org](http://bipartisanpolicy.org)

202 - 204 - 2400

The Bipartisan Policy Center helps policymakers work across party lines to craft bipartisan solutions. By connecting lawmakers across the entire political spectrum, delivering data and context, negotiating policy details, and creating space for bipartisan collaboration, we ensure democracy can function on behalf of all Americans.

 [@BPC\\_Bipartisan](https://twitter.com/BPC_Bipartisan)

 [facebook.com/BipartisanPolicyCenter](https://facebook.com/BipartisanPolicyCenter)

 [instagram.com/BPC\\_Bipartisan](https://instagram.com/BPC_Bipartisan)

## Policy Areas

**Business**

**Child Welfare Initiative**

**Democracy**

**American Congressional Exchange**

**Campus Free Expression**

**Digital Democracy**

**Elections**

**Presidential Leadership**

**Structural Democracy**

**Early Childhood**

**Economy**

**Debt Limit**

**Higher Education**

**Immigration**

**Paid Family Leave**

**Energy**

**Health**

**Housing**

**Infrastructure**

**Technology**



**Bipartisan Policy Center**

**1225 Eye Street NW, Suite 1000  
Washington, D.C. 20005**

**Where democracy gets to work**