



Bipartisan Policy Center

# **The Cost of Waiting to Act on Medicare's Hospital Insurance Trust Fund**

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# Summary

**M**edicare is the nation’s largest health insurance program, covering more than 60 million beneficiaries—primarily Americans over age 65, and younger people with certain health conditions. Administered by the federal government and funded by a combination of payroll taxes, general revenues, premiums, and other sources, the program faces significant financial challenges, with expenditures in recent years consistently outpacing dedicated revenue streams.

As these funding imbalances have attracted growing attention, a variety of reforms have been proposed to address Medicare’s solvency problems. This paper examines five such proposals, focusing specifically on how each would affect the solvency of the Hospital Insurance (HI) Trust Fund, which finances Medicare Part A (primarily covering inpatient health care services).<sup>a</sup> A February 2021 report by the Congressional Budget Office (CBO) projects that the HI Trust Fund will become insolvent in 2026.

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. Medicare draws down on these assets to cover the difference when annual spending exceeds income, and the reserves increase when annual income exceeds spending. Since 2018, annual shortfalls have produced declining assets.

Once the trust fund depletes, CBO projects that annual program revenues will cover only about 92% of annual program outlays starting in 2026. At or before that point, Congress would have to act to close the funding gap. If Congress does not act, Medicare payments will be reduced, as the Medicare Board of Trustees has pointed out, “to levels that could be covered by incoming tax and premium revenues.”<sup>1</sup> 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 reform 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

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<sup>a</sup> The HI Trust Fund is essentially an accounting mechanism (much like the Social Security Trust Funds) for the federal government’s revenues and expenditures related to Medicare Part A. More detailed explanations of the function of the trust fund and the differences between Medicare Parts A, B, C, and D are provided in the body of the paper.

operating on stable financial footing. **Table 1** shows a projection of the fund’s finances over the next 15 years. Note that although the fund’s balance cannot fall below \$0, we list negative balances—in **Table 1** and throughout this issue brief—to illustrate how much additional money from the federal government’s general budget would be required to make the HI Trust Fund whole between now and the year shown.

**Table 1. BPC Analysis of CBO Baseline Projections of the HI Trust Fund’s End-of-Year Balance (billions)<sup>b,2</sup>**

2020	2025	2026 (Year of Insolvency)	2030	2035
\$135	\$22	-\$40	-\$388	-\$1,075

Policymakers have been rightly focused on the COVID-19 pandemic, addressing the public health and economic challenges it created. Now, as the nation emerges from the worst of the crisis, the solvency of Medicare’s HI Trust Fund must rise on the legislative agenda.

Congress has generally demonstrated reluctance to deal with Medicare’s financial imbalances. For example, there has been little action over the past few years to address the reality that the Supplemental Medical Insurance (SMI) Trust Fund, which is responsible for financing Medicare Parts B and D, is consuming a growing portion of general revenues. Similarly, as a result of earlier legislation, Medicare provider payments were slated to be reduced by 2% in April 2021, but President Joe Biden signed a law in mid-April to delay that reduction.<sup>c,3</sup>

Our analysis of different reform packages or proposals for restoring solvency to the HI Trust Fund looks at two discrete measures of impact: projected date of fund insolvency (relative to the current projected date of 2026) and projected status of fund reserves at the end of 2030. In all cases, we compared impacts from immediate implementation (in 2021) to impacts from implementing the same measures four years later, in 2025. An overarching finding from this comparison is that delaying reforms by even a few years significantly changes these impacts and will be quite costly in terms of the fiscal health of the trust fund.

For example, implementing a proposal in 2021 that contains revenue increases as well as spending restraints would push the projected year of insolvency from

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b CBO’s baseline projections are required to assume that scheduled payments will be fully made after the exhaustion of the fund, even though no legal authority exists to make those payments. Given the dependence on future legislation, CBO shows a zero balance in the trust fund after exhaustion. BPC shows the cumulative negative balance instead.

c The Coronavirus Aid, Relief, and Economic Security (CARES) Act that passed in March 2020 exempted Medicare until the end of the year from sequestration, across-the-board reductions to certain kinds of federal spending that were mandated by the Budget Control Act of 2011 and subsequent legislation. The sequester relief was extended to March 31, 2021, by the Consolidated Appropriations Act, 2021, passed at the end of 2020 before being most recently extended again.

2026 to 2034 and result in a projected fund balance of \$240 billion at the end of 2030. Waiting a mere four years to implement the same package of reforms, however, significantly diminishes these benefits. With an implementation date of 2025, the projected date of insolvency moves up to 2031, and the projected fund balance at the end of 2030 is \$28 billion. The net change in program funding as a result from acting in 2021 rather than 2025, in this example, amounts to \$212 billion by 2030. Unanticipated events not factored into the analysis—such as another economic downturn—could further reduce payroll revenues and increase medical expenditures, bringing the trust fund’s depletion date closer and adding to the cost of waiting.

Overall, these results show that the sooner policymakers act, the more leverage they have to improve trust fund finances, and the more flexibility they have to choose among solutions. Delay, on the other hand, only ensures that more aggressive and difficult changes are likely to be needed in the future. Proposals to expand Medicare coverage, meanwhile, may well prove unviable without action to improve the program’s finances. Congress and the administration should prioritize efforts to address the fiscal status, not only of the HI Trust Fund, but of Medicare as a whole, both to ensure the long-term sustainability of this critical program and to protect the federal government’s ability to finance other, non-Medicare budget needs and priorities.

Summary of reform packages included in this analysis and key findings:

1. [Balanced Approach](#) (by Bill Hoagland, Senior Vice President at the Bipartisan Policy Center)

This proposal would raise the eligibility age for Medicare, enact post-acute provider payment reforms, place limits on Medigap coverage to incentivize changes in consumer behavior, and redirect revenues from the Net Investment Income Tax (an Affordable Care Act tax) toward the trust fund.

Implementing the Balanced Approach in 2021 would push projected HI Trust Fund insolvency from 2026 out by **eight years** to 2034. At the end of 2030, the trust fund would have a projected balance of **\$240 billion**.

Waiting until 2025 to implement this proposal would push projected insolvency from 2026 out by **five years** to 2031. At the end of 2030, the trust fund would have a projected balance of **\$28 billion**.

In this case, a delay of four years “costs” three years and \$212 billion in terms of the projected date of trust fund insolvency and net change in fund balance at the end of the decade.

2. [Integration, Competition, and Coverage Reform](#) (by James C. Capretta, Resident Fellow and Milton Friedman Chair at the American Enterprise Institute)

This proposal aims to modernize and integrate the HI and SMI Trust Funds for new Medicare enrollees by introducing a simplified cost-sharing system, implementing a premium support system through competitive bidding and transparency reforms that would allow Medicare Advantage plans and Accountable Care Organizations to compete with traditional fee-for-service on premiums, imposing limits on Medigap coverage, instituting reference pricing for “shoppable” procedures, and reforming Graduate Medical Education payments.

Implementing this proposal in 2021 would push projected insolvency from 2026 out by **more than nine years** to beyond 2035.<sup>d</sup> At the end of 2030, the trust fund would have a projected balance of **\$375 billion**.

Waiting until 2025 to implement this proposal would push projected insolvency from 2026 out by **eight years** to 2034. At the end of 2030, the trust fund would have a projected balance of **\$156 billion**.

In this case, a delay of four years “costs” several years and \$219 billion in terms of the projected date of trust fund insolvency and net change in fund balance at the end of the decade.

3. [Strengthening Trust Funds & Improving Design](#) (by David M. Cutler, Richard G. Frank, Jonathan Gruber, and Joseph P. Newhouse in *Health Affairs*)

This proposal would increase the Medicare surtax paid by high-income households, redirect the Net Investment Income Tax toward the HI Trust Fund, return Medicare Advantage benchmarks to lower, pre-COVID-19 levels and remand savings from Medicare Advantage plans given the drop in elective claims they received during the pandemic, implement site-neutral payments, limit growth in prescription drug spending, and institute competitive bidding in Medicare Advantage.

Implementing this proposal in 2021 would push projected insolvency from 2026 out by **nine years** to 2035. At the end of 2030, the trust fund would have a projected balance of **\$304 billion**.

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<sup>d</sup> Our projections end in 2035 to extrapolate no more than four years beyond 2031, the furthest year for which CBO has projected a baseline balance.

Waiting until 2025 to implement this proposal would still push projected insolvency from 2026 out by **nine years** to 2035. At the end of 2030, however, the trust fund would have a projected balance of **\$173 billion**.

In this case, a delay of four years “costs” \$131 billion in terms of net change in projected fund balance at the end of the decade.

4. Payroll Tax Increase (included in the December 2020 CBO report: [Options for Reducing the Deficit](#))

This policy option would increase the current 2.9% Medicare payroll tax to 3.9%.

Implementation in 2021 would push projected insolvency from 2026 out by **more than nine years** to beyond 2035. At the end of 2030, the trust fund would have a projected balance of **\$487 billion**.

Waiting until 2025 to implement this change would still push projected insolvency from 2026 out by **more than nine years** to beyond 2035. The projected trust fund balance at the end of 2030 would be **\$249 billion**.

In this case, a delay of four years “costs” \$238 billion in terms of the net change in projected fund balance at the end of the decade.

5. Reduction in Provider Payments under Medicare Part A

In this policy option, the productivity adjustment factor used to calculate annual changes in provider payment rates would be adjusted so providers across the board would be paid less.

Implementation in 2021 would push projected insolvency from 2026 out by **three years** to 2029. At the end of 2030, the trust fund would have a projected balance of **-\$115 billion**.

Waiting until 2025 to implement this change would push projected insolvency from 2026 out by **one year** to 2027. At the end of 2030, the trust fund would have a projected balance of **-\$194 billion**.

In this case, a delay of four years “costs” two years and \$79 billion in terms of the projected date of trust fund insolvency and net change in fund balance at the end of the decade.

# Understanding Medicare

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Although this paper focuses on funding for Medicare Part A, we begin with a brief summary of the Medicare program as a whole—both by way of providing necessary context and to highlight the fiscal challenges that exist throughout the program.

Medicare, created in 1965, covers more than 60 million individuals, including people over the age of 65 and those of all ages with disabilities or end-stage renal disease (ESRD).<sup>4</sup> The program is financed mostly through payroll taxes on working individuals, beneficiary premiums, and general revenue from the federal Treasury. CBO estimates that total Medicare expenditures will increase from \$830 billion in fiscal year 2021 to \$1.8 trillion in FY2031, an annual nominal average growth rate of nearly 8%.<sup>5</sup>

Medicare is administered in four parts, with the federal government paying directly for benefits provided under Parts A and B (also known as traditional Medicare) through a fee-for-service (FFS) system, and private insurers providing coverage under Parts C and D through a system of capitated payments from the government.<sup>e</sup>

- Medicare Part A, Hospital Insurance (HI), covers inpatient services, skilled nursing facility stays up to 100 days after hospitalization, home health visits, and hospice care. Individuals do not have to pay premiums if they qualify because of disability or ESRD, or if they have paid Medicare taxes while working for at least 10 years. Nearly all beneficiaries pay no monthly premium, but Part A comes with a deductible that is set at \$1,484 for 2021.<sup>6</sup>
- Medicare Part B covers outpatient health care services, including professional services furnished by physicians and other nonphysician practitioners, hospital outpatient facility and ambulatory surgical center services, some home health services beyond those covered by Part A, dialysis services, and clinical-laboratory services. Individuals pay a monthly premium for Part B, and beneficiaries may elect to have the premium deducted from their Social Security benefit payment. Part B's standard monthly premium for 2021 is \$148.50, with high-income earners paying a higher rate; all beneficiaries have to pay 20% of doctor visits, and outpatient bills have a deductible set at \$203.<sup>7</sup> Low-income individuals with specific conditions may qualify for programs that result in them not having to pay the premium, or paying a reduced premium.<sup>f</sup>

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e In a capitated system, the insurance provider receives a fixed amount of funding per enrollee, regardless of the expenses incurred.

f See [Medicare Savings Programs](#), including the Qualified Medicare Beneficiary program, Specified Low-Income Medicare Beneficiary Program, Qualifying Individual Program, and Qualified Disabled and Working Individuals Program.



- Medicare Part C is Medicare's managed care program. It is available to beneficiaries as an alternative to obtaining Parts A and B coverage directly from the government. About one-third of beneficiaries currently elect to receive services through a so-called Medicare Advantage plan, which takes on risk for providing a set of services to enrollees. These plans are offered by private companies, subject to Medicare rules; they provide services covered under Parts A and B, and usually also cover Part D services. The government pays each Part C insurer a fixed amount every month for each enrollee. The amount is based on bids that insurers submit based on their expected costs. Many Medicare Advantage plans do not charge a premium besides the Part B premium, and offer additional benefits such as vision and dental care. Notably, Medicare Advantage plans must limit beneficiaries' out-of-pocket spending for Parts A and B services to \$6,700 annually.
- Medicare Part D covers outpatient prescription drugs. Medicare Advantage health plans generally offer prescription drug coverage as part of their packages. Those in traditional Medicare or in a Medicare Advantage plan that does not offer drug coverage may purchase a stand-alone prescription plan offered by private insurers. Most beneficiaries must pay premiums. Part D monthly premiums for 2021 average \$33, but actual premiums vary based on geography and enrollee income.<sup>8</sup> Low-income individuals with modest assets are eligible to receive assistance with premiums and cost sharing through the Part D Low-Income Subsidy program.<sup>9</sup> Similar to Medicare Part C, the government pays providers of prescription drug plans under Part D a monthly capitated amount per enrollee. The government does not get involved in negotiations between insurers, drug manufacturers, and pharmacies.<sup>10</sup>

Most traditional Medicare beneficiaries also have supplemental coverage to protect them from potentially high out-of-pocket spending and benefit gaps in the program, though supplemental coverage is not provided through either the HI or SMI Trust Funds. The three major types of supplemental coverage are employer-sponsored retiree coverage, Medigap, and Medicaid. Some employers offer former employees retiree insurance that pays second to Medicare, or Medicare Advantage Plans that combine Medicare and retiree health benefits in one package. Private companies offer Medigap policies, also known as Medicare Supplemental Insurance, that cover the beneficiary's cost share for covered services, including deductibles.<sup>11</sup> People who qualify for Medicare and Medicaid are known as [dual-eligible beneficiaries](#); these individuals have Medicare, and may receive Medicaid benefits or financial assistance with Medicare costs.

## The Role of the Medicare Trust Funds

Medicare uses two trust funds, the HI and SMI Trust Funds, to handle Medicare revenues and expenditures. The HI Trust Fund pays Medicare Part A benefits and a portion of Medicare program administration costs; the SMI Trust Fund partially covers Medicare Parts B and D benefits and a portion of Medicare program administration costs.<sup>12</sup> The trust funds contribute to Part C based on estimates of Parts A and B expenditures within Part C.<sup>13</sup>

Contrary to what their names might suggest, the trust funds work as accounting mechanisms rather than as vehicles for actually holding money in “trust.” When Medicare revenues are larger than Medicare expenditures in a given year, the surplus is used to reduce overall federal borrowing—essentially Medicare makes a loan to the Treasury in the form of an intergovernmental transfer of receipts. Conversely, when revenues are insufficient to cover expenditures for a given year, any outstanding loans to the HI Trust Fund are “called,” meaning that funds are drawn from the general Treasury to cover the shortfall.

The trust fund mechanisms enable Medicare to continue paying established benefits for eligible beneficiaries, even if annual expenditures exceed annual revenues. Indeed, the HI Trust Fund is projected to be in deficit for the foreseeable future. Health care economists predict a significant increase in Medicare enrollment over the next two decades as baby boomers continue to age and while health care costs per capita continue to rise—both factors will drive future deficits.

This deficit financing capability is only true to a point. If the HI Trust Fund is depleted, it is considered insolvent and benefit payments for the year are limited to the revenue that comes in that year. The Social Security Act does not specify what would happen at this point, but most experts predict that 100% of claims would be reimbursed until no money remains, and then claims would be reimbursed as revenue comes in during the year. Some experts speculate that a certain percentage of each claim would be reimbursed.<sup>14</sup> By contrast, the SMI Trust Fund cannot become insolvent, as federal law sets general revenue contributions at the level that automatically makes it solvent.

## **BPC Vice President and Chief Economist Jason Fichtner explains the HI Trust Fund in greater detail:**

“By law, Medicare has to invest any annual surpluses in special issue Treasury bonds only available to Medicare. It cannot buy or hold other financial assets, such as [stocks, mutual funds or corporate bonds](#). Like other government-issued bonds, these special issue bonds pay interest and are backed by the full faith and credit of the U.S. government. These bonds are real assets.

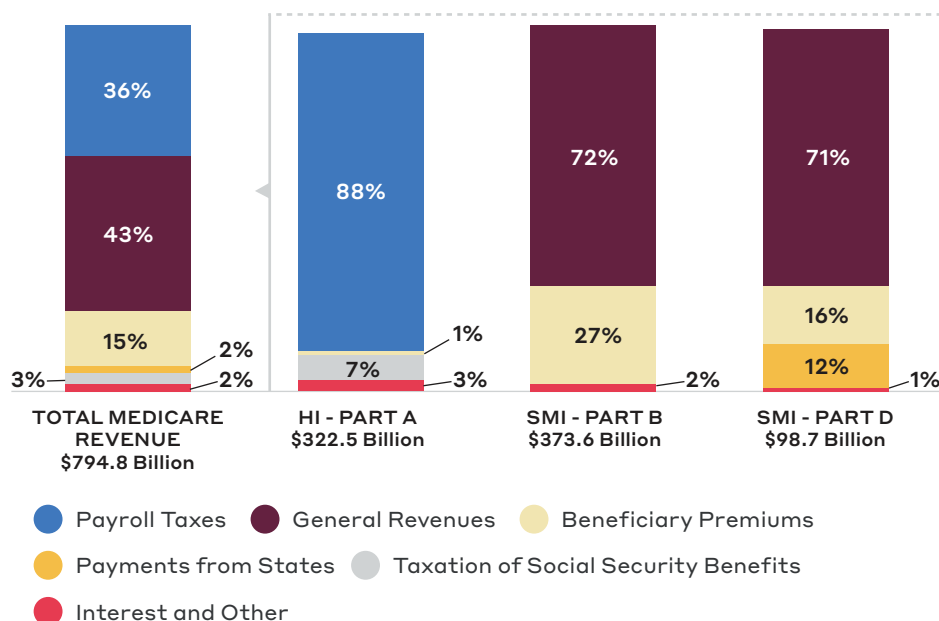
As Medicare draws down the assets in the HI Trust Fund in order to continue paying full benefits, the redemption of those bonds held in the trust fund will require that the Treasury Department issue additional public debt.

Importantly, the way the federal government accounts for the trust funds masks the true size of costs passed on to future generations. While bonds are real assets to the private market, future generations of taxpayers or borrowers will have to cover the future redemptions of bonds issued today because the federal government has used the money it has received from Medicare to pay for education, wars, and other items.

In other words, the government has already spent the money it received in exchange for the Treasury bonds issued to the Medicare Trust Funds. Then-President Barack Obama explained this in his 2011 federal budget this way: [‘The existence of large trust fund balances ... does not, by itself, increase the government’s ability to pay benefits.’](#)

Finally, [despite] the similarities, the government trust funds are meaningfully different from those in the private sector. In a private trust, the beneficiaries legally own the income from it. [That is not the case with a government trust fund.](#)”

**Figure 1: Sources of Medicare Revenue, 2019<sup>15</sup>**



Source: 2020 Report of the Medicare Trustees, April 22, 2020, Table II.B.1.

Notes: Totals may not add to 100% due to rounding. HI = Hospital Insurance; SMI = Supplementary Medical Insurance. In 2019, Part B premiums represented over 25% of Part B income due, in part, to a \$3.00 per month Part B premium surcharge imposed by the Bipartisan Budget Act of 2015 (P.L. 114-74).

## Funding Sources

Even among government trust funds, important distinctions exist. The difference between the HI Trust Fund and the SMI Trust Fund stems mainly from the different ways each is funded: the HI Trust Fund is largely funded by payroll taxes, while the SMI Trust Fund is primarily funded by general revenues (which the federal government collects mostly through individual income taxes, corporate taxes, and excise taxes), as well as premiums to a lesser degree.<sup>16</sup> In 2019 (**Figure 1**), the vast majority—88%—of HI Trust Fund revenues for Medicare Part A came from a 2.9% federal payroll tax. The tax is split between employers and employees, with each contributing 1.45% of the employee’s total earnings under the Federal Insurance Contributions Act tax. As a result of the Affordable Care Act (ACA), individuals with adjusted gross income (AGI) above \$200,000 annually and couples filing jointly with AGI above \$250,000 pay an additional 0.9% Medicare tax on their excess income.<sup>g</sup>

Another 7% of HI Trust Fund revenues come from a portion of the tax on Social Security benefits (most of this tax goes to the Social Security Trust Funds). The remaining 5% comes from premiums that are charged to the very small number

<sup>g</sup> Self-employed individuals also pay a 2.9% Medicare tax as part of their self-employment tax, and they are also subject to the additional Medicare tax rate of 0.9% for income above the same thresholds.

of otherwise ineligible beneficiaries who do pay for Part A benefits, interest on the trust fund balance, and other sources of revenue.

By contrast, the SMI Trust Fund is largely financed by general revenues. For Medicare Part B, premiums make up the bulk of the remainder. The 2021 Part B standard monthly premium is currently set at \$148.50.<sup>17</sup> Higher-income individuals must pay an income-related monthly adjustment amount beyond the standard premium. For Part D, beneficiaries pay about 16% of the cost through premiums and cost sharing, and the federal government covers most of the rest through general revenue, with states transferring the remainder through so-called clawback payments.

Medicare expenditures have consistently increased, and annual deficits in Medicare Part A are projected to continue escalating over the next decade.<sup>18,19</sup> This is because there are increasingly fewer working Americans paying into Medicare to cover the rapidly growing number of Medicare beneficiaries and because systemwide health care costs have been rising.<sup>20</sup> Older Medicare enrollees, a growing share, also have higher rates of co-occurring chronic physical and behavioral health conditions that contribute to greater costs.

## A Failed Federal Response

Despite repeated warnings from the Board of Trustees for the Medicare Trust Funds that the HI Trust Fund will soon be insolvent, and that Medicare is relying too heavily on general revenue, policymakers over the past quarter-century have failed to restore the long-term fiscal health of the program. While Congress has passed and presidents have signed legislation, none of these efforts has been fully successful, and some have been repealed. The Trustees publish annual reports on the current and projected financial status of Medicare.<sup>21</sup> In their latest report, the Trustees point to the “need for substantial changes to address Medicare’s financial challenges” and note that Congress will have more flexibility and time to pursue solutions the sooner they implement them.<sup>22</sup>

At various points in the last 25 years, the Trustees have projected that the HI Trust Fund would be depleted within a time frame of about a decade, and Congress has responded with legislation to push back the date of insolvency.<sup>23</sup> These actions, however, have ultimately provided only short-term fixes and have failed to comprehensively address the underlying issues.

Projections in the 1990s had the trust fund depleting in just four years. To address this, Congress implemented major reforms as part of the Balanced Budget Act of 1997, which established Medicare Part C, or Medicare+Choice—later reworked and renamed Medicare Advantage—and also limited provider payment growth through a sustainable growth rate (SGR) algorithm that was designed to reduce provider payments if physician spending was greater than a target linked to economic growth. Other provisions shifted post-acute care

facilities to operate on a prospective payment system designed to incentivize savings through greater efficiency and increased beneficiary cost-sharing. This legislation—along with increased revenue from a strong economy—temporarily pushed the projected HI Trust Fund insolvency date to 2030.<sup>24</sup>

But Congress then put off the automatic Medicare payment reductions that would have limited spending growth to the statutory targets. Starting in 2002, the first year when providers would have received an across-the-board payment reduction of 4.8% under the SGR algorithm, Congress passed legislation to avert the payment reductions. Similar legislation was then passed each subsequent year. The accumulation of averted payment reductions eventually threatened to impose a massive cut if ever allowed to take effect. Congress avoided this scenario when it replaced the reimbursement system in 2015 entirely with a value-based, incentive system—the original SGR cost savings never materialized.<sup>25</sup>

In 2003, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) required the program's Trustees to: 1) start providing more in-depth reporting of Medicare expenditures and revenues; and 2) make an annual determination of excess general Medicare funding if the Trustees projected that general revenue funding for Medicare would exceed 45% of Medicare expenditures (including expenditures for the SMI Trust Fund) in the next seven fiscal years. Two consecutive determinations would trigger a warning that would require the president to submit proposed legislation to Congress in response. This legislation would be submitted after the president's budget and would have to be considered by Congress on an expedited basis.<sup>26</sup> Funding warnings were triggered from 2007 to 2013 and then in 2018, 2019, and 2020 from consecutive determinations of excess general Medicare funding. Neither President Obama nor President Trump submitted legislation, however, as they considered the requirement to be advisory instead of binding.<sup>27</sup>

Then, in 2010, the ACA created the Independent Payment Advisory Board (IPAB), the so-called Cadillac Tax, and the individual mandate—all efforts [intended](#) to offset the ACA's costs and save money (see below descriptions). These measures, however, largely failed for various reasons. One ACA provision that has persisted is a Net Investment Income Tax on high-income individuals, but the revenue from this tax finances general revenues instead of either trust fund.<sup>28</sup>

Congress created the IPAB in recognition of its reluctance to enact cost control measures when necessary. The purpose of the IPAB was to task an independent group of experts with devising recommendations for reducing Medicare spending in the event that per capita Medicare spending exceeded growth targets specified in the ACA. If the targets were triggered in two consecutive years, the IPAB was to make recommendations, and Congress would have to take action to reduce spending or the recommendations would automatically

take effect. A supermajority of Congress could vote to avoid automatic implementation of the recommendations. Congress ignored the provision, however, and eventually repealed the IPAB altogether in the Bipartisan Budget Act of 2018 without ever appointing a single board member.<sup>29,30</sup>

The Cadillac Tax, a 40% tax on employers for high-cost employer-sponsored health insurance plans, also might have helped the situation. The intent was to discourage unnecessarily generous insurance policies that drove overuse of health care services while also generating considerable tax revenue. The tax, however, was unpopular, and before it could become active, it motivated employers to shift costs to employees through policies such as adding more high-deductible plans.<sup>31</sup> The tax was to take effect in 2018, but Congress delayed it twice before repealing it at the end of 2019.

Moreover, the ACA's individual mandate did not help as intended either. The mandate required Americans to get health insurance starting in 2014 or pay a tax penalty of up to \$695 annually unless they qualified for an exception. The mandate was meant to increase the number of people with insurance and add younger and healthier people to the insurance risk pool to decrease the overall cost of premiums.<sup>32</sup> Over the course of four years, the mandate brought in about \$12 billion in tax penalties.<sup>33</sup> Legislation to eliminate these penalties, however, was passed in December 2017 and became effective in 2019, essentially repealing the individual mandate.

## Worsening Projections

Government agencies anticipate that Medicare will soon be unable to fully meet its obligations, yet policymakers have not reached political consensus on whether to take any action at all, and if so, in what form. The [2020 Medicare Trustees Report](#) stated that the HI Trust Fund would become insolvent in 2026, six years from the date of publication.<sup>h</sup> The HI and SMI Trust Funds collectively drew nearly \$400 billion from general revenues in 2019 based on \$796 billion in expenditures on medical services and \$400 billion collected in payroll taxes and monthly premiums.<sup>34</sup>

Separate from the Medicare Trustees, CBO regularly publishes 10-year projections of major federal trust fund balances, under the assumption that there will be no changes in current laws. CBO [published](#) its latest update in February 2021, considering the impact of COVID-19 and economic recovery. In those projections, CBO pushed back its prior estimate of HI Trust Fund depletion from 2024 to 2026. This is the same estimated depletion date as the report issued by the Trustees in 2020, which did not account for the impact of COVID-19.

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<sup>h</sup> The 2020 report did not account for the impact of COVID-19 because of the high degree of uncertainty about the course of the pandemic at the point of publication.

CBO attributed this change to a better-than-expected increase in payroll tax revenue. CBO further projected that, after a surplus in the HI program of \$1 billion in 2021, the program would again be in deficit for 2022. Absent action by Congress, Medicare would only be able to pay about 92% of scheduled expenditures in 2026, and shortfalls would last through 2031 and beyond.

While much of this paper focuses on the HI Trust Fund, the SMI Trust Fund also deserves attention, as it continues to depend on general revenue transfers. Indeed, while the HI Trust Fund requires changes to restore solvency, the SMI Trust Fund and Medicare generally may require even larger reforms. For perspective on the difference in magnitude of the general revenues covering the HI Trust Fund and the SMI Trust Fund shortfalls, the latest Trustees report indicates that in the next decade, the SMI Trust Fund will receive \$5.3 trillion in general revenue, about 10 times the deficits in HI funding that the Trustees have projected.<sup>35</sup>

Although ideas for reforming Medicare are plentiful, political momentum to implement fundamental changes has not materialized. For example, President Biden has yet to release a public proposal to address Medicare trust fund insolvency, and in fact, has stated that he would finance his campaign proposal to lower Medicare eligibility from age 65 to 60 with general revenues. Funding Medicare for a new population solely with general revenues would greatly exacerbate overall demands on the federal budget and increase federal borrowing.

Some have proposed moving in the opposite direction, raising the eligibility age for Medicare to 67 to reduce program costs. Others have recommended policies ranging from reforming the Medicare Advantage program to a simple increase in the payroll tax that provides much of the HI Trust Fund's annual income. In the past, a go-to solution has been to reduce payments to medical providers, as was planned in the Balanced Budget Act of 1997 and actually executed to a small degree in the Budget Control Act of 2011.<sup>36</sup> The ACA took this step as well, but combined it with value-based payment reforms and reductions to Medicare Advantage plans, while also giving the Centers for Medicare & Medicaid Services authority to conduct experiments in payment and delivery reform.<sup>37</sup>



# Options to Improve HI Trust Fund Solvency

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BPC analyzed five proposals that reflect the diversity of possible solutions for improving HI Trust Fund solvency. This section summarizes each proposal and offers comments on possible effects and trade-offs. Notable alternative proposals have been omitted from our analysis due to the difficulty of quantifying their impacts over the short term. For purposes of our quantitative analysis—which focuses solely on HI Trust Fund solvency—we omit the impact of policies on the SMI Trust Fund. We also omit potential impacts on government spending outside of Medicare.

1. [Balanced Approach](#) by Bill Hoagland, Senior Vice President of BPC

This reform proposal seeks to balance policies that reduce Medicare Part A spending and policies that increase revenues. As such, it offers a potential compromise to advocates of one approach or the other. Key provisions include:

- **Raising the age of Medicare eligibility to 67.**
- **Creating a unified post-acute care payment system**—This provision was included in the Bipartisan Policy Center’s February 2020 report, [Bipartisan Rx for America’s Health Care](#).
- **Restricting Medigap cost sharing**—Specifically, ban new Medigap policies from paying the first \$750 of enrollees’ Parts A and B cost-sharing obligations, and limit coverage of cost sharing for the next \$6,750 to 50%.
- **Redirecting income from the Net Investment Income Tax to the HI Trust Fund**—The ACA levied a 3.8% tax on net investment income for individuals with AGI above \$200,000 and households with AGI above \$250,000. The tax is intended to finance health care spending, but revenues instead go into the Treasury’s general fund.

Raising Medicare’s eligibility age from 65 to 67 would match the Social Security full retirement age for those born in 1960 or later. An argument in favor of raising the eligibility age is that people are living and working longer, and are generally healthier as they age compared to prior generations, so the change would allow the Medicare program to reorient to the population it was designed

**Table 2: Summary Table of Proposals to Restore HI Trust Fund Solvency\***

**Current Law:** CBO projects that the Medicare Hospital Insurance Trust Fund (HI Trust Fund) will become insolvent in 2026, and thus unable to fully pay for all its projected expenditures. Based on those same projections, the cumulative balance at the end of 2030 would be -\$388 billion.

Proposals	Key Elements	Start Date	2030 Trust Fund Balance	Insolvency Year
Balanced Approach	<ul style="list-style-type: none"> <li>Raise Medicare Eligibility Age to 67</li> <li>Standardize Payment Across Post-Acute Care Settings</li> <li>Restrict Medigap Cost-Sharing</li> <li>Redirect NIIT to HI Trust Fund</li> </ul>	2021	\$240 billion	2034
		2025	\$28 billion	2031
Integration, Competition, and Coverage Reform	<ul style="list-style-type: none"> <li>Integrate Medicare Part A and Part B</li> <li>Reform Enrollment and Government Funding</li> <li>Reform Supplemental Coverage</li> <li>Reference Pricing and Competitive Bidding</li> <li>Reform Graduate Medical Education Payments</li> </ul>	2021	\$375 billion	> 2035
		2025	\$156 billion	2034
Strengthening Trust Funds & Improving Design	<ul style="list-style-type: none"> <li>Redirect NIIT to HI Trust Fund</li> <li>Increase Medicare High-Income Add-On Tax</li> <li>End Temporary COVID-19 Related Payments</li> <li>Move Home Health to Part B, Site-Neutral Payments</li> <li>Reduce High-Cost Prescribing</li> <li>Competitive Bidding in Medicare Advantage</li> </ul>	2021	\$304 billion	> 2035
		2025	\$173 billion	2035
Payroll Tax Increase	<ul style="list-style-type: none"> <li>Increase Medicare Payroll Tax from 2.9% to 3.9%</li> </ul>	2021	\$487 billion	> 2035
		2025	\$249 billion	> 2035
Reduction in Part A Provider Payments	<ul style="list-style-type: none"> <li>Adjust Productivity Adjustment Factor to Reduce Scheduled Market Base Increase by Additional 1% Each Year</li> </ul>	2021	- \$115 billion	2029
		2025	- \$194 billion	2027

\* CBO, in accordance with statute, assumes scheduled payments will be made in full even after depletion of the trust fund and therefore does not project the balance to fall below zero. To demonstrate the cumulative shortfall, this analysis assumes the trust fund balance can fall below zero with all scheduled payments continuing. Proposals are named based on their content and not necessarily by their authors. Information on sources and methodology can be found in the Analysis and Findings section of the report.

to serve.<sup>38</sup> Individuals who retire early and do not have retiree coverage could still seek coverage if they qualify for Marketplace health insurance subsidies, COBRA, or Medicaid.<sup>i</sup>

The National Committee to Preserve Social Security & Medicare, an advocacy group, [contends](#) that such a policy would increase overall health spending even if it saves money for Medicare. The 65- and 66-year-old individuals stripped of Medicare would have to buy or maintain coverage through more expensive private insurance, which could in turn raise the premiums of younger beneficiaries given a worsening risk pool. Some experts also argue that delaying Medicare eligibility would cause some beneficiaries to forgo care, leaving them with more costly problems when they do enter the program. Those remaining in Medicare would be part of an older and less healthy risk pool as well, potentially offsetting Medicare savings.

BPC has advocated for post-acute care payment reform to correct overpayment in certain settings, specifically for skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities. The government has initiated efforts to modify payment in these settings—to move away from facility-based care when unnecessary and deliver greater value—but the Medicare Payment Advisory Commission has already created a prototype for a more comprehensive solution that would not only save money but create consistency.

About two-thirds of the 81% of Medicare beneficiaries who have Medigap coverage have what is known as “first-dollar coverage,” which pays for all of a beneficiary’s Part A and B cost-share without a deductible. Hoagland argues that this policy leads to overuse of care, and that those who have supplemental private coverage use more health services. Doctors and patients may seek out low-value or unnecessary care knowing that the insurer is liable for all associated costs. New [research](#), however, shows that higher out-of-pocket costs could prompt beneficiaries to cut back on both necessary and unnecessary care, which [could](#) have worrying consequences, especially for low-income and chronically ill populations.

Implementing the Balanced Approach in 2021 would push projected HI Trust Fund insolvency from 2026 out by **eight years** to 2034. At the end of 2030, the trust fund would have a projected balance of **\$240 billion**.

Waiting until 2025 to implement this proposal would push projected insolvency from 2026 out by **five years** to 2031. At the end of 2030, the trust fund would have a projected balance of **\$28 billion**.

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i COBRA allows most employees and their families to continue their employer-sponsored insurance after they lose it for a limited period following qualifying events, including job loss. They may have to pay up to 102% of the cost of the plan, including the share previously covered by the employer. Medicaid is a program jointly run by states and the federal government that provides health coverage to low-income individuals, certain pregnant women and children, and those receiving Supplemental Security Income. The ACA still currently allows states to expand Medicaid to cover all adults making up to 133% of the Federal Poverty Level, and most states have taken the option.

In this case, a delay of four years “costs” three years and \$212 billion in terms of the projected date of trust fund insolvency and net change in fund balance at the end of the decade.

2. [Integration, Competition, and Coverage Reform](#) by James C. Capretta, Resident Fellow and Milton Friedman Chair at the American Enterprise Institute

Capretta maintains that policymakers have focused too much on the HI Trust Fund and on fixing its financing shortfalls in the short term, when in fact, the SMI Trust Fund is projected to place a greater—and increasingly heavy—burden on taxpayers. His plan combines a restructuring of both trust funds with specific payment and delivery reforms to incentivize changes in consumer, provider, and plan behavior from increased competition and engagement. Elements include:

- **An integrated benefit and trust fund structure**—Both programs would be modernized and integrated with a simplified cost-sharing structure that would be mandatory for new enrollees but optional for current ones. The benefits would equal the actuarial value of benefits under current law, with an annual out-of-pocket limit on beneficiary costs. General fund payments would also be decoupled from SMI spending growth.
- **Structured choice and competition**—Medicare Advantage, Accountable Care Organizations (ACOs), and unmanaged fee-for-service plans would compete for enrollment through their premiums (benefits are the same) in a competitive bid process, with the government contributing through premium support. There would be price transparency, and individuals who wanted more expensive options would pay higher premiums above the government contribution.<sup>j</sup>
- **Related reforms to supplemental coverage**—Medigap enrollment would be brought into the same coverage enrollment process as statutory Medicare benefits, and Medicare Advantage plans and ACOs would be allowed to offer Medigap-like coverage. For unmanaged fee-for-service, Medigap would be restructured to reduce excessive use: Beneficiaries would have to share some costs for outpatient services, and supplemental plans covering all cost-sharing obligations would be eliminated.
- **Reference pricing and competitive bidding**—High-volume services in bundled payment demonstrations would move from the current payment determination methodology to a bidding process where provider groups submit bids for all services related to a procedure, and the government then uses those bids to create a benchmark payment. Beneficiaries who receive services from providers at prices below the benchmark would share in savings. Reference pricing would also be expanded to cover any

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<sup>j</sup> Estimates of savings for this policy come from a [CBO report](#) on premium support.

Medicare service that is responsive to competitive bidding—for example, standardized, high-volume procedures (such as joint replacements).

- **Reform of Graduate Medical Education payments**—The payments would be converted to direct grants to institutions that sponsor residency training programs, including institutions other than hospitals; in addition, total spending would be reduced by \$3 billion annually to reduce excessive payments.

An integrated benefit and trust fund approach with structured choice and competition could greatly improve beneficiary experience, thereby simplifying the range of possible choices for coverage among Medicare Advantage, ACOs, and unmanaged fee-for-service. Having plans compete primarily on premiums could lead to an effective across-the-board drop in costs to the federal government and beneficiaries alike, and could ease the transition from a fee-for-service to a capitated, value-based health care system. One question that would need to be answered is how nonstandard coverage, such as special supplemental benefits for the chronically ill, which are currently only available to certain Medicare Advantage beneficiaries, would be treated.

Reference pricing has demonstrated promising, albeit limited, outcomes. An American Academy of Actuaries [study](#) that looked at reference pricing for a broader set of services than previous research has found potential for considerable savings (up to 28%) for shoppable services. The study also noted that employers have managed to [save money](#) with this method. Opponents, however, worry that this approach could make an already complicated experience more frustrating by placing a greater cost burden on individuals who are unaware that they will owe more out of pocket because their plan is using reference pricing.

Implementing this proposal in 2021 would push projected insolvency from 2026 out by **more than nine years** to beyond 2035. At the end of 2030, the trust fund would have a projected balance of **\$375 billion**.

Waiting until 2025 to implement this proposal would push projected insolvency from 2026 out by **eight years** to 2034. At the end of 2030, the trust fund would have a projected balance of **\$156 billion**.

In this case, a delay of four years “costs” more than one year and \$219 billion in terms of the projected date of trust fund insolvency and net change in fund balance at the end of the decade.

3. [Strengthening Trust Funds & Improving Design](#) by David M. Cutler, Richard G. Frank, Jonathan Gruber, and Joseph P. Newhouse in *Health Affairs*

The authors of this proposal argue that action now would avoid “a more reactive response” beyond the COVID-19 pandemic, given the limited time before the HI Trust Fund is exhausted. They propose a combination

of financial policies and programmatic changes, with the explicit goal of achieving a progressive distribution of the financing burden and promoting quality and efficiency in payment. Provisions in this proposal would:

- **Redirect income from the Net Investment Income Tax to the HI Trust Fund**—The ACA levied a 3.8% tax on net investment income for individuals with AGI above \$200,000 and households with AGI above \$250,000. The tax is intended to finance health care spending, but revenues instead go into the Treasury’s general fund.
- **Increase the Medicare high-income add-on tax for the wealthiest Americans**—The current 0.9% Medicare payroll tax surcharge for individuals with AGI above \$200,000 and households with AGI above \$250,000 would increase to 2% for individuals and households with AGI of more than \$1 million.
- **Exclude temporary COVID-19-related increases in Medicare payments from Medicare Advantage benchmarks**
- **Return savings, resulting from a substantial pandemic-related decline in Medicare Advantage claims**—The reduction in elective procedures and a variety of nonemergency health services during COVID-19 led to a reduction in claims and savings to insurers.
- **Shift the home health benefit to Part B**—One-third of charges for home health services under Medicare are paid under Part A; remaining services that are not linked to hospital/nursing home discharge are paid under Part B. This reform would move all spending to Part B, lowering Part A expenditures and increasing Part B cost and premiums.
- **Implement site-neutral payments for all medical procedures**—Under current law, Medicare pays more for a medical procedure delivered in an outpatient clinic than for the same procedure delivered in a doctor’s office, creating cost-increasing incentives. This policy reform was recommended by both MedPAC and the Trump administration.
- **Adjust the physician add-on to the Part B drug reimbursement structure and the inflation rebate for price increases above the general rate of inflation**—Both actions would reduce incentives for physicians to prescribe the most expensive drugs and effectively limit the ability of drug manufacturers to raise prices.
- **Implement Medicare Advantage benchmarks by extending competitive bidding**—This change would address overpayments and bid instability from the growth of Medicare Advantage enrollment, as competitive bidding would reduce potential distortions and lower premiums. This proposal is based on the “second-lowest-bid option without grandfathering” in CBO’s 2017 report titled [A Premium Support System for Medicare: Updated Analysis of Illustrative Options](#).

Implementing this proposal in 2021 would push projected insolvency from 2026 out by **nine years** to 2035. At the end of 2030, the trust fund would have a projected balance of **\$304 billion**.

Waiting until 2025 to implement this proposal would still push insolvency from 2026 out by **nine years** to 2035. At the end of 2030, however, the trust fund would have a significantly lower projected balance of **\$173 billion**.

In this case, a delay of four years “costs” \$131 billion in terms of net change in projected fund balance at the end of the decade.

4. Payroll Tax Rate Increase, as Discussed in the CBO Report [Options for Reducing the Deficit: 2021 to 2030](#)

This policy would **increase the current Medicare payroll tax rate from 2.9% of total earnings to 3.9%, effective immediately**.<sup>k</sup> Both the Medicare Trustees and MedPAC have pointed to an increase in the payroll tax as a means to keep the HI Trust Fund solvent. Employers tend to respond to payroll tax increases by reducing wages, effectively passing their share of the increase on to employees.<sup>39</sup>

Implementation in 2021 would push projected insolvency from 2026 out by **more than nine years** to beyond 2035. At the end of 2030, the trust fund would have a projected balance of **\$487 billion**.

Waiting until 2025 to implement this change would still push projected insolvency from 2026 out by **more than nine years** to beyond 2035. At the end of 2030, the trust fund would have a projected balance of **\$249 billion**.

In this case, a delay of four years “costs” \$238 billion in terms of the net change in projected fund balance at the end of the decade.

5. Reduction in Provider Payments in Medicare Part A

This policy would change the ACA’s **productivity adjustment factor to reduce the Market Basket Index increase by a further 1 percentage point annually instead of remaining tied to economywide productivity**. The ACA [included](#) a productivity adjustment factor that annually adjusts the payments made to hospitals and other inpatient facilities. By default, the payment changes every year according to an index that tracks the price of goods and services used to provide care, to ensure that payments keep up with inflation. The productivity adjustment factor reduces that payment update by the increase in economywide productivity, so this policy would reduce that payment update further by another 1 percentage point.

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<sup>k</sup> This would increase the Medicare payroll tax only and not affect Social Security payroll taxes. See <https://www.irs.gov/taxtopics/tc751> for more information on payroll taxes.

Implementation in 2021 would push projected insolvency from 2026 out by **three years** to 2029. At the end of 2030, the trust fund would have a projected balance of **-\$115 billion**.

Waiting until 2025 to implement this proposal would push insolvency from 2026 out by **one year** to 2027. At the end of 2030, the trust fund would have a projected balance of **-\$194 billion**.

In this case, a delay of four years “costs” two years and \$79 billion in terms of the projected date of trust fund insolvency and net change in fund balance at the end of the decade.



The Social Security Act provides no corrective mechanism that is automatically activated when the HI Trust fund becomes insolvent. General revenues would not automatically flow to fund Part A services, nor would specific benefits be limited to ensure that obligations are fully paid. As the Congressional Research Service has pointed out, failure to take action before such point means that Congress would likely have to make an immediate decision if it wishes to make up the deficit.<sup>40</sup>

*Disclaimer: Not all authors of these proposals were consulted for this analysis. Any calculations and estimates were performed by BPC staff and should not be interpreted as necessarily having the approval or endorsement of proposal authors.*

## Analysis and Findings

Using data and calculations provided or referenced by the authors of the proposals as a base, BPC used CBO estimates whenever possible, supplemented by data from the 2020 Medicare Trustees Report, other government sources, and the Committee for a Responsible Federal Budget, to project the impact of various proposals on the HI Trust Fund—both in terms of the projected year of fund insolvency and in terms of the projected fund balance at the end of 2030.

CBO’s projections for HI revenue and spending end in 2031. BPC extends these projections by dropping years in which the COVID-19 pandemic and recession cause transitory changes in revenue and spending, smoothing year-to-year spending fluctuations to extract a medium-term trend, and extrapolating trend revenue and spending through 2035.

Most of the authors’ projections use different start dates, so BPC sought to enable a fair comparison between proposals by assuming the same implementation date in each case. We adjusted the authors’ projections where



necessary using updated numbers from the same data sources or extrapolating when updated numbers were not available. The 10-year time frame used to calculate impacts for this analysis counts the year that the proposal is implemented as the first year.<sup>1</sup>

## Key Conclusion: Waiting to Act on Medicare Reform Will Diminish Our Ability to Postpone Insolvency

**Table 3. Cost of Waiting—Effect on Projected Year of Trust Fund Insolvency**

Current Law (No Change)	2026				
If the following policies were implemented in this year...	2021	2022	2023	2024	2025
<b>1. Balanced Approach</b>	+8 Years 2034	+7 Years 2033		+6 Years 2032	+5 Years 2031
<b>2. Integration, Competition, and Supplemental Coverage Reform</b>	+ > 9 Years Beyond 2035			+ 9 Years 2035	+8 Years 2034
<b>3. Strengthening Trust Funds &amp; Improving Design</b>	+ 9 Years 2035				
<b>4. Payroll Tax Increase</b>	+ > 9 Years Beyond 2035				
<b>5. Reduction in Provider Payments</b>	+3 Years 2029	+ 2 Years 2028			+1 Year 2027

There are strong financial reasons not to delay action. In **Table 2**, Proposal Nos. 1, 2, and 5 see a diminished effect on the projected year of trust fund insolvency when implemented at a later date. These policies, if implemented in 2025, would have to make up for additional deficits projected under current law that would not exist if the same policies were implemented in 2021.

The baseline projection that insolvency will occur in 2026 could be altered with future events. When BPC ran this same analysis using CBO’s previous September 2020 projections, which anticipated that the HI Trust Fund would be depleted by the end of 2024 due to a worse economic outlook, differences in the projected year of insolvency depending on when proposals were implemented were even more pronounced. If insolvency was projected to occur sooner due to a drop in payroll taxes or an increase in Medicare Part A expenditures, then most of the above proposals would follow the same pattern as Proposal No. 1, the Balanced Approach, in showing a weaker effect on insolvency with time.

Even where later implementation does not change the projected date of insolvency, as in Proposal Nos. 3 and 4, there are still costs to waiting in terms

<sup>1</sup> More details on data sources and calculations can be found in the accompanying Excel document (titled “Cost of Waiting Analysis”).

of the fiscal health of the HI Trust Fund, as measured by the projected fund balance at the end of 2030.

**Key Conclusion: Waiting to Act on Medicare Reform Could Reduce the Fund Balance in 2030 by Up to \$238 Billion**

**Table 4. Cost of Waiting – Trust Fund Balance at the End of 2030 (Billions)**

Current Law (No Change)	-\$388				
If the following policies were implemented in this year...	2021	2022	2023	2024	2025
1. Balanced Approach	\$240	\$191	\$138	\$84	\$28
2. Integration, Competition, and Supplemental Coverage Reform	\$375	\$329	\$277	\$219	\$156
3. Strengthening Trust Funds & Improving Design	\$304	\$285	\$257	\$221	\$173
4. Payroll Tax Increase	\$487	\$457	\$395	\$325	\$249
5. Reduction in Provider Payments	-\$115	-\$138	-\$155	-\$171	-\$194

While the reforms we analyzed vary in terms of their effect on Medicare finances, the pattern across all proposals is that delayed implementation has a real cost—it results in lower projected fund balances for any given future year. The difference in projected fund balances is drastic in some cases. For example, with Proposal No. 1, immediate implementation (in 2021) would result in a positive fund balance of \$240 billion in 2030, giving the HI Trust Fund a surplus that could be drawn on in future years when revenues fall short of expenditures. Waiting until 2025 to implement the same proposal, however, would result in a dangerously low fund balance at the same point in time. A negative balance would necessitate further congressional action to ensure that beneficiaries’ access to benefits is not affected. The greatest cost lies in waiting four years, until 2025, to implement Proposal No. 4, the Payroll Tax Increase, which reduces the projected HI Trust Fund balance at the end of 2030 from \$487 billion to \$249 billion, a difference of \$238 billion.

These results reinforce the Medicare Trustees’ assertion that policymakers will have a greater number of options and the ability to implement more gradual changes the earlier they act. If policymakers wait, some proposals that would have produced sufficient results had they been implemented earlier will no longer be viable. Instead, more aggressive policies will be needed to produce the combination of increased revenues and reduced costs necessary to restore the HI Trust Fund to solvency.

These costs of delay do not consider the secondary costs that stakeholders, including beneficiaries, private insurers, health care providers, and taxpayers, will bear under any of the proposals. As the Trustees also point out, early notice of reforms gives all stakeholders time to modify expectations and behaviors accordingly. Earlier action also allows more cohorts of workers and beneficiaries to be a part of the solution. Waiting to act until just before or even after the HI Trust Fund becomes insolvent could greatly disrupt planning and impose higher costs.<sup>m</sup>

Further impetus for reform should come from the fact that there are competing proposals to increase coverage through a public option and to expand eligibility for Medicare. It is difficult to have those conversations when the existing program faces financial instability. At the same time, potential savings from Part D reforms and other areas may afford opportunities for bipartisan agreement. Finally, Medicare often serves as a model for private insurers and providers, especially with the growth of Medicare Advantage, so efforts to control costs and improve care also have the potential to deliver benefits for beneficiaries outside the program.

## Conclusion

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Policymakers have a range of options available to ensure Medicare's financial viability, but time is of the essence. Waiting to act carries a real cost: the later a policy goes into effect, the less impact it will have on shoring up the Medicare HI Trust Fund and delaying insolvency, which CBO currently projects for 2026. A simple general revenue transfer that some may call for will address neither increasing expenditures nor insufficient revenues, instead presenting a band-aid fix that will only add to the program's growing dependence on general funds. Congress should act by passing policies such as those considered in this report that stand to make a meaningful difference. While exploring solutions for the HI Trust Fund, policymakers should also consider the state of the SMI Trust Fund; the growing flow of general revenues into that program may eventually crowd out other federal policy priorities.

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<sup>m</sup> Health Management Associates, with support from The Commonwealth Fund, recently developed a [comprehensive assessment tool](#) for evaluating Medicare reform proposals, including impacts on beneficiaries and health care systems. Health Management Associates has examined some of the policies within the reform packages BPC analyzed and has found, among other things, that competitively set benchmarks for Medicare Advantage plans would increase the out-of-pocket cost burden for beneficiaries without supplemental coverage by \$1,200 while reducing Medicare Advantage enrollment by 14%. Another finding is that site-neutral payments would slightly decrease average hospital margins and enrollment in ACO systems. Health Management Associates plans to release its methodology and more modeling results soon.

Ultimately, the fiscal status of the Medicare programs affects all of us, not just Medicare beneficiaries or providers. Workers pay into the Medicare system with the expectation that when they retire or if they are diagnosed with a qualifying disability, they will be able to access health care benefits. This expectation relies on the financial solvency of Medicare—namely, that today’s workers will pay enough in revenue to cover the medical costs of today’s beneficiaries. If Congress waits to pass a solution or settles for a short-term fix that fails to meaningfully improve Medicare’s fiscal condition, the cost is ultimately borne by taxpayers and may jeopardize beneficiaries’ ability to access care without substantial cost.

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