My name is Robert Emmet Moffit. I am a Senior Fellow in Domestic Policy Studies at The Heritage Foundation. The views I express in this testimony are my own and should not be construed as representing any official position of The Heritage Foundation.

My professional experience with the Medicare program began in 1986 when I served as Deputy Assistant Secretary for Legislation at the U.S. Department of Health and Human Services. President Ronald Reagan was then committed to adding a Medicare catastrophic benefit, a hard cap on seniors' out-of-pocket medical costs, giving America's seniors peace of mind, and protecting them from the financial devastation of catastrophic illness. The President thus supported and signed the Medicare Catastrophic Coverage Act of 1988, which passed both the House and Senate overwhelmingly.

The Medicare Catastrophic Coverage Act was the largest expansion of Medicare since the program's inception. Beyond a straightforward cap on out-of-pocket costs (the original Reagan proposal), the law added a new set of benefits, including extended nursing home coverage and prescription drug coverage to be financed by an income-related supplemental premium. Problems quickly mounted. Millions of seniors already had prescription drug coverage that they liked, the drug benefit itself turned out to be far more expensive than originally anticipated, and the additional premium costs had become wildly unpopular. Millions of seniors concluded that the costs of the law outweighed its benefits. The 1988 law that passed with such fanfare was overwhelmingly repealed in 1989.

Harnessing the Power of Personal Choice. One key lesson from that experience: providing personal choice is a superior policy option than mandating the take up of a benefit that is already widely available to the beneficiaries. Not surprisingly, when Congress enacted the Medicare Modernization Act of 2003, beneficiaries were given the choice of enrolling in a voluntary drug benefit under a new Part D, as well as the opportunity to enroll in an upgraded system of private health plan coverage as an alternative to Medicare A and B—Medicare Advantage (MA)—under Medicare Part C. Both defined contribution programs are clearly successful.

Medicare—as we know it—is a fleeting thing. The program has grown and changed dramatically since its inception, let alone since the great debate over the Medicare Catastrophic Coverage Act. In 1990, the program enrolled 34.2 million persons; in 2022, it enrolled over 65 million. In 1990, total program costs amounted to $111 billion; in 2022, they exceeded an estimated $940 billion. In 1990, only about 2 million beneficiaries were enrolled in private health plans; in 2022, over 30 million beneficiaries have enrolled in private health plans—more than 46 percent of the entire Medicare population. Next year, private plan enrollment will be nearly 32 million, or almost 48 percent of total Medicare enrollment.[1]

It is worth noting, in this context, that Florida ranks fifth in the nation in the number of Medicare beneficiaries (2.6 million) enrolled in MA, or an estimated 53.6 percent of all Florida Medicare enrollees.

To cope with this growth and the changing conditions of health care delivery, over the past thirty years Congress has also enacted major changes in Medicare physician and hospital payment, including delivery reforms for doctors and hospitals, created accountable care organizations within traditional Medicare to reward value over volume; all with the goal of achieving savings for both beneficiaries and taxpayers.

Medicare's Growing Fiscal Challenges

Medicare is facing formidable fiscal challenges. The Medicare Trustees report that the Medicare Hospitalization Insurance (HI) Trust Fund, the account for Part A hospital and related medical services, will be insolvent in 2028.[2] With a recession, the decline in employment and payroll tax revenues could bring the impending crisis even closer to our doorstep.

Medicare insolvency does not mean "bankruptcy" in the sense of a total financial collapse. It means that the Medicare hospitalization program will not be able to pay for all the promised Medicare Part A benefits. In 2028, if insolvency hits, Medicare benefit payments would be cut by 10 percent,[3] and, absent congressional action, deepen each year thereafter. That is why the Medicare trustees warn, "Beneficiary access to health care services could be rapidly curtailed."[4]

The HI trust fund meets neither the Trustees' short-term nor long-term standards of financial adequacy, meaning that its assets should equal 100 percent of its annual expenditures. Except for just two years (2016 and 2017), Part A spending exceeded income since 2008. At the beginning of 2021, Part A assets amounted to just 40 percent of the hospital expenditures projected for the year.[5]

Part A insolvency has never occurred. Congressional options to prevent it are, however, both limited and painful: an increase in the federal payroll tax, an added charge on Medicare beneficiaries, and/or a transfer of general revenues into the HI trust fund, meaning higher income or business taxes. Otherwise, Congress could impose a new set of Medicare price controls or payment reductions for Medicare Part A providers, already subject to hundreds of billions of dollars in payment reductions for the foreseeable future under the Affordable Care Act of 2010 (ACA), which in turn already threaten seniors' future access to quality care.

While Medicare Part A is facing insolvency, Medicare Parts B and D, the supplementary insurance program (SMI), also faces fiscal challenges. In 2020, Part B benefit costs alone grew at a rate of 13.2 percent, reflecting the massive increase in COVID-19 spending.[6] For the next ten years, SMI (Parts B and D combined) is projected to grow at an average annual rate of 8 percent—much faster than the growth of wages or the general economy—reflecting the retirement of the big baby-boom generation.[7] As a share of the nation's economy, Part B spending alone amounted to 1.9 percent of the nation's gross domestic product (GDP) in 2020, but is projected to reach 3.3 percent by 2040.[8]

While beneficiary Part B premiums fund about a quarter of benefits and services, automatic drawdowns of general revenues (funded by business and income taxes) account for roughly three-fourths of SMI spending. For beneficiaries, SMI premiums and cost-sharing are going to take larger and larger chunks out of the average Social Security benefit. In 2020, the Part B monthly premium was $144.60, but in 2031, the monthly premium will reach $272.10, while Part B deductible will be $379. For taxpayers, SMI premiums

consumed 17 percent of all business and income taxes in 2017, but they are projected to consume 21.5 percent by 2030 and 26.6 percent by 2040.[9]
Under current law, if general revenues to fund Medicare exceed 45 percent of total Medicare spending twice within 7 years, the trustees must issue a formal Medicare funding warning.[10] The President and Congress are legally obliged to take remedial action. While the trustees have issued multiple warnings, thus far neither presidents nor lawmakers have taken remedial action.
Future Debt. The next major debate on the future of Medicare will take place within the context of multi-trillion-dollar annual deficits, dangerous levels of debt, and perhaps even the threat of a fiscal crisis. Over the past three years, Congress's multi-trillion-dollar spending, including pandemic spending, has already added to the nation's record debt—over $31 trillion (about $95,000 per person in the U.S.). Over the next 75 years, Medicare will generate huge unfunded obligations—meaning the total cost of promised Medicare benefits are not financed either by dedicated revenues or beneficiary premiums. The trustees note that the HI portion of these obligations ($5.1 trillion) are likely to be addressed by future legislation or expenditure cuts, but the SMI portion ($47.5 trillion) "will require general fund transfers of this amount, and these transfers represent a formal budget requirement."[11] In short, Medicare's long-term unfunded obligations will amount to $52.6 trillion (about $160,000 per person), another future taxpayer burden dwarfing the current estimate of America's rapidly rising national debt.

How Washington Has Worsened Medicare's Financial Condition

There is no way America can spend less on Medicare, given the rapid aging of the population, the massive growth in Medicare enrollment, and the rising per capita cost of delivering modern medical care. But we can slow the growth through market forces and secure better value for Medicare dollars.

For the future of Medicare, job one for policymakers is to avoid making the financial situation worse. One simple rule: Every dime of potential budgetary savings in the Medicare program should first be plowed back into the Medicare program. Under no circumstances should Congress ignore or weaken Medicare's financial condition or use the program as a cash cow for other government programs. Unfortunately, Congress has too often chosen the wrong path.

The Inflation Reduction Act. For the recently enacted Inflation Reduction Act, the Congressional Budget Office (CBO) scored the creation of a complex system of price controls on Medicare drugs as saving an estimated $287 billion over 10 years.[12] Because the Medicare hospital insurance (HI) trust fund is facing insolvency in just six years, the right policy would be to statutorily earmark every dime of Medicare savings for the deficit-ridden trust fund. Congress did no such thing.

The Postal Reform Bill. In March 2022 Congress enacted The Postal Service Reform Act (H.R. 3076) to "stabilize" the financially troubled U.S. Postal Service. The Postal Service is supposed to be a self-financing agency. It is not. In 2020, the Government Accountability Office (GAO), the congressional watchdog, detailed the extent of the Postal Service problem.

They found that, as of that date, the Postal Service had thus far accumulated a total of $188 billion (about $580 per person in the U.S.) in debt, including unfunded health benefit obligations; an amount more than 250 percent of its annual revenue.[13]

Among the biggest issues facing the Postal Service was how to handle the large chunk of unfunded obligations of the Postal Service retirees' health benefits. These liabilities amount to a whopping $75 billion—the dollar amount of health benefits promised Postal retirees but not financed.

Sponsors of the House bill have decided to shift the health benefit costs of the Postal Service to the Medicare program. According to the text of the bill, as of January 1, 2023, all Postal retirees, with certain exceptions, will be required to get their primary coverage through Medicare rather than the Federal Employees Health Benefit Program (FEHBP), thus adding new unfunded obligations to the Medicare program, which is already struggling with tens of trillions of dollars in unfunded obligations of its own.
While the House and Senate bill sponsors simply ignored or downplayed the Medicare cost issue, Senator Rick Scott (R–FL) proposed a simple amendment: In any transition of Postal retirees to full Medicare coverage, the Postal Service should be required to reimburse the Medicare program for any additional costs. If the Medicare cost issue was really not a problem, then logically there could be no objection to such an amendment. If the Medicare cost issue was indeed a problem, the financial failures of another government agency did not, and could not, provide a logical justification for making Medicare's condition worse.

On March 8, 2022, Senator Scott asked for unanimous consent for the Senate to vote on his amendment to require the Postal Service to reimburse the Medicare program for the additional Medicare costs. Senate Democrats objected, and thus blocked consideration and a vote on the amendment. After blocking debate on Senator Scott's amendment, Senator Bernie Sanders (I–VT) offered a motion to waive the budget rules knowing the bill would add to the federal deficit. The Senate then passed the House postal bill by a lopsided 79 to 19 vote.[14]
The Affordable Care Act of 2010 (ACA). Over the period 2015 to 2024, the CBO projected that ACA spending would reach nearly $2 trillion.[15] Beyond the health law's long list of tax increases, several of which were subsequently repealed, the CBO estimated that the law's Medicare payment cuts would amount to $716 billion over the period 2013 to 2022.[16] ACA supporters tried to claim that the new law's Medicare payment cuts would not only help pay for the new entitlement programs—the Medicaid expansion and ACA insurance subsidies—but would also extend the solvency of the Medicare HI trust fund.[17] Echoing the CBO's earlier assessment of that claim, in 2010 Medicare's Actuary Richard S. Foster declared: "In practice, the improved HI financing cannot be simultaneously used to finance other federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."[18] In short, one cannot spend the same dollar twice.

The Health Security Act of 1993. The Clinton Administration projected that its proposed Health Security Act would cost an estimated $389 billion over the period 1994 to 2000. Among other measures, the Clinton team proposed reining in Medicare spending through

tougher price controls on medical providers and these would yield an estimated $124 billion in "savings" over that time period.[19] This attempted raid on Medicare was stymied by the collapse of the Clinton Health Plan.

Looking Toward the Future: Improve Medicare Advantage

Medicare Advantage is soon to be the future for most Medicare's beneficiaries. Private plan coverage, new benefit designs, and new plan and provider payment systems will reshape the future of the Medicare program.

There are a variety of reasons for the success of MA. Private health plans are far more flexible in benefit offerings and payment arrangements. The reason is that Congress has deployed a defined contribution payment system to private plans. As Stuart Butler, senior fellow at the Brookings Institution, has observed, "The capitation system permits competing Medicare Advantage plans to offer a variety of benefits beyond a required core of basic benefits. Moreover, in contrast to traditional Medicare's rigid and detailed payments system, it allows plans to explore different payments as a means of achieving greater efficiency and beneficiary satisfaction."[20]

For beneficiaries, MA is cost-effective; MA premiums are relatively low, and most health plans provide comprehensive coverage for the standard Part B Medicare premium. MA is also convenient; most beneficiaries can simply pay one premium, and overwhelmingly they do not need to pay a second (often hefty) premium for Medigap or supplemental coverage to fill in traditional Medicare's crucial coverage gaps, including prescription drugs and protection from the financial devastation of catastrophic illness.

The Quality Factor. Of all these positive features, perhaps the most relevant is that the MA program's plans deliver superior quality of care; that is the predominant finding in a large and growing body of the professional literature. In a comprehensive review of the literature, a team of researchers writing in *Health Affairs* observed: "Evidence from forty-eight studies showed that in most or all comparisons, Medicare Advantage was associated with more preventive care visits, fewer hospital admissions and emergency department visits, shorter hospital and skilled nursing facility lengths of stay, and lower health care spending. Medicare Advantage outperformed traditional Medicare in most studies comparing quality of care metrics."[21]

Several large studies confirm the superior performance of MA in delivering quality care. For example:

- In 2018, analysts with Avalere, a prominent health care research firm, reported that MA enrolled people with greater health problems and higher risk for larger health costs than patients in Medicare fee-for-service (FFS). Compared to Medicare FFS, Medicare Advantage enrolled chronically ill and disabled persons—by a margin of 22 percent to 36 percent.[22] Moreover, Avalere researchers also reported that by a margin of 31 percent to 15 percent, MA enrolled a higher proportion of racial and ethnic minorities than traditional Medicare. By a margin of 9 percent to 5 percent, MA enrolled a larger number of beneficiaries with "serious mental illnesses," and by a slim margin of 7 percent to 6

percent, MA enrolled a higher number of persons who suffer from alcohol, drug, and substance abuse than are enrolled in traditional Medicare.[23]

The Avalere team also found that MA outperformed traditional Medicare on significant quality measures, including a 29 percent lower rate of potentially avoidable hospitalizations, with 41 percent fewer avoidable acute hospitalizations. MA recorded higher rates of preventive screening and tests, notably a 13 percent higher rate of breast cancer screenings.[24] MA patients had better outcomes, too, with lower rates of complications of diabetes, especially dual-eligible patients, and lower hospitalization rates for these comorbidities.

- In a massive 2017 study of 9.9 million Medicare beneficiaries in California, Florida, and New York, researchers writing in the journal *Health Services Research* found that though traditional Medicare enrollees reported "better access" to care, MA enrollees reported "better experiences overall," and MA plans "substantially" outperformed traditional Medicare fee-for-service on a total of 16 health care quality measures.[25] For example, MA outperformed FFS on "all cause" readmissions, breast cancer screening, colorectal cancer screening, rheumatoid arthritis management, cholesterol management, diabetic care, and the provision of annual flu vaccinations.[26] Generally, the comparative performance of the two programs was roughly similar on measures of patient experience. Differences were tiny on such measures as care coordination, the patient rating of health care quality. While FFS enrollees were slightly better at "getting needed care," MA enrollees reported a better experience in "getting appointments and care quickly" and "getting needed prescription drugs."[27]
- A December 2020 Avalere study focused on the frail elderly, the chronically ill, the disabled, and patients with complex medical conditions. For these "high need, high-cost" Medicare beneficiaries, Avalere analysts found that MA performed better than Medicare FFS on 17 out of 22 clinical care measures.[28] Among the key Avalere findings: MA beneficiaries had pneumonia vaccination rates that were 50 percent to 52 percent higher than those enrolled in Medicare FFS; had higher rates of outpatient visits; lower rates of avoidable hospitalizations; and lower costs for inpatient care. MA beneficiaries did, however, have higher costs for physicians' services in "outpatient settings."[29]

The Next Steps to a Better Medicare

Congress should not ignore improvements to traditional Medicare, and there are many changes that could make that program more effective in care delivery while securing savings. As the CBO and many others have recommended, policymakers could combine Medicare Parts A and B into a single comprehensive health plan, with a single deductible and more rational cost-sharing arrangements. Congress could reform the Medigap system and reduce the unnecessary premium and taxpayer costs incurred by the excessive utilization that characterizes the current supplemental insurance arrangements. And, finally, Congress could deliver on the late President Ronald Reagan's promise and provide a catastrophic benefit for America's seniors, providing them with the financial protection and peace of mind that they deserve in their golden years.

But improvements to the rapidly growing Medicare Advantage program should get top priority. While the program has been successful in many ways, it offers certain

opportunities for progress, as well as persistent problems that should be resolved. Specifically:

- **Make Medicare Advantage the default enrollment for new Medicare beneficiaries.** Today, Social Security recipients are automatically enrolled in Medicare Part B; it is the default enrollment for newly retired persons. Given MA's superior record in providing high-quality medical care, Congress should change the default enrollment from traditional Medicare to Medicare Advantage.[30] Congress could require plans qualifying for automatic enrollment to meet certain quality and cost standards. Of course, Medicare beneficiaries would have the right to re-enroll in traditional Medicare if they wished to do so.
- **Reform the plan payment system.** Today, the federal government pays health plans based on a complex formula combining Medicare's administrative price setting and a process of competitive bidding among health plans to offer Medicare benefits. Congress should replace the current system with a simpler process of straight market-based bidding among competing health plans to offer the traditional Medicare benefits, and government payment to plans would reflect the actual market price of coverage and drive more intense competition among plans and providers. Such competitive bidding should be undertaken on a regional basis, reflecting the fact that modern care delivery is also more regionally based. Congress should authorize demonstration of the best payment formula for setting the government contribution for plans, such as basing plan payment on an average bid of competing plans (like the FEHBP), the second-lowest cost plan (like the ACA), or an average of the three lowest cost plans.

- **Reform the risk-adjustment system.** In tandem with MA payment reform, Congress should improve reimbursement of plans for enrolling higher cost (sicker) beneficiaries. Today, the government adjusts plan payment to MA plans to account for enrollees' age, sex, institutional, and Medicaid status. This is perfectly fine. The problem arises in determining beneficiaries' health status. While the current system accounts for health status, it does so *prospectively* using past claims data. While that approach can produce reasonably accurate cost projections for beneficiaries with well-understood chronic conditions, it cannot predict unexpected costs or sudden changes in beneficiary health status. Congress should take the guesswork out of a plan's cost—attributed to health status—by adding a *retrospective* (look-back) system to reimburse plans for the *actual* costs of enrolling a disproportionate number of beneficiaries with higher medical costs. Such reimbursements would come from a common pool, through which MA plans share the costs of expensive enrollees. Such retrospective risk-transfer pools should be organized on a state or regional basis, with funding from all participating MA plans, and should be designed and managed by the plans under the supervision of state insurance regulators. Such a retrospective system would not only be more accurate but would also reduce or eliminate the real problem of insurer gaming of the current MA payment system at the expense of the taxpayer. Once again, Congress should first authorize a demonstration of such a risk-adjustment reform, to ensure that reform will maintain market stability and guaranteed access to care for the most vulnerable beneficiaries.

- **Allow MA MSA Plans to offer drug coverage.** Congress should allow Medical Savings Account (MSA) plans to offer prescription drug coverage just like all other MA plans. Today, they cannot. A level playing field among health plans is essential to securing rational beneficiary choice in a functioning competitive market.

- **Allow MA to offer hospice coverage.** Under current law, enrollees in MA plans must secure their hospice benefits under the traditional Medicare program. Congress should

eliminate this counterproductive restriction and allow MA enrollees to enjoy a full continuum of care, including end-of-life care, through their private plans if they wish.

- **Allow Medicare beneficiaries to continue to make contributions to HSAs.** Under current law, Medicare beneficiaries cannot continue to make tax-free contributions to their health savings accounts. Congress should also revisit the current HSA contribution limits and consider making the accounts free-standing savings vehicles for medical care. Facing much higher per capita costs and far more complex medical conditions, Medicare patients utilize an even greater variety of medical services from a broader range of specialists than the younger working Americans who use HSAs to offset their much lower health care costs.
- This concludes my formal testimony. I would be happy to answer any questions you may have.

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