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# Medicare Funds Projected to Run Out by 2036

Annual trustee reports for Medicare and Social Security highlight the need for changes to mitigate this grim outlook.

The latest annual reports from the trustees of Medicare and the Social Security Board highlight a concerning financial outlook for both programs, despite recent extensions in their projected solvency.

The Medicare Hospital Insurance (HI) Trust Fund is expected to be depleted by 2036, while Social Security funds are anticipated to run out by 2035. These projections, while slightly more favorable than previous estimates due to economic improvements and policy adjustments, still indicate significant challenges ahead.

## Key Findings

The trustees' report indicates that the Medicare HI Trust Fund, which finances Medicare Part A (covering inpatient hospital stays, hospice, skilled nursing, and home health care post-hospitalization), will only be able to pay 89% of total scheduled benefits after 2036. This is a slight improvement due to policy changes, such as the adjustment in how medical education expenses are accounted for in Medicare Advantage rates, and lower-than-expected health care spending, particularly in home health care due to staffing shortages.

Conversely, the Supplemental Medical Insurance (SMI) Trust Fund, which finances Medicare Parts B and D, is expected to remain adequately funded indefinitely. This is because the SMI Trust Fund's financing is adjusted annually to cover projected costs. Medicare Part B covers physician services, outpatient hospital services, and some home health services, while Part D offers subsidized drug insurance coverage. However, spending on Parts B and D is projected to grow faster than the general economy over the next five years, driven by the aging population and increased demand for health care services.

Additionally, the HI Trust Fund does not meet the short-range financial adequacy test nor the long-range actuarial balance. The trustees emphasize that the current projections rely on uncertain cost-saving measures and suggest that without significant changes to the health care delivery system, these savings may

*Continued on pg 2*

not be sustainable. The report calls for "timely and effective action" to address the financial challenges, including the imminent depletion of the HI Trust Fund and the rapid growth in overall Medicare spending.

In response to these challenges, the Biden administration has undertaken various measures to strengthen and preserve Medicare. HHS Secretary Xavier Becerra and CMS Administrator Chiquita Brooks-LaSure have highlighted ongoing efforts, including proposed enhancements aimed at extending the program's solvency. Notable among these changes is the overhaul of the Medicare Part D system to allow price negotiations for certain drugs covered under Parts B and D. Additionally, policymakers are considering site-neutral payments to reduce Medicare expenditures by paying lower rates to hospitals for services that can be delivered in outpatient settings.

### What's Next?

Medicare currently covers approximately 66.7 million people, a figure expected to rise to nearly 94 million by 2060. Despite recent efforts and policy changes, the trustees stress the need for ongoing reforms to ensure the long-term financial health of Medicare. The Biden administration remains "committed to protecting Medicare now and for future generations," Brooks-LaSure said, but significant policy interventions will be required to address the impending financial shortfalls and the anticipated increase in health care demands as the population ages.

Read the Medicare and Social Security reports.

# CMS Proposes Bundling Payment Model to Lower Medicare Spending

## The five-year model aims to improve care quality and reduce Medicare spending through episode-based payments for specific surgical procedures, set to launch Jan. 1, 2026

The Centers for Medicare & Medicaid Services (CMS) has proposed the Transforming Episode Accountability Model (TEAM) to test the effectiveness of episode-based payments in lowering Medicare spending and improving care quality.

Scheduled to launch Jan. 1, 2026, and run for five years, TEAM builds upon previous CMS Innovation Center models like Bundled Payments for Care Improvement Advanced and Comprehensive Care for Joint Replacement.


Traditional Medicare beneficiaries undergoing surgical procedures often experience fragmented care, leading to complications, avoidable hospitalizations, and higher costs. TEAM addresses these issues by providing acute care hospitals with a target price covering all costs associated with an episode of care, which includes the inpatient stay or outpatient procedure and post-discharge services. Providers will be accountable for spending and quality performance within this target price.

TEAM covers five surgical procedures: lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedures. Episodes begin with an inpatient stay or hospital outpatient procedure and end 30 days post-discharge. Hospitals will be selected based on geographic regions.

The model includes a one-year glide path for participants to transition into full-risk participation and offers three tracks with varying levels of risk and reward. Track 1 features no downside risk and lower rewards in the first year.

*Continued on pg 3*

# NEWS & NOTES

## DOJ Forms Task Force to Tackle Health Care Monopolies

The Department of Justice has established the Task Force on Health Care Monopolies and Collusion (HCMC) within its Antitrust Division to address competition issues in the health care sector. Led by experienced antitrust prosecutor Katrina Rouse, the HCMC will focus on identifying and combating "monopolistic and collusive" practices that raise health care costs, reduce quality, and create vulnerabilities within the industry. The team, comprising a diverse group of experts from various fields, will investigate issues such as payer-provider consolidation, serial acquisitions, labor conditions, medical billing, health care IT services, and data misuse.

This initiative follows growing concerns over reduced competition due to widespread consolidation in health care, which has led to increased prices and potential declines in care quality. Recent actions by the DoJ, U.S. Department of Health and Human Services, and Federal Trade Commission include launching a public portal for reporting anti-competitive behaviors. A study from the *American Economic Review: Insights* highlighted that weak antitrust enforcement has exacerbated these issues, resulting in higher hospital care prices. The HCMC aims to rectify these problems through rigorous enforcement and policy advocacy.

Read more here.

## Payer Market Consolidation Surpasses Health Systems

New data from the Association of American Medical Colleges (AAMC) reveals that health payers are more consolidated than health systems. The largest health systems hold an average of 43.1% market share in each state based on inpatient hospital discharges, while the top three insurers in the large-group market control 82.2% on average. In states like Massachusetts, the top insurers collectively dominate 88.4% of the market, far surpassing the 47.6% share held by the largest health systems. Similarly, in California, Kaiser Permanente leads both as the top health system and payer. This disparity suggests that insurer consolidation might be driving down payments to providers, potentially reducing service offerings or causing hospital closures.

The AAMC's analysis highlights the significant market power of insurers compared to health systems, raising concerns about the effects on health care pricing and access. While insurer consolidation has been linked to lower provider payments, its impact on patient premiums remains unclear, with some studies indicating that premiums may actually increase. The number of health systems has remained relatively stable over recent years, but the number of large-group market insurers has significantly declined, indicating a growing concentration in the payer market. This trend suggests that policymakers need to address both insurer and provider consolidations to better manage health care costs and accessibility.

Read the AAMC report.

CMS Proposes cont. from page 2

Track 2 offers lower risk and reward for specific hospitals, such as safety-net hospitals, from the second to fifth years. Track 3 involves higher risk and reward throughout the five years.

Under TEAM, participants continue to bill Medicare fee-for-service, but payments will be adjusted based on performance and spending evaluations. Hospitals' performance will be assessed on three quality measures: hospital readmission rates, patient safety, and patient-reported outcomes. Hospitals that spend less than the target price will receive a payment from CMS, adjusted for quality performance. Conversely, those that exceed the target price may owe CMS a repayment.

The model aims to complement longitudinal care management, aligning with accountable care organizations (ACOs) and promoting primary care. Patients in ACOs can still be included in TEAM if they undergo one of the five surgeries at participating hospitals. These hospitals must refer patients to primary care services to support continuity of care and long-term health outcomes.

TEAM supports health equity by offering flexibility for hospitals serving underserved populations, allowing them to engage in value-based care without added financial burdens. The target pricing methodology includes a social risk adjustment to account for the additional costs of caring for underserved individuals. Participating hospitals must submit health equity plans, report sociodemographic data, and screen for health-related social needs to drive continuous improvement.

The model policies are subject to finalization through rulemaking before TEAM's launch in 2026.

Read more here.

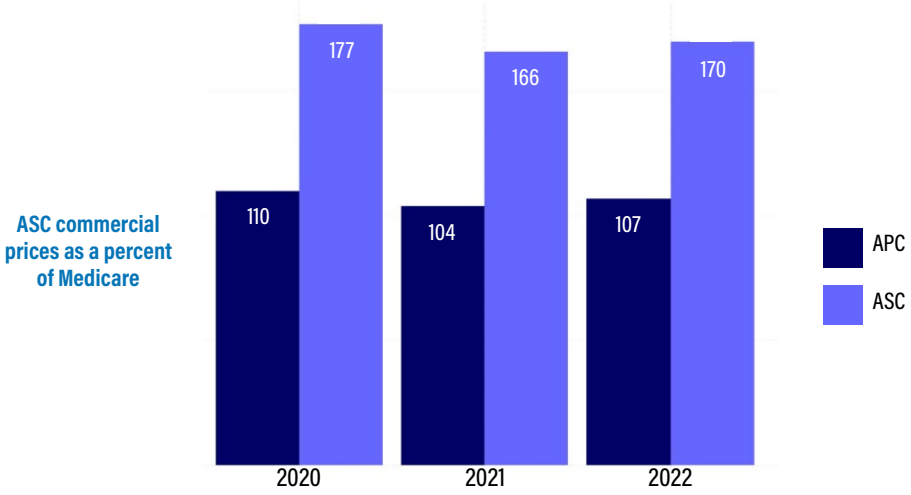
# DATAWATCH

# Study Reveals Private Payers Spend Significantly More on Hospital Services Compared to Medicare

A recent RAND Corporation study, funded by the Robert Wood Johnson Foundation, analyzed claims data from 2020-2022 and found that employers and private payers paid, on average, 254% more than Medicare for the same inpatient and outpatient hospital services in 2022. This study, which included data from over 4,000 hospitals and ambulatory surgery centers across the U.S. (excluding Maryland), highlighted that private payer prices for inpatient hospital services averaged 255% of Medicare prices, while outpatient services averaged 289%, and professional services averaged 188%. Prices for outpatient services at ambulatory surgical centers were lower, averaging 170% of Medicare prices.

The study also revealed significant state-level variations, with some states like California and New York seeing private payer hospital prices exceed 300% of Medicare.

## Trends in Ambulatory Surgical Center Commercial Prices Relative to Medicare, 2020 - 2022

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