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Christopher J. Horton

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CHRISTOPHER J. HORTON

Before the Hourglass Runs Out: A Solution to the Impending Insolvency of Medicare Part A

ABSTRACT¹

Health care dominates public attention and individual concern because it is essential to a society's well-being. Health insurance is ever-evolving. The evolution of health care is largely attributed to political shifts that create and amend health insurance systems. In 1965, under President Lyndon Johnson, the Social Security Act passed with colossal health insurance systems—Medicare and Medicaid.

Originally, Medicare provided health insurance for America's elder population. Medicare looks different now than at its inception. At the beginning, Medicare was composed of only Parts A and B. Now, it houses Parts A, B, C, and D. Parts B, C, and D are funded privately while Part A is funded through payroll taxes and few premium-paying beneficiaries. This expansion is costly—too costly.

The Center for Medicare and Medicaid Services (CMS) issued warnings every year for the past four years. These warnings alert lawmakers and the American people that Medicare Part A's funding is depleting rapidly. It is currently billions of dollars over budget with no end in sight due to ever-increasing expenses. If no change occurs, the government's promise to provide health care to the elder population and others who are qualified is in jeopardy.

¹ The author does not argue that Medicare or government-subsidized health care is the proper or best form of health insurance. However, the author is not under the illusion that Medicare will ever be absent from the American health care system. Therefore, the author presents only possible measures that the government may employ to remain faithful to its promise to the American people that they will have health care in their old age.

Furthermore, this Comment is based on data from fiscal year 2020 provided by CMS and other governmental agencies. Data from fiscal year 2021 includes expenses resulting from the COVID-19 pandemic. The pandemic caused changes to Medicare Part A funding that are atypical. This Comment focuses on issues relating to funding prior to the pandemic. An analysis of the pandemic's effect on Medicare is outside the scope of this Comment and requires an article dedicated to it for full and proper treatment.

The Obama Administration attempted to rectify Part A's spending crisis. One attempt, the hospital value-based purchasing program, allows CMS to reimburse hospitals according to each hospital's performance. CMS uses several measures to calculate how the hospital performs. Performance-based reimbursements shift the focus of delivering health care. Hospitals are incentivized to produce efficient, quality care to attain the highest amount of reimbursement. However, this program is not perfect. Hospitals may still overtreat patients resulting in a heavy burden on Medicare.

This Comment offers a solution—lower health care costs combined with a methodology to increase Medicare's income. This solution is made possible through two means. First, the hospital value-based purchasing program must change to address hospital waste when treating patients. Change may come in the form of an amendment to a statute governing the parameters of how a hospital's performance is judged. The amendment shall require the Secretary of Health and Human Services to establish a parameter that measures hospital waste.

The second solution involves enacting a statute imposing a mandatory premium on all Part A beneficiaries. A mandatory premium provides consistent income for Medicare even when the person is fully retired. Premiums are used in Parts B and D, and garner successful results as both programs have adequate funding. Further, semi-retirees continue to bear the burden of Medicare by having Medicare payments withdrawn from their paychecks. However, fully-retired beneficiaries do not pay the tax. Therefore, a mandatory premium ensures consistent income for Part A and does not disincentivize the semi-retired population.

Medicare is an expensive program with funds quickly depleting. People expect Medicare upon reaching the age of sixty-five. However, the promise of health care in one's old age is in jeopardy absent Medicare Part A's necessary evolution.

AUTHOR

Symposium Editor, LIBERTY UNIVERSITY LAW REVIEW, Volume 16; J.D. Candidate, Liberty University School of Law (2022); Government Politics and Policy, B.S. with a minor in Western Legal Traditions, *summa cum laude*, Liberty University (2019). This Comment would not be possible without the endless support of my parents, my brother's guidance and example of perseverance, and the encouragement of my soon-to-be wife, Janna. Thank you to every law professor at Liberty University who taught me how to think like a lawyer. To God be the glory.

COMMENT

BEFORE THE HOURGLASS RUNS OUT:
A SOLUTION TO THE IMPENDING INSOLVENCY OF MEDICARE
PART A*Christopher J. Horton*[†]

I. INTRODUCTION

Sickness, disease, injury, and the gradual decline of the human body is inevitable. People seek security in their health in the form of preventive medicine, regular check-ups, and insurance to ensure that they can receive the necessary care. Throughout a lifetime, a person will spend thousands of dollars every year in premiums, deductibles, and coinsurance payments to obtain health care insurance. When the individual is working and has a regular income, such expenses are manageable. However, members of the elderly population usually cannot work the same number of hours or the types of jobs they once could, yet they have an increased need of care that requires insurance. For this reason, the Johnson Administration created Medicare.²

In 1965, Medicare started as a program that provided health care to the elderly population in a limited form.³ Eligibility for Medicare was narrow.⁴ However, Medicare drastically transformed over time. The eligibility requirements drastically widened—granting coverage to those with disabilities and specific conditions.⁵ Following Medicare's enactment, it

[†] Symposium Editor, *LIBERTY UNIVERSITY LAW REVIEW*, Volume 16; J.D. Candidate, Liberty University School of Law (2022); Government Politics and Policy, B.S. with a minor in Western Legal Traditions, *summa cum laude*, Liberty University (2019). This Comment would not be possible without the endless support of my parents, my brother's guidance and example of perseverance, and the encouragement of my soon-to-be wife, Janna. Thank you to every law professor at Liberty University who taught me how to think like a lawyer. To God be the glory.

² Lyndon B. Johnson, President of the U.S., Remarks with President Truman at the Signing in Independence of the Medicare Bill (July 30, 1965), in *U.C. SANTA BARBARA: THE AMERICAN PRESIDENCY PROJECT*, <https://www.presidency.ucsb.edu/documents/remarks-with-president-truman-the-signing-independence-the-medicare-bill> (last visited Sept. 8, 2021).

³ Ctrs. for Medicare & Medicaid Servs., *History*, CMS.GOV, <https://www.cms.gov/About-CMS/Agency-Information/History> (Jan. 13, 2020, 2:44 PM).

⁴ *Id.*

⁵ *Id.*

transformed through several major additions. For example, the program added two major parts allowing more services, drugs, and plans to be insured for beneficiaries. The Obama Administration further altered Medicare by introducing incentive-based care instead of solely quality-based care.⁶ Modern-day Medicare is different from the one founded in 1965.

Public policy is at the forefront of Medicare as the struggle ensues over the provision of health care at an unsustainable price. People need health care; however, the government cannot possibly afford the expense that the American health care system demands to service millions of beneficiaries. The tension becomes whether to expand Medicare coverage for only a few or maintain a high number of insureds with minimized coverage.

While this issue seems nonexistent, or at least far in the future, the inevitable truth faces lawmakers: Medicare in its present state is unsustainable.⁷ The colossal program currently operates over budget by billions of dollars.⁸ Medicare Part A's insolvency is inevitable unless lawmakers and the Centers for Medicare and Medicaid Services (CMS)—the federal agency charged with operating Medicare and Medicaid—step in to enact change.

This Comment argues that Medicare Part A is sustainable if health care costs decrease, and the program's income increases. It further proposes two means of carrying out this generalized fix. First, Medicare should cover fewer expenses charged by hospitals. The program will no longer cover wasteful treatment, such as over-treatment of the patient. Second, all beneficiaries should be subject to a mandatory premium regardless of whether the beneficiary qualifies by meeting one of the eligibility requirements or purchases the coverage. The mandatory premium statute will result in consistent income for the Medicare program. Through these adjustments, Part A may continue to provide health care for generations to come.

II. BACKGROUND

“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they so carefully put away over a lifetime”⁹ These words, spoken by President Johnson in 1965, reflect the purpose of Medicare and Medicaid as part of the

⁶ *See id.*

⁷ *See* H.R. Doc. No. 116–122, at 8 (2020).

⁸ *Id.* at 6.

⁹ Johnson, *supra* note 2.

Social Security Act.¹⁰ Medicare and Medicaid have transformed health care by subsidizing costs for millions of elderly and less-fortunate Americans. Specifically, Medicare is a program guaranteeing that retirees are no longer burdened with high medical expenses as they age. From its inception to its modern-day form, Medicare Part A provides far more expansive coverage than before and reimburses medical service providers at higher prices.

A. *Medicare's Debut*

Little doubt exists that today's Medicare program achieves the Johnson Administration's goal for Medicare. Presently, Medicare assumes the burden of more coverage than when it was founded in 1965. This expansion allows for more health care services for more Americans; however, with more coverage comes higher costs. A brief examination of Medicare's original construction assists in understanding that the program provides expansive coverage with insufficient funds to match the demand.

1. Opening the Door for Government Subsidized Health Care

"Free health care for all" is not a recent development in the 21st century.¹¹ Government-subsidized health care had its origin in the early 1900s.¹² Throughout the first half of the 1900s, lawmakers proposed schemes of government-provided health care but ultimately dismissed the legislation.¹³ In the latter half of the century, liberal politicians replaced their conservative counterparts, thereby permitting substantive reform in health care through a Democrat majority.¹⁴

Several factors contributed to Medicare's enactment. First, playing on the American mindset of refusing handouts, Medicare drafters introduced a system whereby a person pays a small portion of each paycheck towards anticipated health care costs upon reaching sixty-five.¹⁵ This effort sought to resolve the tension created through the characterization of Medicare as an abandonment of capitalist principles by the government providing "free" health care.¹⁶ Second, some of the Democrats in Congress saw the need to ensure that coverage included not only hospital care but also physician care,

¹⁰ *Id.*; see PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY 305 (John E. Steiner, Jr. ed., 10th ed. 2014).

¹¹ THE OXFORD HANDBOOK OF U.S. HEALTH LAW 743 (I. Glenn Cohen et al. eds., 2017).

¹² *Id.*

¹³ *Id.*

¹⁴ See *id.* at 745.

¹⁵ *Id.* at 744.

¹⁶ See *id.* at 745.

thereby giving Americans a choice in their providers.¹⁷ Lastly, Medicare's coverage was cabined purposely for the realities of legislative enactment. Coverage excluded "the chronically sick elderly—medical conditions that would not dramatically improve."¹⁸

In 1965, these factors conglomerated to create the Medicare and Medicaid amendments to the Social Security Act.¹⁹ At that time, Medicare had two components, Parts A and B.²⁰ The congressional intent behind enacting Medicare is evidenced in Part A, as the Program provided coverage solely for hospital care.²¹ Financially, each person's paycheck funds Part A.²² In each paycheck, a certain dollar amount is withdrawn in anticipation of the person drawing on Medicare upon reaching the qualifying age.²³

Part B provides different benefits with an alternative means of funding. However, Part B reflected the intentions of the more hesitant and conservative Democrat wing of Congress because it provides coverage for physician care.²⁴ Part B contrasts with Part A in how it is funded—Part B receives funding directly from the individual beneficiary.²⁵ Taxes do not directly subsidize the program; rather, a person's premiums generate the necessary capital.²⁶ To impose and enforce these regulations, Congress established CMS as the governing agency.²⁷ While Medicare originally restricted coverage, the proceeding years demonstrated what Medicare truly represented—government-subsidized health care for consistently growing portions of the population.

B. *Medicare's Expansion*

Since 1965, Medicare has evolved into a program interacting with and

¹⁷ See THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 11, at 745.

¹⁸ *Id.* at 746. Additionally, Democrat Senator Wilbur Mills proved to be more conservative than his fellow Democrat colleagues by creating Medicaid and tacking it to Medicare. *Id.* His intent was to prevent Medicare from providing further coverage. *Id.* Senator Mills was cognizant of his colleagues' desire not to cabin Medicare but expand coverage to anyone. *Id.*

¹⁹ See generally *id.* at 746–47.

²⁰ THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 11, at 747.

²¹ See *id.* at 746–47.

²² *Id.*

²³ See PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 306.

²⁴ See THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 11, at 747.

²⁵ See *id.*

²⁶ *Id.*

²⁷ JAMES F. BARGER, JR. ET AL., HEALTH CARE FRAUD: ENFORCEMENT AND COMPLIANCE § 10.02 (Law Journal Press 1996).

servicing more than the 65-year-old retiree. Like many other public programs, it soon became apparent that change was needed to remedy issues related to cost efficiency, payment and services, and social issues, like racism, within the program. Congress and the executive branch recognized the needs of Medicare and enacted amendments to reflect these changes. Additionally, through the implementation of Parts C and D, Americans have more options to pay health care expenses at a lower price.

1. Changes Addressing Cost and Racism

Transformative changes mark Medicare's evolution from its inception through the 21st century. Following Medicare's first operational year, enrollment was at 19 million enrollees.²⁸ Such a high and immediate demand for services placed a burden on the program, which necessitated cost-efficient measures.²⁹ Congress recognized this issue shortly after the first year; however, resolutions to address the high cost of care were unsuccessful throughout the 1960s and '70s.³⁰

Change did not come until 1983 when the Reagan Administration introduced a new payment system, the Prospective Payment System (PPS).³¹ This new system fundamentally transformed how Medicare payments were issued. Before PPS, Medicare reimbursements were issued retroactively.³² Thus, payment was issued after the patient received care.³³ PPS shifted the focus of payment from retrospective to prospective by using a standardized list of treatments with corresponding prices found in the diagnosis-related groups (DRGs).³⁴ This system also applied to physician reimbursement but under a different title, the resource-based relative-value scale (RBRVS).³⁵ The payment plans incentivized hospitals to reduce excessive spending to ensure reimbursement under this new value-based system.³⁶ However, this incentivized format of pricing gave CMS power to regulate pricing by

²⁸ THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 11, at 747.

²⁹ *Id.* at 748.

³⁰ *See id.* at 751.

³¹ *Id.* at 753.

³² *See* PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 306.

³³ *See id.*

³⁴ *Id.* PPS is foundational to understanding the payment reimbursement systems within Medicare Part A. It is only introduced here, but this Comment later provides a substantive analysis for this payment system. *See* discussion *infra* IV.A.1.

³⁵ THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 11, at 753.

³⁶ *See id.*

adjusting the DRGs and other formulas.³⁷ Undoubtedly, Medicare underwent a powerful expansion under this substantive change because CMS, not the medical service provider, held the power to regulate the cost of health care.³⁸

The cost of services was not the only issue plaguing Medicare. At the time of its enactment, the United States was undergoing a vital shift away from its despicable past of racism by pursuing equality of persons in all respects. Medicare faced the issue of providing federal funding for segregated hospitals, which it addressed swiftly and effectively by withholding funds for failure “to comply with Title VI of the 1964 Civil Rights Act.”³⁹ This measure proved to be highly successful.⁴⁰ In fact, over 1,000 hospitals quickly integrated without any major conflict—health care triumphed over evil presuppositions.⁴¹

2. Implementation of Parts C and D

By the end of the 20th century, the federal government resolved many of the pitfalls that plagued Medicare since its inception, yet the government continued to find new ways to increase health care coverage without taking on further financial burdens. These new ways included creating additional sub-programs to Medicare in addition to Parts A and B—Parts C and D.⁴² Congress enacted Parts C and D upon recognizing the burden that Medicare placed on the federal budget.⁴³ Therefore, the lawmakers sought to provide additional means of care without increasing the cost.

In 1997, Congress passed the Balanced Budget Amendments (BBA), adding Part C.⁴⁴ BBA expands coverage of particular services and amends certain regulatory systems.⁴⁵ Specifically, BBA increased coverage by reimbursing “inpatient, rehabilitation, skilled nursing facilities, and home health services” and implemented provisions “reducing fraud and abuse.”⁴⁶

³⁷ *Id.*

³⁸ *Id.*

³⁹ *See id.* at 749.

⁴⁰ *Id.*

⁴¹ THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 11, at 749.

⁴² Part C is codified in 42 U.S.C. § 1395w-21. Part D is codified in 42 U.S.C. § 1395w-101.

⁴³ THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 11, at 756; Elizabeth A. Weeks, *Cooperative Federalism and Healthcare Reform: The Medicare Part D “Clawback” Example*, 1 ST. LOUIS U. J. HEALTH L. & POL’Y 79, 81–82 (2007).

⁴⁴ THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 11, at 756 (Medicare Part C is frequently referred as Medicare + Choice).

⁴⁵ *See id.*

⁴⁶ *Id.*

Most notably, Part C promotes private insurance plans by allowing enrollees to receive greater benefits without government subsidization.⁴⁷

Congress later enacted Part D to Medicare which helped resolve the rising cost of pharmaceuticals. Part D implements Part D Plans (PDPs) that allow for the cost of outpatient prescription drugs to not fall solely on the shoulders of the beneficiary.⁴⁸ Issued drug payments are determined by formularies or categories of drugs created by CMS.⁴⁹ Parts C and D further show that Medicare has exponentially expanded since its inception—from narrow coverage for retirees undergoing shorter hospitalization to now subsidizing outpatient drugs.

C. Modern Medicare

Today's Medicare system, with all of its expansions, has undergone recent revamping under the Obama Administration's Patient Protection and Affordable Care Act (ACA).⁵⁰ This legislation transformed delivery and payment for health care. The ACA focuses on delivery and payment to ensure that Medicare's expenditures are cabined, allowing the program to remain solvent and provide care for future generations of Americans.⁵¹

1. The ACA's Revamp of Medicare

In 2008, the pendulum of American political thought swung from conservative to liberal ideology upon the election of President Obama. His administration transformed health care regarding quality of care and promotion of incentivized care in 2010 with the ACA.⁵² The ACA is an expansive piece of legislation affecting many different facets of the healthcare industry—the patient, hospital, physician, and insurance providers. The ACA also introduced new methods to lower health care costs.

The ACA implements measures to promote reducing expenditures while providing quality care. One measure is the Medicare Shared Savings Program, which created accountable care organizations (ACOs) that include groups of hospitals lowering the “aggregate annual cost” of Medicare patients.⁵³ If the ACO is successful and meets all prerequisites, the hospitals

⁴⁷ *Id.* at 756–57.

⁴⁸ PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 306.

⁴⁹ *Id.* (footnote omitted).

⁵⁰ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat 119.

⁵¹ THE OXFORD HANDBOOK OF U.S. HEALTH LAW, *supra* note 11, at 760.

⁵² Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat 119.

⁵³ Jessica Mantel, *Spending Medicare's Dollars Wisely: Taking Aim at Hospitals' Cultures of Overtreatment*, 49 U. MICH. J.L. REFORM 121, 155 (2015).

“receive a percentage of the savings.”⁵⁴ If the ACO fails to be efficient and reduce costs, then it is penalized by decreased reimbursements.⁵⁵

Another measure is the Bundled Payments for Care Improvement Initiative,⁵⁶ which provides a new standardized form of payment.⁵⁷ The standard requires CMS to reimburse the hospitals in bundled payments for four pre-determined “episodes of care.”⁵⁸ Each episode contains a particular service.⁵⁹ If the health care provider treats the patient at a cost below the episode of care, the health care provider profits because the reimbursements are standardized.⁶⁰ Standardization of prices encourages hospitals to cut costs and emphasize efficiency when rendering care for the purpose of attaining the highest reimbursement.

2. Value-Based Payer System

The ACA also created the value-based payer system.⁶¹ This new system is intended to incentivize hospitals to lower health care costs by rewarding a top-performing hospital with higher reimbursements for delivery of care.⁶² At first, the system was meant to ensure that the quality of care was constantly improving.⁶³ However, CMS quickly realized that Medicare’s expenses needed some regulation because costs were rising too quickly.⁶⁴

As a component of this program, CMS instituted the Medicare Spending per Beneficiary (MSPB) measure.⁶⁵ Under MSPB, the services provided by health care providers are measured against other providers to determine whether the health care provider is giving treatment that is necessary and relevant to the patient without overcharging Medicare through excessive treatments with little efficacy.⁶⁶ If a hospital is not efficient, it is penalized.⁶⁷ Therefore, while the ACA endured aggressive political debate, it provides many measures to decrease health care costs. Yet, these measures have many

⁵⁴ *Id.*

⁵⁵ *Id.* at 156.

⁵⁶ *Id.* at 154.

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ Mantel, *supra* note 53, at 154.

⁶⁰ *Id.*

⁶¹ *Id.* at 150.

⁶² *Id.*

⁶³ *Id.* at 151.

⁶⁴ *See id.* at 152.

⁶⁵ Mantel, *supra* note 53, at 152.

⁶⁶ *Id.*

⁶⁷ *Id.* at 153.

deficiencies that are further discussed in this Comment.

3. Premiums

Premiums make for a difficult conversation because they force patients to make monthly payments to receive health care coverage. In the private health insurance world, an insured person must pay premiums. The good news for most beneficiaries of Part A is that they do not have to pay a premium.⁶⁸

Part A coverage provides beneficiaries with a specific amount of coverage for which they do not have to pay any premiums.⁶⁹ However, premiums for Part A do exist. Premium-free Part A requires the beneficiary to have “at least [forty] quarters of Medicare-covered employment.”⁷⁰ If the person does not have history of paying into Medicare during forty quarters of employment, then the person can still enroll in the program but must pay a monthly premium.⁷¹ Through this premium, Medicare receives a continual flow of income. The question becomes—is it enough?

4. Deductibles

While Part A may be premium free, it is not deductible free. Deductibles change on a yearly basis and are up to the discretion of the Secretary of the Department of Health and Human Services (HHS).⁷² They are charged on a per-benefit period basis.⁷³ “A benefit period begins the day [the patient is] admitted as an inpatient in a hospital or S[killed] N[nursing] F[acility].”⁷⁴ The benefit period is not limited by year; therefore, one can have many benefit periods in a year.⁷⁵ This deductible covers sixty days from the day of admission into the hospital.⁷⁶ The deductible for 2020 was \$1,408.⁷⁷

If the patient’s condition necessitates a hospital or skilled nursing stay that

⁶⁸ Ctrs. for Medicare & Medicaid Servs., *2020 Medicare Parts A & B Premiums and Deductibles*, CMS.GOV (Nov. 8, 2019), <https://www.cms.gov/newsroom/fact-sheets/2020-medicare-parts-b-premiums-and-deductibles> [hereinafter Ctrs. For Medicare & Medicaid Servs., *2020 Medicare*].

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.* The premium changes depending on quarters worked, disabilities, and other circumstances. *Id.*

⁷² 42 U.S.C. § 1395e(b)(2).

⁷³ THOMSON REUTERS, SOCIAL SECURITY LAW & PRACTICE § 60:84 (2021), Westlaw SSLP.

⁷⁴ Ctrs. for Medicare & Medicaid Servs., *Medicare, Glossary - B*, <https://www.medicare.gov/glossary/b> (last visited Sept. 5, 2021).

⁷⁵ THOMSON REUTERS, *supra* note 73, at § 60:84.

⁷⁶ Ctrs. for Medicare & Medicaid Servs., *2020 Medicare, supra* note 68.

⁷⁷ *Id.*

exceeds the sixty-day time frame, the patient must pay coinsurance.⁷⁸ For 2020, the coinsurance payment was \$352 per day.⁷⁹ If the patient's stay exceeds ninety days, the patient must pay coinsurance for "lifetime reserve days" which, for 2020, was \$704 per day.⁸⁰

Deductibles are standard in most insurance contexts. If CMS increased the amount of the deductible, Medicare may cover less. However, will an increase in deductibles sufficiently save money without frustrating the purpose of the program—secure health care insurance for the retired and semi-retired elderly community?

III. MEDICARE PART A'S IMPENDING INSOLVENCY

Burdens traditionally run tandem with benefits. Medicare's expansive benefits place significant burdens on the shoulders of the federal government and hospitals. The weight of the burden will render the government unable to provide substantial reimbursement, if any, to hospitals. If the government fails to adequately reimburse hospitals, they will eventually curtail services and benefits offered to Medicare patients. Hospitals will then resort to recovering the balance of Medicare's deficient reimbursement from non-Medicare patients.

A. *Medicare's Significant Burden*

Following many reforms, Medicare, after all the amendments, includes four categories of beneficiaries. To qualify for Medicare, potential beneficiaries must meet one of the following requirements:

- (1) individuals aged sixty-five or older;
- (2) individuals who are entitled to disability benefits for twenty-four months or longer (but do not meet the age requirement);
- (3) individuals with end-stage renal disease ("ESRD") who require dialysis or kidney transplant; and
- (4) certain individuals who may purchase benefits under the Medicare Program.⁸¹

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ HEALTH CARE FRAUD: ENFORCEMENT AND COMPLIANCE § 10.2 [2]; 42 U.S.C. § 1395c. In 2010, the ACA added one more category of qualification. Medicare now covers an individual who has developed health complications after living in an area considered an "environmental health hazard" that was subject to an emergency declaration pursuant to the Comprehensive Environmental Response, Compensation, and Liability Act of 1980. HEALTH CARE FRAUD: ENFORCEMENT AND COMPLIANCE § 10.2, [2] n.2.

These four categories undoubtedly expand Medicare's coverage, requiring more federal funds to subsidize people's health care.

According to the Medicare Trustees Report, CMS's annual report, 61.2 million people received Medicare benefits in 2019.⁸² In the first category, 52.6 million people qualified pursuant to the age requirement.⁸³ The second category included 8.7 million disabled Americans.⁸⁴ These statistics reflect Medicare Part A and B's beneficiaries; however, some beneficiaries were also enrolled in private plans under Part C.⁸⁵ In providing coverage to all beneficiaries, the cost of Medicare amounted to \$796.2 billion, exceeding its income of \$794.8 billion.⁸⁶ Furthermore, Medicare's assets, in the form of U.S. securities, decreased by over a billion dollars.⁸⁷ As this financial data indicates, Medicare Part A is a program providing expansive coverage with insufficient funds to match the demand.

B. *The Issue Funnels Down to a Lack of Incentives on Both Sides of Health Care Transactions*

While more categories of coverage expand Medicare, the issue predominantly centers around the amount and quality of care hospitals render to each patient. Recent reforms demonstrate a trend to implement limitations on coverage to eliminate extraneous treatments requested by the patient or conducted by the hospital.⁸⁸ However, the problem persists. The American health care system ranks as one of the most expensive health care systems, yet the "health care outcomes are among the lowest in the world" regardless of a highly educated workforce and advanced technology.⁸⁹

Recent improvements, like the ACA, create an incentive for hospitals to increase efficiency, maintain quality, and lower costs—for example, the ACA's Hospital Value-Based Payer System.⁹⁰ However, the value-based payer system is insufficient, at least in its current form, to pull Medicare out of the red by itself. Medicare needs an influx of money along with incentivized reimbursements to be sustainable beyond the next decade.

⁸² H.R. DOC. NO. 116–22, at 6 (2020).

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.* CMS notes that 37% of the beneficiaries in 2019 were Part C beneficiaries. *Id.*

⁸⁶ *Id.*

⁸⁷ H.R. DOC. NO. 116–22, at 6.

⁸⁸ See 42 U.S.C. § 1395ww(o).

⁸⁹ Marilyn L. Uzdevines, *The Great American Health Care System and the Dire Need For Change: Stark Law Reform as a Path to a Vital Future of Value-Based Care*, 7 TEX. A&ML REV. 573, 574 (2020).

⁹⁰ See *id.* at 575.

Income for Medicare was meant to come from payroll taxes.⁹¹ Reforms have provided supplementary methods to generate income, such as premiums for otherwise non-qualifying Part A beneficiaries.⁹² The current state of deductibles injures Medicare. The current deductible is not difficult to meet through medical expenses. If the deductible is low, the patient does not have an incentive to limit services. Once the deductible is met, the patient is hardly hindered from requesting additional tests and quasi-diagnosis-related procedures that are largely unnecessary.

C. *Prospective Problems*

CMS is not ignorant of the fact that Medicare operates at a deficit, and, as a result, it incessantly begs Congress and the American people to recognize the rapid depletion of Medicare Part A's funds. According to CMS, "[t]he estimated depletion date for the H[ospital] I[nsurance] trust fund is 2026,⁹³ which was also stated in *the previous year's report*."⁹⁴ The news gets worse: "As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI income is projected to be lower than last year's estimates due to low payroll taxes."⁹⁵ These brief excerpts reveal CMS's urgency. While trying to consistently provide health care to over 60 million people, Part A is establishing a history of operating on deficient funding.⁹⁶

Furthermore, CMS issued a "Medicare funding warning" in 2019.⁹⁷ This warning urges two important steps to resolve Part A's deficient funds. First, the President must provide a legislative solution to Congress.⁹⁸ Second, Congress must expediently examine the legislation and make a determination on its passage.⁹⁹ In 2019, CMS issued a similar warning of this type for the *third consecutive year*.¹⁰⁰ The problem is not hidden—Medicare

⁹¹ PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 306.

⁹² WOLTERS KLUWER, 2020 MASTER MEDICARE GUIDE, 40 (2020).

⁹³ The HI trust fund is Medicare Part A's trust fund. "HI" refers to "Hospital Insurance Trust Fund." H.R. DOC. NO. 116-122, at 1 (2020). Part B has a separate account, the Supplementary Medical Insurance Trust Fund, or "SMI." *Id.*

⁹⁴ *Id.* at 6 (emphasis added).

⁹⁵ *Id.*

⁹⁶ *Id.* at 6.

⁹⁷ *Id.* at 7.

⁹⁸ H.R. DOC. NO. 116-122, at 7.

⁹⁹ *Id.*

¹⁰⁰ *Id.* (emphasis added).

Part A is projected to be insolvent in less than a decade.¹⁰¹ Who will tell the recently retired construction worker fully expecting Social Security and Medicare benefits that the person's reasonable reliance on the country's promise of health care will not be honored?

IV. SOLUTIONS

CMS's desperate call for more funding follows attempts to resolve high expenditures in Medicare using the ACA and the regulatory power of CMS. The cost of Medicare skyrocketed as beneficiaries and hospitals had little reason to cabin costs when the government subsidized care. Medical professionals focused primarily on quality of care with little concern of overtreatment.¹⁰² Recent reforms of the ACA's value-based payer system incentivized hospitals to eliminate extraneous expenses by restricting reimbursement to the hospital's performance.¹⁰³ As a result, hospital executives shifted focus to secure higher reimbursement by emphasizing efficient patient care.

However, these reforms have proven less effective than anticipated, allowing the issue of overtreatment to persist. The value-based payer system emphasizes efficiency when carrying out the treatment but does not address the degree of necessity for the treatment itself.¹⁰⁴ The surrounding procedures undoubtedly require efficiency to cut unnecessary expenses, but the greatest financial burden is the actual treatment. This Comment argues that Part A statutes should be amended to allow the value-based payer system to impose a mandatory determination of whether the procedure and surrounding expenses are wasteful within the value-based incentive calculation.

Hospitals dominate the health care conversation; however, there is another key party to this discussion: the patient. Each person expects, and rightfully so, that he or she will receive proper care. Unfortunately, "proper care" cannot serve as a standardized quantum of care or rule of law governing the relevancy and necessity of care because of its subjective nature. For example, one individual could expect the hospital to exhaust every measure to remedy the ailment, while another may only expect the hospital to take reasonable steps when providing treatments. Due to the subjective nature of what constitutes proper care, hospitals must have some protection from patients' requests to exhaust all treatment methods. Hospitals can avoid overtreatment by informing the patient that Part A does not cover the

¹⁰¹ *See id.*

¹⁰² Mantel, *supra* note 53, at 151.

¹⁰³ *Id.* at 152.

¹⁰⁴ *Id.* at 151.

extraneous treatment, and that if the patient insists on receiving the additional care, the patient must provide an alternative form of payment.

Part A generally follows the same format as the traditional health care model. However, Part A's demand for premiums contrasts with the traditional insurance model. It does not require most beneficiaries to pay premiums; rather, only 1% of beneficiaries pay a premium.¹⁰⁵ With so few beneficiaries paying premiums, Part A leaves a source of consistent income untapped. This Comment argues for a statute that mandates universal premium payments by all beneficiaries. The premium can be as low as the cost of a cup of coffee. The goal of the mandated premium is to provide a consistent stream of income to a program operating at a deficit.

A. *Lower Waste by Over-Treatment of Patients to Reduce Health Care Costs*

Since Part A's inception in 1965, the legislative and executive branches have wrestled with the issue of how to address the program's heavy financial burden. One of the most fundamental ways to tackle this issue is by modifying the payment systems. New reimbursement systems have saved money for the federal government by pushing hospitals to increase efficiency in patient care, but further reform in these reimbursement systems will better sustain Part A in the long-term.

1. Medicare's Payment Systems

In 1983, Congress replaced Part A's retrospective payment method with standardized reimbursements for inpatient hospital care under the PPS regime.¹⁰⁶ PPS was the first push to narrow the extraneous expenses burdening Part A. Prior to PPS, CMS reimbursed hospitals under a reasonableness standard,¹⁰⁷ which required reimbursements to amount to "reasonable costs of services rendered."¹⁰⁸ This reasonable standard required CMS and payment distributors to issue payments retroactively, meaning that care was given, and the federal government reimbursed the hospital after the hospital rendered services.¹⁰⁹ The subsequent payment method did not

¹⁰⁵ *Part A Costs*, MEDICARE.GOV, <https://www.medicare.gov/your-medicare-costs/part-a-costs> (last visited Apr. 9, 2021); see Ctrs. for Medicare & Medicaid Servs., *2020 Medicare*, *supra* note 68.

¹⁰⁶ PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 306–07.

¹⁰⁷ WOLTERS KLUWER, *supra* note 92, at 803.

¹⁰⁸ *Id.*

¹⁰⁹ PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 306.

permit the government to mitigate costs. Ultimately, the government was paying the actual cost of each treatment.¹¹⁰

PPS's implementation transformed the reasonableness standard to predetermined payment amounts designated by treatments categorized into classes under DRGs.¹¹¹ Classifications are constructed "on their discharge diagnosis, complications, comorbidities, and whether certain procedures are performed."¹¹² The patient's care is classified "based on information [contained in the beneficiary's bill], including principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status [of the beneficiary]."¹¹³

The PPS system standardized reimbursement amounts.¹¹⁴ Standardization led to incentive-based care.¹¹⁵ DRGs set the payment for the treatment with specific parameters of coverage.¹¹⁶ If costs go beyond those parameters, the federal government does not provide reimbursement.¹¹⁷ For example, if a hospital fails to discharge a patient according to the timeframe specified in the DRG, the hospital is not reimbursed for the extra care resulting in a loss for the hospital.¹¹⁸

DRGs are at the center of the PPS. DRGs are flexible and subject to constant change to meet the needs of health care as medicine and diseases evolve. Following PPS's inception, DRGs' organization transformed into the Medical Severity-DRG (MS-DRG).¹¹⁹ This organization regime remains in use today.¹²⁰ New regulations are instituted every year¹²¹ to ensure that "cases are [properly] classified so each DRG is—(1) [c]linically coherent and (2) [e]mbraces an acceptable range of resource consumption."¹²² While flexible

¹¹⁰ WOLTERS KLUWER, *supra* note 92, at 803.

¹¹¹ *Id.* at 819.

¹¹² PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 307 (citing 69 Fed. Reg. 48,916 (Aug. 11, 2004) (codified at 42 C.F.R. §§ 403, 412, 413, 418, 460, 480, 482, 483, 485, and 489)).

¹¹³ WOLTERS KLUWER, *supra* note 92, at 819.

¹¹⁴ PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 308.

¹¹⁵ *See id.* at 308.

¹¹⁶ *See id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 307.

¹²⁰ PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 307.

¹²¹ WOLTERS KLUWER, *supra* note 92, at 821.

¹²² 42 C.F.R. § 412.10 (2021).

but standardized payments eliminate the federal government's obligation to pay the actual cost of the treatment, they do not stifle the hospital's admittance of patients with dubious claims of need for care.¹²³ Thus, the problem of overtreatment persisted under PPS with little deterrence.¹²⁴

2. Cost-Incentivized Health Care

Following PPS's implementation, Congress and CMS enacted other programs within Part A to curtail extraneous spending.¹²⁵ One of the most impactful measures is the value-based payer system in the ACA, which incentivizes hospitals to deliver quality and efficient care.¹²⁶ The value-based payer system, or value-based purchasing program, is paired with the DRGs to either increase or decrease reimbursement to the hospital.¹²⁷ Whether the hospital increases or decreases its reimbursement amount is determined by the hospital's performance under particular standards for the specified timeframe.¹²⁸

The Hospital Value-Based Payer System¹²⁹ (VBP) focuses on incentivizing health care to ensure a high degree of quality in services.¹³⁰ Quality of care is measured by a hospital's performance score, which determines the degree of reimbursement.¹³¹ Thus, hospitals participating in the program are incentivized to deliver quality care to achieve the best possible performance score. This results in the hospital obtaining the fullest reimbursement possible, which is referred to as the value-based incentive payment amount.¹³²

The Hospital VBP incentive payment program involves a complex

¹²³ Mantel, *supra* note 53, at 149.

¹²⁴ *Id.*

¹²⁵ See PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 308. The PPS applies to institutional providers aside from hospitals, skilled nursing facilities, and hospital outpatient services. *Id.* PPS, relative to hospitals, requires reimbursement determined by DRGs; however, skilled nursing facilities and outpatient services follow separate classification systems. *Id.* Skilled nursing facilities follow the resource utilization group, and outpatient hospital services reimbursements are governed by the ambulatory payment classification system. *Id.*

¹²⁶ Mantel, *supra* note 53, at 151–52.

¹²⁷ WOLTERS KLUWER, *supra* note 92, at 826.

¹²⁸ *Id.*

¹²⁹ Mantel, *supra* note 53, at 150. The Hospital Value-Based Payer System is a separate payment system from the value-based payer system set up for physicians. *Compare* 42 U.S.C. § 1395ww, with 42 U.S.C. § 1395w-4. The value-based payer system discussed in this Comment is tailored solely to hospitals.

¹³⁰ Mantel, *supra* note 53, at 151.

¹³¹ WOLTERS KLUWER, *supra* note 92, at 846.

¹³² See *id.* at 847; Mantel, *supra* note 53, at 151.

formula to calculate a participating hospital's reimbursement based on the hospital's performance in accordance with particular measures given by the Secretary of HHS.¹³³ The value-based payment amount calculation consists of the reductions to the base operating DRGs multiplied by the value-based incentive payment percentage.¹³⁴ The base operating DRG is a rate determined by the location that the hospital serves.¹³⁵ DRGs account for the varying costs of treatment depending on the location of the hospital.¹³⁶ Because DRGs are geographically conscious, base payments are premised on either "a labor-related or nonlabor share."¹³⁷ If the hospital is located in Alaska or Hawaii, then the DRG is affected by the nonlabor share, which is the cost of living.¹³⁸ Otherwise, hospitals located in the continental U.S. are subject to DRGs based on labor-related shares which are determined by a wage index.¹³⁹ The hospital's location determines the wage-index.¹⁴⁰ Add-on payments to compensate the hospital for various conditions are largely not included in the base operating DRG.¹⁴¹

The other component of the calculation is the value-based incentive payment percentage. The value-based incentive payment percentage is the product of the following: CMS's "applicable percent, the hospital's . . . [p]erformance [s]core divided by 100, and the exchange function slope."¹⁴² CMS's applicable percent is 2.0% for all years after 2016, unless decided otherwise.¹⁴³

Under Part A, CMS calculates the performance score of a hospital through an extensive procedure.¹⁴⁴ The process begins when the Secretary of HHS provides measures.¹⁴⁵ These measures are means of gauging the "quality of

¹³³ WOLTERS KLUWER, *supra* note 92, at 846; see 42 C.F.R. § 412.162(a) (2021).

¹³⁴ WOLTERS KLUWER, *supra* note 92, at 847; 42 C.F.R. § 412.162(b)(2) (2021).

¹³⁵ Ctrs. for Medicare & Medicaid Servs., *Acute Inpatient PPS*, CMS.GOV, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS> (Feb. 2, 2020, 2:43 PM).

¹³⁶ *See id.*

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ 42 C.F.R. § 412.160 (2020).

¹⁴² WOLTERS KLUWER, *supra* note 92, at 847.

¹⁴³ 42 C.F.R. § 412.160 (2020); see also 42 U.S.C. § 1395ww(o)(6)(B)–(C).

¹⁴⁴ See 42 C.F.R. § 412.165(b) (2020).

¹⁴⁵ 42 U.S.C. § 1395ww(o)(2)(A); see WOLTERS KLUWER, *supra* note 92, at 848.

care.”¹⁴⁶ Federal law requires that the measures meet requirements.¹⁴⁷ One requirement states that the measures, at a minimum, must account for “5 specific conditions or procedures,” which include “[a]cute myocardial infarction,” “[h]eart failure,” “[p]neumonia,” “[s]urgeries,” and “[h]ealthcare-associated infections.”¹⁴⁸ Another requirement mandates the Secretary to ensure that the efficiency of the hospital is included as a measure, along with the “Medicare spending per beneficiary” (MSPB).¹⁴⁹ MSPB is a focal point of this Comment; however, in order to fully understand the importance of MSPB, one must first become familiar with the role of MSPB in the value-based payer calculation.

Following the development of the measures, the Secretary of HHS provides performance standards sixty days in advance of the performance period.¹⁵⁰ The performance standards function as thresholds that the hospital must meet or surpass for greater reimbursement.¹⁵¹ The Secretary determines each performance standard based on the measures developed.¹⁵² The Secretary, when deciding the standards, must consider four specific factors: “(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods; (ii) historical performance standards; (iii) improvement rates; and (iv) the opportunity for continued improvement.”¹⁵³ The performance standards serve as clearly delineated criteria reflecting the purpose and goal of the corresponding measure to best assess whether the hospital has met or exceeded CMS’s expectations.¹⁵⁴

The next step in the process involves comparing the hospital’s performance to the performance standards. This comparison results in the performance score.¹⁵⁵ The performance score indicates how closely the hospital meets the performance standards reflected by the measures.¹⁵⁶ CMS ultimately decides whether the hospital has performed pursuant to the

¹⁴⁶ WOLTERS KLUWER, *supra* note 92, at 848.

¹⁴⁷ 42 U.S.C. § 1395ww(o)(2)(B).

¹⁴⁸ 42 U.S.C. § 1395ww(o)(2)(B)(i)(I).

¹⁴⁹ 42 U.S.C. § 1395ww(o)(2)(B)(ii).

¹⁵⁰ WOLTERS KLUWER, *supra* note 92, at 848–49. “[T]he Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.” 42 U.S.C. § 1395ww(o)(4).

¹⁵¹ WOLTERS KLUWER, *supra* note 92, at 849.

¹⁵² 42 U.S.C. § 1395ww(o)(3)(A).

¹⁵³ 42 U.S.C. § 1395ww(o)(3)(D).

¹⁵⁴ See WOLTERS KLUWER, *supra* note 92, at 849.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

measure.¹⁵⁷ The performance score awards points to a hospital based on the greater of two scores—the achievement or improvement score.¹⁵⁸ In calculating the hospital’s performance pursuant to the measure, CMS awards the hospital one to nine points if the hospital reaches or surpasses the achievement threshold but fails to meet the measure’s benchmark.¹⁵⁹ A hospital may receive zero to nine points if the hospital reaches or surpasses the improvement threshold but fails to meet the benchmark of the measure.¹⁶⁰ CMS can only award points for the hospital’s performance in a measure if the hospital serves a minimum number of cases.¹⁶¹ If the hospital scores points in both the achievement and improvement score categories, then whichever score is greater will be used in calculating the hospital’s ultimate performance score.¹⁶²

A hospital’s performance relative to these measures determines its performance score. To calculate the performance score, measures are grouped to form “applicable domains.”¹⁶³ Domains may change to adapt to the constant evolution of the health care industry.¹⁶⁴ CMS establishes these domains and assigns various weights to each domain.¹⁶⁵ For 2020, CMS analyzed a hospital’s performance under four domains: clinical outcomes, person and community engagement, safety, and efficiency and cost reduction. Each domain composed 25% of the weight in determining the

¹⁵⁷ *Id.*; see 42 C.F.R. § 412.165(a) (2020).

¹⁵⁸ 42 U.S.C. § 1395ww(o)(5)(B)(ii).

¹⁵⁹ WOLTERS KLUWER, *supra* note 92, at 849; see 42 C.F.R. § 412.165(a)(2) (2020). The achievement threshold is:

the median . . . of hospital performance on a measure during a baseline period with respect to a fiscal year, for Hospital VBP Program measures other than the measures in the Efficiency and Cost Reduction domain, and the median . . . of hospital performance on a measure during the performance period with respect to a fiscal year, for the measures in the Efficiency and Cost Reduction domain.

42 C.F.R. § 412.160 (2020).

¹⁶⁰ WOLTERS KLUWER, *supra* note 92, at 849; see 42 C.F.R. § 142.165(a)(3) (2020). The improvement threshold is “an individual hospital’s performance level on a measure during the baseline period with respect to a fiscal year.” 42 C.F.R. § 412.160 (2020).

¹⁶¹ 42 C.F.R. § 412.165(a)(1) (2020).

¹⁶² 42 U.S.C. § 1395ww(o)(5)(B)(ii).

¹⁶³ 42 C.F.R. § 412.160 (2020).

¹⁶⁴ See WOLTERS KLUWER, *supra* note 92, at 849.

¹⁶⁵ See *id.*

hospital's overall performance.¹⁶⁶

A hospital's point value across all domains makes up the total performance score, which ranges between zero and one hundred.¹⁶⁷ CMS follows the process laid out in Medicare Part A regulation 42 C.F.R. § 412.165(b) to ultimately determine the total performance score of a hospital. First, CMS calculates the domain score of the hospital only after the hospital meets "the minimum threshold of measures in the domain."¹⁶⁸ In other words, the hospital must provide a certain amount of treatment in order for CMS to have sufficient data to compare the hospital's performance to the measures. Second, CMS calculates the unweighted domain score which is the sum of all measures in a domain.¹⁶⁹ Third, CMS normalizes the unweighted domain score to be "expressed as a percentage of points earned out of 100."¹⁷⁰ Fourth, CMS further standardizes the unweighted domain score by weighing the score against CMS's finalized domain weights.¹⁷¹ Lastly, CMS calculates the hospital's total performance score by adding all the hospital's weighed domain scores.¹⁷²

The calculation process is extensive and complicated. The applicable domains are essentially the standard that the hospital's performance must meet; therefore, the applicable domains are the best means to prohibit,

¹⁶⁶ Ctrs. for Medicare & Medicaid Servs., *Hospital Value-Based Purchasing*, CMS.GOV, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-> (Feb. 18, 2021, 3:03 PM); Ctrs. for Medicare & Medicaid Servs., *Hospital Value Based Purchasing (HVBP) Program FY 2018-2026 Measures*, CMS.GOV <https://qualitynet.cms.gov/inpatient/hvbp/measures> (last visited Sept. 1, 2021) (showing clinical outcomes relate to mortality rates for particular illnesses and injuries.). For example, under the first measure, a hospital's performance is measured by the thirty-day mortality rate when it treats patients with chronic obstructive pulmonary disease. *Id.* CMS changed the second domain's label from patient and caregiver-centered experience of care/care coordination to person and community engagement. WOLTERS KLUWER, *supra* note 92, at 849. Regardless of the name change, the domain relates to the hospital's performance in housekeeping matters like nurse-to-patient communication, cleanliness, and discharge information given. Ctrs. For Medicare & Medicaid Servs., *Hospital Value-Based Purchasing (HVBP) Program FY 2018-2026 Measures*, *supra*. The third domain, safety, involves CMS assessing a hospital's safety in conducting surgeries. *Id.* The final domain involves CMS's Medicare Spending per Beneficiary measures, which will be later discussed in this comment. *Id.*; see discussion *infra* Section IV.A.2.

¹⁶⁷ WOLTERS KLUWER, *supra* note 92, at 850.

¹⁶⁸ *Id.*; 42 C.F.R. § 412.165(b) (2020).

¹⁶⁹ WOLTERS KLUWER, *supra* note 92, at 850.

¹⁷⁰ *Id.*

¹⁷¹ 42 C.F.R. § 412.165(b) (2020).

¹⁷² *Id.*

restrict, or promote a particular hospital-related activity. However, the applicable domains focus on efficiency and quality of care in relation to the *commencement* of the procedure or treatment.¹⁷³ The applicable domains fail to address whether the procedure or treatment itself is essential to the health of the patient, which results in the potential for wasteful and expensive care. CMS attempted to address this problem with the MSPB.¹⁷⁴

(1) *Medicare spending per beneficiary measures*

If quality of care is the primary focus, the ACA's Hospital VBP is insufficient to cut costs. So CMS instituted incentives for hospitals to increase the level of efficiency in how they provide health care which resulted in the Medicare Spending per Beneficiary measure.¹⁷⁵ The MSPB is a measure contained within the cost and efficiency applicable domain, which "compares a hospital's overall efficiency relative to the median hospital."¹⁷⁶ The measure examines a narrow timeframe—from three days prior to the patient entering the hospital to thirty days following discharge.¹⁷⁷ The MSPB rewards hospitals that treat the patient with lower costs by increasing the hospital's efficiency score; conversely, the hospital that treats the patient with higher costs is punished with a lower efficiency score.¹⁷⁸ Yet, this measure fails to fully address overtreatment. The measure focuses on the cost and efficiency of the prescribed treatment without addressing the issue of overtreatment.¹⁷⁹

Professor Jessica Mantel at the University of Houston Law Center noted that the cost and efficiency measures do not stop hospitals from two forms of overtreatment.¹⁸⁰ The first form of overtreatment is at the inception of the patient-hospital relationship; more specifically, the measures contained within the cost and efficiency domain fail to account for whether the individual even needs to be admitted to the hospital.¹⁸¹ In her discussion of overtreatment, Professor Mantel cites an article published in the *New England Journal of Medicine*, a prominent medical journal, which reveals

¹⁷³ Mantel, *supra* note 53, at 152; see Ctrs. for Medicare & Medicaid Servs., *Hospital Value-Based Purchasing*, *supra* note 166.

¹⁷⁴ Mantel, *supra* note 53, at 152.

¹⁷⁵ *Id.*

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *See id.*

¹⁸⁰ Mantel, *supra* note 53, at 153.

¹⁸¹ *See id.*

that hospitals recommend the costliest avenue for treatment—surgery.¹⁸² This recommendation is made even when other treatment options, which are less expensive and carry fewer risks, may be more appropriate. Notably, hospitals have promoted the use of spinal-fusion surgery for patients with pre-existing conditions absent any data indicating that the expensive surgery is the most effective treatment under such pre-existing conditions.¹⁸³ Doctors commit waste when they order a surgery where other less expensive measures would serve the same purpose with less risk and expense.

The second form of overtreatment that MSPB overlooks is the outpatient expenses caused by the narrow timeframe of MSPB—three days prior to the admission of the patient to thirty days following discharge.¹⁸⁴ The hospital may create an environment that promotes doctors encouraging patient participation in expensive outpatient services, which may exceed the thirty day window.¹⁸⁵ Professor Mantel summarizes the prevailing issue in the following way: “[T]he current Hospital VBP Program serves as a partial and imperfect tool for addressing hospitals’ cultures for overtreatment.”¹⁸⁶

(2) *Mandatory waste provision to minimize overtreatment*

Problems of overtreatment and hospitalization result in waste. Waste is an unnecessary drain on Part A, a program already plagued with financial difficulties. Thus, efforts to minimize waste are necessary to preserve coverage for future generations. The efforts laid out in regulations and codified in statutes have so far failed to solve the essential problem—waste in the form of overtreatment. For this reason, this Comment argues for the addition of a provision in 42 U.S.C. § 1395ww(o)(3)(D) requiring the Secretary, when determining performance standards, to consider waste—defined as overtreatment by excessive inpatient treatment, excessive outpatient treatment, or unnecessary admission of a patient.

Under the added provision, the Secretary should consider waste per the

¹⁸² *Id.* (citing Richard A. Deyo et al., *Spinal-Fusion Surgery—The Case for Restraint*, 350 NEW ENG. J. MED. 722 (2004)).

¹⁸³ Deyo et al., *supra* note 182, at 723. See generally James S. Goodwin et al., *Overuse of Screening Colonoscopy in the Medicare Population*, 171 ARCH INTERN MED. 1335, 1335 (2011) (authors conducted a study indicating that patients were subjected to colonoscopy retests prior to CMS’s specified time); H. Gilbert Welch et al., *Repeat Testing Among Medicare Beneficiaries*, 172 ARCH INTERN MED. 1745 (2012) (indicating study shows that Medicare beneficiaries had a high probability of being tested and retested).

¹⁸⁴ Mantel, *supra* note 53, at 153–54.

¹⁸⁵ *Id.* at 154.

¹⁸⁶ *Id.*

given definition when developing measures for the respective fiscal year. Possible implementation of the measures includes an examination of the rates of retesting prior to any mandatory retesting, the rate of admission of a patient for an expensive procedure lacking clear data indicative of the procedure's outweighing benefit, or the rate of admission to the hospital when non-hospital medical services are best suited. These measures are simply suggestions and by no means limit other measures the Secretary may implement to minimize waste.

A measure, such as the rate of retests prior to a mandatory retest of a patient, examines whether the patient is subjected to unnecessary testing. Patients are often given more testing than necessary, which ultimately increases the costs paid by Medicare for that patient's health care.¹⁸⁷ The danger of unnecessary tests may supersede any diagnostic value.¹⁸⁸ Several doctors at the University of Texas Medical Branch in Galveston conducted a study exposing the rate of excessive colonoscopies.¹⁸⁹ The study involved a testing pool of Medicare beneficiaries under Parts A and B who underwent colonoscopies for cancer screening.¹⁹⁰ At the time of the study, CMS regulated reimbursement for a colonoscopy to one every ten years; however, the study found that many of the beneficiaries were retested earlier than the ten year mark.¹⁹¹ CMS recognized this issue and regulated accordingly. However, the issue of retesting persists in areas other than colonoscopy screening for cancer, such as imaging stress tests and pulmonary function tests.¹⁹²

Dr. Konger and his colleagues, who conducted the study at the University of Texas Medical Branch in Galveston, specifically mentioned that laboratory and pathology tests are expensive bearing a heavy burden on Medicare.¹⁹³ A possible cause for the expense is retesting the patient for various reasons.¹⁹⁴ One reason involves tests ordered by different doctors who fail to look at what previous or other doctors have ordered.¹⁹⁵ Other reasons include tests given in a narrow timeframe that do not allow for any changes in the patient's

¹⁸⁷ See Raymond L. Konger et al., *Reduction in Unnecessary Clinical Laboratory Testing Through Utilization Management at a US Government Veterans Affairs Hospital*, 145 AM. J. CLINICAL PATHOLOGY 355, 355 (2016).

¹⁸⁸ See Goodwin et al., *supra* note 183, at 1335.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.* at 1336.

¹⁹¹ *Id.* at 1335.

¹⁹² See Konger et al., *supra* note 187, at 355; Welch et al., *supra* note 183, at 1745.

¹⁹³ Konger et al., *supra* note 187, at 355.

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

condition or for a mistake in one test that is part of a large panel of testing.¹⁹⁶ As evidenced by Dr. Konger's study, a measure to eliminate waste may decrease the likelihood of extraneous retesting, which would lower the cost of health care.

If the Secretary must account for waste, specifically in the form of overtreatment, then Part A will be less burdened by unnecessary expenses. Conservation and necessity must be guiding principles to cabin Part A spending, as its funding is projected to be gone in a decade.¹⁹⁷ Factoring a hospital's waste in its reimbursement analysis helps to avoid superficial and futile treatments that burden the dwindling funds to nothing, rendering untenable the American promise of health care to the elderly.

B. *Mandate Universal Premiums to Increase Income*

The adage, "a penny saved is a penny earned" is undoubtedly true, but Part A requires more than a penny saved to be sustainable. Premiums allow for the influx of money into the program. Presently, few beneficiaries of Part A pay a premium.¹⁹⁸ The program has millions of enrollees, as previously noted, yet most of these enrollees pay into the system solely through deductions from paychecks throughout their professional life, absent Medigap insurance or any other supplemental insurance.¹⁹⁹ This large body of "premium-free Part A" beneficiaries (hereinafter referred to as "qualifying beneficiaries") provides a prime, untapped group to pay premiums allowing for increased funding to the program.²⁰⁰

1. Who Pays Premiums?

A divide exists as to who pays premiums in Medicare Part A, which contrasts with the premium requirement in Parts B and D.²⁰¹ Under Parts B and D, beneficiaries must pay premiums.²⁰² Conversely, if the Part A enrollee meets particular qualifications, which most do, then the enrollee is a beneficiary absent any premium.²⁰³ If the enrollee receives benefits from Social Security or the Railroad Retirement Board and the individual is sixty-

¹⁹⁶ *Id.*

¹⁹⁷ H.R. DOC. NO. 116-122, at 6 (2020).

¹⁹⁸ *Part A Costs*, *supra* note 105.

¹⁹⁹ *See id.*

²⁰⁰ *See id.*

²⁰¹ Richard L. Kaplan, *Reflections on Medicare at 50: Breaking the Chains of Path Dependency for a New Era*, 23 ELDER L.J. 1, 3, 12, 13, 17 (2015).

²⁰² *Id.* at 12, 13, 17.

²⁰³ *Id.* at 4.

five, then Medicare Part A is premium-free.²⁰⁴ If the enrollee fails to meet the age qualification of sixty-five, then the enrollee may still qualify for premium-free health care if the individual receives Social Security or benefits for disabilities for twenty-four months, or has ESRD.²⁰⁵ Furthermore, the enrollee must pay into the system long enough to be eligible for Social Security.²⁰⁶ The work requirement is met by “earning a sufficient amount . . . for at least [forty] calendar ‘quarters.’”²⁰⁷

If the enrollee does not qualify for Part A, the enrollee may still enroll for the program by paying monthly premiums (hereinafter referred to as “purchasing beneficiaries”).²⁰⁸ In 2020, the premium for Part A was \$458 per month.²⁰⁹ However, a decrease in the monthly premium may occur depending on the number of quarters of coverage the beneficiary worked.²¹⁰ The threshold number of quarters to decrease the monthly premium is thirty quarters.²¹¹ In 2020, thirty quarters of coverage required the enrollee to pay \$252 in monthly premiums.²¹² The beneficiary does not have to work the quarters of coverage; rather, the beneficiary may be married to the individual who worked for the quarters.²¹³

Commonly, the enrollee meets the qualifications, entitling that individual to premium-free health care.²¹⁴ In its annual statement of premiums and deductibles for the upcoming fiscal year, CMS stated that 99% of beneficiaries are premium-free beneficiaries.²¹⁵ Therefore, 99% of at least 60 million people do not pay premiums for their health insurance—approximately 59,400,000 people.²¹⁶

The divide in enrollees paying monthly premiums for coverage is purposeful. Part A was intended as a program that is “self-financed, almost entirely, through taxes paid on wages and other earned income throughout a

²⁰⁴ *Part A Costs, supra* note 105.

²⁰⁵ *Id.*

²⁰⁶ Kaplan, *supra* note 201, at 4.

²⁰⁷ *Id.* (noting that, in 2015, the requisite amount was \$1,220).

²⁰⁸ *Part A Costs, supra* note 105.

²⁰⁹ Ctrs. for Medicare & Medicaid Servs., *2020 Medicare, supra* note 68.

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² *Id.*

²¹³ *Id.*

²¹⁴ *See id.*

²¹⁵ Ctrs. for Medicare & Medicaid Servs., *2020 Medicare, supra* note 68.

²¹⁶ *See* H.R. Doc. No. 116–122, at 6 (2020).

person's working life."²¹⁷ However, if Part A is to continue, this must change. The program's dire state necessitates steady income from the insureds and not solely spending money on the majority of the insureds.

2. Mandated Premiums Statute

Millions of Americans pay for Part A throughout their working lives through taxes automatically withdrawn from each paycheck. Upon retirement, these Americans stop making payments to the program via taxes and instead begin drawing on their lifelong investment by visiting hospitals and receiving care through Medicare. The idea behind Part A is that the workforce remains sufficiently populated in order to continue the steady flow of income. The workforce is continually taxed to pay for the health care of those who have already retired. However, what happens if the American population greatly decreases or a recession similar to 2007 reoccurs? What happens when the baby boomer generation fully retires and health care costs continue to rise?²¹⁸ Part A is on the brink of bankruptcy, as it is operating on a deficit basis, so such circumstances would render it unable to afford to pay for current beneficiaries' care. Possible remedies incite little enthusiasm.

This Comment argues for the enactment of a statute mandating a premium for all beneficiaries at varying amounts. While mandatory premiums appear contrary to the purpose of Part A, it would allow the idea of pre-paid health care to remain in the program. The statute will require individuals who are entitled to premium-free Part A coverage to pay only a minimal payment. As a result, the small premiums combined with the existing purchasing beneficiaries will create an influx of income for Medicare Part A.

3. Introduction of Premiums in Part A

Evidence supports the enactment of a statute mandating premiums. Premiums imposed on beneficiaries of other Parts in Medicare and the comparison of the benefits of fully retired beneficiaries to the benefits of quasi-retired beneficiaries support the argument that all Medicare beneficiaries should pay premiums. Again, while this possible solution to Medicare Part A's dissolution is not exciting, it is necessary to avoid full-fledged bankruptcy of the insurer for the elderly.

Part A's funding metric greatly differs from Parts B and D. Parts B and D permit beneficiaries to have additional benefits, like reimbursement for

²¹⁷ Kaplan, *supra* note 201, at 5.

²¹⁸ See PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 305.

outpatient drugs or coverage for additional services.²¹⁹ As noted previously, Parts B and D charge premiums for this additional coverage.²²⁰ Part B has premiums that fluctuate based on the beneficiary's tax filing status.²²¹ In 2020, Part B's premium for an individual who filed a tax return with a reported income of \$87,000 or less was \$144.60 per month.²²² An individual who filed a tax return with an annual income of \$500,000 or more paid a monthly premium of \$491.60.²²³ According to CMS, *most* Part B beneficiaries paid the "standard amount" of \$144.60.²²⁴

Part D's premiums follow a similar pattern.²²⁵ However, the nature of a Part D plan is that each plan is different, with varying benefits at respective prices.²²⁶ The premiums set in the plan²²⁷ are adjusted according to the beneficiary's income.²²⁸ The adjustment is an additional amount owed that varies based on a person's tax filing status and annual income.²²⁹ For example, an individual making \$87,000 or less pays only the premium of the plan the beneficiary selected.²³⁰ If the individual makes over \$500,000, then the person pays \$76.40 every month, in addition to the monthly premium contained in the selected plan.²³¹

The fluctuating, but lower, payment amounts in Parts B and D support the feasibility of a mandatory premium for Part A beneficiaries. A mandatory premium would provide income for the program without overburdening the beneficiaries and frustrating its purpose. To illustrate, if the statute mandates that every qualifying Part A beneficiary pay \$144.60 annually, which would

²¹⁹ PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 306.

²²⁰ Kaplan, *supra* note 201, at 12, 17.

²²¹ Ctrs. for Medicare & Medicaid Servs., *Part B Costs*, <https://www.medicare.gov/your-medicare-costs/part-b-costs> (last visited Oct. 1, 2021).

²²² Ctrs. for Medicare & Medicaid Servs., *2020 Medicare*, *supra* note 68.

²²³ *Id.*

²²⁴ Ctrs. for Medicare & Medicaid Servs., *Part B Costs*, *supra* note 221.

²²⁵ Ctrs. for Medicare & Medicaid Servs., *Monthly Premium for Drug Plans*, <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans> (last visited Oct. 1, 2021).

²²⁶ *Id.*

²²⁷ *See id.*

²²⁸ *Id.*

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ Ctrs. for Medicare & Medicaid Servs., *Monthly Premium for Drug Plans*, *supra* note 225.

be required for 99%²³² of the 60 million²³³ beneficiaries, then \$8,592,804,000 is contributed to Medicare Part A.²³⁴ As previously noted, Medicare costs are \$796.2 billion²³⁵ with only \$794.8 billion²³⁶ as available funding; therefore, collecting premiums amounting to over \$8 billion will rectify the deficit.

Aside from Parts B and D premiums, evidence supports that a mandatory premium does not punish beneficiaries who are semi-retired. Medicare and Social Security are both subsidized through payroll taxes.²³⁷ As a result, workers pay their contributions every paycheck, while those who do not work make no contribution. A quasi-retired individual who chooses to work is stuck having to pay into the program. The quasi-retired have less incentive to continue participating in the workforce if they are paying into a program that they are using, while their retired colleagues make no contribution and only drain the program. Therefore, establishing a universal premium does not disincentivize the semi-retired beneficiaries by continually forcing them to contribute to Part A, while a majority of Part A beneficiaries, who are fully retired, do not contribute.

A foreseeable argument against a mandatory premium is: what happens to the elderly individual who cannot make the monthly premiums? This argument highlights the important concern of imposing additional expenses on a person in excess of the amount contributed to the program over a lifetime. However, there are several solutions to resolve this concern. First, if an elderly individual has severe financial complications, then that person may enroll in Medicaid.²³⁸ Medicaid “serves low-income people of every age. Patients usually pay no part of costs for covered medical expenses.”²³⁹ Second, CMS may set the premium at a minimal amount to ensure the population’s overall ability to pay the premium. The amount can start from as little as a cup of coffee to the minimum premium amount for Part B, \$144.60.²⁴⁰

The enactment of a statute mandating premiums provides income for Part

²³² See Ctrs. for Medicare & Medicaid Servs., *2020 Medicare*, *supra* note 68.

²³³ H.R. DOC. NO. 116–122, at 6 (2020).

²³⁴ The formula used in this illustration is $\$144.60 \times (99\% \text{ of } 60,000,000)$.

²³⁵ H.R. DOC. NO. 116–122, at 6.

²³⁶ *Id.*

²³⁷ See PROBLEMS IN HEALTH CARE LAW: CHALLENGES FOR THE 21ST CENTURY, *supra* note 10, at 306.

²³⁸ Dep’t of Health & Hum. Servs., *What is the Difference Between Medicare and Medicaid?*, <https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html> (last visited Oct. 1, 2021).

²³⁹ *Id.*

²⁴⁰ *Id.*

²⁴⁰ See Ctrs. for Medicare & Medicaid Servs., *2020 Medicare*, *supra* note 68.

As health care costs increase and available funds continue to deplete, CMS has already made use of a mandatory premium system in Parts B and D, which have successfully funded Parts B and D for many years.²⁴¹ Further, quasi-retired individuals already are required to pay into the program even if they are beneficiaries. As a result, beneficiaries are disincentivized to continue working—quasi-retired individuals pay while fully-retired individuals only pay deductibles and coinsurance payments. This proposal advantages some but might disadvantage those who may struggle to afford a monthly premium on top of their living costs. The affordability of the premium is, of course, a great concern, but CMS can easily require a very low premium amount. Therefore, a mandatory premium best accomplishes the goal of increasing income into the Part A program.

V. CONCLUSION

Upon reaching the retirement age of sixty-five, Americans expect that the program they paid into throughout their working lives is capable of sustaining them. However, CMS's reports continually warn lawmakers of Medicare's impending bankruptcy. If this problem remains unaddressed, millions of Americans will be disappointed in their government's failed promise to provide health care in their old age.

Medicare's expansion has provided increased health care for millions of Americans. Further, Americans have alternative ways to afford health care through purchasing additional care under Part B, savings plans in Part C, or drug-purchasing plans under Part D. While there are alternative ways to afford care, the price of health care increases with evolving technology and methodologies. The expansion of health care coverage with ever-increasing costs proves to be an overwhelming burden on the program.

Under Part A, the program originated as a program that covered limited services for only the elderly population. Following decades of amendments, Medicare now provides coverage for millions who are disabled or contract a particular illness, and more services than ever are now covered. Part A is not intended to provide such a broad sweep of coverage with skyrocketing costs. Therefore, under the current paradigm, Part A is struggling and will soon falter.

All is not doom and gloom. There are solutions that lawmakers can enact to sustain Medicare Part A. The solution is plain and simple on the surface—lower health care costs and increase income to the program. However, implementation of this solution is difficult because the government is tasked with deciding whether services are curtailed, heavier taxes are imposed, or

²⁴¹ H.R. Doc. No. 116-122, at 9.

both.

The ACA attempted to fix Part A. It introduced an incentive-based care metric into Medicare, the Hospital VBP. This new system changed how health care is delivered to patients—quality of care and patient satisfaction are central. Issues continue as health care costs do not decrease.

Cost and efficiency must be central to the health care delivery system to sustain Part A. An amendment to 42 U.S.C. § 1395ww(o)(3)(D), requiring the Secretary to consider waste when determining performance scores, would accomplish a sustainable health care delivery paradigm. When measuring the performance of a hospital, waste must be examined to determine whether the hospital is wasteful through extraneous treatments. In its current state, Part A is unable to afford unnecessary treatments. Implementation of this amendment will not change the focus of health care from quality of care to solely financial incentives. Instead, it will force medical professionals to be thorough during initial patient examinations. Most importantly, this amendment will eliminate extraneous spending by medical professionals.

While saving money is important, Medicare must not operate at a consistent deficit. Currently, Medicare has qualifying and purchasing beneficiaries. Qualifying beneficiaries do not contribute to the program following enrollment because they qualify. However, beneficiaries that do not meet the eligibility requirements may still enroll in the program by contributing monthly premium payments. Therefore, a small portion of beneficiaries make regular contributions to the program in addition to the payroll taxes of the population. These methods are no longer viable with the increased cost of health care. The enactment of a statute mandating premiums for qualifying beneficiaries provides income for Medicare for more than one generation.

A mandatory premium for qualifying beneficiaries provides a new avenue of income for the program. Premiums are no stranger to the Medicare system, as premiums are already a mandatory component of Parts B and D. Further, premiums ensure that no quasi-retiree is subject to paying payroll taxes to Medicare while a fully retired person is not.

Lawmakers can no longer be silent on Medicare. The U.S. government promised Americans in 1965 that their contributions from their paychecks shall be rewarded with health care at the age of sixty-five. CMS is pleading with lawmakers and Americans—Medicare Part A is in a desperate state; change must happen.