

Weekly Checkup



COVID-19 and the Fiscal Sustainability of Federal Health Care Programs

CHRISTOPHER HOLT | APRIL 24, 2020

Over the course of the last month, Congress has enacted roughly \$4 trillion in spending measures related to the public health and economic fallout of the coronavirus pandemic. And that's only the start: Politicians are already positioning themselves for a likely fourth phase of emergency spending. Much of this money has been devoted to the health care response, and health care will remain a priority for future spending, particularly the costs for the uninsured and [newly uninsured](#). **But all of this new spending is deficit spending, which points to the underlying question facing all of the United States' health care programs: How are we going to pay for them?**

This week the Medicare Trustees released their annual report on the program's fiscal outlook. Unsurprisingly, Medicare's financial future is bleak. AAF has released this [analysis](#) of both the Medicare and Social Security Trustees' reports, but here are the Medicare program highlights (or rather lowlights). Medicare's Hospital Insurance Trust Fund is expected to be bankrupt in 2026. Medicare spent \$396 billion more on medical services in 2019 than it collected in payroll taxes and monthly premiums. Cumulatively, since the creation of the Medicare program, outlays have exceeded revenues by \$5.5 trillion, and Medicare's cash shortfall accounts for 34 percent of the national debt. Much of that shortfall has come in recent years. During the Obama Administration, Medicare's cash shortfall was \$2.4 trillion, and by the end of this year the shortfall under the Trump Administration's stewardship is projected to reach \$1.5 trillion. Combined, Medicare and Medicaid are expected to cost \$2 trillion annually by 2025. Further, those figures don't account for anticipated increases in Medicaid enrollment and future increases in federal funding to states that may occur as a result of the current pandemic and economic collapse. Those numbers also haven't touched on other federal health programs such as the Affordable Care Act's insurance subsidies.

In the absence of structural reforms to the Medicare program, beneficiaries and taxpayers would face extraordinarily burdensome measures to fully fund the current benefits. It would require a 15 percent increase in the annual Medicare payroll tax to cover the Medicare Part A (hospital services) shortfall. To address the shortfall in Medicare Part B (physician services), the typical Medicare enrollee's annual premium would need to increase by \$4,431. And to address the shortfall in Medicare Part D (prescription drugs), the average senior would see their drug plan premium increase by 518 percent, or \$2,062 annually. **These steps are politically untenable, but they serve to highlight just how intractable a problem solving our looming entitlement crisis has proven to be. Nevertheless, in the absence of action, Medicare will collapse.**

As the immediate crisis fades over the next 12 to 18 months, attention will inevitably turn to further expansion of federal health programs. Short-term emergency increases in federal spending on Medicaid, efforts to extend coverage for COVID-19 care, or proposals to [cover COBRA premiums](#) during the immediate aftermath, will shift to renewed calls for Medicare for All as well as efforts to extend the emergency provisions into more permanent expansions. And there will always be another crisis on the horizon to justify pushing off necessary reform to our entitlement programs. **But if we continue down our present course, eventually the health care crisis will be the insolvency of the programs themselves.**

In the midst of this pandemic and requisite emergency spending, it's important not to lose sight of the long-term fiscal impact of federal health care programs. Now may not be the time to sweat the financials, but the bill for both these emergency actions and our long-term obligations will come due eventually. For Medicare, that reckoning will be sooner than many would like to acknowledge. **If we refuse to address entitlement reform before it's too late, the crisis will be one of our own making.**

CHART REVIEW: THE IMPACT OF COVID-19 ON ORGAN TRANSPLANTS

Margaret Barnhorst, Health Care Policy Intern

COVID-19 has heightened the risks of organ transplant surgery, and according to the [United Network for Organ Sharing](#), the number of transplants during March and April is down a third from what it was during those months in 2019. Particularly striking was the drop from the week of March 8-14 to the week of March 15-21, when the number of organ transplants decreased by nearly 60 percent. There are numerous pandemic-related reasons for the observed drop in organ transplants, from both the supply and demand sides. Organ supply is limited by the fact that ventilators are prioritized for treating COVID-19 patients rather than keeping active the organs of a brain-dead donor. In addition, nationwide delays in the distribution of COVID-19 tests limited the availability of COVID-19 tests for organs of brain-dead patients, resulting in a large number of wasted organs out of uncertainty. On the demand side, with health care systems in many places at full or near-full capacity, the lack of available beds and ventilators has delayed “[life-enhancing](#)” transplants—those in which patients are able to survive on their current treatment plans. Adding to the risk of transplant surgeries right now, and thus decreasing demand for organ transplants, are the immune-suppression drugs taken to prevent organ rejection; these same drugs prevent patients from fighting off COVID-19, thus increasing the risk of infection for both them and anyone around them. Other possible reasons for the decreased supply of and demand for organs are the results of stay-at-home orders, such as fewer [traffic accidents](#) and decreased [gun violence](#).