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Medicare in 2030 Irretrievably Broken

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The Medicare Program is the second-largest insurance program in the United States, with approximately 64 million beneficiaries and total expenditures of over $839 billion in 2021 [1]. There are two separate trust funds in the Medicare Program, namely the Hospital Insurance Trust Fund (HI Trust Fund) and the Supplementary Medical Insurance Trust Fund (SMI Trust Fund); both trust funds are held by the U.S. Treasury [2]. The first trust fund covers hospital in-patient expenses; and the second trust fund covers medically necessary services by medical doctors and doctors of osteopathy, preventive services, brand-name prescription drugs, and generic drug coverage [3,4]. Prior to the COVID-19 pandemic, the latest financial calculations projected that the HI Trust Fund would be insolvent by the year 2026. It is a fact that the Medicare HI Trust Fund has never been insolvent because there are no provisions in the Social Security Act that govern what would happen if insolvency were to occur. Ten of the last twelve years have witnessed expenditure outflows outpacing the HI Trust inflows, resulting in total Medicare spending obligations outpacing the increasing demands on the Federal budget as the number of beneficiaries and the per capita healthcare costs increase each year [5].

Uncompensated care refers to uninsured patients who receive care upon hospital emergency room admissions but not ever paying the hospital bill after discharge or death. Uncompensated care is the kryptonite of hospital financing because it is unpredictable and can easily destabilize the monies that hospitals depend on to cover overhead expenses. Nationwide, hospitals protect themselves against the uncertainty of uncompensated care by drastically overcharging prices to different patients receiving the same or similar medical procedures at the very same hospital locations. For all intents and purposes, the creation of Obamacare failed to address this kryptonite. However, it is a fact that the legal system places limitations upon what the federal government can do to deal with this Achilles' heel of the American healthcare system. State governments truly hold the power to effect change towards the future of healthcare in 2030, both private healthcare and government-sponsored healthcare. Since 1970, one state has proactively protected its statewide healthcare system against the dangers of uncompensated care: Maryland. It is the only state in the entire nation to receive a federal waiver from the U.S. Centers for Medicare & Medicaid Services (CMS) because their specific design for accounting for a plethora of poor patients. This effort started with a group of hospital administrators meeting for coffee on a consistent basis to brainstorm the solution from their collective hospitals. Driven by the pride to help their communities, their involvement with the Maryland government led to the creation of the Maryland Health Services Cost Review Commission (Maryland HSCRC). This impartial government institution is backed by Maryland law that gives it the necessary legal powers to set stated singular hospital prices for all services statewide; these prices include the adjustments for uncompensated medical care that is distributed among all stakeholders equally.

In fact, the Maryland HSCRC wrote the law that requires all stakeholders to comply with detailed auditing and data submission requirements for the purpose of providing the federal government with complete transparency regarding healthcare information without violating HIIPA federal patient privacy regulations. With this powerful information, the agency restricts hospital costs without limiting hospital profits, accurately measuring patient volume, and predicting the financial condition of all inpatient and outpatient services in Maryland. Because the Maryland HSCRC is both funded by resident's money and accountable to the public, the hospital savings are as follows: Maryland markups for hospital services increased from 18 percent in 1980 to only 22 percent in 2008. During the same period, the average nationwide markup for hospital services skyrocketed from less than 20 percent in 1980 to over 187 percent by 2008. It is because of these significant savings to the Medicare Program that the Maryland HSCRC continues to receive a CMS waiver every year. In terms of prices, Maryland hospitals are prohibited from giving volume discounts and shifting costs to 4 other payers. The agency enforces a simple and clear mandate: same prices for the same medical services at the same hospitals, no exceptions!

Before leaving office, President Trump instructed the CMS to enforce a price transparency rule though separate machine-readable prices as a protection against the kryptonite of uncompensated medical care. After the authors studied the CMS proposal, it became clear that single-handedly imposing penalties for noncompliance is only one factor in this multidimensional problem. Unlike the extremely efficient Maryland system, the CMS has threatened all hospitals with what will be shown below, to be ineffective measures that yield worthless results. The "Price Transparency Final Rule" penalizes hospitals with fewer than 30 beds at $300 daily for each licensed bed at small hospitals, and large hospitals (more than 30 beds) at $10 daily per licensed bed (cannot exceed the daily penalty of $5,500). Our financial analysis in a prior article on this point, focuses on Free Cash Flow because it represented the cash that a hospital can generate after disbursing the money required to maintain and pursue opportunities that enhance shareholder value. We argued that the proposed CMS civil monetary penalties imposed on hospitals was doomed from the start for failure. Our financial analysis focuses on business valuation, and

specifically an accounting term called Free Cash Flows (FCF), which represents the cash that a company can generate after laying out the money required to maintain or expand its asset base; FCF is important because it allows a company to 5 pursue opportunities that enhance shareholder value [6]. At Pettingill Analytics, we looked at three publicly traded hospitals in the United States reported the following (Figure 1) [7].

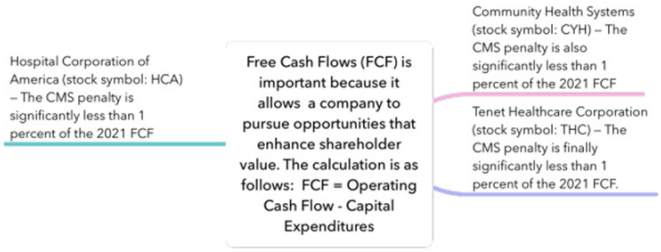

Figure 1: Three publicly traded hospitals in the United States.

We believe the public should understand this quagmire and to prepare for challenges on the horizon regarding the delivery of healthcare in the US by the year 2030.

In 1960, total national health expenditures as a percent of Gross Domestic Product (GDP) was only a meagre 5 percent compared to 19.7 percent in 2020, quadrupling as a percentage of GDP across 60 years [8]. By comparison, the United States economy is over 30 times larger. Our extensive health economics research predicts that this figure will exceed 25 percent by the year 2030, meaning that the government will require one out of every four American taxpayers to commit practically their entire annual incomes towards paying the country's healthcare demands. Simply put, this gigantic burden on the public with force the United States to become significantly weaker against foreign competitors across nearly every industrial category imaginable.

Medicare enrollment by 2030 is projected to grow to over 80 million people. Of these aging Baby Boomers, 40 percent are expected to have diabetes; 43 percent are expected to have heart disease; and 25 percent are expected to have some type of cancer (unless miracle breakthroughs in medicine occur). Additionally, the percentage of Medicare beneficiaries with all three (diabetes, heart disease, and some type of cancer) or other chronic condition is projected to increase to 40 percent by 2030. Facing these challenging predictions of 80 million Medicare beneficiaries by 2030, the 3.6 million projected demand for Registered Nurses (RN) in 2030 will translate into a tragically abysmal ratio of 22 patients for every RN employed nationwide. The retirement of one million veteran RN's between now and 2030 means that years of nursing experience and knowledge accumulated will be lost to the nursing workforce as these expert RN's exit the workforce. Hospital workers overwhelmed by multiple patients assigned to their list of responsibilities have a greater tendency to become injured. The average loss per claim settled for hospital workers' injuries is predicted to be equivalent to $24,458 by 2030.

Assuming the 294,000 number of nonfatal workplace 7 injuries annually remains unchanged, these settled claims would cost the entire hospital industry $7.2 billion annually by 2030. By 2030, additional factors will challenge the future nursing workforce. First, as elderly obesity increases, the projected 2030 figures will be much worse than the current level of 6.0 cases of occupational injuries per 100 full-time healthcare workers. Second, the increasing necessity to retain expert RN's is beyond the current projected retirement ages. As if all the above were amply difficult to overcome, there is another immense hurdle for elderly over 65. In 2016 dollars, this group averaged $11,316 in out of pocket health spending, which represents 36 percent of the share of total spending on health care. Forecasting this figure forward on a straight-line trajectory means that this same group will incur a health spending per capita of $19,360 in 2030 dollars (using only a 4.75 percent future medical inflation rate annually). By 2030, Medicare will need more than $1.548 Trillion to service these 80 million enrolees [9].

Economist Thomas Sowell succinctly explained, there is never enough of anything to fully satisfy all the people who want it. Simply put, healthcare prices will progressively become unbalanced because most people cannot stop purchasing healthcare services regardless of price increases, no matter how high the price of healthcare services. Economists define this situation as cost-push inflation, and it can only exist when people do not have alternatives and are forced into buying the healthcare goods and services despite the price increases directly created by this significant supply scarcity. The second main reason causing cost-push inflation is because for decades the inefficient healthcare infrastructure plus the inability to protect against the kryptonite of hospital financing (uncompensated care) led the industry to portray all the benefits of a monopoly with nonexistent competition. Few Americans can afford the alternative of traveling abroad to participate in medical care tourism, receiving and paying out of pocket for medical goods and services outside the United States.

American senators elected to office have known about this problem for decades through the 57 consecutive annual reports written to date by the U.S. Centers for Medicare & Medicaid Services (CMS). Where most people see problems in the horizon, a few foresee opportunities in the horizon. Our goal in this article was to explain this dilemma so most people can understand the ramifications of the dilemma, which will be a matter of life or death for 80 million Baby Boomers by the year 2030. We hope readers of this article will be among the few who will use this newly acquired knowledge to adjust their future horizons regarding their need for healthcare by the year 2030. The only real solution is self-care and self-preservation.

Conflict of Interest

The authors declare no competing financial interest.

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No.

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