

Growing demand and eroding health care provider operational capability are crippling health and economic wellbeing in rural America

...a look at how Medicare's Financial Challenges are affecting rural areas and what it means for 2025 and beyond

**It's
getting
worse**

In 2022, Medicare provided specified health care services to more than 65 million people, nearly one of every five Americans. That population of enrollees includes those age 65 and older, disabled persons, and/or persons with select severe illnesses, all population segments that are more prevalent in rural areas than urban areas (see below)¹.

The impact and after effects of the pandemic and Medicare's increasingly apparent lack of fiscal sustainability are putting both rural and urban Medicare enrollees at risk, but the situation in rural areas is deteriorating at a significantly faster pace that can legitimately be described as a crisis for rural seniors, their families and their communities.

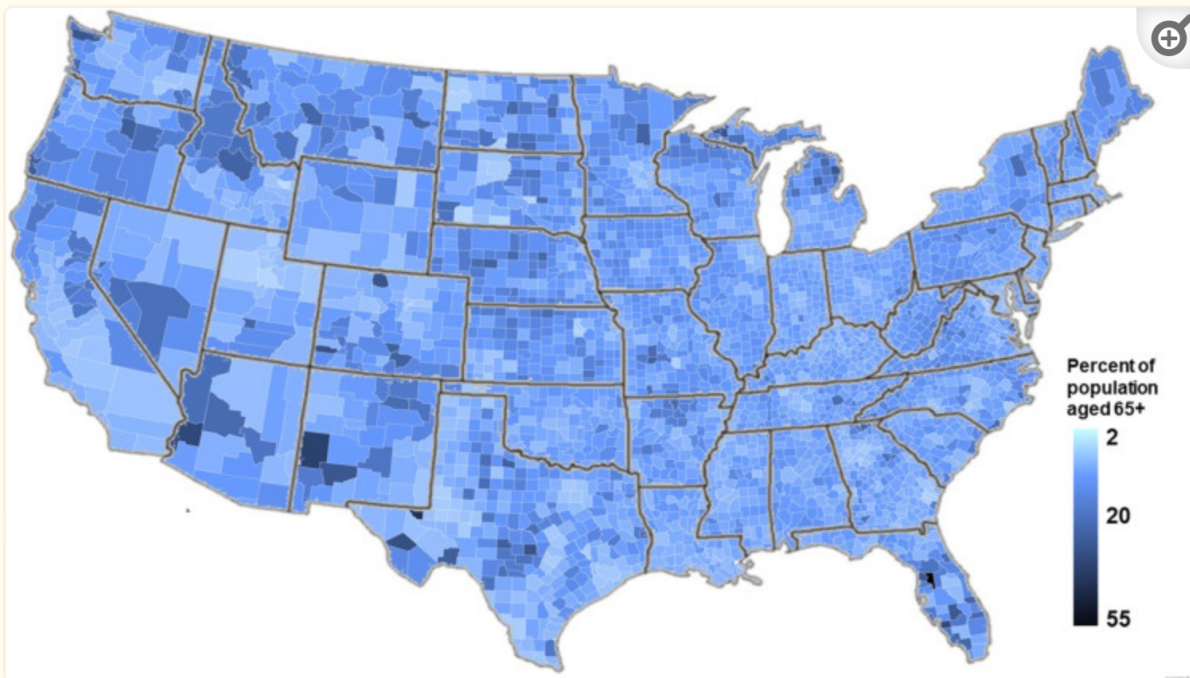


Fig. 1

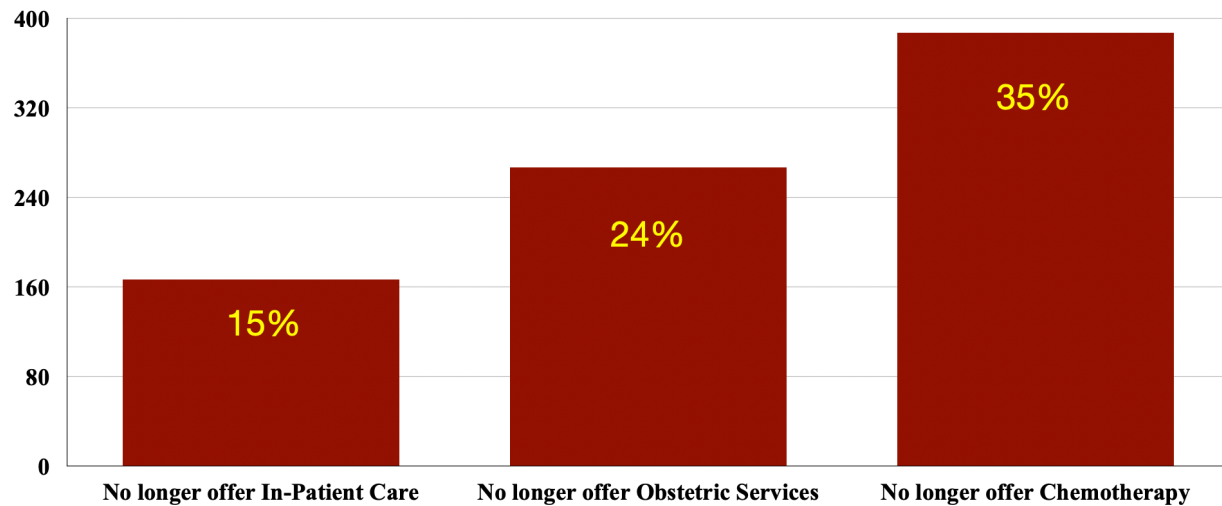
Percent of the population aged 65 + by county (source data: US Census 2020)

More specifically, health care workforce shortages, increasing demand and costs, decreasing reimbursement rates and cost-shifting have led to a much faster erosion of the ability of rural health care

¹ [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9644394/#:~:text=The number of people in,lives in rural areas \(Fig.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9644394/#:~:text=The number of people in,lives in rural areas (Fig.)

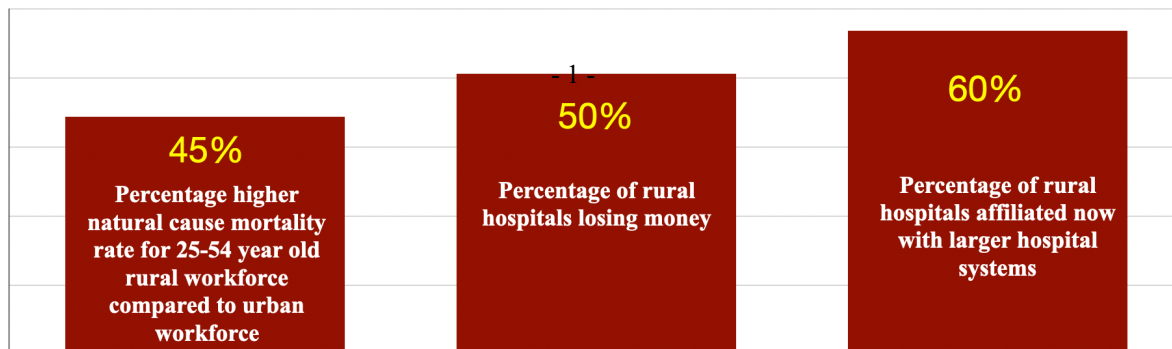
systems to provide Medicare covered services to enrollees and to critical workforce age populations in rural areas. (See below)

Of the 1,100 rural Hospitals in the United States...



And, critical health status and other demographic and economic factors reflect the spreading limitations on delivery of care. (See below)²

In rural areas.....



² There are other contributing factors: Rural areas have by definition fewer people, with overall smaller contributions to GDP. Urbanization has encouraged a net loss of young people from many rural areas, leading to older average age in rural areas with greater dependence on Medicare. More over, incomes in rural environments are generally less per capita than urban neighbors. Medicare pays about 35-40 % what what employed populations pay by fully or self-insured mechanisms in recent years. Over generations, these underinvestments accumulate and result in decreased access to care and consequent poorer health status.

Medicare Insolvency is a big problem

Health care expenditures at ages 65+ are much higher than at earlier ages, while income at ages 65+ tends to be much lower than at earlier ages. For this reason, additional monies for health care are needed for many people at ages 65+. The program also provides benefits for some disabled individuals under age 65. Some form of risk transfer system is necessary to address these risks, and Medicare was intended to do just that.³

Unfortunately, Medicare is now grappling with a variety of factors that have generated significant financial problems, including:

● **Demographic Shifts**

- ➔ People turning 65 are living ~15 years longer today than at the inception and design of Medicare in 1965, while the age of eligibility for Medicare has remained age 65.
- ➔ People are having fewer children today than in 1965; this means fewer than expected Medicare tax paying workers are entering the work force.
- ➔ The net immigration inflow to the work force has also declined during this period. D. The combination of these three factors has led to a dramatic reduction in the ratio of [current contributing workers] to retirees (from roughly 5 in the early in Medicare program years to less than 3 now). As this ratio declines further, which is expected, the current tax/benefit relationship cannot be sustained.

● **Flawed Benefit Design, including Program Changes and Failure to Recognize Impacts of Inflation**

- ➔ The benefit design of the Medicare program encourages high utilization of services, as nearly all costs are paid by Medicare Fee for Service or Medicare Advantage.
- ➔ Medicare pays roughly 75% of all costs, and where private supplemental coverage exists, only a few per cent of costs are paid out of pocket.
- ➔ The design of Medicare in numerous instances covers costs that are predictable, while leaving some catastrophic costs as out-of-pocket, neither of which fully comport with the principles of insurance.
- ➔ Over the years, Medicare has expanded benefit eligibility, such as covering disabled individuals under age 65 and adding more covered benefits. These changes have not only increased costs due to more covered benefits and corresponding higher utilization of such services, but also have likely contributed to inflation of medical costs both within and outside of Medicare.

● **Inadequate funding Mechanisms**

- ➔ From its inception, Medicare was designed to be primarily pay-as-you-go funding, with no intent to become fully funded to cover accumulating benefit liabilities. Modest accumulations occurred in the early years of the program when there were many contributing workers, and relatively few beneficiaries.

³ An estimated 65 million people will receive Medicare benefits in 2023 via Medicare Parts A - Hospital Benefits, Part B - Professional Services, Part C - Medicare Advantage Program, and Part D-Prescription Drugs. Benefits under the program are “earned” for Parts A and/or C through lifetime payment of wage related taxes; once “earned”, benefits are payable based on a fixed formula and are not conditioned on other criteria. Part B and D benefits are conditioned on eligibility for Part A benefits and payment of premiums for Part B and D; those premiums are intended to cover roughly 25% of covered costs with the remaining costs covered by other federal tax revenues.

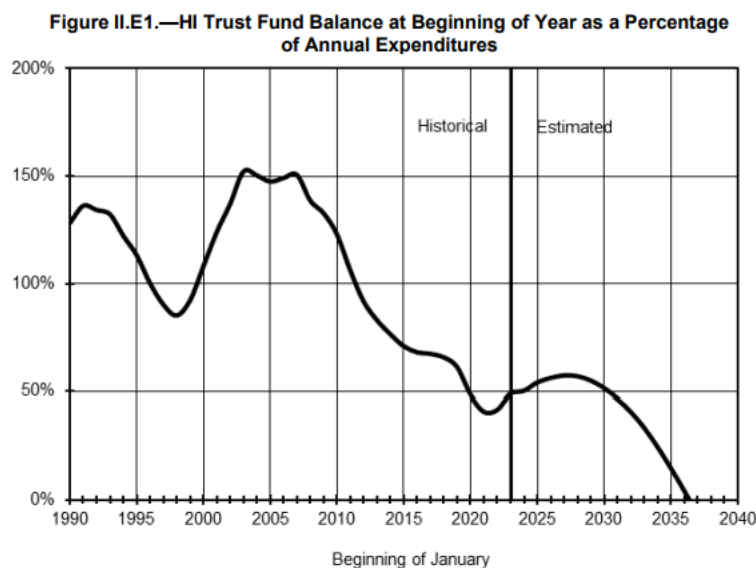
- ➔ Trust Fund investment earnings have not provided meaningful support for plan benefits; primarily because the accumulations were modest; and secondarily because, by law, funds can only be invested in government securities which historically have provided lower returns than other investments (and which have produced artificially low returns for the last 15 years of monetary policy that programmed low interest rates).
- ➔ As the demographic changes have combined with the design and related issues, the modest amounts in the Trust Funds have been further depleted.
- ➔ Medicare has attempted to mitigate funding issues repeatedly by setting prices to vendors at well below market prices; this has had serious ramifications on access to care, utilization of adjacent services and population health status across the entire health care system. These price restraints have not stemmed the financing difficulties.

● Violations of Professional Principles

- ➔ In summary, the combination of the issues above have culminated in a violation of numerous professional principles as established by the actuarial, economic, accounting, medical and legal professions.

These impacts would be predicted to be more prominent where Medicare coverage is a greater proportion of population coverage, for instance, in rural areas.

In the May 2024 Medicare Trustees' Report, the Hospital Insurance Fund Reserves have fallen to ~50% with a negative trend since 2008. If the Fund Exhausts, there is a required combination of decrease in benefits or reimbursements for services, estimated to be ~11%.⁴



There is substantial uncertainty in the economic, demographic, and health care projection factors for HI trust fund expenditures and revenues. Accordingly, the date of HI trust fund depletion could differ substantially in either direction from the 2036 intermediate estimate. As shown in greater detail in section III.B, trust fund assets would increase throughout the entire projection period under the low-cost assumptions. Under the high-cost assumptions, however, asset depletion would occur in 2030.

Without any changes to the

⁴ <https://www.crfb.org/our-work/projects/medicare-hospital-insurance-trust-fund>

existing program, Health Insurance Trust Fund dollars are projected to be depleted in less than 10 years.⁵ If that happens, benefit amounts by law will be automatically reduced so that the program can continue to operate. In there is insolvency, after the initial 10% reduction additional reductions would be expected.⁶ Unlike Social Security benefit reductions, where benefits are proportionately reduced across all recipients, benefit reductions in Medicare would be made by reducing payments to providers and reductions in services covered, affecting most those that use services the most. The ramifications of these actions would be to reduce access to medical services over time, which would result in a cascade of other negative impacts on the health care system and the patient's health status. Impacts to rural areas would be amplified by decades of differential systematic Medicare underinvestment, a higher proportion of older individuals, and lower overall per capita income.

The complexities and challenges that Medicare is currently facing are considerable, shaped by shifting demographics, a benefit design that did not anticipate the costs of care and longevity, and struggling funding mechanisms. Nevertheless, Medicare's role in safeguarding public health and serving the aging population remains essential. In rural areas, the underpayment of Medicare as compared to employer payments from sparsely distributed businesses, the older demographic, the lower per capita income, the higher mortality rate at younger age especially strain Medicare's ability to meet the needs of rural citizens. This is accentuated by the loss of rural programs including inpatient care, chemotherapy, and the economic strain that leads to surrendering OB, often desired if not necessary to retain young families. Program adjustments that take advantage of tighter civic relationships, closer relationships with business and a renewed and authentic focus on primary care that demonstrates impact to health status appear necessary. The financial strain might seem overwhelming, but with thoughtful adaptations and strategic implementations, these pressures in both urban and rural environments can be mitigated.

As we look towards the future, continuous exploration by community members who can trust and collaborate together toward solutions will be critical in ensuring the durability and efficacy Medicare to optimize individual health. In doing so, we can test solutions in smaller rural populations and ultimately translate learnings to urban areas to optimize the health our generation should be able help one another sustain.

Conclusions, Options & an Invitation to learn more It is clear that the current Medicare system is in urgent need of redesign and that actually fixing it will require some combination of benefit cuts, tax/premium increases, changes in funding mechanisms, compliance with professional principles and other program changes.

The Concerned Actuaries of the United States (CAUS)⁷ is a 501(c)(3), non-partisan, organization dedicated to providing public and private sector decision-makers with the comprehensive, holistic analytics they need to assess the most likely outcomes of the policy changes they are considering. To that end, CAUS has spent the past two years developing a Comparative Actuarial Assessment Model (CA2M) capable of holistic analysis customized to specific proposals and circumstances.

⁵ <https://www.crfb.org/our-work/projects/medicare-hospital-insurance-trust-fund>

⁶ Concerned Actuaries.org