Options to Extend Medicare’s Trust Fund: Lessons From Japan’s Statutory Health Insurance

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Abstract
Medicare’s Hospital Trust Fund is projected to become insolvent sometime during 2028 and there will be insufficient funds to cover the costs of beneficiaries’ care if reforms are not made before then. Many options have been proposed on ways to extend the trust fund’s solvency. Some proposals focus on controlling costs and other proposals include options for raising revenues. A fresh perspective on this policy dilemma may arise by considering Japan’s statutory health insurance (SHI) and its financing mechanisms. Japan could be a useful model because it has an older population and it is facing similar fiscal challenges before Medicare. Japan could offer some useful perspectives from its cost containment efforts to extend Medicare’s solvency.

Keywords
Medicare, Hospital Trust Fund, Japanese health care system, cost containment

What do we already know about this topic?
Medicare’s Hospital Trust Fund is projected to become insolvent sometime during 2028 and there will be insufficient funds to cover the costs of beneficiaries’ care if reforms are not made before then.

How does your research contribute to the field?
This research offers a fresh perspective on this policy dilemma by considering Japan’s statutory health insurance (SHI) and its financing mechanisms.

What is your research’s implication toward theory, practice, or policy?
This research could offer some useful perspectives to extend Medicare’s solvency based on Japan’s cost containment efforts, such as co-financing Medicare through a value added tax or an annual spending target.

Medicare’s Hospital Trust Fund is projected to become insolvent sometime during 2028 and there will be insufficient funds to cover the costs of beneficiaries’ care if reforms are not made before then. Many options have been proposed on ways to extend the trust fund’s solvency. Some proposals focus on controlling costs and other proposals include options for raising revenues. A fresh perspective on this policy dilemma may arise by considering Japan’s statutory health insurance (SHI) and its financing mechanisms. Japan could be a useful model because it has an older population and it is facing similar fiscal challenges before Medicare.

Japan’s SHI established more than 50 years ago provides universal coverage. SHI has been able to achieve lower spending per capita than the United States through several cost control mechanisms. Japan has a national fee schedule set by the Central Social Insurance Medical Council. The fee schedule establishes a point system for health care services and prescription drugs—it includes about 4000 service items and 17000 prescription drugs. Under the fee schedule, each health care service is assigned points and a conversion factor translates those points into a payment amount. For example, one point equals 10 yen and a typical physician office visit is worth 280 points or 2800 yen or about $25PPP in 2021. Providers are paid on a fee-for-service (FFS) basis and each provider is paid the same amount for delivering a service without adjustments for geographic location, size, or
whether a provider is in the public or private sector. Although paying providers the same amount for a given service seems disadvantageous to providers with higher costs, such as large urban hospitals, physicians in urban areas appear willing to work for lower wages than those in rural areas. Despite this, there are no widespread provider shortages.1

The provider fee schedule is revised every 2 years and a target revision rate, which acts as a global budget, is set for spending increases. Individual services can have increases or decreases above or below the revision rate as long as aggregate health care spending remains within the target. The revision rate update takes into account population aging and a shift toward new technologies. Historical health care expenditures have increased by about 2% per year. Additional adjustments are made to the national fee schedule to reduce the prices of existing drugs and for services with unjustified increases in volume in the previous 2 years so that the prices of other services can be increased. The fee for new services are set to the most similar existing procedure. For example, when MRIs were first introduced to the fee schedule, its fee was set to be twice as much as a CT scan and not a tenfold price difference in the purchase cost of the equipment at that time.1

Japan’s fee schedule outlines the specific conditions under which a provider can receive payment. For example, a hospital can bill for rehabilitation therapy only if it has a certain number of therapy staff and a patient suffered an injury or stroke within 150 days. Compliance with billing requirements are enforced through a claims review process and onsite audits, and revisions to the billing requirements can be made up to 4 times a year by the Ministry of Health, Labour, and Welfare.1 SHI is financed through premiums, cost sharing, and general revenues.2,3 Because Japan’s social security system has been experiencing significant budgetary pressures due to its rapidly aging population, the country increased its value-added tax (VAT) from 8% to 10% in 2019 to help pay, in part, for the medical care for the elderly as well as other programs, such as pensions.

**Lessons for Medicare’s Trust Fund**

Japan could offer some useful perspectives from its cost containment efforts to extend Medicare’s solvency.

Unlike Japan, Medicare does not have an annual spending target but rather it has a hard spending cap once the trust fund is exhausted. The Office of the Actuary projects Medicare hospital spending growth will be about 8% in 2024 to 2028.4 Medicare Part A could establish an annual spending target to constrain spending growth similar to the Independent Payment Advisory Board (IPAB) or the sustainable growth rate (SGR) formula for physicians. Strict price regulation through a uniform fee schedule under Medicare could help Medicare’s solvency. Both IPAB and SGR were later repealed, however, because of fears of rationing and large provider payment cuts. To enforce compliance with the spending target, future inpatient prospective payment system (IPPS) updates could be adjusted downward for any unexpected increases in volume and/or intensity. The approach of implementing an annual spending target, however, highlights the significant political challenges of restraining provider payment rates under current law.5

In addition, a drawback of this approach is that unlike in Japan, Medicare does not have universal pricing power across all payers and it only has the ability to set prices for Medicare FFS enrollees. Unlike in the United States, Japanese providers have given up their professional freedom to negotiate prices in favor of government control, but providers see a large volume of patients to increase their income. By contrast, US providers firmly believe in price negotiations with health insurers.

Under an all-payer rate setting system, if Medicare’s prices are set too low, providers would likely stop accepting Medicare patients in favor of the commercially insured because commercial payers pay about twice as much as Medicare for hospital services.6 Conversely, providers with a large share of Medicare beneficiaries would likely exit the market if Medicare’s rates do not at least cover their costs. Extending Medicare’s monopsony price regulation to the entire health care system, such as an all-payer system similar to Japan, would be needed to avoid the shifting of services outside of Part A. A potential unintended consequence of a global revision rate applied only to Part A is that hospitals would likely substitute toward services not subject to the spending target instead of inpatient care. Ideally, Part B services would be included to discourage shifting to other sites of care like in Japan.

Secondly, Japan’s medical care for the elderly is financed, in part, through general revenues from its VAT. U.S. policymakers could consider establishing a targeted excise tax on all goods and services. Such an approach would create greater public awareness and more transparency regarding the challenges of Medicare’s solvency.

Third, Japan’s claim processors use artificial intelligence (AI) to check claims for improper billing and coding. If a claim fails a logic check or it has missing information, the claims processor reduces the number of points assigned to the service and this results in a lower final payment amount. Although Medicare is slowly leveraging new technologies, such as AI and machine learning to reduce improper payments, similar to Japan, Medicare could more quickly adopt such technologies and implement more sophisticated algorithms.7

Lastly, Japan pays providers the same regardless of geographic location and this uniformity of payment has not resulted in any maldistribution of providers across the country. US policymakers could consider simplifying Medicare’s hospital wage index and provide additional supplemental subsidies to safety net and critical access hospitals, if needed. MedPAC recently held discussions on reforming the wage index. Because most wage index adjustments are financed through budget neutrality, IPPS hospitals that have higher wage index adjustments have an advantage over those
without such adjustments. Some issues have been raised about the wage index’s geographic reclassification because hospitals can be reclassified to a different market for purposes of determining their wage index. The rural floor has raised concerns because urban hospitals cannot be paid less than those in rural areas.  

Conclusions

To extend Medicare’s trust fund’s solvency, US policymakers will need to increase revenues, reduce expenditures, increase deficit spending, modify benefits, or some combination. Japan’s cost containment efforts could offer some useful insights into options for Medicare. Those policy lessons include an annual spending target, co-financing Medicare through a VAT, using artificial intelligence to check claims for improper billing and coding, and simplifying Medicare’s hospital wage index.

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Ethical Approval

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