

Meeting Medicare's Future Needs

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Affairs**

"Cost and Payment of Medicare Part D"

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**Note: The opinions expressed in this testimony reflect those of the author and not
of AIR or its Board of Trustees**

Mr. Chairman: I am pleased to be here today to discuss issues surrounding the new Medicare prescription drug benefit and cost issues facing Medicare in general.

My testimony argues that Medicare is not a failed program nor unsustainable as some of its critics contend. For 40 years, it has provided nearly universal coverage to a vulnerable population group, changed with the times, and done a better job of constraining costs than has the private sector. This government health care program remains popular with its constituents. In fact, it fares better than private insurance in polls of satisfaction with health insurance. And although financing challenges exist, they are not insurmountable. Maintaining its success and the features that people value about the program should be paramount. From the perspective of Medicare beneficiaries, the goal of changes in Medicare should be to seek genuine efficiencies in the delivery of medical care, to assure access to care for this population, particularly those with limited resources, and to find an equitable way to finance the program.

While concerns about the costs of Medicare are important, it is also the case that Medicare cannot function well if it is inappropriately restricted. The new prescription drug benefit—although limited in its comprehensiveness—is an important addition essential to assuring access to good health care. Delaying its implementation would be detrimental to Medicare beneficiaries. Finding the right balance of comprehensive benefits, access to care, and sources of financing are important decisions for assuring a stable future for Medicare. My testimony today makes several points about Medicare's costs and affordability:

- Historically, Medicare has done as well or better in holding down the costs of care as the private insurance system;

- Improvements in the efficiency and appropriateness of care can help reduce costs but will not be enough to avoid a greater need for financing for Medicare over time;
- Shifting more costs of the program onto beneficiaries is a means of financing and needs to be weighed against other financing options such as higher taxes;
- Medicare—even with drug benefits—is affordable over time; the more relevant issue is whether taxpayers are willing to pay more.

GROWTH IN MEDICARE COSTS

Medicare, like the rest of healthcare spending, has grown at a rapid clip when measured as a share of Gross Domestic Product (GDP). The addition of a drug benefit in 2006 means a substantial upward shift in program spending as compared to GDP. And with the first members of the Baby Boom generation nearing age 65, Medicare promises to grow even faster beginning in 2011 (see Figure 1). But as can also be seen in the figure, the growth closely tracks the increase in the share of Americans receiving Medicare. Medicare has already doubled the number of persons it covers and the numbers will double again by 2030. This doubling of the population in the future will substantially expand Medicare beneficiaries as a share of the total population.

The factors driving Medicare costs upward are not unique to the public sector. They are found throughout our nation's healthcare system, with the rising costs hitting all payers: individuals, businesses, and governments. Medicare influences the overall healthcare system, and vice versa. Although Medicare has been a leader in curbing the costs of care, both in terms of

increasing prices and use of services, costs continue to rise.

As compared to private insurance, Medicare has mostly held the line on growth in healthcare costs in the 1980s and 1990s. For example, between 1985 and 1992 Medicare had lower rates of growth--often considerably lower--than did private insurance. The mid 1990s did experience a short-lived slowdown in private sector spending growth relative to Medicare, the costs are again growing at nearly the same pace. Thus, a historical look at the data suggests that Medicare is not out of sync with the rest of the health care system. Indeed, the patterns in spending growth are very similar, and often below that of private insurance. This is particularly important given factors that could be expected to drive up the costs of care for this population relative to others. For example, Medicare's population is aging overall, adding modest pressures for higher spending over time (Moon 1999). Further, as new technology becomes safer and more effective, it is likely to expand faster among more frail populations like aging Medicare beneficiaries. The important lesson from comparing Medicare to other payers is not so much which sector is doing better at holding the line on costs at one point in time, but rather that healthcare costs tend to change in tandem no matter what the source of payment.

CHANGES TO POSITION MEDICARE FOR THE FUTURE

Efforts to achieve slower program growth have generated ad hoc efforts during many of the annual federal budget cycles since the early 1980s. Over time, these efforts substantially slowed Medicare's rate of growth, culminating in 1997 with substantial cutbacks as part of the Balanced Budget Act. In fact, the 1997 legislation (and some later efforts at reducing fraud and abuse) resulted in substantially lower projections for Medicare spending in the future. In 1998 and through 2000, the projections for spending on Medicare as a share of GDP declined (Figure

2). In fact, in 2005, even after the inclusion of a drug benefit, projections for spending are lower than in 1997. Progress can thus be made over time in holding down Medicare's costs.

Proposals to find additional ways to reduce the costs of providing healthcare to disabled and elderly Americans that eliminate unnecessary care or achieve greater efficiencies can reduce the overall bill for the program. Efforts to make progress on such changes should continue and will be important to Medicare's future. However, we should not be overly optimistic that such savings can overcome the need for increased financing over time.

One popular "magic bullet" suggested has been to shift beneficiaries away from the traditional Medicare program into private health insurance options as a way of achieving cost-saving efficiencies. Many policy makers have put their faith in the market and competition with little actual evidence to back this up. On balance, Medicare's per capita spending growth has actually been below that of private insurance since the early 1970s. Medicare has low administrative costs and gets very good discounts from doctors, hospitals and other providers of care. Thus, to save costs as compared to Medicare, private insurers would have to find improved ways to limit the use of services. This was the hope of managed care in the mid-1990s in the employer health insurance market, but few companies did it well. Push back from consumers and care providers to the arbitrary controls many insurers imposed reduced the hope that managed care would be an easy solution. Finding more reasonable ways to control the growth of costs poses a difficult challenge for both the public and private sectors.

Further, studies have indicated that people with health problems and the very old are not likely to shop for the cheapest health plans—one of the goals of competition. Disrupting health care treatments and finding new providers of care is not only distasteful to many consumers, but also can add to the overall costs of care. Savings from competition and reliance on private plans

will not go very far, however. Such efforts alone cannot assure that the numbers of individuals becoming eligible for the program can be provided.

Many of the remaining proposals to reduce Medicare spending focus on shifting costs onto beneficiaries and away from government spending is an answer for those opposed to taxes but not necessarily for reducing costs of health care to society as a whole. The argument has been to shift more of the responsibility for care to patients. Make them pay high deductibles and copays and they will become responsible consumers. Or, create a voucher program and shift the risks of higher costs over time to consumers. The problem is that this form of consumer “empowerment” can quickly become consumer “impoverishment” especially if consumers are ill-equipped to make decisions about what care is necessary and which providers are the most “efficient.”

And, while senior citizens and persons with disabilities are better off than in the early days of Medicare, most are not driving golf carts at clubs in Florida. Rather, their incomes at best could be considered modest, and except for the wealthy, few have substantial assets upon which to draw. Over half of elderly households have per capita incomes below \$25,000 per year. Baby boomers’ incomes will be a little higher, but incomes will be slow to rise over time. Further, beneficiaries already devote a substantial share of their incomes to healthcare costs (Figure 3). By 2004, they were spending more than before the passage of Medicare. High healthcare spending affects out-of-pocket costs as well as uncovered services. Medicare currently covers only 55 percent of the acute health care costs of its beneficiaries. This share will improve under the new prescription drug benefit, but only modestly.

Another way to shift costs away from government that has been suggested would be to raise premiums on those who do have more resources. But relying on rich seniors to help pay for

Medicare over time just doesn't get you very far because there are too few of them. The only way to make this a "solution" is to treat the definition of high income as \$30,000 or \$35,000 per year. At best, this would be only a modest part of any solution.

A third approach, mirroring one of Social Security's options, would be to raise the age of eligibility for Medicare. But for healthcare, there are substantial barriers. Pushing people out of Medicare would often mean that they would have to seek insurance in the private individual market, which currently functions well only for those without substantial health problems. A 66 year old with multiple health problems would likely find private insurance either very expensive or not available at any price. And reform in every state of the private individual market is not likely to happen any time soon.

Options for "saving money" under Medicare that simply shift costs onto beneficiaries implicitly answer the question of who should pay as "beneficiaries, not taxpayers." Yet the choices are seldom expressed that directly. Rather, in response to questions about the sustainability of Medicare, the usual answers tend to be that beneficiaries must bear a greater share of the costs, or that age of eligibility must change. But this sidesteps the question of who *should* pay by implicitly indicating that while "we" as a society cannot afford the taxes to pay for healthcare for an aging population, that somehow the elderly and disabled themselves can afford to do so.

What then are viable solutions? It is likely that, as in the past, Medicare will need to be re-evaluated periodically to seek savings where feasible and consistent with the rest of the healthcare system. Improving the delivery of health care so that as a society we get the biggest return for our dollars should be on everyone's agenda. Many studies have shown that Americans spend more than necessary on health care. But, efforts to identify unnecessary care and reduce it

are difficult; patients do not like to be controlled and careful attention to all the needs of a patient can sometimes result in higher costs. Investment in better information on what works is both needed and a logical role for society as a whole. Patients need to trust that denial of some services is justified by evidence and not just cost containment. The new prescription drug benefit would be a good place to start such an effort. This can save over the long run, but again is not likely to rise to the status of a “magic bullet.” One way or another, society will have to find ways to pay for health care or accept the costs of unmet needs and the resulting lower quality of life for the Medicare population. Saving dollars for the federal government is not the end of the story. Changes that simply shift costs, such as premium increases or raising the eligibility age, are more appropriately considered financing options and should be contrasted with tax increases in the debate over Medicare’s future.

MEASURING MEDICARE’S FINANCIAL HEALTH

Medicare is currently financed in a variety of ways. Part A relies mainly on payroll taxes with a modest contribution from part of income taxes on Social Security benefits. Part B is financed by enrollee premiums set at 25 percent of the costs of Part B benefits for elderly beneficiaries, and by general revenue contributions sufficient to cover the remaining costs. Part D will use essentially the same financing structure as Part B.

Medicare’s financial health can be viewed from several perspectives. The appropriate question over time is whether, *as a society*, we can afford to support Medicare. That is, are health care costs for the elderly and disabled beneficiaries likely to be so high that some people will need to go without care? And how should that be balanced against healthcare priorities across all age groups and as compared to other spending? The severe limitations imposed by looking only

at current or future federal revenue burdens implies that limitations on government spending can “solve” the problem. But since people will still need to get care somewhere, if the burdens are simply shifted onto beneficiaries and their families, *society* will be no better off. In that case, the issue essentially becomes one of *who* should pay. It is important to look carefully at the claims made on Medicare’s financial status, and recognize that both spending and financing issues are at stake.

Existing Measures

The first and most commonly cited measure is the date of exhaustion of the Part A Trust Fund. This is one of several basic measures that have traditionally been reported in the Medicare Board of Trustees annual reports on Medicare’s financial outlook. The Part A Trust Fund was designed to assure that the designated payroll tax contribution would be used specifically for Part A—Hospital Insurance— spending. As dedicated revenues, payroll and other revenue sources that exceed the amount necessary to cover Part A benefits go into the trust fund and collect interest. When the forecasts indicate a declining balance in the trust fund, this is an early warning of the need for an adjustment either in revenue contributions or spending on the program.

Projections of the Medicare Part A trust fund indicate that it will maintain a positive balance through 2020. Considered in historical context, the date of projected insolvency has moved up compared to 2001, but still remains further into the future than it has been over most of Medicare’s history. The trust fund balance in 2004 was \$269 billion or 158 percent of annual Part A expenditures. It is expected to grow to \$334 billion in 2011 and then decline over time as a share of Part A spending. Certainly this signals a need for change.

However, this measure ignores Part B issues and so does not take into account the full size of the Medicare program. But since Part B's trust fund is kept in balance by automatic infusions of general revenue and funding for the two parts are kept separate by law, a "solvency" measure is difficult to devise for Medicare as a whole.

A second indicator often cited is the ratio of workers contributing to Medicare at any point in time compared to the number of beneficiaries. This measure shows that, given the aging of society, the number of younger persons relative to older ones will decline in the future. This declining ratio of workers to retirees indicates that each worker will have to bear a larger share of the cost of providing payroll tax-financed Medicare benefits. Indeed, the numbers are quite dramatic. Between 2000 and 2035 (several years beyond when most Baby Boomers will have become eligible for Medicare), the ratio of workers to beneficiaries will fall from 3.90 to 2.21. This change represents a 43 percent decline in the ratio through 2035. Indeed, this is one of the statistics commonly cited by those who claim the program is "unsustainable." This measure does signal the need for more revenues per worker—a legitimate issue for debate. However, it fails to assess the level of burden relative to ability to pay from each future worker, ignoring any improvement in the economic circumstances of workers over time due to per capita economic growth.

A third measure, which has long been included in the annual reports but is now getting more attention, is the sum of Part A and B spending as a share of GDP. In 2000, Medicare's total share was 2.3 percent and is projected to rise to 5.0 percent in 2030 for Parts A and B and to 6.8 percent when prescription drugs are included (again see Figure 1). This represents nearly a tripling of the GDP share. Such an increase reflects the fact that health care costs per capita are expected to continue rising, and the number of people covered will double over that time period.

This measure puts potential costs into the context of U.S. aggregate production and offers more information than the worker-to-retiree ratio. Also, since both Parts A and B are included, it provides a broader look into the future than when the focus is only on Part A solvency. It is not a very intuitive measure, however, as there is no natural benchmark for what an appropriate share would be, particularly as the share of the population covered by Medicare rises over time. In addition, it may not be as helpful in the debate on Medicare's future because it does not consider how well off we will be as a society as the level of GDP grows. Some goods and services, like health care, may appropriately grow as a share of GDP in response to higher living standards.

A More Comprehensive Measure of Affordability

Another way to look at affordability is to focus not just on the *number* of workers that contribute to payroll and income taxes nor on aggregate GDP, but instead on how the Medicare per capita burden will affect workers over time. While the share of the pie (GDP) going to Medicare is likely to rise, if the pie (on a per capita basis) is also much larger, then an increasing share is less of a burden. If the future leads to increased national well-being, additional resource sharing would be affordable. So another way to examine affordability is to focus on whether taxpayers of the future will be better off even *after* they pay higher amounts for Medicare. Such a measure examines whether, as a society, we can *afford* such care for this population.

The measure I prefer to use begins with computing per worker GDP over time, resulting in a measure of the nation's output of goods and services divided across the working population. It is an indicator of how well off we will be as a society over time. This provides the base for assessing Medicare's burden on workers, who pay for the bulk of support for the program. Per worker GDP—even after adjusting for inflation—rises substantially, from \$74,914 per worker in

2005 to over \$124,421 in 2035 (in 2004 dollars). This is an increase of 66.1 percent in per worker GDP, a substantial increase in financial well-being.

What about Medicare's costs over this period? The burdens from Medicare spending on each worker are projected to rise at a faster *rate* than per capita GDP because both numbers of beneficiaries and their inflation-adjusted spending will rise over time. But because per worker GDP is a much larger dollar amount than Medicare burdens, the reduction in well-being that this entails for workers is modest. Each worker will bear an increasing share of Medicare over time because of the change in the ratio of workers to retirees. Further, per capita Medicare costs are expected to rise faster than GDP by 2035, also increasing the real dollar burden on workers. But not all of Medicare's costs are borne by workers. Costs are adjusted downward by projected beneficiary contributions both from premiums and from their expected contributions to general revenues.

The resulting real per worker burden estimates range from \$1,906 in 2005 to \$5,567 in 2035 (in 2004 dollars) based on Medicare spending before adding in the costs of prescription drugs. The burden in 2035 rises to \$7,303 per worker in 2035 when the drug benefit is included. From 2005 to 2035, the increase in per worker resources (after subtracting Medicare excluding drugs) would be 60.0 percent as compared to the 66.1 percent increase in per worker GDP. When the cost of the new drug burden is added, the growth in per worker GDP falls to 57.2 percent. That is, workers would still be substantially better off than today, even after paying the full projected costs of Medicare with the prescription drug benefit. And if further cost savings are achieved as is likely, the burdens will be lower and net GDP per worker growth will be higher.

This more comprehensive measure of net per worker output also suggests that, as a society, we will be able to afford Medicare without an inordinate burden on workers or taxpayers once even modest estimates of productivity growth over time are taken into account. The pie will indeed have gotten larger. However, tax rates would have to rise to pay for such benefits. The challenge will be for society to decide whether it is *willing* to pay some or all of these costs.

DECIDING HOW TO SPREAD THE BURDENS OF MEDICARE

The combined effects of rising healthcare costs and an aging population (resulting in a growing share of the total population) will increase Medicare spending as a share of GDP. By 2030, the burden on taxpayers (who are not also beneficiaries) will be a little less than 6 percent of GDP. Also, over this period, the share of income spent by seniors and persons with disabilities will rise from the same healthcare cost increases that help drive up Medicare's spending. If, as discussed earlier, beneficiaries (and their families) pay the same share of total acute care costs through time as at present (and after adjusting for the new drug benefit), they will effectively pay an amount equivalent to about 2.5 percent of GDP in 2030 for their portion of Medicare services (and an even higher amount if non-covered services were to be included. The appropriate question for Medicare is how to balance the 2030 GDP burden of acute care costs of 8.5 percent between taxpayers and beneficiaries over time. Thus, under current law, the share will be split 70/30 between taxpayers and beneficiaries respectively. Should that balance change over time?

Although there has been little public discussion about increasing revenues to help fund the future of Medicare, it is essentially the elephant in the room that no one wants to recognize.

The impetus for change has been almost exclusively in the other direction at the federal level in recent years—i.e. lowering taxes. If Medicare is to remain without massive cuts in eligibility or benefits, additional revenues will be needed. Since it is unlikely that any one change will be sufficient to address the financing issues facing Medicare, a combination of options will likely be needed. A “fair” distribution of the burdens of financing Medicare also needs to be based on a number of considerations. Nonetheless, Medicare is affordable from the perspective of the likely economic situation of the economy as a whole.

Future workers will have higher standards of living so increased contributions are possible. But the will to support tax increases needs to be there. Further, the decision should be an explicit one, weighing the ability to pay of both Medicare beneficiaries and taxpayers (some of whom are also Medicare beneficiaries). At this point in time, it is difficult to contrast the abilities of future younger taxpayers to pay more as compared to future Medicare beneficiaries. In general, however, it would be safe to assume that living standards are less likely to rise as fast for those who are out of the labor force than for those who remain in the labor force. In addition, it is likely that seniors and persons with disabilities will face rising costs of health care over time relative to their incomes. Certainly, they are unlikely to be able to absorb enough new per capita costs to avoid any more general tax increases and still sustain a viable Medicare program. That may suggest the current balance of 70/30 between younger taxpayers and beneficiaries of Medicare’s costs might need to change.

For Medicare to remain a viable program, it will be essential to increase revenues from payroll or other broad-based taxes. Otherwise, it will not be possible to cover the growing share of the eligible population. It is just as harmful to make unnecessary cuts in Medicare as it is to ignore the need to make financing adjustments. A large number of uncertainties over health

service delivery and the private insurance market need to be resolved before it is clear what major steps need to be taken. If some of the reforms described above begin to slow Medicare growth to more reasonable levels, less restructuring or other changes might be needed over time. Thus, a reasonable strategy would be to establish a schedule of financing adjustments to be made periodically on the basis of 10 year projected costs and changes in relative economic well-being between the old and the young. If as a society we decide to support the Medicare program, we have the capability of doing so.