Backgrounder

Published by The Heritage Foundation

No. 2174
September 2, 2008

Medicare's Financial Woes: Bigger Than Official Estimates

J. D. Foster, Ph.D.

The Medicare Trustees' Annual Report released earlier this year projects Medicare's excess costs to be $85.6 trillion.[1] This amount is six times the U.S. economy in 2007. Worse, as the Trustees' Report suggests repeatedly, by rule their analysis reflects a badly flawed assumption and so their calculations understate the magnitude of the problem.[2]

The flawed assumption is that the Trustees are projecting unreasonably low rates for physician compensation under Medicare Part B. Fully acknowledging the problem, the Medicare Office of the Actuary has provided a memorandum discussing the flawed assumption and describing two illustrative alternatives.[3] Using these alternatives, it is then possible to estimate the additional amount of Medicare's excess costs attributable to more realistic assumptions regarding physician compensation.[4] Under one assumption, Medicare's excess costs rise by about $3 trillion in present value; under the somewhat more generous assumption, Medicare's excess costs rise by about $5.9 trillion, to a total of $91.5 trillion.

There is now broad agreement that Medicare must be fundamentally reformed to preserve this vital program for seniors without bankrupting the country. These estimates suggest the full extent of Medicare's fiscal woes is even greater than previously believed.

Medicare in Brief

Medicare's original elements, Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B)

Talking Points

- The federal Medicare program, the primary health insurance system for America's seniors, is financially unsustainable in its current form. The Medicare Trustees' 2008 estimate of the program's total excess costs is $85.6 trillion.
- The Trustees acknowledge an important, flawed assumption used in developing their estimate of excess costs, and provide a public memo describing the flaw, along with two illustrative alternatives.
- The flawed assumption relates to how Congress regularly overrides a significant reduction in Medicare Part B physician compensation rates that would otherwise occur automatically.
- If this flawed assumption were corrected, Medicare's excess costs would increase by an estimated $3.0 trillion under one alternative offered by the Medicare actuaries and $5.9 trillion under a more generous alternative, underscoring the need to reform Medicare quickly and substantially while providing a more realistic measure of the consequences of the necessary changes.

This paper, in its entirety, can be found at:
www.heritage.org/Research/Budget/bg2174.cfm

Produced by the Thomas A. Roe Institute for Economic Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

The Heritage Foundation
LEADERSHIP FOR AMERICA

were enacted into law in 1965. The Medicare drug benefit (Part D) was added to the Supplemental Medical Insurance program in 2004.

Part A—Hospital Insurance. Part A primarily provides health insurance coverage for inpatient care in hospitals, inpatient stays in skilled nursing facilities, and related services. It is largely funded by a 2.9 percent tax on wages, salaries, and related compensation associated with employment.

Part A total outlays will exceed total income by around the year 2011 according to the Medicare Trustees' Report, and that gap is projected to grow steadily. Part A will have exhausted its Trust Fund by 2019, evidence that the Medicare payroll tax has long been inadequate to cover the costs of the benefits promised.

After 2019, Congress may allow Part A to draw on the Treasury's general fund comprising various revenue sources such as corporate and individual income taxes, or it may legislatively reduce Part A benefits to align costs with income. If Congress fails to act, then Medicare will be forced to reduce outlays to match revenues administratively. For ease of discussion, in the following analysis Medicare Part A is assumed to make up any shortfall in income by tapping the Treasury's general fund.

Parts B and D—Supplemental Medical Insurance. The Supplemental Medical Insurance element of Medicare includes Parts B and D. Part B primarily covers physicians' fees and outpatient care. Current beneficiaries offset 24.8 percent of Part B's costs through premiums; 74 percent of the cost is subsidized by drawing on the Treasury's general fund; and the balance is covered by miscellaneous sources. The basic Part B premium in 2008 is $96.40 a month, though the premium is higher for upper-income seniors.

Part D provides a drug benefit as part of Medicare coverage. Part D also provides a sizable subsidy when seniors purchase a drug benefit plan from Medicare-approved private companies. In 2007, premiums charged under Part D offset 25.5 percent of the total cost, with the federal government subsidizing the balance of 74.5 percent by drawing on the Treasury's general fund. In 2007, the average Part D monthly premium was $27.39.[5]

Medicare's projected excess costs are the sum of the projected shortfall in Part A that begins after 2019, plus Part B and D's ongoing draw on the general fund. In 2007, Medicare drew $179 billion from the general fund primarily to cover costs associated with Parts B and D. By 2017 this figure is expected to reach $353.3 billion.[6] In effect, seniors

1. Centers for Medicare and Medicaid Services, Department of Health and Human Services, *2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, March 25, 2008, at *http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf* (August 12, 2008). The Trustee's calculation for the less-informative but more traditional 75-year time frame is $36 trillion. This is the present value of the excess of Medicare's future projected outlays above its projected dedicated funding sources. It is the present value of all general revenue that would have to be directed to Medicare beneficiaries to allow current benefits payment.

   A standard procedure in financial matters is to calculate the present value of a stream of future amounts by discounting them back to the present. The simple idea behind this is to reflect the time value of money, i.e., the principle that one would generally prefer a dollar today to having the same dollar next year. Summing the discounted values for each year then produces the present value.
2. See, for example, 2008 Medicare Trustees Report, p. 3.
3. M. Kent Clemens, Office of the Actuary, Centers for Medicare and Medicaid Services, Department of Health and Human Services, memorandum, March 25, 2008, "Projected Medicare Part B Expenditures Under Two Illustrative Scenarios with Alternative Physician Payment Updates," at *http://www.cms.hhs.gov/ReportsTrustFunds/downloads/AlternativePhysicianUpdate.pdf* (August 12, 2008).
4. These calculations are derived from a model of projections of the Medicare program. The assumptions in the model regarding future outlays, general revenue contributions, discount rates, etc., are those presented by the Medicare Trustees in their Annual Report.
5. The Henry J. Kaiser Family Foundation, "Medicare Part D 2008 Data Spotlight: Premiums," November 2007, at *http://www.kff.org/medicare/upload/7706.pdf* (August 12, 2008).

EXCESS COSTS VERSUS UNFUNDED OBLIGATION

The present value of Medicare's excess costs has often been referred to as Medicare's "unfunded obligation." This expression is accurate for the Hospital Insurance (HI), or Part A, portion of Medicare because this program has no authority to tap general revenues. Part A's expenses will first exceed its income from payroll taxes and interest in 2019, according to the Trustees. At that time, a portion of Part A costs becomes truly unfunded. Absent corrective legislation, Medicare will from that point on and indefinitely thereafter generate excess costs giving rise to an unfunded obligation. It will simply lack the resources under current law to pay all expected claims.

In contrast, because Parts B and D access general revenues as a matter of design and course, they may in theory tap general revenues to cover whatever costs Medicare may incur. Consequently, their costs in excess of organic revenue are automatically covered by general revenues. Therefore, Parts B and D cannot have an unfunded obligation. To simplify the discussion, the combined excess of projected outlays over organic income sources for all of Medicare is referred to here as Medicare's excess costs.

are paying a portion of Medicare's total costs through their premiums, workers are paying a portion of Medicare's costs through the payroll tax, and a large and growing subsidy is drawn from the pool of all other taxes paid to the Treasury.[7]

Estimating Medicare's Excess Costs

Medicare is the primary health insurance system for America's seniors and for non-seniors meeting special health and economic criteria. It is a government-run national health insurance company with a specified customer base. With rapidly changing technologies and fast-rising costs, health insurance is an extraordinarily difficult business to manage under the best of circumstances. These difficulties are heightened by Medicare's core customers—seniors—who typically have more complex, difficult, and costly health care issues than do younger individuals. For Medicare the difficulties are further elevated by the need to operate as a government agency subject to repeated changes in executive management, cumbersome government procurement and management rules, and the vagaries of congressional oversight.

Despite these issues, taking a step back to view Medicare as a health insurance company simplifies the essentials of the matter. Medicare has administrative expenses and it incurs costs when paying health insurance claims. On the income side, Medicare receives dedicated revenues from the Medicare portion of the federal payroll tax and, for a few more years, it will receive a modest amount of interest income from a Trust Fund. Medicare also receives premium income from beneficiaries. Medicare's organic revenue sources, which include dedicated tax revenues, premium income, and a handful of minor revenue sources, covered almost 60 percent of Medicare's costs in 2007.

The difference between its total costs and its organic sources of income is derived from general revenues. That is, all taxpayers collectively contrib-

6. See the 2008 Medicare Trustees Report data, Tables III.C1, Intermediate Estimates. Calculation assumes no general fund support for Part A.
7. Medicare also includes a Part C. Medicare's Parts A, B, and D allow beneficiaries to buy insurance directly from the federal government. Part C, on the other hand, is a system by which beneficiaries buy coverage from private insurance companies that have been approved by Medicare. Premiums under Part C coverage are subsidized by Medicare in an analogous fashion to the subsidies provided under the rest of Medicare. The Medicare Trustees impute Medicare's costs under Part C to the rest of Medicare so, for example, the drug benefit included in a beneficiary's Part C plan purchased from a private company is allocated to Part D's accounting of costs.

uted through their individual income, corporate income, and other non-payroll tax payments to supplement Medicare's other income sources to cover costs of administration and claims. In 2007, Medicare's total costs amounted to $431.5 billion, and taxpayers collectively contributed $179 billion through general revenue transfers.

There are many ways to calculate and refer to Medicare's long-term financial status. One of the simplest, most intuitive ways is to begin by projecting Medicare's total costs into the future, and subtracting projections of its organic revenue sources. The result is a year-by-year projection of excess costs to be met by general revenues. Taking the present value of these year-by-year estimates yields estimates of the excess costs of Medicare Parts A, B, and D of some $34.4 trillion, $34 trillion, and $17.2 trillion, respectively.[8] In total, under current law Medicare faces excess costs of $85.6 trillion. However, these figures understate the true magnitude of the problem because they reflect the flawed assumption discussed below.

The Flawed Assumption

In their Report, the Trustees warn that their estimate of projected excess costs reflects a flawed assumption regarding doctors' compensation. The Trustees' estimates reflect current law, under which payments to doctors in 2009 would be significantly lower than 2008 levels and would grow from that lower level in all future years. Congress has already acted to prevent this dramatic cutting of costs for 2009 through what is sometimes called "doc fix" legislation and will almost certainly prevent such a cut in physician payments in all future years as the Trustees' Report notes repeatedly. For example:

> Part B outlays were 1.3 percent of GDP in 2007 and are projected to grow to about 4.1 percent by 2082. *These cost estimates, however, are understated as a result of the substantial reductions in physician payments that would be required under current law* [emphasis added]. Actual future Part B costs will depend on the steps Congress takes to address the situation but could exceed the current-law projections by 7 to 8 percent in 2010 and by roughly 10 to 20 percent for 2030 or later.
>
> —*2008 Medicare Trustees' Report, p. 3.*

Doc Fix Explained. Medicare payments for physicians' services under Part B are based on a fee schedule which is updated each year. In 1997, in a poorly conceived but well-intended attempt to control growth in Medicare spending on doctors' services, Congress enacted the Sustainable Growth Rate (SGR) system. The principle behind SGR is to constrain the rise in physician payments so total spending grows no faster than the overall economy. In every year since 2002, the SGR formula has called for a significant reduction in Medicare physician payment rates. However, Congress has thwarted the SGR process and prevented these reductions from taking effect through doc fix legislation, enacting legislation either to freeze payment rates at current levels or allow a small increase.

Congress has repeatedly overridden the SGR cuts through legislation that often increased payment rates. One consequence is a growing gap between the payment rates to physicians and those specified by the SGR. Absent doc fix legislation for 2009, physician payment rates would drop by 10.6 percent under the SGR.[9] While Congress must decide what alternative to legislate, such a large drop in payments to physicians who treat Medicare patients is entirely unreasonable and highly improbable.

The Trustees refer to the near certainty of recurring doc fix legislation as the source of the flawed assumption incorporated into their long-run financial analysis. Their estimates reflect current law, not

8. These figures are derived from Tables II.B.10, III.C.15, and III.C.23, respectively, of the 2008 Medicare Trustees' Report.
9. Jeffrey Rich, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, Department of Health and Human Services, letter to the Medicare Payment Advisory Commission (MedPAC) regarding the 2009 physician fee schedule, March 25, 2008, at *http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/medpacfinal.pdf* (August 12, 2008).

their best guess of Congress' legislative correction. But the Trustees also reference in their report a staff memorandum describing the problem and providing estimates of the addition to Medicare outlays under either of two doc fix alternatives.

Alternative Assumptions

It is impossible to know how Congress will update the physician payment schedule each year, but the Medicare Actuaries offer two useful, illustrative alternatives. The first assumes Congress voids the SGR system and freezes physician payment rates at their current level, preventing the cuts to physician payments that follow if SGR were allowed to go into effect, but also not allowing any increase. The second alternative updates physician payment rates each year according to the increase in medical inflation as projected in the Medicare Economic Index (MEI). The MEI is projected to rise by about 2 percent per year. (See Table 1.)

The effect of either alternative is to raise Medicare Part B outlays permanently, with the MEI update having the greater effect. This means that Part B premiums would also be somewhat higher in each future year, and general fund contributions would be significantly higher than under current law. In the case of the MEI-based update, outlays would be $72.1 billion higher after 10 years, income from premiums would be $19.6 billion higher, and the general fund of the Treasury would be tapped for an additional $55.0 billion.

Data provided by the Actuaries also make it possible to estimate the increase to Medicare's excess costs from either of these physician fee update alternatives using the same methodology the Actuaries use when calculating Medicare's excess costs:

- If physician payments are permanently frozen, the present value of the additional excess costs would be about $3.0 trillion.
- If physician payments rise with the MEI, Medicare's excess costs would rise by about $6.7 trillion; in this case for a total of $91.5 trillion.[10]

Effects of Alternative Physician Update Rules

($ Billions)

Current Law	2007	2017
Expenditures	178.9	325.3
Income		
Premiums	46.8	83.0
General Revenue	139.6	241.1
Other	2.2	6.3
Total Income	188.7	330.4

Increase Relative to Current Law in 2017

	Freeze Physician Payment Rates	MEI Update for Physician Payment Rates
Expenditures	54.7	73.2
Income		
Premiums	14.6	19.6
General Revenue	41.0	55.0
Other	0.0	0.1
Total Income	55.6	74.7

Source: M. Kent Clemens, Office of the Actuary, Centers for Medicare and Medicaid Services, Department of Health and Human Services, memorandum, March 25, 2008.

Table 1 • B 2174 heritage.org

Conclusion

Medicare is the federal government's third-largest program by level of spending after Social Security and defense spending, and a vital program for the nation's elderly. It is also unsustainable in its current form. The Medicare Trustees' estimate of the program's long-run excess costs quantifies the problem. The Trustees make a point to acknowledge that their own estimates are based on an assumption of dramatic and highly unlikely cuts to physician compensation rates.

The Medicare Actuaries released a public memo drawing further attention to the flawed assumption and provided therein two illustrative alternatives as to how doctors' fees might be updated each year, including projections of the consequent year-by-year increases in Medicare costs. Estimates derived

10. The increase in the 75-year funding shortfall would be $1.6 trillion under the freeze assumption, and $3.0 trillion assuming the physician fee schedule is updated according to the MEI.

from this information of the additional excess costs suggest the figures included in the Medicare Trustees' Report understate the magnitude of the problem by perhaps $3.0 trillion to $5.9 trillion. These figures underscore the reality of the need to reform Medicare quickly and substantially while providing a more realistic measure of the consequences of the necessary changes.

—J. D. Foster, Ph.D., is Norman B. Ture Senior Fellow in the Economics of Fiscal Policy in the Thomas A. Roe Institute for Economic Policy Studies at The Heritage Foundation.