The Heritage Foundation
LEADERSHIP FOR AMERICA

ISSUE BRIEF

No. 3602 | MAY 14, 2012

The Good News in the Medicare Trustees Report

J. D. Foster, PhD

The release of the annual Medicare trustees report in late April, containing as it did a vast array of very bad news, was immediately greeted with valid dire warnings of fiscal disaster.[1] Little noticed, however, were three important bits of good news: the inevitability of imminent action; a simple key hidden in the report for understanding Medicare's fiscal problem; and a proven bipartisan solution.

First, the Bad News. To be sure, the trustees report provided a wealth of bad news about the program's finances. The key facts:

- Part A, the Hospital Insurance (HI) program, ran a cash deficit in 2011 of almost $28 billion, and the Medicare Trust Fund is projected to be insolvent in about 12 years.
- Medicare has an unfunded obligation of $42.7 trillion.[2]

"Medicare's unfunded obligation" is not a household expression, though it may become one before long. It simply means the cost of all promised Medicare benefits—plus the costs of running the program, over and above the various income streams Medicare now receives, such as payroll taxes, premiums, and so forth. These two streams of costs and income, out into the indefinite future, are then discounted back to the present.[3] So the Medicare unfunded obligation is the present value of the net future costs of the program—one number summarizing the extent of the problem with Medicare's financing.

Interpreting this single number is straightforward: It is the payment that would be required today to make Medicare's financing problem go away with no other reforms. For context, $42.7 trillion is roughly equal to all the income produced by every American and American business for the next two and a half years.

The bad news only restates that Medicare needs real reform as opposed to the incoherent superficialities contained in Obamacare.[4] It also means real reform is coming in the near future, not decades from now, and makes the reality of the good news that much more important.

The good news described here deals only with Medicare's finances. Medicare will need other basic reforms, and many of these other reforms are pretty commonsensical, essentially natural extensions of Medicare's workings today.[5] Defenders of Obamacare and the status quo will shriek that these reforms are radical, but that is absurd as is easily shown.

Some Good News: Reform Is Imminent, the Problem Straightforward. The first item of good news is contained in the first item of bad—that Medicare HI will lack the funds to pay all benefits beginning in about 12 years. At that time, Medicare HI's enrollment is projected to be about 70 million, so it will be of significant interest to a large population of current and future seniors. The Congress, the President, and the nation at large cannot postpone Medicare reform indefinitely. The need for reform has been known for decades, yet it has always been easier to put off to a more propitious moment—frequently, after an election. The days of delay are coming to a close. This is good

This paper, in its entirety, can be found at **http://report.heritage.org/ib3602**

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

The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

news: Reform is inescapable and imminent.

The second item of good news is that it is not difficult to understand the problem or to gauge whether a solution works. The key to unlocking the whole affair is in Table II.B.1 of the trustees report, a fairly basic set of figures laying out the essential Medicare data for 2011. The first clue is the 2011 total cost of Medicare per beneficiary, which the trustees put at $12,042. The key then requires a simple calculation dividing the general revenue income dedicated to Medicare by the number of beneficiaries, which comes to $4,897. This is the average subsidy—essentially extra taxpayer money—provided to every Medicare beneficiary in 2011, an amount that will grow rapidly in years to come.

Understanding Medicare's financial plight simply requires understanding the Medicare subsidy. This is the amount of general revenue funds (corporate and individual income tax revenue, excises, etc.) used to make up the shortfall from Medicare's other financing sources, mostly payroll tax and premiums, plus a few odds and ends. Eliminate the subsidy entirely, and Medicare's shortfall disappears now and forever. The subsidy IS the shortfall. The subsidy is the threat. However, as shown elsewhere, it is not necessary to eliminate the subsidy entirely. It is only necessary to reduce it sufficiently for some seniors so that the aggregate cost reverts to a manageable amount.[6]

Fixing the Subsidy Problem. There are basically three ways to reduce the Medicare subsidy.

1. **Raise payroll taxes.** This would require today's workers to bear an even heavier burden so today's seniors can all get their subsidies. That makes no sense when the vast majority of these workers are low-income and middle-income workers, and many of the seniors have abundant resources of their own.

2. **Slash benefits and/or payments to providers.** The second option is to cut costs in the program by denying coverage altogether, slashing benefits, or slashing payments to doctors and hospitals. Managing costs is obviously necessary, but most reforms to date have largely focused on cutting costs to the point where providers are bailing on the program—and would do so in ever-larger numbers if Obamacare remains.

3. **Market-centered reforms.** Positive pressure to contain costs can also come from certain other reforms to Medicare and to health care in general. Rather than slashing benefits and payment rates, these reforms would harness the power of the marketplace, using the same economic forces that have constrained the costs of most other goods and services in the economy, from laptop computers and personal electronics to soybeans and take-out food.[7]

The health care sector is different in many ways from other sectors of the economy, but not so different that economic forces are rendered ineffective. Even in health care, where market forces are allowed to operate, they do so effectively. Enacting these market-centered reforms would slow the rise in health care costs substantially, but perhaps not enough to halt the recent trend of health care prices rising more rapidly than prices in general. Nor will these reforms reverse the arriving demographic force as the baby boom generation reaches retirement. Thus, it is highly

1. See "2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," April 23, 2012, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads//tr2012.pdf (accessed May 10, 2012).
2. The trustees calculate the unfunded obligation in perpetuity at $42.7 trillion using traditional assumptions. The unfunded obligation over the artificially truncated 75-year horizon using these same assumptions is $26.9 trillion. Using more realistic assumptions, the trustees find both figures to be about one-third higher.
3. Discounting future amounts is necessary because of what is called the "time value of money"—the fact that a dollar tomorrow is inherently worth less than a dollar today, even without inflation.
4. See "The Case Against Obamacare: Health Care Policy Series for the 112th Congress," Heritage Foundation *WebMemo* No. 3052, November 9, 2010, http://www.heritage.org/research/projects/the-case-against-obamacare.
5. J. D. Foster, "Premium Support is Incremental, Not Radical Reform," Heritage Foundation *Backgrounder* No. 2649, February 7, 2012, http://www.heritage.org/research/reports/2012/02/premium-support-is-incremental-not-radical-medicare-reform.
6. See J. D. Foster, "A First Big Step Toward Medicare Reform," Heritage Foundation *Backgrounder* No. 2253, March 24, 2009, http://s3.amazonaws.com/thf_media/2009/pdf/bg2253.pdf.
7. See James C. Capretta and Robert E. Moffit, "How to Replace Obamacare," *National Affairs*, No. 11 (Spring 2012), pp. 3–21.

unlikely that these reforms alone can reverse, let alone halt, the projected unaffordable increases in Medicare costs.

The Best News: A Proven Bipartisan Solution. The sure and necessary solution to Medicare's financing problem lies in the subsidy and the simple questions: Who should receive a subsidy, and how much should they get?

These are simple enough questions, and Congress has already started on bipartisan answers. For example, the 1999 National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Congressman Bill Thomas (R–CA), set the basic template.[8] President George W. Bush started putting the reform in place as part of the 2004 legislation instituting the Medicare drug benefit. President Obama extended it in Obamacare and has proposed to go ever further in his latest budget. The proper term for the policy is "income-relating" premiums. A more colloquial expression would be "means testing." All it really says is that the affluent elderly receive less of a subsidy than low-income and middle-income seniors.

Today, Medicare beneficiaries pay a basic premium for Part B of $99.90 per month, which covers some costs while the rest—the subsidies—are paid from the general revenue.[9] The premium increases (meaning the subsidy declines) for married seniors with combined income above $170,000.[10] When a senior's income reaches $428,000, the premium tops out at $319.70 per month, leaving a 20 percent subsidy. The Medicare drug benefit, Part D, has a similar structure.

It is worth considering those income levels. What is the profile of a senior earning $170,000? If the senior is still working and most of that income is wage or salary, it is likely the senior also has access to employer-sponsored health insurance. So consider instead a retiree with $170,000 in income, which means the income is all Social Security benefits, pension income, and other returns on saving—dividends, interest, and capital gains. If the retiree's overall portfolio is earning 6 percent, a pretty good return today, then the retiree's total financial assets would be worth more than $2.8 million. A retired couple with $428,000 would have total financial assets worth more than $7.1 million, excluding the value of their home. This means that multimillionaire retiree seniors still qualify for a Medicare subsidy. Something is seriously wrong with this picture.

Common but Misplaced Objections to Shaving the Medicare Subsidy. To recap, Medicare's finances are leading the nation off a financial cliff. The financial problem traces directly to a subsidy. The subsidy today is available to all seniors from the richest to the poorest, though the subsidy is smaller for the rich than for the poor. The tried-and-true bipartisan solution, then, is pretty simple: Ensure low-income seniors have the subsidy they need, and eliminate the subsidy for those who can afford their own health insurance. Ideally, this approach would be adopted in conjunction with a more comprehensive set of reforms to address both Medicare's structure and its financing, but the two steps can be taken independently.[11]

This approach frequently leads to certain immediate yet misplaced objections.

Objection 1: You are cutting seniors off from health insurance. Actually, every senior who qualifies for Medicare today would still qualify. No senior would be denied Medicare benefits.

Objection 2: I already paid for Medicare, so this is unfair. Actually, workers pay a payroll tax covering one piece of Medicare: Hospital Insurance. Seniors already pay premiums for the rest. The trouble is the premiums cover only a small—and shrinking—part of the rest.

Objection 3: Low-income seniors cannot afford higher premiums. Correct. Which is why premiums would rise only for the affluent elderly. In fact, if the affluent received less of a subsidy, it might even be possible to reduce premiums for low-income seniors.

8. See the Final Report of the National Bipartisan Commission on the Future of Medicare, "Building a Better Medicare for Today and Tomorrow," March 16, 1999, http://rs9.loc.gov/medicare/bbmtt31599.html (accessed May 10, 2012).
9. See Centers for Medicare and Medicaid Services, Department of Health and Human Services, "Medicare and You," 2012, http://www.medicare.gov/publications/pubs/pdf/10050.pdf (accessed May 10, 2012).
10. The income threshold for singles is half that of married seniors.
11. See Robert E. Moffit, "The Second Stage of Medicare Reform: Moving to a Premium Support Program," Heritage Foundation *Backgrounder* No. 2626, November 28, 2011, http://www.heritage.org/research/reports/2011/11/the-second-stage-of-medicare-reform-moving-to-a-premium-support-program, and Stuart M. Butler, Alison Acosta Fraser, and William W. Beach, *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, 2011, http://www.savingthedream.org/about-the-plan/.

Objection 4: If rich seniors have to pay full price, then they will drop Medicare. That would be their decision, just as it is every senior's right today not to participate in most of Medicare. But if they drop coverage, it just means they think they can do better buying insurance elsewhere.

Objection 5: But you have not really reformed Medicare. True. All this does is fix Medicare's financing so that it does not drive the country off a financial cliff. There is much left to do.

Objection 6: Means testing is socialism. False. Reducing a subsidy is not socialism. Is it socialism to means-test food stamps? Is it socialism to means-test Medicaid? Obviously not. In a very real sense, *not* reducing the subsidy hints at socialism, because it means more pressure to raise taxes on upper-income workers to fund the program. Raising taxes to maintain a subsidy for the affluent is difficult to defend, no matter where one falls on the ideological spectrum.

Targeting the Medicare Subsidy Only Where It Is Needed. Anyone digging deep into the complexities of Medicare is likely to regret the exercise. Medicare is a very complicated program; running a major health insurance company usually is, and all the more so when government is running it. But one need not be a Medicare expert to understand Medicare's essential financing, to realize that the problem is the subsidy, and to see that the solution—already tested and supported on a bipartisan basis—is to ensure that the subsidy goes only to those who really need it.

*—**J. D. Foster, PhD,** 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.*