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2009 TRUSTEES' REPORT UNDERSCORES URGENCY OF HEALTH REFORM, MEDICARE CHANGES

by Paul N. Van de Water

The 2009 annual report of Medicare's trustees underscores the need for system-wide reform of health care financing that will slow the growth of health care costs in both Medicare and the private sector and extend health coverage to the uninsured.¹ In evaluating the new report, it is useful to keep several points in mind.

As expected, the current recession has somewhat worsened Medicare's financial picture. Medicare's Hospital Insurance (HI, or Medicare Part A) Trust Fund is currently running annual deficits. Tax income and trust fund reserves will be sufficient to pay all benefits only until 2017 — two years earlier than projected in last year's trustees' report — when the reserves are projected to be depleted. At that point, if policymakers do not make changes, scheduled HI income will cover 81 percent of estimated expenditures. Over the next 75 years, HI spending is projected to exceed HI tax revenues by an average of 1.74 percent of the gross domestic product (GDP).

Medicare's Supplementary Medical Insurance (SMI) Trust Fund consists of two separate accounts — one for Part B of Medicare, which pays for physician and other outpatient health services, and one for Part D, which pays for outpatient prescription drugs. SMI is always adequately financed because beneficiary premiums and general revenue contributions are set at the levels necessary to cover expected costs each year. However, the rapid growth of program costs will place increasing pressures on both beneficiaries (to pay higher premiums) and taxpayers (to provide the general revenues).

Medicare's long-term financing problems stem primarily from the continuing sharp rise in health care costs throughout the U.S. health care system, not from structural problems with the program. Medicare spending is growing rapidly for the same reasons that private health spending is growing rapidly — increases in the cost and use of medical services. For several decades, increases in Medicare costs per beneficiary have mirrored the increases in costs in the health system as a whole. Between 1970 and 2007, Medicare spending for each enrollee rose by an

¹ 2009 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 12, 2009 (available at <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf>).

average of 8.5 percent annually, and private health insurance spending rose by 9.7 percent per person per year.²

The similarity in growth rates between Medicare and private insurance is not surprising, because Medicare aims to provide its beneficiaries with access to the same doctors, hospitals, and services as the rest of the population. As David Walker, former Comptroller General, has emphasized, “[F]ederal health spending trends should not be viewed in isolation from the health care system as a whole. For example, Medicare and Medicaid cannot grow over the long term at a slower rate than cost in the rest of the health care system without resulting in a two-tier health care system.”³

While the trustees’ insolvency projections are broadly in line with those they have issued in the past, the new report should be viewed as a call to action. Over the past 20 trustees’ reports, changes in the law, the economy, and other factors have moved the projected year of HI insolvency from as early as 1999 to as late as 2030 (see Table 1). Trustees’ reports have been projecting

impending HI insolvency for more than 35 years, but Medicare benefits have always been paid because Congress has taken steps to make sure that they are. In contrast to Social Security, which has had no major changes in law since 1983, the rapid evolution of the health care system has required frequent adjustments to Medicare, and that pattern is certain to continue.

**Table 1:
Projections of Medicare HI Insolvency
Have Varied Substantially**

Year of Trustees’ Report	Projected Year of Insolvency	Year of Trustees’ Report	Projected Year of Insolvency	Year of Trustees’ Report	Projected Year of Insolvency
1990	2003	1997	2001	2004	2019
1991	2005	1998	2008	2005	2020
1992	2002	1999	2015	2006	2018
1993	1999	2000	2025	2007	2019
1994	2001	2001	2029	2008	2019
1995	2002	2002	2030	2009	2017
1996	2001	2003	2026		

HI: Medicare’s Hospital Insurance Trust Fund (Medicare Part A)
Source: Trustees’ reports, various years.

Adopting the President’s Medicare proposals is an essential first step toward shoring up Medicare for the long term. System-wide reform of health care financing and delivery is key to slowing the growth of health care costs in Medicare, Medicaid, and the private sector. But Medicare itself can serve as a model for efforts to slow the growth of costs in the rest of the health care system. Medicare provides health coverage to 46 million people who are age 65 and over or have disabilities — one of every seven Americans. As the largest purchaser and regulator of health care, Medicare exerts a major influence on the rest of the health care system, and its innovations in

² Centers for Medicare and Medicaid Services, “NHE [National Health Expenditure] Web Tables,” January 2009, table 13, available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>. The cited figures refer to benefits commonly covered by Medicare and private health insurance.

³ David M. Walker, “Long-Term Fiscal Issues: The Need for Social Security Reform,” Statement before the Committee on the Budget, U.S. House of Representatives, February 9, 2005 (GAO-05-318T), p. 18.

reimbursement and coverage policies have been widely adopted by private insurers and other public programs.⁴

This new report should prod Congress to adopt President Obama's proposed Medicare reforms, which would reduce Medicare costs by an estimated \$266 billion over the next ten years, and additional reforms from Congress' expert advisory body on Medicare, the Medicare Payment Advisory Commission (MedPAC). Much of these savings would stem from eliminating the overpayments that Medicare makes to private insurance companies that participate in Medicare Advantage (the privatized part of Medicare). MedPAC has found that Medicare is paying the insurance companies 14 percent more, on average, to cover the same beneficiaries than it would cost to cover them through the regular, non-privatized Medicare program. Last year, Medicare's chief actuary reported that these overpayments to insurance companies accelerate the date when the Medicare Hospital Insurance Trust Fund will become insolvent by 18 months. Other proposals would promote care coordination by bundling payments for episodes of illness, encourage hospitals to reduce readmissions, and base provider payments on the quality of care.

These proposals would yield a triple benefit:

1. They would strengthen Medicare's financing;
2. They would help finance health care reform; and
3. They could lead to cost-saving reforms in the *private sector*, as insurers followed Medicare's lead in adopting similar policies.

Trying to solve Medicare's long-term financing problems through changes in Medicare alone would merely shift costs to vulnerable elderly and disabled beneficiaries. Most Medicare beneficiaries live in families with modest incomes. In 2005, 68 percent of Medicare's non-institutionalized beneficiaries had annual family incomes of less than \$30,000. Only 12 percent had incomes of \$50,000 or more.⁵ To assist the neediest, MedPAC has recommended that Congress expand eligibility for the "Medicare Savings Programs," which help low-income beneficiaries pay their Medicare premiums, deductibles, and co-payments.

Medicare spending is highly concentrated in a small group of people with large medical needs. In 2005, just 10 percent of fee-for-service beneficiaries incurred \$20,000 or more in program costs and accounted for nearly two-thirds (63 percent) of all program expenditures. At the same time, 42 percent of beneficiaries incurred less than \$1,000 each in Medicare costs and accounted for only 2 percent of program expenditures.⁶

Measures of "unfunded obligations" should be used with care. A program's unfunded obligation is a way of summarizing its funding shortfall in a single dollar number. Technically speaking, it is the difference between the present value of the projected cost of a program over a specified time period and the present value of projected income (including the initial value of the trust fund). Put another way, the unfunded obligation is the additional money that the trust fund would need today to make the program financially sound for the specified time period. Because

⁴ Paul N. Van de Water, *Medicare Changes Can Complement Health Reform*, Center on Budget and Policy Priorities, July 30, 2008.

⁵ Kaiser Family Foundation analysis of the 2005 Medicare Current Beneficiary Survey.

⁶ Kaiser Family Foundation, *Medicare: A Primer*, January 2009, p. 14.

present values expressed in dollar terms can be easily confused with annual expenditures or deficits, even though the figures are not comparable, unfunded obligations are better displayed as percentages of projected GDP, which is a measure of the economy's ability to support the program.

The trustees estimate that the unfunded obligation of Medicare's Hospital Insurance Trust Fund for past, current, and future participants is \$13.4 trillion over the next 75 years, or the equivalent of 1.7 percent of GDP over that period. The Supplementary Medical Insurance Trust Fund has no unfunded obligation; general revenues cover all spending that is not financed by other dedicated funding sources. However, the trustees' report also provides an estimate of the present value of the required general revenue contributions to Parts B and D of Medicare, which amount to \$24.4 trillion (3.1 percent of GDP) over 75 years.

Since 2004, the trustees' reports have included a measure of unfunded obligations that extends indefinitely. The American Academy of Actuaries has warned, however, that calculations into eternity are unreliable and of little value to policy makers.⁷

⁷ American Academy of Actuaries, Social Insurance Committee, "Letter to the Board of Trustees of the Social Security System," December 19, 2003, http://www.actuary.org/pdf/socialsecurity/tech_dec03.pdf.