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CBPP STATEMENT

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Statement of Paul Van de Water, Senior Fellow, on the 2014 Medicare Trustees' Report

Medicare has grown somewhat stronger financially in both the short and long term since last year but continues to face long-term financing challenges, today's report from its trustees shows. The projected date of insolvency for Medicare's Hospital Insurance (HI) trust fund is 2030 — four years later than projected last year.

Health reform, along with other factors, has significantly improved Medicare's financial outlook, boosting revenues and making the program more efficient. The HI trust fund's projected exhaustion date of 2030 is 13 years later than the trustees projected before the Affordable Care Act. And the HI program's projected 75-year shortfall of 0.87 percent of taxable payroll is down from last year's estimate of 1.11 percent and much less than the 3.88 percent that the trustees estimated before health reform.

In a shift from previous practice, the trustees' report now assumes that Congress will continue to override the substantial reductions in Medicare payments to physicians scheduled under current law, as Congress has consistently done in recent years. This change raises projected Medicare spending and makes the trustees' projections more realistic.

Medicare spending per beneficiary in recent years has grown at historically low rates — 0.3 percent in 2012 and zero in 2013. The trustees have reduced projected Medicare spending, compared to past reports, to reflect this favorable experience. Over the next ten years, they project that Medicare spending per beneficiary will grow by 3.6 percent a year, well below its 2000-2010 average of 7.4 percent a year and below the projected growth in private health insurance costs. They project that total Medicare spending will rise from 3.5 percent of gross domestic product (GDP) in 2013 to 5.2 percent of GDP in 2035 — compared to last year's estimate of 5.6 percent.

The trustees' projections assume that the Affordable Care Act's cost-control provisions, including the productivity adjustments to payment rates and the Independent Payment Advisory Board, will be successfully implemented. The recent slowdown in health care cost growth and the new projections offer encouraging signs that these savings are achievable, if challenging.

The projected insolvency of the HI trust fund doesn't mean that Medicare is "going bankrupt," as some suggest. Even in 2030, when the trust fund is projected for exhaustion, incoming payroll taxes and other revenues will be sufficient to continue paying 85 percent of program costs. Moreover, trustees' reports have been projecting impending Medicare insolvency for four decades, but Medicare has always paid the benefits owed because Presidents and Congresses have taken steps to keep spending and resources in balance in the near term.

The long-run shortfall in the Hospital Insurance program should also be put in context. The 75-year deficit of 0.87 percent of taxable payroll could be closed by increasing the Medicare payroll tax — now 1.45 percent each for employees and their employers — to 1.9 percent, or by enacting an equivalent combination of program cuts and tax increases.

Despite the improvements made by the Affordable Care Act and a slowdown in health-care cost growth nationally, Medicare continues to face significant long-term financial challenges — stemming from the aging of the population and the continued rise in health care costs — that contribute to the challenging long-term fiscal outlook. It is essential that policymakers take further substantial steps to curb cost growth throughout the U.S. health care system as we learn more about how to do so effectively in both public programs and private-sector health care. Those lessons will be based in part on research and pilot projects that the Affordable Care Act establishes to test new approaches to delivering health care in ways that can lower cost while maintaining or improving quality.

Until these efforts bear fruit, it will be difficult to achieve big additional reductions in Medicare expenditures. But we can generate some additional savings over the next ten years while preserving Medicare's guarantee of health coverage and without raising the program's eligibility age or otherwise shifting costs to vulnerable beneficiaries. Possible measures include ending Medicare's excessively high payments to pharmaceutical companies for drugs prescribed to low-income beneficiaries, increasing funding for actions to prevent and detect fraudulent and wasteful Medicare spending, restructuring Medicare's cost sharing and Medigap supplemental insurance (while protecting low- and moderate-income beneficiaries), and raising premiums for better-off beneficiaries.

A key *fiscal policy* goal is to stabilize the federal debt relative to the size of the economy. But it's neither necessary nor desirable to accomplish this by radically restructuring Medicare — such as through "premium support" proposals that would convert Medicare to vouchers whose purchasing power doesn't keep pace with the cost of health care — or by severely cutting Medicare or other programs that protect Americans with low and moderate incomes. Instead, we should pursue a balanced deficit-reduction approach that puts all parts of the budget on the table, including revenues.

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