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CBPP STATEMENT

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STATEMENT OF PAUL VAN DE WATER, SENIOR FELLOW, ON THE 2012 MEDICARE TRUSTEES' REPORT

The new report from Medicare's trustees shows little change from last year's report in the near-term outlook for the program, while indicating that the program continues to face significant financing challenges in the long run. The projected date of insolvency for Medicare's Hospital Insurance (HI) trust fund is 2024 — the same as projected last year.

Medicare spending overall is projected to grow slightly faster than the trustees forecast previously. The trustees project that under current law, total Medicare spending will grow from 3.7 percent of gross domestic product (GDP) in 2011 to 5.7 percent of GDP in 2035 — compared to last year's estimate of 5.6 percent. Much of the projected increase in Medicare expenditures between now and 2035 stems from the aging of the baby boomers, the first of whom became eligible for Medicare last year.

Thanks to the health reform legislation (the Affordable Care Act, or ACA), Medicare's cost outlook remains less troubled than before that legislation's enactment. Over the next ten years, Medicare spending per beneficiary is projected to grow by 3.2 percent a year, well below both its average since 2000 of 7.6 percent a year and the projected rate of growth of private health care costs. Under the trustees' main projection, the HI program's 75-year shortfall is 1.35 percent of taxable payroll — up from last year's estimate of 0.79 percent of payroll, but much less than the 3.88 percent of payroll that the trustees estimated prior to the enactment of health reform. If health reform were fully repealed, as the House of Representatives has voted to do, HI's insolvency date would be moved up eight years, to 2016.

The new projections emphasize the importance of successfully implementing the cost-control provisions of the Affordable Care Act. While history shows that most major Medicare savings measures have been implemented as scheduled, the Medicare actuary has raised strong concerns (including in today's trustees' report) that some of the ACA's savings provisions may not be sustainable. The actuary urges reliance instead on the "illustrative alternative" projection for Medicare, which assumes that only 60 percent of the ACA's Medicare savings will be achieved in the long run. Using this alternative projection would have little or no effect on the projected HI insolvency date, but the 75-year shortfall in the fund would rise to 2.43 percent of payroll— almost twice the trustees' official estimate (of 1.35 percent of payroll). As noted, however, this is still a dramatic improvement over the trustees' pre-ACA estimate of a shortfall equal to 3.88 percent of payroll.

The trustees' finding that health reform has improved Medicare's financial status is fully consistent with the Congressional Budget Office's estimate that health reform will modestly reduce federal budget deficits. Medicare is a part of the federal budget. Therefore, spending cuts or tax increases that reduce projected deficits in Medicare also help reduce projected deficits in the overall budget. Consequently, contrary to some claims, no "double-counting" is involved.

Despite the improvements made by the Affordable Care Act, 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 federal fiscal outlook. It is essential that policymakers take further substantial steps to curb the growth of costs 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 the Medicare research and pilot projects the ACA 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 eligibility age or otherwise shifting costs to vulnerable beneficiaries.

Possible measures include ending Medicare's overpayments to pharmaceutical companies for drugs prescribed to "dual eligible" beneficiaries (people enrolled in both Medicare and Medicaid), improving the coordination of care for dual eligibles, increasing funding for actions to prevent and detect fraudulent and wasteful Medicare spending, raising cost-sharing charges for certain services (while protecting low- and moderate-income beneficiaries), and raising premiums for better-off beneficiaries. The Medicare Payment Advisory Commission (MedPAC) has also sent Congress a long list of savings options that could help offset the cost of repealing Medicare's flawed sustainable growth rate (SGR) formula for setting doctor payments.

Policymakers' key fiscal policy goal should be 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 it 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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