Assessing the Viability of Medicare

Marilyn Moon

Senior Fellow

The Urban Institute

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Mr. Chairman and Members of the Committee: Thank you for extending to me the opportunity to testify at this hearing.

The aging of the U.S. population will generate many challenges in the years ahead, but none more dramatic than the costs of providing health care services for older Americans. Largely because of advances in medicine and technology, spending on both the old and the young has grown at a rate faster than spending on other goods and services. Combining a population that will increasingly be over the age of 65 with health care costs that will likely continue to rise over time is certain to mean an increasing share of national resources devoted to this group. In order to meet this challenge, the nation must plan how to share that burden and adapt Medicare to meet new demands.

Nonetheless, Medicare is a viable program. In terms of meeting the needs of those it is intended to serve—older and disabled individuals—and in terms of future affordability, the program can continue to succeed. It is neither unsustainable nor fatally flawed.

To support these claims, I make five points in my testimony. First, the drivers of healthcare costs are not unique to Medicare, and it is important to recognize that Medicare needs to grow in concert with changes in the healthcare system as a whole. Second, even with no changes in the basic program, the burdens from Medicare are not excessive in the context of reasonable expectations about economic growth in the future. To demonstrate this, I present an alternative measure of affordability that I have written about in more detail elsewhere. Third, passing greater costs onto older and disabled Americans must be done with caution, recognizing that their burdens will also rise even with no change in policy. And no matter what happens to

public policy, this population will still need to get care somewhere. Fourth, part of the argument that Medicare is unsustainable or not viable is often linked to the claim that, as a public program, Medicare is less efficient than if it were run through the private sector. Again, this is not supported by the facts. Finally, I briefly describe a number of changes that could improve Medicare.

REASONS FOR RISING COSTS

Projections from the 2003 Medicare Trustees Report indicate that Medicare's share of the Gross Domestic Product (GDP) will reach 4.75 percent in 2030, up from 2.56 percent in 2002. Although this is a substantial increase, it is actually smaller than what was being projected just a few years ago. In 1996, for example, the projection for 2030 was 7.39 percent of GDP—or 56 percent higher than the projection made this year. This slowdown in growth does not eliminate the need to act, but it does allow time for study and deliberation before putting substantial changes into place.

Projected increases in Medicare's spending arise because of growing numbers of people eligible for the program and the high costs of health care. The beneficiary population is rising because of increased life expectancy (in part reflecting the success of the Medicare program) and that growth will be accelerated in the future by the retirement of the baby boom. The number of younger disabled beneficiaries is also expected to remain high. This creates challenges for Medicare and represents a major component of spending projection increases. By 2030, for example, the number of beneficiaries will reach 79 million—nearly double today's number.

Technological advances that raise the costs of care are the primary reason for higher per

capita spending over time, and this phenomenon occurs systemwide, not just in Medicare. The problems driving Medicare costs upward are not unique to the public sector. They are found throughout our nation's healthcare system, and the crisis of rising healthcare costs affects all payers: individuals, businesses, and governments. And just as Medicare is influenced by the overall healthcare system, the opposite is true as well. Medicare has been a leader in experimenting with options for curbing the costs of care, both in terms of increasing prices and use of services. Further, while costs continue to rise, efforts through time to hold down these costs have led to a better outlook than was the case in the mid-1990s. Similar re-evaluation of the program to make changes where needed will be an important part of Medicare's future.

MEASURING MEDICARE'S FINANCIAL BURDENS

Medicare is currently financed in a variety of ways. Part A relies mainly on payroll taxes with a modest contribution from part of the taxes imposed on Social Security benefits. Part B, on the other hand, is financed by enrollee premiums set at 25 percent of the costs of Part B benefits for elderly beneficiaries and by general revenue contributions sufficient to cover the remaining costs.

Medicare's financial health can be viewed from several perspectives. The appropriate question over time is whether, *as a society*, we can afford to support Medicare. But the measures often used actually focus on a narrower issue of solvency, particularly that of the Part A Trust Fund. That measure does point to the need for some type of policy change in the future, but that could simply mean increasing the revenues going into the trust funds, for example.

Solvency Measures

Solvency, as measured by the date of exhaustion of the Part A Trust Fund, is one of the most commonly reported statistics about Medicare.[1] This is just one of many measures reported in the Medicare Board of Trustees annual reports on Medicare's financial outlook. Critics of Medicare often emphasize the solvency of the Part A Trust Fund as an indicator of *affordability* as well as solvency. This implicitly treats the Part A Trust Fund as establishing a limit on what can be spent on Part A.

The Part A Trust Fund was designed to assure that the specified payroll tax contribution would be used specifically for Part A spending. As dedicated revenues, payroll and other revenue sources that exceed the amount necessary to cover Part A benefits go into the Trust Fund and collect interest. When the trust fund forecasts indicate a declining balance, this serves as an early warning of the need for an adjustment either in revenue contributions or spending on the program. Over the next ten years, Medicare revenues will exceed spending by over $500 billion.

Projections of the Medicare Part A trust fund in the most recent Trustees' Report indicate that it will maintain a positive balance through 2026. Considered in historical context, the date of projected insolvency historically is far into the future as compared to what it has been in earlier years (Figure 1). The trust fund is expected to grow until 2014, after which the trust fund's balances will begin to decline. At that point, payroll tax and other receipts are insufficient to cover all expenditures. After 2014, Part A of Medicare must supplement tax

[1] Although there is also a Part B Trust Fund, it serves a much different purpose and is intentionally kept at a small positive level.

revenues with funds accumulated in the Part A Trust Fund.

Another solvency measure that was contained in the Administration's budget documents for this year indicated that there was a $13.3 trillion unfounded liability facing Medicare over the next 75 years. But this is based on very misleading figures. The text implies that payroll taxes are the only revenue source from which Medicare is allowed to draw to cover its costs. While Part A is largely funded by payroll taxes, Part B *by law* has always relied on general revenues. Including its costs in an analysis of the adequacy of the current payroll tax has as much validity as treating any other expenditure covered by general revenues (such as defense) as having large unfounded liabilities as well. If done correctly, the "unfounded promises" under Medicare would be much lower, more in the range of $5 trillion.

That is not to say that this is not a large amount, but rather that the size is more manageable than the $13.3 trillion implies. It is important to note, for example, that in the next ten years, Part A revenues will exceed Part A spending by over $500 billion.

Affordability Measures

Assessing affordability using the solvency of the Part A Trust Fund as the measure is analogous to individuals arguing that they cannot pay all their bills because the balance in one of their checking accounts is too low. Affordability is a broader issue that turns on whether we as a society can support Medicare into the future. The need for healthcare for this segment of the population will not go away simply because we decide to cut back on government's contribution. But the ability of Medicare beneficiaries to absorb higher healthcare costs if no new revenues are forthcoming would be in serious doubt.

The Medicare Trustees Annual Report offers two broader measures of affordability described below, although each are limited in scope. Thus, an alternative measure presented here proposes a more comprehensive way to examine affordability.

The Worker-to-Beneficiary Ratio. The ratio of workers contributing to Medicare at any point in time compared to the number of beneficiaries shows that the number of younger persons relative to older ones will decline in the future given the aging of society. This declining ratio of workers to retirees indicates that each worker will have to bear a larger share of the cost of providing payroll tax-financed Medicare benefits.

Between 2002 and 2030 (about the time when most Baby Boomers will have become eligible for Medicare), the ratio of workers to beneficiaries will fall from 3.9 to 2.4. Indeed, this is one of the statistics commonly cited by those who claim the program is "unsustainable." This measure does signal the need for more revenues per worker—a legitimate issue for debate. However, it fails to assess the level of burden relative to ability to pay from each future worker, ignoring any improvement in the economic circumstances of workers over time due to per capita economic growth.

Medicare Spending as a Share of GDP. A second measure is the sum of Part A and B spending as a share of GDP. In 2002, Medicare's total share was 2.56 percent and is projected to rise to 4.75 percent in 2030. This represents a doubling of the GDP share. Such an increase reflects the fact that health care costs per capita are expected to continue rising, and the number of people covered will double over that time period. But again, this measure is not as helpful in

the debate on Medicare's future because it does not consider how well off we will be as a society as the level of GDP grows. Some goods and services, like health care, may appropriately grow as a share of GDP in response to higher living standards and preferences of the population. What is needed is more information to be able to understand the consequences of devoting a higher share of society's resources to Medicare.

A More Comprehensive Measure of Affordability. Another way to look at affordability is to focus not just on the number of workers that contribute to payroll and income taxes or on aggregate GDP, but instead on how the Medicare per capita burden will affect workers over time. While the share of the pie (GDP) going to Medicare is likely to rise, if the pie (on a per capita basis) is also much larger, then an increasing share is less of a burden. If the future leads to increased national well-being, additional resource sharing would be affordable. Thus, another way to examine affordability is to focus on whether taxpayers of the future will be better off even after they pay higher amounts for Medicare.

This approach measure begins with computing per worker GDP over time, resulting in a measure of the nation's output of goods and services divided across the working population. This provides the base for assessing Medicare's burden on workers, who pay for the bulk of support for the program. Per worker GDP—even after adjusting for inflation—rises substantially, from $69,000 per worker in 2002 to just under $107,000 in 2035 (in 2003 dollars).[2] This is an increase of 54.9 percent in per worker GDP, a substantial increase in financial well-

[2]The figure used here is based on the intermediate projections from the 2002 Trustees Report, which assumes a 1.1 percent real growth in per worker wages each year. Over the past 50 years, productivity has been

being.

What about Medicare's costs over this period? The burdens from Medicare spending on each worker are projected to rise at a faster rate than per capita GDP because both numbers of beneficiaries and their inflation-adjusted spending will rise over time. But because per worker GDP is a much larger dollar amount than the dollars of Medicare burdens, the reduction in well-being that this entails for workers is modest.

To calculate this per worker burden from Medicare, several adjustments are necessary. First, each worker will bear an increasing share of Medicare over time because of the change in the ratio of workers to retirees. Further, per capita Medicare costs are expected to rise by 90 percent in real terms by 2035, also increasing the real dollar burden on workers. But not all of Medicare's costs are borne by workers. Thus, costs are adjusted downward by the contributions that will be made by beneficiaries themselves. The Part B premium accounts for about 10 percent of Medicare's costs. In addition, beneficiaries make further contributions because some of the taxation of Social Security benefits goes into Part A and older and disabled persons also pay income taxes that help support Part B. Thus, those costs need to be netted out.

The resulting real per worker burden estimates range from $1,556 in 2002 to $4,993 in 2035 (in 2002 dollars). In Figure 2, the bar graph indicates per worker GDP in inflation-adjusted dollars, and the line graph indicates how much would be left after accounting for the Medicare burden.

From 2002 to 2035, the increase in net (after subtracting Medicare) per worker resources

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higher than this amount, averaging over 1.5 percent per year.

would be 51.0 percent as compared to the 54.9 percent increase in per worker GDP. That is, workers would still be substantially better off than today, even after paying the full projected costs of Medicare. The pie will indeed have gotten larger, making it possible to absorb Medicare's higher costs. Essentially our estimates indicate that Medicare's greater burdens would "consume" about 7 percent of increased well-being for workers over that period. There will, of course, be other demands on these resources as well, but this approach puts demands from Medicare into a broader perspective. This measure for examining affordability takes into account Parts A and B of Medicare, and it puts the issue of the burdens of the program into a per worker context.

This more comprehensive measure of net per worker output also suggests that, as a society, we will be able to afford Medicare without an inordinate burden on workers or taxpayers once even modest estimates of productivity growth over time are taken into account. A greater challenge will be for society to decide whether it is *willing* to share these costs.

HOW MUCH SHOULD BENEFICIARIES BE ASKED TO PAY?

The burdens of higher health care costs in the future will likely need to be shared between beneficiaries and younger taxpayers in some manner deemed reasonable. The numbers above already give a sense that future workers will be in a reasonable position to pay more. What about beneficiaries?

Options for passing more costs of the program onto beneficiaries, either directly through new premiums or cost sharing or indirectly through options that place them at risk for health care costs over time, need to be carefully balanced against beneficiaries' ability to absorb

these changes. Just as Medicare's costs will rise to unprecedented levels in the future, so will the burdens on beneficiaries and their families. Even under current law, Medicare beneficiaries will be paying a larger share of the overall costs of the program and more of their incomes in meeting these health care expenses. In 2003, beneficiaries will spend about 23 percent of their incomes on average for acute health care. In a study I did with Stephanie Maxwell and Misha Segal, we projected per capita out-of-pocket spending based on projected Medicare growth into the future and found that the average beneficiary in 2025 would likely have to pay nearly 30 percent of her income on health care because the costs of care grow faster than incomes over time. Figure 3 also indicates how these burdens would grow for other groups of the Medicare population.

Thus, a difficult question to answer will be how much more can be shifted onto beneficiaries over time? If incomes rise faster than anticipated and health care spending moderates, there will certainly be room for greater contributions. But a full shifting of additional costs does not seem to be a viable option. Moreover, it will be very important to take special care with the most vulnerable beneficiaries.

In addition, options to increase beneficiary contributions to the cost of Medicare further increase the need to provide protections for low-income beneficiaries. The current programs to provide protections to low-income beneficiaries are inadequate, particularly if new premium or cost-sharing requirements are added to the program. Participation in the Medicare Savings programs is low, likely in part because these programs are run by Medicaid and are thus tainted by association with a "welfare" program. Further, states, which pay part of the costs, tend to be unenthusiastic about these extra program and likely discourage participation.

WOULD RELYING ON THE PRIVATE SECTOR MAKE MEDICARE A MORE VIABLE PROGRAM?

Much of the debate over how to reform the Medicare program has focused on broad restructuring proposals, moving the management and oversight increasingly under the control of private insurance. What are the tradeoffs from increasingly relying on private plans to serve Medicare beneficiaries? Most important, there is little evidence to suggest even modest savings to Medicare from increased competition and the flexibility that the private sector enjoys. Further, the effort necessary to create, in a private plan environment, all the protections needed to compensate for moving away from traditional Medicare seems too great and too uncertain.

Claims for savings from options that shift Medicare more to a system of private insurance usually rest on two basic arguments: first, it is commonly claimed that the private sector is more efficient than Medicare, and second, that competition among plans will generate more price sensitivity on the part of beneficiaries and plans alike. Although seemingly credible, these claims do not hold up under close examination.

Looking back over the period from 1970 to 2000, a recent study I completed with Cristina Boccuti found that Medicare's cost-containment performance has been better than that of private insurance even after controlling for coverage of comparable services. Starting in the 1970s, Medicare and private insurance plans initially grew very much in tandem, showing few discernible differences (See Figure 4). By the 1980s, per capita spending had more than doubled in both sectors. But Medicare became more cost-conscious than private health insurance in the 1980s, and cost containment efforts, particularly through hospital payment reforms, began to pay

off. From about 1984 through 1988, Medicare's per capita costs grew much more slowly than those in the private sector.

This gap in overall growth in Medicare's favor stayed relatively constant until the mid 1990s when private insurers began to take seriously the rising costs of health insurance. At that time, growth in the cost of private insurance moderated in a fashion similar to Medicare's slower growth in the 1980s. Thus, it can be argued that the private sector was playing "catch up" to Medicare in achieving cost containment. Private insurance thus narrowed the difference with Medicare in the 1990s, but as of 2000, there was still a considerable way for the private sector to go before its cost growth would match Medicare's achievement of lower overall growth. When comparison is made on rates of growth for comparable benefits, Medicare's cumulative rate is 19 percent below that of private insurance.

Technological change and improvement represents a major factor driving high rates of expenditure growth. To date, most of the cost savings generated by *all* payers of care has come from slowing growth in the prices paid for services and making only preliminary inroads in reducing the use of services or addressing the issue of technology. Reining in use of services will constitute a major challenge for private insurance as well as Medicare in the future, and it is not clear whether the public or private sector is better equipped to do this.

Reform options such as the premium support approach also seek savings by allowing the premiums paid by beneficiaries to vary such that those choosing higher cost plans pay substantially higher premiums. The theory is that beneficiaries will become more price conscious and choose lower cost plans. This in turn will reward private insurers that are able to hold down costs. And there is some evidence from the federal employees system and the

Calpers system in California that this has disciplined the insurance market to some degree. Studies that have focused on retirees, however, show much less sensitivity to price differences. Older persons may be less willing to change doctors and learn new insurance rules in order to save a few dollars each month. Thus, what is not known is how well this will work for Medicare beneficiaries.

For example, for a premium support model to work, at least some beneficiaries must be willing to shift plans each year (and to change providers and learn new rules) in order to reward the more efficient plans. Without that shifting, savings will not occur. In addition, there is the question of how private insurers will respond. (If new enrollees go into such plans each year, some savings will be achieved, but these are the least costly beneficiaries, and may lead to further problems as discussed below.) Will they seek to improve service or instead focus on marketing and other techniques to attract a desirable, healthy patient base? It simply isn't known if the competition will really do what it is supposed to do.

In addition, new approaches to the delivery of health care under Medicare may generate a whole new set of problems, including problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients; it is not only disruptive, it can raise costs of care. Some studies have shown that having one physician over a long period of time reduces costs of care. And if it is only the healthier beneficiaries who choose to switch plans, the sickest and most vulnerable beneficiaries may end up being concentrated in plans that become increasingly expensive over time. The case of retirees left in the federal employees high-option Blue Cross plan and in a study of retirees in California suggest that even when plans become very expensive, beneficiaries may be fearful of switching and end up substantially

disadvantaged. Thus, the most vulnerable may stay in plans that become inordinately expensive. Further, private plans by design are interested in satisfying their own customers and generating profits for stockholders. They cannot be expected to meet larger social goals such as making sure that the sickest beneficiaries get high quality care; and to the extent that such goals remain important, reforms in Medicare will have to incorporate additional protections to balance these concerns as described below.

Ultimately, projected cost savings from a private insurance initiative arise from passing costs off onto beneficiaries through higher premiums or increased cost sharing requirements. If that indeed is the case, then this approach merely represents an elaborate way to avoid an honest debate about how to share future burdens.

CHANGES TO IMPROVE MEDICARE

Making changes to Medicare that can improve its viability both in terms of its costs and in how well it serves older and disabled beneficiaries should certainly be pursued. Further, it makes little sense to look for a solution that takes policy makers permanently out of Medicare's future. The flux and complexity of our healthcare system will necessitate continuing attention to this program. At present a number of areas in Medicare need attention.

What I would prefer to see instead is emphasis on improvements in *both* the private plan options and the traditional Medicare program, basically retaining the current structure in which traditional Medicare is the primary option. Rather than focusing on restructuring Medicare to emphasize private insurance, I would place the emphasis on innovations necessary for improvements in health care delivery regardless of setting.

Critics of Medicare rightly point out that the inadequacy of its benefit package has led to the development of a variety of supplemental insurance arrangements which in turn create an inefficient system in which most beneficiaries rely on two sources of insurance to meet their needs. It is sometimes argued that improvements in coverage can only occur in combination with structural reform. And some advocates of a private approach to insurance go further, suggesting that the structural reform itself will naturally produce such benefit improvements. This implicitly holds the debate on improved benefits hostage to accepting other unrelated changes. That logic actually should run in the other direction. It is not reasonable to expect any number of other changes to work without first offering a more comprehensive benefit package for Medicare. In that way, payments made to private plans can improve, allowing them to better coordinate care. And the fee for service system will also be able to change in ways that might encourage better care delivery. For example, it is not reasonable to ask patients to participate in a program to reduce hypertension (which can save costs over the long run) without covering the prescription drugs that are likely to be an essential part of that effort. In addition, a better benefit package will also allow at least some beneficiaries to forego the purchase of inefficient private supplemental insurance. That itself should be a goal of reform.

In addition, better norms and standards of care are needed if we are to provide quality of care protections to all Americans. Investment in outcomes research, disease management and other techniques that could lead to improvements in treatment of patients will require a substantial public commitment. This cannot be done as well in a proprietary, for-profit environment where dissemination of new ways of coordinating care may not be shared. Private plans can play an important role and may develop some innovations on their own, but in much

the same way that we view basic research on medicine as requiring a public component, innovations in health delivery also need such support. Further, innovations in treatment and coordination of care should focus on those with substantial health problems -- exactly the population that many private plans seek to avoid. Some private plans might be willing to specialize in individuals with specific needs, but this is not going to happen if the environment is one emphasizing price competition and with barely adequate risk adjustors. Innovative plans would likely suffer in that environment.

A good area to begin improvements in knowledge about the effectiveness of medical care would be with prescription drugs. Realistically, any prescription drug benefit will require efforts to hold down costs over time. Part of that effort needs to be based on evidence of the comparative effectiveness of various drugs, for example. Establishing rules for coverage of drugs should reflect good medical evidence and not just on which manufacturer offers the best discounts. Undertaking these studies and evaluations represents a public good and needs to be funded on that basis.

Within the fee-for-service environment, it would be helpful to energize both patients and physicians in helping to coordinate care. Patients need information and support as well as incentives to become involved. Many caring physicians, who have often resented the low pay in fee for service and the lack of control in managed care, would likely welcome the ability to spend more time with their patients. One simple way to do this would be to give beneficiaries a certificate that spells out the care consultation benefits to which they are entitled and allow them to designate a physician who will provide those services. In that way, both the patient and the physician (who would get an additional payment for the annual or biannual services) would

know what they are expected to provide and could likely reduce confusion and unnecessary duplication of services that go on in a fee for service environment.

Additional flexibility to CMS to manage and develop payment initiatives aimed at using competition where appropriate also could result in long term cost savings and serve patients well. In the areas of durable medical equipment and perhaps even some testing and laboratory services, contracting could be used to obtain favorable prices.

These are only a few examples of changes, none of which promise to be the magic bullet, but which could aid the Medicare program over time.

CONCLUSION

Not only is Medicare a viable program, it is important to work hard to keep it that way. We simply cannot expect as a society to provide care to the most needy of our citizens for services that are likely to rise in costs and to absorb a rapid increase in the number of individuals becoming eligible for Medicare without taking the financing issue head on. But that does not imply that such additional revenues are beyond our grasp. Medicare now serves one in every seven Americans; by 2035 it will serve nearly one in every four. And these people will need to get care somewhere. If not through Medicare, then where?

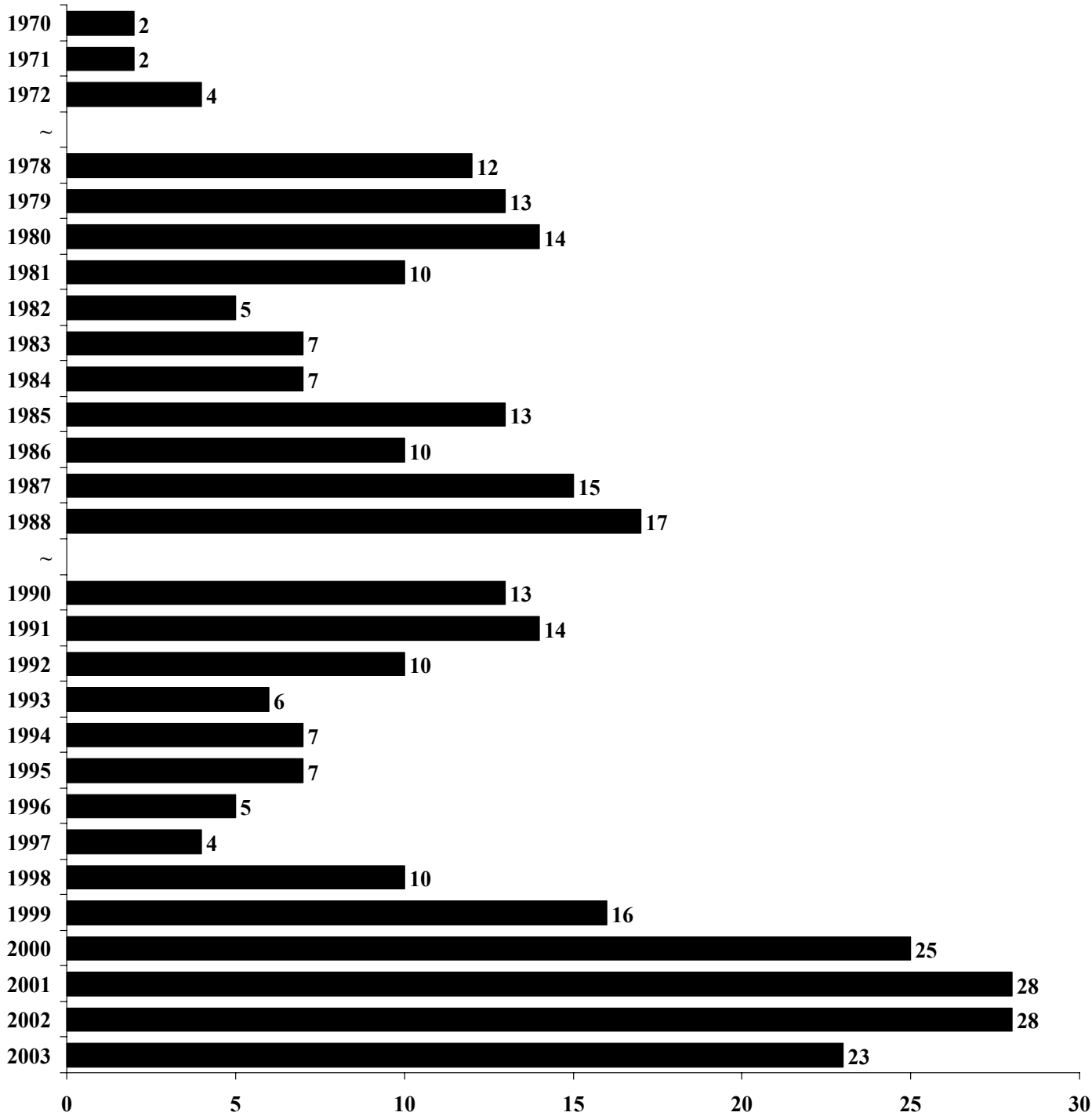
The information provided in this testimony is discussed in more detail in the following three publications:

Cristina Boccuti and Marilyn Moon, “Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades,” *Health Affairs* Vol. 22, March/April 2003, pp. 230-237.

Marilyn Moon and Matthew Storeygard, “Solvency or Affordability? Ways to Measure Medicare’s Financial Health,” Henry J. Kaiser Family Foundation, March 2002.

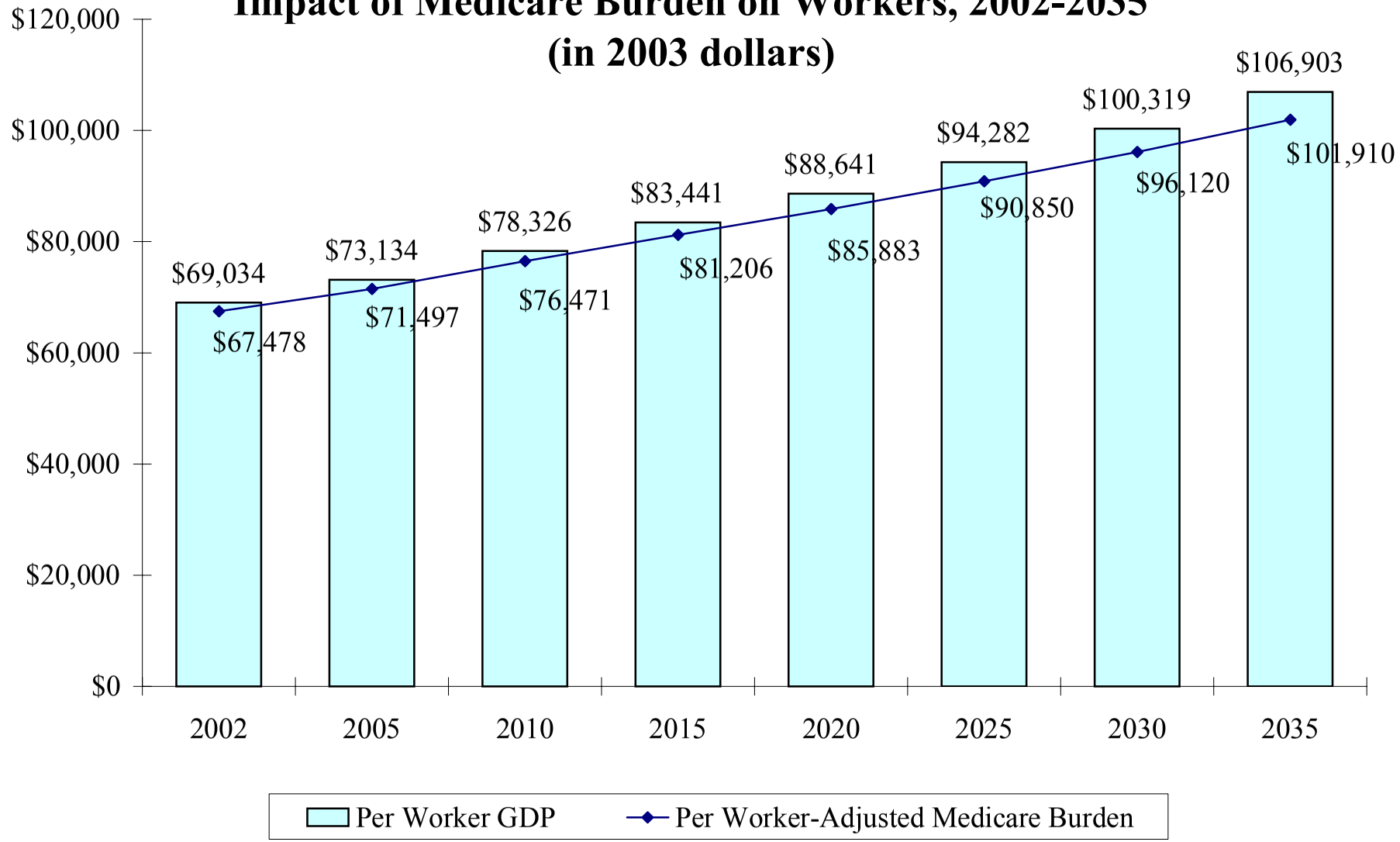
Stephanie Maxwell, Marilyn Moon, and Misha Segal, "Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries," The Commonwealth Fund, January 2001.

Figure 1
Number of Years Before HI Trust Fund Projected to be Exhausted



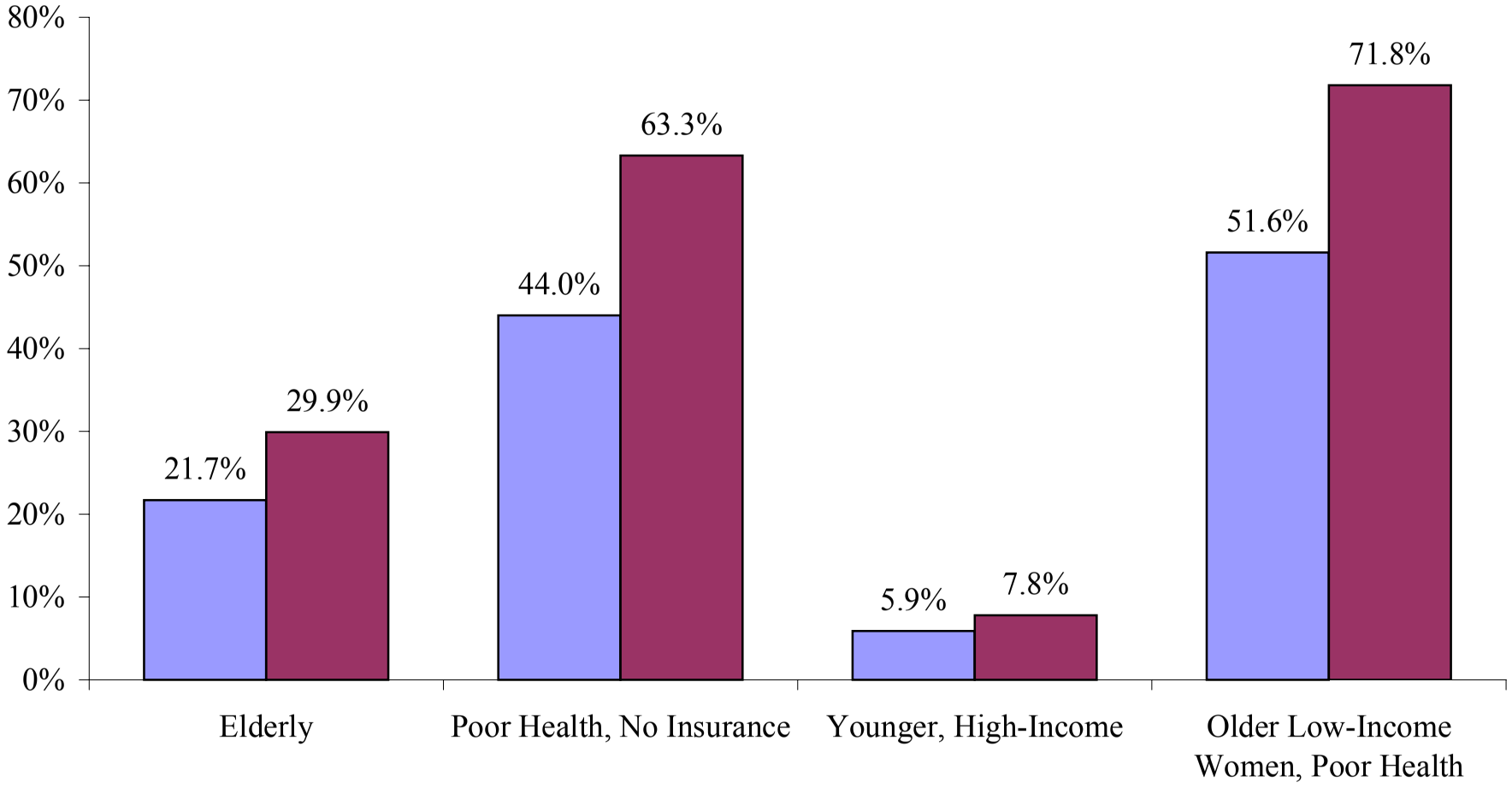
~ Missing Data for Years 1973-1977 and 1989
Source: CRS 1995 and Medicare Trustees Reports

Figure 2
Impact of Medicare Burden on Workers, 2002-2035
(in 2003 dollars)



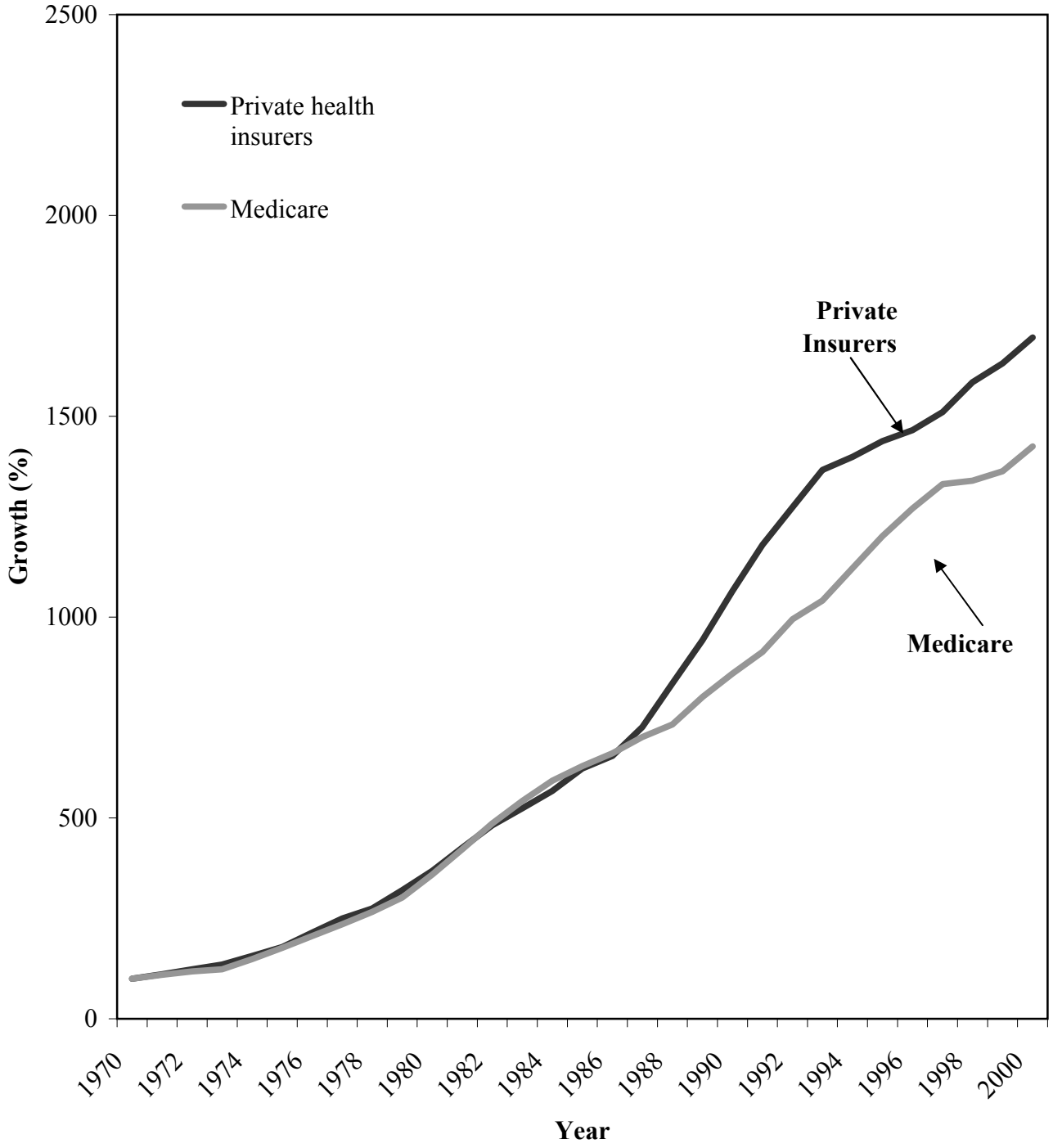
Source: 2003 Trustees Report

Figure 3
Projected Out-of-Pocket Spending as a Share of Income Among Cohorts, 2000 and 2025



Source: The Urban Institute's 1999 Medicare Projections Model

Figure 4
Cumulative Growth in Per Enrollee Payments for Comparable Services, Medicare And Private Insurers, 1970-2000*



* Includes hospital care, physician and clinical services, durable medical equipment, and other professional services.
Source: Urban Institute analysis of National Health Expenditures data from CMS.