



Crisis du Jour or the Real Thing?

By Joseph Antos

The Medicare trustees recently released their annual report on the state of Medicare's financing. Once again, the trustees warn us this year of serious trouble ahead as program outlays outstrip revenue. Medicare's Hospital Insurance (HI) Trust Fund is expected to be depleted in 2018 under current law, and beneficiary costs are expected to rise sharply. The trustees have made such predictions in the past, yet calamity has somehow been avoided. Can we believe the latest report? Is crisis inevitable for Medicare?

Americans are suffering from crisis overload. Newspapers, cable news channels, and talk radio stations are outdoing one another to trumpet the bizarre, lurid, and tragic. Calamities seem to come and go on a daily basis. Medicare's struggle to enroll seniors in its new drug benefit program has attracted crisis-level attention in the press. It is not surprising then that the public has overlooked Medicare's real crisis, which was the subject of a report released on May 1.

Buried in the pages of a dry study, the Medicare trustees report that Medicare will not be able to pay for all the health care seniors have been promised.¹ In a masterpiece of understatement, the trustees tell us that "the financial status of . . . Medicare remain[s] problematic. . . . We do not believe the currently projected long run growth [rate] of . . . Medicare [is] sustainable under current financing arrangements."²

In plain language, Medicare spends more than it takes in, and the deficit will only continue to grow sharply in coming years. The program is running on borrowed time. If we expect Medicare to meet its financial obligations, policymakers will have to take action. We can hike taxes, reduce spending on other federal programs, or cut Medicare costs substantially—

but we do not have the option of ignoring the problem.

If this sounds familiar, that's because it is. The Medicare trustees have warned of Medicare's long-term financing problems in annual reports for most of the past three decades. However, the reports seem unreliable to some observers. Previous predictions of when Medicare's HI Trust Fund would run out of money have ranged from a few years to decades into the future. Regardless of the prediction, doomsday never seems to arrive.

Can we rely on the trustees report for an accurate assessment of Medicare's financing? Will recent changes in the report that are intended to spur the president and Congress to action when program spending rises excessively be effective? Does the report provide enough guidance about the consequences of policy inaction for America's seniors?

What Trust Funds?

The first thing to understand about the Medicare trust funds is that they are not trust funds in the conventional understanding of the term. Medicare does not accumulate funds to be paid out later for benefits, and workers who pay their Medicare payroll tax are not saving for their own future health needs. Instead, all revenue that comes into the trust funds is used to pay for the

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health care of current beneficiaries. Any surpluses are used to pay for other federal programs and activities.³

Nonetheless, an examination of what are actually accounting entries reveals the financial stresses being placed on Medicare over the long term. Those stresses translate into real costs to the economy and real burden on beneficiaries and workers alike.

There are two Medicare trust funds: the HI Trust Fund accounts for all revenue and outlays for Medicare Part A, which helps pay for hospital, home health, skilled nursing facility, and hospice care. The Supplementary Medical Insurance (SMI) Trust Fund accounts for the financial activities of Medicare Part B and Part D. Part B helps pay for physician and other outpatient services, while Part D covers prescription drugs used on an outpatient basis.

Part A is financed primarily by payroll taxes from workers and their employers. In addition, higher-income Medicare beneficiaries pay income taxes on their Social Security benefits that are credited to the Part A trust fund.

Both Parts B and D are voluntary benefits financed by premiums paid by beneficiaries and general tax revenue. Premiums are set to equal 25 percent of the cost of each program, with general revenue transfers (mostly from the income tax) automatically covering the remaining cost. In addition, states pay part of the cost of the drug benefit for beneficiaries who previously had such coverage through Medicaid.

Interest is “paid” to the HI and SMI Trust Funds, which nominally hold nonnegotiable Treasury securities equal to the balance in each fund. However, both the interest and the securities are only accounting entries. If Medicare were to draw on the interest or redeem the securities, the resulting funds would come from general revenue.

Payroll taxes, taxes on Social Security benefits, premiums, and state payments for Part D are revenue sources specifically dedicated to Medicare and are intended to help pay the cost of health care for seniors and the disabled. General revenue, on the other hand, is just that: a general source of federal funds that may be used to finance any federal activity. The more general revenue

required by Medicare, the less is available for other federal programs unless Congress raises income tax rates.

Medicare’s Plate Tectonics

Predicting Medicare’s financial future is similar to the work seismologists do in predicting earthquakes. They study the pressures building up as the continental plates slowly and relentlessly scrape against each other, hoping to ascertain when the Big One will occur. There is no

question that an earthquake eventually will occur along a fault line, but it is difficult to pin down the time and place with any accuracy.⁴

Medicare’s budget pressures build up in much the same relentless way, although the precise path is difficult to predict. The aging of America results in higher Medicare spending over time as enrollment swells, and adds a growing burden on the working population which provides most of the financial support for the program through their income and payroll taxes.

Adding to, but separate from, an increasingly older population is the growing demand for health services by the average Medicare beneficiary. Demand is driven partly by medical progress, which has led to more effective treatment for disease, and partly by Medicare’s financial incentives, which promote the use of health care.

In any one year we will see only small changes in Medicare enrollment and

spending per beneficiary, but over time the unchecked fiscal pressure will jolt the program. In 2011, for example, when the first baby boomers reach age sixty-five, Medicare enrollment will reach 47.5 million, a seemingly modest increase of 1 million people from the previous year.⁵ By 2030, Medicare enrollment will reach 78.6 million people, about double the number of beneficiaries in the program this year.

The number of workers supporting each beneficiary will decline over the same time period, from about 3.6 in 2011 to 2.3 in 2030.⁶ Even with a growing economy, Medicare revenue will fall short of spending under current policy. According to the trustees, Medicare spending in 2030 will reach 6.5 percent of gross domestic product (GDP), but revenue for the program will total

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only 5.3 percent of GDP.⁷ The funding gap is projected to grow rapidly absent new legislation to slow program spending or increase revenue.

The political fault line lies between those who receive Medicare benefits and those who are expected to pay for them. Seniors will be expected to pay more of the cost of their benefits in coming years, but working-age people will still carry the bulk of the burden.

According to the trustees, seniors will see their costs more than double in real terms between 2006 and 2030. They currently pay premiums for Parts B and D. Higher-income seniors also pay income taxes on their Social Security benefits, which are funneled back to Medicare. In 2006, those payments amount to about 0.4 percent of GDP, or about 13 percent of Medicare's total outlays. Under current law, that will increase to 1 percent of GDP in 2030, but that is only about 15 percent of outlays.⁸ Even so, such increases are likely to be met with cries for relief from a large, politically active senior population.

Workers will also see income tax payments for Medicare rise sharply. General tax revenue flowing into Medicare will triple in real terms between 2006 and 2030, rising from about 1 percent to 2.8 percent of GDP.⁹ That is equivalent to a \$240 billion tax increase this year. Medicare payroll taxes are expected to decline slightly, from 1.4 to 1.3 percent of GDP over the time period.

Despite the large increases in beneficiary and worker payments, there will be a funding shortfall equal to about 1.2 percent of GDP, or about \$160 billion in today's dollars. That could be paid through higher income taxes, on top of the already large increase in income tax revenue absorbed by Medicare. But that approach would not be politically popular and higher taxes would slow economic growth and reduce employment.¹⁰

As difficult as it would be to raise taxes on workers, such an action would not help seniors with the hefty increase in their own cost. A sensible approach, then, is to work on the other side of the fiscal equation: do not simply pour more revenue into Medicare without addressing the program features that have promoted unnecessary spending growth.

Ignore the Insolvency Date

Of all the estimates in the 219-page trustees report, the one that attracts the most attention is the predicted year when the HI Trust Fund will no longer be able to pay all the bills. This year's report says that the fund will have a zero balance in 2018. After that date, Medicare will be

able to pay only about 80 percent of the cost of HI benefits out of the payroll and income taxes that continue to be paid into the fund.¹¹

A review of earlier reports shows that the projected "insolvency date" has shifted many times, occasionally by many years. Over the past ten reports, for example, the insolvency date has ranged from as early as 2001 to as late as 2030.¹²

For some commentators, that record is evidence that the trustees are simply being alarmist. If the crisis were real, surely we would already have experienced disruption in the flow of health services to seniors. Instead, something always happens to avert the predicted crisis: the economic outlook improves, updated program information lowers the expected cost trend, or Congress takes an action that shores up Medicare financing.

One of the challenges in estimating the insolvency date is that long-term financial flows and economic indicators are difficult to predict with great precision. In addition, Congress enacts policies from time to time that, at least temporarily, slow program spending. Nonetheless, the incentives embedded into Medicare in 1965 remain largely unchanged, causing program spending to grow substantially faster than program revenue.

The insolvency date is an artifact of Medicare's structure and it is not a valid indicator of the program's overall financial status. The payroll and Social Security taxes that flow into the HI Trust Fund generally grow with the economy, but HI spending grows even faster. Hence, the HI Trust Fund could run short of funds in the future. Because future legislation cannot be predicted, the trustees' estimate assumes that current laws and regulation govern trends in program cost and revenue.

In contrast, the SMI Trust Fund, which pays for more than half of Medicare's benefits, cannot become insolvent. By law, general revenue and premium amounts are automatically adjusted every year in response to expected spending increases, keeping the SMI Trust Fund in balance. Nonetheless, rapid growth in outpatient services, doctor visits, and prescription drugs also exerts fiscal pressure on Medicare that is not reflected in the HI insolvency date.

Better (But More Difficult) Measures

A better indicator of Medicare's fiscal distress would incorporate information from both HI and SMI. Two statistics introduced in recent years in the trustees report are comprehensive and measure the fiscal standing of the

entire program, but neither has the intuitive appeal of the insolvency date.

Both statistics account for the flow of general revenue into Medicare, reasoning that greater inflows to Medicare reduce the money available to finance other federal programs and priorities. This year's report shows that general revenue is the largest single source of income to the Medicare program as a whole. That is the consequence of implementing the Part D drug benefit, which, like Part B, is financed primarily with general tax funds.

One statistic estimates the total amount of general revenue projected to be transferred into Medicare over the long term. Combining the separate figures for HI and SMI, the trustees indicate that we must find \$32.1 trillion in general taxes, measured in today's dollars, if Medicare is to pay all of its bills over the next seventy-five years.¹³ In technical terms, this is the present value of Medicare's funding shortfall measured as the difference between outlays and revenue specifically dedicated to Medicare (that is, payroll and Social Security taxes, premiums, and state payments for Part D). Some \$70.5 trillion is required to fully finance Medicare indefinitely.

Such large numbers are hard to comprehend, even for someone who is used to the Medicare metric of hundreds of billions of dollars. One interpretation is that we would have to (somehow) put away in a savings account more than twice the value of this year's GDP to assure that all of Medicare's obligations would be met over the next seventy-five years—but in the seventy-sixth year, there would be a deficit. Such a stupendous number demonstrates clearly that Medicare is on an unsustainable growth path.

The second comprehensive financial statistic found in the trustees report measures the percentage of Medicare's annual spending that is paid using general revenue. The greater that percentage, the more dependent Medicare will be on general funds that automatically pass into the trust fund.

The Medicare Modernization Act (MMA), which established the program's new prescription drug benefit, requires the trustees to test whether general revenue exceeds 45 percent of Medicare outlays. If that level is attained during the year of the trustees report or in the

following six years, that is considered a period of "excess general funding." This process is intended to alert policy-makers that program spending is rising more rapidly than Congress had envisioned in 2003, when the MMA was passed. The trustees made a determination of excess general funding for the first time in this year's report.

If a determination of excess general funding is made in two succeeding trustees reports, then a "Medicare funding warning" is triggered. Such a finding requires that the president submit proposed legislation to Congress that responds to the warning. Congress is then required to consider this legislation on an expedited basis, but it is under no obligation to take action.

Because the Medicare funding warning mechanism only imposes some procedural requirements on the policymaking process, it is unlikely to have any significant effect on program finances. Moreover, the 45 percent standard is *not* an intuitively obvious fiscal barrier that could not be crossed without immediate dire consequences. Prior to this year, general revenue accounted for about 35 percent of program outlays.¹⁴ Implementing the Part D drug benefit raised that level to 43 percent this year, and the measure is expected to reach 45 percent in 2012.

The president proposed in his 2007 budget to give the provision some teeth.¹⁵ That proposal would build in an automatic across-the-board reduction in Medicare spending of 0.4 percent if a funding warning was declared by the

trustees. That reduction would accumulate, growing by 0.4 percent for every year that exceeds the 45 percent threshold until spending was brought into line. Congress has not been eager to embrace the 0.4 percent solution.

The present value calculation and the 45 percent standard measure two dimensions of Medicare's funding shortfall. The first statistic describes the long-term trend in program financing. That figure is unlikely to change greatly in future reports unless Congress takes a bold action to either increase outlays (as it did by instituting the Part D drug benefit) or decrease outlays (through a comprehensive Medicare reform). The second statistic describes Medicare's financial status in the short term, and it is sensitive to more modest legislative initiatives.

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Preventing a Medicare Quake

Like most financial reports, the Medicare trustees report has an austere quality that stirs the passions of policy wonks and no one else. After a day or two of media coverage, the report will be put on the shelf, but the policy problems will remain.

Unless substantial reforms are initiated, Medicare faces a bleak future of rising costs and tightening revenue. The fact that Medicare has always paid the bills over its four-decade history does not mean that the program's future is manageable with minor policy tweaks. Fundamental restructuring is needed to promote competition and offer beneficiaries a choice of health plans. We need to replace Medicare's culture of entitlement, which distorts the decisions of patients and providers alike, with a culture of individual responsibility and efficient delivery of care.

It is difficult for policymakers to take on the arduous task of overhauling a major social program. The pain of reform is immediate, while the rewards (in terms of improved efficiency, lower cost, and better quality) materialize later. The political calculus is clear.

All too often, the policy horizon for politicians extends only to the next election. We are now five years—less than a senatorial term—away from entry of the first baby boomers into Medicare. This will permanently ratchet up fiscal and political pressure on the program, making it even more difficult to reach an agreement on a reform package that does more than delay the inevitable a few years. The trustees have once again highlighted the need for prudent action if we are to avoid a social insurance tremor. We ignore their warning at our own risk.

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Notes

1. The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2006 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: May 1, 2006), hereafter referred to as "Report," available at www.cms.hhs.gov/ReportsTrustFunds.

2. The Boards of Trustees, Social Security and Medicare, *Status of the Social Security and Medicare Programs: A Summary*

of the 2006 Annual Reports (Washington, D.C.: May 1, 2006), hereafter referred to as "Summary," available at www.ssa.gov/OACT/TRSUM/trsummary.html. Social Security is also unsustainable under current financing arrangements, but the magnitude of that program's problem is much less severe than Medicare's.

3. This is unquestionably true when the federal government is running a budget deficit. If the federal budget is in surplus, one could argue that a portion of any trust fund surplus is saved by buying back part of the federal debt.

4. Alicia Chang, "Predicting Earthquakes Still Elusive," *Washington Post*, April 15, 2006, available at www.washingtonpost.com/wp-dyn/content/article/2006/04/15/AR2006041500512.html.

5. Report, 34, table III.A3.

6. Author's calculation, using the estimated number of workers covered by Social Security (from Board of Trustees, Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, 2006 *Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*, 47, table IV.B2, intermediate assumptions, available at www.ssa.gov/OACT/TR/TR06/index.html) and the estimated number of Medicare beneficiaries (from Report, 34, table III.A3). The number of workers increases over the period less rapidly than the number of beneficiaries, causing the decline in the ratio of workers to beneficiaries.

7. Report, 35, table III.A4.

8. *Ibid.*

9. *Ibid.*

10. The macroeconomic consequences of financing Medicare through higher taxes are discussed in Tracy L. Foertsch and Joseph R. Antos, *The Economic and Fiscal Consequences of Financing Medicare's Unfunded Liabilities*, Center for Data Analysis report CDA05-06 (Washington, D.C.: Heritage Foundation, October 11, 2005).

11. Summary.

12. Dates reflect the trustees' intermediate assumptions.

13. This combines data from Report, 64, table III.B10: 104, table III.C15; and 115, table III.C21.

14. There has been substantial variation in the percent of total outlays paid by general revenue, in part because of frequent legislative and regulatory changes in payment rates to providers. In 2003, 34.1 percent of program outlays were paid by general revenue.

15. See Executive Office of the President of the United States, *Analytical Perspectives: Budget of the U.S. Government, Fiscal Year 2007* (Washington, D.C., 2006), 211, available at www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf.