THE FINANCIAL

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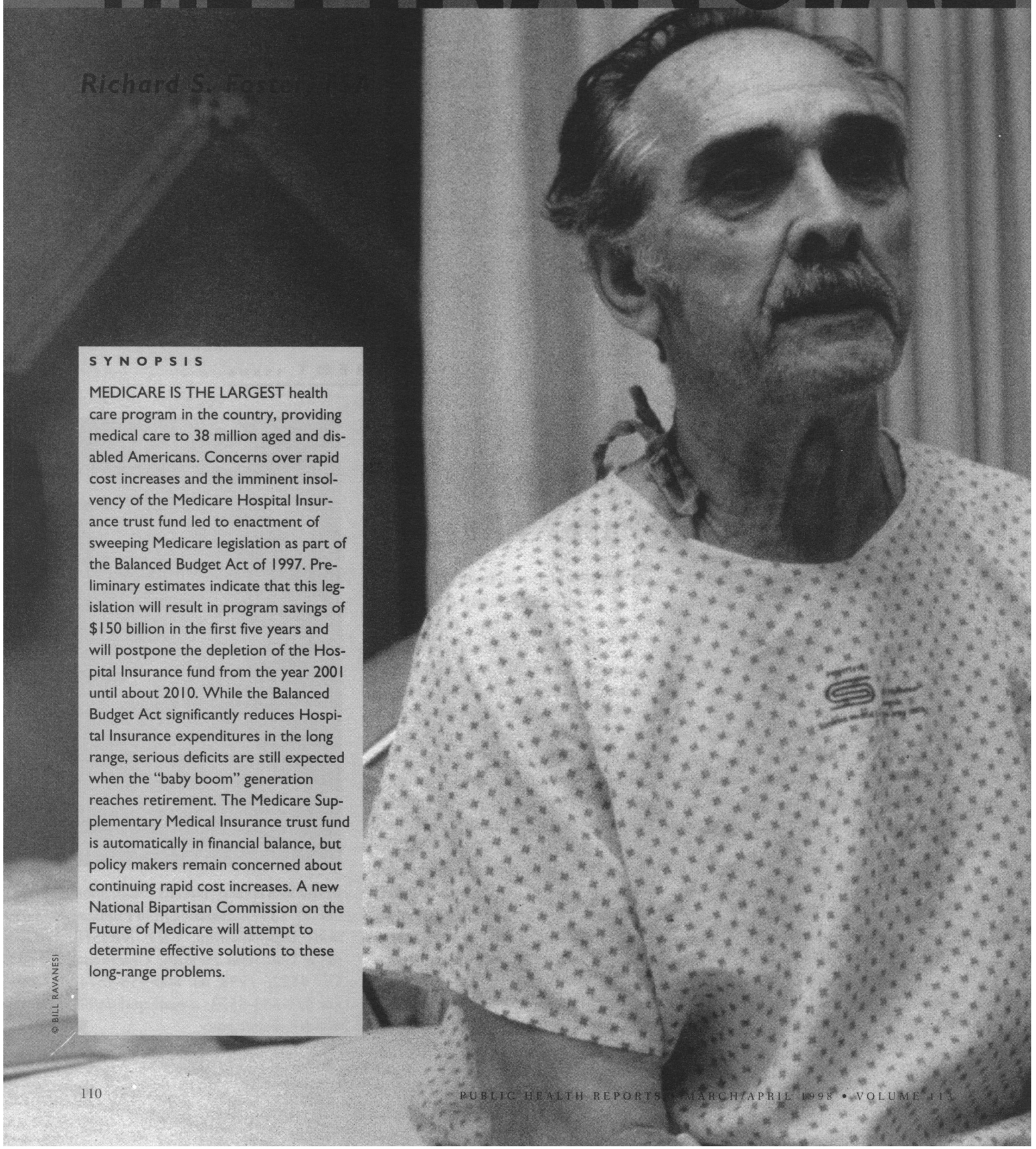
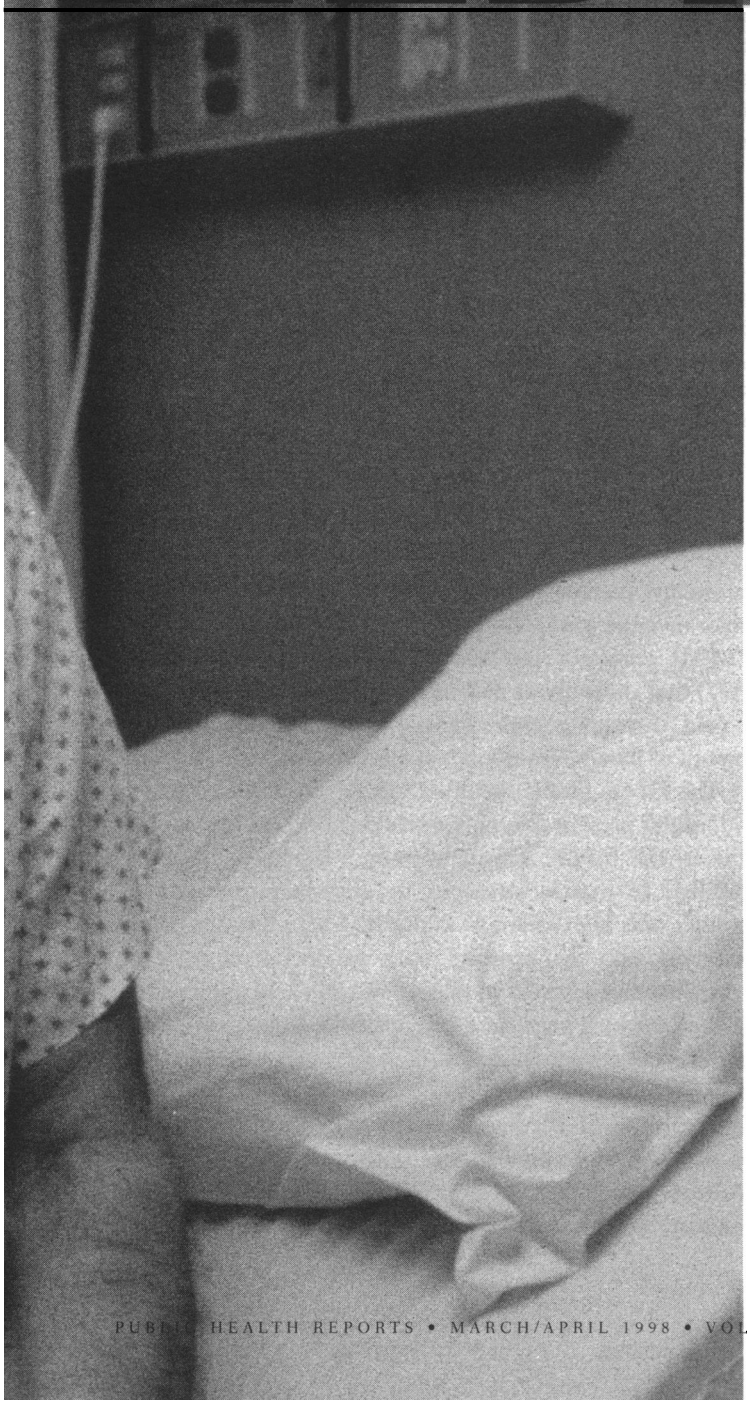


SYNOPSIS

MEDICARE IS THE LARGEST health care program in the country, providing medical care to 38 million aged and disabled Americans. Concerns over rapid cost increases and the imminent insolvency of the Medicare Hospital Insurance trust fund led to enactment of sweeping Medicare legislation as part of the Balanced Budget Act of 1997. Preliminary estimates indicate that this legislation will result in program savings of $150 billion in the first five years and will postpone the depletion of the Hospital Insurance fund from the year 2001 until about 2010. While the Balanced Budget Act significantly reduces Hospital Insurance expenditures in the long range, serious deficits are still expected when the "baby boom" generation reaches retirement. The Medicare Supplementary Medical Insurance trust fund is automatically in financial balance, but policy makers remain concerned about continuing rapid cost increases. A new National Bipartisan Commission on the Future of Medicare will attempt to determine effective solutions to these long-range problems.

STATUS OF MEDICARE



THE FINANCIAL STATUS of the Medicare program has been the subject of extensive news coverage in recent years. Most of the media attention has focused on the projected depletion of the Hospital Insurance trust fund. Occasionally, longer-term issues such as the effects of the baby boomers' retirement are raised. The media attention reflects growing public concern over Medicare's financial viability—a concern that led directly to the sweeping Medicare provisions contained in the Balanced Budget Act of 1997. This article briefly summarizes the benefits and financing of the Medicare program and the impact on Medicare of the Balanced Budget Act.

BENEFITS AND FINANCING

Medicare, the Federal health insurance program for aged and disabled Americans, was created in 1965. The program has two parts: Hospital Insurance (HI), and Supplementary Medical Insurance (SMI).

HI, also known as "Medicare Part A," provides substantial coverage of the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care (subject, in most cases, to certain deductible and coinsurance requirements). To qualify for HI, people must be 65 years of age or older and eligible for Social Security benefits or, without regard to age, must

Figure 1. Medicare enrollment, benefits, and financing

	Hospital Insurance (HI)	*Supplementary Medical Insurance (SMI)*
Enrollment in 1996	38 million	36 million
Proportion using reimbursable services	22%	84%
Benefits[a]	Inpatient hospital care Skilled nursing care Home health care (post-institutional) Hospice care	Physician services Outpatient hospital services Home health care (general) Other services, for example: • Diagnostic tests • Medical equipment • Ambulance
Financing	HI tax on covered earnings: • 1.45% payable by employees and 1.45% payable by employers • 2.90% payable by self-employed • Effective 1994, HI tax applies to *all* earnings in covered employment	Premium paid by enrollees in 1997 (covers 25% of costs): • $43.80 per month for all enrollees
	Revenue from taxation of Social Security benefits (portion between 50% and 85%)	General revenue transfers in 1997 (covers remaining 75% of costs): • $131.40 per month for aged • $177.00 per month for disabled

[a]Subject to certain deductibles and copayments

have received Social Security disability benefits for at least 24 months or have end-stage renal disease.

SMI ("Medicare Part B") covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth. Again, in most instances beneficiaries are subject to deductibles and copayments. SMI is an optional program, open to almost everyone 65 or older as well as to people under age 65 who meet the eligibility requirements for HI.

Roughly 38 million people were eligible for Medicare benefits in 1996 (Figure 1). Only about 22% of HI enrollees received reimbursable services during 1996; hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees (84%) incurred reimbursable SMI costs because the services covered by SMI are more routine and the annual deductible is only $100.

The two parts of Medicare are financed on totally different bases. HI costs are met primarily through FICA (Federal Insurance Contributions Act) and SECA (Self-Employment Contributions Act) payroll taxes. The total FICA payroll tax rate is 7.65% of covered wages payable by employees, with another 7.65% payable by employers. The HI portion of this tax rate is 1.45%, with the remaining 6.20% allocated to the Old-Age, Survivors, and Disability Insurance program, more commonly known as Social Security. The SECA tax rate is equal to the combined employee-employer FICA rate, or 15.30%, payable on net self-employment income. The HI portion of the self-employed tax rate is 2.90%.

Since passage of the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings from covered employment, without limit. (In 1993, the last year before this change, HI taxes had been paid on earnings up to $135,000.) HI is also funded by a portion of the income taxes levied on Social Security benefits and by interest income from investments as well as by other minor revenue sources.

SMI enrollees pay monthly premiums ($43.80 in 1997) that cover about 25% of program costs. The balance is paid through general Federal revenues and a small amount of income from interest on investments.

The HI tax rate is specified in the Social Security Act and, under present law, is not scheduled to change at any time in the future. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, SMI premiums and payments into the program from general revenues are reestablished each year to match estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

Each part of Medicare has its own trust fund, with financial oversight provided for both funds by a Board of Trustees. The Board is comprised of the Secretary of the Treasury, who serves as Managing Trustee, the Secretary

of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security, and two members appointed by the President and confirmed by the Senate who represent the public at large.

In discussing the current status of the Medicare program and the potential impact of the Balanced Budget Act of 1997, I use the financial projections contained in the Board's 1997 reports to Congress, issued on April 24, 1997, combined with preliminary updates developed by my office to reflect the Act's effects.

The Board makes its Medicare projections under three alternative sets of economic and demographic assumptions (low, intermediate, and high projected future costs), to cover both a "short-range" period (the next 10 years) and a "long-range" period (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. In this article, I use the Trustees' "intermediate" set of assumptions. More comprehensive estimates of Medicare's financial status, including a more detailed analysis of the impact of the Balanced Budget Act of 1997, will be published in the Board's 1998 reports to Congress, due in April 1998. (The 1997 reports are available on the World Wide Web at **www.hcfa.gov/pubforms/tr1997.htm**.)

I will first describe the short- and long-range financial outlook for the HI program, and then do the same for the SMI program.

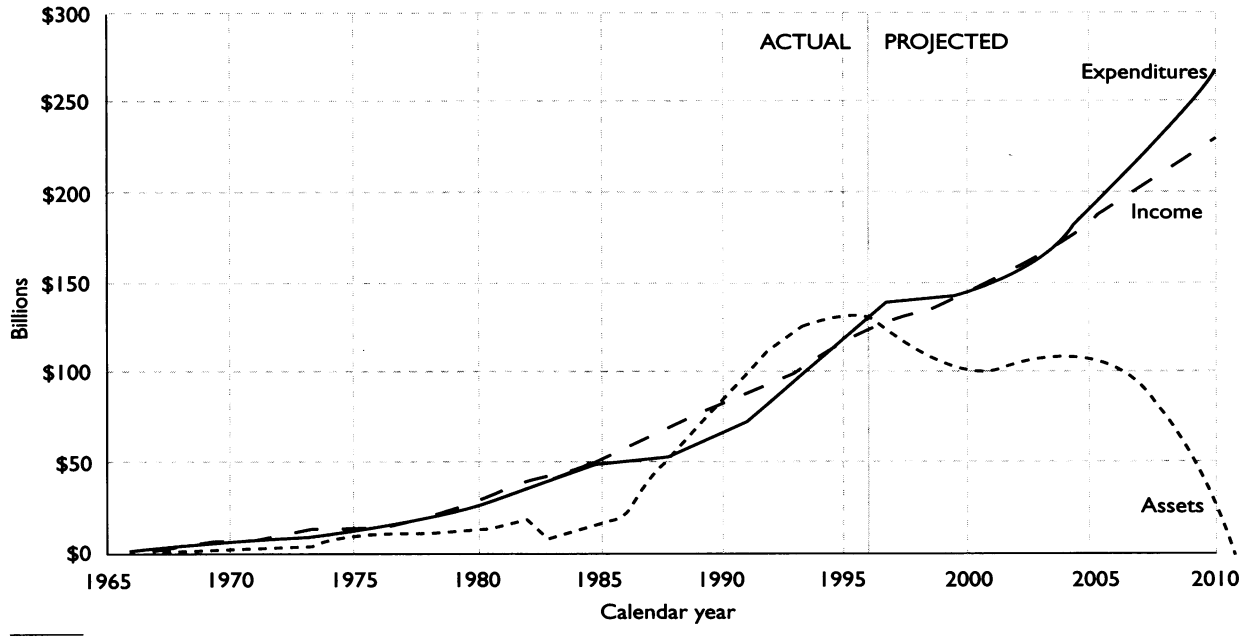
HI's Short-Range Financial Outlook

For most of the HI program's history, income and expenditures have been very close together, illustrating the "pay-as-you-go" nature of HI financing (Figure 2). The taxes collected each year are intended to be roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities. The Board of Trustees has recommended maintaining assets equal to at least one year's expenditures as a contingency reserve.

Figure 2 shows the income, expenditures, and trust fund assets for the HI program for 1966–1996 and projections through the year 2010, based on the Trustees' intermediate assumptions. Since about 1990, HI expenditures have been increasing faster than income. Expenditures exceeded income by $2.6 billion in 1995, $5.3 billion in 1996, and an estimated $12 billion in 1997. Prior to passage of the Balanced Budget Act, this trend was expected to continue, with costs growing at 8% to 9% annually, against revenue growth of only 5% to 6%. The 1995–1997 shortfalls have been met by redeeming trust fund assets. Without corrective legislation, assets would have been depleted in 2001. The Medicare provisions in the Balanced Budget Act were designed to help address this situation. (These provisions are both numerous and complex; summaries of the legislation are available from the Health Care Financing Administration and the Ways and Means Committee of Congress.

The Act reduces HI expenditures by an estimated $152 billion between fiscal year 1998 and fiscal year 2002.

Figure 2. Medicare Hospital Insurance program income, expenditures, and trust fund assets



NOTE: Projections are based on the intermediate assumptions used in the 1997 Trustees Reports and are preliminary.

Most of these savings will be accomplished through reducing the rate of growth in HI payments to health care providers and implementing new prospective payment systems for skilled nursing, home health, and certain other types of care. In addition, a significant portion of the total HI savings (about $35 billion in the first five years) will result from transferring home health care services not associated with a prior stay in an institution to the SMI program. This change does not lower Medicare costs overall but improves the financial position of the HI trust fund, since the costs of the transferred benefits will be financed through SMI premiums and general revenue income.

As shown in Figure 2, these changes will significantly reduce the growth rate in HI expenditures during this period, bringing income and outlays back into approximate balance between 2000 and 2004 and slowing the decline in assets. Thereafter, however, expenditures are projected to again increase at a faster pace than income. Assets would be drawn down to cover the resulting shortfalls but, based on the Trustees' intermediate assumptions, would be exhausted by about 2010.

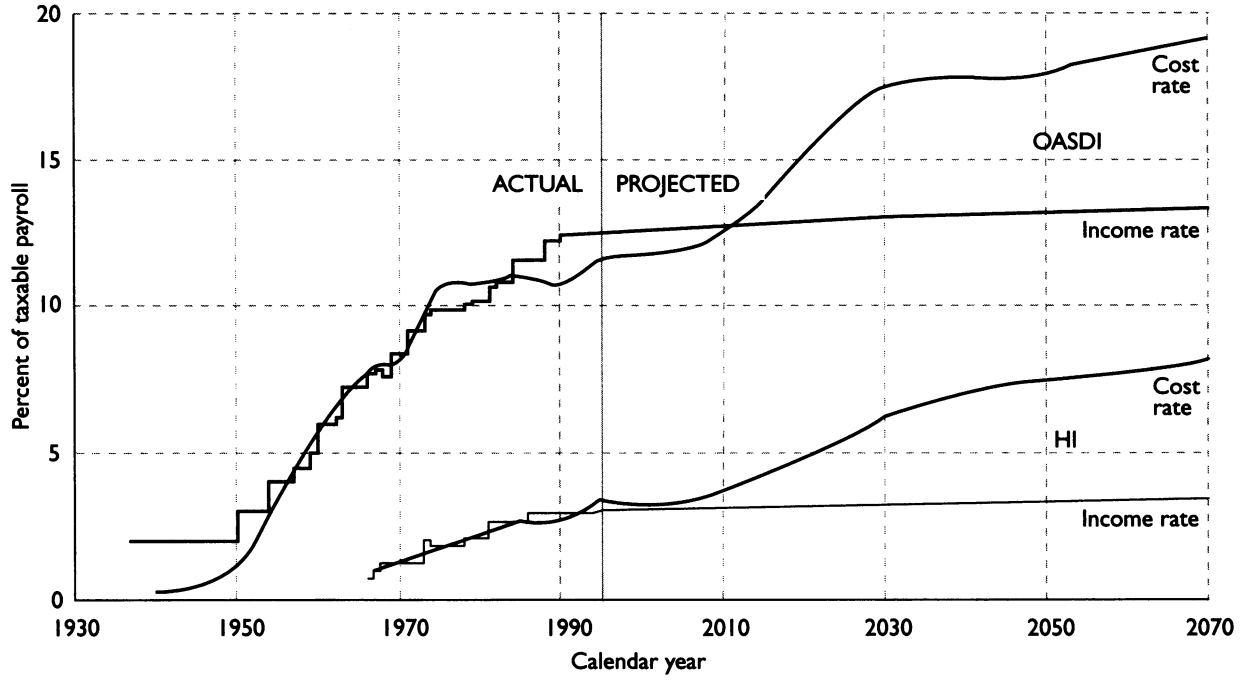
Thus, the Balanced Budget Act of 1997 postpones the projected depletion of the HI trust fund from 2001 to approximately 2010, 13 years from now. This allows time for the nation's policy makers to find ways to address the longer-term financial problems facing Medicare.

HI's Long-Range Financial Outlook

Because of the changing value of the dollar over time, interpreting dollar amounts is very difficult for extremely long periods such as the 75-year time frame used in the 1997 Trustees Reports. For this reason, the HI report expresses long-range tax income and expenditures as percentages of taxable payroll and thus as rates. ("Taxable payroll" is the total amount of wages and self-employment income subject to the HI payroll tax.) In 1997, taxable payroll amounted to about $3.9 trillion. Projected "income rates" and "cost rates" for the HI program are shown in Figure 3, along with the corresponding projections for the Social Security cash payments (OASDI) program. (I use the Social Security program for comparison since many readers may be familiar with the program's past financial crises.)

For both the HI and OASDI programs, income rates have generally followed program costs closely, rising in a stepwise fashion as payroll tax rates have been adjusted by Congress. The financial problems experienced by the OASDI program in the mid-1970s and early 1980s are

Figure 3. Long-range income rates and cost rates (as a percent of taxable payroll), Social Security cash payments (OASDI) program and Hospital Insurance program, Medicare



NOTE: Projections are based on the intermediate assumptions used in the 1997 Trustees Reports. HI projections are preliminary.
OASDI = Old Age, Survivors, and Disability Insurance
HI = Hospital Insurance program, Medicare

illustrated by the gap between the income rate and cost rate for that period. Current OASDI surpluses are also apparent. The differences between OASDI income and costs have generated considerable controversy over the years. Compare their magnitude, however, to that of the projected future deficits for both OASDI and HI.

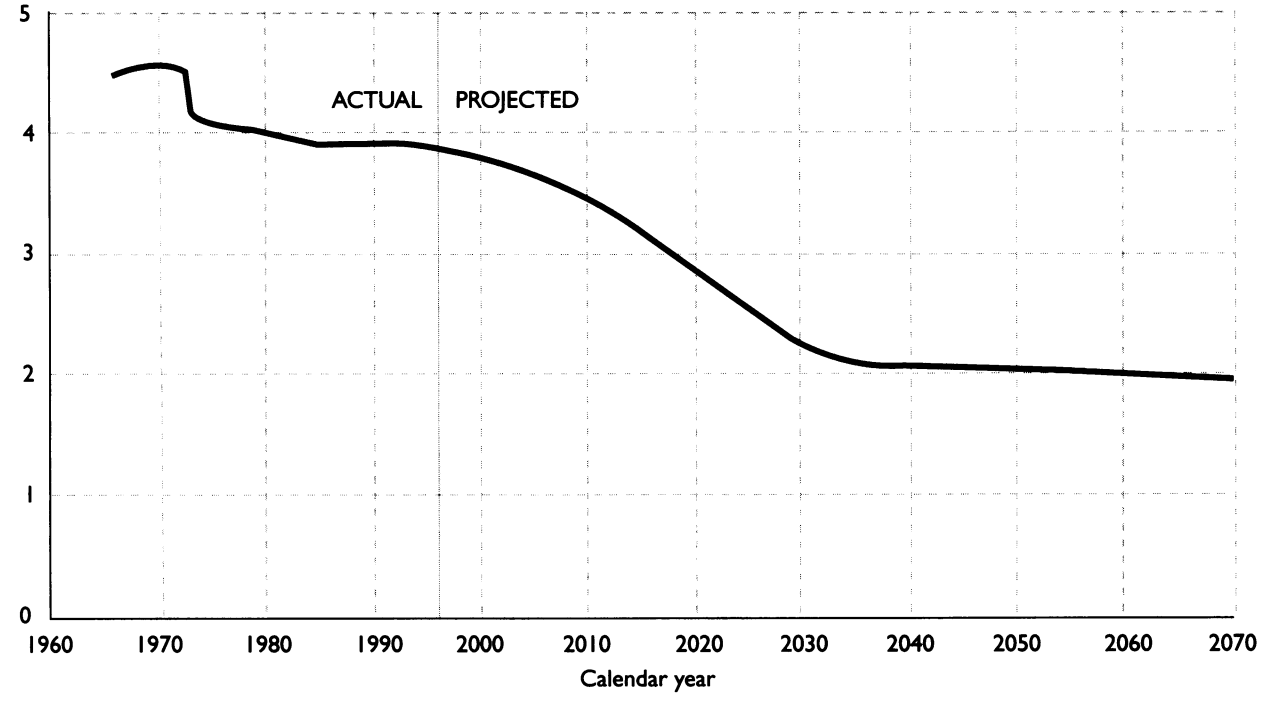
Projected growth in income rates for both programs is minimal due to the fixed tax rates specified in current law. HI trust fund revenue from the taxation of OASDI benefits will increase gradually because the income thresholds specified in the Internal Revenue Code are not indexed to the Consumer Price Index. Over time, payments to an increasing proportion of OASDI beneficiaries will be subject to income taxes. For HI, cost rates are projected to initially decrease as a result of the Balanced Budget Act. Once fully phased in, the Act's provisions are expected to reduce HI expenditures by an estimated 28% from the level that would have existed under prior law. After 2002, however, cost rates are expected to increase steadily, according to intermediate projections, and even accelerate somewhat with the retirement of the baby boomers, beginning in about 2010. Closing the HI deficit over 25 years (1998–2022) would require a 17% reduction in benefits, a 21% increase in income, or some combination of reduced benefits and increased income, starting immediately. Over the full 75-year period, the adjustments would have to be considerably greater.

"The Balanced Budget Act of 1997...will postpone the depletion of the Hospital Insurance fund...until about 2010."

The effect of the baby boomers' retirement on Social Security and Medicare is relatively well known, having been discussed at length for more than 20 years. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary, as shown in Figure 4. Currently, this ratio is 3.9 workers per beneficiary. With the baby boomers' retirement, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to 2.2 in 2030 and 2.0 in 2050 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

Other demographic trends will also affect the widening gap between costs and income. In particular, life expectancy has improved substantially in the United States over time and is projected to continue doing so. The average remaining life expectancy at age 65 increased from 12.4 years in 1935 to the current figure of 17.4 years, with an estimated further

Figure 4. Number of covered workers per Hospital Insurance program beneficiary



NOTE: Projections are based on the intermediate assumptions used in the 1997 Trustees Reports.

increase to over 20 years at the end of the long-range projection period. Medicare costs are also sensitive to the age distribution of beneficiaries. Older people incur substantially greater costs for medical care, on average, than younger people. Thus, as the beneficiary population ages over time, moving into higher-utilization age groups, this will add to the financial pressures on the Medicare program.

SMI's Short- and Long-Range Financial Outlook

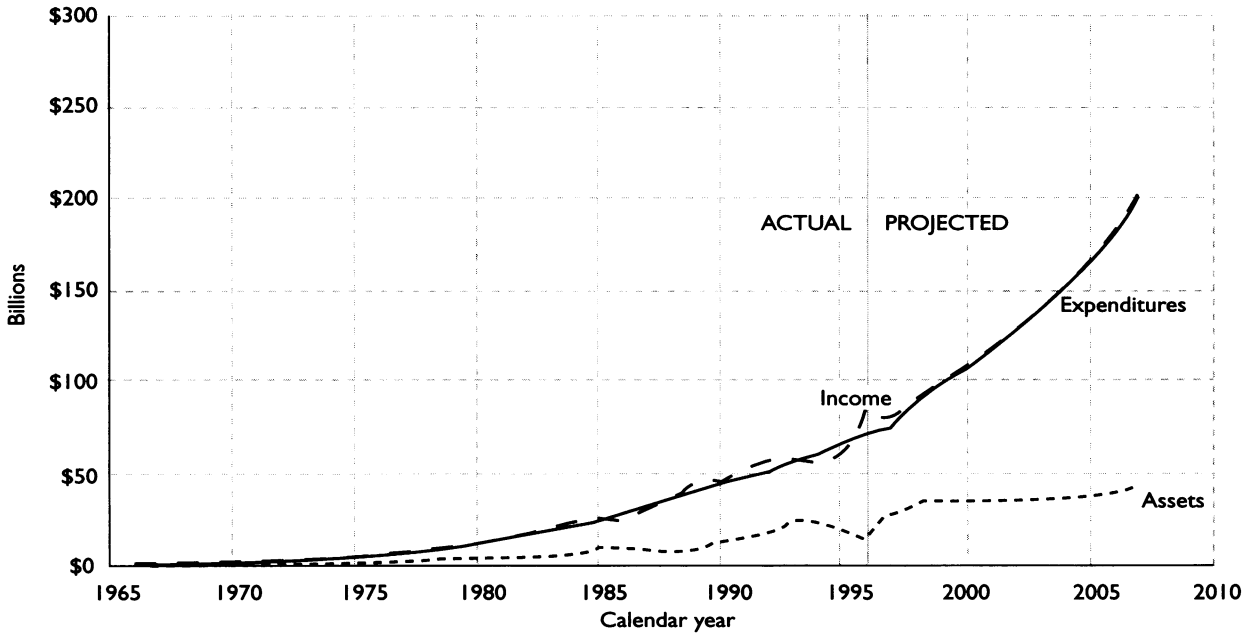
The short-range outlook for SMI (Figure 5) reveals two important differences from the outlook for HI. First, the income and expenditure curves for SMI are nearly indistinguishable, both in the past and as projected for the future. SMI premiums and general revenue income are reestablished annually to match expected program costs for the following year, as noted above. Thus, under present law, the program will automatically be in financial balance regardless of future trends in program costs. The second difference between the short-term projections for SMI and HI is the relative level of trust fund assets. Since financing is reset frequently, SMI does not need to maintain as large a reserve fund as HI.

The primary concern for SMI is the rapid rate of growth in benefits. SMI costs have grown by 45% over the last five years, exceeding the growth in the nation's gross domestic product (GDP) by 14%. Similar growth is projected for the short-range future. Although the Balanced Budget Act contained a number of provisions designed to reduce the rate of growth in SMI expenditures, their impact is more than offset by two other legislative changes. First, as noted above, the Act specified that certain home health services were to be converted from Part A to Part B benefits and paid for by the SMI trust fund (phased in over several years). In addition, the Act provides for several significant new preventive or "screening" benefits, such as colorectal examinations, not previously covered by Medicare. As a result, SMI costs are estimated to increase by a net total of $17 billion during fiscal years 1998–2002 under the Balanced Budget Act.

The increase in SMI costs over this period will be largely offset by an additional $16 billion in premium revenue under a provision of the Act that maintains the SMI premium paid by beneficiaries at the level of 25% of expenditures. Prior to the Balanced Budget Act, premium increases were limited to the Social Security cost-of-living adjustment (COLA) and, over time, would have represented a declining share of total costs. The Balanced Budget Act makes permanent the current relationship between premium revenue and total costs.

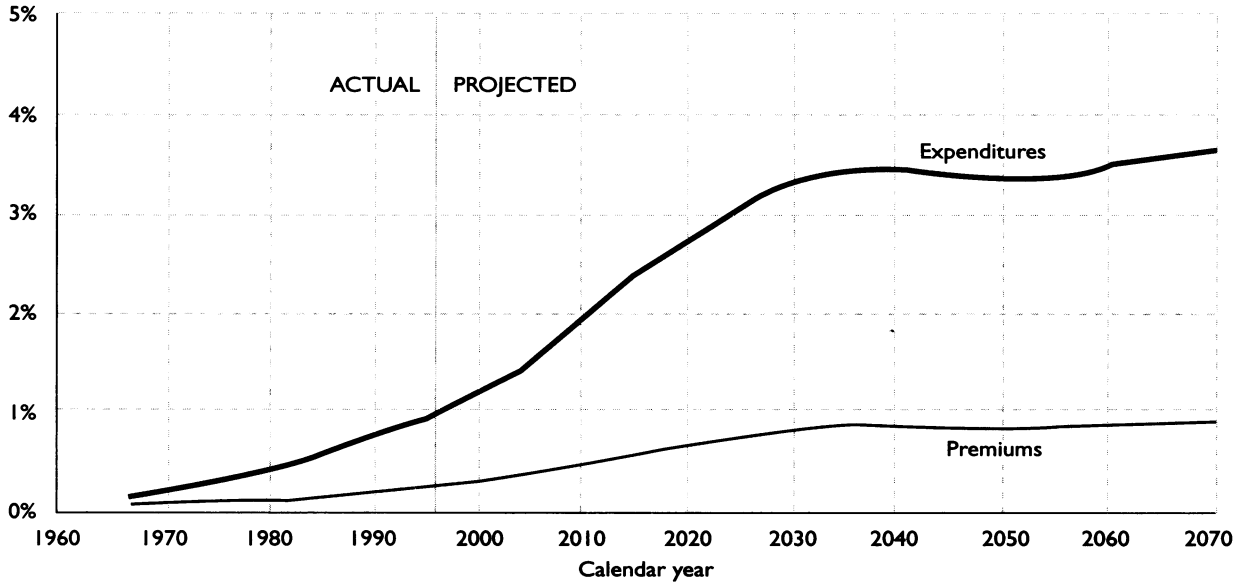
The long-range costs of SMI (shown in Figure 6 as a percentage of GDP) are expected to follow the same general pattern seen previously for HI. In contrast to those of HI, SMI costs will automatically be met through enrollee premiums and general revenues of the Federal government. Policy makers remain concerned about continuing rapid growth in SMI expenditures as it consumes an increasing share of Federal funds.

Figure 5. Medicare Supplementary Medical Insurance program income, expenditures, and trust fund assets



NOTE: Projections are based on the President's 1998 Mid-Session Review assumptions.

Figure 6. Medicare Supplementary Medical Insurance program expenditures and premiums in long range as a percentage of Gross Domestic Product



NOTE: Projections are based on the intermediate assumptions from the 1997 Trustees Reports and are preliminary.

CONCLUSIONS

The Balanced Budget Act of 1997 will have an important impact on the short-range financial outlook for the Medicare program, with projected net savings of $150 billion in the first five years. These changes postpone the year in which the HI trust fund is expected to be exhausted from 2001 to about 2010. Thus, a primary goal of the Balanced Budget Act—addressing the imminent depletion of the HI trust fund—has been accomplished. Moreover, although not intended as a solution to the long-range financial imbalance, the Balanced Budget Act also significantly reduces HI expenditures, thereby reducing the projected gap between income and outgo.

To help address the remaining longer-range financial issues facing HI and SMI, the Balanced Budget Act mandated the establishment of a National Bipartisan Commission on the Future of Medicare (see Box). The Commission's charge is to review the long-term financial condition of Medicare and to make recommendations to the President and Congress concerning the program's financing, benefit structure, and related issues.

Public health professionals have an important opportunity—and obligation—to participate in the coming debate over how to best address Medicare's long-range financial issues. Medicare is the nation's largest health insurance program. Your expertise can help ensure that Medicare continues to meet the health needs of the aged and disabled effectively and affordably.

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