

The Financial Outlook for Medicare

Testimony before the
Senate Finance Committee

March 22, 2001

by

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Chairman Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medicare program as shown in the recently released 2001 annual reports of the Medicare Board of Trustees. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program—one that is a critical factor in the income security of the our aged and disabled populations.

The financial outlook for the Medicare program presents a mixed picture. Over the next 10 years, the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are adequately financed and meet the Trustees' formal tests for short-range financial adequacy. The depletion of the HI trust fund, which had been projected for 2025 in last year's Trustees Report, has been postponed to 2029 in the new estimates.

Over the long range, in contrast, HI and SMI expenditures are projected to grow more rapidly than in previous reports as a result of revised long-range Medicare cost growth assumptions. The assumption change was recommended by the 2000 Medicare Technical Review Panel, an independent, expert group of actuaries and economists convened by the Board of Trustees to review the Medicare financial projections. HI tax revenues are projected after 2015 to fall increasingly short of program expenditures, eventually covering only one-third of estimated costs by the end of the Trustees' 75-year projection period. For SMI, continuing rapid expenditure growth would place growing financial burdens both on beneficiaries and on the Federal budget. The SMI trust fund would remain in financial balance indefinitely, however, due to the annual redetermination of program financing.

Background

Roughly 39 million people were eligible for Medicare benefits in 2000. HI, or "Part A" of Medicare, provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. SMI 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.

Only about 22 percent of HI enrollees received some reimbursable covered services during 2000, since hospital stays and related care tend to be infrequent events even for the aged and disabled.

In contrast, the vast majority of enrollees incur reimbursable SMI costs because the covered services are more routine and the annual deductible for SMI is only \$100.

The two parts of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.¹ Of the total FICA tax rate of 7.65 percent of covered earnings, payable by employees and employers, each, HI receives 1.45 percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. Other HI income includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums (\$50.00 in 2001) that cover about 25 percent of program costs. The balance is paid by general revenue of the Federal government and a small amount of interest income.

The HI tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, SMI premiums and general revenue payments 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.

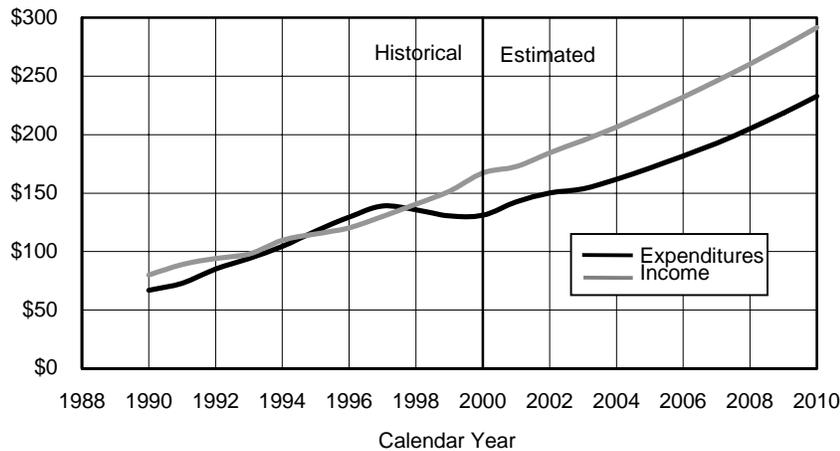
Each part of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 2001 reports to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10 years) and a "long range" (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. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

Short-range financial outlook for Hospital Insurance

Chart 1 shows HI expenditures versus income over the last 10 years and projections through 2010. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. 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.

¹ Federal Insurance Contributions Act and Self-Employment Contributions Act, respectively.

Chart 1—HI expenditures and income
(In billions)



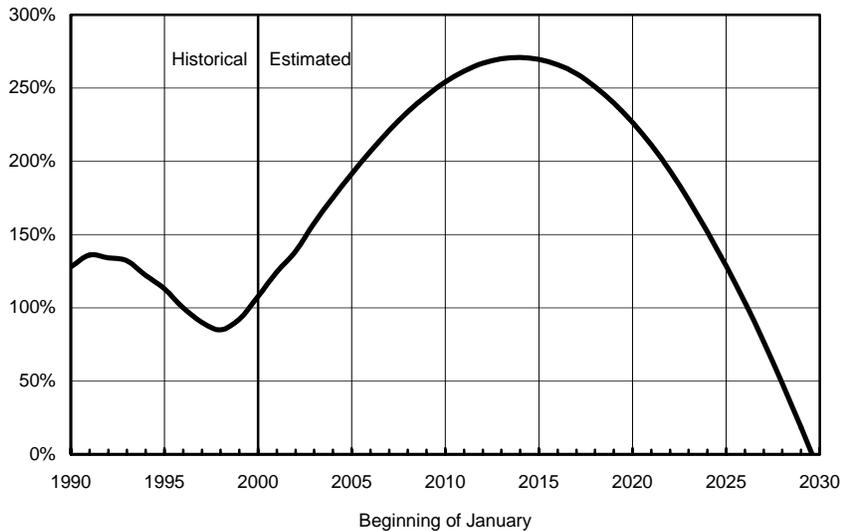
During 1990-97, HI costs increased at a faster rate than HI income. Expenditures exceeded income by a total of \$17.2 billion in 1995-97. Prior to the Balanced Budget Act of 1997, this trend was expected to continue, with costs growing at about 8 percent annually, against revenue growth of only 5 to 6 percent. The 1995-97 shortfalls were met by redeeming trust fund assets, but in the absence of corrective legislation assets would have been depleted in about 2001. The Medicare provisions in the Balanced Budget Act were designed to help address this situation. As indicated in chart 1, these changes—together with subsequent low general and medical inflation and increased efforts to address fraud and abuse in the Medicare program—resulted in a decline in HI expenditures during 1998-2000 and trust fund surpluses totaling \$61.8 billion over this period.

The Board of Trustees has recommended maintaining HI assets equal to at least one year’s expenditures as a contingency reserve. As indicated in chart 2, HI assets at the beginning of 2001 represented about 125 percent of estimated expenditures for the year. The HI trust fund is estimated to continue to experience significant surpluses for about the next 15 years. After 2020, however, expenditures are projected to again exceed income. As shown in chart 2, assets would initially accumulate rapidly but then be drawn down to cover the resulting shortfalls. The trust fund would be exhausted in 2029 under the Trustees’ intermediate assumptions.

The depletion date estimated in the 2001 Trustees Report represents a significant improvement compared to the estimate in last year’s report (2025). The improvement arises from higher payroll tax revenues and income taxes on Social Security benefits in 2000 than had been estimated, together with assumed faster economic growth over the next 10 years. In addition, benefit expenditures in 2000 were lower than estimated, and adjustments have been made to projected expenditure growth for the future based on this experience. The higher payroll taxes in 2000 resulted from robust economic growth, particularly the rapid growth in productivity and

wages. Lower-than-expected HI expenditures reflected a reduction in the utilization of skilled nursing facility services, low increases in health care costs generally, and continuing efforts to combat fraud and abuse in the Medicare program.

Chart 2—HI trust fund assets
 (Assets at beginning of year as percentage of annual expenditures)



2000 Medicare Technical Review Panel

The projections in the new Trustees Reports also reflect a number of recommendations made by the 2000 Medicare Technical Review Panel. The impact of these recommendations on the HI projections for the first 25 years were largely offsetting and had a minimal impact on the estimated year of asset depletion.

The Technical Panel was convened by the Board of Trustees in 2000 to review the financial projections in the Medicare Trustees Reports. It was made up of seven independent health actuaries and health economists, who were nominated by the prior public members of the Board of Trustees. The panel met from June through November 2000 and issued its final recommendations in December 2000.

The panel unanimously found that the projection work of the Office of the Actuary at the Health Care Financing Administration was of excellent quality and was performed in a highly competent and completely professional manner. Overall, the members concluded that the methods and assumptions used to project the status of the Medicare program were reasonable, with the exception of the long-range expenditure growth assumption, which they believed to be too low. In addition to their recommendation to increase this growth rate assumption, the panel issued 37 other findings and recommendations.

For the 2001 Trustees Reports, the Medicare Board of Trustees adopted all of the panel's

recommendations that could realistically be incorporated within the short time available following the panel's report. These included the recommended long-range growth assumptions, corresponding adjustments to short-range "case-mix" growth assumptions, an improvement in certain assumptions relating to the costs for beneficiaries who switch from fee-for-service coverage to Medicare+Choice plans, and several recommendations regarding the content of the Trustees Reports. The Board will consider the panel's remaining recommendations for possible inclusion in future reports, as time and available health research knowledge permit.

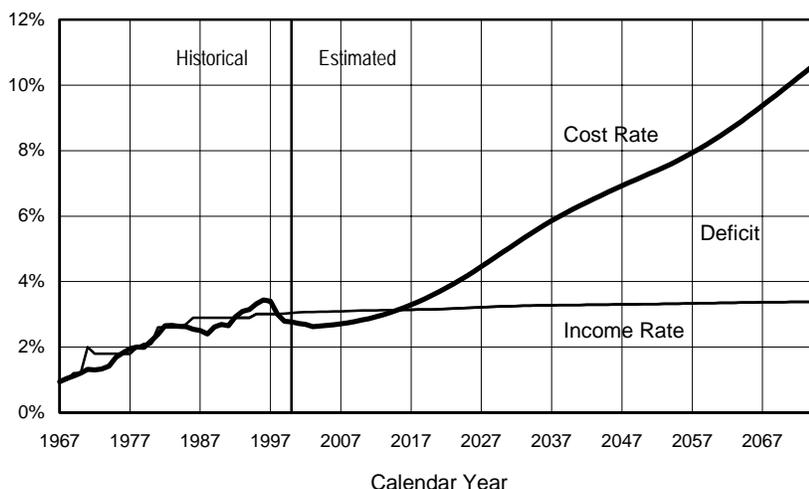
In past Trustees Reports, increases in the average HI cost per unit of service were assumed to gradually decline after the first 15 years and to equal growth in average hourly earnings during the final 50 years of the projection. The last expert review panel, in 1991, concluded that the assumption was "not unreasonable" but recommended that it be monitored carefully in subsequent years. The 2000 Technical Panel recommended that average HI and SMI expenditures per beneficiary be assumed to increase at the rate of per capita GDP plus one percentage point. They based this recommendation primarily on the historical impact of advances in medical technology on health care cost increases, which they expected to continue indefinitely. They also considered other factors contributing to health care cost growth, the assumptions of other forecasters, and the "sustainability" of such cost increases in the very long range. Although they acknowledged the remaining (and considerable) uncertainty regarding health expenditure growth rates over very extended periods, the panel concluded that there is substantially greater evidence in favor of the faster growth assumption than there is in support of the prior HI and SMI Trustees Report assumptions. I concur with their conclusion, as does the Board of Trustees.

Long-range financial outlook for Hospital Insurance

The interpretation of dollar amounts through time is very difficult over extremely long periods like the 75-year projection period used in the Trustees Reports. For this reason, long-range tax income and expenditures are expressed as a percentage of the total amount of wages and self-employment income subject to the HI payroll tax (referred to as "taxable payroll"). The results are termed the "income rate" and "cost rate," respectively. Projected long-range income and cost rates are shown in chart 3 for the HI program.

Past income rates have generally followed program costs closely, rising in a step-wise fashion as the payroll tax rates were adjusted by Congress. Income rate growth in the future is minimal, due to the fixed tax rates specified in current law. Trust fund revenue from the taxation of Social Security benefits increases gradually, because the income thresholds specified in the Internal Revenue Code are not indexed. Over time, an increasing proportion of Social Security beneficiaries will incur income taxes on their benefit payments.

Chart 3—Long-range HI income and costs under intermediate assumptions
(as a percentage of taxable payroll)

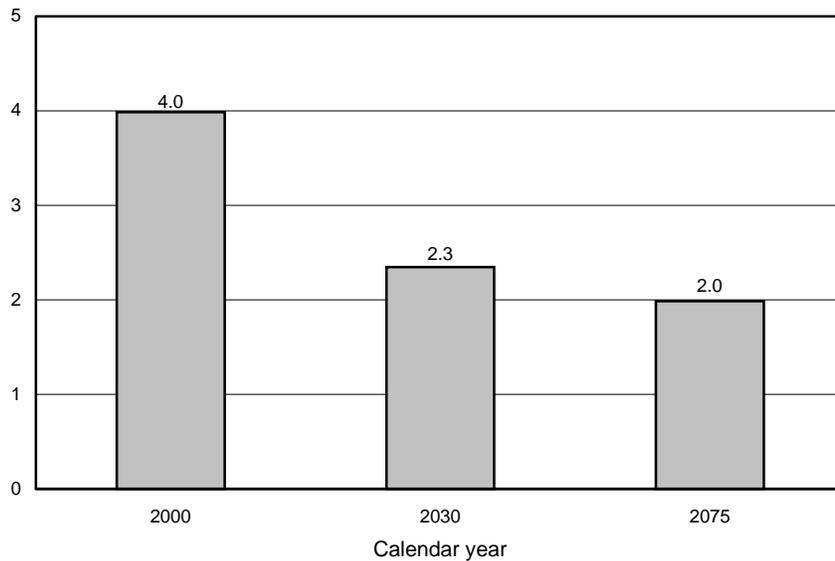


Past HI cost rates have generally increased over time but have periodically declined abruptly as the result of legislation to expand HI coverage to additional categories of workers, raise (or eliminate) the maximum taxable wage base, introduce new payment systems such as the inpatient prospective payment system, etc. Cost rates decreased significantly in 1998-2000 as a result of the Balanced Budget Act provisions together with strong economic growth. After 2002, however, cost rates are projected to increase steadily and accelerate significantly with the retirement of the baby boom, beginning in about 2010. As a result of the revised long-range expenditure growth assumption, projected cost rates after 2030 are substantially greater than the corresponding estimates in last year’s Trustees Report. In particular, by the end of the 75-year period, scheduled tax income would cover only one-third of projected expenditures.

The average value of the financing shortfall over the next 75 years—known as the actuarial deficit—is 1.97 percent of taxable payroll. This deficit could be closed by an immediate increase of 1 percentage point in the HI payroll tax rate, payable by employees and employers, each. (The projected deficit could also be eliminated by many other revenue increases and/or expenditure reductions.) Note, however, that such a change would only correct the deficit “on average.” Initially, HI revenue would be significantly in excess of expenditures, but by the end of the period, only about one-fourth of the projected deficit would be eliminated.

The effect of the baby boom’s retirement on Social Security and Medicare is relatively well known, having been discussed at length for more than 25 years. Basically, by the time the baby boom cohorts have retired, there will be nearly twice as many HI beneficiaries as there are today. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary. As shown in chart 5, this ratio is currently 4.0 workers per beneficiary. With the advent of the baby boom’s retirement, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to 2.3 in 2030 and 2.0 in 2075 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

Chart 4—Workers per HI beneficiary

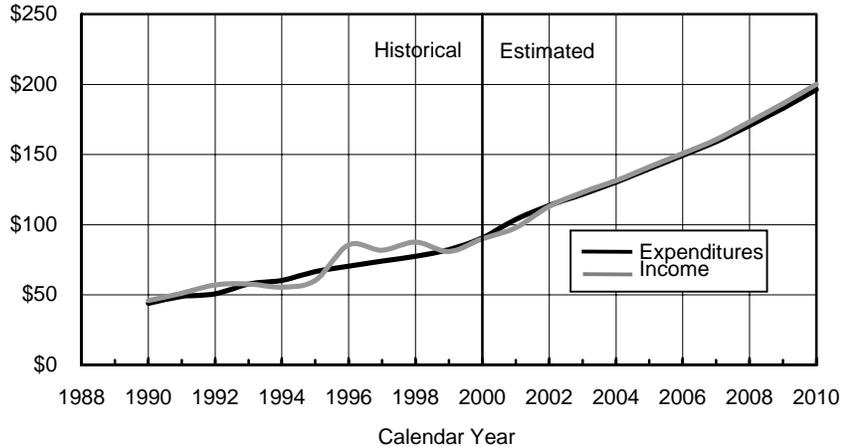


There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 17.4 years currently, with an estimated further increase to about 21 years at the end of the long-range projection period. Medicare costs are also sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than younger persons. Thus, as the beneficiary population ages over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

Financial outlook for Supplementary Medical Insurance

Chart 5 presents estimates of the short-range outlook for SMI and is generally similar to the information presented in chart 1 for the HI program. Two key differences stand out: First, the income and expenditure curves for SMI are nearly indistinguishable in the future. As noted previously, SMI premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, the program will automatically be in financial balance, regardless of future program cost trends. The second difference is—in contrast to the decline in HI expenditures during 1998-2000—SMI expenditures increased at an average rate of 6.9 percent over this period.

Chart 5—SMI expenditures and income
(In billions)



Although the Balanced Budget Act contained a number of provisions designed to reduce the rate of growth in SMI expenditures, their impact was more than offset by other factors. First, the Act specified that home health services not associated with a prior stay in an institution were to be converted 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, and it gradually corrects an excessive level of beneficiary coinsurance for outpatient hospital services. As a result, SMI costs are estimated to increase somewhat as a result of the Balanced Budget Act. Further cost increases have resulted under the Balanced Budget Refinement Act of 1999 and the Benefit Improvement and Protection Act of 2000.

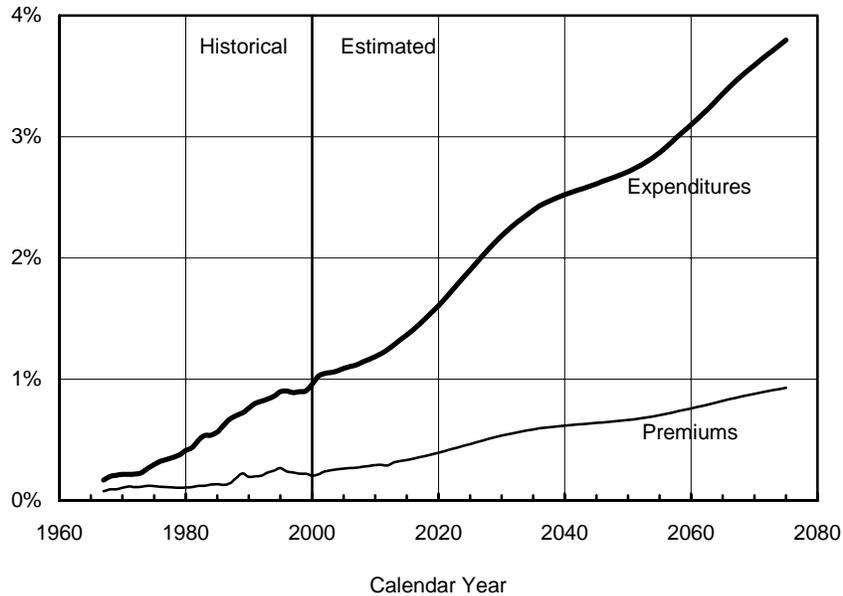
Chart 6 shows projected long-range SMI expenditures and premium income as a percentage of GDP. Under present law, beneficiary premiums will continue to cover approximately 25 percent of total SMI costs, with the balance drawn from general revenues. Expenditures are projected to increase at a significantly faster rate than GDP, for largely the same reasons underlying HI cost growth. After about 2030, the SMI costs projected in the 2001 Trustees Report are substantially higher than those in the 2000 report, again primarily as a result of the revised long-range growth rate assumption recommended by the Medicare Technical Review Panel.

Although SMI is automatically in financial balance, the program’s continuing rapid growth in expenditures places an increasing burden on beneficiaries and the Federal budget. In 2000, for example, about 6 percent of a typical 65-year-old’s Social Security benefit was withheld to pay the monthly SMI premium of \$45.50, and another 8 percent was required to cover average deductible and coinsurance expenditures for the year. Twenty years later, under the intermediate assumptions, the same beneficiary’s premium and copayment costs would average 21 percent of his or her benefit.² Similarly, SMI general revenues in fiscal year 2000 were equivalent to

²The growth in average copayment costs over this period is reduced significantly by (i) the fixed \$100 deductible applicable to SMI services, and (ii) the gradual correction of an excessive level of beneficiary coinsurance on outpatient hospital services, as provided for in the Balanced Budget Act of 1997 and subsequent legislation.

5.4 percent of the personal and corporate Federal income taxes collected in that year. If such taxes remain at their current level, relative to the national economy, then SMI general revenue financing in 2075 would represent 22 percent of total income taxes.

Chart 6—SMI expenditures and premiums as a percentage of GDP

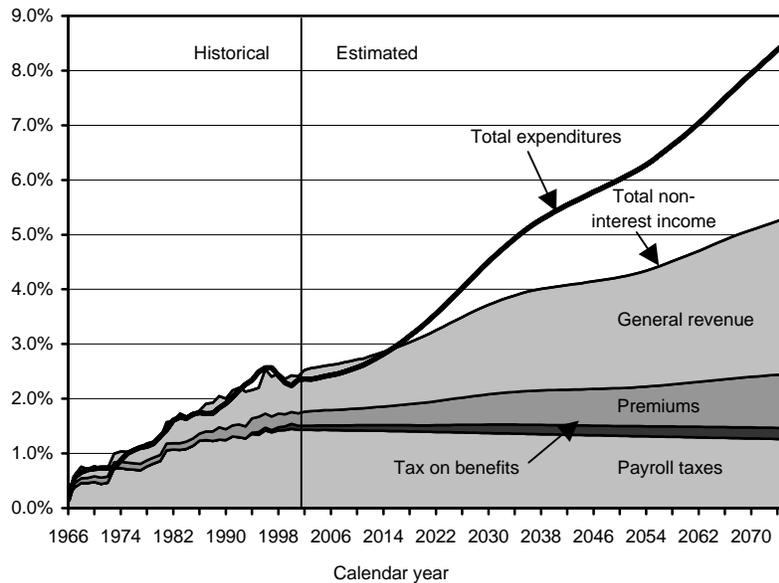


Combined HI and SMI expenditures

The financial status of the Medicare program is appropriately evaluated for each trust fund separately, as summarized in the preceding sections. By law, each fund is a distinct financial entity, and the nature and sources of financing are very different between the two funds. This distinction, however, frequently causes greater attention to the HI trust fund—its projected year of asset depletion in particular—and less attention to SMI, which does not face the prospect of depletion. It is important to consider the total cost of the Medicare program and its overall sources of financing, as shown in chart 7. Interest income is excluded since, under present law, it would not be a significant part of program financing in the long range.

Combined HI and SMI expenditures are projected to increase from 2.2 percent of GDP to about 8.5 percent in 2075, based on the Trustees’ intermediate set of assumptions. In past years, total income from HI payroll taxes, income taxes on Social Security benefits, HI and SMI beneficiary premiums, and SMI general revenues was very close to total expenditures. Over the next 15 years, such Medicare revenues are estimated to slightly exceed program expenditures, reflecting the expected excess of HI tax income over expenditures. Thereafter, however, overall expenditures are expected to exceed aggregate revenues. Again, the growing difference arises from the projected imbalance between HI tax income and expenditures—throughout this period, SMI revenues would continue to approximately match SMI expenditures.

Chart 7—Medicare expenditures and sources of income as a percentage of GDP



Over time, SMI premiums and general revenues would continue to grow rapidly, since they would keep pace with SMI expenditure growth under present law. HI payroll taxes are not projected to increase as a share of GDP, primarily because no further increases in the tax rates are scheduled under present law. Thus, as HI sources of revenue become increasingly inadequate to cover HI costs, SMI premiums and general revenues would represent a growing share of total Medicare income.

Conclusions

In their 2001 reports to Congress, the Board of Trustees notes the significant improvement in the financial outlook for Medicare that has come about as a result of legislation, strong economic growth, relatively slow growth in health costs generally, and efforts to combat fraud and abuse. But they emphasize the continuing financial pressures facing Medicare and urge the nation's policy makers to take further steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future. Today's relatively favorable conditions could change, accelerating the expected return to deficits in the HI trust fund. Moreover, the earlier solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

I concur with the Trustees' assessment and pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine effective solutions to the remaining financial problems facing the Medicare program. I would be happy to answer any questions you might have on Medicare's financial issues.