CENTER for RETIREMENT RESEARCH at BOSTON COLLEGE

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AN UPDATE ON MEDICARE'S FINANCES

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Introduction

The headline from the *2018 Medicare Trustees Report* was that the program's Hospital Insurance trust fund will run out of money in 2026, three years earlier than was estimated last year. That headline suggests that Medicare is facing increasing financial troubles. In fact, the outlook for program costs is considerably more favorable than it was a decade ago, and that picture persists even under an alternative scenario in the *Trustees Report* that assumes that Congress phases out some of the cost controls in recent legislation. This *brief* summarizes the current state of Medicare's finances.

The discussion proceeds as follows. The first section provides a brief overview of Medicare financing. The second section describes the *2018 Trustees Report* projections that use current-law assumptions. The third section explains why observers think some of the cost control provisions in recent legislation are not sustainable. The fourth section compares the current-law projections to an alternative scenario prepared by Medicare's Office of the Actuary. The fifth section tries to put the relatively sanguine assessment of Medicare finances in perspective. The final section concludes that while Medicare's finances – even under the alternative assumptions – have been improving considerably, Medicare operates in a country with extraordinarily high health care costs; its out-of-pocket expenses absorb a large and growing share of Social Security benefits; and it has some serious gaps in protection.

The Financing of Medicare

Medicare is the largest public health program in the United States. It covers virtually all persons ages 65 and older and most disabled citizens. Since its enactment in 1965, it has contributed substantially to the health and well-being of older and disabled Americans. Medicare operates with relatively low administrative costs and enjoys widespread public support.

Medicare is composed of two programs (see Figure 1, on the next page). The first program is Part A, Hospital Insurance (HI), which covers inpatient hospital services, skilled nursing facilities, home health care, and hospice care. HI is financed primarily by a 2.9-percent payroll tax, shared equally by employers and employees. The HI trust fund is the component that is projected to be depleted three years earlier than estimated in the *2017 Trustees Report*.[1] The second and larger program is Supplementary Medical Insurance (SMI), which consists of two separate accounts:

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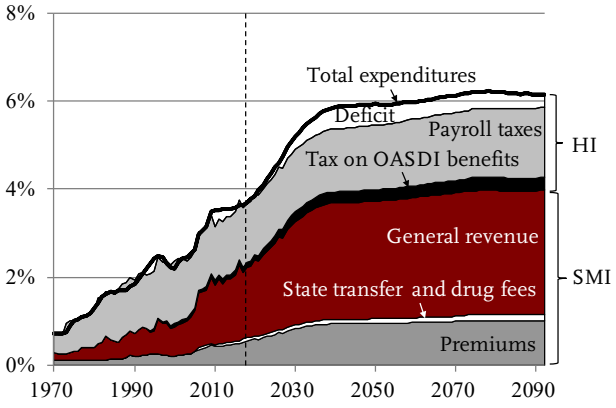
Figure 1. Historical and Projected Medicare Expenditures and Non-Interest Income, Percentage of GDP, 1970-2092



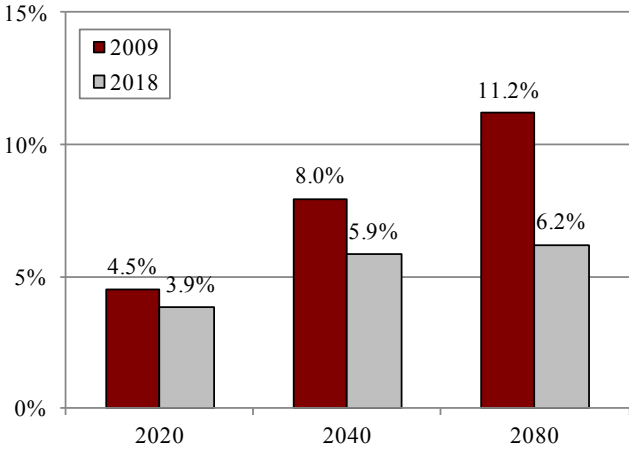
Source: Centers for Medicare & Medicaid Services (CMS) *Medicare Trustees Report* (2018).

Part B, which covers physician and outpatient hospital services, and Part D, which was enacted in 2003 and covers prescription drugs.[2] SMI is adequately financed for the indefinite future because the law provides for general revenues and participant premiums to meet the next year's expected costs. Of course, an increasing claim on general revenues puts pressure on the federal budget and rising SMI premiums place a growing burden on beneficiaries.

Medicare Current-Law Projections

For a number of years, the Medicare current-law projections have assumed a substantial reduction in the growth rate of per capita health expenditures relative to historical experience. It is not clear the extent to which the slowdown in spending growth since 2008 reflects the impact of the Great Recession or subsequent legislation that may be making the health care sector more efficient. The Affordable Care Act (ACA), passed in 2010, contained roughly 165 provisions aimed at reducing costs, increasing revenues, eliminating fraud and waste, and developing research and technological enhancements. More recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) revised the system for paying physicians. Regardless of the reason, between the 2009 and 2018 *Trustees Reports*, projected long-term costs for Medicare – HI and SMI combined – declined dramatically (see Figure 2).

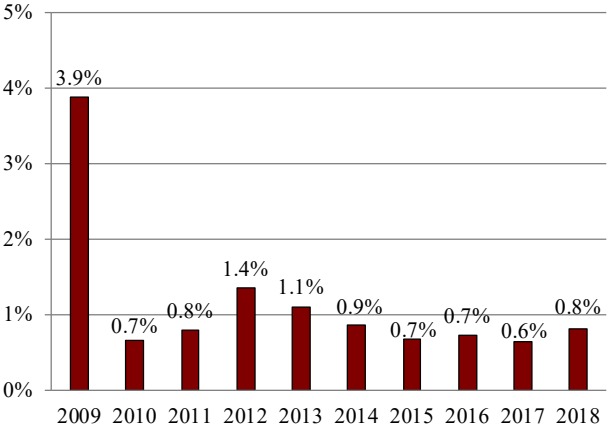
Figure 2. Projected Medicare Expenditures as a Percentage of GDP for Select Years from the 2009 and 2018 Trustees Reports



Sources: Medicare Trustees Reports (2009 and 2018).

In terms of the HI program – the component of Medicare financed by the payroll tax – the lower projected costs have led to substantially smaller 75-year deficits. The 2018 Medicare HI deficit of 0.8 percent of taxable payroll is slightly higher than the year before, but well within the post-2009 range (see Figure 3).

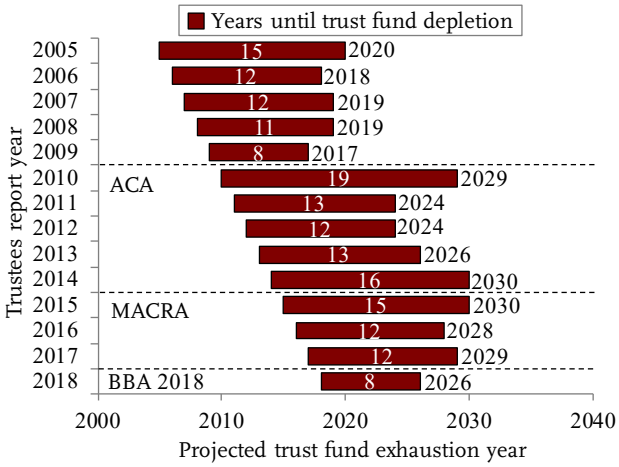
Figure 3. Projected Medicare HI 75-year Deficit as a Percentage of Taxable Payroll, 2009-2018



Sources: Medicare Trustees Reports (2009-2018).

As noted above, the HI trust fund is projected to deplete its reserves in 2026, three years earlier than projected last year (see Figure 4). In fact, this depletion date moves around from year to year because HI trust fund reserves are small relative to costs, which makes the date sensitive to even relatively modest changes in economic and programmatic assumptions.[3] The ACA pushed the depletion date out to 2029 and the MACRA maintained that extension. In contrast, the Bipartisan Budget Act of 2018, which overrides some of the cost-saving provisions that were deemed unsustainable, caused the date to move up. Depletion of the trust fund reserves is an action-forcing event because, after this point, scheduled payroll taxes are projected to cover only 91 percent of scheduled benefits. But the date tells observers little about the finances of the overall Medicare program because the trust fund is small compared to HI expenditures and HI is only about a third of the Medicare system.

FIGURE 4. PROJECTED MEDICARE HI TRUST FUND EXHAUSTION, BY YEAR OF TRUSTEES REPORT, 2005-2018



Sources: Medicare Trustees Reports (2005-2018).

The Trustees' main projections are based on current law and, therefore, include the impact of cost control provisions in the ACA and the MACRA. To the extent that these provisions end up producing inadequate reimbursement rates for Medicare providers, Congress may find it necessary to curtail the payment reductions.[4] To account for the uncertain future of the cost control measures, the Trustees also ask the Medicare actuaries to produce alternative projections.[5]

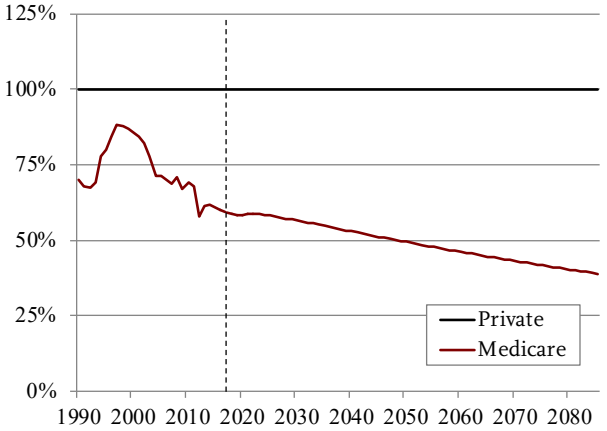
Current-Law vs. Alternative Assumptions

The major difference between the current-law and alternative projections relates to updating the amounts to be paid to hospitals and physicians. The concern is that prices can only be reduced so far before they become unreasonably low and jeopardize Medicare beneficiaries' access to mainstream medical care, as health care providers stop seeing Medicare patients. The illustrative projections are based on the assumption that Congress modifies two provisions by: 1) phasing down the productivity adjustments prescribed for payments for hospital (and other non-physician) services; and 2) increasing physician payment rates.

Productivity Adjustments for Hospital Services

The hospital services covered by Medicare require annual payment increases. The ACA introduced cost-saving measures that would reduce annual increases, which are based on input prices, by the percentage increase in the 10-year moving average of economy-wide productivity.[6] The goal was to create strong incentives for health care providers to improve efficiency. In the *2018 Trustees Report,* economy-wide productivity is estimated to increase by 1.1 percent per year. However, health services are very labor intensive, so productivity gains in this sector are expected to be much smaller.[7] As a result, the reductions in compensation will exceed productivity gains and cut into providers' earnings. Eventually, Medicare payment rates for inpatient hospital services would fall from about 60 percent of private insurance today to just 39 percent by 2092 (see Figure 5, on the next page).

Figure 5. Illustrative Medicare Prices under Current Law Relative to Private Health Insurance Prices for Inpatient Hospital Services, 1990-2092



Note: Illustration assumes that private insurance prices are not affected by Medicare payment rates.
Source: Shatto and Clemens (2018).

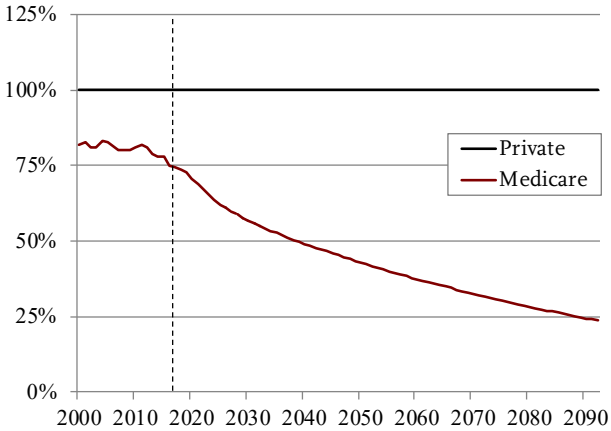
Over time, such large reductions in compensation would cause providers to either stop serving Medicare patients or shift some of the costs to non-Medicare patients.[8] Thus, the alternative scenario assumes that payment updates will reflect health care productivity rather than economy-wide productivity.

Physician Payments

As with hospitals, physicians serving Medicare patients also typically receive annual payment updates. Since April 2015, these updates have been specified by MACRA, which prevented an immediate 21-percent cut in Medicare physician rates and eliminated the need for annual legislative overrides.[9] The new MACRA payment system emphasizes measuring and rewarding the quality, rather than quantity, of health services. MACRA set the physician fee update to a 0.5-percent increase in 2019. However, the Bipartisan Budget Act of 2018 reduced this amount to 0.25 percent, while keeping future adjustments the same. That is, fee reimbursements are scheduled to remain unchanged for 2020-2025, with modest annual increases (less than 1 percent) beginning again in 2026.[10] In addition to the standard fee reimbursements, MACRA also provides a temporary sweetener in the form of incentive payments for certain groups of physicians; these payments expire in 2025.[11]

The question is whether the current payment system will be sustainable in the long run. Specifically, Medicare payment rates are not expected to keep pace with the increase in physician costs, which are projected to average 2.2 percent annually from 2028-2042, according to the actuaries' Medicare Economic Index.[12] As a result, like Medicare hospital payments, Medicare physician payments would fall far below private health insurance payment rates (see Figure 6).

Figure 6. Illustrative Medicare Prices under Current Law Relative to Private Health Insurance Prices for Physician Services, 2000-2092



Note: Illustration assumes that private insurance prices are not affected by Medicare payment rates.
Source: Shatto and Clemens (2018).

Therefore, the alternative projections assume that Congress will modify the reductions in the future to help ensure that Medicare beneficiaries continue to have sufficient access to health care services.

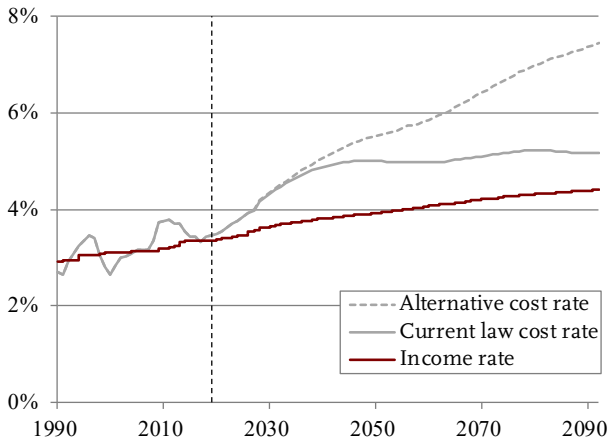
Comparing the Current-Law and Alternative Projections

Since current-law payments could end up being inadequate and reduce access to health services, the alternative projections assume that Medicare price updates will eventually equal those for private health plans. The alternative assumptions pertain only to HI and Part B of the SMI program; Part D, which covers prescription drugs, is unaffected.

HI Program

Productivity adjustments play an important role in projected HI costs. The alternative scenario assumes that the ACA productivity adjustments will be phased out beginning in 2028.[13] While HI cost projections in earlier years are only slightly higher than current-law projections, they increase substantially by the end of the 75-year period (see Figure 7).

Figure 7. Historical and Projected HI Income and Costs as a Percentage of Taxable Payroll, 1990-2090



Source: Medicare Trustees Report (2018).

Another way to compare the two projections is expenditures as a percentage of GDP. Again, as shown in Table 1, the differences are small in the short run but become substantial by 2092, when current-law spending equals 2.2 percent of GDP compared to 3.5 percent of GDP under the alternative scenario. Since revenues as a percentage of GDP are the same under the two scenarios, the projected HI deficit under the alternative scenario is 1.3 percentage points of GDP higher than under current law.

Table 1. Projected HI Expenditures as a Percentage of GDP, Selected Years

Year	Current law	Alternative
2020	1.6%	1.6%
2040	2.2	2.3
2060	2.2	2.7
2080	2.3	3.3
2092	2.2	3.5

Source: Shatto and Clemens (2018).

SMI Program: Part B

In addition to phasing out the ACA productivity adjustments beginning in 2028, the alternative scenario for SMI-Part B assumes: 1) the physician payments transition from current-law updates to the growth in the Medicare Economic Index; and 2) the incentive payments for physician groups will continue after 2025. Expenditures for SMI under the two sets of assumptions are shown in Table 2. By 2092, SMI expenditures under the alternative scenario are projected to be 1.5 percentage points of GDP higher than under current law.

Table 2. Projected SMI-Part B Expenditures as a Percentage of GDP, Selected Years

Year	Current law	Alternative
2020	1.8%	1.8%
2040	2.9	3.0
2060	2.8	3.5
2080	2.8	4.0
2092	2.8	4.3

Source: Shatto and Clemens (2018).

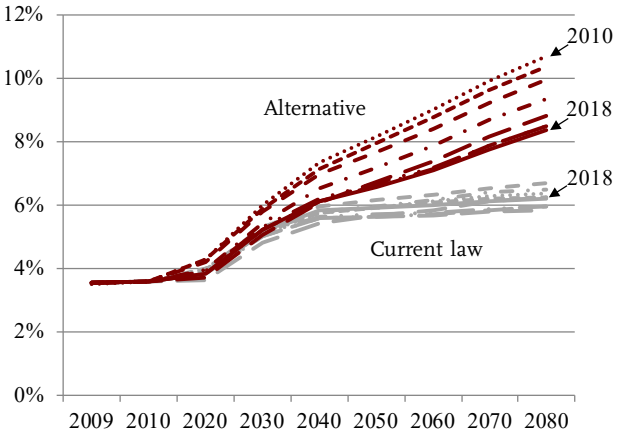
Total Medicare

Alternative projections for total Medicare expenses, which include all the payment adjustments for HI and Part B discussed above, show expenditures equal to 8.9 percent of GDP in 2092 compared to only 6.2 percent under current law.

To provide perspective on how the projections have changed over the past decade, Figure 8 (on the next page) shows total Medicare spending projections from each Trustees Report over the 2010-2018 period under the current-law assumptions and the alternative scenario.

The current-law projections have remained within a relatively narrow band, with the 2018 projections roughly in the middle of that band. In contrast, the alternative projections declined noticeably until 2015,

Figure 8. Historical and Projected Medicare Expenditures as a Percentage of GDP from 2010-2018 for the 75-Year Projection Period

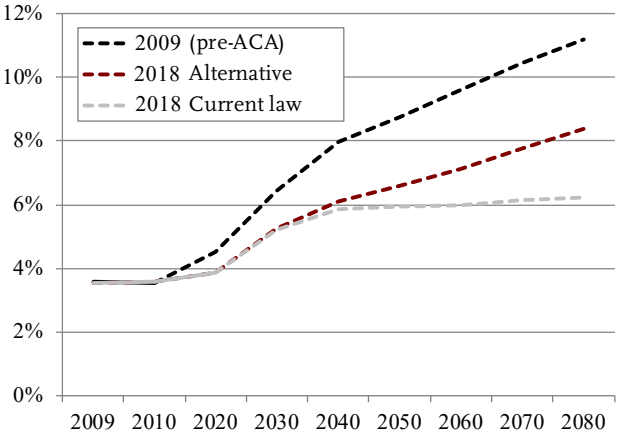


Source: Shatto and Clemens (2010-2018).

at which point they appear to have stabilized. Thus, the gap between the two sets of projections appears to have stabilized as well.

Finally, even using the alternative assumptions, the projected Medicare costs are lower in the future than they were projected to be in 2009 (see Figure 9).

Figure 9. Historical and Projected Medicare Expenditures as a Percentage of GDP, 2010-2018

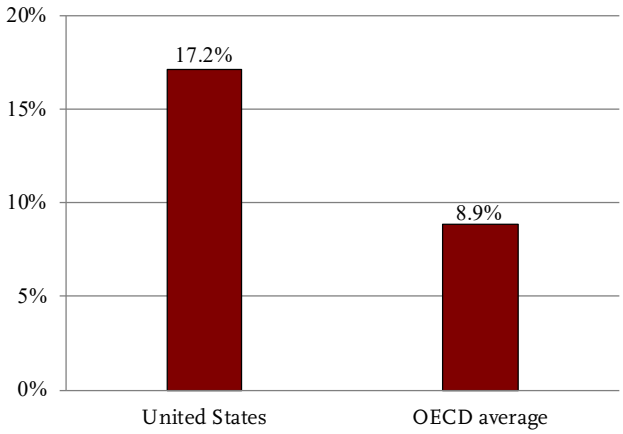


Source: Shatto and Clemens (2010 and 2018).

Medicare Spending in Perspective

While the news seems relatively good on the Medicare front, several comments are necessary. First, Medicare is operating in an expensive environment. U.S. health care costs as a percentage of GDP are the highest in the developed world and nearly twice as high as the average of the countries in the Organization for Economic Cooperation and Development (OECD) (see Figure 10). Differences in U.S. health costs are driven by relatively high salaries for doctors, high drug prices, high administrative costs, and greater usage of certain procedures.[14] These broader market pressures make Medicare an expensive program. It also means that the only real way to control Medicare costs is to get national health care spending under control.

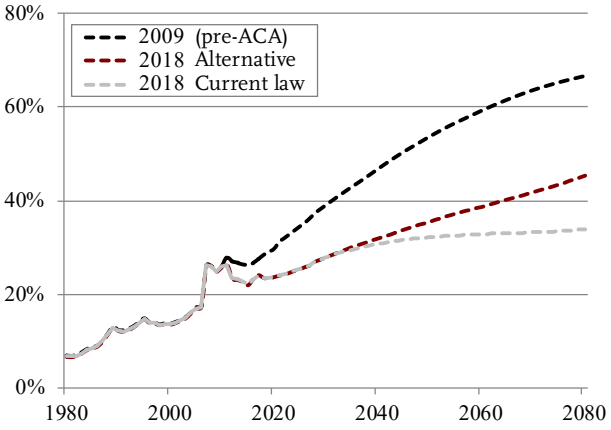
Figure 10. Health Care Expenditures as a Percentage of GDP, OECD Countries, 2017



Source: OECD Health Statistics (2018).

Second, because Medicare is expensive, the out-of-pocket costs that beneficiaries pay through premiums, deductibles, coinsurance, and copayments constitute a significant burden for the typical household. As shown in Figure 11 (on the next page), these costs now amount to about 25 percent of the average Social Security benefit and, under the alternative assumptions, will eventually exceed 40 percent.

Figure 11. Historical and Projected Total SMI Out-Of-Pocket Expenses as a Percentage of Average Social Security Benefit, 1980-2080



Source: Authors' calculations from *Medicare Trustees Reports* (2009 and 2018).

Finally, discussions about Medicare are often framed as if the program were excessively generous, implying that the solution is to cut back. In fact, Medicare's coverage is less comprehensive than most private sector insurance plans. For example, Medicare provides only limited mental health benefits and does not place an upper-bound on cost-sharing responsibilities for hospital stays, skilled nursing facility care, or physician costs. As a result, people with long and complicated illnesses could incur tens of thousands of dollars in out-of-pocket expenses. In addition, participants are not covered for dental services, eye glasses, and hearing aids. Thus, the challenge is not only to control the costs of the benefits currently provided by Medicare, but also to create some room for improvement in the benefit package.

Conclusion

The headline from the *2018 Medicare Trustees Report* was that the program's HI Trust Fund was expected to deplete its reserves three years earlier than estimated in 2017, implying that Medicare faces increasing financial troubles. Annual fluctuations in the depletion year for the HI trust fund, however, provide only a limited view of Medicare's finances. In fact, the outlook for Medicare costs is considerably more favorable than it was a decade ago, and that picture persists even under the alternative projections that assume Congress phases out some of the cost controls in recent legislation. That said, Medicare does face significant financing challenges: it operates in a country with extraordinarily high health care costs; its out-of-pocket expenses take a large and growing share of Social Security benefits; and it has some serious gaps in protection.

Endnotes

1 As shown in Figure 1, payroll tax revenues have risen steadily as a percentage of GDP due to increases in the HI payroll tax rate and in the limit on taxable earnings (which was eliminated in 1994). The Affordable Care Act increased HI trust fund revenues with a 0.9-percent tax on earnings for individuals earning more than $200,000 ($250,000 for married couples). These thresholds are not indexed for price or wage growth so that, over time, a growing proportion of workers will become subject to the additional 0.9-percent tax. Even these rising revenues, however, will not be sufficient to cover HI outlays, and the deficit remains a steady percentage of GDP. The ACA also specifies that individuals with incomes above $200,000 per year and couples above $250,000 pay an additional Medicare contribution of 3.8 percent on some or all of their non-work income (such as investment earnings), but the revenues from this tax are not allocated to Medicare.

2 About 75 percent of the costs of Parts B and D are paid from the government's general revenues. The other 25 percent is paid from monthly premiums charged to beneficiaries, which typically are deducted from Social Security benefits before they are sent to the recipient.

3 The current HI trust fund covers about one year of expenditures.

4 For example, the Balanced Budget Act of 2018 repealed the ACA's Independent Payment Advisory Board, which was supposed to propose reductions in Medicare spending if cost growth surpassed GDP growth by more than one percentage point.

5 The Trustees note that the use of an alternative scenario for analysis should not be construed as an endorsement by either the Trustees or the actuaries.

6 These price indices are determined by measuring the increase in the prices of goods and services a provider must pay to deliver patient care.

7 In recent years, hospital productivity averaged around 0.4 percent per year, while skilled nursing facilities experienced close to zero annual productivity gains.

8 The underlying assumption behind the increasing gap in prices is that Medicare would have no effect on private health insurance prices. Some argue, however, that Medicare costs do influence prices for health care services in the private market (see Frakt, 2014, for a summary of related literature).

9 The annual override (known as the "Doc Fix') arose from the Sustainable Growth Rate (SGR) reimbursement formula established in 1997. The SGR set target levels for Medicare expenditures. If physicians did not exceed these targets, they would receive modest pay increases. If they did exceed the targets, their reimbursement rates would be cut. In fact, physicians continuously exceeded the targets, but every year Congress postponed the cuts.

10 Starting in 2026, MACRA will have two payment rates: 1) for qualifying providers paid through an advanced alternative payment model, payment rates will be increased by 0.75 percent each year; and 2) payment rates for all other providers will be increased each year by 0.25 percent. For more details, see Bloniarz and Glass (2015).

11 The incentive payments include 5-percent annual bonuses provided to physicians who are qualified providers in Medicare's advanced alternative payment model and a pool of money to reward physicians in the separate merit-based incentive payment system who display "exceptional performance."

12 The Medicare Economic Index reflects price changes for all components of physician services.

13 The alternative projections assume that productivity adjustments will be reduced by 0.4 percent annually until Medicare price updates are in line with those for private health plans.

14 For example, see Papanicolas, Woskie, and Jha (2018).

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