

MEDICARE COSTS AND RETIREMENT SECURITY

BY ALICIA H. MUNNELL*

Introduction

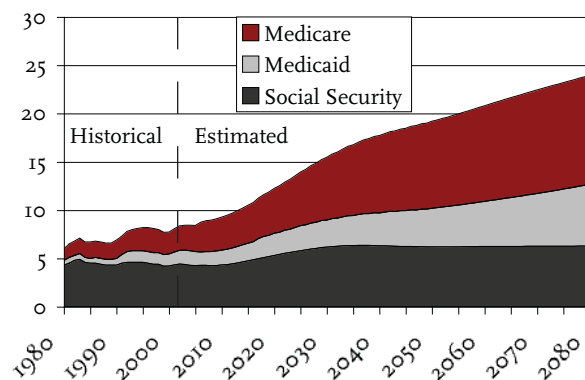
Most of the discussion of retirement security focuses on declining Social Security replacement rates, modest 401(k) balances, the low level of saving, and longer life expectancy. Rising health care costs, which seem too amorphous to incorporate into numerical examples, are often characterized as a “wildcard” that could undermine the best laid plans. This brief focuses on just one component of retiree health care costs — the Medicare program. It discusses the impact on future retirees of both rising out-of-pocket payments and higher taxes that will be needed to cover future health care expenditures. The numbers come directly from the 2007 Annual Report issued by the Medicare Trustees. The conclusion is sobering. The growing cost and tax burdens associated with Medicare alone suggest that even the most conservative target replacement rates may be inadequate.

The Medicare Program in Perspective

The costs of the three programs that support older Americans — Social Security, Medicare, and Medicaid

— are scheduled to rise dramatically. As shown in Figure 1, total program expenditures are projected to increase from 9 percent of GDP in 2007 to 24 percent in 2080. The patterns are quite different for the

FIGURE 1. SOCIAL SECURITY, MEDICAID, AND MEDICARE SPENDING, PERCENT OF GDP, 1980-2080



Sources: U.S. Government Accountability Office (2007); and U.S. Congressional Budget Office (2007).

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program that provides cash benefits — Social Security — and those that provide health benefits — Medicare and Medicaid.¹ The rising costs of Social Security are driven solely by the aging of the population so, as the ratio of retirees to workers climbs, costs increase from 4.3 percent today to 6.3 percent in the future. The costs of the health programs are driven, however, by both the aging of the population and more importantly by the general rise in health care prices and the increase in the volume and intensity of services. As a result of their faster growth, the health programs reflect the bulk of government spending on the elderly in the future. And the bulk of the health care spending on the elderly will come from Medicare.

The Tax Implications of Medicare for Future Retirees

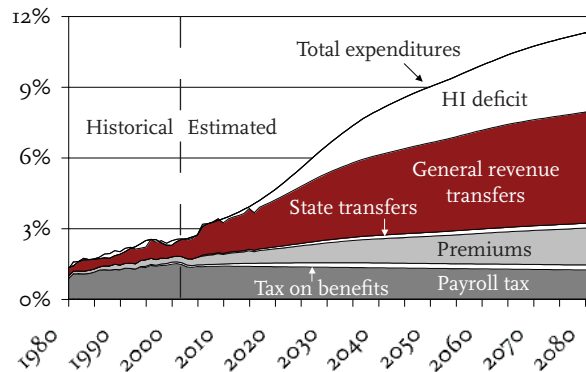
Medicare is composed of two programs. Under Part A, the Hospital Insurance (HI) Trust Fund pays for inpatient hospital services, skilled nursing facilities, home health care, and hospice care. HI is financed by a 2.9 percent payroll tax, shared equally by employers and employees.

The Supplementary Medical Insurance (SMI) Trust Fund consists of two separate accounts: Part B, which covers physician and outpatient hospital services and Part D, which was enacted in 2003 and covers prescription drugs. About 75 percent of the costs of Parts B and D are paid from the government's general revenues, which come from the personal income tax, corporate income tax, etc. The other 25 percent is paid from monthly premiums charged to beneficiaries.

Both HI and SMI are going to require additional money in the future.² But how people talk about the financial status of the two programs differs markedly. In the case of HI, which is financed by the earmarked payroll tax, the actuaries make 75-year projections and calculate a deficit. Thus, the mode of assessment is very similar to that applied to the Social Security program. As a result, the financial status of HI is relatively visible because the reporting of a deficit tends to garner attention. The increasing deficit for the HI portion of Medicare is shown in the top area of Figure 2.

The actuaries also project the costs and expected receipts from beneficiary premiums of the SMI programs — Part B and Part D. Although spending will far exceed the projected premiums, SMI is not characterized as having a deficit because general revenues are required to cover any shortfalls. So, the financial condition of SMI is generally less visible to the media and the general public. The rising contribution from general revenues is shown by the shaded area second from the top in Figure 2.

FIGURE 2. MEDICARE EXPENDITURES AND SOURCES OF NON-INTEREST INCOME, PERCENT OF GDP, 1980-2080

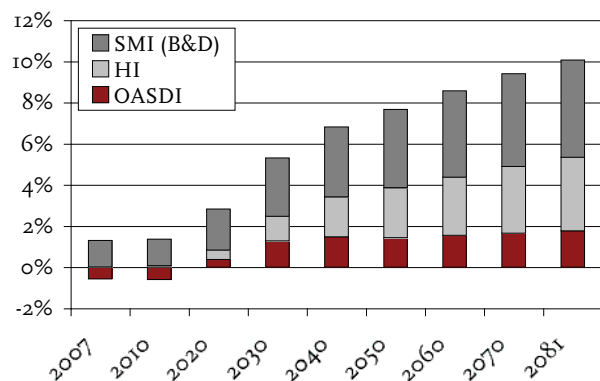


Source: Centers for Medicare and Medicaid Services (2007a).

Figure 3 on the next page shows the income shortfalls for HI and SMI in comparison to that facing the Social Security program. The shortfall for each component of Medicare alone dominates Social Security's financing shortfall. Of the two Medicare programs, SMI will require the greater amount of future revenues.

In terms of how Medicare expenditures will affect future retirees, the SMI program is more relevant than the HI program. The funds to finance HI will most likely come from workers' payroll taxes, but the financing for SMI will come from taxes paid by both retirees and workers. Today, the general revenue contribution to SMI amounts to 1.3 percent of GDP; by 2040 that amount will rise to 3.4 percent of GDP. Assuming all else stays unchanged, rising SMI costs would require Americans, including retirees, to face an 18.5 percent increase in income tax rates in 2040.

FIGURE 3. PROJECTED OASDI AND HI SHORTFALL PLUS THE GENERAL REVENUE CONTRIBUTION TO SMI, PERCENT OF GDP, 2007-2081



Source: U.S. Social Security Administration (2007).

The comparable figures for 2080 are SMI requiring general revenues equal to 4.7 percent of GDP and income tax rates 30 percent higher than they would be otherwise.³

Medicare Out-of-Pocket Spending by Future Retirees

Not only will future retirees have to pay higher income taxes to support Medicare’s SMI program, they will also face higher SMI premiums and co-payments. In 2007, the Part B standard monthly premium is \$93.50. (Medicaid pays this premium for many low-income individuals, and higher-income beneficiaries pay a higher premium (see Box).) The national average Part D monthly premium is \$27.35. (Actual premium amounts depend on the specific plan that the beneficiary has selected.)

In addition to premiums, Parts B and D involve deductibles and coinsurance. Under Part B, the 2007 annual deductible is \$131 and the co-insurance percentage is 20 percent. The Part D annual deductible is \$267 and the coinsurance is 25 percent of the costs up to the initial benefit limit (\$2,400 in 2007). Beyond this limit, the beneficiary pays 100 percent of the costs up to the catastrophic limit (\$3,850 in 2007). Once the catastrophic limit is reached, the beneficiary pays 5 percent of the costs.

BOX: INCOME-RELATED PREMIUMS FOR PART B

Beginning in 2007, beneficiaries with higher incomes pay a greater premium for Part B. The amount by which the premium exceeds the standard is being phased in over two years. The income thresholds are indexed annually to the Consumer Price Index (CPI). By 2009, those with incomes in excess of \$212,000 will pay three times the standard premium.

TABLE I. MEDICARE PART B INCOME-RELATED THRESHOLDS AND PREMIUMS

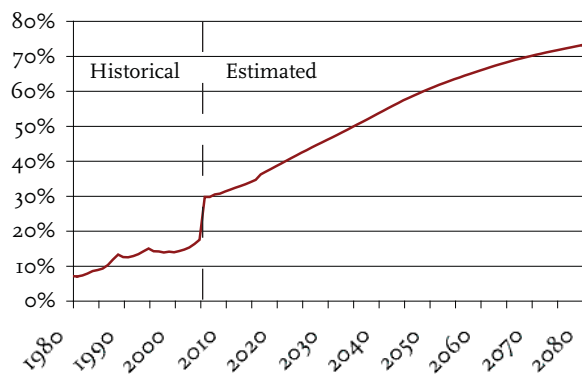
Income thresholds (for 2007)	Less than \$80,000	\$80,000- \$100,000	\$100,000- \$150,000	\$150,000- \$200,000	\$200,000 and over
Income-related Part B premium (for 2007)	\$93.50	\$105.80	\$124.40	\$142.90	\$161.40
Income-related Part B premium (2009 and later)	Standard premium	1.4 x standard premium	2.0 x standard premium	2.6 x standard premium	3.2 x standard premium

Note: This provision is effective in 2007. The amount of the Part B premium above the standard premium will be phased in at 33, 67, and 100 percent for 2007 to 2009 and later. The income thresholds are indexed to the CPI. The income thresholds shown are for beneficiaries filing tax returns as individuals; the thresholds for couples filing jointly are twice these amounts.

Source: Centers for Medicare and Medicaid Services (2007b).

In 2007, on average, these out-of-pocket expenditures for SMI — that is, the premiums, deductibles, and coinsurance for Parts B and D — amount to 29 percent of the average Social Security benefit (see Figure 4). (The big jump in Figure 4 reflects the introduction of the Part D drug benefit in 2006.) By 2040, SMI out-of-pocket expenses will equal 53 percent of the average Social Security benefit; by 2080 73 percent.⁴

FIGURE 4. TOTAL SMI OUT-OF-POCKET EXPENSES AS A PERCENT OF THE AVERAGE SOCIAL SECURITY BENEFIT, 1980-2080



Source: Centers for Medicare and Medicaid Services (2007a).

Conclusion

Everyone knows that health care costs are rising rapidly. But it is stunning to compare future health care costs with future Social Security benefits. Under reasonable assumptions of future growth rates, SMI premiums and cost sharing will eventually represent an unaffordable share of retirement income. At the same time, income tax rates to finance the shortfall in the SMI program will leave future retirees with less after-tax income to cover these costs. As much as people might value the benefits of health care spending, they simply will not have enough income left over to cover the other necessities of life.

Moreover, the Medicare SMI program is only a portion — albeit a significant portion — of the health costs faced by retirees. Under Medicare’s HI program, retirees who are hospitalized must pay a substantial deductible for each “spell of illness,” and, since HI does not have a cap on coinsurance, those with long and complicated illnesses incur very large bills. Finally, many will face the need for long-term care either at home or in a nursing home late in their life.

The long-run solution is to control the costs not just of Medicare, but of the entire health care system. The United States spends a much higher share of GDP on health care services than other countries, yet in many instances produces less favorable outcomes. But reform is unlikely to come quickly, so the message for those approaching retirement is to provide an extra cushion to cover costly health care expenditures.

Endnotes

1 Medicaid began as a program for the destitute and continues to finance much of the medical care of people with extremely low incomes. Medicaid also pays for nursing home care for persons who have low incomes and few assets. Since nursing home residents are typically quite old, the program provides significant financial support to the sick elderly. In 2006, almost a quarter of Medicaid expenditures went to the elderly (with 46 percent going to people with disabilities and the remainder going to the non-elderly, non-disabled poor). See U.S. Congressional Budget Office (2006).

2 The Medicare Trustees note that the projected SMI expenditures are substantially understated because projected physician payment updates are unrealistically reduced under the current-law sustainable growth rate system. See Centers for Medicare and Medicaid Services (2007a).

3 Income taxes include both personal and corporate income taxes. An alternative to paying for such costs without raising taxes is through borrowing. The federal government has routinely run deficits over the past 40 years, but funding such escalating health care costs would require extremely large deficits, even by the standards of recent years.

4 Though SMI costs will increase greatly over the next 75 years, a provision in section 1839(f) of the Social Security Act ensures that dollar value increases in Part B premiums for current beneficiaries do not exceed the dollar value of the annual Social Security Cost of Living Adjustment (COLA).

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The Center for Retirement Research at Boston College was established in 1998 through a grant from the Social Security Administration. The Center's mission is to produce first-class research and forge a strong link between the academic community and decision makers in the public and private sectors around an issue of critical importance to the nation's future.

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