NATIONAL CENTER FOR POLICY ANALYSIS

Medicare Trustees Reports 2010 and 2009: What a Difference a Year Makes

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The new federal health care law — the Patient Protection and Affordable Care Act (or ACA) — uses cuts in Medicare to fund additional federal health care spending on nonseniors. The cuts come from reducing the growth in physicians' Medicare reimbursements using the existing sustainable growth rate (SGR) system and reducing future Medicare payment updates for hospitals and other nonphysician services by the economy-wide increase in productivity.

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Executive Summary

Medicare spending will be cut dramatically in coming years if the new federal health insurance law — the Patient Protection and Affordable Care Act (ACA) — is fully implemented.

An indication of how much the new health overhaul law matters is provided by comparing the 2009 Medicare Trustees Report (which assumes that Medicare spending will largely keep pace with health spending for the country as a whole) with the 2010 report (which reflects the cuts required by the ACA).

Spending Cuts per Patient. What do Medicare spending cuts mean at the individual level?

- Prior to the new law, Medicare spending per beneficiary in 2010 dollars was expected to rise from $11,000 to just over $13,000 by 2019.
- Under the new law, Medicare spending per beneficiary is expected to be only $11,571 in 2019.
- In 10 years, projected per capita Medicare benefits (net of Part B and D premium payments) will be almost $1,700 lower than last year's projections in today's dollars.
- In 20 years, the average net benefit will be $3,256 lower than last year's projections.

Provider Fee Cuts. The lower Medicare spending mostly reflects a reduction in payments to health care providers. The Medicare actuaries estimate that:

- Medicare payments to health care providers will fall from an average of 20 percent less than what private insurers paid in 2010 to almost one-third less (68 percent) in 2019, and to only half by 2050.
- In less than 10 years, Medicare will go from paying 18 percent more than Medicaid today to paying less than Medicaid pays.

What difference does this make? An increasing number of providers may be unwilling to treat additional Medicare patients and may opt out

of the program. They could also reduce amenities and other services in response to lower reimbursements. A growing number of hospitals will lose money treating Medicare patients, which could lead to bankruptcies and closures. Medicare actuaries estimate that as a result of the cuts in Medicare reimbursements, one in seven facilities will be operating in the red by 2015, 25 percent by 2030 and 40 percent by 2050.

Aggregate Spending Cuts. Medicare spending has been rising much faster than growth in the economy for the past four decades, as has other health care spending. However, the ACA will result in per capita Medicare spending growth that is close to the per capita growth of the economy. Thus, the present value of Medicare spending over the next 75 years is much lower in the 2010 Trustees Report than in the 2009 report.

- The 2010 Trustees Report projects that overall, Medicare will spend $13.9 trillion less (24 percent) over the next 75 years than the 2009 report projected.
- Medicare Part A — covering hospitalization, home health care, skilled nursing and hospice care — will decline the most, spending 34 percent less.
- Medicare Part B — covering outpatient hospitalization and physician services — will decline 24 percent.
- Medicare Part D spending on prescription drugs, however, will rise slightly by 3 percent.

Effects on Medicare's Unfunded Liabilities. Because of the projected spending cuts, Medicare's projected deficit — spending in excess of seniors' premium payments, state transfers and dedicated taxes — fell dramatically in one year. The projections into the indefinite future (or infinite horizon) show that:

- Between the 2009 and 2010 Trustees Reports, Medicare's total unfunded obligations — the amount of additional general Treasury revenues required — declined 59 percent, from $89.22 trillion to $36.60 trillion.
- Medicare Part A's unfunded obligation changed from a deficit of $36.72 trillion to a $300 billion surplus.
- Part B's unfunded obligations fell 43 percent.
- Overall, when the ACA was signed into law, nearly $53 trillion of implied federal obligations were wiped out.

Will the spending cuts actually be made? For the past seven years, Congress has overridden the reductions in Part B payments to physicians as recommended under the Sustainable Growth Rate (SGR) system. The savings forecast in the 2010 Trustees Report assumes that Congress will not only enforce the SGR system, but will also allow even more stringent reductions in payments to hospitals and for other nonphysician services. All of the savings expected under the ACA depend on future Congresses doing what past Congresses have been unwilling to do for seven straight years.

A Two-Tiered Health System. Though Medicare spending will be cut, total health care spending (public and private) will keep rising — increasing from about 18 percent of gross domestic product (GDP) in 2010 to about 21 percent in 2019. Cuts in Medicare will be offset by increased spending on the health care of nonseniors. This implies the possibility of moving toward a two-tier health system in which seniors receive fewer amenities and lower quality care than nonseniors. Care will likely be rationed by waiting, as it is in other developed countries and some seniors may opt out of Medicare altogether.

Alternatives to Rationing. There are ways to restrain the growth of Medicare without the potential for rationing implied by the ACA. Today, seniors pay premiums for Medicare Parts B and D, and purchase Medigap policies to cover deductibles and copayments. Instead, seniors could be given a fixed sum of money (premium support) to use to purchase private coverage. The amount could be adjusted for health risks (such as chronic health conditions) and could grow with per capita national income. This would result in Medicare cost growth very similar to the path forecast in the 2010 Trustees Report.

Under this approach, no providers would go out of business due to the reductions in reimbursement rates. However, significant changes would occur in health care delivery systems. Future Medicare participants would pay a greater share of their health care costs, but there would be an increase in the variety of delivery systems as providers compete for their Medicare premiums and additional payments. This would produce all of the cost savings promised by the ACA without the unintended consequences that come from placing price ceilings on what Medicare will pay for different services.

Introduction

The new federal health care law — the Patient Protection and Affordable Care Act (or ACA) — uses cuts in Medicare to fund additional federal health care spending on nonseniors. The cuts come from reducing the growth in physicians' Medicare reimbursements using the existing sustainable growth rate (SGR) system and reducing future Medicare payment updates for hospitals and other nonphysician services by the economy-wide increase in productivity. The 2010 Medicare Trustees Report assumes that the ACA will be implemented. However, the Trustees caution that the projections in the 2010 report may not be realistic, and most observers believe that the provisions in the ACA will prove difficult to implement in the long run.[1] In addition, the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) issued alternative estimates that assume Congress will override scheduled reductions in physician fees (under the SGR system), as it has in past. The alternative estimates also assume the reductions in other payment will be effective for the near future, but that growth in per capita spending will gradually revert to the growth assumed in the previous report.[2]

As this study will show, the 2010 Trustees Report dramatically changed the Medicare forecast from that in the 2009 Trustees Report.

TABLE I

Medicare 75-year Unfunded Obligations

	2009 Trustees Report Trillions	2010 Trustees Report Trillions	Percent Change
Part A	$ 13.77	$ 2.68	-81
Part B	17.20	12.90	-25
Part D	7.20	7.20	0
Total	$ 38.17	$ 22.78	-40

Medicare Infinite Horizon Unfunded Obligations

	2009 Trustees Report Trillions	2010 Trustees Report Trillions	Percent Change
Part A	$ 36.72	$ -0.30	-101
Part B	37.00	21.10	-43
Part D	15.50	15.80	2
Total	$ 89.22	$ 36.60	-59

Source: Tables III.B9, III.B10, III.C15 and III.C23, 2009 and 2010 Medicare Trustees Reports.

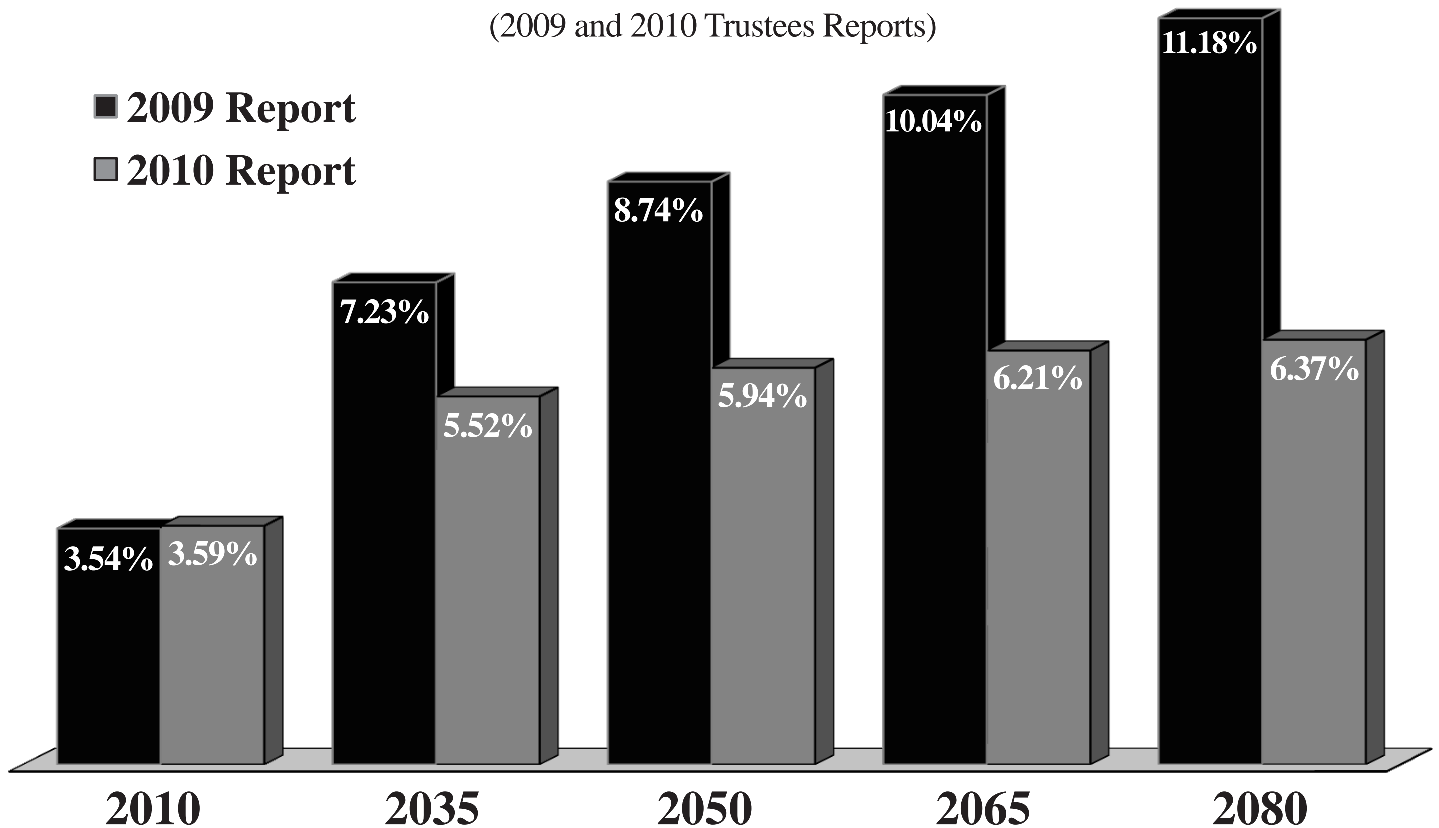
Comparing the 2009 and 2010 Trustees Reports

For the past seven years, Congress has overridden the reductions in payments to physicians that were recommended under the SGR system. The new federal health insurance law, however, assumes that these payment reductions to physicians will take place. It also requires additional cuts in payments to hospitals and for other nonphysician services to reduce the rate of growth in Medicare spending.

Aggregate Medicare Spending. Medicare spending has been rising much faster than the growth in the economy for the past four decades, as has other health care spending. However, the ACA will result in per capita Medicare spending growth that is close to the growth in per capita gross domestic product (GDP). Thus, the present value of Medicare spending over the next 75 years is much lower in the 2010 Trustees Report than in the 2009 report:[3]

- The 2010 Trustees Report projects that overall, Medicare will spend $13.9 trillion less (24 percent) over the next 75 years than the 2009 report projected.
- Medicare Part A — covering hospitalization, home health care, skilled nursing and hospice care — will decline the most, spending 34 percent less.
- Medicare Part B — covering outpatient hospitalization and physician services — will decline 24 percent.
- Medicare Part D spending on prescription drugs, however, will rise slightly by 3 percent.

Medicare's Unfunded Obligations. One way to assess the change between 2009 and 2010 is to compare projected transfers from



Source: Table III.A2, 2009 and 2010 Medicare Trustees Reports.

the Treasury to meet Medicare's unfunded obligations — the shortfall between Medicare spending and the premiums and taxes dedicated to the program. As the top panel of Table I shows:

- The unfunded obligations of Medicare Part A over the next 75 years — covering hospitalization, home health care, skilled nursing and hospice care — declined more than 80 percent from one year's projections to the next.
- The unfunded obligations of Medicare Part B over the next 75 years — covering outpatient hospitalization and physician services — fell 25 percent.
- The shortfall for Medicare Part D spending over the next 75 years on prescription drugs remained essentially the same at $7.2 trillion.[4]

Overall, the ACA eliminated $15.4 trillion in implied federal obligations over the next 75 years.

Table I also shows that into the indefinite future (over the infinite horizon), the total unfunded obligation will decline $53 trillion (60 percent), compared to the 2009 Trustees projections.

Medicare is funded by a combination of payroll taxes, premiums paid by seniors, and state and general revenue transfers. Looking at shortfalls in financing the components of Medicare, the Part A funding gap is transformed from a $36.7 trillion funding shortfall to a slight surplus of $300 billion. The Part B infinite horizon unfunded obligation fell 43 percent between the 2009 and 2010 reports. The lower Part B unfunded

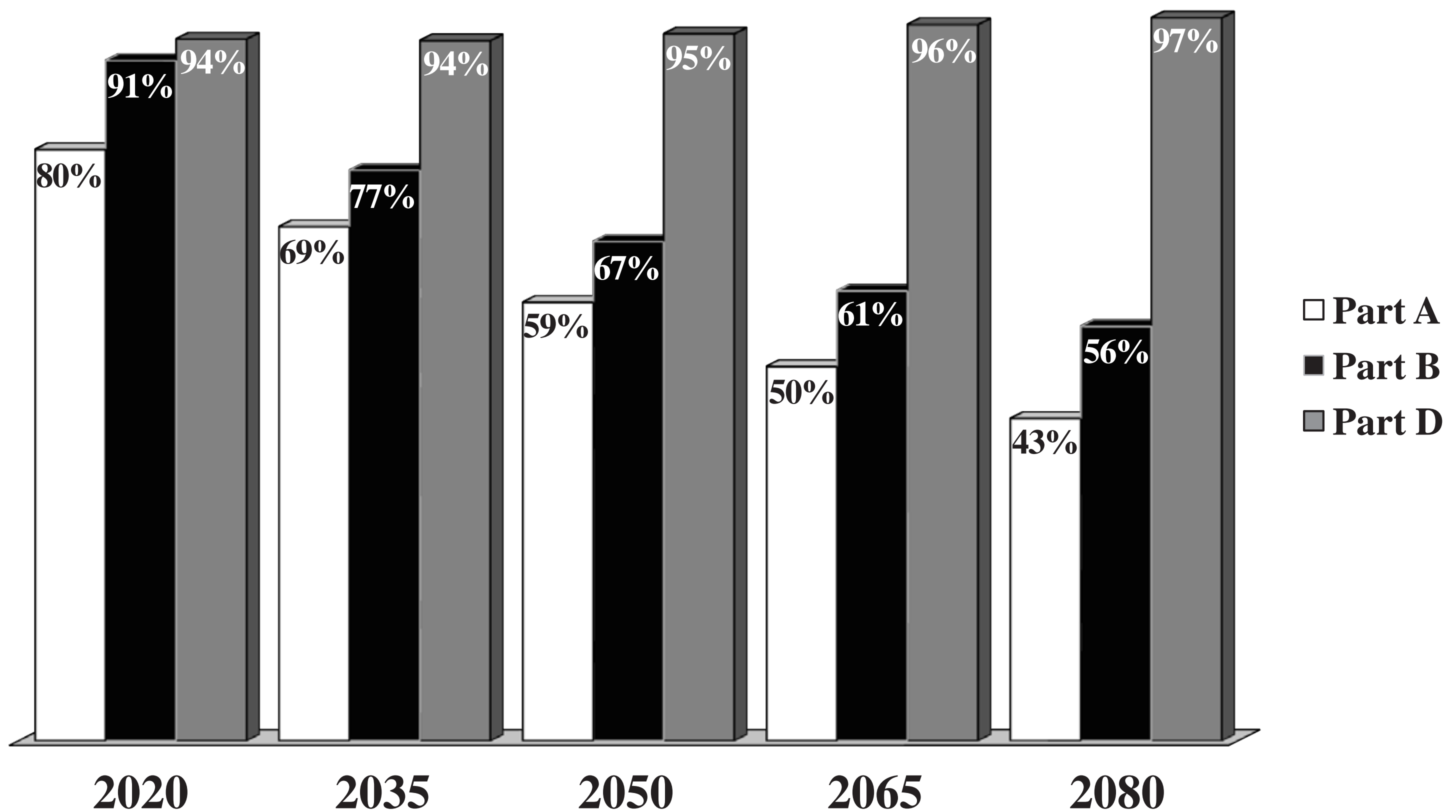


Figure Ib
Medicare Spending from the 2010 Trustees Report as a Percent of Spending from the 2009 Trustees Report

Source: Table III.A2, 2009 and 2010 Medicare Trustees Reports. Percents reflect the 2010 report's shares of GDP as percents of the 2009 estimates.

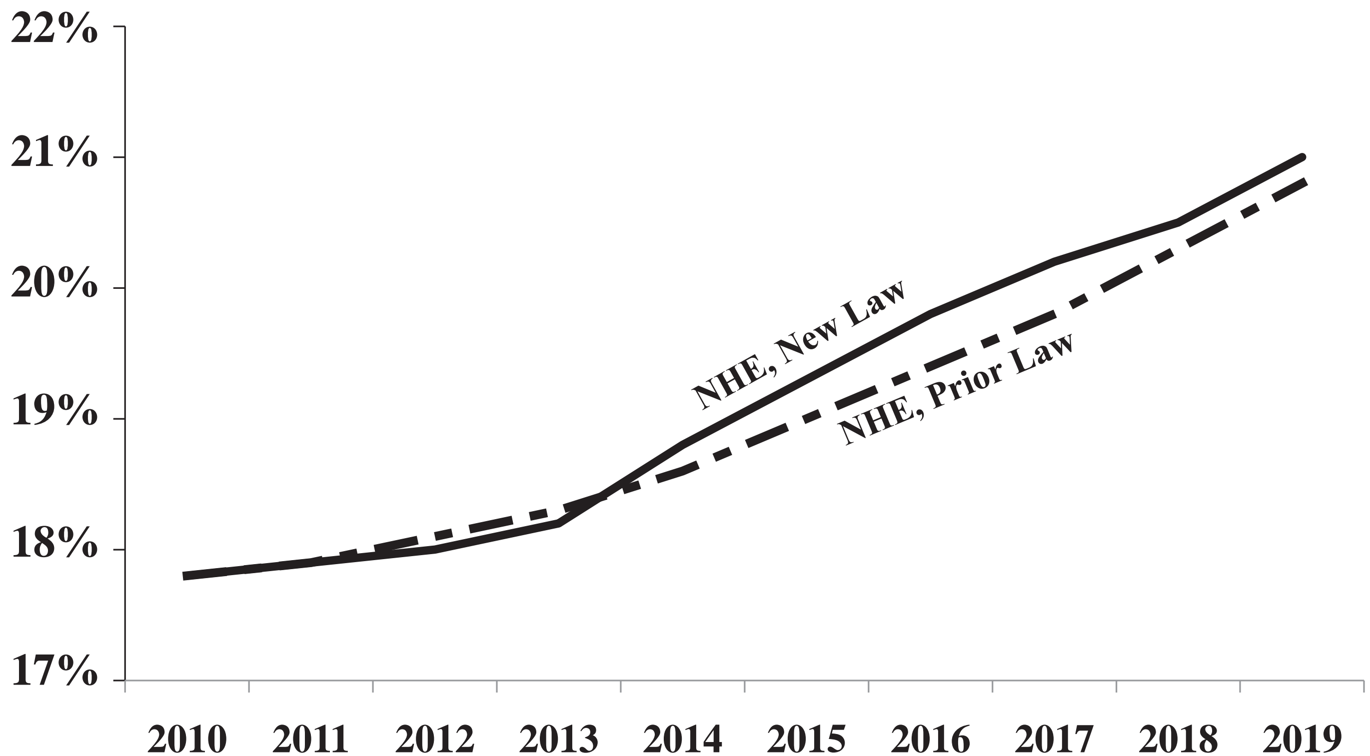
obligation is attributable to applying the productivity reduction to those services that are not already governed by the SGR system. Part D is not subject to the productivity reduction, given that payments to drug benefit firms are determined by competitive bids.[5] The ACA will eventually eliminate the "donut hole" in Part D, but the estimated change in the unfunded obligations was minimal because drug prices are expected to grow more slowly.

Medicare Spending Projections. Another way to assess the changes between the two reports is to consider changes in estimated annual spending. Total Medicare spending in 2010 is $531 billion, or 3.6 percent of roughly $14.8 trillion in GDP. As Figure Ia indicates:

- The 2009 report projected that Medicare will account for $1 in every $11 of GDP (or 8.74 percent of GDP) by 2050 and roughly $1 in every $9 of GDP by 2080.
- By contrast, the 2010 report spending projection was about $1 in every $17 of GDP for 2050 (5.94 percent) and $1 in every $16 by 2080 (6.37 percent).
- Assuming the health law is implemented, spending as a percent of GDP will be reduced by about 43 percent by 2080.

Figure Ib presents each component of forecasted Medicare spending as a percentage of GDP based on the 2009 and 2010 reports:

- By 2035, Part A spending in the 2010 report will be 70 percent of the 2009 projection; by 2065, 50 percent; and by 2080, 43 percent.



Source: Table 5, Office of the Actuary Memorandum, April 22, 2010.

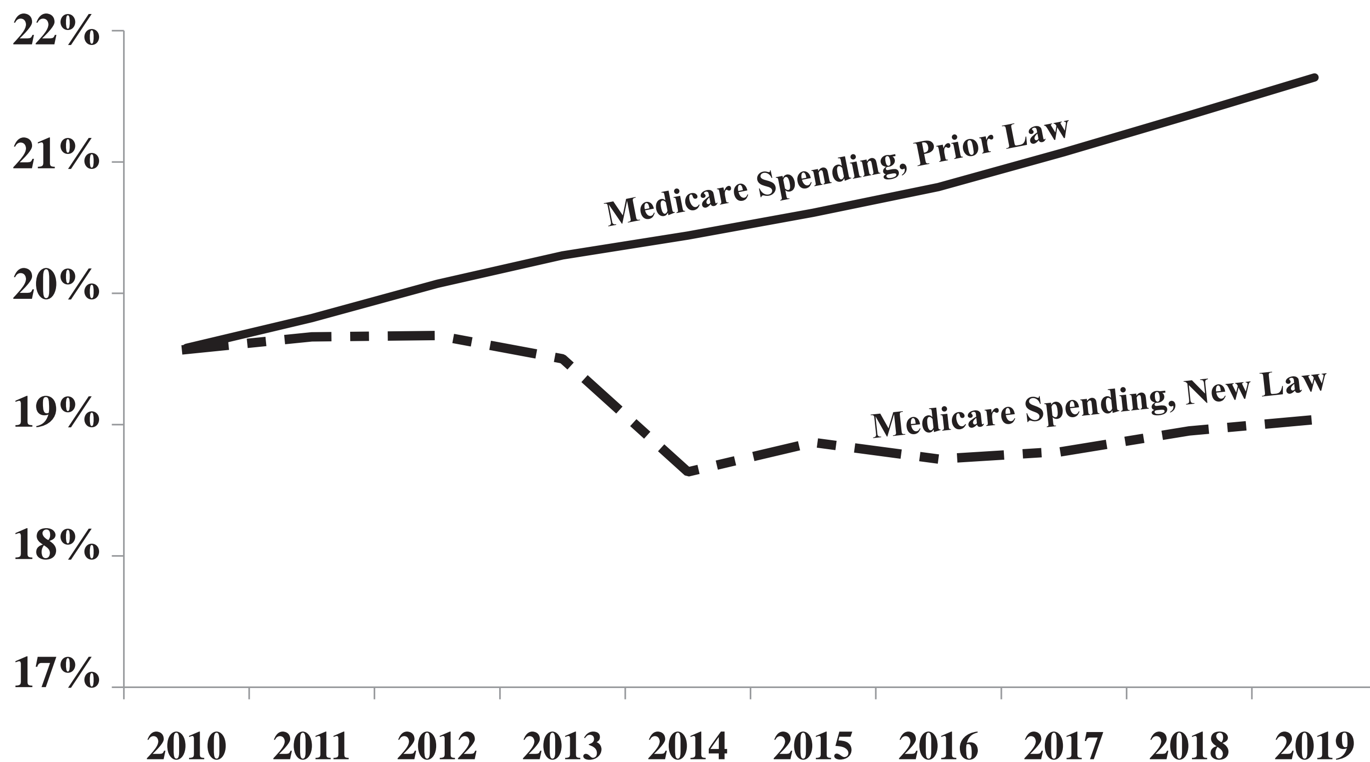
- Part B spending from the 2010 report will be two-thirds of the spending in the 2009 report by 2050 and 56 percent by 2080.

- By 2080, spending on Parts A and B combined as projected in the 2010 report will be less than the projected spending on Part A by itself in the 2009 report.

Medicare Spending as a Share of National Health Expenditures. According to an evaluation of the ACA by Medicare's Chief Actuary, Richard Foster, Medicare's share of national health expenditures (NHE) will decline at the same time that health care spending (NHE) as a percent of GDP will rise.[6] Figure IIa represents the actuary's estimate for NHE as a percent of GDP based on prior law and on the new law. The two estimates are essentially the same over time, rising from about 18 percent in 2010 to about 21 percent in 2019.

However, prior to the passage of the health care legislation, Medicare's share of NHE was expected to rise from 19.6 percent in 2010 to 21.6 percent by 2019. With the new law, Medicare's share is expected to decline to 19 percent, whereas total spending on health care will rise as a percent of GDP. [See Figure IIb.]. Thus, based on Foster's evaluation, ACA will not slow the growth in health care spending as a share of the economy, but it will reduce Medicare's share of total spending.

Comparing Estimates of Medicare Spending per Beneficiary. The Office of the Actuary made alternative estimates in 2009 to address the concern that the Part B estimates in the 2009 Trustees Report based on current law understated expected spending because



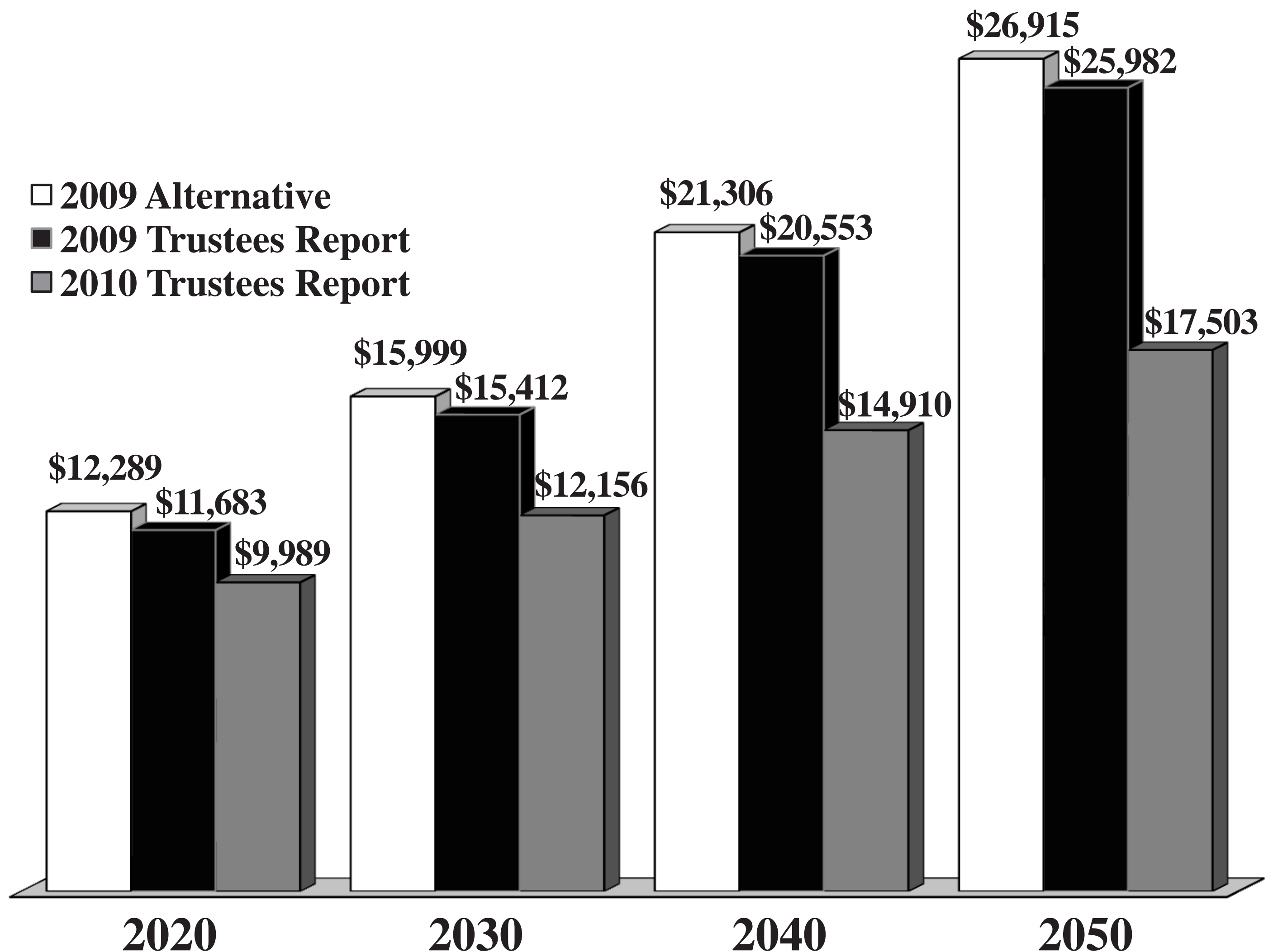
Source: Table 5, Office of the Actuary Memorandum, April 22, 2010.

Congress regularly overrides the recommended physician payment updates based on the sustainable growth rate (SGR) system. The alternative estimate incorporated projected Part B spending consistent with the growth in the Medicare Economic Index (MEI), which tracks the growth in the costs physicians face in their practices.

Figure III compares the long-run projections of Medicare spending per beneficiary in the 2010 Trustees Report with the 2009 Trustees Report and with the 2009 alternative estimate. In current, 2010 dollars:[7]

- In 2020 the projected Medicare benefit net of premium payments based on the 2010 Trustees Report will be $9,989, compared to $11,683 projected in last year's report, or $1,694 higher.
- The alternative 2009 projection was $2,300 higher than the net benefit from the 2010 Trustees Report.
- In 20 years, the average net benefit based on the 2010 Trustees Report is $12,156 compared to $15,412 benefit in the 2009 Report.
- By 2050, the net benefits estimated this year will be 67 percent of the 2009 Trustees Report estimate and 65 percent of the alternative estimate.

Medicare Benefits Compared to Social Security Benefits. Assuming that Medicare spending is constrained, how will Medicare beneficiaries fare? Figure IV presents net Medicare benefits as a percentage of Social Security benefits for new retirees.[8] In 2010, total net Medicare benefits will be about 55 percent of the average new retiree Social Security benefit. These net benefits were projected to reach 58 percent of Social Security



by 2020 in the 2009 Trustees Report and 61 percent in the 2009 actuaries' alternative memo. In contrast, the 2010 Trustees Report estimated net 2020 Medicare benefits will fall to 50 percent of new retiree Social Security benefits.

In the first few years, the ACA will slow the growth in Medicare spending so that net per capita benefits fall relative to Social Security, but then allows Medicare spending to grow at about the same rate per beneficiary as Social Security. As a result, by 2050, net Medicare benefits will be 98 percent as large as Social Security benefits (based on the 2009 alternative), 94 percent (2009 Trustees Report) and 61 percent (2010 Trustees Report). Thereafter the two series associated with the 2009 report will continue to rise relative to Social Security, but the 2010 estimates remain at about 61 percent of Social Security.

If Medicare beneficiaries could supplement their Medicare reimbursements from their own re-

sources and wanted to do so, what percent of Social Security income would be necessary to cover the reduction in estimated spending? Figure V presents the difference between the series in Figure IV based on the 2009 Trustees Report and the series based on the 2010 Trustees Report. For 2020, the difference in the projected net benefit ratio is about 9 percent and by 2050 it reaches 34 percent.

Effects of the Affordable Care Act's Cost Controls

The projections from the 2010 report are difficult to interpret given its caveats concerning current law assumptions. Nonetheless, it is worthwhile to explore how the changes to Medicare under ACA would affect the delivery of care to Medicare patients should they be fully implemented.

Payments to Providers. The main change between long-range estimates in the 2009 and 2010 Medicare Trustees Reports result from a provision in the ACA that reduces payment updates for services under Parts A and B of the program.[9] It is generally believed that those productivity improvements cannot be made, however. As the Trustees state:

> Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services. Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries.[10]

"Medicare will pay providers less than Medicaid rates by the end of the decade."

This statement presents one of many possible outcomes that could occur if the payment growth is indeed constrained as required by the ACA: Namely, "[providers] would eventually become unwilling or unable to treat Medicare beneficiaries."

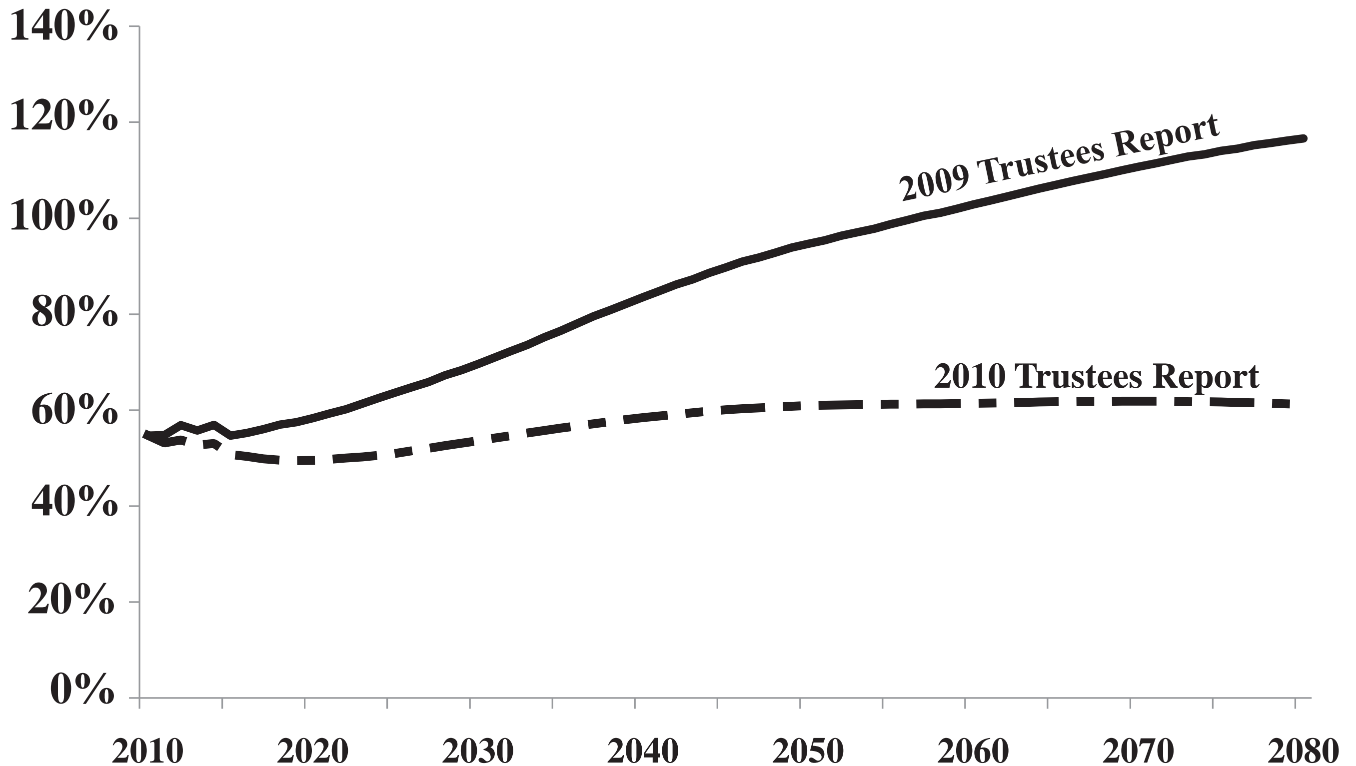
Medicare Reimbursements Will Fall Compared to Other Payers. Assuming that growth of Medicare reimbursements are constrained so that current rates are adjusted downward to match the growth of non-health care total factor productivity, the CMS actuaries estimate that Medicare reimbursements will fall relative to both private market reimbursements and Medicaid. As shown in Figure VI:[11]

- Medicare payment rates will fall below the rates paid by Medicaid (for low-income families) by the end of this decade and will fall even further behind all other payers in succeeding decades.
- Whereas Medicare pays about 80 percent of what private insurance pays today, the payment rates will fall to two-thirds of private payment by the end of this decade and one-half of private payment by midcentury.

Hospitals and Other Facilities Will Operate in the Red. The actuaries also estimated the percentage of facilities — including hospitals, skilled nursing facilities and home health agencies — that will experience operating losses in the future due to the lower projected reimbursements. Since providers must cover cost of operations, facilities operating in the red would be forced to exit the Medicare market or find ways to reduce costs.[12] As Figure VII shows:

- By 2019 the reductions in payments to providers will put about 15 percent of health care facilities have negative margins.[13]
- By 2030, 25 percent will have negative margins.
- By 2050, 40 percent of facilities will be operating at a loss.

For providers that serve both Medicare and non-Medicare patients, a reduction in payments for treating Medicare patients will reduce their margin of revenue less costs. They will have to reduce the



Note: Social Security income is for average new retirees and average Medicare benefits are net of premiums paid. Sources: Table III.A2 and A3, 2009 and 2010 Medicare Trustees Reports and Office of the Actuary Memorandum, May 12, 2009. Also Tables VI. F6 and F10 from 2009 and 2010 Social Security Trustees Reports.

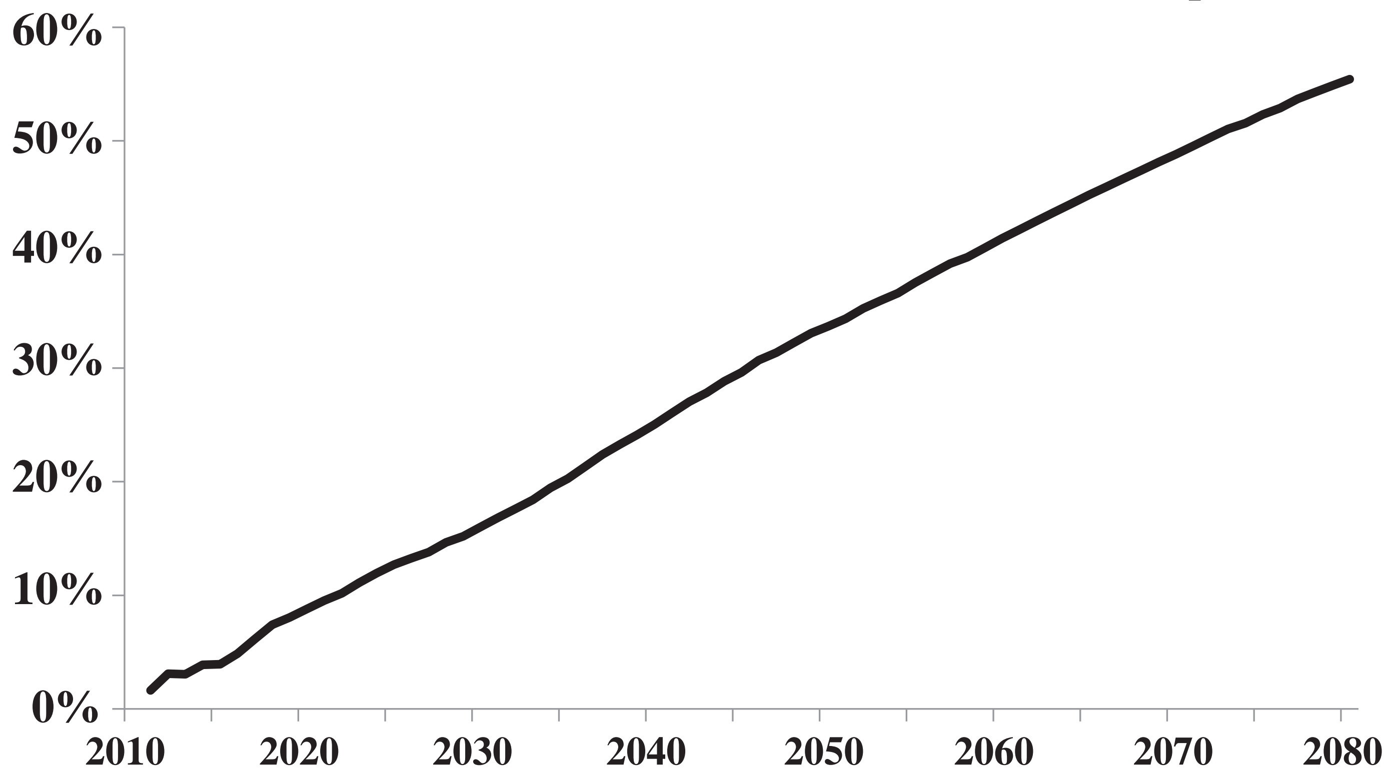
share of their patients who are on Medicare. However, given the projected growth in Medicare enrollees as a proportion of all patients, all providers cannot simultaneously reduce the share of their patients who are on Medicare. Thus, some providers will either cease operation or choose to compete in the non-Medicare health care market only.

Assuming that there is no change in the demand for services by Medicare recipients, the loss of providers and increase in the number of beneficiaries will make it increasingly difficult for Medicare recipients to find providers. Ultimately, waits to see a physician or to enter a hospital for elective procedures will increase significantly.

A Two-Tiered Health System May Evolve. The improvement in Medicare's finances shown in the 2010 Trustees Report was achieved through what are essentially price ceilings on the payments Medicare makes on behalf of beneficiaries. These price controls will produce predictable outcomes, including fewer health care options and lower quality of care for the Medicare population. Importantly, quality here does not mean poorer outcomes, but rather what quality means in most industries: more comfortable access to service. In air travel, quality means bigger seats, more legroom and more amenities, even though all passengers arrive at the destination at the same time. In hotels, quality means larger rooms, higher quality furniture and more amenities, even

Figure V

Percent of Social Security Income Required to Cover the Reduction in Medicare Benefits between the 2009 and 2010 Trustees Reports

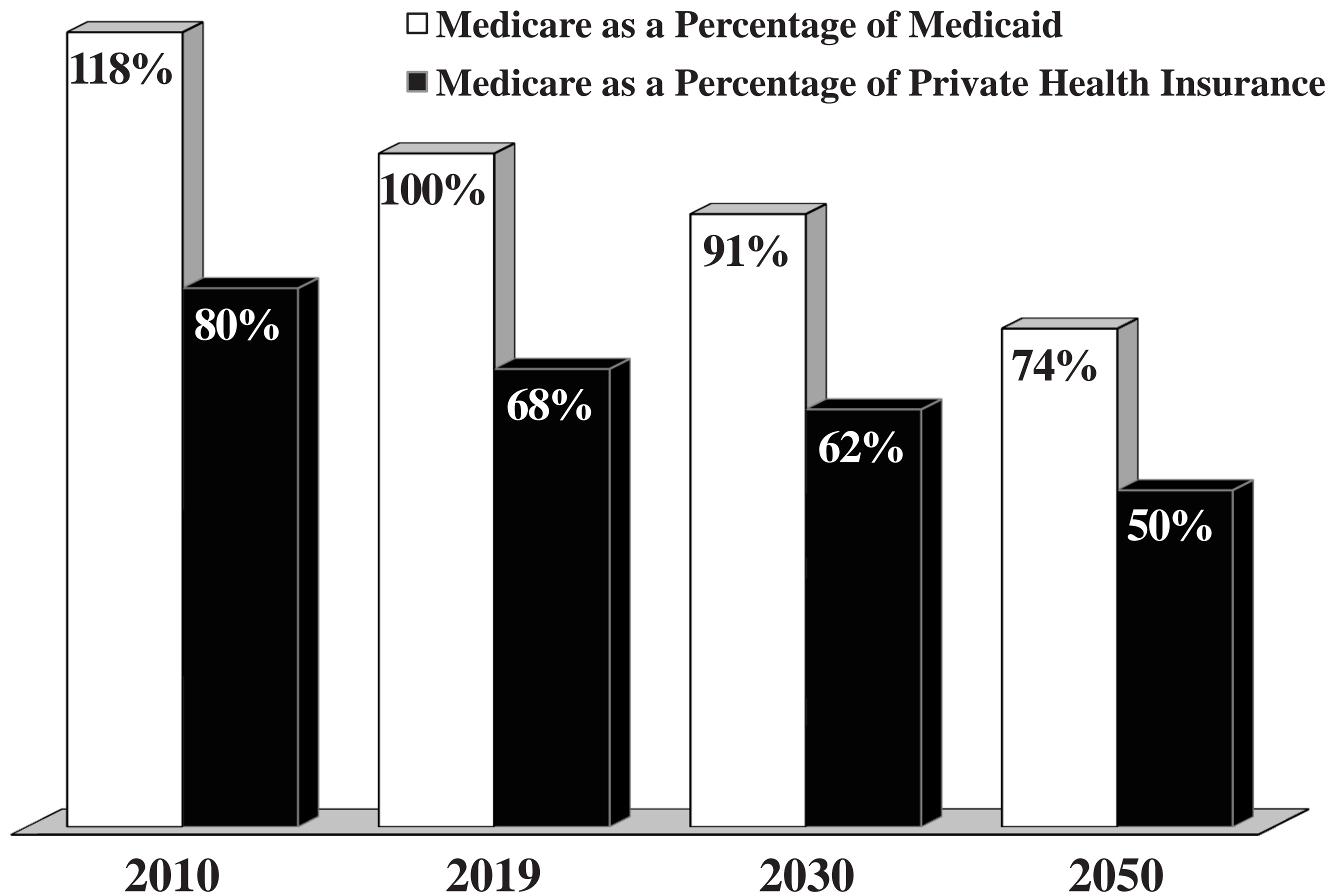


Note: Compared to 2009 Trustees Report. Social Security income is for average new retirees and average Medicare benefits are net of premiums paid.
Sources: Table III.A2 and A3, 2009 and 2010 Medicare Trustees Reports, Tables VI. F6 and F10 from 2009 and 2010 Social Security Trustees Reports, and Office of the Actuary Memorandum, May 12, 2009.

though all guests have a place to spend the night.

The ACA price controls may ultimately lead to many beneficiaries leaving Medicare altogether, unless beneficiaries are allowed to supplement Medicare's payments per service. Historically, however, there have been legal restrictions on both patients and providers that have prevented the parties from negotiating.

The ultimate outcome might well be a bimodal equilibrium of providers who specialize in patients paying Medicare prices and providers who only serve patients paying their full cost. The first set of providers will have full facilities and long waiting lines. There are two types of waiting lines. There is the waiting time patients experience once they arrive at a doctor's office or at a provider's facility; more importantly, however, is the waiting list time — the time between requesting a service and the date on which the patient actually receives it. This waiting list time can span days or months. The second set of providers will be accessible with lower waiting times and will provide more amenities. Medicare recipients will be part of the patient load at each type of facility. Medicare recipients, who choose the second type of providers and avoid the Medicare wait, will pay the full cost of their care. Such a system is the equivalent of means-testing, where wealthier patients, or those who place a high value on quick access and more amenities, will go to the full-cost facilities.



Source: Derived from Office of the Actuary Memorandum, August 5, 2010, Figure 1.

The private health insurance payments to which Medicare payments are compared in Figure VI is essentially a projection of the cost of future health care desired by the non-Medicare population. This projection recognizes the fact that health care is labor intensive relative to other parts of the economy and has not experienced, and is not expected to experience, the same productivity increases as the rest of the economy. In addition, in all developed countries, health care demand rises faster than income or economic growth. This increase in relative demand, coupled with wage increases in non-health care industries due to increased productivity, must increase labor costs in the health care industry.

Given higher operating costs coupled with lower reimbursements from Medicare, providers must reduce the cost of serving Medicare patients in order to stay in business. Such cost reductions, given available technology, must involve reductions in the quality of service. What cost reducing adjustments can be made without an appreciable effect on outcomes? Over the years, hospitals have moved from multiple bed wards to semiprivate and private rooms. In the maternity arena, there has been a move from multiple patient labor rooms and separate delivery rooms to what, at some hospitals, might be referred to as nicely decorated birthing suites with ample room for guests. All of

these quality increases are the result of the increase in income level of patients, who demand and are willing to pay for better quality, coupled with the increase in third-party payers' share of total spending.

If Medicare reimbursements cover less and less of the cost of providing care equivalent in quality to that provided in the non-Medicare market, one solution is to reduce amenities and convenience to the level where reimbursements cover cost. Providers could have Medicare wings with multiple bed wards, offer fewer non-health care required amenities, increase congestion and waiting time for treatment, decrease the number of health care workers per patient, and delay the purchase of the latest technology. Clearly, these changes would affect the quality of care patients receive, but measured productivity may rise. Essentially, Medicare providers would become the budget hotel version of health care providers.

The 2009 and 2010 Trustees Reports Compared to the Office of the Actuary's Alternative Projections

The 2010 Trustees Reports assume that provisions of the ACA remain in force indefinitely. As noted, the Trustees and Medicare's Chief Actuary have serious concerns about the reasonableness of the long-range forecasts. In his statement of actuarial opinion, the Chief Actuary directs readers to alternative estimates presented in an Office of the Actuary memorandum published on the same day as the 2010 Trustees Report.[14] The Office of the Actuary's alternative long-range forecasts of Part A and Part B spending use the same productivity adjustments as the current law Part A forecasts in the 2010 Trustees Report for the first 10 years, but thereafter gradually eliminate the adjustments so that the growth rates in per beneficiary spending return to rates comparable to those used in the 2009 Trustees Report by the mid-2030s.[15] The components of Part B affected by the productivity adjustments are revised in the same way as the Part A spending components, and physician payments are updated at the same rate as the growth in the Medicare Economic Index (MEI), which was used in the 2009 alternative projection referenced previously. (The forecast for Part D in the alternative memorandum remains unchanged from the forecast in the 2010 Trustees Report.)

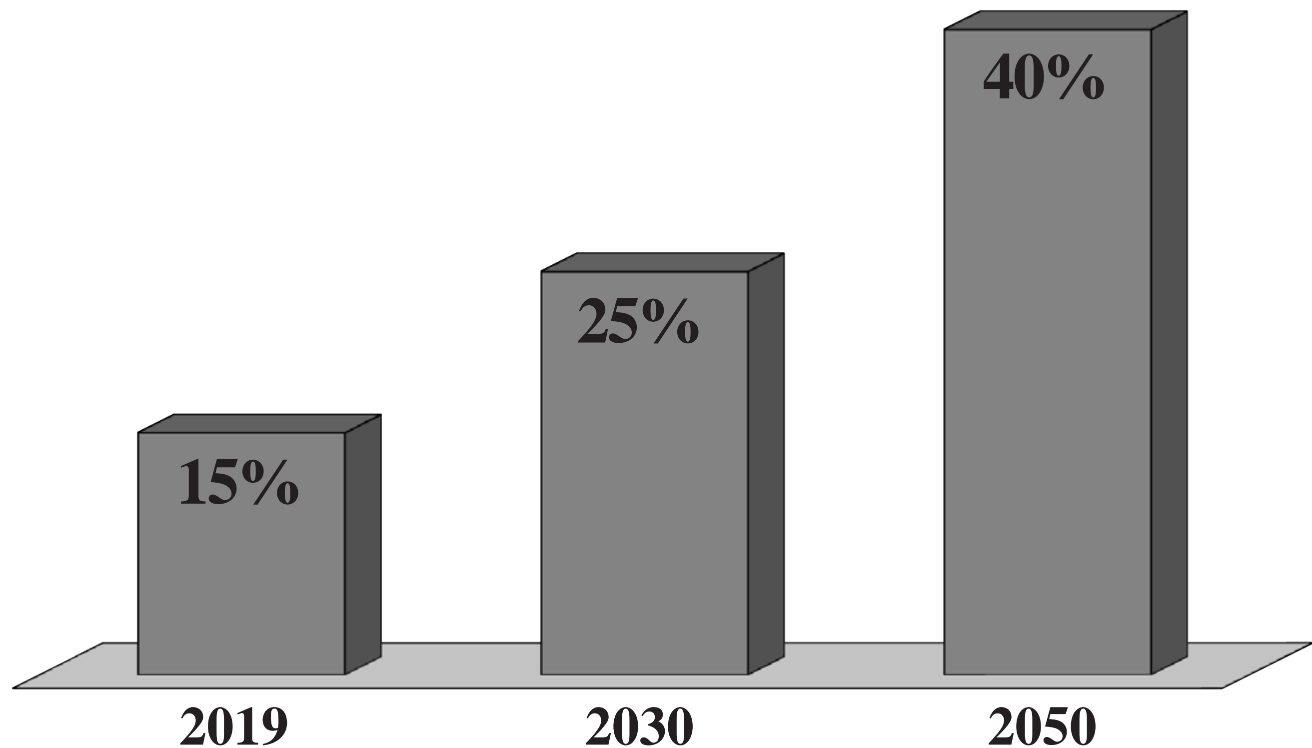
"Cuts in Medicare payments to doctors and hospitals could reduce the quality of care."

Forecasts of Medicare Spending. Figure VIII presents Medicare expenditures as a percent of GDP based on the 2009 and 2010 Trustees Reports and estimates from the 2009 and 2010 alternative memoranda. The forecast with the highest expenditures over time is from the 2009 alternative memorandum in which Part B expenditures are assumed to grow with the MEI. The 2009 Trustees Report current law projections are the second highest. Because the 2010 alternative forecast allows the productivity reductions stipulated in the ACA for the components of Part A and for some of the components of Part B to remain in place for the next 10 years, its expenditure path is lower than the two from 2009, but the growth rate is essentially the same after 20 years.

By the last year of the projection, the alternative 2010 estimate of total expenditure as a percent of GDP is about 95 percent of the 2009 Trustees Report estimate and 92 percent of the alternative 2009 estimate. However, it is two-thirds (68 percent) higher than the 2010 Trustees Report's estimate of Medicare's share of GDP.[16]

Forecasts of Medicare Shortfalls. A final comparison can be made based on the present values of the 75-year expenditures, revenues and shortfalls. Comparing the 2009 and 2010 Trustees Reports and the alterative 2010 memorandum, Table II shows:[17]

- The present value of total Medicare spending in the 2010 Trustees Report is 24 percent less than the 2009 report projections, whereas the 2010 alternative estimate is essentially the same.
- Part A spending estimates decline 34 percent between the 2009 and 2010 reports, but fall only 16 percent in the 2010 alternative.
- Part B spending declines 24 percent between the two official reports whereas the 2010 alternative report, which assumes suspension of the SGR system, produces Part B spending that is



Source: Office of the Actuary Memorandum, August 5, 2010.

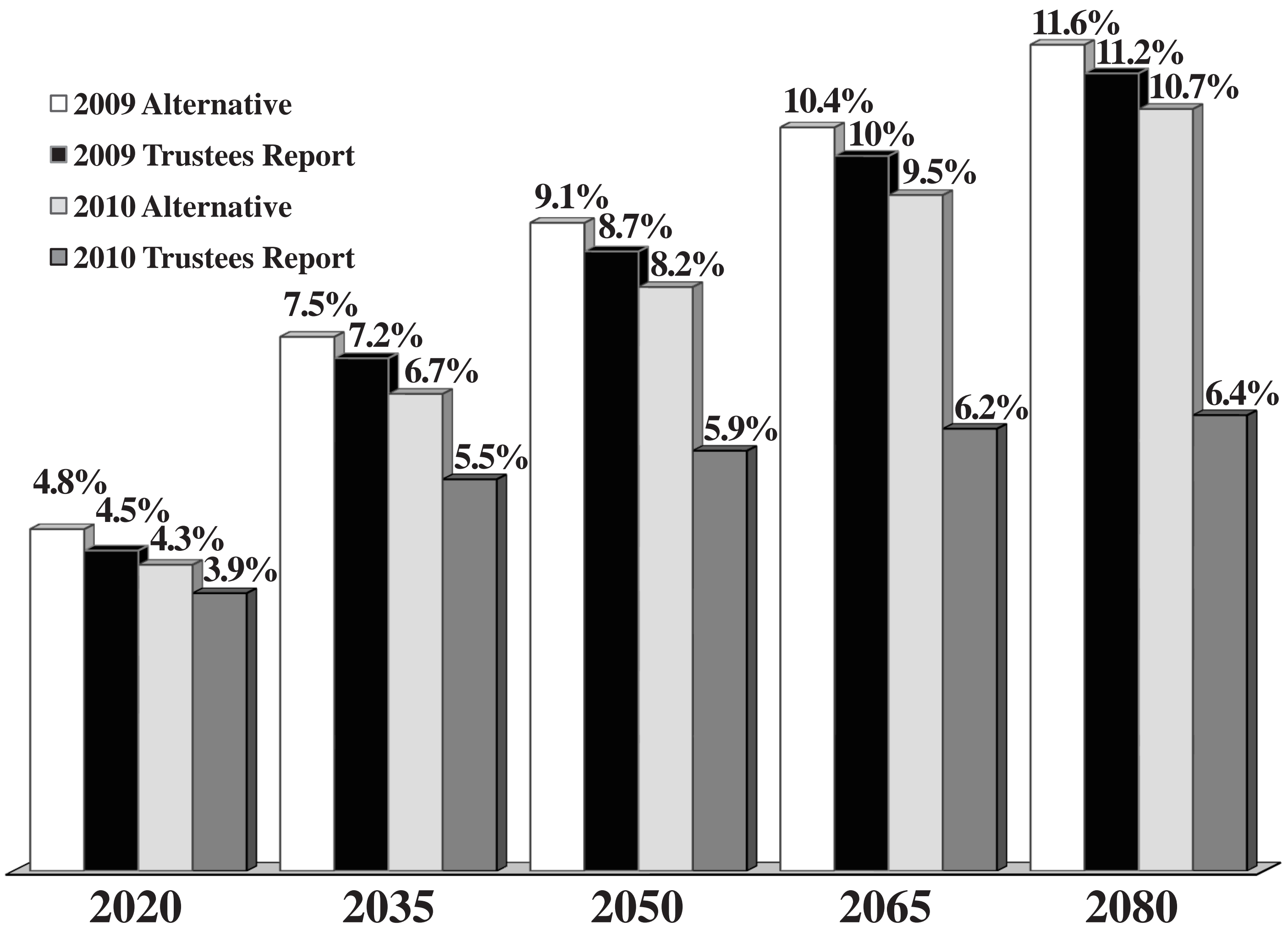
21 percent higher than the 2009 Trustees Report estimate.

- Medicare Part D spending on prescription drugs rises slightly by 3 percent.

The estimates based on the 2010 Trustees Report indicate that Medicare's federal budget financing requirements drop dramatically, these cost savings will produce adverse consequences related to access to care or increased financial burdens on seniors, for which current and near-term retirees are unprepared. The alternative 2010 forecasts are much closer to last year's long run estimates. In the short run, the primary difference between the 2010 Trustees Report and the alternative forecasts arise from the treatment of Part B spending. It is important to note that the estimated deficits over the next 10 years are more than $240 billion higher under the alternative.

An Alternative Medicare Policy

The tax code favors health care spending relative to other consumption due to the deductibility of employers' premium contributions as a business expense and the exclusion of health benefits from employees' taxable income. Reforming the tax code to eliminate that bias would change the level of health care consumption and possibly affect its rate of growth. But these relative growth rates would be much less of a public policy concern if it were not for the fact that government spending accounts for over 45 percent of health care expenditures, and that the tax exclusion in its current form accounts for tax expenditures in excess of $160 billion dollars. Thus, comprehensive reform should begin with reducing the tax preference afforded employer provided health insurance.



Sources: Table III.A2, 2009 and 2010 Medicare Trustees Report. 2009 Alternative from Office of the Actuary Memorandum, May 12, 2009, Table 4. 2010 Alternative from Office of the Actuary Memorandum, August 5, 2010, Table 5.

This would lower the expected costs for the government programs for low income Americans as well as for retirees through Medicare.

Apart from comprehensive health care reform, there are ways to achieve the same Medicare spending reductions as ACA without the adverse effects of the price controls in the ACA.

One alternative is the premium support favored by the majority of members of the 1999 National Bipartisan Commission on the Future of Medicare. Medicare could be converted from a top down pricing system to a bottom up system where providers would face patients armed with risk-adjusted funding from Medicare. Individuals could shop for health care plans and use their premium support amount as full or partial payment. Such a reform would do for all parts of Medicare what competition did for participants in Medicare Part D. The Medicare Part D experience demonstrates the power of competition to control prices. In every year the Trustees estimates of the cost of

TABLE II

Comparison of 75-Year Horizon Expenditures, Revenues and Shortfalls Based on the 2009 and 2010 Trustees Reports and the 2010 Alternative Estimates
(in trillions of dollars)

2009 Medicare Trustees Report 75-Year Horizon

	Expenditures	Revenues Taxes Premiums State Transfers	Unfunded Obligations General Revenue Transfers
Part A	$25.8	$12.0	$13.8
Part B	23.2	6.0	17.2
Part D	9.4	2.2	7.2
Total	$58.4	$20.2	$38.2

2010 Medicare Trustees Report 75-Year Horizon

	Expenditures	Revenues Taxes Premiums State Transfers	Unfunded Obligations General Revenue Transfers
Part A	$17.1	$14.4	$2.7
Part B	17.7	4.9	12.9
Part D	9.7	2.5	7.2
Total	$44.5	$21.8	$22.8

2010 Alternative Estimates 75-Year Horizon

	Expenditures	Revenues Taxes Premiums State Transfers	Unfunded Obligations General Revenue Transfers
Part A	$21.7	$14.4	$7.3
Part B	28.2	7.8	20.4
Part D	9.7	2.5	7.2
Total	$59.6	$24.7	$34.9

Source: Tables III.B9, III.B10, III.C15 and III.C23, 2009 and 2010 Medicare Trustees Reports, and authors' estimates based on the Office of Actuary Memorandum from August 5, 2010.

Medicare Part D were overstated as the competitive market lowered the cost of prescription drugs to users.

The premium support amount would be adjusted upward with the growth in per capita national income but not per capita health care cost. Effectively, this proposal would result in Medicare cost growth very similar to the path forecast in the 2010 Trustees Report. Unlike the imposed reimbursement rates implied by the ACA, no providers would go out of business. However, significant changes would occur in health care delivery systems. With Medicare participants paying for some of their health care, there should be an increase in the variety of delivery systems as providers compete for participants' Medicare stipends and additional payments. Provisions for low income beneficiaries in the form of health spending accounts would be structured to keep pace with the new system. The only requirement would be that outcomes not be compromised. This would accomplish all of the cost savings promised by the ACA with none of the unintended consequences that come from placing price ceilings on what Medicare will pay for different services.

A reform structured in this way would free doctors and patients from the cost-increasing, quality-reducing constraints of the current system. For the long run, we must to replace our pay-as-you-go approach with a funded system in which each generation of young workers saves and invests in order to pay for some of its own postretirement health care needs. We believe that these reforms are doable, without pushing Medicare beneficiaries into a system of second-class care.

Endnotes

[1.] The official summary of the Trustees Reports warns: "If health care efficiency cannot be substantially improved through productivity gains or other measures, then over time the statutory Medicare payment rates would become inadequate. In that situation, the payment update reductions might be suspended, in which case actual long-range costs would be larger than those projected under current law." See *Status of the Social Security and Medicare Programs, A Summary of the 2010 Annual Reports,* Social Security and Medicare Boards of Trustees, August 5, 2010. The Trustees include the Secretaries of the Treasury, Health and Human Services, and Labor, the Commissioner of Social Security, and the Administrator of the Centers for Medicare and Medicaid Services. The two public trustee positions are vacant. The full 2010 Medicare Trustees Report is formally titled "2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," and is available at https://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf.

[2.] The 2010 Medicare Trustees Report cautions: "For these reasons, the financial projections shown in this report for Medicare do not represent a reasonable expectation for actual program operations in either the short range (as a result of the unsustainable reductions in physician payment rates) or the long range (because of the strong likelihood that the statutory reduction in price updates for most categories of Medicare provider services will not be viable)." 2010 Medicare Trustees Report, page 282.

[3.] These numbers are based on Table II.

[4.] As used in the Trustees Report, "unfunded obligation" refers to the difference between the present values of Medicare Part A expenditures and income less the trust fund assets. In the 2010 Trustees Report, the present value of Part A expenditures over the next 75 years is $17,090 billion and the present value of revenues is $14,408 billion for a difference of $2,683 billion. Subtracting the $304 billion trust fund results in the reported 75-year unfunded obligation of $2,378 billion. While the trust fund is viewed as an asset to Medicare it is a federal liability and is excluded from Table I. Officially, Parts B and D do not have unfunded obligations because general revenues make up the difference between spending in these programs and the premiums collected from retirees and transfers from the states. The general revenue transfers for Parts B and D are reported in Table I as unfunded obligations.

[5.] John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Office of the Actuary Memorandum, August 5, 2010.

[6.] Richard S. Foster, Chief Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Office of the Actuary Memorandum, April 22, 2010, Table 5.

[7.] The estimates are based on data from Tables III. A2 and III.A3 from the 2009 and 2010 Medicare Trustees Reports and from Table VI.F6 from the 2009 and 2010 Social Security Trustees Report. The alternative estimates are from M. Kent Clemens, Joseph M. Lizonitz and Suguna M. Murugesan, "Projected Medicare Part B Expenditures under Two Illustrative Scenarios with Alternative Physician Payment Updates," Office of the Actuary Memorandum, May 12, 2009. The Medicare Economic Index update scenario from Table 4 in the memorandum is used here.

[8.] The Social Security benefits for medium scaled workers are from VI.F10 from the 2009 and 2010 Social Security Trustees Report.

[9.] Specifically, "provider payment updates and annual provider price updates related to the CPI are reduced by varying amounts by type of provider during 2010-2019 and permanently by productivity adjustments, with staggered implementation dates. The productivity offset would equal the percentage change in the 10-year moving average of annual private nonfarm business multifactor productivity." See the 2010 Medicare Trustees Report, page 214.

[10.] 2010 Medicare Trustees Report, page 2.

[11.] The numbers in Figure VI are derived from Figure I and the explanatory text in John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Office of the Actuary Memorandum, August 5, 2010.

[12.] 2010 Medicare Trustees Report, page 26.

[13.] Office of the Actuary Memorandum, August 5, 2010.

[14.] 2010 Medicare Trustees Report, page 282.

[15.] John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Office of the Actuary Memorandum, August 5, 2010. See the memorandum for a detailed discussion of how the alternative forecasts compare to those presented in the 2010 Medicare Trustees Report.

[16.] Note that these comparisons are based on spending as percentages of the respective GDP series as they were projected in the 2009 and 2010 Trustees Reports. Consequently the denominators for the two sets of spending forecasts are different. The annual GDP estimates from the 2010 report are higher than the estimates from the 2009 report and this will actually produce a slightly higher present value of aggregate spending for the 2010 alternative estimates than for the 2009 estimates, whereas the annual percents of GDP were lower. Each Trustees Report identifies the sources of the change between the previous year's 75-year estimates and the current year's estimates. The changes are presented in Table III. B12 of the 2010 Report. Apart from the program specific assumptions and legislative changes, the valuation period, the base estimate, and the economic and demographic assumptions affect the relative sizes of the present values. For example, the present value of GDP over the 75 year horizon based on the 2009 Medicare Trustees Report is $790.9 trillion but is $843.3 trillion, or 6.6 percent higher in the 2010 Report.

[17.] In Table II, Part D revenues, expenditures and transfers remain unchanged relative to the 2010 Trustees Report. The present value of Part A spending is estimated, while Part A revenues are assumed to be the same as in the 2010 Trustees Report. Likewise the present value of Part B spending is estimated, and premiums are assumed to be the same share of Part B spending as was presented in the 2010 report.

About the Authors

Dr. Andrew J. Rettenmaier is the Executive Associate Director at the Private Enterprise Research Center at Texas A&M University. His primary research areas are labor economics and public policy economics with an emphasis on Medicare and Social Security. Dr. Rettenmaier and the Center's Director, Thomas R. Saving, presented their Medicare reform proposal to U.S. Senate Subcommittees and to the National Bipartisan Commission on the Future of Medicare. Their proposal has also been featured in the *Wall Street Journal*, *New England Journal of Medicine*, *Houston Chronicle* and *Dallas Morning News*.

Dr. Rettenmaier is the co-principal investigator on several research grants and also serves as the editor of the Center's two newsletters, PERCspectives on Policy and PERCspectives. He is coauthor of a book on Medicare, *The Economics of Medicare Reform* (Kalamazoo, Mich.: W.E. Upjohn Institute for Employment Research, 2000) and an editor of *Medicare Reform: Issues and Answers* (University of Chicago Press, 1999). He is also coauthor of *Diagnosis and Treatment of Medicare* (Washington, D.C.: American Enterprise Institute Press, 2007). Dr. Rettenmaier is a senior fellow with the National Center for Policy Analysis.

Dr. Thomas R. Saving is the Director of the Private Enterprise Research Center at Texas A&M University. A University Distinguished Professor of Economics at Texas A&M, he also holds the Jeff Montgomery Professorship in Economics. Dr. Saving served two terms as a public trustee of the Social Security and Medicare Trust Funds. Dr. Saving's research has covered the areas of antitrust and monetary economics, health economics, the theory of the banking firm and the general theory of the firm and markets. He has served as a referee or as a member of the editorial board of the major U.S. economics journals and is currently an editor of *Economic Inquiry*.

Dr. Saving has authored many articles and two influential books on monetary theory. He has been President of the Western Economics Association and President of the Southern Economics Association. After receiving his Ph.D. in Economics in 1960 from the University of Chicago, Dr. Saving served on the faculty of the University of Washington and Michigan State University. He moved to Texas A&M University in 1968, and served as chairman of the Department of Economics at Texas A&M from 1985-1991. Dr. Saving is a senior fellow with the National Center for Policy Analysis.

NCPA
NATIONAL CENTER FOR POLICY ANALYSIS

The NCPA is a nonprofit, nonpartisan organization established in 1983. Its aim is to examine public policies in areas that have a significant impact on the lives of all Americans — retirement, health care, education, taxes, the economy, the environment — and to propose innovative, market-driven solutions. The NCPA seeks to unleash the power of ideas for positive change by identifying, encouraging and aggressively marketing the best scholarly research.

Health Care Policy.

The NCPA is probably best known for developing the concept of Health Savings Accounts (HSAs), previously known as Medical Savings Accounts (MSAs). NCPA President John C. Goodman is widely acknowledged (*Wall Street Journal*, WebMD and the *National Journal*) as the "Father of HSAs." NCPA research, public education and briefings for members of Congress and the White House staff helped lead Congress to approve a pilot MSA program for small businesses and the self-employed in 1996 and to vote in 1997 to allow Medicare beneficiaries to have MSAs. In 2003, as part of Medicare reform, Congress and the President made HSAs available to all nonseniors, potentially revolutionizing the entire health care industry. HSAs now are potentially available to 250 million nonelderly Americans.

The NCPA outlined the concept of using federal tax credits to encourage private health insurance and helped formulate bipartisan proposals in both the Senate and the House. The NCPA and BlueCross BlueShield of Texas developed a plan to use money that federal, state and local governments now spend on indigent health care to help the poor purchase health insurance. The SPN Medicaid Exchange, an initiative of the NCPA for the State Policy Network, is identifying and sharing the best ideas for health care reform with researchers and policymakers in every state.

NCPA President John C. Goodman is called the "Father of HSAs" by *The Wall Street Journal*, WebMD and the *National Journal*.

Taxes & Economic Growth.

The NCPA helped shape the pro-growth approach to tax policy during the 1990s. A package of tax cuts designed by the NCPA and the U.S. Chamber of Commerce in 1991 became the core of the Contract with America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives in summer 2002. The NCPA's proposal for an across-the-board tax cut became the centerpiece of President Bush's tax cut proposals.

NCPA research demonstrates the benefits of shifting the tax burden on work and productive investment to consumption. An NCPA study by Boston University economist Laurence Kotlikoff analyzed three versions of a consumption tax: a flat tax, a value-added tax and a national sales tax. Based on this work, Dr. Goodman wrote a full-page editorial for *Forbes* ("A Kinder, Gentler Flat Tax") advocating a version of the flat tax that is both progressive and fair.

A major NCPA study, "Wealth, Inheritance and the Estate Tax," completely undermines the claim by proponents of the estate tax that it prevents the concentration of wealth in the hands of financial dynasties. Actually, the contribution of inheritances to the distribution of wealth in the United States is surprisingly small. Senate Majority Leader Bill Frist (R-TN) and Senator Jon Kyl (R-AZ) distributed a letter to their colleagues about the study. In his letter, Sen. Frist said, "I hope this report will offer you a fresh perspective on the merits of this issue. Now is the time for us to do something about the death tax."

Retirement Reform.

With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare, working under the direction of Thomas R. Saving, who for years was one of two private-sector trustees of Social Security and Medicare.

The NCPA study, "Ten Steps to Baby Boomer Retirement," shows that as 77 million baby boomers begin to retire, the nation's institutions are totally unprepared. Promises made under Social Security, Medicare and Medicaid are completely unfunded. Private sector institutions are not doing better — millions of workers are discovering that their defined benefit pensions are unfunded and that employers are retrenching on post-retirement health care promises.

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Pension reforms signed into law include ideas to improve 401(k)s developed and proposed by the NCPA and the Brookings Institution. Among the NCPA/Brookings 401(k) reforms are automatic enrollment of employees into companies' 401(k) plans, automatic contribution rate increases so that workers' contributions grow with their wages, and better default investment options for workers who do not make an investment choice.

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NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the *Wall Street Journal*, the *Washington Times*, *USA Today* and many other major-market daily newspapers, as well as on radio talk shows, on television public affairs programs, and in public policy newsletters. According to media figures from Burrelles*Luce*, more than 900,000 people daily read or hear about NCPA ideas and activities somewhere in the United States.

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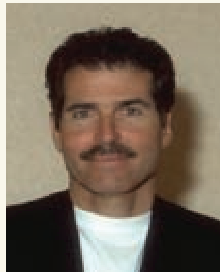

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former U.S. Senator

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Tommy Thompson,
former Secretary of Health and Human Services

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