

The Financing Needs of a Restructured Medicare Program

*by Members of the National Academy of Social Insurance Study Panel on Medicare Financing**

Summary

Through the Bipartisan Commission on the Future of Medicare and other efforts, policy makers have begun to redesign Medicare to meet long-term challenges that include an aging population, rising per capita health care costs, and an inadequate benefit package. However, no proposal as of yet fully addresses Medicare's financing needs. Without any changes, revenues from taxpayers to the program would need to more than double in 2030 over 1998 levels in order to support current benefits. Expanding Medicare to cover prescription drugs or to address other inadequacies in benefits would make Medicare's financing needs even greater. The Breaux/Thomas premium support proposal to the Bipartisan Commission would have required about 80 percent more in revenues from taxpayers in 2030 than Medicare needed in 1998. Although it is important to ensure that Medicare operate as efficiently as possible, this analysis suggests that any comprehensive discussion about Medicare's future must include the need for new revenues.

Throughout the last half of the 1990s, there have been several attempts to reform the Medicare program. The rapid growth in program expenditures and the looming retirement of the Baby Boom generation led to a major set of changes proposed by the Congress in 1995. A scaled down version of reforms passed as part of the Balanced Budget Act of 1997, and a bipartisan commission was tasked with examining further options for change.

The National Bipartisan Commission on the Future of Medicare and other efforts have focused on Medicare as part of the federal budget, stressing the burdens from rising per capita health care costs and

the aging of the United States' population. But a third challenge — a benefit package that increasingly reflects neither the modern practice of medicine nor the medical needs of an increasingly older population and provides less beneficiary protection over time — is also a concern of many seeking to reform Medicare.

As policy makers adjust benefits, eligibility, payments, and other features of Medicare, they will also need to consider the program's financing. Yet this issue has been largely ignored in the recent Medicare debate. The President's June, 1999 proposal identifies the need for new resources but would tap the

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budget surplus rather than seeking new taxes or significantly raising costs to beneficiaries. It is important to ensure that Medicare operates as efficiently as possible and represents a valuable benefit to those it serves. But because the prominent reforms discussed for Medicare would not eliminate the need for new revenues, it is important to add this issue to discussions about Medicare's future.

The National Academy of Social Insurance (NASI) convened a diverse panel of experts to explicitly consider Medicare's financing needs and options for meeting them. This *Brief* reports the group's interim findings about the first of these two charges. Examining financing needs cannot be done in a vacuum, so this project began with asking what savings might be achieved for Medicare before seeking additional revenues for the program, and what the Medicare program of the future might include. Options for savings on the expenditure side of the equation include considerations of what beneficiaries themselves might be required to pay and what might be saved from some of the proposals to modernize or restructure the Medicare program. We conclude that none of these changes to obtain savings will be sufficient to sustain the Medicare program in a form similar to what is now guaranteed without the addition of further revenues. Any expansion of benefits would further increase revenue needs.

What is the History of Medicare Financing?

Since 1966, Medicare financing has represented a partnership between current and future beneficiaries. Future beneficiaries help finance Medicare through earmarked payroll taxes (for Part A, Hospital Insurance) and through general revenue collections (which finance 75 percent of Part B, Supplementary Medical Insurance). In return, taxpayers have the expectation that they and their parents will have financial assistance in securing health care in retirement or if they become disabled.

Current beneficiaries help finance the costs of this health insurance coverage through monthly premiums (\$45.50 per beneficiary per month in 1999) for Part B of the program that account for 25 percent of Part B expenditures, and deductibles and copayments for most covered services. To the extent that beneficiaries continue to work or to pay general income and other federal taxes, they also contribute to the taxpayer share of the program. In 1998, on average, beneficiaries were liable for 21 percent of the \$6,862 in per capita costs for all Medicare-covered services. Beneficiaries' liability consists of premiums and cost sharing requirements.¹ Taxpayers (both current and future beneficiaries) paid for the remaining 79 percent.

Further, Medicare is not a fully comprehensive health insurance program. Beneficiaries are responsible for services not covered by Medicare as well as cost sharing requirements (deductibles and coinsurance) for covered services. Many beneficiaries bear those costs directly (out-of-pocket) or through the purchase of individual supplemental health insurance.² In addition, public programs such as Medicaid also share in the costs of non-covered services, deductibles, and coinsurance. Finally, some employers offer supplemental coverage to retirees, usually at a subsidized rate.³

When Medicare began in 1966, Hospital Insurance (Part A of the program) was financed by payroll taxes of 0.35 percent each for employers and

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employees on the first \$6,600 of earnings. And at that time, Part A represented about three-fourths of total Medicare spending. The much smaller Supplementary Medicare Insurance (Part B) component was financed half from general revenues and half from beneficiary premiums.

Over the years, the payroll tax contribution for Part A has been increased periodically. Even so, Part A financing has tended to lag behind growth in the costs of the program. For example, as early as 1970, the Part A trust fund was projected to be insolvent within just 2 years.⁴ Further, although Congress made all earnings (rather than just the first \$72,600 as is the case for Social Security in 1999) subject to the Medicare Part A payroll tax beginning in 1994, the payroll tax rate has not increased since 1986. It remains 1.45 percent each for employers and employees and is not scheduled to rise in the future. Since 1986, the number of beneficiaries covered by Part A of Medicare has grown from 32.4 million in 1986 to 39 million in 1998. Furthermore, the share of the U.S. population covered by Medicare has increased from 13.5 percent to 14.4 percent during this period.

Part A spending has grown at a slower rate than spending under Part B of the program (largely reflecting the shift from inpatient to outpatient and ambulatory care⁵), resulting in a greater financing burden on general revenues and beneficiaries. The rapid rate of growth in Part B led to several adjustments to the way in which Part B premiums were set. The original Medicare law set the premiums to finance 50 percent of Part B costs. In the late 1960s and early 1970s, the rising premiums were taking up an increasing share of beneficiaries' monthly Social Security checks from which premiums are usually drawn. After legislation to protect beneficiaries by slowing the growth in premiums, the Part B premium declined to about 25 percent of Part B costs by 1982. In 1997, Congress made that 25 percent share a permanent requirement in order to maintain the beneficiaries' contribution level and limit the financial burden on the federal government.⁶ Because federal law funds Part B almost entirely through beneficiaries' premiums

and general revenues, both types of contributions rise as Part B expenditures rise.

Like health care costs overall, Medicare's per beneficiary costs have grown faster than either general inflation in the economy or per capita national income (gross domestic product or GDP) over each of the past three decades (Figure 1).⁷ Experts usually identify the development of new medical technologies as well as the intensity in how and why these services are provided to patients as significant factors in explaining historical and projected growth in per capita health care costs.⁸

Rising health care costs have increased costs for taxpayers and placed greater burdens on beneficiaries. In fact, while elderly persons spent on average 10 percent of their aftertax household income on health care in 1972-73, they spent 18 percent on health care in 1994.⁹ In 1998, the typical noninstitutionalized beneficiary enrolled in traditional ("fee-for-service") Medicare is estimated to have spent 19 percent of her income on health care.¹⁰

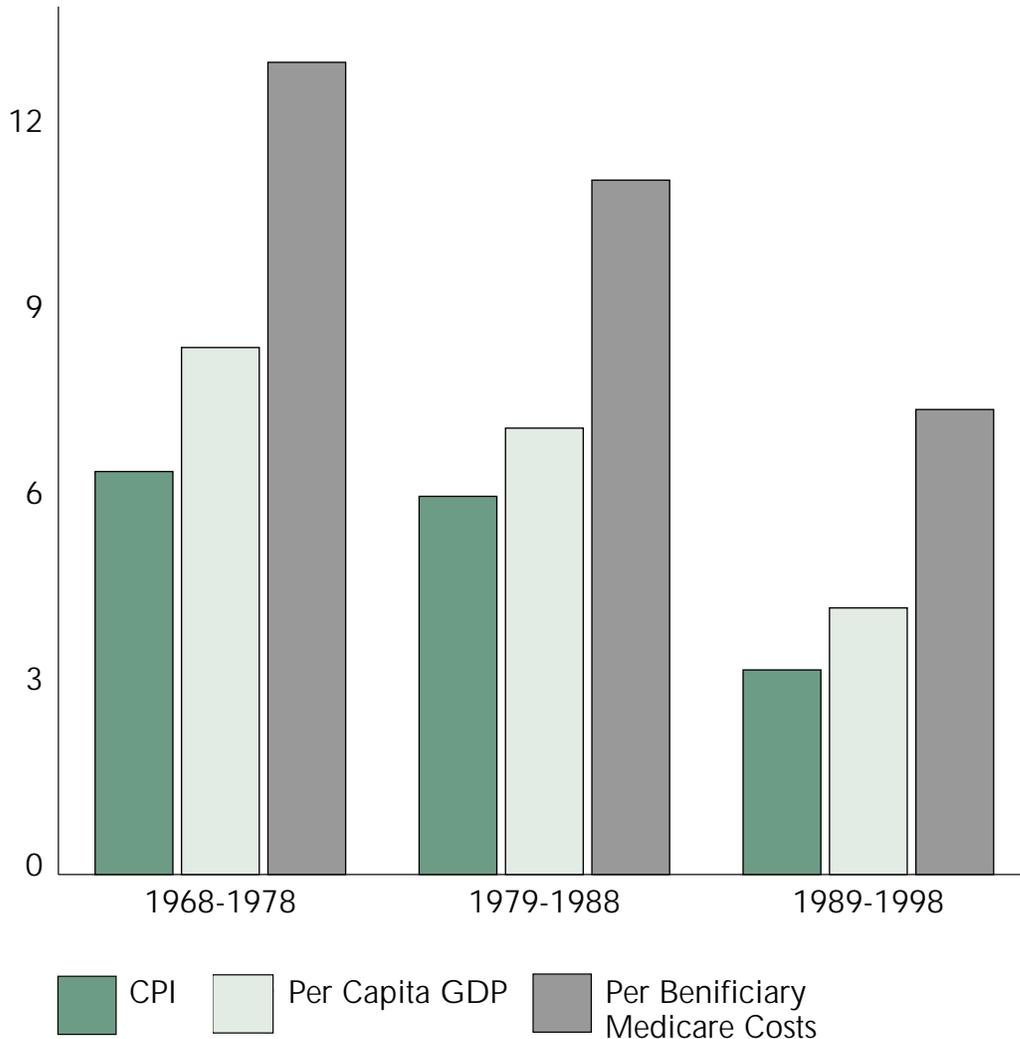
Projections of Future Costs

One measure of future costs of Medicare is the share of the gross domestic product (GDP) that the program would be if no changes in policy were to take place (the so-called "baseline numbers"). Spending as a share of GDP is a useful measure because it shows how much of society's resources are devoted to the Medicare program. Moreover, this measure is relevant for assessing the combined costs of Parts A and B of the program (rather than just focusing on the status of the Part A trust fund as is usually the case when spending is expressed as a share of the nation's total payroll).¹¹

A growing economy can absorb at least some higher spending on Medicare even if the same share of GDP is devoted to the program. This is because GDP is assumed to grow about 2.1 percent a year in real terms over time. Yet, this growth in GDP is not enough to absorb both growth in the number of beneficiaries and per capita costs of care that rise faster than the general Consumer Price Index

Figure 1

Average Annual Percent Increase in the Consumer Price Index (CPI), Per Capita Gross Domestic Product (GDP), and Per Beneficiary Medicare Costs



Source: National Academy of Social Insurance, 1999. Data provided by HCFA (Office of the Actuary), the Department of Commerce (Bureau of Economic Analysis), the Department of Labor (Bureau of Labor Statistics), and the Census Bureau.

(CPI) The number of Medicare beneficiaries has grown at an average of 1.6 percent per year in the 1990s, and that growth will increase as the Baby Boom generation retires starting in 2010. Between 2015 and 2025, Medicare enrollment is projected to grow at an average of 2.7 percent per year.¹² Furthermore, per beneficiary spending on Medicare, like all health care spending, has gone up on average in excess of CPI (Figure 1).

Using the 1998 baseline established by the Medicare Trustees, Medicare spending is projected to reach 5.85 percent of GDP by 2030, up from its current level of 2.53 percent.¹³ This means a more than doubling of the commitment of the nation's resources to funding the Medicare program. But that figure should not be too surprising because we know that over this same time frame, the projected numbers of beneficiaries in the program will more

than double and Medicare will go from covering one in every eight Americans to nearly one in every four.

Another useful way to talk about Medicare's resource consumption is to look at the share of this spending that taxpayers must bear. This is a measure of Part A and B Medicare spending net of the Part B premium, and thus it captures the costs of the program that would come from taxpayers in the form of payroll taxes plus general revenue financing. Using the 1998 estimates, the taxpayer share would be about 5.09 percent of GDP in 2030 (compared to 2.45 percent in 1998). This approach is a valuable way to examine proposals that include, for example, raising the Part B premium under Medicare. If the taxpayer share of GDP were to rise over time, new revenue sources would be needed. Finally, projections about future costs also need to take into consideration what will happen to costs that beneficiaries will bear. By 2025, for example, out-of-pocket health care spending for beneficiaries could average nearly 30 percent of the income of a typical elderly beneficiary if those costs rise in tandem with Medicare's projected cost increases.¹⁴

What Difference Could Other Changes to the Program Make?

A number of broad changes have been proposed to the Medicare program, some of which would raise and some of which would lower projected future costs. Interest in limiting the level of the federal government's contribution to Medicare has led to projections of the savings possible from a wide array of options. On the other hand, the inadequacy of the Medicare benefit package gives rise to proposals that would expand what Medicare covers, likely leading to higher costs and hence, a higher projected share of GDP.

Changes That Would Reduce Financing Demands by Providing Beneficiaries With Incentives to Seek Efficient Care. One important strategy for reducing Medicare's costs would be to seek new ways to eliminate unnecessary expendi-

tures including waste, fraud, and abuse. In addition, some proposals for structural change in Medicare seek to reduce program expenditures by providing beneficiaries with incentives to seek care more efficiently.¹⁵ In particular, supporters of this approach suggest that by asking beneficiaries to pay more of their own health care expenses, they implicitly encourage beneficiaries to avoid unnecessary care. Some proposals also seek to allow greater variety in health plans and benefit package choices so that beneficiaries can enroll in a plan that fits their own needs and preferences.

These proposals vary in the extent to which they ask beneficiaries to pay more. For example, while most incarnations of the "premium support" model guarantee some minimal level of benefits, other proposals would adopt a "defined contribution" approach in which the government would contribute a set amount towards beneficiaries' health care. In one version of this approach examined for illustrative purposes later in this *Brief*, the contribution might rise by each year by the Consumer Price Index or some other specified rate of growth.¹⁶ Depending on how these federal amounts are set, beneficiaries may be able to limit additional out-of-pocket expenditures if they are given the option to choose lower cost plans.¹⁷ However, it is unknown what combinations of lower cost and higher cost health plans beneficiaries would choose and if their choices would lead to reductions in expenditures sufficient to avoid the need for new revenues.

These restructuring options have supporters and detractors, and the panel's charge is not to recommend which, if any, of these approaches to adopt. Rather, the key issue for our undertaking is to consider whether such reforms are likely to solve the financing problem facing Medicare, even when several options are combined.

The Bipartisan Commission's efforts to put together a package of changes (that included the transformation of Medicare into a premium support program) resulted in an assessment by the Health Care Financing Administration actuaries that can shed light on this question. The estimates of

savings were based on an interim proposal by the commission's chairmen that included major restructuring of the program to focus on private provision of insurance to beneficiaries, further cuts in the traditional ("fee-for-service") Medicare program such as those contained in the Balanced Budget Act of 1997, new cost sharing requirements for the traditional "fee-for-service" part of the program, adding an income-related premium, and raising the age of eligibility. Even with all these changes, savings were projected to lower program spending by only 11.2 percent over the period of 2000 to 2030.¹⁸ As a share of GDP, this would lower the 2030 level of the taxpayer share of Medicare from 5.09 percent to about 4.49 percent.

Table 1 illustrates the magnitude of several hypothetical savings options and benefit expansions. Using the Medicare Trustees' 1998 projections for Medicare costs, column A shows how high taxpayers' contributions to Medicare as a percentage of GDP would climb in 2030 if no additional revenues were added to the program. Further, it indicates the taxpayer share of GDP projected to result in response to hypothetical changes such as the "interim" Breaux/Thomas proposal.¹⁹ To place these changes into a further context, column B shows how much each of these scenarios would cause the taxpayer share of GDP devoted to Medicare in 2030 to increase over its 1998 level. Thus, while the "current law" projection results in a 108 percent increase (i.e. 2.08 times the 1998 level) in the taxpayer share, the interim Breaux/Thomas proposal yields an 83 percent increase (i.e. 1.83 times the 1998 level) by 2030. Because revenues grow at about the same rate as GDP, column B is roughly a measure of increases in revenues to Medicare that would be necessary after accounting for the various changes in Medicare described in Table 1. Any percentage value greater than zero in column B implies a financing gap that could be met through additional revenues, by making beneficiaries pay more than envisioned in the specific proposal, or by policies such as raising the age of eligibility.

Another way to describe the spending changes that would be needed to avoid increasing revenues is to

estimate how high the taxpayer share of GDP would be if arbitrary limits on spending growth were adopted. For example, if per beneficiary Medicare spending could be held constant in real terms (that is, adjusted only for the general level of inflation in the economy) and the rate of growth of the beneficiary population, the taxpayer share of Medicare would still grow to about 3.67 percent of GDP by 2030 (from its current 2.45 percent of GDP). The most fiscally stringent option examined, holding per beneficiary increases in Medicare spending to growth in CPI, only reduces the financing gap projected under current law in 2030 by about one-half (i.e. a 50 percent increase over taxpayers' 1998 contributions to Medicare as a percentage of GDP versus a 108 percent increase under current law), still leaving a need for additional revenues. And because we normally believe that health care spending will grow substantially faster than the general rate of inflation, this would be a very restrictive policy. If the restriction were eased to allow Medicare spending on a per beneficiary basis to grow at just 1 percent each year above the rate of general inflation, the taxpayer share would rise to about 4.18 percent of GDP. To achieve such a low rate of growth in spending would be a feat never achieved in Medicare for a period of more than one year.²⁰

Changes that Would Increase Medicare's Costs.

Medicare's benefit package has been criticized widely for its inadequacy,²¹ a problem that leads both to the reliance by many on supplemental insurance and to a very high out-of-pocket burden on beneficiaries. The use of supplemental insurance may make the provision of care less efficient for some beneficiaries when it creates first dollar coverage,²² and the administrative costs of these supplemental policies are relatively expensive. Moreover, beneficiaries already bear a considerable share of the costs of their care and, as noted earlier, a typical elderly beneficiary in traditional "fee-for-service" Medicare spends about 19 percent of her income for medical care and insurance. Even with no change in policy, that share could rise to nearly 30 percent of income for a typical elderly beneficiary in 2025 in the likely event that health care costs continue to outpace income growth.²³

Table 1

Impact of Illustrative Medicare Changes on Taxpayer Contributions to Medicare^a in 2030

	A Taxpayer Contribution to Medicare as a Percent of GDP	B Approximate Increase in Revenues Needed in 2030 Compared to 1998 ^b
Current law, 1998 spending	2.45%	N/A
Current law, projected spending in 2030 ^c	5.09%	108%
Changes in Medicare Designed to Produce Savings		
Interim Breaux/Thomas proposal to the Medicare Commission ^d	4.49%	83%
Hold per beneficiary increases in Medicare spending to growth in the consumer price index (CPI)	3.67%	50%
Hold per beneficiary increases in Medicare spending to growth at 1 percent above CPI	4.18%	71%
Expansions in Medicare^e		
Outpatient prescription drug coverage (\$200 deductible, 50% coinsurance, \$2000 stop loss), fully paid by taxpayers ^f	5.49%	124%
Outpatient prescription drug coverage (\$200 deductible, 50% coinsurance, \$2000 stop loss), financed 75% by taxpayers, 25% by beneficiary premium ^g	5.39%	120%

Key: GDP = gross domestic product; N/A = not applicable.

Source: National Academy of Social Insurance, 1999.

- ^a Taxpayer contributions are defined as all Medicare expenditures except for the 25 percent of Part B costs paid by beneficiaries themselves in premiums. Payroll taxes and general tax revenues make up the bulk of the taxpayer contributions.
- ^b This column presents the percent increase over 1998 in taxpayer contributions to Medicare as a percentage of GDP. As shown in the first row of column A, the taxpayer contribution to Medicare in equaled 2.45 percent of GDP in 1998 (Social Security and Medicare Board of Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 1998 Annual Reports*. Washington, DC: Social Security Administration, April 1998.) Because tax revenues tend to rise at the same rate as GDP, column B is a reasonable approximation of how much revenues would need to rise over their 1998 level to meet Medicare spending requirements under each of the illustrative scenarios presented in the table.
- ^c 1998 baseline projection by the Social Security and Medicare Trustees of Medicare costs in 2030.
- ^d The "interim" Breaux/Thomas proposal contained a provision for an income-related premium for Medicare subsequently dropped from the final version voted on (but not adopted) by the Bipartisan Commission. Hence, the revenue needs of the final version would have been larger than those shown here for the interim proposal.
- ^e The estimates assume all features of the Medicare program other than the specific expansions noted remain as under current law.
- ^f Cost estimates produced for the study panel by Actuarial Research Corporation (ARC). ARC estimates that adding such a benefit would increase overall Medicare spending by 7.9 percent in 2030.
- ^g ARC estimates that if beneficiaries were required to pay for 25 percent of this illustrative drug benefit, such coverage would increase Medicare spending in 2030 by 5.9 percent.

Outpatient pharmaceuticals are a notable part of beneficiaries' health care not covered by Medicare.²⁴ Over the course of Medicare's history, the role of prescription drugs in medical therapy has grown due to scientific advances. During 1993-1998, the Food and Drug Administration approved 149 new drug entities compared to 62 during Medicare's first five years (1966-1970), an increase of 140 percent.²⁵ As with other health care expenses, the out-of-pocket burden that pharmaceutical costs place on beneficiaries is skewed with most facing modest expenses, but a significant minority shouldering heavy burdens. Of those beneficiaries not enrolled in Medicare+Choice plans, half have annual drug expenses of less than \$200, but 14 percent (about 4.5 million beneficiaries) have expenses of \$1,000 or more, and 4 percent (about 1.3 million beneficiaries) have expenses of \$2,000 or more. About one-third of all beneficiaries lack any coverage for prescription drug expenses, and the generosity of drug coverage in supplemental insurance held by beneficiaries varies substantially and appears to be on the wane.²⁶

Prescription drug coverage has been a popular suggested addition to Medicare in various reform proposals, including the Breaux/Thomas March 1999 proposal and the Clinton Administration's June, 1999 Medicare plan.²⁷ If a prescription drug benefit and other modest changes in cost sharing were made to the Medicare program in order to make it more comparable to insurance plans currently available to working people and to help reduce the need for supplemental policies, costs for the program would shift upward substantially. By 2030, the taxpayer share of the program could rise to 5.49 percent of GDP (compared to the 1998 projection of 5.09 percent with no drug benefit and President Clinton's June 1999 proposal for drug coverage).²⁸ These estimates assume that the prescription drug benefit would be fully funded by taxpayer dollars (i.e. not partially financed by beneficiary premiums as is done currently for Part B services). While this might be an area where beneficiaries could be asked to contribute substantially more, some of those costs (particularly for lower

income beneficiaries) might be passed on to states in the form of increased Medicaid costs or to other taxpayers in some form.

Conclusion

The Bipartisan Commission debated (but did not recommend) a number of sweeping proposals intended to slow substantially the rate of growth of spending on Medicare. These changes would both restructure the program and ask some beneficiaries to contribute more over time through higher cost sharing for the basic program, an increasing age of eligibility, and perhaps an income-related premium. This and other related proposals would seek cost savings by making Medicare more efficient (either directly by eliminating unnecessary expenditures or indirectly by providing incentives for beneficiaries to seek care more efficiently). Even the \$340 billion in 30-year savings estimated for an early version of the Breaux/Thomas plan, Medicare's rate of growth of would still require additional resources to meet projected spending.²⁹

Although it is important to ensure that Medicare operate as efficiently as possible, this analysis suggests that any comprehensive discussion about Medicare's future must include the need for new revenues.

These and other proposals for reform have largely been examined in the context of the 1998 projections for Medicare's future. Although that outlook has improved substantially in the recently released 1999 Medicare Trustees' report,³⁰ it also means that some of the slowdown in spending growth that might be obtained from various reform proposals is now implicitly incorporated into the baseline. Savings from enacting such reforms will therefore be of a smaller order of magnitude than

in the past. Thus, a gap between revenues and spending is likely to remain even after estimating savings from these proposals with the new baseline. Consequently, as policymakers search for new ways to reform Medicare, the potential inclusion of new revenues must be part of the discussions.

Notes

- 1 Beneficiaries also contribute towards the program while in the workforce through dedicated Medicare payroll taxes and general income taxes.
- 2 In addition, to the extent that beneficiaries have supplemental insurance, they are likely to use more Medicare-covered services than they would without such supplemental coverage. See, for example, Khanker, R.K., and McCormack, L.A., "Medicare Spending by Beneficiaries with Various Types of Supplemental Insurance," *Medical Care Research and Review*, 56 (June 1999): 137-155. According to one recent estimate, supplemental insurance raised Medicare program expenditures by as much as \$17 billion in 1998. Antos, J.R., and Bilheimer, L., "The Bumpy Road to Medicare Reform," *Medicare in the 21st Century: Seeking Fair and Efficient Reform*, R. B. Helms (ed.) (Washington, DC: AEI Press, forthcoming 1999).
- 3 Physician Payment Review Commission, "Private Secondary Insurance for Medicare Beneficiaries," *Annual Report to Congress* (Washington, DC: U.S. Government Printing Office, 1997). Hewitt Associates, LLC, *Retiree Health Trends and Implications of Possible Medicare Reform* (Washington, DC: The Henry J. Kaiser Family Foundation, September 1997).
- 4 O'Sullivan J., *Medicare: Financing the Part A Hospital Insurance Program*. Report #RS20173 (Washington, DC: Congressional Research Service, April 22, 1999).
- 5 Social Security and Medicare Board of Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 1998 Annual Reports* (Washington, DC: Social Security Administration, April 1998).
- 6 U.S. Congress, House of Representatives, Committee on Ways and Means, *1998 Green Book, WMCP: 105-7* (Washington, DC: U.S. Government Printing Office, 1998).
- 7 While it is clear there are many inefficiencies in the U.S. health care system, it is not unusual for the growth rate in a nation's spending on health care to outpace the growth rate for its overall economy. One can see this trend when comparing growth in per capita health care spending (both in Medicare and overall) to growth in the whole U.S. economy, see the *Health Care Financing Review Medicare and Medicaid Statistical Supplement, 1998* (Baltimore, MD: U.S. Health Care Financing Administration, 1998). When comparing across countries, one also finds higher proportions of national incomes devoted to health care in wealthier countries, see Anderson, G.F., "In Search of Value: An International Comparison of Costs, Access, and Outcomes," *Health Affairs* 16(6): 163-171, November/December 1997.
- 8 Fuchs, V. R., "Health Care for the Elderly: How Much? Who Will Pay For It?" *Health Affairs* 18(1): 11-21, January/February 1999. Newhouse, J.P., "Medicare Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives* 6 (Summer 1992): 3-21.
- 9 U.S. Department of Health and Human Services, Health Care Financing Administration, *Profiles of Medicare* (Washington, DC: March 1996).
- 10 Moon, M., *Growth in Medicare Spending: What Will Beneficiaries Pay?* (Washington, DC: The Urban Institute and The Commonwealth Fund, January 1999).
- 11 Because the Part A (Hospital Insurance) Trust Fund can exhaust its funds if expenditures exceed revenues for a sufficient period of time, its status is often used as a benchmark for the financial status of the overall Medicare program. By contrast, the Part B (Supplementary Medical Insurance) Trust Fund cannot be exhausted since it has the authority to draw sufficient funds from beneficiary premiums and general revenues to meet its obligations each year. However, examining only the Part A Trust Fund gives a limited picture of Medicare's financial status, especially since Part B is growing faster than Part A and is projected to become larger than Part A within the next two decades. Social Security and Medicare Board of Trustees, 1998, *op. cit.*
- 12 Historical and projected Medicare enrollment data provided by the HCFA Office of the Actuary, March 30, 1999. Calculated increases are average annual compound growth rates.
- 13 Using the 1999 baseline of the Medicare Trustees, Medicare spending is projected to only reach 4.88 percent of GDP by 2030. Board of Trustees, Federal Hospital Insurance Trust Fund, *1999 Annual*

- Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund* (Washington, DC: March 30, 1999). This considerable drop from 5.85 percent reflects both how much an improved economy and slowing health care spending can improve the outlook, and the potential uncertainty of such estimates over time. Since many of the estimates of savings discussed in this Brief are tied to the 1998 figure, it is used for purposes of comparison. The orders of magnitude of most changes in spending on the program would move in a consistent fashion, so the results should be thought of in relative terms.
- 14 This would represent a 50 percent increase over the 19 percent of income spent by the average beneficiary in 1998. Also see Fuchs, V.R., 1999, *op. cit.*
 - 15 A completely different approach to reform would change Medicare financing from the current “pay-as-you-go” system in which today’s workers provide funds for today’s beneficiaries to a system in which each cohort of workers saves funds for their own health care needs in retirement. Because this proposal represents a major departure in the nature of Medicare and because this approach itself can have a number of fundamental variations, the implications of such a system for Medicare’s financing needs are complex and not addressed in this report. For a fuller discussion of reforms to “individualize” the financing of Medicare, see Gramm, P., Rettenmaier, A.J., and Saving, T. R., “Medicare Policy for Future Generations — A Search for a Permanent Solution,” *The New England Journal of Medicine* 33(818): 1307-1310, April 30, 1998 and Chollet, D. J., “Individualizing Medicare,” *Medicare Brief No. 3*, (Washington, DC: National Academy of Social Insurance, May 1999).
 - 16 Hence, a defined contribution approach reduces Medicare’s projected costs (and hence, financing needs) by both limiting the government’s obligations and by providing beneficiaries with incentives to reduce their use of care through increased out-of-pocket spending and/or choice of low-cost plans.
 - 17 Furthermore, the total cost of the federal subsidy will also be driven by the cost of the minimum benefit package that Congress chooses to maintain.
 - 18 Breaux, J., *Premium Support Estimate from the HCFA Actuary*, memorandum to the Bipartisan Commission on the Future of Medicare, Washington, DC, February 23, 1999, <http://thomas.loc.gov/medicare/premium.htm>.
 - 19 This “interim” Breaux/Thomas proposal included a provision for an income-related premium subsequently dropped from the final version voted on (but not adopted) by the Bipartisan Medicare Commission in March, 1999.
 - 20 In addition, analysis of proposals to raise the age of eligibility for the program (in combination with slower per capita growth) indicates that such measures would still leave a substantial contribution to be paid by taxpayers. Breaux, J., 1999, *op. cit.*
 - 21 Medicare’s current benefit package remains very similar to the one included in the original 1965 Medicare legislation. Among those changes that Congress has adopted since then are the inclusion of several specific preventive services. In 1988-89, Congress passed (P.L. 100-360) and then repealed (P.L. 101-234) legislation that would have set a maximum out-of-pocket liability for beneficiaries for covered benefits, including outpatient prescription drugs. In response to a 1988 court decision (*Duggan v. Bowen*, 691 F. Supp. 1487 [D.D.C. 1988]), HCFA also liberalized beneficiaries’ ability to receive Medicare reimbursements for home health visits. U.S. House of Representatives, Committee on Ways and Means, *op. cit.*
 - 22 On the other hand, for beneficiaries who might not seek care because of cost-sharing requirements first dollar coverage may be efficient to the extent that early diagnosis and treatment can avoid or lessen subsequent need for extensive and more costly services.
 - 23 Moon, M., 1999, *op. cit.*
 - 24 For a fuller discussion of the financial implications of Medicare’s lack of outpatient prescription drug coverage as well as the issues that would face policy-makers in amending Medicare’s benefit package to add such coverage, see Gluck, M., “A Medicare Prescription Drug Benefit,” *Medicare Brief No. 1*, (Washington, DC: National Academy of Social Insurance, April 1999). In addition to a lack of prescription drug coverage, the lack of protection against extremely high (“catastrophic”) out-of-pocket health care expenses is another commonly mentioned inadequacy of the Medicare benefit package.
 - 25 Hewitt, P., Research Librarian, Tufts Center for the Study of Drug Development, Tufts University, Boston, MA, personal communication, February 12, 1999.
 - 26 Davis, M., et al., “Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries,” *Health Affairs* (18)1: 231-243, January/February 1999. McArdle, F., “Presentation on Employer-Provided Retiree Benefits,” to the Reform Task Force, National Bipartisan

Commission on the Future of Medicare, Washington, DC, July 14, 1998. Gluck, M., *op. cit.* Soumerai, S.B., et al, "Inadequate Prescription-Drug Coverage for Medicare Enrollees — A Call to Action," *New England Journal of Medicine* 340 (9): 722-728, March 4, 1999, <http://www.nejm.org/content/1999/0340/0009/0722.asp>.

- 27 The Breaux/Thomas proposal would provide outpatient prescription drug coverage only for low income beneficiaries (up to 135 percent of poverty) who did not have other drug coverage.
- 28 These cost estimates are based on analysis conducted for the Study Panel by Actuarial Research Corporation (ARC) for an illustrative outpatient prescription drug benefit with a \$200 deductible, 50 percent coinsurance, and a \$2000 catastrophic limit. More details of these estimates are provided in Gluck, M, 1999, *op. cit.* The ARC analysis also shows that it is possible to restructure Medicare's cost-sharing requirements in manner that would not

affect overall projected Medicare costs. For example, according to the ARC analysis, changing Medicare's cost sharing so that beneficiaries would face a \$300 Part B deductible indexed to the consumer price index (CPI), 10 percent home health coinsurance, no more than one hospital deductible annually, no hospital coinsurance, and a \$5000 catastrophic stop loss indexed to CPI would be essentially cost neutral through 2030. In most years it would raise projected Medicare costs by less than 1 percent and never more than 1.1 percent. In the first five years, it would actually save money.

- 29 HCFA actuaries' estimates as reported in Breaux, J., 1999, *op. cit.*
- 30 Social Security and Medicare Board of Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 1999 Annual Reports* (Washington, DC: Social Security Administration, March 1999).

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