

Example 12.3

Medicare

During his second term in office, President George W. Bush submitted a proposal to Congress to reform the pension component of the Social Security System. His goal was to address the projected shortfall in funding the System's pension commitments as the baby-boom generation was approaching retirement. The president sought to privatize a portion of the pensions, as described in Chapter 12 of the textbook. His proposal went nowhere, an outcome that was hardly surprising to observers of the U.S. political scene. Social Security reform has long been described as the “third-rail” of American politics – an issue that no politician dares touch for fear of alienating the public.

Even more telling than the cool reaction to the Bush proposal, however, is that neither the administration nor Congress has offered any formal proposal to reform the other component of the Social Security System, Medicare. Medicare is the true “elephant in the room” in the Social Security debate. The projected shortfall in the funding for Medicare is at once more immediate, much larger, and more persistent than the funding shortfall in the Social Security pensions. The budgetary reforms needed to place Medicare on a sound financial footing dwarf those needed for the System's future pension commitments. Indeed, the required budgetary adjustments are so large that U.S. politicians apparently cannot even bring themselves to think about them.

Medicare

Medicare is the federal government's medical insurance program for the elderly – those 65 and older. It consists of Hospital Insurance (HI) and Supplementary Medical Insurance (SMI). HI is funded by the payroll tax – 2.9% of the 15.3% payroll tax is allocated to HI and, unlike the remaining 12.4% of the tax allocated to pension and disability payments, the HI portion applies to wages and salaries with no income limit. SMI has two parts, referred to as Parts B and D. Part B covers physician and outpatient services and Part D covers prescription drugs. The elderly who choose one or both of these services pay a monthly premium to Social Security. If expenses under either Part

exceed the premiums in any year, the difference must be financed out of the federal government's general revenues, primarily the personal income tax (and the corporation income tax to a lesser extent). It is interesting that despite the huge projected annual deficits in Medicare, the only reform to Medicare since 2000 was to add Part D in 2006, a reform that made the projected deficits even larger

The Relative Size of the Medicare Financial Problem

The Trustees of the Social Security System make annual 75-year projections of the revenues and costs of each component of the Social Security System, the pensions, the disability payments, and the three components of Medicare. To get a sense of the relative magnitudes of the projected pressures on the federal budget coming from the pensions and disability benefits and Medicare, compare the following financial indicators from the Trustees' 2007 Annual Report.¹

*The pension and disability benefits (OASDI):*² One financial indicator that the Trustees use is projected expenditures as a percentage of GDP. In 2006, pension and disability benefits were 4.2% of GDP. They are expected to rise steadily to 6.2% of GDP by 2030 because of the retirement of the baby boomers, after which the percentage levels off. It is projected to be 6.3% in 2081, the last year of the 75-year forecast (p. 14). Another financial indicator is the actuarial deficit of the OASDI Trust Fund, meaning the projected amount by which expenditures exceed revenues from the earmarked payroll taxes (the 12.4% portion of the tax) plus the interest on the accumulated assets in the OASDI Trust Fund.³ The projected actuarial deficit is 1.95% of taxable payrolls over the 75-year period, which translates into \$6.8 trillion (in present value terms, that is, valued in today's dollars) (pp. 10 and 15). The annual deficits first appear in 2027, when expenditures on pensions and disability payments are expected to exceed earmarked payroll tax revenues plus interest on Trust Fund assets, and the assets in the OASDI Trust Fund will be exhausted in 2041. By 2041, payroll tax revenues at current rates will finance only 75% of the pensions and disability benefits (p. 11). Finally, the Trustees project that it would take a 16% increase in the payroll tax (from 12.4% to 14.4%), or a 13% cut in benefits, or a combination of tax increases and benefit reductions, effective immediately, to restore actuarial balance over the 75-year projection period (pp. 1–2).

Medicare: Compare the same financial indicators for Medicare. Medicare expenditures are currently smaller than the OASDI expenditures, 3.2% (vs. 4.2%) of GDP, but they are rising much more rapidly. They are expected to exceed OASDI

¹ The data in the rest of the example are mostly taken from "A Message to the Public", *Status of the Social Security and Medicare Programs, A Summary of the 2007 Annual Reports*, Social Security and Medicare Boards of Trustees, April 23, 2007 www.ssa.gov/OACT/TRSUM/trsummary.html. The Summary includes "A Message from the Public Trustees," (pp. 14–17) by J. Palmer and T. Saving, Trustees. Page numbers for specific data are provided in parentheses.

² OASDI stands for Old Age, Survivors, and Disability Insurance.

³ The assets, almost entirely Treasury securities, have been accumulating since the 1983 Social Security reforms, which were designed to provide a surplus in the Trust Fund to help finance the baby boomers' retirement pensions.

expenditures in 2028, and reach 6.5% of GDP by 2030. Unlike OASDI expenditures, however, the growth of Medicare expenditures relative to GDP does not level off after most of the baby boomers have died. Medicare continues to grow rapidly, to 11.3% of GDP by 2081 (p. 15). Consider next the deficit projections for just the HI component of Medicare, the portion financed by the payroll tax. The projected annual deficits are 3.55% of taxable payroll over the 75-year period, which translates into \$11.6 trillion (in present value) (p. 16). HI expenditures exceeded the earmarked payroll tax revenues in 2007, and will exceed the tax revenues plus interest income of the HI Trust Fund assets in 2011. The assets in the HI Trust Fund will be exhausted by 2019, at which point payroll tax revenues will cover only 79% of HI expenditures, a percentage that continues to decline to 29% by 2081 at the current 2.9% tax rate (pp. 11, 15, and 16). Add to the \$11.6 trillion HI deficit over the 75 years the additional \$13.2 trillion of general fund revenues that will be required to cover the difference between Parts B and D expenditures and premiums, and the total Medicare actuarial deficit over the 75-year period is \$24.8 trillion, 3.6 times larger than the projected OASDI deficit (p. 16). The Trustees project that it would take a 122% increase in the earmarked payroll tax (from 2.9% to 6.4%) or a 51% cut in expenditures, or a combination of tax increases and benefit reductions, effective immediately, to restore actuarial balance to the HI portion of Medicare over the 75-year projection period (p. 2). To raise the necessary general revenues to remove the projected Parts B and D deficits would require that the portion of federal income tax revenues allocated to these programs increase from 12.3% in 2006 to twice that in 15 years and three times that in 25 years (p. 16).

In summary, the financial pressures that Medicare will place on the federal budget are orders of magnitude larger than the financial pressures of OASDI. And, as with OASDI, the sooner taxes and/or benefits are adjusted to restore actuarial balance, the smaller the adjustments will have to be.⁴

The Persistence of Medicare

The ratios of expenditures to GDP noted above point to another big difference between OASDI and Medicare: the persistence of the Medicare financial pressures. Both OASDI and Medicare expenditures rise rapidly until 2030 because of the large number of baby boomers. The passing of the baby-boom generation essentially stops the growth of the OASDI expenditures (relative to GDP), but not the Medicare expenditures. They keep growing just as rapidly, and the main reason why is the rapid increase in the costs of medical care over time. The annual increase the costs of medical care in the U.S. has historically been about 2 to 2.5 percentage points higher, on average, than the increase in the growth of real GDP per capita. The Trustees' Medicare projections given above are based on their Intermediate Assumptions, which assume that the annual increase in the

⁴ Note, also, that redeeming the OASDI and HI Trust Fund assets in itself puts added pressure on the federal budget because the assets are Treasury securities. The federal government has to raise taxes, and/or cut expenditures, and/or issue still more debt to pay for its obligations on the Trust Fund securities.

costs of medical care will decline gradually until it is equal to the growth in real GDP per capita at the end of the 75-year projection period (p. 16). This assumption is based on the premise that the annual increase in the costs of medical care cannot be forever above the annual increase in real GDP per capita without eventually driving the consumption of all other goods and services to zero. If this assumption is too optimistic, however, then the financial pressures of Medicare become that much larger. For example, the Congressional Budget Office estimates that if the medical costs continue to rise 2.5 percentage points above the increase in real GDP per capita, then expenditures on Medicare will rise to 21.3% of GDP by 2050.⁵

Future medical costs are very difficult to predict with much accuracy. They depend on such uncertain factors as the presence of new diseases or the recurrence of old diseases, the development of new medical treatments, the development of new drugs, and the preferences of the population for medical care. But one fact about medical care is fairly distinctive: Technical change tends to increase the cost of medical care rather than lower its cost, as it does for most other goods and services. This matters because, to quote the President's Council of Economic Advisers: "Research suggests that most of the increase in medical spending over time has been driven by the advent of new technologies."⁶ This is a sobering thought, because if technical change is driving up the costs of medical care it is extremely difficult to contain those costs. To give one example, many economists favor a single-payer national health insurance plan for all citizens as opposed to the current mixture of private and public insurance plans. The main reason for favoring the single-payer plan is the savings in administrative costs. The administrative expenses for private insurance plans are on the order of 20–25% of total expenditures. The federal government's administrative expenditures for Medicare are between 1% and 2% of total expenditures (p. 5). Suppose a single-payer plan could reduce medical costs by 20% through the reduction of administrative expenses alone – a huge saving – but suppose, also, that half rather than "most" of the increase in medical costs are due to technical change. The increase in medical costs in the U.S. has averaged about 4% per year, of which we are assuming that 2% per year is due to technical change. A 2% per year increase in medical costs each year would wipe out the one-time 20% saving in medical costs by moving to a single-payer plan in just 11 years!⁷ The conclusion is clear: Unless and until medical science can generate technical changes that lower rather than raise the costs of medical care, there is little hope of containing those costs.

There is one source of comfort in the Trustees' financial indicators for Medicare – the immense size of the U.S. economy. An actuarial deficit of \$24.8 trillion dollars (in present value) sounds daunting. But remember that current (2007) U.S. GDP is in excess

⁵ Labonte, M. (2005) *Social Security and Medicare: The Economic Implications of Current Policy*, *CRS Report for Congress*, January 28, Congressional Research Service, The Library of Congress, p. 4.

⁶ *Economic Report of the President, 2007* (Washington, D.C.: U.S. Government Printing Office, February 2007), Chapter 4, p. 97.

⁷ It takes a 25% increase in the new lower base following a 20% decrease to get back to the original cost. Costs growing at 2% per year increase by 25% in 11 years.

of \$14 trillion. The \$24.8 trillion projected Medicare funding deficit is only 3.4% of GDP over the 75-year projection period, a percentage that is manageable (p. 16).

Put another way, the Trustees estimate that, by 2081, the general revenues required to cover the amount by which the combined OASDI and Medicare expenditures exceed payroll tax revenues and expected increases in premiums for SMI would be 10.1% of GDP. Federal tax revenues (including payroll taxes) were 10.8% of GDP in 2006 (of which payroll taxes were 3.8%) (pp. 13–14).⁸ Increasing federal tax revenues to cover the deficit would certainly be a very large and unprecedented increase in taxes, but one that is not out of the question if the demand for medical care remains high. In many Western European countries tax revenues are 50% of GDP, vs. a historical average of 18.4% in the U.S.⁹ The U.S. could raise taxes to fund Social Security and still have nowhere near the current tax burden of many of the European countries.

⁸ The payroll tax percentage of 3.8% is calculated from the *Budget of the United States Government, Fiscal Year 2008, Supplement* (Washington, D.C.: U.S. Government Printing Office, 2007), Part 5, Historical Tables, Table 2.1.

⁹ M. Labonte, op. cit., p. 20.