The Financial Outlook for Medicare

Testimony before the
House Committee on the Budget
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by

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Chairman Ryan, Representative Van Hollen, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medicare program as shown in the 2011 annual report of the Medicare Board of Trustees. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the nation's second largest social insurance program—one that is a critical factor in the income security of our aged and disabled populations.

I would like to begin by saying a little about the role of the Office of the Actuary at the Centers for Medicare & Medicaid Services. We have the responsibility to provide actuarial, economic, and other technical assistance to policy makers in the Administration and Congress on an independent, objective, and nonpartisan basis. Our highest priority is to help ensure that policy makers have the most reliable technical information possible as they work to sustain and improve Medicare, Medicaid, and health care in the U.S. overall. The Office of the Actuary has performed this role on behalf of Congress and the Administration since the enactment of these programs over 45 years ago.

I am appearing before your Committee today in my role as an independent technical advisor to Congress. My factual statements, estimates, and other information provided in this testimony are drawn from the 2011 Medicare Trustees Report; any opinions offered are my own and do not represent an official position of the Department of Health & Human Services or the Administration.

The financial outlook for the Medicare program, as shown in the new Trustees Report, continues to raise serious concerns, in both the short range and the long range. Although the actuarial projections are much more favorable than those in the 2009 and earlier reports, as a result of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, a significant financial imbalance still remains for the Hospital Insurance (Part A) trust fund. In addition, key elements of current law are probably not sustainable—specifically, the "sustainable growth rate" formula for setting physician payment updates and the downward adjustments to payment rate updates for most other categories of health providers, based on economy-wide productivity growth. Should Congress find it necessary to override these factors in the future, as it has for 2003 through 2011 in the case of the physician payment rates, then actual Medicare costs would be substantially greater than projected in the Trustees Report under current law.

The purpose of the annual Trustees Report is first and foremost to evaluate the financial status of the Medicare trust funds, which must be done separately for each trust fund account since there

is no provision for sharing financing or assets among these accounts. I recognize, however, that the Budget Committee's interest is primarily the overall cost of Medicare. I will first summarize the Trustees' findings for the separate accounts and subsequently address the overall cost of Medicare.

The Hospital Insurance (HI) trust fund once again does not meet the Trustees' formal test for short-range financial adequacy. The exhaustion of the HI trust fund is projected to occur in 2024, 5 years earlier than was projected in last year's Trustees Report, reflecting lower projected payroll tax income as a result of the 2008-2009 economic recession and higher levels of real (inflation-adjusted) expenditures. During 2008 through 2010, HI income fell short of program expenditures by a total of $54 billion, and these shortfalls are expected to continue in all future years under current law. Over the Trustees' long-range 75-year projection period, HI expenditures exceed scheduled tax revenues by an average of 0.79 percent of taxable payroll, primarily as a result of the retirement of the post-World War II "baby boom" generation. As described in more detail below, this actuarial deficit would be substantially larger if the productivity adjustments in current law could not be sustained.

There are two separate accounts within the Supplementary Medical Insurance (SMI) trust fund—one for Part B, which covers physician, outpatient hospital, and other ambulatory care, and one for Part D, which provides subsidized access to prescription drug coverage. Because of the annual redetermination of financing for both Parts B and D, each account will remain in financial balance indefinitely under current law. Expenditures from these trust fund accounts, however, are projected to generally continue increasing at a faster rate than the national economy and beneficiaries' incomes, raising concerns about the long-range affordability of scheduled financing.

In 2010, total Medicare expenditures were $523 billion or about 3.6 percent of gross domestic product (GDP). Under current law and based on the Trustees' intermediate set of economic and demographic assumptions, costs in 2020 would be $932 billion or 4.0 percent of GDP. Total Medicare expenditures would continue to increase somewhat faster than GDP in the long range, reaching 6.2 percent at the end of the 75-year projection period. If the scheduled reductions in physician payment rates were not implemented and if the productivity adjustments to payment updates for most other provider categories were gradually phased out after the first 10 years, then Medicare costs would represent 10.7 percent of GDP in 2085.

Background

Over 47 million people were eligible for Medicare benefits in 2010. HI, or Part A of Medicare, provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. Part B of SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth. SMI Part D provides subsidized access to prescription drug insurance coverage as well as additional drug premium and cost-sharing subsidies for low-income enrollees. A Part D subsidy is also payable to employers who provide qualifying drug coverage to their Medicare-eligible retirees.

Only about 22 percent of Part A enrollees receive some reimbursable covered services in a given year, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incur reimbursable Part B costs because the

covered services are more routine and the annual deductible was only $155 in 2010. Similarly, a large proportion of Part D enrollees have reimbursable prescription drug costs, given the common occurrence of prescriptions, the preponderance of zero-deductible plans, and the significant proportion of low-income enrollees, for whom the deductible does not apply.

The HI and SMI components of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.[1] Of the total FICA tax rate of 7.65 percent of covered earnings, payable by employees and employers, each, HI receives 1.45 percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. The Affordable Care Act introduced an additional 0.9-percent HI payroll tax on individuals and couples with earnings above $200,000 or $250,000, respectively, starting in 2013. Other HI income includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums: $115.40 for the standard Part B premium in 2011 (although, under a "hold harmless" provision, most enrollees pay the same $96.40 premium that was effective in 2008) and an average premium level of about $30 for Part D standard coverage in 2011. For Part B, the standard monthly premium is designed to cover about 25 percent of program costs, with the balance paid by general revenue of the Federal government and a small amount of interest income. Starting this year, the Affordable Care Act requires fees on manufacturers and importers of brand-name prescription drugs, and these fees are allocated to the Part B trust fund account, reducing the need for premium and general revenue financing. Beginning in 2007, there is a higher "income-related" Part B premium for those individuals and couples whose modified adjusted gross incomes exceed specified thresholds. Beneficiaries exceeding the specified income thresholds pay premiums covering 35, 50, 65, or 80 percent of the average program cost for aged beneficiaries, depending on their income level, compared to the standard premium covering 25 percent. The resulting premiums in 2011 range from $161.50 to $369.10 per month. Part D costs are met through monthly premiums, which are designed to cover 25.5 percent of the cost of the basic benefit for an individual, with the balance paid by Federal general revenues and certain State transfer payments. The Affordable Care Act introduced income-related additional Part D premiums, ranging from $12.00 to $69.10 per month in 2011, which are paid by high-income enrollees in addition to their regular plan premiums.

The Part A tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, the premiums and general revenue financing for both Parts B and D of SMI are reestablished each year to match estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

Each component of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the actuarial projections contained in the Board's 2011 report to Congress. Such projections are made for current law under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short-range"

[1]Federal Insurance Contributions Act and Self-Employment Contributions Act, respectively.

period (the next 10 years) and a "long-range" period (the next 75 years). The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions. The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur.

As the Trustees and I have cautioned, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections. Congress is almost certain to override the approximately 30-percent reduction in Medicare payment rates to physicians that is scheduled to take place in 2012. In addition, it is doubtful that other providers will be able to improve their efficiency and productivity sufficiently to match the downward adjustments to Medicare payment updates based on economy-wide productivity. 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 furnish health care to beneficiaries. 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. In this event, Congress would likely override the adjustments, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.

It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. The implementation of payment and delivery system reforms, facilitated by the aggressive research and development program implemented by the Affordable Care Act, could help constrain cost growth to a level consistent with the lower Medicare payments. These outcomes are far from certain, however. As specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in the Trustees Report projections for the initiative.

To help illustrate the degree to which the current-law projections potentially understate actual future costs, the Board of Trustees asked the Office of the Actuary to prepare short- and long-range projections under an illustrative alternative to current law that assumes (i) all future physician payment updates are based on the increase in the Medicare Economic Index, and (ii) the productivity adjustments for most other categories of providers are gradually phased out during 2020-2035.[2] My testimony includes the key results of these alternative projections.

Financial outlook for Hospital Insurance (Part A)

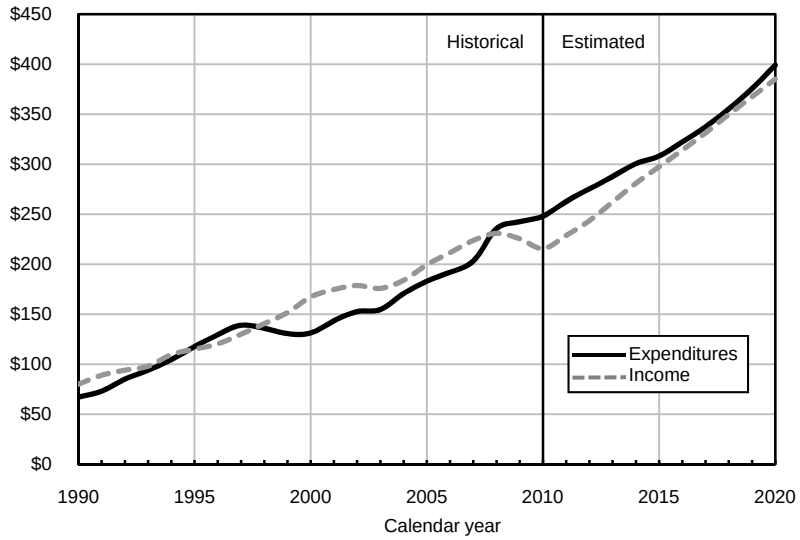
Chart 1 shows HI expenditures versus income since 1990 and projections through 2020. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year have been roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury

[2] The illustrative alternative projections are available at http://www.cms.gov/ReportsTrustFunds/Downloads/2011TRAlternativeScenario.pdf .

securities—in effect, lending the cash to the rest of the Federal government, to be repaid with interest at a specified future date or when needed to meet expenditures.

During 1990-1997, HI costs increased at a faster rate than HI income. Expenditures exceeded income by a total of $17.2 billion in 1995-1997. The Medicare provisions in the Balanced Budget Act of 1997 were designed to help address this situation. As indicated in chart 1, these changes—together with subsequent low general and medical inflation and increased efforts to address fraud and abuse in the Medicare program—resulted in a decline in HI expenditures during 1998-2000 and trust fund surpluses totaling $61.8 billion over this period. (Part of this decrease was attributable to the shift of a substantial portion of home health care costs to Part B, which improved the financial status of the HI trust fund but did not reduce Medicare costs overall.) After 2000, Part A expenditures and income converged slightly, as the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act increased HI expenditures and the 2001 economic recession resulted in lower payroll tax income.

Chart 1—HI expenditures and income
(in billions)



Starting in 2004, the Medicare Modernization Act increased Part A expenditures through higher payments to rural hospitals and to private Medicare Advantage health plans. Costs continued to increase in 2008, reflecting a correction to an accounting system that had inadvertently resulted in the payment of some hospice benefits from Part B, rather than Part A, along with the increasing popularity of Medicare Advantage plans. The year 2008 also saw the start of a significant decline in payroll tax revenues, caused by higher unemployment and slow wage growth associated with the economic recession that began in late 2007.

HI expenditures are projected to increase at a much lower rate than usual during 2012-2020, due to the combined effects of continuing slow general inflation, the slower provider payment rate updates caused by the productivity adjustments, and a substantial downward adjustment in Medicare Advantage payment benchmarks and rebate percentages. Collectively, these factors contribute to a projected average annual cost growth rate of 4.9 percent through 2020, despite the advent of the baby boom generation reaching age 65 and qualifying for HI benefits during this period. About 3 percentage points of this increase are due to growth in the number of HI beneficiaries. For comparison, the average annual growth rate over the last 10 years was 6.6 percent, with enrollment growth contributing less than 2 percentage points to this average.

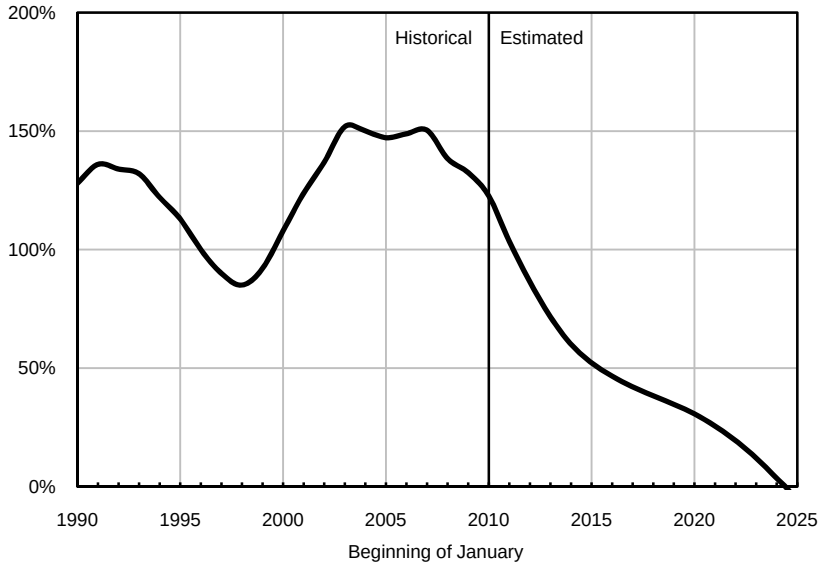
Put another way, the per-beneficiary growth rate for the next 10 years is expected to be less than half of the rate over the last 10 years, principally as a result of the savings provisions in the Affordable Care Act.

At the same time, growth in HI revenues is projected to accelerate, in part as a result of an assumed economic recovery from the 2008-2009 recession (and subsequent weak economic growth) and in part because of the additional 0.9-percent payroll tax on high earners. Together, the slower expenditure growth and faster increase in HI tax revenues would significantly narrow the annual trust fund deficit over most of the short-range projection period.[3]

The Board of Trustees has recommended maintaining HI assets equal to at least one year's expenditures as a contingency reserve. As indicated in chart 2, HI assets at the beginning of 2011 represented 103 percent of estimated expenditures for the year, down significantly from the 150-percent level maintained in 2002-2007. Assets are projected to continue to decline steadily as a percentage of annual expenditures and to be exhausted in 2024. Redemption of trust fund assets, for use in covering annual deficits, requires a transfer of cash amounts from the general fund of the Treasury to the trust fund, thereby increasing the overall Federal Budget deficit. Note also that while ongoing receipts from payroll taxes and income taxes on Social Security benefits would be sufficient to cover roughly 85 to 90 percent of HI expenditures after 2024, it is not clear that many health providers would be willing or able to continue furnishing services to beneficiaries under such circumstances. In any case, Congress has never allowed the HI trust fund to become exhausted.

Chart 2—HI trust fund assets

(assets at beginning of year as percentage of annual expenditures)



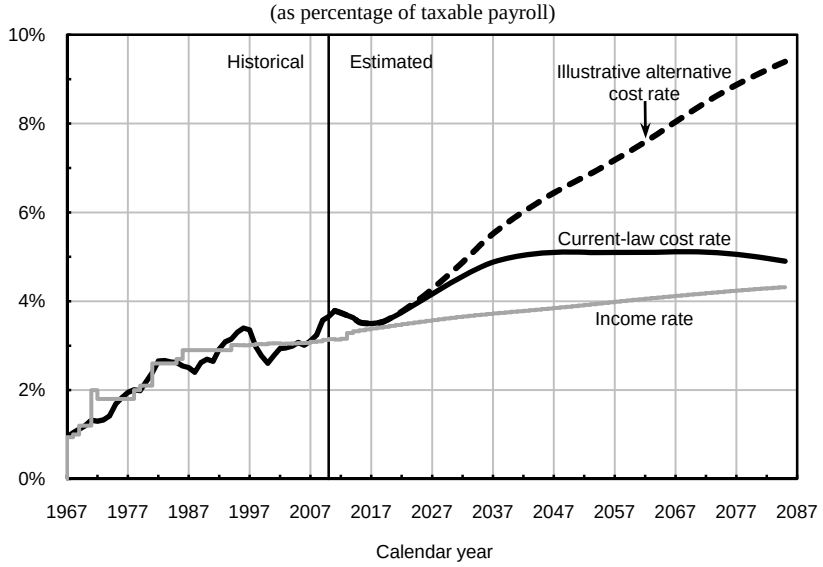
As noted, the projected exhaustion date for the HI trust fund is 5 years earlier than was shown in last year's report (2024 versus 2029). In the absence of the savings provisions of the Affordable Care Act, exhaustion would occur in 2016, or 8 years earlier. The projections under the

[3] Health care costs, including those for Medicare, increase in proportion to the number of beneficiaries, the increase in the average price per service, the number of services performed ("utilization"), and the average complexity of services ("intensity"). In contrast, HI payroll tax revenues increase as a function of the number of workers and the increase in average earnings, together with any changes in tax rates.

illustrative alternative to current law, which assumes that the productivity adjustments are gradually phased out starting in 2020, are nearly identical to those shown in charts 1 and 2.

The interpretation of dollar amounts through time is very difficult over extremely long periods like the 75-year projection used in the Trustees Report. For this reason, long-range tax income and expenditures are expressed as a percentage of the total amount of wages and self-employment income subject to the HI payroll tax (referred to as "taxable payroll"). The results are termed the "income rate" and "cost rate," respectively. Projected long-range income and cost rates are shown in chart 3 for the HI program. Cost rates are shown for both current law and the illustrative alternative to current law. (The income rates are the same under both scenarios.)

Chart 3—Long-range HI income and costs under intermediate assumptions
(as percentage of taxable payroll)



Past income rates have generally followed program costs closely, rising in a step-wise fashion as the payroll tax rates were adjusted by Congress. Although the HI payroll tax rates are fixed in law (at the standard total rate of 2.9 percent, plus the additional 0.9 percent for high earners), total income rates will increase because the income thresholds for taxes on Social Security benefits and for the 0.9-percent additional rate are not indexed. Over time, a growing proportion of Social Security beneficiaries have become subject to income taxes on their OASDI benefits. Similarly, an increasing proportion of workers in the future will have earnings above the $200,000/$250,000 thresholds established by the Affordable Care Act. By 2085, for example, an estimated 80 percent of workers would be subject to the additional 0.9-percent HI payroll tax.

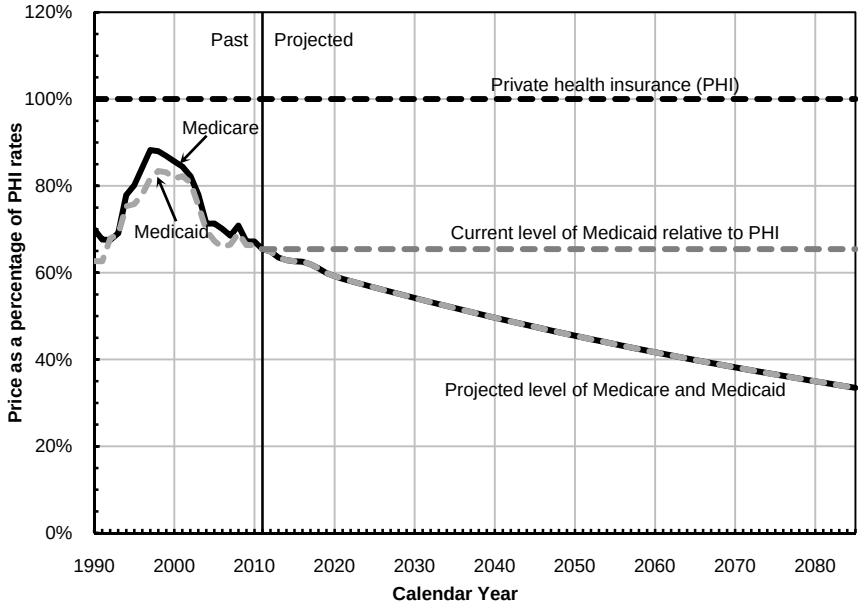
Past HI cost rates have generally increased over time but have periodically declined abruptly as the result of legislation to expand HI coverage to additional categories of workers, raise (or eliminate) the maximum taxable wage base, introduce new payment systems such as the inpatient prospective payment system, and make other changes. Cost rates decreased significantly in 1998-2000 as a result of the Balanced Budget Act provisions together with strong economic growth. After 2000, however, cost rates increased, partly because of the Balanced Budget Refinement Act and the Benefit Improvement and Protection Act and especially in 2008-2010 as the recent economic recession and weak recovery reduced the level of taxable payroll.

Cost rates are initially projected to decline as the economy recovers and unemployment returns to more normal levels. Under current law, costs will increase as the baby boom generation

becomes eligible for HI benefits in 2011-2030 but are projected to largely level off—and even decline somewhat—thereafter. This pattern results from the accumulating effect of the productivity offsets and other payment rate adjustments for Part A providers. For comparison, cost rates under the illustrative alternative projections increase rapidly throughout the long-range period, reaching 9.4 percent of taxable payroll in 2085, compared to only 4.9 percent under current law. Thus, depending on the long-range feasibility of the slower payment updates, scheduled tax revenues would be sufficient to cover about nine-tenths of HI expenditures (current law) or less than one-half (illustrative alternative).

This critical impact can be further assessed by comparing the relative level of HI payment rates to the corresponding prices paid by the Medicaid program and private health insurance plans. Chart 4 shows such a comparison for inpatient hospital services.

Chart 4—Illustrative comparison of relative Medicare, Medicaid, and PHI prices for inpatient hospital services under current law



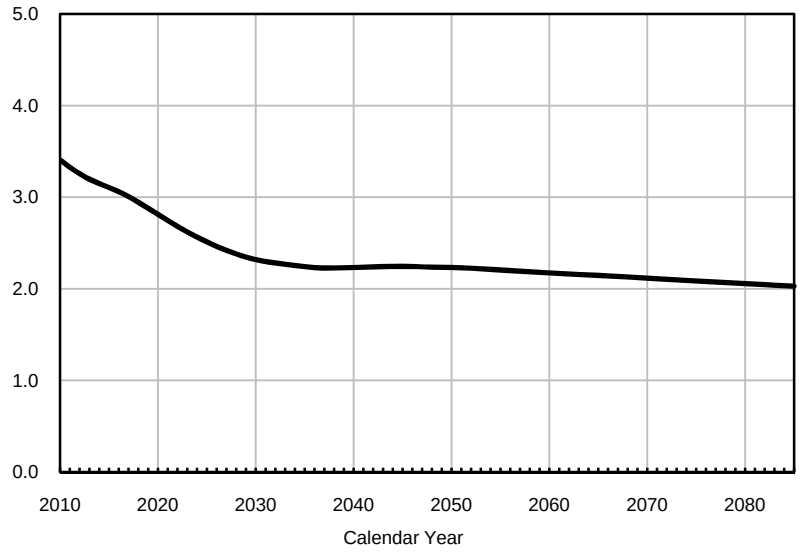
Medicare payment rates for inpatient hospital care in 2009 were about 67 percent, and Medicaid payment rates were about 66 percent, of those paid by private health insurance for their commercial plans. Under current law, Medicare and Medicaid payment rates are estimated to be approximately equal in 2011, and both are expected to decline in tandem relative to private health insurance payment rates over the next 75 years. The increasing differential between Medicare and private payment rates is due to the productivity adjustments in 2012 and later for the Medicare payment updates (and, to a lesser degree, to the other, smaller downward adjustments in 2010-2019 specified by the Affordable Care Act in addition to the productivity adjustments).[4] By the end of the long-range projection period, Medicare and Medicaid payment rates for inpatient hospital services would both represent roughly 33 percent of the average level for private health insurance. Medicare rates would be about one-half of the current relative level for Medicaid.

[4] For inpatient hospital services and some other categories of care, Medicaid payments are subject to certain upper payment limits (UPLs). For these services, total payments for all services in each category by a State Medicaid program cannot exceed what Medicare would have paid for the same care. The smaller UPL established by the Medicare rates forces a similar differential for Medicaid payments.

Per-beneficiary HI costs are normally expected to increase faster than per-worker tax revenues due to health care price inflation and increases in the utilization and intensity of services. Collectively, these factors generally exceed the growth in average earnings per worker, on which HI taxes are based. If the current-law productivity adjustments can be sustained, however, then per-beneficiary costs would likely increase more slowly than per-worker taxes.

Important demographic factors also contribute to the differential between HI income and expenditure growth rates. The effect of the baby boom generation on Medicare and Social Security is relatively well known, having been discussed by actuaries and others for almost 40 years. Basically, by 2030 when the baby boom cohorts have enrolled in Medicare, there will be about 65 percent more HI beneficiaries than there are today, but the number of covered workers will have increased by only about 15 percent. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary. As shown in chart 5, this ratio was about 3.4 workers per beneficiary in 2010. When the baby boom joins Medicare, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to about 2.3 in 2030 and 2.0 by 2085 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

Chart 5—Workers per HI beneficiary



There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 19 years currently, with an estimated further increase to about 23 years at the end of the long-range projection period. Medicare costs are sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than do younger persons. Thus, as the beneficiaries age, over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

Financial outlook for Supplementary Medical Insurance Part B

Chart 6 presents estimates of the short-range outlook for the SMI Part B trust fund account. As noted previously, Part B premiums and general revenue income are reestablished annually to

match expected program costs for the following year. Thus, barring exceptional circumstances, the program will automatically be in financial balance, regardless of future program cost trends.[5]

Historically, Part B expenditures have increased at a rapid pace in most years. The average annual growth rate over the last 10 years was 8.9 percent, for example, despite the modest increases in physician payment rates during this period.[6] (About 1.6 percentage points of this increase were attributable to growth in the number of enrollees.) In contrast, Part B expenditures are projected under current law to increase by 5.9 percent per year, on average, over the next 10 years. As noted in the Trustees Report, this projection is unrealistic in view of the very high probability that Congress will override the roughly 30-percent reduction in physician payment rates that is required on January 1, 2012 under the current SGR formula.

Chart 6—SMI Part B expenditures and income
(in billions)

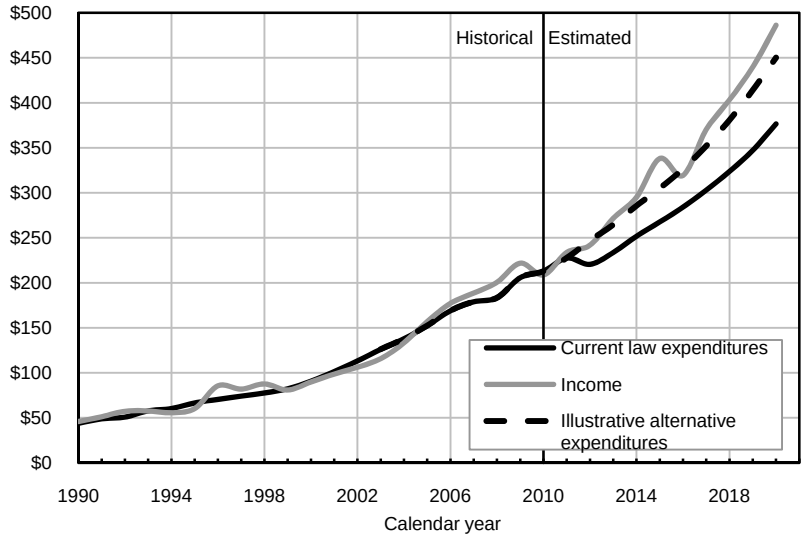


Chart 6 also shows projected expenditures under the illustrative alternative to current law, which would base physician payment updates on the Medicare Economic Index; the average annual growth rate in this scenario is 7.8 percent. (Both the current-law and illustrative alternative projections are affected by the productivity adjustments for other Part B providers and by the lower Medicare Advantage payment rates that are being phased in during 2012-2017.) As noted for HI, the retirement of the baby boom generation will increase the number of Part B enrollees by about 3 percent per year. Projected Part B income under the illustrative alternative scenario is very similar to the current-law levels shown below.

In past years, Part B income from premiums and general revenues has closely matched expenditures year by year, as would be expected given the annual financing basis for this part of Medicare. The projected future operations, however, show a sizable excess of income over current-law expenditures. In view of the near-certainty that Congress will act to prevent the 2012 reduction in physician expenditures, and will probably do so *after* financing is set for 2012,

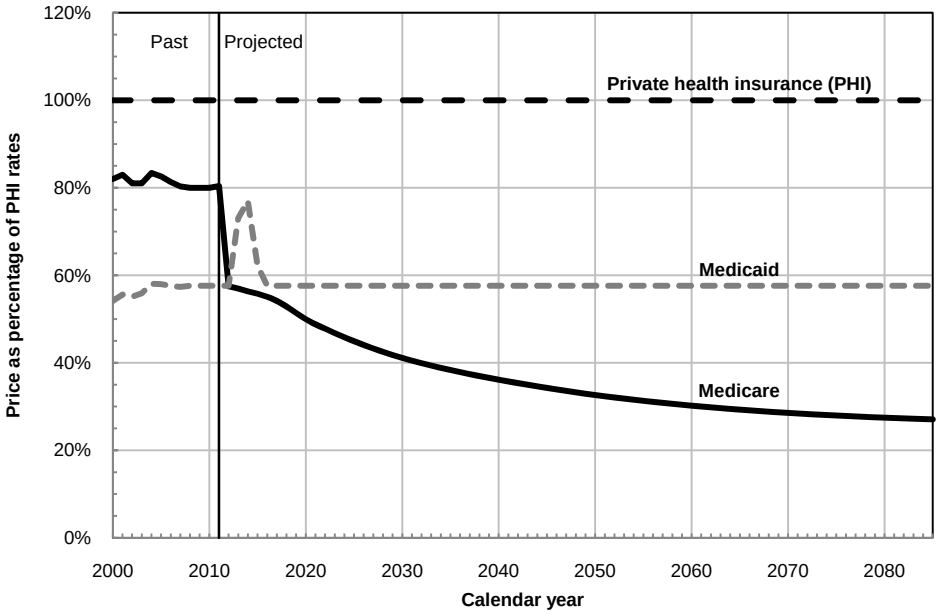
[5] The periodic odd patterns in projected revenues occur when the normal January 3rd payment date for Social Security benefits falls on a Saturday, Sunday, or holiday. In such cases, payment is advanced to the next earlier business day—which is generally December 31st of the prior year. This situation affected calendar-year Part B receipts in 2009-2010 and will do so again in 2015-2016.

[6] The increase in 2010, at 3.5 percent, was a notable exception to this trend. The reasons for this abrupt deceleration in Part B costs, which occurred across most types of services, are still being assessed.

it is necessary to maintain a much higher contingency reserve than normal. In practice, if Congress continues to override the SGR formula, then actual Part B expenditures will more closely resemble the illustrative alternative projection, and the income-outgo relationship will be similar to that in past years.

Chart 7 compares projected future Medicare and Medicaid payment rates for physician services relative to private health insurance levels. Medicare payment levels in 2009 were about 80 percent of private health insurance payment rates, and Medicaid payment rates in 2008 were about 58 percent. In this illustration, Medicaid payment rates increase to 73 percent of private health insurance levels in 2013 and to 77 percent in 2014 and then return to 58 percent. Medicare physician payment rates decline to 57 percent of private health insurance payment rates in 2012, due to the scheduled reduction in the Medicare physician fee schedule of nearly 30 percent under the SGR formula in current law. (As noted, Congress is very likely to override this reduction, as it has consistently for 2003 through 2011.) Under current law, the Medicare rates would eventually fall to 27 percent of private health insurance levels by 2085 and to less than half of the projected Medicaid rates. The continuing slower growth would occur as a result of negative update adjustment factors caused by growth in the volume and intensity of physician services that exceeds the increase factor specified by the SGR formula.

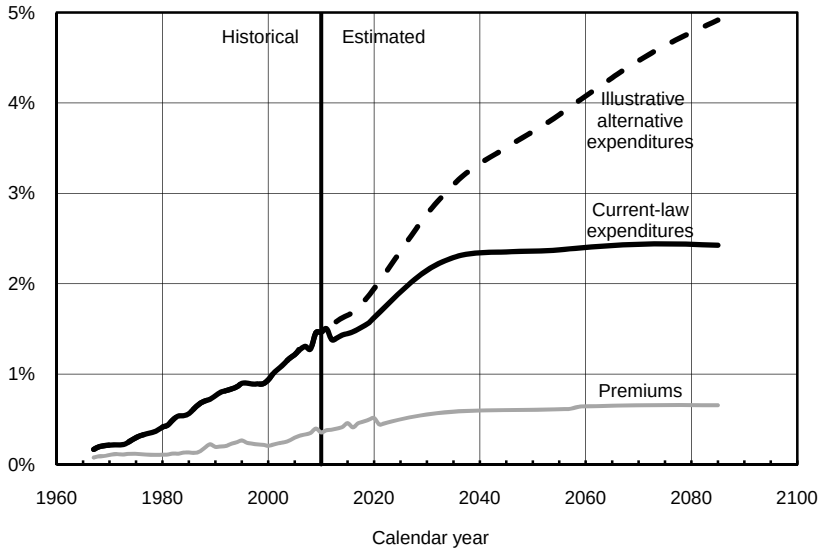
Chart 7—llustrative comparison of relative Medicare, Medicaid, and PHI prices for physician services under current law



Although not shown, the relationship between Medicare, Medicaid, and private health insurance payment rates for outpatient hospital and most other non-physician Part B care would be similar to that shown in chart 4 for inpatient hospital services.

Chart 8 shows projected long-range SMI Part B expenditures and premium income as a percentage of GDP. Under present law, Part B beneficiary premiums will continue to cover about 25 percent of total Part B costs, with most of the balance drawn from general revenues. (Fees on manufacturers and importers of brand-name prescription drugs will provide up to $2.8 billion annually in 2019 and later, with varying amounts in 2011-2018. Over time, the fixed amount of Part B revenues from these fees will represent a declining share of GDP.)

Chart 8—Part B expenditures and premiums as a percentage of GDP



Under current law, SMI expenditures are projected to increase faster than the GDP as the baby boom generation becomes eligible for and enrolls in Part B. After 2030, however, costs as a percentage of GDP would be relatively level as a result of the statutory limits on physician payments and the compounding effects of the productivity adjustments for most other categories of Part B providers. As discussed previously, the physician payment reductions are very unlikely to occur in practice, and there is considerable doubt about the long-range viability of the productivity adjustments. Under the illustrative alternative projection, Part B costs would continue increasing rapidly, reaching 4.9 percent of GDP in 2085 or a little over twice the level projected under current law.

Financial outlook for Supplementary Medical Insurance Part D

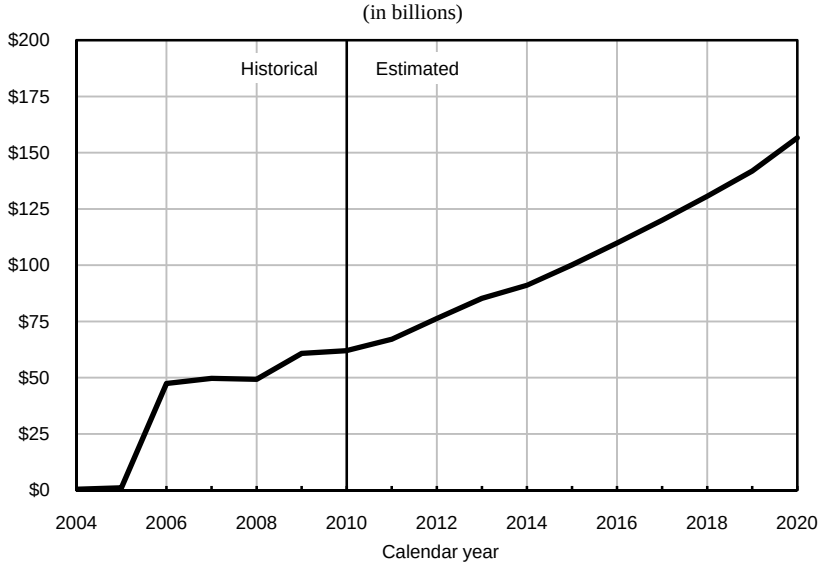
Medicare beneficiaries obtain Part D drug coverage by voluntarily purchasing insurance policies from stand-alone prescription drug plans or through Medicare Advantage health plans. The costs of these plans are heavily subsidized by Medicare through a combination of direct premium subsidies and reinsurance payments. Medicare provides further support on behalf of low-income beneficiaries and a special subsidy to employers who provide qualifying drug coverage to their Medicare-eligible retirees. The financial risk associated with the insurance for prescription drug costs is shared between each plan and Medicare. Medicare's cost for the various drug subsidies is financed primarily from general revenues. A declining portion of the costs for those beneficiaries who also qualify for full Medicaid benefits is financed through special payments from State governments.

Chart 9 presents actual Part D costs in 2004-2010 and estimates through 2020.[7] Part D income and outgo have been, and will continue to be, in virtually exact balance automatically due to (i) annual adjustments of premium and general revenue income to match costs, and (ii) a flexible appropriation process under which general revenues are transferred to the trust fund account on a daily basis as needed to cover that day's outlays. As a result of this latter feature, there is no

[7] Part D financial operations in 2004 and 2005 related only to the prescription drug discount card and low-income transitional assistance. The full Medicare prescription drug coverage became available in 2006.

need to maintain a contingency reserve in the Part D account.[8] Because payments to Part D plans are established based on a competitive-bidding system, the program is not affected by the productivity adjustments; accordingly, projected costs for Part D are the same under both current law and the illustrative alternative.

Chart 9—SMI Part D expenditures and income



Over its short history to date (2006-2010), Part D expenditures have increased at an average annual rate of 6.9 percent (in part due to enrollment growth of 3.1 percent). A somewhat faster increase is projected over the next 10 years (9.7 percent, including enrollment growth of 3.0 percent), based principally on an expectation that the conversion from brand-name to generic prescription drugs cannot continue its very rapid pace for many more years. This change has contributed substantially to slower drug expenditure growth, for both Part D and other drug spending, but a sizable majority of Part D prescriptions is already filled by generic drugs.

Actual Part D expenditure projections have been substantially lower to date than the original projections from 2003. This improvement has arisen primarily from three factors: First, starting in 2004, growth in total prescription drug expenditures in the U.S. slowed abruptly from what had been a decade and a half of double-digit increases to only a few percent per year. As noted, most of the slower growth in drug costs is believed to be attributable to the rapid expansion of tiered copayment arrangements in private health insurance plans, which provide a strong incentive for enrollees to switch to generic drugs. Part D plans also adopted these copayment arrangements, and the generic percentage for Part D is currently about 75 percent. This factor explains 54 percent of our overestimate of Part D costs. (The original estimates were made before this change in trend occurred.)

Next, in our original estimates, we expected strong competition among Part D plans, but we assumed it would take a few years for the competition to build up and reach its full level. In practice, the competition was strong from the very beginning, with negotiated retail discounts and manufacturer rebates achieving the best levels prevailing at that time almost immediately, rather than after a few years. This difference explains another 27 percent of the overestimate.

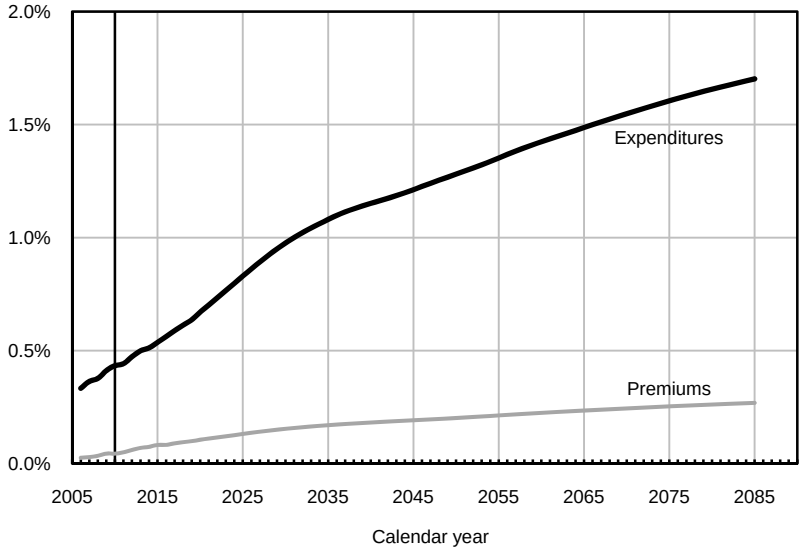
[8] Individual Part D plans maintain contingency reserves in case actual costs during the year exceed their expectations.

Third, in 2003 we anticipated that almost all Part D enrollees would enroll for coverage by January 1, 2006 so that they would have the insurance for the full year. Over a third of people did not sign up until well into the year, however, in part because of the extended first open enrollment period (which did not close until May 15). This factor had a relatively small impact on the overestimate since those beneficiaries who enrolled promptly in Part D tended to have higher-than-average drug expenditures. In addition, significantly more eligible individuals had credible coverage from other sources like the Veterans Administration or Indian Health Service than initially anticipated, based on the data available in 2003. Together, these enrollment factors explain 17 percent of the overestimate.

Finally, all other factors combined explain the last 2 percent of the difference between our original 2003 estimates for Part D and the subsequent actual experience.

Chart 10 shows projected long-range Part D expenditures and premium income as a percentage of GDP. As indicated, expenditures currently represent about 0.4 percent of GDP and are projected under the Trustees' intermediate set of economic and demographic assumptions to increase to 1.7 percent by the end of the long-range period. This increase reflects additional enrollees, as the baby boom generation reaches eligibility age, together with continuing growth in the prices, utilization, and intensity of prescription drugs.

Chart 10—Part D expenditures and premiums as a percentage of GDP



Part D beneficiary premiums are designed to cover 25.5 percent of the basic Part D benefit, on average. Because many enrollees qualify for the Part D low-income subsidy and do not have to pay full (or any) premiums, and because the low-income subsidy and retiree drug subsidy costs are not financed through premiums, total premium revenues currently represent about 11 percent of total Part D costs. The balance is paid by general revenues (79 percent) and State transfers (10 percent).[9]

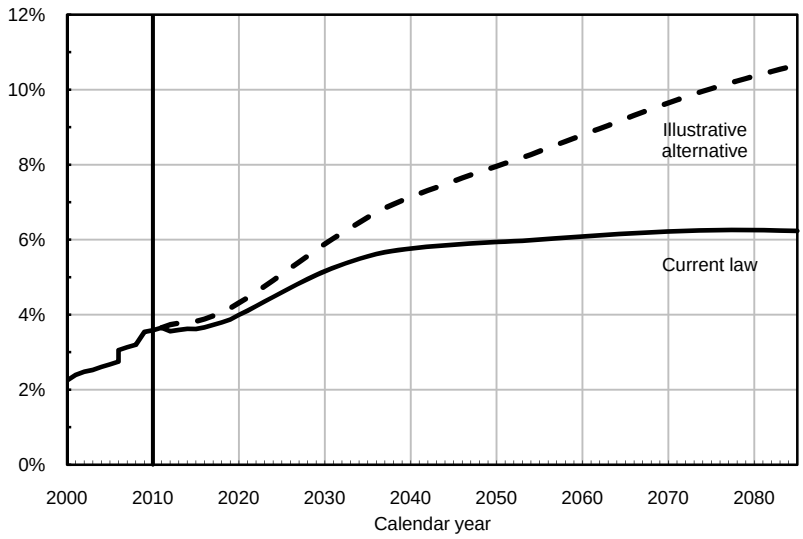
[9] These percentages are estimates for 2011; the balance will shift somewhat over time as (i) the State requirement declines from 90 percent to 75 percent of the forgone cost of prescription drugs for full dual beneficiaries, and (ii) the majority of employer-sponsored retiree health plans transition from the Retiree Drug Subsidy (RDS) to Part D drug plans following the change in tax status of the RDS payments.

Although the Part B and Part D accounts are automatically in financial balance, the rapid growth in combined SMI expenditures places an increasing burden on beneficiaries and the Federal budget. In 2010, for example, a representative beneficiary's Part B and Part D premiums required an estimated 13 percent of his or her Social Security benefit, and another 13 percent would be needed to cover average deductible and coinsurance expenditures for the year. In 2085, about 20 percent of a typical Social Security benefit would be needed to pay the Part B and Part D premiums, and about 26 percent would be required for copayment costs. Similarly, Part B and Part D general revenues in fiscal year 2010 equaled about 19 percent of the personal and corporate Federal income taxes that were collected in that year. If such taxes are set at their long-term, past average level, relative to the national economy, then projected Part B and Part D general revenue financing in 2080 would represent over 26 percent of total income taxes. Both the beneficiary and Federal burdens would be substantially greater in the future if the physician payment reductions were overridden and/or the productivity adjustments were phased out.

Combined HI and SMI expenditures

The financial status of the Medicare program is appropriately evaluated for each trust fund account separately, as summarized in the preceding sections. By law, each account is a distinct financial entity, and the nature and sources of financing are very different between the trust funds. This distinction, however, frequently causes greater attention to be paid to the HI trust fund—and especially its projected year of asset depletion—and less to SMI, which does not face the prospect of depletion. It is also important to consider the total cost of the Medicare program, as shown in chart 11 under current law and the illustrative alternative to current law.

Chart 11—Medicare expenditures as a percentage of GDP



Under current law, combined HI and SMI expenditures are projected to increase relatively quickly from 3.6 percent of GDP in 2010 to 5.6 percent in 2035 and slowly thereafter to 6.2 percent in 2085. Absent the cost constraints imposed by the sustainable growth rate system for physician expenditures and the productivity adjustments to payment updates for most other categories of service, costs would continue to increase rapidly relative to the GDP. As indicated by the illustrative alternative projection, total Medicare expenditures would reach about 10.7 percent of GDP at the end of the long-range period.

The Social Security Act requires a test of whether the difference between Medicare's total outlays and its "dedicated financing sources" is expected to exceed 45 percent of total outlays within the next 7 fiscal years.[10] As required under section 801 of the Medicare Modernization Act, the Board of Trustees has issued a determination of "excess general revenue Medicare funding" (the sixth such determination), since the ratio is estimated to exceed 45 percent in 2011 and 2012. These findings in the 2010 and 2011 reports trigger a fifth consecutive "Medicare funding warning." Section 802 of the MMA requires the President to submit to Congress, within 15 days after the release of the Fiscal Year 2013 Budget, proposed legislation to respond to the warning, and Congress is required to consider such legislation on an expedited basis.

Currently, most of the difference between Medicare expenditures and dedicated revenues is financed by the Part B and Part D general revenue transfers provided by law. The remainder of this difference equals the amount by which HI expenditures exceed HI tax income and premiums. This gap is currently being met by using the interest earnings on the assets of the HI trust fund and by redeeming a portion of these assets. The cash required for the payment of interest and the redemption of assets is drawn from the general fund of the Treasury. It is important to note, however, that there is no provision in current law to address the projected HI trust fund deficits once the fund's assets are depleted. In particular, it would not be possible to transfer general revenues to HI to make up the difference.

The comparison of expenditures and dedicated revenues, as called for by section 801 of the MMA, is a useful measure of the magnitude of general revenue financing for Medicare plus the HI trust fund deficit. Similarly, the test underlying a "Medicare funding warning" can help call attention to the impact on the Federal Budget associated with the general revenue transfers to Medicare. The "Medicare funding warning," however, should not be interpreted as an indication that trust fund financing is inadequate. That assessment can be made only by comparing each trust fund account's expenditures with all sources of income provided under current law, including the statutory general fund transfers and interest payments.

Conclusions

In their 2011 report to Congress, the Board of Trustees emphasizes the continuing financial pressures facing Medicare and urges the nation's policy makers to take steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future, since the earlier that solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

Although the current-law projections are poor indicators of the likely future financial status of Medicare, they serve the useful purpose of illustrating the exceptional improvement that would result if viable means could be found to permanently slow the growth in health care expenditures. The Affordable Care Act establishes a broad program of research into innovative new delivery and payment models in an effort to improve the quality and cost-effectiveness of health care for Medicare—and, by extension, for the nation as a whole. This process is

[10] The dedicated financing sources are principally HI payroll taxes, the portion of income taxes on Social Security benefits that is allocated to the HI trust fund, beneficiary premiums, the fees on manufacturers and importers of brand-name prescription drugs, and the special State payments to Part D.

in the early stages of development but offers an extraordinary opportunity to design and test alternatives with the potential to make quality health care much more affordable. Thus, the projections in this year's Medicare Trustees Report should provide an unequivocal incentive to vigorously pursue the development of effective and sustainable new approaches.

Thank you for this opportunity to meet with your Committee. I pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine effective solutions to the financial challenges facing the Medicare program. I would be happy to answer any questions you might have on Medicare's financial status.