

****THIS TESTIMONY IS EMBARGOED UNTIL 9:30
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Before the Subcommittee on Health

of the U.S. House of Representatives Committee on Ways and Means

June 22, 2011

Thank you, Chairman Herger, Ranking Member Stark, and all of the members of the subcommittee. It is an honor to appear before you today to discuss the latest Trustees' report. By mutual agreement with my fellow Public Trustee, Dr. Robert Reischauer, I will present the primary findings of the Trustees' report with respect to projected Medicare finances. Other important aspects of the topic, such as the reasons for change since last year's report as well as the magnitude of and reasons for continued uncertainty in the projections, I will touch upon only briefly with the understanding that they will be covered in Dr. Reischauer's testimony.

Medicare Trust Funds, Income and Expenditures

Trust Funds: Medicare has two trust funds, the Hospital Insurance (HI) Trust Fund (sometimes known as Part A) and the Supplementary Medical Insurance (SMI) Trust Fund (which includes both Part B, a voluntary enrollment program of physician, outpatient hospital and home health services, and Part D, another voluntary program that provides prescription drug benefits). Medicare also has a Part C, the "Medicare Advantage" program, whose costs are paid from both the HI Part A and SMI Part B Trust Fund accounts. As is the case with Social Security, the HI and SMI Trust Funds contain special-issue Treasury bonds, which earn interest and provide a financing reserve that can be drawn upon whenever incoming dedicated revenues fall short of outgoing expenditures.

Although the income sources for Medicare as a whole are more varied than they are for Social Security, in significant respects the Trustees' projections specifically for the HI Trust Fund are analogous to those made for the Social Security program. For each of these, the majority of program revenues are provided by a payroll tax imposed upon worker wages and self-employment earnings. Also with each of these Funds, the Trustees determine whether there is an aggregate imbalance between projected program income and expenditures, as well as the date (if any) by which Trust Fund assets are projected to be exhausted.

By contrast, the finances of Medicare's SMI Trust Fund operate somewhat differently. Part B and Part D premiums and contributions from general revenues are re-established annually to match expected costs. SMI is thus kept solvent essentially by statutory construction. Financial strains on the SMI side, therefore, are manifested not in a projected actuarial imbalance or a date of trust fund depletion, but in rising requirements of general government revenues and enrollee premiums.

Income: For Part A, the largest source of income is a 2.9% tax upon wage earnings nominally split between employer and employee, though economists generally agree that both ends of the tax are paid from covered wages. Unlike the Social Security payroll tax, the application of the Medicare tax is not capped by wage income level. Starting in 2013, single taxpayers with earnings above \$200,000 and married couples over \$250,000 will pay an additional 0.9% tax to the HI Trust Fund. Medicare also receives income from the taxation of Social Security benefits (up to 85% of such benefits are subject to the income tax, with taxation on 50% dedicated to Social Security and the remaining 35% to Medicare HI).

In Parts B and D, general revenues provide the vast majority of financing (74% of total revenues for Part B, 83% for Part D). Another significant portion of Part B revenues comes from beneficiary premiums. The basic Part B monthly premium for 2011 is \$115.40, but about three-quarters of beneficiaries are as of now continuing to pay a \$96.40 premium, having been held harmless from recent premium increases under a provision of law triggered by the last two “zero COLA (cost-of-living-adjustment)” years in Social Security. Higher-income beneficiaries (\$85,000 for individuals, \$170,000 for married couples) pay higher Part B premiums. For Part D, individual monthly premium payments are averaging about \$31 in 2011, and another smaller portion of revenues is provided via payments by States, these latter revenues representing a partial payment of foregone drug costs for dual beneficiaries as such costs were transferred from Medicaid to Part D.

Medicare Income Sources, 2010 (\$ Billions)

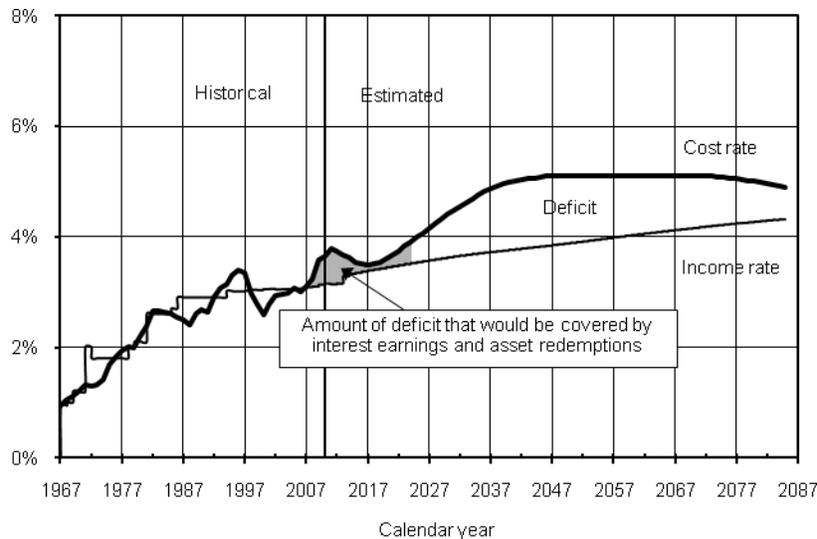
	Part A	Part B	Part D	Total
Payroll taxes	182.0	0.0	0.0	182.0
Taxation of benefits	13.8	0.0	0.0	13.8
Premiums	3.3	52.0	6.5	61.8
Transfers from States	0.0	0.0	4.0	4.0
General revenue	0.1	153.5	51.1	204.7
Interest	13.8	3.1	0.0	16.9
Other	2.7	0.2	0.0	2.9
Total	215.6	208.8	61.7	486.0

Expenditures: Total Medicare expenditures in calendar year 2010 were roughly \$523 billion, of which roughly \$516 billion were benefit payments and the remaining \$7 billion administrative expenses. Categories of expenditures included \$168 billion in hospital benefits (most of which were paid from Part A), \$116 billion in Part C payments, \$65 billion for physician fee schedule services (Part B), \$62 billion in prescription drug payments (Part D), \$27 billion for skilled nursing facilities (Part A), and \$19 billion for home health care (Parts A and B), among other payments.

Findings for Medicare Finances

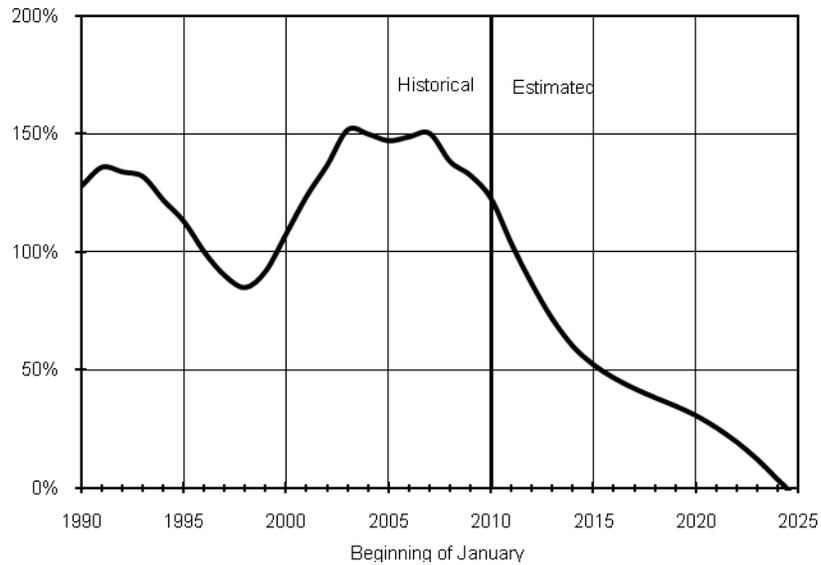
In this year’s Trustees’ report, Medicare’s HI Trust Fund is projected to pay out more in hospital benefits than it receives in income in all future years, as shown on the following graph.

Projected Annual HI Income and Cost as a Percentage of Taxable Payroll



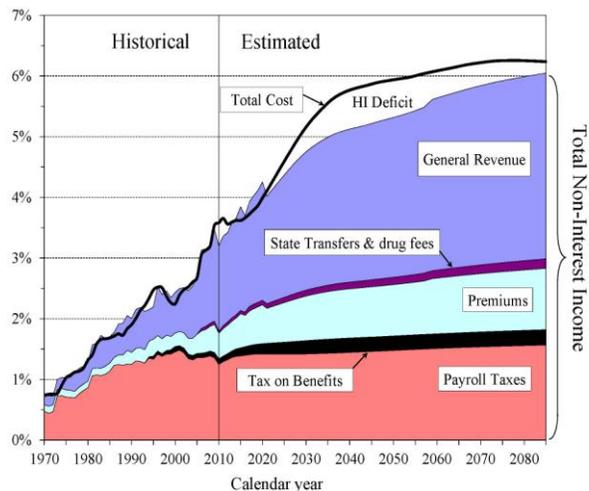
These flows are projected to result in a continuing diminution of the assets of the HI Trust Fund until it is exhausted in 2024. This 2024 Trust Fund depletion date is five years earlier than projected in the previous Trustees’ report. At the point of HI Trust Fund depletion, dedicated revenues would be sufficient to pay 90 percent of HI costs. This share of expenditures that can be financed with HI dedicated revenues is projected to decline slowly afterward until it reaches 75 percent in 2045, after which it is projected to gradually rise again for reasons that I will later touch upon. Averaged over 75 years, under Trustees’ assumptions, the actuarial imbalance of Medicare HI equals 0.79% of taxable payroll, up from 0.66% in the prior year’s report.

Projected HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures (“Trust Fund Ratio”)



As noted earlier in my testimony, projections for the HI Trust Fund represent but one component of Medicare financing, as financial strains on the SMI side are instead manifested by rising pressures on general revenues and premiums rather than Trust Fund depletion. SMI costs equaled roughly 1.9 percent of GDP in 2010 and are projected to rise sharply to 3.4 percent of GDP in 2035. Costs for Medicare as a whole are projected to rise rapidly from 3.6 percent of GDP in 2010 to about 5.6 percent of GDP by 2035, and to increase gradually thereafter to about 6.2 percent of GDP by 2085.

Medicare Costs and Non-interest Income by Source as a % of GDP



As is the case with Social Security, the rapid cost growth in Medicare through 2035 predominantly reflects population aging, as the large Baby Boom generation is leaving the ranks of the workforce and entering the ranks of retirees, causing a sharp decline in the ratio of workers to beneficiaries. Unlike Social Security, Medicare costs under current assumptions would continue to rise relative to GDP in the years after 2035 largely because of continued health care cost inflation.

The Medicare Modernization Act of 2003 requires that the Board of Trustees determine each year whether the annual difference between program outlays and dedicated revenues exceeds 45 percent of total Medicare outlays in any of the first seven fiscal years of the projection period. When that determination is made in two consecutive reports, a "Medicare funding warning" is triggered. This year's report projects the difference between outlays and dedicated financing revenues to exceed 45 percent of total Medicare outlays during fiscal year 2011, prompting a determination of "excess general revenue Medicare funding" for the sixth consecutive report, triggering another "Medicare funding warning."

As the Trustees' report notes in several places, there are several reasons to believe that actual costs in practice will be higher than the figures I have just cited. I will say more about this issue at the end of my statement.

Methodology and Assumptions

The Trustees rely upon the same fundamental demographic and economic assumptions for the Medicare report as are used for the Social Security report. These assumptions are developed based on the recommendations of the Social Security Administration Office of the Chief Actuary, subject to review, possible alteration, and approval by the Trustees as a group. The CMS Office of the Actuary in turn develops the recommendations for the assumptions with respect to future health care cost growth, again subject to review, possible alteration, and approval by the Trustees. These variables are extremely difficult to predict with precision, and they have a very large impact upon Medicare cost projections over the long run.

The methodology used for the 2011 Medicare report is very similar to that employed in the 2010 report and reflects the evolving recommendations of a series of Technical Panels over the years. Over the next 75 years on average, and before consideration of the Affordable Care Act,¹ health care costs are projected to grow at a per-capita rate that is equal to the growth in per-capita GDP plus 1 percentage point. That, however, is an average figure, and the rate of assumed growth is higher earlier in the valuation period than toward the end. The growth rate, for example, is 1.28 percentage points above GDP in 2035, 0.8 above in 2055, and only 0.3 percent above in 2085. This reflects an expected slowing of the rate of health care cost growth as these costs absorb a greater and greater share of the economy as a whole.

From these growth rates are subtracted certain cost-saving provisions of the Affordable Care Act. Critical such provisions permanently reduce payment updates to all Part A providers and most non-physician Part B providers by the 10-year moving average increase in private, nonfarm business multi-factor productivity growth, which is projected to be 1.1 percent annually. Under our assumptions, therefore, per-capita growth in these payments would exceed per-capita GDP growth in the near-term but would increase more slowly than per-capita GDP in the long term. This, along with the flattening of demographic trends after 2035, is one of the reasons why our projections show dedicated HI revenues and expenditures coming much closer together after 2045, after having grown considerably further apart prior to that time. The difference also narrows because the additional 0.9% HI payroll tax on higher-earning workers affects a growing proportion of all workers over time, since the earnings thresholds are not indexed.

A Brief Note Concerning Projection Changes and Uncertainty

I understand that Dr. Reischauer's testimony will review in some detail the various sources of uncertainty in these projections, as well as the reasons for changes in the results since last year's report. I will touch on these subjects just long enough to clarify some of the information that I have just presented.

In a nutshell, Medicare cost projections are highly uncertain and there are significant reasons to believe that actual costs will be higher in practice than projected in the 2011 report, as the report itself notes in several places. Just as the Congressional Budget Office must do, the Trustees must

¹ The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

project forward current law as written, even when there are precedential reasons to be skeptical that it will be implemented without alteration. Early next year, for example, physician payments would be reduced by about 29% under the current-law Sustainable Growth Rate formula, which Congress and the Administration have repeatedly acted together to override. If these reductions continue to be overridden, Medicare Part B costs will be considerably higher than the report shows. A similar set of concerns is expressed about cost-saving provisions on the Part A side, most especially the annual downward payment adjustments for multi-factor productivity growth; under our current assumptions (again, a critical specification) these adjustments would result in Medicare payment rates falling further behind private health insurance over time (and even substantially below the current relative level for Medicaid), threatening the profitability of institutions providing services under Medicare (again, under our existing assumptions).

I will leave matters of behavioral responses to current law to be addressed in greater detail by Dr. Reischauer, but I would simply summarize the effects on our projections by noting that Medicare cost projections are uncertain on the one hand because we don't know how future Congresses (and private health care providers) will deal with these issues, but also that projections would be uncertain *even if* current law were implemented exactly as written. The CMS Medicare Actuary publishes an "illustrative alternative scenario" in which the SGR payment adjustments are overridden, and the ACA productivity adjustments phased out over 2020-2035. This alternative scenario shows total program costs of 10.7% of GDP in 2085, rather than the 6.2% shown in the main report. But even under the political assumption that holds current law in place, long-term cost projections vary significantly as we employ different assumptions for health cost growth and economic factors. Toward the end of refining these projections, we look forward to receiving later this summer the report of a Technical Panel of experts currently reviewing these issues.

I understand that Dr. Reischauer will be explaining the five-year deterioration in the projected depletion date for Medicare HI (from 2029 in last year's report to 2024 in this one). Here I will simply relate this shift to the theme of overall uncertainty in the Medicare projections. It may exaggerate—but not by much—to note that the HI Trust Fund projects to be on a razor's edge for several years, starting by the latter part of this decade. This was true not only in the 2010 report but is also true in this year's report. By mid-2015, for example, we only project enough assets in the HI Trust Fund to cover less than half a year of benefit payments in the absence of incoming dedicated revenues. This financing reserve is thus very low for several years before running out altogether in 2024. It thus does not take a great deal of creativity to imagine a 2012 report in which the HI Fund exhaustion date moves again by several years, in *either* direction, even if there are relatively subtle changes in projections of annual program operations.

Conclusion

The essential message conveyed by the Trustees' report is clear and will not change absent legislation: that Medicare faces real and substantial challenges, and that elected officials will best serve the interests of the public if financial corrections are enacted at the earliest practicable time.