

## Example 12.4

### 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.

Some observers at the time were puzzled that neither the administration nor Congress offered any formal proposal to reform the other component of the Social Security System, Medicare. Medicare was the true elephant in the room in 2005. The projected shortfall in the funding for Medicare was at once more immediate, much larger, and more persistent than the projected shortfall in the Social Security pensions. The budgetary reforms needed to place Medicare on a sound financial footing dwarfed those needed for the System's future pension commitments. Indeed, the required budgetary adjustments were so large that U.S. politicians apparently could not 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. The premiums average about twenty-five percent of total SMI expenditures each year. The remaining seventy-five percent is covered 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 at the time, the only reform to Medicare during the second Bush administration was to add Part D in 2006, a reform that made the projected deficits even larger.

## The Relative Size of the Medicare Financial Problem in 2007

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, which would have used historical data through 2006 in making their projections<sup>1</sup>.

The pension and disability benefits (OASDI)<sup>2</sup>: 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 were expected to rise steadily to 6.2% of GDP by 2030 because of the retirement of the baby boomers, after which the percentage leveled off. It was projected to be 6.3% in 2081, the last year of the 75-year forecast. (p. 14).

Another set of financial indicators that the Trustees always report relate to the OASDI Trust Fund, indicators that also receive a considerable amount of attention from politicians and the press. They require comment because they are somewhat artificial. As noted in the textbook, shortly after the Social Security System was established it became a pay-as-you-go ("paygo") system: the revenues collected each year from the payroll tax were paid out immediately to the retirees. In 1983, President Reagan and Congress agreed to increase the payroll tax and also increase the age from 65 to 67 when retirees could receive full benefits, with the age increase phased in slowly over time. The idea was to build up a Trust Fund which would help pay for the retirement benefits of the huge baby boom generation. The interest on the accumulated assets could supplement the payroll taxes to pay the baby boomers' pensions. Once the required payments exceeded taxes plus interest, the assets (almost entirely Treasury securities) would be drawn down until the Trust Fund was exhausted. After the last baby boomers died, and

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<sup>1</sup> The data in in this section 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](http://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.

<sup>2</sup> OASDI stands for Old Age, Survivors, and Disability Insurance.

the Trust Fund was exhausted, the System would revert to paygo, and payroll taxes would again have to be sufficient to meet the benefits each year. A similar Trust Fund was established for the HI component of Medicaid by increasing the Medicare tax, although the age that people could be insured by Medicare remained at 65.

With these notions in mind, the Trustees report their projection of when benefits will begin to exceed the payroll tax revenues plus interest on the accumulated assets in the Trust Fund such that the assets have to be drawn down, and also their projection of when the Trust Fund will be exhausted. The 2007 Report projected that expenditures on pensions and disability payments were expected to exceed earmarked payroll tax revenues plus interest on Trust Fund assets in 2027, and that the assets in the OASDI Trust Fund would be exhausted in 2041. By 2041, payroll tax revenues at current rates would finance only 75% of the pensions and disability benefits. (p. 11). To avoid deficits in any future years would require a 16 percent increase in the payroll tax (from 12.4% to 14.4%), or a 13 percent cut in benefits, or a combination of tax increases and benefit reductions, effective immediately. (pp. 1-2).

Medicare: Compare the same financial indicators for Medicare. Medicare expenditures were smaller than the OASDI expenditures in 2007, 3.2% (vs. 4.2%) of GDP, but they were rising much more rapidly. They were projected to exceed OASDI expenditures in 2028, and reach 6.5% of GDP by 2030. Unlike OASDI expenditures, however, the growth of Medicare expenditures relative to GDP would not level off after most of the baby boomers have died. Medicare would continue to grow rapidly, to 11.3% of GDP by 2081. (p. 15).

Consider next the projections for just the HI component of Medicare, the portion financed by the payroll tax. HI expenditures already exceeded the earmarked payroll tax revenues in 2007, and were projected to exceed the tax revenues plus interest income of the HI Trust Fund assets in 2011. The assets in the HI Trust Fund would be exhausted by 2019, at which point payroll tax revenues would cover only 79% of HI expenditures, a percentage that would continue to decline to 29% by 2081 at the current 2.9% tax rate. (pp. 11, 15, and 16). The Trustees projected 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, effectively immediately, to cover projected Medicare expenditures each year to 2081. (p. 2). To raise the necessary general revenues to remove the projected Part 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 were projected place on the federal budget at the time were much 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 would have to be<sup>3</sup>.

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<sup>3</sup> Note, also, that redeeming the OASDI and HI Trust Fund assets 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.

Notice that the OASDI and Medicare projections begin to diverge after 2030, by which time many of the baby boomers will have died. 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. had 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 costs of medical care will decline gradually until it is equal to the growth in 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 nominal GDP per capita without eventually driving the consumption of all other goods and services to zero. If this assumption proves to be too optimistic, however, then the financial pressures of Medicare become that much larger. For example, the Congressional Budget Office estimated 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<sup>4</sup>.

### **Things Change: the 2016 Trustees Report** <sup>5</sup>

The 2016 Trustees Report offers a very different 75-year projection of Medicare from that of the 2007 Trustees Report--it is far more optimistic. The Trustees now project that Medicare, which was 3.6% of GDP in 2015, will rise to 5.6% of GDP in 2040 with the retirement of the baby boomers, and then increase very slowly to 6.0% of GDP by 1990, the last year of the 75-year projection. (p. 5) The HI Trust Fund will not be exhausted until 2028, after which payroll taxes will cover 87 of benefits. Payroll tax collections will drop to 79% of expenditures by 2040, but then rise again to reach 86% of expenditures by 1990. (pp. 7, 29) Since the 2016 projections for OASDI were much the same as in 2007, the implication is that the Medicare shortfall will be essentially the same throughout the 21st century as the pension and disability shortfall, and therefore also quite manageable. Medicare no longer appears to be the fiscal elephant in the room in the long run.

What happened in the ten years since 2007 to cause such a dramatic change in the 75-year projections for Medicare? The 2016 Trustees Report lists a number

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<sup>4</sup> M. Labonte, "Social Security and Medicare: The Economic Implications of Current Policy," *CRS Report for Congress*, January 28, 2005, Congressional Research Service, The Library of Congress, p. 4.

<sup>5</sup> The projections listed in this section are from the 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Washington, D.C., June 22, 2016. Page numbers are in parentheses throughout the section. The one reference to the 50-year estimated annual growth in health costs per beneficiary in 2007 is from the 2007 Annual Report, same title, Washington, D.C., April 23, 2007.

of factors but three predominate, two on the revenue side and one on the expenditure side. On the revenue side, the Affordable Care Act (Obamacare) instituted a .9 percentage point increase in the Medicare portion of the payroll tax for single taxpayers with incomes in excess of \$200,000 and joint filers with incomes in excess of \$250,000. It also levied a new 3.8% tax on net interest income earmarked for Medicare, on the same high-income taxpayers as the .9 percentage increase in the payroll tax. An even bigger difference occurred on the expenditure side, occasioned by a sharp decrease since 2007 in the increase in health expenditures in the United States. In the seven years prior to 2007, the average annual rate of growth in health expenditures was 7.8%. In the seven years after 2007, the average annual rate of growth was only 4.1 percent.<sup>6</sup>

No one has come up with a convincing explanation of why such a dramatic decrease occurred in the growth of health expenditures. Was it due to the Great Recession? The increasing computerization of health care data, such that technical change in medical care was for once cost decreasing? It could not have been due to the cost reducing reforms that are contained in the Affordable Care Act, since the Act did not take full effect until 2014. (see Example 10.1). In truth, no one knows. But the more recent experience led the Trustees to assume a substantial reduction in the growth rate of health expenditures in their 75-year projection relative to their 2007 Report. To give one comparison, the Trustees presented in both Reports their projection of the average annual growth in health care costs per beneficiary for all of Medicare during the last fifty years of the 75-year projection period. The 2016 projection is 3.8%, down from 5.1% in the 2007 Report. (p. 13, and p. 7 in the 2007 Report). Even a 1.3% percentage-point reduction in the expected growth of health care costs has large effect on HI and SMI expenditures when projected over a fifty-year period.

Whether this projection is accurate remains to be seen, however, since the growth in health expenditures suddenly increased from 2.9% in 2013 to 5.3% in 2014. One can hope that the pilot programs under the Affordable Care Act will help to lower the rate of increase again, although this hope has to be balanced against large increases in health insurance premiums in 2015 and 2016 for those buying private health insurance under Obamacare. In truth, predicting the path of health care expenditures far into the future is a highly uncertain task. It would not be a great surprise if five to ten years down the road Medicare once again came to be viewed as the long-run fiscal elephant in the room. In any event, the growth in health care costs is the key factor to watch going forward.

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<sup>6</sup> The data on the growth in health care expenditures are from the Centers for Medicare and Medicaid (CMS), NHE Tables, Table 1, available at [cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.htm](https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.htm)