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## The Medicare Spending Program

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# The Medicare Spending Program

## **ABSTRACT**

A brief history of the United States Medicare health insurance program is provided, with a description of each of its parts. The history of the Medicare spending program is outlined, along with the history of the program's funding. Future spending projections for the Medicare program and key factors driving future spending are identified, along with other factors that may affect the future level of program spending that are not currently accounted for in official projections. New lessons learned from the national experiment to provide Medicare beneficiaries with a direct economic stake for lowering the overall cost of the program via the new Medicare Part D prescription drug coverage program may provide the key to bringing the growth of Medicare spending to sustainable levels through the implementation similar reforms to Medicare's core health insurance programs. Additionally, more closely linking the program's expenditures to its actual revenues may ensure its fiscal viability.

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## I. INTRODUCTION

### Overview

The United States federal government provides health insurance for people Age 65 or older through its Medicare social insurance program [12]. In addition to the nation's senior citizens, the program also provides health care coverage for younger individuals who have disabilities, permanent kidney failure, and other debilitating conditions [13].

Medicare's health insurance program assists the program's beneficiaries by covering a considerable portion of the costs of their health care. However, the program does not cover the costs of all medical expenses, nor does it cover the costs associated with long-term care.

As it exists today, Medicare consists of four parts, which cover different aspects of health care for the program's beneficiaries:

**Part A:** Hospital Insurance, which helps pay for inpatient care in a hospital or in a skilled nursing facility following a hospital stay, and also covers some hospice care or home health care [1].

**Part B:** Medical Insurance, which helps pay for medically necessary services like doctors' services and other medical services or supplies that aren't covered under the program's Part A Hospital Insurance component, including outpatient care and home health services. This part of Medicare also covers some preventive medical services [2].

**Part C:** Medicare Advantage, which allows individuals eligible for Medicare's Part A Hospital Insurance and Part B Medical Insurance components to choose among plans provided by private insurers, which combine Medicare's traditional Part A and Part B coverage with augmented coverage,

including vision, hearing, dental and/or health and wellness programs [3].

**Part D:** Prescription Drug Coverage, which allows all Medicare beneficiaries to cover the costs of prescribed medications through plans operated by insurance companies or private companies approved by Medicare [4].

In 2011, the United States federal government's spending to support Medicare's health insurance programs is projected to reach over \$494.3 billion [15].

### Origins

The roots of the United States federal government's Medicare social insurance program may be traced to 1934, when President Franklin D. Roosevelt commissioned the Committee on Economic Security to address the nation's unemployment situation during the Great Depression, with a focus on old-age related issues, including medical care and insurance. As part of their work, the Committee issued an unpublished report "Risks to Economic Security Arising Out of Illness" and developed principles of health reform [8].

Not much came of this early work until 1944, when President Roosevelt outlined an "economic bill of rights" proposing a new right to "adequate medical care and the opportunity to achieve and enjoy good health" in his State of the Union address that year [10]. Later that year, the Social Security Board called for compulsory national health insurance to be part of the Social Security system.

Following the end of World War II, President Harry S Truman, who succeeded to the U.S. presidency after President Roosevelt's death in 1944, sent a number of special messages to Congress advocating for the creation of a National Health Program; these were

successfully resisted by medical professionals acting through the American Medical Association.

In the early 1950s, the attention of health reformers focused upon providing health insurance for the elderly, with considerable effort being expended unsuccessfully on enacting legislation to provide Social Security beneficiaries with health insurance.

Those efforts gained strength in the 1960s. In 1965, taking advantage of his landslide victory in the 1964 presidential election and his political party's large Congressional majority, President Lyndon B. Johnson signed House Resolution 6675 (Public Law 89-97) into law on July 30, 1965, which established both the Medicare health insurance program for the elderly and the Medicaid health insurance program for the poor [7].

Medicare coverage took effect the following year on July 1, 1966 for all individuals Age 65 or older being automatically enrolled in the Part A of the program for Hospital Insurance. Medical Insurance coverage under Part B of the program for individuals who signed up for that portion of the program also began on that date.

In 1972, Medicare was expanded to provide health insurance for individuals under the age of 65 who had long-term disabilities or severe kidney disease, while benefits were expanded to include chiropractic and physical therapy services, and also speech therapy. The following year, individuals who had received Social Security Disability Insurance (SSDI) cash payments for two or more years were also covered by the program.

It wasn't until sixteen years later that the next major expansion of Medicare occurred, with the Medicare Catastrophic Coverage Act of 1988, which capped beneficiaries' out-of-

pocket expenses and included an outpatient prescription drug benefit in addition to expanded hospital and skilled nursing facility benefits. The major provisions of that law were repealed a year later because of their exorbitant costs.

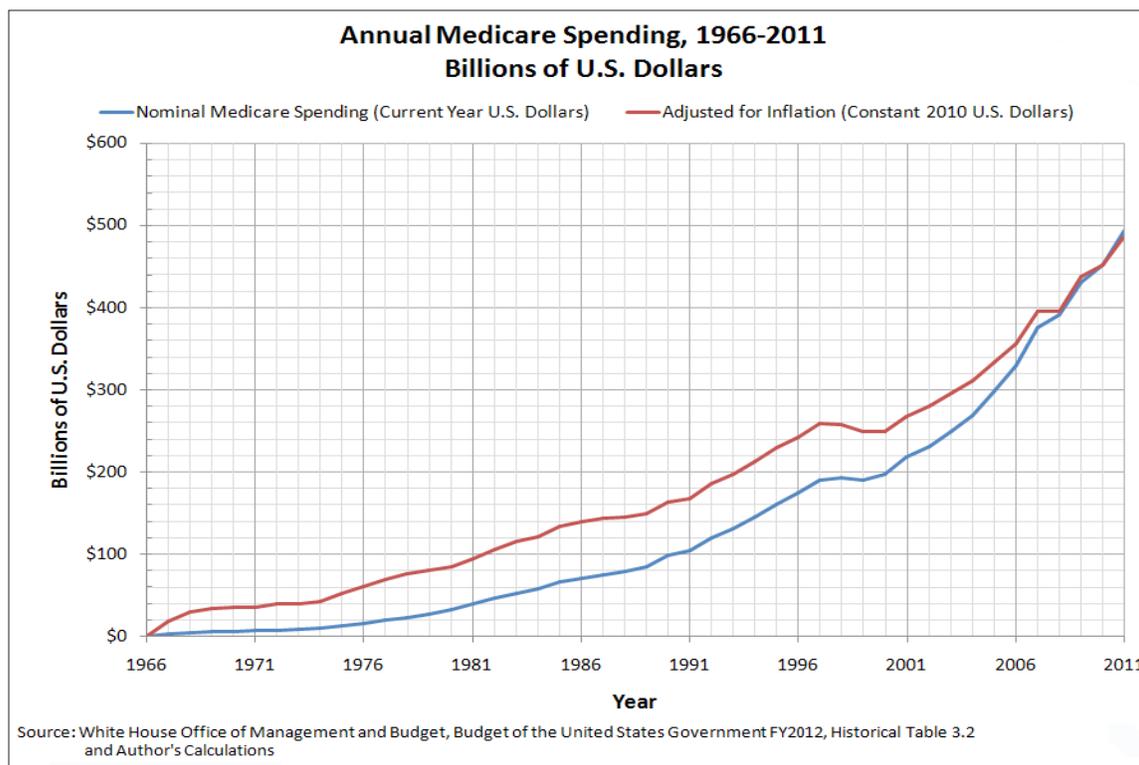
The Balanced Budget Act of 1997 introduced the "Medicare+Choice" program, or Part C, which gave Medicare beneficiaries the option of receiving their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Part A and Part B).

These programs became known as "Medicare Advantage" plans following the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which President George W. Bush signed into law on December 8, 2003, which introduced Medicare's Part D Prescription Drug Coverage benefit.

This new outpatient prescription drug program, which subsidizes the costs of prescription medications for Medicare beneficiaries, took effect on January 1, 2006. The Part D Prescription Drug Benefit represents the last major change to the Medicare health insurance program.

## II. HISTORIC SPENDING

Figure 1 reveals the trajectory of Medicare spending since the program was implemented in 1966, in terms of both nominal "Current Year" U.S. dollars and also inflation-adjusted, "constant" 2010 U.S. dollars. The following discussion will reference Medicare's nominal spending values, however, since these are the spending levels that the U.S. Congress specifically authorized for the program as part of the annual budgets of the United States Government.



**Figure 1: Annual Medicare Spending, 1966-2011 [15]**

Beginning with an annual budget of \$64 million in 1966, spending for Medicare ramped up quickly to nearly \$6 billion once fully implemented in 1969.

From 1969 through 1973, spending for Medicare increased at an average annualized growth rate of approximately 9.0% per year (3.9% in real terms), nearing \$8.1 billion in 1973.

But then, Medicare spending skyrocketed between 1973 and 1982, increasing at an average compound annualized growth rate of 21.5% per year (12.7% in real terms), reaching \$46.6 billion in 1982. That rate of spending growth slowed between 1982 and 1997 to an average of 9.8% per year (6.2% in real terms), which then dropped to just 1.2% between 1997 and 2000 (falling by 1.1% in real terms) as Medicare spending came in at \$197 billion.

The pace of spending for Medicare then

picked up again from 2000 through 2007, growing at an annualized clip of 9.6% (or 6.8% in real terms) to \$375.4 billion. Since that time, the growth of Medicare spending has slowed slightly to 7.1% (or 5.4% in real terms) annually, with total spending in 2011 estimated to be \$494.3 billion, according to White House projections [15] for the federal government's 2012 fiscal year, which we note is significantly less than the \$522.8 billion of actual spending reported by Medicare's Trustees [5] for 2010, suggesting that the White House's figures and projections may be somewhat understated.

Figure 2 presents the annual growth rates for the U.S. government's Medicare spending program from the previous year to the indicated year, spanning 1970 through 2010. Figure 3 presents the average spending per Medicare enrollee to help account for the growth in spending related to the various expansions

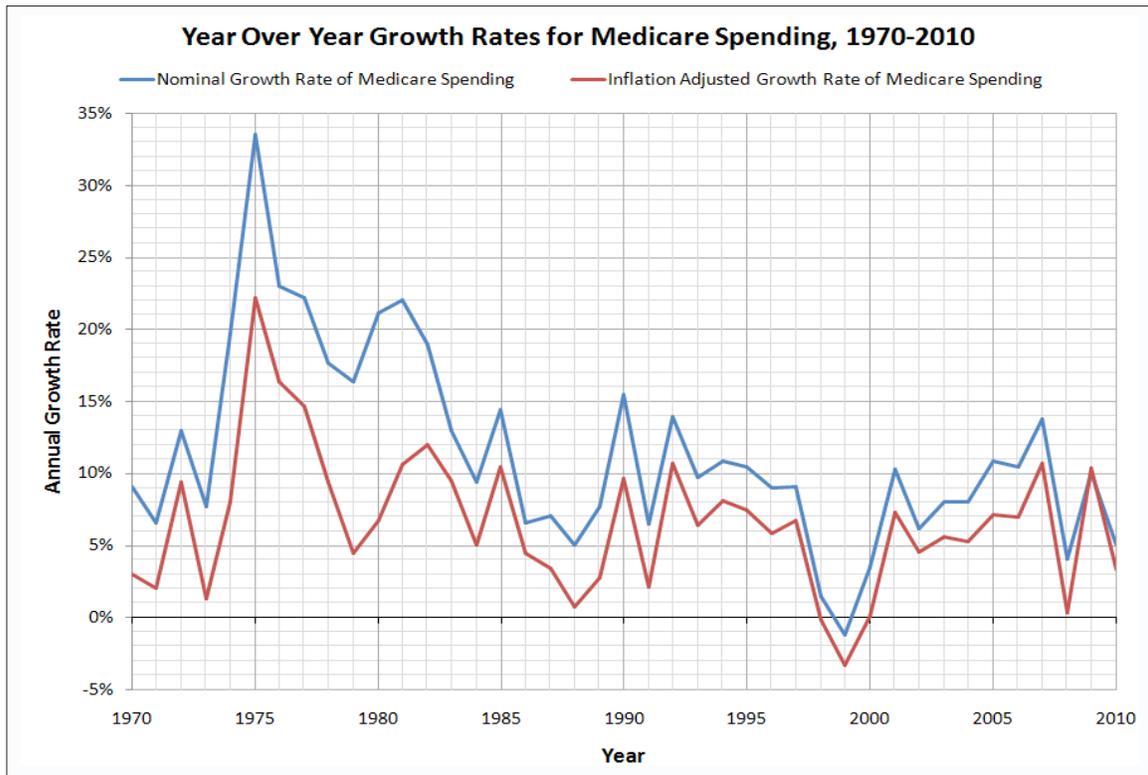


Figure 2: Year Over Year Growth Rates for Medicare Spending, 1970–2010

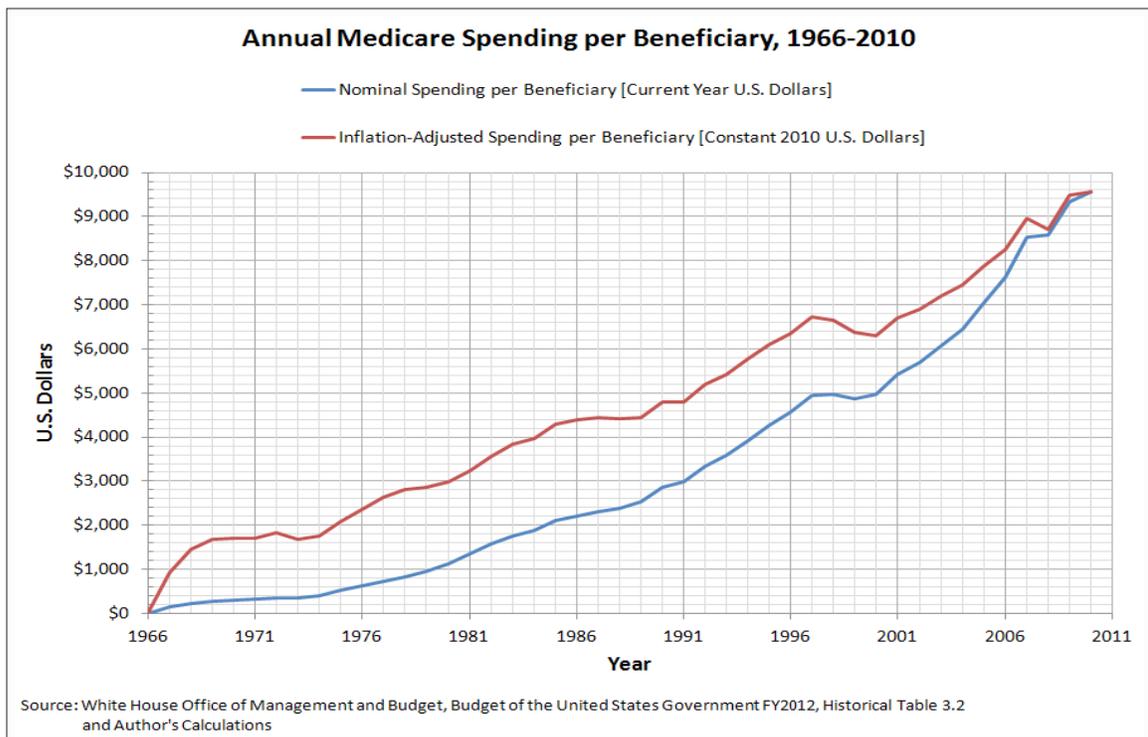
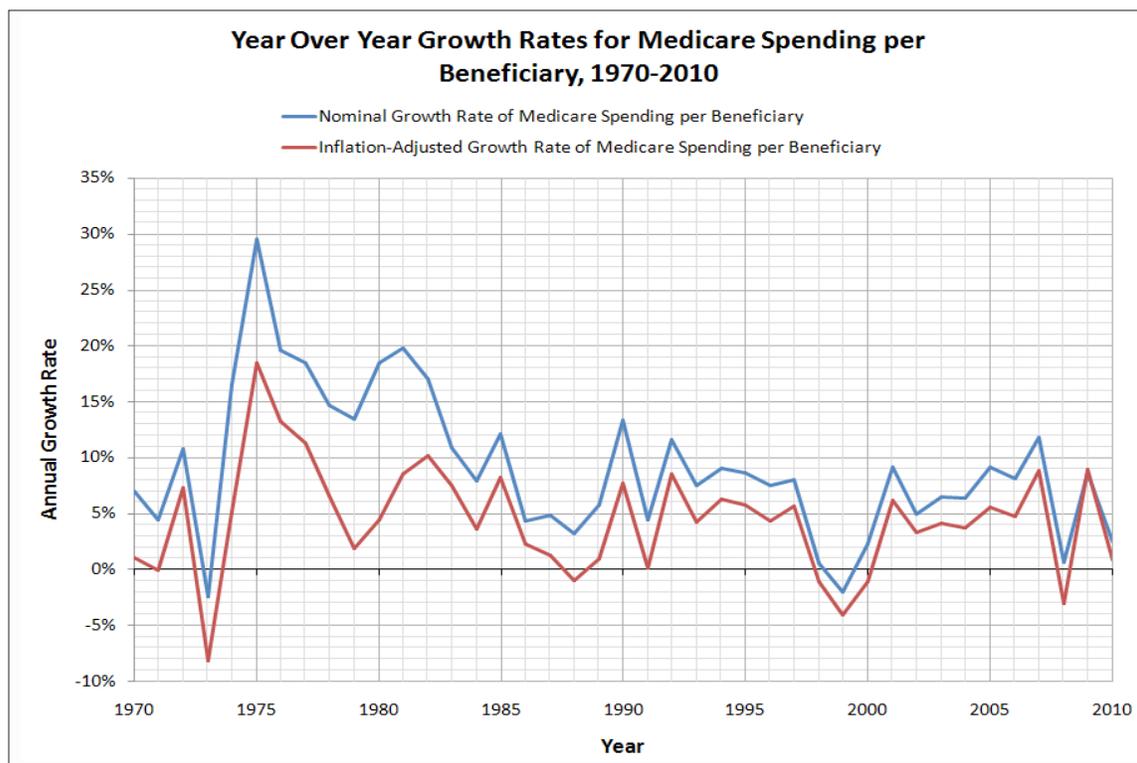


Figure 3: Annual Medicare Spending per Beneficiary, 1966–2010



**Figure 4: Year Over Year Growth Rates for Medicare Spending per Beneficiary, 1970–2010**

in the number of individuals enrolled in the Medicare program since its inception, in terms of both current year U.S. dollars and inflation-adjusted, constant 2010 U.S. dollars. Figure 4 presents the related year over year growth rates in spending per Medicare enrollee from 1970 through 2010.

### III. EFFORTS AT SPENDING CONTROL

From 1966 through 1980, the number of people covered by Medicare had grown from 19 million to 28.4 million, representing an average increase of 2.7% per year. Meanwhile, the deductible for Medical Part A coverage had grown from \$40 per year to \$180 per year, an average increase of 10.6% per year, and the premium for Medicare Part B had increased from \$3 per month to \$8.70 per month, an average increase of 7.4% per year.

However, the rate of growth of federal spending to support Medicare's Part A and

Part B programs was even greater than what Medicare's beneficiaries saw, rising annually at rates ranging from 7% to over 33% per year during much of this period of time.

These rising costs prompted the U.S. Congress to attempt to rein in the growth of Medicare spending in 1981 through the Omnibus Budget Reconciliation Act of that year, which boosted the deductible that Medicare patients would have to pay out of their own pockets under their Medicare Part A Hospital Insurance coverage.

That change was followed up in 1982 with the Tax Equity and Fiscal Responsibility Act, which increased the Part B premium paid by Medicare beneficiaries to cover 25% of program costs. This same 25% premium was applied to Medicare Part C when it was enacted in 1997 and to Medicare Part D when it took effect in 2006.

The U.S. Congress then turned to price controls to try to constrain the growth of Medicare spending, freezing the fees paid to physicians and setting fee schedules for laboratory services under the Deficit Reduction Act of 1984.

By 1985, the number of Americans enrolled in Medicare had grown to 31.1 million, while their Medicare Part A deductible had risen to \$400 per year and their Part B premium had risen to \$15.50 per month as a result of these changes.

The remainder of the 1980s and the 1990s saw the U.S. Congress making a number of changes aimed at reducing Medicare spending through the administration of the program, affecting payments for physicians and placing restrictions on their practices.

In 1990, Medicare had 34.3 million beneficiaries, an average annual increase of 1.7% from 1985. The Medicare Part A deductible had risen to \$592 per year, representing an average annual increase of 6.8%, while the Medicare Part B premium had risen to \$28.60 per month, or an average annual increase of 7.1%.

The Omnibus Budget Reconciliation Act of 1993 further modified payments to Medicare providers and more significantly, removed the cap on wages subject to the Hospital Insurance payroll tax.

By 1995, the number of Medicare beneficiaries had increased to 37.6 million, an annualized rate of growth of 1.5%. The deductible for Medicare Part A had increased by an average rate of 3.2% to \$716 per year, and the premium for Medicare Part B had increased at an annual growth rate of 8.3% to \$46.10 per month.

Between 1995 and 2000, it appeared that the federal government had succeeded in

controlling the rate of growth of Medicare spending. The total population of Medicare beneficiaries had risen by 0.9% per year to 39.7 million from 1995 to 2000. The Medicare Part A deductible had risen by 1.4% per year to \$776 and the Part B premium for Medicare beneficiaries had increased at an annualized rate of just 2.8% to \$54.4 per month.

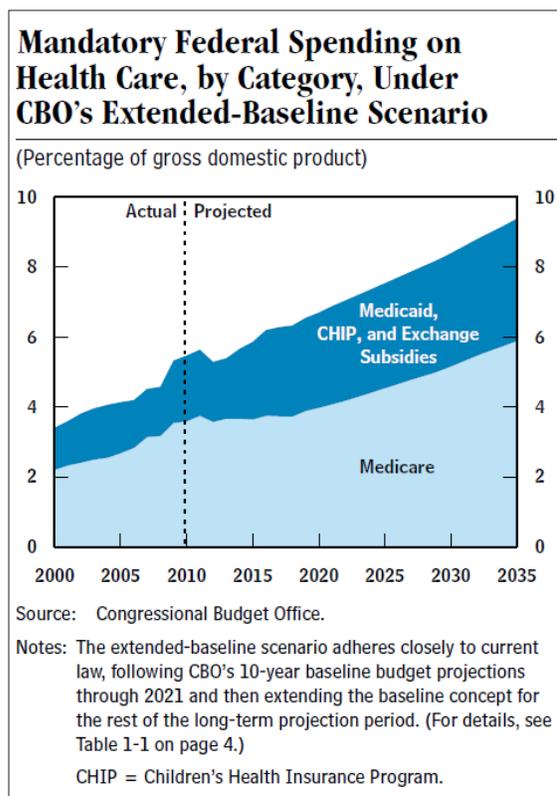
In 2005, some 42.6 million Americans were enrolled in Medicare, with 5.1 million enrolled through Part C. Between 2000 and 2005, the Part A deductible rose at an average rate of 1.2% for Medicare beneficiaries, while the Part B premium increased at an average annual rate of 6.2% to reach \$78.20 per month.

Alarms for the future fiscal solvency of Medicare were sounded in 2007, as the Medicare Board of Trustees issued a “Medicare funding warning.” Compared to 2005, total Medicare spending increased by more than 9.4% per year as Part D prescription drug benefits first went into effect. The year 2007 also saw the introduction of means testing for Medicare beneficiaries, with Part B premiums increasing for individuals with annual incomes over \$80,000 and couples with incomes over \$160,000.

#### **IV. PROJECTED FUTURE SPENDING**

In June 2011, the Congressional Budget Office (CBO) issued its annual report on the Long-Term Budget Outlook for the United States federal government. Figure 5 shows the projected amount of spending for the Medicare program through 2035 as a percent share of the nation’s Gross Domestic Product (GDP) under the CBO’s Extended-Baseline Scenario:

The CBO’s Extended-Baseline Scenario represents a “best case” scenario. In the chart above, we see that the projected federal spending for Medicare in 2011 of \$494.3 billion



**Figure 5: Mandatory Federal Spending on Health Care, by Category, Under CBO's Extended Baseline Scenario [6].**

represents approximately 3.7% of the United States' expected GDP for the year.

By 2035, the percentage share of GDP for Medicare is projected to reach about 6.0% of GDP under this "best case" scenario. In terms of 2011 dollars, the Medicare program alone would consume over 801.6 billion dollars in 2035, the result of real annualized growth of just under 2.0% a year.

The CBO's Alternative Fiscal Scenario foresees even higher levels of spending in the future. This scenario assumes that a number of highly unpopular cost-savings initiatives under current law will not be able to be sustained past 2021, such as the Independent Payment Advisory Board (IPAB) that is intended to set Medicare's payment schedules for physicians,

which was created as part of President Barack H. Obama's Patient Protection and Affordable Care Act of 2010.

With those alternative assumptions, the CBO anticipates that Medicare spending program will account for 7.0% of GDP in 2035, nearly double the amount of today's spending level, as the program would grow at an average annualized rate of roughly 2.6% per year.

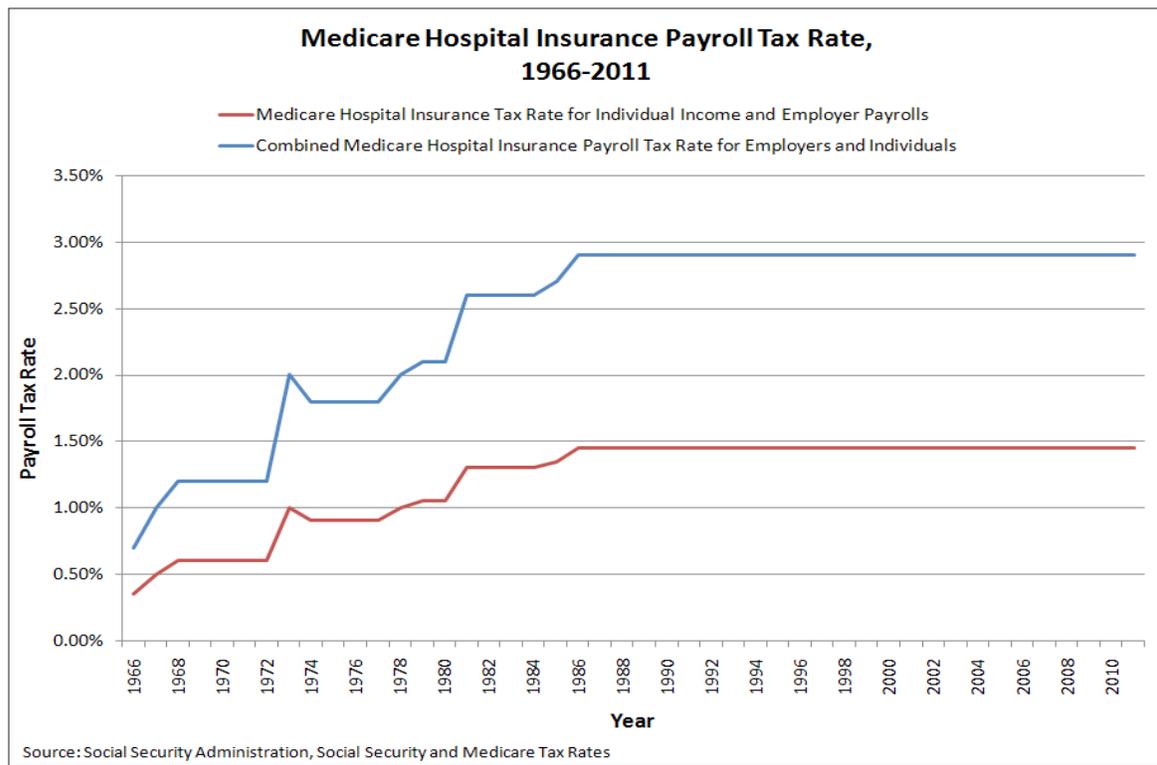
## V. FUNDING

Since its inception, Medicare has been funded by a flat payroll tax imposed on both businesses and individuals based upon the amount of wages and salaries paid by businesses to their employees. Figure 6 shows the tax rate imposed under Medicare's Hospital Insurance payroll tax.

From 1966 to 1986, the payroll tax rate for both employers and employees on the amount of wages and salaries paid to employees was steadily increased in small increments from an initial rate of 0.35% (0.70% combined) to 1.45% (2.90% combined.)

Initially, the amount of employee income that was subject to this tax was capped at \$6,600, but that figure was also increased steadily to reach \$51,300 in 1990. In 1991, the amount of income subject to Medicare's Hospital Insurance Tax was increased to \$125,000, which was then increased at approximate \$5,000 increments through 1993. Since 1993, all wage and salary income paid to individuals has been subject to the Medicare Hospital Insurance payroll tax.

Medicare's Hospital Insurance payroll tax will cease to be a flat tax on January 1, 2013, as a higher tax rate of 2.35% on wages and salary incomes over \$200,000 for individuals and \$250,000 for married couples will go into effect as part of the Patient Protection and Affordable



**Figure 6: Medicare Hospital Insurance Payroll Tax Rate, 1966–2011 [13]**

Care Act (ACA) of 2010. A new 3.8% tax upon “unearned income” will also be imposed on higher income earners, which includes investment income, life insurance proceeds, gifts and inheritances, Social Security benefits, and rental income [14].

## VI. NEW LESSONS FROM MEDICARE PART D

The introduction of the Medicare Part D prescription drug coverage program in 2006 came with some unique cost control elements which gave Medicare beneficiaries a direct economic stake in controlling the program’s costs.

One of those elements related to the structure of the deductible that beneficiaries would have to pay out of their own pockets for their prescription medications. Here, after paying an out-of-pocket deductible on the first \$250 of prescription drug costs, the program

then covered 75% of the next \$2,000 of a beneficiary’s prescription drug costs, but made the beneficiary fully responsible for paying the next \$2,850 in costs above that level. The program’s coverage would then kick back in and cover 95% of the beneficiary’s prescription drug costs once their annual expenditures exceeded \$5,100. The gap in coverage from \$2,250 through \$5,100 of annual prescription drug expenses is commonly known as the “doughnut hole.”

While largely successful in steering Medicare beneficiaries toward low-cost generic drugs, and thus limiting the government’s overall expenditures on prescription drugs below what they would otherwise have been without such an incentive, this cost-control aspect of the program has proven to be unpopular with Medicare beneficiaries. As one of the changes of the Patient Protection and Affordable Care

Act of 2010, the “doughnut hole” coverage gap is scheduled to shrink each year before disappearing after 2020, thereby eliminating this incentive for Medicare beneficiaries to act to control the program’s costs.

Another interesting aspect of Medicare’s Part D prescription drug coverage program is its use of competition among prescription coverage plan providers to lower the program’s overall expenditures. Here, Medicare beneficiaries must choose a prescription drug coverage plan from those offered by up to 50 competing providers. Research conducted by the University of Texas at Austin [9] found that Medicare beneficiaries significantly lowered their costs for the plans they chose between 2006 and 2007, the first two years of the program, by taking advantage of the competing options available to them—reducing both their out-of-pocket costs and also the government’s expenditures for subsidizing the program in the process. In the University of Texas study, some 81% of the study’s sample of 71,399 Medicare beneficiaries reduced their annual out-of-pocket costs for prescription drug coverage by an average amount of \$298.

The success of the strategy of providing Medicare beneficiaries with a direct economic stake in controlling the costs of the Medicare Part D prescription drug coverage program through these methods is reflected in the relative stability of the government’s expenditures per capita for this new portion of the Medicare program. Here, the Centers of Medicare and Medicaid Services reported in 2011 [5] that the government’s average annual cost of benefits per capita for Medicare Part D had risen from \$1,709 in 2006 to just \$1,789 in 2010, a 4.7% increase over that five-year period of time, or a compound annualized growth

rate of 0.9% per year—significantly less than the overall growth rate of health expenditures over that time.

It also appears that the existence of Medicare Part D is helping control the costs of Medicare’s Part A and Part B programs by helping people avoid hospitalization and visits to their doctors, even though the Medicare program’s overall spending has increased with its implementation. The National Center for Policy Analysis’ Greg Scandlen [11] explains the dynamics involved:

Proper use of drugs can help people avoid hospitalization and physician visits. That is the main reason employers and insurance companies have included prescription coverage over the past two decades. These savings on core services may not equal the costs of covering the drugs, but they help offset those new costs and result in better health for the covered population. So it is considered a net gain even if the total cost may be higher.

Only in Medicare are drugs treated as an entirely separate program. So the costs of coverage are all retained in the Part D program, but the savings are reaped by Parts A and B.

The segmentation of spending for Medicare into different plans is an important factor to recognize when comparing the historic cost performance of private versus public health insurance expenditures over time. Since Medicare has only provided prescription drug coverage since 2006, its historic rate of spending growth with respect to those of private health insurance providers before 2006 is not directly comparable, since most private insurers had prescription drug coverage in place for their beneficiaries for many years before that time.

Failing to take this fact into consideration may lead to the inaccurate perception that Medicare has been more efficient in administering health insurance programs than providers in the private sector. The falling expenditures for Medicare’s Part A and Part B programs evident today now that it also provides prescription drug coverage demonstrates that Medicare has long been spending far more money than it really needed to for its Part A and Part B components.

**VIII. AFFORDABILITY**

One element we have not yet discussed is the overall affordability of Medicare spending per U.S. household, which we may measure against the income of a typical American household over time. Figure 7 reveals what we find for the years from 1967 through 2010.

We observe that Medicare spending per U.S.

household grew at a steady rate with respect to median household income in the U.S. from 1967 through 1989, even though there were several major economic recessions during this period of time (1969, 1973, 1980, and 1982). Despite those negative economic conditions, Medicare spending per U.S. household remained closely coupled with the ability of a typical household to support that spending with its annual income.

That changed beginning with the economic recession of 1990–1991, as Medicare spending per U.S. household surged with respect to the median U.S. household income. That continued until 1998 when it appears that Medicare spending per U.S. household stabilized and even fell through 2000, averaging \$1,822 per household in that year.

However, the onset of economic recession in 2001 saw Medicare spending rise sharply,

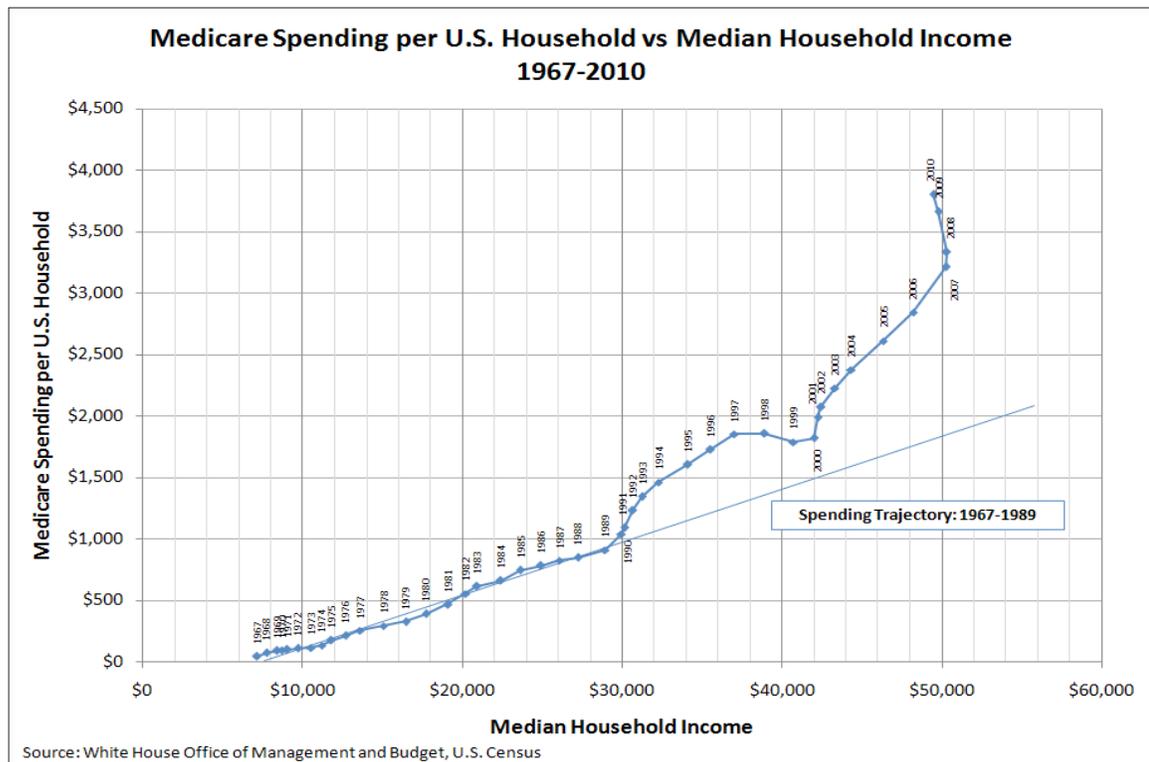


Figure 7: Medicare Spending per U.S. Household vs Median Household Income, 1967–2010

which continued through 2007 when Medicare spending per U.S. household reached \$3,215.

Since that time, the aftermath of the 2008 recession has seen Medicare spending per U.S. household skyrocket, even as median household income has fallen. In 2010, it had reached \$3,805 per American household.

Much of this spending reflects the continuing choice of U.S. politicians to decouple Medicare spending from the ability of American households to pay for it with their incomes since 1989. Consequently, spending on Medicare has become more and more unaffordable for those households over time.

Worse, with spending on Medicare no longer closely tied to the typical income earned in the United States, the decoupling of Medicare spending from the median household's income has weakened the economic incentive for health providers who accept Medicare health insurance to control their costs for the sake of being able to stay in business during times of economic distress, as they had to do during the first 32 years of the Medicare program. This effect has then resulted in making health care more and more costly over time as health providers who accept Medicare are effectively guaranteed to receive whatever increase in spending is provided for in the U.S. government's annual budgets.

We finally observe that the trajectory in Medicare spending per U.S. household with respect to median U.S. household income since 2007 is not sustainable, as Medicare spending is skyrocketing while the typical household income in the U.S. is falling.

## VIII. CONCLUSION

The amount of spending required to support the United States federal government's Medicare health insurance program is

projected to nearly double in real terms over the next 25 years.

Much of that spending growth will be dictated by demographics, as the very large Baby Boomer generation will reach Medicare's eligibility age of 65 during that time. Combined with an expected increase in longevity, the ranks of Medicare recipients will grow substantially, significantly increasing its costs over today's spending to support the program.

Currently, unknown factors, such as those driven by the increasing complexity of the Medicare program over time, may play a major role in increasing the cost of the program beyond officially projected levels. In the worst case, the federal government's cost control efforts may only succeed in transferring the costs of supporting the Medicare program onto other entities, such as health care providers, insurance companies or ultimately, individuals, who will bear the costs of benefits above and beyond those provided through Medicare and who will also bear opportunity costs as a result.

Since that cost transference would impose higher costs upon those entities, which, in turn, would lead to lower-than-projected economic growth along with correspondingly lower revenues for the government to support the program, the sustainability of Medicare spending may be at greater risk than official projections currently estimate.

To deal with those challenges to the sustainability of its spending, the federal government should draw upon the lessons being learned from the implementation of the Medicare Part D program. Here, the early indications are that giving Medicare beneficiaries a direct economic stake in lowering the costs of the program is successfully working to lower the amount of

spending needed to support the program, while also maintaining the quality of health insurance coverage.

Currently, a number of proposals related to reforming Medicare's core insurance programs to do just that are gaining bipartisan support through a concept called "premium support." Here, instead of a "one-size-fits-all" approach, Medicare beneficiaries would be able to choose overall health insurance coverage from options available from many providers, with the Medicare program providing a defined contribution toward covering the cost of the option they select.

Such a program would likely be modeled after the Federal Employees Health Benefits (FEHB) Program, which has been in place for the federal government's millions of employees and retirees since 1960 and today provides the benefits of health insurance to over 8 million people.

In fact, both Medicare Part C and Medicare Part D are modeled after portions of the FEHB program, which in part accounts for the relative success of these components of Medicare in controlling costs while providing better coverage as compared to the coverage available through just the traditional Part A and Part B components of Medicare. In 2011, the FEHB provided \$43 billion in health benefits for 8 million federal workers [16], representing an average annual cost of benefits of \$5,375 per enrollee.

This compares with the average benefit provided per Medicare enrollee of \$11,762 in 2010 [5]. We should note that the FEHB Program covers millions of people below the age of 65, who draw significantly lower benefits than those over the age of 65. For

those federal employees or retirees who are eligible for health insurance coverage through either Medicare or FEHB, the benefits provided through the FEHB program appear to be very similar to those available through the superior coverage available through Medicare Part C, which is perhaps the best apples-to-apples comparison.

Another important factor influencing the rising unsustainability of the Medicare program over time is the decoupling of the program's spending from the ability of typical American households to afford it on their incomes. Here, we would suggest that the United States should follow the examples of nations such as Switzerland and Sweden [17], which limit the growth of spending on social programs to the average rate of growth of their tax collections, which directly pace the growth of household income, and even act to reduce spending for their welfare programs during periods of economic distress, ensuring that the spending supporting the programs remain closely linked to the incomes of the people who must pay for them. Implementing similar economic reforms in the United States may go a very long way to bringing Medicare spending back under control.

Overall, these market-oriented reforms, which provide a direct economic stake to individual beneficiaries for controlling spending, may provide the key needed to bring the growth of the Medicare program's spending to sustainable levels well into the future.

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