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THE VAST, GROWING YET IGNORED MEDICARE CRISIS

Submitted to

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January, 2006

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EXECUTIVE SUMMARY

Part I — History

- Medicare was enacted in 1965; the first Medicare payments for health care began in 1966.
- In 1970, the number of Medicare beneficiaries approximated 20 million; the number of Medicare beneficiaries will exceed 42 million in 2006.
- Medicare prescription drug coverage, the biggest single change to the program since 1965, went into effect in January, 2006.
- Hospital coverage is funded via a payroll tax; other Medicare costs are funded from federal general revenues.

Part II — Impending Financial Crisis

- The Hospital Insurance Trust Fund is expected to be depleted by 2020.
- As “baby boomers” age, Medicare beneficiaries will grow to 70 million, or 21 percent of the total population, by the year 2025.
- The average payment per beneficiary is projected to increase by 75 percent (in current dollars) by 2025, largely as a result of advances in medical technology (including pharmaceuticals).
- Total Medicare costs (in current dollars) are expected to triple between 2005 and 2025.
- Medicare, as currently structured, is projected to equal 30 percent of all federal outlays by 2025.

Part III — Closing Medicare’s Fiscal Gap

- To close Medicare’s fiscal gap, Congress will have to (i) increase revenues available for Medicare, or (ii) reduce total outlays for Medicare benefits, or (ii) do some of each.
- Every option for closing the fiscal gap is difficult politically.

- Failure to curtail projected Medicare outlays will require massive increases in revenues — meaning:
  - higher taxes; or
  - higher payments by beneficiaries (premiums, co-pays, etc.).
- Long-term sustainability of Medicare will require a reduction in outlays, which can be achieved either by:
  - reducing the number of beneficiaries via a higher eligibility age; or
  - reducing the average outlay per beneficiary.
- All choices are tough and unpleasant, even to contemplate; however, since requisite changes must be phased in over many years, issues should be addressed sooner rather than later.

Part IV — Ignoring the Problem

- Neglect of Medicare's fiscal problem is bipartisan.
  - Both Presidential candidates ignored Medicare during the 2004 Presidential campaign.
  - Both parties seem to be ignoring Medicare now.
- The Bush Administration prefers to avoid discussing Medicare's looming fiscal issues:
  - Medicare was not mentioned in the 2005 State of the Union address. It was mentioned only briefly in President Bush's 2006 speech.
  - The chief actuary's cost estimate of the new Medicare drug program was suppressed.
  - Looming fiscal issues were not mentioned at the Medicare Board of Trustee's 2005 annual press conference.
- Congressional appropriations committees are forced to deal annually with incremental growth in Medicare outlays, but have a short-term outlook and no responsibility for detailed program restructuring.

- Substantive oversight committees have held no pertinent hearings, have no such hearings scheduled, and no pending legislation addresses the bigger, long-term issues of Medicare's finances.

- Only one recent report, by the Congressional Research Service, addresses Medicare's thorny fiscal future.

- In his State of the Union Address on January 31, 2006, President Bush announced his intention to create a bipartisan commission to study the impact of baby boomers upon Social Security, Medicare and Medicaid.

INTRODUCTION

Herbert Stein, Chairman of the Council of Economic Advisors during the Nixon Administration, was quoted as saying "If something is unsustainable, it tends to stop." This truism applies readily to Medicare.

Medicare was initiated in 1966. Since then, Congress not only has added new benefits to the program, but also has expanded the base of persons covered by the program. But as Congress's promises have expanded, America's ability to fulfill those promises has declined. As currently structured, Medicare will face serious financial problems in the next few years, and those problems will become untenable in the decades ahead.

Unless major reforms are made soon, the entire Medicare program runs a risk of simply collapsing. Congress has at its disposal a range of policy options, but none appear to offer an easy or ready answer for the Medicare program, as further changes to the program will result in adverse impacts for one constituency or another.

For example, if Congress were to cut Medicare benefits, many seniors' ability to receive quick and affordable medical care would suffer. If Congress were to make additional cuts in reimbursement rates to healthcare providers, it is likely that even more providers would refuse to treat Medicare beneficiaries, on grounds that the government is not competing adequately in the market for medical goods and services and thus Medicare beneficiaries are not cost-effective patients. Many medical providers would be unwilling or unable to provide medical service for below-market prices.

If Congress were to raise the payroll tax rate marginally in order to "buy some time," the increase soon will be insufficient and it will become evident that yet further changes must be made. Such tax increases will become a "slippery-slope" for Congress, as legislators attempt to play catch-up with upward-spiraling Medicare costs. Moreover, continual tax increases likely would prove to have an adverse affect on the economy and job creation.

If Congress were to attempt to fund Medicare by borrowing (either from the United States public or from foreign investors), then stability of the Medicare program and the health of America's senior citizens will come to rest on the necessarily-limited ability and willingness of lenders to finance America's financial deficit.

Nevertheless, decisive action simply must be taken. If Congress continues on its current track, the opportunity to phase in changes gradually will have been squandered. If Congress waits until late in the day when it is forced to make wrenching changes, the problem may be truly insolvable and the program utterly unsustainable.

I. BRIEF HISTORY OF MEDICARE

A. Origins of Medicare

Although Medicare was not enacted until 1965, proposals for a Medicare system extend back as far as those of Social Security in the 1930's. While discussions were taking place as how best to provide retirement benefits to those age 65 and older, so too were officials concerned with providing universal, reliable and efficient medical care for America's older citizens.

In the years during and following the Great Depression, senior citizens not only were the most likely to be living in poverty (leading to the creation of Social Security), but also, because many were in poverty, they were the most likely to be without adequate health insurance — or any health insurance at all. The severity of this situation was compounded by the fact that senior citizens generally were the age group with the greatest medical needs.

Early proponents of national medical insurance were opposed by many, including members of the medical profession — who warned of "the dangers of socialized medicine."[1]

In 1945, Harry Truman pushed, unsuccessfully, for a national health insurance plan designed to provide universal coverage to all Americans.[2]

By 1950, the number of senior citizens had grown to 12 million and, throughout the 1950's, "the single greatest cause of economic dependency in old age" was "the high cost of medical care." The cost of medical care far outstripped seniors' ability to pay; as a result, in 1950, only about 13 percent had health insurance.[3]

By 1963, the number of senior citizens had reached 17.5 million and was growing. So too was the need for comprehensive, affordable health insurance. Even as late as 1965, only about half of all seniors had any health insurance

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[1] Houghton Mifflin.

[2] Senior Journal. 2005.

[3] Medicare Rights Center. 2005.

coverage.[4] Thus, the consensus (whether correct or mistaken) was that the free-market — given the opportunity — had failed to provide what the government now believed it could — universal, comprehensive health care for senior citizens.

On April 8, 1965, the House of Representatives passed the **Social Security Amendments of 1965**, H.R. 6675. The bill created Title XVIII and Title XIX of the Social Security Act. On July 30, 1965, President Johnson signed H.R. 6675 into law as Public Law 89-97.[5] The Amendments created the Medicare and Medicaid programs, providing health insurance for those **over age 65**.

Upon its inception, the Medicare program consisted of two parts: Hospital Insurance **(HI)**, known as **Part A,** which pays the basic hospital bills for senior citizens, and Supplementary Medical Insurance **(SMI)**, known as **Part B**, which pays for a large portion of seniors' doctor bills and other health care bills.[6] Not covered under either program were prescription drugs, as many were concerned that the cost of such an extensive program easily would spiral out of control. On July 1, 1966, the Medicare program took effect, more than 19 million individuals enrolled, and payments were begun to hospitals and medical professionals.[7]

B. Growth of Medicare

The Medicare program operated more-or-less unchanged until Congress passed the **Social Security Amendments of 1972**.[8] These amendments extended Medicare benefits to **disabled persons under age 65**, so long as they had been covered and were receiving benefits for at least two years under Social Security.[9] This change significantly expanded the pool of potential beneficiaries.

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[4] CMS. 2004.

[5] SSA. 1999.

[6] OurDocuments.gov.

[7] CMS. 2004.

[8] On May 19, 1967, a Task Force on Prescription Drugs was created in order to research the possibility of adding drug coverage to the Medicare program. It released its final report in May of 1969, but no legislation regarding drug coverage was passed at that time.

[9] Senior Journal. 2005.

In 1985, Congress passed the **Consolidated Omnibus Budget Reconciliation Act** (COBRA).[10] This act "extended mandatory Medicare coverage to nearly all **State and local government employees** hired after December 31, 1985."[11]

Thus, beginning shortly after its inception, the group of people eligible to receive benefits under the Medicare program has been expanded many times. Medicare beneficiaries have grown not only in absolute numbers, but also as a percentage of the total population. Today **14.7 percent** of the U.S. population receives Medicare benefits (*see* Table 3).

Not only has the number of Medicare beneficiaries increased substantially, but also new and increased benefits have been added to the program. This combination — more beneficiaries and more benefits — has caused cost of the program to increase both absolutely and as a percentage of GDP. In **1970**, the entire cost of the Medicare program was $7.1 billion, which was equivalent to **$34.6 billion** in 2004 dollars. By **2004**, this cost has increased nearly to **$301.5 billion**.[12] In the last 25 years, the real cost of the program has increased fourfold, and has increased almost by a factor of nine in the last 35 years.[13] Table 1 shows growth in the number of beneficiaries (column 1), real program cost (column 4), and real cost per beneficiary (column 5), from inception through 2004.

In 1997, Congress passed the **Balanced Budget Act of 1997.** Among other things, the act **shifted** financial responsibility for a portion of Medicare Part A to Medicare Part B. This was done because Part A, funded only by the payroll tax, **was approaching financial insolvency**. Transferring some of Part A's financial burden helped to reduce the total cost of Part A and delay possible insolvency of the HI trust fund. It did not, however, greatly reduce the total cost of the program. Of the costs shifted to Part B, approximately three-fourths are funded from general revenues and the remaining one-fourth are funded by premiums charged to beneficiaries (*see* Section D, *infra*, for more discussion on funding of Medicare).

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[10] P.L. 99-272.

[11] SSA. 1996. (emphasis added).

[12] CMS. 2005a. p. 177.

[13] Calculated by dividing the real cost of Medicare in 2004 by the real cost of the program in 1980 and in 1970.

Table 1
Medicare Beneficiaries and Costs
1970-2004

Year	Number of Beneficiaries (thousands)	Cost (billions, Nom. $)	Average Payment Per Beneficiary (Nom. $)	Cost (billions, 2005 $)	Average Payment Per Beneficiary (2005 $)
	(1)	(2)	(3)	(4)	(5)
1970	20,398	7.1	356	36	1,793
1975	24,864	14.8	642	54	2,322
1980	28,433	35.0	1,285	83	3,047
1985	31,081	71.4	2,322	130	4,217
1990	34,251	109.7	3,267	164	4,884
1995	37,594	180.1	4,953	231	6,351
2000	39,688	219.3	5,653	249	6,415
2004	41,656	301.5	7,542	312	7,802

Source: Columns 1-3 come from the report of the Medicare Board of Trustees, pp. 30, 177 and 151, respectively. Columns 4 and 5, have been calculated using the Bureau of Labor Statistics CPI Inflation Calculator, at http://data.bls.gov/cgi-bin/cpicalc.pl.

The Balanced Budget Act of 1997 also "established the **National Bipartisan Commission on the Future of Medicare** to develop reforms in anticipation of the baby boomers' retirement."[14] The Commission's study developed what became known as the Breaux-Thomas proposal, which recommended combining Medicare Parts A and B to allow beneficiaries to choose from a menu of health plans. Also proposed was **raising** the Medicare **eligibility age** from 65 to 67, in line with the normal retirement age for Social Security.[15] The report, though, was never officially transmitted to Congress, as it "did not receive the needed 11 of 17 commission member votes."[16]

In 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, better known as the **Medicare Modernization Act ("MMA").**[17] The MMA created Medicare Part D, which expanded Medicare

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[14] Rettenmaier. 2003. (emphasis added).

[15] Under current law, the normal retirement age under Social Security will rise to age 67 by the year 2027.

[16] *Id.*

[17] The Bill was introduced in the House as H.R. 1 and passed on June 27, 2003. Shortly thereafter, the Senate passed S.1 and, on December 8,
(continued...)

benefits to include the option of prescription drug coverage for all those covered under the Medicare program. These provisions are considered "the most dramatic and innovative changes to the Medicare program since it began in 1965."[18] The MMA, however, did not prescribe specific funding for the new program, other than small beneficiary premiums and general revenue transfers.

C. Governance

The Amendments to the Social Security Act that initially created Medicare also established a **Board of Trustees** ("BOT") for each of the two programs, HI and SMI, to oversee operations of the respective trust funds and to report annually on the financial status of the Medicare program. All members serve on both boards and, additionally, are the same members that comprise the Social Security Board of Trustees.

Under the Social Security Amendments of 1983, two public/independent positions were added to the BOT's. Currently, six members serve on the board. Four serve by virtue of their positions in the federal government: (i) the Secretary of the Treasury, (ii) the Secretary of Labor, (iii) the Secretary of Health and Human Services, and (iv) the Commissioner of Social Security. The two other public/independent members are appointed by the President.[19]

D. Funding Medicare

1. Sources of Funding

Each component of the Medicare program has separate and distinct funding sources. Part C refers to private Medicare Advantage plans, such as HMOs, that provide Part A and B benefits to enrollees. The costs and financing of Part C are reflected in the data for Parts A and B.

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[17](...continued)
2003, the MMA was signed into law by President Bush. *See* White House, 2003.

[18] CMS. 2005b.

[19] CMS. 2005a. As of the date of this report, the current public/independent members of the BOT were: (i) John L. Palmer, Senior Research Associate at the Center for Policy Research and Dean Emeritus of the Maxwell School of Syracuse University and (ii) Thomas R. Saving, Senior Fellow at the National Center for Policy Analysis. http://www.ssa.gov/history/reports/trustees/historypt.html

Part A is funded exclusively by a payroll tax. This payroll tax rate has been increased eight times, from 0.7 percent of taxable payroll in 1966 to 2.9 percent in 1986, where it remains today (half paid by employers, half by employees).[20] Starting in 1984, all self-employed persons were required to pay both the employee's and the employer's share of the tax to make up for what the government considered lost revenue.[21] Unlike the Social Security payroll tax, the Medicare payroll tax has no cap, so employers and employees pay the Medicare tax on all wages and salaries, from the first dollar to the last. If future expenses under part A grow disproportionately to taxable wages, it will necessitate either further tax increases or benefit limitations.

Part B is funded in a small part by premiums paid by Medicare beneficiaries, but is funded primarily from the general tax revenues of the United States.

Part D, slated to begin in 2006, is funded only to a small extent by premiums, drug co-payment by beneficiaries and transfers from state Medicaid programs, and is funded primarily from general tax revenues.[22]

Unlike HI or Social Security, for which income and costs must balance annually, Medicare Parts B and D have financing that is "reset each year to match expected costs."[23] Annual increases in premiums paid by beneficiaries will provide some additional revenues, and general revenue transfers simply will make up the difference. This means that **Medicare Parts B and D never will show unfunded liabilities**. As discussed in Section III, however, growth of these programs in the future will impose a fiscal strain on the federal budget.

2. Premiums and Cost for Part B (SMI)

From 1984 to 1990, premium levels were set at a level necessary to cover 25 percent of Part B costs. The **Omnibus Reconciliation Act of 1990** established, by statute, premium levels for 1991 through 1995. However, the

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[20] SSA. 2002.

[21] *Id.*

[22] Peck. 2005.

[23] CMS. 2005a. p. 3. Every year, the funding for Parts B and D is "reset." In order to meet projected costs for the coming year, a portion of the general revenue is dedicated to the Medicare program. Additionally, in order to offset a fixed portion of the projected costs, beneficiary premiums are either raised or lowered.

Omnibus Reconciliation Act of 1993 requires Part B premiums to fund approximately 25 percent of Part B costs.[24] Since Part B cost varies greatly by year, and premiums must be established prior to the beginning of the year, the task of accurately estimating annual premiums has been daunting.

Table 2 shows premiums for Medicare Part B from 1984 to 2006. Monthly premiums are shown in column 2, and annual premiums in column 4. The average cost per person is shown in column 5 and one-fourth of that cost, the amount that should be paid by beneficiaries is shown in column 6. The difference between the annual premium in column 4 and the actual cost in column 6 is shown in column 7. The difference as a percent of the yearly premium is in column 8. As indicated above, setting premiums accurately has been a challenge. During the last two decades, premiums have been set both too high and too low. In some years, Medicare beneficiaries have overpaid by as much as 10 percent (1989 and 1995) and, in other years, they have underpaid by as much as 15 percent (2002-2003). For the period shown in Table 2, however, the cumulative premiums approximate the 25 percent goal – being 24.6 percent of the cumulative costs.

Between 1984 and 2006, premiums for Medicare Part B have increased at a compound annual rate of 8.5 percent. This is more than double the annual increase in the cost-of-living index during those years. In 2005, Part B premiums were $78.20, up 17.4 percent from $66.60 in 2004. In 2006, premiums are slated to rise to $88.50, a further increase of 13.2 percent from 2005. In 2006, **the annual premium increase for Part B will be $124,** which is one-fourth the average cost-of-living increase in Social Security (**$468 a year for 2006**, for an average total benefit of $1,002 per month).

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[24] SSA. 1996.

Table 2
Medicare Part B (SMI): Premiums and Cost
1984-2006

Year	Monthly Premium	Annual Increase (%)	Annual Premium	Avg Cost/ Person	25% of Average Cost/ Person	Difference (4) – (6)*	Avg. (%)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1984	$14.60		$ 175	$ 692	$173	$ 2.10	1.2
1985	15.50	6.2%	186	768	192	-6.00	-3.2
1986	15.50	0.0	186	875	219	-32.80	-17.6
1987	17.90	15.5	214	982	245	-30.80	-14.3
1988	24.80	38.5	297	1,090	272	25.20	8.5
1989	27.90	12.5	334	1,197	299	35.60	10.6
1990	28.60	2.5	343	1,304	326	17.20	5.0
1991	29.90	4.5	358	1,440	359	-1.15	-0.3
1992	31.80	6.4	381	1,576	393	-12.30	-3.2
1993	36.60	15.1	439	1,711	427	11.35	2.6
1994	41.10	12.3	493	1,847	461	31.40	6.4
1995	46.10	12.2	553	1,983	495	57.45	10.4
1996	42.50	-7.8	510	1,900	475	35.00	6.9
1997	43.80	3.1	525	1,996	499	26.60	5.1
1998	43.80	0.0	525	2,071	517	7.85	1.5
1999	45.50	3.9	546	2,180	545	1.00	0.2
2000	45.50	0.0	546	2,381	595	49.25	-9.0
2001	50.00	9.9	600	2,646	661	-61.50	-10.3
2002	54.00	8.0	648	2,992	748	-100.00	-15.4
2003	58.70	8.7	704	3,227	806	-102.35	-14.5
2004	66.60	13.5	799	3,478	869	-70.30	-8.8
2005	78.20	17.4	938	3,794	948	-10.10	-1.1
2006	88.50	13.2	1,062	3,970	992	69.50	6.5
Sum			**$11,369**	**$46,100**	**$11,525**	**-$156.30**	**-1.4%**

* Positive numbers represent beneficiary overpayment, negative numbers represent underpayment. Note: Data in Columns 5&6, 1986-1989, 1991-1994 have been interpolated.
2005 BOT Report, p. 151
http://www.cms.hhs.gov/media/press/release.asp?Counter=237
http://www.hhs.gov/news/press/1995pres/951013b.html
http://thomas.loc.gov/medicare/anne.html
Note: Columns may not add to totals due to rounding.

3. 2004 Income and Finances for Part A (HI) and Part B (SMI)

In calendar year 2004, revenue for **Part A (HI)** amounted to $183.9 billion. Of that revenue, 85.2 percent was derived from the payroll tax, 8.2 percent from interest payments on funds in the HI trust fund, 4.6 percent from taxation of Social Security benefits, and 2.0 percent was from other sources.

In calendar year 2004, Part A (HI) expenditures totaled $170.6 billion, 98.2 percent of which went to pay benefits, and 1.8 percent was used to administer the program.[25]

In calendar year 2004, **Part B (SMI)** received total funding of $133.8 billion, of which 75.0 percent consisted of general revenue transfers, 23.5 percent came from beneficiary premiums, 1.1 percent came from interest payments on funds in the SMI trust fund and 0.3 percent was from other miscellaneous sources. SMI expenditures totaled $138.3 billion, consisting of 98.0 percent for benefit payments, and 2.0 percent to administer the program.[26]

In calendar year 2004, 49.3 percent of **total Medicare** expenditures was financed by payroll taxes, 31.8 percent came from general revenue transfers, 10.5 percent was from beneficiary premiums, 5.2 percent came from interest on trust funds, 2.7 percent came from taxation of social security benefits, and 0.5 percent came from miscellaneous sources.

At the end of 2004, total **trust fund** holdings for HI and SMI rose $8.8 billion over what they were at the end of 2003. HI experienced a surplus of $13.3 billion, while SMI's operation resulted in a deficit of $4.5 billion.[27] The HI Trust Fund totaled $269.3 billion, while the SMI Trust Fund balance was, as always, $0, after being reset for the next year's financing.

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[25] CMS. 2005a. p. 4.

[26] *Id*. p. 4. (Components do not necessarily add to totals, due to rounding).

[27] *Id.* p. 4.

II. MEDICARE'S IMPENDING FINANCIAL CRISIS

The history and growth of the Medicare program to date was discussed in Section I. This section examines where Medicare, as presently structured, appears headed during the next 20 years.

The 20 year outlook is somewhat more certain than a more long term projection beyond 2025 for a number of reasons. First, everyone who will join the labor force in the next 20 years already has been born. Even if the country should experience another "baby boom" period later in this century, the size of the labor force over the next 20 years would not be affected. Second, barring something catastrophic, such as a major pandemic, size of the population over 65 during the next 20 years also is highly predictable. Third, no major technological breakthroughs that might reduce health care costs — such as an inexpensive "miracle cure" for cancer — appear to be on the near-term horizon.

The Trustees' long-range projections, extending out 75 years to 2080, can be found in Appendix A.

A. 2005 Medicare Board of Trustees' 10-Year and 20-Year Projections

The Board of Trustees relies on the Office of the Social Security Chief Actuary for its projections. The Office of the Chief Actuary predicts the outlook for Medicare finances on the basis of a large, complex model that includes all of the more important predictable factors influencing Medicare costs.[28] Since every underlying factor is subject to some uncertainty, the Chief Actuary offers three cost projections, described simply as **low, intermediate and high**. These three projections are updated each year to take account of the most recent data, and the latest projections are considered to be the most authoritative projections available.

As discussed below, the Chief Actuary's projections, adopted and endorsed by the Trustees, along with their accompanying comments, document the major problems facing Medicare. Consequently, one need not look for any private sector Cassandras to foresee major storm clouds on the horizon.

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[28] A one-time, non-recurring unpredictable event, such as a major flu pandemic, could alter the forecast significantly.

1. Growth in Medicare Beneficiaries, 2005 to 2025

By itself, the gradual but steady increase in life expectancy would cause an increase in the relative size of the population over 65, and the total number of Medicare beneficiaries.[29] This projected growth in beneficiaries is one of two major driving forces underlying the financial projections discussed below.

During the decade 2005-2015, as the so-called baby boomers begin reaching age 65, the number of Medicare beneficiaries is expected to grow by 11 million, or 26 percent, from 42 million to 53 million.[30] Over the ensuing decade, 2015 to 2025, beneficiaries are expected to grow by an additional 17+ million, or 34 percent, from 53 million to almost 71 million. These projections are shown in Table 3, column 1. Since the number of persons who will reach age 65 within the next 20 years is a subset of a known population, this estimate involves the least amount of uncertainty of any projection discussed in this section.

To put the above growth rates into perspective, in the 2005 to 2015 time frame, the total U.S. population is expected to grow by 8.5 percent, or **24.6 million** people. The number of new Medicare beneficiaries over this same period is expected to grow by **10.8 million,** a number that is a **little less than half** of the total population growth. However, during the next decade, from 2015 to 2025, the total population is expected to grow by 8.2 percent, or another **25.5 million**, while the number of new Medicare beneficiaries will increase by **17.4 million**, which **slightly-exceeds two-thirds** of the population growth.[31] This comparison reflects the aging of the baby boomers.

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[29] The increasing health care expenditures for people over 65 may be one factor contributing to the increase in average life expectancy.

[30] *Id.* p. 30.

[31] Data sets from the 1990 Census.

Table 3
Increasing Number of Medicare Beneficiaries
1970-2025

Year	Number of Beneficiaries (thousands)	Percentage of Total Population
	(1)	(2)
1970	20,398	9.95%
1975	24,864	11.51
1980	28,433	12.51
1985	31,081	13.06
1990	34,251	13.73
1995	37,594	14.31
2000	39,688	14.42
2005	42,301	14.70
2010	46,328	15.45
2015	53,092	17.00
2020	61,339	18.88
2025	70,512	20.87

Source: Appendix A, Table A-2.

2. Growth in the Average Payment per Beneficiary

During the last 20 years, 1985-2005, in real (constant) dollars, Medicare **expenditures per beneficiary** roughly have doubled and, over the next 20 years, they are projected to almost double again (*see* Table 4, column 5). The increase in per capita expenditures is the second driving force underlying the financial projections for Medicare.

Two factors — the increasing number of beneficiaries, coupled with the increased cost per beneficiary — are each projected to have a major effect on total Medicare spending during the next 20 years. The **projected continuation of the increase in expense for each beneficiary** reflects a number of considerations. The two most important of these are (i) the new drug benefit under Part D, which takes effect in 2006, and (ii) further improvements in medical technology.

From 2005 to 2015, the overall **real** annual cost of the Medicare program is expected to increase by 84 percent, from **$333 billion** in 2005 to **$611 billion** in 2015. Ten years later, by 2025, the overall **real** annual cost of the program is

expected to climb another 64 percent, to over **$1 trillion** (*see* Table 4, column 4).[32]

Table 4
Rising Cost of Medicare: Parts A, B and D
1970-2025

Year (a)	Number of Beneficiaries (thousands)	Total Cost in Billions (Nom. $)	Average Payment Per Beneficiary (Nom. $)	Total Cost in Billions (2005 $)	Average Payment Per Beneficiary (2005 $)
	(1)	(2)	(3)	(4)	(5)
1970	20,398	$ 7	$ 356	$ 36	$1,793
1975	24,864	15	642	54	2,322
1980	28,433	35	1,285	83	3,047
1985	31,081	71	2,322	130	4,217
1990	34,251	110	3,267	164	4,884
1995	37,594	180	4,953	231	6,351
2000	39,688	219	5,653	249	6,415
2005	42,301	333	8,081	333	8,081
2010	46,328	552	12,702	474	10,908
2015	53,092	829	15,619	611	11,518
2020	61,339	1,247	20,337	790	12,878
2025	70,512	1,841	26,110	1,001	14,198

Source: Appendix A, Table A-3.

B. Assessing Solvency

Since different parts of Medicare are financed differently, issues concerning solvency for the various parts need to be discussed separately.

1. Solvency of Medicare Part A

During the course of a year, expenses for HI are paid from (i) money already in the HI Trust Fund plus (ii) current inflows into the fund, most of which come from the payroll tax. So long as these two sources of funds are sufficient to pay all bills, the HI program technically can be considered solvent. However, the Medicare BOT measures solvency of the HI Trust Fund in terms of the "trust fund ratio," which is the amount in the Trust Fund at year end divided by expenditures in the preceding year. The BOT is under no illusion that technical solvency is sufficient, and it defines **adequate solvency** as follows:

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[32] *Id.* p. 177.

> If the HI **trust fund ratio** is at least 100 percent at the beginning of the projection period, then it must be projected to remain at or above 100 percent throughout the 10-year projection period;
> (ii) alternatively, if the fund ratio is initially less than 100 percent, it must be projected to reach a level of at least 100 percent within 5 years (and the trust fund not be depleted at any time during this period), and then remain at or above 100 percent throughout the rest of the 10-year period.[33]

The trustees state that: "**HI tax income fell short of HI expenditures in 2004**, creating an imbalance for the first time since 1998. . .[and]. . **"[t]he HI trust fund does not meet this [10-year] test [of short-range financial adequacy**] because assets are estimated to fall below 100 percent of annual expenditures during 2014."[34] Consequently, "[t]he **HI trust fund is not adequately financed over the next 10 years** under the intermediate assumptions."[35]

Although it appears that Part A of the Medicare program should be **technically solvent** for the next 15 or so years, that solvency does not make it adequately solvent or sustainable into the future, as discussed in section D, below.

2. Solvency of Medicare Parts B and D

As indicated previously in Section I.D.1, Supplementary Medical Insurance (which now includes the new drug benefit provision under Part D) is financed separately from Part A. Consequently, solvency with regard to SMI is not related to solvency of Part A (HI). Moreover, solvency of SMI is not an issue, since it does not rely on payroll taxation and, instead, is financed from general revenues of the Treasury. Solvency of SMI is a function only of the federal government's willingness and ability to pick up the tab. Consequently, the BOT reports SMI to be "adequately financed under current law." The trustees make it clear, though, that simply being "adequately-financed" does not mean that Medicare Parts B and D are sustainable. In fact, the BOT states bluntly that

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[33] *Id.* pp. 49-50. (emphasis added).

[34] *Id.* p. 13 (emphasis added).

[35] *Id.* p. 2 (emphasis added).

"[t]he financial outlook for the Medicare program continues to raise **serious concerns**."[36]

C. Problems with Sustaining Medicare as Presently Structured

Clearly, Medicare is in trouble. Every indicator points to the fact that, barring substantial changes to the program, within one or two decades, it will become exceedingly difficult, if not impossible, to sustain Medicare.[37]

1. Exhaustion of the HI Trust Fund

Although Medicare Part A appears to be more-or-less "solvent" for the next 15 or so years, the trustees have not minced words. Succinctly, costs are expected to increase faster than revenues, and the trustees warn that "[u]nder the high cost assumptions, **asset depletion** would [begin to] occur **in 2013**."[38] The trustees further estimate that, "[u]nder the intermediate assumptions **the HI trust fund is projected to be exhausted in 2020,** one year later than projected in last year's report, due to slightly higher income and slightly lower cost in 2004 than previously estimated. . . . [and at that point] without additional legislation and funding, Medicare Part A will be unable to pay its bills. . . . [and] closing deficits of this magnitude **will require very substantial increases in tax revenues and/or reductions in expenditures.**"[39] Once the HI trust fund is exhausted in 2020, HI tax revenues will be sufficient to finance only **79 percent** of obligations and, at the end of the long-range [75-year] period revenues will be sufficient to cover only **27 percent** of obligations.[40]

The trustees conclude that "[w]ithout corrective legislation ... the assets of the HI trust fund would be exhausted within the next 8 to 15 years under the high cost and intermediate assumptions. The fact that exhaustion would occur under a fairly broad range of future economic conditions, and is expected to occur in

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[36] *Id.* p. 3 (emphasis added).

[37] Medicare is not alone in this regard. Many developed countries in Europe, as well as Canada and Japan, also face the problem of providing health care for an aging population. *See* PWC. 2005.

[38] CMS. 2005a. p. 17 (emphasis added).

[39] CMS. 2005a. p. 3 (emphasis added).

[40] *Id.* pp. 2-3 (emphasis added).

the not-distant future, **indicates the importance of addressing the HI trust fund's financial imbalance**."[41]

2. Sustainability of Parts B and D

The trustees state that SMI "is adequately financed," but this is true only "because of automatic financing."[42] The trustees make it clear that SMI will have a large and increasingly-negative impact on the United States federal government budget and the United States economy as a whole. Simply put, questions about sustainability turn on how much of the federal budget and GDP Medicare will be allowed to claim. According to the trustees, "[w]hen viewed from **the perspective of the entire budget and the economy**, the growth in Medicare spending **will become progressively unsustainable over the longer term.**"[43]

D. Projected Medicare Costs in Perspective

The trustees have pointed out, quite correctly, that the projected growth of Medicare needs to be assessed in terms of (i) its share of the **federal budget**, and (ii) its share of the **entire economy**, as measured by GDP. In 2005, Medicare accounted for 13.5 percent of the federal budget and 2.7 percent of GDP, as shown in Table 5.

As discussed in the following two subsections, projected Medicare costs are on course to reach a level that will **jeopardize almost every other program in the federal budget**. As presently structured, by 2015 Medicare will grow to 20.6 percent of the federal budget and 4.1 percent GDP. **By 2025, only 20 years from now, Medicare will constitute 29.5 percent of the federal budget and 5.9 percent of GDP** (*see* Table 5).

1. Medicare Costs as a Percentage of the Federal Budget

Real, inflation-adjusted costs for Medicare Part B are expected to grow at a rate of 5.9 percent per year, while for Part D they are expected to grow at 10.0 percent per year. Both of these growth rates are projected to exceed growth of the overall federal budget by a significant amount. As a result, **in 10 years, Medicare's funding requirements will consume almost 20 percent of the**

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[41] *Id.* p. 48 (emphasis added).

[42] *Id.* p. 2.

[43] GAO. 2002. p. 14. (emphasis added).

federal budget (up from 13 percent in 2005). And, **only 10 years after that**, by 2025, Medicare alone will take up almost **30 percent** of the budget.

Medicare clearly constitutes a substantial part of the federal government's spending on healthcare for the elderly. It is not, however, the only healthcare component. Other healthcare components include Medicaid (for the poor), Veterans Administration hospitals, the Food and Drug Administration and the National Institutes of Health. Thus, the healthcare component of the federal budget will be somewhat larger than for Medicare alone.

Table 5
Medicare Costs as a Percentage of Federal Outlays and GDP
1970-2025

Year	Medicare as a Percent of Federal Outlays	Medicare as a Percent of GDP
	(1)	(2)
1970	3.6	0.74
1975	4.5	1.03
1980	5.9	1.32
1985	7.6	1.68
1990	8.8	1.90
1995	11.9	2.43
2000	12.3	2.29
2005	13.5	2.69
2010	17.5	3.50
2015	20.6	4.12
2020	24.8	4.96
2025	29.5	5.90

Source: Column 2 from CMS (2005). Column 1, years 2010-2025, assume that federal outlays are equal to 20 percent of GDP.

2. Medicare Costs as a Percentage of GDP

The Medicare Trustees estimate that Part A will grow from 1.45 percent of GDP in 2005 to 1.70 percent in 2015, and to 2.24 percent in 2025. When measured as a share of GDP, this represents an overall **increase of 54 percent** in 20 years. The Trustees estimate that Part B will grow from 1.23 percent of

GDP in 2005 to 1.47 percent in 2015 and to 2.13 percent in 2025. This is an overall **increase of 73 percent** in 20 years.[44]

Part D (prescription drugs) is expected to grow from 0.63 percent in 2006 to 0.96 percent in 2015, and then to 1.52 percent in 2025, an overall **increase of 241 percent** in 20 years. Overall, the Medicare program is projected to grow from 2.7 percent of GDP in 2005 to 4.1 percent in 2015, and 5.9 percent as early as 2025, **an increase of 119 percent in 20 years**.[45]

Some of the increase in Medicare spending will be offset by **reduced private sector spending**, especially in the area of expenditures on drugs. This will be a boon for employer retirement plans and individual families who are relieved of such payments. Nevertheless, at some point in the not-too-distant future, the working population may well ask: How much can the country spend on comprehensive health insurance for the elderly, when (i) such a high percentage of the active workforce has no health insurance whatsoever, and (ii) Social Security payments already take up so much of the budget?

E. The Medicare Trust Fund for Part A (HI): A Small Buffer at Best

Part A (HI) financial reserves are held in the a trust fund until needed. Current law mandates that the funds be invested in federal government securities to earn interest. The trust fund thus is borrowed by the federal government to finance a portion of the national debt. In exchange, the fund receives non-negotiable debt instruments. Upon reaching maturity, the debt and the interest simply are rolled over.

However, the GAO has observed that the Part A trust fund contains nothing more than I.O.U.'s: "While the U.S. Treasury securities in the HI trust fund are backed by the full faith and credit of the U.S. government, they essentially represent an unfunded promise to pay, which will require **tough fiscal choices** in future years."[46]

In order to have a **net repayment** of bonds held by any of the Social Security trust funds, including the HI Trust Fund, the federal government has three choices : (i) raise taxes (ii) cut spending elsewhere, or (iii) borrow from other sources (*e.g.*, foreign investors). Thus, when HI expenses reach a point that requires the HI Trust Fund to cash in its IOU's with the federal government,

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44 CMS. 2005a. p. 29.

45 *Id.* p. 29.

46 GAO. 2002. p. 11.

Congress and the Administration will be faced with **tough choices**. Subsequently, when the Trust Fund is fully depleted, the choices **simply get even tougher**.[47]

Though the Medicare trustees predict that the Trust Fund for Part A (HI) will become **fully-depleted** and insolvent **by 2020**, it is possible that insolvency could occur even earlier unless significant changes are made to the Medicare program. Thus, the question that needs to be addressed deals with "not how much a trust fund has in assets, but whether the government as a whole and the economy can afford the promised benefits now and in the future and at what cost to other claims on scarce resources."[48]

F. Conclusion

This section has focused on the outlook over the next 20 years, which is the relatively near term portion of the Trustees' 75 year projections. As discussed herein, the fiscal outlook gets progressively worse, especially when the "baby boom" generation becomes eligible for Medicare. The Trustees' projections beyond 2025 (Appendix A) not only fail to show any relief in sight, but also project further worsening, at some point reaching a crisis stage.

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[47] A Social Security actuary in 1990 wrote of the OASDI Trust Fund that "in the more relevant area of actually obtaining cash to pay promised benefits in the future, the trust funds accomplish nothing." The same applies to Medicare. *See* McKay. 1990.

[48] GAO. 2003b. p. 10.

III. CLOSING MEDICARE'S FISCAL GAP

Since Medicare was introduced, successive administrations have endeavored, through a variety of efforts, to restrain the rise in per capita spending, and those past efforts to control Medicare costs have met with some success. However, limiting future increases in costs to the extent necessary to make Medicare sustainable is likely to be an exceedingly difficult proposition — as difficult, if not more so, than anything heretofore experienced.

Nevertheless, some way to restrain costs must be found, if for no other reason than because the country simply does not have unlimited resources to devote to health care for the elderly. Yet Medicare, as presently structured, is premised on the concept that if a treatment helps people to any degree, then Medicare should pay for it irrespective of cost (this applies to other health insurance as well). Regrettably, this premise is not sustainable, because far more medical intervention is now available than any health care system can provide — which means that Medicare too, as presently structured, is not sustainable.

In order to make Medicare sustainable over the long term, at some point in time the program will have to be restructured, and done so in a manner designed to reduce and control costs. From the viewpoint of society as a whole, the goal of reducing Medicare costs is best achieved through more healthy life-styles, which would include:

- good diet and weight control (*e.g.*, less obesity);
- decreased risk (*e.g.*, less smoking);
- more exercise on a regular basis;
- preventive health care (*e.g.*, more and better vaccines);
- earlier detection of health problems.

Of course, healthy lifestyles cannot be legislated; *i.e.*, Congress cannot pass a law against obesity or force people to exercise more. About the most it can do to promote more healthy lifestyles would be to sponsor (i) more research into new and better vaccines, and (ii) earlier detection programs that are cost-effective.

It is beyond the scope of this study to analyze the merits of possible solutions to Medicare's future fiscal problems, or to recommend ways to make Medicare a sustainable program over the long run. To the extent that possible solutions are discussed here, it should be understood that none is being

advocated. They are mentioned solely to show how difficult the decisions are going to be, from both an economic and a political perspective. They illustrate the difficult nature of the choices that Congress inevitably must confront and, hopefully, demonstrate why Congress should be engaged in serious debate now. Some understanding of the difficulties involved may provide some appreciation of why Congress is seemingly in no rush to open what promises to be a veritable Pandora's box. Achieving any kind of consensus will be — to use a mixed metaphor — a Herculean task requiring Solomonic wisdom.

To close the looming fiscal gap described in Section II, Congress either will have to: (i) **increase revenues** available for Medicare, (ii) **reduce total outlays** for Medicare benefits, or (iii) do **some of each**.[49] Within the first two broad-based alternatives, Congress has available various options. For example, it can:

- **Increase revenues** available for Medicare by:
  - Curtailing expenditures on other programs; or
  - Increasing taxes, either by:
    - Increasing the payroll tax for HI, or
    - Increasing other taxes to generate additional general revenue, which is used to fund Medicare Parts B and D; or
  - Increasing payments required of current Medicare beneficiaries, either by:
    - Increasing premiums on Parts B and D paid by some or all beneficiaries, or
    - Increasing co-pay/deductibles paid by beneficiaries when they receive a medical good or service.
- **Reduce total outlays** for services provided to Medicare beneficiaries, either by:

[49] The focus here is exclusively on the fiscal imbalance facing Medicare. A plethora of other proposals can be, have been and will be proffered for improving Medicare. Some of those proposals may be revenue neutral, while others may involve added expense. Some may enable a better quality of health care delivery, while others may be more self-serving. All such proposals, regardless of their merits, are beyond the scope of this study, unless they concern (i) increasing the revenues available for Medicare, or (ii) directly and significantly reducing Medicare costs.

- Reducing total payments sufficiently to stabilize or reduce the **per capita expense** of Medicare; or by

- Reducing the **number of beneficiaries**.

The above options, both individually and collectively, constitute a potential political mine field. The late Senator Moynihan (D-NY) characterized Social Security as "the third rail of American politics." His analogy applies equally to Medicare, which is another third rail with even higher voltage. This could help explain why Congress seems to be in no hurry to confront the issues and the tough choices that inevitably must be made. Unfortunately, however, the longer that Congress waits, the more it runs a risk, figuratively speaking, of painting itself into a corner by increasing the gap between expectations and what actually can be delivered (*e.g.*, expectations that (i) benefits will not be reduced and (ii) neither taxes nor beneficiary healthcare payments will be increased).

When discussing the subject of how government can control health care costs, a distinction needs to be made between *shifting* costs and *reducing* total outlays. To date, a great deal of effort at controlling health care cost, by both the government and the private sector, has been directed at cost shifting rather than cost reduction. Cost shifting helps one sector, at the expense of other sectors, but it does not reduce society's healthcare costs.

A. Increasing Revenues Available for Medicare

1. Curtail Expenditures on Other Programs

As outlined above, one major option here is to cut back on or severely restrain the growth of other programs in the federal budget. In one sense, this is the classic annual budget battle.

Since Medicare and Medicaid are part of the federal healthcare budget, one way for the federal government to shift costs is to reduce the reimbursement to states for the federal government's share of Medicaid.[50] However, even if the

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[50] According to news articles during November-December, 2005, Congress sought reduce Medicare/Medicaid budgets by $10 billion over 5 years. Later articles reported that the cuts were imposed primarily upon Medicaid. At the time of this report, these plans have been embodied in S. 1932, "The Deficit Reduction Omnibus Reconciliation Act of 2005." The bill currently is pending, after having been passed back and forth between the House and Senate and reported on in Conference Report 109-362. *See* Freking, 2005; CNN, 2005; and Pear, 2005; *see also* www.thomas.loc.gov.

government were to eliminate all funding for Medicaid, that would not make Medicare sustainable over the long term.

Some people and some interest groups would like to cut, or even to eliminate altogether, many government programs. The reality, however, is that every program and every project — even a bridge to nowhere — has its proponents and a constituency. The budget process, and the debate that surrounds it, will become exceedingly difficult if one program area, such as healthcare — with Medicare by far the largest component of several federal healthcare programs — starts to pre-empt everything else in the federal budget.

A Wall Street adage says that "pigs get fed, hogs get slaughtered." Should Medicare's share of the federal budget be allowed to grow unchecked, figuratively speaking, from that of a pig to that of a hog, it could become a victim of Stein's Law, that "if something is unsustainable, it tends to stop."

2. Increase Taxes

Politicians believe that to run for office on a platform of increasing taxes is akin to political suicide. Instead, popular positions are either to (i) promise tax reductions, or else (ii) instigate "tax reform" (whatever that is, or may mean). In fact, the latest (unsustainable) fad among politicians at the federal level is to couple reduced taxes with increased spending.

As noted previously, the payroll tax for Part A (HI) has been increased eight times since the inception of Medicare. In light of this history, it would be foolhardy to say that it is not possible to entertain any further payroll tax increase, no matter how small or infinitesimal. However, relying to any large degree on higher taxes to fund future Medicare growth, almost surely would encounter strong and increasing resistence.

Up to a point, many working-age people may be willing to pay taxes to fund Medicare because (i) it helps relieve them from an immediate or near-term obligation to take care of their parents and in-laws, and (ii) people can anticipate the day when Medicare will help take care of their own health needs. Despite such support as Medicare may enjoy, however, some unknown limit exists on the willingness to pay taxes to support Medicare.[51] Pushing or exceeding that limit could risk something of a taxpayer revolt.

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[51] For the last several decades, federal, state and local government spending has accounted for approximately 18 to 20 percent of GDP.

3. Increase Payments Required of Medicare Beneficiaries

One of the more obvious ways for the government to shift health care costs onto others is to increase the share of costs for which beneficiaries are responsible. Here Congress has two broad choices: (i) increase the premiums paid by some or all Medicare beneficiaries, regardless of the extent to which they utilize health care services, or (ii) increase the amount paid, based on people's usage of health care services. From a political perspective, neither choice would appear to have much appeal.

Increasing Medicare premiums across-the-board would hit all beneficiaries with the same amount, while increasing premiums (or reducing the subsidy) according to income (as has already been done for those over 65 with higher incomes), has a differential impact on beneficiaries. In either case, an increase in premiums, whether across-the-board or graduated, means that the amount paid by beneficiaries does not depend on how much or how little one uses health care services available under Medicare.[52]

A second way to get Medicare beneficiaries to pay more would be to assess a co-pay or deductible that beneficiaries must pay each time they access the health care system. If money is raised in this way, those people who use the system more, and benefit more from the subsidy, also would pay more, while those who use the system more sparingly would pay less. This approach provides some incentives to limit health care use.[53] The downside is that those who have greater healthcare needs as well as, perhaps, some who are least able to pay, would be asked to pay more.

Congress already has taken a small step in the direction of alternative (i) above — increasing premiums. The MMA of 2003 stipulates that, **beginning in 2007**, and phased in by 2011, the **federal subsidy for Medicare Part B will be reduced** for individuals and couples with **high incomes** (*see* Table 6).

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[52] To the extent that higher premiums cause some people (presumably healthy people) to drop their Medicare coverage, they subsequently may elect (or be forced) to use health care resources in a more sparing manner. In other words, shifting the cost to individuals could result in some amount of self-rationing.

[53] The Henry J. Kaiser Family Foundation (KFF. 2005.) reports that (i) **12 percent of Medicare beneficiaries account for 69 percent of total Medicare expenditures**, and (ii) a disproportionate share of spending occurs in the **last year of life**.

Table 6
Means-Testing for Medicare Part B Premiums
2007-2011

Income ($, thousands)		Percent (%) Paid By Medicare				
Single	**Joint**	**2007**	**2008**	**2009**	**2010**	**2011**
80 – 100	160 – 200	73	71	69	67	65
100 – 150	200 – 300	70	65	60	55	50
150 – 200	300 – 400	67	59	51	43	35
>200	>400	64	53	42	31	20

Currently, premiums paid by beneficiaries cover **25 percent** of Medicare Part B costs, while Medicare pays the other 75 percent. Starting in 2007, beneficiaries with high incomes will be called upon to pay between **27 and 36 percent** of their Part B total costs and, by 2011, a few beneficiaries with substantial incomes will pay as much as **80 percent**. According to the Henry J. Kaiser Family Foundation, an estimated 3 percent of Medicare beneficiaries will be affected by this provision in 2007, and 6 percent will be affected by 2013.[54]

B. Reducing Outlays for Services to Medicare Beneficiaries

As explained in more detail in Section II, the future cost and sustainability of Medicare will be the result of (i) the average cost per beneficiary, and (ii) the total number of beneficiaries. If Medicare costs are to be kept in check, either or both of these factors must be operative.

1. Stabilize Per Capita Medicare Expense

A number of proposals and apparent options exist for attempting to control or reduce the cost of Medicare. For example, (i) reduce reimbursement rates for providers (*e.g.*, hospitals, doctors, manufacturers and distributors of drugs), (ii) reduce the amount of fraud in the system, (iii) improve utilization of medical facilities, (iv) increase competition as a means of cutting costs, (v) reduce the number of medical "accidents" (*i.e.*, malpractice incidents), along with the associated tort costs (malpractice insurance and "defensive" practices that otherwise would be unnecessary), etc. Unfortunately, all of these have problems that limit their future effectiveness — *e.g.*, some either have been tried

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[54] Beneficiary payments for Medicare Part D also are affected by income. Starting with the beginning of the Part D program in January 2006, those with incomes below 135 percent of the federal poverty level (individuals earning less than $12,569 and couples earning less than $16,862 in 2005) may qualify for an additional $600 per year credit towards the cost of their prescription drugs.

and abandoned for good reason, or else they already are in place and little more can be done.

To elaborate, one way to shift costs is to reduce reimbursement rates paid to providers. This already has been tried, and it doubtless will be tried again. At minimum, it needs to be pointed out that, when Congress reduces the rate at which Medicare reimburses providers, they often raise their rates elsewhere, which means (i) higher healthcare costs in the private sector, and (ii) those called upon to pay higher prices will cross-subsidize Medicare. To the extent that providers cannot raise their rates to others, they may well opt not to take any more Medicare patients, or they may even opt out of the Medicare program altogether, as some plans and physicians already have done. Thus, at some point, any effort to force health care providers to absorb further reductions in reimbursement rates may restrict supply to the point where such efforts are counterproductive.

Reducing costs — as opposed to shifting costs — means that some health care will be denied to some patients. Managed care was one such effort to reduce costs, and it met with such strong and widespread political resistance that it now seems to be held in fairly widespread disrepute. It seems unlikely that Congress will want to embark on any managed care experiment in the near future.

Drug formularies, sanctioned under the new Part D, represent another effort to reduce costs. Formularies do this by limiting the number of drugs available. Those operating formularies try to win bigger price reductions from drug suppliers by offering to include their drugs in the formulary and excluding competing drugs from other manufacturers. A formulary need offer only two drugs in each therapeutic class. This gives formularies substantial discretion over which drugs to include when a therapeutic class contains many drugs.

Yet another way to reduce costs, which has been discussed in healthcare literature but not as yet tried in this country, is the use of **cost-effectiveness analysis** to proscribe certain treatments deemed to be relatively ineffective. According to Neumann, *et al* (2005):

> The use of **cost-effectiveness analysis** can help Medicare to target its health care resources more efficiently.... Cost-effectiveness analysis will not solve all of Medicare's problems. Policymakers would do well to keep expectations modest.... But the day may be dawning when the Medicare system will face a severe financial crisis, and the available alternatives **will be far worse**. (Emphasis added.)

Of late, Great Britain is reported to have started using cost-benefit analysis as a means of disallowing certain drugs or other treatments.[55] Such disallowance has been made applicable only to new patients for whom the drug has not yet been prescribed. All patients already taking a drug that is disallowed are "grand-fathered in," which means that the government will continue to pay for their drugs. Nevertheless, the use of cost-effectiveness analysis to limit spending on drugs not considered worth the cost is meeting with the predictable political resistance.

Reducing costs means finding some way to limit, or ration, the amount of health care that some people receive. Of course, any thought of rationing flies in the face of the premise that any treatment which helps people should be paid for without question. According to Neumann, *et al* (2005):

> Americans' preferred style of rationing health care has been to avoid saying no directly and to squeeze the health care system in less obvious ways, such as adjusting cost-sharing arrangements, cutting payments to doctors and hospitals, and allowing one sixth of our citizens to go without health insurance.... Politicians rarely, if ever, mention limits or rationing when discussing Medicare policy.

Another form of rationing is **a cap, or limit**, on lifetime entitlement to certain benefits, and Medicare does have certain caps in place. For instance, Medicare has a lifetime limit on the number of days in a skilled nursing facility for which it will reimburse the cost. Once a Medicare beneficiary has reached this limit, that person's status must change, either to private pay or to Medicaid. Medicare also has certain limits on the total number of days inpatient hospital under Part A (HI). If continued inpatient care is needed beyond the first 60 days of each spell of inpatient hospital care, additional coinsurance payments are required through the 90th day of a benefit period. Each HI beneficiary also has a "lifetime reserve" of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Since September 1, 2003, Medicare also has had a limit on outpatient treatments for physical therapy, speech-language pathology, and occupational therapy.[56]

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[55] WSJ. 2005.

[56] Although each of these caps helps in its own small way to limit total Medicare expenditures, neither individually nor collectively are they sufficient to make Medicare sustainable over the long term.

Another possible way to control Medicare costs would be to offer everyone eligible for Medicare a fixed amount per year with which they could purchase various forms of health insurance. The fixed amount would be sufficient to pay 100 percent of the cost of comprehensive coverage from cheapest qualified provider. Those beneficiaries who desire other, more expensive forms of coverage, would have the option of paying the additional cost. This approach to providing health insurance for the elderly would change greatly the incentives for most Medicare beneficiaries,[57] and it could result in substantial savings. For instance, Stanford University reports that, using this approach, it has reduced its health care costs by as much as 40 percent without compromising quality of care.[58]

The primary driving long-term force underlying the increase in per capita expense for health care is technology.[59] One example of how technology has contributed to increased cost is development of dialysis and transplant techniques for people who suffer kidney failure. As a result of such developments, kidney failure no longer is the death warrant it once was, but the cost of either dialysis or transplant far exceeds the ability to pay of almost every patient with kidney failure. Examples of other technological developments that have driven health costs higher are the development of artificial joints (hips, knees, etc), bypass surgery, angioplasty, stents, etc. On the horizon are specialty drugs — many genetically engineered for but a single person — for cancer, multiple sclerosis and rheumatoid arthritis and other diseases, with annual costs ranging anywhere from $10,000 to $500,000.[60] Technological

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[57] See Enthoven (2003a, 2003b, and 2005) and Enthoven and Tollen (2004 & 2005).

[58] Enthoven. 2003b.

[59] For instance, *see* Glied, 2003, who states that studies across various countries with quite different health care systems, and over long time spans, all point to improved technology as the source of increasing per capita costs. According to Glied (p. 134), “Although technological improvements in other sectors generally lead to falling prices and often to declining expenditures, innovation in health care typically generates increased expenditures.” The reason she gives for this phenomenon is that, even when improved technology reduces the cost for a particular procedure, it often increases utilization of the procedure to the point where total system costs, as well as per capita costs for the system, increase.

[60] AARP Bulletin, Vol. 46, no. 11, p. 3.

developments such as these help increase life expectancy and the quality of life, but also they increase dramatically society's cost of health care.[61]

The fact that technology, on net balance, causes an increase in health care costs creates a fundamental dilemma for efforts to stabilize per capita cost over the next 20 years. On the one hand, it is not possible to stop medical technology from evolving and improving. And, on the other hand, even if stopping (or slowing) technological progress were possible, that obviously would not be a desirable social policy for the government to pursue.

2. Reduce the Number of Beneficiaries.

Another way to shift costs to the private sector would be to raise the eligibility age for Medicare to correspond to the Normal Retirement Age in Social Security, as suggested by the National Bipartisan Commission on the Future of Medicare.[62] This would recognize that people over 65 are, on average, healthier and have longer life expectancy than past generations (which, in part, can be attributed to extra healthcare received under Medicare). Since the Social Security Normal Retirement Age is scheduled to increase gradually until it reaches 67 in 2027, over time this would eliminate two entire cohorts (65 to 66, and 66 to 67) from Medicare eligibility. Given the entitlement nature of Medicare, this may be the only option for limiting the number of beneficiaries.

The fiscal effect of increasing the age at which people qualify for Medicare would be to (i) reduce the government's costs, while (ii) shifting the costs of medical care for the increase in eligibility age back to the private sector (*e.g.*, to employers who provide health insurance for their employees and retirees, and to individuals who must pay for their own health care coverage until they qualify for Medicare). Doubtless, this also would run into substantial resistance from those approaching retirement age. Employers who provide health coverage for their retirees until they become eligible for Medicare also could be expected to resist any such increase in the eligibility age.

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[61] As discussed above, Stanford University has managed to reduce its health care costs substantially below what they otherwise would be. It has done this by paying a flat amount that covers comprehensive quality care (through HMOs) and giving employees the option of buying more expensive fee-for-service coverage. Significantly, however, over time, Stanford's cost of providing quality care through HMOs has increased at about the same rate as fee-for-service costs. Much of this increase in HMO cost is driven by technological developments. *See* Enthoven, 2003b.

[62] *See* fn. 16, *supra*, and the discussion in the text thereat.

Increasing the age at which people qualify for Medicare, even if phased in gradually over a number of years, obviously would meet with widespread political resistence, as every member of Congress has constituents who would be affected. Failing any such move, however, the number of Medicare beneficiaries likely will increase in line with the projections shown in Tables 3, 4 and A-2.

C. Conclusion

As noted in Section II of this report, in 2002, the GAO put Congress on notice that, in order to control spending on the Medicare program, sooner or later it will have to choose among some tough and unpleasant choices. It is exceedingly unlikely that the country would abandon universal health care for the elderly. However, care will have to be scaled back in various and sundry ways, as neither the country nor the government can devote all of its resources to caring for the elderly. For the good of everyone concerned, requisite adjustments should be phased in over a number of years, rather than be implemented on relatively short notice (which can be highly disruptive).

IV. IGNORING THE PROBLEM

Prior sections of this paper examine the Medicare program, reveal its weak financial status, and demonstrate the devastating impact upon the federal budget in next two decades if the issues are left unaddressed. This final section discusses what those in government are doing — and not doing — to address Medicare's problems. Since any substantive change can come only from new legislation, particular attention is given to Congress and its activity with respect to the issue, but the Executive Branch also is discussed.

To assert that the federal government completely has ignored the Medicare program would be an overstatement. Indeed, Congress has addressed the program repeatedly, in a variety of ways, including adding new benefits, expanding coverage, reducing payments to providers, raising premiums, etc. Hearings by Congressional committees and subcommittees have addressed various parts of the Medicare program — and inevitably more hearings will be held in future years. However, even as Congress has tweaked individual aspects of the Medicare program, it assiduously has avoided the big picture, with the overarching issues of financial solvency and economic sustainability that, if left unchanged, threaten the survival of the program.

It would seem that, as the enormity of Medicare's financial problems grows, the amount of attention given to the issue declines. As the Medicare crisis approaches, Medicare projections "are seldom discussed, least of all in the 2004 presidential race. Ironically, as the Baby Boom retirement has neared — and the remedies grow more painful — political discussion has faded. Gone is Ross Perot's anti-deficit crusade. Gone is Newt Gingrich's call for Medicare restraint. Gone is Al Gore's 'lockbox' for the Social Security surplus."[63]

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[63] Lochhead. 2004.

A. The Executive Branch

1. State of the Union Addresses

The State of the Union speech is "the keynote speech by the president to Congress in which he sets out his agenda for the next year and highlights his accomplishments to the American people."[64] Over the past decade, the Medicare program has been mentioned specifically no fewer than 58 times by presidents in their State of the Union Addresses.

Beginning in January, 2001 and continuing through January, 2004, in each of his State of the Union addresses, President Bush has discussed the Medicare program. However, President Bush broke the pattern in 2005, and did not mention the Medicare program in his State of the Union Address. In fact, the only mention whatsoever of healthcare came in the form of the following statement: "I ask Congress to move forward on a comprehensive health care agenda...."[65]

One might argue that many issues other than Medicare must compete for attention in a State of the Union address and that important issues inevitably must be left out. But how can the nation's largest and most important healthcare program, that now consumes about 12 percent of all federal outlays and is headed towards financial crisis, not be important enough even to mention in what is arguably the President's most important speech of the year? Indeed, the omission of Medicare from President Bush's speech speaks loudly to the lack of desire of this President to make Medicare a priority legislative issue.

By taking the oath of office on January 20, 2001, and again on January 20, 2005, President Bush swore to uphold the Constitution of the United States. This same Constitution requires "[the President] from time to time [to] give to the Congress Information of the State of the Union, and recommend to their Consideration such Measures as he shall judge necessary and expedient...."[66] But President Bush neither informed Congress as to the coming Medicare crisis, nor did he recommend to their consideration any measures to address the problem. President Bush apparently judged Medicare reform to be neither "necessary" nor "expedient," even though reforming the Medicare program is necessary and must be undertaken expeditiously.

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[64] Schifferes. 2005.

[65] White House. 2005.

[66] Article II, Section 3, United States Constitution

In his 2006 State of the Union Address, President Bush alluded to Medicare when he stated that "The retirement of the baby boom generation will put unprecedented strains on the federal government."[67] Rather than offer any plan, the President recommended that the Congress "creat[e] a commission to examine the full impact of baby boom retirements on Social Security, Medicare, and Medicaid. This commission should include members of Congress of both parties, and offer bipartisan solutions."[68]

The nation has been down this path before. The National Bipartisan Commission on the Future of Medicare studied Medicare's problems in 1997. However, as discussed elsewhere, that commission failed to advance a legislative proposal. Any new commission will certainly have its work cut out for it to tackle the many complex issues now confronting Medicare, and this work could require study for several years. Any report from such a commission might end up being reviewed after a new President is sworn into office.

2. Agenda

In 2005, President Bush has focused a great deal of effort on reforming Social Security. He proposed a comprehensive reform plan which, irrespective of the merits of his plan, recognized and addressed the future financial instability of the program. Yet, even as the President focused on Social Security, he seemed to ignore the financial situation facing Medicare — one much more serious and imminent than anything facing Social Security: "Of the three demographic time-bombs [Medicare, Medicaid, Social Security], Bush has picked the program least in crisis [Social Security] to tackle with the most ideologic of solutions...."[69]

The "big plans" in recent years to "privatize Medicare" have fallen by the wayside: "The first of the 77 million-strong Baby Boom generation will begin to retire in just four years. The economic consequences of this fact — as scary as they are foreseeable — are all but ignored by President Bush and Democratic challenger John Kerry, who discuss just about everything but the biggest fiscal challenge of modern times."[70] The White House website now devotes only minimal discussion to Medicare, and seems concerned only with implementation

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[67] White House. 2006.

[68] *Id.*

[69] The Next Hurrah. 2005.

[70] Lochhead. 2004.

of Medicare Part D. Occasionally, the President still mentions reforming Medicare through private health savings accounts, but only in passing.

Perhaps other front burner issues such as Iraq and terrorism have diverted the attention of the Administration. Perhaps, with only three years left in office, President Bush does not believe he can achieve meaningful reform. Perhaps, with public support for the president being rather low, addressing another contentious issue is looked upon as political suicide. But, no matter what the reason for the lack of attention shown to Medicare, it is entirely clear the result will be that Medicare's financial problems will be placed squarely upon the shoulders of the next President of the United States.

B. The Legislative Branch

Congress has been much more involved in addressing the Medicare program than has the Executive Branch, but it will be shown that simply being involved with Medicare does not mean that anything meaningful has been or is being done to address to the looming financial crisis and to alter the program in ways designed to make it more sustainable.

For example, during the last three months of 2005, Congress expressed its intention to cut $10 billion of "fat" from the Medicare/Medicaid budget over the next five years,[71] but then became alarmed at the apparently daunting task. S. 1932, discussed above, currently is pending (as of the date of this report) in Congress and, if passed in its current version, will visit the majority of the cuts upon Medicaid. If any Medicare cuts are passed, however, they almost certainly will not get anywhere near to the root of Medicare's financial problems, and will, at best, only nibble at the edges.

When it comes to a Medicare program with an annual cost now exceeding $300 billion (not to mention Medicaid, which consumes another $330 billion of federal and state funds a year[72]), it would appear that Congress has concerned itself with a speck in the eye while ignoring the beam. Moreover, since Congress finds it so difficult to save but $10 billion, it is highly unlikely it will be able to make the exponentially greater changes needed in the future. Instead, Congress will be forced to attempt to increase Medicare revenues, a practice that, even if economically feasible, almost surely will encounter increasing political resistance.

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[71] *See* Freking, 2005 and CNN, 2005.

[72] Stateline.org. 2005.

1. Congressional Hearings

Congressional hearings clearly are one indicator of the level of attention that Congress devotes to an issue. This section covers the broad range of applicable Congressional committees for both the House and the Senate, and highlights the hearings — or lack thereof — that are relevant to the topic at hand. This section discusses hearings from 2004 and 2005 only. (As of the date of this report, none of the committees discussed have yet formally scheduled any hearings on Medicare or Medicare costs for 2006.)

Naturally, many if not most pertinent Congressional committees have had hearings about Medicare or, more broadly, U.S. healthcare. That, however, is not one of the criterion for a relevant hearing. The criteria for relevance are hearings having something to do with the overall rising costs of the Medicare program and/or proposing something to do about the problem.

a. House

(1) Appropriations

On April 13, 2005, the Committee on Appropriations held a hearing entitled "Centers for Medicare and Medicaid Services (CMS), accompanied by the Administration on Aging, Labor, Health and Human Services, Education, and Related Agencies." During this hearing, Mark McClellan, M.D., Ph.D., Administrator for CMS, presented his budget request for his department. But his testimony utterly fails to reveal any problems with Medicare. In fact, the testimony leads one to believe that Medicare is fine, that no problems exist and, thus, there should be no worries.

(2) Budget

For each of the last two years, the House Budget Committee has held hearings entitled "The Economic Outlook & Current Fiscal Issues" (September 8, 2004 and March 2, 2005). Both years, then-Federal Reserve Chairman Alan Greenspan presented testimony. His 2005 testimony did provide some hint at the problem facing Medicare: "The combination of an aging population and the soaring costs of its medical care is certain to place enormous demands on our nation's resources and to exert pressure on the budget that economic growth alone is unlikely to eliminate." However, Mr. Greenspan then went on to say that "considerable uncertainty remains about the precise dimensions of the problem and about the extent to which future resources will fall short of our current statutory obligations to the coming generations of retirees."

As he continues, it becomes evident that Mr. Greenspan seems to believe that the U.S. simply can grow its way out of the Medicare problem. If, as Mr. Greenspan asserts, the economy continues to grow at a healthy rate, much of the deficit can be made up through higher incomes and thus increased taxes. But, as discussed above, it is highly unlikely, if not improbable, that this will happen. Mr. Greenspan seems, in essence, to be "betting the farm" on the proverbial black while prayerfully hoping that the economy, and Medicare, do not fall literally into the red.

(3) Government Reform

Performance of the House Committee on Government Reform and its Subcommittee on Government Management, Finance and Accountability regarding the issue at hand have been disheartening, to say the least, and infuriating at worst. In the last two years, the committee has found time to hold two hearings into the quality of drinking water in Washington, D.C. and three hearings about steroid use in major league sports. This, though, has left little time for apparently unimportant things such as the biggest healthcare program in the entire federal budget — Medicare.

(4) Ways and Means

The Committee on Ways and means has had no hearings in the past two years having anything to do with Medicare costs or reform. Notably, though, there have been about a dozen such hearings for Social Security, that faces problems considerably smaller than does Medicare. The Ways and Means Subcommittee on Health, perhaps the committee most responsible for Medicare's financial outcome, had its last relevant hearings in early 2001.

b. Senate

(1) Health, Education, Labor and Pensions

The Senate Committee on Health, Education, Labor and Pensions, along with its subcommittee on Retirement Security and Aging held no relevant hearings in either 2004 or 2005.

(2) Appropriations

The Senate Committee on Appropriations and its subcommittee on Labor, Health and Human Services, Education, and Related Agencies held no relevant hearings in either 2004 or 2005.

(3) Budget

On February 17, 2005, the Senate Committee on the Budget held a hearing entitled "Medicare and Medicaid: Rising Health Care Costs and the Impact on Future Generations." This hearing was entirely relevant to the issue at hand.

Presenting testimony was, among others, Dr. Thomas Saving. His testimony involves, more or less, the same data and argumentation that have his other papers and presentations, but this testimony differed in that it was presented to members of the Senate and, as one Senator put it, "made me sort of sick...[s]tartling and sobering numbers to say the least." Dr. Saving painted, quite clearly, the picture that:

- "Making the coverage more comprehensive [with the MMA of 2003] has also made the program more costly."
- "even if there were no demographic issues [i.e., baby boomers], the faster than per-capita GDP growth of HI expenditures would rapidly outpace HI revenues."
- "there appears to be no evidence that health care expenditures will not continue to grow at more than [the Board of Trustees'] ultimate assumed one percentage point above per-capita GDP.
- "Regardless of the cause, it seems reforms are inevitable..."

In order to dissuade the committee from simply considering Medicare as a second Social Security with the same sort and magnitude of problems as Social Security, Dr. Saving stated that "[w]hile both Social Security and Medicare share the same demographics, the similarity ends there."

The committee chairman, Senator Judd Gregg (R-NH), seemed to understand the nature of the problem when he stated that "healthcare is the single biggest driver of federal expenditures for the foreseeable future" and that "the big elephant in the room is Medicare." This one hearing and the opinion of one or two Senators, however, clearly does not indicate an overall change in Congress' priorities.

(4) Finance

The Senate Committee on Finance held no relevant hearings in either 2004 or 2005.

2. Government Studies and Reports

a. CBO Reports

For the last two years, no Congressional Budget Office ("CBO") reports have dealt with the overall costs of Medicare. Various reports and letters from CBO have dealt with subjects such as long term care, high cost beneficiaries, Medicare reimbursements and fees paid to physicians and, on March 4, 2005, a letter was sent to Congressman Joe Barton (R-TX) entitled "Updated Estimates of Spending for the Medicare Prescription Drug Program." These estimates, however, deal only with a specific part of the Medicare program, and do not deal with the overall cost of the program.

To find a CBO report relevant to Medicare's financial sustainability, one must go as far back as April 10, 2003, when "Testimony on Medicare's Long-Term Financial Condition" was delivered before the Congressional Joint Economic Committee. A report entitled "Comparing Budgetary and Trust Fund Measures of the Outlook for Social Security and Medicare" was issued on October 10, 2003.[73] No other such CBO reports have appeared since that date.

b. CRS Reports

The Congressional Research Service (CRS) is part of the Library of Congress. Not all of its reports are made available to the public. Since CRS prepares its reports for members of Congress or Congressional committees and subcommittees, it often is up to various members and/or committees to decide whether to release CRS findings. Even so, many (if not most) CRS reports eventually become available online, at a variety of different websites.[74] Literally hundreds of CRS reports from 2002-2005 are available, but only one dealing with overall Medicare costs or, more generally, U.S. healthcare costs has been found. Each year, CRS reports on "The Financial Outlook for Social Security and Medicare,"[75] however these reports are little more than a summary of the Medicare BOT report for that year. Except in passing, they do not address Medicare's looming financial crisis.

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[73] CBO. 2003b.

[74] *See* http://www.ulib.iupui.edu/subjectareas/gov/crs.html; http://fpc.state.gov/c4763.htm; http://www.ncseonline.org/NLE/CRS/; http://libweb.uoregon.edu/govdocs/leg-crs.html; http://pennyhill.com/ and http://digital.library.unt.edu/govdocs/crs/;

[75] CRS. 2004b.

The one exception is a report dated January 28, 2005, "Social Security and Medicare: The Economic Implications of Current Policy."[76] This report not only accurately and succinctly details the problems facing the Medicare program, but also it briefly discusses a wide range of options for change.

c. GAO Reports

Over the last few years, GAO has published dozens of reports having to do with Medicare. None, however, have to do with Medicare's impending financial problems. In fact, one must search back as far as March 2003 in order to find reports dealing with "Medicare's Financial Challenges." However, Comptroller General David Walker repeatedly has discussed the Medicare crisis and, more generally, the federal government's unfunded liabilities.

d. CMS

Browsing the Centers for Medicare & Medicaid Services (CMS) website, one is hard-pressed to find any information about Medicare's impending financial challenges, other than the annual Board of Trustees Reports that discuss the fiscal status of Medicare. In fact, none of the other available information would lead one to believe that Medicare is in any trouble whatsoever. Putting aside the BOT annual report, if one were to form an opinion based solely on CMS information, Medicare would not appear to have any financial problems at all. It would seem that even the organization directly responsible for operation of Medicare — the organization that should, more than any other group, be attuned to Medicare's financial situation — currently does not seem to be working on solutions to the program's coming financial crisis.

3. Pending Legislation

Currently, no bills are pending in Congress that address Medicare's financial crisis, much less get to the root of the problem by providing for either a method of cutting costs or raising revenues. However, a small handful of bills do relate somewhat to the topic of this paper. Some of them are:

- S. 581 (Medicare Prescription Drug Cost Containment Act of 2005, sponsored by Senator Lindsey Graham and co-sponsored by Senator Jeff Sessions) — would attempt to contain Part D costs by requiring the President to submit legislation to Congress if a new and different warning (*see* Section D.2., below) is triggered because of actual costs exceeding target costs in a given year.

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[76] Labonte. 2005.

- H. R. 918 (sponsored by Congressman Jeff Flake with 9 co-sponsors) — also would enact a new type of trigger warning system for Medicare Part D.

- H. R. 116 (Social Security and Medicare Lock-box Act of 2005, sponsored by Congressman Rush D. Holt and currently with no co-sponsors) — would put aside all budget surpluses until the Social Security and Medicare crises have passed. This bill, however, fails to take into account the fact that there have been no true budget surpluses since 1957. Therefore, it is easy for Congress contingently to put aside money that likely will never materialize. Also, the bill fails to address the roots of Medicare's crisis. As previously demonstrated, simply spending more will not salvage the program in the long run.

- H. R. 2487 (Preserving Medicare for All Act of 2005, sponsored by Congressman Benjamin L. Cardin and currently with no co-sponsors) — would repeal the early warning signal (*see* Section D.2., below) and also would eliminate means testing for upper income beneficiaries. Regardless of whether means testing for Medicare is a moral or politically desirable practice, these provisions actually would make the Medicare financial situation worse.

- H.R.4223 (Medicaid Preservation Act of 2005, sponsored by Congressman Bill J. Pascrell with 52 co-sponsors) – would "Establish ... the Bipartisan Commission to review and make recommendations about ... [among other things] ... issues that either threaten or could improve the long-term financial condition of Medicaid...."[77]

C. CMS: Ignoring Medicare, or Covering Up the Problem?

Not only does it appear that Medicare's financial system currently is being given short shift by both our executive and legislative leaders, but also it would seem that continual efforts are being made by Centers for Medicare and Medicaid Services (CMS) to conceal the true magnitude of the looming Medicare crisis. What's more, it would seem that CMS has a lengthy — but not well-documented — history of doing much the same.

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[77] *See* www.thomas.loc.gov

1. 2003

In early 2003, when Congress was considering the Medicare Modernization Act of 2003, Democrats on the House Ways and Means Committee requested cost estimates from CMS about the proposed legislation. Medicare Chief Actuary, Richard S. Foster, prepared the estimates, but they were never released. In 2004, the CRS released a finding that the Bush Administration had "violated federal law,"[78] in that Foster had been ordered by CMS Administrator Thomas A. Scully to conceal his findings — findings that included figures for the legislation that were considerably (52%) higher than the calculations given to Congress by the CBO — calculations upon which Congress relied.[79] In fact, when Foster shared his numbers with Scully, Scully was quoted as saying **"[w]e can't let that get out**."[80] Various news sources report that Scully even threatened Foster with both disciplinary action and also with termination from his post at CMS.[81] Scully's assistant then followed up with an e-mail, saying that **"[t]he consequences for insubordination are extremely severe**."[82]

CRS stressed Congress' "right to receive truthful information from federal agencies to assist in its legislative functions [as being] clear and unassailable."[83] Later in 2004, however, the Health and Human Services Office of the Inspector General's office (not coincidentally, part of the same department as CMS) found that Scully "broke no law."[84]

Many members of Congress subsequently have stated that they never would have voted for the MMA of 2003 if true costs of the program had been

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[78] *See* 5 U.S.C. § 7211 (Lloyd-LaFollette Act, 1912; Treasury and General Government Appropriations, 2003), 5 U.S.C. § 2302(b)(8) (Whistleblower Protection Act), 18 U.S.C. § 1001 (False Statements), 18 U.S.C. § 1505 (obstructing a congressional inquiry), 42 USC § 1317 [H. Conf. Rpt. 105 - 217, 105th Cong., 1st Sess. 837 (1997)]. *See also* Murdock, 2004.

[79] *See* Murdock. 2004.

[80] *California Healthline*. 2004. (emphasis added).

[81] Pear. 2004.

[82] Goldstein. 2004. (emphasis added).

[83] DPC. 2004.

[84] *See California Healthline*. 2004.

revealed by CMS.[85] It appears that CMS wanted Congress to pass the legislation, regardless of cost, and was willing to mislead Congress to make it happen. However, the lack of fervor exhibited by most members of Congress with regard to obtaining Foster's findings shows that many in Congress were willing to vote to enact the MMA of 2003 without accurate cost estimates.

2. 2004

Perhaps emboldened by its success in 2003, CMS restricted the speech of the Medicare trustees in 2004. At the 2004 press conference releasing the 2004 BOT report, the trustees were not given their customary opportunity to speak. Thomas R. Saving, director of the Private Enterprise Research Center at Texas A&M University, one of the two private Medicare trustees, said "I know it was peculiar that we didn't have a [2004] press conference immediately following the release, where all the trustees got to make a statement, which is what we have done every other year...Because elections were coming up, they wanted to argue that there wasn't a problem. If neither party wants to make an issue out of the trustees' report, nobody's going to care about it...."[86]

The four public Medicare trustees can outvote the two private trustees, so as to control what is allowed into the annual report. Thus, it is possible that the best opportunity — and opportunity to reach the largest audience — for the private trustees to speak out concerning the Medicare crisis is at the annual press conference. Thus, it again appears that CMS would go to considerable lengths to conceal the cost of the Medicare program, and the immediateness of the crisis.

3. 2005

In March of 2005, a leading Medicare watchdog group scheduled a press conference to highlight the Medicare projections contained in the 2005 Report by the BOT. The federal government scheduled its press conference to release the 2005 Trustees Report one hour before the private group's press conference. Reporters were not able to cover both events, and the private group's press conference received little attention.

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[85] "Fiscally responsible members of Congress, mainly Republicans, had little interest in a brand-new entitlement with a price tag higher than the $400 billion reserved for it in last year's federal budget...Had market-oriented congressmen, policy analysts, and pundits seem this sum, this entire project would have died more suddenly than HillaryCare." Murdock, 2004.

[86] Serafini. 2005.

D. Possible Reasons for Congressional Inaction

1. Reticence to Revisit Major Legislation Without Evidence that "It's Broke"

Regardless of feelings about the MMA of 2003, virtually all observers would concede that the new Part D drug coverage represents a landmark piece of legislation, constituting the biggest single change in Medicare since it was launched in 1965.

Enrollment for the drug plan, Medicare Part D, started on November 15, 2005, and all Medicare beneficiaries have until May 15, 2006 to enroll in any plan of their choice without penalty. Employers who provide drug benefits to their retirees also have to determine how they want to interface with the new Part D. For those individuals who signed up before the end of 2005, drug coverage was effective January 1, 2006. Hence, no benefits were paid under the new drug coverage until 2006 and only administrative costs were incurred for Part D prior to that date. The private health insurance industry is offering a wide choice of plans, with premiums and coverages that vary widely.[87] Although the subsidy implications are not known with precision, it generally is agreed that Part D will cost the government much more than projected when the legislation was enacted. Until the dust settles, however, existing cost estimates are subject to considerable uncertainty, and Part D clearly is too new to allow a reliable projection of costs.

The MMA also contains a phase-in of reduced Part B subsidies for high-income individuals and couples, as discussed in Section III (*see* Table 6). In time, that change may effect a marginal increase in premium revenues for Part B (unless affected individuals elect not to participate in Part B). However, this phase-in has not even started, and it will not be complete until 2011.

In light of the preceding, and in consideration of all the other issues that Congress must face each year, it should not be surprising that an attitude of "If it ain't broke, don't fix it," would prevail on both sides of the aisle. Since major provisions of the MMA of 2003 have just taken effect, to assert that the situation "is broke," or has gotten out of hand, and "needs fixing," may seem premature to many Congressmen — hence, the reluctance to revisit the legislation at this time.

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[87] The wide number of choices, and differences among plans being offered, is said to have created near-maximum confusion among the public. This situation could slow the rate at which people make their decision during the sign-up period.

2. The Medicare Financial Early Warning Signal Created By the Medicare Modernization Act of 2003

Before Congress passed the MMA, GAO suggested the need for a trigger mechanism, stating that "[a] continued need will exist for measures of program sustainability that can signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues."[88]

Subsequently, the MMA included a provision that requires an annual analysis of the combined expenditures and dedicated revenues of the HI and SMI trust funds. In particular, the MMA requires that the trustees determine whether projected annual "general revenue funding" will exceed 45 percent of total Medicare outlays for the year of the report or for any of the next 6 fiscal years."[89] For this purpose, general revenue funding is defined as (i) total Medicare outlays, minus (ii) all dedicated Medicare financing sources, over 90 percent of which comes from payroll taxes and beneficiary premiums.

For any year in which the difference between projected total annual outlays and dedicated financing would exceed 45 percent of total expenditures, the Trustees must make a determination of **"excess general revenue Medicare funding."** If such a determination is made for two consecutive years it triggers a formal **"Medicare funding warning."** This warning is intended to indicate that a trust fund's financing is inadequate or that the general revenues provided under current law are becoming unduly large.

After the Trustees have issued a formal Medicare funding warning, the President is required to submit to Congress, within 15 days after the date of the next budget submission, proposed legislation to respond to the warning. The MMA stipulates that Congress then is required by law to consider such legislation on an expedited basis. The purpose of this early warning requirement is to call attention to the pending adverse impact of Medicare on the Federal Budget. Although one Congress cannot bind a subsequent Congress, once a legislative proposal has been triggered by this provision, Congress hopefully will take notice on an expedited basis.

This statutory Medicare fund warning can be illustrated as follows. The Trustees issue their annual report, generally during the latter half of March. Assume that, in the next annual report, to be issued in March, 2006, the

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[88] GAO. 2003b. p. 11.

[89] How or why Congress determined the particular percentage (45) used for the MMA's trigger mechanism is not known.

Trustees determine that "excess general revenue Medicare funding" will occur in 2012 — *i.e.*, within the next seven years. Assume further that, in their March, 2007, annual report, the Trustees again determine that excess funding will occur in 2012 and in 2013 as well. This second consecutive finding in March, 2007 triggers a formal **Medicare funding warning,** to which the President is required to respond. Since the Federal Budget is submitted to Congress each February, the President would not be required to submit proposed legislation until the following year, in 2008, within 15 days following submission of the Budget. This means that proposed legislation will be submitted about 3.5 years before the 45 percent threshold on general revenue funding is expected to be exceeded.

It is likely — perhaps almost certain — that events will unfold exactly as described, starting in March of 2006. The immediate reason is that the new Medicare drug benefits become effective in 2006, and the higher costs of providing this new benefit will begin to be reflected in the actual data, as well as in the projections. In the unlikely event that the first trigger point is not reached in 2006, the Trustees' 2005 annual report projects that, in the absence of any remedial legislation, the amount of excess general Medicare funding in excess of the 45 percent limit will grow steadily over the next 75 years. Hence it is only a question of when — not whether — the Trustees will have to issue a formal Medicare funding warning, as required by the MMA.

The preceding Section III, Controlling Medicare Costs, notes the difficult choices that Congress should confront sooner and will be forced to confront later as the money runs out. From a political perspective, Medicare legislation tends to be like the proverbial “hot potato.” The existence of this statutory warning provision in the MMA, coupled with the lack of any official determination by the Trustees of "excess general revenue Medicare funding," may help explain why Congress seemingly has ignored repeated warnings by the Trustees, the Government Accountability Office (“GAO”) and the Congressional Budget Office that (i) the projected long-term growth of Medicare spending is not sustainable, and (ii) necessary remedial actions should be initiated sooner rather than later, so that they can be phased in gradually.

In fact, a disconnect seems to exist between this relatively short-term warning and the long-range projections that the Trustees' report has provided annually for many years. Nothing is wrong with the short-term warning embodied in the current law. However, if remedies require a long lead time, then there also needs to be supplemented by some kind of warning, based on the longer-term outlook, that also would require the Administration and Congress to examine the long-term outlook and propose longer-term solutions.

As a second observation, the MMA places no limits on the legislation that the President is obligated to submit.[90] Since the MMA warning provision is based on a 45 percent limit on general revenue Medicare funding, the Administration might propose legislation designed simply to get the general revenue funding down to a level that is just below the 45 percent limit, without addressing any of the fundamental issues concerning the longer term sustainability of Medicare. For example, the President could propose to increase dedicated financing sources (*e.g.*, tax or premium increases) sufficient to reduce the share of general revenue funding below 45 percent. Although pushing the problems back for a scant few that might be a short-run solution to the Medicare funding warning, it raises the issue of non-sustainable tax levels; *i.e.*, tax levels so high that they trigger a “taxpayer revolt.”[91]

This statutory early warning system may contain other weaknesses as well. For example, if the Trustees — for whatever reason — wanted to avoid (temporarily) a finding of "excess general revenue Medicare funding," they might cease using the intermediate cost projection and instead adopt the low cost projection as the basis for their determination. This might be politically expedient, as it would put off the date when the President would be required to submit any proposed legislation and delay the time when Congress would be required to consider it on an expedited basis. However, the date when "excess" general revenue funding is required actually would be delayed only if the low cost projection should materialize. Otherwise, the Administration and Congress would be in for an unpleasant budgetary surprise.

Finally, even if the Trustees continue to base their determination on the intermediate set of assumptions, a higher cost scenario nevertheless might unfold. Again, the Administration and Congress would be in for an unpleasant budgetary surprise.

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[90] Neither does the MMA make any provisions for the level of consideration that Congress must give the proposed legislation. If Congress was simply to give the legislation an up or down vote and fail to pass it, the entire issue theoretically could be dropped.

[91] Determining when a program such as Medicare is unsustainable is analogous, in some ways, to determining when a drought condition exists. Namely, since a drought comes into being only gradually and, by definition, is preceded by a lack of rain and good weather, it sort of sneaks up unnoticed. But once a genuine drought condition does exist, the economic consequences can be wrenching, far more so than those from other weather-related disasters such as tornadoes, hurricanes, or floods.

Since 2003, the law has contained an early warning signal and, despite any possible shortcomings, the signal that now exists clearly is better than none at all. The existence of the requirement for an early warning signal, coupled with the fact that the Trustees have not issued any warning, also may help explain Congressional inaction. It needs to be recognized, however, that the existing signal contains a number of weaknesses. In particular, it may not force Congress to consider the long-term sustainability issue embedded in the program as it now exists. Instead, political considerations may cause the issue of long-term sustainability to be swept under the rug until a "crisis of non-sustainability" occurs, at which time the program — and its beneficiaries — may be subjected to wrenching changes.

3. Wishful Thinking That Forecasts May Be Excessive

As noted previously in Section II (p. 19), HI costs exceeded revenues in 1998. It often is the case that a one-year change does not a trend make, and that was the case then. For five years thereafter (1999-2003), revenues exceeded costs. Thus, the Part A (HI) trust fund subsequently was restored to a positive balance, until Part A costs again exceeded revenues in 2004.

Currently, the economy is growing, employment is strong and, on a year-to-year basis, total wages in the economy are up. Consequently, HI tax revenues will be up in 2005. Strength in the economy may give rise to hopes that the HI trust fund will continue to reflect positive balances, not only this year and next, but also indefinitely. Unfortunately, though, recessions have continued to be a way of life, and a robust economy over the next five years, without interruption, would be almost unprecedented. It would be unrealistic, to the point of self-deception, to project uninterrupted growth in HI trust fund revenues.

The record of expenditures for Medicare also leaves room for wishful thinking. In some prior years, in real (deflated) terms, Medicare per capita costs have increased very little. This can be observed from Table 4, column 5. For example, for the five years 1995-2000, real per capita costs increased by only 0.1 percent, from $6,351 to $6,415. For all practical purposes, the compound annual growth rate during these five years essentially was zero. And, for the five years 1985-1990, real per capita costs increased from $4,217 to $4,884, or by 15.8 percent, which is a compound rate of just under 3.0 percent per year.[92] Although these two periods do not represent the long-term trend, they could be interpreted as giving reason to hope that the Administration may be able to

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[92] By contrast, over the 15-year period from 1970-1985, real per capita costs grew at a compound rate of 5.9% per year. In any future period when growth in per capita costs exceeds growth in personal income, the HI trust fund is sure to suffer.

control Medicare expenses, if only for a few years. Unfortunately, though, a review of prior projections of Medicare costs shows a pattern of substantial underestimation.[93]

[93] Blevins. 2001.

CONCLUSION

The discussion in Section IV offered several reasons to help understand why Congress seemingly is in no rush to subject the long-term sustainability of Medicare to critical examination. Unfortunately, however, avoiding the issue will not make it go away. Moreover, so long as the basic structure of all entitlements now contained in the Medicare program is left unchanged, the growth in Medicare expenditures is an issue that Congress inevitably will have to deal with, one way or another, every year, as part of the annual budget-appropriations process.

Estimated **total** income and expenditures of the SMI Trust Fund for the years 2004-2014 is shown in Table 7, column 1. The projected data in Table 7 are in constant dollars, meaning the data reflect no inflation.

The **year-to-year growth** in **total** SMI income is shown in column 2. A big jump, $94 billion, is forecast for 2006, largely reflecting startup of Medicare drug benefits under Part D, enacted during 2003 as part of the MMA, but not effective until 2006.

The **federal contribution** to SMI income is estimated at 75 percent of the total income; these amounts are shown in column 3 of Table 7. Projected **year-to-year growth in federal outlays** for SMI is shown in column 4, and year-to-year **growth rates** are shown in column 5. After the one-time 58 percent increase in 2006, the projected growth rate in 2007 drops to just over 4 percent, but then begins a relentless climb to over 10 percent per year by 2013, reflecting demographics of the by-then-aging baby boom generation — *i.e.*, an increase in the proportion of the population over 65.

In real dollar terms, after Congress provides for the big shock of $94 billion in 2006, over the ensuing 8 years, 2007 through 2014, Congress must increase the annual funding level by yet another $144 billion (plus whatever inflation occurs during that interim). Viewed in retrospect, the $10 billion reduction in the 5-year health care budget that Congress struggled so hard to achieve in 2005 will look like small change.

By 2015, it is projected that total Medicare expense will exceed 20 percent of the Federal budget (*see* Table 5). If remedial action is not taken well before that time, Congress likely will find itself ensconced between the proverbial rock and a hard place.

Table 7
Part B (SMI) Income Under BOT Intermediate Assumptions
2004-2014
(Billions of 2005 dollars)

Year	Total SMI Income Parts B&D	Year-to-year Growth	Federal Share at 75%	Year-to-year Growth in Federal Share	Federal Share Growth Rate (%)
	(1)	(2)	(3)	(4)	(5)
2004	$133.8		$100.4		
2005	161.8	$28.0	121.4	$21.0	20.9%
2006	256.0	94.2	192.0	70.7	58.2
2007	267.2	11.2	200.4	8.4	4.4
2008	280.4	13.2	210.3	9.9	4.9
2009	296.3	15.9	222.2	11.9	5.7
2010	317.1	20.8	237.8	15.6	7.0
2011	337.4	20.3	253.1	15.2	6.4
2012	368.3	30.9	276.2	23.2	9.2
2013	406.8	38.5	305.1	28.9	10.5
2014	448.3	41.5	336.2	31.1	10.2

Source: CMS (2005), Table II.F1, p. 19.

In conclusion, it is quite apparent that Medicare is headed into rough waters financially. How soon the problems likely will occur and how dire the situation may become in the near future is a matter for some speculation. What is not speculative, though, is the fact that major changes are needed to address Medicare's long-term fiscal imbalance. Unless the problem is addressed soon, it will become almost insolvable without incurring the wrath of one or more political constituencies.

Unlike Social Security, virtually no political leaders or political constituencies are willing to step forward and propose significant change. Seniors are hesitant to question the system, afraid of their benefits being cut. Taxpayers, too, are hesitant to call for reform as they look forward to someday receiving Medicare benefits and would not wish for an additional tax burden today. Congress, as well as the Administration, are in near-paralysis, stuck between a rock and a hard place — that is, between hard choices today and almost impossible ones tomorrow.

Although the problems are large and looming, Congress owes it to both America's seniors and America's taxpayers to address the issue. Each year that Congress does not act, the Medicare program, upon which so many millions now depend and upon which so many more are counting, runs the risk of eventual collapse. Should that ever happen, will Americans then have any recourse

against the legislators who so callously disregarded the needs of their citizens, so blatantly ignored this country's unfunded legacy costs and whose gross negligence and irresponsibility led to a bigger fiscal debacle than all of today's Tycos, Worldcoms and Enrons combined?

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His wide-ranging assignments include medical malpractice insurance, reorganization of state hospitals in Hawaii, the impact of alternative work schedules, no-fault automobile insurance, reform of state budget systems and merger and acquisition studies. Additionally, he has served as an expert witness in patent infringement cases, testified before the International Trade Commission. Many assignments have been interdisciplinary, involving work with lawyers, political scientists, etc. and have included testifying before Congress and state legislatures.

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APPENDIX A

MEDICARE 75-YEAR PROJECTIONS

The body of this report deals with the direction that Medicare currently is headed in the next 20 years. The focus has been on that time period for two reasons:

- first, because of the need to demonstrate the immediacy, as well as the gravity, of Medicare's financial crisis; and

- second, because the more distant the projection, the more uncertain it is likely to be and, thus, the less weight it deserves.

Nevertheless, it is important to provide some discussion about the future outlook for Medicare beyond 20 years. As demonstrated in this Appendix, Medicare faces grave financial problems that extend far into the foreseeable future. The problems neither diminish nor plateau as time passes. Instead, Medicare's fiscal future becomes bleaker the further out one looks. This fact should help stress the need for immediate change, not only to stem the seriousness of any near-term crisis, but also to avoid future financial crises that, if left unchecked, will be increasingly difficult to resolve.

It must be noted, however, that the estimates and projections given herein, both from the Medicare BOT as well as from these authors, are subject, in large part, to varying degrees of uncertainty. Some forecasts are more reliable than others. For example, the number of future beneficiaries out to 2070 can be estimated with reasonable accuracy because, barring any change in the age of eligibility, all persons who will make up Medicare's cadre already have been born as of the end of 2005. Absent a cataclysmic event such as a natural disaster, major pandemic or large war, the number of people who still will be around to claim benefits 30, 40, 50 or even 65 years from now is fairly predictable. With respect to the number of beneficiaries in the period 2025-2080, the biggest source of uncertainty is future immigration.

Predictions about the ratio of workers to beneficiaries in the period 2025-2080 is subject to more uncertainty, as many of the persons comprising the worker half of that ratio have yet to be born. As birth rates can, and do, change, this ratio possibly will move either up or down. If the United States were to experience a large increase in births, as it did after WWII, some of the financial crisis could be averted due to a higher ratio of workers per Medicare beneficiary.

A birth rate lower than expected, however, could make the situation measurably worse.

Finally, it must be noted that the Medicare BOT projections contained herein are the “intermediate” projections contained in various BOT reports and other CMS documents. Most, if not all, of these data sets contain both “high” and “low” predictions, which indicate the range of uncertainty. As one goes further out in time, the range of possible outcomes increases considerably. The intermediate predictions are widely considered to be the current “most reasonable estimate,” or “best guess” and, therefore, are used herein.

The following appendix discusses first the inherent crisis in the stability of Medicare: the falling ratio of workers to beneficiaries. Attention then is turned to discussing the rising cost of Medicare and the amount of resources the program is expected to consume in the coming years.

A. Weighing Workers and Beneficiaries

1. Workers Per Medicare Recipient

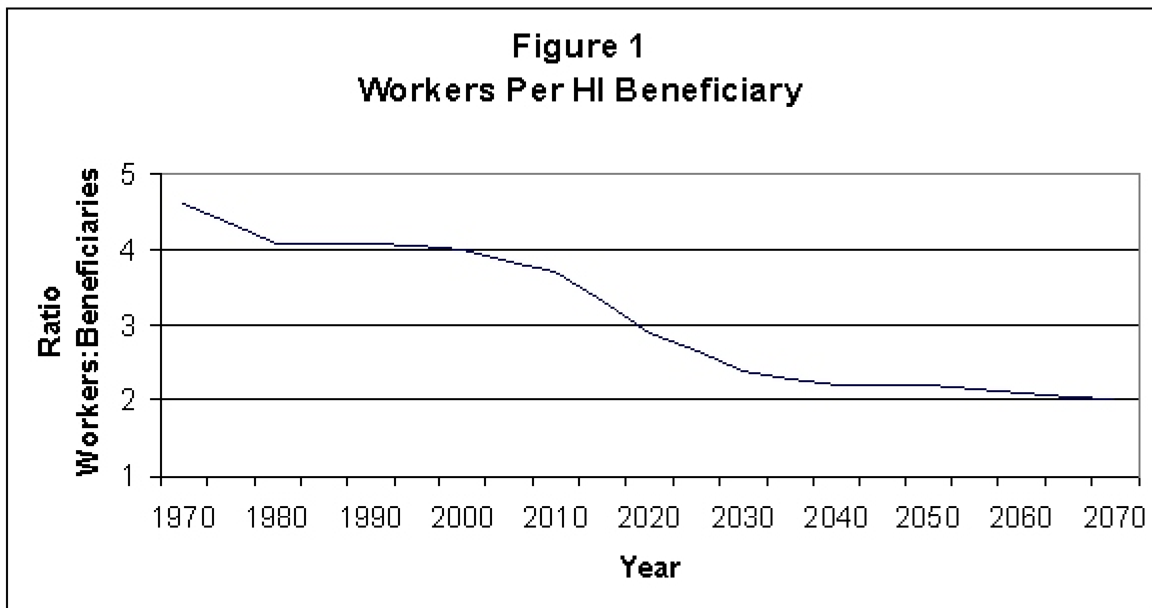
In 1970, every Part A beneficiary was supported by 4.6 workers (*see* Table 8). Thus, including beneficiary premiums, each worker was responsible for less than a fifth of the cost of a beneficiary, through payroll and income taxes. In 2005, however, there were about 3.9 workers for each beneficiary. Due to the long-term decline in U.S. birth rates and the continual rise in the number of Medicare beneficiaries (due in large part to the “baby boom” generation), the ratio of workers to beneficiaries will continue to fall in the coming decades. Absent a large (and, it would appear, highly unlikely) increase in the birth rate, the ratio will continue to fall until it reaches 2.0 workers per beneficiary. This is shown graphically in Figure A-1. At that point, each worker will be responsible for half of a beneficiary’s cost. In short, the burden on taxpayers to support Medicare beneficiaries is expected to increase to approximately 2.5 times what it was in 1970.

Table 8

Workers Per HI Beneficiary
1970-2070

Year	Workers Per Recipient
1970	4.6
1980	4.1
1990	4.1
2000	4.0
2010	3.7
2020	2.9
2030	2.4
2040	2.2
2050	2.2
2060	2.1
2070	2.0

Source: http://www.gao.gov/cghome/hccrisis/img23.html

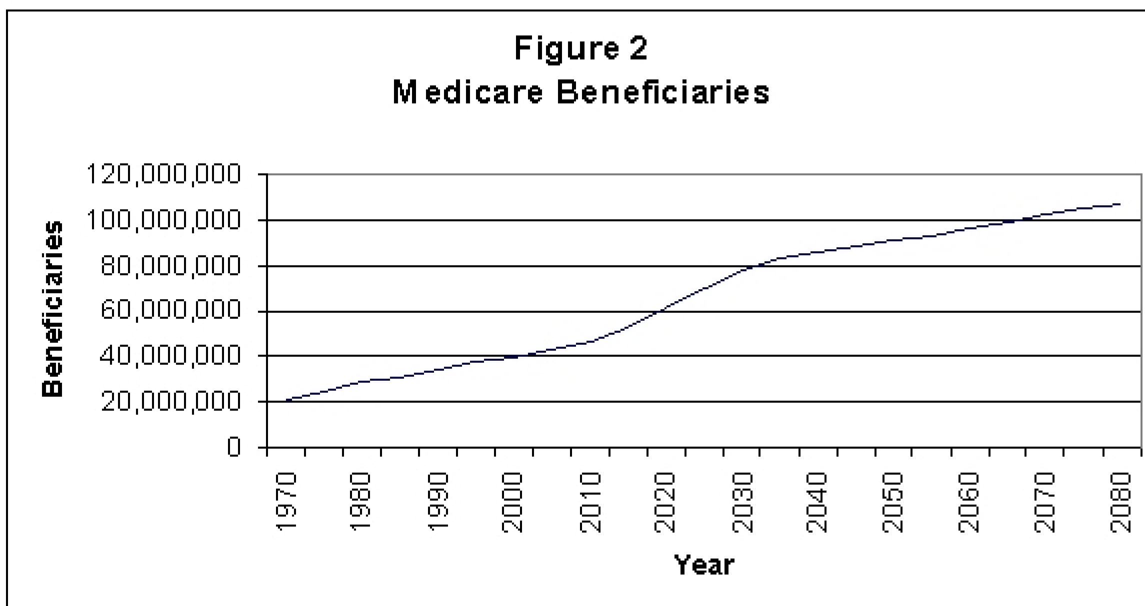


2. Medicare Beneficiaries

In 1970, Medicare had about 20 million beneficiaries. By 2005, that number had more than doubled. The rise in the number of beneficiaries is shown graphically in Figure A-2. During that time, their percentage of the population grew by about 50 percent (from 10 to 15 percent of the population; *see* Table 9, column 3).

By the year 2070, the number of Medicare beneficiaries is expected to increase further, to more than 100 million (column 1), and to about 22 percent of the population (column 3).[94] **By 2080, the end of the BOT's projections, the number of Medicare beneficiaries is expected to balloon to almost four times what it was a century before.**

Also by 2080, Medicare beneficiaries are expected to make up more than twice the percentage of the population they did in 1970. It is worth noting that beneficiaries as a percentage of the population does not peak in 2070. Instead, that occurs much sooner. As shown in Table 9, column 3, Medicare beneficiaries will make up their highest portion of the population as soon as 2035, and decline slightly thereafter.



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[94] CMS 2005a. p. 30.

Table 9
Increasing Number of Medicare Beneficiaries
1970-2080

Year	Number of Beneficiaries (thousands)	Total Population (thousands)	Percentage of Total Population
	(1)	(2)	(3)
1970	20,398	205,052	9.95%
1975	24,864	215,973	11.51
1980	28,433	227,225	12.51
1985	31,081	237,924	13.06
1990	34,251	249,464	13.73
1995	37,594	262,803	14.31
2000	39,688	275,306	14.42
2005	42,301	287,716	14.70
2010	46,328	299,862	15.45
2015	53,092	312,268	17.00
2020	61,339	324,927	18.88
2025	70,512	337,815	20.87
2030	78,327	351,070	22.31
2035	83,166	364,319	22.83
2040	86,054	377,350	22.80
2045	88,335	390,398	22.63
2050	90,794	403,687	22.49
2055	93,440	417,478	22.38
2060	96,547	432,011	22.35
2065	99,305	447,416	22.20
2070	102,376	463,639	22.08
2075	104,809	480,504	21.81
2080	107,278	497,830	21.55

Sources: http://www.census.gov/popest/archives/1990s/popclockest.txt for historical data; http://www.census.gov/population/projections/nation/summary/np-t1.pdf for future projections. Note: future estimates from the Census Bureau reflect projections made based on the 1990 Census (projections 1999-2100), which have not been updated as of the date of this report. Actual data have resulted in a slightly higher total population and, thus, total population estimates may now be higher as well, slightly reducing percentages in Column 2.

B. Medicare's Projected Financial Situation

1. The Rising Cost of Medicare

Section II discussed the "rising costs of Medicare" through the year 2025. The discussion there demonstrated that those responsible for success of the program have their hands full dealing only with the next twenty years.

In the years that follow, the real cost of Medicare is expected to increase at an even faster rate, putting an increasing strain on the government to pay for the program. From 2025 to 2080, the average real cost **per Medicare beneficiary** is expected to increase by 200 percent. This increase in per capital cost reflects the long-term effects of innovations in medical technology. But since the number of beneficiaries also is projected to rise by 75 percent, the total annual cost of the program **in constant 2005 dollars** will increase by more than 350 percent, from $1.0 to $4.6 trillion (*see* Table 10, column 4).

Table 10
Rising Cost of Medicare Parts A, B and D
2005-2080

Year (a)	Number of Beneficiaries (in thousands)	Total Cost in Billions (Nom. $)	Average Payment Per Beneficiary (Nom. $)	Total Cost in Billions (2005 $)	Average Payment Per Beneficiary (2005 $)
	(1)	(2)	(3)	(4)	(5)
1970	20,398	$ 7	$ 356	$ 36	$1,793
1980	28,433	35	1,285	83	3,047
1990	34,251	110	3,267	164	4,884
2000	39,688	219	5,653	249	6,415
2005	42,301	333	8,081	333	8,081
2010	46,328	552	12,702	474	10,908
2015	53,092	829	15,619	611	11,518
2020	61,339	1,247	20,337	790	12,878
2025	70,512	1,841	26,110	1,001	14,198
2030	78,327	2,616	33,401	1,222	15,597
2035	83,166	3,606	43,359	1,446	17,387
2040	86,054	4,848	56,332	1,669	19,398
2045	88,335	6,433	72,820	1,902	21,534
2050	90,794	8,468	93,264	2,150	23,683
2055	93,440	11,143	119,256	2,430	26,006
2060	96,547	14,768	152,964	2,766	28,644
2065	99,305	19,554	196,907	3,144	31,664
2070	102,376	25,918	253,165	3,579	34,960
2075	104,809	34,150	325,831	4,050	38,638
2080	107,278	44,895	418,492	4,572	42,615

Sources: Column 1, *2005 Report of the Medicare Board of Trustees*, p. 30. Column 2, 1970-2010, *Id.* p. 177; 2015-2080, *2005 Report of the Social Security Board of Trustees*. Column 3, 1970-2014, *Id.* p. 151. Columns 4 and 5, 1970-2010, have been calculated using the Bureau of Labor Statistics CPI Inflation Calculator, at http://data.bls.gov/cgi-bin/cpicalc.pl. For Columns 4 and 5, 2015-2080, we use the *2002 Social Security Trustees' Report* which assumes that the CPI will grow at an annual rate of 3.0 percent per year.

Note: With regard to Column 2, the *2005 Medicare Report* contains projected Medicare costs as a percentage of GDP (p. 29), but does not contain projected total costs in $ past 2014. The *2005 Social Security Trustees' Report* (p. 171) gives projected GDP through 2080. Thus, we have multiplied Medicare costs as a percentage of GDP by the projected GDP. For example, the *2005 Medicare Report* estimates that, in 2080, Medicare will be 13.75 percent of 2080 GDP, which the *2005 Social Security Report* projects to be $326,509 billion. Taking 13.75 percent of $326,509 billion yields $44,895 billion, as shown in Column 2. Per capita data in Column 3, 2015-2080 have been calculated by dividing Column 2 by Column 1.

2. Estimated Measures of Medicare and Other Federal Obligations

By the year 2080, Medicare currently is projected to cost $4,572 billion annually in 2005 dollars, signaling a further real increase of 13.7 times the cost in 2005.[95] Ironically, perhaps, in the 100 years from 1970 to 2070, the real cost of the Medicare program is expected to increase by a factor of 100.[96]

The Medicare BOT estimates that HI costs will grow to 5.48 percent of GDP in 2080, (ii) that Part B will grow to 4.90 percent of GDP and (iii) that Part D will grow to 3.37 percent of GDP in 2079.[97] Thus, as currently structured, Medicare is projected to grow to 13.75 percent of GDP by the year 2080.[98] To make matters worse, at the same time that Medicare is increasing as a percentage of GDP, so too are other government obligations with respect to the elderly, in the form of Social Security, and healthcare, in the form of Medicaid (*see* Table 11). This "bigger picture" must be considered in order to realize the grave situation in which Medicare is likely to find itself over the course of the coming decades. Since the government has many important programs in addition to those shown in Table 11, the implication is that outlays by the federal government will be close to half of GDP — an amount unthinkable today. For, even as Medicare costs grow, the ability of the federal government to pay them will diminish, because of smaller and smaller discretionary budgets.

Table 11
Selected Government Obligations as a Percentage of GDP

Program	2005	2080
OASI and DI	4.26%	6.39%
Medicare (A,B,D)	2.69	13.75
Medicaid	1.54	5.30
Total	8.49	25.44

Sources: Social Security Board of Trustees, 2005 Report; Medicare Board of Trustees, 2005 Report

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95 Calculated by dividing the real cost of Medicare in 2080 by the real cost of the program in 2005.

96 Calculated by dividing the real cost of Medicare in 2070 by the real cost of the program in 1970.

97 CMS. 2005a. p. 3.

98 *Id.* p. 29.

An independent study by Medicare Trustee Thomas R. Saving's National Center for Policy Analysis, done early in 2005 with regard to the Medicare BOT 2004 report, shows that, by 2080, Medicare's funding requirements will consume almost all federal income taxes. Mr. Saving calculates that these estimates equate to Medicare's costs requiring 62 percent of all future federal income taxes be set aside to pay for the Medicare program, assuming "federal income tax revenues remain at the 50 year average of 10.89 percent of the nation's gross domestic product."[99] Even if one were to "erase" Medicare's 75-year projected deficit, the government still would need to set aside 43 percent of all income taxes to pay for costs through the "infinite horizon."[100] This means that, **even if Medicare had zero costs for the next 75 years, the government would still have to devote almost half of all future income taxes to pay for Medicare**.

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[99] Mr. Saving also has calculated that, for Medicare to be "affordable" — affordable meaning a constant percent of federal income taxes — "Federal income tax rates would have to be way over 50, 60 percent of – rather than 11 percent of gross domestic product."

[100] Saving. 2005.