



# EUROPEAN PAPERS ON THE NEW WELFARE *the counter-ageing society*

## TOWARDS A NEW WELFARE

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## **Medicare in USA: Present and Future**

by James C. Capretta\*

### **1. Introduction**

The election of former Illinois Senator Barack Obama as the next president of the United States has pushed health-care back to the top of the national agenda, although the exact timing of a legislative initiative remains unclear.

Most of the policy attention in the short-term will necessarily focus on how to pull the U.S. out of the most precarious financial crisis in many decades. And it is possible that pre-occupation with restoring economic growth could delay consideration of a health-care plan for several months or even years. However, key players in the new Administration are eager to move quickly on health-care, regardless of other economic conditions.

The primary focus of American health-care policy debates in recent years has been over what to do about the nation's 46 million uninsured residents. Mr. Obama considers that to be the number one failing of current U.S. health-care policy. His campaign plan, released as a white paper in mid-2007, proposed major revisions in the regulatory structure for health insurance for the working age (under age 65) population and their families. He would also provide substantial new subsidies for households with incomes below 400% of the poverty line to make insurance more affordable. But the Obama plan does very little by way of reform of Medicare, the insurance program already in place for those citizens age 65 and older, as well as for the disabled.

That is not likely to be a sustainable position over the long-run. Left unchanged, Medicare spending will push the federal budget into sustained deficits that could spiral out of control. Many economists consider Medicare's rising costs to be the number one threat to the long-term strength of the U.S. economy.

It is also not yet well understood among health-care policy analysts that Medicare provides a serious disincentive to continued work past age 65. Thus, Medicare reform needs to be considered not only to make the budgetary outlook more favorable, but also to take steps to address the issue of an aging society and the need to encourage work for as long as possible past age 65.

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## 2. Medicare's Current Design and Financing Gap

The U.S. has the very unusual situation of two large health-care entitlement programs but not universal entitlement to health care. This came about because President Lyndon Johnson believed in 1965 it would be better to pass coverage for seniors and the poor than a plan to cover everybody.

The result was legislation creating Medicaid and Medicare.

Medicaid is a joint federal-state program aimed at providing health insurance for those who are either enrolled in welfare programs or working but very poor. The program is funded mainly with general revenue funding from the federal government, with states expected to pay for a portion of the costs as well. On average, the federal contribution covers 57% of total costs. Medicaid's enrollees pay very low cost-sharing when they use health-care services.

Medicare is built more like the Social Security program, with trust funds tracking income and outgoings and eligibility determined by worker contributions and premiums. Currently, workers and their employers each pay taxes on wages — 1.45% — to gain eligibility for hospital insurance. At age 65, senior citizens must also pay a premium equal to 25% of costs for coverage of physician services, and a 35% premium for coverage for prescription drugs.

The latest report from Medicare's Board of Trustees, issued in late March 2008, revealed that the program's unfunded liability now stands at an astounding \$86 trillion, and the trust fund which pays for hospital services is expected to go bankrupt in 2019. Total Medicare spending is projected to more than triple over the projection period as a share of the national economy, from 3.2% of GDP in 2007 to 6.3% in 2030, 8.4% in 2050, and 10.7% in 2080. Federal individual income tax collections only amount to about 8.5% of GDP. Covering just the increase in Medicare spending expected by 2030 would require a 36% across-the-board individual income tax hike.

Many analysts in the U.S. have put forward plans to restore financial balance to Social Security, but there are very few credible Medicare reform proposals to examine.

Why?

Because Medicare's financial problems are much more severe, and the policy environment is much more complex as well.

Medicare is a pay-as-you-go program too, and the aging of population is an important reason program costs will soar in coming years, especially as the baby boomers head into retirement in the next two decades. But, unlike Social Security, Medicare's problems go well beyond shifting demographics.

The Medicare entitlement is not defined by a mathematical formula tied to payroll taxes. Rather, enrollees get government-sponsored insurance coverage, the cost of which is mainly a function of ever-changing standards and technologies of medical practice. Today, Medicare pays for many services, diagnostic tests, operating procedures, and products that did not exist yet when the program was created by Congress in 1965. And there is no limit on the quantity of services Medicare beneficiaries can use each year, so both the volume and intensity of care provided can go up over time without Congress passing benefit expansions.

Still, it is possible to see Medicare's financial problem as fairly simple math. The Congressional Budget Office (CBO) estimates that, between 1975 and 2005, Medicare's cost per enrollee went up, on average, 2.4 percentage points faster than per capita GDP growth each year. Medicare's Trustees make the reasonable assumption that, new information being absent, this long-standing trend of costs outpacing the source of program income (i.e.,

the U.S. economy) will continue into the indefinite future (though the Trustees do expect cost growth will moderate somewhat from its recent trajectory). Compounding is indeed a powerful force; even a small differential in cost and revenue growth rates will, if assumed to continue over many years, produce a massive projected deficit, especially when such a differential is applied to sums as large as those involved in the Medicare program.

Medicare was never expected to be fully funded like Social Security. Federal taxpayers have always subsidized coverage for physician services, and Congress extended this subsidy, much to the chagrin of many fiscal conservatives, to prescription drug coverage in 2003. Enrollees are required to pay their own premium if they elect to enroll in these parts of Medicare, but these premiums now cover only about 25% of costs, with the balance financed automatically from the U.S. Treasury. This annual subsidy is set to rise dramatically in coming years, from 1.5% of GDP in 2007 to 4.7% of GDP in 2050. The entire budget for the Department of Defense now stands at about 4.0% of GDP.

Some health-care analysts argued that it would be unfair to focus reform efforts just on Medicare because the problem of rising costs is really everyone's fault and everyone's to solve. To these analysts, Medicare is just one of many rail cars hooked onto a runaway cost train. The solution is therefore not Medicare reform but a concerted effort, led by the government, to implement reforms that will improve efficiency and eliminate low value services for everyone buying insurance and services, including employers.

This is the kind of thinking behind the health care plan of president-elect Barack Obama. To slow costs, he supports a list of measures: more and better health information technology, new efforts to coordinate care for those with chronic illnesses, and better prevention efforts. These efforts in fact enjoy broad support from politicians, but they are unlikely to solve the problem of costs rising faster than income. Indeed, there is certainly no expectation that they would narrow Medicare's financing gap in any significant way.

To slow health-care costs appreciably in the U.S., policymakers are likely to be forced to adopt much stronger measures. For instance, the U.S. could impose tighter budgets for hospitals and other provider groups, as many European countries do today. But there is concern among many in the U.S. that such arbitrary limits would damage quality and lead to rationed care. Many U.S. voters react negatively to the prospect of the government having the power to deny access to health care to a citizen based on a perceived need to keep total costs down.

Implementing a different approach to cost control, one more in line with U.S. values, requires a deeper understanding of why costs are high and rising in the first place.

An important 2006 study by Amy Finkelstein, an economics professor at the Massachusetts Institute of Technology, demonstrated that the creation of Medicare in the mid-1960's triggered an explosion in the health care infrastructure in regions with previously low levels of insurance enrollment among seniors. Hospitals were built, and physicians and others opened up offices to provide newly enrolled Medicare beneficiaries with a much improved level of service provision. This was, of course, generally to the good, as the primary purpose of Medicare was to improve the quantity and quality of health care services provided to seniors. But, four decades later, with cost escalation now the cause of so much financial distress for families and governments, policymakers must also understand that expansive insurance is the fuel for expensive care and rising costs.

Medicare is not solely to blame of course. Employer-provided insurance also expanded rapidly in the post-war era. And demand for more and better health care naturally rises with increasing wealth and higher incomes. But Medicare is unquestionably a large part of the cost problem. In her paper, Finkelstein offers the rough estimate that about half of the real cost increase in health care spending in the United States from 1950 to 1990 can be attributed to

the spread of Medicare and other, expansive third-party insurance.

Medicare is the largest purchaser of services in most markets today. Four out of five enrollees are in the traditional program, which is fee-for-service insurance. That means Medicare pays a pre-set rate to any provider for any service rendered on behalf of a program enrollee, with essentially no questions asked. Nearly all Medicare beneficiaries also have supplemental insurance, from their former employers or purchased in the Medigap market. With this additional coverage, they pay no charges at the point of service because the combined insurance pays 100% of the cost. This kind of first-dollar coverage provides a powerful incentive for beneficiaries to use as many services as their physicians suggest might help improve their health. Whole segments of the U.S. medical industry have been built around the incentives embedded in these arrangements. To be sure, Medicare's payment rates are low, but political pressure ensures they are just high enough to protect the status quo and allow doctors and hospitals and others to continue operating autonomously, thus underwriting continued fragmentation.

### **3. Medicare's Tax on Work**

Medicare's current rules are also a deterrent to long careers and continued work. This tax occurs because of Medicare's complex interaction with the dominant employer-based insurance arrangements for the American workforce.

Under current law, Medicare becomes the 'secondary payer' when a person age 65 and older continues to work for a firm with at least 20 employees and a company-sponsored health insurance plan. In those cases, the company's health insurance for workers pays for medical care for the workers first (the 'primary payer') and Medicare only pays for those portions of the bills not covered by the company plan.

This rule was put in place to reduce Medicare costs and allow a focus on insuring those without access to an employer-sponsored plan.

But this approach is short-sighted because it imposes an onerous tax on work for those Medicare-eligible people who choose to continue working. Most economists assume that, when an employer pays for health insurance for a worker, those costs reduce what can be paid in cash wages. Consequently, when an employer must assume primary responsibility for the health insurance premiums of an older worker, that means there is less funding available for that worker's wages.

A 2007 analysis by economists at Harvard, Stanford, and Occidental College shows this 'tax on work' to be quite considerable. These researchers found that, at age 65, Medicare's 'secondary payer' rule imposes a 15 to 20% tax on wage income, and this implicit tax rises to 40 to 75% for those approaching 80 years old. Such high marginal tax rates are a significant disincentive to work.

The problem is compounded by Medicare payroll tax financing. Workers age 65 and older who are already getting Medicare benefits must nonetheless continue paying Medicare's payroll tax (2.9% of wages, for the combined employee-employer tax) even though they get no additional benefit for paying it.

The authors of the 2007 paper suggest that reforming these anti-tax provisions of Medicare could provide much strong incentives for continued work. One approach would be to make the Medicare program the primary payer for all workers, even though with access to an employer-sponsored plan, and repeal of the payroll tax for workers who have already worked for forty years. The authors estimate that this kind of reform would increase the total labor supply from the eligible population by over 1%.

## 4. The Challenge

The federal government is taking on substantial new debt in response to the crisis in the financial sector. Even so, these costs, though high, are likely to be temporary, which cannot be said of rising costs for Medicare.

Federal government spending on Medicare increased from 1.0% of GDP in 1975 to 3.1% in 2008, according to CBO. Projections indicate the U.S. will be facing public expenditures on Medicare that are double and triple the rate of today's spending, and these additional costs would occur every year, not once.

To find a solution to this problem, it's important to understand that Medicare is really two programs. The most important feature of Medicare is that it is guaranteed-issue, community-rated insurance. Everyone age 65 and older gets their insurance for the same premium, and they cannot be denied coverage based on their health status. These features of Medicare are highly valued by beneficiaries, and for good reason. Without a regulatory structure putting all seniors into the same risk pool, insurance would naturally move to cover healthier seniors at lower premiums than the unhealthy.

But Medicare is also a large tax-and-transfer program. And it is this feature of Medicare that is substantially out of balance.

Medicare's unfunded liability could be contained with a simple change in program structure. The program could continue to provide guaranteed issue, community-rated insurance, but future retirees would be eligible for premium subsidization commensurate with tax contributions during each generation's working years (a large exception would be made for seniors in the lowest fourth or fifth of the wealth distribution). This change would ensure that program spending rose in tandem with the program's revenue base. And it could be designed to be more neutral toward continued work by the elderly, thus providing a strong incentive for higher labor force participation among Medicare enrollees.

Opponents would immediately argue that this kind of reform would be dangerous for future retirees because health-care costs might rise faster than the premium subsidies. But it does not make good sense for the government to pre-commit health entitlement spending twenty-five and fifty years from today that is unaffordable. It would be better to build a program that is solvent by definition, with ample room for future policymakers to make adjustments if evidence indicates that seniors need more subsidization to secure appropriate health care.

The country can provide generous health insurance coverage for seniors in the future, even coverage that costs much more than it does today. But the program can't double or triple in a generation. The sooner U.S. policymakers face up to this reality, the better.

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