Editorial:

Medicare at 50: Terminally Ill

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The Medicare Board of Trustees 2015 Annual Report,[1] which was published on July 22, 2015, consists of 265 pages of complex tables, graphs, and actuarial technospeak with liberal use of euphemisms, like "financially challenged," to describe the financial state of the Medicare program. To be fair, the Report does use the word "insolvency" once in the 265 pages to warn about what will happen if continuing deficits are not resolved.

The Report, which concedes uncertainty of financial projections, is replete with hopeful speculation about efficiencies not yet achieved, continuing economic recovery, and the endless ability of productive workers and taxpayers to pay more, especially the "wealthy."

If they used the same style to describe an armed robbery, the Trustees might write: Party A, noting a gap between his wants and funding sources, requests a transfer of funds from Party B. Party A visually assists his request with an impressive piece of hardware pointed in Party B's direction. Party B determines that the requested transfer of funds will reduce his income as a percentage of per capita gross domestic product and hesitates to complete the transaction. Party A insists on the transfer of funds but allows Party B to transfer funds more gradually so as to give Party B more time to adjust to a lighter wallet.

The Report offers a glimpse of the thought processes of those who believe in government's ability to "manage" the giant Ponzi scheme that is Medicare and "make it work." Perhaps in recognition of the fact that all Ponzi schemes eventually fail, the authors of the Report acknowledge that a major crisis is coming. The "solutions" proposed in the Report basically focus on how to keep the Ponzi scheme going a bit longer, noting that the Hospital Insurance (HI, Part A Medicare) fund is heading for depletion in the near future. There is, of course, no way to "manage" a wealth transfer Ponzi scheme to make it financially sustainable.

Scope of the Medicare Program

In 2014, the Medicare program had 53.8 million beneficiaries, 44.9 million age 65 or older, and 8.9 million disabled. Approximately 30% of beneficiaries were enrolled in Medicare Part C (Medicare Advantage, Medicare managed care). Total expenditures in 2014 were $613.3 billion with total revenue of $599.3 billion, including $11.2 billion in interest income. The deficit was handled as follows: "Assets held in special issue U.S. Treasury Securities decreased by $14.1 billion to $266.4 billion…. In 2014, $8.1 billion in trust fund assets were redeemed to cover the shortfall of income relative to expenditures."[1, p 7]

For those who are unfamiliar with the shell game accounting gimmicks of Medicare financing, when revenue in the Medicare HI Trust Fund exceeds expenditures for a particular year, the excess funds are invested in special, non-marketable U.S. Treasury Bonds, paid by taxpayers, at a market rate of interest. These special U.S. Treasury Bonds are backed only by the government's promise to repay. They are essentially "IOUs." Repayment of these special bonds depends on the younger generation's ability to pay increased taxes.

Uncertain Projections

The Report acknowledges that "projections of Medicare costs are highly uncertain, especially when looking out more than several decades…. No one knows whether future developments will, on balance, increase or decrease costs."[1, p 2] Yet, the government actuaries who constructed the Report showed no restraint in making projections about the Medicare program over the next 75 years.[1, p 40]

The demographics of Medicare, however, are known with certainty. The Baby Boom generation, those born between 1946 and 1965, began retiring in 2011 at age 65, contributing to a 2% to 3% annual growth in the number of Medicare beneficiaries.[1, p 20]

All Ponzi schemes face the problem of not being able to continually recruit a sufficient number of people paying into the scheme compared to those taking money out. The Report acknowledges this problem in its conclusion: "Total Medicare expenditures were $613 billion in 2014, and the Board projects that they will increase in most future years at a somewhat faster pace than either aggregate workers' earnings or the economy overall. The faster increase is primarily due to the number of beneficiaries increasing more rapidly than the number of workers."[1, p 40]

The ratio of workers to retirees in 1960 (prior to passage of Medicare in 1965) was five to one, and by 2002 had shrunk to three to one. By 2050, the ratio of workers to retirees is predicted to be two to one.[2] Between 2010 and 2050, the population age 65 and older will go from about 40 million to 88.5 million.[3]

From the beginning, the costs of the Medicare program were grossly underestimated. In 1965, government actuaries estimated that Medicare HI (Part A) costs would be about $9,061 million in 1990. In 1990, actual Medicare HI expenditures were $66,997 million, 639% above the estimate. Expressed as a percentage of taxable payroll, the actual expenditures were 165% higher than estimated.[4]

Expenditures Exceed Revenue

Part A expenditures have exceeded income every year since 2008.[1, p 40] The Board projects that expenditures, expressed as a percentage of Gross Domestic Product (GDP), will increase from 3.5% in 2014 to 5.4% in 2035 and by 2089 would increase to 6.0%.[1, pp 9, 19] The Report noted: "The Trustees project that HI tax income and other dedicated revenues will fall short of HI expenditures in most future years."[1, p 10] The consequence of this deficit spending in Medicare was also noted in the Report: "Growth under any of these scenarios, if realized, would substantially increase the strain on the nation's workers, the

economy, Medicare beneficiaries, and the Federal budget."[1, p 9]

Unlike Medicare Part A, which is financed mainly by payroll taxes, the Supplementary Medical Insurance fund (Part B and Part D) will remain adequately financed in future years because SMI is funded through general income tax revenue and Medicare premiums, which are adjusted on an annual basis to cover expected expenditures the following year.[1, p 10] The Report predicts that Part D expenditures will grow at an average annual rate of 9.7%.[1, p 34]

The Report revealed that due to the recent economic recession, general revenue transfers became the main source of income to the Medicare program beginning in 2009.[1, p 23] The Report projects that annual HI expenditures will more than double over the next 5 years: "Growth in HI expenditures has averaged 2.1 percent annually over the last five years and is projected to average 4.8 percent over the next 5 years."[1, p 8]

Despite a growing number of beneficiaries, the Report embraces speculative optimism that somehow efficiencies (cost reductions), not yet realized from "ObamaCare" (Accountable Care Act, ACA) and the Medicare Access and Reauthorization Act (MACRA) and continuing economic recovery, will result in surpluses for the next 8 years. The Trustees project that in 2015, HI income (which includes payments from the general fund) will exceed expenditures by about $2 billion.[1, p 25] However, even if surpluses do occur, deficits are projected to return beginning in 2024 and to persist for the remainder of the projection period.[1, p 25]

The Report reveals that Medicare beneficiaries have been forced to subsidize the managed care plans in Part C whether they were enrolled in them or not:

> Prior to the ACA, private plans were generally paid a higher average amount [compared to regular Medicare], and they used the additional payments to reduce enrollee cost-sharing requirements, provide extra benefits, and/or reduce Part B and Part D premiums. These enhancements were valuable to enrollees but also resulted in higher Medicare costs overall and higher premiums for all Part B beneficiaries, not just those enrolled in Medicare Advantage Plans.[1, pp 20-21]

Short-Term and Long-Term Goals Not Met

The Medicare Board of Trustees has set minimum standards expressed as short-term financial adequacy and long-term actuarial balance. For instance, the Board recommends that the so-called assets in the Medicare Trust Funds (IOUs) be able to cover 100% of expenditures in a given year. For 2014, the Board reported: "The assets were $205.4 billion at the beginning of 2014, representing about 76 percent of expenditures during the year, which is below the Trustees' minimum recommended level of 100 percent."[1, p 8]

Neither short-term nor long-term goals have been met for more than a decade: "The HI trust fund has not met the Trustees' formal test of short-range financial adequacy since 2003….[1, p 8] In addition, as in past reports, the HI trust fund fails to meet the Trustees' long-range test of close actuarial balance."[1, p 40]

Depletion Date for HI Trust Fund

Medicare Trustees predict that the so-called HI trust fund (IOUs) will be depleted in 2030, the same as predicted in last year's report.[1, p 7] However, if costs are higher than estimated, then the HI fund could be depleted as early as 2022.[1, p 27]

Trustees acknowledge that "[i]f assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed."[1, p 26] The word "rationing," of course, does not appear anywhere in the Trustees' Report.

The Report places its faith in the concept of "too big and politically important to fail": "To date, Congress has never allowed the HI trust fund to become depleted."[1, p 26] The Report embraces a delusional belief that Congress can vote to defy basic laws of economics.

Effects of ACA and MACRA

The Report is hopeful that cost reductions under ACA and MACRA will occur as those who provide care to Medicare beneficiaries will gradually adjust and be satisfied with working harder to achieve so-called quality metrics while being paid less: "Trustees are hopeful that U.S. health care practices are in the process of becoming more efficient as providers anticipate more modest rates of reimbursement growth, in both the public and private sectors, than those experienced in recent decades."[1, p 4]

The Report notes the uncertainty of these "cost savings," however, and the fact that continually paying less would likely not be a viable long-term strategy.[1, p 41]

Under MACRA, a significant reduction in payment to physicians is scheduled to occur in 2025 when certain incentives disappear: "In particular, additional payments of $500 million per year for one group of physicians and 5-percent annual bonuses for another group are scheduled to expire in 2025, resulting in a significant one-time payment reduction for most physicians."[1, p 2]

And, despite the American Medical Association's boast of a great victory for physicians when the hated sustainable growth rate formula (SGR) was repealed under MACRA, the Report notes that physicians will be paid less under current law than they would have been paid under the SGR: "The Trustees anticipate that physician payment rates under current law will be lower than they would have been under the SGR formula by 2048 and will continue to worsen thereafter."[1, p 3]

The Report acknowledges that Medicare beneficiaries will suffer in the long term as physician payment rates will not keep up with physicians' costs:

> In addition, the law [MACRA] specifies the physician payment update amounts for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large…. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term under current law.[1, pp 2-3]

The Report admits that the possible effects of these changes on Medicare beneficiaries were not modeled in the Report. It

does not consider the potential effects of "sustained slower payment increases on provider participation, beneficiary access to care, quality of services, and others factors."[1, p 16]

The Report also notes that even if payment rates were adequate, neither short-term nor long-term goals for financing Medicare would be met.[1, p 41] Moreover, it acknowledges that legislative fixes (similar to the "Doc Fixes") likely will be needed and that this will result in significant cost increases. "Under the illustrative alternative, in which adherence to the MACRA and ACA cost-saving measures erodes, projected costs would rise to 6.1 percent of GDP in 2040 and to 9.1 percent in 2089."[1, pp 5-6]

Government-Proposed Solutions

High-income earners will continue to pay more. Medicare Part B has been means-tested since 2007. Single beneficiaries with incomes at $85,000 and above, and couples earning $170,000 and above, pay higher Part B premiums. Part D premiums are similarly means-tested.[5]

Payroll taxes, the primary revenue source for Medicare Part A, have been means-tested since 2013. Single workers with incomes $200,000 and above, and couples with incomes $250,000 and above, pay 0.9% more in payroll tax.[1, p 11]

Unfortunately, these income thresholds are not indexed for inflation, and as a result, over time a majority of workers will be labeled "wealthy." The Report states: "Since these income thresholds are not indexed, over time an increasing proportion of workers and their earnings will become subject to the additional HI tax rate. (By the end of the long-range projection period, an estimated 80 percent of workers would be subject to this tax.)"[1, p 28]

"Wealthy" Medicare beneficiaries will also pay more beginning in 2016 due to a new "hold harmless" provision that limits an individual's dollar increase in the monthly Part B premium to the dollar increase in his Social Security benefits: "In 2016, however, a hold harmless provision that restricts Part B premium increases for most beneficiaries is expected to cause a substantial increase in the Part B premium rate for other beneficiaries…."[1, p 8] In 2016, because the cost-of-living adjustment for Social Security benefits is expected to be 0.0 percent, premiums would not increase from the 2015 level for those beneficiaries to whom the provision applies. So, "under current law, Part B premiums for other beneficiaries must be raised substantially to offset premiums foregone due to the hold-harmless provision, to prevent asset exhaustion, and to maintain a contingency reserve that accommodates normal financial variation."[1, p 32] The increase in Part B premiums would also be matched by an increase in general revenue transfers.[1, p 32]

The Report proposes the choice of a dramatic increase in payroll taxes for all workers vs. a dramatic reduction in expenditures. As further reduction in expenditures will result in restricted access to high quality care for Medicare beneficiaries, an increase in the payroll tax would likely be the choice favored by Congress: "Lawmakers could address the long-range financial imbalance in many ways. They could immediately increase the standard 2.90-percent payroll tax by the amount of the actuarial deficit to 3.58 percent, or they could reduce expenditures by a corresponding amount. These changes would require an immediate 23-percent increase in the standard tax rate or an immediate 15-percent reduction in expenditures."[1, p 30]

The Report also advocates implementing further Medicare reforms sooner rather than later so that physicians, hospitals, Medicare beneficiaries and taxpayers will have more time to get used to their situation getting much worse:

> The financial projections in this report indicate a need for additional steps to address Medicare's remaining financial challenges. Consideration of further reforms should occur in the near future. The sooner solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations and behavior.[1, p 10]

Conclusion

Inadequate payment for those who provide care to Medicare beneficiaries, huge increases in taxation and premiums, especially for those whom the government labels "wealthy," and deteriorating access to care and quality care for Medicare beneficiaries lie ahead as the Medicare program approaches insolvency. The impending collapse of the Ponzi scheme cannot be averted. Increased rationing of care will occur.

As taxation becomes even more oppressive for the younger generation of American workers, it will result in destruction of the "American dream" of getting ahead by working harder. This will likely result in inter-generational resentment, as younger workers are continually taxed more heavily to pay for the care of retirees. And, if increased taxation is deemed insufficient, the possibility of government looking at bank depositors to make up the difference cannot be excluded.

End-of-life initiatives currently being implemented in Medicare will transform into pressure to limit care and treatment. Emphasis will be placed on preserving the program at the expense of preserving individual lives. Younger overtaxed workers will tend to support these life-shortening initiatives.

Under this scheme, expectations of both young and old will indeed have to be adjusted—ever downward.

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