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the growing challenge of Medicare

> The Congressional Budget Office projects Medicare spending will grow at an average annual rate of 9 percent over the next 10 years, reaching \$766 billion by 2015.

- > The Bush administration released an estimate that total spending for Medicare Part D (the new prescription drug benefit) over the period 2006 to 2015 will be about \$720 billion.
- > According to the 2004 Medicare Trustees report, Medicare expenditures are expected to grow to 7.7 percent of GDP by 2035.

“The reforms haven’t begun yet. I signed a piece of legislation, and the major reforms of providing prescription drugs for our seniors kicks in next year . . . I’m convinced they’ll have cost savings for our society, and I know it will make the life of our seniors better.”

—President Bush, in comments made on Feb. 9, the day estimates were released projecting the Medicare prescription drug benefit would cost about \$720 billion over the period of 2006-15.

These projections are pointed reminders of the challenges Medicare poses for the country. Finding the best strategy for meeting these challenges is certain to be a subject of intense national debate.

CBO’s Projections

In addition to predicting a 9 percent annual increase in Medicare spending, CBO predicts Medicare spending will be 3.9 percent of GDP by 2015, up from 2.6 percent in 2004. Worse yet, the CBO’s projections may be optimistic because they include several years of reductions in physician fees required by the sustainable growth rate established in the Balanced Budget Act of 1997. Even though the SGR required fee reductions for the period 2003-05, Congress declined to let the reductions go into effect during those years, and it’s not clear whether Congress will let projected future reductions of 4 percent to 5 percent per year go into effect over the next several years.

Included among CBO’s estimates is a projection that Medicare Part D spending will grow from

\$47 billion in FY06, when it will be in effect for only part of the fiscal year, to \$174 billion in FY15. This projection goes hand in hand with the administration’s estimate of the benefit’s 10-year cost.

Adding Fuel to the Fire?

The Bush administration’s new estimated cost for Medicare Part D caused quite a stir because it was substantially higher than the previously released estimated cost of Part D spending for the period 2004-13. Indeed, \$720 billion does represent a substantial cost, but the difference between the two estimates is easily explained. The first two years of the program, 2004 and 2005, involved only the drug discount program, the low-income support program, and implementation expenses, each of which cost relatively little. These two years are not included in the estimate for the years 2006-15, while the two years that were added for that estimate, 2014 and 2015, necessarily involve much higher costs because the program will have been in effect for eight years and because of medical inflation.

Medicare’s Longer-Term Issues

The so-called “intermediate projections” contained in the 2004 Medicare Trustees report are usually regarded as optimistic because they are based upon a medical inflation rate that’s far smaller than either the rate that has been actually experienced or the rate included in the current 10-year projections. Thus, Medicare expenditures could even exceed 7.7 percent of GDP by 2035.

The report also projects that the hospital insurance trust fund for Medicare Part A will exhaust

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its assets by 2019 and will not meet the test of short-range financial adequacy within the next decade.

Yet, as serious as the concern about the HI trust fund is, Medicare Parts B and D raise a concern that's in many ways a greater one. The concern about these programs is less about insolvency than about the impact the programs will have on the U.S. treasury, because Parts B and D are mostly financed from general revenue along with premiums and copayments made by seniors directly.

No Easy Answers for Medicare

Diagnosing the problem for Medicare is much easier than finding viable solutions. As is well known, 78 million baby boomers will start to turn 65 in 2011. They will continue reaching retirement age over the next 20 years, doubling the population covered by Medicare. Moreover, these boomers will live longer than their predecessors. And almost as important, their generation is followed by the unusually small "baby-bust" generation.

The most obvious types of Medicare options—changing benefits, changing eligibility, or changing the financing of Medicare—could help to meet Medicare's future financing needs. But none of these changes is easy, in either its politics or its economics. Two areas that have received relatively less attention, however, may have some potential to ease the financial burdens from Medicare: rethinking the concept of retirement and finding ways to "spend smarter."

Rethinking retirement. This option means regarding Medicare and Social Security as joint programs supporting retired Americans and reconsidering whether retirement at age 65 should remain the norm. The choice of age 65 occurred at a time when the average lifespan for Americans was far less—and disability rates among the elderly were far greater—than they are today. Although Social Security is now moving to age 67 for full benefits, persons who retire even at this age could expect to live as much as 20 to 25 years in retirement.

Changing the expectation of retirement at 65 will require changes in the country's fiscal policies as well as changes in cultural expectations. Fortunately, the scarcity of new labor entrants associated with the baby-bust generation is likely to make employers more interested in hiring older workers than they have been in the past.

"Spending smarter." If the United States can find ways to promote improved spending—for example, through strategies involving pay for performance, health IT, electronic health records, and changes in the tax code—it may be possible to reduce the growth in healthcare spending to rates that are below historic averages. Because Medicare tends to track the rest of healthcare spending, reduced rates of spending growth in Medicare can be sustained only if spending growth rates are kept down more generally in health care.

It is unknown whether introducing better information on comparative cost and clinical effectiveness and including better incentives for both patients and providers to spend smarter will actually slow healthcare spending growth rates or just provide for better value. But given the other options available, such as artificial budgetary caps or limiting access to medically beneficial health care, improving information and incentives may seem to be the most promising strategies available. ●

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