The 2018 Medicare Trustees Report: Fiscal and Policy Challenges

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Medicare’s financial outlook has deteriorated in the past year, according to the latest annual report by the program’s trustees. The Medicare Hospital Insurance trust fund is projected to be depleted in 2026, three years earlier than estimated in last year’s report. That understates the policy challenge. Every year, the program relies more on general revenues to cover its costs. In total, Medicare will receive $324 billion in general revenues this year. That will more than double by 2026. Prompt action is needed to put Medicare on a sound financial footing.

The ongoing public debate on the future of the American health system has focused on the challenges of making health insurance available and affordable for everyone. Largely overlooked in this debate is the fiscal threat facing the Medicare program resulting from an aging population, an increasing ability to treat disease, and the rising cost of treatment. The recently released 2018 Annual Report of the Medicare Board of Trustees reminds us that a lack of heated debate over the future of Medicare does not mean the program is secure. The report finds that total Medicare costs will grow rapidly over the next two decades as the large baby-boom generation ages into the program, leading to long-term financial shortfalls (Boards of Trustees 2018).

It is vitally important for the public and policymakers to clearly understand that policies to address those shortfalls should be adopted as soon as possible. The trustees argue that more immediate action would “permit consideration of a broader range of solutions and provide more time to phase in changes so that the public has adequate time to prepare” (Social Security and Medicare Boards of Trustees 2018). The Medicare trustees have given similar warnings in annual reports over the past five decades, but policymakers have typically not responded quickly or consistently.

Medicare’s Fiscal Condition

This year’s trustees report warns us once again that Medicare is living on borrowed time. The trustees estimate that Medicare’s Hospital Insurance (HI or Part A) trust fund will be depleted in 2026, three years earlier than projected last year. That date is widely reported in the press because it is the least technical (and most understandable) indicator of Medicare’s fiscal status, but it tells only part of the story.

Outlays for the Supplementary Medical Insurance (SMI) trust fund, which pays for physician and outpatient services (under Medicare Part B) as well as prescription drugs (under Medicare Part D), are growing even faster than spending for inpatient care. Over the next 75 years, Medicare faces $37.7 trillion in liabilities that are not paid for through payroll and other taxes, beneficiary premiums, or other revenue sources specifically dedicated to the program (Boards
of Trustees 2018, 207). With enrollment increasing by 40 percent through 2035, the program will consume an ever-increasing share of the federal budget unless policies are adopted to bend Medicare’s cost curve (Boards of Trustees 2018, 181).

Because of the way the separate components of Medicare are funded, only the HI trust fund can become insolvent (in the sense that it will not be able to pay all its bills). HI is funded primarily from payroll taxes (paid by workers and their employers) and taxes on the benefits provided to high-income enrollees. In 2017, payroll taxes accounted for nearly 90 percent of the income received by the HI trust fund (Boards of Trustees 2018, 11). The trustees report shows that the HI trust fund began to sell off assets to cover its operating cost beginning in 2008, and the trust fund will be exhausted in 2026 (Social Security and Medicare Boards of Trustees 2018).

Trust fund exhaustion is not equivalent to bankruptcy in the private sector. Hospitals and other Part A providers would still be required to provide necessary services to Medicare beneficiaries, but providers would not receive full payment from the program. Providers could only be paid up to the amount of new revenue received by the trust fund during the year. In 2026, dedicated revenues will be sufficient to pay 91 percent of Part A costs (Social Security and Medicare Boards of Trustees 2018). By 2039, payment will drop to 78 percent.

In contrast, the SMI trust fund is financed primarily by beneficiary premiums and general revenue. About one-quarter of Medicare Part B’s funds are from premiums, and about three-quarters are from general revenue. Premiums accounted for 15 percent of Part D revenues in 2017, general revenue accounted for about 74 percent, and the rest came from payments from the states. Transfers from general revenue are automatically made to Part B and Part D to ensure that the cost of operating those programs is fully paid each year.

The differences in the way the HI and SMI trust funds operate often confuse discussions of Medicare’s fiscal future. The HI trust fund is projected to have a balance of $196.8 billion by the end of 2018, about $5.2 billion less than at the end of the previous year (Boards of Trustees 2018, 54). The declining trust fund balance is the result of selling assets—federally issued bonds—to the Treasury. From a trust fund perspective, this is an infusion of cash needed to fund the current operations of Part A.

From a budget perspective, that $5.2 billion is identical to payments from the general revenue received by the SMI trust fund. In 2018, the SMI trust fund will receive general revenue totaling $318.8 billion for Part B and Part D (Boards of Trustees 2018, 87 and 105). In 2026, the year that the HI trust fund is projected to be insolvent, HI will need $51.9 billion in general revenue to fund the budget shortfall. That year, the SMI trust fund will receive $612.2 billion in general revenue to maintain its operation.

Reforms that change provider and consumer incentives and promote efficient health care delivery are needed to resolve Medicare’s long-standing fiscal crisis.

Because general revenue is not automatically transferred to the HI trust fund when spending exceeds income, a funding shortfall would likely force Congress to adopt politically unpalatable policies to preserve the program. The trustees estimate that solvency of the HI program over the full 75-year actuarial window could be maintained if the payroll tax was raised permanently from 2.9 percent (the current rate for most workers, combining tax rates paid by the employee and employer) to 3.72 percent. Even then, the HI trust fund would be exhausted in year 76.

Alternatively, HI spending could be cut by 17 percent if the cut was immediately effective and by a larger amount if the cut was phased in over time (Boards of Trustees 2018, 29–30). Such a reduction would be on top of over $800 billion in Medicare payment cuts imposed over the next decade by the Affordable Care Act (Congressional Budget Office 2015).

Other stopgap measures include enacting a premium to be paid by all Part A enrollees or enacting an intergovernmental transfer of general funds from the Treasury to cover prospective shortfalls. Adding

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1. The funding shortfall equals unfunded obligations (HI) plus general revenue contributions (SMI).
more money to the HI trust fund or cutting provider payment rates are at best temporary fixes that do not address the fundamental structural problems built into Medicare that drive up program spending. Reforms that change provider and consumer incentives and promote efficient health care delivery are needed to resolve Medicare’s long-standing fiscal crisis (Moffit 2011, Antos 2012).

**Medicare Spending Is Accelerating**

Medicare spending, which slowed in the past few years, is once again on an upward trajectory. The trustees project that the program will grow from 3.7 percent of gross domestic product (GDP) in 2017 to 5.9 percent by 2042 (Boards of Trustees 2018, 6). Spending growth moderates somewhat, increasing gradually thereafter to about 6.2 percent of GDP by 2092.

Those estimates, which are based on current law and assume that all policies now in place will be fully implemented over the long term, are likely to underestimate the growth of Medicare spending. In a companion report, the Centers for Medicare and Medicaid Services’ Office of the Actuary presents an illustrative scenario that assumes the tight limits on payment rates for physician, hospital, and other services required under the Medicare Access and CHIP Reauthorization Act (MACRA) and the productivity adjustments required under the Affordable Care Act (ACA) will not be retained (Shatto and Clemens 2018). That report, discussed further below, estimates that program spending will reach 6.1 percent of GDP by 2040 and 8.9 percent in 2092 (Shatto and Clemens 2018, 14).

Under either set of assumptions, Medicare spending growth will be a relentless contributor to the broader and increasingly dangerous fiscal challenge of federal entitlement spending. The Congressional Budget Office (CBO) projects Medicare’s gross spending will grow from $705 billion to $1.4 trillion from 2017 to 2027 (Congressional Budget Office 2017a, 96). It is the biggest driver of federal health care spending, dwarfing Medicaid, the ACA subsidies, and the Children’s Health Insurance Program. If current law remains unchanged, federal health spending led by Medicare will grow larger than any other budget category (Banthin 2017, 14). Today, federal health spending amounts to 28 percent of all noninterest federal health spending. By 2047, it will reach 40 percent of all such spending (Banthin 2017, 16).

The Medicare Payment Advisory Commission (MedPAC) raised concerns about the consequences of the growing cost of federal health programs. MedPAC states: “With their reliance on general tax dollars and federal deficit spending, Medicare and the other major federal health care programs have a substantial effect on the federal debt” (MedPAC 2018, 21). In 2017, the CBO announced that debt reached 77 percent of the GDP and that projected debt would amount to 89 percent of GDP by 2027. Assuming no change in current law, the debt would reach 150 percent by 2047. The CBO observes that this would be the “highest level” in the nation’s history, remarking that “such high and rising debt would have serious budgetary and economic consequences” (Congressional Budget Office 2017b, 1). That understates the seriousness of the fiscal problem.

**The Dangers of Short-Term Policymaking**

The Medicare trustees report provides a 75-year perspective on the program’s finances. In contrast, policymakers typically think shorter term, and the congressional policy process is geared to the 10-year budget window used in CBO estimates. The political imperative to get a “good” CBO score can overwhelm the need for policymakers to consider the long-term consequences of legislation.

The Office of the Actuary’s illustrative scenario that accompanies the trustees report highlights the problems that occur under such circumstances (Shatto and Clemens 2018). The report analyzes the likely impact of two major policies that were enacted to slow Medicare spending: MACRA, which replaced the sustainable growth rate (SGR) formula that limited annual updates for Medicare physician payments, and the productivity adjustments adopted by the ACA to slow the growth of payments for most other Medicare services.

The SGR formula called for double-digit reductions in Medicare payment rates for physicians, although Congress generally took action to avoid making such large cuts. MACRA replaced the SGR formula with a new structure intended to reward physicians who enter into “advanced alternative payment mechanisms”—accountable care organizations, bundled payment arrangements, and other payment...
methods intended to promote more efficient use of services.

The Office of the Actuary determined that MACRA would avoid the possible loss of access to services in the near term if double-digit cuts in physician payments under SGR were allowed to take effect. However, over the longer term, rate increases under MACRA would likely not keep pace with inflation. Moreover, substantial bonus payments that are included in MACRA would expire in 2025, resulting in a significant one-time payment reduction for most physicians. By 2048, physician payment rates would be lower under MACRA than under the SGR and would decline thereafter.

The aging population and rising health care costs are the major drivers of Medicare’s worsening financial situation.

Most other Medicare services receive annual market-basket adjustments that increase the prices paid by the program. The ACA reduced those payment updates to account for economy-wide productivity, beginning in 2011. In principle, adjusting Medicare payment rates for productivity improvements should give providers an incentive to reduce excess cost and become more efficient.

However, measured productivity gains in the health sector have generally been far below economy-wide productivity. The trustees estimate economy-wide productivity will increase by about 1.1 percent per year over the long term. In contrast, hospital productivity has increased in recent years by about 0.4 percent per year and by negligible amounts over longer periods.

There are problems with productivity measures in the health sector, and some argue that the labor-intensive nature of health care limits the scope of efficiency improvements (Sheiner and Malinovskaya 2016). Nonetheless, the law is clear. Payment updates for most nonphysician services will be reduced by economy-wide productivity gains.

The Office of the Actuary estimates that Medicare payments for inpatient hospital services will decline sharply, dropping from about 60 percent of private health insurance payment rates today to about 37 percent of the private-sector level by 2022. Medicare payments for physician services will decline from about 75 percent of private rates to 24 percent in 75 years.

The Office of the Actuary points out that projections of Medicare spending under current law “reflect substantial, but very uncertain, cost reductions” because of provisions in the ACA and MACRA (Boards of Trustees 2018, 41). Although the numbers may be uncertain, the message is unmistakable: Sizable reductions in the growth of Medicare spending are almost certainly not attainable “without fundamental change in the current delivery system.”

A Window of Necessity

The aging population and rising health care costs are the major drivers of Medicare’s worsening financial situation. About 10,000 baby boomers are turning age 65 every day and entering the Medicare program. That increases the number of enrollees relying on Medicare-covered services, and it erodes the pool of workers who are helping pay for the program through payroll and income taxes.

These demographic shifts help explain the recent slowdown in Medicare spending growth but should serve as a warning that spending growth is likely to rise sharply while program revenue growth will fall off. Table 1 shows the Medicare spending growth declined from 9 percent a year between 2000 and 2010 to half that rate between 2010 and 2018.2 Over the same period, annual enrollment increases nearly doubled, from a little over 800,000 a year between 2000 and 2010 to more than 15 million new enrollees a year between 2010 and 2018. Many factors—including the deep recession in 2008–09, the movement of some blockbuster drugs off-patent, and the introduction of new ways of paying for and delivering health services—contributed to the recent slowdown in health spending, which benefited public and private insurers in the US and internationally. One additional factor may have helped Medicare:

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2. The introduction of Part D in 2006 accounts for some of the increase in total spending. Excluding that component of spending does not affect the overall conclusion that Medicare spending slowed in recent years.
Table 1. Medicare Spending and Enrollment, 2000–27

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<th>Spending (Billions)</th>
<th>Enrollment (Thousands)</th>
<th>Average Annual Growth</th>
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<tr>
<td></td>
<td>Spending (Percentage)</td>
<td>Enrollment (Thousands)</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>$221.8</td>
<td>39,688</td>
<td>—</td>
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<tr>
<td>2010</td>
<td>$522.9</td>
<td>47,720</td>
<td>9.0%</td>
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<tr>
<td>2018</td>
<td>$745.0</td>
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<tr>
<td>2027</td>
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<td>7.5%</td>
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Source: Authors’ calculations based on Boards of Trustees 2018, 177 and 181.

the influx of a large cohort of new, relatively healthy enrollees. The baby boomers may have helped hold down spending growth because of their relative youth and lower use of services compared with the average, older Medicare population.3

That dampening effect on spending growth will reverse as the baby boomers reach older ages and need more health services. The trustees estimate that Medicare spending will grow much more rapidly over the next decade, a consequence of enrolling the remainder of this large birth cohort by about 2021 and increasing the use of services for the average enrollee. Medicare spending growth in Medicare is projected to exceed GDP growth by 2–3 percentage points over the next decade (Boards of Trustees 2018, 185).

Adding to this fiscal pressure is a relative decline in payroll tax receipts as workers retire and enroll in Medicare (Adamy and Overberg 2018). Payroll taxes have declined as a share of the program’s income for about two decades. In 2018, 36.2 percent of Medicare’s income comes from payroll taxes (Boards of Trustees 2018, 182). That is expected to fall to 28.8 percent by 2030. Over the same period, general revenue will grow from 43.2 percent to 48.0 percent of Medicare’s income.

The situation is likely to be even more serious than those estimates indicate because they assume that the payment reductions called for under the ACA and MACRA will be fully implemented. It remains to be seen whether policymakers will ignore the requests from provider and patient groups for relief from tight payment updates prescribed under current law.

Conclusion

Medicare is largely a middle-class federal entitlement and as such is a much tougher political challenge than reforming traditional welfare programs.4 Today, American government is increasingly a complex mechanism for transferring money from classes of Americans, mostly those who work, to other classes of Americans, mostly those who do not or cannot work, based on various formulas of eligibility. As Robert J. Samuelson points out, this has been the norm for many years. Americans today live in an “age of entitlement” (Samuelson 1997). Moreover, Americans mostly like it, even if they do not want to pay for it.

The problem is that middle-class entitlements, especially Medicare and Social Security, are crowding out other budgetary priorities, including national defense. Medicare is the most difficult challenge as a fiscal, managerial, and political problem. If Congress and the Trump administration cannot control federal entitlements, they cannot contain the coming explosion in deficits and the growth in

3. Several studies attempt to identify the age profile of health care use; see Berhanu Alemayahu and Kenneth E. Warner (2014) for a thoughtful discussion of estimating challenges. Centers for Medicare and Medicaid Services reports limited data that confirms higher per-enrollee Medicare spending for those age 85 or older compared with those between age 65 and 84; see Centers for Medicare and Medicaid Services (2017), Table 26.

4. Arguably the most ambitious reform of traditional welfare programs was enacted under a Democrat president. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 was signed into law by President Bill Clinton on August 22, 1996. Broad reform of Medicare has received much less support from both sides of the political aisle.
the federal debt, which is already more than three-fourths of the national economy. If they cannot control the debt, they cannot prevent a fiscal crisis and its catastrophic economic consequences.

There are opportunities to make consequential reforms. Carefully calibrated and designed changes can reduce the growth in Medicare per capita costs and thus have a significant fiscal impact over time. Future debt, as MedPAC reports, is sensitive even to the slightest changes in Medicare and Medicaid per capita spending (MedPAC 2018, 22).

Policymakers could take steps to slow the growth of Medicare spending and improve the performance of the program (Antos, Capretta, et al. 2015). Traditional fee-for-service Medicare’s complex design could be simplified by combining Parts A and B, modernizing the benefit structure, and adding protection against catastrophic expenses. That would reduce the need for Medigap and other supplemental coverage, which blunts financial incentives that reduce unnecessary and wasteful use of health services. Medicare’s eligibility age, which has been 65 since the program was enacted, could be raised to 67, the current normal age of eligibility for Social Security benefits. Congress could build on the continued growth of Medicare Advantage, which offers Medicare beneficiaries a choice of private plans as an alternative to the traditional fee-for-service program. Policies could be adopted that promote more vigorous competition between traditional Medicare and Medicare Advantage plans, promote consumer decision-making through improved information on coverage options, and allow more flexibility for health plans to adapt payment and delivery approaches to local conditions. Such changes would provide the platform for shifting from inefficient fee-for-service to expanded use of defined contribution financing for the entire program.

The Medicare trustees have done their job. It is time for Congress and the White House to do theirs.

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References


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