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## **Medicare at 50: Key Facts about Medicare's Fiscal Status and History**

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“A single payer would be even more effective than Medicare is today... It would be a powerful lever for better care.” - Dr. Donald Berwick, international quality expert and former top administrator of Medicare (2010-2011).

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### **Medicare's Fiscal Status – No immediate crisis, but need for reform over long term**

#### **Financing Medicare for the next decade: 2014-2024**

Despite the retirement of the baby boomers over the next decade, there is no immediate crisis in financing Medicare. Medicare's share of the budget (about 14.5 percent) and of the economy (roughly 3 percent) will remain about the same between 2014 and 2024, according to the latest report of the Medicare Trustees and the Kaiser Family Foundation.

In particular, funding for hospital care, or Medicare Part A, is secure for the foreseeable future. Medicare Part A is funded with a 2.90 percent tax on payroll and there is enough money in the Medicare Hospital Insurance Trust Fund, a reserve cushion, to pay for any hospital bills in excess of the payroll tax's revenue until 2030.

After that, Medicare still has enough projected payroll income to cover 85 percent of annual hospital expenditures, falling gradually over time to cover 77 percent in 2088. There have been many times in the history of Medicare when the reserve was said to be nearing depletion, but Congress has never allowed that to happen.

#### **Financing Medicare over the Long Term**

##### **The problem**

Over time, Medicare's costs are projected to rise from their current level of 3.5 percent of GDP to 5.6 percent in 2040 and peak at 6.9 percent in 2088.

Rapid enrollment growth is only a part of the problem. Over the next decade, the number of Medicare beneficiaries will grow by 2.8 percent annually, only slightly faster than the program grew between 1968 and 1993, 2.6 percent. After 2024, enrollment growth will drop to 1.6 percent annually, and then below 1 percent after 2039.

It's worth noting that immigrants, including undocumented immigrants, play an important role in financing Medicare, even though they are excluded from coverage under the Affordable Care Act. According to one study, immigrants contributed over \$115 billion to the Medicare Trust Fund between 2002 and 2009

The real challenge for Medicare over the long-term is controlling the growth in per capita health care costs.

## **False and Real solutions**

The long-range financial imbalance in Medicare Part A hospital financing could be easily addressed. Raising the current 2.90 percent payroll tax to 3.77 percent (by 0.87 percent of taxable payroll) for the 75-year period would make up the projected shortfall. But that wouldn't cover rising costs in other parts of the program.

Increasing premiums on higher income beneficiaries for Parts B and D of Medicare, as has been legislated recently, raises a paltry amount (\$6 billion in 2015 out of \$605.9 billion in Medicare spending), yet threatens the social solidarity that is the foundation of the entire program.

Proponents of privatization, like Paul Ryan, claim that turning Medicare into a voucher program would save money. But Medicare is better at controlling costs than private insurance, and the private plans in Medicare have increased, not lowered, Medicare's costs (see section below). Turning Medicare into a voucher program would shift costs to beneficiaries who on average already spend 20 percent of their incomes on out-of-pocket medical bills. Already, 25 percent of beneficiaries have out-of-pocket costs that exceed their total assets, including their homes, in the last five years of live.

So what is to be done? According to Bruce Vladeck, former top administrator of Medicare, "we can't realistically expect to control the growth of Medicare spending without controlling the growth of health care costs generally."

Only a single payer has the ability to wield tools that will effectively control costs throughout the system, such as slashing administrative costs (saving \$375 billion annually), negotiating fees with providers, global budgets for hospitals, negotiating drug prices with pharmaceutical companies and real health planning and capital investment.

Canada's single payer system has been much more effective at controlling costs, even though they banned co-payments in 1984. If U.S. Medicare spending per elderly enrollee increased as slowly as in Canada, the savings from 1980 through 2009 would have totaled \$2.156 trillion.

### **Medicare is more efficient than private insurance**

- Over the course of its history, Medicare has been more effective at controlling costs than private insurance. Between 1969 and 2012, private health insurance premiums grew 1.5 percentage points faster than Medicare spending per capita (9.2 percent versus 7.7 percent).

- Over the next decade, per capita Medicare spending is expected to grow at about the same rate as the rest of the economy (4.0 percent), while private health insurance premiums are expected to grow 2 percentage points faster than Medicare

This comparison includes benefits commonly covered by Medicare and private health insurance over this period, including hospital services, physician and clinical services, and other professional services, and durable medical products.

-The private plans participating in Medicare, now known as Medicare Advantage plans, have raised Medicare's costs by over \$282.6 billion since 1985. They cherry pick patients who need less care than patients in traditional Medicare, manipulate diagnostic codes to make patients appear sicker than they actually are to obtain inflated fees, and use their clout on Capitol Hill to mandate higher payments.

## Medicare Timeline

“The track record is incontrovertible: Medicare has proven that, as a nation, we are capable of getting medical care to a particularly vulnerable part of the population, and of reducing mortality, morbidity, and human suffering in the process.”

Bruce Vladeck, former top administrator of Medicare (1993-1997)

### 1935

- Social Security passes. The importance of Social Security to Medicare was described by one of the architects of Medicare, Robert Ball (“What Medicare’s Architects Had in Mind,” Health Affairs, Winter 1995):
- “The success of Social Security played an important part in making the case for Medicare. The slogan became ‘health insurance through Social Security’ and references to the ‘tried and true method of Social Security’ abound in the record of the debates. Much was meant by these references to Social Security, some of it explicit and some subliminal. On the one hand, supporters made clear that although a cash payment per month could be made reasonably adequate to cover recurring costs such as food, housing, and clothing, it could not meet the unpredictable cost of major illness. There was no way for persons to budget for the unpredictable. Only insurance, which took care of very high costs by averaging them in with all costs, could do the job.
- “It thus was quite clear that a secure retirement – the objective of Social Security – required that health insurance, particularly hospital insurance, be added. ... Also, it was widely acknowledged that the Social Security program was well administered, even in the case of disability insurance ... Administering the disability insurance program turned out to be a useful experience for those who were to administer Medicare ... and many doctors discovered that the government could really be quite reasonable.”

### 1956

- The first program to be given the name “Medicare” was enacted in 1956 under President Eisenhower, a staunch opponent of national health insurance. It was health insurance for dependents of members of the armed forces.
- Social Security cash benefits for the totally disabled were also enacted in 1956, over the strong objections of the AMA. The AMA suspected that they might lead to working relations between the government and the medical profession, and be a step towards health insurance. The AMA was correct. Art Hess, who was in charge of administering disability benefits, did such a good job that he was appointed the first administrator of Medicare in 1965.

### 1960

- In 1960, the Kerr-Mills Act created the Medical Assistance for the Aged (MAA) program, which provided matching grants to participating states to care for the indigent elderly.
- The American Medical Association vehemently opposed national health insurance. They poured funds into the campaign coffers of opponents of national health insurance running for Congress, and funded the largest public relations campaign in history against what they deemed “socialized medicine.” As Congressional action began to look inevitable, they hired then-actor Ronald Reagan to make a recording for doctors’ wives that concluded by saying if they didn’t defeat Medicare “one of these days we are going to spend our sunset years telling our children and our children’s children, what it once was like in America when men were free.”
- Lyndon Johnson’s re-election in 1964 gave the Democrats both the Presidency and the Congress, with large majorities in both the House and Senate. Johnson stressed the importance of Medicare to his “Great Society” program.

## 1965

- Medicare was signed into law by President Johnson on July 30, 1965, in Independence, Missouri, the birthplace of Harry Truman. Johnson gave a moving speech at the signing. Truman and his wife Bess were awarded the first two Medicare cards in honor of Truman's long advocacy for national health insurance as a logical extension of the present Social Security system. From the start, Medicare was intended to be the cornerstone of a national health program, not a program limited to seniors.
- The legislation made two amendments to the Social Security Act of 1935. Title XVIII, which became known as Medicare, and Title XIX, which became known as Medicaid.
- The bill passed the House by a vote of 313-115, including 70 yeas from Republicans, and the Senate by a vote of 68-21, including 13 Republicans.
- While Medicare was a national health insurance program for almost all seniors, regardless of income, Medicaid, passed at the same time, was launched on a different path. Medicaid was available only to the indigent, and was run by the states with matching grants from the federal government, the way the Kerr-Mills Act had been. Over time, Medicare has proved to be the stronger program because of its broad political base, while Medicaid continues to be subject to underfunding, means testing, cuts, and callous restrictions (e.g. 21 states have not expanded their Medicaid programs under the Affordable Care Act).
- Medicare started with two parts: Medicare Part A covers hospital care and is funded by a payroll tax, currently set at 2.90 percent. Medicare Part B covers medical care and is funded by general revenues and premiums, currently \$104.90 per month.
- Medicare was rolled out smoothly in 1966 at a cost of \$867 million (in today's dollars) for the first year, for both enrolling 19 million seniors and processing medical bills, compared to the over \$6 billion spent on enrollment costs alone in the ACA's first year.
- In an important civil rights victory, Medicare's prohibition on payments to segregated hospitals forced the desegregation of hospitals in the South. In addition, it led to Black physicians getting admitting privileges at hospitals.

## 1972

- Coverage for end stage renal disease was added to Medicare in 1972. Its lifesaving potential was demonstrated to great effect (and national press coverage) on a 43-year-old national advocate and dialysis patient, Shep Glazer, before the House Ways and Means Committee in November of 1971. The hearing was held as a part of 21 days of hearings during that session on national health insurance proposals, including on President Nixon's plan.
- Coverage for people of any age who have been disabled for two years or more was also added in 1972, after having been proposed by President Johnson in 1967.
- Congress authorized capitation payments to private health insurers for services covered under Part A and Part B for the first time, opening the door to what has become the costly Medicare Advantage (Medicare Part C) program. The goal initially was to avoid disrupting existing patient-provider relationships in staff-model health maintenance organizations (HMOs), such as the nonprofit Kaiser plan in California. Private plans accounted for less than \$1 billion in annual Medicare spending until 1985. Since then they have ballooned into a \$156 billion industry.

## 2003

- Medicare Part D, the prescription drug benefit, was added in 2003. Instead of adding the coverage directly to Medicare, Part D is structured differently than traditional Medicare: The federal government pays private companies to administer the benefit. The legislation requires the coverage to be routed through private insurance plans, adding complexity and administrative expense.

- The 2003 law also explicitly prohibits Medicare from negotiating drug prices with pharmaceutical companies, adding greatly to the program's cost. Rep. Billy Tauzin (R-LA) was in charge of getting the votes to pass the bill through the Senate. After the bill passed he became the CEO of Pharma (the drug firms' trade association) with annual compensation of \$2 million.
- Only 10 percent of seniors choose the private plan that would provide the greatest coverage for them, according to a June 2012 study published by the National Bureau of Economic Research.

## 2010

- The 2010 Affordable Care Act added coverage for preventive services without co-payments to Medicare benefits.
- Although the ACA authorized the reduction in Medicare Advantage plan overpayments over a period of several years, the cuts are partly reversed or offset by quality "bonuses", leading to record profits by the insurance industry over the next period.

## 2015

- Medicare is America's most popular social program, along with Social Security
- It covers 55 million people - the oldest, sickest, and most disabled Americans - roughly 17 percent of the population.
- It has contributed to a five year increase in life expectancy at age 65 and dramatically reduced poverty in seniors.
- Polls show that a majority of the Americans public and physicians support Medicare for All, single payer national health insurance.
- Marilyn Tavenner, top administrator of CMS from 2012 to 2015, takes job leading the insurance industry's trade group, AHIP, for a salary of \$2 million. As CEO of AHIP she will be lobbying the agency she used to direct on regulation and payment issues.