

ELECTION 2004

Financing Medicare in the Next Administration

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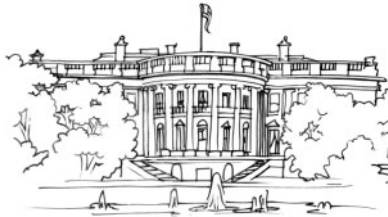
Because of its size and political impact, Medicare will rank high on the domestic policy agenda of any incoming administration. When that administration assumes office in January 2005, Medicare will account for more than 13 percent of total federal expenditures; the only larger domestic program will be Social Security, which will account for 21 percent.¹ By fiscal year 2007, with the phase-in of the prescription-drug benefit, Medicare's share of federal spending will increase to almost 16 percent. In short, the new administration will find the scope of any new initiatives limited by the needs of the Medicare behemoth.

In fiscal year 2005, Medicare will spend an average of almost \$8,000 on each of its 41 million beneficiaries. It is not surprising that with this amount of money on the table, Medicare is a voting issue for those beneficiaries and their adult children. Among Americans 60 years of age or older who voted in the 1996 presidential election, Medicare and Social Security ranked as the top concern; 29 percent of voters in this age group ranked it first, as compared with only 8 percent of voters younger than 30.² And there is a disproportionately high voter turnout among the elderly: 70 percent of Americans 65 years of age or older voted in the 2000 election, as compared with 36 percent of those 18 to 24 years of age and 51 percent of those 25 to 34 years of age.³

Other than the prescription-drug benefit, however, neither President George W. Bush nor Senator John F. Kerry has focused much attention at all on Medicare during the presidential campaign through September. Nonetheless, Medicare will pose both substantive and budgetary questions for any incoming administration, and its sheer size will force those questions to the fore. The substantive questions revolve around how and how much to pay providers of medical goods and services, as well as the role in Medicare of private insurance plans. The budget issues are both short- and long-term. Their resolution will determine how the cost of Medicare

beneficiaries' care is distributed, both between the elderly and the nonelderly and among the elderly of varying incomes.

Although it seems unlikely that any new administration will be willing to address the long-term budget issues, the short-term issues must be tackled. The Congressional Budget Office estimates that the budget deficit for fiscal year 2005 will be \$348 billion, or 2.8 percent of the gross domestic product (GDP) — high by historical standards in a year when the country is not in a recession. Both Bush and Kerry have indicated that they would like to cut that figure in half by 2009. As they confront the budget deficit, they will come eyeball to eyeball with the large proportion not only of the budget, but also of the projected increase in federal spending that is accounted for by Medicare (see Table). These percentages make it difficult to imagine reducing the deficit in any meaningful way without touching Medicare.



The picture is even bleaker than it appears, because the values in the Table reflect current law, which includes 5 percent cuts in physicians' fees each year starting in 2006. Such cuts are unlikely to occur, because they pose a threat to beneficiaries' access to care. Moreover, cutting the funding for the drug benefit is unthinkable; indeed, there already is substantial political pressure to expand this benefit.

Although neither candidate has announced a plan for financing Medicare, one can speculate on strategies they might use on the basis of the policies that have traditionally been favored by Democrats and Republicans in Congress. Kerry might take aim at payments to health plans — the program now called Medicare Advantage. The 2003 Medicare Modernization Act increased the amount of these payments in an effort to increase the participation of health plans, and plans have responded. The Congressional Budget Office, however, estimates that the higher payments cost only \$14 billion over a 10-year period, a modest portion of the \$395 billion increase in Medicare spending. Kerry might

Table. Increases in Medicare Spending as a Percentage of Increases in Federal Spending under Current Law.*

Fiscal Year	Percentage of Increase in Total Federal Spending Attributable to Increase in Medicare Spending	
	Including Spending for Prescription-Drug Benefit	Excluding Spending for Prescription-Drug Benefit
	2005–2006	52
2006–2007	49	21
2007–2008	27	18
2008–2009	23	20

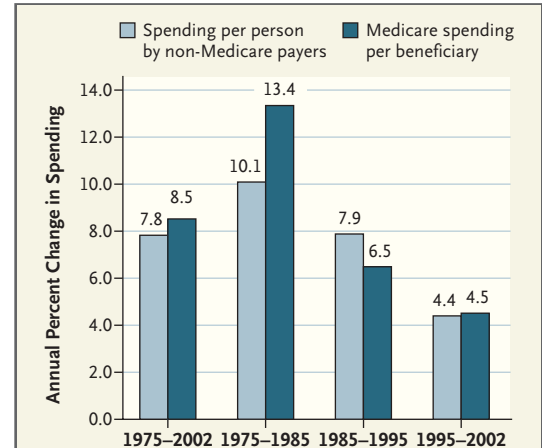
* Data are from the Congressional Budget Office's baseline budget of March 2004¹ and September 2004.⁴ The increases in total federal spending exclude interest on the federal debt. The payments for Medicare Parts A and B in the last column include payments to health plans for services covered by Parts A and B.

also seek to have beneficiaries with higher incomes pay more for Medicare coverage. The Medicare Modernization Act already moved in this direction by reducing the subsidy for Part B premiums for elderly persons with higher incomes; in the future, the subsidy for Part D drug premiums could be similarly reduced.

It is less clear what Bush would do to reduce Medicare spending. Possibly he, too, would look to shift more expenses to higher-income beneficiaries, but he is unlikely to reduce the amount of payments to private plans, because he strongly favors increasing their role in Medicare.

In the longer run, as the baby boomers turn 65, Social Security and Medicare, as well as the quarter of the Medicaid program that finances long-term care, will claim a considerably larger share of public spending than they do today. Any notion of how much larger a share, of course, is highly speculative; it depends in large part on how rapidly per-beneficiary medical spending increases.

One estimate, based on the intermediate of the three assumptions of the trustees of the Medicare program, is that between now and the mid-2020s, annual spending per beneficiary for Parts A and B (i.e., excluding the drug benefit) will increase at a rate 1.1 percentage points faster than the GDP. The trustees do not say how they arrived at this figure, but the historical record suggests that it is optimistic: since 1960, the annual growth of health care spending has exceeded the growth of the GDP by 2.7 percentage points. And Medicare growth must be reasonably related to the growth of total health care costs, or physicians may become unwilling to treat Medicare patients. The Figure shows spend-

**Figure. Annual Rates of Growth in Per-Person Spending on Hospital Care and Provider Services, Medicare versus Non-Medicare Payers, 1975–2002.**

Spending data are from the National Health Accounts, Medicare beneficiary data from the Center for Medicare and Medicaid Services, and U.S. population data from the U.S. Census Bureau.

ing per person on hospital care and provider services by Medicare and other payers; between 1975 and 2002, Medicare spending grew slightly faster than the remainder of health care spending, although the rates of growth have been nearly identical since 1995.

Moreover, increases in health care costs that outpace the growth of the GDP are not unique to the United States; the history is similar even in countries with single-payer health care systems. Among the five G7 countries other than the United States for which data are available (Canada, France, Germany, Japan, and the United Kingdom), the average excess increase in health care costs over the growth in the GDP was 2.0 percentage points per year between 1960 and 2002.⁵

Even if spending per beneficiary does increase only 1.1 percentage points faster than the GDP, approximately 3 percent of the GDP will still have shifted to Medicare by the mid-2020s, and Social Security and the long-term care component of Medicaid will claim additional amounts. If we assume that other federal spending increases at the rate of the GDP and there is no increase in the deficit, this shift to Medicare would require federal tax revenues to increase by more than 15 percent.

The seemingly irresistible forces of medical spending and demography, however, will increas-

ingly run up against the historical reluctance of American voters to allocate much more than 18 percent of the GDP to federal spending. Since 1946 the federal government's share of the GDP has stayed remarkably close to 18 percent, going below 16 percent in only 2 of the 57 years and above 20 percent in only 1.

One response, of course, is to ignore this *de facto* ceiling on federal revenues and assume that an increasingly graying society will want to spend a greater share of its money on pensions and health care for the elderly. But Medicare and Social Security both rely on a substantial component of payroll-tax financing, the burden of which falls primarily on nonelderly workers. Although many of these workers have elderly parents and are anticipating their own age of eligibility, it is unclear whether there would be political support for such a large transfer of resources from the nonelderly to the elderly.

The late Senator Daniel P. Moynihan (D-N.Y.) famously characterized Social Security as the third rail of American politics. Since he made that remark, the dollars spent on both Social Security and Medicare have increased, raising that third rail's voltage. As a result, an enormous amount of polit-

ical capital is required to address the issue of long-term financing, making it highly tempting for the next administration simply to leave the matter to its successors. Unfortunately, deferring the issue will only exacerbate the problem for future administrations and taxpayers.

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Triggering Myocardial Infarction

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Enormous progress made during the past few decades has dramatically enhanced our understanding of the pathobiology and pathophysiology responsible for acute myocardial infarction. Investigations in vascular biology have elucidated the critical role of growth factors, the proliferation of smooth-muscle cells, and the central role of inflammation in the initiation and progression of atherosclerosis.¹ Research has also focused on the initiating events or "triggers" that qualitatively alter the stable or quiescent phase of coronary atherosclerosis and initiate a cascade of events that culminates in acute myocardial infarction. Some triggering phenomena may exert a single, transient effect on the pathophysiologic process, such as a surge of sympathetic activity, whereas others exert a more varied and pervasive effect, amplifying risk at multiple points and over a longer period. In this issue of the

Journal, Peters et al. (pages 1721–1730) provide compelling epidemiologic evidence that particulate air pollution from traffic may trigger the abrupt onset of acute myocardial infarction. An understanding of air pollution in the larger context of triggering of the entire process of atherosclerosis suggests, in addition, that air pollution plays a more complex and multifaceted role in the development of cardiovascular disease over the longer term.

As initially described 15 years ago, the triggering of acute myocardial infarction typically begins with the so-called vulnerable or high-risk coronary atherosclerotic plaque, a focal lesion in jeopardy of plaque disruption.² The vulnerable plaque is usually an inflamed, thin-cap fibroatheroma, characterized by a lipid-rich, atheromatous core with cholesterol crystals and necrotic debris, a thin fibrous cap with an infiltration of macrophages and lymphocytes,