Health Care
Medicare: the 800-Pound Gorilla in the Room
by Gregg Davis

Background
The biggest challenge facing health care in the next decade is how to pay for health care, and, to a more impassioned level of debate, who is to pay? Private health insurance grew rapidly following World War II as employers competed for workers by expanding benefits since wage freezes were in place. Later, legislation for “Medical Assistance to the Aged” was passed in 1960, but it wasn’t until 1965 that Congress passed Title XVIII of the Social Security Act establishing Medicare as the medical care program for the elderly. Coverage was later added in 1973 for certain disabled persons and people with kidney disease.

Medicare, along with Medicaid and the State Children’s Health Insurance Program (CHIP), account for almost half of the $1.95 trillion spent on health care nationally and more than 75 percent of all public spending for health care. But due to aging baby boomers, a major shift toward funding from federal, state, and local government will occur over the next few years.

The Challenge Ahead
General revenues (federal tax dollars not dedicated to a particular use) accounted for 44 percent of total non-interest Medicare income in 2009, surpassing payroll taxes as the largest source of Medicare financing for the first time in history. When general revenue funding exceeds 45 percent of total Medicare spending, Medicare financing is either inadequate or general revenues under current law are unduly large.

In 2008, expenditures for hospital and other services paid from the Hospital Insurance (HI) Trust fund exceeded its revenues, and if left unchecked, could exhaust the fund in the next six years. Even under the most optimistic of assumptions, the trust fund could remain solvent only until 2028. The Supplemental Medical Insurance (SMI) trust is under similar pressure. Both the Board of Trustees of the Medicare Trust Fund and the Congressional Budget Office expect Medicare spending to grow at an annual average rate of 7 percent over the next decade, surpassing even the most optimistic growth rates for the entire economy. As a result, Medicare’s share of the total economy will grow from just under 1 percent in 1970 to more than 6 percent by 2030.

Figure 1
Percent of Net Operating Hospital Revenue from Medicare, 2009

Medicare Funding in Montana

In 2009, Montana received more than $594 million for Medicare Hospital Insurance funding, $515 million for Medicare Supplemental Medical Insurance, and $734 million for Medicare prescription drug coverage.

On the consumer side, Medicare is an important source of health insurance for nearly 17 percent of Montana’s population. A third of Medicare beneficiaries have incomes below 150 percent of the Federal Poverty Level, putting them at additional risk in terms of potentially higher taxes, premiums, and reduced benefits given the current trajectory of Medicare financing.

Medicare funding has drastic ramifications for all Montanans, not just for Medicare beneficiaries. Medicare has long been used as the bellwether for reimbursement rates for all providers. Shortfalls in cost reimbursement by one payer must be made up by other payers.

One way to see the importance of Medicare financing in the Montana economy is to examine Medicare payments to hospitals. In Montana, Medicare accounts for 34 percent of all hospital net revenues. But hospitals depend on Medicare funding to varying degrees. Hospitals in rural areas are particularly dependent on Medicare as a funding source, due to their older populations and lower private insured rates. (Figure 1).

Medicare and Hospital Profit Margins

Rural areas are served by Critical Access Hospitals, which are paid 101 percent of their allowable Medicare costs for most services. Acute Care Hospitals, on the other hand, are reimbursed according to a complicated formula under the acute Inpatient Prospective Payment System. Under the system, rates are supposed to cover costs that reasonably efficient providers would incur in providing high-quality care. But the consensus is that Medicare falls short of true cost reimbursement. This shortfall in Medicare reimbursement is absorbed by the hospital through efficiency improvements and shifted to other payers, primarily the uninsured and private third-party payers.

Hospital Medicare profit margins nationally are dismal, suggesting a significant cost shift to private pay and third-party payers. This cost shift is further necessitated by the hospitals’ role of “catastrophic insurer of last resort” in providing charity care to the uninsured. Last year uncompensated care in Montana totaled $220 million. Table 1 shows Medicare margins for Metropolitan Statistical Area (MSA) and non-MSA hospitals receiving Medicare reimbursement under the Inpatient Prospective Payment System, which excludes Critical Access Hospitals. MSAs include urban areas with populations of 50,000 or more. Even when critical access hospitals are added, the Medicare profit margin improves but remains negative (-4.5).

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<thead>
<tr>
<th>Table 1</th>
<th>Medicare Margins for Services Covered by Acute Inpatient Prospective System</th>
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<tbody>
<tr>
<td></td>
<td>2004</td>
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<tr>
<td>Non MSA Hospitals</td>
<td>-3.3</td>
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<tr>
<td>MSA Hospitals</td>
<td>-3.0</td>
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<tr>
<td>All Hospitals</td>
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Note: Metropolitan Statistical Areas (MSA) include urban areas with populations of 50,000 or more.
Source: Medicare Payment Advisory Commission, June 2010.
Hospitals more dependent on Medicare revenue experienced lower total margins, according to a recent BBER study. Other studies also suggest declines in hospitals’ total margins tend to be associated with major Medicare policy changes.

Figure 2 examines the share of charges received by Montana’s hospitals from private, Medicare, and Medicaid payers. Although charges are not costs, and Medicare charges over costs have increased by a factor of three nationally, it still provides a snapshot of the degree of disparity between charges billed and collected by payer. As shown, private payer reimbursements for charges to private payers are uniformly higher than the public payer charges recovered from charges to public payers. It should be noted that underpayments do not necessarily result in a dollar-for-dollar cost shift. Hospitals are under continued pressure to treat patients more cost efficiently.

**Conclusion**

If Medicare spending increases at a 7 percent annual rate over the next decade, virtually no provider or consumer of health care will go unaffected. For hospitals, the ability to continually serve Medicare patients, particularly at a time when more of the population enters the Medicare years for health care coverage, will continue to be a financial challenge. Medicare, by virtue of serving an older and generally sicker population than other payers, changes the level as well as the distribution of spending across different providers of health care. Efforts to provide medical treatment for Medicare’s costliest beneficiaries will assume even more importance in the future. The costliest 25 percent of fee-for-service Medicare beneficiaries account for over three-fourths of Medicare spending. These beneficiaries tend to have chronic medical conditions, use hospital inpatient care, are Medicaid eligible, and in the last year of life.

In essence, there really is an 800-pound gorilla in the room. Our nation’s ability to reconcile the health care spending dilemma is illustrated by the Medicare program, but not certainly limited to it. Montanans continued access to doctors and health care will depend on the ability of the nation to bend the cost curve of health care while still providing the necessary reimbursement for health care providers. Whether across the board cuts in Medicare will achieve this outcome is questionable.