



**M&I Marshall & Ilsley Bank**



Marshfield Area Chamber  
Of Commerce & Industry's  
Marshfield Economic  
Development Association

# **MARSHFIELD AREA 2006 ECONOMIC INDICATORS**

**4th Quarter 2006  
presented**

**February 15, 2007  
Economic Indicators Report**

**February 22, 2007  
Special Report**

**Presented by:**

**Central Wisconsin Economic Research Bureau**

**Randy F. Cray, Ph.D., Professor of Economics and Director of the CWERB**

**Scott Wallace, Ph.D., Assistant Professor of Economics and Research**

**Associate of the CWERB**

**Alexander Richter, Administrative Assistant**

**Patrick J. Rathsack, Administrative Assistant**

**Special Report: Medicare: Sacred Cow or the Elephant in the Living Room?**

**Jason Davis, Ph.D., Assistant Professor of Economics - University of Wisconsin  
Stevens Point.**

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CWERB - Division of Business and Economics  
University of Wisconsin-Stevens Point  
Stevens Point, WI 54481  
715/346-3774 715/346-2537  
[www.uwsp.edu/business/CWERB](http://www.uwsp.edu/business/CWERB)

## National and Regional Outlook

The GDP in fourth quarter of 2006 grew at an unexpectedly high 3.5 percent annualized growth rate. Most analysts thought the economy would slow during fourth quarter 2006 to the 1 to 2 percent range. Some forecasters even thought GDP might actually contract due to the weakness in the real estate market. Needless to say, their forecast underestimated the resiliency of the economy. The consensus view for 2007 is that the economy will probably continue to expand, albeit at a slower pace than the 3.4 percent registered for the full year of 2006.

Moreover, on January 31<sup>st</sup> the Federal Reserve decided to hold the key federal funds rate at 5.25 percent. In their assessment of economic conditions, the Federal Reserve felt the economy was on firm ground at the start of 2007. Moreover, the important housing market is showing signs of stabilizing and that inflationary pressures in the economy seem to be moderating. The decline in real estate and energy prices has helped clam inflationary pressures. While the Federal Reserve has not completely dismissed the possibility of escalating inflation, it appears to be leaning toward the idea that the economy is now on a sustainable growth path. This may mean the Federal Reserve has concluded its campaign to raise interest rates and of tightening of credit conditions.

Let's turn our attention to some of the major economic indicators for a more in depth look at the situation. The U.S. Department of Labor reports that employment has been trending solidly upwards in both the household and payroll surveys. Payroll employment for the last several years has been trending upwards at about a 2 percent annual rate. Relatedly, personal income has been expanding at around a 6 percent rate nationally. The employment and personal income numbers bode well for a future expansion of the national and state economies. An area of concern, however, has been the weak employment numbers in manufacturing. Approximately 3.5 million manufacturing jobs have been lost since 2000. Overseas competition and gains in manufacturing productivity have played a major role in this decline.

Another positive indicator for the economy has been the rise in the consumer confidence index. The index has been steadily rising since 2003 and has recently moved up sharply. Given that 70 percent of all economic activity comes from household expenditures, it is imperative that households have a positive view of the economy. And, as noted earlier, inflationary pressures have abated. The consumer price index is now rising at approximately a 2 percent annual rate. This is considered to be a rather benign rate of increase and should help to solidify the nation's growth prospects.

Closer to home, the Wisconsin Department of Revenue is forecasting that the state should experience employment growth of about 0.6 percent during 2007, compared to the 1.1 percent forecast for the nation. Moreover, disposable personal income is expected to grow at around 4.7 percent. Meanwhile the nation is expected to see a 5.4 percent growth rate in personal income during 2007. Thus, Wisconsin will see its economy expanding in 2007, but it will trail the overall U.S. averages. Wisconsin's

reliance on manufacturing and its less developed high value services sector (typically found in large metropolitan areas) helps to explain the differences in growth rates. Lastly, Table 1 in the report gives the year over changes for GDP, industrial production, three month U.S. Treasury bill rates, and the consumer price index. For the most part, these variables reflect a healthy economy.

**TABLE 1**

**NATIONAL ECONOMIC STATISTICS**

	<b>2005 Fourth Quarter</b>	<b>2006 Fourth Quarter</b>	<b>Percent Change</b>
Nominal Gross Domestic Product (Billions)	\$12,730.5	\$13,487.2	+5.9
Real Gross Domestic Product (Billions of 2000 \$)	\$11,163.8	\$11,541.6	+3.4
Industrial Production (2002 = 100)	109.1	112.4	+3.0
Three Month U.S. Treasury Bill Rate	3.91%	4.88%	+24.8
Consumer Price Index (1982-84 = 100)	196.8	201.8	+2.5

## Central Wisconsin

A summary of the results for this quarter is as follows: unemployment rates are generally lower in the region; total employment has expanded by about 1.6 percent over the year; industrial sector employment totals have grown by 2.1 percent over the same period; central Wisconsin sales tax distributions collected by the state may not accurately reflect local conditions; and area business executives are modestly upbeat about the economy.

Unemployment rates throughout the region were generally lower than a year ago. The lone exception being the increase from 3.7 percent to 4.1 percent Marathon county. The rates in Portage and Wood counties declined to 4.0 percent and 4.8 percent respectively. Wisconsin's rate rose to 4.5 percent over the period. Meanwhile the U.S. unemployment rate dropped to 4.3 percent. Please note, due to rounding, an area's unemployment rate may show no change. However, changes at the second decimal place may have occurred and these changes are reflected in the table's percentage column.

Employment growth in the region has been impressive. Portage, Marathon, and Wood counties grew by 1.6, 3.7, and 3.9 percent from a year ago. Total central Wisconsin employment increased from 148.6 thousand to 152.2 thousand or by 2.4 percent since December 2005. Wisconsin added around 50,000 positions or grew 1.7 percent over the same period. The U.S. added 2.2 percent to its payrolls or about 3.2 million jobs over the course of the year.

Industrial sector employment in Table 4 comes from a survey of business firms. Total nonfarm employment grew by 2.1 percent over the year. The number of nonfarm positions rose from 150.5 thousand to 153.7 thousand over the year. Sectors experiencing job growth were transportation and utilities, leisure and hospitality, information and business services, education and health services, and government. On the negative side of the ledger, construction, manufacturing, and trade all experienced declines in their respective payrolls.

Sales tax distributions from the state back to the three counties were lower than a year ago. The state's distributions to the local areas may not accurately reflect the amount of economic activity in the counties. These disappointing results may have more to do with technical problems at the state level than local retail activity. Taken at face value, the distributions would suggest a rather sharp downturn in retail activity. This seems to be at variance with other observations on the economy and the level of retail activity.

The CWERB survey of regional business executives is done to gain their views on the economy. This group believes that recent economic changes at the national and local levels have been marginally positive. In other words, matters have improved slightly. This group is somewhat more upbeat about the future direction of the nation,

the local area, and the economic condition in their particular business. Hopefully their forecast comes to fruition for the people of our region.

Figures 2 to 6 in this section of the report present trends in the Wisconsin employment level, the unemployment level, the unemployment rate, the labor force, the average manufacturing wage, and the employment trend in educational and health services for the years 2003 to 2006. The figures show how these important variables have changed in Wisconsin and give the reader a better appreciation of the recent economic history of the state.

**TABLE 2****UNEMPLOYMENT IN CENTRAL WISCONSIN**

	<b>Unemployment Rate December 2005</b>	<b>Unemployment Rate December 2006</b>	<b>Percent Change</b>
Portage County	4.0%	4.0%	-0.1
City of Stevens Point	4.7%	4.6%	-2.1
Marathon County	3.7%	4.1%	+9.3
Wood County	5.0%	4.8%	-3.3
Central Wisconsin	4.1%	4.3%	+4.9
Wisconsin	4.5%	4.5%	+1.0
United States	4.6%	4.3%	-8.3

**TABLE 3****EMPLOYMENT IN CENTRAL WISCONSIN**

	<b>Total Employment December 2005 (Thousands)</b>	<b>Total Employment December 2006 (Thousands)</b>	<b>Percent Change</b>
Portage County	39.5	40.1	+1.6
City of Stevens Point	13.4	13.9	+3.7
Marathon County	71.1	72.6	+2.0
Wood County	38.1	39.5	+3.9
Central Wisconsin	148.6	152.2	+2.4
Wisconsin	2,909.9	2,958.7	+1.7
United States	142,918	146,080	+2.2

\* Percent change figures reflect data before rounding

**TABLE 4****CENTRAL WISCONSIN EMPLOYMENT CHANGE BY SECTOR**

	<b>Employment December 2005 (Thousands)</b>	<b>Employment December 2006 (Thousands)</b>	<b>Percent Change</b>
Total Nonfarm	150.5	153.7	+2.1
Total Private	131.3	132.0	+0.5
Construction & Natural Resources	5.6	5.3	-5.4
Manufacturing	29.5	28.8	-2.4
Trade	27.9	27.5	-1.4
Transportation & Utilities	8.0	8.4	+5.0
Financial Activities	10.4	10.4	0
Education & Health Services	21.7	21.9	+0.9
Leisure & Hospitality	10.6	11.7	+10.4
Information & Business Services	17.5	17.9	+2.3
Total Government	19.2	21.8	+13.5

**TABLE 5****COUNTY SALES TAX DISTRIBUTION**

	<b>Sales Tax 2005 Fourth Quarter (Thousands)</b>	<b>Sales Tax 2006 Fourth Quarter (Thousands)</b>	<b>Percent Change</b>
Portage County	\$1,254.7	\$1,203.2	-4.1
Marathon County	\$2,805.0	\$2,662.8	-5.1
Wood County	\$1,184.7	\$1,088.9	-8.1

\* Percent change figures reflect data before rounding

**TABLE 6**

**BUSINESS CONFIDENCE IN CENTRAL WISCONSIN**

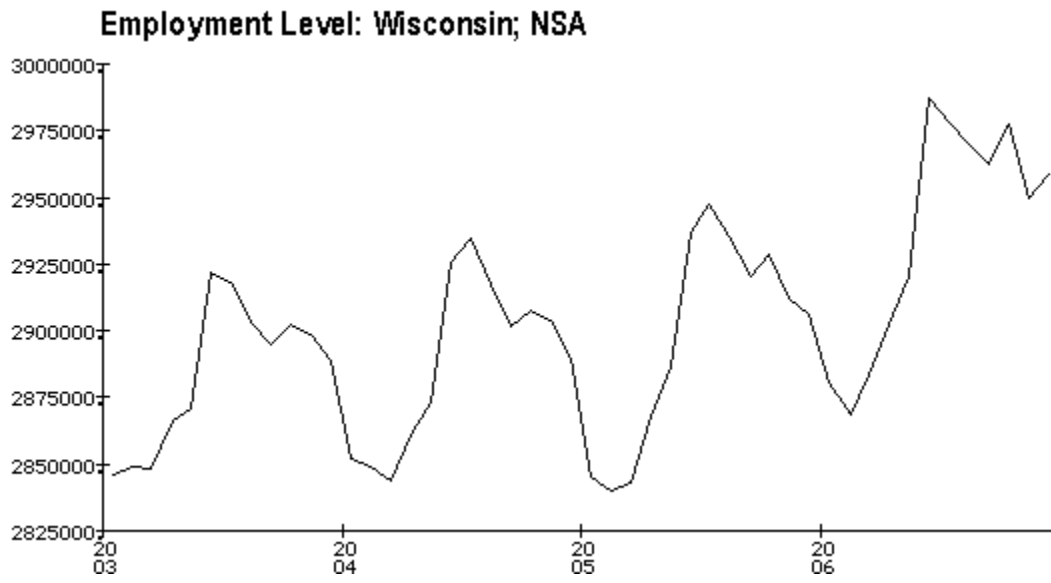
	<b>Index Value</b>	
	<b>September 2006</b>	<b>December 2006</b>
Recent Change in National Economic Conditions	45	54
Recent Change in Local Economic Conditions	51	54
Expected Change in National Economic Conditions	48	55
Expected Change in Local Economic Conditions	51	57
Expected Change in Industry Conditions	50	55

100 = Substantially Better

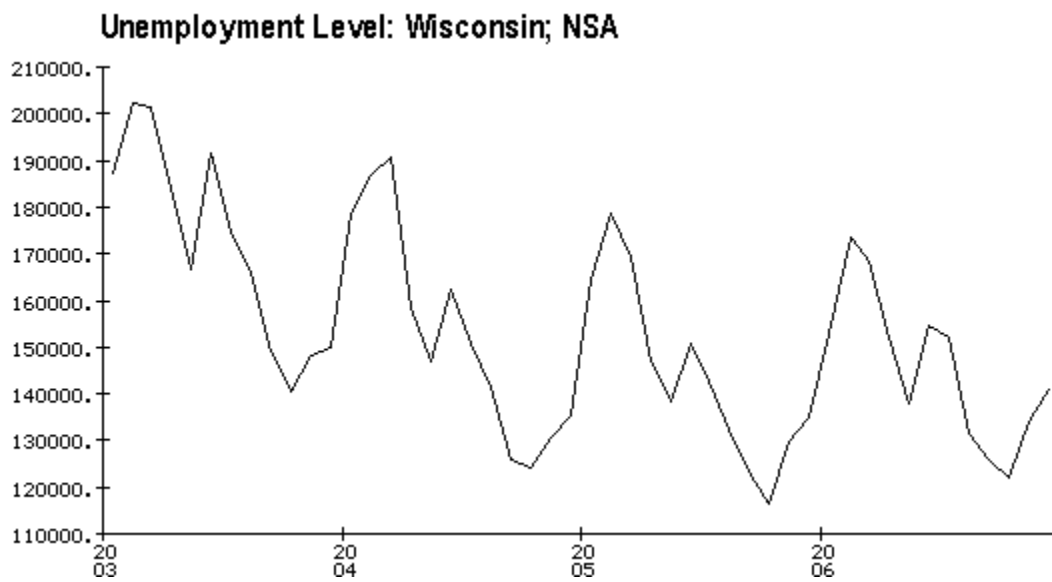
50 = Same

0 = Substantially Worse

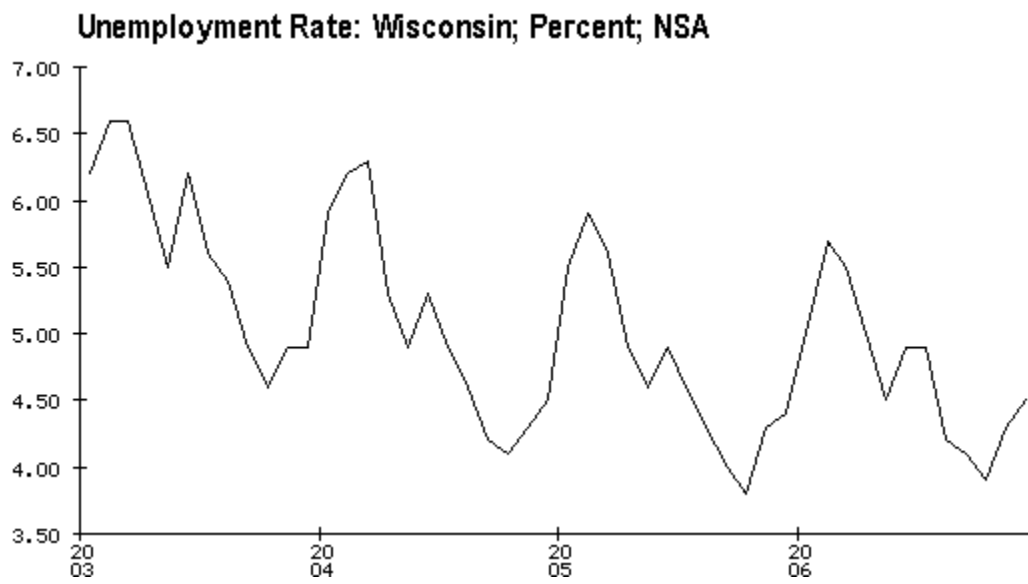
**FIGURE 1**



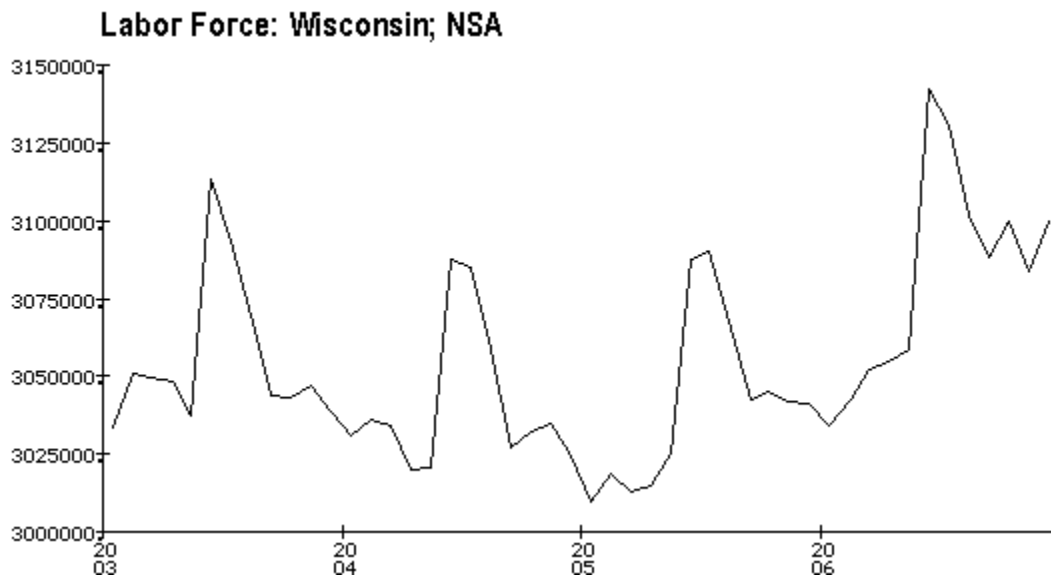
**FIGURE 2**



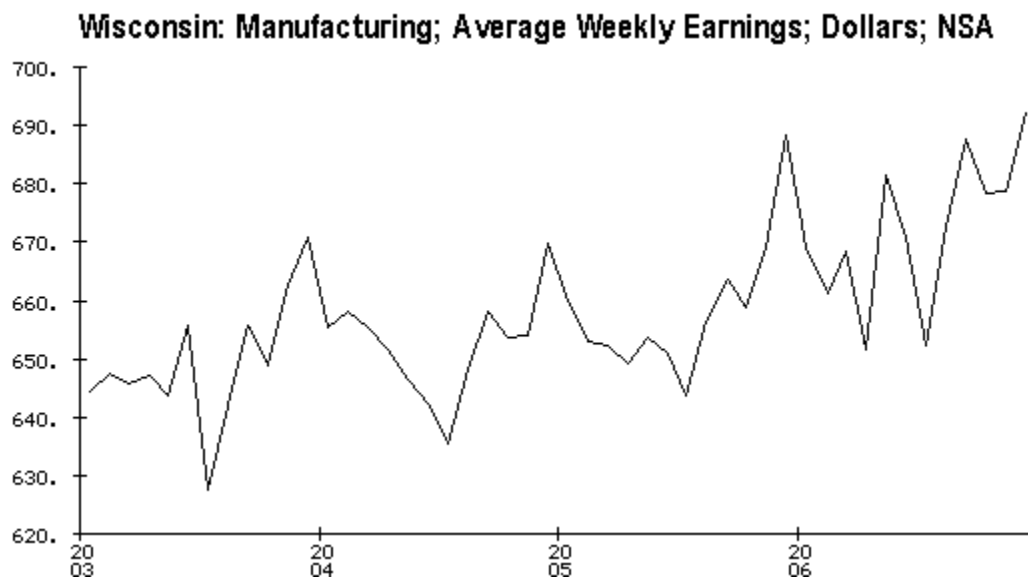
**FIGURE 3**



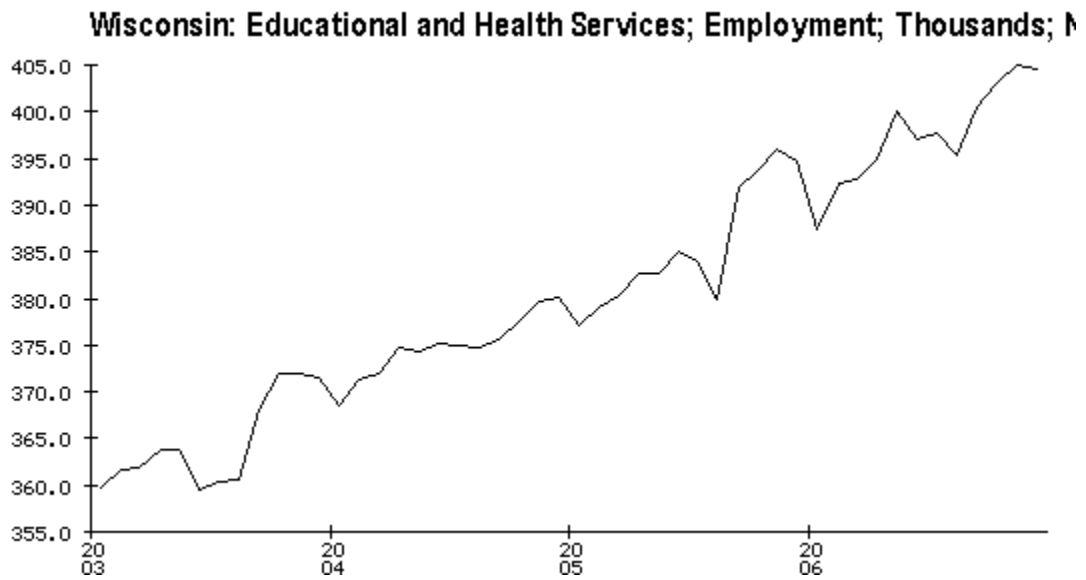
**FIGURE 4**



**FIGURE 5**



**FIGURE 6**



## Marshfield

A summary of the Marshfield section of the report is as follows: total nonfarm employment has increased by 3.7 percent; retailers indicated that store traffic and sales were unchanged from a year ago; help wanted advertising increased a great deal over the year; public assistance claims were lower and unemployment claims were up over last year's amounts; residential construction expanded in activity; and the building of nonresidential structures was lower than a year ago.

Total nonfarm employment in Wood county increased by 3.7 percent from a year ago. Total nonfarm employment estimates are based on a survey of business firms. Most sectors in the survey expanded by a healthy amount. Approximately 3.6 thousand jobs were added to the county's payroll. However, the manufacturing sector contracted from 6.5 to 5.7 thousand jobs or by 12.3 percent from last year.

Retailer confidence for Marshfield is given in Table 8. Total sales and store traffic were judged to be at about the same level as last year. Our panel of local merchants believes expected sales and expected store traffic will be marginally better three months from now compared to a year earlier.

Help wanted advertising in Marshfield area grew from 60 to 77 from last year. This pick up in advertising bodes well for local job seekers. The U.S. help wanted figure actually fell over the past twelve months. Help wanted advertising captures only a small portion of the number of openings in an area. Nevertheless, it is a good barometer of the future direction of the overall job market.

Tables 10 and 11 are given to provide information on the levels of family financial distress in Wood County. Public assistance claims in Wood County on a monthly average basis fell from 91 to 88 claims or by 3.3 percent over the past twelve months. However, unemployment claims data for the county tell a somewhat different story. New claims on a weekly average basis rose from 286 to 325 or by 13.6 percent from fourth quarter 2005. Likewise, total claims increased from 1,290 to 1,349 or by 4.6 percent over the same period.

Table 12 presents residential construction in the Marshfield area. The number of permits was 6 and the estimated value of activity was \$2.2 million. The permits represent 9 new housing units. New home construction figures were above last year's marks. However, alteration activity was generally lower than last year. The number of alteration permits fell from 100 to 13 and the value of this activity contracted from \$854 thousand to \$175 thousand. Due to the volatile nature of nonresidential construction no percentage changes are given. The number of permits issued was 4 and the value \$695 thousand. The number of business alteration permits reached 23 in fourth quarter and they are estimated to have a value of \$2.2 million.

Figures 7 to 10 pertaining to Wood County's employment level, unemployment level, unemployment rate, and labor force are presented to depict how these indicators

have trended in the area from 2003 to 2006. The reader will gain a greater appreciation of the overall economic trends for Wood County.

Tables 14 and 15 present economic data on Clark County. The county is an important market area for Marshfield businesses. Highlights for Clark includes: total nonfarm employment is up by 2.9 percent; total employment has risen by 4.3 percent; and the manufacturing sector expanded by approximately 3.6 percent. In addition, figures 11 to 14 are presented for Clark County and show the trends in the employment level, the unemployment level, the unemployment rate, and the labor force.

**TABLE 7****WOOD COUNTY EMPLOYMENT CHANGE BY SECTOR**

	<b>Employment December 2005 (Thousands)</b>	<b>Employment December 2006 (Thousands)</b>	<b>Percent Change</b>
Total Nonfarm	43.1	44.7	+3.7
Total Private	37.7	37.7	0
Construction & Natural Resources	1.5	1.5	0
Manufacturing	6.5	5.7	-12.3
Trade	6.7	6.9	+3.0
Transportation & Utilities	3.4	3.7	+8.8
Financial Activities	1.2	1.1	-8.3
Education & Health Services	10.5	10.8	+2.9
Leisure & Hospitality	3.0	3.0	0
Information & Business Services	4.9	4.9	0
Total Government	5.4	7.1	+31.5

**TABLE 8****RETAILER CONFIDENCE IN MARSHFIELD\***

	<b>Index Value</b>	
	<b>September 2006</b>	<b>December 2006</b>
Total Sales Compared to Previous Year	56	50
Store Traffic Compared to Previous Year	56	48
Expected Sales Three Months From Now	54	59
Expected Store Traffic Three Months From Now	52	55

100 = Substantially Better

50 = Same

0 = Substantially Worse

\* Data collected by UW Marshfield-Wood County

**TABLE 9**

**HELP WANTED ADVERTISING IN MARSHFIELD**

	<b>Index Value</b>	
	<b>2005</b>	<b>2006</b>
Marshfield (December) 1980=100	60	77
U.S. (November) 1987=100	38	30

**TABLE 10**

**PUBLIC ASSISTANCE CLAIMS IN WOOD COUNTY**

	<b>2005 Fourth Quarter (Monthly Avg.)</b>	<b>2006 Fourth Quarter (Monthly Avg.)</b>	<b>Percent Change</b>
Total Caseload	91	88	-3.3

**TABLE 11**

**UNEMPLOYMENT CLAIMS IN WOOD COUNTY**

	<b>2005 Fourth Quarter (Weekly Avg.)</b>	<b>2006 Fourth Quarter (Weekly Avg.)</b>	<b>Percent Change</b>
New Claims	286	325	+13.6
Total Claims	1290	1349	+4.6

**TABLE 12**

**RESIDENTIAL CONSTRUCTION IN MARSHFIELD AREA\***

	<b>2005 Fourth Quarter</b>	<b>2006 Fourth Quarter</b>	<b>Percent Change</b>
Residential Permits Issued	4	6	+50.0
Estimated Value of New Homes	\$800.3 (thousands)	\$2,155.0 (thousands)	+169.3
Number of Housing Units	4	9	+125.0
Residential Alteration Permits Issued	100	13	-87.0
Estimated Value of Alterations	\$853.6 (thousands)	\$174.7 (thousands)	-79.5

\* Data collected by UW Marshfield-Wood County

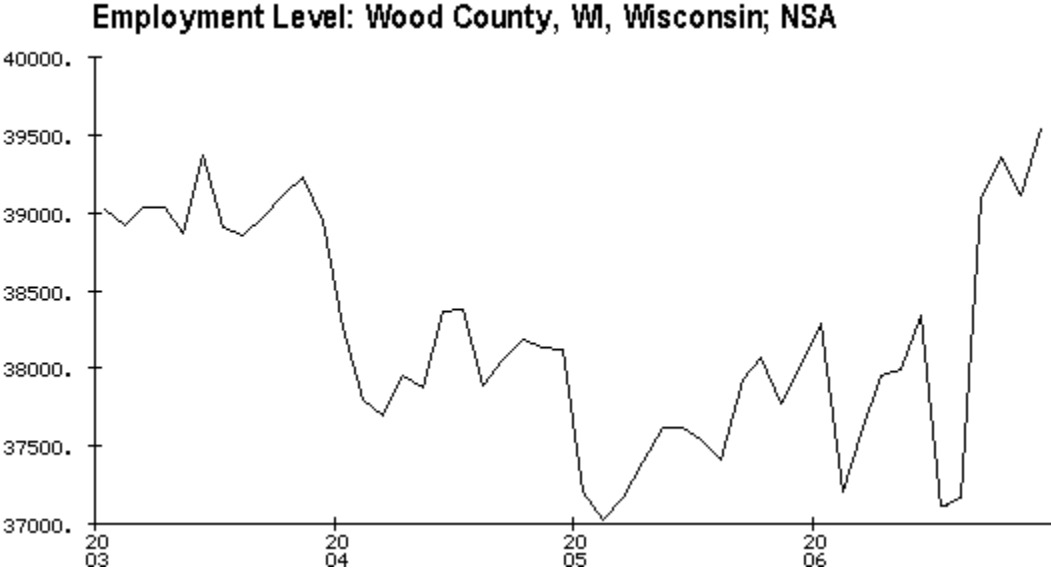
**TABLE 13**

**NONRESIDENTIAL CONSTRUCTION IN MARSHFIELD AREA\***

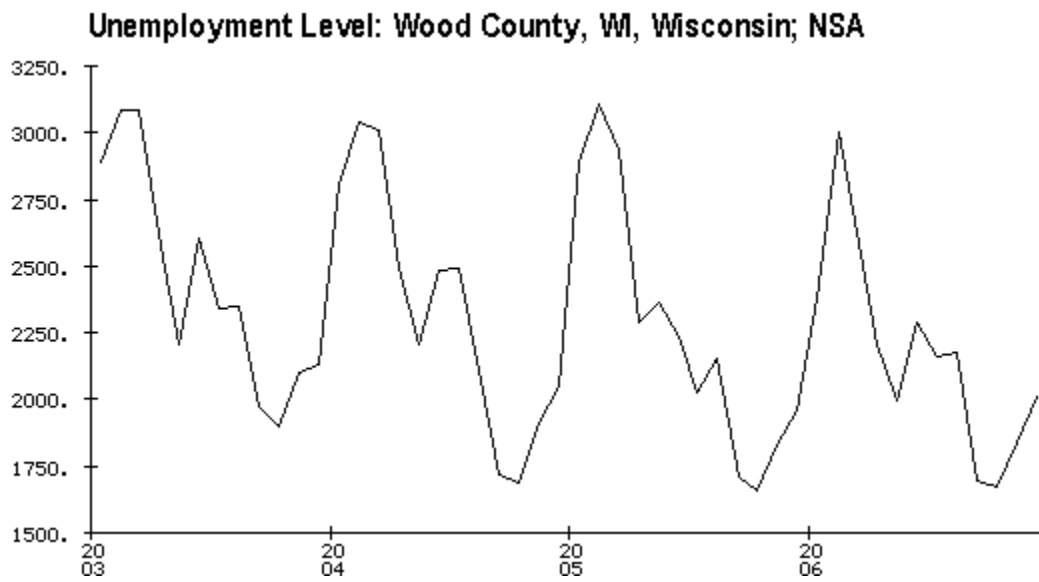
	<b>2005 Fourth Quarter</b>	<b>2006 Fourth Quarter</b>
Number of Permits Issued	9	4
Estimated Value of New Structures	\$12,688.0 (thousands)	\$695.0 (thousands)
Number of Business Alteration Permits	11	23
Estimated Value of Business Alterations	\$1,517.1 (thousands)	\$2,202.0 (thousands)

\* Data collected by UW Marshfield-Wood County

**FIGURE 7**

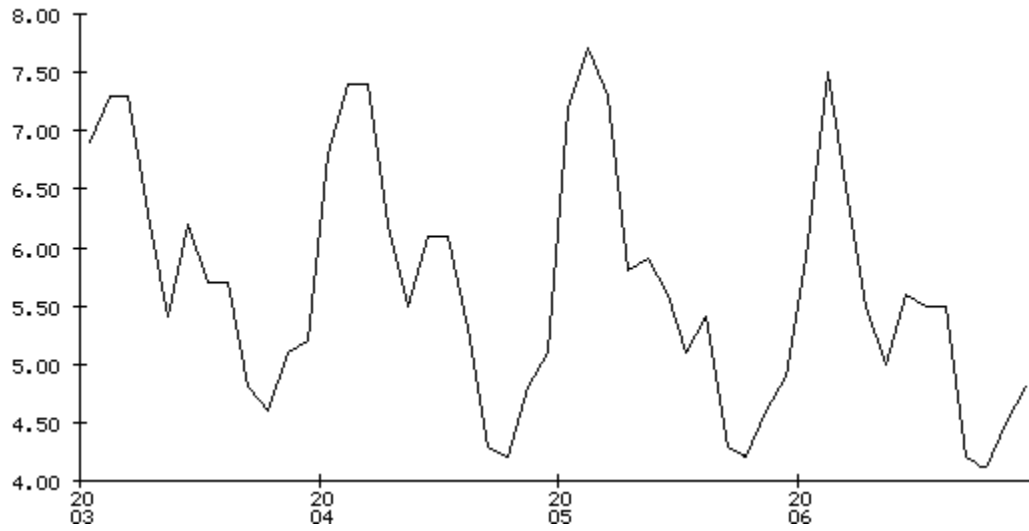


**FIGURE 8**

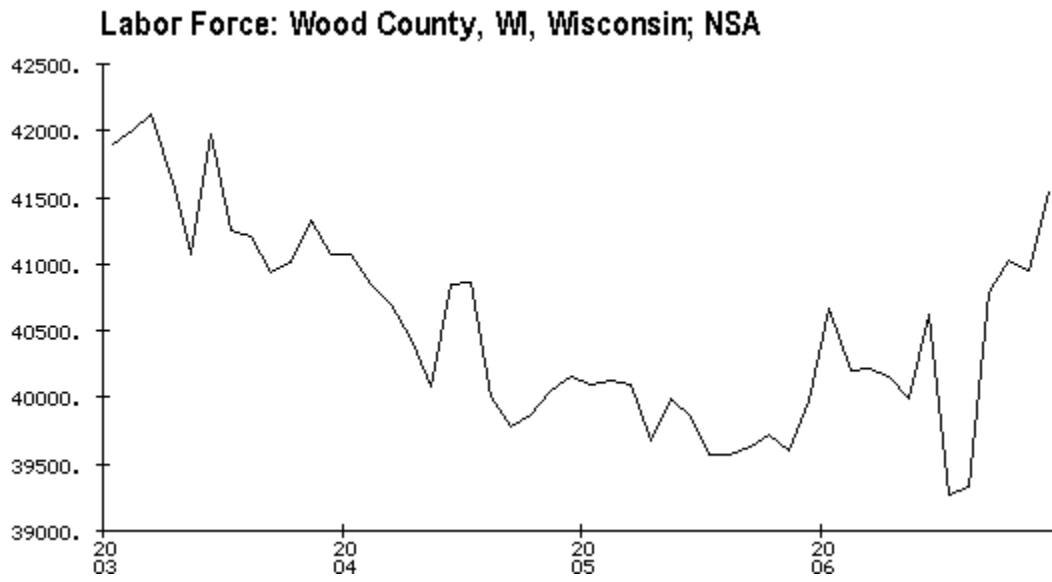


**FIGURE 9**

**Unemployment Rate: Wood County, WI, Wisconsin; Percent; NSA**



**FIGURE 10**



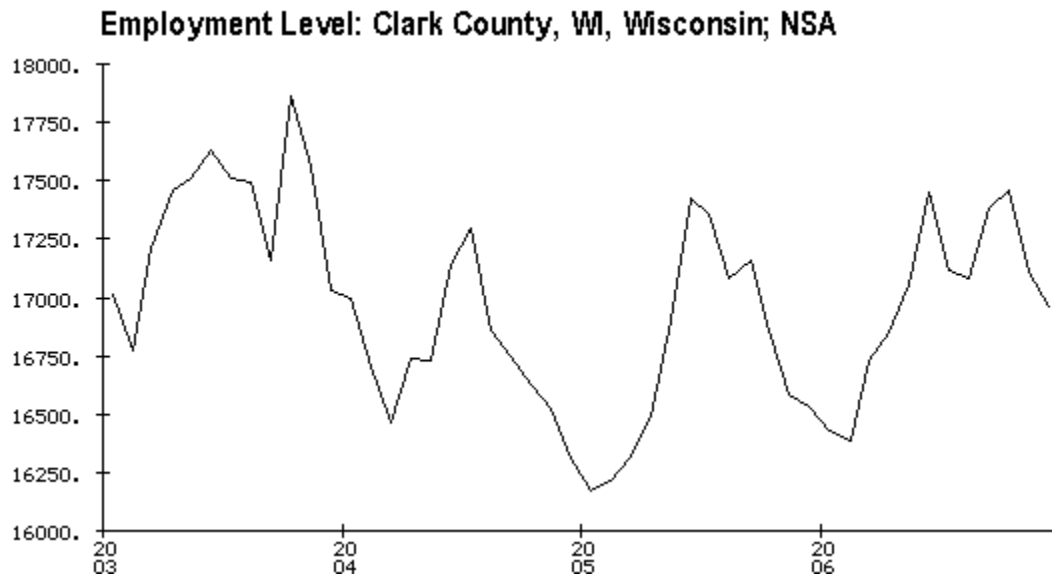
**TABLE 14****CLARK COUNTY EMPLOYMENT BY SECTOR**

	<b>December 2005</b>	<b>December 2006</b>	<b>Percent Change</b>
Total Nonfarm	10.3	10.6	+2.9
Total Private	8.2	8.6	+4.9
Construction & Natural Resources	0.5	0.6	+20.0
Manufacturing	2.8	2.9	+3.6
Trade	1.5	1.5	0.0
Transportation & Utilities	0.5	0.5	0.0
Financial Activities	0.3	0.3	0.0
Education & Health Services	1.2	1.3	+8.3
Leisure & Hospitality	0.8	0.7	-12.5
Information & Business Services	0.8	0.8	0.0
Total Government	2.0	2.1	+5.0

**TABLE 15****CLARK COUNTY EMPLOYMENT STATISTICS**

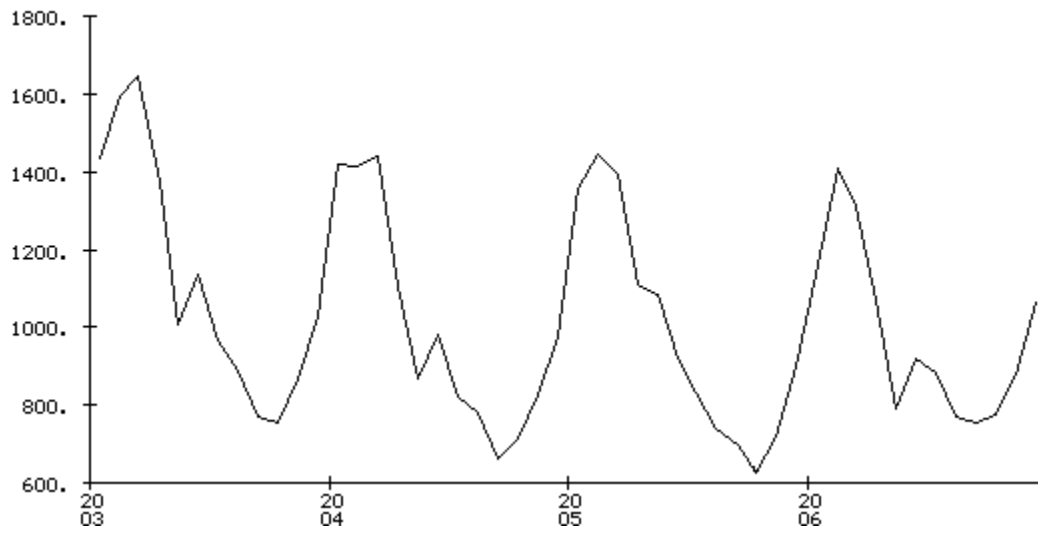
	<b>December 2005</b>	<b>December 2006</b>	<b>Percent Change</b>
Unemployment Rate	5.3%	5.9%	+11.0
Total Employed	16,268	16,965	+4.3
Total Unemployed	911	1,061	+16.5
Labor Force	17,179	18,026	+4.9

**FIGURE 11**



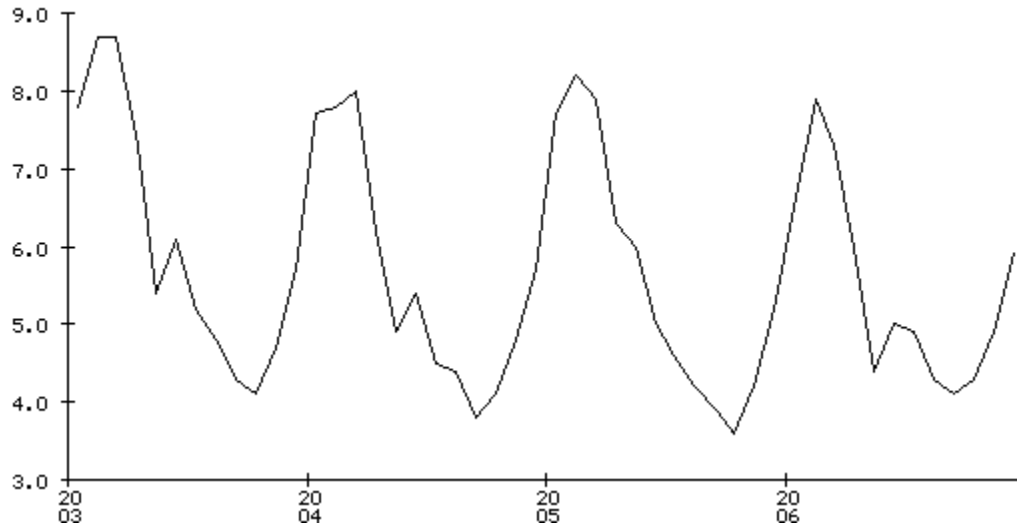
**FIGURE 12**

**Unemployment Level: Clark County, WI, Wisconsin; NSA**

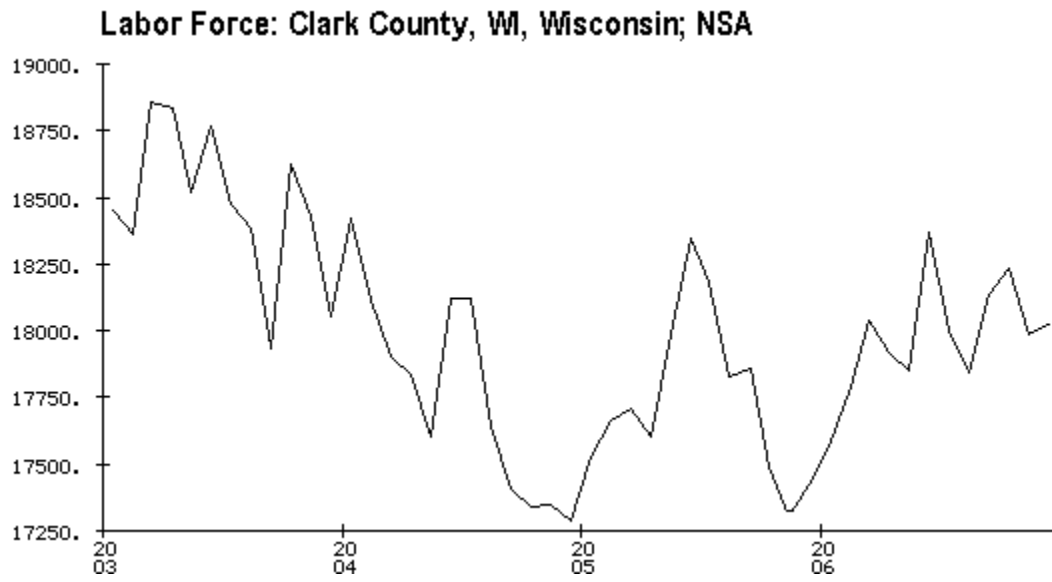


**FIGURE 13**

**Unemployment Rate: Clark County, WI, Wisconsin; Percent; NSA**



**FIGURE 14**



## **MEDICARE: SACRED COW OR THE ELEPHANT IN THE LIVING ROOM?**

Jason R. Davis, Ph.D.

Assistant Professor of Economics  
Division of Business and Economics  
University of Wisconsin-Stevens Point

The aging of the U.S. population continues to be a central concern of many economic forecasts. The combined impact of declining birth rates, increasing life expectancies, and the aging of the baby-boomers will result in a growing percent of the population over the age of 65. As this trend continues, our economy will likely be constrained by the fact that the share of the population engaged in the labor force is declining. In the private sector, this raises questions on how the declining labor force share will be able to provide an adequate level of production to maintain the overall standard of living.

This problem is mirrored in the public-sector social insurance programs, most notably Social Security and Medicare. As the labor force share declines, the growth in payroll taxes is not forecasted to keep pace with the growth in government expenditures under these programs. While there has been substantial political debate regarding the projected Social Security financial shortfalls, there has been relatively little attention paid to the growing financial problems of the Medicare program. To the contrary, the Medicare program was expanded in 2006 to provide prescription drug benefits. This change is clearly beneficial to seniors who previously lacked such coverage, though it comes at added expense to a program which is already facing financial difficulties.

The purpose of this report is to highlight: 1) the current and projected financial difficulties of the Medicare program, 2) the preliminary financial impact of adding prescription drug coverage, and 3) the proposals to address these financial issues. Because Medicare is a federal program, much of the analysis will be at the national level, though there will be some attention paid to the Wisconsin Medicare population.

### **MEDICARE PARTS A AND B**

#### **Coverage**

Medicare was created in 1965, originally covering inpatient-related care through 'part A' and physician and outpatient-related care through 'part B.' All seniors and disabled individuals who qualify for social security benefits automatically qualify for coverage under part A with no premium; seniors who do not qualify for social security can purchase part A coverage. All seniors and qualifying disabled people have the option to purchase part B coverage as well.

Acute nursing home care following an inpatient admission is covered under part A, though there is no provision for long-term nursing home care. Part B has traditionally covered only medically necessary care, with no provision for preventative care or

prescription medications. Thus, while Medicare covers a fairly broad range of medical services, it has traditionally not covered some forms of care which are of particular importance to the beneficiaries. For a more complete description of Medicare coverage under parts A and B, see “Your Medicare Benefits” (CMS, 2006b).

## **Financing**

Medicare part A is financed through a 2.90% payroll tax on total earnings. Employees pay half the payroll tax directly, with the remaining half paid by employers. Unlike social security, all earnings are subject to the payroll tax. For Medicare recipients who qualify for social security payments, there is no additional premium for part A coverage; for those who do not qualify for social security benefits, which accounts for only 1% of the Medicare population, there is a \$410 monthly premium (CMS, 2006a). In addition, some social security benefits are taxable with part of the taxes raised contributing to Medicare part A. These taxes are paid by social security recipients whose gross income including half their social security benefits exceeds \$34,000 for single filers, or \$44,000 for married filers (Rejda, 1999, page 101).

Medicare part A is intended to be fully financed through these sources, with no general tax revenue used to supplement funding. Through 2005, the revenues collected for Medicare part A have exceeded program expenditures, with the net revenues flowing into a trust fund which is invested in government bonds, earning interest over time. However, the revenues for 2006 are expected to fall short of total expenditures marking the first year that the trust fund is used to supplement program expenditures (Social Security and Medicare Board of Trustees, 2006).

Medicare part B is financed in part through premiums equal to \$93.50 per month for most beneficiaries in 2007. Beginning in 2007, part B participants with incomes above \$80,000 (single) or \$160,000 (married) will pay higher premium rates up to a maximum of \$161.40. It is estimated that only 4% of the Medicare participants will pay more than the standard premium. The standard premiums are adjusted annually to cover 25% of the expected part B expenditures for the year. The remaining 75% of part B expenditures are financed through general tax revenues (CMS, 2006a).

For both parts A and B, the Medicare payment rates for services are set by the Medicare administration. The set rates are intended to cover the marginal costs of providing care to Medicare patients. In other words, given that a medical provider already exists and has a stock of medical equipment, what is the cost of providing care to an additional patient? These payments are thus not intended to fully cover the providers' overhead costs and are usually below the prices charged to other patients. By paying lower rates, this helps keep the total expenditures of the program lower than they otherwise if the rates were not controlled by the government.

The potential problem with paying lower government set rates is that medical care providers may choose not to participate in Medicare. ‘Participating providers’ are those who are willing to accept the Medicare payments rates as full payment for their services.

'Non-participating providers' are still able to serve Medicare participants, though the pertinent participant may be responsible for charges above the Medicare-approved rates. While there is no specific requirement for providers to be participating providers, there are a number of incentives for providers to participate. As a result, 98% of medical providers were in fact participating providers in 2000 (Santerre and Neun, 2004, page 280), and that ratio is likely to have stayed relatively constant.

### **Patient Cost-Sharing**

Medicare part A coverage includes an annual deductible of \$992 in 2007, which is equivalent to the Medicare approved payment for one day in the hospital. For additional hospital stays up to 60 days, there is no additional out-of-pocket expense. For patients requiring 61-90 days in the hospital during a year, there is a 25% coinsurance rate, meaning that the patient is responsible for \$248 per day. For patients requiring 91-150 days in the hospital during the year, there is a 50% coinsurance rate, meaning that the patient is responsible for \$496 per day. For patients requiring more than 150 days in the hospital during a year, the patient is fully responsible for payment, with no additional payments made by Medicare (CMS, 2006a).

Medicare part B coverage includes an annual deductible of \$131 in 2007. Once the deductible has been met, there is a 20% coinsurance rate, meaning that patients are responsible for 20% of the Medicare-approved charges (CMS, 2006a).

If Medicare were to include no out-of-pocket expenses, then beneficiaries would face no direct cost for services beyond paying the premium. Under such a policy, patients would respond by using more services than they would otherwise, especially for services which provide very little health benefit. This response would greatly increase the Medicare expenditures, while providing relatively little health benefit in return. The use of cost-sharing measures such as deductibles and coinsurance rates are intended to discourage beneficiaries from 'over-utilizing' medical care, and help to keep Medicare costs down.

### **SUPPLEMENTAL HEALTH INSURANCE BEYOND MEDICARE**

Due to the out-of-pocket expenses present under the traditional Medicare parts A and B coverage, many beneficiaries have additional sources of coverage to supplement Medicare.

Some Medicare beneficiaries also have access to employer-sponsored insurance, either through their own employment or their spouse. Employers are not allowed to discriminate based on age and must offer the same coverage to all eligible employees. Many retired Medicare beneficiaries also receive supplemental health insurance coverage through their pension packages.

Private insurance companies also offer 'Medigap' coverage to individuals which provides additional coverage for expenses not paid by Medicare. Medigap policies must conform to one of the ten standard plans approved by the government. Eight of the ten, which insure 93% of Medigap enrollees, completely cover the deductibles and coinsurance rates under Medicare parts A and B. Thus, there is a tendency for these beneficiaries to over-utilize medical services, driving up both Medicare expenditures and Medigap premiums. Starting in 2006, Medigap policies were not allowed to include prescription drug coverage, though such coverage is still covered in many pension packages.

Finally, Medicare participants with incomes below the poverty level are also eligible for Medicaid coverage. In this case, Medicaid covers the Medicare premiums and cost-sharing measures. In addition, Medicaid covers a wider range of services at no cost to the participant including prescription drug coverage, long-term nursing home care, and in many states, dental services. However, Medicaid participants are limited to providers willing to serve Medicaid patients, often resulting in more difficulty finding providers and, perhaps, reduced quality of care.

### **MEDICARE PART C: MEDICARE ADVANTAGE**

Medicare Advantage is also known as Medicare part C and was formerly known as Medicare+Choice. This provides beneficiaries an option to enroll in a private policy, typically managed care, in lieu of traditional part A and B coverage. Medicare Advantage policies often cover a broader spectrum of services, such as enhanced preventive care and prescription drug coverage, though they often have managed care restrictions on choice of provider. Participants in these plans continue to pay the same premiums for part A (if applicable) and part B coverage and may be subject to an additional premium from the provider. However, the out-of-pocket expenses are typically lower than under traditional Medicare parts A and B and may include expanded services.

Medicare Advantage providers receive premiums directly from Medicare which are below the average expected cost of recipients. The expectation is that these providers will achieve cost savings through managed care restrictions and negotiated prices with medical providers. The additional premiums paid by participants (if applicable) are intended to cover the expanded services and/or reduced cost-sharing measures of the policy.

In its best light, this arrangement allows for cost savings through managed care which can benefit all parties. The Medicare administration is paying a premium below the expected expenditures under parts A and B. The participant saves on out-of-pocket expenses and may receive expanded services (though with restrictions). The private insurer may also enhance profits if the overall cost savings exceeds the cost savings to Medicare and the participant.

There are, however, some potential problems with the above reasoning. First, this is a voluntary program which is likely to be most attractive to those with lower-than-average expected medical care needs. These are the patients that are likely to be attracted to the expanded services and lower cost-sharing, and who also are least likely to be concerned with the managed care restrictions. Those who expect to need a substantial level of medical care are naturally more concerned with the potential restrictions and consequently are likely to remain in 'traditional' Medicare. As a result, the apparent cost savings achieved under Medicare Advantage plans may simply be due to their ability to attract a generally healthier segment of the population. If this is true, the participants in Medicare Advantage plans would have had lower-than-average expenditures regardless, perhaps below the premiums paid by Medicare to the Medicare Advantage insurers.

## **MEDICARE PART D: MEDICARE PRESCRIPTION DRUG COVERAGE**

Medicare prescription drug coverage, also known as Medicare part D, went into effect in 2006. Those who participate in Medicare parts A and B, or in a Medicare Advantage plan that does not include prescription drug coverage, are eligible to enroll. The financing is very similar to part B coverage, with enrollees paying premiums which are expected to cover 25% of the overall program cost. The remaining 75% of expected costs are financed through general tax revenues by the federal government. The set of providers is similar to Medicare Advantage plans since the services are provided through private insurers who must be approved by Medicare.

Medicare prescription drug plans have some latitude in their design, though they must be actuarially equivalent to the 'standard plan.' The standard plan includes a \$250 deductible, with the enrollee paying 25% of additional expenditures until total expenditures reach \$2,250. Enrollees are responsible for all additional expenditures until total expenditures reach \$3,600. For total annual expenditures beyond \$3,600, the enrollee is responsible paying 5% of additional expenditures. The average premium paid for coverage is \$386 per year. (KFF, 2006).

While the new prescription drug benefit does provide gains for those who otherwise would not have had such coverage, it clearly does not eliminate the out-of-pocket expenses for participants. There are plans available with lower out-of-pocket expenses, though such plans also come at higher premiums.

## **DISTRIBUTION OF MEDICARE COVERAGE**

According to the Kaiser Family Foundation, 88% of the Medicare enrollees in 2002 had some form of supplemental coverage beyond simply holding part A and/or part B coverage. Thus, while parts A and B have the potential for large out-of-pocket expenses, the vast majority of enrollees also have additional coverage (KFF 2005). In

Wisconsin, an even greater percent of seniors hold supplementary coverage. According to the Wisconsin Family Health Survey conducted in 2004, only 8% of seniors hold Medicare without supplemental coverage (Wisconsin Department of Health and Family Services, 2005).

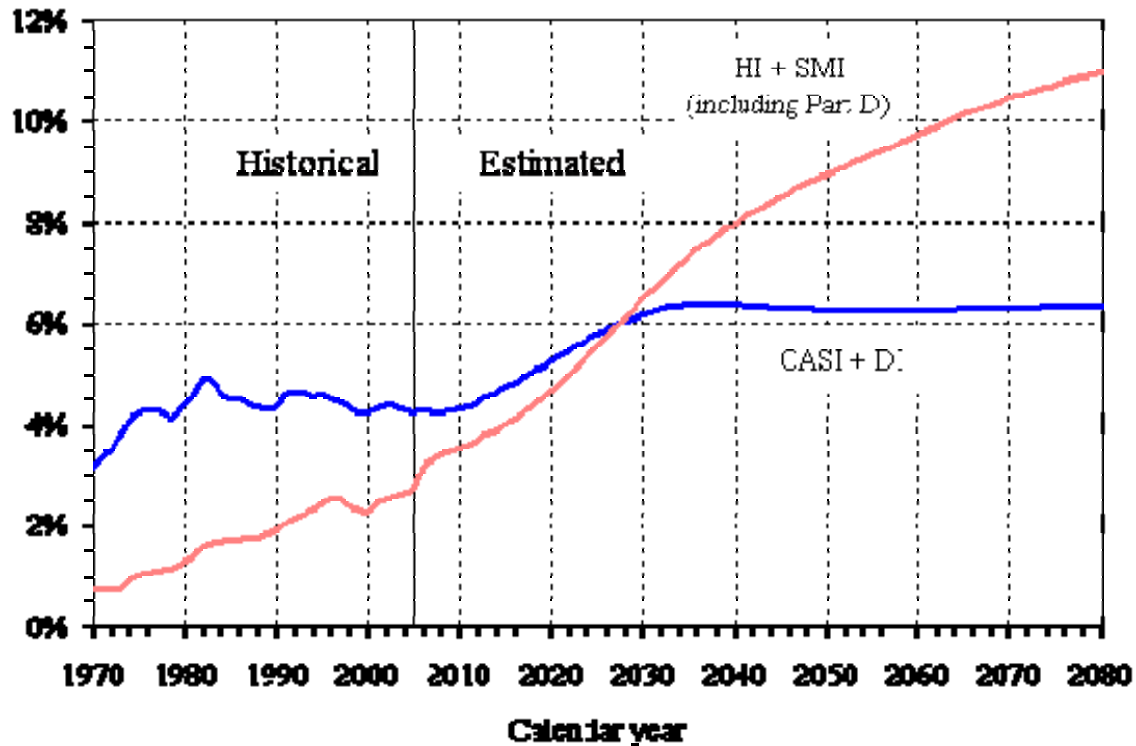
Another report by the Kaiser Family Foundation (2005) indicates that for 2006, 7% of Wisconsin Medicare enrollees participated in a Medicare Advantage program, compared to 12.7% nationally. This same study also found only 16% of Wisconsin Medicare enrollees were also enrolled in Medicaid, compared to 19% nationally. Those who are 'dual-eligible' for both Medicare and Medicaid are typically Medicare enrollees with incomes below the poverty-level. For these seniors, Medicaid covers the expenses not covered by Medicare, which masks the true government expense of these seniors if we look only at Medicare data. For those who do not have separate long-term care insurance, many who require long-term care will eventually qualify for Medicaid once their accumulated assets and savings have been eliminated.

As of June 2006, approximately 90% of Medicare participants were covered by some sort of prescription drug benefit, with 53% receiving coverage either through part D directly or through a Medicare Advantage plan which includes prescription drug coverage. At that time, the estimated federal expenditures for these plans totaled \$31 billion for 2006 and are projected to total \$768 billion for 2007-2016, or an average of \$76.8 billion per year. (KFF, 2006).

## **FINANCIAL PROJECTIONS**

Each year, the Social Security and Medicare Board of Trustees prepares a report on the current and projected financial status of the trust fund accounts and financial solvency of these programs. The 2006 report predicts part A expenditures will exceed part A revenues, requiring part of this year's expenditures to be financed by interest payments flowing into the trust fund. It is not expected to fully exhaust the interest payments flowing to the trust fund, thus the trust fund itself will still gain value this year. However, it is anticipated that as the baby boomers retire, the payroll tax revenues for part A will naturally diminish as expenditures increase. The current projections predict the trust fund itself, valued at \$285.8 billion at the end of 2005, will begin shrinking in 2010 and will be completely exhausted by 2018 (Social Security and Medicare Board of Trustees, 2006).

The following table, taken from the 2006 Trustees report, shows the projected rates of both Medicare spending (labeled 'HI + SMI') and Social Security spending (labeled 'OASI + DI') as a percentage of projected GDP.



While the growth in Social Security expenditures is projected to eventually level off, Medicare expenditures continue to grow. In fact, the current projections show that Medicare spending will exceed Social Security by around 2028 (Social Security and Medicare Board of Trustees, 2006).

The long-run test for financial solvency used by the Board of Trustees determines if the trust fund, together with projected revenues, are sufficient to cover projected expenses over the next 75 years. This test is clearly not met for Medicare, nor is it met for Social Security. For Social Security, the trust fund is expected to be exhausted by 2040; current projections indicate Medicare is in much more serious financial trouble (Social Security and Medicare Board of Trustees, 2006).

The short-run test for financial solvency determines if the projected trust-fund balance in 10 years would be sufficient to fully cover projected expenses in that year. While Social Security passes this test, Medicare does not, again indicating the more severe financial strain on the Medicare program (Social Security and Medicare Board of Trustees, 2006).

In addition, the Medicare Modernization Act of 2003 directs the Board of Trustees to determine if the difference between Medicare expenditures and dedicated revenue sources (primarily payroll taxes and premiums) is projected to exceed 45% of total expenditures within the next seven years. In other words, this determines if the projected revenues in each of the next seven years would be sufficient to cover at least 55% of the projected expenditures in that year. The 2006 Trustees' report indicates this

test also does not pass, with projected revenues falling short of 55% of expenditures in 2012. If this remains true in the 2007 Trustees' report, the Medicare Modernization Act of 2003 specifies that a funding warning for Medicare will be declared, requiring a Presidential policy response with expedited Congressional consideration of the proposal. In the absence of unusually high macroeconomic growth, it is likely such a warning will, in fact, be made in 2007 (Social Security and Medicare Board of Trustees, 2006).

Unfortunately, all of these dismal forecasts are based only on part A financing. The other parts of Medicare are in some sense fully-financed since the premiums for parts B and D are adjusted annually to cover 25% of the program costs. Similarly, the Medicare Advantage premiums are automatically adjusted to keep pace with changes in average Medicare expenditures. Medical care expenditures are anticipated to continue rising for Medicare participants due to both increased participation, increased medical care utilization, and increased medical prices. This will result in higher premiums under parts B and D, along with a greater need for federal general tax revenues, in order to continue subsidizing 75% of the program costs. Increased medical care expenditures will also cause an increase in the premiums paid by both Medicare and participants in the Medicare Advantage program.

Additionally, the growing need for costly long-term care may push more and more seniors into poverty, resulting in an increase in the number of seniors covered by Medicaid, which is financed out of general tax revenues at both the federal and state levels.

## **TWO VIEWS OF HEALTH ECONOMICS**

Economists typically follow two competing schools of thought when it comes to health care. The competitive market view asserts that health care is no different than other types of goods and services and that the most efficient outcomes will result from competitive forces. The role of government in this view is limited to promoting competition and not directly intervening in the market.

At the other end of the spectrum, the government interventionist view argues that the government should play a very active role in the market for health care. There are two basic arguments which are often used to support the government interventionist view. The first is a practical argument that claims market forces will not lead to the optimal societal outcomes in the case of health care services. Based on economic theory, competition is expected to drive efficiency if the market is, in fact, competitive. This implies that both buyers and sellers choose their actions based on the observation of market prices but lack the ability to effectively influence market prices. In the case of providers, this would imply that there are a large number of independently-acting medical providers competing with one another on the basis of price. This is not entirely true for some types of care. In rural areas, for example, the choice of provider within a reasonable geographic area is particularly limited, which allows those providers the

ability to raise prices beyond the competitive level. Consumers of medical care are also not very responsive to price changes and typically do not even know the prices of the care they are consuming. This is most notable for those with some form of insurance, as the patient is not directly responsible for the full cost of care. As a result, providers often compete not through price, but through reputation, quality, and convenience. While this does result in enhanced quality, such as easy access to high-tech medical equipment, it does very little to encourage affordability. Because health care markets do not fit the usual characteristics of competition, it is unclear if promoting competition will actually result in greater efficiency.

The second argument for the government interventionist is more radical. Even if we could achieve a health care system where competition yields maximum efficiency, the question remains whether efficiency should be our real goal. In a competitive model, goods and services are rationed by prices. Those willing to pay the market price receive the product, while those unwilling to pay the price do not. While the U.S. economic system is very focused on market efficiency, there is also a tendency to treat medical care as an inherent right, rather than a product which should go to the highest bidder. This view is reflected, for example, in laws that prevent emergency rooms from refusing treatment based upon the ability to pay for the services. Unfortunately, providing perfect equity in health care would likely result in efficiency losses. The fundamental question is whether we collectively would prefer at least some gains in equity even if it results in a more costly health care system.

## **WHAT CAN BE DONE?**

The pro-market view is consistent with the overall economic policy of the current administration. The main piece of health legislation passed by the current administration is the Medicare Modernization Act of 2003. Included in this act was the creation of the Medicare prescription drug benefit program (part D) and expanding the Medicare Advantage program (which built off the previous 'Medicare+Choice' program). In designing both of these programs, the emphasis has been on promoting competition among providers (albeit with government oversight). Both Medicare part D and Medicare Advantage rely on private insurers competing for the enrollment of Medicare participants. The expectation is that insurers with the ability to offer the best mix of quality and affordability will attract Medicare participants, thus channeling competitive forces toward increased economic efficiency.

The Medicare Modernization Act of 2003 also implemented sliding-scale part B premiums for higher-income participants, beginning in 2007. The intention is to help provide greater funding to help alleviate some of the financial burden of the program. This change is much more consistent with the government-interventionist view.

Separate from Medicare policy, the current administration has also promoted the formation of Health Savings Accounts through the Medicare Modernization Act of 2003. These accounts allow workers to set aside part of their income, tax-free, for medical

expenses including premiums, cost-sharing, and direct payments for medical care services and products. Any funds in the Health Savings Accounts which are not used during the year are allowed to remain in the account and grow through tax-free financial investments. If these accounts become heavily utilized, it may encourage a more competitive health care system as consumers will be more price-sensitive in allocating these funds for health care expenditures. At this point, participation in both Medicare Advantage and Health Savings Accounts is too limited to provide any solid evidence of their effectiveness in reducing medical expenditures.

While the President's health care policies are consistent with his overall economic view, they presume that a competitive market model is the direction we should take. Again, there is considerable debate on whether we should pursue the competitive model.

With respect to the creation of Medicare part D, there is some evidence that competitive forces have reduced the overall costs of the program. Actual part D premiums in 2006 were 40% lower than originally anticipated (CMS 2006b). This is due in part to the competition among the part D insurers and their ability to negotiate reduced rates for medications. The government interventionist response, however, would argue that the Medicare administration could have greater success negotiating lower rates directly.

While the current administration has taken some steps toward reducing Medicare expenditures, it is extremely unlikely that they will prolong Medicare's financial solvency. As a result, the solution will likely require unpopular choices such as restricting benefits or raising taxes. Much of the problem stems from the design of Medicare itself.

The strengths of parts A and B are that they provide partial, uniform benefits. The benefits are partial in the sense that they do not fully cover the cost of medical care. A full-coverage policy, with no out-of-pocket expenses beyond the premium, would be attractive from the participants' view, though it would result in even greater utilization of services. The additional utilization would likely provide little or no added value to the patient (an issue referred to as 'moral hazard' in the economics literature) and further drive up program expenditures. Thus, the partial coverage provided under parts A and B helps to limit frivolous services which reduce overall expenditures of the program.

In reality, though, only 12% of the Medicare population was without some form of supplemental coverage in 2002 (KFF, 2005). The remaining 88% have lower out-of-pocket expenses which results in greater utilization. The fact that most Medigap policies completely eliminate out-of-pocket expenses generates much higher utilizations. Since these policies must conform to Medicare approved standards, the Medicare administration is effectively undermining its own cost controls by creating these policies.

Uniformity of benefits refers to the fact that the benefits are defined at the national level with little variation by age, state, health status, etc. Uniformity, in this case, ensures a degree of equity and avoids problems of adverse selection. The competitive market view would certainly argue that uniformity limits competition and is partially responsible

for the inefficiencies that drive costs upward. However, under a competitive insurance market, insurers would gain from designing policies which are primarily attractive to healthier, lower-cost individuals. If successful, they are able to provide such policies at much lower premiums while still earning a profit. Less healthy, higher cost individuals would perhaps look for insurance policies which have very broad coverage and greater patient control of choices. If these policies are only sought out by high-cost individuals, they will be available only at very high premiums.

Government interventionists argue that as Medicare Advantage participation grows (at least for healthier segments of the Medicare population), it will leave the Medicare administration to directly cover the costs of only the high-cost patients, resulting in little actual cost savings. From the competitive market view, the limited cost savings of Medicare Advantage is due to the low participation rates. The government interventionists argue that we must eliminate Medicare Advantage, while the competitive market view argues to move entirely to the Medicare Advantage model in place of parts A and B.

If we abandon uniformity, the competitive pressures would likely result in some enhanced efficiency, though at a significant loss in equity. Namely, we would no longer have a system which provides adequate coverage to all eligible populations.

Finally, there seems to be renewed momentum for legislation to create a national health care plan. The U.S. is the only industrialized country without a national plan to ensure some sort of equal coverage to all citizens. If the Medicare program were replaced with a national policy applying to all citizens, the average cost per participant would be much lower. This is because the rest of the population is generally healthier than the seniors and disabled populations currently receiving Medicare. While such a program would necessarily have higher total expenditures, it would have the advantage that current workers would see an immediate benefit from their additional tax payments. Thus, converting Medicare to a more universal system may have some political appeal to voters, compared with the potential for increased payroll taxes for current workers who are not yet able to participate in Medicare. While this may have some political appeal, it should be noted that this will not solve the fundamental problem. Empirical results show health care in the U.S. is more costly than in other industrialized countries, though with greater access to high-tech treatments (at least for those with insurance). The problem of growing medical expenses, while exaggerated in the U.S. system, is a growing concern in all industrialized countries.

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