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January 2008

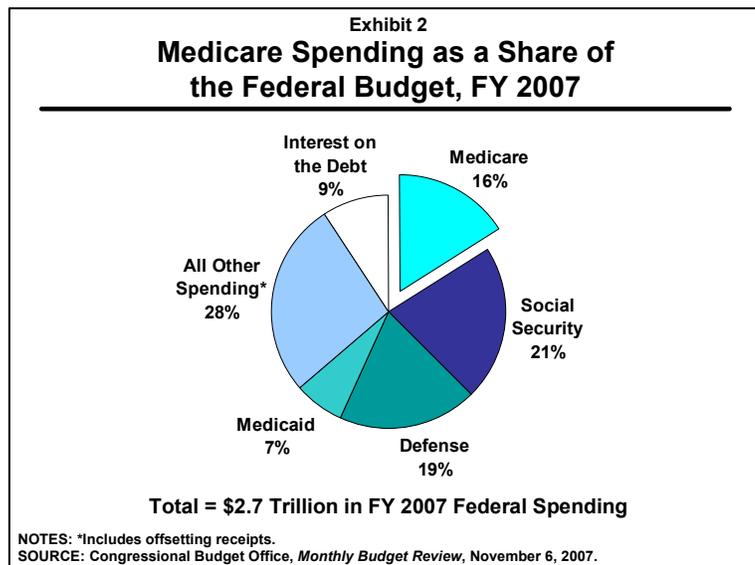
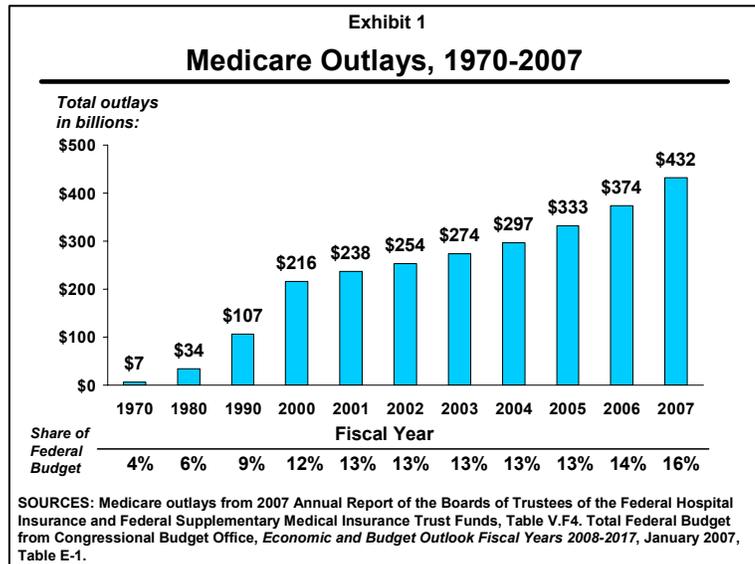
INTRODUCTION

For more than 40 years, Medicare has successfully provided access to needed health care services for the elderly and many people with disabilities and currently covers 44 million Americans. But persistently high rates of growth in national health expenditures combined with demographic trends pose a serious challenge to the financing of Medicare in the 21st century. This paper explains how Medicare is financed, describes the program's long-term financing situation from several perspectives, and reviews the factors contributing to Medicare's financial challenges.

As the nation's single largest health insurance program covering a large population for a broad range of health services, Medicare's influence extends

well beyond the assistance it provides its beneficiaries. The dollars invested through Medicare and the policies under which it operates have a large impact on the nation's health care system. One in five dollars used to purchase health services in 2006 came through the Medicare program, which finances about one-third of all hospital stays nationally.¹

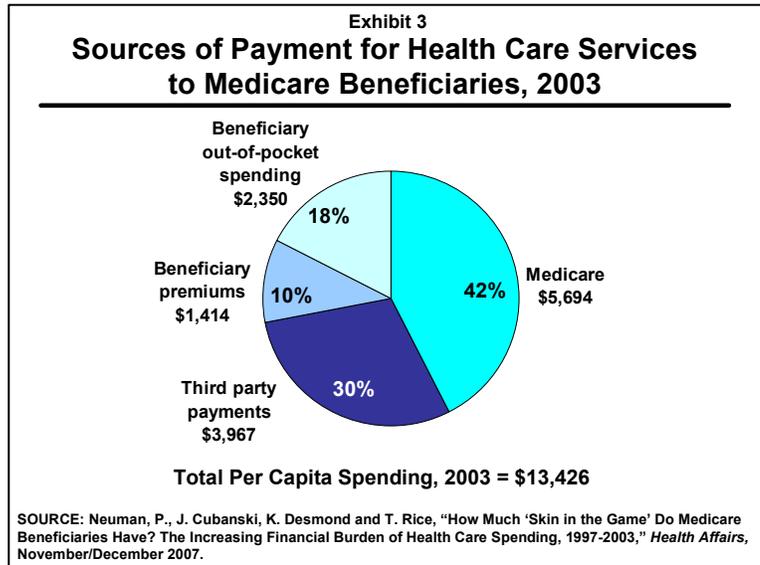
Since its inception, spending on Medicare has grown steadily, both in absolute dollars and as a share of the federal budget (**Exhibit 1**). By fiscal year 2007, Medicare's \$440 billion in total expenditures represented 16 percent of all federal outlays, exceeded only by Social Security benefits at \$577 billion (21 percent) and military spending at \$530 billion (19 percent) (**Exhibit 2**).²



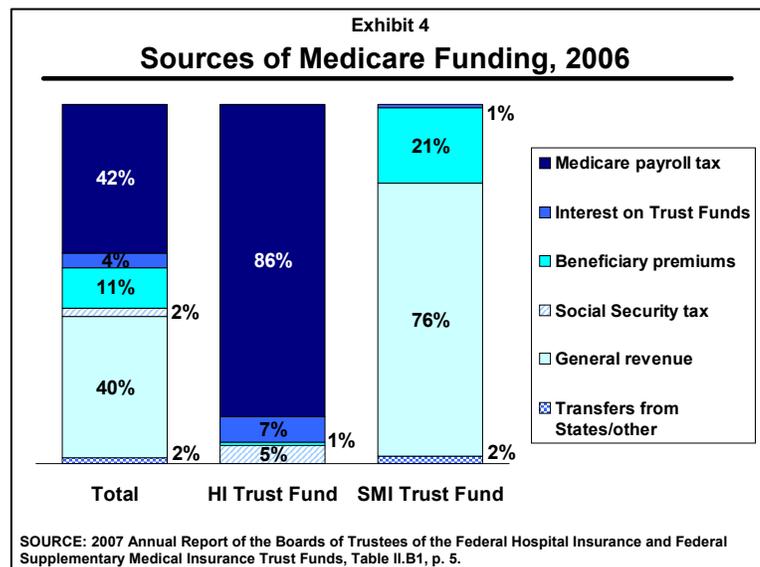
HOW IS MEDICARE FINANCED?

In financing Medicare, the government draws from several sources of revenue: the dedicated Medicare payroll tax, premiums collected from beneficiaries, general revenue (primarily federal income taxes), a tax on Social Security benefits, and beginning in 2006, payments from states required for the Medicare drug benefit, which shifted some Medicaid expenditures to Medicare.

In addition to premiums, beneficiaries also help pay for the cost of their Medicare-covered services through deductibles and coinsurance. In some cases, physicians may charge beneficiaries additional out-of-pocket “balance billing” amounts. Medicare beneficiaries also pay for health care items and services not covered by Medicare such as most vision and hearing services. Overall, Medicare paid 42 percent of beneficiaries’ total medical and long-term care costs in 2003, with 28 percent of the total paid by beneficiaries directly out-of-pocket for premiums and services and another 30 percent paid on behalf of those beneficiaries by third-party payers such as Medicaid, private supplemental “Medigap” coverage, or employer-sponsored health plans (**Exhibit 3**).



Operationally, Medicare financing is conducted through two trust fund accounts (**Exhibit 4**). The Hospital Insurance (HI) Trust Fund, into which Medicare payroll taxes and other dedicated revenue are credited, pays for inpatient hospital stays and other benefits provided under Medicare Part A. In 2006, the payroll tax provided 86 percent of all the revenue attributed to the HI Trust Fund, and 42 percent of Medicare revenue overall. The Supplementary Medical Insurance (SMI) Trust Fund is used to pay for physician visits and other Medicare Part B services as well as the Medicare Part D prescription drug benefit. The SMI Trust Fund is financed primarily through monthly beneficiary Part B premiums, prescription drug plan premiums, and general revenue. General revenue accounted for 76 percent of the SMI Trust Fund revenue in 2006, and 40 percent of all Medicare revenue, while beneficiary premiums made up 21 percent of the Trust Fund revenue and 11 percent of Medicare revenue overall. Both the HI and SMI Trust Funds are used to pay private Medicare



Advantage (MA) plans for those beneficiaries who enroll in these plans for their benefits under Parts A and B and in some cases, Part D drug coverage. (See **Appendix A** for detail on the sources and uses of trust fund revenue.)

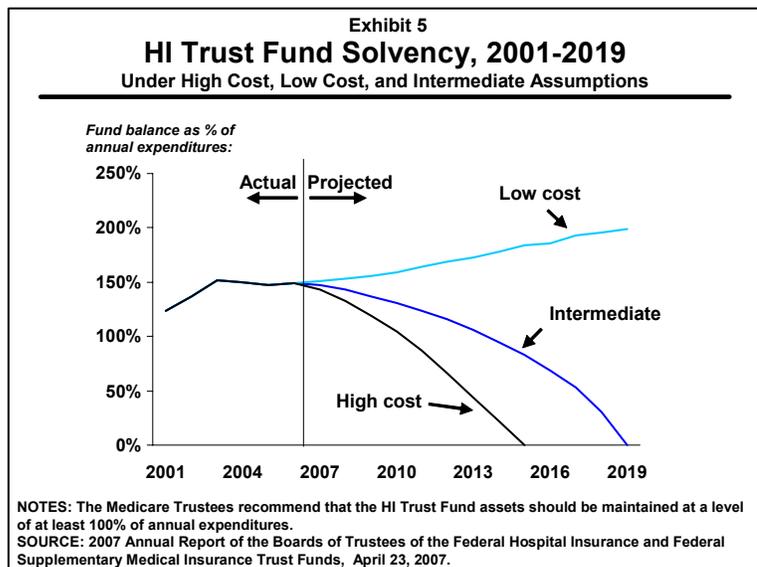
A key difference between the HI and SMI Trust Funds affects their financial status. The revenue dedicated to the HI Trust Fund may be greater or less than expenditures from the Fund in any given year, so that in some years expenditures may exceed income, while in other years, reserve funds may be generated. By contrast, SMI Trust Fund financing does not produce excess revenue or shortfalls due to the way it is structured, with premiums and general revenue contributions adjusted each year in order to cover expenditures for that year. When excess HI Trust Fund revenue is collected, the excess amounts are loaned to the federal government and used to pay for other federal obligations. Interest on the loans is credited to the Trust Fund as income. Interest payments are not actually transferred out of general revenue unless these amounts are needed to pay Medicare claims. As a result, the amounts collected in Medicare payroll taxes and other dedicated revenue but loaned out of the HI Trust Fund, along with the associated interest payments, represent a claim on future general revenue funds. The HI Trust Fund balance, which totaled \$305 billion at the end of fiscal year 2006, is a measure of future claims accumulated to date, to be drawn on when payroll taxes and other dedicated revenue are insufficient to cover expenditures.

HOW IS MEDICARE’S FISCAL STATUS MEASURED?

Serious concerns have been raised about the long-term financial health of the Medicare program. The program’s financial status is often measured in terms of Trust Fund solvency and Medicare spending as a share of the federal budget and of the overall national economy. Each measure addresses a different perspective on the program’s financing and leads to different potential solutions to Medicare’s long-term financing challenges.

Trust Fund Solvency

Solvency of the HI Trust Fund is the measure of Medicare’s financial health that typically receives the most attention (**Exhibit 5**). A report on the financial status of the HI Trust Fund is released annually, as required by law, including short-run and long-run financial forecasts prepared by the Medicare actuaries. The report is issued by the Medicare Trustees, an oversight panel comprised of the Secretaries of HHS, Labor, and Treasury; the Commissioner of Social Security, and two public trustees appointed by the President.



Under the Medicare actuaries’ most recent best estimates (based on their “intermediate assumptions”), annual payments from the HI Trust Fund will exceed annual income to the Trust

Fund beginning in 2011. When such a shortfall occurs, the Trust Fund reserves are drawn upon through general revenue transfers to make up the difference. The shortfalls will accelerate rapidly each year after 2011 and in 2019, the Trust Fund balances are projected to be exhausted.³ This means that even if all the payroll tax amounts that were previously loaned to the rest of the federal government are repaid with interest, the Trust Fund will not have sufficient funds in 2019 to cover the entire cost of inpatient hospital care and other Medicare Part A services.

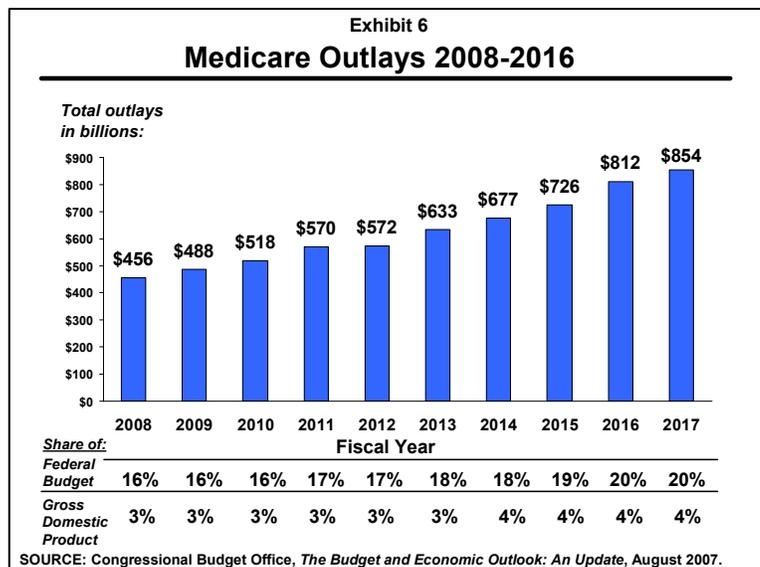
A range around this insolvency date – 2014 to 2042 – is bounded by using the actuaries’ more pessimistic and optimistic assumptions about future economic and demographic factors and health-care costs. That is, assuming faster growth in the economy or slower growth in health spending would delay the insolvency date, while slower economic growth or more rapidly growing health care costs would move the insolvency date up.

The projection of HI Trust Fund exhaustion in 2019 does not mean that the Medicare program will be “bankrupt”, that there will not be any funds available to pay for Medicare Part A benefits that year, or that benefits will cease as a result, since revenue will continue to flow to the HI Trust Fund. Rather, it means that there will be insufficient funds to meet the Trust Fund obligations. What makes the projected funding shortfall problem especially serious is that it is not temporary—the shortfalls will continue to accumulate each year unless something changes either to increase the revenue coming into the Trust Fund or to decrease total Trust Fund expenditures. No process exists for addressing a shortfall in the HI Trust Fund; new legislation would be required to make up the difference.

While technically, the SMI Trust Fund cannot become insolvent, financing the projected growth in spending for Part B and Part D services would require rapidly increasing general revenue contributions. This has important implications for the federal budget, which offers another way to measure Medicare financing.

Medicare Spending as a Share of the Federal Budget

Medicare is one of the largest and fastest growing federal programs. Following historical trends, Medicare spending is projected to continue to grow faster than the rest of the budget, reaching 20 percent of federal spending by 2016 (**Exhibit 6**), and exceeding the cost of Social Security by 2028.⁴ Budget experts have expressed concern about the long-run implications of Medicare spending on federal deficits. Coupled with similar pressure on financing Social Security and Medicaid benefits, the Comptroller General of the United States and others have described the current long-term federal fiscal policy as “unsustainable.”⁵



Medicare Spending as a Share of Gross Domestic Product (GDP)

One common way of evaluating the burden of financing a rapidly growing Medicare program is to consider Medicare spending in relation to the overall US economy. Medicare represented 2.5 percent of the gross domestic product (GDP) in 1996, a share that grew to 3.0 percent in 2006 and at current trends the Congressional Budget Office (CBO) estimates it will reach 6 percent of GDP by 2030, even when only outlays net of beneficiary premiums are considered.⁶ (Including beneficiary premiums to evaluate total program expenditures as a share of GDP rather than only expenditures financed in other ways would increase these figures – under CBO projections premiums will fund 15 percent of total program expenditures by 2016.) While no one amount is the “correct” amount for this measure, the implication of having more economic output devoted to Medicare spending is that fewer resources are available for other purposes.

The Medicare Solvency “Trigger”

Another measure of Medicare’s claim on the federal budget has recently been developed, commonly referred to as the “45 percent trigger.” Under the Medicare Modernization Act of 2003, the Medicare Trustees are required to estimate, using a particular formula, a ratio measuring the extent to which program expenditures exceed dedicated revenue. (See **Appendix B** for a detailed explanation). If the actuaries project that the ratio is expected to exceed 45 percent within seven years, a determination of “excess general revenue funding” is made. If the determination is made for a second consecutive year, a “Medicare funding warning” is issued by the Trustees, which triggers a process by which the President and Congress are expected to respond to the warning.

In their 2007 annual report, the Medicare Trustees issued the first Medicare funding warning when, for the second year in a row, they projected that the 45 percent threshold would be exceeded within seven years. Specifically, they estimated that the ratio would exceed 45 percent in 2013. As a result, the President is required to submit legislation to Congress to respond to the warning within 15 days after submitting the Administration’s budget proposals for fiscal year 2009, which is expected in early February 2008. An expedited process is in place for the Congress to consider the President’s proposed legislation.

The “Medicare funding warning” process is intended to draw attention to Medicare’s financial situation and to prompt the President and Congress to develop a response. Yet no spending reductions or other changes in the program will automatically occur as a result of the warning; rather, legislation to address the situation must be passed by the Congress and signed by the President. Possible steps to limiting the ratio to no more than 45 percent include raising revenue by increasing Medicare payroll taxes, beneficiary premiums, or taxes on Social Security benefits; or lowering spending by reducing benefits or payments to providers. Increasing general revenue contributions would not improve the ratio, although if policy makers decide that increased general revenue funding is an appropriate means of financing Medicare, no steps related to the trigger formula need to be taken.

The funding warning has been criticized on a number of grounds. Chief among them is that the formula promotes certain policy solutions over others, as described above. Under the formula, an increase in beneficiary premiums or payroll taxes would have a greater effect on keeping general revenue funding at or below the 45 percent level than an equally-sized reduction in program spending, even though reducing program spending would contribute to a smaller federal budget and using general revenue financing is more progressive than using the payroll tax.⁷ (This result occurs

because a reduction in spending lowers both the formula's numerator and denominator, while an increase in revenue or premiums only lowers the numerator. Refer to Appendix B for details.)

The narrow focus of the 45 percent trigger measure on general revenue masks the broader picture of Medicare spending in the context of the federal budget or the economy. The 45 percent standard suggests an implicit cap on general revenue contributions to Medicare that appears to be arbitrary, with no policy justification offered for the choice of the 45 percent level. In addition, as noted earlier, the formula is estimated to overstate the reliance of the Medicare program on general revenue. The Children's Health and Medicare Protection Act (H.R. 3162), passed by the House of Representatives in August 2007 included a provision to repeal the 45 percent trigger provision in its entirety.

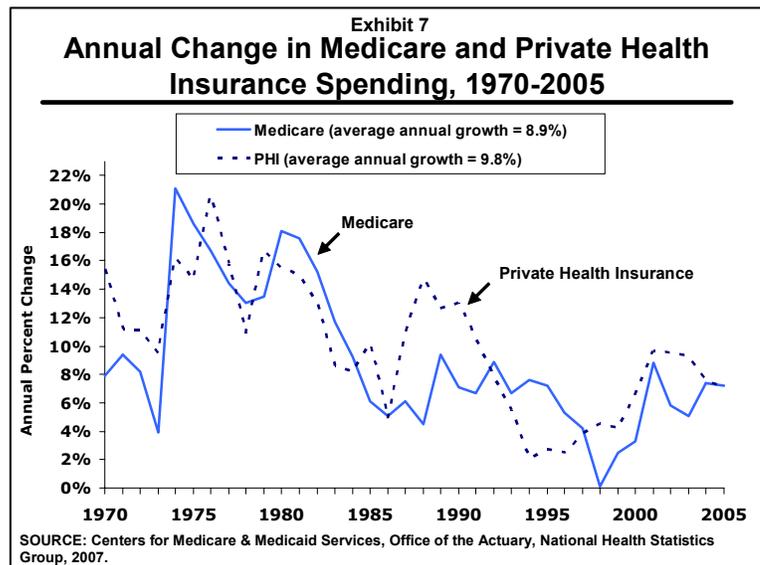
WHAT FACTORS ARE DRIVING GROWTH IN MEDICARE SPENDING?

When considered only in the context of the federal budget, the rapidly growing cost of Medicare might be considered as evidence of failings in the program. But when broader trends in health spending are taken into account, Medicare's financing dilemma can be viewed as a reflection of the nation's overall health care cost trends. In fact, CBO has identified the national growth in health care costs as the key determinant of the nation's long term fiscal outlook.⁸

Medicare Spending Reflects National Health Spending Trends

Since the 1970s, national health care spending has on average grown about 2.5 percentage points faster than the economy, and this trend is expected to continue.⁹ In 2005, national health expenditures totaled \$2 trillion or 16 percent of the GDP, and is projected to double to \$4 trillion and 20 percent of the GDP by 2016.¹⁰ The US ranks far above all other countries in health spending – Switzerland ranks second at less than 12 percent of GDP.¹¹

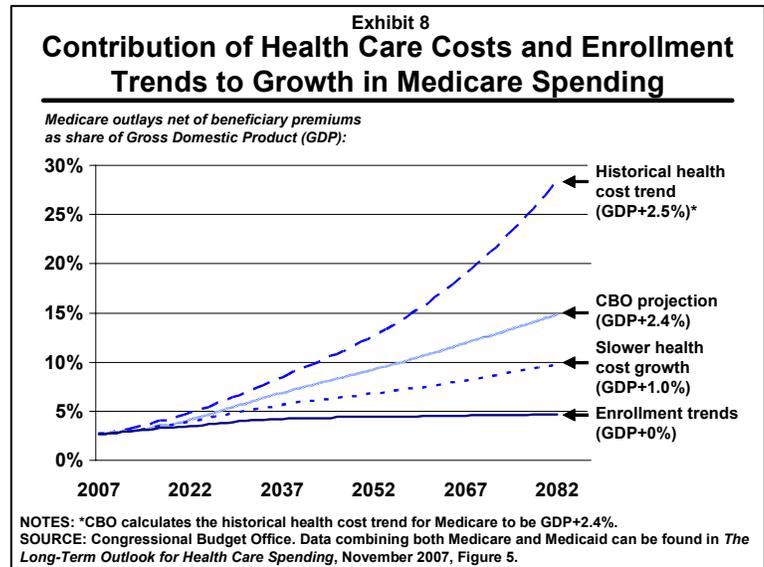
Over the long run, growth in Medicare spending per beneficiary has averaged about the same as per capita growth in private health spending (**Exhibit 7**). In fact, the Medicare actuaries' long-run projections (those more than 25 years out) are built on the assumption that per beneficiary expenditures will increase at the same rate as overall health spending per capita.¹²



Projections from the CBO demonstrate the substantial savings to Medicare if health care spending were to grow more slowly. For example, if the rate of growth in per capita health costs were equal to the growth in GDP plus 1.0 percentage point, by 2050 program spending would be about half the level it would be at the trend of GDP plus 2.5 percentage points, similar to the historic average.

(Exhibit 8).¹³ CBO forecasts a long-run trend that falls somewhere in between these amounts, noting that eventually, under the historic trend, health care would begin to crowd out consumption of other necessary goods and services to a degree that is unsustainable.

Several factors contribute to the growing portion of the economy devoted to health care. These include medical advances and the adoption of new medical technologies and services, changes in disease prevalence that increase the use of services, and increased demand due to lower out of pocket costs at the point of service.¹⁴ Medicare is affected by these overall trends along with other health care purchasers, and the government has taken steps to curb program expenditure growth while maintaining beneficiary access to care. Through various policy changes over the years, policy makers have acted to control the increases in the prices Medicare pays for services and require increased beneficiary contributions. In recent years greater attention has been placed on the process for determining Medicare coverage of new medical technologies.



Other Factors Affecting Growth in Medicare Spending

While overall growth in health spending is the major driver of Medicare spending growth, some additional contributors are unique to the program.

Demographics and an aging population: Most often discussed is the accelerating growth in program enrollment that will occur with the retirement of the post-WWII “baby boom” generation, who will begin to turn 65 in 2011. Since 1995, as the cohort of individuals born during the great depression and World War II have become eligible for benefits, Medicare enrollment has grown by an average of 550,000 beneficiaries annually. By contrast, as the baby boomers reach age 65, Medicare enrollment is expected to increase each year by 1.6 million beneficiaries, and will reach a total of 79 million enrollees in 2030 -- double the program enrollment in 2000.

The contribution of increased enrollment to growing Medicare costs is relatively modest, however. CBO projects that increased program enrollment along with the aging of the Medicare population would only increase Medicare spending from under 3 percent of GDP currently to less than 5 percent of GDP by 2082, compared with nearly 15 percent of GDP when the growth in per capita health costs is included (**Exhibit 8**). The effects of the age mix of Medicare beneficiaries are small. As one would expect, per capita Medicare spending increases as beneficiaries age.¹⁵ But as the baby boom generation ages onto Medicare, the age mix of the program’s beneficiaries will actually be younger than it is today. Only until the bulk of baby boomer beneficiaries reach age 85, between 2040 and 2050, is age mix expected to contribute to higher program spending.

Shifting demographics will affect Medicare financing in other ways. Not only will Medicare need to provide for more beneficiaries, there will be fewer workers per beneficiary contributing to help cover the costs. In 2006, 3.9 workers were contributing taxes for each beneficiary; by 2030 that

figure is projected to fall to 2.4 and continue to decline to 2.0 workers per beneficiary by 2080. As a result, even at a healthy rate of economic growth, Medicare payroll taxes would not keep pace with program growth. This worker-to-retiree ratio problem is not unique to the United States. In fact, the proportional decline in workers is much worse in Japan and many European countries.¹⁶

Medicare Part D: Addition of the Part D prescription drug benefit in 2006 has increased Medicare outlays considerably. Two-thirds of the \$72 billion increase in Medicare expenditures from 2005 to 2006 resulted from the implementation of Part D. Experience with this new benefit is limited, but over the next ten years Part D expenditures are projected to grow more than twice as fast as the rest of the Medicare program.¹⁷

Enrollment in Medicare Advantage (MA): A recent trend contributing to growth in program costs is the rising enrollment of Medicare beneficiaries in Medicare Advantage, under which Medicare benefits are provided by private health plans that contract with the federal government. The amount of benefits derived from the growing role played by private Medicare Advantage plans is a matter of dispute, but strictly from the perspective of program financing it is undisputed that they have added to the cost of Medicare borne by the government. Enrollment in all private plans has risen by about 60 percent since 2004 to a total of 8.9 million beneficiaries, and the Medicare actuaries project that the proportion of beneficiaries enrolled in these plans will grow from its current level of 18 percent to 25 percent by 2011 and 32 percent by 2031.

Growing enrollment in Medicare Advantage plans increases program expenditures because each MA plan enrollee costs 13 percent more on average than if the beneficiary was in the traditional Medicare program.¹⁸ According to CBO, this differential will increase spending by \$149 billion over the nine year period from 2009 to 2017, shorten the solvency of the Hospital Insurance Trust Fund by two years, and increase beneficiary premiums.¹⁹

Physician payment: One challenge in evaluating Medicare financing trends is that official Medicare spending projections are known to be understated due to anticipated changes in physician payments. The law setting forth Medicare payment to physicians specifies an annual update formula that would require reductions in physician fees of about 10 percent in 2008 and roughly 5 percent each year after that through at least 2016. These cuts are therefore assumed in the projections of future program costs. However, Congress has acted in recent years to prevent these cuts from taking place each year, without making changes to the underlying formula that would determine physician payments in the long run.

Most experts believe the government will continue to prevent physician payment cuts from taking place under the current payment formula, resulting in much higher expenditures for physician services than are assumed in official Medicare projections. Under more politically realistic estimates, total Medicare spending for 2016 would be 16 percent to 24 percent higher than the official estimates, and beneficiary contributions for the Part B premium and deductible would rise by the same order of magnitude, unless policy makers held them harmless to some extent.²⁰

Administrative costs: Program administration is not a contributing factor to Medicare's expenditure growth. The costs of administering the Medicare program have remained low over the years – about 2 percent of program expenditures. This covers all expenses by government agencies in administering the program (HHS, Treasury, the Social Security Administration, the Department of Justice and the Medicare Payment Advisory Commission). Included also are the cost of claims contractors and other costs incurred in the payment of benefits, collection of Medicare taxes, fraud

and abuse control activities, various demonstration projects, and building costs associated with program administration.

HOW DO RISING MEDICARE COSTS AFFECT BENEFICIARIES?

The growing cost of Medicare creates a financial burden on beneficiaries as well as the federal government. The Trustees project that over time beneficiaries will pay an increasing share of their income for their Medicare coverage. In 2010, premiums for Part B and Part D are estimated to equal 12 percent of the average Social Security benefit, while average cost sharing absorbs another 18 percent; these figures are estimated to continue to rise as health care cost increases outpace growth in Social Security benefits. These premium figures do not include the income-related Part B premium, under which higher-income beneficiaries pay an amount much greater than the standard monthly premium. Sources of beneficiary income other than Social Security benefits are also excluded from this analysis.

Additionally, beneficiaries will face rising premiums for private Medicare supplemental coverage. Of course, the impact on individual beneficiaries will vary as those who use fewer health services are less affected by cost sharing requirements and those with higher incomes will be able to afford to pay more for their Medicare benefits.

Some of the burden of rising beneficiary premiums and cost sharing ends up back on the government ledger in the form of government subsidies. As beneficiary financing increases, so does the cost of subsidies for Part D premiums and Medicaid subsidies for Part B premiums and cost sharing for the lowest income beneficiaries.²¹ In addition to the direct subsidies for which beneficiaries must apply, the annual dollar increase in a beneficiary's Part B premium is capped to equal the annual dollar increase in their Social Security benefit. This "hold harmless" protection prevents monthly Social Security income from falling as the Part B premium increases.

HOW CERTAIN ARE THE FORECASTS?

Given the complexity of our economy and health care system, Medicare financing projections are always uncertain. Moreover, policy decisions made in the near term can have long-term effects. HI Trust Fund financing crises predicted in the past have been forestalled by Congressional actions increasing revenue and decreasing spending. But the consensus among experts is that substantial changes will be required to keep Medicare financing on a solid footing into the 21st century.

Medicare financing projections rely on a variety of predictions about the economy, demographics, and health care spending trends. Economic factors affect both spending and revenue projections. For example, future payroll taxes are tied to growth in wages, while annual increases in payments to hospitals and other providers are linked to measures of price inflation. Differences between projections and actual expenditures are inevitable. For example, in the 2007 annual report, the Medicare Trustees adjusted their estimated date of the exhaustion of the HI Trust Fund by one year due to higher-than-expected average wages and slower growth in expenditures. Enrollment trends are relatively easy to predict given available information about the age of the population and payroll tax contributors, but trends in life expectancy and health status must also be forecast with more

assumptions required, and changes to immigration policy or patterns could affect demographic projections.

As discussed earlier, Medicare projections are largely driven by movement in national health spending; these trends can shift quickly with the diffusion of new medical technologies or breakthrough drugs. For example, prescription drug spending grew rapidly in the 1990s as a record number of new drugs were introduced, then subsequently decelerated as that trend slowed.²²

Through legislation and regulation, Medicare policy is constantly changing, with implications for long-run program spending trends. Past steps to address program financing have included revenue increases, spending reductions, and increased beneficiary contributions. These were often prompted by federal budget concerns, but some steps were taken specifically to address near-term HI Trust Fund financing problems. For example, prior to 1990, the Medicare payroll tax was only collected on wages up to a cap (which remains in place for the Social Security payroll tax). The cap was raised for the Medicare payroll tax in 1990 and eliminated entirely in 1993. The taxation of Social Security benefits was extended as well in 1990, with the additional funds dedicated to the Medicare HI Trust Fund. In addition, in 1997 a change was enacted to limit coverage of home health services under Part A to 100 visits following a hospital or skilled nursing facility stay; payment for other Medicare-covered home health visits was shifted to Part B, significantly reducing expenditures from the HI Trust Fund for what was then one of the fastest-growing components of Medicare spending.²³

WHAT IS THE OUTLOOK FOR THE FUTURE?

Maintaining Medicare financing over the long run will require major changes from the current projected path, although any policy change that reduces program expenditures will improve Medicare's financing picture, as can seemingly small differences between the forecast and actual economic performance. Policies that the Medicare Trustees estimate would be required to preserve the solvency of the HI Trust Fund over the very long run (75 years) provide one example of the magnitude of change needed: a gradual tripling of the payroll tax, a reduction in Part A expenditures by one-third, or some combination of the two approaches. Similarly, new revenue or reduced growth in expenditures for the rest of the Medicare program (physician visits and other outpatient services and subsidies for private prescription drug plans) will also be required.

These changes will generate controversy, and the challenge to policy makers for the coming decades is to find a balance between limiting growth in payments to providers, increasing contributions from beneficiaries, and raising revenue—all while maintaining beneficiary access to medically necessary services and the overall quality of the care. Past experience underscores the political difficulties in this balancing act. For example, some provider payment reductions enacted as part of the 1997 Balanced Budget Act were considered too burdensome and eased within a few years by subsequent legislation that also included benefit expansions.²⁴ In recognition of the challenges, a number of proposals envision the creation of a bipartisan commission that would weigh the various interests and make recommendations for addressing the long-term financing of Medicare and other entitlement programs. In the late 1990s, the National Bipartisan Commission on the Future of Medicare was created and charged with developing recommendations for strengthening and improving the program in time for the baby boom retirement. The Commission failed to produce consensus on a set of recommendations for Medicare reform, demonstrating the

difficulties of achieving compromise on these issues.²⁵

Policy makers must also consider the broader effects of changes made to the Medicare program. Major reductions in payments to providers would put upward pressure on the prices they charge to private payers and could negatively impact beneficiary access to providers. Additional payments to teaching hospitals and those located in rural areas and serving low-income urban populations are explicitly made to address social needs beyond the care for Medicare patients, and substantially reducing or eliminating these payments would disadvantage the communities that rely on these facilities. Shifting too much of the burden of Medicare financing on beneficiaries could reduce their access to needed health services and increase the proportion of uncompensated health care.

While the focus on Medicare financing is often linked to concerns over the growth in federal spending, many analysts believe that the most successful long-term strategies for dealing with Medicare cost trends are likely to be those that address the growth in overall health care costs.²⁶ Possible approaches to slowing overall growth in health care costs that have been identified include creating and disseminating more information about the comparative effectiveness of alternative medical treatments and linking these findings to payment policy, changing the financial incentives of health care providers by bundling payments, and increasing consumer cost sharing. In addition, with two-thirds of Medicare spending attributed to the 20 percent of beneficiaries with five or more chronic conditions, improving the prevention and management of chronic disease is another potential strategy for reducing health care spending.²⁷

None of these approaches is guaranteed to succeed in reducing overall health spending without unintended consequences, and much effort would be required to identify precise cost-reducing techniques. For example, while evidence to date suggests that chronic disease management improves the quality of care, specific cost-saving approaches have not yet been identified.²⁸ Another suggested approach is to address growth in health care costs through overall health system reform. Such an effort could explicitly account for the subsidies currently provided for services to the uninsured by people with Medicare and other public and private insurance. It would also allow the debate on health care costs to take place within the context of coverage for all Americans, rather than more narrowly focused only on Medicare and other public entitlement program spending.²⁹

Tackling the challenge of slowing growth in overall health care costs will require changes throughout the health care system rather than in Medicare alone. The federal government could play a leadership role in addressing national health spending trends through its obligations to finance health care for the elderly and disabled through Medicare.

This paper was commissioned by the Kaiser Family Foundation. Conclusions or opinions expressed in this report are those of the author and do not necessarily reflect the views of the Kaiser Family Foundation.

APPENDIX A: MEDICARE'S TRUST FUNDS

	Hospital Insurance (HI) Trust Fund	Supplementary Medical Insurance (SMI) Trust Fund
Sources of Funds	<p>The HI Trust Fund is the repository for the Medicare payroll tax contributions (1.45 percent each for employee and employer), which constituted 86 percent of Trust Fund revenue in 2006.</p> <p>Other sources of funding include some of the income taxes paid on Social Security benefits by those exceeding certain income thresholds (5 percent of revenue); interest earned on trust fund balances (7 percent), and enrollee premiums (1 percent).</p>	<p>Premiums paid by beneficiaries constituted 21 percent of SMI Trust Fund revenue in 2006. General revenue contributed 76 percent of the total; transfers from states to offset state savings from implementation of the Medicare drug benefit accounted for 2 percent; interest on the Trust Fund balance was less than 1 percent.</p> <p>Beneficiary premiums include the standard monthly premium paid for Medicare Part B (\$96.40 in 2008); premiums paid by beneficiaries electing to enroll in Medicare Part D for their prescription drug coverage, which vary based on the plan they choose; and beginning in 2007, an income-related Part B premium paid by higher income beneficiaries. In 2007, the threshold was \$80,000 individual/\$160,000 couple, indexed to inflation in subsequent years. When fully phased in (2009), the total premium paid by these beneficiaries will range from 40 percent to 220 percent higher than the standard premium, depending on income.</p>
Use of Funds	<p>Medicare Part A benefits are financed out of the HI Trust Fund. Individuals become eligible for Medicare Part A when they turn age 65 if they have made sufficient payroll tax contributions or choose to pay a premium to enroll; disabled individuals may qualify at a younger age.</p> <p>Part A benefits include inpatient hospital care (63 percent of HI expenditures in 2006); limited skilled nursing facility care (10 percent), home health (3 percent) and hospice services (5 percent). Some 17 percent of payments from the HI Trust Fund are made to cover the costs of services to beneficiaries enrolled in private Medicare Advantage plans.</p> <p>The remaining 2 percent of expenditures pay for Medicare program administration, including government costs incurred in the payment of benefits, collection of taxes, fraud and abuse control activities, and various demonstration projects.</p>	<p>The SMI Trust Fund is used to pay for benefits under Medicare Part B and to pay premiums to private prescription drug plans under Medicare Part D. Unlike Part A, eligible individuals must elect to enroll in Medicare Parts B and D and pay a monthly premium.</p> <p>Part D benefits in fiscal year 2007 (the first full fiscal year for which the benefit was in place) are projected to account for 27 percent of all SMI expenditures.</p> <p>Part B benefits include physician care (35 percent of Part B expenditures in 2006); outpatient hospital services (16 percent); home health care (4 percent). About 19 percent of payments from the SMI Trust Fund are made to cover the costs of services to beneficiaries enrolled in private Medicare Advantage plans. When combined, other benefits, including durable medical equipment, laboratory and ambulance services, clinic care and other services, account for almost 25 percent of SMI expenditures.</p> <p>The remaining 2 percent of expenditures pay for Medicare program administration, including government costs incurred in the payment of benefits, collection of taxes, fraud and abuse control activities, and various demonstration projects.</p>

Financial Status	<p>The financial status of the HI Trust Fund depends on the extent to which the Medicare payroll tax and other revenue that is dedicated to the Trust Fund covers the Part A expenditures that are obligated to be financed by the fund. At the end of fiscal year 2007, the HI Trust Fund had a balance of \$317 billion. Over the next decade, however, the Trust Fund is projected to be in shortfall, with trust fund balances exhausted and therefore insufficient funds to pay all obligations beginning in 2019 under the Medicare actuaries' intermediate (most likely) assumptions.</p>	<p>The Part B premium is set each year to cover 25 percent of the projected cost of Part B benefits. Similarly, the Part D premium is set by statute to cover 25 percent of the projected cost of Part D benefits. General revenue funds are drawn to cover the balance of SMI Trust Fund expenditures.</p> <p>Because of the annual recalculation of premiums and the automatic draw on general revenue, the SMI Trust Fund technically cannot be in shortfall.</p>
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SOURCES: 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, April 23, 2007; Centers for Medicare & Medicaid Services, "Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2008," *Federal Register Vol. 72, No. 19*, October 5, 2007, p. 57039; Department of the Treasury, *Monthly Treasury Statement of Receipts and Outlays of the United States Government for Fiscal Year 2007*.

APPENDIX B: MEASURING GENERAL REVENUE CONTRIBUTIONS FOR THE “45 PERCENT TRIGGER”

While the issuance of a Medicare funding warning depends on two consecutive years’ findings of “excess general revenue funding,” the definition of general revenue used to calculate general revenue funding is computed is not as simple as might be suggested by the label. General revenue is by design a major source of funding for Medicare, intended to cover three-quarters of the cost of both Parts B and Part D. The ratio computed under the “45 percent trigger” formula is intended to account for more than these transfers, however.

For each year, the formula computes the following ratio and compares it to the 45 percent threshold:

$$\frac{\text{Total Medicare outlays – dedicated revenue}}{\text{Total Medicare outlays}} = \text{General Revenue Funding}$$

Whatever is not counted as dedicated revenue in the formula is therefore counted as general revenue. Under the formulation, dedicated revenue consists of payroll taxes, premiums, transfers from states, and HI Trust Fund revenue from taxation of social security benefits. Interest payments made to the Trust Funds are not counted as dedicated revenue, and therefore count as general revenue in the formula. Arguably, treating HI Trust Fund interest payments this way in a calculation intended to measure Medicare’s reliance on general revenue funding is inappropriate.³⁰ While it is true that interest payments are made from general revenue, they are only made at all because excess dedicated Medicare payroll taxes were “borrowed” from Medicare and used to finance other government obligations. Had these excess dedicated Medicare funds not been available, the federal government would have had to borrow funds from elsewhere – necessitating payment of interest to others.

Moreover, the “excess general revenue funding” formula would similarly count repayment of borrowed HI Trust Fund amounts as general revenue subsidies. That is, as HI Trust Fund reserves are drawn down in future years to pay program benefits, these amounts are treated in the formula as general revenue subsidies, even though they represent repayment of dedicated payroll tax amounts collected in earlier years.

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