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Medicare: Financing the Part A Hospital Insurance Program

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Summary

Medicare is the nation's health insurance program for individuals aged 65 and over and certain disabled persons. Medicare consists of four distinct parts: Part A (Hospital Insurance [HI]); Part B (Supplementary Medical Insurance [SMI]); Part C (Medicare Advantage [MA]); and Part D (the new prescription drug benefit added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [MMA]). The Part A program is financed primarily through payroll taxes levied on current workers and their employers; these are credited to the HI trust fund. The Part B program is financed through a combination of monthly premiums paid by current enrollees and general revenues. Income from these sources is credited to the SMI trust fund. Beneficiaries can choose to receive all their Medicare services through managed care plans under the MA program; payment is made on their behalf in appropriate parts from the HI and SMI trust funds. A separate account in the SMI trust fund accounts for the new Part D drug benefit; Part D is financed through general revenues and beneficiary premiums.

The HI and SMI trust funds are overseen by a board of trustees that makes annual reports to Congress. The 2006 report projects that under intermediate assumptions, the HI trust fund will become insolvent in 2018, two years earlier than projected in 2005. The revision reflects slightly higher costs and an upward revision in short-range assumptions about utilization of HI services. The 2006 projection is eight years earlier than that projected in 2003, prior to the enactment of MMA. That law added to HI costs. The HI fund fails to meet both the short- and long-range tests for financial adequacy. Because of the way it is financed, the SMI fund does not face insolvency; however, the trustees are concerned with the program's continued rapid growth rate.

The trustees stress the importance of considering the Medicare program as a whole, They estimate that the difference between outlays and dedicated financing sources is estimated to reach 45% of outlays in 2012. As required by the MMA, they have therefore issued a determination of "excess general revenue Medicare funding." This report will be updated upon receipt of the 2007 trustees' report.

Health Insurance Trust Fund

What It Is. Medicare's financial operations for Part A are accounted for through the HI trust fund maintained by the Department of the Treasury. The trust fund is an accounting mechanism; there is no actual transfer of money into and out of the fund. Income to the trust fund (primarily payroll taxes) is credited to the fund in the form of interest-bearing government securities. Expenditures for services and administrative costs are recorded against the fund. The securities represent obligations that the government has issued to itself. As long as the trust fund has a balance, the Treasury Department is authorized to make payments for it from the U.S. Treasury.

Income and Outgo. The primary source of income credited to the HI trust fund is *payroll taxes* paid by employees and employers. Each pays a tax of 1.45% on earnings; the self-employed pay 2.9%. Unlike Social Security, there is no upper limit on earnings subject to the tax.[1] Additional income consists of (1) premiums paid by voluntary enrollees who are not automatically entitled to Medicare Part A through their (or their spouse's) work in covered employment; (2) government credits; and (3) interest on federal securities held by the trust fund. Since 1994, the HI fund has had an additional funding source: the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) increased the maximum amount of Social Security benefits subject to income tax from 50% to 85% and provided that the additional revenues would be credited to the HI trust fund.

Payments are made from the trust fund for covered Part A benefits, namely, hospital services, skilled nursing facility services, some home health services, and hospice care. Payments are also made for administrative costs associated with operating the program.

Board of Trustees. By law, the six-member Board is composed of the Secretary of the Treasury, the Secretary of Health and Human Services, the Secretary of Labor, the Commissioner of Social Security, and two public members (not of the same political party) nominated by the President and confirmed by the Senate.[2] The Secretary of the Treasury is the Managing Trustee. The Administrator of the Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicare, is designated Secretary of the Board.

Annual Trustees' Report. The Board makes an annual report on the operations of the trust fund. Financial projections included in the report are made by CMS actuaries using major economic and other assumptions selected by the trustees. The report includes three forecasts ranging from pessimistic ("high cost") to mid-range ("intermediate") to optimistic ("low cost"). The intermediate projections represent the Trustees' best

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[1] Prior to 1991, the upper limit on taxable earnings was the same as for Social Security. OBRA 90 raised the limit in 1991 to $125,000. Under automatic indexing provisions, the maximum was increased to $130,200 in 1992 and $135,000 in 1993. OBRA 93 eliminated the upper limit entirely beginning in 1994.

[2] Public members serve four-year terms. Public members John L. Palmer and Thomas Savings were appointed in October 2000 and continued serving through issuance of the 2005 report; they were reappointed in a recess appointment in April 2006.

estimate of economic and demographic trends; they are the projections most frequently cited. The 2006 report was issued May 1, 2006.

2006 Health Insurance Trustees Report — Key Findings

2005 Operations. In calendar year (CY) 2005, total income to the HI trust fund was $199.4 billion. Payroll taxes of workers and their employers accounted for $171.4 billion (86.0%), interest and government credits for $16.8 billion (8.4%), premiums (from those buying into the program) for $2.4 billion (1.2%), and taxation of Social Security benefits for $8.8 billion (4.4%). The program paid out $182.9 billion — $180.0 billion (98.4%) in benefits and $2.9 billion (1.6%) for administrative expenses. The balance at the end of 2005 was $285.8 billion. In FY2005, total income was $196.9 billion, and total disbursements were $184.1 billion; the distribution of income sources and expenditures was similar to those recorded for CY2005. (See **Table 1**)

Table 1. Operation of the Hospital Insurance Trust Fund, Calendar and Fiscal Years 1970-2014

($ billions)

Year	Calendar Year			Fiscal Year		
	Income	Disbursements	Balance at end of year	Income	Disbursements	Balance at end of year
Historical data						
1970	$6.0	$5.3	$3.2	$5.6	$5.0	$2.7
1975	13.0	11.6	10.5	12.6	10.6	9.9
1980	26.1	25.6	13.7	25.4	24.3	14.5
1985	51.4	48.4	20.5	50.9	48.7	21.3
1990	80.4	67.0	98.9	79.6	66.7	95.6
1995	115.0	117.6	130.3	114.8	114.9	129.5
2000	167.2	131.1	177.5	159.7	130.3	168.1
2001	174.6	143.4	208.7	171.0	141.7	197.4
2002	178.6	152.5	234.8	179.8	148.0	229.1
2003	175.8	154.6	256.0	175.8	153.8	251.1
2004	183.9	170.6	269.3	180.8	167.0	264.9
2005	199.4	182.9	285.8	196.9	184.1	277.7
Intermediate estimate						
2006	210.2	200.5	295.5	208.2	189.0	297.0
2007	219.0	213.1	301.4	216.3	212.4	300.9
2008	233.4	226.6	308.3	230.4	222.3	309.1
2009	245.7	242.6	311.3	242.3	238.0	313.3
2010	257.4	259.2	309.6	255.0	254.4	314.0
2011	270.9	276.9	303.5	269.0	277.3	305.7
2012	284.3	296.5	291.3	281.8	284.9	302.6
2013	296.4	317.7	270.0	294.4	311.4	285.5
2014	308.4	339.6	238.9	306.1	333.0	258.6
2015	320.3	362.5	196.6	317.5	356.1	220.1

Source: 2006 HI and SMI Trustees' Report. Sums may not equal totals due to rounding.

Projected Insolvency Date. The 2006 report projects that, under intermediate assumptions, the HI trust fund will become insolvent in 2018, two years earlier than projected in 2005.[3] The revision reflects slightly higher costs in 2005 than previously estimated, and some upward revisions in the short-range assumptions about the utilization of HI services. The 2006 report projects insolvency eight years earlier than did the 2003 report, issued prior to the enactment of MMA.[4] That law added to HI costs, primarily through higher payments to rural hospitals and to private plans under the MA program.

The 2006 report states that beginning in 2004, *tax* income (from payroll taxes and from the taxation of Social Security benefits) began to be less than expenditures. Expenditures will exceed *total* income beginning in 2010. If income falls short of expenditures, costs are met by drawing on HI fund assets through transfers from the general fund of the Treasury until the fund is depleted.

Short- and Long-Range Financial Soundness. The 2006 report states that the fund fails to meet the short-range (i.e., 10-year, 2006-2015) test of financial adequacy since total HI assets at the start of the year are estimated to decline to below 100% of expenditures during 2012.

Further, a substantial actuarial deficit exists over the full long-range projection period (2006-2080). For projections beyond 2015, the trustees do not use actual dollar figures due to the difficulty of comparing dollar values for different time periods. Instead, they measure long-range financial soundness by comparing the fund's *"income rate"* (the ratio of tax income to taxable payroll) with its *"cost rate"* (the ratio of expenditures for insured persons to taxable payroll).[5] Under the 2006 intermediate assumptions, the trustees state that cost rates are projected to exceed income rates by a steadily and rapidly growing margin. In 2006, the income rate is projected at 3.08 while the cost rate is projected at 3.13, a negative gap of 0.05 percentage points. This gap is projected to widen to 0.53% in 2015, 1.03% in 2020, and 8.17% in 2080. By 2080, tax income, will cover less than one-third of projected expenditures. Looked at another way, the trustees estimate the present value of unfunded HI obligations through 2080 at $11.3 trillion.

The trustees state that substantial changes would be required to maintain financial soundness over the 75-year projection period. For example, income could be increased by immediately increasing the payroll tax rate for employees and employers combined from 2.90% to 6.41%. Alternatively, expenditures could be reduced by a corresponding amount, but this would require an immediate decrease in benefits of 51%. These changes could be implemented more gradually throughout the 75-year period, but they would ultimately have to be more stringent.

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[3] Generally, total income to the trust fund has exceeded expenditures; however, this trend was reversed from 1995 to 1997. In 1998, income again began exceeding expenditures. In addition, expenditures actually declined from the previous year's levels for each of three fiscal years (FY1998, FY1999, and FY2000) and for two calendar years (1998 and 1999).

[4] For a history of projections, see CRS Report RS20946, *Medicare: History of Part A Trust Fund Insolvency Projections*, by Jennifer O'Sullivan.

[5] The cost rate calculations exclude expenditures for the relatively small number of persons who buy into Part A.

Projection Factors. The trustees' projections of income and outgo reflect several demographic and economic variables. These include the consumer price index, fertility rate, workforce size and wage increases, and life expectancy. They also include estimates specific to the HI program including the use of inpatient hospital, skilled nursing facility, and home health services. A key variable is the estimated growth rate in the cost of services. Over the long-term, the trustees now assume that per-beneficiary expenditures will decline from the recent rates of growth at 2-3% above the rate of per capita GDP growth to a rate equal to GDP growth at the end of the period.

Beginning in 2011, the program will also begin to experience the impact of major demographic changes. First, baby boomers (persons born between 1946 and 1964) begin to turn age 65 and become eligible for Medicare. The baby boom population is likely to live longer than previous generations. This will mean an increase in the number of "old" beneficiaries (i.e., those 85 and over). The combination of these factors is estimated to contribute to the increase in the size of the HI population from 42.7 million in 2006 to 47.2 million in 2011, and 78.3 million in 2030. Accompanying this significant increase is a shift in the number of covered workers supporting each HI enrollee. In 2005, there were nearly 3.9. This number is predicted to decrease to 2.4 in 2030 and 2.0 by 2080.

The combination of expenditure and demographic factors results in an increase in the size of the HI program relative to other sectors of the economy. According to the 2006 report, if no changes are made in current Medicare law, the HI program's cost is expected to rise from 1.48% of GDP in 2006 to 2.77% in 2030, and 4.9% in 2080.

Congressional Budget Office (CBO) Estimates. The CBO March 2006 10-year baseline estimates are more optimistic than those made by the trustees. On a year-to-year basis over the FY2006-FY2015 period, CBO projects slightly higher amounts of total income and lower amounts of total outlays beginning in FY2009. The impact is cumulative. By FY2015, CBO's end-of-year balance estimate is $93.6 billion more than the trustees' ($313.7 billion versus $220.1 billion).

Issues

Status of Program as a Whole. As noted, HI and SMI are financed very differently. HI is funded by current workers through a payroll tax, while SMI is funded by premiums from current beneficiaries and federal general revenues. Because of this financing, the SMI trust fund's income is projected to equal expenditures for all future years. Historically, therefore, the major focus of concern was the HI fund. More recently attention has also turned to the rapid increase in SMI costs, which have been growing significantly faster than GDP. For a number of years, the trustees have been emphasizing the importance of considering the program as a whole and the fact that the projected increases are unsustainable over time. To further emphasize this point, in 2002 they began issuing a single report covering the entire program.

The enactment of MMA made the consideration of the future of the total program more critical. The legislation increased spending under Parts A, B, and C. In addition, it added a new prescription drug benefit under Part D; spending for this new benefit is recorded as a separate account in the SMI trust fund. The trustees note that these changes have important implications. In 2005, total Medicare expenditures represented 2.73% of GDP. In 2006 (the first year of the new drug benefit), total expenditures are expected to be 3.21% of GDP. The percentage is expected to increase to 7.33% by 2035 and 10.99%

by 2080. The trustees note that over the past 50 years, *total* federal tax receipts have averaged 11% of GDP. They further note that projected Medicare costs will exceed those for Social Security by 2027 and represent nearly twice the cost of Social Security by 2080.

There will also be a shift in the sources of Medicare income. In 2005, HI payroll taxes accounted for 50% of total non-interest income to the program; general revenues represented 35%; and beneficiary premiums accounted for 12%. By 2017 (just prior to the projected exhaustion of the HI fund), payroll tax income will account for a smaller portion (35%) while the portion paid for by general revenues will grow to 46% and the portion paid by premiums will grow to 14%.

Required Response. There is concern that over time the economy will be unable to support the increasing reliance on general revenues which in large measure comes from taxes paid by the under-65 population. In response, MMA (Section 801) requires the trustees report to include an expanded analysis of Medicare expenditures and revenues. Specifically, a determination must be made as to whether general revenue financing will exceed 45% of total Medicare outlays within the next seven years. General revenues financing is defined as total Medicare outlays minus dedicated financing sources (i.e., HI payroll taxes; income from taxation of Social Security benefits; state transfers for prescription drug benefits; premiums paid under Parts A, B, and D; and any gifts received by the trust funds). The trustees project that the 45% trigger will first be exceeded in FY2012 which is within the required seven-year test period (i.e., 2006-2012). The 2006 report, therefore, makes a determination of "excess general revenue Medicare funding". (CBO projects the trigger will be reached in FY2011.)

MMA (Sections 802-804) further requires that if an excess general revenue funding determination is made for two successive years, the President is required to submit a legislative proposal to respond to the warning. The Congress is required to consider the proposal on an expedited basis. However, passage of legislation within a specific time frame is not required.

Prospects. Many persons have suggested that the problems facing Medicare are more urgent than those facing Social Security. The issues confronting the program are unlikely to get any easier. There are no simple solutions to address the problems raised by the aging of the population, the rapid rise in health care costs, and the advances in health care delivery and medical technology. Trustees and many other observers continue to warn that the magnitude of the impending deficit and the expanding drain on the federal budget need to be addressed. At the same time, observers express concern about the impact of any solution on beneficiaries' out-of-pocket costs.

At the time the 2006 trustees report was issued, the Administration stated that the Congress could take an initial step to address the impending shortfall by passing some of the Medicare proposals included in the President's FY2007 budget. These proposals included reductions in payment increases for certain provider categories.[6] As of this writing, it is uncertain whether Congress will consider Medicare legislation this year.

[6] See CRS Report RL33306, *Medicare: FY2007 Budget Issues*, by Hinda Chaikind.