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 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 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 2008 report projects that under intermediate assumptions, the HI trust fund will become insolvent in 2019, the same year projected in 2007. 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 2014. The law requires issuance of a determination of "excess general revenue Medicare funding." This determination triggers the second consecutive funding warning and the second year the President is required to submit a corrective legislative proposal with the following year's budget submission. This report will be updated upon receipt of the 2009 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) 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")

[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] The seats for the two public members are vacant. No public members contributed to the 2008 report.

to mid-range ("intermediate") to optimistic ("low cost"). The intermediate projections represent the Trustees' best estimate of economic and demographic trends; they are the projections most frequently cited. The 2008 report was issued March 25, 2008.

2008 Health Insurance Trustees Report—Key Findings

2008 Operations

In calendar year (CY) 2007, total income to the HI trust fund was $223.7 billion. Payroll taxes of workers and their employers accounted for $191.9 billion (85.8%), interest and government credits for $18.5 billion (8.3%), premiums (from those buying into the program) for $2.8 billion (1.3%), and taxation of Social Security benefits for $10.6 billion (4.7%). The program paid out $203.1billion—$200.2 billion (98.6%) in benefits and $2.9 billion (1.4%) for administrative expenses. The balance at the end of 2007 was $326.0 billion. In FY2007, total income was $219.2 billion, and total disbursements were $202.8 billion; the distribution of income sources and expenditures was similar to those recorded for CY2007. (See **Table 1**.)

Table 1. Operation of the Hospital Insurance Trust Fund, Calendar and Fiscal Years 1970-2015

($ in 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
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
2005	199.4	182.9	285.8	196.9	184.1	277.7
2006	211.5	191.9	305.4	210.3	184.9	303.1
2007	223.7	203.1	326	219.2	202.8	319.5
Intermediate estimate						
2008	221.2	229.5	317.6	218.9	223.0	315.4
2009	246.9	245.5	319.0	243.5	241.7	317.2
2010	258.9	260.5	317.4	256.5	256.6	317.2
2011	271.7	276.0	312.4	269.2	277.5	308.9
2012	283.4	294.7	301.1	280.9	284.5	305.3
2013	296.5	315.6	282.0	294.1	310.4	288.9
2014	309.5	337.8	253.6	306.8	332.3	263.5

Year	Calendar Year			Fiscal Year		
2015	321.9	361.4	214.1	318.9	355.5	226.9
2016	335.0	386.8	162.3	334.3	388.8	172.4
2017	348.4	414.9	95.8	346.5	408.6	110.4

Source: 2008 HI and SMI Trustees' Report. Sums may not equal totals due to rounding.

Projected Insolvency Date

The 2008 report projects that, under intermediate assumptions, the HI trust fund will become insolvent in 2019, the same year as projected in the 2007 report, but at an earlier point within the year. This reflects projections of slightly lower payroll tax income and slightly higher benefit costs. The 2008 report projects insolvency seven years earlier than did the 2003 report, issued prior to the enactment of MMA.[3] That law added to HI costs, primarily through higher payments to rural hospitals and to private plans under the MA program.

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.[4] 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 2008 report states that the fund fails to meet the short-range (i.e., 10-year, 2008-2017) test of financial adequacy since total HI assets at the start of the year are estimated to decline to below 100% of expenditures during 2013.

Further, a substantial actuarial deficit exists over the full long-range projection period (2008-2082). For projections beyond 2017, 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 2008 intermediate assumptions, the trustees state that cost rates are projected to exceed income rates by a steadily and rapidly growing margin. In 2008, the income rate is projected at 3.10, while the cost rate is projected at 3.24, a negative gap of 0.14 percentage points (compared to a negative 0.02 percentage points in 2007). This gap is projected to widen to 0.51% in 2015, 1.00% in 2020, and 7.87% in 2082. By 2082, tax income will cover less than one-third of projected expenditures. Summarized over the 75-year period, the actuarial deficit is 3.54%. (The

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

[4] 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).

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

2007 75-year estimate was 3.55%. The change reflects the use of new methods for projecting immigration. In the absence of this change, the HI actuarial deficit would have increased.) Looked at another way, the trustees estimate the present value of unfunded HI obligations through 2082 at $12.4 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 6.44%. Alternatively, expenditures could be reduced, but this would require an immediate decrease in benefits of 51%. These changes could be implemented more gradually through the period, but they would ultimately have to be more stringent.

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 and cost of inpatient hospital, skilled nursing facility, and home health services.

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 43.8 million in 2007 to 47.5 million in 2011, and 78.4 million in 2030. Accompanying this significant increase is a shift in the number of covered workers supporting each HI enrollee. In 2007, there were about 3.8. This number is predicted to decrease to 2.4 in 2030 and 2.1 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 2008 report, if no changes are made in current Medicare law, the HI program's cost is expected to rise from 1.49% of GDP in 2007 to 2.67% in 2030, and 4.73% in 2080.

Congressional Budget Office (CBO) Estimates

The CBO March 2008 10-year baseline estimates are more optimistic than those made by the trustees. On a year-to-year basis over the FY2008-FY2017 period, CBO projects slightly higher amounts of total income. The impact is cumulative. By FY2017, CBO's end-of-year balance estimate is $56.3 billion more than the trustees' ($166.7 billion versus $110.4 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 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 2.72% of GDP. In 2006 (the first year of the new drug benefit), total expenditures were 3.08% of GDP. The percentage is expected to increase to 7.00% by 2035 and to 10.69% 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 2028, and be 85% more than the cost of Social Security by 2082.

There will also be a shift in the sources of Medicare income. In 2007, HI payroll taxes accounted for 43% of total non-interest income to the program; general revenues represented 41%; and beneficiary premiums accounted for 12%. By 2018 (just prior to the projected exhaustion of the HI fund), payroll tax income will account for a smaller portion (37%) while the portion paid for by general revenues will grow to 44% and the portion paid by premiums will grow to 13%.

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) required 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 2006 report projected that the 45% level would first be exceeded in FY2012; the 2007 report projected that it would first be exceeded in 2013, while the 2008 report projects the first year at 2014. The three findings were within the required seven-year test period. The reports, therefore, made a determination of "excess general revenue Medicare funding." (CBO projects the 45% level will be reached in FY2013.)

MMA (Sections 802-804) 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.[6] The President submitted a proposal on February 15, 2008.[7] Submission of a legislative proposal will also be required in early 2009. The Congress is required to consider the proposals on an expedited basis. However, passage of legislation within a specific time frame is not required.

[6] See CRS Report RS22796, *Medicare Trigger*, by Hinda Chaikind and Christopher M. Davis.

[7] See CRS Report RL34407, *The President's Proposed Legislative Response to the Medicare Funding Warning*, by Hinda Chaikind et al.

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. It seems likely that in the short term, Congress will focus its attention on specific Medicare issues—for example, physician payment updates. It may also consider Medicare spending reductions as part of legislation (such as budget reconciliation) designed to reduce overall federal spending below specified levels over a specific time period.

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