

Redefining Medicare's Long-Term Financial Health: A Closer Look at the "Medicare Funding Warning" in the Trustees' Report

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires a new fiscal analysis of Medicare's finances as part of the annual Medicare Trustees' Report.¹ This analysis is intended to supplement the separate analyses of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds. While the Trustees are not required to include this new analysis until 2005, they did so in the 2004 report "[d]ue to the interest in this new measure."² This *Issue Brief* poses questions and provides answers about this new financial analysis of Medicare.

How is Medicare financed?

Since Medicare's inception in 1965, the HI and SMI programs have maintained separate trust funds. The HI program, also known as Part A,³ has always been financed primarily by payroll taxes. The next largest sources of HI program financing are interest on government securities held as assets in the HI Trust Fund and taxes on a portion of certain high-income earners' Social Security checks.

The SMI program, which historically has consisted only of Part B,⁴ has been mostly financed by a combination of beneficiary premiums (about 25% of total Part B income) and general revenues (about 75%). The MMA created two separate accounts within the SMI Trust Fund: one for Part B and one for Part D.⁵ The Part B account will continue to be funded by a 25%/75% combination of beneficiary premiums and general revenues. Upon its implementation in 2006, the new prescription drug benefit (Part D) will be incorporated into the SMI Trust Fund. Like Part B, Part D will be financed primarily by a roughly 25%/75% combination of beneficiary premiums and general revenues;

it will also be financed in part by state transfers for low-income beneficiaries.⁶ The SMI Trust Fund has also received interest income from the government securities it holds, and will continue to do so under the new structure.

What is the "Medicare funding warning"?

The MMA mandates that the Trustees issue a "Medicare funding warning" if warranted by the results of their analysis. The funding warning is triggered when general revenue funding is projected to account for 45 percent or more of total Medicare expenditures for any one year within the seven-year projection period, which includes the current fiscal year and the subsequent six fiscal years. If two consecutive funding warnings are issued, the MMA directs the President to propose to the Congress legislation intended to prevent general revenue funding from actually accounting for 45 percent of program expenditures.

Why did policymakers require Medicare funding warnings?

Some policymakers have been concerned about the rapid growth in general revenues that could be necessary to finance Part B and Part D. They viewed the inclusion of Medicare funding warning language in the MMA as a way to alert the President and Congress about the level of overall costs in the Medicare program. Others view this provision as making general revenue financing appear inherently undesirable, when, in fact, it may be preferable to other types of financing.

How does the new measure change the assessment of Medicare's financial health?

Historically, Medicare's financial health has been assessed primarily by examining how

long the HI Trust Fund is projected to remain “solvent”—that is, to have sufficient financial resources accumulated from all sources to pay for full Part A benefits in a given year. In their 2004 report, the Trustees project that the HI Trust Fund will remain solvent until 2019 under their intermediate assumptions about, for example, demographics and the economy.

Assessing Medicare’s financial health in the context of the funding warning signals a dramatic shift in Medicare policy, particularly in the way SMI Trust Fund financing is viewed. SMI Trust Fund financing from federal general revenues is adjusted each year to ensure that all expenses are covered, so its solvency has not been in question. In effect, the funding warning measure focuses on SMI Trust Fund financing for the first time. However, rather than assessing whether the SMI program is adequately financed, this measure highlights the magnitude of Medicare’s general revenue obligations.

How is the funding warning ratio calculated?

The new ratio to assess Medicare’s financial health is calculated differently from the usual “solvency” measure in Medicare. First, the measure singles out general revenue funding for scrutiny even though it is a statutorily defined source of financing for the SMI program. If the threshold ratio of general revenue financing exceeds 45 percent, that does not mean that the SMI Trust Fund is insolvent. Second, the ratio does not count interest on government securities held as assets in the HI and SMI Trust Funds, which are sizeable and available to fund Medicare costs. Last, an arbitrary level has been imposed as a funding warning “trigger.” The trigger could have been set at some other level, such as 40 percent, 55 percent, or 75 percent.

For a given fiscal year, the Trustees compute the ratio of Medicare income from “general

revenue funding” to total Medicare expenditures. The MMA defines “general revenue funding” as the difference between total Medicare (Parts A, B, C,⁷ and D) expenditures and program income from Medicare’s *dedicated financing sources*. It is important to note, though, that the amount of general revenue funding based on this definition is not necessarily equal numerically or conceptually to the level of “general revenues” used to finance benefits according to the Trustees’ Report.

Dedicated financing sources consist of:

- Payroll taxes to the HI Trust Fund;
- Income from the taxation of Social Security benefits that is transferred to the HI Trust Fund;
- Part A,⁸ Part B, and Part D premiums;
- State transfers for the Medicare prescription drug benefit; and
- Gifts to the trust funds.

What is the current ratio?

In fiscal year (FY) 2003, before implementation of the prescription drug benefit, dedicated financing sources consisted of income from payroll taxes, the taxation of Social Security benefits, and Part A and Part B premiums. Based on FY 2003 data from the current Trustees’ Report, the funding warning ratio is computed as follows:

- Income from Medicare’s dedicated financing sources: \$187 billion
- Total Medicare expenditures: \$278 billion
- General revenue funding (difference between total Medicare expenditures and income from Medicare’s dedicated financing sources):
\$278 billion–\$187 billion=\$91 billion
- Funding warning ratio (general revenue funding divided by total Medicare expenditures):
\$91 billion/\$278 billion=**33 percent**.

In FY 2003, “general revenues” as reported in the Trustees’ Report were \$81 billion, while “general revenue funding” as computed above was \$91 billion.

If the 2003 ratio was 33 percent, what is the chance that the ratio of general revenue funding to total Medicare expenditures will reach 45 percent?

The 33 percent does not include spending on prescription drugs, which begins in 2006. Prescription drug costs have been—and are projected to continue being—the fastest growing component of national health expenditures.⁹ Therefore, starting in 2006, even greater shares of total Medicare costs will be financed by general revenues (since about 75 percent of Part D will be financed by general revenues). The Trustees project that the ratio will first reach 45 percent in 2012, which is beyond the current seven-year projection period (FY 2004–FY 2010) that would trigger a Medicare funding warning.

The ratio is expected to continue increasing over time as the share of overall Medicare expenditures funded by general revenues grows. This happens when SMI program costs increase relative to HI program costs, which means greater shares of Medicare’s costs are funded by general revenues rather than payroll taxes. Indeed, in recent years, advances in technology have allowed many procedures formerly administered in inpatient hospital settings (paid out of the HI Trust Fund) to be administered in outpatient settings (paid out of the SMI Trust Fund). In addition, prescription drugs, which will be paid for out of the SMI Trust Fund, play an increasing role in the management and treatment of many health conditions.

What are the policy implications of the Medicare funding warning?

The President is required to submit legislation for remedial action to the Congress in the months immediately following the second consecutive Medicare

funding warning. Specifically, a special congressional procedure would be triggered so that cost-reducing and/or income-increasing measures could be considered. The House, which is required to introduce the President’s legislation on this matter, would consider action under expedited procedures. Senate consideration would not be expedited, except that, after June 30, any member could call a bill out of committee for floor vote, subject to a filibuster. The MMA does not require Congress to pass legislation, and inaction would not result in insolvency of the SMI Trust Fund or otherwise restrict general revenue funding of the program.

What options are available for Congress and the President to address the second Medicare funding warning?

One option is for Congress to consider but not pass legislation implementing remedial action. Alternatively, Congress could respond to the funding warning by legislating changes to the Medicare program. Possible responses could include increasing non-general revenue program income from one of the dedicated financing sources for Part A, Part B, or Part D; decreasing program expenditures for Part A, Part B, or Part D; or enacting some combination of these measures. Increasing non-general revenue income reduces how much general revenue is needed to finance the program. Reducing Medicare expenditures lessens how much income from federal general revenues would be needed to finance the program in the future.

Options that are currently available and may have been previously discussed in other contexts include increasing income from a dedicated Part A income source (e.g., payroll taxes or taxes on high-income earners’ Social Security checks); increasing beneficiary premiums; increasing state transfers for the Medicare prescription drug benefit; reducing provider payments; increasing beneficiary cost-sharing; reducing the scope of Medicare’s benefit package; or increasing the

age of eligibility. Each option has potential advantages and disadvantages. Assessing whether policymakers should adopt one option over another is beyond the scope of this brief.

Most policy changes would have the effect of delaying the funding warning. Yet, unless substantial changes are implemented, the impending retirement of the baby boom generation and the rapid growth of the health care sector make it likely that general revenue funding will eventually reach 45 percent of total Medicare expenditures.

What are the potential effects on the Medicare program and its beneficiaries if the 45 percent limit is strictly enforced?

Enforcing a 45 percent limit on general revenue funding would have potentially serious consequences for beneficiaries. Currently, general revenues, together with beneficiary premiums, grow with the cost of the SMI program's statutorily defined benefits. Two consecutive Medicare funding warnings in the Trustees' Report would set into motion a series of actions that, depending on whether Congress passes legislation, could limit the amount of general revenues going to Medicare in a given year.

As noted above, policymakers have different options to address the Medicare funding warning. However, compared with the option of continuing the SMI program's reliance on the more progressive income taxes that generate general revenue funding, each of the other options would disproportionately affect a narrower group (e.g., current beneficiaries, current workers/future beneficiaries, providers, states). Ultimately, policymakers will need to consider the full range of options available to finance the Medicare program. To aid policymakers in making decisions as a result of the funding warning provision in the MMA, it would be informative if future Trustees' Reports discussed the potential beneficiary and healthcare system impacts of

enforcing a 45 percent general revenue funding limit.

¹ See sections 801-804 of the MMA (HR 1). President Bush signed HR 1 into law on December 8, 2003.

² *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, p. 9. Unless otherwise noted, all figures used in this brief were derived from data in the Trustees' Report.

³ The HI program covers inpatient hospital, skilled nursing facility, psychiatric hospital, and hospice care services. Part A also covers up to 100 home health visits following a hospital stay of at least three days.

⁴ Part B covers physician visits, outpatient services, some mental health services, durable medical equipment, and some preventive services. Part B also covers home health visits not preceded by a hospital stay and visits over the 100-day Part A limit.

⁵ The MMA involved both the creation of a prescription drug benefit starting in 2006 and a discount card with subsidies for low-income beneficiaries in 2004 and 2005.

⁶ Unlike the Part B premium, which historically has been uniform across beneficiaries, a beneficiary's Part D premium will vary depending on his/her plan choice. The beneficiary premium will represent 25.5 percent of the expected total plan costs of basic coverage, on average. A 74.5 percent federal general revenue subsidy, which consists of a direct subsidy and reinsurance, will be made to prescription drug plans. Starting in 2007, the Part B premium will be "income-related," i.e., beneficiaries with incomes above certain amounts will pay higher Part B premiums. See Section 811 of the MMA.

⁷ Medicare Part C, also known as Medicare Advantage (and, before the MMA, known as Medicare+Choice), provides alternative options (such as HMOs) for the delivery of health care. Medicare Advantage plan payments are financed from both the HI and SMI trust funds. The dollar amounts taken from each trust fund are in proportion to the relative weights of HI and SMI program benefits to the total benefits paid by Medicare.

⁸ Most beneficiaries pay no monthly Part A premium because they (or their spouse) have at least 40 quarters of Medicare-covered employment. Individuals with fewer than 40 quarters may enroll in Part A if they pay a monthly premium. In 2004, the premium is \$189 per month for people with 30-39 quarters and \$343 per month for those with fewer than 30 quarters.

⁹ Stephen Heffler, Sheila Smith, Sean Keehan, M. Kent Clemens, Mark Zezza, and Christopher Truffer. "Health Spending Projections Through 2013." *Health Affairs* Web Exclusive, February 11, 2004.

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