

THE STATUS OF THE MEDICARE HI AND SMI TRUST FUNDS: THE TRUSTEES' 2005 ANNUAL REPORT

I. Introduction

Financial transactions of the Medicare program operate through two trust funds. The Federal Hospital Insurance (HI) Trust Fund finances Medicare Part A, which covers inpatient hospital, home health,¹ skilled nursing facility, psychiatric hospital, and hospice care services. The Federal Supplementary Medical Insurance (SMI) Trust Fund finances Part B, which covers physician visits, outpatient services, some mental health services, durable medical equipment, some preventive services, and home health visits not covered under Part A.² Additionally, as a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), a Part D account was established within the SMI Trust Fund for new prescription drug expenditures.³ Both Trust Funds also finance Part C, which refers to the Medicare Advantage program (formerly known as Medicare+Choice), whereby private health plans provide Medicare benefits to enrollees. This *Data Digest* summarizes the current and projected financial status of these trust funds, as determined by the Trustees in their year 2005 report to Congress.⁴

The Trustees assess the status of each trust fund under three scenarios (high cost, intermediate, and low cost), each of which uses different sets of assumptions about such factors as general inflation, health care cost growth, wage growth, and mortality and fertility rates. *Unless otherwise noted, the information presented in this Data Digest represents the Trustees' intermediate estimates, commonly referred to as the actuaries' "best guess."*⁵

Traditionally, the actuaries have assessed the trust funds over two time periods: the short-range (ten years) and the long-range

(75 years). The Trustees now provide a measure of Medicare's financial status over the infinite horizon.

II. The Federal Hospital Insurance (HI) Trust Fund—Medicare Part A

The Medicare Board of Trustees examines the HI Trust Fund's financial health by comparing its *projected income* with its *projected expenditures*. The primary source of income for the HI Trust Fund is a 2.9 percent payroll tax paid by employers and employees (1.45 percent each). Self-employed individuals pay 2.9 percent of total wages.⁶

The Trustees report that the HI Trust Fund's annual income in 2004 exceeded annual spending for Part A services by \$13.3 billion. Total expenditures were \$170.6 billion, and total income from payroll taxes and all other sources (including interest) was \$183.9 billion. On December 31, 2004, the HI Trust Fund's assets stood at \$269.3 billion. Trust fund assets are invested in U.S. Government securities, which earned \$15.0 billion in interest at an average rate of 5.8 percent in 2004.

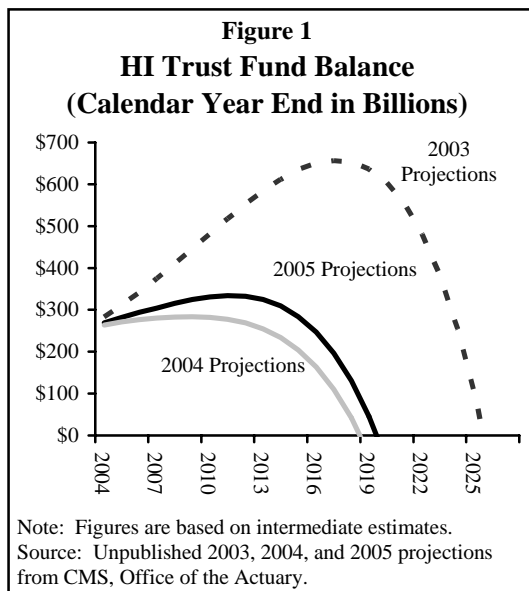
Short-Term Financial Status

To test the short-term financial health of the HI Trust Fund, the Trustees examine the ratio of trust fund assets at the beginning of the year to expenditures during the year. For 2004, the ratio of assets to expenditures was 150 percent, which means that trust fund assets exceeded expenditures by 50 percent. If this ratio remains at or above 100 percent throughout the 10-year projection period (2005-2014),⁷ then the HI Trust Fund meets the short-range test of financial adequacy.

The Trustees project that the ratio will exceed 100 percent for each year through 2014, which would usually mean that it meets the short-term financial test. However, by the beginning of 2015, the projected ratio declines to 89 percent, which indicates that assets would have fallen below the specified level sometime during 2014. Therefore, the Trustees state that financing for the HI Trust Fund is not considered to be adequate in the ten-year projection period.

HI Trust Fund Solvency

The Trustees project that HI Trust Fund assets will increase through 2011, but, beginning in 2012, annual expenditures will exceed annual income, thereby reducing and ultimately depleting the trust fund reserves in 2020. Starting in 2020, Part A will not be able to pay the full cost of benefits throughout the year, under current policy. This date of insolvency is one year later than the Trustees projected in their 2004 report. Figure 1 illustrates projections of the trust fund's financial status through 2020. The later insolvency date is the result of (1) slightly higher income from payroll taxes and other sources than previously projected and (2) slightly lower costs than previously estimated due to slower actual growth in inpatient hospital benefits.



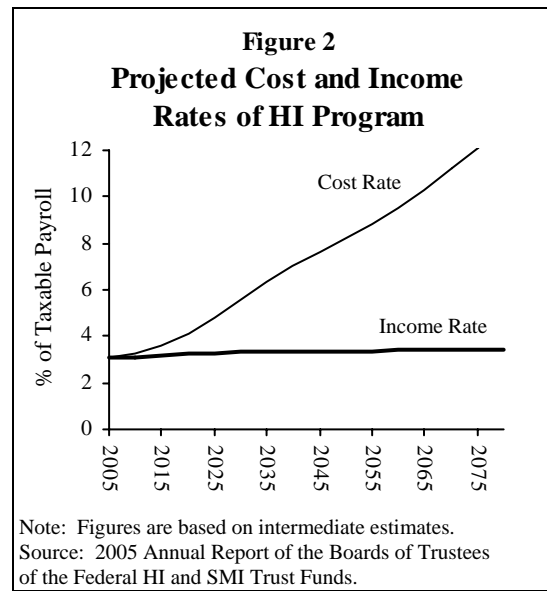
Under the Trustees' high cost scenario, insolvency would occur in 2013. Under the Trustees' low cost scenario, insolvency would occur in 2059.

Long-Term Financial Status

The Trustees also look at the financial health of the HI Trust Fund for the next 25, 50, and 75 years. For this long-term analysis, tax income and costs are expressed as a percentage of taxable payroll (hereafter referred to as the *income rate* and *cost rate*, respectively).

The Trustees project a substantial gap between the income and cost rates for the long term (see Figure 2). The income rate will remain virtually constant over the next 75 years, while the cost rate is expected to increase over time from 3.06 percent of employment earnings subject to the HI tax in 2005 to 13.04 percent in 2080.

To test the long-range financial health of the HI Trust Fund, the Trustees examine its actuarial balance, which is the difference between the income rate and cost rate, each summarized over a given time period (i.e., 25, 50, or 75 years). A negative actuarial balance indicates a cumulative deficit and fails the Trustees' test for long-range financial health.



The Trustees project that, over a 75-year period, the HI Trust Fund will have an actuarial balance deficit of 3.09 percent of taxable payroll.⁸ To demonstrate the magnitude of this deficit, the Trustees project that correcting the financial imbalance would require either immediately increasing the payroll tax from its current level of 2.90 percent to 5.99 percent, or immediately enacting a 48 percent reduction in Part A benefits, or immediately implementing some combination of a payroll tax increase and Part A benefit reductions. This deficit indicates that the program fails by a large margin to meet the Trustees' long-range test of close actuarial balance.

Under the low cost scenario, the HI Trust Fund has a small actuarial balance deficit of 0.39 percent over the next 75 years. By contrast, under the high cost scenario, the actuarial balance deficit is 8.77 percent. The vast differences in these projections illustrate the uncertainty of predicting future spending as well as accounting for economic and demographic changes.

In addition to rising health care costs relative to wage growth, the ratio of workers paying payroll taxes to the number of beneficiaries will steadily decline as baby boomers become eligible for Medicare, life expectancy continues to improve, and future birth rates stay at similar levels as the last two decades. While there were almost 4 workers paying for each beneficiary's Part A benefits in 2004, there will be only 2.4 workers per beneficiary in 2030 (when all of the baby boomers will have reached age 65), and 2 workers per beneficiary in 2079.

III. The Federal Supplementary Medical Insurance (SMI) Trust Fund—Medicare Part B and Part D

The Medicare Board of Trustees does not assess the SMI Trust Fund's financial health in the same manner as it does the HI Trust Fund because of key differences in how the two trust funds operate. Income to the SMI

Trust Fund comes primarily from federal general revenues and beneficiary premiums. General revenues finance about 75 percent of program spending, while beneficiary premiums cover about 25 percent.⁹

Similar to Part A, SMI income and benefit payments are funneled through its Trust Fund. However, in the SMI Trust Fund, the amount of income from the federal government is adjusted each year to ensure that all expenses are covered. Therefore, by statute, SMI Trust Fund assets can never be insufficient to cover costs, unlike the HI Trust Fund. Also, SMI income requirements are calculated each year to match the expected program costs for the following year, which results in fluctuations in the SMI Trust Fund reserves, depending on the difference between estimated spending and actual experience.

The MMA enacted Medicare assistance with outpatient prescription drug costs. This involved the creation of a prescription drug benefit starting in 2006 and a discount card with subsidies for low-income beneficiaries in 2004 and 2005. As with Part B, these Medicare Part D expenditures will be financed primarily through a combination of federal general revenues and beneficiary premiums. Rather than developing a new trust fund for Part D, its income and expenditures flow through a separate account within the SMI Trust Fund.

The Trustees report that, in 2004, total expenditures from the SMI Trust Fund were \$138.3 billion. Federal general revenues accounted for approximately \$100.9 billion, or 75.4 percent of the income to the SMI Trust Fund, and premiums covered \$31.4 billion, or 23.5 percent. Interest and other miscellaneous income paid the remaining 1.1 percent. As of December 31, 2004, the balance in the SMI Trust Fund was \$19.4 billion.

Short-Term and Long-Term Financial Status

Projected SMI expenditures over the next decade were affected by the enactment of the MMA. In addition to establishing a prescription drug benefit and transitional assistance and introducing new preventive benefits in Medicare, the legislation increased payments to physicians, rural health providers, therapists, and private health plans for 2004 and after.

While the Trustees report that the SMI Trust Fund will be adequately financed into the indefinite future because of the automatic yearly financing from the government and beneficiaries, they express concern about the *rate of growth* of SMI spending. The Trustees expect Part B benefit payments to increase at about 7.0 percent annually from 2005 through 2014. This is higher than the growth for the economy as a whole (as measured by Gross Domestic Product or GDP), which is expected to be an average of 5.1 percent annually over the same period. Further, the Trustees expect Part D benefit payments to increase by 10.0 percent per year from 2007 to 2014.

The Trustees predict that SMI spending will grow rapidly over the next decade and beyond, in part because of increases in the volume and intensity of services provided per beneficiary. Starting in about 2011, the influx of baby boomers will also greatly increase spending, as will continued improvements in life expectancy. SMI costs will also grow more rapidly because of the new Part D prescription drug benefit, which begins in 2006.

The Trustees also calculate SMI expenditures as a percentage of GDP in order to examine the potential impact of program spending growth on the economy. From 1966 through 2001, Part B expenditures accounted for less than 1 percent of GDP. Part B expenditures were 1.2 percent of GDP in 2004, but are projected to reach 4.9 percent of GDP by 2080. Part D

expenditures are estimated to be 0.6 percent of GDP in 2006 and are projected to reach 3.4 percent by 2080. These projections indicate that Part B and Part D expenditures can be expected to consume growing shares of our country's productivity.

Under the Trustees' high cost assumptions, SMI spending relative to GDP would grow more rapidly through 2014 and beyond than under intermediate assumptions. Under the Trustees' low cost assumptions, expenditures would also grow faster than GDP, except for 2006-2011 when physician payment updates are assumed to be negative.

Impact on Beneficiaries and on Taxpayers

The pattern for aggregate spending also holds for per capita spending. The Trustees estimate that, in 2010, about 13 percent of a typical 65-year-old beneficiary's Social Security benefit will be withheld to pay the monthly Medicare Part B and Part D premiums, and 22 percent will be used to pay cost-sharing amounts, for a total of 35 percent. In 2070, under the intermediate assumptions, 30 percent of the same beneficiary's Social Security benefit would need to be withheld for Part B and Part D premiums. By 2070, the average cost-sharing amounts are projected to consume over 50 percent of the average 65-year-old's Social Security benefit. One source of increased cost-sharing is the Part B deductible, which, as a result of the MMA, increased from \$100 in 2004 to \$110 in 2005 and will be indexed to Part B spending growth starting in 2006.

In fiscal year 2004, the general revenues required to cover SMI expenditures were equivalent to 9.7 percent of the total collected federal personal and corporate income taxes. The Trustees project that, with the addition of the Medicare prescription drug benefit in 2006, general revenues needed to finance SMI will increase as a percentage of total income taxes collected. In 2080, if these taxes remain at their current level relative to

the national economy, the federal general revenues needed to finance SMI expenditures would equal more than 50 percent of total income taxes.

IV. The HI and SMI Programs Combined

The Trustees also examine the financial status of the Medicare program as a whole (i.e., both Part A and Part B as well as the newly created Part D). In 2004, total Medicare expenditures were \$308.9 billion and accounted for about 2.6 percent of GDP. The Trustees project that, under current law, spending by the HI and SMI programs combined will increase to \$437.7 billion, or about 3.3 percent of GDP, in 2006—the year in which the Medicare prescription drug benefit will be implemented. Total Medicare expenditures are projected to rise to 13.6 percent of GDP in 2079.

Over time, general revenues and beneficiary premiums are expected to grow as a share of Medicare’s financing, while the payroll tax share is expected to decline. In 2004, HI payroll taxes represented 52 percent of total “non-interest income” to Medicare. (The Trustees exclude interest income because, under current law, “it would not be a significant part of program financing in the long range.”) General revenues and beneficiary premiums in 2004 accounted for 34 percent and 11 percent of program financing, respectively. In contrast, in 2019, the year before the HI Trust Fund becomes insolvent, HI payroll taxes are projected to represent 31 percent of total non-interest income to Medicare, whereas general revenues and beneficiary premiums would be 49 percent and 14 percent, respectively.

Medicare Funding Warning

The MMA mandates that the Trustees issue a “Medicare funding warning” if general revenue funding is expected to account for as much as 45 percent of combined Medicare HI and SMI expenditures for any one year within a seven-year

projection period (which includes the current fiscal year and the subsequent six fiscal years). *General revenue funding* is defined as the difference between total Medicare outlays and program income from Medicare’s “dedicated financing sources,” which are:

- 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,¹⁰ Part B, and Part D premiums;
- State transfers for the Medicare prescription drug benefit; and
- Gifts to the trust funds.

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. In FY 2004, for example, *general revenue funding* was \$107.4 billion whereas “general revenues” used to finance SMI expenditures totaled \$94.5 billion.

If two consecutive “Medicare funding warnings” are issued, the MMA directs the President to submit to Congress, within 15 days after the date of the next budget submission, proposed legislation to respond to the Medicare funding warning. Congress is required to consider this legislation on an expedited basis. According to the Trustees, the ratio is projected to be 36 percent in 2005 and to increase to 43 percent in 2006, the year in which the prescription drug benefit will be implemented. The ratio is expected to first exceed 45 percent of expenditures in calendar year 2012, which is barely outside the projection window of 2005-2011. The ratio is projected to continue growing over time, reaching 62 percent of total Medicare outlays in 2030 and 75 percent in 2079.

Infinite Horizon Forecast

For the second consecutive year, the Trustees discuss an “infinite horizon” measurement of the financial status of the HI

trust fund. Instead of 75 years as the longest valuation period, this assessment looks centuries into the future. The actuaries project Medicare HI's "infinite horizon" deficit at \$24.1 trillion; \$15.5 trillion of which occurs after 2079. Although the Trustees forecast the infinite horizon for Parts B and D, there cannot be an "infinite horizon" deficit for either program because, by statute, income from the federal government is adjusted each year to ensure that all expenses are covered.

While the Trustees routinely provide "high-cost" and "low cost" estimates for their 75-year forecasts, none are available for the "infinite horizon" estimates. Also, the methodology used for the "infinite horizon forecast" results in findings that are inconsistent with other trends in the Trustees' Report. For example, in the 2005 Report, long-term costs are lower and the 75-year actuarial balance deficit is smaller than estimated last year. Additionally, the HI Trust Fund faces insolvency one year *later* than the Trustees projected in 2004. Nonetheless, the "infinite horizon" deficit in the HI Trust Fund *increased* by \$2.3 trillion over last year, regardless of the trends in the 75-year projection period. Given the uncertainty of extremely long-term forecasts, the usefulness of this concept is questionable.

V. Trustees' Conclusions

The Trustees now project that the HI Trust Fund will become insolvent in 2020, one year later than projected in their 2004 annual report. This later insolvency date is the result of slightly higher income and slightly lower costs than previously estimated. The Trustees note that the HI Trust Fund fails both the short-term and long-term tests of financial adequacy.

By design, both the Part B and Part D accounts within the SMI Trust Fund are financially solvent into the indefinite future. However, the Trustees are concerned about the growth rate of overall SMI spending,

which is expected to be faster than the GDP growth rate.

The Trustees believe that prompt, effective, and decisive action is needed to address Medicare's financial challenges. The sooner reforms are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms will increase the time available for affected individuals and organizations to adjust their expectations.

¹ Medicare Part A covers up to 100 home health visits following a hospital stay of at least three days.

² Part B covers home health visits not preceded by a hospital stay and visits over the 100-day Part A limit.

³ Expenditures to be made from the Part D account include the general Part D premium subsidy, reinsurance, employer drug subsidy, low-income subsidy, administrative expenses, risk sharing, and state expenses for making low-income eligibility determinations. It also includes amounts for the Transitional Assistance program in fiscal years 2004-2006.

⁴ Through 2001, the Boards of Trustees issued separate annual reports for the HI and SMI Trust Funds. Starting in 2002, the two reports were combined into one document.

⁵ Unless otherwise noted, all figures are calendar year estimates.

⁶ In 2004, payroll taxes made up 85 percent of the HI Trust Fund's income. Additional sources of income include interest on federal securities, federal income taxes on a portion of Social Security benefits, premiums paid by voluntary enrollees, and government credits.

⁷ Alternatively, if the Trust Fund ratio is initially less than 100 percent, it must be projected to reach a level of at least 100 percent within 5 years and then remain at or above 100 percent throughout the balance of the 10-year period. At the same time, the Trust Fund assets may not fall to zero.

⁸ Readers should use caution when comparing these projections to those prior to year 2001, at which time the Trustees revised their assumptions about long-range expenditure growth. See PPI Data Digest #59 for an explanation of how and why the Trustees made these changes.

⁹ The premium rates between 1998 and 2003 were intentionally set to cover less than 25 percent of actual program costs, due to the gradual phase-in of the transfer of some home health costs from Part A to Part B.

¹⁰ 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 2005, the premium is \$206 per month for people with 30-39 quarters and \$375 per month for those with fewer than 30 quarters.

Sources: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, March 23, 2005; and unpublished 2003, 2004, and 2005 projections from CMS, Office of the Actuary.

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