DATA DIGEST

THE STATUS OF THE MEDICARE PART A AND PART B TRUST FUNDS: THE TRUSTEES' 2004 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] This *Data Digest* summarizes the current and projected financial status of these trust funds, as determined by the Trustees in their year 2004 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). In addition, this year the Trustees provide a measure of Medicare's deficit 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 2003 exceeded annual spending for Part A services by $21.2 billion. Total expenditures were $154.6 billion, and total income from payroll taxes and all other sources was $175.8 billion. On December 31, 2003, the HI Trust Fund's assets stood at $256.0 billion. These trust fund assets are invested in U.S. Government securities, which earned an average rate of interest of 6.2 percent in 2003.

Short-Term Financial Status

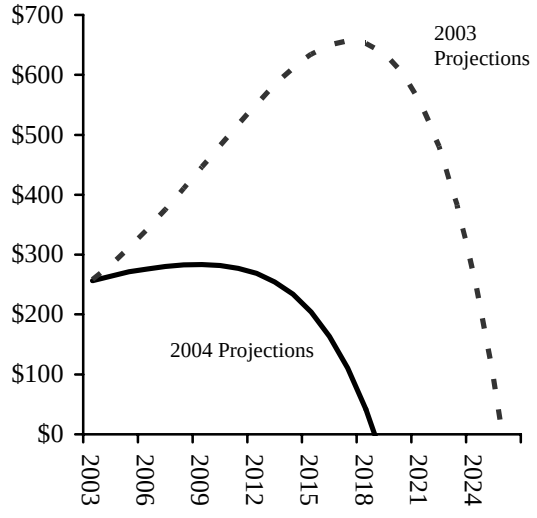
To test the short-term financial health of the HI Trust Fund, the Trustees examine the ratio of trust fund assets at the beginning of the year to expenditures during the year. For 2003, the ratio of assets to expenditures was 152 percent, which means that trust fund assets exceeded expenditures by 52 percent. If this ratio remains at or above 100 percent each year over the 10-year projection period (2004-2013),[7] then the HI Trust Fund meets the short-range test of financial adequacy. The Trustees project that the ratio will exceed 100 percent through 2011, but the ratio is projected to be below 100 percent in 2012 and 2013. Therefore, the trust fund fails the short-term financial test.

HI Trust Fund Solvency

The Trustees project that HI Trust Fund assets will increase through 2009, but, beginning in 2010, annual expenditures will exceed annual income, thereby reducing and ultimately depleting the trust fund reserves in 2019. Starting in 2019, Part A will no longer be able to pay the full cost of benefits, under current policy. This date of insolvency is seven years earlier than the Trustees projected in their 2003 report. Figure 1 illustrates projections of the trust fund's financial status through 2019. The earlier insolvency date is the result of (1) significantly lower projected payroll tax income; (2) higher-than-previously-projected growth in expenditures for inpatient hospital benefits; and (3) increased payments to rural hospitals and private health plans, a result of provisions in the MMA.

Under the Trustees' high cost scenario, insolvency would occur in 2012. Under the Trustees' low cost scenario, insolvency would occur in 2055.

Figure 1
HI Trust Fund Balance
(Calendar Year End in Billions)



Note: Figures are based on intermediate estimates.
Source: Unpublished 2003 and 2004 projections from CMS, Office of the Actuary.

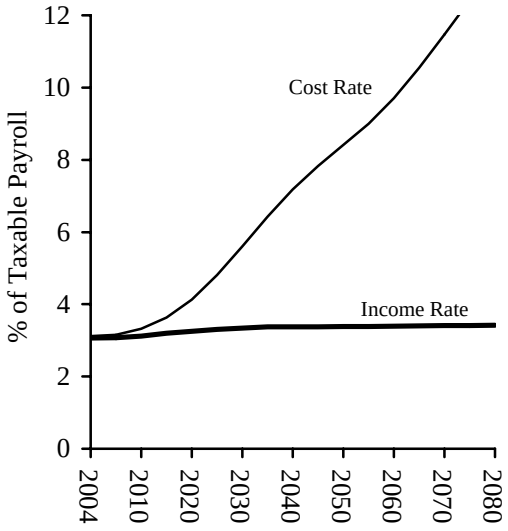
Long-Term Financial Status

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 3.12 percent of employment earnings subject to the HI tax in 2004 to 13.05 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

Figure 2
Projected Cost and Income Rates of HI Program



Note: Figures are based on intermediate estimates.
Source: 2004 Annual Report of the Boards of Trustees of the Federal HI and SMI Trust Funds.

summarized over a given time period (i.e., 25, 50, or 75 years).[8] 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 3.12 percent of taxable payroll.[9] 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 6.02 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 deficit of 0.47 over the next 75 years. By contrast, under the high cost scenario, the actuarial deficit is 8.40 percent. The vast differences in these pro-jections 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 2003, 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 2078.

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.[10]

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, the SMI Trust Fund can never be depleted, 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 2003, expenditures from the SMI Trust Fund were $126.1 billion. Federal general revenues accounted for approximately $86.4 billion, or 74.6 percent of the income to the SMI Trust

Fund, and premiums covered $27.4 billion, or 23.7 percent. Interest and other miscellaneous income paid the remaining 1.7 percent. As of December 31, 2003, the balance of the SMI Trust Fund was $24.0 billion.

Short-Term and Long-Term Financial Status

The Trustees estimate SMI expenditures over the next decade to be higher than those projected in the 2003 annual report, primarily as a result of 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. Additionally, actual 2003 Part B expenditures, which serve as a baseline for projections, were higher than previously estimated.

The Part B premium and general revenue amounts set to finance Part B spending in 2003 were based on spending projections that were lower than what actually occurred. This resulted in a funding shortfall in 2003, which was paid for out of assets held by the SMI Trust Fund. As a result, Part B premiums and general revenue contributions are projected to increase more than expenditures in 2005—a substantial 17 percent—to replenish the level of SMI Trust Fund reserves.

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 6.6 percent annually from 2004 through 2013. 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 5.0 percent annually over the same period. Further, the Trustees expect Part D benefit payments to increase by 9.7 percent per year from 2006 to 2013.

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 and future birth rates that stay at levels similar to those of the past two decades. 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 1.1 percent of GDP in 2002 and 2003, but are projected to reach 4.8 percent of GDP by 2078. Part D expenditures are estimated to be 0.7 percent of GDP in 2006 and are projected to reach 3.4 percent by 2078. 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 much more rapidly through 2013 and beyond than under intermediate assumptions. Under the Trustees' low cost assumptions, expenditures would also grow faster than GDP, except for 2006-2012 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. Because SMI per capita spending is expected to grow faster

than per capita GDP, beneficiaries would see increases in premiums over time. 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 23 percent will be used to pay copayments, for a total of 36 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 will 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, will be indexed to Part B spending growth starting in 2005.

In fiscal year 2003, the general revenues required to cover SMI expenditures were equivalent to 8.7 percent of the total federal personal and corporate income taxes collected in that year. 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 Medicare 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 2003, total Medicare expenditures 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 about 3.4 percent of GDP in 2006—the year in which the Medicare prescription drug benefit will be implemented. Combined expenditures are projected to rise to 7.7 percent of GDP by 2035 and to 13.8 percent by 2078.

Medicare Funding Warning

The MMA mandates that the Trustees issue a "Medicare funding warning" if general revenue funding[11] is expected to account for as much as 45 percent of combined Medicare HI and SMI 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 "Medicare funding warnings" are issued, the MMA directs the Congress and the President to immediately "take action" (i.e., increase program income, reduce Medicare expenditures, or both) before general revenues actually account for 45 percent of program expenditures. Accord-ing to the Trustees, the ratio was 33 percent in 2003 and is not expected to reach 45 percent of expenditures until 2012, which is outside the projection window of 2004-2010.

Infinite Horizon Forecast

The Trustees acknowledge in the report that projecting far into the future is difficult, given the vast uncertainties of actual future events and trends. Nevertheless, in its 2004 report, the Trustees introduce the concept of "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 $21.8 trillion; $13.6 trillion of this amount occurs in the years following 2078. Although the Trustees forecast the infinite horizon for Parts B and D, the results are not meaningful due to the fact that, by statute, income from the federal government is adjusted each year to ensure that all expenses in the SMI Trust Fund are covered. While the Trustees routinely estimate statistical confidence for their 75-

year forecasts, they provide none for the "infinite horizon" estimates. Given the lack of statistical testing, the uncertainty of extremely long-term forecasts, and the speed of economic change, it is difficult to see the utility of this concept or take such an estimate seriously.

V. Trustees' Conclusions

The Trustees now project that the HI Trust Fund will become insolvent in 2019, seven years earlier than projected in their 2003 annual report. This earlier insolvency date is the result of significantly lower projected payroll tax income, higher than anticipated expenditures for inpatient hospital care, and increased payments to rural hospitals and private health plans as a result of provisions in the MMA. 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 creation of a Part D account within the SMI Trust Fund means that fund expenditures will increase more rapidly than previously projected. Consequently, 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 solutions should be found in the near future to ensure the financial integrity of the HI program and to provide effective means to reduce the rate of growth in Medicare costs. Further, they state that prompt, effective, and decisive action is necessary to address these concerns.

[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 2003, 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] The actuarial balance is adjusted to include the beginning fund balance and the cost of ending the projection period with a fund balance equal to estimated spending for the following year.
[9] 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.
[10] 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 trans-fer of some home health costs from Part A to Part B.
[11] General revenue funding is defined as the difference between Medicare outlays and dedicated Medicare financing sources.

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

Written by Craig Caplan and Ryan Cool
AARP Public Policy Institute, March 2004
601 E Street, N.W., Washington, DC 20049