98-457 EPW
May 5, 1998

Medicare: Financing the Part A Hospital Insurance Program

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Summary

Medicare is the nationwide health insurance program for the aged and certain disabled persons. Medicare consists of two distinct parts — Part A (Hospital Insurance (HI)) and Part B (Supplementary Medical Insurance (SMI)). Part A is financed primarily through payroll taxes levied on current workers and their employers. Income from these taxes is credited to the HI trust fund. Part B 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. Each fund is overseen by a Board of Trustees who make annual reports to Congress concerning their financial status. The 1998 HI report, issued April 28, 1998, projected that, under its intermediate assumptions, the HI trust fund would become insolvent in 2008. The SMI fund does not face exhaustion because of the way it is financed; however, the trustees are concerned about the rapid growth of Part B.

The trustees noted that to bring the HI fund into financial solvency over 25 years (CY1998-2022), either outlays would have to be reduced by 18% or income increased by 22% (or some combination thereof). The trustees do not give a dollar estimate for the outlay reductions needed to maintain financial solvency over this 25-year period.

The 1998 estimates represent a significant improvement over the 1997 projections. This reflects the impact of the Balanced Budget Act of 1997 (BBA 97) which provided for reductions in Medicare program outlays and transferred some Part A spending to Part B. BBA 97 also provided for the establishment of the National Bipartisan Commission on the Future of Medicare. This Commission is charged with making recommendations by March 1, 1999 concerning financing, benefit structure, and other program issues. This product will be updated upon receipt of the 1999 trustees report.

HI 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. As noted, 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 to the trust fund 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 1993) 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, 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 the Department 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 Managing Trustee. The Administrator of the Health Care Financing Administration (HCFA — 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 HCFA 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 estimate of economic and demographic trends; they are the projections most frequently cited. The reports are generally issued in April; the 1998 report was issued April 28, 1998.

1998 HI Trustees Report — Key Findings

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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. The OBRA 93 eliminated the indexing provision entirely beginning in 1994.

[2] Public members serve 4-year terms. The 1995 appointees are Stephen Kellison, Variable Life Insurance Company of Houston, Texas; and Marilyn Moon, Urban Institute, Wash., D.C.

1997 Operations. In 1997, total income to the trust fund was $130.2 billion. Payroll taxes of workers and their employers accounted for $114.7 billion (88.1%), premiums for $1.3 billion (1.0%), interest and government credits for $10.6 billion (8.2%), and taxation of social security benefits for $3.6 billion (2.7%). The program paid out $139.5 billion —$137.8 billion (98.8%) in benefits and $1.7 billion (1.2%) for administrative expenses. The balance at the end of 1997 was $115.6 billion. In FY1997, total income was $128.5 billion and total disbursements were $137.8 billion; the distribution of income sources and expenditures were similar to those recorded for CY1997. (See **Table 1**.)

Table 1. Operation of the Hospital Insurance Trust Fund, Fiscal and Calendar Years 1970-2007

(in millions)

Year	Fiscal Year			Calendar Year		
	Income	Disburse-ments	Balance at end of year	Income	Disburse-ments	Balance at end of year
Historical data						
1970	$5,614	$4,953	$2,677	$5,979	$5,281	$3,202
1975	12,568	10,612	9,870	12,980	11,581	10,517
1980	25,415	24,288	14,490	26,097	25,577	13,749
1985	50,933	48,654	21,277	51,397	48,414	20,499
1990	79,563	66,687	95,631	80,372	66,997	98,933
1995	114,847	114,883	129,520	115,027	117,604	130,267
1996	121,135	125,317	125,338	124,603	129,929	124,942
1997	128,501	137,789	116,050	130,154	139,452	115,643
Intermediate estimate						
1998	136,102	141,568	110,584	135,882	143,595	107,930
1999	139,890	145,814	104,660	140,414	147,214	101,130
2000	144,652	148,460	100,852	145,028	149,460	96,698
2001	149,644	155,266	95,230	150,582	153,800	93,480
2002	155,476	155,400	95,306	156,545	160,623	89,402
2003	161,974	167,067	90,213	163,108	170,068	82,442
2004	168,690	177,525	81,378	170,207	180,853	71,796
2005	177,905	189,751	69,532	178,072	193,305	56,563
2006	185,024	207,608	46,948	185,953	206,664	35,852
2007	193,610	217,448	23,110	194,844	221,177	9,519

Source: 1998 HI Trustees Report. Numbers may not add due to rounding.

Projected Insolvency Date. The 1998 Trustees report stated that the program failed to meet both short-range and long-range tests of financial adequacy. Under the Trustee's 1998 intermediate assumptions, the fund would become insolvent in 2008. This is considerably better than the 2001 date projected in the 1997 report. The later insolvency date reflects the substantial changes made by the BBA 97. The trustees estimate that BBA 97 is expected to substantially reduce the gap between income and assets over the next 5 years; however there would be a return to steadily increasing deficits beginning in 2003.

The projected date of the trust fund depletion has been reestimated several times since the August 1997 enactment of BBA 97. At the time of enactment, the Congressional Budget Office (CBO) estimated that the HI fund would be depleted in FY2007. Shortly thereafter, in September 1997, the Trustees estimated that the fund would be depleted in CY2010. In January 1998, CBO (using its January 1998 baseline) estimated that the fund would become insolvent early in FY2010. The trustees report now estimates 2008. While these reestimates reflect slight changes in economic assumptions, they all show that the problems facing the HI fund have been only partially addressed.

Long-Range Financial Soundness. The 1998 HI Trustees report does not contain actual dollar projections beyond the year 2007. Instead, *the trustees measure long-range financial soundness by comparing: (1) HI tax income (payroll tax contributions and income from the taxation of social security benefits) as a percentage of taxable payroll ("income rate") with (2) HI incurred cost as a percentage of taxable payroll ("cost rate").* The trustees view this measure as more meaningful since the value of the dollar changes over time. There is already a gap between the cost rate and the income rate. In 1998, the estimated cost rate is 3.40% of taxable payroll, while the estimated income rate is only 3.02%. The gap is thus 0.38% of taxable payroll in 1998. Since costs are rising faster than payroll tax receipts, this deficit increases dramatically over the 75-year projection period rising to 0.59 in 2010, 2.68% in 2030 and 4.39% by 2070.

The trustees state that to bring the program into actuarial balance for the first 25 years, would require either a reduction in outlays of 18% or an increase in total income of 22% (or some combination thereof) throughout the 25-year period. If changes were *just made to the payroll tax*, the rate would have to be immediately increased from the current level of 1.45% to 1.81% for employees and employers, each; the rate for the self-employed would go from the current 2.9 % to 3.62%.

Larger changes would be required to maintain financial soundness over the 75-year projection period. To achieve long-term financial solvency, the payroll tax for both employees and employers would have to be immediately increased by 1.05 percentage points; the rate would thus go from 1.45% to 2.5%. This represents a substantial improvement over the 1997 report when the trustees estimated that the rate would need to be increased by 2.16 percentage points (for a total of 3.61%). The trustees estimate that the BBA 97 changes reduced the long-range financial deficit by half.

What the Projections Reflect. Both the short-range and long-range projections reflect the fact that HI costs (reflecting largely increases in medical costs) are rising faster than HI income. Beginning in 2011, the program will begin to experience the impact of

major demographic changes. First, baby boomers (persons born between 1946-1964) begin turning age 65. Second, there is a shift in the number of covered workers supporting each HI enrollee. In 1997, there were 3.9; in 2010 there will be 3.6; while in 2030 there will only be an estimated 2.3.

The combination of expenditure and demographic factors is also reflected in the increasing size of the HI program relative to other sectors of the economy. According to the 1998 report, the program's cost is expected to rise from 1.7% of gross domestic product (GDP) in 1997 to about 3.4% of GDP in 2070.

Related Issues

What Outlays are Needed to Keep Fund Solvent? The trustees do not give a dollar estimate for the outlay reductions needed to maintain financial solvency over the long-range projection periods. The 2008 projected insolvency date is one year beyond the date that dollar projections are made. Similarly, CBO's 2010 projected insolvency date is beyond its 10-year projection period.

Previous Projections. Trustees have projected impending insolvency for the HI trust fund beginning with the 1970 report. (See **Table 2**.) Since that time, Congress made a number of changes in the program which had the effect of reducing expenditure growth. Most of the changes were made as part of budget reconciliation legislation and have had the effect of delaying the insolvency date. BBA 97 made the most significant changes. In addition to constraining increases in payments for services, it also shifted a significant portion of home health spending from HI (Part A) trust fund to the SMI (Part B) trust fund. As a result the projected insolvency date has been delayed.

Table 2. Year in Which the Hospital Insurance Trust Fund Was Projected to Become Insolvent in past Trustees' Reports

Year of trustees' report	Year of insolvency	Year of trustees' report	Year of insolvency	Year of trustees' report	Year of insolvency
1970	1972	1980	1994	1989	*
1971	1973	1981	1991	1990	2003
1972	1976	1982	1987	1991	2005
1973	none indicated	1983	1990	1992	2002
1974	none indicated	1984	1991	1993	1999
1975	late 1990s	1985	1998	1994	2001
1976	early 1990s	1986	1996	1995	2002
1977	late 1980s	1986 amended	1998	1996	2001
1978	1990	1987	2002	1997	2001
1979	1992	1988	2005	1998	2008

Source: Intermediate projections of various HI trustees' reports, 1970-1998.

*Contained no long-range projections.

What Happens When Fund Becomes Insolvent? Payments cannot be made from the HI fund unless there are sufficient monies credited to it. Neither the Social Security trust fund nor the Medicare trust fund has ever run out of money and there are no provisions in the Social Security Act governing what would happen in such an event. There is no authority in law for a general revenue funding of the shortfall. Of course, the fund would continue to have payroll taxes credited to it though these would be insufficient to pay all the pending claims. At least in the initial days or months, the Secretary could elect to hold up payment of the bills until the fund was credited with sufficient payroll tax receipts. Over the longer term this would not be a viable option.

Recommendations for Change. In 1997, the trustees recommended that in the short term, the Congress enact, at the earliest possible date, legislation to reduce the growth in HI costs and extend the date of exhaustion of the fund. They stated that enactment of short-term measures would provide time to address the long-term issues. To facilitate this process they recommended establishment of a national advisory group on Medicare Reform. BBA 97 restrained the rate of HI growth through a combination of measures. It limited the growth in annual payment updates for all providers and provided for the establishment of prospective payment systems for skilled nursing facilities and home health agencies. The legislation also transferred a significant portion of home health spending to the Part B program; while this action does not reduce overall program spending , it does reduce Part A costs and thus delays the program's insolvency.

BBA 97 also provided for the establishment of a 17-member National Bipartisan Commission on the Future of Medicare. This Commission is required to review the program's financial condition, identify problems that threaten its financial security and analyze potential solutions. The Commission, which began its work in March 1998, is required to submit a report by March 1, 1999. The report is to include only those detailed recommendations, findings and conclusions that receive approval of at least 11 Commission members. During its review, the Commission is expected to examine a number of recommendations which have been offered for addressing some of Medicare's problems. These include raising the program's eligibility age, means testing, combining Part A and Part B (perhaps in conjunction with a change in the benefit package), replacing the program's guarantee of a defined package of benefits with a defined per beneficiary contribution utilizing the Federal Employees Health Benefits Plan (FEHBP) model, and privatizing all or a portion of the program.

The trustees have recommended that reforms be developed and enacted as rapidly as possible. They note that the sooner solutions are enacted, the more flexible and gradual they can be. Further, the early introduction of further reforms increases the time for affected parties to adjust their expectations.

Some observers have expressed concern that the Commission, faced with almost 10 years of projected solvency, may be unable to come to an agreement on major reform recommendations. Some observers have also noted that the Commission's required reporting date, March 1999 is too early to allow review of the impact of major reform changes included in BBA 97. The legislation significantly expanded the private plan options available to beneficiaries for obtaining services. Under the new Medicare+Choice program, beneficiaries will continue to be able to enroll in a health maintenance organization; they will also be able to select from preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), and private fee-for-service plans.

Further, under a demonstration program, a limited number of beneficiaries will be able to establish medical savings accounts (MSAs) in conjunction with a high deductible plan.