THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE

A PRIMER ON MEDICARE FINANCING

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INTRODUCTION

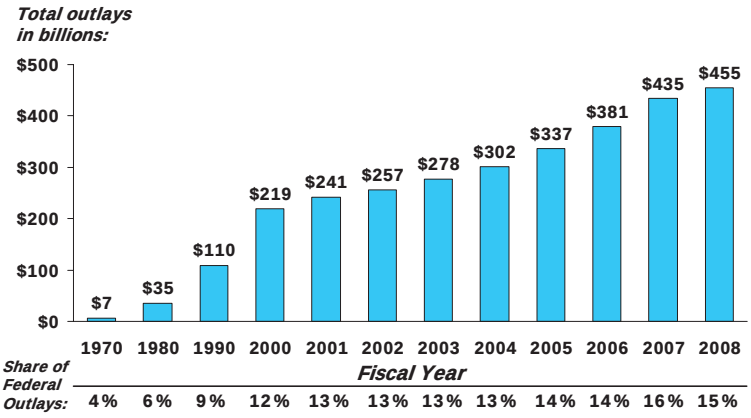
For more than 40 years, Medicare has successfully provided access to needed health care services for the elderly and many people with disabilities and currently covers 46 million Americans. Persistently high rates of growth in national health expenditures combined with demographic trends, however, pose a serious challenge to the financing of Medicare in the 21st century. This paper explains how Medicare is financed, describes the program's long-term financing situation from several perspectives, and reviews the factors contributing to the growth in Medicare spending and the program's financial challenges.

As the nation's single largest health insurance program covering a large population for a broad range of health services, Medicare's influence extends well beyond the assistance it provides to its beneficiaries. The dollars invested through Medicare and the policies under which it operates have a large impact on the nation's health care system. One in five dollars used to purchase health services in 2007 came through the Medicare program, which finances more than one-third of all hospital stays nationally.[1]

Since its inception in 1965, spending on Medicare has grown steadily, both in absolute dollars and as a share of the federal budget **(Exhibit 1)**. By fiscal year 2008, Medicare's $455 billion in total expenditures represented 15 percent of all federal outlays, exceeded only by Social Security benefits and defense spending, which each accounted for 21 percent **(Exhibit 2)**.[2]

Exhibit 1

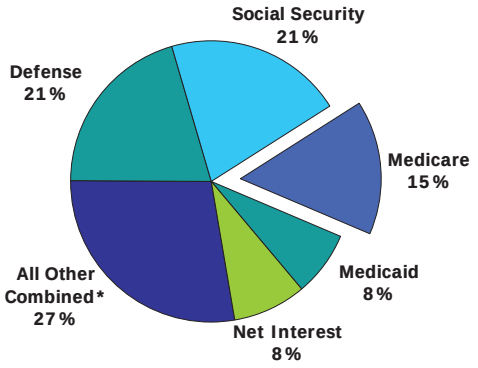
Medicare Outlays, 1970-2008



NOTE: Outlays exclude offsetting receipts.
SOURCES: Medicare outlays from 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table V.E4. Total outlays for share of Federal Budget from Congressional Budget Office, Historical Budget Data, 1969-2008, March 2009.

Exhibit 2

Medicare Spending as a Share of Total Federal Outlays, FY 2008



FY 2008 Total Federal Outlays = $3.0 trillion

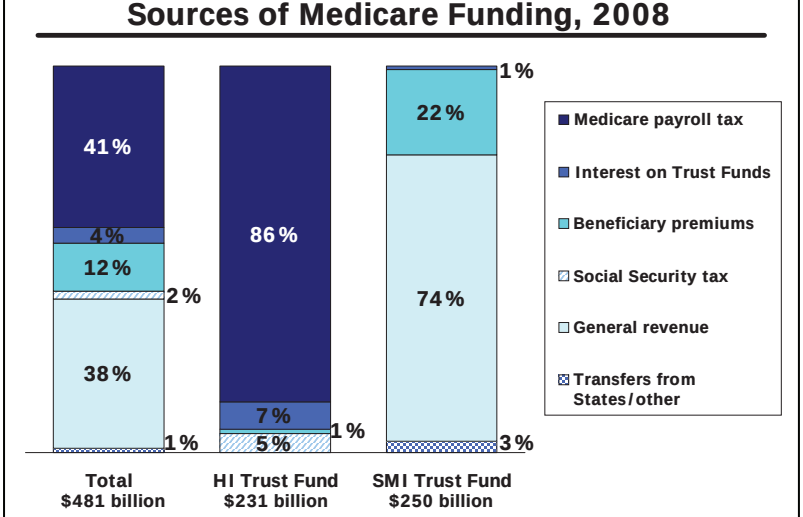
NOTE: *"All Other Combined" includes offsetting receipts.
SOURCE: Kaiser Family Foundation based from Congressional Budget Office, *Historical Budget Data,* March 2009.

HOW IS MEDICARE FINANCED?

In financing Medicare, the government draws from several sources of revenue: a dedicated Medicare payroll tax, general revenue (primarily federal income taxes), premiums collected from beneficiaries, a tax on Social Security benefits, and, since 2006, payments from states required for the Medicare drug benefit, which shifted some state Medicaid program expenditures to Medicare.

Operationally, Medicare financing is conducted through two trust fund accounts **(Exhibit 3)**. The Hospital Insurance (HI) Trust Fund, into which Medicare payroll taxes and other dedicated revenue are credited, pays for inpatient hospital stays and other benefits provided under Medicare Part A. In 2008, the payroll tax provided 86 percent of all the revenue attributed to the HI Trust Fund, and 41 percent of Medicare revenue overall. The Supplementary Medical Insurance (SMI) Trust Fund is used to pay for physician visits and other Medicare Part B services as well as the Medicare Part D prescription drug benefit. The SMI Trust Fund is financed primarily through monthly Part B and Part D premiums paid by beneficiaries and general revenue. In 2008, general revenue accounted for 74 percent of the SMI Trust Fund revenue and 38 percent of all Medicare revenue, while total beneficiary premiums made up 22 percent of the SMI Trust Fund revenue and 12 percent of Medicare revenue overall. Both the HI and SMI Trust Funds are used to pay private Medicare Advantage (MA) plans for providing benefits under Parts A and B and, in some cases, Part D to enrollees. *(See Appendix A for detail on the sources and uses of Trust Fund revenue.)*

Exhibit 3



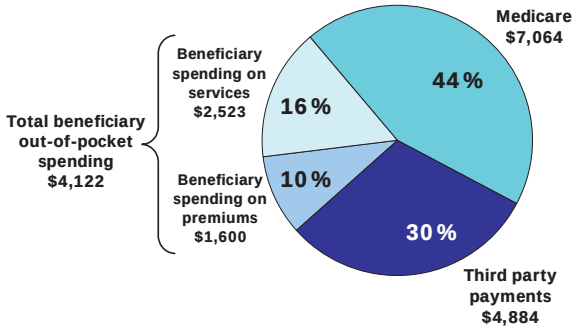
SOURCE: Kaiser Family Foundation based on 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table II.B1.

In addition to premiums, beneficiaries contribute to the cost of their Medicare-covered services through deductibles and coinsurance, amounts that are not reflected in data on Medicare spending or financing. In 2009, for example, beneficiaries face a $1,068 deductible for Part A inpatient hospital services, a $135 deductible for services covered under Part B, a 20 percent coinsurance for many services covered by Part B, and in some cases, an additional amount for physician services, known as "balance billing" amounts. Medicare beneficiaries also pay for health care items and services not covered by Medicare, such as most vision and hearing services and long-term care.

Overall, Medicare paid 44 percent of beneficiaries' total medical and long-term care costs in 2005; beneficiaries paid 16 percent of the total for Medicare-covered and other services and another 10 percent for premiums for Part B and supplemental insurance; and third-party payers (Medicaid, private supplemental "Medigap" plans, and employer-sponsored health plans) paid 30 percent of the total on behalf of beneficiaries **(Exhibit 4)**.

Exhibit 4

Sources of Payment for Health Care Services to Medicare Beneficiaries, 2005



Total Per Capita Spending, 2005 = $16,071

NOTE: Excludes Medicare Advantage enrollees.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2005.

Differences Between the HI and SMI Trust Funds

A key difference in the structure of the HI and SMI Trust Funds affects their financial status. In the case of the HI Trust Fund, dedicated revenue may be greater or less than expenditures in any given year, so that in some years HI expenditures may exceed income, while in other years, reserve funds may be generated. By contrast, SMI Trust Fund financing does not produce excess revenue or shortfalls due to the way it is structured, with premiums and general revenue contributions adjusted each year in order to cover projected expenditures for that year. When excess HI Trust Fund revenue is collected, the excess amounts are loaned to the federal government and used to pay for other federal obligations. Interest on the loans is credited to the Trust Fund as income. Interest payments are not actually transferred out of general revenue unless these amounts are needed to pay Medicare claims. As a result, the amounts collected in Medicare payroll taxes and other dedicated revenue but loaned out of the HI Trust Fund, along with the associated interest payments, represent a claim on future general revenue funds. The HI Trust Fund balance, which totaled $321 billion at the end of fiscal year 2008, is a measure of future claims accumulated to date, to be drawn on when payroll taxes and other dedicated revenue are insufficient to cover expenditures.

HOW IS MEDICARE'S FISCAL STATUS MEASURED?

Serious concerns have been raised about the long-term financial health of the Medicare program. The program's financial status is often measured in terms of the HI Trust Fund solvency or Medicare spending as a share of the federal budget and of the overall national economy. Each measure addresses a different perspective on the program's financing and points toward different potential solutions to Medicare's long-term financing challenges.

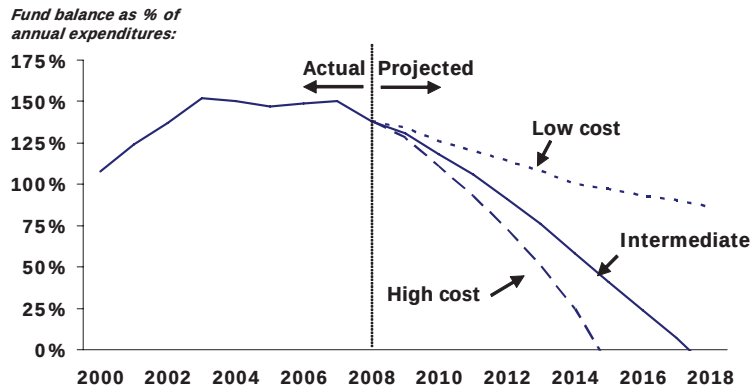
Trust Fund Solvency

Solvency of the HI Trust Fund is the measure of Medicare's financial health that typically receives the most attention **(Exhibit 5)**. A report on the financial status of the HI Trust Fund is released annually, as required by law, including short-run and long-run financial forecasts prepared by the Medicare actuaries. The report is issued by the Medicare Trustees, an oversight panel comprised of the Secretaries of Health and Human Services (HHS), Labor, and Treasury; the Commissioner of Social Security; and two public trustees appointed by the President.

Exhibit 5

Medicare Part A Trust Fund Balance, 2001-2018

Under High Cost, Low Cost, and Intermediate Assumptions



NOTE: The Medicare Trustees recommend that the HI Trust Fund assets should be maintained at a level of at least 100% of annual expenditures.
SOURCE: Kaiser Family Foundation based on 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

In the most recent annual report, the precarious financial health of the HI Trust Fund was made apparent.[3] The Trustees reported that in 2008, total payments from the HI Trust Fund exceeded total income to the Fund by $4.7 billion. When such a shortfall occurs, the Trust Fund reserves are drawn upon through general revenue transfers to make up the difference. The annual shortfall is projected to grow to $21 billion in 2009, further drawing down the HI Trust Fund reserves. Shortfalls are forecast to occur annually in future years so that in 2017, Trust Fund balances are expected to be exhausted. This means that even if all the payroll tax amounts that were previously loaned to the rest of the federal government are repaid with interest, the Trust Fund will not have sufficient funds in 2017 to cover the entire cost of inpatient hospital care and other Medicare Part A services.

A range around this insolvency date – 2014 to 2028 – is bounded by the actuaries' more pessimistic and optimistic assumptions about future economic and demographic factors and health-care costs (shown in Exhibit 5 as "high cost" and "low cost" assumptions). That is, assuming slower economic growth or more rapidly growing health care costs would move up the insolvency date prior to 2017, while faster growth in the economy or slower growth in health spending would push back the insolvency date beyond 2017.

The projection of HI Trust Fund exhaustion in 2017 does not mean that the Medicare program will be "bankrupt", or that there will be no funds available to pay for Medicare Part A benefits that year, since revenue will continue to flow to the HI Trust Fund. Rather, it means that there will be insufficient funds to meet all the Trust Fund obligations. What makes the problem especially serious, however, is that it is not temporary—the shortfalls in HI benefit financing will continue to accumulate each year unless something changes either to increase the revenue coming into the Trust Fund or to decrease total Trust Fund expenditures. No process currently

exists for addressing insufficiencies in the HI Trust Fund; new legislation would be required to make up the difference.

In the past, policymakers have taken steps to address concerns about Medicare financing, such as increasing revenue, reducing spending, and increasing beneficiary contributions. These actions were often prompted by federal budget concerns, but some were undertaken specifically to address near-term HI Trust Fund financing problems. For example, prior to 1990, the Medicare payroll tax was only collected on wages up to a certain amount (a cap which remains in place for the Social Security payroll tax). The cap was raised for the Medicare payroll tax in 1990 and eliminated entirely in 1993. The taxation of Social Security benefits was extended in 1990, with the additional funds dedicated to the Medicare HI Trust Fund. In addition, in 1997 a change was enacted to limit coverage of home health services under Part A to 100 visits following a hospital or skilled nursing facility stay; payment for other Medicare-covered home health visits was shifted to Part B, significantly reducing expenditures from the HI Trust Fund for what was then one of the fastest-growing components of Medicare spending.[4]

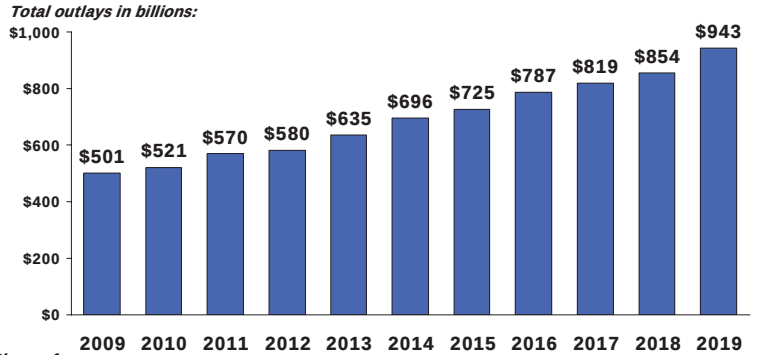
While technically, the SMI Trust Fund cannot become insolvent, financing the projected growth in spending for Part B and Part D services would require rapidly increasing general revenue and beneficiary premium contributions. The increase in general revenue contributions has important implications for the federal budget, which offers another way to measure Medicare financing.

Medicare Spending as a Share of the Federal Budget

Medicare is one of the largest and fastest growing federal programs. Following historical trends, Medicare spending is projected to grow faster than the rest of the budget, reaching 20 percent of federal spending by 2019 **(Exhibit 6)**. Budget experts have expressed concern about the long-run implications of Medicare spending on federal deficits. Coupled with similar pressure to finance Social Security and Medicaid benefits, the Government Accountability Office has labeled the U.S. long-term federal fiscal policy as "unsustainable."[5]

Exhibit 6

Projected Medicare Outlays, 2009-2019



Share of:	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Federal Outlays	13%	15%	16%	17%	18%	19%	19%	19%	19%	19%	20%
Gross Domestic Product	3.6%	3.6%	3.8%	3.7%	3.8%	4.0%	4.0%	4.2%	4.2%	4.2%	4.5%

NOTE: Outlays have been rounded to nearest whole number and exclude offsetting receipts.
SOURCE: Kaiser Family Foundation based on data from Congressional Budget Office, March 2009.

Medicare Spending as a Share of Gross Domestic Product (GDP)

One common way of evaluating the burden of financing a rapidly growing Medicare program is to consider Medicare spending in relation to the overall U.S. economy. Total Medicare spending

represented 2.5 percent of the gross domestic product (GDP) in 1996, a share that grew to 3.2 percent in 2008.[6] The Congressional Budget Office (CBO) has projected that Medicare spending will reach about 6 percent of GDP by 2025.[7] While no particular amount of GDP is the "correct" amount for Medicare spending, the implication of having more economic output devoted to Medicare is that fewer resources are available for other purposes.

The Medicare Solvency "Trigger"

Another measure of Medicare's claim on the federal budget was recently developed, a measure commonly referred to as the "45 percent trigger." Implemented as part of the Medicare Modernization Act of 2003, the trigger provision requires the Medicare Trustees to estimate, using a particular formula, a ratio measuring the extent to which program expenditures exceed dedicated revenue. If, for two consecutive years, the actuaries project that the ratio is expected to exceed 45 percent within seven years, a "Medicare funding warning" is issued by the Trustees. The trigger is intended to draw attention to Medicare's financial situation and to prompt the President and Congress to develop a response. However, no automatic spending reductions or other changes in the program are set to occur as a result of the warning. *(See Appendix B for more details.)*

The Medicare Trustees have issued a Medicare funding warning each year since 2007. Most recently, in the 2009 annual report, they estimated that the ratio would reach 45 percent in 2014. To date, no action has been taken by any Administration or Congress in direct response to the warnings.

The Medicare funding warning has been criticized on a number of grounds. Chief among them is that the 45 percent level is arbitrary, and the formula promotes certain policy solutions over others. Under the formula, an increase in beneficiary premiums or payroll taxes would have a greater effect on keeping general revenue funding at or below the 45 percent level than an equally-sized reduction in program spending, even though reducing program spending would contribute to a smaller federal budget and using general revenue financing is more progressive than using the payroll tax.[8] Due in part to these concerns, in January 2009, the House of Representatives passed a rule stating that the process for House action on a Medicare funding warning will not apply during the 111th Congress.[9]

WHAT FACTORS CONTRIBUTE TO GROWTH IN MEDICARE SPENDING?

When considered only in the context of the federal budget, the rapidly growing cost of Medicare might be considered as evidence of flaws in the program. When broader trends in health spending are taken into account, however, Medicare's financing dilemma can be viewed as a reflection of the nation's overall health care cost trends. In fact, CBO has identified the national growth in health care costs as the key determinant of the nation's long-term fiscal outlook.[10]

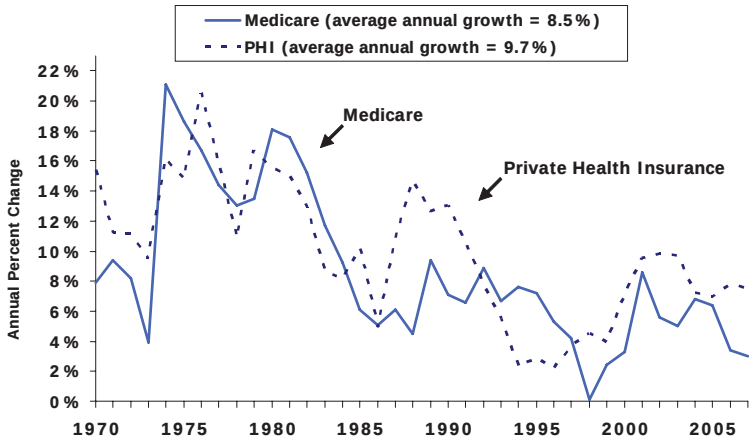
Medicare Reflects National Health Spending

Since the 1970s, national health care spending has grown on average about 2.5 percentage points faster than the economy, and this trend is expected to continue.[11] In 2007, national health expenditures totaled more than $2 trillion or 16 percent of GDP, and are projected to double to $4 trillion or 20 percent of GDP by 2018.[12] The U.S. ranks far above all other countries in terms of health spending as a share of the economy, with France ranking second at 11 percent of GDP.[13]

Over the long run, average growth in Medicare spending per beneficiary has been lower than per capita growth in private health spending for comparable benefits, although over some periods of time the opposite has been true **(Exhibit 7)**. The Medicare actuaries' long-run projections (those more than 25 years out) are based on the assumption that per beneficiary expenditures will increase at the same rate as overall health spending per capita.[14]

Exhibit 7

Annual Change in Medicare and Private Health Insurance Spending, 1970-2007

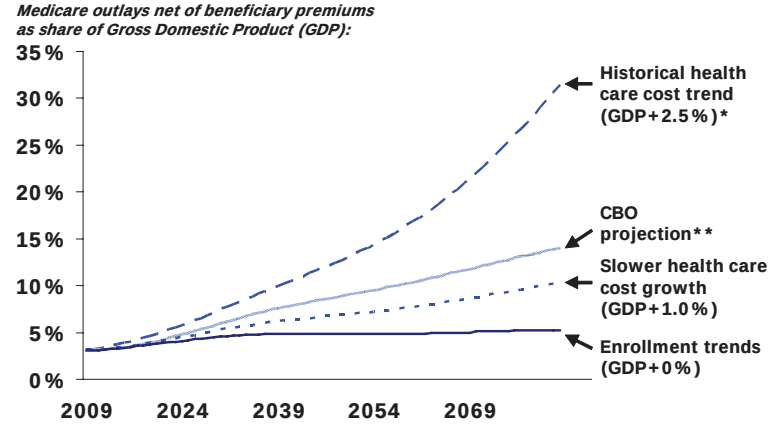


SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, 2007.

Projections from the CBO demonstrate the substantial savings to Medicare if health care spending were to grow more slowly. For example, if the rate of growth in per capita health costs were equal to the growth in GDP plus 1.0 percentage point, instead of GDP plus 2.5 percentage points, which is closer to the historic trend, by 2038 program spending would be reduced by half **(Exhibit 8)**.[15] CBO's extended baseline trend falls in between these amounts, assuming that eventually, under the historic trend, health care would begin to crowd out consumption of other necessary goods and services to a degree that is unsustainable, resulting in pressure to slow growth in health care costs even in the absence of changes in federal law.

Exhibit 8

Contribution of Health Care Costs and Enrollment Trends to Growth in Medicare Spending



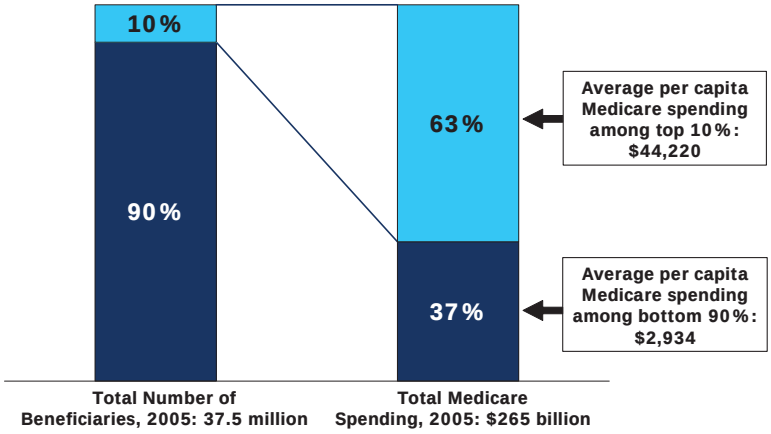
NOTE: *CBO calculates the average historical (1975-2007) health care cost trend for Medicare to be GDP+2.3%.
**CBO assumes that cost growth slows over the projection period, averaging GDP+1.5% from 2020 to 2083.
SOURCE: Congressional Budget Office. Data combining both Medicare and Medicaid can be found in *The Long-Term Budget Outlook*, June 2009, Figure 2-3.

Several factors contribute to the growing portion of the economy devoted to health care. These include medical advances and the adoption of new medical technologies and services, changes in disease prevalence that increase the use of services, and increased demand due to lower out-of-pocket costs at the point of service.[16] Medicare is affected by these overall trends along with other health care purchasers.

Spending for High-Need Populations. Medicare spending is highly skewed, much as it is for the entire health care system. A relatively small share of the Medicare population, ten percent, accounts for nearly two-thirds of all Medicare spending **(Exhibit 9)**. The high per capita spending among this subset of the Medicare population – generally for those with complex medical needs and multiple chronic conditions – has spurred interest in models to improve the management of care for high-cost beneficiaries.

Exhibit 9

Distribution of Medicare Enrollment and Spending, 2005



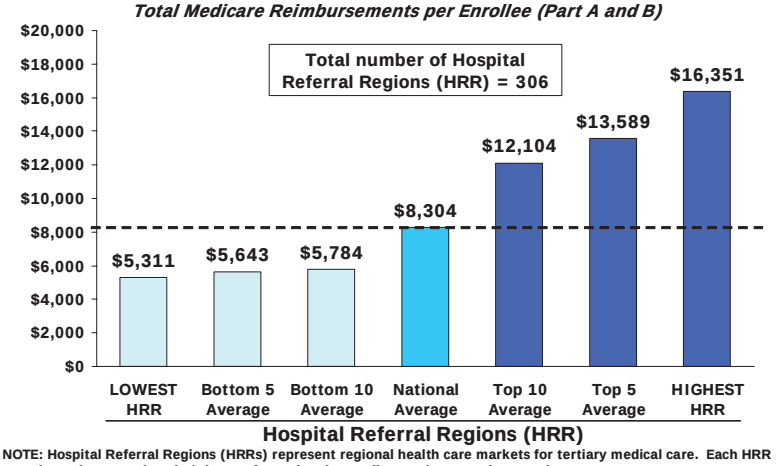
NOTE: Analysis excludes Medicare Advantage enrollees.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost & Use file, 2005.

Geographic Variation in Health Spending. The inexorable trend of high and rising aggregate U.S. health spending is made more perplexing by the wide variation in spending observed around the country, which is not explained entirely by demographics nor associated with outcomes of care. For many years, researchers have been documenting wide variations in Medicare spending across various geographic areas.[17] Dartmouth's *Atlas of Health Care* shows, for example, that in 2006 Medicare spending per beneficiary across 306 geographic areas, defined by hospital referral patterns, ranged from $5,311 in Honolulu, Hawaii and $5,542 in Minot, North Dakota to $16,351 in Miami, Florida and $14,946 in McAllen, Texas – averaging $8,304 **(Exhibit 10)**.[18]

Exhibit 10

Geographic Variation in Medicare Spending, 2006

Total Medicare Reimbursements per Enrollee (Part A and B)

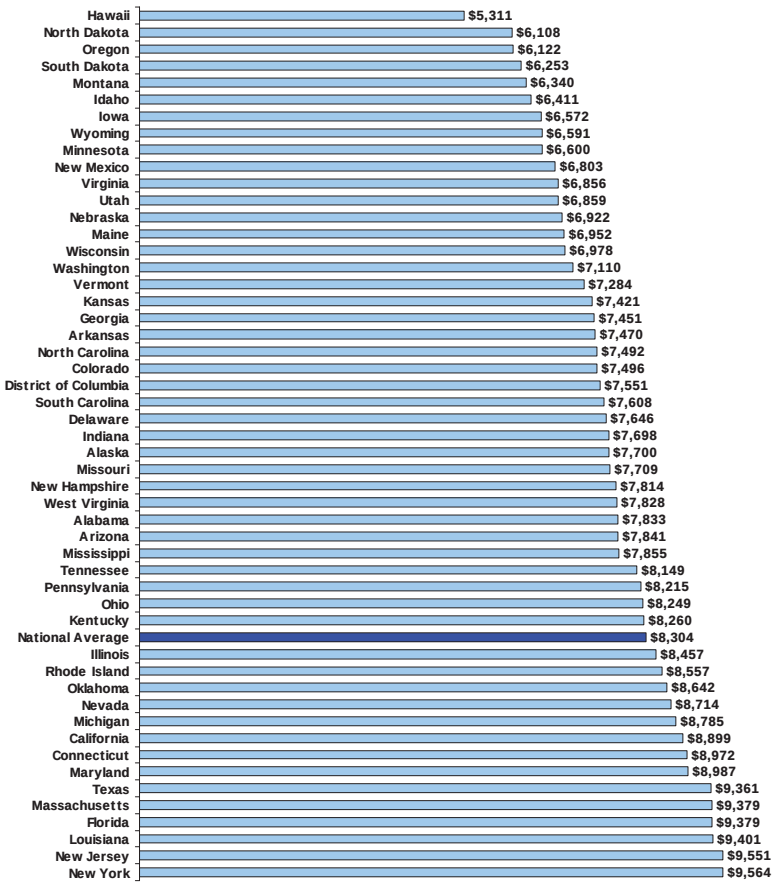


NOTE: Hospital Referral Regions (HRRs) represent regional health care markets for tertiary medical care. Each HRR contains at least one hospital that performed major cardiovascular procedures and neurosurgery.
SOURCE: Kaiser Family Foundation based on the Dartmouth Atlas of Health Care, Selected Medicare Reimbursement Measures.

Spending also varies by state, but to a lesser degree, with Medicare spending per beneficiary ranging from $5,311 in Hawaii to $9,564 in New York (**Exhibit 11**). While the data used for geographic variation analysis are most often from the Medicare program, experts agree that these estimates reflect underlying health care delivery patterns that affect private payers as well.

Exhibit 11

Geographic Variation in Medicare Spending Per Enrollee, 2006



NOTE: Excludes Medicare Advantage enrollees.
SOURCE: Kaiser Family Foundation based on the Dartmouth Atlas of Health Care, 2006

Differences in the cost of living and the underlying health of the population contribute to the observed geographic variation in health spending, but most variation is unexplained, and clinical practice patterns appear to be an important contributing factor. Available resources, including numbers of hospital beds and physicians, and local social norms regarding medical practice combine to influence clinical decision making.[19] Patients in higher-cost areas have more physician visits, hospital stays, intensive care unit days, and diagnostic tests than similar patients in lower-cost areas. Yet studies have shown that higher spending in these areas does not result in better quality of care as measured by processes, outcomes, or patient satisfaction. Differences in how providers respond to payment policies that encourage a high volume of services also contribute to geographic variation in spending.[20]

Translating the research on geographic variation in health care spending into policy prescriptions is not straightforward. If practice patterns everywhere matched those in the lowest-spending areas, Medicare spending could be reduced by as much as 30 percent, according to one estimate.[21] CBO recently detailed several policy options designed to minimize geographic spending variations and reduce Medicare spending by reducing provider fees in high-spending areas.[22] Blunt cuts to payments in high-spending areas would apply to all services, however, not only to unnecessary services, and could therefore have the effect of limiting beneficiary access to needed care. Suggested alternatives to simple price reductions aimed at addressing the issues raised by geographic variation analysis include policies that provide financial incentives to hold providers accountable for total expenditures and quality outcomes in an area.[23]

Other Factors Affecting Growth in Medicare Spending

While overall growth in health spending is the major driver of Medicare spending growth, some additional contributors are unique to the program.

Increased enrollment and an aging population: Most often discussed is the accelerating growth in program enrollment that will occur with the retirement of the post-World War II "baby boom" generation, who will begin to turn 65 in 2011. Between 1995 and 2008, as the cohort of individuals born during the Great Depression and World War II have become eligible for benefits, Medicare enrollment has grown by an average of 587,000 beneficiaries annually. Looking to the future, as the baby boomers reach age 65, net annual Medicare enrollment growth is expected to average 1.6 million beneficiaries between 2010 and 2030, and the program will grow to a total of 79 million enrollees in 2030 – double the enrollment in 2000.[24]

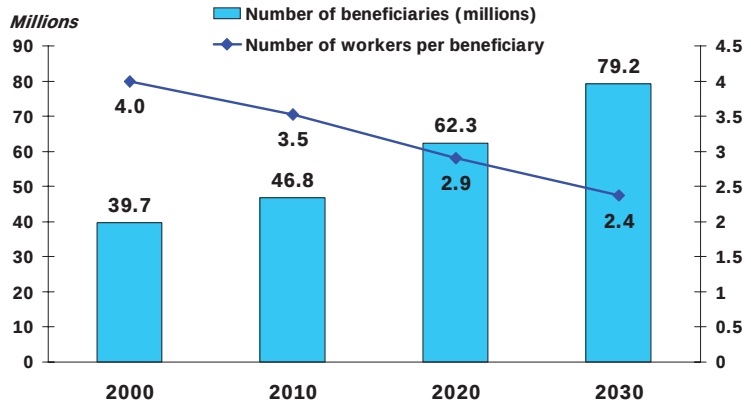
The contribution of increased enrollment to growing Medicare spending, however, is relatively modest. CBO projects that increased program enrollment along with the aging of the Medicare population would only increase net Medicare spending from 3 percent of GDP currently to 5 percent of GDP by 2083, compared with 14 percent of GDP by that year when per capita health cost growth is included, along with the interaction between these two factors **(Exhibit 8)**.

Likewise, the effect on Medicare spending of the age mix of Medicare beneficiaries is small. As one would expect, per capita Medicare spending increases as beneficiaries age. For example, in 2005, per capita Medicare spending for beneficiaries in the traditional fee-for-service program who were age 85 or older totaled $10,674, more than double the $5,072 average for beneficiaries ages 65 to 74.[25] As the baby boom generation ages onto Medicare, however, the age mix of the program's beneficiaries will actually be younger than it is today. Only until the bulk of baby boomer beneficiaries reach age 85, between 2040 and 2050, is age mix expected to contribute to higher program spending.

Shifting demographics will affect Medicare financing in other ways. Not only will Medicare need to provide for more beneficiaries, but there will also be fewer workers per beneficiary contributing to help cover the costs **(Exhibit 12)**. In 2008, 3.7 workers were contributing taxes for each beneficiary; by 2030 that figure is projected to fall to 2.4 and continue to decline to 2.1 workers per beneficiary by 2080.[26] As a result, even at a healthy rate of economic

Exhibit 12

Change in the Medicare Population and the Number of Workers per Beneficiary



SOURCE: Kaiser Family Foundation based on the 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

growth, Medicare payroll taxes would not keep pace with program growth. This worker-to-retiree ratio problem is not unique to the United States. In fact, the proportional decline in workers is expected to be much worse in Japan and many European countries.[27]

Enrollment in Medicare Advantage (MA): A trend contributing to growth in program costs in recent years has been the rising enrollment of Medicare beneficiaries in Medicare Advantage, under which Medicare benefits are provided by private health plans that contract with the federal government. Enrollment in all private plans has almost doubled since 2004 to a total of 11 million beneficiaries, or 24 percent of the total Medicare population.[28] The benefits derived from the growing role played by private Medicare Advantage plans is a matter of dispute, but strictly from the perspective of program financing it is undisputed that Medicare Advantage payments have added to the cost of Medicare borne by the government. Historically, Medicare paid 95 percent of average fee-for-service costs for private plans that participated in Medicare, but that is no longer the case.[29] Growing enrollment in Medicare Advantage plans has increased program expenditures because each MA plan enrollee costs significantly more on average than if the beneficiary was in the traditional Medicare program, a differential of 14 percent in 2009.[30] These higher payments contribute to the fiscal pressure on the Medicare program, including the HI Trust Fund.

Physician payment: One challenge in evaluating Medicare financing trends is that official Medicare spending projections are known to be understated due to anticipated changes in physician payments. The law setting forth Medicare payment to physicians specifies an annual update formula that would require reductions in physician fees of 21.5 percent in 2010 and about 5.5 percent each year for 2011 through 2014. These cuts are therefore assumed in the projections of future program costs. However, for the last 7 years, Congress has acted to prevent similar cuts from taking place. Most experts believe the government will continue to prevent physician payment cuts from taking place under the current payment formula, resulting in much higher expenditures for physician services than are assumed in official Medicare projections. Under more politically realistic estimates, total Medicare Part B spending for 2015 would be 18 percent to 21 percent higher than the official estimates, and beneficiary contributions for the Part B premium and deductible would rise by the same order of magnitude, unless policy makers protected beneficiaries from some or all of the increase.[31]

Medicare Part D: Addition of the Part D prescription drug benefit in 2006 increased Medicare outlays considerably. Two-thirds of the $72 billion increase in Medicare expenditures from 2005 to 2006 resulted from the implementation of Part D, and the drug benefit added significantly to future program obligations. Expenditures to date for Part D, however, have been lower than projected before the program was implemented. The Medicare actuaries have explained that the lower projections are largely the result of changing forecasts for the national trend in prescription drug costs. Fewer new drugs, which are more expensive, are expected to reach the market over the next decade, thus lowering the trend line faced by all payers, including Medicare.[32] Other explanations for why spending on Part D has been lower than originally projected include more use of generic drugs by beneficiaries, lower enrollment in Part D plans overall and in the low-income drug subsidy program, and an initial underestimate of the drug price rebates received by Part D plans.

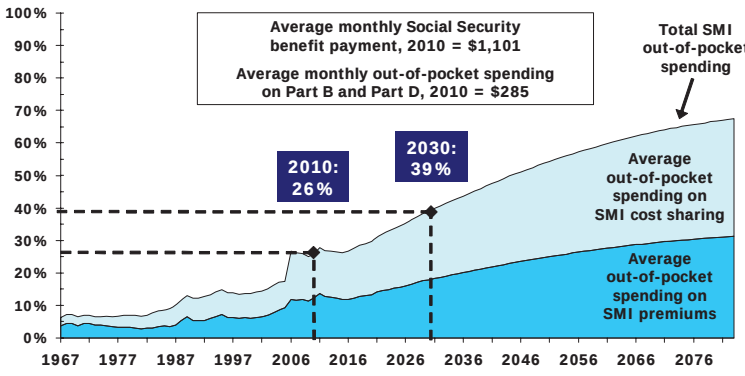
Administrative costs: Program administration is not a contributing factor to Medicare's expenditure growth. The costs of administering the Medicare program have remained low over the years – less than 2 percent of program expenditures. This covers all expenses by government agencies in administering the program (HHS, Treasury, the Social Security Administration, the Department of Justice, and the Medicare Payment Advisory Commission). Included also are the cost of claims contractors and other costs incurred in the payment of benefits, collection of Medicare taxes, fraud and abuse control activities, various demonstration projects, and building costs associated with program administration.

HOW DOES THE RISING COST OF MEDICARE AFFECT BENEFICIARIES?

The growing cost of Medicare creates a financial burden on beneficiaries as well as the federal government. The Trustees project that over time beneficiaries will pay an increasing share of their income for their Medicare coverage. In 2010, premiums for Part B and Part D are estimated to equal 12 percent of the average Social Security benefit, while average cost sharing absorbs another 14 percent; these figures are estimated to continue to rise as health care cost increases outpace growth in Social Security benefits. For example, by 2030 total out-of-pocket costs (premiums and cost sharing) for Part B and Part D will grow to about 40 percent of average Social Security benefits **(Exhibit 13)**.[33,34] Additionally, beneficiaries will face rising premiums for private Medicare supplemental coverage. The impact on individual beneficiaries will vary as those who use fewer health services are less affected by cost-sharing requirements and those with higher incomes will be able to afford to pay more for their Medicare benefits.

Exhibit 13

Total Part B and Part D (SMI) Out-of-Pocket Spending as a Share of the Average Social Security Benefit, 1967-2083



NOTE: SMI is Supplemental Medical Insurance. Out-of-pocket spending includes SMI premiums and out-of-pocket cost-sharing expenses for SMI covered services.
SOURCE: Kaiser Family Foundation based on data from 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds; Social Security Administration.

Some of the burden of rising beneficiary premiums and cost sharing ends up back on the government ledger in the form of subsidies. As beneficiary financing increases, so does the cost of federal subsidies for Part D premiums and the cost of federal and state Medicaid subsidies for Part B premiums and cost sharing for the lowest-income beneficiaries under the Medicare Savings Programs.[35] In addition to the direct subsidies for which beneficiaries must apply, the annual dollar increase in a beneficiary's Part B premium is capped to equal the annual dollar increase in their Social Security benefit. This "hold-harmless" provision prevents monthly Social Security income from falling as the Part B premium increases. The hold-harmless provision does not apply to Part D premiums.

For 2010, the Social Security cost-of-living adjustment is expected to be zero, and under the hold-harmless provision, Medicare Part B premiums will not increase for almost all Medicare beneficiaries. Current inflation projections suggest this could occur for two or three consecutive years. During this time, the hold-harmless provision would protect most beneficiaries from any Part B premium increase, but new Medicare beneficiaries who were not already receiving Social Security benefit payments would pay higher premiums.[36] The Medicaid program, financed in part by the states, would also pay higher premiums on behalf of low-income beneficiaries (known as "dual eligibles"). Higher-income beneficiaries who pay income-related premiums for Part B would also face increased premiums.

HOW CERTAIN ARE THE FORECASTS?

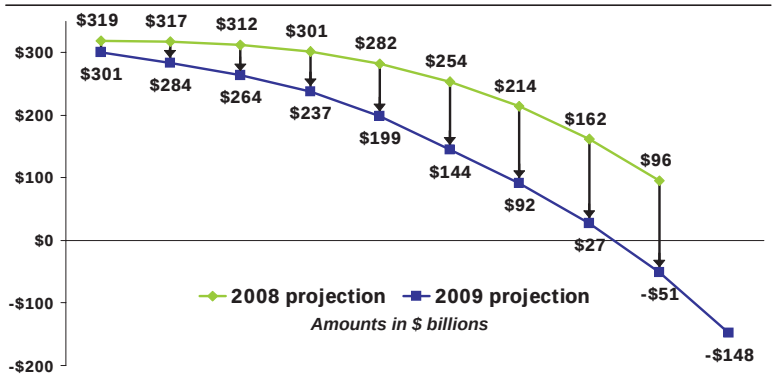
Given the complexity of both the U.S. economy and health care system, Medicare financing projections are always uncertain. Moreover, through legislation and regulation, Medicare policy is constantly changing, and policy decisions made in the near term can have long-term effects and implications for long-run program spending trends. HI Trust Fund financing crises predicted in the past have been forestalled by Congressional actions increasing revenue and decreasing spending. Even so, experts agree that substantial changes will be required to keep Medicare financing on a solid footing into the 21st century.

Medicare financing projections rely on a variety of predictions about the economy, demographics, and health care spending trends. Economic factors affect both spending and revenue projections. For example, future payroll taxes are tied to growth in wages, while annual increases in payments to hospitals and other providers are linked to measures of price inflation.

Differences between projections and actual expenditures are inevitable, as the recent recession underscores. For example, in the 2009 annual report, the Medicare Trustees moved up the best estimate of the date of the exhaustion of the HI Trust Fund by two years because the recession led to lower than expected payroll tax income as fewer workers were contributing and average wages were lower than forecast **(Exhibit 14)**. Enrollment trends are relatively easy to predict, but trends in life expectancy and health status involve more assumptions, and changes to immigration policy or patterns could affect demographic projections.

Exhibit 14

2008 and 2009 Projections of the Part A Hospital Insurance Trust Fund Balance, 2009-2018



NOTE: 2008 projection period does not include 2018. Estimate for each year represents the trust fund balance at calendar year's end.
SOURCE: Kaiser Family Foundation based on data from the 2008 and 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

As discussed earlier, Medicare spending and financing projections are largely driven by movement in national health spending; these trends can shift quickly with the diffusion of new medical technologies or breakthrough drugs. For example, prescription drug spending grew rapidly in the 1990s as a record number of new drugs were introduced, then subsequently decelerated as that trend slowed.[37]

WHAT IS THE OUTLOOK FOR THE FUTURE?

Major changes from the program's current path will be required to preserve Medicare financing for the long run, although any policy changes that reduce expenditures or increase revenues will help. The amounts that the Medicare Trustees estimate will be required to preserve the solvency of the HI Trust Fund over the very long run offer one measure of the magnitude of change needed. Over the next 75 years, increases in revenue or reductions in program expenditures equivalent to a lump sum of more than $13 trillion today would be required to bring the HI Trust Fund into balance.[38] Similarly, new revenue or reduced growth in expenditures for the rest of the Medicare program (physician visits, other outpatient services, and private prescription drug plans) will also be required.

Because of its size, policy makers must also consider the broader effects of changes made to the Medicare program. Major reductions in payments to providers could put upward pressure on the prices they charge to private payers or negatively impact beneficiary access to providers. Additional payments to teaching hospitals and those located in rural areas and serving low-income urban populations are explicitly made to address social needs beyond the care of Medicare patients, and substantially reducing or eliminating these payments would disadvantage the communities that rely on these facilities. Shifting too much of the burden of Medicare financing on beneficiaries could reduce their access to needed health services and increase the proportion of uncompensated health care.

President Obama has linked the future of Medicare to broader health reform. Rather than target changes to Medicare alone, he and others argue that the best way to sustain the Medicare program is to slow the overall growth rate in health care spending.[39] This approach focuses on policies that are aimed at improving the efficiency of the health care system, such as expanding the use of electronic medical records and other forms of health information technology, creating and disseminating more information about the comparative effectiveness of alternative medical treatments and linking these findings to payment policy, improving the prevention and management of chronic disease, and changing the financial incentives of health care providers. The American Recovery and Reinvestment Act of 2009 (Pub. Law 111-5) includes federal funding for comparative effectiveness research and implementation of electronic health records and other information technology to improve the quality and efficiency of health care.

In some cases, Medicare could be a leader in promoting changes to the health care delivery system that could help lower costs and improve the quality of care. The President's FY 2010 budget proposes several changes to Medicare that are intended to change provider incentives to encourage the delivery of more efficient, higher-quality health care services. These include bundling payments for inpatient hospital and post-acute care services, modifying payments for

preventable hospital readmissions, tying payment to performance on quality measures, encouraging better management of care for the chronically ill, and offering incentive payments to providers who meet efficiency and quality goals. The Medicare Payment Advisory Commission has endorsed such changes in how services are delivered to Medicare beneficiaries and how providers are paid to bring greater efficiency to the program.[40]

Whether changes are part of overall health reform or are unique to Medicare, the level of changes required to sustain the program over the long term will be far-reaching and, as such, contentious. The challenge to policy makers for the coming decades is to find a balance between limiting growth in Medicare payments to providers, increasing contributions from Medicare beneficiaries, and raising revenue – all while maintaining, if not improving, beneficiary access to medically necessary services and the quality of care they receive.

APPENDIX A: MEDICARE'S TRUST FUNDS

	Hospital Insurance (HI) Trust Fund	Supplementary Medical Insurance (SMI) Trust Fund
Sources of Funds	The HI Trust Fund is the repository for the Medicare payroll tax contributions (1.45 percent each for employee and employer), which constituted 86 percent of Trust Fund revenue in 2008. Other sources of funding include some of the income taxes paid on Social Security benefits by those exceeding certain income thresholds (5 percent of revenue); interest earned on trust fund balances (7 percent), and enrollee premiums (1 percent).	Premiums paid by beneficiaries constituted 22 percent of SMI Trust Fund revenue in 2008. General revenue contributed 74 percent of the total; transfers from states to offset state savings from implementation of the Medicare drug benefit accounted for 3 percent; interest on the Trust Fund balance was 1 percent. Beneficiary premiums include the standard monthly premium paid for Medicare Part B ($96.40 in 2009); premiums paid by beneficiaries electing to enroll in Medicare Part D for their prescription drug coverage, which vary based on the plan they choose; and beginning in 2007, an income-related Part B premium paid by higher income beneficiaries. In 2009, the threshold was $85,000 individual/$170,000 couple; these amounts are indexed to increase with inflation each year. The total premium paid by these beneficiaries ranges from 40 percent to 220 percent higher than the standard premium, depending on income.
Use of Funds	Medicare Part A benefits are financed out of the HI Trust Fund. Individuals become eligible for Medicare Part A when they turn age 65 if they have made sufficient payroll tax contributions or choose to pay a premium to enroll; disabled individuals may qualify at a younger age. Part A benefits include inpatient hospital care (58 percent of net HI expenditures for health services in 2008); limited skilled nursing facility care (11 percent), home health (3 percent) and hospice (5 percent). Some 23 percent of payments from the HI Trust Fund are made to cover the costs of services to beneficiaries	The SMI Trust Fund is used to pay for benefits under Medicare Part B and to pay premiums to private prescription drug plans under Medicare Part D. Unlike Part A, eligible individuals must elect to enroll in Medicare Parts B and D and pay a monthly premium. Part D benefits in 2008 accounted for 21 percent of all SMI expenditures. Part B benefits include physician care (26 percent of SMI expenditures in 2008); outpatient hospital services (12 percent); home health care (4 percent). About 21 percent of payments from the SMI Trust Fund are made to cover the costs of services to beneficiaries enrolled in private Medicare Advantage plans.

	Hospital Insurance (HI) Trust Fund	Supplementary Medical Insurance (SMI) Trust Fund
	enrolled in private Medicare Advantage plans. The remaining 1 percent of expenditures pays for Medicare program administration, including government costs incurred in the payment of benefits, collection of taxes, fraud and abuse control activities, and various demonstration projects.	When combined, other benefits, including durable medical equipment, laboratory and ambulance services, clinic care and other services, account for about 15 percent of SMI expenditures. The remaining 1 percent of expenditures pays for Medicare program administration, including government costs incurred in the payment of benefits, collection of taxes, fraud and abuse control activities, and various demonstration projects.
Financial Status	The financial status of the HI Trust Fund depends on the extent to which the Medicare payroll tax and other revenue that is dedicated to the Trust Fund covers the Part A expenditures that are obligated to be financed by the fund. At the end of calendar year 2008, the HI Trust Fund had a balance of $321 billion. Over the next decade, however, the Trust Fund is projected to be in shortfall, with trust fund balances exhausted and therefore insufficient funds to pay all obligations beginning in 2017 under the Medicare actuaries' intermediate (most likely) assumptions.	The Part B premium is set each year to cover 25 percent of the projected cost of Part B benefits. Similarly, the Part D premium is set by statute to cover 25 percent of the projected cost of Part D benefits. General revenue funds are drawn to cover the balance of SMI Trust Fund expenditures. Because of the annual recalculation of premiums and the automatic draw on general revenue, the SMI Trust Fund technically cannot be in shortfall.

SOURCE: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 12, 2009.

APPENDIX B: MEASURING GENERAL REVENUE CONTRIBUTIONS FOR THE "45 PERCENT TRIGGER"

While the issuance of a Medicare funding warning depends on two consecutive years' findings of "excess general revenue funding," the definition of general revenue used to calculate general revenue funding is computed is not as simple as might be suggested by the label. General revenue is by design a major source of funding for Medicare, intended to cover three-quarters of the cost of both Parts B and Part D. The ratio computed under the "45 percent trigger" formula is intended to account for more than these transfers, however.

For each year, the formula computes the following ratio and compares it to the 45 percent threshold:

$$\frac{\text{Total Medicare outlays} - \text{dedicated revenue}}{\text{Total Medicare outlays}} = \text{General Revenue Funding}$$

Whatever is not counted as dedicated revenue in the formula is therefore counted as general revenue. Under the formulation, dedicated revenue consists of payroll taxes, premiums, transfers from states, and HI Trust Fund revenue from taxation of Social Security benefits. Interest payments made to the Trust Funds are not counted as dedicated revenue, and therefore count as general revenue in the formula. Arguably, treating HI Trust Fund interest payments this way in a calculation intended to measure Medicare's reliance on general revenue funding is inappropriate.[41] While it is true that interest payments are made from general revenue, they are only made at all because excess dedicated Medicare payroll taxes were "borrowed" from Medicare and used to finance other government obligations. Had these excess dedicated Medicare funds not been available, the federal government would have had to borrow funds from elsewhere – necessitating payment of interest to others.

Moreover, the "excess general revenue funding" formula would similarly count repayment of borrowed HI Trust Fund amounts as general revenue subsidies. That is, as HI Trust Fund reserves are drawn down in future years to pay program benefits, these amounts are treated in the formula as general revenue subsidies, even though they represent repayment of dedicated payroll tax amounts collected in earlier years.

No automatic changes are made to Medicare if the warning is issued; rather, legislation to address the situation must be passed by the Congress and signed by the President. Under the provision, the President is required to submit legislation to Congress to respond to the warning, and an expedited process is in place for the Congress to consider the President's proposed legislation.

Possible steps to limiting the ratio to no more than 45 percent include raising revenue by increasing Medicare payroll taxes, beneficiary premiums, or taxes on Social Security benefits; or lowering spending by reducing benefits or payments to providers. Increasing general revenue contributions would not improve the ratio, although if policy makers decide that increased general revenue funding is an appropriate means of financing Medicare, no steps related to the trigger formula need to be taken.

REFERENCES

[1] One in five dollars from Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 2007-1960," http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp
Data on hospital stays from Agency for Health Care Research and Quality, Health Cost and Utilization Project http://hcupnet.ahrq.gov/

[2] Congressional Budget Office, *Historical Budget Data,* March 2009.

[3] 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 12, 2009.

[4] This change was in keeping with the original design of the Medicare home health benefit, which had been more restrictive until it was expanded in 1980. See Health Care Financing Administration, Testimony on Reforming the Medicare Home Health Benefit by Bruce C. Vladeck, Ph.D., Administrator, before the House Commerce Committee, Subcommittee on Health and Environment, March 5, 1997. http://www.hhs.gov/asl/testify/t970305a.html

[5]Government Accountability Office, *The Federal Government's Financial Health: A Citizen's Guide to the Financial Report of the U.S. Government,* 2008. *http://www.gao.gov/financial/fy2008/citizensguide2008.pdf*

[6] Congressional Budget Office, *The Long Term Budget Outlook*, June 2009, supplemental data. Available at http://www.cbo.gov/ftpdocs/102xx/doc10297/SupplementalData2009LTBO.xls

[7] Congressional Budget Office, *The Long Term Budget Outlook*, June 2009, supplemental data. Available at http://www.cbo.gov/ftpdocs/102xx/doc10297/SupplementalData2009LTBO.xls

[8] This result occurs because a reduction in spending lowers both the formula's numerator and denominator, while an increase in revenue or premiums only lowers the numerator. For a complete discussion, see Moon, M. "The Policy Implications of Medicare's New Measure of Financial Health," Medicare Policy Brief, Kaiser Family Foundation, October 2005, http://www.kff.org/medicare/upload/7414.pdf.

[9] Section 3(e) of H. Res 5, passed on January 6, 2009.

[10] Congressional Budget Office, Statement of Peter R. Orszag, Director, "The Long-Term Budget Outlook and Options for Slowing the Growth of Health Care Costs," before the Committee on Finance United States Senate, June 17, 2008.

[11] Centers for Medicare and Medicaid Services, Office of the Actuary, " NHE summary including share of GDP, CY 1960-2007," http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage

[12] Sisko A. and others. "Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook," Health Affairs web exclusive, February 24, 2009. http://content.healthaffairs.org/cgi/reprint/hlthaff.26.2.w242.pdf

[13] Organisation for Economic Cooperation and Development, "OECD Health Data 2009, Frequently Requested Data," June 2009.

[14] 2009 Annual Report of the Trustees, p. 179.

[15] Congressional Budget Office. Data on Medicare and Medicaid combined are included in *The Long-Term Budget Outlook*, June 2009.

[16] Kaiser Family Foundation, *Health Care Costs: A Primer*, March 2009.

[17] For a summary, see Fisher, E. and others. "Health Care Spending, Quality and Outcomes, More Isn't Always Better," The Dartmouth Institute for Health Policy & Clinical Practice, February 27, 2009. http://dartmouthatlas.org/atlases/Spending_Brief_022709.pdf See also Congressional Budget Office, *Geographic Variation in Health Care Spending*, February 2008.

[18] Wennberg, J. and others. *Dartmouth Atlas of Healthcare 2008*. http://www.dartmouthatlas.org

[19] Fisher, E. and others. Also, Congressional Budget Office, *Geographic Variation in Health Spending*, February 2008.

[20] Gawande, A. "The Cost Conundrum," *The New Yorker*, June 1, 2009.

[21] Wennberg, J. and others. "Geography and the Debate Over Medicare Reform," *Health Affairs* web exclusive, February 13, 2002.

[22] Congressional Budget Office, *Budget Options Volume 1. Health Care*. December 2009.

[23] Fisher, E. and others. "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," *Health Affairs* web exclusive, December 5,2006.

[24] 2009 Annual Report of the Trustees, p. 37.
[25] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2005.
[26] 2009 Annual Report of the Trustees, p. 63.
[27] Organisation for Economic Co-operation and Development, Old Age Dependency Ratio in 2050, Data Chart GE2.1A, http://www.oecd.org/dataoecd/34/28/34542290.xls
[28] 2009 Annual Report of the Trustees; 2009; plan enrollment for 2009 from Centers for Medicare and Medicaid Services, "Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report - Monthly Summary Report (Data as of June 2009)."
[29] Section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248).
[30] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2009.
[31] Centers for Medicare and Medicaid Services, "Projected Part B Expenditures under Two Illustrative Scenarios with Alternative Physician Payment Updates," May 12, 2009. http://www.cms.hhs.gov/ReportsTrustFunds/05_alternativePartB.asp#TopOfPage
[32] 2009 Annual Report of the Trustees, p.26.
[33] 2009 Annual Report of the Trustees, p.85.
[34] These estimates do not include the income-related Part B premium, under which higher-income beneficiaries pay an amount much greater than the standard monthly premium. Sources of beneficiary income other than Social Security benefits are also excluded from this analysis.
[35] For background on Medicare subsidies see Nemore, P. and others. *Toward Making Medicare Work for Low-Income Beneficiaries: A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules*, Kaiser Family Foundation, May 2006.
[36] Kaiser Family Foundation, *The Social Security COLA and Medicare Part B Premium: Questions, Answers, and Issues,* May 2009.
[37] Smith, S. and others. "The Next Decade Of Health Spending: A New Outlook," *Health Affairs*, July/August 1999; 18(4): 86-95.
[38] 2009 Annual Report of the Trustees, p.68.
[39] Remarks of President Barack Obama, White House Forum on Health Reform, March 5, 2009.
[40] Medicare Payment Advisory Commission, "Reforming America's Health Care Delivery System," Statement before the Senate Finance Committee Roundtable on Reforming America's Health Care Delivery System, April 21, 2009.
[41] Greenstein, R., and others. "Trustees' Report Focuses Attention on Misguided Medicare "45-Percent Trigger," Center on Budget and Policy Priorities, May 1, 2006. http://www.cbpp.org/4-28-06health.pdf

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