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The Policy Implications of Medicare's New Measure of Financial Health

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Executive Summary

Attention to the details of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) has largely focused on the new drug benefit and, to a lesser degree, to new payments and rules for private plan participation in Medicare. Less noticed is a provision in the law that created a new measure of financial health of the Medicare program to be included in the annual report of the Boards of Trustees of the Medicare Trust Funds. With members of Congress from both political parties expressing concern about the projected costs of Medicare's new prescription drug benefit, this measure could have a significant impact on the future of the drug program and the provision of Medicare benefits overall.

Historically, the annual report of the Boards of Trustees on the financing of the Medicare program has provided important information that measures the adequacy of future funding. These measures offer an early warning about the financial health of this important social insurance program. Measuring the program's financial health is important to both policy makers and the program's current and future beneficiaries. Since workers and their families need to plan for retirement, it is essential to know whether funds will be available to meet the future promises of income and health benefits. That is a major reason why Medicare and Social Security are held to higher standards of financial integrity than other federal spending programs. And in that sense, the goal of any such measure is not to lead to rapid or dramatic changes but rather to enable gradual adjustments as needed.

The new financial measure established by the MMA assesses how much of Medicare spending is financed by general revenues (mainly made up of income taxes). When general revenues exceed 45 percent of total Medicare spending, general revenues are deemed to be used "in excess." The intent of the measure is to treat a 45 percent contribution of general revenues to Medicare as the upper bound of reasonable support for the program from this one funding source.

This measure differs from other commonly reported indicators of Medicare's financial health in important ways. This new measure incorporates spending from all parts of the program (Parts A, B and, beginning in 2006, D), addressing a major criticism of the Part A (Hospital Insurance) Trust Fund solvency test that is limited to only one part of the program. However, in comparing Medicare spending to revenues coming in, the new measure focuses on only one of three major funding sources–general revenues. Thus, measuring the ratio of general revenues to total spending does not provide a complete picture of either the financial burden that Medicare creates, nor of Medicare's ability to meet obligations over time. Another way in which the 45 percent measure differs from other measures, such as the Part A Trust Fund solvency test, is that it is more than a new fiscal indicator; attached to the 45 measure in the MMA is a provision that compels both the President to propose and the Congress to consider a remedy after a general revenue "funding warning" is issued.

Several issues associated with the 45 percent measure deserve careful attention:

- **The new measure implicitly endorses a policy decision to cap general revenue funds for Medicare, by defining general revenue contributions above 45 percent of total spending on Medicare as excessive.** A cap on general revenue funding would mark a dramatic change in the program, and could have significant implications for financing benefits for current and future generations. General revenue funding above a specified threshold is treated as undesirable, although many economists point to general revenues as desirable because they are progressive and do not discourage work effort as does the payroll tax. In addition, general revenues effectively tax high-income seniors as well as younger taxpayers who bear most of the burden of payroll taxes.

- **By focusing only on the general revenue portion of Medicare, the measure will provide an inadequate picture at any point in time because it examines only a portion of the revenues going into Medicare.** If the issue of concern is to signal when Medicare becomes so large that it crowds out other government spending or is in some other way deemed unaffordable, the new measure will not necessarily identify the problem. The problem of excess general revenues could simply be "fixed" by raising payroll taxes or other new dedicated revenue sources.

- **The MMA, which included the provision for the general revenue funding warning, also designated general revenues as the main funding source for the drug benefit, potentially hastening the time in which a funding warning would be issued—perhaps as soon as 2006.** If the new drug benefit had been funded through some other mechanism, it would likely be several years before general revenues accounted for 45 percent or more of Medicare spending.

- **The new solvency measure favors certain policy options over others—even when other options could have a greater impact on slowing the growth in Medicare spending or in reducing the share of Medicare spending as a share of the total budget.** For example, all other things being equal, a $50 billion reduction in spending on the drug benefit would be less effective in lowering the share of general revenues as a percentage of total Medicare spending than an equally sized increase in either payroll taxes or Part B premiums. Even dramatic reductions in spending—such as cutting Part B spending by one-fourth—would only delay an excess funding warning by two years. In essence, this encourages Congress to turn to other sources of revenue, such as beneficiary premium increases, to respond to the financing "gap."

- **The 45 percent level used to trigger the Medicare funding warning appears arbitrary.** No justification is offered in the legislation or conference report for the choice of 45 percent. It is unclear why 50 percent or 60 percent or some other level was not chosen instead.

With the aging of the baby boom generation, there is a clear need to monitor and address the long-term financing challenges facing the Medicare program. Indeed, measures of the financial burden of the program need to be examined in the context of the benefits that seniors and persons

with disabilities receive. But this new measure of Medicare's financial health provides neither information about the value of Medicare benefits nor a sense of the relative size and growth of the program. Moreover, the new measure limits the range of options available to policymakers to address the long-term fiscal challenges facing Medicare, while accelerating the appearance of a fiscal crisis.

Introduction

Attention to the details of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (also known as the Medicare Modernization Act or MMA) has largely been focused on the new drug benefit and, to a lesser degree, to new payments and rules for private plan participation in Medicare. Less noticed is a provision of the law that created a new measure of financial health of the Medicare program that will summarize for each fiscal year the amount of general revenue funds that will be used to finance Medicare as a share of total spending on the program. The new measure (hereafter referred to as the "45 percent measure") will be included in the annual report of the Boards of Trustees of the Medicare Trust Funds. The law requires not only that a warning be generated when a funding imbalance is projected, but also requires action by the President and Congress in response to warnings issued in two consecutive annual reports from the Medicare Trustees.

Historically, the annual report from the Medicare Trustees on the financing of the Medicare program has provided important information that measures the adequacy of funding into the future. These measures offer an early warning about the financial health of this important social insurance program. Measuring the program's financial health is important to both policy makers and the program's current and future beneficiaries. Since workers and their families need to plan for retirement, it is essential to know whether funds will be available to meet the future promises of government-sponsored income and health benefits. That is a major reason why Medicare and Social Security are held to higher standards of financial integrity than other federal spending programs. In that sense, the goal of any such financing measure is not to lead to rapid or dramatic changes, but rather to enable gradual adjustments as needed.

Another, more recent application of these measures, however, is to signal the need for restricting program growth. Policy makers worried about the size and growth of the Medicare program sometimes refer to it as "unsustainable."[1] Those who make such a claim are concerned either about the level of taxes necessary to support the Medicare program over time or the size of Medicare relative to the whole economy.

While the goals for measuring Medicare's financial status may vary, there is clear consensus on the need to have reliable measures, projected several years into the future, in order to monitor the program's financial health. Any measure should represent a balanced view of the future to aid policy makers in understanding both the short- and long-term financing challenges. However, the 45 percent measure provides neither an accurate indicator of the tax burden created by Medicare nor of the affordability of Medicare relative to the economic output of the country. Furthermore, in practice, its impact could go well beyond the goal of measuring and providing information on overall Medicare spending, confounding measurement with policy prescriptions and setting the stage for policy change in response to a general revenue funding warning.

[1] See, for example, the statement by Senator Don Nickles concerning the MMA. See United States Budget Committee press release, November 25, 2003, "Nickles Opposes Medicare Bill, Warns Cost is underestimated and Unsustainable."

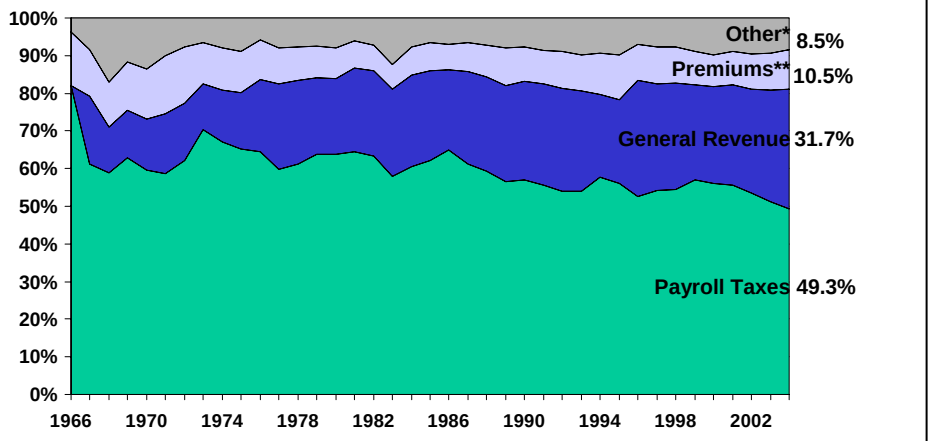
Medicare Funding Sources

Since 1966, Medicare has been financed by three main sources of revenue. Part A, the Hospital Insurance Program, covers inpatient hospital stays, skilled nursing facility care, hospice coverage, and some home health services. It is primarily funded by a dedicated payroll tax and a small amount of the taxation of Social Security benefits. Part B, the Supplementary Medical Insurance Program, covers physician services, hospital outpatient care and other ambulatory needs. It is funded by a combination of general revenues (75 percent) and beneficiary premiums (25 percent). Part D, the new Prescription Drug Benefit that begins in 2006, is funded in the same way as Part B.

Because Medicare benefits have been divided into separate parts, each with different funding sources, and because the size of each part of Medicare has changed over time, the share of revenues coming from different sources has also varied. In 1970, payroll taxes provided the majority of Medicare funding, while general revenues and beneficiary premiums each accounted for approximately 14 percent of total Medicare revenues (Figure 1). In 2004, payroll taxes were 49 percent, general revenue was 32 percent, and beneficiary premiums were 11 percent of total Medicare revenues.

Figure 1

Income of the Hospital Insurance and Supplementary Medical Insurance Trust Funds by Source, 1966-2004



Note: *Includes income from taxation of Social Security benefits, railroad retirement account transfers, reimbursement for uninsured persons, payments for military wage credits, recoveries of amounts reimbursed from the trust fund which are not obligations of the trust fund, amounts from the fraud and abuse control system, interest, and a small amount of miscellaneous income. **Includes premiums from voluntary enrollees in the Hospital Insurance Program and all enrollees in the Supplementary Medical Insurance Program.
SOURCE: Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, various years.

The New 45 Percent Measure

The new measure of Medicare's financial health established by the MMA responds to the concern that policymakers need a comprehensive measure that looks at spending and revenues for all parts of the Medicare program, rather than relying exclusively on the projected insolvency date of the Part A Trust Fund. Although Medicare now consists of Part A (the Hospital

Insurance program), Part B (the Supplementary Insurance Program), and Part C (which is not separately financed), the most-often cited indicator of Medicare's financial health—the projected date of exhaustion of the HI Trust Fund—relates only to Part A of Medicare.

The new 45 percent measure uses revenue and spending amounts for the existing Parts A and B of the Medicare program, and Part D, the prescription drug benefit (beginning in 2006). In that sense, it encompasses all of Medicare, but it focuses on only one of Medicare's three main funding sources. As stated earlier, Medicare is mainly financed through general revenues, the payroll tax, and beneficiary premiums. The new measure defines funding as being *imbalanced* when the share of total Medicare spending coming from general revenue rises above 45 percent. The Medicare Trustees are required to issue a funding warning if, in looking ahead for the current and next six fiscal years, general revenue funding is projected to exceed 45 percent of Medicare's spending at any time during that period. Any amount of general revenue that exceeds 45 percent of Medicare's spending will be categorized as "excess general revenues."

The calculation of excess general revenue funding established in the MMA is based on several factors. "Dedicated" revenues are named specifically in the legislation and are generally those that are earmarked for Medicare. The most important of these are payroll taxes and beneficiary premiums. "General revenues" are then defined as the amount remaining after subtracting "dedicated revenues" from total spending.[2] This measure of "general revenues" is the amount needed to fully fund Medicare beyond what the "dedicated" revenue sources bring in. As **Table 1** indicates, in 2006, Medicare's "dedicated" revenues are projected to total $249.8 billion. Dedicated revenues are subtracted from total spending of $433.5 billion, and the difference of $183..7 billion is reported as "general revenues."

Table 1
Calculations of "General Revenue" Share

	Fiscal Year	
	2006	**2012**
Total Spending	$433.5	$643.3*
Minus "Dedicated Revenues"	249.8	351.6
Equals "General Revenues"	183.7	291.7
General Revenue Share of Total Spending	42.4%	45.3%

Source: Unpublished data from CMS OACT, 2005.
*Spending in 2012 is adjusted upward since that year has only 11 managed care payments instead of the usual 12. This also affects estimated general revenues.

This dollar amount for general revenues is then compared to total Medicare spending projected for the year. General revenues are considered to be in excess if, as a share of total spending, the amount exceeds 45 percent. In 2006, the general revenue share would be 42.4 percent ($183.7 billion divided by $433.5 billion). It is noteworthy that the addition of the new prescription drug benefit to the Medicare program in 2006 results in a substantial increase in the general revenue

[2] In the past, general revenues in the reports include only the federal contributions made to Part B. And, since the new Part D benefit will be financed in the same way as Part B, it is natural to also include these revenues as well. But, the new MMA measure also adds elements of spending from Part A, as described in Appendix A.

share of Medicare funding, from 35 percent in 2005 to 42.4 percent in 2006. Like Part B, the drug benefit is largely financed through general revenues.

In their 2005 annual report, the Medicare Trustees stated that the measure will likely first exceed 45 percent in 2012. Between 2006 and 2012, as shown in Table 1 spending is projected to increase faster than "dedicated taxes," resulting in a higher required general revenue contribution. Thus the general revenue share rises to 45.3 percent. Because a funding warning would be issued when the 45 percent share will be reached within six years, the first warning would be triggered in 2006 if the 2005 projections remain basically the same in 2006.

According to the MMA provision, an excess general revenue funding warning made in two consecutive annual reports triggers a set of required responses from the President and the Congress. First, the President must include in his next budget submission a proposal to respond to the warning, presumably one that would bring the general revenue share below 45 percent. The two houses of Congress must then respond. The Majority and Minority leaders of both the House of Representatives and the Senate are required to introduce the President's proposal within three legislative days of receiving the bill. The relevant committees are required to report out this legislation (or any bill that is entitled "A bill to respond to a Medicare funding warning") by June 30 with a vote taken in the full House by July 30. If the House fails to pass this legislation, special fallback procedures may be triggered to discharge legislation that has been certified by the Budget committee as having eliminated the excess general revenue funding for the entire seven-year reporting period.

It is more difficult to require a vote on the President's proposal in the Senate. The requirements are initially the same as for the House for introduction of a bill and its submission to committee. If the committee (in this case, the Finance committee) does not report on Medicare financing legislation by June 30, any Senator may move to discharge from the committee any bill entitled "A bill to respond to a Medicare funding warning" as long as the legislation has been passed by the House of Representatives or contains matter within the jurisdiction of the committee on Finance in the Senate. Only one motion to discharge is in order in the Senate. Debate on the motion to discharge is limited to two hours and no amendments may be offered. If the full Senate approves the discharge motion, any member may move to proceed to consideration of the legislation. However, there are no fast-track procedures in the Senate that guarantee floor consideration or a vote.

In practice, it will be difficult to ensure that Medicare legislation proposed in response to the general revenue funding warning will pass, but the law makes it easier to consider such a bill as compared to other legislation (particularly in the House). Thus, while the 45 percent measure does not *require* a policy response to the warnings, it sets the stage to facilitate a change in the law relating to the Medicare program.

The Measure as an Impetus for Policy Change

The financial status measures for Medicare that are currently produced do not require a legislative response. As established, the 45 percent measure facilitates a call to action and restricts what actions can reasonably be taken. If the preliminary estimate in the 2005 Trustees

Report is correct that the general revenue share will rise above 45 percent in 2012, an initial warning would be triggered in the 2006 report. This is the same year in which the new drug benefit—which will be a major factor generating the funding warning—goes into effect. That is, adding the drug benefit will cause general revenue contributions to rise by over 7 percentage points between 2005 and 2006. If another funding warning were to follow in 2007, the President would need to start the required legislative process by early 2008.

The new measure effectively limits what policy changes can be implemented. By indicating that general revenues should be limited to a specific share of Medicare's funding, it means that only increases in funding from other "dedicated" revenue sources or from cuts in Medicare spending would reduce the excessive general revenue share. To meet the goal of lowering general revenue's share, any new funding sources must be created as dedicated funding sources. Thus, some funding sources will effectively be preferred over others simply because of the definitions established in the new measure.

For example, the measure implicitly favors use of payroll tax funding for Medicare over general revenues (which mainly consist of income tax receipts), although many would argue that an income tax is fairer in a number of ways. The income tax is more progressive, relieving low-income persons of having to pay taxes, while the payroll tax is assessed on the first dollar of wages. And, a larger share of the income tax is paid by Medicare beneficiaries as compared to beneficiaries' contributions to the payroll tax. Thus, those who are concerned that well-off seniors and people with disabilities pay a greater share of Medicare costs might prefer using the income tax to support Medicare.

Another funding source that could be used to reduce the general revenue share, added by the MMA, is the income-related premium. Since the amount raised by that premium will increase the share that beneficiaries pay for Part B services, this will help reduce general revenue contributions. However, the new premium does not go into effect until 2007 and then is phased in gradually. Thus, it is not expected to initially have much of an effect on revenues. Over time, however, it could have a larger impact, especially if the income limits were lowered, thereby increasing the share of the Medicare population affected by this premium.

Benefit reductions are another potential policy response to a funding warning, which would reduce total Medicare spending and hence the general revenues needed to fund the program. Part B premiums or cost sharing also could be increased. For example, additional funding could come from rolling back the extra payments currently being used to attract private plans to the Medicare program or to subsidize care in rural areas.

To understand how potential types of policy responses could have differential impacts on who bears the burdens and how the program could change over time, consider four hypothetical changes that could be put in place in 2012 in reaction to a funding warning (see Table 2 below). The four illustrative options include: an increase in the payroll tax, an increase in the Part B or D premium, a reduction in spending for Part B benefits, and a reduction in spending for Part A benefits. Each of these policy changes would reduce general revenue spending by $50 billion in 2012.

Increase the payroll tax. To obtain $50 billion in new dedicated revenues, the payroll tax would need to be increased by 21 percent. This would bring the tax rate on both employers and employees to just over 1.75 percent of wages. On a per worker basis, this would mean an increase of an average of $143 each on employers and employees in 2012. Because of the artificial way in which general revenues are calculated—that is, as what is left after subtracting dedicated taxes from total spending—"general revenue" contributions will fall by an amount equal to the payroll tax increase. If this were done in 2012, as shown in Table 2, the general revenue share would fall to 37.5 percent, and would delay until 2017 any excess funding warning. But, the *overall* level of spending would be unchanged. Revenues would simply shift from the general revenue category to the dedicated category. This policy option would not address concerns about the overall level of Medicare spending.

Increase Part B or Part D premiums. An increase in the Part B or D premiums to bring in an additional $50 billion in 2012 would have exactly the same impact on the 45 percent measure as the payroll tax increase shown above. Since premiums are also part of dedicated revenues, the same exchange between dedicated and general revenues would take place. But the impacts on taxpayers and beneficiaries would be quite different. To raise $50 billion in Part B premiums would result in a 90.6 percent increase in the premium in 2012, from an estimated $99.70 per month to $190 per month. When combined with estimated Part D premiums, the annual beneficiary premium contribution would total $2,946—which is $1,084 more than currently estimated.

Reduce Part B spending. Another response to a general revenue funding warning could be to reduce benefits. Consider a cut in Part B spending equal to the $50 billion that the tax or premium increase above would generate. This would be equivalent to cutting the Part B benefit by a little less than one-fourth in 2012. Deductibles and co-pays would have to be realigned so that the benefits would be about 77 percent of the level projected under current law. Consequently, total Medicare spending would fall by $50 billion. Dedicated revenues would fall modestly (since the premium on Part B, equal to 25 percent of costs, would be reduced), and the general revenue amount needed would fall by a larger amount. In this case, the general revenue share of total spending would fall to 42.8 percent, and the 45 percent level would not be reached until 2014.

Reduce Part A spending. A $50 billion reduction in Part A spending would have a larger impact on the general revenue share than an equivalent decrease in Part B because beneficiaries generally do not pay a premium for benefits covered under Part A. According to the calculation, the full $50 billion reduction in spending would thus decrease needed general revenues.[3] In 2012 the share of general revenues as a percent of total spending would fall to 40.7 percent, and delay the excess funding warning until 2015. Spending reductions under Parts A or B would have direct and indirect affects on beneficiaries, likely increasing their out of pocket costs or affecting access to care. The impact would vary depending upon which services faced higher co-pays or coverage reductions.

[3] According to the formula, a cut in Part A spending should "free up" payroll taxes to be used to fund Part B and D services. Under the law, however, the Part A Trust Fund cannot be used for that purpose.

Not all changes in Medicare will have an equal impact on the general revenue share. Because of how the general revenue share is calculated, a cut in spending actually reduces the percentage share by less than an equal dollar increase in payroll taxes or premiums. This could bias the incentives to respond to the funding warning with an increase in dedicated taxes.[4] The policy choices implicitly dictated by the 45 percent measure likely would be either to increase the payroll tax, which is often criticized as hurting employment over time, or to adopt policy changes that would directly or indirectly disadvantage beneficiaries by assessing higher premiums (either flat or income-related) or reducing benefits. Few policy makers are likely to be indifferent to the type of policy changes that might be made, and any of these decisions ought to be made with careful consideration of the goals of the Medicare program. An even more basic question, however, is whether this new measure is a helpful tool or one that should lead to policy change.

Table 2
Effects of Alternative Changes of Equal Magnitude on 45 Percent Measure *
General Revenue Spending Reduction Target = $50 Billion

	Policy Change Required		
	Payroll Tax Increase of 21%**	25% Reduction in Part B Spending	20% Reduction in Part A Spending
Total Medicare Spending	$643 billion	$588 billion***	$588 billion***
Minus Dedicated Revenues	402 billion	338 billion	352 billion
Equals General Revenues	241 billion	250 billion	236 billion
General Revenues as Share of Total Spending	37.5%	42.6%	40.2%
Revised Date for General Revenue Share to Exceed 45 Percent	2021	2018	2020
Who bears burden	Taxpayers	Beneficiaries	Beneficiaries

*Changes over time are assumed to grow at the same rate as payroll taxes to keep dollars the same through time
**The 21 percent payroll tax increase would be equivalent to a 90.6 percent increase in the Part B premium; the burden of a premium increase would be on beneficiaries, not taxpayers.
*** Spending levels assume policy change

The Validity of the New Measure for Identifying Financing Problems with Medicare

Presumably, a key objective of the 45 percent measure is to alert the President and the Congress to a financing *crisis* for Medicare. In fact, it does not appear that the measure would accomplish

[4] Actually, if the drug benefit were subject to higher premiums as a means for "reducing" the benefit, spending would not fall, but dedicated taxes would rise in the same way that they do for the payroll tax increase since both are considered dedicated taxes.

this goal. It does not measure the total amount of federal government resources used to support the Medicare program, the relative growth in overall Medicare spending, or the amount of society's resources necessary to fund the program.

By focusing on only one source of Medicare financing, the "problem" of excess general revenues could simply be "fixed" by raising payroll taxes or other new dedicated revenue sources. If the issue of concern is to signal when Medicare becomes so large that it crowds out other government spending or is in some other way deemed unaffordable, the 45 percent measure will not necessarily identify the problem. The measure will provide an inadequate picture at any point in time because it examines only part of the revenues (the general revenue share) going into Medicare.

The 45 percent measure could lead to Medicare policy changes as a result of events that are not necessarily adverse or cause for alarm about the program's financial solvency. For example, if enrollment in Medicare prescription drug plans rises more rapidly than anticipated or if drug use goes up by more than expected among certain groups of beneficiaries who previously lacked access to prescription drug coverage, policy makers would likely view these circumstances as desirable outcomes of the MMA. However, the resulting spending increase would lead to an increase in the general revenue share and speed up the triggering of a general revenue funding warning.

Comparing the 45 Percent Measure with Other Indicators of Medicare's Financial Status

Critics have argued that the existing measures of Medicare's financial health are insufficient to address the full range of financing issues facing the Medicare program. The most commonly reported measure of Medicare's financial health has been the number of years before Medicare's Part A Trust Fund is exhausted. At that point, new legislation would be necessary in order to pay Part A benefits. The solvency test is one indicator of Medicare's financial status. (Table 3 summarizes this and other measures that can be used to assess Medicare's financial health.) But this indicator does not include any consideration of Part B (or Part D) of Medicare, and hence only offers a partial look at the program.[5] Since Part B spending has been rising faster than Part A over time, policymakers concerned about Medicare's future have often called for alternative measures of Medicare's financial health that are more comprehensive. The addition of Part D increases the need to assess the overall financial status of Medicare.

However, other measures, in addition to the Part A solvency test, are included in the Medicare Trustees' Annual Reports that can help to put overall Medicare spending into an appropriate context. One often-reported statistic, for example, is the number of workers per beneficiary over time. This illustrates the potential increasing burden on workers and implicitly captures the issue for all of Medicare.

Probably the most important indicator in the Trustees' annual report on the *overall* costs of Medicare is the share of Gross Domestic Product (GDP) that will be devoted to Parts A, B and D

[5] Although Part B also has a trust fund, the law requires that it be kept in balance by the addition of general revenues as needed.

if the program continues with the same rules and regulations as currently apply. This measure indicates what share of resources generated by the U.S. economy will be required to support Medicare each year. The 2005 Medicare Trustees' Annual Report indicates that by 2030, combined Medicare spending (including the new drug benefit) is expected to reach 6.8 percent of GDP, up from 2.3 percent in 2000. It is also easy to use these numbers to estimate the rate of growth of the different parts of the program. For example, Part A grew 179 percent as a share of GDP between 1970 and 2003, while Part B grew 414 percent. The rapid growth in Part D spending in the future is captured in this measure as well.

Table 3
Measures of Medicare Financial Status

Measure	Where Found	Pros & Cons	Requires Policy Response	A Comprehensive Look at Fiscal Status?
45 Percent General Revenue Share of Total Medicare Spending	Trustees Report	• Includes spending from all parts of the program (A,B and D) • Captures only the general revenue share of spending. ▪ Establishes arbitrary measure of fiscal "problem". ▪ Gives false positives/negatives about problems.	Yes	No
Date of Part A Trust fund exhaustion	Trustees Report	▪ Only measures Part A financial health. ▪ Indicates when benefits can no longer be paid	Implicitly	No
Ratio of Workers to Beneficiaries	Trustees Report	▪ Captures demographic challenges but ignores economic growth. ▪ No context for interpreting what ratio is "acceptable".	No	No
Medicare as Share of GDP	Trustees Report	▪ Reflects all Medicare spending as share of economic output. ▪ Does not put share in context for interpretation. ▪ Leaves determination of problem size to reader.	No	Yes

The share of GDP measure differs from the new 45 percent measure in two important ways. First, it focuses on total spending and hence captures the full picture of what it would cost to support the Medicare program. Since it is expressed as a share of GDP, it offers information on the affordability of Medicare relative to the size of the output of goods and services by the economy as a whole. Spending as a share of GDP also can be linked to other federal government spending and hence create an estimate of the size of Medicare related to all federal spending.

Second, the GDP-share measure does not come with an explicit cutoff indicating when a financial crisis is at hand. It lacks the provision attached to the 45 percent measure that triggers a policy response from the President and Congress. Although there is no automatic warning mechanism, the GDP measure circumvents the question of whether the excess general revenue funding warning established by the MMA is a valid indicator of a financial crisis in Medicare.

Other Issues Concerning the 45 Percent Measure

The 45 percent measure may affect the Medicare program in a number of unexpected ways. By creating a crisis to which the President and Congress are required to respond, the entitlement nature of Medicare may be affected. An entitlement program is one that is not subject to the vagaries of annual appropriations decisions, but this new measure and its requirements could begin to move the Medicare program away from the protection that entitlement status bestows. Periodic calls for changes in Medicare from the excess funding warnings could result in more frequent benefit changes, reducing the ability of individuals to plan for their health care costs into the future.

Further, the measure implies changes in Medicare that are not allowed under current law. Technically, the 45 percent measure would reduce the amount of general revenue funds needed in a particular year if payroll taxes were increased or Part A spending was reduced. If payroll taxes are not needed to cover Part A spending, the measure implicitly assumes that excess payroll taxes in any given year could be used to fund some Part B or Part D expenses. However, this runs counter to what current law allows. As the 2004 Trustees' report states: "Under current law, the HI and SMI trust funds are separate and distinct, each with its own sources of financing. There are no provisions for using HI revenues to finance SMI expenditures or vice versa." (p. 31).

Further, no "credit" is given for any revenue that is used to increase the Part A Trust Fund balance. Effectively this means that if the payroll tax is raised and generates revenues beyond what Part A requires in that year, no credit is given for building up the Part A Trust Fund. This is contrary to the way that payroll tax revenues are treated in other sections of the Trustees' Report and how the HI Trust Fund has been characterized over time. The measure treats Medicare as if it were being funded only on a "pay as you go" basis.

Finally, it is important to note that the 45 percent level used to identify a financing problem is not derived from any analysis or discussion among policy makers about the appropriate share of funding that should come from general revenues. When a similar measure was proposed by the

co-chairs of the 1998-99 Bipartisan Medicare Commission, the general revenue target was 40 percent—again offered with no supporting analysis.

Conclusion

During the brief debate over the final version of the MMA legislation (in which the 45 percent measure was included for the first time) and immediately after its passage, supporters sought to downplay the measure by indicating that it did not require any change in policy, but only that policy changes would have to be considered. This claim is correct—the requirements only dictate that the President draft a proposal and that the Congress consider it via an expedited process. Nonetheless, the announcement of problems with Medicare's financial status operates as a strong imperative for action. Terms such as "preserving" or "saving" Medicare are often used in these cases to justify policies to reduce spending levels. For example, Oberlander points out the strong historical relationship between earlier notices that the Part A Trust Fund was in trouble and legislation cutting spending on Medicare.[6] Impetus for the 1997 changes in Medicare resulted from debates that began in 1995 when the Part A Trust Fund was expected to be exhausted within just a few years. Consequently, it is reasonable to assume that an "excess funding warning" would provide strong political support for making further changes in the Medicare program.

The 45 percent measure represents a major change in how Medicare's financial health is currently reported, and could either prematurely or inaccurately signal a problem or fail to indicate a rapid increase in the overall level of Medicare spending if payroll or other taxes are increased over time. Thus, it is a flawed measure from the perspective of both policymakers who wish to expand the Medicare program or at least maintain it over time at close to its current level, as well as those policymakers who believe that Medicare spending is too high already. As noted in the examples shown, even dramatic reductions in spending would only postpone the excess funding warning for a few years.

Determining whether Medicare spending is affordable from society's perspective would likely be based on the share of the economy devoted to expenditures on this program, and whether, after a debate on its value alone and in comparison with other desires, it should be expanded or curtailed. If society's concern is that spending on Medicare should be lower or should grow at a slower rate over time, then a target for overall spending—in dollars or as a share of GDP—would be a better measure to use to generate a funding warning. This type of measure would address affordability and not just willingness to use a particular type of revenue. Over time, the 45 percent measure may have far-reaching impacts on the Medicare program and how it is viewed. Therefore, a broad-based debate on what this new measure implies and whether it is consistent with the goals for the Medicare program or how the program does and should operate ought to be undertaken well before an "excess funding warning" is issued.

[6] Jonathan Oberlander, *The Political Life of Medicare,* 203.

Appendix A
A New Way of Calculating "General Revenue"

The calculation of "general revenue" used in the 45 percent measure differs from how general revenue figures cited elsewhere in the Medicare Trustees' Annual Report are calculated. If measured as in the past, the focus would be on the general revenue contributions needed for Medicare Parts B and D, and the total for 2006 is $178.7 billion. However, the 45 percent measure uses an amount for general revenue that is calculated by subtracting "dedicated revenues" as defined by the MMA from total Medicare spending. Using this definition, the "general revenue" amount for 2006 ($183.7 billion) is $5 billion greater than the $178.7 million in general revenues for Parts B and D reported by the Medicare Trustees.

Table A1 categorizes the various sources of revenues as those which are "dedicated" and those which help support Medicare but are not included in the definition of "dedicated" revenues. In Part A, two sources of revenue are not treated as dedicated. First, several contributions required by law for Part A help to defray costs for specific populations such as Railroad Retirees. Second, revenues from interest on the Part A Trust Fund ($15.6 billion in 2006) are excluded. This exclusion of income from Part A is the major source of difference in the measure of general revenue.

The Medicare Trustees state that there is no shortfall between spending and income for the Part A Trust Fund since the interest payments of $15.6 billion will be more than enough to fill in the gap. Indeed, the current way of reporting Part A revenues and spending results in an increased balance in the Part A Trust Fund because interest payments of $15.6 billion exceed the difference in current tax revenues and spending. The Part A Trust Fund is projected to end the year with a balance of $293.8 billion. However, using the new way to calculate general revenues, $1.2 billion in general revenues are needed to fully finance Part A in 2006.

Table A1
Calculations of "General Revenue" and General Revenue Share of Medicare Spending (MMA Definition)

	2006 Fiscal Year Projections in billions*	
	New Medicare Calculations	**Other Revenue Sources**
Part A		
Total Spending	$191.2	
Revenues		
"Dedicated Sources"	$190.0	
Interest on Trust Fund		$15.6
Transfer for Railroad Retirement & Uninsured		$0.8
"General Revenue"	$1.2	
Parts B and D		
Total Spending	$242.3	
Revenues		
"Dedicated sources"	$59.9	
General Revenue**		$178.7
Interest on Trust Fund		$1.9
"General Revenue"	$182.4	
Total "General Revenue"	$183.7	
Total Medicare Spending	$433.5	
"General Revenue Share"	42.4%	

*The first column indicates how general revenues are calculated in the new measure, in which residual left after subtracting "dedicated" sources of revenue from spending yields the new "general revenue" amount. The second column indicates other revenues to Medicare as commonly reported.
**General revenue as normally defined.

Appendix B
Explaining Growth in the General Revenue Share of Medicare Spending

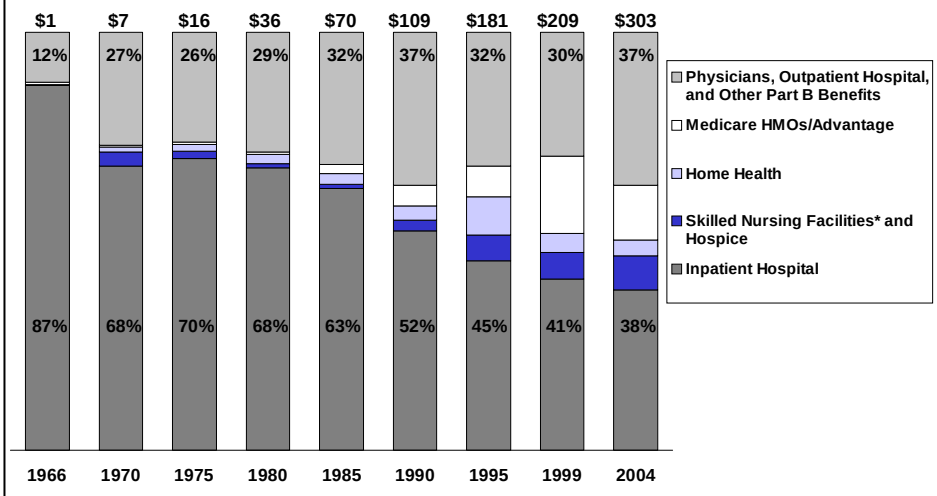
Growth in the general revenue share of Medicare funding has occurred for two main reasons. First, when the Medicare legislation was passed, beneficiary premiums for Part B were automatically set to equal 50 percent of Part B spending, with the remainder coming from general revenues. As Medicare Part B spending grew, the Part B premium consumed an ever-larger share of beneficiaries' Social Security checks. Legislation in 1976 changed the calculation of the Part B premium to grow at the same rate as Social Security benefits. Beginning in 1982, the premium was temporarily held at 25 percent of Part B costs, and in 1997, the law was changed to set the share at 25 percent permanently. This naturally resulted in growth in general revenue contributions for Part B, which make up the remaining 75 percent difference.

A second reason for the increase in general revenue funding has resulted from changes in the delivery of health care for people of all ages, whereby more services and procedures are now delivered in places other than inpatient hospital settings, such as hospital outpatient facilities, surgi-centers, and even physician's offices. Therefore, a sizeable share of Medicare benefits spending has shifted from Part A to Part B of Medicare. Figure B1 shows how Medicare benefit payments shifted between 1966 and 2004, with Part B benefits spending growing from 12 percent of total benefit payments to 37 percent in 2004. Because general revenues increase automatically to cover the 75 percent portion of Part B spending not paid by premiums, the share of funding from general revenues has naturally risen over time.

In the future, a third factor—the Medicare prescription drug benefit—will work to increase the general revenue share of Medicare funding. When the drug benefit begins in 2006, general revenue contributions will rise substantially. From 2005 to 2006, the share will increase by over 4 percentage points.

Figure B1

Distribution of Medicare Benefit Payments, Calendar Years 1966-2004



Note: *Coverage for skilled nursing facilities was effective January 1, 1967. Total includes expenditures for ESRD beneficiaries, but excludes administrative payments.
SOURCE: All data are from the Health Care Financing Administration (Office of the Actuary, Medicare and Medicaid Cost Estimates Group), December 2000, except for 2004 data, which are from the 2005 Annual Report of the Medicare Trustees.

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