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OVERLOOKED ELEMENT OF MEDICARE TRUSTEES' REPORT COULD SPELL TROUBLE FOR BENEFICIARIES IN FUTURE YEARS

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The report that the Social Security and Medicare trustees issued March 23 on the state of Medicare's finances contains a key "finding" that has been largely overlooked in initial discussion and media coverage of the report. The Medicare drug law enacted last December contains a provision requiring the trustees to estimate in each of their annual reports the point at which general revenues will finance at least 45 percent of Medicare costs. Once the trustees estimate in two successive reports that this 45-percent level will be reached within the next six years, the President is required to include a proposal in his next budget — and to submit legislation within 15 days of the budget's release — to alter Medicare so the 45-percent threshold will not be exceeded. The Congressional committees with jurisdiction over Medicare must then report the President's proposal or other Medicare legislation by June 30.

The new trustees' report projects that the 45-percent level will be reached in 2012, eight years from now.[1] If this projection remains unchanged in future trustees' reports, the trigger date (i.e., the date on which two consecutive reports project that the 45-percent level will be reached within the coming six years[2]) will come in just three years, when the trustees issue their 2007 report.

Ensuring that policymakers begin to address Medicare's long-term financing problems soon is important. The Medicare Hospital Insurance program is projected to become insolvent in 2019, and Medicare expenditures are projected to rise rapidly in coming decades as the baby-boom generation retires and health care costs continue to increase. A trigger that would prompt Presidential and Congressional review of measures to extend the solvency of the Medicare Hospital Insurance program and address the larger budgetary issues raised by the rising costs of health care — and hence of public health insurance programs such as Medicare — might be quite useful. But the new 45-percent trigger is *not* designed to address these challenges. To the contrary, the 45-percent threshold is an arbitrary benchmark laden with ideological overtones and inconsistent with Medicare's basic financing structure. That the 45-percent level will soon be reached is of little significance. Indeed, the 45-percent threshold will be reached even if Medicare costs rise much more slowly than is now projected.

Furthermore, complying with the 45-percent threshold will *rule out* certain approaches to strengthening Medicare's finances, rather than allowing all approaches to be on the table. By and large, the only approaches that could be considered would be those favored by individuals on

[1] See "2004 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," March 23, 2004, pages 29 and 30.

[2] Technically, the trigger date is the date on which two consecutive trustees' reports project that the 45-percent level will be reached within a seven-year period that includes the current year and the six subsequent years.

the right of the political spectrum. As this analysis explains, the 45-percent trigger seems designed more to rule out scaling back any part of the 2001 and 2003 tax cuts and using the proceeds to help address even a fraction of Medicare's financing needs than to address Medicare's solvency problems forthrightly.

Marilyn Moon, a former Social Security and Medicare trustee who is widely regarded as one of the nation's leading Medicare experts, recently observed that the 45-percent measure "is a measure that actually makes very little sense the more you look into it" and is "a measure that not only is indicating a warning but it essentially limits the options that you have to finding a solution." Moon commented that establishing a trigger that would be pulled when Medicare expenditures reach a certain share of the U.S. economy would represent a far sounder policy.[3]

Moon also noted that Medicare's financing problems are sufficiently large that long-term solutions almost certainly will need to include changes in health care generally, reforms in Medicare, *and* additional general revenues. If revenues are not a part of the solution, Moon observed, Medicare cuts will have to be severe. "[The] solution is not going to be an easy one to come up with, and it probably cannot be done and keep a viable Medicare program without tax increases at some point in the future," she said. But the 45-percent threshold is designed largely to take general revenue increases off the table, intensifying the pressure for cuts in Medicare that ultimately would have to become extremely deep.

Background: The 45-Percent Provision and the Problems It Poses

As a result of a provision added to the Medicare drug legislation in the closed-door conference that produced the final bill, the Medicare trustees now are required to include in their annual reports a projection of the year in which general revenues will finance at least 45 percent of overall Medicare expenditures.[4] Once two consecutive annual trustees' reports show this 45-percent level will be reached within the next seven years, the trustees are required to issue a warning that triggers Presidential and Congressional action, as described above. The 2004 Medicare trustees' report released on March 23 projects that general revenues will cover 45 percent of total Medicare expenditures starting in 2012.

This new statutory requirement — and the projection that the 45-percent threshold will be reached in 2012 — may create an impression that this benchmark is an important measure of Medicare's overall financial health and that 2012 is an important date, following which Medicare's finances will be in substantial danger. Neither is the case.

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[3] All citations of statements by Marilyn Moon come from presentations and comments by Moon in two audio-conferences sponsored by the Center on Budget and Policy Priorities on March 23, 2004. Transcripts are available from the Center.

[4] In directing the trustees to calculate the percentage of Medicare expenditures financed by general revenues, the Medicare drug law requires the percentage to be computed in the following manner. The trustees calculate the percentage that total Medicare expenditures minus dedicated revenues (i.e., minus revenues *other than* general revenues) make up of total Medicare expenditures. Dedicated revenues are defined in the Medicare drug law as Medicare Part A payroll taxes, the portion of income taxes on Social Security benefits that is dedicated by law to the Medicare Part A trust fund, Medicare beneficiary premiums, and "clawback" payments from state Medicaid programs, which will finance a portion of the cost of the Medicare drug benefit for low-income beneficiaries who are enrolled in Medicaid.

The 45-percent level is an artificial threshold that has no substantive merit. By law, Medicare is *supposed* to be financed in substantial part by general revenues, not payroll tax revenues. Furthermore, an increase over time in the share of Medicare costs that is financed by general revenues is not necessarily a sign of trouble, since such an increase can indicate that progress is being made in reducing the rate of growth in Medicare hospital expenditures.

- Under Medicare's financing structure, the Medicare Hospital Insurance program (Medicare Part A) covers hospital costs and is financed through payroll taxes. The remainder of Medicare — Part B, which covers physician and other outpatient services, and Part D, which provides the new drug benefit — are designed to be financed with general revenues rather than regressive payroll tax revenues. That these parts of Medicare are financed with general revenues is no more problematic than that defense, education, veterans' benefits, Medicaid, the war on terrorism, or most other parts of the budget are financed by general revenues. Moreover, nothing in Medicare law bars the general fund from paying Part B and Part D benefits if general-fund financing reaches 45 percent of total Medicare costs. To the contrary, the federal government is required by law to use general revenues to the full extent needed to pay Part B and Part D costs that are not covered by beneficiary premiums.

- The 45-percent threshold is certain to be reached in coming years for two reasons. First, Congress and the President specifically elected to fund the new drug benefit with general revenues (and beneficiary premiums), rather than payroll taxes. This decision increased the share of Medicare costs that are financed with general revenues.

- The second reason that the 45-percent threshold is certain to be reached — and that the share of Medicare costs financed by general revenues is projected to continue rising in future years — is that total Medicare expenditures are projected to rise more rapidly than dedicated revenues. The payroll tax — the main source of dedicated revenues — generally grows more slowly than the economy because an increasing portion of income is received in forms not subject to the payroll tax, such as untaxed fringe benefits, capital gains, and dividends. In contrast, Medicare expenditures — whether for hospitalization, outpatient care, or prescription drugs — are projected to grow faster than the economy for the indefinite future. Under the formula in the new prescription drug law, this mismatch in growth rates will cause the share of Medicare costs that is financed by general revenues to rise toward 45 percent and ultimately well past it, even if Medicare expenditures grow more slowly than expected in coming years.

- Adding to these problems with the 45-percent measure, the calculation that the Medicare drug law requires the trustees to make in determining when the 45-percent level will be reached itself is flawed. The trustees are required to treat the interest that the Medicare Part A trust fund earns on the Treasury securities it holds as though this interest income were a subsidy from the general fund. But it is not, as the box on this page explains. This unjustifiable aspect of the 45-percent measure accelerates the date when the 45-percent threshold will be

Law Requires Flawed Calculation of When 45-Percent Level is Reached

Adding to the problems that the 45-percent threshold provision poses, the calculation that the Medicare drug law requires the trustees to make in determining when the 45 percent threshold will be reached is flawed. In making this calculation, the law requires the trustees to treat the interest earnings that the Medicare Part A trust fund earns on its trust fund balances as though these savings were a general fund subsidy. Yet these earnings are *not* a subsidy from the general fund.

The Part A trust fund balances currently total about $250 billion, and the trustees project that these reserves will grow to $283 billion by 2009. These balances are invested in Treasury securities and earn interest. The interest earnings are essential; interest is the way in which $1 in payroll taxes that is collected today but intended for future benefits can hold its value until it is eventually needed.

These interest earnings essentially represent dedicated trust fund revenues rather than a subsidy from the general fund. It is easy to see why. Suppose the Medicare Part A trust fund invested its balances in private financial markets rather than in Treasury securities. Those balances would still accrue earnings. Yet the general fund would not be involved; it would not be making interest payments to the Medicare Part A Trust Fund. The balances are invested in Treasury securities rather than in private financial markets because that is what federal law requires. That does not make the interest earnings a subsidy from the rest of the government to the trust fund.

Moreover, the general fund would have to pay *the same amount of interest* even if no trust fund balances were invested in Treasury securities. If the general fund of the Treasury did not borrow from the Medicare Part A trust fund to help finance general fund deficits and debt, it would have to borrow the same amount from the public instead and pay interest on it. Borrowing from the Medicare Part A trust fund and paying interest on the borrowed funds does not increase total general fund spending or total interest payments.

Despite this, the provision of the Medicare drug law that established the 45-percent measure requires that the interest the Part A trust fund earns on its balances be counted as part of the general fund financing subject to the 45-percent threshold. Medicare faces serious fiscal challenges in future decades. But this dubious accounting of the trust fund's interest income will make Medicare's financing problems look even worse than they are. This misleading accounting maneuver will cause the 45-percent threshold to be hit as much as eight years earlier than it otherwise would be reached. This maneuver also will necessitate more drastic changes in Medicare if the 45-percent threshold is adhered to.

reached by as much as eight years and ultimately will necessitate deeper cuts in Medicare unless the 45-percent threshold is disregarded.

These are among the reasons that the 45-percent general-revenue financing threshold built into the Medicare drug law is not rational. As Marilyn Moon has stated, "general revenue contributions have been in this program since 1965 when it was first passed and are an intended and not a problematic part of the program." It makes no more sense to say that the reliance of Medicare Parts B and D on general revenues is inherently problematic than to say that the reliance of the Pentagon, education, or veterans benefits on general revenues is a problem. Moon also has noted that "the 45 percent measure … is a very convoluted measure and has a lot of problems that will give you also a lot of false positives in terms of indicating a crisis."

If Congress' goal was to establish a measure to trigger review by policymakers when Medicare costs threaten to reach too high a level, a measure could have been designed to trigger such a review when Medicare costs are projected to reach a certain share of the economy or of

the federal budget. Such a measure was suggested last fall, but the designers of the Medicare drug law rejected it.

Staying Within 45-Percent Level Would Limit Options Available to Policymakers

As Marilyn Moon has pointed out, adhering to a goal of holding general-revenue financing below 45 percent of Medicare expenditures will limit the options available to policymakers. To remain below the 45-percent level will entail cutting Medicare services, raising beneficiary premiums and/or other co-payments, cutting provider payments, and/or shifting more of the burden of financing Medicare from progressive income taxes to regressive payroll taxes (and hence from wealthy taxpayers to those with more modest incomes).

- As Medicare expenditures rise over time with the aging of the population and increases in the cost of health care in the United States, the amount of revenues needed to finance Medicare will increase. The 45-percent measure is designed to limit sharply any increases in *general* revenues. If general revenues cannot exceed 45 percent of total Medicare costs, Medicare will face artificially induced financing crises that become deeper with each passing year. Moreover, the only way that the 45-percent threshold will be able to be met — other than through the regressive step of increasing Medicare payroll taxes and shifting a steadily increasing share of the burden of financing Medicare physician or drug costs from the income tax to new, dedicated payroll taxes — will be through ever-deeper cuts over time in Medicare eligibility, the medical services covered, and/or Medicare provider payments, or through increases that grow larger over time in beneficiary premiums and co-payments. To stay within the 45-percent threshold, such cuts and/or beneficiary payment increases eventually would have to reach stunning dimensions.

- As just noted, the primary revenue-raising measure that could help meet the 45-percent threshold would be to increase payroll taxes and convert part of the financing for Medicare physician and outpatient services or the new Medicare drug benefit from general revenues — i.e., from financing through the income tax — to higher payroll taxes. Such a change would be regressive, shifting tax burdens from upper-income individuals to middle-class families and the working poor.

In short, the 45-percent threshold appears designed to skew the Medicare debate by ensuring that progressive income taxes are not used to help pay for rising Medicare costs — and, in so doing, by making the burden of future increases in Medicare costs (other than increases averted through program cuts) fall entirely on increases in premiums, deductibles, and co-payments, and/or on increases in payroll taxes (and the replacement of some of the program's general-revenue financing with higher payroll tax burdens). *All* of the permissible options have one common element: they heavily shield the most affluent Americans and pass more of the costs to those lower on the income spectrum.

The 45-percent provision should be viewed as an ideological cousin to fiscal policy proposals to establish austere spending caps and erect pay-as-you-go rules that apply to expenditures for federal programs, while exempting tax cuts — and in particular, the costs of making the 2001 and 2003 tax cuts permanent — from fiscal discipline. Like these budget proposals, the 45-percent provision appears designed, in part, to protect the tax cuts enacted in 2001 and 2003, which provide extremely large tax-cut benefits to the nation's highest-income individuals, from being scaled back even modestly to help contribute to the financing of anticipated increases in Medicare costs.

The Types of Measures that Could be Considered

With measures to raise more general tax revenue essentially ruled out — and with Medicare cuts that grow deeper with each passing year becoming necessary if the 45-percent threshold is to be adhered to over time — the types of "remedies" that would be in order would include the following.

- Converting some or all of Medicare into a voucher system under which Medicare would pay a fixed dollar amount per beneficiary to subsidize the purchase of private-sector health insurance. To avoid exceeding the 45-percent level, the value of the vouchers would have to be capped, with the capped amount growing much more slowly than the rate of growth in health costs. That would cause Medicare's elderly and disabled beneficiaries to bear out of pocket a steadily increasing share of the costs of their health care.

- Gradually increasing the age at which persons would become eligible for benefits under Medicare. This would result in substantial numbers of people in their mid-to-late 60s becoming uninsured. Many such individuals would have no access to employer-based coverage and would be unlikely to obtain health care coverage in the generally unregulated individual market, given their age and, in many cases, their medical conditions.

- Increasing Medicare premiums, deductibles, and/or co-payments. Some such increases are likely to be necessary to deal with Medicare's long-term financing problems and to help address rising Medicare costs. The magnitude of the increases that would be required over time to remain within the 45-percent threshold, however, would ultimately grow so large as to risk access to health care for many beneficiaries who could not afford the payments. (While the Medicaid program helps pay Medicare Part B premiums and/or co-payments for some low-income beneficiaries, the Congressional Budget Office estimates that in 2006, some 58 percent of beneficiaries with incomes below 150 percent of the poverty line will receive no assistance with their Part B premiums and 68 percent will receive no assistance with their Part A and part B co-payments.[5])

[5] Congressional Budget Office, "Medicare Beneficiaries by Medicaid Eligibility and Asset Eligibility, CY 2006," June 2003. The CBO data also indicate that, in 2006, some 39 percent of beneficiaries with incomes below 150 of the poverty line will receive no assistance with the premiums charged for Medicare prescription drug coverage and 52 percent will receive no help with deductibles and co-payments related to drug coverage. CBPP analysis of

- Reducing provider payments. Here, as well, there would be serious risk that the depth of the reductions that ultimately would be needed to stay below the 45-percent threshold would be so great as to threaten access to Medicare, due to providers declining to accept Medicare patients.

- As noted above, converting some of the financing for Medicare physicians and outpatient services — or for the Medicare drug benefit — from general-revenue financing through the income tax to higher payroll taxes, thereby shifting more of the tax burden to the middle class and the working poor.[6]

Conclusion

The 45-percent threshold for general-fund financing of the Medicare program is arbitrary. It could lead to a mistaken belief that Medicare will face a financing crisis when the 45-percent level is reached or that keeping general-fund revenue below the 45-percent level is key to restoring Medicare's long-term financial health or to overall fiscal stability.

The parts of Medicare that cover physician and outpatient services and prescription drugs, however, are *supposed* to be financed with general revenues (and beneficiary premiums). Federal policymakers need to consider solutions that shore up financing for Medicare Part A, which is scheduled to become insolvent in 2019. They also need to address the larger problems — for Medicare, the budget, and society as a whole — posed by the continued rapid rise in health care costs in the private and public sectors alike. They should not, however, act under the false presumption that general revenues should never constitute more than 45 percent of overall Medicare financing.

Congressional Budget Office, "Table 4: Eligibility of Medicare Beneficiaries in 2006 for Low-Income Subsidies under the Conference Agreement for H.R. 1, the Medicare Prescription Drug, Improvement and Modernization Act of 2003," November 2003.

[6] One other permissible option would be to shift to the states more of the cost of providing the Medicare drug benefit to low-income beneficiaries who also are enrolled in Medicaid. The Medicare drug law contains a provision requiring state Medicaid programs to pay for a substantial portion of the cost of the Medicare drug benefit for low-income beneficiaries who are enrolled in Medicaid. This represents the first time in the history of Medicare and Medicaid that state Medicaid programs are being required to finance a substantial share of the cost of a *Medicare* benefit, and the financial burdens that this requirement will place on states will rise over time, as the population ages and drug costs continue to increase. Since the payments that states must make to the Medicare program under this requirement are considered *dedicated* revenues, requiring that states pay even more would reduce the share of Medicare that is financed by *general* revenues.

This option, too, would be regressive. To come up with the funds to make even larger payments to the federal Medicare program, states generally would have to cut other Medicaid benefits, cut other services that they provide, most of which are of benefit primarily to middle- and lower-income households, or raise taxes, which are regressive in most states.