

Medicare Finances: Findings of the 2006 Trustees Report

By Paul N. Van de Water and Joni Lavery

Summary

Medicare helps pay medical expenses for 37 million Americans age 65 and older and 6 million persons with disabilities. The benefits are financed primarily by dedicated taxes on wages and self-employment income, premiums paid by beneficiaries, and payments from general revenues. According to the 2006 report of Medicare's trustees, Medicare's Hospital Insurance (HI) program is not adequately financed. The HI trust fund is projected to start drawing down its reserves in 2010. Its reserves will be depleted in 2018, at which time scheduled income will cover 80 percent of estimated expenditures. The Supplementary Medical Insurance program is adequately financed but will require continuing increases in both premiums and general revenue contributions. Medicare spending is growing rapidly because of increases in the cost and use of medical services. Total Medicare expenditures are projected to grow from 2.7 percent of gross domestic product (GDP) in 2005 to 9.0 percent of GDP in 2050.

How is Medicare financed?

Medicare helps pay medical expenses for most people age 65 and older and for qualified disabled individuals under age 65. The program's financial affairs are handled through two trust funds, the Hospital Insurance (HI, or Medicare Part A) Trust Fund and the Supplementary Medical Insurance (SMI, or Part B) Trust Fund. The SMI trust fund consists of two separate accounts—one for Part B of Medicare (which pays for physician and other outpatient health services) and one for Part D (which pays for outpatient prescription drugs). A Board of Trustees oversees the management and investment of the trust funds and issues an annual report on their financial status. Table 1 summarizes the major features of the programs.

Part A of Medicare is funded primarily by payroll taxes on wages and self-employment income. Workers and employers each pay 1.45 percent of wages, for a total of 2.9 percent. Unlike Social Security taxes, which are not imposed on earnings above a set level, Medicare taxes are collected on workers' entire earnings. Payroll tax revenue will provide 86 percent of the income of the HI program in 2006. Interest earned on the investments of the trust funds (8 percent of the total) and income taxes on a portion of Social Security benefits (5 percent) make up most of the balance.

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Table 1
Medicare Coverage and Financing

Program Details	Hospital Insurance (HI) Trust Fund	Supplementary Medical Insurance(SMI) Trust Fund
Services Covered	Inpatient hospital, skilled nursing facilities, hospice, home health	Part B: Physicians, outpatient hospital, lab tests, medical supplies, home health. Part D: Outpatient prescription drugs
Major Funding Sources	Payroll taxes paid by workers and employers; interest earned on trust fund reserves; income taxes on part of Social Security benefits paid by upper income beneficiaries	Monthly premiums paid by beneficiaries; general revenues, which are made up largely of federal income taxes; payments from states for premiums and a portion of the cost of outpatient prescription drugs for low-income beneficiaries eligible for Medicaid
Percent of Medicare Spending in 2006	46.4 percent	Part B: 40.1 percent Part D: 13.5 percent

Beneficiaries enrolled in Parts B and D of Medicare pay monthly premiums that are usually deducted from their Social Security benefits. These premiums cover about a quarter of the cost of supplementary medical insurance. The premium for Part B is \$88.50 a month in 2006. Part D, the new prescription drug benefit, requires an additional premium, which averages about \$25 a month. The premium amounts grow each year at roughly the same rate as the increase in the cost of the programs. The remaining three-quarters of the cost of Parts B and D is financed by general revenues, which come mostly from income taxes paid by taxpayers of all ages.

Medicare beneficiaries are responsible for paying part of the cost of their care, in the form of deductibles and coinsurance for covered health services. In addition, beneficiaries are also liable for the cost of health services not covered by Medicare, which includes routine dental care, eyeglasses, hearing aids, and most long-term care.

What is Medicare's financial situation?

The Hospital Insurance Trust Fund is projected to run surpluses for the next few years but is not adequately financed beyond then. According to the trustees' best-guess (or "intermediate") assumptions, the HI trust fund will receive income of \$210 billion in 2006 and pay out \$200 billion in benefits and administrative expenses, leaving a surplus of \$10 billion for the year. At the end of the year, the trust fund will hold \$296 billion in assets. Income will continue to exceed expenditures through 2009. After that, current income and trust fund reserves will be sufficient to pay hospital insurance benefits until 2018, when the reserves are projected to be depleted. At that point, if no changes are made, scheduled HI income will cover 80 percent of estimated expenditures.

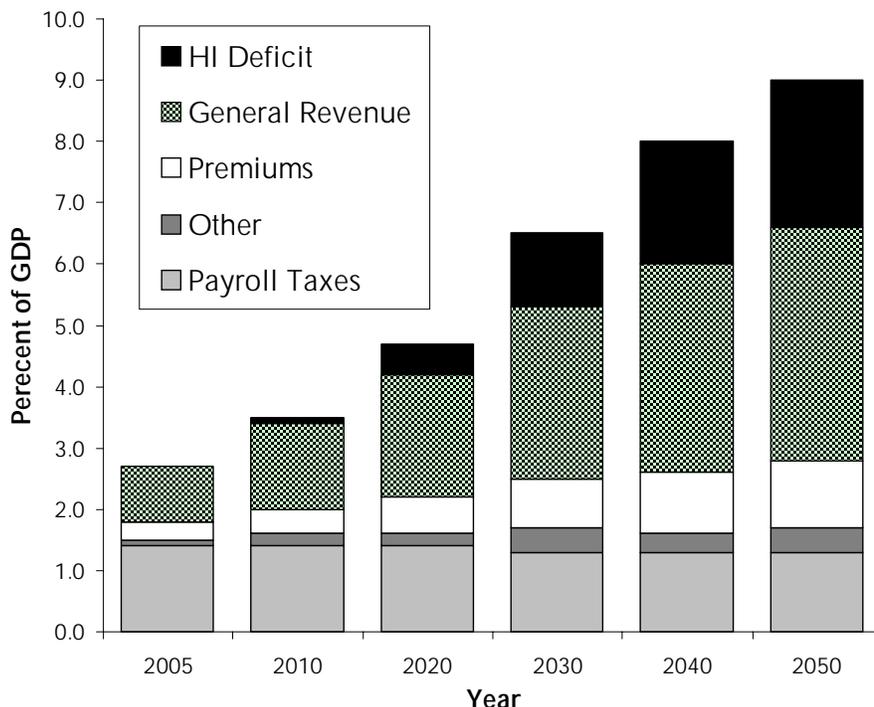
The Supplementary Medical Insurance Trust Fund is always adequately financed because beneficiary premiums and general revenue contributions are set annually to cover the expected costs of Parts B and D for the coming year. However, the rapid rate of growth in program costs will place increasing demands on both beneficiaries (to pay the premiums) and taxpayers (to provide the general revenues). The SMI trust fund will have income of \$236 billion in 2006 and expenditures of \$232 billion.

What are the long-range trends in Medicare costs?

The trustees report includes projections of Medicare’s income and expenditures over the next 75 years. There are several ways of making comparisons over such a long period of time, and here we examine two of them.

Medicare Income and Expenditures as a Percent of GDP. One way to express the growth in the total Medicare program is as a percentage of the gross domestic product (GDP), which is the total value of all goods and services produced in the United States. This measure shows how much of society’s current resources are devoted to Medicare and allows one to assess the combined costs of HI and SMI. Under the trustees’ intermediate assumptions, total Medicare expenditures will grow from 2.7 percent of GDP in 2005 to 4.7 percent of GDP in 2020 and 9.0 percent of GDP in 2050, as shown by the height of the bars in Figure 1. The components of the bars show the projected sources of financing and HI’s financial shortfall. Payroll taxes will remain relatively constant as a share of GDP, while the other sources of financing will all increase. The HI deficit will grow from 0.5 percent of GDP in 2020 to 2.4 percent of GDP in 2050 and average 1.6 percent of GDP over the next 75 years.

Figure 1.
Medicare Non-Interest Financing by Source as a Percent of GDP



Source: Board of Trustees 2006.

HI Income and Expenditures as a Percent of Taxable Payroll. The long-range estimates for the Hospital Insurance program are also often expressed as a percentage of the total earnings on which people pay Hospital Insurance payroll taxes (“taxable payroll”). Over the next 75 years, using the trustees’ intermediate assumptions, HI income will average 3.39 percent of taxable payroll, while costs will average 6.90 percent of taxable payroll, leaving a deficit of 3.51 percent of payroll over the 75 years. This means, for example, that an immediate increase in the HI payroll tax of 1.75 percentage points each for workers and employers (an increase from 1.45 percent to 3.2 percent) would close this projected deficit.

How confident can we be in these projections?

The financial projections for Medicare depend on assumptions about future birth rates, longevity, productivity, growth in health care costs, and other variables that are surrounded by considerable uncertainty. The estimates are particularly sensitive to the assumed rate of growth of health care costs relative to the rate of growth of the economy. To illustrate this uncertainty, the trustees show projections under high-cost and low-cost assumptions, as well as under the intermediate assumptions.

Two points are important to remember. First, the projections become more uncertain the further they are extended into the future. Small changes in assumptions can lead to big differences in estimated costs or revenues when projected over many decades. Second, even under the low-cost assumptions, the Hospital Insurance program is projected to run a deficit over the next 75 years.

Who receives Medicare? How much does Medicare spend per person?

In 2006, some 43 million people, or 1 out of every 7 Americans, will be enrolled in one or more parts of Medicare. Almost 37 million of them are eligible for benefits because they are age 65 or older. Another 6 million are eligible because they have been receiving Social Security disability benefits for at least two years or have end-stage renal disease.

Most Medicare beneficiaries live in families with modest incomes. In 2002, half of Medicare’s non-institutionalized beneficiaries had annual family incomes of \$20,000 or less. Only 12 percent had annual income greater than \$50,000 (Cubanski *et al.* 2005).

Medicare will spend an average of about \$10,700 per beneficiary in 2006, but the average is not very meaningful, because spending is highly concentrated in a small group of people who have large medical needs. In 2002, for example, 47 percent of fee-for-service beneficiaries incurred less than \$1,000 each in Medicare costs and accounted for only 2 percent of program spending. Seven percent of beneficiaries incurred \$25,000 or more in costs and accounted for 53 percent of spending. (Cubanski *et al.* 2005).

Beneficiaries’ out-of-pocket spending is also highly skewed. Fifty-five percent of beneficiaries spent less than \$1,000 out of pocket in 2002, but 9 percent spent \$5,000 or more. Two-thirds of this spending was for benefits and services for which Medicare provided partial or no coverage, including long-term care and prescription drugs (Cubanski *et al.* 2005).

How do the 2006 projections compare to last year's?

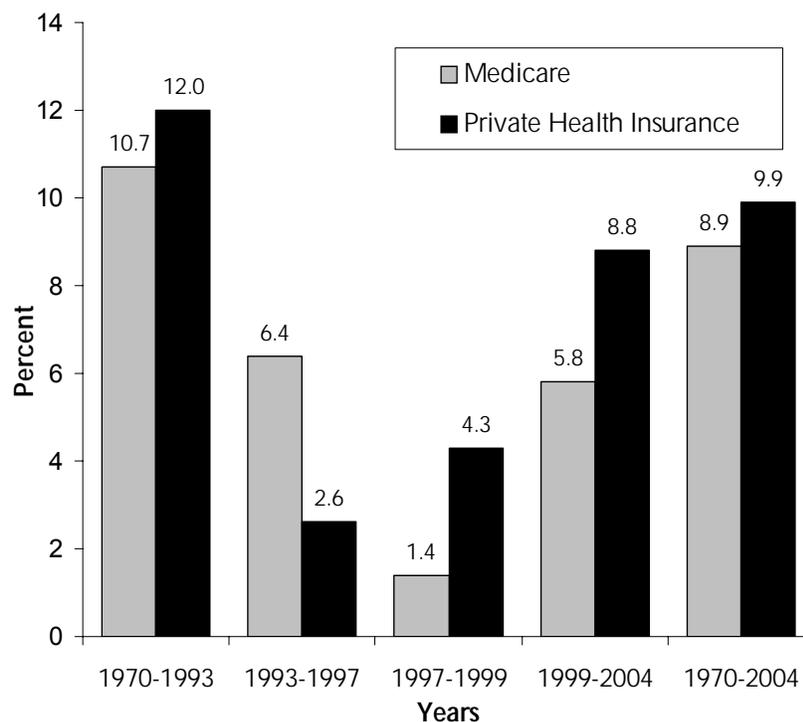
The new projections are slightly less favorable in the short run and more favorable in the long run. Hospital Insurance spending is projected to grow more rapidly, and the projected date of exhaustion of the HI trust fund has advanced by two years (from 2020 to 2018). The 75-year HI deficit has increased from 3.09 percent to 3.51 percent of taxable payroll. From 2020 onwards, however, total Medicare spending as a percentage of gross domestic product is lower than the trustees projected last year. Medicare spending is now projected to total 11.0 percent of GDP in 2080, compared to 13.7 percent of GDP in last year's report.

Why is Medicare spending growing so rapidly?

Medicare's spending is growing rapidly for the same reasons that private health spending is growing rapidly—increases in the cost and use of medical services. Much of these increases stem from advances in medical practice and technology that have enabled people to live longer and healthier lives. These technological advances have generally raised costs.

Over the years, spending for Medicare enrollees has grown at about the same rate as spending for people covered by private health insurance (see Figure 2). Medicare's costs have grown more slowly than those of the private sector in some periods, more rapidly in others, and this pattern is likely to continue. This similarity in growth rates is not surprising, because Medicare aims to provide its beneficiaries with access to the same health care services and providers as the rest of the population.

Figure 2.
Growth in Medicare Spending and Private Health Insurance Premiums per Enrollee for Comparable Benefits



Source: Centers for Medicare & Medicaid Services 2006.

The aging of the population makes only a small contribution to the growth in Medicare's costs. Over the next 75 years, the trustees project that total Medicare expenditures will grow at an average rate of 6.8 percent a year. During this period, the number of enrollees will grow by 1.2 percent a year, and expenditures per enrollee will grow by 5.5 percent a year. In contrast, GDP per capita is projected to grow by only 4.0 percent a year.

What are the unfunded obligation and the infinite horizon?

A program's unfunded obligation is a way of summarizing its funding shortfall in a single dollar number. Technically speaking, it is the difference between the present value of the projected cost of a program over a specified time period and the present value of projected income (including the initial value of the trust fund). Put another way, the unfunded obligation is the amount of money that would have to be added to the trust fund today to make the program financially sound for the specified time period.

The 2006 trustees report estimates that the unfunded obligation of the Hospital Insurance Trust Fund for past, current, and future participants is \$11.0 trillion over the next 75 years, or the equivalent of 1.6 percent of GDP over that period. The Supplementary Medical Insurance Trust Fund has no unfunded obligation, because general revenues cover all spending that is not financed by other dedicated funding sources. However, the trustees report also provides an estimate of the present value of the required general revenue contributions to Parts B and D of Medicare, equal to \$21.1 trillion.

Some economists have argued that limiting the estimate of unfunded obligations to 75 years is inadequate because it includes the full amount of taxes paid by the next few generations of workers but not the full amount of their benefits. Therefore, since 2004, the trustees report has included a measure of unfunded obligations that extends indefinitely. Measured through this "infinite horizon," the unfunded obligation of the Hospital Insurance Trust Fund is \$28.1 trillion, or 2.5 percent of GDP. Other analysts contend that calculations over an infinite period are unreliable and of little value to policy makers (American Acad. of Actuaries 2003).

What is the Medicare funding warning?

The Medicare Modernization Act of 2003 (Public Law 108-173) establishes a process for issuing a "Medicare funding warning" when the amount of general revenue financing is projected to exceed a certain level. If the trustees project that general revenues will finance 45 percent or more of total Medicare spending in any of the next seven fiscal years, they must issue a determination of "excess general revenue Medicare funding." If the trustees make such a determination two years in a row, their action is treated as a Medicare funding warning. When the next budget is submitted to the Congress, the President must propose legislation to deal with the warning, and the Congress must consider the legislation on an expedited basis. However, the Congress may decide not to enact any legislation.

For purposes of the calculation, general revenue financing includes the general revenue contributions to Parts B and D and the interest on the assets of the trust funds. It excludes specified "dedicated financing sources," such as payroll taxes, premiums, income from the taxation of benefits, and payments from states for prescription drug benefits for Medicare/Medicaid dual eligibles.

The Medicare funding warning derives from a proposal made in 1999 by Senator John Breaux and Representative Bill Thomas, who described it as “programmatically solvency test.” According to Breaux and Thomas, “This concept should more accurately reflect the implications of the program’s financing structure, i.e., the ratio of relative financing burdens on the general fund, the Hospital Insurance payroll tax, and the premiums beneficiaries pay. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test of this entitlement program is one based on the amount of general revenues needed to fund program outlays” (Breaux and Thomas 1999). When the funding warning was added to the 2003 legislation, the intent was to generate proposals for reducing the amount of general revenues going to support the Medicare program.

Critics of the provision argue that the 45-percent level is not a measure of solvency but an arbitrary benchmark that is unrelated to the financial health of the program. Moreover, this measure is inconsistent with Medicare’s basic financing structure, because by design Medicare is financed in large part by general revenues. Congress reaffirmed this financing arrangement in 2003 when it created the prescription drug benefit. Restricting general revenues to 45 percent of Medicare spending would require raising dedicated taxes, such as the payroll tax, or cutting benefits even when the trust funds are in financial balance (Greenstein, Kogan, and Park 2005).

The 2006 trustees report is the first to include a determination of excess general revenue Medicare funding, which is projected to occur in 2012. If the trustees issue a second such determination in 2007, the President will be required to submit legislation in early 2008, and Congressional action could occur in June 2008.

What can be done to strengthen Medicare’s financing?

The National Academy of Social Insurance’s Study Panel on Medicare’s Long-Term Financing identified three basic approaches to meeting Medicare’s projected financing needs:

1. Slowing the growth of program costs by creating incentives for beneficiaries and providers to make more efficient use of health care services or by reducing payments to providers of care
2. Asking beneficiaries to pay a larger share of the cost of their health care, and
3. Raising revenues through taxes.

Choosing among these approaches will require making choices about the portion of national resources devoted to health care, the allocation of those health care resources, and the way society spreads the financial risk associated with becoming sick in old age or disability. It will also involve more specific criteria, such as distributional effects, economic impacts, administrative efficiency, access to care, and incentives for the efficient use of care. Whatever approach is adopted, the panel concluded that “securing additional financing for Medicare will be necessary to avoid eroding the financial protection Medicare provides” (Gluck and Moon 2000).

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