Medicare Financial Status, Budget Impact, and Sustainability—Which Concept is Which?

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Medicare is continually undergoing change, as it must in order to reflect advances in medical technology, new health care delivery systems, financial pressures, and other developments. Modifications to the program are debated by policymakers in Congress and the administration, together with academic experts and others. These debates would be improved if policymakers and the public had a clearer understanding of Medicare and certain commonly cited views of the program's overall status. Three such concepts—the financial status of the Medicare trust funds, the impact of Medicare on the Federal budget, and the long-run sustainability of Medicare—are often confused with each other and are sometimes used interchangeably. Each concept is important but needs to be used for its own purpose. This article clarifies the differences among these three views of Medicare and provides examples of each.

INTRODUCTION

Over the past 40 years, Medicare has been the principal source of health care coverage for elderly and disabled Americans. During that time, increasing costs, new delivery systems, and rapid developments in medical technology have pushed Congress to adjust many aspects of the program. Every year, the discussion among policymakers continues regarding how to address Medicare's financial status and long-range sustainability. However, if policymakers cannot agree on the current status of the Medicare Program, then their efforts will be hampered.

When the status of the Medicare Program is evaluated, several fundamentally different concepts are sometimes used interchangeably, a practice that can muddy the waters of the Medicare debate. The financial status of Medicare, the impact of Medicare on the Federal budget, and the sustainability of Medicare are three very different ideas. Each is important and has its own purpose, but the three issues are not interchangeable. The following sections will illustrate the differences between Medicare's financial status, impact on the budget, and sustainability.

TRUST FUND VERSUS BUDGET PERSPECTIVES

Medicare provides access to health insurance coverage for over 40 million people who qualify due to disability, permanent kidney failure, or age. The three components of Medicare are Parts A, B, and D.[1] Part A, or hospital insurance (HI), provides coverage for inpatient hospital services, skilled nursing facility services, hospice services, and post-institutional home health care. Covered services and items under Part B—one component of supplementary medical insurance (SMI)—include physician services, durable medical equipment, laboratory services, outpatient hospital services, physician-administered drugs, dialysis, and certain other home

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[1] There is also a Part C, which governs the private Medicare Advantage health plans that contract with Medicare to provide Parts A and B coverage and, optionally, Part D coverage.

health care services. The other component of SMI, Part D, principally provides access to prescription drug coverage through private insurance plans beginning in 2006.

Medicare's financial transactions consist of payments for health care services and administrative expenses, and receipt of taxes and other revenues. These operations are handled through the HI trust fund and the Parts B and D accounts in the SMI trust fund, and they can be considered from two different viewpoints: a trust fund perspective and a budget perspective.

The annual report of the Medicare Board of Trustees to Congress focuses on the financial status of the Medicare Trust Funds—that is, whether these funds have sufficient revenues and assets to enable the payment of Medicare benefits and administrative expenses in full and on time. For each trust fund account, this analysis compares income, from all sources, to expenditures and determines whether the account is operating with a surplus or a deficit in a given year. From this trust fund perspective, all types of income are equivalent, and their collective adequacy in covering expenditures is paramount.

In particular, the existence of trust fund assets provides the statutory authority to make benefit payments and cover other expenditures without the need for an appropriation from Congress for this purpose. Medicare benefits can be paid if and only if the relevant trust fund account has sufficient assets. Congress established the trust fund mechanism for financing Medicare (as well as Social Security and certain other Federal programs), not only to impart financial discipline, but also to serve as an early warning if program financing and expenditures fall out of balance. The role of the Trustees Report is to assess the adequacy of trust fund financing and to help ensure the funds' continuing ability to pay benefits promised by the Medicare Program.

As previously noted, it is also possible to view the operations of the Medicare Program from a budget perspective. The Federal budget comprises all tax and other amounts received by the government from the public and all amounts paid to the public in the form of benefits, government purchases from the private sector, wages to Federal employees, etc. If aggregate receipts from the public exceed total outlays to the public, then the Federal Government has a surplus; the opposite relationship results in a Federal budget deficit. In the context of the Federal budget, amounts paid from the general fund of the Treasury to a Federal trust fund, referred to as intragovernmental transfers, have no impact on the overall budget surplus or deficit and, consequently, are excluded from consideration in the budget analysis.

In the budget context, one can look at the public receipts and outlays associated with the Medicare Program and determine whether Medicare is making a net contribution to the Federal budget or is drawing on the budget. Whether the HI or SMI trust funds are running a surplus or deficit may have little or nothing to do with whether Medicare is contributing to a Federal budget surplus or deficit. Due in part to the similarity of terminology, however, people have sometimes confused these two different points of view and reached inaccurate conclusions.

Under both the trust fund perspective and the budget perspective, the accounting for expenditures is straightforward. Expenditures for Parts A, B, and D are paid out of their respective trust fund accounts and are all shown as a draw on the Federal budget. However, confusion can occur with the income and assets of Medicare. The differences between the trust fund and budget perspectives can be clarified by examining how revenues and assets are treated under each viewpoint.

Sources of Income

All of the sources of income to the Medicare trust funds are specified by law. Some of these sources are received directly from the public (budget receipts) while others are transfers from the general fund of the Treasury (intragovernmental transfers). The primary sources of income for Part A are taxes paid by workers and their employers on the workers' total wages and taxes paid by the self-employed on their net income. These payroll taxes are collected by the Internal Revenue Service and credited to the HI trust fund. Employees and employers each pay 1.45 percent of wages and salaries, and self-employed persons pay 2.90 percent of their net incomes.

Another source of income designated specifically for the HI trust fund is a portion of the income taxes paid by certain beneficiaries on their Social Security benefits. If an individual or couple who receives Social Security benefits has income exceeding certain thresholds, then up to 85 percent of their benefits may be counted as taxable income. The income tax on the first 50 percent of Social Security benefits goes to the Social Security trust funds, while the income tax attributable to the amount between 50 and 85 percent of Social Security benefits is allocated to the HI trust fund. As with the HI payroll taxes, these income taxes represent an earmarked source of revenues to the trust fund. Moreover, since they are received from the public, they count as program income from both the trust fund and budget perspectives.

Part B premiums are paid by (or on behalf of) Medicare beneficiaries and are earmarked for the Part B account of the SMI trust fund. The premium is reset annually and pays for about 25 percent of the Part B program costs, as specified in law.[2] Most enrollees have their premiums deducted from their Social Security checks and credited directly to the Part B account of the SMI trust fund. Similarly, beginning in 2006, Part D enrollees will pay the monthly premiums charged by their prescription drug plan, which will be reset annually and on average will cover 25.5 percent of the cost of standard Part D coverage. These amounts may be deducted from the enrollees' Social Security checks and credited to the Part D account of the SMI trust fund or may be paid by the enrollees directly to the Part D prescription drug plan. A few individuals, who are not otherwise eligible for Part A coverage, choose to enroll in Part A and pay a monthly premium. As with Part B, these Part A premium amounts are deposited directly into the HI trust fund.

The Part D account will also receive special payments from the States, representing a declining portion of the amounts that each State would have paid for Medicaid prescription drug coverage, in the absence of Part D, for those persons eligible for both Medicare and Medicaid.[3]

All of the preceding sources of revenues for the Medicare trust funds represent receipts from the public. As such, they meet the budget definition of receipts and are counted for Federal budget purposes as well as for trust fund accounting.

The other Medicare revenue sources are intragovernmental transfers, which are made from the general fund of the Treasury to the appropriate trust fund

[2] The Part B monthly premium is currently the same for all enrollees who enroll promptly and is set equal to one-half of the aged actuarial rate (which is one-half of the average monthly Part B expenditures for an enrollee age 65 or over, less interest income on the relevant assets in the Part B account, plus a margin of contingency to maintain an adequate Part B account level). Starting in 2007, higher-income beneficiaries will pay an increased premium rate.

[3] This portion is 90 percent in 2006 and declines to 75 percent for 2015 and later.

account. The financing mechanism for Part B requires that each dollar of Part B premium revenue be matched with about $3 of general revenue. The matching amount is reset each year to cover about 75 percent of Part B costs. General revenue is the largest Part B source of income.

Similarly, for Part D, the law specifies that about 74.5 percent of the cost of standard Part D coverage be paid by transfers from the general fund of the Treasury. The costs of the premium and cost-sharing subsidies for low-income enrollees, and the subsidies payable to employers with qualifying retiree health benefit plans, are also covered by general revenues.

For Part A, certain individuals were grandfathered into the program, and transfers from the general fund of the Treasury are made to pay for their costs.[4] In addition to these general revenue transfers, interest income for each trust fund account is an intragovernmental transfer.

Trust Funds

Income to the HI trust fund in excess of the amount needed to pay expenditures is invested, on a daily basis, in interest-bearing obligations of the U.S. Government. The excess income may be invested in special-issue interest-bearing securities of the U.S. Government or obligations guaranteed as to interest and principal by the United States. Currently, all assets in the Medicare trust funds are in the form of special-issue securities. The assets in the trust fund accounts (both principal and interest) represent the statutory authority to draw on the general fund of the Treasury, as needed, to make benefit and administrative expense payments without the need for an appropriation from Congress for this purpose. Interest is paid semi-annually on fund assets at rates specified by law; accrued interest on these securities is paid when the security is redeemed.

Each day, Part A expenses for that day are paid by the general fund of the Treasury, and the HI trust fund assets—both principal and accrued interest—are reduced by the amount of the expenses. Unlike a typical certificate of deposit purchased at a bank, there is no penalty for early withdrawal. The entire amount of principal and accrued interest is paid whenever a security is redeemed, regardless of the term of the security. In effect, the security is redeemed by cash from the general fund, and the cash is used to pay the Part A expenditure. In practice, the asset is simply deducted from the HI trust fund, and the general fund is authorized to make the outlay on behalf of Part A.

At the end of each day, all Part A income received that day is invested in new special-issue securities, and HI trust fund assets are increased accordingly. Cash income from earmarked sources goes into the general fund of the Treasury, increasing the amount in the general fund. The income is then credited to the trust fund and invested in special-issue securities. The actual cash receipts are expended from the general fund for whatever purpose arises. In this way, Part A cash receipts that are not immediately needed to cover Part A costs are lent to the rest of the Federal Government and used to meet its expenditures. Income from intragovernmental transfers comes from the general fund of the Treasury, purchases special-issue trust fund securities, and thereby returns to the general fund of the Treasury, causing no change in the amount of the fund.

[4] Entitlement to Part A benefits was provided to almost all persons age 65 or over when Part A was enacted. Similarly, certain Federal employees who were scheduled to retire before having a chance to earn sufficient quarters of coverage were given entitlement when Federal employees were covered by Medicare starting in 1983. The costs of these enrollees are reimbursed from the general fund of the Treasury.

Table 1

Parts A and B Financial Operations from the Trust Fund and Budget Perspectives: Calendar Year 2004

Category	Trust Fund Perspective	Budget Perspective
	(Billions)	
Part A		
Payroll Taxes	$156.9	$156.9
Taxation of Benefits	8.6	8.6
General Revenue	0.6	—
Premiums	1.9	1.9
Fraud and Abuse Penalties	0.7	0.7
Interest	15.2	—
Total Income	183.9	168.1
Benefits	167.6	167.6
Administrative Expenses	3.0	3.0
Total Expenditures	170.6	170.6
Income less Expenditures	13.3	-2.5
Part B		
General Revenue	$100.4	—
Premiums	31.4	$31.4
Interest	1.5	—
Total Income	133.3	31.4
Benefits	135.0	135.0
Administrative Expenses	2.9	2.9
Total Expenditures	137.9	137.9
Income Less Expenditures	-4.5	-106.4

NOTE: Totals do not necessarily equal the sums of rounded components.

SOURCE: Office of the Actuary, Centers for Medicare & Medicaid Services.

The Part B account and the Part D account of the SMI trust fund operate separately, but in an identical fashion, for expenses and income for Parts B and D, respectively. There is no provision under current law to transfer or lend assets among the HI trust fund and the Parts B and D accounts in the SMI trust fund.

Comparison of Past Financial Operations

Table 1 displays the financial operations of Parts A and B for calendar year (CY) 2004 under the trust fund perspective and the budget perspective.[5] Income from all sources is equivalent under the trust fund perspective. Income from intragovernmental transfers is not counted under the budget perspective.

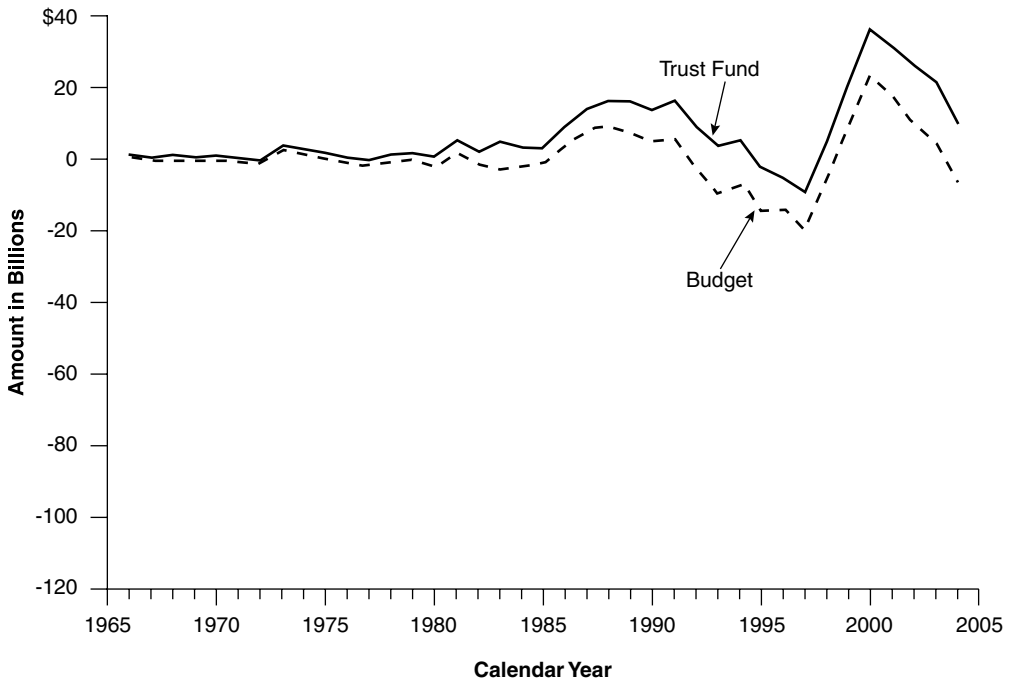
In CY 2004, the HI trust fund increased $13.3 billion, but HI outlays to the public exceeded receipts from the public by $2.5 billion. Consequently, the HI trust fund drew a net amount of $2.5 billion from the general fund of the Treasury. For Part B, the account assets decreased by $4.5 billion in CY 2004, and $106.4 billion was received from the general fund of the Treasury.[6] The latter amount was provided through the statutory general revenue financing of

[5] Part D financial operations in 2004 have been excluded from the table; these transactions related only to the transitional low-income drug card subsidy, with expenditures of $0.4 billion—all of which was financed by general revenues.

[6] The decline in Part B account assets in 2004 occurred primarily because legislation to increase payments to physicians in 2004 was enacted in December 2003, after the Part B financing rates had been established for 2004.

Figure 1

Medicare Hospital Insurance Income Less Expenditures Based on Both the Trust Fund Perspective and the Budget Perspective: Calendar Years 1966 to 2004



SOURCE: Office of the Actuary, Centers for Medicare & Medicaid Services.

Part B ($100.4 billion), interest earnings ($1.5 billion), and asset redemptions ($4.5 billion).

It is appropriate that the general revenue transfers, interest earnings, and asset redemptions are counted as financial resources from a trust fund perspective, since these amounts are available, by law, to support Medicare expenditures. Accordingly, such amounts are included in an analysis of the financial status of the Medicare trust funds. The financial impact of Medicare on the Federal budget, however, excludes these intragovernmental transfers, since they do not represent transactions external to the Federal Government.

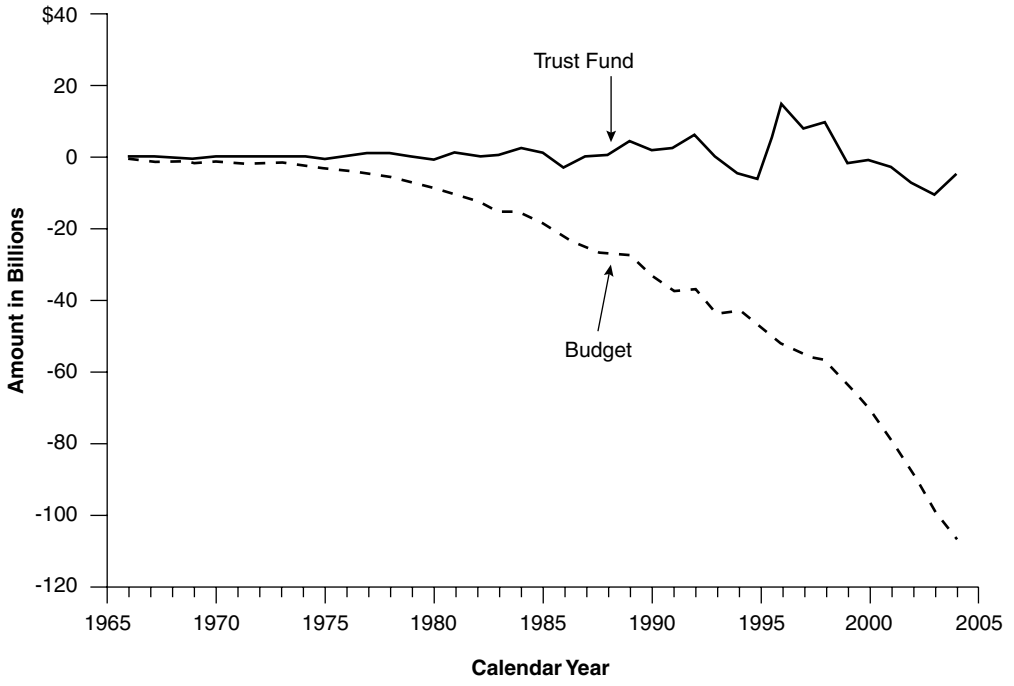
Figures 1, 2, and 3 show the historical differences between income and expenditures under both the trust fund and budget perspectives, for HI, SMI, and total Medicare, respectively. Under the trust fund perspective for the entire history of Medicare, income from all sources has been sufficient to meet expenditures in most years for both HI and SMI.[7] The trust funds could not operate satisfactorily with sustained fund deficits, since benefits could not be paid in full or on time. In practice, the year-by-year financial status of the trust funds has been satisfactory, with expenditures fully met by trust fund revenues, interest, and/or asset redemptions when necessary.

Note, however, that the annual balance between trust fund income and expenditures depends critically on the interest and general revenue financing provided from the Federal budget, particularly for

[7] In the years when income under the trust fund perspective is less than expenditures, the assets in the relevant trust fund account are drawn down to meet the income shortfall for the year.

Figure 2

Medicare Supplementary Medical Insurance Income Less Expenditures Based on Both the Trust Fund Perspective and the Budget Perspective: Calendar Years 1966 to 2004



SOURCE: Office of the Actuary, Centers for Medicare & Medicaid Services.

SMI. Under the statutory financing mechanism, SMI general revenues are the largest source of financing; consequently, SMI has required a net draw on the Federal budget in every year since its inception (Figure 2). For HI, the budget perspective is fairly similar to the trust fund perspective because general revenue transfers have been a relatively small part of total HI income (Figure 1).

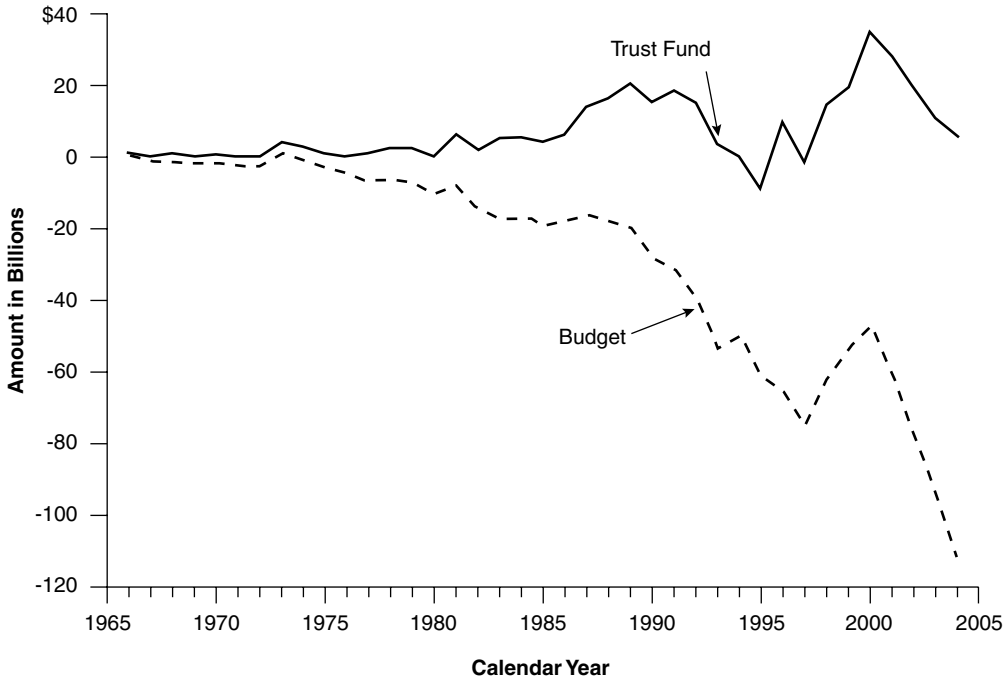
The financial status of the combined Medicare trust funds is not a meaningful concept, since each fund is separate and the adequacy of its income and assets must be evaluated on a stand-alone basis. From a budget perspective, however, it is interesting to note that total Medicare payments to the public have exceeded total receipts from the public in virtually every year (Figure 3). Thus, to operate, Medicare overall has almost always required a net flow of funds from the budget, principally in the form of the SMI general revenue financing.

Conclusion on Differing Perspectives

The annual report of the Medicare Board of Trustees to Congress conveys the financial status of the Medicare trust funds for the recent historical period and over the next 75 years. The primary purpose of the report is to analyze whether each of the two trust funds has sufficient income and assets to enable the payment of Medicare benefits and administrative expenses. The Medicare Trustees Report necessarily has a trust fund perspective. In contrast, the annual budget of the United States includes estimates of projected Medicare income and expenditures, but reports on how all three parts of the program

Figure 3

Total Medicare Income Less Expenditures Based on Both the Trust Fund Perspective and the Budget Perspective: Calendar Years 1966 to 2004



SOURCE: Office of the Actuary, Centers for Medicare & Medicaid Services.

contribute toward Federal budget surpluses or deficits over the next 5 or 10 years. The Federal budget appropriately has a budget perspective.

The majority of Medicare trust fund revenue is received directly from individuals and businesses, either in the form of earmarked tax revenues, such as payroll taxes and a portion of the Federal income taxes paid on Social Security benefits, or through beneficiaries' monthly premiums. Other types of revenue, while mandated by law, do not have earmarked sources and are received from the general fund of the Treasury. These latter sources include interest earnings on trust fund account assets and general revenue financing. From the standpoint of the trust fund accounts, all revenue sources contribute toward a positive balance and support the payments of benefits and other expenditures. From the standpoint of the budget, intragovernmental transfers have no impact on the balance in the general fund and so are excluded from consideration.

Each viewpoint—the trust fund perspective and the budget perspective—is appropriate for its intended purpose. One point of view cannot be used to answer questions related to the other, however. Trust fund surpluses or deficits reveal nothing about the impact of Medicare on the Federal budget, and the impact of Medicare on the Federal budget offers no insight into whether a trust fund account has sufficient assets to permit payment of benefits.

FINANCIAL STATUS VERSUS SUSTAINABILITY

Medicare's financial status is a relatively narrow issue and is fairly easy to assess. By comparing expected income and assets

with expected outgo, separately for Parts A, B, and D of Medicare, one can determine whether benefits for each particular part can be paid in full and on time. The evaluation of Medicare's financial status is a technical, actuarial issue. Medicare's impact on the Federal budget is a similarly narrow and straightforward calculation.

In contrast, assessing the long-range sustainability of Medicare is anything but straightforward. Sustainability is much more difficult to assess because it is a very broad issue and ultimately one that involves societal values. There is no agreed-upon standard by which to measure the sustainability of Medicare—indeed, there is considerable confusion about the differences between the concepts of sustainability, financial status, and budget impact.

Sustainability is not the same as adequate financing. A program may be adequately financed but unsustainable. For example, Part B is projected to always be in financial balance because of the annual determination of the financing to meet expected expenditures, but some would argue that Part B is unsustainable because of the very rapid projected expenditure growth. On the other hand, a program might be sustainable, but temporarily inadequately financed. (If a program was permanently inadequately financed, then it would clearly be unsustainable, as well.) Though the financial status of State unemployment insurance programs fluctuates with the economy, these programs are considered sustainable. After the 1982 recession, the unemployment insurance trust funds of most States had negative balances. As a result, the States had to borrow from the Federal Government to pay benefits. Despite the temporary financial imbalance, the unemployment insurance programs continued to operate satisfactorily, and few questions have been raised about their ability to continue to do so in the long term.

Sustainability for Medicare is a judgment about whether the program, as currently constructed, will meet the demands of all affected parties today and in the future. The evaluation of Medicare sustainability requires examination from more than one standpoint. For example, while the projected future cost of Medicare is the most widely raised concern about the program's sustainability, it is also important to consider whether the program's design continues to meet the needs of society.

The assessment of Medicare's long-range sustainability is, ultimately, a judgmental, qualitative, and political question. Our purpose is not to attempt to answer this question, but rather to (1) point out that the question is different from either Medicare's financial status or budget impact, and (2) provide several possible measures that might help inform the discussion.

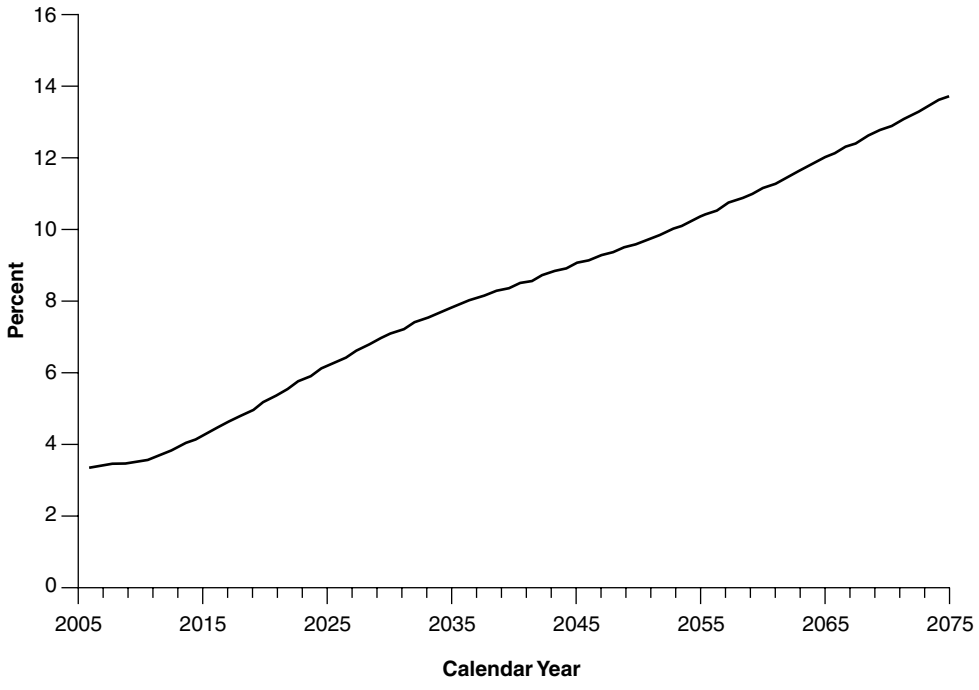
Cost Considerations

As previously mentioned, the cost to society of the Medicare Program is frequently cited as a source of concern regarding the program's future sustainability. Figure 4 shows total Medicare expenditures as a share of the gross domestic product (GDP).

Under current law, and using the intermediate assumptions from the 2005 Medicare Trustees Report, total Medicare expenditures are projected to increase from 3.3 percent of GDP in 2006 to 13.8 percent of GDP by 2080. While Figure 4 objectively measures the share of total U.S. output that is expected to be devoted to Medicare spending, a decision as to whether this share of GDP is good or bad is very subjective. On the surface, the projected cost would seem to represent an impossible burden—approaching the size of the current total cost of the Federal Government

Figure 4

Medicare Expenditures as a Percent of Gross Domestic Product: Selected Years, 2005-2075



SOURCE: Office of the Actuary, Centers for Medicare & Medicaid Services.

relative to GDP (19.8 percent in fiscal year 2004). On the other hand, society may place less weight on consumption of material goods in the future and continue to value improvements in health and longevity very highly.

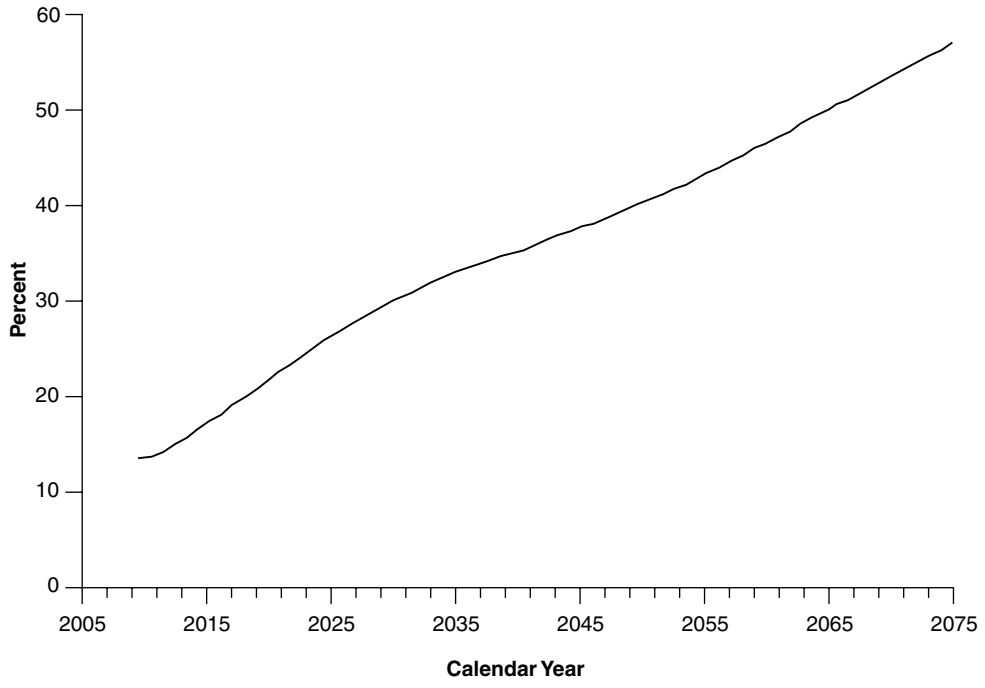
Figure 5 shows Medicare general revenue income as a share of Federal income tax revenue, if income taxes maintain their historical relationship with GDP. (From 1954 through 2003, total Federal individual and corporate income taxes averaged 10.9 percent of GDP. This relationship is assumed to continue indefinitely into the future.)

Under the previously mentioned assumption, Medicare general revenues are projected to increase from 13.6 percent of Federal income taxes in 2010 to 57 percent by 2080. The figure gives an illustration of the projected impact of current law Medicare growth on the Federal budget. Implications of this sort of growth could include reduced spending on other Federal programs, increased Federal borrowing, or increased taxes. While some of these outcomes may be undesirable, their impact would have to be considered in relation to the effect of slowing the growth of Medicare spending. Again, society will ultimately be the judge of Medicare's sustainability.

Figure 6 compares projected future SMI out-of-pocket health costs and illustrative beneficiary income (Social Security and total). The SMI out-of-pocket costs include the projected average level of Part B plus Part D cost sharing (deductibles and coinsurance) together with the average Part B plus Part D beneficiary premiums. (Part A cost-sharing amounts are not included.) The Social Security benefit shown is based

Figure 5

Medicare General Revenue as a Percent of Federal Income Tax Revenue: Selected Calendar Years, 2005-2075



SOURCE: Office of the Actuary, Centers for Medicare & Medicaid Services.

on the projected average amount for retired workers. The total income curve assumes an average amount of additional income in the future (from earnings, private pensions, and/or investments), assuming a continuation of the actual relative relationship in 2002.

While this comparison is limited due to many factors (including the use of averages), it shows that growth in Medicare enrollee out-of-pocket spending for SMI Parts B and D is expected to outpace income growth. As out-of-pocket costs consume an increasing share of beneficiary income, use of Medicare-covered health care services could become unaffordable for many beneficiaries. Once again, there is no agreed-upon basis for deciding at what point such a problem would make the Medicare Program unsustainable.

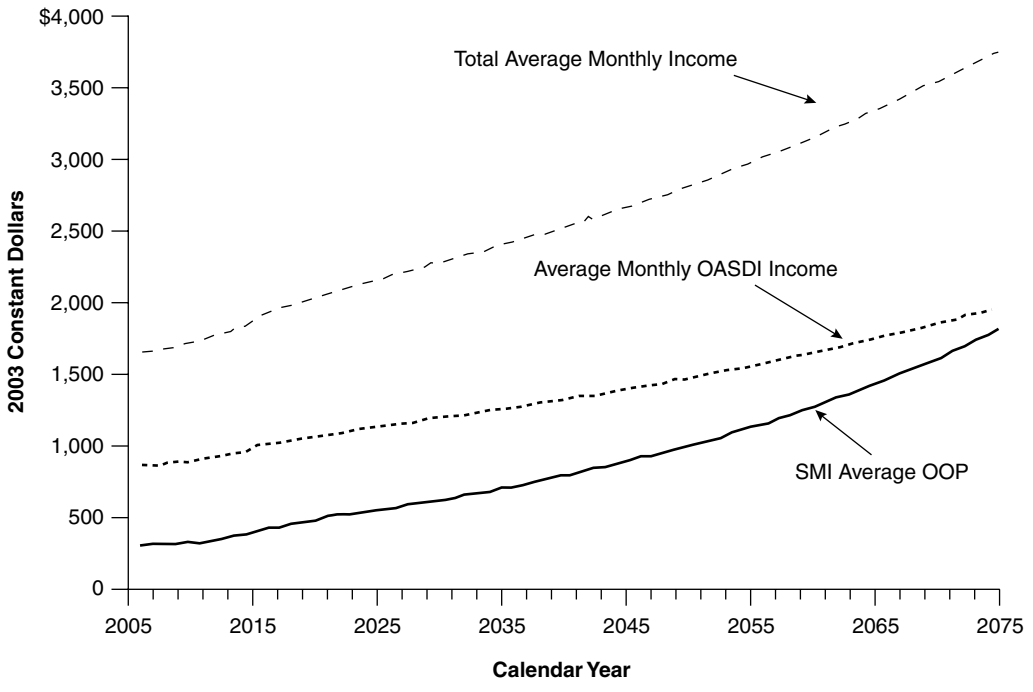
Design Considerations

The Medicare Program, in many respects, is a 1960s design. Most modern health plans use cost sharing as a way to discourage unnecessary services and to reduce overall plan costs. For Medicare, the Part B deductible has become a token amount with little or no effect on spending behavior,[8] and overall Medicare cost-sharing effects are distorted through the broad availability of supplemental coverage (such as Medicaid, employer-sponsored retiree health plans, and private Medigap insurance policies). One reason for the popularity of such supplemental coverage is that

[8] In 1967, the Part B deductible was $50 compared with total Part B spending per enrollee of about $73. In 2004, the Part B deductible was $100 compared with total Part B spending per enrollee of about $3,431.

Figure 6

Average Monthly SMI Cost Sharing and Premiums per Enrollee as a Percent of a Typical Monthly Social Security Benefit and Income: Selected Calendar Years, 2005-2075



NOTES: SMI is Supplementary Medical Insurance. OASDI is Old-Age and Survivors Insurance and Disablility Insurance. OOP is out of pocket.

SOURCES: Office of the Actuary, Centers for Medicare & Medicaid Services and the Social Security Administration (2002 Income of the Aged Chartbook—median total income and Office of the Chief Actuary—illustrative Social Security benefit).

Medicare Parts A and B do not provide catastrophic coverage—that is, a maximum on beneficiary out-of-pocket costs—even though the great majority of other health insurance plans do. In addition, until Part D begins in 2006, fee-for-service Medicare provides virtually no prescription drug coverage, which is a standard benefit for all modern health insurance plans.

Another design issue involves the categories of people eligible to enroll in Medicare. In 2004, people are healthier, on average, at age 65 than they were at Medicare's inception and will live significantly longer, healthier lives, yet Medicare maintains a permanent age 65 eligibility threshold. Persons with end-stage renal disease (ESRD) are eligible for Medicare coverage, but those with other extremely expensive health problems are not eligible exclusively because of their disease.[9]

Critics and supporters of Medicare alike have raised questions of fairness across different categories of participants. Some have argued that Medicare should be available only on a means-tested basis, while others believe such a change would be detrimental. In practice, the role of participant income in Medicare is convoluted: workers pay the HI payroll tax on their earnings, but all participants qualify for the same HI benefits regardless of the total amount of taxes they have paid. Part B is voluntary, with the same benefits regardless of

[9] Individuals with amyotrophic lateral sclerosis (Lou Gehrig's Disease) can qualify for Medicare coverage based on disability without needing to meet the normal 24-month waiting period.

income, but, starting in 2007, high-income beneficiaries will pay higher Part B premiums. Low-income Part D beneficiaries can qualify for Medicare assistance with Part D premiums and cost-sharing requirements.

Medicare also raises important intergenerational equity questions. The retirement of the post-World War II baby boom generation will substantially increase the ratio of Medicare beneficiaries to working-age persons. Since Medicare is financed on a pay-as-you-go basis, the demographic change will have a sizable effect on the cost of the program relative to workers' earnings and the GDP. Proposals to address Medicare's financial status can have markedly different impacts on one generation's Medicare value compared to another's.

As suggested by these examples, Medicare could become unsustainable over time if its eligibility, benefit, financing, and other provisions do not adapt to changes in the provision of health care or in the population at large.

CONCLUSIONS

The question of sustainability is not easily quantified or agreed on. Financial adequacy does not imply sustainability, and sustainability does not indicate financial adequacy. The sustainability of Medicare is a policy issue, and society, through its elected representatives, makes choices according to what it desires and what it is willing to accept. The desired Medicare coverage is balanced against the reasonableness of the cost of that coverage, but this balance is not easily quantified and is not the same as financial adequacy.

With an understanding of the differences surrounding the concepts of financial status, budget impact, and sustainability, the following statements are fair, in our opinion:

- *Financial Status*—The financial status of the HI trust fund is not satisfactory, based on the measures and tests employed by the Medicare Board of Trustees to assess such status. Based on the corresponding measures and tests for the Parts B and D accounts in the SMI trust fund, the financial status of these accounts is satisfactory.
- *Budget Impact*—Medicare, overall, requires a significant amount of financing from the Federal budget beyond the earmarked sources of Medicare revenue. Thus, in contrast to the Social Security program, which currently makes a net contribution to the budget, Medicare represents a net draw on the budget.
- *Sustainability*—Each of several relevant measures of Medicare's long-range future sustainability raises serious questions about the affordability of Medicare to society, generally, or to the Federal budget and beneficiaries, specifically. In addition, some believe that the program's design will not match society's needs in the future. However, there is no agreed-upon standard or test for determining sustainability on either basis. The concept remains subjective.

Medicare has provided valuable health care coverage to the elderly over the past 40 years (and the disabled over the last 33 years). Many aspects of the program have changed, as needed, to meet society's demands. In the next 40 years and beyond, Medicare will continue to evolve through public debate and legislation. Our intent is to improve the discussion by clarifying three of the viewpoints commonly used—and often confused—in evaluating Medicare: trust fund financial status, impact on the Federal budget, and sustainability. An enhanced understanding of the distinctions among these three viewpoints

should make the real Medicare issues more transparent and help lead to a better Medicare Program for all of us.

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