REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - A-08

Subject: The Medicare Trust Funds

Presented by: Georgia A. Tuttle, MD, Chair

At the 2007 Interim Meeting the House of Delegates adopted as amended the following recommendation in Council on Medical Service Report 6-I-07: That the American Medical Association (AMA) continue studying the combination of Parts A and B of the Medicare Trust Funds into a single unit, clearly delineating the advantages and disadvantages of this action, including the effect on graduate medical education (GME) funding, and of adding a means test to Medicare Part A.

This report, which is presented for the information of the House, reviews the history and structure of the Medicare Trust Funds, including the role of Medicare in funding GME; discusses Medicare's current financial status; and outlines the potential benefits and challenges associated with combining the Medicare Trust Funds into a single structure. It also reviews AMA policy that addresses means testing in the Medicare program.

HISTORY AND STRUCTURE OF THE TRUST FUNDS

Prior to Medicare's enactment in 1965, legislators were primarily focused on creating a program that would help the elderly with hospital costs, since incidents of hospitalization tended to represent the greatest financial risk for individuals seeking medical care. The offering of hospitalization-only insurance was consistent with trends in the private insurance market, in which Blue Cross offered coverage for hospital services, and Blue Shield – a separate organization - offered coverage for physician services. From a political perspective, early Medicare supporters believed they had a better chance of creating an insurance program for the elderly if they limited the scope of coverage, at least in the initial phases of the program. Accordingly, legislators made the enactment of hospitalization insurance their legislative priority.

As noted by economist and former Medicare Trustee Marilyn Moon, it was not until "very late in the legislative process" that Congress considered adding a benefit that would cover physician services along side hospital services. The fact that enrollment in what would ultimately become "Part B" would be voluntary, and subject to additional premiums and deductibles paid by enrollees, presumably made it more politically palatable than if Medicare had been designed as a single entitlement program that would cover all health care services. Thus, Medicare emerged with a two-part structure that mirrored the private insurance market at the time, offering hospital insurance (Part A) as an entitlement, and separate, optional coverage for physician services (Part B) for those individuals who were willing to pay a premium and separate deductibles and co-payments.

Consistent with the legislative evolution of Medicare, the program is supported by two separate trust funds--the Hospital Insurance (HI) Trust Fund, financed through fixed payroll taxes of 2.9%, and the Supplementary Medical Insurance (SMI) Trust Fund, which is financed through a combination of general tax revenues and beneficiary premiums that are adjusted each year based on

program costs. The services funded by each Trust Fund have shifted and expanded since Medicare was enacted. Today the Federal HI Trust Fund finances Medicare Part A, which covers inpatient hospital, some home health, skilled nursing facility, psychiatric hospital, and hospice care services; and the SMI Trust Fund finances Medicare Part B, which covers physician and other provider services, hospital outpatient services, some mental health services, durable medical equipment, ambulatory surgical center services, physician-administered drugs, some lab tests, and home health visits not covered under Part A. The SMI Trust Fund also finances Part D, which offers prescription drug coverage. Eligible beneficiaries (based on work history) are automatically enrolled in Part A; enrollment in Part B and Part D is voluntary, and beneficiaries are responsible for paying premiums.

GRADUATE MEDICAL EDUCATION FUNDING UNDER MEDICARE

Funding graduate medical education has been part of the Medicare program since its enactment, and Medicare remains a major source of GME funding. Medicare's authorizing legislation stated that "educational activities enhance the quality of care in an institution, and it is intended…that a part of the net cost of such activities…should be borne to an appropriate extent by the (Medicare) hospital insurance program" (cited in Cooper, 2007). The HI Trust Fund pays hospitals for direct medical education (DME) costs based on a formula that includes the number of residents being trained and the percentage of Medicare beneficiaries in the hospital's inpatient population ("Medicare Payments for Graduate Medical Education," AAMC, 2006). DME payments are calculated and awarded to hospitals separately from payments for clinical services. Hospitals also receive indirect medical education (IME) payments, which compensate for increased costs associated with inpatient care at teaching hospitals. These increased costs may result from treating patients with more complex medical conditions, or from the use of more intensive or specialized treatments. Unlike DME, IME payments are made through adjustments to regular clinical reimbursement rates. Medicare currently spends approximately $2.5 billion on DME payments, and about $5.1 billion on IME payments (Cooper, 2007).

FINANCIAL STATUS OF THE CURRENT MEDICARE PROGRAM

Medicare's fiscal health is formally measured by analyzing the solvency of the HI Trust Fund. Historically, payroll taxes have yielded a small surplus over current year expenditures. Over the past several years, however, the balance between payroll taxes and Part A expenditures has shifted so that tax revenue is being supplemented by interest earnings to meet current obligations. In its 2008 report to Congress, the Medicare Trustees project that current HI tax revenues will cover approximately 96% of Part A costs in 2008, and that interest earnings will be needed to fund the remaining 4%. Demographic and spending trends forecast a continual erosion of Trust Fund assets in the near future. The Trustees project exhaustion of HI Trust Fund assets (i.e., "insolvency") in 2019, when taxes will cover only 78% of Part A costs.

There is no equivalent measure of insolvency for the SMI Trust Fund. Unlike the HI Trust Fund, revenues in the SMI Trust Fund automatically expand to meet program costs (i.e., increasing shares of general tax revenue are allocated to the fund). Although there is no clear benchmark indicating when revenues and expenditures are out of balance, policy experts are increasingly concerned about the growing share of general revenues that are being consumed by the SMI Fund.

In an attempt to dispel the myth that the financial stability of Medicare can be adequately determined by examining the HI Trust Fund alone, the Medicare Prescription Drug Improvement

and Modernization Act established a benchmark to evaluate the status of the program as a whole. Known as the "45% trigger," the Administration is required to present a financing plan to Congress if two consecutive reports of the Medicare Trustees predict that, within seven years, 45% or more of total Medicare funding will come from general revenues. The 2006 and 2007 Trustees reports made this prediction, and in February 2008, the President presented Congress with a proposal that that would increase premiums for higher-income Part D enrollees, promote the use of health information technology, provide beneficiaries with more information about the cost and quality of their medical services, and link provider payments to improvements in quality. The 2008 Trustees report also projected general revenue funding will exceed 45% within seven years, so a presidential proposal will be required in 2009 as well.

BENEFITS OF COMBINING THE MEDICARE TRUST FUNDS

Unlike private insurance companies – which have responded to changes in medical practice by realigning their coverage and cost-sharing structures - Medicare has maintained essentially the same bifurcated structure of coverage and benefits since its enactment. Many believe that combining the Medicare Funds would help lay essential groundwork for critical reforms that could help strengthen the Medicare program overall. Combining the HI and SMI Trust Funds would be an appropriate acknowledgement of changes in medical practice patterns since Medicare's inception. According to the final report of the National Bipartisan Commission on the Future of Medicare, "health care delivery changes have blurred the distinctions originally contemplated when Parts A and B of Medicare were enacted. Parts A and B should be combined into a single Medicare Trust Fund" (1999). Technological advances and societal expectations have resulted in a blurring of the line between inpatient and outpatient services, and new drugs and improved chronic care management have created more options for patients and their physicians. Medicare's historical distinction between "hospital services" and "physician services" is inconsistent with new paradigms in the health care environment that emphasize a more flexible approach to the provision and delivery of patient care.

To illustrate the "blurring" of the distinctions between traditional Part A and Part B services, the following table identifies a number of procedures that in 1998 were predominately performed as inpatient procedures, but are now predominately performed as hospital outpatient procedures.

Table 1: Site of Service Changes, 1998 to 2006

Code	Descriptor	1998 % Hospital Inpatient	2006 % Hospital Inpatient	1998 % Hospital Outpatient and Ambulatory Surgery Center	2006 % Hospital Outpatient and Ambulatory Surgery Center
33213	Insertion or replacement of pacemaker pulse generator only, dual chamber	58	31	41	68
33233	Removal of permanent pacemaker pulse generator	63	40	37	59
33240	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator	64	41	35	59

These shifts from the inpatient to the outpatient setting reflect shifts from Part A-funded services to Part B-funded services, resulting in a decrease in Part A expenditures for these services, and a corresponding increase in Part B expenditures.

Changes in medical practice have also affected graduate medical education and the way residents are trained. Medicare DME and IME funding for residents continues to be based heavily on calculations related to the delivery of hospital-based services, yet increasing numbers of residents are being trained outside the hospital setting. The Council on Medical Education is preparing a report for the 2008 Interim Meeting that will explore current funding mechanisms for residency training programs, including the role of Medicare in providing GME funding for non-hospital based settings. AMA policy advocates that GME funding should support training of residents in both hospital and non-hospital settings, and calls for federal and state funding formulas to take into account resources needed for training residents in ambulatory sites (Policy H-305.929, AMA Policy Database). Changes in the Medicare Trust Fund structure should accommodate an updated GME funding methodology that better reflects educational and policy goals for training physicians.

The existence of separate Trust Funds to finance Part A services and Part B services discourages flexibility and may create disincentives for various partners in the health care system to work together to improve the efficiency of the Medicare program. Because the Trust Funds operate and are financed separately, each with a different set of rules depending primarily on site of service, shifting services from one category to another is often seen as advantageous (or, conversely, disadvantageous) from the perspective of providers or entities. There is also the illusion that placing more services in one category (generally Part B) will help strengthen the financial outlook for the entire Medicare program. In a 2000 statement before the Senate Special Committee on Aging, Paul Posner of the US General Accountability (formerly Accounting) Office said:

> When outlays outstrip revenues in the HI fund, it is tempting to shift some expenditures to SMI. Such cost shifting extends the solvency of the HI Trust Fund, but does nothing to address the fundamental fiscal health of the program. Worse, it masks the problem and may cause fiscal imbalances to go unnoticed. For example, in 1997 the Balanced Budget Act modified the home health benefit, which resulted in shifting a portion of home health spending from the HI trust fund to SMI. Although this shift extended HI trust fund solvency, it increased the draw on general revenues in SMI while generating little net savings. Ultimately, the critical question is not how much a trust fund has in assets, but whether the government as a whole can afford the promised benefits…and at what cost to other claims on scarce resources.

Despite the illusion that one Trust Fund is more “robust” than the other, the Funds are highly interdependent, and, as a whole, the Medicare program is on a trajectory that cannot be sustained. Unifying the Trust Funds would be a critical first step in breaking down the barrier between providers and sites of service that exist under the current Medicare system, and would provide the basis for the development of a uniform set of administrative and payment rules that would govern all Medicare providers. Several AMA policies already support being able to shift funds to recognize savings accrued from changes in site of service or improved outpatient care that results in fewer hospitalizations (H-400.957, D-390.977, D-390.979). Rather than perpetuating tensions among service providers, unifying the Medicare Trust Funds could encourage all groups to work together to ensure adequate and sustainable financing mechanisms for the program as a whole.

In general, combining the trust funds would allow for a more comprehensive measure of Medicare's financial status. As noted, there is an illusion that the SMI Trust Fund is more robust than the HI Trust Fund, since revenues to the SMI Trust Fund are automatically increased to meet expenditures. The fact is, neither Trust Fund represents a fiscally efficient or sustainable program, and shifting services and expenditures between the two will not affect Medicare's long-term viability. Combining the HI and SMI Funds into a single Medicare fund would be a more rational way to measure the fiscal strength of the Medicare program overall, which could facilitate the development of realistic solutions for all areas of the program.

Finally, on a practical level, merging the Trust Funds could expedite a restructuring of beneficiary cost-sharing, which experts agree is critical to helping improve the longevity of the program. As outlined in Council on Medical Service Report 10 (A-07), the current Medicare cost-sharing structure is fragmented, involving several levels of Part A, B, and D deductibles and co-payments/coinsurance, and provides only limited protection against catastrophic costs. This fragmentation has increased over the years, and the development of any rational cost-sharing design has been precluded by the need to maintain a separation between the different Trust Fund programs. AMA policy already supports the development of a Medicare cost-sharing structure that provides incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. Specifically, AMA policy supports combining the cost-sharing requirements of Parts A and B into a single deductible (H-330.898 and H-330.896), and restructuring beneficiary cost-sharing so that patients also have a single premium for all Medicare services (H-330.896). Merging the Trust Funds would ensure that beneficiary cost-sharing applies to a single program that offers a comprehensive and integrated set of services that facilitate efficient and appropriate use of care.

CHALLENGES OF COMBINING THE MEDICARE TRUST FUNDS

The potential benefits of combining the Trust Funds (e.g., more equitable allocation of resources, better measure of overall financial status) can only be realized if policymakers are committed to reinventing the financing and administrative rules that have governed the Medicare program for over 40 years. This point was heavily emphasized in testimony before the House Subcommittee on Health, Committee on Energy and Commerce in 2001. GAO's William Scanlon cautioned, "improved measures of Medicare sustainability and agreed-upon thresholds will not, however, alter the difficult decisions facing this and future Congresses….Better measures of Medicare's financial health may help identify the need for action, but will not lessen the difficulty of implementing a solution."

The creation and implementation of financing, payment and other rules that would govern a combined Medicare structure would be a significant challenge for policymakers. All assumptions about revenue sources, payment methodologies, and sites of training and service would need to be reevaluated in the context of a combined structure. Among other things, the current artificial distinctions and differential rules based on site of service could not be perpetuated under a unified Medicare. Marilyn Moon notes that, although some analysts are concerned with the rapid growth in Part B spending, the growth "represents a natural shift" from inpatient to outpatient services, and "improvements in health care delivery that have allowed such changes reflect improvements that speed recovery and enhance the quality of life for beneficiaries. Without such a shift, Part A spending would have had to be much higher than it is today" (2001). Proposals to combine the Medicare Trust Funds must acknowledge the need for new rules that accurately and fairly reflect the realities of current medical training and practice.

Unifying the Trust Funds would also require the development of new benchmarks to gauge changes in Medicare's fiscal health. These benchmarks must be developed thoughtfully, and in the context of a comprehensive analysis that takes into account changes in medical practice and technology, demographic shifts, and other factors that could influence Medicare's revenues and expenditures. There is a risk that benchmarks – and subsequent corrective actions – could be unrealistically restrictive and arbitrary, thus jeopardizing the integrity of the Medicare program even further. Current debates over Sustainable Growth Rate levels are in large part the result of unrealistic and arbitrary attempts to artificially control Medicare spending.

A final consideration with regard to combining the Trust Funds relates to identifying the best way to design Medicare financing so that it will "facilitate, not impede, needed reform and fiscal discipline" (Posner, 2001). Some believe that it is easier to control a program financed primarily through a specific tax - like the current HI Trust Fund - than one that relies on general tax revenues (see Patashnik and Zelizer, 2001). Others believe that reliance on general revenues puts a program at risk because it is forced to compete with limited federal resources. Any change in Medicare's financing and delivery structure should consider how to maximize Medicare's resources in the future.

MEANS TESTING IN MEDICARE

The House of Delegates asked that our AMA consider adding a means test to Medicare Part A. AMA policy supports means testing in conjunction with an adoption of a single premium and deductible for all Medicare services. Specifically, AMA Policy H-330.896 supports restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. Although combining the Trust Funds is not a prerequisite for establishing a single premium and deductible, it could facilitate such a restructuring.

DISCUSSION

The AMA continues to support ultimately transitioning the current Medicare program to a self-funded, private sector approach in which the government makes contributions to health care retirement accounts of economically disadvantaged individuals (Policy H-330.898). This long-term vision may ultimately move the system away from the trust fund structure altogether. However, interim steps must be taken to ensure that Medicare remains a reliable source of insurance for seniors in the near-term.

The Council on Medical Service continues to support the concept of combining the Medicare Trust Funds into a single unit. As noted in previous reports on this issue (Council on Medical Service Reports 10-A-07 and 6-I-07), the Council believes that the structure of the Medicare program is best conceptualized as a single entity, and that combining the Trust Funds would be an important first step that could stimulate and facilitate the development of realistic policy solutions for all areas of the program.

As the Council has noted, combining the Trust Funds alone will have minimal impact on the solvency of Medicare. However, it has the potential to stimulate creative and meaningful reforms that could help strengthen the Medicare program in the short term. The Council has identified the following potential benefits to transitioning to a unified trust fund:

- Acknowledge changes in medical practice since Medicare's creation, specifically with respect to changes in technology that have blurred the line between traditional "inpatient" and "outpatient" services.

- Facilitate the development of an updated GME funding methodology that better reflects educational and policy goals for training physicians.

- Improve the efficiency of Medicare by creating a uniform set of administrative and payment rules that would govern all Medicare providers, which could encourage all groups to work together to ensure the stability of Medicare as a whole.

- Establish a more comprehensive measure of Medicare's financial status.

- Expedite a restructuring and rationalization of beneficiary cost sharing structure.

However, the Council is also aware of significant challenges associated with restructuring the Medicare Trust Funds, and recognizes that many questions remain unanswered with regard to exactly how such a change would be implemented. The level of uncertainty surrounding the potential implications of combining the Medicare Trust Funds is too great to merit AMA support for this strategy at this time. The Council believes that these issues will ultimately be resolved only after active, and well-reasoned consideration by policymakers and physician leaders, and will continue to monitor this issue on behalf of the House.

References for this report are available from the AMA Division of Socioeconomic Policy Development.