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MEDICARE TRUST FUND SOLVENCY PROBLEM

Unlike the Republicans, This is Not a Problem Democrats Just Discovered. The President, his Administration and the Democrats have been concerned about Medicare trust fund from the beginning. OBRA 1993 and economic improvements resulting from this legislation have strengthened the trust fund and pushed out the insolvency date by three years. Furthermore, in the context of broader reforms, the Administration's proposal would have extended the life of the trust fund another 5 years. **The Republicans rejected each and every initiative that would have strengthened the Medicare Trust Fund.**

The Medicare Trust Fund is a Long-Term Problem that Needs to be Addressed. Of course with the aging of our population, there is a long-term solvency problem for the Medicare trust fund. This is nothing new, but it needs to be addressed. It needs to be addressed thoughtfully, outside the budgetary process, and independent of partisan politics.

In Contrast to the Democrats, the Republicans Have Just Discovered this Issue. In the last two years, all the Republicans have done has been to oppose our efforts to improve the Trust Fund. As a matter of fact, the only proposal they have put forth (their tax cut for the highest income seniors -- the top 13 percent) actually exacerbates the problem.

The Republicans are Using the Trust Fund as a Smoke Screen for Cuts. Let's be clear: Their proposals have nothing to do with the long-term solvency issue; they do not address the underlying problems of an aging population. The Republicans want to use the Medicare program as a bank for their tax cuts for the wealthy and to fulfill their campaign promises.

When they Finally Put Forth a Detailed Budget and Commit to Dealing with Medicare in the Context of Serious Health Care Reform, the President Stands Ready to Work Toward a Real Solution: Currently, the issue of Medicare is only being addressed by Republicans as they face a political crisis to find funds to pay for large tax cuts for the well-off and fulfill their campaign budget promises. When Republicans finally put forth a budget that is detailed and makes clear they are not slashing Medicare to pay for tax cuts, the President stands ready to work with Republicans to address the real problems facing the Trust Fund and the American people in the health care system.

REPUBLICAN MEDICARE CUTS

Republicans are considering proposals that would cut Medicare funding by between \$250 billion and \$305 billion between now and 2002. Slashing Medicare at this level translates into 20% to 25% cuts in 2002 alone for this program serving our most vulnerable Americans -- the elderly and disabled.

COERCION INSTEAD OF CHOICE: Managed care simply cannot produce anywhere near the magnitude of Federal savings being suggested by the Republicans without turning Medicare into a fixed voucher program. That would put Medicare's 36 million beneficiaries, many of whom have pre-existing conditions, into the private insurance market to shop for what they can get. With a fixed and limited voucher, beneficiaries would have to pay far more to stay in the current Medicare program if large savings are to be realized. That's not choice, that is financial coercion.

ADDING TO ALREADY HIGH COSTS FOR SENIORS: Today, despite their Medicare benefits, health care consumes major amounts of older Americans' income. According to the Urban Institute, the typical Medicare beneficiaries already dedicate a staggering 21% (or \$2,500) of their incomes to pay for out-of-pocket health care expenditures.

\$3,100-\$3,700 Out-of-Pocket Payments: If the Republican cuts (\$250 billion to \$305 over seven years) are evenly distributed between health care providers and beneficiaries, the cuts would add an additional \$815 to \$980 in out-of-pocket burdens to Medicare beneficiaries in 2002. Over the seven year period, the typical beneficiary would pay between \$3,100 to \$3,700 more.

Reduce Half of Social Security COLA: The Republicans say they aren't cutting Social Security, but these Medicare cuts are a back-door way of doing just that. By 2002, the typical Medicare beneficiary would see 40 to 50 percent of his or her cost-of-living adjustment eaten up by the increases in Medicare cost sharing and premiums. In fact, about 2 million Medicare beneficiaries will have all or more than all of their COLAs consumed by the Republican beneficiary cost increases.

\$40-\$50 Billion in Cost-Shifting: Assuming the other half of the Republicans' cuts go to providers, hospitals, physicians and other providers would be targeted with between a \$125 billion to \$150 billion cut over seven years. In 2002 alone, a \$33 billion cut in providers would be needed. Even if only one-third of Medicare provider cuts overall are shifted onto other payers (an assumption consistent with a 1993 CBO analysis), businesses and families would be forced to pay a hidden tax of \$40 billion to \$50 billion in increased premiums and health care costs between now and 2002.

Rural and Inner City Hospitals At Risk: Cuts of this magnitude, combined with the growing uncompensated care burden (which would be further exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. As a result, quality and access to needed health care would be threatened.

THE REALITY OF MEDICARE GROWTH

- Despite the current rhetoric, Medicare expenditure growth is comparable to the growth in private health insurance.
 - Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is projected to grow only about one percentage point faster than private health insurance.
 - So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

MAJOR BURDEN ON RURAL AMERICA

- Reducing Medicare payments would disproportionately harm rural hospitals.
 - Nearly 10 million Medicare beneficiaries (25% of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and serve large numbers of Medicare patients.
 - Significant cuts in Medicare revenues has great potential to cause a good number of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are already substantial local subsidies.
 - Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.
 - Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

UNDERMINES URBAN SAFETY NET

- Large reductions in Medicare payments would have a devastating impact on a significant number of urban safety-net hospitals. These hospitals already are bearing a disproportionate share of the nation's growing burden of uncompensated care. **On average, Medicare accounted for a bigger share of net operating revenues for these hospitals than did private insurance payers.**

REPUBLICAN MEDICAID CUTS

Republicans are considering cutting federal Medicaid funding by \$160 to more than \$190 billion between 1996 and 2002. The Republicans claim that they are not cutting the program, but simply reducing the rate of growth. Yet, these technical number disputes avoid the real question: who will be hurt, who will lose coverage and who will lose benefits if \$160 to \$190 billion are cut from a program that provides critical health care services. It also ignores the fact that 3 to 4 percent of program growth is for the increasing number of people being covered, without which millions more Americans would be uninsured.

- **HEAVY BURDEN TO FAMILIES FACING LONGTERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average \$38,000 a year.
- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little to no evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.
- **FLEXIBILITY CAN'T MASK DEEP CUTS:** Republicans defend these cuts by saying that what they are doing is giving added flexibility to states through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous federal cuts -- forcing them to cut spending for education, law enforcement or other priorities -- and that's unrealistic.

LIKELY IMPACTS: So let's look at what these cuts really mean. Even accounting for some managed care savings, they mean deep cuts in eligibility, benefits and payments to doctors, hospitals, nursing homes and other health care providers. If the Republicans were to cut \$160 to \$190 billion between 1996 and 2002 and those cuts were divided evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, that would mean -- in the year 2002 alone -- that:

- **5 TO 7 MILLION KIDS WOULD LOSE COVERAGE; and**
- **800,000 TO 1 MILLION ELDERLY AND DISABLED BENEFICIARIES WOULD LOSE COVERAGE; and**
- **TENS OF MILLION LOSE BENEFITS:** All preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the \$190 billion were cut; and
- **OVER TEN BILLION REDUCED TO HEALTH CARE PROVIDERS:** Already low payments to health care providers would be reduced by \$10.7 to \$12.8 billion.

**MEDICARE/MEDICAID CUTS:
BUSINESS, PROVIDER AND ADVOCACY GROUPS' RESPONSES**

The National Association of Manufacturers says:

"Across the board reductions in [Medicare and Medicaid] should be avoided, since they are likely to exacerbate cost-shifting to the private sector." (February 11, 1995)

Eastman Kodak says:

"My message to you as you wrestle with the growing costs of the Medicare program is that greater use of managed care and aggressive purchasing of care on the part of the government are more appropriate solutions than massive across-the-board cuts in payments to providers, which result in cost shifting or an invisible tax on companies providing coverage to employees in the private sector." (March 21, 1995)

American Hospital Association says:

"One of every four hospitals in the United States is in 'serious trouble,' and with deep reductions in Medicare growth will be forced to cut services or close its doors." (April 13, 1995)

"The wrong way [to reform Medicare] is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors." (February 6, 1995)

"Sixty-four percent of the electorate believes that if you ran for office saying that you would not cut social security, and if Congress votes this year to cut Medicare then that Member of Congress has broken their campaign promise." (April 1995 Polling Data Report)

American Association of Retired Persons says:

"Medicare was hardly discussed in the last election; and there was certainly no mandate from the electorate to change the system." (March 28, 1995)

Medicare cuts "would mean that over the next 5 years older Americans would pay at least \$2000 more out of pocket than they would pay under current law. And over the next seven years they would pay \$3489 more out of pocket." (March 6, 1995)

"...[T]he total number of Medicaid beneficiaries in need who would lose long-term care services...could reach 1.75 million in the year 2000." (March 6, 1995)

The National Council of Senior Citizens says:

"The facts do not warrant a panic approach or a fundamental recasting of Medicare. The trust fund is not about to go belly-up; a seven-year window does not merit a panic button."

"The levels of the cuts in Medicare contemplated by the Senate and House Budget Committees will not just devastate the finances of millions of older citizens, but more importantly, they will devastate the hopes for a secure and healthy old age for all Americans." (April 1995)

Older Women's League says:

"We receive hundreds of letters from women who are already forced to choose between paying for food and rent and buying much needed medicine that is not covered by their Medicare. Substantial cuts in Medicare will literally take food out of the mouths of these older women." (January 10, 1995)

Children's Defense Fund says:

"States could make these cuts in several ways: by raising taxes substantially; by excluding groups of children from programs or putting them on waiting lists; by reducing benefits or the quality of services; or by making low-income families pick up more costs through co-payments and fees. Regardless of which method is chosen, the overall effect would be large." (April 19, 1995)

Catholic Health Association says:

"Budget cuts of such magnitude [in Medicare and Medicaid] would attack the very fiber of these programs and, in fact, decimate them. Consequently, the Catholic Health Association believes that Congress should put aside consideration of tax cuts for now and refocus the debate on how best to solve the deficit problem." (March 2, 1995)

THE WHITE HOUSE

WASHINGTON

May 1, 1995

The Honorable Newt Gingrich
Speaker
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

The President has asked me to respond to your letter of April 28, 1995. As the Administration has shown over the last two and a half years, we are committed to reducing the deficit and achieving meaningful health care reform. We continue to seek progress on both of these fronts, while also making our tax system fairer and our system of investing in education and children even stronger.

When this President took office on January 20, 1993, he inherited an escalating deficit and a Medicare Trust Fund that was projected to be insolvent in 1999. Twenty-seven days later, he proposed, and then helped pass, a historic deficit reduction plan that included several serious policies to strengthen the Trust Fund. Indeed, these proposals pushed out the insolvency date by three full years.

Last year, the President spoke directly to the nation about the need to reform our health care system and made clear that further federal health savings needed to take place in the context of serious health care reform. In December 1994, the President wrote the Congressional leadership and made clear that he would work with Republicans to control health care spending in the context of serious health care reform. The President repeated this offer in his 1995 State of the Union speech.

Despite these repeated calls for significant action on health care reform, the reply from the Republicans has been silence. Indeed, the only proposal in the Contract with America that specifically addresses the Medicare Trust Fund would explicitly *weaken* it by \$27 billion over seven years and undo some of the progress made in 1993.

Moreover, the over \$300 billion in Medicare cuts over seven years -- the largest Medicare cut in history -- you are reported to be considering would be completely unnecessary if you did not have to pay for a seven-year \$345 billion tax cut that goes predominantly to well-off Americans. *No amount of accounting gimmicks, separate accounts, dual budget resolutions or reconcillations can hide the reality that you are essentially calling for the largest Medicare cut in history to pay for tax cuts for the well-off.*

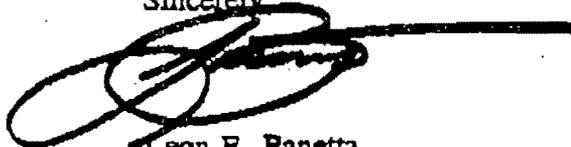
The President has long stated that making significant cuts in Medicare and Medicaid outside the context of health care reform will not work. Such dramatic cuts could lead to

less coverage and lower quality, much higher costs to poor and middle income Medicare recipients who cannot afford them, a coercive Medicare program, and cost-shifting that could lead to a hidden tax on the health premiums of average Americans. That is why it is essential to deal with the Medicare Trust Fund in the context of health care reform that protects the integrity of the program, expands not reduces coverage, and protects choice as well as quality and affordability.

The Medicare Trust Fund is an important issue that needs to be addressed in a bipartisan way in the context of larger health care reform. To do that, you must first meet the requirements of the budget law that Congress pass a budget resolution. The April 15 deadline has passed, and the American people are still waiting to see the new Republican majority fulfill this responsibility. If you really want to work together on the Medicare Trust Fund, you must first pass a budget plan that fully specifies how you plan to balance the budget and pay for the proposed tax cuts.

We hope that you will work hard to respond to these issues. The Administration and the American people continue to await your proposals.

Sincerely,

A handwritten signature in black ink, appearing to read 'Leon E. Panetta', with a long horizontal line extending to the right.

Leon E. Panetta
Chief of Staff

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

MEDICARE CUTS? LOOK WHAT REPUBLICANS SAID LAST YEAR!

Dear Democratic Colleague:

The Republicans are about to try to cut Medicare \$250 to \$310 billion over the next 7 years.

Last year all 14 Republican Members of the Ways and Means Committee signed the following minority views to HR 3600, the Health Reform bill:

"The reimbursement levels of medicare have reached potentially disastrous levels, as ProPAC's current report underscores.

"Anyone who doubts this only has to look at the current Medicare program for the elderly and the Medicaid program for the poor. For more than a decade, Congress has cut back on payments to doctors and hospitals until they no longer cover the cost of care for Medicare and Medicaid patients--and the additional massive cuts in reimbursement to providers proposed in this bill will reduce the quality of care for the nation's elderly."

As you remember, HR 3600 did cut Medicare spending \$157 billion over 7 years but returned ALL the money to the health care system by insuring everyone (no more bad debt and uncompensated care for doctors and hospitals) and providing seniors with a prescription drug coverage and better Medicare benefits. The Republican cuts won't go for Medicare improvements or health care reform--they will just be cuts.

We should all remind the Republicans--often--of what they said last year.

Sincerely,

Pete Stark
Member of Congress

***How should the transfers to Medicare
be calculated and described?***

Background

- In the State of the Union framework, the transfers to Medicare were described as “15 percent of the unified surpluses over the next 15 years.” These transfers were sufficient to extend the life of the Trust Fund from 2008 to 2020.
- Since the SOTU address, the Trustees have revised the exhaustion date under current law to 2015.
- In the Mid-Session Review, the unified surpluses will be larger than was projected when the SOTU framework was being put together. Under MSR assumptions, therefore, 15 percent of the unified budget surpluses will exceed 15 percent as of the SOTU.
- We may want to preserve our flexibility to frame the transfers to Medicare in some way other than as a percent of unified surpluses.

Options

- *15 percent of the unified surpluses over the 15-year period, regardless of how the projection may change.*

Pros

- Most consistent with our rhetoric immediately following the SOTU address.
- Would minimize the risk of tipping others off that we may recast the President’s Social Security proposal in on-budget/off-budget terms.
- Could allow flexibility with respect to timing.

Cons

- If the MSR has not been released by the time of the Medicare roll-out, could require that we revise our stream of Medicare transfers in short order.
- With the upward revision to the MSR, would commit more resources to Medicare, and so would leave less for other purposes, relative to other options.
- Would keep the conceptual focus on the unified surplus.

- *Exactly the same stream of nominal transfers as assumed in the SOTU framework*

Pros

- Could also be construed as maintaining the President's SOTU commitment.
- Relative to the first option, would free up more resources for other purposes.

Cons

- Because it would allow no flexibility with respect to timing of transfers, could put greater pressure on the on-budget account relative to other options.

- *Same as SOTU in PDV terms, but without a specified time path for transfers.*

Pros

- Could be portrayed as maintaining the SOTU commitment.
- Would reserve more resources for non-Medicare purposes relative to the first option.
- By allowing the transfers to be more backloaded than under the SOTU framework, would reduce pressure on the on-budget surpluses early in the 15-year period relative to the second option.

Cons

- Could be difficult to explain when most people don't know what a "PDV" is.
- Not clear the HCFA actuary will score a plan with indeterminate time pattern for the transfers.

- *Commit to extending the life of the Medicare Trust Fund to some specific date.*

Pros

- Easier to explain than anything involving present-discounted values.
- Could be portrayed as exceeding the SOTU commitment, since it would be possible to commit to a date beyond 2020, even with drugs.

Cons

- Could be attacked as merely providing cover for transferring less to Medicare.

What should be included in the MSR?

Background

- Traditionally, the MSR discusses both the current-law baseline *and* the President's policy program.
- Therefore, a traditional approach would probably involve showing year-by-year numbers for the transfers to Medicare. (Under the budget scoring we propose to implement, the transfers would reduce the *reported* "on-budget surplus" dollar for dollar, even though Medicare is an on-budget program.)
- The MSR is scheduled to be "put to bed" June 17, and it is unlikely that year-by-year Medicare transfer numbers can be finalized by then, not least because the Social Security framework is still in flux.

Options

- *Provide the specifics of the Medicare proposal, including specific annual numbers for the stream of transfers to Medicare. Also include a fully-specified updated Social Security reform proposal.*

Pros

- The most appropriate presentation if everything (Medicare and Social Security reform) were ready to go.

Cons

- Not everything is ready to go.

- *Same as the first option, but stick with the SOTU Social Security plan.*

Pros

- Would allow us not to nail down a Social Security program in time for the MSR.

Cons

- Might put us in the position of revising the MSR almost immediately, if we issue a revamped Social Security framework.

- *A verbal description of the mechanics of Medicare reform without detailed numbers. "The President proposes to transfer to Medicare resources of the following general description..."*

Pros

- By avoiding providing specific year-by-year numbers, would maintain greater flexibility with respect to possible redesign of Social Security proposal.

Cons

- Would provide less information than traditional in the MSR.

- *General discussion of the importance of health care for the elderly.*

Pros

- Would maintain maximum flexibility with respect to redesign of Social Security proposal.

Cons

- Would be attacked as lacking concreteness.

How should the Medicare rollout be timed relative to the release of the Mid-Session Review?

Background

- The Medicare rollout is currently targeted for June 28-30.
- The MSR will be ready on June 28 at the earliest.
- OMB wants the MSR to come out before or, at worst, only a day or two after the CBO Update which is apparently on target for release on July 1.

Options

- *Do Medicare rollout first.*

Pros

Cons

- *Do Medicare rollout and MSR release simultaneously.*

Pros

Cons

- *Do MSR release first. Then either follow quickly with Medicare, or delay Medicare rollout into July.*

Pros

- Would allow Medicare plan to reflect latest budget numbers.
- If Medicare rollout is delayed, might be possible to avoid discussing Medicare reform plan in detail in MSR.

Cons

- Would risk renegeing on President's commitment to release Medicare plan by the end of June.

**What is the connection between Medicare reform and
Save Social Security First?**

Background

- In the 1998 and 1999 SOTUs, the President declared that the unified surpluses should not be used for any other purpose until Social Security reform has been accomplished.
- In the early going, this was interpreted to mean that no element of the President's plan (Medicare transfers, USAs, or discretionary spending increases) could be enacted before Social Security reform.
- The Medicare reform plan, by itself, will reduce the unified surpluses because the cost of the drug benefit exceeds the savings from the plan's reform elements.

Options

- *Status quo "hardline": No Medicare reform (and no new drug benefit) without Social Security reform first.*

Pros

- Might offer a real opportunity of enacting *both* Social Security reform and Medicare reform.

Cons

- Risks forgoing a Medicare deal, even if one could be had, if Social Security reform goes nowhere.

- *No legislation without agreed timepaths of Medicare and Social Security transfers.*

Pros

- Might accomplish the main objective of the President's program -- to set aside the bulk of the projected unified surpluses -- without requiring all sides to come to terms on full 75-year solvency for Social Security.

Cons

- Might needlessly give up the tactical highground associated with Save Social

Security First.

- *It's time to do Medicare!*

Pros

- Allows maximum flexibility to take a deal on Medicare -- if one becomes available -- without regard to progress on Social Security.

Comments due
tomorrow
11 am

The Financial Outlook for Medicare

Testimony before the
Senate Finance Committee
on May 5, 1999

by

Richard S. Foster, F.S.A.
Chief Actuary
Health Care Financing Administration

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting me to testify today about the financial outlook for the Medicare program. I welcome the opportunity to assist you in your efforts to ensure the future financial viability of the Nation's second largest social insurance program—one that is a critical factor in the income security of the our aged and disabled populations.

The financial outlook for the Medicare program has improved dramatically since 1997 as a result of the Balanced Budget Act of 1997, together with recent strong economic growth, moderate increases in health costs generally, and continuing efforts to combat fraud and abuse. Even so, there remains a serious imbalance between long-range income and expenditures for the Hospital Insurance (HI) trust fund and growth rates for Supplementary Medical Insurance (SMI) benefits are expected to continue to exceed growth in the Nation's economy.

Background

Chart 1 summarizes the enrollment, covered services, and financing provisions of the Medicare program. Information is shown separately for the HI and SMI programs, also known as "Parts A and B," respectively. As indicated, roughly 39 million people were eligible for Medicare benefits in 1998. HI provides partial protection against the costs of inpatient hospital services, skilled nursing care, post-institutional home health care, and hospice care. SMI covers most physician services, outpatient hospital care, home health care not covered by HI, and a variety of other medical services such as diagnostic tests, durable medical equipment, and so forth.

Only about 22 percent of HI enrollees received some reimbursable covered services during 1998, since hospital stays and related care tend to be infrequent events even for the aged and disabled. In contrast, the vast majority of enrollees incur reimbursable SMI costs because the covered services are more routine and the annual deductible for SMI is only \$100.

The two parts of Medicare are financed on totally different bases. HI costs are met primarily through a portion of the FICA and SECA payroll taxes.¹ Of the total FICA tax rate of 7.65

¹ Federal Insurance Contributions Act and Self-Employment Contributions Act, respectively.

percent of covered earnings, payable by employees and employers, each, HI receives 1.45 percent. Self-employed workers pay the combined total of 2.90 percent. Following the Omnibus Budget Reconciliation Act of 1993, HI taxes are paid on total earnings in covered employment, without limit. Other HI income includes a portion of the income taxes levied on Social Security benefits, interest income on invested assets, and other minor sources.

SMI enrollees pay monthly premiums (\$45.50 in 1999) that cover about 25 percent of program costs. The balance is paid by general revenue of the Federal government and a small amount of interest income.

The HI tax rate is specified in the Social Security Act and is not scheduled to change at any time in the future under present law. Thus, program financing cannot be modified to match variations in program costs except through new legislation. In contrast, SMI premiums and general revenue payments are reestablished each year to match estimated program costs for the following year. As a result, SMI income automatically matches expenditures without the need for legislative adjustments.

Each part of Medicare has its own trust fund, with financial oversight provided by the Board of Trustees. My discussion of Medicare's financial status is based on the financial projections contained in the Board's 1999 report to Congress. Such projections are made under three alternative sets of economic and demographic assumptions, to illustrate the uncertainty and possible range of variation of future costs, and cover both a "short range" period (the next 10 years) and a "long range" (the next 75 years). The projections are not intended as firm predictions of future costs, since this is clearly impossible; rather, they illustrate how the Medicare program would operate under a range of conditions that can reasonably be expected to occur. The projections shown in this testimony are based on the Trustees' "intermediate" set of assumptions.

Short-range financial outlook for Hospital Insurance

Chart 2 shows past income, expenditures, and trust fund assets for the HI program and projections through 2015. For most of the program's history, income and expenditures have been very close together, illustrating the pay-as-you-go nature of HI financing. The taxes collected each year are intended to be roughly sufficient to cover that year's costs. Surplus revenues are invested in special Treasury securities. The Board of Trustees has recommended maintaining assets equal to at least one year's expenditures as a contingency reserve.

During 1990-97, HI expenditures increased at a faster rate than HI income. Expenditures exceeded income by \$2.6 billion in 1995, \$5.3 billion in 1996, and \$9.3 billion in 1997. Prior to the Balanced Budget Act, this trend was expected to continue, with costs growing at about 8 percent annually, against revenue growth of only 5 to 6 percent. The 1995-97 shortfalls were met by redeeming trust fund assets, but in the absence of corrective legislation assets would have been depleted in about 2001. The Medicare provisions in the Balanced Budget Act were designed to help address this situation and, as indicated in chart 2, these changes significantly reduce the

the Balanced Budget Act provisions. After 2002, however, cost rates would increase steadily and accelerate significantly with the retirement of the baby boom, beginning in about 2010. Closing the HI deficit over the first 25 years would require either an 11-percent reduction in benefits or a 12-percent increase in income, or some combination, starting immediately. Over the full 75-year period, the adjustments would have to be considerably greater.

The effect of the baby boom's retirement on Social Security and Medicare is relatively well known, having been discussed at length for more than 25 years. When the HI program began, there were 4.5 workers in covered employment for every HI beneficiary, as shown in chart 5. Currently, this ratio is 3.9 workers per beneficiary. With the advent of the baby boom's retirement, the number of beneficiaries will increase more rapidly than the labor force, resulting in a decline in this ratio to 2.2 in 2030 and 2.0 in 2050 under the intermediate projections. Other things being equal, there would be a corresponding increase in HI costs as a percentage of taxable payroll.

There are other demographic effects beyond those attributable to the varying number of births in past years. In particular, life expectancy has improved substantially in the U.S. over time and is projected to continue doing so. The average remaining life expectancy for 65-year-olds increased from 12.4 years in 1935 to 17.4 years currently, with an estimated further increase to over 20 years at the end of the long-range projection period. Medicare costs are also sensitive to the age distribution of beneficiaries. Older persons incur substantially larger costs for medical care, on average, than younger persons. Thus, as the beneficiary population ages over time they will move into higher-utilization age groups, thereby adding to the financial pressures on the Medicare program.

The key factors underlying past and projected increases in HI expenditures are summarized in chart 6. Aggregate cost increases have been factored into (i) growth in the number of beneficiaries, (ii) increases in general inflation, as measured by the Consumer Price Index, and (iii) all other factors, reflecting per capita increases in the utilization of health services and the "intensity" (or average complexity) of such services. Through the early 1980s, general inflation was a major contributor to growth in HI costs. The "all other" category has seen major swings in the past, from average annual increases of as much as 6 percent to as little as 0.7 percent.

Under the intermediate projections, the impact of the baby boom's retirement clearly shows up in its effect on beneficiary growth rates. The Trustees project a fairly constant rate of inflation at about 3.3 percent annually. Projected growth in the "all other" category varies significantly, reflecting the net impact of several factors. Initially, residual growth rates are low due to the impact of the Balanced Budget Act. After 2002, utilization is expected to reaccelerate, although not as severely as in past years, due to the new prospective payment systems mandated by the Act. Future demographics will also play a role: as an influx of 65-year-old baby boomers arrives, average per capita utilization will actually decrease temporarily, as the average age of beneficiaries declines. As the baby boom generation ages, however, their utilization will increase and drive up residual HI growth rates overall.

A final factor affecting the residual growth rates shown in chart 6 is an assumption that health costs cannot continue to grow indefinitely at the high rates frequently experienced in the past. A simple extrapolation of the past quickly leads to a situation where Medicare alone would represent a substantial portion of total gross domestic product—an untenable and unrealistic situation. For this reason, residual growth rates are purposely assumed to gradually moderate toward the end of the first 25-year projection period. This assumption has been used for many years and has been found appropriate in the past by independent panels of expert actuaries and economists. More recently, however, it has received considerable criticism. Accordingly, I have asked my staff to carefully review the long-range Medicare growth assumptions. In addition, the Board of Trustees is convening a new expert panel for the purpose of reviewing the Medicare trust fund projections. We will also ask this group to review the long-range growth assumptions.

Financial outlook for Supplementary Medical Insurance

Chart 7 presents estimates of the short-range outlook for SMI and is generally similar to the information presented in chart 2 for the HI program. Two key differences stand out: First, the income and expenditure curves for SMI are nearly indistinguishable in the future. As noted previously, SMI premiums and general revenue income are reestablished annually to match expected program costs for the following year. Thus, the program will automatically be in financial balance, regardless of future program cost trends. The second difference is the relative level of trust fund assets. Since financing is reset frequently, a lower level of assets can suffice for contingency reserve purposes.

The primary concern for SMI is the rapid rate of growth in benefits. SMI costs grow by 41 percent over the last 5 years, exceeding the growth in the nation's gross domestic product (GDP) by 9 percent. Similar growth is projected for the short-range future. Although the Balanced Budget Act contained a number of provisions designed to reduce the rate of growth in SMI expenditures, their impact is more than offset by two other factors. First, the Act specified that home health services not associated with a prior stay in an institution were to be converted to Part B benefits and paid for by the SMI trust fund (phased in over several years). In addition, the Act provides for several significant new preventive or "screening" benefits, such as colorectal examinations, not previously covered by Medicare. As a result, SMI costs are estimated to increase somewhat as a result of the Balanced Budget Act.

The increase in SMI costs is offset by additional premium revenue under a provision to maintain the SMI premium at the level of 25 percent of expenditures. Prior to the Balanced Budget Act, premium increases would have been limited to the Social Security cost-of-living adjustment (COLA) and, over time, would have represented a declining share of total costs. The Balanced Budget Act makes permanent the current relationship between premium revenue and total costs.

The long-range cost of SMI (shown in chart 8 as a percentage of GDP) is expected to follow the same general pattern seen previously for HI. In contrast to HI, these costs will automatically be met through enrollee premiums and general revenues of the Federal government. Policy makers remain concerned about continuing rapid growth in SMI expenditures.

Conclusions

In their 1999 report to Congress, the Board of Trustees notes the substantial improvements in the financial outlook for Medicare that have come about as a result of the Balanced Budget Act of 1997, together with recent strong economic growth and relatively slow growth in health costs generally. But they emphasize the continuing financial pressures facing Medicare and urge the Nation's policy makers to take further steps to address these concerns. They also argue that consideration of further reforms should occur in the relatively near future. Today's relatively favorable conditions could change, accelerating the expected return to deficits in the HI trust fund. Moreover, the earlier solutions are enacted, the more flexible and gradual they can be. Finally, the Trustees note that early action increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations.

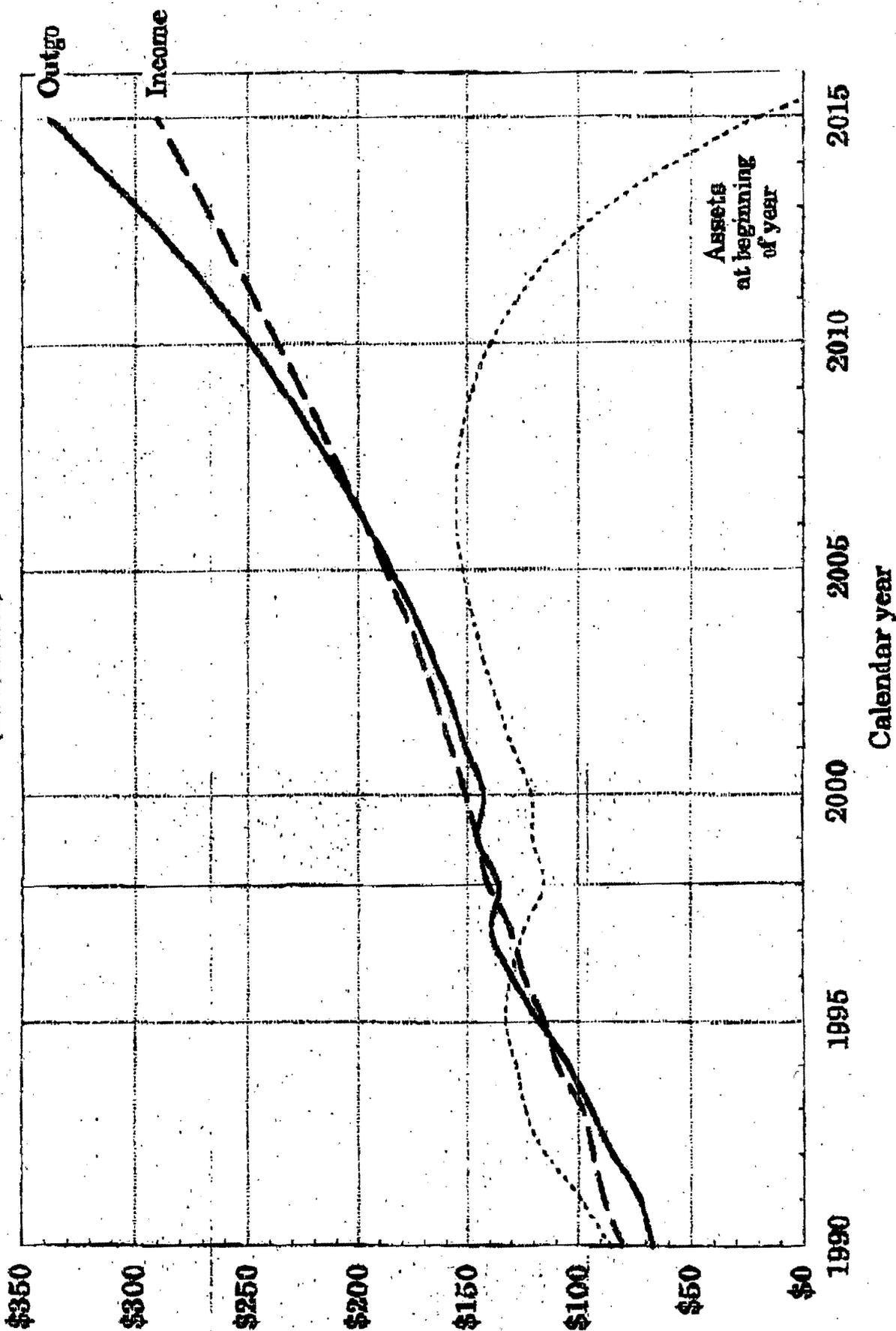
I concur wholeheartedly with the Trustees' assessment and pledge the Office of the Actuary's continuing assistance to the joint effort by the Administration and Congress to determine effective solutions to the remaining financial problems facing the Medicare program. I would be happy to answer any questions you might have on Medicare's financial issues.

Chart 1—Medicare enrollment, benefits, and financing

	Hospital Insurance (HI)	Supplementary Medical Insurance (SMD)
Enrollment in CY 1998:		
Total	39 million	37 million
Proportion with services	22%	87%
Benefits*	<p>Inpatient hospital care</p> <p>Skilled nursing care</p> <p>Home health care (post-institutional)</p> <p>Hospice care</p>	<p>Physician services</p> <p>Outpatient hospital services</p> <p>Home health care (general)</p> <p>Other services, e.g.</p> <ul style="list-style-type: none"> • Diagnostic tests • Medical equipment • Ambulance
* Subject to certain deductible and coinsurance requirements		
Financing	<p>HI tax on covered earnings:</p> <ul style="list-style-type: none"> • 1.45% payable by employees and employers, each • 2.90% payable by self-employed • Following elimination of HI contribution base (effective 1994), HI tax applies to all earnings in covered employment. <p>Revenue from taxation of OASDI benefits (portion between 50% & 85%)</p>	<p>Premiums paid by enrollees in 1999:</p> <ul style="list-style-type: none"> • \$45.50 per month for all enrollees • Covers 25% of costs <p>General revenue transfers in 1999:</p> <ul style="list-style-type: none"> • \$139.10 per month for aged persons • \$160.50 per month for disabled • Covers remaining 75% of costs

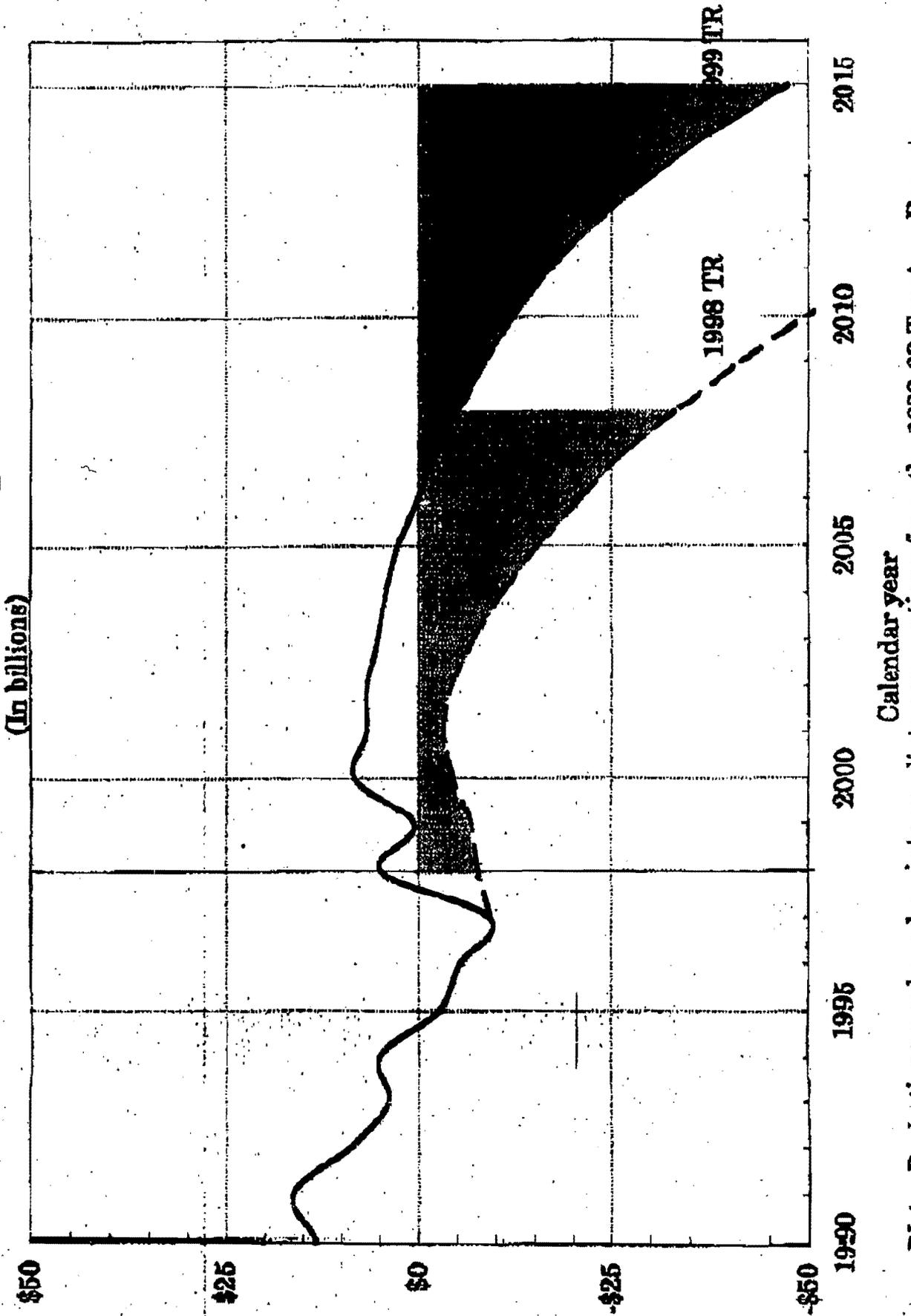
MAY-03-1999 11:23 TO:204 - C. JENNINGS FROM: JULIA VUILLE P. 8/15

Chart 2—HI income, outgo, and trust fund assets
(In billions)



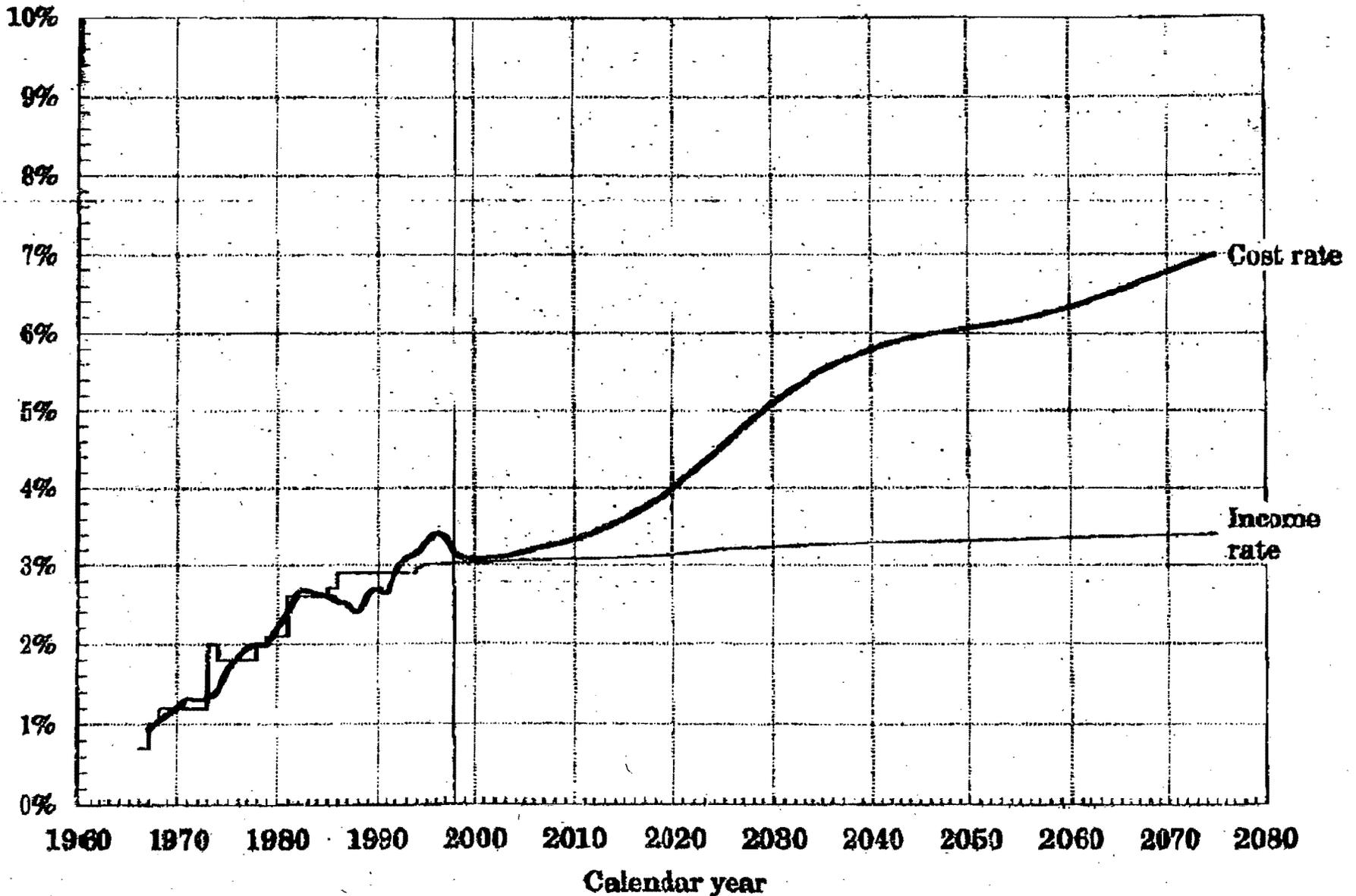
Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

**Chart 3—Net increase in HI trust fund assets,
1998 vs. 1999 Trustees Reports**



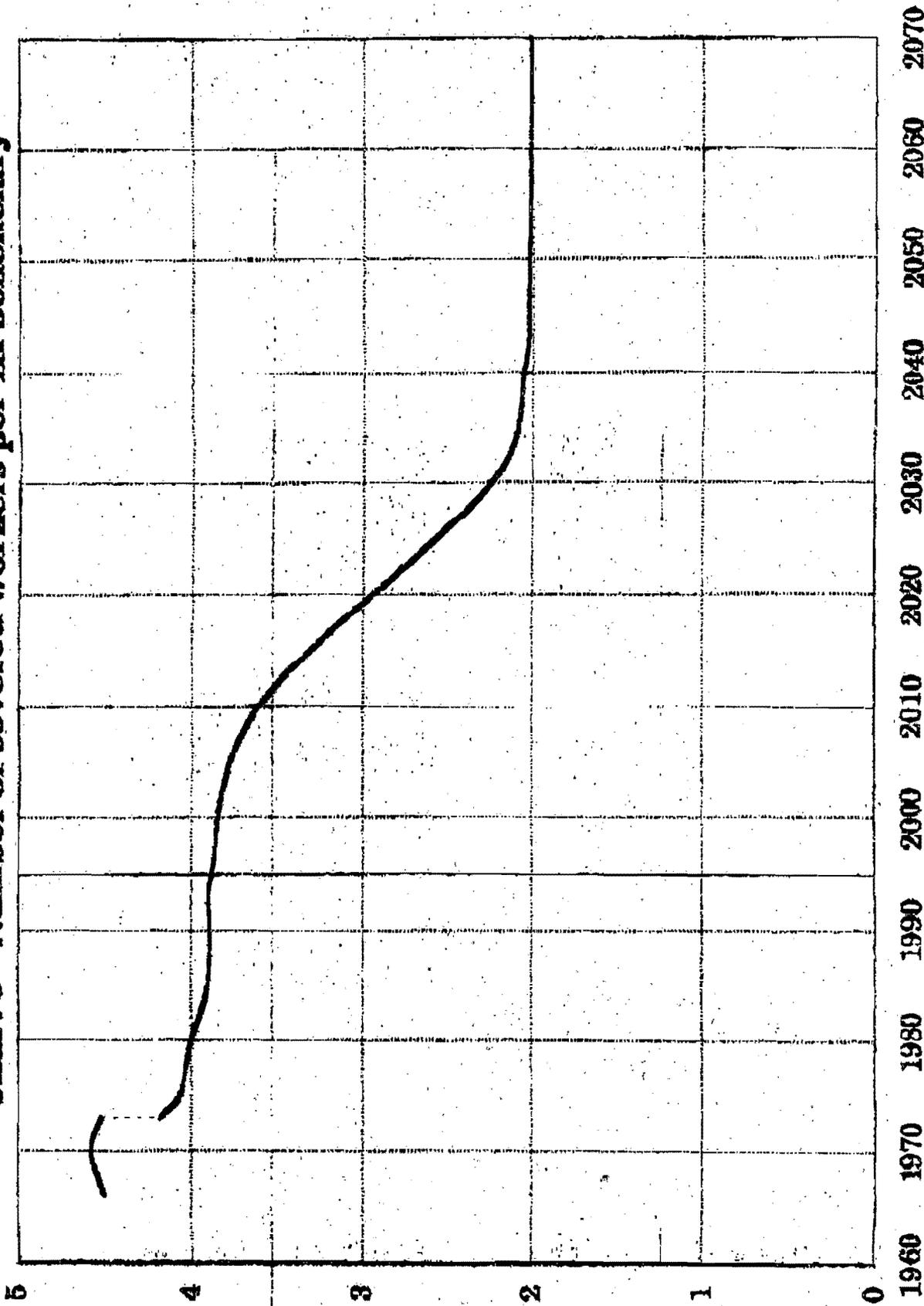
Note: Projections are based on intermediate assumptions from the 1998-99 Trustees Reports.

Chart 4—Long-range HI income and cost rates
(As a percentage of taxable payroll)



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

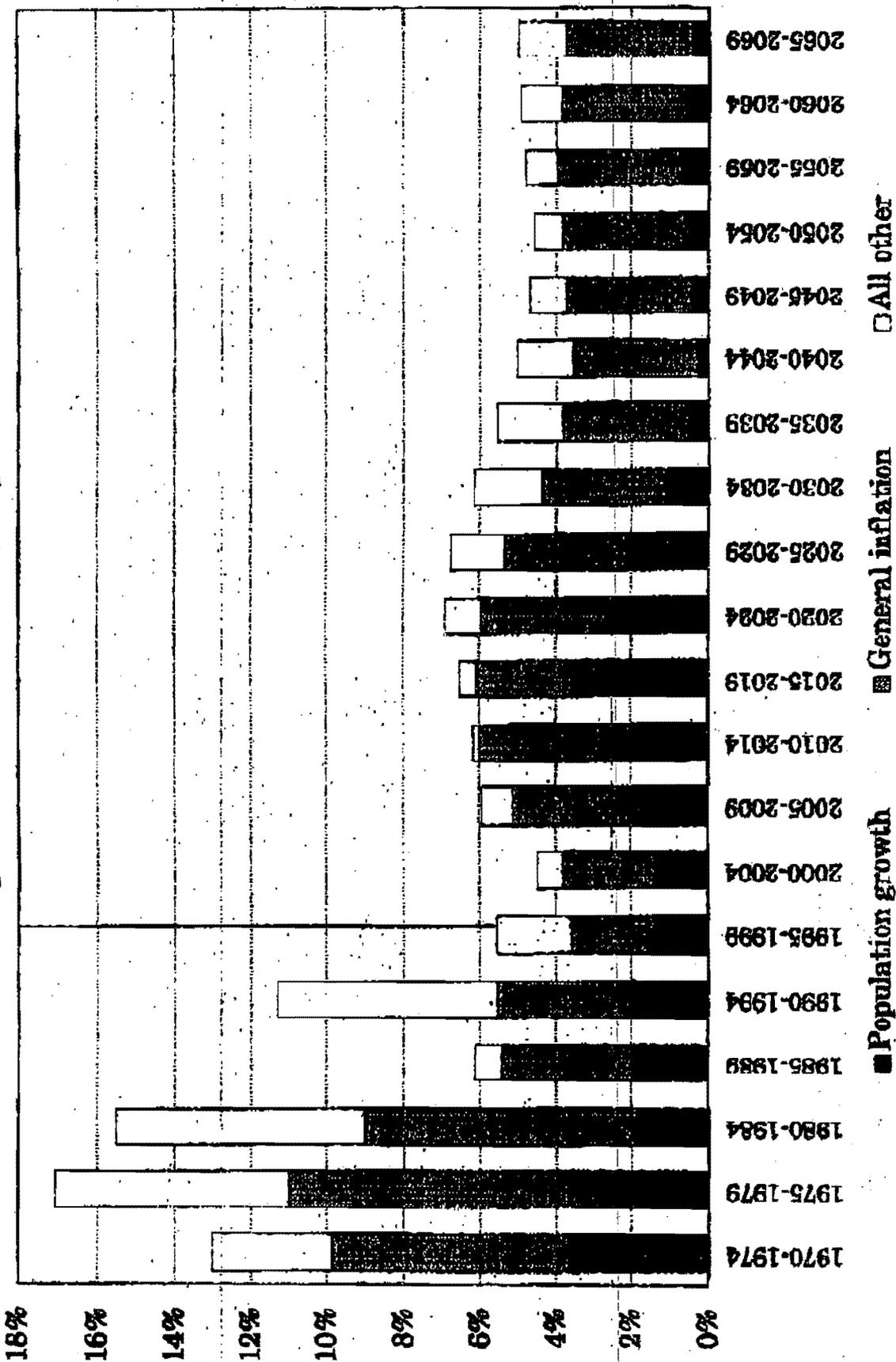
Chart 5—Number of covered workers per HI beneficiary



Calendar year

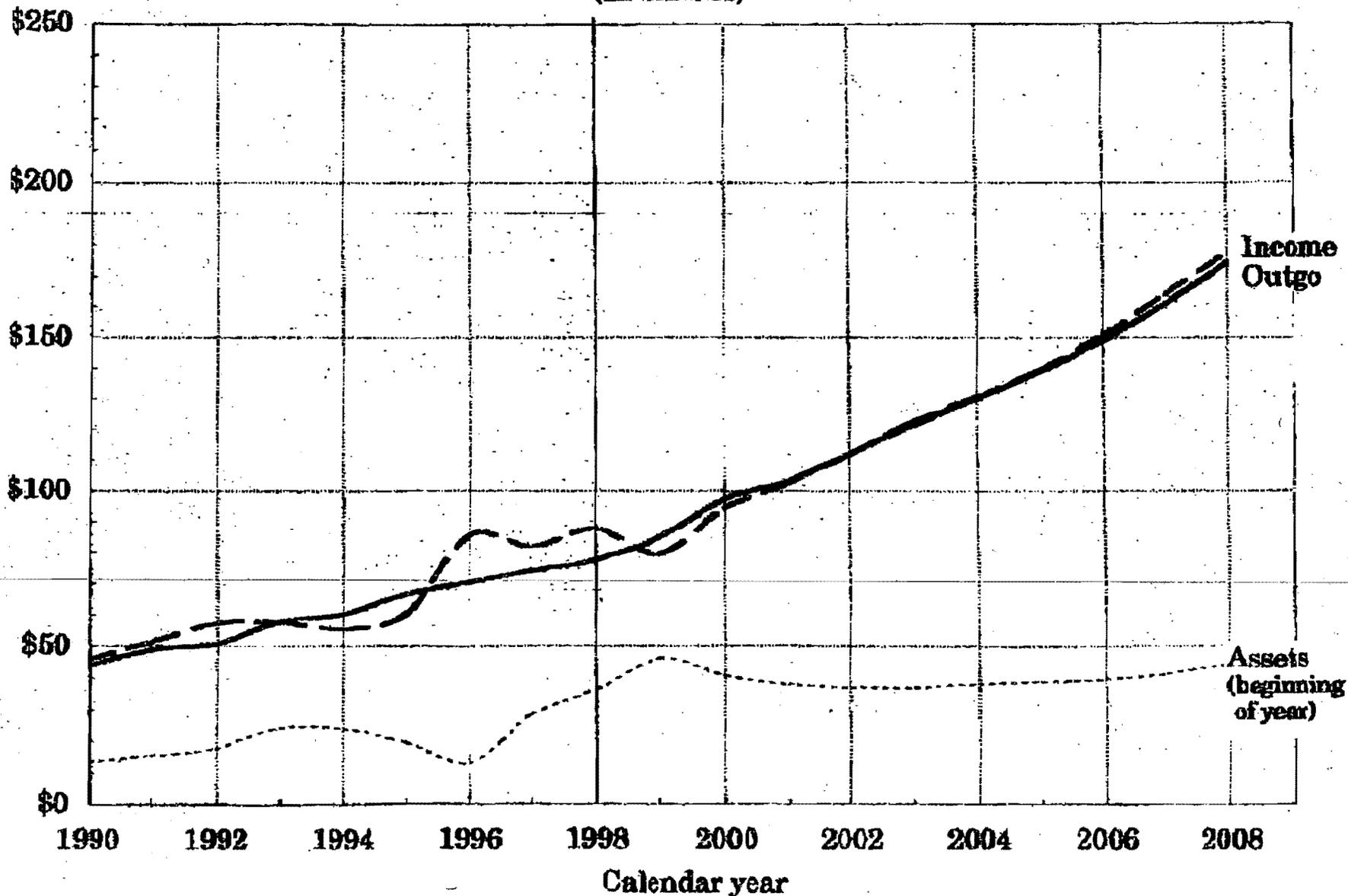
Note: Projections are based on the intermediate assumptions from the 1998 Trustees Reports

Chart 6—HI expenditure growth factors
(average annual increase over 5-year periods)



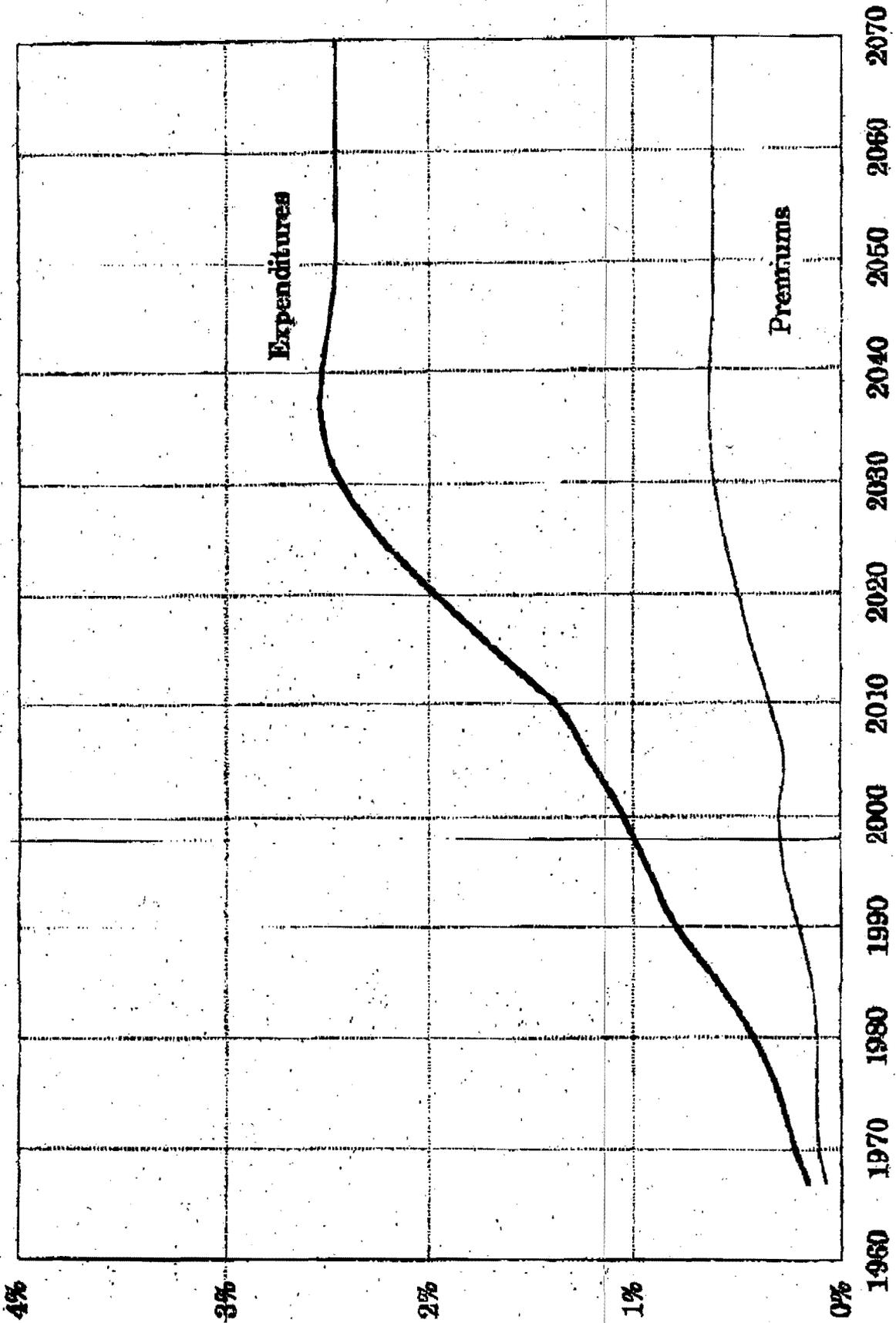
Note: Projections are based on the intermediate set of assumptions from the 1999 Trustees Reports.

Chart 7—SMI income, outgo, and trust fund assets
(In billions)



Note: Projections are based on the intermediate assumptions from the 1999 Trustees Reports.

Chart 8—SMI expenditures and premium income
[as a percentage of Gross Domestic Product (GDP)]



Calendar year

Note: Projections are based on the intermediate assumptions from the 1998 Trustees Reports.



Paul D. Glastris
03/30/99 12:20:45 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: new final trustees speech

Final 3/30/99 12:20 p.m.

Paul Glastris

**PRESIDENT WILLIAM J. CLINTON
REMARKS ON SOCIAL SECURITY AND MEDICARE
TRUSTEES REPORT
ROSE GARDEN, THE WHITE HOUSE
March 30, 1999**

Twice in the last six years, Americans have looked to the future by addressing great fiscal challenges. In 1993, we met the threat of mounting deficits and a stagnant economy with an economic plan of fiscal discipline, expanded trade, and investment in our people. Thanks to that action, the red ink of the federal budget has turned to black, and we are enjoying the longest peacetime expansion in our nation's history. In 1997, we reaffirmed our commitment to fiscal discipline with a bipartisan balanced budget agreement that also took important steps to improve Medicare, saving tens of billions of dollars in costs while expanding choices and benefits for recipients.

Today, we have new evidence that those determined actions were the right ones. I have just been briefed by the four Social Security and Medicare trustees for the administration: Secretaries Rubin, Shalala, Herman and Social Security Commissioner Apfel. The trustees have issued their annual report on the future financial health of these vital programs.

The trustees report shows that the strength of our economy has led to modest but real improvements in the outlook for Social Security. They project that economic growth today will extend the solvency of the Social Security trust fund to 2034, two years longer than was projected in last year's report. After that date, however, the trust fund will be exhausted and Social Security will not be able to pay the full benefits older Americans have been promised. Therefore we must move forward with my plan to set aside 62 percent of the budget surplus for Social Security, investing a small portion in the private sector for a better return, just as any private or state government pension plan would. And as I said in my State of the Union address, we must go further, with difficult but achievable reforms that put Social Security on a sound footing for 75 years and beyond.

The trustees have also told us today that the financial future for Medicare has improved even more. The trustees project that the life of the Medicare Trust Fund has been extended until 2015 --7 years longer than projected in last year's report. These improvements are only partially due to the strong economy. According to the trustees, they are also the result of the difficult but necessary reforms we made to Medicare in 1997, and to our successful efforts to fight waste, fraud, and abuse in the Medicare program.

The Trustees report is good news. We should be pleased. We should be proud. But we should not be lulled into complacency, because the improvements we see today did not happen not by accident. When I became President six years ago, Medicare was projected to go bankrupt this year. We worked hard in 1993 and 1997 to make sure that didn't happen. These were not easy actions. In fact, at the time, some of them were politically unpopular. But they helped strengthen Medicare while paying down the debt and allowing us room to increase investment in our children. And they laid the foundations for the difficult reforms we must still make.

Social Security and Medicare still face serious, long-term challenges, with the baby boom aging, with medical science extending the lives of millions, and with the number of elderly Americans set to double by 2030. Even with today's good news, Social Security will run out of money in just 35 years; Medicare in just 16 years. We cannot allow that to happen.

For three decades, Medicare has protected seniors and the disabled while expressing the values of care and mutual obligation that bind families and generations of Americans together. In my State of the Union address in January, I said we must seize the opportunity created by our prosperity by devoting 15 percent of the budget surplus to strengthen Medicare, while modernizing the program with real reforms and helping seniors with prescription drugs. When the Medicare Commission completed its work two weeks ago, I said we must build on its work by adopting the best practices from the private sector while also maintaining high quality services, continuing to provide every citizen with a guaranteed set of benefits, and making prescription drugs more accessible and affordable to Medicare beneficiaries.

Now, we must build on the good news we have received today. We must extend the life of Medicare even further, modernize the program even more, and make prescription drugs more accessible and affordable.

Medicare cannot remain static in the face of sweeping changes in our nation's health care system--a system that increasingly relies on prescription drugs. Today, 13 million seniors each spend more than a thousand dollars a year out-of-pocket for prescription medications. At the same time, seniors who have no drug coverage do not benefit from the lower prices that insurance firms negotiate from pharmaceutical companies. The higher prices seniors pay are like a hidden tax. We must find a way though Medicare to inject more competition into the health care system, and make the medications seniors need more affordable.

Some might say this good news means we can delay reform. Nothing could be further from the truth. Strengthening and modernizing Medicare will require tough but achievable changes. Now is the time to make those changes, when our economy is strong and our people have renewed confidence. Nothing in this report lessens the need to devote 15 percent of the surplus to strengthening Medicare, make tough but achievable reforms, and help beneficiaries with prescription drugs. If we wait--if we turn the good news of today or the hard work that lies ahead into excuses for inaction--then we will be condemning ourselves to future changes that will be much more costly and wrenching.

Today, we face a choice, a test of our wisdom as a self-governing people: will we seize this moment of prosperity and devote some of the surpluses we have created to strengthen Medicare for the future? Or will we rush into a tax cut that avoids our generation's responsibility and puts the future of Medicare at risk? This Trustees report brings welcome news, and a clear lesson: with tough, disciplined action we **can** extend the life of Social Security and Medicare. Now we must apply that lesson by acting this year to strengthen Social Security and Medicare for the 21st Century.

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Message Sent To:

Melissa G. Green/OPD/EOP
Jeff B. Liebman/OPD/EOP
Devorah R. Adler/OPD/EOP
Joshua S. Gottheimer/WHO/EOP
Loretta M. Ucelli/WHO/EOP
Tracy Pakulniewicz/WHO/EOP

Jeanne —

This is a draft of paper for tomorrow's Social Security discussion. As you review the tables you'll see it affects Medicare. Can you give me a call?

SOCIAL SECURITY MEETING

May 25, 1999

11:00am

Bill D

AGENDA

I. OPTIONS FOR FITTING SOCIAL SECURITY IN THE BUDGET:

- A: Transfers after 15 years.
- B: Add prescription drugs and benefit changes.
- C: Begin transfers after 10 years.
- D: Scale back USAs to 75 percent.
- E: Transfer available on-budget surpluses.

Budget clean

→ adding to isolate or identify

→ broken into - 2 or 3

OPTION A: TRANSFERS AFTER 15 YEARS

- SOTU discretionary.
- Phase in USAs.
- Delay Medicare transfers, but transfer the same net present value.
- Make Social Security transfers only after debt reduction has been achieved from off-budget surplus – beginning in 2015.

Percent of trust fund in stocks:	0	15	22	32	35
Trust fund exhausted in:	2047	2052	2055	2060	2061
Change in actuarial balance:	0.87	1.25	1.43	1.66	1.73
Average percent of stock market in trust fund 2001-2040:	0	2.8	4.2	6.2	6.8
Peak percent of stock market in trust fund:	0	4.0	5.9	8.5	9.3

Plan A: SOTU Discret; Phase-in USAs; Delayed Medicare with same PDV as SOTU
 Transfer interest on difference between 2014 debt and 1999 debt

year	baseline on-bud surp	discret	USAs	Medicare transfers	Soc Sec transfers	remaining on-bud surp
SSA bond PDV 2000-75:				417	1398	
2000-04:	187	138	29	0	0	6
2000-09:	1008	318	229	203	0	345
2000-14:	2681	481	469	821	0	1375
2000	1	0	0	0	0	1
2001	13	26	0	0	0	-14
2002	57	41	0	0	0	14
2003	47	36	2	0	0	5
2004	69	34	27	0	0	0
2005	82	37	34	0	0	0
2006	134	41	41	22	0	37
2007	168	39	41	40	0	67
2008	200	33	42	60	0	100
2009	237	30	42	80	0	134
2010	268	31	44	94	0	157
2011	305	32	46	112	0	186
2012	337	33	48	126	0	209
2013	367	34	50	138	0	230
2014	396	35	52	149	0	249
2015	424	36	54	0	217	43
2016	455	37	56	0	217	51
2017	488	38	58	0	217	58
2018	521	39	60	0	217	65
2019	553	40	63	0	217	69
2020	585	41	65	0	217	71
2021	618	43	67	0	217	73
2022	653	44	70	0	217	74
2023	686	45	73	0	217	73
2024	719	46	75	0	217	69
2025	752	48	78	0	217	63
2026	789	49	81	0	217	58
2027	827	51	84	0	217	53
2028	866	52	87	0	217	46
2029	906	54	90	0	217	37
2030	947	55	94	0	217	25
2031	997	57	97	0	217	21
2032	1051	59	101	0	217	17
2033	1107	61	105	0	217	12
2034	1176	62	109	0	217	16
2035	1247	64	113	0	217	19
2036	1321	66	118	0	217	20
2037	1400	68	122	0	217	24
2038	1483	70	127	0	217	25
2039	1567	72	132	0	217	25
2040	1653	75	137	0	217	21
2041	1746	77	142	0	217	20
2042	1843	79	148	0	217	16
2043	1942	81	153	0	217	9
2044	2027	84	159	0	217	-18
2045	2127	86	165	0	217	-36
2046	2232	89	171	0	217	-55
2047	2340	92	178	0	217	-79
2048	2448	94	184	0	217	-109
2049	2557	97	191	0	217	-147
2050	2666	100	198	0	217	-192

OPTION B: ADD PRESCRIPTION DRUGS AND BENEFIT CHANGES

- Same as option A, plus:
- Add prescription drug funding (ramping up to \$15 billion a year over 15 years and growing at the rate of GDP plus 1 percent thereafter).
- Add widows' benefits (phased in over 10 years).
- Add repeal of earnings test.

Percent of trust fund in stocks:	0	15	31	35
Trust fund exhausted in:	2045	2049	2055	2057
Change in actuarial balance:	0.73	1.12	1.50	1.60
Average percent of stock market in trust fund 2001-2040:	0	2.6	5.6	6.3
Peak percent of stock market in trust fund:	0	3.7	7.7	8.7

Plan B: Extra Spending (\$100b prescrip drugs, widows' benefits, earnings test)
 Transfer interest on difference between 2014 debt and 1999 debt

year	baseline on-bud	discret surp	USAs	Medicare transfers	Soc Sec transfers	remaining on-bud surp
SSA bond PDV 2000-75:				411	1294	
2000-04:	187	164	29	0	0	-22
2000-09:	1008	399	229	190	0	247
2000-14:	2681	641	469	813	0	1164
2000	1	0	0	0	0	1
2001	13	31	0	0	0	-20
2002	57	47	0	0	0	7
2003	47	43	2	0	0	-3
2004	69	42	27	0	0	-9
2005	82	46	34	0	0	-10
2006	134	51	41	17	0	25
2007	168	50	41	36	0	53
2008	200	45	42	57	0	84
2009	237	43	42	79	0	117
2010	268	45	44	94	0	138
2011	305	47	46	112	0	165
2012	337	48	48	127	0	187
2013	367	50	50	139	0	205
2014	396	52	52	151	0	222
2015	424	54	54	0	201	31
2016	455	56	56	0	201	37
2017	488	58	58	0	201	43
2018	521	60	60	0	201	48
2019	553	62	63	0	201	50
2020	585	64	65	0	201	51
2021	618	67	67	0	201	51
2022	653	69	70	0	201	50
2023	686	72	73	0	201	47
2024	719	74	75	0	201	40
2025	752	77	78	0	201	32
2026	789	80	81	0	201	24
2027	827	83	84	0	201	16
2028	866	86	87	0	201	6
2029	906	89	90	0	201	-7
2030	947	92	94	0	201	-21
2031	997	96	97	0	201	-30
2032	1051	100	101	0	201	-38
2033	1107	103	105	0	201	-47
2034	1176	107	109	0	201	-48
2035	1247	111	113	0	201	-49
2036	1321	115	118	0	201	-53
2037	1400	120	122	0	201	-56
2038	1483	124	127	0	201	-60
2039	1567	129	132	0	201	-67
2040	1653	134	137	0	201	-77
2041	1746	139	142	0	201	-86
2042	1843	145	148	0	201	-97
2043	1942	150	153	0	201	-113
2044	2027	156	159	0	201	-148
2045	2127	161	165	0	201	-175
2046	2232	168	171	0	201	-205
2047	2340	174	178	0	201	-239
2048	2448	181	184	0	201	-280
2049	2557	188	191	0	201	-330
2050	2666	195	198	0	201	-387

OPTION C: BEGIN TRANSFERS AFTER 10 YEARS

- Same as option B, only:
- Begin transfers in 2010.

Percent of trust fund in stocks:	0	15	16	26	35
Trust fund exhausted in:	2049	2054	2055	2060	2066
Change in actuarial balance:	0.93	1.34	1.36	1.62	1.83
Average percent of stock market in trust fund 2001-2040:	0	3.2	3.4	5.6	7.6
Peak percent of stock market in trust fund:	0	4.5	4.8	7.8	10.5

C.

Plan #: Extra Spending

Begin Social Security transfers on same basis in 2010

year	baseline on-bud surp	discret	USAs	Medicare transfers	Soc Sec transfers	remaining on-bud surp
SSA bond PDV 2000-75:				241	1613	
2000-04:	187	164	29	0	0	-22
2000-09:	1008	399	229	280	0	247
2000-14:	2681	641	469	421	678	397
2000	1	0	0	0	0	1
2001	13	31	0	0	0	-20
2002	57	47	0	0	0	7
2003	47	43	2	0	0	-3
2004	69	42	27	0	0	-9
2005	82	46	34	0	0	-10
2006	134	51	41	25	0	25
2007	168	50	41	53	0	53
2008	200	45	42	84	0	84
2009	237	43	42	117	0	117
2010	268	45	44	40	96	40
2011	305	47	46	42	114	42
2012	337	48	48	36	134	36
2013	367	50	50	24	156	24
2014	396	52	52	0	178	8
2015	424	54	54	0	201	-12
2016	455	56	56	0	201	-8
2017	488	58	58	0	201	-4
2018	521	60	60	0	201	-2
2019	553	62	63	0	201	-3
2020	585	64	65	0	201	-5
2021	618	67	67	0	201	-9
2022	653	69	70	0	201	-13
2023	686	72	73	0	201	-19
2024	719	74	75	0	201	-29
2025	752	77	78	0	201	-42
2026	789	80	81	0	201	-54
2027	827	83	84	0	201	-66
2028	866	86	87	0	201	-81
2029	906	89	90	0	201	-98
2030	947	92	94	0	201	-118
2031	997	96	97	0	201	-132
2032	1051	100	101	0	201	-146
2033	1107	103	105	0	201	-161
2034	1176	107	109	0	201	-168
2035	1247	111	113	0	201	-176
2036	1321	115	118	0	201	-188
2037	1400	120	122	0	201	-198
2038	1483	124	127	0	201	-210
2039	1567	129	132	0	201	-225
2040	1653	134	137	0	201	-244
2041	1746	139	142	0	201	-262
2042	1843	145	148	0	201	-283
2043	1942	150	153	0	201	-309
2044	2027	156	159	0	201	-356
2045	2127	161	165	0	201	-394
2046	2232	168	171	0	201	-436
2047	2340	174	178	0	201	-483
2048	2448	181	184	0	201	-538
2049	2557	188	191	0	201	-602
2050	2666	195	198	0	201	-674

OPTION D: SCALE BACK USAs TO 75 PERCENT

- Same as option C, only:
- Scale back USAs to 75 percent of planned stream.

Percent of trust fund in stocks:	0				
Trust fund exhausted in:					
Change in actuarial balance:					
Average percent of stock market in trust fund 2001-2040:	0				
Peak percent of stock market in trust fund:	0				

Plan ^D F: like Plan B but USAs = .75*planned amount

year	baseline on-bud	discret surp	USAs	Medicare transfers	Soc Sec transfers	remaining on-bud surp
SSA bond PDV 2000-75:				415	1350	
2000-04:	187	164	16	0	0	-9
2000-09:	1008	399	160	202	0	328
2000-14:	2681	641	340	817	0	1335
2000	1	0	0	0	0	1
2001	13	31	0	0	0	-20
2002	57	47	0	0	0	7
2003	47	43	2	0	0	-3
2004	69	42	15	0	0	4
2005	82	46	19	0	0	6
2006	134	51	31	23	0	37
2007	168	50	31	40	0	66
2008	200	45	31	60	0	98
2009	237	43	32	80	0	131
2010	268	45	33	94	0	154
2011	305	47	34	111	0	182
2012	337	48	36	125	0	205
2013	367	50	37	137	0	224
2014	396	52	39	148	0	243
2015	424	54	40	0	209	44
2016	455	56	42	0	209	52
2017	488	58	44	0	209	59
2018	521	60	45	0	209	65
2019	553	62	47	0	209	69
2020	585	64	49	0	209	71
2021	618	67	51	0	209	73
2022	653	69	52	0	209	74
2023	686	72	54	0	209	72
2024	719	74	56	0	209	68
2025	752	77	59	0	209	61
2026	789	80	61	0	209	56
2027	827	83	63	0	209	50
2028	866	86	65	0	209	42
2029	906	89	68	0	209	32
2030	947	92	70	0	209	20
2031	997	96	73	0	209	14
2032	1051	100	76	0	209	10
2033	1107	103	79	0	209	4
2034	1176	107	82	0	209	6
2035	1247	111	85	0	209	8
2036	1321	115	88	0	209	8
2037	1400	120	92	0	209	10
2038	1483	124	95	0	209	10
2039	1567	129	99	0	209	8
2040	1653	134	103	0	209	3
2041	1746	139	107	0	209	-1
2042	1843	145	111	0	209	-7
2043	1942	150	115	0	209	-16
2044	2027	156	119	0	209	-46
2045	2127	161	124	0	209	-66
2046	2232	168	129	0	209	-88
2047	2340	174	133	0	209	-116
2048	2448	181	138	0	209	-149
2049	2557	188	143	0	209	-190
2050	2666	195	149	0	209	-239

OPTION E: TRANSFER AVAILABLE ON-BUDGET SURPLUSES

- Same as option D, plus:
- Transfer any available on-budget surpluses to Social Security in years 2006 – 2010 and scale back transfers to Social Security in late 2020s or early 2030s to avoid generating on-budget deficits.

Percent of trust fund in stocks:	0				
Trust fund exhausted in:					
Change in actuarial balance:					
Average percent of stock market in trust fund 2001-2040:	0				
Peak percent of stock market in trust fund:	0				

June 25, 1999

was on your
email - FYI

To: Jack Lew
Sylvia Mathews

From: Dan Mendelson

Re: Medicare Solvency and Double Counting

Due to concerns about perceived double-counting in the Medicare plan, you are interested in transferring the Part A savings in the Medicare plan that offset drug costs out of the Part A trust fund.

Under current convention, the Part A savings would both offset part of the drug costs and extend the life of the HI Trust Fund. This is consistent with all previous Medicare scoring, in that Part A offsets for other purposes (e.g., funding discretionary activities in the Budget, producing savings for the BBA) also help the Trust Fund. The assets of the trust fund (Treasury bonds) increase, and the government uses the money from those bonds for other purposes. This is the way the Congress, with the blessing of the Finance Committee, scored the BBA.

While all parties understand the sensitivity of this issue, OMB staff and HHS do not see a double-counting problem in the Medicare plan for two reasons: (1) The surplus and the Part A savings are achieved through two separate actions (i.e., the surplus being transferred does not include the Medicare HI savings); and (2) under current scoring and trust account rules, savings from Part A are counted as scorable savings and have the effect of extending the life of the trust fund. In addition the Secretary and the Medicare actuary are adamantly opposed to any action that would transfer funds out of the Part A trust fund because they see it as a long-term threat to solvency.

Option 1. Modify Current Medicare scoring practice to exclude Part A savings used to offset drug costs from calculation of Trust Fund solvency for this plan

This option would modify current practice by directing the Trustees not to count Part A savings used to offset drug costs when estimating solvency. While the Part A Trust Fund would still hold the assets generated by the savings policies, we would characterize the solvency estimate accompanying the plan as a very conservative estimate that does not include these assets.

Display:

This approach would look something like this:

Sources	2000-2009
HI savings	-60
Total surplus transfer	-518
<u>Total Sources</u>	-578
Uses	

Drug Costs offset by HI savings	+60
Net Drug Costs	+50
<u>Total Uses</u>	+110
Net of sources and uses	-468
Amount used to calculate Trust Fund solvency	
From Part A savings	0
Surplus transfer net of drug costs	-468
<u>Total impact on Trust Fund</u>	-468

Pro: We would characterize this as a one-time change in standard practice, done to remove any possible charge of double-counting. This would allow us to go back to the normal scoring system for future bills that require Part A offsets for non-Part A spending.

Con: The savings would still be in the Part A Trust Fund, and so the insolvency date estimates would not reflect the full assets in the Fund. We may be criticized for manipulating the conventions used to calculate solvency, although the change works to our disadvantage. Finally, this action will make it more difficult to use program integrity and other savings for solvency in the future.

In the extreme case, we might be asked whether such funds could be used for Medicare expenditures. An affirmative answer might enable a questioner to charge that we were being inconsistent, since the funds reside in the trust fund but cannot be used for solvency. We would need to reply that we were trying to be conservative and responsive to their concerns about double counting.

2. Transfer Part A savings out of the Trust Fund

This approach differs from the above case by shifting the \$60 billion in Part A savings over 2000-2009 out of the HI Trust Fund, so they would not affect Trust Fund solvency (they would offset the drug costs). HI solvency would be extended in this case only by the amount of the surplus transfer to the Trust Fund.

Sources	2000-2009
HI savings (transferred out of Trust Fund)	-60
Total surplus transfer	-518
<u>Total Sources</u>	-578
Uses	
Drug Costs offset by HI savings	+60
Net Drug Costs	+50
<u>Total Uses</u>	+110
Net of sources and uses	-468

Amount realized in the Trust Fund for solvency

From Part A savings	0
Surplus transfer net of drug costs	-468
<u>Total impact on Trust Fund</u>	<u>-468</u>

Pro: Eliminates double-counting concern.

Con: Without the justification that a hospital cut helps the Trust Fund, in the future we will not be able to use Part A savings for anything other than Part A. For example, that we will not be able to use Part A offsets to pay for the buy-in or preventive benefits (because part of the buy-in costs and all of the preventive benefits costs are Part B costs). This means that in the context of the BBA, we would not have been able to justify the large Medicare cuts, at least in part, on basis of paying for the CHIP program.

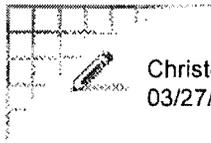
We can also expect harsh criticism from Senate Finance Committee, house Democrats (including the health leadership), MedPAC, and traditional health validators for moving assets out of the Trust Fund, which is expected to become insolvent in the near future.

Finally, transferring money out of the Trust Fund requires that we either estimate the annual dollar amount of savings to transfer out of the Trust Fund or that we estimate a percentage of drug spending to be paid out of the Trust Fund. If our drug cost estimates prove to be low, a flat dollar amount transferred from the Trust Fund may be insufficient to pay for the drug benefit.

Recommendation: Option 1, on the assumption that allegations of double counting would be more damaging than allegations that we manipulated solvency calculations. I believe that option 2 would impose real damage on the ability of the President to press his agenda in the future, in addition to strong criticism from the Congress.

Health Financing staff contributed to this memo.

Medicare Reform ~~Adler~~ Greenspan File

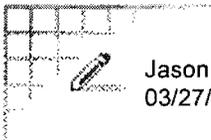


Christopher C. Jennings
03/27/2000 06:00:13 PM

Record Type: Record

To: Devorah R. Adler/OPD/EOP@EOP
cc:
Subject: Quick analysis of Greenspan testimony

----- Forwarded by Christopher C. Jennings/OPD/EOP on 03/27/2000 06:00 PM -----



Jason Furman
03/27/2000 02:42:53 PM

Record Type: Record

To: See the distribution list at the bottom of this message
cc:
Subject: Quick analysis of Greenspan testimony

Greenspan is testifying on Medicare and Social Security transfers. His prepared remarks are below. Overall they are negative for us, but he does hedge his comments and leave some room to argue for our proposals.



greenspan0327.d

Testimony of Chairman Alan Greenspan
General revenue transfers for social security and Medicare
Before the Special Committee on Aging, U.S. Senate
March 27, 2000

Mr. Chairman and other members of the committee, I am pleased to be here today as you begin your discussion of using general revenue transfers to shore up social security and Medicare. A thorough consideration of the options available for placing these programs on a firmer fiscal footing is essential given the pressures that loom in the not-too-distant future. I commend the committee for your efforts to advance this important discussion.

As you are well aware, the dramatic increase in the number of retirees relative to workers that is set to begin in about ten years makes our pay-as-you-go social security and Medicare programs, as currently constituted, unsustainable in the long run. Eventually, social security and Medicare will have to undergo reform. The goal of this reform must be to increase the real resources available to meet the needs and expectations of retirees, without blunting the growth in living standards among our working population and, presumably, without necessitating sizable reductions in other government spending programs.

The only measures that can accomplish this goal are those aimed at increasing the total amount of goods and services produced by our economy. As I have argued many times before, any sustainable retirement system--private or public--requires that sufficient resources be set aside over a lifetime of work to fund an adequate level of retirement consumption. At the most rudimentary level, one could envision households saving by actually storing goods purchased during their working years for consumption during retirement. Even better, the resources that would have otherwise gone into the stored goods could be diverted to the production of new capital assets, which would cumulatively produce an even greater quantity of goods and services to be consumed in retirement.

From this perspective, it becomes clear that increasing our national saving is essential to any successful reform of social security or Medicare. The impressive improvement in the budget picture since the early 1990s has helped greatly in this regard. And it appears that both the Administration and the Congress have wisely chosen to wall off the bulk of the unified budget surpluses projected for the next several years and allow it to build. This course would boost saving, raise the productive capital stock, and thus help provide the wherewithal to meet our future obligations.

The idea that we should stop borrowing from the social security trust fund to finance other outlays has gained surprising--and welcome--traction. It has established, in effect, a new budgetary framework that is centered on the on-budget surplus and the way it should be used. The focus on the on-budget surplus measure is useful because it offers a clear objective that should help to strengthen budgetary discipline. Moreover, it moves the budget process closer to accrual accounting, the private-sector norm, and--I believe--a sensible direction for federal budget accounting.

Under accrual accounting, benefits would be counted when they are earned by workers rather than when they are paid out. Under full accrual accounting, the social security program would have shown a substantial deficit last year. So would have the total federal budget. To the extent that such accruals are not formally accounted for in the unified budget--as they generally are not--we create contingent liabilities that, under most reasonable sets of assumptions, currently amount to many trillions of dollars for social security benefits alone. The contingent liabilities implicit in the Medicare program are much more difficult to calculate--but they are likely also in the trillions of dollars. For the federal government as a whole, an accrual-based budget measure would record noticeable unified budget deficits over the next few years and increasing, rather than decreasing, implicit national indebtedness.

The expected slowdown in the growth of the labor force, the direct result of the decrease in the birth rate following the baby boom, means that financing our debt--whether explicit debt or the implicit debt represented by social security and Medicare's contingent liabilities--will become increasingly difficult. I should add, parenthetically, that the problem we face is much smaller than that confronting the more rapidly aging populations of Europe and Japan. Nonetheless, pressures will mount, and I believe that the growth potential of our economy is best served by maintaining the unified budget surpluses presently in train and thereby reducing Treasury debt held by the public. The resulting boost to the pool of domestic saving will help sustain the current boom in productivity-generating investment in the private sector. Indeed, if productivity growth continues at its recent pace, our entitlement programs will be in much better shape. Saving the surpluses--if politically feasible--is, in my judgment, the most important fiscal measure we can take at this time to foster continued improvements in productivity.

The vehicle through which we save our surpluses is less important than the fact that we save them. One method that has been proposed, and that is the focus of today's hearing, is to transfer general revenues from the on-budget accounts to the social security trust fund. These transfers in themselves do nothing to the unified budget surplus. The on-budget surplus is reduced, but the off-budget surplus increases commensurately. The transfers have no effect on the debt held by the public and, hence, no direct effect on national saving. But transferring monies from the on-budget to the off-budget social security accounts could make it politically more likely that the large projected unified surpluses will, in fact, materialize. Given that our record of sustaining surpluses for extended periods of time is not good, any device that

might accomplish this goal is worth examining.

Using general revenues to fund social security is an idea that has been considered previously but rejected. Indeed, the commission that I chaired in 1983 was strongly opposed, for a variety of reasons, to the notion of using general revenues to shore up social security. One argument was that using general revenues would blur the distinction between the social security system, which was viewed as a social insurance program, and other government spending programs.

Both social security and, for that matter, Medicare part A are loosely modeled on private insurance systems, with benefits financed out of worker contributions. Like private insurance systems, they are intended to be in long-term balance. But the standard adopted for social security and Medicare part A--that taxes and other income are to be sufficient to pay benefits for 75 years--falls short of the in-perpetuity full funding standard of private pension plans, and, in many years, social security and Medicare have not met even this less stringent standard.

Furthermore, the requirement that social security and Medicare be in long-term balance does not mean that each generation gets in benefits only what it contributed in taxes plus earnings. Indeed, most social security beneficiaries to date have received far higher rates of return on their contributions than that available, for example, on U.S. Treasury securities. But the reduction in the birth rate following the baby boom and the continued increase in life expectancy beyond age sixty-five mean that the social security system will no longer provide workers with such high returns.

Although the analogy between social security and private insurance has never been that tight, the perception of social security as insurance has been widespread and quite powerful. Many supporters of social security feared that breaking the link between payroll taxes and benefits by moving to greater reliance on general revenue financing would transform social security into a welfare program.

But now, when payroll taxes are no longer projected to be sufficient to pay even currently legislated benefits, moving toward a system of general revenue finance raises the concern that the fiscal discipline of the current social security system could be reduced. Once the link between payroll taxes and social security benefits is broken, the pressure to reform the social security system may ease, particularly in this environment of budget surpluses. For example, Medicaid and Medicare part B--both of which will face increasing demands as the population ages--are already financed with general revenues, and, consequently, there has been much less pressure to date to reform these programs.

The availability of general revenue finance when the baby boom generation begins to enter retirement and press on our overall fiscal resources could make it more difficult to argue for program cuts, regardless of their broader merits. As I have testified on many previous occasions, there are a number of social security benefit reforms--such as extending the age of full retirement benefit entitlement and indexing it to longevity, altering the benefit calculation bend points, and adjusting annual cost-of-living escalation to a more accurate measure--that should be given careful consideration. The potential for enhancing efficiency by restructuring the Medicare program is probably even greater than in social security. Relaxing fiscal discipline in the Medicare program by expanding the use of general revenues before the underlying program has been tightened could take the steam out of efforts to improve the way health services are delivered.

That said, I think it is important to note that most government programs are funded through general revenues, so allowing general revenues to finance some of social security or Medicare part A is clearly an idea that would not necessarily eliminate all fiscal responsibility. It might be feasible, for example, to legislate temporary general revenue transfers that would end long before the baby boom generation starts to retire, without opening the possibility of completely eliminating the need for program cuts in social security or changes to Medicare.

It is, of course, difficult to predict the political and economic environment that will be facing policymakers

fifteen or twenty years in the future. Legislation passed today that affects the distribution of resources between future workers and retirees could easily be changed later. That is why the most important decision facing policymakers today is not about the distribution of future resources but about the level of future resources available for future workers and retirees. The most effective means of raising the level of future resources, in my judgment, is to allow the budget surpluses projected in the coming years to be used to pay down the nation's debt. The Congress and the Administration will have to decide whether transferring general revenues to the entitlement programs is the best way to preserve the surpluses, or whether better mechanisms exist.

Message Sent To:

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Attached is Greenspan's testimony that he gave this afternoon (2 pm) on general revenue transfers for Social Security and Medicare. His remarks were generally critical of the President's approach.

Main Criticisms of the President's Approach

- "Using general revenues to fund social security is an idea that has been considered previously and rejected."
- He argues that these transfers would turn Social Security and Medicare part A from less of a self-funding system, to more of a welfare system.
- "Once the link between payroll taxes and social security benefits is broken, the pressure to reform the social security stem may ease, particularly in this environment of budget surpluses." He goes on to say that there is less pressure to reform Medicaid and Medicare Part B because these are funded by general revenue.
- "Relaxing fiscal discipline in the Medicare program by expanding the use of general revenues before the underlying program has been tightened could take the steam out of efforts to improve the way health services are delivered."

Positive Points about the President / Qualifications of Criticisms

- **Debt reduction good for future economy and sustainability.** He is very positive about the focus on the on-budget surplus and using the Social Security surplus for debt reduction. He says this will increase savings, investment, and the future size of the economy, easing the burden on future generations. *Note he makes this bipartisan praise of the President and Congress.*
- **Transfers may protect surpluses.** He acknowledges "But transferring monies from the on-budget to the off-budget social security accounts could make it politically more likely that the large projected unified surpluses will, in fact, materialize. Given that our record of sustaining surpluses for extended periods of time is not good, any device that might accomplish this goal is worth examining."
- **Temporary transfers may be reasonable.** He also acknowledges "That said, I think it is important to note that most government programs are funded through general revenues, so allowing general revenues to finance some of social security or Medicare part A is clearly an idea that would not necessarily eliminate all fiscal responsibility. It might be feasible, for example, to legislate temporary general revenue transfers that would end long before the baby boom generation starts to retire, without opening the possibility of completely eliminating the need for program cuts in social security or changes to Medicare."

In Addition to Debt Reduction, Greenspan Recommends Benefit Cuts / Reforms

- "There are a number of social security benefit reforms – such as extending the age of full retirement benefit entitlement and indexing it to longevity, altering the benefit calculation bend points, and adjusting annual cost-of-living escalation to a more accurate measure – that should be given careful consideration. The potential for enhancing efficiency by restructuring the Medicare program is probably even greater than in social security."



Selected GOP Quotes from Budget Committee Markup of the FY99 Budget Resolution, March 17, 1998

Sen. Domenici:

"For every dollar you divert to some other program you are hastening the day when Medicare falls into bankruptcy, and you are making it more and more difficult to solve the Medicare problem in a permanent manner into the next millennium."

(Transcript of Proceedings, page 43)

Sen. Gramm:

" Medicare is in crisis. We want to save Medicare first."

(Transcript of Proceedings, page 128)

*Chris -
not as good as
I thought - we
are still
looking
sure*

Medicare

President Clinton has proposed to dedicate 15 percent of the projected budget surpluses to secure the solvency of the Medicare Trust Fund until the year 2020.

76/20% support/oppose this proposal.

76% support (38% strongly + 38% somewhat)

20% oppose (15% strongly + 5% somewhat)

D	R	Net
83/10	69/25	72/24

Tax Cuts vs. Medicare

16% would prefer using this part of the surplus for tax cuts, 70% to extend Medicare.]

D	R	Net
0/79	36/47	17/78

CS -
Is this what
I said I'd
get?
Tom
- They're
looking
for the
rest

For Weinstein

MEMORANDUM

May 14, 1998

From: Richard S. Foster
Solomon M. Mussey
Elliott A. Weinstein
Office of the Actuary
Health Care Financing Admin.

Subject: Actuarial Evaluation of Illustrative Approaches for Improving HI Solvency Through Expenditure Reductions or Payroll Tax Increases—Update Based on 1998 Trustees Report

The long-range solvency of the Medicare Hospital Insurance (HI) program remains the subject of considerable discussion. Most of the discussion has focused on the reductions in HI expenditures that would be required to meet certain financing or budgetary goals. This memorandum provides an analysis of the effects on the HI trust fund of various illustrative approaches for reducing future HI expenditures or raising payroll tax rates.

The analysis presented here should not be interpreted as advocating a particular approach to addressing the projected financial imbalance for the HI trust fund; nor should a negative inference be made from the absence of other analyses. Our purpose is to help provide a framework for analysis by the program's policymakers. Also, in the case of the illustrative proposals to reduce expenditures, this memorandum provides no information as to how such reductions might be accomplished. In other words, these estimates illustrate the financial impact of various theoretical changes in expenditure levels or growth rates—development of legislative provisions that would result in such changes is rather more challenging.

The illustrations presented in this memorandum are based on the intermediate financial projections from the 1998 HI Trustees Report. Under different economic and demographic conditions, such as the Trustees' "low cost" or "high cost" assumptions, the steps required to reach financial balance can differ significantly from those based on the intermediate assumptions. Equivalently, a legislative package designed to restore balance under the intermediate assumptions could ultimately result in too much or too little savings, depending on actual future economic and other conditions.

I. Background

Under section 1817(b) of the Social Security Act, the Board of Trustees for the HI program is required to report to Congress annually on the financial status of the HI trust fund. In keeping with the program's long-term financial obligations, the law requires both a short-range and a long-range evaluation of the trust fund's actuarial status. The latest Trustees Report was issued to Congress on April 28, 1998.

The Balanced Budget Act of 1997 was designed in part to postpone the imminent exhaustion of the HI trust fund, which was expected to occur in 2001 in the absence of corrective legislation. The Act included numerous provisions to (i) implement new prospective payment systems for most HI services not already reimbursed on a prospective basis, (ii) reduce payment updates for all HI providers, and (iii) shift payment for the majority of home health care services from the HI trust fund to the SMI trust fund. Under the BBA, and based on the intermediate assumptions in the 1998 Trustees Report, the HI trust fund is estimated to be depleted in 2008. Although not designed to address the program's long-range financial imbalance, the Balanced Budget Act also had the important effect of reducing the 75-year actuarial deficit by about one-half, from 4.32 percent of taxable payroll to 2.10 percent in the 1998 Trustees Report.

The 1998 Trustees Report projections still show that the program faces a serious imbalance between projected income and expenditures in the long range, in part due to the demographic changes that will occur with the retirement of the post-World War II "baby boom" generation. To bring HI into actuarial balance for the next 25 years under the intermediate assumptions would require that expenditures be reduced by 18 percent or revenues increased by 22 percent or some combination thereof. Alternative combinations of such measures are shown in the table below. Over the full 75 years of the Trustees' projection, substantially greater changes would be required.

Alternative combinations of revenue increases or
expenditure reductions for actuarial balance during
1998-2022 (1998 intermediate assumptions)

Revenue Increase	Expenditure Reduction
0%	18%
5%	14%
10%	10%
15%	6%
20%	2%
22%	0%

The analysis shown in the annual Trustees Report is significantly different in scope and purpose from the financial projections for the HI trust fund shown in the President's Budget or the projections of the Congressional Budget Office (CBO). Budget estimates are generally prepared for at most the next 10 years and are based on somewhat different assumptions concerning future economic growth, inflation rates, medical care utilization, etc. For purposes of evaluating the financial status of the Social Security and Medicare programs, Congress normally relies on the Trustees' projections. Specific proposals to address the current financial imbalance would normally be evaluated using the Trustees' assumptions. Their effects would also be "scored" for budget purposes using Administration and/or CBO budget assumptions.

HI expenditures for benefits and administrative expenses are projected to increase in the future for several reasons. One factor is growth in the number of eligible beneficiaries. Chart 1 shows the projected annual rate of increase in the number of beneficiaries over the next 75 years. Enrollment is estimated to grow around 2 percent or less annually until 2010, around 2-3 percent between 2010 and 2030, when the baby boom generation retires, and well under 1 percent afterwards. While the baby boom represents a serious long-term issue for HI solvency, they are not the cause of the short-range financial problem. In particular, the trust fund is projected to be depleted in 2008 under the intermediate assumptions—just as the first baby boomers near age 65.

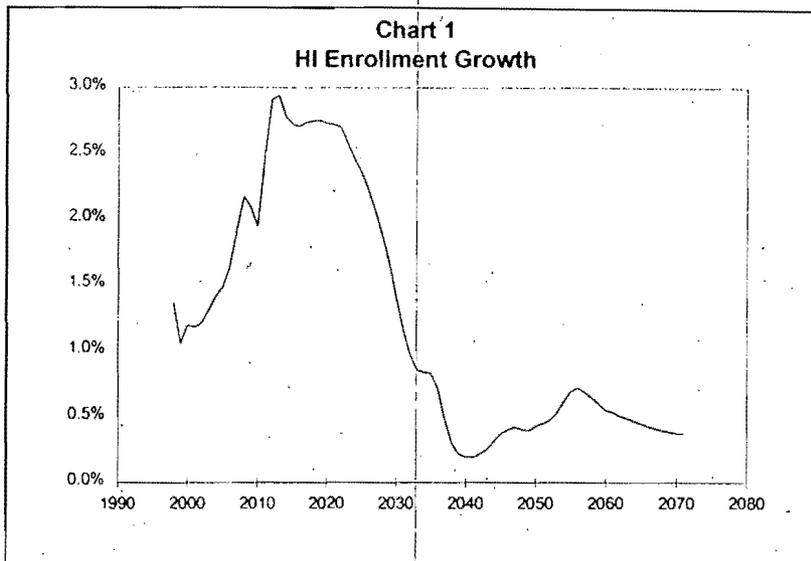
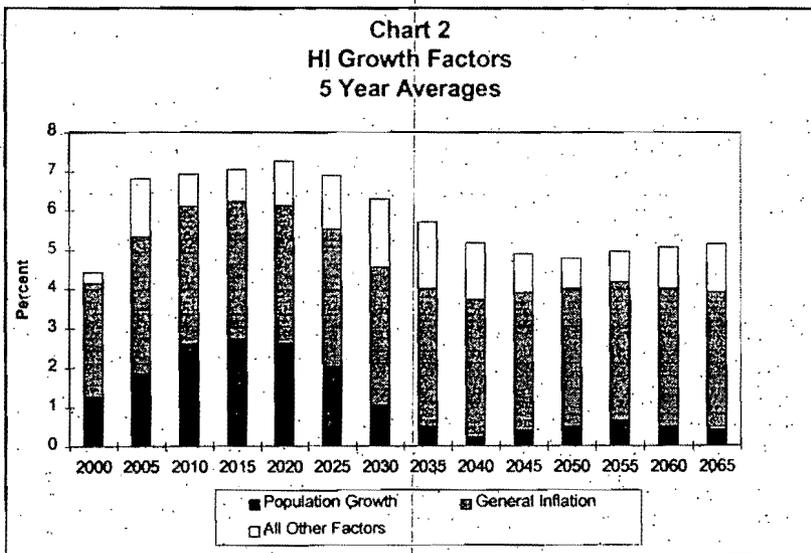


Chart 2 shows projected enrollment growth, general inflation (as measured by the Consumer Price Index), and other cost factors which contribute to HI expenditure growth. Each bar represents the average annual growth rate over the 5-year period beginning with the year shown. During 2005-2009, for example, HI expenditures are expected to increase by about 6.9 percent annually. Beneficiary growth accounts for 1.9 percent of the total and general inflation represents another 3.5 percent. The residual, 1.4 percent, is attributable to all other factors, including assumed additional inflation in the health care sector, increasing utilization and intensity of medical services, and so forth.¹



¹A portion of the increasing utilization of services is attributable to projected increases in the average age of beneficiaries. The average residual growth rate shown for 2000-2004 (0.3 percent) reflects the average of substantially slower rates in 2000-2002, attributable to the Balanced Budget Act provisions, and reaccelerating growth thereafter.

As noted above, future growth in the number of beneficiaries will vary considerably. General inflation is assumed to be fairly stable in the range of about 3.5 percent annually throughout the projection period. The residual factors vary somewhat over time (see section II.F of the HI Trustees Report for the specific assumptions). Table 1, attached, lists the components of HI expenditure growth rates.

During calendar years 1999 through 2007, the HI program is projected to spend a total of \$1,583 billion under the intermediate assumptions. If growth in program spending were limited to increases attributable to population growth alone, then the resulting reduction in HI expenditures compared to present law would be about \$207 billion for those years. If spending growth were constrained to population growth plus an allowance for general inflation, then the reduction in HI expenditures for 1999-2007 would be about \$50 billion.

II. Measures used to evaluate financial effect of proposals

In the budget context, most attention is focused on the dollar amount of expenditure reductions over a given period of time. To evaluate trust fund solvency, however, several key factors are considered. For each of the illustrative proposals to reduce HI expenditures or increase taxes, we show the following results:

- A. The "actuarial balance" for the next 25, 50, and 75 years. This amount is expressed as a percentage of the total wages, salaries, and self-employment earnings subject to the HI payroll tax. It represents the net difference between future HI income and expenditures over the period in question. Positive figures are surpluses and negative figures are deficits.
- B. The dollar reduction in HI expenditures or increase in tax revenues for various years. (Estimates are shown only for the next 10 years since such amounts are difficult to interpret for long periods of time, due to the changing value of the dollar.)
- C. The "trust fund ratio," which is the ratio of HI trust fund assets at the beginning of the year to HI expenditures for that year. The Board of Trustees has recommended that HI assets be maintained at the level of one year's expenditures, to serve as an adequate contingency reserve against temporary economic downturns or other adverse circumstances.
- D. The year the trust fund is depleted.
- E. The results of the Trustees' tests for short-range financial adequacy and long-range close actuarial balance.²

²These tests are complex. See the Glossary in the 1998 HI Trustees Report for complete definitions.

It is important to note the extreme sensitivity of measures based on trust fund assets (i.e., the trust fund ratio and the year of trust fund depletion described in C and D above). As can be seen in the attached tables, seemingly minor differences in expenditure growth rates can result in major changes in the projected level of assets. For this reason, evaluation of the long-range financial status of the HI program (and Social Security) has generally focused more on the actuarial balance, which is a more stable measure of the program's financial status. Conversely, short-range analysis is generally based on the trust fund ratio.

III. Reducing future expenditures by an overall percentage (Table 2)

Four general approaches to reducing HI expenditures are illustrated in this memorandum. The first would reduce outlays by the same overall percentage in all years, compared to current law projections. For example, under present law HI expenditures are projected to increase from \$139 billion in calendar year 1997 to \$221 in 2007 (see chart 3). If policymakers wished to address the actuarial deficit in the first 25 years by uniformly reducing HI expenditures in all years, then as noted previously expenditures would have to be reduced by about 18 percent in each year. Such a reduction is illustrated in chart 3. (Mathematically, this approach is equivalent to reducing outlays in the first year by the desired percentage and then allowing subsequent expenditures to increase at the same rates as projected under current law.)

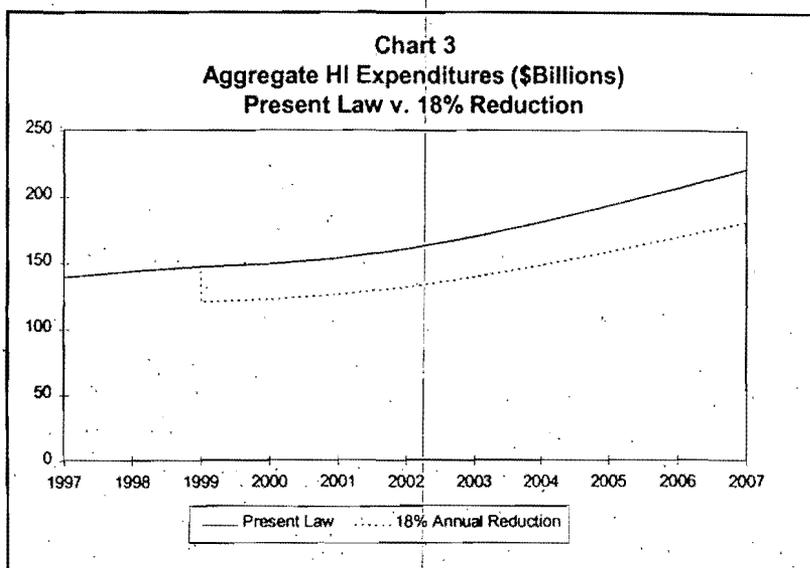


Table 2 shows the effects on the financial status of the HI trust fund of alternative proposals to reduce outlays in all future years by 10, 20, 30, or 40 percent relative to the levels projected under present law. These results indicate that a 10-percent reduction would delay trust fund depletion by 9 years; a 20-percent reduction by 20 years. A 20-percent reduction would also result in an actuarial balance of 0.03 percent for 1998-2022 (i.e., almost exact balance between future income and expenditures for the period), but an overall reduction of close to 40 percent would be required to achieve a zero balance over the full 75-year projection period.

As noted previously, these examples are intended to illustrate the nature of the financial imbalance facing the HI program and the impact of theoretical general approaches to closing the imbalance. In practice, developing legislative packages that would result in overall expenditure reductions of the magnitude illustrated here would be very challenging.

IV. Reducing annual growth in expenditures by a specified percentage (Table 3)

Another approach would be to reduce the rate of growth by a fixed percentage each year. Under present law, for example, HI expenditures are projected to increase at about 4.5 percent annually during 2000-2004. Under this category of proposals, an attempt would be made to reduce annual growth rates by a specified amount, such as 1 percentage point each year (i.e., to about 3.5 percent during 2000-2004). Similarly, growth rates in subsequent years would also be reduced by 1 percentage point. Over time, the effects of these lower growth rates would accumulate.

The effects of alternative reductions in growth rates are shown in table 3. To achieve solvency over the full 75-year projection period, growth rates would have to be reduced by about 2 percentage points in every year, relative to the intermediate projections. The effects of such a reduction are illustrated in chart 4. As can be seen by comparing charts 3 and 4, a reduction in growth rates would produce a different pattern of savings than would an overall percentage reduction.

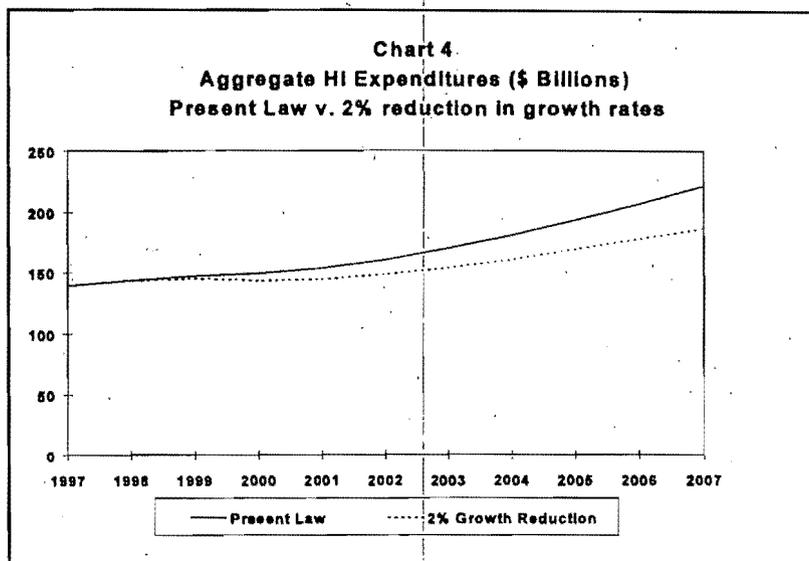
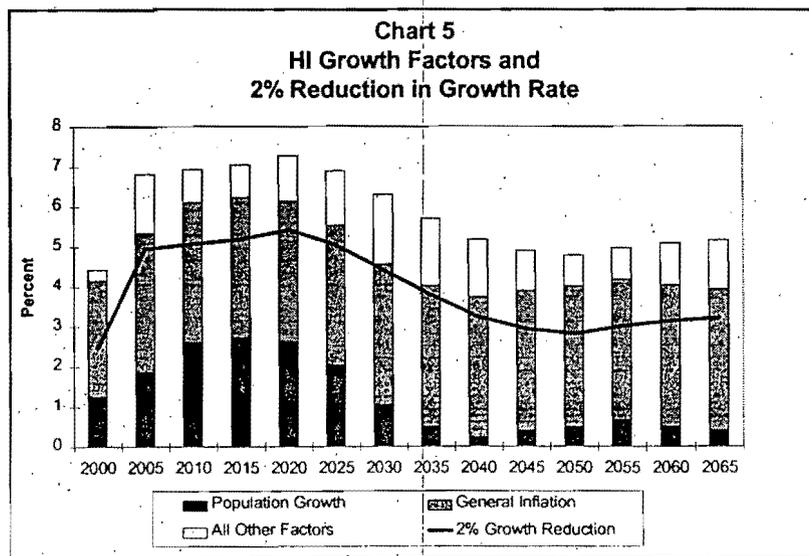


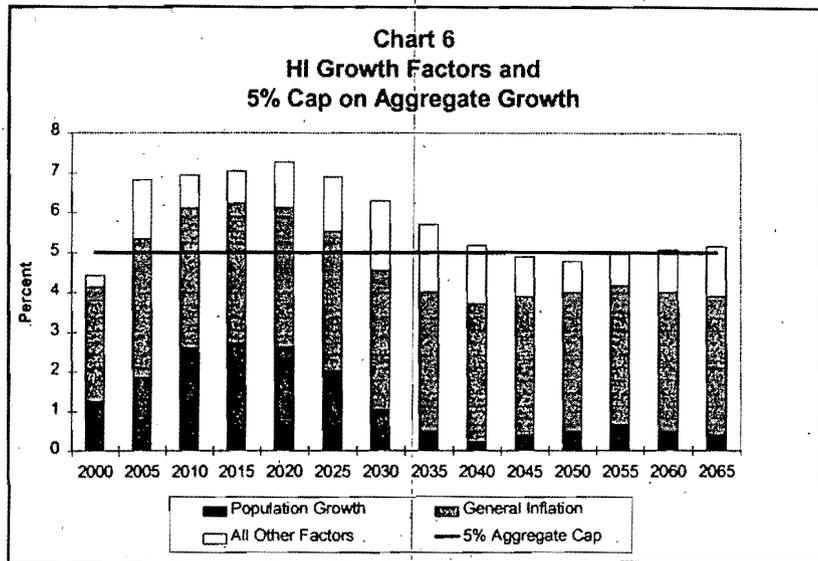
Chart 5 illustrates the nature of proposals to reduce expenditure growth rates. Growth rates under present law would be reduced by the same amount in each period (in this illustration, 2 percentage points). It is also apparent from chart 5 that achieving a 2-percentage-point reduction would necessitate growth rates below the level associated with population growth plus general inflation.



V. Limiting annual growth in aggregate expenditures to a specified maximum percentage
(Table 4)

A variation of the approach described in the previous section would be to cap aggregate expenditure increases at a targeted level. If annual program growth fell below the target, the cap would have no effect; however, if expenditures grew faster than the target, then growth would be limited to the target level. For example, under the 1998 Trustees Report assumptions HI expenditure growth is projected to be 3.6 percent in 2000 and 7.1 percent in 2007. A 6-percent cap would not affect growth in 2000 but would reduce 2007 growth by 1.1 percentage points.

The financial effects of alternative caps on aggregate spending growth are shown in table 4. A 5-percent cap would fall a little short of bringing the program into exact actuarial balance throughout the long-range projection period.³ Chart 6 compares a 5-percent cap with the projected expenditure growth rates under present law. As indicated, most of the reduction in growth rates under such a proposal would occur in the first half of the projection period:

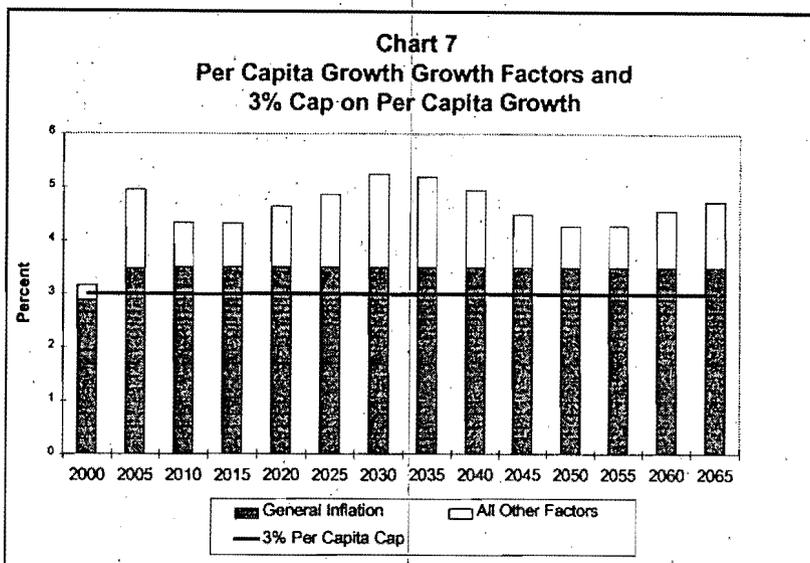


VI. Limiting annual growth in per capita expenditures to a specified maximum percentage
(Table 5)

Since Medicare population growth will not be constant (as indicated in the introduction), capping aggregate growth at constant levels would result in arbitrary fluctuations in per capita growth. Accordingly, some analysts have considered a cap on per capita expenditure growth rather than a cap on aggregate growth rates.

³Under the intermediate assumptions, HI tax revenue is projected to increase at around 5 percent per year. Most of this increase is due to assumed increases in average earnings subject to the HI payroll tax;⁶ a small portion is attributable to growth in the number of covered workers. Thus, if annual expenditure growth could be reduced to below 5 percent, then income and outgo would remain in approximate balance indefinitely.

Table 5 presents the estimated financial effects of alternative caps on per capita HI expenditure growth. The results indicate that a 3-percent per capita cap would fall somewhat short of bringing the program into balance for the first 25 years. Chart 7 illustrates the 3-percent per capita growth limitation in comparison to the projected per capita growth rates. As indicated, such a cap would require restricting growth to less than the levels required to keep pace with projected general inflation.



VII. Increasing the employer/employee tax rate by a specified percentage (Table 6)

Section I of this report illustrated the combination of expenditure reductions and/or revenue increases necessary to achieve actuarial balance over the first 25-year projection period. The scenarios in this report have so far considered the effects of reductions in HI expenditures. Alternatively, the effects of increasing the HI employer/employee tax rate by a specified percentage can be considered. Currently, the HI payroll tax rate is 1.45% for employers and employees, each, for a total of 2.9%, and this tax rate will remain in effect in all future years unless legislation is enacted to modify the rate. Table 6 illustrates the financial effects of alternative proposals to increase the employer/employee tax rate by a specified percentage. For example, a 0.25% increase in the tax rate for employers and employees, each, yielding a combined 0.5% increase and hence a new total payroll tax rate of 3.4%, would result in an exhaustion date of 2020 (close to the end of the first 25-year projection period). A 1% employer/employee tax increase, increasing the combined tax rate from 2.9% to 4.9%, would nearly maintain solvency over the full 75-year projection period and would just meet the Trustees' long-range test.

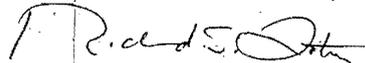
In each of these tax illustrations, an increase in the tax rate would initially result in an accumulation of trust fund assets while tax income exceeded expenditures. Subsequently, as expenditures increased as a percentage of taxable payroll to a level in excess of the combined tax rate, income would be inadequate to cover costs and trust fund assets would be drawn down to cover the shortfall. This financing pattern is very similar to the projected financial operations for the Social Security program and has generated considerable debate over the advantages and disadvantages of accumulating large trust fund reserves invested in Treasury securities. A discussion of these issues exceeds the scope of this memorandum.

VIII. Conclusion

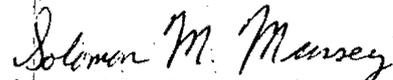
The results here indicate that substantial reductions in future HI expenditures or expenditure growth rates and/or increases in payroll tax rates would be required to address projected deficits. The illustrations also show that the year-by-year patterns of savings can vary substantially among the different approaches.

As a final illustration, table 7 shows the year-by-year expenditure reductions or payroll tax revenue increases that would be required to exactly balance income and outlays and to maintain trust fund assets at the level of one year's expenditures. The results indicate that a reduction in expenditures of about \$149 billion or about 10 percent of present-law expenditures would be required during 1999-2007, with steadily larger reductions necessary in later years. The corresponding increases in HI tax revenues are slightly larger in the short range, and considerably larger in the long run.

Once again, these estimates are illustrative and do not represent an expression of desired policy by the Office of the Actuary or the Health Care Financing Administration. Moreover, the implications of any effort to reduce HI costs or increase HI taxes deserve careful consideration and analysis extending well beyond these illustrations.



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Attachments: 7

Table1--Projected growth of factors affecting future HI expenditures,
based on the intermediate set of assumptions from the 1998
Trustees Report

Average annual percentage increase in...

Period	No. of HI beneficiaries	General inflation 1/	All other factors 2/	HI expenditures	
				Aggregate	Per Capita
1998-1999	1.21%	1.90%	-0.40%	2.72%	1.49%
2000-2004	1.26	2.88	0.28	4.47	3.17
2005-2009	1.86	3.48	1.48	6.96	5.01
2010-2014	2.61	3.50	0.83	7.08	4.36
2015-2019	2.73	3.50	0.81	7.19	4.34
2020-2024	2.63	3.50	1.14	7.43	4.68
2025-2029	2.03	3.50	1.36	7.04	4.91
2030-2034	1.05	3.50	1.74	6.41	5.30
2035-2039	0.51	3.50	1.69	5.79	5.25
2040-2044	0.23	3.50	1.45	5.24	5.00
2045-2049	0.40	3.50	0.99	4.94	4.52
2050-2054	0.50	3.50	0.77	4.82	4.30
2055-2059	0.67	3.50	0.78	5.01	4.31
2060-2064	0.51	3.50	1.06	5.13	4.60
2065-2069	0.41	3.50	1.24	5.21	4.78
1998-2019	2.03	3.21	0.75	6.09	3.98
2020-2044	1.29	3.50	1.47	6.38	5.03
2045-2069	0.50	3.50	0.96	5.02	4.50

1/ As measured by the Consumer Price Index.

2/ All other factors include "excess" wage and price increases in the health sector relative to the CPI, and increases in the average volume and intensity of services per beneficiary. After 2010, much of the variation shown in the all-other category is related to change in the utilization of services as the baby boom generation moves into and through the beneficiary population.

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by an overall percentage in all years, relative to present law ("overall reduction")

Reduce present-law expenditures in each year by...

	Present law	Reduce present-law expenditures in each year by...			
		10%	20%	30%	40%
A. Actuarial Balance (percentage of taxable payroll)					
1998-2022.....	-0.73%	-0.35%	0.03%	0.41%	0.79%
1998-2047.....	-1.61%	-1.14%	-0.66%	-0.19%	0.29%
1998-2072.....	-2.10%	-1.57%	-1.04%	-0.52%	0.01%
B. Reduction in HI expenditures (in billions)					
1999.....	-	\$11	\$22	\$32	\$43
2000.....	-	15	29	44	59
2001.....	-	15	30	46	61
2002.....	-	16	32	48	64
2003.....	-	17	34	50	67
2004.....	-	18	36	54	72
2005.....	-	19	38	57	77
2006.....	-	20	41	61	82
2007.....	-	22	44	66	88
1999-2003.....	-	74	147	220	294
1999-2007.....	-	153	306	458	613
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)					
1999.....	73%	81%	91%	104%	121%
2000.....	68%	88%	111%	141%	182%
2001.....	63%	93%	129%	177%	240%
2002.....	58%	98%	148%	213%	299%
2003.....	53%	103%	166%	248%	356%
2004.....	46%	105%	181%	278%	408%
2005.....	37%	106%	194%	307%	457%
2006.....	27%	106%	205%	333%	503%
2007.....	16%	104%	215%	357%	547%
2010.....	(*)	90%	234%	418%	664%
2015.....	(*)	37%	228%	473%	801%
2020.....	(*)	(*)	176%	472%	868%
2025.....	(*)	(*)	77%	414%	863%
2030.....	(*)	(*)	(*)	318%	819%
2035.....	(*)	(*)	(*)	200%	762%
2040.....	(*)	(*)	(*)	65%	703%
2045.....	(*)	(*)	(*)	(*)	644%
2050.....	(*)	(*)	(*)	(*)	583%
2055.....	(*)	(*)	(*)	(*)	515%
2060.....	(*)	(*)	(*)	(*)	433%
2065.....	(*)	(*)	(*)	(*)	334%
2070.....	(*)	(*)	(*)	(*)	220%
D. Year of trust fund depletion.....					
	2008	2017	2028	2042	Never
E. Board of Trustees tests:					
Short range test.....	No	Yes	Yes	Yes	Yes
Long-range test.....	No	No	No	No	Yes

* Fund is depleted.

- Notes:
1. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.
 2. Illustrative proposals are assumed to take effect starting in 1999.
 3. All years shown are calendar years.
 4. The Board of Trustees tests are complex. Complete definitions of these tests are available in the Glossary of the 1998 HI Trustees Report.

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Reduce expenditure growth rate in each year by...

	Present law	1%	2%
A. Actuarial Balance (percentage of taxable payroll)			
1998-2022.....	-0.73%	-0.28%	0.09%
1998-2047.....	-1.61%	-0.60%	0.15%
1998-2072.....	-2.10%	-0.61%	0.36%
B. Reduction in HI expenditures (in billions)			
1999.....	-	\$1	\$2
2000.....	-	3	6
2001.....	-	4	9
2002.....	-	6	12
2003.....	-	8	16
2004.....	-	10	20
2005.....	-	12	24
2006.....	-	15	29
2007.....	-	18	35
1999-2003.....	-	22	45
1999-2007.....	-	77	153
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)			
1999.....	73%	73%	74%
2000.....	68%	71%	74%
2001.....	63%	68%	73%
2002.....	58%	66%	75%
2003.....	53%	64%	78%
2004.....	46%	62%	82%
2005.....	37%	60%	86%
2006.....	27%	57%	90%
2007.....	16%	53%	95%
2010.....	(*)	38%	112%
2015.....	(*)	0%	145%
2020.....	(*)	(*)	176%
2025.....	(*)	(*)	196%
2030.....	(*)	(*)	211%
2035.....	(*)	(*)	239%
2040.....	(*)	(*)	299%
2045.....	(*)	(*)	411%
2050.....	(*)	(*)	597%
2055.....	(*)	(*)	876%
2060.....	(*)	(*)	1254%
2065.....	(*)	(*)	1745%
2070.....	(*)	(*)	2369%
D. Year of trust fund depletion.....			
	2008	2015	Never
E. Board of Trustees tests:			
Short range test.....	No	No	No
Long-range test.....	No	No	Yes

* Fund is depleted.

- Note 1. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.
 2. Illustrative proposals are assumed to take effect starting in 1999.
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Cap annual growth in aggregate expenditures at...

	Present law	4%	5%	6%
A. Actuarial Balance (percentage of taxable payroll)				
1998-2022.....	-0.73%	0.10%	-0.16%	-0.43%
1998-2047.....	-1.61%	0.37%	-0.17%	-0.81%
1998-2072.....	-2.10%	0.54%	-0.22%	-1.08%
B. Reduction in HI expenditures (in billions)				
1999.....	-	\$0	\$0	\$0
2000.....	-	0	0	0
2001.....	-	0	0	0
2002.....	-	1	0	0
2003.....	-	3	1	0
2004.....	-	8	4	1
2005.....	-	13	7	3
2006.....	-	20	12	5
2007.....	-	27	16	8
1999-2003.....	-	4	1	0
1999-2007.....	-	72	40	17
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)				
1999.....	73%	73%	73%	73%
2000.....	68%	68%	68%	68%
2001.....	63%	63%	63%	63%
2002.....	58%	58%	58%	58%
2003.....	53%	54%	53%	53%
2004.....	46%	49%	47%	46%
2005.....	37%	46%	40%	38%
2006.....	27%	44%	35%	30%
2007.....	16%	43%	30%	21%
2010.....	(*)	49%	15%	(*)
2015.....	(*)	84%	(*)	(*)
2020.....	(*)	151%	(*)	(*)
2025.....	(*)	252%	(*)	(*)
2030.....	(*)	388%	(*)	(*)
2035.....	(*)	566%	(*)	(*)
2040.....	(*)	792%	(*)	(*)
2045.....	(*)	1068%	(*)	(*)
2050.....	(*)	1397%	(*)	(*)
2055.....	(*)	1787%	(*)	(*)
2060.....	(*)	2243%	(*)	(*)
2065.....	(*)	2775%	(*)	(*)
2070.....	(*)	3391%	(*)	(*)
D. Year of trust fund depletion.....				
	2008	Never	2013	2009
E. Board of Trustees tests:				
Short range test.....	No	No	No	No
Long-range test.....	No	No	No	No

* Fund is depleted.

- Note 1. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.
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Cap annual growth in per capita expenditures at...

	Present law	2%	3%	4%	5%
A. Actuarial Balance (percentage of taxable payroll)					
1998-2022.....	-0.73%	0.10%	-0.20%	-0.50%	-0.70%
1998-2047.....	-1.61%	0.37%	-0.21%	-0.93%	-1.53%
1998-2072.....	-2.10%	0.68%	-0.03%	-1.04%	-1.98%
B. Reduction in HI expenditures (in billions)					
1999.....	-	\$0	\$0	\$0	\$0
2000.....	-	0	0	0	0
2001.....	-	1	0	0	0
2002.....	-	2	0	0	0
2003.....	-	6	2	0	0
2004.....	-	12	6	3	1
2005.....	-	18	11	5	1
2006.....	-	25	15	8	2
2007.....	-	33	20	10	2
1999-2003.....	-	9	2	0	0
1999-2007.....	-	97	54	26	6
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)					
1999.....	73%	73%	73%	73%	73%
2000.....	68%	68%	68%	68%	68%
2001.....	63%	63%	63%	63%	63%
2002.....	58%	59%	58%	58%	58%
2003.....	53%	56%	53%	53%	53%
2004.....	46%	54%	48%	46%	46%
2005.....	37%	53%	43%	37%	37%
2006.....	27%	54%	40%	32%	28%
2007.....	16%	57%	36%	25%	18%
2010.....	(*)	73%	28%	(*)	(*)
2015.....	(*)	114%	8%	(*)	(*)
2020.....	(*)	164%	(*)	(*)	(*)
2025.....	(*)	224%	(*)	(*)	(*)
2030.....	(*)	311%	(*)	(*)	(*)
2035.....	(*)	468%	(*)	(*)	(*)
2040.....	(*)	739%	(*)	(*)	(*)
2045.....	(*)	1161%	(*)	(*)	(*)
2050.....	(*)	1757%	(*)	(*)	(*)
2055.....	(*)	2557%	(*)	(*)	(*)
2060.....	(*)	3599%	(*)	(*)	(*)
2065.....	(*)	4988%	(*)	(*)	(*)
2070.....	(*)	6815%	(*)	(*)	(*)
D. Year of trust fund depletion.....					
	2008	Never	2016	2009	2008
E. Board of Trustees tests:					
Short range test.....	No	No	No	No	No
Long-range test.....	No	No	No	No	No

* Fund is depleted.

- Note 1. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.
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Increase the employer/employee payroll tax rate by ...

	Present law	Increase the employer/employee payroll tax rate by ...			
		0.25%	0.50%	0.75%	1.00%
A. Actuarial Balance (percentage of taxable payroll)					
1998-2022.....	-0.73%	-0.25%	0.23%	0.71%	1.18%
1998-2047.....	-1.61%	-1.13%	-0.64%	-0.15%	0.33%
1998-2072.....	-2.10%	-1.61%	-1.12%	-0.64%	-0.15%
B. Increase in payroll tax revenues (in billions)					
1999.....	-	\$16	\$32	\$49	\$65
2000.....	-	23	45	68	90
2001.....	-	24	47	71	94
2002.....	-	25	49	74	98
2003.....	-	26	51	77	103
2004.....	-	27	54	81	108
2005.....	-	28	57	85	113
2006.....	-	30	60	90	119
2007.....	-	31	63	94	126
1999-2003.....	-	114	224	339	450
1999-2007.....	-	230	458	689	916
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)					
1999.....	73%	73%	73%	73%	73%
2000.....	68%	84%	99%	115%	130%
2001.....	63%	94%	125%	156%	187%
2002.....	58%	104%	151%	198%	245%
2003.....	53%	114%	176%	238%	301%
2004.....	46%	121%	198%	275%	352%
2005.....	37%	127%	218%	309%	400%
2006.....	27%	131%	236%	341%	446%
2007.....	16%	134%	252%	371%	489%
2010.....	(*)	133%	290%	447%	605%
2015.....	(*)	97%	310%	524%	737%
2020.....	(*)	20%	279%	538%	797%
2025.....	(*)	(*)	195%	490%	784%
2030.....	(*)	(*)	73%	402%	730%
2035.....	(*)	(*)	(*)	292%	659%
2040.....	(*)	(*)	(*)	166%	582%
2045.....	(*)	(*)	(*)	27%	502%
2050.....	(*)	(*)	(*)	(*)	415%
2055.....	(*)	(*)	(*)	(*)	319%
2060.....	(*)	(*)	(*)	(*)	208%
2065.....	(*)	(*)	(*)	(*)	81%
2070.....	(*)	(*)	(*)	(*)	(*)
D. Year of trust fund depletion.....					
	2008	2020	2032	2045	2068
E. Board of Trustees tests:					
Short range test.....	No	Yes	Yes	Yes	Yes
Long-range test.....	No	No	No	No	Yes

* Fund is depleted.

- Note 1. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.
 2. Illustrative proposals are assumed to take effect starting in 1999.
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Table 7--Estimated reductions in HI expenditures or increases in payroll tax revenues required to maintain HI trust fund assets at 100% of annual expenditures ("actuarial balance")

CY	Reduction in HI expenditures...		Increase in payroll tax revenues...	
	In billions of dollars	As a % of present law expenditures	In billions of dollars	As a % of present law payroll taxes
1999	\$9	6%	\$19	15%
2000	20	14%	31	24%
2001	26	17%	7	5%
2002	8	5%	10	7%
2003	10	6%	12	8%
2004	13	7%	16	10%
2005	16	8%	20	12%
2006	22	11%	25	14%
2007	25	11%	28	15%
2010	(*)	15%	(*)	22%
2015	(*)	23%	(*)	34%
2020	(*)	31%	(*)	52%
2025	(*)	39%	(*)	73%
2030	(*)	44%	(*)	92%
2035	(*)	48%	(*)	108%
2040	(*)	50%	(*)	115%
2045	(*)	51%	(*)	121%
2050	(*)	52%	(*)	125%
2055	(*)	52%	(*)	128%
2060	(*)	53%	(*)	132%
2065	(*)	54%	(*)	140%
2070	(*)	56%	(*)	149%
1999-2007	149	10%	168	13%
1999-2070	(*)	51%	(*)	120%

* Estimates of the dollar expenditure reductions and payroll tax increases and their totals are shown only through 2007, since inflation and interest cause such amounts to lose their meaning over long periods.

Notes: 1. Currently, the trust fund ratio is slightly under 100%. Under these scenarios, the ratio would reach 100% in the year 2001, after which the necessary reductions or increases would maintain the ratio at 100% every year thereafter. This would result in a slightly negative actuarial balance over the entire period beginning from 1999, and a zero actuarial balance beginning from 2001. Both the short-range and long-range tests of the Trustees would be satisfied over the entire period.

2. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.

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