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*Medicare Trigger*

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January 15, 2009

**Abstract.** A determination of excess general funding, as required by 801 of P.L. 108-173, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), is issued if general revenue Medicare funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years. If the determination is issued for two consecutive years, a warning is issued requiring certain presidential and congressional action (802-804 of MMA). The warning alerts policy makers of one measure of the financial health of Medicare. It attempts to focus on the impact of Medicare revenues and outlays on the federal budget, by looking at Medicare's burden on the Treasury. Because such a determination was issued in both the 2006 and 2007 Medicare Trustee's reports, in 2008, the President was required to submit a legislative proposal to Congress to lower the ratio to the 45% level. Similarly, the 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds included an estimate that general revenue funding would exceed 45% in 2014, creating a new warning, based on the estimates of excess general revenues for 2007 and 2008. As a result of this new warning, in 2009, the President will be required to submit a legislative proposal to Congress to lower the ratio to the 45% level. Some options for reducing general revenue spending below the 45% level would have a greater impact than others.



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**CRS Report for Congress**

*Prepared for Members and Committees of Congress*

## Summary

A determination of excess general funding, as required by §801 of P.L. 108-173, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), is issued if general revenue Medicare funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years. If the determination is issued for two consecutive years, a warning is issued requiring certain presidential and congressional action (§802-§804 of MMA). The warning alerts policy makers of one measure of the financial health of Medicare. It attempts to focus on the impact of Medicare revenues and outlays on the federal budget, by looking at Medicare's burden on the Treasury. Because such a determination was issued in both the 2006 and 2007 Medicare Trustee's reports, in 2008, the President was required to submit a legislative proposal to Congress to lower the ratio to the 45% level. Similarly, the 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds included an estimate that general revenue funding would exceed 45% in 2014, creating a new warning, based on the estimates of excess general revenues for 2007 and 2008. As a result of this new warning, in 2009, the President will be required to submit a legislative proposal to Congress to lower the ratio to the 45% level. Some options for reducing general revenue spending below the 45% level would have a greater impact than others.

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As required by the Social Security Act, a Medicare Board of Trustees oversees the financial operations of the Medicare Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) trust fund. The HI trust fund covers Medicare Part A services, including hospital, home health, skilled nursing facility care, and hospice care, and the SMI trust fund covers Medicare Parts B and D, including physician, outpatient hospital, home health, and access to prescription drug coverage. The two trust funds are statutorily completely separate. The Act requires that the Board report annually to Congress on the financial and actuarial status of the funds. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173, MMA) amended the Social Security Act, adding an additional responsibility that requires the trustees to examine and make a determination if general revenue Medicare funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years. An affirmative determination in two consecutive annual reports is considered to be a Medicare funding warning in the year in which the second report is made. This requirement is found in §1817(b)(2) and §1841(b)(2) of the Social Security Act, as amended by the MMA.

Thus, the Medicare warning is a mechanism for alerting policy makers of the impact of Medicare revenues and outlays on the federal budget, in effect looking at the burden of the Medicare program on the Treasury. The trigger and the subsequent required legislative proposal by the President and congressional action serve as an warning that Medicare spending has reached a statutorily defined critical level. There is no inherent significance to establishing 45% as the trigger, rather it serves as a level at which Congress has determined it agrees to examine Medicare's effect on the Treasury. The formula used to calculate excess general revenue spending inherently favors some options over others.

While the President must propose, and Congress must consider, legislation to reduce spending below the trigger, there is no requirement that legislation must be enacted and no automatic mechanism in place to sequester money. It is also important to note that either chamber may alter these procedures should a numerical majority choose to do so. Most recently, on January 6, 2008, the House approved a rules package (H.Res. 5) that nullifies the trigger provision in the House for two years (the duration of the 111<sup>th</sup> Congress).

## Definition of the Excess General Funding Warning

Section 801 of the MMA defines the key terms for a Medicare funding warning:

- *Excess* general revenue Medicare funding occurs when general revenue Medicare funding divided by total Medicare outlays exceeds 45%.
- General revenue Medicare funding is defined as *total Medicare outlays minus dedicated* financing sources.<sup>1</sup>
- *Dedicated* financing sources include the following: (1) HI payroll taxes; (2) amounts transferred from the Railroad Retirement Act; (3) income from taxation of certain Social Security benefits which are credited to the HI trust fund; (4) state transfers for the state share of amounts paid to the federal government for certain beneficiaries; (5) Medicare premiums paid under Parts A (HI), B (SMI) and D (prescription drugs) of Medicare—including any amounts paid as a result

<sup>1</sup> This definition of general revenues should not be confused with the transfers from Treasury to the SMI trust fund, required under current law to cover about 75% of Part B outlays.

of late enrollment penalties (without taking into account reductions in premiums as a result of rebates received by beneficiaries enrolled in Medicare managed care plans); (6) and any gifts received by the trust funds. (Interest earned on the trust fund is excluded from dedicated sources.)

- *Total Medicare outlays* include the following: (1) total outlays from the HI and SMI trust funds, (2) payments made to plans under Part C (Medicare Advantage) for rebates, (3) administrative expenditures for carrying out Medicare, (4) offsets to outlays by the amount of fraud and abuse collections that are applied or deposited into a Medicare trust fund.

## Required Presidential Action

Because the Medicare trustees issued a warning in 2007,<sup>2</sup> President Bush was required to submit legislation to Congress responding to the warning, within the 15-day period, beginning on the date of the budget submission to Congress this year.<sup>3</sup> The President submitted the legislation on February 15, 2008. This requirement could have been waived if after the warning is issued, but before the deadline for the Presidential response (1) Congress enacted legislation to eliminate excess general revenue Medicare funding for the seven-fiscal year reporting period, and (2) if within 30 days after enactment, the Board of Trustees of the Medicare Trust Funds certified that the legislation eliminates the funding warning.

## Expedited Congressional Consideration

In any year in which the MMA requires the President to submit draft Medicare funding legislation, the act directs that in each chamber, within three days of session after the proposal is received, the two floor leaders (or their designees) introduce a bill reflecting it, with the title “A bill to respond to a Medicare funding warning.” The President’s bill was submitted on February 14, 2008, and introduced in the House and the Senate on February 25, 2008. This measure, or, under certain circumstances, an alternative Medicare funding measure, is potentially subject to consideration under “fast track” rules established by the statute, rather than under the regular rules and procedures that govern consideration of legislation in the two chambers.<sup>4</sup>

These expedited procedures place limits on committee consideration, as well as potentially on Members’ ability to debate and amend legislation on the floor and to offer certain motions that would otherwise be in order. These procedures are designed to guarantee that each house will have an opportunity to consider legislation to eliminate the funding warning. They do not guarantee, however, that (1) the President’s specific proposal will be the one considered or (2) Congress will pass legislation to lower general revenue spending below the trigger amount. As noted above, either chamber may alter these procedures should a numerical majority choose to do

<sup>2</sup> 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, pp. 35-40.

<sup>3</sup> Similarly, the 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds included an estimate that general revenue funding would exceed 45% in 2014, creating a new warning, based on the estimates of excess general revenues for 2007 and 2008.

<sup>4</sup> The text of this expedited procedure is contained in U.S. Congress, House, *Constitution, Jefferson’s Manual, and Rules of the House of Representatives of the United States, One Hundred Tenth Congress*, H.Doc. 109-157, 109<sup>th</sup> Cong., 2<sup>nd</sup> sess., [compiled by] John V. Sullivan, Parliamentarian (Washington: GPO, 2007), sec. 1130(31).

so. Such action was taken by the House on January 6, 2008, when it approved a rules package (H.Res. 5) that nullifies the trigger provision for the 111<sup>th</sup> Congress. The following description of the procedures and activities for the House thus serves as reference of how the procedures would otherwise work in the House.

### **Procedures (and Activity) for the House**

In any year in which the MMA requires the President to submit draft Medicare funding legislation, the committee(s) of referral must report Medicare funding legislation by June 30. For this purpose, any other bill with the same title as required for the President's proposal also qualifies as Medicare funding legislation, and the requirement to report applies whether or not the President has submitted a proposal. As a result, the committee may choose to report some other Medicare funding measure rather than that of the President. The Chairman of the House Committee on the Budget is responsible for certifying whether or not any Medicare funding legislation (or any subsequent amendments to it) eliminates the excess general revenue Medicare funding.

Whether or not the reported measure is affirmatively certified as responding to the funding warning, the House may consider that measure under its regular procedures. In any year in which the President is required to submit Medicare funding legislation, however, if the House has not voted on final passage of an affirmatively certified measure by July 30, then after 30 more calendar days, including five days of session, any Member may offer a highly privileged motion to discharge a committee from further consideration of any Medicare funding legislation of which he or she is in favor, but only if it has been in committee for 30 days, and is affirmatively certified.<sup>5</sup> The MMA describes these procedures as a "fallback," in that they apply only if the House has not already voted on legislation affirmatively certified to respond to the funding warning (regardless of whether that legislation passed or not). In addition, once the House agrees to one such motion to discharge, the motion is no longer in order during that session of Congress.

A motion to discharge made under this "fallback" provision must be made by a supporter, seconded by one-fifth of the House's membership (a quorum being present), and is debatable for one hour. If the House adopts the motion to discharge, the Speaker must, within three days of session thereafter, resolve the House into Committee of the Whole for consideration of the legislation. Debate on the measure is not to exceed five hours, and only amendments that have the affirmative certification of the Committee on the Budget are admitted. Debate on any amendment is not to exceed 1 hour, and the total time for consideration of all amendments is capped at 10 hours. At the conclusion of consideration, the Committee rises and reports the legislation back to the House for a final dispositive vote. A motion to recommit the measure with or without instructions is not precluded.

On July 24, 2008, the House of Representatives adopted H.Res. 1368, a resolution which provided that the expedited parliamentary procedures contained in Section 803 of the MMA would not apply in the House during the remainder of the 110<sup>th</sup> Congress.

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<sup>5</sup> This motion to discharge is not in order if, during the previous session of Congress, the House voted on Medicare funding legislation which was affirmatively certified by the House Committee on the Budget to eliminate the general funding warning.

## Procedures for the Senate

The statutory procedures provided in the Senate for Medicare funding legislation apply to a bill reflecting a Presidential proposal pursuant to the MMA or to any other bill with the same title that either (1) was passed by the House or (2) contains matter within the jurisdiction of the Finance Committee. A measure reflecting the President's proposal is to be referred to the Senate Committee on Finance. In a year in which the MMA requires the President to submit Medicare funding legislation, and whether or not he does so, if the Committee on Finance has not reported the bill reflecting the President's proposal or some other Medicare funding legislation by June 30, then any Senator may move to discharge that committee from any single Medicare funding measure. Only one such motion to discharge is in order during a session of Congress.<sup>6</sup> Debate on the motion to discharge is limited to two hours, a restriction which ensures that a vote on the motion cannot be prevented by a filibuster.

In combination, these provisions afford the Senate only one assured opportunity to consider Medicare funding legislation, which will be either the measure the Committee on Finance reports or the one specified in the discharge motion. In either case, the legislation the Senate will have the opportunity to consider may or may not be the one that embodies the President's proposal.

After the date on which the Committee on Finance has reported or been discharged from further consideration of Medicare funding legislation, it is in order for any Senator to move to proceed to consideration of the bill. The MMA does not explicitly make this motion non-debatable, although Senate precedent exists for treating as non-debatable a motion to proceed to consider a measure under procedures specified by statute. In the absence of such a limitation, it might be possible for opponents to use a filibuster to prevent this motion from coming to a vote. In any case, because the MMA establishes no further requirements regarding consideration, if the motion to proceed is agreed to, the Senate would consider the measure under its general rules. The statute, then, does not preclude a filibuster of the measure. Nor, if the House and Senate both pass a bill, does the act make any provision to expedite the resolution by conference committee or otherwise of differences between the two versions of Medicare funding legislation.

## Impact of Legislation to Lower the General Revenue Share

In order to understand the impact of legislation designed to lower the general revenue share, it is important to understand how the Medicare program is funded. The primary source of financing for the HI trust fund is the payroll tax on covered earnings, making up about 95% of the money in the fund. Employers and employees each pay 1.45% of wages and unlike the Social Security tax, there is no annual maximum limit on taxable earnings. The other sources of revenue for the HI trust fund include interest paid on the U.S. Treasury securities held in the HI trust fund, a portion of the federal income taxes that individuals pay on their Social Security benefits, premiums paid for individuals who would otherwise not qualify for Medicare Part A, and a small amount of general revenue transfers. HI funding is established through statutory tax rates that cannot be adjusted to match expenditures. All expenditures for HI benefits are paid for from the HI fund.

The SMI trust fund has different revenue sources. There are no payroll taxes collected for this fund, and individuals enrolled in Medicare Parts B and D must pay a premium, of about 25% of

<sup>6</sup> This motion is not in order at all if the Chairman of the Senate Committee on the Budget has certified that Medicare funding legislation has already been enacted that eliminates the excess general revenue Medicare funding.



program costs.<sup>7</sup> Enrollment in Parts B and D is voluntary. Most of the revenues, about 75%, for the SMI trust fund come from general revenue transfers, with the remainder coming from premiums, interest paid on the U.S. Treasury securities held in the fund, and other sources, such as Part D state transfers for certain Medicaid beneficiaries. All SMI benefit expenditures are paid from the SMI trust fund.

When considering proposals to reduce the general revenue share, some changes have a larger impact than others for lowering the 45% level. For example, an increase in dedicated revenues, by either increasing payroll taxes or premiums would have the greatest impact on reducing the excess general revenues. A equal dollar amount decrease in Part A spending would have the second greatest impact, and an equal dollar amount decrease in Part B or D spending would have the least impact. The table below illustrates the effect of changes designed to reduce excess general revenues. In this hypothetical example, assume that under current law, the general revenue share would reach 55% in the given year. A \$68 billion increase in dedicated revenues would lower the percent of general revenues to 45%, while a \$68 billion decrease in Part A spending (thus lowering total Medicare outlays) would only reduce the level to 49.4%. Reducing total outlays by reducing Part B or D spending has the least impact, because for every dollar saved, about \$0.25 would be offset by reduced beneficiary premiums. Thus, a \$68 billion decrease in Part B spending would only reduce the level to 51.9%. Also as shown in the table, in order to bring the level down to 45% through reductions in spending, it would require a \$124 billion dollar reduction in Part A spending or a \$227 billion reduction in Part B or D spending. Thus dollar for dollar, options to reduce the trigger level are not equal.

**Table 1. Illustrative Effect of Options to Lower General Revenues as Percentage of Total Medicare Outlays under the Trigger Calculation**  
(dollars in billions)

	Current Law	Increase Dedicated Revenues by \$68	Decrease Part A Spending by \$68	Decrease Part B Spending by \$68	Decrease Part A Spending by \$124	Decrease Part B Spending by \$227
Total Medicare Outlays	\$760	\$760	\$692	\$692	\$636	\$533
Dedicated Revenues	\$350	\$418	\$350	\$333	\$350	\$293.25
General Revenues (Total Outlays-Dedicated Revenues)	\$410	\$342	\$342	\$359	\$286	\$239.75
General Revenues as a % of Total Medicare Outlays	53.9%	45.0%	49.4%	51.9%	45.0%	45.0%

**Notes:** The table should only be used to provide an illustration of the mathematical effect of alternative options on the formula for calculation of excess general revenues. Changing current law components would yield different results.

<sup>7</sup> Beginning in 2007, certain higher income beneficiaries are required to pay an income related premium covering more than the 25% to enroll in Part B. For Part D, those with low incomes receive premium support. Medicaid pays Part B premiums for certain low-income individuals.

Even though the trigger combines the HI and SMI trust funds, it is only a formula that does not directly relate to how the Medicare trust funds operate. Legally, any funds raised for one fund cannot be used to pay expenses out of the other. As a result of the statutory independence of the trust funds, the revenues and outlays of each trust fund do not bear upon the other fund. Therefore, reducing Part A spending would not reduce federal contribution requirements for Part B and D spending as required under statute. In other words, Parts B and D of Medicare are financed by a combination of premiums and federal contributions funded through general revenues transfers. While lowering Part A spending would lower overall Medicare spending and therefore reduce any “excess general revenue spending,” it would have no impact whatsoever on the amount of general revenues required to be transferred from the Treasury to the SMI trust fund in order to finance Part B outlays. Further, increasing dedicated revenues through increased payroll taxes has no impact on Medicare spending, so that Medicare expenditures could continue to grow, unchecked, while still technically lowering excess general revenue spending below the 45% level.

Finally, another measure of financial health of the trust fund that is often cited is the date on which the HI trust fund is expected to be insolvent. This measure is not specifically addressed in the trigger, as lowering the percentage of general revenue spending through changes in Medicare Parts B and D would have no impact on the solvency of the HI trust fund.

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