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# Medicare Trigger

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# Summary

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) requires the Medicare Board of Trustees to provide in its annual reports, starting with the 2005 report, an expanded analysis of Medicare expenditures and revenues (MMA §801). If the Medicare trustees determine that general revenue funding for Medicare is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years, a determination of excess general revenue Medicare funding is made. If the determination is issued for two consecutive years, a funding warning is triggered, which requires certain presidential and congressional actions (MMA §§802-804). Specifically, in the event of a funding warning, the President would be required to submit to Congress proposed legislation to respond to the funding warning within 15 days of submitting a budget in the next year (for the subsequent fiscal year); Congress would then be required to consider that legislation on an expedited basis.

The Medicare trustees made a determination of excess general revenue funding in each of their 2006 through 2013 reports and in each of their 2017 through 2020 reports. The Medicare trustees therefore issued funding warnings in their 2007 through 2013 and 2018, 2019, and 2020 reports, thus requiring specified actions by the President and Congress. To date, only one presidential proposal has been submitted (in response to the 2007 funding warning) and no legislation responding to these warnings has been enacted. Because the Medicare trustees issued a funding warning in their 2020 report, the MMA provides that the President will be required to submit a responsive legislative proposal after the 2021 release of his FY2022 budget.

The Medicare trigger focuses attention on the impact of program spending on the federal budget, and it provides one measure of the financial health of the program. However, some options for reducing general revenue spending below the 45% level would have a greater impact than others. Proponents of the trigger maintain that it forces fiscal responsibility, whereas critics of the trigger suggest that other measures of Medicare spending, such as total Medicare spending as a portion of federal spending, would be more useful indicators.

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# Background

As required by the Social Security Act, a Medicare Board of Trustees oversees the financial operations of the two Medicare trust funds: the 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, and hospice care; the SMI Trust Fund covers Medicare Parts B and D, including physician and outpatient hospital services and outpatient prescription drugs. The two trust funds are statutorily separate, with all HI and SMI benefit expenditures paid out of their respective trust funds. The Medicare trustees are required to report annually to Congress on the financial and actuarial status of the funds.[1]

## Medicare Financing[2]

The primary source of financing for the HI Trust Fund is the payroll tax on covered earnings of current workers. Employers and employees each pay 1.45% of wages, and unlike the Social Security tax, there is no annual maximum limit on taxable earnings. Workers with annual wages over $200,000 for single tax filers or $250,000 for joint filers pay an additional 0.9%.[3] 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, and premiums paid by individuals who would otherwise not qualify for Medicare Part A.

The SMI Trust Fund has different revenue sources. There are no payroll taxes collected for this fund, and enrollment in Medicare Parts B and D is voluntary. Individuals enrolled in Parts B and D must pay premiums, which cover about 25% of program costs.[4] The other 75% of revenues for the SMI Trust Fund primarily comes from general revenue transfers. Other sources of revenue include interest paid on the U.S. Treasury securities held in the fund and Part D state transfers for Medicare beneficiaries who are also eligible for Medicaid (dual-eligibles).

The 2020 report of the Medicare Board of Trustees estimates that by 2026, HI revenues and assets will no longer be sufficient to fully cover Part A costs and the fund will become insolvent.[5] Because of the way it is financed, the SMI fund cannot face insolvency; however, the Medicare trustees project that SMI expenditures will continue to grow rapidly and thus place increasing strains on the federal budget.

# The Medicare Trigger

Because of concerns over the potential for growth in general revenue spending for Medicare over time, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) created a Medicare *trigger* that requires certain actions to be taken should general

[1] The annual Medicare Trustees' Reports may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html.

[2] For additional detail, see CRS Report R43122, *Medicare Financial Status: In Brief*.

[3] See Internal Revenue Service, *Questions and Answers for the Additional Medicare Tax*, at http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax.

[4] Higher-income beneficiaries are required to pay an income related premium covering more than the 25% of Part B and D costs. Certain beneficiaries with low incomes may receive assistance with their premiums.

[5] For information on prior insolvency estimates, see CRS Report RS20946, *Medicare: Insolvency Projections*.

revenue funding be expected to exceed a certain proportion of total Medicare outlays within a certain number of years.[6]

Specifically, Section 801 of the MMA requires the Medicare trustees, beginning with their 2005 report, to examine and make a determination each year of whether general revenue funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the following six fiscal years.[7] 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.[8] If such a warning is issued, the MMA (Sections 802-804) specifies certain requirements and procedures for the President and Congress to follow related to the introduction and consideration of legislation designed to respond to the warning. There is, however, 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.

## Determination of a Medicare Funding Warning

Section 801 of the MMA defines the key measures and terms used in determining 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*.[9]
- *Total Medicare outlays* include total outlays from the HI and SMI Trust Funds. The law specifies that payments made to plans under Part C (Medicare Advantage, MA) for rebates, and administrative expenditures for carrying out Medicare, are to be included in the total. Fraud and abuse collections that are applied or deposited into a Medicare trust fund are to be deducted from the total.
- *Dedicated revenue* sources include the following: (1) HI payroll taxes; (2) amounts transferred to the Medicare trust funds from the Railroad Retirement pension fund; (3) income from taxation of certain Social Security benefits which is credited to the HI Trust Fund; (4) state transfers for the state share of amounts paid to the federal government for dual-eligible beneficiaries enrolled in Part D; (5) Medicare premiums paid under Parts A (HI), B (SMI) and D (SMI) of Medicare—including any amounts paid as a result of late enrollment penalties (without taking into account reductions in premiums as a result of rebates received by beneficiaries enrolled in MA plans); and (6) any gifts received by the trust funds. Interest earned on the trust fund is excluded from dedicated sources.
- A *Medicare funding warning* is triggered when two consecutive Medicare trustees' reports contain projections that *general revenue Medicare funding* will

[6] As described in more detail later, general revenue funding as defined under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA; P.L. 108-173) trigger provision is not identical to that used to denote the share of Medicare spending financed out of general revenues; however, the definitions are very similar.

[7] The MMA also created the Medicare outpatient prescription drug benefit program (Part D), which increased the amount of general revenues needed to finance the Medicare program.

[8] This requirement is found in §1817(b)(2) and §1841(b)(2) of the Social Security Act, as added by §801 of the MMA.

[9] This definition of general revenues is not the same as the transfers from the Treasury to the Supplementary Medical Insurance (SMI) Trust Fund, required under current law to cover about 75% of Part B outlays.

exceed 45% of *total Medicare outlays* at some point during the next seven years (this includes the current and six subsequent fiscal years).

**Medicare Trigger Formula**

$$\text{General Revenue Funding Percentage} = \frac{\text{Total Medicare Outlays - Dedicated Revenues}}{\text{Total Medicare Outlays}}$$

## Issuance of Funding Warnings

The Medicare trustees made a determination of excess general revenue funding in each of their 2006 through 2013 reports and in their 2017 through 2020 reports. Therefore, in their 2007 through 2013 and in their 2018, 2019, and 2020 reports, the Medicare trustees issued Medicare funding warnings, thus requiring specified actions by the President and Congress (as described in the "Required Presidential Action" and "Expedited Congressional Consideration" sections of this report).

Specifically, the Medicare trustees first made a determination of excess general revenue Medicare funding in their 2006 report and did so in each report through 2013.[10] As two consecutive such determinations trigger a funding warning, funding warnings were issued each year from 2007 through 2013. The 2013 report was the eighth consecutive time that the threshold was estimated to be exceeded within the first seven years of the projection, and it was the seventh time that a Medicare funding warning was triggered.[11]

However, the Medicare Trustees Reports issued in 2014 through 2016 projected that Medicare general revenue funding would *not* exceed 45% of total Medicare outlays within the next seven years. Therefore, the Medicare trustees did not issue determinations of excess general revenues and funding warnings were not triggered in those years. Specifically, in their 2014 and 2015 reports, the Medicare trustees projected that the expected higher tax income and lower outlays due to provisions in the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) and other legislation would result in general revenue funding remaining below the 45% threshold over the next seven years. For similar reasons, as well as a slowing in Medicare spending, the Medicare trustees estimated in their 2016 report that general revenue funding would remain below the 45% threshold through the next seven years (through FY2022); however, the 2016 report projected that the threshold would be exceeded in FY2023 (the eighth year).

In their 2017 report, consistent with their 2016 projections, the Medicare trustees estimated that general revenues would exceed the 45% threshold in FY2023, now within the seven-year

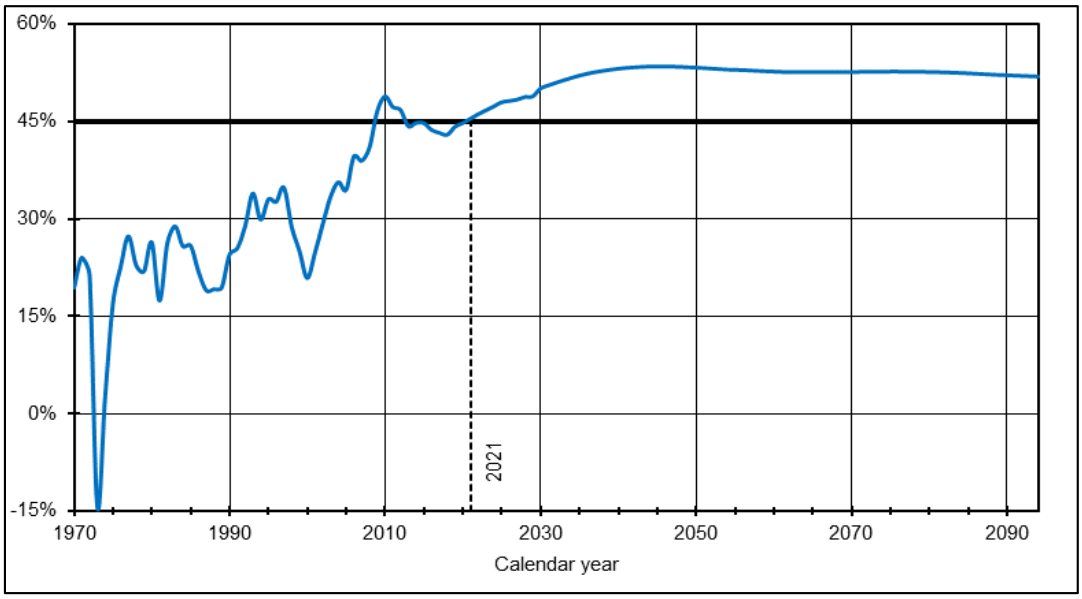
[10] The Medicare trustees did not project excess general revenue funding within the next seven fiscal years in their 2005 report.

[11] In their 2006 report, the Medicare trustees projected that the 45% level would be exceeded in FY2012. The 2007 report projected that it would be exceeded in FY2013, and both the 2008 and 2009 reports projected the level would be exceeded for the first time in FY2014. The 2010 report moved up the expected date that general revenue funding would exceed 45%, to FY2010; the 2011 report confirmed that the threshold was breached in FY2010 and was expected to be breached again in FY2011 and FY2012. The 2012 report confirmed that the ratio was exceeded in FY2010 and FY2011 and estimated that it would again be exceeded in FY2012. The 2013 report estimated that the Medicare general revenue funding would exceed the 45% ratio in FY2013, and the 2014 report confirmed that this occurred.

projection window. Therefore, the trustees issued a determination of excess general revenue Medicare funding in that year.[12] In their 2018,2019 and 2020 reports, the trustees also estimated that general revenues would exceed the 45% threshold within the seven-year projection window, but now in FY2022 (at the end of CY2021); they therefore issued a determination of excess general revenue Medicare funding in each of these years (see **Figure 1**).[13] Because such a determination was made in three consecutive years, a funding warning was triggered each year from 2018 to 2020.

In their 2020 report, the Medicare trustees projected that the ratio of dedicated funding to outlays would exceed 45% by the end of CY2021, grow to almost 54% by CY2044, and decline to about 52% by the end of the 75-year projection period, in CY2094.

**Figure 1. Projected Difference between Total Medicare Outlays and Dedicated Financing Sources, as a Percentage of Total Outlays**




**Source:** Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Figure V.B1, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html.

**Note:** Although excess general revenue Medicare funding is determined on a fiscal-year basis, the trustees' long-term projection uses calendar years.

[12] In their 2017 report, the Medicare trustees issued a determination of excess general revenue Medicare funding. However, as such a determination must be made in two consecutive years to trigger a funding warning and such a determination was not made in 2016, the trustees did not issue a funding warning in their 2017 report.

[13] In their 2018 report, the trustees estimated that the threshold would be exceeded earlier than projected in their 2017 report due to projections of slightly higher Medicare spending based on expected growth in Medicare Advantage payments and to legislated changes made by the Bipartisan Budget Act of 2018. See CRS Report R45126, *Bipartisan Budget Act of 2018 (P.L. 115-123): Brief Summary of Division E—The Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act*.

# Required Presidential Action

In years in which the Medicare trustees issue a Medicare funding warning, the President is required to submit to Congress proposed legislation that "respond[s] to such warning."[14] Although the precise contents of the proposal remain within the President's discretion,[15] Section 802 of the MMA requires that the proposal be submitted within 15 days of submitting a budget in the next year (for the subsequent fiscal year).[16] The requirement that the President submit proposed legislation in response to a funding warning does not apply, however, if, "during the year in which the warning is made," Congress enacts legislation to eliminate excess general revenue Medicare funding for the seven-fiscal year reporting period, as certified by the Medicare trustees within 30 days of the legislation's enactment.[17]

The executive branch has generally taken the position that, under the Constitution's Recommendation Clause, Congress cannot compel the President, or executive branch officials, to submit legislative proposals directly to Congress.[18] These objections have been registered in numerous presidential signing statements and Department of Justice, Office of Legal Counsel opinions, and have repeatedly been asserted in litigation.[19] For example, upon signing the MMA on December 8, 2003, President George W. Bush issued a signing statement registering his constitutional objections to Section 802's requirement that the President submit proposed legislation to Congress in response to a Medicare funding warning. Specifically, President Bush noted that his Administration would construe Section 802 "in a manner consistent with the President's constitutional authority to supervise the unitary executive branch and to recommend for the consideration of the Congress such measures as the President judges necessary and expedient."[20] Similarly, the Obama Administration considered "the requirement to submit

[14] 31 U.S.C. §1105(h)(1).

[15] 31 U.S.C. §1105(h)(1). P.L. 108-173 included a "Sense of Congress" provision providing that "[i]t is the sense of Congress, that legislation submitted pursuant to section 1105(h)…in a year should designed to eliminate excess general revenue Medicare funding (as defined in section 801(c)) for the 7-fiscal-year period that begins in such year." Given the discretionary language, this provision does not appear to bind the President or dictate the contents of the President's legislative proposal. Thus, it would appear that the President need only submit a legislative proposal that "respond[s] to such warning." 31 U.S.C. §1105(h)(1).

[16] Current law (31 U.S.C. §1105(a)) requires that the President submit a budget on or after the first Monday in January but not later than the first Monday in February of each year for the following fiscal year.

[17] 31 U.S.C. §1105(h)(2).

[18] The executive branch has generally argued that the recommendation clause prevents Congress from directing the President to submit legislative proposals that the President does not personally find to be "necessary and expedient." See, for example, "Common Legislative Encroachments of Executive Branch Constitutional Authority," 13 OLC 248, 256 (1989). ("Because the President has plenary exclusive authority to determine whether and when he should propose legislation, any bill purporting to require the submission of recommendations is unconstitutional. If enacted, such 'requirements' should be construed as only a recommendation to the President that he submit legislative proposals.")

[19] See, for example, George W. Bush, Statement on Signing the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, December 8, 2003; Barack Obama, Statement on Signing the Omnibus Appropriations Act of 2009, March 11, 2009 ("Because the Constitution gives the President the discretion to recommend only 'such measures as he shall judge necessary and expedient,'…I shall treat these directions as precatory."); "Constitutional Issues Raised by Commerce, Justice and State Appropriations Bill," 2001 OLC LEXIS 37, November 28, 2001 ("Under the Recommendations Clause, Congress cannot compel the President to submit legislative proposals to Congress."); Ass'n of Am. Physicians and Surgeons v. Clinton, 997 F.2d 898, 906 (D.C. Cir. 1993) ("According to the government, [the Recommendation Clause] gives the President the sole discretion to decide what measures to propose to Congress, and it leaves no room for congressional interference."); Walker v. Cheney, 230 F. Supp. 2d 51 (D.D.C. December 9, 2002) (arguing that "the swath of Presidential policy-making authority falling within the Opinions and Recommendations Clause is entirely exempt from congressional [] review").

[20] George W. Bush, Statement on Signing the Medicare Prescription Drug, Improvement, and Modernization Act of

legislation in response to the Medicare funding warning to be advisory and not binding, in accordance with the Recommendations Clause of the Constitution."[21]

Notwithstanding his objections to Section 802, President Bush submitted legislation in 2008 responding to the Medicare trustees' 2007 funding warning.[22] No action was taken on the President's proposal. Although the Medicare trustees subsequently issued funding warnings each year from 2008 through 2013, and again in 2018 and 2019, no additional legislative proposals have been submitted to Congress pursuant to Section 802.[23] (Since the Medicare trustees did not issue funding warnings in their 2014 through 2017 reports,[24] the President was not required to submit related legislation subsequent to his 2015 through 2018 budget submissions [for FY2016 through FY2019].) Because the Medicare trustees issued a funding warning in their 2020 report, the MMA provides that the President will be required to submit a responsive legislative proposal after the 2021 release of his FY2022 budget.

The Recommendation Clause provides that the President "shall from time to time give to the Congress Information of the state of the Union, and recommend to their Consideration such Measures as he shall judge necessary and expedient."[25] Courts have rarely been presented with the opportunity to interpret the scope of this clause. However, the text of the clause, read in conjunction with analogous case law, does not appear to support an interpretation that would prevent Congress from directing the President to submit legislative recommendations. The clause is perhaps most accurately characterized as establishing a *right* as opposed to a substantive source of authority[26]—ensuring that the President may submit directly to Congress legislative proposals that he views as "necessary and expedient."[27] Thus, this *right* would appear only to be infringed

2003, December 8, 2003, http://www.gpo.gov/fdsys/pkg/WCPD-2003-12-15/pdf/WCPD-2003-12-15-Pg1774.pdf.

[21] Letter from OMB Director Jeffrey D. Zients to Senator Jeff Sessions, February 5, 2013.

[22] For additional information on the legislation, see out-of-print CRS Report RL34407, *The President's Proposed Legislative Response to the Medicare Funding Warning*, available to congressional clients upon request from the author.

[23] Various Members of Congress have periodically criticized a President's failure to submit a legislative proposal to address the Medicare funding warnings. See, for example, Letter from Senator Jeff Sessions and Hon. Paul Ryan, to President Barack Obama, March 1, 2012 (advising the President that "[t]he law requires you to submit a legislative proposal to Congress following a warning by the Medicare Trustees").

[24] In their 2017 report, the Medicare trustees issued a determination of excess general revenue Medicare funding. However, as such a determination must be made in two consecutive years to trigger a funding warning, and such a determination was not made in 2016, the trustees did not issue a funding warning in their 2017 report. Therefore, the President was not required to submit Medicare funding legislation subsequent to the issuance of his FY2019 budget.

[25] U.S. Const., Art. II, §3.

[26] Ass'n of Am. Physicians and Surgeons v. Clinton, 997 F.2d 898, 908 (D.C. Cir. 1993). ("[T]he Recommendation Clause is less an obligation than a right.") In this sense, the Recommendation Clause has often been compared to language, also found within Article II, §3 of the Constitution, that establishes the President's responsibility to "take Care that the Laws be faithfully executed." U.S. Const., Art. II, §3. The courts have consistently interpreted the "take Care" Clause as a responsibility as opposed to a source of substantive power. See, for example, Kendall ex rel Stokes v. United States, 37 U.S. 522, 612-13 (1838). ("To contend that the obligation imposed on the President to see the laws be faithfully executed, implies a power to forbid execution, is a novel construction of the Constitution, and entirely inadmissible.")

[27] Indeed, the Recommendation Clause appears to have been inserted as a proactive measure to clearly establish the President's ability to recommend legislation to Congress. See, James Madison, Notes of Debates in the Federal Convention of 1787, 464 (Gaillard Hunt and James Brown Scott, eds. 1987) ("On motion of Mr. Govr. Morris, 'he may' was struck out, & 'and' inserted before 'recommend' in the clause 2d sect 2d art: X in order to make it the duty of the President to recommend, & thence prevent umbrage or cavil at his doing it."); Ass'n of Am. Physicians and Surgeons v. Clinton, 997 F.2d 898, 908 n.7 (D.C. Cir. 1993) ("Gouverneur Morris' amendment suggests that the clause was intended to squelch any congressional objections to the President's *right* to recommend legislation—hence the prevention of 'umbrage or cavil.'"(citing J. Gregory Sidak, *The Recommendation Clause*, 77 Geo. L. J. 2079, 2082

where Congress *prevents* the President from submitting his own legislative proposal or attempts to dictate the contents of a required legislative proposal. Under this reading, it is unlikely that Congress imposes an excessive burden on the President where it merely directs the President to submit a proposal, the contents of which remain within the President's discretion, in response to a specific trigger. Whereas the Department of Justice may assert that "any bill purporting to require the submission of recommendations is unconstitutional," no judicial decision has accepted such a broad proposition.[28]

# 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." 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.[29]

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 respond to 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 so. 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.

In response to President Bush's legislative proposal submitted on February 14, 2008, the House and the Senate both introduced a bill (H.R. 5480 and S. 2662 respectively) on February 25, 2008.[30] On July 24, 2008, the House of Representatives adopted H.Res. 1368, a resolution providing that the expedited parliamentary procedures contained in Section 803 of the MMA would not apply in the House during the remainder of the 110th Congress. Similar action was taken by the House on January 6, 2009, when it approved a rules package (H.Res. 5) that nullified the trigger provision for the 111th Congress. No action to waive these rules has been taken in subsequent Congresses.

## 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

[1989]).

[28] "Common Legislative Encroachments of Executive Branch Constitutional Authority," 13 OLC 248, 256 (1989). The Clause does, however, appear to "presuppose[] the [President's] ability to collect information and advice necessary to make such recommendations." Judicial Watch, Inc. v. Nat. Energy Policy Dev. Gr., 219 F. Supp 2d 20, 50-51 n. 15 (D.D.C. 2002).

[29] 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 Fifteenth Congress,* H.Doc. 114-192, 114th Cong., 2nd sess., [compiled by] Thomas J. Wickham, Parliamentarian (Washington: GPO, 2017), Section 1130(31), pp. 1308-1312.

[30] CBO issued a score on H.R. 5480 on March 12, 2008; http://www.cbo.gov/publication/19548.

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 legislation to address the Medicare funding warning 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) would eliminate 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. 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 5 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.[31] 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 5 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.

## 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 Senate Committee on Finance (Finance Committee). A measure reflecting the President's proposal is to be referred to the Finance Committee. In a year in which the MMA requires the President to submit Medicare funding legislation, and whether or not he does so, if the Finance Committee 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.[32] 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.

[31] 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.

[32] 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.

In combination, these provisions afford the Senate only one assured opportunity to consider Medicare funding legislation, which will be either the measure the Finance Committee 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 Finance Committee 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 nondebatable, although Senate precedent exists for treating as nondebatable 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.

# Varying Impact of Legislative Options

As noted earlier, the Medicare HI and SMI Trust Funds are statutorily independent; this means that any funds raised for one fund cannot be used to pay expenses out of the other. However, the formula used to determine excess general revenue Medicare funding combines revenue streams from both the HI and SMI Trust Funds.

Because of the way that the trigger formula is structured, the various methods that could be used to reduce the general revenue Medicare funding percentage would not necessarily reduce federal general revenue outlays (used to finance Parts B and D) or reduce the percentage in direct proportion to reductions in total spending.

Specifically, to reduce the percentage, one could increase dedicated financing (e.g., payroll taxes or premiums) or reduce outlays (HI and/or SMI spending), or some combination of the two. In the illustrative example presented in **Table 1** below, applying FY2012 CBO estimates to the equation shown in the "The Medicare Trigger" section of this report,[33] the total expected outlays of $585.0 billion and $289.3 billion in dedicated revenues results in a level of general revenue funding of about 50.5%. Given this scenario, one option to reduce the general revenue percentage to 45% would be to increase payroll taxes by an amount sufficient to raise an additional $32.5 billion in dedicated revenues.

**Table 1. Illustrative Effect of Options to Lower General Revenue Medicare Funding as a Percentage of Total Medicare Outlays Under the Trigger Calculation**

(dollars in billions)

| | **FY2012** (*estimated*) | **Increase Dedicated Revenues[a] by $32.5** | **Decrease Part A Spending by $59.0** | **Decrease Part B Spending by $108.2** |
|---|---|---|---|---|
| Total Medicare Outlays | $585.0 | $585.0 | $526.0 | $476.8 |

[33] Congressional Budget Office, Medicare Baseline, March 2012, "Comparison of Medicare Spending and Dedicated Funding," p. 4, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43060_Medicare.pdf. More recent CBO Medicare Baselines have not included the specific spending and revenue estimates used in the trigger calculation; therefore, the earlier, FY2012 data is used in this illustrative example.

| | FY2012 (*estimated*) | Increase Dedicated Revenues[a] by $32.5 | Decrease Part A Spending by $59.0 | Decrease Part B Spending by $108.2 |
|---|---|---|---|---|
| Dedicated Revenues | $289.3 | $321.8 | $289.3 | $262.3 |
| General Revenues (Total Outlays-Dedicated Revenues) | $295.7 | $263.3 | $236.8 | $214.5 |
| General Revenues as a % of Total Medicare Outlays | 50.5% | 45.0% | 45.0% | 45.0% |

**Source:** Congressional Research Service analysis based on the Congressional Budget Office's (CBO's) March 2012 *Medicare Baseline* estimates, the most recent source of this data. CBO has not provided similar data in subsequent baseline estimates. This analysis is provided for illustrative purposes only. (The above dollar amounts would differ if more recent data were available and used.)

a. For example, increasing payroll taxes or beneficiary premiums.

Another option would be to decrease total outlays by reducing Part A (HI Trust Fund) spending. However, because the *total Medicare outlays* measure is included in both the top and bottom parts of the mathematical formula (i.e., the denominator as well as the numerator is reduced), a reduction in outlays would have less of an effect than an increase in dedicated revenues on the percentage of general revenue funding. Therefore a reduction of $59.0 billion in Part A funding would be needed to reduce general revenue funding to 45% (in contrast to the $32.5 billion increase in taxes).[34] While the above options of increasing the payroll tax or lowering Part A spending would eliminate *excess general revenue Medicare funding* as defined under the Medicare trigger, these options would have no impact on actual federal general revenue spending (used to finance Parts B and D outlays) because Part A is primarily funded through payroll taxes.[35]

Similarly, continuing with the examples in **Table 1**, one could reach the 45% general revenue spending level by increasing beneficiaries' Part B premiums by a percentage that would increase dedicated revenues by $32.5 billion.[36] Although total Medicare outlays would remain the same, the general revenue percentage as defined by the trigger calculation and the level of Medicare spending financed through federal general revenues would both decline under this scenario.

Alternatively, Part B outlays could be reduced. However, because approximately 25% of SMI spending is financed by premiums, income from premiums (which are calculated based on expected outlays) would also be reduced under this option (i.e., a reduction in Part B outlays would be partially offset by a reduction in dedicated revenues). Therefore, greater spending reductions would be needed under Part B than under Part A to achieve the same amount of reduction in the general revenue funding percentage. In this example, a reduction in Part B outlays of $108.2 billion would be needed to bring down the level of general revenue funding to 45%.

[34] By comparison, decreasing total outlays by reducing Part A spending (Hospital Insurance, or HI, Trust Fund spending) the same amount, $32.5 billion, would result in an excess general revenue percentage of about 47.6%.

[35] Another measure of Medicare's financial health is the date on which the HI Trust Fund is expected to become insolvent. Although actions taken to reduce Part A spending or increase HI revenue would not impact federal general revenue spending, such actions would extend the solvency of the HI Trust Fund.

[36] By comparison, if Part B spending (SMI Trust Fund) were reduced by $32.5 billion, the general revenue funding percentage would decrease to only 49.1%.

# Discussion

*Excess general revenue Medicare funding* is one measure that can be used to depict the financial status of the Medicare program. Other measures, discussed in CRS Report R43122, *Medicare Financial Status: In Brief* include the date of HI insolvency, HI income and costs relative to payroll taxes, long-term unfunded obligations, and Medicare costs as a percentage of GDP.

Proponents of the 45% threshold measurement believe that it can serve as an effective early warning system of the impact of Medicare spending on the federal budget, and that it forces fiscal responsibility. Opponents of the measure suggest that it does not adequately recognize a shift toward the provision of more services on an outpatient basis (thus shifting spending from Medicare Part A to Part B) or the impact of the Part D program on general revenue increases, and that other measures, such as Medicare spending as a portion of total federal spending, are better ways to determine the health of the Medicare program.

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