Medicare Financing

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Summary

Medicare is the nation's health insurance program for individuals aged 65 and over and certain disabled persons. Medicare consists of four distinct parts: Part A, or Hospital Insurance (HI); Part B, or Supplementary Medical Insurance (SMI); Part C, or Medicare Advantage (MA); and Part D, the prescription drug benefit. The Part A program is financed primarily through payroll taxes levied on current workers and their employers; these are credited to the HI trust fund. The Part B program is financed through a combination of monthly premiums paid by current enrollees and general revenues. Income from these sources is credited to the SMI trust fund. Beneficiaries can choose to receive all their Medicare services, except hospice, through managed care plans under the MA program; payment is made on their behalf in appropriate parts from the HI and SMI trust funds. A separate account in the SMI trust fund accounts for the Part D drug benefit; Part D is financed through general revenues, beneficiary premiums, and state contributions. The HI and SMI trust funds are overseen by a board of trustees that makes annual reports to Congress.

The 2013 report of the Medicare Board of Trustees estimates that the HI trust fund will become insolvent in 2026, two years later than it had predicted in the 2012 report. Because of the way it is financed, the SMI fund cannot face insolvency; however, the trustees project that SMI expenditures will continue to grow rapidly, and thus place increasing demands on Medicare beneficiaries and all taxpayers. The trustees estimate that total Medicare costs will increase from 3.6% of GDP in 2012 to 6.5% in 2087.

Although the Medicare trustees report that the financial outlook for the Medicare program appears to have improved as a result of changes made by the Patient Protection and Affordable Care Act as amended (ACA, P.L. 111-148), they caution that the projections in the report are somewhat uncertain, due to the potential for future expenditure reductions not to materialize. In addition, the report projections assume that reductions in physician payment rates scheduled under current law will occur, although these reductions have usually been overridden by Congress. As such, as it has done each year subsequent to the enactment of ACA, the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary issued a supplemental analysis that provides projections based on an *illustrative alternative* to current law.

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Introduction

Medicare is a federal insurance program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act as a federal entitlement program to provide health insurance to individuals 65 and older, and has been expanded over the years to include permanently disabled individuals under 65. Generally, individuals are eligible for premium-free Part A of Medicare if they or their spouse worked for at least 40 quarters in Medicare-covered employment, are at least 65 years old, and are a citizen or permanent resident of the United States. Individuals under 65 may also qualify for coverage if they have a permanent disability, have end-stage renal disease (permanent kidney failure requiring dialysis or transplant), or have amyotrophic lateral sclerosis (Lou Gehrig's disease).[1]

Medicare consists of four parts—A through D. Part A covers hospital services, skilled nursing facility services, home health visits, and hospice services. Part B covers a broad range of medical services, including physician services, laboratory services, durable medical equipment, and outpatient hospital services. Enrollment in Part B is voluntary, however most beneficiaries with Part A also enroll in Part B. Part C, also known as Medicare Advantage, provides private plan options, such as managed care, for beneficiaries who are enrolled in both Parts A and B. Part D provides optional outpatient prescription drug coverage.[2]

Medicare serves approximately one in six Americans and virtually all of the population aged 65 and over. In 2012, the program covered 50.7 million persons (42.1 million aged and 8.5 million disabled) at a total cost of $574 billion, accounting for about 21% of national health spending and 3.6% of Gross Domestic Product (GDP). Medicare is an entitlement program, which means that it is required to pay for covered services provided to enrollees so long as specific criteria are met.

Since 1965, the Medicare program has undergone considerable change. Most recently, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended), made numerous changes to the Medicare program that modify provider reimbursements, provide incentives to increase the quality and efficiency of care, and enhance certain Medicare benefits.[3] For example, under the legislation, annual updates of the prices paid by Medicare for almost all non-physician categories of health services are being reduced by the growth in economy-wide productivity (productivity adjustments). The ACA also established a new Independent Payment Advisory Board (IPAB), which, beginning in 2014, is required to make recommendations to reduce Medicare spending in years in which Medicare costs are projected to exceed a target growth rate.[4] The legislation did

[1] In addition, individuals with one or more specified lung diseases or types of cancer who lived for six months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009, are also deemed entitled to benefits under Part A and eligible to enroll in Part B.

[2] For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

[3] For additional detail, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis, and CRS General Distribution Memorandum, *Estimates of Medicare Savings in the Patient Protection and Affordable Care Act*, by Patricia A. Davis, August 31, 2012, available upon request.

[4] The board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The board is prohibited from making proposals that ration care, raise taxes, increase Part B premiums, or change Medicare benefits, eligibility, or cost-sharing. As of the date of this report, the board has not yet been established. For additional information on IPAB, see CRS Report R41511, *The Independent Payment Advisory Board*, (continued...)

not, however, make changes to the physician sustainable growth rate (SGR) payment system; unless Congress takes action in 2013, reductions in physician payment rates of about 25% will be required beginning January 1, 2014.[5] Additionally, unless Congress passes legislation later this year to block automatic cuts required under the Budget Control Act of 2011 (BCA, P.L. 112-25), the 2% reduction in Medicare benefit spending, which began April 1, 2013, could continue into 2014.[6]

This report provides an overview of how the Medicare program is financed, including a description of the Medicare trust funds and a summary of key findings and estimates from the 2013 Report of the Medicare Board of Trustees[7] regarding 2012 program operations and future financial soundness.[8]

Medicare Trust Funds

Medicare's financial operations are accounted for through two trust funds maintained by the Department of the Treasury—the Hospital Insurance (HI) trust fund for Part A and the Supplementary Medical Insurance (SMI) trust fund for Parts B and D. For beneficiaries enrolled in Medicare Advantage (Part C), payments are made on their behalf in appropriate portions from the HI and SMI trust funds. HI is primarily funded by payroll taxes, while SMI is primarily funded through general revenue transfers and premiums (see **Figure 1**). The HI and SMI trust funds are overseen by a board of trustees that provides annual reports to Congress.

(...continued)

by Jim Hahn and Christopher M. Davis.

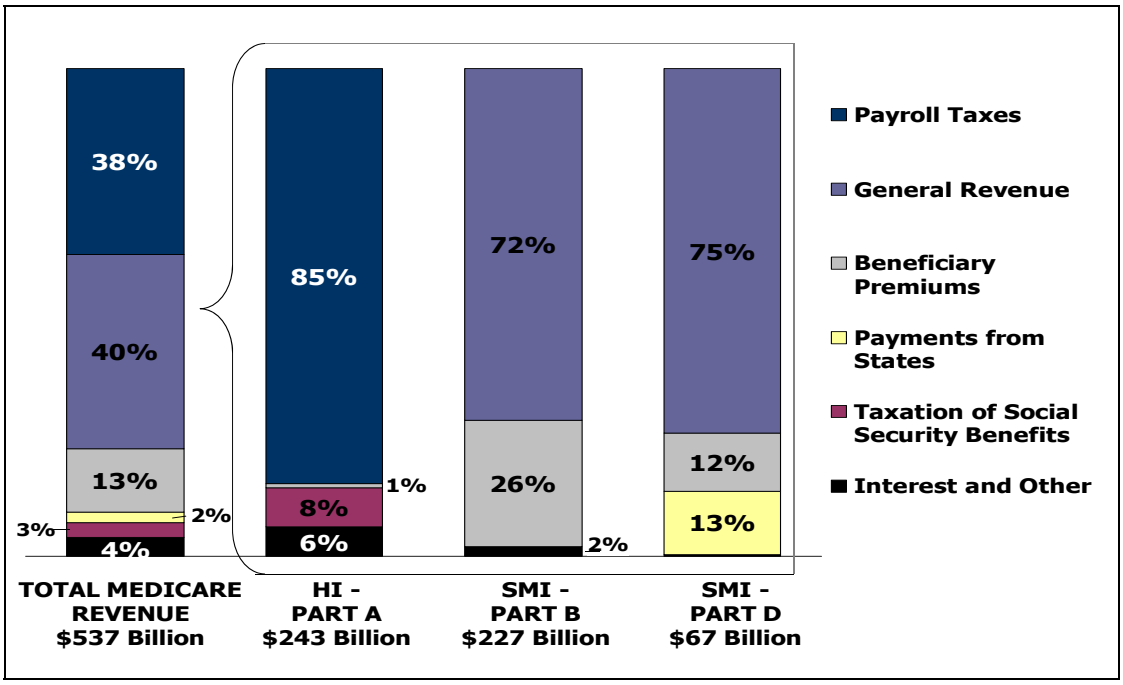
[5] Congress has overridden these required reductions in every year since 2003, most recently by the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). Section 601 of the Act averts the SGR-determined reduction and maintains the Medicare physician fee schedule payments at their current rates through December 31, 2013. See CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn and Janemarie Mulvey.

[6] For additional information on the BCA and required spending reductions, see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan; and CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

[7] *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 31, 2013, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf.

[8] A short summary of the financial status of the Medicare program may be found in CRS Report R43122, *Medicare Financial Status: In Brief*, by Patricia A. Davis.

Figure 1. Sources of Medicare Revenue: 2012



Source: 2013 Report of the Medicare Trustees, Table II.B1.

Note: Totals may not add to 100% due to rounding.

Hospital Insurance (HI) Trust Fund

Covered Part A benefits, namely, inpatient hospital services, skilled nursing facility services, some home health services, and hospice care are paid for out of the HI trust fund. Payments are also made for administrative costs associated with operating this part of the program.

Similar to the Social Security system, the HI portion of Medicare was designed to be self-supporting, and is financed through dedicated sources of income rather than relying on general tax revenues. The primary source of income credited to the HI trust fund is *payroll taxes* paid by employees and employers; each pays a tax of 1.45% on earnings. The self-employed pay 2.9%. Unlike Social Security, there is no upper limit on earnings subject to the tax.[9] ACA imposes an additional tax of 0.9% on high-income workers with wages over $200,000 for single filers, and $250,000 for joint filers effective for taxable years beginning in 2013.[10] (ACA also imposes an additional tax on unearned income beginning in 2013; however, this tax is not credited to the trust fund.)[11]

[9] Prior to 1991, the upper limit on taxable earnings was the same as for Social Security. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) raised the limit in 1991 to $125,000. Under automatic indexing provisions, the maximum was increased to $130,200 in 1992 and $135,000 in 1993. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93, P.L. 103-66) eliminated the upper limit entirely beginning in 1994.

[10] See archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, for additional detail.

[11] For more information on this tax, see CRS Report R41413, *The 3.8% Medicare Contribution Tax on Unearned Income, Including Real Estate Transactions*, by Mark P. Keightley, and the 2013 Medicare Trustees Report, page 24.

Additional income to the HI trust fund consists of: premiums paid by voluntary enrollees who are not entitled to premium-free Medicare Part A through their (or their spouse's) work in covered employment; a portion of the federal income taxes paid on Social Security benefits;[12] and interest on federal securities held by the trust fund.

The HI trust fund is primarily an accounting mechanism used to track whether the program has sufficient income and assets to make payments for Part A benefits.[13] When the government receives Medicare revenues (payroll taxes), income is credited by the Treasury to the appropriate trust fund in the form of special issue interest-bearing government securities.[14] (Interest on these securities is also credited to the trust funds.) The tax income exchanged for these securities then goes into the general fund of the Treasury and is indistinguishable from other cash in the general fund; this cash may be used for any government spending purpose. When payments for Medicare Part A benefits are made, the payments are paid out of the general treasury, and a corresponding amount of securities is deleted from (written off) the HI trust fund.

The trust fund surpluses are not reserved for future Medicare benefits, but are simply bookkeeping entries that indicate how much Medicare has lent to the Treasury (or alternatively, what is owed to Medicare by the Treasury). From the unified budget perspective, these "asset" balances are regarded as future spending obligations and are thus treated as liabilities. (See the "Medicare Expenditures and the Federal Budget" section for an overview of differences in trust fund and unified budget accounting conventions.)

As long as the HI trust fund has a balance, the Treasury Department is authorized to make payments for Medicare Part A services. To date, the HI trust fund has never run out of money (i.e., become *insolvent*), and there are no provisions in the Social Security Act that govern what would happen if that were to occur. For example, there is no authority in law for the program to use general revenue to fund Part A services in the event of such a shortfall. Since the beginning of the Medicare program, the payroll tax rate has been adjusted periodically by Congress as one of the mechanisms to maintain the financial adequacy of the HI trust fund.[15] Additonally, Congress has taken numerous actions to slow the growth in expected Part A spending.[16]

Supplementary Medical Insurance (SMI) Trust Fund

Medicare Part B benefits include physician services, outpatient hospital care, some home health services, durable medical equipment, diagnostic tests and other services; Part D outpatient prescription drug benefits are paid for out of the Supplementary Medical Insurance (SMI) trust

[12] Since 1994, the HI fund has had an additional funding source. OBRA 93 increased the maximum amount of Social Security benefits subject to income tax from 50% to 85% and provided that the additional revenues would be credited to the HI trust fund.

[13] The Congressional Budget Office argues that trust fund balances are not meaningful from an economic standpoint, rather they primarily serve a bookkeeping role. See Congressional Budget Office, *Federal Debt and Interest Costs*, December 2010, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/119xx/doc11999/12-14-federaldebt.pdf.

[14] Unlike marketable securities, special issues can be redeemed at any time at face value. Investment in special issues gives the trust funds the same flexibility as holding cash.

[15] Historical Medicare payroll tax rates may be found in Appendix B of CRS Report RS20946, *Medicare: Insolvency Projections*, by Patricia A. Davis.

[16] Specific actions that have been taken are outlined in CRS Report RS20946, *Medicare: Insolvency Projections*.

fund.[17] Unlike the HI program, the SMI program was not intended to be fully supported through dedicated sources of income. Instead, it relies primarily on general tax revenues and beneficiary premiums as revenue sources. Beginning in 2011, additional revenues from an annual fee imposed on certain manufacturers and importers of branded prescription drugs (including biological products and excluding orphan drugs) are being credited to the SMI trust fund.[18]

Because contributions (general revenue and premiums) into the SMI trust fund are automatically updated each year to ensure that the program has enough money to continue operating, the SMI trust fund is kept in balance and will remain in financial balance indefinitely (i.e., the SMI trust fund cannot become insolvent). Income from these sources is credited to the SMI trust fund and any SMI revenues that exceed SMI spending accumulate in the SMI trust fund; however, SMI trust fund balances are generally small. Similar to HI, the basic structure of the SMI financing system can be changed only through an act of Congress.

Part B Financing

Medicare Part B is financed mostly by federal general revenues, with beneficiaries' premiums set to cover 25% of estimated Part B program costs for the aged.[19] The 2013 monthly premium is $104.90 for most Medicare Part B enrollees, and individuals who receive Social Security benefits have their Part B premium payments automatically deducted from their Social Security benefit checks.[20] Since 2007, higher-income enrollees pay higher premiums.[21] As a result of ACA, the income thresholds used to determine which beneficiaries are subject to higher Part B premium rates will be frozen at 2010 levels through 2019. Over time, this freeze will result in a larger number of beneficiaries paying the higher premiums and is expected to bring in increased revenue to the SMI trust fund.

Part D Financing

Medicare Part D is primarily financed through a combination of beneficiary premiums and federal general revenues. In addition, certain transfers are made from the states. These transfers, referred to as "clawback payments," represent a portion of the amounts states could otherwise have been expected to pay for drugs under Medicaid if drug coverage for the dual-eligible

[17] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), which created the Part D outpatient prescription drug benefit, added the Part D account to the SMI trust fund. The Part D program began operation in 2006.

[18] See archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, for more detail.

[19] See CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis.

[20] Due to a "hold harmless" provision in the Social Security Act, (Section 1839(f)) an individual's Social Security check cannot go down from one year to the next as a result of the annual Part B premium increase. High-income individuals, new enrollees, those eligible for both Medicare and Medicaid (dual-eligibles), and those who do not have premiums deducted from thier Social Security checks are not covered by this provision.

[21] The higher monthly premium amounts for 2013 are based on 2011 income levels and are (1) $146.90—for single beneficiaries with annual incomes of $85,000.01-$107,000 or for each member of a couple filing jointly with incomes of $170,000.01-$214,000; (2) $209.80—for single beneficiaries with incomes of $107,000.01-$160,000 or for each member of a couple filing jointly with incomes of $214,000.01-$320,000; (3) $272.70—for single beneficiaries with incomes of $160,000.01-$214,000 and each member of a couple filing jointly with incomes of $320,000.01-$428,000; and (4) $335.70—for single beneficiaries with incomes greater than $214,000 and each member of a couple filing jointly incomes above $428,000.

population (those who qualify for both Medicare and Medicaid) had not been transferred to Part D.

In 2013, the base monthly premium is $31.17; however, beneficiaries pay different premiums depending on the plan they have selected (and whether they are entitled to low-income premium subsidies). Part D premium payments may be automatically deducted from Social Security benefit checks, paid directly to the prescription drug plan sponsor, or made through an electronic funds transfer.[22] Premiums for the Part D program are required to cover 25.5% of standard benefit costs; however, as recipients of the Part D low-income subsidies are not required to pay premiums, premiums covered only about 12% of Part D program costs in 2012 (see **Figure 1**). As required by ACA, beginning in 2011, high-income Part D prescription drug program enrollees are required to pay higher premiums similar to high-income Part B enrollees; the income thresholds are set at the same levels as those under Part B and frozen in the same manner through 2019.

Board of Trustees

The Medicare Board of Trustees was established under the Social Security Act to oversee the financial operations of the HI and SMI trust funds. By law, the six-member Board is composed of the Secretary of the Treasury, the Secretary of Health and Human Services, the Secretary of Labor, the Commissioner of Social Security, and two public members (not of the same political party) nominated by the President and confirmed by the Senate.[23] The Secretary of the Treasury is the Managing Trustee. The Administrator of the Centers for Medicare & Medicaid Services (CMS) is designated Secretary of the Board.

Annual Trustees Report

The Medicare Board provides an annual report to Congress on the operations of the trust funds. Financial projections included in the report are made by CMS actuaries using major economic and other assumptions selected by the trustees based on current law. Among the variables used are estimations of consumer price index (CPI), fertility rate, mortality rate, workforce size, wage increases, and life expectancy. The assumptions are reviewed annually and updated as warranted by new analyses of trends and data. The report includes three forecasts ranging from pessimistic ("high cost") to mid-range ("intermediate") to optimistic ("low cost"). The intermediate projections represent the trustees' best estimate of economic and demographic trends and are the projections most frequently cited.

The 2013 report of the Medicare trustees was issued May 31, 2013.[24] However, the report warned that estimates based on current-law assumptions may not be realistic. As such, the actuaries of CMS conducted a separate analysis that provides projections based on an "illustrative alternative"

[22] The "hold harmless" provision described in the footnote on the previous page does not apply to Part D; beneficiaries are not protected from Part D premium increases.

[23] The nominations of Charles P. Blahous III and Robert D. Reischauer to be public members of the Medicare and Social Security Boards of Trustees were confirmed by the Senate on September 16, 2010. The seats for the two public members had been vacant since 2008.

[24] The 2013 report includes data on actual expenditures and income through 2012, and projections for years 2013 and beyond. *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf.

to current law.[25] The alternative estimates are based on the assumption that the economy-wide productivity adjustments mandated by ACA would be made through 2019, but then would be phased out from 2020 to 2034, and that IPAB recommendations for cost reductions would not be implemented. The alternative scenario also assumes that, instead of being cut, physician payments will grow annually by 0.7% each year.

The projection methodology used to estimate future Medicare spending is reviewed periodically by an independent panel of expert actuaries and economists who make recommendations to the Board regarding the most appropriate long-range growth assumptions for Medicare projections. Most recently, the Board of Trustees convened an independent panel of expert actuaries and economists in 2010 to make recommendations to the Board regarding the most appropriate long-range growth assumptions for Medicare projections. The panel issued its final report in 2012, and one of its recommended models was used to develop long-term projections in the 2013 Trustees Report.[26]

2012 Medicare Program Operations

In calendar year (CY) 2012, Medicare provided about 50.7 million beneficiaries with benefits at a total cost of about $574 billion, or $12,103 per enrollee. (See **Appendix A**, **Appendix B,** and **Appendix C** for historical and projected enrollment, total Medicare income and expenditures, and per capita expenditures.) Because HI and SMI have different funding mechanisms, a description of each fund's 2012 operations is presented separately below.

Hospital Insurance Trust Fund Operations in 2012

As shown in **Table 1**, in CY2012, total income to the HI trust fund was $243.0 billion. Payroll taxes of workers and their employers accounted for $205.7 billion (84.7%), with the remainder coming from interest and government credits, premiums (from those buying into the program), and taxation of Social Security benefits. The HI program paid out $266.8 billion; most of which was for benefit costs, and about 1.5% was for administrative expenses. Similar to years 2008 through 2011, expenditures again exceeded income in 2012, and the trust fund balance was reduced from $244.2 billion at the end of 2011 to $220.4 billion at the end of 2012 (a loss of $23.8 billion).[27] (See **Appendix D** for funding amounts in prior years and estimates for future years.)

[25] 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Appendix C: Illustrative Alternative Projections; and memo from John D. Shatto and M. Kent Clemens, CMS Office of the Actuary, "Projected Medicare Expenditures Under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers," May 31, 2013, hhttp://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2013TRAlternativeScenario.pdf.

[26] *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections***,** Technical Review Panel on the Medicare Trustees Reports, December 2012, http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf.

[27] In comparison, in CY2011, total income was $228.9 billion and total disbursements were $256.7 billion; this represents an increase in income of $14.1 billion (a 6.2% increase) and a growth in expenditures of $10.1 billion (a 3.9% increase) from 2011 to 2012.

Table 1. Medicare Data for Calendar Year 2012

	HI - Part A	SMI - Part B	SMI - Part D	Total Medicare
Enrollment (millions)				
Aged	41.8	38.7	n/a	42.1
Disabled	8.5	7.7	n/a	8.5
Total	50.3	46.4	37.4	50.7
Average expenditures per enrollee	**$5,227**	**$5,097**	**$1,779**	**$12,103**
Trust Fund Balance at end of 2011 (billions)	**$244.2**	**$79.7**	**$1.0**	**$324.9**
Total Income	**$243.0**	**$227.0**	**$66.9**	**$536.9**
Payroll Taxes	205.7	—	—	205.7
Interest	10.6	2.8	0.0	13.4
Taxation of Benefits	18.6	—	—	18.6
Premiums	3.4	58.0	8.3	69.8
General Revenue	0.5	163.8	50.1	214.4
Transfers from States	—	—	8.4	8.4
Other	4.1	2.4	—	6.5
Total Expenditures	**$266.8**	**$240.5**	**$66.9**	**$574.2**
Benefits	262.9	236.5	66.5	565.9
Hospital	139.7	39.1	—	178.8
Skilled Nursing	28.0	—	—	28.0
Home Health Care	6.8	11.8	—	18.6
Physician Services	—	69.6	—	69.6
Private plans (Part C)	70.2	66.0	—	136.2
Prescription Drugs	—	—	66.5	66.5
Other	18.1	50.1	—	68.2
Administrative Expenses	$3.9	$3.9	$0.4	$8.3
Net Change	-$23.8	-$13.5	$0.0	-$37.3
Trust Fund Balance at end of 2012	**$220.4**	**$66.2**	**$1.0**	**$287.6**

Source: 2013 Report of Medicare Trustees, Table II.B1.

Notes: Totals do not necessarily equal the sums of rounded components; n/a = data not available.

Supplementary Medical Insurance Trust Fund Operations in 2012

In CY2012, the SMI trust fund (Part B and Part D accounts combined) brought in $293.9 billion in revenue ($227.0 billion from Part B and $66.9 billion from Part D), and expended $307.4 billion ($240.5 billion from Part B and $66.9 from Part D), with accumulated SMI trust fund surpluses from prior years making up the $13.5 billion difference. General revenues accounted for 72.8% of total revenues, and premiums accounted for 22.6%.[28] (See **Table 1** for 2012 Parts B and D operations data.)

Of the $227.0 billion in income to Part B, general revenues made up $163.8 billion of that amount (72.2%), premiums accounted for $58.0 billion (25.6%), and interest and other income made up the remaining $5.2 billion (2.3%). In 2012, the program paid out $240.5 billion; similar to HI, almost all of this amount was used to cover benefits and 1.6% covered administrative expenses.[29] (See **Appendix E** for historical and projected income and expenditures in the SMI Part B account.)

Of the $66.9 billion in Part D income, general revenues accounted for $50.1 billion (74.9%), premiums accounted for $8.3 billion (12.4%), and transfers from states for $8.4 billion (12.6%). Almost all of the 2012 Part D program expenditures of $66.9 billion were used to pay benefit costs and 0.6% was used for administrative expenses.[30] (See **Appendix F** for historical and projected income and expenditures in the SMI Part D account.)

Short-Range Financial Soundness (10 Years)

Over the next 10 years, total Medicare expenditures are projected to increase at an average annual rate of 6.6%,[31] with total spending growing from $574.2 billion in 2012 to close to $1.1 trillion in 2022 (see **Figure 2** and **Appendix B**). The average growth rate reflects the expected growth in the number of individuals eligible for Medicare as well as expected increases in utilization and complexity of services per beneficiary and in the prices of those services. The growth rate also factors in ACA changes that affect cost growth rates, such as the productivity adjustments to the annual payment updates to certain providers and changes in payments to Medicare Advantage plans. Additionally, these growth rates assume that the scheduled physician payment reductions of about 25% in 2014 will go into effect.

[28] In comparison, in CY2011, total income for SMI was $301.0 billion and total expenditures were $292.4 billion. This represents a growth in SMI expenditures of $15.0 billion, or an increase of 5.1%, from 2011 to 2012.

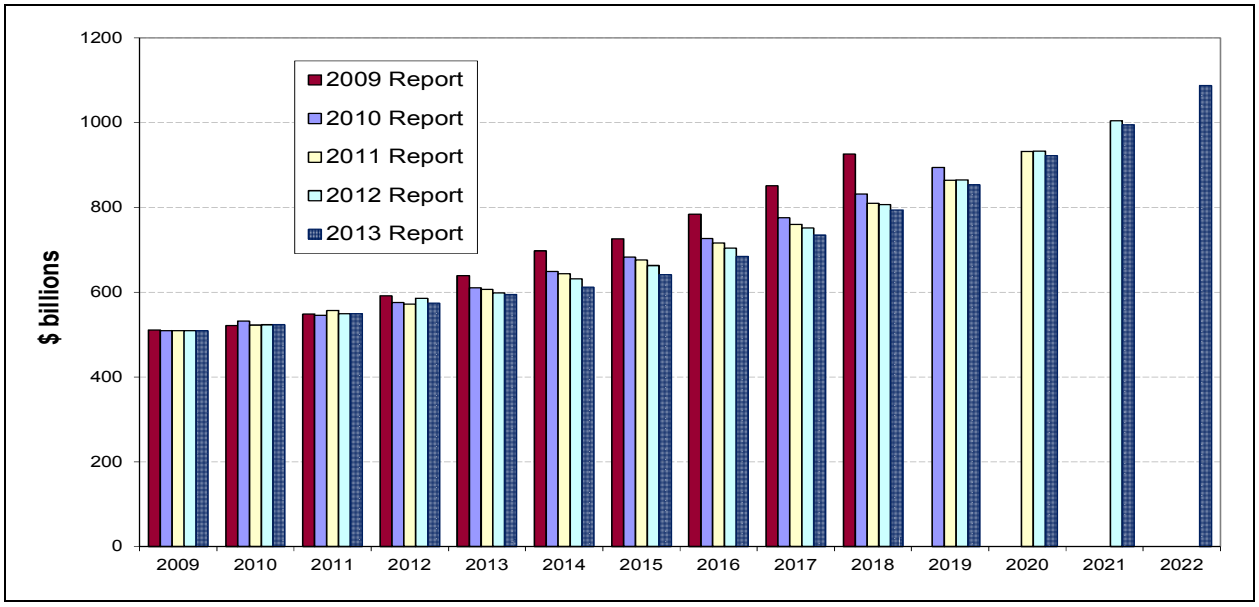
[29] This represents an expenditure increase of 6.7% over the $225.3 billion in Part B expenditures in 2011.

[30] The 2012 Part D expenditures represent a 0.3% decrease from the 2011 expenditures of $67.1 billion.

[31] By comparison, total Medicare expenditures grew at an average annual rate of 8.0% from 1985 to 2012.

Figure 2. Medicare Expenditures

Comparison of Estimates of 2009 – 2013 Medicare Trustees Reports



Sources: Data from the 2009, 2010, 2011, 2012, and 2013 Reports of the Medicare Boards of Trustees, Table III.A1 (2009-2011) and Table V.B1 (2012 and 2013).

Notes: The 2009 report was issued prior to ACA enactment. Reports issued in 2010 and beyond incorporate ACA changes into projections of estimated spending. The 10-year projection window for the 2009 report only extended to 2018; there are no corresponding projections for 2019 through 2022. Similarly, the 2010, 2011, and 2012 report projections only extend to 2019 through 2021, respectively.

HI Short-Range Financial Status

In the short term, the adequacy of the HI trust fund is determined by comparing its assets at the beginning of the year to expected costs for that year. The trustees consider the fund to be adequate if the ratio of assets to expenditures is at least 100% at the beginning of and throughout the 10-year projection period.[32] The trustees note that the HI fund is not adequately financed over the next 10 years. Specifically, the new report states that the fund fails to meet the short-range (i.e., 10-year, 2013-2022) test of financial adequacy because total HI assets at the start of the year ($220.4 billion) are expected to be below 100% of expenditures during 2013. The trustees also project that the ratio of trust fund assets to expenditures will decline steadily through 2022.

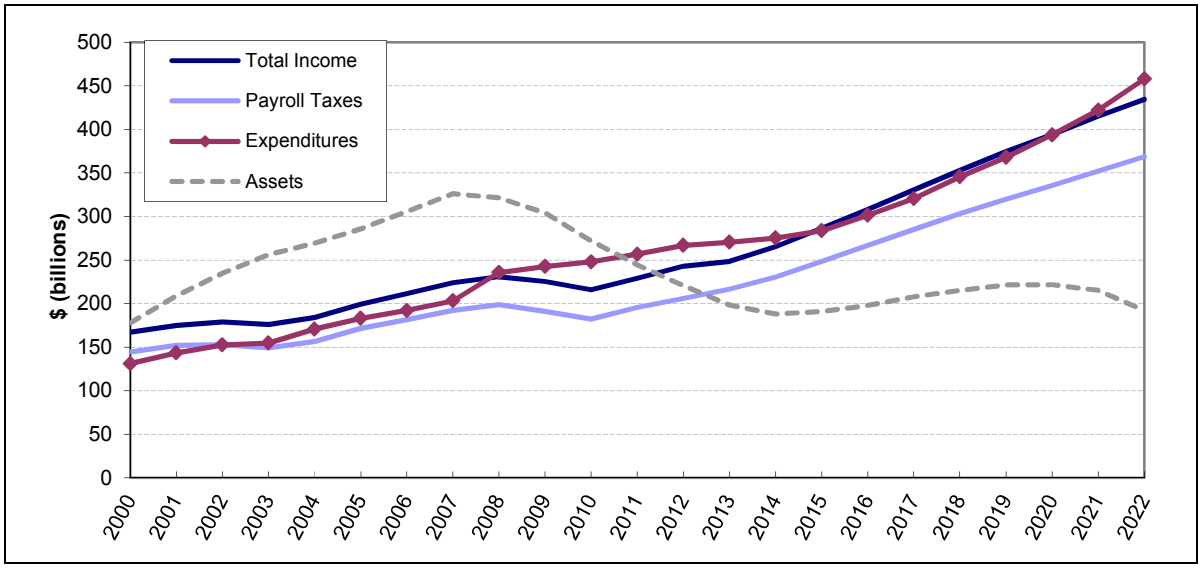
HI expenditures have exceeded income every year since 2008 and are projected to continue doing so under current law through 2014. In 2009 and 2010, income from payroll taxes decreased substantially due to higher unemployment and slow growth in wages. While revenues increased somewhat in 2011, they did not keep pace with the growth in expenditures resulting from increased utilization and updates to provider payment rates. In 2012, HI taxable earnings, and

[32] If the ratio is less than 100% at the beginning of the 10-year period, it must increase to 100% within 5 years and then remain at or above 100% during the rest of the period. This amount is considered a sufficient contingency reserve to allow Congress enough time to address any anticipated short-term financing problems.

therefore income from payroll taxes, were slightly less than expected, and the HI trust fund experienced a deficit of $23.8 billion.

Income is expected to increase at a faster rate than expenditures through 2017 due to the projected economic recovery, the application of an additional 0.9% HI payroll tax for high-income enrollees beginning in 2013, and the 2% reduction in benefit spending required by BCA from April 1, 2013 through March 31, 2022.[33] Specifically, over the next 10 years, HI income is expected to grow on average by 6.0% per year, while expenditures are expected to grow at an average rate of 5.5% per year. From 2015 through 2020, the HI trust fund is expected to run a slight surplus (see **Figure 3**); after that period, expenditures are once again expected to outpace income.

Figure 3. Short-Term HI Expenditures and Income



Source: Data from 2013 Report of Medicare Trustees, Table III.B4.

Note: The trustees report does not project dollar figures beyond 2022.

SMI Short-Range Financial Status

As premium and general revenue income for Medicare Parts B and D are reset each year to match expected costs, the SMI trust fund is deemed to be adequately financed over the next 10 years and beyond. However, over the past five years, Medicare Part B costs have been increasing rapidly—by an average of 6.1% annually, exceeding GDP average growth by 3.8 percentage points. If the physician payment cuts are allowed to go into effect at the end of 2013, Part B expenditures (and corresponding income) are expected to grow at a slower average growth rate of 5.1% annually over the next five years (2013-2017), slightly lower than GDP growth over the same period (5.4%). If Congress overrides these reductions as it has done in the past, the Part B growth rate during this period is projected to instead average about 6.3% each year. For Part D, annual average growth over the past five years has been around 6.1%; however, due to costs associated

[33] See CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar, for information on how sequestration is applied to Medicare.

with the gradual elimination of the coverage gap[34] and expected growth in the number of enrollees, the average annual increase in expenditures is estimated to be 9.3% through 2017.[35] Part D cost estimates are somewhat lower than estimated in the prior trustees report due to a larger than expected impact of the expiration in 2012 of several major drug patents, continued growth in the utilization of generic drugs, and lower projected expenditures for 2013.

Projected Date of HI Insolvency

Medicare's fiscal health is often gauged by the projected solvency of the HI trust fund.[36] As noted in the section "Medicare Trust Funds," in years in which HI expenditures exceed income, the program still has authority to continue to make payments as long as the trust fund has a balance. However, when the trust fund balance reaches $0, it is deemed insolvent and this part of the program would no longer have the authority to cover expenditures that exceed HI trust fund income. The 2013 trustees report estimates that the HI trust fund will become insolvent in 2026, two years later than projected in last year's report (see **Figure 4**). The improved projections are primarily due to lower than expected expenditures in 2012, the base year used to project future expenditures, and a larger than previously projected impact of ACA payment methodology changes on Medicare Advantage costs.[37]

Beginning in 2004, HI expenditures began exceeding *tax* income (from payroll taxes and from the taxation of Social Security benefits). Expenditures began to exceed *total* income (tax income plus all other sources of revenue) in 2008. (Refer to **Figure 3** for illustration of expenditure and income trends through 2022.) At that time, HI assets (the balance of the HI trust fund at the beginning of the year) were used to meet the portion of expenditures that exceeded income (the *HI deficit*). Expenditures have exceeded income every year since then, and are expected to continue doing so through 2014. Although the trust fund is projected to run a small surplus in years 2015 through 2020, after that time expenditures are expected to again exceed income, with trust fund assets making up the difference until the asset balance is depleted in 2026. At that time, the trust fund is projected to only have sufficient income to cover 87% of Part A expenditures. Unless action is taken prior to that date to increase HI revenue and/or decrease expenditures, Congress would need to appropriate additional funding (e.g., through general revenue transfers) to make up for these deficits and to allow for full and on time payments to providers of Part A services.

[34] After the beneficiary and the prescription drug plan have spent a certain amount of money for covered drugs during a year, there is a gap in Part D coverage. During the coverage gap (also known as the "doughnut hole"), the beneficiary pays a large portion of his or her prescription drug expenditures. Once a certain threshold is reached, Medicare again begins providing substantial coverage. The ACA gradually reduces the amount of beneficiary cost-sharing during this gap each year from 2011 to 2020.

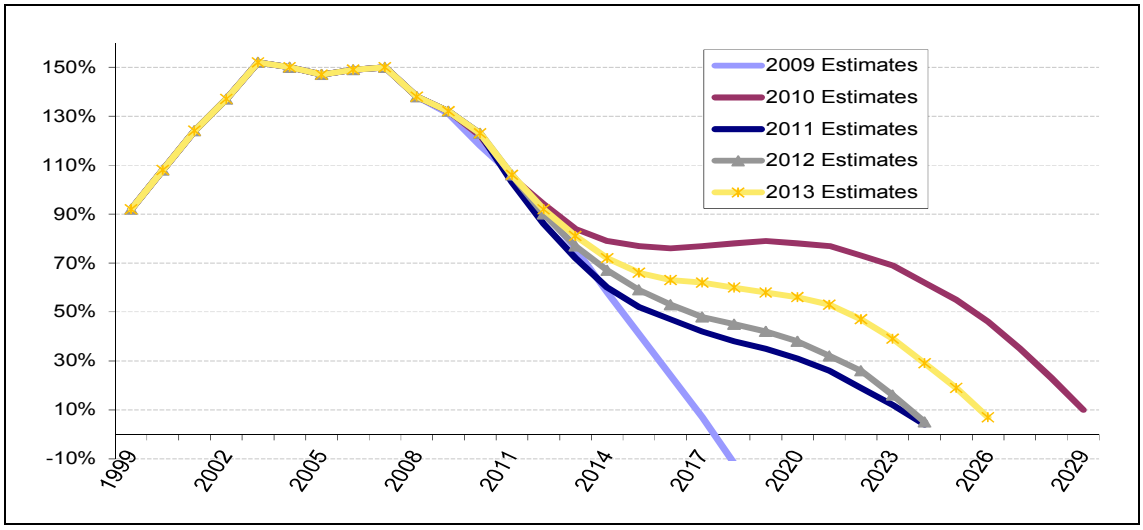
[35] The average annual growth per enrollee is expected to be 6.3%.

[36] For a history of projections of insolvency dates, see CRS Report RS20946, *Medicare: Insolvency Projections*, by Patricia A. Davis.

[37] See CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis, and CRS General Distribution Memorandum, *Estimates of Medicare Savings in the Patient Protection and Affordable Care Act*, by Patricia A. Davis, August 31, 2012, available upon request.

Figure 4. HI Trust Fund Assets at Beginning of Year as a Percentage of Annual Expenditures

Comparison of Estimates from 2009-2013 Trustees Reports



Sources: Data from the 2009 Medicare Trustees Report, Table II.E1, and Summaries of the 2010, 2011, 2012, and 2013 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart D (2010 and 2011) and Chart E (2012 and 2013).

Because the impact of the ACA productivity adjustments is relatively modest in the short term, the expected trust fund exhaustion date provided in the *illustrative alternative* is the same as that under the current law scenario, 2026; however, the trust fund is projected to be depleted slightly earlier in the year.

Long-Range Financial Soundness (75 Years)

For projections beyond 2022, the Medicare trustees do not provide actual dollar figures due to the difficulty of making meaningful comparisons of dollar values for different time periods over a long timeframe. Instead, the long-term financial soundness of the Medicare program is generally determined using one or more of the following measures:

- A comparison of the program's income and its cost as a percentage of taxable payroll (how much would need to be added to the payroll tax to keep HI solvent; this measure is only applicable to the HI trust fund);
- A determination of the present value of the program's unfunded liabilities over a particular period (the amount in today's dollars that would be needed to be in the trust fund for the program to remain financially sound for a specified period); and/or
- A comparison of expected benefit costs with GDP, the most frequently used measure of the total output of the U.S. economy (the amount spent on Medicare compared to the size of the economy in general).

The trustees caution that while these estimates can provide indications as to whether the trust funds are in adequate financial condition, financial outcomes are inherently uncertain, especially over a very long time period.

HI Income and Costs Relative to Payroll Taxes

The long-range financial soundness of the HI trust fund is often determined by comparing the fund's *income rate* (the ratio of tax income to taxable payroll) with its *cost rate* (the ratio of program expenditures to taxable payroll). The term *taxable payroll* refers to the total amount of wages, salaries, and self-employment income in the economy that is subject to the HI tax. By relating income and expenditure projections to expected future taxable payroll, comparisons can be made for long periods of time without the distortions caused by the changing value of the dollar (e.g., through inflation). Additionally, it indicates the relative amount of the nation's earnings that may be needed to cover the program's commitments in the future when compared to what is needed today.

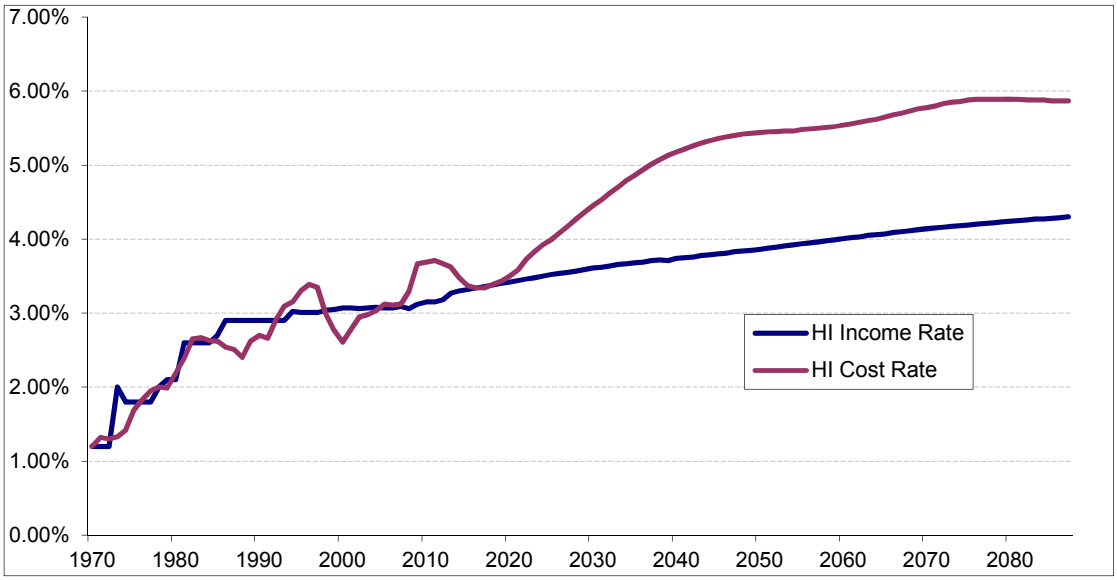
Year-by-Year Estimates

In the past, *cost rates* have generally increased over time, rising from 0.94% in 1967 to 3.39% in 1996 (see **Figure 5**). This growth reflects both the higher rate of increase in medical care costs than in average earnings subject to HI taxes and the higher rate of increase in the number of HI beneficiaries than in the number of covered workers. Cost rates after that time have fluctuated primarily due to the passage of legislation affecting Medicare expenditures, including the Balanced Budget Act of 1997 (P.L. 105-33) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), as well as favorable economic performance. Rates increased again each year from 2008 through 2011 (3.30%, 3.67%, 3.69% and 3.71%, respectively) due to the lower amount of taxable payroll as a result of the recession and subsequent slow recovery. Due to a slower growth in spending, the 2012 cost rates decreased to 3.67%, and the 2013 trustees report projects that in the short-term, due to the expected economic recovery and changes made by the ACA, the cost rate will continue to decline through 2017. Over the long run however, expenditures as a percentage of taxable payroll are expected to increase to 5.87% in 2085, primarily due to the aging of the baby boom generation and expected growth in health care costs. (Under the *illustrative alternative*, the expected HI cost rate for 2085 is 9.22%, about a third more than the rate projected under current law.)

The HI *income rate* is projected to increase gradually from 3.18% in 2012 to 4.28% in 2085 due to ACA's increase of 0.9% in payroll taxes for high-income earners starting in 2013. As the income thresholds used to determine who qualifies as "high-income" are not indexed to grow with inflation, it is expected that more workers will be subject to this higher tax rate over time. Additionally, it is expected that income from taxation of Social Security benefits will increase as the number of recipients increases over time. (Because the *illustrative alternative* only assumes changes in payments, the income rate is the same as that in the trustees report.)

As indicated earlier, expenditures in most future years are expected to exceed payroll tax income, resulting in a negative difference between cost and income rates. In 2026, payroll taxes are expected to cover 87% of HI expenditures, decline to 70% by 2045; and by the end of the 75-year period, taxes are expected to cover 73% of the expected costs. The decreasing cost rate beyond 2045 is due to the expected compounding of the ACA reductions in provider payment updates and the assumed slowing of growth in the volume and intensity of services.

Figure 5. Long-Range HI Income and Cost as a Percentage of Taxable Payroll



Source: Data from Summary of the 2013 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart B, http://www.ssa.gov/oact/TRSUM/images/LD_ChartB.html.

Note: Rates through 2012 are actual; rates for 2013 and beyond are projections.

The 2013 trustees report estimates that at the end of the 75-year period, there will be an HI deficit of 1.59% of taxable payroll (see **Figure 5**).[38] Under the *illustrative alternative* scenario, which assumes that the ACA productivity adjustments will eventually be phased out, the HI deficit at the end of the 75-year period is expected to be about 4.94% of taxable payroll.

Actuarial Balance

The *actuarial balance* can be interpreted as the percentage that would need to be added to the current-law income rates and/or subtracted from the current-law cost rates in each of the next 75 years in order for the financing to support HI costs and to meet the targeted trust fund balance at the end of the projection period. The actuarial balance of the HI trust fund is defined as the difference between the sum of the *income rate* expected for each year in the 75-year projection period (including the beginning trust fund balance) and the sum of the *cost rates* for each year, expressed as a percentage of taxable income. This summarized rate is based on the present values of future income, costs, and taxable payroll.

The 2013 trustees report estimates that the summarized HI *income rate* for the entire 75-year period is 3.83% of taxable payroll and the summarized *cost rate* is expected to be 4.94%. The difference, the *actuarial balance*, is -1.11%. Because this is a negative number, the HI trust fund fails to meet the trustees' long-range test of actuarial balance. This means that the income rate would need to increase by 1.11% of taxable payroll throughout the next 75 years for the trust fund to reach actuarial balance (e.g., by increasing the standard payroll tax from 2.90% to 4.01%), program spending would need to be reduced by a corresponding amount, or some combination of the two would need to occur. (The trustees note that if no changes in the payroll tax or HI

[38] The projected deficit is lower than the deficit of 1.96% in the prior Trustee's report.

spending occurs prior to 2026, then the required increase after that time would be 1.44% of taxable payroll.) If the productivity adjustments to HI provider payment updates cannot be continued in the long run, the CMS actuaries estimate that the actuarial deficit would be much higher, 2.17% of taxable payroll, under their *illustrative alternative* scenario.

Unfunded Obligations

The *unfunded obligation* is a measure of the long-term funding shortfall of the Medicare program. It is defined as the difference between the present value of the expected cost of the Medicare program over a specified time period and the present value of projected income (including the initial value of the trust fund). Put another way, the unfunded obligation is the amount of money that would have to be added to the trust fund today to make the program financially sound over a specified time period.

HI Long-Term Obligations

The 2013 trustees report estimates that the unfunded obligation of the HI trust fund is $4.6 trillion (0.5% of GDP) over the next 75 years. This means that if $4.6 trillion were added to (or expenditures reduced from) the trust fund at the beginning of 2013, the program could meet the projected cost of current-law expenditures over the next 75 years.

The trustees note that limiting the estimates of HI unfunded obligations to 75 years understates the full magnitude of these obligations because the 75-year measures only reflect the full amount of taxes paid by the next few generations of workers, but not the full amount of their expected benefits. Therefore, since 2004, the trustees report has included a measure of unfunded obligations that extends indefinitely (through infinity). Such extended projections can help indicate whether the HI financial imbalance would be improving or continuing to worsen beyond the 75-year period. In making these estimates, the trustees assume that the current-law HI program, demographic, and economic trends used for the 75-year projection will continue indefinitely, except that average HI expenditures per beneficiary will increase at the same rate as GDP per capita less the productivity adjustments beginning in 2087. If the slower ACA price updates were to continue indefinitely, then the HI financial imbalance actually improves beyond the 75-year period. Under these assumptions, over the infinite horizon, the HI program is projected to have a deficit of $3.5 trillion (see **Table 2**).

Table 2. Unfunded HI Obligations

(Present values as of January 1, 2013)

	Present Value	% of GDP
Unfunded obligations through 2087	$4.6 trillion	0.5%
Unfunded obligations through infinite horizon	$3.5 trillion	0.2%

Source: 2013 Medicare Trustees Report, Table V.G1.

SMI Long-Term Obligations

Due to its automatic financing provisions, the SMI account is expected to be adequately financed into the indefinite future; therefore the unfunded obligations are considered to be $0 (see **Table 3**). However, estimated SMI expenditures of $30.6 trillion over the next 75 years are expected to exceed premium revenues and state payments by $22.6 trillion; general fund transfers of this amount will be needed to keep the SMI trust fund in balance for the next 75 years.[39]

The estimated present value of Part B expenditures through the infinite horizon is $34.2 trillion, of which $21.4 trillion would occur during the first 75 years. Approximately 27% of expenditures for each time period would be financed through beneficiary premiums, and a fraction of a percent would be financed through fees collected related to brand-name prescription drugs. The remaining 73% is expected to be paid by general revenues. (However, as noted previously, the trustees consider Part B expenditures after 2013 to be substantially understated due to the large physician payment reductions scheduled under current law.) Similarly, the estimated present value of Part D expenditures through the infinite horizon is $19.3 trillion, of which $9.2 trillion would occur during the first 75 years. For each time period, approximately 16% of expenditures would be financed through beneficiary premiums, 9% through state transfers, and the remaining 75% funded by general revenues.

Table 3. Unfunded Part B and Part D Obligations

(Present values as of January 1, 2013; dollar amounts in trillions)

	SMI—Part B		SMI—Part D	
	Present Value	**% of GDP**	**Present Value**	**% of GDP**
Unfunded obligations through 2087	$0.0	0.0%	$0.0	0.0%
Expenditures through 2087	$21.4	2.3%	$9.2	1.0%
General Revenue Contributions	15.7	1.7	6.9	0.7
Beneficiary Premiums	5.7	0.6	1.5	0.2
State Transfers	—	—	0.9	0.1
Fees related to brand-name drugs	0.1	0.0	—	—
Unfunded obligations through infinite horizon	$0.0	0.0%	$0.0	0.0%
Expenditures through infinite horizon	$34.2	2.2%	$19.3	1.2%
General Revenue Contributions	25.0	1.6	14.4	0.9
Beneficiary Premiums	9.1	0.6	3.1	0.2
State Transfers	—	—	1.8	0.1
Fees Related to brand-name drugs	0.1	0.0	—	—

Source: 2013 Medicare Trustees Report, Tables V.G3 and V.G5.

Note: Totals may not add due to rounding.

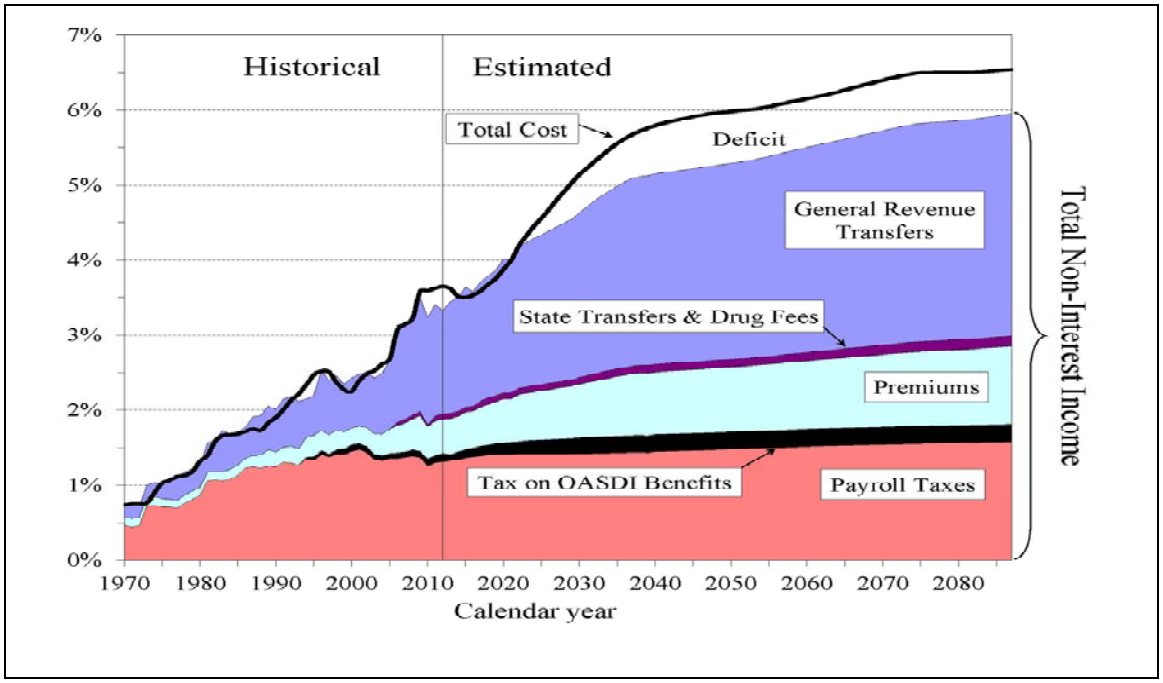
[39] These transfers represent a formal budget requirement under current law.

Medicare Costs as a Percentage of GDP

A comparison of Medicare costs (for Medicare Parts A through D combined) to GDP provides a measure of the amount of financial resources that will be necessary to pay for Medicare services relative to the output of the U.S. economy. The rising costs of health services, increasing utilization rates, and anticipated increases in the complexity of services are expected to contribute to the rising costs of Medicare relative to GDP. Additionally, it is expected that as increasing numbers of people become eligible for Medicare, there will be a significant growth in benefit expenditures. Under current law, the trustees expect Medicare costs to increase from 3.6% in 2012 to 5.8% of GDP in 2040 and to 6.5% in 2087. Under the *illustrative alternative*, similar to estimates made under the law prior to ACA, projected Medicare costs are expected to represent about 9.8% of GDP in 2087. (See **Appendix G** for a comparison of projections of Medicare expenditures as a percentage of GDP from the 2009 through 2013 trustees reports.)

Over the next 75 years, general revenues and beneficiary premiums are expected to play an increasing role in financing the program. **Figure 6** shows actual and projected expenditures and non-interest revenues for HI and SMI combined as a percentage of GDP.

Figure 6. Medicare Cost and Non-Interest Income by Source as a Percentage of GDP



Source: Summary of the 2013 Annual Reports of the Social Security and Medicare Boards of Trustees, http://ssa.gov/oact/TRSUM/index.html, Chart C.

General revenue transfers to the SMI trust fund are projected to increase from 1.5% of GDP in 2013 to 2.9% in 2087, and beneficiary premiums from 0.5% of GDP in 2013 to 1.0% in 2087. As shown, the share of Medicare income from payroll taxes and taxation of benefits is expected to fall substantially during that period (from 41% to 30%), while the share of general fund revenue is expected to rise (from 43% to 50%) as are premiums (from 14% to 17%). Any excess in

projected spending over revenues represents the HI deficit; in 2087, the HI deficit is projected to represent 0.7% of GDP.

Medicare Funding Warning ("Medicare Trigger")[40]

As noted, HI and SMI are financed very differently. HI is funded by current workers through a payroll tax, while SMI is funded by premiums from current beneficiaries and federal general revenues. Because of this financing, the SMI trust fund's income is projected to equal expenditures for all future years. However, there is concern that over time the economy will be unable to support the increasing reliance on general revenues which in large measure comes from taxes paid by the under-65 population. In response, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) required the trustees report to include an expanded analysis of Medicare expenditures and revenues. Specifically, a determination must be made as to whether general revenue financing will exceed 45% of total Medicare outlays within the next seven years (on a fiscal year basis).[41] The law specifies that if an excess general revenue funding determination is made for two successive years, a "Medicare funding warning" is triggered, and the President is to submit a legislative proposal to respond to the warning. The Congress is required to consider the proposals on an expedited basis; however, passage of legislation within a specific time frame is not required.

In each report issued from 2006 through 2012, the Medicare trustees made a determination of excess general revenue funding. The 2013 report, again, made such a determination, projecting that general revenue funding would exceed 45% in FY2013.[42] This represents the eighth consecutive time that the threshold was estimated to be exceeded within the first seven years of the projection, and the seventh time that the trustees have issued a funding warning.

Proponents of the 45% threshold measurement believe that it can serve as an effective early warning system and that it forces fiscal responsibility. Opponents of the measure suggest that it doesn't adequately recognize a shift towards the provision of more services on an outpatient basis or the impact of the Part D program on general revenue increases, and that other measures, such as Medicare spending as a percentage of GDP, Medicare spending as a portion of total federal spending, or the number of workers subject to payroll taxes per Medicare beneficiary, are better ways to measure the health of the Medicare program. On January 6, 2009, the House approved a rules package (H.Res. 5) that nullified the trigger provision for the 111th Congress.[43] Neither the 112th nor the 113th Congress have passed a similar measure; therefore, the trigger provision is in effect in the House. To date, no legislation has been enacted to specifically respond to these funding warnings.

[40] For additional information, see CRS Report RS22796, *Medicare Trigger*, by Patricia A. Davis, Todd Garvey, and Christopher M. Davis.

[41] Under the Trigger formula, general revenue funding is defined slightly differently. The main difference is that after the assets in the HI trust fund are depleted, HI deficits are included in the general revenue funding measure when determining whether the 45% threshold has been exceeded.

[42] The Trustees estimate that additional revenues of at least $10 billion or expenditure reductions of at least $18 billion (or some combination of the two) would be needed to reduce the ratio below 45% in 2013.

[43] H.Res. 5 declared that the accelerated legislative procedures required by MMA for a presidential legislative proposal in response to a Medicare funding warning would not apply during the 111th Congress.

Medicare Expenditures and the Federal Budget

By law, the annual Medicare trustees reports focus on the financial status of the Medicare HI and SMI trust funds. Trust fund accounting methods are used to determine whether dedicated sources of Medicare revenue, together with any asset balances, are sufficient to allow the payment of expected expenditures on a timely basis. In contrast, when examining Medicare finances under unified budget accounting methods, the total flow of money into and out of the U.S. Treasury is typically examined regardless of the source of revenue.[44]

The expected shortfall in payroll taxes needed to fully cover HI expenses and the rapid growth of SMI, which relies primarily on general revenues for financing, have made it increasingly important to look at Medicare expenditures from the perspective of the federal budget as a whole. To illustrate, over the next 75 years, revenues from payroll taxes are projected to fall short of HI expenditures by $4.8 trillion in present value terms. This is the additional amount that is expected to be needed in order to pay HI benefits at the level expected under current law over the next 75 years. Note that the federal liability from a budget perspective includes the beginning accumulated assets in the HI trust fund ($0.2 trillion, as of January 1, 2013) as they represent federal payment obligations.[45]

Additionally, general revenue transfers in present value terms of $22.6 trillion are expected to be needed to cover SMI expenditures (Parts B and D combined) over the next 75 years.[46] The Medicare trustees estimate that, assuming personal and corporate income taxes in the future maintain their historical average level relative to the national economy, the portion of income taxes that will be needed to fund the general revenue portion of SMI will grow from 13.4% in 2013 to 25.6% in 2080 (see **Table 4**).[47]

Table 4. SMI General Revenues as a Percentage of Personal and Corporate Federal Income Taxes

Comparison of Estimates of the 2009 - 2013 Medicare Trustees Reports

Fiscal Year	Percentage of Income Taxes 2009 Report	Percentage of Income Taxes 2010 Report	Percentage of Income Taxes 2011 Report	Percentage of Income Taxes 2012 Report	Percentage of Income Taxes 2013 Report
Historical					
1970	0.8%	0.8%	0.8%	0.8%	0.8%
1980	2.2	2.2	2.2	2.2	2.2
1990	5.9	5.9	5.9	5.9	5.9
2000	5.4	5.4	5.4	5.4	5.4

[44] Spending is normally categorized either as mandatory (not subject to the appropriations process) or discretionary (must be appropriated). Medicare benefit spending is mandatory, while some administrative costs are discretionary.

[45] The net 75-year unfunded liability from the trust fund perspective of $4.6 trillion in present value terms, does not include the trust fund assets. See "Unfunded Obligations."

[46] This amount could be substantially higher if Congress modifies the physician payment system to eliminate scheduled payment reductions.

[47] This amount is in addition to the HI payroll tax.

Fiscal Year	Percentage of Income Taxes 2009 Report	Percentage of Income Taxes 2010 Report	Percentage of Income Taxes 2011 Report	Percentage of Income Taxes 2012 Report	Percentage of Income Taxes 2013 Report
2008	10.9	12.0	12.0	12.0	12.0
2009	n/a	17.7	17.7	17.7	17.7
2010	12.2	18.6	19.2	19.2	19.2
2011	n/a	n/a	18.0	17.2	17.2
2012	n/a	n/a	n/a	14.4	14.5
Intermediate Estimates					
2013	n/a	n/a	n/a	n/a	13.4
2020	15.8	15.0	17.1	16.3	15.3
2030	24.0	19.5	19.9	18.6	19.2
2040	28.9	21.8	22.1	22.6	22.4
2050	31.9	22.7	23.0	23.0	23.0
2060	35.1	24.6	24.7	24.0	24.0
2070	38.1	25.7	25.7	25.0	25.1
2080	40.5	26.6	26.3	25.7	25.6

Source: 2009 - 2013 Medicare Trustees Reports, Table III.C4 (2009-2011) and Table II.F3 (2012 and 2013).

Note: Includes the Part D prescription drug benefit beginning in 2006; n/a = not available.

ACA and Medicare Spending

As noted earlier, ACA contains numerous provisions that are expected to reduce Medicare spending growth (both HI and SMI) in future years.[48] The ACA did not reduce beneficiaries' Medicare covered benefits or change Medicare's financing structure. Medicare is still funded primarily through mandatory spending, and aside from certain constraints in HI, there are still generally no limits on Medicare spending. The ACA mainly changes the way that payments are made to healthcare providers who provide services to Medicare beneficiaries. Because of these changes, Medicare expenditures *are expected to* be less than they would have been under prior law, but spending *is not limited* to those amounts. Actual benefit spending could be greater or less than projections depending on a variety of factors, including beneficiary health care needs and their utilization of services in a given year. As shown in **Figure 2**, Medicare spending is still expected to increase in the future, just not as quickly as projected under prior law. As Medicare is not "pre-funded," these expected "savings" are neither cut from, nor credited to, the Medicare trust funds.[49] The expected reduction in future Medicare spending mainly just means that the

[48] For a summary of savings estimates of Medicare ACA provisions, see CRS General Distribution Memorandum, *Estimates of Medicare Savings in the Patient Protection and Affordable Care Act*, by Patricia A. Davis, August 31, 2012, available upon request.

[49] Certain ACA revenue changes, i.e., increased Medicare payroll taxes for high-income workers, and fees paid by brand name drug and medical device manufacturers are, however, specifically credited to the Medicare trust funds. For additional detail, see archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*.

federal government and Medicare beneficiaries are expected to spend less on Medicare than they would have under prior law.[50]

Concluding Observations

As shown in this report, a wide array of measures can be used to describe the short- and long-term financial status of the Medicare program. While trust fund solvency issues are important, they only present part of the picture. When viewed from the perspective of the entire federal budget and the economy, Medicare spending obligations, even under the more optimistic scenario presented in the 2013 Medicare trustees report, are expected to consume an increasing portion of federal budgetary resources over time. Budget experts have expressed concern about the long-run implications of Medicare expenditures on federal deficits; for example, in its long-term budget forecast, CBO noted:

> The aging of the baby-boom generation, together with growth in health care spending per person and an expansion of federal subsidies for health insurance, is expected to steadily boost the government's spending for Social Security and major health care programs. Barring changes to current law, that additional spending would contribute to rising budget deficits starting in a few years, causing federal debt to swell from a level that is already very high relative to the size of the economy.[51]

The Medicare trustees caution that it is difficult to forecast health and economic indicators over an extended period of time. For example, forecasts are based on the assumption that health spending will outpace GDP growth in the future because it has consistently done so in the past. It is possible that in the future, advances in medical technology, changes in consumer preferences, shifts in the health status of the population, or changes in the way health care services are delivered could result in very different financial outcomes from those estimated in the trustees report.[52] Further, as evidenced by the issuance of an *illustrative alternative* to the 2013 trustees report, if changes to current health care policies are enacted (most notably these affecting physician reimbursement or productivity adjustments), future Medicare costs could be significantly different from current projections.

There are no simple solutions to address the problems raised by the rapid growth in health care costs, the economic conditions, and the aging of the population. Additionally, as an entitlement program, Medicare must pay for all medically necessary covered benefits for enrollees; except for constraints placed on the program by the HI financing mechanism, there are no limits on overall

[50] Therefore, it would not be correct to conclude that "Medicare savings" are being diverted to other purposes. The perception that Medicare spending reductions are "paying for" new entitlements mainly stems from the provisions being in the same legislation, and because Medicare savings estimates were used as an offset of estimates of increased costs in ACA to meet legislative PAYGO rules at a particular point in time. For illustration purposes, if the Medicare savings provisions had been in one bill that was passed at one time, and the rest of the ACA had been in another bill that passed at a different time, then it would be clearer that one is not directly funding the other. See CRS Report R41510, *Budget Enforcement Procedures: House Pay-As-You-Go (PAYGO) Rule*, and CRS Report RL31943, *Budget Enforcement Procedures: Senate Pay-As-You-Go (PAYGO) Rule*, both by Bill Heniff Jr.

[51] "The 2013 Long-Term Budget Outlook," Congressional Budget Office, September 2013, p. 7, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44521-LTBO_0.pdf.

[52] For example, information learned from pilot programs and demonstrations mandated by recent legislation, such as changing financial incentives of health care providers and improving the care coordination of beneficiaries with chronic conditions, could lead to long-term changes in how health care is delivered and in the cost of that care.

Medicare spending. As such, policy options to restrain the growth of Medicare spending will continue to attract considerable interest.

Proposals to reduce Medicare spending generally fall into one of two categories: (1) those that would reduce the federal share of Medicare spending (for example, by increasing beneficiary premiums and/or cost-sharing; changing Medicare eligibility criteria such as age; reducing the range of covered benefits; establishing defined federal contributions;[53] or setting federal spending limits), and (2) those that would reduce the total amount of health care spending regardless of who is paying (e.g., reducing prices paid for items and services;[54] decreasing medical errors; reducing unneeded, duplicative and/or ineffective care; and eliminating fraud and abuse). On the revenue side, options to increase program income may include modifying dedicated Medicare payroll taxes or general income taxes, and/or imposing new fees or dedicated taxes.[55] Some of the above changes could be made while still retaining Medicare's current structure, while others could only be made in the context of major program restructuring. Many of the proposals could be combined as part of an overall reform package.

The challenge to policy makers will be to slow the growth in Medicare spending over the long-term, to establish fair levels of contributions from beneficiaries and taxpayers, and to ensure continued beneficiary access to needed health care services. The Medicare trustees suggest that prompt action is needed to address both the short- and the long-range financial challenges of the Medicare program; the sooner that solutions can be enacted, the more flexible these solutions can be, and the more gradually they may be phased in.

[53] See CRS Report R43017, *Overview of Health Care Changes in the FY2014 Budget Proposal Offered by House Budget Committee Chairman Ryan*, by Patricia A. Davis, Alison Mitchell, and Bernadette Fernandez for a description of the premium support model proposed in the House FY2014 budget.

[54] Some may argue that reducing prices for some payers, such as Medicare, can lead to shifting costs to other payers, such as private insurers, and thus not decrease the overall cost of health care.

[55] Additionally, broadening the tax base through increased levels of employment and/or wages (e.g., through economic recovery) would also result in increased Medicare payroll tax income.

Appendix A. Medicare Enrollment

Table A-1. Medicare Enrollment, 1970 - 2085

(in thousands)

Year	HI—Part A	SMI—Part B	SMI—Part D	Part C	Total
Historical					
1970	20,104	19,496	—	—	20,398
1975	24,481	23,744	—	—	24,864
1980	28,002	27,278	—	—	28,433
1985	30,621	29,869	—	1,271	31,081
1990	33,747	32,567	—	2,017	34,251
1995	37,175	35,641	—	3,467	37,594
2000	39,257	37,335	—	6,856	39,688
2005	42,233	39,752	1,841	5,794	42,606
2006	43,065	40,361	30,560	7,291	43,436
2007	44,010	41,093	31,392	8,667	44,368
2008	45,150	41,975	32,589	10,010	45,500
2009	46,256	42,908	33,644	11,104	46,604
2010	47,365	43,882	34,772	11,692	47,720
2011	48,528	44,906	35,720	12,382	48,884
2012	50,298	46,405	37,367	13,586	50,655
Estimated					
2013	51,939	47,982	38,906	14,837	52,294
2014	53,608	49,459	40,063	15,562	53,961
2015	55,276	50,924	41,140	15,439	55,629
2016	56,938	52,390	42,256	15,010	57,289
2017	58,636	53,883	43,475	14,260	58,987
2018	60,362	55,404	44,709	14,156	60,713
2019	62,118	56,958	45,969	14,549	62,469
2020	63,919	58,611	47,420	15,117	64,272
2021	65,751	60,247	48,694	15,842	66,105
2022	67,619	61,921	50,057	16,617	67,975
2025	73,164	66,903	54,144	18,402	73,526
2030	81,111	74,090	60,003	20,343	81,482
2035	86,106	78,539	63,683	21,554	86,479
2040	88,519	80,770	65,459	[a]	88,891
2045	89,978	82,070	66,536	[a]	90,353
2050	92,003	83,918	68,032	[a]	92,385

Year	HI—Part A	SMI—Part B	SMI—Part D	Part C	Total
2055	94,679	86,323	70,011	[a]	95,073
2060	98,152	89,512	72,582	[a]	98,563
2065	101,701	92,734	75,208	[a]	102,130
2070	105,597	96,286	78,092	[a]	106,046
2075	109,486	99,867	80,972	[a]	109,957
2080	112,114	102,257	82,919	[a]	112,601
2085	115,914	105,702	85,733	[a]	116,422

Source: 2013 Medicare Trustees Report, Table V.B4.

a. The trustees report did not provide enrollment projections separately for Part C beyond 2035.

Appendix B. Total Medicare Income and Expenditures (HI and SMI Combined)

Table B-1. Medicare Income and Expenditures, Calendar Years 1970-2022

($ in billions)

	Income						Expenditures		
Year	Payroll Taxes	General Revenue	Premiums	State Transfers	Interest & Other	**Total**	Benefit Payments	Admin. Expenses	**Total**
Historical Data									
1970	$4.9	$1.1	$1.1	—	$1.2	$8.2	$7.1	$0.4	$7.5
1975	11.5	2.6	1.9	—	1.5	17.7	15.6	0.8	16.3
1980	23.8	7.5	3.0	—	2.5	37.0	35.7	1.1	36.8
1985	47.6	18.3	5.6	—	5.1	76.5	70.5	1.7	72.3
1990	72.0	33.0	11.4	—	9.9	126.3	108.7	2.3	111.0
1995	98.4	39.0	20.7	—	17.3	175.3	181.4	2.8	184.2
2000	144.4	65.9	22.0	—	24.9	257.1	217.4	4.4	221.8
2005	171.4	119.2	39.9	—	27.0	357.5	330.3	6.1	336.4
2006	181.3	171.9	49.0	$5.5	29.4	437.0	402.0	6.3	408.3
2007	191.9	178.4	53.7	6.9	31.3	462.1	425.4	6.3	431.7
2008	198.7	184.1	58.1	7.1	32.7	480.8	461.6	6.6	468.2
2009	190.9	209.9	65.2	7.6	34.7	508.3	502.4	6.6	509.0
2010	182.0	204.6	61.8	4.0	33.6	486.1	515.9	7.1	522.9
2011	195.6	222.8	68.5	7.1	36.0	530.0	541.3	7.8	549.1
2012	205.7	213.9	69.7	8.4	39.1	536.9	565.9	8.2	574.2
Intermediate Estimate									
2013	216.5	239.0	77.0	8.6	33.8	574.9	586.4	7.6	594.0
2014	230.4	257.9	79.6	8.7	37.2	614.0	604.2	8.1	612.2
2015	248.4	286.1	90.0	9.0	41.4	674.9	632.1	8.9	641.0
2016	266.5	290.1	92.8	9.6	46.3	705.3	674.9	9.8	684.8
2017	284.9	318.4	105.6	10.3	52.4	771.6	723.5	11.0	734.5
2018	303.2	343.4	116.2	11.1	58.1	831.9	782.5	12.0	794.4
2019	319.7	371.8	127.0	11.9	63.6	894.0	840.5	12.8	853.4
2020	335.5	418.1	139.6	13.0	69.3	975.4	908.2	13.7	921.9
2021	352.0	431.9	143.0	14.2	76.2	1,017.3	979.7	14.8	994.5
2022	368.4	486.0	162.1	15.5	81.5	1,113.4	1,071.4	16.3	1,087.7

Source: Data from 2013 Medicare Trustees Report, Tables III.B4, III.C4, III.D3 and VB1.

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

Appendix C. Medicare Per Capita Expenditures

Table C-1. Average Medicare Benefit Costs Per Beneficiary, Calendar Years 1970-2022

		SMI		
Year	HI	Part B	Part D	Total
Historical Data				
1970	$255	$101	—	$356
1975	462	180	—	642
1980	895	390	—	1,285
1985	1,554	768	—	2,322
1990	1,963	1,304	—	3,267
1995	3,130	1,823	—	4,953
2000	3,272	2,381	—	5,653
2005	4,262	3,754	—	8,016
2006	4,388	4,111	$1,708	10,208
2007	4,548	4,293	1,556	10,397
2008	5,145	4,296	1,504	10,945
2009	5,172	4,721	1,798	11,692
2010	5,161	4,779	1,775	11,715
2011	5,212	4,938	1,868	12,019
2012	5,227	5,097	1,779	12,103
Intermediate Estimates				
2013	5,134	5,155	1,846	12,135
2014	5,057	5,049	2,077	12,183
2015	5,048	5,184	2,165	12,396
2016	5,202	5,401	2,267	12,870
2017	5,369	5,639	2,412	13,420
2018	5,621	5,932	2,562	14,115
2019	5,815	6,221	2,720	14,755
2020	6,045	6,553	2,904	15,502
2021	6,297	6,901	3,079	16,276
2022	6,643	7,392	3,287	17,322

Source: 2013 Report of Medicare Trustees, Table V.D1.

Notes: These amounts do not include administrative costs. The expenditure figures do not net out premiums and state transfers.

Appendix D. Operation of the Hospital Insurance Trust Fund

Table D-1. Operation of the Hospital Insurance Trust Fund, Calendar Years 1970-2022

($ in billions)

	Income			Expenditures			Trust Fund	
Year	Payroll Taxes	Interest, Transfers, Other	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data								
1970	$4.9	$1.2	$6.0	$5.1	$0.2	$5.3	$0.7	$3.2
1975	11.5	1.4	13.0	11.3	0.3	11.6	1.4	10.5
1980	23.8	2.1	26.1	25.1	0.5	25.6	0.5	13.7
1985	47.6	3.9	51.4	47.6	0.8	48.4	4.8	20.5
1990	72.0	8.4	80.4	66.2	0.8	67.0	13.4	98.9
1995	98.4	16.7	115.0	116.4	1.2	117.6	-2.6	130.3
2000	144.4	22.9	167.2	128.5	2.6	131.1	36.1	177.5
2005	171.4	28.0	199.4	180.0	2.9	182.9	16.4	285.8
2006	181.3	30.2	211.5	189.0	2.9	191.9	19.6	305.4
2007	191.9	31.9	223.7	200.2	2.9	203.1	20.7	326.0
2008	198.7	32.0	230.8	232.3	3.3	235.6	-4.7	321.3
2009	190.9	34.5	225.4	239.3	3.2	242.5	-17.1	304.2
2010	182.0	33.6	215.6	244.5	3.5	247.9	-32.3	271.9
2011	195.6	33.4	228.9	252.9	3.8	256.7	-27.7	244.2
2012	205.7	37.3	243.0	262.9	3.9	266.8	-23.8	220.4
Intermediate Estimate								
2013	216.5	31.8	248.2	266.6	3.9	270.5	-22.2	198.1
2014	230.4	34.6	265.1	271.1	4.2	275.2	-10.2	188.0
2015	248.4	38.0	286.4	279.0	4.6	283.6	2.8	190.8
2016	266.5	41.7	308.2	296.2	5.1	301.3	6.9	197.7
2017	284.9	45.5	330.4	314.8	5.7	320.5	9.9	207.6
2018	303.2	49.6	352.8	339.3	6.2	345.5	7.3	214.9
2019	319.7	54.7	374.3	361.2	6.7	367.9	6.4	221.3
2020	335.5	58.5	393.9	386.4	7.2	393.6	0.3	221.6
2021	352.0	63.2	415.1	414.0	7.7	421.8	-6.7	215.0
2022	368.4	66.2	434.6	449.2	8.5	457.7	-23.1	191.8

Source: 2013 Medicare Trustees Report, Table III.B4.

Notes: Sums may not equal totals due to rounding.

Appendix E. Operation of the Supplementary Insurance Trust Fund, Part B Account

Table E-1. Operation of the Part B Account of the SMI Trust Fund, Calendar Years 1970-2022

($ in billions)

	Income				Expenditures			Trust Fund	
Year	Premiums	General Revenue	Interest & Other	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data									
1970	$1.1	$1.1	$0.0	$2.2	$2.0	$0.2	$2.2	-$0.0	$0.2
1975	1.9	2.6	0.1	4.7	4.3	0.5	4.7	-0.1	1.4
1980	3.0	7.5	0.4	10.9	10.6	0.6	11.2	-0.4	4.5
1985	5.6	18.3	1.2	25.1	22.9	0.9	23.9	1.2	10.9
1990	11.3	33.0	1.6	45.9	42.5	1.5	44.0	1.9	15.5
1995	19.7	39.0	1.6	60.3	65.0	1.6	66.6	-6.3	13.1
2000	20.6	65.9	3.4	89.9	88.9	1.8	90.7	-0.8	44.0
2005	37.5	118.1	1.4	157.0	149.2	3.2	152.4	4.6	24.0
2006	42.9	132.7	1.8	177.3	165.9	3.1	169.0	8.3	32.3
2007	46.8	139.6	2.2	188.7	176.4	2.5	178.9	9.7	42.1
2008	50.2	146.8	3.6	200.6	180.3	3.0	183.3	17.3	59.4
2009	56.0	162.8	3.1	221.9	202.6	3.1	205.7	16.2	75.5
2010	52.0	153.5	3.3	208.8	209.7	3.2	212.9	-4.1	71.4
2011	57.5	170.2	5.9	233.6	221.7	3.6	225.3	8.3	79.7
2012	58.0	163.8	5.2	227.0	236.5	3.9	240.5	−13.5	66.2
Intermediate Estimates									
2013	63.6	185.6	5.5	254.7	248.0	3.3	251.3	3.5	69.7
2014	64.6	194.6	6.0	265.3	249.9	3.5	253.4	11.9	81.6
2015	73.0	219.1	6.9	299.0	264.0	3.9	267.9	31.1	112.7
2016	74.5	218.0	8.3	300.8	282.9	4.3	287.3	13.5	126.2
2017	85.2	239.8	10.8	335.7	303.8	4.8	308.6	27.1	153.3
2018	93.7	257.7	12.7	364.0	328.6	5.3	333.9	30.1	183.4
2019	102.3	278.4	13.3	394.0	354.3	5.6	360.0	34.1	217.5
2020	112.4	315.3	15.5	443.2	384.1	6.0	390.1	53.1	270.5
2021	114.2	319.4	18.0	451.6	415.8	6.5	422.2	29.4	299.9
2022	130.1	362.8	20.7	513.6	457.7	7.2	464.9	48.7	348.6

Source: 2013 Medicare Trustees Report, Table III.C4.

Notes: Sums may not equal totals due to rounding.

Appendix F. Operation of the Supplementary Insurance Trust Fund, Part D Account

Table F-1. Operation of the Part D Account in the SMI Trust Fund, Calendar Years 2004-2022

($ in billions)

	Income				Expenditures			Trust Fund	
Year	Premiums	General Revenue	Transfers from States	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data									
2004	—	$0.4	—	$0.4	$0.4	—	$0.4	—	—
2005	—	1.1	—	1.1	1.1	—	1.1	0	0
2006	$3.5	39.2	$5.5	48.2	47.1	$0.3	47.4	$0.8	$0.8
2007	4.1	38.8	6.9	49.7	48.8	0.9	49.7	0.0	0.8
2008	5.0	37.3	7.1	49.4	49.0	0.3	49.3	0.1	0.9
2009	6.3	47.1	7.6	61.0	60.5	0.3	60.8	0.1	1.1
2010	6.5	51.1	4.0	61.7	61.7	0.4	62.1	-0.4	0.7
2011	7.7	52.6	7.1	67.4	66.7	0.4	67.1	0.3	1.0
2012	8.3	50.1	8.4	66.9	66.5	0.4	66.9	0.0	1.0
Intermediate Estimates									
2013	9.9	53.4	8.6	71.9	71.8	0.4	72.2	−0.3	0.7
2014	11.6	63.3	8.7	83.6	83.2	0.4	83.6	0.0	0.7
2015	13.5	67.0	9.0	89.5	89.1	0.4	89.5	0.0	0.8
2016	14.6	72.1	9.6	96.3	95.8	0.4	96.3	0.1	0.8
2017	16.5	78.6	10.3	105.4	104.9	0.5	105.3	0.1	0.9
2018	18.3	85.7	11.1	115.1	114.6	0.5	115.0	0.1	0.9
2019	20.3	93.4	11.9	125.6	125.0	0.5	125.5	0.1	1.0
2020	22.5	102.8	13.0	138.3	137.7	0.5	138.2	0.1	1.1
2021	23.8	112.5	14.2	150.6	149.9	0.6	150.5	0.1	1.2
2022	26.6	123.2	15.5	165.2	164.5	0.6	165.1	0.1	1.3

Source: 2013 Medicare Trustees Report, Table III.D3.

Notes: Sums may not equal totals due to rounding.

Appendix G. Medicare Expenditures as a Percentage of GDP

Table G-1. Projected HI and SMI Expenditures as a Percentage of GDP

Comparison of 2009 - 2013 Medicare Trustees Report Estimates

	HI					SMI-B					SMI-D					Total Medicare				
Year	2009 Report	2010 Report	2011 Report	2012 Report	2013 Report	2009 Report	2010 Report	2011 Report	2012 Report	2013 Report	2009 Report	2010 Report	2011 Report	2012 Report	2013 Report	2009 Report	2010 Report	2011 Report	2012 Report	2013 Report
2009	1.71%	1.67%	1.67%	1.70%	1.69	1.44%	1.45%	1.46%	1.48%	1.47	0.43%	0.41%	0.41%	0.42%	0.42	3.59%	3.53%	3.54%	3.59%	3.58
2010	1.71	1.66	1.69	1.68	1.68	1.38	1.49	1.46	1.48	1.48	0.45	0.43	0.43	0.43	0.43	3.54	3.59	3.58	3.59	3.59
2020	2.05	1.63	1.70	1.70	1.64	1.76	1.61	1.63	1.65	1.65	0.71	0.67	0.67	0.61	0.58	4.53	3.91	3.99	3.96	3.88
2030	2.75	1.99	2.03	2.16	2.06	2.30	2.10	2.15	2.25	2.25	1.08	1.02	0.98	0.88	0.83	6.43	5.11	5.16	5.29	5.14
2040	3.43	2.24	2.27	2.53	2.37	3.15	2.30	2.34	2.42	2.45	1.28	1.21	1.15	1.02	0.97	7.96	5.76	5.77	5.97	5.79
2050	3.85	2.27	2.30	2.62	2.46	3.47	2.33	2.36	2.41	2.45	1.42	1.35	1.28	1.11	1.07	8.74	5.94	5.94	6.15	5.98
2060	4.21	2.23	2.26	2.63	2.47	3.82	2.39	2.40	2.45	2.50	1.57	1.50	1.42	1.23	1.18	9.60	6.12	6.09	6.31	6.15
2070	4.61	2.21	2.24	2.70	2.54	4.16	2.45	2.44	2.50	2.56	1.69	1.63	1.55	1.35	1.29	10.46	6.29	6.22	6.55	6.40
2080	4.96	2.17	2.16	2.73	2.56	4.43	2.47	2.43	2.52	2.56	1.80	1.75	1.66	1.45	1.38	11.18	6.37	6.25	6.69	6.50

Sources: 2009 - 2013 Reports of the Medicare Trustees, Table III.A2 (2009-2011), Table V.B2 (2012), and Table V.B3 (2013).

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