Medicare Financial Status: In Brief

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Overview of the Medicare Program

Medicare, administered by the Centers for Medicare & Medicaid Services (CMS), is the nation's federal insurance program that pays for covered health services for most persons aged 65 years and older and for most permanently disabled individuals under the age of 65.[1] As a health insurance program, Medicare reimburses health care providers and suppliers, such as hospitals, physicians, and medical equipment companies, for the services and products they provide to Medicare beneficiaries. Medicare is prohibited by law from interfering in the practice of medicine or controlling the manner in which medical services are provided. It also is required to pay for covered services provided to eligible persons so long as specific criteria are met. As such, the growth in per person Medicare expenditures largely reflects the medical practices, use of technology, and underlying costs in the broader health care system. Spending under the program (except for a portion of administrative costs) is considered mandatory spending and is not subject to the appropriations process. Thus, there generally are no limits on annual Medicare spending.

Since its enactment in 1965, the Medicare program has undergone considerable change. Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of deficit reduction legislation passed by Congress.[2] With a few exceptions, reductions in program spending have been achieved largely through freezes or reductions in payments to providers, primarily hospitals and physicians, and by making changes to beneficiary premiums and other cost-sharing requirements. For example, 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 improve the quality and efficiency of care, and enhance certain Medicare benefits.[3]

Four Parts of Medicare

Medicare consists of four distinct parts, A through D:

- **Part A** covers inpatient hospital services, skilled nursing care, hospice care, and some home health services. Most persons aged 65 and older automatically are entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems.
- **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 optional; however, most beneficiaries with Part A also enroll in Part B.

[1] For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by (name redacted) and (name redacted). More detailed information on Medicare's financial status may be found in CRS Report R41436, *Medicare Financing*, and CRS Report RS20946, *Medicare: Insolvency Projections*, both by (name redact ed) .

[2] For a brief history of changes to the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by (name redacted) and (name redacted), and the Medicare chapter of the House of Representatives, Committee on Ways and Means, *Greenbook,* at http://greenbook.waysandmeans.house.gov/2014-green-book/chapter-2-medicare.

[3] For details on individual Medicare provisions in the Patient Protection and Affordable Care Act (ACA; 111-148, as amended), see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by (name redacted) .

- **Part C** (Medicare Advantage, or MA) is a private plan option for beneficiaries that covers all Parts A and B services, except hospice. Individuals choosing to enroll in Part C must be eligible for Part A and also must enroll in Part B. About 30% of Medicare beneficiaries are enrolled in MA.
- **Part D** covers outpatient prescription drug benefits. This portion of the program is optional. About 75% of Medicare beneficiaries are enrolled in Medicare Part D or have coverage through an employer retiree plan subsidized by Medicare.

Beneficiary Costs

In addition to paying premiums for Medicare Parts B and D,[4] beneficiaries must pay other out-of-pocket costs, such as deductibles and coinsurance, for services provided under all parts of the Medicare program. There is no limit on beneficiary out-of-pocket spending, and most beneficiaries have some form of supplemental insurance through private Medigap plans, employer-sponsored retiree plans, or Medicaid to help cover a portion of their Medicare premiums and/or deductibles and coinsurance.

Provider and Plan Payments

Under traditional Medicare, Parts A and B, the government generally pays providers directly for services on a *fee-for-service* basis using different prospective payment systems, or fee schedules.[5] Under Parts C and D, Medicare pays private insurers a monthly *capitated* per person amount to provide coverage to enrollees. The capitated payments are adjusted to reflect differences in the relative cost of sicker beneficiaries with different risk factors including age, disability, or end-stage renal disease.

Medicare Trust Funds and Sources of Revenue

The Medicare program has two separate trust funds—the Hospital Insurance (HI) trust fund for Part A and the Supplementary Medical Insurance (SMI) trust fund for Parts B and D.[6] (For beneficiaries enrolled in MA (Part C), payments are made on their behalf in appropriate portions from the HI and SMI trust funds.) Both the HI and SMI trust funds are maintained by the Department of the Treasury and overseen by a Board of Trustees that reports annually to

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[4] Beneficiaries enrolled in a Medicare Advantage (MA; Part C) plan must pay Part B premiums as well as any additional premium required by the MA plan.

[5] Under a *prospective payment system* (PPS), Medicare payments are made using a predetermined, fixed amount based on the classification system for a particular service. The Centers for Medicare & Medicaid Services (CMS) uses separate PPSs to reimburse acute inpatient hospitals, home health agencies, hospice, hospital outpatient departments, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. A *fee schedule* is a listing of fees used by Medicare to pay doctors or other providers/suppliers. Fee schedules are used to pay for physician services; ambulance services; clinical laboratory services; and durable medical equipment, prosthetics, orthotics, and supplies in certain locations.

[6] Many government programs are financed through trust funds. Despite the name, federal trust funds are not the same as private-sector trust funds. A trust in the private sector is "a fiduciary relationship in which one person (the trustee) holds property for the benefit of another (the beneficiary)." The trustee must follow the express terms of the trust instrument and administer the trust for the benefit of the beneficiary. Most federal trust funds are not based on a legal fiduciary relationship. Congress creates trust funds that involve a commitment to use monies for a specific purpose, but it can alter the terms (e.g., receipts, outlays, or purpose) of the trust fund at any time. For additional information, see CRS Report R41328, *Federal Trust Funds and the Budget*.

Congress concerning the funds' financial status.[7] Financial projections are made using economic assumptions based on current law, including estimates of consumer price index (CPI), workforce size, wage increases, and life expectancy.

The Medicare trust funds are financial accounts in the U.S. Treasury into which all income to the program is credited and from which all benefits and associated administrative costs of the program are paid. The trust funds are solely accounting mechanisms—there is no actual transfer of money into and out of the funds. As long as a trust fund has a balance, the Department of the Treasury is authorized to make payments for it from the U.S. Treasury.

Hospitalization Insurance Trust Fund

The Part A portion of Medicare is financed through the HI trust fund.

Sources of HI Revenue

The HI trust fund is funded primarily by a dedicated payroll tax of 2.9% of earnings, shared equally between employers and workers. (See **Figure 1**.) Unlike Social Security, there is no upper limit on wages subject to Medicare payroll taxes. Beginning in 2013, the ACA has imposed an additional tax of 0.9% on high-income workers with wages over $200,000 for single tax filers and over $250,000 for joint filers.[8] Other sources of income to the HI trust fund include premiums paid by voluntary enrollees who are not entitled to premium-free Medicare Part A, a portion of the federal income taxes paid on Social Security benefits, and interest on federal securities held by the trust fund.

HI Trust Fund Mechanics

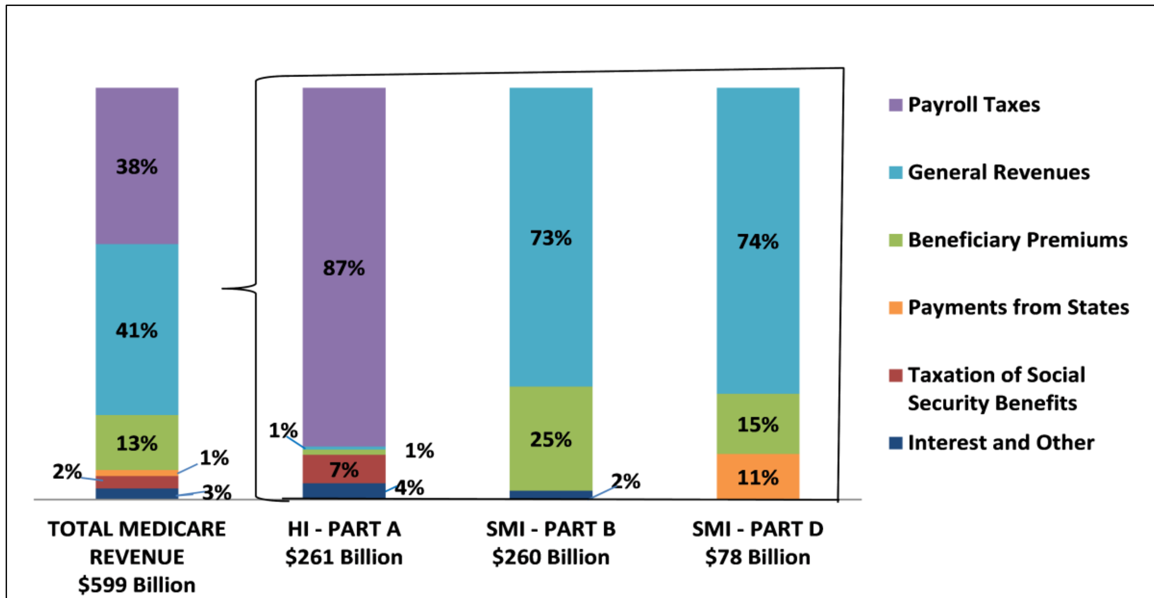
HI operates on a pay-as-you-go basis; the taxes paid by current workers and their employers are used to pay Part A benefits for today's Medicare beneficiaries. When the government receives Medicare revenues (payroll taxes), income is credited by the Treasury to the HI trust fund in the form of special-issue interest-bearing government securities.[9] (Interest on these securities also is credited to the trust fund.) 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 services 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.

[7] These reports may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html.

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

[9] 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.

Figure 1. Sources of Medicare Revenues: 2014



Source: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table II.B1, July 22, 2015. (Hereinafter 2015 Report of the Medicare Trustees.)

Notes: Totals may not add to 100% due to rounding. HI = Hospital Insurance; SMI = Supplementary Medical Insurance.

In years in which the trust fund spends less than the income it receives, the trust fund securities exchanged for any income in excess of spending show up as *assets* on the financial accounting balance sheets and are available to the system to meet future obligations. 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 a unified budget perspective, these assets represent future budget obligations and are treated as liabilities. If the HI trust fund is not able to pay all current expenses out of current income and accumulated trust fund assets, it is considered to be *insolvent*.[10]

Supplementary Medical Insurance Trust Fund

The SMI trust fund consists of two accounts: Part B and Part D.

Sources of SMI Revenue

Unlike the HI portion of Medicare, the SMI program was not intended to be supported through dedicated sources of income. Instead, it relies primarily on general tax revenues and beneficiary premiums as revenue sources.[11]

[10] From time to time, it is reported that Medicare is on the verge of *bankruptcy*; however, in the context of federal trust funds, this term is not meaningful. While a federal trust fund's spending can be greater than its income and trust funds can have a zero balance, unlike private businesses, the federal government is not in danger of "going out of business" or having its assets seized by creditors.

[11] There have been reports that Medicare beneficiaries receive more from the program than what they have paid (continued...)

The Part B portion of SMI is funded mainly through beneficiary premiums (set at 25% of estimated program costs for the aged)[12] and general revenues (most of the remaining amount, approximately 73%). In 2015, most enrollees pay a monthly premium of $104.90. However, certain low-income enrollees receive assistance with their premiums from Medicaid (joint federal-state funding), and, starting in 2007, high-income enrollees pay higher premiums. Beginning in 2011, additional revenues from an annual fee imposed on certain manufacturers and importers of branded prescription drugs also are credited to the SMI trust fund.[13]

Part D is financed through a combination of beneficiary premiums (set at 25.5% of the estimated cost of the standard benefit), general revenues, and state transfer payments (to cover a portion of the costs of beneficiaries enrolled in both Medicare and Medicaid—the *dual-eligibles*). Actual Part D premiums may vary depending on which plan the enrollee selects. Low-income enrollees may receive premium assistance through the Part D low-income subsidy (all federal funding), and, starting in 2011, higher income enrollees pay higher premiums.

SMI Trust Fund Mechanics

The level of SMI funding is automatically updated each year to cover expenditures in the upcoming year. If actual costs exceed those estimated when the funding was set, the amount of financing in the next year (i.e., general revenues and beneficiary premiums) may be adjusted to recover the shortfall. Similarly, if actual costs are less than expected in a given year, income levels needed for the next year may be adjusted downward. Because of these automatic adjustments, the SMI trust fund is always kept in balance and cannot become insolvent.

Medicare Spending in 2014[14]

In calendar year (CY) 2014, Medicare provided benefits to about 53.8 million people (44.9 million people aged 65 and over, and 8.9 million disabled people) at an estimated total cost of $613 billion.[15] Most of that amount, almost $605 billion (99%), was spent on program benefits, with the remaining amount used for program administration. (See **Table 1**.)

(...continued)

throughout their working years in payroll taxes; however, as noted, unlike Part A, the costs of Medicare Parts B and D were designed in the original statute to be subsidized by the government and not through dedicated taxes.

[12] For additional information, see CRS Report R40082, *Medicare: Part B Premiums*, by (name redacted) .

[13] This revenue source is included in "Interest and Other" for Part B in **Figure 1**. For additional detail, see archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*.

[14] Data is from the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 22, 2015.

[15] This amount reflects Medicare total spending regardless of revenue source; it does not net out nonfederal income (e.g., premiums, state transfers). By law, the Medicare Trustees' report focuses on the financial status of the program's trust funds and does not examine the impact of Medicare spending on the overall federal budget.

Table 1. Medicare Expenditures and Enrollment: CY2014

		SMI		
	HI - Part A	**Part B**	**Part D**	**Total**
Expenditures (billions)				
Benefits	$264.9	$261.9	$77.7	$604.5
Hospital	139.2	44.1	—	183.3
Skilled Nursing	28.8	—	—	28.8
Home Health Care	6.6	11.2	—	17.8
Physician Services	—	69.2	—	69.2
Private plans (Part C)	74.0	85.7	—	159.7
Prescription Drugs	—	—	77.7	77.7
Other	16.3	51.7	—	68.0
Administrative Expenses	$4.5	$4.0	$0.4	$8.8
Total Expenditures	**$269.3**	**$265.9**	**$78.1**	**$613.3**
Enrollment (millions)				
Aged	44.6	41.3	NA	44.9
Disabled	8.9	8.1	NA	8.9
Total Enrollment	53.5	49.3	40.5	53.8
Average expenditures per enrollee	**$4,951**	**$5,308**	**$1,920**	**$12,179**

Source: 2015 Report of the Medicare Trustees, Table II.B1.

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

2014 HI Operations

At the beginning of CY2014, the HI trust fund had an asset balance of a little over $205 billion. During 2014, Part A expenditures were about $269 billion. Approximately $227 billion of that amount was funded by payroll taxes and $34 billion by interest income and other sources. (See "Sources of HI Revenue.") Because expenditures exceeded revenue income, close to $8 billion was drawn out of accumulated assets in the HI trust fund to make up the difference. At the end of 2014, the HI trust fund had an asset balance of approximately $197 billion. This means that if or when HI spending exceeds income in future years, the trust fund will be able to spend a total of $197 billion in addition to what it receives in income.[16]

2014 SMI Operations

In CY2014, total spending for Part B was close to $266 billion, with general revenues financing approximately $189 billion of that amount and premiums covering most of the remainder. Total spending for Part D reached about $78 billion in 2014, with more than $58 billion of that amount

[16] In years in which income exceeds expenditures, the surplus amount(s) would be added to this balance.

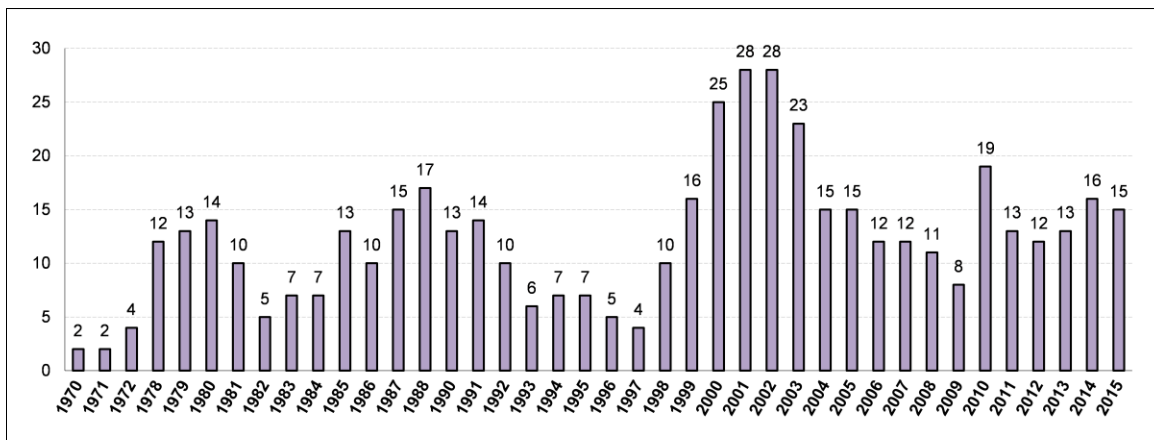
paid for by general revenues. In addition, approximately $9 billion was covered by state transfer payments and $11 billion was covered by beneficiary premiums. It should be noted that although beneficiary premiums are set at a rate to cover 25.5% of the costs of standard Part D benefits, the program pays for the premiums of about one-third of enrollees because these enrollees qualify for low-income assistance. As a result, Part D premiums cover only about 15% of program costs. (See **Figure 1**.)

Estimated Date of HI Trust Fund Insolvency

Since 2008, Part A expenditures have exceeded HI income each year, and the assets credited to the trust fund have been drawn down to make up the deficit. The 2015 report of the Medicare Trustees projects slight surpluses in years 2015 through 2023,[17] and then a return to deficits in 2024 and thereafter until the HI trust fund becomes depleted (insolvent) in 2030. At that time, there no longer will be sufficient funds to fully cover Part A expenditures; although HI would continue to receive tax income, the funds would be sufficient to pay for only 86% of Part A expenses. The Trustees suggest that, under these circumstances, beneficiary access to Part A services "would rapidly be curtailed."

Almost from its inception, the HI trust fund has faced a projected shortfall and eventual insolvency (see **Figure 2**), with insolvency dates ranging from 2 years to 28 years from the year of the projection. However, to date, the HI trust fund has never 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 revenues to fund Part A services in the event of such a shortfall. Unless action is taken prior to the expected date of insolvency to increase HI revenues or decrease expenditures, Congress may need to appropriate additional funding to make up for these deficits and to allow for full and on-time payments to Part A providers.

Figure 2. Projected Number of Years Until Hospital Insurance Insolvency



Source: Intermediate projections of various Medicare Trustees' reports, 1970-2015.

Notes: No specific estimates were provided by the Trustees for years 1973-1977 and 1989.

[17] The Trustees attribute this expected period of surplus to ACA provisions that are expected to reduce Part A spending, to an assumed strengthening economy, and to the sequestration of 2% of Medicare benefit spending.

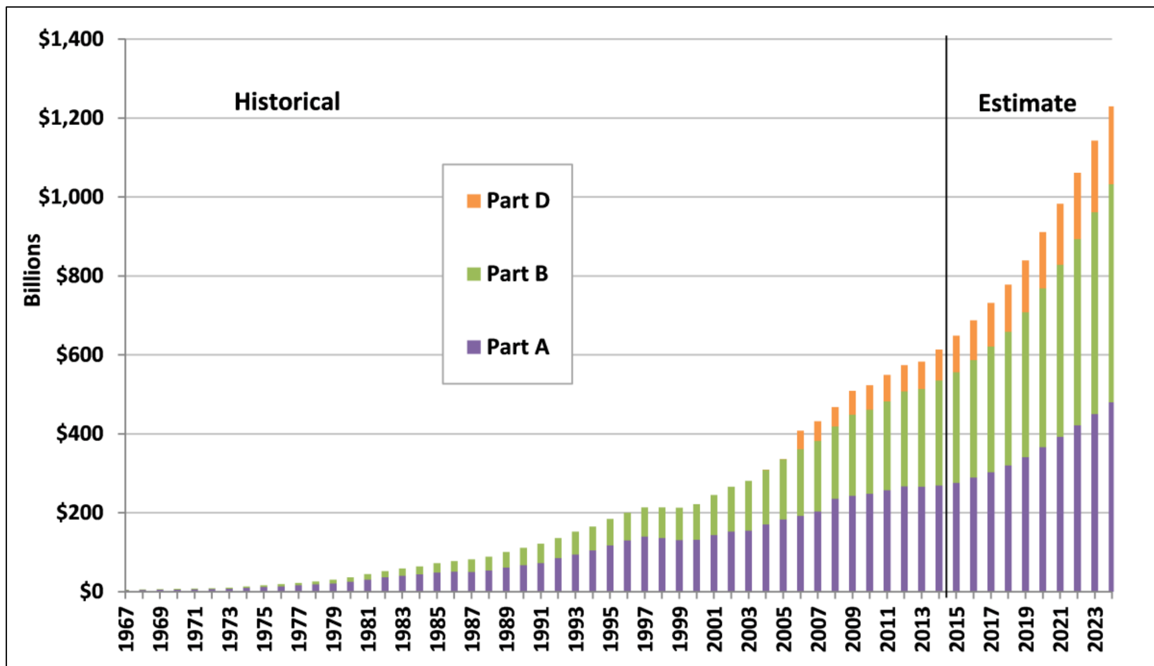
Because income (general revenue and premiums) to the SMI trust fund is updated automatically each year to ensure that the program has enough money to continue operating, the SMI trust fund is kept in balance and is always solvent. However, the Medicare Trustees continue to express concerns about the rapid growth in SMI costs.

Projected Medicare Spending Growth

Although the 2015 Medicare Trustees' report notes a recent slowing in the growth of U.S. national health expenditures,[18] the Trustees still project that U.S. health care expenditures, including Medicare spending, will grow faster than gross domestic product (GDP) in most future years. For Medicare, the projected growth in the prices of health services plus anticipated increases in utilization rates and in the complexity of services provided are expected to contribute to rising costs of Medicare relative to GDP. The aging of the baby boom population also is expected to contribute to significant increases in benefit expenditures.[19]

Over the next 10 years, the Medicare Trustees estimate that total Medicare expenditures will increase from $613 billion in 2014 to more than $1.2 trillion in 2024. Of the $1.2 trillion, about $480 billion is expected to be spent on Part A services, $553 billion on Part B services, and $197 billion on Part D services. (See **Figure 3**.)

Figure 3. Historical and Projected Medicare Expenditures



Source: 2015 Report of the Medicare Trustees, Expanded and Supplementary Tables (historical data); and Report Tables III.B4; III.C4; and III.D3 (projected data).

[18] The Trustees are uncertain whether this slowing is of limited duration (e.g., due to recent economic downturns) or whether it may be a longer-term trend due to structural changes in the health care industry.

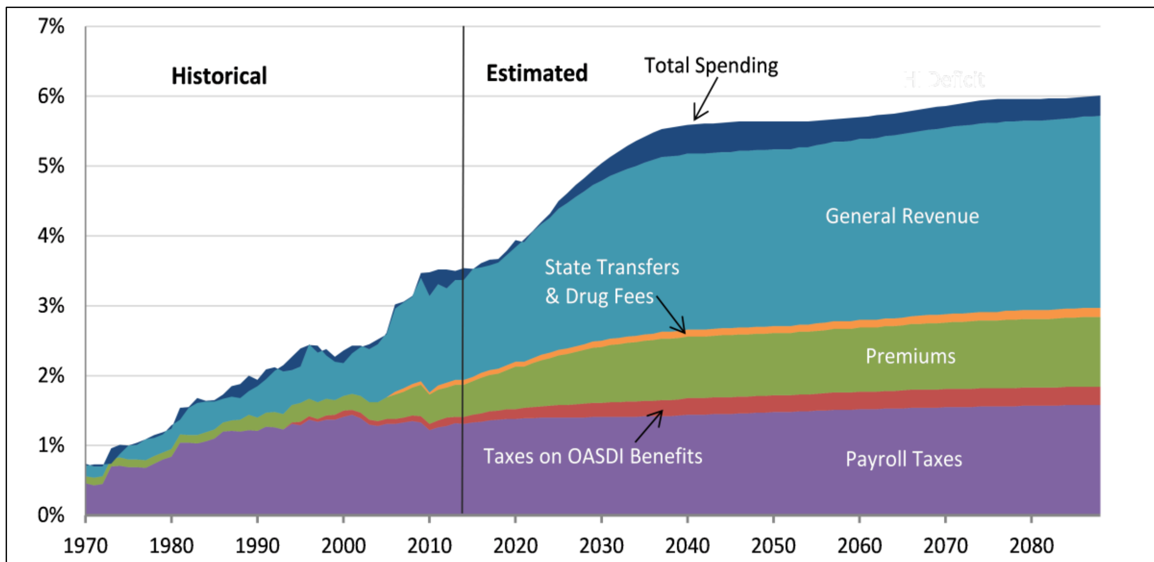
[19] When Medicare first began, there were about 19 million beneficiaries. This number has grown to about 54 million enrollees in 2014 and is expected to increase to about 87 million in 2035 and to 118 million in 2085.

Growth in Medicare Expenditures Relative to GDP

A comparison of Medicare expenditures (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. Under current law, the Trustees expect total Medicare expenditures to increase from 3.5% of GDP in 2015 to about 5.4% of GDP by 2035, mainly due to the rapid growth in the number of beneficiaries, and then to 6.0% of GDP in 2089, with growth in health care cost per beneficiary becoming the more significant factor in those years, especially for Part D. (See **Figure 4**.)

Over the next 75 years, general revenues and beneficiary premiums are expected to play an increasing role in financing the program. For example, the level of general revenues needed to fund SMI is expected to increase from 1.5% of GDP in 2015 to an estimated 2.8% in 2089 under current law.[20] Similarly, income from beneficiary premiums is expected to increase from 0.5% of GDP in 2015 to 1.0% in 2089. In 2014, about 13.7% of total federal income taxes collected that year were used to fund the general revenue portion of SMI. It is expected that the portion of personal and corporate income taxes needed to fund SMI will increase to about 22% in 2030 and to almost 26% in 2080. This amount is *in addition to* the payroll taxes used to fund the Part A (HI) portion of the program.

Figure 4. Medicare Cost and Non-interest Income, by Source as a Percentage of GDP



Source: Summary of the 2015 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart C, at http://www.ssa.gov/oact/TRSUM/index.html.

[20] Total Part B outlays were 1.5% of GDP in 2014, and the Trustees project that they will grow to just over 2.4% of GDP by 2089. The Trustees also estimate that total Part D outlays will increase from 0.5% of GDP in 2014 to about 1.4% of GDP in 2089.

Unfunded and General Revenue Obligations

The Trustees' report provides estimates of the present value of the HI deficit—the *unfunded obligation*—over both a 75-year horizon and an "infinite" horizon. (See **Table 2**.) This unfunded obligation represents the dollar amount by which expenditures would need to be reduced or revenue increased to maintain the financial soundness of the program over a period of time. The Trustees estimate that the current value of funding needed to cover the expected difference between income to the HI trust fund and expenditures over the next 75 years is $3.0 trillion. The Trustees note that this financial imbalance could be addressed by immediately increasing payroll taxes to 3.58% (from the current 2.9%) or by immediately decreasing expenditures by 15%.

The Trustees' report also provides estimates of the present value of future SMI spending. Although SMI is funded automatically and does not face a shortfall, the general revenue portion represents obligated federal spending. The present value of expected general revenues needed to pay for Medicare Parts B and D over the next 75 years is $24.8 trillion. Adding the HI unfunded obligation estimate and the present value of future SMI spending for the 75-year period yields a total of $27.8 trillion.[21] In other words, it would take about $27.8 trillion in current dollars to cover the cost of Medicare not funded through dedicated sources over the next 75 years.

Table 2. Current Value of Estimated Medicare Unfunded Obligations and General Revenue Spending

Present Value of HI Deficit		Present Value of SMI General Revenues			Total
			Part B	Part D	
Unfunded obligations through 2089	$3.0 trillion	General revenue contributions through 2089	$17.5 trillion	$7.3 trillion	$27.8 trillion
Unfunded obligations through infinite horizon	$0.4 trillion	General revenue contributions through infinite horizon	$28.3 trillion	$15.0 trillion	$43.7 trillion

Source: 2015 Report of the Medicare Trustees, Tables V.G1, V.G3, V.G5.

Comparison to Prior Year Estimates

Over the short term, projections of Medicare's total spending in the 2015 Trustees' report are slightly higher compared with last year's report, mainly due to higher recent actual experience for Parts B and D. However, over the longer range, spending estimates are substantially lower, primarily due to a methodological change[22] and to provisions in the recently enacted Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10) that changed the way Medicare physician payment rates are determined.[23] (See **Figure 5**.)

[21] The Trustees note that while SMI general revenue transfers represent formal budget commitments under current law, no provision exists for covering the HI trust fund once assets are depleted.

[22] The 2015 report changed some assumptions about the effect of increases in income, technology, and health care prices on health care spending.

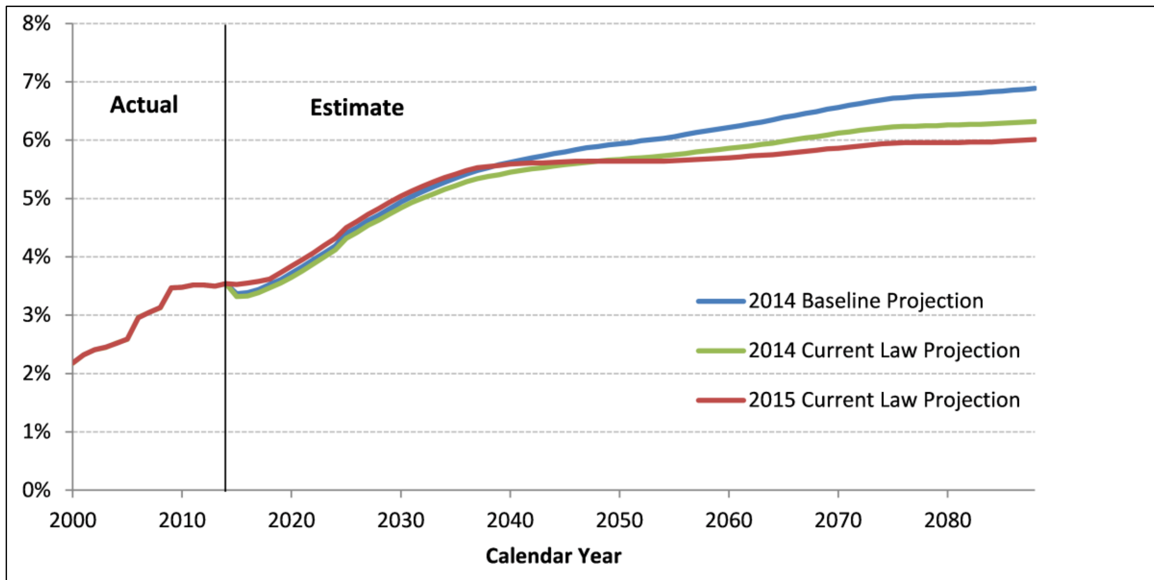
[23] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10) repealed the sustainable growth rate (SGR) formula that was used to determine physician payment rates. The 2015 report projects that after 20 years, physician payments will be much lower compared with the 2014 projections.

The short-term financial outlook for the HI trust fund is similar to that in last year's report. The estimated depletion date of the HI trust fund is 2030, the same as in the 2014 report. Over the next 75 years, the estimated HI actuarial deficit (the amount that would need to be added to the payroll tax to maintain HI solvency for this period) decreased from 0.87% of taxable payroll in last year's report to 0.68% of taxable payroll in the 2015 report. The change is primarily due to the methodological change mentioned above, and to certain Part A provider payment reductions under MACRA.[24] Partially offsetting these lower estimates is the assumption that a higher proportion of Medicare beneficiaries will enroll in MA plans, where benefits may be more costly.

For both Parts B and D, projected short-term costs are higher in this year's report. For Part B, the increased estimates are mainly due to (1) higher than expected actual 2014 spending for most types of services; (2) higher assumed volume and intensity growth for some types of services based on recent experience; and (3) provisions in MACRA that increased Part B spending for certain services. For Part D, the expected higher spending is mainly due to higher projected drug-cost trends, primarily due to the introduction of high-cost specialty drugs used to treat hepatitis C. Over the long term, Part B projections are lower than in the prior report due to lower physician fee updates under MACRA and lower assumptions for long-range health care cost growth for other Part B services. Part D long-term projections also are slightly lower than in last year's report, mainly due to lower assumptions regarding growth in the cost of long-term health care.

Figure 5. Comparison of 2014 and 2015 Medicare Expenditure Projections

(expenditures as a percentage of GDP)



Sources: 2014 and 2015 Medicare Trustees' Reports, Supplementary Tables.

Notes: In the 2014 report, the Trustees provided two separate estimates. One was based on current law at the time, which assumed that physician payments would be reduced under the sustainable growth rate formula, and the second was based on the assumption that Congress would override the reductions and payments would increase in most years. The 2015 estimate assumes current law, which includes physician payment rate changes made by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10).

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[24] These Part A providers include inpatient hospitals, skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, hospices, and home health agencies.

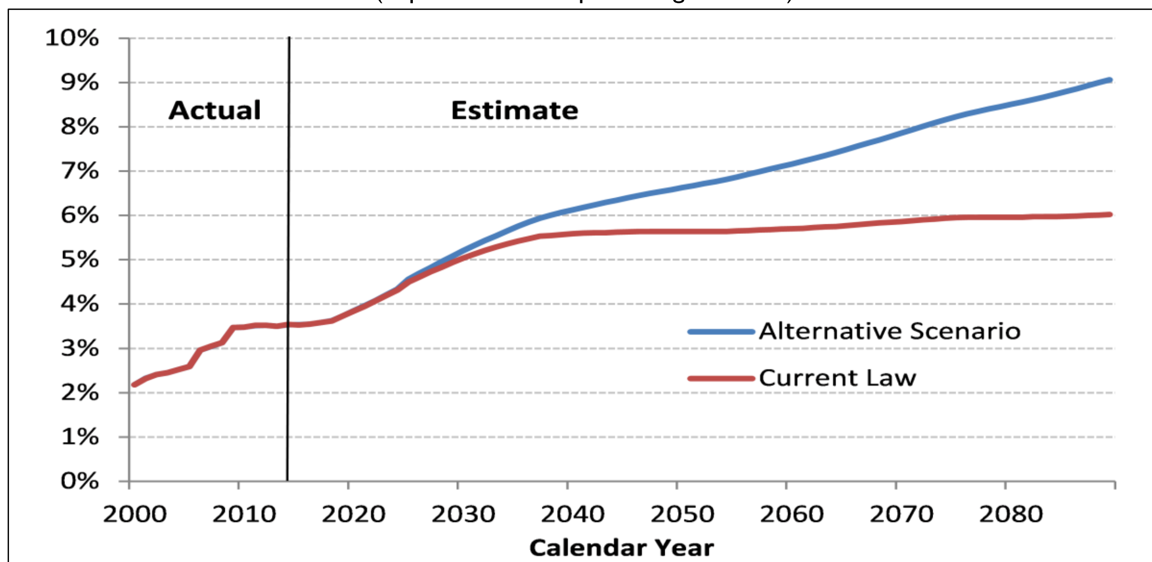
Alternative Projections

Throughout the 2015 report, the Medicare Trustees caution that actual costs are likely to be higher than their intermediate projections. For example, because the Trustees are required to base their estimates on current law, their assumptions assume that physician payments will be updated according to levels set forth in MACRA, that the full ACA-required Medicare plan and provider payment reductions will be maintained, and that Independent Payment Advisory Board (IPAB) proposals to reduce Medicare costs will go into effect.[25]

Because of concerns about the accuracy of these projections, the Medicare Trustees asked the CMS Office of the Actuary to prepare an alternative projection based on the assumptions that annual physician payment updates will transition beginning in 2024 from 0.0% to 2.3% by 2039, that ACA provider payment adjustments will be partially phased out beginning in 2020, and that reductions proposed by the IPAB will not occur.[26] Under this alternative scenario, long-term Medicare costs are projected to reach 8.5% of GDP in 2080, instead of 6.0% under the Trustees' current-law projections. Additionally, under the alternative scenario, the HI actuarial deficit would be 1.70% of taxable payroll (compared with 0.68% under the current-law projection), which could be addressed by immediately increasing payroll taxes to 4.60% or by immediately decreasing expenditures by 31% (compared with 3.58% and 15%, respectively, under current law). The alternative scenario also projects that HI insolvency would occur one year earlier, in 2029.

Figure 6. Comparison of Medicare Expenditure Projections Based on Current Law and Alternative Scenarios

(expenditures as a percentage of GDP)



Source: 2015 Report of the Medicare Trustees, Supplementary Tables.

Note: The alternative scenario assumes phasing out certain MACRA and ACA provider payment reductions.

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[25] For information on the Independent Payment Advisory Board, see CRS Report R44075, *The Independent Payment Advisory Board (IPAB): Frequently Asked Questions*, by (name redacted), (name redacted), and (name redacted)

[26] John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," July 22, 2015, at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2015TRAlternativeScenario.pdf.

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