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Medicare: Insolvency Projections

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Summary

Medicare is the nation's health insurance program for persons aged 65 and older and certain disabled persons. Medicare consists of four distinct parts: Part A (Hospital Insurance, or HI); Part B (Supplementary Medical Insurance, or SMI); Part C (Medicare Advantage, or MA); and Part D (the outpatient prescription drug benefit).

The Part A program is financed primarily through payroll taxes levied on current workers and their employers; these taxes 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. As an alternative, beneficiaries can choose to receive all their Medicare services through private health plans under the MA program; payment is made on beneficiaries' behalf in appropriate parts from the HI and SMI Trust Funds. The Part D drug benefit is funded through a separate account in the SMI Trust Fund and is financed through general revenues, state contributions, and beneficiary premiums. The HI and SMI Trust Funds are overseen by the Medicare Board of Trustees, which makes an annual report to Congress concerning the financial status of the funds.

From its inception, the HI Trust Fund has faced a projected shortfall. The insolvency date has been postponed a number of times, primarily due to legislative changes that have had the effect of restraining growth in program spending. The 2017 Medicare Trustees Report projects that, under intermediate assumptions, the HI Trust Fund will become insolvent in 2029, one year later than estimated in the prior year's report.

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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 aged 65 and older, and it has been expanded over the years to include permanently disabled individuals under the age of 65.

Medicare consists of four distinct parts, A through D. Part A covers hospital services, skilled nursing facility (SNF) services, home health visits, and hospice services. Most persons aged 65 and older are automatically 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 voluntary; however, most beneficiaries with Part A also enroll in Part B. Part C, Medicare Advantage (MA), provides private plan options, such as managed care, for beneficiaries who are enrolled in both Part A and Part B. Part D provides optional outpatient prescription drug coverage.[1]

Medicare expenditures are driven by a variety of factors, including the level of enrollment, the complexity of medical services provided, health care inflation, and life expectancy. In 2016, Medicare provided benefits to about 56.8 million persons at an estimated total cost of $678.7 billion.[2]

The Medicare program has two separate trust funds—the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund. The Part A program, which is financed mainly through payroll taxes levied on current workers, is accounted for through the HI Trust Fund. The Part B and Part D programs, which are funded primarily through general revenue and beneficiary premiums, are accounted for through the SMI Trust Fund.[3] Both funds are maintained by the Department of the Treasury and overseen by the Medicare Board of Trustees, which reports annually to Congress concerning the funds' financial status.[4] Financial projections are made using economic assumptions based on current law, including estimates of consumer price index, workforce size, wage increases, and life expectancy.

From its inception, the HI Trust Fund has faced a projected shortfall and eventual insolvency. Because of the way it is financed, the SMI Trust Fund cannot become insolvent; however, the Medicare trustees continue to express concerns about the rapid growth in SMI costs.[5]

[1] For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*.

[2] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 13, 2017, Table II.B, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf.

[3] Payments are made for beneficiaries enrolled in Part C in appropriate portions from the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds.

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

[5] For further information on Medicare financing, see CRS Report R43122, *Medicare Financial Status: In Brief*.

Medicare Hospital Insurance Financing

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.[6] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) 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.[7]

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,[8] and interest on federal securities held by the HI Trust Fund.

What Is the HI Trust Fund?

The HI Trust Fund is a financial account in the U.S. Treasury into which all income to the Part A portion of the Medicare program is credited and from which all benefits and associated administrative costs of the Part A program are paid. The trust fund is solely an accounting mechanism—no actual money is transferred into or out of the fund.[9]

HI operates on a "pay-as-you-go" basis, meaning the annual revenues to the HI Trust Fund, primarily 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 (e.g., payroll taxes), income is credited by the Treasury to the appropriate trust fund in the form of special issue interest-bearing government securities.[10] (Interest on these securities is also 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 Fund of the Treasury and a corresponding amount of securities is deleted from (written off) the HI Trust Fund.

In years in which the HI Trust Fund spends less than it receives in income, the fund has a *cash-flow surplus*. When this occurs, the HI Trust Fund securities exchanged for any income in excess of spending show up as assets on the trust fund's financial accounting balance sheets and are

[6] 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.

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

[8] Since 1994, the HI Trust 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.

[9] There are about 200 federal trust funds. For additional information on how federal trust funds operate within the context of the federal budget, see CRS Report R41328, *Federal Trust Funds and the Budget*.

[10] 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.

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.[11]

If, in a given year, the HI Trust Fund spends more than it receives in income, the fund has a *cash-flow deficit*. In deficit years, Medicare can redeem any securities accumulated in previous years (including interest). When the securities are redeemed, the government needs to raise the resources necessary to pay for the securities and the monies are transferred from the Treasury's General Fund to the HI Trust Fund. When the assets credited to the trust fund reach zero, the fund is deemed *insolvent*.

(See **Appendix A** for a discussion of recent and projected HI cash flows and for data on historical and projected HI operations through 2026.)

History of HI Solvency Projections

The HI Trust Fund has never become insolvent. The Medicare Board of Trustees projected insolvency for the HI Trust Fund beginning with the 1970 report,[12] at which time the trust fund was expected to become insolvent in only two years. (See **Table 1** and **Figure 1**.) The insolvency date has been postponed a number of times since the beginning of Medicare through various methods. For example, 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. (See **Appendix B** for historical payroll tax rates.)

Other legislative changes have been made at various times to slow the growth in HI program spending; generally, these measures have been part of larger budget reconciliation laws that attempt to restrain overall federal spending. To illustrate, in the mid-1990s, efforts to curtail Medicare spending intensified as Congress considered legislation to bring the entire federal budget into balance and culminated in the passage of the Balanced Budget Act of 1997 (BBA 97; P.L. 105-33). In early 1997, the Medicare trustees had projected that the HI Trust Fund would become insolvent within four years, in 2001. Following the enactment of BBA 97, significant improvements were made in the short-term projections over the next few years. The new projections reflected a number of factors, including lower expected expenditures as a result of changes made by BBA 97 (primarily resulting from modifications in Medicare Part C payments and the establishment of prospective payment systems for certain Part A providers);[13] continued efforts to combat fraud and abuse; and strong economic growth, which was expected to generate more revenues to the trust fund from payroll taxes.

[11] For additional information, see Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Appendix F, "Medicare and Social Security Trust Funds and the Federal Budget," July 13, 2017 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf.

[12] Medicare Trustees Reports from 1966 through 1994 may be found on the Social Security History webpage at https://www.ssa.gov/history/reports/trust/trustyears.html. More recent reports may be found on the CMS webpage, "Trustees Report & Trust Funds," at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html.

[13] The Balanced Budget Act of 1997 (BBA 97; P.L. 105-33) established the Medicare + Choice program under Part C. Medicare Part C was changed to Medicare Advantage by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173).

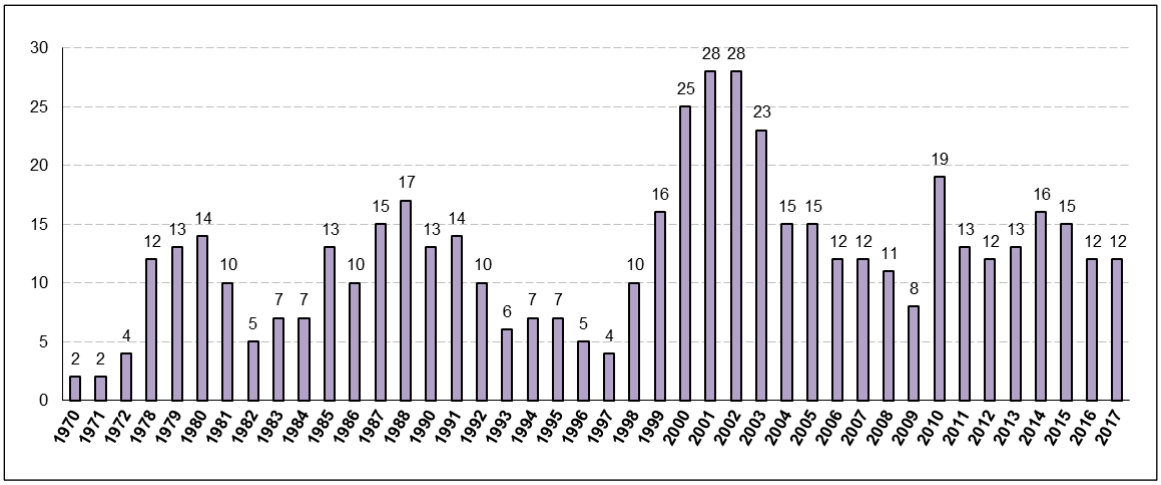
There were concerns that the savings achieved through the enactment of BBA 97 were greater than intended at the time of enactment and had unintended consequences for health care providers. As a result of these concerns, Congress enacted two measures: the Balanced Budget Refinement Act of 1999 (BBRA 99; P.L. 106-113) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000; P.L. 106-554). These measures were designed to reverse some of the BBA 97 spending reductions.

Table 1. Year of Projected Insolvency of the Hospital Insurance (HI) Trust Fund in Past and Current Trustees Reports

Year of Trustees Report	Year of Projected Insolvency	Year of Trustees Report	Year of Projected Insolvency	Year of Trustees Report	Year of Projected Insolvency
1970	1972	**1986** (amended)	1998	**2003**	2026
1971	1973	**1987**	2002	**2004**	2019
1972	1976	**1988**	2005	**2005**	2020
1973	None Indicated	**1989**	None Indicated	**2006**	2018
1974	None Indicated	**1990**	2003	**2007**	2019
1975	Late 1990s	**1991**	2005	**2008**	2019
1976	Early 1990s	**1992**	2002	**2009**	2017
1977	Late 1980s	**1993**	1999	**2010**	2029
1978	1990	**1994**	2001	**2011**	2024
1979	1992	**1995**	2002	**2012**	2024
1980	1994	**1996**	2001	**2013**	2026
1981	1991	**1997**	2001	**2014**	2030
1982	1987	**1998**	2008	**2015**	2030
1983	1990	**1999**	2015	**2016**	2028
1984	1991	**2000**	2025	**2017**	2029
1985	1998	**2001**	2029	**—**	**—**
1986	1996	**2002**	2030	**—**	**—**

Source: Intermediate projections of various Medicare Trustees Reports, 1970-2017.

Figure 1. Projected Number of Years Until Medicare HI Trust Fund Insolvency



Source: Intermediate projections of various Medicare Trustees Reports, 1970-2017.

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

Despite enactment of BBRA 99 and BIPA 2000, which increased program spending, the 2001 and 2002 Medicare Trustees Reports continued to delay the projected insolvency date. These improvements in solvency projections reflected both stronger-than-expected economic growth and lower-than-expected program costs due to lower projected enrollment in Medicare Part C, heightened antifraud and abuse initiatives, and lower-than-expected increases in health care costs.

The 2003 report projections, however, shifted direction. The projected insolvency date was 2026, four years earlier than the 2030 date projected in the 2002 report. The revision was due to lower-than-expected HI-taxable payroll and higher-than-expected hospital expenditures. In the next year, the 2004 report projected that the HI Trust Fund would become insolvent in 2019, seven years earlier than projected in 2003. A number of factors contributed to the revision of the projected insolvency date, including slow wage growth (on which payroll taxes are based) and faster growth in inpatient hospital benefits. In addition, the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) added significantly to HI costs, primarily through higher payments to rural hospitals and to private plans under the MA program.[14]

The 2005 Medicare Trustees Report projected that the HI Trust Fund would become insolvent one year later than projected in 2004, in 2020. The revision reflected slightly higher income and slightly lower costs in 2004 than previously estimated. The 2006 report moved the insolvency date forward again, to 2018. The revision reflected expectations of slightly higher costs and increased utilization of HI services. Both the 2007 and 2008 reports projected a 2019 insolvency date, although the 2008 report indicated that insolvency would occur earlier in the year. The 2009 report moved the insolvency date forward to 2017, due primarily to the economic recession.

The 2010 Medicare Trustees Report, issued subsequent to the enactment of the ACA, estimated that the combination of lower Part A costs and higher payroll-tax revenues expected to result from the ACA would postpone depletion of the HI Trust Fund's assets until 2029, 12 years later

[14] The Part D outpatient prescription drug program, which was created by the MMA, is funded under SMI; the increased expenditures associated with this new benefit therefore had little impact on projections of Medicare (HI) solvency.

than the date projected in the 2009 report.[15] However, the 2011 report projected that the HI Trust Fund would become insolvent in 2024, five years earlier than projected in the 2010 report. The worsening financial outlook was primarily due to lower-than-expected payroll taxes stemming from higher-than-expected unemployment and slow wage growth in 2010. The 2012 Medicare Trustees Report projected the same 2024 insolvency date. Although income from payroll taxes was expected to increase at a faster rate than expenditures through 2018 due to the projected economic recovery, the application of an additional 0.9% HI payroll tax for high-income workers beginning in 2013,[16] and the 2% reduction in spending required by the Budget Control Act of 2011 (BCA; P.L. 112-25) from 2013 through 2021,[17] income was still expected to be insufficient to fully cover projected HI expenses during that period.

In their 2013 report, the Medicare trustees projected a somewhat better short-term outlook for the HI Trust Fund. They moved the insolvency date two years later than their 2012 estimate, to 2026. The improved projections were primarily due to lower-than-expected expenditures in 2012, the base year used to project future expenditures, and a larger-than-estimated impact of ACA payment methodology changes on MA costs.[18] In their 2014 report, the Medicare trustees reported some improvement in Medicare's financial outlook and therefore moved the insolvency date four years later than their 2013 estimate, to 2030. This improvement was mainly due to lower expected utilization of and/or spending for certain Part A services, including inpatient hospital, skilled nursing, and home health care. The 2015 trustees report projected a similar short-term financial outlook and maintained the 2030 insolvency date estimate.

The 2016 Medicare Trustees Report projected a slightly worsened short-term outlook for the HI Trust Fund and therefore moved the insolvency date two years earlier than their 2015 estimate, to 2028 (from 2030 in the 2015 report). This change was primarily due to lower-than-expected payroll-tax income resulting from a slowing in real wage growth.

Current Insolvency Projections

In their 2017 report,[19] the Medicare trustees projected a slightly improved short-term outlook for the HI Trust Fund and therefore moved the insolvency date one year later than their 2016 estimate, to 2029 (from 2028 in the 2016 report). This change was primarily due to lower-than-expected HI expenditures in 2016 (which reduce the projection base) and lower projected future utilization of inpatient hospital services.

While expenditures in the HI Trust Fund exceeded income each year from 2008 through 2015, the Medicare trustees reported a small surplus in 2016 and projected the continuation of surpluses through 2022. (See **Table A-1**.) In 2023 and beyond, expenditure growth is expected to again

[15] The expected reductions were primarily due to productivity adjustments to Part A provider payment updates and reduced payments to Medicare Advantage plans.

[16] The high-income payroll tax was added by the ACA. See "Medicare Hospital Insurance Financing."

[17] Subsequent legislation extended the reductions for an additional four years, through FY2025. For additional information on the Budget Control Act of 2011 (BCA; P.L. 112-25) and required Medicare spending reductions, see archived CRS Report R41965, *The Budget Control Act of 2011* and CRS Report R40425, *Medicare Primer*.

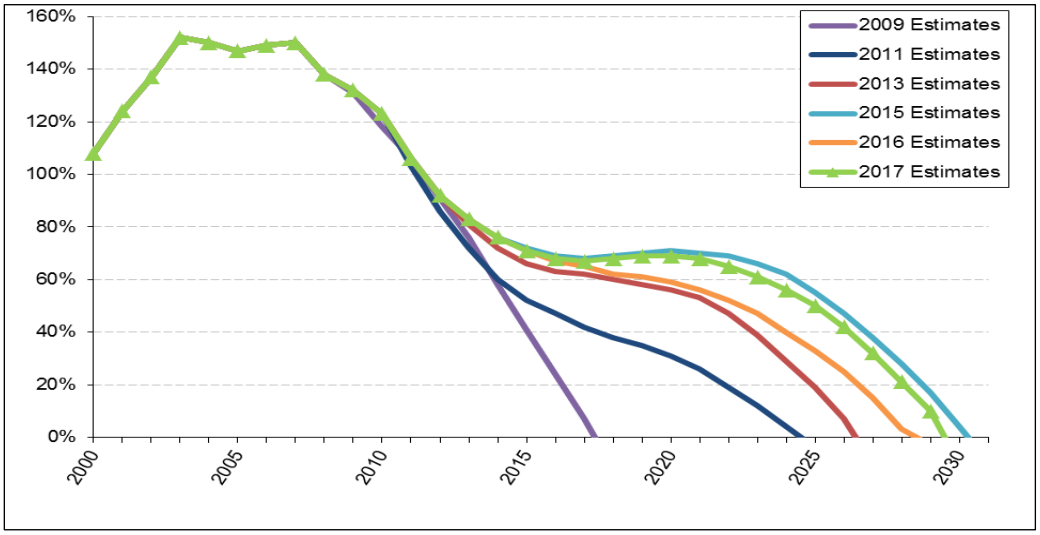
[18] See CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

[19] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 13, 2017, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf.

outpace growth in income. At that time, trust fund assets would be used to make up the difference between income and expenditures, until the assets were depleted in 2029. (See **Figure 2**.)

Figure 2. HI Trust Fund Assets at Beginning of Year as a Percentage of Annual Expenditures

(estimates from selected 2009-2017 Medicare Trustees Reports)



Sources: Data from the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds*, Table II.E1, and Summaries of the 2011 through 2017 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart D (2011) and Chart E (2013, 2015, 2016, and 2017).

Notes: The 2010 estimated insolvency date was 2029. The 2012 insolvency date estimate was the same as the date projected in the 2011 report (2024), and the 2014 insolvency date estimate was the same as that in the 2015 report (2030).

Each year, beginning in 2010, the Centers for Medicare & Medicaid Services (CMS) actuaries have issued an illustrative alternative scenario that has assumed that certain ACA changes that reduce Part A provider reimbursements would be made through 2019 and then gradually phased out starting in 2020.[20] The 2017 alternative scenario thus suggests higher total Medicare spending levels than the trustees report's baseline figures. Although it also projects a 2029 insolvency date, the alternative scenario suggests that insolvency would occur earlier in the year.

What Would Happen If the Fund Became Insolvent?

The practical function of the HI Trust Fund is to permit the continued payment of bills in the event of a temporary financial strain (e.g., lower income or higher costs than expected) without requiring legislative action. As long as the HI Trust Fund has a balance (i.e., securities are credited to the fund), the Treasury Department is authorized to make payments for Medicare

[20] Memo from John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," July 13, 2017, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2017TRAlternativeScenario.pdf.

Part A services. If the HI Trust Fund is not able to pay all current expenses out of current income and accumulated trust fund assets, the HI Trust Fund is considered to be *insolvent*.[21]

To date, the HI Trust Fund has never become insolvent. There are no provisions in the Social Security Act that govern what would happen if insolvency were to occur. For example, the program has no statutory authority to use general revenues to fund Part A services in the event of such a shortfall.

In their 2017 report, the Medicare trustees project that the HI Trust Fund will be exhausted in 2029. At that time, HI would continue to receive tax income from which some benefits could be paid; however, funds would be sufficient to pay for only 88% of Part A expenses. Unless action is taken prior to that date to increase revenues or to decrease expenditures (or some combination of the two), Congress may face a legislative decision regarding whether, and how, to provide for another source of funding (e.g., general revenues) to make up for these deficits.

Medicare Financing Issues

Much of the concern about the financial status of Medicare tends to focus on the HI Trust Fund date of insolvency, when Medicare no longer has the authority to pay for Part A health care services in full. This focus can, however, detract from the larger issues confronting the Medicare program as a whole and from the program's current and future impact on the federal budget and on taxpayers. When viewed from the perspective of the entire federal budget, as the number of beneficiaries and per capita health care costs continue to grow, total Medicare spending obligations (HI and SMI spending combined) are expected to place increasing demands on federal budgetary resources.

As noted earlier, because of the way it is financed, the SMI (Parts B and D) portion of Medicare cannot become insolvent. However, a continuing shift from providing care in inpatient (Part A) settings to outpatient (Parts B and D) settings has resulted in a greater portion of Medicare spending being covered by beneficiary premiums and general revenues than by dedicated payroll taxes.[22] In the future, the Medicare trustees estimate that the portion of personal and corporate income taxes needed to fund SMI will increase from about 15.7% in 2016 to about 21% in 2030 and close to 25% in 2091.[23]

[21] 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. It is true that a trust fund's outgo can be greater than its income and that trust funds can have a zero balance, but, unlike private businesses, the federal government is not in danger of "going out of business" or having its assets seized by creditors. As noted, Congress has often taken actions to increase the trust fund's revenues or reduce its outgo when the Medicare HI Trust Fund has faced imminent insolvency.

[22] The Congressional Budget Office estimates that the share of Medicare spending financed by dedicated payroll taxes declined from 67% in 2000 to about 39% in 2016. Congressional Budget Office, *The 2016 Long-Term Budget Outlook*, July 2016, p. 44, at https://www.cbo.gov/publication/51580.

[23] This amount is separate from and in addition to the payroll taxes used to fund the Part A (HI) portion of the program.

Appendix A. Operation of the Hospital Insurance Trust Fund

Beginning in 2004, 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, and Hospital Insurance (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. Expenditures exceeded income every year from 2008 through 2015. In 2016, the HI Trust Fund ran a small surplus. It is expected to continue to do so through 2022. 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 2029. At that time, the HI Trust Fund would no longer have sufficient funds to allow for the full payment of Part A expenditures (see **Table A-1**, below, for historical and projected Medicare financial data through 2026).

Table A-1. Operation of the Hospital Insurance Trust Fund, Calendar Years 1970-2026

(in billions of dollars)

	Income			Expenditures			Trust Fund	
Year	Payroll Taxes	Interest, Transfers, Other[a]	Total	Benefit Payments	Admin. Expenses	Total	Net Change from Prior Year	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	33.7	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
2013	220.8	30.3	251.1	261.9	4.3	266.2	−15.0	205.4
2014	227.4	33.9	261.2	264.9	4.5	269.3	−8.1	197.3
2015	241.1	34.3	275.4	273.4	5.5	278.9	−3.5	193.8

	Income			Expenditures			Trust Fund	
Year	Payroll Taxes	Interest, Transfers, Other[a]	Total	Benefit Payments	Admin. Expenses	Total	Net Change from Prior Year	Balance at End of Year
2016	253.5	37.3	290.8	280.5	4.9	285.4	5.4	199.1
Intermediate Estimates								
2017	267.2	38.7	306.0	290.1	5.1	295.2	10.8	209.9
2018	281.7	42.2	324.0	301.8	5.5	307.3	16.7	226.6
2019	297.5	46.1	343.6	321.6	5.9	327.5	16.1	242.7
2020	314.0	50.3	364.2	344.7	6.3	351.0	13.2	255.9
2021	330.5	54.5	385.1	369.6	6.8	376.4	8.7	264.5
2022	346.7	58.6	405.3	396.9	7.2	404.1	1.2	265.8
2023	362.3	62.5	424.9	425.2	7.6	432.8	−8.0	257.8
2024	378.8	66.7	445.5	453.0	8.1	461.1	−15.7	242.1
2025	395.5	71.2	466.6	479.2	8.7	487.9	−21.2	220.9
2026	413.2	75.3	488.4	520.3	9.6	529.9	−41.5	179.4

Source: Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 13, 2017, Table III.B4.

Notes: Sums may not equal totals due to rounding.

a. Includes income from the taxation of Social Security benefits, Railroad Retirement account transfers, premiums paid by voluntary enrollees, and interest.

Appendix B. Historical Payroll Tax Rates

Table B-1. Tax Rates and Maximum Tax Bases

		Tax Rate (percentage of taxable earnings)	
Calendar Year	Maximum Tax Base	Employees and Employers, Each	Self-Employed
1966	$6,600	0.35%	0.35%
1967	6,600	0.50	0.50
1968-1971	7,800	0.60	0.60
1972	9,000	0.60	0.60
1973	10,800	1.00	1.00
1974	13,200	0.90	0.90
1975	14,100	0.90	0.90
1976	15,300	0.90	0.90
1977	16,500	0.90	0.90
1978	17,700	1.00	1.00
1979	22,900	1.05	1.05
1980	25,900	1.05	1.05
1981	29,700	1.30	1.30
1982	32,400	1.30	1.30
1983	35,700	1.30	1.30
1984	37,800	1.30	2.60
1985	39,600	1.35	2.70
1986	42,000	1.45	2.90
1987	43,800	1.45	2.90
1988	45,000	1.45	2.90
1989	48,000	1.45	2.90
1990	51,300	1.45	2.90
1991	125,000	1.45	2.90
1992	130,200	1.45	2.90
1993	135,000	1.45	2.90
1994-2012	no limit	1.45	2.90
2013 and later**Error! Reference source not found.**	no limit	1.45	2.90

Source: 2017 Medicare Trustees Report, Table III.B2.

Note:

a. Beginning in 2013, workers pay an additional 0.9% of their earnings above $200,000 (those who file individual tax returns) or $250,000 (those who file joint tax returns).

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