



Medicare Financing

Patricia A. Davis

Acting Section Research Manager/Specialist in Health Care Financing

January 5, 2011

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 2010 report of the Medicare Boards of Trustees estimates that the combination of lower Part A costs and higher tax revenues expected as a result of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 ("the Reconciliation Act," or HCERA, P.L. 111-152), will postpone the depletion of HI trust fund assets until 2029, 12 years later than projected last year's report. Because of the way it is financed, the SMI fund can not face insolvency; however, the trustees project that SMI expenditures will continue to grow rapidly.

Although the Medicare trustees report that the financial outlook for the Medicare program appears to have improved as a result of PPACA, they caution that the projections in the report are more uncertain than normal, 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.

This report will be updated upon receipt of the 2011 trustees' report or as circumstances warrant.

Contents

Introduction	1
Medicare Trust Funds.....	2
Hospital Insurance (HI) Trust Fund	2
Supplementary Medical Insurance (SMI) Trust Fund.....	3
Part B Financing	4
Part D Financing	4
Board of Trustees	5
Annual Trustees' Report.....	5
2009 Medicare Program Operations	6
Hospital Insurance Trust Fund Operations in 2009.....	6
Supplementary Medical Insurance Trust Fund Operations in 2009.....	6
Short-Range Financial Soundness (10 Years).....	8
Projected Date of HI Insolvency.....	10
Long-Range Financial Soundness (75 Years).....	11
HI Income and Costs Relative to Payroll Taxes	11
Year-by-Year Estimates	11
Actuarial Balance.....	12
Unfunded Obligations	13
HI Long-Term Obligations	13
SMI Long-Term Obligations	14
Medicare Costs as a Percentage of GDP	15
Medicare Funding Warning	16
Medicare Expenditures and the Federal Budget	17
Concluding Observations	18

Figures

Figure 1. Sources of Medicare Revenue: 2009.....	2
Figure 2. Medicare Expenditures, Comparison of Estimates of 2009 and 2010 Medicare Trustees Reports	8
Figure 3. Short-Term HI Expenditures and Income	9
Figure 4. HI Trust Fund Assets at Beginning of Year as a Percentage of Annual Expenditures	10
Figure 5. Long-Range HI Income and Cost as a Percentage of Taxable Payroll	12
Figure 6. Medicare Cost and Non-interest Income by Source as a Percentage of GDP.....	15

Tables

Table 1. Medicare Data for Calendar Year 2009.....	7
Table 2. Unfunded HI Obligations	14

Table 3. Unfunded Part B and Part D Obligations 14

Table 4. SMI General Revenues as a Percentage of Personal and Corporate Federal
Income Tax 18

Table A-1. Operation of the Hospital Insurance Trust Fund, Calendar Years 1970-2019 20

Table B-1. Operation of the Part B Account of the SMI Trust Fund, Calendar Years 1970-
2019 22

Table C-1. Operation of the Part D Account in the SMI Trust Fund, Calendar Years 2004-
2019 23

Table D-1. Projected HI and SMI Expenditures as a Percentage of GDP 24

Appendixes

Appendix A. Operation of the Hospital Insurance Trust Fund 20

Appendix B. Operation of the Supplementary Insurance Trust Fund, Part B Account 22

Appendix C. Operation of the Supplementary Insurance Trust Fund, Part D Account 23

Appendix D. Medicare Expenditures as a Percentage of GDP 24

Contacts

Author Contact Information 25

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 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).

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 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.¹

Medicare serves approximately one in seven Americans and virtually all of the population aged 65 and over. In 2010, the program covered an estimated 47 million persons (39 million aged and 8 million disabled) at an estimated total cost of \$531.5 billion, accounting for about 23% of national health spending and approximately 3.6% of Gross Domestic Product (GDP). Medicare is an entitlement program, which means that it is required to pay for 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 (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 ("the Reconciliation Act" or HCERA, P.L. 111-152), 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.² For example, under the new legislation, annual updates of the prices paid by Medicare for almost all non-physician categories of health services will be reduced by the growth in economy-wide productivity (productivity adjustments). The legislation did not, however, make changes to the physician sustainable growth rate (SGR) payment system; therefore, unless Congress takes action, reductions in physician payment rates of over 25% will be required in 2012.³

¹ For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

² See CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis, for additional detail.

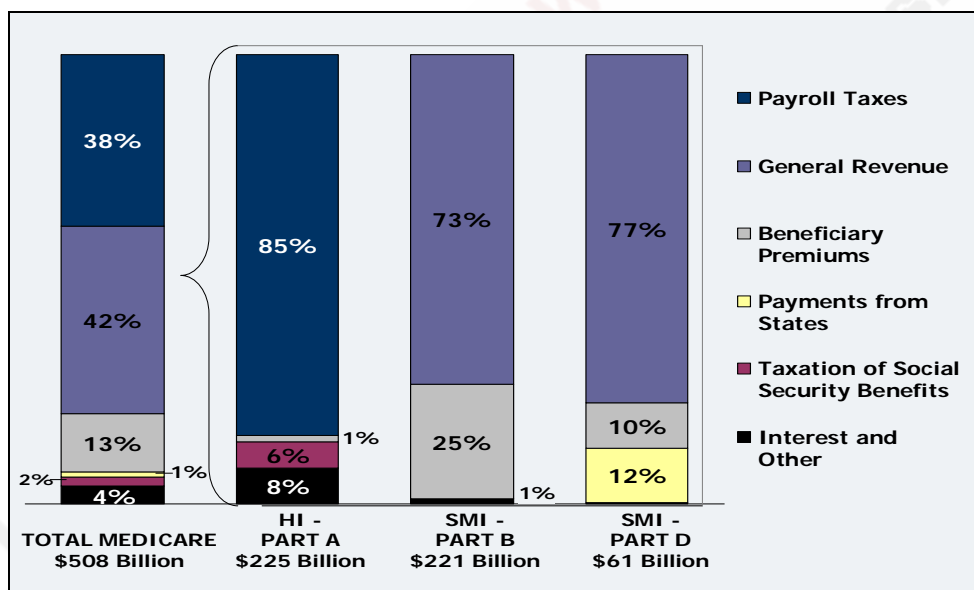
³ Congress has overridden these required reductions in every year since 2002, most recently by the Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309), signed into law December 15, 2010. See memo from John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," August 5, 2010, <http://www.cms.gov/ReportsTrustFunds/downloads/2010TRAlternativeScenario.pdf>.

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 2010 Report of the Medicare Trustees regarding 2009 program operations and future financial soundness.⁴

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.

Figure 1. Sources of Medicare Revenue: 2009



Source: 2010 Report of the Medicare Trustees, Table II.B, p. 10, and the Kaiser Family Foundation

Notes: 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.

⁴ 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, <http://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf>.

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.⁵ PPACA 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. PPACA also imposes an additional tax on unearned income, beginning in 2013.⁶

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;⁷ and interest on federal securities held by the trust fund.

The HI trust fund is solely an accounting mechanism—there is no actual transfer of money into and out of the fund. 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.⁸ (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.⁹ 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.

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.

Supplementary Medical Insurance (SMI) Trust Fund

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), which created the Part D outpatient prescription drug benefit, created two separate accounts

⁵ 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.

⁶ See CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Janemarie Mulvey, for additional detail.

⁷ 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.

⁸ 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.

⁹ 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).

within the SMI trust fund: one for Part B, to cover physician services, outpatient hospital care, durable medical equipment, diagnostic tests and other services; and one for Part D, to cover outpatient prescription drug benefits. 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) will be credited to the SMI trust fund.¹⁰

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. Income from these sources is credited to the SMI trust fund, and similar to the HI trust fund, any SMI revenues that exceed SMI spending accumulate in the SMI trust fund; however, SMI trust fund balances are generally small. Also, 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 from federal general revenues, with beneficiaries' premiums set to cover 25% of estimated Part B program costs for the aged. The 2011 monthly premium is \$96.40 for most established Medicare beneficiaries who enroll in Part B.¹¹ Individuals receiving Social Security benefits have their Part B premium payments automatically deducted from their Social Security benefit checks. Since 2007, higher-income enrollees pay higher premiums. As a result of PPACA, 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 population (those who qualify for both Medicare and Medicaid) had not been transferred to Part D.

¹⁰ See CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Janemarie Mulvey, for more detail.

¹¹ About 75% of Part B enrollees were not subject to Part B premium increases in 2010 and 2011. The Social Security Act includes a provision that holds most Social Security beneficiaries harmless for increases in the Medicare Part B premium; affected beneficiaries' Part B premiums are reduced to ensure that their Social Security checks do not decline from one year to the next. Those not protected by the "hold harmless" provision include those who pay the high income premium, those eligible for both Medicare and Medicaid (dual-eligibles), and new Part B enrollees. See CRS Report R40561, *Interactions Between the Social Security COLA and Medicare Part B Premiums*, by Jim Hahn and Alison M. Shelton.

In 2011, the base monthly premium is \$32.34; however, beneficiaries pay different premiums depending on the plan they have selected (and whether they are entitled to low-income premium subsidies).¹² 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. Premiums for the Part D program are required to cover approximately 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 10% of Part D program costs in 2009. As required by PPACA, 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 will also be frozen in the same manner as those under Part B 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.¹³ The Secretary of the Treasury is the Managing Trustee. The Administrator of the Centers for Medicare and 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. Variables used include such things as 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; they are the projections most frequently cited.

The 2010 report of the Medicare trustees was issued August 5, 2010.¹⁴ However, the 2010 Report warned that estimates based on current-law assumptions may not be realistic. As such, at the request of the trustees, the Office of the Actuary of CMS issued a separate memorandum that provides projections based on an "illustrative alternative" to current law.¹⁵ The alternative

¹² The "hold harmless" provision described in the previous footnote does not apply to Part D; beneficiaries are not protected from Part D premium increases.

¹³ The seats for the two public members have been vacant since 2008. No public members contributed to the 2010 report. 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.

¹⁴ The 2010 report includes data on actual expenditures and income through 2009, and projections for years 2010 and beyond. The Medicare and Medicaid Extenders Act of 2010 (P.L. 111-309) was signed into law subsequent to the issuance of the 2010 Trustees report; the impact of that legislation on future expenditures is not included in their estimates.

¹⁵ Memo from John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," August 5, 2010, <http://www.cms.gov/ReportsTrustFunds/> (continued...)

estimates are based on the assumption that the productivity adjustments mandated by PPACA would be made through 2019, but then would be phased out over the next 15 years. The alternative scenario also assumes that, instead of being cut, physician payments will grow annually based on the Medicare Economic Index.¹⁶

The Board of Trustees will also convene an independent panel of expert actuaries and economists to make recommendations to the Board regarding the most appropriate long-range growth assumptions for Medicare projections. It is expected that the panel's work will help both to inform the selection of assumptions for the 2011 report and to assess the sustainability of the Medicare price adjustments under current law.

2009 Medicare Program Operations

In calendar year (CY) 2009, Medicare provided about 46 million beneficiaries with benefits at a total cost of \$509 billion, or \$11,743 per enrollee. Because HI and SMI have different funding mechanisms, a description of each fund's 2009 operations is described separately below.

Hospital Insurance Trust Fund Operations in 2009

As shown in **Table 1**, in CY2009, total income to the HI trust fund was \$225.4 billion. Payroll taxes of workers and their employers accounted for \$190.9 billion (84.7%), with the remainder from interest and government credits, premiums (from those buying into the program), and taxation of Social Security benefits. The HI program paid out \$242.5 billion; most of which was for benefit costs, and about 1.3% was for administrative expenses. Similar to 2008, expenditures exceeded income in 2009, and the trust fund balance was reduced to \$304.2 billion at the end of 2009 (a loss of \$17.1 billion).¹⁷ (See **Appendix A** for funding amounts in prior years and estimates for future years.)

Supplementary Medical Insurance Trust Fund Operations in 2009

In CY2009, the SMI trust fund (Part B and Part D accounts combined) brought in \$282.8 billion in revenue (\$221.9 billion from Part B and \$60.9 billion from Part D), and expended \$266.5 billion (\$205.7 billion from Part B and \$60.8 from Part D). General revenues accounted for 74.2% of total revenues and premiums accounted for 22.0%.¹⁸ (See **Table 1** for 2009 Parts B and D operations data.)

(...continued)

[downloads/2010TRAlternativeScenario.pdf](#).

¹⁶ The Medicare Economic Index is an inflation measure used to determine reimbursement to Medicare physicians. It includes such factors as the costs of a physician's time and time of medical staff, and overhead costs such as rent and medical equipment.

¹⁷ In comparison, in CY2008, total income was \$230.8 billion, and total disbursements were \$235.6 billion, with an end of the year trust fund balance of \$321.3 billion; this represents a growth in expenditures of \$6.9 billion (increase of 2.9%) from 2008 to 2009.

¹⁸ In comparison, in CY2008, total income was \$250.0 billion and total expenditures were \$232.6 billion. This represents a growth in SMI expenditures of \$33.9 billion, or an increase of 14.6%, from 2008 to 2009.

Table I. Medicare Data for Calendar Year 2009

	HI (Part A)	SMI - Part B	SMI - Part D	Total Medicare
Enrollment (millions)				
Aged	38.3	36.0	n/a	38.7
Disabled	7.6	6.8	n/a	7.6
Total	46.0	42.8	33.4	46.3
Average expenditures per enrollee	\$5,205	\$4,728	\$1,810	\$11,743
Trust Fund Balance at end of 2008 (billions)	\$321.3	\$59.4	\$0.9	\$381.6
Total Income	\$225.4	\$221.9	\$60.9	\$508.2
Payroll Taxes	190.9	—	—	190.9
Interest	15.3	3.0	0.0	18.3
Taxation of Benefits	12.4	—	—	12.4
Premiums	2.9	56.0	6.3	65.2
General Revenue	1.9	162.8	47.1	211.7
Transfers from States	—	—	7.6	7.6
Other	2.1	0.1	—	2.2
Total Expenditures	\$242.5	\$205.7	\$60.8	\$509.0
Benefits	239.3	202.6	60.5	502.3
Hospital	133.9	30.5	—	164.4
Skilled Nursing	26.3	—	—	26.3
Home Health Care	7.3	11.4	—	18.6
Physician Services	—	62.5	—	62.5
Private plans (Part C)	59.4	53.4	—	112.7
Prescription Drugs	—	—	60.5	60.5
Other	12.5	44.9	—	57.4
Administrative Expenses	3.2	3.1	0.3	6.7
Net Change	-17.1	16.2	0.1	-0.7
Trust Fund Balance at end of 2009	\$304.2	\$75.5	\$1.1	\$380.8

Source: 2010 Report of Medicare Trustees, Table II.B1.

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

Of the \$221.9 billion in income to Part B, general revenues accounted for \$162.8 billion (73.4%), premiums accounted for \$56.0 billion (25.2%), and interest and other income made up the remaining \$3.1 billion (1.4%). The program paid out \$205.7 billion; similar to HI, almost all of

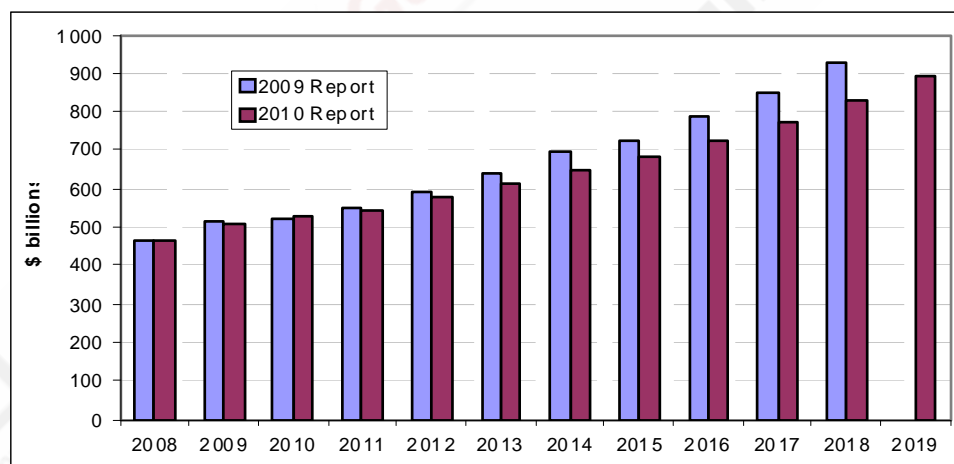
this amount was used to cover benefits and 1.5% covered administrative expenses.¹⁹ (See **Appendix B** for historical and projected income and expenditures in the SMI Part B account.)

Of the \$60.9 billion in Part D income, general revenue accounted for \$47.1 billion (77.3%), premiums accounted for \$6.3 billion (10.3%), and transfers from states for \$7.6 billion (12.5%). Almost all of the 2009 Part D program expenditures of \$60.8 billion were used to pay benefit costs and 0.5% was used for administrative expenses.²⁰ (See **Appendix C** for historical and projected income and expenditures in the SMI Part D account.)

Short-Range Financial Soundness (10 Years)

The 2010 Medicare trustees report predicts a slower growth rate of Medicare expenditures compared to their projections in last year's report. Over the next 10 years, Medicare expenditures are projected to increase at an average annual rate of 5.8% compared to 7.1% as projected in the prior report. The 2010 report estimates that Medicare spending will grow from \$509.0 billion in 2009 to \$894.6 billion in 2019. In comparison, the prior report projected 2018 expenditures of \$926.1 billion (see **Figure 2**). The trustees attribute most of the expected reduction in spending to changes made by PPACA to slow the growth rate of payments to Medicare providers.

Figure 2. Medicare Expenditures, Comparison of Estimates of 2009 and 2010 Medicare Trustees Reports



Source: Data from the 2009 and 2010 Reports of the Medicare Boards of Trustees, Table III.A1.

Note: The 10-year projection window for the 2009 report only extended to 2018; there is no corresponding 2019 estimate.

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 level of assets is expected to be equal to projected costs in a year.²¹ Although the 2010

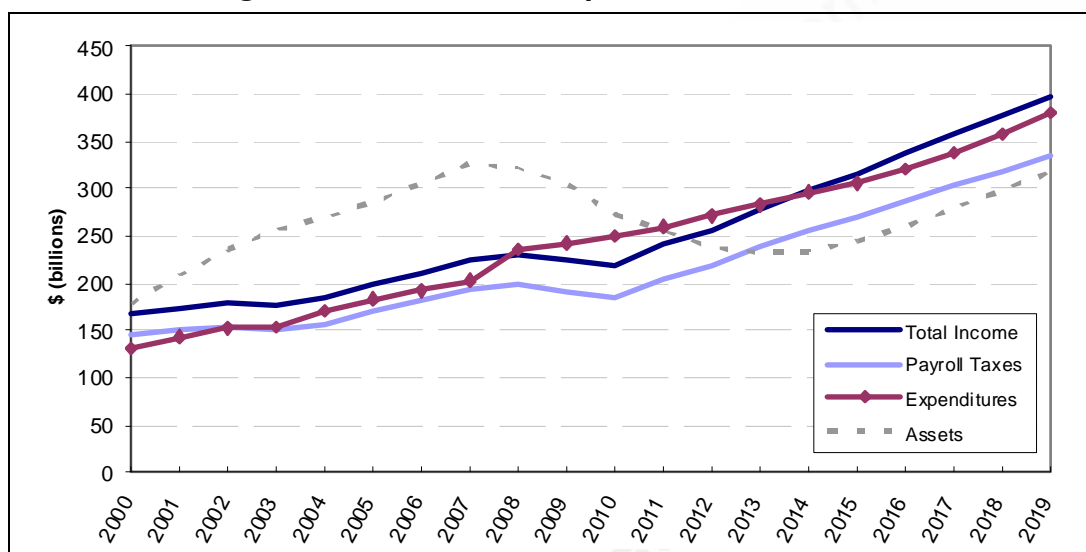
¹⁹ This represents an expenditure increase of 12.2% over the \$183.3 billion in Part B expenditures in 2008.

²⁰ The 2009 Part D expenditures represent a 23.3% growth over the 2008 expenditures of \$49.3 billion.

²¹ This amount is considered a sufficient contingency reserve to allow Congress enough time to address anticipated short-term financing problems.

report noted significant improvements compared with the prior report, the trustees note that the HI fund is still 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, 2010-2019) test of financial adequacy because total HI assets at the start of the year are expected to decline below 100% of expenditures during 2010. Expenditures have exceeded income every year since 2008 and are projected to continue doing so under current law through 2013. In the short run, the Medicare program faces deficits due mainly to the recession's negative effect on payroll tax revenues. Beginning in 2014, trust fund surpluses are expected to occur through the rest of the projection period (through 2019) (see **Figure 3**).

Figure 3. Short-Term HI Expenditures and Income



Source: Data from 2010 Report of Medicare Trustees, Table III.B4.

Note: The trustees report does not project actual dollar amount expenditures beyond 2019.

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 8.3% annually. If the physician payment cuts are allowed to go into effect, Part B expenditures (and corresponding income) are expected to grow at a slower average growth rate of 5.9% annually over the next 10 years. However if Congress overrides these reductions, the Part B growth rate during this period is projected to instead average about 8% each year (similar to past growth rates).²² For Part D, in part due to the costs associated with the gradual elimination of the coverage gap,²³ the average annual increase in expenditures and income is estimated to be 9.4% through 2019. By comparison, GDP is projected to grow at an average annual rate of 5.1% during this 10-year period.

²² Subsequent to the issuance of the 2010 Trustees report, Congress passed legislation to postpone these payment cuts through the end of 2011 (the Medicare and Medicaid Extenders Act of 2010, P.L. 111-309).

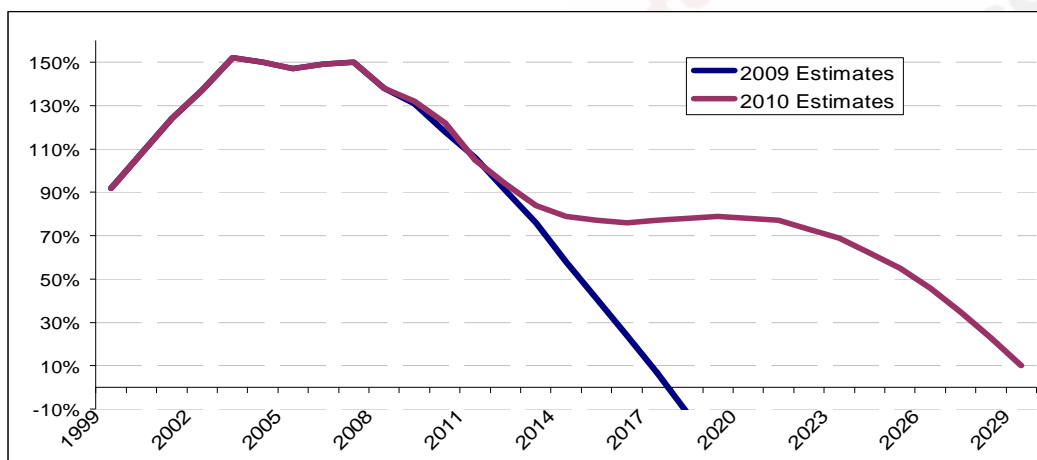
²³ After the beneficiary and the prescription drug plan have spent a certain amount of money for covered drugs during a year, there is a gap in Part D coverage. During the coverage gap (also known as the “doughnut hole”), the beneficiary pays 100% of his or her prescription drug expenditures. Once a certain threshold is reached, Medicare again begins providing coverage.

Projected Date of HI Insolvency

Medicare's fiscal health is often gauged by the projected solvency of the HI trust fund.²⁴ The 2010 trustees report notes that the financial status of the HI trust fund has substantially improved since the last report due to the lower expenditures and higher tax revenues expected as a result of PPACA. These changes are estimated to postpone the exhaustion of the trust fund assets from 2017, as predicted in the prior report, to 2029 (see **Figure 4**). Since the impact of the PPACA productivity adjustments is relatively modest in the short term, there is only a minor difference in the expected trust fund exhaustion date provided in the *alternative illustration*—2028 or one year earlier than the current-law projections.

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

Estimates from 2009 and 2010 Trustees Reports



Source: Data from the 2009 Medicare Trustees Report, Table II.E1, and Summary of the 2010 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart A.

Beginning in 2004, *tax* income (from payroll taxes and from the taxation of Social Security benefits) began to be less than expenditures. 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 2019.) 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*). The 2010 trustees report estimates a large deficit for 2010, due primarily to the recession's continued impact on payroll taxes. After 2010, the report predicts declining deficits from 2011 through 2013, and small surpluses from 2014 through 2019 as the tax revenues increase with the expected economic recovery and the PPACA provisions that reduce spending and increase revenue begin to take effect.

The trustees project that expenditures will again begin exceeding income starting in 2020, as the baby boom generation begins to age into Medicare. Interest income on the trust fund assets is expected to be enough to make up for the deficit; however, beginning in 2022, the HI trust fund

²⁴ For a history of projections of insolvency dates, see CRS Report RS20946, *Medicare: History of Part A Trust Fund Insolvency Projections*, by Patricia A. Davis.

will again need to redeem its assets (U.S. government securities) in order to pay for benefits. The drawdown of assets will be required to meet expenditures each year until the trust fund is exhausted in 2029. At that time there will be insufficient funds to fully pay for Part A benefits. Unless action is taken prior to that date to increase revenue or decrease expenditures, Congress would need to pass legislation that would provide for another source of funding (e.g., general revenues or increased taxes) to make up for these deficits.

Long-Range Financial Soundness (75 Years)

For projections beyond 2019, 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, 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 (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; 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 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

Long-range financial soundness 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 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

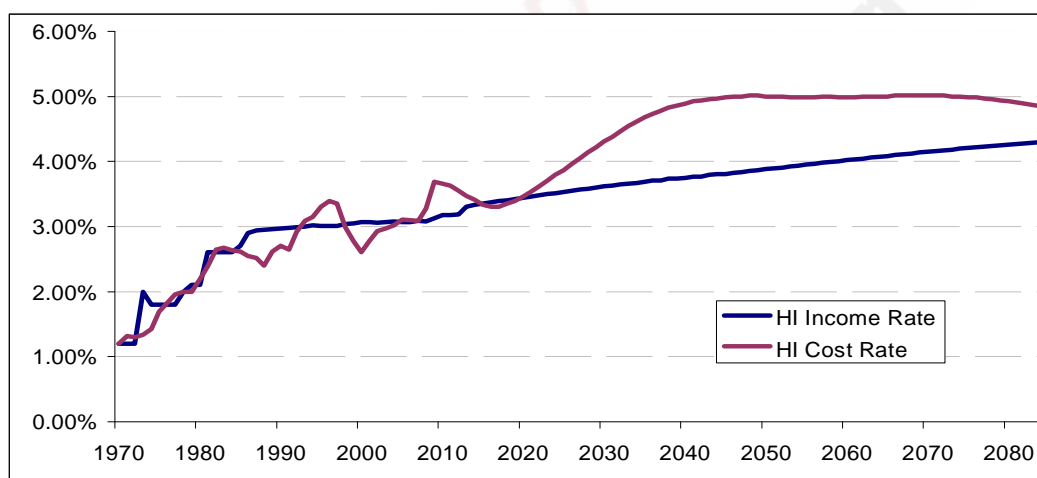
In the past, *cost rates* have generally increased over time, rising from 0.94% in 1967 to 3.39% in 1996 (see **Figure 5**). This growth reflects both the more rapid rate of increase in medical care costs than in average earnings subject to HI taxes and the higher rate of increase in the number of HI beneficiaries than in the number of covered workers. Cost rates since 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 Modernization Act of 2003. Rates increased again in 2008 and 2009 (3.27% and 3.69%) due to the lower amount of taxable payroll reflecting the impact of the recession. In future years, the 2010 trustees report projects that

expenditures as a percentage of taxable payroll will increase over the long run, from 3.69% in 2009 to 4.92% in 2080. (Under the *alternative illustration*, the expected HI cost rate for 2080 is 8.88%.)

The HI *income rate* is projected to increase gradually from 3.13% in 2009 to 4.26% in 2080 due to PPACA's increase in payroll taxes for high income earners starting in 2013. Because the thresholds 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 increase over time.

As indicated earlier, expenditures in the short term are expected to exceed tax income over the next several years (2014-2019). In 2020, deficits are again expected, with the highest level occurring in 2045, at which time there will be a difference of 1.18% between the cost and income rates. In 2029, payroll taxes are expected to cover 85% of HI expenditures, decline to 77% by 2050; and by the end of the 75-year period, taxes are expected to cover 89% of the expected costs. The decreasing cost rate beyond 2045 is due to the expected compounding of the PPACA reductions in provider payment updates.

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



Source: Data from Summary of the 2010 Annual Reports of the Social Security and Medicare Boards of Trustees, <http://ssa.gov/OACT/TRSUM/index.html>, Chart C.

The 2010 trustees report estimates that at the end of the 75-year period (in 2084), there will be an HI deficit of 0.55% of taxable payroll. Under the *illustrative alternative* scenario, which assumes that the PPACA productivity adjustments will eventually be phased out, the HI deficit at the end of the 75-year period is expected to be about 4.84% of taxable payroll. Both estimates are significantly lower than the estimate in last year's report under prior law of 8.55%.

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 2010 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 4.49%. The difference, the *actuarial balance*, is -0.66%. 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 0.66% of taxable payroll throughout the next 75 years for the trust fund to reach actuarial balance, program spending would need to be reduced by a corresponding amount, or some combination of the two would need to occur. The HI actuarial balance estimated in the 2010 report has decreased from -3.88% of taxable payroll projected in the prior year's report, a reduction of 3.16%. If the productivity adjustments to HI provider price updates cannot be continued in the long run, the CMS actuaries estimate that the actuarial deficit would be much higher, -1.91% of taxable payroll under the *illustrative alternative* scenario.

Unfunded Obligations

The *unfunded obligation* is a measure of the long-term funding shortfall (or surplus) 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 2010 trustees report estimates that the unfunded obligation of the HI trust fund is \$2.4 trillion, or 0.3% of GDP over the next 75 years. This means that if \$2.4 trillion were added to (or expenditures reduced from) the trust fund at the beginning of 2010, the program could meet the projected cost of current-law expenditures over the next 75 years. This is substantially lower than last year's estimate of \$13.4 trillion. (Under the *illustrative alternative* projections, the 75-year HI unfunded obligation is expected to be about \$7.0 trillion.)

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. 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 2085. Under these assumptions, over the infinite horizon, the HI program is projected to have a surplus of \$0.6 trillion (see **Table 2**). (Under the *illustrative alternative* scenario, unfunded obligation through the infinite horizon is estimated to be \$22.5 trillion.)

Table 2. Unfunded HI Obligations

(Present values as of January 1, 2010)

	Present Value	% of GDP
Unfunded obligations through 2084	\$2.4 trillion	0.3%
Unfunded obligations through infinite horizon	-\$0.6 trillion	0.0%

Source: 2010 Medicare Trustees' Report, Table III.B10.

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, the 2010 trustees report estimates that SMI expenditures of \$27.4 trillion over the next 75 years will exceed premium revenues and state payments by \$20.1 trillion; general fund transfers of this amount will be needed to keep the SMI trust fund solvent for the next 75 years.²⁵

Table 3. Unfunded Part B and Part D Obligations

(Present values as of January 1, 2010; dollar amounts in trillions)

	SMI—Part B		SMI—Part D	
	Present Value	% of GDP	Present Value	% of GDP
Unfunded obligations through 2084	\$0.0	0.0%	\$0.0	0.0%
Expenditures through 2084	\$17.7	2.1%	\$9.7	1.2%
General Revenue Contributions	12.9	1.5	7.2	0.9
Beneficiary Premiums	4.8	0.6	1.5	0.2
State Transfers	—	—	1.0	0.1
Unfunded obligations through infinite horizon	\$0.0	0.0%	\$0.0	0.0%
Expenditures through infinite horizon	\$29.1	2.1%	\$21.2	1.5%
General Revenue Contributions	21.1	1.5	15.8	1.1
Beneficiary Premiums	7.9	0.6	3.3	0.2
State Transfers	—	—	2.1	0.2

Source: 2010 Medicare Trustees' Report, Tables III.C15 and III.C23.

The estimated present value of Part B expenditures through the infinite horizon is \$29.1 trillion, of which \$17.7 trillion would occur during the first 75 years. Approximately 27% of expenditures for each time period would be financed through beneficiary premiums and less than 0.3% 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 2009 to be substantially understated due to the large physician payment reductions scheduled under current law.) Similarly, the estimated present value of Part D

²⁵ These transfers represent a formal budget requirement under current law.

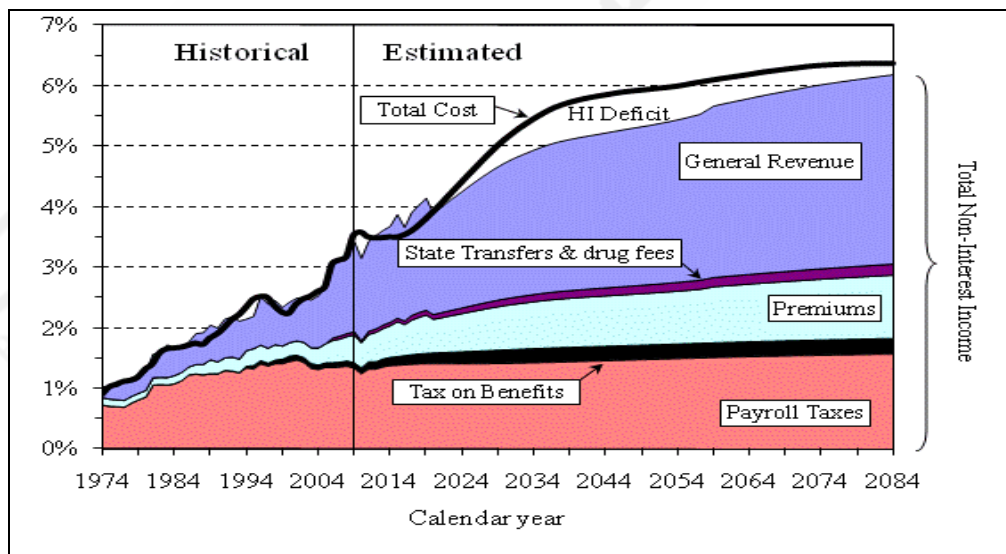
expenditures through the infinite horizon is \$21.2 trillion, of which \$9.7 trillion would occur during the first 75 years. Approximately 16% of expenditures would be financed through beneficiary premiums, 10% through state transfers, and the remaining 74% paid by general revenues.

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 cost 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 3.5% in 2009 to 5.5% of GDP in 2035 and to 6.4% in 2084. (By comparison, last year's report projected Medicare costs to increase to 7.2% of GDP by 2035 and reach 11.4% by the end of the 75 year projection period.) Under the *illustrative alternative*, similar to estimates made under prior law, projected Medicare costs are expected represent about 11% of GDP in 2084. (See **Appendix D** for a comparison of projections of Medicare expenditures as a percentage of GDP by the 2009 Trustees Report, the 2010 Trustees Report, and the Illustrative Alternative Scenario.)

General revenues and beneficiary premiums are expected to play an increasing role in financing the program over the next 75 years. **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 2010 Annual Reports of the Social Security and Medicare Boards of Trustees, <http://ssa.gov/OACT/TRSUM/index.html>, Chart D.

General revenue contributions are projected to increase from 1.4% of GDP in 2010 to 3.1% in 2084, and beneficiary premiums from 0.4% of GDP in 2010 to 1.0% in 2084. As shown, the share of Medicare income from payroll taxes and taxation of benefits is expected to fall substantially during that period (from 43% to 30%), while the share of general fund revenue is expected to rise

(from 43% to 51%) as would premiums (from 13% to 17%). Any excess in projected spending over revenues represents the HI deficit; in 2084, the HI deficit is projected to represent 0.2% of GDP.

Medicare Funding Warning

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, MMA 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). The 2006 trustees report projected that the 45% level would first be exceeded in FY2012; the 2007 report projected that it would first be exceeded in 2013, and both the 2008 and 2009 trustees reports project the first year at 2014. In the 2010 trustees report, the difference is projected to exceed 45% in FY2010; this represents the fifth consecutive time that the threshold was estimated to be exceeded within the first seven years of the projection. The 45% ratio is expected to be reached much earlier in the projection period in this year's report due to lower projected payroll tax income for 2010. However, changes made by PPACA affecting future Medicare spending are expected to reduce the ratio below 45% in years 2012 through 2021. (This is assuming the physician payment rate reductions go into effect.)

MMA requires that if an excess general revenue funding determination is made for two successive years, a "Medicare funding warning" is triggered, and the President must submit a legislative proposal to respond to the warning.²⁶ The Congress is required to consider the proposals on an expedited basis. However, passage of legislation within a specific time frame is not required. 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.²⁷ If the 112th Congress does not pass a similar measure, then the trigger provision would go back into effect in 2011 in the House.

²⁶ See CRS Report RS22796, *Medicare Trigger*, by Hinda Chaikind and Christopher M. Davis.

²⁷ H.Res. 5 declared that the accelerated legislative procedures required by MMA for a presidential legislative proposal in response to a Medicare funding warning shall 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. However, 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 also 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 \$2.7 trillion in present value terms.²⁸ 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. Additionally, general revenue transfers in present value terms of \$20.1 trillion are expected to be needed to cover SMI expenditures over the next 75 years.²⁹ 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 17.7% in 2009 to 26.6% in 2080 (see **Table 4**).

As previously described, PPACA contains numerous provisions that are expected to reduce Medicare spending growth (both HI and SMI) in future years. From the trust fund perspective, the slower growth in HI spending, coupled with payroll tax increases, is expected to extend the solvency of the HI trust fund for an additional 12 years beyond that projected in last year's report (see "Projected Date of HI Insolvency"). From a federal budget perspective, these expected savings represent a reduction in expected future federal spending compared to spending levels estimated before the passage of PPACA. Medicare savings (reduced expenditures) can be used to fund new, or supplement existing, government programs, given all other expenditure projections are unchanged.

Both CBO and the CMS Office of the Actuary caution against combining trust fund accounting conventions with budget accounting rules. Reductions in Medicare expenditures can be used to extend the solvency of the HI trust fund *or* used to offset other costs of the federal government; using both accounting methods at the same time would result in double-counting a large share of those savings. CBO concluded that "(i)n effect, the majority of the HI trust fund savings under [PPACA] and [the Reconciliation Act] would be used to pay for other spending and therefore would not enhance the ability of the government to pay for future Medicare benefits."³⁰

²⁸ The federal liability from a budget perspective includes the beginning accumulated assets in the HI trust fund (\$0.3 trillion, as of January 1, 2010) as they represent federal payment obligations. The net 75-year unfunded liability from the trust fund perspective of \$2.4 trillion in present value terms, does not include the trust fund assets. (See "Unfunded Obligations".)

²⁹ This amount could be substantially higher than that if Congress modifies the physician payment system to eliminate scheduled payment reductions.

³⁰ CBO letter to Rep. Paul Ryan, March 19, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11376/RyanLtrhr4872.pdf>.

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

Fiscal Year	Percentage of Income Taxes 2009 Report	Percentage of Income Taxes 2010 Report
<i>Historical</i>		
1970	0.8%	0.8%
1980	2.2	2.2
1990	5.9	5.9
2000	5.4	5.4
2008	10.9	12.0
2009	n/a	17.7
<i>Intermediate Estimates</i>		
2010	12.2	18.6
2020	15.8	15.0
2030	24.0	19.5
2040	28.9	21.8
2050	31.9	22.7
2060	35.1	24.6
2070	38.1	25.7
2080	40.5	26.6

Source: 2009 and 2010 Medicare Trustees reports, Table III.C4.

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

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 2010 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, CBO recently noted that the growth in spending on federal health care programs, including Medicare, remains the “central fiscal challenge facing the nation.”³¹

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,

³¹ “Long-Term Budget Outlook,” Congressional Budget Office Director’s Blog, June 30, 2010, <http://cboblog.cbo.gov/?p=1112>.

shifts in the health status of the population, or changes in the way health services are delivered could result in very different financial outcomes from those estimated in the trustees report.³² Further, as evidenced by the issuance of an illustrative alternative to the 2010 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 regardless of cost; except for constraints placed on the program by the HI financing mechanism, there are no limits on overall Medicare spending. As such, policy options to restrain the growth of Medicare costs will continue to attract considerable interest. The challenge to policy makers will be to slow the growth in Medicare costs 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.

³² 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 of the cost of that care.

Appendix A. Operation of the Hospital Insurance Trust Fund

**Table A-1. Operation of the Hospital Insurance Trust Fund,
Calendar Years 1970-2019**
(\$ in billions)

Year	Income			Expenditures			Trust Fund	
	Payroll Taxes	Interest, Transfers, Other	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
<i>Historical Data</i>								
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	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	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
<i>Intermediate Estimate</i>								
2010	184.5	33.1	217.6	245.9	3.4	249.3	-31.7	272.5
2011	205.5	35.9	241.5	255.6	3.7	259.3	-17.8	254.7
2012	217.4	37.0	254.4	267.3	4.0	271.2	-16.8	237.9
2013	237.7	39.4	277.0	278.1	4.4	282.5	-5.5	232.4
2014	255.5	41.7	297.2	291.1	4.9	296.0	1.2	233.6
2015	270.9	45.0	315.9	299.7	5.4	305.0	10.8	244.4
2016	287.2	49.4	336.6	315.3	5.9	321.2	15.4	259.8

Year	Income			Expenditures			Trust Fund	
	Payroll Taxes	Interest, Transfers, Other	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
2017	303.0	54.1	357.2	331.8	6.5	338.2	19.0	278.8
2018	318.8	59.1	377.9	350.9	7.0	357.9	20.0	298.8
2019	333.9	63.9	397.9	372.1	7.6	379.7	18.2	317.0

Source: 2010 Medicare Trustees Report, Table III.B4.

Notes: Sums may not equal totals due to rounding.

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

Table B-1. Operation of the Part B Account of the SMI Trust Fund, Calendar Years 1970-2019

(\$ in billions)

Year	Income				Expenditures			Trust Fund	
	Premiums	General Revenue	Other	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
<i>Historical Data</i>									
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
<i>Intermediate Estimates</i>									
2010	51.2	149.7	2.8	203.7	217.3	2.9	220.1	-16.4	59.1
2011	58.4	172.2	4.4	235.0	212.2	3.0	215.3	19.7	78.9
2012	65.7	192.0	6.5	264.2	222.6	3.3	225.9	38.4	117.2
2013	71.9	206.6	9.0	287.5	238.4	3.6	242.1	45.4	162.7
2014	79.0	221.1	12.2	312.2	255.8	4.0	259.8	52.4	215.1
2015	92.9	255.4	15.4	363.8	271.3	4.4	275.8	88.0	303.1
2016	84.4	229.8	19.2	333.4	288.3	4.9	293.2	40.2	343.3
2017	100.1	270.8	24.5	395.4	308.7	5.4	314.0	81.3	424.7
2018	110.6	295.4	29.7	435.7	332.2	5.8	338.0	97.7	522.3
2019	121.6	321.1	34.4	477.0	358.8	6.3	365.0	112.0	634.4

Source: 2010 Medicare Trustees Report, Table III.C8.

Notes: Sums may not equal totals due to rounding; changes in the SMI-B account are not shown because of the automatic annual adjustments in program income to meet the following year's projected expenditures.

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

Table C-1. Operation of the Part D Account in the SMI Trust Fund, Calendar Years 2004-2019

(\$ in billions)

Year	Income				Expenditures			Trust Fund	
	Premiums	General Revenue	Transfers from States	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
<i>Historical Data</i>									
2004		\$0.4		\$0.4	\$0.4		\$0.4	—	—
2005		1.1		1.1	1.1		1.1	—	—
2006	\$3.5	39.2	\$5.5	48.2	47.1	\$0.3	47.4	\$0.8	\$0.8
2007	4.0	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	60.9	60.5	0.3	60.8	0.1	1.1
<i>Intermediate Estimates</i>									
2010	6.4	50.8	4.2	61.4	61.8	0.2	62.0	-0.6	0.5
2011	8.0	55.4	8.0	71.5	71.0	0.3	71.2	0.3	0.7
2012	10.1	59.2	9.2	78.5	78.2	0.3	78.4	0.0	0.8
2013	11.9	63.9	9.8	85.6	85.3	0.3	85.6	0.0	0.8
2014	13.4	69.3	10.3	93.0	92.7	0.3	93.0	0.0	0.9
2015	15.9	75.8	10.9	102.5	102.2	0.3	102.5	0.0	0.9
2016	16.5	84.3	11.7	112.6	112.2	0.3	112.5	0.1	1.0
2017	18.9	91.9	12.7	123.5	123.1	0.3	123.4	0.1	1.1
2018	21.0	101.1	13.8	135.9	135.5	0.3	135.8	0.1	1.2
2019	23.4	111.5	15.0	150.0	149.5	0.4	149.9	0.1	1.3

Source: 2010 Medicare Trustees Report, Table III.C19.

Notes: Sums may not equal totals due to rounding; changes in the SMI-D account are not shown because of the automatic annual adjustments in program income to meet the following year's projected expenditures.

Appendix D. Medicare Expenditures as a Percentage of GDP

Table D-1. Projected HI and SMI Expenditures as a Percentage of GDP
Comparison of 2009 and 2010 Medicare Trustees Reports and 2010 Alternative Scenario

Year	HI			SMI-B			SMI-D ^a		Total Medicare		
	2009 Report (prior law)	2010 Report (current law)	2010 Alternative Projection	2009 Report (prior law)	2010 Report (current law)	2010 Alternative Projection	2009 Report (prior law)	2010 Report (current law)	2009 Report (prior law)	2010 Report (current law)	2010 Alternative Projection
2009	1.71%	1.67%	1.67%	1.44%	1.45%	1.45%	0.43%	0.41%	3.59%	3.53%	3.53%
2010	1.71	1.66	1.66	1.38	1.49	1.50	0.45	0.43	3.54	3.59	3.59
2020	2.05	1.63	1.63	1.76	1.61	1.98	0.71	0.67	4.53	3.91	4.28
2030	2.75	1.99	2.09	2.30	2.10	2.91	1.08	1.02	6.43	5.11	6.02
2040	3.43	2.24	2.62	3.15	2.30	3.52	1.28	1.21	7.96	5.76	7.34
2050	3.85	2.27	2.94	3.47	2.33	3.89	1.42	1.35	8.74	5.94	8.17
2060	4.21	2.23	3.23	3.82	2.39	4.30	1.57	1.50	9.60	6.12	9.03
2070	4.61	2.21	3.57	4.16	2.45	4.73	1.69	1.63	10.46	6.29	9.93
2080	4.96	2.17	3.87	4.43	2.47	5.07	1.80	1.75	11.18	6.37	10.70

Source: Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers, August 5, 2010, Tables 2, 4 and 5, and 2009 and 2010 Reports of the Medicare Trustees, Table III.A2.

a. Illustrative Scenario assumed no changes to current law affecting Part D; alternative projection same as projections in 2010 Report.

Author Contact Information

Patricia A. Davis
Acting Section Research Manager/Specialist in
Health Care Financing
pdavis@crs.loc.gov, 7-7362



<http://www.crsdocuments.com>

GalleryWatch.com™