Medicare Financing

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Summary

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

The 2012 report of the Medicare Board of Trustees estimates that the HI trust fund will become insolvent in 2024, the same as it had predicted in the 2011 report. This recent projection still postpones depletion further in the future than the year of 2017, as projected in the 2009 report prior to the passage of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended, but earlier than the 2029 date estimated in the 2010 report immediately after the ACA's enactment. Because of the way it is financed, the SMI fund cannot face insolvency; however, the trustees project that SMI expenditures will continue to grow rapidly, and thus place increasing demands on Medicare beneficiaries and all taxpayers. The trustees estimate that total Medicare costs will increase from 3.7% of GDP in 2011 to 6.7% in 2086.

Although the Medicare trustees report that the financial outlook for the Medicare program appears to have improved as a result of ACA, 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. As such, as it has done each year subsequent to the enactment of ACA, the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary issued a supplemental analysis that provides projections based on an "illustrative alternative" to current law.

This report will be updated upon receipt of the 2013 trustees report or as circumstances warrant.

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Introduction

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

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

Medicare serves approximately one in seven Americans and virtually all of the population aged 65 and over. In 2011, the program covered 48.7 million persons (40.4 million aged and 8.3 million disabled) at a total cost of about $549 billion, accounting for about 20% of national health spending and 3.7% of Gross Domestic Product (GDP). Medicare is an entitlement program, which means that it is required to pay for covered services provided to enrollees so long as specific criteria are met.

Since 1965, the Medicare program has undergone considerable change. Most recently, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148), as amended 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.[3] 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 ACA also established a new Independent Payment Advisory Board (IPAB), which, beginning in 2014, is required to make recommendations to reduce Medicare spending in years in which Medicare costs are projected to exceed a target growth rate.[4] The legislation did not, however, make changes to the physician sustainable growth

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

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

[3] 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.

[4] The board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The board is prohibited from making proposals that ration care, raise taxes, increase Part B premiums, or (continued...)

rate (SGR) payment system; unless Congress takes action in 2012, reductions in physician payment rates of close to 31% will be required beginning January 1, 2013.[5] Additionally, unless Congress passes alternative legislation later this year to block automatic cuts required under the Budget Control Act of 2011 (BCA, P.L. 112-25), a 2% reduction in Medicare benefit spending will be required each year from CY2013 through CY2021.[6]

This report provides an overview of how the Medicare program is financed, including a description of the Medicare trust funds and a summary of key findings and estimates from the 2012 Report of the Medicare Board of Trustees regarding 2011 program operations and future financial soundness.[7]

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.

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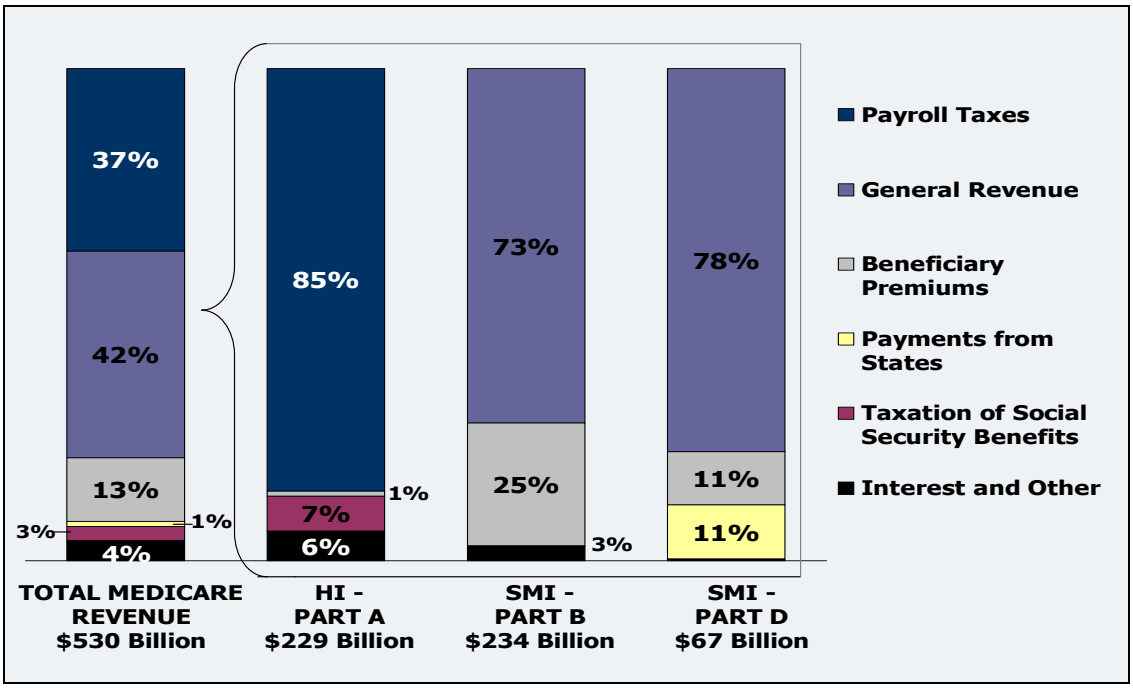
change Medicare benefits, eligibility, or cost-sharing. For additional information on IPAB, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

[5] Congress has overridden these required reductions in every year since 2003, most recently by the Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96) signed February 22, 2012. See CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn and Janemarie Mulvey.

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

[7] 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads//tr2012.pdf.

Figure 1. Sources of Medicare Revenue: 2011



Source: 2012 Report of the Medicare Trustees, Table II.B1.

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

Hospital Insurance (HI) Trust Fund

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

Similar to the Social Security system, the HI portion of Medicare was designed to be self-supporting, and is financed through dedicated sources of income rather than relying on general tax revenues. The primary source of income credited to the HI trust fund is *payroll taxes* paid by employees and employers; each pays a tax of 1.45% on earnings. The self-employed pay 2.9%. Unlike Social Security, there is no upper limit on earnings subject to the tax.[8] ACA imposes an additional tax of 0.9% on high-income workers with wages over $200,000 for single filers, and $250,000 for joint filers effective for taxable years beginning in 2013.[9] (ACA also imposes an additional tax on unearned income, beginning in 2013; however, this tax is not credited to the trust fund.)[10]

[8] 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.

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

[10] See CRS Report R41413, *The 3.8% Medicare Contribution Tax on Unearned Income, Including Real Estate Transactions*, by Mark P. Keightley, and the 2012 Medicare Trustees Report, page 24 including footnote 14, (continued...)

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;[11] 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.[12] (Interest on these securities is also credited to the trust funds.) The tax income exchanged for these securities then goes into the general fund of the Treasury and is indistinguishable from other cash in the general fund; this cash may be used for any government spending purpose. When payments for Medicare Part A benefits are made, the payments are paid out of the general treasury, and a corresponding amount of securities is deleted from (written off) the HI trust fund.

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

As long as the HI trust fund has a balance, the Treasury Department is authorized to make payments for Medicare Part A services. To date, the HI trust fund has never run out of money (i.e., become insolvent), and there are no provisions in the Social Security Act that govern what would happen if that were to occur. For example, there is no authority in law for the program to use general revenue to fund Part A services in the event of such a shortfall. Since the beginning of the Medicare program, the payroll tax rate has been adjusted periodically by Congress as one of the mechanisms to maintain the financial adequacy of the HI trust fund.[13]

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 within the SMI trust fund: one for Part B, to cover physician services, outpatient hospital care, some home health services, 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

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https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads//tr2012.pdf#page=30.

[11] 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.

[12] 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.

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

relies primarily on general tax revenues and beneficiary premiums as revenue sources. Beginning in 2011, additional revenues from an annual fee imposed on certain manufacturers and importers of branded prescription drugs (including biological products and excluding orphan drugs) are credited to the SMI trust fund.[14]

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. 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 2012 monthly premium is $99.90 for most Medicare Part B enrollees,[15] and individuals who receive 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 ACA, the income thresholds used to determine which beneficiaries are subject to higher Part B premium rates will be frozen at 2010 levels through 2019. Over time, this freeze will result in a larger number of beneficiaries paying the higher premiums and is expected to bring in increased revenue to the SMI trust fund.

Part D Financing

Medicare Part D is primarily financed through a combination of beneficiary premiums and federal general revenues. In addition, certain transfers are made from the states. These transfers, referred to as "clawback payments," represent a portion of the amounts states could otherwise have been expected to pay for drugs under Medicaid if drug coverage for the dual-eligible population (those who qualify for both Medicare and Medicaid) had not been transferred to Part D.

In 2012, the base monthly premium is $31.08; however, beneficiaries pay different premiums depending on the plan they have selected (and whether they are entitled to low-income premium subsidies). Part D premium payments may be automatically deducted from Social Security benefit checks, paid directly to the prescription drug plan sponsor, or made through an electronic

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

[15] 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 paid a standard premium of $115.40 in 2011; these include those who were subject to the high income premium adjustments, those eligible for both Medicare and Medicaid (dual-eligibles), those who do not participate in Social Security, and new Part B enrollees. For additional detail, see CRS Report R40561, *Interactions Between the Social Security COLA and Medicare Part B Premiums*, by Jim Hahn and Alison M. Shelton.

funds transfer.[16] Premiums for the Part D program are required to cover 25.5% of standard benefit costs; however, as recipients of the Part D low-income subsidies are not required to pay premiums, premiums covered only about 11% of Part D program costs in 2011 (see **Figure 1**). As required by ACA, beginning in 2011, high-income Part D prescription drug program enrollees are required to pay higher premiums similar to high-income Part B enrollees; the income thresholds are set at the same levels as those under Part B and frozen in the same manner through 2019.

Board of Trustees

The Medicare Board of Trustees was established under the Social Security Act to oversee the financial operations of the HI and SMI trust funds. By law, the six-member Board is composed of the Secretary of the Treasury, the Secretary of Health and Human Services, the Secretary of Labor, the Commissioner of Social Security, and two public members (not of the same political party) nominated by the President and confirmed by the Senate.[17] The Secretary of the Treasury is the Managing Trustee. The Administrator of the Centers for Medicare & Medicaid Services (CMS) is designated Secretary of the Board.

Annual Trustees Report

The Medicare Board provides an annual report to Congress on the operations of the trust funds. Financial projections included in the report are made by CMS actuaries using major economic and other assumptions selected by the trustees based on current law. Among the variables used are 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 2012 report of the Medicare trustees was issued April 23, 2012.[18] However, the report warned that estimates based on current-law assumptions may not be realistic. As such, actuaries of CMS conducted a separate analysis that provides projections based on an "illustrative alternative" to current law.[19] The alternative estimates are based on the assumption that the economy-wide

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

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

[18] The 2012 report includes data on actual expenditures and income through 2011, and projections for years 2012 and beyond. 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads//tr2012.pdf.

[19] Appendix C: *Illustrative Alternative Projections*, 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads//tr2012.pdf#page=221; and, memo from John D. Shatto and M. Kent Clemens, CMS Office of the Actuary, "Projected Medicare Expenditures Under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers," May 18, 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2012TRAlternativeScenario.pdf.

productivity adjustments mandated by ACA would be made through 2019, but then would be phased out from 2020 through 2034, and that IPAB recommendations for cost reductions would not be implemented The alternative scenario also assumes that, instead of being cut, physician payments will grow annually by 1% each year.

In 2010, the Board of Trustees convened 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. The panel members met in November 2010 and issued an interim report in February 2011.[20] In particular, the panel noted "the extreme difficulty involved in developing a long-range average per capita growth assumption, due to the many uncertainties that surround not only the long-term evolution of the U.S. health care system but also its interaction with the provisions of (ACA)." While the panel was not able to recommend changes in time for use in the development of the 2011 Medicare trustees report, the 2012 report incorporated short-term assumptions and long-range cost projection methods recommended by the panel. The use of these new methods increased projected short-range costs compared to projections in the prior report; however, these increased costs are expected to be offset by the 2% Medicare benefit spending reductions under BCA from 2013 through 2021. The new methods also increased the projected long-term growth rate by 0.3 percentage points.

2011 Medicare Program Operations

In calendar year (CY) 2011, Medicare provided about 48.7 million beneficiaries with benefits at a total cost of about $549 billion, or $12,042 per enrollee. (See **Appendix A**, **Appendix B,** and **Appendix C** for historical and projected enrollment, total Medicare income and expenditures, and per capita expenditures.) Because HI and SMI have different funding mechanisms, a description of each fund's 2011 operations is presented separately below.

Hospital Insurance Trust Fund Operations in 2011

As shown in **Table 1**, in CY2011, total income to the HI trust fund was $228.9 billion. Payroll taxes of workers and their employers accounted for $195.6 billion (85.5%), 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 $256.7 billion; most of which was for benefit costs, and about 1.5% was for administrative expenses. Similar to 2008, 2009, and 2010, expenditures again exceeded income in 2011, and the trust fund balance was reduced from $271.9 billion at the end of 2010 to $244.2 billion at the end of 2011 (a loss of $27.7 billion).[21] (See **Appendix D** for funding amounts in prior years and estimates for future years.)

[20] 2010 Technical Review Panel on the Medicare Trustees Report, "Review of the Long Range Assumptions of the Medicare Trustees' Projections Interim Report," February 2011, http://aspe.hhs.gov/health/medpanel/2010/interim1103.shtml.

[21] In comparison, in CY2010, total income was $215.6 billion and total disbursements were $247.9 billion; this represents an increase in income of $13.3 billion (increase of 6.2%) and a growth in expenditures of $8.8 billion (increase of 3.5%) from 2010 to 2011.

Table 1. Medicare Data for Calendar Year 2011

	HI - Part A	SMI - Part B	SMI - Part D	Total Medicare
Enrollment (millions)				
Aged	40.0	37.5	n/a	40.4
Disabled	8.3	7.4	n/a	8.3
Total	48.3	44.9	35.7	48.7
Average expenditures per enrollee	**$5,232**	**$4,940**	**$1,870**	**$12,042**
Trust Fund Balance at end of 2010 (billions)	**$271.9**	**$71.4**	**$0.7**	**$344.0**
Total Income	**$228.9**	**$233.6**	**$67.4**	**$530.0**
Payroll Taxes	195.6	—	—	195.6
Interest	12.0	3.2	0.0	15.2
Taxation of Benefits	15.1	—	—	15.1
Premiums	3.3	57.5	7.7	68.5
General Revenue	0.5	170.2	52.6	223.3
Transfers from States	—	—	7.1	7.1
Other	2.4	2.7	—	5.1
Total Expenditures	**$256.7**	**$225.3**	**$67.1**	**$549.1**
Benefits	252.9	221.7	66.7	541.3
Hospital	132.7	35.1	—	167.8
Skilled Nursing	32.9	—	—	32.9
Home Health Care	7.3	12.4	—	19.6
Physician Services	—	67.6	—	67.6
Private plans (Part C)	64.6	59.1	—	123.7
Prescription Drugs	—	—	66.7	66.7
Other	15.4	47.5	—	62.9
Administrative Expenses	$3.8	$3.6	$0.4	$7.8
Net Change	-$27.7	$8.3	$0.3	-$19.2
Trust Fund Balance at end of 2011	**$244.2**	**$79.7**	**$1.0**	**$324.9**

Source: 2012 Report of Medicare Trustees, Table II.B1.

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

Supplementary Medical Insurance Trust Fund Operations in 2011

In CY2011, the SMI trust fund (Part B and Part D accounts combined) brought in $301.0 billion in revenue ($233.6 billion from Part B and $67.4 billion from Part D), and expended $292.4 billion ($225.3 billion from Part B and $67.1 from Part D). General revenues accounted for 74.0% of total revenues, and premiums accounted for 21.7%.[22] (See **Table 1** for 2011 Parts B and D operations data.)

Of the $233.6 billion in income to Part B, general revenues accounted for $170.2 billion (72.9%), premiums accounted for $57.5 billion (24.6%), and interest and other income made up the remaining $5.9 billion (2.5%). The program paid out $225.3 billion; similar to HI, almost all of this amount was used to cover benefits and 1.6% covered administrative expenses.[23] (See **Appendix E** for historical and projected income and expenditures in the SMI Part B account.)

Of the $67.4 billion in Part D income, general revenues accounted for $52.6 billion (78.0%), premiums accounted for $7.7 billion (11.4%), and transfers from states for $7.1 billion (10.5%). Almost all of the 2011 Part D program expenditures of $67.1 billion were used to pay benefit costs and 0.6% was used for administrative expenses.[24] (See **Appendix F** for historical and projected income and expenditures in the SMI Part D account.)

Short-Range Financial Soundness (10 Years)

The 2012 Medicare trustees report predicts a slightly higher growth rate of Medicare expenditures compared to their projections in last year's report. Over the next 10 years, total Medicare expenditures are projected to increase at an average annual rate of 6.2% compared to 6.0% as projected in the prior report.[25] The 2012 report estimates that Medicare spending will grow from $549.1 billion in 2011 to $1.0 trillion in 2021 (see **Figure 2** and **Appendix B**). The average growth rate reflects the expected growth in the number of individuals eligible for Medicare as well as expected increases in utilization and complexity of services per beneficiary and in the prices of those services. The growth rate also factors in ACA changes that affect cost growth rates, such as the productivity adjustments to the annual payment updates to certain providers and changes in payments to Medicare Advantage plans. These growth rates also assume that the scheduled physician payment reductions of about 31% in 2013 will go into effect.

[22] In comparison, in CY2010, total income for SMI was $270.5 billion and total expenditures were $274.9 billion. This represents a growth in SMI expenditures of $17.5 billion, or an increase of 6.4%, from 2010 to 2011.

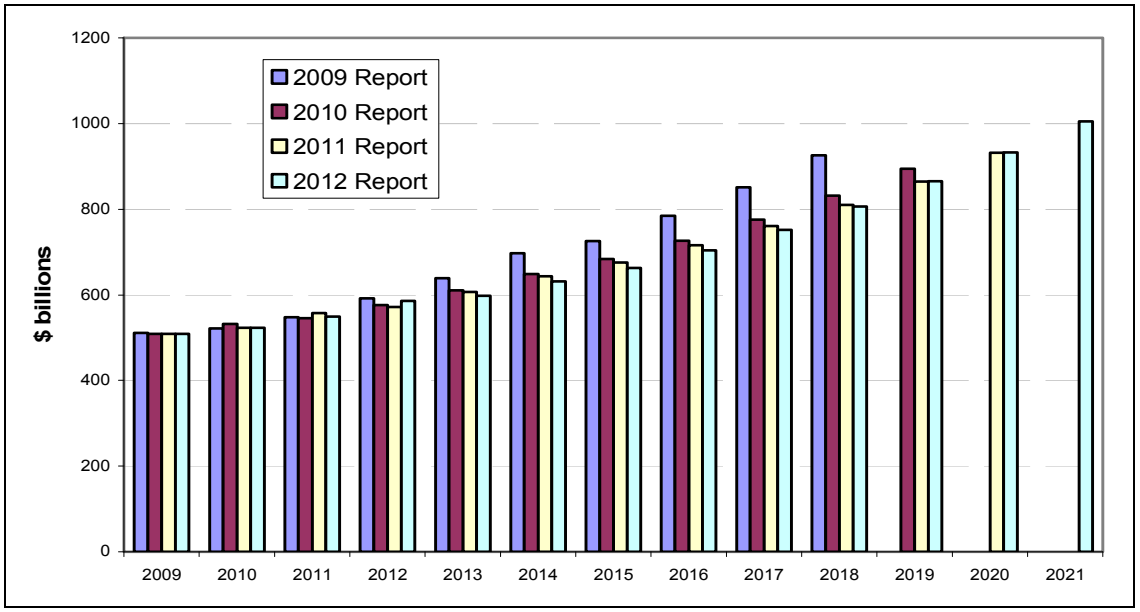
[23] This represents an expenditure increase of 5.8% over the $212.9 billion in Part B expenditures in 2010.

[24] The 2010 Part D expenditures represent an 8.2% growth over the 2010 expenditures of $62.0 billion.

[25] By comparison, Medicare expenditures grew at an average annual rate of 8.1% from 1985 to 2011.

Figure 2. Medicare Expenditures

Comparison of Estimates of 2009, 2010, 2011, and 2012 Medicare Trustees Reports



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

Notes: The 10-year projection window for the 2009 report only extended to 2018; there are no corresponding projections for 2019 through 2021. Similarly, the 2010 and 2011 report projections only extend to 2019 and 2020, respectively.

HI Short-Range Financial Status

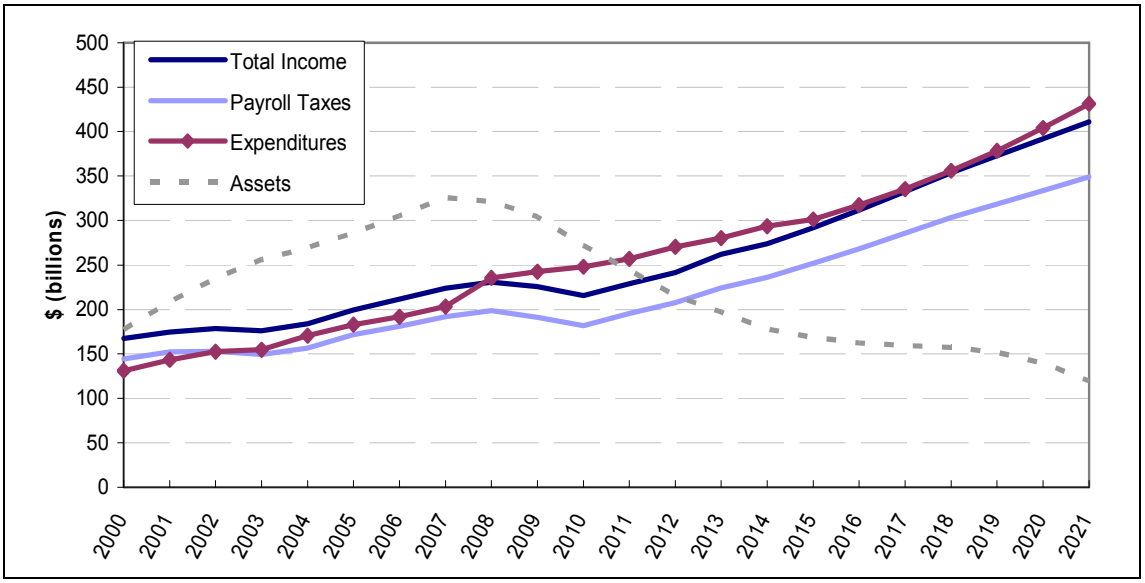
In the short term, the adequacy of the HI trust fund is determined by comparing its assets at the beginning of the year to expected costs for that year. The trustees consider the fund to be adequate if the level of assets is expected to be at least equal to projected costs in a year.[26] The trustees note that the HI fund is not adequately financed over the next 10 years. Specifically, the new report states that the fund fails to meet the short-range (i.e., 10-year, 2012-2021) test of financial adequacy because total HI assets at the start of the year ($244.2 billion) are expected to be below 100% of expenditures during 2012. The trustees also project that the ratio of trust fund assets to expenditures will decline steadily through 2021.

HI expenditures have exceeded income every year since 2008 and are projected to continue doing so under current law over the next 10 years. In 2009 and 2010, income from payroll taxes decreased substantially due to higher unemployment and slow growth in wages. In 2011, revenues increased somewhat, but did not keep pace with the growth in expenditures resulting from increased utilization and updates to provider payment rates. In 2011, the HI trust fund experienced a deficit of $27.7 billion.

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

Income from payroll taxes is expected to increase at a faster rate than expenditures during 2012 through 2018 due to the projected economic recovery, the application of an additional 0.9% HI payroll tax for high-income enrollees beginning in 2013, and the 2% reduction in spending required by BCA from 2013 through 2021. Specifically, over the next 10 years, HI income is expected to grow on average by 6.0% per year, while expenditures are expected to grow on average at a rate of 5.3% per year. However, income will still be insufficient to cover projected HI expenses during this period (see **Figure 3**).

Figure 3. Short-Term HI Expenditures and Income



Source: Data from 2012 Report of Medicare Trustees, Table III.B4.

Note: The trustees report does not project dollar figures beyond 2021.

SMI Short-Range Financial Status

As premium and general revenue income for Medicare Parts B and D are reset each year to match expected costs, the SMI trust fund is deemed to be adequately financed over the next 10 years and beyond. However, over the past five years, Medicare Part B costs have been increasing rapidly—by an average of 5.9% annually, exceeding GDP growth by 3.4 percentage points. If the physician payment cuts are allowed to go into effect at the end of 2012, Part B expenditures (and corresponding income) are expected to grow at a slower average growth rate of 4.9% annually over the next five years (2012-2016), slightly lower than GDP growth over the same period (5.1%). If Congress overrides these reductions, as it has done in the past, the Part B growth rate during this period is projected to instead average about 7.1% each year. For Part D, annual average growth over the past five years has been around 7.2%; however, due to costs associated with the gradual elimination of the coverage gap and growth in the number of enrollees,[27] the

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

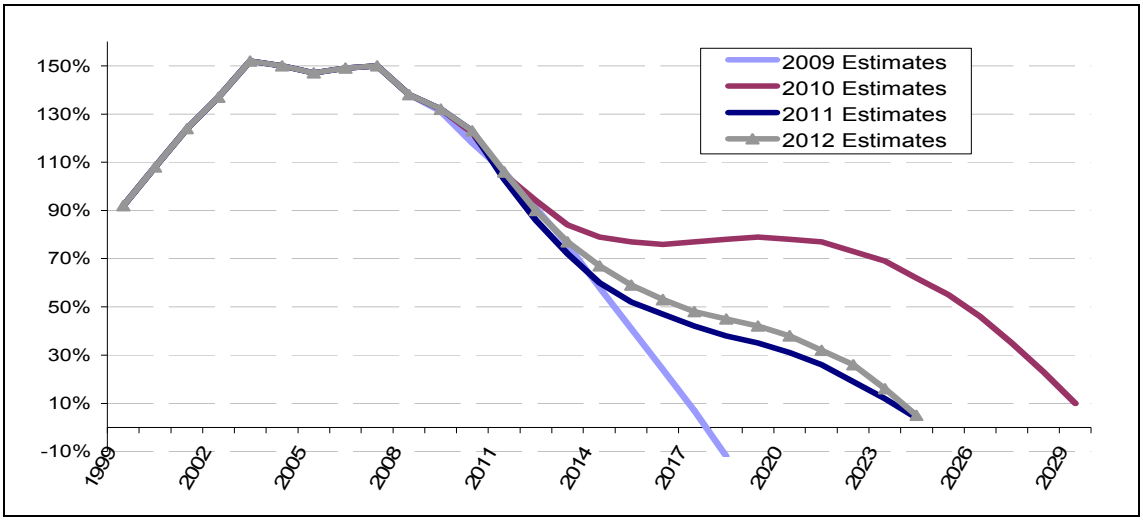
average annual increase in expenditures is estimated to be 8.8% through 2021.[28] (By comparison, GDP is projected to grow at an average annual rate of 5.0% during this 10-year period.) Part D cost estimates are somewhat lower than projected in the prior trustees report due to lower than expected spending in 2011, and future expectations of increased availability of generic drugs and reduced utilization due to slower economic growth.

Projected Date of HI Insolvency

Medicare's fiscal health is often gauged by the projected solvency of the HI trust fund.[29] As noted in the section "Medicare Trust Funds," in years in which the level of HI expenditures exceed income, the program still has authority to continue to make payments as long as the trust fund has a balance. The 2012 trustees report estimates that the HI trust fund will become insolvent in 2024, the same year as projected in last year's report (see **Figure 4**).

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

Estimates from 2009, 2010, 2011, and 2012 Trustees Reports



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

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 2021.) 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 trustees project that expenditures will continue to exceed income through 2024. Therefore, the HI trust fund will need to redeem its assets (U.S. government

[28] The average annual growth per enrollee is expected to be 5.6%.

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

securities) in order to pay for benefits each year until the trust fund is exhausted in 2024. At that time, there will be insufficient funds to fully pay for Part A covered health care services. Unless action is taken prior to that date to increase HI revenue or decrease expenditures, Congress would need to appropriate additional funding (e.g., through general revenue transfers) to make up for these deficits and to allow for full and on time payments to Part A providers.

Because the impact of the ACA productivity adjustments is relatively modest in the short term, the expected trust fund exhaustion date provided in the *alternative illustration* is the same as that under the current law scenario, 2024; however, the trust fund is projected to be depleted slightly earlier in the year under the alternate scenario.

Long-Range Financial Soundness (75 Years)

For projections beyond 2021, the Medicare trustees do not provide actual dollar figures due to the difficulty of making meaningful comparisons of dollar values for different time periods over a long timeframe. Instead, the long-term financial soundness of the Medicare program is generally determined using one or more of the following measures:

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

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

HI Income and Costs Relative to Payroll Taxes

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

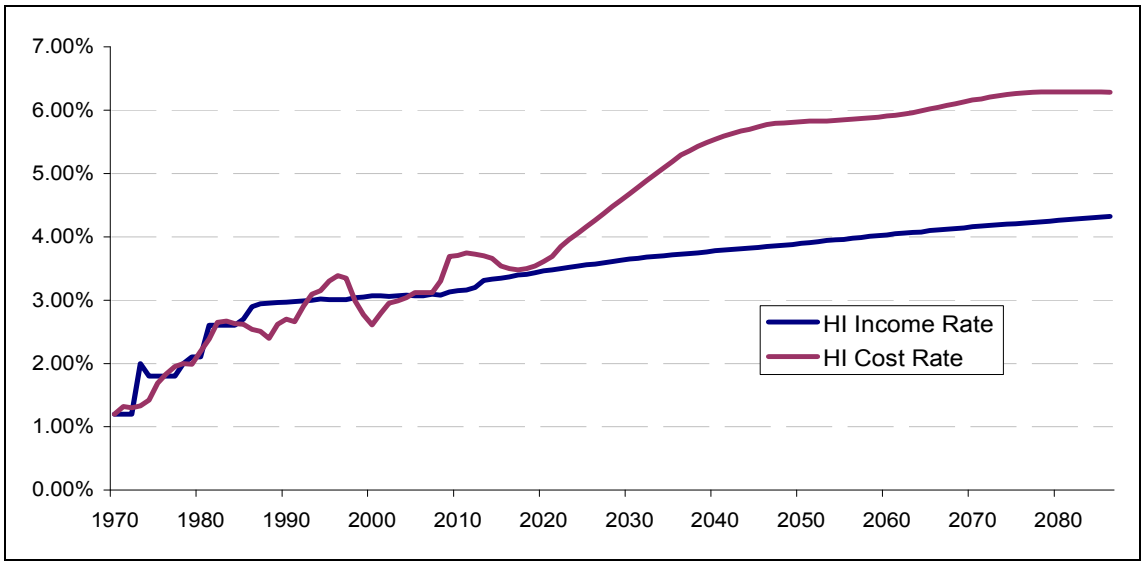
Year-by-Year Estimates

In the past, *cost rates* have generally increased over time, rising from 0.94% in 1967 to 3.39% in 1996 (see **Figure 5**). This growth reflects both the higher rate of increase in medical care costs than in average earnings subject to HI taxes and the higher rate of increase in the number of HI beneficiaries than in the number of covered workers. Cost rates 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 Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), as well as favorable economic performance. Rates increased again in 2008, 2009, 2010, and 2011 (3.30%, 3.69% and 3.71% and 3.75%, respectively) due to the lower amount of taxable payroll reflecting the impact of the recession and subsequent slow recovery. The 2012 trustees report projects that in the short-term, due to the expected economic recovery, the cost rate will decline from 2012 through 2017. Over the long run, expenditures as a percentage of taxable payroll are expected to increase, from 3.75% in 2011 to 6.29% in 2085, primarily due to the aging of the baby boom generation and expected growth in health care costs. (Under the *alternative illustration*, the expected HI cost rate for 2085 is 9.93%, about a third more than the rate projected under current law.)

The HI *income rate* is projected to increase gradually from 3.15% in 2011 to 4.31% in 2085 due to ACA's increase of 0.9% in payroll taxes for high-income earners starting in 2013. As 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 increases over time. (Because the *alternative illustration* only assumes changes in payments, the income rate is the same as that in the trustees report.)

As indicated earlier, expenditures in future years are expected to exceed tax income, resulting in a negative difference between cost and income rates. In 2024, payroll taxes are expected to cover 87% of HI expenditures, decline to 67% by 2045; and by the end of the 75-year period, taxes are expected to cover 69% of the expected costs. The decreasing cost rate beyond 2045 is due to the expected compounding of the ACA reductions in provider payment updates and assumed slowing of growth in the volume and intensity of services, coupled with the increased proportion of workers subject to the high income payroll tax mentioned above. The income rate and the first 10 years of the cost rate in the 2012 report are similar to that projected in the prior report. However, due to changes in the methodology based on recommendations of the Medicare Technical Review Panel, long-term cost-growth rate is assumed to grow more quickly than under the prior method.

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



Source: Data from Summary of the 2012 Annual Reports of the Social Security and Medicare Boards of Trustees, http://ssa.gov/oact/TRSUM/index.html, Chart B.

The 2012 trustees report estimates that at the end of the 75-year period, there will be an HI deficit of 1.96% of taxable payroll (compared to a projected deficit of 0.58% in the prior report). Under the *illustrative alternative* scenario, which assumes that the ACA productivity adjustments will eventually be phased out, the HI deficit at the end of the 75-year period is expected to be about 5.68% of taxable payroll. Both estimates are still lower than the 2009 report estimate of 8.55%, which was based on law prior to ACA.

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 2012 trustees report estimates that the summarized HI *income rate* for the entire 75-year period is 3.86% of taxable payroll and the summarized *cost rate* is expected to be 5.21%. The difference, the *actuarial balance*, is -1.35%. Because this is a negative number, the HI trust fund fails to meet the trustees' long-range test of actuarial balance. This means that the income rate would need to increase by 1.35% 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 2012 report has increased from -0.79% in the 2011 report, but is lower than the -3.88% of taxable payroll projected in the 2009 report. (The trustees note that if no changes in the payroll tax or HI spending occurs prior to 2024, then the required increase after that time would be 1.72% of taxable payroll.) If the productivity adjustments to HI provider payment updates cannot be

continued in the long run, the CMS actuaries estimate that the actuarial deficit would be much higher, -2.43% of taxable payroll, under their *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 2012 trustees report estimates that the unfunded obligation of the HI trust fund is $5.3 trillion (0.6% of GDP) over the next 75 years. This means that if $5.3 trillion were added to (or expenditures reduced from) the trust fund at the beginning of 2012, the program could meet the projected cost of current-law expenditures over the next 75 years. This is still lower than the 2009 estimate of $13.4 trillion, but higher than the $3.0 trillion in the 2011 estimate. (Under the *illustrative alternative* projections, the 75-year HI unfunded obligation is expected to be about $9.7 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 (through infinity). Such extended projections can help indicate whether the HI financial imbalance would be improving or continuing to worsen beyond the 75-year period. In making these estimates, the trustees assume that the current-law HI program, demographic, and economic trends used for the 75-year projection will continue indefinitely, except that average HI expenditures per beneficiary will increase at the same rate as GDP per capita less the productivity adjustments beginning in 2087. If the slower ACA price updates were to continue indefinitely, then the HI financial imbalance actually improves beyond the 75-year period. Under these assumptions, over the infinite horizon, the HI program is projected to have a deficit of $4.8 trillion (see **Table 2**). (Under the *illustrative alternative* scenario, the HI unfunded obligation thorough the infinite horizon is estimated to be $8.3 trillion.)

Table 2. Unfunded HI Obligations

(Present values as of January 1, 2012)

	Present Value	% of GDP
Unfunded obligations through 2086	$5.3 trillion	0.6%
Unfunded obligations through infinite horizon	$4.8 trillion	0.3%

Source: 2012 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, estimated SMI expenditures of $29.3 trillion over the next 75 years are expected to exceed premium revenues and state payments by $21.6 trillion; general fund transfers of this amount will be needed to keep the SMI trust fund in balance for the next 75 years.[30]

The estimated present value of Part B expenditures through the infinite horizon is $32.3 trillion, of which $20.2 trillion would occur during the first 75 years. Approximately 26% of expenditures for each time period would be financed through beneficiary premiums, and a fraction of a percent would be financed through fees collected related to brand-name prescription drugs. The remaining 73% is expected to be paid by general revenues. (However, as noted previously, the trustees consider Part B expenditures after 2012 to be substantially understated due to the large physician payment reductions scheduled under current law.) Similarly, the estimated present value of Part D expenditures through the infinite horizon is $19.2 trillion, of which $9.1 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.

Table 3. Unfunded Part B and Part D Obligations

(Present values as of January 1, 2012; dollar amounts in trillions)

	SMI—Part B		SMI—Part D	
	Present Value	**% of GDP**	**Present Value**	**% of GDP**
Unfunded obligations through 2086	$0.0	0.0%	$0.0	0.0%
Expenditures through 2086	$20.2	2.2%	$9.1	1.0%
General Revenue Contributions	14.8	1.6	6.8	0.7
Beneficiary Premiums	5.3	0.6	1.5	0.2
State Transfers	—	—	0.9	0.1
Fees related to brand-name drugs	0.1	0.0	—	—
Unfunded obligations through infinite horizon	$0.0	0.0%	$0.0	0.0%
Expenditures through infinite horizon	$32.3	2.2%	$19.2	1.3%
General Revenue Contributions	23.7	1.6	14.3	1.0
Beneficiary Premiums	8.5	0.6	3.1	0.2
State Transfers	—	—	1.9	0.1
Fees Related to brand-name drugs	0.1	0.0	—	—

Source: 2012 Medicare Trustees Report, Tables III.C11 and III.D7.

Note: Totals may not add due to rounding.

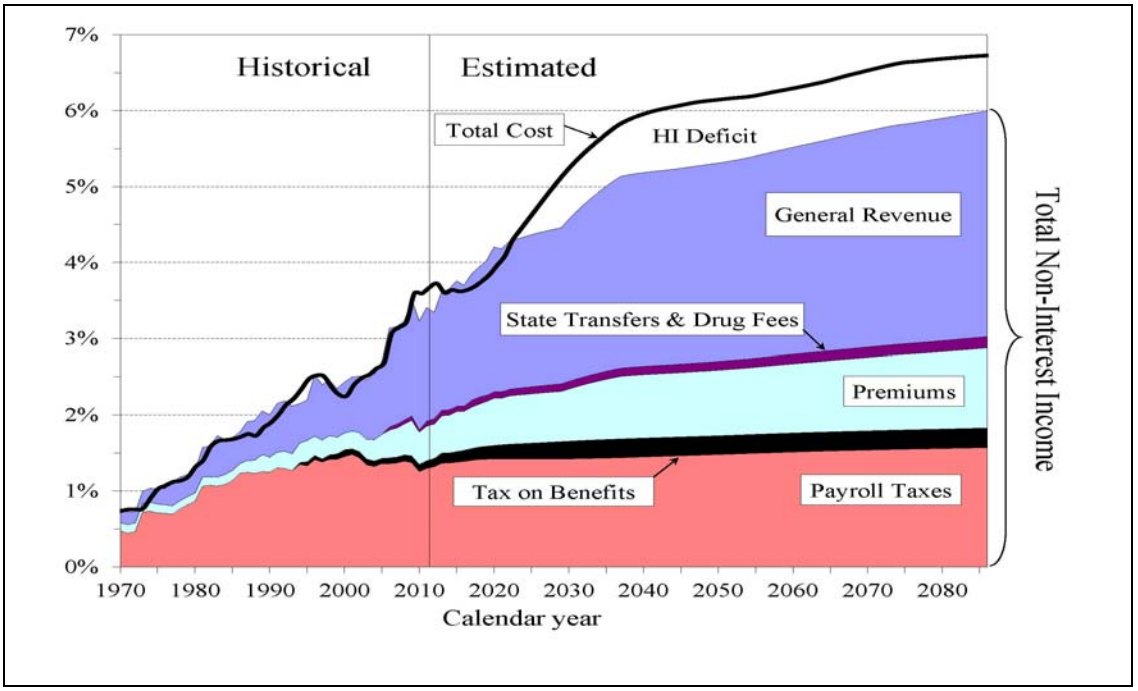
[30] These transfers represent a formal budget requirement under current law.

Medicare Costs as a Percentage of GDP

A comparison of Medicare costs (for Medicare Parts A through D combined) to GDP provides a measure of the amount of financial resources that will be necessary to pay for Medicare services relative to the output of the U.S. economy. The rising costs of health services, increasing utilization rates, and anticipated increases in the complexity of services are expected to contribute to the rising costs of Medicare relative to GDP. Additionally, it is expected that as increasing numbers of people become eligible for Medicare, there will be a significant growth in benefit expenditures. Under current law, the trustees expect Medicare costs to increase from 3.7% in 2011 to 6.0% of GDP in 2040 and to 6.7% in 2085.[31] Under the *illustrative alternative*, similar to estimates made under the law prior to ACA, projected Medicare costs are expected to represent about 10.3% of GDP in 2085. (See **Appendix G** for a comparison of projections of Medicare expenditures as a percentage of GDP from the 2009 through 2012 trustees reports.)

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

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



Source: Summary of the 2012 Annual Reports of the Social Security and Medicare Boards of Trustees, http://ssa.gov/oact/TRSUM/index.html, Chart C.

General revenue transfers to the SMI trust fund are projected to increase from 1.4% of GDP in 2012 to 3.0% in 2086, and beneficiary premiums from 0.5% of GDP in 2012 to 1.0% in 2086. As shown, the share of Medicare income from payroll taxes and taxation of benefits is expected to

[31] By comparison, last year's report projected that Medicare costs would increase to 5.6% of GDP by 2035 and reach 6.2% by the end of the 75-year projection period.

fall substantially during that period (from 43% to 31%), while the share of general fund revenue is expected to rise (from 42% to 50%) as are premiums (from 14% to 17%). Any excess in projected spending over revenues represents the HI deficit; in 2086, the HI deficit is projected to represent 0.8% of GDP.

Medicare Funding Warning ("Medicare Trigger")[32]

As noted, HI and SMI are financed very differently. HI is funded by current workers through a payroll tax, while SMI is funded by premiums from current beneficiaries and federal general revenues. Because of this financing, the SMI trust fund's income is projected to equal expenditures for all future years. However, there is concern that over time the economy will be unable to support the increasing reliance on general revenues which in large measure comes from taxes paid by the under-65 population. In response, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) required the trustees report to include an expanded analysis of Medicare expenditures and revenues. Specifically, a determination must be made as to whether general revenue financing will exceed 45% of total Medicare outlays within the next seven years (on a fiscal year basis).[33] The law specifies that if an excess general revenue funding determination is made for two successive years, a "Medicare funding warning" is triggered, and the President is to submit a legislative proposal to respond to the warning. The Congress is required to consider the proposals on an expedited basis. However, passage of legislation within a specific time frame is not required.

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 projected the first year at 2014. In the 2010 trustees report, the level of general revenue financing was projected to exceed 45% in FY2010; the 2011 report confirmed that the threshold was breached in FY2010 and was expected to do so again in FY2011 and FY2012. The 2012 report confirmed that the 45% level was exceeded in 2011 and projects that it will be exceeded again in 2012.[34] This represents the seventh consecutive time that the threshold was estimated to be exceeded within the first seven years of the projection, and the sixth time that the trustees have issued a funding warning.

Proponents of the 45% threshold measurement believe that it can serve as an effective early warning system and that it forces fiscal responsibility. Opponents of the measure suggest that it doesn't adequately recognize a shift towards the provision of more services on an outpatient basis or the impact of the Part D program on general revenue increases, and that other measures, such as Medicare spending as a percentage of GDP, Medicare spending as a portion of total federal spending, or the number of workers subject to payroll taxes per Medicare beneficiary, are better ways to measure the health of the Medicare program. On January 6, 2009, the House approved a

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

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

[34] The trustees estimate that additional revenues of at least $12 billion or expenditure reductions of at least $23 billion (or some combination of the two) would be needed to reduce the ratio below 45% in 2012.

rules package (H.Res. 5) that nullified the trigger provision for the 111th Congress.[35] The 112th Congress has not passed a similar measure; therefore, the trigger provision has gone back into effect in the House. To date, no legislation has been enacted to specifically respond to these funding warnings.

Medicare Expenditures and the Federal Budget

By law, the annual Medicare trustees reports focus on the financial status of the Medicare HI and SMI trust funds. Trust fund accounting methods are used to determine whether dedicated sources of Medicare revenue, together with any asset balances, are sufficient to allow the payment of expected expenditures on a timely basis. In contrast, when examining Medicare finances under unified budget accounting methods, the total flow of money into and out of the U.S. Treasury is typically examined regardless of the source of revenue.[36]

The expected shortfall in payroll taxes needed to fully cover HI expenses and the rapid growth of SMI, which relies primarily on general revenues for financing, have made it increasingly important to look at Medicare expenditures from the perspective of the federal budget as a whole. To illustrate, over the next 75 years, revenues from payroll taxes are projected to fall short of HI expenditures by $5.6 trillion in present value terms. This is the additional amount that is expected to be needed in order to pay HI benefits at the level expected under current law over the next 75 years. Note that the federal liability from a budget perspective includes the beginning accumulated assets in the HI trust fund ($0.2 trillion, as of January 1, 2012) as they represent federal payment obligations.[37]

Additionally, general revenue transfers in present value terms of $21.6 trillion are expected to be needed to cover SMI expenditures (Parts B and D combined) over the next 75 years.[38] 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 14.4% in 2012 to 25.7% in 2080 (see **Table 4**).[39]

[35] 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.

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

[37] The net 75-year unfunded liability from the trust fund perspective of $5.3 trillion in present value terms, does not include the trust fund assets. (Figures do not add due to rounding.) See "Unfunded Obligations".

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

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

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

Fiscal Year	Percentage of Income Taxes—2009 Report	Percentage of Income Taxes—2010 Report	Percentage of Income Taxes—2011 Report	Percentage of Income Taxes—2012 Report
Historical				
1970	0.8%	0.8%	0.8%	0.8%
1980	2.2	2.2	2.2	2.2
1990	5.9	5.9	5.9	5.9
2000	5.4	5.4	5.4	5.4
2008	10.9	12.0	12.0	12.0
2009	n/a	17.7	17.7	17.7
2010	12.2	18.6	19.2	19.2
2011	n/a	n/a	18.0	17.2
Intermediate Estimates				
2012	n/a	n/a	n/a	14.4
2020	15.8	15.0	17.1	16.3
2030	24.0	19.5	19.9	18.6
2040	28.9	21.8	22.1	22.6
2050	31.9	22.7	23.0	23.0
2060	35.1	24.6	24.7	24.0
2070	38.1	25.7	25.7	25.0
2080	40.5	26.6	26.3	25.7

Source: 2009, 2010, 2011, and 2012 Medicare Trustees Reports, Table III.C4 (2009-2011) and Table II.F3 (2012).

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

As noted earlier, ACA contained 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 for high-income workers, is currently expected to extend the solvency of the HI trust fund for an additional seven years beyond the pre-ACA estimate of 2017, to 2024. Under federal budget accounting rules (used by CBO when scoring legislation), these expected savings, together with income and savings from other ACA provisions, represent a reduction in expected future federal spending compared to spending levels estimated before the passage of ACA. Both CBO and the CMS Office of the Actuary, however, caution against combining trust fund accounting conventions with budget accounting rules, as doing so can result in the appearance of double counting ACA savings.

As previously described, as Medicare is an open-ended entitlement program funded primarily through mandatory spending, generally whatever expenses are incurred for covered Medicare benefits in a given year are reimbursed. Further, as a social insurance program, most funding for

Medicare (aside from premiums paid by beneficiaries) comes from current workers through Medicare payroll taxes and income taxes (i.e., current income is used to pay current expenditures). Medicare is *not* "pre-funded," and aside from certain constraints in HI, the program is not subject to spending limits. (While CBO and the Medicare trustees make estimates of future Medicare expenditures, actual spending may differ from their projections.)

Under *trust fund accounting rules*,[40] Medicare program expenditures are tracked through its two trust funds (HI and SMI) and the program is only authorized to pay up to the amount of revenues received plus any balance credited to the funds. There is no actual flow of money in or out of the funds, and trust fund "balances" are not retained in an actual account and set aside for future spending—they are just bookkeeping entries that indicate the amount that the program is *authorized* to pay without the need for Congress to appropriate additional funds.[41]

In their three reports issued subsequent to the enactment of ACA (2010, 2011, and 2012), the Medicare trustees have projected that Medicare HI expenditures will continue to exceed income in the foreseeable future, but because of slower than expected spending growth in the near term, coupled with additional taxes paid by higher income workers, the difference between the two (the deficit) in each year will not be as large as had been projected under prior law. Therefore, from a trust fund perspective, this balance (spending authority) will decrease more slowly over time and solvency has been extended. As Medicare is not "pre-funded," the difference in expected spending before and after the enactment of ACA is not "credited" to Medicare; the program simply does not spend as much as had been previously estimated. (See **Figure 2** for a comparison of pre- and post-ACA Medicare expenditure estimates.) Therefore, it would not be correct to conclude that "Medicare savings" are being diverted to other purposes. [42]

On the other hand, from the *unified budget accounting* **perspective,** under which only the total inflow of revenues and outflow of funds are tracked, it does not matter whether specific monies are being credited to or deducted from various trust funds. As HI trust fund balances are regarded as *liabilities* under budget accounting rules, these amounts are included in estimates of the national debt; when the special securities credited to the fund are redeemed, resources need to be generated from taxes, other government income, or government borrowing. Therefore, from the standpoint of the federal budget as a whole, if Medicare spending is reduced, but spending is increased by an *equivalent* amount somewhere else, overall federal spending has not decreased and thus the ability of the federal budget to support Medicare spending has not improved, it just stays the same.

[40] The relationship between federal trust funds and the budget is explained in CRS Report R41328, *Federal Trust Funds and the Budget*, by Thomas L. Hungerford.

[41] In other words, in 2012 and beyond, the HI program is *authorized* to spend $244 billion more than it receives in income; it doesn't actually *have* $244 billion set aside in an account.

[42] The misperception that Medicare spending reductions are "paying for" new entitlements mainly stems from the provisions being in the same legislation and because Medicare savings estimates were used as an offset to estimates of increased costs in ACA to meet budget pay-go rules at a particular point in time. For illustration purposes, if the Medicare savings provisions had been in one bill passed at one time (e.g., in 2010) and other parts of the reform legislation (costs) had been passed in a different bill at a different time (e.g., in 2011), then it would be clearer that one is not directly funding the other.

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 2012 Medicare trustees report, are expected to consume an increasing portion of federal budgetary resources over time. Budget experts have expressed concern about the long-run implications of Medicare expenditures on federal deficits; for example, in its long-term budget forecast, CBO noted:

> The aging of the baby-boom generation portends a significant and sustained increase in the share of the population receiving benefits from Social Security and Medicare, as well as long-term care services financed by Medicaid. Moreover, per capita spending for health care is likely to continue rising faster than spending per person on other goods and services for many years (although the magnitude of that gap is uncertain). Without significant changes in government policy, those factors will boost federal outlays relative to GDP well above their average of the past several decades—a conclusion that holds under any plausible assumptions about future trends in demographics, economic conditions, and health care costs.[43]

The Medicare trustees caution that it is difficult to forecast health and economic indicators over an extended period of time. For example, forecasts are based on the assumption that health spending will outpace GDP growth in the future because it has consistently done so in the past. It is possible that in the future, advances in medical technology, changes in consumer preferences, shifts in the health status of the population, or changes in the way health care services are delivered could result in very different financial outcomes from those estimated in the trustees report.[44] Further, as evidenced by the issuance of an illustrative alternative to the 2012 trustees report, if changes to current health care policies are enacted (most notably these affecting physician reimbursement or productivity adjustments), future Medicare costs could be significantly different from current projections.

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

Proposals to reduce Medicare spending generally fall into one of two categories: (1) those that would reduce the federal share of Medicare spending (for example, by increasing beneficiary premiums and/or cost-sharing; changing Medicare eligibility criteria such as age; reducing the range of covered benefits; establishing defined federal contributions; [45] or setting federal spending

[43] "The 2012 Long-Term Budget Outlook," Congressional Budget Office, June 5, 2012, p. 1, http://www.cbo.gov/sites/default/files/cbofiles/attachments/06-05-Long-Term_Budget_Outlook.pdf.

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

[45] See CRS Report R42441, *Overview of Health Care Changes in the FY2013 Budget Proposal Offered by House* (continued...)

limits), and (2) those that would reduce the total amount of health care spending regardless of who is paying (e.g., reducing prices paid for items and services;[46] decreasing medical errors; reducing unneeded, duplicative and/or ineffective care; and eliminating fraud and abuse). On the revenue side, options to increase program income may include modifying dedicated Medicare payroll taxes or general income taxes, and/or imposing new fees.[47] Some of the above changes could be made while still retaining Medicare's current structure, while others could only be made in the context of major program restructuring. Many of the proposals could be combined as part of an overall reform package.

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

(...continued)

Budget Committee Chairman Ryan, by Patricia A. Davis, Alison Mitchell, and Bernadette Fernandez, for a description of the premium support model proposed in the House FY2013 budget.

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

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

Appendix A. Medicare Enrollment

Table A-1. Medicare Enrollment, 1970 - 2085

(in thousands)

Year	HI—Part A	SMI—Part B	SMI—Part D	Part C	Total
Historical					
1970	20,104	19,496	—	—	20,398
1975	24,481	23,744	—	—	24,864
1980	28,002	27,278	—	—	28,433
1985	30,621	29,869	—	1,271	31,081
1990	33,747	32,567	—	2,017	34,251
1995	37,175	35,641	—	3,467	37,594
2000	39,257	37,335	—	6,856	39,688
2001	39,669	37,667	—	6,166	40,103
2002	40,065	37,982	—	5,538	40,508
2003	40,738	38,584	—	5,302	41,188
2004	41,485	39,123	1,217	5,375	41,902
2005	42,233	39,752	1,841	5,794	42,606
2006	43,065	40,361	30,560	7,291	43,436
2007	44,010	41,093	31,392	8,667	44,368
2008	45,150	41,975	32,589	10,010	45,500
2009	46,256	42,908	33,644	11,104	46,604
2010	47,336	43,871	34,772	11,692	47,685
2011	48,334	44,879	35,693	12,381	48,685
Estimated					
2012	50,344	46,560	37,214	13,521	50,695
2013	52,076	48,136	38,372	13,676	52,426
2014	53,736	49,595	39,487	12,948	54,085
2015	55,331	51,007	40,586	11,703	55,679
2016	56,911	52,404	41,688	10,232	57,259
2017	58,524	53,825	42,844	9,748	58,871
2018	60,184	55,290	43,995	9,781	60,531
2019	61,904	56,815	45,180	10,204	62,252
2020	63,687	58,454	46,760	10,668	64,036
2021	65,497	60,076	48,083	11,134	65,848
2025	72,825	66,673	53,440	12,636	73,185
2030	80,628	73,759	59,145	13,947	80,997
2035	85,179	77,827	62,470	14,703	85,551

Year	HI—Part A	SMI—Part B	SMI—Part D	Part C	Total
2040	87,249	79,775	63,981	—	87,620
2045	88,363	80,759	64,795	—	88,735
2050	90,279	82,505	66,201	—	90,660
2055	92,884	84,858	68,110	—	93,274
2060	96,141	87,853	70,497	—	96,543
2065	99,420	90,839	72,898	—	99,831
2070	103,152	94,246	75,629	—	103,571
2075	106,902	97,705	78,373	—	107,329
2080	110,481	100,953	80,989	—	110,911
2085	114,417	104,557	83,865	—	114,851

Source: 2012 Medicare Trustees Report, Table V.B3.

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

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

Table B-1. Medicare Income and Expenditures, Calendar Years 1970-2021

($ in billions)

	Income						Expenditures		
Year	Payroll Taxes	General Revenue	Premiums	State Transfers	Interest and Other	Total	Benefit Payments	Admin Expenses	Total
Historical Data									
1970	$4.9	$1.1	$1.1	—	$1.2	$8.2	$7.1	$0.4	$7.5
1975	11.5	2.6	1.9	—	1.5	17.7	15.6	0.8	16.3
1980	23.8	7.5	3.0	—	2.5	37.0	35.7	1.1	36.8
1985	47.6	18.3	5.6	—	5.1	76.5	70.5	1.7	72.3
1990	72.0	33.0	11.4	—	9.9	126.3	108.7	2.3	111.0
1995	98.4	39.0	20.7	—	17.3	175.3	181.4	2.8	184.2
2000	144.4	65.9	22.0	—	24.9	257.1	217.4	4.4	221.8
2005	171.4	119.2	39.9	—	27.0	357.5	330.3	6.1	336.4
2006	181.3	171.9	49.0	$5.5	29.4	437.0	402.0	6.3	408.3
2007	191.9	178.4	53.7	6.9	31.3	462.1	425.4	6.3	431.7
2008	198.7	184.1	58.1	7.1	32.7	480.8	461.6	6.6	468.2
2009	190.9	209.9	65.2	7.6	34.7	508.3	502.4	6.6	509.0
2010	182.0	204.6	61.8	4.0	33.6	486.1	515.9	7.1	522.9
2011	195.6	222.8	68.5	7.1	36.0	530.0	541.3	7.8	549.1
Intermediate Estimate									
2012	207.6	217.1	70.7	8.4	36.2	540.0	578.6	7.5	586.1
2013	224.0	254.0	80.1	8.9	39.9	607.1	590.4	8.0	598.4
2014	236.3	271.5	85.8	9.2	41.3	644.1	622.3	8.8	631.2
2015	252.0	297.7	96.5	9.5	45.4	701.1	652.7	9.9	662.6
2016	268.3	303.1	99.0	10.2	50.3	731.0	692.9	11.1	704.0
2017	285.7	334.1	111.1	10.9	57.0	798.7	739.8	12.1	752.0
2018	303.3	361.6	121.1	11.8	63.3	861.2	793.2	13.1	806.3
2019	318.6	393.1	132.3	12.7	69.1	925.9	851.2	14.0	865.1
2020	333.7	442.2	146.3	13.8	77.1	1,013.2	918.3	14.9	933.2
2021	348.9	457.8	150.3	15.1	85.6	1,057.7	989.3	15.8	1,005.1

Source: Data from 2012 Medicare Trustees Report, Tables III.B4, III.C4, III.D3 and VB1.

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

Appendix C. Medicare Per Capita Expenditures

Table C-1. Average Medicare Benefit Costs Per Beneficiary, Calendar Years 1970-2021

Year	HI	SMI		Total
		Part B	Part D	
Historical Data				
1970	$255	$101	—	$356
1975	462	180	—	642
1980	895	390	—	1,285
1985	1,554	768	—	2,322
1990	1,963	1,304	—	3,267
1995	3,130	1,823	—	4,953
2000	3,272	2,381	—	5,653
2005	4,262	3,754	—	8,016
2006	4,388	4,111	$1,708	10,208
2007	4,548	4,293	1,556	10,397
2008	5,145	4,296	1,504	10,945
2009	5,172	4,721	1,798	11,692
2010	5,164	4,780	1,775	11,720
2011	5,232	4,940	1,870	12,042
Intermediate Estimates				
2012	5,291	5,222	1,838	12,351
2013	5,299	4,891	2,058	12,247
2014	5,373	5,018	2,146	12,537
2015	5,350	5,197	2,256	12,803
2016	5,473	5,367	2,402	13,243
2017	5,620	5,611	2,543	13,774
2018	5,797	5,887	2,700	14,385
2019	5,991	6,173	2,869	15,032
2020	6,216	6,497	3,050	15,763
2021	6,452	6,847	3,230	16,530

Source: 2012 Report of Medicare Trustees, Table V.D1.

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

Appendix D. Operation of the Hospital Insurance Trust Fund

Table D-1. Operation of the Hospital Insurance Trust Fund, Calendar Years 1970-2021

($ in billions)

	Income			Expenditures			Trust Fund	
Year	Payroll Taxes	Interest, Transfers, Other	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data								
1970	$4.9	$1.2	$6.0	$5.1	$0.2	$5.3	$0.7	$3.2
1975	11.5	1.4	13.0	11.3	0.3	11.6	1.4	10.5
1980	23.8	2.1	26.1	25.1	0.5	25.6	0.5	13.7
1985	47.6	3.9	51.4	47.6	0.8	48.4	4.8	20.5
1990	72.0	8.4	80.4	66.2	0.8	67.0	13.4	98.9
1995	98.4	16.7	115.0	116.4	1.2	117.6	-2.6	130.3
2000	144.4	22.9	167.2	128.5	2.6	131.1	36.1	177.5
2001	152.0	22.7	174.6	141.2	2.2	143.4	31.3	208.7
2002	152.7	25.8	178.6	149.9	2.6	152.5	26.1	234.8
2003	149.2	26.5	175.8	152.1	2.5	154.6	21.2	256.0
2004	156.5	27.5	183.9	167.6	3.0	170.6	13.3	269.3
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
2010	182.0	33.6	215.6	244.5	3.5	247.9	-32.3	271.9
2011	195.6	33.4	228.9	252.9	3.8	256.7	-27.7	244.2
Intermediate Estimate								
2012	207.6	33.9	241.5	266.4	4.0	270.4	-28.9	215.3
2013	224.0	37.8	261.9	275.9	4.3	280.2	-18.3	197.0
2014	236.3	37.8	274.2	288.7	4.8	293.5	-19.3	177.7
2015	252.0	40.2	292.1	296.0	5.3	301.4	-9.2	168.5
2016	268.3	43.2	311.5	311.5	6.0	317.5	-5.9	162.5
2017	285.7	46.7	332.4	328.9	6.6	335.5	-3.1	159.4
2018	303.3	50.4	353.7	348.9	7.1	356.0	-2.3	157.2
2019	318.6	54.2	372.8	370.9	7.6	378.4	-5.6	151.6
2020	333.7	58.3	392.0	395.9	8.1	404.0	-12.0	139.6
2021	348.9	62.2	411.0	422.6	8.6	431.2	-20.2	119.4

Source: 2012 Medicare Trustees Report, Table III.B4.

Notes: Sums may not equal totals due to rounding.

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

Table E-1. Operation of the Part B Account of the SMI Trust Fund, Calendar Years 1970-2021

($ in billions)

	Income				Expenditures			Trust Fund	
Year	Premiums	General Revenue	Interest and Other	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data									
1970	$1.1	$1.1	$0.0	$2.2	$2.0	$0.2	$2.2	-$0.0	$0.2
1975	1.9	2.6	0.1	4.7	4.3	0.5	4.7	-0.1	1.4
1980	3.0	7.5	0.4	10.9	10.6	0.6	11.2	-0.4	4.5
1985	5.6	18.3	1.2	25.1	22.9	0.9	23.9	1.2	10.9
1990	11.3	33.0	1.6	45.9	42.5	1.5	44.0	1.9	15.5
1995	19.7	39.0	1.6	60.3	65.0	1.6	66.6	-6.3	13.1
2000	20.6	65.9	3.4	89.9	88.9	1.8	90.7	-0.8	44.0
2005	37.5	118.1	1.4	157.0	149.2	3.2	152.4	4.6	24.0
2006	42.9	132.7	1.8	177.3	165.9	3.1	169.0	8.3	32.3
2007	46.8	139.6	2.2	188.7	176.4	2.5	178.9	9.7	42.1
2008	50.2	146.8	3.6	200.6	180.3	3.0	183.3	17.3	59.4
2009	56.0	162.8	3.1	221.9	202.6	3.1	205.7	16.2	75.5
2010	52.0	153.5	3.3	208.8	209.7	3.2	212.9	-4.1	71.4
2011	57.5	170.2	5.9	233.6	221.7	3.6	225.3	8.3	79.7
Intermediate Estimates									
2012	58.5	165.7	5.8	230.0	243.8	3.1	246.9	-16.9	62.8
2013	65.9	194.2	5.6	265.7	235.5	3.3	238.8	26.9	89.7
2014	69.7	208.0	7.1	284.8	248.9	3.6	252.5	32.2	122.0
2015	78.4	229.6	8.9	316.9	265.1	4.1	269.2	47.7	169.7
2016	79.5	228.2	11.0	318.7	281.3	4.6	285.9	32.9	202.6
2017	89.6	252.9	14.4	356.8	302.0	5.0	307.1	49.7	252.3
2018	97.7	273.2	17.2	388.1	325.5	5.5	331.0	57.1	309.4
2019	106.7	296.7	19.4	422.8	350.7	5.8	356.5	66.3	375.7
2020	118.5	335.8	23.6	477.9	379.8	6.2	386.0	91.9	467.6
2021	121.1	341.1	28.4	490.6	411.4	6.6	418.0	72.6	540.2

Source: 2012 Medicare Trustees Report, Table III.C4.

Notes: Sums may not equal totals due to rounding.

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

Table F-1. Operation of the Part D Account in the SMI Trust Fund, Calendar Years 2004-2021

($ in billions)

	Income				Expenditures			Trust Fund	
Year	Premiums	General Revenue	Transfers from States	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data									
2004	—	$0.4	—	$0.4	$0.4	—	$0.4	—	—
2005	—	1.1	—	1.1	1.1	—	1.1	0	0
2006	$3.5	39.2	$5.5	48.2	47.1	$0.3	47.4	$0.8	$0.8
2007	4.1	38.8	6.9	49.7	48.8	0.9	49.7	0.0	0.8
2008	5.0	37.3	7.1	49.4	49.0	0.3	49.3	0.1	0.9
2009	6.3	47.1	7.6	61.0	60.5	0.3	60.8	0.1	1.1
2010	6.5	51.1	4.0	61.7	61.7	0.4	62.1	-0.4	0.7
2011	7.7	52.6	7.1	67.4	66.7	0.4	67.1	0.3	1.0
Intermediate Estimates									
2012	8.7	51.4	8.4	68.5	68.4	0.4	68.8	-0.3	0.7
2013	10.7	59.8	8.9	79.4	79.0	0.4	79.4	0.0	0.7
2014	12.5	63.5	9.2	85.2	84.7	0.4	85.2	0.0	0.8
2015	14.4	68.1	9.5	92.1	91.6	0.5	92.0	0.0	0.8
2016	15.6	74.9	10.2	100.7	100.1	0.5	100.6	0.1	0.9
2017	17.4	81.2	10.9	109.5	108.9	0.5	109.5	0.1	0.9
2018	19.1	88.4	11.8	119.4	118.8	0.5	119.3	0.1	1.0
2019	21.1	96.4	12.7	130.3	129.6	0.6	130.2	0.1	1.1
2020	23.0	106.4	13.8	143.3	142.6	0.6	143.2	0.1	1.2
2021	24.2	116.7	15.1	156.0	155.3	0.6	155.9	0.1	1.3

Source: 2012 Medicare Trustees Report, Table III.D3.

Notes: Sums may not equal totals due to rounding.

Appendix G. Medicare Expenditures as a Percentage of GDP

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

Comparison of 2009, 2010, 2011 and 2012 Medicare Trustees Reports

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

Sources: 2009, 2010, 2011, and 2012 Reports of the Medicare Trustees, Table III.A2 (2009-2011) and Table V.B2 (2012).

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