



Medicare Financial Status: In Brief

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Overview of the Medicare Program

Medicare, administered by the Centers for Medicare & Medicaid Services (CMS), is the nation's federal insurance program that pays for covered health services for most persons age 65 years and older and for most permanently disabled individuals under the age of 65.¹ As a health insurance program, Medicare reimburses health care providers and suppliers, such as hospitals, physicians, and medical equipment companies, for the services and products they provide to Medicare beneficiaries. Medicare is prohibited by law from interfering in the practice of medicine or controlling the manner in which medical services are provided, and is required to pay for covered services provided to eligible persons so long as specific criteria are met. As such, the growth in per person Medicare expenditures largely reflects the medical practices, use of technology, and underlying costs in the broader health care system. Spending under the program (except for a portion of the administrative costs) is considered mandatory spending and is not subject to the appropriations process. Thus, there are generally no limits on annual Medicare spending.

Since its enactment in 1965, the Medicare program has undergone considerable change. Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of deficit reduction legislation passed by Congress.² With a few exceptions, reductions in program spending have been achieved largely through freezes or reductions in payments to providers, primarily hospitals and physicians, and by making changes to beneficiary premiums and other cost-sharing requirements. Most recently, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) made numerous changes to the Medicare program that modify provider reimbursements, provide incentives to improve the quality and efficiency of care, and enhance certain Medicare benefits.³

Four Parts of Medicare

Medicare consists of four distinct parts, A through D:

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

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

² For a brief history of changes to the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga, and the Medicare chapter of the House of Representatives, Committee on Ways and Means *Greenbook* at <http://greenbook.waysandmeans.house.gov/2012-green-book/chapter-2-medicare>.

³ For details on individual Medicare provisions in the ACA, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.

- **Part C** (Medicare Advantage, or MA) is a private plan option for beneficiaries that covers all Part A and B services, except hospice. Individuals choosing to enroll in Part C must be eligible for Part A and must also enroll in Part B. About 27% of Medicare beneficiaries are enrolled in MA.
- **Part D** covers outpatient prescription drug benefits. This portion of the program is optional. About 74% of Medicare beneficiaries are enrolled in a Medicare Part D plan or have coverage through an employer retiree plan subsidized by Medicare.

Beneficiary Costs

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

Provider and Plan Payments⁴

Under traditional Medicare, Parts A and B, services are generally paid directly by the government on a “fee-for-service” basis, using different prospective payment systems or fee schedules.⁵ Under Parts C and D, private insurers are paid a monthly “capitated” per person amount to provide coverage to enrollees.⁶ The capitated payments are adjusted to reflect the differences in the relative cost of sicker beneficiaries with different risk factors including age, disability, or end-stage renal disease.

Medicare Spending in 2012

In 2012, Medicare provided benefits to about 50.7 million people (42.1 million age 65 and over, and 8.5 million disabled) at an estimated total cost of \$574 billion. Most of that amount, \$566 billion (99%), was spent on program benefits, with the remaining amount used for program administration. (See **Table 1**.) Growth in Medicare expenditures is driven by a variety of factors, including the level of Medicare enrollment, the complexity of medical services provided, health care inflation, and life expectancy.

⁴ For additional information, see CRS Report RL30526, *Medicare Payment Updates and Payment Rates*, coordinated by Paulette C. Morgan.

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

⁶ Medicare pays Parts C and D plans a set monthly per person amount to provide covered benefits.

Table I. Medicare Expenditures and Enrollment: 2012

	SMI			Total Medicare
	HI - Part A	Part B	Part D	
Expenditures (billions)				
<i>Benefits</i>	\$262.9	\$236.5	\$66.5	\$565.9
Hospital	139.7	39.1	—	178.8
Skilled Nursing	28.0	—	—	28.0
Home Health Care	6.8	11.8	—	18.6
Physician Services	—	69.6	—	69.6
Private plans (Part C)	70.2	66.0	—	136.2
Prescription Drugs	—	—	66.5	66.5
Other	18.1	50.1	—	68.2
<i>Administrative Expenses</i>	\$3.9	\$3.9	\$0.4	\$8.3
Total Expenditures	\$266.8	\$240.5	\$66.9	\$574.2
Enrollment (millions)				
Aged	41.8	38.7	n/a	42.1
Disabled	8.5	7.7	n/a	8.5
Total Enrollment	50.3	46.4	37.4	50.7
Average expenditures per enrollee	\$5,227	\$5,097	\$1,779	\$12,103

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

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

Medicare Trust Funds and Sources of Revenue

The Medicare program has two separate trust funds—the Hospital Insurance (HI) trust fund for Part A and the Supplementary Medical Insurance (SMI) trust fund for Parts B and D.⁷ (For beneficiaries enrolled in Medicare Advantage (Part C), payments are made on their behalf in appropriate portions from the HI and SMI trust funds.) Both the HI and SMI trust funds are maintained by the Department of the Treasury and are overseen by a Board of Trustees that reports annually to Congress concerning the funds’ financial status.⁸ Financial projections are

⁷ Many government programs are financed through trust funds. Despite the name, federal trust funds are not the same as private sector trust funds. A trust in the private sector is “a fiduciary relationship in which one person (the trustee) holds property for the benefit of another (the beneficiary).” The trustee must follow the express terms of the trust instrument and administer the trust for the benefit of the beneficiary. Most federal trust funds are not based on a legal fiduciary relationship. Congress creates trust funds that involve a commitment to use monies for a specific purpose, but can alter the terms (e.g., receipts, outlays, or purpose) of the trust fund at any time. For additional information on how federal trust funds operate within the context of the federal budget, see CRS Report R41328, *Federal Trust Funds and the Budget*.

⁸ These reports may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html>.

made using economic assumptions based on current law, including estimates of consumer price index (CPI), workforce size, wage increases, and life expectancy.

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

Hospitalization Insurance (HI) Trust Fund

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

Sources of Revenue

The HI trust fund is mainly funded by a dedicated payroll tax of 2.9% of earnings, shared equally between employers and workers. (See **Figure 1**.) Unlike Social Security, there is no upper limit on wages subject to Medicare payroll taxes. Beginning in 2013, the ACA imposes an additional tax of 0.9% on high-income workers with wages over \$200,000 for single tax filers, and over \$250,000 for joint filers.⁹ Other sources of income to the HI trust fund include premiums paid by voluntary enrollees who are not entitled to premium-free Medicare Part A through their (or their spouse's) work in covered employment, a portion of the federal income taxes paid on Social Security benefits, and interest on federal securities held by the trust fund.

HI Trust Fund Mechanics

HI operates on a “pay-as-you-go” basis; the taxes paid by current workers and their employers are used to pay Part A benefits for today’s Medicare beneficiaries. When the government receives Medicare revenues (payroll taxes), income is credited by the Treasury to the HI trust fund in the form of special issue interest-bearing government securities.¹⁰ (Interest on these securities is also credited to the trust fund.) The tax income exchanged for these securities then goes into the general fund of the Treasury and is indistinguishable from other cash in the general fund; this cash may be used for any government spending purpose. When payments for Medicare Part A services are made, the payments are paid out of the general treasury and a corresponding amount of securities is deleted from (written off) the HI trust fund.

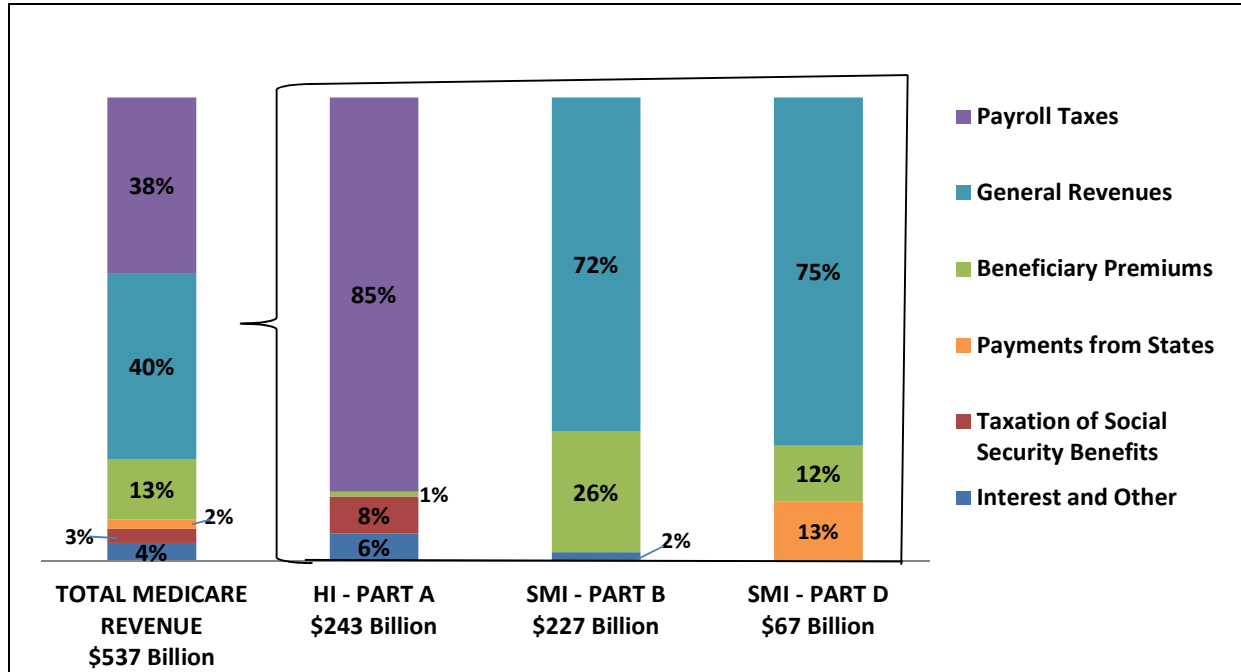
In years in which the trust fund spends less than the income it receives, the trust fund securities exchanged for any income in excess of spending show up as “assets” on the financial accounting balance sheets and are available to the system to meet future obligations. The trust fund surpluses are not reserved for future Medicare benefits, but are simply bookkeeping entries that indicate how much Medicare has lent to the Treasury (or alternatively, what is owed to Medicare by the Treasury). From a unified budget perspective, these “assets” represent future budget obligations and are treated as liabilities. If the HI trust fund is not able to pay all of current expenses out of

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

¹⁰ Unlike marketable securities, special issues can be redeemed at any time at face value. Investment in special issues gives the trust funds the same flexibility as holding cash.

current income and accumulated trust fund assets, it is considered to be *insolvent*.¹¹ (See “Estimated Date of HI Trust Fund Insolvency.”)

Figure I. Sources of Medicare Revenues: 2012



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

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

2012 HI Operations

At the beginning of CY2012, the HI trust fund had an asset balance of a little over \$244 billion. During 2012, Part A expenditures were about \$267 billion, and approximately \$206 billion of that amount was funded by payroll taxes and \$37 billion by interest income and other sources. Because expenditures exceeded revenue income, close to \$24 billion was drawn out of accumulated assets in the HI trust fund to make up the difference. At the end of 2012, the HI trust fund had an asset balance of approximately \$220 billion. This means that if or when HI spending exceeds income in any future years, the trust fund will have up to \$220 billion in spending authority in addition to what it receives in income.¹²

Supplementary Medical Insurance (SMI) Trust Fund

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

¹¹ From time to time, it is reported that Medicare is on the verge of “bankruptcy,” however, in the context of federal trust funds, this term is not meaningful. It is true that a trust fund’s outgo can be greater than its income and trust funds can have a zero balance, but, unlike private businesses, the federal government is not in danger of “going out of business” or having its assets seized by creditors.

¹² In years in which income exceeds expenditures, the surplus amount(s) would be added to this balance.

Sources of Revenue

Unlike the HI portion of Medicare, the SMI program was not intended to be supported through dedicated sources of income. Instead, it relies primarily on general tax revenues and beneficiary premiums as revenue sources.¹³

The Part B portion of SMI is mainly funded through beneficiary premiums (set at 25% of estimated program costs for the aged)¹⁴ and general revenues (most of the remaining amount, approximately 72%). Most enrollees pay a monthly premium of \$104.90; however, certain low-income enrollees receive assistance with their premiums from Medicaid (joint federal-state funding), and since 2007, high-income enrollees pay higher premiums. Beginning in 2011, additional revenues from an annual fee imposed on certain manufacturers and importers of branded prescription drugs are also credited to the SMI trust fund.¹⁵

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

SMI Trust Fund Mechanics

The level of SMI funding is automatically updated each year to cover expenditures in the upcoming year. If actual costs exceed those estimated when the funding was set, future financing rates can include adjustments to recover the shortfall. Similarly, if actual costs are less than expected, income levels needed for the next year may be adjusted downward. Because of these automatic adjustments, the SMI trust fund is always kept in balance and cannot become insolvent.

2012 SMI Operations

In CY2012, total spending for Part B was close to \$241 billion, with general revenues financing approximately \$164 billion (72%) of that amount, and premiums covering most of the remainder. In CY2012, total spending for Part D reached about \$67 billion, with over \$50 billion (75%) of that amount paid for by general revenues. An additional \$8 billion was covered by state transfer payments, and \$8 billion by beneficiary premiums. It should be noted that although beneficiary premiums are set at a rate to cover 25.5% of the costs of their standard Part D benefits, the program pays for the premiums of about one-third of enrollees because they qualify for low-income assistance. As a result, Part D premiums only cover about 12% of program costs. (See **Figure 1.**)

¹³ There have been reports that Medicare beneficiaries receive more from the program than what they have paid throughout their working years in payroll taxes; however as noted, unlike Part A, the costs of Medicare Parts B and D were designed in the original statute to be subsidized by the government and not through dedicated taxes.

¹⁴ For additional information, see CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis.

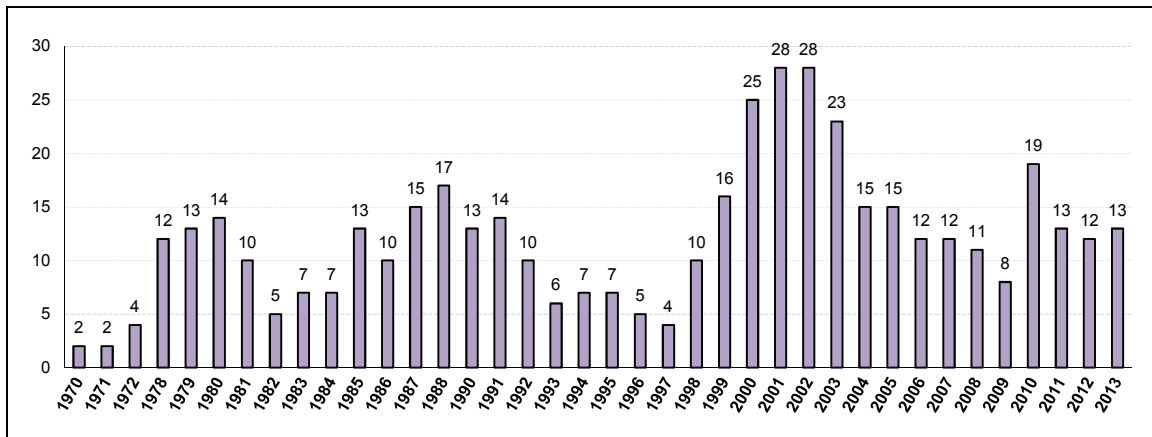
¹⁵ See archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Janemarie Mulvey, for more detail.

Estimated Date of HI Trust Fund Insolvency

Since 2008, Part A expenditures have exceeded HI income each year, and the assets credited to the trust fund have been drawn down to make up the deficit. The 2013 report of the Medicare Trustees estimates that under current law the HI trust fund will become insolvent in 2026 (i.e., the balance of the trust fund will reach \$0), at which time there will no longer be sufficient funds to fully cover Part A expenditures.¹⁶ At that time, HI would continue to receive tax income from which some benefits could be paid; however, funds would only be sufficient to pay for 87% of Part A expenses. The Trustees suggest that, under these circumstances, beneficiary access to Part A services “would be rapidly curtailed.”

Almost from its inception, the HI trust fund has faced a projected shortfall and eventual insolvency (see **Figure 2**), with insolvency dates ranging from 2 to 28 years from the year of the projection. However, to date, the HI trust fund has never become insolvent, and there are no provisions in the Social Security Act that govern what would happen if that were to occur. For example, there is no authority in law for the program to use general revenues to fund Part A services in the event of such a shortfall. Unless action is taken prior to the expected date of insolvency to increase HI revenue or decrease expenditures, Congress may need to appropriate additional funding to make up for these deficits and to allow for full and on time payments to Part A providers.

Figure 2. Projected Number of Years Until HI Insolvency
Medicare Trustee Report Estimates 1970-2013



Source: Intermediate projections of various Medicare Trustees reports, 1970-2013.

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

Because income (general revenue and premiums) to the SMI trust fund is automatically updated each year to ensure that the program has enough money to continue operating, the SMI trust fund

¹⁶ To illustrate the sensitivity and uncertainty inherent in developing future projections, the Trustees provide both low-cost and high-cost estimates, in addition to their intermediate projections (the figures most often cited). Under low-cost assumptions, trust fund assets would begin accumulating in 2014, and the HI trust fund would continue to run a surplus over the next 10-years. Under the high-cost assumption, the Trustees estimate that the HI trust fund would become insolvent seven years earlier, in 2019 rather than in 2026.

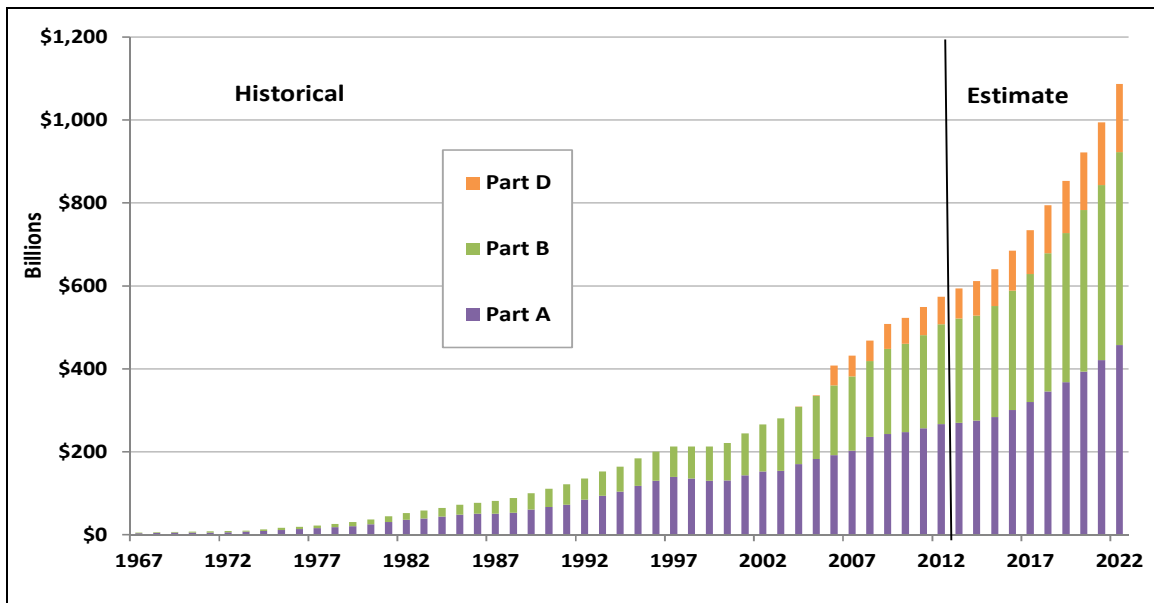
is kept in balance and is always solvent. However, the Medicare trustees continue to express concerns about the rapid growth in SMI costs.

Projected Medicare Spending Growth

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. When Medicare first began, there were about 19 million beneficiaries. This number has grown to about 52 million enrollees in 2013, and is expected to increase to about 86 million in 2035, and 116 million in 2085. The Trustees expect that demographic trends will be the primary driver of cost growth for Medicare over the next couple of decades, with most of the growth occurring by 2035, by which time all the baby boomers will have aged into Medicare.¹⁷

Over the next 10 years, the Medicare Trustees estimate that total Medicare expenditures will increase from \$574 billion in 2012 to close to \$1.1 trillion in 2022. Of the \$1.1 trillion, about \$458 billion is expected to be spent on Part A services, \$465 billion for Part B services, and \$165 billion for Part D. (See **Figure 3**.)

Figure 3. Historical and Projected Medicare Expenditures



Source: 2013 Report of the Medicare Trustees, Expanded and Supplementary Tables (historical data); and Report Tables III.B4; III.C4; and III.D3 (projected data).

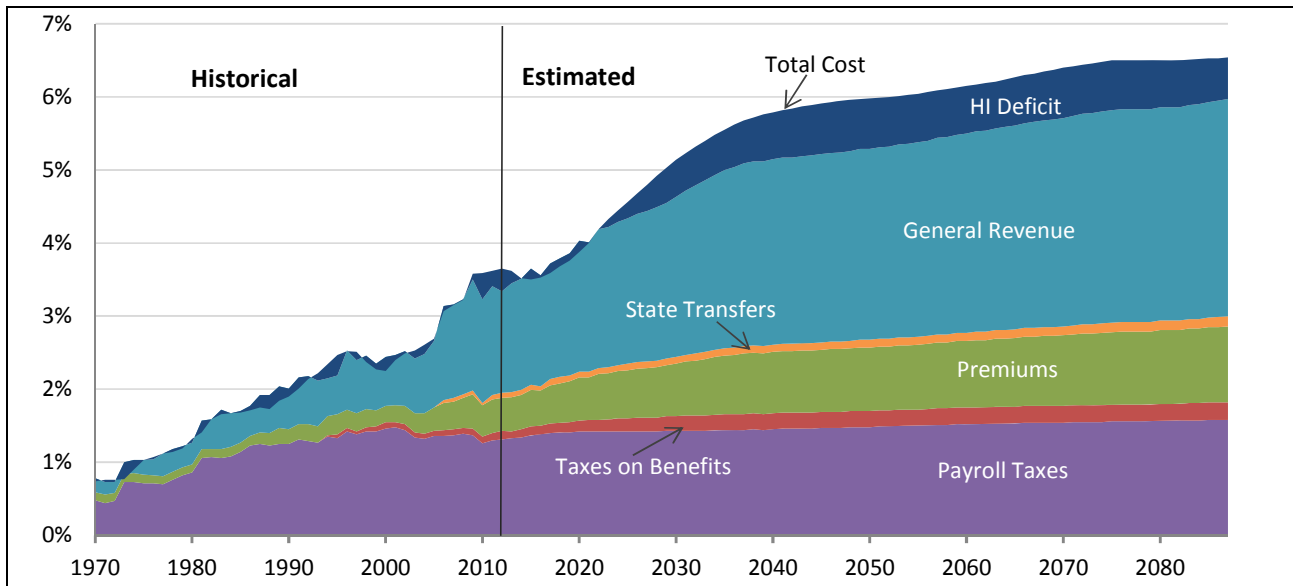
¹⁷ 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 21.

Growth in Medicare Expenditures Relative to 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. Under current law, the trustees expect total Medicare expenditures to increase from 3.6% of GDP in 2012 to about 5.6% of GDP by 2035, mainly due to the rapid growth in the number of beneficiaries, and then to 6.5% of GDP in 2087, with growth in health care cost per beneficiary becoming the more significant factor in those years. (See **Figure 4.**)

Over the next 75 years, general revenues and beneficiary premiums are expected to play an increasing role in financing the program. For example, the level of general revenues needed to fund SMI is expected to increase from 1.5% of GDP in 2013 to an estimated 2.9% in 2087 under current law.¹⁸ Similarly, income from beneficiary premiums is expected to increase from 0.5% of GDP in 2013 to 1.0% in 2087. In 2012, about 14.5% of total federal income taxes collected that year were used to fund the general revenue portion of SMI. It is expected that the portion of income taxes needed to fund SMI will increase to about 19% in 2030, and to almost 26% in 2080. This amount is *in addition* to the payroll taxes used to fund the Part A (HI) portion of the program.

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



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

¹⁸ Total Part B outlays were 1.5% of GDP in 2012, and the Trustees project that they will grow to about 2.6% by 2087. The Trustees also estimate that total Part D outlays will increase from 0.4% of GDP in 2012 to about 1.4% in 2087.

Unfunded and General Revenue Obligations

The Trustees’ report provides estimates of the present value of the HI deficit—the “unfunded obligation” over both a 75-year horizon and an “infinite” horizon. This unfunded obligation represents the dollar amount by which expenditures would need to be reduced or revenue increased to maintain the financial soundness of the program over a period of time. The Trustees estimate that the current value of funding needed to cover the expected difference between income to the HI trust fund and expenditures over the next 75 years is \$4.6 trillion. The Trustees note that this financial imbalance could be addressed by immediately increasing payroll taxes to 4.01% (from the current 2.9%) or by immediately decreasing expenditures by 22%.

The report also provides estimates of the present value of future SMI spending. Although SMI is automatically funded and does not face a shortfall, the general revenue portion represents obligated federal spending. The present value of expected general revenues needed to pay for Medicare Parts B and D over the next 75 years is \$22.6 trillion. Adding the HI unfunded obligation estimate and the present value of future SMI spending for the 75-year period yields a total of \$27.2 trillion.¹⁹ In other words, it would take about \$27.2 trillion in current dollars to cover the cost of Medicare not funded through dedicated sources over the next 75 years.

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

Present Value of HI Deficit	Present Value of SMI General Revenues				
		Part B	Part D	Total	
Unfunded obligations through 2087	\$4.6 trillion	General revenue contributions through 2087	\$15.7 trillion	\$6.9 trillion	\$27.2 trillion
Unfunded obligations through infinite horizon	\$3.5 trillion	General revenue contributions through infinite horizon	\$25.0 trillion	\$14.4 trillion	\$42.9 trillion

Source: 2013 Report of the Medicare Trustees, Tables V.G1, V.G3, V.G5.

Comparison to 2012 Estimates

In their 2013 report, the Medicare Trustees reported some improvement in Medicare’s financial outlook from projections in their 2012 report. For example, the expected depletion date of the HI trust fund (2026) is two years later than had been projected in last year’s report (2024). Additionally, over the next 75 years, the estimated HI actuarial deficit (the amount that would need to be added to the payroll tax to maintain HI solvency for this period) decreased from 1.35% of taxable payroll in last year’s report, to 1.11% of taxable payroll in the 2013 report. The main reasons cited include (1) lower projected spending for most services covered under Part A, especially for skilled nursing facilities, to reflect lower than expected spending in 2012 and other recent data; (2) lower projected Medicare Advantage (Part C) costs that reflect data suggesting that provisions of the ACA will reduce growth in these costs by more than had been estimated;

¹⁹ The Trustees note that while SMI general revenue transfers represent formal budget commitments under current law, no provision exists for covering the HI trust fund once assets are depleted.

and (3) a refinement in certain projection methods that reduces long-term per beneficiary cost growth. These positive changes were somewhat offset by lower projected levels of payroll tax income reflecting lower than expected 2012 tax income.

Part B outlay projections are slightly higher than in last year's report, mostly due to a change in how Medicare Advantage payment rates will be determined beginning in 2014.²⁰ Projected Part D expenditures are slightly lower than in last year's report mainly due to a greater than expected impact of expirations of the patents for several major drugs in 2012, and the increase in use of generic drugs.

Alternative Projections

Throughout the 2013 report, the Medicare Trustees caution that actual costs are likely to be higher than their intermediate projections. For example, because the Trustees are required to base their estimates on current law, their assumptions assume that the ACA-required Medicare plan and provider payment reductions are maintained;²¹ that scheduled physician payment reductions of approximately 25% under the sustainable growth rate system (SGR) will occur beginning in 2014;²² that the Independent Payment Advisory Board (IPAB) proposals to reduce Medicare costs will go into effect;²³ and that the 2% reduction in Medicare benefit spending under the Budget Control Act of 2011 sequestration requirements, which began in April 2013,²⁴ will continue through 2021.

Because of concerns about the accuracy of these projections, the Medicare Trustees asked the CMS Office of the Actuary to prepare alternative projections based on the assumptions that the physician payment reductions would not occur, that some of the ACA provider payment adjustments would be phased out beginning in 2020, and that some reductions proposed by the IPAB would not occur.²⁵ Under this alternative scenario, long-term Medicare costs are projected to reach 9.8% of GDP in 2087, instead of 6.5% under current law.²⁶ Additionally, under the alternative scenario, the HI actuarial deficit would be 2.17% of taxable payroll (compared to 1.11% under current law), which could be addressed by immediately increasing payroll taxes to

²⁰ The determination of future payments will take into account expected future legislative overrides of physician payment reductions. For additional information, see "Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," April 1, 2013, at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Announcement2014.pdf>.

²¹ See CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis for more information.

²² For additional information on the Medicare physician payment system, see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn and Janemarie Mulvey.

²³ For information on the IPAB, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

²⁴ See CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

²⁵ John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers," May 31, 2013, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2013TRAlternativeScenario.pdf>.

²⁶ Under the illustrative alternative projections, Part B costs would be 4.3% of GDP in 2087, compared to 2.6% under current law. This is mainly due to the assumption that future physician payment rates would not be reduced as scheduled under current law.

5.07% or by immediately decreasing expenditures by 36% (compared to 4.01% and 22% respectively under current law). Similar to current law projections, the alternative scenario also projects an HI insolvency date of 2026, although it expects it to occur earlier in the year.

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