Health Policy Brief

May 2011 • No. 2

NATIONAL ACADEMY OF SOCIAL INSURANCE

Medicare Finances: Findings of the 2011 Trustees Report

By Sabiha Zainulbhai and Lee Goldberg

Summary

Each year, the Trustees of the Medicare program issue a report on the expected condition of the program's two trust funds over a 10-year (short-term) and a 75-year (long-term) period. The 2011 report projects that Medicare's Hospital Insurance (HI) Trust Fund will remain solvent until 2024, at which time projected annual income will cover 90 percent of expenditures. This year's report decreases the date of solvency by five years.

The Trustees Report will spur further debate over Medicare expenditures and the federal debt. Although the passage of the Patient Protection and Affordable Care Act (ACA) in 2010 significantly improved the financial condition of Medicare's HI Trust Fund, some contend that Medicare must be fundamentally restructured in order to improve the fiscal condition of the program and reduce its projected share of federal spending. Others point out that Medicare spending is influenced by the same factors that drive private sector health care spending; policies to limit Medicare spending without addressing dysfunctions in the larger health care system would shift costs to beneficiaries and reduce access to care for the aged and disabled.

Medicare's History and Structure

Medicare was established in 1965 as a federal social insurance program to provide what the private insurance market did not: adequate, affordable health insurance for America's elderly population. Prior to Medicare's enactment, only about half of the elderly population in America had health insurance, and they paid close to three times as much as younger people while having half as much income (NASI, 1999). Forty-six years later, Medicare helps pay medical expenses for 39.6 million individuals aged 65 and older and 7.9 million individuals with disabilities.

Medicare's finances are managed through two trust funds, the Hospital Insurance (HI) Trust Fund (which pays for Part A benefits) and the Supplementary Medical Insurance (SMI) Trust Fund (which pays for Part B and Part D benefits). Table 1 summarizes the major features of the program.

Lee Goldberg is Director of Health Policy and **Sabiha Zainulbhai** is Health Policy Assistant at the National Academy of Social Insurance. Unless otherwise indicated, data in this brief come from the 2011 Medicare Trustees Report.

Table 1.
Medicare Coverage and Financing

Program Details	Hospital Insurance (HI) Trust Fund	Supplementary Medical Insurance (SMI) Trust Fund
Services Covered	Inpatient hospital stays, skilled nursing facility stays, hospice care, home health visits.	Part B: Physician visits, outpatient services, lab tests, medical supplies, home health. Part D: Outpatient prescription drugs.
Major Funding Sources	Payroll taxes paid by workers and employers; interest earned on Trust Fund reserves; income taxes on part of Social Security benefits of upper income beneficiaries.	Monthly premiums paid by beneficiaries; general revenues composed of federal income taxes; payments from states for premiums and a portion of the cost of outpatient prescription drugs for low-income beneficiaries eligible for Medicaid.
Percent of Medicare Spending in 2010	47 percent.	Part B: 41 percent. Part D: 12 percent.

Part A of Medicare automatically enrolls individuals age 65 and older if they (or their spouse) are entitled to Social Security benefits and have contributed payroll taxes on their wages for at least 10 years. The Medicare payroll tax is 1.45 percent on the wages of both employers and employees (2.9 percent cumulatively),[1] and is the primary source of funding for Part A benefits. Unlike Social Security taxes, which are limited to earnings below a certain level[2], Medicare taxes are collected on worker's entire earnings. In fact, beginning in 2013, the ACA increases Medicare payroll taxes by 0.9% for high-income taxpayers (individuals making more than $200,000 annually and couples making more than $250,000 annually). In 2010, payroll tax revenue provided 84.4 percent of the income of the HI Trust Fund, with interest earned on the investments of the Trust Fund and income taxes on a portion of Social Security benefits making up most of the balance.

The SMI Trust Fund consists of two separate accounts – one for Part B (which pays for physician and other outpatient health services) and one for Part D (which pays for outpatient prescription drugs). Beneficiaries who choose to participate in Part B or Part D must enroll and pay monthly premiums. Premiums for Part B are required by law to cover 25 percent of SMI expenditures. In 2011, beneficiaries pay a monthly premium of $115.40 for outpatient and other services covered by Part B. The Part D program, which covers prescription drugs, requires an additional premium that averages $31 per month. As predicted in last year's report, premiums for Part B rose significantly for approximately one-fourth of beneficiaries in 2011 due to Congressional delay of the scheduled physician fee reductions and the existing "hold harmless" provision restricting premium increases for most Part B beneficiaries.[3] The cost of Parts B and

[1] The self-employed pay both halves of the Medicare tax, but can deduct half of the tax as an adjustment to income.
[2] The Social Security program limits the amount of annual earnings subject to taxation. In 2010, the amount is $106,800 (SSA, 2010).
[3] The "hold harmless" provision protects individuals from Part B premium increases when the Social Security cost-of-living adjustment (COLA) is not sufficient to cover the increase in Part B premiums. Since there was no COLA for 2010, premiums for Part B beneficiaries protected by the hold-harmless provision did not rise. However, those not protected by the hold-harmless provision (roughly a quarter of Part B beneficiaries who are either new enrollees who did not receive Social Security payments the previous year, high-income enrollees or dual eligibles whose premiums are paid by state Medicaid programs) saw a significant increase in their Part B premiums. The premium increase for this group of beneficiaries should offset the loss of revenue from those protected by the hold-harmless provision (Kaiser, 2010).

Part D not covered by premiums is financed through general revenues that include income taxes paid by taxpayers of all ages.

Medicare beneficiaries are subject to cost-sharing provisions in the form of deductibles and coinsurance. In addition, beneficiaries must pay for health services not covered by Medicare, which include routine dental care, eyeglasses, hearing aids, and most long-term services and supports.

Table 2.
Trust Fund Results in 2010 (in billions)

	HI	SMI		Total
	Part A	Part B	Part D	
Total Income (2010)	**$215.6**	**$208.8**	**$61.7**	**$486.0**
Payroll taxes	182.0	---	---	182.0
Interest	13.8	3.1	0.0	16.9
Taxes on benefits	13.8	---	---	13.8
Premiums	3.3	52.0	6.5	61.8
General revenue	0.1	153.5	51.1	204.7
Transfers from States	---	---	4.0	4.0
Other	2.7	0.2	---	2.9
Total Expenditures (2010)	**$247.9**	**$212.9**	**$62.0**	**$522.8**
Benefits	244.5	209.7	61.7	515.8
Hospital	136.1	31.9	---	168.0
Skilled nursing facility	26.9	---	---	26.9
Home health care	7.0	12.1	---	19.1
Physician fee schedule services	---	64.5	---	64.5
Private health plans (Part C)	60.7	55.2	---	115.9
Prescription drugs	---	---	61.7	61.7
Other	13.8	46.1	---	59.9
Administrative expenses	3.5	3.2	0.4	7.0
Net change in assets	**-$32.3**	**-$4.1**	**-$0.4**	**-$36.8**
Assets (end of 2010)	**$271.9**	**$71.4**	**$0.7**	**$344.0**

Source: Board of Trustees, 2011. Table II.B1.

What Is Medicare's Financial Situation?

In 2010, the HI Trust Fund received income of $215.6 billion and paid out $247.9 billion in benefits and administrative expenses, leaving a deficit of $32.3 billion for the year. At the end of 2010, the HI Trust Fund held $271.9 billion in assets. Table 2 presents 2010 data for each part of the Medicare program.

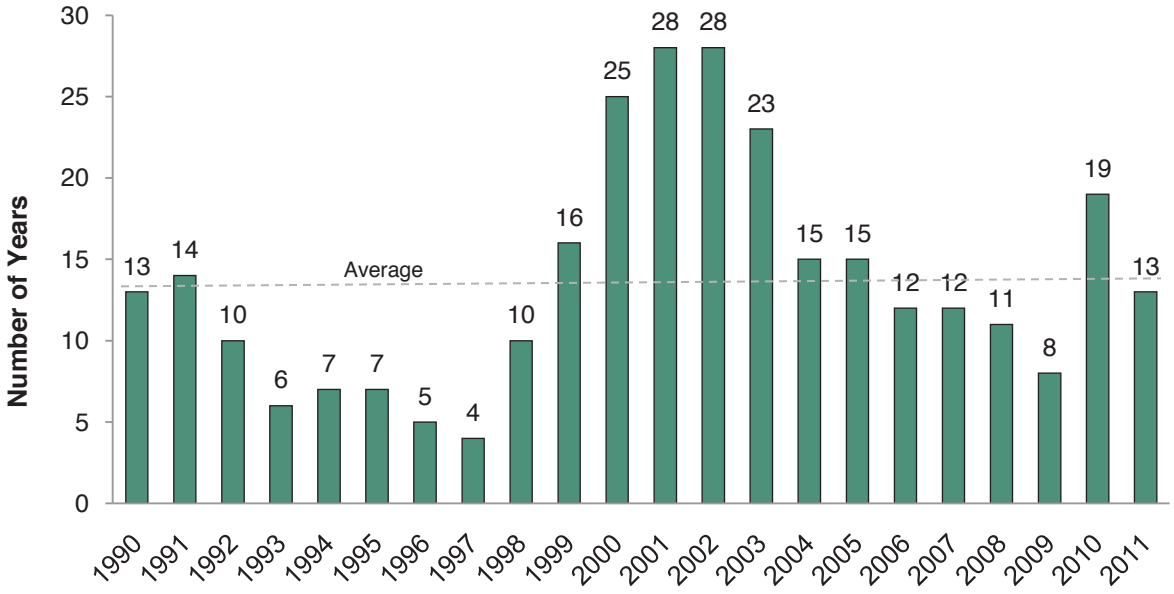
Each year, the Trustees Report projects the year that the HI Trust Fund will become insolvent. The HI Trust Fund began running deficits in 2008 and according to the 2011 report, reserves are projected to be depleted by 2024. At that point, if no changes are made, scheduled HI income will cover 90 percent of estimated expenditures. Put another way, when HI Trust Fund reserves are depleted in 2024, payments to doctors and hospitals can still be made, but only from current

payroll tax contributions; these tax contributions will only be sufficient to cover 90 cents on the dollar. Congress could make up this gap through direct appropriations.

The estimation of the HI Trust Fund's solvency is based on a number of economic factors, including changes in demographics and the health care system. As shown in Figure 1, since 1990, estimates of continued HI solvency have ranged from as few as four years to as much as 28 years, with the length of continued solvency averaging 13.7 years. Projections of HI solvency in 2011 fall just below the average over the last 21 years. HI insolvency has been avoided in part because Congress has made frequent adjustments to the program to ensure future spending and resources are in balance.

The SMI Trust Fund, on the other hand, is always adequately financed because beneficiary premiums and general revenue contributions are set annually to cover the expected cost of Part B and Part D benefits. However, the rapid rate of growth in program costs will place increasing financial demands on both beneficiaries (to pay the premiums) and taxpayers (to provide the general revenues). In 2010, the SMI Trust Fund had an income of $270.5 billion and expenditures of $274.9 billion.

Figure 1. Projected Years of Solvency for HI Trust Fund (1990-2011)



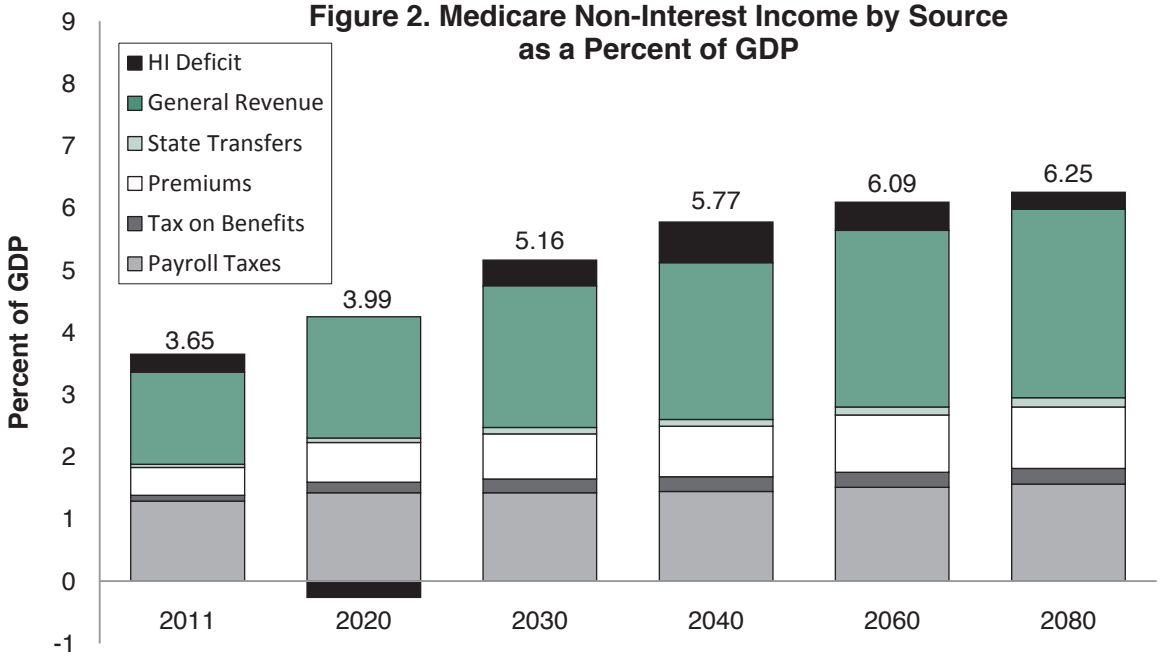
Source: National Academy of Social Insurance, based on data from Board of Trustees (various years).

What Are the Long-Range Trends in Medicare Costs?

The Trustees Report includes a long-term projection of Medicare's income and expenditures over the next 75 years. There are several ways of making comparisons over such a long period of time, and here we examine two of them.

1. *Medicare Income and Expenditures as a Percent of Gross Domestic Product (GDP).* One way to express the growth in the total Medicare program is as a percentage of the GDP, which is the total value of all goods and services produced in the United States. This reflects society's current resources devoted to Medicare and provides a broader context for the combined costs of HI and SMI. Under the Trustees' intermediate assumptions[4], total Medicare expenditures will grow from 3.65 percent of GDP in 2011 to 3.99 percent of GDP in 2020 and 6.25 percent of GDP in 2080, as shown by the height of the bars in Figure 2. The components of the bars show projected HI funding and its projected financial shortfall. Payroll taxes will remain relatively constant as a share of GDP, while the other sources of financing will increase as a share of GDP. The HI deficit will decrease from 0.29 percent of GDP in 2011 to 0.27 percent in 2080, and will average 0.37 percent of GDP over the next 75 years.

Figure 2. Medicare Non-Interest Income by Source as a Percent of GDP



Source: Summary of Board of Trustees 2011, Chart C.

[4] The financial projections for Medicare rely on economic assumptions about future birth rates, longevity, productivity, labor force participation rates, health care costs, and other variables that involve considerable uncertainty. While many of the demographic factors are unlikely to change significantly in the near term, estimates of HI solvency and SMI expenditures are particularly sensitive to small differences between projected and actual economic outcomes. As a result, the Trustees rely on three sets of economic assumptions that embody alternative scenarios:

- A "low-cost" assumption that represents an optimistic outlook assuming relatively strong economic growth and relatively optimistic levels for other parameters;
- A "high-cost" assumption that represents a pessimistic scenario assuming weak economic growth in the short-range period and relatively pessimistic levels for other parameters; and
- An intermediate assumption that reflects the Trustees' consensus expectations with underlying assumptions of moderate economic growth throughout the projected period and moderate levels for other parameters.

2. *HI Income and Expenditures as a Percent of Taxable Payroll*. An alternative measure of Medicare's future costs is the actuarial balance of the HI Trust Fund. The actuarial balance of a fund is the difference between annual income and costs, expressed as a percentage of taxable payroll over the 75-year projection period. According to the Trustees' intermediate assumptions, HI income will average 3.84 percent of taxable payroll, while costs will average 4.63 percent, leaving a deficit of 0.79 percent of taxable payroll over the next 75 years. This means that an immediate increase in the HI payroll tax of 0.4 percent each for workers and employers (an increase from 1.45 percent to 1.85 percent) would close this projected HI deficit.

How Do the 2011 Projections Compare to Last Year's?

There are small changes in Medicare's financial outlook as compared to last year. The projected date of exhaustion of the HI Trust Fund changes from 2029 to 2024. The 75-year HI deficit has increased slightly from 0.66 percent to 0.79 percent of taxable payroll. Medicare spending is now projected to total 6.25 percent of GDP in 2080, compared to 6.37 percent in last year's report.

What Is the Unfunded Obligation?

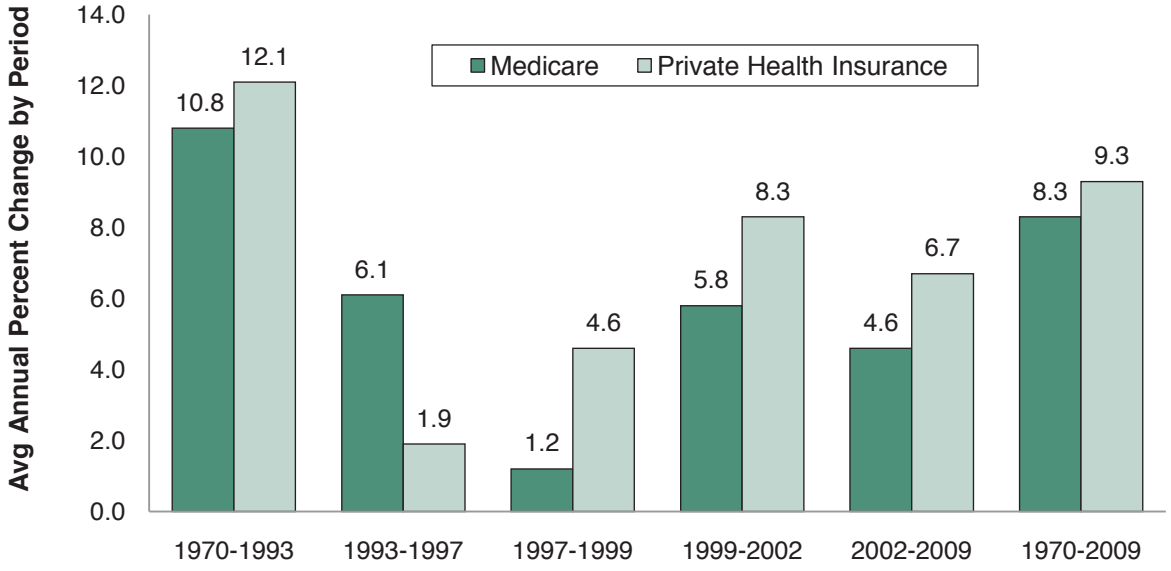
A program's unfunded obligation is a way of summarizing its funding shortfall in a single dollar number. Technically speaking, it is the difference between the present value of the projected cost of a program over a specified time period and the present value of projected income (including the initial value of the Trust Fund). In other words, the unfunded obligation is the amount of money that would have to be added to the HI Trust Fund today to make the program financially sound for the specified time period.

The 2011 Trustees Report estimates that the unfunded obligation of the HI Trust Fund for past, current, and future participants is $3 trillion over the next 75 years, or the equivalent of 0.3 percent of GDP over that period. The SMI Trust Fund has no unfunded obligation because general revenues cover all spending that is not financed by other dedicated funding sources. However, the Trustees Report also provides an estimate of the present value of the required general revenue contributions to Parts B and D of Medicare, equal to $21.2 trillion (2.4 percent of GDP).

Why Is Medicare Spending Growing So Rapidly?

Medicare's spending is growing rapidly for many of the same reasons that private health spending is growing rapidly — increases in the cost and use of medical services. Much of these increases stem from advances in medical practice and technology that have enabled people to live longer and healthier lives. Additionally, as the baby boom generation reaches age 65 and becomes eligible to receive benefits, health care resources will be further strained. Over the years, Medicare's per capita costs have grown more slowly than those of the private sector in some periods and more rapidly in others; in recent years however, Medicare spending has grown more slowly than private health spending (see Figure 3).

Figure 3. Growth in Medicare Spending and Private Health Insurance Premiums per Enrollee for Common Benefits* (1970-2009)



*Common benefits refers to benefits commonly covered by Medicare and Private Health Insurance. These benefits are hospital services, physician and clinical services, other professional services and durable medical products.

Source: Centers for Medicare and Medicaid Services, 2009.

Who Receives Medicare? How Much Does Medicare Spend Per Person?

In 2010, some 47.5 million people, or one out of every seven individuals, receive care financed through one or more parts of Medicare. Most enrollees live in families with modest incomes and almost half (47 percent) have an income below 200 percent of the poverty level (Kaiser, 2010). In 2010, the median income among Medicare beneficiaries was $20,644, and half of all beneficiaries have less than $60,000 in home equity, less than $2,000 in retirement savings, and less than $30,000 in financial assets (Kaiser, 2011).

Medicare spending is highly concentrated among a small group of people who have significant medical needs. Ten percent of beneficiaries accounted for almost 60 percent of spending, while 22 percent of beneficiaries incurred less than $1,000 each in Medicare costs (accounting for only 1 percent of program spending), and 12 percent incurred no costs at all (Kaiser, 2010).

How Confident Can We Be In These Projections?

The Trustees Report includes alternative economic scenarios, but two points are important to remember. First, under the low-cost assumptions, the HI program is projected to run a deficit over the next 75 years. Second, the projections become more uncertain the further they are extended into the future. Small changes in the assumptions used can lead to big differences in estimated costs or revenues when projected over many decades.

References

Board of Trustees. 2010. *2010 Annual Report of the Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Centers for Medicare & Medicaid Services.

Board of Trustees. 2011. *2011 Annual Report of the Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Centers for Medicare & Medicaid Services.

Centers for Medicare & Medicaid Services. "National Health Expenditure Web Tables." Table 13. Baltimore, MD: Center for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. Available at https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf. Accessed May 5, 2011.

Kaiser Family Foundation. 2010. *Medicare Chartbook*. Washington, DC. Available at http://www.kff.org/medicare/upload/8103.pdf. Accessed May 5, 2011.

Kaiser Family Foundation. 2010. *Medicare: A Primer*. Washington, DC. Available at http://www.kff.org/medicare/upload/7615-03.pdf. Accessed May 5, 2011.

Kaiser Family Foundation. 2011. "Projecting Income and Assets: What Might the Future Hold for the Next Generation of Medicare Beneficiaries". Washington, DC. Available at http://www.kff.org/medicare/upload/8172.pdf. Accessed May 5, 2011.

The National Academy of Social Insurance. 1999. *Medicare and the American Social Contract*. Washington, DC. Available at http://www.nasi.org/sites/default/files/research/med_report_soc_contract.pdf. Accessed May 5, 2011.

Social Security Administration. 2011. "Actuarial Publications: Status of the Social Security and Medicare Programs." Baltimore, MD: Social Security Administration, Office of the Chief Actuary. Available at http://www.ssa.gov/OACT/TRSUM/index.html. Accessed May 5, 2011.

Social Security Administration. 2010. "Automatic Increases: Contribution and Benefit Base." Baltimore, MD: Social Security Administration, Office of the Chief Actuary. Available at http://www.ssa.gov/oact/cola/cbb.html. Accessed May 5, 2011.

National Academy of Social Insurance (NASI)
1776 Massachusetts Avenue, NW, Suite 400
Washington, DC 20036-1904
(202) 452-8097 ▪ (202) 452-8111 Fax
e-mail: nasi@nasi.org ▪ web: www.nasi.org ▪ twitter: @socialinsurance

The National Academy of Social Insurance (NASI) is a nonprofit, nonpartisan organization made up of the nation's leading experts on social insurance. Its mission is to promote understanding of how social insurance contributes to economic security and a vibrant economy.

Printed on recycled paper using
vegetable-based inks and 100% wind power.

MIX
Paper from responsible sources
FSC® C011270