

Medicare Finances: Findings of the 2012 Trustees Report

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Summary

Medicare is the federal health insurance program for Americans aged 65 and older and younger adults 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). Each year, the Medicare Trustees give a detailed account of the expected condition of the program's two trust funds over the short and long-term.

According to the 2012 Trustees Report, expenditures from Medicare's HI Trust Fund exceeded revenues by \$27.7 billion in 2011. Without a policy change that would increase revenues or reduce expenditures, the accumulated surplus in the HI Trust Fund will be depleted by 2024, the same as last year's projection; after that, the HI Trust Fund would rely on the annual revenues from Medicare payroll taxes, which are projected to cover 87 percent of annual expenditures.

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 regardless of income or health status. Prior to Medicare, only half of the population age 65 and older had health insurance. Even among those 65 and older who were insured, premiums and other out of pocket costs were close to three times what younger people paid, even though the elderly had on average only half as much income (NASI, 1999). The program has since expanded to include people under 65 with disabilities, and those with end stage renal disease.

Forty-seven years after its creation, Medicare helps pay medical expenses for nearly all individuals 65 years and older (40.4 million) and 8.3 million individuals under 65 with disabilities.

Approximately 19 percent of Medicare enrollees are also eligible for Medicaid, the federal-state health insurance program for low and modest income people, and are known as "dual eligibles".

Table 1 summarizes the major features of the program.

Medicare Part A 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

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Table 1. Medicare Coverage and Financing

Program Details	Hospital Insurance (HI) Trust Fund (Part A)	Supplementary Medical Insurance (SMI) Trust Fund (Part B and D)
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: 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.
Percent of Medicare Spending in 2011	47%	Part B: 41% Part D: 12%

years.¹ The Medicare payroll tax is 1.45 percent on the wages of both employers and employees (2.9 percent cumulatively).² Unlike Social Security taxes, which are limited to income up to a certain level³, Medicare taxes are collected on a worker’s total wages.⁴ Last year, the Trustees found revenue from payroll taxes provided 85.5 percent of the income for 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. Medicare payroll taxes are not levied on dividends, returns or other passive investments.

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 set so that the aggregate amount paid by beneficiaries will cover roughly 25 percent of Part B expenditures. In 2012, beneficiaries pay a standard monthly premium of \$99.90 for physician outpatient and other services covered by Part B; high-income enrollees (individuals with annual incomes greater than \$85,000 and married couples with annual incomes greater than \$170,000) pay a higher, income-related premium that ranges from \$139.90 to \$319.70 per month. The Part D program, which covers prescription drugs, requires an additional premium that averages \$31 per month.⁵ The cost of Part B and 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 on certain benefits in the form of deductibles and coinsurance. Beneficiaries must also pay for health services not covered by Medicare, which include routine dental care, eyeglasses, hearing aids, and most long-term services and supports. For Medicare beneficiaries who also qualify for Medicaid (dual eligibles), Medicaid pays for a portion of Medicare premiums and cost-sharing⁶; Medicaid also offers benefits not covered by Medicare, such as long-term services and supports.

¹ A U.S. Court of Appeals recently ruled that those who receive Social Security cannot opt out of Medicare Part A. For the full opinion, see: <http://thefundforpersonalliberty.org/pdf/120207-1356903-Appeals-Court-Opinion.pdf>.

² The self-employed pay both halves of the Medicare tax, but can deduct half of the tax as an adjustment to income.

³ The limit to the amount of earnings subject to Social Security taxes in 2012 is \$110,100 (SSA, 2012).

⁴ In fact, beginning in 2013, the ACA increases Medicare payroll taxes by 0.9 percent for individuals earning more than \$200,000 annually and couples earning more than \$250,000 annually.

⁵ For Part D drug plan enrollees, Medicare provides a subsidy that averages 74.5 percent of standard coverage. The subsidy takes two forms: one part is a capitated payment to Part D drug plans calculated as a share of the adjusted national average of plan bids and the second is individual reinsurance drug spending above an enrollee’s catastrophic threshold (MedPAC, 2008).

⁶ State-administered Medicare Savings Programs may cover all or part of Part A and Part B cost-sharing, depending on an individual’s or married couple’s income and assets. Medicare also has a Low Income Subsidy program that covers Part D premiums for individuals and married couples below a certain income threshold (CMS, 2012).

Table 2. Trust Fund Results in 2011 (in billions)

	HI	SMI		Total
	Part A	Part B	Part D	
Total Income (2011)	\$228.9	\$233.6	\$67.4	\$530.0
Payroll taxes	195.6	---	---	195.6
Interest	12.0	3.2	0.0	15.2
Taxes on 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 (2011)	\$256.7	\$225.3	\$67.1	\$541.3
Benefits	252.9	221.7	66.7	541.3
Hospital	132.7	35.1	---	167.8
Skilled nursing facility	32.9	---	---	32.9
Home health care	7.3	12.4	---	19.6
Physician fee schedule services	---	67.6	---	67.6
Private health 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 in assets	-\$27.7	\$8.3	\$0.3	-\$19.2
Assets (end of 2011)	\$244.2	\$79.7	\$1.0	\$324.9

Source: Board of Trustees, 2012. Table II.B1.

What Is Medicare's Financial Situation?

In 2011, the HI Trust Fund received income of \$228.9 billion and paid out \$256.7 billion in benefits and administrative expenses, leaving a deficit of \$27.7 billion for the year. The HI Trust Fund has been running a deficit since 2008, when annual expenditures first exceeded income.⁷ At the end of 2011, however, the HI Trust Fund still held \$244.2 billion in assets. Table 2 presents 2011 data for each part of the Medicare program.

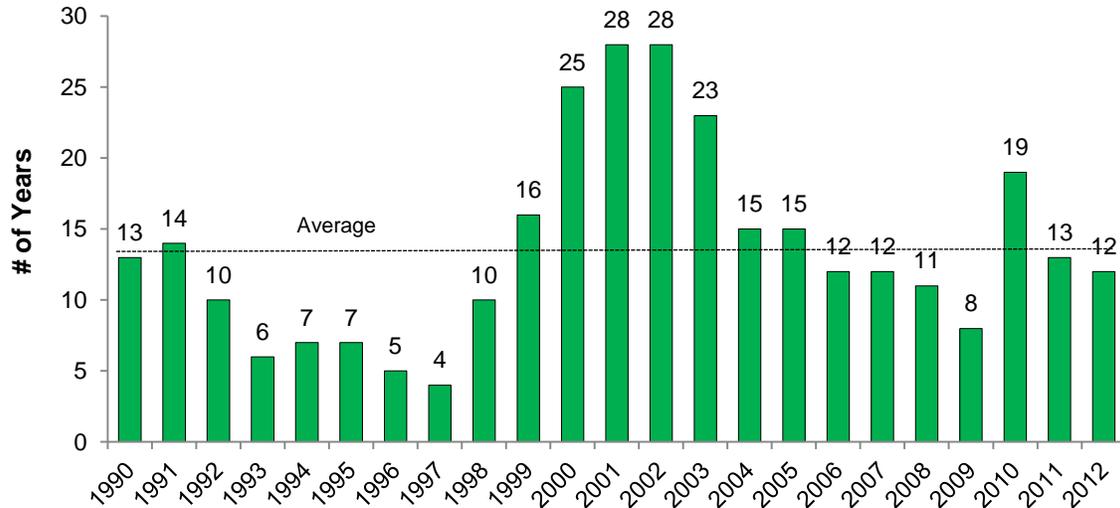
Each year, the Trustees estimate the year through which the HI Trust Fund will remain solvent, i.e. the date through which reserves are sufficient to cover 100 percent of costs. The 2012 report finds that HI Trust Fund will be solvent through 2024. If no changes are made by that year, the HI Trust Fund will still be able to cover 87 percent of hospital insurance expenditures that year. 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 Medicare payroll tax contributions; these tax contributions will be sufficient to cover 87 cents on the dollar.

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 four years to 28 years, with the length of continued solvency averaging 13.6 years. Projections of HI solvency in 2012 fall below the average over the last 23 years.

⁷ In years when there is an HI deficit, special bonds that are issued during surpluses are redeemed from the Treasury Department to pay for Medicare benefits. This requires a cash transfer from the general fund of the Treasury. The cash transfer, along with any interest earned on reserves, is used to pay benefits.

In the past, HI insolvency has been avoided through frequent adjustments to the program to ensure that spending and resources are in balance.

Figure 1. Projected Years of Solvency for HI Trust Fund, 1990-2012



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

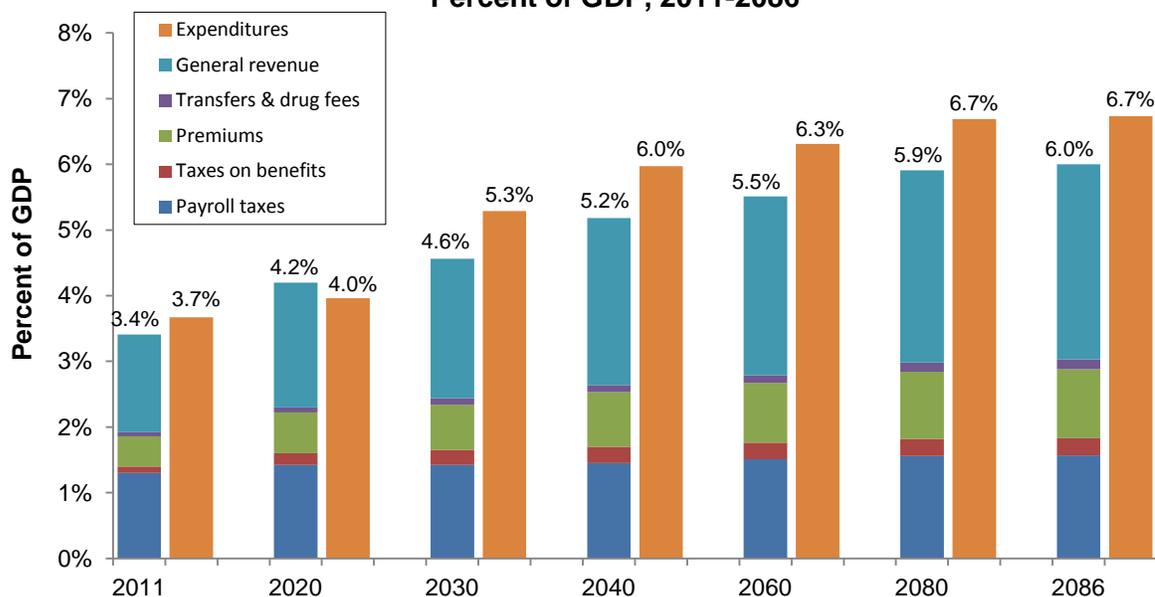
The SMI Trust Fund, on the other hand, is always adequately financed because beneficiary premiums and general revenue contributions together are set annually to cover the expected cost of Part B and Part D benefits. The rapid growth in the cost of Part B and Part D benefits is projected to place increasing financial demands on both beneficiaries (to pay the premiums) and taxpayers (to provide the general revenues).

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. 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 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 total Medicare expenditures will grow from 3.7 percent of GDP in 2011 to 4 percent of GDP in 2020 and 6.7 percent of GDP in 2086, as shown in Figure 2. The components of the bars show projected HI income (payroll taxes, tax on benefits, premiums, state transfers and drug fees and general revenue) and projected HI expenditures through 2086. While payroll taxes will remain relatively constant as a share of GDP, other relatively minor sources of financing will increase slightly. The HI deficit (the difference between HI income and HI expenditures) will increase from 0.26 percent of GDP in 2011 to 0.73 percent in 2086, and will average 0.63 percent of GDP over the next 75 years.

Figure 2. Medicare Cost and Non-Interest Income as a Percent of GDP, 2011-2086



Source: Summary of Board of Trustees 2012, Chart C.

2. *HI Income and Expenditures as a Percent of Taxable Payroll.* Medicare’s long-range HI deficit could be avoided by increasing the standard Medicare payroll tax by 0.67 percent each for workers and employers (an increase from 1.45 percent to 2.12 percent)⁸. This measure, known as the actuarial balance, is the difference between annual income and costs expressed as a percentage of total earnings and self-employment income that is subject to Medicare taxes over the 75-year projection period. According to the Trustees’ intermediate assumptions, HI income will average 3.86 percent of taxable payroll, while costs will average 5.21 percent, leaving a deficit of 1.35 percent over the next 75 years.⁹ Closing the actuarial deficit over the next 75 years amounts to an extra 75 cents a day or \$11.25 a biweekly paycheck¹⁰ for a worker making \$40,000 a year.¹¹

How Do the 2012 Projections Compare to Last Year’s?

There are small changes in Medicare’s financial outlook as compared to last year. The projected date of continued solvency of the HI Trust Fund did not change, however; it remains at 2024. The 75-year HI deficit has increased from 0.79 percent to 1.35 percent of taxable payroll. Medicare spending is now projected to total 6.69 percent of GDP in 2080, compared to 6.25 percent in last year’s report.

What Is the Unfunded Obligation?

Medicare’s unfunded obligation is another way of summarizing the funding shortfall in a single dollar amount. 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 by which expenditures

⁸ The Trustees also calculate the 25- and 50-year actuarial balance. In 2012, these were 0.69 and 1.17 percent, respectively.

⁹ The long-range HI deficit could also be eliminated by reducing HI expenditures by an amount equal to the difference between income and expenditures, though this is not an analysis the Trustees undertake.

¹⁰ The calculation assumes 26 paychecks per year.

¹¹ Employers would also pay the matching rate of 75 cents a day or \$11.25 per biweekly paycheck.

would have to be reduced or the amount that would have to be added to the HI Trust Fund to make the program financially sound for the next 75 years.

The 2012 Trustees Report estimates that the unfunded obligation of the HI Trust Fund for past, current, and future participants is \$5.3 trillion over the next 75 years. This is the equivalent of 1.3 percent of the HI taxable payroll and 0.6 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 \$21.6 trillion (2.4 percent of GDP).

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

In 2011, some 48.7 million people, or approximately one out of every seven individuals, received care financed through one or more parts of Medicare. While 83 percent of Medicare enrollees are 65 and older, 17 percent are under 65 and disabled.

Most people who receive Medicare benefits have modest incomes. In 2010, the median income among Medicare enrollees was under \$22,000 and nearly half of enrollees had incomes below 200 percent of the federal poverty level. Poverty rates for Medicare enrollees who are under 65 are even greater; of this population, over two-thirds live on incomes below 200 percent of the poverty level and more than one-third live in poverty. Moreover, half of those enrolled in Medicare 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).

Despite people's lifetime contributions in Medicare payroll taxes (which amount to \$84,000 for a couple with low to average wages)¹², enrollees also pay a significant amount out of pocket (Steuerle, 2011). In 2006, Medicare enrollees spent roughly 16 percent of their income on out of pocket expenses, an amount that rises dramatically with age, poor health status and low income (Kaiser, 2011).

Medicare spending is highly skewed, however. Medicare spends \$8,300 per enrollee on average, but that overall spending is highly concentrated on a small group of people who have significant chronic conditions, functional limitations, and acute care needs (Feder, 2012). In 2006, the top ten percent of beneficiaries accounted for almost 60 percent of spending, or \$48,200 per enrollee, while the bottom 90 percent of enrollees only cost Medicare around \$3,900 on average (Kaiser, 2010).

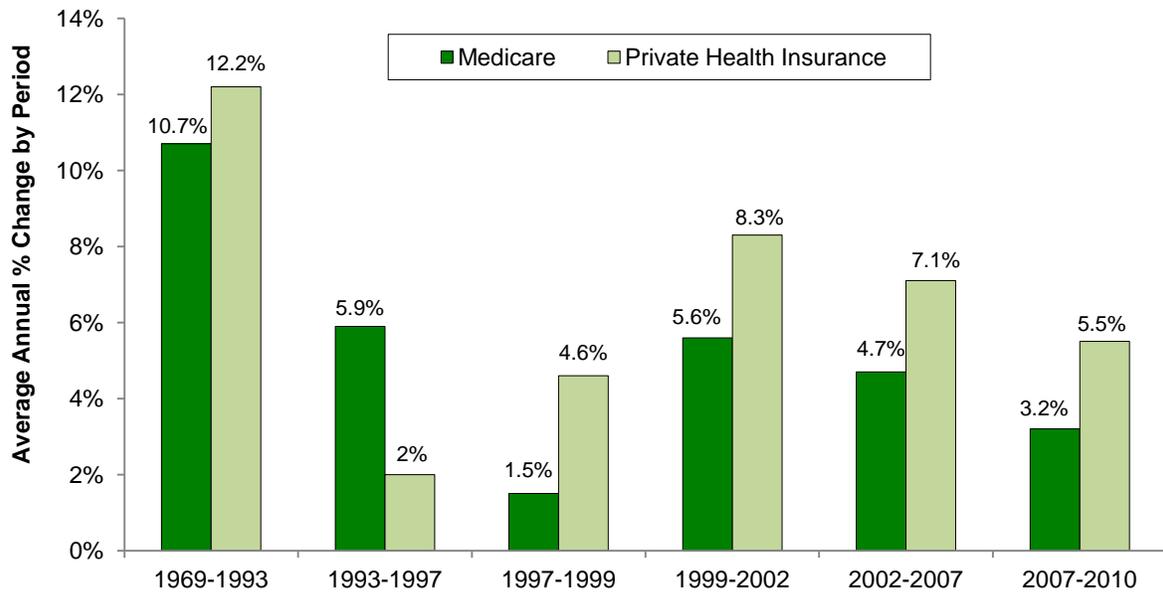
Why Is Medicare Spending Growing So Rapidly?

Medicare spending is growing for many of the same reasons health care spending in the private sector is growing -- higher prices for providers, intensity of services and new medical technology. Medicare, however, has an additional reason for its rapid growth: the projected increase in individuals eligible to enroll as the baby boom generation ages.

Figure 3 compares per capita spending in Medicare and private health insurance over time. Medicare's per capita costs have grown more slowly than those of the private sector in some periods and more rapidly in others; since 1997, however, Medicare spending, on average, has grown more slowly than private health spending.

¹² A couple with low to average wages retiring in 2010 would pay roughly \$84,000 over their lifetime in Medicare payroll taxes, but would receive around \$350,000 in benefits.

Figure 3. Growth in Medicare Spending and Private Health Insurance Premiums per Enrollee for Common Benefits*, 1969-2010



*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 & Medicaid Services, 2010.

How Confident Can We Be In These Projections?

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.¹³ While demographic factors are unlikely to change significantly in the near term, estimates of HI solvency and SMI expenditures are sensitive to small differences between projected and actual economic performance. 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 underlying assumptions of moderate economic growth throughout the projected period and moderate levels for other parameters.

Conclusion

There is a broadly shared concern in both political parties about the projected impact of Medicare on the federal budget. Although the 2012 Trustees Report is likely to spur debate over proposed changes to the program, the challenges are clear: efforts to improve the financial condition of the program must deal with the increasing number of enrollees, not just health care costs per capita. The Congressional Budget Office estimates that enrollment in Medicare will nearly double in coming decades, reaching 80 million people by 2030. Although efforts to reduce Medicare expenditures are controversial, the Trustees Report clarifies the revenue needs of the program.

¹³ For example, projections in the report are based on the assumption that there will be large reductions in physician fees required by the sustainable growth rate, which have been waived by Congress every year since 2001.

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