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Medicare Finances: Findings of the 2020 Trustees Report

By: Bethany Cole

Summary

Medicare provides health insurance coverage to about 61 million Americans – 52.6 million ages 65 and older and 8.7 million persons with disabilities – and is one of the nation's largest sources of health coverage. Close to 20 percent of U.S. health expenditures flow through Medicare, which provides coverage for about one of every six people residing in the U.S.

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 both the short and long terms.

According to the 2020 Medicare Trustees Report, expenditures from Medicare's HI Trust Fund exceeded revenues by $5.8 billion in 2019. Without a policy change aimed at increasing revenues or reducing expenditures, the surplus that has accumulated in the HI Trust Fund over the years will be depleted by 2026. The HI Trust Fund will have to rely on the annual revenue from Medicare payroll taxes and to a lesser extent its other sources of income, which together are projected to cover 90 percent of annual expenditures in 2026. The solvency of the HI Trust Fund is separate and apart from the program's impact on the federal budget and the continued affordability of beneficiary cost-sharing.

The projected solvency date for the HI Trust Fund is 2026, unchanged from last year. The 75-year actuarial deficit for the HI Trust Fund has decreased from 0.91 percent to 0.76 percent of taxable payroll in this year's report and is equivalent to 0.3 percent of GDP through 2094. Part B and Part D benefits are not at risk of insolvency because financing is derived through beneficiary premiums and cost-sharing requirements with general revenues filling the gap.

At the National Academy of Social Insurance, **Bethany Cole** is a Research Assistant for Health Policy.

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. Among those 65 and older who were insured, premiums and other out-of-pocket costs were close to three times that of younger people's, even though the elderly had on average only half as much income (National Academy of Social Insurance, 1999).

In 2019, 61 million Americans – 52.6 million ages 65 and older and 8.7 million persons with disabilities – were enrolled in Medicare. The Medicare program organizes benefits into four separate components, each with its own cost-sharing and premium requirements. Parts A and B together are referred to as traditional fee-for-service (FFS) Medicare, in which the federal government directly pays for covered health services. Medicare beneficiaries may elect to receive Part A and Part B benefits through a private Part C Medicare Advantage (MA) plan, which offers coverage with an integrated benefit package similar to private insurance coverage. Beneficiaries in Part A and/or Part B or in an MA plan without drug coverage are eligible to enroll voluntarily in prescription drug plans (PDPs) under Part D. **Table 1** summarizes the major features of the Medicare program.

Table 1. Medicare Coverage and Financing

Program Details	Part A: Hospital Insurance (HI) Trust Fund	Part B and D: Supplementary Medical Insurance (SMI) Trust Fund
Services Covered	Inpatient hospital stays Skilled nursing facility care Hospice health care Home health care	Part B: Physician care, outpatient medical services, preventative care, and durable medical equipment. 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 Trust Fund Spending in 2019	41.2%	Part B: 46.5% Part D: 12.3%

Individuals are eligible to enroll once they reach age 65. Persons under the age of 65 who have received Social Security Disability Insurance (SSDI) benefits for at least 24 months are automatically enrolled in Medicare and are entitled to premium-free Part A benefits. Individuals receiving Social Security retirement benefits are automatically enrolled in traditional Medicare

(Part A and Part B) once they turn 65. A vast majority of enrollees are eligible for premium-free Part A benefits if they or their spouse are eligible for Social Security payments and have paid Medicare eligible payroll taxes for 40 quarters (10 years).

The primary source of funding for Part A is a payroll tax contribution of 1.45 percent on both employers and employees, with self-employed workers paying the full 2.9 percent. The tax revenues are added to the HI Trust Fund along with interest on federal securities held by the trust fund, federal income taxes paid on Social Security benefits, and premiums paid by enrollees not entitled to premium-free Part A. Unlike Social Security taxes, there is no ceiling on wages subject to Medicare payroll taxes. Payments and spending under MA (Part C) are set based on spending in traditional Medicare and are taken from the HI and SMI Trust Funds.

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). Medicare beneficiaries who choose to participate in Part B or Part D must enroll and pay monthly premiums. Premiums for Part B and for Part D are set such that the aggregate amount paid by beneficiaries will cover roughly 25 percent of expenditures. Part B and Part D benefits are not at risk of insolvency because financing is derived through beneficiary premiums and cost-sharing requirements with general revenues filling the gap.

In 2019, the standard monthly premium for Part B coverage was $135.50. Since 2007, individuals with modified adjusted gross incomes that exceed a specific threshold (individuals with annual incomes greater than $85,000 and couples with annual incomes greater than $170,000 who file jointly) are subject to a higher income-related premium that reflects a greater percentage of estimated program costs. Depending on income level, high-income beneficiaries' premiums are set to cover 35 percent to 85 percent of the expected per capita Part B costs for the year. The highest income adjusted monthly premium is $460.50 in 2019 for individuals with incomes over $500,000 (Centers for Medicare & Medicaid Services 2019).

The Part D program, which covers prescription drugs, has a standard monthly premium of $33.19 in 2019 and since 2011, individuals with modified adjusted gross incomes that exceed a specific threshold are subject to a higher income-related premium that reflects a greater percentage of estimated program costs. The highest income adjusted monthly premium is $110.59 in 2019 for individuals with incomes over $500,000. Additional revenue for Part D comes from state "clawback" payments, which reflect a portion of the amounts that state Medicaid programs would otherwise have had to pay for dual-eligible enrollees' drug coverage (Centers for Medicare & Medicaid Services 2019).

Findings from the 2020 Trustees Report

Medicare's Current Financial Situation

In 2019, total revenue accrued by the HI Trust Fund was $322.5 billion, total expenditures accounted for $328.3 billion, and the HI assets (compiled surpluses from previous years) were

reduced by $5.8 billion.[1] The assets were $194.6 billion at the beginning of 2020, representing about 55 percent of expenditures projected for 2020. Total revenue for the SMI Trust Fund in 2018 was $472.3 billion, and total expenditures were $467.9 billion, adding $4.5 billion to the SMI assets, which totaled $108.8 billion at the beginning of 2020. **Table 2** presents 2019 data for each part of the Medicare program.

Table 2. Trust Fund Finances in 2019 (in billions)

		SMI		
	HI or Part A	Part B	Part D	Total
Assets at end of 2018 (billions)	$200.4	$96.3	$8.0	$304.7
Total income	$322.5	$373.6	$98.7	$794.8
Payroll taxes	285.1	—	—	285.1
Interest	6.5	2.6	0.1	9.1
Taxation of benefits	23.8	—	—	23.8
Premiums	3.9	99.4	15.8	119.1
General revenue	1.3	268.2	70.2	339.8
Transfers from States	—	—	12.3	12.3
Other	1.8	3.4	0.4	5.6
Total expenditures	$328.3	$370.3	$97.6	$796.2
Benefits	322.8	365.7	97.1	785.6
Hospital	147.3	59.6	—	206.9
Skilled nursing facility	27.6	—	—	27.6
Home health care	7.0	11.4	—	18.4
Physician fee schedule services	—	74.2	—	74.2
Private health plans (Part C)	119.1	154.7	—	273.8
Prescription drugs	—	—	97.1	97.1
Other	21.9	65.8	—	87.7
Administrative expenses	5.5	4.6	0.5	10.6
Net change in assets	−$5.8	$3.3	$1.2	−$1.4
Assets at end of 2019	$194.6	$99.6	$9.2	$303.3
Enrollment (millions)				
Aged	52.2	48.2	40.2	52.6
Disabled	8.7	7.9	7.0	8.7
Total	60.9	56.1	47.2	61.2
Average benefit per enrollee	$5,305	$6,517	$2,057	$13,879

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

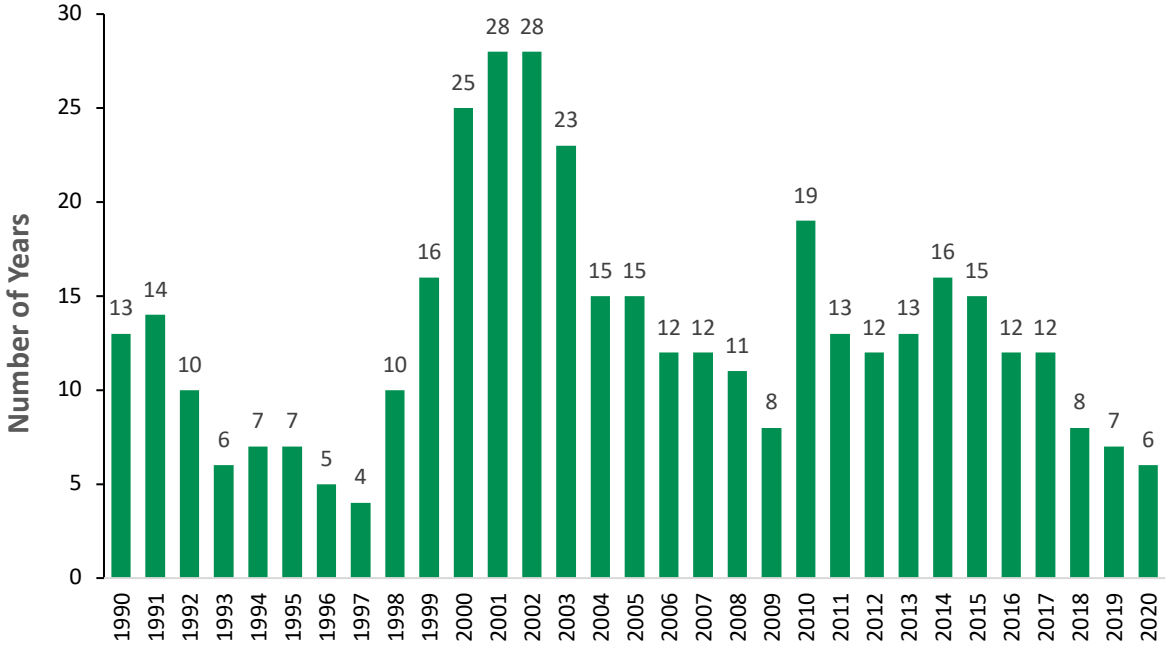
Source: Board of Trustees, 2020. Table II.B1.

The Trustees annually estimate the year through which the HI Trust Fund will remain solvent, i.e. the year to which reserves in the Trust Fund are sufficient to cover 100 percent of Medicare's costs. The 2020 report finds that the HI Trust Fund assets are expected to be depleted in 2026, at which point Medicare revenues will cover 90 percent of expenditures (in 2026), declining to 78 percent by 2044, and rising to 90 percent by 2094.

[1] 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.

The estimation of the HI Trust Fund's solvency is based on a number of economic factors, including changes in demographics and the nation's health care system. As **Figure 1 shows**, since 1990, estimates of continued HI solvency have ranged from four years to 28 years, with the length of continued solvency averaging 13 years. In the past, HI insolvency has been pushed back through legislative adjustments to the program to ensure that has impacted Medicare outlays and revenues, such as the Balanced Budget Act in 1997 and the Patient Protection and Affordable Care Act in 2010.

Figure 1. Projected Years of Solvency for HI Trust Fund, 1990-2020



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 since premiums and general revenue contributions 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 increase the financial demands on both beneficiaries (to pay the premiums) and taxpayers (to provide the general revenues).

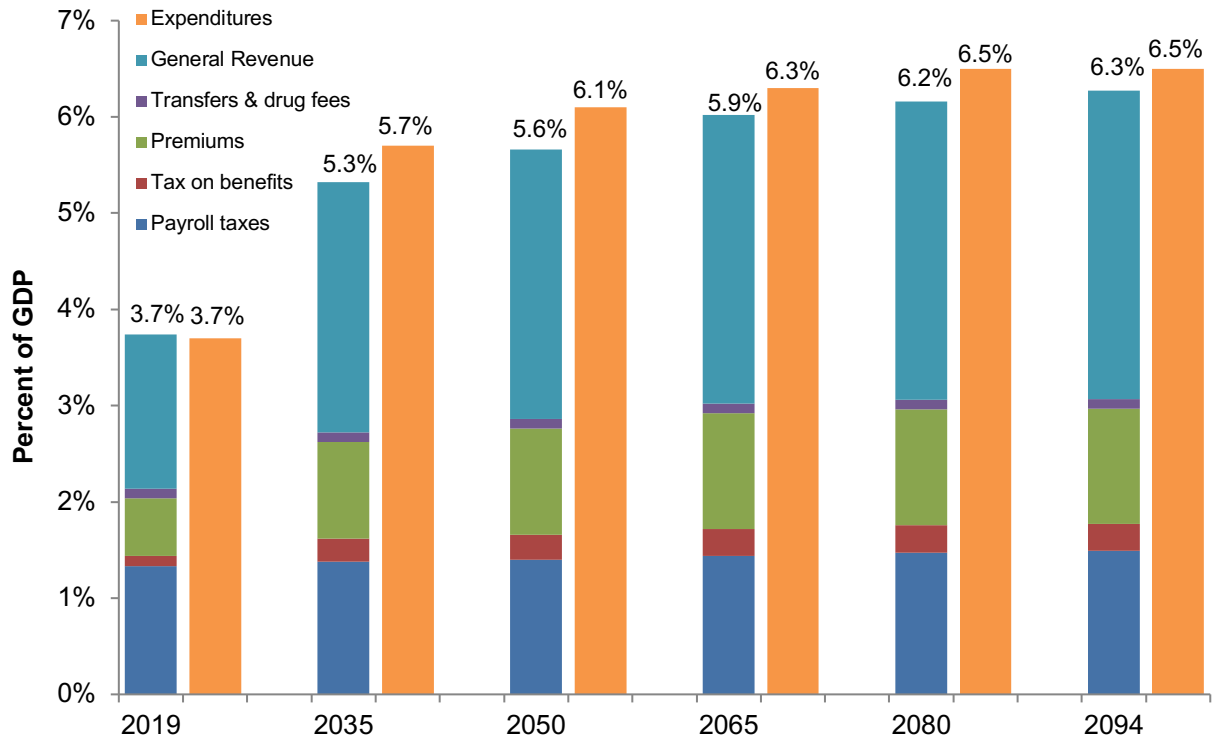
Medicare's Long-Range Costs

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; here are two of the most common.

1) *Medicare Income and Expenditures as a Percent of Gross Domestic Product (GDP).*

One way to express the future outlook of the 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 2019 to 6.0 percent of GDP in 2044, mainly due to increases in the number of beneficiaries, before slowing to reach 6.5 percent of GDP in 2094, as shown in **Figure 2.**

Figure 2: Medicare Costs and Non-Interest Income as a Percent of GDP, 2019-2094



The components of the bars show projected income (payroll taxes, tax on benefits, premiums, state transfers and drug fees, and general revenue) and projected expenditures for Medicare through 2094. The difference between the heights of the bars shows the HI deficit (the difference between HI income and expenditures). The HI deficit is projected to rise to .5 percent of GDP between 2035-60 and then decline to 0.2 percent in 2094. While payroll taxes will remain relatively constant as a share of GDP, general revenue financing increases, mainly due to the faster growth rate in Part B and Part D spending.

The growth in Medicare spending is not evenly dispersed across the parts of Medicare. Part A spending is projected to increase from 1.5 percent of GDP in 2019 to 2.16 percent in 2045 before slowing down to a more gradual growth reaching 2 percent by 2090. Part B and Part D are spending are projected to grow at a much faster rate primarily due growth in drug prices. Part B spending is projected to increase from 1.7 percent of GDP in 2019 to 3.5 percent by 2094. Part D is projected to double, rising from 0.5 percent of GDP in 2019 to about 1 percent in 2094.

However, despite that anticipated rise, the Part D projection is slightly lower than the estimate in last year's report primarily due to slower growth in overall drug prices and higher direct and indirect remuneration.

2) HI Income and Expenditures as a Percent of Taxable Payroll.

Another method of expressing Medicare's future outlook is to compare its income and expenditures to taxable payroll. According to the Trustees' intermediate assumptions, HI income will average 3.98 percent of taxable payroll, while program costs will average 4.74 percent. This leaves a deficit of 0.76 percent of taxable payroll over the next 75 years. Medicare's long-range HI deficit could be avoided by increasing the standard Medicare payroll tax to 3.66 percent from the current rate of 2.9 percent (an increase from 1.45 percent to 1.83 percent of covered wages for workers and employees) or reducing expenditures immediately by 16 percent.[2] This measure, the annual deficit expressed as a percentage of total earnings and self-employment income subject to Medicare taxes over the 75-year projection period, is known as the actuarial balance.

Medicare's Unfunded Obligation

Medicare's unfunded obligation is another way of summarizing the funding shortfall in a single dollar amount. It is the difference between the present value of the projected costs of a program over a specific period of time, and the present value of the projected income (including the initial value of the Trust Fund). In other words, the unfunded obligation is the dollar amount by which expenditures will have to be reduced or the amount that will have to be added to the HI Trust Fund in order to make the program financially sound for the next 75 years.

The 2020 Trustees Report estimates that the unfunded obligation of the HI Trust Fund for past, current, and future participants is $4.6 trillion. This means that if $4.6 trillion were added to the HI Trust Fund in the beginning of 2020, the program would meet the projected cost of expenditures over the next 75 years. The SMI Trust Fund has no unfunded obligation because general revenues cover all spending that is not financed by other dedicated funding sources. However, SMI expenditures are projected to exceed premiums and dedicated revenues by $40.9 trillion over the next 75 years, meaning the present value of the required general revenue contributions for Part B and D is equal to $40.9 trillion over the next 75 years.

What underlies the Medicare projections?

Differences from Previous Years

After having deficits from 2008-2015, the HI Trust Fund experienced small surpluses in 2016 and 2017. However, it again experienced deficits in 2018 and 2019 and is projected to experience deficits for the remainder of the 75-year projection period. This is because the HI Trust Fund income is projected to be lower due in part to the repeal of the health insurance excise tax which lowered payroll tax revenue. Second, there was lower-than-predicted spending in 2019, lower projected provider payment updates, and the Trustees incorporation

[2] 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.

of the time-to-death measure in the demographic factors of the projection model. This reduction is offset by higher enrollment and spending growth in Medicare Advantage.

As a result, the 75-year actuarial deficit for the HI Trust Fund has decreased from 0.91 percent to 0.76 percent of taxable payroll in this year's report and is equivalent to 0.3 percent of GDP through 2094. The projected solvency date for the HI Trust Fund is 2026, the same as last years.

As in previous years reports, Part B and Part D spending are expected to increase significantly as a share of GDP over the next 75 years, increasing from 2.2 percent of GDP to 4.5 percent in 2094. The projected Part B spending is higher in this year's report than in 2019 due to higher predicted spending for Part B drugs. Although high, the Part D spending projection is slightly lower than the estimate in last year's report primarily due to slower growth in overall drug prices and higher direct and indirect remuneration.

Long-Term Trends

Total Medicare expenditures were $796 billion in 2019, and the Trustees Report projects that expenditures will increase at a faster pace than either aggregate workers' earnings or the U.S. economy as a whole. In the longer run, Medicare spending is expected to grow for many of the same reasons health care spending in the private sector is growing – higher utilization rates, greater intensity of services, and new medical technology. Medicare, however, has an additional reason for its rapid growth: the projected increase of individuals eligible to enroll as the baby boom generation ages. Medicare enrollment is expected to grow by 22 million – from about 61 million to 83 million – between 2019 and 2035.

The projected ratio of workers per HI beneficiary began to decline significantly during and after the recession and has continued to decline further due the retirement of the baby boom generation. In 2019, each HI beneficiary had about 3.0 current workers to pay for their HI benefit. Under the intermediate demographic assumptions this declines to about 2.5 workers per beneficiary in 2030 and only 2.1 in 2094. This implies an increase in the HI cost rate of about 40 percent in 2094 compared to the current level, solely due to the worker-to-beneficiary decline.

Between 2010 and 2018, Medicare per capita spending grew at a rate of just 1.7 percent, compared with 3.8 percent for private insurance; however, per capita Medicare spending growth is projected to increase over the next decade (Cubanski, Neuman, and Freed 2019). According to the 2020 Trustees Report, average per-beneficiary costs for the Medicare program are expected to increase from $14,151 at the end of 2019 to $22,513 at the end of 2029, averaging an annual growth rate of 4.76 percent. The projected growth in the HI cost rate is primarily due to the aging of the baby boom generation along with increased per-beneficiary spending on high volumes and intensities of services.

Additionally, Medicare Advantage enrollment and spending is expected to increase over time from about 40 percent of Medicare enrollment in 2020 to 43 percent by 2029 and thereafter. Spending per MA beneficiary is projected to be higher in this year's report than due to expected implementation of the 21st Century Cures Act, which allows individuals with End-Stage Renal Disease to enroll in MA plans. Medicare expenditures per MA enrollee is projected to increase from $10,848 in 2019 to $17,645 in 2029.

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. While demographic factors are unlikely to change significantly in the short term, estimates of HI solvency and SMI expenditures are sensitive to small differences between projected and actual economic performance; however, the actuarial deficit is large enough that averting insolvency under current law is extremely unlikely. In order to capture the effects of different demographic and economic factors, 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.
- An intermediate assumption that reflects underlying assumptions of moderate economic growth throughout the projected period and moderate levels for other parameters. The projections presented in this brief are based on the intermediate assumptions.

The projections in the 2020 Trustees Report do not reflect the potential effects of the COVID-19 pandemic on the current finances and long-term outlook of the Medicare program, however, the high-cost scenario could provide a peak into the potential effects of weaker economic growth in the short-term. Under the high-cost assumptions, the Trustees assume lower annual growth in GDP and average covered wages. In this scenario, depletion of the HI Trust Fund would occur in 2023, three years earlier than under the intermediate assumption.

The Medicare Trustees report states that estimates over 75 years can indicate whether the trust fund—as seen from today's vantage point—is in satisfactory financial condition. These long-term projections are made under the assumption that existing institutional arrangements and program features in the current law will extend for the entire projection period, and are thus reflective of a policy-neutral baseline that can be used to consider the need for changes or adjustments in national policy. The challenges with projecting Medicare expenditures over 75 years are well documented. Many claim that projections that extend so far into an uncertain future are of limited value and are unreasonable (CMS, 2012).

The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary also prepares an illustrative set of Medicare trust fund projections under hypothetical alternatives to the current law to quantify the potential magnitude of the cost understatement in current law.

Is Medicare sustainable?

Contrary to what many might think, insolvency does not mean that the Medicare program will not exist for current seniors or for future generations of Americans. There are policy options

available to fill in the gap in Medicare's financing, such as increasing the standard Medicare payroll tax to 3.66 percent from the current rate of 2.9 percent (an increase from 1.45 percent to 1.83 percent of covered wages for both workers and employees to pay). Other broader health care spending measures, such as lowering health care and prescription drug spending, can also increase the long-term solvency of the HI and SMI Trust Funds.

To date, the HI Trust Fund has not become insolvent and no provisions exist in the Social Security Act that outline procedures if solvency were to occur. Even if no action were taken prior to 2026, HI funds would be able to pay 90 percent of Part A expenses that year and Congress would face a legislative decision on how, and if, to provide another source of funding to make up for the shortfall.

All of the measures outlined by the Medicare Trustees cannot answer the question of whether Medicare is sustainable or not. Sustainability is an inherently subjective concept that reflects societal values and the political viability of the program. Medicare beneficiaries have relatively comprehensive coverage, and access to care and satisfaction among beneficiaries and the country as a whole have been consistently high (Lopes et al 2019). A Kaiser Family Foundation poll found that, among the general public, 82 percent of individuals hold either a very or somewhat favorable view of Medicare (Kirzinger, Munana, and Brodie 2019). The COVID-19 pandemic may also increase value of Medicare for current beneficiaries and future generations.

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