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Medicare Finances: Findings of the 2013 Trustees Report

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Summary

Medicare is the federal health insurance program for Americans age 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 terms.

According to the 2013 Trustees Report, expenditures from Medicare's HI Trust Fund exceeded revenues by $23.8 billion in 2012. Without a policy change that would increase revenues or reduce expenditures, the surplus that has accumulated to the HI Trust Fund since the program's inception will be depleted by 2026; after that, the HI Trust Fund would rely on the annual revenues from Medicare payroll taxes and to a lesser extent, its other sources of income, which together are projected to cover 87 percent of annual expenditures.

This year's report reflects small improvements in Medicare's financial outlook. The projected solvency date for the HI Trust Fund is two years later than last year's report. The 75-year actuarial deficit for the HI Trust Fund has decreased from 1.35 percent to 1.11 percent of taxable payroll.

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 that faced by younger people, 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 and Lou Gehrig's disease (amyotrophic lateral sclerosis).

Medicare helps pay medical expenses for 42.1 million individuals age 65 years and older and 8.5 million individuals under 65 with disabilities. Approximately 20 percent of Medicare enrollees are dually eligible for full or partial benefits under Medicaid, the federal-state health insurance program for low income people. Table 1 summarizes the major features of the Medicare program.

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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 2012	46%	Part B: 42% Part D: 12%

People are automatically enrolled into Medicare Part A at age 65 if they (or their spouse) are entitled to Social Security benefits and have contributed payroll taxes for at least 10 years. The Medicare payroll tax is 2.9 percent of a worker's wages – 1.45 percent deducted from a worker's wages and 1.45 percent paid by the employer.[1] Beginning in 2013, the Medicare payroll tax increased by 0.9 percent for higher-income individuals (those individuals earning more than $200,000 and couples earning more than $250,000 who file jointly). And unlike Social Security taxes, which are applied to wages up to $113,700, there is no ceiling on wages subject to Medicare taxes.[2] Last year, revenue from payroll taxes provided 85 percent of the income for the HI Trust Fund. Interest earned on the investments of the Trust Fund and income taxes on a portion of Social Security benefits make 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). 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 so that the aggregate amount paid by beneficiaries will cover roughly 25 percent of expenditures. In 2013, beneficiaries pay a standard monthly premium of $104.90 for physician outpatient and other services covered by Part B; high-income enrollees (individuals with annual incomes greater than $85,000 and couples with annual incomes greater than $170,000 who file jointly) pay a higher, income-related premium that ranges from $146.90 to $335.70 per month. The Part D program, which covers prescription drugs, requires a separate premium that averages $31.17 per month, though premiums range anywhere from $11.60 to $66.60 depending on income level. The cost of Part B and Part D not covered by premiums or cost-sharing is financed through general revenues from taxpayers of all ages.

Medicare beneficiaries are also subject to cost-sharing on certain benefits in the form of deductibles and coinsurance, and must pay for health services not covered by Medicare on their own. This includes routine dental care, eyeglasses, hearing aids, and most long-term services and supports. For dual eligibles (Medicare beneficiaries who are also enrolled in Medicaid), Medicaid helps to cover Medicare premiums and cost-sharing;[3] Medicaid also offers benefits not covered by Medicare, such as long-term services and supports.

[1] The self-employed pay both halves of the Medicare tax, but can deduct half of the tax as an adjustment to income.
[2] Medicare payroll taxes are not levied on dividends, returns or other passive investments.
[3] 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 Finances in 2012 (in billions)

	HI	SMI		
	Part A	Part B	Part D	Total
Total Income (2012)	**$243.0**	**$227.0**	**$66.9**	**$536.9**
Payroll taxes	205.7	---	---	205.7
Interest	10.6	2.8	0.0	13.4
Taxes on benefits	18.6	---	---	18.6
Premiums	3.4	58.0	8.3	69.8
General revenue	0.5	163.8	50.1	214.4
Transfers from States	---	---	8.4	8.4
Other	4.1	2.4	---	6.5
Total Expenditures (2012)	**$266.8**	**$240.5**	**$66.9**	**$574.2**
Benefits	262.9	236.5	66.5	565.9
Hospital	139.7	39.1	---	178.8
Skilled nursing facility	28.0	---	---	28.0
Home health care	6.8	11.8	---	18.6
Physician fee schedule services	---	69.6	---	69.6
Private health plans (Part C)	70.2	66.0	---	136.2
Prescription drugs	---	---	66.5	66.5
Other	18.1	50.1	---	68.2
Administrative expenses	$3.9	$3.9	$0.4	$8.3
Net change in assets	**-$23.8**	**-$13.5**	**$0.0**	**-$37.3**
Assets (end of 2012)	**$220.4**	**$66.2**	**$1.0**	**$287.6**

Source: Board of Trustees, 2013. Table II.B1.

What Is Medicare's Financial Situation?

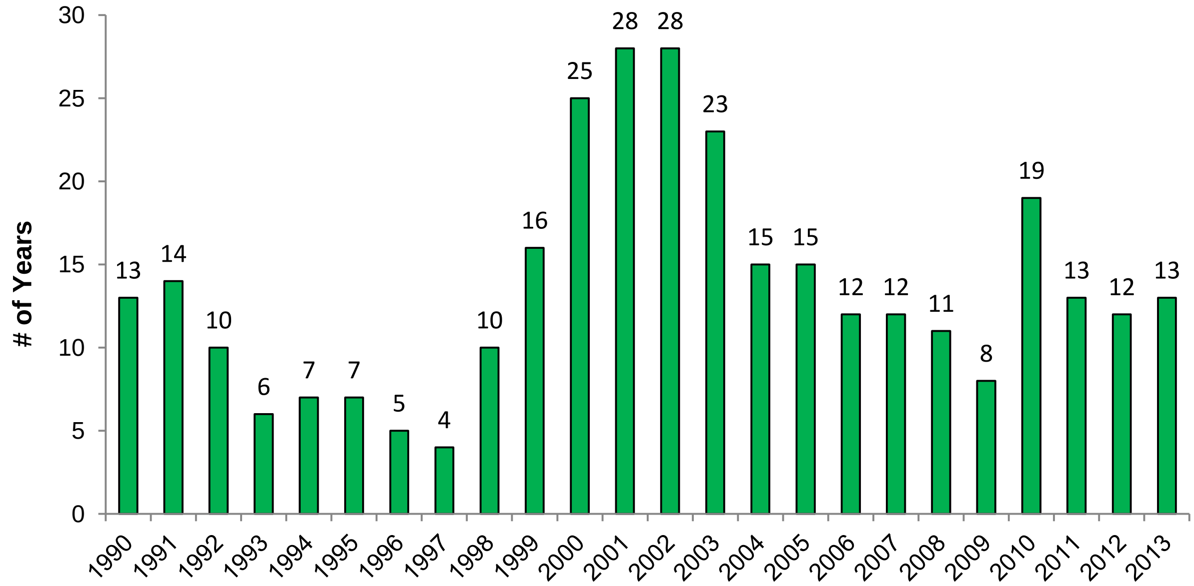
In 2012, the HI Trust Fund received income of $243.0 billion and paid out $266.8 billion in benefits and administrative expenses, leaving a deficit of $23.8 billion for the year. The HI Trust Fund has been running a deficit since 2008, when annual expenditures first exceeded income.[4] At the end of 2012, however, the HI Trust Fund still held $220.4 billion in assets. Table 2 presents 2012 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 year through which reserves in the Trust Fund are sufficient to cover 100 percent of Medicare's costs. The 2013 report finds that the HI Trust Fund will be solvent through 2026. If no changes are made by that year, the HI Trust Fund will still be able to cover 87 percent of payments to hospitals and other providers from current payroll contributions and other revenue.

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 2013 fall just below the average over the last 24 years. In the past, HI insolvency has been avoided through frequent adjustments to the program to ensure that spending and resources are in balance.

[4] 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.

Figure 1. Projected Years of Solvency for HI Trust Fund, 1990-2013



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

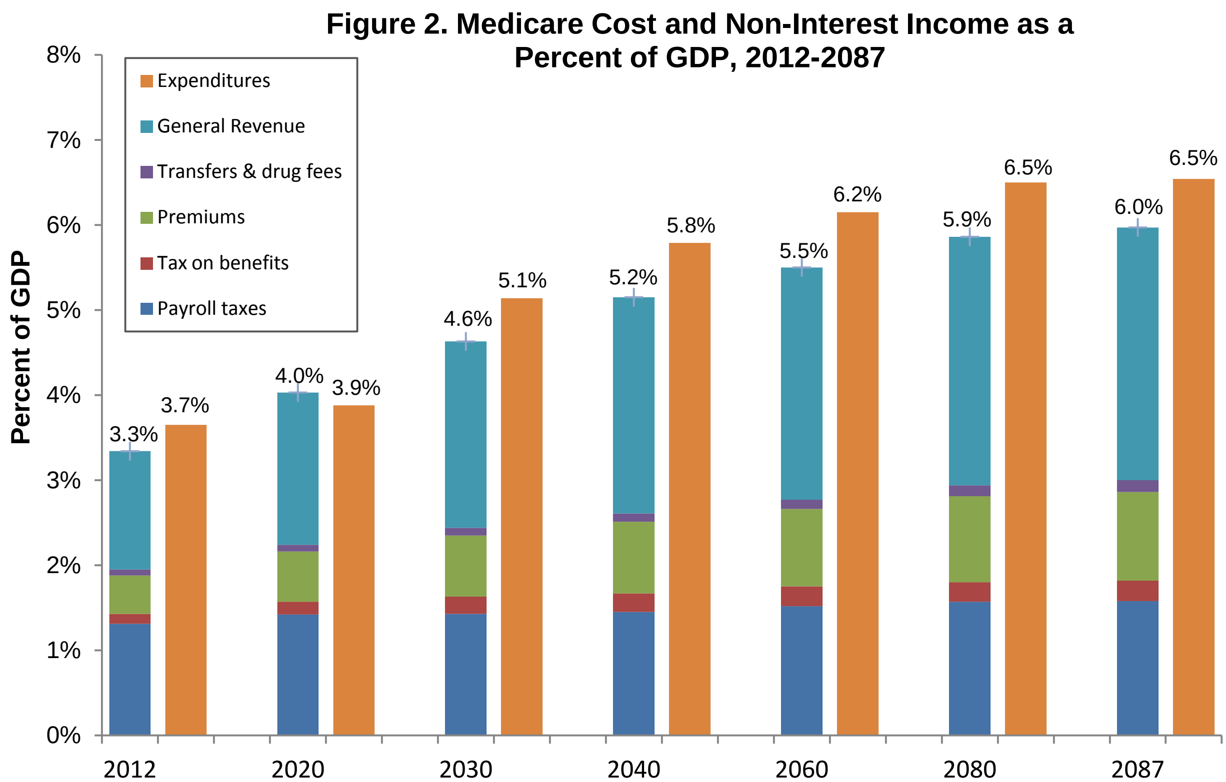
The SMI Trust Fund, on the other hand, is always adequately financed since premiums and general revenue contributions are set annually to cover the expected cost of Part B and Part D benefits. The rapid growth in the cost of Part B and Part D benefits is projected to increase the financial demands on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

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.[5] 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 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 (defined on page 7), total Medicare expenditures will grow from 3.7 percent of GDP in 2012 to 3.9 percent of GDP in 2020 and 6.5 percent of GDP in 2087, 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 2087. 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 expenditures) will increase from 0.31 percent of GDP in 2012 to 0.57 percent in 2087, and will average 0.52 percent of GDP over the next 75 years.

[5] 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).



Source: Summary of Board of Trustees 2013, Chart C.

2. *HI Income and Expenditures as a Percent of Taxable Payroll*. According to the Trustees' intermediate assumptions, HI income will average 3.83 percent of taxable payroll, while program costs will average 4.94 percent. This leaves a deficit of 1.11 percent of taxable payroll over the next 75 years. Medicare's long-range HI deficit could be avoided simply by increasing the standard Medicare payroll tax by 0.56 percent each for workers and employers (an increase for each from 1.45 percent to 2.00 percent of covered wages).[6] This measure, the annual deficit expressed as a percentage of total earnings and self-employment income that is subject to Medicare taxes over the 75-year projection period, is known as the actuarial balance.[7]

What Is the 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 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 dollar amount by which expenditures 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 2013 Trustees Report estimates that the unfunded obligation of the HI Trust Fund for past, current, and future participants is $4.6 trillion over the next 75 years. This is the equivalent of 1.1 percent of the HI taxable payroll and 0.5 percent of GDP over that period. The SMI Trust Fund has no unfunded

[6] 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.
[7] The Trustees also calculate the 25- and 50-year actuarial balance. In 2013, these were 0.58 and 0.97 percent, respectively

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 $22.4 trillion (2.4 percent of GDP).

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

In 2012, some 50.7 million people, or approximately one out of every six individuals, received care financed through one or more parts of Medicare. While 42.1 million of Medicare enrollees are 65 and older, 8.5 million 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, 2011a).

Despite people's lifetime contributions in Medicare payroll taxes (which amount to $84,000 in nominal dollars for a couple with low to average wages),[8] enrollees also pay a significant amount out-of-pocket (Steuerle and Rennane, 2011). In 2006, Medicare enrollees spent roughly 16 percent of their income on out-of-pocket medical expenses, an amount that rises with age, poor health status and low income. Those age 85 and older spent 23.5 percent of their income on out-of-pocket medical expenses, while those in poor health spent 20.4 percent and those below 100 percent of the federal poverty level spent 20.9 percent (Kaiser 2011b).

Spending on Medicare enrollees is highly skewed, however. Medicare spends $8,300 per enrollee on average, but spending is highly concentrated on a small group of people who have significant chronic conditions, functional limitations, and acute care needs (Feder and Komisar, 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).

What Explains the Medicare Projections?

This year's report reflects continued slow growth in per beneficiary spending that is projected to continue over the next several years. From 2010 to 2012, Medicare spending per beneficiary grew 1.7 percent annually, which is less than the average growth in the Consumer Price Index and less than the rate of growth in the economy overall.

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 prices charged by providers, greater 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. The Congressional Budget Office estimates that enrollment in Medicare will nearly double in coming decades, reaching 80 million people by 2030.

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, Medicare spending, on average, has grown 3.9 percent, compared to 6.3 percent for private health spending.

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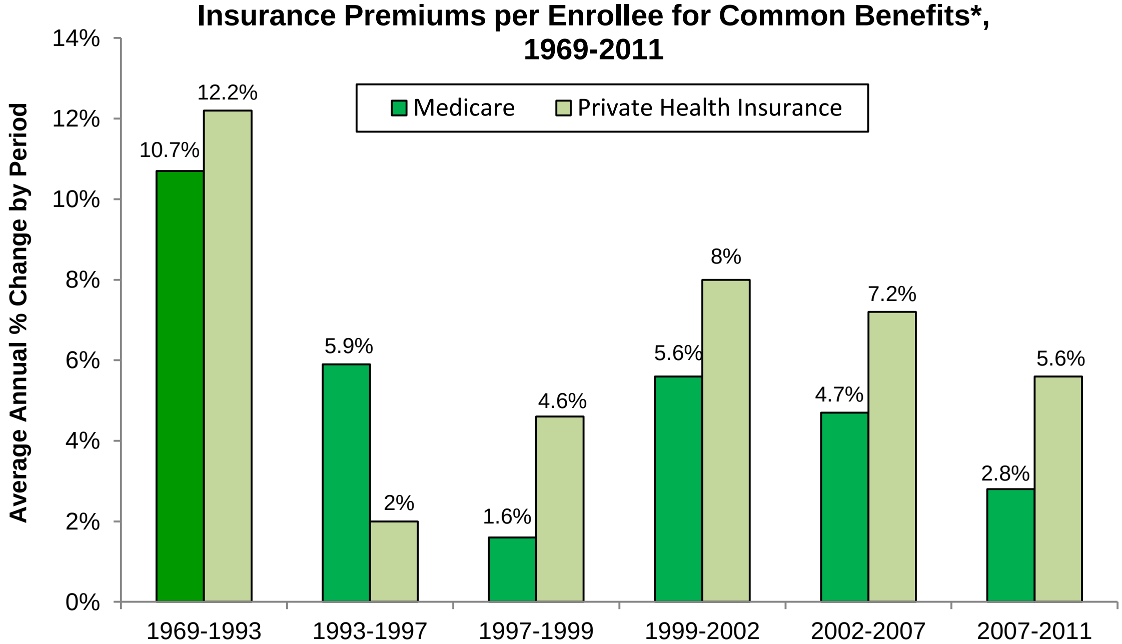
[8] A couple with low to average wages retiring in 2010 would pay roughly $84,000 over their lifetime in Medicare payroll taxes, but would receive around $350,000 in benefits.

Figure 3. Growth in Medicare Spending and Private Health Insurance Premiums per Enrollee for Common Benefits*, 1969-2011



*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, 2011.

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.[9] 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.

[9] 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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