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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 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.

[1] For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga. More detailed information on Medicare's financial status may be found in CRS Report R41436, *Medicare Financing*, and CRS Report RS20946, *Medicare: Insolvency Projections*, both by Patricia A. Davis.

[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.

Enrollment in Part B is optional; however, most beneficiaries with Part A also enroll in Part B.

- **Part C** (Medicare Advantage, or MA) is a private plan option for beneficiaries that covers all Parts 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 28% of Medicare beneficiaries are enrolled in MA.
- **Part D** covers outpatient prescription drug benefits. This portion of the program is optional. About 75% of Medicare beneficiaries are enrolled in Medicare Part D or have coverage through an employer retiree plan subsidized by Medicare.

Beneficiary Costs

In addition to paying premiums for Medicare Parts B and D,[4] 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 Payments[5]

Under traditional Medicare, Parts A and B, the government generally pays providers directly for services on a "fee-for-service" basis using different prospective payment systems or fee schedules.[6] Under Parts C and D, Medicare pays private insurers a monthly "capitated" per person amount to provide coverage to enrollees. 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 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

[4] Beneficiaries enrolled in a Medicare Advantage (Part C) plan must pay Part B premiums as well as any additional premium required by the MA plan.

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

[6] 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 departments, 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.

[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 (continued...)

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 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 HI 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, 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

(...continued)

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*, by Mindy R. Levit.

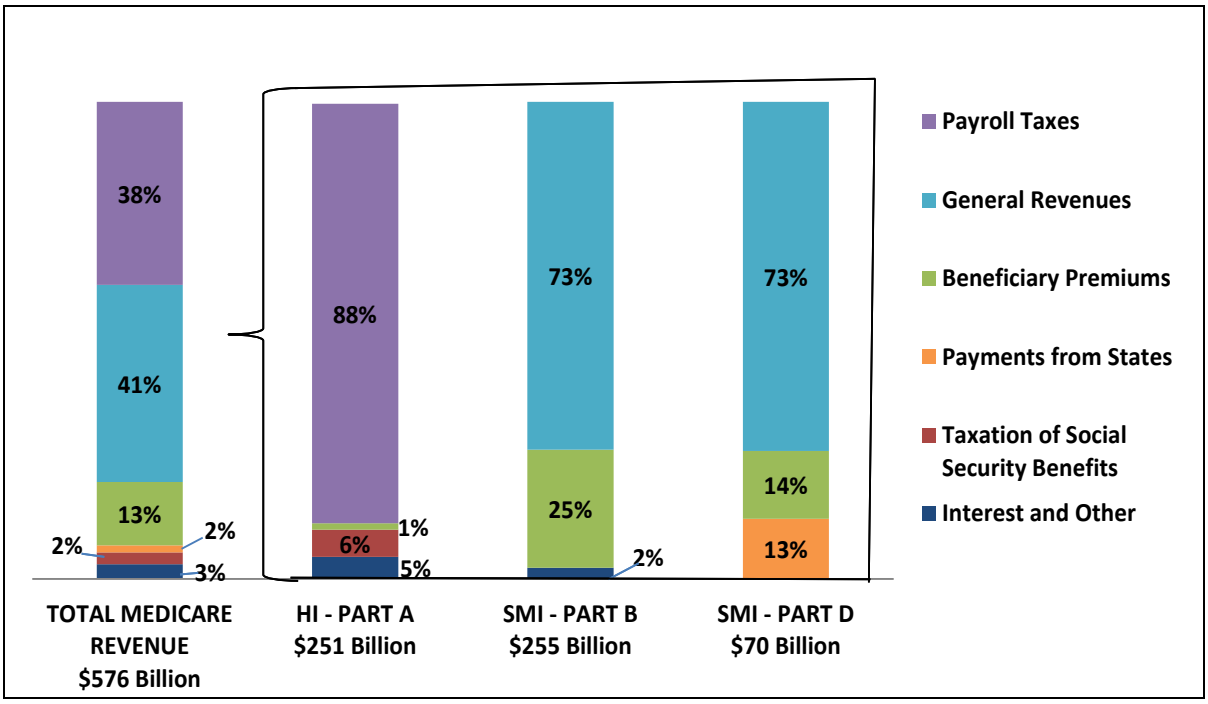
[8] These reports may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html.

[9] See archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, 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.

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.

Figure 1. Sources of Medicare Revenues: 2013



Source: 2014 Report of the Medicare Trustees, Table II.B1.

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

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 current income and accumulated trust fund assets, it is considered to be *insolvent*.[11]

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 spending 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.

Sources of SMI 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.[12]

The Part B portion of SMI is mainly funded through beneficiary premiums (set at 25% of estimated program costs for the aged)[13] and general revenues (most of the remaining amount, approximately 73%). In 2014, 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.[14]

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, the amount of financing in the next year (i.e., general revenues and beneficiary premiums) may be adjusted to recover the shortfall. Similarly, if actual costs are less than expected in a given year, 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.

Medicare Spending in 2013[15]

In calendar year (CY) 2013, Medicare provided benefits to about 52.3 million people (43.5 million age 65 and over, and 8.8 million disabled) at an estimated total cost of $583 billion.[16] Most of that amount, $575 billion (99%), was spent on program benefits, with the remaining amount used for program administration. (See **Table 1**.)

[12] 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.

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

[14] This revenue source is included in "Interest and Other" for Part B in **Figure 1**. For additional detail, see archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*.

[15] Data is from the *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 28, 2014.

[16] This amount reflects Medicare total spending regardless of revenue source; it does not net out non-federal income (e.g., premiums, state-transfers). By law, the Medicare Trustees report focuses on the financial status of the program's trust funds and does not examine the impact of Medicare spending on the overall Federal budget.

Table 1. Medicare Expenditures and Enrollment: CY2013

		SMI		
	HI - Part A	**Part B**	**Part D**	**Total**
Expenditures (billions)				
Benefits	$261.9	$243.8	$69.3	$575.0
Hospital	136.8	41.8	—	178.6
Skilled Nursing	28.4	—	—	28.4
Home Health Care	6.8	11.5	—	18.4
Physician Services	—	68.6	—	68.6
Private plans (Part C)	73.2	72.7	—	145.9
Prescription Drugs	—	—	69.3	69.3
Other	16.7	49.2	—	65.8
Administrative Expenses	$4.3	$3.3	$0.4	$7.9
Total Expenditures	**$266.2**	**$247.1**	**$69.7**	**$582.9**
Enrollment (millions)				
Aged	43.1	40.0	n/a	43.5
Disabled	8.8	7.9	n/a	8.8
Total Enrollment	51.9	47.9	39.1	52.3
Average expenditures per enrollee	**$5,045**	**$5,092**	**$1,773**	**$11,910**

Source: 2014 Report of Medicare Trustees, Table II.B1.

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

2013 HI Operations

At the beginning of CY2013, the HI trust fund had an asset balance of a little over $220 billion. During 2013, Part A expenditures were about $266 billion, and approximately $221 billion of that amount was funded by payroll taxes and $30 billion by interest income and other sources. Because expenditures exceeded revenue income, close to $15 billion was drawn out of accumulated assets in the HI trust fund to make up the difference. At the end of 2013, the HI trust fund had an asset balance of approximately $205 billion. This means that if or when HI spending exceeds income in future years, the trust fund will be able to spend a total of $205 billion in addition to what it receives in income.[17]

2013 SMI Operations

In CY2013, total spending for Part B was close to $247 billion, with general revenues financing approximately $186 billion (73%) of that amount, and premiums covering most of the remainder. Total spending for Part D reached about $70 billion in 2013, with over $51 billion (73%) of that

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

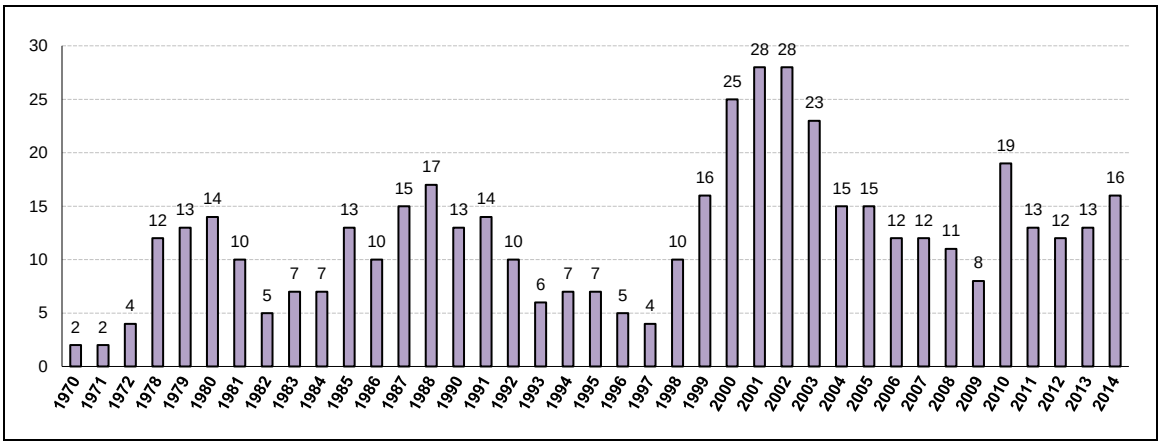
amount paid for by general revenues. In addition, approximately $9 billion was covered by state transfer payments, and $10 billion by beneficiary premiums. It should be noted that although beneficiary premiums are set at a rate to cover 25.5% of the costs of their standard Part D benefits, the program 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 14% of program costs. (See **Figure 1**.)

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 2014 Trustees report projects slight surpluses in years 2015 through 2022,[18] and then a return to deficits in 2023 and thereafter until the HI trust fund becomes depleted (insolvent) in 2030. At that time, there will no longer be sufficient funds to fully cover Part A expenditures; although HI would continue to receive tax income, the funds would only be sufficient to pay for 85% of Part A expenses. The Trustees suggest that, under these circumstances, beneficiary access to Part A services "would rapidly be 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 revenues 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



Source: Intermediate projections of various Medicare Trustees reports, 1970-2014.

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

[18] The Trustees attribute this expected period of surplus to ACA provisions that are expected to reduce Part A spending, to an assumed strengthening economy, and to the sequestration of 2% of Medicare benefit spending.

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 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

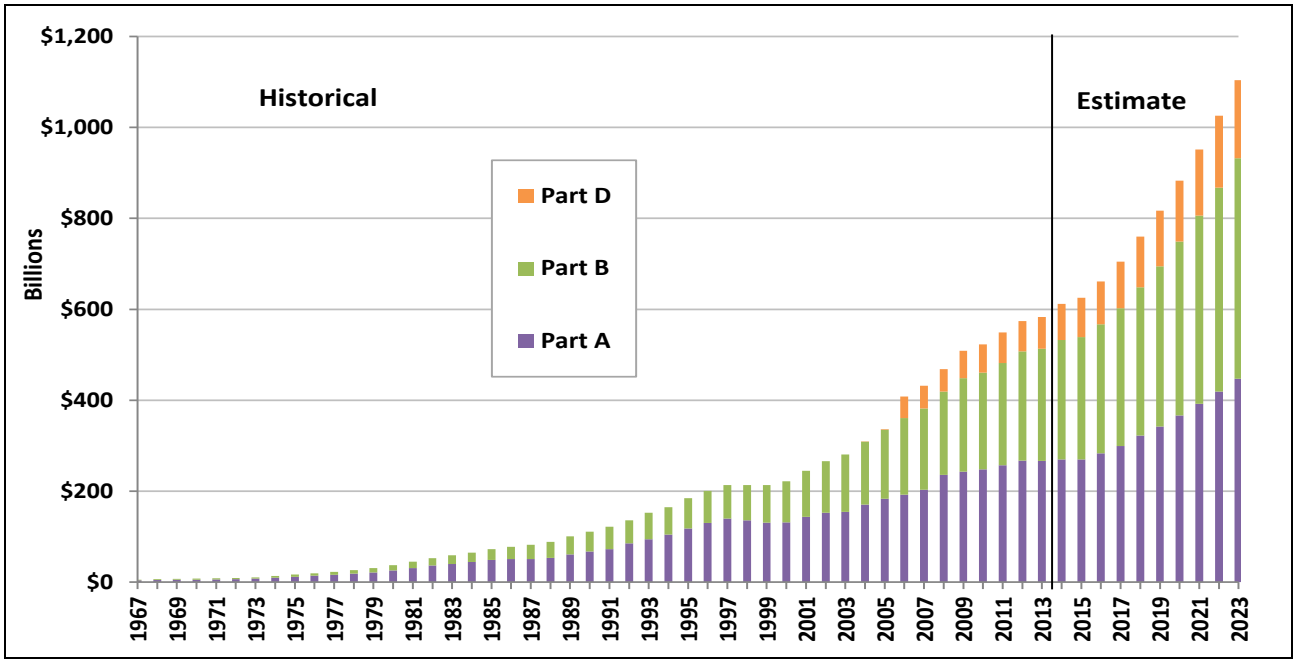
Although the 2014 Medicare Trustees report notes a recent slowing in the growth of U.S. national health expenditures,[19] the Trustees still project that U.S. health care expenditures, including Medicare spending, will grow faster than Gross Domestic Product (GDP) in most future years. For Medicare, the projected growth in the prices of health services plus anticipated increases in utilization rates and in the complexity of services provided are expected to contribute to rising costs of Medicare relative to GDP. The aging of the baby boom population is also expected to contribute to significant increases in benefit expenditures.[20]

Over the next 10 years, the Medicare Trustees estimate that total Medicare expenditures will increase from $583 billion in 2013 to close to $1.1 trillion in 2023. Of the $1.1 trillion, about $447 billion is expected to be spent on Part A services, $485 billion for Part B services, and $172 billion for Part D. (See **Figure 3**.)

[19] The Trustees are uncertain whether this slowing is of limited duration, e.g., due to recent economic downturns, or whether this may be a longer term trend due to structural changes in the health care industry.

[20] 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 87 million in 2035, and to 117 million in 2085.

Figure 3. Historical and Projected Medicare Expenditures



Source: 2014 Report of the Medicare Trustees, Expanded and Supplementary Tables (historical data); and Report Tables III.B4; III.C4; and III.D3 (projected data).

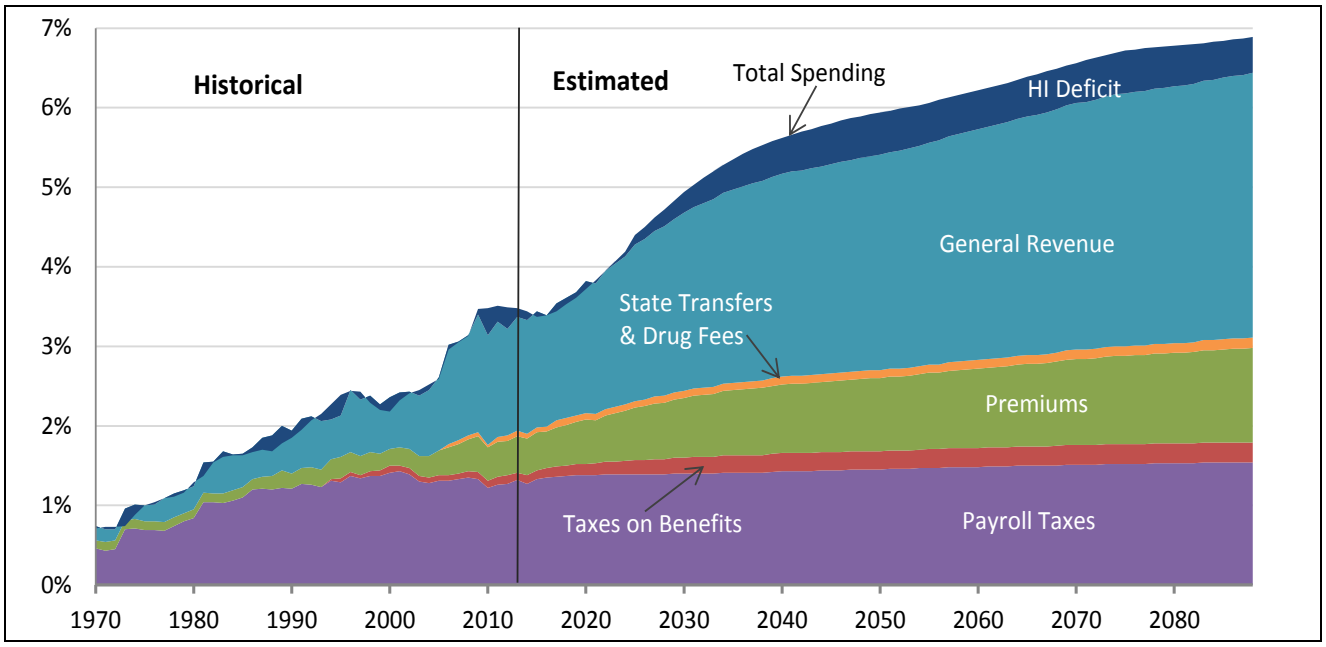
Growth in Medicare Expenditures Relative to GDP

A comparison of Medicare expenditures (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 3.5% of GDP in 2013 to about 5.3% of GDP by 2035, mainly due to the rapid growth in the number of beneficiaries, and then to 6.9% of GDP in 2088, 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 1.4% of GDP in 2014 to an estimated 3.3% in 2088 under current law.[21] Similarly, income from beneficiary premiums is expected to increase from 0.5% of GDP in 2014 to 1.2% in 2088. In 2013, about 13.8% 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 21% in 2030, and to almost 31% in 2080. This amount is *in addition* to the payroll taxes used to fund the Part A (HI) portion of the program.

[21] Total Part B outlays are expected to be about 1.5% of GDP in 2014, and the Trustees project that they will grow to almost 3.2% by 2088. The Trustees also estimate that total Part D outlays will increase from 0.4% of GDP in 2014 to about 1.4% in 2088.

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



Source: Summary of the 2014 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart C, http://www.ssa.gov/oact/TRSUM/index.html.

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. (See **Table 2**.) 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 $3.6 trillion. The Trustees note that this financial imbalance could be addressed by immediately increasing payroll taxes to 3.77% (from the current 2.9%) or by immediately decreasing expenditures by 19%.

The Trustees 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 $24.7 trillion. Adding the HI unfunded obligation estimate and the present value of future SMI spending for the 75-year period yields a total of $28.3 trillion.[22] In other words, it would take about $28.3 trillion in current dollars to cover the cost of Medicare not funded through dedicated sources over the next 75 years.

[22] 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.

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 2088	$3.6 trillion	General revenue contributions through 2088	$17.9 trillion	$6.8 trillion	$28.3 trillion
Unfunded obligations through infinite horizon	$1.9 trillion	General revenue contributions through infinite horizon	$31.5 trillion	$14.2 trillion	$47.6 trillion

Source: 2014 Report of the Medicare Trustees, Tables V.G1, V.G3, V.G5.

Comparison to 2013 Estimates

In their 2014 report, the Medicare Trustees reported some improvement in Medicare's financial outlook from projections in their 2013 report. For example, the expected depletion date of the HI trust fund (2030) is four years later than was projected in last year's report (2026). 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 1.11% of taxable payroll in last year's report, to 0.87% of taxable payroll in the 2014 report. The main reasons cited include (1) lower than expected spending in 2013 for most HI service categories, especially for inpatient hospital services; (2) lower projected utilization of inpatient hospital services; and (3) lower estimates of spending for skilled nursing facilities and home health agencies due to changes in assumptions of the case-mix of individuals receiving those services. Taxable HI earnings in 2013 were also slightly higher than expected.

As noted earlier, the Medicare Trustees generally make their projections based on current law. However, in their 2014 report, the Trustees made an exception with regard to the sustainable growth rate (SGR) formula for physician payments under Part B. Although under current law, physician payments are scheduled to be reduced by close to 21% in April 2015, the Trustees recognized that in almost every year, Congress has overridden these reductions. The Trustees therefore used a "projected baseline" for Part B spending that assumed that physician payments would remain at their current levels through the end of 2015, and then would be increased by 0.6% annually through 2023.[23]

Due to the above change in projection method, the expected growth rate of Part B costs is 0.3 percentage points higher over the next 75 years than the estimate in the 2013 report that was based on current law (which assumed that the physician cuts would go into effect).[24] However, compared to similar baseline projections contained in the last year's report "alternative to SGR" scenario, the expected growth in Part B outlays projected in the 2014 report is slightly lower. This decrease is attributed to (1) lower than expected spending in 2012 and 2013 for most types of Part B services; (2) assumptions of reduced future volume and intensity for some types of services based on recent experience; and (3) lower CPI assumptions. Part B expenditure growth rates

[23] This is equal to the average of the SGR overrides over the most recent 10 years.

[24] Under current law assumptions, projected 2023 Part B costs in the 2014 report are about 4% lower than projected in the 2013 report.

projections for 2013 through 2024 are also affected by the 2% sequestration of Medicare benefit expenditures under current law.[25]

Additionally, the 2014 report projected slightly lower Part D outlays compared to last year's report due primary to (1) lower projected cost trends over the next 10 years, and (2) higher expected rebates from drug manufacturers reflecting recent experience. Certain Part D expenditures are also affected by the 2% sequestration of Medicare benefit expenditures through 2024.[26] The Trustees, however, expect that per capita Part D spending will increase more quickly that other types of medical spending due to a slowing in the growth in generic drug utilization and an increase in the use and price of specialty drugs.

Even after accounting for the change in methodology used to determine the projected baseline for Part B spending, this year's total Medicare spending projections to year 2055 are lower than equivalent projections in the 2013 report, primary due to lower recent spending and slower expected growth rates in payments to Part A and Part B providers and Part D plans.

Alternative Projections

Throughout the 2014 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,[27] and that Independent Payment Advisory Board (IPAB) proposals to reduce Medicare costs will go into effect.[28] (As noted above, unlike in previous years, the Trustees assumed that future scheduled physician payment reductions under the sustainable growth rate system (SGR) will be overridden.)

Because of concerns about the accuracy of these projections, the Medicare Trustees asked the CMS Office of the Actuary to prepare an alternative projection based on the assumptions 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.[29] Under this alternative scenario, long-

[25] The Budget Control Act of 2011 (BCA; P.L. 112-25) provided for increases in the debt limit and established procedures designed to reduce the federal budget deficit, including the creation of a Joint Select Committee on Deficit Reduction. The failure of the Joint Committee to propose deficit reduction legislation by its mandated deadline triggered automatic spending reductions ("sequestration" of mandatory spending and reductions in discretionary spending) in fiscal years 2013 through 2021. The American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240) delayed the automatic reductions by two months, while the Bipartisan Budget Act of 2013 (BBA, P.L. 113-67) extended sequestration for mandatory spending for an additional two years—through FY2023. On February 15, 2014, the President signed into law an amended version of S. 25 (P.L. 113-82), which, among other things, included a provision to extend BCA's sequester of mandatory spending through FY2024. Also see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan, and CRS Report R43411, *The Budget Control Act of 2011: Legislative Changes to the Law and Their Budgetary Effects*, by Mindy R. Levit.

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

[27] 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.

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

[29] John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under Current Law, the Projected Baseline, and an Illustrative Alternative Scenario," August 28, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2014TRAlternativeScenario.pdf.

term Medicare costs are projected to reach 8.8% of GDP in 2080, instead of 6.8% under the Trustees' baseline projections. Additionally, under the alternative scenario, the HI actuarial deficit would be 1.92% of taxable payroll (compared to 0.87% under the projected baseline), which could be addressed by immediately increasing payroll taxes to 4.82% or by immediately decreasing expenditures by 33% (compared to 3.77% and 19% respectively under current law). The alternative scenario also projects that HI insolvency would occur one year earlier, in 2029.