Congressional Research Service
Informing the legislative debate since 1914

Medicare Financial Status: In Brief

Updated October 21, 2021

Congressional Research Service
https://crsreports.congress.gov
R43122

CRS REPORT
Prepared for Members and
Committees of Congress

Contents

Overview of the Medicare Program 1
Four Parts of Medicare 1
Beneficiary Costs 2
Provider and Plan Payments 2
Medicare Trust Funds and Sources of Revenue 2
Hospital Insurance Trust Fund 3
Sources of HI Revenue 3
HI Trust Fund Mechanics 4
Supplementary Medical Insurance Trust Fund 4
Sources of SMI Revenue 4
SMI Trust Fund Mechanics 5
Medicare Spending in 2020 5
2020 HI Operations 5
2020 SMI Operations 5
Estimated Date of HI Trust Fund Insolvency 6
Projected Medicare Spending Growth 7
Growth in Medicare Expenditures Relative to GDP 8
Unfunded and General Revenue Obligations 9
Comparison to Prior-Year Estimates 10
Alternative Projections 12

Figures

Figure 1. Sources of Medicare Revenues: 2020 3
Figure 2. Projected Number of Years Until Hospital Insurance Insolvency 7
Figure 3. Historical and Projected Medicare Expenditures 8
Figure 4. Medicare Cost and Non-interest Income, by Source as a Percentage of GDP 9
Figure 5. Comparison of 2020 and 2021 Medicare Expenditure Projections 11
Figure 6. Comparison of Medicare Expenditure Projections Based on Current Law and an Alternative Scenario 12

Tables

Table 1. Medicare Expenditures and Enrollment: CY2020 6
Table 2. Current Value of Estimated Medicare Unfunded Obligations and General Revenue Spending 10

Contacts

Author Information 13
Acknowledgments 13

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 aged 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. It also 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. For example, the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) made numerous changes to the Medicare program that modified provider reimbursements and provided incentives to improve the quality and efficiency of care.[3]

Four Parts of Medicare

Medicare consists of four distinct parts, A through D:

- **Part A** covers inpatient hospital services, skilled nursing care, hospice care, and some home health services. Most persons aged 65 and older are entitled to premium-free Part A because they or their spouse paid payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems.[4]
- **Part B** covers a broad range of medical services, including physician services, laboratory services, durable medical equipment, and outpatient hospital services. 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

[1] For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*.

[2] For a brief history of changes to the Medicare program, see CRS Report R40425, *Medicare Primer*.

[3] For details on individual Medicare provisions in the Patient Protection and Affordable Care Act (ACA; 111-148, as amended), see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*.

[4] The number of quarters of coverage required depends on whether the person is filing for Part A based on age, disability, or end-stage renal disease (ESRD).

enroll in Part C must be eligible for Part A and also must enroll in Part B. About 43% of Medicare beneficiaries are enrolled in MA.[5]

- **Part D** covers outpatient prescription drug benefits. This portion of the program is optional. About 78% of Medicare beneficiaries are enrolled in Medicare Part D or have coverage through an employer retiree plan subsidized by Medicare.[6]

Beneficiary Costs

In addition to paying premiums for Medicare Parts B and D,[7] beneficiaries may 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 deductibles and coinsurance.

Provider and Plan Payments

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.[8] 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 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.[9] (For beneficiaries enrolled in MA [Part C], payments are made on their behalf in appropriate portions from the HI and SMI trust funds based on CMS estimates of spending for Part A and Part B

[5] Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, August 31, 2021 (hereinafter, the 2021 Report of the Medicare Trustees), Table V.B3.

[6] Ibid.

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

[8] Under a *prospective payment system* (PPS), Medicare payments are made using a predetermined, fixed amount based on the classification system for a particular service. The Centers for Medicare & Medicaid Services (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.

[9] 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 fiduciary relationship. Congress creates trust funds that involve a commitment to use monies for a specific purpose, but it can alter the terms (e.g., receipts, outlays, or purpose) of the trust fund at any time. For additional information, see CRS Report R41328, *Federal Trust Funds and the Budget*.

services.) Both the HI and SMI trust funds are maintained by the Department of the Treasury and overseen by a Medicare Board of Trustees that reports annually to Congress concerning the funds' financial status.[10] 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 Department of the Treasury is authorized to make payments for it from the U.S. Treasury.

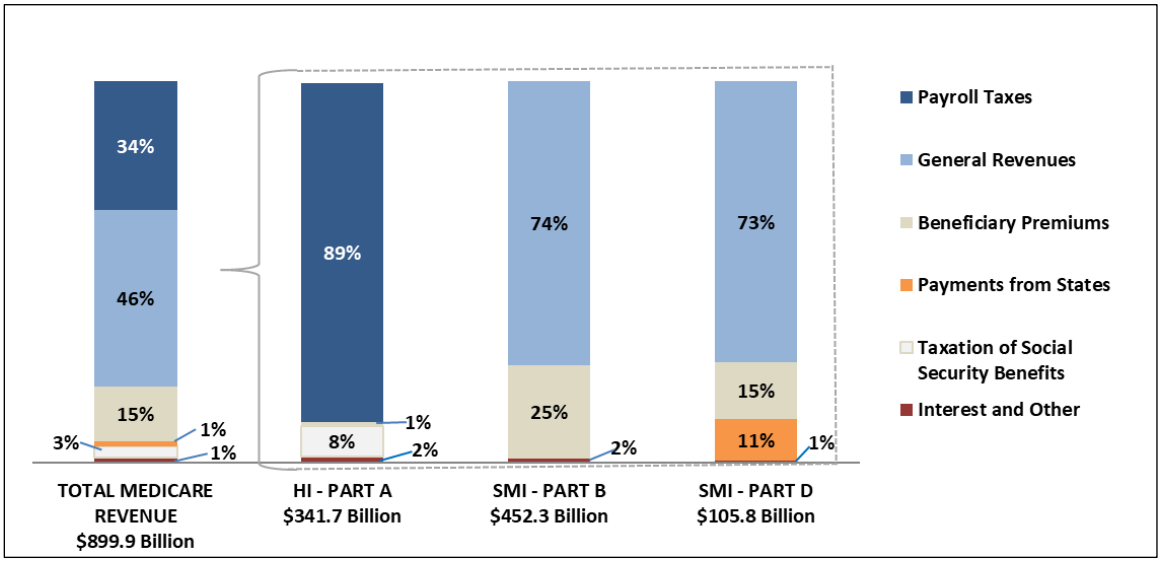
Hospital Insurance Trust Fund

The Part A portion of Medicare is financed through the HI trust fund.

Sources of HI Revenue

The HI trust fund is funded primarily 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 has imposed 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. 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.

Figure 1. Sources of Medicare Revenues: 2020



Source: 2021 Report of the Medicare Trustees, August 31, 2021, Table II.B1.

Notes: Totals may not add to 100% due to rounding. HI = Hospital Insurance; SMI = Supplementary Medical Insurance.

[10] These reports may be found at CMS, "Trustees Report and Trust Funds," at https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds.

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 (e.g., payroll taxes), income is credited by the Treasury to the HI trust fund in the form of special-issue interest-bearing government securities.[11] (Interest on these securities also is 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 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.

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 current expenses out of current income and accumulated trust fund assets, it is considered to be *insolvent*.[12]

Supplementary Medical Insurance Trust Fund

The SMI trust fund consists of two accounts: Part B and Part D.

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.[13] (See **Figure 1**.)

The Part B portion of SMI is funded mainly through beneficiary premiums (set at 25% of estimated program costs for the aged)[14] and general revenues (most of the remaining amount). In 2021, the standard monthly Part B premium is $148.50. 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.[15]

---

[11] 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.

[12] 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. Although a federal trust fund's spending can be greater than its income and trust funds can have a zero balance, unlike private businesses, the federal government is not in danger of "going out of business" or having its assets seized by creditors.

[13] 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.

[14] For additional information, CRS Report R40082, *Medicare Part B: Enrollment and Premiums*.

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

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*). (See **Figure 1**.) 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 2020[16]

In CY2020, Medicare provided benefits to about 62.6 million people (54.1 million people aged 65 and older and 8.5 million disabled people under the age of 65) at an estimated total cost of $926 billion.[17] Most of that amount, about $916 billion (99%), was spent on program benefits, with the remaining amount used for program administration. (See **Table 1**.)

2020 HI Operations

At the beginning of CY2020, the HI trust fund had an asset balance of $194.6 billion. During 2020, Part A expenditures reached $402.2 billion; about $303.3 billion of that amount was funded by payroll taxes and $38.4 billion by interest income and other sources. (See "Sources of HI Revenue.") Because expenditures exceeded revenue income, $60.4 billion was drawn out of the HI trust fund to cover the shortfall. At the end of 2020, the HI trust fund had an asset balance of $134.1 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 $134.1 billion in addition to what it receives in income.

2020 SMI Operations

In CY2020, total spending for Part B was $418.6 billion, with general revenues financing $336.0 billion of that amount and premiums covering most of the remainder. Total spending for Part D reached $105.0 billion in 2020, with $77.7 billion of that amount paid for by general revenues. In addition, $15.8 billion was covered by beneficiary premiums and $11.6 billion was covered by state transfer payments. Although Part D premiums are set at a rate to cover 25.5% of the costs of standard Part D benefits, the program pays for the premiums of about one-third of enrollees because these enrollees qualify for low-income assistance. As a result, Part D premiums represented about 15% of Part D revenues in 2020. (See **Figure 1**.)

[16] All data is from the 2021 Report of the Medicare Trustees, Table II.B1.

[17] This amount reflects Medicare total spending regardless of revenue source; it does not net out nonfederal 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: CY2020

	HI	SMI		
	Part A	**Part B**	**Part D**	**Total**
Expenditures (billions)				
Benefits	$397.7	$414.1	$104.6	$916.3
Hospital	141.2	54.9	—	196.0
Skilled Nursing	28.3	—	—	28.3
Home Health Care	6.5	10.9	—	17.4
Physician Services	—	65.3	—	65.3
Private Plans (Part C)	136.4	180.7	—	317.1
Prescription Drugs	—	—	104.6	104.6
Other	85.3	102.3	—	187.6
Administrative Expenses	4.5	4.5	0.4	9.5
Total Expenditures	**$402.2**	**$418.6**	**$105.0**	**$925.8**
Enrollment (millions)				
Aged	53.8	49.5	41.5	54.1[a]
Disabled	8.5	7.8	7.2	8.5
Total Enrollment	62.3	57.3	48.7	62.6
Average Expenditures per Enrollee	**$6,388**	**$7,227**	**$2,148**	**$15,763**

Source: 2021 Report of the Medicare Trustees, Table II.B1.

Notes: Totals do not necessarily equal the sums of rounded components. HI = Hospital Insurance; SMI = Supplementary Medical Insurance.

a. Number of beneficiaries with HI and/or SMI coverage.

Estimated Date of HI Trust Fund Insolvency

Under their most recent projections, the Medicare trustees estimate the HI trust fund will become insolvent in 2026.[18] Specifically, from 2008 to 2015, Part A expenditures exceeded HI income each year, and the assets credited to the trust fund were drawn down to make up the deficit. In 2016 and 2017, the HI trust fund ran a small surplus;[19] however, the Medicare trustees reported a return to deficits in 2018 and 2019. In 2020, the HI trust fund experienced a larger deficit, primarily due to the accelerated and advance payments made to providers during the COVID-19 public health emergency.[20] The trustees project that these payments will be repaid in 2021 and 2022, resulting in a smaller HI trust fund deficit in 2021 and a surplus in 2022. Following 2022,

[18] For additional information on HI trust fund solvency, see CRS Report RS20946, *Medicare: Insolvency Projections*.

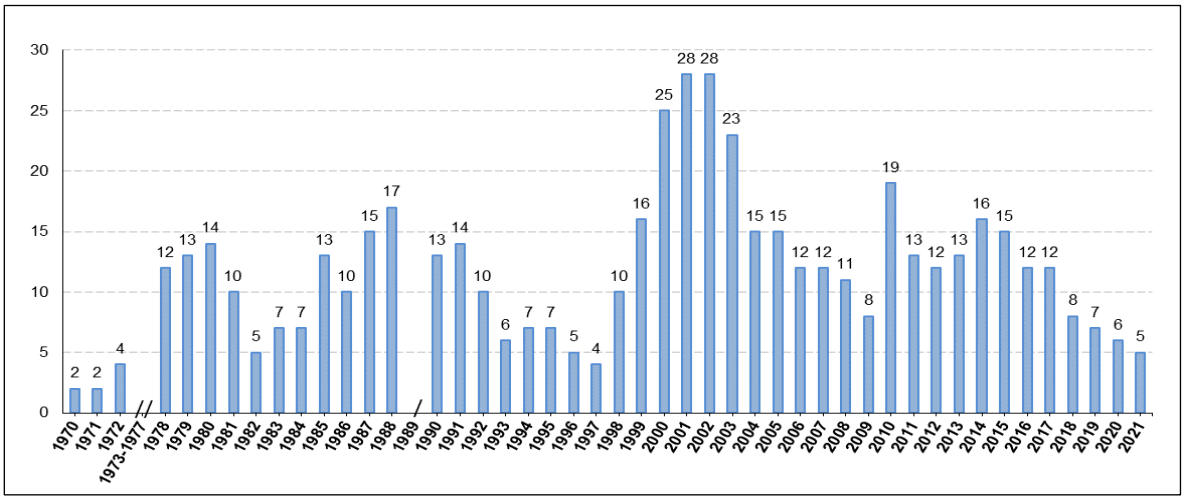
[19] The trustees attributed this period of surplus to low spending growth for Part A services, to a strengthening economy, and to the continued sequestration of 2% of Medicare benefit spending.

[20] For additional information on the impact of the COVID-19 pandemic on HI financing, see CRS Report RS20946, *Medicare: Insolvency Projections*. For details on Medicare accelerated and advance payments, see CRS Report R46698, *Medicare Accelerated and Advance Payments and COVID-19: Frequently Asked Questions*.

the trustees project a continuation of deficits in all following years until the HI trust fund becomes depleted (insolvent) in 2026. At that time, there would no longer be sufficient funds to fully cover Part A expenditures; although HI would continue to receive tax income, the funds would cover only 91% of Part A expenses. The trustees suggest that, under these circumstances, beneficiary access to Part A services "could rapidly be curtailed."[21]

Almost from its inception, the HI trust fund has faced a projected shortfall and eventual insolvency, with insolvency dates ranging from 2 years to 28 years from the year of the projection. (See **Figure 2**.) However, to date, the HI trust fund has never become insolvent. 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 face a decision regarding the provision of 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 Hospital Insurance Insolvency



Source: Intermediate projections of various Medicare Trustees Reports, 1970-2021.

Notes: The trustees did not provide specific estimates for years 1973-1977 and 1989.

Because income (general revenue and premiums) to the SMI trust fund is updated automatically 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 (Parts B and D) costs.

Projected Medicare Spending Growth

Medicare expenditures have increased rapidly throughout most of the program's history. For the period of 1985 through 2020, program spending grew at an average annual rate of 7.6%.

Although the 2021 Medicare Trustees Report noted a slowing in the growth of U.S. national health expenditures since 2008,[22] the trustees still project that U.S. health care expenditures,

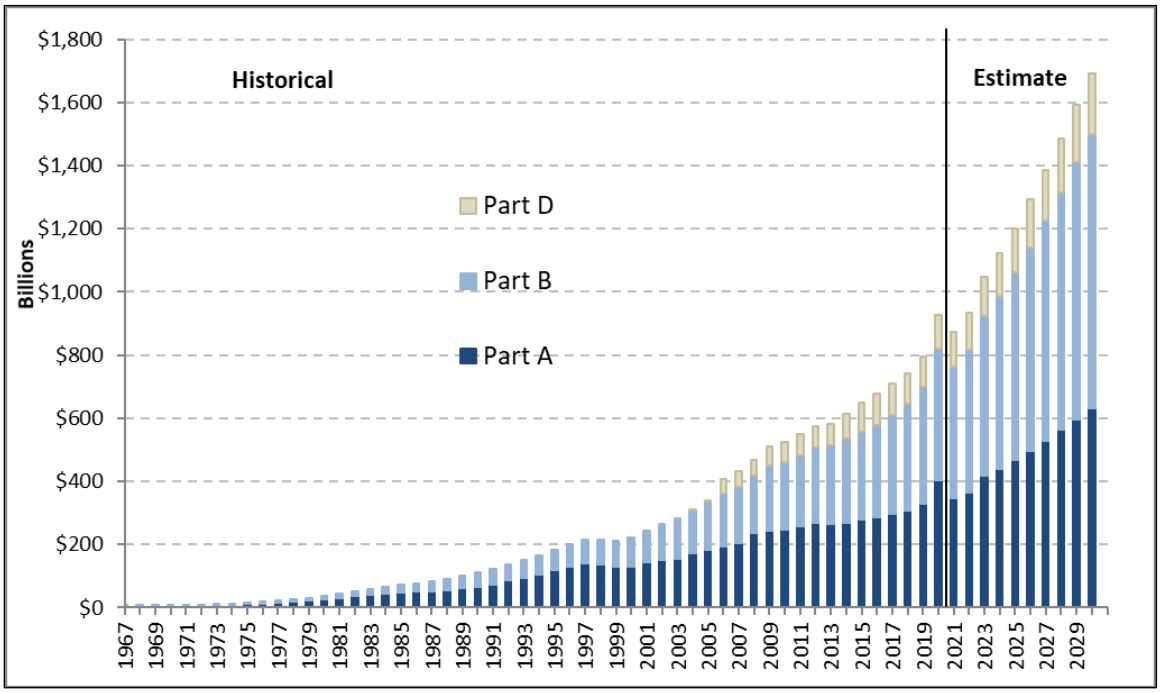
[21] The 2021 Report of the Medicare Trustees, p. 27.

[22] 2021 Report of the Medicare Trustees, p. 5. The trustees are uncertain whether this slowing is of limited duration

including Medicare expenditures, 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.[23]

The trustees project that from 2021 through 2030, Medicare expenditures will increase at an average annual rate of 6.2%. During that time, total Medicare expenditures are projected to increase from $875 billion (in 2021) to close to $1.7 trillion (in 2030).[24] Of the $1.7 trillion, about $630 billion is expected to be spent on Part A services, $871 billion on Part B services, and $192 billion on Part D services. (See **Figure 3**.)

Figure 3. Historical and Projected Medicare Expenditures



Sources: 2021 Report of the Medicare Trustees, Expanded and Supplementary Tables (historical data); and Report Tables III.B4; III.C4; and III.D3 (projected data).

Note: The spike in spending in 2020 is primarily due to the accelerated and advance payments made to providers during the COVID-19 pandemic during 2020. These payments are projected to be repaid in 2021 and 2022. For additional information on these payments, see CRS Report R46698, *Medicare Accelerated and Advance Payments and COVID-19: Frequently Asked Questions*.

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

(e.g., due to cyclical economic factors) or whether it may be a longer-term trend due to structural changes in the health care industry.

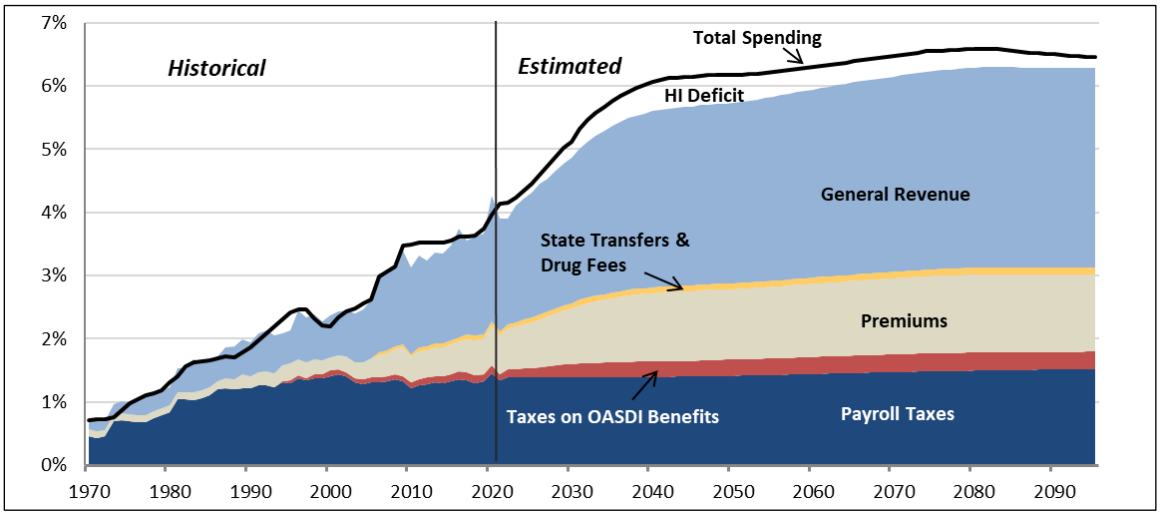
[23] When Medicare first began in 1966, there were about 19 million beneficiaries. This number has grown to over 63 million enrollees in 2021 and is expected to increase to about 77 million in 2030 and close to 110 million in 2095. 2021 Report of the Medicare Trustees, Table V.B3, p. 193.

[24] In nominal dollars.

Medicare services relative to the output of the U.S. economy. Under current law, the trustees expect total Medicare expenditures to increase from 4.1% of GDP in 2021 to about 6.2% of GDP by 2045, mainly due to the rapid growth in the number of beneficiaries, and then to about 6.5% of GDP in 2095, 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 1.8% of GDP in 2021 to an estimated 3.1% in 2095 under current law.[25] Similarly, income from beneficiary premiums is expected to increase from 0.6% of GDP in 2021 to 1.2% in 2095. The Medicare trustees estimate that about 19.6% of federal personal and corporate income taxes collected in 2020 will be used to fund the general revenue portion of SMI, and they project that this portion will increase to 23.6% in 2030 and to 32.5% in 2095. This amount is *in addition to* the payroll taxes used to fund the Part A (HI) portion of the program.

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



Source: Summary of the 2021 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart D, at http://www.ssa.gov/oact/TRSUM/index.html.

Unfunded and General Revenue Obligations

The Medicare 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.[26] (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

[25] Total Part B outlays are expected to be about 2.0% of GDP in 2021, and the Medicare trustees project they will grow to about 3.6% of GDP by 2095. The trustees also estimate that total Part D outlays will increase from about 0.5% of GDP in 2021 to close to 0.9% of GDP in 2095.

[26] The trustees note that using a 75-year timeframe can understate the magnitude of the long-range unfunded obligation. While the full amount of the payroll taxes paid by the next two or three generations of workers is reflected in this summary measure, the full amount of their expected benefits is not. Extending the projection horizon indefinitely allows both projected revenues and costs after the first 75 years to be reflected in the unfunded obligation estimate.

difference between income to the HI trust fund and expenditures over the next 75 years is $4.9 trillion. The trustees note that this financial imbalance could be addressed by immediately increasing payroll taxes to 3.67% (from the current 2.9%), or by immediately decreasing expenditures by 16%, or by some combination of the two. From a budgetary standpoint, the accumulated assets in the trust fund are considered liabilities, as the redemption of the assets represents a formal budget commitment. Therefore, the starting balance of about $0.2 trillion in the HI trust fund needs to be added to the unfunded obligation of $4.9 trillion for a present value of $5.1 trillion shortfall in dedicated revenues.

The Trustees Report also provides estimates of the present value of future SMI spending. Although SMI is funded automatically 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 $43.2 trillion. Adding the HI unfunded obligation estimate and the present value of future SMI spending for the 75-year period yields a total of $48.3 trillion.[27] In other words, it would take about $48.3 trillion in current dollars to cover the cost of Medicare not funded through dedicated sources over the next 75 years.

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 A		**Part B**	**Part D**	**Total**
Unfunded obligations through 2095	$5.1 trillion[a]	General revenue contributions through 2095	$35.5 trillion	$7.7 trillion	$48.3 trillion
Unfunded obligations through infinite horizon	-$10.3 trillion[a]	General revenue contributions through infinite horizon	$87.6 trillion	$26.1 trillion	$103.4 trillion

Source: 2021 Report of the Medicare Trustees, Tables V.F2, V.G1, V.G3, V.G5

a. Budgetary and trust fund accounting rules differ in the treatment of trust fund assets. From a budgetary standpoint, the accumulated assets in the trust fund are considered liabilities, as the redemption of the assets represents a formal budget commitment. The starting balance of $0.2 trillion in the HI trust fund is thus included in this figure. Under trust fund accounting methods, which exclude the asset balance, the unfunded HI obligation for the 75-year projection period would be $4.9 trillion and -$10.5 trillion for the infinite projection period.

Comparison to Prior-Year Estimates

Projections of total Medicare spending in the 2021 Trustees Report are similar to those in the 2020 report. (See **Figure 5**.) Although the COVID-19 pandemic significantly affected Medicare-short-term financing and spending, the trustees expect the pandemic will not have a large effect on the financial status of the trust funds after 2024. Therefore, the values for key measures of financial adequacy for the trust funds in the 2021 report are fairly comparable to those reported in last year's report.

In the short term, the financial outlook for the HI trust fund is similar to estimates in the 2020 report. The estimated 2026 depletion date in the 2021 report is the same as that in the 2020 report.

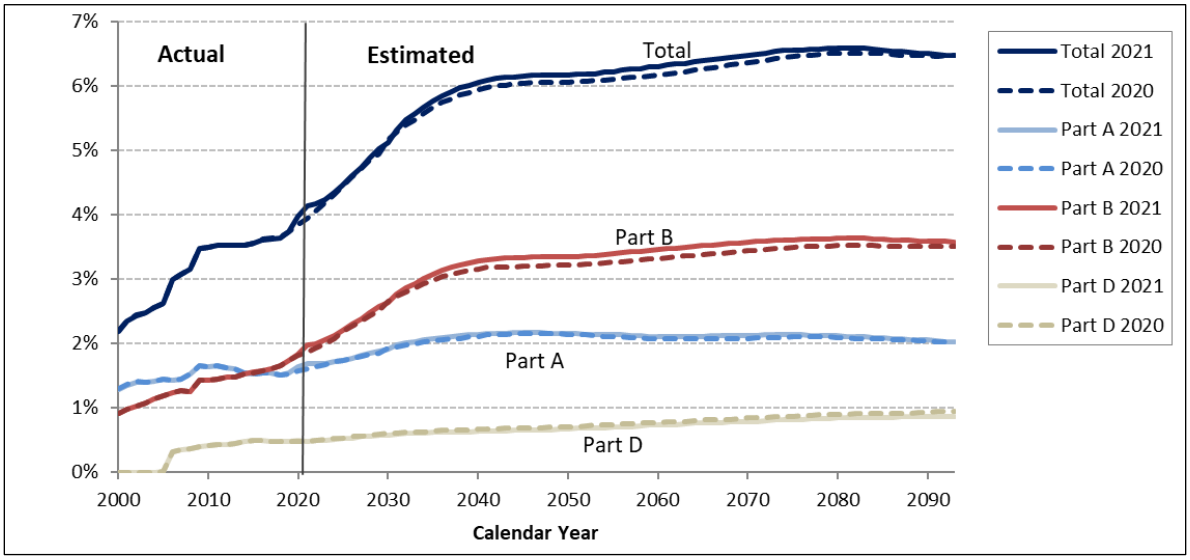
[27] The trustees note that while SMI general revenue transfers represent formal budget commitments under current law, no provision exists for covering the HI trust fund once assets are depleted.

The trustees attribute the consistency of their insolvency date estimate to the offsetting effects of lower income and expenditures in the near term and to their expectation that the effects of the COVID-19 pandemic on Medicare financing will last only a few years. Specifically, although HI payroll tax income over the next 10 years is projected to be lower than the 2020 report estimates due to the economic effects of the COVID-19 pandemic on labor markets, expenditures are also projected to be comparatively lower due to projections of lower provider payment updates and changes in the trustees' projection methodology.[28]

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) increased by 0.01 percentage point—from 0.76% of taxable payroll in the 2020 report to 0.77% of taxable payroll in the 2021 report. The trustees noted that several factors contributed to this change, including lower projected spending for Medicare Advantage and the above noted-methodological changes, which were offset by changes in the projection base and to certain economic and demographic assumptions.[29]

Figure 5. Comparison of 2020 and 2021 Medicare Expenditure Projections

(Expenditures as a Percentage of GDP)



Sources: 2020 and 2021 Medicare Trustees Reports, Supplementary Tables.

Projected Part B expenditures are slightly higher than those projected in the 2020 report, due to higher expected spending for outpatient hospital services and physician-administered drugs.[30] Part D cost projections, however, are slightly lower than the estimates in last year's report. This change is due primarily to assumptions of higher negotiated drug manufacturer and pharmacy rebates and a continuing enrollment shift from stand-alone prescription drug plans to Medicare Advantage prescription drug plans.[31]

[28] The updates to the demographic factors used for projections may be found in "Time-to-Death Demographic Factors," at https://www.cms.gov/research-statistics-data-systems/trustees-report-trust-funds/time-death-demographic-factors.

[29] The specific factors contributing to the change in the 75-year actuarial balance projections from 2020 to 2021 are listed in Table III.B10 and described on pages 73-74 of the 2021 Report of the Medicare Trustees.

[30] The Medicare trustees did not take into account any potential impacts from Medicare coverage of Aduhelm, the recently approved Alzheimer's disease drug, in developing their projections for their 2021 report.

[31] On a per capita basis, average Part D costs are lower for Medicare Advantage prescription drug plan enrollees than

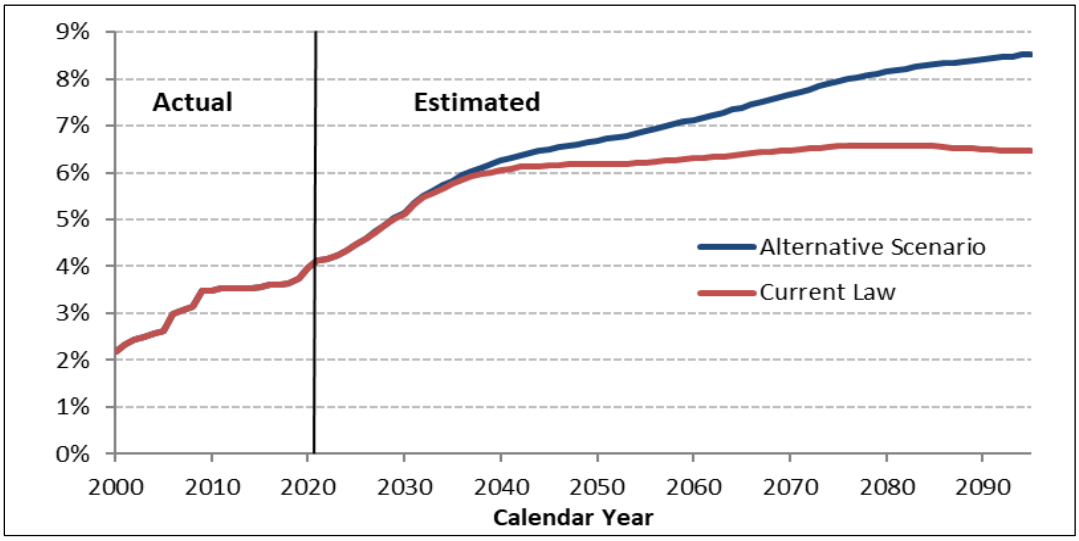
Alternative Projections

Throughout the 2021 report, the Medicare trustees caution that actual costs may be higher than their intermediate projections. For example, because the trustees are required to base their estimates on current law, their projections assume that physician payments will be updated according to levels set forth in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10),[32] and that the full ACA-required Medicare plan and provider payment reductions will be maintained.

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 annual physician payment updates will transition beginning in 2028 from current law to 2.05% from 2028 to 2042, that the 5% bonuses for physicians in the advanced alternative payment models (APM) and the $500 million in additional payments to physicians in the merit-based incentive system (MIPS) will continue for 2025 and later, and that ACA provider payment adjustments will be phased down beginning in 2028.[33] Under this alternative scenario, long-term Medicare costs are projected to reach about 8.5% of GDP in 2095, instead of 6.5% under the trustees' current-law projections. Additionally, under the alternative scenario, the HI actuarial deficit would be 1.61% of taxable payroll (compared with 0.77% under the current-law projection), which could be addressed by immediately increasing payroll taxes to 4.51% or by immediately decreasing expenditures by 29% (compared with 3.67% and 16% under current law). Because the differences in assumptions between current law and the alternative scenario do not begin until 2028, the alternative scenario projects the same 2026 date of HI insolvency.

Figure 6. Comparison of Medicare Expenditure Projections Based on Current Law and an Alternative Scenario

(Expenditures as a percentage of GDP)



Source: 2021 Report of the Medicare Trustees, Supplementary Tables.

Note: The alternative scenario assumes phasing out certain MACRA and ACA provider payment reductions.

for stand-alone prescription drug plan enrollees.

[32] See CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*.

[33] John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," August 31, 2021.

Author Information

Patricia A. Davis
Specialist in Health Care Financing

Acknowledgments

Isaac A. Nicchitta, CRS Research Assistant, contributed to this report update.

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.