2014 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS

COMMUNICATION

From

**THE BOARDS OF TRUSTEES,
FEDERAL HOSPITAL INSURANCE AND
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE
TRUST FUNDS**

Transmitting

**THE 2014 ANNUAL REPORT OF
THE BOARDS OF TRUSTEES OF THE
FEDERAL HOSPITAL INSURANCE AND
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE
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LETTER OF TRANSMITTAL

BOARDS OF TRUSTEES OF THE
FEDERAL HOSPITAL INSURANCE AND
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS,
Washington, D.C., July 28, 2014

HONORABLE JOHN A. BOEHNER,
Speaker of the House of Representatives

HONORABLE JOSEPH R. BIDEN, JR.,
President of the Senate

GENTLEMEN:

We have the honor of transmitting to you the 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the 49th such report.

Respectfully,

JACOB J. LEW,
Secretary of the Treasury,
and Managing Trustee of the Trust Funds.

THOMAS E. PEREZ,
Secretary of Labor, and Trustee.

SYLVIA M. BURWELL,
Secretary of Health and Human Services,
and Trustee.

CAROLYN W. COLVIN,
Acting Commissioner of Social Security,
and Trustee.

CHARLES P. BLAHOUS III,
Trustee.

ROBERT D. REISCHAUER,
Trustee.

MARILYN B. TAVENNER,
Administrator,
Centers for Medicare & Medicaid Services,
and Secretary, Boards of Trustees.

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I. INTRODUCTION

The Medicare program has two components. Hospital Insurance (HI), otherwise known as Medicare Part A, helps pay for hospital, home health following hospital stays, skilled nursing facility, and hospice care for the aged and disabled. Supplementary Medical Insurance (SMI) consists of Medicare Part B and Part D. Part B helps pay for physician, outpatient hospital, home health, and other services for the aged and disabled who have voluntarily enrolled. Part D provides subsidized access to drug insurance coverage on a voluntary basis for all beneficiaries and premium and cost-sharing subsidies for low-income enrollees. Medicare also has a Part C, which serves as an alternative to traditional Part A and Part B coverage. Under this option, beneficiaries can choose to enroll in and receive care from private *Medicare Advantage* and certain other health insurance plans. Medicare Advantage and Program of All-Inclusive Care for the Elderly (PACE) plans receive prospective, capitated payments for such beneficiaries from the HI and SMI Part B trust fund accounts; the other plans are paid on the basis of their costs.

The Social Security Act established the Medicare Board of Trustees to oversee the financial operations of the HI and SMI trust funds.[1] The Board has six members. Four members serve by virtue of their positions in the Federal Government: the Secretary of the Treasury, who is the Managing Trustee; the Secretary of Labor; the Secretary of Health and Human Services; and the Commissioner of Social Security. Two other members are public representatives whom the President appoints and the Senate confirms. Charles P. Blahous III and Robert D. Reischauer began serving on September 17, 2010. The Administrator of the Centers for Medicare & Medicaid Services (CMS) serves as Secretary of the Board.

The Social Security Act requires that the Board, among other duties, report annually to the Congress on the financial and actuarial status of the HI and SMI trust funds. The 2014 report is the 49th that the Board has submitted.

The basis for the projections in this report has changed since last year. Specifically, this year's projections reflect a second exception to current law, as explained below.

[1]The Social Security Act established separate boards for HI and SMI. Both boards have the same membership, so for convenience they are collectively referred to as the Medicare Board of Trustees in this report.

Overview

In last year's report, with one exception related to Part A, the projections were based on current law; that is, they assumed that laws on the books would be implemented and adhered to with respect to scheduled taxes, premium revenues, and payments to providers and health plans. The exception was that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. Under current law, payments would be reduced to levels that could be covered by incoming tax and premium revenues when the HI trust fund was depleted. If the projections reflected such payment reductions, then any imbalances between payments and revenues would be automatically eliminated, and the report would not serve its essential purpose, which is to inform policy makers and the public about the size of any trust fund deficits that would need to be resolved to avert program insolvency. To date, lawmakers have never allowed the assets of the Medicare HI trust fund to become depleted.

The exception described above remains in this year's report. In addition, a further exception to current law is being made this year with regard to the sustainable growth rate (SGR) formula for physician fee schedule payment under Part B. Current law requires CMS to implement a reduction in Medicare payment rates for physician services of almost 21 percent in April 2015. However, it is a virtual certainty that lawmakers will override this reduction as they have every year beginning with 2003. For this reason, the income, expenditures, and assets for Part B shown throughout the report reflect a *projected baseline*, which includes an override of the provisions of the SGR and an assumed annual increase in the physician fee schedule equal to the average SGR override over the 10-year period ending with March 31, 2015.[2] Since 2008, legislation overriding physician fee reductions has included provisions offsetting the 10-year cost of the overrides, but the division of those offsets between Medicare savings and savings in other parts of the budget has varied. Because it is difficult to predict the extent to which policy makers will finance future overrides with other Medicare savings, the projected Medicare baseline does not include any offsets, which may result in overstating program costs.

Projections of Medicare costs are highly uncertain, especially when looking out more than several decades. One reason for uncertainty is that scientific advances will make possible new interventions, procedures, and therapies. Some conditions that are untreatable today will be handled routinely in the future. Spurred by economic

[2]See appendix V.C for projections under current law.

incentives, the institutions through which care is delivered will evolve, possibly becoming more efficient. While most health care technological advances to date have tended to increase expenditures, the health care landscape is shifting. No one knows whether these future developments will, on balance, increase or decrease costs.

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, introduced large policy changes and additional projection uncertainty. This legislation, referred to collectively as the Affordable Care Act or ACA, contains roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving benefits, combating fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs. The Board assumes that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity—will occur as the Affordable Care Act requires. The Trustees believe that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. However, if the health sector cannot transition to more efficient models of care delivery and achieve productivity increases commensurate with economy-wide productivity, and if the provider reimbursement rates paid by commercial insurers continue to follow the same negotiated process used to date, then the availability and quality of health care received by Medicare beneficiaries would, under current law, fall over time relative to that received by those with private health insurance.

In recent years U.S. national health expenditure (NHE) growth has slowed relative to previous historical patterns. There is some debate regarding the extent to which this cost deceleration reflects one-time effects of the recent economic downturn versus the extent to which it reflects positive reforms in the health care sector that may carry forward to produce additional cost savings in the years ahead. The Trustees are hopeful that U.S. health care practices are in the process of becoming more efficient as providers anticipate a future in which the rapid cost growth rates of previous decades, in both the public and private sectors, do not return. Indeed, the Trustees have revised down their projections for near term Medicare expenditure growth in response to the recent favorable experience. In addition, the methodology for projecting Medicare finances had already assumed a substantial long-term reduction in per capita health expenditure

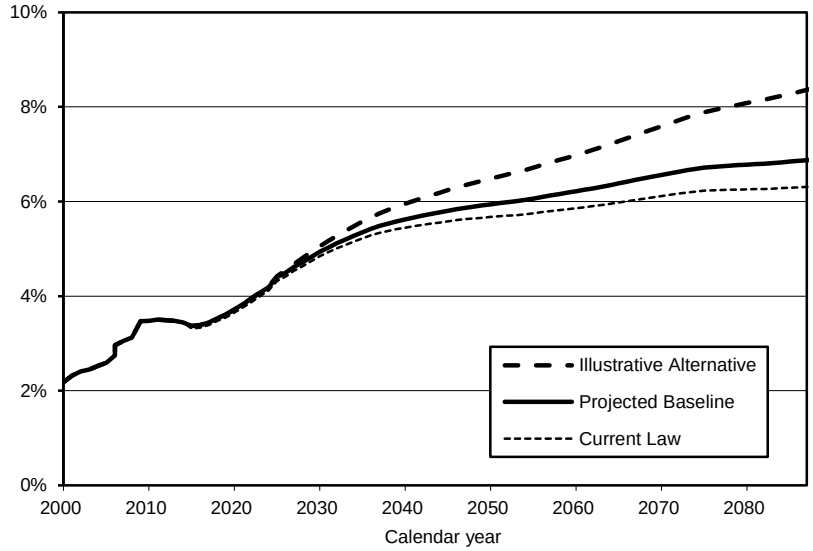
growth rates relative to historical experience, to which the ACA's cost-reduction provisions would add substantial further savings. Notwithstanding recent favorable developments, both the projected baseline and current law projections indicate that Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation. Such legislation should be enacted sooner rather than later to minimize the impact on beneficiaries, providers, and taxpayers.

Figure I.1 shows Medicare's projected costs as a percentage of the Gross Domestic Product (GDP) under three sets of assumptions: projected baseline, current law, and illustrative alternative, described below.[3]

The projected baseline, which is shown in the middle line of figure I.1 and is the basis of estimates presented throughout the main body of this report, assumes that the scheduled SGR reductions are overridden so that physicians' payment rates increase at a 0.6-percent annual rate from 2016 through 2023. This is the same average update that has been occurring over the 10-year period ending with March 31, 2015. From 2024 through 2038 (after the short-range valuation period has ended), the payment updates in this scenario are assumed to gradually rise so that Medicare expenditures per beneficiary for physician services are increasing at the same rate as per capita national health expenditures by 2038.

[3]At the request of the Trustees, the Office of the Actuary at CMS has prepared a set of illustrative Medicare projections under a hypothetical modification to current law. A summary of the projections under the illustrative alternative is contained in appendix V.C of this report, and a more detailed discussion is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2014TRAlternativeScenario.pdf. Readers should not infer any endorsement of the policies represented by the illustrative alternative by the Trustees, CMS, or the Office of the Actuary. Appendix V.C also provides additional information on Medicare projections under current law and the uncertainties associated with productivity adjustments to certain provider payment updates.

Figure I.1.—Medicare Expenditures as a Percentage of the Gross Domestic Product under Current Law, Projected Baseline, and Illustrative Alternative Projections



The current-law cost projections reflect the scheduled SGR reductions to physicians' payment rates and the ACA-mandated reductions in other Medicare payment rates, but not the payment reductions and/or delays that would result from the HI trust fund depletion. The difference between the projected baseline and the current-law projections represents the financial impact of the current practice of overriding the scheduled SGR reductions.

The illustrative alternative shown in the top line of figure I.1 incorporates the override of SGR physician payment rates included in the projected baseline and a partial phase-out of the ACA reductions in Medicare payment rates from 2020 through 2034, as well as an assumed legislative override of the cost-saving actions of the Independent Payment Advisory Board (IPAB). The difference between the illustrative alternative and the projected baseline projections demonstrates that the long-range costs could be

substantially higher than shown throughout much of the report if the ACA's cost reduction measures prove ineffectual or are scaled back.[4]

As figure I.1 shows, Medicare's costs under the Trustees' projected baseline assumptions rise from their current level of 3.5 percent of GDP to 5.6 percent in 2040 and 6.9 percent in 2088. If the SGR reductions under current law were implemented, projected Medicare costs would rise to 5.5 percent of GDP in 2040 and 6.3 percent in 2088. Under the illustrative alternative, in which adherence to the ACA cost-saving measures also erodes, projected costs would rise to 6.0 percent of GDP in 2040 and 8.4 percent in 2088.

As the preceding discussion explains, and as the substantial differences among the Trustees' projected baseline, current-law, and illustrative alternative projections demonstrate, Medicare's actual future costs are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Because the physician payment reduction required by current law has been overridden for 12 consecutive years, the Trustees decided for the 2014 report to emphasize projections that reflect the current practice of modest payment increases in the physician fee schedule. These projections do not represent either a policy recommendation or a prediction of legislative outcomes. Nevertheless, the Board recommends that readers interpret the projected baseline estimates in the report as the result of the outcomes that would be experienced if the productivity adjustments and IPAB measures in the Affordable Care Act could be sustained in the long range under the Trustees' economic and demographic assumptions. Readers are encouraged to review appendix V.C for further information on this important subject. Where applicable, the Trustees note the key financial outcomes under the current-law and illustrative alternative projections in addition to the projected baseline projections that are highlighted in the text and tables of the report.

[4]Under the ACA, Medicare's annual payment rate updates for most categories of providers would be reduced below the increase in providers' input prices by the growth in economy-wide multifactor productivity (1.1 percent over the long range). In addition, the IPAB would be charged with recommending cost savings as are necessary to hold overall per capita Medicare growth to the average of the Consumer Price Index (CPI) and CPI-medical increases in 2015-2019 and to the rate of per capita GDP growth plus 1 percentage point thereafter (subject to certain limits). Unless overridden by lawmakers, these recommendations would be implemented automatically.

II. OVERVIEW

A. HIGHLIGHTS

The major findings of this report under the intermediate set of assumptions appear below. The balance of the Overview and the following Actuarial Analysis section describe these findings in more detail.

In 2013

In 2013, Medicare covered 52.3 million people: 43.5 million aged 65 and older, and 8.8 million disabled. About 28 percent of these beneficiaries have chosen to enroll in Part C private health plans that contract with Medicare to provide Part A and Part B health services. Total expenditures in 2013 were $582.9 billion, and, for the second year in a row, per beneficiary costs were essentially unchanged. Total income was $575.8 billion, which consisted of $564.1 billion in non-interest income and $11.7 billion in interest earnings. Assets held in special issue U.S. Treasury securities decreased by $7.1 billion to $280.5 billion.

Short-Range Results

The estimated depletion date for the HI trust fund is 2030, 4 years later than was shown in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI taxable earnings in 2013 were slightly higher than last year's estimate; after 2013, however, projections of earnings throughout the period are lower mostly due to lower GDP based on lower assumptions for the GDP deflator and real GDP. HI expenditures in 2013 were significantly lower than the previous estimate, and through 2016 the projected level grows more slowly than shown in last year's report largely due to reductions in utilization assumptions, reflecting recent trends.

HI expenditures have exceeded income annually since 2008 and are projected to continue doing so through 2014. The Trustees project slight surpluses in 2015 through 2022, with a return to deficits thereafter until the fund becomes depleted in 2030. In 2013, $15.0 billion in trust fund assets were redeemed to cover the shortfall of income relative to expenditures. The Treasury also paid from the general fund $9.3 billion in interest to the HI trust fund in 2013. The assets were $220.4 billion at the beginning of 2013, representing about 83 percent of expenditures during the year, which is below the

Trustees' minimum recommended level of 100 percent. The HI trust fund has not met the Trustees' formal test of short-range financial adequacy since 2003 (as discussed in section III.B). Growth in HI expenditures has averaged 2.5 percent annually over the last 5 years and is projected to average 3.9 percent over the next 5 years.

The SMI trust fund is adequately financed over the next 10 years and beyond because premium and general revenue income for Parts B and D are reset each year to cover expected costs and ensure a reserve for Part B contingencies. Part B and Part D costs have averaged annual growth of 6.2 percent and 7.2 percent, respectively, over the last 5 years, as compared to growth of 2.7 percent for GDP. Under the projected baseline scenario,[5] the Trustees project an average annual Part B growth rate of 5.7 percent over the next 5 years; under current law, the average annual Part B growth rate would instead be 4.9 percent. For Part D, the estimated average annual increase in expenditures is 9.9 percent over the next 5 years. The projected average annual rate of growth for the U.S. economy is 5.0 percent during this period, significantly slower than for Part D and slightly slower than the growth rate for Part B.

The difference between Medicare's total outlays and its *dedicated financing sources* is not estimated to reach 45 percent of outlays in fiscal years 2014 through 2020. Therefore, the Trustees will not be issuing a determination of projected excess general revenue Medicare funding in this report. Determinations were previously made in each of the 2006 through 2013 reports.

Long-Range Results

For the 75-year projection period, the HI actuarial deficit has decreased from 1.11 percent of taxable payroll, as shown in last year's report, to 0.87 percent of taxable payroll. (Under the illustrative alternative projections, the HI actuarial deficit would be 1.92 percent of taxable payroll, compared to 2.17 percent in last year's report.) The 0.24 percent of payroll reduction in the actuarial deficit was primarily due to (i) lower-than-expected spending in 2013 for most HI service categories, especially for inpatient hospitals (about 0.11 percent of payroll); (ii) lower utilization assumptions for inpatient hospital (about 0.11 percent of payroll); and (iii) lower case mix increase assumptions about skilled nursing facilities and home health agencies (about 0.07 percent of payroll). Partially offsetting these

[5]The projected baseline scenario includes the assumption that the current-law physician updates will be legislatively overridden and that physician updates will be 0.6 percent each year starting with 2016.

favorable changes were assumptions about MA plan beneficiaries (about 0.06 percent of payroll).

Part B outlays were 1.5 percent of GDP in 2013, and the Board projects that they will grow to just less than 3.2 percent by 2088 under the projected baseline scenario. These projections are lower than those in last year's report under the "alternative to SGR" scenario mostly due to (i) lower-than-expected spending in 2012 and 2013 for most types of services; and (ii) lower assumptions for volume and intensity for some types of service. (Part B costs in 2088 would be 2.6 percent and slightly over 3.2 percent of GDP under current law and the illustrative alternative scenario, respectively.)

The Board estimates that Part D outlays will increase from 0.4 percent of GDP in 2013 to about 1.4 percent by 2088. These outlay projections are slightly lower than those shown in last year's report primarily because (i) the projected drug cost trend for the next 10-year period is lower than last year; and (ii) rebates are assumed to be higher throughout the projection.

Transfers from the general fund are the major source of financing for the SMI trust fund and are central to the automatic financial balance of the fund's two accounts. Such transfers represent a large and growing requirement for the Federal budget. SMI general revenues currently equal 1.4 percent of GDP and would increase to an estimated 3.3 percent in 2088.

Conclusion

Total Medicare expenditures were $583 billion in 2013. The Board projects that expenditures will increase in future years at a somewhat faster pace than either aggregate workers' earnings or the economy overall and that, as a percentage of GDP, they will increase from 3.5 percent in 2013 to 6.9 percent by 2088 (based on the projected baseline under the Trustees' intermediate set of assumptions). Under current law, Medicare spending would represent 6.3 percent of GDP in 2088. If the reduced price increases for other health services under Medicare are not sustained and do not take full effect in the long range as in the illustrative alternative projection, then Medicare spending would instead represent roughly 8.4 percent of GDP in 2088. Growth under any of these scenarios, if realized, would substantially increase the strain on the nation's workers, the economy, Medicare beneficiaries, and the Federal budget.

Overview

The Trustees project that HI tax income and other dedicated revenues will fall short of HI expenditures in most future years. The HI trust fund does not meet either the Trustees' test of short-range financial adequacy or their test of long-range close actuarial balance.

The Part B and Part D accounts in the SMI trust fund are adequately financed because premium and general revenue income are reset each year to cover expected costs. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth.

The financial projections in this report indicate a need for additional steps to address Medicare's remaining financial challenges. Consideration of further reforms should occur in the near future. The sooner solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations and behavior. The Trustees recommend that Congress and the executive branch work closely together with a sense of urgency to address the depletion of the HI trust fund and the projected growth in HI (Part A) and SMI (Parts B and D) expenditures.

B. MEDICARE DATA FOR CALENDAR YEAR 2013

HI (Part A) and SMI (Parts B and D) have separate trust funds, sources of revenue, and categories of expenditures. Table II.B1 presents Medicare data for calendar year 2013, in total and for each part of the program. For fee-for-service Medicare, the largest category of Part A expenditures is inpatient hospital services, while the largest Part B expenditure category is physician services. Payments to private health plans for providing Part A and Part B services currently represent roughly 30 percent of total A and B benefit outlays.

Table II.B1.—Medicare Data for Calendar Year 2013

		SMI		
	HI or Part A	Part B	Part D	Total
Assets at end of 2012 (billions)	$220.4	$66.2	$1.0	$287.6
Total income	$251.1	$255.0	$69.7	$575.8
Payroll taxes	220.8	—	—	220.8
Interest	9.3	2.4	0.0	11.7
Taxation of benefits	14.3	—	—	14.3
Premiums	3.4	63.1	9.9	76.4
General revenue	0.9	185.8	51.0	237.7
Transfers from States	—	—	8.8	8.8
Other	2.4	3.7	—	6.1
Total expenditures	$266.2	$247.1	$69.7	$582.9
Benefits	261.9	243.8	69.3	575.0
Hospital	136.8	41.8	—	178.6
Skilled nursing facility	28.4	—	—	28.4
Home health care	6.8	11.5	—	18.4
Physician fee schedule services	—	68.6	—	68.6
Private health 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
Net change in assets	−$15.0	$7.9	−$0.0	−$7.1
Assets at end of 2013	$205.4	$74.1	$1.0	$280.5
Enrollment (millions)				
Aged	43.1	40.0	n/a	43.5
Disabled	8.8	7.9	n/a	8.8
Total	51.9	47.9	39.1	52.3
Average benefit per enrollee	$5,045	$5,092	$1,773	$11,910

Notes: 1. Totals do not necessarily equal the sums of rounded components.
2. n/a indicates data are not available.

For HI, the primary source of financing is the payroll tax on covered earnings. Employers and employees each pay 1.45 percent of a worker's wages, while self-employed workers pay 2.9 percent of their net earnings. Starting in 2013, high-income workers pay an additional 0.9-percent tax on their earnings above an unindexed threshold ($200,000 for single taxpayers and $250,000 for married couples). Other HI revenue sources include a portion of the Federal income taxes that Social Security recipients with incomes above

certain unindexed thresholds pay on their benefits, as well as interest paid from the general fund on the U.S. Treasury securities held in the HI trust fund.

For SMI, transfers from the general fund of the Treasury represent the largest source of income and currently cover about 75 percent of program costs. Also, beneficiaries pay monthly premiums for Parts B and D that finance a portion of the total cost. As with HI, the U.S. Treasury securities held in the SMI trust fund earn interest paid from the general fund.

C. ECONOMIC AND DEMOGRAPHIC ASSUMPTIONS

Future Medicare expenditures will depend on a number of factors, including the size and composition of the population eligible for benefits, changes in the volume and intensity of services, and increases in the price per service. Future HI trust fund income will depend on the size of the covered work force and the level of workers' earnings, and future SMI trust fund income will depend on projected program costs. These factors will depend in turn upon future birth rates, death rates, labor force participation rates, wage increases, and many other economic and demographic factors affecting Medicare. To illustrate the uncertainty and sensitivity inherent in estimates of future Medicare trust fund operations, the Board has prepared projections under a *low-cost* and a *high-cost* set of economic and demographic assumptions as well as under an intermediate set.

Table II.C1 summarizes the key assumptions used in this report. Many of the demographic and economic variables that determine Medicare costs and income are common to the Old-Age, Survivors, and Disability Insurance (OASDI) program, and the OASDI annual report explains these variables in detail. These variables include changes in the Consumer Price Index (CPI) and wages, real interest rates, fertility rates, mortality rates, and net immigration levels. (*Real* indicates that the effects of inflation have been removed.) The assumptions vary, in most cases, from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period.

Other assumptions are specific to Medicare. As with all of the assumptions underlying the financial projections, the Trustees review the Medicare-specific assumptions annually and update them based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010-2011 Technical Review Panel on the Medicare Trustees Report.[6]

[6]The Panel's final report is available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf.

Table II.C1.—Ultimate Assumptions

	Intermediate	Low-Cost	High-Cost
Economic:			
Annual percentage change in:			
Gross Domestic Product (GDP) per capita[1]	4.0	5.2	2.7
Average wage in covered employment	3.8	5.2	2.5
Private non-farm business multifactor productivity	1.1	—	—
Consumer Price Index (CPI)	2.7	3.4	2.0
Real-wage differential (percent)	1.1	1.8	0.5
Real interest rate (percent)	2.9	3.4	2.4
Demographic:			
Total fertility rate (children per woman)	2.00	2.30	1.70
Average annual percentage reduction in total age-sex adjusted death rates from 2038 to 2088	0.72	0.41	1.04
Net annual immigration:			
Legal	790,000	1,000,000	595,000
Other	215,000	278,000	169,000
Health cost growth:			
Annual percentage change in per beneficiary Medicare expenditures (excluding demographic impacts)[1]			
HI (Part A)	4.2[2]	[3]	[3]
SMI Part B	4.6[2]	[3]	[3]
SMI Part D	5.0[2]	[3]	[3]
Total Medicare	4.5[2]	[3]	[3]

[1]The assumed ultimate increases in per capita GDP and per beneficiary Medicare expenditures can also be expressed in real terms, adjusted to remove the impact of assumed inflation. When adjusted by the chain-weighted GDP price index, assumed real per capita GDP growth under the intermediate assumptions is 1.7 percent, and real per beneficiary Medicare cost growth is 1.9 percent, 2.3 percent, and 2.7 percent for Parts A, B, and D, respectively.

[2]Amounts shown represent the average cost growth assumption in the last 50 years of the projection. The year-by-year assumptions vary by following the path determined by the "factors contributing to growth" model. See text for the basis of these assumptions.

[3]See section III.B3 for further explanation of the Part A alternative (low-cost and high-cost) assumptions. Long-range alternative projections are not prepared for Parts B and D.

Section IV.D describes the methodology used to derive the long-range cost growth assumptions. Under the projected baseline, the long-range cost growth assumptions are developed for the following three[7] categories of providers:

(i) *All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.*

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year increases for these provider services start at 4.4 percent in 2038, or GDP plus 0.4 percent, declining gradually to 3.5 percent in 2088, or GDP minus 0.5 percent. On average, the ultimate cost

[7] The current-law treatment of the SGR provision was a separate category in previous reports. The projected baseline SGR approach allows physician payment updates to be treated as other Medicare services unaffected by productivity price reductions.

growth rate for these provider services is 4.2 percent, or GDP plus 0.2 percent.

(ii) *Certain SMI Part B services that are updated annually by the CPI increase less the increase in productivity.*

Such services include durable medical equipment, care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.6 percent in 2038, or GDP minus 0.4 percent, declining to 2.7 percent in 2088, or GDP minus 1.3 percent. On average, the total assumed rate of growth for these services is 3.4 percent, which equates to GDP minus 0.6 percent.

(iii) *All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services, including physician payments.*[8]

These Part B outlays constitute an estimated 50 percent of total Part B expenditures in 2023 and consist mostly of payments for physician services, laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[9] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year growth rates for these services are 5.2 percent in 2038, or GDP plus 1.2 percent, declining to 4.3 percent by 2088, or GDP plus 0.3 percent. On average, the rate of growth for these services is 5.0 percent, or GDP plus 1 percent.

After combining the rates of growth from the three long-range assumptions, the weighted average growth rate for Part B is 4.6 percent per year for the last 50 years of the projection period, or GDP plus 0.6 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate for Medicare is

[8]In the long range under the projected baseline, physician services are assumed to increase at the rate equal to the per capita increase in health spending in the U.S. overall.

[9]For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

4.5 percent over this same period. Both rates are shown in table II.C1.

As in the past, the Trustees establish detailed growth rate assumptions for the initial 10 years (2014 through 2023) by individual type of service (for example, inpatient hospital care and physician services). These assumptions reflect recent trends and the impact of all provisions of the Affordable Care Act, Budget Control Act, and other applicable statutory provisions, with the exception of the assumptions for physician services, which are the same as described for the projected baseline. For each of Parts A, B, and D, the assumed growth rates for years 11 through 25 of the projection period are set by interpolating between the rate at the end of the short-range projection period and the rate at the start of the last 50 years of the long-range period described above.

The basis for the Medicare cost growth rate assumptions, described above, has been chosen primarily to incorporate the productivity adjustments in a relatively simple, straightforward manner and with the assumption that this element of current law will operate in all future years as specified. The Trustees use this approach in part due to the uncertainty associated with this provision and in part due to the difficulty of modeling such consequences as access to care, health status, and utilization if this provision of current law does not operate as intended. Purposely not considered at this time are the potential effects of sustained slower payment increases on provider participation, beneficiary access to care, quality of services, and other factors. Similarly, there has been no modeling of the possible effects of future changes in payment mechanisms, delivery systems, and other aspects of health care that could arise in response to the payment limitations and the ACA-directed research activities.[10]

Consistent with the practice in recent reports, the Trustees have asked the Office of the Actuary to develop the illustrative alternative projections. This information is presented in appendix V.C. Also included in the appendix are current-law projections, which, for 2014, have been replaced in the body of the report with the projected baseline projections. An actuarial memorandum on the illustrative

[10]The 2010-2011 Medicare Technical Review Panel considered these issues at some length. Their final report contains an extensive discussion of alternative long-term scenarios with different possible behavioral reactions by providers and with varying implications for the financial viability of providers and the availability and quality of health care services for beneficiaries.

alternative is available on the CMS website.[11] For the long range, the illustrative alternative projection assumes that the economy-wide productivity adjustments would be gradually phased out during 2020 to 2034 and replaced with adjustments based on estimated health-specific provider productivity gains of 0.4 percent annually. Based on the factors model, the year-by-year long-range growth rate assumptions for HI and SMI Part B under the illustrative alternative projections are 5.2 percent in 2038, or GDP plus 1.2 percent, declining to 4.3 percent by 2088, or GDP plus 0.3 percent. (The average ultimate assumption equals the traditional GDP + 1 percent assumption for per capita national health expenditures, as described previously for Part D and other Medicare services for which price updates are based on market processes.)

For the HI high-cost assumptions under the projected baseline, the assumed annual increase in the ratio of aggregate costs to taxable payroll (the cost rate) during the initial 25-year period is 2 percentage points greater than under the intermediate assumptions. Under the low-cost assumptions, the assumed annual rate of increase in the cost rate for the initial period is 2 percentage points less than under the projected baseline intermediate assumptions. After 25 years, the Trustees assume that the 2-percentage-point differentials will decline gradually to zero in 2063, after which the growth in cost rates is the same under all three sets of assumptions. The low-cost and high-cost projections shown in this report provide an indication of how Medicare expenditures could vary in the future under current law as a result of different economic and demographic trends.[12]

While it is reasonable to expect that actual economic and demographic experience under the projected baseline will fall within the range defined by the three alternative sets of assumptions, there can be no assurances that it will do so in light of the wide variations in these factors over past decades. In general, readers can place a greater degree of confidence in the assumptions and estimates for the earlier years than for the later years. Nonetheless, even for the earlier years, the estimates are only an indication of the expected trends and the general ranges of future Medicare experience. Also, as a result of the uncertain long-range adequacy of other payments affected by the statutory productivity adjustments, actual future Medicare expenditures could exceed the intermediate projections

[11]See http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2014TRAlternativeScenario.pdf.

[12]Due to the automatic financing provisions for Parts B and D, the Trustees expect that the SMI trust fund will be adequately financed in all future years and so have not conducted a long-range analysis using high-cost and low-cost assumptions.

shown in this report, possibly by quite large amounts. Reference to key results under the illustrative alternative projection demonstrates this potential understatement.

D. FINANCIAL OUTLOOK FOR THE MEDICARE PROGRAM

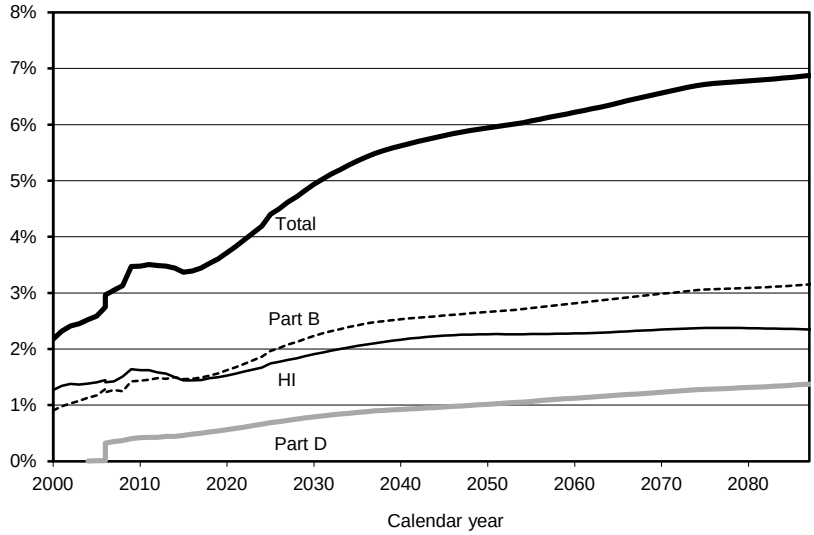
This report evaluates the financial status of the HI and SMI trust funds. For HI, the Trustees apply formal tests of financial status for both the short range and the long range; for SMI, the Trustees assess the ability of the trust fund to meet incurred costs over the period for which financing has been set.

HI and SMI are financed in very different ways. Within SMI, current law provides for the annual determination of Part B and Part D beneficiary premiums and general revenue financing to cover expected costs for the following year. In contrast, HI is subject to substantially greater variation in asset growth, since employee and employer tax rates under current law do not change or adjust to meet expenditures except through new legislation.

Despite the significant differences in benefit provisions and financing, the two components of Medicare are closely related. HI and SMI operate in an interdependent health care system. Most Medicare beneficiaries are enrolled in HI and SMI Parts B and D, and many receive services from all three. Accordingly, efforts to improve and reform either component must necessarily have repercussions for the other component. In view of the anticipated growth in Medicare expenditures, it is also important to consider the distribution among the various sources of revenues for financing Medicare and the manner in which this distribution will change over time.

This section reviews the projected total expenditures for the Medicare program, along with the primary sources of financing. Figure II.D1 shows projected costs as a percentage of GDP. Medicare expenditures represented 3.5 percent of GDP in 2013. Under the projected baseline, costs would increase to about 5.4 percent of GDP by 2035, largely due to the rapid growth in the number of beneficiaries, and then to 6.9 percent of GDP in 2088, with growth in health care cost per beneficiary becoming the larger factor later in the valuation period. If payment updates were made under current law, then Medicare expenditures would reach an estimated 6.3 percent of GDP in 2088, and if the payment update constraints were phased down as in the illustrative alternative projections, then Medicare expenditures would reach an estimated 8.4 percent of GDP in 2088.

Figure II.D1.—Medicare Expenditures as a Percentage of the Gross Domestic Product



The Medicare projections reflect (i) continuing growth in the volume and intensity of services provided per beneficiary throughout the projection period; (ii) the impact of a large increase in beneficiaries, which started in 2011, as members of the 1946-1965 baby boom generation reach age 65 and become eligible to receive benefits (thereby increasing the annual growth in the number of beneficiaries from 2 percent to about 3 percent); and (iii) other key demographic trends, including future birth rates at roughly the same level as the last 2 decades and continuing improvements in life expectancy. See appendix V.A for recently passed legislation that is also included in the projections.

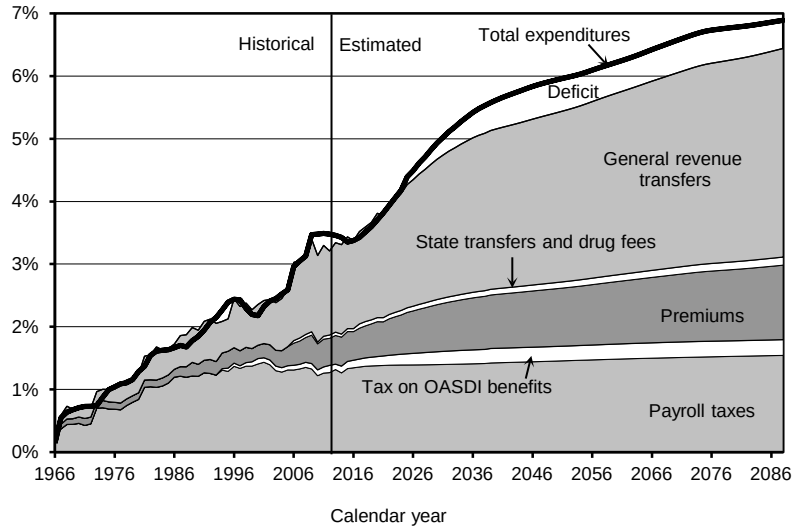
Most beneficiaries have the option to enroll in private health insurance plans that contract with Medicare to provide Part A and Part B medical services. The share of Medicare beneficiaries in such plans has risen rapidly in recent years; it reached 28.4 percent in 2013 from 12.8 percent in 2004. Plan costs for the standard benefit package can be significantly lower or higher than the corresponding cost for beneficiaries in the traditional or fee-for-service Medicare program. Prior to the Affordable Care Act, private plans were generally paid a higher average amount, and they used the additional payments to reduce enrollee cost-sharing requirements, provide extra benefits, and/or reduce Part B and Part D premiums. These enhancements were valuable to enrollees but also resulted in higher Medicare costs overall and higher premiums for all Part B

beneficiaries, not just those enrolled in Medicare Advantage plans. The ACA requires that payments to plans (i) be based on benchmarks that range from 95 to 115 percent of local fee-for-service Medicare costs, with bonus amounts payable for plans meeting high quality-of-care standards,[13] and (ii) be phased in during 2012 through 2017. The Trustees project that the overall participation rate for private health plans will be 29 percent in 2015 and will reach 32 percent by 2023, which is significantly higher than assumed in prior reports primarily because enrollment in these plans has been less sensitive to ACA benchmark reductions than previously assumed.

Figure II.D2 shows the past and projected amounts of Medicare revenues under the projected baseline excluding interest income, which will not be a significant part of program financing in the long range as trust fund assets decline. The figure compares total Medicare expenditures to Medicare non-interest income—from HI payroll taxes, HI income from the taxation of Social Security benefits, SMI Part D State transfers for certain Medicaid beneficiaries, HI and SMI premiums, fees under the ACA on manufacturers and importers of brand-name prescription drugs (allocated to Part B), and HI and SMI statutory general revenues. For 2014, the Trustees expect total Medicare expenditures to exceed non-interest revenue by only a very small margin due to the expenditures of recent years being lower than expected and the effects of the 2-percent sequester of Medicare benefits. Modest surpluses are projected for 2015 and 2017-2020, but deficits are expected to return in 2021 and remain for the balance of the projection.

[13]Prior to the ACA, the benchmark range was generally 100 to 140 percent of fee-for-service costs.

Figure II.D2.—Medicare Sources of Non-Interest Income and Expenditures as a Percentage of the Gross Domestic Product



As shown in figure II.D2, for most of the historical period, payroll tax revenues increased steadily as a percentage of GDP due to increases in the HI payroll tax rate and in the limit on taxable earnings, the latter of which lawmakers eliminated in 1994. Under the Affordable Care Act, beginning in 2013 high-income workers pay an additional 0.9 percent of earnings to the HI trust fund.[14] The Trustees project that, as a result of this provision, payroll taxes will grow slightly faster than GDP.[15] HI revenue from income taxes on Social Security benefits will gradually increase as a share of GDP as additional beneficiaries become subject to such taxes.

The Trustees expect growth in SMI Part B and Part D premiums and general fund transfers to continue to outpace GDP growth and HI

[14]The ACA also specifies that individuals with incomes greater than $200,000 per year and couples above $250,000 pay an additional Medicare contribution of 3.8 percent on some or all of their non-work income (such as investment earnings). However, the revenues from this tax are not allocated to the Medicare trust funds.

[15]Although the Trustees expect total worker compensation to grow at the same rate as GDP, wages and salaries would increase more slowly and fringe benefits (health insurance costs in particular) more rapidly. Thus, taxable earnings would gradually decline as a percentage of GDP. Absent any change to the tax rate scheduled under current law, HI payroll tax revenue would similarly decrease as a percentage of GDP (since fringe benefits are not subject to this tax). Over time, however, a growing proportion of workers will exceed the fixed earnings thresholds specified in the ACA ($200,000 and $250,000) and will become subject to the additional 0.9-percent HI payroll tax. The net effect of these factors is an increasing trend in payroll taxes as a percentage of GDP.

payroll tax growth in the future. This phenomenon occurs primarily because SMI revenue increases at the same rate as expenditures, whereas HI revenue does not. Accordingly, as the HI sources of revenue become increasingly inadequate to cover HI costs, SMI revenues will represent a growing share of total Medicare revenues. Beginning in 2009, as HI payroll tax receipts declined due to the recession and general revenue transfers increased, the latter income source became the largest single source of income to the Medicare program as a whole. General revenues are expected to continue growing as a share of total Medicare financing after 2022 and to add significantly to the Federal budget pressures. Although a smaller share of the total, SMI premiums will grow in proportion to general revenue transfers, thereby placing a growing burden on beneficiaries. For high-income enrollees, SMI premiums began to increase more rapidly in 2011 and will continue to do so as a result of ACA provisions that increase Part D premiums and freeze the income thresholds used to determine Part B and Part D income-related premiums for 2011-2019.

The interrelationship between the Medicare program and the Federal budget is an important topic—one that will become increasingly critical over time as the general revenue requirements for SMI continue to grow. Transfers from the general fund are the major source of financing for the SMI trust fund, and are central to the automatic financial balance of the fund's two accounts, while representing a large and growing requirement for the Federal budget. SMI general revenues currently equal 1.4 percent of GDP and will increase to an estimated 3.3 percent in 2088 under the projected baseline. Moreover, in the absence of legislation to address the financial imbalance, interest earnings on trust fund assets and redemption of those assets will cover the difference between HI dedicated revenues and expenditures until 2030.[16] Both of these financial resources for the HI trust fund require cash transfers from the general fund of the Treasury, placing a further obligation on the budget. In 2029, these transactions would require general fund transfers equal to 0.3 percent of GDP. Appendix F describes the interrelationship between the Federal budget and the Medicare and Social Security trust funds; it illustrates the programs' long-range financial outlook from both a trust fund perspective and a budget perspective.

[16]After asset depletion in 2030, as described in the next section, no provision exists to use general revenues or any other means to cover the HI deficit.

Overview

The Medicare Modernization Act requires the Board of Trustees to test whether the difference between program outlays and dedicated financing sources[17] exceeds 45 percent of Medicare outlays under current law. If this level is attained within the first 7 fiscal years of the projection, Federal law requires a determination of projected excess general revenue Medicare funding. The Trustees made such determinations in the 2006 through 2013 reports. For this year's report, however, the difference between program outlays and dedicated revenues is not expected to exceed 45 percent in fiscal years 2014 through 2020 (the first 7 years of the projection), and therefore the Trustees are not issuing this determination. (Section V.B contains additional details on these tests.)

This section has summarized the total financial obligation posed by Medicare and the manner in which it is financed. However, the HI and SMI components of Medicare have separate and distinct trust funds, each with its own sources of revenues and mandated expenditures. Accordingly, it is necessary to assess the financial status of each Medicare trust fund separately. The next two sections of the overview present such assessments for the HI trust fund and the SMI trust fund, respectively.

[17]The dedicated financing sources are HI payroll taxes, the HI share of income taxes on Social Security benefits, Part B receipts from the new fees on manufacturers and importers of brand-name prescription drugs, Part D State transfers, and beneficiary premiums. These sources are the first four layers depicted in figure II.D2.

E. FINANCIAL STATUS OF THE HI TRUST FUND

1. 10-Year Actuarial Estimates (2014-2023)

Expenditures from the HI trust fund have exceeded income each year since 2008, with the fund deficit amounting to $15.0 billion in 2013. As a result of recently enacted legislation and the assumed continuation of the economic recovery, however, the Trustees project that HI income will grow faster than expenditures through 2017 under the intermediate assumptions. Specifically, HI expenditure growth would average 5.3 percent per year over the next 10 years, while HI income growth would average 5.9 percent per year. In 2014, total income to the HI trust fund would again fall short of estimated expenditures by about $14 billion, in part due to depressed levels of economic activity. Trust fund surpluses would occur for the next 8 years before deficits would return for the remainder of the projection period in the absence of further corrective legislation. Payment of expenditures in full and on time will continue to require redemption of trust fund assets most years until the trust fund's depletion in 2030.

Table II.E1 presents the projected operations of the HI trust fund under the intermediate assumptions for the next decade. At the beginning of 2014, HI assets represented 76 percent of annual expenditures. This ratio has declined from 150 percent over the past 7 years. The Board has recommended an asset level at least equal to annual expenditures, to serve as an adequate contingency reserve in the event of adverse economic or other conditions.

The Trustees apply an explicit test of short-range financial adequacy, described in section III.B2 of this report. Based on the 10-year projection shown in table II.E1, the HI trust fund does not meet this test because estimated assets are below 100 percent of annual expenditures and are not projected to attain this level under the intermediate assumptions. This outlook indicates the need for prompt legislative action to achieve financial adequacy for the HI trust fund throughout the short-range period.

Table II.E1.—Estimated Operations of the HI Trust Fund under Intermediate Assumptions, Calendar Years 2013-2023

[Dollar amounts in billions]

Calendar year	Total income[1]	Total expenditures	Change in fund	Fund at year end	Ratio of assets to expenditures[2]
2013[3]	$251.1	$266.2	−$15.0	$205.4	83
2014	255.9	269.5	−13.6	191.7	76
2015	281.9	269.9	12.0	203.8	71
2016	300.3	283.2	17.1	220.8	72
2017	320.4	299.2	21.2	242.0	74
2018	342.0	322.0	20.0	262.0	75
2019	362.9	342.3	20.6	282.6	77
2020	383.9	366.3	17.5	300.1	77
2021	404.9	391.9	13.0	313.2	77
2022	425.9	419.1	6.8	319.9	75
2023	447.0	447.2	−0.2	319.8	72

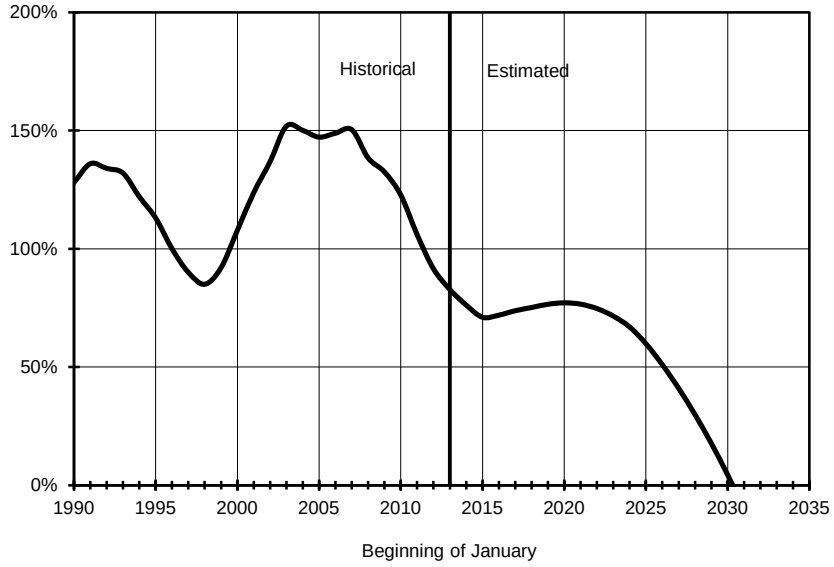
[1]Includes interest income.
[2]Ratio of assets in the fund at the beginning of the year to expenditures during the year.
[3]Figures for 2013 represent actual experience.

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

The short-range financial outlook for the HI trust fund is somewhat better than projected in last year's annual report, and the estimated date of depletion is 4 years later. A number of factors have changed as compared to last year's report, including (i) lower-than-expected spending in 2013 and other recent data for most HI service categories, especially for inpatient hospital; (ii) lower utilization assumptions for inpatient hospital; and (iii) lower case mix increases for skilled nursing facilities and home health agencies. Partially offsetting these favorable changes are assumptions about MA plan beneficiaries.

Under the intermediate assumptions, the assets of the HI trust fund would continue decreasing as a percentage of annual expenditures through 2015 and then remain at approximately that level for the rest of the short-range projection period. After 2023 the ratio starts to decline quickly until the fund is depleted in 2030, as illustrated in figure II.E1. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

Figure II.E1.—HI Trust Fund Balance at Beginning of Year as a Percentage of Annual Expenditures



There is substantial uncertainty in the economic, demographic, and health care projection factors for HI trust fund expenditures and revenues. Accordingly, the date of HI trust fund depletion could differ substantially in either direction from the 2030 intermediate estimate. Under the low-cost assumptions, trust fund assets would start to increase in 2015 and would continue to increase in all future years. Under the high-cost assumptions, however, asset depletion would occur in 2021.

2. 75-Year Actuarial Estimates (2014-2088)

Each year, the Board prepares 75-year estimates of the financial and actuarial status of the HI trust fund. Although financial outcomes are inherently uncertain, particularly over periods as long as 75 years, such estimates can indicate whether the trust fund—as seen from today's vantage point—is in satisfactory financial condition.

Due to the difficulty in comparing dollar values for different periods without some type of relative scale, the Trustees show income and expenditure amounts relative to the earnings in covered employment that are taxable under HI (referred to as *taxable payroll*). The ratio of HI tax income (including both payroll taxes and income from taxation of Social Security benefits, but excluding interest income) to taxable

payroll is called the *income rate*, and the ratio of expenditures to taxable payroll is the *cost rate*.[18]

The standard HI payroll tax rate is scheduled to remain constant at 2.90 percent (for employees and employers, combined). As noted, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns) in 2013 and later. Since these income thresholds are not indexed, over time an increasing proportion of workers and their earnings will become subject to the additional HI tax rate. Thus, HI payroll tax revenues will increase steadily as a percentage of taxable payroll. (By the end of the long-range projection period, an estimated 80 percent of workers would pay the higher tax rate.) Similarly, income from taxation of Social Security benefits will also increase as a greater proportion of Social Security beneficiaries and their benefits becomes subject to such taxation over time, since the income thresholds determining taxable benefits are not indexed for price inflation.

The cost rate declined in 2012 and 2013 largely due to the economic recovery. During the expected continuation of the economic recovery, the projected cost rate continues to decline in 2014-2017, but then it escalates in the longer term primarily due to retirements of those in the baby boom generation and partly due to health services cost growth, as mentioned in the prior section. The accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average 0.9 percent through 2030 and 1.1 percent per year thereafter, will somewhat offset the effect of these factors. After 25, 50, and 75 years, for example, the prices paid to HI providers under the projected baseline would be 22 percent, 41 percent, and 55 percent lower, respectively, than prices absent the productivity reductions.

Figure II.E2 compares projected income and cost rates under the intermediate assumptions. As indicated, projected HI expenditures continue to exceed tax income for 2014. Thereafter, the income rate is projected to exceed the cost rate for several years before falling below it in 2022 and later. The HI cost rate increases more rapidly than the income rate through about 2045. The projected annual deficits would

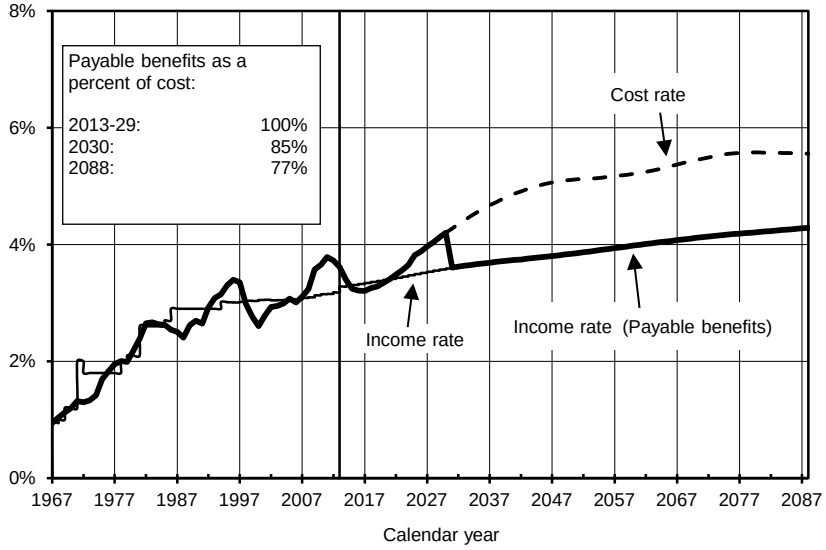
[18]Includes estimated costs attributable to insured beneficiaries only, on an incurred basis. There are certain *uninsured beneficiaries* who are not entitled to HI coverage based on their work history but are eligible through special statutes. The Trustees expect benefits and administrative costs for these uninsured beneficiaries to be financed through general revenue transfers and premium payments, rather than through payroll taxes.

increase from a low of 0.06 percent of taxable payroll in 2022 to between 1.20 and 1.40 percent after 2045. During this latter period, expenditures and tax revenues would be growing at roughly similar rates on average. The convergence of growth rates reflects the continuing effects of the slower payment rate updates under the ACA, assumed decelerating growth in the volume and intensity of services, and the increasing proportion of workers affected by the additional 0.9-percent payroll tax. The percentage of projected expenditures covered by tax revenues is assumed to decrease from 85 percent in 2030 to 75 percent in 2045 and to stabilize at about this level thereafter.

The area in figure II.E2 between the cost rate and income rate for 2020 through 2030 represents the excess of expenditures over tax income. This excess is covered by interest earnings and the redemption of trust fund assets, which occur through transfers from the general fund of the Treasury. Starting in 2008, the fund began using interest earnings and asset redemptions to cover the excess of expenditures over tax income. The deficits in 2008-2013 required the redemption of more than one-third of the assets available at the beginning of this period. In the absence of other changes, this process would occur in 2014 and again in each year from 2023 through 2030, at which time the fund would be depleted. For a few years, asset redemptions would not be needed, but interest earnings would, and for 6 years (2015-2020) neither of these sources would be required.

Although the Trustees project that the HI trust fund would not be depleted until 2030 under the projected baseline, the demands on general revenue (to pay interest and redeem the Treasury bonds held by the trust fund) have been occurring every year since 2008. Without legislation to address the HI deficits, redemption of assets would have to cover an estimated 13 percent of HI expenditures in 2029.

Figure II.E2.—Long-Range HI Income and Cost as a Percentage of Taxable Payroll, Intermediate Assumptions



It is possible to summarize the year-by-year cost rates and income rates shown in figure II.E2 into single values representing, in effect, the average value over a given period. Based on the intermediate assumptions, the Trustees project an actuarial deficit of 0.87 percent of taxable payroll for the 75-year period under the projected baseline, which represents the difference between the summarized income rate of 3.82 percent and the corresponding cost rate of 4.69 percent. Based on this measure, the HI trust fund fails the Trustees' test for long-range financial balance, as it has for many years. Under the illustrative alternative projections, the long-range HI deficit would be 1.92 percent of payroll.

Lawmakers could address the long-range financial imbalance in several different ways. In theory, they could immediately increase the standard 2.90-percent payroll tax by the amount of the actuarial deficit to 3.77 percent, or they could reduce expenditures by a corresponding amount. Note, however, that these changes would require an immediate 30-percent increase in the standard tax rate or

an immediate 19-percent reduction in expenditures.[19] More realistically, the tax and/or benefit changes could occur gradually but would ultimately have to reach significantly higher levels to eliminate the deficit throughout the long-range period.

The projected long-range HI cost rates shown in this report are lower than those from the 2013 report. The primary reasons are lower-than-expected recent spending and revised utilization assumptions.

[19]The corresponding immediate changes in the standard tax rate or expenditure levels are 66 percent and 33 percent, respectively, under the illustrative alternative projection. Under either of these two scenarios, tax income would initially be substantially greater than expenditures, and trust fund assets would accumulate rapidly. Subsequently, however, tax income would be inadequate, and assets would be drawn down to cover the difference. This example illustrates that if lawmakers designed legislative solutions only to eliminate the overall actuarial deficit, without consideration of such year-by-year patterns, then a substantial financial imbalance could still remain at the end of the period, and the long-range sustainability of the program could still be in doubt.

F. FINANCIAL STATUS OF THE SMI TRUST FUND

SMI differs fundamentally from HI in regard to the nature of its financing and the method by which its financial status is evaluated. SMI comprises two parts, Part B and Part D, each with its own separate account within the SMI trust fund. The Trustees must determine the financial status of the SMI trust fund by evaluating the financial status of each account separately, since there is no provision in the law for transferring assets or income between the Part B and Part D accounts. The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding transfers from general revenues for each part, are sufficient to cover the following year's estimated expenditures. Accordingly, each account within SMI is automatically in financial balance under current law. This result contrasts with OASDI and HI, for which financing established many years earlier may prove significantly higher or lower than subsequent actual costs. Moreover, Part B and Part D are voluntary (whereas OASDI and HI are generally compulsory), and payroll taxes are not the source of income for these programs. These disparities result in a financial assessment that differs in important ways from that for OASDI or HI, as described in the following sections.

1. 10-Year Actuarial Estimates (2014-2023)

Table II.F1 shows the estimated operations of the Part B account, the Part D account, and the total SMI trust fund under the intermediate assumptions of the projected baseline scenario during calendar years 2013 through 2023. For Part B, expenditures grew at an average annual rate of 6.2 percent over the past 5 years, exceeding GDP growth by 3.5 percentage points annually, on average. Estimated Part B cost increases average about 5.7 percent for the 5-year period 2014 to 2018, faster than the GDP growth rate of 5.0 percent for the same 5-year period.

Due to the nature of Part B financing, Part B income growth is normally quite close to expenditure growth. Assets were somewhat above the customary range at the end of 2013, and projected assets held in the Part B account would decrease, but still be slightly above

this range at the end of 2014[20], and would maintain an adequate contingency reserve thereafter.

The projected baseline scenario estimates shown throughout the main body of the report reflect a change from prior reports in the treatment of the sustainable growth rate (SGR)[21] formula for physician fee schedule payment under Part B. Current law requires CMS to implement a reduction in Medicare payment rates for physician services of an estimated 20.8 percent starting in April 2015. However, it is a virtual certainty that lawmakers will override this reduction as they have for every year starting with 2003. For this reason, the income, expenditures, and assets for Part B shown throughout the tables in the report reflect a *projected baseline* scenario, which includes an override of the SGR payment provisions and an assumed increase in the physician fee schedule equal to the average of the most recent 10 years of SGR overrides (through March 2015) or 0.6 percent.[22] These projections do not represent either a policy recommendation or a prediction of legislative outcomes by the Trustees.

[20]The traditional measure used to evaluate the status of the Part B account of the SMI trust fund is defined as the ratio of the excess of Part B assets over Part B liabilities to the next year's Part B incurred expenditures. The customary range for this ratio is 15 to 20 percent; the CMS Office of the Actuary developed this range based on private health insurance standards and past studies indicating that this asset reserve level is sufficient to protect against adverse events. Due to the strong likelihood of Congressional action to override the physician fee reductions required under current law, and to do so after establishment of Part B financing for 2014, it was appropriate to maintain a higher level of reserve assets to prevent fund depletion under this contingency.

[21]For additional information about the physician payment updates and the sustainable growth rate system, see section IV.B1.

[22]In prior reports, income and expenditures were projected on a current-law basis, with income including a large contingency margin for the likely legislative override of scheduled physician payment reductions.

Table II.F1.—Estimated Operations of the SMI Trust Fund under Intermediate Assumptions, Calendar Years 2013-2023

[Dollar amounts in billions]

Calendar year	Total income[1]	Total expenditures	Change in fund	Fund at year end
Part B account:				
2013[2]	$255.0	$247.1	$7.9	$74.1
2014	260.1	262.8	−2.7	71.4
2015	278.6[3]	268.9	9.7	81.1
2016	273.8[3]	283.6	−9.8	71.3
2017	307.9	303.0	4.9	76.2
2018	332.1	326.2	5.9	82.1
2019	358.7	352.3	6.4	88.5
2020	402.9[3]	382.5	20.4	108.9
2021	407.9[3]	414.3	−6.4	102.5
2022	456.8	448.7	8.1	110.6
2023	494.9	485.2	9.8	120.4
Part D account:				
2013[2]	69.7	69.7	0.0	1.0
2014	79.1	79.4	−0.3	0.7
2015	86.7[3]	86.7	0.0	0.7
2016	94.5[3]	94.5	0.1	0.8
2017	102.6	102.6	0.1	0.8
2018	112.0	111.9	0.1	0.9
2019	122.4	122.3	0.1	1.0
2020	134.1[3]	134.0	0.1	1.1
2021	145.5[3]	145.4	0.1	1.1
2022	158.3	158.2	0.1	1.2
2023	171.8	171.7	0.1	1.4
Total SMI:				
2013[2]	324.6	316.7	7.9	75.1
2014	339.2	342.2	−3.0	72.1
2015	365.3[3]	355.6	9.7	81.8
2016	368.3[3]	378.1	−9.7	72.1
2017	410.5	405.6	5.0	77.0
2018	444.1	438.1	6.0	83.0
2019	481.1	474.6	6.5	89.5
2020	537.1[3]	516.5	20.5	110.0
2021	553.4[3]	559.7	−6.3	103.7
2022	615.0	606.8	8.2	111.9
2023	666.8	656.9	9.9	121.7

[1]Includes interest income.
[2]Figures for 2013 represent actual experience.
[3]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of those benefits normally due January 3, 2016 is expected to occur on December 31, 2015. Consequently, the Part B and Part D premiums withheld from these benefits and the associated Part B general revenue contributions are expected to be added to the respective Part B or Part D account on December 31, 2015. Similarly, the payment date for those benefits normally due January 3, 2021 will be December 31, 2020.

The projected Part B and total SMI expenditures shown in table II.F1 differ from the corresponding amounts in the 2013 Trustees Report due to the incorporation of the projected baseline scenario for this year's report. The projected baseline scenario shown above is comparable to the "alternative to SGR" scenario in last year's report.[23] The expenditures shown in table II.F1 are lower than those in the 2013 SGR alternative due to (i) lower-than-expected actual spending in 2012 and 2013 for most types of services; (ii) lower

[23]See appendix C in the 2013 report.

assumptions for volume and intensity for some types of service due to the most recent experience; and (iii) lower CPI assumptions.

The Medicare prescription drug benefit began full operation in 2006. For the 10-year period 2014 to 2023, the Trustees project that income and expenditures for the Part D account will grow at an average annual rate of 9.4 percent, due to expected further increases in enrollment and growth in per capita drug costs. As with Part B, income and outgo would remain in balance as a result of the annual adjustment of premium and general revenue income to cover costs. The appropriation for Part D general revenues has generally been set such that amounts can be transferred to the Part D account on an as needed basis. When this process is implemented, there is no need to maintain a contingency reserve

The projected Part D costs shown in table II.F1 and elsewhere in this report are lower than those in the 2013 report. The difference is primarily attributable to a lower projected drug cost trend, and higher drug rebates, consistent with recent experience.

The primary test of financial adequacy for Parts B and D pertains to the level of the financing established for a given period (normally, through the end of the current calendar year). The financing for each part of SMI is considered satisfactory if it is sufficient to fund all services, including benefits and administrative expenses, provided through a given period. In addition, to protect against the possibility that cost increases under either part of SMI will be higher than expected, the accounts of the trust fund would normally need assets adequate to cover a reasonable degree of variation between actual and projected costs. For Part B, as stated previously, the Trustees estimate that the financing established through December 2014 will be sufficient to cover benefits and administrative costs incurred through that time period and that assets will be adequate to cover potential variations in costs as a result of new legislation or cost growth factors that exceed expectations. The estimated financing established for Part D, together with the flexible appropriation authority for this trust fund account, would be sufficient to cover benefits and administrative costs incurred through 2014.

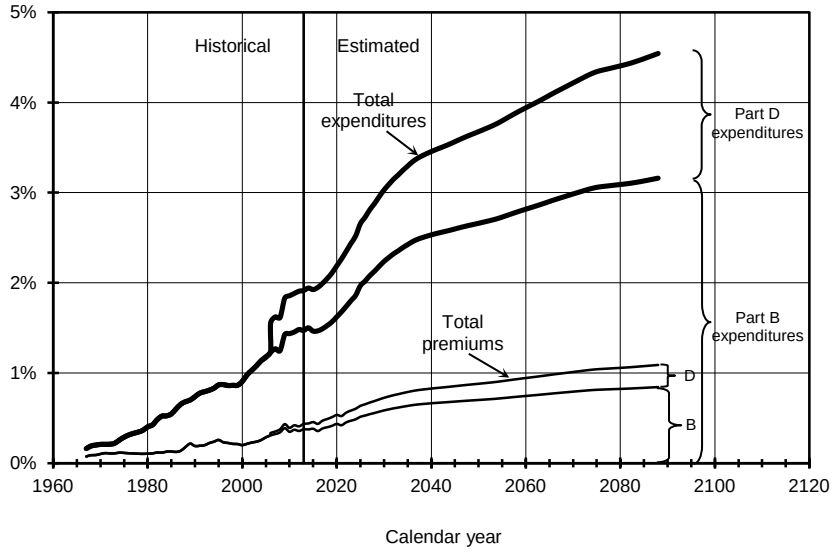
The amount of the contingency reserve needed in Part B is normally much smaller (both in absolute dollars and as a fraction of annual costs) than in HI or OASDI. A smaller reserve is adequate because the premium rate and corresponding general revenue transfers for Part B are determined annually based on estimated future costs, while the HI and OASDI payroll tax rates are set in law and are

therefore much more difficult to adjust should circumstances change. A statutory competitive bidding process establishes Part D revenues annually to cover estimated costs. Moreover, the flexible appropriation authority established by lawmakers for Part D allows additional general fund financing if costs are higher than anticipated.

2. 75-Year Actuarial Estimates (2014-2088)

Figure II.F1 shows past and projected total SMI expenditures and premium income as a percentage of the Gross Domestic Product (GDP). Annual SMI expenditures grew from about 1.2 percent of GDP in 2005 to 1.6 percent of GDP in 2006 with the commencement of prescription drug coverage. Under the projected baseline, SMI expenditures would grow to about 3.4 percent of GDP within 25 years and to more than 4.5 percent by the end of the projection period. (Total SMI expenditures in 2088 would be 4.0 percent of GDP if physician payment rates were set as assumed under the current-law projections. Such costs would represent more than 4.6 percent of GDP under the illustrative alternative, which includes larger payment updates for most non-physician categories of Part B providers.)

Figure II.F1.—SMI Expenditures and Premiums as a Percentage of the Gross Domestic Product



3. Implications of SMI Cost Growth

Financing for the SMI trust fund is adequate because beneficiary premiums and general revenue contributions, for both Part B and

Part D, are established annually to cover the expected costs for the upcoming year. Should actual costs exceed those anticipated when the financing is determined, future financing rates can include adjustments to recover the shortfall. Likewise, should actual costs be less than those anticipated, the savings would result in lower future financing rates. As long as the future financing rates continue to cover the following year's estimated costs, both parts of the SMI trust fund will remain financially solvent.

A critical issue for the SMI program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers. This section compares the past and projected growth in SMI costs under the projected baseline with GDP growth; it also assesses the implications of the rapid growth on beneficiaries and the budget of the Federal Government.

Table II.F2 compares the growth in SMI expenditures with that of the economy as a whole. Under the projected baseline, SMI costs would continue to outpace growth in GDP. Compared to the last 10 years, the estimated growth differential in the future is significantly smaller in most years. The growth differential reflects the net effects of (i) the productivity adjustments to certain Part B price updates; (ii) reduced Medicare Advantage payment benchmarks[24]; (iii) the increase in the SMI population as the baby boom generation turns age 65, enrolls, and is eligible to receive benefits; (iv) the faster growth trend associated with the Part D prescription drug benefit compared to other medical services; and (v) varying amounts of sequestration of Medicare expenditures, as required by law, for 2013-2024. (The implementation of this reduction, and its subsequent removal, decreases the growth rate in 2013 and increases the growth rate in 2025.)

[24]The administrative action that increased Medicare Advantage benchmark rates beginning in 2014 partially offsets the benchmark reductions required by the ACA.

Table II.F2.—Average Annual Rates of Growth in SMI and the Economy

[In percent]

Calendar years	SMI			U.S. Economy			Growth differential[1]
	Beneficiary population	Per capita expenditures	Total expenditures	Total population	Per capita GDP	Total GDP	
Historical data:							
1968-1993	2.6%	12.4%	15.2%	1.0%	7.3%	8.3%	6.4%
1994-2003	1.1	7.2	8.4	1.0	4.3	5.3	2.9
2004-2013	2.2	7.6[2]	10.0[2]	0.8	3.0	3.8	5.9[2]
Intermediate estimates:							
2014-2023	2.8	4.5	7.5	0.9	4.0	4.9	2.4
2024-2038	1.6	5.2	6.8	0.7	3.8	4.5	2.3
2039-2063	0.5	4.6	5.2	0.5	4.0	4.5	0.7
2064-2088	0.7	4.2	4.9	0.4	4.0	4.4	0.5

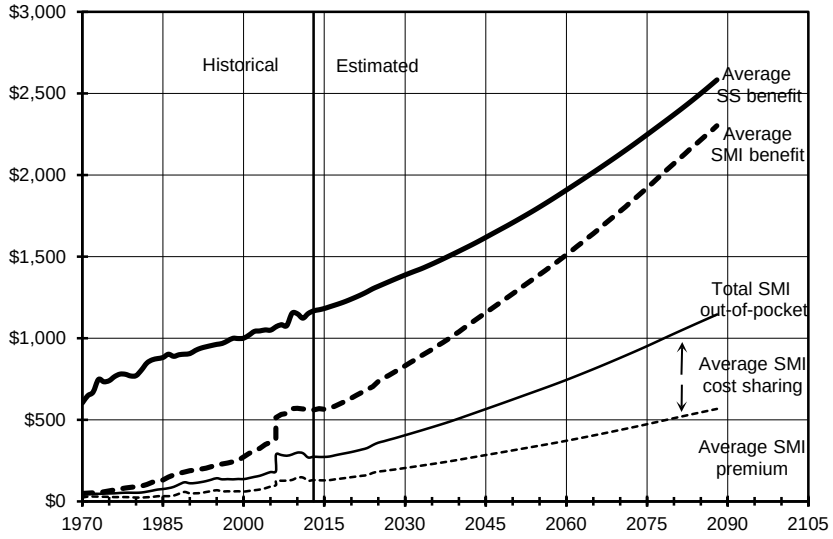
[1]Excess of total SMI expenditure growth above total GDP growth, calculated as a multiplicative differential.

[2]Includes the addition of the prescription drug benefit to the SMI program in 2006. Excluding 2006, the average annual per capita expenditure increase is 4.8 percent, the total expenditure increase is 7.1 percent, and the growth differential is 3.4 percent.

If, as is generally expected, SMI per capita benefits continued to grow faster than average income or per capita GDP, the premiums and coinsurance amounts paid by beneficiaries would represent a growing share of their total income. Figure II.F2 compares past and projected growth in average benefits for SMI versus Social Security. The figure also shows amounts for the average SMI premium payments and average cost-sharing payments. To facilitate comparison across long time periods, all values are in constant 2013 dollars.

Over time, the average Social Security benefit tends to increase at about the rate of growth in average earnings. As noted previously, health care costs generally reflect increases in the earnings of health care professionals, growth in the utilization and intensity of services, and other medical cost inflation. As indicated in figure II.F2, average SMI benefits in 1970 were only about one-twelfth the level of average Social Security benefits but had grown to more than one-third by 2005. With the introduction of the Part D prescription drug benefit in 2006, this ratio grew to almost one-half. Under the projected baseline intermediate projections, SMI benefits would continue increasing at a faster rate and would represent about four-fifths of the average Social Security retired-worker benefit in 2088.

Figure II.F2.—Comparison of Average Monthly SMI Benefits, Premiums, and Cost Sharing to the Average Monthly Social Security Benefit
[Amounts in constant 2013 dollars]



Average beneficiary premiums and cost-sharing payments for SMI will increase at about the same rate as average SMI benefits.[25] Thus, a growing proportion of most beneficiaries' Social Security and other income would be necessary over time to pay total out-of-pocket costs for SMI, including both premiums and cost-sharing amounts. Most SMI enrollees have other income in addition to Social Security benefits. Other possible sources include earnings from employment, employer-sponsored pension benefits, and investment earnings. In addition, most draw down their accumulated assets to supplement their income in retirement. For simplicity, the comparisons in figure II.F2 apply to Social Security benefits only; a comparison of average SMI premiums and cost-sharing amounts to average total beneficiary income would lead to similar conclusions. For illustration, the Trustees estimate that the average Part B plus Part D premium in 2014 would equal about 11 percent of the average Social Security benefit but would increase to an estimated 22 percent in 2088. Similarly, an average cost-sharing amount in 2014 would be equivalent to about 12 percent of the Social Security benefit, which would increase to about 22 percent in 2088.

[25]As a result, the projected ratio of average SMI out-of-pocket payments to average SMI benefits is nearly constant over time.

Overview

The availability of SMI Part B and Part D benefits greatly reduces the costs that beneficiaries would otherwise pay for health care services. The introduction of the prescription drug benefit increased beneficiaries' costs for SMI premiums and cost sharing, but reduced their costs for previously uncovered services by substantially more. Figure II.F2 highlights the impact of rapid cost growth for a given SMI benefit package.

The average OASI benefit amount for all retired workers is the basis for the Social Security benefits shown in figure II.F2; individual retirees may receive significantly more or less than the average, depending on their past earnings. For purposes of illustration, figure II.F2 shows the average SMI benefit value and cost-sharing liability for all beneficiaries. The value of SMI benefits to individual enrollees, and their cost-sharing payments, varies even more substantially than OASI benefits, depending on their income, assets, and use of covered health services in a given year. In particular, Medicaid pays Part B premiums and cost-sharing amounts for beneficiaries with very low incomes, and the Medicare low-income drug subsidy pays the corresponding Part D amounts (except for nominal copayments). Moreover, Part B beneficiaries with high incomes have been required to pay a higher income-related premium since 2007, and Part D enrollees have been required to pay an income-related premium since 2011. Further information on the nature of this comparison, and on the variations from the average results, is available in a memorandum by the CMS Office of the Actuary at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Beneficiaryoop.html.

Another way to evaluate the implications of rapid SMI cost growth is to compare government contributions to the SMI trust fund with total Federal income taxes (personal and corporate income taxes). Table II.F3 indicates that SMI general revenues in fiscal year 2008 were equivalent to about 12.0 percent of total Federal income taxes collected in that year. Income tax revenue then decreased due to both the effects of the recession and income tax rate reductions designed to stimulate the economy. As a result, for 2009, 2010, 2011, 2012, and 2013, the amounts were 17.7, 19.2, 17.2, 14.7, and 13.8 percent, respectively. Should such taxes in the future maintain their historical average level of the last 50 years relative to the national economy, then, based on the intermediate assumptions, SMI general revenue financing in 2088 would represent about 31.5 percent of total income taxes under the projected baseline scenario.

Table II.F3.—SMI General Revenues as a Percentage of Personal and Corporate Federal Income Taxes

Fiscal year	Percentage of income taxes[1]
Historical data:	
1970	0.8%
1980	2.2
1990	5.9
2000	5.4
2008	12.0
2009	17.7
2010	19.2
2011	17.2
2012	14.7
2013	13.8
Intermediate estimates:	
2014	13.8
2020	15.4
2030	21.1
2040	24.2
2050	25.7
2060	27.4
2070	29.3
2080	30.6

[1]Includes the Part D prescription drug benefit beginning in 2006.

These examples illustrate the significant impact of SMI expenditure growth on beneficiaries, taxpayers, and the Federal budget. The projected SMI expenditure increases associated with the cost of providing health care, plus the impact of the baby boom generation reaching eligibility age, would continue to require a growing share of the economic resources available to finance these costs. This outlook reinforces the Trustees' recommendation for development and enactment of further reforms to reduce the rate of growth in SMI expenditures.

G. CONCLUSION

Total Medicare expenditures were $583 billion in 2013, and the Board projects that they will increase in most future years at a somewhat faster pace than either aggregate workers' earnings or the economy overall. The excess increase is primarily due to growth in the number of beneficiaries, and partly due to growth in expenditures per beneficiary, which are projected to increase slightly faster than the per capita rate of growth of the economy overall. Based on the intermediate set of assumptions under the projected baseline scenario, expenditures as a percentage of GDP would increase from the current 3.5 percent to a projected 6.9 percent by 2088.

The assets of the HI trust fund declined by $15.0 billion in 2013 and are expected to continue to decline through 2014, but then annual surpluses are expected to occur for the next 8 years, with deficits returning for the remainder of the 75-year projection period. The projected trust fund depletion date is 2030, 4 years later than estimated in last year's report. Actual HI expenditures in 2013 were slightly lower than the previous estimate and remain that way throughout the projection period. Actual HI taxable earnings in 2013 were slightly higher than the level previously projected, but the projected level of real (inflation-adjusted) HI taxes is lower than in last year's report through 2021, with the difference narrowing as the economy recovers from the recent economic recession and then becoming more level throughout the remainder of the 75 years. The HI trust fund fails to meet the Board of Trustees' short-range test of financial adequacy.

The HI actuarial deficit in this year's report is 0.87 percent of taxable payroll, down from 1.11 percent in last year's report, due to lower-than-expected recent spending and revised utilization assumptions. As in past reports, the HI trust fund fails to meet the Trustees' long-range test of close actuarial balance.

The financial outlook for SMI is fundamentally different than for HI due to the statutory differences in the methods of financing for these two components of Medicare. The Trustees project that both the Part B and Part D accounts of the SMI trust fund will remain in financial balance for all future years because beneficiary premiums and general revenue transfers will be set at a level to meet expected costs each year. However, projected SMI costs more than double as a share of GDP over the next 75 years, from 1.9 percent to 4.5 percent under the projected baseline. The projected Part B costs in this report are slightly lower than the comparable projections in the previous

report due to lower actual spending for most types of service in 2012 and 2013 and lower assumptions for volume and intensity for some types of service. The Part D projections are lower than in past years' reports largely due to a lower projected drug cost trend and higher rebates.

The financial projections shown for the Medicare program in this report reflect substantial, but very uncertain, cost savings deriving from provisions of the Affordable Care Act. The improved results for HI and SMI Part B depend in part on the long-range feasibility of the various cost-saving measures in the Affordable Care Act—in particular, the lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely.

In view of these issues with provider payment rates, the Trustees note that the actual future costs for Medicare could exceed those shown in this report. Use of alternative projections, as provided in appendix V.C and in a memorandum from the Office of the Actuary,[26] can help illustrate the potential magnitude of this understatement. For example, the total cost of Medicare in 2088 is 8.4 percent of GDP under the alternative projections (versus 6.9 percent under the projected baseline), and the HI actuarial deficit would be 1.92 percent of taxable payroll (versus 0.87 percent). (The projected depletion date for the HI trust fund would be one year earlier.) Readers should not interpret the projections shown in this report as the Trustees' most likely expectation of actual Medicare financial operations in the future but rather as illustrations of the very favorable impact of permanently slower growth in health care costs, if such slower growth is achievable. The illustrative alternative projections underscore the uncertainty associated with these elements of current law.

Policy makers should determine effective solutions to the long-range HI financial imbalance. Even assuming that the provider payment rates will be adequate, the HI program does not meet either the Trustees' short-range test of financial adequacy or long-range test of close actuarial balance. Scheduled HI tax income would cover only 85 percent of estimated expenditures in 2030 and 75 percent in 2050. By the end of the 75-year projection period, HI revenues could pay 77 percent of HI costs. Policy makers should also consider the likelihood that the price adjustments in current law may prove

[26]See http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2014TRAlternativeScenario.pdf.

difficult to adhere to fully and may require even more changes to address the financial imbalance.

The projections in this year's report continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then these further policy reforms will have to address much larger financial challenges than those assumed under the projected baseline scenario. The Board of Trustees believes that solutions can and must be found to ensure the financial integrity of HI in the short and long term and to reduce the rate of growth in Medicare costs through viable means. Consideration of such reforms should not be delayed. The sooner the solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations and behavior. The Board recommends that Congress and the executive branch work closely together with a sense of urgency to address these challenges.

III. ACTUARIAL ANALYSIS

A. INTRODUCTION

The Actuarial Analysis section focuses on the costs and financing of the individual HI and SMI trust fund accounts. The Trustees perform an analysis for each trust fund individually, to determine whether each account's income and expenditures are balanced as necessary to maintain solvency. (It is also valuable to consider Medicare's total expenditures and the sources and relative magnitudes of the program's revenues. Appendix V.B presents such information for Medicare overall.)

Under current law, the HI and SMI trust funds are separate and distinct, each with its own sources of financing. There are no provisions for using HI revenues to finance SMI expenditures, or vice versa, or for lending assets between the two trust funds. Moreover, the benefit provisions, financing methods, and, to a lesser degree, eligibility rules are very different between these Medicare components. In particular, both accounts of the SMI trust fund are automatically in financial balance under current law, whereas the HI fund is not.

For these reasons, the Trustees can evaluate the financial status of the Medicare trust funds only by separately assessing the status of each fund. Sections III.B, III.C, and III.D of this report present such assessments under the projected baseline for HI (Part A), SMI Part B, and SMI Part D, respectively. The Trustees also provide key results based on current law and an illustrative alternative scenario in appendix V.C.

B. HI FINANCIAL STATUS

1. Financial Operations in Calendar Year 2013

On July 30, 1965, the Social Security Act established the Federal Hospital Insurance Trust Fund as a separate account in the U.S. Treasury. All the HI financial operations occur within this fund.

Table III.B1 presents a statement of the revenue and expenditures of the fund in calendar year 2013, and of its assets at the beginning and end of the calendar year.

The total assets of the trust fund amounted to $220.4 billion on December 31, 2012. During calendar year 2013, total revenue amounted to $251.1 billion, and total expenditures were $266.2 billion. Total assets thus decreased by $15.0 billion during the year to $205.4 billion on December 31, 2013.

Table III.B1.—Statement of Operations of the HI Trust Fund during Calendar Year 2013

[In thousands]

Total assets of the trust fund, beginning of period	$220,394,432
Revenue:	
Payroll taxes	$220,816,703
Income from taxation of OASDI benefits	14,310,000
Interest on investments	9,280,447
Premiums collected from voluntary participants	3,417,334
Premiums collected from Medicare Advantage participants	263,272
ACA Medicare shared savings program receipts	1,311
Transfer from Railroad Retirement account	547,400
Reimbursement, transitional uninsured coverage	228,000
Reimbursement, program management general fund	567,301
Interfund interest receipts[1]	288
Interest on reimbursements, Railroad Retirement	29,224
Other	1,299
Reimbursement, Union activity	1,114
Fraud and abuse control receipts:	
Criminal fines	708,406
Civil monetary penalties	15,322
Civil penalties and damages, Department of Justice	799,818
Asset forfeitures, Department of Justice	28,086
3% administrative expense reimbursement, Department of Justice	24,824
General fund transfer, Discretionary	109,003
Total revenue	$251,149,153
Expenditures:	
Net benefit payments	$261,905,773
Administrative expenses:	
Treasury administrative expenses	128,617
Salaries and expenses, SSA[2]	800,890
Salaries and expenses, CMS[3]	1,768,773
Salaries and expenses, Office of the Secretary, HHS	21,830
Medicare Payment Advisory Commission	6,376
CMS program management–Affordable Care Act	13,154
Transfer to Patient-Centered Outcomes Research Trust Fund[4]	49,097
Fraud and abuse control expenses:	
HHS Medicare integrity program	619,554
HHS Office of Inspector General	365,949
Department of Justice	53,388
FBI	119,371
HCFAC Department of Justice Discretionary, CMS	30,506
HCFAC Office of Inspector General Discretionary, CMS	89,054
HCFAC Other HHS Discretionary, CMS	41,986
HCFAC Discretionary, CMS	163,658
Total administrative expenses	4,272,204
Total expenditures	$266,177,977
Net addition to the trust fund	−15,028,824
Total assets of the trust fund, end of period	$205,365,608

[1]Reflects interest adjustments on the reallocation of administrative expenses among the Medicare trust funds, the OASDI trust funds, and the general fund of the Treasury. Estimated payments are made from the trust funds and then are reconciled, with interest, the next year when the actual costs are known. A positive figure represents a transfer to the HI trust fund from the other trust funds. A negative figure represents a transfer from the HI trust fund to the other funds.

[2]For facilities, goods, and services provided by SSA.

[3]Includes administrative expenses of the intermediaries.

[4]Represents amount transferred from the HI trust fund to the Patient-Centered Outcomes Research trust fund, as authorized by the Patient Protection and Affordable Care Act of 2010.

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

a. Revenues

The trust fund's primary source of income consists of amounts appropriated to it, under permanent authority, on the basis of taxes paid by workers, their employers, and individuals with self-employment income, in work covered by HI. Included in HI are workers covered under the OASDI program, those covered under the Railroad Retirement program, and certain Federal, State, and local employees not otherwise covered under the OASDI program.

HI taxes are payable without limit on a covered individual's total wages and self-employment income. For calendar years prior to 1994, taxes were computed on a person's annual earnings up to a specified maximum annual amount called the *maximum tax base*. Table III.B2 presents the maximum tax bases for 1966-1993. Legislation enacted in 1993 removed the limit on taxable income beginning in calendar year 1994.

Table III.B2 also shows the HI tax rates applicable in each of calendar years 1966 and later. For 2015 and thereafter, the tax rates shown are the rates scheduled in current law. As indicated in the footnote to the table, in 2013 and later employees and self-employed individuals pay an additional HI tax of 0.9 percent on their earnings above certain thresholds.

Table III.B2.—Tax Rates and Maximum Tax Bases

Calendar years	Maximum tax base	Tax rate (Percentage of taxable earnings)	
		Employees and employers, each	Self-employed
Past experience:			
1966	$6,600	0.35%	0.35%
1967	6,600	0.50	0.50
1968-71	7,800	0.60	0.60
1972	9,000	0.60	0.60
1973	10,800	1.00	1.00
1974	13,200	0.90	0.90
1975	14,100	0.90	0.90
1976	15,300	0.90	0.90
1977	16,500	0.90	0.90
1978	17,700	1.00	1.00
1979	22,900	1.05	1.05
1980	25,900	1.05	1.05
1981	29,700	1.30	1.30
1982	32,400	1.30	1.30
1983	35,700	1.30	1.30
1984	37,800	1.30	2.60
1985	39,600	1.35	2.70
1986	42,000	1.45	2.90
1987	43,800	1.45	2.90
1988	45,000	1.45	2.90
1989	48,000	1.45	2.90
1990	51,300	1.45	2.90
1991	125,000	1.45	2.90
1992	130,200	1.45	2.90
1993	135,000	1.45	2.90
1994-2012	no limit	1.45	2.90
2013-2014	no limit	1.45[1]	2.90[1]
Scheduled in current law:			
2015 & later	no limit	1.45[1]	2.90[1]

[1]Beginning in 2013, workers pay an additional 0.9 percent of their earnings above $200,000 (for those who file an individual tax return) or $250,000 (for those who file a joint income tax return).

Total HI payroll tax income in calendar year 2013 amounted to $220.8 billion—an increase of 7.3 percent over the amount of $205.7 billion for the preceding 12-month period. This increase in tax income resulted primarily from increases in the number of workers and in their average earnings.

Up to 85 percent of an individual's or couple's OASDI benefits may be subject to Federal income taxation if their income exceeds certain thresholds. The income tax revenue attributable to the first 50 percent of OASDI benefits is allocated to the OASI and DI trust funds. The revenue associated with the amount between 50 and 85 percent of benefits is allocated to the HI trust fund. Income from the taxation of OASDI benefits amounted to $14.3 billion in calendar year 2013.

Another substantial source of trust fund income is interest credited from investments in government securities held by the fund. In calendar year 2013, the fund received $9.3 billion in such interest. A

description of the trust fund's investment procedures appears later in this section.

Section 1818 of the Social Security Act provides that certain persons not otherwise eligible for HI protection may obtain coverage by enrolling in HI and paying a monthly premium. In 2013, premiums collected from such voluntary participants (or paid on their behalf by Medicaid) amounted to about $3.4 billion.

The Railroad Retirement Act provides for a system of coordination and financial interchange between the Railroad Retirement program and the HI trust fund. This financial interchange requires a transfer that would place the HI trust fund in the same position in which it would have been if the Social Security Act had always covered railroad employment. In accordance with these provisions, a transfer of $547 million in principal and about $19 million in interest from the Railroad Retirement program's Social Security Equivalent Benefit Account to the HI trust fund balanced the two systems as of September 30, 2012. The trust fund received this transfer, together with interest to the date of transfer totaling about $10 million, in June 2013.

Legislation in 1982 added transitional entitlement for those Federal employees who retire before having had a chance to earn sufficient quarters of Medicare-qualified Federal employment. The general fund of the Treasury provides reimbursement for the costs of this coverage, including administrative expenses. In calendar year 2013, such reimbursement amounted to $228 million for estimated benefit payments for these beneficiaries.

The Health Insurance Portability and Accountability Act of 1996 established a health care fraud and abuse control account within the HI trust fund. Monies derived from the fraud and abuse control program are transferred from the general fund of the Treasury to the HI trust fund. During calendar year 2013, the trust fund received about $1,685 million from this program.

b. Expenditures

The HI trust fund pays expenditures for HI benefit payments and administrative expenses. All HI administrative expenses incurred by the Department of Health and Human Services, the Social Security Administration, the Department of the Treasury (including the Internal Revenue Service), and the Department of Justice in administering HI are charged to the trust fund. Such administrative

duties include payment of benefits, the collection of taxes, fraud and abuse control activities, and experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under HI and SMI.

In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of HI. Although trust fund expenditures include these costs, the statement of trust fund assets presented in this report does not carry the net worth of facilities and other fixed capital assets because the proceeds of sales of such assets revert to the General Services Administration. Since the value of fixed capital assets does not represent funds available for benefit or administrative expenditures, the Trustees do not consider it in assessing the actuarial status of the funds.

Of the $266.2 billion in total HI expenditures, $261.9 billion represented net benefits paid from the trust fund for health services.[27] Net benefit payments decreased 0.4 percent in calendar year 2013 over the corresponding amount of $262.9 billion paid during the preceding calendar year. This decrease was due to the implementation of certain provisions of the Affordable Care Act, a reduction in hospital admissions as more patients were being treated as outpatients, and the sequestration of Medicare benefits. Further information on HI benefits by type of service is available in section IV.A.

The remaining $4.3 billion in expenditures was for net HI administrative expenses, after adjustments to the preliminary allocation of administrative costs among the Social Security and Medicare trust funds and the general fund of the Treasury. This amount included $1.5 billion for the health care fraud and abuse control program.

c. Actual experience versus prior estimates

Table III.B3 compares the actual experience in calendar year 2013 with the estimates presented in the 2012 and 2013 annual reports. A number of factors can contribute to differences between estimates and subsequent actual experience. In particular, actual values for key

[27]Net benefits equal the total gross amounts initially paid from the trust fund during the year, less recoveries of overpayments identified through fraud and abuse control activities.

economic and other variables can differ from assumed levels, and legislative and regulatory changes may occur after a report's preparation. The comparison in table III.B3 indicates that actual HI tax income in 2013 was slightly higher than estimated in the 2013 report—mostly because HI taxable wage data for the last 2 quarters of 2012, which were received after the completion of the 2013 report, indicated higher wages than expected. The higher wage data led to higher actual initial tax transfers, as well as higher adjustments to transfers for prior periods, in the last 2 quarters of 2013 than estimated in the report. Actual HI benefit payments in calendar year 2013 were lower than the amounts projected in the 2012 and 2013 reports largely due to lower utilization of all types of services, except hospice benefits, than previously estimated.

Table III.B3.—Comparison of Actual and Estimated Operations of the HI Trust Fund, Calendar Year 2013

[Dollar amounts in millions]

		Comparison of actual experience with estimates for calendar year 2013 published in—			
		2013 report		2012 report	
Item	Actual amount	Estimated amount[1]	Actual as percentage of estimate	Estimated amount[1]	Actual as percentage of estimate
Payroll taxes	$220,817	$216,455	102%	$224,025	99%
Benefit payments[2]	261,906	266,642	98	275,948	95

[1]Under the intermediate assumptions.

[2]Benefit payments include additional premiums for Medicare Advantage plans that are deducted from beneficiaries' Social Security benefits, costs of Quality Improvement Organizations, and health information technology payments.

d. Assets

The Department of Treasury invests, on a daily basis, the portion of the trust fund not needed to meet current expenditures for benefits and administration in interest-bearing obligations of the U.S. Government. The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the trust fund. The law requires that these special public-debt obligations bear interest at a rate based on the average market yield (computed on the basis of market quotations as of the end of the calendar month immediately preceding the date of such issue) for all marketable interest-bearing obligations of the United States forming a part of the public debt that are not due or callable until after 4 years from the end of that month. Currently, all invested assets of the HI trust fund are in the form of such special-issue securities.[28] Table V.H9,

[28]The Department of Treasury may also make investments in obligations guaranteed as to both principal and interest by the United States, including certain federally sponsored agency obligations.

presented in appendix H, shows the assets of the HI trust fund at the end of fiscal years 2012 and 2013.

2. 10-Year Actuarial Estimates (2014-2023)

While the previous section addressed the transactions of the HI trust fund during the preceding calendar year, this section presents estimates of the trust fund's operations and financial status for the next 10 years. The next section discusses the long-range actuarial status of the trust fund. In both this and the following section, the projections shown are under the projected baseline scenario.[29]

The estimates shown in this section provide detailed information concerning the short-range financial status of the trust fund, including the estimated levels of future income and outgo, annual differences between income and outgo, and annual trust fund balances. This section also discusses two particularly important indicators of solvency for the HI trust fund—the estimated year of depletion and the test of short-range financial adequacy.

To illustrate the sensitivity of future costs to different economic and demographic factors and to portray a reasonable range of possible future trends, the Trustees show estimates for the projected baseline under three alternative sets of economic and demographic assumptions. Due to the uncertainty inherent in such projections, however, the actual operations of the HI trust fund in the future could differ significantly from these estimates.

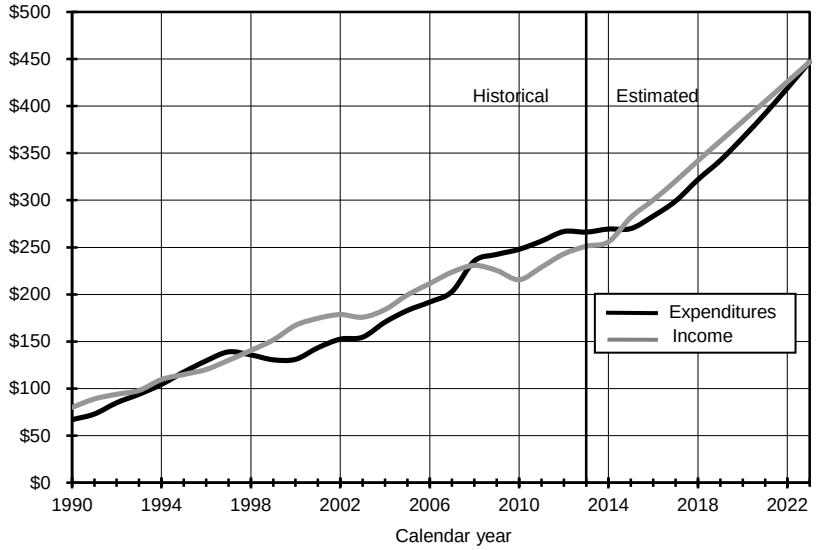
Figure III.B1 shows past and projected income and expenditures for the HI trust fund under the Trustees' intermediate assumptions. Following the Balanced Budget Act of 1997, the fund experienced annual surpluses in the range of $21 billion to $36 billion through 2003. This difference decreased to between $13 billion and $16 billion in 2004 and 2005, but then reached about $20 billion in 2006 and 2007—in large part as a result of a misallocation of certain hospice benefit costs to the Part B trust fund account. CMS corrected this accounting error in 2008. Beginning in 2008, expenditures exceeded income, and the Trustees expect this situation to continue through 2014. Annual surpluses are expected from 2015 through 2022, and

[29]There are only minor differences between this scenario and current law due to the small modifications in the IPAB operations. The projected baseline reflects a 0.6-percent physician payment update, resulting in slightly different IPAB operations under this scenario and current law, since the Trustees assume that reductions in spending recommended by the IPAB are spread proportionately across Parts A, B, and D.

annual deficits are expected to return in 2023 and to continue throughout the remainder of the projection period.

Figure III.B1.—HI Expenditures and Income

[In billions]



The impact of the December 2007 through June 2009 recession on HI payroll tax income is apparent in figure III.B1. In 2009 and 2010, payroll taxes decreased substantially as a result of higher unemployment and slow growth in wages along with collection lags; these factors contributed to the $32.3-billion trust fund deficit in 2010. For 2011 through 2013, revenues rebounded somewhat but not enough to reach the level of expenditures, which continue growing due to increased enrollment and the regular updating of the payment rates. Together these factors resulted in trust fund deficits of $27.7 billion in 2011, $23.8 billion in 2012, and $15.0 billion in 2013.

The provisions of the Affordable Care Act and other recent legislation, and an assumed strengthening economic recovery, sharply reduce the magnitude of, and for most years eliminate, trust fund deficits in the short-range period. A downward adjustment to price updates for all HI providers by the growth in economy-wide productivity will slow expenditure growth rates by 0.5 to 1.0 percentage point from 2014 through 2023. The significant reductions in Medicare Advantage payment benchmarks under the ACA have reduced the level of expenditures and will continue do so in 2014 and 2015, with less of an impact for the rest of the projection period, and the additional

0.9-percent tax rate for high-income workers in 2013 and later will increase HI payroll tax revenues.

HI expenditures are further affected by the sequestration of non-salary Medicare expenditures. The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2023, by 2.9 percent from April 1, 2023 through September 30, 2023, by 1.1 percent from October 1, 2023 through March 31, 2024, and by 4 percent from April 1, 2024 through September 30, 2024. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2024. Together, the statutory and economic factors would eliminate the trust fund deficits in 2015-2022, and small surpluses would result. After 2022, annual deficits would occur.

As figure III.B1 illustrates, estimated HI income increases at a faster rate during 2011-2017 than projected HI expenditures, in contrast to the situation that has prevailed during most of the program's history. The projected recovery from the economic recession (which ended in 2009) accelerates income growth during this period, as does the additional 0.9-percent HI payroll tax rate, which began in 2013 and will result in an increasing proportion of workers paying this tax over time. At the same time, the other ACA provisions mentioned previously will slow expenditure growth significantly.

Table III.B4 shows the expected operations of the HI trust fund during calendar years 2014 to 2023 based on the intermediate set of assumptions, together with the past experience. Section IV.A of this report presents the detailed assumptions underlying the intermediate projections.

Table III.B4.—Operations of the HI Trust Fund during Calendar Years 1970-2023

[In billions]

	Income								Expenditures			Trust fund	
Calendar year	Payroll taxes	Income from taxation of benefits	Railroad Retirement account transfers	Reimburse-ment for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other[1,2]	Total	Benefit payments[2,3]	Adminis-trative expenses[4]	Total	Net change	Fund at end of year
Historical data:													
1970	$4.9	—	$0.1	$0.9	—	$0.0	$0.2	$6.0	$5.1	$0.2	$5.3	$0.7	$3.2
1975	11.5	—	0.1	0.6	$0.0	0.0	0.7	13.0	11.3	0.3	11.6	1.4	10.5
1980	23.8	—	0.2	0.7	0.0	0.1	1.1	26.1	25.1	0.5	25.6	0.5	13.7
1985	47.6	—	0.4	0.8	0.0	−0.7[5]	3.4	51.4	47.6	0.8	48.4	4.8[6]	20.5
1990	72.0	—	0.4	0.4	0.1	−1.0[7]	8.5	80.4	66.2	0.8	67.0	13.4	98.9
1995	98.4	$3.9	0.4	0.5	1.0	0.1	10.8	115.0	116.4	1.2	117.6	−2.6	130.3
2000	144.4	8.8	0.5	0.5	1.4	0.0	11.7	167.2	128.5[8]	2.6	131.1	36.1	177.5
2005	171.4	8.8	0.4	0.3	2.4	0.0	16.1	199.4	180.0	2.9	182.9	16.4	285.8
2006	181.3	10.3	0.5	0.4	2.6	0.0	16.4	211.5	189.0	2.9	191.9	19.6	305.4
2007	191.9	10.6	0.5	0.5	2.8	0.0	17.5	223.7	200.2	2.9	203.1	20.7	326.0
2008	198.7	11.7	0.5	0.5	2.9	0.0	16.4	230.8	232.3[9]	3.3	235.6	−4.7	321.3
2009	190.9	12.4	0.5	0.6	2.9	1.0[10]	17.1	225.4	239.3	3.2	242.5	−17.1	304.2
2010	182.0	13.8	0.5	−0.1	3.3	0.0	16.1	215.6	244.5	3.5	247.9	−32.3	271.9
2011	195.6	15.1	0.5	0.3	3.3	0.0	14.2	228.9	252.9	3.8	256.7	−27.7	244.2
2012	205.7	18.6	0.5	0.3	3.4	0.0	14.5	243.0	262.9	3.9	266.8	−23.8	220.4
2013	220.8	14.3	0.6	0.2	3.4	0.0	11.8	251.1	261.9	4.3	266.2	−15.0	205.4
Intermediate estimates:													
2014	221.6	18.9	0.6	0.2	3.5	0.0	11.1	255.9	265.0	4.5	269.5	−13.6	191.7
2015	245.2	21.0	0.6	0.2	3.4	0.0	11.6	281.9	265.0	5.0	269.9	12.0	203.8
2016	260.3	23.2	0.6	0.2	3.5	0.0	12.4	300.3	277.9	5.4	283.2	17.1	220.8
2017	276.6	25.8	0.7	0.2	3.7	0.0	13.5	320.4	293.4	5.8	299.2	21.2	242.0
2018	293.8	28.5	0.7	0.2	3.9	0.0	14.9	342.0	315.8	6.2	322.0	20.0	262.0
2019	310.0	31.3	0.7	0.2	4.1	0.0	16.5	362.9	335.6	6.6	342.3	20.6	282.6
2020	326.3	34.3	0.7	0.2	4.4	0.0	18.0	383.9	359.3	7.1	366.3	17.5	300.1
2021	342.7	37.5	0.7	0.1	4.7	0.0	19.2	404.9	384.3	7.5	391.9	13.0	313.2
2022	359.3	40.8	0.8	0.1	4.9	0.0	20.0	425.9	411.1	8.0	419.1	6.8	319.9
2023	375.8	44.5	0.8	0.1	5.2	0.0	20.7	447.0	438.7	8.5	447.2	−0.2	319.8

[1]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund, receipts from the fraud and abuse control program, and a small amount of miscellaneous income. These receipts amount to $2.5-$4.9 billion each year for the 10-year projection period. In 2008, other income includes an adjustment of −$0.9 billion for interest earned as a result of Part A hospice costs that were misallocated to the Part B trust fund account.
[2]Values after 2005 include additional premiums for Medicare Advantage plans that are deducted from beneficiaries' Social Security benefits. These additional premiums are beneficiary obligations and occur when a beneficiary chooses an MA plan whose monthly plan payment exceeds the benchmark amount. Beneficiaries subject to such premiums may choose to either reimburse the plans directly or have the premiums deducted from their Social Security benefits. The premiums deducted from the Social Security benefits are transferred to the HI and SMI trust funds and then transferred from the trust funds to the plans.
[3]Includes costs of Peer Review Organizations from 1983 through 2001 (beginning with the implementation of the prospective payment system on October 1, 1983) and costs of Quality Improvement Organizations beginning in 2002.
[4]Includes costs of experiments and demonstration projects. Beginning in 1997, includes fraud and abuse control expenses, as provided for by Public Law 104-191.
[5]Includes the lump-sum general revenue adjustment of −$0.8 billion, as provided for by section 151 of Public Law 98-21.
[6]Includes repayment of loan principal, from the OASI trust fund, of $1.8 billion.
[7]Includes the lump-sum general revenue adjustment of −$1.1 billion, as provided for by section 151 of Public Law 98-21.
[8]For 1998 to 2003, includes monies transferred to the SMI trust fund for home health agency costs, as provided for by Public Law 105-33.
[9]Includes the $8.5 billion transferred to the general fund of the Treasury for Part A hospice costs that were previously misallocated to the Part B trust fund account.
[10]Includes the lump-sum general revenue adjustment of $1.0 billion, as provided for by section 151 of Public Law 98-21.

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

Actuarial Analysis

The increases in estimated income shown in table III.B4 primarily reflect increases in payroll tax income to the trust fund since such taxes are the main source of HI financing. As noted, payroll tax revenues increase in 2013 and later as a result of the additional 0.9-percent tax rate on earnings for high-income workers. For all other workers, while the payroll tax rate will remain constant under current law, covered earnings would increase every year after 2010 under the intermediate assumptions due to projected increases in both the number of HI workers covered and the average earnings of these workers.

The Trustees project that over the next 10 years most of the smaller sources of financing for the HI trust fund will increase as well. More detailed descriptions of these sources of income were discussed earlier in this section.

Interest earnings have been a significant source of income to the trust fund for many years, surpassed only by payroll taxes and, recently, income from the taxation of OASDI benefits. As the trust fund balance begins to increase again in the next several years, interest earnings would follow the same pattern.

The Trustees have recommended maintenance of HI trust fund assets at a level of at least 100 percent of annual expenditures throughout the projection period. Such a level would provide a cushion of several years in the event that income falls short of expenditures, thereby allowing time for policy makers to implement legislative corrections.

The Trustees have also prepared projections under the projected baseline scenario using two alternative sets of assumptions. Table III.B5 summarizes the estimated operations under all three alternatives. Section IV.A presents in substantial detail the assumptions underlying the intermediate assumptions, as well as the assumptions used in preparing estimates under the low-cost and high-cost alternatives.

Table III.B5.—Estimated Operations of the HI Trust Fund during Calendar Years 2013-2023, under Alternative Sets of Assumptions

[Dollar amounts in billions]

Calendar year	Total income	Total expenditures	Net increase in fund	Fund at end of year	Ratio of assets to expenditures[1] (percent)	Expenditures as a percent of taxable payroll
Intermediate:						
2013[2]	$251.1	$266.2	−$15.0	$205.4	83%	3.55%
2014	255.9	269.5	−13.6	191.7	76	3.40
2015	281.9	269.9	12.0	203.8	71	3.24
2016	300.3	283.2	17.1	220.8	72	3.21
2017	320.4	299.2	21.2	242.0	74	3.20
2018	342.0	322.0	20.0	262.0	75	3.25
2019	362.9	342.3	20.6	282.6	77	3.28
2020	383.9	366.3	17.5	300.1	77	3.34
2021	404.9	391.9	13.0	313.2	77	3.41
2022	425.9	419.1	6.8	319.9	75	3.49
2023	447.0	447.2	−0.2	319.8	72	3.56
Low-cost:						
2013[2]	251.1	266.2	−15.0	205.4	83	3.52
2014	258.4	263.6	−5.3	200.1	78	3.28
2015	292.4	261.4	31.1	231.1	77	3.03
2016	319.0	274.7	44.3	275.4	84	2.94
2017	348.6	289.4	59.2	334.6	95	2.87
2018	378.5	309.0	69.5	404.2	108	2.86
2019	409.0	325.6	83.3	487.5	124	2.83
2020	441.3	345.8	95.5	583.0	141	2.82
2021	475.4	367.0	108.4	691.4	159	2.83
2022	512.4	390.1	122.3	813.7	177	2.83
2023	551.5	413.6	137.9	951.6	197	2.84
High-cost:						
2013[2]	251.1	266.2	−15.0	205.4	83	3.57
2014	252.5	275.5	−23.0	182.4	75	3.54
2015	269.4	278.0	−8.6	173.7	66	3.49
2016	282.2	292.0	−9.9	163.9	59	3.53
2017	295.5	309.8	−14.3	149.6	53	3.59
2018	309.5	335.5	−26.0	123.6	45	3.72
2019	322.2	359.3	−37.1	86.5	34	3.83
2020	334.7	388.3	−53.6	32.9	22	3.98
2021[3]	347.6	419.8	−72.2	−39.3	8	4.14
2022[3]	360.8	454.2	−93.4	−132.7	−9	4.32
2023[3]	371.2	489.4	−118.2	−250.9	−27	4.50

[1]Ratio of assets in the fund at the beginning of the year to expenditures during the year.
[2]Figures for 2013 represent actual experience.
[3]Estimates for 2021 and later are hypothetical, since the HI trust fund would be depleted in those years.

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

These alternatives provide two possible Part A scenarios but represent a narrow range of possible outcomes for total expenditures. Given the considerable variation in future demographic, economic, and healthcare-usage factors, actual Part A expenditure experience could easily fall outside of this range. The low- and high-cost scenarios in this year's report result in a narrower dollar expenditure range than in previous years, due to a change in the alternative

assumptions from last year.[30] The taxable payroll assumptions for the alternative scenarios are also affected by the assumption change. Therefore, spending as a percent of taxable payroll provides better insight into the variability of spending than the nominal dollar amounts, as shown in table III.B5.

The Board of Trustees has established an explicit test of short-range financial adequacy. The requirements of this test are as follows: (i) if the HI trust fund ratio is at least 100 percent at the beginning of the projection period, then it must remain at or above 100 percent throughout the 10-year projection period; (ii) alternatively, if the fund ratio is initially less than 100 percent, it must reach a level of at least 100 percent within 5 years (with no depletion of the trust fund at any time during this period), and then remain at or above 100 percent throughout the rest of the 10-year period. The Trustees apply this test based on the intermediate projections.

Failure of the trust fund to meet this test is an indication that HI solvency over the next 10 years is in question and that action is necessary to improve the short-range financial adequacy of the fund. The HI trust fund does not meet this short-range test. While the short-range test is stringent, its purpose is to ensure that health care benefits continue to be available without interruption to the millions of aged and disabled Americans who rely on such coverage. Table III.B6 shows the ratios of assets in the HI trust fund at the beginning of a calendar year to total expenditures during that year. As table III.B6 shows, the Trustees project that the trust fund ratio, which was below the 100-percent level at the beginning of 2014, will decrease slightly through 2023. Accordingly, the financing for HI is not considered adequate in the short-range projection period (2014-2023).

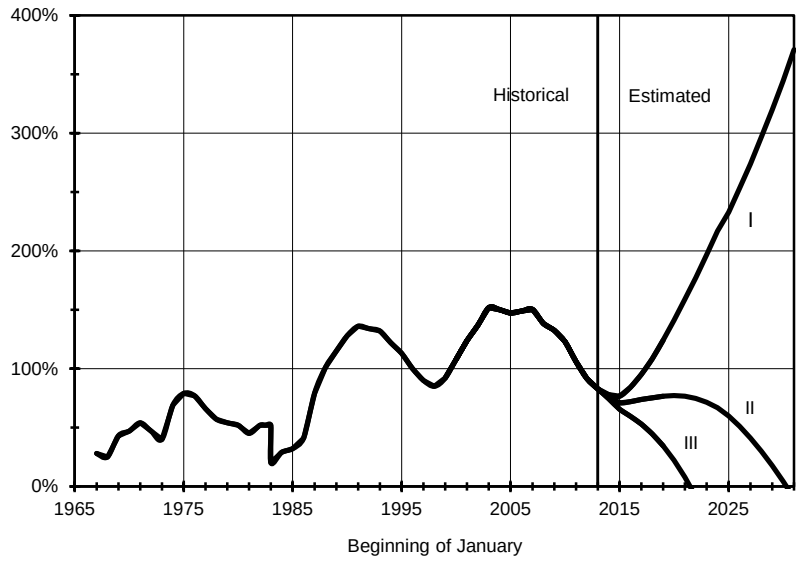
[30]The Trustees' alternative CPI assumptions are reversed in this year's report compared with those in previous reports, so that the high-cost assumptions in the 2013 report are now the low-cost assumptions for this year's report, and vice versa. Inflation rates are now ordered across alternatives according to their effect on the OASDI actuarial balance. This change resulted in a narrow range of expenditure impacts.

Table III.B6.—Ratio of Assets at the Beginning of the Year to Expenditures during the Year for the HI Trust Fund

Calendar year	Ratio
Historical estimates:	
1967	28%
1970	47
1975	79
1980	52
1985	32
1990	128
1995	113
2000	108
2005	147
2006	149
2007	150
2008	138
2009	132
2010	123
2011	106
2012	92
2013	83
Intermediate Estimates:	
2014	76
2015	71
2016	72
2017	74
2018	75
2019	77
2020	77
2021	77
2022	75
2023	72

Figure III.B2 shows the historical trust fund ratios and the projected ratios under the three sets of assumptions. The labels I, II, and III indicate projections under the low-cost, intermediate, and high-cost alternatives, respectively. Figure III.B2 shows the declining level of assets (as a percentage of expenditures) through 2015 under all three sets of assumptions, reflecting the current financial imbalance, as exacerbated by the recent economic recession. The fund ratio would continue declining under the intermediate and high-cost assumptions. Only under conditions of robust economic growth and extremely low health care cost increases, as assumed in the low-cost alternative, would HI assets grow significantly relative to expenditures, absent legislative changes.

Figure III.B2.—HI Trust Fund Balance at the Beginning of the Year as a Percentage of Annual Expenditures



3. Long-Range Estimates

This section examines the long-range actuarial status of the trust fund under the three alternative sets of economic and demographic assumptions, while section IV.A summarizes the assumptions used in preparing projections. Since the vast majority of total HI costs are related to insured beneficiaries, and since the Trustees expect general revenue appropriations and premium payments to support the uninsured segments (those paying the HI premium and those receiving HI coverage through special statutes requiring general revenue transfers to cover their costs), the remainder of this section will focus on the financing for insured beneficiaries only.

The Trustees measure the long-range actuarial status of the HI trust fund by comparing, on a year-by-year basis, the income (from payroll taxes and from taxation of OASDI benefits) with the corresponding incurred costs, expressed as percentages of taxable payroll.[31] These percentages are referred to as *income rates* and *cost rates*, respectively.

Table III.B7 shows historical and projected current-law HI costs and income under the intermediate assumptions, expressed as

[31]Taxable payroll is the total amount of wages, salaries, tips, self-employment income, and other earnings subject to the HI payroll tax.

percentages of taxable payroll. The ratio of expenditures to taxable payroll has generally increased over time; it rose from 0.94 percent in 1967 to 3.39 percent in 1996, an increase that reflected rapid growth in HI expenditures, which more than offset growth in average earnings per worker, and increases in (and eventual elimination of) the maximum taxable wage base for HI. Cost rates declined significantly between 1996 and 2000 to 2.61 percent due to favorable economic performance, the impact of the Balanced Budget Act of 1997, and efforts to curb fraud and abuse in the Medicare program. The cost rate increased to 3.12 percent by 2005 as a result of legislation and, after remaining about level through 2007, increased rapidly to 3.67 percent in 2009, reflecting the impact of the recession, which lowered taxable payroll. The resulting deficit in 2009 as a percentage of taxable payroll was the largest since the program began (0.55 percent). Cost rates then increased slightly in 2010 and 2011 due to the lower taxable payroll, which was not offset by lower spending. In 2012, the cost rate decreased to 3.60 percent due to a lower increase in spending, and in 2013 it decreased again to 3.55 percent.

Table III.B7.—HI Cost and Income Rates[1]

Calendar year	Cost rates[2]	Income rates	Difference[3]
Historical data:			
1967	0.94%	1.00%	+0.06%
1970	1.20	1.20	0.00
1975	1.69	1.80	+0.11
1980	2.19	2.10	−0.09
1985	2.62	2.70	+0.08
1990	2.70	2.90	+0.20
1995	3.30	3.01	−0.29
2000	2.61	3.07	+0.46
2005	3.12	3.07	−0.05
2006	3.11	3.07	−0.04
2007	3.12	3.09	−0.03
2008	3.30	3.06	−0.24
2009	3.67	3.12	−0.55
2010	3.69	3.15	−0.54
2011	3.68	3.15	−0.53
2012	3.60	3.18	−0.42
2013	3.55	3.28	−0.27
Intermediate estimates:			
2014	3.40	3.29	−0.11
2015	3.24	3.31	0.06
2016	3.21	3.32	0.11
2017	3.20	3.34	0.14
2018	3.25	3.36	0.10
2019	3.28	3.38	0.10
2020	3.34	3.39	0.05
2021	3.41	3.41	0.00
2022	3.49	3.43	−0.06
2023	3.56	3.45	−0.11
2025	3.82	3.50	−0.33
2030	4.20	3.59	−0.61
2035	4.55	3.67	−0.89
2040	4.83	3.72	−1.10
2045	5.01	3.78	−1.23
2050	5.11	3.84	−1.27
2055	5.15	3.91	−1.24
2060	5.21	3.98	−1.23
2065	5.32	4.05	−1.27
2070	5.45	4.11	−1.33
2075	5.55	4.17	−1.38
2080	5.58	4.21	−1.36
2085	5.57	4.26	−1.31

[1]Based on the Trustees intermediate assumptions, and expressed as a percentage of taxable payroll.
[2]Estimated costs attributable to insured beneficiaries only, on an incurred basis. The Trustees expect benefits and administrative costs for noninsured persons to be financed through general revenue transfers and premium payments, rather than through payroll taxes. Taxable payroll includes statutory wage credits for military service for 1957-2001.
[3]Difference between the income rates and cost rates. Negative values represent deficits.

The Trustees expect the recovery from the recession and recently enacted legislation, including the Affordable Care Act, to generate a small surplus from 2015 through 2021. Then the impact of demographic shifts—notably, the aging of the baby boom population—causes the annual deficits to increase rapidly through about 2045. After 2050, the income rates are still insufficient, but the size of the projected deficit largely levels off at roughly 1.3 percent of taxable payroll. Projected HI expenditures are 5.11 and 5.57 percent of taxable payroll in 2050 and 2085, respectively. (Under the

illustrative alternative projections, the corresponding HI cost rates would equal 6.17 and 8.75 percent, respectively.)

Figure III.B3 shows the year-by-year costs as a percentage of taxable payroll for each of the three sets of assumptions. The labels I, II, and III indicate projections under the low-cost, intermediate, and high-cost alternatives, respectively. Figure III.B3 also shows the income rates, but only for the intermediate assumptions in order to simplify the presentation—and because the variation in the income rates by alternative is very small (by 2088, the annual income rates under the low-cost and high-cost alternatives differ by less than 0.1 percent of taxable payroll).

Figure III.B3.—Estimated HI Cost and Income Rates as a Percentage of Taxable Payroll

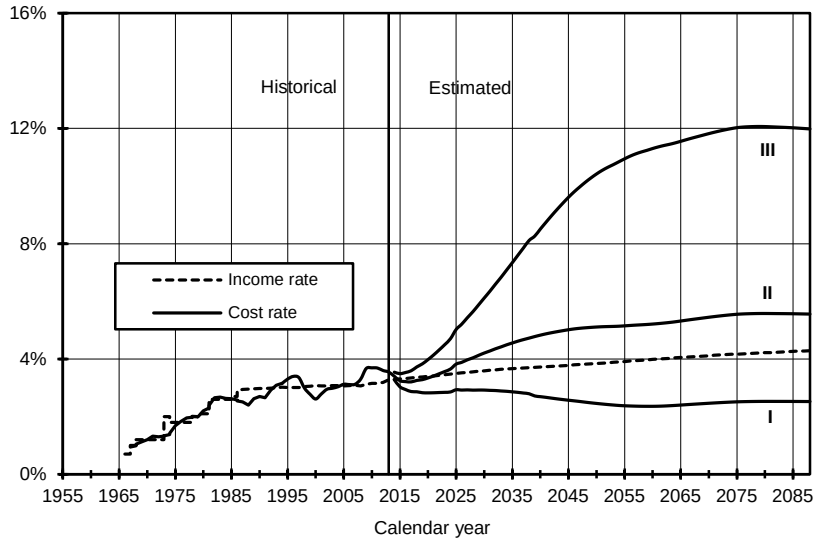


Figure III.B3 shows the remaining projected financial imbalance, based on the intermediate assumptions. The Trustees project that cost rates will continue to exceed income rates in most years, with the exception of 2015 through 2021, when small surpluses are expected. After 2021, deficits begin to increase. By the end of the 75-year period, the difference between income rates and cost rates would be about 1.3 percent of taxable payroll. The declines during the long-range portion of the projection are generally attributable to the compounding nature of reducing payment updates by economy-wide multifactor productivity.

Under the more favorable economic and demographic conditions assumed in the low-cost assumptions, HI costs would be lower than scheduled income during 2014-2088, and surpluses would steadily grow throughout the entire 75-year projection period. This very favorable result is due in large part to HI expenditure growth rates that would average only about 4 percent per year, reflecting the combined effects of slower growth in utilization and intensity of services, and slower improvement in beneficiary life expectancies.

The high-cost projections illustrate the large financial imbalance that could occur if future economic conditions resemble those of the 1973-95 period, if HI expenditure growth accelerates toward pre-1997 levels, and if fertility rates decline to the levels currently experienced in comparable European countries.[32]

The Trustees project costs beyond the initial 25-year period for the intermediate estimate based on the assumption that average HI expenditures per beneficiary will increase at a rate determined by the economic model described in sections II.C and IV.D, less the price update adjustments based on economy-wide multifactor productivity gains. This net rate is about 0.4 percent faster than the increase in Gross Domestic Product (GDP) per capita in 2038 and declines to about 0.5 percent *slower* than the growth in GDP by 2088. This pattern reflects the changing demographic composition of the population and average benefits that grow more rapidly than average wages through about 2066 and more slowly thereafter. Beyond the initial 25-year projection period, the low-cost and high-cost alternatives assume that HI cost increases, relative to taxable payroll increases, are initially 2 percentage points less rapid and 2 percentage points more rapid, respectively, than the results under the intermediate assumptions. The assumed initial 2-percentage-point differentials decrease gradually until the year 2063, when HI cost increases (relative to taxable payroll) are assumed to be the same as under the intermediate assumptions.

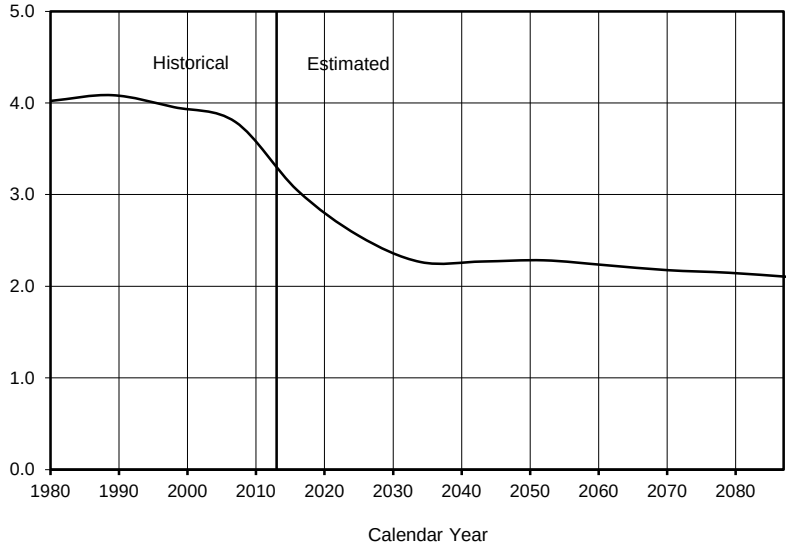
Figure III.B3 shows the cost rates and income rates over a 75-year valuation period in order to present fully the future economic and demographic developments that one may reasonably expect to occur, such as the impact of the large increase in the number of people over age 65 that began to take place in 2011. Growth occurs in part because the ratio of workers to beneficiaries will decrease as persons born during the period between the end of World War II and the

[32]Actual experience during these periods was similar on average to the high-cost economic and programmatic assumptions for the future.

mid-1960s (known as the baby boom generation) will reach eligibility age and begin to receive benefits.

Figure III.B4 shows the projected ratio of workers per HI beneficiary from 1980 to 2088. As figure III.B4 indicates, the ratio was relatively stable at about 4 workers per beneficiary from 1980 through 2008. It began to decline initially due to the recession but then declined further due to the retirement of the baby boom generation.

Figure III.B4.—Workers per HI Beneficiary
[Based on intermediate assumptions]



While every beneficiary in 2013 had about 3.2 workers to pay for his or her HI benefit, in 2030 under the intermediate demographic assumptions there would be only about 2.3 workers for each beneficiary. This ratio would then continue to decline until there are only 2.1 workers per beneficiary in 2088. This reduction implies an increase in the HI cost rate of about 50 percent by 2088, relative to its current level, solely due to this demographic factor.[33]

While year-by-year comparisons of revenues and costs are necessary to measure the adequacy of HI financing, the financial status of the trust fund is often summarized, over a specific valuation period, by a

[33]In addition to this factor, the projected increase in the HI cost rate reflects greater use of health care services as the beneficiary population ages and higher average costs per service due to medical price inflation and technological advances in care. The slower growth in Medicare payment rates to HI providers under the Affordable Care Act substantially offsets these increases under current law.

single measure known as the *actuarial balance*. The actuarial balance of the HI trust fund is defined as the difference between the summarized income rate for the valuation period and the summarized cost rate for the same period.

The summarized income rates, cost rates, and actuarial balance are based upon the present values of future income, costs, and taxable payroll. The Trustees calculate the present values, as of the beginning of the valuation period, by discounting the future annual amounts of income and outgo at the assumed rates of interest credited to the HI trust fund, and then obtain the summarized income and cost rates over the projection period by dividing the present value of income and cost, respectively, by the present value of taxable payroll. The difference between the summarized income rate and cost rate over the long-range projection period, after an adjustment to take into account the fund balance at the valuation date and a target trust fund balance at the end of the valuation period, is the actuarial balance.

In keeping with a decision by the Board of Trustees that it is advisable to maintain a balance in the trust fund equal to a minimum of one year's expenditures, the target trust fund balance is equal to the following year's estimated costs at the end of the 75-year projection period. While a zero or positive actuarial balance implies that the end-of-period trust fund balance is at least as large as the target trust fund balance, there is no such implication for the trust fund balance at other times during the projection period.

Table III.B8 shows the actuarial balances under current law and based on the Trustees' three sets of economic and demographic assumptions, for the next 25, 50, and 75 years. Based on the intermediate set of assumptions, the summarized income rate for the entire 75-year period is 3.82 percent of taxable payroll and the summarized cost rate is 4.69 percent. As a result, the actuarial balance is −0.87 percent, and the HI trust fund fails to meet the Trustees' long-range test of close actuarial balance.[34]

One can interpret the actuarial balance as the percentage that could be added to the current-law income rates and/or subtracted from the current-law cost rates immediately and throughout the entire valuation period in order for the financing to support HI costs and provide for the targeted trust fund balance at the end of the projection period. The income rate increase according to this method

[34]This test is defined in section V.I.

is 0.87 percent of taxable payroll. However, if no such changes occurred until 2030, when the trust fund would be depleted under current law, then the required increase would be 1.21 percent of taxable payroll under the intermediate assumptions. If changes instead occurred year by year, as needed to balance each year's costs and tax revenues, the changes would be minor over the next 10 years and then would grow rapidly to roughly 1.3 percent of taxable payroll in 2045, remaining at about that level through the end of the projection period.

Table III.B8.—HI Actuarial Balances under Three Sets of Assumptions

	Intermediate assumptions	Alternative	
		Low-Cost	High-Cost
Valuation periods:[1]			
25 years, 2014-2038:			
Summarized income rate	3.61	3.59	3.64
Summarized cost rate	4.03	2.99	5.55
Actuarial balance	−0.42	0.60	−1.90
50 years, 2014-2063:			
Summarized income rate	3.71	3.73	3.72
Summarized cost rate	4.46	2.75	7.45
Actuarial balance	−0.75	0.98	−3.72
75 years, 2014-2088:			
Summarized income rate	3.82	3.84	3.81
Summarized cost rate	4.69	2.68	8.34
Actuarial balance	−0.87	1.17	−4.52

[1]Income rates include beginning trust fund balances, and cost rates include the cost of attaining a trust fund balance at the end of the period equal to 100 percent of the following year's estimated expenditures.

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

The divergence in outcomes among the three sets of assumptions is apparent both in the estimated operations of the trust fund on a cash basis (as discussed in section III.B2) and in the 75-year summarized costs. Under the low-cost economic and demographic assumptions, the summarized cost rate for the 75-year valuation period is 2.68 percent of taxable payroll, and the summarized income rate is 3.84 percent of taxable payroll; accordingly, HI income rates would be adequate under the highly favorable conditions assumed in the low-cost alternative. Under the high-cost assumptions, the summarized cost rate for the 75-year projection period is 8.34 percent of taxable payroll, which is more than twice the summarized income rate of 3.81 percent of taxable payroll.

As suggested earlier, past experience has indicated that economic and demographic conditions that are as financially adverse as those assumed under the high-cost alternative can, in fact, occur. Readers should view all of the alternative sets of economic and demographic assumptions as plausible. The wide range of results under the three sets of assumptions is indicative of the uncertainty of HI's future cost

and its sensitivity to future economic and demographic conditions. Accordingly, it is important to maintain an adequate balance in the HI trust fund as a reserve for contingencies and to promptly address financial imbalances through corrective legislation.

Table III.B9 shows the long-range actuarial balance under the intermediate projections with its component parts—the present values of tax income, expenditures, and asset requirement of the HI program over the next 75 years.

Table III.B9.—Components of 75-Year HI Actuarial Balance under Intermediate Assumptions (2014-2088)

Present value as of January 1, 2014 (in billions):	
a. Payroll tax income	$14,251
b. Taxation of benefits income	2,121
c. Fraud and abuse control receipts	170
d. Total income (a + b + c)	16,542
e. Expenditures	20,365
f. Expenditures minus income (e − d)	3,823
g. Trust fund assets at start of period	205
h. Open-group unfunded obligation (f − g)	3,618
i. Ending target trust fund[1]	199
j. Present value of actuarial balance (d − e + g − i)	−3,816
k. Taxable payroll	438,354
Percent of taxable payroll:	
Actuarial balance (j ÷ k)	−0.87%

[1]The calculation of the actuarial balance includes the cost of accumulating a target trust fund balance equal to 100 percent of annual expenditures by the end of the period.

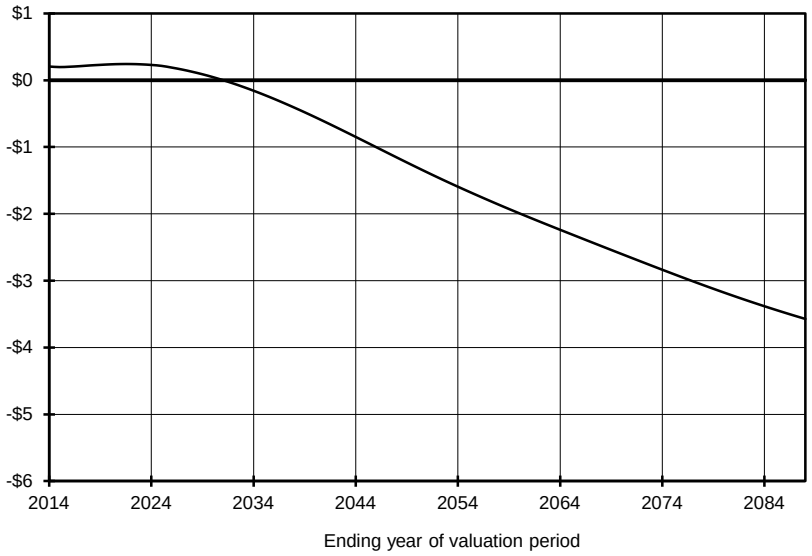
Note: Totals do not necessarily equal the sums of rounded components.

The present value of future expenditures less future tax income, decreased by the amount of HI trust fund assets on hand at the beginning of the projection, amounts to $3.6 trillion. This value is referred to as the 75-year unfunded obligation for the HI trust fund, and it is considerably lower than last year's value of $4.6 trillion. The actuarial balance is like the unfunded obligation except that (i) it is a measure of the degree to which the program is funded rather than unfunded and so is opposite in sign; (ii) it includes the trust fund balance at the end of 75 years as a cost; and (iii) it is expressed as a percent of taxable payroll. Specifically, the actuarial balance is −0.87 percent of taxable payroll and is calculated as the trust fund balance plus the present value of revenues less the present value of costs (−$3.6 trillion), less the present value of the target trust fund balance ($199 billion), all divided by the present value of future taxable payroll ($438.4 trillion).

Figure III.B5 shows the present values, as of January 1, 2014, of cumulative HI taxes less expenditures (plus the 2014 trust fund) through each of the next 75 years. The Trustees estimate these values under current-law expenditures and tax rates.

Figure III.B5.—Present Value of Cumulative HI Taxes Less Expenditures through Year Shown, Evaluated under Current-Law Tax Rates and Legislated Expenditures

[Present value as of January 1, 2014; in trillions]



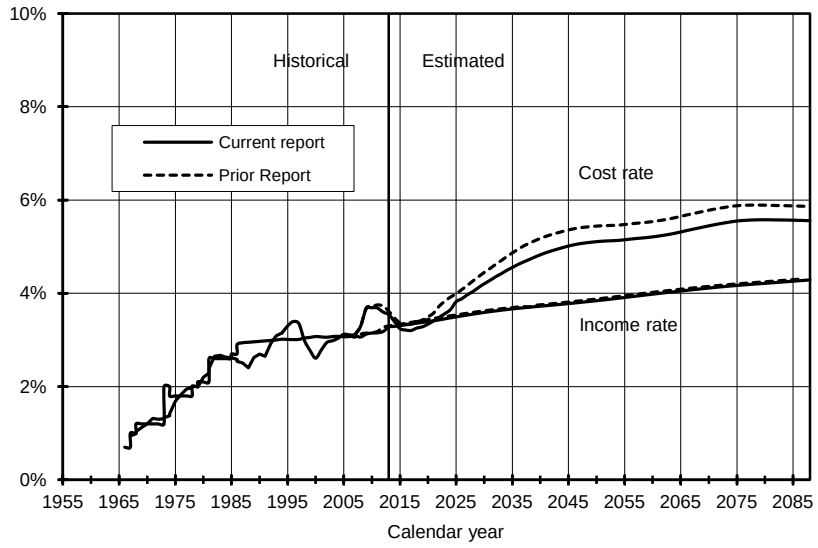
The cumulative annual balance of the trust fund is highest at the beginning of 2014 with beginning trust fund assets of about $0.2 trillion. The cumulative present value trends steadily downward over the projection period due to the anticipated shortfall of tax revenues, relative to expenditures, in all years beginning in 2022. The projected depletion date of the trust fund is 2030, at which time cumulative expenditures would have exceeded cumulative tax revenues by enough to equal the initial fund assets accumulated with interest. The continuing downward slope in the line thereafter further illustrates the unsustainable difference between the HI expenditures promised under current law and the financing currently scheduled to support these expenditures. As noted previously, over the full 75-year period, the fund has a projected present value unfunded obligation of $3.6 trillion. This unfunded obligation indicates that if $3.6 trillion were added to the trust fund at the beginning of 2014, the program would meet the projected cost of current-law expenditures over the next 75 years. More realistically, additional annual revenues and/or reductions in expenditures, with a present value totaling $3.6 trillion, would be necessary to reach financial balance (but with zero trust fund assets at the end of 2088).

The estimated unfunded obligation of $3.6 trillion and the closely associated present value of the actuarial deficit ($3.8 trillion) are

useful indicators of the sizable financial burden facing the American public. In other words, increases in revenues and/or reductions in benefit expenditures—equivalent to a lump-sum amount today of about $4 trillion—would be necessary to bring the HI trust fund into long-range financial balance. At the same time, long-range measures expressed in dollar amounts can be difficult to interpret, even when calculated as present values, which are sensitive to the underlying discount rate assumptions. For this reason, the Board of Trustees has customarily emphasized relative measures, such as the income rate and cost rate comparisons shown earlier in this section, and comparisons to the present value of future taxable payroll or GDP.

Figure III.B6 compares the year-by-year HI cost and income rates for the current annual report with the corresponding projections from the 2013 report.

Figure III.B6.—Comparison of HI Cost and Income Rate Projections: Current versus Prior Year's Reports



As figure III.B6 indicates, the intermediate HI cost rate projections in this year's report are lower than those in the 2013 report for the entire projection period. The projected income rates are very slightly lower.

Both of the HI expenditure projections described above are based on the same set of projected long-range rates of increase in average HI costs per beneficiary. For both the 2013 and 2014 reports, the long-range growth rates are drawn from a "factors contributing to growth"

economic model developed by the Office of the Actuary at CMS. In both reports, these assumptions reflect the price update reductions in the Affordable Care Act, which lower HI prices by the productivity adjustments. In addition, both sets of income rates include the impact of the higher tax rate required of high-income workers by the ACA, together with the growing proportion of workers who will be required to pay the higher tax over time, since the income thresholds are not indexed.

The Trustees' estimate of the 75-year HI actuarial balance under the intermediate assumptions, −0.87 percent of taxable payroll, is 0.24 percentage point larger (more favorable) than estimated in the 2013 annual report. The reasons for this change, which are listed in table III.B10, are explained below:

(1) Change in valuation period: Updating the valuation period from 2013-2087 to 2014-2088 adds a larger deficit year to the calculation of the actuarial balance. The effect on the actuarial balance is −0.02 percent of taxable payroll.
(2) Updating the projection base: Actual 2013 incurred HI expenditures were lower than previously estimated, and taxable payroll was slightly higher. The result is a slightly lower cost as a percentage of taxable payroll for 2013 than estimated previously. These base-year differences change the actuarial balance by +0.11 percent of taxable payroll.
(3) Private health plan assumptions: Compared to last year's report, this year more beneficiaries are assumed to be enrolled in Medicare Advantage plans, where their benefits will be more costly. The impact on the actuarial balance of this assumption change and other minor changes is −0.06 percent of taxable payroll.
(4) Hospital assumptions: The primary change in hospital assumptions in this report is lower utilization than assumed in last year's report. The impact of this and other minor changes results in a +0.11-percent change in the actuarial balance.
(5) Other provider assumptions: The Trustees assume lower skilled nursing facility and home health agency case mix increases for the next several years in this year's report, as well as a slightly lower market basket differential for skilled nursing facilities. The effect of these changes, along with other minor factors, is a +0.07-percent difference in the actuarial balance.
(6) Economic and demographic assumptions: The net effect of several adjustments to the economic and demographic

assumptions is a +0.03-percent change in the actuarial balance. The major changes in these assumptions in this year's report are the higher increases in productivity and refinements in the methodology used to transition from the short-range projections to the long-range projections, resulting in smaller increases during this transition period. In addition, the ultimate increase in CPI is slightly lower in this year's report.

Table III.B10.—Change in the 75-Year Actuarial Balance since the 2013 Report

1. Actuarial balance, intermediate assumptions, 2013 report	−1.11%
2. Changes:	
a. Valuation period	−0.02
b. Base estimate	0.11
c. Private health plan assumptions	−0.06
d. Hospital assumptions	0.11
e. Other provider assumptions	0.07
f. Economic and demographic assumptions	0.03
Net effect, above changes	+0.24
3. Actuarial balance, intermediate assumptions, 2014 report	−0.87

4. Long-Range Sensitivity Analysis

This section presents estimates that illustrate the sensitivity of the long-range HI cost rate, income rate, and actuarial balance of HI to changes in selected individual assumptions. The estimates based on the three alternative sets of assumptions (intermediate, low-cost, and high-cost) demonstrate the effects of varying all of the principal assumptions simultaneously in order to portray a generally more optimistic or pessimistic future for the projected financial status of the HI trust fund. In the sensitivity analysis presented in this section, the intermediate set of assumptions is the reference point, and one assumption at a time varies within that alternative. In each case, the Trustees assume that the provisions of current law remain unchanged throughout the 75-year projection period.

Each table that follows shows the effects of changing a particular assumption on the HI summarized income rates, summarized cost rates, and actuarial balances for 25-year, 50-year, and 75-year valuation periods. The discussion of the tables generally does not include the income rate, since it varies only slightly with changes in assumptions. The change in each of the actuarial balances is approximately equal to the change in the corresponding cost rate, but in the opposite direction. For example, a lower projected cost rate would result in an improvement or increase in the corresponding projected actuarial balance.

a. Real-Wage Differential

Table III.B11 shows the estimated HI income rates, cost rates, and actuarial balances on the basis of the intermediate assumptions, with various assumptions about the real-wage differential. These assumptions are that the ultimate real-wage differential will be 0.5 percentage point (as assumed for the high-cost alternative), 1.1 percentage points (as assumed for the intermediate assumptions), and 1.8 percentage points (as assumed for the low-cost alternative). In each case, the assumed ultimate annual increase in the Consumer Price Index (CPI) is 2.7 percent (as assumed for the intermediate assumptions), yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.5 percent under the three illustrations, respectively.

Past increases in real earnings have exhibited substantial variation. During 1951-1970, real earnings grew by an average of 2.2 percent per year. During 1972-1996, however, the average annual increase in real earnings amounted to only 0.53 percent.[35] Poor performance in real-wage growth would have substantial consequences for the HI trust fund; as shown in table III.B11, projected HI cost rates are fairly sensitive to the assumed growth rates in real wages. For the 75-year period 2014-2088, the summarized cost rate decreases from 5.03 percent (for a real-wage differential of 0.5 percentage point) to 4.32 percent (for a differential of 1.8 percentage points). The HI actuarial balance over this period shows a corresponding improvement for faster rates of growth in real wages.

[35]The Trustees chose this period because it begins and ends with years in which the economy reached full employment. The period thus allows measurement of trend growth over complete economic cycles.

Table III.B11—Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates with Various Real-Wage Assumptions

[As a percentage of taxable payroll]

	Ultimate percentage increase in wages-CPI[1]		
Valuation period	3.2−2.7	3.8−2.7	4.5−2.7
Summarized income rate:			
25-year: 2014-2038	3.62	3.61	3.61
50-year: 2014-2063	3.67	3.71	3.78
75-year: 2014-2088	3.73	3.82	3.93
Summarized cost rate:			
25-year: 2014-2038	4.17	4.03	3.90
50-year: 2014-2063	4.71	4.46	4.21
75-year: 2014-2088	5.03	4.69	4.32
Actuarial balance:			
25-year: 2014-2038	−0.55	−0.42	−0.29
50-year: 2014-2063	−1.03	−0.75	−0.42
75-year: 2014-2088	−1.30	−0.87	−0.39

[1]The first value in each pair is the assumed ultimate annual percentage increase in average wages in covered employment. The second value is the assumed ultimate annual percentage increase in the CPI. The difference between the two values is the real-wage differential.

The sensitivity of the HI actuarial balance to different real-wage assumptions is significant, but not as substantial as one might intuitively expect. Higher real-wage differentials immediately increase both HI expenditures for health care and wages for all workers. Though there is a full effect on wages and payroll taxes, the effect on benefits is only partial, since not all health care costs are wage-related. The HI cost rate decreases with increasing real-wage differentials because the higher real-wage levels increase the taxable payroll to a greater extent than they increase HI benefits. In particular, each 0.5-percentage-point increase in the assumed real-wage differential increases the long-range HI actuarial balance, on average, by about 0.35 percent of taxable payroll.

b. Consumer Price Index

Table III.B12 shows the estimated HI income rates, cost rates, and actuarial balances on the basis of the intermediate alternative, with various assumptions about the rate of increase for the CPI. These assumptions are that the ultimate annual increase in the CPI will be 3.4 percent (as assumed for the low-cost alternative), 2.7 percent (as assumed for the intermediate assumptions), and 2.0 percent (as assumed for the high-cost alternative).[36] In each case, the assumed ultimate real-wage differential is 1.1 percent (as assumed for the intermediate assumptions), which yields ultimate percentage increases in average annual wages in covered employment of 3.1, 3.8, and 4.5 percent under the three illustrations.

Table III.B12.—Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates with Various CPI-Increase Assumptions

[As a percentage of taxable payroll]

	Ultimate percentage increase in wages-CPI[1]		
Valuation period	4.5−3.4	3.8−2.7	3.1−2.0
Summarized income rate:			
25-year: 2014-2038	3.65	3.61	3.58
50-year: 2014-2063	3.87	3.71	3.58
75-year: 2014-2088	3.99	3.82	3.60
Summarized cost rate:			
25-year: 2014-2038	4.02	4.03	4.03
50-year: 2014-2063	4.45	4.46	4.46
75-year: 2014-2088	4.68	4.69	4.70
Actuarial balance:			
25-year: 2014-2038	−0.37	−0.42	−0.45
50-year: 2014-2063	−0.58	−0.75	−0.88
75-year: 2014-2088	−0.69	−0.87	−1.09

[1]The first value in each pair is the assumed ultimate annual percentage increase in average wages in covered employment. The second value is the assumed ultimate annual percentage increase in the CPI.

Faster assumed growth in the CPI results in a somewhat larger HI income rate because current law does not index the income thresholds for the taxation of Social Security benefits and the application of the additional 0.9-percent payroll tax rate. Over time, consequently, these provisions affect an increasing proportion of beneficiaries and workers as their incomes exceed the fixed thresholds, and this impact accelerates under conditions of faster CPI growth. In contrast, the cost rate remains about the same with greater assumed rates of increase in the CPI. The relative insensitivity of projected HI cost rates to different levels of general inflation occurs because of the assumption that inflation affects both the taxable payroll of workers

[36]Prior to this year's report, the Trustees used the lower CPI for the low-cost alternative and the higher CPI for the high-cost alternative.

and medical care costs about equally.[37] In practice, differing rates of inflation could occur between the economy in general and the medical-care sector. Readers can judge the effect of such a difference from the sensitivity analysis shown in the subsequent section on miscellaneous health care cost factors. Overall, variation in the rate of change assumed for the CPI has only a modest effect on the long-range actuarial balance.

c. Real-Interest Rate

Table III.B13 shows the estimated HI income rates, cost rates, and actuarial balances under the intermediate alternative, with various assumptions about the annual real-interest rate for special public-debt obligations issuable to the trust fund. These assumptions are that the ultimate annual real-interest rate will be 2.4 percent (as assumed for the high-cost alternative), 2.9 percent (as assumed for the intermediate assumptions), and 3.4 percent (as assumed for the low-cost alternative). In each case, the assumed ultimate annual increase in the CPI is 2.7 percent (as assumed for the intermediate assumptions), which results in ultimate annual yields of 5.1, 5.6, and 6.1 percent under the three illustrations.

Table III.B13.—Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates with Various Real-Interest Assumptions

[As a percentage of taxable payroll]

	Ultimate annual real-interest rate		
Valuation period	2.4 percent	2.9 percent	3.4 percent
Summarized income rate:			
25-year: 2014-2038	3.61	3.61	3.61
50-year: 2014-2063	3.72	3.71	3.71
75-year: 2014-2088	3.84	3.82	3.80
Summarized cost rate:			
25-year: 2014-2038	4.05	4.03	4.00
50-year: 2014-2063	4.51	4.46	4.41
75-year: 2014-2088	4.77	4.69	4.61
Actuarial balance:			
25-year: 2014-2038	−0.45	−0.42	−0.39
50-year: 2014-2063	−0.79	−0.75	−0.70
75-year: 2014-2088	−0.93	−0.87	−0.81

For all periods, the cost rate decreases slightly with increasing real-interest rates. Over 2014-2088, for example, the summarized HI cost rate would decline from 4.77 percent (for an ultimate real-interest rate of 2.4 percent) to 4.61 percent (for an ultimate real-interest rate of 3.4 percent). Accordingly, each 1.0-percentage-point increase in the

[37]The slight sensitivity shown in the table results primarily from the fact that the fiscal year 2014 payment rates for all providers have already been set before publication of the actual CPI.

assumed real-interest rate increases the long-range actuarial balance, on average, by about 0.12 percent of taxable payroll.

d. Health Care Cost Factors

Table III.B14 shows the estimated HI income rates, cost rates, and actuarial balances on the basis of the intermediate set of assumptions, with two variations on the relative annual growth rate in the aggregate cost of providing covered health care services to HI beneficiaries. These assumptions are that starting in 2014 the ratio of costs to taxable payroll will grow 1 percentage point more slowly than in the intermediate assumption, the same as the intermediate assumption, and 1 percentage point faster than the intermediate assumption. In each case, the taxable payroll will be the same as assumed for the intermediate assumptions.[38]

As noted previously, factors such as wage and price increases may simultaneously affect HI tax income and the costs incurred by hospitals and other providers of medical care to HI beneficiaries. (Sections III.B4a and III.B4b evaluate the sensitivity of the trust fund's financial status to these factors.) Other factors, such as the utilization of services by beneficiaries or the relative complexity of the services provided, can have an impact on provider costs without affecting HI tax income. The sensitivity analysis shown in table III.B14 illustrates the financial effect of any combination of these factors that results in the ratio of cost to payroll taxes increasing by 1 percentage point faster or slower than the intermediate assumptions.

[38]These variations in HI cost growth rates are not equivalent to the high- and low-cost alternative assumptions, which use a different level and pattern of growth differentials and also vary other assumptions in addition to the cost growth factors.

Table III.B14.—Estimated HI Income Rates, Cost Rates, and Actuarial Balances, Based on Intermediate Estimates with Various Health Care Cost Growth Rate Assumptions

[As a percentage of taxable payroll]

	Annual cost/payroll relative growth rate		
Valuation period	−1 percentage point	0 percentage point	+1 percentage point
Summarized income rate:			
25-year: 2014-2038	3.61	3.61	3.61
50-year: 2014-2063	3.71	3.71	3.71
75-year: 2014-2088	3.82	3.82	3.82
Summarized cost rate:			
25-year: 2014-2038	3.51	4.03	4.64
50-year: 2014-2064	3.48	4.46	5.82
75-year: 2014-2088	3.34	4.69	6.86
Actuarial balance:			
25-year: 2014-2038	0.10	−0.42	−1.03
50-year: 2014-2063	0.24	−0.75	−2.10
75-year: 2014-2088	0.48	−0.87	−3.04

As illustrated in table III.B14, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs versus taxable payroll. For the 75-year period, the cost rate increases from 3.34 percent (for an annual cost/payroll growth rate of 1 percentage point less than the intermediate assumptions) to 6.86 percent (for an annual cost/payroll growth rate of 1 percentage point more than the intermediate assumptions). Each 1.0-percentage-point increase in the assumed cost/payroll relative growth rate decreases the long-range actuarial balance, on average, by about 1.76 percent of taxable payroll.

C. PART B FINANCIAL STATUS

1. Financial Operations in Calendar Year 2013

Table III.C1 presents a statement of the revenue and expenditures of the Part B account of the SMI trust fund in calendar year 2013, and of its assets at the beginning and end of the year.

Table III.C1.—Statement of Operations of the Part B Account in the SMI Trust Fund during Calendar Year 2013

[In thousands]

Total assets of the Part B account in the trust fund, beginning of period		$66,226,074
Revenue:		
Premiums from enrollees:		
Enrollees aged 65 and over	$52,814,187	
Disabled enrollees under age 65	10,270,484	
Total premiums		63,084,671
Premiums collected from Medicare Advantage participants		260,759
Government contributions:		
Enrollees aged 65 and over	145,858,580	
Disabled enrollees under age 65	35,693,031	
Total government contributions		181,551,611
Other		6,058
Interest on investments		2,384,005
Interfund interest receipts[1]		209
HITECH		4,263,092
ACA Medicare shared savings program receipts		1,238
Annual fees–branded Rx manufacturers and importers		3,415,530
Total revenue		$254,967,174
Expenditures:		
Net Part B benefit payments		$243,788,006
Administrative expenses:		
Transfer to Medicaid[2]	477,445	
Treasury administrative expenses	352	
Salaries and expenses, CMS[3]	1,756,638	
Salaries and expenses, Office of the Secretary, HHS	21,830	
Salaries and expenses, SSA	910,425	
Medicare Payment Advisory Commission	4,251	
Railroad Retirement administrative expenses	25,005	
Transfer to Patient-Centered Outcomes Research trust fund[4]	57,870	
CMS program management–Affordable Care Act	26,087	
Total administrative expenses		3,279,904
Total expenditures		$247,067,910
Net addition to the trust fund		7,899,265
Total assets of the Part B account in the trust fund, end of period		$74,125,338

[1]Reflects interest adjustments on the reallocation of administrative expenses among the Medicare trust funds, the OASDI trust funds, and the general fund of the Treasury. Estimated payments are made from the trust funds and then are reconciled, with interest, the next year when the actual costs are known. A positive figure represents a transfer to the Part B account in the SMI trust fund from the other trust funds. A negative figure represents a transfer from the Part B account of the SMI trust fund to the other funds.
[2]Represents amount transferred from the Part B account in the SMI trust fund to Medicaid to pay the Part B premium for certain qualified individuals, as legislated by the Balanced Budget Act of 1997.
[3]Includes administrative expenses of the carriers and intermediaries.
[4]Represents amount transferred from the Part B account of the SMI trust fund to the Patient-Centered Outcomes Research trust fund, as authorized by the Patient Protection and Affordable Care Act of 2010.

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

The total assets of the account amounted to $66.2 billion on December 31, 2012. During calendar year 2013, total revenue amounted to $255.0 billion, and total expenditures were $247.1 billion. Total assets thus increased $7.9 billion during the year, to $74.1 billion as of December 31, 2013. The increase in assets occurred primarily because of lower-than-expected Part B expenditures and a correction to income that was made during 2013. A general revenue amount of $4.3 billion was transferred in 2013 to

the Part B account to pay for health information technology (HIT) bonus payments that occurred from 2011 through 2013 but for which the required monthly general revenue transfers had not been made.

a. Revenues

The major sources of revenue for the Part B account are (i) contributions of the Federal Government that the law authorizes to be appropriated and transferred from the general fund of the Treasury; and (ii) premiums paid by eligible persons who voluntarily enroll. A new source of revenues, which began in 2011 as specified by the Affordable Care Act, is the annual fees assessed on manufacturers and importers of brand-name prescription drugs. The ACA directs that these fees be allocated to the Part B trust fund account, where they will serve to slightly reduce the need for premium revenues and Federal general revenues. Eligible persons aged 65 and over have been able to enroll in Part B since its inception in July 1966. Since July 1973, disabled persons who are under age 65 and who have met certain eligibility requirements have also been able to enroll.

Of the total Part B revenue, $63.1 billion represented premium payments by (or on behalf of) aged and disabled enrollees—an increase of 8.8 percent over the amount of $58.0 billion for the preceding year.

Government contributions matched the premiums paid for fiscal years 1967 through 1973 dollar for dollar. Beginning July 1973, the amount of government contributions corresponding to premiums paid by each of the two groups of enrollees is determined by applying a matching rate, prescribed in the law for each group, to the amount of premiums received from that group. This ratio is equal to twice the monthly actuarial rate applicable to the particular group of enrollees, minus the standard monthly premium rate, divided by the standard monthly premium rate.

The Secretary of Health and Human Services promulgates standard monthly premium rates and actuarial rates each year. Table III.C2 shows past monthly premium rates and actuarial rates together with the corresponding percentages of Part B costs covered by the premium rate. Estimated future premium amounts under the intermediate set of assumptions appear in section V.E.

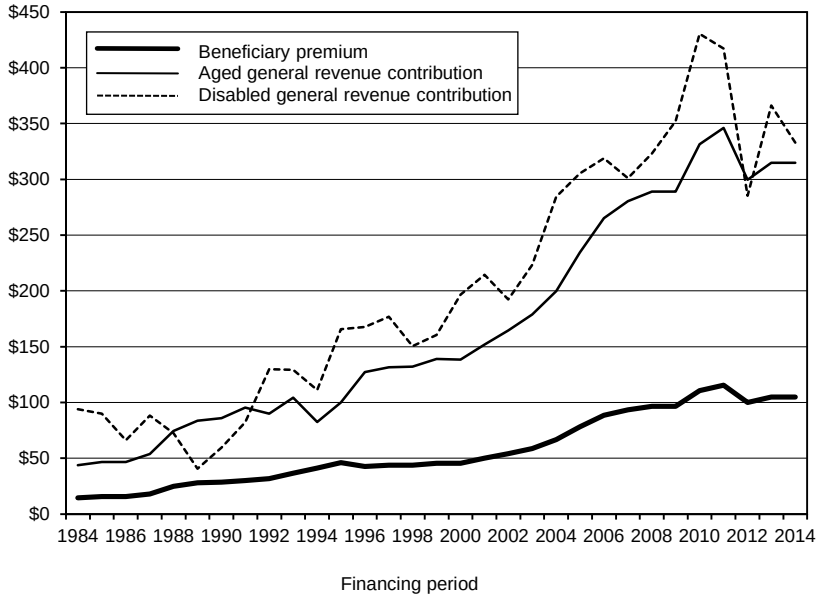
Table III.C2.—Standard Part B Monthly Premium Rates, Actuarial Rates, and Premium Rates as a Percentage of Part B Cost

		Monthly actuarial rate		Premium rates as a percentage of Part B cost	
	Standard monthly premium rate[1]	Enrollees aged 65 and over	Disabled enrollees under age 65	Enrollees aged 65 and over	Disabled enrollees under age 65
July 1966-March 1968	$3.00	—	—	50.0%	—
April 1968-June 1970	4.00	—	—	50.0	—
12-month period ending June 30 of					
1975	6.70	6.70	18.00	50.0	18.6
1980	8.70	13.40	25.00	32.5	17.4
Calendar year					
1985	15.50	31.00	52.70	25.0	14.7
1990	28.60	57.20	44.10	25.0	32.4
1991	29.90	62.60	56.00	23.9	26.7
1992	31.80	60.80	80.80	26.2	19.7
1993	36.60	70.50	82.90	26.0	22.1
1994	41.10	61.80	76.10	33.3	27.0
1995	46.10	73.10	105.80	31.5	21.8
1996	42.50	84.90	105.10	25.0	20.2
1997	43.80	87.60	110.40	25.0	19.8
1998	43.80	87.90	97.10	24.9	22.6
1999	45.50	92.30	103.00	24.6	22.1
2000	45.50	91.90	121.10	24.8	18.8
2001	50.00	101.00	132.20	24.8	18.9
2002	54.00	109.30	123.10	24.7	21.9
2003	58.70	118.70	141.00	24.7	20.8
2004	66.60	133.20	175.50	25.0	19.0
2005	78.20	156.40	191.80	25.0	20.4
2006	88.50	176.90	203.70	25.0	21.7
2007	93.50	187.00	197.30	25.0	23.7
2008	96.40	192.70	209.70	25.0	23.0
2009	96.40	192.70	224.20	25.0	21.5
2010	110.50	221.00	270.40	25.0	20.4
2011	115.40	230.70	266.30	25.0	21.7
2012	99.90	199.80	192.50	25.0	25.9
2013	104.90	209.80	235.50	25.0	22.3
2014	104.90	209.80	218.90	25.0	24.0

[1]The amount shown for each year represents the standard Part B premium paid by, or on behalf of, most Part B enrollees. It does not reflect other amounts that certain beneficiaries must pay, such as the income-related monthly adjustment amount for beneficiaries with high incomes and the premium surcharge for beneficiaries who enroll late. In addition, it does not reflect a reduction in premium for beneficiaries covered by the hold-harmless provision. As a result of this provision, most Part B beneficiaries had their 2010 and 2011 monthly premium held to the 2009 rate of $96.40. Section V.E describes these amounts in more detail.

Figure III.C1 is a graph of the monthly per capita financing rates in all financing periods after 1983 for enrollees aged 65 and over and for disabled individuals under age 65. The graph shows the portion of the financing contributed by the beneficiaries and by general revenues. As indicated, general revenue financing is the largest income source for Part B.

Figure III.C1.—Part B Aged and Disabled Monthly Per Capita Trust Fund Income



Note: The amounts shown do not include the catastrophic coverage monthly premium rate for 1989.

In calendar year 2013, premium matching contributions received from the general fund of the Treasury amounted to $181.6 billion, which accounted for 71.2 percent of total revenue. The annual fees assessed on manufacturers and importers of brand-name prescription drugs amounted to $3.4 billion in revenue. Transfers from the general fund of the Treasury to correct an error of previously unreimbursed HIT incentive payments were $4.3 billion in 2013.

Another source of Part B revenue is interest received on investments held by the Part B account. A description of the investment procedures of the Part B account appears later in this section. In calendar year 2013, $2.4 billion of revenue was from interest on the investments of the account.

The Department of Treasury may accept and deposit in the Part B account unconditional money gifts or bequests made for the benefit of the fund. The Part B account received contributions in the amount of $6 million in calendar year 2013.

b. Expenditures

The account pays expenditures for Part B benefit payments and administrative expenses. All expenses incurred by the Department of

Health and Human Services, the Social Security Administration, and the Department of the Treasury in administering Part B are charged to the account. Such administrative duties include payment of benefits, fraud and abuse control activities, and experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services while maintaining the quality of these services.

In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of Part B. The account expenditures include such costs. The net worth of facilities and other fixed capital assets, however, does not appear in the statement of Part B assets presented in this report, since the value of fixed capital assets does not represent funds available for benefit or administrative expenditures and is not, therefore, pertinent in assessing the actuarial status of the funds.

Of total Part B expenditures, $243.8 billion represented net benefits paid from the account for health services.[39] Net benefits increased 3.1 percent over the corresponding amount of $236.5 billion paid during the preceding calendar year. This spending growth incorporates the effects of the sequestration and the net change in both the number of beneficiaries and the price, volume, and intensity of services. Additional information on Part B benefits by type of service is available in section IV.B1.

The remaining $3.3 billion of expenditures was for administrative expenses and represented 1.3 percent of total Part B expenditures in 2013.[40] Administrative expenses are shown on a net basis, after adjustments to the preliminary allocation of such costs among the Social Security and Medicare trust funds and the general fund of the Treasury.

c. Actual experience versus prior estimates

Table III.C3 compares the actual experience in calendar year 2013 with the estimates presented in the 2012 and 2013 annual

[39]Net benefits equal the total gross amounts initially paid from the trust fund during the year less recoveries of overpayments identified through fraud and abuse control activities.

[40]In 2013, the Part B salaries and expenses for CMS, including the administrative expenses of the carriers and intermediaries, amounted to $1.8 billion, or 0.7 percent of total Part B expenditures.

reports. A number of factors can contribute to differences between estimates and subsequent actual experience. In particular, actual values for key economic and other variables can differ from assumed levels, and lawmakers may adopt legislative and regulatory changes after a report's preparation. Table III.C3 indicates that actual Part B benefit payments were lower than estimated in the 2013 report and, because legislation increased physician payments for 2013 after the release of the 2012 report, were higher than estimated in the 2012 report. Actual premiums and government contributions were close to those estimated in 2013, as the financing rates were determined in the fall of 2012 and were included in the 2013 report, but were lower than estimated in 2012. The estimated financing rates in the 2012 report were based on estimated benefit payments plus a margin for the likely legislative increase in physician payments in 2013. However, actual benefit payments, which reflect the legislative increase in physician payments, were lower than the estimated benefit payments plus the margin used for estimating the financing in the 2012 report.

Table III.C3.—Comparison of Actual and Estimated Operations of the Part B Account in the SMI Trust Fund, Calendar Year 2013

[Dollar amounts in millions]

Item	Actual amount	Comparison of actual experience with estimates for calendar year 2013 published in: 2013 report: Estimated amount[1]	2013 report: Actual as a percentage of estimate	2012 report: Estimated amount[1]	2012 report: Actual as a percentage of estimate
Premiums from enrollees	$63,085	$63,594	99%	$65,949	96%
Government contributions	181,552	185,646	98	194,155	94
Benefit payments[2]	243,788	248,004	98	235,535	104

[1]Under the intermediate assumptions.
[2]Benefit payments include additional premiums for Medicare Advantage plans that are deducted from beneficiaries' Social Security benefits, costs of Quality Improvement Organizations, and health information technology payments.

d. Assets

The Department of Treasury invests the portion of the Part B account not needed to meet current expenditures for benefits and administration in interest-bearing obligations of the U.S. Government.

The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the account. The law requires that these special public-debt obligations shall bear interest at a rate based on the average market yield (computed on the basis of market quotations as of the end of the calendar month immediately preceding the date of such issue) for all marketable interest-bearing obligations of the United States forming a part of the public debt that are not due

or callable until after 4 years from the end of that month. Since the inception of the SMI trust fund, the Department of Treasury has always invested the assets in special public-debt obligations.[41] Table V.H10, presented in appendix H, shows the assets of the SMI trust fund (Parts B and D) at the end of fiscal years 2012 and 2013.

2. 10-Year Actuarial Estimates (2014-2023)

The bases of the projected future operations of the Part B account are the Trustees' economic and demographic assumptions, as detailed in the OASDI Trustees Report, as well as other assumptions unique to Part B. Section IV.B1 presents an explanation of the effects of these assumptions on the estimates in this report. The Trustees also assume that financing for future periods will be determined according to the statutory provisions described in section III.C1a, although Part B financing rates have been set only through December 31, 2014.

In 2014 the monthly Part B premium rate is $104.90, which is unchanged from the 2013 monthly premium. Under the projected baseline scenario and the intermediate economic assumptions, the estimated monthly premium for 2015 is again $104.90. This premium, paid by affected enrollees and Medicaid and matched by general revenue transfers,[42] would maintain a contingency reserve at the level necessary to accommodate normal financial variation plus the likelihood of legislative action that would raise costs after the establishment of financing rates.[43]

The basis for the Part B projections has changed since last year's report. The scheduled reductions under the sustainable growth rate (SGR) formula for updating the physician fee schedule have been overridden by lawmakers each year beginning with 2003. Current law

[41]The Department of Treasury may also make investments in obligations guaranteed as to both principal and interest by the United States, including certain federally sponsored agency obligations.

[42]Premium amounts are multiplied by either the aged or disabled matching rate to determine the amount of the general revenue transfer. For 2014, the aged matching rate is 3.00, and the disabled matching rate is 3.17.

[43]In the highly unlikely event that lawmakers allow the current-law negative physician payment update to occur on April 1, 2015 without legislative intervention, the projected Part B financing levels required to maintain an adequate level of assets in the Part B account would be substantially lower. However, the Secretary of Health and Human Services sets Part B financing rates prospectively, and the rates must include a margin that accounts for the probability of legislative changes that would significantly increase Part B costs after the financing had been determined. For 2003 through March 2015, Congress legislatively overrode the negative updates that the sustainable growth rate formula would otherwise have required.

requires CMS to implement a reduction in Medicare payment rates for physician services of an estimated 20.8 percent in April 2015. However, it is a virtual certainty that lawmakers will override this reduction as they have for every year starting with 2003. For this reason, the income, expenditures, and assets for Part B reflect the projected baseline scenario, which includes an override of the provisions of the SGR. Appendix V.C summarizes projections on a current-law basis and shows that Part B costs would be about 4 percent lower in 2023 under current law.

Projected Part B expenditures are further affected by the sequestration of Medicare expenditures required by current law. The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2023, by 2.9 percent from April 1, 2023 through September 30, 2023, by 1.1 percent from October 1, 2023 through March 31, 2024, and by 4 percent from April 1, 2024 through September 30, 2024. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2024.

Table III.C4 shows the estimated operations of the Part B account under the intermediate assumptions of the projected baseline scenario on a calendar-year basis through 2023.

Table III.C4.—Operations of the Part B Account in the SMI Trust Fund (Cash Basis) during Calendar Years 1970-2023

[In billions]

	Income				Expenditures			Account	
Calendar year	Premium income	General revenue[1]	Interest and other[2,3]	Total	Benefit payments[3,4]	Adminis-trative expenses	Total	Net change	Balance at end of year[5]
Historical data:									
1970	$1.1	$1.1	$0.0	$2.2	$2.0	$0.2	$2.2	−$0.0	$0.2
1975	1.9	2.6	0.1	4.7	4.3	0.5	4.7	−0.1	1.4
1980	3.0	7.5	0.4	10.9	10.6	0.6	11.2	−0.4	4.5
1985	5.6	18.3	1.2	25.1	22.9	0.9	23.9	1.2	10.9
1990	11.3	33.0	1.6	45.9	42.5	1.5	44.0	1.9	15.5
1995	19.7	39.0	1.6	60.3	65.0	1.6	66.6	−6.3	13.1
2000	20.6	65.9	3.4	89.9	88.9[6]	1.8	90.7	−0.8	44.0
2005	37.5	118.1	1.4	157.0	149.2	3.2	152.4	4.6	24.0
2006	42.9	132.7	1.8	177.3	165.9	3.1	169.0	8.3	32.3
2007	46.8	139.6	2.2	188.7	176.4	2.5	178.9	9.7	42.1
2008	50.2	146.8	3.6	200.6	180.3[7]	3.0	183.3	17.3	59.4
2009	56.0[8]	162.8[8]	3.1	221.9	202.6	3.1	205.7	16.2	75.5
2010	52.0[8]	153.5[8]	3.3	208.8	209.7	3.2	212.9	−4.1	71.4
2011	57.5	170.2	5.9	233.6	221.7	3.6	225.3	8.3	79.7
2012	58.0	163.8	5.2	227.0	236.5	3.9	240.5	−13.5	66.2
2013	63.1	185.8	6.1	255.0	243.8	3.3	247.1	7.9	74.1
Intermediate estimates:									
2014	65.6	188.4	6.0	260.1	260.1	2.7	262.8	−2.7	71.4
2015	70.3[8]	202.2[8]	6.1	278.6	265.9	3.0	268.9	9.7	81.1
2016	69.0[8]	198.5[8]	6.2	273.8	280.3	3.3	283.6	−9.8	71.3
2017	78.5	221.8	7.5	307.9	299.5	3.5	303.0	4.9	76.2
2018	85.6	238.4	8.1	332.1	322.4	3.7	326.2	5.9	82.1
2019	93.5	257.9	7.3	358.7	348.3	4.0	352.3	6.4	88.5
2020	103.0[8]	292.1[8]	7.8	402.9	378.3	4.2	382.5	20.4	108.9
2021	104.4[8]	295.1[8]	8.4	407.9	409.8	4.5	414.3	−6.4	102.5
2022	117.4	330.4	9.0	456.8	443.9	4.8	448.7	8.1	110.6
2023	127.5	357.8	9.7	494.9	480.1	5.1	485.2	9.8	120.4

[1]General fund matching payments, plus certain interest-adjustment items.

[2]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income. In 2008, includes an adjustment of $0.8 billion for interest earned as a result of Part A hospice costs that were misallocated to the Part B trust fund account.

[3]See footnote 2 of table III.B4.

[4]Includes costs of Peer Review Organizations from 1983 through 2001 and costs of Quality Improvement Organizations beginning in 2002.

[5]The financial status of Part B depends on both the assets and the liabilities of the trust fund (see table III.C8).

[6]Benefit payments less monies transferred from the HI trust fund for home health agency costs, as provided for by the Balanced Budget Act of 1997.

[7]Benefits shown for 2008 are lower by the $8.5 billion transferred from the general fund of the Treasury to reimburse Part B for Part A hospice costs that were previously misallocated to the Part B trust fund account.

[8]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of those benefits normally due January 3, 2010 actually occurred on December 31, 2009. Consequently, the Part B premiums withheld from these benefits and the associated general revenue contributions were added to the SMI trust fund on December 31, 2009. Similarly, the payment date for those benefits normally due on January 3, 2016 will be December 31, 2015, and the payment date for those benefits normally due on January 3, 3021 will be December 31, 2020.

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

As shown in table III.C4, the Part B account would decrease during 2014 to an estimated $71.4 billion by the end of the year. Legislation enacted at the end of 2013 and the beginning of 2014 raised Part B

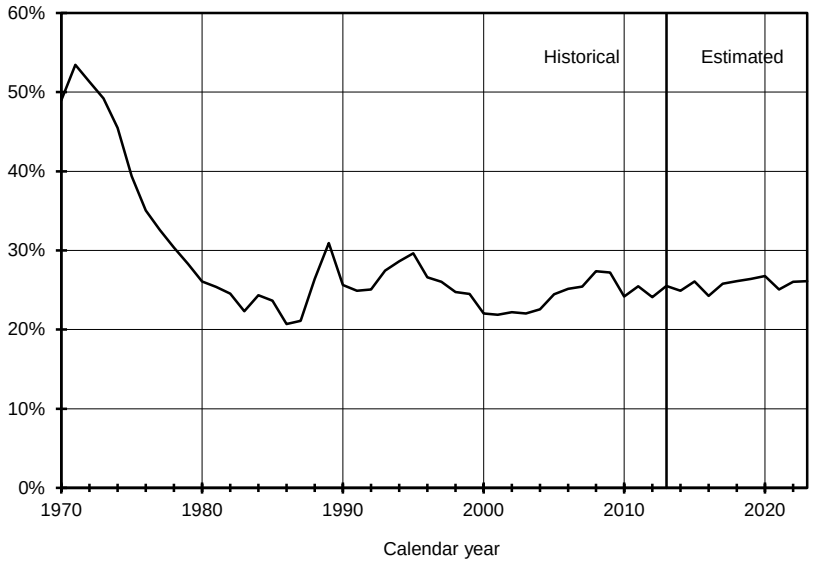
physician expenditures substantially compared to the law in effect in the fall of 2013 when the 2014 financing was established. Maintenance of an asset reserve that is sufficient to handle this type of contingency is an important element in ensuring solvency for the Part B trust fund account.

The Part B expenditures shown in this report for 2014 are significantly higher than estimated last year as a result of legislation to prevent a 23.7-percent reduction in physician payment rates. The expenditures under the projected baseline scenario in this report are lower than those under the comparable "alternative to SGR" scenario associated with the 2013 report due to several factors, including lower-than-estimated spending for 2012 and 2013 and lower payment updates.

The statutory provisions governing Part B financing have changed over time. Most recently, the Balanced Budget Act of 1997 provided for the permanent establishment of the standard Part B premium at the level of about 25 percent of average expenditures for beneficiaries aged 65 and over.[44] Figure III.C2 shows historical and projected ratios of premium income to Part B expenditures.

[44]Part B beneficiaries with high incomes pay a higher income-related premium beginning in 2007.

Figure III.C2.—Premium Income as a Percentage of Part B Expenditures



Beneficiary premiums are also affected by a provision of the Affordable Care Act that imposes fees on the manufacturers and importers of brand-name prescription drugs and allocates the fees to the Part B account of the SMI trust fund. The new legislation does not modify the determination of the Part B actuarial rates, premiums, or general revenue matching contributions; consequently, the normal financing, plus the new fees, would result in an excessive level of program financing without other action. Thus, there will be a reduction in the premium margin for maintaining an appropriate level of trust fund assets such that total revenues from premiums, matching general revenues, and the earmarked fees relating to brand-name prescription drugs will equal the appropriate level needed for program financing.

The amount and rate of growth of benefit payments have caused concern for many years. Table III.C5 shows payment amounts in the aggregate, on a per capita basis, and relative to the Gross Domestic Product (GDP). Rates of growth appear historically and for the next 10 years based on the intermediate assumptions of the projected baseline scenario.

Part B benefit growth has averaged 6.2 percent annually over the past 5 years following many years of much faster growth. A one-time hospice payment correction in 2008 led to higher growth in 2009.

During 2013, Part B benefits grew 3.1 percent on an aggregate basis and were 1.45 percent of GDP.

Table III.C5.—Growth in Part B Benefits (Cash Basis) through December 31, 2023

Calendar year	Aggregate benefits [billions]	Percent change	Per capita benefits	Percent change	Part B benefits as a percentage of GDP
Historical data:					
1970	$2.0	5.9%	$101	3.5%	0.18%
1975	4.3	28.8	180	24.6	0.25
1980	10.6	22.1	390	19.3	0.37
1985	22.9	16.7	768	14.5	0.53
1990	42.5	10.9	1,304	9.1	0.71
1995	65.0	10.8	1,823	9.2	0.85
2000	90.6[1]	11.4	2,425	10.5	0.88
2005	149.2	10.6	3,754	8.8	1.14
2006	165.9	11.2	4,111	9.5	1.20
2007	176.4	6.3	4,293	4.4	1.22
2008	180.3[2]	2.2	4,296	0.1	1.22
2009	202.6	12.4	4,721	9.9	1.41
2010	209.7	3.5	4,779	1.2	1.40
2011	221.7	5.7	4,936	3.3	1.43
2012	236.5	6.7	5,090	3.1	1.46
2013	243.8	3.1	5,092	0.0	1.45
Intermediate estimates:					
2014	260.1	6.7	5,270	3.5	1.48
2015	265.9	2.2	5,234	−0.7	1.44
2016	280.3	5.4	5,366	2.5	1.45
2017	299.5	6.8	5,575	3.9	1.47
2018	322.4	7.7	5,838	4.7	1.50
2019	348.3	8.0	6,134	5.1	1.54
2020	378.3	8.6	6,479	5.6	1.60
2021	409.8	8.3	6,829	5.4	1.65
2022	443.9	8.3	7,197	5.4	1.71
2023	480.1	8.2	7,578	5.3	1.77

[1]See footnote 6 of table III.C4.
[2]See footnote 7 of table III.C4.

The projected Part B per capita benefits reflect an assumed legislative override of the estimated physician payment update of −20.8 percent that would occur in April 2015 under the sustainable growth rate system (SGR). Instead of −20.8 percent, the physician payment update of 0.0 percent established for January through March 2015 is assumed for the remainder of 2015, and an update of 0.6 percent per year is assumed for each year thereafter under the projected baseline scenario, which is shown throughout this report. The Part B expenditure growth rates in 2013-2024 are also affected by the sequestration of Medicare benefits required under current law. Projected Part B costs continue to increase faster than GDP in most years, as indicated in table III.C5.

The Trustees have also prepared estimates under the projected baseline scenario using two alternative sets of assumptions. Table III.C6 summarizes the estimated operations of the Part B account for all three alternatives. Section IV.B1 presents in substantial detail the assumptions underlying the intermediate

assumptions, as well as the assumptions used in preparing estimates under the low-cost and high-cost alternatives.

Table III.C6.—Estimated Operations of the Part B Account in the SMI Trust Fund during Calendar Years 2013-2023, under Alternative Sets of Assumptions

[Dollar amounts in billions]

Calendar year	Premiums from enrollees	Other income[1]	Total income	Total expenditures	Balance in fund at end of year	Expenditures as a percent of GDP
Intermediate:						
2013[2]	$63.1	$191.9	$255.0	$247.1	$74.1	1.47%
2014	65.6	194.4	260.1	262.8	71.4	1.49
2015	70.3[3]	208.3[3]	278.6	268.9	81.1	1.46
2016	69.0[3]	204.8[3]	273.8	283.6	71.3	1.46
2017	78.5	229.3	307.9	303.0	76.2	1.48
2018	85.6	246.5	332.1	326.2	82.1	1.52
2019	93.5	265.2	358.7	352.3	88.5	1.56
2020	103.0[3]	300.0[3]	402.9	382.5	108.9	1.61
2021	104.4[3]	303.5[3]	407.9	414.3	102.5	1.67
2022	117.4	339.4	456.8	448.7	110.6	1.73
2023	127.5	367.4	494.9	485.2	120.4	1.79
Low-cost:						
2013[2]	63.1	191.9	255.0	247.1	74.1	1.47
2014	65.6	194.6	260.2	260.7	73.6	1.46
2015	70.3[3]	207.6[3]	277.9	266.8	84.7	1.40
2016	68.0[3]	202.7[3]	270.7	282.1	73.3	1.38
2017	76.9	225.7	302.6	300.5	75.4	1.37
2018	83.9	242.0	325.9	320.7	80.6	1.37
2019	91.1	258.5	349.5	343.8	86.3	1.38
2020	99.5[3]	290.2[3]	389.7	370.6	105.4	1.40
2021	100.0[3]	291.4[3]	391.4	398.0	98.8	1.42
2022	111.5	323.3	434.8	427.9	105.7	1.44
2023	120.3	347.7	468.0	459.4	114.3	1.46
High-cost:						
2013[2]	63.1	191.9	255.0	247.1	74.1	1.47
2014	65.6	194.3	260.0	263.6	70.5	1.52
2015	70.3[3]	208.5[3]	278.8	269.4	79.9	1.51
2016	69.8[3]	206.5[3]	276.3	284.6	71.7	1.55
2017	79.3	231.2	310.5	305.3	76.9	1.60
2018	86.8	249.7	336.6	330.2	83.2	1.67
2019	95.5	270.2	365.7	358.8	90.2	1.75
2020	106.1[3]	308.5[3]	414.6	392.7	112.1	1.85
2021	108.7[3]	315.3[3]	424.0	429.4	106.6	1.95
2022	123.3	355.4	478.7	469.8	115.5	2.06
2023	135.1	388.3	523.4	512.6	126.3	2.18

[1]Other income contains government contributions, fees on manufacturers and importers of brand-name prescription drugs, and interest.
[2]Figures for 2013 represent actual experience.
[3]See footnote 8 of table III.C4.

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

These alternatives provide two possible Part B scenarios but represent a narrow range of possible outcomes for total expenditures. Given the considerable variation in future demographic, economic, and healthcare-usage factors, actual Part B experience could easily fall outside of this range. The low- and high-cost scenarios in this year's report result in a narrower dollar range than in previous years,

due to a change in the alternative assumptions from last year.[45] The GDP assumptions for the alternative scenarios are also affected by the assumption change. Therefore, spending as a percent of GDP provides better insight into the variability of spending than the nominal dollar amounts, as shown in table III.C6.

The alternative projections shown in table III.C6 illustrate two important aspects of the financial operations of the Part B account:

- Despite the differing assumptions underlying the three alternatives, the balance between Part B income and expenditures remains relatively stable. This result occurs because the Secretary of Health and Human Services annually reestablishes the premiums and general revenue contributions underlying Part B financing to cover each year's anticipated incurred benefit costs and other expenditures and then increases these amounts by a margin that reflects the uncertainty of the projection. Thus, Part B income will automatically track Part B expenditures fairly closely, regardless of the specific economic and other conditions.

- As a result of the close matching of income and expenditures described above, projected account assets show similar, stable patterns of change under all three sets of assumptions.

Adequacy of Part B Financing Established for Calendar Year 2014

The traditional concept of financial adequacy, as it applies to Part B, is closely related to the concept as it applies to many private group insurance plans. Part B is somewhat similar to private yearly renewable term insurance, with financing established each year based on estimated costs for the year. For Part B, premium income paid by the enrollees and general revenues contributed by the Federal Government provide financing. As with private plans, the income during a 12-month period for which financing is being established should be sufficient to cover the costs of services expected to be rendered during that period (including associated administrative costs), even though payment for some of these services will not occur until after the period closes. The portion of income required to cover those benefits not paid until after the end of the year is added to the

[45]The Trustees' alternative CPI assumptions are reversed in this year's report compared with those in previous reports, so that the high-cost assumptions in the 2013 report are now the low-cost assumptions for this year's report, and vice versa. Inflation rates are now ordered across alternatives according to their effect on the OASDI actuarial balance. This change resulted in a narrow range of impacts.

account; thus assets in the account at any time should not be less than the costs of the benefits and the administrative expenses incurred but not yet paid.

Since the Secretary of Health and Human Services establishes the income per enrollee (premium plus government contribution) prospectively each year, it is subject to projection error. Additionally, legislation enacted after the financing has been established, but effective for the period for which financing has been set, may affect costs. Account assets, therefore, should be maintained at a level that is adequate to cover not only the value of incurred-but-unpaid expenses but also a reasonable degree of variation between actual and projected costs (in case actual costs exceed projected).

The Trustees traditionally evaluate the actuarial status or financial adequacy of the Part B account over the period for which the enrollee premium rates and level of general revenue financing have been established. The primary tests are that (i) the assets and income for years for which financing has been established should be sufficient to meet the projected benefits and associated administrative expenses incurred for that period; and (ii) the assets should be sufficient to cover projected liabilities for benefits that have not yet been paid as of the end of the period. If Part B does not meet these adequacy tests, it can still continue to operate if the account remains at a level adequate to permit the payment of claims as presented. However, to protect against the possibility that costs will be higher than assumed, assets should be sufficient to include contingency levels that cover a reasonable degree of variation between actual and projected costs.

As noted above, the tests of financial adequacy for Part B rely on the incurred experience of the account, including a liability for the costs of services performed in a year but not yet paid. Table III.C7 shows the estimated transactions of the account on an incurred basis. Readers should view the incurred experience as an estimate, even for historical years.[46]

[46]Part B experience is substantially more difficult to determine on an incurred basis than on a cash basis. For some services, reporting of payment occurs only on a cash basis, and it is necessary to infer the incurred experience from the cash payment information. Moreover, for recent time periods the tabulations of bills are incomplete due to normal processing time lags.

Table III.C7.—Estimated Part B Income and Expenditures (Incurred Basis) for Financing Periods through December 31, 2014

[In millions]

	Income				Expenditures			
Financing period	Premium income	General revenue	Interest and other	Total	Benefit payments	Adminis-trative expenses	Total	Net operations in year
Historical data:								
12-month period ending June 30,								
1970	$936	$936	$12	$1,884	$1,928	$213	$2,141	−$257
1975	1,887	2,396	105	4,388	3,957	438	4,395	−7
1980	2,823	6,627	421	9,871	9,840	645	10,485	−614
Calendar year								
1985	5,613	18,243	1,248	25,104	22,750	986	23,736	1,368
1990	11,320	33,035	1,558	45,913	42,577	1,541	44,118	1,795
1995	19,717	45,743	1,739	67,199	64,923	1,607	66,531	668
2000	20,555	65,898	3,450	89,903	91,059[1]	1,770	92,828	−2,925
2005	37,535	118,091	1,365	156,992	151,416	3,185	154,601	2,390
2006	42,853	132,673	1,791	177,317	167,014	3,062	170,075	7,242
2007	46,773	148,717[2]	2,238	197,728	177,463	2,492	179,955	17,773
2008	50,232	137,731[2]	3,591	191,554	180,587	2,990	183,577	7,977
2009	52,376	151,944	3,084	207,403	202,647	3,135	205,782	1,621
2010	55,649	164,302	3,281	223,232	211,616	3,153	214,769	8,462
2011	57,514	170,224	5,867	233,605	222,131	3,609	225,740	7,865
2012	58,024	163,827	5,164	227,015	236,697	3,947	240,644	−13,628
2013	63,085	185,815	6,068	254,967	243,685	3,280	246,965	8,002
Intermediate estimates:								
2014	65,633	188,445	5,996	260,073	260,503	2,726	263,230	−3,156

[1] See footnote 6 of table III.C4.

[2] A July 1, 2008 general revenue transfer was made in the amount of $9.3 billion to restore the Part B account assets for hospice benefit accounting errors that occurred from 2005 through September 2007. An estimated $9.1 billion was due but unpaid by the end of 2007 when the error was discovered, and an additional estimated $0.2 billion in interest accrued until July 1, 2008 when the corrective payment was made.

Estimates of the liability amounts for benefits incurred but unpaid as of the end of each financing period, and of the administrative expenses related to processing these benefits, appear in table III.C8. In some years, account assets have not been as large as liabilities. Nonetheless, the fund has remained positive, which has allowed payment of all claims.

Table III.C8.—Summary of Estimated Part B Assets and Liabilities as of the End of the Financing Period, for Periods through December 31, 2014

[Dollar amounts in millions]

	Balance in trust fund	General revenue due but unpaid	Total assets	Benefits incurred but unpaid	Administrative costs incurred but unpaid	Total liabilities	Excess of assets over liabilities	Ratio[1]
Historical data:								
As of June 30,								
1970	$57	$15	$72	$567	—	$567	−$495	−0.21
1975	1,424	67	1,491	1,257	$14	1,271	—	0.04
1980	4,657	—	4,657	2,621	188	2,809	1,848	0.15
As of December 31,								
1985	10,924	—	10,924	3,142	−38	3,104	7,820	0.28
1990	15,482	—	15,482	4,060	20	4,080	11,402	0.24
1995	13,130	6,893[2]	20,023	4,298	−214	4,084	15,939	0.23
2000	44,027	—	44,027	8,715	−285	8,430	35,597	0.35
2001	41,269	—	41,269	9,721	0	9,721	31,549	0.28
2002	34,301	—	34,301	9,386	0	9,386	24,915	0.20
2003	23,953	—	23,953	9,688	0	9,688	14,266	0.10
2004	19,430	—	19,430	11,330	0	11,330	8,100	0.05
2005	24,008	—	24,008	13,518	0	13,518	10,490	0.06
2006	32,325	—	32,325	14,593	0	14,593	17,732	0.10
2007	42,062	9,296[3]	51,358	15,626	0	15,626	35,732	0.19
2008	59,382	—	59,382	15,900	0	15,900	43,482	0.21
2009	75,545	—	75,545	15,962	0	15,962	59,583	0.28
2010	71,435	—	71,435	17,870	0	17,870	53,565	0.24
2011	79,882	—	79,882	18,175	0	18,175	61,707	0.26
2012	68,093	—	68,093	18,268	0	18,268	49,825	0.20
2013	74,259	—	74,259	18,386	0	18,386	55,873	0.22
Intermediate estimates:								
2014	71,466	—	71,466	18,722	0	18,722	52,744	0.20

[1]Ratio of the excess of assets over liabilities to the following year's total incurred expenditures.

[2]This amount includes both the principal of $6,736 million and the accumulated interest through December 31, 1995 for the shortfall in the fiscal year 1995 appropriation for government contributions. Normally, this transfer would have occurred on December 31, 1995, and the trust fund balance would have reflected it. However, due to absence of funding, there was a delay in the transfer of the principal and the appropriate interest until March 1, 1996.

[3]Part B erroneously paid certain Part A benefits from 2005 through September 2007. Therefore, on July 1, 2008 the Part B account of the SMI trust fund received a general revenue transfer of $9,296 million to restore the Part B account. Beginning in 2007, the year in which the errors were discovered, the table shows these amounts to be repaid to the Part B account. The 2007 amount shown includes both the estimated principal of $8,484 million and the estimated accumulated interest through December 31, 2007.

The amount of assets minus liabilities, compared with the estimated incurred expenditures for the following calendar year, forms a relative measure of the Part B account's financial status. The last column in table III.C8 shows such ratios for past years and the estimated ratio at the end of 2014. Actuarial analysis has indicated that a ratio of roughly 15-20 percent is sufficient to protect against unforeseen contingencies, such as unusually large increases in Part B expenditures.

The Secretary of Health and Human Services established Part B financing through December 31, 2014. Estimated incurred expenditures exceed estimated income in 2014, as shown in table III.C7. The excess of assets over liabilities decreases by an

estimated $3 billion by the end of December 2014, as indicated in table III.C8. This decrease occurs because 2014 Part B financing was set at a level that would intentionally reduce the contingency reserve.

Since the financing rates are set prospectively, variations between assumed cost increases and subsequent actual experience could affect the actuarial status of the Part B account. To test the status of the account under varying assumptions, the Trustees prepared a lower-growth-range projection and an upper-growth-range projection by varying the key assumptions for 2013 and 2014. These two alternative sets of assumptions provide a range of financial outcomes within which one might reasonably expect the actual experience of Part B to fall under current law. The values for the lower- and upper-growth-range assumptions were determined from a statistical analysis of the historical variation in the respective increase factors.

This sensitivity analysis differs from the low-cost and high-cost projections discussed previously in this section in that this analysis examines the variation in the projection factors in the period for which the financing has been established (2014 for this report). The low-cost and high-cost projections, on the other hand, illustrate the financial impact of slower or faster growth trends throughout the short-range projection period.

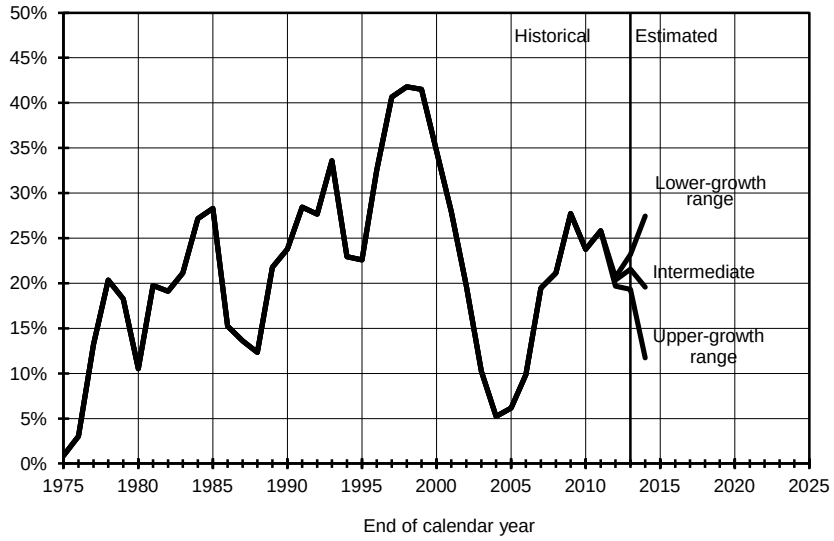
Table III.C9 indicates that, under the lower-growth-range scenario, account assets would exceed liabilities at the end of December 2014 by a margin equivalent to 27.5 percent of the following year's incurred expenditures. Under the upper-growth-range scenario, account assets would still exceed liabilities, but by a margin of 11.7 percent of incurred expenditures in 2014. Under either scenario, assets would be sufficient to cover outstanding liabilities. Figure III.C3 shows the reserve ratio for historical years and for 2014 under the three cost growth scenarios.

Table III.C9.—Actuarial Status of the Part B Account in the SMI Trust Fund under Three Cost Sensitivity Scenarios for Financing Periods through December 31, 2014

As of December 31,	2012	2013	2014
Intermediate scenario:			
Actuarial status (in millions)			
Assets	$68,093	$74,259	$71,466
Liabilities	18,268	18,386	18,722
Assets less liabilities	49,825	55,873	52,744
Ratio[1]	20.4%	21.5%	19.6%
Lower-range scenario:			
Actuarial status (in millions)			
Assets	$68,093	$74,259	$83,427
Liabilities	18,268	18,028	17,410
Assets less liabilities	49,825	56,232	66,017
Ratio[1]	20.7%	23.2%	27.5%
Upper-range scenario:			
Actuarial status (in millions)			
Assets	$68,093	$74,259	$55,716
Liabilities	18,268	19,220	20,432
Assets less liabilities	49,825	55,039	35,283
Ratio[1]	19.7%	19.3%	11.7%

[1]Ratio of assets less liabilities at the end of the year to the total incurred expenditures during the following year, expressed as a percent.

Figure III.C3.—Actuarial Status of the Part B Account in the SMI Trust Fund through Calendar Year 2014



Note: The Trustees measure the actuarial status of the Part B account in the SMI trust fund by the ratio of (i) assets minus liabilities at the end of the year to (ii) the following year's incurred expenditures.

Based on the tests described above, the Trustees conclude that the financing established for the Part B account for calendar year 2014 is adequate to cover 2014 expected expenditures and to maintain the

financial status of the Part B account in 2014 at a satisfactory level under current law.

3. Long-Range Estimates

The prior section presented the expected operations of the Part B account over the next 10 years. This section examines the long-range expenditures of the account under the intermediate assumptions of the projected baseline scenario. Due to its automatic financing provisions, the Trustees expect the Part B account to be adequately financed into the indefinite future and so have not conducted a long-range analysis using high-cost and low-cost assumptions.

Table III.C10 shows the estimated Part B incurred expenditures under the intermediate assumptions of the projected baseline scenario expressed as a percentage of GDP for selected years over the calendar-year period 2013-2088.[47] The 75-year projection period fully allows for the presentation of future trends that one may reasonably expect to occur, such as the impact of the large increase in enrollees as the baby boom generation begins to receive benefits.

Table III.C10.—Part B Expenditures (Incurred Basis) as a Percentage of the Gross Domestic Product[1]

Calendar year	Part B expenditures as a percentage of GDP
2013	1.47%
2014	1.50
2015	1.46
2016	1.47
2017	1.49
2018	1.53
2019	1.57
2020	1.62
2021	1.68
2022	1.74
2023	1.80
2025	1.97
2030	2.24
2035	2.42
2040	2.53
2045	2.60
2050	2.66
2055	2.73
2060	2.82
2065	2.90
2070	2.99
2075	3.06
2080	3.09
2085	3.13

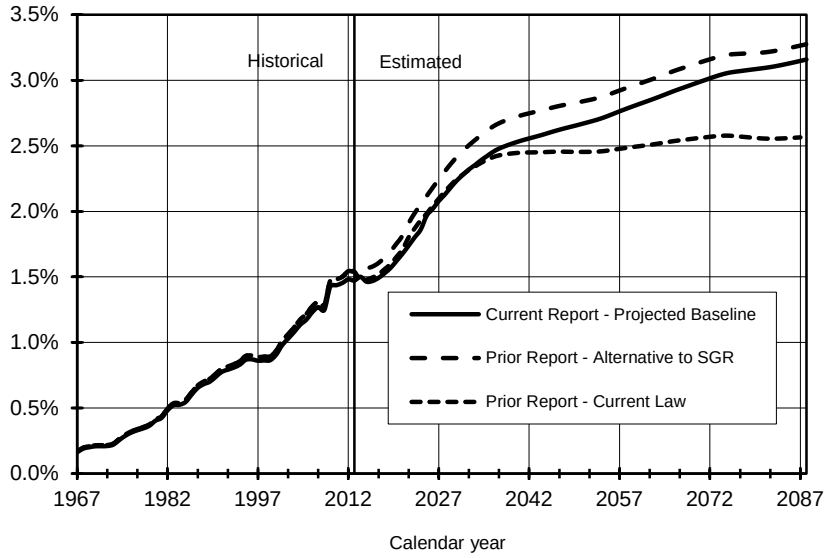
[1]Expenditures are the sum of benefit payments and administrative expenses.

[47]These estimated incurred expenditures are for benefit payments and administrative expenses combined, unlike the values in table III.C5, which express only benefit payments on a cash basis as a percentage of GDP.

Sections II.C and IV.D describe the basis for the long-range assumptions. Based on these assumptions and the projected demographic changes, incurred Part B expenditures as a percentage of GDP would increase from 1.47 percent in 2013 to 3.16 percent in 2088. Part B expenditures would instead increase to 2.58 percent and 3.22 percent in 2088 under current law and the illustrative alternative scenario, respectively.

Figure III.C4 compares (i) the year-by-year Part B expenditures as a percentage of GDP for the 2014 report under the projected baseline scenario with (ii) the projections from the 2013 report under current law and (iii) the projections from the 2013 report under the "alternative to SGR" scenario. As indicated, the costs shown in this year's report are somewhat higher than the current-law costs shown in the 2013 annual report due to the change in assumptions regarding future physician updates. The expenditures under the projected baseline scenario in this report are lower than those under the comparable "alternative to SGR" scenario associated with the 2013 report due to several factors, including lower-than-estimated spending for 2012 and 2013 and lower payment updates.

Figure III.C4.—Comparison of Part B Projections as a Percentage of the Gross Domestic Product: Current versus Prior Year's Reports



D. PART D FINANCIAL STATUS

The Medicare Modernization Act, enacted on December 8, 2003, established within SMI two Part D accounts related to prescription

drug benefits: the Medicare Prescription Drug Account and the Transitional Assistance Account. The Medicare Prescription Drug Account handles the financial transactions for the prescription drug benefits that commenced in 2006. The purpose of the Transitional Assistance Account was to provide transitional assistance benefits, beginning in 2004 and extending through 2005, for certain low-income beneficiaries prior to the start of the new prescription drug benefit. For simplicity, this report combines both accounts and refers to them as the Part D account.

The Medicare prescription drug benefit is significantly different from the HI and SMI Part B fee-for-service benefits. Beneficiaries obtain the drug benefit by voluntarily purchasing insurance policies from private stand-alone drug plans or private Medicare Advantage health plans. Medicare heavily subsidizes the premiums established by these plans. In addition, Medicare pays some or all of the remaining beneficiary drug premiums and cost-sharing liabilities for low-income beneficiaries. Medicare also pays special subsidies on behalf of beneficiaries retaining primary drug coverage through retiree drug subsidy (RDS) plans. General revenues primarily finance the various Medicare drug subsidies. In addition, special payments from State governments finance a declining portion of the subsidy costs associated with beneficiaries who also qualify for full Medicaid benefits. Beneficiaries may have their drug insurance premiums withheld from their Social Security benefits, if they wish, and then forwarded to the drug plans on their behalf.[48] In 2013, around 28 percent of the non-low-income enrollees in Part D drug plans exercised this option.

1. Financial Operations in Calendar Year 2013

The total assets of the account amounted to $1.0 billion on December 31, 2012. During calendar year 2013, total Part D expenditures were approximately $69.7 billion. General revenue was provided on an as-needed basis to cover the portion of these expenditures supported through Medicare subsidies. Total Part D receipts were $69.7 billion. As a result, total assets in the Part D account remained at $1.0 billion as of December 31, 2013.

Table III.D1 presents a statement of the revenue and expenditures of the Part D account of the SMI trust fund in calendar year 2013, and of its assets at the beginning and end of the calendar year.

[48]The Part D income-related premium adjustment amount for each beneficiary is deposited into the Part D account.

Table III.D1—Statement of Operations of the Part D Account in the SMI Trust Fund during Calendar Year 2013

[In thousands]

Total assets of the Part D account in the trust fund, beginning of period ..		$999,858
Revenue:		
Premiums from enrollees:		
Premiums deducted from Social Security benefits	$3,208,722	
Premiums paid directly to plans[1]	6,719,863	
Total premiums		9,928,585
Government contributions:		
Prescription drug benefits	50,586,571	
Prescription drug administrative expenses	371,586	
Total government contributions		50,958,157
Payments from States		8,775,818
Interest on investments		8,041
Total revenue		$69,670,601
Expenditures:		
Part D benefit payments[1]		$69,305,831
Part D administrative expenses		371,586
Total expenditures		$69,677,417
Net addition to the trust fund		−6,817
Total assets of the Part D account in the trust fund, end of period		$993,041

[1]Premiums paid directly to plans are not displayed on Treasury statements and are estimated. These premiums have been added to the benefit payments reported on the Treasury statement to obtain an estimate of total Part D benefits. Direct data on such benefit amounts are not yet available.

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

a. Revenues

The major sources of revenue for the Part D account are (i) contributions of the Federal Government authorized to be apportioned and transferred from the general fund of the Treasury; (ii) premiums paid by eligible persons who voluntarily enroll; and (iii) contributions from the States.

Of the total Part D revenue, $3.2 billion represented premium amounts withheld from Social Security benefits or other Federal benefit payments. Total premium payments, including those paid directly to the Part D plans, amounted to an estimated $9.9 billion or 14.3 percent of total revenue.

In calendar year 2013, contributions received from the general fund of the Treasury amounted to $51.0 billion, which accounted for 73.1 percent of total revenue.

With the availability of Part D drug coverage and low-income subsidies beginning in 2006, Medicaid is no longer the primary payer of drug costs for full-benefit dually eligible beneficiaries. States are subject to a contribution requirement and must pay the Part D account in the SMI trust fund a portion of their estimated forgone drug costs for this population. Starting in 2006, States must pay

90 percent of the estimated costs; this percentage phases down over a 10-year period to 75 percent in 2015. For calendar year 2013, these State payments amounted to $8.8 billion.

Another source of Part D revenue is interest received on investments held by the Part D account. Since this account holds only a very low amount of assets, and only for brief periods of time, the interest on the investments of the account in calendar year 2013 was negligible ($8 million).

b. Expenditures

Part D expenditures include both the costs of prescription drug benefits provided by Part D plans to enrollees and Medicare payments to RDS plans on behalf of beneficiaries who obtain their primary drug coverage through such plans. Unlike Parts A and B of Medicare, the Part D account in the SMI trust fund does not directly make or support all Part D expenditures. In particular, enrollee premiums that are paid directly to Part D plans, and thus do not flow through the Part D account, finance a portion of these expenditures. However, these premium amounts are included in the Part D account operations (both income and expenditures) presented in this report. Total expenditures are characterized as either benefits (representing the gross cost of enrollees' prescription drug coverage plus RDS amounts) or Federal administrative expenses.

All expenses incurred by the Department of Health and Human Services, the Social Security Administration, and the Department of the Treasury in administering Part D are charged to the account. Such administrative duties include making payments to Part D plans, the fraud and abuse control activities, and experiments and demonstration projects designed to improve the quality, efficiency, and economy of health care services.

In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of Part D. The account expenditures include such costs. However, the statement of Part D assets presented in this report does not carry the net worth of facilities and other fixed capital assets, because the value of fixed capital assets does not represent funds available for benefit or administrative expenditures and is not, therefore, pertinent in assessing the actuarial status of the funds.

Of the $69.7 billion in total Part D expenditures, $69.3 billion represented benefits, as defined above, and the remaining $0.4 billion was for Federal administrative expenses. (The Medicare direct premium subsidy and reinsurance subsidy, together with enrollee premiums, implicitly cover administrative expenses incurred by Part D plans.)

c. Actual experience versus prior estimates

Table III.D2 compares the actual experience in calendar year 2013 with the estimates presented in the 2012 and 2013 annual reports. A number of factors can contribute to differences between estimates and subsequent actual experience. In particular, actual values for key economic and other variables can differ from assumed levels, and lawmakers may adopt legislative and regulatory changes after a report's preparation. Actual Part D benefit costs in calendar year 2013 were somewhat lower than those projected last year and about 12 percent lower than the projection from the 2012 report. Premium revenues were about the same as estimated in 2013 and about 7 percent lower than estimated in 2012. Actual benefit payments were somewhat lower than projected in the 2013 report, in part due to the higher risk receipts from the plans and the timing of the reconciliation payments for 2012. The lower actual experience as compared with prior estimates from the 2012 report reflected the larger-than-expected impact from the patent expiration for some high-cost drugs and the continual shift from brand-name to generic drugs. Part D revenue from State transfers in 2013 was 2 percent above the projection from last year and about 1 percent lower than estimated in the 2012 Trustees Report.

Table III.D2.—Comparison of Actual and Estimated Operations of the Part D Account in the SMI Trust Fund, Calendar Year 2013

[Dollar amounts in millions]

		Comparison of actual experience with estimates for calendar year 2013 published in:			
		2013 report		2012 report	
Item	Actual amount	Estimated amount[1]	Actual as a percentage of estimate	Estimated amount[1]	Actual as a percentage of estimate
Premiums from enrollees	$9,929	$9,935	100%	$10,716	93%
State transfers	8,776	8,575	102	8,865	99
Government contributions	50,958	53,401	95	59,830	85
Benefit payments	69,306	71,831	96	78,955	88

[1]Under the intermediate assumptions.

d. Assets

The Department of Treasury invests the portion of the Part D account not needed to meet current expenditures for benefits and

administration in interest-bearing obligations of the U.S. Government.

The Social Security Act authorizes the issuance of special public-debt obligations for purchase exclusively by the account. The law requires that these special public-debt obligations shall bear interest at a rate based on the average market yield (computed on the basis of market quotations as of the end of the calendar month immediately preceding the date of such issue) for all marketable interest-bearing obligations of the United States forming a part of the public debt that are not due or callable until after 4 years from the end of that month. Since the inception of the SMI trust fund, the Department of Treasury has always invested the assets in special public-debt obligations.[49] Table V.H10, presented in appendix H, shows the assets of the SMI trust fund (Parts B and D) at the end of fiscal years 2012 and 2013.

As explained in the following section, the flexible apportionment of general revenues for Part D eliminates the need to maintain a contingency reserve. As a result, Part D assets are very low and are held only briefly in anticipation of immediate expenditures.

2. 10-Year Actuarial Estimates (2014-2023)

The projected future operations of the Part D account are based on the Trustees' economic and demographic assumptions, as detailed in the OASDI Trustees Report, as well as other assumptions unique to Part D. Section IV.B2 presents an explanation of the effects of the Trustees' intermediate assumptions, and of the other assumptions unique to Part D, on the estimates in this report. This section presents estimates of the trust fund's operations and financial status for the next 10 years. The next section discusses the long-range actuarial status of the trust fund. In both this and the following section, the projections shown are under the projected baseline scenario.[50]

Generally, the income to the Part D account includes the beneficiary premiums described above and transfers from the general fund of the

[49]The Department of Treasury may also make investments in obligations guaranteed for both principal and interest by the United States, including certain federally sponsored agency obligations.

[50]There are only minor differences between this scenario and current law due to the small modifications in the IPAB operations. The projected baseline reflects a 0.6-percent physician payment update, resulting in slightly different IPAB operations under this scenario and current law, since the Trustees assume that reductions in spending recommended by the IPAB are spread proportionately across Parts A, B, and D.

Treasury to cover each year's incurred benefit costs and other expenditures. The language that has generally been included in the Part D appropriation provides, without further Congressional action, resources for benefit payments under the Part D drug benefit program on an as-needed basis.[51] The transfers from the Treasury are based on the direct premium subsidy, amounts of reinsurance payments, RDS amounts, low-income subsidies, net risk-sharing payments, administrative expenses, and advanced discount payments. This income requirement is reduced by the anticipated State transfers for the full-benefit dually eligible beneficiaries who used to be covered under Medicaid.

The beneficiary premiums and direct subsidy rate are calculated based on the national average bid amounts and defined prior to each year's operations, with the average premium amounting to 25.5 percent of the expected total plan costs for basic coverage. Beginning in 2011, beneficiaries with modified adjusted gross incomes exceeding a specified threshold pay income-related premiums in addition to the premiums charged by the plans in which the individuals have enrolled. The extra premiums are credited to the Part D trust fund account and reduce the general fund financing amounts. Also starting in 2011, the drug manufacturers provide a 50-percent ingredient cost discount for brand-name drugs in the coverage gap that reduces beneficiary out-of-pocket expenses. Medicare Part D pays advanced discount payments prospectively to the non-employer Part D plans and will be reimbursed for these amounts once the plans receive the discounts from the drug manufacturers.

Expenditures from the account include the premiums withheld from beneficiaries' Social Security or other Federal benefit payments and transferred to the private drug plans, the direct premium subsidy payments, reinsurance payments, RDS amounts, low-income subsidy payments, risk-sharing payments, administrative expenses, and advanced discount payments. As noted previously, the Trustees adjust these direct expenditures to include the amount of enrollee premiums paid directly to Part D plans, thereby providing an estimate of total Part D benefit payments and other expenditures.

Projected Part D expenditures on direct premium subsidy payments, retiree drug subsidy amounts, advanced discount payments, and

[51]The private Part D drug insurance plans maintain contingency reserves for incurred-but-unpaid claims and for the possibility that actual costs will exceed plan estimates. The statutory risk-sharing arrangement between Part D and the drug insurance plans mitigates this latter financial risk.

administrative expenses are affected by the sequestration of Medicare expenditures required by current law. The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2023, by 2.9 percent from April 1, 2023 through September 30, 2023, by 1.1 percent from October 1, 2023 through March 31, 2024, and by 4 percent from April 1, 2024 through September 30, 2024. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2024.

Table III.D3 shows the estimated operations of the Part D account under the intermediate assumptions on a calendar-year basis through 2023.

Table III.D3.—Operations of the Part D Account in the SMI Trust Fund (Cash Basis) during Calendar Years 2004-2023

[In billions]

	Income					Expenditures			Account	
Calendar year	Premium income[1]	General revenue[2]	Transfers from States[3]	Interest and other	Total	Benefit payments[4]	Administrative expense	Total	Net change	Balance at end of year[5]
Historical data:										
2004	—	$0.4	—	—	$0.4	$0.4	—	$0.4	—	—
2005	—	1.0	—	—	1.0	1.1	—	1.1	−0	−0
2006	$3.5	39.2	$5.5	$0.0	48.2	47.1	$0.3	47.4	$0.8	$0.8
2007	4.1	38.8	6.9	0.0	49.7	48.8	0.9	49.7	0.0	0.8
2008	5.0	37.3	7.1	0.0	49.4	49.0	0.3	49.3	0.1	0.9
2009	6.3[6]	47.1	7.6	0.0	61.0	60.5	0.3	60.8	0.1	1.1
2010	6.5[6]	51.1	4.0	0.0	61.7	61.7	0.4	62.1	−0.4	0.7
2011	7.7	52.6	7.1	0.0	67.4	66.7	0.4	67.1	0.3	1.0
2012	8.3	50.1	8.4	0.0	66.9	66.5	0.4	66.9	0.0	1.0
2013	9.9	51.0	8.8	0.0	69.7	69.3	0.4	69.7	0.0	1.0
Intermediate estimates:										
2014	11.6	59.2	8.3	0.0	79.1	79.0	0.4	79.4	−0.3	0.7
2015	13.6[6]	64.5	8.5	0.0	86.7	86.3	0.4	86.7	0.0	0.7
2016	15.4[6]	70.0	9.1	0.0	94.5	94.0	0.4	94.5	0.1	0.8
2017	17.7	75.2	9.8	0.0	102.6	102.1	0.4	102.6	0.1	0.8
2018	19.6	81.8	10.6	0.0	112.0	111.4	0.5	111.9	0.1	0.9
2019	21.7	89.2	11.5	0.0	122.4	121.9	0.5	122.3	0.1	1.0
2020	23.8[6]	97.9	12.5	0.0	134.1	133.5	0.5	134.0	0.1	1.1
2021	25.3[6]	106.7	13.5	0.0	145.5	144.9	0.5	145.4	0.1	1.1
2022	28.0	115.5	14.7	0.0	158.3	157.6	0.5	158.2	0.1	1.2
2023	30.6	125.2	16.0	0.0	171.8	171.2	0.6	171.7	0.1	1.4

[1]Premiums include both amounts withheld from Social Security benefits or other Federal payments and those paid directly to Part D plans.

[2]Includes, net of transfers from States, all government transfers required to fund benefit payments, administrative expenses, and State expenses for making low-income eligibility determinations.

[3]Payments from States with respect to the Federal assumption of Medicaid responsibility for drug expenditures for full-benefit dually eligible individuals.

[4]Includes payments to Part D plans, payments to retiree drug subsidy plans, payments to States for making low-income eligibility determinations, Part D drug premiums collected from beneficiaries, and transfers to Medicare Advantage plans and private drug plans. Includes amounts for the Transitional Assistance program of $0.2, $1.1, and $0.2 billion in 2004-2006, respectively.

[5]See text concerning the nature of the general revenue allocations process and the implications for contingency reserve assets.

[6]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of those benefits normally due January 3, 2010 actually occurred on December 31, 2009; consequently, the Part D premiums withheld from these benefits were added to the Part D account on December 31, 2009. The premium income for 2010 excludes this amount. Similarly, the expected payment date for those benefits normally due January 3, 2016 is December 31, 2015, and the expected date for those benefits normally due January 3, 2021 is December 31, 2020.

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

Table III.D4 shows prescription drug payment amounts in the aggregate, on a per capita basis, and relative to the Gross Domestic Product (GDP). It also shows rates of growth for the next 10 years based on the intermediate set of assumptions.

Over the past 7 years, Part D expenditures have increased by an annual rate of 5.7 percent in aggregate and only 0.5 percent on a per enrollee basis. These results reflect the rapid growth in enrollment as the new program began, together with a substantial increase in the

proportion of prescriptions filled with low-cost generic drugs and patent expiration for some major drugs in 2012.

Table III.D4.—Growth in Part D Benefits (Cash Basis) through December 31, 2023

Calendar year	Aggregate benefits [billions]	Percent change	Per capita benefits	Percent change	Part D benefits as a percentage of GDP
Historical data:					
2004	$0.4	—	$362	—	0.00%
2005	1.1	—	596	—	0.01
2006	47.1	—	1,708	—	0.34
2007	48.8	3.7%	1,556	−8.9%	0.34
2008	49.0	0.4	1,504	−3.3	0.33
2009[1]	60.5	23.4	1,798	19.6	0.42
2010[1]	61.7	2.0	1,775	−1.3	0.41
2011	66.7	8.1	1,868	5.3	0.43
2012	66.5	−0.4	1,777	−4.9	0.41
2013	69.3	4.3	1,773	−0.3	0.41
Intermediate estimates:					
2014	79.0	14.0	1,943	9.6	0.45
2015[1]	86.3	9.1	2,044	5.2	0.47
2016[1]	94.0	9.0	2,150	5.2	0.49
2017	102.1	8.6	2,253	4.8	0.50
2018	111.4	9.1	2,391	6.1	0.52
2019	121.9	9.3	2,541	6.3	0.54
2020[1]	133.5	9.6	2,704	6.4	0.56
2021[1]	144.9	8.5	2,853	5.5	0.58
2022	157.6	8.8	3,017	5.8	0.61
2023	171.2	8.6	3,188	5.7	0.63

[1]See footnote 6 of table III.D3.

The per capita drug cost growth rate is expected to exceed the rate of increase in other categories of medical spending due to an expected slowing of the trend toward greater generic usage and an increase in the use and price of specialty drugs. The relatively rapid projected aggregate cost growth reflects the expected per capita cost increase and also includes projected increases in Part D enrollment as well as changes in the distribution of enrollees by coverage category. Over the next 10 years, aggregate benefits are projected to increase at 9.5 percent annually, on average, while the per enrollee rate is 6.0 percent, as shown in table III.D4.

The payment structure of the Part D program causes the somewhat volatile pattern of annual growth rates; prospective payments to the plans are made based on the plan bids and then reconciled with actual prescription drug expenditures after the end of the year. For example, since actual prescription drug expenditures in 2006 were substantially less than the plan bids, the plans owed the Part D program over $4 billion in the form of risk-sharing returns and reimbursement of overpayments for reinsurance and low-income subsidy capitation amounts. These reconciliation payments reduced Part D spending in 2007 and 2008, resulting in per capita drug cost growth rates that are lower than normal for those years. In contrast, actual drug spending exceeded the plan bids in 2008, which resulted

in more than $2 billion in additional Part D outlays for 2009. For 2013, the Trustees expect that spending will exceed plan bids and will result in more than $6 billion in reconciliation payments to be paid by Part D in 2014.

Legislation also contributes to the volatility of the annual growth rates. For example, the Affordable Care Act imposed an insurance premium fee starting in 2014, which was passed along to the plan enrollees by the Part D drug plans in the form of higher bid amounts.

The Trustees have also prepared estimates under the projected baseline scenario using two alternative sets of assumptions. Table III.D5 summarizes the estimated operations of the Part D account for all three alternatives. Section IV.B2 presents in substantial detail the assumptions underlying the intermediate assumptions, as well as the assumptions used in preparing estimates under the low-cost and high-cost alternatives.

Table III.D5.—Estimated Operations of the Part D Account in the SMI Trust Fund during Calendar Years 2013-2023, under Alternative Sets of Assumptions

[Dollar amounts in billions]

Calendar year	Premiums from enrollees	Other income[1]	Total income	Total expenditures	Balance in account at end of year	Expenditures as a percent of GDP
Intermediate:						
2013	$9.9	$59.7	$69.7	$69.7	$1.0	0.41%
2014	11.6	67.5	79.1	79.4	0.7	0.45
2015	13.6[2]	73.1	86.7	86.7	0.7	0.47
2016	15.4[2]	79.1	94.5	94.5	0.8	0.49
2017	17.7	85.0	102.6	102.6	0.8	0.50
2018	19.6	92.4	112.0	111.9	0.9	0.52
2019	21.7	100.7	122.4	122.3	1.0	0.54
2020	23.8[2]	110.3	134.1	134.0	1.1	0.57
2021	25.3[2]	120.3	145.5	145.4	1.1	0.59
2022	28.0	130.3	158.3	158.2	1.2	0.61
2023	30.6	141.3	171.8	171.7	1.4	0.63
Low-cost:						
2013	9.9	59.7	69.7	69.7	1.0	0.41
2014	11.6	65.8	77.3	77.7	0.7	0.44
2015	12.5[2]	67.0	79.6	79.6	0.7	0.42
2016	13.7[2]	72.3	86.0	85.9	0.7	0.42
2017	15.6	77.5	93.1	93.1	0.8	0.42
2018	17.1	82.9	100.0	99.9	0.8	0.43
2019	18.8	88.9	107.7	107.7	0.9	0.43
2020	20.5[2]	96.1	116.6	116.5	0.9	0.44
2021	21.7[2]	103.1	124.8	124.7	1.0	0.45
2022	23.9	110.1	134.1	134.0	1.0	0.45
2023	26.0	117.8	143.8	143.7	1.1	0.46
High-cost:						
2013	9.9	59.7	69.7	69.7	1.0	0.41
2014	11.6	69.3	80.9	81.2	0.7	0.47
2015	14.8[2]	78.9	93.7	93.6	0.7	0.53
2016	17.2[2]	86.2	103.5	103.4	0.8	0.56
2017	19.8	92.9	112.8	112.7	0.9	0.59
2018	21.9	102.2	124.1	124.0	1.0	0.63
2019	24.3	112.8	137.1	137.0	1.1	0.67
2020	26.7[2]	125.6	152.3	152.2	1.2	0.72
2021	28.6[2]	139.3	167.8	167.7	1.4	0.76
2022	31.9	153.6	185.5	185.3	1.5	0.81
2023	35.0	169.5	204.5	204.3	1.7	0.87

[1]Other income contains Federal and State government contributions and interest.
[2]See footnote 6 of table III.D3.

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

These alternatives provide two possible Part D scenarios but represent a narrow range of possible outcomes for total expenditures. Given the considerable variation in future demographic, economic, and healthcare-usage factors, actual Part D experience could easily fall outside of this range. The low- and high-cost scenarios in this year's report result in a narrower dollar range than in previous years, due to a change in the alternative assumptions from last year.[52] The

[52]The Trustees' alternative CPI assumptions are reversed in this year's report compared with those in previous reports, so that the high-cost assumptions in the 2013 report are now the low-cost assumptions for this year's report, and vice versa. Inflation rates are now ordered across alternatives according to their effect on the OASDI actuarial balance. This change resulted in a narrow range of impacts.

GDP assumptions for the alternative scenarios are also affected by the assumption change. Therefore, spending as a percent of GDP provides better insight into the variability of spending than the nominal dollar amounts, as shown in table III.D5.

The alternative projections shown in table III.D5 illustrate two important aspects of the financial operations of the Part D account:

- Despite the differing assumptions underlying the three alternatives, the balance between Part D income and expenditures remains relatively stable. This result occurs because the premiums and general revenue contributions underlying the Part D financing will be reestablished annually. Thus, Part D income will automatically track Part D expenditures fairly closely, regardless of the specific economic and other conditions.

- As a result of the close matching of income and expenditures described above, together with anticipated continuing flexibility in the apportionment of general revenues, the need for a contingency reserve to handle unanticipated fluctuations is minimal. The next section describes this issue in more detail.

Adequacy of Part D Financing Established for Calendar Year 2014

As noted previously, the Part D account in the SMI trust fund will be in financial balance indefinitely because the premiums paid by enrollees and the amounts apportioned from the general fund of the Treasury are determined each year so as to adequately finance Part D expenditures. Moreover, the appropriation for Part D general revenues has generally included an indefinite authority provision allowing for amounts to be transferred to the Part D account on an as-needed basis. This provision allows previously apportioned amounts to change without additional Congressional action if those amounts are later determined to be insufficient. Consequently, once an appropriation with this provision has been made, no deficit will occur in the Part D account, and no contingency fund will be necessary to cover deficits.[53]

As described in the section on the financial status of the Part B account, it is important to maintain an appropriate level of assets to cover the liability for claims that have been incurred but not yet reported or paid. In the case of Part D, however, most such claims are the responsibility of the prescription drug plans rather than the

[53]The indefinite authority applies to all Part D outlays other than Federal administrative expenses. Those amounts are appropriated each year.

Part D program. Accordingly, the Part D account is generally not at risk for incurred-but-unreported claim amounts, and no asset reserve is necessary for this purpose.

Another potential Part D liability exists to the extent that Part D reinsurance payments and low-income cost-sharing subsidy payments are based on plan estimates.[54] Since actual Part D costs, as subsequently determined, will generally differ somewhat from the plan bids, payment adjustments are made after the close of the year as necessary to reconcile the accounts. When the plan bids have been below actual costs, Medicare has made such settlements in favor of the plans from the following year's appropriated general revenues; thus, creation of a reserve for payment of such settlement amounts is unnecessary.

For these reasons, the Trustees have concluded that maintenance of Part D account assets for contingency or liability purposes is unnecessary at this time. Accordingly, evaluation of the adequacy of Part D assets is also unnecessary, and the Part D account is considered to be in satisfactory financial condition for 2013 and all future years as a consequence of its basis for financing.

To the extent that actual future account transactions and apportionment measures differ from the current expectations, it may be necessary to reconsider this conclusion.

3. Long-Range Estimates

Section III.D2 presented the expected operations of the Part D account over the next 10 years. This section describes the long-range expenditures of the account under the intermediate assumptions. Due to its automatic financing provisions, the Trustees expect adequate financing of the Part D account into the indefinite future and so have not conducted a long-range analysis using high-cost and low-cost assumptions. The 10-year projections under the alternative assumptions are presented in section IV.B2.

Table III.D6 shows the estimated Part D incurred expenditures under the intermediate assumptions expressed as a percentage of GDP, for selected years over the calendar-year period 2013-2088.[55] The 75-year projection period fully allows for the presentation of likely future

[54]These estimates are subject to actuarial review by the CMS Office of the Actuary.

[55]These estimated incurred expenditures are for benefit payments and administrative expenses combined, unlike the values in table III.D4, which express only benefit payments on a cash basis as a percentage of GDP.

trends, such as the large increase in enrollees after 2010 as the baby boom generation begins to receive benefits.

Table III.D6.—Part D Expenditures (Incurred Basis) as a Percentage of the Gross Domestic Product[1]

Calendar year	Part D expenditures as a percentage of GDP
2013	0.44%
2014	0.44
2015	0.46
2016	0.48
2017	0.50
2018	0.52
2019	0.54
2020	0.57
2021	0.59
2022	0.61
2023	0.64
2025	0.69
2030	0.79
2035	0.87
2040	0.92
2045	0.97
2050	1.02
2055	1.07
2060	1.12
2065	1.18
2070	1.23
2075	1.28
2080	1.32
2085	1.36

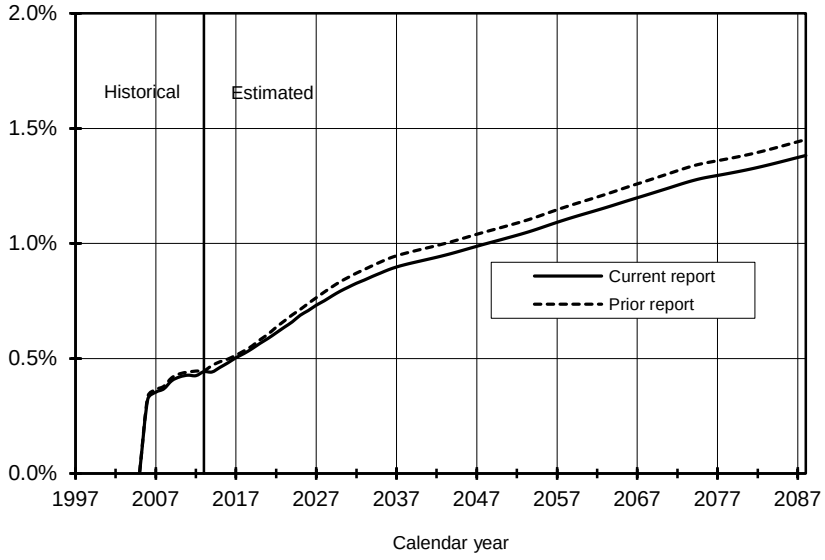
[1]Expenditures are the sum of benefit payments and administrative expenses.

The Trustees assume that increases in Part D costs per enrollee during the initial 25-year period will decline gradually to the growth rates described in sections II.C and IV.D. Based on these assumptions and projected demographic changes, incurred Part D expenditures as a percentage of GDP would increase rapidly from 0.44 percent in 2013 to 1.36 percent in 2085.

The long-range Part D projections are based on the baseline cost growth assumptions described previously. More information on these assumptions is available in section IV.D of this report. Section IV.B2 describes the data sources and assumptions underlying the updated Part D estimates.

Figure III.D1 compares the year-by-year Part D costs as a percentage of GDP for the current annual report with the corresponding projections from 2013. This year's estimates are slightly lower than those in last year's report. The percentage differential is slightly less than 0.01 percent of GDP in 2013 and grows to 0.07 percent of GDP in 2088, primarily due to a lower projected prescription drug cost trend and assumed higher rebates from the drug manufacturers.

Figure III.D1.—Comparison of Part D Projections as a Percentage of the Gross Domestic Product: Current versus Prior Year's Reports



IV. ACTUARIAL METHODOLOGY AND PRINCIPAL ASSUMPTIONS FOR COST ESTIMATES FOR THE HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS

This section describes the basic methodology and assumptions used in the estimates for the HI and SMI trust funds under the intermediate assumptions and presents projections of HI and SMI costs under two alternative sets of assumptions.

The economic and demographic assumptions underlying the projections of HI and SMI costs shown in this report are consistent with those in the 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds. That report describes these assumptions in more detail.

A. HOSPITAL INSURANCE

1. Cost Projection Methodology

The principal steps involved in projecting future HI costs are (i) establishing the present cost of services provided to beneficiaries, by type of service, to serve as a projection base; (ii) projecting increases in HI payments for inpatient hospital services; (iii) projecting increases in HI payments for skilled nursing, home health, and hospice services covered; (iv) projecting increases in payments to private health plans; and (v) projecting increases in administrative costs.

a. Projection Base

To establish a suitable base from which to project future HI costs, the incurred payments for services provided must be constructed for the most recent period for which a reliable determination can be made. Accordingly, payments to providers must be attributed to dates of service, rather than to payment dates; in addition, the nonrecurring effects of any changes in regulations, legislation, or administration, and of any items affecting only the timing and flow of payments to providers, must be eliminated. As a result, the rates of increase in the HI incurred costs differ from the increases in cash expenditures shown in the tables in section III.B.

For those expenses still reimbursed on a reasonable-cost basis, the costs for covered services are determined on the basis of provider cost reports. Due to the time required to obtain cost reports from

providers, to verify these reports, and to perform audits (where appropriate), final settlements have lagged behind the original costs by as much as several years for some providers. Additional complications arise from legislative, regulatory, and administrative changes, the effects of which cannot always be determined precisely.

The process of allocating the various types of HI payments made to the proper incurred period—using incomplete data and estimates of the impact of administrative actions—presents difficult problems, and the solutions to these problems can be only approximate. Under the circumstances, the best that one can expect is that the actual HI incurred cost for a recent period can be estimated within a few percent. This process increases the projection error directly by incorporating any error in estimating the base year into all future years.

b. Fee-for-Service Payments for Inpatient Hospital Costs

Payment for almost all inpatient hospital services for fee-for-service beneficiaries occurs under a prospective payment system. The law stipulates that the annual increase in the payment rate for each admission relate to a hospital input price index (also known as the hospital market basket), which measures the increase in prices for goods and services purchased by hospitals for use in providing care to hospital inpatients. For fiscal year 2014, the prospective payment rates have already been determined. For fiscal years 2015 and later, the statute mandates that the annual increase in the payment rate per admission equal the annual increase in the hospital input price index (for those hospitals submitting required quality measure data), minus a specified percentage. For this report, the Trustees assume that all hospitals will submit these data.

Increases in aggregate payments for inpatient hospital care covered under HI can be analyzed in six broad categories, presented in table IV.A1:

(1) Labor factors—the increase in the hospital input price index attributable to increases in hospital workers' hourly compensation (including fringe benefits);

(2) Non-labor factors—the increase in the hospital input price index attributable to factors other than hospital workers' hourly compensation, such as the costs of energy, food, and supplies;

(3) Unit input intensity allowance—an amount added to or subtracted from the input price index (generally called for in legislation) to yield the prospective payment update factor;

(4) Volume of services—the increase in total output of units of service (as measured by covered HI hospital admissions);

(5) Case mix—the financial effect of changes in the average complexity of hospital admissions; and

(6) Other sources—a residual category reflecting all other factors affecting hospital cost increases (such as legislative increases).

Table IV.A1 shows the estimated historical values of these principal components, as well as the projected trends used in the estimates. Unless otherwise indicated, the following discussions apply to projections under the intermediate assumptions.

Table IV.A1.—Components of Historical and Projected Increases in HI Inpatient Hospital Payments[1]

	Labor			Non-labor					Units of service					
Calendar year	Average hourly compensation	Hospital hourly compensation differential	Hospital hourly compensation	CPI	Hospital price differential	Non-labor hospital prices	Input price index	Unit input intensity allowance[2]	HI enrollment	Managed care shift effect	Admission incidence	Case mix	Other sources	HI inpatient hospital payments
Historical data:														
2004	4.9%	−1.0%	3.9%	2.6%	1.4%	4.0%	3.9%	−0.6%	1.8%	0.1%	−0.7%	0.5%	0.8%	5.9%
2005	3.2	0.7	3.9	3.5	0.6	4.1	4.0	−0.5	1.8	−0.9	−0.3	0.4	1.2	5.8
2006	4.2	−0.4	3.8	3.2	0.7	3.9	3.8	−0.2	2.0	−3.7	−1.3	0.7	−0.7	0.4
2007	3.0	0.6	3.6	2.9	0.6	3.5	3.6	−0.3	2.2	−3.4	1.0	−0.2	−2.2	0.6
2008	3.7	−0.4	3.3	4.1	1.0	5.1	4.0	−0.2	2.6	−3.1	−4.4	1.9	2.2	2.8
2009	1.8	0.9	2.7	−0.7	1.9	1.2	2.1	0.7	2.5	−2.4	−2.3	2.7	−1.1	2.1
2010	2.7	−0.7	2.0	2.1	0.7	2.8	2.3	−0.3	2.4	−0.9	−1.0	0.6	−1.8	1.3
2011	3.2	−1.4	1.8	3.6	0.4	4.0	2.7	−0.3	2.5	−1.1	−1.7	0.0	−0.8	1.2
2012	2.5	−0.9	1.6	2.1	0.7	2.8	2.1	−0.3	4.1	−1.9	−4.9	0.7	1.1	0.6
2013	2.7	−1.0	1.7	1.4	1.1	2.5	2.0	−0.3	2.8	−2.3	−2.5	1.4	−0.4	0.6
Intermediate estimates:														
2014	2.9	−0.3	2.6	1.6	0.0	1.6	2.2	−0.5	3.3	−2.4	−2.2	0.5	−1.4	−0.6
2015	4.0	0.0	4.0	1.9	0.5	2.4	3.4	−0.8	3.1	0.9	−1.7	0.5	−4.1	1.1
2016	4.3	0.0	4.3	2.2	0.4	2.6	3.6	−1.0	3.0	0.0	−0.4	0.5	−1.5	4.3
2017	4.5	0.0	4.5	2.4	0.3	2.7	3.8	−1.5	3.0	−0.6	−0.2	0.5	−1.1	4.0
2018	4.4	0.0	4.4	2.6	0.2	2.8	3.8	−1.7	3.0	0.1	0.1	0.5	1.7	7.7
2019	4.4	0.0	4.4	2.7	0.1	2.8	3.8	−1.5	2.9	−0.6	−0.2	0.5	0.1	5.1
2020	4.3	0.0	4.3	2.7	0.0	2.7	3.7	−0.9	2.9	−0.6	−0.2	0.5	0.1	5.5
2021	4.3	0.0	4.3	2.7	0.0	2.7	3.7	−0.9	2.9	−0.6	−0.1	0.5	0.0	5.5
2022	4.2	0.0	4.2	2.7	0.0	2.7	3.6	−0.9	2.9	−0.5	0.0	0.5	0.0	5.7
2023	4.1	0.0	4.1	2.7	0.0	2.7	3.6	−0.9	2.8	−0.4	0.1	0.5	−0.2	5.5
2025	4.0	0.0	4.0	2.7	0.0	2.7	3.5	−0.9	2.6	0.0	0.1	0.5	2.3	8.3
2030	4.0	0.0	4.0	2.7	0.0	2.7	3.5	−1.0	1.7	0.0	0.6	0.5	−0.1	5.4
2035	4.0	0.0	4.0	2.7	0.0	2.7	3.6	−1.1	1.1	0.0	0.7	0.5	−0.1	4.8

[1]Percent increase in year indicated over previous year, on an incurred basis.

[2]Reflects the allowances provided for in the prospective payment update factors. Also reflects the downward adjustments to price updates based on the 10-year moving average of private, nonfarm business multifactor productivity growth in 2012 and later, and additional decreases in updates ranging from 0.1 percentage point to 0.75 percentage point from 2010 through 2019, as introduced by the Affordable Care Act. Historical values also include any difference between the official payment update, which is based on an estimate for the following year, and subsequent actual data.

Note: Historical and projected data reflect the hospital input price index, which was recalibrated to a 2002 base year in 2005.

Increases in hospital workers' hourly compensation can be analyzed and projected in terms of (i) the assumed increases in hourly compensation in employment in the general economy; and (ii) the difference between increases in hourly compensation in the general economy and the hospital hourly compensation used in the hospital input price index. Since HI began, the differential between hospital workers' hourly compensation and hourly compensation in the general economy has fluctuated widely and averaged about −0.4 percent since 2004. After 2014, this differential is assumed to be zero for the entire projection period.

Non-labor cost increases can similarly be analyzed in terms of a known, economy-wide price measure (the Consumer Price Index, or CPI) and a differential between the CPI and hospital-specific prices. This differential reflects price increases for hospital-purchased non-labor goods and services that do not parallel increases in the CPI. Although the price differential has fluctuated erratically in the past, it averaged about 0.9 percent during 2004-2013. Over the next few years, the hospital price differential is assumed to decrease from recent levels and by 2020 to level off at zero for the remainder of the projection period.

The final input price index is calculated as a weighted average of the labor and non-labor factors described above. The weights reflect the relative use of each factor by hospitals (currently about 60 percent labor and 40 percent non-labor).

The unit input intensity allowance is generally a downward adjustment provided for by law in the prospective payment update factor; that is, it is the amount subtracted from the input price index to yield the update factor.[56] Beginning in fiscal year 2004, the law provides that increases in payments to prospective payment system hospitals for covered admissions will equal the increase in the hospital input price index for those hospitals that submit the required quality measure data. For other hospitals, the increase will be slightly smaller. For this report, the Trustees assume that all hospitals will submit these data. Beginning in fiscal year 2010, the

[56]The update factors are generally prescribed on a fiscal-year basis, while table IV.A1 is on a calendar-year basis. Calculations have therefore been performed to estimate the unit input intensity allowance on a calendar-year basis. Also, because the displayed input price index amounts are the latest estimates available, as opposed to the estimates used when each prospective payment update factor was originally prescribed, the unit input intensity allowance includes, if necessary, an adjustment to offset this change. Accordingly, the sum of the input price index and the unit input intensity allowance generally reflects the prescribed prospective payment update factor, but on a calendar-year, rather than a fiscal-year, basis.

Affordable Care Act mandates amounts to be subtracted from the input price index, including the increase in economy-wide multifactor productivity in 2012 and later, and amounts ranging from 0.1 percentage point to 0.75 percentage point for 2010 through 2019. As a result of these adjustments, the unit input intensity allowance, as indicated in table IV.A1, is negative throughout the first 25-year projection period.

Increases in payments for inpatient hospital services also reflect growth in the number of inpatient hospital admissions covered under HI. As shown in table IV.A1, increases in admissions are attributable to growth in both HI fee-for-service enrollment and admission incidence (admissions per beneficiary).[57] The historical and projected growth in enrollment reflects a more rapid increase in the population aged 65 and over than in the total population of the United States, as well as increasing numbers of disabled beneficiaries and persons with end-stage renal disease. Growth in enrollment is expected to continue and to mirror the ongoing demographic shift into categories of the population eligible for HI benefits.

In the 1990s the choice of more beneficiaries to join private health plans was an offsetting factor to the HI enrollment growth, as shown in the "managed care shift effect" column of table IV.A1. In other words, greater enrollment in private health plans reduced the number of beneficiaries with fee-for-service Medicare coverage and thereby reduced hospital admissions paid through fee-for-service. This factor reversed during 2000-2003, when significant numbers of beneficiaries left private health plans. More recently, with the changes introduced in the Medicare Modernization Act, enrollment in Medicare Advantage plans accelerated rapidly. Private Medicare health plan membership is projected to continue to grow.

Since the beginning of the prospective payment system (PPS), inpatient hospital payments have varied based on the complexity of admissions. These variations are primarily due to (i) the changes in diagnosis-related group (DRG) coding as hospitals continue to adjust to the PPS and (ii) the trend toward treating less complicated (and thus less expensive) cases in outpatient settings, which results in an increase in the average prospective payment per admission.

[57]For 2010-2021, this factor is estimated to be negative, reflecting the influx of beneficiaries aged 65 (and the resulting reduction in the average age of beneficiaries) due to the retirement of the baby boom generation. By 2025, the aging of this group is expected to increase the incidence of admissions.

The average complexity of hospital admissions (case mix) is expected to increase by 0.5 percent annually in fiscal years 2014 through 2038 as a result of an assumed continuation of the current trend toward treating less complicated cases in outpatient settings, ongoing changes in DRG coding, and the overall impact of new technology. This assumption is based on the recommendation of the 2010-2011 Medicare Technical Review Panel.

Hospital payments are also affected by other factors, as reflected in the "other sources" column of table IV.A1. A complicating factor is the advent of the new MS-DRG system, which led to significant increases in case mix as a result of claims coding. Statutory budget neutrality adjustments have offset much of the MS-DRG impact. Although the law limited the size of these adjustments in 2008 and 2009, it allows subsequent recovery of any extra payments that resulted. The "other sources" column reflects all of these actual and anticipated effects and adjustments. In addition, one can attribute part of the increase from "other sources" to the increase in payments for certain costs, not included in the DRG payment, that are generally growing at a rate slower than the input price index. These other costs include capital, medical education (both direct and indirect), disproportionate share (DSH) payments, and payments to hospitals not included in the prospective payment system. A particularly important change affecting these costs is the reduction in Medicare DSH payments under the ACA. This change reflects the major coverage expansions beginning in 2014 that will result in significantly fewer uninsured hospital patients.

Additional possible sources of changes in payments include (i) a shift to higher-cost or lower-cost admissions due to changes in the demographic characteristics of the covered population; (ii) changes in medical practice patterns; and (iii) adjustments in the relative payment levels for various DRGs, or addition/deletion of DRGs, in response to changes in technology.

The "other sources" column reflects, as appropriate, the impact of certain enacted legislation, including the sequestration process which requires a reduction of about 2 percent for April 2013 through September 2024. Also reflected in this column is the impact of the estimated bonus payments and penalties for hospitals due to the health information technology incentive provisions of the American Recovery and Reinvestment Act of 2009.

The increases in the input price index (less any intensity allowance specified in the law), units of service, and other sources are

compounded to calculate the total increase in payments for inpatient hospital services. The last column of table IV.A1 shows these overall increases.

c. Fee-for-Service Payments for Skilled Nursing Facility, Home Health Agency, and Hospice Services

Historically, the number of days of care covered in skilled nursing facilities (SNFs) under HI has varied widely. This extremely volatile experience has resulted, in part, from legislative and regulatory changes and from judicial decisions affecting the scope of coverage. At the start of the prospective payment system (PPS) in 1998 and 1999, there were large decreases in utilization. Since that time, utilization rates have increased at fairly high rates. The intermediate projections assume that these increases in covered SNF days will reflect the growth and aging of the population plus 1 percent annually, as an underlying trend. This assumption is based on the recommendation of the 2010-2011 Medicare Technical Review Panel.

Rising payroll costs for nurses and other required skilled labor are the principal cause of increases in the average HI cost per day[58] in SNFs. For 1998 and later, such costs reflect the implementation of the new PPS for SNFs, as required by the Balanced Budget Act of 1997. Increases in reimbursement per day also reflect the implementation and expiration of special provisions from the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000. The implementation of the new RUG-53 system of payment in 2006 was accompanied by an increase of over 7 percent in case mix for 2006 and more than 3 percent for 2007 through 2009. In 2010, a reduction of about 3.3 percent was applied to all the rates to better match payments from the old payment system to the new payment system. The implementation of a new RUG system again caused a very large increase in case mix in 2011, and a reduction of about 12.6 percent was applied in 2012 to once again match payments. The required reduction in costs due to sequestration (about 2 percent for the period April 2013 through September 2024) is also reflected in the projected expenditures. The case mix increases are assumed to grow at a level of 1.5 percent annually, based on the recommendation of the 2010-2011 Medicare Review Panel. These assumed trends result in projected rates of increase in cost per day that are assumed to decline to a level slightly higher than increases in general earnings throughout the projection period.

[58]Cost is defined to be the total of HI reimbursement and beneficiary cost sharing.

Table IV.A2 shows the resulting increases in fee-for-service expenditures for SNF services.

Table IV.A2.—Relationship between Increases in HI Expenditures and Increases in Taxable Payroll[1]

Calendar year	Inpatient hospital[2,3]	Skilled nursing facility[3]	Home health agency[3,7]	Private plans	Weighted average[3,4]	HI administrative costs[3,5]	HI expenditures[3,5]	HI taxable payroll	Growth rate differential[6]
Historical data:									
2004	5.7	13.6	9.5	10.5	7.7	18.3	7.9	6.0	1.8
2005	5.6	10.7	6.9	21.0	8.6	−2.6	8.4	5.5	2.8
2006	0.5	7.8	2.4	28.0	6.0	0.0	5.9	6.2	−0.3
2007	0.6	8.3	3.9	22.6	5.9	−1.0	5.8	5.4	0.3
2008	2.8	9.3	7.8	21.6	7.7	10.6	7.8	2.0	5.6
2009	1.5	5.1	4.1	19.2	6.3	−2.5	6.1	−4.7	11.4
2010	1.3	6.3	3.3	2.9	2.6	8.0	2.7	2.1	0.6
2011	1.2	11.7	−5.3	6.6	4.0	7.0	4.0	4.2	−0.2
2012	0.6	−9.3	−1.4	9.0	1.9	7.8	2.0	4.4	−2.3
2013	0.5	2.3	−0.3	3.9	1.9	8.4	2.0	3.5	−1.4
Intermediate estimates:									
2014	−0.6	2.8	0.2	−0.2	0.3	4.6	0.4	4.8	−4.2
2015	1.1	7.7	4.4	−4.4	0.7	10.8	0.9	5.7	−4.5
2016	4.3	7.8	4.0	4.9	5.0	8.3	5.1	6.1	−0.9
2017	4.0	7.6	4.4	8.1	5.8	7.4	5.8	6.1	−0.3
2018	7.7	8.3	8.4	7.1	7.6	8.0	7.6	6.0	1.6
2019	5.1	7.0	7.6	7.7	6.3	6.8	6.3	5.4	0.8
2020	5.5	7.6	7.6	9.2	7.0	6.5	7.0	5.1	1.8
2021	5.5	7.8	7.7	8.9	7.0	6.5	7.0	4.9	2.0
2022	5.7	8.2	8.1	8.3	7.0	6.6	7.0	4.6	2.3
2023	5.5	8.2	7.9	7.6	6.7	6.3	6.7	4.4	2.2
2025	8.3	11.1	10.9	9.1	9.1	10.6	9.2	4.3	4.7
2030	5.4	8.5	8.1	6.2	6.3	5.6	6.3	4.3	1.9
2035	4.8	8.1	7.5	5.8	5.9	4.9	5.8	4.4	1.4

[1]Percent increase in year indicated over previous year.
[2]This column may differ slightly from the last column of table IV.A1, since table IV.A1 includes all persons eligible for HI protection while this table excludes noninsured persons.
[3]Costs attributable to insured beneficiaries only, on an incurred basis. Benefits and administrative costs for noninsured persons are expected to be financed through general revenue transfers and premium payments, rather than through payroll taxes.
[4]Includes costs for hospice care.
[5]Includes costs of Quality Improvement Organizations.
[6]The ratio of the increase in HI costs to the increase in taxable payroll. This ratio is equivalent to the percent increase in the ratio of HI expenditures to taxable payroll (the cost rate).
[7]Includes the declining share of costs drawn from HI for coverage of certain home health services transferred from HI to SMI Part B.

For most historical years, HI experience with home health agency (HHA) payments had shown an upward trend, frequently with sharp increases in the number of visits from year to year. The enactment of the Balanced Budget Act of 1997, which introduced interim per beneficiary cost limits at levels that resulted in substantially lower aggregate payments, also heavily affected the growth in the benefit. These cost limits were used until the implementation of the prospective payment system in October 2000. For 1998 through 2001, data show large decreases in utilization, with utilization leveling off in 2002 and 2003. For 2004 through 2009, the increases were slightly larger. Moreover, in certain areas of the country, outlier payments for treatment episodes increased at extraordinary rates during this

period, prompting special rules to limit abusive practices. In 2010, limits were placed on the proportion of total payments that an agency could receive in the form of outlier payments, and prosecution of fraud cases resulted in the closing of a number of purported home health agencies. There was a slight decrease in utilization in 2010, followed by large decreases in 2011 and 2012. Preliminary data show a rebound in utilization in 2013. For 2014 and the rest of the projection period, these utilization and intensity increases are assumed to be equal to the growth and aging of the population plus 1 percent annually. This assumption is based on the recommendation of the 2010-2011 Medicare Technical Review Panel. As is the case for all types of Medicare benefits, the projected home health expenditures also reflect the specified reductions due to sequestration (about 2 percent for the period April 2013 through September 2024).

Reimbursement per episode of care[59] is assumed to increase at a slightly higher rate than increases in general earnings, but adjustments to reflect statutory limits on HHA reimbursement per episode are included where appropriate. In particular, payments were set to be equivalent to a 15-percent reduction in the prior interim cost limits, effective October 2002. Under the Affordable Care Act, HHA payment rates will be rebased starting in 2014, with an estimated 14-percent reduction in payments phased in over a 4-year period. Reimbursement per episode also includes any change in the mix of services being provided. During 2001, the first year that the prospective payment system was in effect, this mix of services was much higher than anticipated. Since then the case mix increases have been more modest and decreased the last several years. CMS adjusted HHA payment levels from 2008 through 2013 to offset gradually the financial effect of the unduly high mix of services in the first and subsequent years. Projected HHA costs reflect these regulatory adjustments. Based on the recommendation of the 2010-2011 Medicare Technical Review Panel, HHA case mix increases are projected to increase until reaching 1.5 percent annually beginning in 2016. Table IV.A2 shows the resulting increases in fee-for-service expenditures for HHA services.

HI covers certain hospice care for terminally ill beneficiaries. Hospice payments were originally very small relative to total HI benefit payments, but they have grown rapidly in most years and now substantially exceed the level of HI home health expenditures. This growth rate slowed dramatically in the mid-to-late 1990s but

[59]Under the HHA prospective payment system, Medicare payments are made for each episode of care, rather than for each individual home health visit.

rebounded sharply during the 1999-2007 period. From 2008 to 2013 the growth slowed, and this growth rate is expected to continue at this level for the remainder of the projection period. Although detailed hospice data are scant at this time, estimates for hospice benefit payment increases are based on mandated daily payment rates and annual payment caps, and these estimates assume a deceleration in the growth in the number of covered days. Table IV.A2 does not show increases in hospice payments separately but includes them in the weighted average increase for all HI types of service.

d. Private Health Plan Costs

HI payments to private health plans have generally increased significantly from the time that such plans began to participate in the Medicare program in the 1970s. Most of the growth in expenditures has been attributable to the increasing numbers of beneficiaries who have enrolled in these plans. Section IV.C of this report contains a description of the private health plan assumptions and methodology.

e. Administrative Expenses

Historically, the cost of administering the HI trust fund has remained relatively small in comparison with benefit amounts. The ratio of administrative expenses to benefit payments has generally fallen within the range of 1 to 3 percent. The short-range projection of administrative cost is based on estimates of workloads and approved budgets for intermediaries and CMS. In addition, the administrative costs reflect an assumed 5 percent reduction due to the sequester for the period April 2013 through September 2024. In the long range, administrative cost increases are based on assumed increases in workloads, primarily due to growth and aging of the population, and on assumed unit cost increases of slightly less than the increases in average hourly compensation that appear in table IV.A1.

2. Summary of Aggregate Reimbursement Amounts on a Cash Basis under the Intermediate Assumptions

Table IV.A3 shows aggregate historical and projected reimbursement amounts by type of service on a cash basis under the intermediate assumptions. The difference between reimbursement amounts on a cash versus incurred basis results from the lag between the time of service and the time of payment. This lag has gradually decreased.

Table IV.A3.—Aggregate Part A Reimbursement Amounts on a Cash Basis
[In millions]

Calendar year	Inpatient hospital	Skilled nursing facility	Home health agency	Hospice	Total FFS	Private health plans	Total Part A
Historical data:							
2004	$117,004	$17,202	$5,440	$6,849	$146,494	$20,750	$167,244
2005	123,300	19,326	5,994	8,016	156,636	24,945	181,581
2006	124,203	20,212	5,854	9,368	159,637	32,923	192,560
2007	124,500	22,268	6,148	10,518	163,434	38,958	202,392
2008	130,534	24,282	6,623	11,404	172,843	50,576	223,419
2009	133,833	26,309	7,087	12,290	179,519	59,353	238,872
2010	135,887	27,125	7,213	13,088	183,313	60,666	243,979
2011	134,432	32,118	7,104	14,034	187,689	64,622	252,311
2012	141,137	28,719	6,900	15,184	191,939	70,232	262,171
2013	136,778	28,391	6,841	15,893	187,902	73,219	261,121
Intermediate estimates:							
2014	137,567	29,778	6,815	16,787	190,946	73,256	264,202
2015	137,542	31,586	7,061	17,912	194,100	70,059	264,159
2016	143,036	34,124	7,353	19,230	203,743	73,333	277,076
2017	148,273	36,690	7,669	20,736	213,368	79,192	292,560
2018	159,729	39,716	8,265	22,330	230,040	84,839	314,879
2019	167,882	42,486	8,891	24,046	243,306	91,355	334,661
2020	177,276	45,686	9,566	25,957	258,484	99,740	358,225
2021	187,003	49,234	10,300	28,011	274,549	108,665	383,214
2022	197,609	53,225	11,123	30,215	292,172	117,741	409,913
2023	208,511	57,557	12,005	32,512	310,584	126,792	437,377

3. Financing Analysis Methodology

Because payroll taxes are the primary basis for financing the HI trust fund, HI costs can be compared on a year-by-year basis with the taxable payroll in order to analyze costs and evaluate the financing. Since the vast majority of total HI costs relate to insured beneficiaries, and since general revenue appropriations and premium payments are expected to support the uninsured segments, the remainder of this section will focus on the financing for insured beneficiaries only.

a. Taxable Payroll

Taxable payroll increases occur as a result of increases in both average covered earnings and the number of covered workers. The taxable payroll projection used in this report is based on the same economic assumptions used in the 2014 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds (OASDI). Table IV.A2 shows the projected increases in taxable payroll for this report, under the intermediate assumptions.

b. Relationship between HI Costs and Taxable Payroll

The most meaningful measure of HI cost increases, with regard to the financing of the system, is the relationship between cost increases and taxable payroll increases. If costs increase more rapidly than taxable payroll, either income rates must be increased or costs reduced (or some combination thereof) to finance the system in the future. Table IV.A4 shows the projected increases in HI costs relative to taxable payroll over the first 25-year projection period. These relative increases fluctuate, starting at −4.2 percent per year in 2014, remaining negative as the assumed continuation of the economic recovery leads to faster growth in employment and earnings, and then changing to a positive differential of about 1.4 percent per year by 2035 for the intermediate assumption.

The result of these relative growth rates is an initial decrease, followed by a steady increase, in the year-by-year ratios of HI expenditures to taxable payroll, as shown in table IV.A4. Under the low-cost alternative, increases in HI expenditures follow a similar pattern relative to increases in taxable payroll, but at a somewhat lower rate; the rate becomes about 7.0 percent less than the rate for taxable payroll by 2014 but then increases, reaching about 0.6 percent less per year than taxable payroll by 2035. The high-cost alternative follows a comparable pattern but at a somewhat higher rate than under the intermediate assumptions, sharply increasing from about 0.8 percent less than taxable payroll in 2014 to about 3.6 percent more than taxable payroll by 2035.

Table IV.A4.—Summary of HI Alternative Projections

[In percent]

Calendar year	Increases in aggregate HI inpatient hospital payments[1]				Changes in the relationship between expenditures and payroll[1]		
	Average hourly compensation	CPI	Other factors[2]	Total[3]	HI expenditures[3,4,5]	Taxable payroll	Ratio of expenditures to payroll
Intermediate:							
2014	2.9%	1.6%	−2.9%	−0.5%	0.4%	4.8%	−4.2%
2015	4.0	1.9	−2.0	1.1	0.9	5.7	−4.5
2016	4.3	2.2	0.8	4.3	5.1	6.1	−0.9
2017	4.5	2.4	0.3	3.9	5.8	6.1	−0.3
2018	4.4	2.6	3.8	7.7	7.6	6.0	1.6
2019	4.4	2.7	1.3	5.1	6.3	5.4	0.8
2020	4.3	2.7	1.8	5.5	7.0	5.1	1.8
2021	4.3	2.7	1.7	5.5	7.0	4.9	2.0
2022	4.2	2.7	2.0	5.7	7.0	4.6	2.3
2023	4.1	2.7	1.8	5.5	6.7	4.4	2.2
2025	4.0	2.7	4.6	8.3	9.2	4.3	4.7
2030	4.0	2.7	1.8	5.4	6.3	4.3	1.9
2035	4.0	2.7	1.2	4.8	5.8	4.4	1.4
Low-cost:							
2014	3.6	1.8	−5.6	−2.9	−1.4	6.1	−7.0
2015	5.4	2.8	−3.3	0.9	−0.1	8.0	−7.5
2016	6.0	3.4	−0.5	4.4	5.3	8.6	−3.1
2017	5.8	3.4	−1.2	3.6	5.5	8.1	−2.4
2018	5.2	3.4	2.2	6.8	6.8	7.1	−0.3
2019	5.4	3.4	−0.4	4.2	5.4	6.6	−1.2
2020	5.4	3.4	0.0	4.7	6.2	6.4	−0.2
2021	5.4	3.4	0.0	4.7	6.2	6.0	0.1
2022	5.4	3.4	0.3	5.0	6.3	6.0	0.3
2023	5.2	3.4	0.2	4.8	6.0	5.8	0.2
2025	5.1	3.4	3.0	7.6	8.6	5.7	2.7
2030	5.1	3.4	0.1	4.7	5.7	5.7	−0.1
2035	5.1	3.4	−0.4	4.1	5.1	5.8	−0.6
High-cost:							
2014	1.9	1.5	0.0	1.7	2.1	2.9	−0.8
2015	2.8	1.5	−1.2	1.0	1.7	3.2	−1.5
2016	3.2	1.5	1.8	4.3	5.2	4.0	1.2
2017	3.5	1.7	1.5	4.4	6.3	4.5	1.7
2018	3.5	1.9	5.3	8.3	8.3	4.5	3.7
2019	3.5	2.0	2.8	5.9	7.1	4.1	2.9
2020	3.5	2.0	3.5	6.5	8.1	4.1	3.9
2021	3.3	2.0	3.7	6.6	8.2	4.0	4.0
2022	3.2	2.0	4.0	6.8	8.2	3.8	4.3
2023	3.0	2.0	3.7	6.5	7.7	3.3	4.3
2025	2.9	2.0	6.3	9.0	9.9	3.0	6.8
2030	2.9	2.0	3.3	6.0	7.1	2.9	4.0
2035	2.9	2.0	2.8	5.5	6.6	3.0	3.6

[1]Percent increase for the year indicated over the previous year.
[2]Other factors include hospital hourly earnings, hospital price input intensity, unit input intensity allowance, units of service as measured by admissions, and additional sources.
[3]On an incurred basis.
[4]Includes expenditures attributable to insured beneficiaries only.
[5]Includes hospital, SNF, HHA, private health plan, and hospice expenditures; administrative costs; and costs of Quality Improvement Organizations.

4. Projections under Alternative Assumptions

In almost every year since the trust fund was established, average HI expenditures per beneficiary have increased substantially faster than increases in average earnings and prices in the general economy.

Table IV.A2 shows the estimated past experience of HI from 2004 to 2013. As mentioned earlier, HI now makes payments to the great majority of providers on a prospective basis. The prospective payment systems have made (and are expected to continue to make) HI outlays potentially less vulnerable to excessive rates of growth in the health care industry. However, there is still considerable uncertainty in projecting HI expenditures—for inpatient hospital services as well as for other types of covered services—due to the uncertainty of the underlying economic assumptions and utilization increases. Uncertainty in projecting HI expenditures also exists because of the possibility that future legislation will affect unit payment levels, particularly for inpatient hospital services. Legislation has been enacted affecting the inpatient PPS payment levels to hospitals in most of the past 30 years. For future market basket updates for hospitals and most other providers, the Affordable Care Act mandates reductions that are estimated to average 0.9 percent through 2030 and 1.1 percent per year thereafter.

In view of the uncertainty of future cost trends, projected HI costs based on current law have been prepared under three alternative sets of assumptions. Table IV.A4 shows a summary of the assumptions and results. Increases in the economic factors (average hourly compensation and Consumer Price Index) for the three alternatives are consistent with those underlying the OASDI report.

Under the intermediate assumptions, HI costs beyond the first 25-year projection period are based on the assumption that average per beneficiary expenditures (excluding demographic impacts) will increase at the baseline rates determined by the economic model described in sections II.C and IV.D less the economy-wide productivity adjustments. This rate is about 0.4 percent faster than the increase in the Gross Domestic Product (GDP) per capita in 2038 but would decelerate to about 0.5 percent slower than GDP per capita by 2088. HI expenditures, which were 3.5 percent of taxable payroll in 2013, increase to 4.6 percent by 2035 and to 5.6 percent by 2088 under the intermediate assumptions. Accordingly, if all of the projection assumptions are realized over time, the HI income rates provided in current law (3.82 percent of taxable payroll) would be inadequate to support the HI cost.

During the first 25-year projection period, the low-cost and high-cost alternatives contain assumptions that result in HI costs increasing, relative to taxable payroll increases, approximately 2 percentage points less rapidly and 2 percentage points more rapidly, respectively, than the results under the intermediate assumptions. Costs beyond

the first 25-year projection period assume that the 2-percentage-point differential gradually decreases until 2063, when HI cost increases relative to taxable payroll are approximately the same as under the intermediate assumptions.

B. SUPPLEMENTARY MEDICAL INSURANCE

SMI consists of Part B and, since 2004, Part D. The benefits provided by each part are quite different. The actuarial methodologies used to produce the estimates for each part reflect these differences and thus appear in separate sections.

1. Part B

a. Cost Projection Methodology

Estimates under the intermediate assumptions are calculated separately for each category of enrollee and for each type of service. The estimates are prepared by establishing the allowed charges or costs incurred per enrollee for a recent year (to serve as a projection base) and then projecting these charges through the estimation period. The per enrollee charges are then converted to reimbursement amounts by subtracting the per enrollee values of the deductible and coinsurance. Aggregate reimbursement amounts are calculated by multiplying the per enrollee reimbursement amounts by the projected enrollment. In order to estimate cash expenditures, an allowance is made for the delay between receipt of, and payment for, the service.

The Part B expenditure estimates reflect a *projected baseline* scenario. This scenario includes an assumed override of the current-law SGR system physician updates and assumed increases in the physician fee schedule equal to the average legislated physician payment update for the 10 years prior to April 2015. The yearly adjustments, required under current law, for economy-wide productivity growth are applied to most non-physician Part B types of service in the projected baseline scenario.

(1) Projection Base

To establish a suitable base from which to project the future Part B costs, the incurred payments for services provided must be constructed for the most recent period for which a reliable determination can be made. Accordingly, payments to providers must be attributed to dates of service, rather than to payment dates; in addition, the nonrecurring effects of any changes in regulations,

legislation, or administration, and of any items affecting only the timing and flow of payments to providers, must be eliminated. As a result, the rates of increase in the Part B incurred cost differ from the increases in cash expenditures.

(a) Carrier Services

Organizations acting for the Centers for Medicare & Medicaid Services (CMS) pay reimbursement amounts for physician services, durable medical equipment (DME), laboratory tests performed in physician offices and independent laboratories, and other services (such as physician-administered drugs, free-standing ambulatory surgical center facility services, ambulance, and supplies). These organizations, referred to as *carriers*, determine whether Part B covers billed services, establish the allowed charges for covered services, and transmit to CMS a record of the allowed charges, the applicable deductible and coinsurance, and the amount reimbursed after reduction for coinsurance and the deductible.

The data are tabulated on an incurred basis. As a check on the validity of the projection base, incurred reimbursement amounts are compared with carrier cash expenditures.

(b) Intermediary Services

The same fiscal intermediaries that pay for HI services pay reimbursement amounts for institutional services under Part B. Institutional care covered under Part B includes outpatient hospital services, home health agency services, laboratory services performed in hospital outpatient departments, and such services as renal dialysis performed in free-standing dialysis facilities, services in outpatient rehabilitation facilities, and services in rural health clinics.

Separate payment systems exist for almost all the Part B institutional services. For these systems, the intermediaries determine whether Part B covers billed services, establish the allowed payment for covered services, and send to CMS a record of the allowed payment, the applicable deductible and coinsurance, and the amount reimbursed after reduction for coinsurance and the deductible.

For those services still reimbursed on a reasonable-cost basis, the costs for covered services are determined on the basis of provider cost reports. Reimbursement for these services occurs in two stages. First,

bills are submitted by providers to the intermediaries, and interim payments are made on the basis of these bills. The second stage takes place at the close of a provider's accounting period, when a cost report is submitted and lump-sum payments or recoveries are made to correct for the difference between interim payments and final settlement amounts for providing covered services (net of coinsurance and deductible amounts). Tabulations of the bills are prepared by date of service, and the lump-sum settlements, which are reported only on a cash basis, are adjusted (using approximations) to allocate them to the time of service.

(c) Private Health Plan Services

Private health plans with contracts to provide health services to Medicare beneficiaries are reimbursed directly by CMS on either a reasonable-cost or capitation basis. Section IV.C of this report contains a description of the assumptions and methodology used to estimate payments to private plans.

(2) Projected Fee-for-Service Payments for Aged Enrollees and Disabled Enrollees without End-Stage Renal Disease

Part B enrollees with end-stage renal disease (ESRD) have per enrollee costs that are substantially higher and quite different in nature from those of most other beneficiaries. Accordingly, the analysis in this section excludes their Part B costs. Those costs are discussed later in this section, as well as costs associated with beneficiaries enrolled in private health plans.

(a) Carrier Services

i. Physician Services

Medicare payments for physician services are based on a fee schedule, which reflects the relative level of resources required for each service. The fee schedule amount is equal to the product of the procedure's relative value, a conversion factor, and a geographic adjustment factor. Payments are based on the lower of the actual charge and the fee schedule amount. Increases in physician fees are based on growth in the Medicare Economic Index (MEI),[60] plus an update adjustment factor (UAF) that reflects whether past growth in the volume and

[60]The MEI is a measure of inflation in physician practice costs and general wage levels. It includes a reduction for economy-wide private nonfarm business multifactor productivity.

intensity of services met specified targets under the sustainable growth rate (SGR) mechanism.

Table IV.B1 shows the actual and projected MEI increases and update adjustment factors for 2004 through 2023. The actual physician fee updates are established by law through March 2015, including a 0.0-percent update for January through March 2015. Under the projected baseline scenario, the same physician update is assumed for the remainder of 2015, and the updates for 2016 and later are assumed to be 0.6 percent. The modified update shown in column 4 reflects the growth in the MEI, the update adjustment factor, and all legislative impacts, such as the addition of certain preventive services under the Affordable Care Act. The sequestration of all Medicare payments in 2013 through 2023 does not affect allowed charges and therefore is not reflected in table IV.B1. Its impact is included in table IV.B2.

Table IV.B1.—Components of Increases in Total Allowed Charges per Fee-for-Service Enrollee for Carrier Services

[In percent]

	Physician fee schedule									
	Increase due to price changes									
Calendar year	MEI	UAF[1]	Physician update[2]	Modified update[3]	Residual factors	Total increase[4]	CPI	DME	Lab	Other carrier
Aged:										
2004	2.9%	−1.4%	1.8%	3.8%	5.9%	10.0%	2.6%	−0.5%	7.6%	7.6%
2005	3.1	−1.6	1.5	2.1	3.2	5.4	3.5	1.4	6.3	3.1
2006	2.8	−2.6	0.2	0.2	4.6	4.7	3.2	5.0	7.7	5.5
2007	2.1	−2.1	0.0	−1.4	3.5	2.1	2.9	2.9	9.8	4.7
2008	1.8	−1.3	0.5	0.4	3.3	3.7	4.1	6.4	7.3	4.2
2009	1.6	−0.5	1.1	1.6	1.4	3.0	−0.7	−7.4	8.4	7.9
2010	1.2[5]	0.1[5]	1.3[5]	2.5	1.4	4.0	2.1	1.2	1.4	3.3
2011	0.4	0.5	0.9	0.9	2.2	3.2	3.6	−3.8	−2.8	4.5
2012	0.6	−0.6	0.0	−1.1	0.9	−0.2	2.1	0.7	6.5	3.2
2013	0.8	−0.8	0.0	−0.1	−0.5	−0.6	1.4	−12.1	−1.4	2.3
2014	0.8	−0.3	0.5	0.5	1.7	2.2	1.6	−11.3	3.2	3.9
2015	1.3	−1.3	0.0	−1.0	−2.7	−3.7	1.9	1.3	3.4	2.0
2016	1.9	−1.3	0.6	0.2	2.0	2.1	2.2	−11.2	5.1	2.3
2017	2.7	−2.0	0.6	0.7	2.3	3.0	2.4	3.4	−2.1	4.1
2018	3.0	−2.3	0.6	0.9	3.2	4.1	2.6	5.2	4.4	4.4
2019	3.2	−2.5	0.6	0.5	3.8	4.4	2.7	5.1	4.0	4.2
2020	2.8	−2.1	0.6	0.4	3.7	4.2	2.7	5.0	11.7	4.6
2021	2.6	−1.9	0.6	0.6	3.6	4.3	2.7	5.2	4.0	4.7
2022	2.6	−1.9	0.6	0.6	3.8	4.5	2.7	5.2	4.2	4.9
2023	2.6	−1.9	0.6	0.6	3.8	4.5	2.7	5.2	12.9	4.9
Disabled (excluding ESRD):										
2004	2.9	−1.4	1.8	3.8	−1.2	2.6	2.6	15.4	1.1	15.2
2005	3.1	−1.6	1.5	2.1	6.2	8.4	3.5	−0.8	6.1	11.7
2006	2.8	−2.6	0.2	0.2	3.9	4.1	3.2	2.0	5.8	5.5
2007	2.1	−2.1	0.0	−1.4	4.3	2.8	2.9	5.5	8.0	−5.1
2008	1.8	−1.3	0.5	0.4	−0.1	0.3	4.1	2.1	10.4	3.8
2009	1.6	−0.5	1.1	1.6	1.8	3.4	−0.7	6.3	11.9	8.5
2010	1.2[5]	0.1[5]	1.3[5]	2.5	3.4	6.0	2.1	−2.3	21.3	9.5
2011	0.4	0.5	0.9	0.9	4.6	5.5	3.6	1.7	−3.4	4.9
2012	0.6	−0.6	0.0	−1.1	3.8	2.6	2.1	−3.0	6.6	3.9
2013	0.8	−0.8	0.0	−0.1	1.1	1.0	1.4	1.1	24.8	2.4
2014	0.8	−0.3	0.5	0.5	1.1	1.6	1.6	−10.0	10.3	−0.3
2015	1.3	−1.3	0.0	−1.0	3.5	2.4	1.9	−11.1	3.4	4.1
2016	1.9	−1.3	0.6	0.2	−3.7	−3.6	2.2	1.4	3.6	1.7
2017	2.7	−2.0	0.6	0.7	1.5	2.2	2.4	−11.1	5.2	1.8
2018	3.0	−2.3	0.6	0.9	2.1	3.0	2.6	3.2	−2.1	3.8
2019	3.2	−2.5	0.6	0.5	3.5	4.0	2.7	5.1	4.3	4.1
2020	2.8	−2.1	0.6	0.4	3.9	4.4	2.7	5.0	4.0	3.9
2021	2.6	−1.9	0.6	0.6	3.5	4.1	2.7	5.0	11.6	4.4
2022	2.6	−1.9	0.6	0.6	3.6	4.3	2.7	5.1	4.0	4.5
2023	2.6	−1.9	0.6	0.6	3.6	4.3	2.7	5.1	4.0	4.5

[1]Update adjustment factor.
[2]Reflects the growth in the MEI, the update adjustment, and legislation that affects the physician fee schedule update. The projected baseline scenario includes the assumption of a physician update of 0 percent for all of 2015 and of 0.6 percent for 2016 and later.
[3]Reflects the growth in the MEI, the update adjustment, and all legislation affecting physician services—for example, the addition of new preventative services enacted in 1997, 2000, and 2010. The legislative impacts would include those listed in footnote 2.
[4]Equals combined increases in allowed fees and residual factors.
[5]A physician payment price change occurred on June 1, 2010.

Per capita physician charges also have changed each year as a result of a number of other factors besides fee increases, including more physician visits and related services per enrollee, the aging of the

Medicare population, greater use of specialists and more expensive techniques, and certain administrative actions. The fifth column of table IV.B1 shows the increases in charges per enrollee resulting from these residual factors. Because the measurement of increased allowed charges per service is subject to error, residual causes implicitly include any such errors. Residual growth has been slow for 2009 through 2013.

Part B expenditures are further affected by the sequestration of non-salary Medicare expenditures, which applies from April 1, 2013 to September 30, 2024. Under the sequestration, Medicare benefit payments will be reduced by a specified percentage (usually around 2 percent), and administrative expenses will be reduced by an assumed 5 percent. Based on the increases in table IV.B1, and incorporating the sequestration of Medicare expenditures, table IV.B2 shows the estimates of the average incurred reimbursement for carrier services per fee-for-service enrollee.

Table IV.B2.—Incurred Reimbursement Amounts per Fee-for-Service Enrollee for Carrier Services

Calendar year	Fee-for-service enrollment [millions]	Physician fee schedule	DME	Lab	Other carrier
Aged:					
2004	28.440	$1,638.83	$212.88	$96.88	$426.09
2005	28.433	1,724.29	215.43	103.01	440.39
2006	27.613	1,801.14	225.20	110.95	464.47
2007	26.936	1,836.65	231.39	121.86	486.45
2008	26.457	1,905.33	246.10	130.70	506.47
2009	26.230	1,963.18	227.83	141.76	546.20
2010	26.427	2,037.27	229.67	143.74	564.26
2011	26.592	2,114.84	221.13	139.73	591.21
2012	26.898	2,133.03	223.45	148.81	611.14
2013	27.100	2,089.88	193.59	144.58	616.89
2014	27.210	2,152.87	170.46	148.75	627.03
2015	28.372	2,046.66	172.78	153.81	640.09
2016	29.288	2,090.82	152.75	161.69	654.97
2017	30.029	2,147.55	157.74	158.32	681.42
2018	31.017	2,232.90	166.01	165.24	711.56
2019	31.865	2,329.74	174.51	171.84	741.16
2020	32.729	2,425.10	183.25	191.86	775.19
2021	33.623	2,527.86	192.83	199.54	811.19
2022	34.582	2,639.91	202.89	207.94	850.53
2023	35.589	2,749.99	212.96	234.15	889.86
Disabled (excluding ESRD):					
2004	5.100	1,338.08	322.06	84.81	391.10
2005	5.309	1,390.70	328.14	89.72	413.68
2006	5.236	1,426.47	345.20	96.98	392.00
2007	5.264	1,432.39	351.98	107.07	407.05
2008	5.276	1,483.87	373.92	119.74	440.45
2009	5.337	1,574.35	365.36	145.23	482.08
2010	5.518	1,672.53	370.83	140.45	506.14
2011	5.691	1,724.43	359.90	149.78	527.16
2012	5.726	1,769.64	364.95	186.98	540.86
2013	5.677	1,776.29	323.95	203.18	531.52
2014	5.640	1,880.20	288.91	210.57	555.21
2015	5.760	1,790.32	293.07	218.19	564.87
2016	5.806	1,830.32	259.68	229.57	575.25
2017	5.787	1,879.47	267.90	224.76	596.95
2018	5.837	1,952.04	281.65	234.36	621.26
2019	5.761	2,036.30	295.71	243.71	645.27
2020	5.660	2,119.32	310.52	272.09	673.80
2021	5.545	2,208.81	326.39	282.98	703.91
2022	5.431	2,301.71	343.06	294.29	735.37
2023	5.320	2,392.38	359.72	330.73	766.38

ii. Durable Medical Equipment (DME), Laboratory, and Other Carrier Services

Along with physician services, unique fee schedules or reimbursement mechanisms have been established for virtually all other non-physician carrier services. Table IV.B1 shows the increases in the allowed charges per fee-for-service enrollee for DME, laboratory services, and other carrier services, which are not affected by the sequestration of payment. Based on the increases in table IV.B1 in addition to the impact of sequestration for 2013 through 2023, table IV.B2 shows the corresponding estimates of the

average incurred reimbursement for these services per fee-for-service enrollee.

The fee schedules for each of these expenditure categories are updated by increases in the CPI, together with any applicable legislated limits on payment updates. In particular, under the Affordable Care Act, starting in 2011 these fees are updated by the increase in the CPI minus the increase in the 10-year moving average of private, nonfarm business multifactor productivity. Starting in 2017, laboratory services will no longer be affected by the annual productivity adjustments, as the Protecting Access to Medicare Act of 2014 links payments for Medicare laboratory services to private payment rates.[61] Per capita charges for these expenditure categories have also grown as a result of other factors, including increased number of services provided, the aging of the Medicare population, more expensive services, and certain administrative actions. This expenditure growth is projected based on recent past trends in growth per enrollee.

(b) Intermediary Services

Over the years, legislation has established new payment systems for virtually all Part B intermediary services, including a fee schedule for tests performed in laboratories in hospital outpatient departments. The Balanced Budget Act (BBA) of 1997 implemented a prospective payment system (PPS), which began August 1, 2000, for services performed in the outpatient department of a hospital. It also implemented a PPS for home health agency services, which began October 1, 2000. Table IV.B3 shows the historical and projected increases in charges and costs per fee-for-service enrollee for intermediary services, excluding the impact of sequestration.

[61]This change to laboratory payments also applies to outpatient hospital laboratory services.

Table IV.B3.—Components of Increases in Recognized Charges and Costs per Fee-for-Service Enrollee for Intermediary Services

[In percent]

Calendar year	Outpatient hospital	Home health agency	Outpatient lab	Other intermediary
Aged:				
2004	11.1%	14.6%	7.1%	15.6%
2005	10.8	15.9	5.4	13.5
2006	5.1	17.6	4.4	7.5
2007	8.3	18.9	3.0	7.5
2008	6.3	12.4	5.1	6.0
2009	8.9	14.7	8.2	8.2
2010	5.8	2.0	2.6	3.2
2011	7.6	−6.1	4.6	2.9
2012	7.4	−3.4	3.9	4.2
2013	6.4	−0.9	−1.3	−2.3
2014	12.2[1]	−0.2	−63.6[1]	4.1
2015	6.2	0.4	3.6	−5.3
2016	5.8	1.0	5.2	0.8
2017	6.9	2.1	−2.0	4.0
2018	7.1	5.2	4.4	4.3
2019	6.8	5.1	4.1	4.6
2020	7.1	5.2	11.7	4.9
2021	7.2	5.3	4.1	4.7
2022	7.1	5.5	4.1	4.8
2023	7.1	5.4	12.8	4.8
Disabled (excluding ESRD):				
2004	12.7	14.2	8.8	14.9
2005	10.7	16.8	6.6	13.2
2006	5.4	20.3	6.1	11.5
2007	8.0	20.2	6.4	14.3
2008	7.4	14.4	6.1	6.0
2009	9.9	16.3	9.8	8.8
2010	5.8	−0.4	0.8	−0.2
2011	7.1	−5.3	5.7	0.7
2012	8.5	−0.7	4.5	1.8
2013	7.1	−0.2	−0.6	2.2
2014	12.4[1]	1.1	−63.5[1]	5.0
2015	6.5	0.6	3.7	−1.5
2016	5.8	1.5	5.2	2.7
2017	6.8	2.4	−2.1	4.6
2018	6.7	5.3	4.3	4.9
2019	6.7	5.5	4.0	4.7
2020	7.1	5.6	11.6	5.0
2021	7.1	5.6	4.0	4.9
2022	7.0	5.5	4.0	5.0
2023	7.0	5.2	12.7	5.0

[1]Effective January 1, 2014, a large portion of outpatient laboratory services was bundled into the outpatient prospective payment system.

Based on the increases in table IV.B3, table IV.B4 shows the estimates of the incurred reimbursement for the various intermediary services per fee-for-service enrollee. Each of these expenditure categories is projected on the basis of recent trends in growth per enrollee, along with applicable legislated limits on payment updates and the effects of sequestration.

Table IV.B4.—Incurred Reimbursement Amounts per Fee-for-Service Enrollee for Intermediary Services

Calendar year	Fee-for-service enrollment [millions]	Outpatient hospital	Home health agency	Outpatient lab	Other intermediary
Aged:					
2004	28.440	$482.14	$187.68	$93.14	$238.85
2005	28.433	555.13	217.43	98.14	267.20
2006	27.613	604.29	255.72	102.43	284.40
2007	26.936	664.56	303.92	105.51	304.20
2008	26.457	723.78	341.56	110.89	323.05
2009	26.230	802.97	391.61	119.95	348.10
2010	26.427	853.91	399.30	123.09	356.83
2011	26.592	928.29	374.88	128.76	364.76
2012	26.898	1,002.28	362.22	133.72	379.39
2013	27.100	1,057.88	358.85	129.97	362.50
2014	27.210	1,190.53[1]	358.28	47.11[1]	382.29
2015	28.372	1,274.49	359.54	48.79	362.62
2016	29.288	1,353.52	363.07	51.35	365.69
2017	30.029	1,447.26	370.63	50.33	380.30
2018	31.017	1,550.54	389.94	52.53	396.60
2019	31.865	1,656.12	409.94	54.68	414.97
2020	32.729	1,773.26	431.10	61.06	435.14
2021	33.623	1,900.92	454.09	63.57	455.45
2022	34.582	2,035.66	479.22	66.18	477.26
2023	35.589	2,174.79	504.92	74.45	498.85
Disabled (excluding ESRD):					
2004	5.100	561.94	143.06	101.91	163.96
2005	5.309	642.26	167.11	108.59	181.52
2006	5.236	698.06	200.97	115.25	198.83
2007	5.264	762.03	241.55	122.66	226.48
2008	5.276	834.04	276.45	130.10	239.38
2009	5.337	933.24	321.48	142.86	258.26
2010	5.518	989.91	320.07	143.95	254.29
2011	5.691	1,068.54	303.17	152.10	251.64
2012	5.726	1,165.84	300.92	158.98	254.11
2013	5.677	1,239.54	300.23	155.71	253.45
2014	5.640	1,397.15[1]	303.53	56.48[1]	275.21
2015	5.760	1,500.29	305.30	58.54	271.13
2016	5.806	1,599.56	309.82	61.61	278.52
2017	5.787	1,711.36	317.27	60.32	291.40
2018	5.837	1,826.36	334.07	62.90	305.75
2019	5.761	1,948.44	352.36	65.41	320.22
2020	5.660	2,085.99	371.98	73.03	336.16
2021	5.545	2,233.75	392.75	75.95	352.45
2022	5.431	2,389.57	414.44	78.99	369.95
2023	5.320	2,550.20	436.12	88.76	387.49

[1]Effective January 1, 2014, a large portion of outpatient laboratory services was bundled into the outpatient prospective payment system.

As indicated in table IV.B4, expenditures for outpatient hospital services increased significantly due to provisions in the BBA, the Balanced Budget Refinement Act of 1999, and the Benefits Improvement and Protection Act of 2000 that reduced beneficiaries' coinsurance payments to levels more consistent with other Part B services but maintained the same total payment to the hospital. The result is that Medicare pays a larger portion of the total outpatient hospital costs.

Actuarial Methodology

Part B expenditures for home health services had been increasing very rapidly through 2009, in part due to suspected fraud and abuse in South Florida and certain other parts of the country. In late 2008, CMS suspended payments to a number of home health agencies and increased program integrity efforts for this category of services. From 2010 onward, outlier payments to agencies have been capped as a percentage of total payments. Assumed growth rates for home health expenditures reflect this initiative, along with the ongoing effects of growth in the number of beneficiaries, payment rates, utilization of services, and legislated changes affecting future payments.

(3) Projected Fee-for-Service Payments for Persons with End-Stage Renal Disease

Most persons with ESRD are eligible to enroll for Part B coverage. For analytical purposes, this section includes both enrollees who qualify for Medicare due to ESRD and those who are also eligible as Disability Insurance beneficiaries because their per enrollee costs are both higher and different in nature from those of most other disabled persons. Specifically, most of the Part B reimbursements for both groups are related to kidney transplants and renal dialysis.

The estimates under the intermediate assumptions reflect the payment mechanism for reimbursing ESRD services. Payment for dialysis services occurs through a bundled payment system, which began in 2011. The bundled payment rate is updated annually by an annual ESRD market basket less the increase in economy-wide productivity. Also, the estimates assume a continued increase in enrollment. Table IV.B5 shows the historical and projected enrollment and costs for Part B benefits, including the effects of sequestration.

Table IV.B5.—Enrollment and Incurred Reimbursement for End-Stage Renal Disease

	Average enrollment [thousands]		Reimbursement [millions]	
Calendar year	Disabled	Non-disabled	Disabled	Non-disabled
2004	124	84	$3,168	$1,978
2005	130	87	3,477	2,236
2006	132	89	3,824	2,463
2007	137	89	4,001	2,613
2008	141	90	4,240	2,693
2009	146	91	4,640	2,816
2010	152	93	4,725	2,773
2011	157	95	4,855	2,847
2012	158	98	5,157	2,985
2013	158	101	5,296	2,939
2014	160	103	5,410	3,045
2015	162	105	5,513	3,123
2016	163	107	5,693	3,250
2017	164	108	5,887	3,395
2018	164	109	6,104	3,556
2019	163	110	6,347	3,752
2020	161	111	6,590	3,956
2021	160	112	6,825	4,163
2022	158	112	7,068	4,377
2023	157	113	7,311	4,591

(4) Private Health Plan Costs

Part B payments to private health plans have generally increased significantly from the time that such plans began to participate in the Medicare program in the 1970s. Most of the growth in expenditures has been due to the increasing numbers of beneficiaries who have enrolled in these plans. Section IV.C of this report contains a description of the assumptions and methodology for the private health plans that provide coverage of Part B services for certain enrollees.

(5) Administrative Expenses

The ratio of Part B administrative expenses to total expenditures has declined to roughly 1.5 percent in recent years. Projections of administrative costs are based on estimates of changes in average annual wages, fee-for-service enrollment, and an assumed 5-percent reduction in expenditures due to sequestration.

b. Summary of Aggregate Reimbursement Amounts on a Cash Basis under the Intermediate Assumptions

Table IV.B6 shows aggregate historical and projected reimbursement amounts by type of service on a cash basis under the intermediate assumptions. The difference between reimbursement amounts on a cash versus incurred basis results from the lag between the time of service and the time of payment. Historically, this lag has gradually decreased.

Table IV.B6.—Aggregate Part B Reimbursement Amounts on a Cash Basis

[In millions]

	Carrier					Intermediary							
Calendar year	Physician fee schedule	DME	Lab	Other	Total	Hospital	Lab	Home health agency	Other	Total	Total FFS	Private health plans	Total Part B
Historical data:													
2004	$54,080	$7,739	$3,318	$14,177	$79,314	$16,861	$3,297	$5,852	$10,856	$36,865	$116,179	$18,672	$134,851
2005	57,678	8,007	3,548	15,283	84,516	18,692	3,354	7,080	11,403	40,529[1]	125,045	22,012	147,057
2006	58,145	8,314	3,694	15,509	85,662	20,836	3,541	7,814	12,392	44,583[1]	130,245	31,460	161,704
2007	58,785	8,163	4,144	15,801	86,894	22,022	3,471	9,191	13,033	47,716[1]	134,610	38,858	173,468
2008	60,556	8,627	4,260	16,583	90,026	23,571	3,615	10,304	13,005	50,494	140,520	48,106	188,626
2009	61,801	8,211	4,671	17,760	92,443	26,244	3,983	11,737	14,615	56,578	149,021	53,378	202,400
2010	63,893	8,272	4,808	18,262	95,236	27,990	4,118	11,971	14,960	59,039	154,275	55,186	209,460
2011	67,474	8,171	4,579	19,261	99,485	31,379	4,420	12,111	14,951	62,862	162,347	59,124	221,471
2012	69,475	8,235	5,102	20,252	103,063	34,675	4,675	11,467	16,385	67,201	170,265	65,968	236,233
2013	68,583	7,139	5,116	20,314	101,152	37,217	4,630	11,541	16,230	69,619	170,771	72,656	243,427
Intermediate estimates:													
2014	70,960	6,401	5,277	20,828	103,466	40,767	1,837	11,444	16,558	70,605	174,071	84,846	258,917
2015	70,017	6,681	5,641	21,989	104,329	45,426	1,749	11,860	16,739	75,774	180,103	85,187	265,290
2016	73,671	6,192	6,094	23,159	109,115	49,692	1,892	12,344	17,194	81,121	190,237	89,684	279,921
2017	77,025	6,378	6,120	24,561	114,085	54,174	1,900	12,864	18,129	87,068	201,153	97,877	299,030
2018	82,263	6,864	6,519	26,343	121,990	59,559	2,028	13,852	19,244	94,682	216,672	105,307	321,979
2019	87,699	7,346	6,913	28,030	129,988	64,904	2,153	14,888	20,444	102,389	232,377	115,402	347,779
2020	93,176	7,841	7,811	29,901	138,728	70,789	2,438	15,998	21,721	110,947	249,676	128,010	377,686
2021	99,100	8,379	8,316	31,919	147,715	77,289	2,597	17,207	23,047	120,139	267,854	141,368	409,222
2022	105,691	8,966	8,825	34,168	157,650	84,413	2,757	18,558	24,490	130,218	287,867	155,381	443,248
2023	112,468	9,568	10,055	36,503	168,594	91,969	3,148	19,975	25,957	141,049	309,643	169,751	479,394

[1]Amounts shown exclude payments inadvertently made from the Part B account in 2005-2007 to cover the costs of certain Part A hospice benefits.

c. Projections under Alternative Assumptions

Projections of Part B cash expenditures under the projected baseline for the low-cost and high-cost alternatives were developed by modifying the growth rates estimated under the intermediate assumptions. Beginning in calendar year 2014, the low-cost and high-cost alternatives contain assumptions that result in benefits increasing, relative to the Gross Domestic Product (GDP), 2 percent less rapidly and 2 percent more rapidly, respectively, than the results under the intermediate assumptions. Administrative expenses under the low-cost and high-cost alternatives are projected on the basis of their respective wage series growth.

2. Part D

Part D is a voluntary Medicare prescription drug benefit that offers beneficiaries enrolled in either Part A or Part B a choice of private drug insurance plans in which to enroll. Medicare substantially subsidizes the cost of the drug coverage. Low-income beneficiaries can receive additional assistance on the cost sharing and premiums, depending on their resource levels. Each year drug plan sponsors submit bids that include estimated total plan costs, prospective reinsurance payments (which are roughly 80 percent of the cost above the Part D catastrophic threshold), and low-income cost-sharing subsidies according to their experience and their expectations for the coming year. Upon approval of these bids, a national average bid amount and premium are calculated, and, based on the plan's bid relative to the national average bid, the individual plan premiums are determined dollar-for-dollar above or below the national average premium.

Each drug plan receives direct subsidies (calculated as the risk-adjusted plan bid amount minus the plan premium), prospective reinsurance payments, and prospective low-income cost-sharing subsidies from Medicare, as well as premiums from the beneficiaries and premium subsidies from Medicare on behalf of low-income enrollees. At the end of the year, the prospective reinsurance and low-income cost-sharing subsidy payments are reconciled to match the plan's actual experience. In addition, if actual experience differs from the plan's bid beyond specified risk corridors, Medicare shares in the plan's experience gain or loss.

Expenditures for this voluntary prescription drug benefit, which started on January 1, 2006, were determined by combining estimated Part D enrollment with projections of per capita spending. Actual

Part D spending information for 2013 was used as the base year in the projected baseline.

a. Participation Rates

All individuals enrolled in Medicare Part A or Part B are eligible to enroll in the voluntary prescription drug benefit.

(1) Employer-Sponsored Plans

There are several ways that employer-sponsored plans can benefit from the Part D program. One way is the retiree drug subsidy (RDS), in which, for qualifying employer-sponsored plans, Medicare subsidizes a portion of their qualifying retiree drug expenses. Beginning in 2013 under the Affordable Care Act, employers are no longer able to deduct retiree health plan costs reimbursed by the RDS. In addition, RDS claims are not eligible for the 50-percent brand-name drug discount, and the 28-percent RDS subsidy rate remains constant even though the coverage gap will be closing over time for other Part D drug plan participants. As a result of these changes, RDS program participation declined significantly from 15 percent of all Part D beneficiaries in 2012 to 8 percent in 2013 and is assumed to decline steadily to about 2 percent of total Part D enrollment by 2019. The Trustees expect that the majority of the retirees losing drug coverage through RDS plans will participate in other Part D plans.

Another way that an employer-sponsored plan can benefit from Part D is to enroll in an employer/union-only group waiver plan (EGWP) by either wrapping around an existing Part D plan or becoming a prescription drug plan itself. The subsidies for these types of arrangements will generally be calculated in the same way as for other Part D plans. The Trustees expect that such plans will offer additional benefits beyond the standard Part D benefit package. EGWP enrollment increased significantly from 2012, when 9 percent of all beneficiaries participated in Part D, to 2013, when 15 percent participated. This proportion is estimated to increase to about 19 percent by 2019, primarily due to a switch to EGWPs by a large percentage of the beneficiaries who lost RDS coverage as a result of the changes under the Affordable Care Act.

(2) Low-Income Subsidy

Qualifying low-income beneficiaries can receive additional Part D subsidies to help finance premium and cost-sharing payments.

Subsidies are estimated for beneficiaries who apply for this assistance and meet the income and asset requirements. Most beneficiaries who qualify for both Medicare and Medicaid are automatically enrolled in plans with premiums below the low-income premium benchmarks within their regions, thereby receiving full subsidization of their Part D premiums. After several years of the continuing outreach effort and the enactment of the Medicare Improvements for Patients and Providers Act of 2008, which expanded the number of individuals eligible for low-income status, the estimated number of low-income enrollees is projected to remain at approximately 28 percent of total beneficiaries participating in Part D from 2013 to 2023.

(3) Other Part D Beneficiaries

Medicare beneficiaries not covered by employer-sponsored plans and not qualified for the low-income subsidy have the option to enroll in a Part D plan. Once enrolled, they will pay for premiums and any applicable deductible, coinsurance, and/or copayment. The percentage of non-employer and non-low-income Medicare beneficiaries[62] opting to enroll in a Part D plan was about 58 percent in 2013. Based on recent experience, this participation rate is projected to grow to 63 percent by 2023.

Table IV.B7 provides a summary of the estimated average enrollment in Part D, by category.

[62]A significant portion of the remaining eligible beneficiaries who do not participate in Part D plans receive creditable coverage through another source (such as the Federal Employees Health Benefits Program, TRICARE for Life, the Veterans Administration, and the Indian Health Service).

Table IV.B7.—Part D Enrollment

[In millions]

Calendar year	Retiree drug subsidy[1]	EGWP	Low-income subsidy: Medicaid full-benefit dual eligible	Low-income subsidy: Other, with full subsidy	Low-income subsidy: Other, with partial subsidy	Low-income subsidy: Total	All others	Total
Historical estimates:								
2006	7.2	1.4	5.7	2.3	0.2	8.3	10.7	27.6
2007	7.1	1.8	5.9	3.0	0.3	9.2	13.3	31.4
2008	6.8	2.1	6.3	3.2	0.3	9.7	13.9	32.6
2009	6.7	2.3	6.4	3.3	0.3	10.0	14.6	33.6
2010	6.8	2.4	6.6	3.5	0.3	10.4	15.1	34.8
2011	6.2	2.8	6.6	3.7	0.3	10.6	16.0	35.7
2012	5.6	3.5	6.9	3.7	0.3	11.0	17.2	37.4
2013	3.3	5.9	7.1	4.0	0.3	11.5	18.4	39.1
Intermediate estimates:								
2014	2.6	6.8	7.1	4.1	0.3	11.5	19.8	40.7
2015	2.1	7.4	7.3	4.3	0.4	11.9	20.9	42.2
2016	1.6	7.9	7.5	4.4	0.4	12.2	22.0	43.7
2017	1.3	8.4	7.7	4.5	0.4	12.6	23.1	45.3
2018	1.0	8.8	7.9	4.7	0.4	13.0	23.8	46.6
2019	0.9	9.2	8.2	4.8	0.4	13.4	24.5	47.9
2020	0.9	9.4	8.4	4.9	0.4	13.7	25.3	49.4
2021	0.9	9.7	8.6	5.1	0.4	14.1	26.0	50.8
2022	1.0	10.0	8.9	5.2	0.4	14.5	26.8	52.2
2023	1.0	10.3	9.1	5.4	0.4	14.9	27.5	53.7

[1]Excludes Federal Government and military retirees covered by either the Federal Employees Health Benefit Program or the TRICARE for Life program. Such programs qualify for the retiree drug subsidy, but the subsidy will not be paid since it would amount to the Federal Government subsidizing itself.

b. Cost Projection Methodology on an Incurred Basis

(1) Drug Benefit Categories

Projected drug expenses are allocated to the beneficiary premium, direct subsidy, and reinsurance subsidy by the Part D premium formula based on the benefit formula specifications (deductible, coinsurance, initial coverage limit, and catastrophic threshold) for beneficiaries in prescription drug plans and Medicare Advantage drug plans. Low-income beneficiaries receive additional subsidies to help finance premium and cost-sharing payments. Subsidies are estimated for beneficiaries who meet the income and asset requirements.

The statute specifies that the base beneficiary premium is equal to 25.5 percent of the sum of the national average monthly bid amount and the estimated catastrophic reinsurance. The actual premium is greater, dollar for dollar, for plans with bids above the national average and lower for plans with lower bids. The average premium amount per enrollee is estimated based on the base beneficiary premium with an adjustment to reflect enrollees' tendency to select plans with below-average premiums. Beginning in 2011, Part D collects income-related premiums (in addition to the premiums charged by the plans) for individuals whose modified adjusted gross

income exceeds a specified threshold. The amount of the income-related premium depends upon the individual's income level. The extra premium amount is the difference between 35, 50, 65, or 80 percent and 25.5 percent applied to the national average monthly bid amount adjusted for reinsurance.

(2) Projection Base

The projected baseline in this year's report is based in part on actual Part D spending data through 2013. These data include amounts for total prescription drug costs, costs above the catastrophic threshold, plan payments, and low-income cost-sharing payments.

Estimates under the intermediate assumptions are calculated by establishing the total prescription drug costs for 2013 and then projecting these costs through the estimation period. The drug cost trends for 2012 through 2015 are relatively low since a number of commonly used drugs will be losing patent protection in those years. The projected Part D growth rates for those years are slightly different from the national health expenditure (NHE) trends to account for the different proportion of spending for those drugs in Part D versus the NHE projections. The per capita drug expenses for the total U.S. population transition to the NHE projections by 2017. Then the financial effects of the Affordable Care Act on Part D are estimated and translated to an additional growth rate factor. The combined growth rates are used as the Part D per capita cost trends to project the future drug expenses. Table IV.B8 shows the Part D per capita growth rates along with the NHE trends.

To determine the estimated benefits for Part D, the total per capita drug costs are adjusted for two key factors. First, Part D benefit costs are reduced for the total amount of rebates that the prescription drug plans receive from drug manufacturers. Second, these plans incur administrative costs for plan operation and earn profits. Since drug expenses grow faster than administrative costs, the administrative expenses as a percentage of benefits slowly decrease over time. However, beginning in 2014 health insurance plans are assessed an annual insurer fee that will be calculated based on their applicable premiums written in the prior year. As a result, administrative costs are projected to increase from 2014 through 2017. Table IV.B8 displays these key factors affecting Part D expenditure estimates.

Table IV.B8.—Key Factors for Part D Expenditure Estimates[1]

Calendar year	National health expenditure (NHE) drug projections[2]	Part D per capita cost trend[3]	Manufacturer rebates	Plan administrative expenses and profits[4]
Historical data:				
2006	—	—	8.6%	12.4%
2007	4.3%	1.4%	9.6	13.6
2008	1.9	3.8	10.4	13.2
2009	4.1	3.0	11.1	12.7
2010	−0.4	1.3	11.3	13.7
2011	1.9	3.8	11.5	13.1
2012	−0.4	−1.7	11.7	12.1
Intermediate estimates:				
2013	0.0	2.2	12.0	12.0
2014	2.3	2.3	13.5	12.7
2015	3.6	3.7	13.5	13.1
2016	4.5	4.5	13.5	13.1
2017	5.0	5.2	13.5	13.3
2018	5.2	5.3	13.5	13.2
2019	5.5	5.6	13.5	13.0
2020	5.7	5.7	13.4	12.8
2021	5.8	5.8	13.4	12.6
2022	5.8	5.8	13.4	12.5
2023	5.8	5.8	13.4	12.3

[1]These factors do not reflect the impact of the sequestration for 2013-2024.
[2]The CMS Office of the Actuary expects to publish a full account of the updated NHE projections in September 2014. Values do not reflect the additional Part D expenditure growth that will result from the gradual elimination of the coverage gap from 2011 to 2020. This impact is accounted for separately in the projection.
[3]Values reflect ACA add-on and other law changes.
[4]Expressed as a percentage of plan benefit payments.

(3) Manufacturer Rebates

Prescription drug plans can negotiate rebates with drug manufacturers. Actual rebates for 2012 were approximately 11.7 percent of total prescription drug costs, which was somewhat higher than the plans estimated in their bid submissions. In the 2014 plan bids, however, plans significantly increased the projected rebates. Since the plans have historically underbid the amount of rebates, it is assumed that the plans have adjusted their projections appropriately and are now closer to the future rebate amount. As a result, rebates are projected to increase from 12.0 percent in 2013 to 13.4 percent in 2023, as shown in table IV.B8.[63]

(4) Administrative Expenses

The plans' expected administrative costs and projected profit margins from their 2014 bids are used as the base-year amounts. Administrative expenses are then projected forward with wage

[63]These are average rebate percentages across all prescription drugs. Generic drugs, which represent about 84 percent of all Part D drug use in 2013, typically do not carry manufacturer rebates. Many brand-name prescription drugs carry substantial rebates, often as much as 20-30 percent.

increases. The plan profit margins are projected using the per capita benefit trend. Beginning in 2014, the ACA requires insurers, including Part D plans, to pay a fee based on their applicable premiums from the prior year. This requirement results in an increase in administrative expenses included in plan bids beginning in 2014, as shown in table IV.B8.

(5) Incurred Per Capita Reimbursements

Table IV.B9 shows estimated enrollments and average per capita reimbursements for beneficiaries in private prescription drug plans, low-income beneficiaries, and beneficiaries in RDS plans. The direct subsidy and retiree drug subsidy are affected by the sequestration of Medicare expenditures, which applies from April 1, 2013 to September 30, 2024. Under the sequestration, Medicare benefit payments will be reduced by a specified percentage (usually around 2 percent), and administrative expenses will be reduced by an assumed 5 percent.

Table IV.B9.—Incurred Reimbursement Amounts per Enrollee for Part D Expenditures

	Private plans (PDPs and MA-PDs)						
	All beneficiaries			Low-income subsidy		Retiree drug subsidy	
Calendar year	Enrollment (millions)	Direct subsidy	Reinsur-ance	Enrollment (millions)	Subsidy amount	Enrollment (millions)	Subsidy amount
Historical data:							
2006	20.3	$867	$297	8.3	$1,817	7.2	$527
2007	24.3	744	330	9.2	1,820	7.1	548
2008	25.8	687	366	9.7	1,858	6.8	553
2009	26.9	702	375	10.0	1,955	6.7	579
2010	28.0	705	399	10.4	2,019	6.8	570
2011	29.5	681	465	10.6	2,093	6.2	578
2012	31.8	655	487	11.0	2,045	5.6	575
2013	35.8	566	544	11.5	2,029	3.3	569
Intermediate estimates:							
2014	38.1	491	576	11.5	1,971	2.6	582
2015	40.1	548	614	11.9	1,996	2.1	604
2016	42.1	597	650	12.2	2,063	1.6	631
2017	44.1	645	683	12.6	2,154	1.3	663
2018	45.6	693	714	13.0	2,259	1.0	697
2019	47.1	745	753	13.4	2,376	0.9	735
2020	48.5	809	788	13.7	2,502	0.9	777
2021	49.9	851	838	14.1	2,633	0.9	822
2022	51.3	896	893	14.5	2,773	1.0	870
2023	52.7	940	951	14.9	2,919	1.0	918

c. Cost Projection Methodology on a Cash Basis

(1) Prospective Payments

Prospective payments are made to the drug plans each month based on their actuarial bid submissions for that year. These data represent the plans' expectations of costs for pharmacy expenses (including

discounts, rebates, and utilization management savings) and administrative costs (including profit margins). Separate amounts are determined for the direct subsidy, reinsurance, and low-income cost-sharing payments. All Part D plans receive the same direct subsidy adjusted for the enrollees' risk profile. In contrast, the prospective payments for reinsurance and low-income cost sharing are unique to each plan.

For 2012, the average plan bid was somewhat higher than actual prescription drug spending. In 2013, average bid amounts declined slightly and are expected to be close to the actual costs. Based on both the 2014 plan bids, which decreased from 2013, and the NHE projections, the 2014 and 2015 actual spending is assumed to be higher than the bid amounts. Beyond 2015, the bids are assumed to be about 1 percent higher than actual spending.

A new prospective payment began in 2011 under the brand-name drug discount program introduced by the Affordable Care Act. This program requires drug manufacturers to provide a 50-percent ingredient cost discount on brand-name drugs used by non-low-income subsidy enrollees within the coverage gap. The annual expected discount amounts are determined for each non-employer Part D plan based on their bids. Medicare initially pays these amounts to the plans prospectively, on a monthly basis, and the plans use these amounts to pay half of the ingredient costs for brand-name drugs purchased by beneficiaries with spending in the coverage gap. The Part D drug plans then pay back the prospective payments once they receive the actual discount amounts from the drug manufacturers.

(2) Reconciliation

After each plan year, the prospective payments are reconciled with actual plan costs. Either additional payments to plans or refunds to Part D will result from this reconciliation. Since the Federal Government fully funds the reinsurance and low-income benefits, the prospective reinsurance and low-income cost-sharing payments to drug plans will be reconciled with actual expenses on a dollar-for-dollar basis. Costs for the basic Part D benefit are subject to an arrangement in which the Federal Government shares the risk that these costs will differ from the plan's expectation. For each category of prospective payments, reconciliation payments for a particular year have typically been made in the latter part of the following year. Future reconciliation payments are also assumed to be made in the same time frame.

For plan year 2012, the total prospective reinsurance payments were below the actual reinsurance costs. As a result, Medicare net reconciliation payments amounted to $3.2 billion to the Part D plans in 2013. The Part D plans' estimate of reinsurance for plan year 2013 is expected to again be lower than the actual reinsurance costs. In addition, enrollment in EGWPs increased significantly in 2013 due to the program changes of the retiree drug subsidy as legislated by the Affordable Care Act. Since prospective reinsurance payments are not paid to EGWPs, all reinsurance payments will be paid through the reconciliation process. Accordingly, the Trustees expect that Medicare will make a larger reconciliation payment to the Part D plans in 2014 for plan year 2013 than in the previous year. In future plan years, the Trustees project that Medicare will continue to pay reconciliation payments to the Part D plans.

The prospective low-income cost-sharing payments in 2012 were slightly lower than the actual low-income cost-sharing amounts. As a result, there were modest net reconciliation payments totaling $0.6 billion from Medicare to the Part D plans. For 2013 through 2014, the Trustees expect that the actual low-income cost-sharing subsidies will continue to somewhat exceed the bid expectations. Thereafter, the prospective payments are projected to be slightly lower than the actual amounts, resulting in smaller net reconciliation payments to the drug plans.

Risk-sharing payments are calculated based on the actual level of expenditures compared to the expected level of expenditures included in the plan bids for the basic Part D benefit. Each plan's differential is allocated to the appropriate risk corridor using the statutory formula and the risk corridor thresholds for each year, together with the risk-sharing percentages within each threshold layer. To estimate aggregate net risk-sharing amounts, payments or receipts are calculated for each plan and then aggregated.

The drug plans made net risk-sharing payments of $1.1 billion to Medicare in 2013 because the 2012 bids were slightly higher than the actual experience. For plan year 2013, plan bids are again expected to be higher than the actual costs, but to a lesser extent. As a result, about $0.2 billion of net payments by Part D plans are anticipated. The bids for plan year 2014 are projected to be lower than the actual cost, and accordingly Medicare will make net payments of about $1.4 billion to the Part D plans. Beyond plan year 2014, actual costs are estimated to be slightly lower than the plan bids. Therefore, small net risk corridor receipts from plans to Medicare are projected.

As mentioned in section III.D, a new program of brand-name drug discounts began in 2011, requiring prospective payments from Part D to the drug plans. Part D does not ultimately bear the cost of the discounts, and the prospective payments and plans' repayments will be reconciled after the year end. The reconciliation amounts are expected to be minimal.

(3) Aggregate Reimbursements

Table IV.B10 shows aggregate projected reimbursements to plans and employers by type of payment. The 2014 Part D cash reimbursements are expected to have a higher growth rate from the 2013 level for the following reasons: (i) higher reconciliation payments in 2014 based on the assumption that 2013 bids will be lower than actual experience for reinsurance and low-income subsidies; and (ii) the projected increase of the administrative expenses in the 2014 bid amounts due to the aforementioned ACA-imposed insurance premium fees. After 2014, plan bids are expected to more closely match actual spending, resulting in cash and incurred amounts increasing at generally the same rate for 2015 and beyond. The direct subsidy and retiree drug subsidy are affected by the sequestration process, as discussed previously in this section.

Table IV.B10.—Aggregate Part D Reimbursement Amounts on a Cash Basis

[In billions]

Calendar year	Premiums[1]	Direct subsidy	Reinsurance	Low-income subsidy	Retiree drug subsidy	Risk sharing[2]	Advanced discount payment[3]	Other[4]	Total
Historical data:									
2006	$3.5	$17.3	$8.6	$15.1	$2.1	—	—	$0.3	$47.0
2007	4.1	18.4	7.1	16.5	3.5	−$0.7	—	0.0	48.8
2008	5.0	17.5	6.7	17.4	3.8	−1.3	—	—	49.0
2009	6.1[5]	18.8	11.4	20.3	4.0	−0.1	—	—	60.5
2010	6.7[5]	19.9	10.4	20.9	3.8	−0.7	—	0.7	61.7
2011	7.3	20.1	12.8	22.3	3.2	−1.0	$1.8	0.3	66.7
2012	7.8	20.8	13.8	22.3	3.8	−0.8	−1.1	—	66.5
2013	9.3	20.3	16.8	22.4	2.0	−1.1	−0.3	—	69.3
Intermediate estimates:									
2014	10.8	18.7	24.0	23.3	2.2	−0.2	0.3	—	79.0
2015	12.4[5]	21.9	24.9	24.1	1.4	1.4	0.1	—	86.3
2016	14.3[5]	25.1	27.4	25.4	1.1	0.6	0.1	—	94.0
2017	16.1	28.4	29.7	27.1	0.9	−0.3	0.1	—	102.1
2018	17.8	31.5	32.3	29.3	0.8	−0.3	0.1	—	111.4
2019	19.6	35.0	35.1	31.7	0.7	−0.4	0.2	—	121.8
2020	21.6[5]	39.2	38.0	34.3	0.7	−0.5	0.2	—	133.5
2021	23.6[5]	42.4	41.4	37.2	0.7	−0.5	0.1	—	144.9
2022	25.8	45.9	45.3	40.3	0.8	−0.6	0.2	—	157.6
2023	28.1	49.5	49.6	43.6	0.9	−0.7	0.2	—	171.1

[1]Total premiums paid to Part D plans by enrollees (directly, or indirectly through premium withholding from Social Security benefits).

[2]Positive amounts represent net loss-sharing payments to plans, and negative amounts are net gain-sharing receipts from plans. These amounts may include the delayed settlement of risk sharing from prior years.

[3]The advanced discount payment serves as loans to plans for the 50-percent ingredient cost discount on brand-name drugs in the coverage gap. The plan sponsors will reimburse Part D once they receive the payments from the drug manufacturers.

[4]Other payments are one-time in nature. Amount shown in 2006 is the reimbursement of State costs under the Medicare Part D transition demonstration. Amounts in 2010 and 2011 represent the $250 rebate to beneficiaries spending more than the initial coverage limit.

[5]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of benefits normally due January 3, 2010 is expected to occur on December 31, 2009; consequently the Part D premiums withheld from the benefits were added to the Part D account December 31, 2009. The premium income for 2010 excludes this amount. Similarly, the expected payment date for benefits normally due January 3, 2016 is December 31, 2015, and the expected date for benefits normally due January 3, 2021 is December 31, 2020.

d. Projections under Alternative Assumptions

Part D expenditures for the low-cost and high-cost alternatives were developed by modifying the estimates under the intermediate assumptions. The 2013 per capita estimates increased by about 3 percent under the high-cost scenario and decreased by about 3 percent under the low-cost scenario.

The 2013 base modifications include the following adjustments, since final data for 2013 will not be available until later in 2014:

- ±2 percent to account for the uncertainty of the completeness of the actual spending in 2013. The high-cost scenario increases the

spending by 2 percent, and the low-cost scenario decreases the spending by 2 percent.

- ±1 percent for the average manufacturer rebate that drug plans negotiate. The high-cost scenario decreases the average rebate by 1 percent, and the low-cost scenario increases the average rebate by 1 percent.

For the projections beyond 2013, the per capita drug costs for the high-cost and low-cost scenarios are increased, relative to GDP, 2 percent more rapidly and 2 percent less rapidly, respectively, than under the intermediate assumptions. In addition, for RDS participation, participation in the low-income subsidies, and the participation rate for Part D-eligible individuals who do not qualify for the low-income subsidy or receive coverage through employer-sponsored plans, assumptions vary in the alternative scenarios. Table IV.B11 compares these varying assumptions.

Table IV.B11.—Part D Assumptions under Alternative Scenarios for Calendar Years 2013-2023

Calendar year	Intermediate assumptions	Alternatives	
		Low-cost	High-cost
Participation of retiree drug subsidy as a percentage of Part D enrollees			
2013	8.4%	8.4%	8.4%
2014	6.3	6.3	6.3
2015	4.9	6.4	3.3
2016	3.7	6.5	1.3
2017	2.8	6.4	—
2018	2.2	6.5	—
2019	1.9	6.5	—
2020	1.9	6.5	—
2021	1.9	6.5	—
2022	1.9	6.5	—
2023	1.9	6.5	—
Participation of low-income as a percentage of Part D enrollees			
2013	29.4	29.4	29.4
2014	28.3	28.3	28.3
2015	28.2	28.1	28.2
2016	28.0	27.5	28.5
2017	27.8	26.6	29.0
2018	27.8	26.0	29.7
2019	27.9	25.4	30.5
2020	27.8	24.8	31.2
2021	27.8	24.2	31.9
2022	27.8	23.6	32.7
2023	27.8	23.1	33.5
Part D participation rate of the non-employer and non-low-income Part D-eligible individuals			
2013	58.3	58.3	58.3
2014	59.8	59.8	59.8
2015	60.8	57.9	63.7
2016	61.8	57.8	65.6
2017	62.7	58.8	66.6
2018	62.7	58.8	66.6
2019	62.7	58.7	66.5
2020	62.8	58.8	66.6
2021	62.8	58.8	66.6
2022	62.8	58.8	66.6
2023	62.8	58.8	66.6

C. PRIVATE HEALTH PLANS

1. Legislative History

Dating back to the 1970s, some Medicare beneficiaries have chosen to receive their coverage for Part A and Part B services through private health plans. Over time, numerous pieces of legislation have been enacted that have increased or decreased the attractiveness of private plan coverage.

The foundation of the current program was established by the Medicare Modernization Act (MMA) of 2003, which renamed most of the private plans as Medicare Advantage (MA) plans. The MMA also

formally designated all private health insurance coverage options available through Medicare as Part C.[64]

The MMA increased the level of the payment rates for private health plans. The higher payment rates enabled Medicare Advantage plans to offer attractive benefit packages with lower cost-sharing requirements and/or additional benefits, compared to the standard Medicare fee-for-service benefit package. Although the additional benefits were very valuable to beneficiaries choosing to enroll in Medicare Advantage plans, they increased Medicare costs substantially compared to fee-for-service beneficiary costs.

Beginning in 2006, payments are based on competitive bids and their relationship to corresponding benchmarks, which are based on the ratebook. Also, rebates were introduced and are used to provide additional benefits not covered under Medicare, reduce cost sharing, and/or reduce Part B or Part D premiums. Prior to the passage of the Affordable Care Act, rebates were calculated as 75 percent of the difference, if any, between the benchmark and the bid.

In addition to the plan types that already existed, the MMA provided for the establishment of Regional Preferred Provider Organizations (RPPOs) and special needs plans (SNPs). Unlike other MA plans, which define their own service areas, RPPOs operate in pre-defined service areas referred to as regions and have special rules for capitation payment benchmarks, and they received special incentives under the MMA.

SNPs are products designed for, and marketed to, these special population groups: Medicaid dual-eligible beneficiaries, individuals with specialized chronic conditions, and institutionalized beneficiaries. The statutory authority for SNPs is scheduled to expire on January 1, 2017 under current law but has been extended several times.

The Affordable Care Act made fundamental changes to MA funding by linking the benchmark rates to Medicare fee-for-service costs and by requiring the use of quality measures to determine eligibility for bonuses and the share of bid savings versus benchmarks to be provided as a rebate.

[64]Of Medicare beneficiaries enrolled in private plans, about 97 percent are in Medicare Advantage plans, with the remainder in certain holdover plans reimbursed on a cost basis, rather than through capitation payments.

Beginning in 2012, the ACA requires the MA county-level benchmarks to be based on a multiple of estimated fee-for-service costs in the county. The multiple applied for a given county is based on the ranking of its fee-for-service cost relative to that for other counties, and the multiplier factors are phased in. The 25 percent, or quartile, of counties with the highest fee-for-service costs will have a multiple of 95 percent of county fee-for-service costs; the second quartile, 100 percent; the third quartile, 107.5 percent; and the lowest quartile, 115 percent. Prior to the ACA, most county benchmarks were in the range of 100-140 percent of local fee-for-service costs.

Starting in 2012, plans are eligible to receive specified increases to their benchmark based on their quality rating scores. For calendar years 2012 through 2014, the bonuses will be paid under demonstration authority initially approved in November 2010 and enhanced in April 2011. During this period, bonuses will range from 3 percent of the local Medicare fee-for-service cost for plans with a quality score of 3 stars (out of 5) to 5 percent for plans with a quality score of 5 stars. Also, for plans with at least 3 stars during 2012 through 2014 the demonstration waives the statutory cap on the phased-in benchmark, including bonuses, at the pre-ACA level. Beginning in 2015, the statutory provisions will apply, which call for a bonus of 5 percent for plans with at least a 4-star rating.

The bonuses are doubled for health plans in a qualifying county, defined as a county in which (i) per capita spending in original Medicare is lower than average; (ii) 25 percent or more of eligible beneficiaries enrolled in Medicare Advantage as of December 2009; and (iii) the benchmark rate in 2004 was based on the minimum amount applicable to an urban area. There are special bonus provisions for newly established and low-enrollment plans.

The ACA benchmarks will phase in over 2, 4, or 6 years, depending upon the size of the benchmark reduction, with a longer phase-in schedule for areas in which the benchmark decreases by larger amounts. After the demonstration period is over in 2015, the phased-in benchmarks, including bonuses, will be capped at the pre-ACA level.

The ACA also makes changes regarding the share of the excess of benchmarks over bids to be paid to the plan sponsors as rebates. Prior to the ACA, the rebate share was 75 percent. The ACA varies plan rebates based on quality. The highest quality plans (4.5 stars or higher) will receive a 70-percent rebate, plans with a quality rating of at least 3.5 stars and less than 4.5 stars will receive a 65-percent

rebate, and plans with a rating of less than 3.5 stars will receive a 50-percent rebate. The change in rebate from the fixed 75-percent level to the variable ACA percentages phases in over 3 years beginning in 2012.

Finally, the ACA requires that private insurers pay an assessment, or fee, based on their revenues from the prior year. The fees, which will be first collected in 2014, apply to most health insurance sectors, including the majority of Medicare private health plans.

The basis for the 2015 MA benchmarks has been calculated reflecting an assumption that Congress will act to prevent the scheduled 20.8-percent reduction in Medicare physician payment rates from occurring. The precedent establishes a higher baseline for Medicare Advantage payments that is reflected throughout these projections.

It is important to note that Medicare coverage provided through private health plans, or Part C, does not have separate financing or an associated trust fund. Rather, the Part A and Part B trust funds are the source for payments to such private health plans.

2. Participation Rates

a. Background

To account for the distinct benefit, enrollment, and payment characteristics of private health plans, enrollment and spending trends for such plans are analyzed at the product level:

- Local coordinated care plans (LCCPs), which include HMOs, HMOs with a point-of-service option, local PPOs, PSOs, and Medical Savings Accounts.
- Private Fee-for-Service (PFFS) plans.
- Regional PPO (RPPO) plans.
- Special needs plans (SNPs).
- Other products, which include cost plans and Program of All-Inclusive Care for the Elderly (PACE) plans.

All types of coverage except for those represented in the "other" category are Medicare Advantage plans. Also, the values represented in each category include enrollment not only in plans available to all

beneficiaries residing in the plan's service area, but also in plans available only to members of employer or union groups.

b. Historical

One can trace the past trend in private health plan enrollment largely to the corresponding legislated payment policies. During the period 1985 through 1999, private plan enrollment grew steadily and reached a peak in 1999 shortly after the passage of the BBA in 1997.

One intent of the BBA was to expand the availability of plans by providing for new coverage options and by increasing payment rates in rural areas through the addition of the payment floors. However, instead of increasing plan availability, many of the contracts existing in 1997 were eventually withdrawn, primarily because their costs were growing faster than the annual payment, which generally rose at 2 percent.[65] As a direct consequence of the plan terminations, the percentage of Medicare beneficiaries who enrolled in private health plans declined each year from 2000 through 2004.

These declines reversed after the MMA established higher payment rates in 2005, which was the first post-MMA opportunity for plan expansion. Between 2004 and 2013, private plan enrollment grew by 9.5 million or 176 percent, which compares to growth in the overall Medicare population of 25 percent for the same period.

The Trustees previously estimated that plan enrollment would decrease, starting in 2011, as a result of the benchmark and rebate changes in the Affordable Care Act. In practice, enrollment continued to increase from 2011 through 2013 in part due to higher payments to MA plans than previously projected. These payments are higher because of the quality bonus demonstration that began in 2012 and due to the coding intensity adjustment factor remaining level despite evidence that private plan risk scores increase more rapidly than those for the Medicare fee-for-service population.

PFFS enrollment dropped 84 percent between 2009 and 2013 primarily due to plan reaction to new statutory provider network requirements beginning in 2011. Most of the terminating enrollees transferred to a LCCP or RPPO plan.

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[65]The BBA included numerous provisions affecting Medicare fee-for-service payment rates. As a result, the floor payment levels and blended private plan payment rates increased very slowly for several years, and the statutory rates for most plans increased by the 2-percent minimum.

The 2013 enrollment includes 2.6 million beneficiaries with coverage through employer-only or union-only plans, the vast majority of whom are in LCCPs.

c. Projected

Now that the majority of the ACA benchmark phase-in has been completed, the projection of private plan enrollment has changed from the county-based approach to one based on aggregate enrollment levels. The relative growth for each county continues to be tied to the projected level of net extra benefits, which account for such factors as statutory benchmark requirements and plan quality ratings. The projected private Medicare health plan enrollment is higher than in the prior report largely because the effect of the ACA benchmark reductions was less than previously assumed.

Similar to the growth in the Medicare population, private Medicare health plan membership is projected to grow indefinitely. In 2015, the enrollment growth rate is expected to slow down due to the expiration of the nationwide quality measure demonstration described previously. Beginning in 2025, the private plan enrollment growth rate is expected to closely follow that of the MA-eligible population—those with coverage under both Part A and Part B.

The share of Medicare enrollees in private health plans is projected to increase from 28.4 percent in 2013 to 31.9 percent in 2025. Modest increases are expected in private plan penetration rates between 2018 and 2025 due to higher relative bonus payments stemming from assumed improvements in quality rating scores. Overall, total health plan membership is expected to increase by 21 percent between 2022 and 2030 due to the large increase in total Medicare beneficiaries during those years. (The total Medicare population is expected to increase by 20 percent between 2022 and 2030.)

SNP enrollment is expected to increase (8 percent) between 2013 and 2016. The statutory authority for SNPs will expire as of January 1, 2017 under current law.[66] Beginning in 2017, it is expected that the majority of existing SNP enrollees will join local coordinated care plans and that the remaining enrollees will transfer to the Medicare fee-for-service program.

The growth in LCCPs is expected to be 10 percent in 2014 after increasing 9 percent in 2013. The expected increase in LCCPs in 2014

[66]In practice, the SNP authority has been set to expire as far back as 2008 but has been extended by lawmakers.

follows closely the overall 2014 increase in private Medicare health plan membership of 9 percent. A further spike in enrollment of 19 percent is expected in 2017 due to the influx of enrollees from terminating SNPs under current law.

RPPO enrollment, which experienced rapid growth from 2006 to 2011 and not much change from 2011 to 2013, is projected to increase by 13 percent in 2014. The recent fluctuations in the RPPO enrollment are due primarily to the migration of beneficiaries of employer-sponsored plans to either RPPO (in 2013) or LCCP (in 2012) offerings stemming from changes in sponsors' marketing strategies. Table IV.C1 shows past and projected enrollment for private health plans.

Table IV.C1.—Private Health Plan Enrollment[1]

[In thousands]

Calendar year	Local CCP	PFFS	Regional PPO	SNP	Other	Total private health plan	Total Medicare	Ratio of private health plan to total Medicare
1985	498	—	—	—	773	1,271	31,081	0.0%
1990	1,263	—	—	—	754	2,017	34,251	5.9
1995	2,735	—	—	—	732	3,467	37,594	9.2
2000	6,435	1	—	—	420	6,856	39,688	17.3
2005	5,248	125	—	—	421	5,794	42,606	13.6
2006	5,428	712	74	660	417	7,291	43,436	16.8
2007	5,529	1,623	183	930	403	8,667	44,368	19.5
2008	5,966	2,244	290	1,148	362	10,010	45,500	22.0
2009	6,605	2,433	422	1,270	373	11,104	46,604	23.8
2010	7,546	1,674	833	1,227	412	11,692	47,720	24.5
2011	8,925	602	1,153	1,256	446	12,382	48,896	25.3
2012	10,247	526	955	1,376	483	13,587	50,862	26.7
2013	11,211	388	1,104	1,612	526	14,841	52,256	28.4
2014	12,358	314	1,242	1,705	618	16,237	53,992	30.1
2015	12,317	314	1,239	1,699	827	16,395	55,651	29.5
2016	12,646	322	1,273	1,744	897	16,883	57,324	29.5
2017	15,049	338	1,333	—	917	17,636	59,025	29.9
2018	15,728	354	1,394	—	630	18,105	60,761	29.8
2019	16,410	369	1,455	—	647	18,882	62,540	30.2
2020	17,150	386	1,521	—	666	19,722	64,362	30.6
2021	17,897	403	1,587	—	684	20,571	66,210	31.1
2022	18,622	419	1,652	—	704	21,396	68,104	31.4
2023	19,309	435	1,713	—	723	22,179	69,996	31.7
2025	20,467	461	1,815	—	760	23,502	73,718	31.9
2030	22,633	509	2,007	—	841	25,991	81,759	31.8
2035	23,976	540	2,126	—	890	27,532	86,771	31.7

[1]Most private plan enrollees are eligible for Medicare Part A and enrolled in Medicare Part B. Some enrollees have coverage for only Medicare Part B. For example, in 2009 the Part B-only private plan enrollment consisted of 3,000 in local CCPs, 2,000 in PFFS plans, and 68,000 in the "other" coverage category.

3. Cost Projection Methodology

a. Background

Benchmarks form the foundation for payments to Medicare Advantage plans. Along with geographic, demographic, and risk characteristics of plan enrollees, these values determine the monthly prospective payments made to private health plans. Medicare Advantage benchmarks vary substantially by county. Historically, benchmarks have been in the range of 100 percent of local fee-for-service costs (for Parts A and B) to more than 200 percent of such costs in a few areas. Under the Affordable Care Act, benchmarks will transition to the range of 95-115 percent of fee-for-service costs, plus applicable quality bonuses.

For non-RPPO plans, a plan's benchmark is an average of the statutory capitation ratebook values, weighted by projected plan enrollment in each county in the plan's service area. For RPPOs, the benchmark is a blend of the weighted ratebook values for all Medicare-eligible beneficiaries in the region and an enrollment-weighted average of RPPO bids for the region. The weight applied to the bid component to calculate the blended benchmark is the national Medicare Advantage participation rate.

Plans submit bids equal to their projected per enrollee cost of providing the standard Medicare Part A and Part B benefits. Plans with bids below the benchmark apply the rebate share of the *savings* to aid plan enrollees through coverage of Part A and Part B cost sharing, coverage of additional non-drug benefits, and/or reduction in the Part B or Part D premium. From 2006 to 2011, the rebate share of the difference between a plan's benchmark and bid was 75 percent. For 2012 and later, the rebate percentage is based on the quality rating of the health plan and will range from 50 to 70 percent once fully phased in for 2014. Beneficiaries choosing plans with bids above the benchmark must pay for both the full amount of the difference between the bid and the benchmark and the projected cost of the plans' supplemental benefits.

Medicare capitation payments to a Medicare Advantage plan are a product of the standardized plan bid, which is equal to the bid divided by the plan's projected risk score, and the actual enrollee risk score, which is based on demographic characteristics and medical diagnosis data. The risk score for a given enrollee may be adjusted retrospectively since CMS receives diagnosis data after the payment date.

Rebate payments are based on the projected risk profile of the plan and are not adjusted based on subsequent actual risk scores.

b. Incurred Basis

Private health plan expenditures are forecast on an incurred basis by coverage type. The bid-based expenditures for each quarter are a product of the average enrollment and the projected average per capita bid. Similarly, the rebate expenditures are a product of enrollment and projected average rebates.

Annual per capita benchmarks, bids, and rebates were determined on an incurred basis for calendar years 2006-2013 for each coverage category. These amounts include adjustments processed after the payment due date for retroactive enrollment and risk score updates. The annual per capita benchmark values are calculated as the prior year's value increased with the projected increase in the benchmark rates for each plan category. The rebates are equal to the applicable percent of the positive difference, if any, between the benchmarks and bids.

Factors accounted for in the benchmark growth trend include the projected increase in the fee-for-service per capita costs (USPCCs), the scheduled phase-out of the ratebook indirect medical expenses, and assumed changes in the risk-coding practices of private health plans relative to Medicare fee-for-service providers.

For the period 2006 through 2009, aggregate payments for bids and rebates experienced double-digit annual growth resulting from rapid increases in private plan enrollment, growth in per capita Medicare fee-for-service costs affecting the benchmarks, inflation in plan costs, and growth in private plan risk scores.

Growth in bids for 2010 and 2011 slowed to 6 percent per annum primarily due to flattening of the enrollment trend and relatively flat growth in the per capita bids. During the period, the aggregate rebates decreased by 4 percent per annum. The reduction in rebates was primarily attributable to a decrease in 2010 risk scores due to the application of an across-the-board reduction to account for differences in coding between private plans and Medicare fee-for-service providers.

Benchmark growth for 2013 and later will be significantly lower than historical trends because of the phase-in of the fee-for-service based ratebook beginning in 2012, which will result in lower benchmark

rates in most areas. Also, the productivity offsets to Medicare fee updates and other savings provisions of the Affordable Care Act will dampen the projected increase in the per capita fee-for-service base of the benchmark.

Private health plan expenditure growth rates are affected by the sequestration of non-salary Medicare expenditures, which applies from April 1, 2013 to September 30, 2024. Under the sequestration, private health plan benefit payments will be reduced by a specified percentage (usually around 2 percent). The trend in the per capita bids for 2015 through 2017 is estimated to be equal to the average of the fee-for-service trend and the benchmark trend plus the incremental cost of the ACA insurer fees. The expectation is that bids will grow faster than benchmarks but more slowly than fee-for-service rates, which results in lower per capita rebates in 2014 and 2015. For years 2018 and later, the trend in the per capita bids is estimated to be equal to that of beneficiaries enrolled in Medicare fee-for-service.

c. Cash Basis

Cash Medicare Advantage expenditures are largely identical to incurred amounts, since both arise primarily from the monthly capitation payments to plans. Small cash payment adjustments are developed from incurred spending by accounting for the payment lag that results from CMS' receipt of post-payment diagnosis data, retroactive enrollment notifications, and corrections in enrollees' demographic characteristics.

Table IV.C2 shows Medicare private plan expenditures on an incurred and cash basis, separately for the Part A and Part B trust funds. The incurred payments are reported separately for the bid-related and rebate expenditures. As noted, most payments to plans are made as they are incurred, and cash and incurred amounts are generally the same.

Table IV.C2.—Medicare Payments to Private Health Plans, by Trust Fund

[In billions]

Calendar year	Incurred basis[1]			Cash basis
	Bid	Rebate	Total	
Expenditures from the HI (Part A) trust fund:				
2006	$29.7	$3.5	$33.2	$32.9
2007	36.4	4.3	40.7	39.0
2008	44.1	5.4	49.5	50.6
2009	52.7	6.3	59.0	59.4
2010	55.5	5.2	60.7	60.7
2011	59.0	5.7	64.7	64.6
2012	64.3	6.2	70.5	70.2
2013	66.9	6.4	73.3	73.1
2014	67.6	5.6	73.2	73.2
2015	65.7	4.3	70.0	70.1
2016	68.8	4.6	73.4	73.3
2017	74.4	4.9	79.3	79.2
2018	79.5	5.5	85.0	84.8
2019	85.5	6.0	91.5	91.4
2020	92.8	7.1	99.9	99.7
2021	100.6	8.3	108.9	108.7
2022	108.8	9.1	117.9	117.7
2023	117.0	10.0	127.0	126.6
Expenditures from the Part B account of the SMI trust fund:				
2006	28.8	3.2	32.0	31.5
2007	35.6	3.9	39.5	38.9
2008	43.0	5.0	48.0	48.1
2009	47.8	5.5	53.3	53.4
2010	50.7	4.6	55.3	55.2
2011	54.0	5.1	59.1	59.1
2012	60.6	5.6	66.2	66.0
2013	66.8	6.1	72.9	72.7
2014	78.6	6.3	84.9	84.8
2015	80.0	5.1	85.1	85.1
2016	84.2	5.5	89.7	89.6
2017	92.2	5.9	98.1	97.9
2018	98.9	6.6	105.5	105.3
2019	108.2	7.4	115.6	115.4
2020	119.4	8.9	128.3	128.0
2021	131.2	10.5	141.7	141.4
2022	143.9	11.8	155.7	155.4
2023	157.2	13.0	170.2	169.8

[1]The bid category includes all expenditures for non-Medicare Advantage coverage.

d. Incurred Expenditures per Enrollee

Table IV.C3 shows estimated incurred per enrollee expenditures for beneficiaries enrolled in private health plans. It combines the values for expenditures from the Part A and Part B trust funds.

Table IV.C3.—Incurred Expenditures per Private Health Plan Enrollee[1]

Calendar year	Local CCP	PFFS	Regional PPO	SNP	Other	Total
Bid-based expenditures[2]						
2006	$8,203	$6,925	$7,624	$10,027	$4,852	$8,084
2007	8,547	7,367	8,316	9,989	5,044	8,342
2008	8,781	8,088	9,223	10,429	5,343	8,727
2009	9,016	8,753	9,194	11,008	5,288	9,089
2010	8,975	8,489	8,937	12,065	5,174	9,112
2011	8,960	8,281	8,963	12,498	4,849	9,157
2012	8,996	8,554	9,000	12,657	4,943	9,223
2013	8,720	8,815	8,912	12,547	5,033	9,035
2014	8,671	9,519	9,280	12,419	5,691	9,024
2015	8,517	9,369	9,123	12,204	7,316	8,907
2016	8,684	9,552	9,300	12,442	7,679	9,087
2017	9,526	9,952	9,691	n/a	7,962	9,470
2018	9,985	10,432	10,157	n/a	5,720	9,871
2019	10,400	10,867	10,580	n/a	5,990	10,284
2020	10,902	11,385	11,087	n/a	6,299	10,783
2021	11,416	11,916	11,607	n/a	6,615	11,294
2022	11,964	12,487	12,164	n/a	6,953	11,838
2023	12,521	13,068	12,730	n/a	7,314	12,392
Rebate expenditures[2]						
2006	958	616	565	1,489	—	920
2007	947	703	952	1,777	—	951
2008	1,123	613	784	1,874	—	1,049
2009	1,211	478	663	1,833	—	1,064
2010	990	320	436	1,176	—	842
2011	955	450	510	1,158	—	878
2012	935	355	561	1,099	—	872
2013	889	255	560	1,112	—	842
2014	799	208	388	918	—	739
2015	644	35	222	704	—	575
2016	672	46	238	736	—	599
2017	694	29	230	n/a	—	612
2018	749	47	259	n/a	—	673
2019	791	55	277	n/a	—	711
2020	900	132	362	n/a	—	814
2021	1,004	193	434	n/a	—	912
2022	1,076	226	478	n/a	—	979
2023	1,139	248	513	n/a	—	1,038
Total expenditures						
2006	9,162	7,541	8,189	11,515	4,852	9,004
2007	9,494	8,070	9,268	11,766	5,044	9,293
2008	9,904	8,701	10,007	12,303	5,343	9,775
2009	10,227	9,230	9,857	12,840	5,288	10,152
2010	9,965	8,808	9,373	13,241	5,174	9,954
2011	9,915	8,731	9,473	13,656	4,849	10,034
2012	9,931	8,910	9,561	13,756	4,943	10,094
2013	9,608	9,070	9,472	13,660	5,033	9,877
2014	9,470	9,727	9,668	13,337	5,691	9,763
2015	9,161	9,405	9,345	12,907	7,316	9,482
2016	9,355	9,598	9,538	13,178	7,679	9,686
2017	10,220	9,981	9,921	n/a	7,962	10,082
2018	10,734	10,479	10,416	n/a	5,720	10,544
2019	11,191	10,922	10,857	n/a	5,990	10,995
2020	11,802	11,517	11,449	n/a	6,299	11,598
2021	12,420	12,109	12,041	n/a	6,615	12,206
2022	13,040	12,713	12,642	n/a	6,953	12,817
2023	13,660	13,316	13,243	n/a	7,314	13,429

[1]Values represent the sum of per capita expenditures for Part A and Part B.
[2]The bid category includes all expenditures for non-Medicare Advantage coverage.

Average Medicare payments per private plan enrollee vary by geographic location of the plan, plan efficiency, and average reported health status of plan enrollees. Local coordinated care plans and special needs plans tend to be located in urban areas where prevailing health care costs tend to be above average. Conversely, private fee-for-service plans and regional PPOs generally reflect a more rural enrollment. These factors complicate meaningful comparisons of average per capita costs by plan category.

In general, the per capita increases in bids for 2006 through 2009 were in the single-digit range and were correlated with the Medicare fee-for-service trend and the change in risk profile of the plan populations. Per capita bid payments in 2010 decreased for all types of coverage (except for SNP) since the application of the risk score coding intensity adjustment more than offset the relatively low Medicare fee-for-service growth. The primary factor driving the growth in SNP per capita bids for 2010 was the change in definition of Medicare required benefits, which takes into account the waiver of plan cost sharing for many beneficiaries who are dually eligible for Medicare and Medicaid. Per capita bid payments in 2011 and 2012 were relatively flat, increasing by 0.5 percent and 0.7 percent, respectively, in aggregate. Per capita bid payments proceeded to decline by 2.0 percent in 2013, due to the sequester of Medicare payments, and are expected to remain relatively flat in 2014, decreasing by 0.1 percent.

Beginning in 2015 through 2017, the overall per capita bid trend is expected to be the average of the growth in Medicare fee-for-service expenditures and the benchmark growth plus the per capita growth in the ACA insurer fees. For years 2018 and later, the per capita bid trend is expected to be equal to the growth in Medicare fee-for-service expenditures. If MA plans are not able to hold their cost increases to a level consistent with the expected growth in trends as defined above—including the impact of the productivity adjustments to provider payment updates—then actual MA rebate levels and enrollment would be lower than the projections shown here.

After 2021, average Medicare payments to private plans per enrollee are assumed to follow the aggregate growth trends of the HI and SMI Part B per capita benefits, as described in section IV.D of this report.

There was significant variation in the per capita trend in rebates for 2006 through 2009; this variation reflected the difference in the annual trend between bids and benchmarks. All types of coverage experienced significant decreases in rebates for 2010 as a result of the

reduction in risk-adjusted benchmarks—both in absolute terms and relative to the change in bids. Per capita rebates increased in aggregate by 4 percent in 2011 due to the flat bid payments in 2011 and an increase in the plans' average risk scores. Per capita rebates were relatively flat in 2012 and declined by 3 percent in 2013 due to the sequester and the phase-in period of the fee-for-service based ratebook. Rebates are projected to decline in 2014 and 2015 as a result of the mandated benchmark reductions and the lower statutory share of benchmark-versus-bid savings to be provided as a rebate. Beginning in 2016, modest annual increases in per capita rebates are forecast.

D. LONG-RANGE MEDICARE COST GROWTH ASSUMPTIONS

The prior three sections have described the detailed assumptions and methodology underlying the projected expenditures for HI (Part A) and SMI (Parts B and D) during 2014 through 2023. These projections are made for individual categories of Medicare-covered services, such as inpatient hospital care and physician services.

As the projection horizon lengthens, it becomes increasingly difficult to anticipate changes in the delivery of health care, the development of new medical technologies, and other factors that will affect future health care cost increases. Accordingly, rather than extending the detailed projections by individual type of service for all future years, the Trustees use a more aggregated basis for setting cost growth assumptions in the long range. With enactment of the Affordable Care Act, such increases are subject to greater uncertainty in the long term, especially for the Medicare program.

For this year's report, the assumed long-range rate of growth in annual Medicare expenditures per beneficiary is based on statutory price updates (except for physician fee schedule services) and assumptions for volume and intensity growth derived from a "factors contributing to growth" model, which, developed by the Office of the Actuary, decomposes the major drivers of historical and projected health spending growth into distinct factors. Additionally, the Trustees assume that the Medicare payment rate updates that reflect an economy-wide productivity adjustment will reduce volume and intensity growth slightly below the assumption from the factors model for affected Medicare services. The Trustees' methodology is consistent with the recommendations by the 2010-2011 Technical

Review Panel on the Medicare Trustees Report,[67] which incorporated a more refined analysis of the factors behind those assumptions. The Trustees plan to continue to direct research into the factors approach and will consider additional refinements and improvements in forthcoming reports.

For the 2001-2005 Trustees Reports, the Trustees assumed that the increase in average expenditures per beneficiary for the 25th through 75th years of the projection would equal the growth in per capita GDP plus 1 percentage point,[68] as recommended by the 2000 Medicare Technical Review Panel. With the inclusion of infinite-horizon projections starting in the 2004 Trustees Report, per beneficiary expenditures after the 75th year were assumed to increase at the same rate as per capita GDP. The 2004 Technical Review Panel recommended that the Trustees continue to use these assumptions, given the limits of current knowledge, but also conduct further research.

Beginning with the 2006 report, the Trustees adopted a refinement of the long-range growth assumption that provided a more gradual transition from historical health cost growth rates, which had been roughly 2 to 3 percentage points above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future. The year-by-year growth assumptions were based on a simplified economic model and were determined in a way such that the 75-year actuarial balance for the HI trust fund was consistent with that generated by the constant GDP plus 1 percent assumption.

The stylized economic model made assumptions about (i) continuing improvements in medical technology; (ii) the extent to which new medical technology either increases health care costs or reduces them; and (iii) society's relative preference for improved health versus consumption of other goods and services. The theory behind the model was that, should innovations in medical technology continue to increase rapidly in the future and add substantially to costs as in the past, then eventually society would be unwilling and unable to devote a steadily increasing share of its income to obtaining better health. Such unwillingness could be expressed in a number of ways consistent with current law, such as private and public health plans'

[67]The Panel's final report is available at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf.

[68]This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population and changes in the gender composition of the Medicare population, which the Trustees estimated separately.

reluctance to cover expensive new technologies unless they offer significant health improvement over existing techniques, or the inability on the part of individuals to afford health insurance premiums or cost-sharing payments.

For the 2010 and 2011 Medicare Trustees Reports, the Trustees assumed a baseline long-range Medicare cost growth assumption, using the process described above, and then incorporated the effects of the provisions of the Affordable Care Act. For all HI (Part A) providers and some SMI Part B providers (outpatient hospitals, ambulatory surgical centers, diagnostic laboratories[69], and most other non-physician services) the annual increases in Medicare payment rates for most categories of health service providers were reduced for 2011 and later by the 10-year moving average increase in private, nonfarm business multifactor productivity.[70] The resulting long-range growth assumption was the increase in per capita GDP plus 1 percent, minus the productivity factor. The sustainable growth rate formula in current law at that time governed increases in average physician expenditures per beneficiary to equal the rate of per capita GDP growth. The remaining Part B services and all Part D outlays had an assumed average growth rate of per capita GDP plus 1 percent.

In December 2011, the 2010-2011 Medicare Technical Review Panel unanimously recommended a new approach that builds off of the longstanding GDP plus 1 percent assumption while incorporating several key refinements.[71] Specifically, the panel recommended two separate means of establishing long-range growth rates:

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the ACA) compared to private health insurance and other payers of health care in the U.S. The details are discussed later in this section of the report, but most importantly this refinement results in an increase in the long-range pre-ACA baseline cost growth assumption for Medicare to GDP plus 1.4 percent. (The

[69] Starting in 2017, the Protecting Access to Medicare Act of 2014 links payments for laboratory services to private payment rates.

[70] *Multifactor productivity* is a measure of real output per combined unit of labor and capital, reflecting the contributions of all factors of production.

[71] For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate. Similarly, these growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

corresponding assumed average growth rate for all national health expenditures continues to be GDP plus 1 percent.)

- The second approach recommended by the Technical Panel is the "factors contributing to growth" model developed by the Office of the Actuary at CMS as a possible replacement for the existing process. This model builds upon the key considerations used in establishing the earlier GDP plus 1 percent assumption, together with subsequent refinements in the analysis of growth factors, additional years of data on national health expenditures available since the 2000 Technical Panel's deliberations, and use of projected trends in the model's key factors. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.[72]

For the 2012 report, the Trustees based the average ultimate Medicare growth rate on the refinement recommended by the Technical Panel and used the factors model to create the specific, year-by-year declining growth rates during the last 50 years of the projection. For 2013 and this report, the Trustees (i) used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period and (ii) checked the ultimate Medicare cost growth assumptions derived from this approach for reasonableness by comparing them to results produced by an average "GDP plus" approach. The remainder of this section discusses the derivation of the assumption for overall health spending using the factors model. This section also explains the detailed long-range assumptions underlying the Medicare projected baseline. Appendix V.C provides the methods used to derive the long-range cost growth assumptions for the projections based on current law and the illustrative alternative.

1. Long-Range Growth Assumptions for the Overall Health Sector

The first step to estimate the long-range Medicare trends is to determine the long-range assumptions affecting the overall health sector. For this report, as noted previously, the Trustees use the factors model to determine the year-by-year growth rates for the

[72]Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs,* 28, no. 5 (2009): 1276-1284.

overall health sector over the last 50 years of the projection. This approach produces a result that is consistent with an ultimate average rate of per capita GDP plus 1 percent, as had been assumed since the 2001 report. Based on the factors model, the Trustees assume that the long-range per capita overall health spending growth is GDP plus 1.2 percent (or 5.2 percent) for 2038, gradually declining to GDP plus 0.3 percent by 2088 (or 4.3 percent). The per capita increase in overall health care costs is due to the combined effects of general inflation, medical-specific *excess* price inflation (above general price growth), and changes in the utilization of services per person and the intensity or average complexity per service. The Trustees assume that beginning in 2038 (i) general price inflation will remain constant at 2.3 percent per year, as measured by the GDP deflator; (ii) excess medical price inflation will remain constant at 0.8 percent per year, as discussed in more detail below; and (iii) the annual increase in the volume and intensity of services per person will decline gradually from approximately 2.0 percent in 2038 to 1.1 percent in 2088 based on the key economic assumptions and elasticity estimates from the factors model, as described below.

Excess medical price inflation for the overall health sector is assumed to grow at 0.8 percent annually. The method used by the Trustees for developing the medical price changes that the market will bear is to decompose this price into its two main factors[73]: (i) medical input price growth and (ii) resource-based health sector productivity growth.[74] The Trustees assume that medical input price growth for the overall health sector will equal the increase in the hospital input price index over the long range, which is estimated at about 3.5 percent per year, as seen previously in table IV.A1. For resource-based health sector productivity, the Trustees assume that the rate of growth will be equivalent to recently published research[75] on historical measures for hospitals and physicians and that

[73]A third factor, provider profit margins, is assumed to remain constant over the long range.

[74]Resource-based productivity is defined as the real value of provider goods and services divided by the real value of the resources (inputs) used to produce the goods and services, where price changes are measured across constant products—that is, defined health services with a constant mix of inputs. Resource-based productivity is used for this decomposition, rather than outcomes-based productivity (which incorporates the estimated value of improvements in health resulting from the services) because Medicare and most other payers reimburse providers based on their resource use.

[75]Cylus, Jonathan D., and Dickensheets, Bridget A. "Hospital Multifactor Productivity: A Presentation and Analysis of Two Methodologies." *Health Care Financing Review,* 29, no. 2 (2007): 49-64; Fisher, Charles. "Multifactor Productivity in Physicians' Offices: An Exploratory Analysis." *Health Care Financing Review,* 29, no. 2 (2007): 15-32.

productivity growth for all other provider categories, such as skilled nursing facilities, home health agencies, hospices, diagnostic laboratories, dialysis centers, and ambulance companies, will average to roughly zero. Taken together, the estimate of overall resource-based health sector productivity is determined to be 0.4 percent per year. Combining the 3.5-percent medical input price growth with the 0.4-percent health sector productivity growth results in medical sector price growth of 3.1 percent per year, which is 0.8 percentage point faster than growth in the GDP deflator.

As stated earlier, the factors model is based on economic research that separates health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual that primarily reflects the impact of technological development. The factors model provides the ability to model the likely behavioral effects associated with a continuing increase in the share of national income devoted to consumption of health care services. In particular, this approach is based on historically estimated income and price elasticities and uses measurable key variables, thereby improving the underlying basis for developing the long-range growth assumptions.[76]

In the factors model, the sensitivity of health cost growth to each of the three factors must be estimated. Each such sensitivity is measured as an elasticity, which is the percentage change in cost growth that is caused by a 1-percent change in a factor. The first elasticity, the income-technology elasticity, reflects the increase in demand for health care and new medical technologies in response to growth in income. This elasticity is estimated at 1.4 based on cross-country comparisons of the historical relationship between health spending and GDP growth for member countries in the Organisation for Economic Co-operation and Development. (A similar elasticity was estimated using only U.S.-specific data.) The second elasticity, the relative medical price elasticity, reflects the sensitivity of consumers and purchasers in consuming health care to changes in excess medical price inflation. Based on the Office of the Actuary's national health expenditure (NHE) projection model for 1970-2009, which uses observed price changes, this price elasticity was estimated at −0.4. The final key elasticity is the insurance elasticity, which reflects the change in demand for medical care as the level of

[76]Additional information on the "factors contributing to growth" model is available in a memorandum by the Office of the Actuary titled "The Long-Term Projection Assumptions for Medicare and Aggregate National Health Expenditures," available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ProjectionMethodology.pdf.

insurance coverage changes. Based on the RAND Health Insurance Experiment, the insurance elasticity is estimated at −0.2.[77]

The insurance elasticity is assumed to be unchanged over the long-range projection period at −0.2. The income-technology elasticity and price elasticity, in contrast, are assumed to vary over time. Both of these elasticities are assumed to equal their long-term historical average in the 25th year of the projection period (2038). After 2038, the income-technology elasticity is assumed to decline linearly and to reach 1.0 by the end of the 75-year projection period (2088) under the assumption that the preference for additional health care will lessen as health care continues to consume a greater proportion of income. The price elasticity, on the other hand, is assumed to become larger in absolute value as the share of income devoted to health care increases.[78] As the overall health sector share of GDP is projected to double during the projection period, and as the income-technology elasticity approaches 1.0, the price elasticity is assumed to reach −0.6 by the end of the 75-year projection period (2088). The decline in the price elasticity from −0.4 to −0.6 is also assumed to occur linearly.

Two additional assumptions are required to complete the factors model determination. First, relative medical price inflation must be estimated over the long-range projection period. As discussed previously, the Trustees assume that relative medical price growth is 0.8 percent per year. Second, insurance coverage is assumed to be unchanged over the long range in order to maintain consistency with the concept of a Medicare current-law projection in which the Medicare benefit package is not altered.

2. Long-Range Growth Assumptions for Medicare under Projected Baseline

The Trustees have assumed since 2001 that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010-2011 Medicare Technical Review Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the

[77]Newhouse, Joseph P., and the Insurance Experiment Group. *Free for All? Lessons from the RAND Health Insurance Experiment*. Cambridge: Harvard University Press, 1993. The coefficient of this elasticity is negative because the level of insurance coverage is measured using individuals' cost-sharing requirements (such as deductibles and coinsurance).

[78]Silberberg, Eugene, and Suen, Wing C. *The Structure of Economics: A Mathematical Analysis.* 3rd ed. New York: McGraw-Hill/Irwin, 2000.

total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions under current law.

Prior to the Affordable Care Act, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the ACA were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall.[79] In particular, the Trustees assume that the full market basket increase would be approximately 3.5 percent annually, or about 0.4 percent greater than the net price increase of 3.1 percent per year described above for the total health sector. The Affordable Care Act requires that many of these Medicare payment updates be reduced by the 10-year moving average increase in private, nonfarm business multifactor productivity, which the Trustees assume will be 1.1 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for three categories of health care providers:

(i) *All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.*

Under the Affordable Care Act, the annual increase in Medicare payment rates for these services will be reduced by the 10-year moving average increase in private, nonfarm business multifactor productivity. These gains are estimated to be 1.1 percent per year over the long-range period. Combined with an assumed market basket increase of 3.5 percent, the statutory price update for these services is 2.4 percent per year over the long-range projection period. The initial projected increase in the

[79]Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices. Prior to the ACA, the law did not specify any such adjustments after 2009.

volume and intensity of these Medicare services is assumed to be equivalent to the average projected growth in the volume and intensity of services for the overall health sector. The Trustees believe that the use of a common baseline rate of volume and intensity growth is reasonable, as there would be only a small likelihood that one part of the health sector could continue to grow indefinitely at significantly faster rates of growth than do other parts.

Additionally, the Trustees assume that the growth in Medicare payment rates under current law will reduce the volume and intensity growth of these services by 0.1 percent per year relative to the assumption from the factors model. The Trustees' assumption is also based on recommendations by the 2010-2011 Medicare Technical Review Panel, which concluded that there would likely be a small net negative impact on volume and intensity growth due to reduced incentives to develop new technologies, provider exits, and the impact of greater bundling of services for payment purposes.[80] For new technology that leads to new services, the ACA will result in lower fees than would otherwise be the case, and providers will be less likely to adopt new services and innovations, thereby lowering the demand for, and intensity of, the medical care provided. Regarding provider exits, as fee-for-service fees decline relative to the pre-ACA levels, facilities of marginal profitability are likely to exit the Medicare market, reducing capacity and volume. This change could also cause a more bifurcated health system in which only providers who can operate profitably under Medicare offer services to Medicare beneficiaries, with a tendency to provide only the more basic services not associated with new medical technologies. Finally, the innovations being tested under the ACA, such as bundled payments or accountable care organizations, could reduce incentives to adopt new cost-increasing technologies and increase incentives to adopt new cost-decreasing technologies for those participating in these programs and/or could contribute to greater efforts to avoid services of limited or no value within the service bundle.

Reflecting all of these considerations, the year-by-year long-range current-law cost growth assumption for these HI and SMI

[80]Other factors, such as reduced beneficiary cost-sharing requirements, would tend to increase the volume and intensity of services. The assumption of −0.1 percent reflects the Technical Panel's assessment that the overall impact would be a small net decrease in volume and intensity growth.

Part B services starts at 4.4 percent in 2038, or GDP plus 0.4 percent, and gradually declines to 3.5 percent by 2088, or GDP minus 0.5 percent. On average over the long-range projection period, these services are assumed to increase at 4.2 percent per year under the intermediate assumptions, which is roughly equivalent to GDP plus 0.2 percent. This average growth rate is consistent with Recommendation III-4 of the 2010-2011 Medicare Technical Review Panel's report.

(ii) *Certain SMI Part B services that are updated annually by the CPI increase less the increase in productivity.*

Such services include durable medical equipment, ambulatory surgical centers, ambulance services, and medical supplies, which are updated by the CPI and affected by the ACA productivity adjustment. For these services, the Trustees initially assume that the rate of per beneficiary volume and intensity growth is equivalent to that derived for the overall health sector using the factors model. This volume and intensity growth is assumed to be reduced by 0.1 percent per year to reflect the ACA impact, as described above. The post-ACA volume and intensity assumption is combined with the long-range CPI assumption (2.7 percent) minus the productivity factor (1.1 percent) to produce a long-range growth assumption for these SMI Part B services. The corresponding year-by-year growth rates are 3.6 percent in 2038, or GDP minus 0.4 percent, gradually declining to 2.7 percent in 2088, or GDP minus 1.3 percent. On average over the long range, the growth is about 3.4 percent per year, which equates to GDP minus 0.6 percent.

(iii) *All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services, including physician fee schedule payments.*

The Trustees assume that per beneficiary outlays for these other Part B services, which constitute about 50 percent of total Part B expenditures in 2023, and for all Part D services grow at the same rate as the overall health sector as determined from the factors model. The services are assumed to grow similarly because their payment updates are determined by market forces, such as the competitive-bidding process for Medicare Part D. The year-by-year growth rates are 5.2 percent in 2038, or GDP plus 1.2 percent, gradually declining to 4.3 percent by 2088, or GDP

plus 0.3 percent. On average over the long range, the growth rate is 5.0 percent, or GDP plus 1 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the three long-range assumptions, the weighted average growth rate for Part B is 4.6 percent per year for the last 50 years of the projection period, or GDP plus 0.6 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 4.5 percent over this same time period or GDP plus 0.5 percent, while the growth rate in 2088 is 3.8 percent or GDP minus 0.2 percent.

As in the past, the Trustees have established detailed growth rate assumptions for the initial 10 years of the projection period by individual type of service (for example, inpatient hospital care and physician services), reflecting recent trends and the impact of all provisions of the Affordable Care Act and other applicable statutory provisions. For each of Parts A, B, and D, the assumed growth rates for years 11 through 25 of the projection period are set by interpolating between the rate at the end of the short-range period and the rate at the start of the final 50 years of the long-range period described above.

V. APPENDICES

A. MEDICARE AMENDMENTS SINCE THE 2013 REPORT

Since the 2013 annual report was transmitted to Congress on May 31, 2013, three laws have been enacted that have a significant effect on the Medicare trust funds: the Continuing Appropriations Resolution, 2014; Sections 1 and 3 of Public Law 113-82; and the Protecting Access to Medicare Act of 2014. The more important provisions, from an actuarial standpoint, are described, in brief, in the following paragraphs. Certain provisions with a relatively minor financial impact, but which are important from a policy perspective, are briefly described as well.

1. The Continuing Appropriations Resolution (CAR), 2014 (Public Law 113-67, enacted on December 26, 2013) included several provisions that affect the HI and SMI programs.

CAR Provisions Affecting HI

- Medicare inpatient hospital add-on payments for low-volume hospitals (having less than 1,600 Medicare discharges annually and located 15 miles or greater from the nearest like hospital) are extended through March 31, 2014.

- The Medicare-Dependent Hospital Program is extended through March 31, 2014. This program enhances reimbursement for Medicare inpatient hospital services provided in small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges.

- Long-term care hospitals will receive the traditionally higher long-term care hospital payment rates only for those patients who either (i) spent at least 3 days in an intensive care unit during a short-term acute care hospital stay that occurs immediately prior to being admitted to the long-term care hospital (and do not have a principal psychiatric or rehabilitation diagnosis) or (ii) received certain qualifying ventilator services (and do not have a principal psychiatric or rehabilitation diagnosis). All other cases will be reimbursed at a rate that is the lower of the inpatient hospital prospective payment system comparable rate or 100 percent of the estimated cost of the services. This change to site-neutral

payments is effective for discharges during cost-reporting periods beginning on or after October 1, 2015, but with a 2-year transition period, during which blended payment rates will apply.

Long-term care hospital discharges paid at the site-neutral payment rate or by a Medicare Advantage plan will be excluded from calculations to determine whether the average length of stay of a long-term care hospital exceeds 25 days.

For cost-reporting periods beginning in fiscal year 2020 and later, if a long-term care hospital's percentage of discharges for which payment was made at the site-neutral rate is greater than 50 percent, payments will be made as if the hospital were under the inpatient prospective payment system (IPPS), beginning in the next cost-reporting period.

Also, for the 25-percent rule (which reduces payment for long-term care hospitals that exceed established percentage thresholds for patients admitted from certain referring hospitals), implementation is delayed until October 1, 2017, or until July 1, 2017 for freestanding long-term care hospitals; certain retroactive relief will be granted for long-term hospitals previously required to comply; and certain grandfathered long-term care hospitals will be permanently exempted.

In addition, the moratorium on new long-term care hospitals and the expansion of existing long-term care hospitals is reinstated for the period from January 1, 2015 to September 30, 2017.

CAR Provisions Affecting Part B of SMI Only

- A 23.7-percent reduction in physician payment rates, set to begin on January 1, 2014, is eliminated. In the formula for determining physician payment rates, the update to the single conversion factor is set at 0.5 percent for the period beginning on January 1, 2014 and ending on March 31, 2014.

  For the period beginning on April 1, 2014 and ending on December 31, 2014, and for 2015 and subsequent calendar years, the physician fee schedule conversion factor will be computed as if the conversion factor for the period beginning

on January 1, 2014 and ending on March 31, 2014 had not been changed by CAR.

- The 1.00 floor on the geographic index for physician work is extended through March 31, 2014.

- The exceptions process for limits on therapy services is extended through March 31, 2014.

- Certain ambulance add-on payments are extended through March 31, 2014. These add-on payments include a 3-percent bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a super rural bonus for rural areas with the lowest population densities.

- The Qualifying Individual program is extended through March 31, 2014. This program is part of Medicaid and pays the Medicare Part B premium on behalf of certain beneficiaries with relatively low income and assets, with the cost financed from the Part B account of the SMI trust fund.

CAR Provisions Affecting Part C

- The authorization for specialized Medicare Advantage (MA) plans for special needs individuals is extended through December 31, 2015.

- Medicare Cost Plans are allowed to extend or renew for one additional year (that is, through December 31, 2015) in service areas that, during the entire past year, had (i) two or more MA regional plans not offered by the same organization or (ii) two or more MA local plans not offered by the same organization.

CAR Provisions Affecting All Parts of Medicare

- The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines, as described in previous Trustees Reports, is extended 2 years, through fiscal years 2022 and 2023. (In general, Medicare benefit payments for services provided during periods under the sequestration incur a 2-percent payment reduction.)

- Under the sequestration process described above, the 2-percent limit on Medicare provider payment reductions is

raised to 2.9 percent for the first 6 months of fiscal year 2023 and reduced to 1.11 percent for the last 6 months of fiscal year 2023.

- Funding for the National Quality Forum, which was previously transferred from the HI and SMI trust funds for each of fiscal years 2009 through 2013, will remain available until expended.

- Funding for certain low-income outreach and assistance programs is extended through March 31, 2014.

2. Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014, included two provisions that affect the HI and SMI programs.

Provision Affecting Part B of SMI Only

- The Secretary of Health and Human Services (HHS) is required to establish a Transitional Fund for Sustainable Growth Rate (SGR) Reform, available to provide funds to pay for physicians' services under Part B to supplement the conversion factor for 2017 if it is less than the conversion factor for 2013. For services furnished during or after 2017, $2.3 billion is to be made available to this fund, from the SMI trust fund, as expenditures from the fund are made.

Provision Affecting All Parts of Medicare

- The sequestration process, as described earlier in the CAR portion of this section, is extended for another year, through fiscal year 2024.

3. The Protecting Access to Medicare Act (PAMA) of 2014 (Public Law 113-93, enacted on April 1, 2014) included several provisions that affect the HI and SMI programs.

PAMA Provisions Affecting HI

- Medicare inpatient hospital add-on payments for low-volume hospitals (having less than 1,600 Medicare discharges annually and located 15 miles or greater from the nearest like hospital) are extended through March 31, 2015.

- The Medicare-Dependent Hospital Program is extended through March 31, 2015. This program enhances

reimbursement for Medicare inpatient hospital services provided in small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges.

- Technical corrections are made to the long-term care hospital (LTCH) provisions recently enacted in CAR, including a clarification that the LTCH discharge payment percentage is calculated using Medicare fee-for-service discharges instead of all discharges. In addition, the reinstatement of the moratorium on new LTCHs and LTCH expansions is modified to start earlier—as of PAMA's April 1, 2014 date of enactment, rather than January 1, 2015—but exceptions are allowed for new LTCHs that, on or before the date of enactment, are already under construction, obtained a certificate of need, or began their LTCH qualifying period.

- A new skilled nursing facility (SNF) value-based purchasing program (VBP) is created that, beginning on October 1, 2018, ties Medicare reimbursement for each SNF to its performance on a quality measure (described below). SNFs will be eligible for incentive payments based on their performance (that is, their achievement or improvement) on the measure, subject to certain rules. A pool of funding for the incentive payments is to be created by reducing every SNF's Medicare per diem payment by 2 percent, and only 50-70 percent of the pool can be distributed back to SNFs as incentive payments. (Therefore, this program results not only in a redistribution of payments among SNFs based on performance but also in an overall payment reduction to SNFs.)

  To determine performance under this new SNF VBP, the Secretary of HHS is required to use one of two quality measures, both of which are related to reducing readmissions and are described in the law, along with requirements and timeframes for their use. Beginning no later than October 1, 2017, the performance of individual SNFs will be reported publicly on Medicare's "Nursing Home Compare" website, but SNFs will be given confidential feedback on their performance (beginning October 1, 2016), as well as the opportunity to review and submit corrections prior to the public postings.

PAMA Provisions Affecting HI and Part B of SMI

- Enforcement of the two-midnight rule by Medicare Recovery Audit Contractors for certain hospital stays is delayed through March 31, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider of services. (The two-midnight rule is a payment policy that requires a patient to stay across two midnights in a hospital to qualify for inpatient status in most instances; hospital stays that do not continue across two midnights are to be paid for as an outpatient visit in most instances.) CMS is allowed to continue using Medicare Administrative Contractor probe and educate programs to assess provider understanding of, and compliance with, the two-midnight rule, on a pre-payment basis, through March 31, 2015.

- The transition from International Statistical Classification of Diseases (ICD)-9 to ICD-10 is delayed one year, from October 1, 2014 until October 1, 2015.

PAMA Provisions Affecting Part B of SMI Only

- A 24.1-percent reduction in physician payment rates, set to begin on April 1, 2014, is eliminated. In the formula for determining physician payment rates, the update to the single conversion factor is set at 0.5 percent for the period beginning on April 1, 2014 and ending on December 31, 2014 and at 0 percent for the period beginning on January 1, 2015 and ending on March 31, 2015.

  For the period beginning on April 1, 2015 and ending on December 31, 2015, and for 2016 and subsequent calendar years, the physician fee schedule conversion factor will be computed as if the conversion factors for the period beginning on April 1, 2014 and ending on March 31, 2015 had not been changed by PAMA.

- The 1.00 floor on the geographic index for physician work is extended through March 31, 2015.

- The exceptions process for limits on therapy services is extended through March 31, 2015.

- Certain ambulance add-on payments are extended through March 31, 2015. These add-on payments include a 3-percent

bonus for services originating in rural areas, a 2-percent bonus for services originating in other locations, and a *super rural* bonus for rural areas with the lowest population densities.

- The Qualifying Individual program is extended through March 31, 2015. This program is part of Medicaid and pays the Medicare Part B premium on behalf of certain beneficiaries with relatively low income and assets, with the cost financed from the Part B account of the SMI trust fund.

- Clinical laboratories that receive the majority of their Medicare revenues from payments made under the clinical laboratory or physician fee schedules will report to CMS, beginning January 1, 2016 and then every 3 years thereafter (or annually in the case of advanced diagnostic laboratory tests, which are discussed below), the rates that each private payer paid (including all discounts, rebates, coupons, and other price concessions) and the volume for each type of test.

  Based on the data from the most recent collection period, Medicare's reimbursement rate will equal the median of the rates private payers paid, weighted by volume, effective January 1, 2017. If the rates calculated under the new methodology are lower than existing rates, the reductions will be phased in over time periods specified in the law. Maximum reductions are also specified.

  New or substantially revised tests that are not advanced diagnostic laboratory tests (described below) will initially be paid by either a cross-walking process (as is already defined in the law) to the most appropriate existing test, or if no such existing test exists, a gap-filling process (which is newly defined). For each new test, the Secretary must publicly explain how the rate is established.

  An advanced diagnostic laboratory test is defined as a clinical diagnostic laboratory test that is furnished by the single laboratory that developed it and (i) is an analysis of multiple biomarkers of DNA, RNA, or proteins uniquely combined or (ii) is cleared or approved by the Food and Drug Administration (or meets similar criteria established by the Secretary in the future). New advanced diagnostic laboratory tests will be paid for at the actual list charge (that is, the publicly available rate) for the first 9 months and will be paid

using the median weighted methodology described above thereafter. If the payment rate for the first 9 months exceeds the market-based payment rate by more than 130 percent, the Secretary will recoup the difference from the laboratory.

Also, the nominal Medicare payment to clinical laboratories for samples collected in a skilled nursing facility or by a laboratory on behalf of a home health agency will be increased by $2.

- A new quality incentive payment policy to improve radiation dosing safety is prescribed. Specifically, for hospital outpatient departments and physicians' offices that provide certain computed tomography (CT) services using equipment that does not meet certain standards for radiation dosing safety, payment penalties of 5 percent in 2016 and 15 percent in 2017 and later will be applied for each service provided to Medicare beneficiaries.

  Additionally, the legislation seeks to promote evidence-based care in diagnostic imaging by ordering the Secretary to establish a program that promotes the utilization of appropriate-use criteria. Dates are set by which (i) a list of criteria and guidance must be published; (ii) professionals must consult the list and document their claims in specific ways; (iii) professionals with low adherence to the requirements must be identified; and (iv) the identified professionals with low adherence must obtain authorization prior to providing applicable imaging services.

- Funding for the Transitional Fund for Sustainable Growth Rate (SGR) Reform is eliminated. (This fund was recently established by Section 3 of Public Law 113-82 and is described in that portion of this section.)

- The Secretary is authorized to collect and use certain data on services paid under the physician fee schedule—such as time spent, practice expenses incurred, overhead, and accounting information—to establish or adjust the relative values used in the formulae for setting physicians' fees. The data are to be provided voluntarily, and funding is provided to compensate providers who submit data. Nine new criteria under which coding could be subject to review are added. For 2017-2020, an annual target rate for identifying misvalued services is set at 0.5 percent of the estimated amount of fee schedule

expenditures. If the target is met, the reduced expenditures are to be redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments are reduced by the difference between the target and the amount of misvalued services identified. If the relative value unit reduction for a code would be more than 20 percent compared to the previous year, the reduction will be phased in over a 2-year period. Also, the transition of fee schedule areas in California from county-based localities to Metropolitan Statistical Areas, starting in 2017, is required.

PAMA Provision Affecting SMI

- For the Medicare end-stage renal disease (ESRD) prospective payment system, the required inclusion of oral-only ESRD-related drugs into the ESRD bundled payment system is delayed, from 2016 to 2024; a new quality measure related to conditions (such as anemia) that are treated by oral-only drugs must be specified and incorporated into the ESRD quality incentive program; the payment reductions required by the American Taxpayer Relief Act of 2012, to adjust for the reduced use of certain drugs, are replaced, such that there will be a market basket freeze in 2015, a 1.25-percentage-point reduction to the market basket updates for 2016 and 2017, and a 1.0-percentage-point reduction to the market basket update for 2018; and the Secretary is required to conduct audits of Medicare cost reports for a representative sample of dialysis providers, beginning with 2012 cost reports, using funding provided from the SMI trust fund for this purpose.

PAMA Provisions Affecting Part C

- The authorization for specialized Medicare Advantage (MA) plans for special needs individuals is extended through December 31, 2016.

- Medicare Cost Plans are allowed to extend or renew for one additional year (that is, through December 31, 2016) in service areas that, during the entire past year, had in operation (i) two or more MA regional plans not offered by the same organization or (ii) two or more MA local plans not offered by the same organization.

PAMA Provisions Affecting All Parts of Medicare

- Funding for the National Quality Forum is provided from the HI and SMI trust funds for the remainder of fiscal year 2014 and the first 6 months of fiscal year 2015, and the provided amounts remain available until expended.

- Funding for certain low-income outreach and assistance programs is extended through March 31, 2015.

- Under the sequestration process described earlier in the CAR portion of this section, the 2-percent limit on Medicare provider payment reductions is raised to 4.0 percent for the first 6 months of fiscal year 2024 and reduced to 0.0 percent for the last 6 months of fiscal year 2024.

B. TOTAL MEDICARE FINANCIAL PROJECTIONS

Medicare is the nation's second largest social insurance program, exceeded only by Social Security (OASDI). Although Medicare's two components—Hospital Insurance (HI) and Supplementary Medical Insurance (SMI)—are very different from each other in many key respects, it is important to consider the overall cost of Medicare and its financing. By reviewing Medicare's total expenditures, readers can assess the financial obligation created by the program. Similarly, the sources and relative magnitudes of HI and SMI revenues are an important policy matter.

The issues of Medicare's total cost to society and the means of financing that cost are different from the question of the financial status of the Medicare trust funds. The latter focuses on whether a specific trust fund's income and expenditures are in balance. The separate HI and SMI financial projections prepared for this purpose, however, can be usefully combined for the broader purposes outlined above. To that end, this section presents information on combined HI and SMI costs and revenues. Sections III.B, III.C, and III.D of this report present detailed assessments of the financial status of the HI trust fund, and the Part B and Part D accounts of the SMI trust fund, respectively.

1. 10-year Actuarial Estimates (2014-2023)

Table V.B1 shows past and projected Medicare income, expenditures, and trust fund assets in dollar amounts for calendar years,[81] with projections shown under the intermediate set of assumptions and the projected baseline for the short-range projection period 2014 through 2023.

[81]The table shows amounts on a *cash* basis, reflecting actual expenditures made during the year, even if the payments were for services performed in an earlier year. Similarly, income figures represent amounts actually received during the year, even if incurred in an earlier year.

Table V.B1.—Total Medicare Income, Expenditures, and Trust Fund Assets during Calendar Years 1970-2023

[In billions]

Calendar year	Total income	Total expenditures	Net change in assets	Assets at end of year
Historical data:				
1970	$8.2	$7.5	$0.7	$3.4
1975	17.7	16.3	1.3	12.0
1980	37.0	36.8	0.1	18.3
1985	76.5	72.3	4.2	31.4
1990	126.3	111.0	15.3	114.4
1995	175.3	184.2	−8.9	143.4
2000	257.1	221.8	35.3	221.5
2005	357.5	336.4	21.0	309.8
2006	437.0	408.3	28.7	338.5
2007	462.1	431.7	30.4	368.9
2008	480.8	468.2	12.7	381.6
2009	508.3[1]	509.0	−0.7	380.8
2010	486.1[1]	522.9	−36.8	344.0
2011	530.0	549.1	−19.2	324.9
2012	536.9	574.2	−37.3	287.6
2013	575.8	582.9	−7.1	280.5
Intermediate estimates:				
2014	595.0	611.7	−16.6	263.8
2015	647.2[1]	625.5	21.7	285.6
2016	668.6[1]	661.3	7.3	292.9
2017	730.9	704.7	26.2	319.1
2018	786.0	760.1	25.9	345.0
2019	844.0	816.9	27.1	372.1
2020	920.9[1]	882.9	38.0	410.1
2021	958.3[1]	951.6	6.7	416.9
2022	1,040.9	1,026.0	15.0	431.8
2023	1,113.8	1,104.1	9.7	441.5

[1]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of those benefits normally due January 3, 2010 actually occurred on December 31, 2009. Consequently, the Part B and Part D premiums withheld from these benefits and the associated Part B general revenue contributions were added to the respective Part B or Part D account on December 31, 2009. The total income for 2010 excludes these amounts. Similarly, the payment date for those benefits normally due January 3, 2016 will be December 31, 2015, and the payment date for those benefits normally due January 3, 2021 will be on December 31, 2020.

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

As indicated in table V.B1, Medicare expenditures have increased rapidly during most of the program's history. From 1985 to 2013, expenditures grew at an average annual rate of 7.7 percent, and they are projected to increase at an average annual rate of 6.8 percent during 2014-2023.

Through most of Medicare's history, trust fund income has kept pace with increases in expenditures.[82] The Trustees estimate that total Medicare income will increase at a somewhat faster rate (7.2 percent annually) than expenditures during 2014-2023. This difference arises

[82]This balance resulted from periodic increases in HI payroll tax rates and other HI financing, from annual increases in SMI premium and general revenue financing rates (to cover the following year's estimated expenditures), and from frequent legislation designed to slow the rate of growth in expenditures.

in part because of the lower expenditures under the Affordable Care Act and the sequestration of Medicare benefits during this period. It is also attributable to faster growth in HI payroll tax revenues because the income threshold for application of the additional 0.9-percent tax rate is not indexed for inflation (with the result that an increasing proportion of workers becomes subject to the additional tax rate over time).

The Department of Treasury has invested past excesses of income over expenditures in U.S. Treasury securities, with total trust fund assets accumulating to $280.5 billion at the end of calendar year 2013. Combined assets decreased during 2009 through 2013, and the Trustees estimate that they will do so again, in 2014, mainly due to the continuing deficits in the HI trust fund and an intentional drawdown of excess Part B assets to help ameliorate premium increases otherwise required in 2014. Although it remains positive, the change in assets fluctuates slightly over the remainder of the short-range projection period due to the timing of premium collections as described in the footnote to table V.B1. The shift from the actual and expected declines in total Medicare trust fund assets in 2009-2014 to significant growth in assets during 2015-2020 reflects that the projected HI deficits decrease and become HI surpluses as key provisions of the Affordable Care Act phase in and as the lower provider payment updates compound over time.[83]

The Affordable Care Act of 2010 established a 15-member Independent Payment Advisory Board (IPAB) to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost growth, and improving the quality of care delivered to Medicare beneficiaries. The IPAB is required to submit proposals to the President the year following a determination that the projected rate of growth in Medicare spending per beneficiary exceeds a target growth rate.[84] Since 2013, the Chief Actuary at CMS has been required to determine the projected and target growth rates. If the Chief Actuary makes a determination that the projected Medicare per capita growth rate exceeds the per capita target growth rate in

[83]See sections III.B, III.C, and III.D regarding the asset projections for HI and Part B and Part D of SMI, separately.

[84]Beginning in 2019, the ACA provides an exception to the requirement that the IPAB submit proposals if the projected rate of growth for Medicare is less than that for national health expenditures. This exception can occur only if the IPAB was required to submit a proposal in the prior year, and it may not be used in 2 consecutive years. In addition, when there is a determination that the projected increase in the medical CPI is less than the CPI for the implementation year, the IPAB is not required to submit a proposal.

the implementation year, the Chief Actuary will establish a savings target for that year. For the 2013 and 2014 determination years, the target growth rates have not been exceeded.

For a given determination year, the rates of growth for Medicare spending and the target are calculated as the 5-year average consisting of the 2 prior years, the current year, and the 2 following years. For example, for the 2014 determination year, 2015 is the proposal year, 2016 is the implementation year, and the 5-year period is 2012-2016. For determination years 2013 through 2017, the target growth rate is equal to the average in the Consumer Price Index for All Urban consumers (all items; United States city average) and the medical care expenditure category of the Consumer Price Index for All Urban consumers (United States city average). For determination years 2018 and after, the target growth rate is equal to the nominal gross domestic product per capita plus one percentage point. Table V.B2 presents the projected rates of growth that are used in the IPAB determination based on current law. The first determination that the Medicare per capita growth rate exceeds the per capita target growth rate is projected to be made in 2022.[85]

Table V.B2.—Key Rates of Growth for IPAB Determination under Current Law

[In percent]

Calendar year	Medicare per capita[1]	CPI	CPI medical care	GDP per capita	NHE per capita[2]	IPAB determination[3,4]	
						Medicare	Target[5]
2011	1.9%	3.2%	3.0%	3.1%	3.1%	—	—
2012	0.1	2.1	3.7	3.8	3.1	—	—
2013	−1.0	1.5	2.5	2.5	3.0	1.46%	3.04%
2014	0.8	1.5	3.2	3.7	5.2	0.43	2.61
2015	−0.6	1.9	3.7	4.0	4.9	1.04	2.67
2016	2.8	2.2	3.8	4.2	4.7	2.17	2.95
2017	3.2	2.4	4.0	4.3	4.9	2.86	3.18
2018	4.7	2.6	4.2	4.3	5.3	3.98	5.19
2019	4.2	2.7	4.3	4.1	5.6	4.39	5.11
2020	4.9	2.7	4.3	4.0	5.7	4.68	4.96
2021	4.8	2.7	4.3	3.8	5.6	4.65	4.82
2022	4.7	2.7	4.3	3.6	5.6	4.76	4.71
2023	4.6	2.7	4.3	3.6	5.6	5.15	4.65

[1]These amounts differ from those presented in section V.D because they are determined based on the methodology required for the IPAB determination. They are calculated as the sum of the average per capita spending under each of Parts A, B, and D. For Parts B and D, the spending is net of premiums. In addition, the amounts in section V.D include other miscellaneous items such as Medicare Advantage additional premiums.

[2]Source: National health expenditure (NHE) projections article published in September 2013 (*Health Affairs,* vol. 32, no. 10). The findings presented in this article, along with the paper outlining its methodology, are available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[3]5-year average starting 2 years prior to the determination year and ending 2 years after the determination year. An implementation year is 2 years after a determination year in which Medicare per capita costs are projected to grow at a faster rate than the target, requiring a reduction in spending.

[4]The determination values for 2013 reflect the actual determination made in 2013.

[85]Under the projected baseline scenario, the first determination is also projected to be made in 2022.

[5]For determinations made in 2013-2017, the target is equal to the average of the growth in the Consumer Price Index for all urban consumers (all items; United States city average) and the medical care expenditure category of the Consumer Price Index for all urban consumers (United States city average). For 2018 and later determinations, the target rate of growth is per capita GDP plus 1 percent.

2. 75-year Actuarial Estimates (2014-2088)

Table V.B3 shows past and projected Medicare expenditures expressed as a percentage of GDP.[86] This percentage provides a relative measure of the size of the Medicare program compared to the general economy and represents the portion of the nation's total resources dedicated each year to providing health care services to beneficiaries through Medicare. Expenditures represented 0.7 percent of GDP in 1970 and had grown to 2.6 percent of GDP by 2005, reflecting rapid increases in the factors affecting health care cost growth. Starting in 2006, Medicare provided subsidized access to prescription drug coverage through Part D, which caused most of the increase in Medicare expenditures to 3.0 percent of GDP in the first year. The Trustees project much more moderate continuing growth in the long range, partially as a result of the lower price updates under the Affordable Care Act, with total Medicare expenditures projected to reach about 6.8 percent of GDP by 2085. Projected Medicare costs would slightly exceed those for Social Security in 2052 and later under the projected baseline.

Part of the projected increase is attributable to the prescription drug benefit in Medicare. In its first (partial) year of operation, this benefit increased aggregate Medicare costs by about one-eighth.[87] With continuing faster growth in drug costs, relative to the traditional HI and SMI Part B expenditures, the Trustees project that the prescription drug benefit will increase Medicare costs by roughly 18 percent beginning in 2023 and by about 25 percent at the end of the projection period. The Affordable Care Act provisions reduce growth rates for all HI and most SMI Part B non-physician services by the productivity adjustments to price updates; these adjustments do not apply to Part D, since a bidding process establishes payments to drug plans.

The change to the projected baseline increases costs compared to last year's report and is the reason that the projections shown in

[86]In contrast to the expenditure amounts shown in table V.B1, table V.B3 shows historical and projected expenditures on an incurred basis. Incurred amounts relate to the expenditures for services performed in a given year, even if payment for those expenditures occurs in a later year.

[87]Although the Part D drug benefit became available on January 1, 2006, beneficiaries had until May 15 to enroll. About 62 percent of the ultimate number of enrollees had enrolled as of January 1.

table V.B3 for total Medicare in 2055 and later are higher than in the 2013 report. Prior to 2055, even after accounting for the projected baseline change, this year's projections are lower than those in 2013 primarily due to lower recent actual experience and slower growth rates for Part A and Part B providers and Part D plans.

The details of these changes are described in sections III.B, III.C, and III.D.

Table V.B3.—HI and SMI Incurred Expenditures as a Percentage of the Gross Domestic Product

	HI	SMI		
Calendar year	Part A	Part B	Part D	Total
Historical data:				
1970	0.50%	0.21%	—	0.71%
1975	0.71	0.29	—	1.00
1980	0.88	0.40	—	1.29
1985	1.09	0.55	—	1.63
1990	1.11	0.74	—	1.85
1995	1.52	0.87	—	2.39
2000	1.27	0.91	—	2.18
2005	1.41	1.17	0.01%	2.59
2006	1.41	1.23	0.32	2.96
2007	1.43	1.27	0.35	3.05
2008	1.51	1.25	0.37	3.13
2009	1.64	1.43	0.40	3.47
2010	1.62	1.44	0.42	3.48
2011	1.62	1.45	0.43	3.51
2012	1.58	1.48	0.43	3.49
2013	1.56	1.47	0.44	3.48
Intermediate estimates:				
2014	1.50	1.50	0.44	3.44
2015	1.44	1.46	0.46	3.37
2016	1.44	1.47	0.48	3.39
2017	1.45	1.49	0.50	3.44
2018	1.48	1.53	0.52	3.53
2019	1.50	1.57	0.54	3.61
2020	1.53	1.62	0.57	3.72
2021	1.56	1.68	0.59	3.83
2022	1.60	1.74	0.61	3.95
2023	1.63	1.80	0.64	4.07
2025	1.74	1.97	0.69	4.40
2030	1.91	2.24	0.79	4.94
2035	2.06	2.42	0.87	5.35
2040	2.17	2.53	0.92	5.62
2045	2.24	2.60	0.97	5.80
2050	2.26	2.66	1.02	5.94
2055	2.27	2.73	1.07	6.06
2060	2.28	2.82	1.12	6.22
2065	2.31	2.90	1.18	6.39
2070	2.35	2.99	1.23	6.56
2075	2.38	3.06	1.28	6.72
2080	2.37	3.09	1.32	6.78
2085	2.36	3.13	1.36	6.84

The 75-year projection period fully allows for the presentation of anticipated future developments, such as the impact of a large increase in enrollees during 2010-2030. This increase in the number of beneficiaries will occur because the relatively large number of

persons born during the period between the end of World War II and the mid-1960s (known as the baby boom generation) will reach eligibility age and begin to receive benefits. Moreover, as this generation ages, these individuals will experience greater health care utilization and costs, thereby adding further to growth in program expenditures. Table V.B4 shows past and projected enrollment in the Medicare program.

As indicated in table V.B4, the total number of Medicare beneficiaries approximately doubled over the last 35 years, and the Trustees expect the total to double again over approximately the next 35 years. During this same historical period, the number of covered workers also increased rapidly (by about 53 percent) but is projected to increase much more slowly (about 27 percent) over the next 35 years. This demographic shift and its implications for Medicare costs, relative to workers' earnings or to the GDP, are fairly well known.

The enrollment data also show that the number of Medicare beneficiaries enrolled in private health plans under Part C has increased substantially in recent years. This increase reflects the higher Medicare payments to Medicare Advantage plans specified by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which enabled these plans to offer additional benefit coverage.

From 2005 to 2009, the number of Part C enrollees increased by more than 90 percent (an average of about 18 percent per year). Enrollment growth continued in 2010 and 2011 but at a slower pace of about 5 to 6 percent annually. In 2012 and 2013, enrollment growth increased again to about 9 to 10 percent per year. (Section IV.C of this report describes the factors contributing to the acceleration and deceleration in enrollment growth during these periods.) In 2013, enrollment in private health plans represented over 28 percent of total Medicare beneficiaries, with nearly all such enrollees participating in Medicare Advantage health insurance plans. Another large enrollment increase of 9 percent is expected in 2014.

Now that the majority of the Affordable Care Act benchmark phase-in is complete, it can be seen that the decrease in the blended benchmark did not have as large an impact on enrollment as previously assumed. In years 2015 through 2018, when the benchmark changes have fully phased in, the enrollment growth rate is expected to slow substantially, ranging between 1 to 4 percent annually. By 2018, about 30 percent of Medicare beneficiaries are

estimated to be enrolled in private Part C health plans. Modest increases are expected in private plan penetration rates between 2019 and 2025, with the estimated proportion of beneficiaries in such plans ultimately stabilizing at about 32 percent.

Table V.B4.—Medicare Enrollment
[In thousands]

Calendar year	HI	SMI			
	Part A	Part B	Part D	Part C	Total[1]
Historical data:					
1970	20,104	19,496	—	—	20,398
1975	24,481	23,744	—	—	24,864
1980	28,002	27,278	—	—	28,433
1985	30,621	29,869	—	1,271	31,081
1990	33,747	32,567	—	2,017	34,251
1995	37,175	35,641	—	3,467	37,594
2000	39,257	37,335	—	6,856	39,688
2005	42,233	39,752	1,841	5,794	42,606
2006	43,065	40,361	30,560	7,291	43,436
2007	44,010	41,093	31,392	8,667	44,368
2008	45,150	41,975	32,589	10,010	45,500
2009	46,256	42,908	33,644	11,104	46,604
2010	47,365	43,882	34,772	11,692	47,720
2011	48,549	44,917	35,720	12,382	48,896
2012	50,516	46,468	37,402	13,587	50,862
2013	51,913	47,878	39,095	14,841	52,256
Intermediate estimates:					
2014	53,651	49,350	40,687	16,237	53,992
2015	55,312	50,794	42,200	16,395	55,651
2016	56,987	52,247	43,742	16,883	57,324
2017	58,689	53,723	45,329	17,636	59,025
2018	60,427	55,231	46,618	18,105	60,761
2019	62,206	56,781	47,947	18,882	62,540
2020	64,028	58,383	49,377	19,722	64,362
2021	65,877	60,011	50,792	20,571	66,210
2022	67,770	61,680	52,242	21,396	68,104
2023	69,662	63,358	53,690	22,179	69,996
2025	73,383	66,649	56,545	23,502	73,718
2030	81,422	73,815	62,712	25,991	81,759
2035	86,438	78,215	66,557	27,532	86,771
2040	88,879	80,419	68,426	[2]	89,207
2045	90,344	81,722	69,550	[2]	90,673
2050	92,439	83,617	71,160	[2]	92,772
2055	95,189	86,067	73,275	[2]	95,529
2060	98,707	89,270	75,979	[2]	99,054
2065	102,198	92,414	78,659	[2]	102,548
2070	106,062	95,907	81,624	[2]	106,414
2075	110,003	99,508	84,646	[2]	110,353
2080	112,666	101,910	86,679	[2]	113,004
2085	116,414	105,324	89,545	[2]	116,740

[1]Number of beneficiaries with HI and/or SMI coverage.
[2]The Trustees do not explicitly project enrollment in Part C beyond 2035.

Table V.B5 shows the past and projected amounts of Medicare revenues as a percentage of total non-interest Medicare income, under the projected baseline intermediate assumptions. The table excludes interest income, which would not be a significant part of program financing in the long range under current law.

Table V.B5.—Medicare Sources of Income as a Percentage of Total Non-Interest Income[1]

Calendar year	Payroll taxes	Tax on benefits	Premiums[1]	Brand-name drug fees	State transfers	General revenue
Historical data:						
1970	61.8%	—	13.7%	—	—	24.6%
1980	68.0	—	8.6	—	—	23.4
1990	62.2	—	9.8	—	—	27.9
2000	59.8	3.6%	9.1	—	—	27.6
2010	38.9	2.9	13.3	—	0.9%	44.0
2013	39.2	2.5	13.6	0.6%	1.6	42.4
Intermediate estimates:						
2014	38.0	3.2	13.9	0.5	1.4	42.9
2020	36.2	3.8	14.6	0.3	1.4	43.7
2030	29.9	4.4	16.1	0.2	1.6	47.9
2040	27.7	4.5	16.7	0.1	1.7	49.4
2050	26.9	4.3	17.0	0.1	1.7	50.0
2060	25.9	4.2	17.4	0.0	1.8	50.6
2070	25.0	4.1	17.8	0.0	1.9	51.2
2080	24.4	3.9	18.2	0.0	1.9	51.5

[1]Includes premium revenue from HI and both accounts in the SMI trust fund.

Note: Row sums may not exactly equal 100 percent due to rounding.

In 2013, general revenues (primarily those for SMI) represented 42 percent of total non-interest income to the Medicare program—becoming, for the fifth year in a row, the largest share of Medicare financing. HI payroll taxes were the next largest source of overall financing at 39 percent. Beneficiary premiums (again, primarily for SMI) were third, at 13 percent. Projected HI tax revenues fall short of projected HI expenditures for most future years. In contrast, SMI premium and general revenues will keep pace with SMI expenditure growth, and, once fully phased down,[88] State payments (on behalf of Medicare beneficiaries who also qualify for full Medicaid benefits) will grow with Part D expenditures. Under the Affordable Care Act, a new source of Part B financing, from fees on manufacturers and importers of brand-name prescription drugs, will increase from $2.5 billion in 2011 to $4.1 billion in 2018 but then decrease to $2.8 billion for 2019 and later. In the absence of legislation, HI tax income would represent a declining portion of total Medicare revenues. In 2030, for example, the projected year of depletion of the HI trust fund, currently scheduled HI payroll taxes would represent about 30 percent of total non-interest Medicare income. General revenues and beneficiary premiums would equal about 48 and 16 percent, respectively.

The Medicare Modernization Act requires an expanded analysis of the combined expenditures and dedicated revenues of the HI and SMI

[88]State payments to Part D amounted to 90 percent of their projected foregone Medicaid prescription drug costs in 2006, with this percentage phasing down over a 10-year period to 75 percent in 2015.

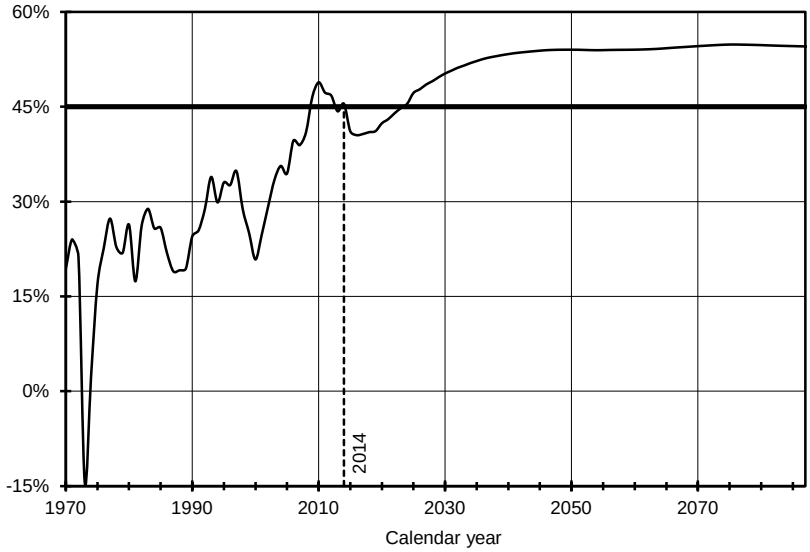
trust funds. In particular, the Act requires a determination as to whether projected annual *general revenue funding* exceeds 45 percent of total Medicare outlays within the next 7 fiscal years (2014-2020). For this purpose, the law defines general revenue funding as total Medicare outlays minus dedicated Medicare financing sources. Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees on brand-name prescription drugs paid to Part B; fines and penalties collected as a result of program integrity efforts; and any gifts received by the Medicare trust funds. The test uses expenditures adjusted to avoid temporary distortions arising from the payment of Medicare Advantage capitation amounts in September when the normal October payment date is a Saturday or Sunday.

Lawmakers established the 45-percent test to help call attention to Medicare's impact on the Federal budget. The Trustees made determinations of excess general revenue Medicare funding in each of the reports for 2006 through 2013. Two consecutive such determinations trigger a *Medicare funding warning*, which indicates that a trust fund's financing is inadequate or that the general revenues provided under current law are becoming unduly large. The 2007 through 2013 reports thus prompted Medicare funding warnings. Such findings require the President to submit to Congress, within 15 days after the date of the Budget submission for the succeeding year, proposed legislation to respond to the warning. The law also requires Congress to consider the legislation proposed in response to Medicare funding warnings on an expedited basis. To date, elected officials have not enacted legislation responding to these funding warnings.

Figure V.B1 displays, on a calendar-year basis under current law, the historical and projected ratio of the difference between total Medicare outlays and dedicated financing sources to total Medicare outlays. As indicated, this ratio exceeded 45 percent at the end of calendar years 2009 through 2013, and the Trustees estimate that it will do so in calendar year 2014 (as a result of expected low payroll tax caused by the continuing effects of the recent economic recession, together with a planned drawdown of excess Part B assets). Formal application of the test, however, is on a fiscal-year basis. As a result of the recent slowdown in Medicare spending, in this year's report the Trustees project that the difference will not exceed 45 percent in the next 7 fiscal years (2014-2020), meaning there is no determination of

excess general revenue Medicare funding in this report.[89] As projected in past reports, beginning in 2014 and extending through about 2022, higher tax income is expected, along with lower outlays due to provisions of the ACA and other legislation, causing excess general revenue funding to remain below 45 percent.

Figure V.B1.—Projected Difference between Total Medicare Outlays and Dedicated Financing Sources, as a Percentage of Total Outlays, under Current Law



As figure V.B1 also indicates, the Board projects that the difference between outlays and dedicated funding sources will reach 55 percent of outlays by 2043 and will remain at about that level throughout the remainder of the 75-year period. Although the law characterizes this difference as *general revenue funding*, it is important to recognize that current law provides for general revenue transfers only for certain purposes related to Parts A, B, and D, as follows:

- Financing specified portions of SMI Part B and SMI Part D expenditures;
- Reimbursing the HI trust fund for the costs of certain uninsured beneficiaries;
- Paying interest on invested assets of the trust funds; and

[89]The Trustees estimate that the ratio will again exceed 45 percent beginning in fiscal year 2024 under both current law and the projected baseline scenario.

- Redeeming the special Treasury securities held as assets by the trust funds.

The difference between outlays and dedicated funding sources, as shown in figure V.B1, reflects all of these general revenue transfers, plus the imbalance between HI expenditures and dedicated revenues after HI asset depletion in 2030. There is no provision under current law to cover the shortfall. In particular, transfers from the general fund of the Treasury could not occur for the purpose of avoiding asset depletion without new legislation.

The Medicare Modernization Act also requires a comparison of projected growth in the difference between outlays and dedicated revenues with other health spending growth rates. Table V.B6 contains this comparison.

Table V.B6.—Comparative Growth Rates of Medicare under Current Law, Private Health Insurance, National Health Expenditures, and GDP

	Average annual growth in:				
Calendar year	Incurred outlays minus dedicated revenues	Incurred Medicare outlays	GDP	National health expenditures[1]	Private health insurance[1]
2008	3.5%	4.3%	1.7%	4.7%	3.9%
2009	24.1	8.7	−2.1	3.9	3.2
2010	10.8	4.0	3.7	3.9	3.4
2011	0.8	4.7	3.8	3.9	3.8
2012	2.6	4.1	4.6	3.9	3.8
2013	−0.9	3.0	3.4	3.8	3.4
2014	4.5	3.5	4.6	6.1	7.7
2015	−8.5	1.1	4.9	5.8	6.2
2016	4.6	5.7	5.2	5.6	5.1
2017	8.1	7.1	5.3	5.8	5.0
2018	8.7	7.9	5.3	6.2	6.0
2019	7.8	7.3	5.1	6.5	6.7
2020	11.3	8.0	4.9	6.6	6.2
2021	9.5	7.8	4.7	6.5	6.2
2022	10.2	7.8	4.5	6.5	5.6
2023	9.7	7.7	4.5	6.5	5.6
2024-2038	7.8	6.5	4.5	—	—
2039-2063	5.0	4.9	4.5	—	—
2064-2088	4.7	4.7	4.4	—	—

[1]Source: National health expenditure (NHE) projections article published in September 2013 (*Health Affairs,* vol. 32, no. 10). The findings presented in this article, along with the paper outlining its methodology, are available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

As shown in table V.B6, the gap between outlays and dedicated revenues increased substantially, as did Medicare outlays, through 2010. The growth in both then slows initially as Medicare spending decelerates and as provisions of the ACA begin taking effect. In addition, this gap will increase faster than outlays in most years through 2063 since the dedicated sources of income to the HI trust fund will generally cover a decreasing percentage of HI outlays.

In addition to projected Medicare outlay growth, table V.B6 shows projected growth in GDP, total NHE in the U.S., and private health insurance expenditures. The Trustees expect each of the health expenditure categories to continue the longstanding trend of increasing more rapidly than GDP in most years. Private health insurance expenditures equal the total premiums earned by private health insurers, including benefits incurred and the net cost of insurance. The net cost of insurance includes administrative costs, additions to reserves, rate credits and dividends, premium taxes, and profits or losses.

Several factors affect comparisons between aggregate Medicare and private health insurance cost growth:

- The number of Medicare beneficiaries is currently increasing by about 3 percent per year, and this growth rate will continue as more of the post-World War II baby boom generation reaches eligibility age. The number of individuals with private health insurance is estimated to be stable through 2013 as the economy continues to slowly recover from the recent recession. Thereafter, with the availability of Federal premium and cost-sharing subsidies for many individuals and families under the Affordable Care Act, the projected number of people with private health insurance increases significantly.

- Certain ACA provisions, such as the limitation on maximum out-of-pocket costs in 2014 and later and the 40-percent excise tax on high-cost employer-sponsored insurance plans in 2018 and later, will also affect the average actuarial value of private health insurance benefits.

- The use of health care services differs significantly between Medicare beneficiaries (who are generally over 65) and individuals with private health insurance (who are predominantly below age 65). The former group, for example, has a higher incidence of hospitalization, skilled nursing care, and home health care. For the latter group, physician services represent a greater proportion of their total health care needs. Different cost growth trends by type of service will affect overall growth rates and reflect the distribution of services for each category of people.

- There is some overlap between people with Medicare and those with private health insurance. For example, many Medicare beneficiaries have supplemental health insurance coverage

through private Medigap insurance policies or employer-sponsored retiree health benefits, and private health insurance includes both of these categories. About 10 million Medicare beneficiaries receive supplemental coverage through the Medicaid program; neither the growth rates for Medicare nor those for private health insurance reflect the Medicaid costs for these *dual beneficiaries*.

A number of research studies have attempted to control for some or all of these differences in comparing growth trends. Over long historical periods, average, demographically adjusted, per capita growth rates for common benefits have been somewhat lower for Medicare than for private health insurance. For shorter periods, however, the rates of growth have often diverged substantially, and the differential has been negative in some years and positive in others. More information on past and projected national and private health expenditures, and on comparisons to Medicare growth rates, is available in the sources cited in table V.B6.

C. CURRENT LAW AND ILLUSTRATIVE ALTERNATIVE PROJECTIONS

Current Law Projections

The Social Security Act requires the Trustees to evaluate the financial status of the Medicare trust funds. To comply with this mandate, the Trustees must assess whether the financing provided under current law is adequate to cover the benefit payments and other expenditures. The estimates shown throughout this report are based on a *projected baseline* that assumes that the physician payment updates required under the current-law sustainable growth rate (SGR) formula will be permanently overridden by lawmakers. Since the only differences between the projected baseline and current law for Part A and Part D are minor modifications[90] in the IPAB operations, and since the financial status of Part A and Part D are unchanged from the separate assessments for these parts under the projected baseline scenario shown throughout this report, this section will primarily focus on the 10-year projections for Part B only under current law, along with a discussion of the long-range implications for total Medicare. Since the financial adequacy of Part B is evaluated only through 2014, and since the projected baseline and current-law scenarios do not differ during that period, the Trustees estimate that the financing established through 2014 will also be adequate under current law.

Table V.C1 shows the estimated operations of Part B under current law. By 2023, the estimated Part B benefit payments are 4 percent less than under the projected baseline. Readers should interpret the estimates for 2015 and later cautiously, since the estimates include only the direct impacts of the negative payment updates on physician expenditures and do not incorporate potential secondary effects[91] on other Medicare outlays. Despite the fact that these projections are lower than the projected baseline scenario, rapid growth in the cost of these health care services remains a major concern for Part B under current law.

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[90]The projected baseline reflects a 0.6-percent physician payment update, resulting in slightly different IPAB operations under this scenario and current law, since the Trustees assume that reductions in spending recommended by the IPAB are spread proportionately across Parts A, B, and D.

[91]Such secondary effects could include (i) substantially reduced beneficiary access to physicians; (ii) a significant shift in enrollment to Medicare private health plans; (iii) an increase in emergency room services; (iv) an increase in mortality rates; and/or (v) an increase in hospital services.

Table V.C1.—Operations of the Part B Account in the SMI Trust Fund (Cash Basis) under Current Law during Calendar Years 2013-2023

[In billions]

	Income				Expenditures			Account	
Calendar year	Premium income	General revenue[1]	Interest and other[2,3]	Total	Benefit payments[3,4]	Adminis-trative expenses	Total	Net change	Balance at end of year
2013	$63.1	$185.8	$6.1	$255.0	$243.8	$3.3	$247.1	$7.9	$74.1
2014	65.6	188.4	6.0	260.1	260.1	2.7	262.8	−2.7	71.4
2015	70.3[5]	200.1	6.2	276.5	257.2	3.0	260.2	16.4	87.8
2016	68.0[5]	194.6	6.6	269.2	269.0	3.3	272.3	−3.1	84.7
2017	72.8	207.8	7.9	288.4	288.6	3.5	292.1	−3.7	81.0
2018	79.7	224.1	8.1	311.9	310.4	3.7	314.1	−2.3	78.7
2019	89.7	247.7	7.0	344.4	334.4	4.0	338.4	6.0	84.7
2020	98.7[5]	280.4	7.5	386.6	362.7	4.2	366.9	19.6	104.4
2021	100.1[5]	283.3	8.0	391.4	392.8	4.5	397.3	−6.0	98.4
2022	112.5	317.1	8.6	438.2	425.7	4.8	430.4	7.7	106.1
2023	122.2	343.3	9.2	474.7	460.4	5.1	465.4	9.2	115.4

[1]General fund matching payments, plus certain interest-adjustment items.

[2]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income.

[3]See footnote 2 of table III.B4.

[4]Includes costs of Quality Improvement Organizations beginning in 2002.

[5]Section 708 of the Social Security Act modifies the provisions for the payment of Social Security benefits when the regularly designated day falls on a Saturday, Sunday, or legal public holiday. Payment of those benefits normally due January 3, 2016 actually will occur on December 31, 2015. Consequently, the Part B premiums withheld from these benefits and the associated general revenue contributions are assumed to be added to the SMI trust fund on December 31, 2015. Similarly, the payment date for those benefits normally due on January 3, 3021 will be December 31, 2020.

Notes: 1. Totals do not necessarily equal the sums of rounded components.
2. This table is comparable to table III.C4, which shows projections under the projected baseline scenario.

Starting on April 1, 2015, the scheduled physician payment reduction of almost 21 percent heavily influences the Part B projections estimated under current law.

Table V.C2 shows the estimated total Medicare incurred expenditures under current law expressed as a percentage of GDP for selected years over the calendar-year period 2013-2088.

Table V.C2.—HI and SMI Incurred Expenditures as a Percentage of the Gross Domestic Product under Current Law

	HI	SMI		
Calendar year	Part A	Part B	Part D	Total
2013	1.56%	1.47%	0.44%	3.48%
2014	1.50	1.50	0.44	3.44
2015	1.44	1.41	0.46	3.32
2016	1.44	1.41	0.48	3.33
2017	1.45	1.44	0.50	3.39
2018	1.48	1.47	0.52	3.47
2019	1.50	1.51	0.54	3.55
2020	1.53	1.56	0.57	3.65
2021	1.56	1.61	0.59	3.76
2022	1.60	1.67	0.61	3.88
2023	1.63	1.73	0.64	4.00
2025	1.75	1.89	0.69	4.32
2030	1.91	2.14	0.79	4.84
2035	2.06	2.29	0.87	5.22
2040	2.17	2.35	0.93	5.45
2045	2.24	2.37	0.97	5.58
2050	2.27	2.38	1.02	5.67
2055	2.27	2.41	1.07	5.75
2060	2.28	2.45	1.13	5.86
2065	2.31	2.49	1.18	5.98
2070	2.35	2.53	1.23	6.12
2075	2.38	2.56	1.29	6.23
2080	2.38	2.56	1.32	6.26
2085	2.36	2.57	1.36	6.29

Note: This table is comparable to table V.B3, which shows projections under the projected baseline scenario.

As shown in table V.C2, total Medicare expenditures would represent 6.3 percent of GDP at the end of the long-range projection period under current law, which is less than the estimated 6.9 percent under the projected baseline.[92]

Illustrative Alternative Projections

As discussed in the Introduction, there is additional uncertainty regarding the adequacy of future Medicare payment rates beyond the concerns raised in relation to the physician sustainable growth rate (SGR) formula. This section illustrates the higher Medicare outlays that would result if certain statutory Medicare payment provisions were not fully implemented in all future years.

For all Part A services and some other (non-physician) Part B services, payment updates will be reduced in all future years by the

[92]Additional current-law tables are available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013Tables.zip.

increase in economy-wide multifactor productivity.[93] By the end of the long-range projection period, payment rates for affected providers would be about 55 percent lower than their level in the absence of these reductions. Currently, the Medicare payment rates for inpatient hospital services are about 67 percent of those paid by private health insurance. If future improvements in productivity remain similar to what providers have achieved in the recent past (about 0.4 percent annually), then Medicare payment levels for inpatient hospital services at the end of the long-range projection period would be less than 40 percent of the corresponding level paid by private health insurance.[94] Absent other changes, lower Medicare payment rates as stipulated by the ACA through the productivity adjustments and other payment provisions would result in a deterioration of facility margins for hospitals, skilled nursing facilities, and home health agencies, particularly over the long run. Simulations suggest that up to 5 percent more hospitals would experience negative total facility margins by 2019 and an additional 5-10 percent would experience negative Medicare margins by 2019. Other factors such as the coverage expansions and efforts to improve efficiency in lower performing hospitals could mitigate some of the impact of the ACA payment provisions, though there is a wide range of uncertainty regarding these types of behavioral changes. By 2040, simulations suggest that approximately half of hospitals, two-thirds of skilled nursing facilities, and 90 percent of home health agencies would have negative total facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries. A memorandum on these provider margin simulations is available on the CMS website.[95]

Over time, unless providers could alter their use of inputs to reduce their cost per service correspondingly, Medicare's payments for health services would fall increasingly below providers' costs. Providers could not sustain continuing negative margins and would have to

[93]In addition to the productivity adjustments, current law requires certain other reductions in payment updates for 2010 through 2019. For inpatient hospital services, the cumulative impact of these adjustments is a further reduction of 3.6 percent in payment levels. Also, Medicare payments to providers will be affected by the sequestration of outlays in April 2013 through September 2024.

[94]This comparison assumes that private payer rate increases would continue to be set through the same negotiation process used to date, independent of the Medicare reductions or other health system changes. Specifically, private payer rates would grow by 3.1 percent per year, or the increase in the price of inputs to the provision of health care (3.5 percent) less the assumed growth in hospital productivity (0.4 percent). By comparison, Medicare payment rates would grow by 2.4 percent per year, or 3.5 percent less the assumed growth in economy-wide multifactor productivity (1.1 percent).

[95]See http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/ACAmarginsimulations2014.pdf.

withdraw from serving Medicare beneficiaries or (if total facility margins remained positive) shift substantial portions of Medicare costs to their non-Medicare, non-Medicaid payers. Under such circumstances, lawmakers might feel substantial pressure to override the productivity adjustments, much as they have done to prevent reductions in physician payment rates.

The Independent Payment Advisory Board (IPAB) must submit proposals to the President for years in which the projected rate of growth in Medicare spending per beneficiary exceeds specified thresholds. For 2015 through 2019, the threshold rate of growth in Medicare spending per beneficiary is the average of the increases in the Consumer Price Index (CPI) for all items and in the CPI for Medical Care. Thereafter, the law requires IPAB proposals if the projected rate of growth in Medicare spending exceeds the estimated increase in GDP plus 1.0 percentage point.[96] The IPAB's proposals will automatically take effect unless lawmakers enact an alternative measure that achieves the same level of savings. As a result of the other savings provisions incorporated into the projected baseline, the Trustees estimate that the IPAB provision will reduce Medicare growth rates for the first time in 2024, and by only 0.1 percent in that year. Rates are also projected to be reduced by similar small amounts in every second year through about 2042. In the absence of these other ACA provisions, however, reducing cost growth rates to the degree required by the IPAB provision would be challenging. (See section V.B for more details about the IPAB determination.)

In view of these issues, it is important to note that the actual future costs for Medicare may exceed those shown by the projected baseline projections in this report, possibly by substantial amounts. Use of an alternative projection can illustrate the potential magnitude of this difference.

It is possible that health care providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain

[96]The effects of the IPAB's proposals on Medicare expenditures are limited to 0.5 percentage point in 2015, 1.0 percentage point in 2016, 1.25 percentage points in 2017, and 1.5 percentage points in 2018 and subsequent years (or, if smaller, the amount by which the rate of growth in Medicare spending exceeds the threshold growth rate). A number of other provisions govern the operations of the IPAB; appendix V.A in the 2010 Medicare Trustees Report summarizes these additional provisions.

unprecedented levels of productivity gains—a very challenging and uncertain prospect.

A transformation of health care in the U.S., affecting both the means of delivery and the method of paying for care, is also a possibility. Private health insurance and Medicare are taking important steps in this direction by initiating programs of research into innovative payment and service delivery models, such as accountable care organizations, patient-centered medical homes, improvement in care coordination for individuals with multiple chronic health conditions, better coordination of post-acute care, payment bundling, pay for performance, and assistance for individuals in making informed health choices. Such changes have the potential to reduce health care costs and cost growth rates and could, as a result, help lower health care spending to levels compatible with the lower price updates payable under current law.

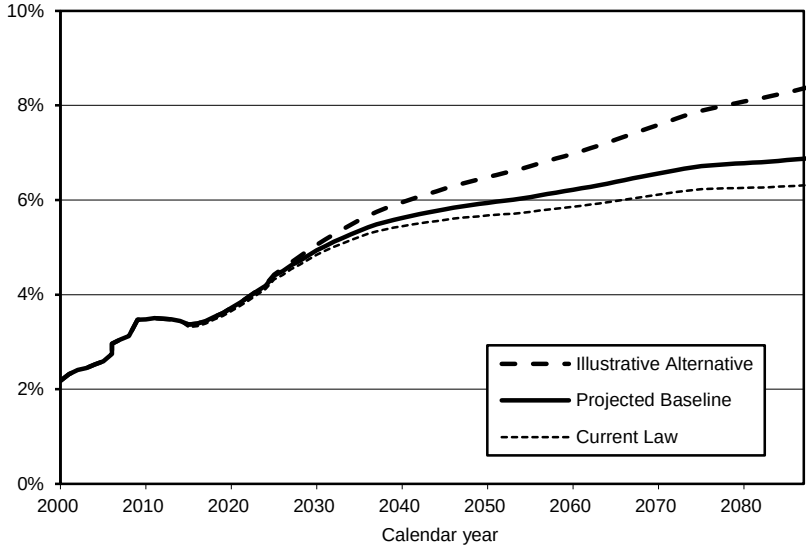
The ability of new delivery and payment methods to lower cost growth rates is uncertain at this time, since specific changes have not yet been designed, tested, or evaluated. Hopes for success are high, but at this time there is insufficient evidence to support an assumption that improvements in efficiency can occur of the magnitude needed to align with the statutory Medicare price updates. Given these uncertainties, it will be important for policy makers to monitor the adequacy of Medicare payment rates over time to ensure beneficiary access to high-quality care.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees have asked the Office of the Actuary to prepare an illustrative Medicare trust fund projection under a hypothetical alternative that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent.[97] Figure V.C1 compares the illustrative alternative

[97]The Trustees have used this approach since 2007 to address concerns with the SGR provision. The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the Affordable Care Act.

projection with the projections under the projected baseline and under current law.[98]

Figure V.C1.— Medicare Expenditures as a Percentage of the Gross Domestic Product under Current Law, Projected Baseline, and Illustrative Alternative Projections



The middle line in figure V.C1 illustrates the projected baseline emphasized in the main body of this report. The lower line illustrates the current-law projections summarized earlier in this appendix.

The top curve in figure V.C1 shows the cost levels under the illustrative alternative. This scenario illustrates the impact that would occur if the productivity adjustments gradually phased down, starting in 2020, until the Medicare price updates equaled those assumed for private health plans in 2034.[99] In addition, the projection assumes that the IPAB requirements would not be implemented. On average under this alternative, the long-range per beneficiary growth rate for all Medicare services would be similar to the long-range

[98]The 2010-2011 Medicare Technical Review Panel supported the continued use of illustrative alternative projections for this purpose. In addition, the Panel recommended a graphical comparison of the current-law and alternative projections within the Medicare annual report, highlighting the potential effects of both SGR and productivity adjustments. The *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* can be found at http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf. The text summarizes the specific assumptions chosen by the Trustees for the illustrative alternative projections.

[99]Section IV.D of this report describes the price component of health care cost increases for the overall health sector.

growth rate assumed for the overall health sector. These growth rates are very similar to the full illustrative alternative projections referenced in the 2010-2013 reports.

As indicated in figure V.C1, Medicare costs as a percentage of GDP would continue to increase rapidly throughout the projection period absent the full economy-wide productivity adjustments and IPAB effects. The illustrative projection reaches 6.0 percent of GDP in 2040 and 8.4 percent in 2088—considerably higher than the 5.6 percent of GDP in 2040 and 6.9 percent of GDP in the projected baseline.

Difficult challenges lie ahead in making health care far more cost-efficient while ensuring its high quality, and awareness of these challenges must temper expectations. The sizable differences in projected Medicare cost levels among the projected baseline, current-law, and illustrative alternative projections highlight the critical importance of the new research authorized by the Affordable Care Act. It is necessary to expend every effort not only to bring Medicare costs—and health care costs in the U.S. generally—more in line with society's ability to afford them but also to improve health care outcomes.

D. AVERAGE MEDICARE EXPENDITURES PER BENEFICIARY

Table V.D1 shows historical average per beneficiary expenditures for HI and SMI, as well as projected costs for calendar years 2014 through 2023 under the intermediate assumptions. In prior years, this section has discussed per beneficiary expenditure projections based on when payment for the services is made. However, this approach has resulted in strange patterns because of the lag between the time the service is incurred and when it is paid, in particular with regard to Part D. In order to alleviate this issue, this section now presents per beneficiary expenditures based on when the service is incurred.

For both HI and SMI Part B, costs increased very rapidly in the early years, in part because the availability of Medicare coverage enabled many beneficiaries to obtain the full range of health services they needed. The rapid inflation of the 1970s and early 1980s also contributed to rapid Medicare expenditure increases, and the cost-based reimbursement mechanisms in place provided relatively little incentive for efficiency in the provision of health care. Growth in average HI expenditures moderated dramatically following the introduction of the inpatient hospital prospective payment system in fiscal year 1984, but accelerated again in the late 1980s and early 1990s due to rapid growth in skilled nursing and home health expenditures. During this same period, SMI Part B average costs generally continued to increase at relatively fast rates but slowed somewhat in the early 1990s with the implementation of physician fee reform legislation.

Expenditure growth moderated again during the late 1990s due to the effects of further legislation, including the Balanced Budget Act of 1997 (BBA), and efforts to control fraud and abuse. In addition, historically low levels of general and medical inflation helped reduce Medicare payment updates. HI per beneficiary costs actually decreased in 1998 and 1999, and slowed substantially in 2000, in part because of such BBA mandates as a reduction in payment updates to providers and a shift in home health benefits from HI to SMI Part B, and in part because of a decline in utilization of services. Growth rates returned to more typical levels during 2001-2004.

For 2005 through 2006, Part B grew substantially, reflecting increases in the volume and intensity of physician services. Growth returned to more moderate levels in 2007 through 2009.

Growth rates in 2010 slowed for both HI and Part B of SMI due to low provider payment updates caused by slow growth in wages and prices following the recent economic recession, an adjustment for excess HI documentation and coding under the new Medicare Severity-Diagnosis Related Group (MS-DRG) classification system for inpatient admissions, unusually low volume and intensity growth for Part B services, and an adjustment to Medicare Advantage (MA) payment rates to compensate for excess growth in MA risk scores relative to fee-for-service beneficiaries.

Growth rates for 2011 rebounded somewhat for both HI and Part B of SMI, but slowed again for HI in 2012 and 2013. Part B growth also slowed in 2013.

Although SMI Part D began in 2004, full prescription drug coverage did not start until 2006. Accordingly, this discussion includes only the per beneficiary expenditures for 2006 and later. The initial open enrollment period for Part D ran through May 15, 2006. Beneficiaries who enrolled at the beginning of the year tended to have higher costs than did those who enrolled toward the end of the open enrollment period. As a result, the average per beneficiary costs in 2006 were relatively high, resulting in a lower growth rate in 2007 than normal. Growth rebounded in 2008 through 2011. Part D growth in 2012 was negative due to the patent expiration of certain high-cost drugs.

Table V.D1.—HI and SMI Average per Beneficiary Costs

Calendar year	Average per beneficiary costs				Average percent change[1]			
		SMI				SMI		
	HI	Part B	Part D	Total	HI	Part B	Part D	Total
Historical data:								
1970	$270	$115	—	$385	13.8%	13.8%	—	13.8%
1975	472	205	—	677	11.8	12.3	—	12.0
1980	929	423	—	1,352	14.5	15.6	—	14.8
1985	1,579	795	—	2,373	11.2	13.4	—	11.9
1990	1,979	1,355	—	3,334	4.6	11.3	—	7.0
1995	3,194	1,867	—	5,061	10.0	6.6	—	8.7
2000	3,348	2,496	—	5,844	0.9	6.0	—	2.9
2005	4,440	3,839	—	8,278	5.8	9.0	—	7.2
2006	4,603	4,117	$1,619	10,338	3.7	7.2	—	24.9
2007	4,762	4,315	1,630	10,707	3.5	4.8	0.7%	3.6
2008	4,998	4,576	1,662	11,236	5.0	6.0	2.0	4.9
2009	5,197	4,796	1,730	11,723	4.0	4.8	4.1	4.3
2010	5,211	4,896	1,808	11,915	0.3	2.1	4.5	1.6
2011	5,288	5,028	1,859	12,175	1.5	2.7	2.8	2.2
2012	5,182	5,179	1,847	12,209	−2.0	3.0	−0.6	0.3
2013	5,145	5,164	1,901	12,210	−0.7	−0.3	2.9	0.0
Intermediate estimates:								
2014	4,999	5,340	1,904	12,243	−2.8	3.4	0.2	0.3
2015	4,893	5,310	2,014	12,217	−2.1	−0.6	5.8	−0.2
2016	4,992	5,443	2,132	12,567	2.0	2.5	5.9	2.9
2017	5,128	5,663	2,266	13,056	2.7	4.0	6.3	3.9
2018	5,360	5,936	2,403	13,699	4.5	4.8	6.1	4.9
2019	5,534	6,234	2,555	14,323	3.3	5.0	6.3	4.6
2020	5,753	6,584	2,716	15,053	4.0	5.6	6.3	5.1
2021	5,982	6,937	2,870	15,789	4.0	5.4	5.7	4.9
2022	6,220	7,310	3,035	16,565	4.0	5.4	5.7	4.9
2023	6,454	7,703	3,206	17,364	3.8	5.4	5.6	4.8

[1]Percent changes for 1970 represent the average annual increases from 1967 (the first full year of trust fund operations) through 1970. Similarly, percent changes shown for 1975, 1980, 1985, 1990, 1995, 2000, and 2005 represent the average annual increase over the 5-year period ending in the indicated year.

On average, annual increases in per beneficiary costs have been greater for SMI Part B than for HI during the previous 4 decades—by approximately 1.0 percent, 4.5 percent, 1.0 percent, and 2.5 percent per year in the 1970s, 1980s, 1990s, and 2000s, respectively. The HI increase remains lower than the SMI Part B increase due to the productivity adjustment and other payment rate adjustments affecting all of the HI providers but only some of the SMI Part B providers.

Note that the rapid growth rates in the 1970s and 1980s are not expected to recur for either HI or SMI Part B, due to more moderate inflation rates and the conversion of Medicare's remaining cost-based reimbursement mechanisms to prospective payment systems as part of the Balanced Budget Act of 1997, and due to the physician updates under the SGR. In addition, the reduction in Medicare price updates for most categories of providers will reduce growth rates by an average of 0.8 percent annually through 2023. The growth rates also reflect the impact of the mandatory sequestration process that is required under current law, which reduces Medicare expenditures by

2 percent per year. This results in a negative increase in 2013 for HI, followed by further negative increases in 2014 and 2015, due to enacted legislation. Specifically, the growth rates reflect a 0.8-percent reduction, for 2014 through 2017, in inpatient hospital spending to recoup overpayments resulting from changes in documentation and coding during 2008-2010, per the American Taxpayer Relief Act of 2012, and further reductions to disproportionate share payments in 2015, required by the Affordable Care Act.

The average annual increases in Part D per beneficiary costs are expected to be somewhat greater than for HI or SMI Part B for the period 2015-2023, in part because the savings provisions of the Affordable Care Act affect Parts A and B only.

E. MEDICARE COST SHARING AND PREMIUM AMOUNTS

HI beneficiaries who use covered services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the HI trust fund to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible for each of days 61-90 in the hospital. After 90 days in a spell of illness, each individual has 60 lifetime reserve days of coverage, for which the coinsurance amount is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each of days 21-100 of skilled nursing facility services furnished during a spell of illness. No cost sharing is required for home health or hospice services.

Most persons aged 65 and older and many disabled individuals under age 65 are insured for HI benefits without payment of any premium. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, subject to the payment of a monthly premium. In addition, since 1994, voluntary enrollees may qualify for a reduced premium if they have at least 30 quarters of covered employment.

Table V.E1 shows the historical levels of the HI deductible, coinsurance amounts, and premiums, as well as projected values for future years based on the projected baseline scenario and the intermediate set of assumptions used in estimating the operations of the trust funds. Certain anomalies in these values resulted from specific trust fund features in particular years (for example, the effect of the Medicare Catastrophic Coverage Act of 1988 on 1989 values). The values listed in the table for future years are estimates, and the actual amounts are likely to be somewhat different as experience emerges.

Table V.E1.—HI Cost-Sharing and Premium Amounts

Year	Inpatient hospital deductible[1]	Inpatient daily coinsurance[1]		SNF daily coinsurance[1]	Monthly premium	
		Days 61-90	Lifetime reserve days		Standard[2]	Reduced[1]
Historical data:						
1967	$40	$10	—	$5.00	—	—
1968	40	10	$20	5.00	—	—
1969	44	11	22	5.50	—	—
1970	52	13	26	6.50	—	—
1971	60	15	30	7.50	—	—
1972	68	17	34	8.50	—	—
1973	72	18	36	9.00	$33	—
1974	84	21	42	10.50	36	—
1975	92	23	46	11.50	40	—
1976	104	26	52	13.00	45	—
1977	124	31	62	15.50	54	—
1978	144	36	72	18.00	63	—
1979	160	40	80	20.00	69	—
1980	180	45	90	22.50	78	—
1981	204	51	102	25.50	89	—
1982	260	65	130	32.50	113	—
1983	304	76	152	38.00	113	—
1984	356	89	178	44.50	155	—
1985	400	100	200	50.00	174	—
1986	492	123	246	61.50	214	—
1987	520	130	260	65.00	226	—
1988	540	135	270	67.50	234	—
1989[3]	560	—	—	25.50	156	—
1990	592	148	296	74.00	175	—
1991	628	157	314	78.50	177	—
1992	652	163	326	81.50	192	—
1993	676	169	338	84.50	221	—
1994	696	174	348	87.00	245	$184
1995	716	179	358	89.50	261	183
1996	736	184	368	92.00	289	188
1997	760	190	380	95.00	311	187
1998	764	191	382	95.50	309	170
1999	768	192	384	96.00	309	170
2000	776	194	388	97.00	301	166
2001	792	198	396	99.00	300	165
2002	812	203	406	101.50	319	175
2003	840	210	420	105.00	316	174
2004	876	219	438	109.50	343	189
2005	912	228	456	114.00	375	206
2006	952	238	476	119.00	393	216
2007	992	248	496	124.00	410	226
2008	1,024	256	512	128.00	423	233
2009	1,068	267	534	133.50	443	244
2010	1,100	275	550	137.50	461	254
2011	1,132	283	566	141.50	450	248
2012	1,156	289	578	144.50	451	248
2013	1,184	296	592	148.00	441	243
2014	1,216	304	608	152.00	426	234
Intermediate estimates:						
2015	1,248	312	624	156.00	402	221
2016	1,288	322	644	161.00	410	226
2017	1,324	331	662	165.50	422	232
2018	1,360	340	680	170.00	440	242
2019	1,396	349	698	174.50	455	250
2020	1,444	361	722	180.50	473	260
2021	1,492	373	746	186.50	492	271
2022	1,540	385	770	192.50	511	281
2023	1,588	397	794	198.50	531	292

[1]Amounts shown are effective for calendar years.

[2]Amounts shown for 1967-1982 are for the 12-month periods ending June 30; amounts shown for 1983 are for the period July 1, 1982 through December 31, 1983; amounts shown for 1984 and later are for calendar years.
[3]Anomalies in the 1989 values are due to the Medicare Catastrophic Coverage Act of 1988. Most of the provisions of the Act were repealed the following year.

The *Federal Register* notice announcing the HI deductible and coinsurance amounts for 2014 included an estimate of the aggregate cost to HI beneficiaries for the changes in the deductible and coinsurance amounts from 2013 to 2014. At the time of the notice's publication, it was estimated that in 2014 there would be 8.07 million inpatient deductibles paid at $1,216 each, 2.09 million inpatient days subject to coinsurance at $304 per day (for hospital days 61 through 90), 1.04 million lifetime reserve days subject to coinsurance at $608 per day, and 43.40 million extended care days subject to coinsurance at $152.00 per day. Similarly, it was estimated that in 2013 there would be 7.91 million deductibles paid at $1,184 each, 2.04 million days subject to coinsurance at $296 per day (for hospital days 61 through 90), 1.02 million lifetime reserve days subject to coinsurance at $592 per day, and 42.10 million extended care days subject to coinsurance at $148.00 per day. The total increase in cost to beneficiaries was estimated to be $874 million due to (i) the increase in the inpatient deductible and coinsurance amounts; and (ii) the change in the number of deductibles and daily coinsurance amounts paid.

Table V.E2 displays the SMI cost-sharing and premium amounts for Parts B and D. The projected values for future years are based on the projected baseline scenario and the intermediate set of assumptions used in estimating the operations of the Part B and Part D accounts. As a result, these values are estimates, and the actual amounts are likely to be somewhat different as experience emerges. The premiums for 2010 and 2011 also reflect significant additional increases designed to offset the loss of revenues attributable to the *hold-harmless provision*, as described in section III.C and later in this appendix.

Table V.E2.—SMI Cost-Sharing and Premium Amounts

	Part B		Part D			
Calendar year	Standard monthly premium[1]	Annual deductible[2]	Base beneficiary premium	Deductible	Initial benefit limit	Catastrophic threshold
Historical data:						
1967	$3.00	$50	—	—	—	—
1968	4.00	50	—	—	—	—
1969	4.00	50	—	—	—	—
1970	4.00	50	—	—	—	—
1971	5.30	50	—	—	—	—
1972	5.60	50	—	—	—	—
1973	5.80	60	—	—	—	—
1974	6.30[3]	60	—	—	—	—
1975	6.70	60	—	—	—	—
1976	6.70	60	—	—	—	—
1977	7.20	60	—	—	—	—
1978	7.70	60	—	—	—	—
1979	8.20	60	—	—	—	—
1980	8.70	60	—	—	—	—
1981	9.60	60	—	—	—	—
1982	11.00	75	—	—	—	—
1983	12.20	75	—	—	—	—
1984	14.60	75	—	—	—	—
1985	15.50	75	—	—	—	—
1986	15.50	75	—	—	—	—
1987	17.90	75	—	—	—	—
1988	24.80	75	—	—	—	—
1989[4]	31.90	75	—	—	—	—
1990	28.60	75	—	—	—	—
1991	29.90	100	—	—	—	—
1992	31.80	100	—	—	—	—
1993	36.60	100	—	—	—	—
1994	41.10	100	—	—	—	—
1995	46.10	100	—	—	—	—
1996	42.50	100	—	—	—	—
1997	43.80	100	—	—	—	—
1998	43.80	100	—	—	—	—
1999	45.50	100	—	—	—	—
2000	45.50	100	—	—	—	—
2001	50.00	100	—	—	—	—
2002	54.00	100	—	—	—	—
2003	58.70	100	—	—	—	—
2004	66.60	100	—	—	—	—
2005	78.20	110	—	—	—	—
2006	88.50	124	$32.20	$250	$2,250	$3,600
2007	93.50	131	27.35	265	2,400	3,850
2008	96.40	135	27.93	275	2,510	4,050
2009	96.40	135	30.36	295	2,700	4,350
2010	110.50	155	31.94	310	2,830	4,550
2011	115.40	162	32.34	310	2,840	4,550
2012	99.90	140	31.08	320	2,930	4,700
2013	104.90	147	31.17	325	2,970	4,750
2014	104.90	147	32.42	310	2,850	4,550
Intermediate estimates:						
2015	104.90	147	34.28	320[5]	2,960[5]	4,700[5]
2016	106.50	149	37.19	330	3,060	4,850
2017	113.20	158	39.63	345	3,190	5,050
2018	119.20	166	42.09	360	3,350	5,300
2019	125.80	175	44.85	380	3,530	5,550
2020	133.00	185	47.89	400	3,730	5,950
2021	140.20	195	50.71	425	3,950	6,300
2022	148.00	206	53.72	450	4,180	6,650
2023	156.20	217	56.90	475	4,430	7,050

[1]Amounts shown for 1967-1982 are for the 12-month periods ending June 30; amounts shown for 1983 are for the period July 1, 1982 through December 31, 1983; amounts shown for 1984 and later are for calendar years.
[2]Prior to the Medicare Modernization Act, the Part B deductible was fixed by statute and had only occasionally been adjusted. The Medicare Modernization Act raised the deductible to $110 in 2005 and specified that it be indexed by average per beneficiary Part B expenditures thereafter.
[3]In accordance with limitations on the costs of health care imposed under Phase III of the Economic Stabilization program, the standard premium rates for July and August 1973 were set at $5.80 and $6.10, respectively. Effective September 1973, the rate increased to $6.30.
[4]Anomalies in the 1989 values are due to the Medicare Catastrophic Coverage Act of 1988. Most of the provisions of the Act were repealed the following year.
[5]These amounts have already been determined.

The Part B monthly premiums displayed in table V.E2 are the standard premium rates paid by most Part B enrollees. However, there are three provisions that alter the premium rate for certain Part B enrollees. First, there is a premium surcharge for those beneficiaries who enroll after their initial enrollment period. Second, beginning in 2007, there is a higher income-related premium for those individuals whose modified adjusted gross income exceeds a specified threshold. Table V.E3 displays these Part B income-related premium amounts for 2007-2023, based on the projected baseline scenario and the intermediate set of assumptions.

Table V.E3.—Part B Income-Related Monthly Premium Amounts[1]

	Ultimate percentage of program costs represented by premium			
Calendar year	35%	50%	65%	80%
Historical data:				
2007	$105.80	$124.40	$142.90	$161.40
2008	122.20	160.90	199.70	238.40
2009	134.90	192.70	250.50	308.30
2010	154.70	221.00	287.30	353.60
2011	161.50	230.70	299.90	369.10
2012	139.90	199.80	259.70	319.70
2013	146.90	209.80	272.70	335.70
2014	146.90	209.80	272.70	335.70
Intermediate estimates:				
2015	146.90	209.80	272.70	335.70
2016	149.00	212.90	276.80	340.60
2017	158.50	226.40	294.30	362.20
2018	166.80	238.30	309.80	381.30
2019	176.10	251.60	327.10	402.60
2020	186.10	265.90	345.70	425.40
2021	196.30	280.40	364.50	448.60
2022	207.20	296.00	384.80	473.60
2023	218.70	312.40	406.10	499.80

[1]Includes the impact of the 3-year transition in 2007 and 2008.

In 2013 the initial threshold is $85,000 for an individual tax return and $170,000 for a joint return. The thresholds are not indexed to inflation in the years 2011-2019 but are thereafter. Individuals exceeding the threshold will pay premiums covering 35, 50, 65, or 80 percent of the average program cost for aged beneficiaries, depending on their income level, compared to the standard premium covering 25 percent.

Lastly, Part B premiums may also vary from the standard rate because a hold-harmless provision can lower the premium rate for individuals who have their premiums deducted from their Social Security benefits. On an individual basis, this provision limits the dollar increase in the Part B premium to the dollar increase in the individual's Social Security benefit. As a result, the person affected pays a lower Part B premium, and the net amount of the individual's Social Security benefit does not decrease despite the greater increase in the premium.

Most services under Part B are subject to an annual deductible and coinsurance. The annual deductible was set by statute through 2005. Thereafter, it increases with the increase in the Part B aged actuarial rate to approximate the growth in per capita Part B expenditures.[100] After meeting the deductible, the beneficiary pays an amount equal to the product of the coinsurance percentage and the remaining allowed charges. The coinsurance percentage is 20 percent for most services. For those services not subject to the deductible or coinsurance (clinical lab tests, home health agency services, and most preventive care services), the beneficiary pays nothing.

The Part D average premiums displayed in table V.E2 are the estimated base beneficiary premiums. For 2006, the base beneficiary premium was calculated based on a national average plan bid that gave each bid an equal weight. The actual premium that a beneficiary pays varies according to the plan in which the beneficiary enrolls. Some pay lower premiums than those displayed in table V.E2, and others pay more. The average premium rate that beneficiaries paid in 2006 was roughly $23. In 2007 and 2008, the national average was calculated under a transitional demonstration program using 80 percent and then 40 percent of the equally weighted bids and 20 percent and then 60 percent of the enrollment-weighted average bid. As a result of this calculation, the average premium rate paid by beneficiaries fell to about $22 in 2007 and increased to $24 in 2008.

Starting in 2009, the national average plan bid is based on the enrollment-weighted average. The average premiums paid in 2009

[100]The current mechanism to index the Part B deductible has technical computational issues mainly due to the timing of the calculation. Under current law, the Part B deductible for any given year is indexed by the increase in the monthly aged actuarial rate for that same year, which represents estimated monthly per capita expenditures. However, these expenditures are dependent on the Part B deductible, which is not known until the actuarial rate is determined. The result is circularity in the modeling process. A possible alternative approach is to index the Part B deductible using the increase in the actuarial rate from the prior year, which is already known when the determination is made, thereby removing any circularity.

and 2010 were around $28 and $30, respectively. The average premium for 2011 was approximately $31 and fell to about $30 in both 2012 and 2013, primarily due to the patent expiration of several high-volume prescription drugs and a lower projected trend for 2013. The 2014 average premium increases to about $31 because the drug spending is expected to gradually return to its normal growth rate. Since beneficiaries may switch plans each year once the premium rates become known, it is assumed that the estimated average premium rate paid by beneficiaries will continue to be slightly less than the base beneficiary premium in future years.

Similar to Part B, there are two provisions that affect the premium rate for certain Part D beneficiaries. First, there is a Part D late enrollment penalty for those beneficiaries enrolling after their initial enrollment period. Second, starting in 2011, individuals whose modified adjusted gross income exceeds the same thresholds applicable to the Part B premium pay an income-related premium in addition to the premium charged by the plan in which the individual enrolled. The amount of the income-related premium adjustment is dependent on the individual's income level, and the extra premium amount is the difference between 35, 50, 65, or 80 percent and 25.5 percent, applied to the National Average Monthly Bid Amount adjusted for reinsurance. Table V.E4 displays the historical and projected Part D income-related premium adjustment amounts for 2011-2023, based on the intermediate set of assumptions.

Table V.E4.—Part D Income-Related Monthly Premium Adjustment Amounts

	Percentage of program costs represented by premium			
Calendar year	35%	50%	65%	80%
Historical data:				
2011	$12.00	$31.10	$50.10	$69.10
2012	11.60	29.90	48.10	66.40
2013	11.60	29.90	48.30	66.60
2014	12.10	31.10	50.20	69.30
Intermediate estimates:				
2015	12.80	32.90	53.10	73.30
2016	13.90	35.70	57.60	79.50
2017	14.80	38.10	61.40	84.70
2018	15.70	40.40	65.20	90.00
2019	16.70	43.10	69.50	95.80
2020	17.80	46.00	74.20	102.40
2021	18.90	48.70	78.50	108.40
2022	20.00	51.60	83.20	114.80
2023	21.20	54.70	88.10	121.60

In addition, there are premium and cost-sharing subsidies for those beneficiaries with incomes less than 150 percent of the Federal poverty level and with assets in 2014 less than $13,440 for an individual and $26,860 for a couple. The asset thresholds are indexed in subsequent years by the Consumer Price Index (CPI). Under the

current statutory adjustment formula, the asset figures for 2014 increase for both an individual and a couple as a result of increases in the CPI.

Under standard Part D coverage, there is an initial deductible. After meeting the deductible, the beneficiary pays 25 percent of the remaining costs up to the initial benefit limit. Beyond this limit, prior to 2011, the beneficiary paid all the drug costs until his or her total out-of-pocket expenditures reached the catastrophic threshold. (This total includes the deductible and coinsurance payments for expenses up to the initial benefit limit.) The ACA will gradually fill in the coverage gap from 2011 until 2020, when beneficiaries will pay 25 percent of the drug costs between the deductible and the catastrophic threshold under the standard coverage. In 2014, after reaching the catastrophic threshold, the beneficiary pays the greater of (i) 5 percent of the drug cost; or (ii) $2.55 for generic or preferred multiple-source drugs or $6.35 for preferred single-source drugs. The latter copayment amounts from 2014 are indexed annually by per enrollee Part D average costs. Beneficiaries qualifying for the Part D low-income subsidy pay substantially reduced premium and cost-sharing amounts. Many Part D plans offer alternative coverage that differs from the standard coverage described above. The majority of beneficiaries have not enrolled in the standard benefit design but rather in plans with low or no deductibles, flat copayments for covered drugs, and, in some cases, partial coverage in the coverage gap.

F. MEDICARE AND SOCIAL SECURITY TRUST FUNDS AND THE FEDERAL BUDGET

One can view the financial operations of Medicare and Social Security in the context of the programs' trust funds or in the context of the overall Federal budget. The financial status of the trust funds differs fundamentally from the impact of these programs on the budget, and people often misunderstand the relationship between these two perspectives. Each perspective is appropriate and important for its intended purpose; this appendix attempts to clarify their roles and relationship.

By law, the annual reports of the Medicare and Social Security Boards of Trustees to Congress focus on the financial status of the programs' trust funds—that is, whether these funds have sufficient revenues and assets to enable the payment of benefits and administrative expenses. This trust fund perspective is important because the existence of trust fund assets provides the statutory authority to make such payments without the need for an appropriation from Congress. Medicare and Social Security benefits can be paid only if the relevant trust fund has sufficient income or assets.

The trust fund perspective does not encompass the interrelationship between the Medicare and Social Security trust funds and the overall Federal budget. The budget is a comprehensive display of all Federal activities, whether financed through trust funds or from the general fund of the Treasury. This broader focus may appropriately be termed the budget perspective or government-wide perspective and is officially presented in the *Budget of the United States Government* and in the *Financial Report of the United States Government*.

Payroll taxes, income taxes on Social Security benefits, Medicare premiums, and special State payments to Medicare finance the majority of Medicare and Social Security costs. In addition to these earmarked receipts from workers, employers, beneficiaries, and States, Medicare and Social Security rely on Federal general fund revenues for some of their financing (principally for the SMI trust fund), and the trust funds are credited with interest payments on their accumulated assets as well. The financial status of a trust fund appropriately considers all sources of financing provided for that fund, including the availability of trust fund assets that Medicare or Social Security can use to meet program expenditures. From a budget perspective, however, general fund transfers, interest payments to the trust funds, and asset redemptions represent a draw on other

Federal resources for which there is no earmarked source of revenue from the public.

In the past, general fund and interest payments for Medicare and Social Security were relatively small. These amounts have increased substantially over the last 2 decades, however, and the expected rapid future growth of Medicare and Social Security will make their interaction with the Federal budget increasingly important. As the difference between earmarked and total trust fund revenues grows, the financial operations of Social Security and Medicare can appear markedly different depending on which of the two perspectives one uses.[101]

Illustration with Actual Data for 2013

Table V.F1 illustrates the trust fund and budget perspectives using actual data on Federal financial operations for fiscal year (FY) 2013. The first three columns show revenues and expenditures for HI, SMI, and OASDI, respectively, and the fourth column is the sum of these three columns. The fifth column shows total revenues and expenditures for all other government programs (including the general fund account of the Treasury), and the final column is the sum of the "Combined" and "Other Government" columns. The table shows earmarked revenues from the public separately from revenues from other government accounts (general revenue transfers and interest credits). Note that the transfers and interest credits received by the trust funds appear in total as negative entries under the "Other Government" column and are thus offsetting when summed for the total budget in the final column. These two intragovernmental transactions are key to the differences between the two perspectives.

[101]A more complete treatment of this topic appears in the *2013 Financial Report of the United States Government* at www.fms.treas.gov/fr/ and in a May 2009 Treasury report titled "Social Security and Medicare Trust Funds and the Federal Budget" at http://www.treasury.gov/resource-center/economic-policy/ss-medicare/Documents/budget_trust_fund_perspectives_2009.pdf. Additional information is available in a *Health Care Financing Review* article titled "Medicare Financial Status, Budget Impact, and Sustainability: Which Concept Is Which?" at http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/05-06Winpg127.pdf.

Table V.F1.—Annual Revenues and Expenditures for Medicare and Social Security Trust Funds and the Total Federal Budget, Fiscal Year 2013

(In billions)

Revenue and expenditures categories	Trust funds				Other government	Total[1]
	HI	SMI	OASDI	Combined		
Revenues from public:						
Payroll and benefit taxes	$227.2	—	$714.3	$941.6	—	$941.6
Premiums[2]	6.4	$71.5	—	77.9	—	77.9
Other taxes, fees, and payments[3]	—	9.3	—	9.3	$1,746.4	1,755.7
Total	233.6	80.8	714.3	1,028.7	1,746.4	2,775.1
Total expenditures to public[4]	266.5	315.1	813.3	1,395.0	2,059.6	3,454.6
Net Results for Budget Perspective	**−33.0**	**−234.3**	**−99.0**	**−366.2**	**−313.3**	**−679.5**
Revenues from other government accounts:						
Transfers	0.1	227.2	30.9	258.3	−258.3	—
Interest credits	9.9	2.5	105.7	118.1	−118.1	—
Total	10.0	229.7	136.6	376.3	−376.3	—
Net Results for Trust Fund Perspective	**−23.0**	**−4.6**	**37.6**	**10.1**	**n/a**	**n/a**

[1]This column is the sum of the preceding two columns and shows data for the total Federal budget. The figure $679.5 billion was the total Federal budget deficit for fiscal year 2013.
[2]Includes Part D premiums paid directly to plans, which are not displayed on Treasury statements and are estimated.
[3]Includes Part D State transfers.
[4]The OASDI figure includes $4.5 billion transferred to the Railroad Retirement Board.

Notes: 1. For comparison, HI taxable payroll, OASDI taxable payroll, and GDP were $7,402 billion, $5,892 billion, and $16,790 billion, respectively, in 2013.
2. Totals do not necessarily equal the sums of rounded components.
3. n/a indicates not applicable.

The trust fund perspective reflects both categories of revenues for each trust fund. For HI, revenues from the public plus transfers/credits from other government accounts were $23.0 billion less than total expenditures in FY 2013, as shown at the bottom of the first column.[102] For the SMI trust fund, the statutory revenues from beneficiary premiums, State transfers, general revenue transfers, and interest earnings collectively were $4.6 billion less than expenditures in FY 2013. Note that it is appropriate to view the general revenue transfers from other government accounts as financial resources from the trust fund perspective since they are available to help meet trust fund outlays. For OASDI, total trust fund revenues from all sources (including $105.7 billion in interest

[102]The Department of Treasury invests surplus revenues from the public over expenditures to the public in special Treasury securities, which thereby represent a loan from the trust funds to the general fund of the Federal Government. These loans reduce the amount that the general fund has to borrow from the public to finance a deficit (or likewise increase the amount of debt paid off if there is a surplus). Interest is credited to the trust funds while the securities are being held. Trust fund securities can be redeemed at any time if needed to help meet program expenditures. Thus, the accumulation of fund assets creates budget commitments for future years when interest earnings and asset redemptions are used to meet expenditures. Note that there were no surpluses to invest in fiscal year 2013.

payments and $30.9 billion in general fund reimbursements) exceeded total expenditures by $37.6 billion.

From the government-wide or budget perspective, only earmarked revenues received from the public—principally taxes on payroll and benefits, plus premiums—and expenditures made to the public are important for the final balance.[103] For HI, the difference between such revenues ($233.6 billion) and total expenditures made to the public ($266.5 billion) was $33.0 billion in FY 2013, indicating that HI had a negative effect on the overall budget in FY 2013. For SMI, beneficiary premiums, fees on brand-name prescription drugs to Part B, and State payments to Part D of Medicare were the only sources of revenues from the public in FY 2013 and represented only about 26 percent of total expenditures. The remaining $234.3 billion in FY 2013 outlays represented a substantial net draw on the Federal budget in that year.[104] For OASDI, the difference between revenues from the public ($714.3 billion) and total expenditures ($813.3 billion) was $99.0 billion, indicating that OASDI also had a negative effect on the overall budget last year.

Thus, from the trust fund perspective, OASDI had an annual surplus in FY 2013, and HI and SMI had deficits. From the budget perspective, HI, SMI, and OASDI each required a net draw on the budget. HI, SMI, and OASDI collectively had a trust fund surplus of $10.1 billion in FY 2013 but a net draw of $366.2 billion on the budget.

It is important to recognize that each viewpoint is appropriate for its intended purpose but that one perspective cannot be used to answer questions related to the other. In the case of SMI, the trust fund will always be in balance and there will always be a net draw on the Federal budget. In the case of HI, trust fund surpluses in a given year may occur with either a positive or negative direct impact on the budget for that year. Conversely, a positive or negative budget impact from HI offers minimal insight into whether its trust fund has sufficient total revenues and assets to permit payment of benefits.

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[103]For this purpose, the public includes State governments since they are outside of the Federal Government.

[104]Three types of trust fund transactions constituted this net budget obligation: $227.2 billion was drawn in the form of general revenue transfers, and another $2.5 billion in interest payments, while $4.6 billion was transferred to the trust fund from the general fund through the redemption of special-issue Treasury securities in an amount equal to the trust fund deficit for the year.

The next section illustrates the magnitude of the long-range difference between projected expenditures and revenues for Medicare and Social Security from both the trust fund and budget perspectives.

Future Obligations of the Trust Funds and the Budget

Table V.F2 collects from the Medicare and OASDI Trustees Reports the present values of projected future revenues and expenditures over the next 75 years. For HI and OASDI, tax revenues from the public are projected to fall short of statutory expenditures by $3.8 trillion and $13.3 trillion, respectively, in present value terms.[105]

Table V.F2.—Present Values of Projected Revenue and Cost Components of 75-Year Open-Group Obligations for HI, SMI, and OASDI
(In trillions, as of January 1, 2014)

Revenue and expenditure categories	HI	SMI	OASDI	Combined
Revenues from public:				
Payroll and benefit taxes	$16.5	—	$51.0	$67.5
Premiums	0.0	$8.0	—	8.0
Other taxes and fees[1]	—	0.9	—	0.9
Total	16.5	9.0	51.0	76.5
Total expenditures to public	20.4	33.6	64.3	118.3
Net Results for Budget Perspective	**−3.8**	**−24.7**	**−13.3**	**−41.8**
Revenues from other government accounts:				
Transfers	0.0	24.5	0.0	24.5
Interest credits	n/a	n/a	n/a	n/a
Total	0.0	24.5	0.0	24.5
Trust fund assets on January 1, 2014	0.2	0.1	2.8	3.0
Net Results for Trust Fund Perspective	**−3.6**	**0.0**	**−10.6**	**−14.2**

[1]Includes Part B revenues from fees on manufacturers and importers of brand-name prescription drugs and Part D State transfers.

Notes: 1. For comparison, the present values of HI taxable payroll, OASDI taxable payroll, and GDP are $438.4 trillion, $386.9 trillion, and $987.6 trillion, respectively, over the next 75 years. This present value of GDP is calculated using HI-specific interest discount factors and differs slightly from the corresponding amount shown in the OASDI Trustees Report.
2. Medicare present values are calculated using HI-specific discount factors, while OASDI amounts use OASDI-specific discount factors.
3. Totals do not necessarily equal the sums of rounded components.
4. n/a indicates not applicable.
5. 0.0 indicates an amount of less than $50 billion.

From the budget perspective, these are the additional amounts that would be necessary in order to pay HI and OASDI benefits and other costs at the level scheduled over the next 75 years. From the trust fund perspective, the amounts needed are smaller by the value of the accumulated assets in the respective trust funds—$0.2 trillion for HI and $2.8 trillion for OASDI—that could be drawn down to cover a

[105]Interest income is not a factor in this table, as dollar amounts are in present value terms.

part of the projected shortfall in tax revenues. Two points about this comparison are important to note:

- Other than asset redemptions and interest payments, no provision exists to address the projected HI and OASDI financial imbalances. Once assets are depleted, expenditures cannot be made except to the extent covered by ongoing tax receipts.

- From a trust fund perspective, the long-range HI and OASDI deficits reflect the net imbalance after redemption of trust fund assets. From a government-wide perspective, the deficits represent the cost of redeeming those assets plus the additional legislative authorization that would be necessary to fully satisfy future scheduled benefit payments.[106]

The situation for SMI is somewhat different. SMI expenditures for Part B and Part D are projected to exceed premium and other dedicated revenues by $24.7 trillion. To keep the SMI trust fund solvent for the next 75 years will require general fund transfers of this amount, and these transfers represent a formal budget requirement. From the trust fund perspective, the present value of projected total premiums and general revenues is about equal to the present value of future expenditures.

From the 75-year budget perspective, the present value of the additional resources that would be necessary to meet projected expenditures, for the three programs combined, is $41.8 trillion.[107] To put this very large figure in perspective, it would represent 4.2 percent of the present value of projected GDP over the same period ($988 trillion). The components of the $41.8-trillion total are as follows:

[106]In practice, the long-range HI and OASDI deficits could be addressed by reducing expenditures, increasing payroll or other earmarked tax revenues, implementing a general revenue subsidy, or some combination of such measures. For Medicare, in particular, lawmakers have frequently enacted legislation to slow the growth of expenditures.

[107]As noted previously, the long-range HI and OASDI financial imbalances could instead be partially addressed by expenditure reductions, thereby reducing the need for additional revenues. Similarly, SMI expenditure reductions would reduce the need for general fund transfers.

Unfunded Medicare and OASDI obligations (trust fund perspective)[108]	$14.2 trillion	(1.4% of GDP)
HI, SMI, and OASDI asset redemptions	3.0 trillion	(0.3% of GDP)
SMI general revenue financing	24.5 trillion	(2.5% of GDP)

These resource needs would be in addition to the payroll taxes, benefit taxes, and premium payments. As noted, the asset redemptions and SMI general revenue transfers represent formal budget commitments, but no provision exists for covering the HI and OASDI trust fund deficits once assets are depleted.

As discussed throughout this report, the Medicare projections shown here are based on a projected baseline that assumes that the negative updates to physician payments required under current law would be permanently overridden. Furthermore, the projected HI and SMI expenditures could be substantially understated as a result of other potentially unsustainable elements of current law. Although this issue does not affect the nature of the budget and trust fund perspectives described in this appendix, it is important to note that actual long-range present values for HI expenditures and SMI expenditures and revenues could exceed the amounts shown in table V.F2 by a substantial margin.

[108]Additional revenues and/or expenditure reductions totaling $14.2 trillion, together with $3.0 trillion in asset redemptions, would cover the projected financial imbalance but would leave the HI and OASDI trust funds depleted at the end of the 75-year period. The long-range actuarial deficits for HI and OASDI include a cost factor to allow for a normal level of fund assets. See section III.B3 in this report, and section IV.B4 in the OASDI Trustees Report, for the numerical relationship between the actuarial deficit and the unfunded obligations of each program.

G. INFINITE HORIZON PROJECTIONS

Consistent with the practice of previous reports, this report focuses on the 75-year period from 2014 to 2088 for the evaluation of the long-range financial status of the Medicare program. The estimates are based on the projected baseline scenario, are for the open-group population—all persons, some of whom are not yet born, who will participate during the period as either taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce over the next 75 years.

Experts have noted that limiting the projections to 75 years understates the magnitude of the long-range unfunded obligations because summary measures (such as the actuarial balance and open-group unfunded obligations) reflect the full amount of taxes paid by the next two or three generations of workers, but not the full amount of their benefits. One approach to addressing the limitations of 75-year summary measures is to extend the projection horizon indefinitely, so that the overall results reflect the projected costs and revenues after the first 75 years.[109] Such extended projections can also help indicate whether the financial imbalance would be improving or continuing to worsen beyond the normal 75-year period.

Table V.G1 presents estimates of HI unfunded obligations that extend to the infinite horizon. The extension assumes that the HI program and the demographic and economic trends used for the 75-year projection continue indefinitely except that average HI expenditures per beneficiary increase at the same rate as GDP per capita less the productivity adjustments after 2088. If the slower HI price updates under the ACA can continue indefinitely, then the HI financial imbalance would actually improve beyond the 75-year period. Specifically, under these assumptions, extending the calculations beyond 2088 *subtracts* $1.7 trillion in unfunded obligations from the amount estimated through 2088. Over the infinite horizon, the HI program thus has a projected deficit of $1.9 trillion. This amount represents 0.3 percent of the present value of future HI taxable payroll over the infinite horizon, or 0.1 percent of GDP.

[109]The calculation of present values, in effect, applies successively less weight to future amounts over time, through the process of interest discounting. For example, the weights associated with the 25th, 75th, and 200th years of the projection would be about 29 percent, 2 percent, and 0.0015 percent, respectively, of the weight for the first year. In this way, it is possible to calculate a finite summary measure for an infinite projection period.

Table V.G1.—Unfunded HI Obligations from Program Inception through the Infinite Horizon

[Present values as of January 1, 2014; dollar amounts in trillions]

	Present value	As a percentage of: HI taxable payroll	GDP
Unfunded obligations through the infinite horizon[1]	$1.9	0.3%	0.1%
Unfunded obligations from program inception through 2088[1]	3.6	0.8	0.4

[1]Present value of future expenditures less income, reduced by the amount of trust fund assets at the beginning of the period.

Notes: 1. The present values of future HI taxable payroll for 2014-2088 and for 2014 through the infinite horizon are $438.4 trillion and $680.8 trillion, respectively.
2. The present values of GDP for 2014-2088 and for 2014 through the infinite horizon are $987.6 trillion and $1,632.5 trillion, respectively. (These present values differ slightly from the corresponding amounts shown in the OASDI Trustees Report due to the use of HI-specific interest discount factors.)
3. Totals do not necessarily equal the sums of rounded components.

It is possible to separate the projected HI unfunded obligation over the infinite horizon into the portions associated with current participants versus future participants. The first line of table V.G2 shows the present value of future expenditures less future taxes for current participants, including both beneficiaries and covered workers. Subtracting the current value of the HI trust fund (the accumulated value of past HI taxes less outlays) results in a closed-group unfunded obligation of $8.7 trillion. In contrast, the projected difference between taxes and expenditures for future participants is a surplus of $6.8 trillion.

The year-by-year HI deficits described in section III.B have shown that HI taxes will not be adequate to finance the program on a pay-as-you-go basis (whereby payroll taxes from today's workers provide benefits to today's beneficiaries).[110] The unfunded obligations shown in table V.G2 for current participants further indicate that their HI taxes are not adequate to cover their own future costs when they become eligible for HI benefits—and that this situation has also occurred for workers in the past. For future workers, however, the compounding effects of the lower HI price updates would, if they can continue indefinitely, lower costs to the point that scheduled HI taxes would be more than sufficient. In practice, lawmakers could address the projected aggregate HI deficits by raising additional revenue or reducing benefits (or some combination of these actions). The impact of such changes on the unfunded obligation amounts for current versus future participants would depend on the specific policies selected.

[110]As noted previously, the HI trust fund also receives small amounts of income in the form of income taxes on OASDI benefits, interest, and general revenue reimbursements for certain uninsured beneficiaries.

Table V.G2.—Unfunded HI Obligations for Current and Future Program Participants through the Infinite Horizon

[Present values as of January 1, 2014; dollar amounts in trillions]

	Present value	As a percentage of: HI taxable payroll	GDP
Future expenditures less income for current participants	$8.9	1.3%	0.5%
Less current trust fund (income minus expenditures to date for past and current participants)	0.2	0.0	0.0
Equals unfunded obligations for past and current participants[1]	8.7	1.3	0.5
Plus expenditures less income for future participants for the infinite horizon	−6.8	−1.0	−0.4
Equals unfunded obligations for all participants for the infinite future	1.9	0.3	0.1

[1]This concept is also referred to as the closed-group unfunded obligation.

Notes: 1. The estimated present value of future HI taxable payroll for 2014 through the infinite horizon is $680.8 trillion.
2. The estimated present value of GDP for 2014 through the infinite horizon is $1,632.5 trillion. See note 2 in table V.G1.
3. Totals do not necessarily equal the sums of rounded components.

Tables V.G3 and V.G4 show the infinite horizon estimates for Part B. The extension assumes that the demographic and economic trends used for the 75-year projection continue indefinitely and that the productivity adjustments to payment updates for some providers remain unchanged. To simplify and stabilize the modeling for the infinite horizon, the Trustees project that average Part B expenditures per beneficiary will increase at about the same rate as GDP per capita minus 0.3 percentage point in every year, reflecting the mix of costs by provider category after 2088 and the payment rate updates applicable to each category.

Table V.G3 shows an estimated present value of Part B expenditures through the infinite horizon of $43.0 trillion, of which $24.3 trillion would occur during the first 75 years. Because such amounts, calculated over extremely long horizons, can be difficult to interpret, they are also shown as percentages of the present value of future GDP. So expressed, the corresponding figures are 2.6 percent and 2.5 percent, respectively. The table also indicates that beneficiary premiums will finance approximately 26 percent of expenditures for each time period and that fees collected related to brand-name prescription drugs will finance about 0.2 percent. General revenues pay for the remaining 73 percent.

Table V.G3.—Unfunded Part B Obligations from Program Inception through the Infinite Horizon

[Present values as of January 1, 2014; dollar amounts in trillions]

	Present value	As a percentage of GDP
Unfunded obligations through the infinite horizon[1]	$0.0	0.0%
Expenditures	43.0	2.6
Income	43.0	2.6
Beneficiary premiums	11.4	0.7
General revenue contributions	31.5	1.9
Fees related to brand-name prescription drugs	0.1	0.0
Unfunded obligations from program inception through 2088[1]	0.0	0.0
Expenditures	24.3	2.5
Income	24.3	2.5
Beneficiary premiums	6.4	0.6
General revenue contributions	17.9	1.8
Fees related to brand-name prescription drugs	0.1	0.0

[1]Present value of future expenditures less income, reduced by the amount of trust fund assets at the beginning of the period.

Notes: 1. The present values of GDP for 2014-2088 and for 2014 through the infinite horizon are $987.6 trillion and $1,632.5 trillion, respectively. See note 2 of table V.G1.
2. Totals do not necessarily equal the sums of rounded components.

Table V.G4 shows corresponding present values separately for current versus future beneficiaries. As indicated, about 47 percent of the projected total, infinite-horizon cost is attributable to current beneficiaries, with the remaining 53 percent attributable to beneficiaries becoming eligible for Part B benefits after January 1, 2014.

Table V.G4.—Unfunded Part B Obligations for Current and Future Program Participants through the Infinite Horizon

[Present values as of January 1, 2014; dollar amounts in trillions]

	Present value	As a percentage of GDP
Future expenditures less income for current participants	$0.2	0.0%
Expenditures	20.2	1.2
Income	20.0	1.2
Beneficiary premiums	5.3	0.3
General revenue contributions	14.7	0.9
Fees related to brand-name prescription drugs	0.0	0.0
Less current trust fund (Income minus expenditures to date for past and current participants)	0.1	0.0
Equals unfunded obligations for past and current participants[1]	0.1	0.0
Expenditures	20.1	1.2
Income	19.9	1.2
Beneficiary premiums	5.2	0.3
General revenue contributions	14.6	0.9
Fees related to brand-name prescription drugs	0.0	0.0
Plus expenditures less income for future participants for the infinite horizon	−0.2	0.0
Expenditures	22.8	1.4
Income	23.0	1.4
Beneficiary premiums	6.1	0.4
General revenue contributions	16.8	1.0
Fees related to brand-name prescription drugs	0.0	0.0
Equals unfunded obligations for all participants for the infinite future	−0.1	0.0
Expenditures	42.9	2.6
Income	42.9	2.6
Beneficiary premiums	11.3	0.7
General revenue contributions	31.4	1.9
Fees related to brand-name prescription drugs	0.0	0.0

[1] This concept is also referred to as the closed-group unfunded obligation.

Notes: 1. The estimated present value of GDP for 2014 through the infinite horizon is $1,632.5 trillion. See note 2 of table V.G1.
2 Totals do not necessarily equal the sums of rounded components.

Tables V.G5 and V.G6 present revenue and expenditures estimates for Part D that extend to the infinite horizon. The extension assumes the demographic and economic trends used for the 75-year projection continue indefinitely except that average Part D expenditures per beneficiary would increase at the same rate as GDP per capita after 2088.

Table V.G5 shows an estimated present value of Part D expenditures through the infinite horizon of $19.4 trillion, of which $9.3 trillion would occur during the first 75 years. To put the estimates in perspective, they are also shown as percentages of the present value of future GDP. Expressed in this way, the corresponding figures are 1.2 percent and 0.9 percent of GDP, respectively. The table also indicates that, for each time period, beneficiary premiums would finance approximately 18 percent of expenditures and State transfers would finance 9 percent, with general revenues paying for the remaining 73 percent.

Table V.G5.—Unfunded Part D Obligations from Program Inception through the Infinite Horizon

[Present values as of January 1, 2014; dollar amounts in trillions]

	Present value	As a percentage of GDP
Unfunded obligations through the infinite horizon[1]	$0.0	0.0%
Expenditures	19.4	1.2
Income	19.4	1.2
Beneficiary premiums	3.4	0.2
State transfers	1.8	0.1
General revenue contributions	14.2	0.9
Unfunded obligations from program inception through 2088[1]	0.0	0.0
Expenditures	9.3	0.9
Income	9.3	0.9
Beneficiary premiums	1.6	0.2
State transfers	0.9	0.1
General revenue contributions	6.8	0.7

[1]Present value of future expenditures less income, reduced by the amount of trust fund assets at the beginning of the period.

Notes: 1. The present values of GDP for 2014-2088 and for 2014 through the infinite horizon are $987.6 trillion and $1,632.5 trillion, respectively. See note 2 of table V.G1.
2 Totals do not necessarily equal the sums of rounded components.

Table V.G6 shows corresponding projections separately for current versus future beneficiaries. As indicated, about 35 percent of the projected total, infinite-horizon cost is attributable to current beneficiaries, with the remaining 65 percent attributable to beneficiaries becoming eligible for Part D benefits after January 1, 2014.

Table V.G6.—Unfunded Part D Obligations for Current and Future Program Participants through the Infinite Horizon

[Present values as of January 1, 2014; dollar amounts in trillions]

	Present value	As a percentage of GDP
Future expenditures less income for current participants	$0.0	0.0%
Expenditures	6.7	0.4
Income	6.7	0.4
Beneficiary premiums	1.2	0.1
State transfers	0.6	0.0
General revenue contributions	4.9	0.3
Less current trust fund (Income minus expenditures to date for past and current participants)	0.0	0.0
Equals unfunded obligations for past and current participants[1]	0.0	0.0
Expenditures	6.7	0.4
Income	6.7	0.4
Beneficiary premiums	1.2	0.1
State transfers	0.6	0.0
General revenue contributions	4.9	0.3
Plus expenditures less income for future participants for the infinite horizon	0.0	0.0
Expenditures	12.7	0.8
Income	12.7	0.8
Beneficiary premiums	2.2	0.1
State transfers	1.2	0.1
General revenue contributions	9.3	0.6
Equals unfunded obligations for all participants for the infinite future	0.0	0.0
Expenditures	19.4	1.2
Income	19.4	1.2
Beneficiary premiums	3.4	0.2
State transfers	1.8	0.1
General revenue contributions	14.2	0.9

[1] This concept is also referred to as the closed-group unfunded obligation.

Notes: 1. The estimated present value of GDP for 2014 through the infinite horizon is $1,632.5 trillion. See note 2 of table V.G1.
2. Totals do not necessarily equal the sums of rounded components.

H. FISCAL YEAR HISTORICAL DATA AND PROJECTIONS THROUGH 2023

Tables V.H1, V.H2, and V.H3 present detailed operations of the HI trust fund, along with Part B and Part D of the SMI trust fund, for fiscal year 2013. These tables are similar to the calendar-year operation tables displayed in sections III.B, III.C, and III.D.

Table V.H1.—Statement of Operations of the HI Trust Fund during Fiscal Year 2013

[In thousands]

Total assets of the trust fund, beginning of period	$229,371,934
Revenue:	
Payroll taxes	$212,901,291
Income from taxation of OASDI benefits	14,310,000
Interest on investments	9,886,941
Premiums collected from voluntary participants	3,396,949
Premiums collected from Medicare Advantage participants	260,413
Transfer from Railroad Retirement account	547,400
Interfund interest receipts[1]	288
Interest on reimbursements, Railroad Retirement	29,224
Other	914
Reimbursement, union activity	1,015
Fraud and abuse control receipts:	
Criminal fines	708,406
Civil monetary penalties	14,484
Civil penalties and damages, CMS	3
Civil penalties and damages, Department of Justice	1,322,786
Asset forfeitures, Department of Justice	30,166
3% administrative expense reimbursement, Department of Justice	40,973
General fund transfer, Discretionary	109,003
Total revenue	$243,560,256
Expenditures:	
Net benefit payments	$262,411,328
Administrative expenses:	
Treasury administrative expenses	130,105
Salaries and expenses, SSA[2]	818,486
Salaries and expenses, CMS[3]	1,608,590
Salaries and expenses, Office of the Secretary, HHS	21,830
Medicare Payment Advisory Commission	6,376
CMS program management–Affordable Care Act	9,909
Transfer to Patient-Centered Outcomes Research Trust Fund[4]	24,730
Fraud and abuse control expenses:	
HHS Medicare integrity program	679,059
HHS Office of Inspector General	327,506
Department of Justice	55,639
FBI	119,371
HCFAC Discretionary, CMS	192,729
HCFAC Other HHS Discretionary, CMS	35,849
HCFAC Department of Justice Discretionary, CMS	31,712
HCFAC Office of Inspector General Discretionary, CMS	72,832
Total administrative expenses	4,134,722
Total expenditures	$266,546,050
Net addition to the trust fund	−22,985,795
Total assets of the trust fund, end of period	$206,386,139

[1]Reflects interest adjustments on the reallocation of administrative expenses among the Medicare trust funds, the OASDI trust funds, and the general fund of the Treasury. Estimated payments are made from the trust funds, and then reconciled, with interest, the next year when the actual costs are known. A positive figure represents a transfer to the HI trust fund from the other trust funds. A negative figure represents a transfer from the HI trust fund to the other funds.

[2]For facilities, goods, and services provided by SSA.

[3]Includes administrative expenses of the intermediaries.

[4]Represents amount transferred from the HI trust fund to the Patient-Centered Outcomes Research trust fund, as authorized by the Patient Protection and Affordable Care Act of 2010.

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

Table V.H2.—Statement of Operations of the Part B Account in the SMI Trust Fund during Fiscal Year 2013

[In thousands]

Total assets of the Part B account in the trust fund, beginning of period		$70,949,320
Revenue:		
Premiums from enrollees:		
Enrollees aged 65 and over	$51,678,974	
Disabled enrollees under age 65	10,090,687	
Total premiums		61,769,661
Premiums collected from Medicare Advantage participants		245,522
Government contributions:		
Enrollees aged 65 and over	143,394,070	
Disabled enrollees under age 65	33,545,836	
Total government contributions		176,939,906
Other		5,225
Interest on investments		2,510,442
Interfund interest receipts[1]		209
Annual fees–branded Rx manufacturers and importers		616,223
Total revenue		$242,087,188
Expenditures:		
Net Part B benefit payments		$243,401,661
Administrative expenses:		
Transfer to Medicaid[2]	477,445	
Treasury administrative expenses	478	
Salaries and expenses, CMS[3]	1,894,873	
Salaries and expenses, Office of the Secretary, HHS	21,830	
Salaries and expenses, SSA	921,818	
Medicare Payment Advisory Commission	4,251	
Railroad Retirement administrative expenses	21,575	
CMS program management–Affordable Care Act	19,258	
Transfer to Patient-Centered Outcomes Research trust fund[4]	27,265	
Total administrative expenses		3,388,794
Total expenditures		$246,790,455
Net addition to the trust fund		−4,703,268
Total assets of the Part B account in the trust fund, end of period		$66,246,053

[1]Reflects interest adjustments on the reallocation of administrative expenses among the Medicare trust funds, the OASDI trust funds, and the general fund of the Treasury. Estimated payments are made from the trust funds, and then reconciled, with interest, the next year when the actual costs are known. A positive figure represents a transfer to the Part B account of the SMI trust fund from the other trust funds. A negative figure represents a transfer from the Part B account in the SMI trust fund to the other funds.

[2]Represents amount transferred from the Part B account in the SMI trust fund to Medicaid to pay the Part B premium for certain qualified individuals, as legislated by the Balanced Budget Act of 1997.

[3]Includes administrative expenses of the carriers and intermediaries.

[4]Represents amount transferred from the Part B account of the SMI trust fund to the Patient-Centered Outcomes Research trust fund, as authorized by the Patient Protection and Affordable Care Act of 2010.

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

Table V.H3—Statement of Operations of the Part D Account in the SMI Trust Fund during Fiscal Year 2013

[In thousands]

Total assets of the Part D account in the trust fund, beginning of period		$834,018
Revenue:		
Premiums from enrollees		
Premiums deducted from Social Security benefits	$3,224,377	
Premiums paid directly to plans[1]	6,304,463	
Total premiums		9,528,841
Government contributions:		
Prescription drug benefits	49,900,298	
Prescription drug administrative expenses	367,449	
Total government contributions		50,267,747
Payments from States		8,665,782
Interest on investments		6,786
Total revenue		$68,469,156
Expenditures:		
Part D benefit payments[1]		$67,963,608
Part D administrative expenses		367,449
Total expenditures		$68,331,056
Net addition to the trust fund		138,100
Total assets of the Part D account in the trust fund, end of period		$972,118

[1]Premiums paid directly to plans are not displayed on Treasury statements and are estimated. These premiums have been added to the benefit payments reported on the Treasury statement to obtain an estimate of total Part D benefits. Direct data on such benefit amounts are not yet available.

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

Tables V.H4, V.H5, V.H6, V.H7, and V.H8 present estimates of the fiscal-year operations under the *projected baseline* of total Medicare, the HI trust fund, the SMI trust fund, the Part B account in the SMI trust fund, and the Part D account in the SMI trust fund, respectively. These tables correspond to the calendar-year trust fund operation tables shown in section V.B and in section III.

Table V.H4.—Total Medicare Income, Expenditures, and Trust Fund Assets during Fiscal Years 1970-2023

[In billions]

Fiscal year	Total income	Total expenditures	Net change in assets	Assets at end of year
Historical data:				
1970	$7.5	$7.1	$0.3	$2.7
1975	16.9	14.8	2.1	11.3
1980	35.7	35.0	0.7	19.0
1985	75.5	71.4	4.1	31.9
1990	125.7	109.7	16.0	110.2
1995	173.0	180.1	−7.1	143.4
2000	248.9	219.3	29.6	214.0
2005	349.4	336.9	12.5	294.6
2006	422.3	380.5	41.8	336.4
2007	457.1	434.8	22.2	358.7
2008	474.6	455.1	19.5	378.1
2009	491.5	498.3	−6.8	371.4
2010	500.7	521.2	−20.5	350.9
2011	528.0	560.3	−32.3	318.6
2012	532.6	550.0	−17.5	301.2
2013	554.1	581.7	−27.6	273.6
Intermediate estimates:				
2014	595.7	603.2	−7.4	266.2
2015	624.4	620.7	3.7	269.9
2016	675.9	672.9	3.0	272.8
2017	718.5	695.7	22.8	295.6
2018	766.4	725.4	40.9	336.6
2019	830.8	802.5	28.2	364.8
2020	890.2	866.4	23.9	388.7
2021	956.9	934.4	22.5	411.2
2022	1,034.7	1,039.7	−5.0	406.2
2023	1,096.8	1,085.2	11.6	417.8

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

Table V.H5.—Operations of the HI Trust Fund during Fiscal Years 1970-2023

[In billions]

	Income								Expenditures			Trust fund	
Fiscal year[1]	Payroll taxes	Income from taxation of benefits	Railroad Retirement account transfers	Reimburse-ment for uninsured persons	Premiums from voluntary enrollees	Payments for military wage credits	Interest and other[2,3]	Total	Benefit payments[3,4]	Adminis-trative expenses[5]	Total	Net change	Balance at end of year
Historical data:													
1970	$4.8	—	$0.1	$0.6	—	$0.0	$0.1	$5.6	$4.8	$0.1	$5.0	$0.7	$2.7
1975	11.3	—	0.1	0.5	$0.0	0.0	0.6	12.6	10.4	0.3	10.6	2.0	9.9
1980	23.2	—	0.2	0.7	0.0	0.1	1.1	25.4	23.8	0.5	24.3	1.1	14.5
1985	46.5	—	0.4	0.8	0.0	0.1	3.2	50.9	47.8	0.8	48.7	4.1[6]	21.3
1990	70.7	—	0.4	0.4	0.1	0.1	7.9	79.6	65.9	0.8	66.7	12.9	95.6
1995	98.1	$3.9	0.4	0.5	1.0	0.1	11.0	114.8	113.6	1.3	114.9	0.0	129.5
2000	137.7	8.8	0.5	0.5	1.4	0.0	10.8	159.7	127.9[7]	2.4	130.3	29.4	168.1
2005	169.0	8.8	0.4	0.3	2.3	0.0	16.2	196.9	181.3	2.9	184.1	12.8	277.7
2006	180.4	10.3	0.5	0.4	2.6	0.0	16.1	210.3	181.8	3.1	184.9	25.4	303.1
2007	188.0	10.6	0.5	0.5	2.8	0.0	16.9	219.2	200.2	2.6	202.8	16.4	319.5
2008	197.2	11.7	0.5	0.5	2.9	0.0	16.9	229.7	227.0[8]	3.2	230.2	−0.5	319.0
2009	194.1	12.4	0.5	0.6	2.8	1.0[9]	17.5	228.9	234.7	3.3	238.0	−9.1	309.9
2010	183.6	13.8	0.5	−0.1	3.3	0.0	16.9	218.0	245.6	3.3	249.0	−31.0	278.9
2011	192.1	15.1	0.5	0.3	3.3	0.0	15.3	226.5	255.7	3.9	259.6	−33.1	245.8
2012	204.8	18.6	0.5	0.3	3.4	0.0	14.2	241.7	254.5	3.7	258.2	−16.4	229.4
2013	212.9	14.3	0.6	0.0	3.4	0.0	12.4	243.6	262.4	4.1	266.5	−23.0	206.4
Intermediate estimates:													
2014	224.4	18.9	0.6	0.4	3.5	0.0	11.9	259.7	265.1	4.4	269.5	−9.9	196.5
2015	235.8	21.0	0.6	0.2	3.4	0.0	11.3	272.3	263.8	4.8	268.6	3.7	200.2
2016	257.5	23.2	0.6	0.2	3.5	0.0	12.1	297.2	280.7	5.3	286.0	11.2	211.4
2017	272.4	25.8	0.7	0.2	3.7	0.0	13.0	315.6	289.4	5.7	295.1	20.5	231.9
2018	289.4	28.5	0.7	0.2	3.9	0.0	14.2	336.9	304.2	6.1	310.3	26.6	258.5
2019	306.0	31.3	0.7	0.2	4.1	0.0	15.8	358.1	330.6	6.5	337.1	21.0	279.4
2020	320.6	34.3	0.7	0.2	4.3	0.0	17.3	377.5	353.5	7.0	360.4	17.1	296.5
2021	339.2	37.5	0.7	0.1	4.6	0.0	18.8	400.9	378.1	7.4	385.5	15.4	311.9
2022	356.3	40.8	0.8	0.1	4.9	0.0	19.8	422.6	414.1	7.9	422.0	0.7	312.6
2023	371.6	44.5	0.8	0.1	5.2	0.0	20.4	442.6	431.5	8.4	439.9	2.6	315.2

[1]Fiscal years 1970 and 1975 consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.
[2]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund, receipts from the fraud and abuse control program, and a small amount of miscellaneous income. In 2008, includes an adjustment of −$0.9 billion for interest inadvertently earned as a result of Part A hospice costs that were misallocated to the Part B trust fund account.
[3]See footnote 2 of table III.B4.
[4]Includes costs of Peer Review Organizations from 1983 through 2001 (beginning with the implementation of the prospective payment system on October 1, 1983) and costs of Quality Improvement Organizations beginning in 2002.
[5]Includes costs of experiments and demonstration projects. Beginning in 1997, includes fraud and abuse control expenses, as provided for by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).
[6]Includes repayment of loan principal, from the OASI trust fund, of $1.8 billion.
[7]For 1998 to 2003, includes monies transferred to the SMI trust fund for home health agency costs, as provided for by the Balanced Budget Act of 1997 (Public Law 105-33).
[8]Includes the $8.5 billion transferred to the general fund of the Treasury for Part A hospice costs that were previously misallocated to the Part B trust fund account.
[9]Includes the lump-sum general revenue adjustment of $1.0 billion, as provided for by section 151 of the Social Security Amendments of 1983 (Public Law 98-21).

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

Table V.H6.—Operations of the SMI Trust Fund (Cash Basis) during Fiscal Years 1970-2023

[In billions]

	Income					Expenditures			Trust fund	
Fiscal year[1]	Premium income	General revenue[2]	Transfers from States	Interest and other[3,4]	Total	Benefit payments[4,5]	Adminis-trative expense	Total	Net change	Balance at end of year[6]
Historical data:										
1970	$0.9	$0.9	—	$0.0	$1.9	$2.0	$0.2	$2.2	−$0.3	$0.1
1975	1.9	2.3	—	0.1	4.3	3.8	0.4	4.2	0.2	1.4
1980	2.9	6.9	—	0.4	10.3	10.1	0.6	10.7	−0.5	4.5
1985	5.5	17.9	—	1.2	24.6	21.8	0.9	22.7	1.8	10.6
1990	11.5[7]	33.2	—	1.4[7]	46.1[7]	41.5	1.5[7]	43.0[7]	3.1[7]	14.5[7]
1995	19.2	37.0	—	1.9	58.2	63.5	1.7	65.2	−7.0	13.9
2000	20.5	65.6	—	3.2	89.2	87.2[8]	1.8	89.0	0.2	45.9
2005	35.9	115.2	—	1.4	152.5	149.8	2.9	152.7	−0.2	16.9
2006	44.2	162.6	$3.6	1.5	212.0	192.1	3.5	195.6	16.4	33.3
2007	49.7	179.2	7.0	2.1	237.9	228.6	3.4	232.0	5.9	39.1
2008	54.2	180.4	7.0	3.2	244.9	221.4[9]	3.4	224.9	20.0	59.1
2009	57.7	194.3	7.5	3.1	262.6	256.9	3.3	260.3	2.3	61.5
2010	61.4	213.7	4.5	3.2	282.7	268.7	3.5	272.2	10.5	72.0
2011	64.5	225.2	6.5	5.3	301.5	296.8	3.8	300.7	0.9	72.8
2012	66.1	210.5	8.3	6.0	290.8	287.8	4.1	291.9	−1.0	71.8
2013	71.3	227.2	8.7	3.4	310.6	311.4	3.8	315.1	−4.6	67.2
Intermediate estimates:										
2014	76.9	243.9	8.5	6.8	336.1	330.6	3.1	333.6	2.4	69.7
2015	80.3	257.3	8.4	6.1	352.1	348.7	3.4	352.1	0.0	69.7
2016	85.6	278.0	8.9	6.2	378.7	383.4	3.6	387.0	−8.3	61.4
2017	93.9	293.0	9.6	6.5	403.0	396.8	3.9	400.6	2.3	63.8
2018	102.9	308.3	10.4	7.9	429.5	411.0	4.1	415.2	14.3	78.1
2019	112.7	340.3	11.2	8.5	472.7	461.0	4.4	465.4	7.3	85.4
2020	120.9	371.9	12.2	7.7	512.7	501.3	4.7	505.9	6.8	92.2
2021	130.9	403.6	13.3	8.3	556.1	543.9	4.9	548.9	7.2	99.4
2022	142.4	446.3	14.4	8.9	612.0	612.5	5.2	617.8	−5.7	93.6
2023	154.9	474.1	15.7	9.5	654.2	639.7	5.6	645.3	9.0	102.6

[1]Fiscal years 1970 and 1975 consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.

[2]Includes Part B general fund matching payments, Part D subsidy costs, and certain interest-adjustment items.

[3]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income. In 2008, includes an adjustment of $0.8 billion for interest inadvertently earned as a result of Part A hospice costs that were misallocated to the Part B trust fund account.

[4]See footnote 2 of table III.B4.

[5]See footnote 3 of table III.B4.

[6]The financial status of SMI depends on both the assets and the liabilities of the trust fund (see table III.C8).

[7]Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

[8]Benefit payments less monies transferred from the HI trust fund for home health agency costs, as provided for by the Balanced Budget Act of 1997.

[9]Benefits shown for 2008 are lower by the $8.5 billion transferred from the general fund of the Treasury to reimburse Part B for Part A hospice costs that were previously misallocated to the Part B trust fund account.

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

Table V.H7.—Operations of the Part B Account in the SMI Trust Fund (Cash Basis) during Fiscal Years 1970-2023

[In billions]

	Income				Expenditures			Account	
Fiscal year[1]	Premium income	General revenue[2]	Interest and other[3,4]	Total	Benefit payments[4,5]	Adminis-trative expense	Total	Net change	Balance at end of year[6]
Historical data:									
1970	$0.9	$0.9	$0.0	$1.9	$2.0	$0.2	$2.2	−$0.3	$0.1
1975	1.9	2.3	0.1	4.3	3.8	0.4	4.2	0.2	1.4
1980	2.9	6.9	0.4	10.3	10.1	0.6	10.7	−0.5	4.5
1985	5.5	17.9	1.2	24.6	21.8	0.9	22.7	1.8	10.6
1990	11.5[7]	33.2	1.4[7]	46.1[7]	41.5	1.5[7]	43.0[7]	3.1[7]	14.5[7]
1995	19.2	37.0	1.9	58.2	63.5	1.7	65.2	−7.0	13.9
2000	20.5	65.6	3.2	89.2	87.2[8]	1.8	89.0	0.2	45.9
2005	35.9	114.0	1.4	151.3	148.6	2.9	151.5	−0.2	16.9
2006	41.6	134.3	1.5	177.4	158.3	3.3	161.6	15.7	32.6
2007	45.7	137.8	2.0	185.6	177.2	2.4	179.7	6.0	38.6
2008	49.4	144.9	3.2	197.5	174.7[9]	3.0	177.7	19.8	58.3
2009	51.9	150.7	3.1	205.7	200.3	3.1	203.4	2.3	60.6
2010	54.8	161.1	3.2	219.0	205.1	3.3	208.4	10.7	71.3
2011	57.0	168.8	5.3	231.2	226.2	3.4	229.6	1.5	72.8
2012	57.9	165.3	6.0	229.1	227.2	3.8	230.9	−1.8	70.9
2013	61.8	176.9	3.4	242.1	243.4	3.4	246.8	−4.7	66.2
Intermediate estimates:									
2014	65.7	190.2	6.8	262.7	257.3	2.7	260.0	2.7	69.0
2015	67.4	193.7	6.1	267.1	264.1	3.0	267.1	0.0	69.0
2016	70.5	202.8	6.2	279.6	283.9	3.2	287.1	−7.5	61.4
2017	76.8	217.7	6.4	300.9	295.1	3.4	298.6	2.3	63.8
2018	83.8	234.2	7.9	326.0	308.8	3.7	312.5	13.4	77.2
2019	91.5	253.0	8.5	353.0	341.9	3.9	345.8	7.2	84.4
2020	97.9	276.0	7.7	381.7	370.8	4.2	374.9	6.7	91.1
2021	105.8	299.4	8.3	413.5	401.9	4.4	406.4	7.1	98.2
2022	115.0	324.1	8.8	448.0	447.8	4.7	452.5	−4.6	93.6
2023	125.0	350.9	9.5	485.4	471.4	5.0	476.4	9.0	102.6

[1]Fiscal years 1970 and 1975 consist of the 12 months ending on June 30 of each year; fiscal years 1980 and later consist of the 12 months ending on September 30 of each year.

[2]General fund matching payments, plus certain interest-adjustment items.

[3]Other income includes recoveries of amounts reimbursed from the trust fund that are not obligations of the trust fund and other miscellaneous income. In 2008, includes an adjustment of $0.8 billion for interest earned as a result of Part A hospice costs that were misallocated to the Part B trust fund account.

[4]See footnote 2 of table III.B4.

[5]See footnote 3 of table III.B4.

[6]The financial status of Part B depends on both the assets and the liabilities of the trust fund (see table III.C8).

[7]Includes the impact of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

[8]Benefit payments less monies transferred from the HI trust fund for home health agency costs, as provided for by the Balanced Budget Act of 1997.

[9]Benefits shown for 2008 are lower by the $8.5 billion transferred from the general fund of the Treasury to reimburse Part B for Part A hospice costs that were previously misallocated to the Part B trust fund account.

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

Table V.H8.—Operations of the Part D Account in the SMI Trust Fund (Cash Basis) during Fiscal Years 2004-2023

[In billions]

	Income					Expenditures			Account	
Fiscal year	Premium income	General revenue[1]	Transfers from States[2]	Interest and other	Total	Benefit payments[3]	Adminis-trative expense	Total	Net change	Balance at end of year
Historical data:										
2004	—	$0.2	—	—	$0.2	$0.2	—	$0.2	—	—
2005	—	1.2	—	—	1.2	1.2	—	1.2	—	—
2006	$2.6	28.3	$3.6	$0.0	34.6	33.7	$0.2	33.9	$0.7	$0.7
2007	3.9	41.4	7.0	0.0	52.3	51.4	1.0	52.4	−0.1	0.6
2008	4.8	35.5	7.0	0.0	47.4	46.8	0.4	47.2	0.2	0.8
2009	5.8	43.5	7.5	0.0	56.9	56.6	0.2	56.8	0.0	0.9
2010	6.6	52.6	4.5	0.0	63.7	63.6	0.3	63.8	−0.2	0.7
2011	7.5	56.3	6.5	0.0	70.4	70.6	0.4	71.0	−0.7	0.0
2012	8.2	45.3	8.3	0.0	61.7	60.6	0.4	60.9	0.8	0.8
2013	9.5	50.3	8.7	0.0	68.5	68.0	0.4	68.3	0.1	1.0
Intermediate estimates:										
2014	11.2	53.7	8.5	0.0	73.4	73.3	0.4	73.7	−0.3	0.7
2015	13.0	63.6	8.4	0.0	85.0	84.6	0.4	85.0	0.0	0.7
2016	15.1	75.2	8.9	0.0	99.2	99.5	0.4	99.9	−0.7	0.0
2017	17.1	75.3	9.6	0.0	102.1	101.6	0.4	102.1	0.0	0.0
2018	19.1	74.1	10.4	0.0	103.5	102.2	0.5	102.6	0.9	0.9
2019	21.2	87.3	11.2	0.0	119.7	119.2	0.5	119.6	0.1	1.0
2020	23.0	95.8	12.2	0.0	131.1	130.5	0.5	131.0	0.1	1.1
2021	25.1	104.2	13.3	0.0	142.6	142.0	0.5	142.5	0.1	1.1
2022	27.4	122.2	14.4	0.0	164.1	164.7	0.5	165.2	−1.1	0.0
2023	29.9	123.2	15.7	0.0	168.8	168.3	0.6	168.8	0.0	0.0

[1]Includes, net of transfers from States, all government transfers required to fund benefit payments, administrative expenses, and State expenses for making low-income eligibility determinations.

[2]See footnote 3 of table III.D3.

[3]Includes payments to Part D plans, payments to retiree drug subsidy plans, payments to States for making low-income eligibility determinations, Part D drug premiums collected from beneficiaries, and transfers to Medicare Advantage plans and private drug plans. Includes amounts for the Transitional Assistance program of $0.2, $1.1, and $0.2 billion in 2004-2006, respectively.

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

Table V.H9 shows the total assets of the HI trust fund and their distribution by interest rate and maturity date at the end of fiscal years 2012 and 2013. The assets at the end of fiscal year 2013 totaled $206.4 billion: $206.0 billion in the form of U.S. Government obligations and an undisbursed balance of $0.4 billion.

Table V.H9.—Assets of the HI Trust Fund, by Type, at the End of Fiscal Years 2012 and 2013[1]

	September 30, 2012	September 30, 2013
Investments in public-debt obligations sold only to the trust funds (special issues):		
Certificates of indebtedness:		——
1.375-percent, 2012	8,098,001,000.00	
2.375-percent, 2014	——	8,841,177,000.00
Bonds:		
3.250-percent, 2023-2024	18,380,800,000.00	18,380,800,000.00
3.500-percent, 2015	1,491,941,000.00	——
3.500-percent, 2016-2018	20,001,687,000.00	20,001,687,000.00
4.000-percent, 2015	1,201,235,000.00	——
4.000-percent, 2016-2023	30,297,364,000.00	30,297,364,000.00
4.125-percent, 2015	986,225,000.00	——
4.125-percent, 2016-2020	22,749,120,000.00	22,749,120,000.00
4.625-percent, 2015	977,467,000.00	——
4.625-percent, 2016-2019	20,750,369,000.00	20,750,369,000.00
5.000-percent, 2015	979,723,000.00	——
5.000-percent, 2016-2022	26,565,823,000.00	26,565,823,000.00
5.125-percent, 2015	903,572,000.00	——
5.125-percent, 2016-2021	24,225,592,000.00	24,225,592,000.00
5.250-percent, 2015	2,028,429,000.00	——
5.250-percent, 2016-2017	17,199,676,000.00	17,199,676,000.00
5.625-percent, 2015	2,537,726,000.00	——
5.625-percent, 2016	13,320,128,000.00	13,320,128,000.00
6.000-percent, 2014	1,807,985,000.00	——
6.500-percent, 2014	3,007,022,000.00	——
6.500-percent, 2015	10,782,402,000.00	3,678,142,000.00
Total investments	$228,292,287,000.00	$206,009,878,000.00
Undisbursed balance	1,079,646,649,92	376,261,114.98
Total assets	$229,371,933,649.92	$206,386,139,114.98

[1]Certificates of indebtedness and bonds are carried at par value, which is the same as book value.

The effective annual rate of interest earned by the assets of the HI trust fund during the 12 months ending on December 31, 2013 was 4.5 percent. Interest on special issues is paid semiannually on June 30 and December 31. The interest rate on public-debt obligations issued for purchase by the trust fund in June 2013 was 1.75 percent, payable semiannually.

Table V.H10 shows a comparison of the total assets of the SMI trust fund, Parts B and D combined, and their distribution at the end of fiscal years 2012 and 2013. At the end of 2013, assets totaled $67.2 billion: $67.4 billion in the form of U.S. Government obligations and an undisbursed balance of −$0.2 billion.

Table V.H10.—Assets of the SMI Trust Fund, by Type, at the End of Fiscal Years 2012 and 2013[1]

	September 30, 2012	September 30, 2013
Investments in public-debt obligations sold only to the trust funds (special issues):		
Certificates of indebtedness:		
1.250-percent, 2013	3,905,872,000.00	——
2.375-percent, 2014	——	9,146,845,000.00
Bonds:		
2.500-percent, 2015	563,904,000.00	——
2.500-percent, 2016-2026	10,944,209,000.00	10,825,851,000.00
2.875-percent, 2015	488,228,000.00	——
2.875-percent, 2016-2025	9,135,303,000.00	9,135,303,000.00
3.250-percent, 2015	337,422,000.00	——
3.250-percent, 2016-2024	6,952,408,000.00	6,952,408,000.00
4.000-percent, 2015	882,474,000.00	——
4.000-percent, 2016-2023	12,639,582,000.00	12,639,582,000.00
5.000-percent, 2017-2022	14,896,093,000.00	14,896,093,000.00
5.125-percent, 2015	1,000.00	——
5.125-percent, 2016-2017	1,669,335,000.00	1,669,335,000.00
5.250-percent, 2016	297,753,000.00	297,753,000.00
5.625-percent, 2016	1,822,107,000.00	1,822,107,000.00
6.000-percent, 2014	1,715,335,000.00	——
6.500-percent, 2014-2015	3,074,382,000.00	——
Total investments	$69,324,408,000.00	$67,385,277,000.00
Undisbursed balance[2]	2,458,929,972.36	−167,106,750.92
Total assets	$71,783,337,972.36	$67,218,170,249.08

[1]Certificates of indebtedness and bonds are carried at par value, which is the same as book value.
[2]Negative figures represent an extension of credit against securities to be redeemed within the following few days.

The effective annual rate of interest earned by the assets of the SMI trust fund for the 12 months ending on December 31, 2013 was 3.2 percent. Interest on special issues is paid semiannually on June 30 and December 31. The interest rate on special issues purchased by the account in June 2013 was 1.75 percent, payable semiannually.

I. GLOSSARY

Accountable care organizations (ACOs). Groups of clinicians, hospitals, and other health care providers that choose to come together to deliver coordinated, high-quality care to the Medicare patients they serve.

Actuarial balance. The difference between the summarized income rate and the summarized cost rate over a given valuation period.

Actuarial deficit. A negative actuarial balance.

Actuarial rates. One-half of the Part B expected monthly benefit and administrative costs for each aged enrollee adjusted for interest earned on the Part B account assets attributable to aged enrollees and a contingency margin (for the aged actuarial rate), and one-half of the expected monthly benefit and administrative costs for each disabled enrollee adjusted for interest earned on the Part B account assets attributable to disabled enrollees and a contingency margin (for the disabled actuarial rate), for the duration the rate is in effect.

Actuarial status. A measure of the adequacy of the financing as determined by the difference between assets and liabilities at the end of the periods for which financing was established.

Administrative expenses. Expenses incurred by the Department of Health and Human Services and the Department of the Treasury in administering HI and SMI and the provisions of the Internal Revenue Code relating to the collection of contributions. Such administrative expenses, which are paid from the HI and SMI trust funds, include expenditures for contractors to determine costs of, and make payments to, providers, as well as salaries and expenses of the Centers for Medicare & Medicaid Services.

Aged enrollee. An individual, aged 65 or over, who is enrolled in HI or SMI.

Allowed charge. Individual charge determined by a carrier for a covered Part B medical service or supply.

Annual out-of-pocket threshold. The amount of out-of-pocket expenses that must be paid for prescription drugs before significantly reduced Part D beneficiary cost sharing is effective. Amounts paid by a third-party insurer are not included in testing this threshold, but amounts paid by State or Federal assistance programs are included.

Assets. Treasury notes and bonds guaranteed by the Federal Government, and cash held by the trust funds for investment purposes.

Assumptions. Values relating to future trends in certain key factors that affect the balance in the trust funds. Demographic assumptions include fertility, mortality, net immigration, marriage, divorce, retirement patterns, disability incidence and termination rates, and changes in the labor force. Economic assumptions include unemployment, average earnings, inflation, interest rates, and productivity. Three sets of economic assumptions are presented in the Trustees Report:

(1) The low-cost alternative, with relatively rapid economic growth, low inflation, and favorable (from the standpoint of program financing) demographic conditions;
(2) The intermediate assumptions, which represent the Trustees' best estimates of likely future economic and demographic conditions; and
(3) The high-cost alternative, with slow economic growth, more rapid inflation, and financially disadvantageous demographic conditions.

See also *Hospital assumptions*.

Average market yield. A computation that is made on all marketable interest-bearing obligations of the United States. It is computed on the basis of market quotations as of the end of the calendar month immediately preceding the date of such issue.

Baby boom. The period from the end of World War II through the mid-1960s marked by unusually high birth rates.

Base estimate. The updated estimate of the most recent historical year.

Beneficiary. A person enrolled in HI or SMI. See also *Aged enrollee* and *Disabled enrollee*.

Benefit payments. The amounts disbursed for covered services after the deductible and coinsurance amounts have been deducted.

Benefit period. An alternate name for spell of illness.

Board of Trustees. A Board established by the Social Security Act to oversee the financial operations of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The Board is composed of six members, four of whom serve

automatically by virtue of their positions in the Federal Government: the Secretary of the Treasury, who is the Managing Trustee; the Secretary of Labor; the Secretary of Health and Human Services; and the Commissioner of Social Security. Two other members are public representatives who are appointed by the President and confirmed by the Senate. Charles P. Blahous III and Robert D. Reischauer began serving on September 17, 2010. The Administrator of the Centers for Medicare & Medicaid Services (CMS) serves as Secretary of the Board of Trustees.

Bond. A certificate of ownership of a specified portion of a debt due by the Federal Government to holders, bearing a fixed rate of interest.

Callable. Subject to redemption upon notice, as is a bond.

Carrier. A private or public organization under contract to CMS to administer the Part B benefits under Medicare. Also referred to as contractors, these organizations determine coverage and benefit amounts payable and make payments to physicians, suppliers, and beneficiaries.

Case mix index. A relative weight that captures the average complexity of certain Medicare services.

Cash basis. The costs of the service when payment was made rather than when the service was performed.

Certificate of indebtedness. A short-term certificate of ownership (12 months or less) of a specified portion of a debt due by the Federal Government to individual holders, bearing a fixed rate of interest.

Closed-group population. Includes all persons currently participating in the program as either taxpayers or beneficiaries, or both. See also *Open-group population*.

Coinsurance. Portion of the costs for covered services paid by the beneficiary after meeting the annual deductible. See also *Hospital coinsurance* and *SNF coinsurance*.

Consumer Price Index (CPI). A measure of the average change in prices over time in a fixed group of goods and services. In this report, all references to the CPI relate to the CPI for Urban Wage Earners and Clerical Workers (CPI-W).

Contingency. Funds included in the SMI Part B trust fund account to serve as a cushion in case actual expenditures are higher than those projected at the time financing was established. Since the financing is set prospectively, actual experience may be different from the estimates used in setting the financing.

Contingency margin. An amount included in the actuarial rates to provide for changes in the contingency level in the SMI Part B trust fund account. Positive margins increase the contingency level, and negative margins decrease it.

Contribution base. See *Maximum tax base*.

Contributions. See *Payroll taxes*.

Cost rate. The ratio of HI cost (or outgo or expenditures) on an incurred basis during a given year to the taxable payroll for the year. In this context, the outgo is defined to exclude benefit payments and administrative costs for those uninsured persons for whom payments are reimbursed from the general fund of the Treasury, and for voluntary enrollees, who pay a premium to be enrolled.

Covered earnings. Earnings in employment covered by HI.

Covered employment. All employment and self-employment creditable for Social Security purposes. Almost every kind of employment and self-employment is covered under HI. In a few employment situations—for example, religious orders under a vow of poverty, foreign affiliates of American employers, or State and local governments—coverage must be elected by the employer. However, effective July 1991, coverage is mandatory for State and local employees who are not participating in a public employee retirement system. All new State and local employees have been covered since April 1986. In a few situations—for instance, ministers or self-employed members of certain religious groups—workers can opt out of coverage. Covered employment for HI includes all Federal employees (whereas covered employment for OASDI includes some, but not all, Federal employees).

Covered Part D drugs. Prescription drugs covered under the Medicaid program plus insulin-related supplies and smoking cessation agents. Drugs covered in Parts A and B of Medicare will continue to be covered there, rather than in Part D.

Covered services. Services for which HI or SMI pays, as defined and limited by statute. Covered HI services are provided by hospitals

(inpatient care), skilled nursing facilities, home health agencies, and hospices. Covered SMI Part B services include most physician services, care in outpatient departments of hospitals, diagnostic tests, durable medical equipment, ambulance services, and other health services that are not covered by HI. See *Covered Part D drugs* for SMI Part D.

Covered worker. A person who has earnings creditable for Social Security purposes on the basis of services for wages in covered employment and/or on the basis of income from covered self-employment. The number of HI covered workers is slightly larger than the number of OASDI covered workers because of different coverage status for Federal employment. See *Covered employment*.

Creditable prescription drug coverage. Prescription drug coverage that meets or exceeds the actuarial value of Part D coverage provided through a group health plan or otherwise.

Dedicated financing sources. The sum of HI payroll taxes, HI share of income taxes on Social Security benefits, Part D State transfers, and beneficiary premiums. This amount is used in the test of excess general revenue Medicare funding.

Deductible. The annual amount payable by the beneficiary for covered services before Medicare makes reimbursement. See also *Inpatient hospital deductible*.

Deemed wage credit. See *Non-contributory or deemed wage credits*.

Demographic assumptions. See *Assumptions*.

Diagnosis-related groups (DRGs). A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the inpatient hospital prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Direct subsidy. The amount paid to the prescription drug plans representing the difference between the plan's risk-adjusted bid and the beneficiary premium for basic coverage.

Disability. For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special

rules apply for workers aged 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled-worker cash benefit. An additional 24 months is necessary to qualify for benefits under Medicare.

Disability Insurance (DI). See *Old-Age, Survivors, and Disability Insurance (OASDI).*

Disabled enrollee. An individual under age 65 who has been entitled to disability benefits under Title II of the Social Security Act or the Railroad Retirement system for at least 2 years and who is enrolled in HI or SMI.

DRG Coding. The DRG categories used by hospitals on discharge billing. See also *Diagnosis-related groups (DRGs).*

Dual beneficiary. An individual who is eligible for both Medicare and Medicaid.

Durable medical equipment (DME). Items such as iron lungs, oxygen tents, hospital beds, wheelchairs, and seat lift mechanisms that are used in the patient's home and are either purchased or rented.

Earnings. Unless otherwise qualified, all wages from employment and net earnings from self-employment, whether or not taxable or covered.

Economic assumptions. See *Assumptions*.

Economic stabilization program. A legislative program during the early 1970s that limited price increases.

End-stage renal disease (ESRD). Permanent kidney failure.

Extended care services. In the context of this report, an alternate name for skilled nursing facility services.

Fallback prescription drug plan. Prescription drug coverage provided by plans bearing no risk. One fallback plan will be approved in regions that do not have a choice of at least two at-risk plans.

Federal Insurance Contributions Act (FICA). Provision authorizing taxes on the wages of employed persons to provide for

OASDI and HI. The tax is paid in equal amounts by covered workers and their employers.

Financial interchange. Provisions of the Railroad Retirement Act providing for transfers between the trust funds and the Social Security Equivalent Benefit Account of the Railroad Retirement program in order to place each trust fund in the same position as if railroad employment had always been covered under Social Security.

Fiscal year. The accounting year of the U.S. Government. Since 1976, each fiscal year has begun October 1 of the prior calendar year and ended the following September 30. For example, fiscal year 2014 began October 1, 2013 and will end September 30, 2014.

Fixed capital assets. The net worth of facilities and other resources.

Frequency distribution. An exhaustive list of possible outcomes for a variable, and the associated probability of each outcome. The sum of the probabilities of all possible outcomes from a frequency distribution is 100 percent.

General fund of the Treasury. Funds held by the U.S. Treasury, other than revenue collected for a specific trust fund (such as HI or SMI) and maintained in a separate account for that purpose. The majority of this fund is derived from individual and business income taxes.

General revenue. Income to the HI and SMI trust funds from the general fund of the Treasury. Only a very small percentage of total HI trust fund income each year is attributable to general revenue.

General revenue funding. For the purpose of making a determination as to whether there is projected to be excess general revenue Medicare funding, as required by section 802 of the Medicare Modernization Act, general revenue funding is defined as the difference between outlays and dedicated funding sources.

Gross Domestic Product (GDP). The total dollar value of all goods and services produced in a year in the United States, regardless of who supplies the labor or property.

High-cost alternative. See *Assumptions*.

Hold-harmless provision. A provision limiting the dollar increase in the Part B premium to the dollar increase in an individual's Social Security benefit. As a result, the person affected pays a lower Part B

premium, and the net amount of the individual's Social Security benefit does not decrease despite the greater increase in the premium.

Home health agency (HHA). A public agency or private organization that is primarily engaged in providing the following services in the home: skilled nursing services, other therapeutic services (such as physical, occupational, or speech therapy), and home health aide services.

Hospice. A provider of care for the terminally ill; delivered services generally include home health care, nursing care, physician services, medical supplies, and short-term inpatient hospital care.

Hospital assumptions. These include differentials between hospital labor and non-labor indices compared with general economy labor and non-labor indices; rates of admission incidence; the trend toward treating less complicated cases in outpatient settings; and continued improvement in DRG coding.

Hospital coinsurance. For the 61st through 90th day of hospitalization in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-fourth of the inpatient hospital deductible; for lifetime reserve days, a daily amount for which the beneficiary is responsible, equal to one-half of the inpatient hospital deductible (see *Lifetime reserve days*).

Hospital input price index. An alternate name for hospital market basket.

Hospital Insurance (HI). The Medicare trust fund that covers specified inpatient hospital services, posthospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A.

Hospital market basket. The cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services.

Income rate. The ratio of income from tax revenues on an incurred basis (payroll tax contributions and income from the taxation of OASDI benefits) to the HI taxable payroll for the year.

Incurred basis. The costs based on when the service was performed rather than when the payment was made.

Infinite horizon. The period extending into the indefinite future.

Independent laboratory. A free-standing clinical laboratory meeting conditions for participation in the Medicare program and billing through a carrier.

Initial coverage limit. The amount up to which the coinsurance applies under the standard prescription drug benefit.

Inpatient hospital deductible. An amount of money that is deducted from the amount payable by Medicare Part A for inpatient hospital services furnished to a beneficiary during a spell of illness.

Inpatient hospital services. These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

Interest. A payment for the use of money during a specified period.

Intermediary. A private or public organization that is under contract to CMS to determine costs of, and make payments to, providers for HI and certain SMI Part B services.

Intermediate assumptions. See *Assumptions*.

Late enrollment penalty. Additional beneficiary premium amounts for those who either do not enroll in Part D at the first opportunity or fail to maintain other creditable coverage for more than 63 days.

Lifetime reserve days. Under HI, each beneficiary has 60 lifetime reserve days that he or she may opt to use when regular inpatient hospital benefits are exhausted. The beneficiary pays one-half of the inpatient hospital deductible for each lifetime reserve day used.

Long range. The next 75 years.

Low-cost alternative. See *Assumptions*.

Low-income beneficiaries. Individuals meeting income and assets tests who are eligible for prescription drug coverage subsidies to help finance premiums and out-of-pocket payments.

Managed care. See *Private Health Plans*.

Market basket. See *Hospital market basket*.

Maximum tax base. Annual dollar amount above which earnings in employment covered under HI are not taxable. Beginning in 1994, the maximum tax base was eliminated under HI.

Maximum taxable amount of annual earnings. See *Maximum tax base*.

Medicare. A nationwide, federally administered health insurance program authorized in 1965 under Title XVIII of the Social Security Act to cover the cost of hospitalization, medical care, and some related services for most people age 65 and over. In 1972, lawmakers extended coverage to people receiving Social Security Disability Insurance payments for 2 years and people with end-stage renal disease. (For beneficiaries whose primary or secondary diagnosis is Amyotrophic Lateral Sclerosis, the 2-year waiting period is waived.) In 2010, people exposed to environmental health hazards within areas under a corresponding emergency declaration became Medicare-eligible. In 2006, prescription drug coverage was added as well. Medicare consists of two separate but coordinated trust funds: Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI). The SMI trust fund is composed of two separate accounts: the Part B account and the Part D account. Almost all persons who are aged 65 and over or disabled and who are entitled to HI are eligible to enroll in Part B and Part D on a voluntary basis by paying monthly premiums.

Medicare Advantage (formerly called Medicare+Choice). An expanded set of options, established by the Medicare Modernization Act, for the delivery of health care under Medicare. Most Medicare beneficiaries can choose to receive benefits through the original fee-for-service program or through one of the following Medicare Advantage plans: (i) coordinated care plans (such as Health Maintenance Organizations, Provider Sponsored Organizations, and Preferred Provider Organizations); (ii) Medical Savings Account (MSA)/High Deductible plans; (iii) Private Fee-for-Service plans; or (iv) special needs plans.

Medicare Advantage Prescription Drug Plan (MA-PDP). Prescription drug coverage provided by Medicare Advantage plans.

Medicare Advantage ratebook. A set of statutory capitation payment rates, by county, originally used directly to establish payments to private health insurance plans contracting with

Medicare. Under current law, the ratebook amounts are used as benchmarks, against which plan costs are compared in the calculation of plan payments.

Medicare Economic Index (MEI). An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule.

Medicare funding warning. A warning to lawmakers indicating that a trust fund's financing is inadequate or that general revenue funding is becoming unduly large. Such a finding requires the President to submit to Congress, within 15 days after the date of the Budget submission for the succeeding year, proposed legislation to respond to the warning. The law also requires Congress to consider the legislation proposed in response to Medicare funding warnings on an expedited basis.

Medicare Payment Advisory Commission (MedPAC). A commission established by Congress in the Balanced Budget Act of 1997 to replace the Prospective Payment Assessment Commission and the Physician Payment Review Commission. MedPAC is directed to provide the Congress with advice and recommendations on policies affecting the Medicare program.

Medicare Prescription Drug Account. The separate account within the SMI trust fund to manage revenues and expenditures of the Part D drug benefit.

Medicare Severity-Diagnosis Related Groups (MS-DRGs). A refinement of the Diagnosis Related Group classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the inpatient hospital prospective payment system, hospitals are paid a set fee for treating patients in a single MS-DRG category, regardless of the actual cost of care for the individual.

Military service wage credits. Credits recognizing that military personnel receive other cash payments and wages in kind (such as food and shelter) in addition to their basic pay. Noncontributory wage credits of $160 were provided for each month of active military service from September 16, 1940 through December 31, 1956. For years after 1956, the basic pay of military personnel is covered under the Social Security program on a contributory basis. In addition to

contributory credits for basic pay, noncontributory wage credits of $300 were granted for each calendar quarter in which a person received pay for military service from January 1957 through December 1977. Deemed wage credits of $100 were granted for each $300 of military wages, up to a maximum of $1,200 per calendar year, from January 1978 through December 2001. See also *Quinquennial military service determinations and adjustments*.

Multifactor productivity. A measure of real output per combined unit of labor and capital, reflecting the contributions of all factors of production.

National average monthly bid. The weighted average of all Part D drug bids including all of the bids from PDPs and the drug portion of bids from MA-PDPs.

Noncontributory or deemed wage credits. Wages and wages in kind that were not subject to the HI tax but are deemed as having been. Deemed wage credits exist for the purposes of (i) determining HI eligibility for individuals who might not be eligible for HI coverage without payment of a premium were it not for the deemed wage credits; and (ii) calculating reimbursement due the HI trust fund from the general fund of the Treasury. The first purpose applies in the case of providing coverage to persons during the transitional periods when HI began and when it was expanded to cover Federal employees; both purposes apply in the cases of military service wage credits and deemed wage credits granted for the internment of persons of Japanese ancestry during World War II.

Old-Age, Survivors, and Disability Insurance (OASDI). The Social Security programs that pay for (i) monthly cash benefits to retired-worker (old-age) beneficiaries, their spouses and children, and survivors of deceased insured workers (OASI); and (ii) monthly cash benefits to disabled-worker beneficiaries and their spouses and children, and for providing rehabilitation services to the disabled (DI).

Open-group population. Includes all persons who will ever participate in the program as either taxpayers or beneficiaries, or both. See also *Closed-group population*.

Outpatient hospital. Part of the hospital providing services covered by SMI Part B, including services in an emergency room or outpatient clinic, ambulatory surgical procedures, medical supplies such as splints, laboratory tests billed by the hospital, etc.

Part A. The Medicare Hospital Insurance trust fund.

Part A premium. A monthly premium paid by or on behalf of individuals who wish for and are entitled to voluntary enrollment in Medicare HI. These individuals are those who are aged 65 and older, are uninsured for Social Security or Railroad Retirement, and do not otherwise meet the requirements for entitlement to Part A. Disabled individuals who have exhausted other entitlement are also qualified. These individuals are those not now entitled but who have been entitled under section 226(b) of the Act, who continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because the individuals had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Act).

Part B. The account within the Medicare Supplementary Medical Insurance trust fund that pays for a portion of the costs of physician services, outpatient hospital services, and other related medical and health services for voluntarily enrolled aged and disabled individuals.

Part B premium. The monthly amount paid by those individuals who have voluntarily enrolled in Part B. Most enrollees pay the standard premium amount, which currently represents approximately 25 percent of the average program costs for an aged beneficiary. Beneficiaries with high income are also required to pay an income-related monthly adjustment amount starting in 2007, and those who enroll late are required to pay a penalty. In addition, beneficiaries who are affected by the hold-harmless provision pay a lower premium. See section V.E for more details about the Part B premium.

Part C. See *Private Health Plans*.

Part D. The account within the Medicare Supplementary Medical Insurance trust fund that pays private plans to provide prescription drug coverage.

Pay-as-you-go financing. A financing scheme in which taxes are scheduled to produce just as much income as required to pay current benefits, with trust fund assets built up only to the extent needed to prevent depletion of the fund by random fluctuations.

Payroll taxes. Taxes levied on the gross wages of employees and net earnings of self-employed workers.

PDP regions. Regional areas that are fully serviced by prescription drug plans.

Peer Review Organization (PRO). A group of practicing physicians and other health care professionals paid by the Federal Government to review the care given to Medicare patients. Starting in 2002, these organizations are called Quality Improvement Organizations.

Percentile. A number that corresponds to one of the equal divisions of the range of a variable in a given sample and that characterizes a value of the variable as not exceeded by a specified percentage of all the values in the sample. For example, a score higher than 97 percent of those attained is said to be in the 97th percentile.

Prescription Drug Plans (PDPs). Stand-alone prescription drug plans offered to beneficiaries in traditional fee-for-service Medicare and to beneficiaries in Medicare Advantage plans that do not offer a prescription drug benefit.

Present value. The present value of a future stream of payments is the lump-sum amount that, if invested today, together with interest earnings would be just enough to meet each of the payments as it fell due. At the time of the last payment, the invested fund would be exactly zero.

Private Health Plans. Plans offered by private companies that contract with Medicare to provide coverage for Part A and Part B services. Medicare Advantage plans, cost plans, and Program of All-Inclusive Care for the Elderly (PACE) plans are all private health plans.

Projected baseline. A scenario that includes an override of the provisions of the sustainable growth rate (SGR) payment system and an assumed increase in the physician fee schedule equal to the average SGR override over the 10-year period ending with March 31, 2015.

Projection error. Degree of variation between estimated and actual amounts.

Prospective payment system (PPS). A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

Provider. Any organization, institution, or individual who provides health care services to Medicare beneficiaries. Hospitals (inpatient services), skilled nursing facilities, home health agencies, and hospices are the providers of services covered under Medicare Part A. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

Quality Improvement Organization (QIO). See *Peer Review Organization*.

Quinquennial military service determination and adjustments. Prior to the Social Security Amendments of 1983, quinquennial determinations (that is, estimates made once every 5 years) were made of the costs arising from the granting of deemed wage credits for military service prior to 1957; annual reimbursements were made from the general fund of the Treasury to the HI trust fund for these costs. The Social Security Amendments of 1983 provided for (i) a lump-sum transfer in 1983 for (a) the costs arising from the pre-1957 wage credits, and (b) amounts equivalent to the HI taxes that would have been paid on the deemed wage credits for military service for 1966 through 1983, inclusive, if such credits had been counted as covered earnings; (ii) quinquennial adjustments to the pre-1957 portion of the 1983 lump-sum transfer; (iii) general fund transfers equivalent to HI taxes on military deemed wage credits for 1984 and later, to be credited to the fund on July 1 of each year; and (iv) adjustments as deemed necessary to any previously transferred amounts representing HI taxes on military deemed wage credits.

Railroad Retirement. A Federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Ratebook. See *Medicare Advantage ratebook*.

Real-wage differential. The difference between the percentage increases, before rounding, in (i) the average annual wage in covered employment, and (ii) the average annual CPI.

Reasonable-cost basis. The calculation to determine the reasonable cost incurred by individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of

providers, and excluding any costs that are unnecessary in the efficient delivery of services covered by a health insurance program.

Reinsurance subsidy. Payments to the prescription drug plans in the amount of 80 percent of drug expenses that exceed the annual out-of-pocket threshold.

Residual factors. Factors other than price, including volume of services, intensity of services, and age/sex changes.

Risk corridor. Triggers that are set to protect Part D prescription drug plans from unexpected losses and that allow the government to share in unexpected gains.

Self-employment. Operation of a trade or business by an individual or by a partnership in which an individual is a member.

Self-Employment Contributions Act (SECA). Provision authorizing taxes on the net income of most self-employed persons to provide for OASDI and HI.

Sequester. The reduction of funds to be used for benefits or administrative costs from a Federal account, based on the legislated requirements.

Short range. The next 10 years.

Skilled nursing facility (SNF). An institution that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or that is engaged in the rehabilitation of injured, disabled, or sick persons.

SNF coinsurance. For the 21st through 100th day of extended care services in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-eighth of the inpatient hospital deductible.

Social Security Act. Public Law 74-271, enacted on August 14, 1935, with subsequent amendments. The Social Security Act consists of 20 titles, four of which have been repealed. The HI and SMI trust funds are authorized by Title XVIII of the Social Security Act.

Special public-debt obligation. Securities of the U.S. Government issued exclusively to the OASI, DI, HI, and SMI trust funds and other Federal trust funds. Sections 1817(c) and 1841(a) of the Social

Security Act provide that the public-debt obligations issued for purchase by the HI and SMI trust funds, respectively, shall have maturities fixed with due regard for the needs of the funds. The usual practice in the past has been to spread the holdings of special issues, as of every June 30, so that the amounts maturing in each of the next 15 years are approximately equal. Special public-debt obligations are redeemable at par at any time.

Spell of illness. A period of consecutive days, beginning with the first day on which a beneficiary is furnished inpatient hospital or extended care services, and ending with the close of the first period of 60 consecutive days thereafter in which the beneficiary is in neither a hospital nor a skilled nursing facility.

Standard prescription drug coverage. Part D prescription drug coverage that includes a deductible, coinsurance up to an initial coverage limit, and protection against high out-of-pocket expenditures by having reduced coinsurance provisions for individuals exceeding the out-of-pocket threshold.

Stochastic model. An analysis involving a random variable. For example, a stochastic model may include a frequency distribution for one assumption. From the frequency distribution, possible outcomes for the assumption are selected randomly for use in an illustration.

Summarized cost rate. The ratio of the present value of expenditures to the present value of the taxable payroll for the years in a given period. In this context, the expenditures are on an incurred basis and exclude costs for those uninsured persons for whom payments are reimbursed from the general fund of the Treasury, and for voluntary enrollees, who pay a premium in order to be enrolled. The summarized cost rate includes the cost of reaching and maintaining a target trust fund level, known as a contingency fund ratio. Because a trust fund level of about 1 year's expenditures is considered to be an adequate reserve for unforeseen contingencies, the targeted contingency fund ratio used in determining summarized cost rates is 100 percent of annual expenditures. Accordingly, the summarized cost rate is equal to the ratio of (i) the sum of the present value of the outgo during the period, plus the present value of the targeted ending trust fund level, plus the beginning trust fund amount, to (ii) the present value of the taxable payroll during the period.

Summarized income rate. The ratio of (i) the present value of the tax revenues incurred during a given period (from both payroll taxes

and taxation of OASDI benefits), to (ii) the present value of the taxable payroll for the years in the period.

Supplemental prescription drug coverage. Coverage in excess of the standard prescription drug coverage.

Supplementary Medical Insurance (SMI). The Medicare trust fund composed of the Part B account, the Part D account, and the Transitional Assistance Account. The Part B account pays for a portion of the costs of physician services, outpatient hospital services, and other related medical and health services for voluntarily enrolled aged and disabled individuals. The Part D account pays private plans to provide prescription drug coverage, beginning in 2006. The Transitional Assistance Account paid for transitional assistance under the prescription drug card program in 2004 and 2005.

Sustainable growth rate. A system for establishing goals for the rate of growth in Medicare Part B expenditures for physician services.

Tax rate. The percentage of taxable earnings, up to the maximum tax base, that is paid for the HI tax. Currently, the percentages are 1.45 for employees and employers, each. The self-employed pay 2.9 percent.

Taxable earnings. Taxable wages and/or self-employment income under the prevailing annual maximum taxable limit.

Taxable payroll. A weighted average of taxable wages and taxable self-employment income. When multiplied by the combined employee-employer tax rate, it yields the total amount of taxes incurred by employees, employers, and the self-employed for work during the period.

Taxable self-employment income. Net earnings from self-employment—generally above $400 and below the annual maximum taxable amount for a calendar or other taxable year—less any taxable wages in the same taxable year.

Taxable wages. Wages paid for services rendered in covered employment up to the annual maximum taxable amount.

Taxation of benefits. Beginning in 1994, up to 85 percent of an individual's or a couple's OASDI benefits is potentially subject to Federal income taxation under certain circumstances. The revenue

derived from taxation of benefits in excess of 50 percent, up to 85 percent, is allocated to the HI trust fund.

Taxes. See *Payroll taxes*.

Term insurance. A type of insurance that is in force for a specified period of time.

Test of Long-Range Close Actuarial Balance. The conditions required to meet this test are as follows: (i) the trust fund satisfies the short-range test of financial adequacy; and (ii) the trust fund ratios stay above zero throughout the 75-year projection period, such that benefits would be payable in a timely manner throughout the period. This test is applied to HI trust fund projections made under the intermediate assumptions.

Test of Short-Range Financial Adequacy. The conditions required to meet this test are as follows: (i) If the trust fund ratio for a fund exceeds 100 percent at the beginning of the projection period, then it must be projected to remain at or above 100 percent throughout the 10-year projection period; (ii) alternatively, if the fund ratio is initially less than 100 percent, it must be projected to reach a level of at least 100 percent within 5 years (and not be depleted at any time during this period), and then remain at or above 100 percent throughout the rest of the 10-year period. This test is applied to HI trust fund projections made under the intermediate assumptions.

Transitional assistance. An interim benefit for 2004 and 2005 that provided up to $600 per year to assist low-income beneficiaries who had no drug insurance coverage with prescription drug purchases. This benefit also paid the enrollment fee in the Medicare Prescription Drug Discount Card program.

Transitional Assistance Account. The separate account within the SMI trust fund that managed revenues and expenditures for the transitional assistance drug benefit in 2004 and 2005.

Trust fund. Separate accounts in the U.S. Treasury, mandated by Congress, whose assets may be used only for a specified purpose. For the HI and SMI trust funds, monies not withdrawn for current benefit payments and administrative expenses are invested in interest-bearing Federal securities, as required by law; the interest earned is also deposited in the trust funds.

Trust fund ratio. A short-range measure of the adequacy of the HI and SMI trust fund level; defined as the assets at the beginning of the year expressed as a percentage of the outgo during the year.

Uninsured beneficiaries. HI beneficiaries who do not have 40 quarters of covered earnings but are entitled to HI coverage either because (i) they were deemed additional wage credits during the transitional periods when the HI program began or when it was expanded to cover Federal employees or (ii) they pay a monthly premium that is intended to cover their full cost. See *Part A premium*.

Unit input intensity allowance. The amount added to, or subtracted from, the hospital input price index to yield the prospective payment system update factor.

Valuation period. A period of years that is considered as a unit for purposes of calculating the status of a trust fund.

Voluntary enrollees. Certain individuals, aged 65 or older or disabled, who are not otherwise entitled to Medicare and who opt to obtain coverage under Part A by paying a monthly premium.

Year of depletion. The first year in which a trust fund is unable to pay full benefits when due because the assets of the fund are depleted.

TABLES

FIGURES

J. STATEMENT OF ACTUARIAL OPINION

It is my opinion that (1) the techniques and methodology used herein to evaluate the financial status of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund are based upon sound principles of actuarial practice and are generally accepted within the actuarial profession; and (2) with the important caveats noted below, the principal assumptions used and the resulting actuarial estimates are, individually and in the aggregate, reasonable for the purpose of evaluating the financial status of the trust funds, taking into consideration the past experience and future expectations for the population, the economy, and the program. I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

In past reports, the Board of Trustees has emphasized the virtual certainty that actual Part B expenditures will exceed the projections under current law due to further legislative action to avoid substantial reductions in the Medicare physician fee schedule. Current law would require a physician fee reduction of almost 21 percent on April 1, 2015—an implausible expectation.

Since lawmakers have overridden these scheduled reductions each year since 2003, the Trustees have changed the basis of their projections of Part B expenditures from current law to a projected baseline, which includes an assumption that the physician payment updates will equal the increase averaged over the last 10 years. This change results in a far more reasonable expectation of Medicare expenditures than occurs under current law. The projected baseline estimates are summarized throughout the main body of this report, while current-law estimates are included in appendix C.

The Affordable Care Act is making important changes to the Medicare program that are designed, in part, to substantially improve its financial outlook. While the ACA has been successful in reducing many Medicare expenditures to date, there is a strong possibility that certain of these changes will not be viable in the long range. Specifically, the annual price updates for most categories of non-physician health services will be adjusted downward each year by the growth in economy-wide productivity. The ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot

improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services.

Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. By the end of the long-range projection period, Medicare prices for many services would be less than half of their level without consideration of the productivity price reductions. Before such an outcome would occur, lawmakers would likely intervene to prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result. Overriding the productivity adjustments, as lawmakers have done repeatedly in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

I encourage readers to review the illustrative alternative projection. This scenario includes price update assumptions that were constructed to be consistent with historic levels of productivity in the health sector, and therefore it provides the potential magnitude of the understatement of Medicare costs relative to the projected baseline. The illustrative alternative scenario is summarized in appendix V.C of this report, along with the projection under current law. Additional details about the illustrative alternative projection are available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2014TRAlternativeScenario.pdf.

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