Medicare Solvency
As an increasing proportion of the U.S. population ages and enrolls in Medicare, the program will face concrete funding challenges. These challenges are the result of the reality that over the next 20 years the percentage of the population that will be over age 65 and receiving Medicare benefits will nearly double, but the growth in the number of workers paying taxes to fund Medicare will not keep up.

In 2010, 47 million beneficiaries, representing about 13 percent of the population, received Medicare benefits and 3.4 workers paid taxes to support each beneficiary; by 2030, 80 million Medicare beneficiaries, equal to approximately 20 percent of the population, will receive benefits, but only 2.3 taxpayers, on average, will pay taxes to support each beneficiary, according to the 2012 Medicare Trustees Report.

The National Academy of Social Insurance, a nonprofit and nonpartisan organization made up of experts on social insurance, noted in an issue brief that the “rate of growth in program costs will place increasing financial demands on both beneficiaries (to pay the premiums) and taxpayers (to provide the general revenues).”

In addition, in 2012, people age 65 can expect to live an additional 19.2 years, a substantial increase from a total life expectancy of an average of 70 years in 1965, when Medicare was created. While this improvement in life expectancy is something to be celebrated, it means that growing numbers of people will receive Medicare benefits for longer, squeezing fewer workers per beneficiary with more taxes to finance them.

Finally, Medicare spending per beneficiary also increases with age. For example, in 2008, the average spending for a beneficiary age 85 or older enrolled in Traditional Medicare was $13,219, which is nearly twice the average cost of $7,626 per beneficiary between the ages of 65 and 74, according to MedPac’s 2012 report, released June 2012. In 2030, the earliest of the baby boom generation will start to cross that age threshold, creating a Medicare beneficiary population that will be substantially older, and therefore likely to be sicker and more expensive. According to the Centers for Disease Control, the number of persons older than 80 years old is expected to more than double, from 9.3 million in 2000 to 19.5 million in 2030. As a result, Medicare’s spending growth after 2030 will accelerate even faster, although the research on the potential impact cannot be definitive.

The result of an aging population, with an expected increase in the volume and intensity of medical services, is that Medicare spending will rise at a rate faster than the
general economy, as measured by the gross domestic product (GDP). In 2012, Medicare spending grew at a rate of 3.5 percent, according to the CBO, while the GDP grew by 3.1 percent; wages by 1.9 percent; and inflation, as measured by the Consumer Price Index (CPI), by 1.7 percent. This increase is despite the fact that Medicare's per capita spending is increasing at roughly the same rate as other health care spending throughout the country.

Looking forward, the Office of the Actuary at the Centers for Medicare & Medicaid Services predicts that Medicare spending will rise much faster. “Medicare spending is projected to increase at an average annual rate of 6.8 percent for 2015 through 2021. This rate is the net result of fast enrollment growth as more baby boomers become eligible for Medicare; provisions of the Affordable Care Act that call for slower growth in fee-for-service provider payment updates; lower payments to private Medicare Advantage health plans; and the 2-percent sequestration reduction in the Budget Control Act.”

As a result, health care spending will consume an ever-greater share of the nation’s economic output and that Medicare will consume an ever-greater share of the federal budget. In 2020, it is expected that the government will spend more than $900 billion on Medicare and that Medicare’s share of the federal budget will increase from to nearly 20 percent, up from $524 billion and 15.1 percent, respectively, of the federal budget in the 2010.

**Insolvency Is Not Bankruptcy**

As long as people are working and paying taxes, Medicare will always have funds. Neither the Hospital Insurance (HI) Trust Fund, which primarily finances Medicare Part A, nor the Supplemental Medical Insurance (SMI) Trust Fund, which finances physician services and other services under Part B and the Part D prescription drug benefit, has ever run out of money. However, it is possible for some parts of Medicare to spend more than it receives in tax revenue and, in doing so, gradually exhaust the Medicare trust fund balances.

While politicians often claim that insolvency predictions mean that Medicare will go “bankrupt,” this is not true. There is a difference between going “bankrupt” and insolvency. The former means there is no money left in the fund, whereas insolvency is the inability of incoming revenues and remaining trust fund balances to cover 100 percent of Medicare costs.

Each year, the Medicare Board of Trustees, which oversees Medicare’s financial operations, performs a rigorous analysis of Medicare’s financial status and releases a report that includes estimates of the percentage of spending that revenues can cover,
as well as predictions of when the Medicare trust funds may be exhausted, causing the program to become insolvent.

However, only the HI Trust Fund can be depleted, as it is legislatively allowed to spend more than it receives in Medicare payroll tax revenue in any given year. Thus, conversations about Medicare “going bankrupt” center on the HI Trust Fund, not the SMI Trust Fund, because the law prevents the SMI fund from having excess revenue or shortfalls. As a result, beneficiary premiums and general revenue contributions to the SMI Trust Fund automatically adjust each year in order to prevent a fund imbalance.

In 2012 the HI Trust Fund ran a deficit of $16 billion, spending $265 billion but only receiving revenue of $249 billion from the Medicare payroll tax and trust fund interest. In order to make up the difference, the HI Trust Fund drew on its balances, yet in doing so it is gradually depleting the fund. If the HI Trust Fund continues to run a deficit and spending continues to exceed revenues, then the fund can be entirely depleted. In that case, payments to hospitals and physicians can still be made, but only from current Medicare payroll tax contributions, which would be sufficient to cover only a percentage of payments.

Currently, the Board of Trustees projects that the HI Trust Fund will be exhausted in 2024 under intermediate cost-growth assumptions. If costs grow at a higher rate, the HI Trust Fund could be exhausted in 2017; under a low-cost alternative the trust fund would continue to grow indefinitely and would not face insolvency. Prior to the passage of the 2010 Affordable Care Act, the Medicare Trustees predicted that the HI Trust Fund would be insolvent by 2016. After the passage of the ACA, which includes up to $716 billion in Medicare spending cuts between 2013 and 2022, the trustees pushed back this date.

The date of projected insolvency has varied widely throughout the years because of the uncertainty surrounding health care cost growth estimates, as well as changing economic, political and demographic projections. A 2009 Congressional Research Service Report said the HI Trust Fund has faced a projected budget shortfall nearly from its inception in 1966. In 1970, the projected insolvency of the HI Trust Fund was 1972. Congress has, in the past, regularly taken steps to curtail Medicare program spending in order to balance revenues and outlays, and that is likely to continue.

Before Medicare can become insolvent, there are two warnings to prompt Congress to act. First, Medicare Trustees are required under the Medicare Modernization Act of 2003 (MMA) to estimate when program expenditures will exceed dedicated revenue. If the actuaries determine a threshold will be reached within seven years, an “excess general revenue funding” alarm is issued. This is known as the “Medicare Solvency Trigger.”
Second, if that determination is made for two consecutive years, it sets off what is known as a “Medicare Funding Warning.” The aim of this warning is to prompt the president and Congress to take action, whether to revise benefits, adjust controls on costs or some of both. It is an effort to limit the amount of money from general revenues that finance Medicare and is thought to be a cost-control measure.

Should Congress and the president fail to act, however, there are currently no federal statutory provisions to govern what would happen if Medicare were unable to pay all of its bills. Thus, Medicare will remain available for seniors, but if spending continues to exceed revenues it is likely it will provide fewer benefits, many elected officials and experts say.