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Medicare: Insolvency Projections

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Summary

Medicare is the nation's health insurance program for persons age 65 and older and certain disabled persons. Medicare consists of four distinct parts: Part A (Hospital Insurance, or HI); Part B (Supplementary Medical Insurance, or SMI); Part C (Medicare Advantage, or MA); and Part D (the outpatient prescription drug benefit). The Part A program is financed primarily through payroll taxes levied on current workers and their employers; these are credited to the HI trust fund. The Part B program is financed through a combination of monthly premiums paid by current enrollees and general revenues. Income from these sources is credited to the SMI trust fund. As an alternative, beneficiaries can choose to receive all their Medicare services through private health plans under the MA program; payment is made on their behalf in appropriate parts from the HI and SMI trust funds. The Part D drug benefit is funded through a separate account in the SMI trust fund and is financed through general revenues, state contributions, and beneficiary premiums. The HI and SMI trust funds are overseen by a board of trustees that makes an annual report to Congress concerning the financial status of the funds.

Almost from its inception, the HI trust fund has faced a projected shortfall. The insolvency date has been postponed a number of times, primarily due to legislative changes that have had the effect of restraining growth in program spending. The 2014 Medicare Trustees report projects that, under intermediate assumptions, the HI trust fund will become insolvent in 2030, four years later than estimated in the prior year's report.

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Introduction

Medicare is a federal insurance program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act as a federal entitlement program to provide health insurance to individuals 65 and older, and has been expanded over the years to include permanently disabled individuals under 65.

Medicare consists of four distinct parts, A through D. Part A covers hospital services, skilled nursing facility (SNF) services, home health visits, and hospice services. Most persons aged 65 and older are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement systems. Part B covers a broad range of medical services, including physician services, laboratory services, durable medical equipment, and outpatient hospital services. Enrollment in Part B is voluntary; however, most beneficiaries with Part A also enroll in Part B. Part C, Medicare Advantage (MA), provides private plan options, such as managed care, for beneficiaries who are enrolled in both Parts A and B. Part D provides optional outpatient prescription drug coverage.[1]

Medicare expenditures are driven by a variety of factors, including the level of enrollment, the complexity of medical services provided, health care inflation, and life expectancy. In 2013, Medicare provided benefits to about 52 million persons at an estimated total cost of $583 billion.

The Medicare program has two separate trust funds—the Hospital Insurance (HI) trust fund and Supplementary Medical Insurance (SMI) trust fund. The Part A program, which is financed mainly through payroll taxes levied on current workers, is accounted for through the HI trust fund. The Parts B and D programs, which are primarily funded through general revenue and beneficiary premiums, are accounted for through the SMI trust fund.[2] Both funds are maintained by the Department of the Treasury and are overseen by a board of trustees that reports annually to Congress concerning the funds' financial status.[3] Financial projections are made using economic assumptions based on current law, including estimates of consumer price index (CPI), workforce size, wage increases, and life expectancy.

Almost from its inception, the HI trust fund has faced a projected shortfall and eventual insolvency. Because of the way it is financed, the SMI trust fund cannot become insolvent; however, the Medicare Trustees continue to express concerns about the rapid growth in SMI costs.[4]

[1] For additional information on the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

[2] Payments are made for beneficiaries enrolled in Part C in appropriate portions from the HI and SMI trust funds.

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

[4] For further information on Medicare financing, see CRS Report R43122, *Medicare Financial Status: In Brief*, and CRS Report R41436, *Medicare Financing*, both by Patricia A. Davis.

Medicare Hospital Insurance (HI) Financing

Similar to the Social Security system, the HI portion of Medicare was designed to be self-supporting and is financed through dedicated sources of income rather than relying on general tax revenues. The primary source of income credited to the HI trust fund is *payroll taxes* paid by employees and employers; each pays a tax of 1.45% on earnings. The self-employed pay 2.9%. Unlike Social Security, there is no upper limit on earnings subject to the tax.[5] The Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) imposes an additional tax of 0.9% on high-income workers with wages over $200,000 for single filers, and $250,000 for joint filers effective for taxable years beginning in 2013.[6]

Additional income to the HI trust fund consists of premiums paid by voluntary enrollees who are not entitled to premium-free Medicare Part A through their (or their spouse's) work in covered employment; a portion of the federal income taxes paid on Social Security benefits;[7] and interest on federal securities held by the trust fund.

What Is the HI Trust Fund?

The HI trust fund is a financial account in the U.S. Treasury into which all income to the Part A portion of the program is credited, and from which all benefits and associated administrative costs of the program are paid. The trust fund is solely an accounting mechanism—there is no actual transfer of money into and out of the fund.[8]

HI operates on a "pay-as-you-go" basis; the annual revenues to the HI trust fund, primarily the taxes paid by current workers and their employers, are used to pay Part A benefits for today's Medicare beneficiaries. When the government receives Medicare revenues (payroll taxes), income is credited by the Treasury to the appropriate trust fund in the form of special issue interest-bearing government securities.[9] (Interest on these securities is also credited to the trust fund.) The tax income exchanged for these securities then goes into the general fund of the Treasury and is indistinguishable from other cash in the general fund; this cash may be used for any government spending purpose. When payments for Medicare Part A services are made, the payments are paid out of the general treasury and a corresponding amount of securities is deleted from (written off) the HI trust fund.

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[5] Prior to 1991, the upper limit on taxable earnings was the same as for Social Security. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) raised the limit in 1991 to $125,000. Under automatic indexing provisions, the maximum was increased to $130,200 in 1992 and $135,000 in 1993. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93, P.L. 103-66) eliminated the upper limit entirely beginning in 1994.

[6] See archived CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Janemarie Mulvey, for additional detail.

[7] Since 1994, the HI fund has had an additional funding source—OBRA 93 increased the maximum amount of Social Security benefits subject to income tax from 50% to 85% and provided that the additional revenues would be credited to the HI trust fund.

[8] There are about 200 federal trust funds. For additional information on how federal trust funds operate within the context of the federal budget, see CRS Report R41328, *Federal Trust Funds and the Budget*, by Mindy R. Levit.

[9] Unlike marketable securities, special issues can be redeemed at any time at face value. Investment in special issues gives the trust funds the same flexibility as holding cash.

In years in which the trust fund spends less than the income it receives, it has a *cash-flow surplus*; the trust fund securities exchanged for any income in excess of spending show up as "assets" on the financial accounting balance sheets and are available to the system to meet future obligations. The trust fund surpluses are not reserved for future Medicare benefits, but are simply bookkeeping entries that indicate how much Medicare has lent to the Treasury (or alternatively, what is owed to Medicare by the Treasury). From a unified budget perspective, these "assets" represent future budget obligations and are treated as liabilities.

If, in a given year, the trust fund spends more than the income it receives, it has a *cash-flow deficit*. In deficit years, Medicare can redeem any securities accumulated in previous years (including interest). When the securities are redeemed, the government needs to raise the resources necessary to pay for the securities, and the monies are transferred from the Treasury's general fund to the HI trust fund. When the assets credited to the trust fund reach zero, the fund is deemed *insolvent*.

(See **Appendix A** for a discussion of recent and projected HI cash flows, and data on historical and projected HI operations through 2023.)

History of HI Solvency Projections

The HI trust fund has never become insolvent. The Medicare Board of Trustees projected insolvency for the HI fund beginning with the 1970 report, at which time the HI trust fund was expected to become insolvent in only two years. (See **Table 1** and **Figure 1**.) The insolvency date has been postponed a number of times since the beginning of Medicare through a variety of methods. For example, the payroll tax rate has been adjusted periodically by Congress as one of the mechanisms to maintain the financial adequacy of the trust fund. (See **Appendix B** for historical payroll tax rates.)

Other legislative changes have been made at various times to slow the growth in HI program spending; generally, these measures were part of larger budget reconciliation laws that attempted to restrain overall federal spending. To illustrate, in the mid-1990s, efforts to curtail Medicare spending intensified as Congress considered legislation to bring the entire federal budget into balance and culminated in the passage of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). In early 1997, the Medicare Trustees had projected that the HI trust fund would become insolvent within four years, in 2001. Following the enactment of BBA 97, significant improvements were made in the short-term projections over the next few years. The new projections reflected a number of factors, including lower expected expenditures as a result of changes made by BBA 97 (primarily resulting from modifications in Medicare Part C payments,[10] and the establishment of prospective payment systems for certain Part A providers), continuing efforts to combat fraud and abuse, and strong economic growth which was expected to generate more revenues to the trust fund from payroll taxes.

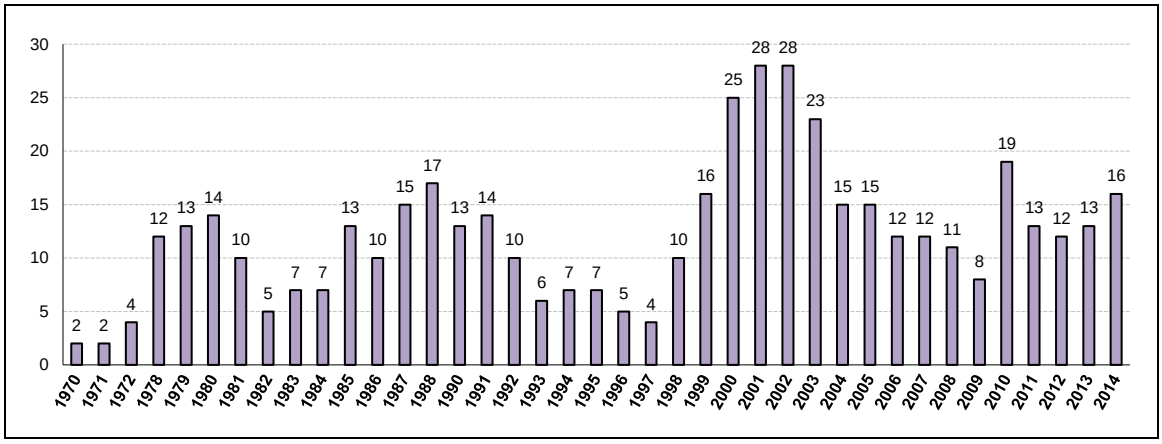
[10] BBA 97 established the "Medicare+Choice" program under Part C. Medicare Part C was changed to "Medicare Advantage" by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173).

Table 1. Year of Projected Insolvency of the Hospital Insurance Trust Fund in Past and Current Trustees Reports

Year of Trustees report	Year of projected insolvency	Year of Trustees report	Year of projected insolvency	Year of Trustees report	Year of projected insolvency
1970	1972	**1986**	1996	**2001**	2029
1971	1973	**1986** amended	1998	**2002**	2030
1972	1976	**1987**	2002	**2003**	2026
1973	none indicated	**1988**	2005	**2004**	2019
1974	none indicated	**1989**	none indicated	**2005**	2020
1975	late 1990s	**1990**	2003	**2006**	2018
1976	early 1990s	**1991**	2005	**2007**	2019
1977	late 1980s	**1992**	2002	**2008**	2019
1978	1990	**1993**	1999	**2009**	2017
1979	1992	**1994**	2001	**2010**	2029
1980	1994	**1995**	2002	**2011**	2024
1981	1991	**1996**	2001	**2012**	2024
1982	1987	**1997**	2001	**2013**	2026
1983	1990	**1998**	2008	**2014**	2030
1984	1991	**1999**	2015		
1985	1998	**2000**	2025		

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

Figure 1. Projected Number of Years Until HI Insolvency



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

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

There were concerns that the savings achieved through the enactment of BBA 97 were greater than intended at the time of enactment and had unintended consequences for health care providers. As a result of these concerns, Congress subsequently enacted two measures (the Balanced Budget Refinement Act of 1999 [BBRA 99, P.L. 106-113] and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 [BIPA 2000, P.L. 106-554]). These measures were designed to reverse some of the BBA 97 spending reductions. Despite enactment of both BBRA 99 and BIPA 2000, which increased program spending, the 2001 and 2002 Trustees reports continued to delay the projected insolvency date. These improvements in solvency projections reflected both stronger-than-expected economic growth and lower-than-expected program costs due to lower projected enrollment in Medicare Part C, heightened anti-fraud and abuse initiatives, and lower-than-expected increases in health care costs.

The 2003 report projections, however, shifted direction. Its projected insolvency date was 2026, four years earlier than the 2030 date projected in the 2002 report. The revision was due to lower-than-expected HI-taxable payroll and higher-than-expected hospital expenditures. In the next year, the 2004 report projected that the HI trust fund would become insolvent in 2019, seven years earlier than projected in 2003. The revision of the projected insolvency date was due to a number of factors, including slow wage growth (on which payroll taxes are based) and faster growth in inpatient hospital benefits. In addition, the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173) added significantly to HI costs, primarily through higher payments to rural hospitals and to private plans under the MA program.[11]

The 2005 Trustees report projected that the HI trust fund would become insolvent one year later than projected in 2004, in 2020. The revision reflected slightly higher income and slightly lower costs in 2004 than previously estimated. The 2006 report moved the insolvency date forward again, to 2018. The revision reflected expectations of slightly higher costs and increased utilization of HI services.

Both the 2007 and 2008 reports projected a 2019 insolvency date, though the 2008 report indicated it would occur earlier in the year. The 2009 report moved the insolvency date forward to 2017, due primarily to the economic recession.

The 2010 Medicare Trustees report, issued subsequent to the enactment of the ACA, estimated that the combination of lower Part A costs[12] and higher payroll tax revenues expected as a result of the ACA would postpone the depletion of HI trust fund assets until 2029, 12 years later than the date projected in their 2009 report. Although the Medicare Trustees noted that the financial outlook for the Medicare program appeared to have improved as a result of the ACA, they cautioned that the projections in the report were more uncertain than normal, due to the potential for some of the expenditure reductions not to materialize. As such, the actuaries of the Centers for Medicare & Medicaid Services (CMS) issued a supplemental memorandum that explained and quantified the potentially higher costs than those estimated in the 2010 Trustees report.[13] This

[11] The Part D outpatient prescription drug program, which was created by MMA, is funded under SMI; the increased expenditures associated with this new benefit therefore had little impact on projections of Medicare (HI) solvency.

[12] The expected reductions were primarily due to productivity adjustments to Part A provider payment updates and reduced payments to Medicare Advantage plans.

[13] Memo from John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures Under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," August 5, 2010, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads//2010TRAlternativeScenario.pdf.

"illustrative alternative" projected that the HI trust fund would become insolvent in 2028, one year earlier than that projected in the 2010 Trustees report.

The 2011 Report of the Medicare Trustees projected that the HI trust fund would become insolvent in 2024, five years earlier than projected in the 2010 report. The worsening financial outlook was primarily due to lower than expected payroll taxes stemming from higher than expected unemployment and slow growth in wages in 2010. The 2012 Trustees Report projected the same 2024 insolvency date. The Trustees expected that income from payroll taxes would increase at a faster rate than expenditures through 2018 due to the projected economic recovery, the application of an additional 0.9% HI payroll tax for high-income workers beginning in 2013, and the 2% reduction in spending required by the Budget Control Act of 2011 (BCA, P.L. 112-25) from 2013 through 2021;[14] however, income was still expected to be insufficient to fully cover projected HI expenses during that period. The 2011 and 2012 "illustrative alternatives" also projected that the HI trust fund would become insolvent in 2024, although earlier in the year.[15]

In their 2013 report, the Trustees projected a somewhat better short-term outlook for the HI trust fund, and moved the insolvency date two years later than their 2012 estimate, to 2026. The improved projections were primarily due to lower than expected expenditures in 2012, the base year used to project future expenditures, and a larger than previously estimated impact of ACA payment methodology changes on Medicare Advantage costs.[16] The "illustrative alternative" projected trust fund insolvency date was the same as that under the current law scenario, 2026; however, the trust fund was expected to be depleted somewhat earlier in the year.

Current Insolvency Projections

In their 2014 report,[17] the Trustees project a somewhat better short-term outlook for the HI trust fund, and have therefore moved the insolvency date four years later than their 2013 estimate, to 2030 (from 2026 in the prior report). The 2014 Trustees report estimates that in the short term, expenditures will continue to exceed income through 2014, and that from 2015 through 2022, the fund will run a slight surplus. (See **Table A-1**.) Beyond 2022, expenditure growth is expected to again outpace growth in income. At that time, trust fund assets would be used to make up the difference between income and expenditures, until the assets are depleted in 2030. (See **Figure 2**.)

[14] Subsequent legislation extended the reductions for an additional two years, through FY2023. For additional information on the BCA and required spending reductions, see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan; and CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

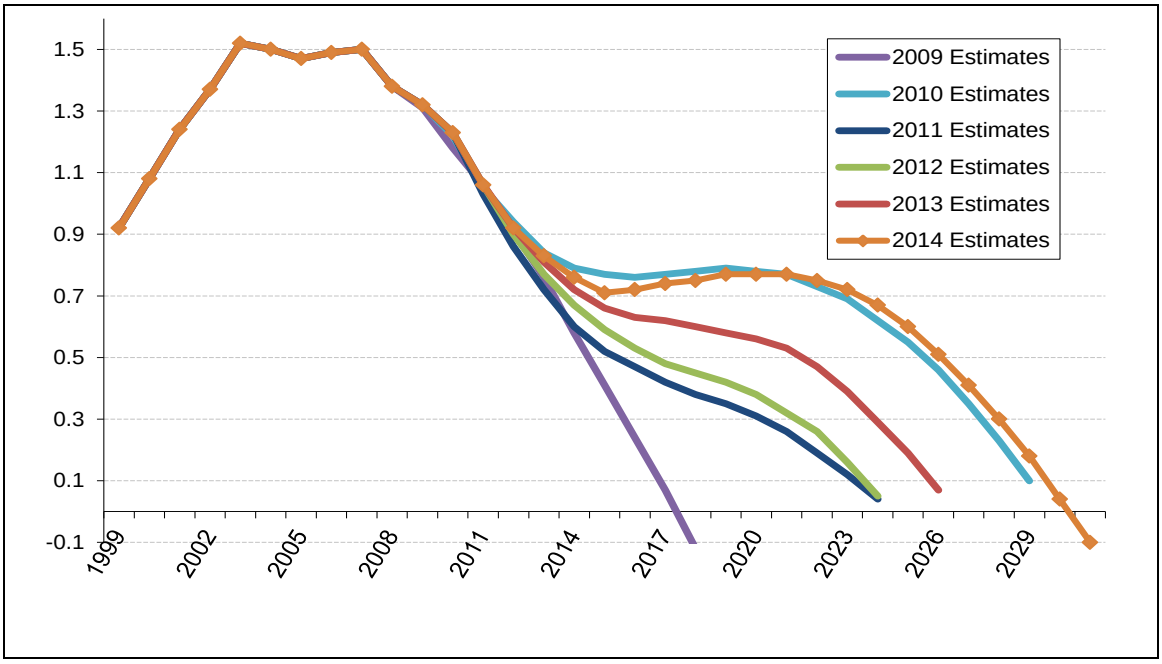
[15] The 2011 through 2014 alternative projections may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/alternativePartB.html.

[16] See CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by Patricia A. Davis.

[17] *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 28, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf.

Figure 2. HI Trust Fund Assets at Beginning of Year as a Percentage of Annual Expenditures

Estimates from 2009 - 2014 Trustees Reports



Sources: Data from the 2009 Medicare Trustees Report, Table II.E1, and Summaries of the 2010 through 2014 Annual Reports of the Social Security and Medicare Boards of Trustees, Chart D (2010 and 2011) and Chart E (2012, 2013 and 2014).

Similar to years 2010 through 2013, the CMS actuaries issued an illustrative alternative scenario that assumed that certain ACA changes that reduce Part A provider reimbursements would be made through 2019, and then gradually phased out starting in 2020.[18] This alternative projection suggests higher total Medicare spending levels than the report's baseline figures and a slightly earlier HI trust fund depletion date of 2029.

What Would Happen If the Fund Became Insolvent?

The practical function of the HI trust fund is that it permits the continued payment of bills in the event of a temporary financial strain (e.g., lower income or higher costs than expected) without requiring legislative action. As long as the HI trust fund has a balance (i.e., there are securities credited to the fund), the Treasury Department is authorized to make payments for Medicare Part A services. If the trust fund is not able to pay all of current expenses out of current income and accumulated trust fund assets, it is considered to be *insolvent*.[19]

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

[19] From time to time, it is reported that Medicare is on the verge of "bankruptcy," however, in the context of federal trust funds, this term is not meaningful. It is true that a trust fund's outgo can be greater than its income and trust funds can have a zero balance, but, unlike private businesses, the federal government is not in danger of "going out of (continued...)

To date, the HI trust fund has never become insolvent, and there are no provisions in the Social Security Act that govern what would happen if that were to occur. For example, there is no authority in law for the program to use general revenue to fund Part A services in the event of such a shortfall.

In their 2014 report, the Medicare Trustees project that the HI trust fund will be exhausted in 2030. At that time, HI would continue to receive tax income from which some benefits could be paid; however, funds would only be sufficient to pay for 85% of Part A expenses. Unless action is taken prior to that date to increase revenues or decrease expenditures (or some combination of the two), Congress may face a legislative decision regarding whether, and/or how, to provide for another source of funding (e.g., general revenues) to make up for these deficits.

Financing Issues

Much of the concern about the financial status of Medicare tends to focus on the HI trust fund date of insolvency when Medicare no longer has the authority to pay for Part A health care services in full. This focus can, however, detract from the larger issues confronting the Medicare program as a whole, and its current and future impact on the federal budget and on taxpayers. When viewed from the perspective of the entire federal budget, as the number of beneficiaries and per capita health care costs continue to grow, total Medicare spending obligations (HI and SMI spending combined) are expected to place increasing demands on federal budgetary resources. For example, changes to the physician sustainable growth rate (SGR) payment system to prevent scheduled cuts in Medicare payments to doctors beginning in April 2015 would require significant additional federal funding. However, because payments to physicians are made through the SMI trust fund, which is funded through premiums and general revenues, these additional expenditures would have little to no effect on estimates of Medicare solvency (which reflects only expected HI trust fund spending).

(...continued)

business" or having its assets seized by creditors. As noted, Congress has often taken actions to increase a trust fund's revenues or reduce its outgo when the Medicare HI trust fund has faced imminent insolvency.

Appendix A. Operation of the Hospital Insurance Trust Fund

Beginning in 2004, expenditures began exceeding *tax* income (from payroll taxes and from the taxation of Social Security benefits). Expenditures began to exceed *total* income (tax income plus all other sources of revenue) in 2008, and HI assets (the balance of the HI trust fund at the beginning of the year) were used to meet the portion of expenditures that exceeded income. Expenditures have exceeded income every year since then and are expected to continue doing so through 2014. Although the trust fund is projected to run a small surplus in years 2015 through 2022, after that time expenditures are expected to again exceed income, with trust fund assets making up the difference until the asset balance is depleted in 2030. At that time, the trust fund will no longer have sufficient funds to allow for the full payment of Part A expenditures (see **Table A-1** below for historical and projected Medicare financial data through 2023).

Table A-1. Operation of the Hospital Insurance Trust Fund, Calendar Years 1970-2023

($ in billions)

	Income			Expenditures			Trust Fund	
Year	Payroll Taxes	Interest, Transfers, Other[a]	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
Historical Data								
1970	$4.9	$1.2	$6.0	$5.1	$0.2	$5.3	$0.7	$3.2
1975	11.5	1.4	13.0	11.3	0.3	11.6	1.4	10.5
1980	23.8	2.1	26.1	25.1	0.5	25.6	0.5	13.7
1985	47.6	3.9	51.4	47.6	0.8	48.4	4.8	20.5
1990	72.0	8.4	80.4	66.2	0.8	67.0	13.4	98.9
1995	98.4	16.7	115.0	116.4	1.2	117.6	-2.6	130.3
2000	144.4	22.9	167.2	128.5	2.6	131.1	36.1	177.5
2001	152.0	22.7	174.6	141.2	2.2	143.4	31.3	208.7
2002	152.7	25.8	178.6	149.9	2.6	152.5	26.1	234.8
2003	149.2	26.5	175.8	152.1	2.5	154.6	21.2	256.0
2004	156.5	27.5	183.9	167.6	3.0	170.6	13.3	269.3
2005	171.4	28	199.4	180.0	2.9	182.9	16.4	285.8
2006	181.3	30.2	211.5	189.0	2.9	191.9	19.6	305.4
2007	191.9	31.9	223.7	200.2	2.9	203.1	20.7	326.0
2008	198.7	32	230.8	232.3	3.3	235.6	-4.7	321.3
2009	190.9	34.5	225.4	239.3	3.2	242.5	-17.1	304.2
2010	182.0	33.6	215.6	244.5	3.5	247.9	-32.3	271.9
2011	195.6	33.4	228.9	252.9	3.8	256.7	-27.7	244.2

	Income			Expenditures			Trust Fund	
Year	Payroll Taxes	Interest, Transfers, Other[a]	Total	Benefit Payments	Admin. Expenses	Total	Net Change	Balance at End of Year
2012	205.7	37.3	243.0	262.9	3.9	266.8	-23.8	220.4
2013	220.8	30.3	251.1	261.9	4.3	266.2	−15.0	205.4
Intermediate Estimate								
2014	221.6	34.3	255.9	265.0	4.5	269.5	−13.6	191.7
2015	245.2	36.8	281.9	265.0	5.0	269.9	12.0	203.8
2016	260.3	39.9	300.3	277.9	5.4	283.2	17.1	220.8
2017	276.6	43.9	320.4	293.4	5.8	299.2	21.2	242.0
2018	293.8	48.2	342.0	315.8	6.2	322.0	20.0	262.0
2019	310.0	52.8	362.9	335.6	6.6	342.3	20.6	282.6
2020	326.3	57.6	383.9	359.3	7.1	366.3	17.5	300.1
2021	342.7	62.2	404.9	384.3	7.5	391.9	13.0	313.2
2022	359.3	66.6	425.9	411.1	8.0	419.1	6.8	319.9
2023	375.8	71.3	447.0	438.7	8.5	447.2	−0.2	319.8

Source: 2014 Medicare Trustees Report, Table III.B4.

Notes: Sums may not equal totals due to rounding.

a. Includes income from the taxation of Social Security benefits, Railroad Retirement account transfers, premiums paid by voluntary enrollees, and interest.

Appendix B. Historical Payroll Tax Rates

Table B-1. Tax Rates and Maximum Tax Bases

		Tax rate (percentage of taxable earnings)	
Calendar Year	Maximum tax base	Employees and employers, each	Self-employed
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 and later	no limit	1.45	2.90

Source: 2014 Report of the Medicare Trustees, Table III.B2.

Notes: Beginning in 2013, workers pay an additional 0.9% of their earnings above $200,000 (those who file individual tax returns) or $250,000 (those who file joint tax returns).