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The Facts on Medicare Spending and Financing

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Key Facts

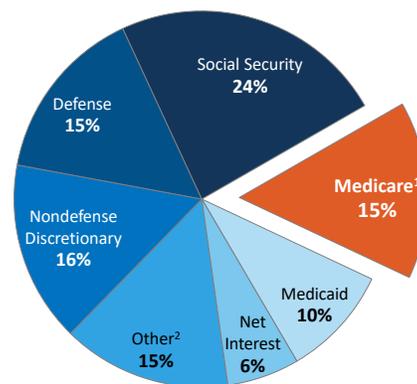
- Medicare spending was 15 percent of total federal spending in 2016, and is projected to rise to 17.5 percent by 2027.
- The Medicare Hospital Insurance (Part A) trust fund is projected to be depleted in 2029, one year later than the 2016 projection.
- Medicare’s actuaries project that the Independent Payment Advisory Board (IPAB) process will be triggered for the first time in 2021, four years later than their 2016 forecast.
- The share of Medicare benefit spending on hospital inpatient services fell by one-third between 2006 and 2016, while spending on Medicare Advantage private health plans doubled.
- Average annual growth in Medicare per capita spending growth was 1.3 percent between 2010 and 2016, down from 7.4 percent between 2000 and 2010.
- Medicare per capita spending is projected to grow at an average annual rate of 4.5 percent over the next ten years, slightly lower than the growth rate for private insurance.

Overview of Medicare Spending

Medicare, the federal health insurance program for 57 million people ages 65 and over and younger people with permanent disabilities, helps to pay for hospital and physician visits, prescription drugs, and other acute and post-acute care services. In 2016, spending on Medicare accounted for 15 percent of the federal budget (**Figure 1**). Medicare plays a major role in the health care system, accounting for 20 percent of total national health spending in 2015, 29 percent of spending on retail sales of prescription drugs, 25 percent of spending on hospital care, and 23 percent of spending on physician services.¹ This issue brief includes the most recent historical and projected Medicare spending data published in the [2017 annual report](#) of the Boards of Medicare Trustees from the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) and the [2017 Medicare baseline](#) and projections from the Congressional Budget Office (CBO).

Figure 1

Medicare as a Share of the Federal Budget, 2016



Total Federal Outlays, 2016: **\$3.9 trillion**
Net Federal Medicare Outlays, 2016: **\$588 billion**

NOTE: All amounts are for federal fiscal year 2016. ¹Consists of mandatory Medicare spending minus income from premiums and other offsetting receipts. ²Includes spending on other mandatory outlays minus income from offsetting receipts.
SOURCE: Congressional Budget Office, An Update to the Budget and Economic Outlook, 2017 to 2027 (June 2017).

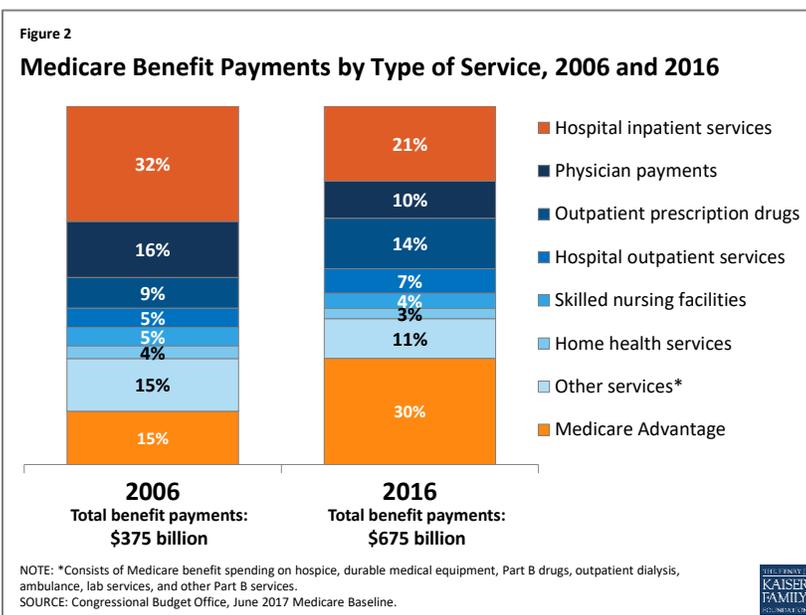
Historical Trends in Medicare Spending

TRENDS IN MEDICARE BENEFIT PAYMENTS

In 2016, Medicare benefit payments totaled \$675 billion, up from \$375 billion in 2006. The distribution of Medicare benefit payments has changed in significant ways over the past ten years (**Figure 2**).

Most notably, the share of total spending on hospital inpatient services declined by one-third between 2006 and 2016, from 32 percent to 21 percent, while payments to Medicare Advantage (private health plans which cover all Part A and Part B benefits) doubled, from 15 percent to 30 percent, as private plan enrollment has grown steadily since 2006. Thirty percent of benefit spending was for Medicare Advantage plans; in 2017, [33 percent of Medicare beneficiaries](#) are enrolled in

Medicare Advantage plans, up from 16 percent in 2006. Over these years, spending on outpatient prescription drugs (Part D) increased from 9 percent of total benefit payments to 14 percent in 2016.



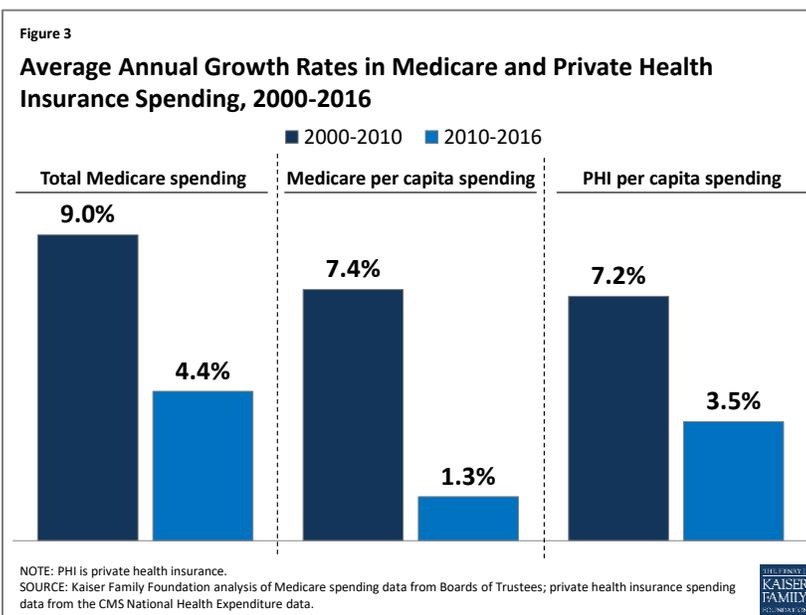
TRENDS IN TOTAL AND PER CAPITA MEDICARE SPENDING

Recent years have seen a notable reduction in the growth of Medicare spending compared to prior decades, both overall and per beneficiary.

- Average annual growth in total Medicare spending was 4.4 percent between 2010 and 2016, down from 9.0 percent between 2000 and 2010, despite faster growth in enrollment since 2011 with the baby boom generation reaching Medicare eligibility age (**Figure 3**).
- Average annual growth in Medicare spending per beneficiary was just 1.3 percent between 2010 and 2016, down from 7.4 percent between 2000 and 2010.

Slower growth in Medicare spending in recent years can be attributed in part to [policy changes](#) adopted as part of the Affordable Care Act (ACA) and the Budget Control Act of 2011

(BCA). The ACA included reductions in Medicare payments to plans and providers, increased revenues, and introduced delivery system reforms that aimed to improve efficiency and quality of patient care and reduce costs, including accountable care organizations (ACOs), medical homes, bundled payments, and value-based purchasing initiatives. The BCA lowered Medicare spending through sequestration that reduced payments to providers and plans by 2 percent beginning in 2013. Medicare spending trends in recent years have also been affected by changes



in prescription drug spending and hospital inpatient readmissions, a sharp decline in home health spending, and recoveries from program integrity efforts. In addition, although Medicare enrollment has been growing around 3 percent annually with the aging of the baby boom generation, the influx of younger, healthier beneficiaries has contributed to slower spending growth.

SPENDING TRENDS FOR MEDICARE COMPARED TO PRIVATE HEALTH INSURANCE

Over the past 25 years, Medicare spending has grown at a slightly slower rate than private health insurance spending on a per enrollee basis. With the recent slowdown in the growth of Medicare spending, the difference in growth rates between Medicare and private health insurance spending per enrollee widened.

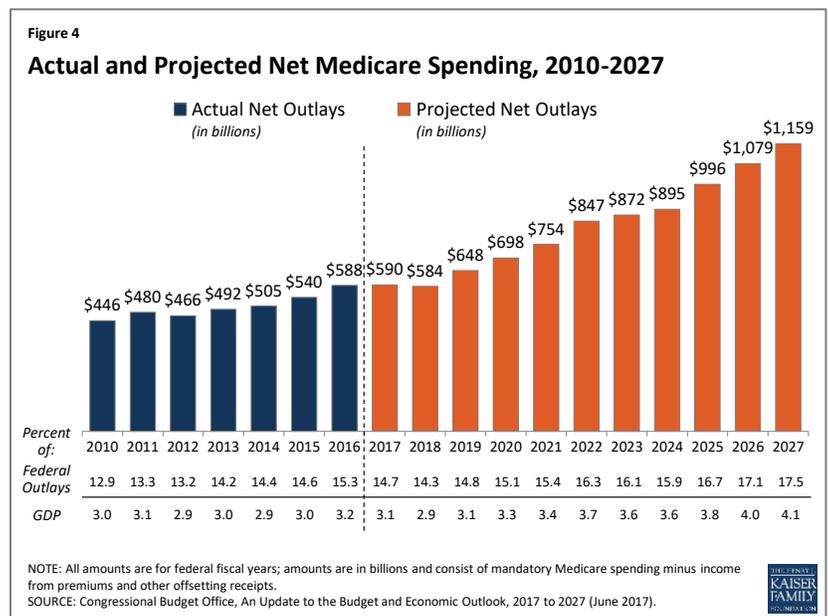
- Between 1991 and 2016, Medicare spending per enrollee grew at an average annual rate of 5.0 percent, slower than the 5.7 percent average annual growth rate in private insurance spending per enrollee.²
- Between 2000 and 2010, per enrollee spending growth rates were comparable for Medicare and private insurance (**Figure 3**). Between 2010 and 2016, however, Medicare per capita spending grew considerably more slowly than private insurance spending, increasing at an average annual rate of just 1.3 percent over this time period, while average annual private health insurance spending per capita grew at 3.5 percent.

Medicare Spending Projections

SHORT-TERM SPENDING PROJECTIONS FOR THE NEXT TEN YEARS

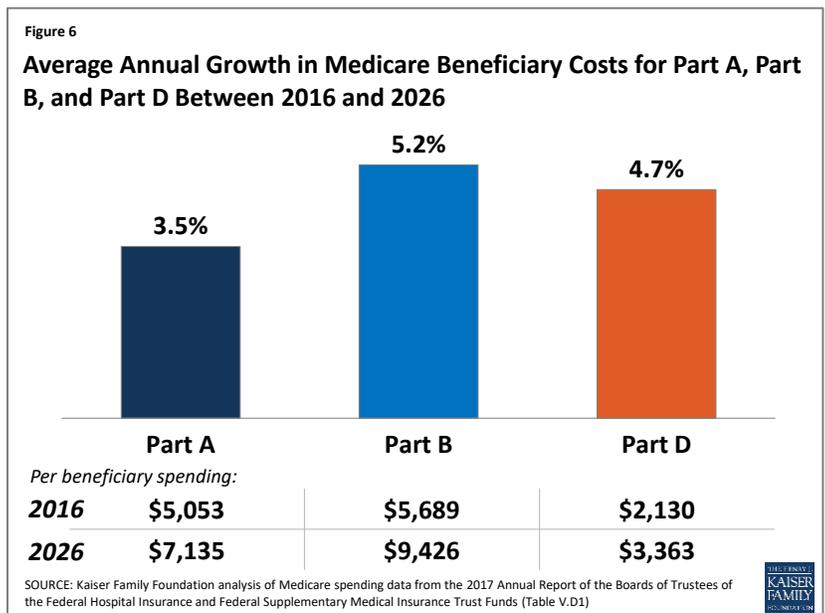
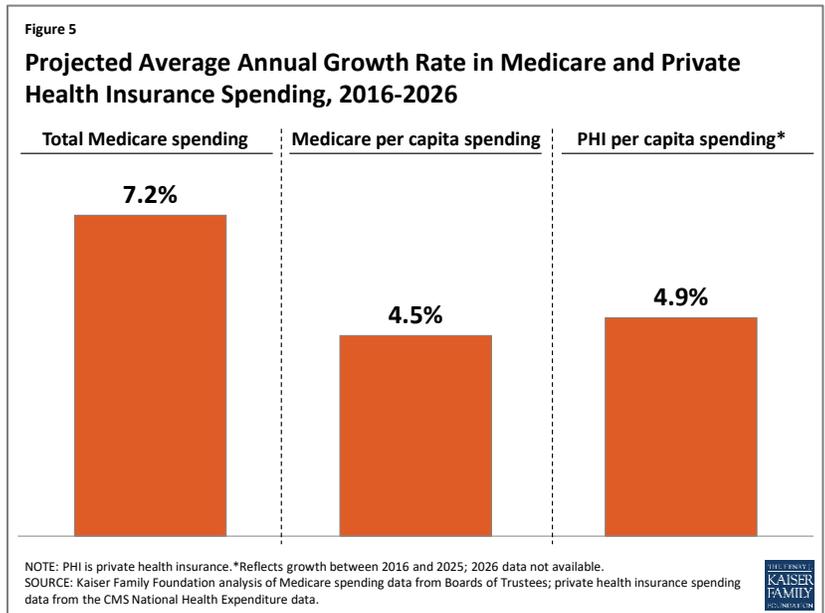
While spending is expected to continue to grow more slowly in the future compared to long-term historical trends, there are signs that spending growth is likely to increase at a faster rate than in recent years, in part due to growing enrollment in Medicare, increased use of services, and rising health care prices.³

Looking ahead, net Medicare spending (that is, mandatory Medicare spending minus income from premiums and other offsetting receipts) is projected to increase from \$590 billion in 2017 to \$1.2 trillion in 2027, [according to CBO](#). CBO projects total Medicare spending to increase from \$708 billion to \$1.4 trillion over this time period. Net Medicare spending is projected to grow modestly as a share of the federal budget and the nation's economy over the next ten years. Between 2017 and 2027, Medicare's share of the budget is projected to increase from 14.7 percent to 17.5 percent, while Medicare spending as a share of the gross domestic product (GDP) is projected to increase from 3.1 percent to 4.1 percent (**Figure 4**).



SPENDING GROWTH RATE PROJECTIONS

- Average annual growth in total Medicare spending is projected to be 7.2 percent between 2016 and 2026 (**Figure 5**). This is faster than the 4.4 percent average annual growth rate between 2010 and 2016.
- On a per capita basis, Medicare spending is projected to grow at a faster rate between 2016 and 2026 (4.5 percent) than between 2010 and 2016 (1.3 percent), and slightly lower than the average annual growth in per capita private health insurance spending over this time period (4.9 percent).
- Medicare per capita spending is not expected to grow uniformly across the coming ten-year period, however. Average annual per capita spending growth is expected to be slower in the first five years of the projection period than in the last five years: 4.0 percent between 2016 and 2021, increasing to 5.0 percent between 2021 and 2026.
- OACT projects a comparatively higher per capita growth rate in the coming years for Part B than for the other parts of the program. Per capita spending growth is projected to be 5.2 percent for Part B, compared to 3.5 percent for Part A and 4.7 percent for Part D (**Figure 6**). Among the reasons for the higher growth in Part B spending is slightly higher-than-expected actual spending in 2016 for outpatient hospital services and physician-administered drugs (which are covered under Part B). OACT has revised downward somewhat the projections for Part D spending compared to 2016, primarily attributable to significantly higher drug manufacturer rebates and lower utilization of hepatitis C drugs, which was a significant driver of higher Part D spending in 2014 and 2015.



LONG-TERM SPENDING PROJECTIONS

Over the longer term (that is, beyond the next ten years), both CBO and OACT expect Medicare spending to rise more rapidly relative to GDP due to a number of factors, including the aging of the population and faster growth in health care costs than growth in the economy on a per capita basis. According to CBO's most recent [long-term projections](#), net Medicare spending will grow from 3.1 percent of GDP in 2017 to 4.2 percent in 2027, 5.3 percent in 2037, and 6.1 percent in 2047.

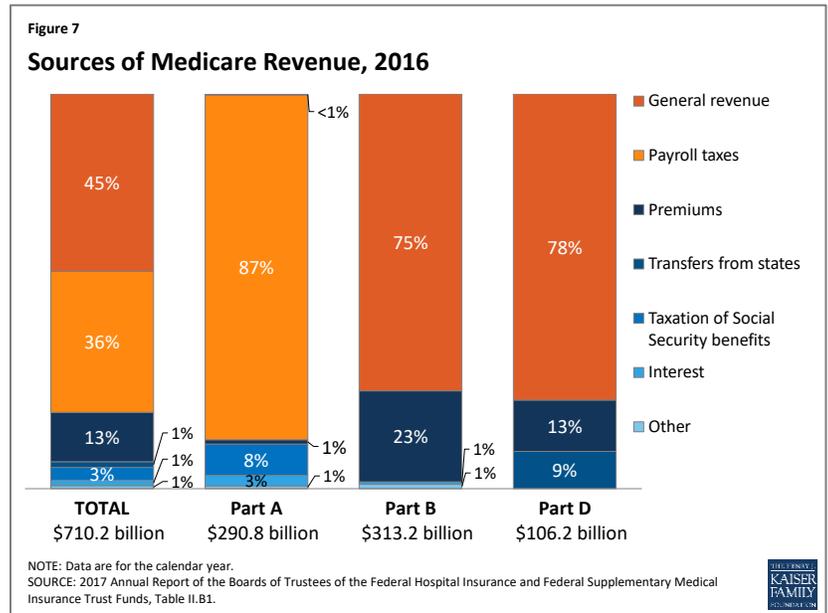
Over the next 30 years, CBO projects that "excess" health care cost growth—defined as the extent to which the growth of health care costs per beneficiary, adjusted for demographic changes, exceeds the growth of potential GDP

per person—will account for a somewhat larger share of projected growth in spending on the nation's major health care programs (Medicare, Medicaid, and subsidies for ACA Marketplace coverage) than the aging of the population. CBO cites new medical technology and rising personal income as the driving factors behind projections of rising health care costs.

How Is Medicare Financed?

Medicare is funded primarily from three sources: general revenues (45 percent), payroll taxes (36 percent), and beneficiary premiums (13 percent) (**Figure 7**).

- Part A is financed primarily through a 2.9 percent tax on earnings paid by employers and employees (1.45 percent each) (accounting for 88 percent of Part A revenue). Higher-income taxpayers (more than \$200,000/individual and \$250,000/couple) pay a higher payroll tax on earnings (2.35 percent).
- Part B is financed through general revenues (75 percent), beneficiary premiums (23 percent), and interest and other sources (2 percent). Beneficiaries with annual incomes over \$85,000/individual or \$170,000/couple pay a higher, income-related Part B premium reflecting a larger share of total Part B spending, ranging from 35 percent to 80 percent. The ACA froze the income thresholds through 2019, and beginning in 2020, the income thresholds will once again be indexed to inflation, based on their levels in 2019 (a provision in the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA⁴). As a result, the number and share of beneficiaries paying income-related premiums will increase as the number of people on Medicare continues to grow in future years and as their incomes rise.



- Part D is financed by general revenues (78 percent), beneficiary premiums (13 percent), and state payments for dually eligible beneficiaries (9 percent). As for Part B, higher-income enrollees pay a larger share of the cost of Part D coverage.
- The Medicare Advantage program (Part C) is not separately financed. Medicare Advantage plans such as HMOs and PPOs cover all Part A, Part B, and (typically) Part D benefits. Beneficiaries enrolled in Medicare Advantage typically pay monthly premiums for additional benefits covered by their plan, in addition to the Part B premium.

Assessing Medicare's Financial Condition

Medicare's financial condition can be assessed in different ways, including estimating the solvency of the Medicare Hospital Insurance (Part A) trust fund, and comparing various measures of Medicare spending—overall or per capita—to other spending measures, such as Medicare spending as a share of the federal budget or as a share of GDP. Such measures are also used in the context of broader discussions of the national budget and federal debt and in the Independent Payment Advisory Board (IPAB) process, described below.

SOLVENCY OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND

The solvency of the Medicare Hospital Insurance trust fund, out of which Part A benefits are paid, is one way of measuring Medicare's financial status, though because it only focuses on the status of Part A, it does not present a complete picture of program spending overall. The solvency of Medicare in this context is measured by the level of assets in the Part A trust fund. In years when annual income to the trust fund exceeds benefits spending, the asset level increases, and when annual spending exceeds income, the asset level decreases. When spending exceeds income and the assets are fully depleted, Medicare will not have sufficient funds to pay all Part A benefits.

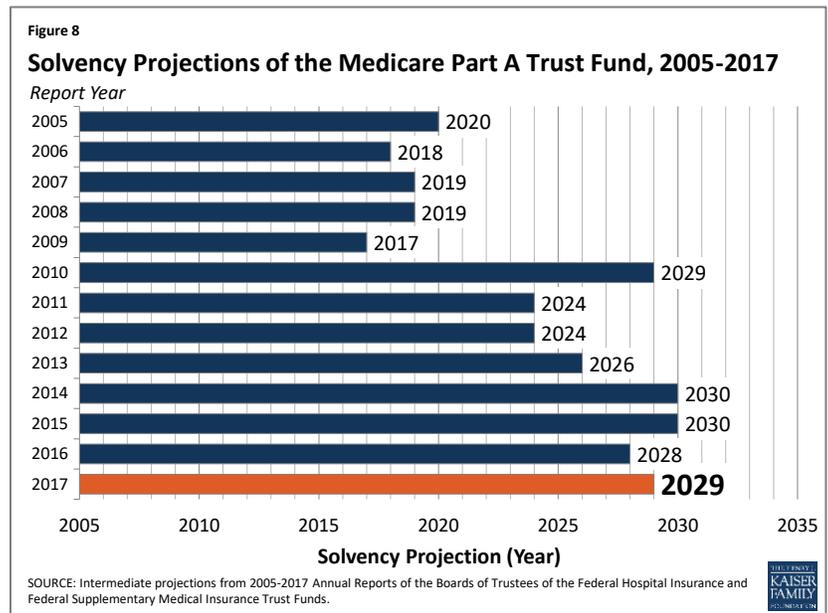
Each year, the Medicare Trustees provide an estimate of the year when the asset level is projected to be fully depleted. In their 2017 report, the Medicare Trustees project that the Part A trust fund will be depleted in 2029, one year later than was projected in 2016. The trustees attribute this to lower-than-expected hospital inpatient utilization in 2016, which affects assumptions about use of hospital services in the future (**Figure 8**).

Because of slower growth in Medicare spending in recent years, the solvency of the Part A trust fund has been extended further into the future compared to projections before the ACA was passed. Part A trust fund solvency is also affected by the level of growth in the economy, which affects Medicare's revenue from payroll tax contributions, by overall health care spending trends, and by demographic trends—of note, an increasing number of beneficiaries, especially between 2010 and 2030 when the baby boom generation reaches Medicare eligibility age, and a declining ratio of workers per beneficiary making payroll tax contributions.

Part B and Part D do not have financing challenges similar to Part A, because both are funded by beneficiary premiums and general revenues that are set annually to match expected outlays. Expected future increases in spending under Part B and Part D, however, will require increases in general revenue funding and higher premiums paid by beneficiaries.

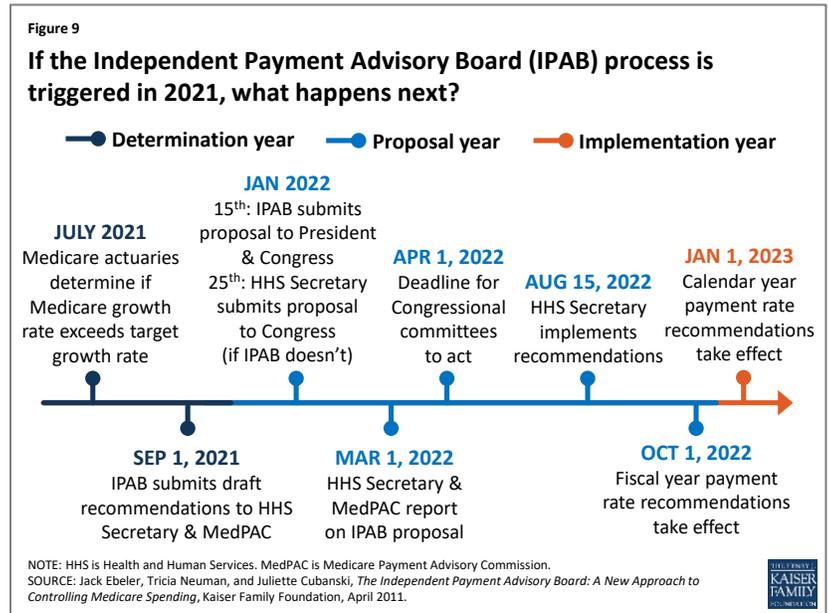
THE INDEPENDENT PAYMENT ADVISORY BOARD

The Independent Payment Advisory Board (IPAB), authorized by the ACA, is required to recommend Medicare spending reductions to Congress if projected spending growth exceeds specified target levels. IPAB is required to propose spending reductions if the 5-year average growth rate in Medicare per capita spending is projected to exceed the per capita target growth rate, based on general and medical inflation (for determination years 2015 to 2019) or growth in the economy (2020 and beyond). The Board is to consist of 15 full-time members appointed by the President and confirmed by the Senate, but no individuals have been nominated to serve on IPAB by either former President Obama or President Trump. If there are no Board members appointed when a proposal for spending reductions is required, the Secretary of the Department of Health and Human Services is responsible for making recommendations to achieve the required spending reductions.



Based on its most recent Medicare spending growth rate projections relative to the targets, OACT has estimated that the IPAB process will first be triggered in 2021 (**Figure 9**). This would initiate a three-year cycle ending with spending reductions implemented in 2023. OACT also projects that spending growth will exceed the target growth rate in 2024, 2025, and 2026. [CBO has projected](#) that Medicare spending growth will exceed the target growth rate in 2019, 2023, 2025, and 2027. Based on its projections, CBO estimates Medicare savings of \$20 billion as a result of the IPAB process between 2019 and 2027.

IPAB has been a source of controversy since before the enactment of the ACA, in part related to concern among members of Congress and other stakeholders about the authority granted to IPAB to make decisions about the Medicare program that are typically within the purview of Congress. There have been several attempts by Congress to repeal the IPAB since 2010, and the Trump Administration’s proposed [Fiscal Year 2018 budget](#) included a provision to do the same.



The Future Outlook

While Medicare spending is on a slower upward trajectory now than in past decades, total and per capita annual growth rates appear to be edging away from their historically low levels of the past few years. This raises several questions about recent spending trends and projections for future spending growth: Can the recent slowdown in Medicare spending be sustained and can this be done without adversely affecting access to or quality of care? How are payment and delivery system reforms influencing spending levels? How will future spending be affected by Medicare's new approaches to physician payment that will be established pursuant to MACRA? What steps could be taken to moderate the projected growth in Medicare spending due to the availability of new specialty drugs and medical technology?

A number of [changes to Medicare](#) have been proposed that could help to address the health care spending challenges posed by the aging of the population, including: restructuring Medicare benefits and cost sharing; eliminating “first-dollar” Medigap coverage; further increasing Medicare premiums for beneficiaries with relatively high incomes; raising the Medicare eligibility age; shifting Medicare from a defined benefit structure to a “premium support” system; and accelerating the ACA’s delivery system reforms. At the same time, changes have been proposed to improve coverage under Medicare in order to limit the financial burden of health care costs on older Americans and younger beneficiaries with disabilities, though such changes would likely require additional spending. In addition to these potential changes, which would affect future spending levels, revenue options could also be considered to help finance care for Medicare’s growing and aging population.

The prospects for these and other proposals that would affect Medicare spending and financing are unknown, but few would question the importance of carefully deliberating ways to bolster the Medicare program for today’s beneficiaries and for the growing number of people who will depend on Medicare in the future.

Endnotes

¹ Kaiser Family Foundation analysis based on Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Expenditures Tables, Table 4: National Health Expenditures by Source of Funds and Type of Expenditures: Calendar Years 2009-2015 (December 2016).

² Kaiser Family Foundation analysis based on Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Expenditures Tables, Table 21: Expenditures, Enrollment and Per Enrollee Estimates of Health Insurance: United States, Calendar Years 1987-2015 (December 2016), and Table 17: Health Insurance Enrollment and Enrollment Growth Rates, Calendar Years 2009-2025 (March 2017).

³ Sean Keehan, et al. “National Health Expenditure Projections, 2016-25: Price Increases, Aging Push Sector to 20 Percent of Economy,” *Health Affairs*, published online February 15, 2017.

⁴ The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Public Law 114-10) is a law to repeal and replace Medicare’s Sustainable Growth Rate (SGR) formula which will establish new payment systems designed to reward quality over quantity of physician services.