

## MEDICARE SPENDING AND FINANCING

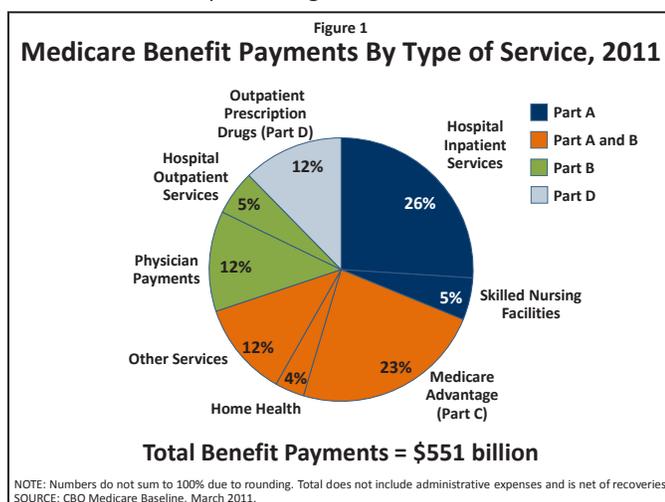
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### OVERVIEW OF MEDICARE SPENDING

Medicare, the federal health insurance program for 49 million elderly and disabled Americans, helps to pay for hospital and physician visits, prescription drugs, and other acute and post-acute services. In 2011, spending on Medicare accounts for 15% of the federal budget. Medicare also plays a major role in the health care system, accounting for 21% of total national health care spending in 2011, 29% of total national spending on hospital care, and 23% of total spending on physician services.

Medicare benefit payments are expected to total \$551 billion in 2011 (**Figure 1**):

- Part A – Hospital Insurance (HI) = 35%
- Part B – Supplementary Medical Insurance (SMI) = 29%
- Part C – Medicare Advantage (private health plans) = 23%
- Part D – Prescription drug benefit = 12%

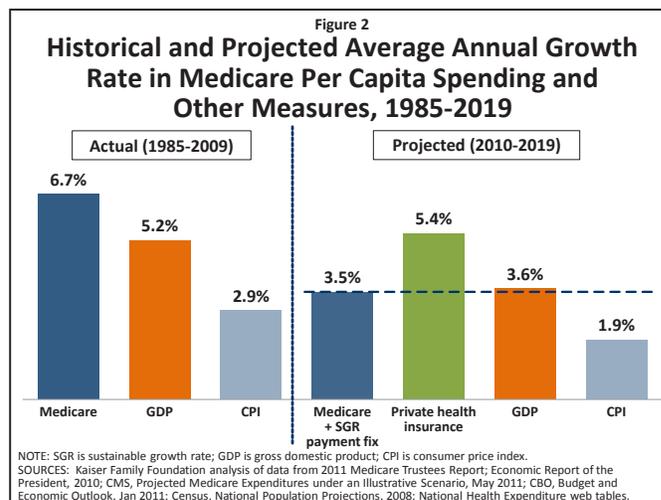


Medicare spending per beneficiary is highly skewed, with the top 10% of beneficiaries in fee-for-service (FFS) Medicare accounting for 59% of total Medicare spending in 2007—on a per capita basis, more than five times greater than the average across all FFS beneficiaries (\$48,693 versus \$9,083).

### MEDICARE SPENDING GROWTH

Medicare spending is projected to increase from \$555 billion in 2011 to \$903 billion in 2020 (CBO, August 2011). Growth in the Medicare population and sustained increases in health care costs are placing upward pressure on Medicare spending. Annual growth in health spending, which affects all payers, is influenced by increasing volume and use of services, new technologies, and increasing prices. Over the next decade, Medicare spending is projected to grow more rapidly for prescription drugs, hospital outpatient services, and skilled nursing facility services than for hospital inpatient care and home health services.

While Medicare spending is projected to represent a growing share of the economy, federal spending, and the nation's total health spending, Medicare per capita spending over the next decade is projected to grow at a slower rate than private health insurance spending, and a much slower rate than in previous decades (**Figure 2**). Average Medicare per capita



spending is projected to grow by 3.5% between 2010 and 2019 (assuming no reduction in physician fees), less than the 5.4% per capita growth in private health insurance spending and on par with the 3.6% projected growth in GDP. Medicare's relatively low growth rate is largely due to provisions in the 2010 health reform law.

### THE 2010 HEALTH REFORM LAW AND MEDICARE SPENDING

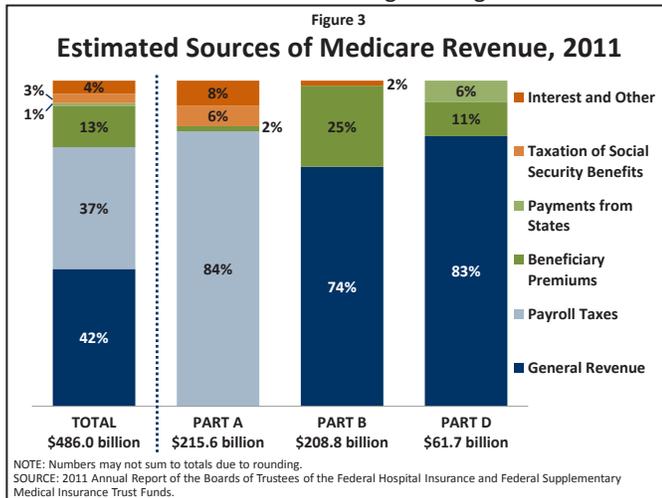
The Patient Protection and Affordable Care Act (ACA) of 2010 includes more than \$424 billion in net Medicare spending reductions over a ten-year period, reducing annual payment updates to hospitals and other providers and payments to Medicare Advantage plans. The law also establishes several new policies and programs designed to reduce costs and improve quality of patient care, as well as a new Independent Payment Advisory Board to recommend Medicare spending reductions if projected spending growth rates exceed target levels. The law also increases the Medicare Part A payroll tax rate on earnings for higher-income people, and increases Part B and Part D premiums for higher-income beneficiaries. Altogether, the Medicare provisions included in the law were projected to reduce Medicare spending by 6% over ten years.

### HOW IS MEDICARE FINANCED?

Medicare is funded primarily from three sources: general revenues (42%), payroll tax contributions (37%), and beneficiary premiums (13%) (**Figure 3**). Medicare Parts A, B, and D are financed separately, as follows:

- Part A is financed primarily through a 2.9% tax on earnings paid by employers and employees (1.45% each) (accounting for 84% of Part A revenue). For higher-income taxpayers (more than \$200,000/individual and \$250,000/couple), the payroll tax on earnings will increase by 0.9 percentage points, from 1.45% to 2.35%, in 2013.
- Part B is financed through general revenues (74%) and beneficiary premiums (25%). 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% to 80%; the ACA froze the income thresholds through 2019.

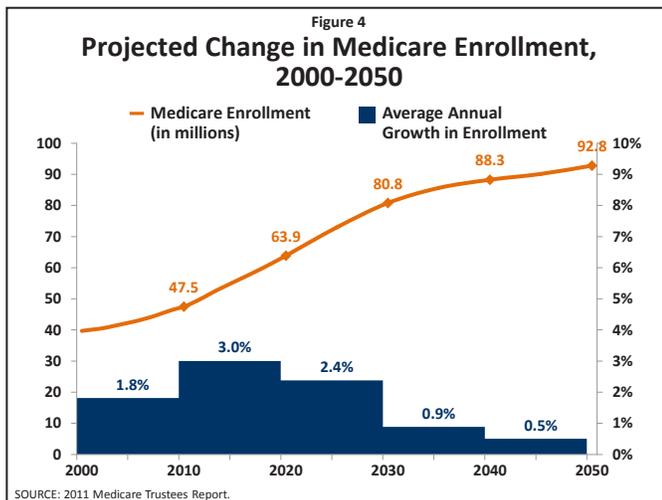
- Part D is financed through general revenues (83%), beneficiary premiums (11%), and state payments for dual eligibles (6%). The health reform law established a new income-related Part D premium similar to the Part B premium, where higher-income beneficiaries pay a larger share of the cost of standard drug coverage.



**MEDICARE’S FINANCIAL CONDITION**

Medicare’s financial condition is measured in several ways, including the solvency of the Part A Trust Fund, the annual growth in spending, and growth in spending on a per capita basis. Average annual growth in total Medicare spending is projected to be 6.6% between 2010 and 2019, but 3.5% on a per capita basis (assuming no reduction in physician fees).

The Part A Trust Fund is projected to be depleted in 2024—eight years longer than in the absence of the health reform law—at which point Medicare would not have sufficient funds to pay full benefits, even though revenue flows into the Trust Fund each year. Part A Trust Fund solvency is affected by growth in the economy, which directly affects revenue from payroll tax contributions, and by demographic trends: 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 contributions (Figure 4).



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

Various measures of Medicare spending are also used in the context of broader discussions of the national budget and federal deficit, including Medicare spending as a share of the federal budget and of GDP. Medicare’s share of the federal budget is projected to increase from 15.4% in 2011 to 17.5% in 2020, raising concerns about the government’s ability to fund other priorities, in the absence of additional revenues. In addition, Medicare is projected to grow from 3.6% of GDP in 2010 to 4.1% in 2020, without taking into account additional Medicare spending that is likely to occur to avoid reductions in physician fees scheduled under current law.

**MEDICARE AND BENEFICIARY SPENDING**

In 2007, Medicare paid half of the nearly \$18,000 in medical and long-term care expenses per beneficiary in FFS Medicare, on average, with the remaining half divided between beneficiary out-of-pocket spending and supplemental insurance payments. While Medicare provides important benefits and valuable financial protections, beneficiaries incur significant out-of-pocket costs, including premiums (for Medicare and supplemental insurance), Medicare deductibles and cost sharing, and payments for services not covered by Medicare (including long-term care, eyeglasses, hearing aids, and dental services). As a result, one in four beneficiaries spends 30% or more of their income on health expenses.

**FUTURE OUTLOOK**

In the near term, Medicare is expected to play a major role in policy discussions about reducing the federal budget deficit and debt. The Budget Control Act of 2011 establishes a process for reducing federal spending that could include Medicare spending reductions, and if that fails, a sequester could result in as much as a 2% reduction in Medicare payments to providers and plans. In addition, policymakers are expected to consider proposals to prevent a reduction in physician fees from occurring in 2012; the ten-year cost of freezing physician payments at 2011 rates is estimated to be \$300 billion. Addressing this issue while at the same time reducing federal spending as required by the Budget Control Act could be difficult to achieve.

A challenge facing policymakers is finding ways to constrain Medicare spending growth without negatively affecting patient care, imposing an undue financial burden on elderly and disabled beneficiaries, or shifting costs onto other payers. Some proposals under discussion, such as raising the age of Medicare eligibility, would limit Medicare spending growth, but would do so by shifting costs onto beneficiaries and raising costs for employers, states and other individuals. While the 2010 health reform law includes several changes designed to slow the growth in Medicare spending and improve the quality and delivery of care through system reforms, additional efforts to curtail health care costs system-wide could also help to improve Medicare’s financial outlook.

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