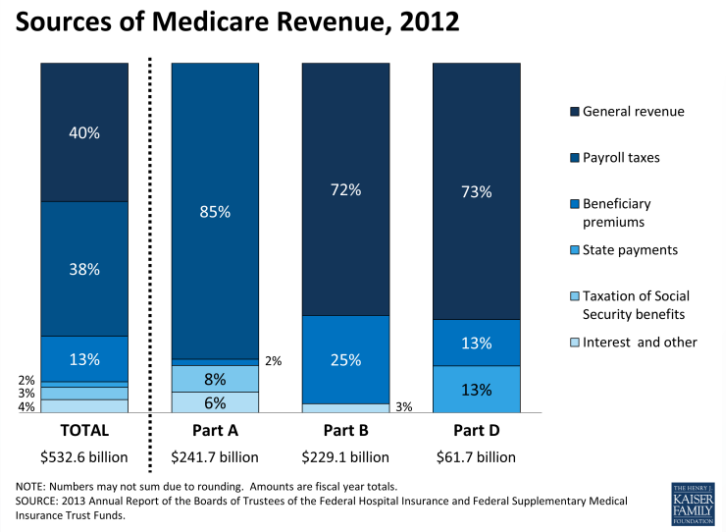
Medicare Spending and Financing

Updated March 2014

Overview of Medicare Spending and Financing

Medicare is the nation's largest health insurance program, which has provided access to health care services for the elderly (ages 65 and older) and many non-elderly people with disabilities for the last 48 years. Given its size and scope, Medicare has particular significance with regard to its spending and financing methods and their effects on the federal budget and deficit.

To finance the Medicare program the government utilizes several sources of revenue: a dedicated Medicare payroll tax, general revenues, premiums collected from beneficiaries, a tax on Social Security benefits, some interest, and payments from states for the Medicare drug benefit.[i] These revenue streams are funneled through two distinct trust fund accounts. The Hospital Insurance (HI) Trust Fund, which finances Medicare Part A, is comprised of revenue from payroll taxes, interest, taxation of Social Security benefits and other sources. The Supplementary Medical Insurance (SMI) Trust Fund, which primarily finances Part B and also funds the Part D prescription drug benefit, is comprised of general revenue, beneficiary premiums, and interest.[ii]



In 2012 Medicare's total income amounted to $532.6 billion, while spending reached approximately $551 billion.[iii] Since the program's inception, Medicare spending has continued to grow and has become an increasing share of the nation's gross domestic product (GDP) and a contributing factor to the federal deficit. If spending patterns continue at their current rate and additional revenue sources are not established, the HI Trust Fund will be insolvent by 2026.[iv] As costs of the Medicare program continue to rise and the possibility of insolvency looms, beneficiaries are threatened with having to pay an increasing share of their coverage. It has been projected that premiums and cost-sharing for Parts B and D will rise from 27 percent of average Social Security benefits in 2010 to 36 percent in 2030.[v]

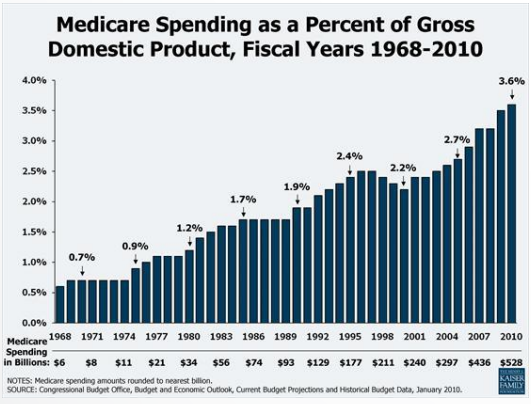
Medicare Spending Growth

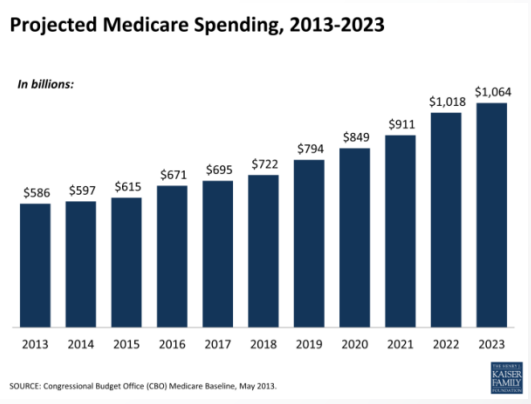
Medicare's growth in spending is due to a number of factors, some of which are inherent to the population it serves and many of which are inherent to the overall health system, in which spending is growing at an increasing rate. Influences on spending that are tied to larger health system issues include the price paid for services, the volume and complexity of services, and new medical technology.[vi]

Medicare has unique factors that contribute to growing spending, including increased enrollment with the entry of the baby boomer population, as well as the high cost associated with caring for an aging population that is living longer and experiencing more costly chronic health conditions.[vii] Additionally, Medicare spending increased significantly with the addition of the Medicare Part D prescription drug benefit, passed in the Medicare Modernization Act of 2003 (MMA). Part D accounts for two-thirds of the $72 billion increase in spending from 2005 to 2006.[viii]

The Affordable Care Act of 2010 (ACA) included a number of provisions aimed at slowing spending growth, and specifically imposed $716 billion in spending reductions over a ten-year period.[ix] A majority of these reductions come from a reduction in annual provider payment updates and changes to payments to Medicare Advantage (MA) plans.[x] In addition to spending reductions, the ACA also raises revenue for the program through an increase in the Medicare payroll tax on certain high-income workers, new income-related premiums for Part B and Part D, as well as other new taxes on investment income and fees on manufacturers and importers of brand name pharmaceuticals.[xi]

In recent years, Medicare spending, and health care spending generally, has grown at a historically slow rate. Economists and health policy experts have cited, to varying degrees, the recent recession and ongoing structural reforms to the health system as probable explanations for the change. While there is no true consensus on exactly how long current patterns will last, most agree that spending will increase in the future; longer-term projections offered by the Congressional Budget Office (CBO) and Medicare actuaries still point to significant cost growth, at a pace faster than the rest of the economy, that is not sustainable over time.[xii,xiii]





Sustainable Growth Rate

One issue that compounds underlying growth in the cost and volume of health services is the way in which Medicare pays physicians. The sustainable growth rate (SGR) is the formula used by the Centers for Medicare and Medicaid Services (CMS) to determine the appropriate fee schedule for payment to physicians that will keep costs to the program in line with GDP. The SGR became law with the passage of the Balanced Budget Act of 1997, and replaced the previous Medicare Volume Performance Standard formula. However, despite its attempt to improve upon the old formula, the SGR has not worked to control spending as intended.

In nearly every year since its inception, the formula has required a cut to the physician fee schedule in order to balance expenditures that have exceeded the target SGR. Congress, however, has the power to override the SGR's scheduled cuts and has exercised this power every time, never allowing them to go into effect. Despite Congressional action to avoid scheduled cuts, the need for payment reductions to balance expenditures remains and the cuts have accumulated to what most recently would have been a 20.1 percent cut for providers in 2014, if Congress hadn't acted again to override it.[xiv] Continuous action to override the SGR has meant that Medicare outlays have and continue to increase significantly.

An alternative to ongoing, intermittent SGR overrides would be for Congress to enact permanent repeal and replacement of the formula. While members of Congress on both sides of the aisle have traditionally agreed that SGR repeal is a worthwhile policy goal, it has been difficult to accomplish because of its high cost. The CBO's estimated cost of a permanent SGR fix has grown over time and in early 2012 had a price tag of $316 billion.[xv] In late 2013 however, based largely on new Medicare spending data, CBO revised its estimate, lowering the cost of permanent SGR repeal by over $200 billion, to $116.5 billion.[xvi] This significant reduction in cost is encouraging for policymakers and other stakeholders who seek permanent repeal.

Future Challenges

Issues related to spending and financing of the Medicare program are a primary challenge for policymakers in the years ahead. Debate around possible solutions to high spending and impending insolvency has been ongoing, but the consensus around the need for action on this front has never been greater. Possible solutions include capping Medicare spending by limiting it to the annual increase in GDP plus a certain percentage, increasing beneficiary contributions, reducing provider payments, raising the age of Medicare eligibility, increasing revenue, or completely restructuring the Medicare program by, for example, converting it into a voucher based program. Any of these possible solutions would have significant implications for beneficiaries, as well as the vast array of stakeholders involved in the delivery of health care. Finding a solution to reducing costs without sacrificing quality of care will be difficult and the political landscape will require a careful balancing of diverse interests.

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[i] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf
[ii] http://www.kff.org/medicare/upload/7731-03.pdf
[iii] http://www.cbo.gov/sites/default/files/cbofiles/attachments/43894_Medicare2.pdf
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[v] http://www.kff.org/medicare/upload/7731-03.pdf
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