

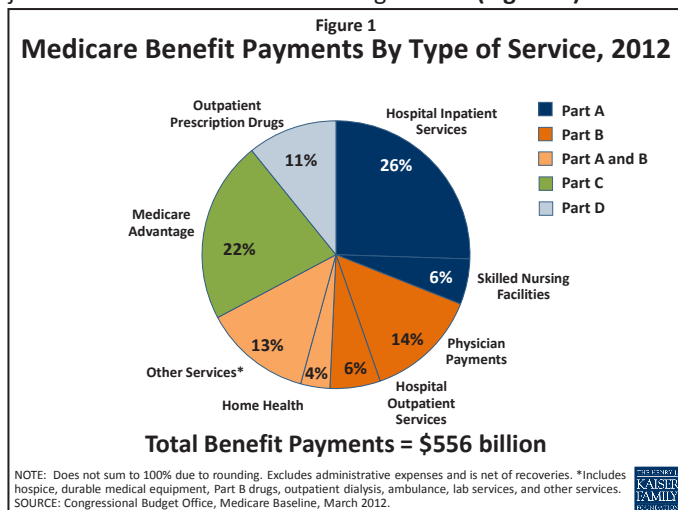
NOVEMBER 2012

MEDICARE SPENDING AND FINANCING

OVERVIEW OF MEDICARE SPENDING

Medicare, the federal health insurance program for 50 million elderly and disabled Americans, helps to pay for hospital and physician visits, prescription drugs, and other acute and post-acute services. In 2012, 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 2012, 28% of spending on hospital care, and 24% of spending on physician services.

Medicare benefit payments are expected to total \$556 billion in 2012; roughly two-thirds is for Part A (Hospital Insurance, or HI), and Part B (Supplementary Medical Insurance, or SMI) services. More than 20% is for Part C, Medicare Advantage private health plans covering all Part A and B benefits, and just over 10% is for the Part D drug benefit (Figure 1).

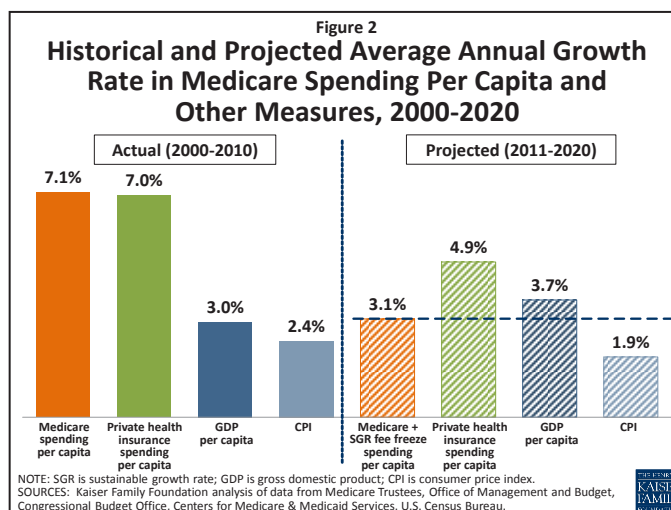


Medicare spending per beneficiary is highly skewed, with the top 10% of beneficiaries in traditional Medicare accounting for 57% of total Medicare spending in 2009—on a per capita basis, more than five times greater than the average across all beneficiaries in traditional Medicare (\$55,763 vs. \$9,702).

MEDICARE SPENDING GROWTH

Total Medicare spending is projected to double from \$560 billion in 2011 to \$1.1 trillion in 2022 due to growth in the Medicare population and sustained increases in health care costs (CBO, August 2012). The growth in health spending, which affects all payers, is influenced by increasing volume and use of services, new technologies, and increasing prices.

Medicare spending is projected to represent a growing share of the economy, the federal budget, and the nation's total health spending. Between 2012 and 2022, Medicare's share of the federal budget is projected to increase from 15.4% to 19.3%, while Medicare spending as a share of GDP is projected to grow from 3.5% to 4.3% (without taking into account additional spending that is likely to occur to avoid reductions in physician fees scheduled under current law). Yet on a per capita basis, Medicare spending is projected to grow at a slower rate than private health insurance spending over the next decade (3.1% vs. 4.9%), and slower than it did in the past decade (Figure 2).



THE 2010 HEALTH REFORM LAW AND MEDICARE SPENDING

The Patient Protection and Affordable Care Act (ACA) of 2010 includes \$716 billion in net Medicare spending reductions over the next ten years (2013-2022), reducing annual payment updates to hospitals and other providers and payments to Medicare Advantage plans. The law also includes several payment and delivery system reforms designed to reduce costs and improve quality of patient care, including accountable care organizations (ACOs), medical homes, bundled payments, and value-based purchasing initiatives. The ACA also authorized a new Independent Payment Advisory Board to recommend Medicare spending reductions to Congress if projected spending growth exceeds target levels (see below). In addition, the law 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.

THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

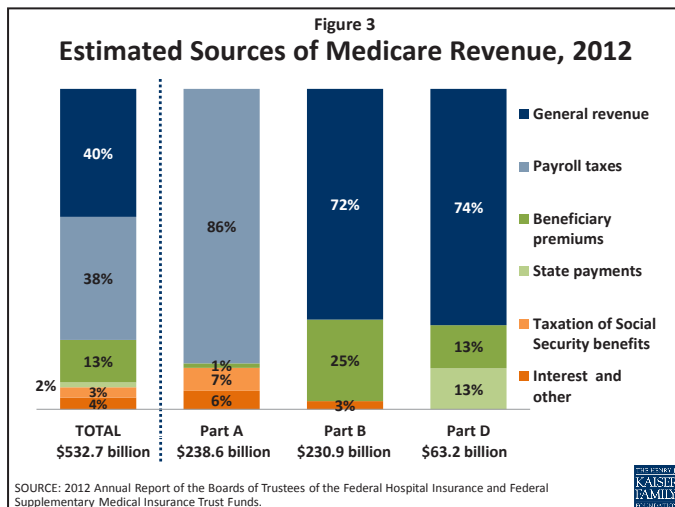
The Independent Payment Advisory Board, authorized by the ACA, is a new approach to controlling Medicare spending. The Board is to consist of 15 full-time members appointed by the President and confirmed by the Senate; to date, however, no members have been appointed. IPAB is required to propose spending 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 inflation (2015-2019) or growth in the economy (2020 and beyond). The ACA required the IPAB process to begin in 2013, but CBO estimated that spending reductions will not be triggered for several years because Medicare spending growth is expected to be below the target growth rate each year through 2022.

The Board is prohibited from making recommendations to ration care, change Medicare benefits or eligibility, or increase taxes or beneficiary premiums or cost sharing. The recommendations made by IPAB move to the Congress for fast-track consideration. The Secretary of Health and Human Services is required to implement the Board's recommendations unless Congress adopts alternative proposals that produce equivalent savings.

HOW IS MEDICARE FINANCED?

Medicare is funded primarily from three sources: general revenues (40%), payroll tax contributions (38%), and beneficiary premiums (13%) (**Figure 3**):

- Part A is financed primarily through a 2.9% tax on earnings paid by employers and employees (1.45% each) (accounting for 86% of Part A revenue). For higher-income taxpayers (more than \$200,000/individual and \$250,000/couple), the payroll tax on earnings increases by 0.9 percentage points, from 1.45% to 2.35%, in 2013.
- Part B is financed through general revenues (72%), beneficiary premiums (25%), and interest and other sources (3%). 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, which is expected to increase the share of beneficiaries paying the higher Part B premium.
- Part D is financed through general revenues (74%), beneficiary premiums (13%), and state payments for dual eligibles (13%). Similar to Part B, enrollees with higher incomes pay a larger share of the cost of Part D coverage.



MEDICARE'S FINANCIAL CONDITION

Medicare's financial condition can be measured in several ways, including the solvency of the Part A Trust Fund, annual growth in spending, and growth in spending on a per capita basis. Average annual growth in total Medicare spending is projected to be 5.3% between 2011 and 2020, but 3.1% 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 will 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. 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 and in the Independent Payment Advisory Board process, including Medicare spending as a share of the federal budget and of GDP.

MEDICARE AND BENEFICIARY SPENDING

In 2009, Medicare paid half of the over \$19,000 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

Medicare is expected to play a major role in policy discussions about reducing the federal budget deficit and debt. As part of these discussions, a number of Medicare proposals have been made, including: strengthening the role of the new IPAB; restructuring Medicare benefits and cost sharing; eliminating "first-dollar" Medigap coverage; increasing Medicare premiums for all beneficiaries or those 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.

In the meantime, the Budget Control Act of 2011 established a process for reducing federal spending that will reduce Medicare payments to providers and plans by 2%, beginning in 2013 (unless policymakers take action beforehand to avert these reductions). Policymakers may also take steps to prevent a 27% reduction in physician fees from occurring in 2013; CBO estimates the ten-year cost to keep these payments at 2012 rates is roughly \$270 billion.

A challenge facing policymakers is finding ways to constrain Medicare spending growth, while setting fair payments to providers and plans, and without negatively affecting patient care, imposing an undue financial burden on elderly and disabled beneficiaries, or shifting costs onto other payers. 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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