Medicare Economics
Medicare expenditures are a substantial part of the federal budget—$556 billion, or 15 percent in 2012. They also comprise 3.7 percent of the country's gross domestic product (GDP), a measure of the total economy, and are expected to increase to 6.7 percent of the GDP by 2037.

Medicare expenditures are sometimes compared to the costs of Social Security, which, at $707 billion in 2012, was roughly 5 percent of the GDP. While currently Social Security expenditures are greater than Medicare, they are expected to total only 6.2 percent of the GDP by 2037, at that point having been surpassed by Medicare growth.

Ninety-one percent of the money Medicare spends comes from three primary sources: general revenue (40 percent), payroll tax contributions (38 percent) and beneficiary premiums (13 percent). Money also comes into Medicare from interest income, taxation of some Social Security benefits (Medicare Part A) and some state funding (Medicare Part D).

Part A (Hospital Insurance) Funding

The Medicare Hospital Insurance (HI) Trust Fund funds Part A. It is funded primarily by a 2.9 percent tax on earnings split by employers and employees (1.45 percent each),
or taxed at the full rate of 2.9 percent by self-employed people. Starting in 2013, those individuals with earnings above $200,000 and married couples with earnings above $250,000 will pay 2.35 percent on the amount above those thresholds through Medicare payroll taxes (the employer tax rate remains the same at 1.45 percent).

Additional funds come from interest on trust fund investments; Part A premiums from beneficiaries who aren't eligible for premium-free Part A; and income taxes on some Social Security benefits. (To be eligible for premium-free Part A, a person must be eligible for Social Security or Railroad Retirement benefits, or had (or whose spouse had) Medicare-covered government employment.)

In years when there is a surplus—taxes collected exceed money paid out for hospital bills—the surplus is invested in a special issue of U.S. Treasury bonds that pay a competitive rate of interest.

The Hospital Insurance Trust Fund had income of $228.9 billion and expenditures of $256.7 billion in 2011. It is expected to become insolvent in 2024, based on estimates of income and spending from the Medicare Trustees Report. At that point, the fund’s revenue will be sufficient to pay only 87 percent of Part A costs.

**Part B (Supplementary Medical Insurance) Funding**

The Supplementary Medical Insurance Trust Fund (SMI) funds Medicare Part B benefits (doctors and outpatient service fees), Medicare Part D prescription drug benefits and Medicare program administration (the costs of paying claims, collecting Medicare taxes and combating fraud and abuse).
Medicare Economics

The SMI Trust Fund is funded differently than Part A. Money comes primarily from three sources. In 2011, general revenue funds (money collected from federal income taxes) authorized by Congress comprised about 74 percent; premiums paid by people enrolled in Part B and Part D comprised approximately 22 percent; and other sources such as interest income on trust fund investments and transfers from states were about 4 percent. The trust fund consists of two separate accounts: one for Part B and one for Part D.

Beneficiaries who choose to participate in Part B or Part D must enroll and pay monthly premiums for each. For 2013, most people pay a Part B premium of $104.90 per month if they have the premium deducted from their Social Security checks. The premium is higher for individuals with incomes above $85,000 per year and for married couples with incomes above $170,000 per year.

The SMI had income of $301 billion and outlays of about $292 billion in 2011.

Part D (Prescription Drug Plan) Funding

In addition to funding by the SMI from general revenues, Part D is also funded by beneficiary premiums and by state payments for dual eligible people, who are beneficiaries who qualify for both Medicare and Medicaid. Enrollees with higher incomes pay a larger share of the cost of Part D coverage, similar to Part B.
Medicare Advantage plans (Part C) are health insurance plans offered by private insurance companies that are contracted with Medicare to insure beneficiaries who purchase those plans. Part C plans offer benefits at least equal to those in Traditional Medicare and some offer more, such as prescription drug coverage, routine dental care, eye examinations and glasses. In Part C, beneficiaries are limited to care within the specific plan’s network of doctors and hospitals. Members of Medicare Advantage plans usually pay an additional monthly premium above what they would pay for Part A and Part B.

Part C plans are funded from Part A and Part B sources. Medicare pays the private health plans a fixed amount every month. Reimbursement rates are set by the federal government on a county-by-county basis using formulas established by the Centers for Medicare & Medicaid Services (CMS), and linked to the average cost of caring for beneficiaries enrolled in Parts A and B.

The CMS also factors quality into Part C payment amounts. Beginning in 2012, a bonus program, based on 53 performance measures, began. The Star Ratings program rates plans on more than 50 measures within five domains: keeping beneficiaries healthy via preventive services such as screenings and vaccines; managing chronic conditions; plan responsiveness and care; number of complaints, appeals and voluntary disenrollment; and telephone customer service. Data comes from surveys, empirical observation, claims and medical records. Bonus payments are linked to the ratings.

The government has estimated that the typical Part C plan collects 12 to 14 percent
more for each beneficiary than the cost of caring for a person enrolled in Traditional Medicare, an extra margin that will be gradually eliminated under the Affordable Care Act (ACA). As payments from the government are reduced, Part C providers will need to decide which extra services to continue to cover or whether to offset the losses through other methods, such as raising beneficiary premiums.

### Medicare Expenditures

In 2011, Medicare spent a total of $549.1 billion on health care coverage for 48.7 million beneficiaries. This dollar amount accounted for roughly 15 percent of the national budget and 21 percent of overall U.S. health care spending, according to the Congressional Budget Office.

The HI Trust Fund started the 2011 fiscal year with a balance of $271.9 billion. During that fiscal year, Medicare spent $256.7 billion on Part A benefits but only had an income of $228 billion, resulting in a $27.7 billion shortfall borrowed from the balance.

The SMI fund started with a balance of $271.4 billion in 2011, and spent $225.3 billion on Part B services and $67.1 billion on Part D benefits during the fiscal year.

Medicare also spent $64.6 billion from the HI Trust Fund and $59.1 billion in SMI funds to provide Medicare Advantage (Part C) benefits.

Inpatient hospital services (Part A) are the greatest Medicare expenditures, followed by Part C, physician payments (Part B) and prescription drugs under Part D.
Key Drivers of Medicare Spending Growth

In the next 10 years, the amount spent on Medicare beneficiaries will climb from about $555 billion in 2011 to nearly $1 trillion by 2021. There are several driving forces.

First, members of the baby boom generation are joining the Medicare rolls. According to AARP, starting in 2011, every day about 8,000 Americans turns 65, making them eligible for Medicare.

Second, the amount of money spent on each beneficiary is rising, as new treatments and tests become available.

Drivers of Medicare spending largely mirror those that contribute to the overall spending growth in the nation's health care system. Service-related changes, such as changes in price and volume, as well as advances in medical technology, contribute to Medicare's spending growth. The rising incidence and prevalence of chronic disease in the United States also ripples through to Medicare spending.

Reasons for spending growth have changed over the past 20 years. Two decades ago, most growth was linked to inpatient (hospital) services. Recently, growth has been in treating chronic conditions such as diabetes, arthritis, hypertension and kidney disease; these are conditions that are more likely to be managed on an outpatient basis. Increased enrollment and an aging population are also factors, but the largest increase is due to the rising costs of health care itself. More people are getting more expensive treatment today than ever before.
As just noted, Medicare costs are rising because of an aging population. Medicare spending increases as people get older because they are also usually sicker. In 2006, beneficiaries between ages 65 and 74.8 averaged $5,887 in costs, while those 85 and older averaged $12,059. As the baby boomers continue to enroll in Medicare, which began in 2011, the percentage of younger beneficiaries will initially grow and average costs per beneficiary may go down. After 2030, however, the bulk of the baby boom will be older and costs will most likely go up.

Out-of-pocket health care spending by beneficiaries also increases as they get older, as health and long-term care needs rise. In 2010, Medicare beneficiaries spent 15 percent of their household budget on health care to meet Medicare's cost-sharing obligations. This is nearly three times the percent spent on health care by non-Medicare households.