

## The Long-Term Outlook for the Major Federal Health Care Programs

**A**lthough spending for health care in the United States has grown more slowly in recent years than it did previously, high and rising amounts of such spending continue to pose a challenge, not only for the federal government, but also for state and local governments, businesses, and households. Federal spending for the major health care programs rose from 2.0 percent of gross domestic product (GDP) in 1985 to 5.3 percent in 2015. Over approximately that same period, total national spending on health care services and supplies—that is, health care spending by all public and private sources combined—also increased, from 9.5 percent of GDP in 1985 to 16.6 percent, or about one-sixth of the economy, in calendar year 2014, the most recent year for which such data are available.<sup>1</sup>

One significant factor underlying those trends is that, on a per-person basis, health care spending has grown faster, on average, than the nation’s economic output over the past few decades. The Congressional Budget Office estimates that growth in health care spending per person outpaced growth in potential (or maximum sustainable) GDP per person by an average of 1.4 percent per year between calendar years 1985 and 2014.<sup>2</sup> Key factors contributing to that faster growth were the emergence and increasing use of new medical technologies, rising personal income, and (to a lesser extent in recent years) the declining share of health care costs that people paid out

of pocket. The effects of those factors were partly offset by those of other developments, including the increased prevalence of managed care plans in the 1990s, the 2007–2009 recession, and various legislated changes in Medicare’s payment policies.

Outlays for the major health care programs consist of spending for Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), as well as spending on subsidies for health insurance purchased through the marketplaces established under the Affordable Care Act (ACA) and related spending.<sup>3</sup> CBO expects that, under current law, federal spending on those programs would continue to rise substantially in relation to GDP.<sup>4</sup> In CBO’s extended baseline, net federal spending for those programs grows from an estimated 5.5 percent of GDP in 2016 to 8.9 percent in 2046: Net spending for Medicare

1. Centers for Medicare & Medicaid Services, National Health Expenditure Accounts, “National Health Expenditures by Type of Service and Source of Funds, CY 1960–2014” (accessed March 30, 2016), <http://go.usa.gov/jmGY>.

2. As is explained later in this chapter, CBO derived that estimate after adjusting for demographic changes and giving greater weight to more recent years (to more closely reflect current trends in spending for health care).

3. Spending related to subsidies for insurance purchased through the marketplaces (formerly called exchanges in CBO’s publications) includes spending for subsidies for insurance provided through the Basic Health Program, spending for the risk-adjustment and reinsurance programs that were established by the ACA to stabilize premiums for health insurance purchased by individuals and small employers, and spending to provide grants to states for establishing a marketplace.

4. Federal spending on those programs is mandatory; that is, it results from budget authority provided in laws other than appropriation acts. Federal discretionary spending on health care—that is, spending that is subject to annual appropriations—is not included in the budget projections described here; rather, it is included in projections for other noninterest spending (see Chapter 4). Such discretionary spending includes spending for health research and for health care provided by the Veterans Health Administration. Some mandatory spending on health care (for example, spending for health insurance for federal retirees) is included in other noninterest spending; that mandatory spending represents a very small share of the federal budget.

amounts to 5.7 percent of GDP that year, and spending on Medicaid and CHIP, combined with outlays for subsidies for insurance purchased through the marketplaces and related spending, equals 3.1 percent.<sup>5</sup>

The extent of growth in federal spending on health care in coming years will depend on many factors, including demographic changes and the behavior of households, businesses, and state and local governments. (It will also depend on federal laws and could thus be influenced by changes in those laws, but CBO's extended baseline projections, which cover the 30-year period ending in 2046, are based on the assumption that current laws generally will not change.) The first 10 years of CBO's extended baseline projections of federal health care spending match its 10-year baseline projections.<sup>6</sup> For the remaining 20 years of the projection period, CBO uses a formulaic approach to project such spending because health care delivery and financing systems could evolve in a number of different ways in the long run. Specifically, the agency combined estimates of the number of people who will receive benefits from those government health care programs with fairly mechanical estimates of the growth of spending per beneficiary:

- The number of people receiving benefits from the major federal health care programs is, under current law, projected to increase during the next few decades. The most important factor contributing to that increase is the aging of the population—particularly of the large baby-boom generation—which will increase the number of people who receive benefits from Medicare by about one-third over the next decade.
- The growth of spending per beneficiary relative to the growth of potential GDP per person in most of the major health care programs is generally projected to move from the average rate projected for the years 2024 through 2026 (with certain adjustments) to

1.0 percent in 2046, or about three-quarters of the average from 1985 to 2014. CBO projects that the growth rate will be lower in the future than it has been in the past for two reasons: The agency anticipates that people will limit their spending for health care to maintain their consumption of other goods and services, and it expects that state governments, private insurers, employers, and the Centers for Medicare & Medicaid Services (CMS) will respond to the pressures of rising health care costs by taking steps to slow spending growth.

Those projections are subject to considerable uncertainty (as Chapter 7 explains). One challenge, in particular, is assessing how much of the recent slowdown in the growth of health care spending can be attributed to temporary factors, such as the recession, and how much reflects more enduring developments. Several studies have concluded that the slowdown is not entirely the result of the weak economy, but they differ considerably in their assessment of other factors' importance.<sup>7</sup> CBO's own analysis found no direct link between the recession and slower growth in Medicare spending.<sup>8</sup> Accordingly, over the past several years, the agency has substantially reduced its 10-year and long-term projections of Medicare and Medicaid spending per beneficiary.

## Overview of the Major Federal Health Care Programs

Health care in the United States is financed by a combination of private and public sources, mostly through various forms of health insurance. Many people obtain insurance through government programs such as Medicare, Medicaid, and CHIP. In addition, most private health insurance coverage is subsidized through the federal tax code, which allows employers and employees to exclude their shares of the cost of employment-based coverage from income and payroll taxes, or through refundable tax credits for people who purchase coverage through the health insurance marketplaces established by

5. Net federal spending for Medicare refers to gross spending for Medicare minus offsetting receipts (mostly premiums paid by beneficiaries to the government), which are recorded in the budget as offsets to spending. Net federal spending for all major federal health care programs refers to gross spending for all those programs minus offsetting receipts for Medicare.

6. The 10-year baseline referred to in this chapter is the one issued in March 2016. See Congressional Budget Office, *Updated Budget Projections: 2016 to 2026* (March 2016), [www.cbo.gov/publication/51384](http://www.cbo.gov/publication/51384).

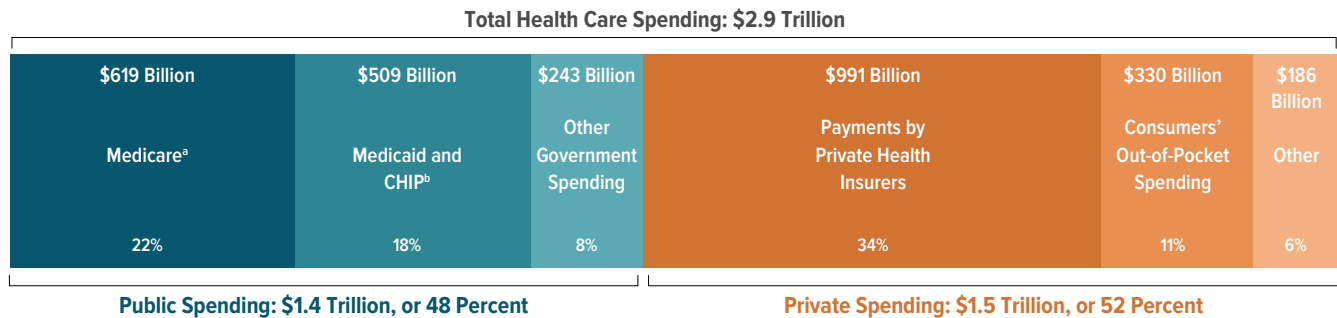
7. See, for example, Amitabh Chandra, Jonathan Holmes, and Jonathan Skinner, "Is This Time Different? The Slowdown in Health Care Spending," *Brookings Papers on Economic Activity* (Fall 2013), pp. 261–323, <http://tinyurl.com/zt8w5v2>.

8. Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* Working Paper 2013-06 (Congressional Budget Office, August 2013), [www.cbo.gov/publication/44513](http://www.cbo.gov/publication/44513).

Figure 3-1.

### National Spending for Health Care, 2014

Total health care spending amounted to \$2.9 trillion in calendar year 2014, about half of which was private spending. The federal government subsidizes a substantial part of that private spending, primarily through the tax exclusion for employment-based health insurance.



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

CHIP = Children's Health Insurance Program.

- a. Refers to gross spending for Medicare, which does not account for offsetting receipts that are credited to the program. Those offsetting receipts are mostly premium payments made by beneficiaries to the government.
- b. Includes federal and state spending.

the ACA.<sup>9</sup> This chapter focuses on federal spending (or outlays) for health insurance; the effects of tax provisions related to health insurance on federal revenues are included in the projections presented in Chapter 5.

In calendar year 2016, on an average monthly basis, 57 million people will be enrolled in Medicare, 77 million will be enrolled in Medicaid, about 6 million will be enrolled in CHIP, and about 12 million will be covered by insurance purchased through the marketplaces, CBO estimates. Among people who are under age 65, most—about 155 million—will have private health insurance obtained through an employer, roughly 9 million will be covered by a nongroup policy purchased directly from an insurer, and about 27 million (or 10 percent of the under-65 population) will be uninsured, CBO and the staff of the Joint Committee on Taxation (JCT) estimate.<sup>10</sup>

9. CBO and the Joint Committee on Taxation estimate that the tax preferences that subsidize employment-based coverage for people under age 65 will total about \$268 billion in 2016—a sum that is roughly equal to federal spending in that year for Medicaid benefits provided to noninstitutionalized people under age 65. For more information, see Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (March 2016), [www.cbo.gov/publication/51385](http://www.cbo.gov/publication/51385).

In calendar year 2014, national spending for health care was an estimated \$2.9 trillion (see Figure 3-1).<sup>11</sup> Of that amount, 52 percent was initially financed by private

10. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (March 2016), [www.cbo.gov/publication/51385](http://www.cbo.gov/publication/51385). The sum of those estimates exceeds CBO's estimate of the total population because some people will have multiple sources of coverage and CBO has not assigned a primary source to such people. For example, currently, about 8.5 million people with Medicaid coverage are also covered by Medicare, which is their primary source of coverage. For information about people eligible for benefits through both programs, see Congressional Budget Office, *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (June 2013), [www.cbo.gov/publication/44308](http://www.cbo.gov/publication/44308).

11. This report defines national spending for health care as the health consumption expenditures in the national health expenditure accounts maintained by the Centers for Medicare & Medicaid Services. That definition excludes spending on medical research, structures, and equipment but includes administrative costs for insurers and all spending on medical goods and services. With spending for those excluded categories added to the total, national spending for health care was \$3.0 trillion in calendar year 2014. For more information, see Anne B. Martin and others, "National Health Spending in 2014: Faster Growth Driven by Coverage Expansion and Prescription Drug Spending," *Health Affairs*, vol. 35, no. 1 (January 2016), pp. 150–160, <http://dx.doi.org/10.1377/hlthaff.2015.1194>.

sources—34 percent came from private health insurers; 11 percent, from consumers in the form of out-of-pocket spending; and 6 percent, from other sources of private funds, such as philanthropy.<sup>12</sup> The remaining 48 percent of national spending on health care was public: Gross federal spending for Medicare accounted for 22 percent of the total; federal and state spending for Medicaid and CHIP, for 18 percent; and spending on various other programs (including those run by state and local governments' health departments, by the Department of Veterans Affairs, and by the Department of Defense), for 8 percent.

### Medicare

In 2016, according to CBO's estimates, Medicare will provide health insurance to about 57 million people who are at least 65 years old, are disabled, or have end-stage renal disease. Most people become eligible for Medicare when they reach 65; about 85 percent of enrollees are 65 or over. Disabled people generally become eligible 24 months after they qualify for benefits under Social Security's Disability Insurance program.<sup>13</sup>

The Medicare program provides a specified set of benefits. Hospital Insurance (HI), or Medicare Part A, covers inpatient hospital services, care provided in skilled nursing facilities, home health care, and hospice care. Part B mainly covers services provided by physicians, other practitioners, and hospitals' outpatient departments. Part D provides a prescription drug benefit, which is administered by private insurance plans.

Most enrollees in Medicare are in the traditional fee-for-service program, in which the federal government pays for covered services under Parts A and B directly, but about 30 percent have opted for Part C of the program, known as Medicare Advantage, in which they receive Medicare benefits through a private health insurance

plan. In 2015, gross spending for Medicare was \$634 billion, and net spending (that is, gross spending minus offsetting receipts, which mostly consist of beneficiaries' premium payments to the government) was \$540 billion.

Parts A, B, and D of the program are financed in different ways. Outlays for Part A are financed by dedicated sources of income credited to a fund called the Hospital Insurance Trust Fund. The primary source is a payroll tax (amounting to 2.9 percent of all earnings); the other sources are a 0.9 percent tax on earnings over \$200,000 (or \$250,000 for married couples) and a portion of the federal income taxes paid on Social Security benefits.<sup>14</sup> For Part B, premiums paid by beneficiaries cover just over one-quarter of outlays, and the government's general fund covers the rest. Enrollees' premiums under Part D are set to cover about one-quarter of the cost of the basic prescription drug benefit (although many low-income enrollees pay no premiums), and the general fund covers most of the rest. Federal payments to private insurance plans under Part C comprise a blend of funds drawn from Parts A, B, and D. All told, in 2015, about 40 percent of gross federal spending on Medicare was financed by the HI trust fund's dedicated taxes, about 15 percent came from offsetting receipts, and the rest came from other sources (mostly transfers from the general fund), CBO estimates.

In the fee-for-service portion of Medicare, beneficiaries' cost-sharing obligations (that is, what they are obliged to pay out of pocket) vary widely by type of service, and the program does not set an annual limit on the health care costs for which beneficiaries are responsible. However, the great majority of beneficiaries—about 84 percent of them in 2011, according to one recent study—have supplemental insurance that covers many or all of the program's cost-sharing requirements.<sup>15</sup> The most common sources of supplemental coverage are plans for retirees offered by former employers, Medicare Advantage plans, individually purchased policies (called medigap insurance), and Medicaid.

12. For the purposes of that analysis, out-of-pocket payments include payments made to satisfy cost-sharing requirements for services covered by insurance as well as payments for services not covered by insurance. They do not, however, include the premiums that people pay for health insurance—because premiums fund the payments that insurers provide, which have already been accounted for.

13. People with amyotrophic lateral sclerosis (also known as Lou Gehrig's disease) and those with end-stage renal disease are exceptions: Those with Lou Gehrig's disease become eligible when their Disability Insurance benefits start; those with end-stage renal disease usually become eligible for Medicare on the first day of the fourth month of dialysis treatment.

14. The thresholds for the 0.9 percent tax are not indexed for inflation. Certain people are subject to an additional 3.8 percent tax on unearned income that is officially labeled a Medicare tax even though the revenues are credited to the government's general fund rather than to the HI trust fund.

15. Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program* (June 2015), p. 23, <http://go.usa.gov/xqRnk> (PDF, 1.7 MB).

The Medicare program includes a number of incentives and mechanisms that could reduce spending growth in the program over time:

- The program’s premiums and cost sharing will consume a growing share of beneficiaries’ income—because the growth of health care spending in general is projected to outpace the growth of income—and that will constrain demand for some Medicare services.
- The rules governing the annual updates that are made to Medicare’s payment rates for health care services will generally cause those updates to be smaller than the increases in the prices of inputs (namely, labor, supplies, capital equipment, and facilities) used to deliver care.
- Changes being made in the structure of Medicare’s payments to providers, such as financial incentives to reduce hospital-acquired infections and readmissions, may help hold down federal spending.
- The Center for Medicare & Medicaid Innovation, an arm of CMS, is testing ways to modify rules and payment methods that could reduce costs without impairing the quality of health care; the changes that prove effective may be expanded by the Secretary of Health and Human Services (HHS).
- If the rate of growth in spending per beneficiary is projected to exceed specified targets in certain years, an Independent Payment Advisory Board is required to submit a package of changes in program rules that would reduce Medicare spending in those years, and the Secretary of HHS is required to implement those changes.<sup>16</sup>

### Medicaid

A joint federal-state program, Medicaid pays for health care services, mostly for low-income people. In any given month in 2016, an average of about 77 million people will be enrolled in Medicaid, CBO estimates. Nearly half of Medicaid’s current enrollees are children in low-income families, slightly more than one-third are adults under age 65 who are not disabled, and the remaining one-fifth or so are people who are at least 65 or who are

disabled. Expenses for beneficiaries who are 65 or older or who have disabilities, many of whom require long-term care, tend to be higher than those for other beneficiaries. In 2015, almost one-quarter of federal spending for Medicaid benefits was for long-term services and supports, a category that includes institutional care provided in nursing homes and certain other facilities as well as care provided in a person’s home or in the community. In that year, people age 65 or older and people with disabilities accounted for about half of federal spending for Medicaid benefits.<sup>17</sup>

States administer their Medicaid programs under federal guidelines that mandate a minimum set of services that must be provided to certain categories of low-income people. The required services include inpatient and outpatient hospital services, services provided by physicians and laboratories, comprehensive and preventive health care services for children, nursing home and home health care, and transportation. The required eligibility categories include families that would have met the financial requirements of the Aid to Families With Dependent Children program when it existed, people age 65 or over and disabled people who qualify for the Supplemental Security Income program, and children and pregnant women in families with income below 138 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL).<sup>18</sup>

In addition, under an option created by the ACA, states are permitted but not required to expand eligibility for Medicaid to adults under age 65 whose income is equal to or less than 138 percent of the FPL.<sup>19</sup> By the end of

16. If the board failed to submit a package of program changes that would achieve the target savings, the Secretary would be required to develop and implement such changes.

17. Congressional Budget Office, “Baseline Projections for Selected Programs: Medicaid” (March 2016), [www.cbo.gov/publication/51301](http://www.cbo.gov/publication/51301).

18. In 1996, the Aid to Families With Dependent Children (AFDC) program, which provided cash assistance to low-income families, was replaced by the Temporary Assistance for Needy Families (TANF) program. Under AFDC rules, recipients generally received Medicaid benefits automatically. When TANF replaced AFDC, TANF recipients did not automatically qualify for Medicaid, but the Congress established a new category under Medicaid whose eligibility criteria matched the former AFDC criteria. The FPL is currently \$24,300 for a family of four. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Poverty Guidelines” (January 2016), <https://aspe.hhs.gov/poverty-guidelines>.

19. The statute specifies a threshold of 133 percent of the FPL, but an automatic deduction to income equal to 5 percent of the FPL effectively makes the threshold 138 percent of the FPL.



calendar year 2015, 30 states and the District of Columbia had expanded their programs; about half of the people who meet the new eligibility criteria reside in those states, CBO estimates.<sup>20</sup>

As long as they meet federal requirements, state governments have substantial flexibility to determine eligibility, benefits, and payments to providers under Medicaid. They may choose to make additional groups of people eligible (such as people who have income above the usual eligibility thresholds but whose medical expenses exceed a certain portion of their income) or to provide additional benefits (such as coverage for prescription drugs and dental services). Moreover, many states seek and receive waivers of federal statutory limitations that allow them to provide benefits and cover groups that would otherwise be excluded.

The federal government's share of spending for Medicaid benefits varies by state. That share averaged about 57 percent for many years, but it has increased in recent years. For those enrollees who were made eligible by the ACA, the federal government will pay all costs through 2016, a slightly declining share of costs each year from 2017 to 2019, and 90 percent of costs in 2020 and beyond.

In 2015, federal spending for Medicaid amounted to \$350 billion. Of that amount, \$319 billion went to benefits for enrollees, and the remainder covered payments to hospitals that served a disproportionate share of Medicaid patients and uninsured, low-income patients; costs for the Vaccines for Children program; and administrative expenses.<sup>21</sup> States spent \$205 billion on Medicaid that year, CBO estimates.<sup>22</sup>

### Children's Health Insurance Program

CHIP, a much smaller joint federal-state program, provides health insurance coverage for children in families

whose income, though modest, is too high for them to qualify for Medicaid. States have discretion to determine the income threshold for eligibility, but it generally falls between 138 percent and 300 percent of the FPL. Nearly 6 million people will be enrolled in the program, on average, during 2016. Like Medicaid, CHIP is administered by the states within broad federal guidelines. Unlike Medicaid, however, CHIP has a fixed nationwide limit on federal spending. In 2015, federal spending on CHIP was \$9.2 billion.<sup>23</sup> The federal share of CHIP spending varies among the states but usually averages about 70 percent.<sup>24</sup>

### Subsidies for Insurance Purchased Through the Health Insurance Marketplaces

Many people can buy subsidized insurance through the marketplaces operated by the federal government, state governments, or partnerships between federal and state governments. There are two kinds of subsidies: tax credits to help pay for premiums and cost-sharing subsidies to reduce out-of-pocket expenses, such as deductibles and copayments. The premium tax credits are refundable: A large portion is paid to taxpayers and categorized as outlays, and a smaller portion reduces taxes paid, which in turn reduces income tax revenues. To qualify for the premium tax credits, a person generally must have household income between 100 percent and 400 percent of the FPL and must not have access to certain other sources of health insurance coverage, including coverage through an employer that meets the law's definition of affordable and coverage from a government program, such as Medicare or Medicaid. To qualify for the cost-sharing subsidies, a person must meet the requirements for the premium tax credits, enroll in what the law defines as a silver plan (which covers about 70 percent of the cost of covered benefits), and have household income below 250 percent of the FPL.

The size of a person's premium tax credit is the difference between the cost of the second-lowest-cost silver plan available to him or her and a specified percentage of his or her household income. For example, for calendar year

20. Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (March 2016), [www.cbo.gov/publication/51385](http://www.cbo.gov/publication/51385).

21. The Vaccines for Children program helps provide vaccines to those children under age 19 whose parents or guardians may not be able to afford them. The eligible group includes people who are Medicaid-eligible or uninsured.

22. CBO's calculations rely on unpublished data from states' filings of Form CMS-64 for fiscal year 2015. States use that form to report their quarterly spending for Medicaid benefits and administrative activities to CMS.

23. Congressional Budget Office, "Baseline Projections for Selected Programs: Children's Health Insurance Program" (March 2016), [www.cbo.gov/publication/51296](http://www.cbo.gov/publication/51296).

24. For fiscal years 2016 through 2019, the federal share of CHIP spending is expected to average 93 percent, reflecting a temporary 23 percentage-point increase in the federal share of spending for that program.

2016, the tax credit was set so that people with income between 100 percent and 133 percent of the FPL would pay 2.03 percent of their income to enroll in the second-lowest-cost silver plan, while people with higher income would pay a larger share of their income, up to 9.66 percent for those with income between 300 percent and 400 percent of the FPL. If a person's premium for such a plan is less than the applicable percentage of income, that person receives no tax credit. The amounts that enrollees must pay are indexed so that the subsidies cover roughly the same portion of the premiums over time. After calendar year 2018, however, an additional indexing factor may apply in some years; if that factor applied, the share of the premiums that enrollees paid would increase, and the share of the premiums that the subsidies covered would decline.<sup>25</sup>

Spending related to subsidies for insurance purchased through the marketplaces consists of outlays for the risk-adjustment and reinsurance programs.<sup>26</sup> Those programs were established under the ACA to stabilize premiums in the nongroup and small-group insurance markets by reducing the likelihood that particular health insurers would bear especially high costs for having a disproportionate share of less healthy enrollees. The programs make payments to insurers that reflect differences in the health status of each insurer's enrollees and in the resulting costs to insurers. Payments for the risk-adjustment program are financed by collections from insurers with healthier enrollees, and those for reinsurance are funded by an assessment on a broad range of insurers. Those payments are recorded in the budget as mandatory outlays, and the collections are recorded as revenues.

CBO and JCT estimate that during calendar year 2016, an average of about 12 million people will be covered by insurance purchased through the marketplaces each

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25. The additional indexing factor will apply in any calendar year after 2018 in which the total costs of the subsidies for health insurance purchased through the marketplaces exceed a specified percentage of GDP. CBO expects that the indexing factor may apply in some years, although the uncertainty of projections of both the subsidies and GDP make the timing unclear. For an explanation of the indexing factor, see Congressional Budget Office, *Additional Information About CBO's Baseline Projections of Federal Subsidies for Health Insurance Provided Through Exchanges* (May 2011), [www.cbo.gov/publication/41464](http://www.cbo.gov/publication/41464).

26. Between 2016 and 2018, spending related to subsidies also includes a small amount of outlays for grants to states for establishing the marketplaces.

month and that about 10 million of them, on average, will receive subsidies. An additional 1 million people are estimated to participate in the Basic Health Program, which offers subsidies to certain low-income people.<sup>27</sup> In fiscal year 2015, outlays for those subsidies and related spending were about \$38 billion, CBO and JCT estimate.<sup>28</sup> (The agencies estimate that the subsidies and related programs also added between \$8 billion and \$9 billion to revenues that year. That effect consists of an increase in revenues of about \$11 billion from payments collected under the risk-adjustment and reinsurance programs, offset in part by a \$2 billion to \$3 billion reduction in taxes paid resulting from premium subsidies. Those effects on revenues are included in the projections discussed in Chapter 5.)

### **CBO's Method for Making Long-Term Projections of Federal Health Care Spending**

CBO's extended baseline projections of federal spending on the major health care programs, like the rest of the agency's extended baseline projections, generally reflect the provisions of current law. The first 10 years of projections in the extended baseline match the agency's 10-year baseline projections, which are based on a detailed analysis of the major health care programs. Beyond the coming decade, however, projecting federal spending on health care becomes increasingly difficult because of the considerable uncertainties involved. A wide range of changes could occur—in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care—that are almost impossible to predict but that could nevertheless have a significant effect on federal health care spending.

Therefore, for the projections beyond 2026, CBO has adopted a formulaic approach—one that combines estimates of the number of people who will receive benefits from government health care programs with fairly mechanical projections of growth in spending per beneficiary

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27. The Basic Health Program, which was created under the ACA, allows states to establish a coverage program primarily for people with income between 138 and 200 percent of the FPL. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would have been eligible if they had instead purchased coverage through a marketplace.

28. See Congressional Budget Office, *Updated Budget Projections: 2016 to 2026* (March 2016), Table 4, [www.cbo.gov/publication/51384](http://www.cbo.gov/publication/51384).

Table 3-1.

### Average Annual Rates of Excess Cost Growth in Spending for Health Care

Percent	Medicare	Medicaid	Other <sup>a</sup>	Overall <sup>b</sup>
1975 to 2014	1.9	1.7 <sup>c</sup>	1.8	1.8
1980 to 2014	1.6	1.4	1.7	1.6
1985 to 2014	1.4	1.0	1.5	1.4
1990 to 2014	1.2	0.6	1.3	1.2

Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

Excess cost growth refers to the extent to which the growth rate of nominal health care spending per person—adjusted for demographic characteristics of the relevant populations—exceeds the growth rate of potential GDP per person. (Potential GDP is the maximum sustainable output of the economy.) The historical rates of excess cost growth are weighted averages of annual rates: Twice as much weight is placed on the latest year as on the earliest year.

GDP = gross domestic product.

- To calculate these values, CBO began with overall excess cost growth and removed the effects of excess cost growth for Medicare and Medicaid. The values therefore include the excess cost growth of payments by private health insurers and of other health care spending, such as consumers' out-of-pocket spending and spending financed by other private and public sources.
- Refers to the excess cost growth of national spending for health care—specifically, to the excess cost growth of the health consumption expenditures in the national health expenditure accounts maintained by the Centers for Medicare & Medicaid Services.
- Shows the average rate from 1976 to 2014 because data for 1975 are unavailable.

(adjusted to account for demographic changes in the beneficiaries of each program). CBO has estimated such growth by combining projected growth in potential GDP per person and projected excess cost growth for the program in question. (From 2017 to 2026, potential GDP per person is projected to grow at an average rate of about 3.2 percent per year; from 2017 to 2046, the average growth rate is projected to be about 3.5 percent.)

Excess cost growth is the growth rate of health care spending per person (after the effects of demographic changes are removed) relative to the growth rate of potential GDP per person.<sup>29</sup> The *excess* in excess cost growth is

29. CBO uses potential GDP rather than actual GDP in its estimate of excess cost growth to limit the effect of cyclical changes in the economy on its estimate.

not intended to imply that growth in health care spending per person is necessarily excessive or undesirable; the term is simply used to describe the extent to which the growth in such spending *exceeds* the growth in potential output per person. According to CBO's calculations, average rates of excess cost growth for various parts of the health care system have ranged from 0.6 percent to 1.9 percent over different periods of the past several decades (see Table 3-1).<sup>30</sup> Although such rates are quite variable from year to year, they have generally declined. Excess cost growth has been especially low, on average, during two periods—the mid-to-late 1990s and from the mid-2000s to 2014 (the most recent year for which such data are available).

In CBO's extended baseline, the projected rates of excess cost growth for Medicare, Medicaid, and private health insurance premiums slowly converge after 2026, from the rates derived from the detailed 10-year baseline projections toward a rate of 1.0 percent—which is CBO's projection of the rate of excess cost growth for the health care sector 30 years from now. All told, annual rates of excess cost growth from 2017 to 2046 are projected to average 0.9 percent for Medicare, 1.0 percent for Medicaid, and 1.6 percent for private health insurance premiums.

### Excess Cost Growth During the Next Decade

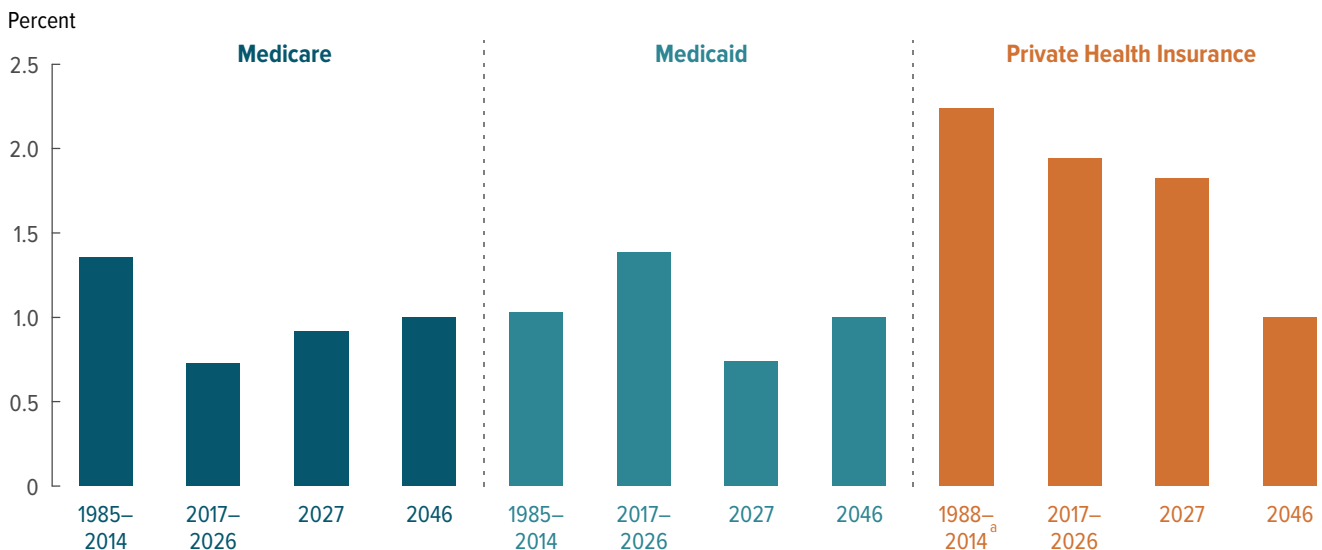
For 2017 through 2026, the projected rates of excess cost growth for Medicare, Medicaid, and private health insurance premiums in CBO's extended baseline are derived from CBO's 10-year baseline (see Figure 3-2). Those rates are as follows:

30. The historical rates of excess cost growth are a weighted average of annual rates: Twice as much weight was placed on the latest year as on the earliest year. In calculating excess cost growth for Medicare, CBO made adjustments to account for changes in the age distribution of beneficiaries. In calculating excess cost growth for Medicaid, CBO adjusted the rates to account for changes in the program's case mix—that is, the proportions of types of beneficiaries, including children, people at least 65 years old, people with disabilities, and adults who did not fall into any of those categories—rather than for changes in the age distribution of beneficiaries. The rates of excess cost growth that have been adjusted to account for demographic changes reflect changes in spending per person rather than changes in the number or composition of beneficiaries. The introduction of Medicare's Part D drug benefit in 2006 resulted in a onetime shift in some spending from Medicaid to Medicare; to adjust for that shift, CBO assumed that excess cost growth in 2006 for both Medicare and Medicaid was equal to the average of excess cost growth in the two programs for that year.



Figure 3-2.

### Estimated and Projected Rates of Excess Cost Growth in Spending for Health Care



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

Excess cost growth refers to the extent to which the growth rate of nominal health care spending per person—adjusted for demographic characteristics of the relevant populations—exceeds the growth rate of potential GDP per person. (Potential GDP is the maximum sustainable output of the economy.) The historical rates of excess cost growth are weighted averages of annual rates: Twice as much weight is placed on the latest year as on the earliest year.

GDP = gross domestic product.

a. Shows excess cost growth beginning in 1988 because data for earlier years are unavailable.

■ For Medicare, the average annual rate of excess cost growth implicit in CBO’s baseline projections is about 0.7 percent, meaning that Medicare spending per beneficiary (adjusted for demographic changes) is projected to grow faster than potential GDP per person over the next 10 years.<sup>31</sup> CBO projects that rate of growth, which is below the average rate since 1985, in part because the agency anticipates that the use of Medicare services will continue to grow at a slow rate, as it has in recent years. In addition, under current law

many of the annual updates to Medicare’s payment rates will be smaller than they have been in the past. Consequently, excess cost growth in Medicare is projected to be slow during the next few years and then to rise to about 0.9 percent per year by the end of the 10-year period.

■ For Medicaid, the average annual rate of excess cost growth implicit in CBO’s baseline projections of the federal share of such spending is 1.4 percent, which is above the average rate from 1985 to 2014.<sup>32</sup> That rate

31. Medicare is typically scheduled to make certain payments under Parts C and D on the first of the month. If the day on which payments are due falls on a weekend or holiday, Medicare accelerates those payments to the last business day of the previous month. As a result, Medicare makes 11 or 13, rather than the normal 12, payments in certain years. For example, because October 1, 2023, falls on a Sunday, Medicare will issue payments due on that day on September 29, 2023, meaning that Medicare is scheduled to make 11 monthly payments in fiscal year 2024. CBO made adjustments to the Medicare spending amounts to account for such shifts in the timing of payments. In addition, in calculating the rate of excess cost growth, the effect of sequestration was removed because that cancellation of funding will not affect spending after 2025. In all subsequent discussion, the annual rates of excess cost growth for Medicare between 2017 and 2026 reflect those adjustments.

32. Medicaid spending amounts were adjusted to remove the effect of changes in the federal share of such spending. The number of Medicaid enrollees was adjusted to account for the projected faster growth in the number of beneficiaries known as partial duals than in the number of other types of Medicaid beneficiaries in the 10-year baseline. (Partial duals are Medicare beneficiaries who qualify to have Medicaid pay some of the expenses that they incur under Medicare, such as premiums; Medicaid does not, however, cover additional health care services they might receive, such as long-term services and supports.) That adjustment is necessary because the extended baseline reflects the expectation that the rate of growth in the number of partial duals will be similar to the growth rates of other types of Medicaid beneficiaries after 2026. In all subsequent discussion, the annual rates of excess cost growth for Medicaid between 2017 and 2026 reflect those adjustments.

is projected to gradually slow to about 0.7 percent by the end of the 10-year projection period. The higher rate of excess cost growth over the next few years can largely be explained by CBO's expectation that some states will expand coverage to include people with income of up to 138 percent of the FPL. That expansion would change the average cost per beneficiary because average spending on new enrollees who are made eligible by such an expansion (mostly adults who are not disabled) tends to be higher than average spending on adults who would have been eligible otherwise. (Although measures of excess cost growth reflect an attempt to adjust for policy changes and demographic changes, accounting for the effects of Medicaid expansions can be difficult.) CBO expects that the rate of excess cost growth will moderate later in the decade as the number of Medicaid enrollees who were made eligible by the ACA stabilizes.

- For private health insurance premiums, the average annual rate of excess cost growth implicit in the agency's baseline projections is about 2 percent by the end of the 10-year projection period. (That rate is similar to the average from 1988 to 2014.) CBO uses that average rate to project premiums, a key input in determining spending for the subsidies for insurance purchased through the marketplaces. In addition, the agency's baseline projections of such spending reflect the likelihood that the share of premiums covered by the subsidies will decline over time as a result of the additional indexing factor mentioned above.

### Excess Cost Growth After the Next Decade

Underlying CBO's projections of federal health care spending for 2027 and later years is the assumption that the rates of excess cost growth for Medicare, Medicaid, and private health insurance premiums, all of which are projected to be different in 2027, converge over the subsequent 20 years. In 2027, the rate of excess cost growth specific to each of those three categories equals the average of the specific rates projected for 2024 through 2026. For Medicare, that average rate is 0.9 percent; for Medicaid, it is 0.7 percent; and for private health insurance premiums, it is about 2 percent. After 2027, the excess cost growth rate of each of those three categories moves linearly, by the same fraction of a percentage point each year, from that category-specific rate to a rate of 1.0 percent in 2046 (see Figure 3-2).<sup>33</sup>

CBO projects that the excess cost growth rates for Medicare, Medicaid, and private health insurance premiums will all be the same in 30 years. Because the health care system is integrated to a significant degree, spending growth in all parts of the system will be affected by common factors, such as changes in physicians' practices and the development and diffusion of new medical technologies. CBO does not have a basis for projecting that the rates of excess cost growth for those three categories would differ in the long term. The agency used a value for excess cost growth three decades from now that is roughly three-quarters of the overall 30-year historical average of 1.4 percent. In determining that overall long-term growth rate, CBO considered each category's growth rate over the past 30 years, recently, and as projected at the end of the coming decade, as well as the flexibility within each category to restrain costs.

For Medicare, excess cost growth from 1985 to 2014 averaged 1.4 percent, but such growth was slower in recent years, averaging about 0.2 percent from 2008 to 2014. The reasons for that slowdown are not well understood.<sup>34</sup> Nevertheless, the slowdown has been substantial and has continued for several years. CBO has partially incorporated that slower growth into its projections for the next 10 years. In the second and third decades of the extended baseline, excess cost growth is projected to be between 0.9 percent and 1.0 percent, slower than the historical average. Although not a factor in the recent slowdown, one reason why that growth will probably remain below historical rates beyond the next 10 years is that the

33. The approach that CBO used to project long-term excess cost growth for Medicare, Medicaid, and private health insurance premiums is simpler this year than the method that the agency used last year. The change in method is described in Appendix B.

34. The rate of growth in Medicare spending per beneficiary for the elderly fell by nearly one-half from the early 2000s to the end of that decade. In studying that change, CBO could not identify the factors that caused most of the difference and found no evidence directly linking the declining rate of growth to the financial crisis and economic downturn. According to CBO's analysis, nearly one-fifth of that drop was attributable to the following three developments, which together slowed growth in spending for Medicare services: changes in the age and health status of beneficiaries, growth in the proportion of beneficiaries who enrolled only in Part A, and growth in the use of prescription drugs. About 6 percent of the drop stemmed from slower growth in average payment rates, and the remainder was not explained by any of the factors that CBO investigated. See Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* Working Paper 2013-06 (Congressional Budget Office, August 2013), [www.cbo.gov/publication/44513](http://www.cbo.gov/publication/44513).

program now includes a number of institutions, incentives, and mechanisms, such as the Center for Medicare & Medicaid Innovation and the Independent Payment Advisory Board, that could reduce spending growth in the program over time.

For Medicaid, the rate of excess cost growth is projected to be 0.7 percent in 2027 and to rise over the subsequent two decades. In 2046, the rate is projected to gradually return to its 1985–2014 average of 1.0 percent and to match the rates for Medicare and private health insurance premiums. That trajectory of excess cost growth reflects competing pressures that are expected to affect the Medicaid program—gradually boosting the rate between 2027 and 2046, though holding it below the projected rates for Medicare and private health insurance premiums. On the one hand, states are likely to face pressure—stemming from physicians’ practice patterns, new technology, and other factors in the broader health care system—to increase payments to health care providers so that they continue to treat Medicaid beneficiaries. On the other hand, as health care costs rise, states are also expected to face pressure to slow the growth of spending for the program through actions—such as constraining payment rates for providers and managed care plans or limiting the optional services that Medicaid covers—that would reduce both state and federal expenditures.

For health insurance premiums in the private sector, the rate of excess cost growth is projected to decline from 2027 to 2046 and to be lower in 2046 than it has averaged historically. (By itself, that rate does not determine projections for subsidies for health insurance purchased through the marketplaces, but it is a key input into them.) Excess cost growth for private health insurance premiums is projected to decline in the long term because CBO expects that pressure to restrain health care costs will mount as those costs increase and become a greater and greater share of economic activity. When its share of GDP increases, health care spending absorbs a growing share of people’s income, forcing them to consume fewer other goods and services, which in turn increases pressure to slow its growth. In the private sector, employers could intensify their efforts to reduce the costs of the insurance plans that they offered, and workers might pressure their employers to offer less expensive plans as health insurance premiums rose. Private insurers could also work to reduce that growth; they have more scope than the federal and state governments have to do so because the starting point of excess cost growth for private health insurance

premiums is higher than excess cost growth for Medicare and Medicaid.

### How Spending Is Projected in the Long Term

To generate estimates of total spending for Medicare and Medicaid in the long term, CBO used the projections of program-specific excess cost growth and the number of beneficiaries. For Medicare, CBO estimates that the number of beneficiaries would grow with the size of the population age 65 or over and with the number of recipients of Social Security’s Disability Insurance benefits.<sup>35</sup> Such growth is projected to average 1.7 percent per year between 2017 and 2046.

For Medicaid, what decisions states will make about Medicaid eligibility and covered benefits over even the next 10 years is quite uncertain, and that uncertainty grows with time; accordingly, CBO adopted a formulaic approach to generate the number of Medicaid beneficiaries each year after the next decade. That approach takes into account population growth, increasing earnings (which will reduce the number of eligible beneficiaries), and prospective actions by states.<sup>36</sup> (In particular, the projections incorporate the assumption that states would make changes over time in their Medicaid programs that offset roughly half of the effect of earnings growth on eligibility.) Overall, the number of enrollees is projected to remain roughly the same after 2026.

For CHIP, as well as for subsidies for health insurance purchased through the marketplaces and related spending, outlays are projected differently. Under current law, funding for CHIP expires after September 2017. Following statutory guidelines, CBO’s baseline spending projections reflect the assumption that funding for the program will amount to \$5.7 billion each year from 2018 through 2026.<sup>37</sup> For years after 2026, spending for the program, measured as a share of GDP, is assumed to remain at the 2026 level.

35. For more information about how CBO projects the number of beneficiaries of Social Security’s Disability Insurance program, see Appendix A of this report as well as Congressional Budget Office, *CBO’s Long-Term Model: An Overview* (June 2009), [www.cbo.gov/publication/20807](http://www.cbo.gov/publication/20807).

36. For additional discussion, see Congressional Budget Office, *The 2015 Long-Term Budget Outlook* (June 2015), Appendix A, [www.cbo.gov/publication/50250](http://www.cbo.gov/publication/50250).

37. Congressional Budget Office, “Baseline Projections for Selected Programs: Children’s Health Insurance Program” (March 2016), [www.cbo.gov/publication/51296](http://www.cbo.gov/publication/51296).

CBO uses two approaches to project the costs of subsidies after the initial 10-year projection period: one for the first year of the long-term projection period and another for the end of that period. For the years in between, CBO uses a blend of those two approaches. For the first year of the projection period, subsidies are projected to grow at the average rate projected for the end of the 2017–2026 period; the agency makes adjustments to account for the increased probability that the additional indexing factor described above will be in effect. For the end of the projection period, the projections of subsidies are based on the rate of excess cost growth for private health insurance premiums and account for the effects of the additional indexing factor and of growth in real (inflation-adjusted) income. The additional indexing factor would limit the growth of the average subsidy, thereby moderating the growth of total spending on subsidies. Growth in real income would further moderate such spending: Although some people who had previously been eligible for Medicaid would become eligible for subsidies as their income increased, other people would move into higher income brackets and become eligible for less generous subsidies or become ineligible for subsidies altogether. (As a share of GDP, other spending related to those subsidies is assumed to remain at the 2026 level.)

### Long-Term Projections of Spending for the Major Health Care Programs

In CBO's extended baseline projections, which generally reflect current law, federal spending on the major health care programs increases significantly as a percentage of the economy over the next 30 years.

#### Projected Spending

In 2016, federal spending for the major health care programs will amount to 5.5 percent of GDP, CBO estimates: Medicare spending (net of offsetting receipts) will equal 3.2 percent of GDP and federal spending on Medicaid and CHIP, combined with outlays for the subsidies for health insurance purchased through the marketplaces and related spending, will equal 2.3 percent. In CBO's extended baseline, federal spending for those programs rises to 8.9 percent of GDP in 2046, about 60 percent greater than it is estimated to be in 2016; net Medicare spending accounts for 5.7 percent of GDP, and spending on Medicaid and CHIP, combined with outlays for the marketplace subsidies and related spending, accounts for 3.1 percent (see Figure 3-3).<sup>38</sup> Growth of Medicare spending will account for about three-quarters of the

increase in federal spending for the major health care programs as a share of GDP.

**Why Projected Spending Grows.** The aging of the population and the expectation that health care costs per beneficiary—for beneficiaries of all ages—will continue to grow faster than potential GDP per capita are the two key factors causing federal spending for the major health care programs to rise in CBO's projections. Those factors contribute to the rise in roughly equal proportions over the next 30 years (see Figure 1-5 on page 18). Without changes in the age distribution of the population and without any excess cost growth, CBO projects that such spending would stay roughly constant as a share of GDP over time.

In addition to adding to the number of Medicare beneficiaries, the aging of the population is projected to increase spending for the program because the beneficiaries will be older, on average, and older beneficiaries have higher average spending. Among the 65-or-older population, both the portion older than 75 and the portion older than 85 will increase over the next 30 years (see Figure 3-4). Medicare spending has traditionally been higher, on average, for older people within the 65-or-older group. For example, in calendar year 2012, spending in Parts A and B of the fee-for-service portion of Medicare averaged about \$5,000 for 66-year-olds, \$8,500 for 75-year-olds, and \$12,500 for 85-year-olds.<sup>39</sup> CBO expects that pattern to persist.

**Distribution of Spending Among Types of Beneficiaries.** The factors that underlie the projected rise in total federal spending for the major health care programs also affect the amounts of spending that would subsidize care for different types of beneficiaries. Although federal support

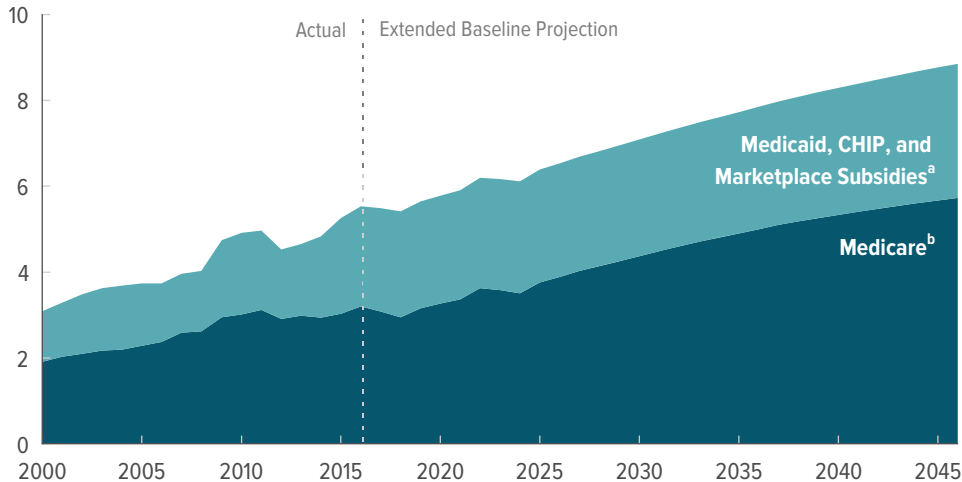
38. Gross Medicare spending is projected to increase from 3.8 percent of GDP in 2016 to 7.0 percent in 2046. In all of the projections, the outlays for subsidies for insurance purchased through the marketplaces and related spending are presented in combination with outlays for Medicaid and CHIP; they all constitute federal subsidies for health insurance for low- and moderate-income households.

39. Calculating average spending for 65-year-old beneficiaries is not helpful for this comparison because most beneficiaries are enrolled in Medicare for only part of the calendar year in which they turn 65. The amounts reported here include spending under Parts A and B of Medicare averaged among all beneficiaries of a given age in the traditional fee-for-service program who were enrolled in Part A, Part B, or both. The proportion of beneficiaries enrolled in both Parts A and B increases as beneficiaries age.

Figure 3-3.

### Federal Spending on the Major Health Care Programs, by Category

Percentage of Gross Domestic Product



The projected rise in federal spending for the major health care programs results from the aging of the population and the expectation that health care costs per person will continue to grow more quickly than potential GDP per person.

Source: Congressional Budget Office.

The extended baseline generally reflects current law, following CBO's 10-year baseline budget projections through 2026 and then extending most of the concepts underlying those baseline projections for the rest of the long-term projection period.

Potential GDP is the maximum sustainable output of the economy.

CHIP = Children's Health Insurance Program; GDP = gross domestic product.

- "Marketplace Subsidies" refers to outlays to subsidize health insurance purchased through the marketplaces established under the Affordable Care Act, as well as spending to subsidize insurance provided through the Basic Health Program and spending to stabilize premiums for insurance purchased by individuals and small employers.
- Refers to net spending for Medicare, which accounts for offsetting receipts that are credited to the program. Those offsetting receipts are mostly premium payments made by beneficiaries to the government.

for health care for people under age 65 has expanded, only about one-fifth of federal spending for the major health care programs in 2026 would, under current law, finance care for able-bodied people under age 65, CBO projects; less than one-fifth would go toward care for people under age 65 who were blind or otherwise disabled, and about three-fifths would go toward care for people who were at least 65 years old. After 2026, according to CBO's estimates, the share of federal spending for the major health care programs that financed care for people age 65 or older would continue to rise because of the aging of the population.

**Uncertainty.** All long-term economic and demographic developments are uncertain, but federal spending on health care programs may be particularly so because both the number of enrollees in those programs and average spending for those enrollees are uncertain. Federal health care programs provide benefits to different socioeconomic groups, so changes in population demographics and economic growth could lead to changes in the

number of people eligible for those programs. Uncertainty about those demographic and economic factors, combined with uncertainty about people's willingness to enroll in those programs, makes it difficult to project the number of enrollees.

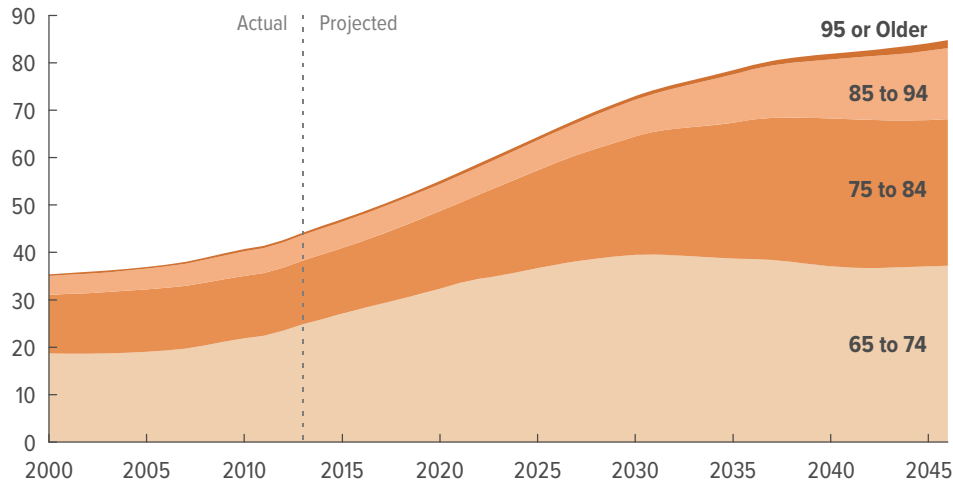
Average spending for those enrollees is also very uncertain. Pharmaceuticals, medical procedures and technology, and the delivery of care all continue to evolve, and average spending for any of the federal health care programs could prove to be much higher or lower than CBO projects—especially as the projection period lengthens. Compounding the uncertainty stemming from those factors are the uncertain responses of beneficiaries and providers to changes in health insurance design, payment arrangements, and federal and state policies, as well as uncertainty about how broader changes in the economy may affect the health care sector. Chapter 7 shows how CBO's projections would differ if the growth of costs per beneficiary in Medicare and Medicaid proved significantly higher or lower than the agency projects in the extended baseline.



Figure 3-4.

**Number of People Age 65 or Older, by Age Group**

Millions of People



Medicare spending per person tends to be higher for older beneficiaries than for younger ones. Therefore, it is projected to rise as the average age of beneficiaries increases.

Source: Congressional Budget Office.

This figure shows actual data through calendar year 2013, the most recent year for which such data are available.

Also uncertain is the extent of support from federal spending that beneficiaries of federal health care programs will receive in the future. For example, scheduled updates to Medicare's payment rates will generally be smaller in the future than increases in the prices of inputs, which could cause changes in providers' behavior. If health care providers cannot increase their productivity over time—that is, if they cannot provide the same quantity and quality of treatments and procedures with fewer or less costly inputs—they would respond in other ways, such as by reducing the quality of care, reducing Medicare beneficiaries' access to care (which might reduce spending), or trying to increase revenues by other means (which might increase spending). Providers that are not able to adjust to the constraints imposed by the payment rate updates might merge with more profitable providers or go out of business. If access to providers under the traditional fee-for-service program declined, more enrollees might shift into Medicare Advantage plans, which are not bound by the updates to payment rates that apply to traditional Medicare. Medicare Advantage plans might be able to offer better access to care than the fee-for-service program if they increased the rates that they paid providers, but doing so would probably require enrollees in such plans to pay higher premiums. (Because federal payments to those plans are based largely on costs in the fee-for-service program, it is unclear whether such a shift—if it occurred—would substantially alter the trajectory of Medicare spending.)

**Projected Financing**

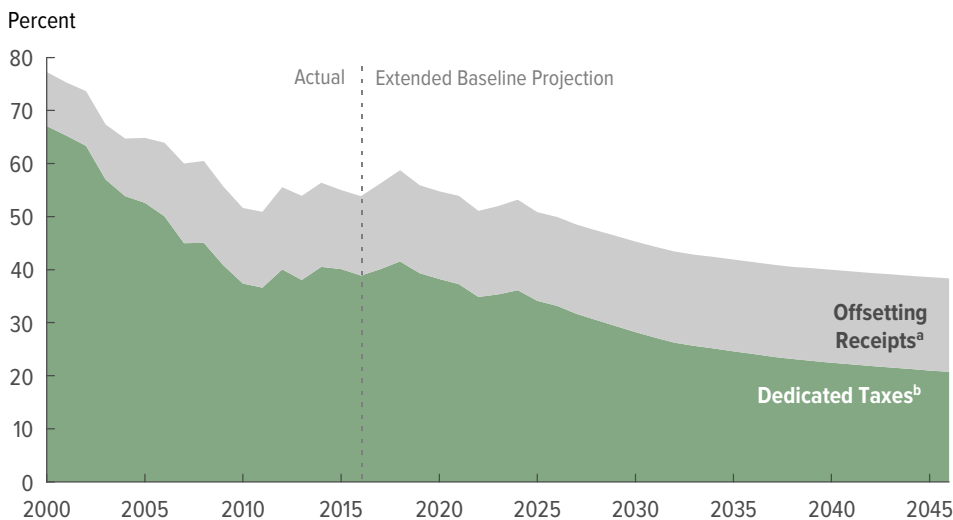
Spending on the federal government's major health care programs is financed in various ways. For Medicaid and CHIP, states and the federal government share in the financing. The federal share of spending on those programs is funded entirely from the government's general fund, as are the subsidies for insurance purchased through the marketplaces and related spending.

In contrast, Medicare is funded mostly by a mix of dedicated taxes, beneficiaries' premiums, and money from the government's general fund. The relative magnitudes of those sources of funding have changed significantly over time. As a result, the share of gross Medicare spending financed by dedicated taxes has declined from 67 percent in 2000 to an estimated 39 percent in 2016 (see Figure 3-5). The increase in the share of spending covered by sources other than dedicated taxes is largely the result of an increase in the share of benefits provided by the parts of the program that are financed mainly by premiums and money from the general fund—Part B and, since 2006, Part D.<sup>40</sup> Those shifts are expected to

40. In 2000, Part B accounted for 41 percent of gross Medicare spending; in 2016, Parts B and D will account for 57 percent of gross Medicare spending, CBO estimates. In 2016, the percentage of benefits covered by premiums and other offsetting receipts would be higher than shown here if the two-thirds of Part D premiums paid directly by beneficiaries to Part D plans and the resulting benefit payments were included; however, they are not recorded in the federal budget.

Figure 3-5.

### Medicare's Dedicated Taxes and Offsetting Receipts as a Percentage of Medicare Spending



Since 2000, the share of Medicare spending funded by dedicated taxes and premiums has dropped. The share funded by the government's general fund has consequently grown.

Source: Congressional Budget Office.

The extended baseline generally reflects current law, following CBO's 10-year baseline budget projections through 2026 and then extending most of the concepts underlying those baseline projections for the rest of the long-term projection period. The extended baseline incorporates the assumption that spending for Medicare continues as scheduled even if its trust funds are exhausted.

- a. Mostly premium payments made by beneficiaries to the government.
- b. Payroll taxes and a portion of the federal income taxes paid on Social Security benefits.

continue: In CBO's extended baseline, receipts from dedicated Medicare taxes provide only 21 percent of gross federal spending for Medicare in 2046, and beneficiaries' premiums and other offsetting receipts account for 18 percent, leaving 62 percent financed by other sources.

Benefits under Part A of Medicare are paid from the Hospital Insurance Trust Fund, which is credited with receipts largely from payroll taxes and from other revenues. A commonly used measure of the sustainability of Part A of Medicare is the timing of the projected exhaustion of the HI trust fund. According to CBO's baseline projections, under current law, the balance of the HI trust fund would increase from \$196 billion at the end of fiscal year 2015 to \$204 billion at the end of fiscal year 2019. Starting in 2020, CBO estimates, expenditures would outstrip income. The trust fund is projected to become exhausted in 2026.<sup>41</sup>

Once the HI trust fund was exhausted, total payments to health plans and providers for services covered under Part A of Medicare would be limited to the amount of

revenues subsequently credited to that trust fund. If that occurred, beneficiaries' access to health care services covered under Part A almost certainly would be reduced as well. Despite that, CBO's projections reflect the statutory requirement that the agency incorporate into its baseline an assumption that full benefits will continue to be paid as scheduled under current law regardless of the status of a trust fund.<sup>42</sup>

41. Congressional Budget Office, "Baseline Projections for Selected Programs: Medicare" (March 2016), [www.cbo.gov/publication/51302](http://www.cbo.gov/publication/51302). In contrast, the Supplementary Medical Insurance Trust Fund, which pays for benefits covered under Parts B and D of Medicare, cannot be exhausted because it is financed mainly through premiums and money from the general fund. The amounts of contributions from those sources are set to cover the costs of those benefits.

42. See sec. 257(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985, Public Law 99-177 (codified at 2 U.S.C. §907(b)(1) (2012)).