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FROM: John D. Shatto
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SUBJECT: Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers

In the *2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, the Board warns that there is "substantial uncertainty regarding the adequacy of future Medicare payment rates under current law." Questions regarding the operations of certain Medicare provisions may result in the current-law projections included in the Trustees Report understating expenditures for most categories of health care providers. The purpose of this memorandum is to present a Medicare projection under a hypothetical alternative to these provisions to help illustrate and quantify the magnitude of the potential cost understatement under current law.

This analysis is for comparison purposes only and should not be interpreted or construed as advocating any particular legislative change. In particular, no endorsement of this alternative by the Office of the Actuary (OACT), the Centers for Medicare & Medicaid Services (CMS), or the Medicare Board of Trustees should be inferred. Similarly, this memorandum's description of the problems that would likely result from the legislated physician payment updates and/or the long-term application of the productivity adjustments should not be interpreted as a criticism of the statutory policy. OACT's intent is to help inform Congress and the public at large that an evaluation of the financial status of Medicare that is based on the provisions of current law is likely to portray an overly optimistic outcome. This memorandum is also an attempt to promote awareness of these issues, to illustrate and quantify the amount by which the Medicare projections are potentially understated, and to help inform discussions of potential policy reactions to the situation.

Overview

Among the most important factors in projecting Medicare expenditures are the annual payment updates to Medicare providers. The estimates shown in the 2025 Trustees Report are complicated substantially by specified low physician payment updates and reductions in payment updates for most other Medicare services by economy-wide productivity.[1]

As described in more detail below, in our view there is a strong likelihood that the scheduled physician payment updates and the productivity adjustments will not be achievable in the long range. It is reasonable to expect that Congress would find it necessary to legislatively override or otherwise modify the reductions in the future to ensure that Medicare beneficiaries continue to have access to health care services.

Because of the concerns regarding the viability of the Medicare payment rates, the 2025 Trustees Report incorporates comparisons of the current-law projections with an illustrative alternative projection. The alternative includes adjustments to (i) the scheduled physician payment updates and bonuses and (ii) the reductions in payment updates by the increase in economy-wide productivity for most other provider categories.[2]

(1) Physician Payments

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) specified physician payment updates for every future year. The Consolidated Appropriations Act, 2021, the Protecting Medicare and American Farmers from Sequester Cuts Act, the Consolidated Appropriations Act, 2023, and the Consolidated Appropriations Act, 2024 together put in place updates of 3.75 percent for 2021, −0.7 percent for 2022, −0.5 percent for 2023, 0.1 percent for 2024, and −2.5 percent for 2025, and they further stipulated that future updates not take into account these updates. For 2026 and later, there will be two payment rates: for qualified providers paid through an advanced alternative payment model (advanced APM), payment rates will be increased by 0.75 percent each year, while payment rates for all other providers will be increased each year by 0.25 percent.

Over the next several years, a number of factors will contribute to the concerns about the physician payment rates. As mentioned previously, the rates were reduced in 2022, 2023, and 2025. While overall inflation rates have moderated since 2022 when they reached 40-year highs,[3] they continue to meaningfully exceed the physician payment rate updates. Moreover, the additional payments of $500 million per year for one group of physicians expired in 2025, and

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[1] The law specifies that payment updates for most non-physician services be reduced in all future years by the 10-year moving average increase in economy-wide private nonfarm business multifactor productivity, which is a measure of real output per combined unit of labor and capital and which reflects the contributions of all factors of production. For convenience, the term *economy-wide private nonfarm business multifactor productivity* will henceforth be referred to as *economy-wide productivity*. Beginning with the November 18, 2021, release of the productivity data, the Bureau of Labor Statistics (BLS) replaced the term *multifactor productivity* with the term *total factor productivity*, a change in name only as the underlying methods and data were unchanged.

[2] While provisions of the Inflation Reduction Act require the change in drug prices to be limited to the rate of growth in the Consumer Price Index (CPI) and require price negotiation for certain drugs, the 2025 Trustees Report includes the assumptions that Part B drug price growth will be unaffected in the long range and that Part D price trends will be reduced but will continue to outpace the CPI over the long range. Therefore, we have determined that the current-law drug projections are unlikely to bias the expenditures, and thus they are not adjusted for in the illustrative alternative scenario presented in the report.

[3] See the April 12, 2022, press release from BLS, available at https://www.bls.gov/news.release/archives/cpi_04122022.htm.

the annual bonuses for another group are scheduled to expire in 2027, resulting in significant one-time payment reductions for most physicians.

After 2025, the law specifies the physician payment update amounts for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. While there are mounting concerns in the near term regarding Medicare physician payment rates, we expect that access to Medicare-participating physicians will become a significant issue in the long term as these concerns continue to grow, absent a change in the delivery system or level of update by subsequent legislation.

(2) Productivity Adjustments

Most of the services covered by the Medicare fee-for-service program (including inpatient and outpatient hospital services, skilled nursing facility services, and home health care) receive annual payment increases based on statutory input price indices. These price indices, or *market baskets*, measure the increase in prices that each category of provider must pay for the goods and services they purchase to enable them to care for patients. Such inputs include wages and other compensation for their employees, medical and other equipment, and such overhead expenses as heating, utilities, and rent. Other Medicare services, including ambulance services, care at ambulatory surgical centers, certain durable medical equipment, and prosthetics, have their payments updated annually by the increase in the Consumer Price Index (CPI). These payment updates have been reduced by the percentage increase in the 10-year moving average of economy-wide productivity since 2011.[4]

Because most Medicare payment updates, by law, are based on *input* price indices, it makes sense to apply a productivity offset and thereby approximate the increase in *output* prices that providers must charge to maintain a constant margin level. Medicare could reasonably reduce payments by such an adjustment, if it were based on attainable health sector productivity gains, and thus share in the financial benefit achieved through improved productivity. Additionally, to the extent that there is currently excess cost or waste in the health care system, providers should be able to withstand slower payment updates for a period until such excess or waste is eliminated. Medicare can create a strong incentive for the removal of excess cost and waste by reducing these payment updates.

In the 2025 Trustees Report, economy-wide productivity is estimated to increase by about 1.0 percent per year in the long range, an amount that is roughly its long-run historical average. This assumption reflects the expectation of continuing relatively high rates of productivity in the manufacturing sector and much lower rates in the service sector, as have occurred historically.[5]

[4] Note that these payment updates affect all the services covered under Part A and many of the services covered under Part B. The Medicare Part D payments to drug plans and qualifying employers are not affected by the productivity adjustments.

[5] Service sector productivity—and health sector productivity in particular—is notoriously hard to measure. While overall private nonfarm business total factor productivity is estimated to have increased by 0.8 percent per year from 1987 through 2022, manufacturing total factor productivity grew 0.7 percent compared with 0.1 percent for services. See https://www.bls.gov/mfp/.

The theory of these findings is consistent with Baumol's cost disease, which suggests that sustained productivity gains in service industries are difficult to achieve as long as the services remain labor-intensive.[6]

For the health sector, measured productivity gains have generally been quite small, given the labor-intensive nature of health services and the individual customization of treatments required in many instances. Hospital productivity has increased in recent years by about 0.4 percent per year (and by negligible levels, on average, over longer periods).[7] For skilled nursing facilities and home health agencies, productivity gains are believed to be close to zero.[8] As noted earlier, some Medicare payment systems are updated by the CPI, which is already an output price index. These updates will also be reduced by economy-wide productivity gains, essentially requiring that these providers and suppliers achieve twice the rate of economy-wide productivity increases to break even.

Based on the historical evidence of health sector productivity gains, the labor-intensive nature of health care services, and presumed limits on the current excess costs and waste that could be removed from the system, actual health provider productivity is very unlikely to achieve improvements equal to the economy as a whole over sustained periods. Despite this conclusion, the payment update reductions are scheduled to occur under current law and are therefore included in the 2025 Medicare Trustees Report. As a result of the update reductions, affected providers will certainly have an even stronger financial incentive to reduce unnecessary aspects of care and to eliminate wasteful costs. Moreover, it is possible that providers will find new ways to take advantage of technology and otherwise improve their productivity to a greater extent than they appear to have been able to do in the past. Finally, new approaches to health care service delivery and payment may lead to more cost-effective care, with the potential to help reduce cost growth to rates compatible with the lower Medicare price updates. These outcomes, while highly desirable, are far from certain. Until such gains can be demonstrated, it is more reasonable to expect that provider costs per service will continue to increase in the long range in a manner that is more in line with long-term past input price growth.

(3) Implications of Payment Reductions

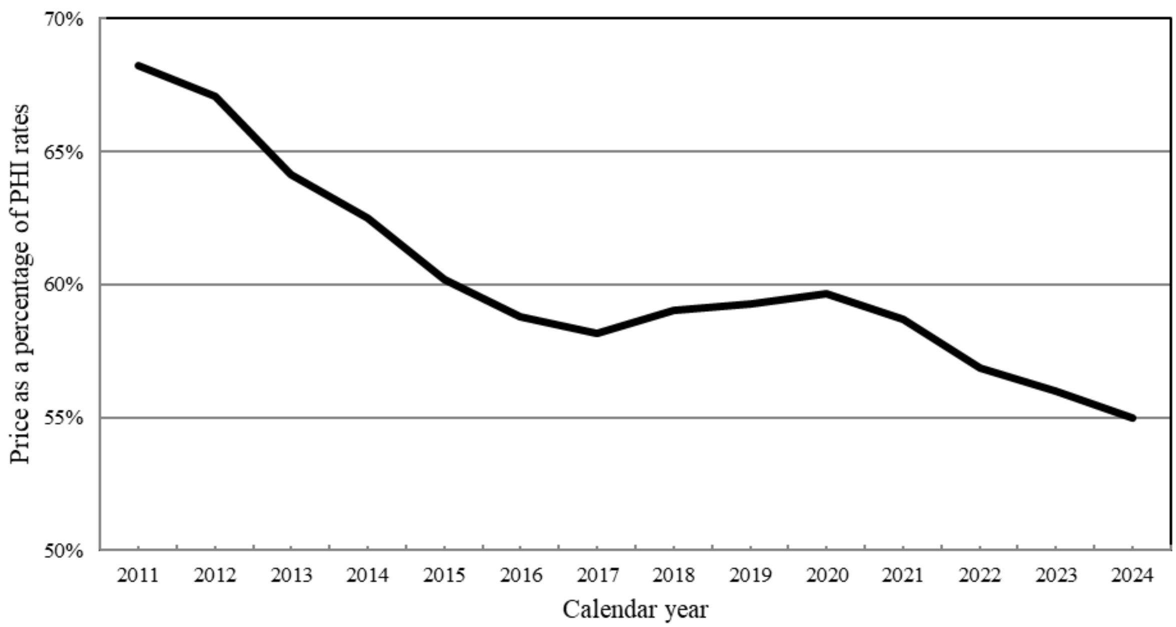
The implications of the hospital payment updates that include the productivity adjustments, and of the payment reductions to the physician payment update, are shown by comparing Medicare price levels with private health insurance.

Figure 1 compares Medicare payment rates for inpatient hospital services with private health insurance rates for 2011 through 2024. In 2011, Medicare payment rates were about 68 percent

[6] Baumol, William J. "Macroeconomics of Unbalanced Growth: The Anatomy of Urban Crisis," *American Economic Review*, 57, no. 3 (1967): pp. 415–26.
[7] See https://www.cms.gov/files/document/productivity-memo.pdf and Cylus *et al.*, "Hospital Multifactor Productivity: A Presentation and Analysis of Two Methodologies," available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/07-08Winterpg49.pdf.
[8] From 1987 through 2022, multifactor productivity averaged a 0.2-percent decline per year in ambulatory health care services, and it averaged a 0.6-percent decline per year in hospitals and nursing and residential care facilities over the same period. See https://www.bls.gov/mfp/.

of private health insurance payment rates.[9] For 2012 through 2024, the period in which the productivity adjustments were in place, the Bureau of Labor Statistics reported that Medicare prices experienced cumulative growth of 23 percent (or about 1.6 percent per year) while private health insurance grew by 53 percent (or about 3.3 percent per year)[10]; by comparison, the hospital market basket grew by 42 percent (or about 2.8 percent per year). Based on these trends, Medicare payment rates fell to roughly 55 percent of private health insurance rates in 2024.

Figure 1. Comparison of Medicare prices relative to private health insurance (PHI) prices for inpatient hospital services under current law



If Medicare rates continue as prescribed under current law and private rates grow by hospital input price inflation less achievable hospital productivity gains, then, by the end of the long-range projection period, Medicare payment rates for inpatient hospital services will represent roughly 37 percent of the average level for private health insurance.

As hospital rates have decreased relative to private rates, more hospitals have been experiencing negative Medicare margins. In 2011, roughly two-thirds of hospitals had negative Medicare margins, and the average overall Medicare margin was –5.8 percent. The latest cost report data for 2023 now indicate that nearly 80 percent of hospitals were losing money on Medicare inpatient services that year and that the average overall Medicare margin for inpatient prospective payment system hospitals was –13.0 percent (excluding COVID-19 relief funds).[11] By 2040, based on simulations, nearly 90 percent of hospitals would experience negative

[9] American Hospital Association, *2020 TrendWatch Chartbook*, Table 4.4. The 2020 Chartbook reflects data through 2018.

[10] See https://www.bls.gov/ppi/.

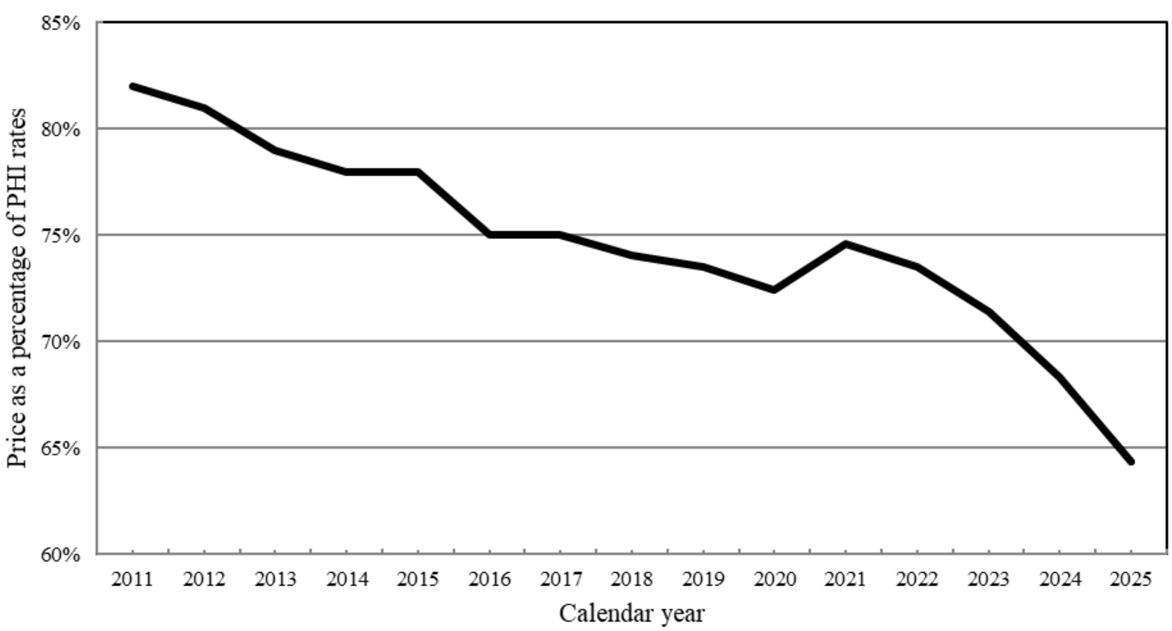
[11] CMS analysis of Medicare Cost Reports, available at https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-update-provisions-part-provider-financial-margins.pdf, and Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2025, available at https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf.

Medicare margins (and approximately one-third of hospitals would have negative total facility margins), raising the possibility of access and quality-of-care issues for Medicare beneficiaries.[12]

Over time, unless providers could alter their use of inputs to reduce their cost per service correspondingly, Medicare's payments for services affected by the productivity adjustments would fall increasingly below providers' costs. Providers could not sustain continuing negative margins and would have to withdraw from serving Medicare beneficiaries or (if total facility margins remained positive) shift substantial portions of Medicare costs to their non-Medicare, non-Medicaid payers. Under such circumstances, lawmakers might feel substantial pressure to override the productivity adjustments, much as they did to prevent reductions in physician payment rates while the sustainable growth rate (SGR) was in effect.

Figure 2 shows Medicare payment rates for physician services relative to private health insurance payment rates based on the comparison published annually by the Medicare Payment Advisory Commission (MedPAC). Medicare payment levels were roughly 82 percent of private health insurance payment rates in 2011 and decreased steadily to 72 percent by 2020. In 2021, because of the temporary Medicare payment rate increase of 3.75 percent that was required by law, the rates relative to private health insurance increased to 75 percent. As that rate increase was phased out from 2022 through 2025, Medicare payment levels dropped to 71 percent of private rates in 2023[13] and are estimated to continue to fall to 64 percent in 2025.

Figure 2. Comparison of Medicare prices relative to private health insurance (PHI) prices for physician services under current law



[12] See https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-update-provisions-part-provider-financial-margins.pdf.
[13] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2025.

For comparison purposes, Medicaid payment rates in 2022 constituted about 71 percent of Medicare payments,[14] or 52 percent of private health insurance payment rates. If Medicare rates continue as prescribed by current law and private rates increase annually at the rate of increase of the Medicare Economic Index (MEI),[15] the Medicare rates will eventually fall to 23 percent of private health insurance levels by the end of the projection period, which is less than half of the current Medicaid rates.

Since the payment rate reductions were put in place beginning in 2012, Medicare payments to providers have fallen significantly relative to private insurance rates. The 2024 survey of the MedPAC indicated that "Medicare beneficiaries reported access to clinician services that was comparable to or, in most cases, better than that of privately insured people"[16] and that "the share of clinicians accepting Medicare is comparable to the share accepting private insurance, despite private health insurers' higher payment rates." However, MedPAC "…is concerned that these relatively low payment increases may make it difficult for clinicians to absorb recent and continued cost increases."

On behalf of OACT and the Medicare Board of Trustees, the 2010–2011 and 2016–2017 Medicare Technical Review Panels considered the potential effects of sustained slower payment increases on provider participation, beneficiary access to care, quality of services, and other factors. These issues were considered both in the context of the current health care system and in conjunction with possible future changes in payment mechanisms, delivery systems, and other aspects of health care that could arise in response to the Affordable Care Act-supported research program for innovations in health care. The 2010–2011 Panel's final report contains an extensive discussion of alternative long-term scenarios with different possible behavioral reactions by providers and with varying implications for the financial viability of providers and the availability and quality of health care services for beneficiaries.[17] The 2016–2017 Panel recommended continued research regarding the long-range financial, quality, and access

[14] L. Skopec, A. Pugazhendhi, and S. Zuckerman, "Updated Medicaid-to-Medicare Fee Index: Medicaid Physician Fees Still Lage Behind Medicare Physician Fees," *Health Affairs*, May 2025, available at https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2024.01530, and S. Zuckerman *et al*., "Medicaid Physician Fees after the ACA Primary Care Fee Bump," *Urban Institute*, March 2017. Medicaid physician payment rates relative to those of private health insurance are derived by multiplying (i) the ratio of Medicare rates to private health insurance (0.75, MedPAC) by (ii) the ratio of Medicaid rates to Medicare (0.72, Zuckerman).

[15] The MEI is a price index reflecting the weighted-average price change for various inputs needed to furnish physician services, adjusted by the change in economy-wide productivity. Medicaid payments for physician services have generally not kept pace with the MEI in recent years. At today's levels, Medicaid payment rates have contributed to problems with access to such services. Because further below-MEI growth would likely exacerbate these problems, especially in the long range, it is reasonable to illustrate future Medicaid physician payment rates based on assumed growth equal to the MEI increase.

[16] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2025.

[17] The 2010–2011 Medicare Technical Review Panel's *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* is available at https://aspe.hhs.gov/pdf-report/review-assumptions-and-methods-medicare-trustees'-financial-projections.

implications of current-law payment updates, bonuses, and provider compensation (Recommendation 2-5).[18,19]

Estimation Methodology

Since there is substantial uncertainty regarding the adequacy of future Medicare payment rates under current law, OACT prepared a set of alternative projections to illustrate the level of Medicare expenditures that could result should these current-law provisions not be sustained in all future years. There are multiple ways in which the law could be changed if these provider updates were to prove unsustainable. The illustrative scenario presented in this memorandum is just one possibility among many that demonstrates the degree to which the current-law projections may be understated. The following describes the methodology used to determine the projections for the alternative scenario that is shown in the 2025 Trustees Report.

While a particular set of illustrative alternative update assumptions for specific years is used, the transition from current law to the illustrative alternative ultimate assumptions over time is intended to reflect an increasing likelihood of modifications to current law rather than a specific forecast of when current law will cease to be fully implemented. This illustrative alternative assumes that (i) starting in 2028, the economy-wide productivity adjustments will gradually phase down to 0.4 percent until the Medicare price updates equal those assumed for private health plans in 2042;[20] and (ii) physician payments will transition from current-law updates to the MEI increase of 2.05 percent from 2028 through 2042. On average under this alternative, the long-range per beneficiary growth rate for all Medicare services would be similar to the long-range growth rate assumed for the overall health sector.

Comparison of Results

The illustrative alternative projections are shown for Parts A and B and for Medicare in total. The Part D projections under current law are not affected by the payment-update issues.

(1) Part A

The alternative scenario phases down the productivity adjustments prescribed in the Affordable Care Act beginning in 2028. The resulting alternative expenditure projections for Part A are therefore slightly higher than the current-law projections in the early years and ultimately become substantially higher by the end of the 75-year period. Under the alternative scenario

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[18] The 2016–2017 Medicare Technical Review Panel's *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* is available at https://aspe.hhs.gov/pdf-report/review-assumptions-and-methods-medicare-trustees-financial-projections.

[19] The 2016–2017 Panel also recommended that the Trustees consider later start dates for the transition to the ultimate assumptions for the illustrative alternative scenario (Recommendation 2-4). We adopted this recommendation.

[20] For the few small Part B types of service that are updated by the CPI minus economy-wide productivity under current law, the illustrative alternative includes the assumption that the economy-wide productivity adjustments will gradually be eliminated because the CPI is an output price index, which means that it implicitly reflects changes in economy-wide productivity.

projections, the Part A trust fund is estimated to be depleted in 2033, the same year as under current law.

Figure 3 shows the projected Hospital Insurance (HI) income and cost rates for the illustrative alternative compared with the current-law results shown in the 2025 Trustees Report. Since the alternative projections vary only the payment rates to providers, the income rate is virtually unchanged from current law.

HI expenditures are projected under current law to rise from about 3.3 percent of taxable payroll in 2024 to 4.7 percent in 2078 and then to gradually decline to 4.5 percent in 2099. Under the illustrative alternative scenario, costs would continue increasing as a percentage of taxable payroll throughout the long-range period, reaching 6.98 percent in 2099—or 2.4 percentage points higher than under current law. This comparison shows the strong impact of the statutory productivity adjustments; as the slower payment rate updates compounded over time, their impact on HI costs as a percentage of taxable payroll would offset much of the combined effects of the aging of the beneficiary population, excess medical price inflation, and growth in the volume and intensity of services. As noted, however, there is considerable doubt as to the long-range feasibility of the lower HI payment rates.

Figure 3. Projected HI income and costs as a percentage of taxable payroll under the illustrative alternative projection compared with current law

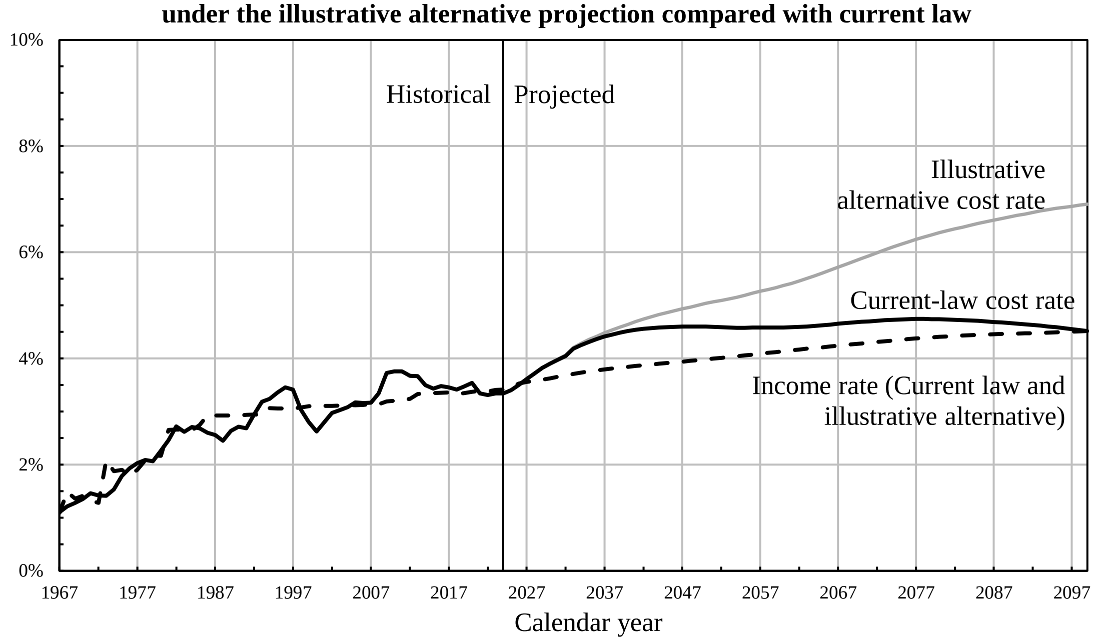


Table 1 shows the HI actuarial balances, for the next 25, 50, and 75 years, from the 2025 Trustees Report under current law and the illustrative alternative. For the 75-year projection period, the HI actuarial deficit is projected to be 0.42 percent of taxable payroll in this year's report. If the productivity adjustments were gradually phased down, then the long-range HI deficit would be 1.28 percent of taxable payroll, as indicated by the alternative projection.

Table 1. HI actuarial balances under the illustrative alternative scenario compared with the 2025 Trustees Report
(as a percentage of taxable payroll)

	2025 Report (current law)	Alternative projection
Valuation periods:		
25 years, 2025–2049:		
Summarized income rate[1]	3.83%	3.84%
Summarized cost rate[1]	4.41	4.54
Actuarial balance	−0.57	−0.70
50 years, 2025–2074:		
Summarized income rate[1]	3.98	3.99
Summarized cost rate[1]	4.49	4.97
Actuarial balance	−0.51	−0.98
75 years, 2025–2099:		
Summarized income rate[1]	4.10	4.12
Summarized cost rate[1]	4.53	5.39
Actuarial balance	−0.42	−1.28

[1]Income rates include beginning trust fund balances, and cost rates include the cost of attaining a trust fund balance at the end of the period equal to 100 percent of the following year's estimated expenditures.

Note: Totals do not necessarily equal the sums of rounded components.

Another way to compare the expenditures in the alternative scenario with the current-law amounts in the 2025 Trustees Report is to examine HI expenditures as a percentage of Gross Domestic Product (GDP) over the next 75 years. Table 2 shows that, under current law, HI costs are projected to increase from 1.46 percent of GDP in 2024 to 1.88 percent of GDP in 2099. Under the illustrative alternative to current law, costs would represent 2.87 percent of GDP in 2099, which is 53 percent greater than the current-law projection.

Table 2. Projected HI expenditures as a percentage of GDP under the illustrative alternative compared with current law, selected calendar years 2024–2099

Calendar year	Current law	Alternative projection
2024	1.46%	1.46%
2030	1.73	1.73
2040	1.99	2.05
2050	2.00	2.19
2060	1.97	2.31
2070	2.00	2.51
2080	2.00	2.69
2090	1.95	2.80
2099	1.88	2.87

The 2025 Trustees Report notes that the HI trust fund still fails both the short-range test of financial adequacy and the long-range test of close actuarial balance, indicating a need for further reforms to bring the program into financial balance. As illustrated by the alternative projections, if the annual productivity adjustments were to become unworkable over time and were overridden, the financial challenges would be much more severe.

(2) Part B

The illustrative alternative scenario for Part B assumes that (i) the physician payment update will transition from current law to the MEI increase of 2.05 percent from 2028 through 2042; and (ii) the productivity adjustments for most other Part B providers will be phased down beginning in 2028 until they reach the estimated level of achievable health provider productivity (0.4 percent) in 2042.

Table 3 shows the long-range Part B expenditure projections from the 2025 Trustees Report under current law and under the illustrative alternative. It is customary to express long-range Part B costs as a percentage of GDP to facilitate interpretation and comparison of costs over such distant periods. As shown in table 3, under current law Part B spending is projected to increase from 1.86 percent of GDP in 2024 to 3.71 percent by 2050 and to 4.18 percent of GDP by 2099. For the alternative scenario, Part B spending grows to 5.30 percent of GDP by 2099. Under the illustrative alternative, the Part B cost in 2099 would be 27 percent larger than the current-law projection.

Table 3. Projected Part B expenditures as a percentage of GDP under current law and the illustrative alternative, selected years 2024–2099

Calendar year	Current law	Alternative projection
2024	1.86%	1.86%
2030	2.48	2.48
2040	3.41	3.52
2050	3.71	3.98
2060	3.88	4.32
2070	4.06	4.68
2080	4.19	5.00
2090	4.19	5.17
2099	4.18	5.30

(3) Total Medicare

Total Medicare spending under the illustrative alternative scenario includes (i) the increased costs for Part B, which are caused by the transition to updates equal to the MEI; and (ii) the higher costs for Parts A and B, which result from the phase-down of the productivity adjustments. The Medicare payments to Part D plans and qualifying employers are not affected by the productivity adjustments and are therefore equal to the current-law projections in the 2025 Medicare Trustees Report.

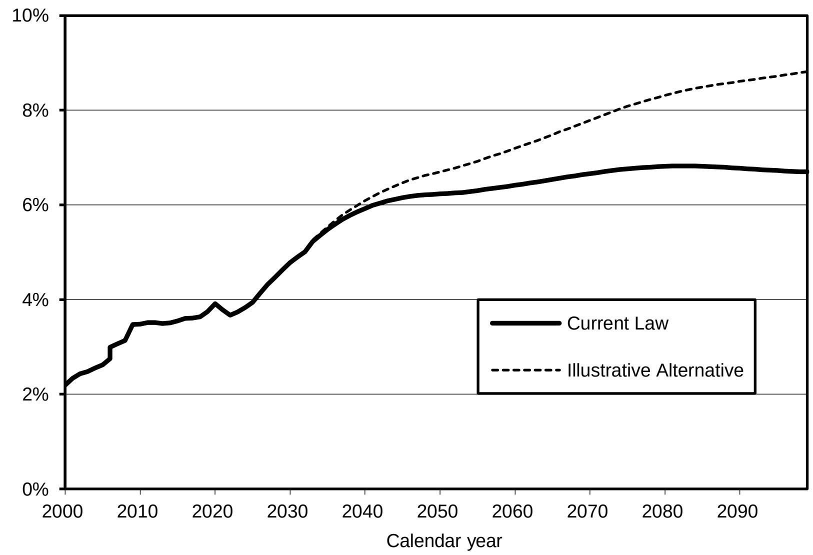
Table 4 indicates the magnitude of the difference relative to the current-law projections by showing total Medicare expenditures as a percentage of GDP. Under the alternative scenario, Medicare spending is estimated to have constituted 3.83 percent of GDP in 2024 and is projected to account for 8.82 percent by 2099. Under current law, such spending would represent 3.83 percent of GDP in 2024 and 6.70 percent in 2099. In other words, if these elements of current law are not sustained in all future years, then Medicare expenditures in 2099 could be roughly 32 percent greater than projected under current law.

Table 4. Projected total Medicare expenditures as a percentage of GDP under current law and the illustrative alternative, selected years 2024–2099

Calendar year	Current law	Alternative projection
2024	3.83%	3.83%
2030	4.78	4.79
2040	5.92	6.09
2050	6.23	6.70
2060	6.41	7.19
2070	6.66	7.79
2080	6.81	8.31
2090	6.77	8.61
2099	6.70	8.82

Figure 4 illustrates the very large impact on Medicare expenditures in the long range from the steadily compounding effect of the current-law productivity adjustments to most provider payment updates and the payment updates to physicians.

Figure 4. Medicare expenditures as a percentage of GDP under current law and the illustrative alternative



Under current law, Medicare expenditures as a percentage of GDP are projected to increase rapidly as the baby boom generation continues to reach eligibility age. After about 2070, however, the effects of the productivity adjustments and physician updates would largely offset the growth that would otherwise occur because of the aging of the beneficiary population, excess medical price inflation, and increases in the volume and intensity of Medicare services. In the absence of these reductions in payment rate updates, Medicare costs would continue to grow steadily as a percentage of GDP throughout the long-range period.

Conclusion

As the substantial differences between current-law and illustrative alternative projections demonstrate, Medicare's actual future costs are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Since 2012, Medicare payment rates have dropped significantly relative to private insurance rates. The current-law projections reflect substantial, but very uncertain, cost reductions that continue to lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. Given the anticipated challenges in achieving such a transformation, particularly over the long run, actual Medicare expenditures are likely to exceed the projections shown in the 2025 Trustees Report for current law, possibly by considerable amounts.

In practice, of course, lawmakers may enact any number of changes to the Medicare program in coming years. While some of these are likely to address the adequacy of provider payment rates, others may be designed to reduce expenditure levels or growth rates in other ways that may be more sustainable over time. In view of the very substantial uncertainty associated with possible changes to Medicare, readers should interpret the current-law Medicare projections cautiously.

Thus, the current-law projections should not be interpreted as the most likely expectation of actual Medicare financial operations in the future. Rather, these projections illustrate the very favorable impact of permanently slower growth in health care costs, if such slower growth can be achieved, while the illustrative alternative projections help to quantify and underscore the potential understatement of the current-law projections in the 2025 Trustees Report. The sizable differences in projected Medicare cost levels between current law and the illustrative alternative scenario highlight the critical importance of finding ways to bring Medicare costs—and health care costs in the U.S. generally—more in line with society's ability to afford them.

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