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MEDICARE FINANCES: A PERSPECTIVE ON THE 2025 TRUSTEES REPORT

By Alicia H. Munnell*

Introduction

What captures the headlines about Medicare is the exhaustion date of the Hospital Insurance (HI) trust fund. But HI is only 38 percent of Medicare expenditures today and is projected to decline further, and the HI shortfall – once the trust fund assets are depleted – is only 11 percent of HI expenditures. Thus, the challenge is not that Medicare is running out of money.

The important issue is that Medicare is really expensive because it operates in an inordinately expensive environment, and the growing popularity of Medicare Advantage is further driving up the bill. On top of that, the actuaries are concerned that the program's current-law controls on reimbursements to doctors and hospitals may be unrealistic and costs could be substantially higher. This *brief* summarizes the current state of Medicare's finances and takes a quick look at some of the underlying issues

The discussion proceeds as follows. The first section provides an overview of the Medicare program. The second section describes the 2025 Trustees Report projections that use current-law assumptions. The third section compares the current-law projections to an alternative scenario prepared by Medicare's Office of the Actuary. The fourth explores possible reasons for Medicare's high costs – focusing on both the cost of U.S. health care and the growth of Medicare Advantage. The final section concludes that while lowering the cost of health care generally is beyond the purview of a Medicare discussion, dealing with the high costs of Medicare Advantage is not.

An Overview of Medicare

Medicare is the largest public health program in the United States. It covers virtually all people ages 65+ and those who receive federal disability insurance benefits. As shown in Figures 1 and 2 (on the next page), the program accounts for 21 percent of national healthcare spending and 13 percent of the federal budget.

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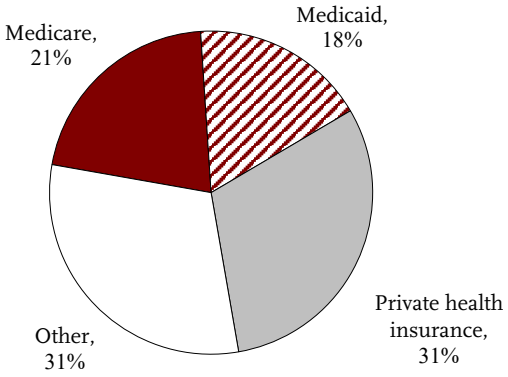
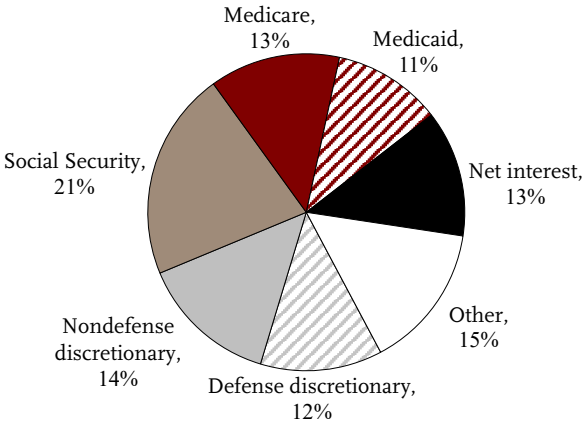
Figure 1. Medicare Spending as a Percentage of Total National Health Expenditures, 2024



Notes: Data are projections. "Other" mainly covers out-of-pocket payments, other third-party payers, and investment.
Source: Centers for Medicare and Medicaid Services (2024).

Figure 2. Medicare as a Percentage of Total Federal Budget, 2024



Note: Medicare and "Other" include offsetting receipts.
Sources: Congressional Budget Office (2025a, 2025b).

Traditional Medicare has two components (see Table 1). The first – Part A, Hospital Insurance (HI) – covers inpatient hospital services, skilled nursing facilities, home health care, and hospice care. The second – Supplementary Medical Insurance (SMI) – consists of two separate accounts: Part B, which covers physician and outpatient hospital services, and Part D, which was enacted in 2003 and covers prescription drugs. The arrangements are more complicated because Medicare also includes Part C – the Medicare Advantage plan option, which makes payments to private insurance plans that provide both Part A and Part B as required and often Part D as well. Medicare Advantage now accounts for almost half of total outlays (see Table 1).

Table 1. Medicare Spending in Billions of Dollars, 2024

Program	HI	SMI		Total
	Part A	Part B	Part D	
Traditional Medicare				
HI (Part A)	$230			$230
SMI				
Part B		$252		$252
Part D			$146	$146
Part C	$193	$302		$494
Total	$423	$553	$146	$1,122

Source: Medicare Trustees Report (2025).

The Medicare program has two trust funds, each with its own source of revenues. Part A (HI) gets most of its money from a 2.9-percent payroll tax, shared equally by employers and employees. In addition, high-income workers pay a 0.9-percent tax on their earnings above a threshold of $200,000 for singles ($250,000 for couples). Since these thresholds are not indexed for wage growth or inflation, an increasing share of workers and their earnings will become subject to the higher HI tax rate.[1] Overall, payroll taxes accounted for 88 percent of Part A revenue in 2024. Most of the remaining revenue comes from a portion of the federal income taxes that Social Security recipients pay on their benefits.

The SMI trust fund contains the revenues for Parts B and D. Part B is financed primarily by government general revenues (72 percent), augmented primarily by participant premiums. Part D, which covers outpatient prescription drugs, is also financed primarily by general revenues (75 percent) and beneficiary premiums (13 percent), with an additional 12 percent coming from state payments for beneficiaries enrolled in both Medicare and Medicaid.[2]

The Medicare Trustees issue an annual report projecting the program's finances over the next 75 years under current law. In addition, the actuaries prepare an alternative scenario that limits the extent to which Medicare payments to hospitals and physicians fall below those made by private insurers.

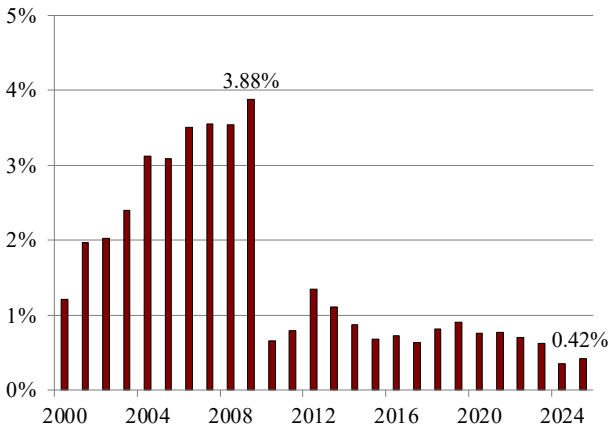
Medicare Finances under Current Law

In the wake of the Affordable Care Act of 2010 (ACA), the Medicare current-law projections have assumed a substantial reduction in the growth rate of per-capita health expenditures relative to historical experience, due to limitations on hospital and physician reimbursement rates.

The Outlook for HI – Part A

In terms of the HI program, the lower projected costs have led to substantially smaller 75-year deficits over the last 15 years (see Figure 3). This year's HI 75-year deficit of 0.42 percent of taxable payrolls is slightly higher than last year's primarily because expenditures in 2024 were higher than the Trustees anticipated – increasing the base and spending in all future years.

Figure 3. HI 75-year Deficit as a Percentage of Taxable Payroll, 2000-2025



Sources: Medicare Trustees Reports (2000-2025).

The HI program is projected to run small surpluses through 2027, after which it will have to draw down trust fund reserves to bridge the gap between scheduled costs and revenues. In 2033, the Trustees project that reserves in the HI trust fund will be depleted, and revenues will be sufficient to cover only 89 percent of program costs. The depletion of the trust fund's reserves moved up three years from last year's Report due in large part to the higher-than-expected expenditures in 2024. Interestingly, at the risk of feeding the beast, enactment of the One Big Beautiful Bill Act (OBBBA) may have accelerated the exhaustion date by one more year to 2032 (see Box).

Box. Impact of OBBBA on Medicare HI Trust Fund

While the OBBBA does not impact Medicare directly, it does so indirectly – by reducing the revenue that Medicare will receive from the taxation of Social Security benefits. Under current law, 50 percent of Social Security benefits are taxable for seniors with over $25,000 ($32,000 for couples) of annual income, and 85 percent are taxable for those with over $34,000 ($44,000 for couples). The revenues from the 50 percent go to the Social Security trust fund, and the revenues from the additional 35 percent go to Medicare's HI trust fund.

The projections for HI revenues were based on the assumption that the 2017 tax cuts expired at the end of 2025. Since the OBBBA extended the tax cuts, seniors will pay lower-than-projected rates on their income, including their Social Security benefits. The new law also makes permanent the larger standard deduction that was included in the 2017 legislation but set to expire, which means fewer households will pay taxes on their Social Security benefits.

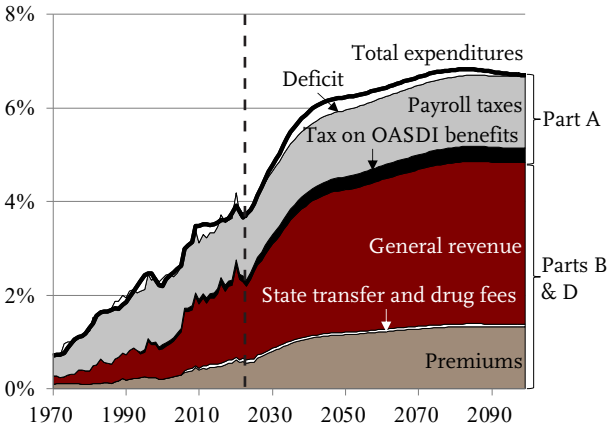
In addition, the OBBBA further increased the standard deduction by raising the 2025 level for all ages from $15,000 to $15,750 for individuals ($30,000 to $31,500 for couples) and by introducing an additional temporary (2025-2028) deduction for individuals 65+ of $6,000, phased out starting at $75,000 ($12,000 for couples, phased out starting at $150,000).

The Committee for a Responsible Federal Budget estimates that the extension and expansion of the 2017 tax cuts, the expanded senior deduction, and other OBBBA changes would reduce the total taxation of benefits by roughly $30 billion per year. This reduction would accelerate the insolvency of the HI trust fund from late 2033 to mid-2032.[3]

The Outlook for SMI – Parts B and D

The SMI trust fund has adequate revenues throughout the projection period to cover the cost of Parts B and D, because the law provides for general revenues and participant premiums to meet each year's expected costs. The problem is that costs are high and rising (see Figure 4), claiming a growing share of general revenues and burdening beneficiaries with rapidly increasing premiums.

Figure 4. Medicare Sources of Non-Interest Income, Percentage of GDP, 1970-2099

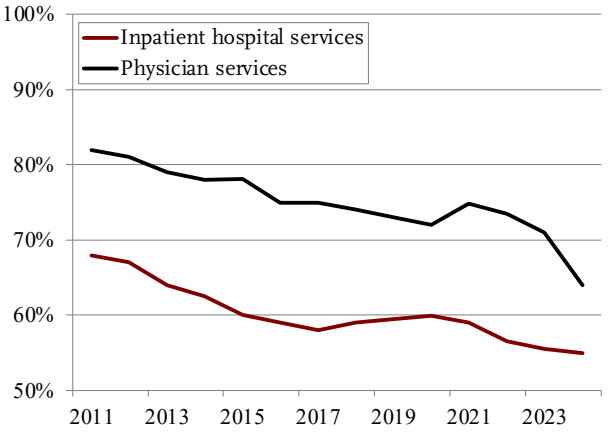


Source: Medicare Trustees Report (2025).

The pattern of projected expenditures compared to last year is mixed. For Part B, projected expenditures are higher – primarily due to higher spending for outpatient and physician-administered drugs. In contrast, Part D expenditures are projected to be lower than last year, reflecting lower-than-projected Part D enrollment.

All the Trustees' projections are based on current law and, as such, include the impact of cost-control provisions in the ACA and subsequent legislation.[4] The concern is that these provisions will produce inadequate reimbursement rates, which could lead hospitals and doctors to stop serving Medicare patients. Indeed, a major discrepancy already exists: in 2024 Medicare prices for hospital services amounted to only 55 percent of those covered by private insurance and for physician services 64 percent (see Figure 5). At some point, Congress may find it necessary to curtail the payment reductions to ensure access to care for Medicare beneficiaries. To account for the uncertain future of the cost control measures, the Medicare actuaries produce alternative projections.[5]

Figure 5. Medicare Prices Relative to Private Health Insurance (PHI) Prices under Current Law



Source: Shatto and Clemens (2025).

Actuaries' Projections under Alternative Assumptions

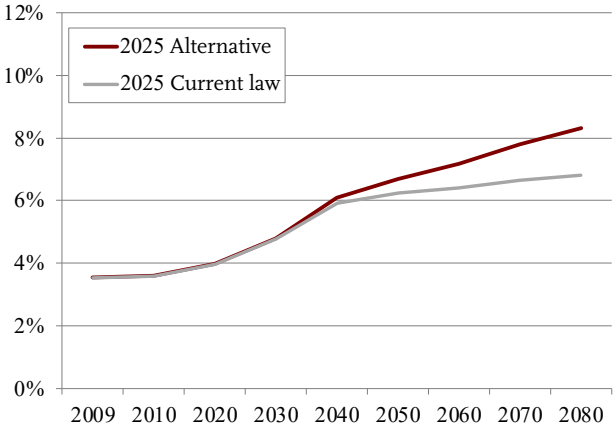
The major differences between the current-law and alternative projections relate to updating the amounts to be paid to hospitals and physicians.

Productivity Adjustments for Hospital Services. The hospital services covered by Medicare require annual payment increases. To create strong incentives for health care providers to improve efficiency, the ACA reduced the annual increases by the percentage increase in economy-wide productivity. The problem is that health services are very labor intensive, so productivity gains in this sector are likely to be much smaller than those in other parts of the economy and subtracting economy-wide productivity will lead to inadequate increases. The alternative scenario assumes that, between 2028 and 2042, the economy-wide productivity adjustment will gradually phase down until annual Medicare price updates equal those assumed for private plans.

Physician Payments. Cost-saving restrictions also sharply limit the annual payment updates for physicians. The alternative scenario for Part B assumes that the increases in physician payments will gradually transition, over the period 2028-2042, from current law to the growth in the Medicare Expenditure Index.

With the relaxation of cost-saving provisions in current law, expenditures under Parts A and B would increase as a percentage of GDP. (Part D costs were not affected by legislated cost controls.) By 2099, the total cost of Medicare is about 2 percent of GDP higher under the alternative than under the current-law provisions (see Figure 6).

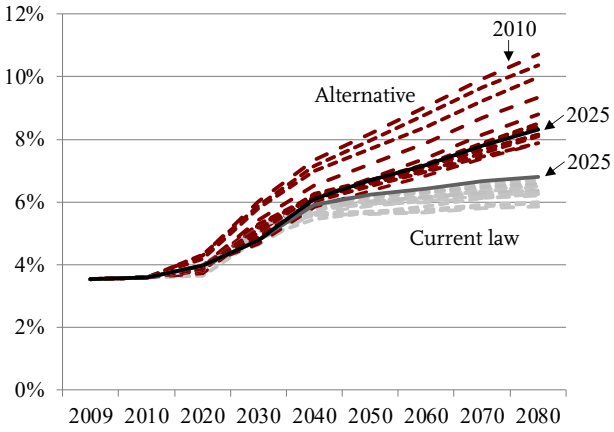
Figure 6. Projected Medicare Expenditures as a Percentage of GDP, 2009-2099



Source: Shatto and Clemens (2025).

With 16 years of Trustees' and alternative projections for comparison, an interesting question is whether they are converging or diverging over time. As shown in Figure 7, the current-law projections have remained within a relatively narrow band, with the 2025 projections at the top of the range. In contrast, the alternative projections have declined noticeably, with 2025 towards the low end. Thus, the two sets of estimates have converged substantially, and the expenditure gap in the 2090s appears to have stabilized at roughly 2 percent of GDP.

Figure 7. Projected Medicare Expenditures as a Share of GDP under Trustees and Alternative Assumptions from 2010-2025 for 75-Year Projection Period



Sources: Shatto and Clemens (2010-2025).

Possible Reasons for Medicare's High Cost

While the 2025 Trustees Report did not produce alarming news on the Medicare front, Medicare costs are high and growing – placing a burden on the government budget and on beneficiaries. The question is why?

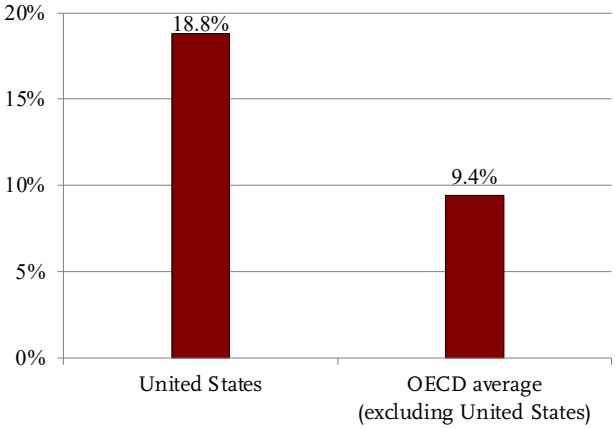
An Expensive Environment

Discussions about Medicare are often framed as if the program were excessively generous, implying that the solution is to cut back. In fact, Medicare coverage is less comprehensive than most private sector plans. For example, Medicare provides only limited mental health benefits and does not place an upper-bound on cost-sharing responsibilities for hospital stays, skilled nursing facility care, or physician costs.

A better explanation for why Medicare's costs are so high is that it operates in an expensive environment. U.S. health care costs as a percentage of GDP are the highest in the developed world and twice as high as the average of all the other countries in the

Organisation for Economic Co-operation and Development (OECD) (see Figure 8). Differences in U.S. health costs are driven by relatively high salaries for doctors, high drug prices, high administrative costs, and greater usage of certain procedures.[6] These broader market pressures make Medicare an expensive program.

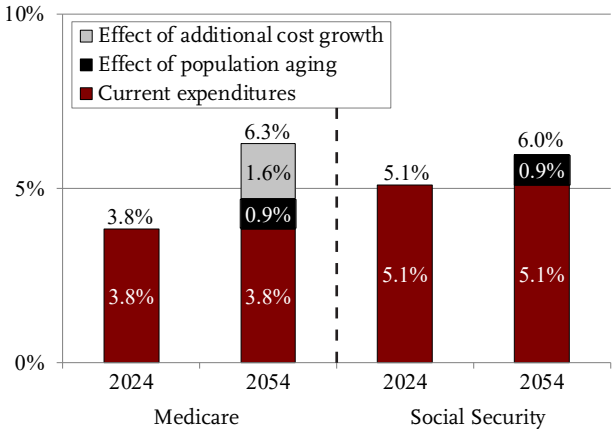
Figure 8. Health Care Expenditures as a Percentage of GDP, OECD Countries, 2024



Source: OECD (2024).

Moreover, these same pressures that produce high current costs also help explain much of Medicare's future growth. In contrast to Social Security, where population aging can explain all the growth in expenditures over the next 30 years, an aging population explains much less than half of projected future growth in Medicare (see Figure 9). The rest comes from the costs for hospital and physician services rising faster than GDP. Hence, one way to control Medicare costs is to get national health care spending under control. But some of the problem is also embedded in the design of Medicare – namely the cost of Medicare Advantage.

Figure 9. Expenditures for Medicare and Social Security as a Percentage of GDP, 2024 and 2054

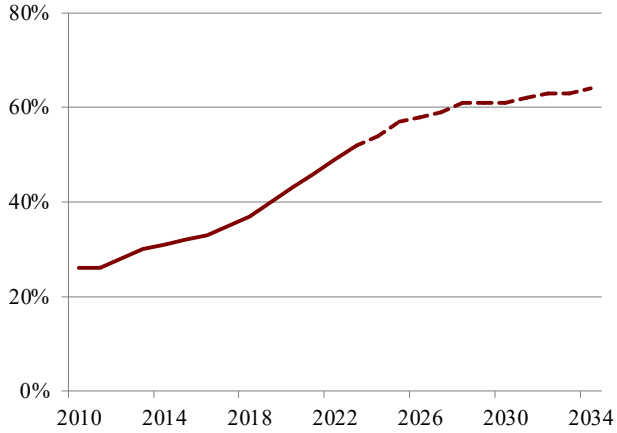


Sources: Author's estimates from *Medicare Trustees Report* (2025) and *Social Security Trustees Report* (2025).

The High Cost of Medicare Advantage

Increasingly, Medicare participants receive their benefits through a Medicare Advantage plan offered by a private insurer rather than through government-run traditional Medicare (see Figure 10).[7]

Figure 10. Medicare Advantage Enrollment as a Percentage of Those Eligible, 2010-2034



Sources: Medicare Payment Advisory Commission (2025) and Congressional Budget Office (2024).

Medicare Advantage plans must provide all benefits covered under Parts A and B, and most cover Part D benefits. Three factors, however, make Medicare Advantage plans particularly attractive to beneficiaries: 1) enhanced benefits, such as dental, vision, hearing, and fitness; 2) a limit on annual out-of-pocket costs for Part A and B services (unlike traditional Medicare); and 3) low or zero premiums. In return, enrollees must accept the plans' procedures, such as prior authorization for accessing care, and more limited networks of health care providers.

While Medicare usually pays for services that participants actually receive, the program pays Medicare Advantage plans a fixed amount per enrollee. That amount is tied to local benchmarks that reflect per capita expenditures in traditional Medicare and reflect the plan's estimated costs of providing Part A and B benefits to its enrollees. Plans with higher ratings also receive higher payments. Payments are risk adjusted to reflect the health status of each plan's enrollees.

Congress's Medicare Payment Advisory Commission estimates that payments for Medicare Advantage beneficiaries in 2025 were 20 percent higher than for traditional Medicare.[8] These overpayments arise for three main reasons:

- Coding intensity: Because Medicare Advantage plans receive higher payments for less-healthy enrollees, they have an incentive to identify as many health conditions as possible for each enrollee. As a result, Medicare Advantage plans record more health conditions than traditional Medicare for comparable beneficiaries.

- Favorable selection: Recent research shows that Medicare Advantage enrollees are distinctly healthier than those in traditional Medicare.[9] The most likely explanation is that people who need more health care are less willing to accept prior authorization and the limited networks of providers that Medicare Advantage plans impose. Failing to account for favorable selection, like higher coding intensity, makes Medicare Advantage enrollees appear less healthy than they really are and thus results in overpayments.

- Quality bonuses: Medicare rates Medicare Advantage plans on a 5-star scale and generally increases benchmark payment rates by 5 percent for plans with 4 or 5 stars. The quality bonus program further increases payments to Medicare Advantage plans relative to traditional Medicare.

The bottom line is that the shift away from traditional Medicare to Medicare Advantage is raising the cost of a program that is already operating in a high-cost environment.

Conclusion

While the world fixates on the exhaustion date of the HI trust fund, the real message from the Medicare Trustees in report after report is that Medicare costs taxpayers and beneficiaries a lot of money. And if the constraints on reimbursements to hospitals and physicians prevent Medicare beneficiaries from accessing care, costs will be even higher than the Trustees project. Part of the problem is that the U.S. health care system is twice as expensive as systems in other countries, and so a fix requires redesigning the nation's whole approach to the provision of health care. Another part of the high cost, however, can be traced to the growth in Medicare Advantage plans, which cost the program 20 percent more per recipient than traditional Medicare. Reducing these overpayments should be high on Medicare's agenda.

Endnotes

1 By the end of the long-range projection period, an estimated 80 percent of workers would be subject to this additional tax. Thus, HI payroll tax revenues will increase steadily as a percentage of taxable payroll.

2 For these "dually eligible" individuals, state Medicaid programs cover Medicare cost-sharing obligations in order to reduce the financial burden on low-income older adults and people with disabilities.

3 Committee for a Responsible Federal Budget (2025).

4 The ACA, passed in 2010, contained roughly 165 provisions aimed at reducing costs, increasing revenues, eliminating fraud and waste, and developing research and technological enhancements. Subsequently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) revised the system for paying physicians.

5 The actuaries note that the use of an alternative scenario for analysis should not be construed as an endorsement by the Trustees, CMS, or the actuaries themselves.

6 For example, see Papanicolas, Woskie, and Jha (2018).

7 For a good summary, see Van de Water (2025).

8 Medicare Payment Advisory Commission (2025).

9 Catlett et al. (2025).

References

Catlett, Kierstin, Nathan Smith, Megan S. Jarvis, Jane Sullivan, Caroline Goldzweig, and Susan Dentzer. 2025. "Health Outcomes Under Full-Risk Medicare Advantage vs Traditional Medicare." *The American Journal of Managed Care* 31(10): 294-301.

Centers for Medicare & Medicaid Services. 2000-2025. *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: U.S. Department of Health and Human Services.

Centers for Medicare & Medicaid Services. 2024. *National Health Expenditure Accounts*. Washington, DC: U.S. Department of Health and Human Services.

Committee for a Responsible Federal Budget. 2025. "OBBBA Would Accelerate Social Security & Medicare Insolvency." Washington, DC.

Congressional Budget Office. 2024. "Baseline Projections for Selected Programs." Washington, DC. Available at: https://www.cbo.gov/data/baseline-projections-selected-programs#10

Congressional Budget Office. 2025a. "Historical Budget Data." Washington, DC. Available at: https://www.cbo.gov/data/budget-economic-data#2

Congressional Budget Office. 2025b. "The Budget and Economic Outlook: 2025 to 2035." Washington, DC.

Medicare Payment Advisory Commission. 2025. "The Medicare Advantage Program: Status Report." Washington, DC.

Organisation for Economic Cooperation and Development (OECD). 2024. "OECD Indicators: Health Spending (% of GDP)." Paris, France.

Papanicolas, Irene, Liana R. Woskie, and Ashish K. Jha. 2018. "Health Care Spending in the United States and Other High-Income Countries." *JAMA* 319(10): 1024-1039.

Shatto, John D. and M. Kent Clemens. 2010-2025. "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers." Washington, DC: U.S. Department of Health and Human Services.

U.S. Social Security Administration. 2025. *The Annual Reports of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*. Washington, DC: U.S. Government Printing Office.

Van de Water, Paul. 2025. "Growth in Medicare Advantage Raises Concerns." Washington, DC: Center for Budget and Policy Priorities.

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