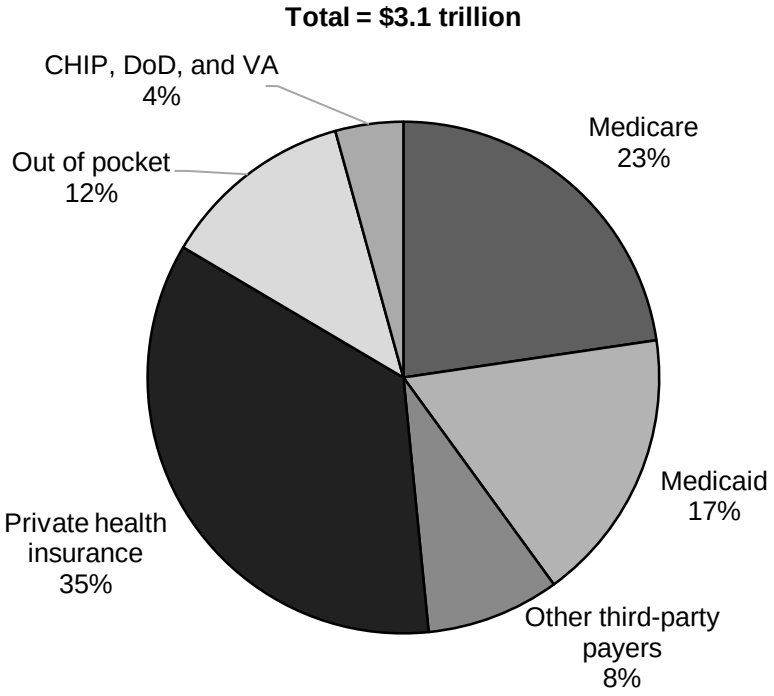
SECTION 1

National health care and Medicare spending

Chart 1-1. Medicare was the largest single purchaser of personal health care, 2018



Note: CHIP (Children's Health Insurance Program), DoD (Department of Defense), VA (Department of Veterans Affairs). "Personal health care" is a subset of national health expenditures. It includes spending for all medical goods and services that are provided for the treatment of an individual and excludes other spending, such as government administration, the net cost of health insurance, public health, and investment. "Out-of-pocket" spending includes cost sharing for both privately and publicly insured individuals. Premiums are included in the shares of each program (e.g., Medicare, private health insurance) rather than in the share of the out-of-pocket category. "Other third-party payers" includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs such as the Substance Abuse and Mental Health Services Administration, other state and local programs, and school health. Slices do not total 100 percent because of rounding.

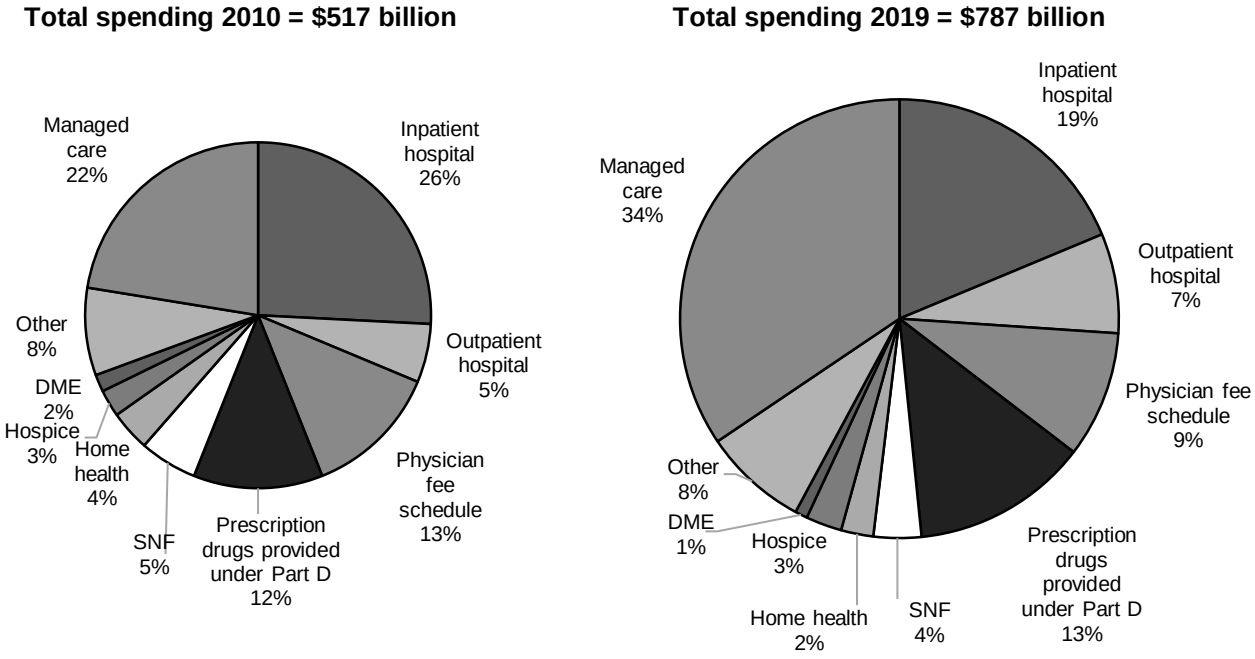
Source: CMS Office of the Actuary, National Health Expenditure Accounts, "Table 6: Personal Health Care Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2018," released December 2019.

- Medicare is the largest single purchaser of health care in the United States. (Though the share of spending accounted for by private health insurance is greater than Medicare's share, private health insurance is not a single purchaser of health care; rather, it includes many private plans, including managed care, self-insured health plans, and indemnity plans.) Of the $3.1 trillion spent on personal health care in 2018, Medicare accounted for 23 percent, or $697 billion. This amount includes spending on direct patient care and excludes certain administrative and business costs.

- Thirty-five percent of personal health care spending was financed through private health insurance, and 12 percent was consumer out-of-pocket spending.

- In this chart, Medicare and private health insurance spending include premium contributions from enrollees.

Chart 1-2. Medicare spending is concentrated in certain services and has shifted over time



Note: DME (durable medical equipment), SNF (skilled nursing facility). All data are by calendar year. Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. "Other" includes items such as laboratory services, physician-administered drugs, renal dialysis performed in freestanding dialysis facilities, services provided in freestanding ambulatory surgical center facilities, and ambulance. Components may not total 100 percent because of rounding.

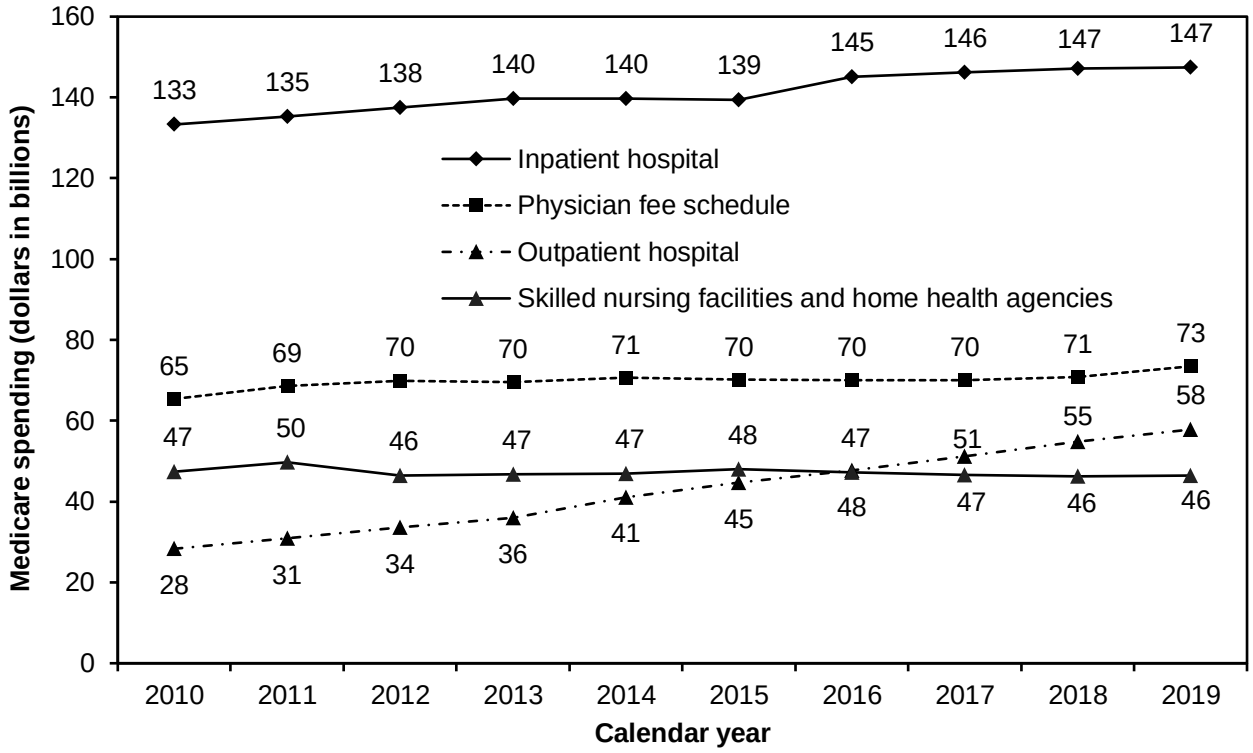
Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- In 2019, Medicare spent $787 billion on benefits. Managed care (Medicare Advantage) was the largest spending category (34 percent), followed by inpatient hospital services (19 percent), prescription drugs provided under Part D (13 percent), and services reimbursed under the physician fee schedule (9 percent).

- The distribution of Medicare spending among services has changed over time. Spending on Medicare Advantage plans has grown from 22 percent of Medicare spending in 2010 to 34 percent in 2019. This growth is largely due to a 96 percent increase in the number of beneficiaries enrolled in Medicare Advantage over this period (data not shown). Meanwhile, the number of beneficiaries in fee-for-service Medicare has stayed relatively flat (data not shown).

- Spending on fee-for-service (FFS) inpatient hospital services has declined as a share of total Medicare spending, falling from 26 percent in 2010 to 19 percent in 2019. Spending on physician fee schedule services has also declined as a share of Medicare spending, falling from 13 percent to 9 percent over this period. At the same time, spending on FFS outpatient services has grown (from 5 percent to 7 percent of Medicare spending), partly due to physician practices being acquired by hospitals and beginning to bill under the outpatient payment system.

Chart 1-3. Aggregate Medicare spending for FFS beneficiaries, by sector, 2010–2019



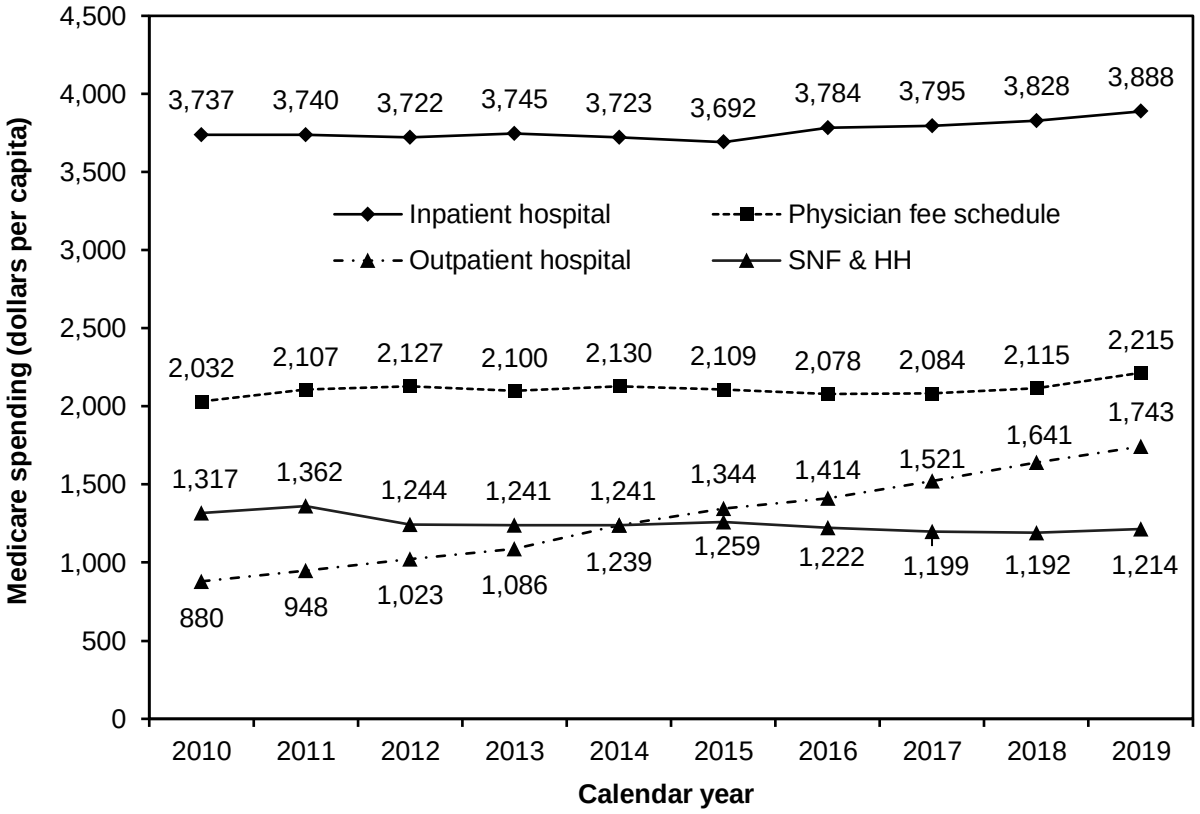
Note: FFS (fee-for-service). "Physician fee schedule" includes spending on services provided by physicians and other health professionals such as nurse practitioners, physician assistants, and physical therapists. Dollar amounts are Medicare spending for FFS beneficiaries only and do not include beneficiary cost sharing or spending for Medicare Advantage enrollees.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- Medicare fee-for-service spending on inpatient hospital services and physician fee schedule services increased modestly from 2010 to 2019, averaging 1.1 percent and 1.3 percent growth per year, respectively. Spending on skilled nursing facilities and home health services decreased over this period, contracting by –0.2 percent per year on average.

- In contrast, spending on outpatient hospital services doubled during this period (averaging growth of 8.3 percent per year from 2010 to 2019) as more physician practices were acquired by hospitals and began billing Medicare's outpatient payment system.

Chart 1-4. Per capita Medicare spending for FFS beneficiaries, by sector, 2010–2019



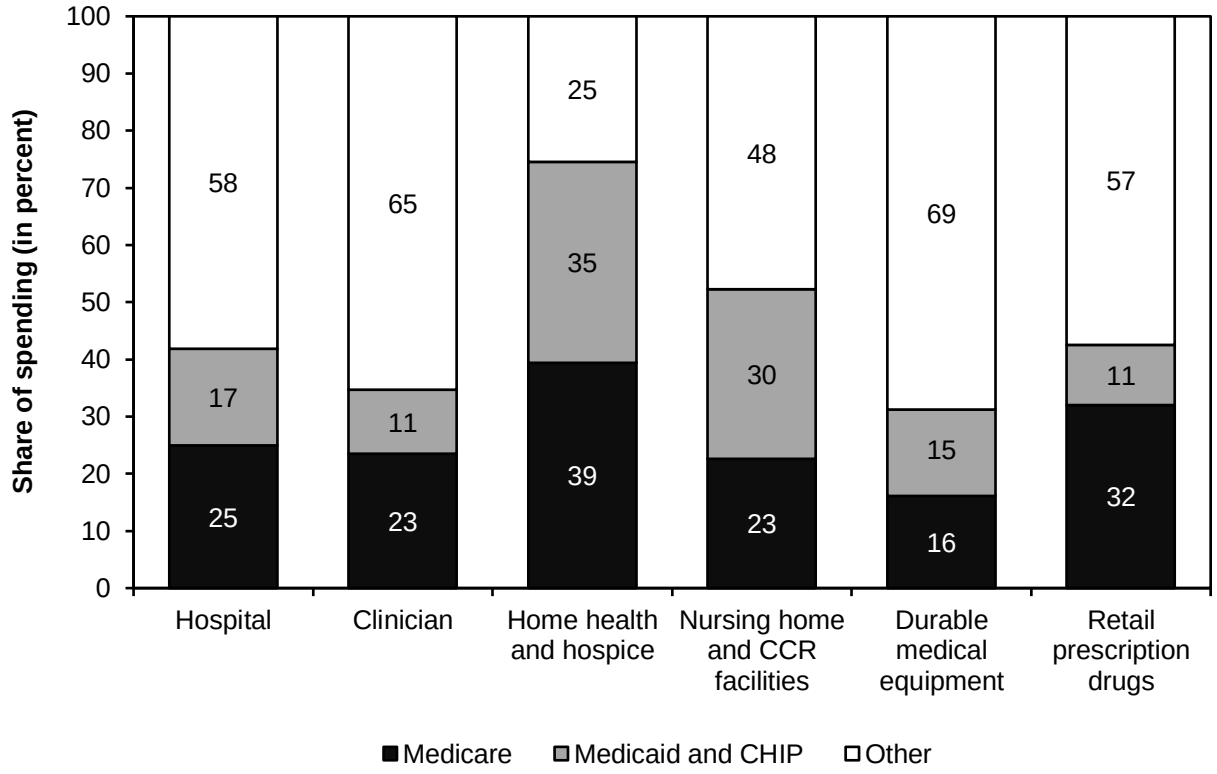
Note: FFS (fee-for-service), SNF (skilled nursing facility), HH (home health). "Physician fee schedule" includes spending on services provided by physicians and other health professionals such as nurse practitioners, physician assistants, and physical therapists. Dollar amounts are Medicare spending for FFS beneficiaries only and do not include beneficiary cost sharing or spending for Medicare Advantage enrollees. Spending per beneficiary for inpatient hospital services equals spending for the sector (see Chart 1-3) divided by FFS enrollment in Medicare Part A. Spending per beneficiary for physician fee schedule services and outpatient hospital services equals spending for the sector (see Chart 1-3) divided by FFS enrollment in Medicare Part B. Spending per beneficiary for skilled nursing facility services and home health services equals spending for those sectors (see Chart 1-3) divided by total FFS enrollment.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- Consistent with the trends shown in Chart 1-3, Medicare FFS spending per capita on inpatient hospital services and physician fee schedule services increased modestly from 2010 to 2019 (averaging 0.4 percent and 1.0 percent per year, respectively). Per capita spending on skilled nursing facilities and home health services decreased over this period (averaging –0.9 percent per year).

- Also consistent with trends in Chart 1-3, per capita spending on outpatient hospital services almost doubled during this period (averaging growth of 7.9 percent per year from 2010 to 2019).

Chart 1-5. Medicare's share of spending on personal health care varied by type of service, 2018



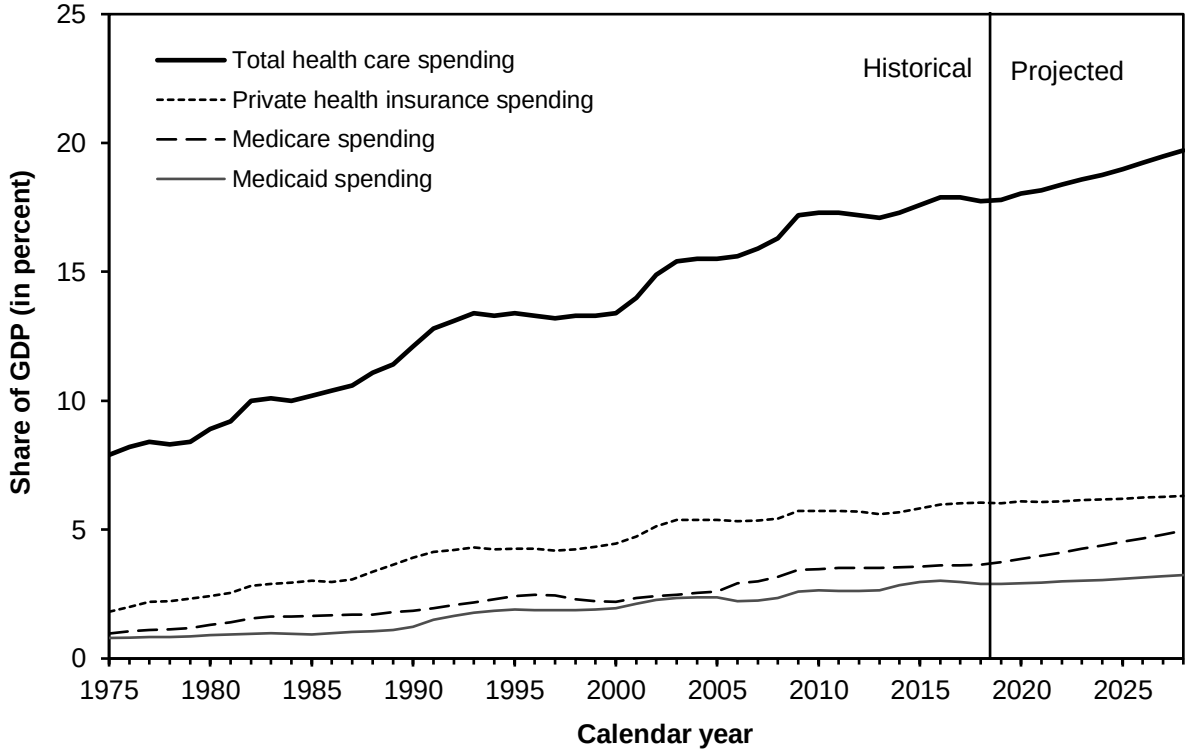
Note: CCR (continuing care retirement), CHIP (Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures. It includes spending for all medical goods and services that are provided for the treatment of an individual and excludes other spending such as government administration, the net cost of health insurance, public health, and investment. "Other" includes private health insurance, out-of-pocket spending, and other private and public spending. Other service categories included in personal health care that are not shown here are other professional services; dental services; other health, residential, and personal care; and other nondurable medical equipment. Bars may not total 100 percent because of rounding.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, historical data released December 2019.

- While Medicare's share of total personal health care spending was 23 percent in 2018 (see Chart 1-1), its share of spending by type of service varied, from 16 percent of spending on durable medical equipment to 39 percent of spending on home health and hospice services.

- Medicare's share of spending on nursing homes and continuing care retirement facilities was smaller than Medicaid's share. Medicare pays for nursing home services only for Medicare beneficiaries who require skilled nursing or rehabilitation services, whereas Medicaid pays for custodial care (assistance with activities of daily living) provided in nursing homes for people with limited income and assets.

Chart 1-6. Health care spending has consumed an increasing share of the country's GDP



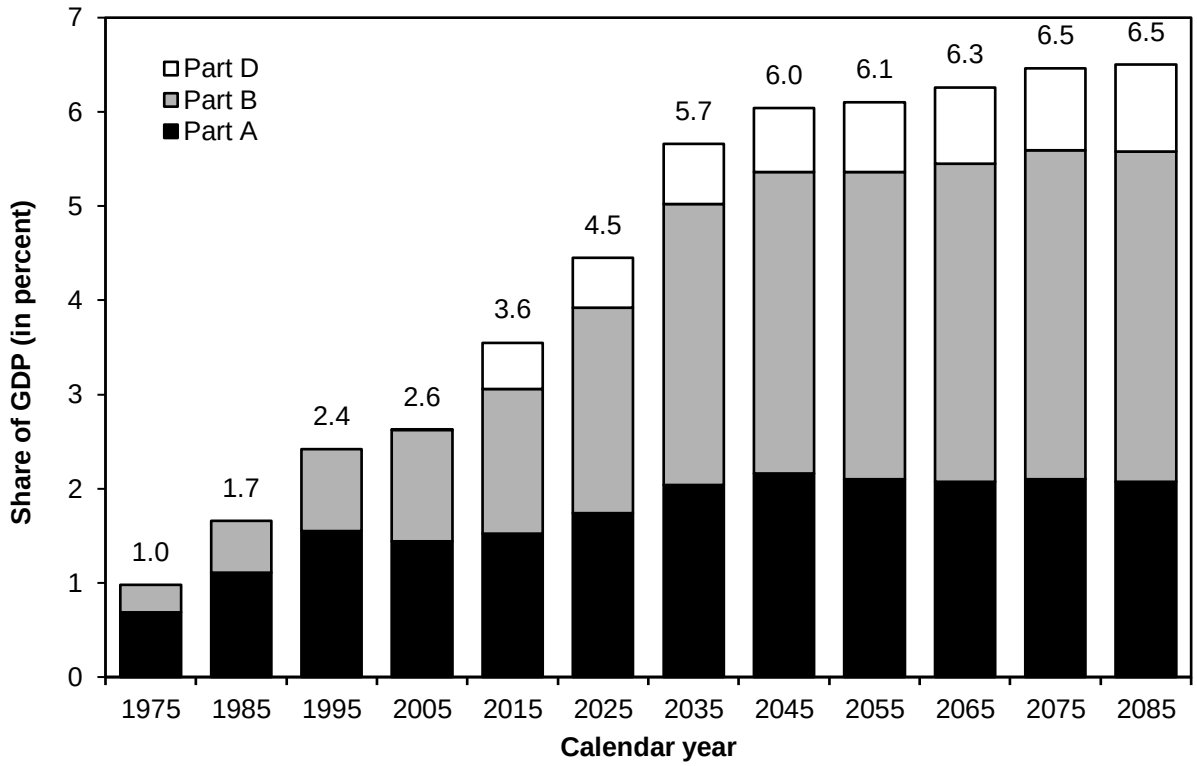
Note: GDP (gross domestic product). The potential effects of the COVID-19 pandemic are not reflected in these projections.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, historical data released December 2019 and projections released March 2020.

- In 2018, total health care spending made up 17.7 percent of the country's GDP. Private health insurance spending constituted 6.0 percent of GDP spending, Medicare constituted 3.6 percent, and Medicaid constituted 2.9 percent.

- Health care spending as a share of GDP more than doubled from 1975 to 2015, increasing from 7.9 percent to 17.6 percent. Private health insurance spending, Medicare spending, and Medicaid all more than tripled over that same time period, increasing from 1.8 percent to 5.8 percent, from 1.0 percent to 3.6 percent, and from 0.8 percent to 3.0 percent, respectively, as a share of GDP.

Chart 1-7. Trustees project Medicare spending to continue to increase as a share of GDP

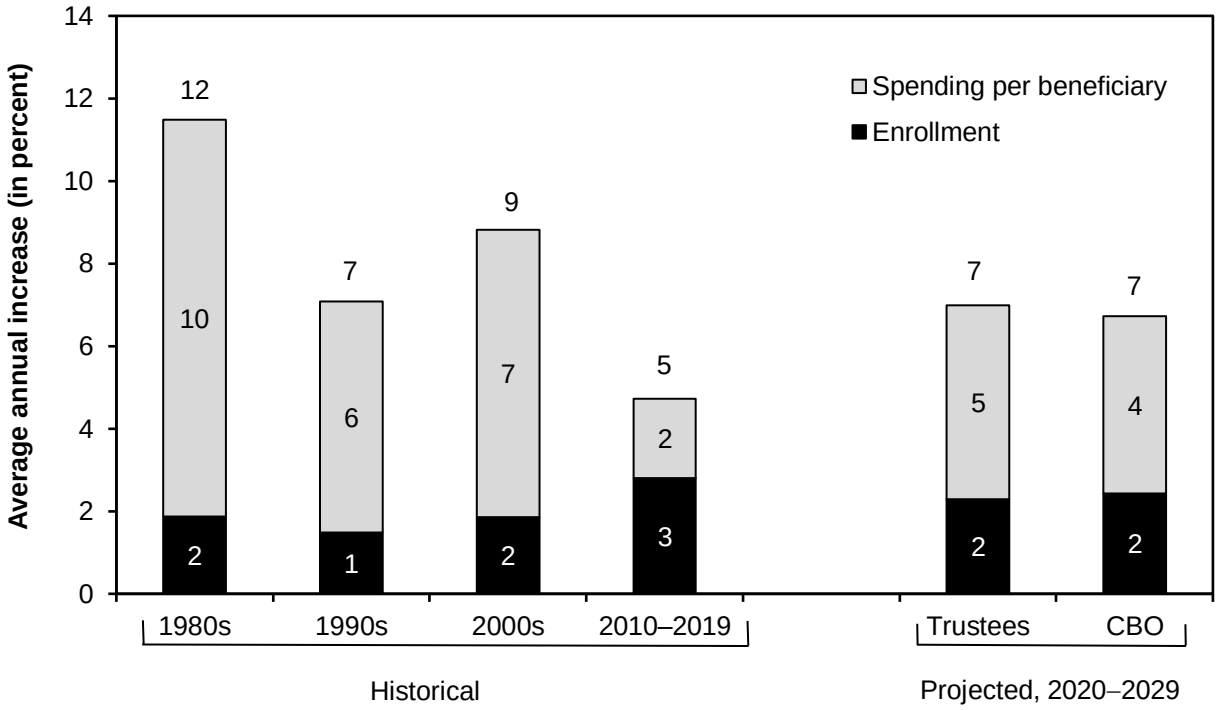


Note: GDP (gross domestic product). The Part D benefit began in 2006. Shares for 2025 and later are projections based on the Trustees' intermediate set of assumptions. The potential effects of the COVID-19 pandemic are not reflected in these projections.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- Over time, Medicare spending has accounted for an increasing share of GDP. From 1 percent in 1975, it is projected to reach 6 percent of GDP in 2045.
- The Medicare Trustees project that spending will rise from 3.6 percent of GDP in 2015 to 5.7 percent of GDP by 2035, largely because of rapid growth in the number of beneficiaries, and then to 6.5 percent of GDP by 2075, with growth in spending per beneficiary becoming the greater factor in the later years of the forecast. The rapid growth in the number of beneficiaries began in 2011 and will continue through 2030 as members of the baby-boom generation reach age 65 and become eligible to enroll in Medicare.
- In the later decades of the Trustees' forecast, Medicare spending is projected to continue rising as a share of GDP, but at a slower pace than in the past.
- Drug costs are projected to grow faster than Part A and Part B expenditures, and to account for 14 percent of Medicare expenditures by 2085.

Chart 1-8. Per beneficiary spending growth slowed in recent years but is projected to accelerate



Note: CBO (Congressional Budget Office). The potential effects of the COVID-19 pandemic are not reflected in these projections. Bar totals reflect average annual increase in total Medicare spending (including both fee-for-service and Medicare Advantage enrollees) and may, because of rounding, differ from the sum of the average annual increase in spending per beneficiary and the average annual increase in Medicare enrollment. Trustees data are presented for calendar years. CBO data are presented for fiscal years.

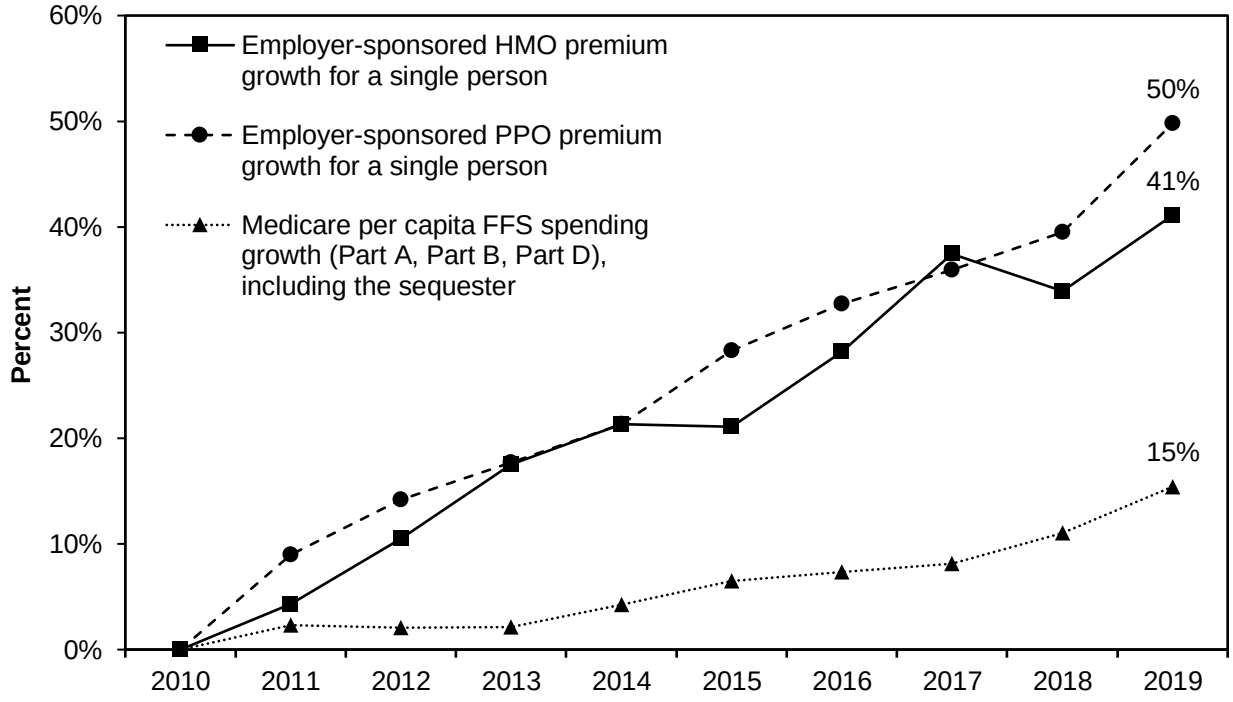
Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020 and the Congressional Budget Office's March 2020 Medicare Baseline.

- The growth in Medicare's per beneficiary spending slowed in the past decade. The average annual increase equaled or exceeded 6 percent in the 1980s, 1990s, and 2000s, but fell to 2 percent between 2010 and 2019. For 2020 to 2029, the Trustees and CBO project that growth in per beneficiary spending will accelerate but remain lower than historical highs, with the Trustees expecting average annual growth in spending per beneficiary of 5 percent, and the CBO expecting average annual growth of 4 percent.

- The aging of the baby-boom generation accelerated Medicare enrollment growth over the last decade. The average annual growth rate rose to 3 percent between 2010 and 2019. Medicare enrollment is expected to increase an average of 2 percent per year in the next decade.

- Total Medicare spending over the next decade is projected by the Trustees and CBO to increase by an average of 7 percent annually, which would outpace the projected average annual GDP growth of about 4 percent (data not shown).

Chart 1-9. Employer-sponsored insurance premiums have risen more than twice as fast as Medicare FFS costs



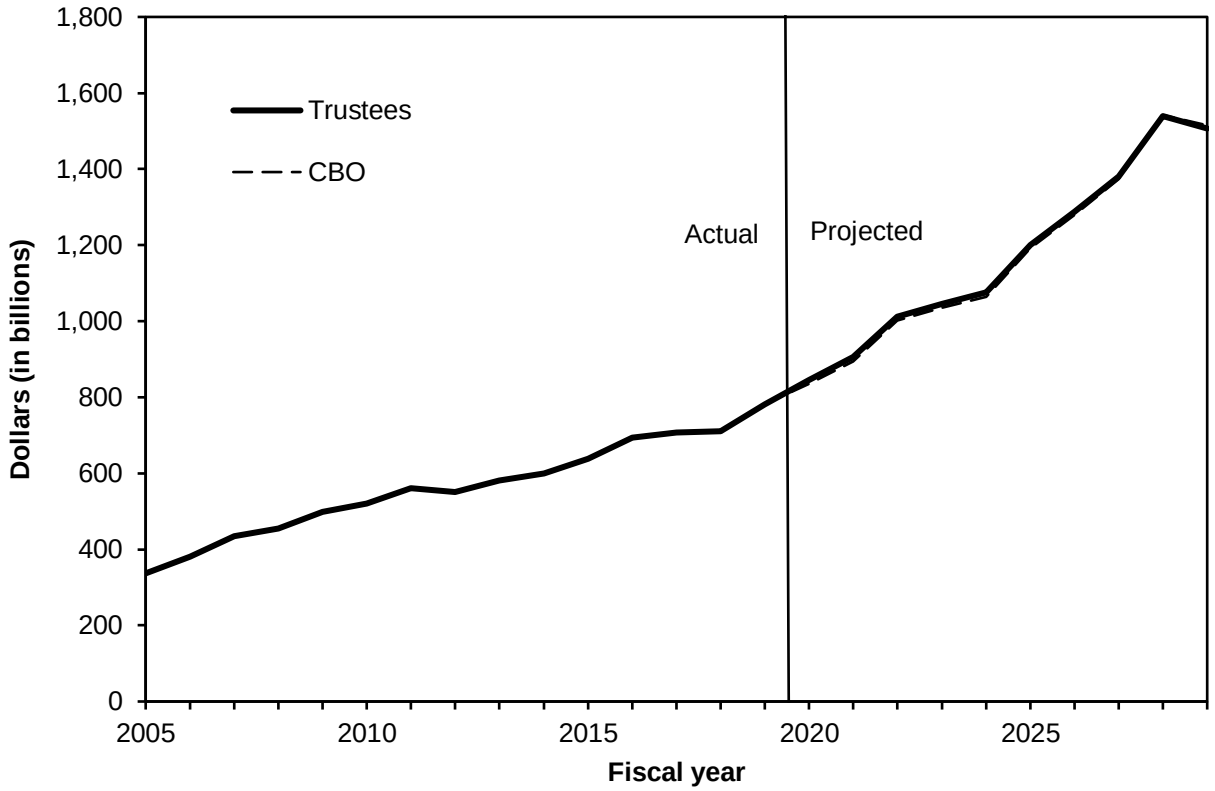
Note: FFS (fee-for-service), HMO (health maintenance organization), PPO (preferred provider organization). The chart shows cumulative growth since 2010. Medicare spending includes Part A and Part B benefits and Part D coverage. Part D spending does not include the portion of premiums paid by enrollees, but does include: (1) Part D spending on non-FFS beneficiaries enrolled in Medicare Advantage plans with prescription drug coverage, (2) premiums and cost sharing that Medicare pays on behalf of some low-income beneficiaries (who can enroll in either FFS or Medicare Advantage plans), and (3) subsidies Medicare pays employers and unions for drug coverage offered to retirees. Medicare spending includes the effects of the sequester that began in March 2013, which reduced program spending by 2 percent.

Source: Employer-sponsored premium data are from Kaiser Family Foundation surveys, 2010–2019. Medicare spending figures are from MedPAC analysis of data from the 2020 annual report of the Boards of Trustees of the Medicare trust funds.

- Employer-sponsored insurance premiums have risen faster than the cost of Medicare Part A, Part B, and Part D benefits, despite the richness of employer plans decreasing (due to higher deductibles over time) and the richness of the Medicare benefit increasing (due to changes to Part D). Changes in law have resulted in the phaseout of Part D's coverage gap—the phase of drug benefit spending in which beneficiaries previously paid much higher cost sharing. Much of the increased generosity was financed by requiring manufacturers of brand-name drugs to discount their prices in the coverage gap.

- Increased prices were largely responsible for spending growth in the private sector. One key driver of the private sector's higher prices has been provider market power. Hospitals and physician groups have increasingly consolidated, in part to gain leverage over insurers in negotiating higher payment rates. By 2017, 57 percent of hospital markets were so concentrated that one health system produced a majority of hospital discharges (data not shown). Studies have found that prices tend to increase as consolidation increases.

Chart 1-10. Trustees and CBO project Medicare spending to exceed $1 trillion by 2022



Note: CBO (Congressional Budget Office). The potential effects of the COVID-19 pandemic are not reflected in these projections. All data are nominal, mandatory outlays (benefit payments plus mandatory administrative expenses) by fiscal year.

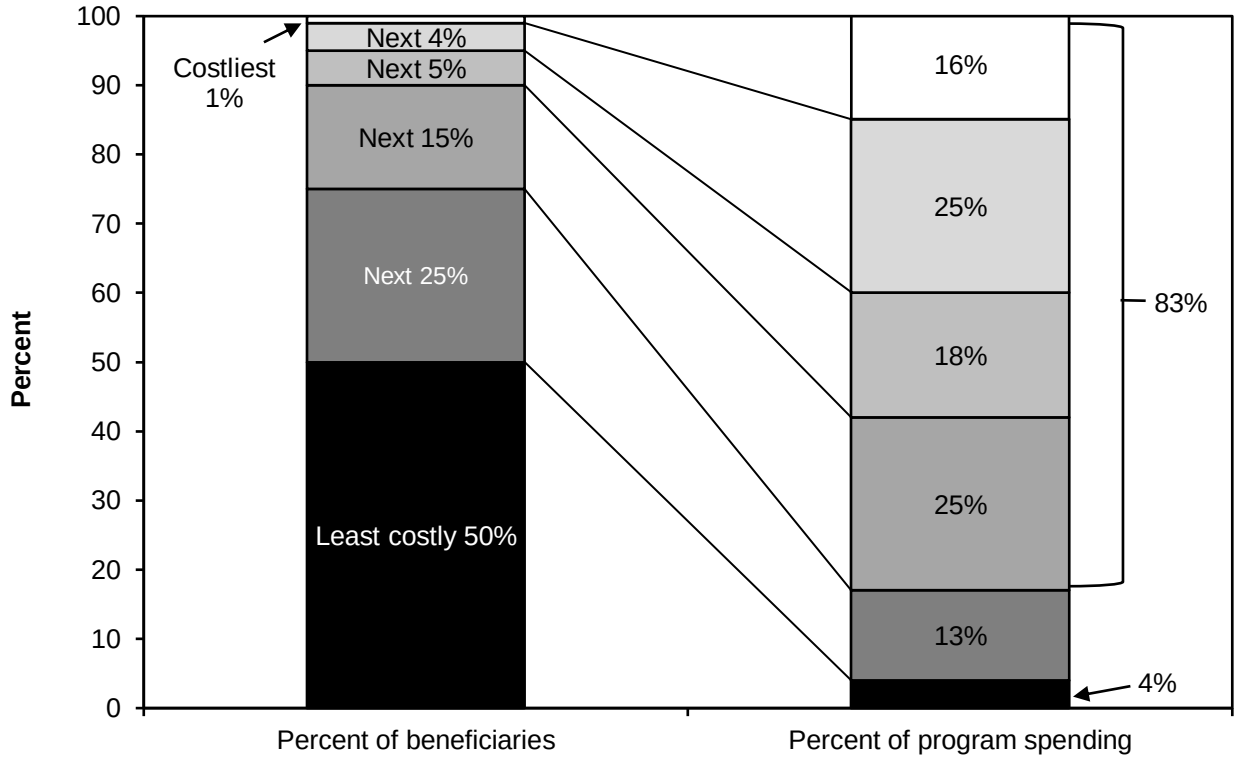
Source: Congressional Budget Office's March 2020 Medicare Baseline; the annual report of the Boards of Trustees of the Medicare trust funds 2020.

- Medicare spending has more than doubled since 2005, increasing from $337 billion to $782 billion by 2019 (these data are by fiscal year and include benefit payments and mandatory administrative expenses).

- The Medicare Trustees and CBO both project that spending for Medicare between 2019 and 2029 will grow at an average annual rate of 6.8 percent. Medicare spending will reach $1 trillion in 2022 under both sets of projections.

- Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy that in turn affect annual updates to provider payments and the number of workers paying Medicare payroll taxes. In addition, forecasts can assume different amounts of growth in the volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 1-11. FFS program spending was highly concentrated in a small group of beneficiaries, 2017



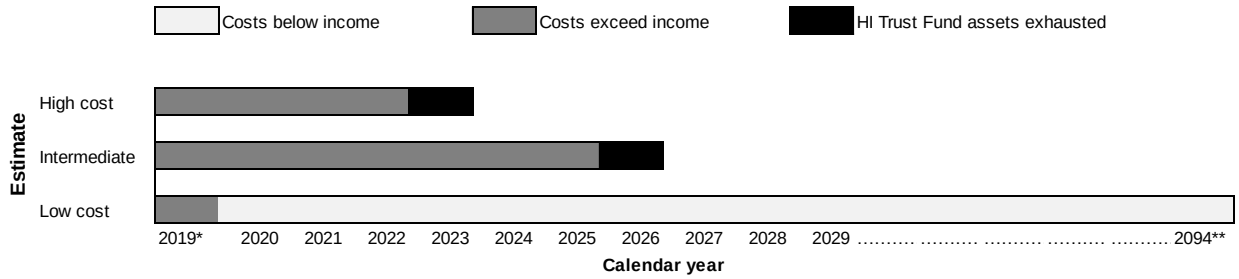
Note: FFS (fee-for-service). Analysis excludes beneficiaries with any enrollment in a Medicare Advantage plan or other health plan that covers Part A and Part B services (e.g., Medicare cost plans, Medicare–Medicaid Plans, and Medicare and Medicaid's Program of All-Inclusive Care for the Elderly [PACE]). Components do not sum to totals due to rounding.

Source: Medicare Current Beneficiary Survey, 2017.

- Medicare FFS spending is concentrated among a small number of beneficiaries. In 2017, the costliest 5 percent of beneficiaries (i.e., adding the costliest 1 percent and the next-costliest 4 percent at the top of the bar at left) accounted for 41 percent of annual Medicare FFS spending. The costliest 25 percent of beneficiaries accounted for 83 percent of Medicare spending (calculated on unrounded numbers). The least costly 50 percent of beneficiaries accounted for only 4 percent of FFS spending.

- Costly beneficiaries tend to be those who have multiple chronic conditions, are using inpatient hospital services, are dually eligible for Medicare and Medicaid, and are in the last year of life.

Chart 1-12. Medicare HI Trust Fund is projected to be depleted in 2026 under Trustees' intermediate assumptions



Note: HI (Hospital Insurance). The potential effects of the COVID-19 pandemic are not reflected in these projections. The primary source of income for HI is the payroll tax on covered earnings. Other HI income sources include (1) a portion of the federal income taxes that Social Security recipients with incomes above certain thresholds pay on their benefits and (2) interest paid on the U.S. Treasury securities held in the HI Trust Fund.
*Costs and income for 2019 represent actual (not projected) experience.
**Under the low-cost assumption, HI Trust Fund costs would be below income through the 75-year projection period ending in 2094.

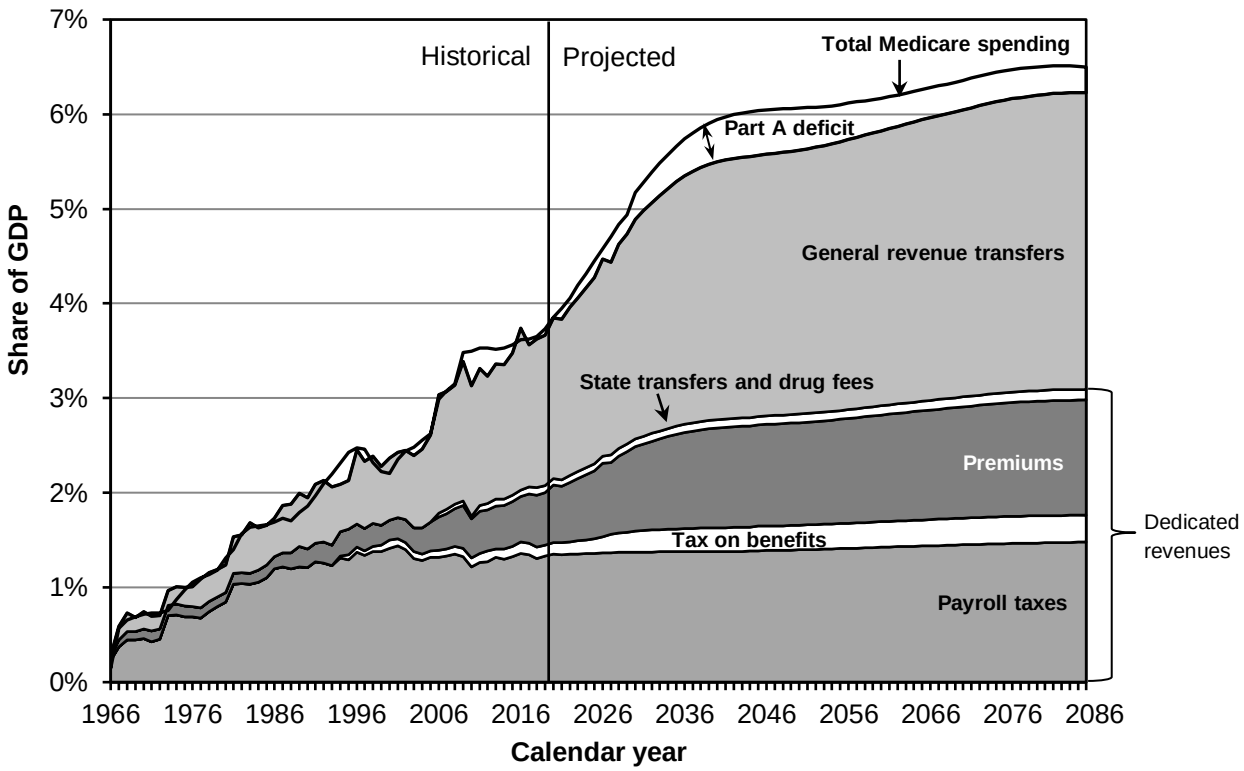
Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- The HI Trust Fund, which helps pay for Part A services such as inpatient hospital stays and post-acute care provided by skilled nursing facilities and hospice, is mainly financed through a dedicated payroll tax (i.e., a tax on wage earnings).

- From 2008 to 2015, the HI Trust Fund ran an annual deficit (i.e., paid more in benefits than it collected in payroll taxes) (data not shown). In 2016 and 2017, the HI Trust Fund ran a surplus (data not shown). However, deficits returned in 2018 and 2019 and are projected to continue until trust fund assets are depleted in 2026 (under the Trustees' intermediate assumptions). Under high-cost assumptions, the HI Trust Fund could be depleted as early as 2023. Under low-cost assumptions, it would remain able to pay full benefits indefinitely.

- The Trustees estimate that the payroll tax would need to be immediately increased from its current rate of 2.90 percent to 3.66 percent to balance the HI Trust Fund over the next 75 years. Alternatively, Part A spending would need to be immediately reduced by 16 percent (data not shown).

Chart 1-13. General revenues have overtaken Medicare payroll taxes as the largest source of Medicare funding



Note: GDP (gross domestic product). These projections are based on the Trustees' intermediate set of assumptions and do not reflect the potential effects of the COVID-19 pandemic. "Tax on benefits" refers to the portion of income taxes that higher income individuals pay on Social Security benefits, which is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments from the states to Medicare for assuming primary responsibility for prescription drug spending that were mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. "Drug fees" refers to the fee imposed by the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance Trust Fund.

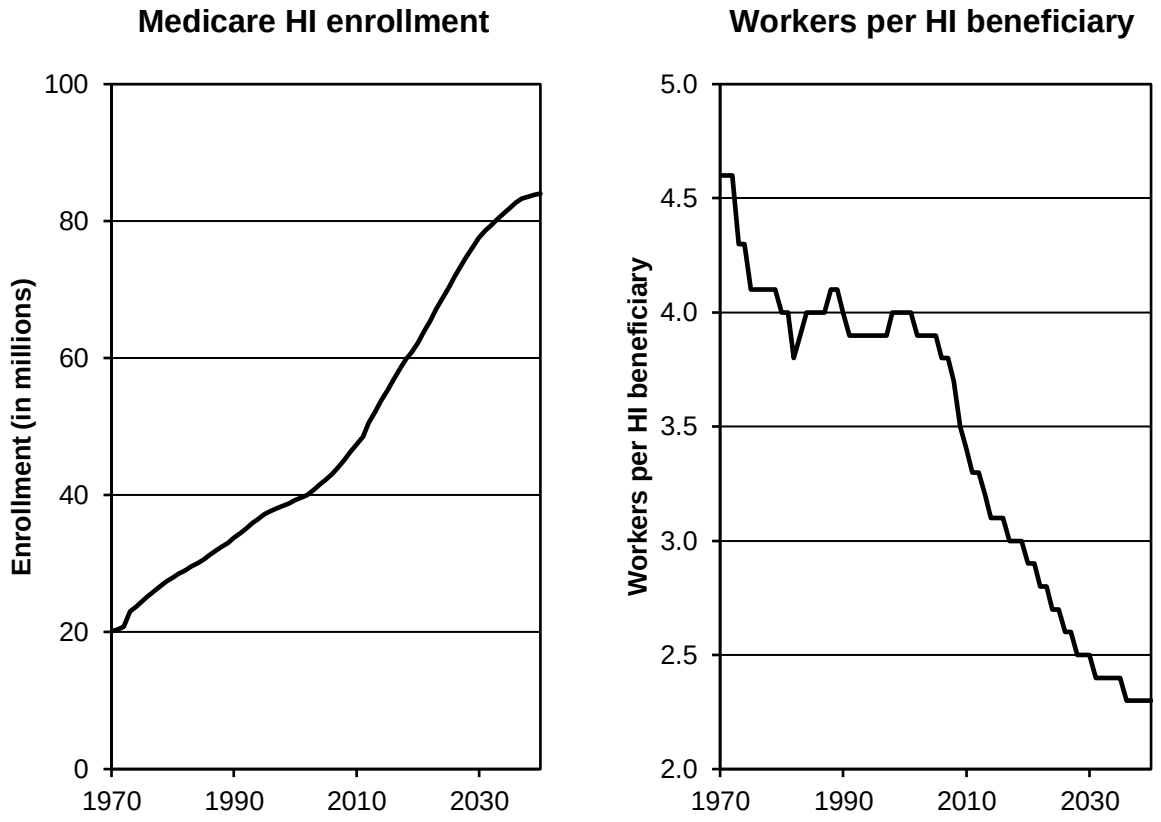
Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- Medicare spending accounted for 3.7 percent of GDP in 2019. The Medicare Trustees project that Medicare's share of GDP will rise to 5.5 percent by 2033 and to 5.9 percent by 2038.

- In the early years of the Medicare program, payroll taxes deposited into Medicare's Hospital Insurance Trust Fund (which finances Part A) were the main source of funding for the program, but beginning in 2009, general revenue transfers (which help finance Part B and Part D) became the largest single source of Medicare income. General revenue transfers are expected to continue to be a substantial share of Medicare financing, growing to about 49 percent by 2034, and then remaining stable through the rest of the century.

- As more general revenues are devoted to Medicare, fewer resources will be available to invest in growing the economic output of the future or in supporting other national priorities.

Chart 1-14. Medicare enrollment is rising while the number of workers per HI beneficiary is declining



Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A. The potential effects of the COVID-19 pandemic are not included in these projections.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- As the baby-boom generation ages, enrollment in the Medicare program is surging. By 2033, Medicare is projected to have over 80 million beneficiaries—up from 62 million beneficiaries in 2020.
- While Medicare enrollment is rising, the number of workers per beneficiary is rapidly declining. Workers are the primary funder of Medicare's HI Trust Fund, which they fund through payroll taxes. However, the number of workers per Medicare beneficiary has declined from 4.6 during the early years of the program to 2.9 in 2020 and is projected by the Medicare Trustees to fall to 2.5 by 2028.
- These demographics threaten the financial stability of the Medicare program.

Chart 1-15. Medicare HI and SMI benefits and cost sharing per FFS beneficiary, 2018

	Average benefit in 2018 (in dollars)	Average cost sharing in 2018 (in dollars)
HI (Part A)	$4,972	$415
SMI (Part B, excludes Part D)	5,959	1,513

Note: HI (Hospital Insurance), SMI (Supplementary Medical Insurance), FFS (fee-for-service). Dollar amounts are nominal for FFS Medicare only and do not include Part D. "Average benefit" represents amounts paid for covered services per FFS beneficiary and excludes administrative expenses. "Average cost sharing" represents the sum of deductibles, coinsurance, and balance billing paid for covered services per FFS beneficiary and excludes all monthly premiums.

Source: CMS Program Statistics, CMS Office of Enterprise Data and Analytics, CMS Chronic Conditions Data Warehouse.

- In calendar year 2018, the Medicare program made $4,972 in HI (Part A) benefit payments and $5,959 in SMI (Part B) benefit payments on average per FFS beneficiary.
- Beneficiaries owed an average of $415 in cost sharing for HI and $1,513 in cost sharing for SMI in calendar year 2018. (Cost sharing excludes all monthly premiums.)
- To cover some of those cost-sharing requirements, 89 percent of beneficiaries have coverage that supplements or replaces the Medicare benefit package, such as Medicare Advantage, Medicaid, supplemental coverage through former employers, and Medigap coverage.