

CHAPTER

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**Context for Medicare  
payment policy**

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# Context for Medicare payment policy

## Chapter summary

Part of the Commission’s mandate is to consider the effect of its recommendations on the federal budget and view Medicare in the context of the broader health care system. To help meet its mandate, this chapter examines health care spending growth—for the nation at large and Medicare in particular—and considers its effect on federal and state budgets and on the budgets of individuals and families. The chapter also profiles the next generation of Medicare beneficiaries and reviews evidence of inefficient health care spending, structural features of the Medicare program that contribute to inefficient spending, and the Commission’s approach to combating those challenges.

Health care spending growth may be beginning to accelerate after several years of historic lows. National health care spending and Medicare spending grew robustly from 1974 to 2009. Then from 2009 to 2013, growth in national health care spending and Medicare spending slowed to average annual rates of 3.6 percent and 4.1 percent, respectively.

The causes of the system-wide slowdown and whether it will be sustained or is transient are still a matter of speculation. A variety of factors could have contributed—weak economic conditions, payment and delivery system reforms, lower Medicare payment rates for most types of providers as

## In this chapter

- National health care spending
- Medicare spending
- Medicare’s financing challenge
- Health care spending also consumes growing shares of state budgets and the budgets of individuals and families
- Assessing the impact of Medicare spending on quality
- Baby boomers will make up the next generation of Medicare beneficiaries
- Evidence of inefficient spending suggests Medicare could spend less without compromising care, but improving efficiency is challenging
- Conclusion

mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA), and the increased use of generic drugs as top-selling brand-name drugs lost patent protection.

However, experience in 2014 could indicate that the slowdown is coming to an end. Government actuaries estimate that spending grew faster that year: National health care spending grew 5.3 percent, and Medicare spending grew 5.5 percent. The increase in national health care spending growth was due largely to coverage expansions for health insurance that commenced that year under PPACA, as well as to a substantial increase in prescription drug spending, especially on new treatments for hepatitis C. Growth in outpatient medical services also contributed to the increase in Medicare spending.

The aging of the baby-boom generation will have a profound impact both on the Medicare program and the taxpayers who support it. Over the next 15 years, as Medicare enrollment surges, the number of taxpaying workers per beneficiary is projected to decline. By 2030 (the year baby boomers will have all aged into Medicare), the Medicare Trustees project there will be just 2.4 workers for each Medicare beneficiary, down from 4.6 around the time of the program's inception. Those demographics create a financing challenge not only for the Medicare program but also for the entire federal budget. By 2040, under federal tax and spending policies specified in current law, Medicare spending combined with spending on other major health care programs, Social Security, and net interest on the national debt would exceed total federal revenues and would crowd out spending on all other national priorities.

The growth in health care spending also affects state budgets and the budgets of individuals and families. States pay for a significant portion of Medicaid spending (spending funded jointly by states and the federal government for health care services provided to state residents with low incomes). Under PPACA, the Medicaid population is expanding; however, the federal government will pay for most of the costs associated with the expansion. Increases in private insurance premiums have outpaced the growth of individual and family incomes over the past decade, and out-of-pocket costs for Medicare beneficiaries have also increased.

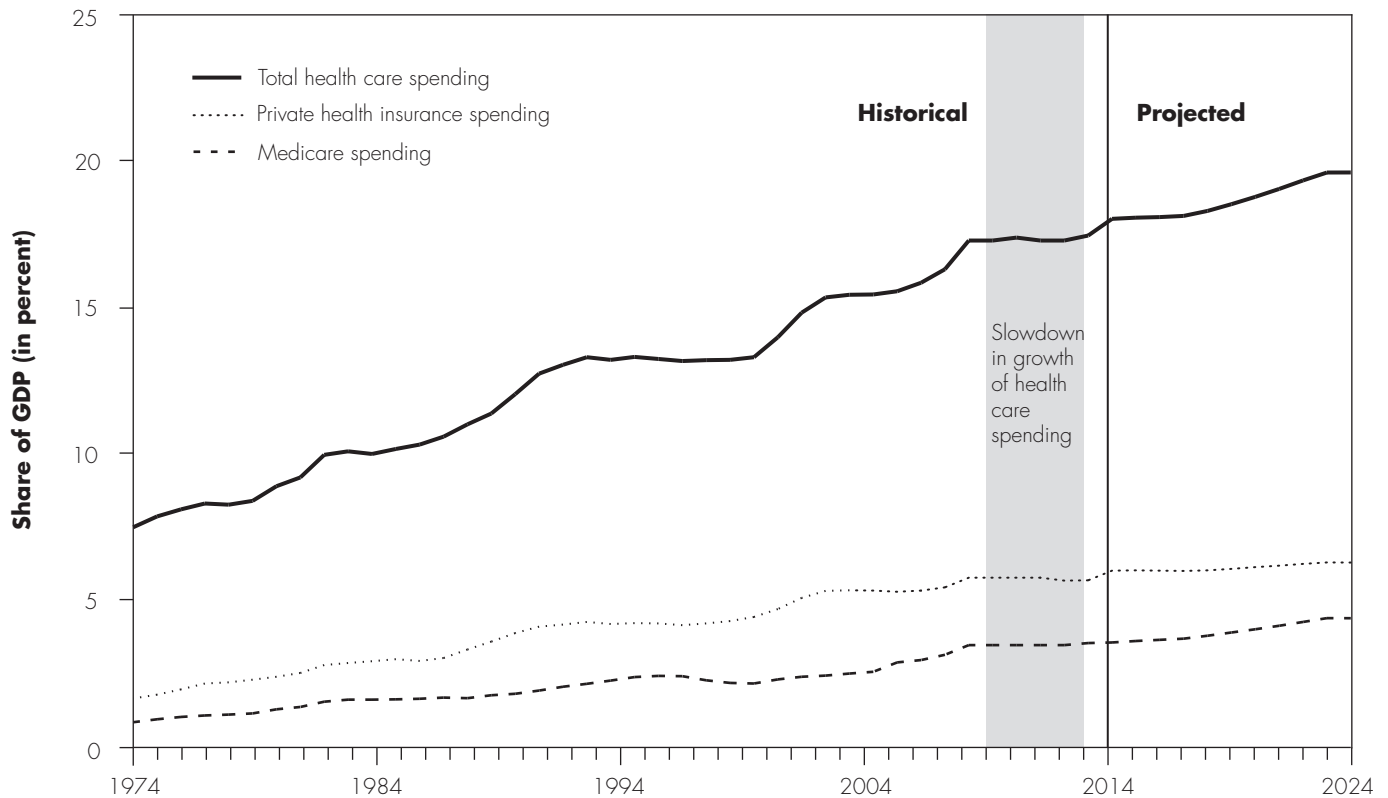
Some health care spending is inefficient. For Medicare, if such spending can be identified and eliminated, it could result in each Medicare dollar being spent more efficiently, improving beneficiary health, supporting the program's fiscal sustainability, and reducing federal budget pressures. Certain structural features of the Medicare program pose challenges for targeting inefficient spending, but the

Commission has a framework to address those challenges that focuses on (1) payment accuracy and efficiency, (2) care coordination and quality, (3) information for patients and providers, (4) engaged beneficiaries, and (5) an aligned health care workforce. ■



**FIGURE 1-1**

**Recent historically low growth rates of health care spending are projected to gradually and modestly increase**



Note: GDP (gross domestic product). First projected year is 2015. Federal subsidies—beginning in 2014—for the Patient Protection and Affordable Care Act of 2010 health insurance exchanges both for premiums and cost sharing are reflected as private health insurance spending.

Source: MedPAC analysis of National Health Expenditures Accounts from CMS, historical data released December 2015, projected data released July 2014.

## Introduction

The Medicare program lies at the junction between the national health care system as a whole and the federal government. For this reason, it is important to review the following context in which Medicare operates to understand the payment policies discussed in the rest of this report:

- national health care spending and Medicare spending,
- impact of health care spending on federal and state budgets,
- effects of health care spending on individuals and families,
- impact of Medicare spending on the quality of health care,

- the next generation of Medicare beneficiaries, and
- evidence of inefficient health care spending.

This chapter also reviews the challenges that Medicare in particular faces and the Commission’s principles for constructing recommendations to address those challenges.

## National health care spending

For decades, health care spending has risen as a share of gross domestic product (GDP), but in the recent past its growth rate slowed. That general trend is true both for private health care spending and Medicare (Figure 1-1). From 1974 to 2009, health care spending as a share of GDP more than doubled, from 7.5 percent to 17.3 percent.

Private health insurance spending as a share of GDP more than tripled over that period, from 1.7 percent to 5.8 percent. Medicare spending as a share of GDP rose by a factor of four over that period, from 0.9 percent to 3.5 percent. In contrast, from 2009 through 2013, health care spending as a share of GDP remained relatively constant (Centers for Medicare & Medicaid Services 2014c).

The recent slowdown in the rate of health care spending growth has not been fully explained. Contributing factors could include weak economic conditions, payment and delivery system reforms, lower Medicare payment rates for most types of providers as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA), and the increased use of generic drugs as top-selling brand-name drugs lost patent protection.

However, government actuaries estimate that spending accelerated in 2014, both nationally and for Medicare. After averaging 3.6 percent growth annually from 2009 to 2013, national health care spending is estimated to have grown 5.3 percent and reached 17.5 percent of GDP in 2014. That growth is due largely to the increase in the insured population in that year because the PPACA health insurance exchanges and the Medicaid expansions commenced. It is also due to a substantial increase in prescription drug spending, especially on new treatments for hepatitis C.

After averaging 4.1 percent growth annually from 2009 to 2013, Medicare spending is estimated to have grown 5.5 percent in 2014. Like the increase in national health care spending, part of the increase in Medicare spending was due to an increase in prescription drug spending, especially for new treatments for hepatitis C. It was also due to an increase in per capita spending on health care services provided on an outpatient basis (for example, services received in hospital outpatient departments and physician services) and an increase in enrollment as members of the baby-boom generation aged into Medicare.

Over the next decade, government actuaries project growth rates for health care spending to gradually and modestly increase because of health insurance expansions under PPACA, faster economic growth, and population aging (Keehan et al. 2015). The growth rates are projected to be higher than the lows of the recent past, but lower than the historic highs. For 2024, actuaries project total health care spending as a share of GDP to increase to 19.6 percent. In that year, private health insurance spending and Medicare spending are projected to reach 6.3 percent and 4.4 percent of GDP, respectively.

To better understand who is paying for health care, we examine personal health care spending—all medical goods and services provided for an individual's treatment. In 2014, personal health care spending—which excludes spending on government public health activities (e.g., epidemiological surveillance and disease prevention programs), administration of private and public health insurance, and investments in medical research, equipment, and structures—accounted for 85 percent of total health care spending.

Over the past four decades, total personal health care spending increased from \$0.1 trillion to \$2.6 trillion. On a per person basis, spending increased from \$453 to \$8,062, a 7 percent increase per year, on average. During this period, out-of-pocket spending (e.g., cost sharing, deductibles, and health care services not covered by insurance) as a share of total personal health care spending declined from 35 percent to 13 percent, while the shares accounted for by private health insurance, Medicare, and Medicaid all increased (Figure 1-2). At the same time, Medicare has remained the largest single purchaser of health care in the United States (Centers for Medicare & Medicaid Services 2015b).<sup>1</sup>

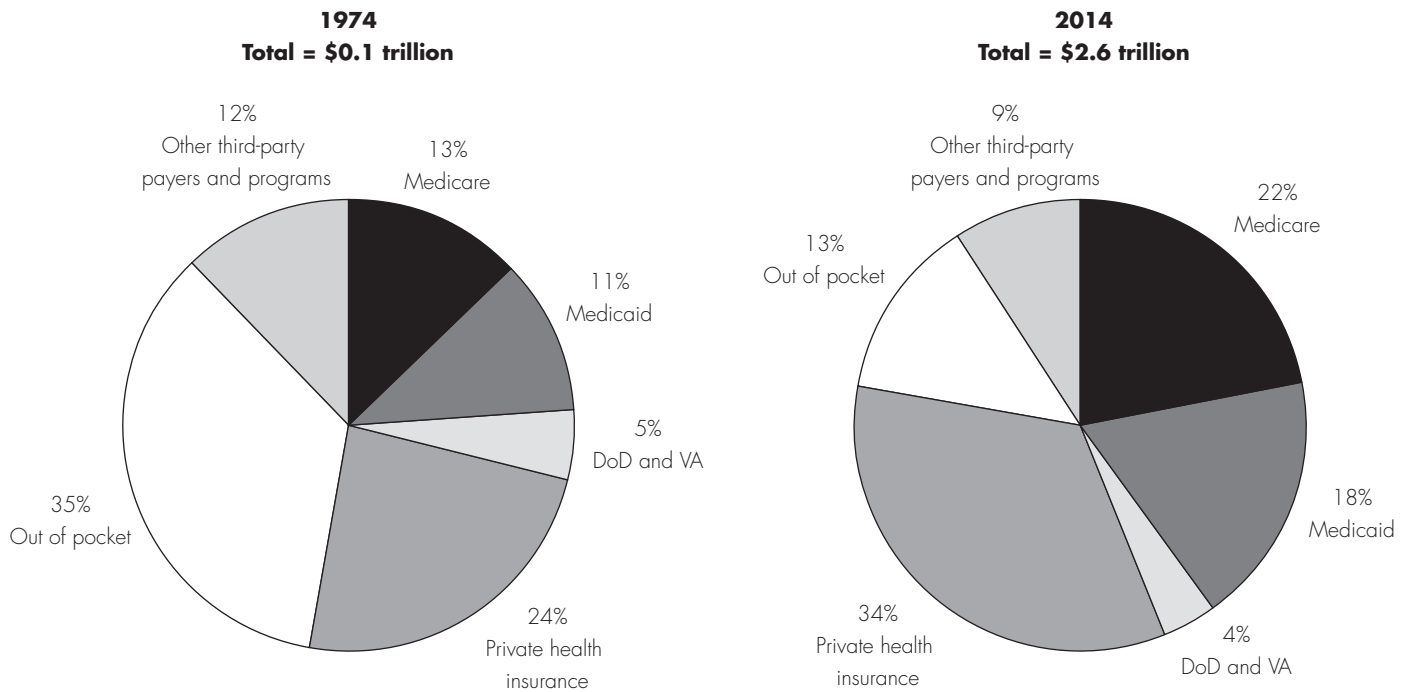
Despite the decline in the share of health care spending paid directly out of pocket by individuals and the increase in the share of health care spending paid by private and public insurance, people have not experienced similar declines in the share of health care costs they pay. One reason is that in the commonly defined health care spending categories, the premiums people pay are not included in the out-of-pocket category, but rather in the private health insurance and Medicare categories. Second, people receive lower salaries and reduced benefits in exchange for employer-sponsored health insurance. When an employer contributes to premiums, most economists agree that salary and other benefits are reduced to offset the employer contribution.

In 2014, Medicare covered 54 million people, and government actuaries estimate that Medicaid covered about 65 million people (Boards of Trustees 2015, Centers for Medicare & Medicaid Services 2014a). Private health insurance covered 171 million people under the age of 65, and 36 million people were uninsured (National Center for Health Statistics 2015b). Enrollment in Medicare, Medicaid, and private health insurance is continuing to increase due to the aging of the baby-boom generation and the enactment of PPACA.



**FIGURE 1-2**

**Out-of-pocket spending's share of personal health care spending declined while private, Medicare, and Medicaid spending's share increased, 1974 and 2014**



Note: DoD (Department of Defense), VA (Department of Veterans Affairs). Private health insurance accounted for a greater share of spending than Medicare (34 percent vs. 22 percent in 2014). However, in contrast to Medicare, private health insurance is not a single purchaser of health care; rather, it includes many payers, including traditional managed care, self-insured health plans, and indemnity plans. "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 and private insurance) rather than in the out-of-pocket share category. Medicaid includes the Children's Health Insurance Program. "Other third-party payers and programs" includes work-site 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.

Source: MedPAC analysis of National Health Expenditure Accounts from CMS, data released in December 2015.

Some people have coverage from more than one source. In 2014, about 11 million people were enrolled in both Medicare and Medicaid (Boards of Trustees 2015). Medicaid pays for either a portion or all of the Medicare premium and out-of-pocket health care expenses for those enrollees who qualify for dual enrollment based on limited income and resources. Enrollees in public health insurance programs may also have private health insurance. For example, Medicare beneficiaries may also have supplemental insurance sold by private companies to pay some of the health care costs that Medicare does not cover, such as copayments, coinsurance, and deductibles.

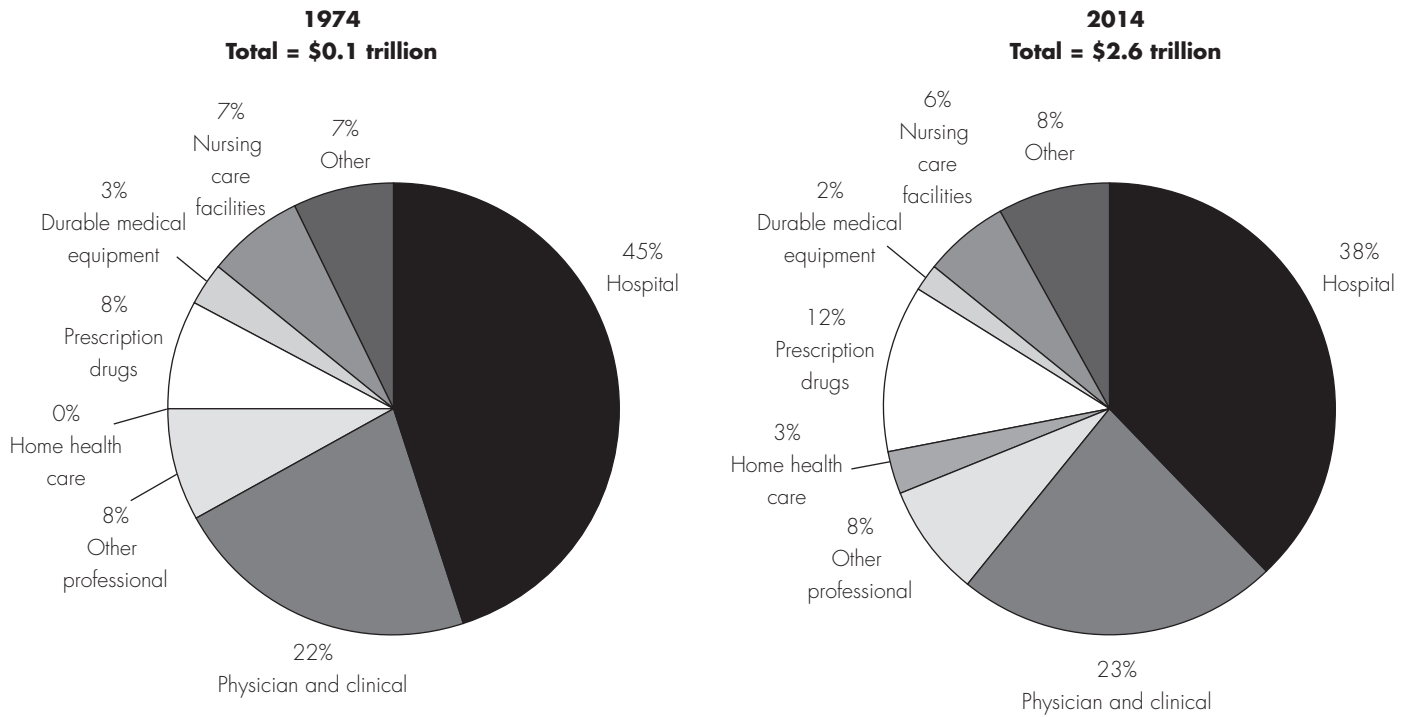
In 2014 as well as 1974, the largest shares of personal health care spending were for hospital care and physician and clinical services (Figure 1-3, p. 10). In 2014, hospital

care accounted for 38 percent of spending, or \$972 billion, and physician and clinical services accounted for 23 percent of spending, or \$604 billion. Smaller shares went to spending on prescription drugs (12 percent, or \$298 billion), nursing care facilities (6 percent, or \$156 billion), and home health care services (3 percent, or \$83 billion). Between 1974 and 2014, the share of spending on hospital care declined and the share of spending for prescription drugs increased (Centers for Medicare & Medicaid Services 2015b).

In 2014, Medicare accounted for 22 percent of spending for all services (Figure 1-2), but its share varied by type of service, with a slightly higher share of spending on hospital care (26 percent) and a much higher share of spending on home health services (42 percent)

**FIGURE 1-3**

**Hospital care and physician services accounted for the largest shares of personal health care spending in 1974 and 2014**



Note: "Other" includes expenditures on nondurable medical products and other health, residential, and personal care. "Other professional" includes expenditures on dental and other professional services. "Nursing care facilities" includes nursing care facilities and continuing care retirement communities.

Source: MedPAC analysis of National Health Expenditure Accounts from CMS, data released in December 2015.

(Figure 1-4). Medicare's share of spending on nursing care facilities was smaller than Medicaid's share because Medicare's benefit pays for skilled nursing or rehabilitation services only, whereas Medicaid pays for custodial care (assistance with activities of daily living) provided in nursing homes for people with limited income and assets.

**Medicare spending**

Medicare spending can be divided into three program components: the traditional fee-for-service (FFS) program, the Medicare Advantage (MA) program, and the Part D prescription drug program.

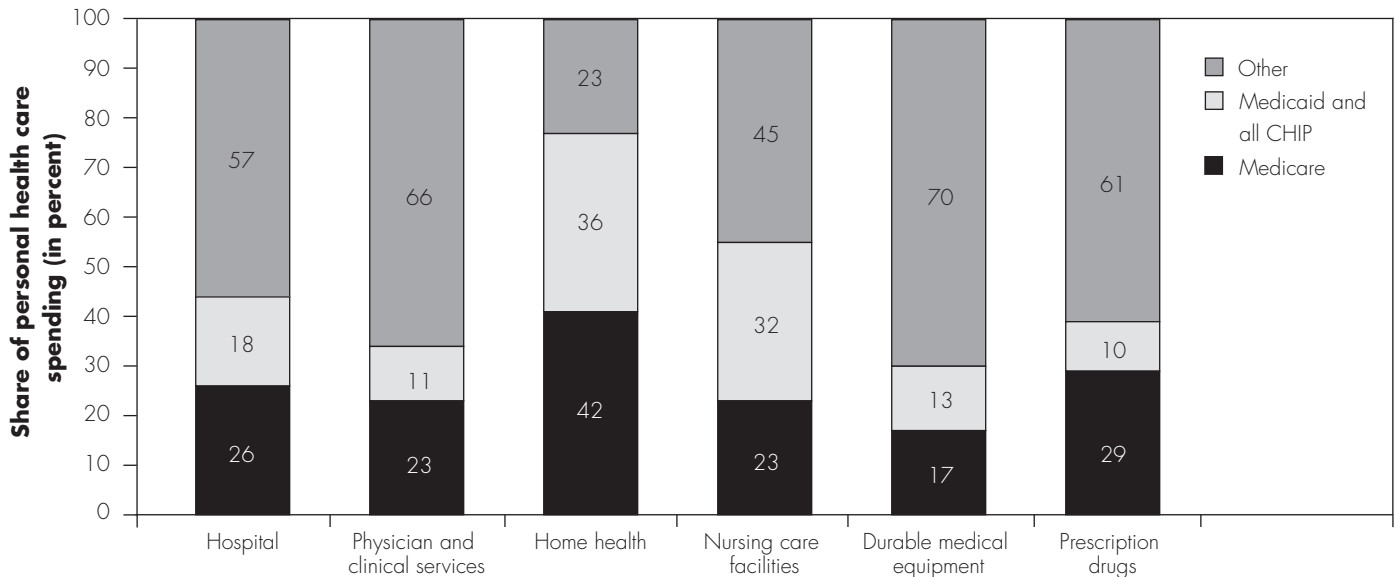
- **Medicare's traditional fee-for-service program.** In FFS, Medicare pays health care providers directly for health care goods and services furnished to Medicare

FFS beneficiaries at prices set through legislation and regulation.

- **Medicare Advantage program.** As an alternative to FFS, beneficiaries can choose to enroll in MA, which consists of private health plans that receive capitated payments (or per enrollee payments) for providing health care coverage for enrollees. MA plans pay health care providers for health care goods and services furnished to their enrollees at prices negotiated between the plans and providers.
- **Medicare Part D prescription drug program.** Through Part D, beneficiaries can obtain subsidized prescription drug coverage by voluntarily purchasing insurance policies from private stand-alone drug plans or MA plans. Medicare heavily subsidizes the premiums established by those plans.

**FIGURE 1-4**

**Medicare's share of spending on personal health care varies by type of service, 2014**



Note: 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. "Nursing care facilities" includes nursing care facilities and continuing care retirement communities. "Other" includes private health insurance, out-of-pocket spending, and other private and public spending.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, "Table 19: National Health Expenditures by Type of Expenditure and Program: Calendar Year 2014," released December 2015.

Recent growth in per beneficiary Medicare spending has been slow, but 2014 showed signs of acceleration; Figure 1-5 (p. 12) presents average annual growth rates for the last decade (from 2005 to 2014) in three-year periods. Growth was particularly low from 2011 to 2014 (the last period) for FFS and MA. The lower growth rates were generally because of decreased use of health care services and restrained payment rate increases.

In FFS, per beneficiary spending remained stable from 2011 to 2014. PPACA lowered payment rate updates in FFS for many types of providers (other than physicians) beginning in 2012. However, in 2014, FFS growth increased because of an increase in per beneficiary spending on a wide range of outpatient services, including services received in hospital outpatient departments and physician services.

MA spending also had little growth from 2011 to 2014. Historically, Medicare has spent more when a beneficiary is enrolled in MA than if that same beneficiary were enrolled in FFS. To bring payments more in line with FFS, PPACA began lowering payments to plans in

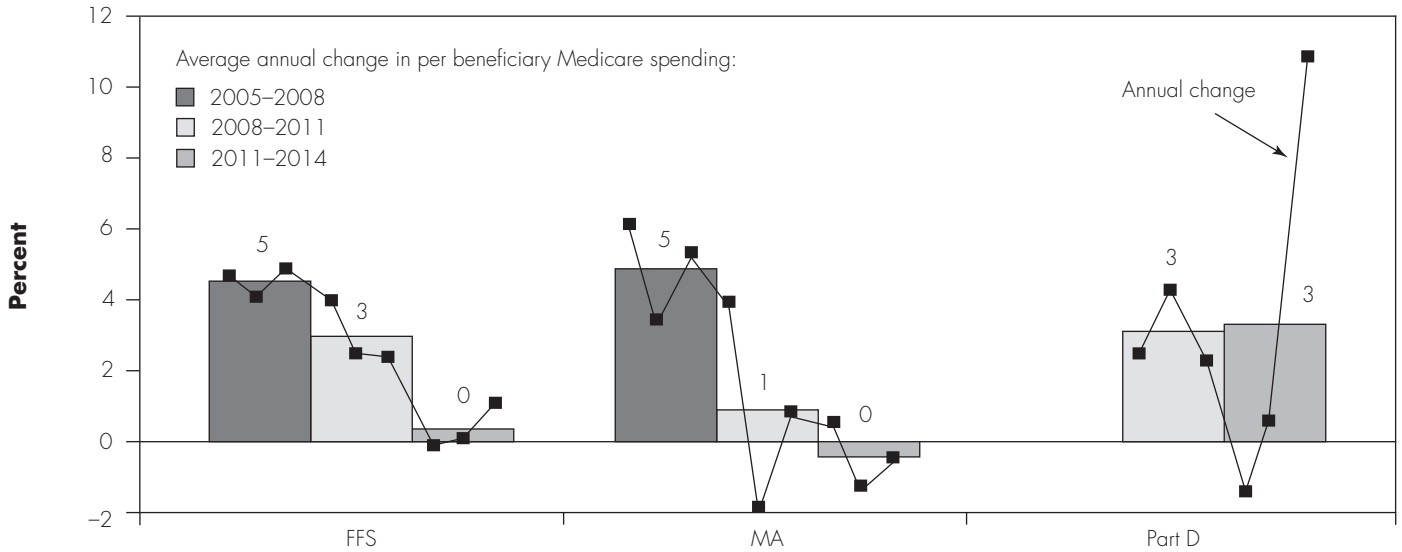
2011. The growth rate would have been lower, but the PPACA payment reductions were offset somewhat by new quality bonus payments and plans' increased coding of beneficiaries' medical conditions (payments to MA plans are higher when beneficiaries have more medical conditions, all other things being equal).

In Part D, growth averaged 3 percent annually from 2011 to 2014. The three-year annual average masks the spike in spending that occurred in 2014. From 2011 to 2013, per beneficiary spending was relatively constant at about \$1,600 per year. The low growth for those years was in part due to the increase in low-priced generic drugs on the market and plans' efforts to steer beneficiaries to generics and other low-priced drugs.

However, in 2014, per beneficiary spending spiked to \$1,811, growing 11 percent in one year.<sup>2</sup> That jump was mainly because of increased spending on high-priced specialty drugs to treat hepatitis C. The Medicare Trustees project the annual growth in per beneficiary Part D spending to remain high from 2016 to 2024 (ranging from 5 percent to 7 percent) because of a slowing of the trend

**FIGURE 1-5**

**Recent growth in per beneficiary Medicare spending has been slow, but 2014 shows signs of acceleration**

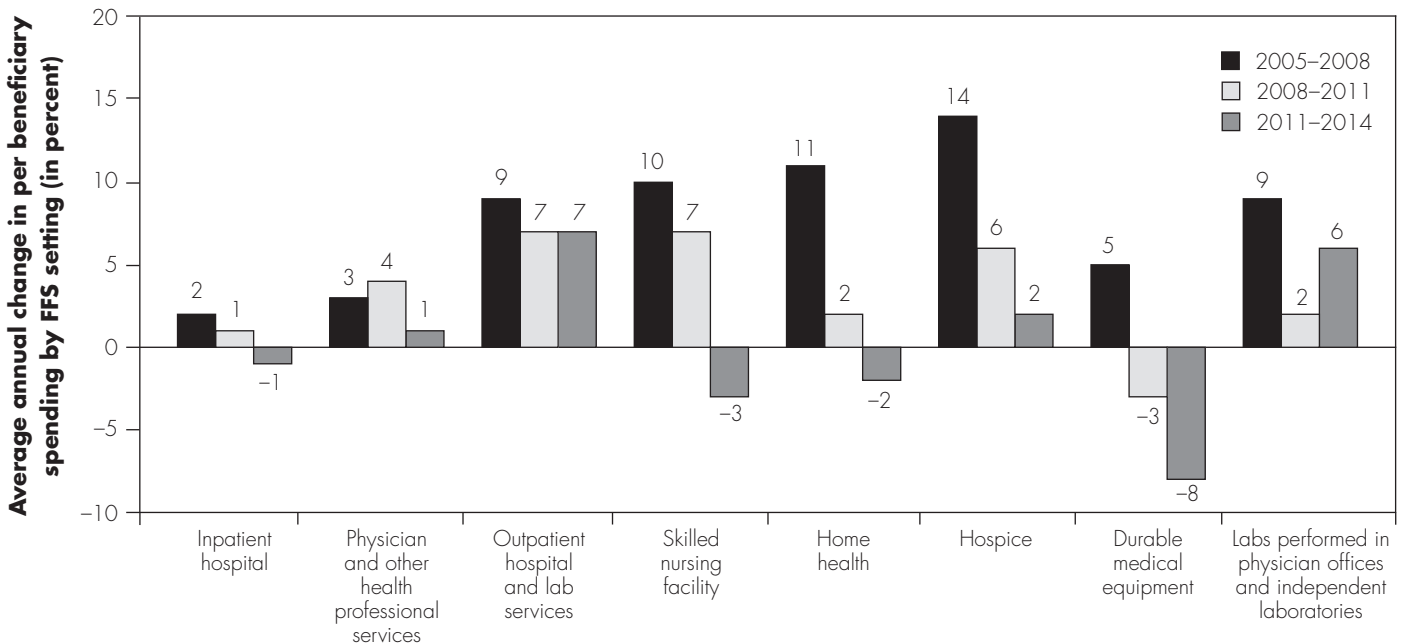


Note: FFS (fee-for-service), MA (Medicare Advantage). Part D average annual change from 2005 to 2008 is not shown because the program began in 2006.

Source: 2015 annual report of the Boards of Trustees of the Medicare trust funds.

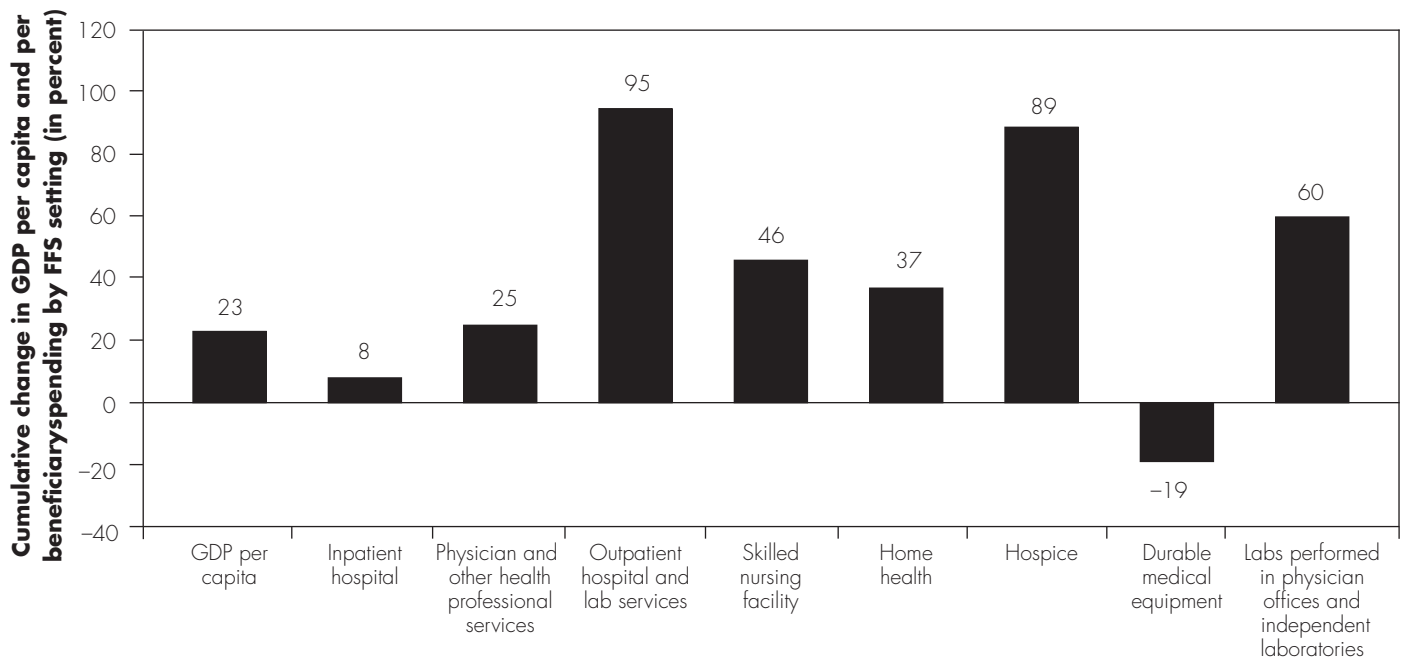
**FIGURE 1-6**

**Per beneficiary spending growth in some FFS settings remained strong**



Note: FFS (fee-for-service). Outpatient hospital services and outpatient lab services are combined in the figure because a large portion of outpatient laboratory services were bundled into the outpatient prospective payment system effective January 1, 2014.

Source: 2015 annual report of the Boards of Trustees of the Medicare trust funds.

**FIGURE  
1-7****Per beneficiary spending grew over the decade in almost all FFS settings, 2005–2014**

Note: FFS (fee-for-service), GDP (gross domestic product). Outpatient hospital services and outpatient lab services are combined in the figure because a large portion of outpatient laboratory services were bundled into the outpatient prospective payment system effective January 1, 2014.

Source: 2015 annual report of the Boards of Trustees of the Medicare trust funds.

toward greater generic drug use and a continuing increase in the use and price of specialty drugs (Boards of Trustees 2015).

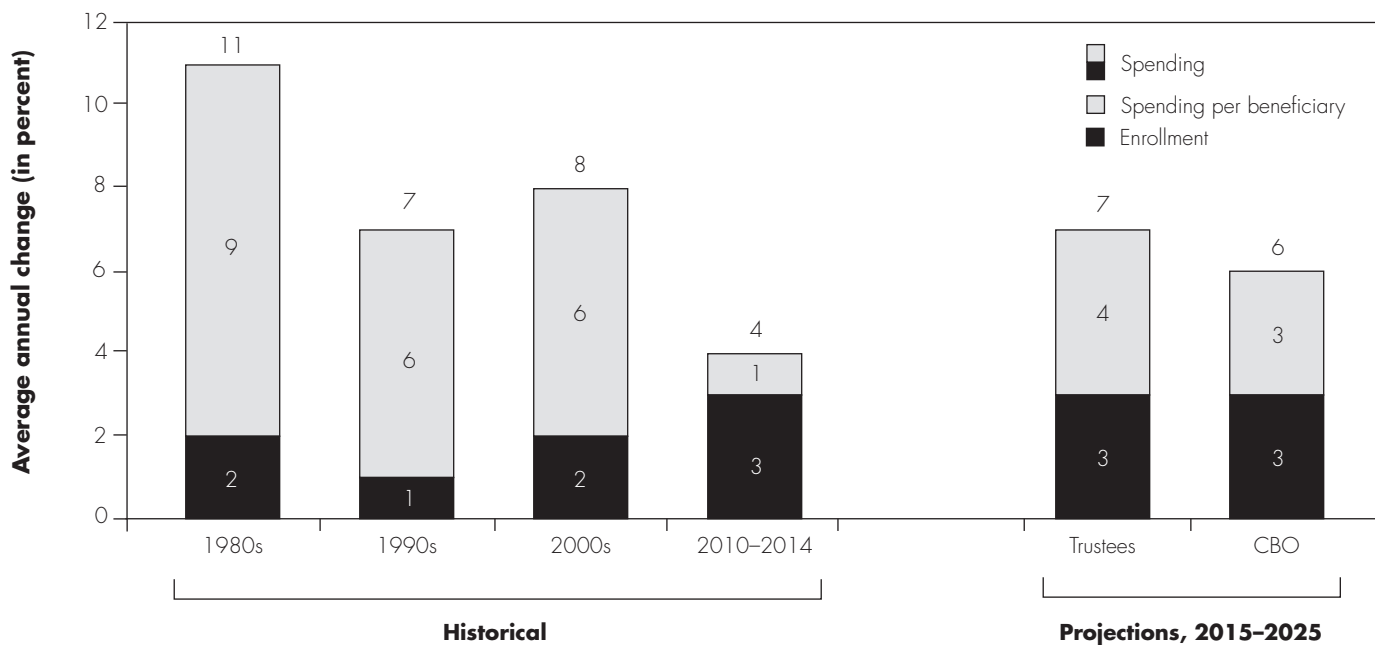
Figure 1-6 provides a more detailed look at FFS spending. Generally, all settings experienced a slowdown in per beneficiary spending growth; however, the impact was not uniform. For example, for inpatient hospital care, the average annual growth in per beneficiary spending fell from 2 percent in the first period to -1 percent in the last period. The per beneficiary spending growth in outpatient hospital and lab services declined but was still robust in the last period at 7 percent annually, in part because of shifts in site of care from both the inpatient hospital setting and physician offices to the outpatient hospital setting.<sup>3</sup>

Despite the recent slowing of annual growth rates, cumulative growth in per beneficiary FFS spending over the last decade has increased in almost all settings and increased substantially in some settings (Figure 1-7). Per beneficiary spending on physician and other health professional services, outpatient hospital and lab services, skilled nursing facilities, home health, hospice,

and labs performed in physician offices and independent laboratories all grew faster than per capita GDP. In contrast, during this time, per beneficiary spending on durable medical equipment fell 19 percent. That decline was due primarily to the phasing in of a competitive bidding program for durable medical equipment in which suppliers submit bids to provide services to beneficiaries.

### **A comparison of private sector and Medicare spending trends**

Per capita spending on health care in the private sector grew steadily from 2010 to 2014 (Health Care Cost Institute 2015). Spending growth was largely driven by increased prices and occurred despite a decline in service use. One key driver of the private sector's higher prices was provider market power (Baker et al. 2014a, Baker et al. 2014b, Gaynor and Town 2012, Robinson and Miller 2014). Hospitals and physician groups have increasingly consolidated, in part to gain leverage over insurers in negotiating higher payment rates. For the private sector, that consolidation resulted in per capita spending

**FIGURE 1-8****Despite recent slowdown in per beneficiary spending growth, total Medicare spending growth is projected to rise**

Note: CBO (Congressional Budget Office). See online Appendix 1-A, available at <http://www.medpac.gov>, for annual growth rates of spending, enrollment, and spending per beneficiary, as well as more detail on trends in spending per beneficiary.

Source: 2015 annual report of the Boards of Trustees of the Medicare trust funds and CBO report *Updated Budget Projections: 2015 to 2025*, released March 2015.

growth from 2010 to 2014 of 3.3 percent annually. By comparison, over that same period, Medicare spending per beneficiary increased by 1.0 percent annually, partly attributable to restrained increases in Medicare's payment rates.

Over the long term, private sector trends can influence Medicare trends. If the private sector is unable to constrain price growth, the profitability of caring for commercially insured patients will increase relative to the profitability of caring for Medicare beneficiaries, potentially impeding access to care for Medicare beneficiaries and exerting pressure on the Medicare program to increase its payment rates (Medicare Payment Advisory Commission 2009, Stensland et al. 2010, White and Wu 2014).

### Medicare spending projections

What do these current trends portend for Medicare? The growth in Medicare's per beneficiary spending has fallen from average annual rates of 9 percent in the 1980s and 6 percent in the 1990s and 2000s to 1 percent over the last

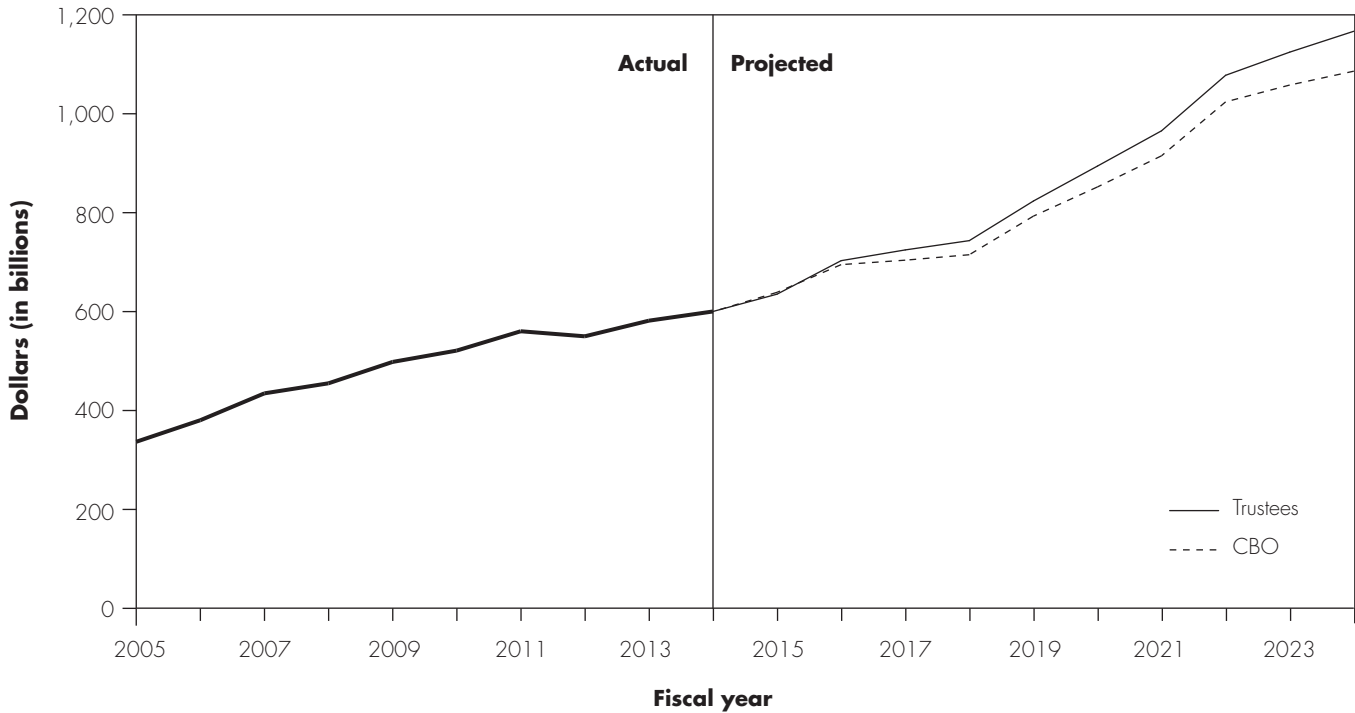
four years (Figure 1-8). This average annual growth over the last four years, however, includes some zero-growth years and growth of about 2 percent in 2014.

For the next 10 years, the Trustees and the Congressional Budget Office (CBO) project that growth in per beneficiary spending will be higher than the recent lows but lower than the historic highs, with an average annual growth rate of either 4 percent (the Trustees' projection) or 3 percent (CBO's projection) (Boards of Trustees 2015, Congressional Budget Office 2015d).<sup>4</sup>

At the same time, the aging of the baby-boom generation is causing an increase in enrollment. The growth rate of enrollment increased from about 2 percent per year historically to 3 percent. That increase occurred over the last few years and is projected to continue throughout the next decade.<sup>5</sup> So despite the slowdown in spending per beneficiary (relative to historical standards), growth in total spending over the next decade is projected by the Trustees to average 7 percent annually, or 6 percent annually according to the CBO. Under either projection,

**FIGURE  
1-9**

**Trustees and CBO project Medicare annual spending to reach 1 trillion dollars within 10 years**



Note: CBO (Congressional Budget Office).

Source: 2015 annual report of the Boards of Trustees of the Medicare trust funds and CBO report *An Update to the Budget and Economic Outlook: 2015 to 2025*, August 2015.

the rate of growth in spending outpaces the projected average annual growth in GDP of 5 percent.

At those rates, Medicare annual spending would rise from about \$600 billion today to \$1 trillion within the coming decade (by 2022) under either projection (Figure 1-9) (Boards of Trustees 2015, Congressional Budget Office 2015c).

### Medicare's financing challenge

The aging of the baby-boom generation will have a profound impact both on the Medicare program and the taxpayers who support it. Over the next 15 years, as Medicare enrollment surges, the number of workers per beneficiary is projected to decline (Figure 1-10, p. 16). Workers pay for the Medicare program through payroll taxes and taxes that are deposited into the general fund of the Treasury. However, the number of workers per

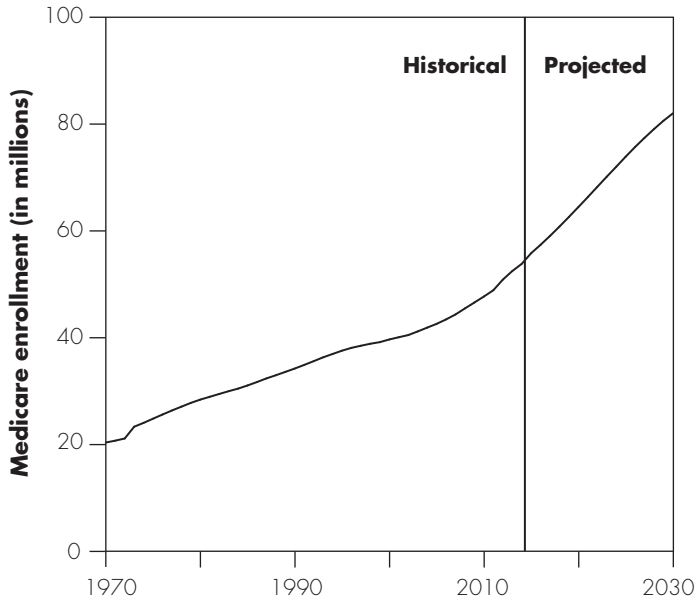
Medicare beneficiary has already declined from about 4.6 around the program's inception to 3.1 today. By 2030 (the year by which all baby boomers will have aged into Medicare), the Medicare Trustees project there will be just 2.4 workers for each Medicare beneficiary.

These demographics are creating a financing challenge for the Medicare program. The Trustees project that Medicare's Hospital Insurance (HI) Trust Fund will become insolvent by 2030, but that date does not tell the whole financial story. The HI Trust Fund covers less than half of Medicare spending (44 percent in 2014), and that share is projected to continue to shrink over the next decade (Figure 1-11, p. 16). The Supplementary Medical Insurance (SMI) Trust Fund covers the remainder and is described below. The HI Trust Fund pays for Medicare Part A services, such as inpatient hospital stays, skilled nursing facilities, and hospice, and is largely funded through a dedicated payroll tax (i.e., a tax on wage earnings).

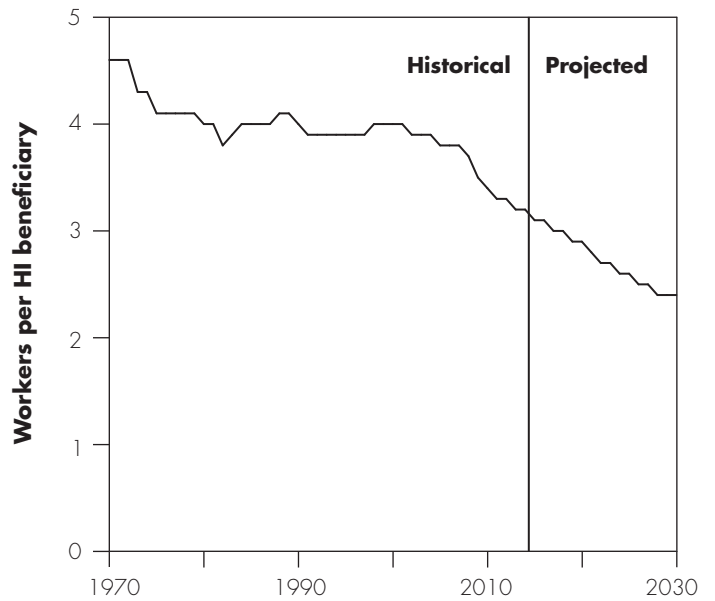
**FIGURE 1-10**

**Medicare enrollment is rising while the number of workers per HI beneficiary is declining**

**Figure 1-10a. Medicare enrollment**



**Figure 1-10b. Workers per HI beneficiary**

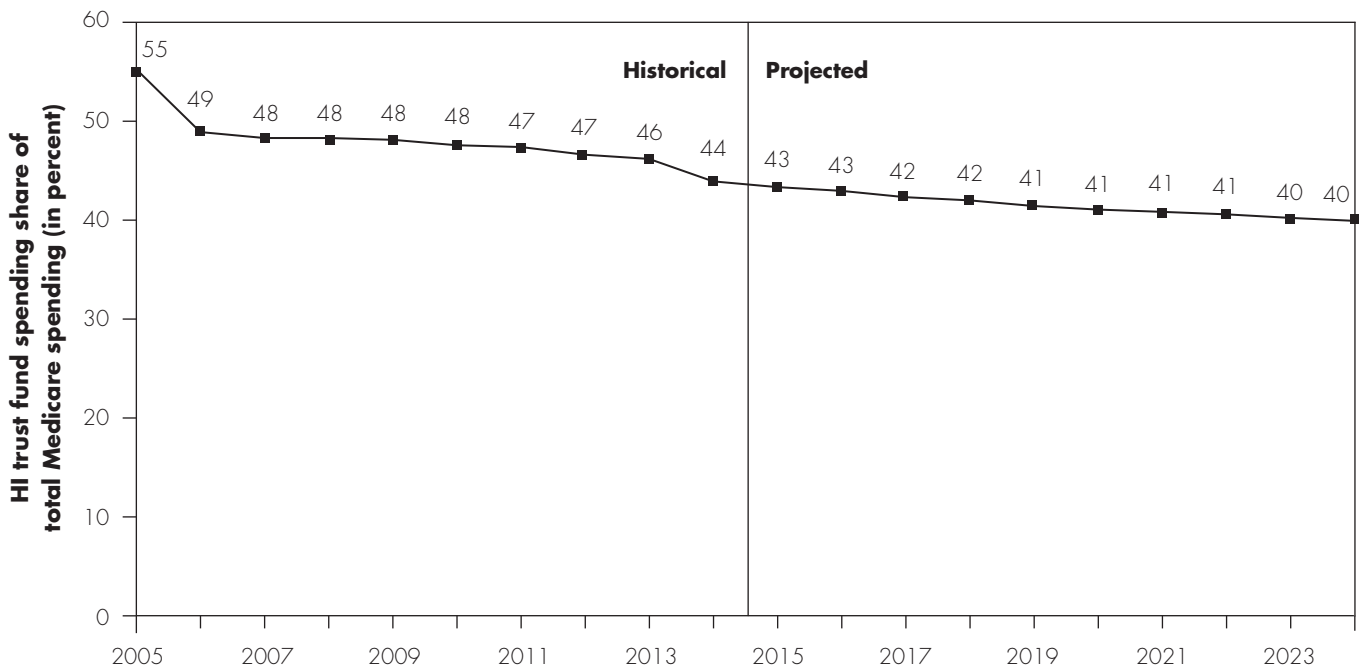


Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A.

Source: 2015 annual report by the Boards of Trustees of the Medicare trust funds.

**FIGURE 1-11**

**The HI Trust Fund covers a declining share of total Medicare spending**



Note: HI (Hospital Insurance). The rest of Medicare spending is covered by the Supplementary Medical Insurance Trust Fund.

Source: 2015 annual report of the Boards of Trustees of the Medicare trust funds.



**TABLE  
1-1**

**Increase in payroll tax or decrease in HI spending needed to maintain HI Trust Fund solvency for specific time periods**

To maintain HI Trust Fund solvency for:	Increase 2.9 percent payroll tax by:	Or decrease HI spending by:
25 years (2015–2039)	16%	11%
50 years (2015–2064)	22	15
75 years (2015–2089)	23	15

Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A.

Source: 2015 annual report of the Boards of Trustees of the Medicare trust funds.

Since payroll tax revenues are not growing as fast as Part A spending, the HI Trust Fund is projected to become insolvent by 2030 (Boards of Trustees 2015). To keep the HI Trust Fund solvent over the next 50 years—the time at which millennials will all have aged into the program—the Trustees estimate that either the payroll tax would need to be increased immediately by 22 percent, rising from its current rate of 2.9 percent to 3.54 percent, or Part A spending would need to be reduced immediately by 15 percent (Boards of Trustees 2015). (For periods of 25, 50, and 75 years, see Table 1-1.)

The rest of Medicare spending (56 percent) is covered by SMI, which covers services under Part B (physician services and other ambulatory care received in hospital outpatient departments) and Part D (prescription drug coverage). Part B and Part D are financed by premiums paid by beneficiaries (covering 25 percent of spending) and general tax revenues (covering 75 percent of spending). Premiums and general tax revenue transfers from the nation’s Treasury are reset each year to match expected Part B and Part D spending. Since premiums and general tax revenue transfers are set to grow at the same rate as Part B and Part D spending, the SMI Trust Fund is expected to remain solvent by construction. However, as SMI spending rises, premiums and transfers from the nation’s Treasury to the Medicare program also grow, increasing deficits, the debt, and the strain on the household budgets both of workers and retirees and—assuming no other policy or legislative interventions—reducing the resources available to make investments that expand future economic output (e.g., investments in education, transportation, and research and development).

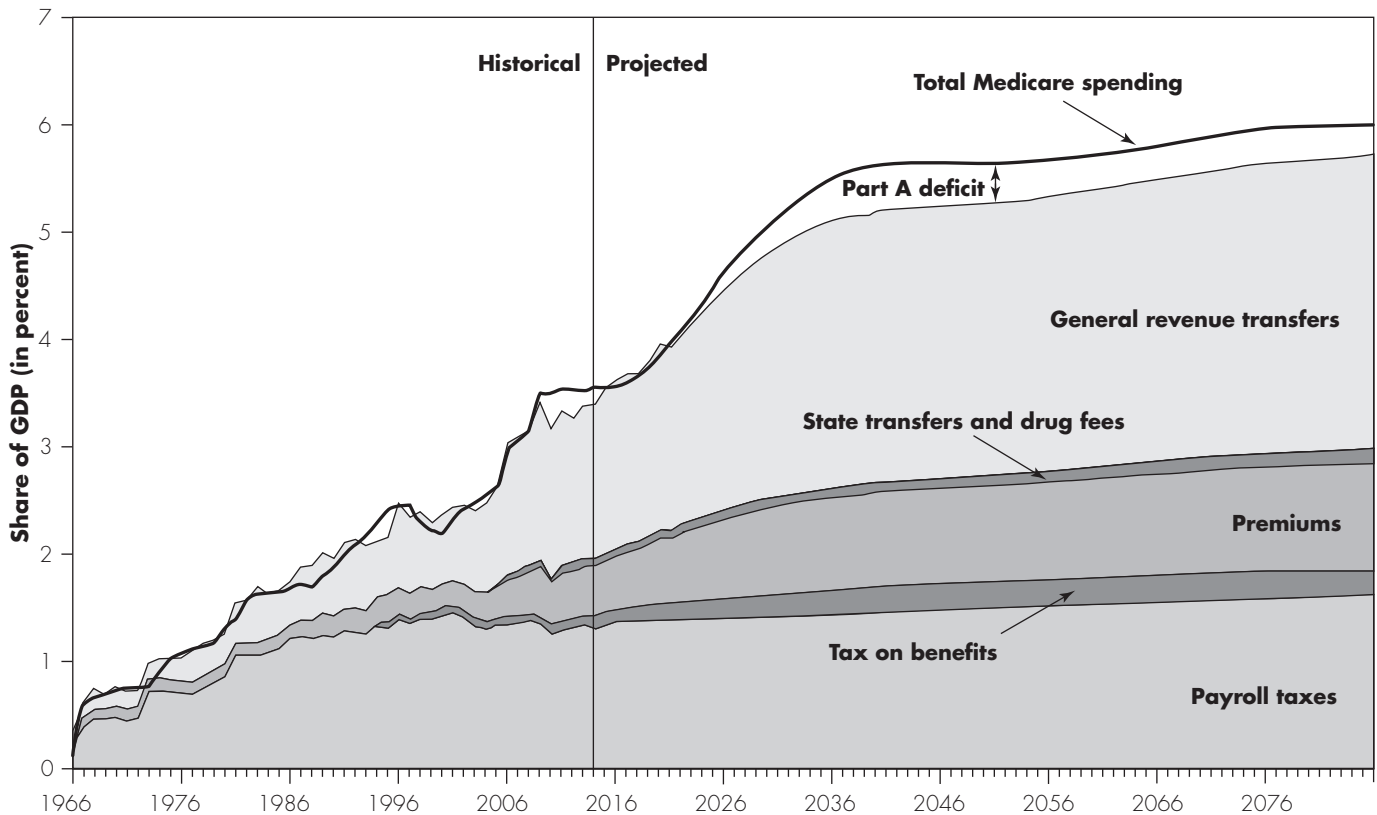
For a more complete financial picture, consider the combined spending and sources of income from the two

trust funds: The black line at the top of Figure 1-12 (p. 18) depicts Medicare spending as a share of GDP, and the layers below the line represent sources of Medicare income. Medicare’s three primary sources of income are payroll taxes, premiums paid by beneficiaries, and general revenue transfers. The white space below the Medicare spending line in Figure 1-12 (p. 18) represents the Part A deficit created when payroll taxes fall short of Part A spending.

Undeniably, the Part A deficit is a financing challenge, but so too is the large and growing share of Medicare spending funded through general revenues. General revenues account for 42 percent of Medicare funding today and are projected to grow to 48 percent by 2030; notably, in this context, general revenues include both general tax revenue and federal borrowing since with few exceptions federal spending has exceeded federal revenues since the Great Depression.

To understand why the growing reliance on general revenues presents a financing challenge, consider the situation from the perspective of the federal budget: The line at the top of Figure 1-13 (p. 19) represents total federal spending as a share of GDP, and the line below spending represents total federal revenues. Year after year, the federal government has spent more than it collects in revenues, increasing the federal debt to levels not seen since World War II.

The layers below the top line in Figure 1-13 (p. 19) depict federal spending by program. Medicare spending is projected to rise from 3.5 percent of our economy today to a little over 6 percent of our economy in 25 years, in 2040. In fact, in 25 years—assuming no other policy or legislative interventions—spending on Medicare, Medicaid, the other major health programs, Social

**FIGURE  
1-12****General revenue is paying for growing share of Medicare spending**

Note: GDP (gross domestic product). "Tax on benefits" refers to the portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments from the states to Medicare, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed in 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: 2015 annual report of the Boards of Trustees of the Medicare trust funds.

Security, and net interest payments will reach about 20 percent of our economy, and by themselves will exceed total federal revenues.<sup>6</sup>

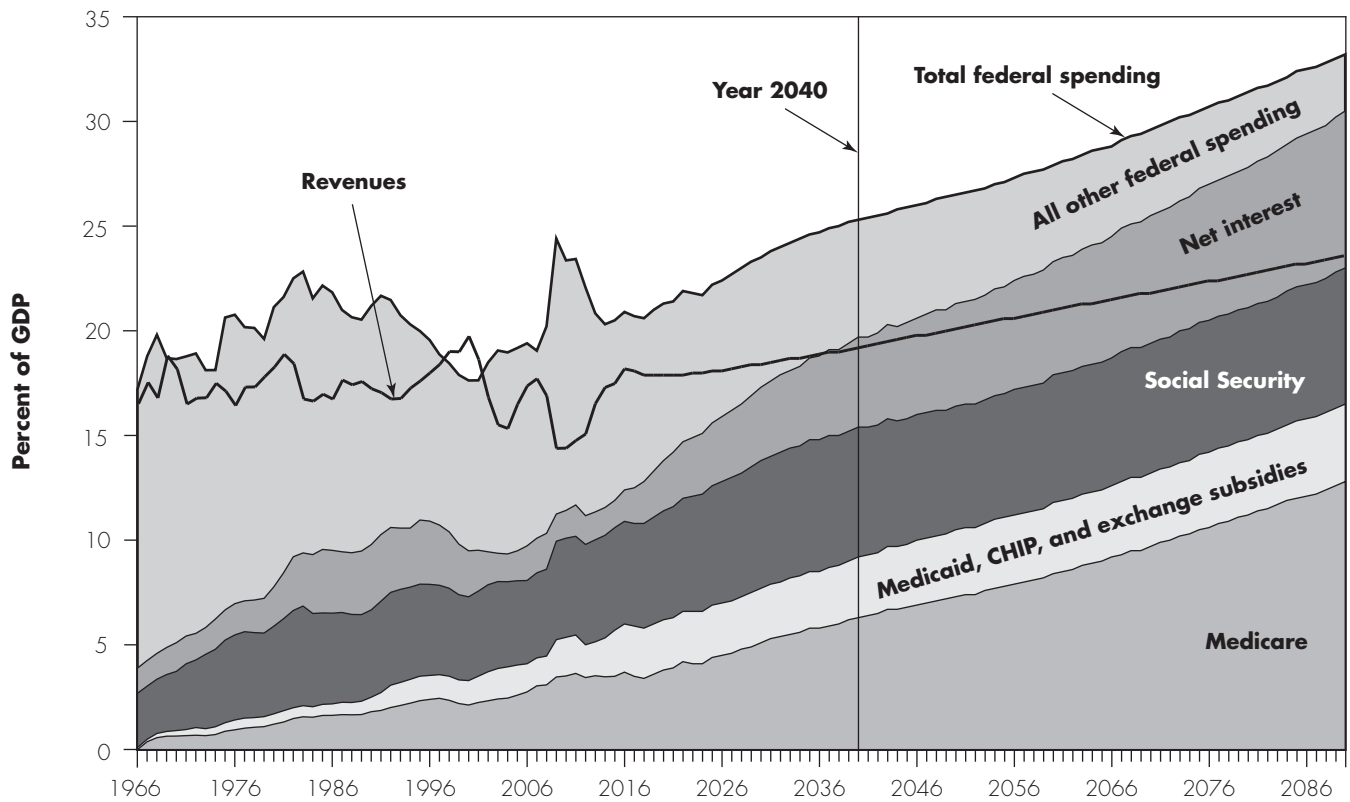
Moreover, the projection assumes that federal revenues will rise above 20 percent of GDP, well above the historical average of 17 percent of GDP. The increase in revenues is projected to occur mainly because income is projected to grow more rapidly than inflation, pushing more income into higher inflation-indexed tax brackets over time. However, if federal revenues continue at their historical average of 17 percent of GDP, spending on these major programs and net interest payments would exceed total federal revenues even sooner.

With their reliance on general tax dollars and federal deficit spending, Medicare and the other major health care programs have a substantial effect on the federal debt. Debt equaled 35 percent of GDP at the end of 2007 as the economy entered the last recession (Figure 1-14, p. 20). As a result of the recession, the debt soared, reaching 72 percent of GDP in 2013—a higher share than at any point in U.S. history, except briefly around World War II.

Under baseline assumptions, which reflect current law, CBO projects the debt will reach 107 percent of GDP in about 25 years (or by 2040). However, the CBO baseline assumes that per beneficiary spending for Medicare and Medicaid increases more slowly in the future than it has during the past several decades. If per beneficiary

**FIGURE  
1-13**

**Spending on Medicare, other major health programs, Social Security, and net interest is projected to exceed total federal revenues in 25 years (by 2040)**



Note: GDP (gross domestic product), CHIP (Children's Health Insurance Program).

Source: Congressional Budget Office 2015a.

spending growth were three-quarters of a percentage point higher than that of the baseline, the federal debt would be 129 percent of GDP by 2040. On the other hand, if per beneficiary spending growth were three-quarters of a percentage point lower, the federal debt would be 89 percent of GDP by 2040. Still, under all three scenarios, the debt is projected to be at levels not seen since the aftermath of World War II.

### Health care spending also consumes growing shares of state budgets and the budgets of individuals and families

Part of the Commission's mandate is to view Medicare in the context of the broader health care system. This

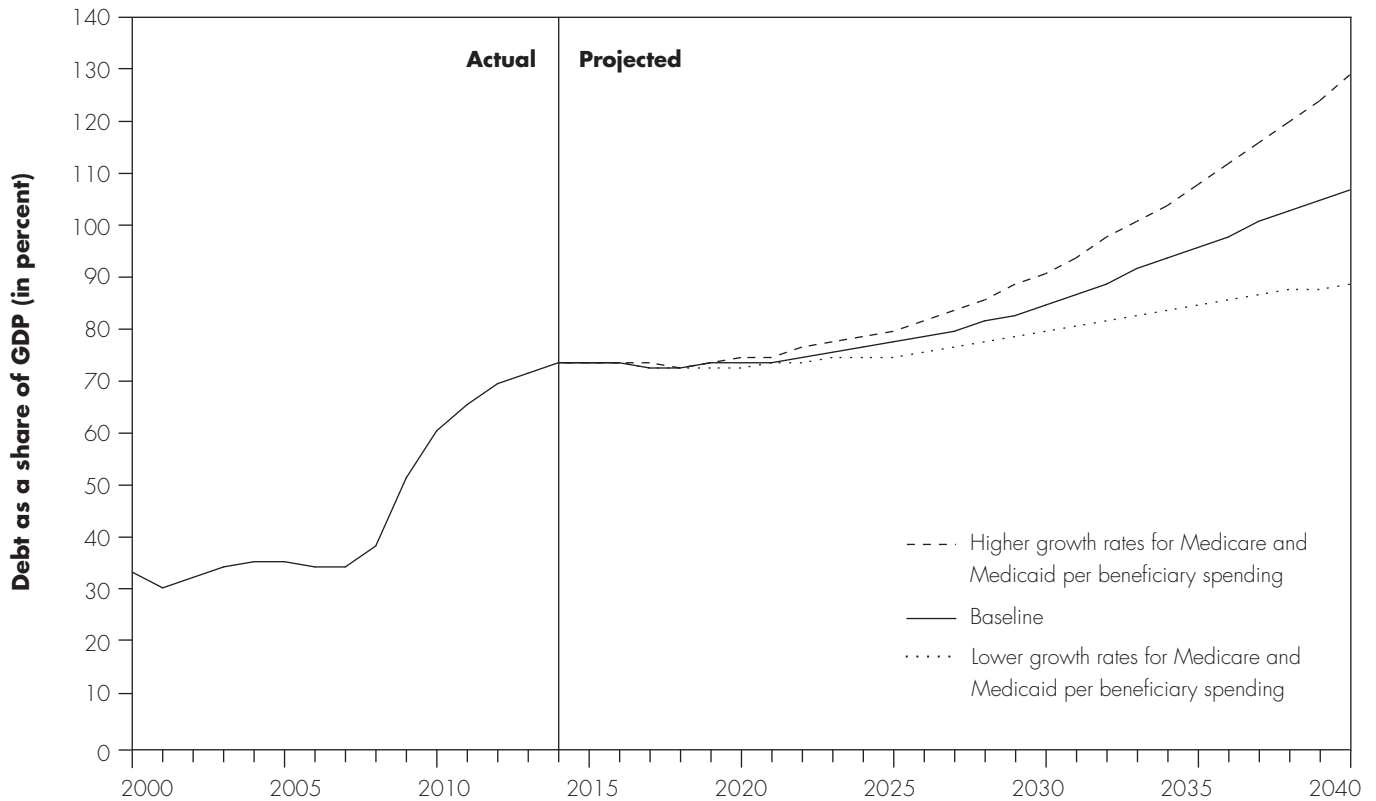
section examines the effect of health care spending on state budgets and on the budgets of individuals and families. States bear a significant share of Medicaid costs, so rising health care spending also has implications for state budgets. For individuals and families, increases in premiums and cost sharing have negated real income growth in the past decade. Likewise, premiums and cost sharing for Medicare beneficiaries are projected to grow faster than Social Security benefits, which make up a significant share of many beneficiaries' income.

### Health care spending and state budgets

States and the federal government jointly finance Medicaid, a program that pays for health care services provided to people with low incomes. In 2013, before the coverage expansions made by PPACA, monthly enrollment in Medicaid averaged about 59 million people,

**FIGURE  
1-14**

**Health care spending growth impacts future debt levels**



Note: GDP (gross domestic product). The higher growth rate of per beneficiary spending on Medicare and Medicaid is 0.75 percentage point per year higher than under the baseline assumptions; the lower growth rate is 0.75 percentage point per year lower than under the baseline assumptions.

Source: Congressional Budget Office 2015a.

and total spending was \$457.8 billion, with the states paying 42 percent and the federal government paying the remainder. Medicaid spending accounted for an estimated 18.9 percent of state expenditures in that year (Centers for Medicare & Medicaid Services 2014a).

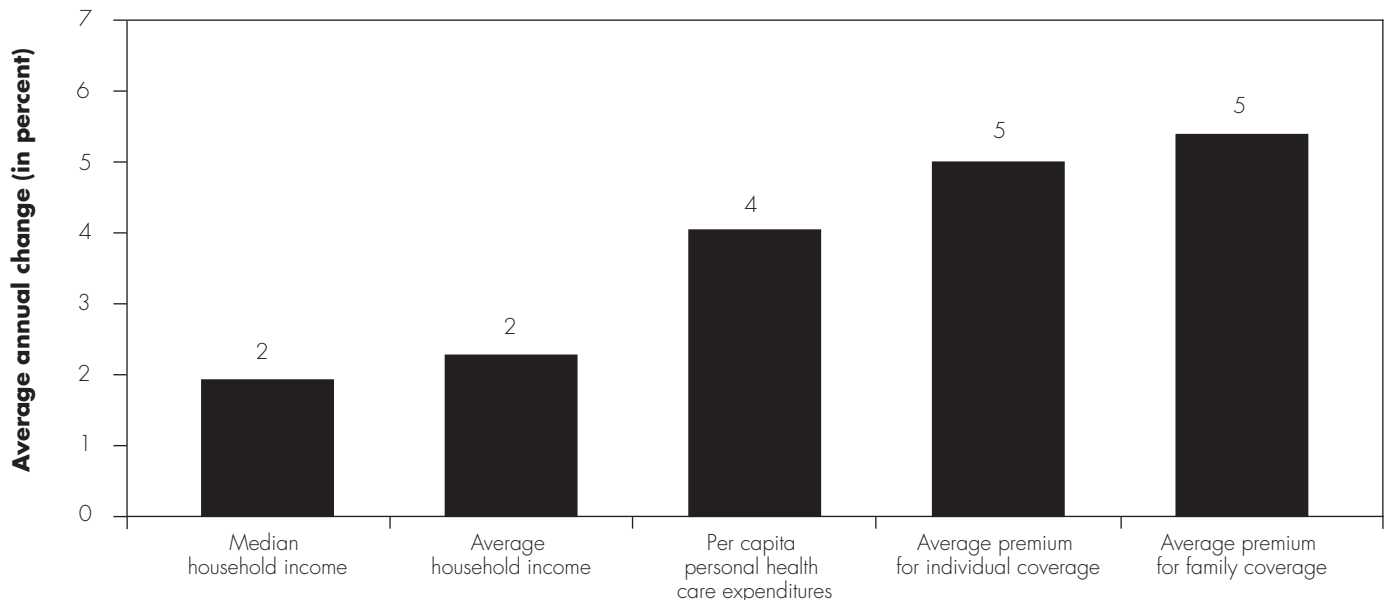
Under PPACA, states are given the option to expand Medicaid coverage—beginning in 2014—to nonelderly individuals with total family income of less than 138 percent of the federal poverty threshold. States receive full federal financing to cover this expansion population in 2014, phasing down to 90 percent federal financing by 2020. In 2014, government actuaries projected that monthly enrollment in Medicaid would increase 9.6 percent, reaching 64.6 million people, and total spending would increase 9.4 percent, reaching \$498.9 billion. Because the federal government paid for 100 percent of

the costs of newly eligible enrollees, the states’ share of all Medicaid expenditures decreased to 40 percent in 2014 (Centers for Medicare & Medicaid Services 2014a). CBO projects that the states’ share will be slightly lower than 40 percent over the next 10 years as more states expand coverage (the states’ share is projected to range between 36 percent and 38 percent from 2015 to 2025) (Congressional Budget Office 2015a).

PPACA also increased the payment amount primary care providers received for seeing Medicaid patients in 2013 and 2014 so that it equaled Medicare’s payment. This policy represented a significant increase in payments to providers since Medicaid primary care FFS payment rates averaged 59 percent of Medicare fee levels in 2012. The federal government incurs 100 percent of the cost of the payment increase. Total spending for the primary care

**FIGURE  
1-15**

**Growth in health care spending and premiums  
outpaced growth in household income, 2004–2014**



Note: Household income, health expenditures, and premiums are all measured in nominal dollars. Average premiums for individual and family coverage are for employer-sponsored health insurance and include contributions from workers and employers. Labels for these columns were rounded.

Source: MedPAC analysis of Census Bureau, Current Population Survey, Annual Social and Economic Supplements 2015, National Health Expenditure Accounts from CMS 2015, Kaiser Family Foundation and Health Research & Educational Trust 2015.

add-on to Medicaid payments is expected to reach about \$12 billion. (The actual amount is not yet known because states have up to two years to submit claims for federal reimbursement.) Even though the federal subsidies expired at the end of 2014, 16 states and the District of Columbia are continuing to pay enhanced rates (Tollen 2015).

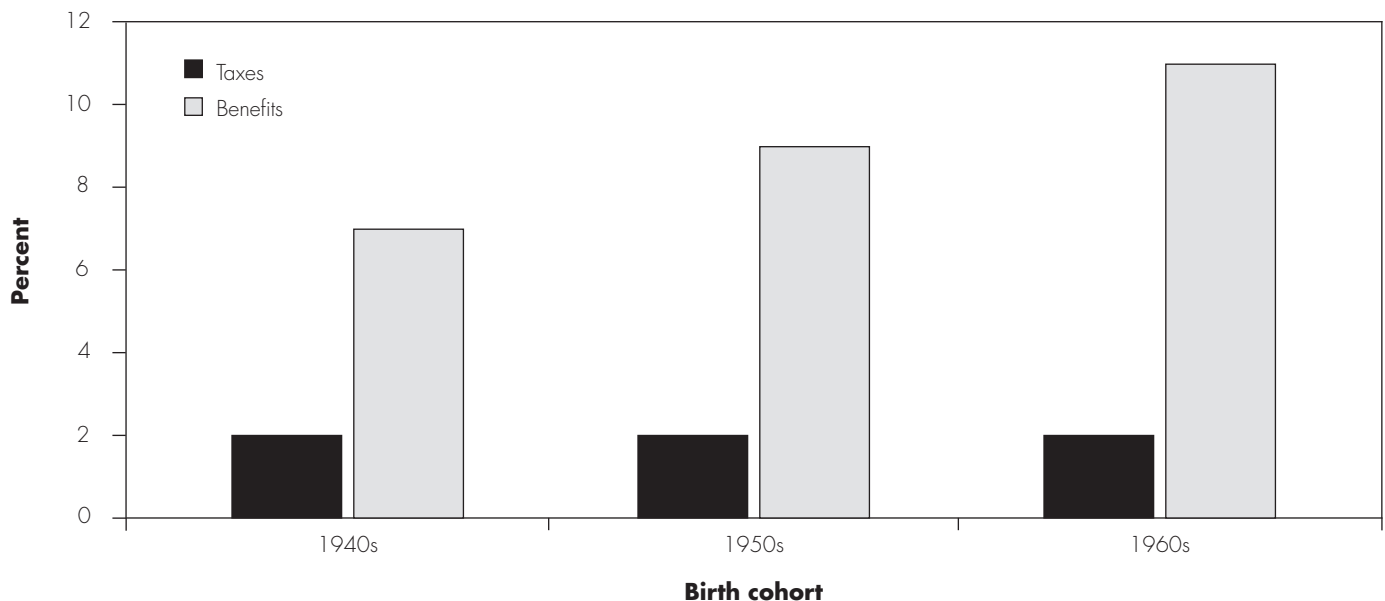
A provision also established under PPACA authority allows state demonstrations for beneficiaries dually eligible for Medicare and Medicaid. In 2011, the Medicare–Medicaid Coordination Office at CMS announced a financial alignment demonstration through which states can develop integrated care programs for full-benefit dual-eligible beneficiaries. States have the option to implement a capitated model, a managed fee-for-service model, or both. Under the capitated model, a health plan receives Medicare and Medicaid capitation payments to cover all Medicare and Medicaid services. Ten states have approved capitated models, two states have approved managed fee-for-service models, and one has an alternative model (Centers for Medicare & Medicaid Services 2014b). As of January 1, 2015, about 350,000

beneficiaries are being served under this demonstration in eight states.

**Health care spending and individual and family budgets**

For individuals and families, growth in health care spending means higher health insurance premiums and higher taxes devoted to health care (Auerbach and Kellermann 2011). Additionally, for those covered by employer-sponsored health insurance, an increase in premiums results in lower wage growth because employers offset their increased costs of providing health insurance to their employees (Baicker and Chandra 2006, Gruber 2000). As health care spending increases, an increasing share of income from individuals and families is transferred to hospitals, physicians, and other providers of health care services.

In the last decade, per capita health care spending and premiums have grown much more rapidly than median and average household incomes (Figure 1-15). From 2004 to 2014, per capita personal health care spending grew

**FIGURE  
1-16****Mean lifetime Medicare payroll taxes and benefits relative to lifetime earnings, by decade of birth**

Source: Congressional Budget Office 2015a.

at an average annual rate of 4 percent, and premiums for individuals and families grew at an average annual rate of 5 percent (Centers for Medicare & Medicaid Services 2015b, Kaiser Family Foundation and Health Research & Educational Trust 2015). In contrast, during this period, median and average household incomes grew at an average annual rate of just 2 percent (Census Bureau 2015).

Medicare beneficiaries are not exempt from the financial challenges of the program's ever-growing cost-sharing liabilities. In 2014, SMI (Medicare Part B and Part D) premiums and cost sharing consumed 23 percent of the average Social Security benefit, up from 7 percent in 1980 (Boards of Trustees 2015). (Those percentages do not include beneficiary spending on premiums for Medicare supplemental insurance.) The Medicare Trustees estimate that those costs will consume 30 percent of the average Social Security benefit by 2030. On average, Social Security benefits account for about 70 percent of income for seniors. For more than one-fifth of seniors, Social Security benefits account for 100 percent of income (Social Security Administration 2012). However, seniors also rely on accumulated assets to supplement their income in retirement. Additionally, despite the increasing cost-sharing burden, the availability of SMI Part B and Part D benefits

greatly reduces the costs that beneficiaries would otherwise pay for health care services without those benefits since general revenues cover a large share of those costs.

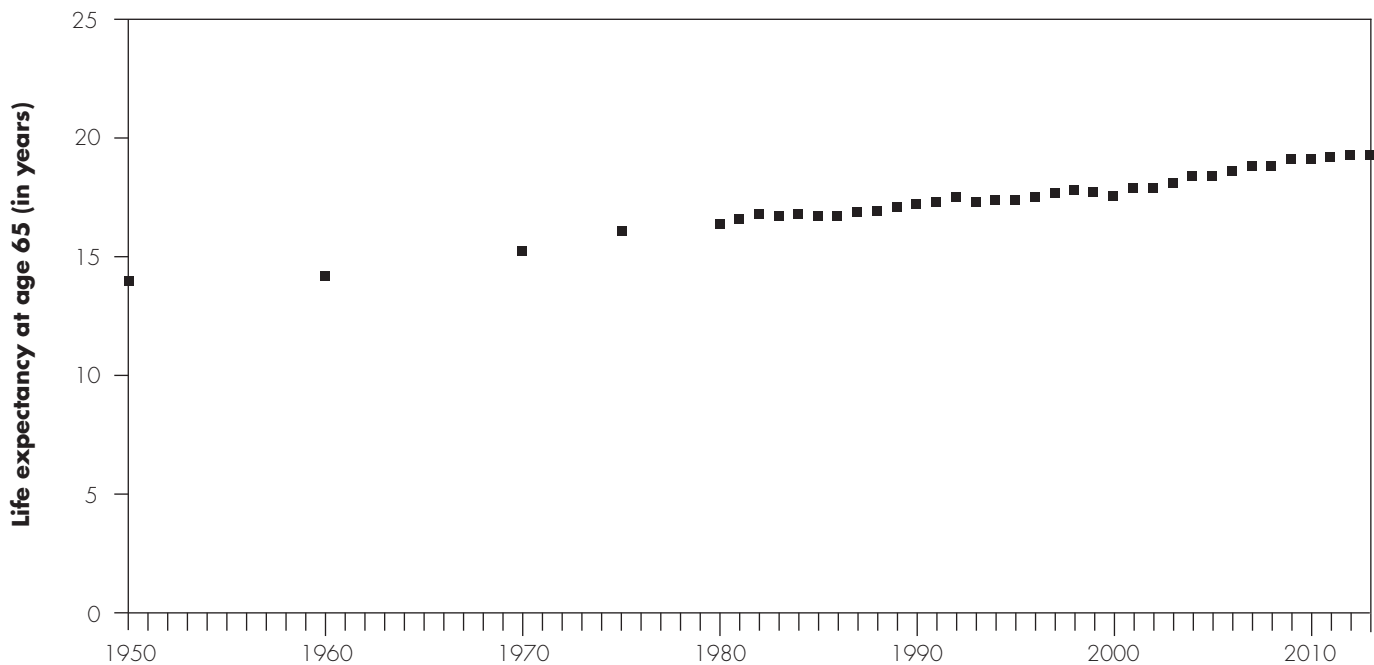
A final factor to keep in mind is that over the course of their lifetimes, members of different generations will pay different amounts of Medicare payroll taxes and receive different amounts of Medicare benefits. Generally, benefits will be greater for later generations because of growth in per capita health care spending and longer life expectancy (Congressional Budget Office 2015a). CBO estimates that benefits received over a lifetime will equal about 7 percent of lifetime earnings for people born in the 1940s, on average, but 11 percent for people born in the 1960s (Congressional Budget Office 2015a). By contrast, real average lifetime payroll taxes relative to lifetime earnings will be about 2 percent for most cohorts (Figure 1-16).

**Assessing the impact of Medicare spending on quality**

Medicare beneficiaries are financially better off because of the Medicare program because it reduces their out-of-pocket spending on health care services. But as

**FIGURE  
1-17**

**Life expectancy at age 65 has steadily increased over time, available years 1950–2013**



Source: National Center for Health Statistics 2015a.

Medicare per beneficiary spending has increased over the life of the program, has the quality of health care received by Medicare beneficiaries improved? One way to examine this issue is to look at the health and longevity of beneficiaries. From that perspective, there are several indications that great improvements have been made:

- Life expectancy at age 65 has steadily increased since the introduction of Medicare (Figure 1-17). Individuals who reached age 65 in 2013 had a remaining life expectancy of 19 years, 5 more years than the life expectancy for individuals who reached age 65 in 1960.
- The share of people age 65 or older reporting fair or poor health status has declined from 29 percent in 1991 to 23 percent in 2013 (Figure 1-18, p. 24).
- While the percentage of people age 65 or older with chronic conditions such as diabetes, hypertension, and high cholesterol has increased over time, the percentage of people who have those conditions under control has also increased (National Center for Health Statistics 2015a).

(Comparable information for the Medicare population under age 65 is not readily available.)

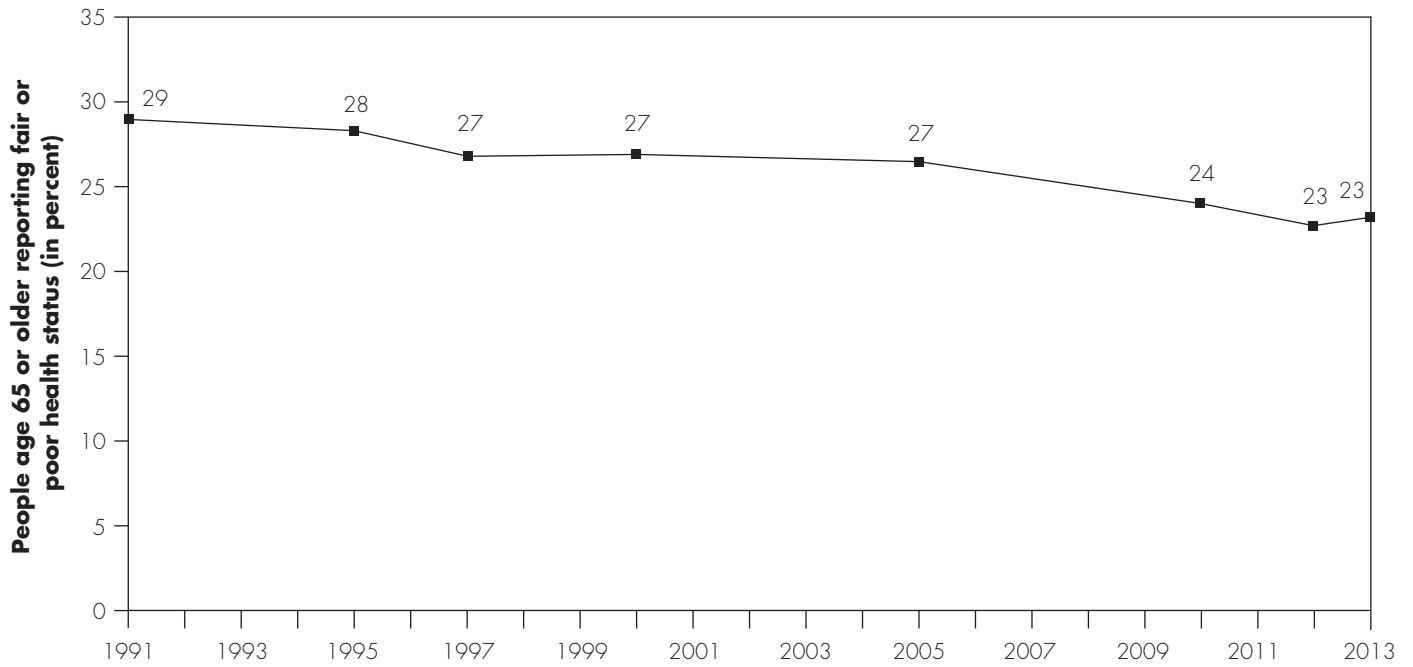
However, many factors other than health care also impact individual and population health, including poverty, income levels, and individual behavioral choices such as smoking and alcohol consumption. For example, with the support of the Social Security program, the poverty rate among people ages 65 years and older has fallen dramatically over time, potentially having a substantial effect on individual and population health for that age group (Figure 1-19, p. 24).

### **Baby boomers will make up the next generation of Medicare beneficiaries**

As the baby-boom generation ages, enrollment in the Medicare program will surge. In 15 years, Medicare is projected to have over 80 million beneficiaries, almost 90 percent of whom will be of the baby-boom generation. The baby-boom generation will define the next generation

**FIGURE  
1-18**

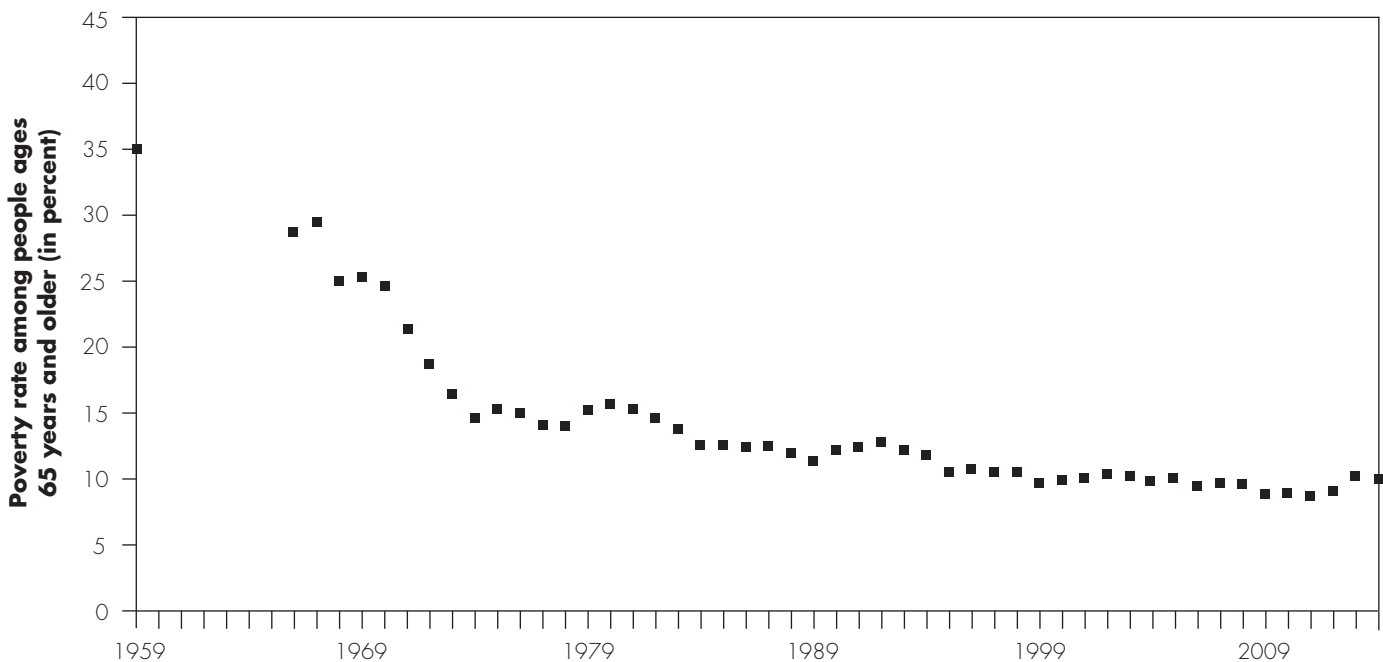
The percentage of people ages 65 or older reporting fair or poor health status has declined over time, available years 1991-2013



Source: National Center for Health Statistics 2015a.

**FIGURE  
1-19**

The poverty rate among people ages 65 years and older has fallen dramatically over time, available years 1959-2014

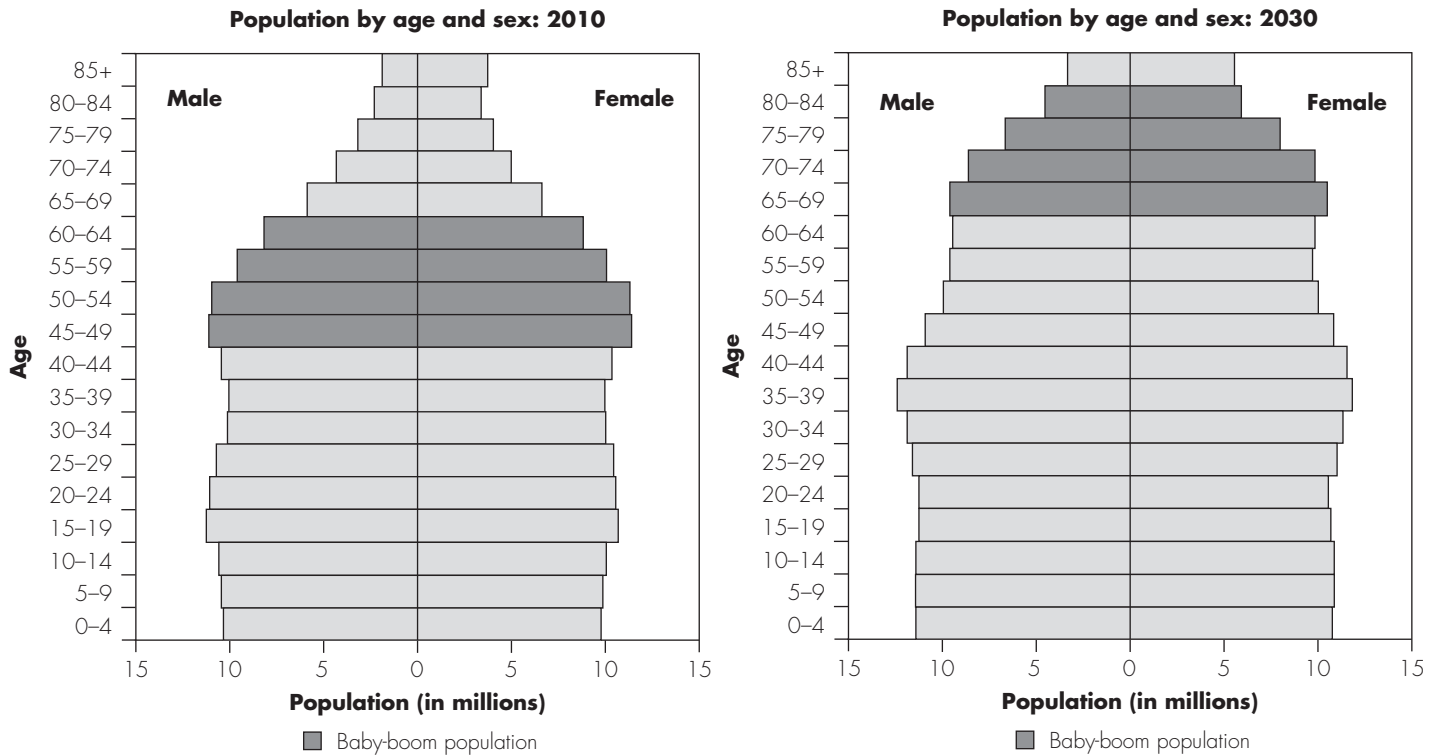


Source: Bureau of the Census, Current Population Survey, Annual Social and Economic Supplements.



**FIGURE  
1-20**

**By 2030, the entire baby-boom generation will be eligible for Medicare**



Source: Census Bureau, 2010 Census and 2012 National Population Projections, Middle series.

of Medicare beneficiaries in terms of its age distribution, race and ethnic diversity, population health, health insurance experiences before Medicare enrollment, and financial security.

**The Medicare population will expand, become younger, and then grow older as the baby-boom generation ages**

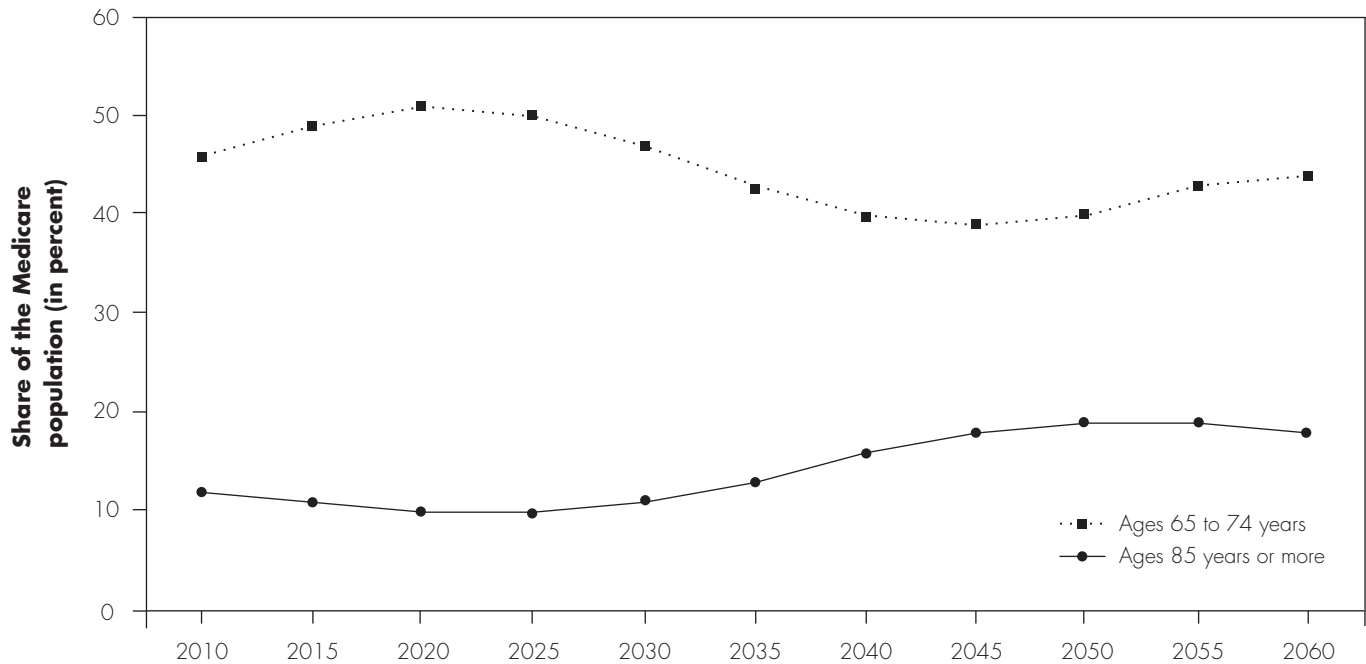
Enrollment in the Medicare program is projected to grow rapidly over the next two decades as members of the baby-boom generation age into the program (Figure 1-10a, p. 16). These individuals began aging into Medicare in 2011 at an average rate of 10,000 people per day. By 2030, Medicare is projected to have over 80 million beneficiaries—up from 54 million beneficiaries today—almost entirely made up of baby boomers (Figure 1-20) (Census Bureau 2012).

The Medicare population over the next 15 years will be relatively younger as members of the baby-boom generation join its ranks and increase the number of

beneficiaries in younger age categories (Figure 1-21, p. 26). The share of the Medicare population ages 85 years or older is projected to decline slightly through 2025 and then grow as baby boomers continue to age (Boards of Trustees 2014, Census Bureau 2012). In 2012, per beneficiary spending for those ages 85 and older was about twice that of those ages 65 to 74. So the changing age structure of the Medicare population will exert somewhat less pressure on spending in the very near term, at least on a per capita basis, and then pressure will increase again over the longer term.<sup>7</sup>

**Racial and ethnic diversity of the older population will lag behind that of the total population**

The older population is, and will be for some time, less diverse racially and ethnically than the total population. Non-Hispanic Whites are projected to remain a majority of the older population through 2060, whereas Non-Hispanic Whites are projected to no longer be a majority of the total population by 2043 (Figure 1-22, p. 27). The older

**FIGURE  
1-21****The Medicare population will become younger and then older**

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds and Census Bureau, 2012 National Population Projections.

population's racial and ethnic diversity will lag behind that of the total population for several reasons. First, at any given time, the racial and ethnic composition of the Medicare population largely reflects the U.S. population 66 to 100 years ago—when currently aged Medicare beneficiaries were born. When the baby-boom generation was born—between 1946 and 1964—almost 90 percent of the total U.S. population was Non-Hispanic White (Ortman et al. 2014). Second, since 1964, the nation's population has become increasingly diverse through increases in immigration and minority births. However, recent immigration does not have much of an effect on the age structure of the older population because most immigrants are under the age of 40 when they arrive in the United States (Ortman et al. 2014).

**The health of the future Medicare population**

How will the health of the Medicare population change over the next couple of decades as the baby-boom generation ages into the program? A lot of uncertainty surrounds that question. What is known is that members of the baby-boom generation have longer life expectancies and a much lower rate of smoking than earlier generations.

However, the baby-boom generation has higher rates of some diseases and chronic conditions, although those higher rates could be driven in part by expanded testing and disease definitions. Moreover, baby boomers are much more likely than prior generations to have some of those chronic conditions under control.

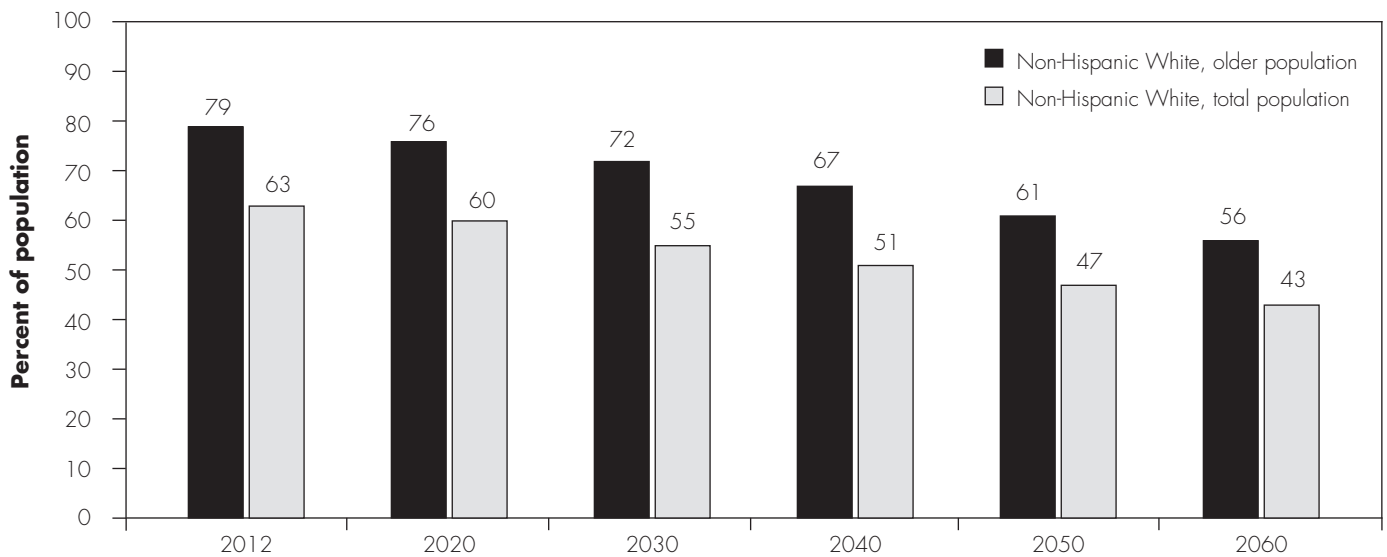
**Positive indicators: Longer life expectancies and lower rates of smoking**

The baby-boom generation enjoys much longer life expectancies than earlier generations. Between 1900 and 1960, life expectancy at birth improved by more than 20 years, from 47 years to 70 years. The baby-boom generation compared with earlier generations also enjoys longer life expectancies at older ages (Census Bureau 2014). Individuals born in 1905 who reached age 65 in 1970 had a remaining life expectancy of about 15 years. Individuals born in 1945 who reached age 65 in 2010 had a remaining life expectancy of about 19 years, a 4-year increase over the 1905 birth cohort.

The baby-boom generation's rate of smoking is much lower than it was in previous generations (Cutler and Glaeser 2006). When members of the previous generation

**FIGURE  
1-22**

**The older population (ages 65 and older) is less racially and ethnically diverse than the total population**



Source: Census Bureau, 2012 National Population Projections.

were adults in the 1950s and mid-1960s, Americans had one of the highest smoking rates in the developed world; in 1965, over 40 percent of those ages 18 years and older smoked (Census Bureau 2014). But since the mid-1960s and throughout the period in which baby boomers entered adulthood, that rate has been on a dramatic decline. By 2012, only 18 percent of those ages 18 years and older smoked.

**Negative indicators: Higher rates of obesity and diabetes**

Although smoking rates have declined, the share of adults who are obese has risen dramatically over the last 40 years. In the 1970s, about 15 percent of the adult population ages 20 to 74 years were obese. By 2010, the share more than doubled—reaching 36 percent. The proportion of baby boomers who were obese in 2010 was even higher, at about 40 percent.

Related to higher rates of obesity, baby boomers have higher rates of diabetes than the previous generation (15.0 percent versus 13.9 percent, respectively). However, baby boomers diagnosed with diabetes are much more likely to have the disease under control than members of the previous generation.<sup>8</sup> For the U.S. adult population

overall, researchers found a doubling of the share with diabetes from 1990 to 2008 and a plateauing between 2008 and 2012 (Geiss et al. 2014). Despite the leveling off in recent years, the share of African Americans, Hispanics, and those with a high school education or less who have diabetes appears to continue to increase.

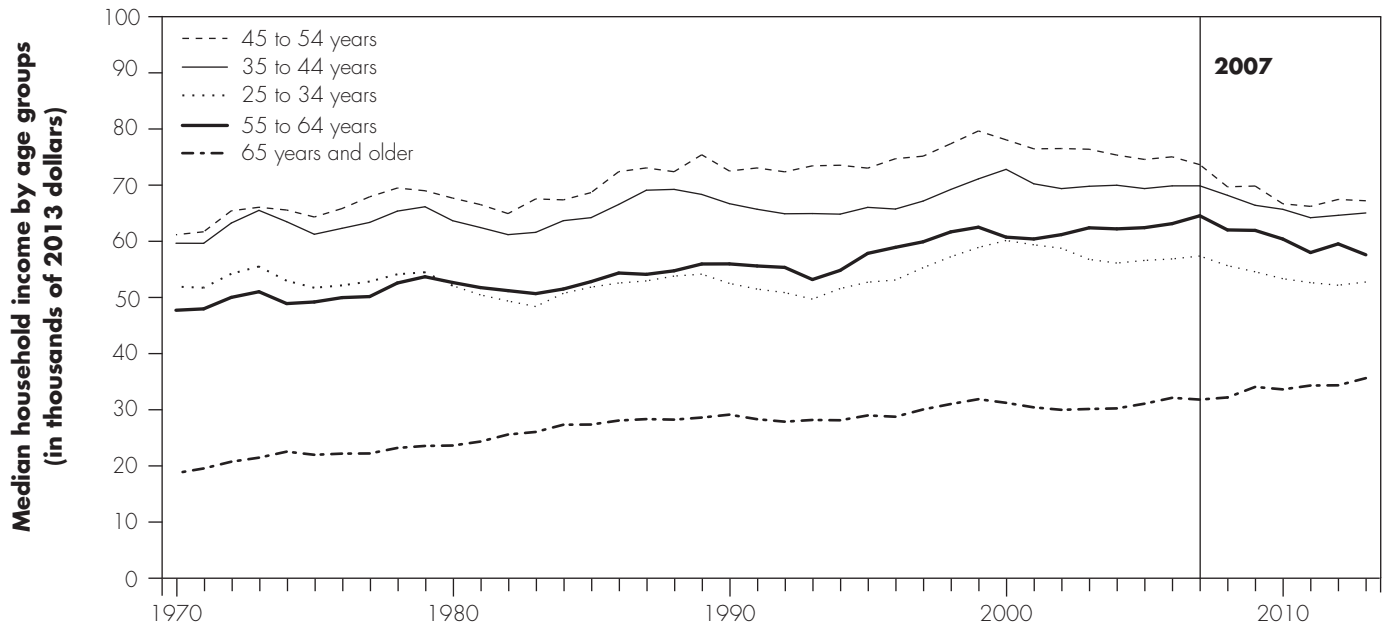
Mortality from diabetes has declined, leading to more years spent with diabetes but fewer years lost to the disease for the average individual with diabetes (Gregg et al. 2014a, Gregg et al. 2014b). For the population as a whole, however, the number of years lost to diabetes has increased due to the increase in the numbers of people who have the disease.

**Mixed indicators: Higher rates of some diseases and chronic conditions, but evidence of better management**

When compared with the previous generation, the baby-boom generation has higher rates of hypertension and high cholesterol, but baby boomers with those conditions are much more likely to have them under control.<sup>9</sup> Perhaps because of better management of those conditions, baby boomers have shares of heart disease and stroke similar to the previous generation. Some research also indicates that

**FIGURE  
1-23**

**Real median household income declined substantially for all age groups under age 65 since the Great Recession began in 2007**



Source: Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

cancer rates have increased in the baby-boom population (National Center for Health Statistics 2014).

However, higher rates of disease and chronic conditions could also be the result of increased use of diagnostic testing and more aggressive or expansive treatment practices (Welch et al. 2011). For example, an extremely slow-growing cancer may now be detectable in a person with no symptoms, but it would never progress to make the person sick; in such cases, treatment might be unwise.

Also, not all diseases and chronic conditions have the same impact on per beneficiary spending. For example, high blood pressure and high cholesterol were the two most prevalent chronic conditions among Medicare beneficiaries in 2012, but were not the most costly. Stroke, heart failure, and chronic kidney disease were among the chronic conditions associated with the highest per beneficiary spending (Centers for Medicare & Medicaid Services 2015a, Centers for Medicare & Medicaid Services 2015c).

Another factor affecting per beneficiary Medicare spending is whether beneficiaries were continuously

insured before age 65. Research has found that Medicare spending is significantly higher for previously uninsured adults than for previously insured adults (McWilliams et al. 2009). Therefore, the increased availability of health insurance under PPACA could reduce future Medicare spending for younger baby boomers. Coverage under PPACA through Medicaid expansions (in participating states) and federal and state exchanges began in 2014, when the youngest baby boomers were 50 years old. So some baby boomers who otherwise would have been uninsured before aging into the Medicare program now may have up to 15 years of continuous coverage before becoming eligible for Medicare.

A final factor to consider regarding the effect of the baby-boom generation on future Medicare spending is that Medicare spending on beneficiaries in their last year of life is substantial (per beneficiary spending was more than six times higher for decedents than for survivors annually throughout the last decade). So as the baby-boom generation ages, the increased number of beneficiaries entering their last year of life will likely exert upward pressure on Medicare spending (Hogan 2015).

## **Health insurance experience of baby boomers before Medicare enrollment and its effect on enrollment decisions for Medicare**

The health insurance experience of baby boomers before Medicare enrollment may also affect enrollment decisions for Medicare Advantage and medigap and preferences about trade-offs between cost sharing and limitations placed on choice of providers. The baby-boom generation's experience with private health insurance coverage has been evolving.

Baby boomers likely began their working years in conventional health plans—that is, plans in which health care can be delivered by any provider, with the insurer paying a share of the provider's charges. But over time, many also experienced the disappearance of conventional plans and the rise and subsequent decline of managed care in the form of HMOs—plans in which health care must be delivered by providers in a network.

Throughout the lives of this generation, the share of the insured population enrolled in preferred provider organizations (PPOs) has grown steadily. PPOs generally have lower cost sharing for services delivered by in-network providers versus out-of-network providers. PPO plans likely had broad provider networks supported by rapidly rising premiums, deductibles, and copayments. After the backlash against managed care in the mid-1990s, employees and employers favored the broadest possible access to providers and demanded very large networks. Only since the Great Recession that began in 2007 did employees and employers become increasingly willing to accept plans with narrower networks in return for lower premiums, deductibles, and copayments.

All but the youngest baby boomers are not likely to have had much experience with either high-deductible plans—plans with lower premiums than traditional plans but that require the enrollee to pay a large deductible before receiving insurance benefits—or the health insurance exchanges that commenced in 2014 under PPACA, owing to their recency.

### **The baby boomers may be less financially secure than previous generations in retirement**

Over the past decade, real median household income remained relatively flat or declined for all age groups under age 65 and declined substantially since the Great Recession began in 2007 (Figure 1-23).<sup>10</sup> Since many baby boomers were either near retirement or in their peak earning years during the economic slowdown, they may

be less financially secure than previous generations in retirement.

Baby boomers nearing retirement and turning 64 in 2013 saw real median household income for their age group fall 7 percent over the decade (Figure 1-24, p. 30). In contrast, members of the previous generation (called the “silent generation”) during the same 10-year age span, turning 55 in 1986 and 64 in 1995, saw real median household income for the same age group increase by 6 percent.<sup>11</sup> In fact, a 64-year-old baby boomer in 2013 would have slightly less income than a 64-year-old member of the silent generation in 1995 (at median real household incomes for 55- to 64-year-olds).

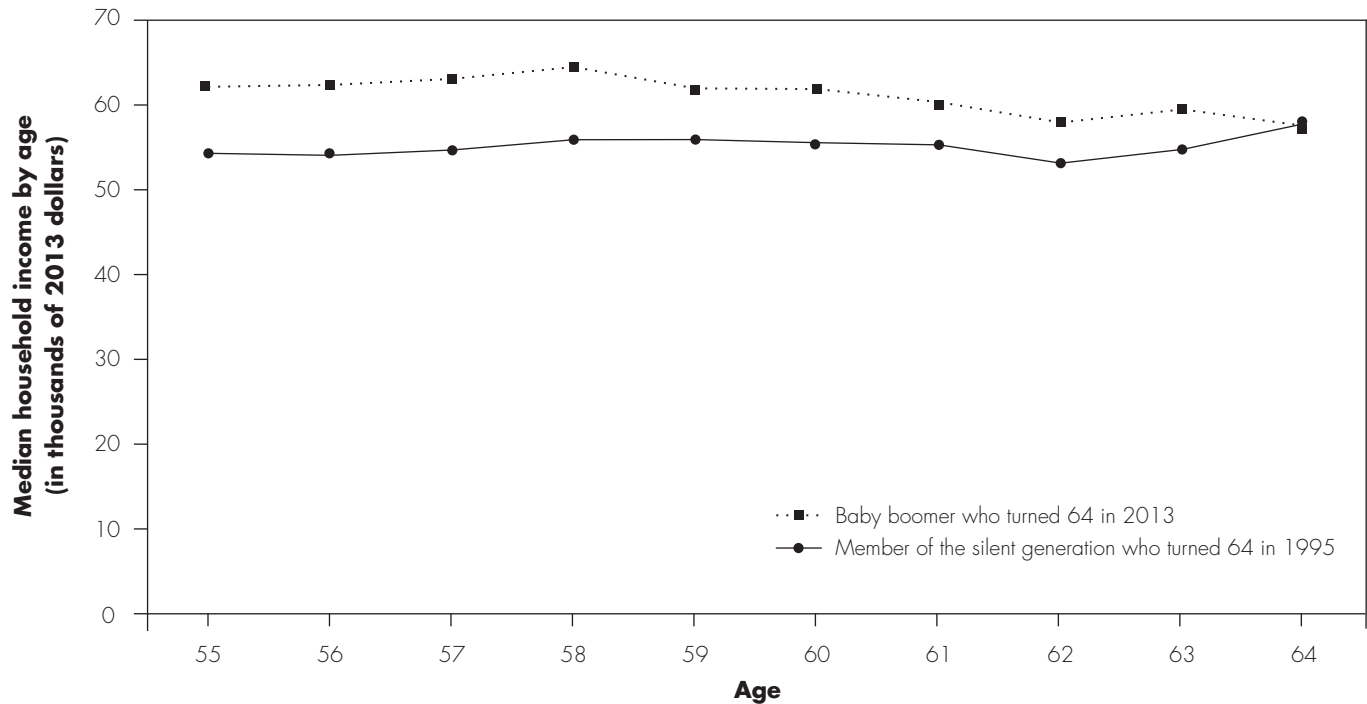
Income tends to peak when people are between ages 45 and 54 (Figure 1-23). However, baby boomers in those typical peak-earning years, turning 45 in 2004 and 54 in 2013, saw real median household income for their age group plummet, falling by 11 percent over the decade (Figure 1-25, p. 31). In contrast, members of the silent generation during the same 10-year age span, turning 45 in 1986 and 54 in 1995, saw real median household income for the same age group increase by 1 percent. In fact, the income of a 54-year-old baby boomer in 2013 would be about 8 percent less than the income of a 54-year-old member of the silent generation in 1995 (at real median household incomes of 45- to 54-year-olds).

Since the Great Recession, family net worth (assets minus liabilities) has also declined (Figure 1-26, p. 31). Baby boomers nearing retirement and turning 64 in 2013 saw real median family net worth for their age group fall 42 percent in the last 6 years (Figure 1-27, p. 32). In contrast, a member of the silent generation turning 64 in 1995 saw real median family net worth for the same age group fall 1 percent over the six-year period from 1989 to 1995. In fact, a 64-year-old baby boomer in 2013 would have slightly lower net worth than a 64-year-old member of the silent generation in 1995 (at median real family net worth for 55- to 64-year-olds).

To be sure, the economic slowdown also took its toll on the generation that came after the baby boomers (called “Generation X”).<sup>12</sup> When compared at similar ages, members of Generation X are less financially secure than the baby boomers. The extent to which members of Generation X will recover financially depends in part on the pace of economic growth from now until they retire. Some experts expect the economy to grow more slowly in the future than it did in the 1980s and 1990s because

**FIGURE  
1-24**

**At age 64, median income, in 2013 dollars, was slightly lower for the baby boom generation than for the silent generation**



Note: Data are for the median household income for 55- to 64-year-olds. Members of the baby-boom generation were born between 1946 and 1964. Members of the silent generation were born between 1928 and 1945.

Source: Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

the labor force is anticipated to expand more slowly than it did then. Labor force growth is anticipated to be held down by the ongoing retirement of the baby boomers and by a relatively stable labor force participation rate among working-age women, after sharp increases from the 1960s to the mid-1990s (Congressional Budget Office 2015b).

### **Evidence of inefficient spending suggests Medicare could spend less without compromising care, but improving efficiency is challenging**

With few exceptions throughout modern history, health care spending in the United States has grown robustly, outpacing the growth in the economy. Even if Medicare's recent low growth in per beneficiary spending is sustained (and experience in 2014 suggests it may not be), enrollment growth from the aging of the baby boomers still will contribute to growth in total spending. However,

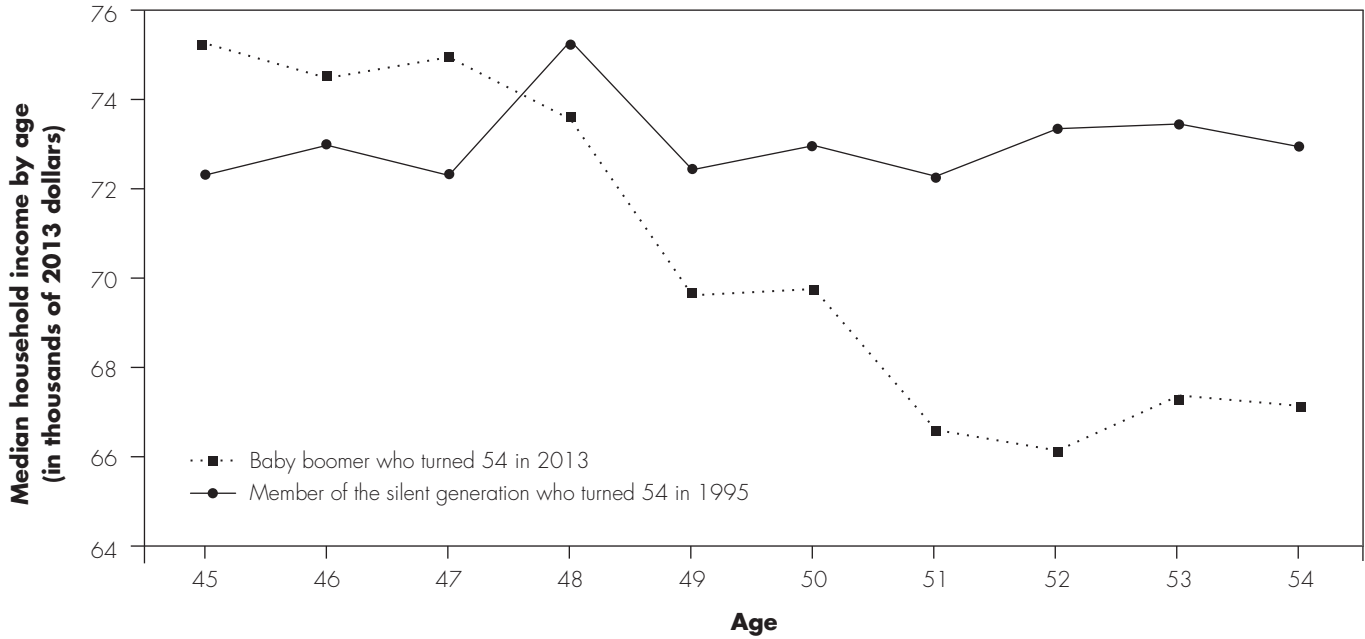
the Commission does not believe that ever-increasing health care spending is inevitable. There is strong evidence that a sizeable share of current health care spending—both nationally and by Medicare—is inefficient or unnecessary, providing an opportunity for policymakers to reduce spending, extend the life of the program, and reduce pressure on the federal budget.

### **Geographic variation within and outside the United States indicates that some share of spending is inefficient**

Research on Medicare spending shows that areas with higher spending or more intensive use of services do not have higher quality of care or improved patient outcomes (Fisher et al. 2003a, Fisher et al. 2003b, Institute of Medicine 2013). Even measures of service use, adjusted for health status and standardized prices, show considerable variation (Medicare Payment Advisory Commission 2011b). Services that have been widely recognized as low value continue to be performed regularly (Schwartz et al. 2014).

**FIGURE 1-25**

**A 54-year-old baby boomer in 2013 would have substantially lower income than a 54-year-old member of the silent generation in 1995**

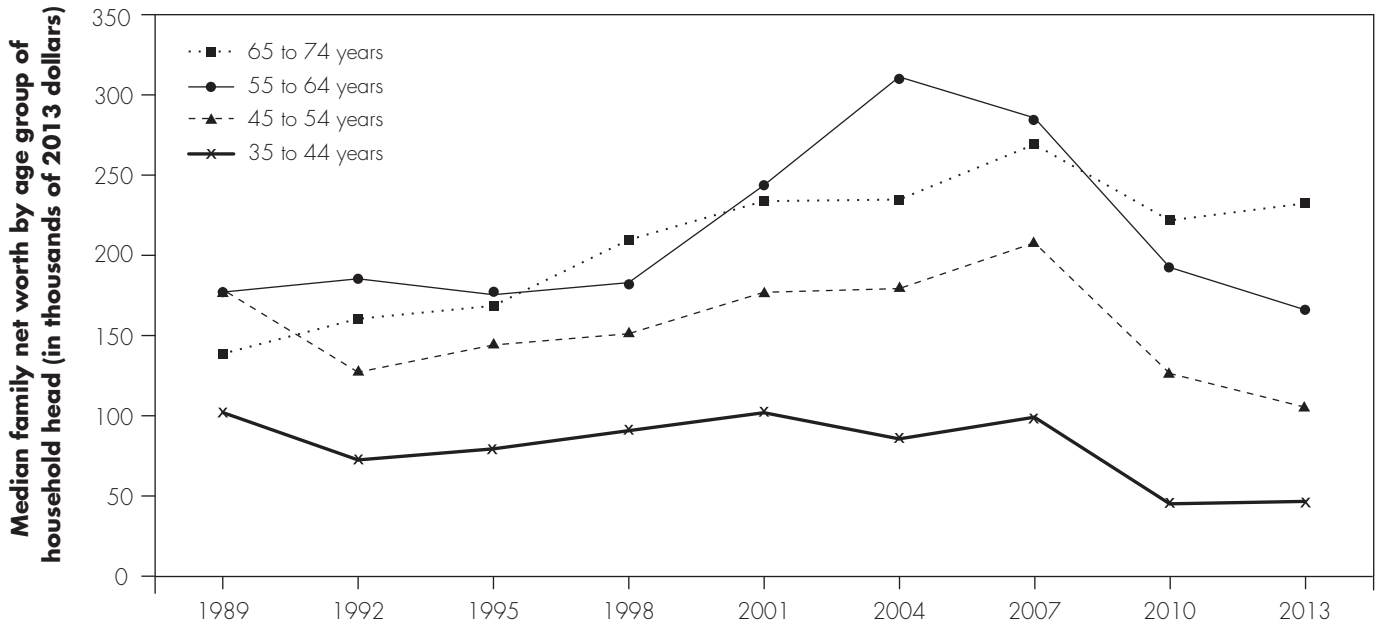


Note: Data are for the median household income for 45- to 54-year-olds. Members of the baby-boom generation were born between 1946 and 1964. Members of the silent generation were born between 1928 and 1945.

Source: Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

**FIGURE 1-26**

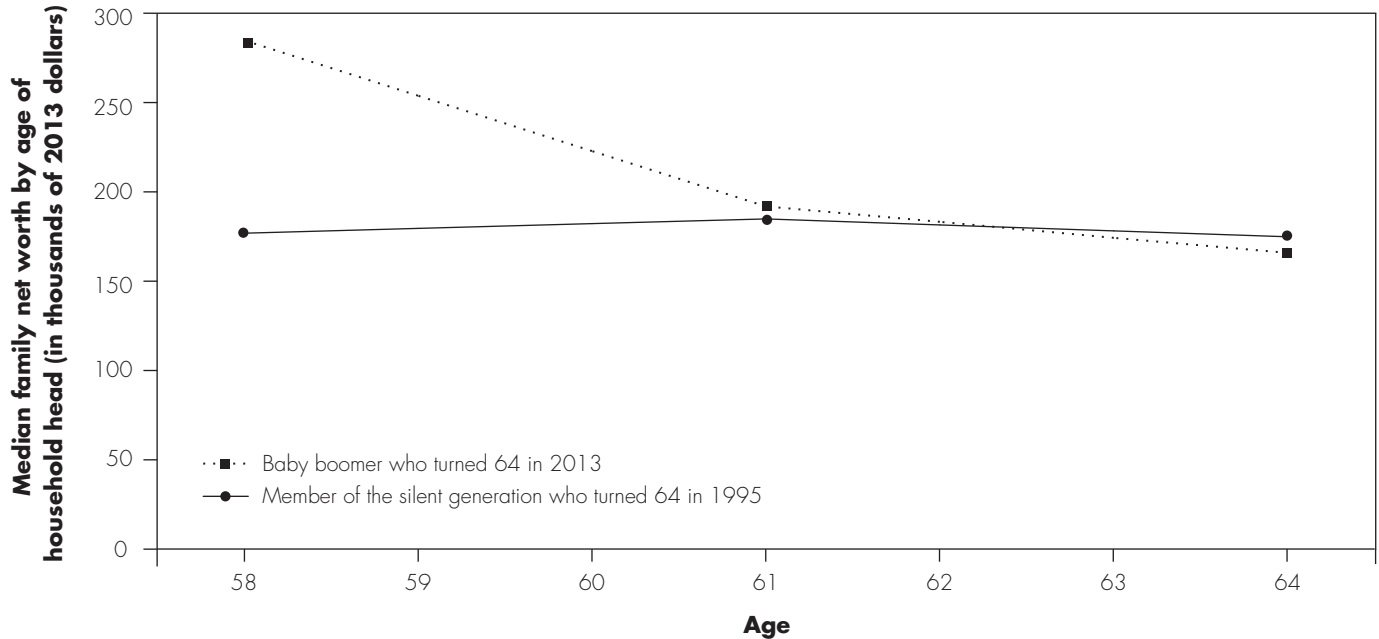
**Real family net worth declined substantially for all age groups under age 65 since the Great Recession began in 2007**



Source: Federal Reserve 2014.

**FIGURE  
1-27**

**A 64-year-old baby boomer in 2013 would have lower net worth than a 64-year-old member of the silent generation in 1995**



Note: Data are for the median real family net worth for 55- to 64-year-olds. Members of the baby-boom generation were born between 1946 and 1964. Members of the silent generation were born between 1928 and 1945.

Source: Federal Reserve 2014.

The United States spends more on health care than any other country in the world (both on a per capita basis and as a share of GDP), but studies consistently show it ranks poorly on indicators of efficiency, equity, and outcomes. According to a 2014 study by the Commonwealth Fund, the United States ranks last of 11 nations on 2 indicators of healthy lives—mortality amenable to medical care and healthy life expectancy at age 60 (Davis et al. 2014).

### Medicare's challenges to increasing efficiency

The Medicare program is a complex and fragmented system, consisting of multiple paths to entitlement, multiple types of coverage (Part A, Part B, Part C, and Part D), multiple payment systems, and different rules for each setting. The Medicare program must set prices for thousands of discrete services at different levels of aggregation (e.g., inpatient hospital payments are paid based on the stay, while physician payments are based on the service) and in different labor markets across the country. The Medicare program statute and rule making include a substantial number of exceptions, adjustments,

and modifications to its general policies. Several of Medicare's structural features (and some shared across the health care system) complicate efforts to achieve spending efficiencies:

- **Fragmented payment system across multiple settings.** The program sets payment rates each year for at least nine different health care settings or provider types: inpatient and outpatient hospitals, physician and other health professional services, home health agencies, skilled nursing facilities, long-term care facilities, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and outpatient dialysis facilities. In addition to the yearly rule-making process involved in setting these rates, administrators oversee other parts of the program that operate on fee schedules (ambulances, outpatient lab facilities) or on cost-based payment (rural health centers, critical access hospitals). Payment rates for Part C (Medicare Advantage) are set using administrative pricing based on a competitive process, and Part D payments (prescription drugs) are set generally by market rates.



The fragmented payment system across multiple health care settings reduces incentives to provide patient-centered, coordinated care.

- **Coverage of services delivered by any willing provider.** Under Medicare’s statute, the program generally covers all medically necessary services in each benefit category that are delivered by any willing provider (any provider that is willing to meet Medicare’s rules). As a result, Medicare does not have the authority to develop provider networks or to credential providers, tools that private payers often use to reduce the potential for fraud and abuse. In some cases, the Medicare program even has difficulty removing providers or suppliers whose claims history clearly demonstrates aberrant patterns of billing, care, or both.
- **The program’s benefit design.** Beneficiaries face differential cost sharing by service (for example, coinsurance for physician services is 20 percent, while home health has no coinsurance); in addition, the cost-sharing amounts, percentages, and deductibles vary by setting, and some services are altogether not covered (for example, Medicare does not generally cover long-term care). Medicare Part A and Part B lack a cap on out-of-pocket costs, a feature that exists in nearly all private insurance policies. In response, many beneficiaries purchase supplemental coverage that includes an out-of-pocket maximum. Most supplemental policies also substantially reduce or eliminate most of the beneficiary liability for coinsurance and deductibles, thereby blunting the impact of cost sharing. As a result, there is little incentive for beneficiaries to be cost conscious—that is, to select only those services that are necessary and choose providers who employ efficient clinical practices (Medicare Payment Advisory Commission 2012).
- **Different prices for the same or similar services.** Given the different settings in which services are delivered, the Medicare program in some cases has different payment rates for the same or similar services. Under these circumstances, providers have an incentive to shift care to the higher paid setting, which leads to increased program spending and higher beneficiary cost sharing.
- **Undervalued and overvalued services.** In the process of setting rates for thousands of services, certain services are undervalued relative to others, providing

incorrect incentives for their use. For example, the Commission has raised concerns that the Medicare fee schedule overpays for services provided by clinicians in procedural specialties and underpays for services provided by clinicians in primary care specialties (Medicare Payment Advisory Commission 2011a). This imbalance results in significantly higher income for clinicians in procedural specialties relative to those in primary care specialties, contributing to a corresponding imbalance in clinician supply.

- **Prompt payment standards.** The Medicare program also follows prompt payment requirements, paying claims within 30 days of receipt. Otherwise, Medicare is liable for interest. This emphasis on timely payment means that, in many cases, the claim may be paid and only thereafter identified as potentially fraudulent or erroneous.
- **Vulnerability to patient selection, steering, and overuse.** Another consequence of Medicare’s payment structure is its vulnerability to patient selection, steering, and overuse. For example, with some payment systems it is financially advantageous for providers to treat certain kinds of beneficiaries and avoid others, provide certain types of services over others, or treat beneficiaries in a higher paid setting. In addition, in Medicare’s FFS system, providers may be able to increase their revenue by increasing the volume of services they provide without commensurate value to the beneficiary. In addition, clinicians can prescribe pharmaceutical drugs and medical devices while receiving payment from the manufacturers.

These features make the program vulnerable to inappropriate care, waste, and fraud. In recent years, CMS has gained new authorities to exclude potentially fraudulent providers from the program and apply different levels of scrutiny to new providers based on their fraud potential. CMS has also further developed its ability to identify potentially fraudulent billing patterns. However, all of CMS’s activities in this area are constrained by resources and subject to statutory requirements that limit its ability to use the same tools as private insurers to reduce fraud (Government Accountability Office 2013).

### **The Commission’s approach to addressing these challenges**

Medicare’s goal should be to obtain the greatest possible value for the program’s expenditures, which means maintaining beneficiaries’ access to high-quality services

while encouraging their efficient use. However, managing payment rates alone will not address the Medicare FFS system's key challenge—that providers are paid more for doing more services and are not held accountable for outcomes. Resolving this conundrum will require reform of both the payment and delivery systems.

The Commission's work can be categorized in the following domains: (1) payment accuracy and efficiency, (2) care coordination and quality, (3) information for patients and providers, (4) engagement of beneficiaries, and (5) alignment of the health care workforce. Regardless of the issue, the Commission always considers the interests of three main actors: the beneficiary—access to high-quality, efficient care; the provider—fair and equitable pay; and the taxpayer—the most prudent and valuable use of the public's dollar.

- **Payment accuracy and encouraging efficiency.** In Medicare's payment systems, the payment rates for individual products and services may not accurately reflect the cost of furnishing the product or service. Inaccurate payment rates create incentives for higher volume growth for certain services, thereby unduly disadvantaging some providers and unintentionally rewarding others. The Commission pursues payment accuracy in its update recommendations as well as other policy recommendations, with a focus on ensuring that payment is adequate for the efficient provision of care.
- **Care coordination and quality.** Providers may provide quality care to uphold professional standards and satisfy patients, but until recently Medicare did not have the authority to hold them accountable for improving, or to provide incentives to improve, the quality of care they provide. Similarly, few structures exist in Medicare to hold providers accountable for the full spectrum of care a beneficiary may use, even when they make the referrals that dictate additional resource use. The Commission has supported policies that move Medicare beyond FFS into payment systems that make a provider responsible for the patient's entire episode of care to help address these gaps between settings.
- **Broadening information available to patients and providers.** Medicare and its providers lack the information and tools needed to improve quality and use program resources efficiently. For example, Medicare lacks quality data from many settings of

care and does not have timely cost or market data to set accurate payment rates. In addition, beneficiaries are called on to make complex choices among delivery systems, drug plans, and providers. Medicare has started to make available for beneficiaries the information that could help them choose higher quality providers or lower cost treatments and improve their satisfaction. The Commission has supported policies that promote comparative effectiveness, disclosure of physician financial relationships, and public reporting of quality information.

- **Engaging beneficiaries.** While much of the Commission's work focuses on providers and their payment incentives, how beneficiaries view the Medicare program and how they make decisions about their health care are vital to the program's success. Developing policies that engage the beneficiary as well as the provider has the potential to improve health, improve the experience of health care provided through Medicare, and control costs for the beneficiary and taxpayer alike. The Commission has supported reforming the current benefit design and has promoted shared decision making.
- **Aligning the health care workforce.** Our nation's system of medical education and graduate training is not aligned with the delivery system reforms essential for increasing the value of health care in the United States. The Commission has pursued policies that increase the incentives for residency programs to focus on quality, efficiency, and accountability so that the future clinician workforce can better address the needs of beneficiaries.

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## Conclusion

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The level and growth of health care spending as a share of the economy suggest that an ever-increasing amount of the country's economic activity and gain will be dedicated to purchasing health care. Medicare is the single largest payer in the health care sector and will expand with the aging of the baby-boom generation, greatly increasing program spending. Significant cross-sectional variation in use and spending does not correspond with quality outcomes, raising concern that higher health care use and spending are not improving overall health and are putting beneficiaries at risk, both medically and financially.

Because of its size, and because other payers use its payment methods, Medicare is an important influence on the nation's health care delivery system and its evolution. Reciprocally, trends in the private health care insurance market can influence whether Medicare's payment reforms are ultimately successful. Because of this interaction between public and private payers, the alignment of incentives across payers is an important consideration for delivery system reforms.

Despite the relatively lower rates of spending growth recently experienced by Medicare, the program will continue to absorb increasing amounts of federal revenue. Other public investments such as education and infrastructure will be crowded out by high and growing levels of health care spending. State and federal budgets face continued fiscal pressure, effects intensified by health care spending trends. In light of strained federal, family, and individual budgets, the Medicare program must be vigilant in pursuing reforms that decrease spending and improve quality. ■

## Endnotes

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- 1 Figure 1-2 (p. 9) shows that the share of spending accounted for by private health insurance (34 percent in 2014) is greater than Medicare's share (22 percent in 2014). However, in contrast to Medicare, private health insurance is not a single purchaser of health care; rather, it includes many payers, including traditional managed care, self-insured health plans, and indemnity plans.
- 2 The Commission's calculations are based on aggregate Part D reimbursements to plans and employers on an incurred basis as shown in Table IV.B10 of the 2015 annual report of the Boards of Trustees of the Medicare trust funds. Per beneficiary spending excludes premium payments.
- 3 Outpatient hospital services and outpatient lab services are combined in Figure 1-6 (p. 12) and Figure 1-7 (p. 13) because a large portion of outpatient laboratory services were bundled into the outpatient prospective payment system effective January 1, 2014.
- 4 The Trustees' and CBO's projections of per beneficiary spending growth differ slightly (by about 1 percentage point per year on average) in the initial 10-year period because each agency establishes its own detailed growth rate assumptions by individual type of service. So for example, slightly different assumptions about the average mix of services provided to beneficiaries would affect per beneficiary spending growth in the short run. Each agency derives long-run assumptions about per beneficiary spending growth. In the long run, the Trustees assume that the weighted average growth rate for per beneficiary Medicare spending is 4 percent, or GDP plus 0 percent, and CBO assumes 5 percent, or GDP plus 1 percent. So while the Trustees' projection of spending is higher than CBO's initially, by the early 2040s CBO's projection of spending begins to exceed the Trustees'. Both agencies emphasize the uncertainty of their long-range projections stemming from unknown future changes in tax and spending policies and unexpected changes in the economy, demographics, and other factors.
- 5 An estimate of the fiscal impact of the higher rate of enrollment growth is not available. However, CBO scored a budget option to raise the eligibility age for Medicare that provides an illustrative example of the fiscal impact of lower enrollment growth. CBO assumed the eligibility age would be raised by two months every year until it reached age 67. Since the eligibility age would increase gradually in that scenario, CBO estimated minimal short-term effects. For the long term, CBO estimated that spending on Medicare would be about 3 percent less by 2038; however, roughly two-thirds of those long-term savings would be offset by increases in federal spending for Medicaid and subsidies to purchase health insurance through the PPACA insurance exchanges (Congressional Budget Office 2013).
- 6 Other major health programs include Medicaid, the Children's Health Insurance Program, and federal subsidies for the federal and state exchanges legislated under PPACA.
- 7 For example, the Medicare Trustees estimate hospital inpatient admissions per beneficiary to decline through 2021 and begin increasing thereafter because of the aging of the baby-boom population (Boards of Trustees 2014). The Congressional Budget Office also projects comparatively slow growth in per beneficiary spending for the next decade (2015 to 2025), in part because of the influx of younger beneficiaries, who tend to use fewer health care services and therefore lower Medicare's average spending per beneficiary (Congressional Budget Office 2015b).
- 8 When compared with the previous generation at ages 45 to 64, the baby-boom generation had a larger share of individuals with physician-diagnosed and undiagnosed diabetes (15.0 percent versus 13.9 percent, respectively), but a smaller share of individuals with diagnosed diabetes who had poor glycemic control (14.1 percent versus 26.0 percent, respectively) (National Center for Health Statistics 2014).
- 9 When compared with the previous generation at ages 45 to 64, the baby-boom generation had larger shares of individuals with hypertension (42.2 percent of male and 39.5 percent of female baby boomers versus 34.2 percent and 32.8 percent, respectively, of males and females in the previous generation), but smaller shares of individuals with hypertension who had uncontrolled high blood pressure (50.2 percent of male and 36.5 percent of female baby boomers vs. 73.1 percent and 62.1 percent, respectively, of males and females in the previous generation).  
  
Similarly, when compared with the previous generation at ages 45 to 64, the baby-boom generation had larger shares of individuals with high cholesterol or taking cholesterol-lowering medication (39.8 percent of male and 42.4 percent of female baby boomers vs. 30.1 percent and 36.4 percent, respectively, of males and females in the previous generation) but smaller shares of the population with high serum total cholesterol (16.2 percent of male and 22.4 percent of female baby boomers vs. 27.2 percent and 33.4 percent, respectively, of males and females in the previous generation) (National Center for Health Statistics 2014).
- 10 Income for individuals over age 65 grew slightly because as individuals leave the workforce Social Security makes up a larger and larger share of their income (DeNavas-Walt and Proctor 2013, National Bureau of Economic Research 2014).
- 11 Members of the silent generation were born between 1928 and 1945.
- 12 Members of Generation X were born between 1965 and 1980.

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