Context for Medicare payment policy

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Overview

- COVID-19's impact on: Medicare beneficiaries, health care providers, and the Medicare program's finances
- Spending trends for: health care nationally, Medicare, and Medicare's components (FFS, MA, Part D)
- Trends in Medicare's revenue sources
- Medicare beneficiaries' cost sharing
- Trends in beneficiaries' reported health status
- Beneficiaries' most common and costly chronic conditions

Note: FFS (fee-for-service), MA (Medicare Advantage).

COVID-19 has had a disproportionate impact on Medicare beneficiaries

- 75% of COVID-19 deaths were among people ages 65+
- Medicare beneficiaries with disabilities (of any age) have had a 50% higher risk of hospitalization than beneficiaries who qualify for Medicare due to age alone
- Beneficiaries with ESRD have been six times more likely to be hospitalized for COVID-19 than aged beneficiaries

Note: ESRD (end-stage renal disease). Data are preliminary and subject to change.
Source: CDC's "2022 Demographic trends of COVID-19 cases and deaths in the U.S. reported to the CDC"; Yuan et al's "COVID-19 cases and hospitalizations among Medicare beneficiaries with and without disabilities" in *Morbidity and Mortality Weekly Report;* CMS's "Preliminary Medicare COVID-19 data snapshot: Medicare claims and encounter data."

COVID-19 impacted health care utilization rates and health care providers' revenues

- In early months of the pandemic, people ages 65+ avoided care:
  - 30% avoided routine care; 4% avoided urgent / emergency care
- Health care utilization began to rebound within a few months
- Nearly half of Medicare beneficiaries ages 65+ reported having a telehealth visit in the past year (in our 2021 survey)
- Congress appropriated hundreds of billions of dollars to providers to ensure they remained a viable source of care
  - Provider Relief Fund: $122 billion in 2020, $28 billion in 2021
  - Paycheck Protection Program: $53 billion in 2020, $22 billion in 2021

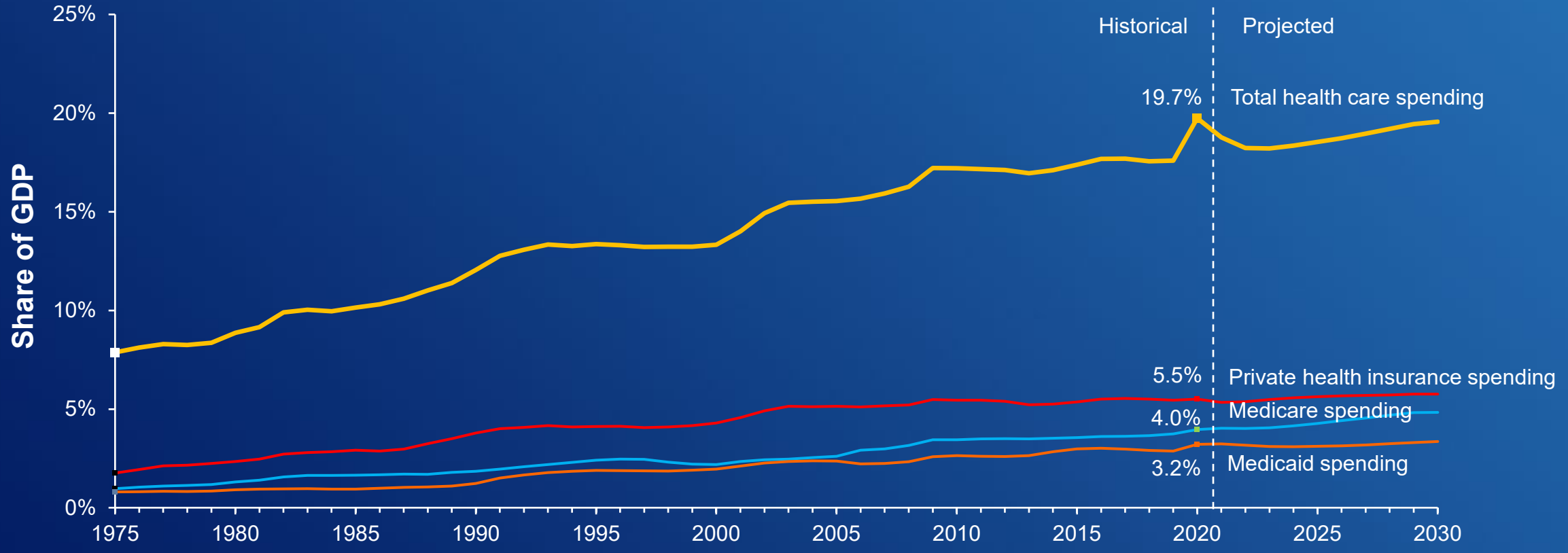
Note: Paycheck Protection Program amounts are the subset of funds estimated to have been paid to health care providers. All data are preliminary and subject to change.
Sources: Czeisler et al's "Delay or avoidance of medical care because of COVID-19-related concerns," in *Morbidity and Mortality Weekly Report*; MedPAC's 2021 access-to-care survey; Poisal et al's "National health expenditure projections, 2021-2030" in *Health Affairs*, 2022.

Medicare program is now in a slightly better position financially than it was a year ago

- Strong economic growth has led to higher-than-expected Medicare payroll tax revenues
  - This has delayed the projected insolvency date of Medicare's trust fund to 2028
- Medicare beneficiaries who died of COVID-19 in 2020 tended to be high-cost beneficiaries with multiple medical conditions
  - The remaining beneficiaries are 2% less costly, on average

Note: Data are preliminary and subject to change.
Source: 2022 Medicare Trustees' report; presentation by CMS actuary Paul Spitalnic, June 6, 2022.

National health care spending consumes a growing share of the country's GDP



Note: GDP (gross domestic product). Beginning in 2014, private health insurance spending includes federal subsidies for both premiums and cost sharing for the health insurance marketplaces created by the Affordable Care Act of 2010. Health care spending also includes the following expenditures (not shown): out-of-pocket spending; spending by other health insurance programs (the Children's Health Insurance Program, the Department of Veterans Affairs, and the Department of Defense); and other third-party payers and programs and public health activity (including Indian Health Service; Substance Abuse and Mental Health Services Administration; maternal and child health; school health; workers' compensation; worksite health care; vocational rehabilitation; other federal, state, and local programs; other private revenues; and general assistance). Data are preliminary and subject to change.
Source: MedPAC analysis of CMS's National Health Expenditure Data.

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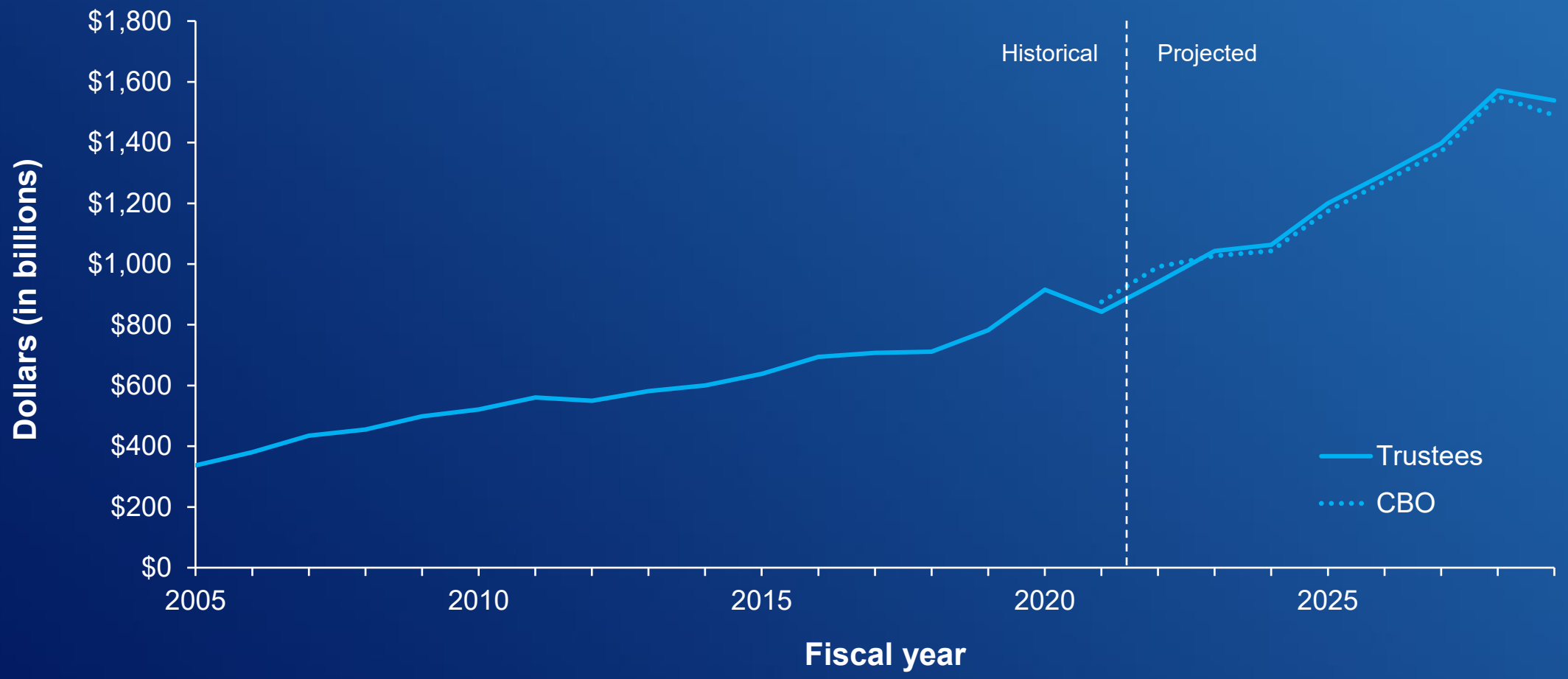
Medicare spending is expected to double in the next ten years



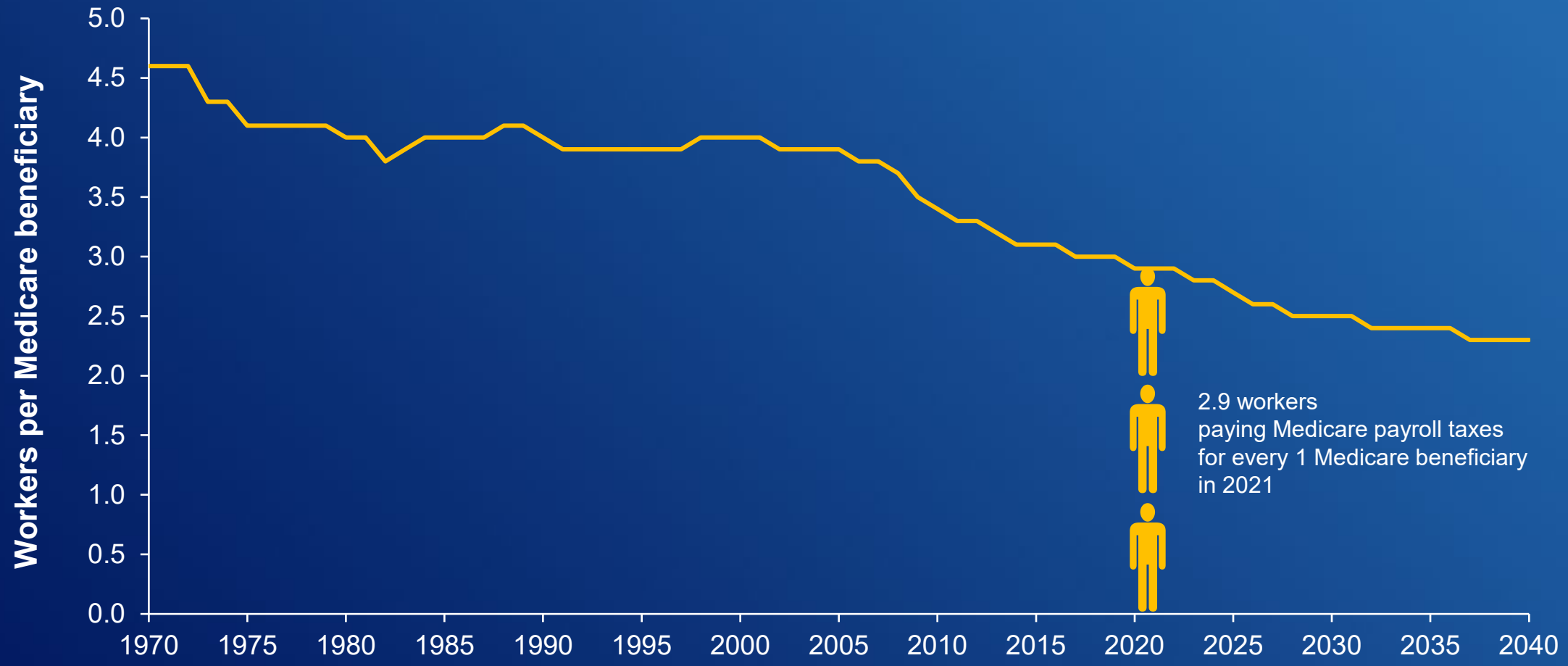
Note: CBO (Congressional Budget Office). The sharp increase in spending in 2020 includes $104 billion in Medicare Accelerated and Advance Payments paid to providers that year; these payments were expected to be repaid to the Medicare program in 2021 and 2022. Data are preliminary and subject to change.
Source: 2022 Medicare Trustees' report; CBO's May 2022 baseline projections for the Medicare program.

Medicare Advantage spending per beneficiary has grown faster than FFS spending per beneficiary

	Annual percent change in spending per beneficiary		
Year	**FFS Medicare**	**MA & other private plans**	**Medicare Part D**
2013	0.2%	-1.4%	0.3%
2014	1.3	-1.1	8.2
2015	1.7	1.8	6.2
2016	1.2	2.9	-0.9
2017	1.7	2.8	-2.4
2018	3.8	4.7	0.5
2019	3.6	7.7	3.0
2020	-2.4	6.1	2.1
2021	10.0	3.6	0.5
Average	**2.3%**	**3.0%**	**1.9%**

Note: FFS (fee-for-service), MA (Medicare Advantage). Other private plans include Medicare–Medicaid plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and cost-based (as opposed to capitated) plans. FFS Medicare spending per beneficiary is calculated by summing (1) Part A FFS spending divided by Part A FFS enrollees and (2) Part B FFS spending divided by Part B FFS enrollees. Spending per beneficiary on MA & other private plans is calculated by summing Part A spending on private health plans and Part B spending on private health plans, then dividing that by the number of enrollees in Part C (in private health plans). Annual percent change in spending per beneficiary is calculated using annual spending on an incurred basis that is not risk standardized and not adjusted for health status or coding differences between MA and FFS. Part D is calculated by taking total Part D spending, subtracting premiums (mostly paid by enrollees), then dividing that by the number of enrollees in Part D. Data are preliminary and subject to change.
Source: MedPAC analysis of data from the 2022 Medicare Trustees' report.

Medicare faces a financing challenge: The number of workers per Medicare beneficiary is declining



Note: "Beneficiaries" referenced in this graph are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). Part A is mainly financed by Medicare payroll taxes. Data are preliminary and subject to change.
Source: 2022 Medicare Trustees' report.

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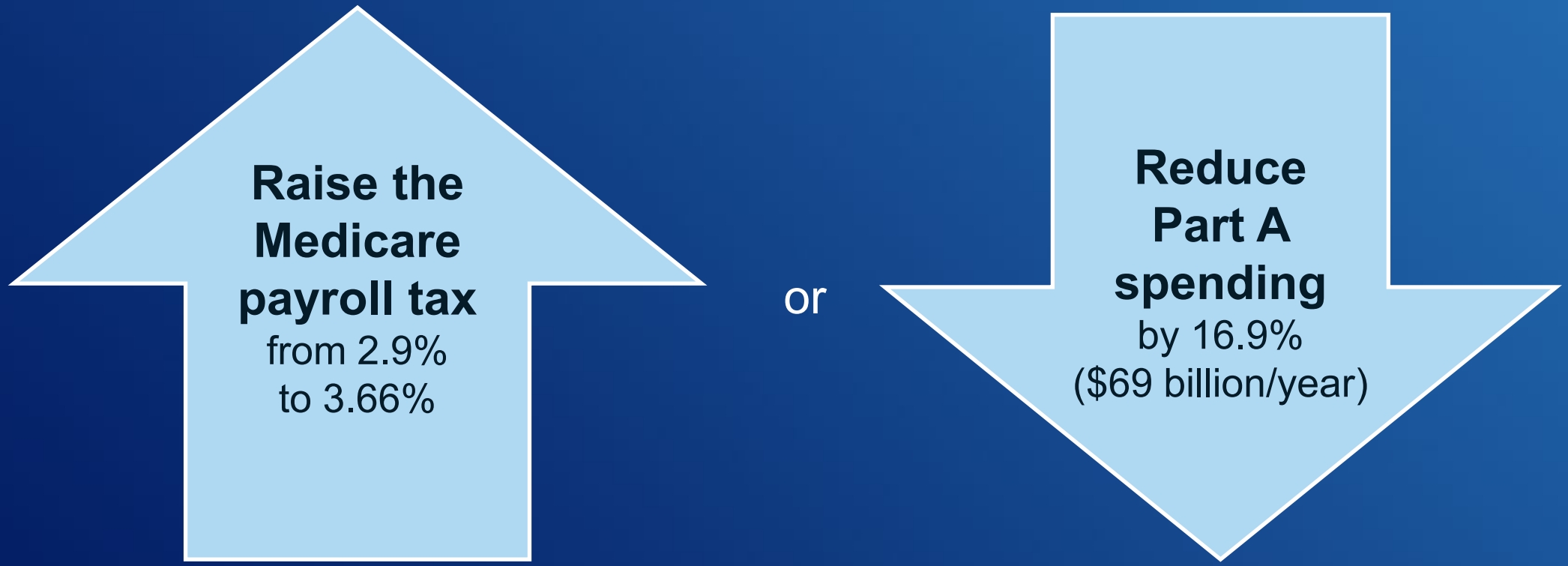
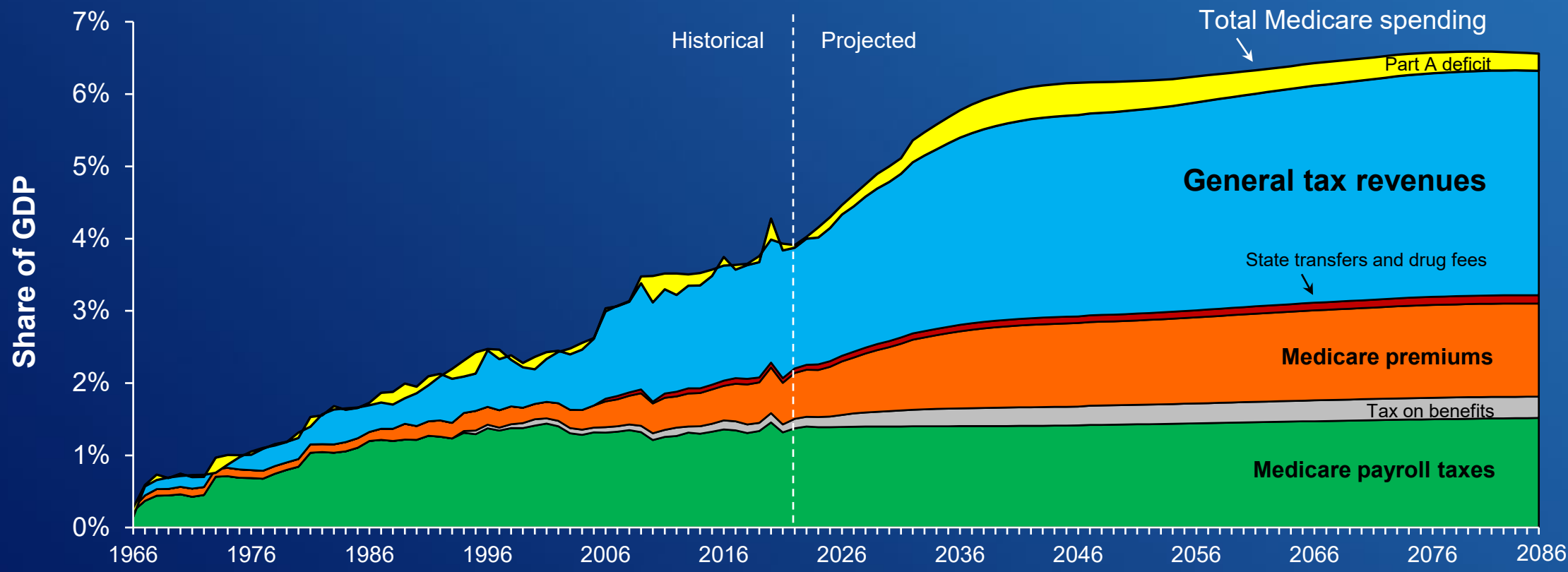
To extend the solvency of Medicare's Hospital Insurance Trust Fund for 25 years…



Note: Workers and their employers split the cost of the payroll tax (workers pay 1.45% and employers pay the remaining 1.45%). Meanwhile, self-employed people pay both the worker's and the employer's share of this tax, totaling 2.9% of their net earnings. High-income workers pay an additional 0.9% of their earnings above $200,000 for single workers or $250,000 for married couples filing joint income tax returns. Part A spending includes spending on inpatient hospital, skilled nursing facility, home health agency, and hospice services and includes spending for beneficiaries in traditional Medicare and Medicare Advantage. Data are preliminary and subject to change.
Source: MedPAC analysis of 2022 Medicare Trustees' report.

General tax revenues have become the largest source of Medicare funding



Note: GDP (gross domestic product). Projections are based on the Trustees' intermediate set of assumptions. "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, 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 by the 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. Graph does not include interest earned on trust fund investments (which makes up 1 percent of the HI Trust Fund's income and is expected to decline in coming years as trust fund assets decline). Data are preliminary and subject to change.
Source: 2022 Medicare Trustees' report.

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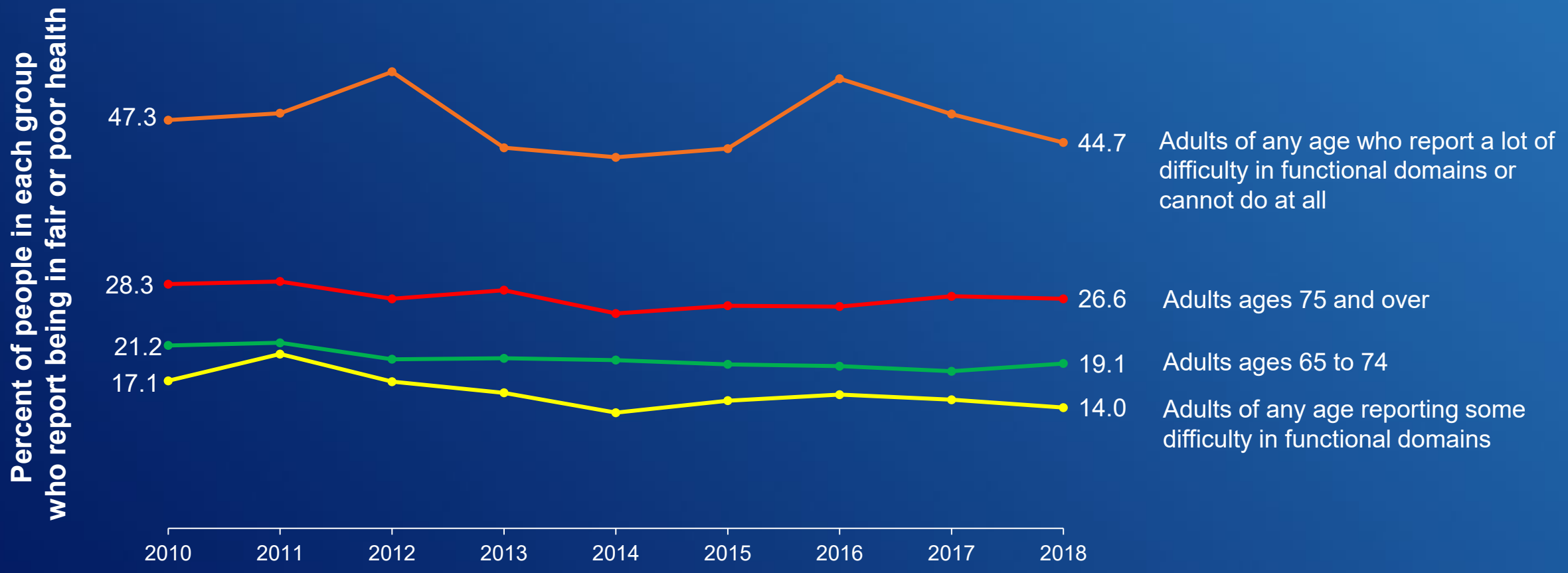
Medicare FFS beneficiaries pay substantial premiums and cost sharing

Premiums (2022)	
Part B (actual):	$2,041
Part D (average):	480
Average cost sharing (2020)	
Part A:	383
Part B:	1,469
Part D:	432

- Medicare beneficiaries' median income: $30,000 (2019)
- 10% of beneficiaries who received care had a problem paying a medical bill (2019)

Note: Part B premium shown is the standard premium that FFS beneficiaries pay if they sign up for Part B on time and have an annual income of $91,000 or less. Part D premium shown is the average enrollment-weighted monthly premium for stand-alone prescription drug plans. Percent shown refers to the percent of beneficiaries (including those in MA) who received care in the past year and reported having a problem paying a medical bill. Data are preliminary and subject to change.
Source: MedPAC's 2022 *Data book*; Kaiser Family Foundation's 2020 *Medicare beneficiaries' financial security before the coronavirus pandemic*; MedPAC analysis of CMS's 2019 Medicare Current Beneficiary Survey.

Beneficiaries' reported health status has been improving over time



Note: "Adults of any age reporting a lot of difficulty in functional domains or cannot do at all" are people ages 18 and over who reported that for at least one of six functional domains (e.g., mobility, communication, self-care) they had a lot of difficulty or could not do the activity at all. "Adults of any age reporting some difficulty in functional domains" are people ages 18 and over who reported that for at least one of six functional domains, they had some difficulty. Data are preliminary and subject to change.
Source: National Center for Health Statistics, *Health, United States, 2019*, released 2021.

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The most common chronic conditions are relatively inexpensive, and the most expensive conditions are relatively rare (2020)

	Prevalence among FFS beneficiaries	Spending per FFS beneficiary with the specified condition
Most prevalent conditions:		
Hypertension (high blood pressure)	67%	$16,434
Hyperlipidemia (high cholesterol)	63	15,791
Rheumatoid arthritis / Osteoarthritis	35	17,210
Diabetes	27	17,999
Benign prostatic hyperplasia (enlarged prostate)	27	NA
Most costly conditions:		
Acute myocardial infarction (heart attack)	1	58,981
Lung cancer	1	42,549
Stroke / Transient ischemic attack (mini stroke)	6	37,390
Heart failure	12	31,222
Colorectal cancer	2	30,596

Note: N/A (not available). Beneficiaries may be counted in more than one chronic condition category. The information should not be used to attribute utilization or payments strictly to the condition selected because beneficiaries with any of the conditions presented could have other health conditions that contribute to their Medicare utilization and spending amounts. Spending per beneficiary is actual spending, as opposed to age- or risk-standardized spending. Spending shown does not include Part D spending. Prevalence data for chronic conditions are not directly comparable to prevalence data reported in prior years' Commission reports due to a change in our data source's methodology. Data are preliminary and subject to change.
Source: CMS's Chronic Conditions Warehouse; CMS's Mapping Medicare Disparities by Population interactive tool.

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Discussion

- Does anything in the chapter need to be clarified?
- Do you have any other guidance for the chapter?