CHAPTER 1

Context for Medicare payment policy

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Chapter summary

This year, both the short- and long-term context for the Medicare program are sobering. In the short term, the nation is in the midst of a historic coronavirus pandemic. Medicare beneficiaries are at particular risk of COVID-19. Those over 65 are more likely to suffer severe cases and complications and die than those who are younger and have fewer comorbidities. Beneficiaries in nursing facilities have accounted for a disproportionate share of fatalities from COVID-19. In addition, non-White Medicare beneficiaries have faced disproportionately high rates of mortality due to COVID-19, reflecting, in part, longstanding inequalities in the health care system and society. Providers are also under stress. The demands put upon individual clinicians and other staff have been extreme. The financial stress on providers is unpredictable, although it has been alleviated to some extent by government assistance and rebounding service utilization levels.

The longer-term context is also sobering. The financial future of the Medicare program was already problematic, but as a result of pandemic job losses, in 2020 the Congressional Budget Office projected that Medicare's Hospital Insurance Trust Fund will become insolvent two years earlier than previously expected—by 2024. (Aside from this projection, long-range projections in this chapter do not reflect the impact of the pandemic.) Driven by growth in the volume and intensity of services provided to beneficiaries and the number of beneficiaries aging into the program, Medicare's annual spending is projected

In this chapter

to double in the 10-year period between 2019 and 2029, from $782 billion to $1.5 trillion. During this period, Medicare's share of federal spending is expected to rise from 14.6 percent to 17.5 percent.

Increasing Medicare spending also strains beneficiaries' household budgets. In 2020, Medicare Part B and Part D premiums and cost sharing are estimated to consume 24 percent of the average Social Security benefit, up from 14 percent in 2000. The Medicare Trustees estimate that in another 20 years, these costs will consume 31 percent of the average Social Security benefit.

One of the most powerful ways Medicare can control spending growth is by setting prices. Over the last 10 years, Medicare's spending per beneficiary has grown much more slowly than private health insurance spending per enrollee. Increasing prices were the main cause of health care spending growth for the privately insured, which was in turn driven by high levels of provider market power. Hospitals and physician groups have increasingly consolidated, in part to gain leverage over private insurers in negotiating higher payment rates. From 2009 to 2019, that consolidation contributed to average annual per enrollee growth in spending on private health insurance of 3.6 percent. By comparison, over that same period, Medicare spending per enrollee increased an average of 1.9 percent annually—nearly the same as the general inflation rate of 1.8 percent over this period. This difference suggests that private plans' greater ability to constrain volume has less of an effect on costs than the Medicare program's greater ability to constrain prices under its administered pricing system.

The Commission makes recommendations about appropriate payment levels for various Medicare payment systems in our March report each year. These recommendations are based on our review of the latest available data and attempt to balance the need to pay high enough prices to ensure beneficiaries' access to high-quality care with the need to be a responsible steward of fiscal resources.

Given Medicare's financing challenges, many believe that restraining price growth will not be enough to ensure Medicare's fiscal sustainability and that growth in the quantity of health care services must also be reduced. Medicare has piloted a number of alternative payment models that give providers incentives to more closely manage and coordinate beneficiaries' care to keep them healthy and reduce unnecessary utilization. The ultimate goal of these payment models is to save Medicare money by financially rewarding providers for efficiently delivering health care services while maintaining or improving the quality of care.

Prices and utilization rates can also be influenced through other means. The Commission has identified a number of aspects of Medicare payment systems that hamper the program's ability to achieve fiscal sustainability. The Commission has made numerous recommendations that, if implemented, could address these challenges and allow Medicare to improve payment accuracy and equity. Some key recommendations from prior years are summarized at the end of this chapter.

Medicare's fiscal challenges must be met in a manner that improves quality and reduces inequities in access to care across the Medicare population. Although quality of care appears stable, there is room for improvement. The Commission is also dedicated to understanding and reducing disparities in access to care across racial and ethnic groups. As Medicare consumes growing shares of the federal budget and beneficiaries' incomes, the Commission will continue to identify changes that could improve Medicare payment policy, including through recommendations contained in this report and future reports to the Congress. ■

Introduction

Each March, the Commission reports to the Congress on traditional Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage program, and the Medicare prescription drug program. To place the information presented in those chapters in some context, this chapter highlights key national trends in health care spending for the country as a whole and for the Medicare program in particular. We also review the factors that contribute to Medicare spending growth—including trends in demographics and the price of health care services—and discuss how Medicare's payment policies can either moderate or exacerbate program spending. Through the graphs and statistics that follow, we show that sustaining Medicare fiscal solvency is a growing and pressing challenge. For example, in 2020 the Congressional Budget Office (CBO) estimated that Medicare's Hospital Insurance Trust Fund will become insolvent by 2024. (Aside from this projection, long-range projections in this chapter do not yet reflect the impact of the pandemic.)

This year, in addition to the long-term financial context for the Medicare program, we also consider the short-term context: the coronavirus pandemic. Medicare beneficiaries are at particular risk from COVID-19. Providers are also under stress. The demands put upon individual clinicians and other staff have been extreme. In addition, the financial stress on providers has been unpredictable, although it has been alleviated to some extent by government assistance and rebounding service utilization levels. We discuss the financial effects on providers, to the extent they are germane to our payment adequacy analyses, in each update chapter. We look at some of the effects of the pandemic on beneficiary mortality and access to care in the section below.

The impact of the coronavirus pandemic on beneficiaries

The coronavirus pandemic has proven especially tragic for older adults. People ages 65 and over are more likely than younger populations to suffer severe cases of COVID-19, develop complications, and die. Beneficiaries in long-term care and assisted living facilities are particularly at risk and have accounted for a disproportionate share of fatalities nationwide. In addition, non-White Medicare beneficiaries have faced disproportionately high rates of mortality due to COVID-19, reflecting, in part, longstanding inequalities in the health care system and society.

Beneficiaries and clinicians have had to adjust to new care delivery approaches and priorities during the pandemic—at times switching from in-person appointments to telehealth appointments and delaying elective procedures to avoid potential exposure to the coronavirus and preserve clinicians' supplies of personal protective equipment.

Increased mortality during the pandemic

In 2020, COVID-19 was the third leading cause of death in the U.S., and in the spring and winter, it overtook heart disease and cancer to become the leading cause of death in the country (Cox and Amin 2021, Woolf et al. 2020a). Medicare beneficiaries face disproportionately high mortality rates compared with younger age groups. As of late September 2020, adults 65 and older accounted for 79 percent of the deaths attributed to COVID-19 in the U.S. (Kamp and Evans 2020, National Center for Health Statistics 2021).[1] As of mid-January 2021, 38 percent of COVID-19 deaths occurred among long-term care and assisted living facility residents and staff (Kaiser Family Foundation 2021).[2]

Beyond mortality directly attributed to COVID-19, some studies have found that the number of excess deaths (that is, deaths beyond what would have been expected in a typical year) are even greater (Weinberger et al. 2020, Woolf et al. 2020b). From late January 2020 through early December, there were an estimated 475,000 excess deaths (National Center for Health Statistics 2021, Overberg et al. 2021). One study observed that only about two-thirds of excess deaths were caused by COVID-19; it noted that deaths from noninfectious causes increased during COVID-19 surges, which could reflect unrecognized or undocumented coronavirus infections or deaths from uninfected patients that resulted from care disruptions produced by the pandemic (Woolf et al. 2020b).

The pandemic has had a disproportionate effect on non-White individuals. According to age-adjusted COVID-19 mortality data, White Americans have the lowest COVID-19 mortality rate by a significant margin. Mortality rates for Black, Hispanic, and Native American people are at least double the rates for White Americans (APM Research Lab 2021). The rates of excess deaths also reflect these disparities. Comparing actual deaths in 2020 with deaths that would have been expected based on 2015 to 2019 experience, White Americans' deaths

were 12 percent higher, Native Americans' deaths were 29 percent higher, Black Americans' deaths were 33 percent higher, Asian Americans' deaths were 37 percent higher, and Hispanic Americans' deaths were 54 percent higher (Rossen et al. 2020).

Numerous factors could contribute to racial and ethnic differences in COVID-19 mortality rates, including employment, multigenerational housing arrangements, income, preexisting conditions, and access to health care. For example, non-White workers are disproportionately represented in frontline industries, such as public transit, health care, and building cleaning services (Rho et al. 2020). Those workers are at higher risk for contracting the disease due to their close contact with others and their inability to work from home, as well as not having sufficient access to paid time off (Gould and Wilson 2020). One study found that among Hispanic adults at high risk of severe COVID-19 illness (of any age), 64.5 percent lived with a worker who was unable to work from home, and the same was true of 56.5 percent of Black high-risk adults, compared with 46.6 percent of White high-risk adults (Selden and Berdahl 2020). Non-White individuals are also more likely to delay or avoid urgent or emergency care during the pandemic: A Centers for Disease Control and Prevention (CDC) survey found that 25 percent of Hispanics and 23 percent of Blacks (of any age) reported having avoided care, compared with 7 percent of Whites (Czeisler et al. 2020).

Medicare beneficiaries' access to care was largely maintained during the pandemic, although many beneficiaries temporarily delayed care

A number of surveys have tried to assess how many Medicare beneficiaries (and others) have delayed or forgone care because of the pandemic. These surveys have found that widely varying shares of respondents have forgone or delayed care, depending on how the question was asked, when the survey was fielded, and what time period was referenced. For example, a large national survey by the Census Bureau, fielded in mid-July, found that among respondents age 60 and over, 34 percent had delayed care and 26 percent had forgone care *in the past month* (Census Bureau 2020). In contrast, the Commission's 2020 survey, fielded from April to October, asked about forgone care *in the past year*, and found that only 10 percent of elderly Medicare beneficiaries had forgone care they thought they should have gotten. Since our survey is fielded annually, we are able to observe trends over time, unlike many surveys that were fielded only during the pandemic. We found that the share of beneficiaries who reported forgoing care in 2020 was not statistically significantly different from prior years—although many respondents in 2020 cited the pandemic as the reason they had forgone care instead of other reasons commonly cited in prior years. When beneficiaries do forgo or delay medical care, a CDC survey found that they were far more likely to delay or avoid routine care (which 30 percent of elderly respondents reported doing during the pandemic) than they were to delay or avoid urgent or emergency care (which only 4 percent reported doing) (Czeisler et al. 2020). In some cases, beneficiaries may have put off care because providers and facilities ceased to provide in-person services. In other cases, beneficiaries may have been unwilling to seek in-person care because of the risk of COVID-19 infection.

Many of the findings above are reinforced by what we heard from beneficiaries and clinicians in focus groups held virtually during the summer of 2020 in three cities in different regions of the country. Many of the beneficiaries in each of the groups expressed their reluctance to seek in-person care because of fear of infection from COVID-19, especially during the first two months of the pandemic. Telehealth visits replaced many in-person visits; however, beneficiaries and clinicians noted that many procedures (e.g., colonoscopies) and tests (e.g., blood work) were canceled or delayed. Both beneficiaries and clinicians reported that the number of in-person visits and procedures had been increasing throughout the summer, but some beneficiaries continued to be reluctant to seek in-person care. We will continue to monitor trends in the use of telehealth and health care more generally.

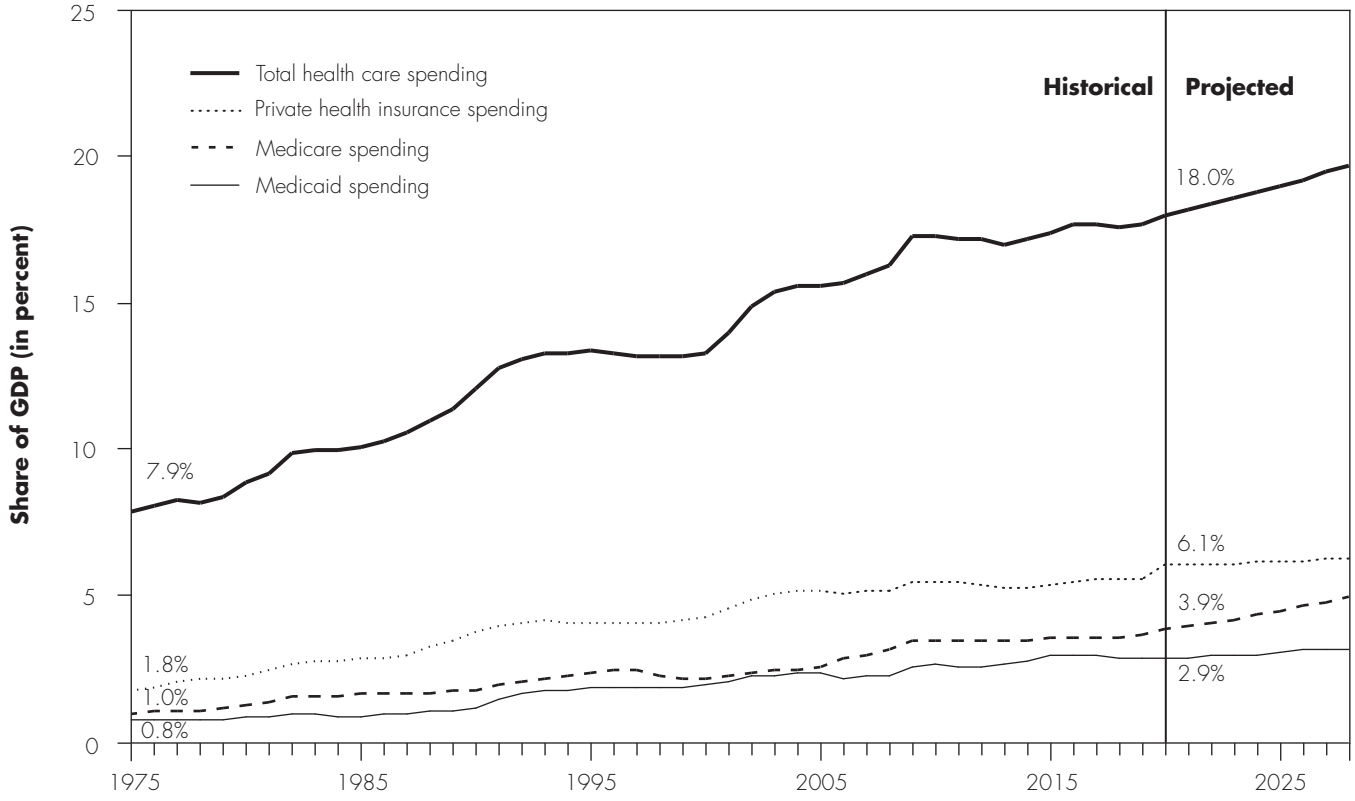
The remainder of this chapter discusses Medicare's longer-term financial outlook. As a note of caution, most of the data sources used in this chapter do not yet reflect the impact of the pandemic in their projections of future-year health care utilization or spending.

National health care spending

For decades, health care spending in the U.S. has grown as a share of the nation's gross domestic product (GDP) (Figure 1-1). From 1975 to 2020, health care spending as a share of GDP more than doubled, from 7.9 percent to 18.0 percent. Private health insurance spending as a share of GDP more than tripled, from 1.8 percent to 6.1 percent. And Medicare spending as a share of GDP nearly quadrupled, from 1.0 percent to 3.9 percent.

FIGURE 1–1

Health care spending has grown as a share of the country's GDP



Note: GDP (gross domestic product). First projected year is 2020. Percentages labeled on graph are for 1975 and 2020. 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. 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; and other federal, state, and local programs). The potential effects of the coronavirus pandemic are not reflected in these projections.

Source: MedPAC analysis of CMS's National Health Expenditure Accounts, historical data released December 2020 and projections released March 2020.

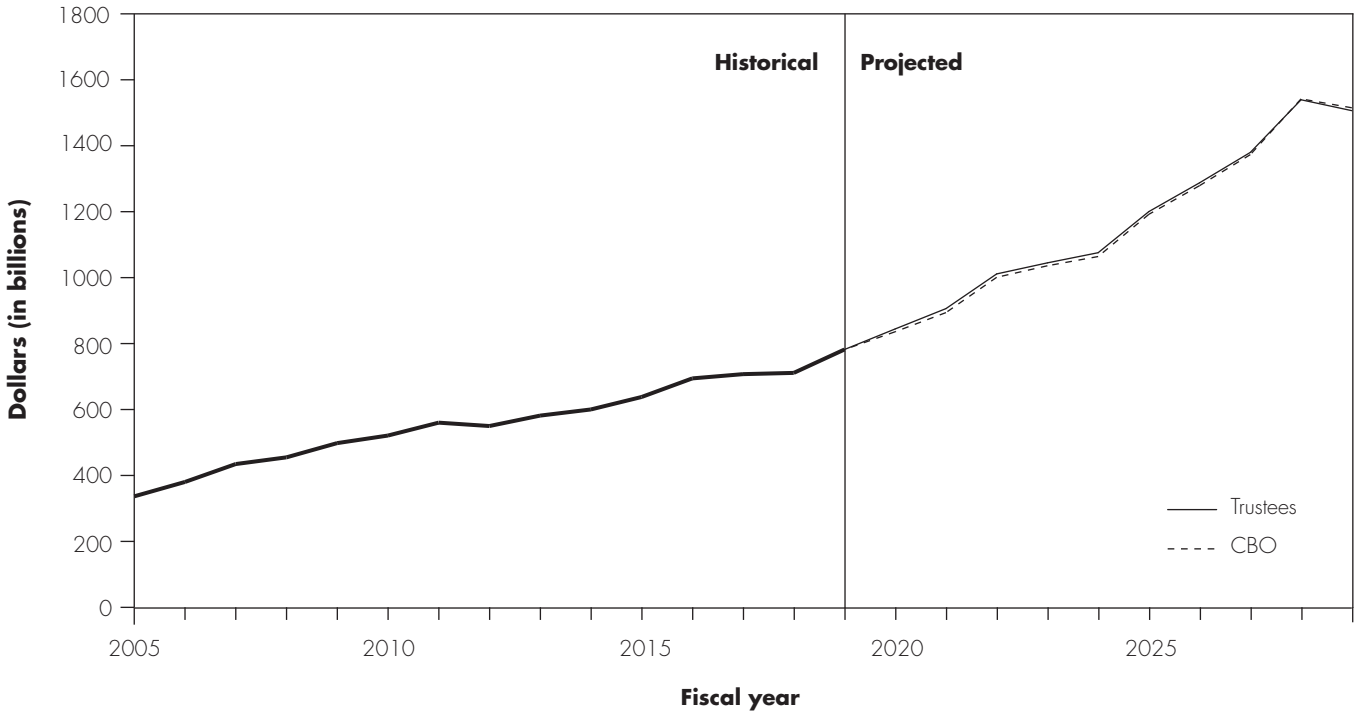
Actuaries expect national health care spending to increase at an average annual rate of 5.4 percent from 2019 to 2028, when total health care spending is projected to constitute 19.7 percent of GDP. The largest driver of personal health care spending increases is rising prices, which account for 43 percent of projected growth; for the 2019 to 2028 period, actuaries expect prices to grow at an average annual rate of 2.4 percent, compared with 1.2 percent for the 2014 to 2018 period. The accelerated growth in health care prices is partly a result of an expected acceleration in economy-wide inflation, which will increase input prices for medical providers. The second-largest driver of national spending growth is growth in the use and intensity of services per patient, which accounts for about a third of the projected growth in spending between 2019 and 2028. Only about a tenth of the projected growth in health care spending is explained by the aging of the population (Keehan et al. 2020). Retail spending for prescription drugs is projected to grow only slightly faster than overall national health expenditures. However, over the past few decades, drugs' share of spending has expanded significantly (see text box, p. 11).

Medicare spending projections

Similar to national health care spending trends, Medicare is also projected to see increases in spending over the 10 years between 2019 and 2029—rising from $782 billion

FIGURE 1–2

Medicare Trustees and CBO project Medicare spending to nearly double over the next decade



Note: CBO (Congressional Budget Office). Figure shows spending per fiscal year (as opposed to calendar year). The potential effects of the coronavirus pandemic are not reflected in these projections. At the time these projections were developed, a statutorily required sequestration was scheduled to increase in size in 2029 (growing from the current 2 percent reduction to benefit payments to a 4 percent reduction for the period from April 1, 2029, through September 30, 2029). Subsequent legislation delayed the 4 percent sequester past 2029 (not reflected above).

Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds and CBO's March 2020 Medicare baseline.

to $1.5 trillion (Figure 1-2) (Boards of Trustees 2020, Congressional Budget Office 2020a).

Unlike in the private health care sector, price growth is not expected to drive Medicare's increasing spending over the next 10 years (Table 1-1, p. 12) because Medicare is able to unilaterally set prices for health care providers. Medicare's ability to set prices is becoming an increasingly valuable tool as more and more providers consolidate into ever larger organizations able to command increasingly high prices from private payers (see text box, pp. 13–15, on price growth in the private sector). In contrast, Medicare's projected spending in the next 10 years is driven by the increasing number of beneficiaries (which is set to grow a little more than 2 percent per year) and the increasing volume and intensity of services delivered per beneficiary (which is expected to grow by 2.6 percent per year) (Table 1-1, p. 12). Because enrollment growth is largely outside of the program's control, the most promising avenue for slowing the growth in Medicare spending is likely to be to reduce the quantity (and mix) of services used by beneficiaries, such as through efforts to reduce consumption of low-value care—defined as services with little or no clinical benefit or that have more risk of harm than potential benefit. Consumption of low-value care varies by geography, reflecting different practice patterns—with previous Commission analyses finding high amounts of low-value care delivered in parts of Florida, for example. CMS has tested a number of alternative payment models that

Prescription drug spending has increased significantly

Spending on prescription drugs has increased significantly compared with other sectors over the past few decades—doubling as a share of personal health care spending between 1979 and 2019, from 6 percent to 12 percent (Centers for Medicare & Medicaid Services 2020).

CMS actuaries project that national spending on retail prescription drugs will grow between 2019 and 2028 at an average annual rate of 5.5 percent (Keehan et al. 2020). This projection is driven by accelerating growth in drug prices in coming years and greater use and intensity of prescription drugs, caused in part by new drugs coming on the market. The American Academy of Actuaries has also attributed prescription drug spending growth in the U.S. to "delays in introducing generics, higher cost inflation in the United States for pharmaceuticals relative to other nations, and the compensation of numerous stakeholders throughout the pharmacy supply chain" (Hanna and Uccello 2018).

In 2018, across all payers, retail drug spending made up 9 percent of national health expenditures, compared with 14 percent of Medicare expenditures (Keehan et al. 2020). (Both percentages are net of manufacturers' rebates.)

Spending for prescription drugs that are administered during a physician visit or a hospital or nursing home stay are not included in measures of retail drug spending. The Commission has previously estimated that in 2016 total drug and pharmacy services (including retail and nonretail spending) accounted for 23 percent of Medicare spending (excluding beneficiary cost sharing)—up from 20 percent in 2007. Over this period, the amount spent by facilities to buy drugs and operate pharmacies increased much more quickly for hospital outpatient facilities than for inpatient facilities. Between 2007 and 2016, drug and pharmacy costs for hospital outpatient departments grew at an annual average rate of about 14 percent, while estimates of comparable costs for inpatient hospitals increased at an average of less than 2 percent annually. ■

incentivize more efficient use of services, but savings for Medicare have been only modest and concentrated in population-based payment models and certain episode-based payment models. The Commission has asserted that it may therefore be time to give accountable entities stronger incentives to control costs and improve quality (Medicare Payment Advisory Commission 2020b).

Medicare's financing challenge

The aging of the baby-boom generation will have an impact on both the Medicare program and the taxpayers who support it. Workers finance the bulk of Medicare Part A through payroll taxes that are deposited into the Hospital Insurance (HI) Trust Fund; workers also help finance Part B and Part D through income taxes and other contributions that are deposited into the general fund of the Treasury.[3] The ratio of workers per Medicare beneficiary has already declined from about 4.6 workers per beneficiary around the time of the program's inception to 3.0 workers per beneficiary in 2019 (Figure 1-4b, p. 16). Over the next decade, as Medicare enrollment continues to grow, the number of workers per beneficiary is projected to decline further: by 2029, the Medicare Trustees project just 2.5 workers per beneficiary.

By 2030, the entire baby-boom generation will be eligible for Medicare. That year, Medicare is projected to have nearly 80 million beneficiaries—up from 61 million beneficiaries in 2019 (Figure 1-4a, p. 16) (Boards of Trustees 2020).[4] Baby boomers aging into Medicare will lower the average beneficiary age over the next 10

TABLE 1–1

Factors contributing to Medicare's projected spending growth from 2020 to 2029 (not including general economy-wide inflation)

	Average annual percent change in:				
Medicare Part	**Medicare prices**	**Number of beneficiaries**	**Beneficiary demographic mix**	**Volume and intensity of services used**	**Medicare's projected spending**
Part A	0.2%	2.3%	0.1%	1.2%	3.8%
Part B	–0.7	2.3	0.0	4.0	5.7
Part D	–0.4	2.6	–0.1	1.8	3.9
Total	–0.3	N/A*	0.0	2.6	4.7

Note: N/A (not available). Includes Medicare Advantage enrollees. Price increases reflect Medicare's annual updates to payment rates (not including inflation, as measured by the consumer price index), multifactor productivity reductions, and any other reductions required by law or regulation (including a statutorily required 2 percent sequester to Medicare benefit payments, which was scheduled to increase to 4 percent for a six-month period in 2029 at the time these projections were developed, but has since been delayed). Part A prices are expected to rise faster than economy-wide inflation in the 2020s in part due to statutorily required increases. Specifically, in each of fiscal year 2020 through 2023, there is a statutory 0.5 percent increase in inpatient operating payments due to unwinding a temporary reduction in payments that was put in place to recoup past overpayments resulting from changes in providers' documentation and coding. Volume and intensity together are the residual after the other three factors shown in the table (Medicare price increases, the increase in the number of beneficiaries, and changes in beneficiary demographic mix) are removed. Much of the 1.2 percent projected increase in Part A volume and intensity may be due to increased coding of hospital severity of illness, which may reflect real changes in patients' needs and/or coding changes; we do not expect the 1.2 percent to reflect increases in volume per capita given that the number of discharges per beneficiary has declined for several decades and fell by 6.1 percent from 2015 to 2019. The "Medicare's projected spending" column is the product of the other columns in the table. The "Total" row is the sum of the other rows of the table, each weighted by their Part's share of total Medicare spending in 2019 (as measured by shares of gross domestic product). Any potential effects of the coronavirus pandemic are not reflected in these projections.
*We are unable to calculate the total contribution of the increasing number of beneficiaries to projected spending growth because there is beneficiary overlap in enrollment in Part A, Part B, and Part D.

Source: MedPAC analysis of data from the 2020 annual report of the Boards of Trustees of the Medicare trust funds.

years. Then, around 2030, the share of the Medicare population ages 85 and older is projected to grow as baby boomers continue to age (Boards of Trustees 2020). This aging will have cost implications for the Medicare program because spending per beneficiary for individuals ages 85 and older is much higher than that for younger elderly beneficiaries (Figure 1-5, p. 16). The changing age structure of the Medicare population will thus exert somewhat less pressure on spending in the near term, then exert increasing pressure over the longer term.

These demographics create a financing challenge for the Medicare program. Payroll tax revenues are not growing as fast as Part A spending, and Medicare already spends more on Part A services each year than it collects through HI Trust Fund revenues—creating annual deficits. (Part A pays for services such as inpatient hospital stays.) Leftover surpluses from prior years have been used in recent years to pay for this deficit spending. As a result, the Trust Fund's reserves have been dwindling; before the coronavirus pandemic, the Medicare Trustees estimated that by 2026 the Trust Fund's prior surpluses would be depleted—meaning the HI Trust Fund would be unable to fully cover its obligations each year (Boards of Trustees 2020). In light of job losses caused by the pandemic, CBO estimated in 2020 that a drop in payroll tax revenues will cause the Trust Fund to become insolvent two years sooner—by 2024 (Congressional Budget Office 2020b).

According to Medicare's Trustees, if Medicare's HI Trust Fund is depleted, "Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs," which they warn could rapidly curtail beneficiary access to care. However, the Trustees note that lawmakers have never allowed the assets of the HI Trust Fund to become depleted (Boards of Trustees 2020).

Rapid price growth in the private sector has not affected Medicare beneficiaries' access to care

Over the recent decade between 2008 and 2018, spending per enrollee on health care in the private sector has grown faster than spending per enrollee in the Medicare program (Centers for Medicare & Medicaid Services 2020). Increased prices were largely responsible for this faster spending growth, which occurred at a time of low growth in private sector health care utilization (Health Care Cost Institute 2020a). Our analysis of payer data and a review of the literature suggests that, although there is wide variation geographically and by service, private insurers generally pay rates about twice as high as Medicare for hospital services and about one and a half times Medicare rates for physician services (Chernew et al. 2020, Kaiser Family Foundation 2020, Medicare Payment Advisory Commission 2017).

One key driver of the private sector's higher prices is provider market power (Baker et al. 2014a, Baker et al. 2014b, Cooper et al. 2018, Gaynor and Town 2012, Medicare Payment Advisory Commission 2020c, Medicare Payment Advisory Commission 2017, Robinson and Miller 2014, Scheffler et al. 2018). Hospitals and physician groups have increasingly consolidated, in part to gain leverage in negotiating higher payment rates with private insurers (which, themselves, have become more concentrated). Between 2009 and 2019, consolidation contributed to average annual per enrollee growth in spending on private health insurance of 3.6 percent. By comparison, over that same period, Medicare spending per enrollee increased an average of 1.9 percent annually—nearly the same as the general inflation rate of 1.8 percent over this period (Bureau of Labor Statistics 2020, Centers for Medicare & Medicaid Services 2020).

The difference between private sector spending growth and Medicare spending growth becomes more stark once patient cost sharing is taken into account. Between 2014 and 2018, total health care spending per capita (including cost sharing) grew 24 percent for the privately insured, compared with 10 percent for beneficiaries in traditional fee-for-service Medicare (Figure 1-3, p. 14). (These figures do not include retail spending on prescription drugs.) Actual spending amounts are lower for the privately insured, who tend to be younger and healthier than Medicare beneficiaries. Between 2014 and 2018, annual spending per capita on services for the privately insured rose from $4,106 to $5,104. Over the same period, spending per beneficiary in traditional Medicare increased from $10,406 to $11,262. (These amounts do not include the cost of premiums.)

Health care prices have been influenced by hospital consolidation since hospital systems with larger market shares are in a stronger bargaining position to negotiate higher prices (Abelson 2018, Department of Justice and the Federal Trade Commission 1996, Federal Trade Commission 2016a, Federal Trade Commission 2016b). One summary of the literature stated:

> Overall, … studies consistently show that when hospital consolidation is between close competitors, it raises prices by substantial amounts. Consolidated hospitals that are able to charge higher prices due to reduced competition are able to do so on an ongoing basis, making this a permanent rather than a transitory problem. (Gaynor 2020)

While most of the literature suggests hospital systems with larger market shares are in a stronger bargaining position to negotiate higher prices, the hospital industry generally disputes the assertion that market power causes an increase in prices (American Hospital Association 2019, Noether and May 2017). Also, while the American Hospital Association asserts that readmission and mortality rates improve following mergers, a more recent study suggests that mortality and readmission rates do not improve and patient satisfaction declines slightly after mergers (Beaulieu et al. 2020). Another study of commercial hospital prices and consolidation finds that prices tend to increase faster in markets where consolidation increases (Health Care Cost Institute 2020b). A third study finds higher prices for hospital services in California markets with higher levels of concentration (California Healthcare Foundation 2019). Taken together, the preponderance

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Rapid price growth in the private sector has not affected Medicare beneficiaries' access to care (cont.)

of evidence suggests that hospital consolidation leads to higher prices (Medicare Payment Advisory Commission 2020c).

From 2003 to 2017, the share of hospital markets that were "super" concentrated increased from 47 percent to 57 percent.[5] Super-concentrated markets have a single dominant system that accounts for a majority of hospital discharges.

Consolidation of clinician practices has also increased. A study of available data found a steady increase between 2014 and 2018 in the number of mergers and acquisitions involving physician medical groups (62 such deals vs. 252 deals, respectively) (Irving Levin Associates Inc. 2019). The American Medical Association's survey of physicians indicates that, over time, physicians have shifted from solo and small practices to larger practices (Kane 2015).

The number of physicians in "vertically consolidated" practices—hospital-acquired physician practices, physicians hired as salaried employees, or both—nearly doubled between 2007 and 2013 (Government Accountability Office 2015). And according to one

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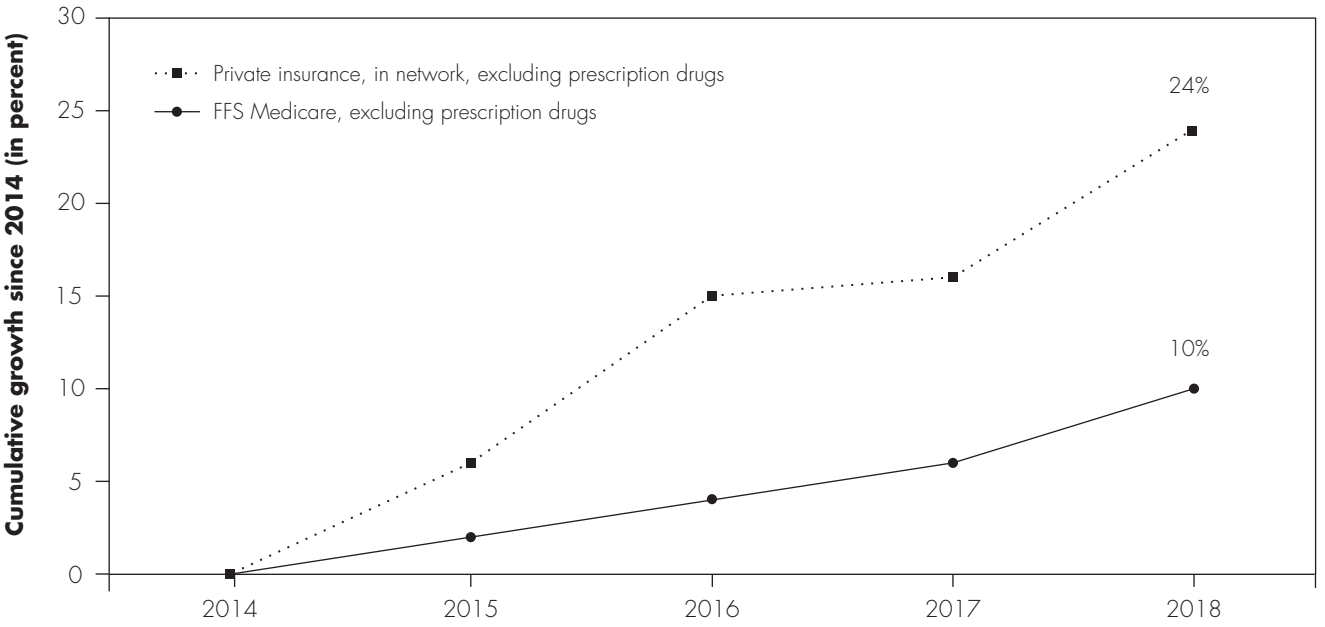
FIGURE 1–3

Health care spending per enrollee has grown faster for the privately insured than for beneficiaries in traditional FFS Medicare, 2014–2018



Note: FFS (fee-for-service). The figure shows cumulative growth since 2014. It reflects payments to providers from health insurers and patients (i.e., cost sharing) but not payments from other sources (e.g., worker's compensation or auto insurance). Spending on retail prescription drugs is not available for the privately insured, so it is excluded from both lines in this graph. Spending on out-of-network services for the privately insured is not available for that group and thus is not included in this graph. The figure reflects spending for individuals with full-year insurance coverage (including individuals with $0 of health care spending). "Private insurance" reflects spending for individuals ages 18 to 64 in fully insured and self-insured plans (i.e., employer self-funded plans) contributed by national and regional plans and third-party administrators nationwide; it includes claims from individual and group plans as well as marketplace plans and Medicare Advantage plans for non-elderly disabled individuals.

Source: MedPAC analysis of Medicare's Master Beneficiary Summary File; FAIR Health analysis of its National Private Insurance Claims database (which reflects 150 million covered lives) for the subset of enrollees ages 18 to 64.

Rapid price growth in the private sector has not affected Medicare beneficiaries' access to care (cont.)

recent study, by 2018, more than half of physicians and 72 percent of hospitals were affiliated with one of 637 vertically integrated health systems, with particularly fast growth in physician affiliations (Furukawa et al. 2020). The Federal Trade Commission observed that "providers increasingly pursue alternatives to traditional mergers such as affiliation arrangements, joint ventures, and partnerships, all of which could also have significant implications for competition" (Federal Trade Commission 2016b). After controlling for the level of horizontal concentration of physician services, three recent studies found that hospital–physician integration led to commercial price increases of 3 percent to 14 percent (Capps et al. 2018, Medicare Payment Advisory Commission 2017, Neprash et al. 2015).

The Commission is concerned that market concentration effects will lead to higher Medicare spending if commercial prices are "imported" into Medicare. The Commission has tried to counteract these effects by recommending restrained payment updates and site-neutral payments (paying the same for a service regardless of the setting of care). But over time, private sector trends may 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. Eventually, the difference between commercial rates and Medicare rates could grow so large that hospitals have an incentive to focus primarily on patients with commercial insurance, which could create pressure to increase Medicare's payment rates. It is also possible that higher private prices enabled by consolidation could prompt providers to increase their costs; if Medicare payment rates do not keep pace with these higher costs, then Medicare beneficiaries' access to care could become threatened. Thus, in the long term, Medicare beneficiaries' access to care may in part depend on commercial payers restraining rates paid to hospitals (Medicare Payment Advisory Commission 2009, Stensland et al. 2010, White and Wu 2014).

Notwithstanding the higher payment rates often available from commercial insurers, the vast majority of clinicians continue to participate in the Medicare program. The number of clinicians who have opted out of Medicare (26,000 clinicians as of October 2020) is overwhelmingly outweighed by the number still in the program (almost 1.3 million clinicians in 2019). The majority of opted-out clinicians are behavioral health providers and dentists. In addition, although nonparticipating clinicians are permitted to balance-bill beneficiaries for higher copayments than Medicare's usual payment rates, it is extremely rare for clinicians to do so. The Commission closely monitors the numbers of clinicians who have opted out of the program or become nonparticipants each year, and it will continue to do so in the future. ■

To keep the HI Trust Fund solvent over the next 25 years, the Trustees estimate that either the payroll tax would need to be increased immediately from its current rate of 2.9 percent to 3.7 percent or Part A spending would need to be permanently reduced by 17 percent (Table 1-2, p. 17), which is equivalent to about $62 billion in 2021, and comparable amounts in subsequent years (Boards of Trustees 2020).[6] The Commission regularly makes recommendations to the Congress that would change Medicare's spending trajectory, but these recommendations typically achieve much smaller savings. For example, the recommendations in the Commission's March and June 2020 reports would decrease Medicare spending by a total of between $7 billion and $12.5 billion in their first year of implementation.[7]

The HI Trust Fund is a major financing mechanism for the Medicare program, but it covers less than half of Medicare spending (41 percent in 2019), and that share is declining (Figure 1-6, p. 17).

The rest of Medicare benefit spending, under Part B and Part D, is covered by the Supplementary Medical

FIGURE 1–4

Medicare enrollment is rising while number of workers per beneficiary is declining

Figure 1-4a. Medicare enrollment

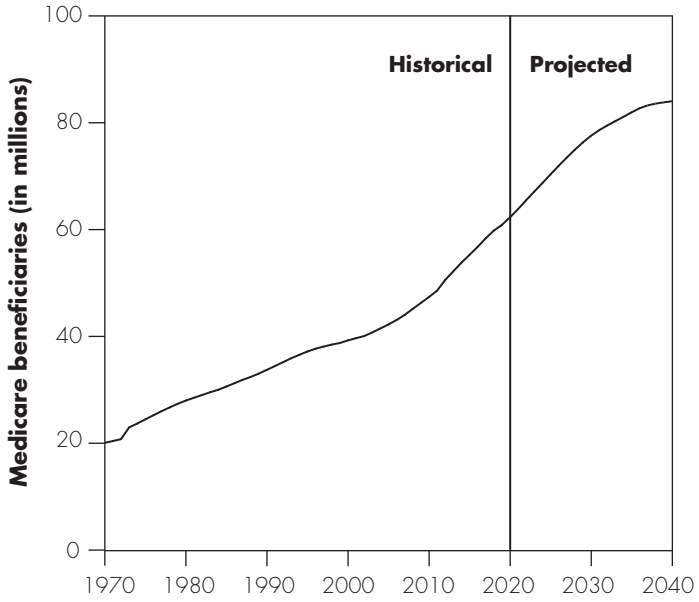
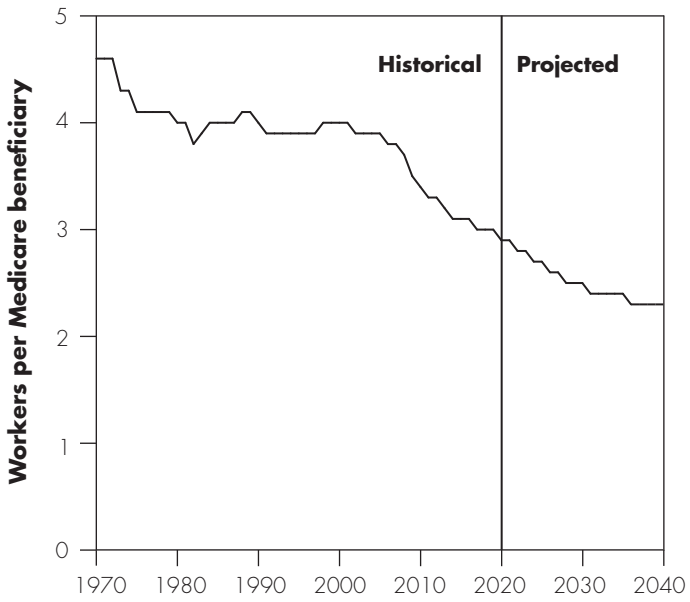


Figure 1-4b. Workers per beneficiary

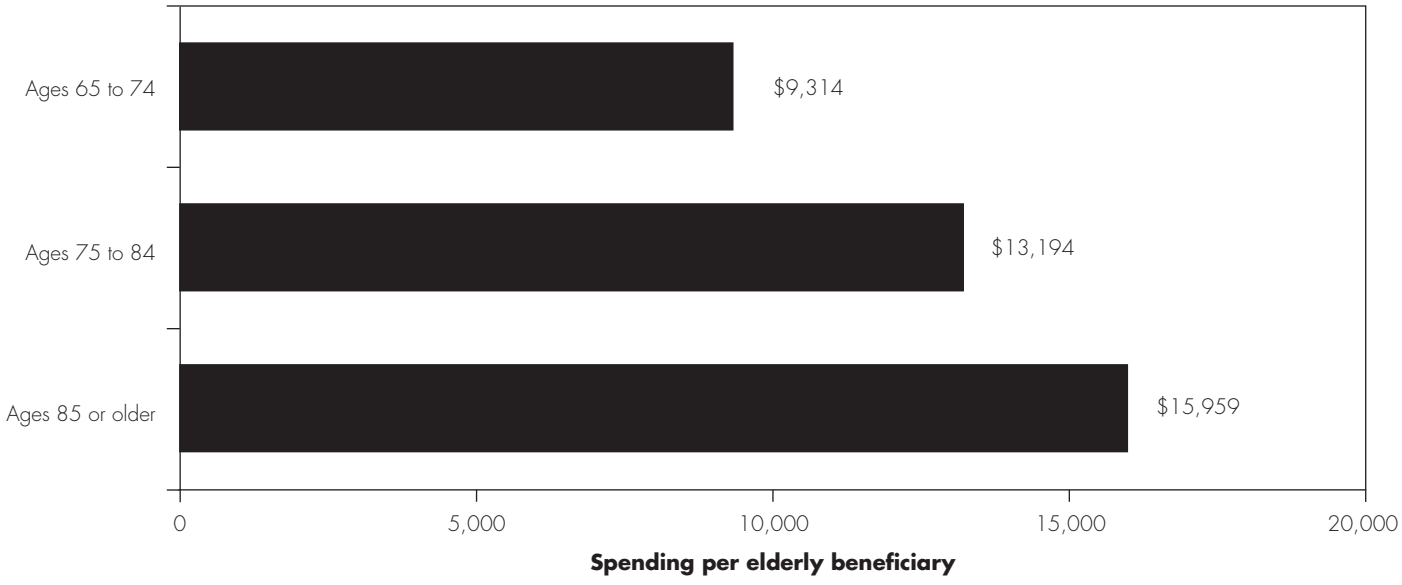


Note: "Beneficiaries" referenced in these graphs are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). Part A is financed by Medicare's Hospital Insurance Trust Fund. The potential effects of the coronavirus pandemic are not included in these projections.

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

FIGURE 1–5

Spending per elderly beneficiary varied by age, 2017



Note: Includes beneficiaries in traditional Medicare and Medicare Advantage dwelling in the community and in institutions. Spending per beneficiary for non-elderly enrollees (who are eligible for Medicare due to end-stage renal disease or disability) was $15,879 (not shown above).

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file, 2017.

TABLE 1–2

Increases to payroll tax or decreases in Part A spending needed to maintain HI Trust Fund solvency for certain time periods

To maintain HI Trust Fund solvency for:	Increase 2.9% payroll tax to:	Or decrease Part A spending by:
25 years (2020–2044)	3.67%	17.1%
50 years (2020–2069)	3.71	17.3
75 years (2020–2094)	3.66	16.0

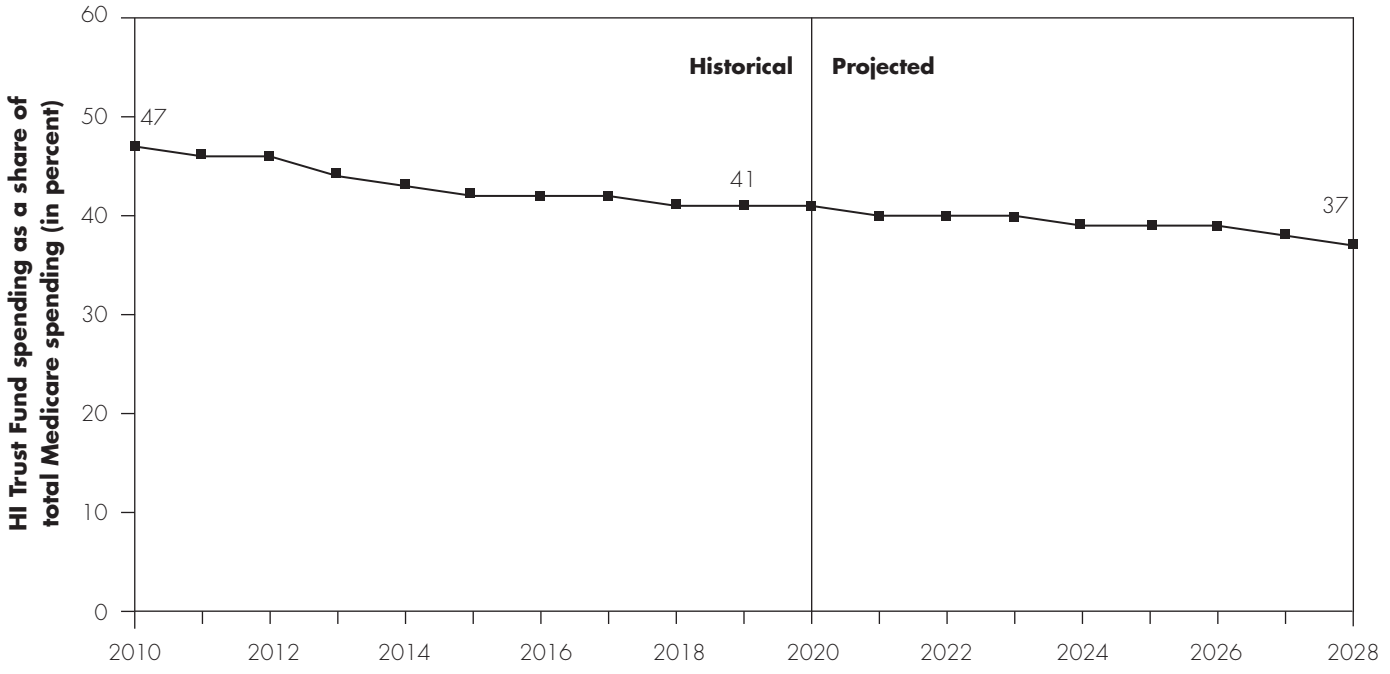
Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A. The potential effects of the coronavirus pandemic are not included in these projections.

Source: MedPAC calculations based on Table III.B8 in the 2020 annual report of the Boards of Trustees of the Medicare trust funds.

Insurance (SMI) Trust Fund. The SMI Trust Fund is not funded through dedicated taxes like the HI Trust Fund, but by premiums paid by beneficiaries and transfers from the general fund of the Treasury.[8] Since premiums and transfers are set to grow at the same rate as Part B and Part D spending, the SMI Trust Fund automatically remains solvent. However, as Part B and Part D spending rises, so do premiums and transfers from the Treasury—increasing deficits, the debt, and the strain on household budgets both of workers and retirees (Figure 1-7, p. 18).

FIGURE 1–6

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

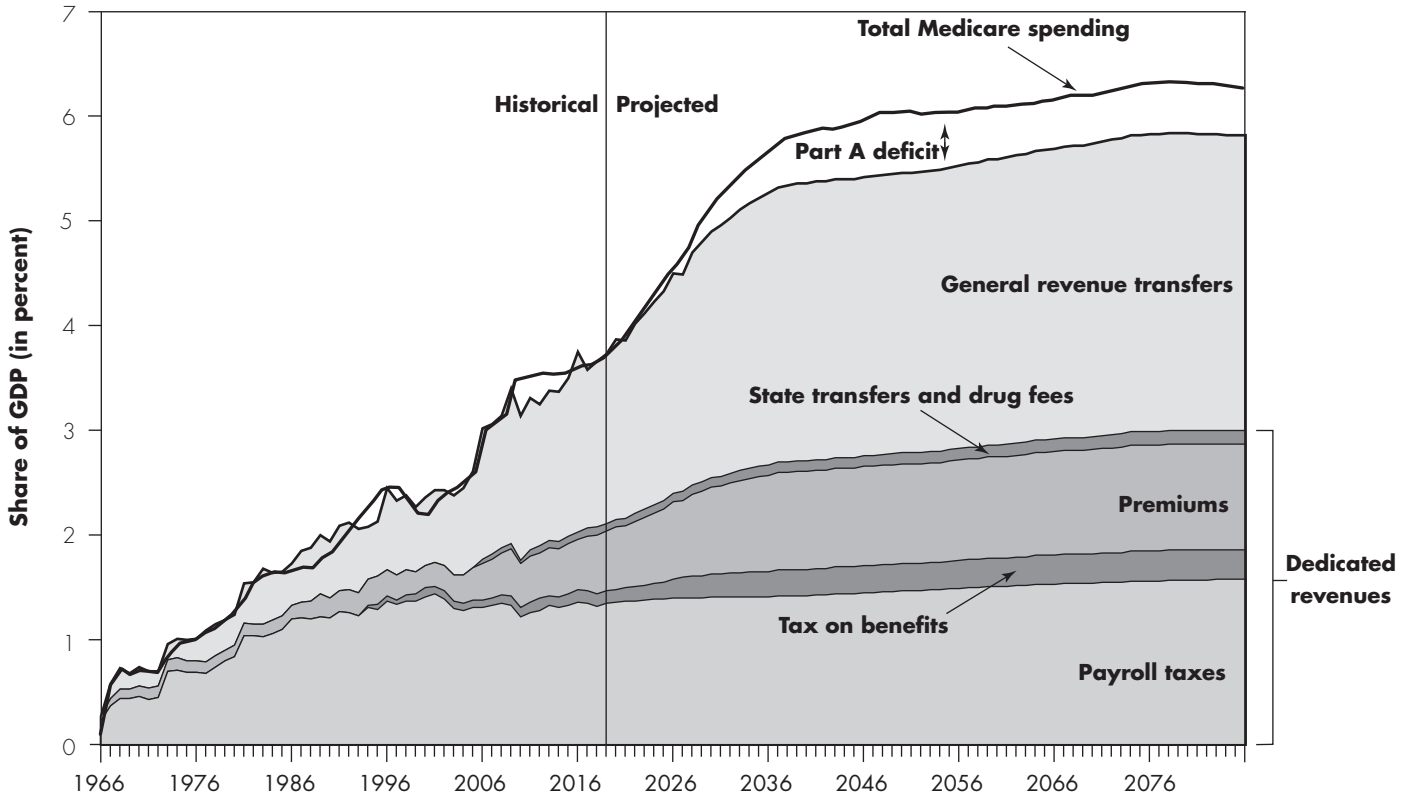


Note: HI (Hospital Insurance). Under intermediate assumptions. HI is also known as Medicare Part A. The rest of Medicare spending (Part B and Part D) is paid for through the Supplementary Medical Insurance Trust Fund. The potential effects of the coronavirus pandemic are not included in these projections.

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

FIGURE 1–7

General revenues have overtaken Medicare payroll taxes as the largest source of Medicare funding



Note: GDP (gross domestic product). These projections are based on the Trustees' intermediate set of assumptions and do not reflect the potential effects of the coronavirus pandemic. "Tax on benefits" refers to the portion of income taxes that higher income individuals pay on Social Security benefits, which is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments from the states to Medicare, 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 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.

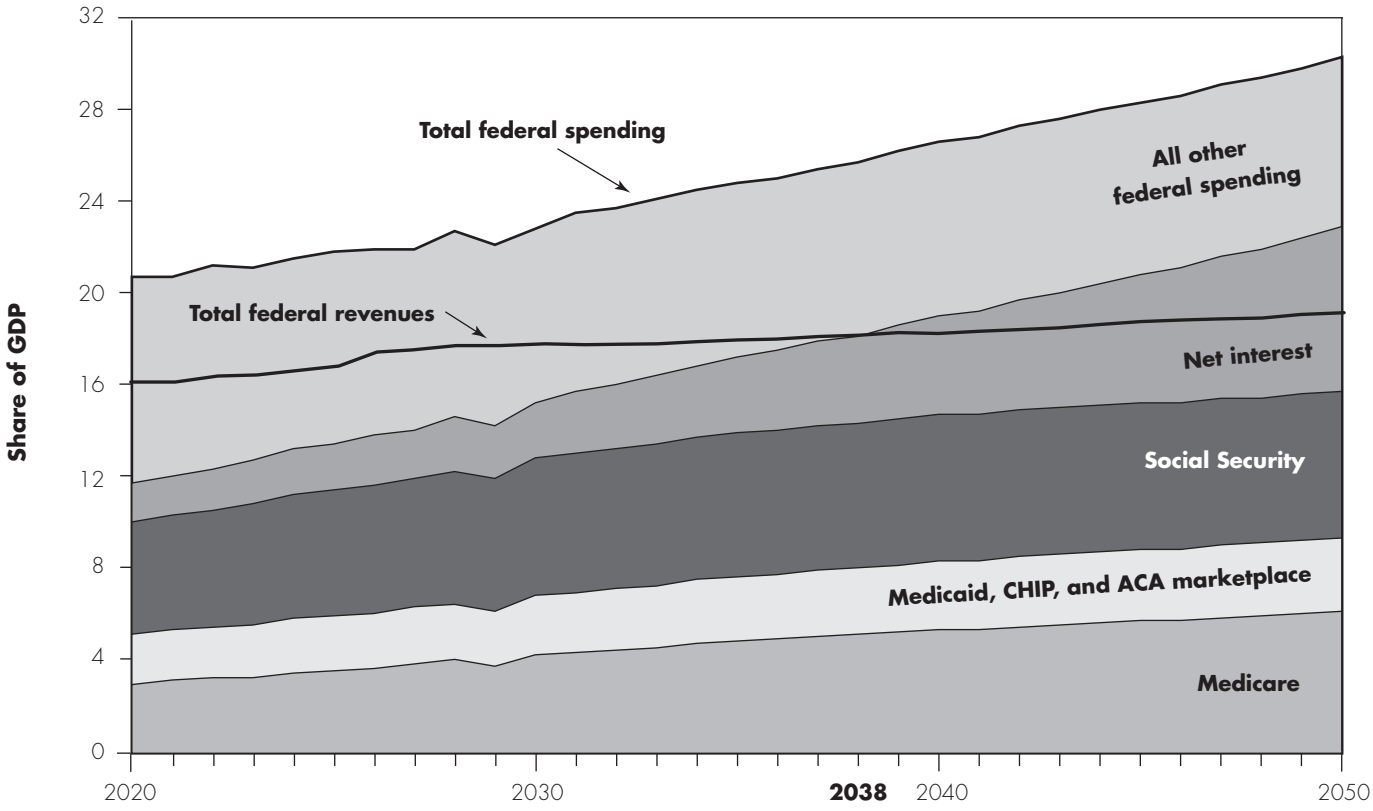
Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds.

The large and growing share of Medicare spending funded through general revenues is a financing challenge. In 2019, general revenues accounted for 43 percent of Medicare funding and, under current law, are projected to grow to 47 percent by 2029. In this context, general revenues include both general tax revenue as well as federal borrowing. As the amount of general revenues needed to finance Medicare increases, it reduces resources available for other priorities, including making investments that expand future economic output (e.g., federal investments in education, transportation, and research and development).

The increasing expenditure of general revenues is a looming problem because the federal government already spends more than it collects in revenues each year. The line at the top of Figure 1-8 represents total federal spending as a share of GDP; the line below spending represents total federal revenues (all estimated before the effects of the coronavirus pandemic). The difference between these two

FIGURE 1–8

Spending on Medicare, other major health programs, Social Security, and net interest is projected to exceed total federal revenues by 2038



Note: GDP (gross domestic product), CHIP (Children's Health Insurance Program), ACA (Affordable Care Act). The potential effects of the coronavirus pandemic are not included in these projections.

Source: Congressional Budget Office's *Long-Term Budget Projections* (published January 2020).

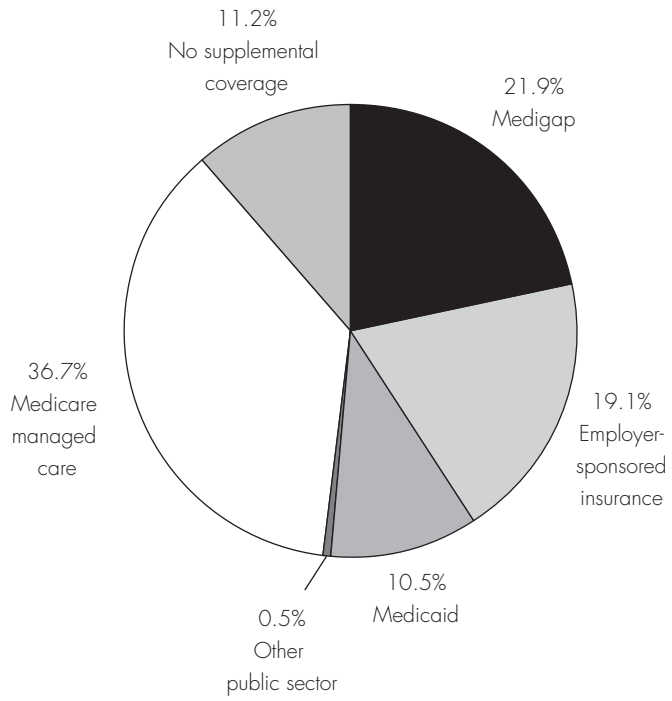
lines represents the budget deficit, which must be covered by federal borrowing. The layers below the top line in Figure 1-8 depict federal spending by program. Assuming no other policy or legislative interventions, spending on Medicare, the other mandatory programs shown in the figure, and net interest payments are projected to reach 18.3 percent of the nation's GDP by 2038 and, by themselves, will exceed total federal revenues.[9] In other words, by 2038, every dollar spent on programs funded through annual discretionary appropriations—such as the military, the national highway system, and air traffic control, just to name a few—would need to be financed through federal borrowing. That date may change (likely becoming sooner) once the impact of pandemic-related spending and revenue declines are included.

The affordability of health care for Medicare beneficiaries

As Medicare spending increases, it affects beneficiaries' ability to afford health care—by increasing their premiums (and to a lesser extent, their cost sharing, which many beneficiaries are shielded from). Beneficiaries typically do not pay premiums for Part A (hospital insurance)

FIGURE 1–9

Most Medicare beneficiaries had supplemental coverage or were enrolled in a Medicare Advantage plan that reduced their cost sharing, 2017



Note: Beneficiaries were assigned to the supplemental coverage category they were in for the most time in 2017; they could have had coverage in other categories during 2017. Analysis does not include beneficiaries living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2017 or who had Medicare as a secondary payer. Figure represents 47.4 million beneficiaries. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, survey file 2017.

coverage, but the annual cost of Part B (supplementary medical insurance) premiums is $1,735 in 2020, and the average annual cost of Part D (drug plan) premiums is $456 (Medicare Payment Advisory Commission 2020a). In addition, in 2018, cost sharing for beneficiaries in traditional Medicare averaged $415 for Part A services, $1,513 for Part B services, and $432 for beneficiaries with Part D coverage (although supplemental plans can cover beneficiaries' cost sharing). Taken together, beneficiary spending on Medicare premiums and cost sharing consumed 24 percent of the average Social Security benefit in 2020, up from 14 percent in 2000 (Boards of Trustees 2020). (These percentages do not include beneficiary spending on premiums for Medicare supplemental insurance.) The Medicare Trustees estimate that in another 20 years, premiums and cost sharing will consume 31 percent of the average Social Security benefit. (As a point of reference, Social Security benefits account for more than 60 percent of income for seniors, on average, and for 100 percent of income for more than a fifth of seniors (Social Security Administration 2016).)

Medicare uses beneficiary cost sharing, in part, to deter overuse of services. However, the effectiveness of this mechanism for discouraging unnecessary care is blunted by the fact that most beneficiaries have supplemental coverage that pays some or all of their cost sharing (Figure 1-9). Specifically, 22 percent of beneficiaries have traditional Medicare plus supplemental insurance that they purchase from private companies (Medigap plans).[10] About 37 percent of beneficiaries enroll in private MA plans or some other Medicare managed care plan.[11] Another 19 percent are insured through employer-sponsored retiree health plans that are subsidized by Medicare. And 10.5 percent of Medicare beneficiaries are dually enrolled in both Medicare and Medicaid due to low income and resources. Only 11 percent of Medicare beneficiaries are in traditional Medicare without any other type of coverage.

Medicare spending trends

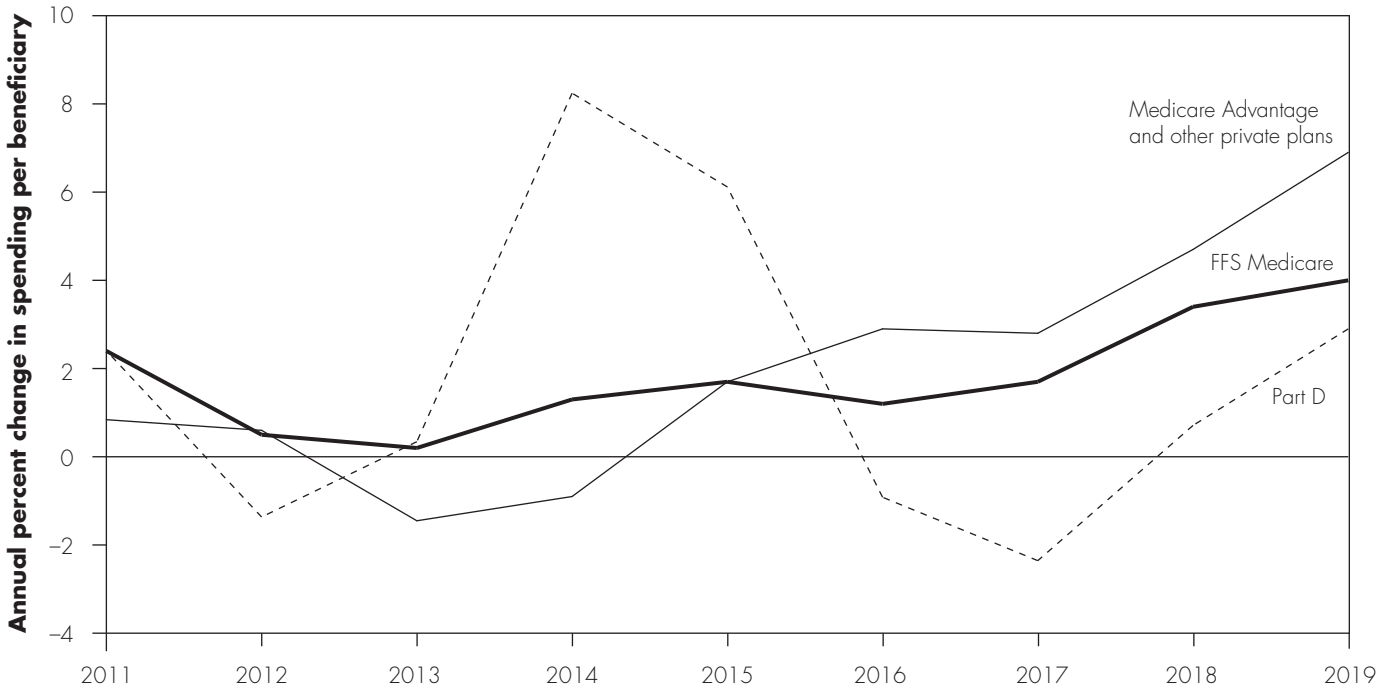
Medicare spending can be divided into three program components: traditional Medicare, Medicare Advantage (MA), and Medicare Part D prescription drug coverage.

- ***Traditional Medicare.*** In the traditional fee-for-service (FFS) Medicare program, Medicare pays health care providers directly for health care goods and services furnished to Medicare beneficiaries at prices set through legislation and regulation. In 2019, about 38 million beneficiaries had coverage through traditional Medicare, at a cost of $414 billion (Boards of Trustees 2020).[12]

- ***MA and other types of private plans.*** Beneficiaries can choose, as an alternative to traditional Medicare, to enroll in MA, which consists of private health plans that receive capitated payments per enrollee to provide Part A and Part B coverage. MA plans pay health care providers for health care goods and services furnished

FIGURE 1–10

Since 2016, spending per beneficiary on Medicare Advantage and other private plans has grown faster than other Medicare components



Note: FFS (fee-for-service), Medicare Advantage (MA). Percent change is calculated using annual spending on an incurred basis that is not risk standardized. Private plans include Medicare Advantage plans, Medicare–Medicaid Plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and cost-based (as opposed to capitated) plans. Spending per beneficiary on Medicare Advantage and 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 private health 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. 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.

Source: MedPAC analysis of data from the 2020 annual report of the Boards of Trustees of the Medicare trust funds.

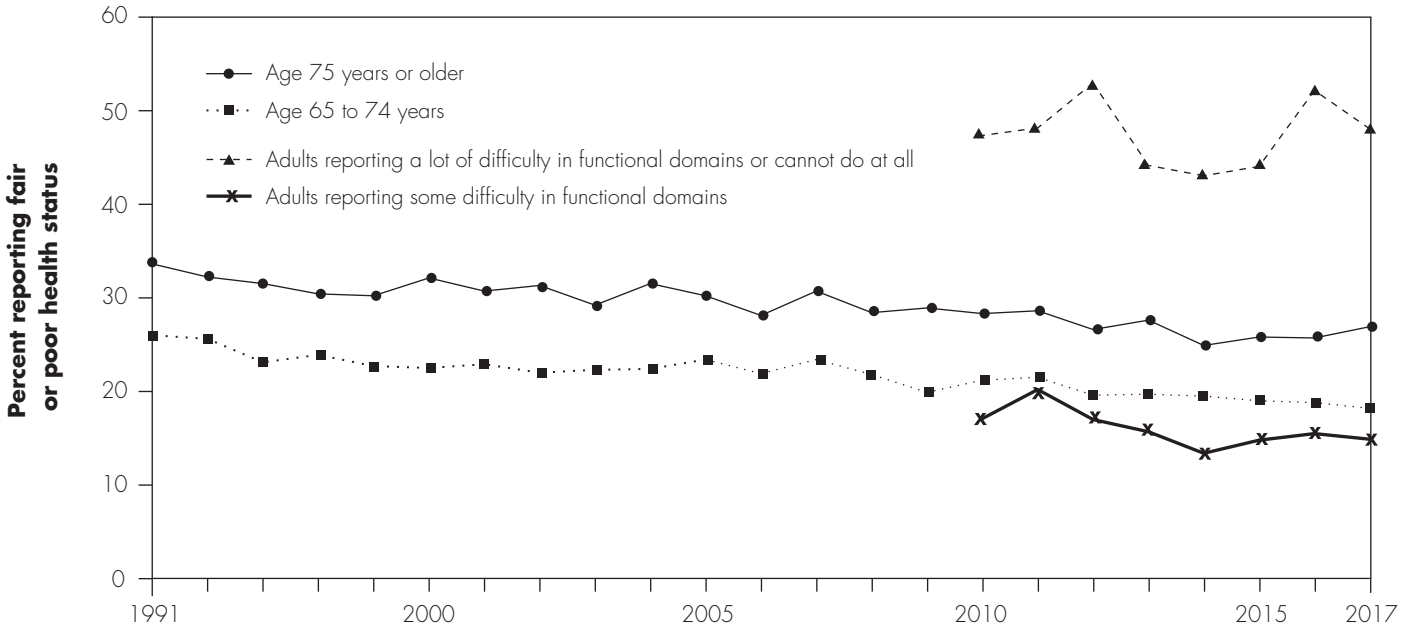
to their enrollees at prices negotiated between the plans and providers, using FFS payment approaches or other payment models such as partial capitation. MA is funded through a combination of the Hospital Insurance (Part A) Trust Fund and the Supplementary Medical Insurance (Part B) Trust Fund, just like traditional Medicare. In addition to MA, there are other types of private health plans available to Medicare beneficiaries: Medicare–Medicaid Plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and cost-based (as opposed to capitated) plans. Only about 6 percent of the beneficiaries in private plans are in non-MA plans. In 2019, Medicare spent $271 billion on MA and other types of private plans for about 23 million beneficiaries (Boards of Trustees 2020).[13]

- ***Medicare Part D prescription drug coverage.*** Through Part D, beneficiaries can obtain subsidized prescription drug coverage from private insurers by purchasing a stand-alone drug plan or by enrolling in an MA plan that includes prescription drug coverage. In 2019, Medicare spent $88 billion on Part D coverage for 47 million beneficiaries (Boards of Trustees 2020).

Growth in spending per beneficiary differs across the three program components (Figure 1-10).[14] Since 2016, spending per beneficiary (not risk standardized)

FIGURE 1–11

The share of Medicare eligibles reporting fair or poor health status has changed over time, available years 1991–2017



Note: "Adults reporting a lot of difficulty in functional domains or cannot do at all" and "Adults reporting some difficulty in functional domains" include people 18 years and older who report one or more of the following six functional limitations: seeing (even if wearing glasses), hearing (even if wearing hearing aids), mobility (walking or climbing stairs), communication (understanding or being understood by others), cognition (remembering or concentrating), and self-care (such as washing all over or dressing). These measures of functional limitations among adults 18 years and older did not begin being reported until 2010.

Source: National Center for Health Statistics, National Health Interview Survey.

in MA and other private plans has grown faster than in traditional FFS Medicare and Part D. From 2018 to 2019 alone, Medicare private plan spending per beneficiary increased by 6.9 percent, compared with 4.0 percent in FFS Medicare and 2.9 percent in Part D. The relatively faster growth in private plan spending per beneficiary in recent years at least partially reflects MA demographic changes, the increasing number of MA plans receiving higher payments due to their quality bonus status, growth in the risk scores MA plans report for their enrollees, and Medicare enrollment growth in areas of the country where MA payment benchmarks are set at 115 percent of FFS Medicare's spending per beneficiary (Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2020c, Medicare Payment Advisory Commission 2018).

Trends in Medicare beneficiaries' morbidity and mortality

In recent decades, a declining share of Medicare eligibles report being in poor health. Between 1991 and 2017, the share of people ages 65 to 74 reporting fair or poor health status declined from 26 percent to 18 percent (Figure 1-11). The share of people ages 75 and older reporting fair or poor health status also declined, from 34 percent to 27 percent. Among adults of any age who report "some" difficulty in functional domains (and thus may serve as a proxy for beneficiaries who qualify for Medicare due to disability or end-stage renal disease), the share reporting fair or poor health status has declined modestly from 2010 to 2017 (declining from 17 percent to 15 percent). Among adults who report "a lot" of difficulty in functional

TABLE 1–3

Leading causes of death at ages 65 and older, 1980 and 2017

Table 1-3a. Leading causes of death at ages 65 and older, 1980

Cause of death	Share of deaths
1. Heart disease	44.4%
2. Cancer	19.3
3. Stroke	10.9
4. Pneumonia and influenza	3.4
5. Chronic lower respiratory diseases	3.2
6. Atherosclerosis	2.1
7. Diabetes mellitus	1.9
8. Unintentional injuries	1.9
9. Nephritis, nephrotic syndrome, and nephrosis	1.0
10. Chronic liver disease and cirrhosis	0.7

Table 1-3b. Leading causes of death at ages 65 and older, 2017

Cause of death	Share of deaths
1. Heart disease	25.1%
2. Cancer	20.7
3. Chronic lower respiratory diseases	6.6
4. Stroke	6.1
5. Alzheimer's disease	5.8
6. Diabetes mellitus	2.9
7. Unintentional injuries	2.7
8. Pneumonia and influenza	2.3
9. Nephritis, nephrotic syndrome, and nephrosis	2.0
10. Septicemia	1.5

Note: "Chronic lower respiratory diseases" was formerly known as "chronic obstructive pulmonary diseases." Starting with 1999 data, the rules for selecting "chronic lower respiratory diseases" and "pneumonia" as the underlying cause of death changed, resulting in an increase in the number of deaths for chronic lower respiratory diseases and a decrease in the number of deaths for pneumonia. Therefore, trend data for these two causes of death should be interpreted with caution. Also, starting with 2011 data, the rules for selecting renal failure as the underlying cause of death were changed, affecting the number of deaths in the "nephritis, nephrotic syndrome, and nephrosis" and "diabetes mellitus" categories. The result is a decrease in the number of deaths attributed to nephritis, nephrotic syndrome, and nephrosis, and an increase in the number of deaths attributed to diabetes mellitus. Therefore, trend data for these two causes of death should also be interpreted with caution.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. https://www.cdc.gov/nchs/hus/contents2018.htm.

domains or not being able to perform them at all, 48 percent reported fair or poor health both in 2010 and 2017.

Declines in the share of people reporting fair or poor health occurred despite rising shares of people ages 65 and older having chronic conditions such as diabetes, hypertension, and high cholesterol—perhaps because these increases have coincided with increases in the share of people who have such conditions under control (Federal Interagency Forum on Aging-Related Statistics 2016, National Center for Health Statistics 2015). (Comparable information for the Medicare population under age 65 is not readily available.)

Leading causes of death

Over the past few decades, there has been little change in the leading causes of death in the U.S., with heart disease and cancer remaining the first and second leading causes of death (Table 1-3)—except in the spring and winter of 2020, when COVID-19 overtook them (Cox and Amin 2021, Hoyert 2012, National Center for Health Statistics 2018, Woolf et al. 2020a).

Some of the leading causes of death are also the most prevalent and most expensive chronic conditions among beneficiaries in traditional Medicare (Table 1-4, p. 24)—for example, heart disease (which can lead to heart failure).

Disparities among Medicare beneficiaries

Race and ethnicity are associated with variations in life expectancy. Among individuals who live to age 65, Black individuals can expect to live an additional 18 years, while White individuals can expect an additional 19 years, and Hispanic individuals can expect another 21 years (Table 1-5, p. 25).

Race and ethnicity are also associated with differences in access to care. In the Commission's 2020 telephone survey, smaller shares of Black beneficiaries reported looking for a new specialist in the past year (9 percent) compared with White beneficiaries (15 percent), and markedly higher shares of Black beneficiaries reported experiencing "a small problem" finding a new specialist compared with White beneficiaries (22 percent vs.

TABLE 1–4 **The most prevalent and costly chronic conditions in traditional FFS Medicare, 2018**

Chronic condition	Prevalence among beneficiaries in traditional Medicare	Spending per beneficiary for those with the specified condition
Five chronic conditions most prevalent among beneficiaries in traditional Medicare:		
Hypertension	58.8%	$15,514
Hyperlipidemia	49.1	14,970
Rheumatoid arthritis / osteoarthritis	34.7	16,890
Diabetes	27.7	17,380
Ischemic heart disease	27.7	21,138
Five chronic conditions with highest spending per beneficiary in traditional Medicare:		
Stroke / transient ischemic attack	3.9	34,627
Heart failure	14.5	30,940
Hepatitis (chronic viral B and C)	N/A	28,015
Chronic obstructive pulmonary disease	11.9	27,255
Atrial fibrillation	8.7	27,124

Note: FFS (fee-for-service), 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 specific condition selected because beneficiaries with any of the specific 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 standardized spending.

Source: Centers for Medicare & Medicaid Services' Chronic Condition Data Warehouse. https://www2.ccwdata.org/documents/10280/19096644/ccw-website-table-b2a.pdf; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.

8 percent). Among those beneficiaries seeking an appointment for routine care, higher shares of Hispanic beneficiaries reported waiting longer than they wanted to get such appointments (35 percent) compared with White beneficiaries (27 percent). Similarly, among those beneficiaries seeking an appointment for an illness or injury, 24 percent of Hispanic beneficiaries reported waiting longer than they wanted for such appointments, compared to only 18 percent of White beneficiaries. Given these trends, it is perhaps not surprising that lower shares of Hispanic beneficiaries reported being satisfied with their health care, compared with White beneficiaries (83 percent vs. 89 percent). All of these trends were also observed among privately insured individuals age 50 to 64, who were also included in this survey.

Differences by race and ethnicity in the level of care coordination have also been found. One study found that fewer non-White beneficiaries reported that their doctor helped manage their care and had up-to-date information on care they had received from specialists compared with White beneficiaries. The study also found that higher shares of non-White beneficiaries reported difficulty getting timely follow-up on test results (Martino et al. 2016).

Alternative payment models incentivize clinicians to deliver care more efficiently

One way traditional FFS Medicare has attempted to slow the growth in its spending is through alternative payment models (APMs). APMs are intended to give providers financial incentives to deliver care efficiently, to counteract FFS payment systems' incentives to maximize the volume

TABLE 1–5 **Years of life expectancy at age 65, by race/ethnicity and sex, 2008 to 2017**

	2008	2016	2017	Change 2008–2017 (in years)	Change 2016–2017 (in years)
All races and ethnicities, both sexes	18.8	19.4	19.4	0.6	0
White, not Hispanic, both sexes	18.8	19.4	19.3	0.5	–0.1
Black, not Hispanic, both sexes	17.4	18.1	18.1	0.7	0
Hispanic, both sexes	20.4	21.5	21.4	1.0	–0.1
All races and ethnicities, female	20.0	20.6	20.6	0.6	0
White, not Hispanic, female	20.0	20.5	20.5	0.5	0
Black, not Hispanic, female	18.8	19.5	19.5	0.7	0
Hispanic, female	21.6	22.7	22.7	1.1	0
All races and ethnicities, male	17.4	18.1	18.1	0.7	0
White, not Hispanic, male	17.4	18.0	18.0	0.6	0
Black, not Hispanic, male	15.4	16.2	16.2	0.8	0
Hispanic, male	18.7	19.8	19.7	1.0	–0.1

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

of services provided. APMs are often layered on top of traditional Medicare's FFS payment systems and are intended to give participating providers incentives to avoid low-value services, select more efficient sites of care, and possibly invest in closer management and coordination of their Medicare beneficiaries' care to reduce their need for costly types of services (e.g., hospital care). Other payers besides FFS Medicare are also experimenting with APMs to pay the providers in their networks.

The most prominent types of APMs are population-based payment models (e.g., accountable care organizations), episode-based payment models, and advanced primary care models. In population-based payment models and episode-based payment models, CMS offers participating providers bonuses (and in some models, collects financial penalties) based on the degree to which providers can keep beneficiaries' spending below a target while maintaining care quality. Advanced primary care models typically offer primary care providers supplemental monthly payments per beneficiary to expand the breadth and depth of services they offer and pay bonuses based on performance on quality measures (e.g., beneficiaries' rates of hospital utilization).

Most APMs are piloted in different parts of the country for three to six years at a time. Models are evaluated by researchers, and CMS uses findings from these evaluations to develop successor APMs that build on lessons learned. CMS is allowed to make permanent any APMs that save Medicare money while maintaining quality or that improve quality without increasing spending. Evidence analyzing the impact of APMs is still emerging, and APM impacts, even when positive, have been modest. Some types of APMs (population-based models and episode-based payment models for some conditions) have performed better than others. Despite modest effects to date, the Commission believes APMs hold great promise and is currently exploring potential improvements to APMs that could increase their success rate.

The Commission's recommendations for restraining Medicare spending growth

Several aspects of Medicare's payment systems hamper the program's ability to maximize efficiencies. The Commission highlights some of Medicare's key payment

policy challenges and recommends ways to address them below.

MEDICARE CHALLENGE: Medicare pays higher prices in some care settings than in others—for the same service. Because of the different payment systems used for different care settings, Medicare 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 more profitable setting, which leads to increased program spending and higher beneficiary cost sharing, often without any corresponding increase in quality.

- **COMMISSION RECOMMENDATIONS: Make payments site neutral.** The Commission supports equalizing payments when the same services are delivered in different care settings. In this regard, the Commission has made these recommendations:
  - ***March 2012 and March 2014—***Medicare should reduce or eliminate differences between hospital outpatient departments (HOPDs) and physician offices in payment rates for evaluation and management office visits and selected other services. (This recommendation was partially implemented: The Congress required CMS to reduce payment rates for HOPD services provided at off-campus HOPDs that began billing Medicare on or after November 2, 2015.)
  - ***March 2014—***Medicare should set long-term care hospital base payment rates for non–chronically critically ill cases equal to those of acute care hospitals and redistribute the savings to create additional inpatient outlier payments for chronically critically ill cases treated in inpatient prospective payment system hospitals. (In 2013, the Congress directed CMS to pay the standard long-term care hospital payment rate for certain beneficiaries and lower payments for beneficiaries with lower severity illnesses; this policy was phased in starting in 2016 and will be fully in effect after the coronavirus public health emergency ends.)
  - ***March 2015—***Medicare should eliminate the differences in payment rates between inpatient rehabilitation facilities and skilled nursing facilities for selected conditions.

MEDICARE CHALLENGE: Medicare undervalues primary care and overvalues specialty care. In the process of setting rates for thousands of physician fee schedule services, certain services are undervalued relative to others, which creates financial incentives to provide some services more than others. For example, the Commission has long raised concerns that the 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 2011). This imbalance leads to significantly higher incomes for clinicians in procedural specialties relative to those in primary care specialties, which contributes to a corresponding imbalance in the clinician supply. Starting in 2021, fee schedule payment rates will rise for evaluation and management office and outpatient visits (commonly provided by primary care clinicians), which will begin to address this imbalance. However, more can be done to improve the accuracy of the fee schedule and further rebalance the fee schedule toward primary care.

- **COMMISSION RECOMMENDATIONS: Improve the accuracy of payments and increase payments to primary care providers.** In this regard, the Commission has made these recommendations:
  - ***October 2011—***Regularly collect data from a cohort of efficient practices to establish more accurate relative value units (RVUs) for physician fee schedule services. Use this information to identify overpriced services and reduce their RVUs. The Congress should also specify an annual numeric goal for RVU reductions. (This recommendation was partially implemented: The Congress specified an annual numeric target for reductions to the RVUs of overpriced services, which expired at the end of 2018.)
  - ***March 2015—***Establish a prospective payment per beneficiary for primary care practitioners, funded by reducing fees for non–primary care services in the fee schedule.

MEDICARE CHALLENGE: Providers have financial incentives to selectively treat some patients over others and furnish certain types of services, regardless of clinical value. Another consequence of Medicare's payment structure is its vulnerability to providers admitting patients with certain care needs

because they are more profitable to treat than others. For example, until the skilled nursing facility and home health agency payment systems were revised, it was financially advantageous for providers to admit patients with rehabilitation care needs (and to furnish more, rather than less, therapy) and avoid medically complex patients.

- **COMMISSION RECOMMENDATIONS: Reduce incentives to treat certain types of patients and to furnish certain types of services.** In this regard, the Commission has made these recommendations:
  - ***March 2008 (and subsequent years)*—**Revise the prospective payment system for skilled nursing facilities to reduce incentives to treat rehabilitation patients over medically complex patients. (This recommendation has been implemented.)
  - ***March 2011 (and subsequent years)*—**Revise the prospective payment system for home health agencies to eliminate the use of the number of therapy visits as a factor in payment determination. (This recommendation has been implemented.)
  - ***March 2016*—**Expand the inpatient rehabilitation facility outlier pool to redistribute payments more equitably, to ease the financial burden for facilities that have a relatively high share of costly cases.
  - ***June 2016*—**Implement a unified prospective payment system for post-acute care (in place of the separate payment systems for skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals) that would base payments on patient characteristics, not the setting of care or the amount of therapy furnished to patients.

MEDICARE CHALLENGE: Spending on drugs is growing rapidly. Hospitals that participate in the 340B Drug Pricing Program qualify for deeply discounted prices from drug manufacturers, while historically, Medicare payments for Part B drugs have substantially exceeded 340B hospitals' drug acquisition costs. The Commission is also concerned about the overall price Medicare Part B pays for drugs that are administered by infusion or injection in physicians' offices and hospital outpatient departments and the lack of price competition among drugs with similar health effects. In addition, over time, changes to Medicare Part D's benefit design combined with trends in prescription drug pricing and spending have eroded plan sponsors' incentives to control costs.

- **COMMISSION RECOMMENDATIONS: Strengthen Medicare's payment systems to address rising drug prices and costs.** In this regard, the Commission has made these recommendations:
  - ***March 2016*—**Medicare should reduce payment rates for 340B hospitals' separately payable 340B drugs by 10 percent of the average sales price (ASP) and direct these program savings to hospitals with high uncompensated care costs. (In 2018, CMS reduced payment rates for some Part B drugs furnished by 340B hospitals.)
  - ***June 2017*—**Medicare should improve Part B drug payment in the short term by spurring competition, protecting Medicare beneficiaries and taxpayers from substantial price increases over time for individual drug products, and improving the accuracy of CMS's drug prices. Specifically, the Commission recommended that CMS:
    - Require manufacturers of Part B drugs to report ASP data and impose civil monetary penalties for failure to report. (Noting the Commission's concerns about manufacturers not reporting ASP data for Part B drugs, as of 2020, CMS conditioned the payment of a transitional drug add-on payment under the Part B end-stage renal disease prospective payment system on the availability of ASP data for the drug in question.)
    - Implement an ASP inflation rebate as protection against the potential for rapid price increases by manufacturers.
    - Use consolidated billing codes to pay for Part B products with a reference biologic and its associated biosimilars to spur price competition.
  - ***June 2017*—**Medicare should improve Part B drug payment in the long term by creating a voluntary market-based alternative to the current average sales price payment system: the Part B Drug Value Program (DVP). The DVP's intent is to obtain lower prices for Part B drugs by permitting private vendors to negotiate prices

with manufacturers and by improving incentives for provider efficiency through shared savings opportunities. Specifically, the Commission recommended that:

- Medicare contract with a small number of private vendors to negotiate prices for Part B drugs and biologicals.
- Vendors use tools including a formulary and, for products meeting selected criteria, binding arbitration.
- Providers purchase all DVP products at the price negotiated by their selected DVP vendor.
- Medicare pay providers the DVP-negotiated price and pay vendors an administrative fee, with opportunities for shared savings.
- Medicare payments under the DVP not exceed 100 percent of average sales price.

- ***June 2020—***Medicare should restructure Part D's benefit and its subsidies to restore the role of risk-based, capitated payments and improve pricing incentives faced by biopharmaceutical manufacturers. Specifically, the Commission recommended changes that would create a standard benefit for all enrollees, with plans responsible for substantially more insurance risk than they bear today. Instead of the coverage-gap discount, manufacturers would become responsible for at least 30 percent of catastrophic spending.

MEDICARE CHALLENGE: Medicare is required to pay providers' claims, regardless of clinical appropriateness. In traditional Medicare, providers can augment their revenue by increasing the volume of services they provide. The program's lack of utilization management can lead to overuse of services because the program pays claims for care that is "reasonable and necessary" even if that care might be considered inappropriate for a given patient. Under traditional Medicare's statute, the program generally covers services delivered by any provider who is willing to meet Medicare's participation requirements. As a result, traditional Medicare does not have the authority to develop provider networks or to credential providers—tools that private payers (including MA plans) can use to reduce the potential for overutilization as well as fraud and abuse. In some cases, the traditional Medicare program even has difficulty removing providers or suppliers whose claims histories clearly demonstrate aberrant patterns of billing, care, or both.

- **COMMISSION RECOMMENDATIONS: Scrutinize claims more closely.** In this regard, the Commission has made these recommendations:
  - ***March 2010—***Review home health agencies that exhibit unusual billing patterns and implement new safeguards—such as a moratorium on new providers, prior authorization, and suspension of prompt payment requirements—in areas that appear to be high risk.
  - ***June 2011—***Establish a prior authorization program for practitioners who order a substantially greater number of advanced imaging services than their peers.
  - ***June 2013—***Develop national guidelines for physical, occupational, and speech therapy services and implement payment edits based on these guidelines to target implausible amounts of therapy. Also use existing authorities to target high-use geographic areas and aberrant providers.
  - ***June 2013—***Promulgate national guidelines to more precisely define medical necessity requirements for ground ambulance transports and develop national edits for claims processors based on those guidelines. Identify geographic areas and ambulance suppliers and providers that display aberrant patterns of use and address clinically inappropriate use of ground transports that are nonemergency and require only basic life support.
  - ***March 2016—***Conduct focused medical record review of inpatient rehabilitation facilities that have unusual patterns of case mix and coding.
  - ***June 2019—***Develop and implement national guidelines for coding hospital emergency department visits, instead of allowing hospitals to use their own internal guidelines, which would give CMS a firmer foundation for assessing and auditing hospitals' coding behavior.

MEDICARE CHALLENGE: Medicare coverage interacts with beneficiaries' other coverage, sometimes resulting in fragmented care. While Medicare is the single largest payer in the health care sector, the policy signals from multiple payers can interact in ways that sometimes result in unintended consequences. For example, if a dual-eligible nursing home resident is hospitalized for three days, he or she would potentially qualify for a Medicare-covered skilled nursing facility stay, shifting responsibility from the Medicaid program to the Medicare program. Other care for beneficiaries who are dually eligible for Medicare and Medicaid can also be fragmented.

- **COMMISSION RECOMMENDATIONS: Encourage better integration with Medicaid.** In this regard, the Commission has made this recommendation:
  - ***March 2013*—**Require MA dual-eligible special needs plans to assume clinical and financial responsibility for Medicare and Medicaid benefits.

MEDICARE CHALLENGE: Medicare's benefit package does not protect against high out-of-pocket (OOP) costs, and many beneficiaries have limited incentives to use care efficiently. 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 not covered (for example, Medicare does not generally cover long-term care). Traditional Medicare lacks a cap on OOP costs (a feature that exists in MA plans and nearly all private insurance policies). In response, many beneficiaries purchase supplemental coverage that includes an OOP maximum. Most supplemental policies also substantially reduce or eliminate most of the beneficiary liability for coinsurance and deductibles, thereby blunting the effect of cost sharing. As a result, there is little incentive for many beneficiaries to be cost conscious—that is, to select only those services that are necessary and to choose providers who practice efficiently (Medicare Payment Advisory Commission 2012). Separately, Part D also lacks an OOP maximum on cost sharing.

- **COMMISSION RECOMMENDATIONS: Modify beneficiary cost sharing to incentivize high-value care.** In this regard, the Commission has made these recommendations:
  - ***June 2012*—**Replace the current Part A and Part B benefit design in traditional Medicare with one that would include an OOP maximum, deductibles for Part A and Part B services, and copayments that could vary by type of service and provider or be eliminated for high-value services. The Commission also recommended discouraging the purchase of Medigap plans through an additional charge on supplemental insurance.
  - ***June 2020*—**Modify the structure of the Part D benefit to include an annual OOP maximum.
  - ***March 2012, June 2016, June 2020*—**Modify the Part D low-income subsidy copayments to encourage the use of generic drugs, preferred multisource drugs, and biosimilars.

MEDICARE CHALLENGE: MA data limitations prevent study of utilization and program effectiveness. Having complete, detailed encounter data for Medicare beneficiaries enrolled in MA plans could inform improvements to MA payment policy, provide a useful comparator with the traditional Medicare program, and generate new policy ideas that could be applied more broadly to the Medicare program. However, given the data errors and omissions that the Commission found in a recent analysis, we cannot use MA encounter data for such purposes at present.

- **COMMISSION RECOMMENDATIONS: Collect more complete and accurate MA data.** In this regard, the Commission has made this recommendation:
  - ***June 2019*—**Give robust feedback to MA plans on the completeness and accuracy of their encounter data; withhold some payments from MA plans and allow plans to earn back those payments if their encounter data meet thresholds for completeness and accuracy; and, if necessary, require providers to submit MA encounter data to Medicare administrative contractors as a means of ensuring more accurate encounter data submissions.

MEDICARE CHALLENGE: Traditional Medicare lacks strong incentives to improve population-based outcomes and the coordination of care. Some key challenges for the traditional Medicare program are that providers are usually paid more for providing more

services and lack strong incentives to improve population-based outcomes or the coordination of their patients' care.

- **COMMISSION RECOMMENDATIONS: Incentivize improving population-based outcomes.** The Commission has recommended holding providers accountable for hospital readmissions, which could in turn incentivize stronger coordination of care, and has recommended new payments to encourage care coordination. In this regard, the Commission has made these recommendations:

  - ***June 2008*—**Reduce payments to hospitals with relatively high readmission rates for select conditions and allow gainsharing between hospitals and physicians.
  - ***March 2012*—**Reduce payments to skilled nursing facilities with relatively high rates of rehospitalization.
  - ***March 2014*—**Reduce payments to home health agencies with relatively high rates of hospital readmission.
  - ***March 2015*—**Establish a prospective payment per beneficiary for primary care practitioners, funded by reducing fees for non–primary care services in the fee schedule.

The Commission has also recommended adopting value-based payment programs based on meaningful measures. In this regard, the Commission has made these recommendations:

- ***March 2012*—**Implement a value-based purchasing program for ambulatory surgical center services.
- ***March 2018*—**Eliminate the current Merit-based Incentive Payment System for clinicians in traditional Medicare and replace it with a new voluntary value program in which clinicians in voluntary groups can qualify for a value payment based on their group's performance on a set of population-based measures.
- ***March 2019*—**Replace Medicare's current hospital quality programs with a new hospital value incentive program that:
  - includes a small set of population-based outcome, patient experience, and value measures;
  - scores all hospitals based on the same absolute and prospectively set performance targets; and
  - accounts for differences in patients' social risk factors by distributing payment adjustments through peer grouping.

Beyond these recommended changes to Medicare's payment systems, the Commission also seeks to influence payment rates in each of Medicare's payment systems through the annual recommendations we include in our March reports. These recommendations are based on our review of the latest available data and are aimed at obtaining good value for the program's expenditures—which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. ■

Endnotes

1 To put these numbers into some perspective, the over-65 age category accounted for 75 percent of total deaths in the first week of February 2020, which had no reported COVID-19 deaths (National Center for Health Statistics 2020).

2 The Kaiser Family Foundation's analysis of long-term care and assisted living facilities includes nursing facilities, assisted living facilities, adult care centers, intermediate care facilities, and/or other long-term care facilities.

3 The HI Trust Fund's income derives from several sources, including payroll taxes, taxation of Social Security benefits (7 percent of the Trust Fund's income in 2019), interest earned on Trust Fund investments (3 percent in 2019), and premiums collected from voluntary participants (1 percent in 2019). The Supplemental Medical Insurance Trust Fund is discussed later in this section of the chapter.

4 Baby boomers are people born between the years 1946 and 1964.

5 The most concentrated markets have a Herfindahl–Hirschman Index above 5,000, meaning in a market with two systems, one of the systems has more than a 50 percent market share; these have been referred to as "super-concentrated" markets (Fulton et al. 2018).

6 Workers and their employers split the cost of the payroll tax (workers pay 1.45 percent and employers pay the remaining 1.45 percent). Meanwhile, self-employed people pay both the worker's and the employer's share of this tax, totaling 2.9 percent of their net earnings. High-income workers pay an additional 0.9 percent of their earnings above $200,000 for single workers or $250,000 for married couples filing joint income tax returns.

7 The Congressional Budget Office provides a range of the expected change in Medicare spending for each of the Commission's recommendations separately, without taking into account interactions between the recommendations and without formal legislative language.

8 For Part B, the beneficiary premium equals 25 percent of projected program spending. For Part D, the beneficiary premium share is based on 25.5 percent of the average cost of the basic benefit.

9 Other major health programs include Medicaid, the Children's Health Insurance Program, and federal subsidies for the federal and state exchanges created under the Affordable Care Act. These programs are considered "mandatory" programs; their spending levels are determined by the number of people entitled by law to enroll in such programs and are not subject to the spending limits that apply to "discretionary" programs funded through the annual appropriations process.

10 Some Medigap plans nearly eliminate cost sharing and any disincentive to overuse services, while others maintain higher levels of cost sharing.

11 Medicare managed care includes Medicare Advantage, health care prepayment, and cost plans.

12 The Trustees' estimates of spending in the traditional Medicare program include, but do not break out, spending on accountable care organizations, which have grown to represent a significant share of program spending.

13 The amount of spending on MA in 2019 that we identify in this chapter slightly differs from the amount reported in the MA chapter of the Commission's March 2020 report. Our March 2020 MA chapter presents a preliminary estimate from CBO, whereas this chapter presents a subsequent estimate released by the Medicare Trustees.

14 Spending per beneficiary on MA and 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 private health 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. 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.

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