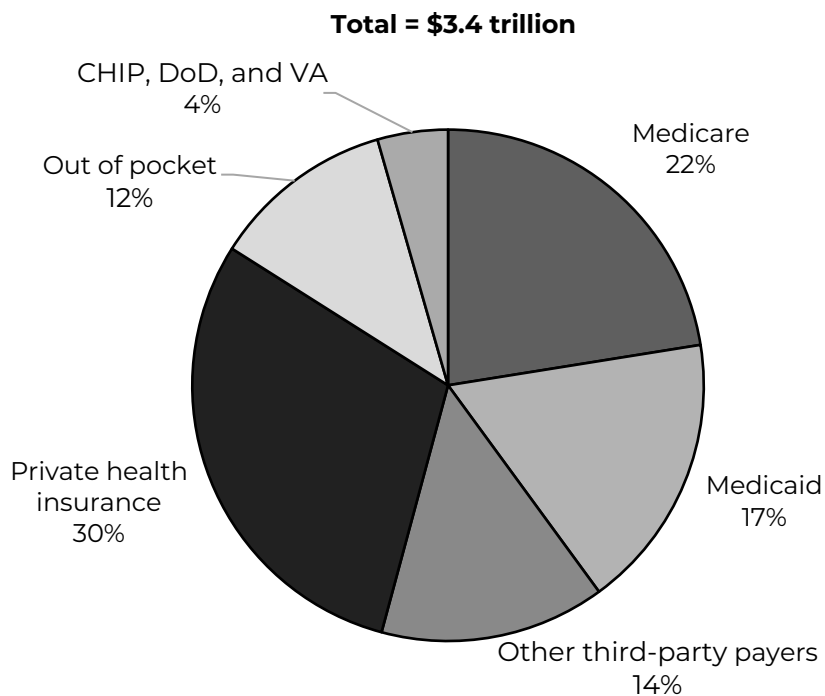


SECTION

1

**National health care and
Medicare spending**

Chart 1-1. Medicare was the largest single purchaser of personal health care, 2020

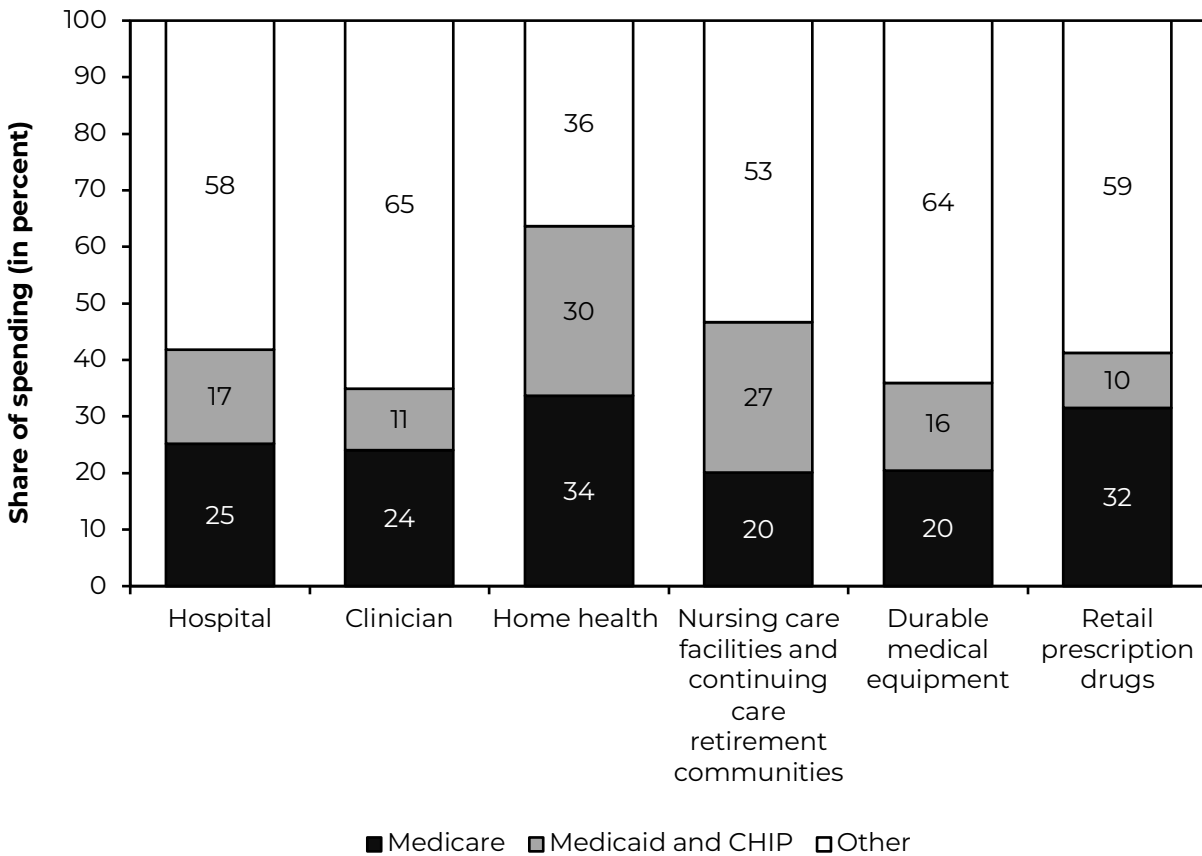


Note: CHIP (Children’s Health Insurance Program), DoD (Department of Defense), VA (Department of Veterans Affairs). “Personal health care” is a subset of national health expenditures that comprises spending for all medical goods and services that are provided for the treatment of an individual. “Out-of-pocket” spending includes cost sharing for both privately and publicly insured individuals. Premiums are included in the shares of each program (e.g., Medicare, private health insurance) rather than in the share of the “out-of-pocket” category. “Other third-party payers” includes worksite health care, other private revenues, Indian Health Service, workers’ compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs (including COVID-19 Paycheck Protection Program loans and the Provider Relief Fund), the Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

Source: CMS Office of the Actuary, Table 6: Personal Health Care Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2020, released December 2021, <https://www.cms.gov/files/zip/nhe-tables.zip>.

- Medicare is the largest single purchaser of health care in the U.S. (Although the share of spending accounted for by private health insurance is greater than Medicare’s share, private health insurance is not a single purchaser of health care; rather, it includes many private plans, including managed care, self-insured health plans, and indemnity plans.) Of the \$3.4 trillion spent on personal health care in 2020, Medicare accounted for 22 percent, or \$754.5 billion. This amount comprises spending on direct patient care and excludes administrative and business costs.
- Private health insurance plans financed 30 percent of total personal health care spending, and consumer out-of-pocket spending (not including premiums) amounted to 12 percent.
- In this chart, enrollees’ premium contributions are included in the spending category of their insurance type.

Chart 1-2. Medicare’s share of spending on personal health care varied by type of service, 2020

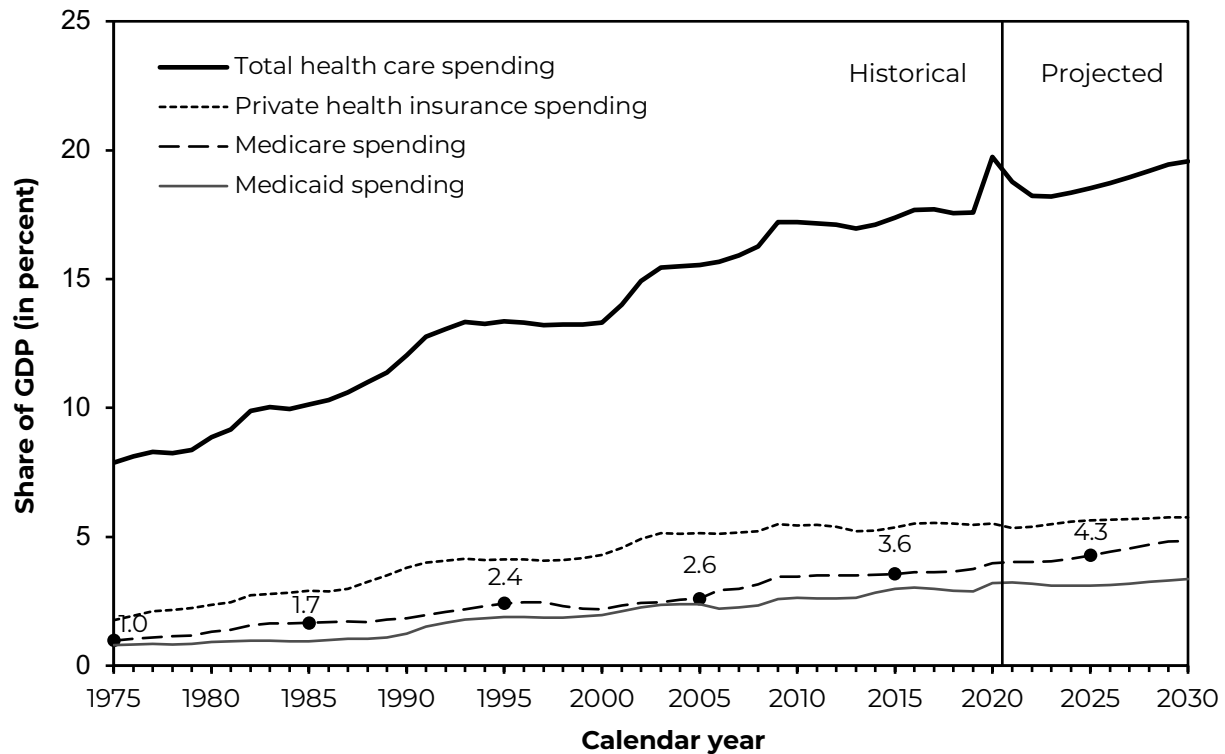


Note: CHIP (Children’s Health Insurance Program). “Personal health care” is a subset of national health expenditures that comprises spending for all medical goods and services that are provided for the treatment of an individual. “Other” includes private health insurance, out-of-pocket spending, and other private and public spending. Other service categories included in personal health care that are not shown here are other professional services; dental services; other health, residential, and personal care; and other nondurable medical equipment.

Source: CMS Office of the Actuary, National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960 to 2020, released December 2021, <https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2020.zip>.

- While Medicare’s share of total personal health care spending was 22 percent in 2020 (see Chart 1-1), its share of spending by type of service varied, from 20 percent of spending on durable medical equipment to 34 percent of spending on home health care.
- Medicare’s share of spending on nursing care facilities and continuing care retirement communities was smaller than Medicaid’s share. Medicare pays for nursing home services only for Medicare beneficiaries who require skilled nursing or rehabilitation services, whereas Medicaid pays for custodial care (assistance with activities of daily living) provided in nursing homes for people with limited income and assets.

Chart 1-3. Health care spending has consumed an increasing share of the country's GDP

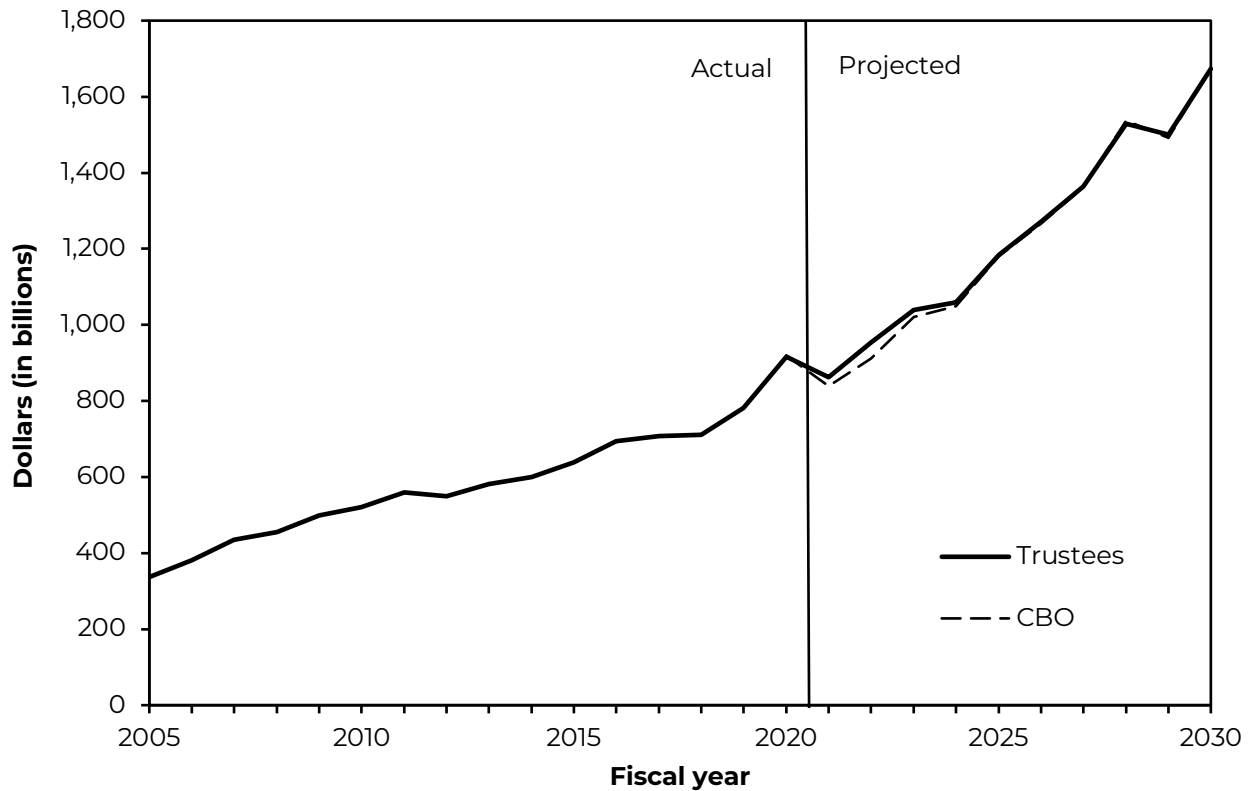


Note: GDP (gross domestic product).

Source: CMS Office of the Actuary, National Health Expenditure Data, historical data released December 2021 and projections released April 2022, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata>.

- In 2020, total health care spending made up 19.7 percent of the country's GDP—driven upward by one-time spending prompted by the COVID-19 pandemic.
- Private health insurance spending constituted 5.5 percent of GDP spending in 2020, Medicare constituted 4.0 percent, and Medicaid constituted 3.2 percent.
- Over time, Medicare spending has accounted for an increasing share of GDP. From 1 percent in 1975, it is projected to reach nearly 5 percent of GDP by 2030.
- One of the drivers of Medicare spending growth between now and 2030 is the continued aging of the baby-boom generation into the Medicare program, which began in 2011. By 2030, all baby boomers will have reached Medicare-eligibility age.

Chart 1-4. The Medicare Trustees and CBO both project Medicare spending to exceed \$1 trillion by 2023



Note: CBO (Congressional Budget Office). All data are nominal, mandatory outlays (benefit payments plus mandatory administrative expenses) by fiscal year.

Source: Congressional Budget Office's July 2021 baseline spending projections for Medicare, <https://www.cbo.gov/system/files/2021-07/51302-2021-07-medicare.xlsx>; the 2021 annual report of the Boards of Trustees of the Medicare trust funds.

- Medicare spending has more than doubled since 2005, increasing from \$337 billion to over \$800 billion by 2021. (Medicare spending reached \$919 billion in 2020 due to one-time spending prompted by the COVID-19 pandemic.)
- The Medicare Trustees and CBO both project that Medicare spending between 2020 and 2030 will grow at an average annual rate of 6.2 percent. Medicare spending will reach \$1 trillion by 2023 under both sets of projections.

Chart 1-5. Factors contributing to Medicare’s projected spending growth, 2021–2030 (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%	2.1%	–0.6%	2.4%	3.8%
Part B	–1.2	2.2	–0.2	5.1	6.0
Part D	–0.4	2.4	–0.2	1.8	3.5
Total*	–0.7	N/A**	–0.4	3.6	4.7

Note: N/A (not available). Includes Medicare Advantage enrollees. “Medicare prices” reflects 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. Part A prices are expected to decrease to a smaller degree than Part B and Part D in part due to statutorily required increases. Specifically, in each of fiscal years 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” is the residual after the other three factors shown in the table (growth in “Medicare prices,” “number of beneficiaries,” and “beneficiary demographic mix”) are removed. Much of the 2.4 percent projected increase in Part A “volume and intensity” may be due to increased coding of hospital severity of illness, which could reflect real changes in patients’ needs, changes in coding practices, or both; the 2.4 percent projected increase is not likely to reflect growth in volume per capita, given that the number of discharges per beneficiary has been declining for several decades. Figures in the “Medicare’s projected spending” column are the product of the other columns in the table.

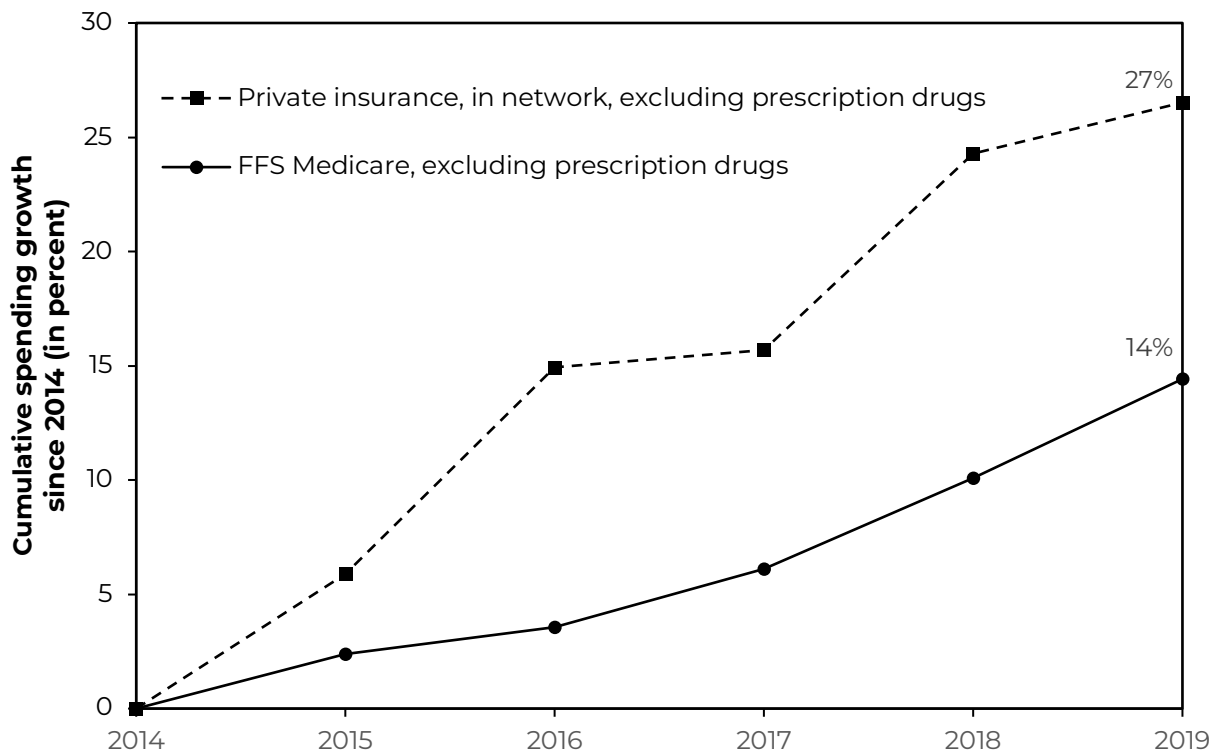
* The “total” row is the sum of the other rows of the table, each weighted by their part’s share of total Medicare spending in 2020 (as measured by shares of gross domestic product).

** We are unable to calculate the total contribution to projected spending growth made by the growth in “Number of beneficiaries” because there is beneficiary overlap in enrollment in Part A, Part B, and Part D.

Source: MedPAC analysis of data from the 2021 annual report of the Boards of Trustees of the Medicare trust funds.

- Medicare’s spending is projected to grow 4.7 percent per year, on average, between 2021 and 2030 (not including growth due to general economy-wide inflation).
- Medicare’s projected spending growth is driven by growth in the number of beneficiaries (expected to increase by a little more than 2 percent per year over this period) and growth in the volume and intensity of services delivered per beneficiary (expected to rise by 3.6 percent per year).
- Unlike in the private health care sector, price growth is not expected to drive Medicare’s increased spending because Medicare is able to administratively set prices for many health care providers.

Chart 1-6. Health care spending per enrollee grew faster for those who were privately insured than for beneficiaries in traditional FFS Medicare, 2014–2019

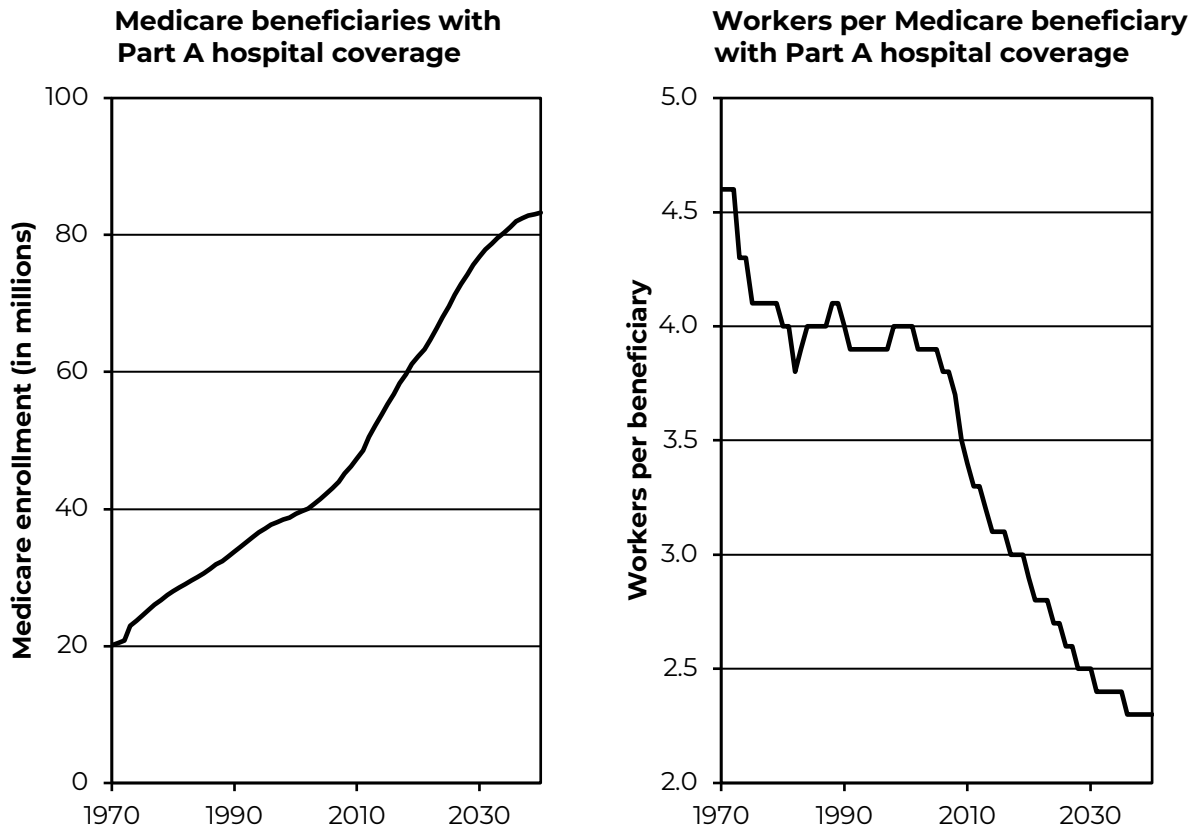


Note: FFS (fee-for-service). The figure shows cumulative growth since 2014. It reflects payments to providers from health insurers and patients (i.e., cost sharing) but not payments from other sources (e.g., workers' compensation or auto insurance). Data for spending on retail prescription drugs is not 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. "Private insurance" reflects spending contributed by national and regional plans and third-party administrators nationwide for adults ages 18 to 64 in self-insured plans (i.e., employer self-funded plans) and fully insured plans, including individual and group plans, marketplace plans, and Medicare Advantage plans for non-elderly disabled individuals. The figure reflects spending for individuals with full-year insurance coverage (including individuals with \$0 of health care spending).

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.

- Between 2014 and 2019, total health care spending per enrollee (including cost sharing) grew 27 percent for people with private insurance, compared with 14 percent for beneficiaries with traditional FFS Medicare coverage.
- Increased prices were largely responsible for spending growth in the private sector. One key driver of the private sector's higher prices has been provider market power. Hospitals and physician groups have increasingly consolidated, in part to gain leverage over insurers in negotiating higher payment rates. By 2017, 57 percent of hospital markets were so concentrated that one health system in the market produced a majority of the market's hospital discharges (data not shown). Studies have found that prices paid by private payers tend to increase as provider consolidation increases.

Chart 1-7. The declining ratio of workers to Medicare beneficiaries threatens the Medicare program’s financial stability

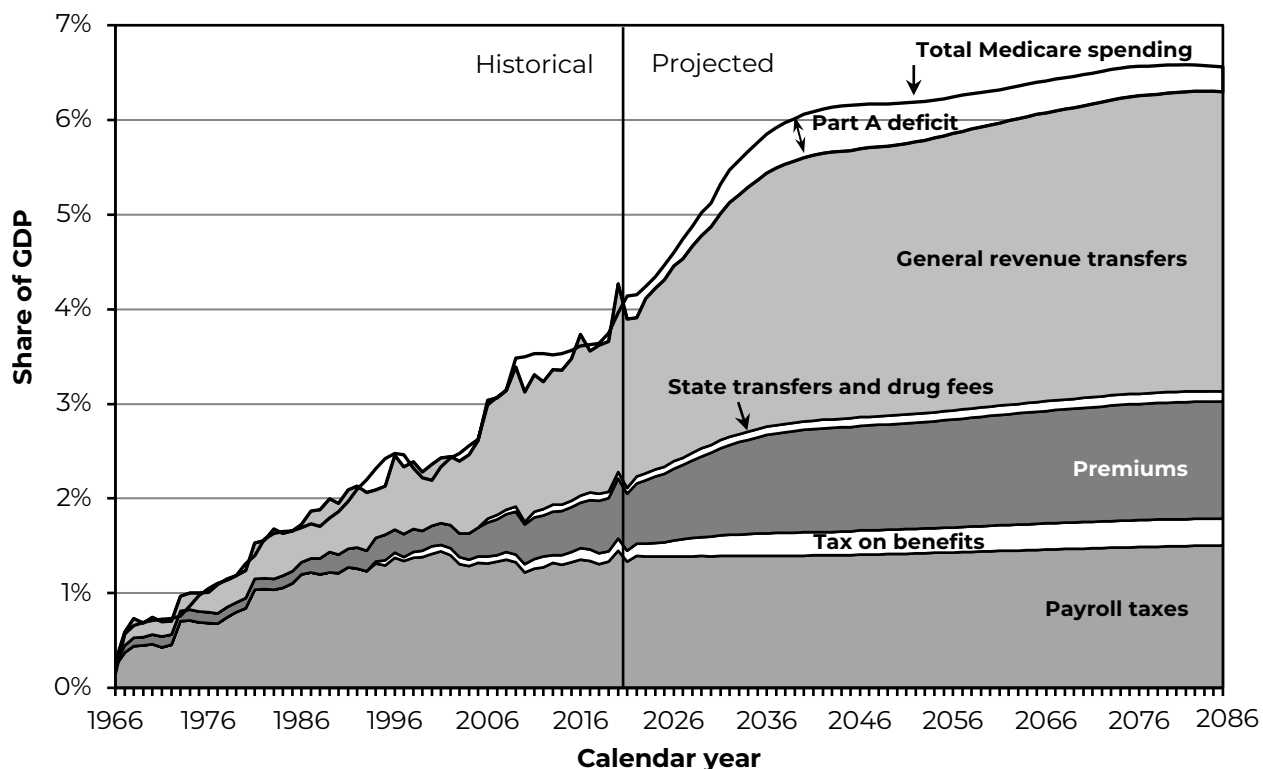


Note: Part A Hospital Insurance is largely financed by Medicare payroll taxes paid by workers. More beneficiaries have Part A Hospital Insurance than Part B Supplemental Medical Insurance. Part A Hospital Insurance is usually available to fee-for-service (FFS) Medicare beneficiaries at no cost, while FFS beneficiaries usually pay a premium for Part B Supplemental Medical Insurance. Medicare Advantage enrollees are considered to have both Part A and Part B coverage and are included in the above graphs.

Source: The 2021 annual report of the Boards of Trustees of the Medicare trust funds.

- As the baby-boom generation ages, enrollment in the Medicare program is surging. By 2030, all baby boomers will have reached the age of eligibility for the Medicare program, and 77 million beneficiaries are expected to have Medicare Part A Hospital Insurance—up from 62 million beneficiaries in 2020.
- While Medicare enrollment is rising, the number of workers per beneficiary is rapidly declining. Part A Hospital Insurance is primarily financed by workers’ Medicare payroll taxes. However, the number of workers per Medicare beneficiary with Part A Hospital Insurance has declined from 4.6 in the early years of the program to 2.9 in 2020 and is projected to fall to 2.5 by 2030.

Chart 1-8. Medicare is mainly financed by general tax revenues, Medicare payroll taxes, and beneficiary premiums



Note: GDP (gross domestic product). These 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 the interest earned on trust fund investments (which makes up 1 percent of the Hospital Insurance Trust Fund's income and is expected to decline in coming years as trust fund assets decline).

Source: The 2021 annual report of the Boards of Trustees of the Medicare trust funds.

- Medicare spending accounted for 4.0 percent of GDP in 2020. By 2030, the Medicare Trustees project that Medicare's share of GDP will rise to 4.8 percent.
- In the early years of the Medicare program, Medicare payroll taxes deposited into the Hospital Insurance Trust Fund (which finances Part A) were the main source of funding for the Medicare program, but beginning in 2009, general revenue transfers (which help finance Part B and Part D) became the largest single source of Medicare funding. General revenue transfers are expected to grow to 51 percent of Medicare financing by 2031.
- As more general revenues are devoted to Medicare, fewer general tax revenues will be available to invest in growing the economic output of the country or supporting other national priorities.

Chart 1-9. The Medicare payroll tax will need to increase and/or Part A spending will need to decrease to maintain the solvency of Medicare’s Hospital Insurance Trust Fund

To maintain Hospital Insurance Trust Fund solvency for:	Increase 2.9% payroll tax to:	Or decrease Part A spending by:
25 years (2020–2044)	3.71%	17.8%
50 years (2020–2069)	3.73	17.7
75 years (2020–2094)	3.67	16.2

Source: MedPAC analysis of Table III.B8 in the 2021 annual report of the Boards of Trustees of the Medicare trust funds.

- Medicare’s Hospital Insurance Trust Fund helps pay for Part A services such as inpatient hospital stays, post-acute care provided by skilled nursing facilities, and hospice services. The trust fund is mainly financed through a dedicated payroll tax (i.e., a tax on wage earnings).
- Payroll tax revenues are not growing as fast as Part A spending, and Medicare often spends more on Part A services than it collects through trust fund revenues—creating annual deficits. 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. Medicare’s Trustees estimate that by 2026, the Hospital Insurance Trust Fund’s prior surpluses will be depleted—meaning it will be unable to fully cover its obligations. The Congressional Budget Office also tracks the trust fund’s financial status and projects that it will become insolvent within a similar time frame, by 2027.
- To keep the trust fund solvent over the next 25 years, the Medicare Trustees estimate that either the Medicare payroll tax would need to be increased immediately from its current rate of 2.9 percent to about 3.7 percent or Part A spending would need to be permanently reduced by about 18 percent (about \$70 billion in 2022). Alternatively, some combination of smaller tax increases and smaller spending reductions could be used to achieve solvency.

Chart 1-10. Medicare Part A and Part B benefits and cost sharing per FFS beneficiary, 2020

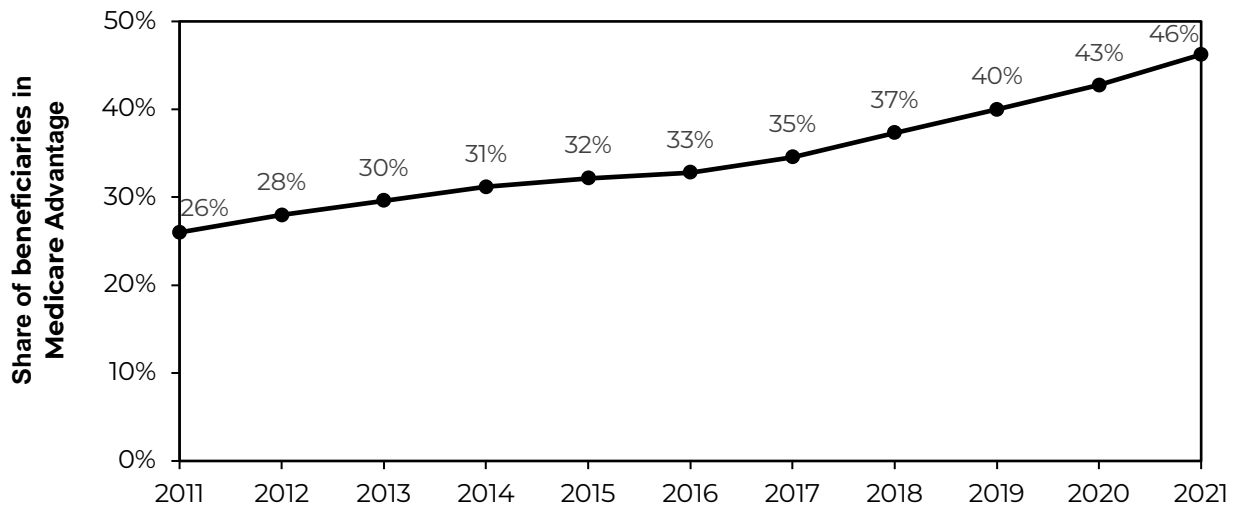
	Average benefit in 2020 (in dollars)	Average cost sharing in 2020 (in dollars)
Part A	\$5,003	\$383
Part B	5,959	1,469

Note: FFS (fee-for-service). Dollar amounts are nominal for FFS Medicare only and do not include Part D. “Average benefit” represents amounts paid for covered services per FFS beneficiary and excludes administrative expenses. “Average cost sharing” represents the sum of deductibles, coinsurance, and balance billing paid for covered services per FFS beneficiary and excludes all monthly premiums. The “Part A” row reflects spending for 37 million beneficiaries with Part A, and the “Part B” row reflects spending for 32 million beneficiaries with Part B.

Source: CMS, Medicare Part A and Part B Summary, 2020, <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/medicare-part-a-part-b-all-types-of-service>.

- In calendar year 2020, the Medicare program made \$5,003 in Part A benefit payments and \$5,959 in Part B benefit payments, on average, per FFS beneficiary.
- Beneficiaries owed an average of \$383 in cost sharing for Part A and \$1,469 in cost sharing for Part B that year. (Cost sharing excludes monthly premiums.)
- These amounts are all down slightly from 2019, which could reflect reduced health care usage in the early months of the COVID-19 pandemic in 2020.
- To cover some cost-sharing requirements, 90 percent of beneficiaries had coverage that supplemented or replaced the Medicare benefit package in 2019, such as Medicare Advantage, Medigap coverage, supplemental coverage through former employers, or Medicaid (see Chart 3-1).

Chart 1-11. The share of Medicare beneficiaries enrolled in Medicare Advantage has grown rapidly

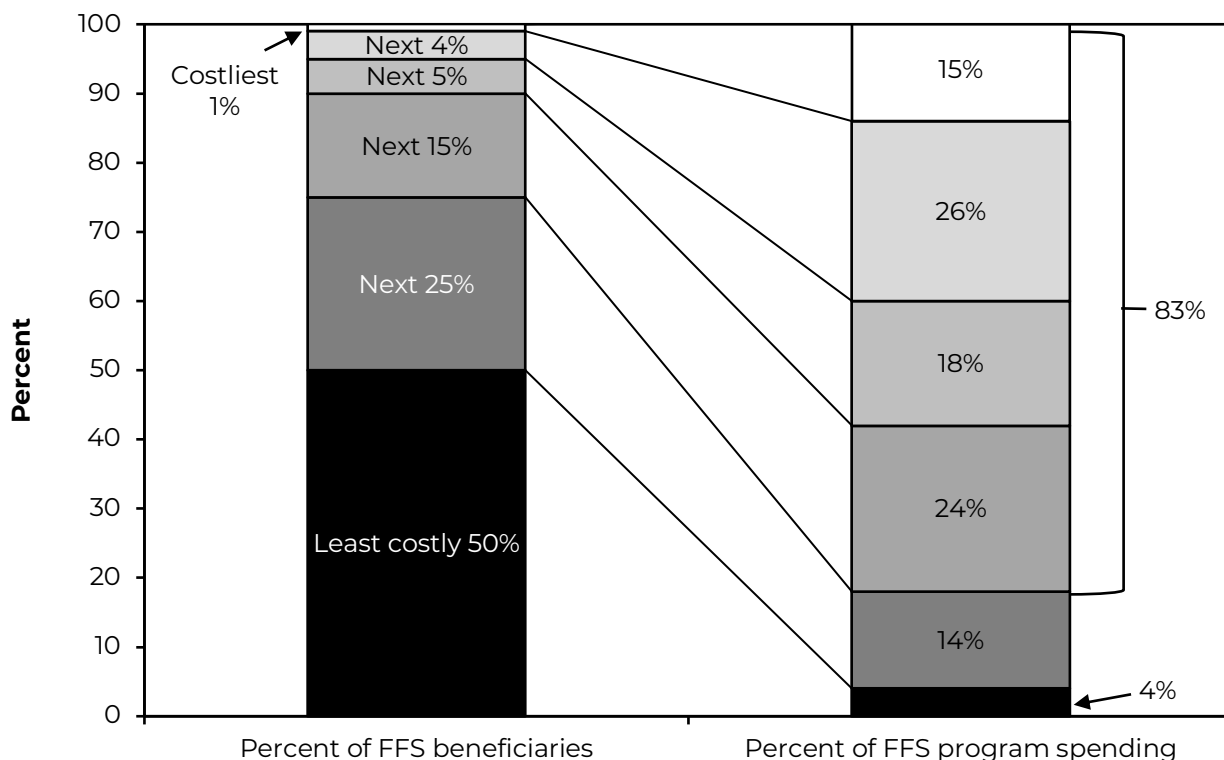


Note: Figure shows share of Medicare beneficiaries enrolled in Medicare Advantage plans, from among those beneficiaries with both Part A and Part B coverage. For detailed information on Medicare Advantage enrollment, see Section 9 of this report.

Source: MedPAC analysis of CMS enrollment files, July 2011–2021.

- The share of Medicare beneficiaries with both Part A and Part B coverage who chose to enroll in Medicare Advantage (MA) plans grew rapidly from 2011 to 2021—rising from 26 percent to 46 percent.
- Since 2016, spending per beneficiary (not risk standardized) in MA and other private plans has grown faster than in traditional fee-for-service (FFS) Medicare. From 2018 to 2019 alone, Medicare private plan spending per beneficiary rose 7.7 percent, compared with 3.5 percent in FFS Medicare (data not shown). (Medicare private plan spending includes spending on extra benefits that nearly all private plans provide.)
- The relatively faster growth in private plan spending per beneficiary in recent years at least partially reflects MA demographic changes, the growing 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.

Chart 1-12. FFS program spending was highly concentrated in a small group of beneficiaries, 2019



Note: FFS (fee-for-service). Analysis excludes beneficiaries with any enrollment in a Medicare Advantage plan or other health plan that covers Part A and Part B services (e.g., Medicare cost plans, Medicare–Medicaid Plans, and Medicare and Medicaid’s Program of All-Inclusive Care for the Elderly [PACE]). Percentages in second bar do not sum due to 100 percent due to rounding. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, 2019.

- Medicare FFS spending is concentrated among a small number of beneficiaries. In 2019, the costliest 5 percent of beneficiaries (i.e., adding the costliest 1 percent and the next-costliest 4 percent at the top of the bar at left) accounted for 41 percent of annual Medicare FFS spending. The costliest 25 percent of beneficiaries accounted for 83 percent of Medicare spending. The least costly 50 percent of beneficiaries accounted for only 4 percent of FFS spending.
- Costly beneficiaries tend to be those who have multiple chronic conditions, are using inpatient hospital services, are dually eligible for Medicare and Medicaid, and are in the last year of life.