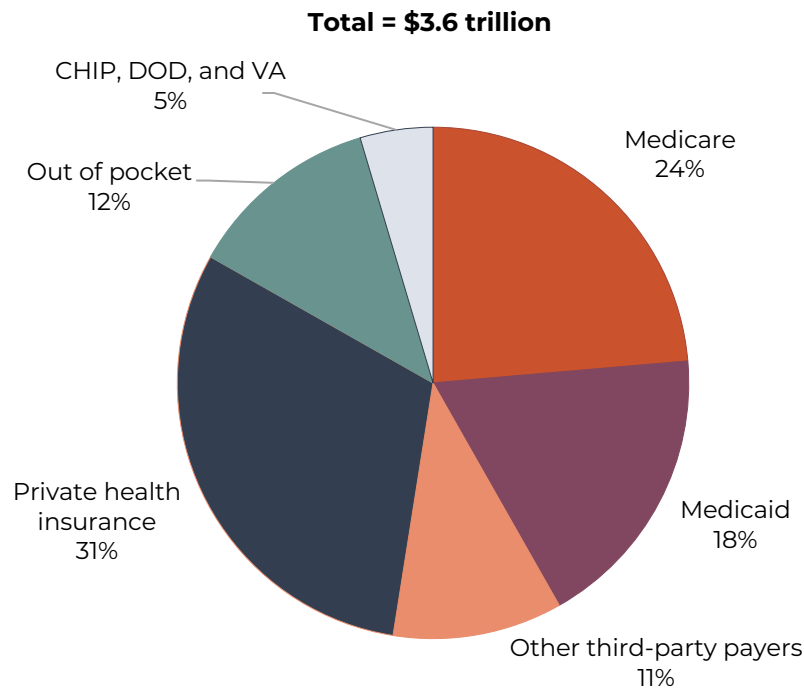


SECTION

1

National health care and Medicare spending

Chart 1-1 Medicare was the largest single purchaser of personal health care in the U.S., 2021

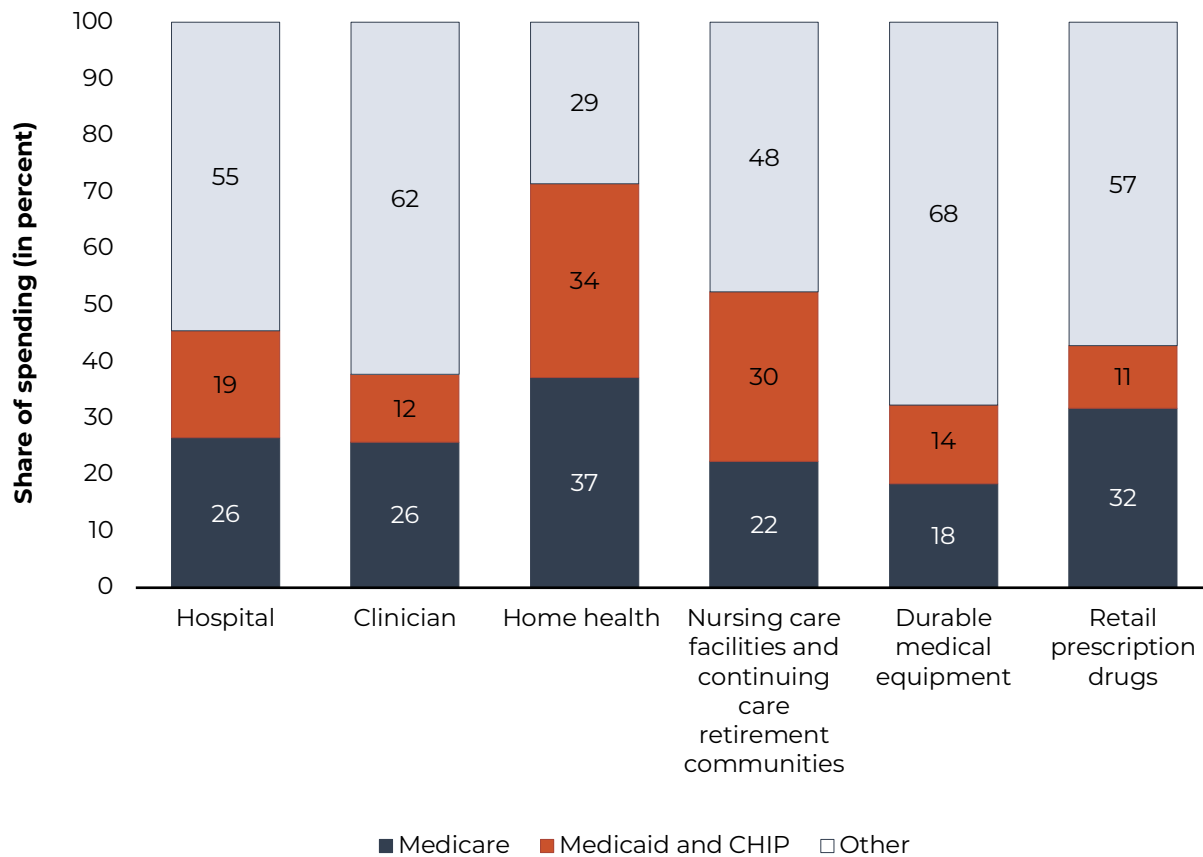


Note: CHIP (Children’s Health Insurance Program), DoD (Department of Defense), VA (Department of Veterans Affairs). “Personal health care” is a subset of national health expenditures that comprises spending for all medical goods and services that are provided for the treatment of an individual. “Out-of-pocket” 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 “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 1970–2021, released December 2022, <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 \$3.6 trillion spent on personal health care in 2021, Medicare accounted for 24 percent, or \$840 billion. This amount comprises spending on direct patient care and excludes administrative and business costs.
- > Private health insurance plans financed 31 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 national spending on personal health care varied by type of service, 2021

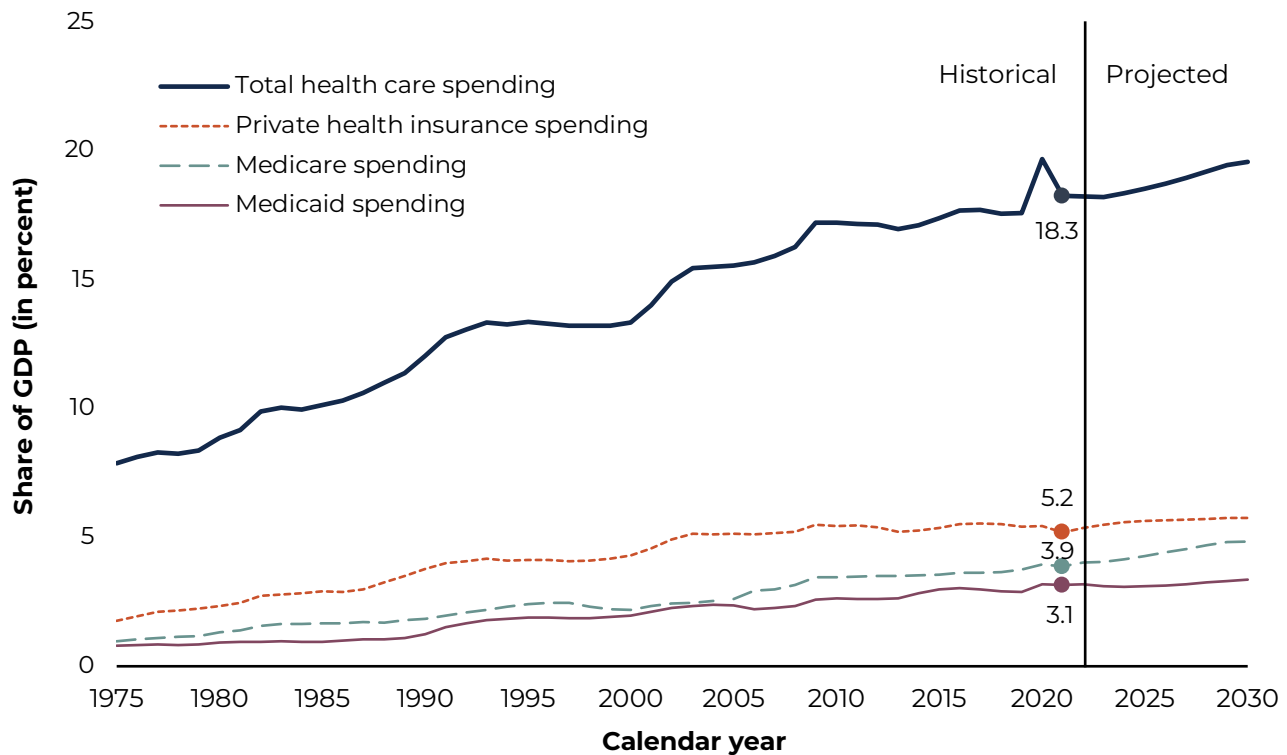


Note: CHIP (Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures that comprises spending for all medical goods and services that are provided for the treatment of an individual. "Other" includes private health insurance, out-of-pocket spending, and 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 products.

Source: CMS Office of the Actuary, National Health Expenditures by type of service and source of funds: Calendar Years 1960 to 2021, released December 2022, <https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2021.zip>.

- > While Medicare's share of total personal health care spending was 24 percent in 2021 (see Chart 1-1), its share of spending by type of service varied, from 18 percent of spending on durable medical equipment to 37 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 grown as a share of the country's GDP



Note: GDP (gross domestic product). First projected year is 2022. Funds paid to health care providers through the Paycheck Protection Program and the Provider Relief Fund are counted in total health care spending but not counted in Medicare spending.

Source: MedPAC analysis of CMS's National Health Expenditure Data (projected data released April 2022 and historical data released December 2022), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData>.

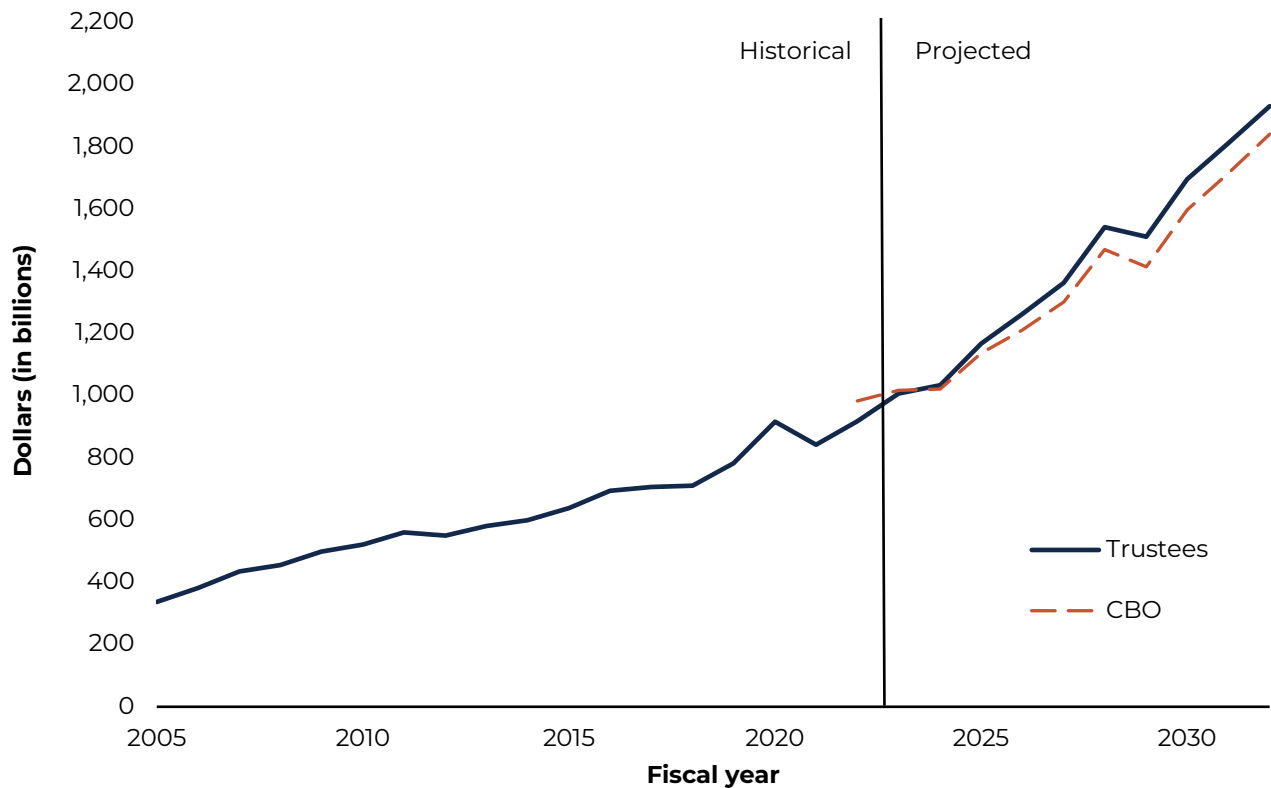
> In 2020, total health care spending increased sharply—reaching 19.7 percent of the country's GDP or \$4.1 trillion—due to one-time spending by the federal government on COVID-19 pandemic relief funds for health care providers and public health activities at a time when the country's GDP was shrinking.

> In 2021, the federal government continued to distribute pandemic relief funds, but at much lower levels. Meanwhile, payers' spending on health care increased as patients resumed receiving health care, and GDP expanded rapidly. The net effect of these forces was a sharp decline in national health care spending as a share of GDP. At 18.3 percent, this was still a larger share of GDP than in 2019.

> 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. By 2030, all baby boomers will have reached Medicare's age of eligibility.

Chart 1-4 Medicare spending is expected to double in the next 10 years



Note: CBO (Congressional Budget Office). First projected year is 2023. The sharp increase in spending in 2020 includes \$104 billion in Medicare Accelerated and Advance Payments paid to providers that year; these payments were expected to be recouped by the Medicare program in 2021 and 2022.

Source: 2023 annual report of the Boards of Trustees of the Medicare trust funds, Table V.H4; CBO's May 2023 baseline projections for the Medicare program, <https://www.cbo.gov/system/files?file=2023-05/51302-2023-05-medicare.xlsx>.

- > Medicare spending doubled between 2008 and 2022, increasing from \$455 billion to \$918 billion.
- > Medicare spending is expected to again double between 2022 and 2032, when the Trustees estimate it will reach \$1.9 trillion. The Trustees expect Medicare spending to increase at an average annual rate of 7.5 percent over the next 10 years.
- > The Medicare Trustees and CBO both estimate that Medicare spending will reach \$1 trillion in 2023.

Chart 1-5 Factors contributing to Medicare’s projected spending growth, 2023–2032 (after subtracting economy-wide inflation)

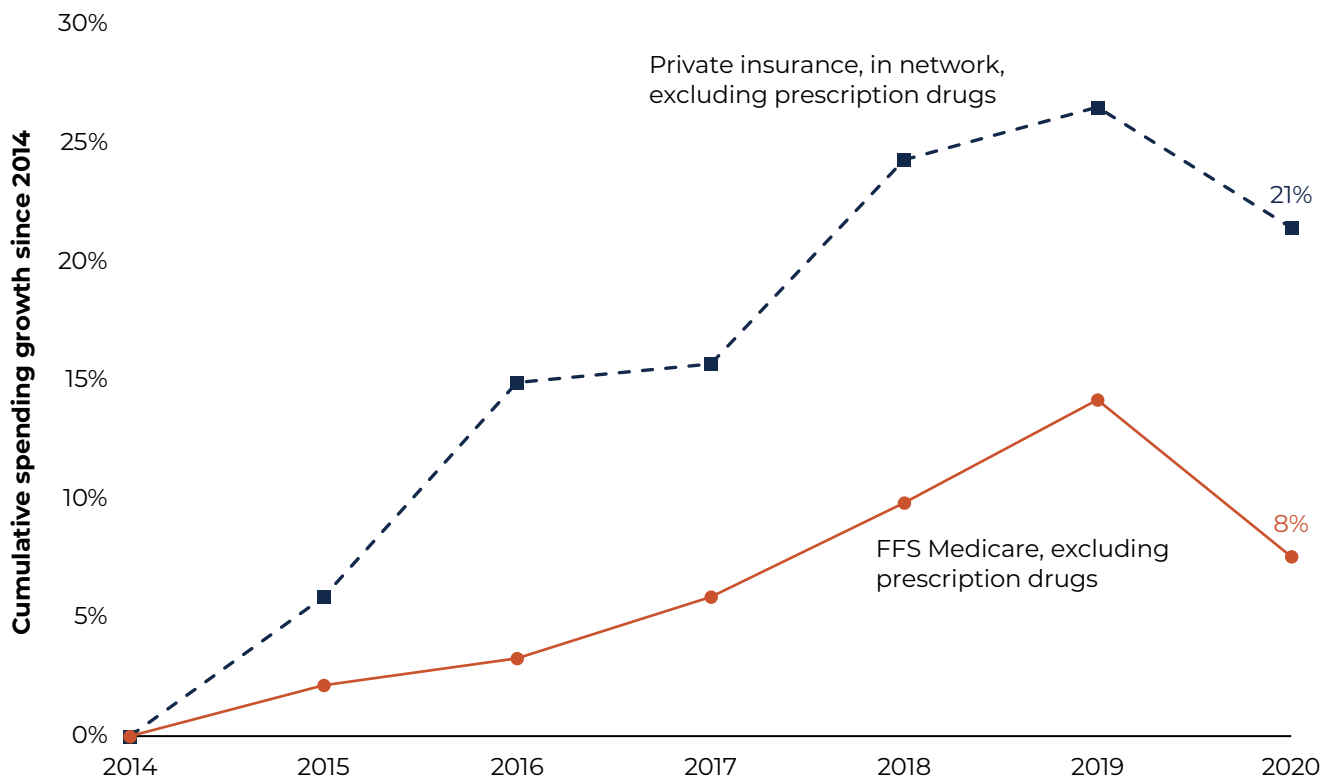
Medicare part	Average annual percent change in:				
	Medicare prices (minus inflation)	Number of beneficiaries	Beneficiary demographic mix	Volume and intensity of services used	Medicare’s projected spending (minus inflation)
Part A	-0.2%	1.9%	0.1%	1.8%	3.7%
Part B	-1.1	2.0	0.1	4.2	5.1
Part D	N/A*	2.4	-0.2	N/A*	2.5
Total	N/A*	N/A**	0.1	N/A*	4.2

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), total factor productivity reductions, and any other reductions required by law or regulation. “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. 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 2022 (as measured by shares of gross domestic product).
 *Not available for Part D due to the current methodology used to incorporate the provisions of the Inflation Reduction Act of 2022.
 **Not available because there is beneficiary overlap in enrollment in Part A, Part B, and Part D.

Source: MedPAC analysis of data from the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

- > Medicare’s spending is projected to grow 4.2 percent per year, on average, between 2022 and 2031 (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 about 2 percent per year over this period) and growth in the volume and intensity of services delivered per beneficiary (expected to rise by 1.8 percent per year for Part A spending and by 4.2 percent per year for Part B spending).
- > 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 has grown faster for the privately insured than for beneficiaries in traditional FFS Medicare, 2014–2020



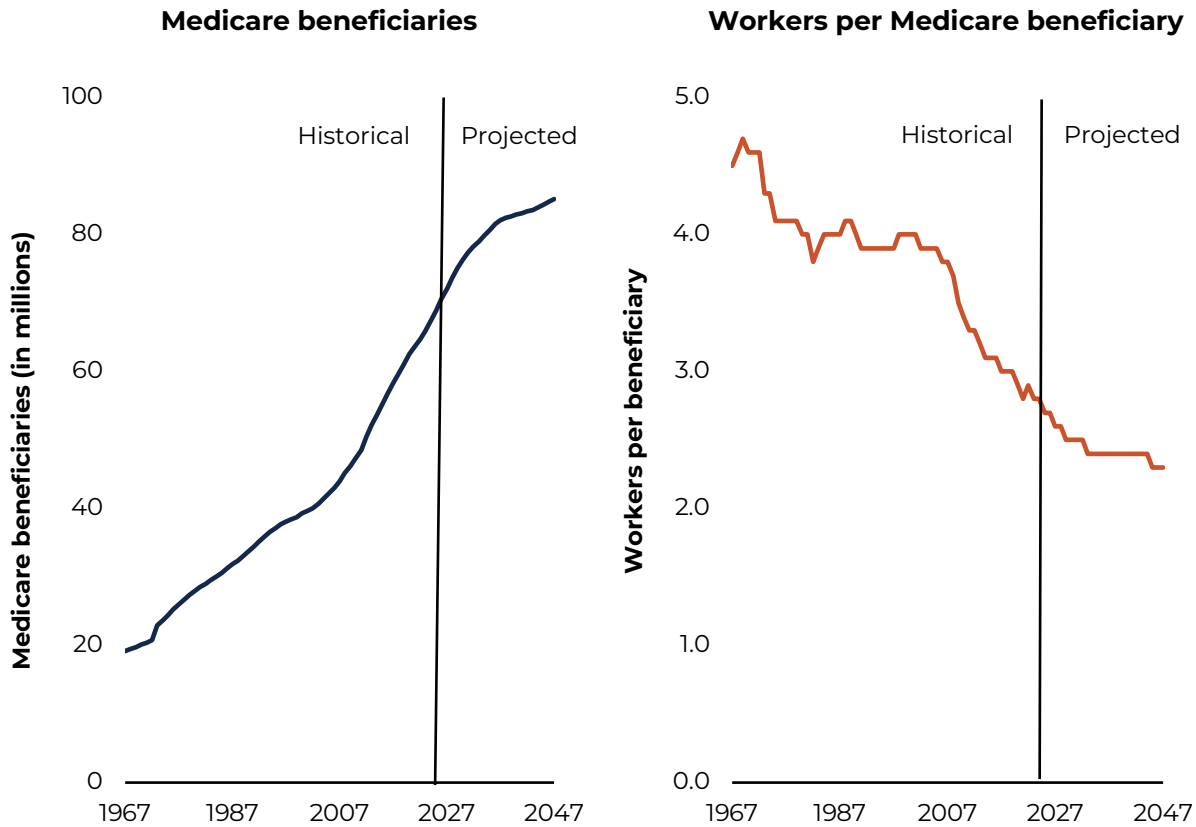
Note: FFS (fee-for-service). Spending in figure includes payments to providers from health insurers and patients (i.e., cost sharing) but not payments from other sources (e.g., workers' compensation or auto insurance). Spending on retail prescription drugs is not available for the privately insured, 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 disabled individuals under the age of 65. 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 2020, total health care spending per enrollee (including cost sharing) grew 21 percent for people with private insurance, compared with 8 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

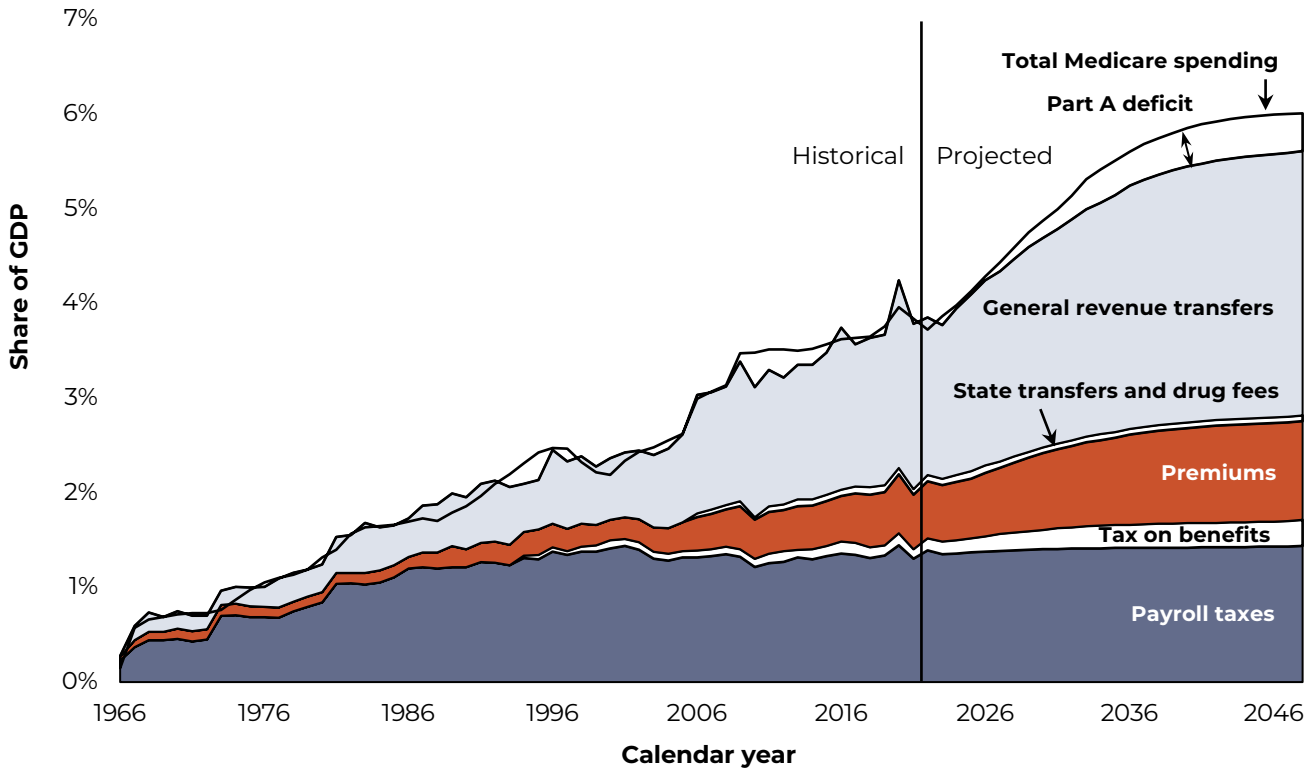


Note: “Beneficiaries” referenced in these graphs are beneficiaries covered by Medicare Part A (including beneficiaries in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplemental Medical Insurance because Part A Hospital Insurance is usually available to fee-for-service (FFS) Medicare beneficiaries at no cost while FFS beneficiaries usually pay a premium for Part B Supplemental Medical Insurance. First projected year is 2023.

Source: 2023 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 2029, all baby boomers will have reached the age of eligibility for the Medicare program, and 75 million beneficiaries are expected to have Medicare Part A Hospital Insurance—up from 65 million beneficiaries in 2022.
- > While Medicare enrollment is rising, the number of workers per beneficiary is rapidly declining. This presents a financing challenge for Medicare because Part A Hospital Insurance is primarily financed by workers’ Medicare payroll taxes. The number of workers per Medicare beneficiary with Part A Hospital Insurance has declined from 4.5 workers per Medicare beneficiary at the program’s inception in 1967 to 2.9 workers per beneficiary in 2022 and is projected to fall to 2.5 workers per beneficiary by 2029.

Chart 1-8 General revenues are the largest source of Medicare funding



Note: GDP (gross domestic product). First projected year is 2023. 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" refers to payments from the states to Medicare, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed by the Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs; these fees are deposited in the Part B account of the Supplementary Medical Insurance Trust Fund. Graph does not include interest earned on trust fund investments (which makes up 1 percent of the Hospital Insurance Trust Fund's income and is expected to decline in coming years as trust fund assets decline).

Source: 2023 annual report of the Boards of Trustees of the Medicare trust funds.

> Medicare spending accounted for 3.7 percent of GDP in 2022. By 2031, the Medicare Trustees project that Medicare's share of GDP will rise to 5.0 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 currently pay for nearly half of Medicare spending and are expected to continue to do so in future decades.

> As increasing amounts of general revenues have been devoted to Medicare, less general tax revenues have been available to invest in growing the economic output of the country or supporting other national priorities.

Chart 1-9 Higher Medicare payroll tax or lower Medicare Part A spending needed to maintain 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 (2023–2047)	3.6%	15.6%

Note: Part A spending includes spending on inpatient hospital, skilled nursing facility, home health agency, and hospice services and includes spending for beneficiaries in fee-for-service Medicare and Medicare Advantage.

Source: MedPAC analysis of Table III.B8 in 2023 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).
- > In some years, such as 2022, payroll tax revenues exceed Part A spending—creating a surplus that causes the trust fund’s account balance to increase. (For example, the Trustees report that in 2022, annual trust fund revenues equaled \$397 billion, but Part A spending only amounted to \$343 billion, thus yielding a surplus of \$54 billion that year. This surplus increased the balance in the trust fund from \$143 billion at the start of the year to \$197 billion by the end of the year.)
- > In other years, payroll tax revenues are less than Medicare Part A spending—creating a deficit that causes the trust fund’s account balance to decline. Medicare’s Trustees estimate that annual deficits in coming years will cause the Hospital Insurance Trust Fund’s account balance to drop to zero dollars in 2031—which will leave Medicare with enough funds to cover only 89 percent of its incurred Part A costs that year. The Congressional Budget Office also tracks the trust fund’s financial status and projects that it will take longer for the trust fund to become insolvent (sometime after its 10-year budget projection window, which runs through 2033).
- > 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 3.6 percent or Part A spending would need to be permanently reduced by 15.6 percent (about \$62 billion in 2023). 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, 2021

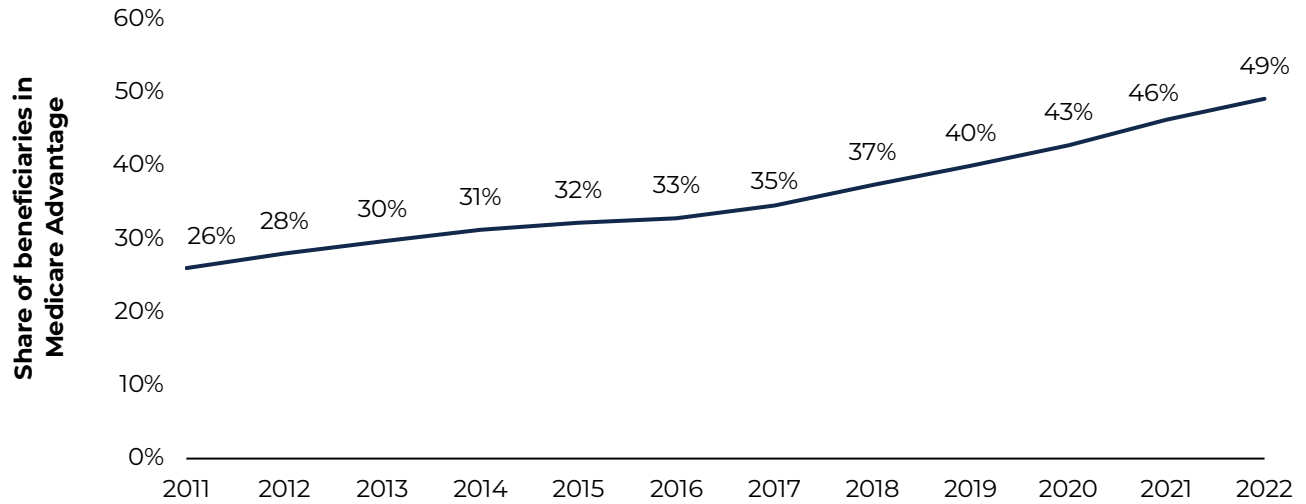
	Average benefit in 2021 (in dollars)	Average cost sharing in 2021 (in dollars)
Part A	\$5,207	\$396
Part B	6,757	1,621

Note: FFS (fee-for-service). “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 premiums.

Source: CMS, Medicare Part A and Part B Summary Utilization, Program Payments, and Cost Sharing for All Original Medicare Beneficiaries, by Type of Coverage and Type of Service Calendar Years 2016-2021, <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/cms-program-statistics-medicare-part-a-part-b-all-types-of-service>.

- > In 2021, the Medicare program made \$5,207 in Part A benefit payments and \$6,757 in Part B benefit payments, on average, per FFS beneficiary.
- > In 2021, FFS beneficiaries owed an average of \$396 in cost sharing for Part A services (such as hospital fees) and \$1,621 in cost sharing for Part B services (such as clinician services provided in any setting, including in hospitals). (Cost sharing does not include premiums.)
- > To help cover cost-sharing obligations, 91 percent of non-institutionalized beneficiaries had coverage that supplemented or replaced the Medicare benefit package in 2020, such as Medicare Advantage, Medigap coverage, supplemental coverage through a former employer, or Medicaid (see Chart 3-1).

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

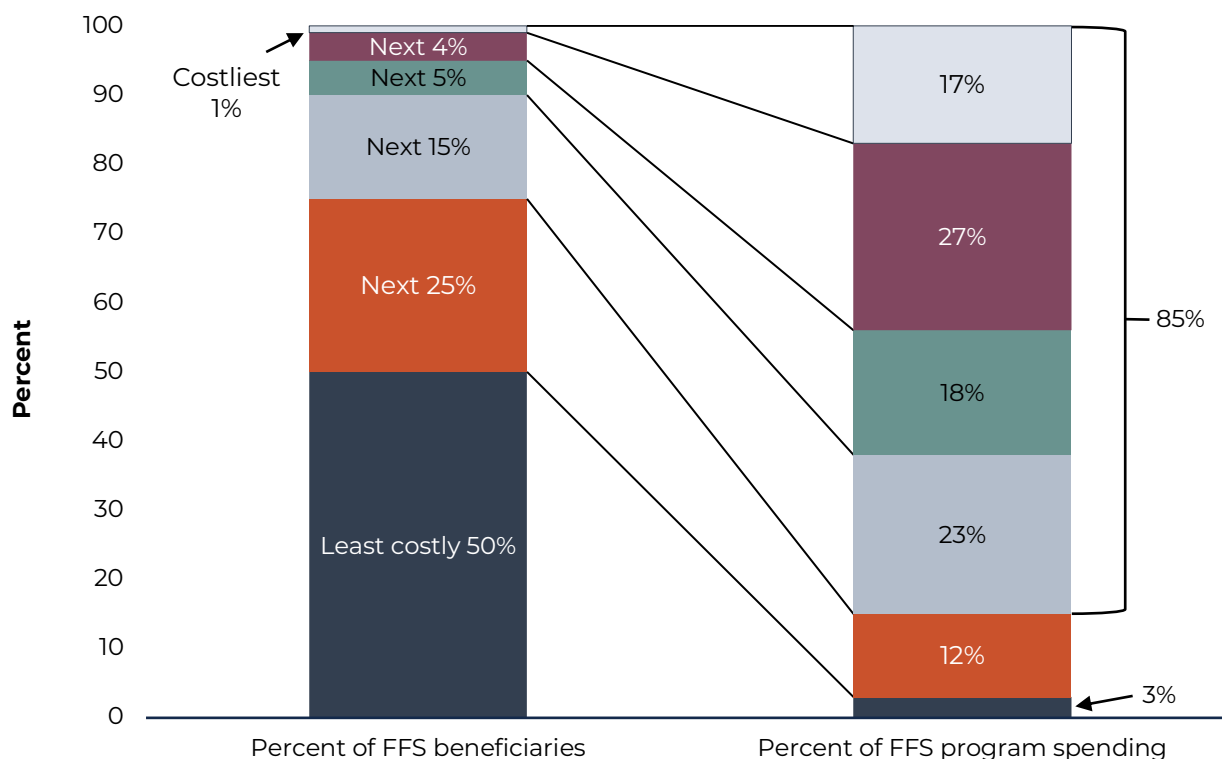


Note: Figure shows share of Medicare beneficiaries enrolled in Medicare Advantage plans, from the total number of beneficiaries with both Part A and Part B coverage. For detailed information on Medicare Advantage enrollment, see Section 9 of this report.

Source: MedPAC analysis of CMS enrollment files, July 2011–2022.

> The share of Medicare beneficiaries with both Part A and Part B coverage who chose to enroll in Medicare Advantage plans grew rapidly from 2011 to 2022—rising from 26 percent to 49 percent.

Chart 1-12 FFS program spending was highly concentrated in a small group of beneficiaries, 2020



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]). 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, 2020.

> Medicare FFS spending is concentrated among a small number of beneficiaries. In 2020, 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 44 percent of annual Medicare FFS spending. The costliest 25 percent of beneficiaries accounted for 85 percent of Medicare spending. The least costly 50 percent of beneficiaries accounted for only 3 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.