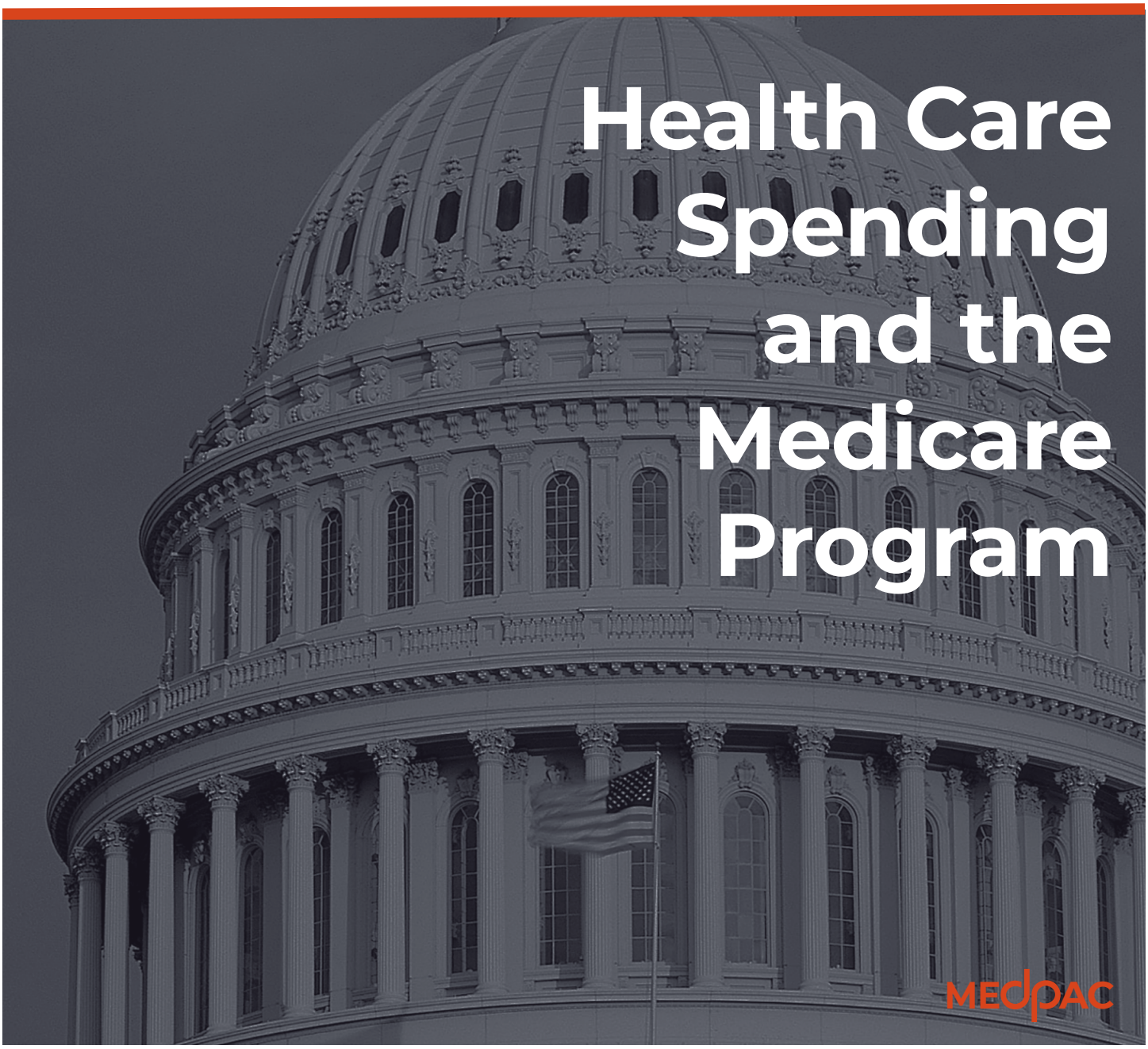
JULY 2024

A Data Book

Health Care Spending and the Medicare Program



MEDPAC

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A DATA BOOK

Health Care Spending and the Medicare Program

MEDPAC | Medicare Payment Advisory Commission

Introduction

The MedPAC Data Book provides information on national health care and Medicare spending as well as Medicare beneficiary demographics, dual-eligible beneficiaries, quality of care in the Medicare program, and Medicare beneficiary and other payer liability. It also examines provider settings—such as hospitals and post-acute care—and presents data on Medicare spending, beneficiaries' access to care in the setting (measured by the number of beneficiaries using the service, number of providers, volume of services, length of stay, or through direct surveys), and the sector's Medicare profit margins, if applicable. In addition, it covers the Medicare Advantage program and prescription drug coverage for Medicare beneficiaries, including Part D. Some of the information contained herein is derived from MedPAC's March and June reports to the Congress; other information is unique to the Data Book. The information is presented in tables and figures with brief discussions.

Notes on data

Changes in aggregate spending for the fee-for-service sectors presented in this Data Book partly reflect the shift in Medicare enrollment from the traditional fee-for-service program to Medicare Advantage. Fee-for-service spending per capita may present a more complete picture of spending changes.

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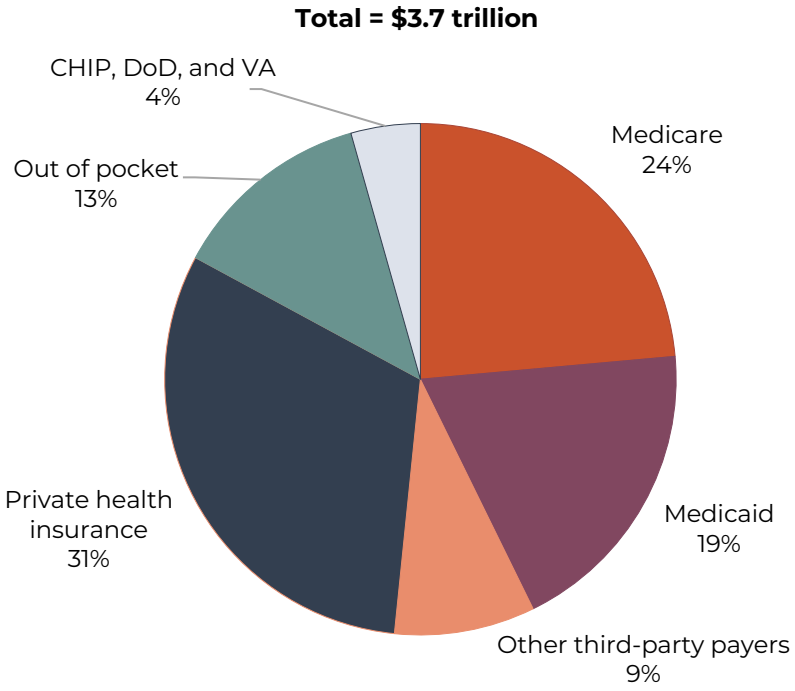
1

National health care and Medicare spending

Chart 1-1 Medicare was the largest single purchaser of personal health care in the U.S., 2022



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.

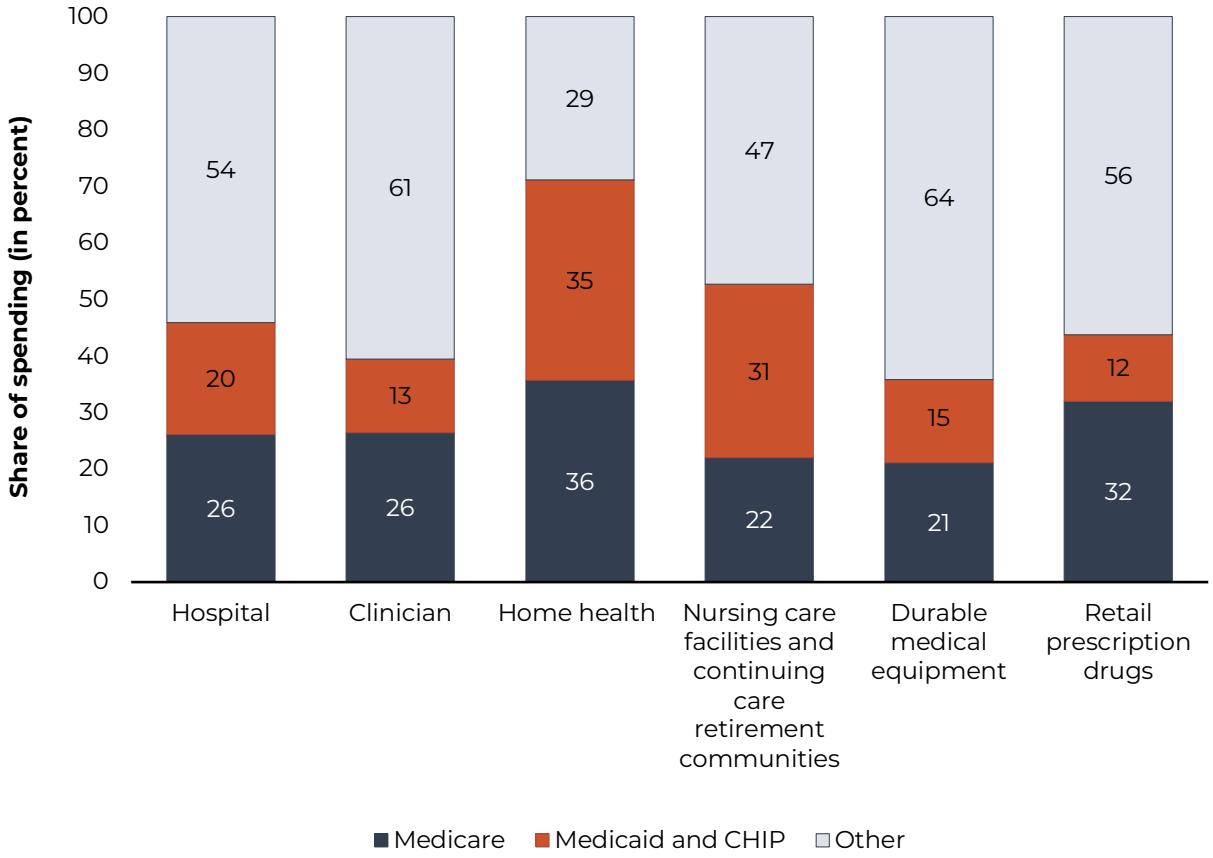
Source: CMS Office of the Actuary, Table 6: Personal Health Care Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2022, released December 2023, https://www.cms.gov/files/zip/nhe-tables.zip.

> 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, the category is composed of many private plans, including managed care, self-insured health plans, and indemnity plans.) Of the $3.7 trillion spent on personal health care in 2022, Medicare accounted for 24 percent, or $873 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 13 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, 2022



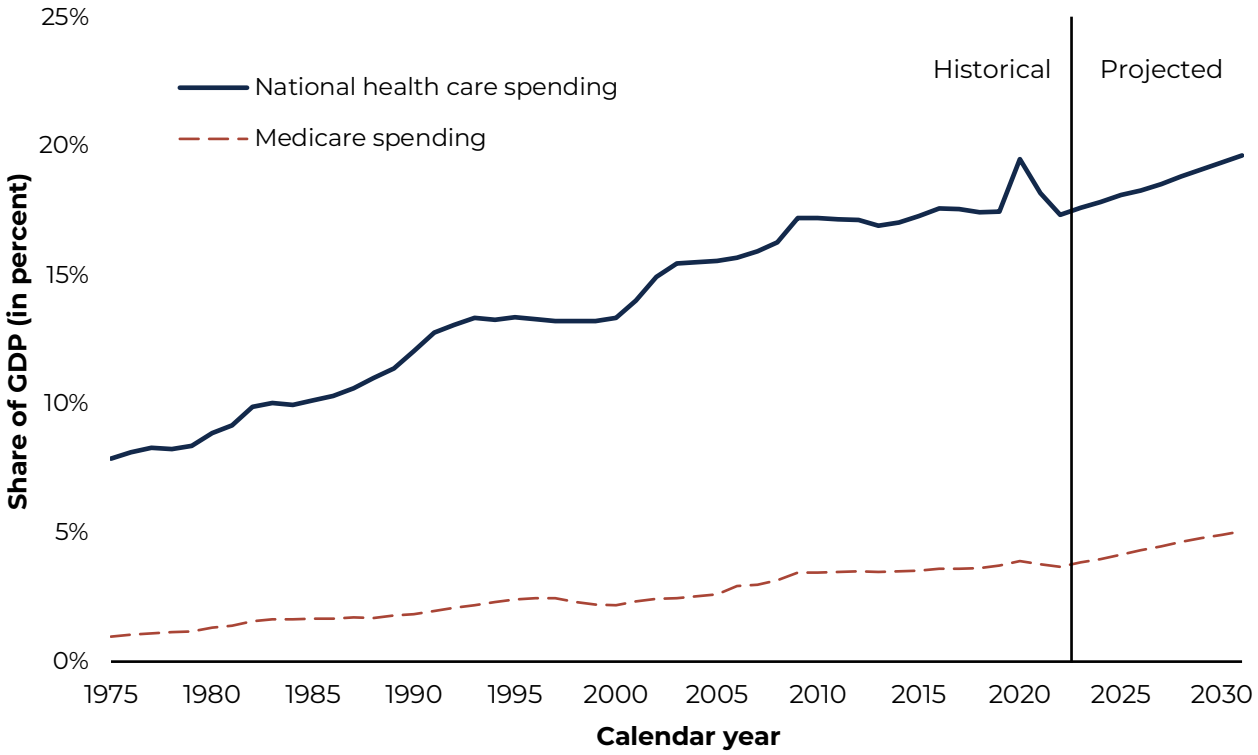
Note: CHIP (Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures that comprises spending for all medical goods and services that are provided for the treatment of an individual. "Other" includes private health insurance, out-of-pocket spending, and 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 2022, released December 2023, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2022.zip.

> While Medicare's share of total personal health care spending was 24 percent in 2022 (see Chart 1-1), its share of spending by type of service varied, from 21 percent of spending on durable medical equipment to 36 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 2023. Pandemic relief funds are counted as national health care spending rather than Medicare spending since they were meant to offset pandemic-related revenue losses from all payers, not just Medicare.

Source: MedPAC analysis of CMS's National health expenditure data (projected data released June 2023 and historical data released in December 2023), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

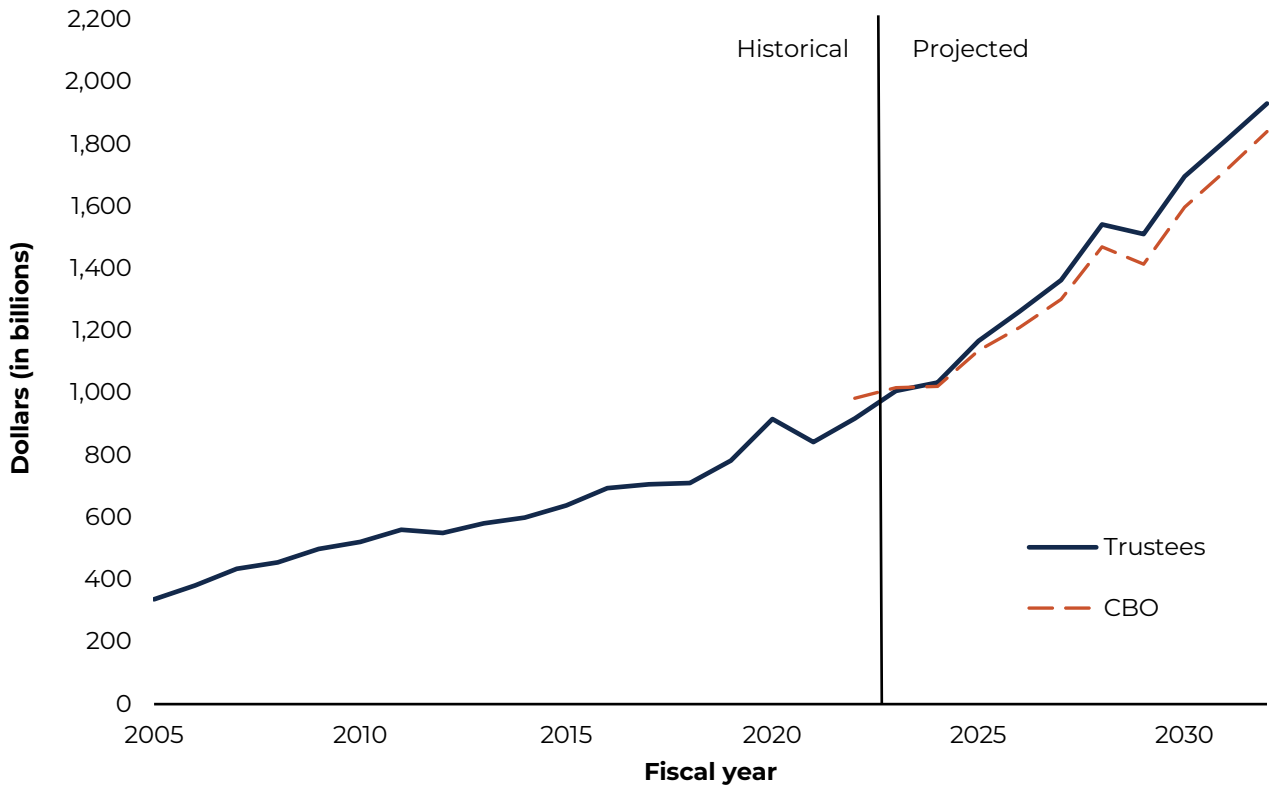
> In 2020, total health care spending increased sharply—reaching 19.5 percent of the country's GDP, or $4.2 trillion—due to one-time spending by the federal government on coronavirus pandemic relief funds for health care providers, a relaxation of Medicaid's eligibility rules during the pandemic, and an increase in spending on public health activities (e.g., for vaccine development) 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 18.2 percent, this amount 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 Medicare Accelerated and Advance Payments paid to providers—payments that were then recouped by the Medicare program in 2021 and 2022. Dollar amounts are nominal figures, not adjusted for inflation.

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 on a nominal basis.

> 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 estimate that by 2023, Medicare spending reached $1 trillion.

Chart 1-5 Factors contributing to projected spending growth for Medicare Part A and Part B, 2023–2032 (after subtracting economy-wide inflation)

	Average annual percent change in:				
Medicare part	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
Total	–0.7	N/A*	0.1	3.1	4.5

Note: N/A (not applicable). 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. "Medicare's projected spending" 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 (Part A plus Part B) Medicare spending in 2022 (as measured by shares of gross domestic product). Part D spending growth is not shown.
*Not applicable because there is beneficiary overlap in Part A and Part B enrollment.

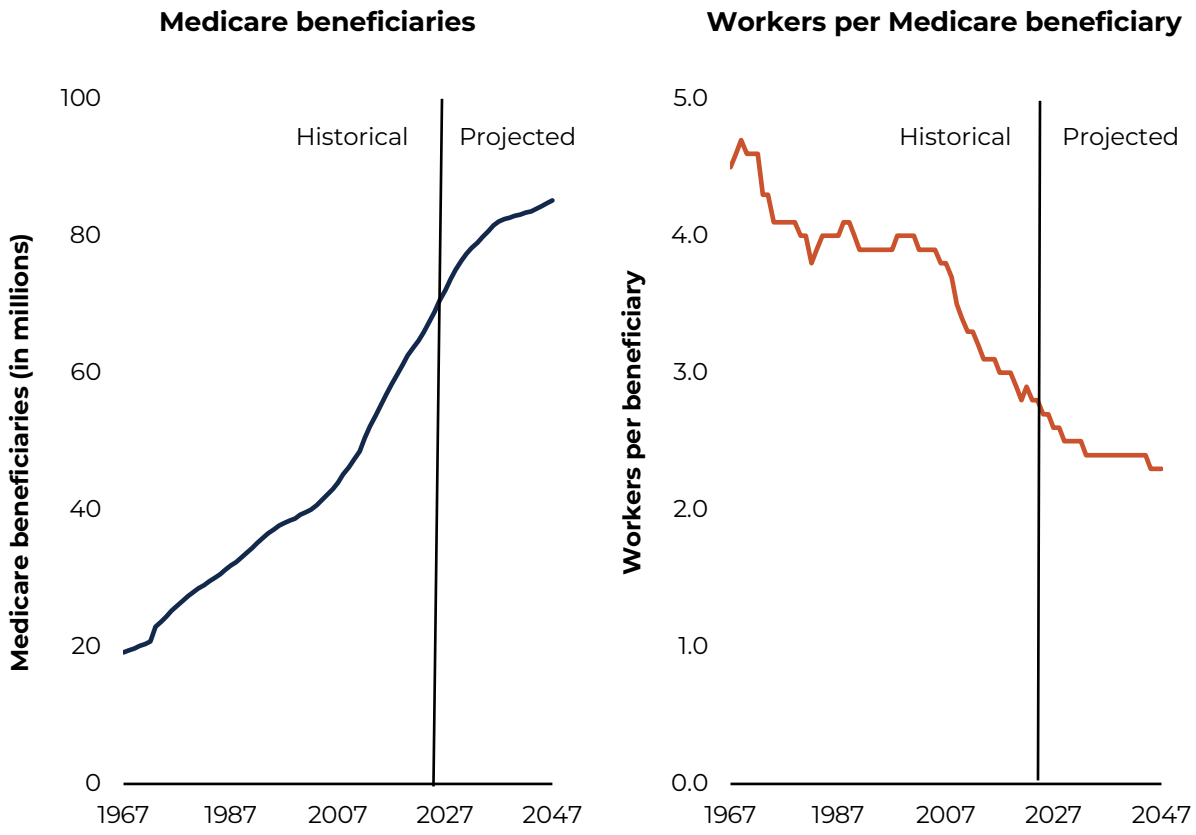
Source: MedPAC analysis of data from the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

> Medicare's spending on Part A and Part B services and items for beneficiaries in traditional Medicare and Medicare Advantage plans is projected to grow 4.5 percent per year, on average, between 2023 and 2032 (not including growth due to general economy-wide inflation).

> Medicare's projected spending growth over this period 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).

> Price growth is not expected to drive Medicare's increased spending because, unlike in the private health care sector, Medicare is able to administratively set prices for many health care providers.

Chart 1-6 The declining ratio of workers to Medicare beneficiaries threatens the Medicare program's financial sustainability



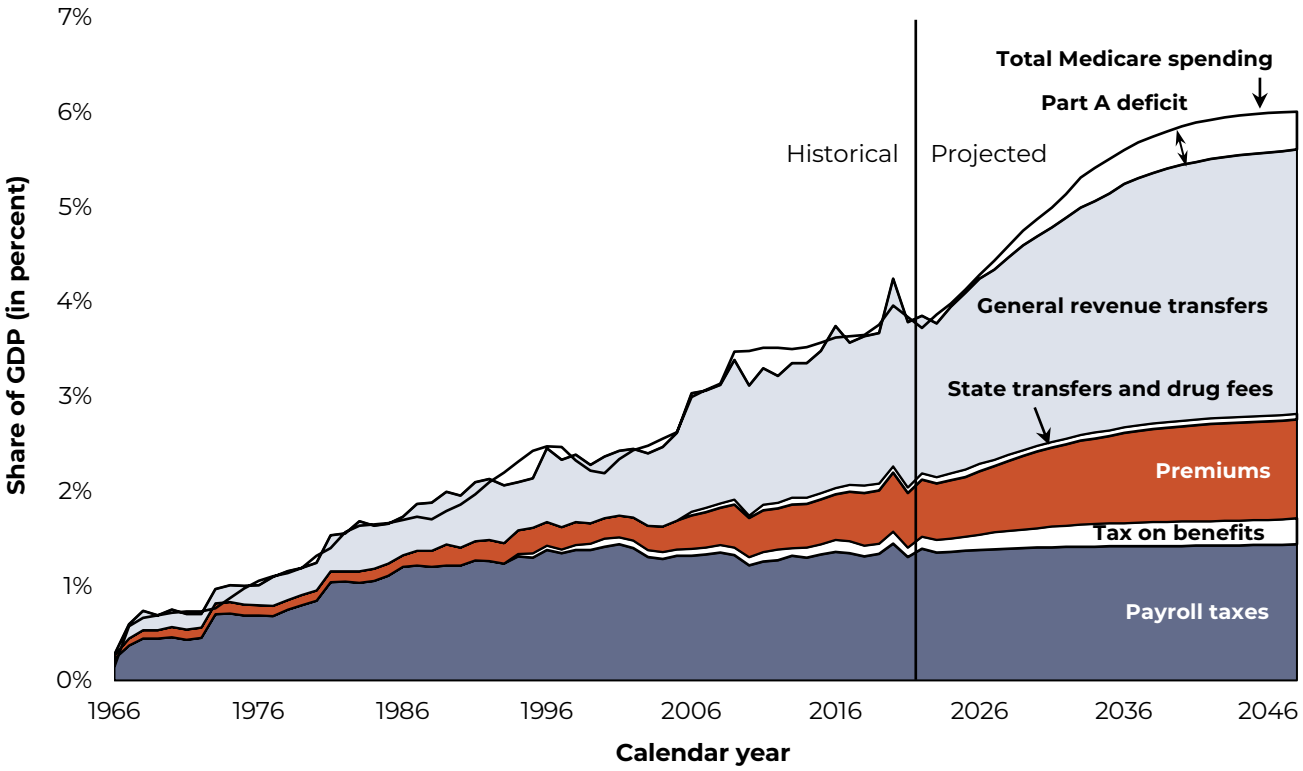
Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplemental Medical Insurance because Part A is usually available to beneficiaries at no cost. First projected year is 2023. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

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. These diverging trends present 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 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 1-7 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 have projected 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 tax revenues have been devoted to Medicare, less tax revenue has been available for other priorities such as deficit reduction or investments that could grow the economic output of the country (e.g., federal investments in education, transportation, and research and development).

Chart 1-8 A higher Medicare payroll tax or lower Medicare Part A spending would extend the solvency of Medicare's Hospital Insurance Trust Fund by 25 years

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.

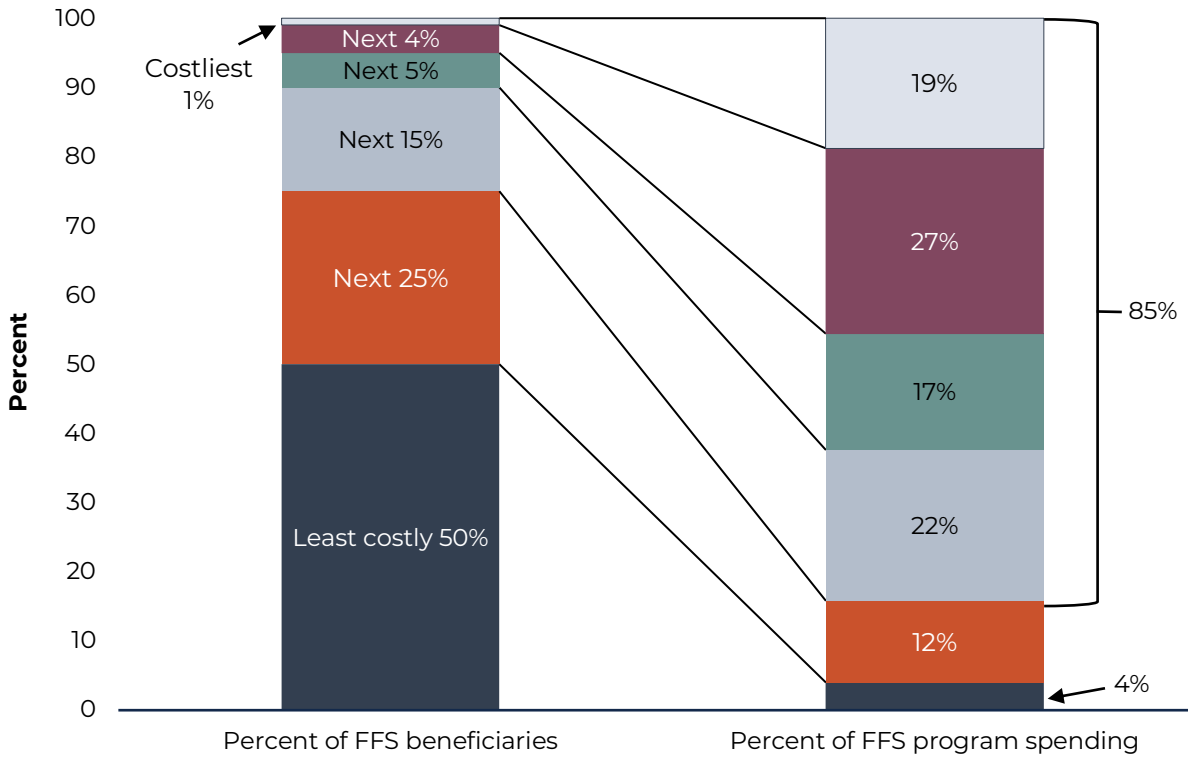
> Medicare's Hospital Insurance Trust Fund helps pay for Part A services such as inpatient hospital stays, post-acute care provided by skilled nursing facilities, and hospice services. The trust fund is mainly financed through a dedicated payroll tax (i.e., a tax on wage earnings).

> In some years, such as 2022, trust fund revenues exceed Part A spending—creating a surplus that increases the trust fund's account balance. (For example, the Trustees have reported that in 2022, annual trust fund revenues equaled $397 billion but Part A spending 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. In their 2023 report, Medicare's Trustees estimated that annual deficits in coming years would cause the Hospital Insurance Trust Fund's account balance to drop to zero dollars in 2031—leaving 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; it projects that it will take longer for the trust fund to become insolvent (until 2035).

> To keep the trust fund solvent over the next 25 years, the Medicare Trustees have estimated 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 $65 billion in 2024). Alternatively, some combination of smaller tax increases and smaller spending reductions could be used to achieve solvency.

Chart 1-9 FFS program spending was highly concentrated on a small share of beneficiaries, 2021



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)). Component percentages may not sum to 100 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, 2021.

> Medicare FFS spending is concentrated among a small number of beneficiaries.

>> In 2021, the costliest 5 percent of beneficiaries (i.e., the costliest 1 percent and the next-costliest 4 percent at the top of the bar at left) accounted for 46 percent of annual Medicare FFS spending.

>> The costliest 25 percent of beneficiaries accounted for 85 percent of Medicare spending (indicated by the bracket at right).

>> The least costly 50 percent of beneficiaries accounted for only 4 percent of FFS spending.

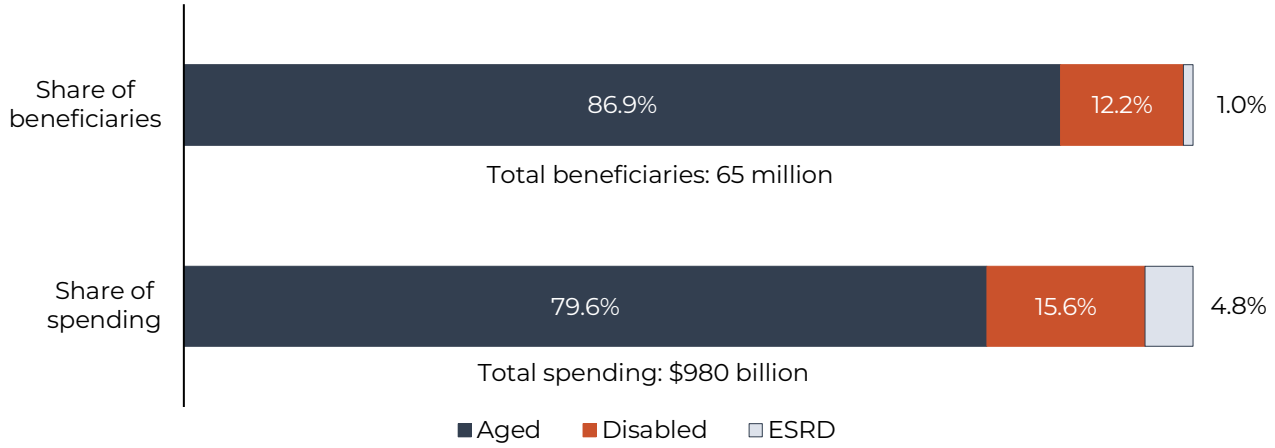
> Costly beneficiaries tend to be those who have multiple chronic conditions, are using inpatient hospital services, are dually eligible for Medicare and Medicaid, and are in the last year of life.

SECTION

2

Medicare beneficiary demographics

Chart 2-1 Aged beneficiaries accounted for the greatest share of the Medicare population and program spending, 2021



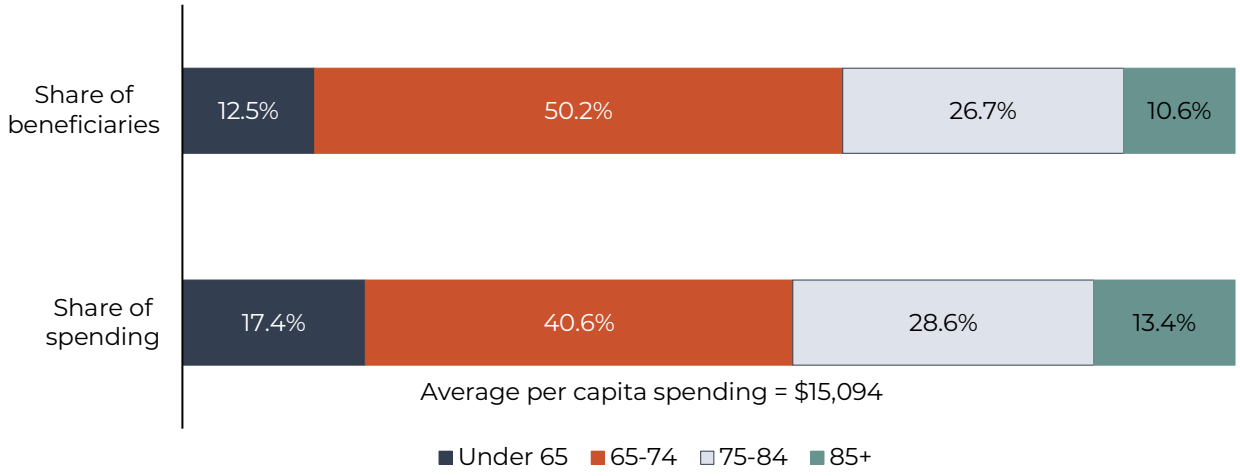
Note: ESRD (end-stage renal disease). The "aged" category comprises beneficiaries ages 65 and older without ESRD. The "disabled" category comprises beneficiaries under age 65 without ESRD. The "ESRD" category comprises beneficiaries with ESRD, regardless of age. Results include fee-for-service, Medicare Advantage, community-dwelling, and institutionalized beneficiaries. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file 2021.

> In 2021, beneficiaries ages 65 and older without ESRD composed 86.9 percent of the beneficiary population and accounted for 79.6 percent of Medicare spending. Beneficiaries under 65 with a disability and beneficiaries with ESRD accounted for the remaining population and spending.

> Medicare beneficiaries with ESRD incur a disproportionate share of Medicare expenditures. On average, spending on an ESRD beneficiary is almost six times greater than spending on an aged beneficiary (age 65 years or older without ESRD) and almost four times greater than spending for a beneficiary under age 65 with a disability (non-ESRD) (data not shown).

Chart 2-2 Beneficiaries younger than 65 accounted for a disproportionate share of Medicare spending, 2021



Note: Results include fee-for-service, Medicare Advantage, community-dwelling, and institutionalized beneficiaries. 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, Cost Supplement file 2021.

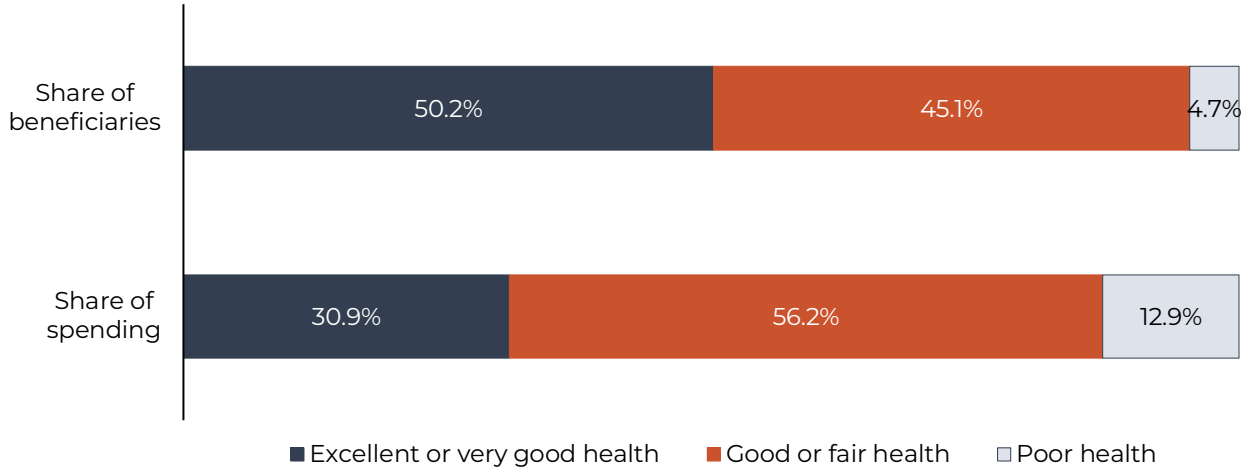
> Beneficiaries younger than 65 made up 12.5 percent of the beneficiary population in 2021 but accounted for 17.4 percent of Medicare spending.

> In 2021, average Medicare spending per beneficiary was $15,094.

> For the aged population (65 and older), per capita expenditures increase with age. In 2021, per capita expenditures were $12,230 for beneficiaries 65 to 74 years old, $16,140 for those 75 to 84 years old, and $19,163 for those 85 or older (data not shown).

> In 2021, per capita expenditures for Medicare beneficiaries under age 65 who were enrolled because of end-stage renal disease or disability were $20,885 (data not shown).

Chart 2-3 Beneficiaries who reported being in poor health accounted for a disproportionate share of Medicare spending, 2021



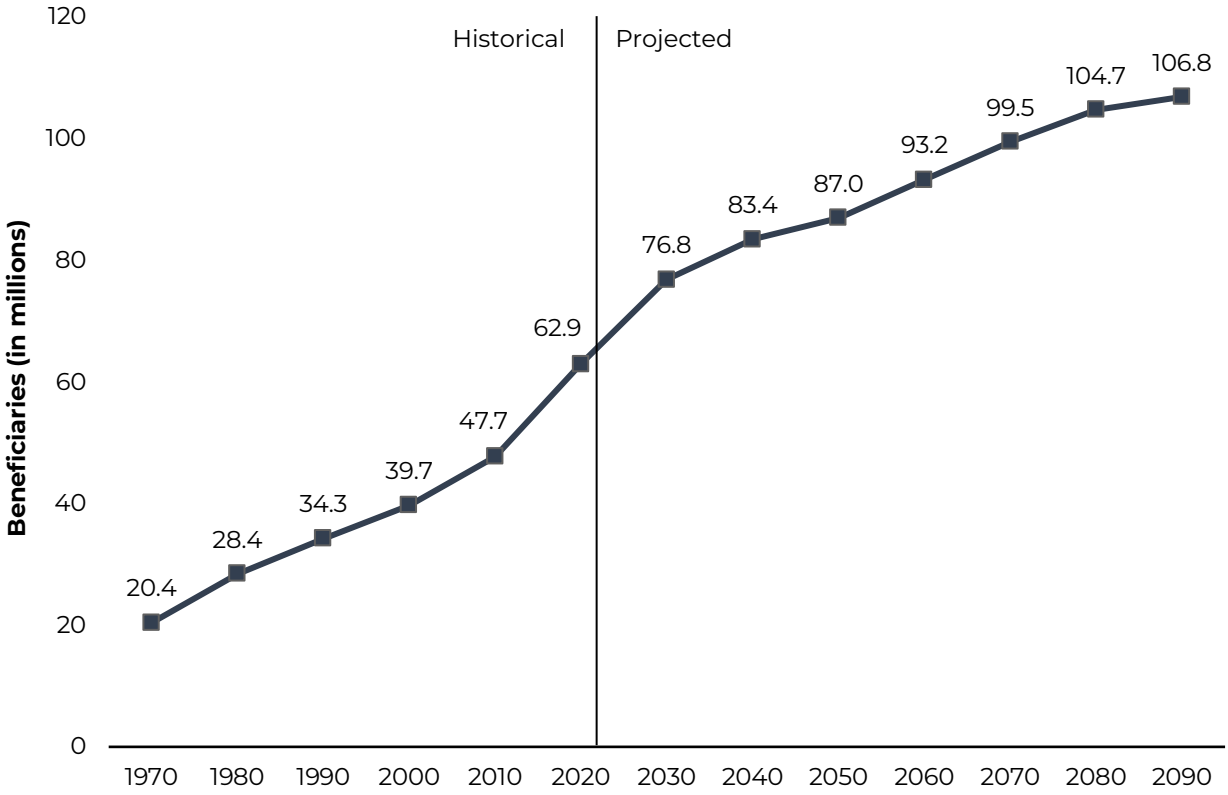
Note: Results include fee-for-service, Medicare Advantage, community-dwelling, and institutionalized beneficiaries. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Beneficiaries who reported "other" are not included in the figure.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file 2021.

> In 2021, most beneficiaries reported fair to excellent health. Only 4.7 percent reported poor health.

> Medicare spending is strongly associated with self-reported health status. In 2021, per capita expenditures were $8,935 for those who reported excellent or very good health, $18,124 for those who reported good or fair health, and $39,962 for those who reported poor health (data not shown).

Chart 2-4 Enrollment in the Medicare program is projected to grow rapidly through 2030



Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.

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

> The total number of people enrolled in the Medicare program is projected to increase from about 63 million in 2020 to about 77 million in 2030.

> The rate of increase in Medicare enrollment has been accelerating since about 2010 as more members of the baby-boom generation become eligible for the program. Beginning in 2030, when the entire baby-boom generation will have become eligible, Medicare enrollment will continue to increase, but more slowly.

Chart 2-5 Characteristics of the Medicare population, 2021

Characteristic	Share of the Medicare population	Characteristic	Share of the Medicare population
Total (59.3 million)	100%	Living arrangement	
		Institution	2
Sex		Alone	30
Male	45	With spouse	44
Female	55	Other	24
Race/ethnicity		Education	
White, non-Hispanic	75	No high school diploma	12
Black, non-Hispanic	10	High school diploma only	25
Hispanic	9	Some college or more	62
Other	6		
		Income status	
Age		Below poverty	14
<65	13	100–125% of poverty	7
65–74	49	125–150% of poverty	6
75–84	28	150–200% of poverty	12
85+	10	200–400% of poverty	27
		Over 400% of poverty	35
Health status		Supplemental insurance status	
Excellent or very good	49	Medicare only	7
Good or fair	46	Medicare managed care	44
Poor	5	Employer-sponsored insurance	21
		Medigap	20
Residence		Medigap with employer-sponsored insurance	1
Urban	83	Medicaid	7
Rural	17	Other	0

Note: Components may not sum to 100 percent due to rounding and exclusion of an "other" category. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs) as defined by the Office of Management and Budget. "Rural" indicates beneficiaries living outside MSAs. The income status categories were modified from previous years to align with other charts in this publication. The "Medicare managed care" category includes Medicare Advantage, cost, and health care prepayment plans. Those in the "employer-sponsored insurance" category had employer-sponsored insurance as primary payer or they had employer-sponsored Medigap coverage. Those in the "Medigap with employer-sponsored insurance" category had both Medigap and employer-sponsored coverage. Some beneficiaries may have more than one type of supplemental insurance. 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, Cost Supplement file 2021.

> A majority of Medicare beneficiaries are female (55 percent) and White (75 percent).

> About one-fifth of beneficiaries live in rural areas.

> Thirty percent of the Medicare population lives alone.

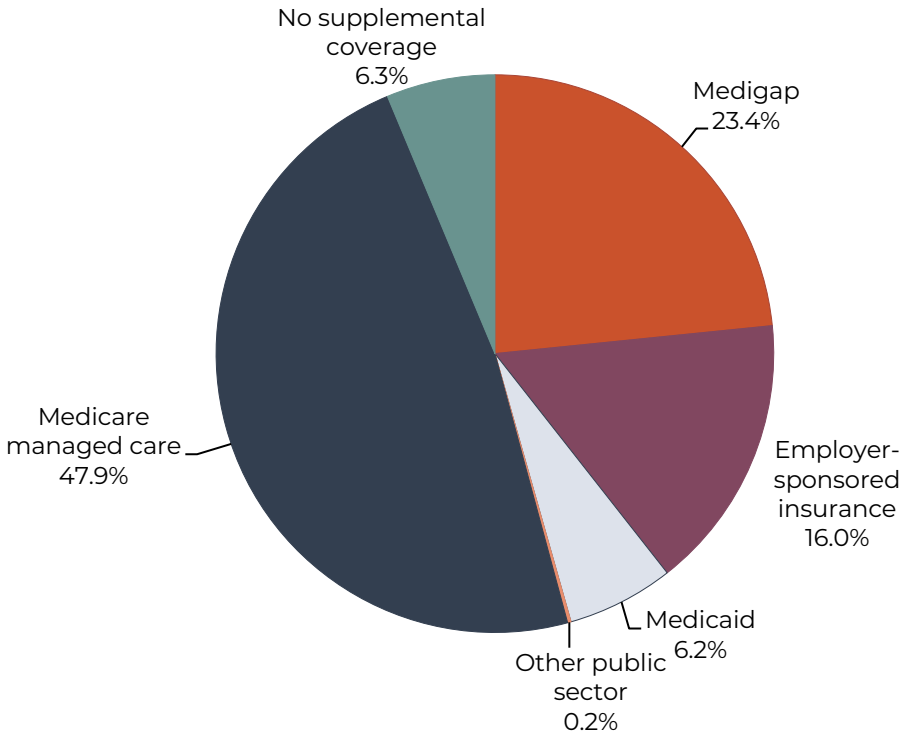
> Most Medicare beneficiaries have some source of supplemental insurance. Managed care plans are the most common source of supplemental coverage.

SECTION

3

Medicare beneficiary and other payer financial liability

Chart 3-1 Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2021



Note: We assigned beneficiaries to the supplemental coverage category in which they spent the most time in 2021. They could have had coverage in other categories during 2021. "Other public sector" includes federal and state programs not included in other categories. This analysis includes only beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in Part A and Part B throughout their Medicare enrollment in 2021 or who had Medicare as a secondary payer. The number of beneficiaries represented in this chart is 52.5 million. 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 Medicare Current Beneficiary Survey, Survey File 2021.

> Most beneficiaries living in the community (noninstitutionalized beneficiaries) have coverage that supplements or replaces the Medicare benefit package. In 2021, 94 percent of beneficiaries had supplemental coverage or participated in Medicare managed care.

> About 39 percent of beneficiaries had private sector supplemental coverage such as Medigap (about 23 percent) or employer-sponsored retiree coverage (16 percent). Beneficiaries in the Medigap category either had Medigap coverage exclusively or had both Medigap and employer-sponsored coverage. Beneficiaries in the employer-sponsored category had employer-sponsored retiree coverage as their only source of supplemental insurance.

> About 6 percent of beneficiaries had public sector supplemental coverage, primarily Medicaid.

> Forty-eight percent of beneficiaries participated in Medicare managed care, which includes Medicare Advantage, health care prepayment, and cost plans. These types of arrangements generally replace Medicare's fee-for-service coverage and often provide more coverage.

> The numbers in this chart differ from those in Chart 2-5, Chart 4-1, and Chart 4-4 because of differences in the populations represented in the charts. This chart excludes beneficiaries in long-term care institutions, while Chart 2-5 and Chart 4-4 include all Medicare beneficiaries, and Chart 4-1 excludes beneficiaries in Medicare Advantage.

Chart 3-2 Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2021

	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	52,461	16%	23%	6%	48%	0%	6%
Age							
<65	6,518	7	5	25	52	0	11
65–69	11,615	15	27	5	48	0	6
70–74	13.178	17	27	2	47	0	6
75–79	9,699	18	25	3	49	0	4
80–84	6,003	19	25	4	47	0	5
85+	5,449	20	23	4	45	0	7
Income-to-poverty ratio							
≤1.00	7,196	2	7	26	59	0	5
1.00 to 1.25	3,542	4	12	20	58	0	7
1.25 to 2.00	9,518	8	19	6	57	0	10
2.00 to 4.00	14,671	17	27	1	47	0	7
>4.00	17,534	28	31	0	38	0	4
Eligibility status							
Aged	45,656	17	26	3	47	0	6
Disabled	6,321	7	5	24	52	0	11
ESRD	484	11	21	26	35	0	7
Residence							
Urban	43,335	16	22	6	50	0	5
Rural	9,126	17	28	8	36	0	10
Sex							
Male	23,330	16	24	6	46	0	7
Female	29,132	16	23	6	49	0	6
Health status							
Excellent/ very good	25,721	19	27	3	46	0	5
Good/fair	24,075	14	20	8	50	0	7
Poor	2,480	8	17	15	50	1	8

Note: ESRD (end-stage renal disease). We assigned beneficiaries to the supplemental coverage category in which they spent the most time in 2021. They could have had coverage in other categories during that year. "Medicare managed care" includes Medicare Advantage, cost, and health care prepayment plans. "Other public sector" includes federal and state programs not included in other categories. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs), as defined by the Office of Management and Budget. "Rural" indicates beneficiaries living outside MSAs. Analysis excludes beneficiaries living in institutions such as nursing homes. Analysis also excludes beneficiaries who were not in Part A and Part B throughout their Medicare enrollment in 2021 or who had Medicare as a secondary payer. The number of beneficiaries in the "Age" and "Sex" groupings do not sum to the total because of rounding. The number of beneficiaries in the "Health status" grouping is less than the total because some beneficiaries had missing values. Numbers in some rows do not sum to 100 percent because of 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 Medicare Current Beneficiary Survey, Survey File 2021.

> Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are age 65 or older, have income above twice the poverty level, and report better than poor health.

> Medigap is the most common source of supplemental coverage among those who are age 65 or older, have income higher than 1.25 times the poverty level, are eligible because of age, are rural dwelling, and report excellent or very good health.

> Medicaid coverage is most common among those who are under age 65, have income lower than 1.25 times the poverty level, are eligible because of disability or ESRD, are rural dwelling, and report poor health.

> Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, have income between 1.00 and 4.00 times the poverty level, are eligible because of disability, are rural dwelling, and report less than excellent or very good health.

Chart 3-3 Covered benefits and enrollment in standardized Medigap plans, 2023

	Medigap standardized plan type											
						High deductible		High deductible				
Benefit	A	B	C*	D	F*	F	G	G	K	L	M	N
Part A hospital costs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B cost sharing	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	$20/ $50
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice cost sharing	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
SNF coinsurance			✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible		✓	✓	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible			✓		✓	✓						
Part B excess charges					✓	✓	✓	✓				
Foreign travel emergency			✓	✓	✓	✓	✓	✓			✓	✓
Lives covered (in thousands)	109	133	404	141	4,932	151	58	5,069	50	28	1	1,321

Note: SNF (skilled nursing facility). Three states (Massachusetts, Minnesota, and Wisconsin) have different plan types and are not included in this chart. The second column of Plan F and the first column of Plan G are high-deductible versions of those plans. The ✓ indicates that the plan covers all cost sharing for that benefit. Percentages indicate that the plan covers that share of the total cost sharing. The "$20/$50" indicates that the plan covers all but $20 for physician office visits and all but $50 for emergency room visits.
*Beginning in 2020, new policies for Plan C or Plan F can no longer be sold. However, beneficiaries who purchased C plans or F plans before 2020 will be able to continue to purchase those plans.

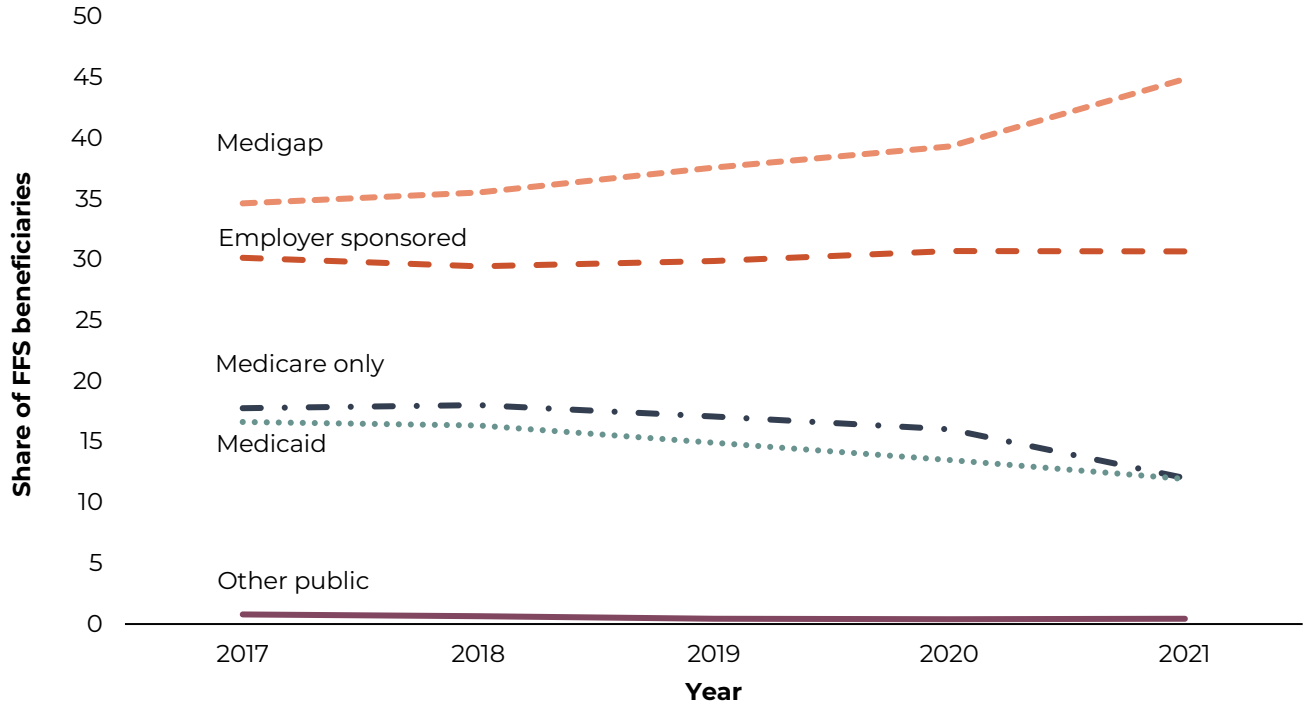
Source: MedPAC analysis of National Association of Insurance Commissioners data, 2023.

> Medicare beneficiaries often purchase Medigap plans, also known as Medicare supplementary insurance plans, to cover fee-for-service Medicare cost sharing. Statute specifies 12 standardized plans. States enforce the standards based on model regulations developed by the National Association of Insurance Commissioners. Three states (Massachusetts, Minnesota, and Wisconsin) have waivers from these standards and have different standard plan types not included in this chart.

> Plan G, which covers all Medicare cost sharing except the Part B deductible, is the most popular plan, with 5.1 million enrollees. In previous years, Plan F had been the most popular plan. Because the Congress was concerned about the overuse of Medicare services, legislation prohibits the sale of new Plan F policies as of 2020. As a result, insurers have begun to direct beneficiaries into other plan types, namely G, K, and N plans, which do not cover the Part B deductible.

> During 2023, 13 million beneficiaries enrolled in Medigap plans (including those in Massachusetts, Minnesota, and Wisconsin). Chart 3-2 indicates that about 12 million beneficiaries had Medigap coverage (23.4 percent of the 52.5 million beneficiaries included in that chart). The difference in Medigap enrollment between Chart 3-2 and Chart 3-3 is due to a difference in populations evaluated (Chart 3-2 excludes institutionalized beneficiaries, while Chart 3-3 includes them) and different years evaluated (Chart 3-2 is based on 2021, while Chart 3-3 is based on 2023).

Chart 3-4 The share of FFS beneficiaries who had Medigap coverage increased, while the share who had Medicaid or had only Medicare coverage decreased, 2017–2021



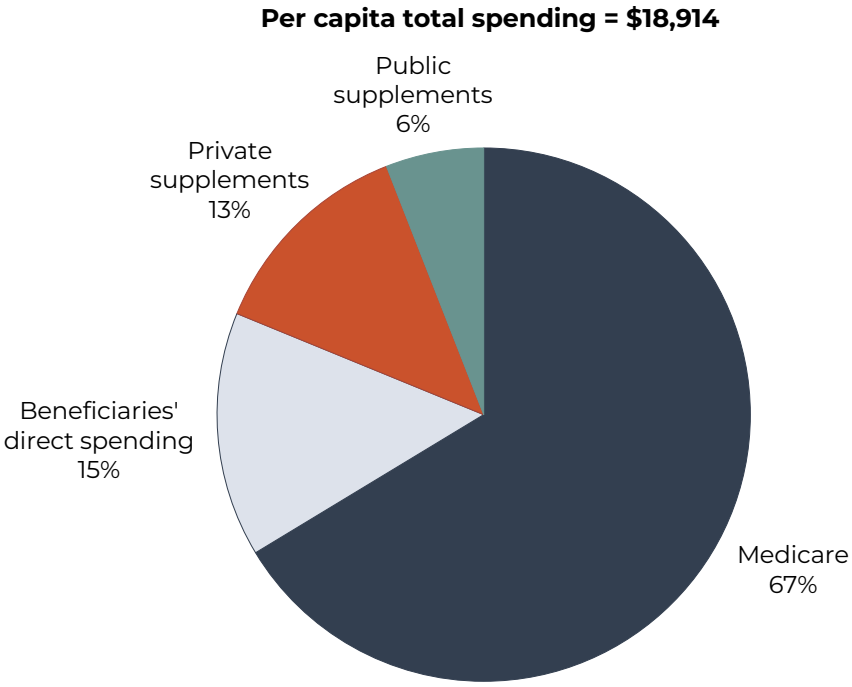
Note: FFS (fee-for-service). We assigned beneficiaries to the supplemental coverage category in which they spent the most time in 2021. They could have had coverage in other categories during that year. "Other public" includes federal and state programs not included in other categories. This analysis includes only FFS beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in Part A and Part B throughout their Medicare enrollment in 2021 or who had Medicare as a secondary payer. It also excludes beneficiaries in Medicare Advantage. 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 Medicare Current Beneficiary Survey, Survey File 2021.

> From 2017 to 2021, the share of FFS beneficiaries who had Medigap supplemental coverage rose from 35 percent to 45 percent. Over the same period, the share who had Medicaid coverage decreased from 17 percent to 12 percent, and the share who had no supplemental coverage ("Medicare only") dropped from 18 percent to 12 percent. The share that had employer-sponsored supplemental coverage stayed nearly constant at around 30 percent.

> These trends in FFS supplemental coverage could be due in part to beneficiaries with Medicaid coverage or no supplemental coverage opting to enroll in Medicare Advantage over FFS Medicare, while those who have Medigap coverage might choose to stay in FFS Medicare.

Chart 3-5 Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2021



Note: FFS (fee-for-service). "Private supplements" includes employer-sponsored plans and individually purchased coverage. "Public supplements" includes Medicaid, Department of Veterans Affairs, and other public coverage. "Beneficiaries' direct spending" includes Medicare cost sharing and spending on noncovered services but not supplemental premiums. Analysis excludes beneficiaries who are not in FFS Medicare and those living in institutions such as nursing homes. The percentages do not sum to 100 because of 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 Medicare Current Beneficiary Survey, Cost Supplement file, 2021.

> Among FFS beneficiaries living in the community (rather than in an institution), the total cost of health care services (beneficiaries' direct spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) averaged almost $19,000 in 2021. Medicare was the largest source of payment: It paid about 67 percent of the health care costs for FFS beneficiaries living in the community, an average of $12,611 per beneficiary.

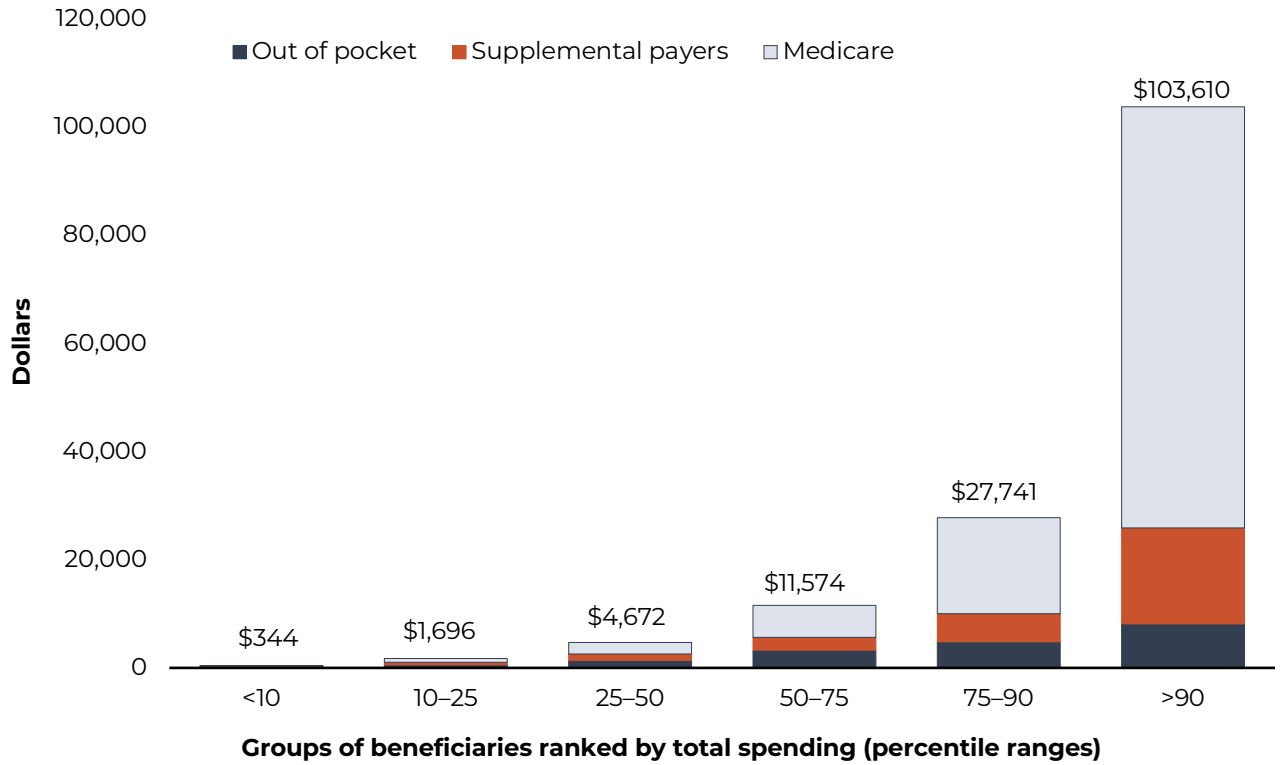
> Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and Medigap—paid about 13 percent of beneficiaries' costs, an average of $2,384 per beneficiary.

> Beneficiaries paid about 15 percent of their health care costs (not including supplemental insurance premiums) out of pocket, an average of $2,826 per beneficiary.

> Public sources of supplemental coverage—primarily Medicaid—paid about 6 percent of beneficiaries' health care costs, an average of $1,092 per beneficiary.

> The aggregate per capita spending in this chart ($18,914) was much higher than the aggregate spending in 2020 ($14,910) that we reported last year. The higher spending in 2021 reflects at least in part the rebound in service use from the relatively low level that occurred during the early months of the coronavirus pandemic.

Chart 3-6 Distribution of per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2021



Note: FFS (fee-for-service). Analysis excludes beneficiaries who are not in FFS Medicare and those living in institutions such as nursing homes. "Out-of-pocket" spending includes Medicare cost sharing and noncovered services but not supplemental premiums. 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, Cost Supplement File, 2021.

> Total spending on health care services varied dramatically among FFS beneficiaries living in the community in 2021. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged $103,610. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged $344.

> Among FFS beneficiaries living in the community, Medicare paid a larger share and beneficiaries' out-of-pocket spending was a smaller share as total spending increased. For example, Medicare paid 67 percent of total spending for all beneficiaries, but paid 75 percent of total spending for the 10 percent of beneficiaries with the highest total spending (data not shown). Among all FFS beneficiaries living in the community, out-of-pocket spending amounted to 15 percent of total spending but only 8 percent of total spending for the 10 percent of beneficiaries with the highest total spending (data not shown).

Chart 3-7 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" in this chart does not include premiums.)

> To help cover cost-sharing obligations, 94 percent of noninstitutionalized beneficiaries had coverage that supplemented or replaced the Medicare benefit package in 2021, such as Medicare Advantage, Medigap coverage, supplemental coverage through a former employer, or Medicaid (data not shown; see Chart 3-1).

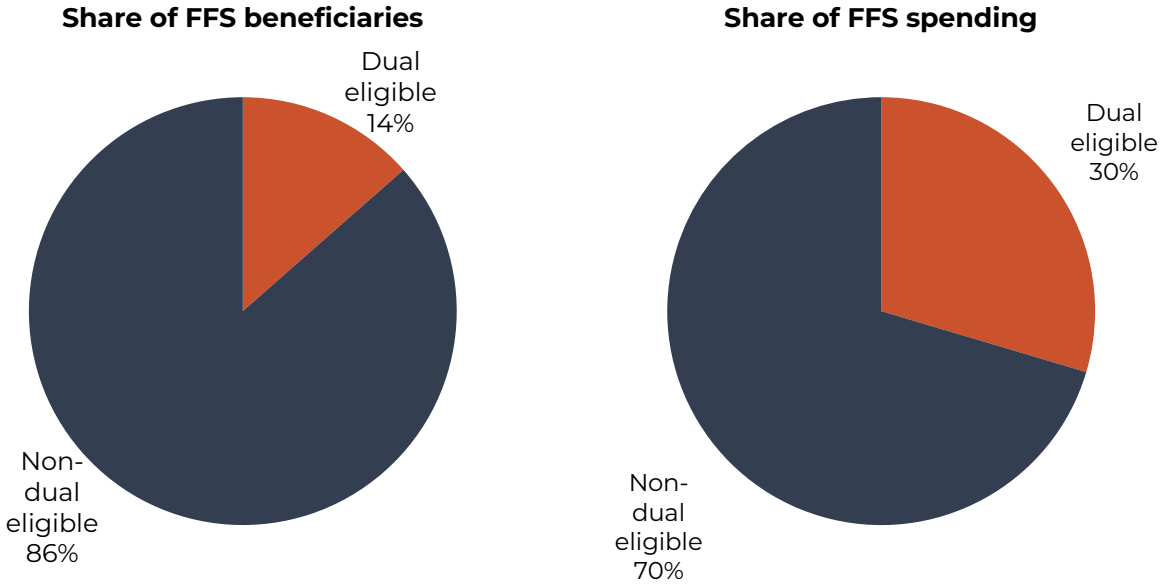
> The results in this chart are based on all Medicare FFS beneficiaries, while the results in Chart 3-5 and Chart 3-6 exclude the FFS Medicare beneficiaries who were living in institutions. Also, this chart includes only Medicare-covered services; Chart 3-5 and Chart 3-6 include both Medicare-covered services and services not covered under FFS Medicare.

SECTION

4

Dual-eligible beneficiaries

Chart 4-1 Dual-eligible beneficiaries accounted for a disproportionate share of Medicare spending, 2021



Note: FFS (fee-for-service). "Dual-eligible beneficiaries" are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. The Medicare Current Beneficiary Survey is a point-in-time survey from a sample of Medicare beneficiaries. Year-to-year variation in reported data is expected.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2021.

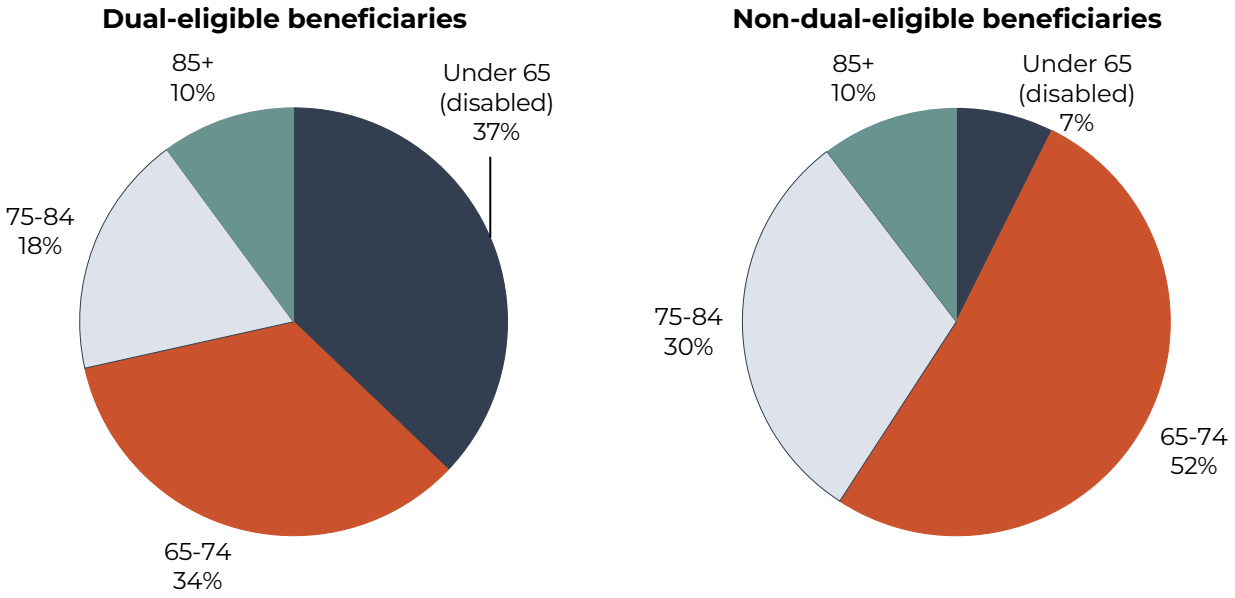
> Dual-eligible beneficiaries are those who qualify for both Medicare and Medicaid. Medicaid is a joint federal and state program designed to help people with low incomes obtain needed health care.

> Dual-eligible beneficiaries account for a disproportionate share of Medicare FFS expenditures. Although they were 14 percent of the FFS Medicare population in 2021, they represented 30 percent of aggregate FFS Medicare spending.

> On average, FFS Medicare per capita spending is more than twice as high for dual-eligible beneficiaries compared with non-dual-eligible beneficiaries: In 2021, $29,328 was spent per dual-eligible beneficiary, and $10,907 was spent per non-dual-eligible beneficiary (data not shown).

> In 2021, average total spending—which includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending across all payers—for dual-eligible beneficiaries was $45,598 per beneficiary, about twice the amount for other Medicare beneficiaries (data not shown).

Chart 4-2 Dual-eligible beneficiaries were more likely than non-dual-eligible beneficiaries to be under age 65 and have a disability, 2021



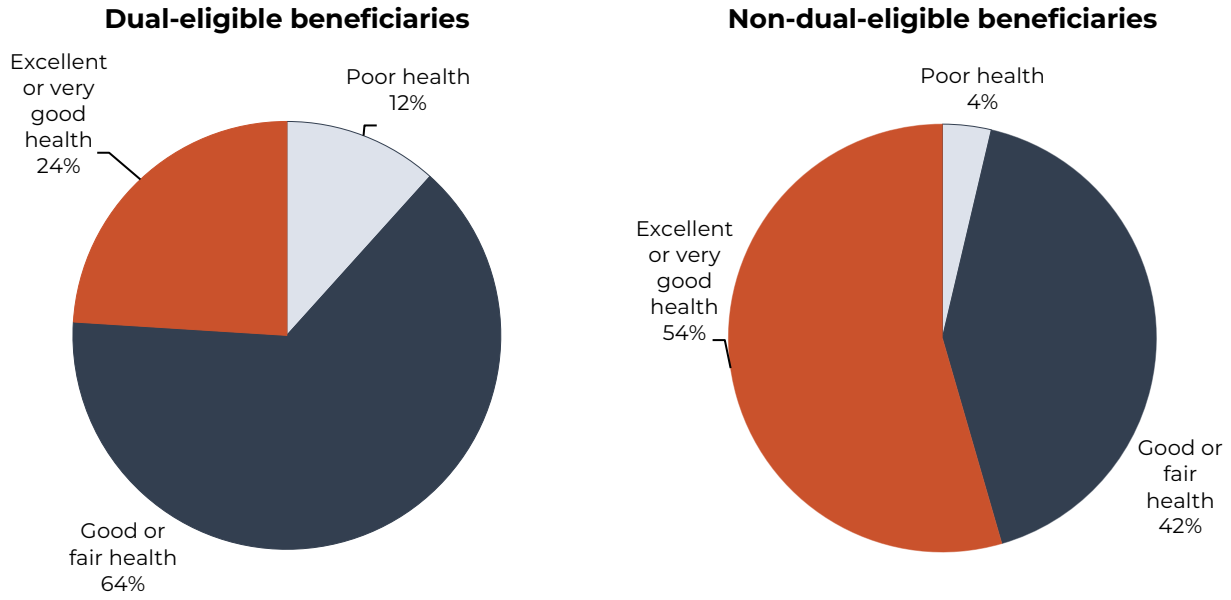
Note: Beneficiaries who are under age 65 generally qualify for Medicare because of disability. Once beneficiaries with disabilities reach age 65, they are counted as aged beneficiaries. "Dual-eligible beneficiaries" are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. Components do not sum to 100 percent due to rounding. The Medicare Current Beneficiary Survey is a point-in-time survey from a sample of Medicare beneficiaries. Year-to-year variation in reported data is expected.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2021.

> Disability is a pathway for individuals to become eligible for both Medicare and Medicaid benefits.

> Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to be under age 65 and have a disability. In 2021, 37 percent of dual-eligible beneficiaries were under age 65 with a disability compared with 7 percent of the non-dual-eligible population.

Chart 4-3 Dual-eligible beneficiaries were more likely than non-dual-eligible beneficiaries to report being in poor health, 2021



Note: "Dual-eligible beneficiaries" are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. The Medicare Current Beneficiary Survey is a point-in-time survey from a sample of Medicare beneficiaries. Year-to-year variation in reported data is expected.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2021.

> Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to report being in poor health. In 2021, 12 percent of dual-eligible beneficiaries reported being in poor health compared with 4 percent of non-dual-eligible beneficiaries.

> Over half of non-dual-eligible beneficiaries (54 percent) reported being in excellent or very good health in 2021. In comparison, less than one-quarter (24 percent) of dual-eligible beneficiaries reported being in excellent or very good health.

Chart 4-4 Demographic differences between dual-eligible beneficiaries and non-dual-eligible beneficiaries, 2021

Characteristics	Share of dual-eligible beneficiaries	Share of non-dual-eligible beneficiaries
Sex		
Male	39%	47%
Female	61	53
Race/ethnicity		
White, non-Hispanic	47	81
Black, non-Hispanic	23	8
Hispanic	22	6
Other	9	6
Limitations in ADLs		
No limitations in ADLs	48	77
Limitations in 1–2 ADLs	25	16
Limitations in 3–6 ADLs	27	7
Residence		
Urban	82	83
Rural	18	17
Living arrangement		
Institution	8	1
Alone	38	28
With spouse	13	50
With children, nonrelatives, others	41	20
Education		
No high school diploma	35	7
High school diploma only	32	23
Some college or more	33	69
Income status		
Below poverty	57	4
100–125% of poverty	19	4
125–150% of poverty	9	5
150–200% of poverty	9	12
200–400% of poverty	6	32
Over 400% of poverty	<1	43
Supplemental insurance status		
Medicare or Medicare/Medicaid only	32	8
Medicare managed care	59	41
Employer-sponsored insurance	2	25
Medigap	5	24
Medigap/employer	<1	1
Other*	2	1

Note: ADL (activity of daily living). "Dual-eligible beneficiaries" were eligible for both Medicare and Medicaid for at least one month during the year. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs). "Rural" indicates beneficiaries living outside of MSAs. Totals may not sum to 100 percent due to rounding and exclusion of an "other" category. The Medicare Current Beneficiary Survey is a point-in-time survey of a sample of beneficiaries. Year-to-year data variation is expected.
*Includes public programs such as the Department of Veterans Affairs and state-sponsored drug plans.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2021.

> Dual-eligible beneficiaries qualify for Medicaid due in part to low incomes. In 2021, 57 percent of dual-eligible beneficiaries lived below the poverty threshold, and 93 percent lived below 200 percent of the poverty threshold. Compared with non-dual-eligible beneficiaries, dual-eligible beneficiaries are more likely to be female, be Black or Hispanic, have greater limitations in activities of daily living, live in an institution, and lack a high school diploma. They are more likely to be enrolled in a Medicare managed care plan and less likely to have supplemental employer-sponsored or Medigap coverage.

Chart 4-5 Differences in Medicare spending and service use between dual-eligible beneficiaries and non-dual-eligible beneficiaries, 2021

Service	Dual-eligible beneficiaries	Non-dual-eligible beneficiaries
Average FFS Medicare payment for all beneficiaries		
Total Medicare FFS payments	$29,328	$10,907
Inpatient hospital	5,681	2,751
Physician[a]	3,476	3,001
Outpatient hospital	3,008	2,121
Home health	976	325
Skilled nursing facility[b]	1,368	405
Hospice	487	229
Prescribed medication[c]	14,233	1,921
Share of FFS beneficiaries using service		
Share using any type of service	96.8%	85.4%
Inpatient hospital	19.8	10.9
Physician[a]	91.0	82.9
Outpatient hospital	74.6	62.8
Home health	12.4	7.6
Skilled nursing facility[b]	6.4	2.8
Hospice	3.6	2.0
Prescribed medication[c]	91.6	57.4

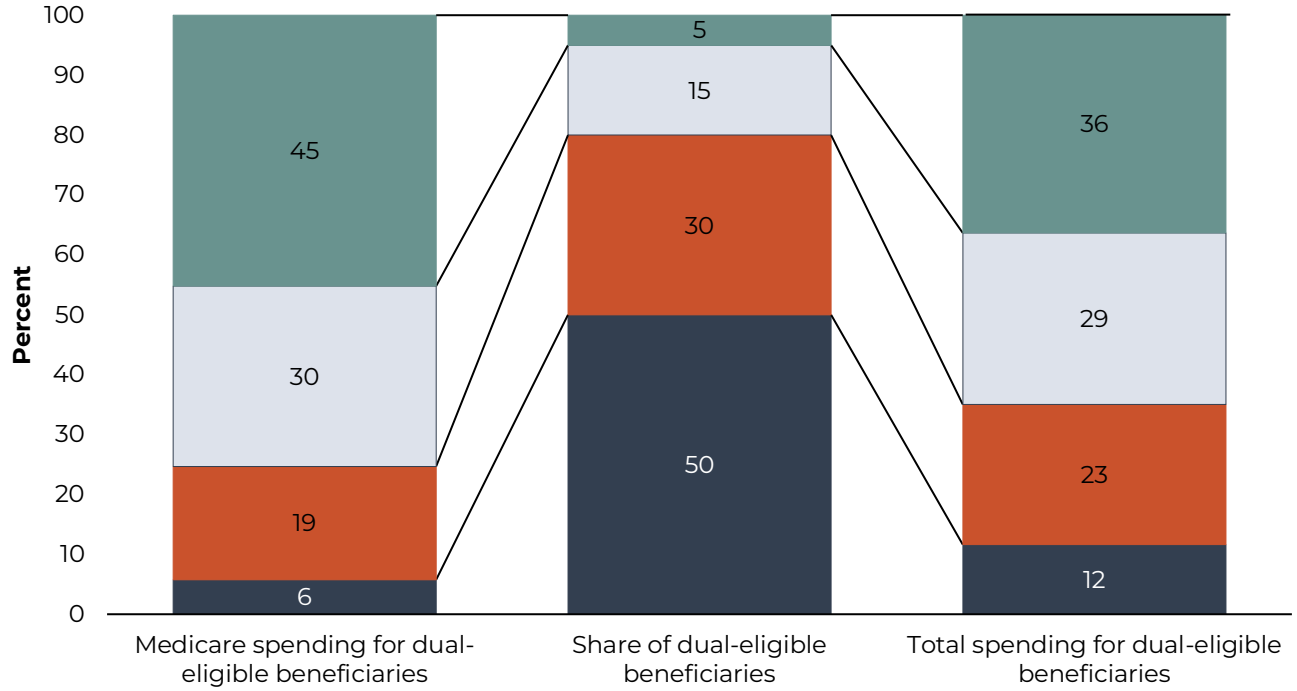
Note: FFS (fee-for-service). Data in this analysis are restricted to beneficiaries in FFS Medicare. "Dual-eligible beneficiaries" are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. Spending totals derived from the Medicare Current Beneficiary Survey (MCBS) do not necessarily match estimates from CMS's Office of the Actuary. Total payments do not equal the sum of line items due to omitted "other" category. The MCBS is a point-in-time survey from a sample of Medicare beneficiaries. Year-to-year variation in reported data is expected.
[a]Includes a variety of medical services, equipment, and supplies.
[b]Individual short-term facility (usually skilled nursing facility) stays for the MCBS population.
[c]Data from stand-alone prescription drug plans.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2021.

> In 2021, average per capita Medicare FFS spending for dual-eligible beneficiaries was more than twice that for non-dual-eligible beneficiaries—$29,328 compared with $10,907.

> For each type of service, average Medicare FFS per capita spending was higher for dual-eligible beneficiaries than for non-dual-eligible beneficiaries. Higher average per capita FFS spending for dual-eligible beneficiaries is a function of greater use of these services by dual-eligible beneficiaries compared with their non-dual-eligible counterparts. Dual-eligible beneficiaries are more likely than non-dual-eligible beneficiaries to use each type of Medicare-covered service.

Chart 4-6 Both Medicare and total spending were concentrated among a small number of dual-eligible beneficiaries, 2021



Note: "Total spending" includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending. Data in this analysis are restricted to beneficiaries in fee-for-service (FFS) Medicare. "Dual-eligible beneficiaries" are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. The Medicare Current Beneficiary Survey is a point-in-time survey from a sample of Medicare beneficiaries. Year-to-year variation in reported data is expected.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2021.

> Annual Medicare FFS and total spending on dual-eligible beneficiaries are concentrated among a small number of people. The costliest 5 percent of dual-eligible beneficiaries accounted for 45 percent of Medicare spending and 36 percent of total spending on dual-eligible beneficiaries in 2021. In contrast, the least costly 50 percent of dual-eligible beneficiaries accounted for only 6 percent of Medicare FFS spending and 12 percent of total spending on dual-eligible beneficiaries.

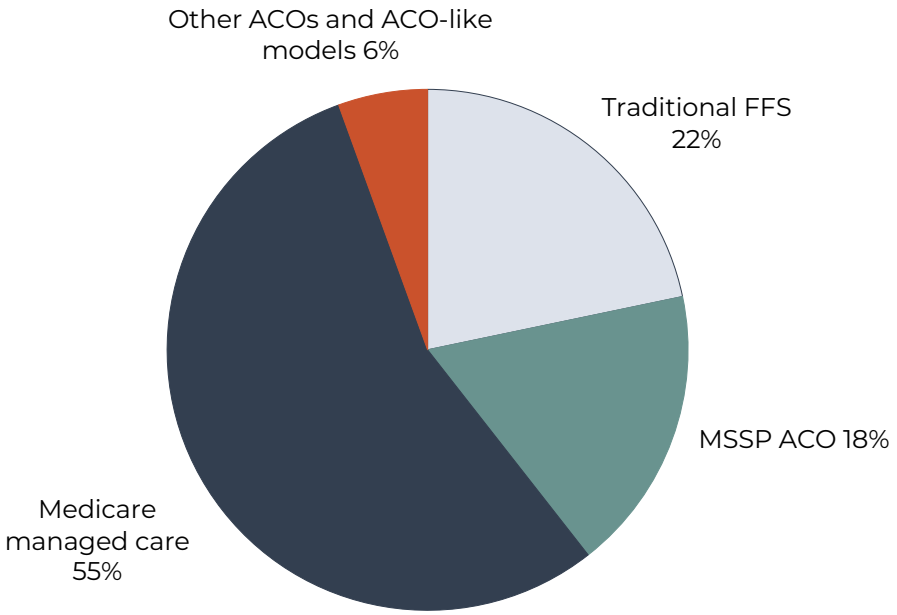
> On average, total spending (including Medicaid, Medigap, etc.) for dual-eligible beneficiaries in 2021 was more than twice that for non-dual-eligible beneficiaries—$45,598 compared with $18,142, respectively (data not shown).

SECTION

5

Alternative payment models

Chart 5-1 Most Medicare beneficiaries are in managed care plans or are assigned to accountable care organizations, 2024



Note: ACO (accountable care organization), FFS (fee-for-service), MSSP (Medicare Shared Savings Program). This chart includes only beneficiaries enrolled in both Part A and Part B in January 2024. Both Part A and Part B coverage is necessary for either Medicare Advantage enrollment or ACO assignment. In general, Medicare managed care plans include Medicare Advantage plans as well as cost-reimbursed plans and Medicare–Medicaid demonstration plans. "Other ACOs and ACO-like models" include the ACO Realizing Equity, Access, and Community Health (REACH) Model, the Maryland Total Cost of Care (TCOC) Model, and the Vermont All-Payer ACO. In the Maryland TCOC Model, all FFS beneficiaries are assigned to a hospital, and each hospital is responsible for all Part A and Part B spending for all Medicare beneficiaries in its market. This system creates ACO-like incentives for the hospital and qualifies physicians affiliated with those hospitals for the Medicare Access and CHIP Reauthorization Act (MACRA) bonus payments for participation in eligible alternative payment models.

Source: CMS January 2024 enrollment data, CMS Shared Savings Program January 2024 Fast Facts, CMS ACO REACH 2024 Fast Facts, and State of Vermont Green Mountain Care Board 2023 Medicare total cost of care annual report.

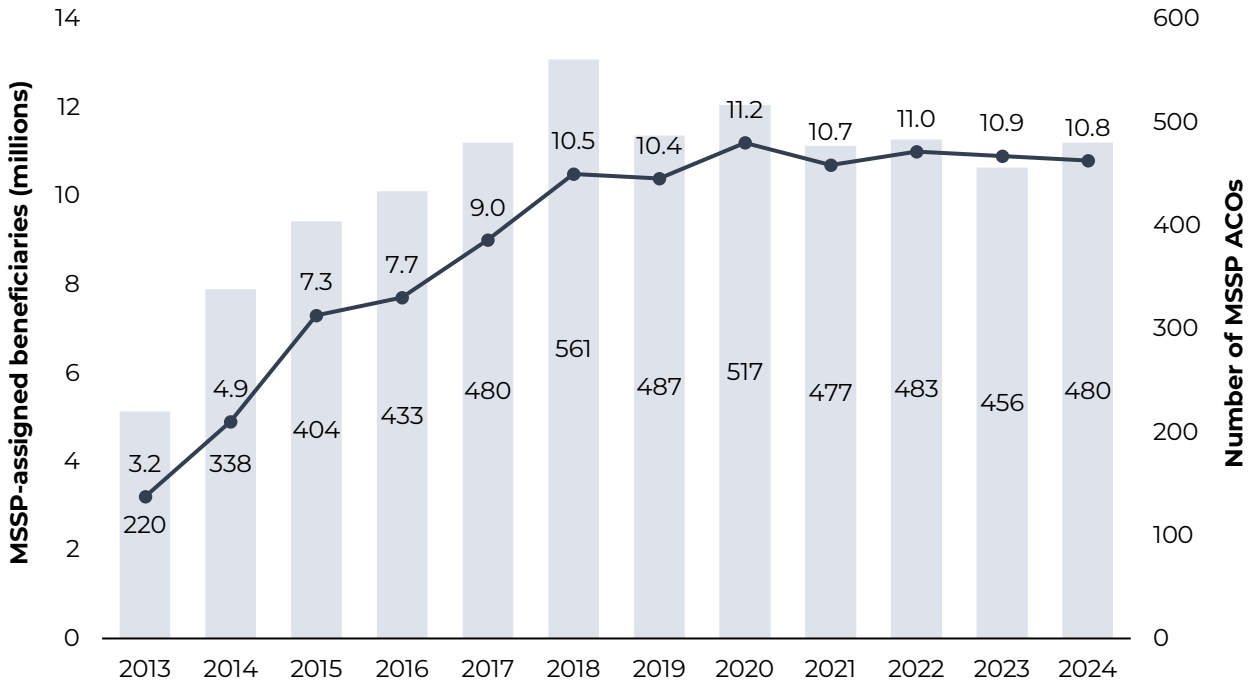
> Among the 61.0 million Medicare beneficiaries with both Part A and Part B coverage in 2024, approximately three-fourths (78 percent) are in Medicare managed care (Medicare Advantage or other private plans) or ACO models.

> The MSSP, a permanent ACO model established through the Affordable Care Act of 2010, accounts for most of the beneficiaries assigned to ACO or ACO-like payment models.

> Only 22 percent of Medicare beneficiaries with both Part A and Part B coverage are now in traditional FFS Medicare—a share that has declined in recent years.

> Even among the share of beneficiaries in FFS Medicare, some beneficiaries may be assigned to other alternative payments models such as the Bundled Payments for Care Improvement Advanced Model.

Chart 5-2 The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 and then leveled off



Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). Numbers are as of January in each year. In 2019, MSSP ACOs were allowed to join the program in July. Those ACOs and the beneficiaries assigned to them were therefore not in the program as of January 2019 and so are not included in the 2019 counts on this chart. As of July 2019, there were 518 MSSP ACOs and 10.9 million beneficiaries assigned to them (data not shown). In 2021, new MSSP ACOs were not allowed to join the program due to the coronavirus pandemic, though ACOs were still allowed to exit the program.

Source: CMS Shared Savings Program January 2024 Fast Facts.

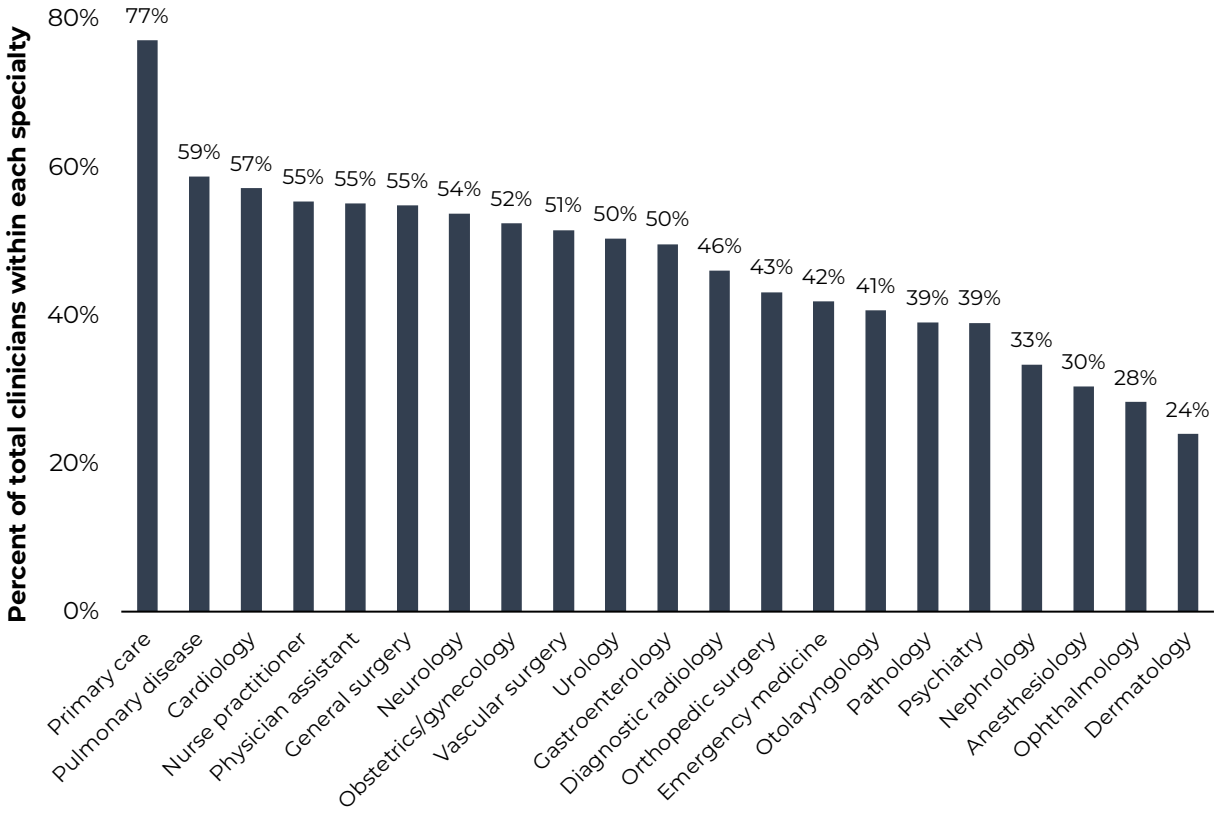
> The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 but has leveled off in recent years. In 2023, 18 percent of beneficiaries enrolled in both Part A and Part B were assigned to an MSSP ACO (see Chart 5-1).

> The number of ACOs peaked at 561 in 2018 and then declined to 487 in January 2019. In 2024, there were 480 ACOs—an increase relative to 2023.

> CMS finalized changes to MSSP at the end of 2018 that included (1) requiring ACOs to transition toward greater levels of financial risk and (2) using regional spending as a component of all ACO benchmarks (the spending levels used to measure an ACO's financial performance). These changes coincided with some ACOs dropping out of the program and fewer new ACOs joining.

> In 2024, the number of assigned beneficiaries is similar to the amount in 2021, as is the number of beneficiaries per ACO (latter data not shown).

Chart 5-3 Participation in MSSP ACOs among select specialties, 2022



Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). "Total clinicians" includes all clinicians from each specialty who treated at least one Medicare fee-for-service (FFS) beneficiary in 2022, including those who participated in an MSSP ACO. "Primary care" includes physicians who specialize in internal medicine, family medicine, geriatric medicine, and pediatric medicine.

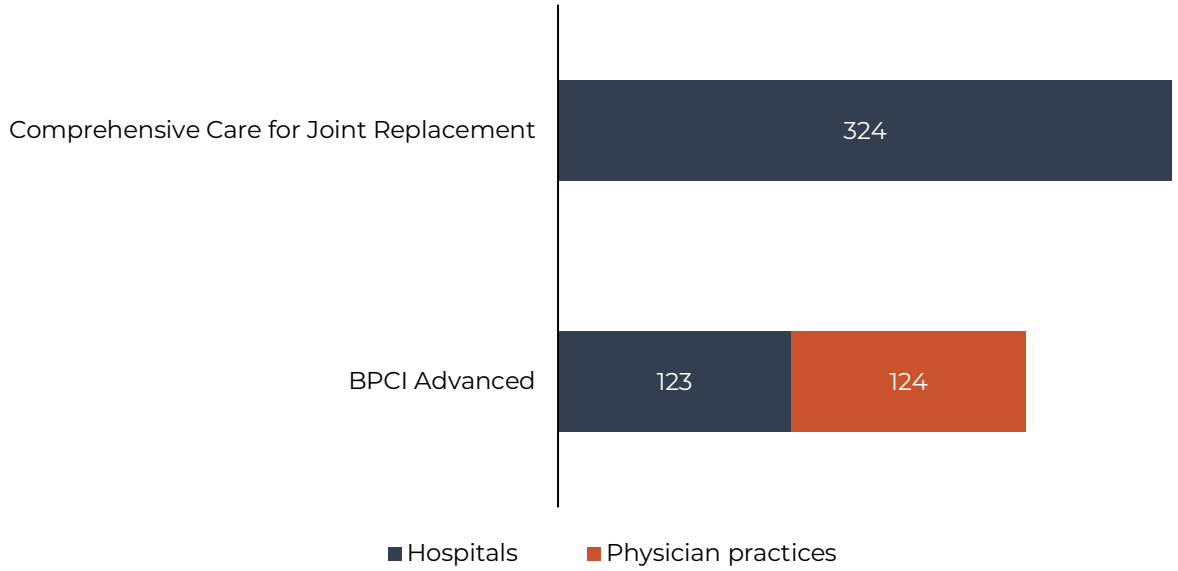
Source: Shared Savings Program Accountable Care Organizations public use files and research identifiable files from CMS; Carrier Standard Analytic File for 100 percent of Medicare beneficiaries from CMS.

> ACOs by design are oriented around primary care, but specialists also participate in these models. Most MSSP ACOs have a mix of physicians among various clinical specialties.

> Among all primary care physicians who billed FFS Medicare in 2022, 77 percent participated in an MSSP ACO.

> Among other specialties, participation in ACOs as a share of all clinicians within the specialty varies greatly. For example, 59 percent of all pulmonologists participating in FFS Medicare in 2022 also participated in an ACO. By contrast, less than 30 percent of ophthalmologists and dermatologists participated in an MSSP ACO.

Chart 5-4 Comprehensive Care for Joint Replacement is Medicare's largest episode-based payment model, 2024



Note: BPCI (Bundled Payments for Care Improvement).

Source: Comprehensive Care for Joint Replacement website (https://www.cms.gov/priorities/innovation/innovation-models/cjr); information on BPCI Advanced participants is from CMS's Where Innovation Is Happening website (https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced).

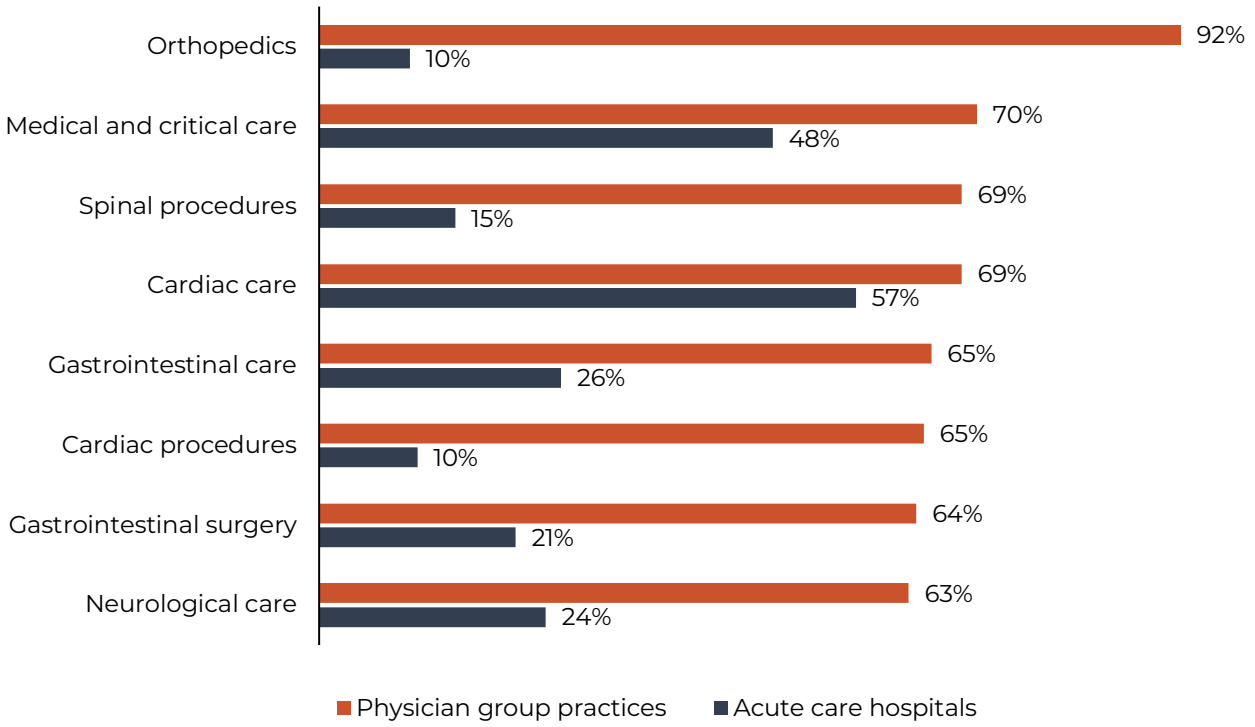
> Episode-based payment models give health care providers a spending target for most types of care provided during a clinical episode (e.g., 6 months of chemotherapy or an inpatient admission or outpatient procedure plus most other care provided in the subsequent 90 days). If total spending is less than the target, Medicare pays providers a bonus; if total spending is more than the target, Medicare recoups money from providers.

> Within fee-for-service Medicare, the episode-based payment model with broadest participation is the Comprehensive Care for Joint Replacement (CJR) Model, with 324 participating hospitals.

> Participation in the BPCI Advanced Model shrank from 280 acute care hospitals and physician group practices in 2023 to 247 in 2024. The number of participants in the model is divided evenly between hospitals (123) and physician practices (124).

> CMS plans to test another episode-based payment model, the Transforming Episode Accountability Model (TEAM), starting in 2026. TEAM will draw on lessons learned from the CJR and BPCI Advanced models. As proposed, TEAM will be a mandatory model that focuses on quality and spending metrics during the 30-day period following certain surgical procedures.

Chart 5-5 Share of BPCI Advanced episode initiators accepting responsibility for each clinical-episode group, 2024



Note: BPCI (Bundled Payments for Care Improvement). BPCI Advanced participants can accept episode-based payments for multiple clinical-episode service-line groups. The denominators for each group are 124 episode initiators among physician group practices and 123 episode initiators among acute care hospitals in 2024.

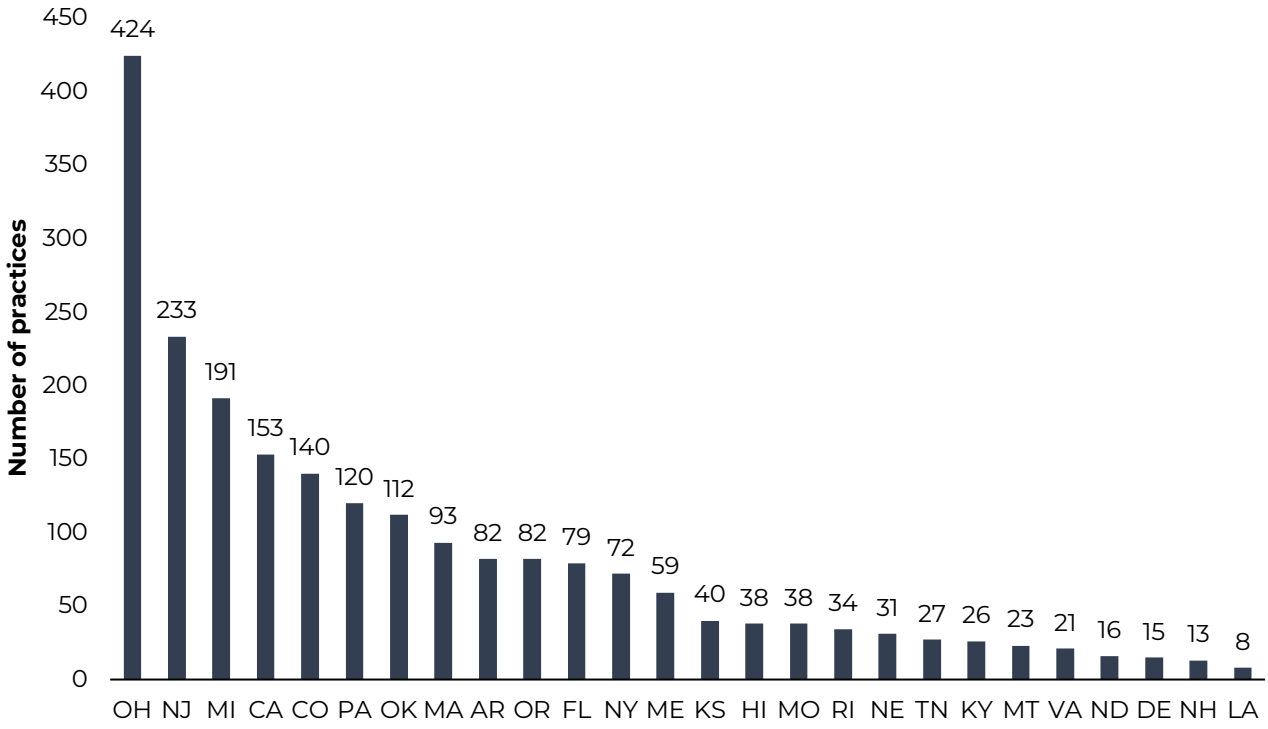
Source: List of clinical-episode service-line groups that each BPCI Advanced participating episode initiator agreed to take financial responsibility for in Model Year 7 (2024), downloaded from CMS's BPCI Advanced webpage (https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced).

> BPCI Advanced covers dozens of types of inpatient and outpatient clinical episodes, aggregated into eight clinical-episode service-line groups (e.g., the cardiac care group includes acute myocardial infarction, cardiac arrhythmia, and congestive heart failure). Participating hospitals and physician practices select the service-line groups for which they will be financially responsible under the model.

> More than 60 percent of physician practices participating in the model initiate episodes in all of the service-line groups in 2024, which is substantially less than the 80 percent of practices that initiated episodes in all service-line groups in 2023 (data not shown). Among participating hospitals, there is more variation. Nearly 57 percent of hospitals initiate episodes within the cardiac care service-line group, while only 10 percent of hospitals opt to initiate episodes in the orthopedic and cardiac procedures service-line groups.

> About one-third of all BPCI Advanced episode initiators accept episode-based payments for more than four of the eight clinical-episode service-line groups. Twenty-eight percent accept episode-based payments for only one clinical-episode service-line group (data not shown).

Chart 5-6 Almost 2,200 practices are testing the Primary Care First model, 2024



Note: Primary Care First is an advanced alternative payment model that CMS began testing with the first cohort in 2021 and the second cohort in 2022. Primary Care First is a multipayer model, with some Medicaid and private insurers voluntarily paying similar fees for their enrollees.

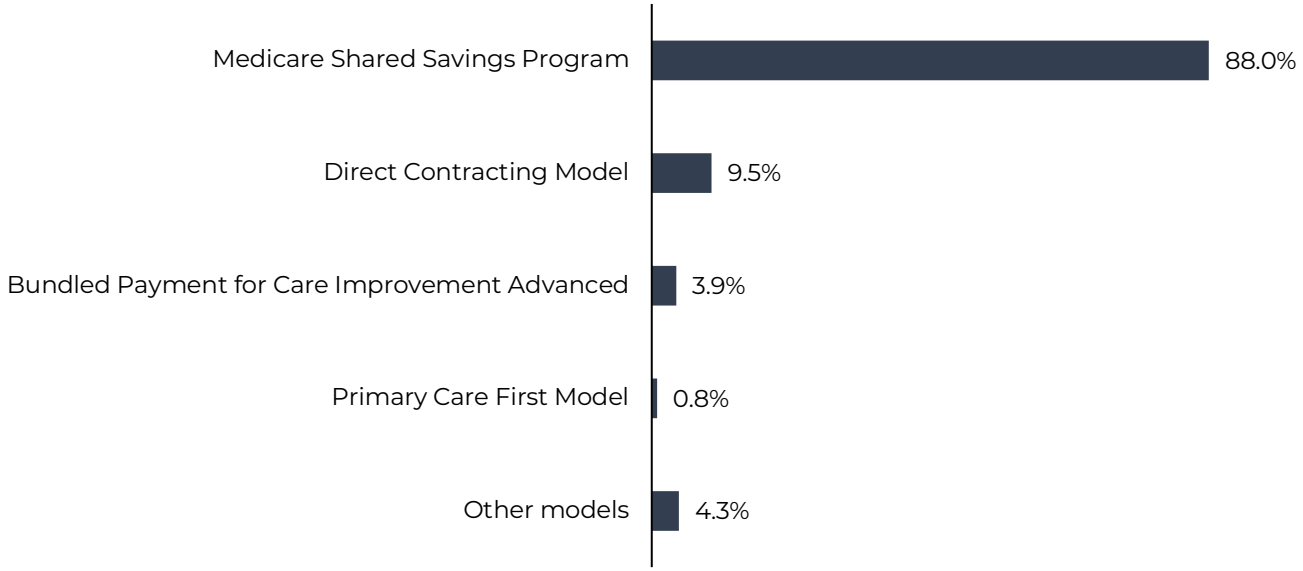
Source: CMS's list of Primary Care First practices (https://innovation.cms.gov/innovation-models/primary-care-first-model-options).

> CMS's Primary Care First is an advanced alternative payment model that has just under 2,200 participating practices in 26 states. The model aims to strengthen primary care by testing alternative ways of paying participating providers of primary care services. These payments are intended to support enhanced, coordinated care management and assist with care delivery transformation.

> Participating practices receive a risk-adjusted per beneficiary per month care management fee, plus a flat primary care visit fee instead of fee-for-service payments for certain primary care services. These payments are subject to adjustments determined by each practice's performance on specified quality and utilization measures.

> Participants are highly concentrated in just a few states. Two-thirds of practices in Primary Care First are located in three states (Ohio, New Jersey, and Michigan), while 10 percent of participants are in 10 states (Rhode Island, Nebraska, Tennessee, Kentucky, Montana, Virginia, North Dakota, Delaware, New Hampshire, and Louisiana).

Chart 5-7 Almost 90 percent of the clinicians who qualified for a 5 percent A–APM bonus in 2024 were in the Medicare Shared Savings Program



Note: A–APM (advanced alternative payment model). Clinicians' 2022 A–APM participation determines their 2024 bonuses. Shares do not sum to 100 percent because clinicians can participate in more than one A–APM simultaneously. To qualify for the A–APM bonus in 2024, clinicians had to receive 50 percent of their professional services payments or provide 35 percent of their patients with professional services through an A–APM in 2022. The A–APM bonus is equal to 5 percent of a clinician's professional services payments from Medicare (not including cost sharing paid by beneficiaries). "Other models" includes the Maryland Total Cost of Care Model, Comprehensive Care for Joint Replacement Model, Kidney Care Choices Model, Oncology Care Model, and Vermont ACO model. For the payment models shown, only those model tracks that require clinicians to take on some financial risk qualify as A–APMs (e.g., physicians participating in Track 1 of the Medicare Shared Savings Program did not qualify for A–APM bonuses because Track 1 involved no financial risk for participants).

Source: CMS data on clinicians who qualified for the 5 percent bonus in 2024 is based on clinicians' 2022 model participation.

> The payment models that CMS has designated as A–APMs place health care providers at some financial risk for Medicare spending while expecting them to meet quality goals for a defined patient population. Clinicians who participate in A–APMs qualify for bonuses equal to 5 percent of their professional services payments from Medicare. Those 5 percent bonus payments have been available from 2019 to 2024. A–APM bonuses for qualifying clinicians will equal 3.5 percent of professional service payments in 2025 and 1.88 percent in 2026.

> In 2024, nearly 384,000 clinicians nationwide qualified for the A–APM bonus (based on 2022 A–APM participation) out of about 1.3 million who billed the Medicare physician fee schedule (data not shown). More than 95 percent of clinicians who qualified for an A–APM bonus participated in at least one of the ACO initiatives administered by CMS, which gives clinicians an opportunity to earn shared savings payments from Medicare if they lower health care spending while meeting care quality standards (data not shown).

> Among clinicians who qualified for an A–APM bonus in 2024, 37 percent were specialists, 23 percent were primary care physicians, and 40 percent were nonphysician practitioners such as nurse practitioners or physician assistants (data not shown).

SECTION

6

Acute inpatient services

General acute care hospitals
Inpatient psychiatric facilities

Chart 6-1 Nearly one-quarter of inpatient stays at general acute care hospitals were for FFS Medicare beneficiaries, and almost all of those were paid under IPPS, 2022

	Number of hospitals	All-payer inpatient stays	FFS Medicare inpatient stays	FFS Medicare share of all inpatient stays
All general acute	**4,500**	**29.4 million**	**7.0 million**	**24%**
Share of total				
IPPS	69%	96%	95%	23
Location				
Metropolitan (urban)	52	89	86	23
Rural micropolitan	12	6	8	31
Other rural	5	1	1	31
Ownership				
For profit	17	16	15	22
Nonprofit	42	68	69	24
Government	10	13	11	11
DSH and teaching				
Both	26	64	60	22
DSH only	33	26	28	25
Teaching only	2	3	3	28
Neither	8	3	4	34
Critical access	30	2	3	40
Maryland	1	2	2	26

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital). Data are for general acute care hospitals in the U.S. that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. "Number of hospitals" is the number of Medicare provider numbers; a single provider number can represent multiple hospital locations. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people. Components may not sum to totals due to rounding. The year is fiscal.

Source: MedPAC analysis of hospital cost report data from CMS and census data on metropolitan and micropolitan areas.

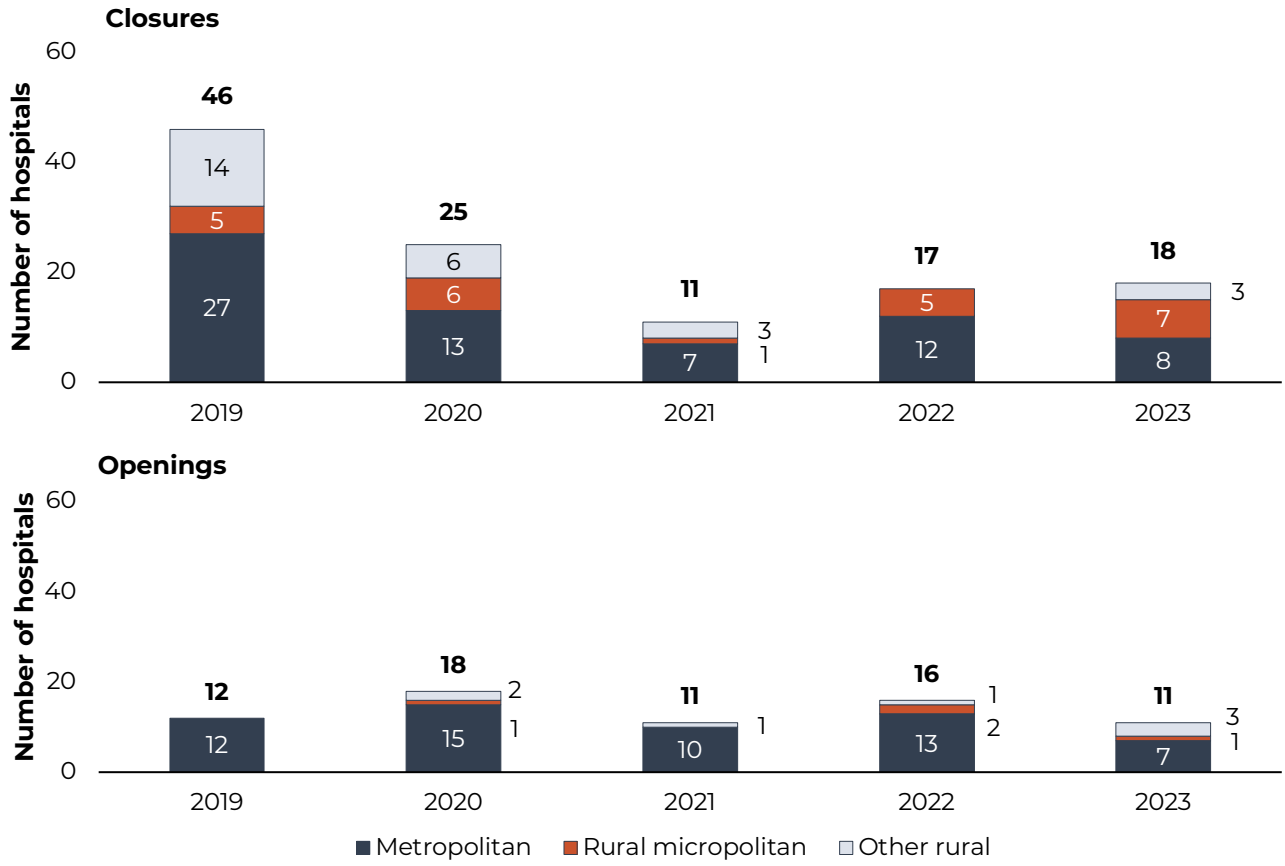
> In 2022, there were approximately 4,500 general acute care hospitals, at which there were 29.4 million inpatient stays. Nearly a quarter of these stays (7.0 million) were for FFS Medicare beneficiaries.

> For about two-thirds of general acute care hospitals, FFS Medicare pays for inpatient stays under Medicare's IPPS. Nearly all (96 percent) inpatient stays and FFS Medicare stays were at IPPS hospitals; further, the vast majority of all FFS Medicare stays were at the half of IPPS hospitals located in urban areas. FFS Medicare inpatient stays were a larger share of all stays at rural hospitals and a lower share at government-run hospitals.

> About 30 percent of general acute care hospitals are designated critical access hospitals (CAHs), which are hospitals with fewer than 25 beds, which FFS Medicare pays on a cost basis. However, only 2 percent of all inpatient stays and 3 percent of FFS Medicare inpatient stays were at CAHs. FFS Medicare patients accounted for 40 percent of all CAH inpatient stays.

> Data on Medicare Advantage (MA) inpatient stays in 2022 were not available at the time of publication. In 2021, there were over 5 million MA inpatient stays at general acute care hospitals (data not shown).

Chart 6-2 Number of general acute care hospital closures exceeded openings in 2023



Note: "Closure" refers to a general acute care hospital that ceased inpatient services and did not convert to a rural emergency hospital, while "opening" refers to a new location for general acute care inpatient services. The counts do not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor does it include hospitals that both opened and closed within a 5-year period. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." The years are fiscal. The number of hospital closures and openings in a given year can change over time as hospitals reopen or dates of closure are updated.

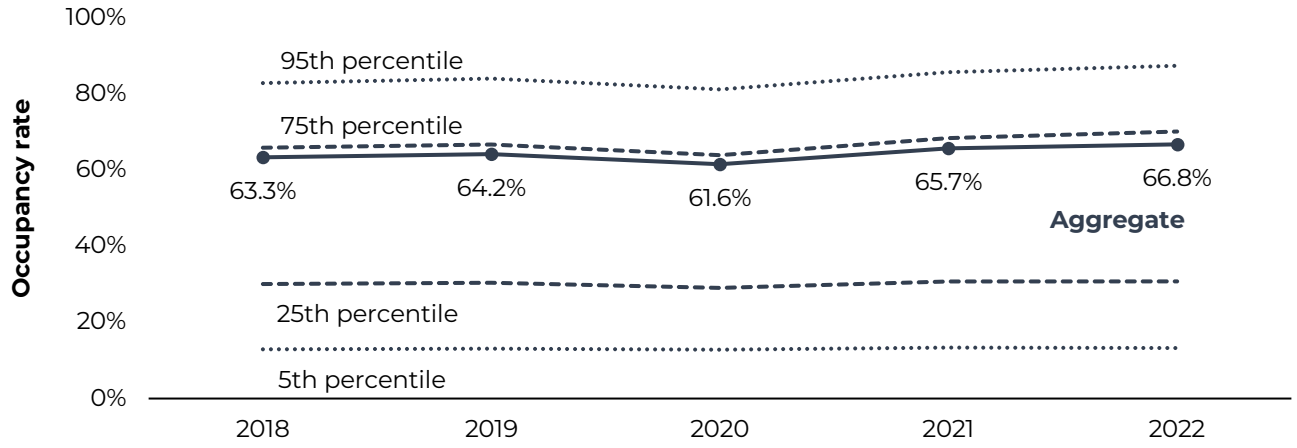
Source: MedPAC analysis of the CMS Provider of Services file, census data on metropolitan and micropolitan areas, and internet searches.

> In fiscal year (FY) 2023, 18 general acute care hospitals closed and 11 opened, leading to a slight net decrease in the number of hospitals providing inpatient services to Medicare beneficiaries.

> In addition to these changes, about 20 hospitals converted to the new rural emergency hospital (REH) designation (data not shown). Some of the hospitals that closed are considering reopening as REHs.

> The decrease in the supply of hospitals in FY 2023 was a contrast to FY 2021 and FY 2022, in which the supply was steady. However, it is similar to the slight decrease in 2020 and markedly smaller than the large decrease in 2019.

Chart 6-3 General acute care hospitals continued to have excess inpatient capacity in aggregate, but some hospitals neared capacity



Note: "Aggregate" occupancy rate is calculated as total used bed days (including inpatient, swing, and observation bed days but excluding nursery bed days) divided by total bed days available; total bed days available may be higher than staffed bed days. Data are for general acute care hospitals in the U.S. that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal.

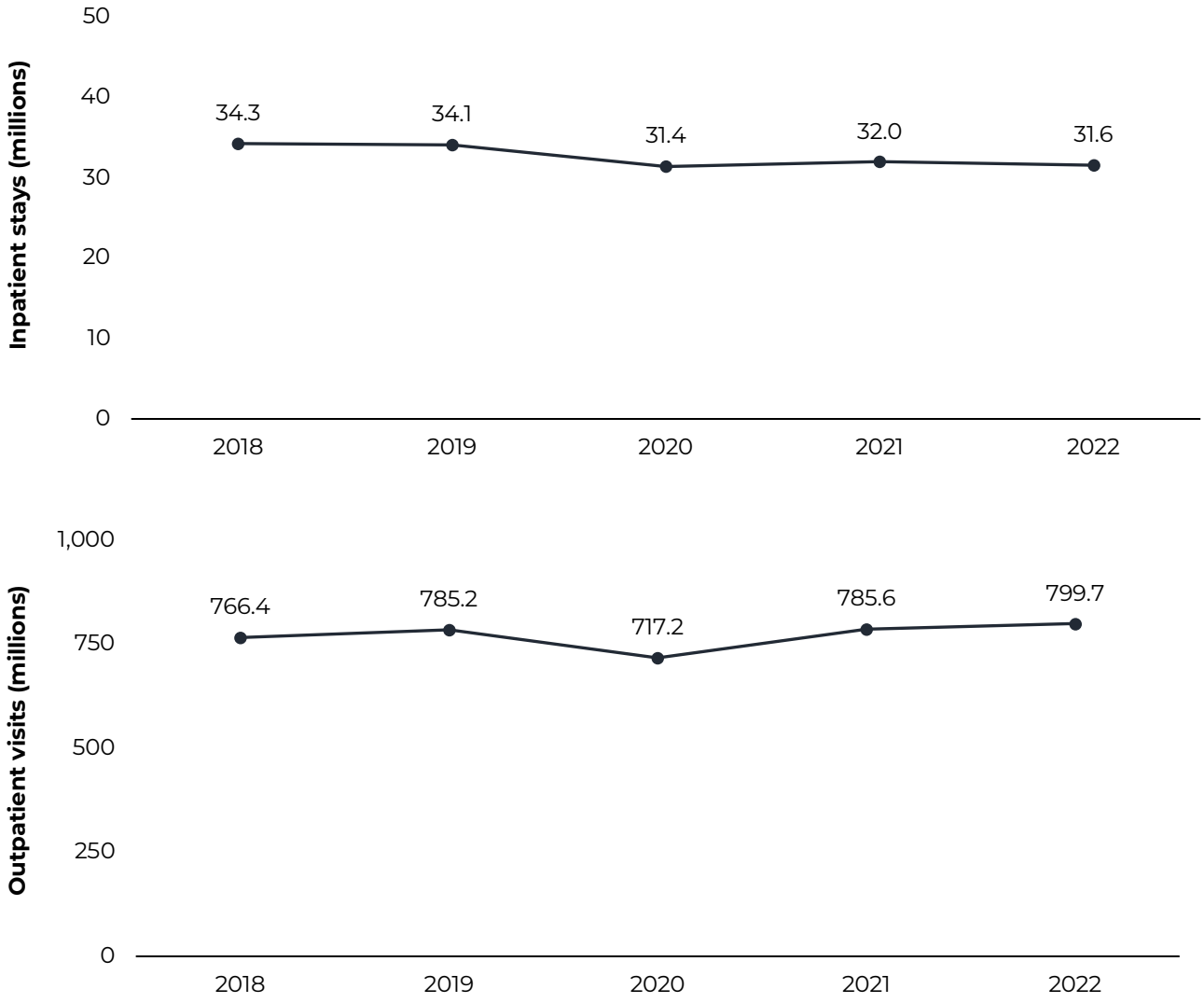
Source: MedPAC analysis of hospital cost report data from CMS.

> General acute care hospitals continued to have excess capacity in aggregate, with about 67 percent of all beds occupied during fiscal year 2022, slightly higher than in previous years.

> However, inpatient capacity continued to vary substantially across hospitals, with some reaching near capacity while others had substantial excess capacity. For example, in 2022, 5 percent of hospitals had occupancy rates of over 85 percent while 5 percent had occupancy rates below 15 percent. These hospitals with significant excess capacity were more likely to be small rural hospitals, while those with higher occupancy rates were more likely to be large hospitals with over 250 beds or more than 100 medical residents.

> Although hospital employment has increased to above prepandemic levels, some hospitals continued to report staffing shortages (data not shown).

Chart 6-4 All-payer inpatient stays remained below prepandemic levels in 2022, while hospital outpatient visits grew to above prepandemic levels



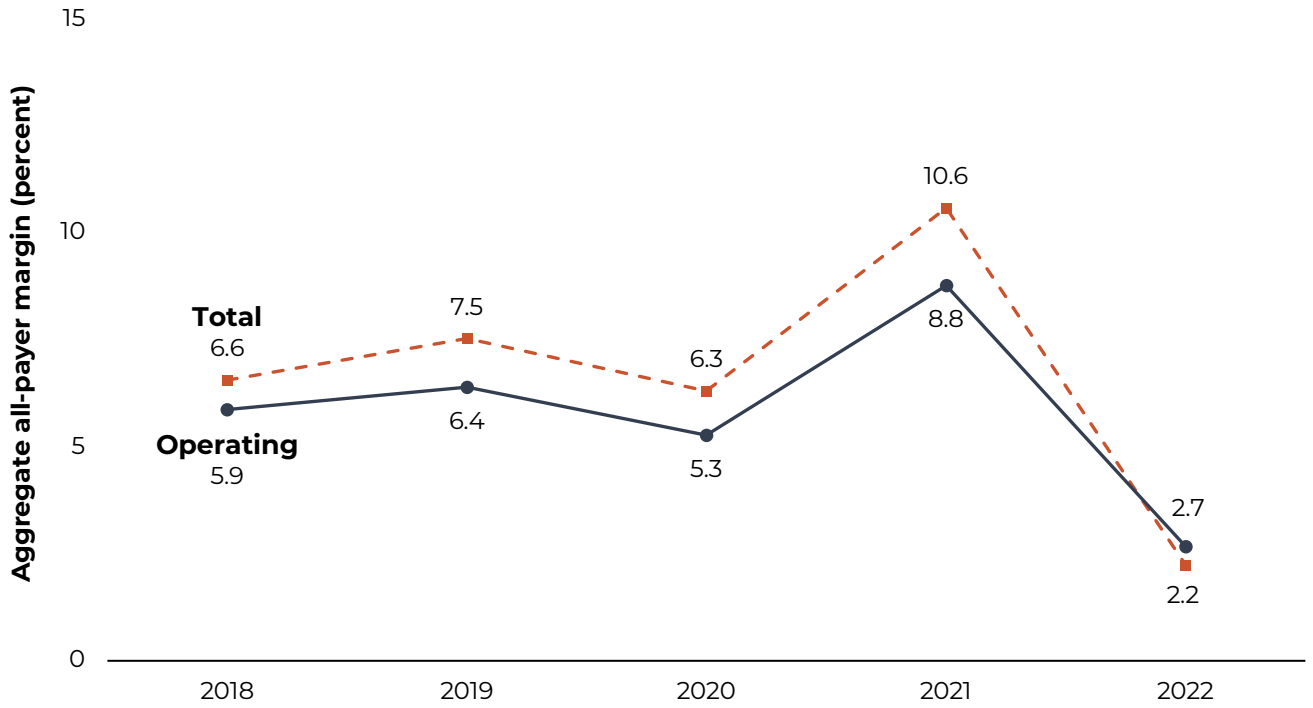
Note: "Outpatient visits" includes all clinic visits, referred visits, observation services, outpatient surgeries, and emergency department visits, regardless of the number of diagnostic and/or therapeutic treatments the patient received during the visit. Data are for community hospitals (nonfederal short-term general and specialty hospitals), estimated from those who responded to the American Hospital Association survey, and reflect each hospital's own fiscal year. Given that not all hospitals are reporting the same 12-month period, the data reflect varying numbers of months of COVID-19 impacts. The years are fiscal.

Source: MedPAC analysis of Hospital Statistics data from the American Hospital Association.

> In 2020, all-payer inpatient stays and hospital outpatient visits declined, reflecting delayed and forgone care during the COVID-19 public health emergency.

> By 2022, all-payer inpatient stays remained below levels immediately prior to the pandemic, while hospital outpatient visits grew to above prepandemic levels.

Chart 6-5 IPPS hospitals' aggregate all-payer margin fell from a record high in 2021 to a relative low in 2022



Note: IPPS (inpatient prospective payment systems). Hospitals' margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer" margin includes payments from all payers and, for 2020 through 2022, federal relief funds that were reported by hospitals. "Total" margin includes investments; "operating" margin excludes revenue from investments and contributions. Data are for IPPS hospitals that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. Given that not all hospitals are reporting the same 12-month period, the data reflect varying numbers of months of COVID-19 impacts. The years are fiscal.

Source: MedPAC analysis of hospital cost report data from CMS.

> Hospitals' aggregate all-payer margin reflects the relationship between hospitals' payments and costs across all payers (Medicare, Medicaid, other government payers, and private payers). The all-payer total margin includes investment income, while the operating margin excludes revenue from investments and contributions. For 2020 through 2022, these measures include reported federal relief funds to support hospitals during the COVID-19 public health emergency.

> IPPS hospitals' aggregate all-payer total and operating margins remained strong in 2020 with the support of about $35 billion in reported federal relief funds and reached record highs in 2021 when including the nearly $18 billion in reported relief funds. The 2021 operating margin excluding relief funds was 7.3 percent, also a record high (data not shown).

> However, in 2022, IPPS hospitals' all-payer total and operating margins fell to relative lows; the 2.7 percent aggregate all-payer operating margin was the lowest level since 2008 (data not shown). Federal relief funds contributed a much smaller amount to revenue in 2022 ($9 billion), while operating costs grew about 8 percent (data not shown). Furthermore, IPPS hospitals' all-payer total margin decreased to below their operating margin due to investment losses.

Chart 6-6 Magnitude of 2022 decrease in IPPS hospitals' all-payer operating margin varied by type, with less decline among for-profit hospitals

	Aggregate all-payer operating margin							
			2020		2021		2022	
	2018	2019	With relief funds	Without relief funds	With relief funds	Without relief funds	With relief funds	Without relief funds
IPPS	5.9%	6.4%	5.3%	1.9%	8.8%	7.3%	2.7%	1.9%
Location								
Metropolitan (urban)	6.1	6.5	5.3	1.9	8.8	7.4	2.8	2.1
Rural micropolitan	3.8	5.0	5.8	1.5	8.9	6.4	1.1	–0.8
Other rural	–0.2	0.4	2.8	–1.9	7.4	2.5	–0.2	–3.5
Ownership								
For profit	11.3	12.1	12.6	10.4	15.5	14.3	12.7	12.3
Nonprofit	5.5	6.1	4.7	1.1	8.3	6.9	1.2	0.4
DSH and teaching								
Both	5.5	6.1	4.7	1.2	8.6	7.2	2.5	1.8
DSH only	6.0	6.7	6.4	3.0	8.9	7.2	2.5	1.6
Teaching only	8.2	8.1	5.6	3.6	7.4	6.4	3.2	2.9
Neither	8.6	8.9	8.5	6.0	13.5	11.8	6.4	5.7
CAH	1.7	2.4	4.9	0.4	10.7	5.9	4.2	2.3

Note: IPPS (inpatient prospective payment systems), DSH (disproportionate share hospital), CAH (critical access hospital). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports. Hospitals' margins are calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. "All-payer operating margin" includes payments from all payers, excluding revenue from investments and contributions and, for 2020 through 2022, is reported with and without reported federal relief funds. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. Because not all hospitals report the same 12-month period, the data reflect varying numbers of months of COVID-19 impacts. The years are fiscal. Results for some years are different from previous reports due to newer data and updated group definitions.

Source: MedPAC analysis of hospital cost report data from CMS and census data on metropolitan and micropolitan areas.

> Within IPPS hospitals' aggregate all-payer operating margin, there continued to be significant variation: The 2022 operating margin ranged from –6 percent to 10 percent among the middle half of IPPS hospitals (data not shown).

> While there was variation within each group of IPPS hospitals, in aggregate, the operating margin continued to be higher among for-profit hospitals and, to a lesser extent, urban hospitals. For-profit hospitals' operating margin remained above levels in the immediate prepandemic period, while the margin fell among nonprofits and most other hospital groups.

> Critical access hospitals' aggregate all-payer operating margin also declined in 2022. However, it remained above the levels in the immediate prepandemic period (when including federal relief funds).

Chart 6-7 IPPS hospitals' FFS Medicare margin across service lines fell to a record low in 2022, but for-profit hospitals' margin remained positive

	Aggregate FFS Medicare margin							
			2020		2021		2022	
Hospital group	2018	2019	With relief funds	Without relief funds	With relief funds	Without relief funds	With relief funds	Without relief funds
IPPS	–9.3%	–8.5%	–8.1%	–12.3%	–6.1%	–8.1%	–11.6%	–12.7%
Location								
Metropolitan (urban)	–9.5	–8.8	–8.6	–12.6	–6.5	–8.4	–11.9	–12.8
Rural micropolitan	–7.0	–6.5	–4.1	–9.0	–2.3	–5.7	–9.5	–12.2
Other rural	–6.9	–5.2	–0.3%	–5.9	5.3	–1.1	–2.5	–7.1
Ownership								
For profit	–0.6	0.8	4.3	1.7	5.9	4.4	0.9	0.4
Nonprofit	–10.6	–10.0	–10.3	–14.7	–8.1	–10.1	–13.5	–14.7
DSH and teaching								
Both	–8.1	–7.6	–7.6	–11.8	–5.9	–7.8	–7.8	–11.1
DSH only	–10.2	–8.9	–7.6	–11.9	–5.6	–.7.9	–12.3	–13.7
Teaching only	–13.4	–13.7	–14.8	–17.4	–9.8	–11.4	–15.8	–16.3
Neither	–15.7	–15.2	–15.4	–18.7	–9.6	–12.1	–13.3	–14.2
CAH	–1.7	–1.7	3.8	–0.9	6.5	0.1	1.8	–0.5

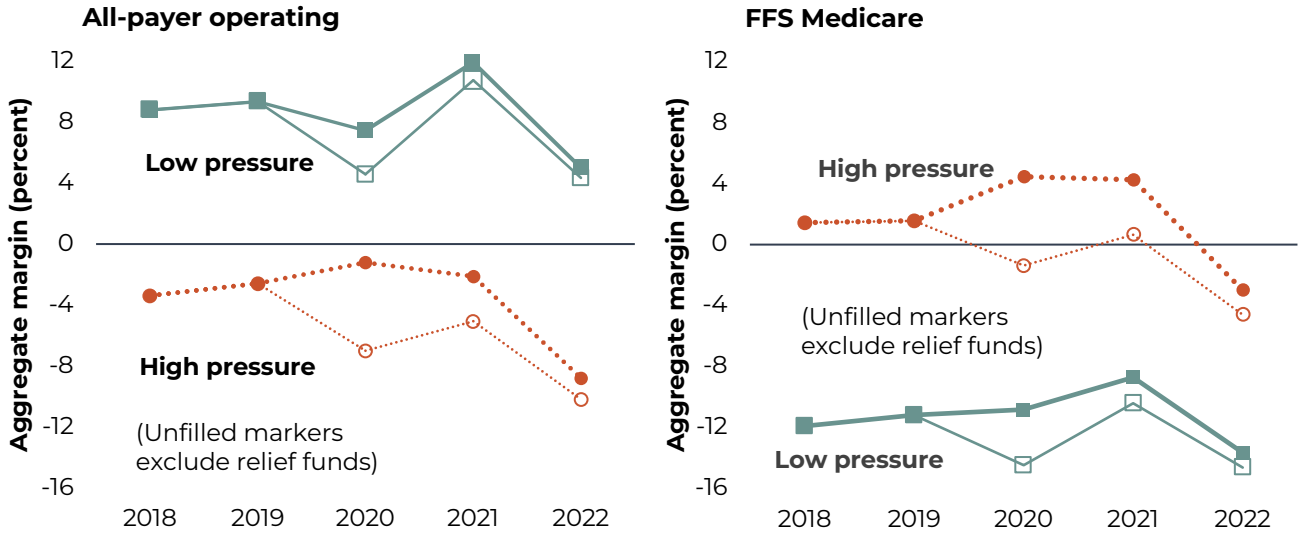
Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service), DSH (disproportionate share hospital), CAH (critical access hospital). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports, with the Medicare share calculated using FFS Medicare's share of 2019 all-payer operating revenue. Hospitals' "Medicare margin" is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Data are for IPPS hospitals or CAHs that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal. Results for some years are different from prior-year reports' results due to newer data and updated group definitions.

Source: MedPAC analysis of hospital cost reports and census geographic files.

> Hospitals' Medicare margin across service lines reflects the relationship between hospitals' FFS Medicare payments and Medicare-allowable costs across inpatient, outpatient, and other services, as well as supplemental Medicare payments not tied to the provision of services (such as uncompensated care and direct graduate medical education payments).

> In 2022, IPPS hospitals' aggregate FFS Medicare margin fell to a record low. Among most groups of IPPS hospitals, the FFS Medicare margin fell below levels in the immediate prepandemic period; however, for-profit hospitals' margin remained positive and near prepandemic levels.

Chart 6-8 IPPS hospitals under high financial pressure continued to have higher FFS Medicare margins



Note: IPPS (inpatient prospective payment systems). "Relief funds" refers to Provider Relief Fund payments and Paycheck Protection Program forgiven loans recorded on hospitals' cost reports. Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate payments. Payments and costs include multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services) as well as direct graduate medical education and uncompensated care payments. "High-pressure" hospitals are defined as those with a median non-Medicare profit margin of 1 percent or less over five years and a net worth (assets minus liabilities) that would have grown by less than 1 percent per year over that period if the hospital's Medicare profits had been zero. "Low-pressure" hospitals are defined as those with a median non-Medicare profit margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's Medicare profits had been zero. Data are for IPPS hospitals that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal. Results for some years are different from prior-year reports' results due to newer data and updated group definitions.

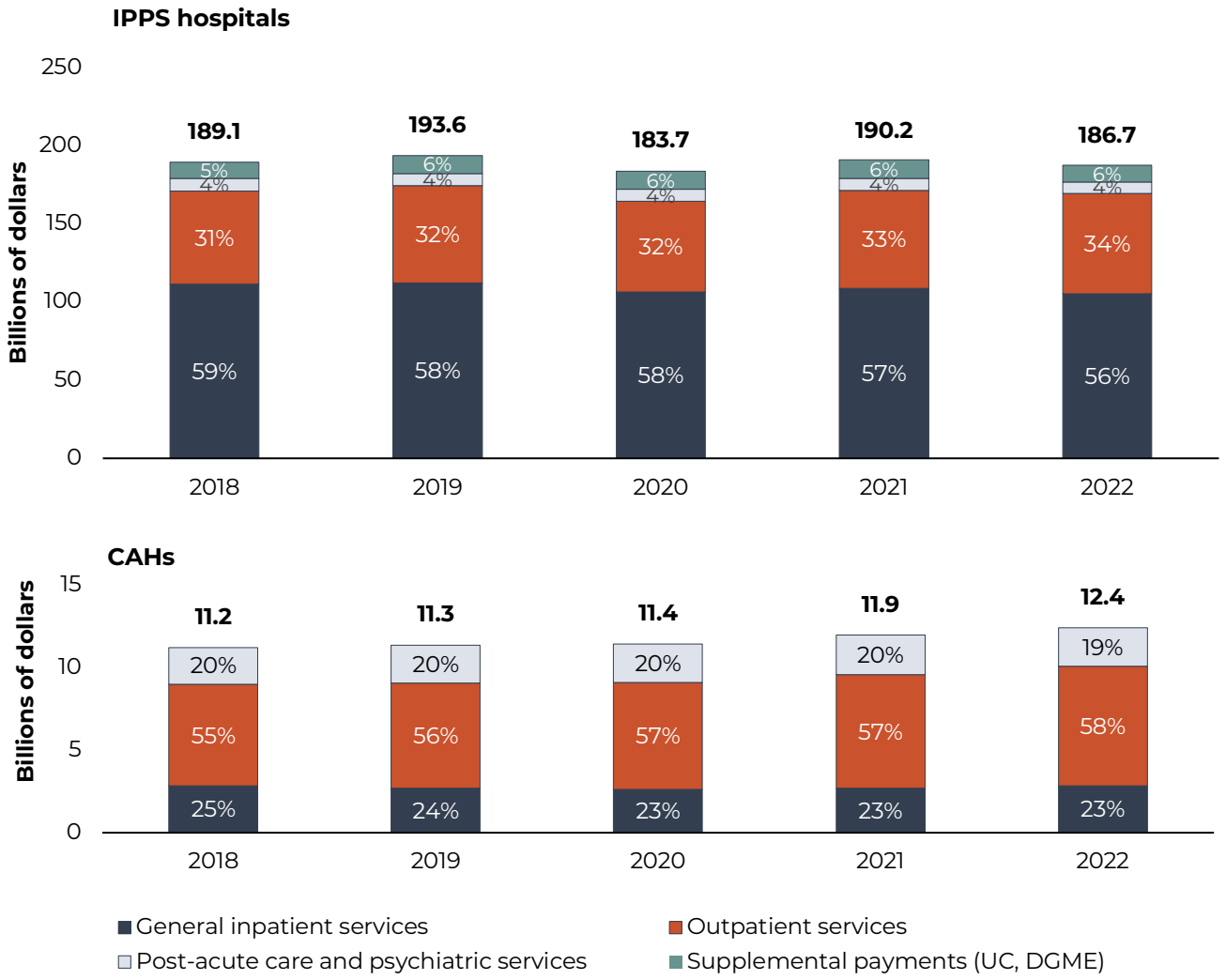
Source: MedPAC analysis of hospital cost report data from CMS.

> IPPS hospitals experience different levels of financial pressure from non-Medicare payers. Hospitals under higher financial pressure from non-Medicare payers continue to have lower all-payer operating margins but higher FFS Medicare margins than hospitals under low financial pressure.

> This finding suggests that hospitals with high non-Medicare margins—that is, those under low fiscal pressure—have, on average, negotiated prices that are high enough to not only offset their losses on non-Medicare patients but also generate above-average all-payer margins.

> Nonprofit hospitals under high levels of financial pressure tended to have lower standardized inpatient and outpatient costs than nonprofit hospitals under low pressure to constrain their costs (data not shown). The relationship between financial pressure and costs is less consistent for for-profit hospitals.

Chart 6-9 FFS Medicare payments for inpatient services continued to be the largest component of payments to IPPS hospitals but not to CAHs, 2018–2022



Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), CAH (critical access hospital), UC (uncompensated care), DGME (direct graduate medical education). Hospitals also receive payments from FFS Medicare that are not included in these totals, such as payments for hospital-based clinics. The 2020 through 2022 payment amounts do not include Medicare's share of Provider Relief Fund payments or Paycheck Protection Program forgiven loans that were provided as part of the public health emergency. Data are for IPPS hospitals or CAHs that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of hospital cost report data from CMS.

> For IPPS hospitals, general inpatient services continued to be the largest component of FFS Medicare payments; however, the share for inpatient payments has been slowly declining, from 59 percent in 2018 to 56 percent in 2022.

> For CAHs, outpatient services continued to be the largest component of FFS Medicare payments, and the share has been slowly increasing, from 55 percent in 2018 to 58 percent in 2022. In addition, 19 percent of FFS Medicare payments to CAHs in 2022 were for post-acute care and psychiatric services, almost all of which were for swing-bed skilled nursing facility services.

Chart 6-10 Over 15 percent of IPPS payments in 2022 were from adjustments and additional payments

Hospital group	Share of IPPS payments for FFS Medicare inpatient services					
	Base PPS	Low income (DSH)	Teaching (IME)	Outliers	Rural and/or isolated	Quality
All IPPS	82.6%	3.3%	7.2%	5.4%	1.4%	–0.7%
Location						
Metropolitan (urban)	82.7	3.3	7.6	5.6	0.7	–0.7
Micropolitan	82.0	2.4	2.9	3.0	9.2	–0.7
Other rural	77.4	2.0	0.6	2.5	16.3	–0.7
Ownership						
For profit	88.4	3.6	4.3	2.7	1.2	–0.8
Nonprofit	82.9	3.1	7.1	5.4	1.3	–0.7
Government	74.9	4.0	10.8	8.2	1.9	–0.9
DSH and teaching						
Both	89.4	3.6	10.1	6.2	0.5	–0.7
DSH only	89.6	3.1	0.0	3.6	3.4	–0.8
Teaching only	86.5	0.1*	7.6	4.7	1.0	–0.7
Neither	91.9	0.1*	0.0	3.3	4.1	–0.7
Rural and/or isolated						
Sole community	78.3	2.2	2.7	4.2	12.0	–0.6
Medicare dependent	78.2	1.6	2.0	2.2	15.8	–0.7
Low volume	76.5	1.9	0.6	2.6	17.5	–0.5

Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service), DSH (disproportionate share hospital), IME (indirect medical education). Payments are shares of IPPS payments for FFS Medicare inpatient services and exclude uncompensated care payments. "Rural and/or isolated" includes additional payments to sole community hospitals, Medicare-dependent hospitals, and low-volume hospitals. For sole community and Medicare-dependent hospitals that are paid on their hospital-specific rate, the "rural and/or isolated" column includes the amount by which their rate exceeds the otherwise applicable IPPS payments. "Quality" includes payments and penalties from the Value-Based Purchasing Program and penalties from the Hospital Readmissions Reduction Program and Hospital-Acquired Conditions Reduction Program. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people; rural micropolitan counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Components may not sum to totals due to rounding and because other types of payments, such as new technology payments, are not included in the table. Data are for IPPS hospitals that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. The years are fiscal.
*The DSH group is defined by receiving inpatient operating DSH payments, while the DSH payments column includes both inpatient operating and capital DSH payments. All urban hospitals with more than 100 beds are eligible for inpatient capital DSH payments.

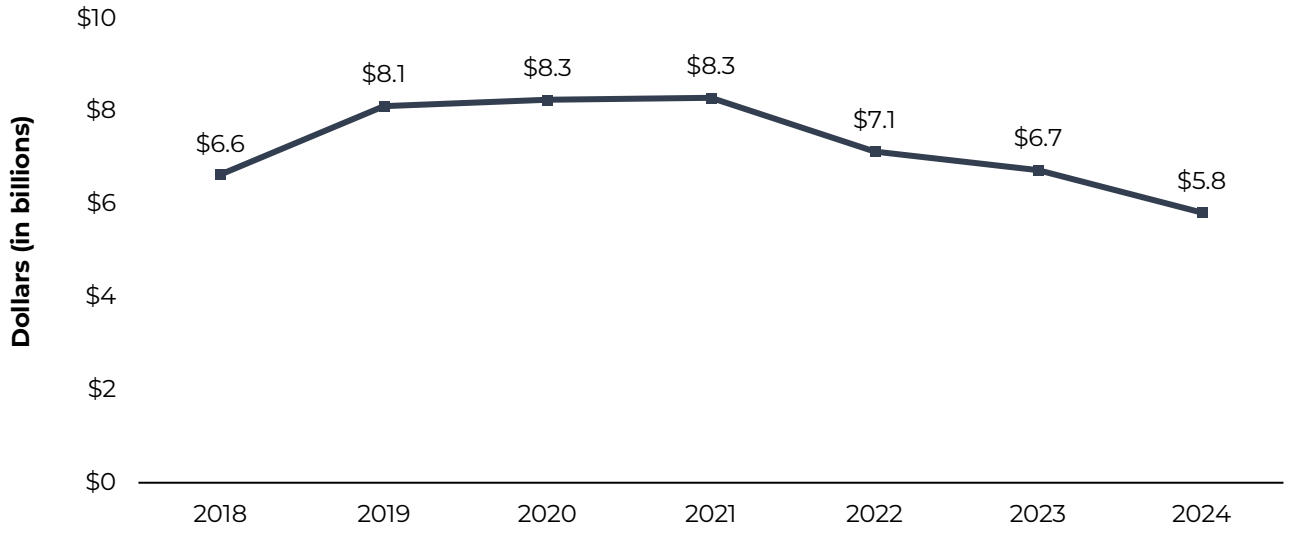
Source: MedPAC analysis of hospital cost report data from CMS and census data on metropolitan and micropolitan areas.

> In 2022, base payments accounted for 82.6 percent of IPPS payments to hospitals for inpatient services provided to FFS Medicare beneficiaries. The remaining amount—over 15 percent—comprised IPPS adjustments to the base rates and additional payments such as low-income and teaching adjustments, outlier payments, and rural and/or isolated payments.

> The IPPS adjustments and additional payments are targeted to specific groups of hospitals. For example, the additional rural/isolated payments to low-volume hospitals accounted for 17.5 percent of those hospitals' IPPS payments.

> IPPS hospitals also receive payments from Medicare that are not for the provision of inpatient services to FFS Medicare beneficiaries, such as uncompensated care and direct graduate medical education payments, or are otherwise paid outside of the IPPS, such as organ acquisition (data not shown).

Chart 6-11 Medicare's uncompensated care payments to IPPS hospitals fell between 2021 and 2024



Note: IPPS (inpatient prospective payment systems). "Uncompensated care payments" are postsequestration; the 2 percent sequestration of Medicare payments was suspended in May 2020 and reinstated in spring 2022. The years are fiscal.

Source: MedPAC analysis of IPPS final rules published by CMS.

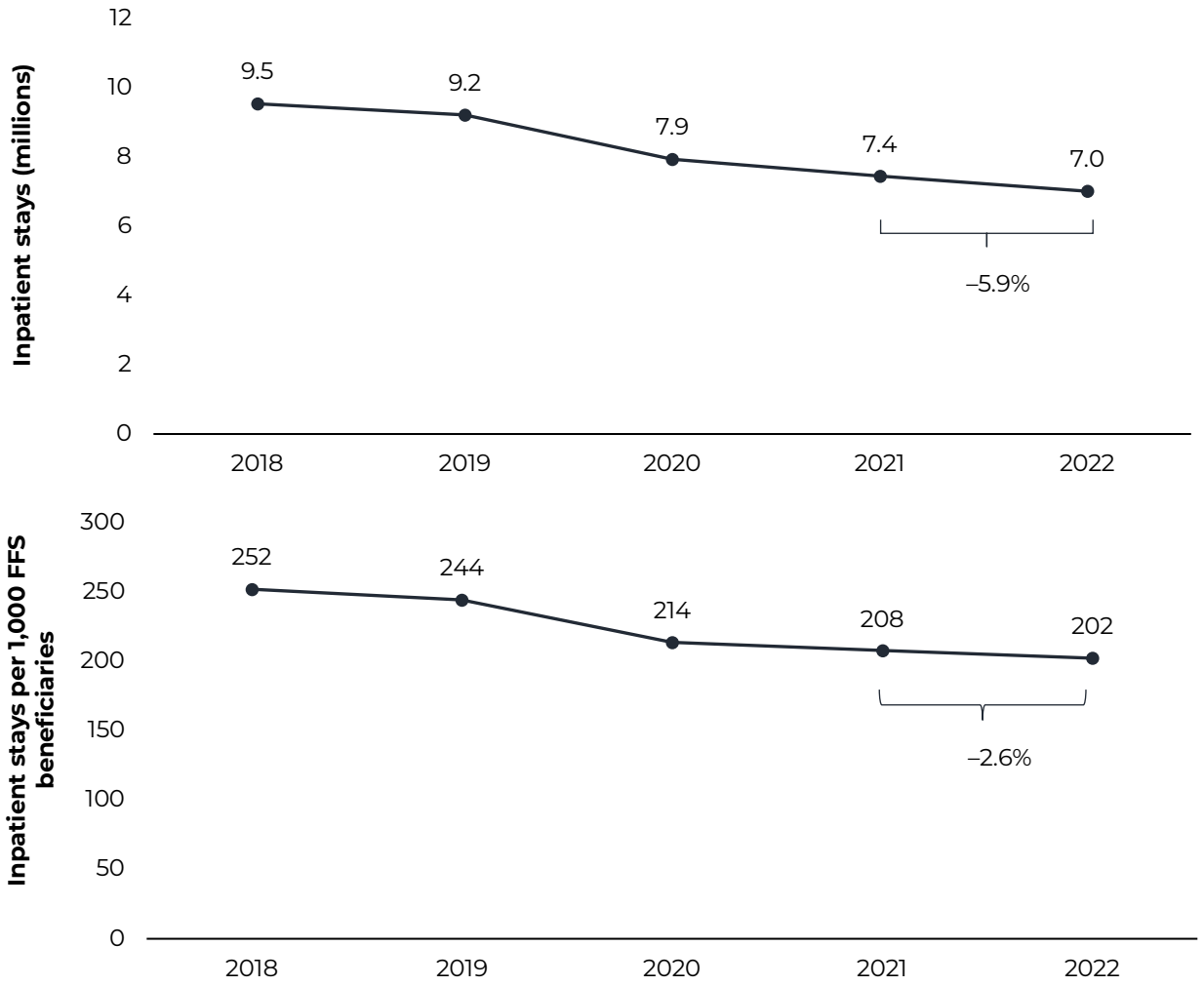
> In addition to IPPS payments for fee-for-service Medicare beneficiaries' inpatient stays, the Medicare program makes uncompensated care payments to IPPS hospitals to help cover their costs of treating uninsured patients. When the rate of uninsured individuals increases and hospitals have greater losses on uncompensated care, the Medicare program makes higher uncompensated care payments to hospitals.

> Under current law, aggregate uncompensated care payments for a fiscal year are set prospectively as the product of two estimates for the upcoming payment year: 75 percent of the operating disproportionate share hospital (DSH) payments under prior law and the uninsured rate as a percentage of the rate in 2013. This amount is subject to sequestration (when the sequester is in effect).

> In 2019 through 2021, uncompensated care payments rose to slightly over $8 billion dollars.

> However, uncompensated care payments fell in each year from 2022 through 2024, down to $5.8 billion, or similar to the level in 2017 (2017 data not shown). These declines stemmed from decreases in estimated DSH payments and in the national uninsured rate, as well as the reinstatement of the 2 percent sequestration on Medicare payments.

Chart 6-12 FFS Medicare inpatient stays and stays per capita declined in 2022



Note: FFS (fee-for-service). Data are for FFS Medicare beneficiaries' stays at general acute care hospitals in the U.S. The number of inpatient stays per 1,000 FFS Part A beneficiaries can change from what was previously published when CMS updates its estimates of FFS enrollment. The years are fiscal.

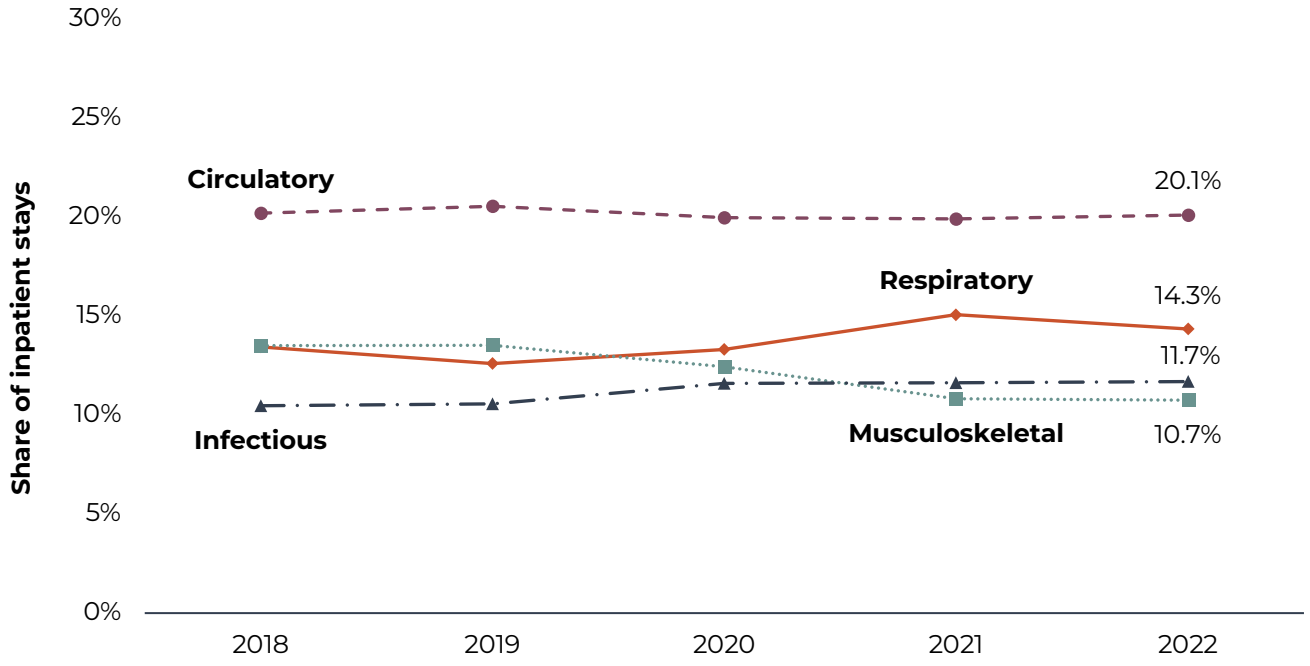
Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and reports of the Boards of Trustees of the Medicare trust funds.

> From 2021 to 2022, the number of inpatient stays by FFS Medicare beneficiaries at general acute care hospitals declined by 5.9 percent to 7.0 million stays. Controlling for the number of FFS beneficiaries, the number of inpatient stays declined by 2.6 percent, to 202 stays per 1,000 FFS beneficiaries. (The number of all-payer inpatient stays also decreased (see Chart 6-4).)

> The decline in FFS Medicare inpatient stays was larger than the decline in stays per capita because the number of FFS Medicare beneficiaries continued to decline (FFS enrollment data not shown).

> While FFS Medicare inpatient stays have continued to decline, the average length of stay has continued to increase (see Chart 6-15).

Chart 6-13 Four major diagnostic categories accounted for over half of all FFS Medicare inpatient stays, but distribution changed during the public health emergency



Note: FFS (fee-for-service). Data are for FFS Medicare beneficiaries' stays at general acute care hospitals in the U.S. The years are fiscal.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

> In each year from 2018 through 2022, over half of all FFS Medicare inpatient stays at general acute care hospitals were for beneficiaries with a primary diagnosis in one of four major diagnostic categories: circulatory, respiratory, musculoskeletal, or infectious diseases.

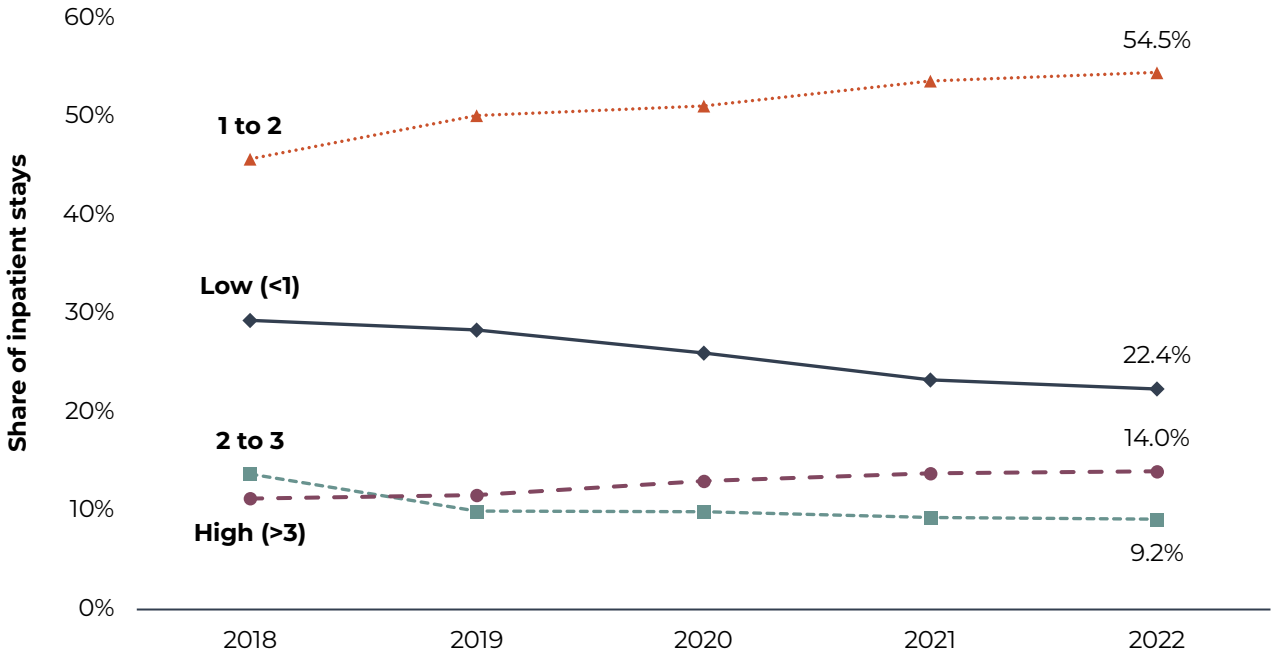
> The most common major diagnostic category is circulatory system diseases, such as heart failure and cardiac arrhythmia, accounting for about 20 percent of FFS Medicare inpatient stays in each year from 2018 through 2022.

> The share of FFS Medicare inpatient stays for respiratory infections surged during the pandemic but declined in 2022, though it remained above the immediate prepandemic level.

> The share of FFS Medicare inpatient stays for musculoskeletal conditions, which can increasingly be safely treated in outpatient settings, has declined substantially since 2018.

> The share of FFS Medicare stays for infectious diseases has slowly increased in each year from 2018 through 2022.

Chart 6-14 The least resource-intensive cases have made up a declining share of FFS Medicare inpatient stays



Note: FFS (fee-for-service). The lines refer to the Medicare severity–diagnosis related group weight, which reflects CMS's estimate of the relative average resource intensity (i.e., costs) of that type of stay. Data are for FFS Medicare beneficiaries' stays at hospitals general acute care hospitals in the U.S. The years are fiscal. Components do not sum to 100 percent due to rounding.

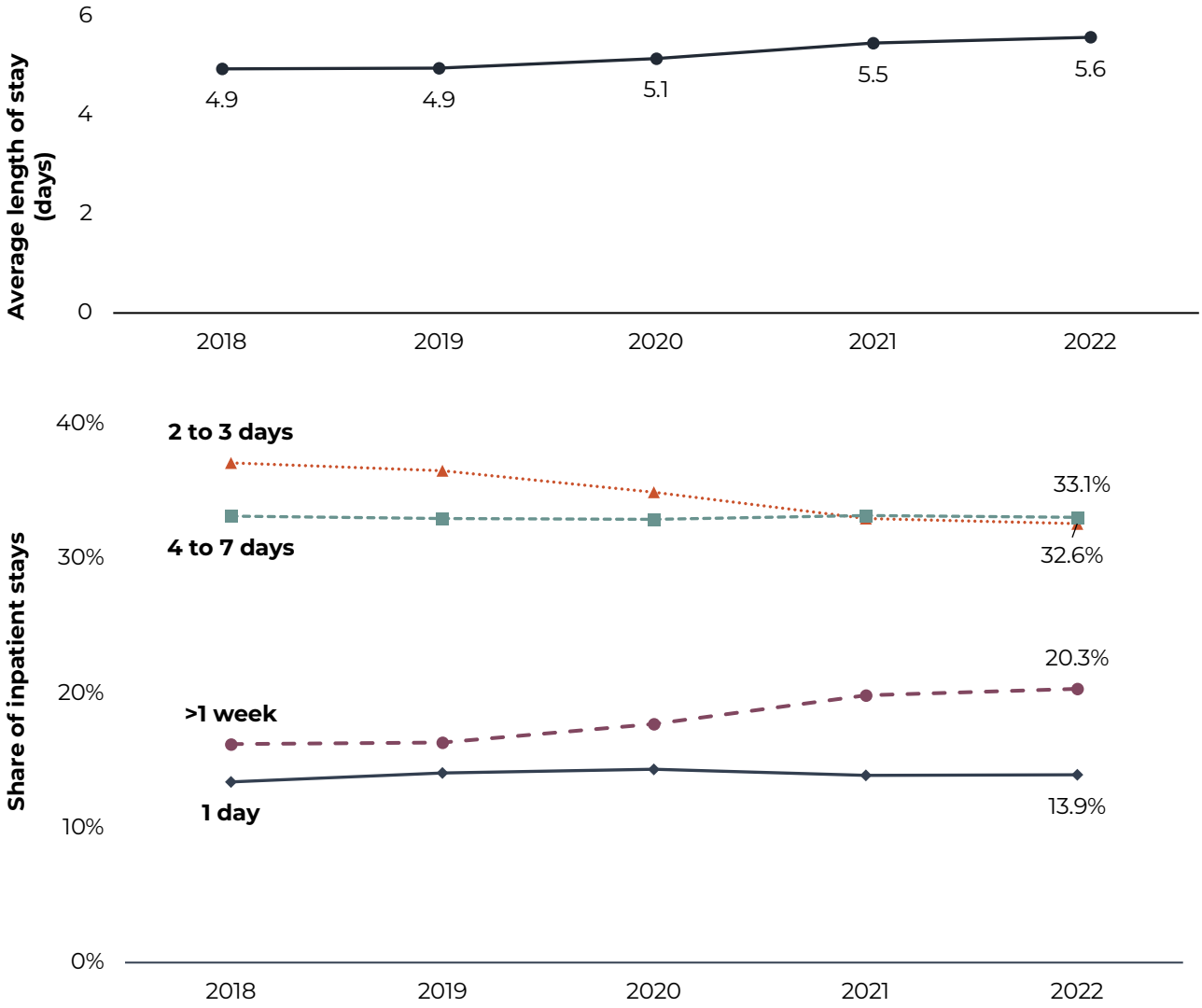
Source: MedPAC analysis of Medicare Provider Analysis and Review data and IPPS final rules published by CMS.

> IPPS payments are adjusted using a Medicare severity–diagnosis related group (MS–DRG) weight, which reflects CMS's estimate of the relative average resource intensity (i.e., costs) of that type of stay.

> The share of inpatient stays with a weight of less than 1 had been declining for multiple years because these less resource-intensive conditions can increasingly be treated in hospital outpatient settings. However, this decline accelerated during the public health emergency, falling to under 23 percent of stays in 2022. (In 2022, the most common FFS Medicare inpatient stays with a weight of less than 1 were those for kidney and urinary tract infections, esophagitis and gastroenteritis, gastrointestinal hemorrhage, and renal failure, all without major complications or comorbidities (MCCs).)

> In contrast, the share of inpatient stays with a weight of greater than 3 accelerated its increase, reaching 14 percent in 2022. (In 2022, the most common FFS inpatient stays with a weight of greater than 3 were stays for infectious diseases with operating room procedures and MCCs, percutaneous and other intracardiac procedures, and endovascular cardiac valve replacement and supplement procedures.)

Chart 6-15 Average length of FFS Medicare inpatient stays increased during public health emergency, driven by increase in share of inpatient stays longer than one week



Note: FFS (fee-for-service). Data are for FFS Medicare beneficiaries' stays at general acute care hospitals in the U.S. The years are fiscal. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

> FFS Medicare beneficiaries' average length of stay at general acute care hospitals increased from 4.9 days prior to the public health emergency to 5.6 days in 2022.

> The increase in average length of stay during the COVID-19 public health emergency was driven by the increase in the share of FFS Medicare beneficiaries' inpatient stays that were longer than 1 week, which increased from about 16 percent in 2019 to 20 percent in 2022.

> In contrast, the share of FFS inpatient stays that were two or three days declined, which likely in part reflects the waiver during the public health emergency of the three-day-stay requirement for skilled nursing facilities.

Chart 6-16 The number of Medicare-certified inpatient psychiatric facilities declined in 2022, but the number of freestanding and for-profit facilities increased

Type of IPF	2018	2019	2020	2021	2022	Average annual change 2018–2020	Average annual change 2020–2022
All	1,610	1,580	1,540	1,530	1,480	–1.6%	–2.3%
Share of all							
Urban	78%	79%	79%	80%	80%	0.5	0.6
Rural	20	20	20	19	19	–2.0	–2.2
Teaching	36	37	38	38	38	1.8	0.4
Nonteaching	64	63	62	62	62	–1.1	–0.3
Hospital-based units	67	65	64	63	62	–1.8	–2.1
Nonprofit	41	40	39	39	38	–2.1	–1.5
For profit	14	14	14	13	13	–2.2	–3.2
Government	12	12	12	11	11	–0.3	–2.7
Freestanding	33	35	36	37	38	3.6	3.6
Nonprofit	5	5	5	5	5	–1.0	–0.5
For profit	19	20	21	22	23	5.2	5.5
Government	10	10	10	11	11	2.6	1.7

Note: IPF (inpatient psychiatric facility). Data are from facilities that had a cost report that was valid as of our analysis and had at least one Medicare IPF prospective payment system stay in the given fiscal year. IPF counts are rounded to the 10s' place. "Average annual change" represents the change in the number of all IPFs in the first row and represents changes in shares of IPFs by type for all other rows. The years are fiscal. Components and annual changes may not match totals due to rounding.

Source: MedPAC analysis of Medicare Provider of Analysis and Review, Medicare hospital cost reports, and Provider of Services data from CMS.

> Medicare beneficiaries experiencing an acute mental health or alcohol- or drug-related crisis can be treated in specialty IPFs that provide 24-hour care in a structured, intensive, and secure setting.

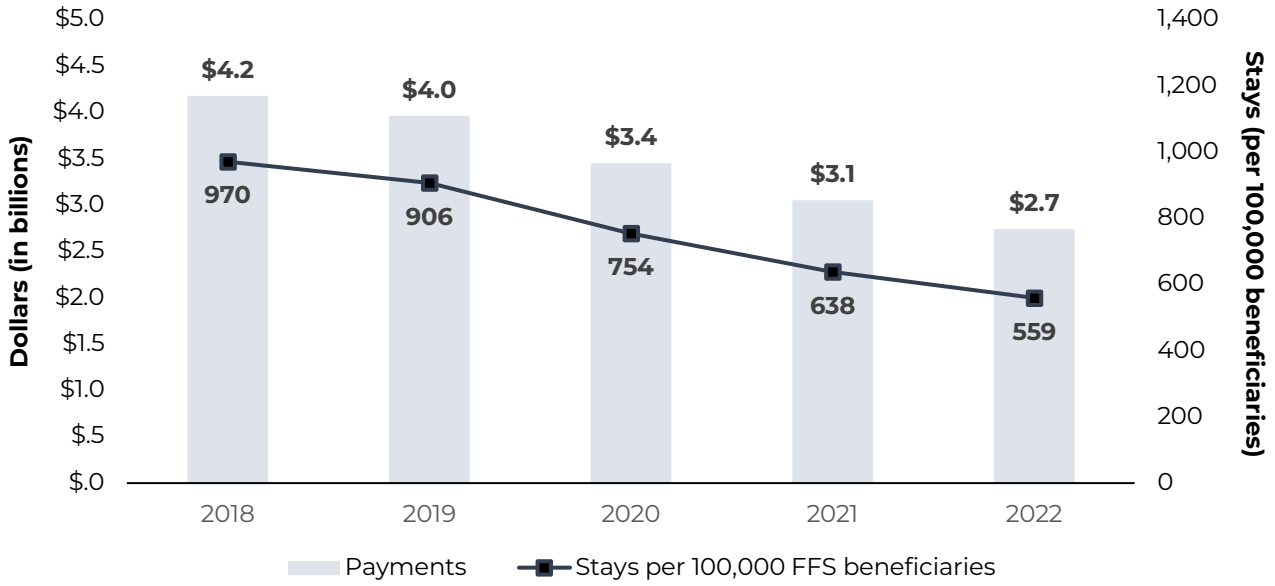
> From 2018 to 2020, the number of IPFs nationwide decreased by 1.6 percent each year, from 1,610 to 1,540. From 2020 to 2022, the decline in the number of IPFs was over 2 percent.

> Most IPFs are located in urban areas (80 percent in 2022). The share of IPFs in urban and rural areas remained mostly steady between 2018 and 2022, with a slight shift toward urban areas.

> In 2022, a majority of IPFs (62 percent) were hospital-based units; however, from 2018 to 2022, the share of freestanding IPFs grew by 3.6 percent annually while the share of hospital-based IPFs declined.

> Over 20 percent of IPFs are freestanding and for profit, and the share of freestanding for-profit IPFs has been increasing by more than 5 percent annually in the past five years.

Chart 6-17 FFS Medicare inpatient psychiatric facility stays and payments continued to decline in 2022



Note: FFS (fee-for-service). The 2020 to 2022 payment amounts do not include Medicare's share of Provider Relief Fund payments or Paycheck Protection Program forgiven loans provided as part of the public health emergency. The years are fiscal. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of Medicare Provider of Analysis and Review and enrollment data from CMS.

> The Medicare FFS program pays for inpatient psychiatric facility (IPF) services under the IPF prospective payment system (PPS).

> From 2018 to 2022, FFS Medicare inpatient stays in IPFs decreased by 13 percent per year, on average, declining from 970 stays per 100,000 Medicare FFS beneficiaries to 559. Total (Medicare FFS plus beneficiary) payments for IPF PPS services decreased from $4.2 billion to $2.7 billion—equivalent to a 10 percent annual decrease on a nominal basis. Some of the decline in IPF use is likely related to avoidance or deferral of stays during the coronavirus pandemic, though the decline began prior to 2020 and continued into 2022. Some observers have suggested that IPFs faced staffing challenges after 2020 that may have limited bed capacity.

> Medicare beneficiaries may also receive inpatient psychiatric services in general acute care hospitals (sometimes referred to as "scatter-bed" stays). These cases are inpatient stays with a principal diagnosis in the major diagnostic category of mental diseases and disorders (MDC 19). In 2022, about 30 percent of Medicare FFS inpatient psychiatric stays occurred in general acute care hospitals (the remaining 70 percent occurred in IPFs) (data not shown).

Chart 6-18 A growing share of Medicare FFS beneficiaries' stays at IPFs were for schizophrenia, 2019–2022

Psychiatric MS–DRG grouping	2019	2020	2021	2022	Annual change 2019–2022
Share of total					
Psychosis	73.4%	74.4%	74.8%	75.1%	0.8%
Mood disorders	38.6	37.5	36.9	36.8	–1.6
Schizophrenia and other non-mood psychotic disorders	34.8	36.9	37.9	38.3	3.3
Organic disturbances	7.0	6.9	6.8	7.0	–0.2
Alcohol/drug dependency	6.4	6.2	6.2	5.7	–3.7
Neurosis	4.5	4.2	3.9	4.0	–3.8
Nervous system disorder	5.9	5.4	5.3	5.2	–4.0
Other psychiatric	1.8	1.9	2.0	2.0	4.3
Other nonpsychiatric	1.0	1.0	1.0	0.9	–2.0

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), MS–DRG (Medicare severity–diagnosis related group). Data represent FFS beneficiaries with an IPF stay ending in each respective fiscal year. Psychiatric MS–DRG groupings are categorized as the following: mood disorders (885 and International Classification of Diseases, 10th Revision (ICD-10), diagnosis codes F30–F39); schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders (885 and ICD-10 diagnosis codes F20–F29); organic disturbances and mental retardation (884); alcohol/drug abuse or dependency with and without rehabilitation and with and without major complication or comorbidity (MCC) (894, 895, 896, 897); neurosis with and without depressive (881, 882); degenerative nervous system disorders with and without MCC (056, 057); other psychiatric MS–DRGs (880, 883, 896, 876, 887); other nonpsychiatric MS–DRGs (all others). The years are fiscal. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

> Medicare FFS patients in IPFs are generally assigned to 1 of 17 psychiatric MS–DRGs. However, the MS–DRG system does not differentiate well among Medicare beneficiaries in IPFs; in 2022, over 75 percent of cases were assigned to the psychosis MS–DRG.

> The psychosis MS–DRG is a broad category that includes patients with principal diagnoses of mood disorders (such as bipolar disorder and major depression) and non-mood psychotic disorders (such as schizophrenia). Between 2019 and 2022, the share of patients with non-mood psychotic disorders increased annually by 3.3 percent. In contrast, the share of patients with mood disorders decreased each year between 2019 and 2022. Part of the increase may be explained by the start of the coronavirus pandemic when the number of overall IPF stays decreased substantially and patients with certain diagnoses (such as schizophrenia) were likely less able than others to avoid or defer IPF use. However, the increase in the share of patients with non-mood psychotic disorders continued to increase in 2022.

Chart 6-19 Medicare FFS beneficiaries using IPFs tended to be disabled, under age 65, low income, and non-White, 2022

Characteristic	Share of all IPF users	Share of IPF users with more than one IPF stay in 2022	Share of all FFS beneficiaries
All	100%	26%	—
Current eligibility status and demographics			
Aged	46	33	89
Disabled	54	67	11
ESRD	0.1	0.0	0.2
Female	50	46	53
Male	50	54	47
<45	25	35	3
45–64	28	33	8
65–79	33	26	67
80+	13	7	22
Non-Hispanic White	72	67	78
Black	15	19	8
Asian/Pacific Islander	2	2	3
Hispanic	7	7	6
American Indian/Alaska native	1	1	0.5
Other or unknown	4	4	4
Urban	80	82	80
Rural	20	18	20
Dual eligible or LIS during year			
No	35	24	84
Yes	65	76	16

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), FY (fiscal year), ESRD (end-stage renal disease), LIS (low-income subsidy). The year is fiscal. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review and enrollment data from CMS.

> Of Medicare FFS beneficiaries who had at least one IPF stay in 2022, 54 percent qualified for Medicare because of a disability, compared with 11 percent across all FFS beneficiaries. Beneficiaries who used IPF care also tended to be younger and poorer.

> Twenty-six percent of Medicare FFS beneficiaries who used an IPF in 2022 had more than one IPF stay during the year. These beneficiaries were even more likely than all IPF users to be disabled (often because of a psychiatric disorder), under age 65, low income, and non-White.

Chart 6-20 Medicare beneficiaries near or reaching the lifetime limit on care in freestanding IPFs were highly vulnerable, 2022

Characteristic	Any day in freestanding IPF	Within 15 days of reaching limit	Reached limit
Number of beneficiaries	800,380	9,920	37,250
Current eligibility status and demographics (share)			
Aged	40%	28%	27%
Disabled	60	72	73
ESRD	0.0	0.0	0.0
Female	50	39	40
Male	50	61	60
<45	17	18	17
45–64	43	54	56
65–79	32	26	23
80+	9	2	5
Non-Hispanic White	70	64	63
Black	18	25	26
Asian/Pacific Islander	1	2	1
Hispanic	8	7	6
American Indian/Alaska native	1	1	1
Other or unknown	2	1	1
Urban	83	87	86
Rural	17	12	14
Dual eligible or LIS during year (share)			
No	27	12	13
Yes	73	88	87

Note: IPF (inpatient psychiatric facility), ESRD (end-stage renal disease), LIS (low-income subsidy). Components may not sum to 100 percent due to rounding. "Any day in freestanding IPF" includes Medicare beneficiaries (fee-for-service and Medicare Advantage enrollees) who were alive through the end of 2022 and stayed for at least one day in a freestanding IPF from the time of Medicare enrollment through December 31, 2022. "Within 15 days of reaching limit" includes Medicare beneficiaries who were alive through the end of 2022 and were within 1 to 15 days of reaching the 190-day coverage limit in freestanding IPFs as of December 31, 2022. "Reached limit" includes Medicare beneficiaries who were alive through the end of 2022 and had reached or exceeded the 190-day limit as of December 31, 2022. The year is fiscal.

Source: MedPAC analysis of Medicare enrollment data from CMS.

> Under Medicare, coverage of treatment in freestanding psychiatric hospitals is subject to a lifetime limit of 190 days. This provision was established in 1965 (with the implementation of Medicare), when most inpatient psychiatric care was provided by state-run freestanding facilities. There is no lifetime limit for treatment in hospital-based IPFs or for behavioral health care provided in general acute care hospitals.

> As of December 31, 2022, 800,380 Medicare (fee-for-service and Medicare Advantage) beneficiaries had at least one day in a freestanding IPF since enrolling in Medicare. Of these beneficiaries, 47,170 (9,920 + 37,250) were within 15 days of reaching the 190-day limit or had reached the limit as of the end of 2022. These beneficiaries were highly vulnerable: The majority were disabled and had low incomes (as indicated by dual eligibility for Medicare and Medicaid or by having the LIS).

> About 1,100 Medicare beneficiaries (who were alive through the end of 2022) exhausted the 190-day limit between 2022 and 2023 (data not shown).

SECTION

7

Ambulatory care

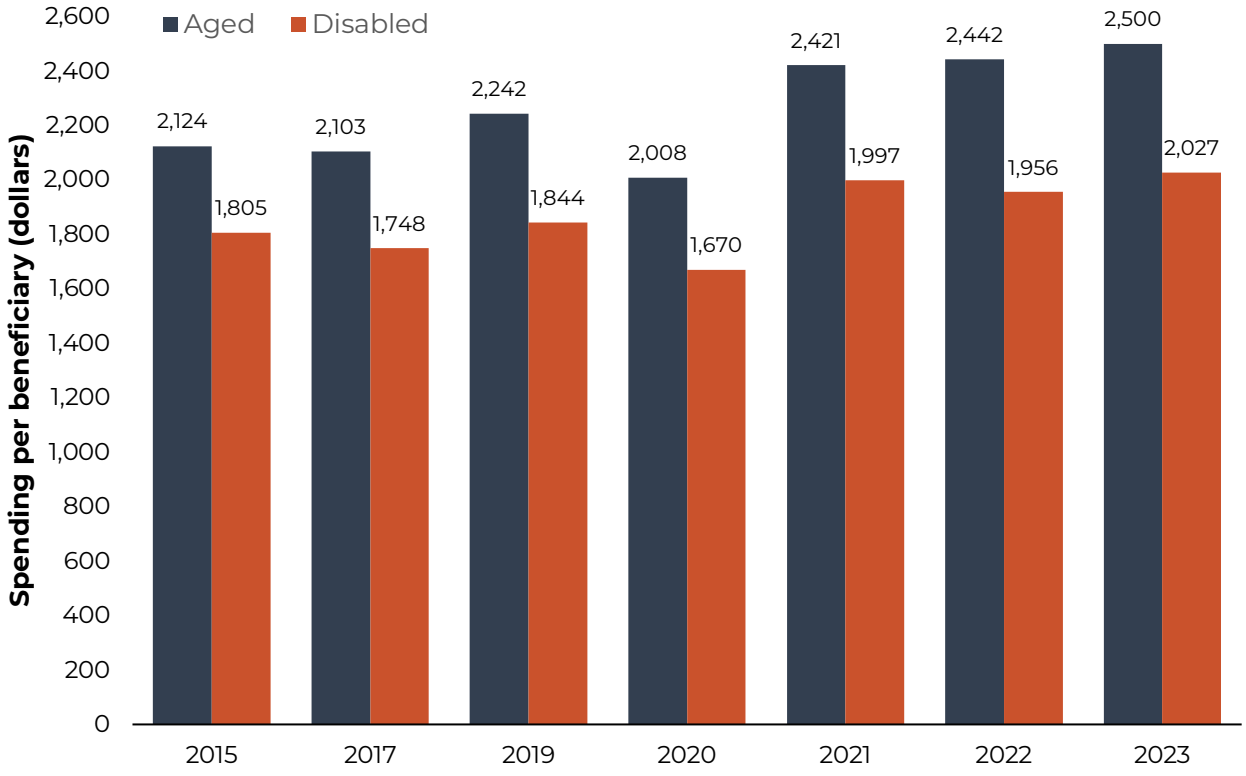
Physicians and other health professionals

Hospital outpatient services

Ambulatory surgical centers

Results of MedPAC's access-to-care survey

Chart 7-1 Medicare spending per FFS beneficiary on services in the physician fee schedule, 2015–2023



Note: FFS (fee-for-service). Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. The "disabled" category excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries ages 65 and over are included in the "aged" category. Dollar amounts are nominal figures, not adjusted for inflation.

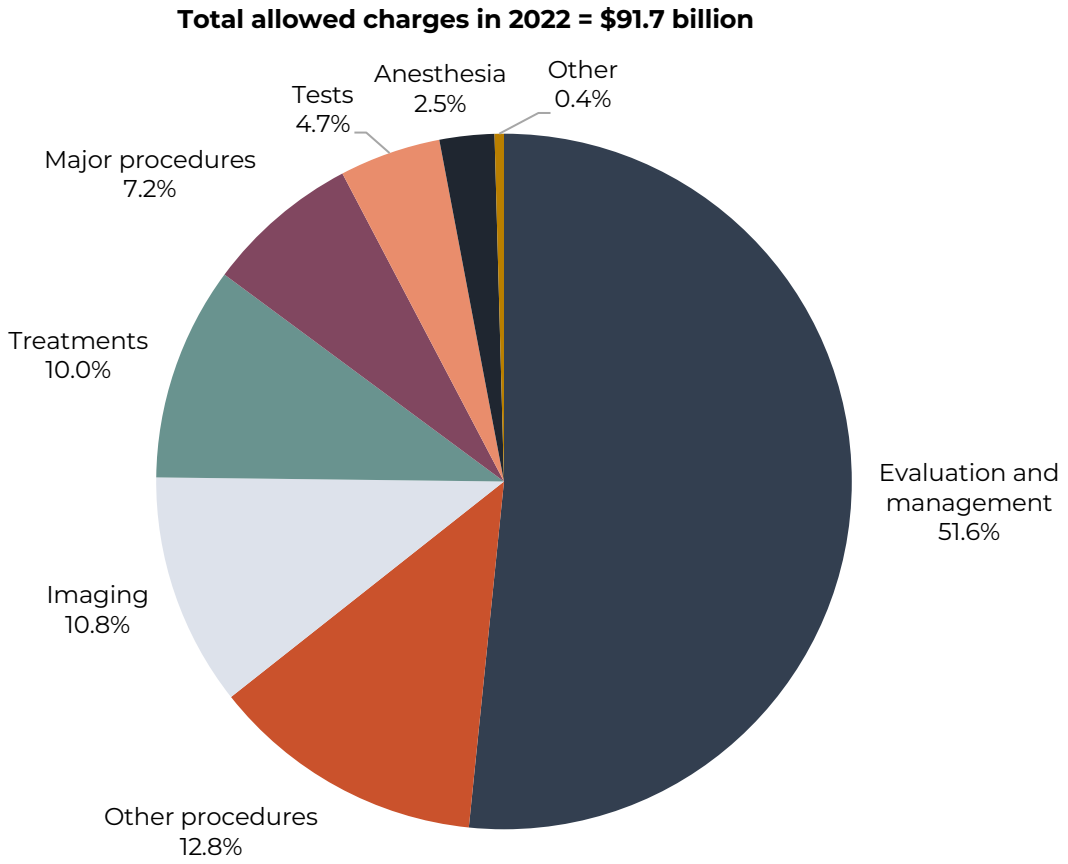
Source: The annual report of the Boards of Trustees of the Medicare trust funds, 2024.

> The physician fee schedule includes a broad range of services, such as office visits, surgical procedures, and diagnostic and therapeutic services. Total fee schedule spending (excluding beneficiary cost sharing) was $70.9 billion in 2023 (data not shown).

> Spending per FFS beneficiary for fee schedule services remained largely stable between 2015 and 2017, then increased in 2019 (on a nominal basis). Spending per FFS beneficiary declined in 2020 due to the effects of the coronavirus pandemic, but spending rebounded in 2021. From 2021 to 2023, spending per beneficiary has continued to grow among aged beneficiaries and has been flat for those with disabilities.

> Per capita spending for beneficiaries with disabilities (under age 65) is lower than per capita spending for aged beneficiaries (ages 65 and over). In 2023, for example, per capita spending for beneficiaries with disabilities was $2,027 compared with $2,500 for aged beneficiaries. Over the 2015 to 2023 period, spending per capita for aged beneficiaries grew at a faster rate (1.7 percent per year) than it did among beneficiaries with disabilities (1.2 percent per year).

Chart 7-2 Physician fee schedule–allowed charges by type of service, 2022



Note: This chart shows "other procedures" and "treatments" as separate categories; versions of this chart that were published before 2023 had combined them.

Source: MedPAC analysis of the Carrier Standard Analytic File for 100 percent of beneficiaries.

> In 2022, allowed charges for physician fee schedule services totaled $91.7 billion. "Allowed charges" includes both program spending and beneficiary cost sharing. Allowed charges declined by 1.2 percent from 2021 (data not shown). That decline is attributable to a 3.9 percent decline in the number of beneficiaries enrolled in FFS Medicare as enrollment in Medicare Advantage continues to grow.

> In 2022, more than half of all allowed charges were for evaluation and management (E&M) services.

> Within the E&M category, about half of allowed charges were for office/outpatient visits (data not shown). The remaining allowed charges within the E&M category were for various types of services provided across a broad range of settings, including hospital inpatient departments, emergency departments, and nursing facilities (data not shown).

> The treatments category includes physical therapy, cancer treatments, and dialysis. The two procedure categories (major and other) include various eye, cardiovascular, skin, and vascular procedures. The distinction between major procedures and other procedures is determined by the size of the payment rate for each procedure and whether it is typically furnished in an inpatient setting.

Chart 7-3 Total number of encounters per FFS beneficiary was higher in 2022 compared with 2017, and the mix of clinicians furnishing them changed

Specialty category	Encounters per beneficiary 2017	2021	2022	Percent change in encounters per beneficiary: Average annual 2017–2021	2021–2022
Total (all clinicians)	21.5	21.6	22.3	0.1%	3.1%
Primary care physicians	3.7	3.1	3.1	–3.7	–0.3
Specialists	12.7	12.3	12.4	–0.8	1.3
APRNs/PAs	2.0	2.7	3.0	8.0	10.4
Other practitioners	3.2	3.5	3.7	2.3	6.7

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). We define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and the national provider identifiers of the clinicians who billed for the service. Figures do not account for "incident to" billing, meaning, for example, that encounters with APRNs/PAs that are billed under Medicare's "incident to" rules are included in the physician totals. We use the number of FFS beneficiaries enrolled in Part B to define encounters per beneficiary. Components may not sum to totals due to rounding.

Source: MedPAC analysis of the Carrier Standard Analytic File for 100 percent of beneficiaries and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

> An "encounter" is a measure of beneficiary interaction with clinicians. For example, if a physician billed for an office visit and an X-ray on the same claim, we count that as one encounter.

> The overall number of encounters per beneficiary grew by just 0.1 percent over the 2017 to 2021 period. The low growth rate was due to the effects of the coronavirus pandemic, which sharply reduced encounters in 2020, but also a partial rebound that occurred in 2021 and 2022.

> Encounters with specialist physicians accounted for the majority of all encounters. These encounters fell by an average of 0.8 percent per year between 2017 and 2021 but grew by 1.3 percent from 2021 to 2022.

> Encounters with APRNs and PAs grew rapidly from 2017 to 2022 (50 percent in total), and encounters with primary care physicians declined substantially (–16 percent). These changes continue a longer-term trend of declines in services billed by primary care physicians and rapid increases in the number of services billed by APRNs and PAs.

> The decline in encounters with primary care physicians occurred across a broad range of services, including evaluation and management services, tests, procedures, and imaging services (data not shown).

Chart 7-4 The number of clinicians billing Medicare's physician fee schedule increased, and the mix of clinicians changed, 2017–2022

	Number (in thousands)					Number per 1,000 beneficiaries				
	Physicians					Physicians				
Year	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total
2017	140	455	218	168	981	2.6	8.5	4.1	3.1	18.4
2018	139	462	237	174	1,012	2.5	8.4	4.3	3.2	18.5
2019	138	468	258	180	1,045	2.5	8.4	4.6	3.2	18.7
2020	135	468	268	172	1,044	2.4	8.2	4.7	3.0	18.2
2021	134	473	286	180	1,073	2.3	8.1	4.9	3.1	18.4
2022	133	477	308	185	1,103	2.2	8.0	5.2	3.1	18.5

Note: APRN (advanced practice registered nurse), PA (physician assistant). "Primary care specialties" includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in "other specialties." "Other practitioners" includes clinicians such as physical therapists, psychologists, social workers, and podiatrists. The number of clinicians shown in this table includes only those with a caseload of more than 15 beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include beneficiaries enrolled in traditional Medicare Part B and those in Medicare Advantage, based on the assumption that clinicians generally furnish services to beneficiaries in both programs. Numbers exclude nonperson providers such as clinical laboratories and independent diagnostic testing facilities. Components may not sum to totals due to rounding.

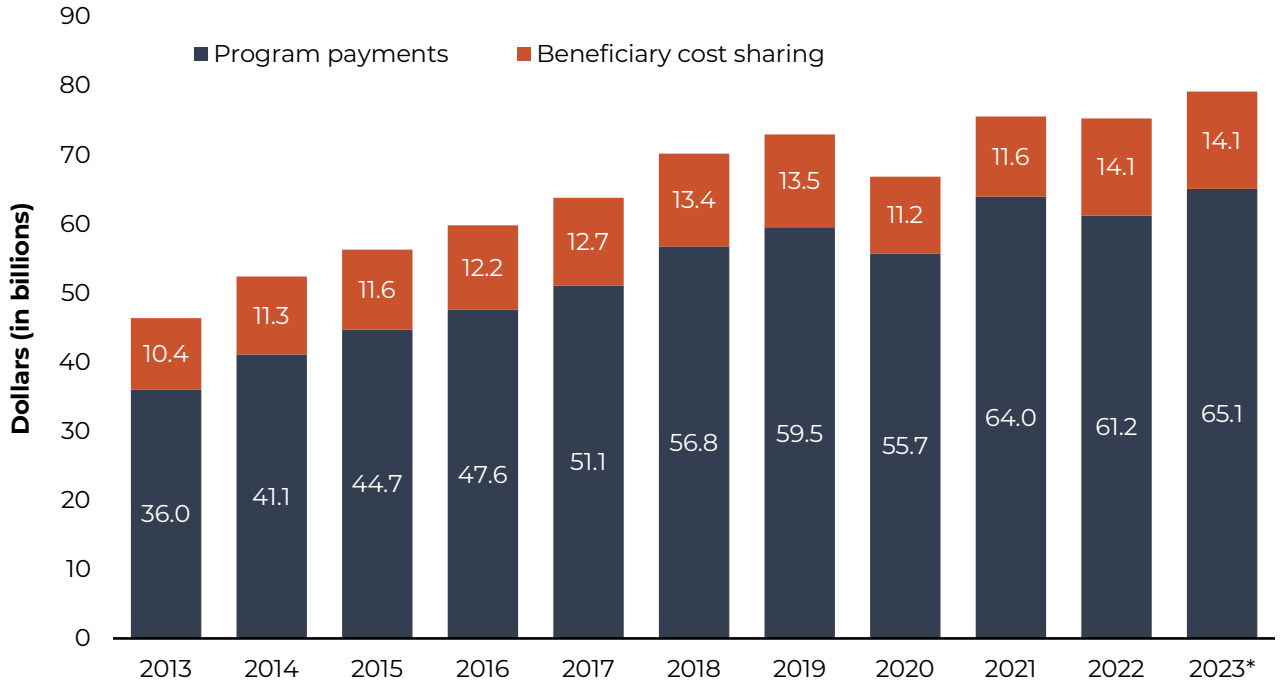
Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

> From 2017 to 2019, the total number of clinicians billing the fee schedule grew in absolute terms and relative to the size of the overall Medicare population. In 2020, the overall number of clinicians shrank slightly, likely due to the effects of the coronavirus pandemic, but rebounded in 2021.

> The total number of clinicians per 1,000 beneficiaries increased from 18.4 to 18.7 over the 2017 to 2019 period before falling to 18.2 in 2020. Although the ratio of clinicians to Medicare beneficiaries decreased in 2020 (probably due to the pandemic), the effect on the overall supply of clinicians was relatively small. The fact that the ratio grew to 18.5 in 2022 suggests that the reduction in 2020 was temporary.

> Over the 2017 to 2022 period, the number of primary care physicians billing the fee schedule slowly declined—yielding a net loss of about 7,000 primary care physicians by 2022. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 218,000 to 308,000. The number of specialist physicians and other practitioners, such as physical therapists and podiatrists, who billed the fee schedule increased at a steady pace.

Chart 7-5 Spending on hospital outpatient services covered under the outpatient PPS increased, 2013–2023



Note: PPS (prospective payment system). Spending amounts are for services covered by the Medicare outpatient PPS. They do not include services paid on separate fee schedules (such as ambulance services and durable medical equipment) or those paid on a cost basis (such as corneal tissue acquisition and flu vaccines) or payments for clinical laboratory services, except those packaged into payment bundles. Dollar amounts are nominal figures, not adjusted for inflation.
*Figures in 2023 are estimated.

Source: CMS, Office of the Actuary.

> The Office of the Actuary estimates that spending under the outpatient PPS was $79.2 billion in 2023 ($65.1 billion in program spending, $14.1 billion in beneficiary cost sharing). We estimate that the outpatient PPS accounted for about 6.5 percent of total Medicare program spending in 2023 (data not shown).

> From calendar year 2013 to 2023, overall spending by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS increased by 71 percent, an average of 5.5 percent per year on a nominal basis. The Office of the Actuary projects continued growth in total spending, averaging 5.3 percent per year from 2023 to 2025 (data not shown).

> Beneficiary cost sharing under the outpatient PPS includes the Part B deductible and coinsurance for each service. Under the outpatient PPS, beneficiary cost sharing was about 18 percent in 2023.

Chart 7-6 Most hospitals provide outpatient services

Year	Acute care hospitals	Share offering:		
		Outpatient services	Outpatient surgery	Emergency services
2010	3,518	95%	90%	N/A
2012	3,483	95	91	93%
2014	3,429	96	92	93
2016	3,370	96	93	93
2018	3,301	96	93	90
2020	3,194	96	93	91
2021	3,189	96	93	91
2023	3,158	96	93	91

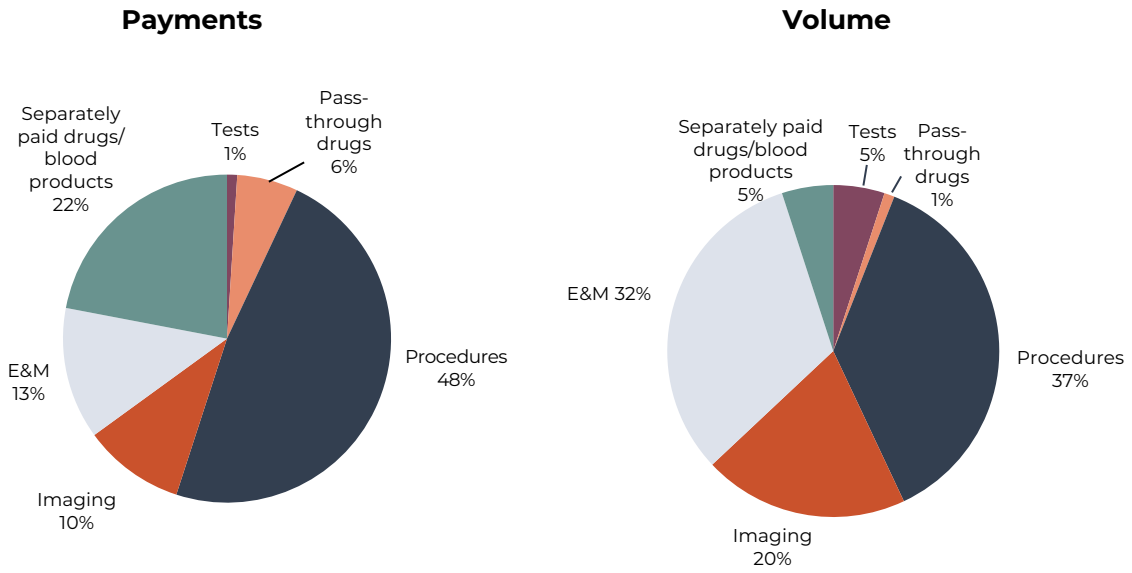
Note: N/A (not applicable). We list emergency services for 2010 as "N/A" because the data source we used for this chart changed the variable for identifying hospitals' provision of emergency services. This change in variable definition would make it appear that the share of hospitals providing emergency services increased sharply from 2010 to 2012, but we question whether such a large increase occurred. This chart includes services provided or arranged by acute care short-term hospitals and excludes long-term, Christian Science, psychiatric, rehabilitation, children's, critical access, and alcohol/drug hospitals.

Source: Medicare Provider of Services files from CMS.

> The number of acute care hospitals declined slowly from 3,518 in 2010 to 3,158 in 2023. In 2023, most of these hospitals (3,144) furnished services under Medicare's outpatient prospective payment system.

> The share of hospitals providing outpatient services remained stable, and the share offering outpatient surgery steadily increased from 2010 through 2016 and has remained stable since then. The share offering emergency services declined slightly from 2016 to 2018.

Chart 7-7 Procedures were the type of service with the highest payments and volume under the Medicare hospital outpatient PPS, 2022



Note: PPS (prospective payment system), E&M (evaluation and management). "Payments" includes both program spending and beneficiary cost sharing. We grouped services into the following categories, according to the Berenson-Eggers Type of Service codes developed by CMS: evaluation and management, procedures, imaging, and tests. "Pass-through drugs" and "separately paid drugs/blood products" are classified by their payment status indicator in the outpatient prospective payment system.

Source: MedPAC analysis of standard analytic file of outpatient claims for 2022.

> Hospitals provide many types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.

> The payments for services are distributed differently from volume. For example, in 2022, procedures accounted for 48 percent of payments but only 37 percent of volume.

> Procedures (such as endoscopies, surgeries, skin and musculoskeletal procedures) accounted for the greatest share of payments for services (48 percent) in 2022, followed by separately paid drugs and blood products (22 percent), E&M services (13 percent), and imaging services (10 percent).

Chart 7-8 Hospital outpatient services with the highest Medicare expenditures, 2022

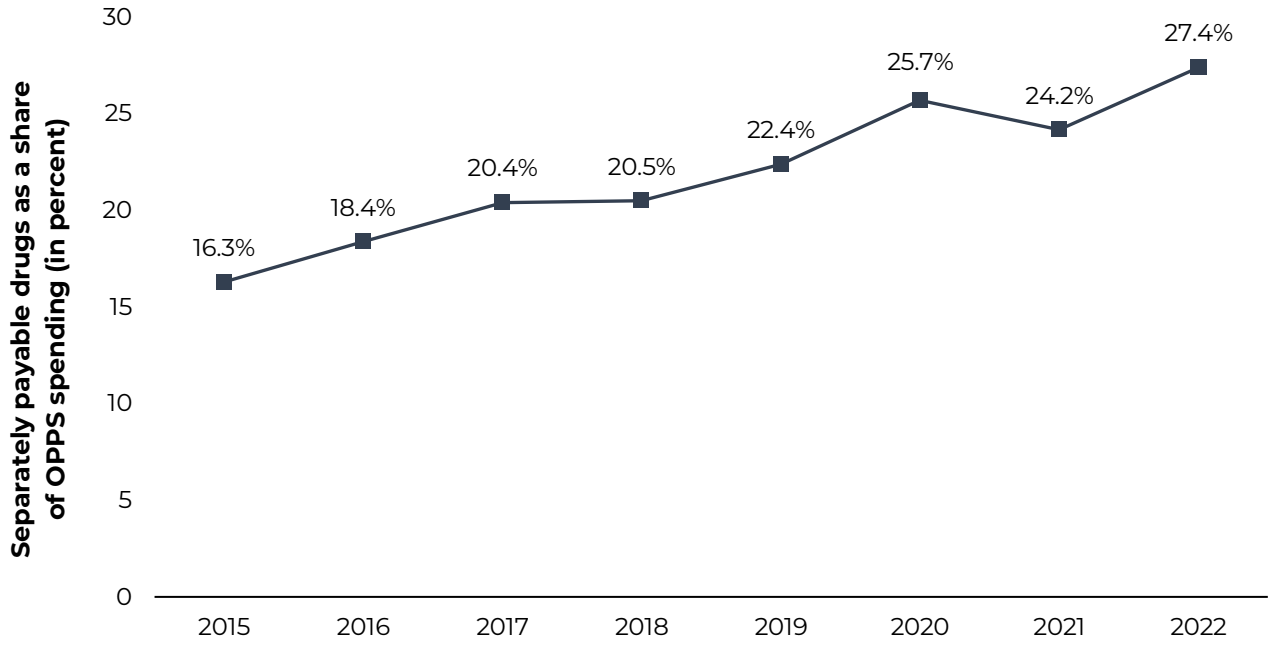
APC title	Share of Medicare expenditures	Volume (thousands)	Payment rate
Level 5 musculoskeletal procedures	8%	429	$12,593
All emergency visits	5	9,655	364
Clinic visits	4	27,392	121
Comprehensive observation services	3	925	2,332
Level 3 electrophysiologic procedures	3	89	21,916
Level 3 endovascular procedures	2	115	10,258
Level 4 musculoskeletal procedures	2	186	6,397
Level 3 drug administration	2	5,437	209
Level 3 radiation therapy	1	1,830	554
Level 2 ICD and similar procedures	1	31	33,547
Level 1 laparoscopy and related procedures	1	172	5,168
Level 4 imaging without contrast	1	1,742	493
Level 1 endovascular procedures	1	286	2,962
Level 2 imaging with contrast	1	2,238	376
Level 2 imaging without contrast	1	7,511	111
Level 2 lower GI procedures	1	878	1,059
Level 3 nuclear medicine and related services	1	585	1,335
Level 3 pacemaker and similar procedures	1	71	10,619
Level 4 drug administration	1	2,33	326
Level 2 laparoscopy and related services	1	80	19,096
Level 4 endovascular procedures	1	45	16,402
Level 3 imaging without contrast	1	3,007	235
Level 1 intraocular procedures	1	329	2,121
Level 5 urology and related services	1	152	4,506
Level 4 nuclear medicine and related services	1	448	1,512
Level 5 neurostimulator and related procedures	1	21	30,063
Level 3 vascular procedures	1	198	2,924
Level 1 imaging without contrast	1	6,949	83
Total	49		
Average for all APCs		620	$444

Note: APC (ambulatory payment classification), ICD (implantable cardioverter-defibrillator), GI (gastrointestinal). The payment rate for "all emergency visits" is a weighted average of payment rates for 10 emergency-visit APCs (not listed on this chart). The average APC figures in the last line represent averages for all APCs.

Source: MedPAC analysis of 100 percent analytic files of outpatient claims for calendar year 2022.

> Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a few categories that have high volume, high payment rates, or both.

Chart 7-9 Separately payable drugs have increased as a share of total spending in the outpatient prospective payment system, 2015–2022



Note: OPPS (outpatient prospective payment system). "Separately payable drugs" includes those that are new to the market and those that are established in the drug market but are deemed by CMS to qualify for separate payments because they are relatively expensive.

Source: MedPAC analysis of hospital outpatient standard analytic claims files from 2015 through 2022.

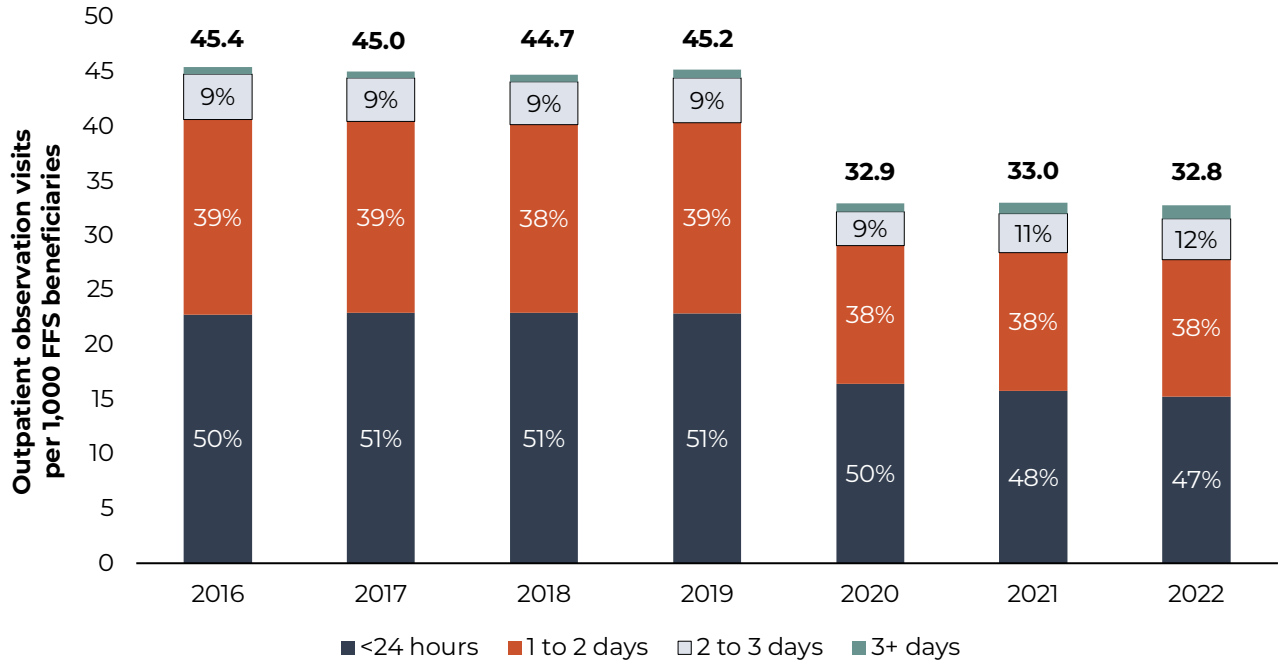
> Under the OPPS, most drugs are packaged, meaning their cost is reflected in the payment for the related services. However, drugs that are new to the market and established drugs that are relatively expensive are paid separately.

> Separately payable drugs have become an increasingly large share of OPPS spending, growing from 16.3 percent in 2015 to 27.4 percent in 2022.

> Except for 2021, the share of OPPS spending attributable to separately payable drugs increased each year from 2015 to 2022, though the increase was relatively small from 2017 to 2018. The small increase during that period was the result of a policy implemented by CMS that substantially decreased the payment rates for relatively expensive established drugs that hospitals obtained through the 340B Drug Pricing Program. Without that policy, we estimate that separately payable drugs would have been 22.7 percent of OPPS spending in 2018 and 24.8 percent in 2019.

> On September 28, 2022, the U.S. Supreme Court ruled that CMS's policy of paying reduced payment rates for the established drugs that are relatively expensive and are obtained through the 340B program was unlawful because the Secretary of Health and Human Services did not first conduct a survey of hospitals' acquisition costs. Consequently, for the remainder of 2022, CMS set the OPPS payment rates for these drugs at the standard OPPS payment rates and reprocessed the OPPS claims for 340B-acquired drugs from January 1, 2022, through September 27, 2022. This reprocessing of claims provided 340B hospitals with an additional $1.5 billion in OPPS payments for drugs in 2022, substantially increasing the share of total OPPS spending that was attributable to separately payable drugs that year.

Chart 7-10 Number of Medicare FFS outpatient observation visits per capita remained at a relatively low level in 2022



Note: FFS (fee-for-service). Observation visits are separately payable visits with a length of stay of at least eight hours. Data for outpatient observation visits include short-term acute care hospitals in the U.S. (exclusive of territories) paid under the inpatient prospective payment system or under the Maryland state waiver. "Outpatient observation visits per 1,000 FFS beneficiaries" refers to observation visits that did not result in an inpatient admission per Medicare FFS Part B beneficiary. Years are calendar years. Components do not sum to 100 percent due to rounding and component values that are not shown.

Source: MedPAC analysis of hospital outpatient standard analytic claims files from 2016 through 2022.

> Hospitals sometimes use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.

> The number of Medicare FFS outpatient observation visits per capita remained relatively steady from 2016 to 2019, at about 45 visits per 1,000 beneficiaries. The distribution of observation visits by length of stay also remained steady, with about half longer than 24 hours, including 10 percent that spanned more than 2 days.

> In 2020, with the onset of the coronavirus pandemic, the number of Medicare FFS outpatient observation visits per capita declined 30 percent to about 33 visits per 1,000 beneficiaries, though the distribution by length of stay remained similar to prior years. The number of emergency room visits also declined (data not shown). In 2021 and 2022, the number of outpatient observation visits per capita was relatively unchanged from 2020.

Chart 7-11 Number of Medicare-certified ASCs increased by 12 percent, 2016–2022

	2016	2017	2018	2019	2020	2021	2022
Medicare payments (billions of dollars)	$4.3	$4.6	$4.9	$5.2	$4.9	$5.7	$6.1
Percent growth in payments	4.9%	7.4%	6.4%	7.3%	–6.4%	17.6%	5.8%
New centers (during year)	172	217	237	246	186	265	220
Closed or merged centers (during year)	121	128	146	131	86	108	92
Net total number of centers (end of year)	5,473	5,562	5,653	5,768	5,868	6,025	6,153
Net percent growth in number of centers	0.9%	1.6%	1.6%	2.0%	1.7%	2.7%	2.1%
Volume per 1,000 FFS Part B beneficiaries	190	193	197	202	174	205	210
Share of all centers that are:							
Urban	93	93	93	93	94	94	94
Rural	7	7	7	7	6	6	6

Note: ASC (ambulatory surgical center), FFS (fee-for-service). "Medicare payments" includes program spending and beneficiary cost sharing for ASC facility services. Some figures differ from Chart 7-15 in our 2023 data book because CMS updated the Provider of Services file. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of Provider of Services file from CMS, 2023. Payment data are from MedPAC analysis of carrier standard analytic claims files.

> ASCs are distinct entities that furnish ambulatory surgical services that do not require an overnight stay in a hospital. The most common ASC procedures are cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures.

> Total Medicare payments per FFS Medicare beneficiary for ASC services increased by approximately 8 percent per year, on average, from 2016 through 2022 on a nominal basis (data not shown). From 2021 to 2022, total payments per FFS beneficiary rose 10 percent as the average complexity of services provided to FFS beneficiaries in ASCs increased (data not shown).

> The number of Medicare-certified ASCs grew at an average annual rate of 2.0 percent from 2016 through 2022. In this same period, an annual average of 220 new facilities entered the market, while an average of 116 closed or merged with other facilities.

Chart 7-12 Between 34 and 71 low-value services were provided per 100 FFS beneficiaries in 2022; Medicare spent between $1.9 billion and $5.8 billion on these services

	Broader version of measure			Narrower version of measure		
Measure	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)
Imaging for nonspecific low back pain	13.1	9.5%	$260	3.7	3.3%	$73
PSA screening at age > 75 years	10.3	7.0	93	6.0	4.9	54
Spinal injection for low back pain	6.7	3.7	1,311	2.6	1.6	502
PTH testing in early CKD	6.2	3.7	118	5.2	3.2	99
Colon cancer screening for older adults	6.0	5.7	413	0.2	0.2	2
T3 level testing for patients with hypothyroidism	5.5	3.3	34	5.5	3.3	34
Carotid artery disease screening in asymptomatic adults	4.0	3.7	217	3.3	3.1	180
Preoperative chest radiography	3.4	3.1	51	0.8	0.7	11
Head imaging for uncomplicated headache	3.2	2.9	220	2.0	1.9	136
Stress testing for stable coronary disease	2.8	2.6	799	0.3	0.3	83
Cervical cancer screening at age > 65 years	1.5	1.5	31	1.3	1.3	28
Homocysteine testing in cardiovascular disease	1.1	0.8	9	0.2	0.1	1
Head imaging for syncope	1.0	1.0	70	0.6	0.6	40
Preoperative echocardiography	1.0	0.9	79	0.3	0.3	24
BMD testing at frequent intervals	0.6	0.6	13	0.4	0.4	8
Preoperative stress testing	0.6	0.6	169	0.2	0.2	50
CT for uncomplicated rhinosinusitis	0.6	0.5	41	0.2	0.2	18
Vitamin D testing in absence of hypercalcemia or decreased kidney function	0.5	0.5	9	0.5	0.5	9
Imaging for plantar fasciitis	0.5	0.4	10	0.2	0.2	4
Screening for carotid artery disease for syncope	0.4	0.4	24	0.3	0.3	15
PCI/stenting for stable coronary disease	0.3	0.3	1,155	0.04	0.04	173
Cancer screening for patients with CKD on dialysis	0.3	0.2	8	0.1	0.05	1
Hypercoagulability testing after DVT	0.2	0.1	6	0.1	0.1	2
Vertebroplasty/kyphoplasty for osteoporotic vertebral fractures	0.2	0.1	312	0.2	0.1	306
Arthroscopic surgery for knee osteoarthritis	0.2	0.2	135	0.03	0.03	22
Preoperative PFT	0.2	0.1	2	0.1	0.1	0.8
IVC filter to prevent pulmonary embolism	0.1	0.1	16	0.1	0.1	16
Renal artery angioplasty/stenting	0.1	0.1	138	0.01	0.01	32
EEG for headache	0.04	0.04	2	0.02	0.02	1
Carotid endarterectomy for asymptomatic patients	0.03	0.03	83	0.01	0.01	34
Pulmonary artery catheterization in ICU	0.01	0.01	0.2	0.004	0.004	0.2
Total	70.5	36.1	5,827	34.3	22..4	1,921

(Chart continued next page)

Chart 7-12 Between 34 and 71 low-value services were provided per 100 FFS beneficiaries in 2022; Medicare spent between $1.9 billion and $5.8 billion on these services (continued)

Note: FFS (fee-for-service), PSA (prostate-specific antigen), PTH (parathyroid hormone), CKD (chronic kidney disease), CT (computed tomography), BMD (bone mineral density), PFT (pulmonary function test), PCI (percutaneous coronary intervention), DVT (deep vein thrombosis), IVC (inferior vena cava), EEG (electroencephalography), ICU (intensive care unit). "Count" refers to the number of unique services. Some totals do not equal the sum of their components due to rounding. The total for "share of beneficiaries affected" does not equal the column sum because some beneficiaries received services covered by multiple measures. "Spending" includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2022. This method was developed by Schwartz et al. (2014). The broad and narrow versions of the measures for T3 level testing for patients with hypothyroidism and IVC filter to prevent pulmonary embolism are the same.

Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

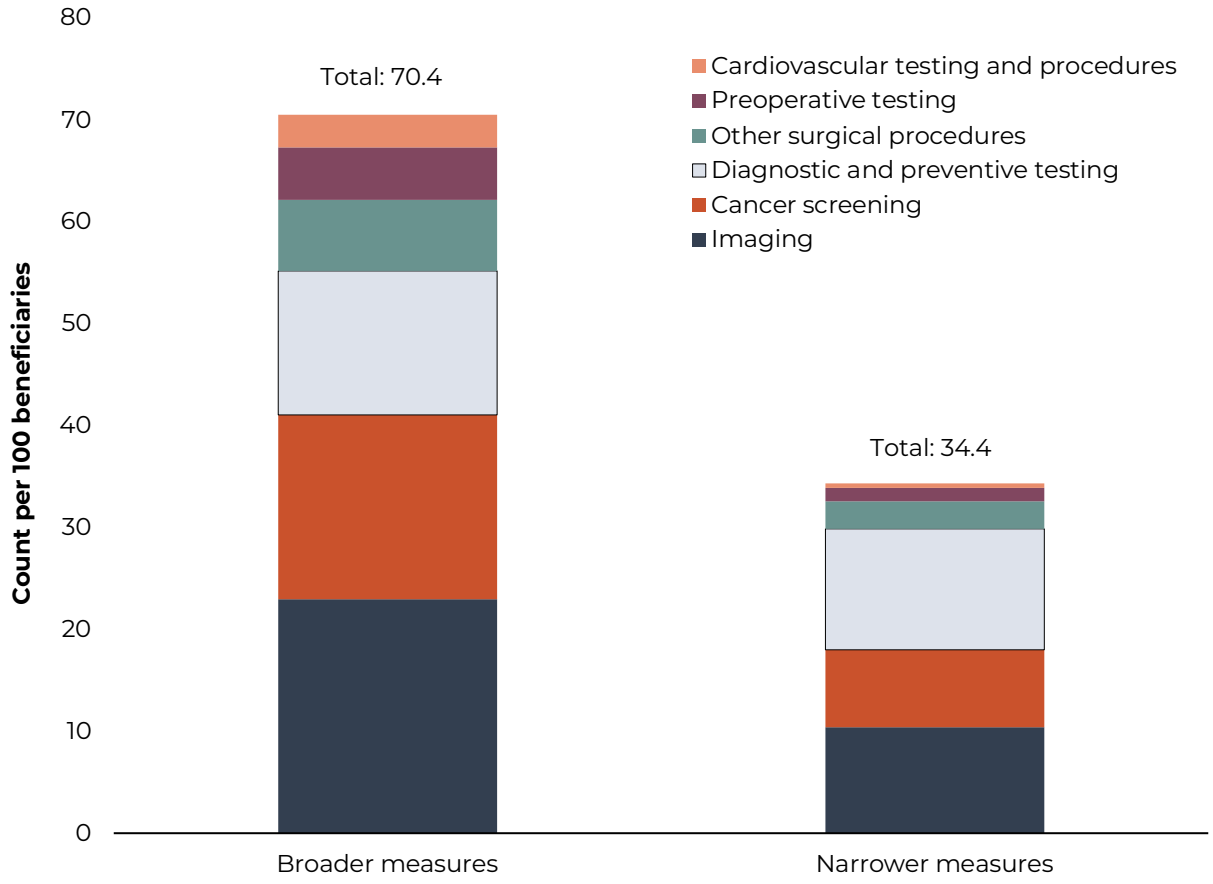
> Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.

> The 31 measures of low-value care in this chart were developed by a team of researchers. The measures are drawn from evidence-based lists—such as Choosing Wisely—and the medical literature. We applied these measures to 100 percent of Medicare claims data from 2022. These 31 measures do not represent all instances of low-value care; the actual number (and corresponding spending) may be much higher.

> The researchers developed two versions of each measure: a broader version (more sensitive, less specific) and a narrower version (less sensitive, more specific). Increasing the sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure's specificity leads to less misclassification of appropriate use as inappropriate at the expense of potentially missing some instances of inappropriate use.

> Based on the broader versions of the measures, our analysis found about 71 instances of low-value care per 100 beneficiaries in 2022, with about 36 percent of beneficiaries receiving at least 1 low-value service that year. Medicare spending for these services was $5.8 billion. Based on the narrower versions of the measures, our analysis showed about 34 instances of low-value care per 100 beneficiaries, with 22 percent of beneficiaries receiving at least 1 low-value service. Medicare spending for these services totaled about $1.9 billion.

Chart 7-13 Imaging, cancer screening, and diagnostic and preventive testing accounted for most of the volume of low-value care in 2022



Note: "Count" refers to the number of unique services provided to fee-for-service Medicare beneficiaries.

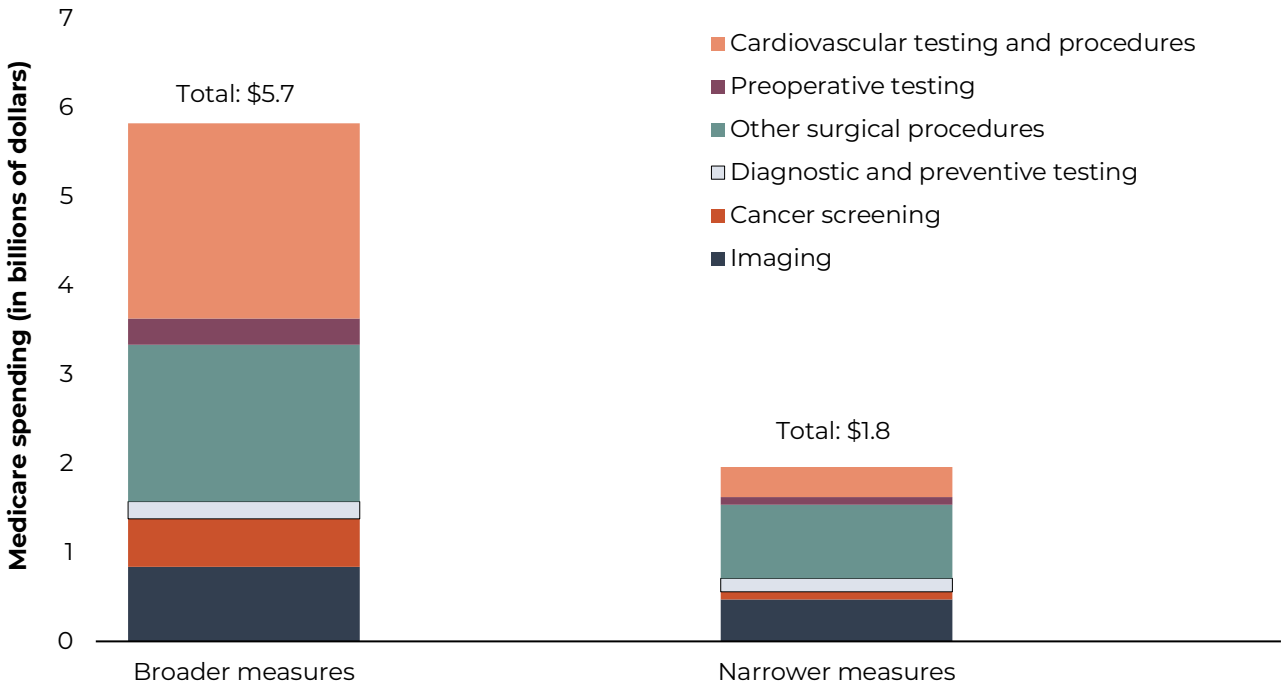
Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

> We assigned each of the 31 measures of low-value care in Chart 7-12 to 1 of 6 clinical categories.

> Using the broader versions of the measures, imaging and cancer screening accounted for 58 percent of the volume of low-value care per 100 beneficiaries. The "imaging" category includes back imaging for patients with nonspecific low back pain and screening for carotid artery disease in asymptomatic adults. The "cancer screening" category includes prostate-specific antigen testing for men ages 75 and older and colorectal cancer screening for older adults.

> Using the narrower versions of the measures, imaging and diagnostic and preventive testing accounted for 65 percent of the volume of low-value care per 100 beneficiaries.

Chart 7-14 Cardiovascular testing and procedures, other surgical procedures, and imaging accounted for most spending on low-value care in 2022



Note: "Spending" includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2021. This method was developed by Schwartz et al. (2014).

Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

> Cardiovascular testing and procedures and other surgical procedures accounted for about 70 percent of total spending on low-value care using the broader measures. Other surgical procedures and imaging made up nearly two-thirds of spending on low-value care using the narrower measures.

> The "cardiovascular testing and procedures" category includes stress testing for stable coronary disease and percutaneous coronary intervention with balloon angioplasty or stent placement for stable coronary disease. The "other surgical procedures" category includes spinal injection for low back pain and arthroscopic surgery for knee osteoarthritis. The "imaging" category includes back imaging for patients with nonspecific low back pain and screening for carotid artery disease in asymptomatic adults.

> The spending estimates probably understate actual spending on low-value care because they do not include the cost of downstream services (e.g., follow-up tests and procedures) that may result from the initial low-value service. Also, we are not capturing all low-value care through these 31 measures.

Chart 7-15 In MedPAC's 2023 survey, Medicare beneficiaries were more likely to report satisfaction with their access to care than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Received health care in past year: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"		
Yes	94%*	91%*
Providers that accept your insurance: Among those who received health care, "In the past 12 months, how satisfied or dissatisfied have you been with your ability to find health care providers that accept [Medicare / your insurance]?"		
Satisfied (net)	96*	91*
Very satisfied	80*	65*
Somewhat satisfied	16*	26*
Dissatisfied (net)	4*	9*
Somewhat dissatisfied	3*	7*
Very dissatisfied	1*	2*
Providers with timely appointments: Among those who received health care, "In the past 12 months, how satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?"		
Satisfied (net)	87*	77*
Very satisfied	52*	38*
Somewhat satisfied	35*	39*
Dissatisfied (net)	13*	23*
Somewhat dissatisfied	10*	17*
Very dissatisfied	3*	6*

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. *Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> MedPAC surveys Medicare beneficiaries ages 65 and over and privately insured people ages 50 to 64 each year to compare these two groups' experiences accessing care in the prior 12 months.

> Our sample includes Medicare beneficiaries with any type of coverage, including Medicare Advantage plans, since it can be difficult to identify beneficiaries' type of Medicare coverage in a survey. Among the privately insured people we survey, most report having employer-sponsored health insurance. For example, in 2023, 85 percent were insured through their or their spouse's employer, and 15 percent were insured through an individual health insurance plan.

> In our 2023 survey, higher shares of Medicare beneficiaries reported receiving any health care in the past year (94 percent) compared to privately insured individuals (91 percent).

> Among those who received health care in the past year, higher shares of Medicare beneficiaries were satisfied with their ability to find health care providers that accepted their insurance (96 percent) compared with privately insured people (91 percent). Higher shares of Medicare beneficiaries were also satisfied with their ability to find providers that had appointments when needed (87 percent) compared with privately insured people (77 percent).

Chart 7-16 In MedPAC's 2023 survey, Medicare beneficiaries reported having slightly better access to primary care providers than did privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Have a primary care provider: "A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?"		
Yes	96%*	92%*
See an NP or PA for primary care: "People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?"		
For none of my primary care (I always see a doctor)	41*	35*
For any of my primary care (net)	56*	61*
For some of my primary care	37	39
For all or most of my primary care	19*	22*
Don't know	3	4
Tried to get a new primary care provider: "In the past 12 months, have you tried to get a new primary care provider?"		
Yes	12%*	15%*
Reason looked for new primary care provider: Among those who tried to get a new primary care provider, "Which of the following best describes the main reason you tried to get a new primary care provider in the last 12 months?" (Overall share)		
My provider retired or stopped practicing	43 (5)	37 (5)
I wanted to change providers	34 (4)	31 (4)
I recently moved, so I needed to find a primary care provider in my area	15 (2)	13 (2)
I changed my health plan and had to find a new provider who participated in the new plan	5* (1*)	11* (2*)
My primary care provider was no longer accepting [Medicare / my insurance]	3* (0*)	8* (1*)

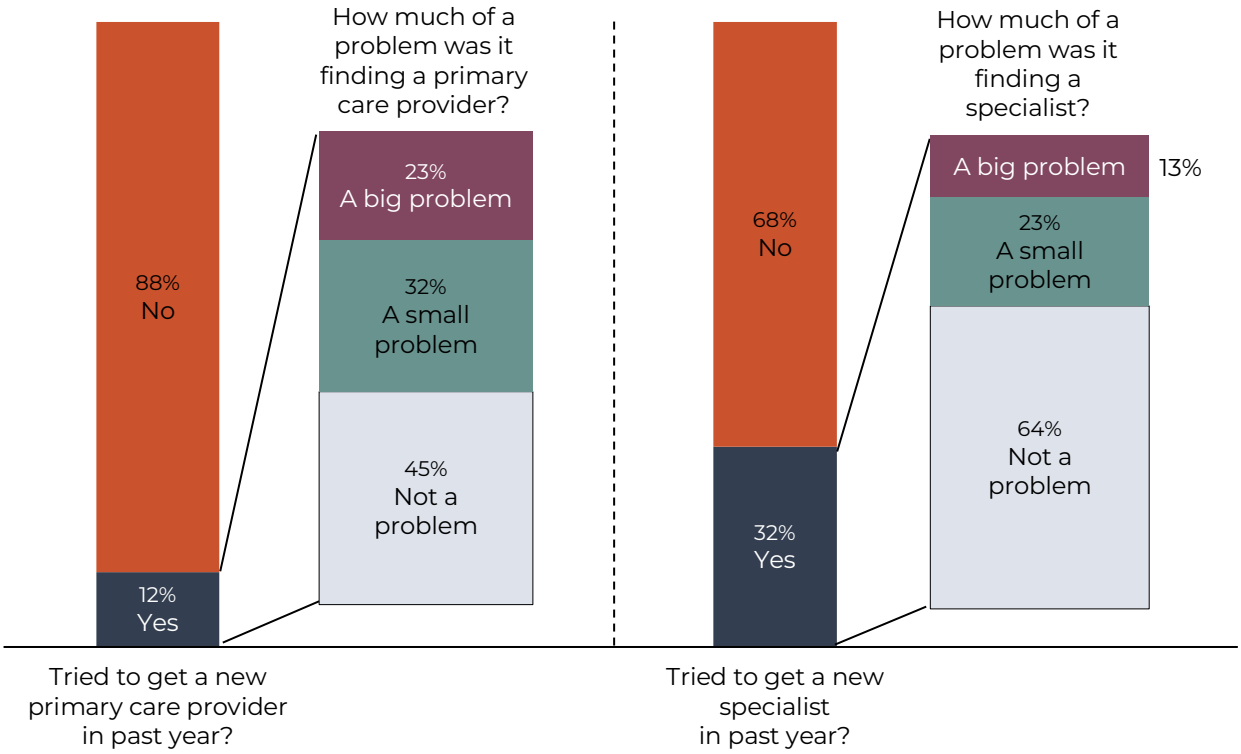
Note: NP (nurse practitioner), PA (physician assistant). We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "Overall share" refers to the share of all respondents with this insurance. *Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In our 2023 survey, higher shares of Medicare beneficiaries reported having a primary care provider (96 percent) compared with privately insured people (92 percent).

> Among Medicare beneficiaries looking for a new primary care provider, only 3 percent did so because their existing primary care provider was no longer accepting Medicare (equivalent to slightly more than 0 percent of all Medicare beneficiaries). Among privately insured people looking for a new primary care provider, 8 percent did so because their existing primary care provider no longer accepted their insurance (equivalent to 1 percent of all privately insured people).

Chart 7-17 **In our 2023 survey, Medicare beneficiaries looking for a new primary care provider were more likely to report problems finding one compared with beneficiaries seeking a new specialist**



Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In our 2023 survey, among the 12 percent of Medicare beneficiaries who tried to get a new primary care provider in the past year, over half (55 percent) reported problems finding one: 23 percent reported a "big problem" finding a new one and another 32 percent reported a "small problem." These figures combined are equivalent to 7 percent of Medicare beneficiaries reporting problems finding a new primary care provider in the past year (data not shown).

> A larger share of patients look for a new specialist each year: In 2023, 32 percent of Medicare beneficiaries tried to get a new specialist. Among these beneficiaries, a little over a third (36 percent) reported problems finding a new specialist: 13 percent reported a "big problem" and 23 percent reported a "small problem" finding one. Combined, these figures are equivalent to 11 percent of Medicare beneficiaries reporting problems finding a new specialist in the past year (data not shown).

Chart 7-18 In our 2023 survey, Medicare beneficiaries were less likely to report problems finding a new clinician compared with privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Get a new primary care provider: "In the past 12 months, have you tried to get a new primary care provider?"		
Yes	12%*	15%*
Problems finding a primary care provider: Among those who tried to get a new primary care provider, "How much of a problem was it finding a primary care provider who would treat you?" (Overall share)		
A problem (net)	55* (7*)	68* (10*)
A big problem	23* (3*)	33* (5*)
A small problem	32 (4*)	35 (5*)
Not a problem	45* (5)	32* (5)
Primary care providers not accepting your insurance: Among those who had a problem finding a new primary care provider, "Did anyone from a doctor's office tell you they didn't accept [Medicare / your insurance]?" (Overall share)		
Yes	15* (1*)	28* (3*)
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"		
Yes	32	33
Problems finding a specialist: Among those who tried to get a new specialist, "How much of a problem was it finding a specialist who would treat you?" (Overall share)		
A problem (net)	36* (11*)	46* (15*)
A big problem	13* (4*)	18* (6*)
A small problem	23 (7*)	28 (9*)
Not a problem	64* (20)	54* (18)
Specialists not accepting your insurance: Among those who had a problem finding a new specialist, "Did anyone from a doctor's office tell you they didn't accept [Medicare / your insurance]?" (Overall share)		
Yes	15* (2*)	28* (4*)
Get a new mental health professional: "Some specialists and other clinicians focus on mental health. In the past 12 months, have you tried to get a new mental health professional?"**		
Yes	3*	7*
Problems finding a mental health professional: Among those who tried to get a mental health professional, "How much of a problem was it finding a mental health professional who would treat you?" (Overall share)		
A problem (net)	63 (2*)	70 (5*)
A big problem	38 (1*)	45 (3*)
A small problem	25 (1*)	25 (2*)
Not a problem	37 (1*)	30 (2*)
Mental health professionals not accepting your insurance: Among those who had a problem finding a new mental health professional, "Did anyone from a mental health professional's office tell you they didn't accept [Medicare / your insurance]?" (Overall share)		
Yes	33* (1*)	54* (3*)

(Chart continued next page)

Chart 7-18 In our 2023 survey, Medicare beneficiaries were less likely to report problems finding a new clinician compared with privately insured people (continued)

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "Overall share" refers to the share of all respondents with this insurance.
*Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).
**Under this question, the following definition appeared: "Mental health professionals are clinicians like psychiatrists, psychologists, therapists, counselors, or clinical social workers you see to help treat conditions such as depression, anxiety, addiction, post-traumatic stress disorder, schizophrenia, or bipolar disorder."

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> Similar shares of Medicare beneficiaries and privately insured people looked for a new provider in 2023. Among Medicare beneficiaries, 12 percent reported looking for a new primary care provider in the past year and 32 percent reported looking for a new specialist. Among the privately insured, those shares were 15 percent and 33 percent, respectively.

> Among those looking for a new primary care provider (PCP), privately insured people were more likely than Medicare beneficiaries to report problems finding one. In 2023, 68 percent of the privately insured people who were looking for a new PCP reported problems (equivalent to 10 percent of all privately insured people), while 55 percent of Medicare beneficiaries who were looking for a new PCP reported problems (equivalent to 7 percent of all Medicare beneficiaries). Privately insured people also reported more problems finding specialists than did Medicare beneficiaries (46 percent vs. 36 percent, respectively, equivalent to 15 percent of privately insured people and 11 percent of Medicare beneficiaries).

> Privately insured people (7 percent) were more likely than Medicare beneficiaries (3 percent) to report looking for a new mental health professional in the last year. However, a majority of both groups reported problems finding such a provider: In our 2023 survey, 63 percent of Medicare beneficiaries who were looking for a mental health professional and 70 percent of privately insured people who were looking reported problems finding one.

> Whether they were looking for a new primary care provider, specialist, or mental health professional, privately insured people were more likely to encounter a clinician who did not accept their insurance compared with Medicare beneficiaries. For example, among those looking for a new primary care provider, 15 percent of these Medicare beneficiaries encountered a doctor's office that did not accept their insurance (equivalent to 1 percent of all Medicare beneficiaries); in contrast, 28 percent of privately insured people looking for a new primary care provider had this experience (equivalent to 3 percent of all privately insured people).

Chart 7-19 In MedPAC's 2023 survey, Medicare beneficiaries ages 65 and over reported less interest in using telehealth in the future than did privately insured people ages 50 to 64

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Had a telehealth visit: "In the past 12 months, have you had a [video / telephone] visit . . . with any type of health care provider?"		
Telehealth visit (video or telephone) (net)	34%	34%
Video visit	17*	24*
Telephone visit (audio only)	26*	20*
Satisfaction with telehealth visit: Among those who had a [video / telephone] visit, "How satisfied were you with the [video / telephone] visit(s) you had in the past 12 months?"		
Video visit(s)		
Satisfied (net)	89	89
Very satisfied	55	53
Somewhat satisfied	34	36
Dissatisfied (net)	11	11
Somewhat dissatisfied	7	8
Very dissatisfied	4	3
Telephone visit(s)		
Satisfied (net)	93	89
Very satisfied	59*	49*
Somewhat satisfied	34*	40*
Dissatisfied (net)	7	11
Somewhat dissatisfied	5*	9*
Very dissatisfied	3	2
Interest in using telehealth in the future: "Would you be interested in having the option to use [video / telephone] visits to see health care providers in the future?"		
Interested in at least one type of telehealth visit (net)	35*	48*
Interested in video visits	26*	43*
Interested in telephone visits	26*	34*

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. In our questions about having had any telehealth visits in the past 12 months (the first set of questions shown above), video visits were defined as "using a smartphone, computer, or tablet" and telephone visits were defined as "a phone call with audio but no video."
*Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

(Chart continued next page)

Chart 7-19 In MedPAC's 2023 survey, Medicare beneficiaries ages 65 and over were less interested in using telehealth in the future than privately insured people ages 50 to 64 (continued)

> In our 2023 survey, about a third (34 percent) of Medicare beneficiaries and privately insured people each reported having had some type of telehealth visit in the past year. Medicare beneficiaries were somewhat more likely than privately insured people to have had an audio-only telephone visit (26 percent vs. 20 percent). Meanwhile, privately insured people were somewhat more likely to have had a video visit than Medicare beneficiaries (24 percent vs. 17 percent).

> About 90 percent of telehealth users reported being satisfied with their video visits or telephone visits in 2023.

> Fewer Medicare beneficiaries were interested in having the option to use telehealth in the future (35 percent) compared with privately insured people (48 percent). About one in four Medicare beneficiaries was interested in having the option to use video visits, and one in four was interested in having the option to use audio-only telephone visits.

> In analyses of Medicare beneficiary subgroups (not shown):

>> Video visits and telephone visits were more commonly used by Medicare beneficiaries who lived in urban areas and had higher household incomes (of at least $80,000). A lower share of Medicare beneficiaries ages 85 and over reported using video visits compared with younger beneficiaries.

>> Interest in continuing to have the option to use telehealth visits was higher among Medicare beneficiaries who were under the age of 75, had higher incomes, and lived in urban areas.

>> There were not statistically significant differences in the shares of White, Black, and Hispanic Medicare beneficiaries who used telehealth.

>> There were not statistically significant differences in the shares of different subgroups who were satisfied with their telehealth visits.

Chart 7-20 In 2023, Medicare beneficiaries were less likely than privately insured people to report waiting longer than they wanted to get appointments

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Long wait for an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"		
For regular or routine care		
Never	49%*	37%*
Sometimes	39	40
Usually	9*	14*
Always	4*	8*
For an illness or injury		
Never	65*	55*
Sometimes	27*	30*
Usually	6*	10*
Always	2*	5*
Response to long wait: Among those who had to wait longer than they wanted for an appointment, "What did you do?" (Overall share)		
For regular or routine care		
Took the later appointment date	87* (42*)	82* (48*)
Went to a walk-in clinic	7* (3*)	10* (6*)
Decided not to schedule the appointment	4* (2*)	6* (4*)
Went to a hospital emergency room	2 (1)	2 (1)
For an illness or injury		
Took the later appointment date	68* (20)	58* (21)
Went to a walk-in clinic	16* (5*)	27* (10*)
Went to a hospital emergency room	9 (3)	8 (3)
Decided not to schedule the appointment	7 (2)	7 (3)

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. Instructions for the questions shown above read: "For the next few questions, please think about the number of days or weeks you had to wait to get a doctor's appointment. Do not include time spent on hold or in the waiting room" and "Please count video visits and phone visits as appointments." "Overall share" refers to the share of all respondents with this insurance.
*Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In 2023, our survey found that Medicare beneficiaries were less likely than privately insured people to report having to wait longer than they wanted to get a doctor's appointment.

> About half (49 percent) of Medicare beneficiaries reported never waiting longer than they wanted to get an appointment for routine care, compared with 37 percent of privately insured people. For appointments for an illness or injury, about two-thirds (65 percent) of Medicare beneficiaries said they never had to wait longer than they wanted to get such an appointment, compared with 55 percent of privately insured people.

> Both Medicare beneficiaries and privately insured people were less likely to report waits for illness or injury appointments compared with regular or routine care appointments.

Chart 7-21 In our 2023 survey, Medicare beneficiaries were less likely than privately insured people to report forgoing care

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Forgoing care: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"		
Yes	20%*	27%*
Reason for forgoing care: "There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the **main reason** you did not see a doctor about this condition during the past 12 months?" (Overall share)		
I just put it off	27 (5)	22 (6)
I didn't think the problem was serious	25 (5)	21 (5)
I couldn't get an appointment soon enough	20 (4*)	22 (6*)
I thought it would cost too much	7* (1*)	22* (6*)
I couldn't find a doctor who would treat me	5 (1)	4 (1)
I had to put if off because of the COVID-19 pandemic	3 (1)	1 (0)
Other	12 (2)	9 (2)

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. Components do not sum to 100 percent due to rounding. "Overall share" refers to the share of all respondents with this insurance.
*Statistically significant difference between Medicare and private insurance groups (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In our 2023 survey, 20 percent of Medicare beneficiaries and 27 percent of privately insured people reported forgoing care in the past year that they thought they should have gotten.

> About half of care-forgoers did so because they "didn't think the problem was serious" or "just put it off" (52 percent of Medicare beneficiaries and 43 percent of privately insured people reported one of these reasons).

> About one in five care-forgoers skipped care because they could not get an appointment soon enough: This was true for 20 percent of Medicare beneficiaries who reported forgoing care (equivalent to 4 percent of all Medicare beneficiaries) and 22 percent of privately insured people who reported forgoing care (equivalent to 6 percent of all privately insured people).

> Medicare beneficiaries were much less likely to forgo care due to concerns about cost compared with privately insured people: In 2023, only 7 percent of Medicare beneficiaries who reported forgoing care did so because they "thought it would cost too much" (equivalent to 1 percent of all Medicare beneficiaries), while 22 percent of privately insured people who reported forgoing care did so for this reason (equivalent to 6 percent of all privately insured people).

Chart 7-22 In our 2023 survey, lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
	Lower income	Middle income	Higher income	Lower income	Middle income	Higher income
Received health care in past year: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"						
Yes	91%[a]	97%[ab]	97%[ab]	82%[a]	90%[ab]	93%[ab]
See an NP or PA for primary care: "People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?"						
For all or most of my primary care	22[a]	18	14[ab]	28[a]	23	20[ab]
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"						
Yes	26	36[b]	38[b]	26	33[b]	35[b]
Forgoing care: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Yes	23[a]	17[ab]	17[ab]	28[a]	31[a]	25[a]
Reason for forgoing care: "There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the **main reason** you did not see a doctor about this condition during the past 12 months?" (Overall share)						
I just put it off	26 (6)	31 (5)	26 (5)	20 (6)	23 (7)	23 (6)
I didn't think the problem was serious	23 (5)	28 (5)	29 (5)	15 (4)	19 (6)	24[b] (6)
I couldn't get an appointment soon enough	19 (4)	21 (4)	24 (4)	22 (6)	20 (6)	22 (5)
I thought it would cost too much	10[a] (2[a])	5[a] (1[a])	1[ab] (0[ab])	31[a] (9[a])	21[a] (6[a])	19[ab] (5[ab])
I couldn't find a doctor who would treat me	6 (1)	4 (1)	4 (1)	4 (1)	3 (1)	4 (1)
I had to put if off because of the COVID-19 pandemic	4 (1)	2 (0)	2 (0)	1 (0)	2 (1)	1 (0)
Other	12 (3)	8 (1[a])	13[a] (2)	8 (2)	12 (4[a])	7[a] (2)

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "Lower income" refers to respondents with household incomes of less than $50,000 per year, "middle income" refers to respondents with household incomes between $50,000 and $79,999, and "higher income" refers to respondents with household incomes of $80,000 or more. "Overall share" refers to the share of all respondents with this insurance.

[a]Statistically significant difference between Medicare beneficiaries and private insurance people within the same income category (at a 95 percent confidence level).

[b]Statistically significant difference between lower-income respondents and middle- or higher-income respondents within the same insurance category (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

(Chart continued next page)

Chart 7-22 In our 2023 survey, lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries (continued)

> In 2023, we found a number of differences in access to care for lower-income Medicare beneficiaries (with household incomes below $50,000) and higher-income beneficiaries (with household incomes of $80,000 or more). For example:

>> Only 91 percent of lower-income beneficiaries reported receiving any health care in the past year, compared with 97 percent of middle- and higher-income beneficiaries.

>> Lower shares of lower-income beneficiaries reported looking for a new specialist in the past year (26 percent) compared with higher-income beneficiaries (38 percent).

>> Higher shares of lower-income beneficiaries reported forgoing care in the past year (23 percent) compared with higher-income beneficiaries (17 percent).

> Among lower-income respondents with private insurance who had forgone care, 31 percent reported cost as the main reason they had done so (equivalent to 9 percent of lower-income privately insured people). By contrast, among lower-income Medicare beneficiaries who had forgone care, 10 percent cited cost as the reason they had done so (equivalent to 2 percent of lower-income Medicare beneficiaries).

Chart 7-23 In our 2023 survey, lower shares of Black and Hispanic Medicare beneficiaries reported receiving any health care in the past year compared with White beneficiaries

	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
Survey question	White	Black	Hispanic	White	Black	Hispanic
Received health care in past year: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"						
Yes	95%[a]	92%[b]	86%[b]	91%[a]	92%	85%[b]
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"						
Yes	33	23[b]	25	33	28	34

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "White" refers to non-Hispanic White respondents, "Black" refers to non-Hispanic Black respondents, and "Hispanic" refers to Hispanic respondents of any race.
[a]Statistically significant difference between Medicare beneficiaries and private insurance people within the same race/ethnicity category (at a 95 percent confidence level).
[b]Statistically significant difference between White and Black or Hispanic within the same insurance category (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

> In our 2023 survey, Black and Hispanic Medicare beneficiaries generally reported care experiences comparable with those of White beneficiaries, with a few exceptions:

>> Lower shares of Hispanic and Black beneficiaries reported receiving any health care in the past year compared with White beneficiaries (86 percent and 92 percent vs. 95 percent). We also observed somewhat lower shares of Hispanic beneficiaries receiving care among the privately insured (85 percent) compared with White privately insured individuals (91 percent).

>> Lower shares of Black beneficiaries looked for a new specialist in the past year (23 percent) compared with White beneficiaries (33 percent).

> There were no statistically significant differences between the shares of White beneficiaries and Black or Hispanic beneficiaries who:

>> were satisfied with their ability to find health care providers who accepted their insurance,

>> were satisfied with their ability to find providers who had timely appointments available,

>> had a primary care provider,

>> saw a nurse practitioner or physician assistant for various shares of their primary care,

>> tried to get a new primary care provider,

>> tried to get a new mental health professional,

>> had to wait longer than they wanted to get an appointment, or

>> reported forgoing care that they thought they should have gotten.

Chart 7-24 In our 2023 survey, rural Medicare beneficiaries were more likely to receive most or all of their primary care from a nonphysician and were less likely to seek out specialty care compared with urban beneficiaries

	Medicare (ages 65 and older)		Private insurance (ages 50–64)	
Survey question	Urban	Rural	Urban	Rural
See an NP or PA for primary care: "People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?"				
For none of my primary care (I always see a doctor)	42%[ab]	34%[b]	36%[ab]	26%[b]
For any of my primary care (net)	55[a]	61	60[ab]	69[b]
For some of my primary care	39	33	40	34
For all or most of my primary care	17[b]	29[b]	20[b]	36[b]
Don't know	3[ab]	5[b]	4[a]	4
Long wait for an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"				
For regular or routine care				
Never	47[ab]	56[ab]	36[ab]	45[ab]
Get a new specialist: "Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?"				
Yes	34[b]	23[b]	34[b]	27[b]
Problems finding a specialist: Among those who tried to get a new specialist, "How much of a problem was it finding a specialist who would treat you?" (Overall share)				
A small problem	21[ab]	33[b]	28[a]	27

Note: We received completed surveys from 4,991 Medicare beneficiaries and 5,527 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. "Urban" respondents live in an urban or suburban part of a metropolitan statistical area (MSA); the Census Bureau defines MSAs as having at least one urbanized area with a population of 50,000 or more and including adjacent territory that has a high degree of social and economic integration as measured by commuting ties. "Rural" respondents live outside of an MSA.

[a]Statistically significant difference between Medicare beneficiaries and private insurance people within the same area type (at a 95 percent confidence level).

[b]Statistically significant difference between urban and rural respondents within the same insurance category (at a 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 27 to September 13, 2023.

(Chart continued next page)

Chart 7-24 In our 2023 survey, rural Medicare beneficiaries were more likely to receive most or all of their primary care from a nonphysician and were less likely to seek out specialty care compared with urban beneficiaries (continued)

> Our survey found a few differences related to the mix of clinicians whom rural and urban beneficiaries see:

>> More rural beneficiaries reported receiving all or most of their primary care from a nurse practitioner or physician assistant (29 percent) compared with urban beneficiaries (17 percent). This finding was also true among the privately insured.

>> More rural beneficiaries reported never having to wait longer than they wanted to get an appointment for regular or routine care (56 percent) compared with urban beneficiaries (47 percent), among those who needed this type of appointment.

>> Fewer rural beneficiaries reported looking for a new specialist in the past year (23 percent) compared with urban beneficiaries (34 percent).

>> Among those looking for a new specialist, a greater share of rural beneficiaries reported experiencing "a small problem" finding one (33 percent) compared with urban beneficiaries (21 percent).

> Among Medicare beneficiaries, there were no statistically significant differences between the shares of urban and rural residents who:

>> had received any health care in the past year,

>> were satisfied with their ability to find health care providers who accepted their insurance,

>> were satisfied with their ability to find health care providers who had appointments available when they needed them,

>> had a primary care provider,

>> tried to get a new primary care provider or a new mental health professional,

>> experienced a problem finding a new primary care provider,

>> waited longer than they wanted to get an appointment for an illness or injury,

>> reported forgoing care that they thought they should have gotten.

SECTION

8

Post-acute care

Skilled nursing facilities
Home health services
Inpatient rehabilitation facilities
Long-term care hospitals

Chart 8-1 Change in the number of post-acute care providers in Medicare differed across sectors in 2023

	2018	2019	2020	2021	2022	2023	Average annual percent change 2018–2023	Percent change 2022–2023
Skilled nursing facilities	15,359	15,305	15,173	15,098	14,973	14,800	–0.7%	–1.0%
Home health agencies	11,556	11,356	11,386	11,506	11,657	12,057	0.9	3.4
Inpatient rehabilitation facilities	1,170	1,152	1,159	1,181	1,181	1,206	0.6	2.1
Long-term care hospitals	386	371	351	345	341	338	–2.6	–0.9

Source: MedPAC analysis of active provider counts from CMS Survey and Certification's Quality, Certification, and Oversight Reports (skilled nursing facilities) and CMS Provider of Services files (home health agencies, inpatient rehabilitation facilities, and long-term care hospitals).

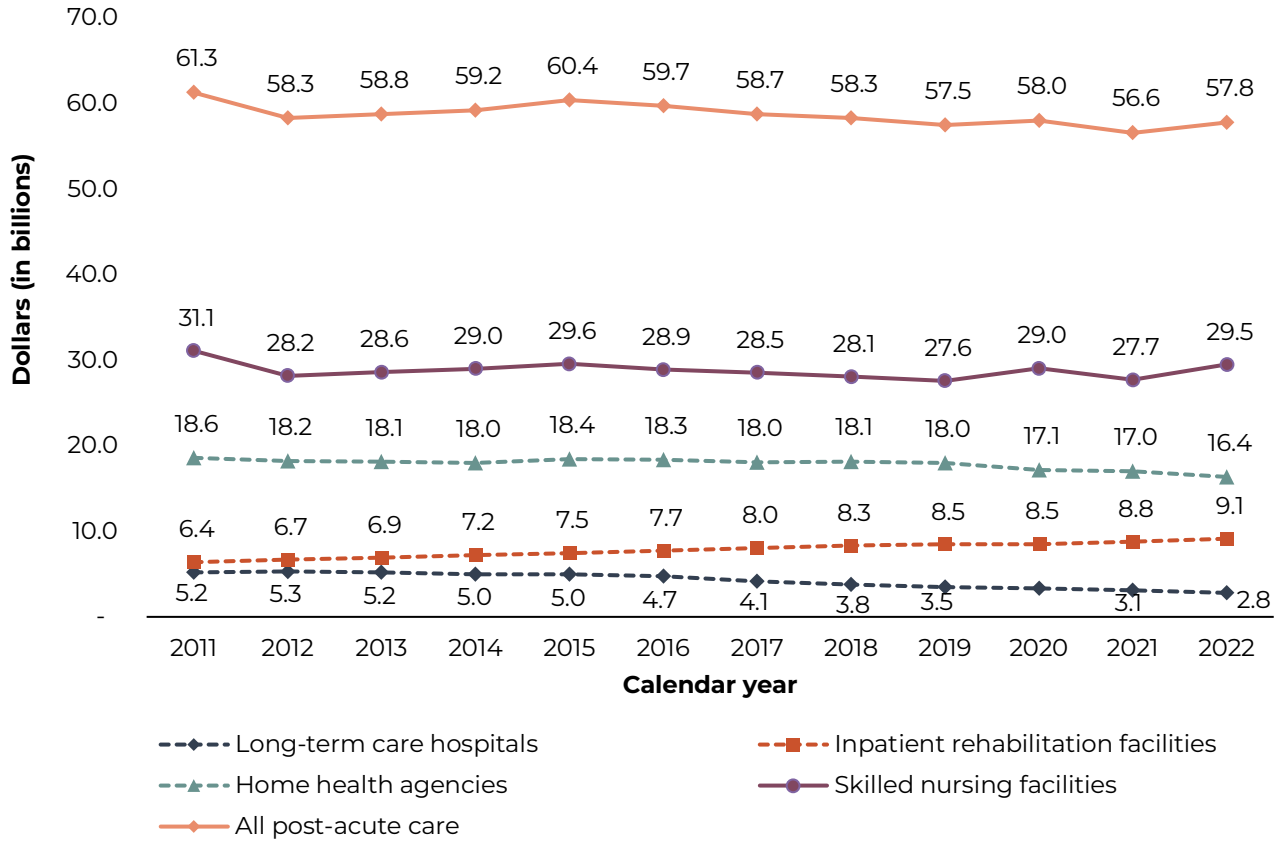
> The number of skilled nursing facilities decreased less than 1 percent per year between 2018 and 2023.

> The number of home health agencies has increased since 2018, but much of this growth has been concentrated in California; excluding that state, the supply of agencies declined by about 2 percent between 2018 and 2023 (data not shown).

> After declining for several years, the total number of inpatient rehabilitation facilities started to increase slightly in 2020 and continued to increase in 2023.

> After peaking in 2012 (data not shown), the number of long-term care hospitals (LTCHs) decreased. The decline became more rapid after the implementation of a dual payment-rate system that reduced payments for certain Medicare discharges from LTCHs beginning in fiscal year 2016, but the decline slowed in 2022 and 2023.

Chart 8-2 Aggregate Medicare fee-for-service spending for post-acute care declined between 2015 and 2022



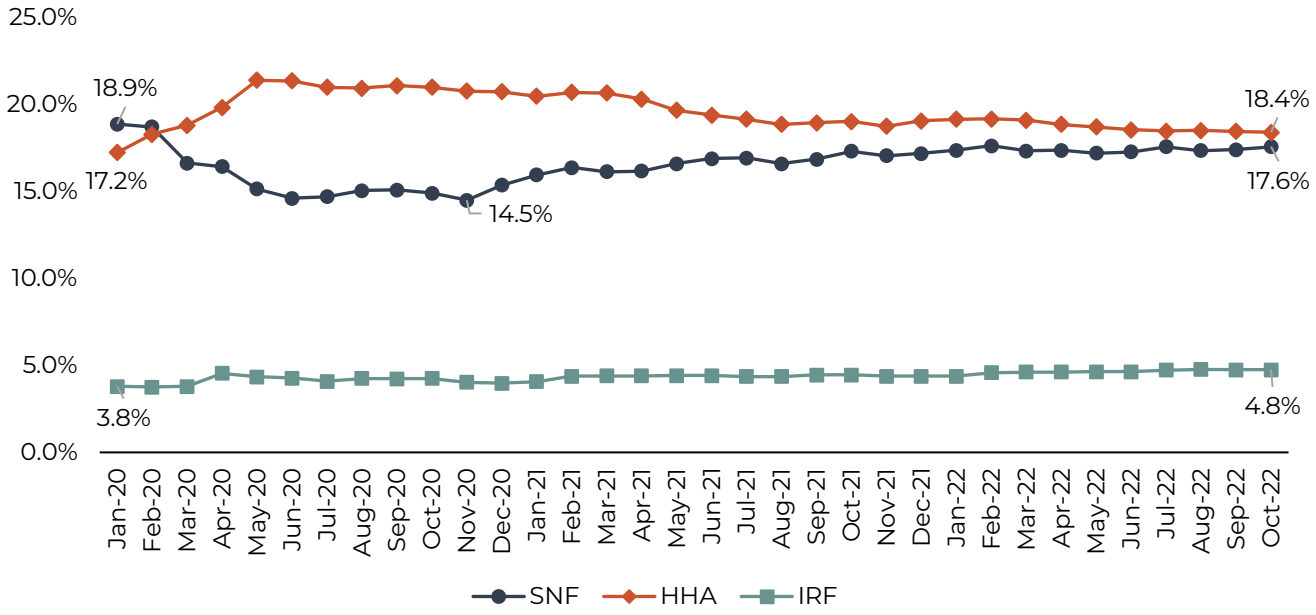
Note: These calendar year–incurred data represent program spending only; they do not include beneficiary cost sharing. Dollar amounts are nominal figures, not adjusted for inflation.

Source: CMS Office of the Actuary, 2024.

> Aggregate fee-for-service (FFS) spending on all post-acute care sectors combined increased between 2021 and 2022 on a nominal basis despite decreased enrollment in FFS.

> Between 2021 and 2022, spending for skilled nursing facility care increased due to an increase in volume. Spending declined for home health care and long-term care hospitals, while spending on IRFs increased slightly.

Chart 8-3 Between January 2020 and October 2022, SNFs lost and then gradually regained some of the share of IPPS discharges to PAC, and the shares going to HHAs and IRFs increased



Note: SNF (skilled nursing facility), IPPS (inpatient prospective payment systems), PAC (post-acute care), HHA (home health agency), IRF (inpatient rehabilitation facility). This chart shows where beneficiaries enrolled in fee-for-service Medicare received PAC after a hospitalization.

Source: MedPAC analysis of Medicare claims data.

> In January 2020, immediately prior to the pandemic, SNFs were the most common PAC destination after discharge from the acute care hospital, with 18.9 percent of discharges. That same month, 17.2 percent of inpatient discharges received home health care. As the number of inpatient discharges began to fall in March 2020 due to the pandemic, the share of beneficiaries discharged from a hospital to a SNF also declined. At the same time, the share receiving services from HHAs and IRFs increased, making home health the most commonly used PAC setting. Home health remained the most frequent PAC setting postdischarge throughout 2021 and 2022. Although SNFs had not regained their prepandemic share of discharges, by September 2022, SNFs had gradually recovered some of the share of IPPS discharge volume lost during the pandemic.

> Overall, about 41 percent of inpatient hospital discharges in both 2021 and 2022 were followed by services from a SNF, HHA, IRF, or long-term acute care hospital (data not shown). Use of PAC after hospital discharge varied depending on the condition or treatment a patient received while hospitalized. For example, in 2022, the share of hospital discharges using PAC was 47 percent for postsurgical patients compared with about 40 percent for patients who received mostly medical services during their inpatient stay (data not shown).

Chart 8-4 Freestanding SNFs, urban SNFs, and for-profit SNFs accounted for the majority of facilities, Medicare stays, and Medicare spending in 2022

Type of SNF	Facilities	Medicare-covered FFS stays	Medicare FFS payments
Totals	14,691	1,842,676	$27 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	84	86
Rural	27	16	14
For profit	72	76	79
Nonprofit	22	21	18
Government	5	3	3

Note: SNF (skilled nursing facility), FFS (fee-for-service). Components may not sum to 100 percent due to rounding and missing values. The number of facilities and the Medicare FFS spending amounts shown here are lower than those displayed in Charts 8-1 and 8-2 due to the use of different data sources. Table includes covered stays and program spending in SNFs and does not include swing beds.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files from CMS.

> In 2022, freestanding facilities accounted for 98 percent of Medicare-covered SNF stays and 98 percent of Medicare's payments to SNFs.

> In 2022, urban facilities accounted for 73 percent of facilities, 84 percent of stays, and 86 percent of Medicare payments.

> In 2022, for-profit facilities accounted for 72 percent of facilities, 76 percent of stays, and 79 percent of Medicare payments.

Chart 8-5 Fee-for-service SNF admissions increased in 2022

Volume measure	2019	2020	2021	2022	Average annual change 2019–2022	Average annual change 2021–2022
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	–3.1%	10.3%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,500	3.6	10.2
Covered days per admission	26.1	28.5	28.0	28.0	7.0	–0.1

Note: SNF (skilled nursing facility), FFS (fee-for-service). Data are for the calendar years and include 50 states and the District of Columbia. Average annual changes are calculated using unrounded values and then rounded to the nearest tenth.

Source: Calendar year data from CMS, Office of Information Products and Data Analytics, 2019–2022.

> To control for changes in fee-for-service (FFS) enrollment, we examine service use per 1,000 FFS beneficiaries. Between 2021 and 2022, SNF admissions per 1,000 FFS beneficiaries increased 10.3 percent. Compared with 2019, covered admissions per FFS beneficiary were 3.1 percent lower, but covered days were 7 percent higher due to longer lengths of stay.

Chart 8-6 Freestanding SNF Medicare margins remained high in 2022

	2018	2019	2020	2021	2022
All	10.8%	12.1%	18.1%	17.6%	18.4%
Rural	8.6	10.2	19.3	17.1	17.5
Urban	11.2	12.5	18.0	17.1	18.5
Nonprofit	0.8	1.7	3.2	2.7	1.1
For profit	13.6	15.2	21.5	21.1	22.0

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports, 2017–2022.

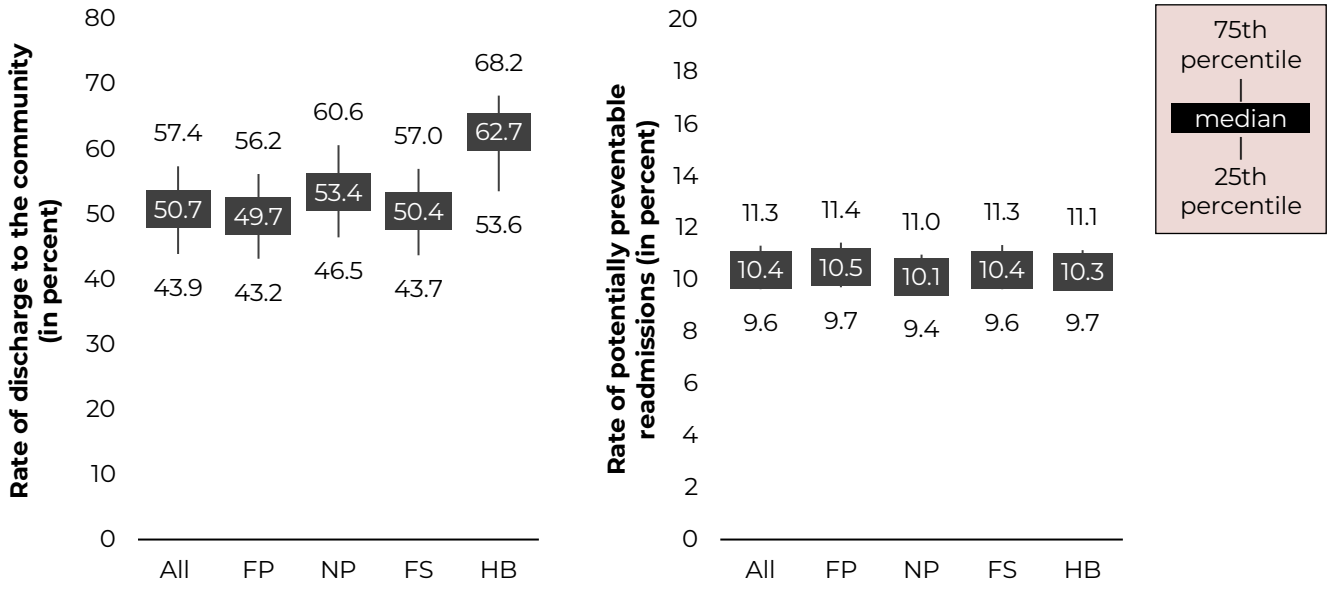
> The aggregate Medicare margin for freestanding SNFs in 2022 (18.4 percent) exceeded 10 percent for the 23rd consecutive year (not all years are shown). Had we considered an allocated share of the federal relief funds providers received due to the coronavirus pandemic, we estimate the aggregate margin in 2022 would have been even higher, at 20 percent (not shown).

> The aggregate Medicare margin increased in 2022 because the average payment per day in freestanding SNFs increased 2.2 percent, while costs per day increased just 1.7 percent (data not shown). The relatively lower growth in costs per day reflects more covered days over which to spread fixed costs. Another factor was the decline in ancillary costs per day. Between 2021 and 2022, SNFs provided 11 percent fewer minutes of rehabilitation therapy per discharge (data not shown). In addition, a greater share of the minutes was provided in group therapy or concurrently, both of which are lower-cost modalities compared with individual therapy.

> Aggregate Medicare margins for freestanding SNFs varied widely: One-quarter of SNFs had Medicare margins that were 28.9 percent or higher, and one-quarter had margins that were 4.4 percent or lower (data not shown). Consistent with several years before the pandemic, urban SNFs had a higher aggregate Medicare margin than rural SNFs in 2022. For-profit SNFs had a considerably higher aggregate Medicare margin than nonprofit SNFs. Compared with for-profit SNFs, nonprofit facilities were smaller (fewer beds and lower volume) and had lower payments per day, higher costs per day, and higher growth in costs per day between 2021 and 2022 (data not shown).

> In 2021, the average total margin (the margin across all payers and all lines of business) for freestanding facilities was –1.4 percent, down from 3.4 percent in 2021 (data not shown). One contributing factor to the lower total margin in fiscal year 2022 was the reduced amount of provider relief funds. These funds were reported that year, but the amounts in aggregate were about half of what they were in 2020 and 2021.

Chart 8-7 SNF quality measures: Risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2021 and FY 2022



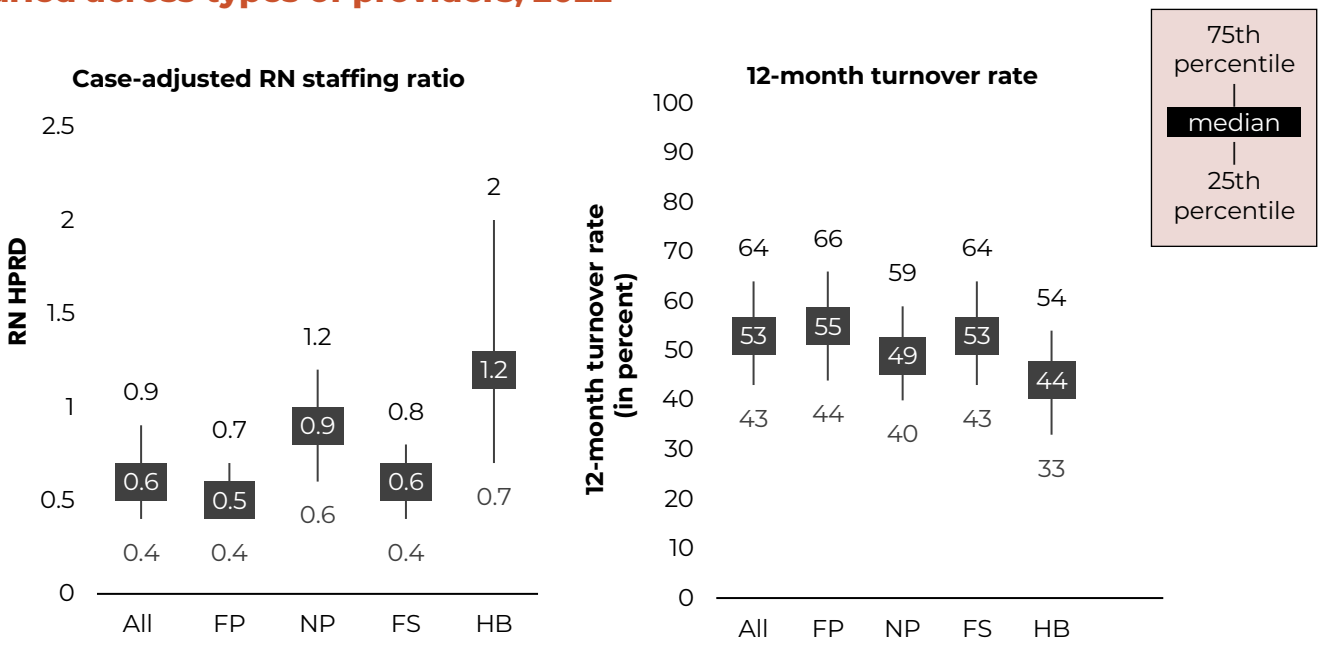
Note: SNF (skilled nursing facility), FY (fiscal year), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (fiscal years 2021 and 2022 combined). Rates are computed from Medicare claims for eligible Medicare Part A–covered SNF stays and do not include swing-bed stays. The measure of discharge to the community is a SNF's risk-standardized rate of fee-for-service Medicare residents who were discharged to the community after a SNF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of potentially preventable readmissions after discharge is calculated as the risk-adjusted percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better.

Source: MedPAC analysis of SNF claims-based outcome measures from the Provider Data Catalog, fiscal year 2021 through fiscal year 2022.

> In FY 2021 and FY 2022 (combined), the median rate of discharge to the community from SNFs was 50.7 percent, which was a slight decline compared with the FY 2018 and FY 2019 combined rate of 51.7 percent (latter data not shown; higher rates are better). In FY 2021 and FY 2022, one-quarter of SNFs had rates above 57.4 percent and one-quarter had rates below 43.9 percent. The median rates for nonprofit SNFs and hospital-based SNFs were higher than the median rates for for-profit SNFs and freestanding SNFs.

> In FY 2021 and FY 2022, SNFs' median rate of potentially preventable readmissions to the hospital was 10.4 percent. (Lower rates indicate better quality.) One-quarter of SNFs had rates above 11.3 percent and one-quarter had rates below 9.6 percent.

Chart 8-8 SNFs' RN staffing ratios and total nursing staff turnover rates varied across types of providers, 2022



Note: SNF (skilled nursing facility), RN (registered nurse), HPRD (hours per resident day), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). Staffing ratios for the year are determined by averaging the quarterly values for each provider for the calendar year. All Medicare- and Medicare/Medicaid–certified SNFs with valid data are included.

Source: MedPAC analysis of quarterly nursing facility staffing measures from CMS's provider data catalog.

> In 2022, the median SNF provided 0.6 RN HPRD. One-quarter of SNFs provided 0.9 or more HPRD, while one-quarter provided 0.4 or less HPRD. Freestanding SNFs had lower median case-mix-adjusted RN staffing than hospital-based SNFs, and for-profit SNFs had lower median case-mix-adjusted RN staffing than nonprofit SNFs. Although the staffing ratios are adjusted for acuity, some of the differences could reflect the mix of long-stay and short-stay patients in a facility.

> In 2022, the 12-month nursing staff turnover rate as of the fourth quarter of 2022 was 53 percent for the median SNF. One-quarter of facilities had turnover rates greater than 64 percent—meaning that nearly two-thirds of their nursing staff left the facility in the 12-month period. For-profit SNFs and freestanding SNFs had higher turnover rates than nonprofit SNFs and hospital-based SNFs.

Chart 8-9 Fee-for-service home health care use and spending declined in 2022

	2019	2020	2021	2022	Average annual change 2019–2022	Average annual change 2021–2022
Medicare FFS home health users (millions)	3.3	3.1	3.0	2.8	–5.0%	–6.3%
Share of Medicare FFS beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	–1.8	–3.0
30-day periods (millions)	N/A	9.6	9.3	8.6	N/A	–4.3
30-day periods per 100 FFS Medicare beneficiaries	N/A	25	26	24	N/A	–1.3
Total in-person visits (millions)	99.7	81.1	76.8	61.5	–11.3	–9.6
Visit per user	30.2	26.6	25.4	24.6	–6.7	–3.5

Note: FFS (fee-for-service), N/A (not available). Average annual changes are calculated using unrounded values and then rounded to the nearest tenth. Payment amounts shown here are lower than those displayed in Chart 8-2 due to the use of different data sources. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of home health standard analytic files from CMS and the 2022 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2022, the number of beneficiaries using FFS-covered home health care declined by 6.3 percent, reflecting both a decrease in the number of beneficiaries enrolled in FFS Medicare and a decline in the share of FFS beneficiaries who used home health care. FFS home health utilization and spending have been declining for several years as more beneficiaries enroll in Medicare Advantage and per capita FFS hospitalizations—a common source of referral to home health care—have fallen. Controlling for the decline in FFS Medicare enrollment, the number of 30-day home health periods declined 1.3 percent in 2022.

> The number of in-person visits per home health user fell 3.5 percent from 2021 to 2022. During the public health emergency, CMS expanded the use of telehealth in home health care, permitting agencies to provide virtual visits and other telehealth services under the benefit. (These changes were later made permanent.) No data are available on the number and type of telehealth services that home health agencies provided in 2020 through 2022. It is not known, therefore, whether the decline in visits represents a real reduction in service provision or some or all of those visits were replaced with telehealth services. Since July 1, 2023, home health agencies have been required to report telehealth visits on Medicare claims, similar to what is required for in-person visits.

Chart 8-10 Most home health periods are not preceded by hospitalization or PAC stay

Type of 30-day period	2021	2022
Periods by source of referral		
Preceded by hospitalization or institutional PAC	24.3%	25.2%
Community admitted	75.6%	74.8%
Periods by timing of 30-day period		
Early	29.3%	30.9%
Late	70.7%	69.1%

Note: PAC (post-acute care). Periods "preceded by hospitalization or institutional PAC" refer to periods that occurred less than 15 days after a stay in a hospital (including a long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility. "Community admitted" refers to periods for which there was no hospitalization or PAC stay in the previous 15 days. "Early" periods are periods for beneficiaries who have not received any home health care in the prior 60 days; "late" periods are the second or later in a series of consecutive periods.

Source: MedPAC analysis of 2022 home health standard analytic file.

> Most home health periods are not preceded by a hospitalization or institutional PAC stay. "Community-admitted" home health periods accounted for about three-quarters of PAC stays in 2021 and 2022.

> Under the home health payment system, home health periods for beneficiaries who have not received any home health care in the prior 60 days are classified as "early," while periods that are the second or later in a series of consecutive periods are classified as "late." The share of periods by timing or source of referral did not change substantially in 2022 compared with the prior year. The mix of cases by clinical payment group also did not change significantly (data not shown).

Chart 8-11 Medicare margins for freestanding home health agencies, 2021 and 2022

	2021	2022	Share of freestanding agencies 2022
All	24.9%	22.1	100%
Geography			
Mostly urban	24.8	22.2	85
Mostly rural	25.2	21.8	15
Type of control			
For profit	26.1	23.5	92.5
Nonprofit	20.2	15.8	7.5
Volume quintile (lowest to highest)			
First	14.0	13.4	20
Second	15.9	14.4	20
Third	19.3	17.0	20
Fourth	22.8	20.9	20
Fifth	28.3	24.7	20

Note: Agencies are characterized as urban or rural based on the residence of the majority of their patients.

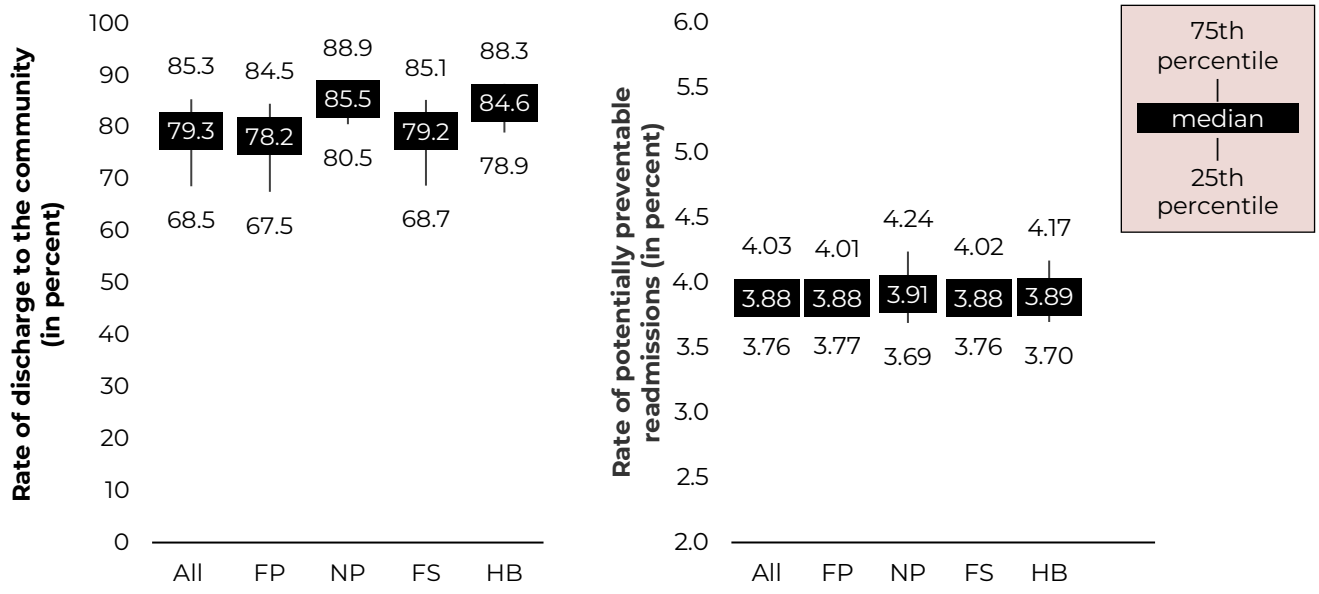
Source: MedPAC analysis of Medicare Cost Report files from CMS.

> In 2022, freestanding home health agencies (HHAs) (87 percent of all HHAs; data not shown) had an aggregate Medicare margin of 22.1 percent. The 2022 margin is consistent with the historically high margins the home health industry has experienced since the prospective payment system (PPS) was implemented in 2000. The margins from 2001 to 2019 averaged 16.4 percent (data not shown), indicating that most agencies have been paid well in excess of their costs for more than 20 years.

> Freestanding HHAs that served mostly urban patients in 2022 had an aggregate margin of 22.2 percent; HHAs that served mostly rural patients had an aggregate margin of 21.8 percent. Over 90 percent of these agencies are for profit; these agencies had an average margin of 23.5 percent in 2022, compared with an average margin of 15.8 percent for nonprofit agencies.

> Agencies with higher volumes of 30-day periods had higher margins. The agencies in the lowest-volume quintile in 2022 had an aggregate margin of 13.4 percent, while those in the highest quintile had an aggregate margin of 24.7 percent.

Chart 8-12 Risk-standardized rates of successful discharge to the community and potentially preventable readmissions for HHAs



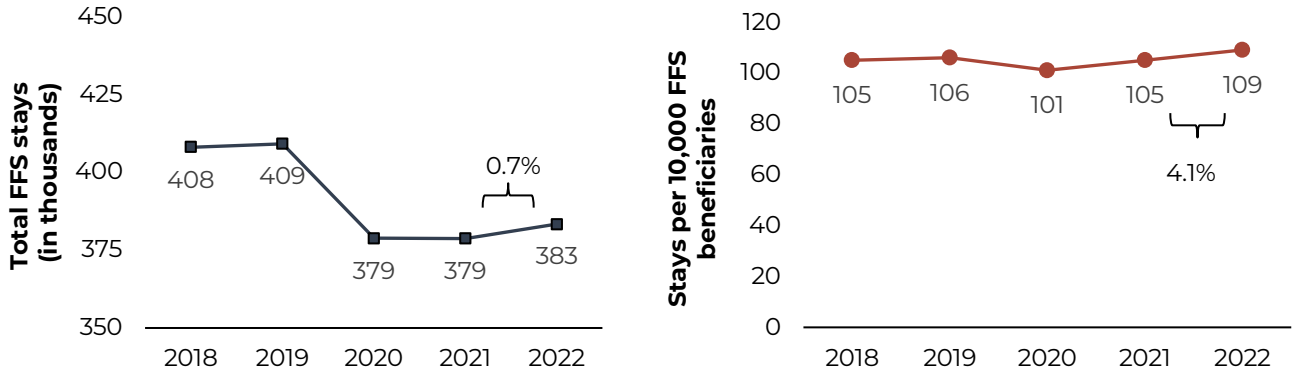
Note: HHA (home health agency), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). The measure of discharge to the community is an HHA's risk-standardized rate of fee-for-service (FFS) Medicare patients who were discharged to the community after a home health stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of potentially preventable readmissions after discharge is calculated as the risk-adjusted percentage of patients discharged from an HHA who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Rates are computed from Medicare claims for eligible Medicare Part A–covered home health stays in the 50 states and the District of Columbia, regardless of whether the home health stay was preceded by a hospitalization. Rates for successful discharge are for the 24-month period from January 1, 2021, to December 31, 2022; rates for potentially preventable readmissions are for the 30-month period from July 1, 2020, to December 31, 2022.

Source: MedPAC analysis of claims-based outcome measures from the Provider Data Catalog.

> The median rate of discharge to the community from home health was 79.3 percent in the period from January 1, 2021, to December 31, 2022 (higher rates indicate better quality). For-profit providers had the lowest median rates of discharge to community in both periods, while hospital-based providers had the highest rates. From January 1, 2021, to December 31, 2022, the HHAs at the 25th percentile and 75th percentile had rates of 68.5 percent and 85.3 percent, respectively.

> For the 30-month period from July 1, 2020, to December 31, 2022, the share of home health stays with a potentially preventable readmission was 3.88. The average rates of potentially preventable rehospitalization did not differ significantly across ownership categories or facility type. In this same period, the HHAs at the 25th percentile and 75th percentiles had potentially preventable rehospitalization rates of 3.76 percent and 4.03 percent, respectively.

Chart 8-13 In 2022, the number of IRF stays grew for the first time since the start of the pandemic



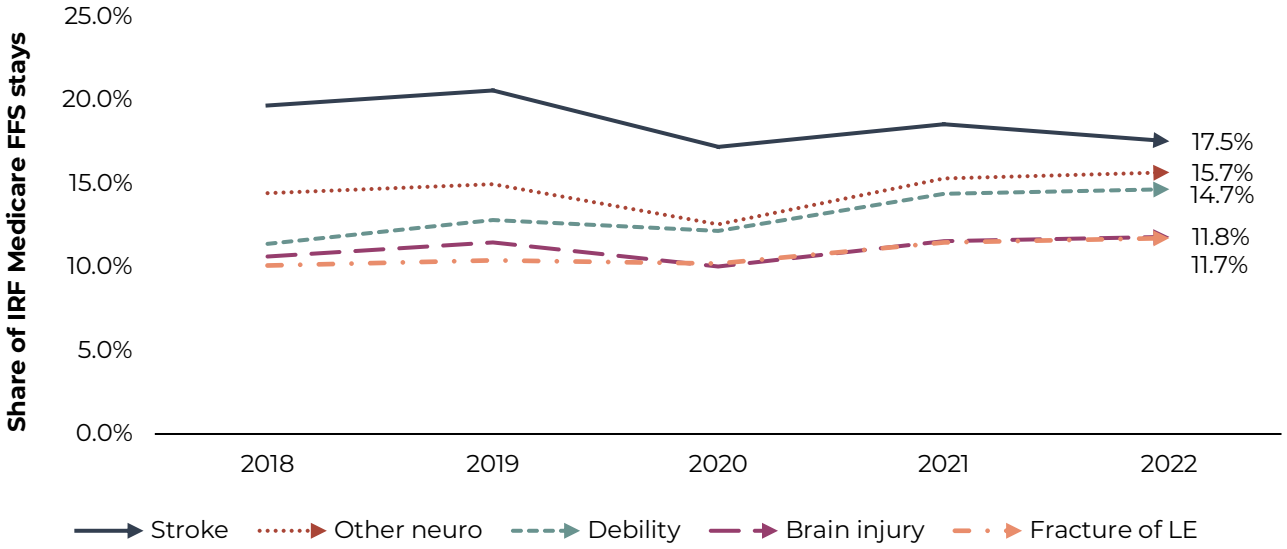
Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). The number of FFS stays and the number of beneficiaries are rounded.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

> From 2021 to 2022, the number of FFS cases slightly rose, to about 383,000 cases. However, when controlling for the number of FFS beneficiaries, the number of cases increased 4.1 percent in 2022, from 105 to 109.

> The average length of stay remained relatively stable at 12.8 days, a 0.7 percent reduction from 12.9 days in 2021 (data not shown).

Chart 8-14 Stroke, other neurological conditions, and debility remain the most common conditions for FFS beneficiaries in IRFs



Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), LE (lower extremity). "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. "Brain injury" includes both traumatic and nontraumatic injuries. All FFS Medicare IRF stays with valid patient assessment information were included in this analysis. Yearly figures presented in this table are rounded.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

> Although the share of stroke cases slightly decreased from 2021 to 2022 (18.5 percent in 2021), stroke continues to be the most frequently occurring case type among FFS beneficiaries admitted to IRFs, accounting for 17.5 percent of Medicare FFS cases in 2022.

> Between 2021 and 2022, the share of IRF cases with a diagnosis of "other neurological conditions" increased slightly from 15.3 percent to 15.7 percent of IRF discharges, while the share of cases with debility increased from 14.4 percent to 14.7 percent.

Chart 8-15 IRFs' aggregate FFS Medicare margin decreased to just under 14 percent in 2022

	2018	2019	2020	2021	2022
All IRFs	14.4%	14.1%	13.3%	16.9%	13.7%
Hospital based	2.0	1.7	1.4	5.7	0.9
Freestanding	25.3	24.6	23.4	25.9	23.3
Urban	14.7	14.5	13.6	17.3	14.1
Rural	9.1	7.6	9.0	11.7	7.8
Nonprofit	2.5	1.1	−0.3	5.3	−0.4
For profit	24.4	24.2	23.4	25.3	22.7
Number of beds					
1–10	–9.1	−9.1	−7.3	−2.7	−6.3
11–24	1.4	1.6	2.2	5.7	1.2
25–64	16.8	15.8	14.8	18.6	15.0
65+	21.1	20.9	19.3	22.2	19.8

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups where applicable (e.g., "all IRFs").

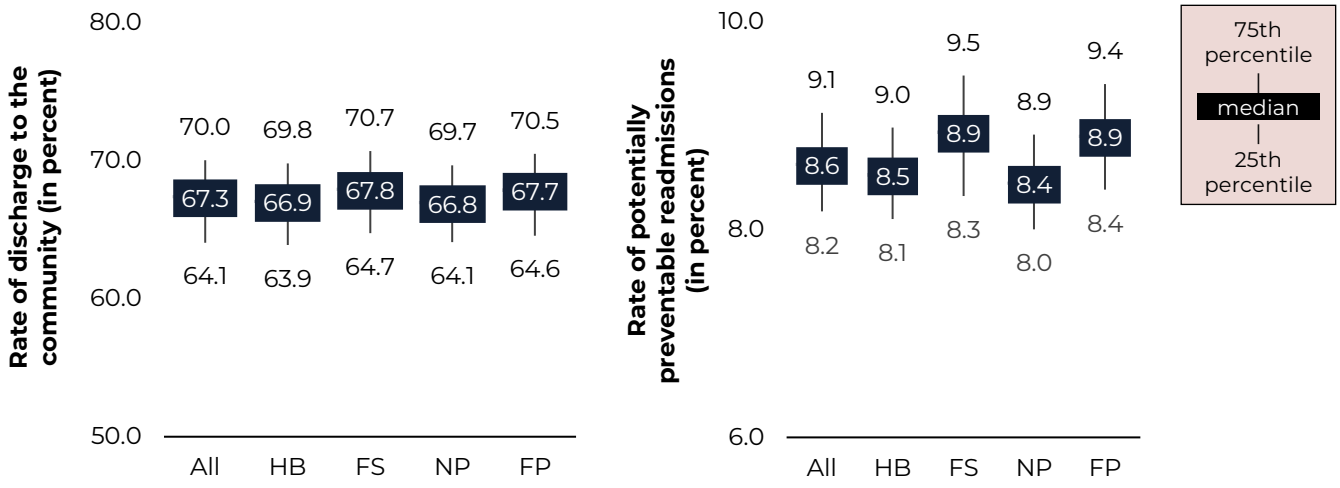
Source: MedPAC analysis of cost report data from CMS.

> In 2022, IRFs' per case payments grew much more slowly than costs; as a result, the aggregate Medicare margin decreased but remained strong at 13.7 percent (14.2 percent when including Medicare's share of federal relief funds; data not shown).

> Medicare margins vary by IRF type. In 2022, freestanding IRFs and for-profit IRFs had substantially higher aggregate margins (23.3 percent and 22.7 percent, respectively) than hospital-based IRFs and nonprofit IRFs (0.9 percent and –0.4 percent, respectively).

> There are large differences in Medicare margins by IRF size. In 2022, the aggregate Medicare margin for IRFs with 10 or fewer beds was –6.3 percent. By contrast, the Medicare margin for IRFs with 65 or more beds was 19.8 percent. These differences are in large measure due to economies of scale since smaller facilities have higher unit costs.

Chart 8-16 IRF quality measures: Risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2021 and FY 2022



Note: IRF (inpatient rehabilitation facility), FY (fiscal year), HB (hospital based), FS (freestanding), NP (nonprofit), FP (for profit). Data include IRFs in the 50 states and the District of Columbia and cover 24 months (fiscal years 2021 and 2022 combined). The measure of discharge to the community includes beneficiaries discharged from an IRF to the community who did not have an unplanned hospitalization and/or die in the 31 days following discharge. Higher rates are better. The measure of potentially preventable readmissions after discharge is calculated as the risk-adjusted percentage of patients discharged from an IRF who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Providers with at least 25 stays in the year were included in calculating the average facility rate.

Source: Medicare IRF claims from CMS.

> In 2021 and 2022, the median facility risk-adjusted rate of discharge to the community from IRFs was 67.3 percent, about 2 percentage points higher (better) than the rate for the period from 2018 to 2019 (latter data not shown).

> The median facility risk-adjusted rate of potentially preventable readmission was 8.6 percent and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers. (Because of a change in the measure calculation, we cannot compare this rate to a prior time period.)

Chart 8-17 In 2022, fee-for-service LTCH volume continued to decline compared with 2021

		2021	Average annual percent change 2018–2021	2022	Percent change 2021–2022
Cases	All	70,021	–11.8%	60,278	–13.9%
	Nonqualifying cases	20,072	–11.9	19,386	–3.4
	Qualifying cases	49,949	–11.3	40,892	–18.1
	Share of qualifying cases	71%	0.6	68%	–4.9
Cases per 10,000 FFS beneficiaries	All	19.4	–10.0	17.3	–10.9
	Nonqualifying cases	5.6	–9.9	5.6	0.0
	Qualifying cases	13.8	–9.6	11.7	–15.2
Payment per case	All	$48,557	6.6	$48,582	0.1
	Nonqualifying cases	$39,063	17.5	$38,839	–0.6
	Qualifying cases	$52,745	4.1	$53,201	0.9
Length of stay (in days)	All	27.6	1.3	27.8	0.7
	Nonqualifying cases	25.7	3.4	26.3	2.2
	Qualifying cases	28.3	0.4	28.5	0.8

Note: LTCH (long-term care hospital), FFS (fee-for-service). "Qualifying cases" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system. All counts are for stays covered by FFS Medicare and do not include those in private plans. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and the annual report of the Boards of Trustees of the Medicare trust funds.

> Beginning in fiscal year 2016, only certain LTCH cases qualify for the higher standard LTCH prospective payment system (PPS) rate. Cases that do not meet LTCH-qualifying criteria are paid a lower site-neutral rate—the lower of (1) an amount based on Medicare's inpatient hospital PPS rate or (2) 100 percent of the cost of the case.

> The number of LTCH cases per 10,000 FFS beneficiaries declined, on average, by 10.0 percent per year between 2018 and 2021 (data not shown). In contrast, the number of cases meeting the LTCH-qualifying criteria declined more slowly, falling 9.6 percent per year during the same period.

> In 2022, the volume of all LTCH cases fell nearly 14 percent. The volume of qualifying cases fell 18.1 percent that year. The volume of nonqualifying cases also decreased by 3.4 percent, likely owing to the expiration of the waiver of site-neutral payments for nonqualifying cases.

> During the public health emergency (PHE), all cases were paid the higher, standard LTCH PPS rate. As a result of this temporary PHE-related payment change, the average payment per nonqualifying case between 2020 and 2021 increased by 20.6 percent on a nominal basis (not shown) but remained the same from 2021 to 2022.

Chart 8-18 Ten MS–LTC–DRGs accounted for over half of LTCH fee-for-service discharges in 2022

MS–LTC–DRG	Description	Discharges	Share of cases
189	Pulmonary edema and respiratory failure	13,774	22.9%
207	Respiratory system diagnosis with ventilator support 96+ hours	8,629	14.3
177	Respiratory infections and inflammations with MCC	2,343	3.9
871	Septicemia without ventilator support 96+ hours with MCC	1,920	3.2
208	Respiratory system diagnosis with ventilator support <96 hours	1,969	3.3
166	Other respiratory system OR procedures with MCC	1,556	2.6
981	Extensive OR procedure unrelated to principal diagnosis with MCC	1,413	2.3
949	Aftercare with CC/MCC	1,205	2.0
539	Osteomyelitis with MCC	1,128	1.9
592	Skin ulcers with MCC	944	1.6
	Top 10 MS–LTC–DRGs	34,881	57.9
	Total	60,278	100.0

Note: MS–LTC–DRG (Medicare severity long-term care–diagnosis related group), LTCH (long-term care hospital), MCC (major complication or comorbidity), OR (operating room), CC (complication or comorbidity). MS–LTC–DRGs are the case-mix system for LTCHs. Shares for each MS–LTC–DRG presented in the table are rounded, but the sum of the top 10 was calculated using unrounded values.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

> Cases in LTCHs are concentrated in a relatively small number of MS–LTC–DRGs. In 2022, the top 10 MS–LTC–DRGs accounted for about 58 percent of LTCHs' fee-for-service cases. Cases in LTCHs have grown less concentrated over time. In 2021, the top 10 MS–LTC–DRGs accounted for 60.9 percent of fee-for-service cases in LTCHs (data not shown).

> The share of fee-for-service LTCH cases in MS–LTC–DRG 177 (respiratory infections and inflammations with major complication or comorbidity) decreased from 9.1 percent of cases in 2021 (not shown) to 3.9 percent of cases in 2022. The share of cases in MS–LTC–DRG 207 (respiratory system diagnosis with ventilator support for 96+ hours) also decreased, from 15.6 percent of cases in 2021 (not shown) to 14.3 percent of cases in 2022.

Chart 8-19 Aggregate LTCHs' Medicare margins decreased in 2022

LTCH	2018	2019	2020	2021	2022
All	–0.5%	–1.6%	3.8%	7.5%	–1.3%
Type of control					
Nonprofit	–13.3	–13.2	–13.1	–8.9	–24.0
For profit	1.5	0.6	6.5	9.9	2.2
Facility share of qualifying cases					
High share	2.0	2.2	4.5	5.4	–1.5
Low share	0.1	–2.4	3.0	7.1	–2.0

Note: LTCH (long-term care hospital). "Qualifying cases" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system. "High share" means more than 85 percent of a provider's cases were qualifying cases in the year. "Low share" means 85 percent or fewer of a provider's cases were qualifying cases in the year.

Source: MedPAC analysis of cost report and Medicare Provider Analysis and Review data from CMS.

> In fiscal year 2016, CMS began implementing a dual payment-rate system under which LTCH cases not meeting criteria specified in law are paid a lower site-neutral rate—the lower of an amount based on (1) Medicare's inpatient hospital prospective payment system rate or (2) 100 percent of the cost of the case. As a result, the aggregate Medicare margin fell to –2.2 percent in 2017 (data not shown) and remained negative through 2019.

> Due to the public health emergency waiver of site-neutral payment rates, all cases were paid the higher standard LTCH prospective payment system rates starting January 27, 2020. That year, the Medicare aggregate margin (excluding relief funds) for all LTCHs increased to 3.8 percent. In 2021, when LTCHs were paid the higher LTCH rate for the entire year, the aggregate margin nearly doubled to 7.5 percent. With reported Provider Relief Fund revenue allocated to Medicare payments, the aggregate margin in 2021 was 9.8 percent (data not shown).

> In 2022, LTCHs had a negative aggregate Medicare margin (of –1.3 percent) for the first time since the implementation of the public health emergency waiver of site-neutral payment rates. LTCHs with a high share (greater than 85 percent) of qualifying cases had an aggregate Medicare margin of –1.5 percent, while LTCHs with a low share (85 percent or less) of qualifying cases had an aggregate margin of –2.0 percent, excluding relief funds.

Chart 8-20 LTCH Medicare PPS payments per case declined in 2022, while LTCH Medicare PPS costs per case increased for all LTCHs

	Percent change			
	2018–2019	2019–2020	2020–2021	2021–2022
Payments per case				
All LTCHs	3.1%	9.7%	7.9%	–0.4%
LTCHs with >85% qualifying cases	2.6	9.1	7.7	0.2
Cost per case				
All LTCHs	4.5	4.5	4.1	9.2
LTCHs with >85% qualifying cases	2.6	6.5	7.8	7.3

Note: LTCH (long-term care hospital), PPS (prospective payment system). "Qualifying cases" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system. Percentages reflect changes in nominal dollars, not adjusted for inflation.

Source: MedPAC analysis of cost report data from CMS.

> Between 2021 and 2022, aggregate Medicare payments per case for all LTCHs decreased 0.4 percent on a nominal basis to more than $48,000 per case (latter data not shown). For LTCHs with high shares (more than 85 percent) of qualifying cases, payments per case increased 0.2 percent to more than $58,000 per case (not shown) during the same period.

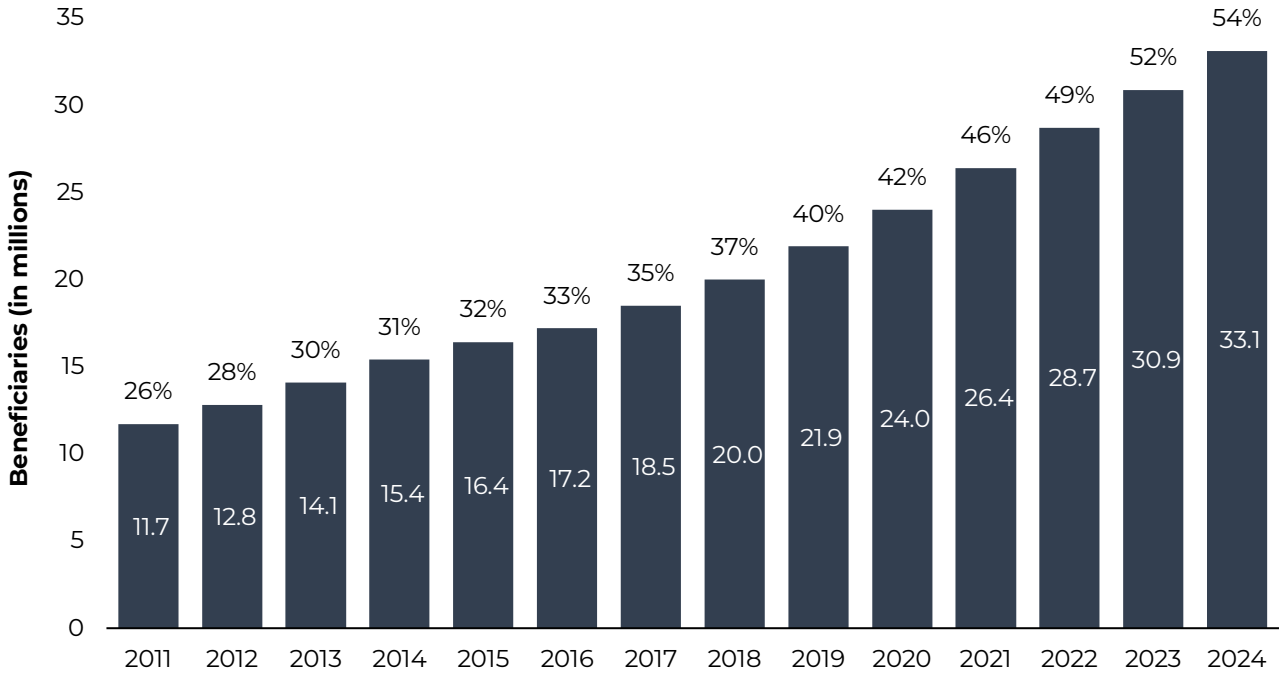
> In 2022, reduced case volume and coronavirus pandemic–related costs likely contributed to aggregate growth in costs per case. Between 2021 and 2022, aggregate cost per case for all LTCHs rose 9.2 percent to more than $49,000 per case (latter data not shown). For LTCHs with high shares of qualifying cases, costs increased 7.3 percent to more than $59,000 per case (latter data not shown) during the same period.

SECTION

9

Medicare Advantage

Chart 9-1 Enrollment in MA plans, 2011–2024



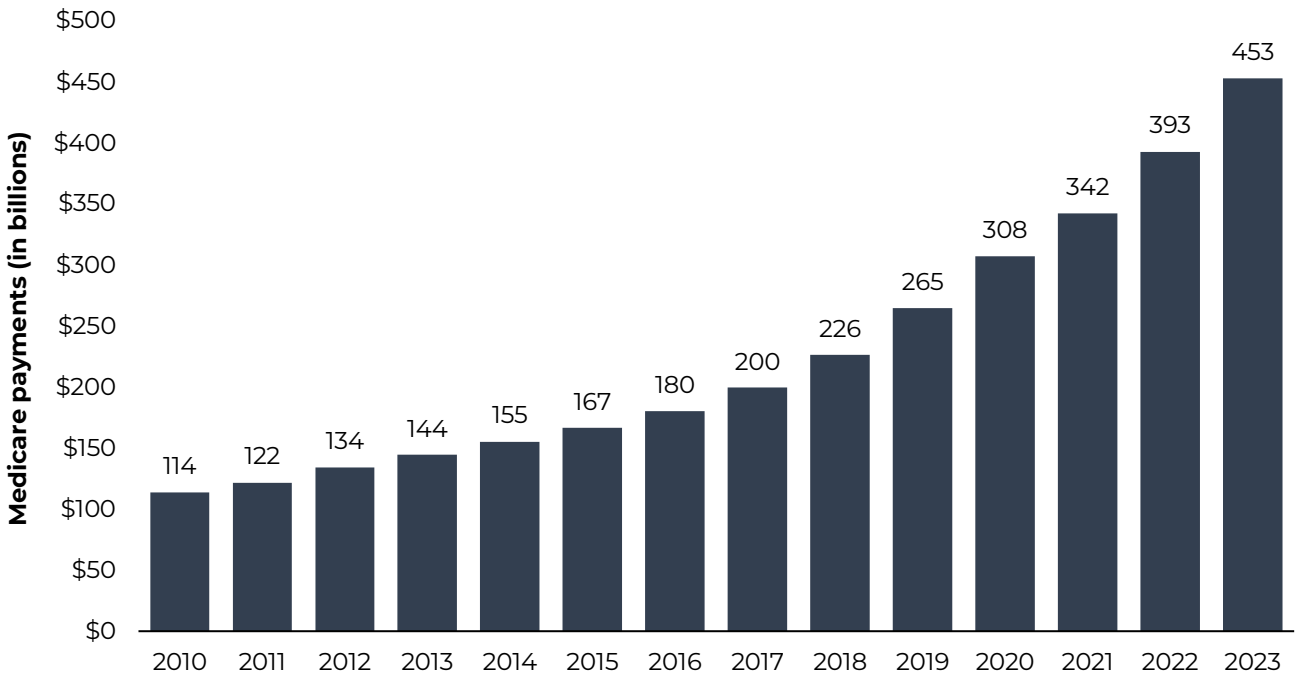
Note: MA (Medicare Advantage). Percentages indicate the share of total MA-eligible enrollment.

Source: CMS Medicare managed care contract reports and monthly summary reports, February 2011–2024.

> In February 2024, enrollment in MA plans, which are paid on an at-risk capitated basis, reached 33.1 million, or 54 percent of all eligible Medicare beneficiaries (only beneficiaries enrolled in both Part A and Part B are eligible to enroll in an MA plan). An additional 1 percent of all Medicare beneficiaries with both Part A and Part B coverage are enrolled in other private plans such as cost plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid Plans participating in CMS's financial alignment demonstration (data not shown).

> MA enrollment has grown steadily since 2011, increasing nearly threefold. Enrollment growth has been particularly rapid in recent years, climbing by at least 7 percent in each of the last six years.

Chart 9-2 Medicare payments to MA plans, 2010–2023



Note: MA (Medicare Advantage). In contrast to prior MedPAC estimates, the figures above do not include Medicare Medical Savings Account plans, cost-reimbursed plans, Medicare-Medicaid demonstration plans, and the Program of All-Inclusive Care for the Elderly. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC estimates based on the reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance trust funds, 2020–2024.

> The Medicare program paid MA plans an estimated $453 billion in 2023 to cover Part A and Part B services for MA enrollees.

> The rapid growth in MA enrollment (see Chart 9-1) coincided with rapid growth in total Medicare payments to MA plans. From 2018 to 2024, total estimated payments to MA plans doubled on a nominal basis.

Chart 9-3 MA plans available to almost all Medicare beneficiaries, 2017–2024

	Share of Medicare beneficiaries living in counties with plans available					Average plan offerings per beneficiary
	CCPs					
	HMO or local PPO (local CCP)	Regional PPO	Any CCP	PFFS	Any MA plan	
2017	95	74	98	45	99	18
2018	96	74	98	41	99	20
2019	97	74	98	38	99	23
2020	98	73	99	36	99	27
2021	98	72	99	34	99	32
2022	99	74	99	35	99	36
2023	99	74	99	29	>99.5	41
2024	>99.5	74	>99.5	30	>99.5	43

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). These data do not include plans that have restricted enrollment (special needs plans, employer plans) or are not paid based on MA rates (cost plans and certain demonstration plans). For 2017 through 2021, "share of Medicare beneficiaries" includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). As of 2022, "share of Medicare beneficiaries" includes only beneficiaries with both Part A and Part B coverage (i.e., MA-eligible beneficiaries).

Source: MedPAC analysis of plan bid data from CMS, 2017–2024.

> There are four types of MA plans, three of which are CCPs. Local CCPs include HMOs and local PPOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional PPOs cover one or more entire states and have networks that may be looser than those of local PPOs. CCPs accounted for 98 percent of Medicare private plan enrollees as of February 2024 (data not shown). Since 2011, PFFS plans are required to have networks in areas with two or more CCPs. In other areas, PFFS plans are not required to have networks, and enrollees are free to use any Medicare provider.

> Since 2006, almost all Medicare beneficiaries have had MA plans available (data not shown). In 2024, local CCPs are available to nearly 100 percent of eligible Medicare beneficiaries, and regional PPOs are available to 74 percent of beneficiaries.

> The number of plans from which beneficiaries may choose in 2024 is higher than at any time during the years examined. In 2024, beneficiaries can choose from an average of 43 plans operating in their counties and have access to plans offered by an average of 8 insurers (latter data not shown).

Chart 9-4 Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands)					Percent change 2023–2024
	2020	2021	2022	2023	2024	
Local CCPs	22,703	25,325	27,878	30,291	32,667	8%
Regional PPOs	1,170	1,003	756	534	385	–28
PFFS	87	61	48	37	32	–14

Note: CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). Local CCPs include HMOs and local PPOs.

Source: CMS health plan monthly summary reports, February 2020–2024.

> Almost all Medicare Advantage (MA) enrollees (over 99 percent) choose local CCPs (HMOs or local PPOs), which limit or discourage use of out-of-network providers (Chart 9-3). Though network requirements may be looser in regional PPOs and PFFS plans, enrollment in both types of plans has been declining for several years and dropped sharply in 2024, with enrollment in regional PPOs falling by 28 percent and enrollment in PFFS plans falling by 14 percent.

> Combined enrollment in the three types of plans grew by 7 percent from February 2023 to February 2024 (data not shown). Enrollment in local CCPs grew by 8 percent over the past year, and special needs plans (SNPs) accounted for 46 percent of this growth (latter data not shown). Local PPOs grew by 13 percent over the past year and accounted for more than two-thirds (69 percent) of the growth in local CCP enrollment (data not shown). Most enrollment growth among HMOs (99 percent) occurred in SNPs (data not shown). The growth in SNP and local PPO enrollment may be driven by increases in Medicare payments for extra benefits for MA enrollees.

Chart 9-5 MA and cost plan enrollment by state and type of plan, 2024

State or territory	All MA-eligible beneficiaries (in thousands)	Distribution (in percent) of beneficiaries by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	61,136	30%	23%	1%	0%	0%	54%
Alabama	1,025	28	36	0	0	0	64
Alaska	103	0	2	0	0	0	2
Arizona	1,362	38	16	0	0	0	54
Arkansas	627	18	29	1	1	0	49
California	6,150	49	7	0	0	0	56
Colorado	933	36	21	0	0	0	57
Connecticut	674	18	43	0	0	0	61
Delaware	223	14	20	0	0	0	34
Florida	4,768	37	21	1	0	0	59
Georgia	1,763	16	42	2	0	0	60
Hawaii	264	20	41	0	0	0	61
Idaho	362	34	18	0	0	0	52
Illinois	2,167	14	29	0	0	0	43
Indiana	1,269	23	29	1	0	0	53
Iowa	635	18	19	0	0	2	39
Kansas	538	12	23	1	0	0	36
Kentucky	905	28	28	1	0	0	57
Louisiana	867	44	15	1	0	0	60
Maine	346	35	27	0	0	0	62
Maryland	981	16	12	0	0	0	28
Massachusetts	1,298	18	17	1	0	0	36
Michigan	2,091	24	39	0	0	0	63
Minnesota	1,056	16	42	0	0	6	64
Mississippi	596	19	25	1	0	0	45
Missouri	1,224	30	26	1	0	0	57
Montana	240	6	25	0	0	0	31
Nebraska	350	18	18	0	0	1	37
Nevada	537	45	11	0	0	0	56
New Hampshire	305	14	24	0	0	0	38
New Jersey	1,553	12	33	0	0	0	45
New Mexico	419	26	28	0	0	0	54
New York	3,540	32	22	2	0	0	56
North Carolina	2,059	29	29	1	0	0	59
North Dakota	134	0	27	0	0	9	36
Ohio	2,325	37	20	1	0	0	58
Oklahoma	729	20	23	0	0	0	43
Oregon	867	36	23	0	0	0	59
Pennsylvania	2,684	29	28	0	0	0	57
Puerto Rico	684	94	1	0	0	0	95
Rhode Island	216	45	14	0	0	0	59
South Carolina	1,132	12	35	1	0	0	48
South Dakota	181	2	19	0	0	17	38
Tennessee	1,361	37	20	0	0	0	57
Texas	4,296	33	23	2	0	0	58
Utah	416	38	19	0	0	0	57
Vermont	151	5	28	2	0	0	35
Virgin Islands	19	0	29	0	0	0	29
Virginia	1,501	26	15	1	0	0	42
Washington	1,374	34	19	0	0	0	53
Washington, D.C.	80	12	27	0	0	0	39
West Virginia	420	10	44	0	0	4	58
Wisconsin	1,222	31	25	0	0	3	59
Wyoming	116	0	17	0	1	0	18

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports rather than bids to CMS. "U.S. total" includes beneficiaries in U.S. territories but does not include beneficiaries residing in foreign areas. Sum of beneficiaries by state does not equal U.S. total due to rounding. We report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage).

Source: CMS enrollment and population data, February 2024.

Chart 9-6 MA enrollment patterns, by age, dual-eligibility status, and ESRD status, June 2023

	All MA-eligible beneficiaries		FFS		MA		MA enrollment as a share of total MA-eligible category
	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	
Total	59.1	100%	28.3	100%	30.8	100%	52%
Aged (65 or older)	52.1	88	25.2	89	26.9	87	52
Under 65	7.0	12	3.1	11	3.9	13	56
Non–dual eligible	47.1	80	23.8	84	23.3	76	50
Aged (65 or older)	44.3	75	22.5	80	21.8	71	49
Under 65	2.8	5	1.3	4	1.5	5	55
Full dual eligibility	8.7	15	3.7	13	5.0	16	58
Aged (65 or older)	5.5	9	2.1	8	3.3	11	61
Under 65	3.2	5	1.5	5	1.7	5	52
Partial dual eligibility	3.3	6	0.8	3	2.5	8	76
Aged (65 or older)	2.3	4	0.5	2	1.8	6	78
Under 65	1.0	2	0.3	1	0.7	2	62
Enrollment subcategories, all ages							
ESRD	0.4	1	0.2	1	0.2	1	47
Beneficiaries with partial dual eligibility							
QMB only	1.7	3	0.4	2	1.3	4	75
SLMB only	1.0	2	0.2	1	0.8	2	77
QI	0.6	1	0.1	<1	0.5	2	77

Note: MA (Medicare Advantage), ESRD (end-stage renal disease), FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualifying individual). Data for 2024 were not available as of the date of publication. Data exclude cost plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid Plans participating in CMS's financial alignment demonstration. MA-eligible beneficiaries are Medicare beneficiaries with both Part A and Part B coverage. Dual-eligible beneficiaries are eligible for Medicare and Medicaid. Data exclude Puerto Rico because enrollment data undercount dual-eligible categories. In 2023, Puerto Rico had about 654,000 Medicare beneficiaries enrolled in MA plans, and about 302,000 were enrolled in dual-eligible special needs plans. Figures may not sum to totals due to rounding.

Source: MedPAC analysis of 2023 common Medicare environment files.

> Medicare beneficiaries with Medicaid benefits are more likely to enroll in MA than beneficiaries without Medicaid. Beneficiaries who have full dual eligibility with Medicaid (i.e., those who have coverage of their Medicare out-of-pocket costs (premiums and cost sharing) as well as coverage for services such as long-term care services and supports) are less likely to enroll in MA plans than beneficiaries with "partial" dual eligibility (i.e., those who receive assistance only with Medicare premiums and, in some cases, with cost sharing). Fully dual-eligible beneficiaries have coverage through state Medicaid programs, including certain QMBs (i.e., QMB-Plus) and certain SLMBs (i.e., SLMB-Plus) who also have Medicaid coverage for services. Beneficiaries with partial dual eligibility (such as QIs or SLMBs) have coverage for Medicare premiums or premiums and Medicare cost sharing (such as QMBs).

> Medicare plan enrollment among the dually eligible continues to increase. In 2023, 58 percent of fully dual-eligible beneficiaries were in MA plans (up from 52 percent in 2022), and 76 percent of partially dual-eligible beneficiaries were in MA plans (up from 71 percent in 2022) (2022 data not shown). QI and SLMB-only beneficiaries have the highest rates of MA enrollment among partial dual eligibles (77 percent). About 50 percent of Medicare beneficiaries who are not dually eligible for Medicaid were enrolled in an MA plan.

> A substantial share of the dually eligible population (35 percent; data not shown) are under the age of 65 and entitled to Medicare on the basis of disability or ESRD. Beneficiaries under age 65 who are fully dual eligible are less likely than aged fully dual-eligible beneficiaries to enroll in MA (52 percent vs. 61 percent, respectively). A higher share of MA enrollees is fully dual eligible compared with FFS enrollees (16 percent vs. 13 percent, respectively).

> ESRD beneficiaries had higher rates of plan enrollment in 2023 (47 percent) compared with 2022 (42 percent; data not shown).

Chart 9-7 MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2024

	Share of FFS spending in 2024		
	Benchmarks	Bids	Payments
Overall estimate	132%*	101%*	122%
Estimated before coding and selection	108*	82*	100
Estimated coding effect	+14	+11	+13
Estimated selection effect	+10	+7	+9

Note: MA (Medicare Advantage), FFS (fee-for-service). "Benchmarks" are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We use CMS's projected FFS spending estimates by county from the 2024 MA rate book. Although MA enrollees must be enrolled in both Part A and Part B, the FFS spending denominator used in the MA rate book includes all Part A and Part B spending (including spending on beneficiaries covered only by Part A). To assess the impact of that discrepancy, for each year from 2016 through 2021 (when necessary data were available), we retrospectively compared overall Medicare spending on MA with actual FFS spending for beneficiaries enrolled in both Part A and Part B and found that the results of those retrospective comparisons were similar (within 1 percentage point) compared with our prospective analyses that use CMS's projected FFS spending estimates. Therefore, we concluded that the inclusion of Part A–only enrollees in the FFS spending denominator did not have a meaningful impact on the estimates for the years we analyzed. We also removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals.

To incorporate our most recent estimate of the effect of coding on payments (13 percent), we estimated what overall benchmarks, bids, and payments would be if the risk-adjusted spending differences between MA and FFS did not include any effect of differential coding. The coding effect accounts for CMS's annual coding adjustment. We project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the version 28 risk-adjustment model, which is being phased in over three years.

Favorable selection accounts for the estimated lower risk-standardized spending that MA enrollees would have had in FFS without any plan intervention (e.g., utilization management, provider network, or beneficiary incentives). We assume that the 2024 effect of selection would be the same as our 2019 estimate of selection (before the coronavirus pandemic). More details on our coding and selection analyses are found in Chapter 13 of our March 2024 report to the Congress. Components of the bid column do not sum to the total due to rounding.

For more information, see the Commission's March 2023 and March 2024 reports to the Congress.

*Specified estimates of benchmarks and bids relative to FFS spending do not include employer plans.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

> Since 2006, plan bids have partly determined the Medicare payments that plans receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.

> The benchmark is a bidding target in each county and is set by means of a statutory formula based on percentages (ranging from 95 percent to 115 percent) of CMS's projections of each county's per capita, risk-standardized Medicare FFS spending. Plans with quality ratings of 4 or more stars typically have their benchmarks raised by up to 5 percent (and up to 10 percent in some counties).

(Chart continued next page)

Chart 9-7 MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2024 (continued)

> The risk-adjustment model used by Medicare to adjust payments to plans is based on FFS data and therefore reflects the expected spending and diagnostic coding patterns in FFS Medicare. The model accounts for differences in demographics and recorded diagnoses. The Commission's comparisons use that risk-adjustment model as a starting point to standardize MA and FFS spending. However, Medicare's risk-adjustment model does not account for the effects of coding intensity (i.e., the extent to which the same beneficiary could have more diagnoses recorded in MA, and thus a higher risk score, than they would in FFS) or favorable selection (i.e., the extent to which the risk-adjustment model used to standardize spending overpredicts spending for MA enrollees even for beneficiaries who have diagnoses coded with the same level of intensity). Therefore, the Commission's final comparisons of MA payments and FFS spending incorporate adjustments for coding and selection to account for those ways in which Medicare's risk-adjustment model overstates what FFS spending would have been for MA beneficiaries.

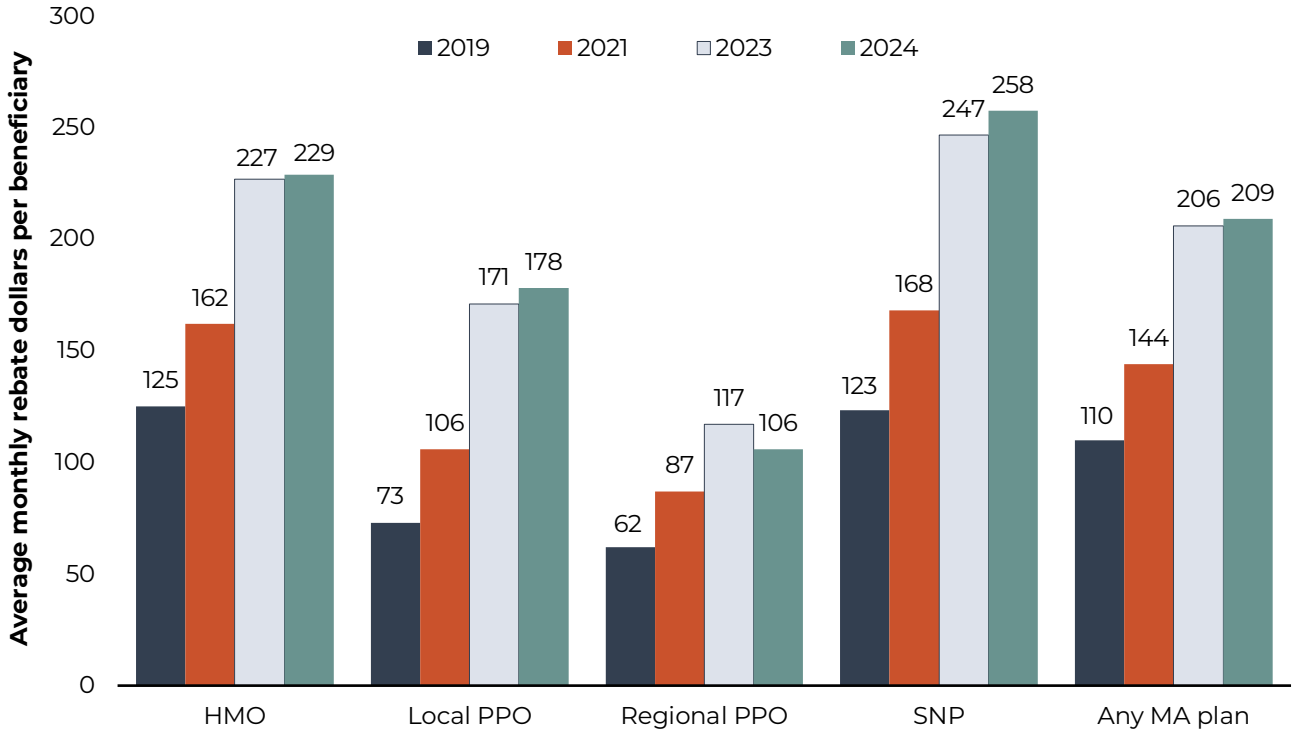
> If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it is typically 65 percent or 70 percent. After accounting for administrative expenses and profit, plans must return rebates to enrollees in the form of lower cost sharing, supplemental benefits not covered by FFS Medicare, or lower premiums. (If a plan's bid is above the benchmark, then the plan receives the benchmark amount as payment from Medicare and enrollees have to pay an additional premium that equals the difference; however, bidding over the benchmark is rare. For 2023, virtually all plans bid below their benchmarks).

> Using CMS's projections of FFS spending that do not fully account for the effects of coding or selection, we estimate that benchmarks will be an average of 108% of FFS spending in 2024. After accounting for the effects of coding and selection, we estimate that MA benchmarks in 2024 will average 132 percent of FFS spending.

> Plans have generally bid below benchmarks since the current system began, and the difference between bids and benchmarks has grown in recent years. We estimate plans' enrollment-weighted bids to be slightly higher (101 percent), on average, than FFS spending for 2024. Not accounting for coding or selection, plan bids are estimated to average about 18 percent below FFS spending.

> Altogether, we estimate that MA payments are 22 percent higher than what Medicare would have spent to cover the same group of enrollees in FFS. That estimate incorporates adjustments for the effects of coding and selection. Before accounting for those effects, we estimate that payments to MA plans are about equal to FFS spending.

Chart 9-8 Average monthly rebate dollars, by plan type, 2019–2024



Note: HMO (health maintenance organization), PPO (preferred provider organization), SNP (special needs plan), MA (Medicare Advantage). Employer group waiver plans are excluded. SNPs are a subset of HMO and PPO plans. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of bid data from CMS.

> The average rebate, which plans receive to provide additional benefits that are not covered under Medicare Part A and Part B, is an important summary measure of plan generosity. Plans are awarded rebates for bidding under their benchmarks. The rebates must be returned to the plan members in the form of extra benefits (after accounting for plan margins and administrative costs). The extra benefits can include lower cost sharing, supplemental benefits not covered by Medicare, or lower premiums. The average rebate for all nonemployer, non–special needs plans slightly increased to $209 per month per beneficiary for 2024.

> HMOs have had, by far, the highest rebates because they tend to bid lower than other types of plans. Average rebates for HMOs are $229 per month per beneficiary for 2024.

> Local PPOs' rebates have risen sharply in recent years, more than doubling since 2019.

> In recent years, rebates have grown the most for SNPs, a subset of HMOs and PPOs that offer benefit packages tailored to specific populations (beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). Average rebates for SNPs rose to $258 per month in 2024 (up from $247 per month in 2023). The relatively large rebates for SNPs coincide with historically higher reported margins than conventional MA plans (data not shown) and higher relative coding intensity for beneficiaries who are dually eligible for Medicaid (see Chart 9-9).

Chart 9-9 Impact of diagnostic coding intensity on MA risk scores was larger for enrollees eligible for partial or full Medicaid benefits, 2022

Beneficiary group	Coding intensity relative to FFS Medicare
All MA enrollees	17.8%
New enrollees	N/A
Long-term institutional	13.2
No Medicaid benefits	17.6
Partial Medicaid benefits	29.9
Full Medicaid benefits	20.6

Note: MA (Medicare Advantage), FFS (fee-for-service), N/A (not applicable). In this analysis, we first determined whether a beneficiary was a new enrollee, then we determined long-term institutional status (based on the presence of a 90-day Minimum Data Set assessment for nursing home residents), and then Medicaid eligibility. New enrollees have a risk score based only on demographic factors and therefore do not exhibit diagnostic coding intensity. Analysis uses the demographic estimate of coding intensity (DECI) method, which is the MA-to-FFS CMS hierarchical condition (HCC) risk-score ratio divided by the MA-to-FFS demographic risk-score ratio, estimated separately for each beneficiary group. MedPAC's DECI estimate for all MA enrollees accounts for differing shares of MA and FFS enrollment across the beneficiary groups by weighting MA enrollment for each group to calculate overall average MA and FFS CMS–HCC risk scores and demographic risk scores. See Chapter 13 of our March 2024 report to the Congress for more information about our analysis using the DECI method.

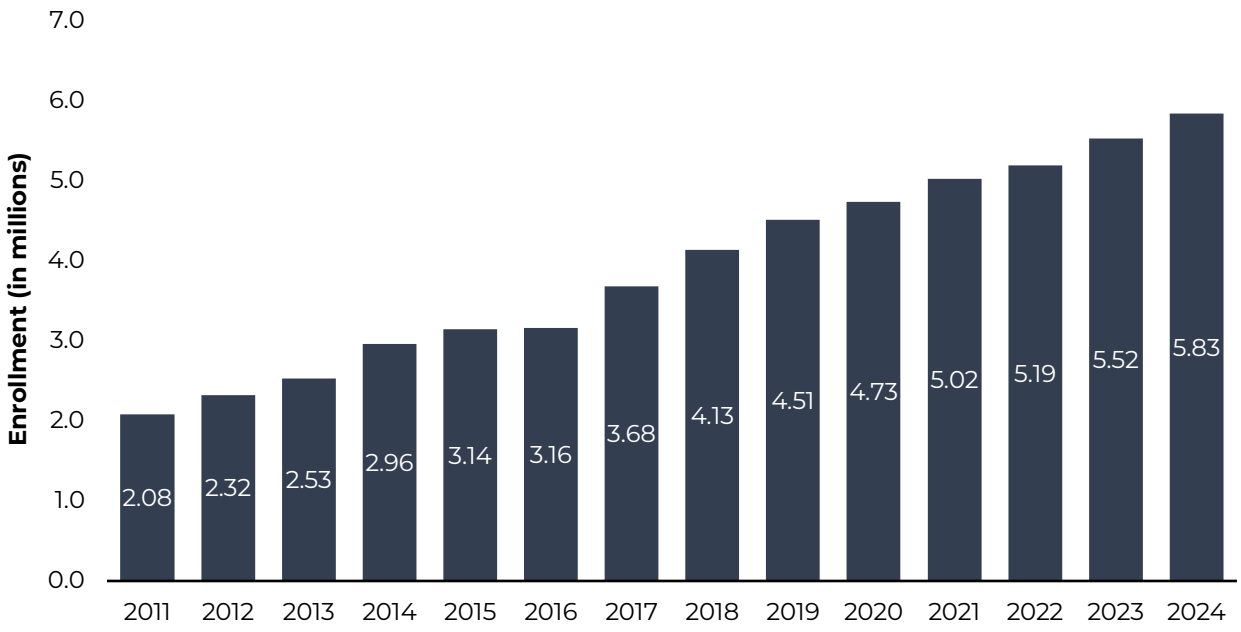
Source: MedPAC analysis of CMS enrollment and risk score files, 2021 and 2022.

> Payments to MA plans are risk adjusted to account for differences in health status. Risk adjustment increases payments to plans for enrollees with higher expected Medicare spending. An enrollee's risk score is based on demographic information and diagnoses that plans submit to CMS. Documenting additional diagnosis codes raises plan enrollees' risk scores, generating two distinct benefits for MA plans: (1) increasing plans' monthly payments and (2) increasing the rebates plans use to provide extra benefits to enrollees. Plans that document relatively more diagnosis codes therefore have a competitive advantage over other plans. In contrast, the payment policies in FFS Medicare offer relatively little incentive to code all diagnoses. This difference in coding incentives results in higher risk scores when a beneficiary enrolls in MA than if the same beneficiary had enrolled in FFS Medicare. As a result of higher MA coding intensity, the Medicare program pays more, on average, when a beneficiary enrolls in MA than it would if the same beneficiary were in FFS Medicare. This phenomenon is true both for beneficiaries who have higher than average and lower than average spending.

> In 2022, MA risk scores on average were 17.8 percent higher than risk scores for comparable FFS beneficiaries.

> MA enrollees who were eligible for full or partial Medicaid benefits had higher coding intensity relative to FFS than enrollees who were not eligible for Medicaid. Risk scores for MA enrollees who were eligible for partial Medicaid benefits were 29.9 percent higher than the scores for FFS beneficiaries who were eligible for partial Medicaid benefits. Risk scores for MA enrollees who were eligible for full Medicaid benefits were 20.6 percent higher than the scores for FFS beneficiaries who were eligible for full Medicaid benefits. By contrast, risk scores for MA enrollees who were not eligible for Medicaid were 17.6 percent higher than the scores for their FFS counterparts, and risk scores for MA enrollees with long-term institutional status were 13.2 percent higher than the scores for their FFS counterparts.

Chart 9-10 Enrollment in employer group MA plans, 2011–2024



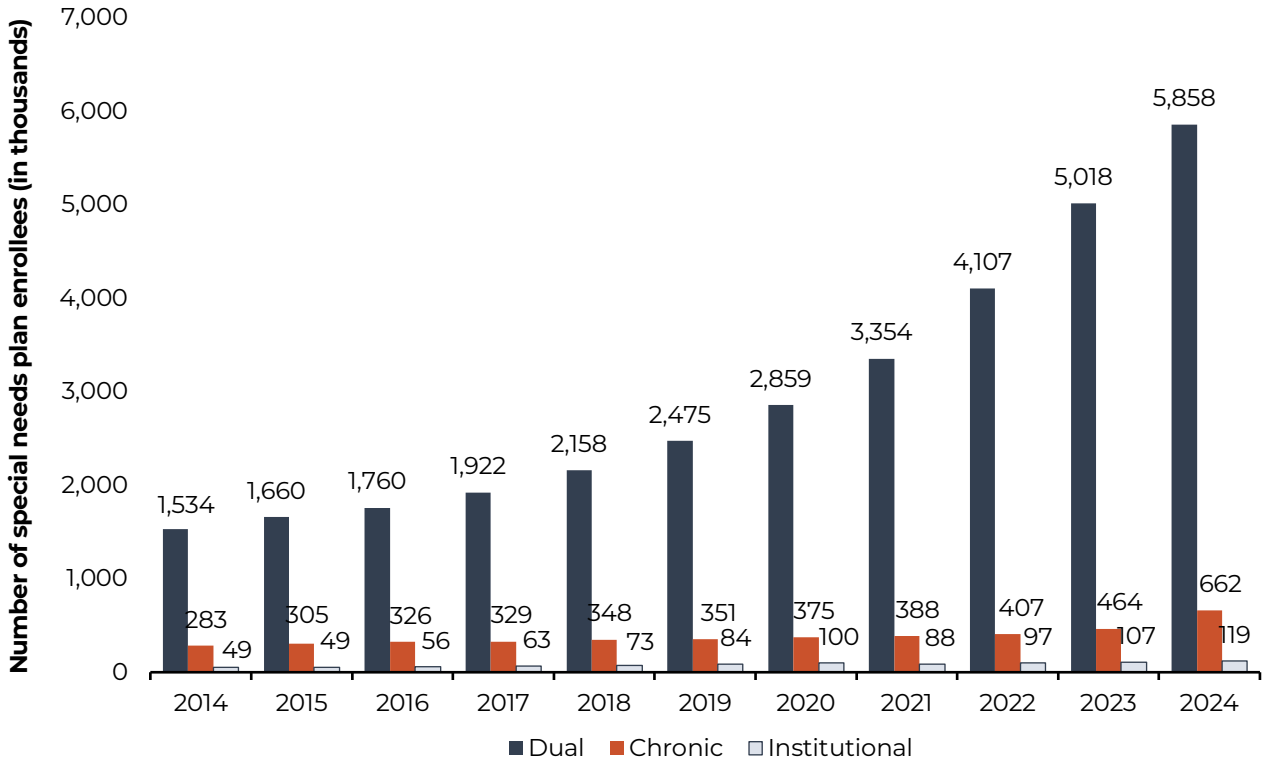
Note: MA (Medicare Advantage).

Source: CMS enrollment data, February 2011–2024.

> While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.

> As of February 2024, about 5.8 million enrollees were in employer group plans, or about 18 percent of all MA enrollees. Employer plan enrollment grew by 6 percent from 2023 and has more than doubled since 2013.

Chart 9-11 Number of special needs plan enrollees, 2014–2024



Source: CMS special needs plans comprehensive reports, February 2014–2024.

> Special needs plans (SNPs) offer benefit packages that are tailored to specific populations. Dual-eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing-home certified.

> The vast majority of SNP enrollees are in dual-eligible SNPs. Enrollment in dual-eligible SNPs has tripled since 2014, exceeding 5.8 million—about 19 percent of all MA enrollees—in 2024.

> Enrollment in chronic condition SNPs has grown at varying rates as plan requirements have changed, but it has generally risen annually since 2014. In 2024, about 662,000 beneficiaries (about 2 percent of all MA enrollees) were enrolled in chronic condition SNPs.

> Enrollment in institutional SNPs increased to its highest level ever in 2024 but accounts for less than 1 percent of all MA enrollees.

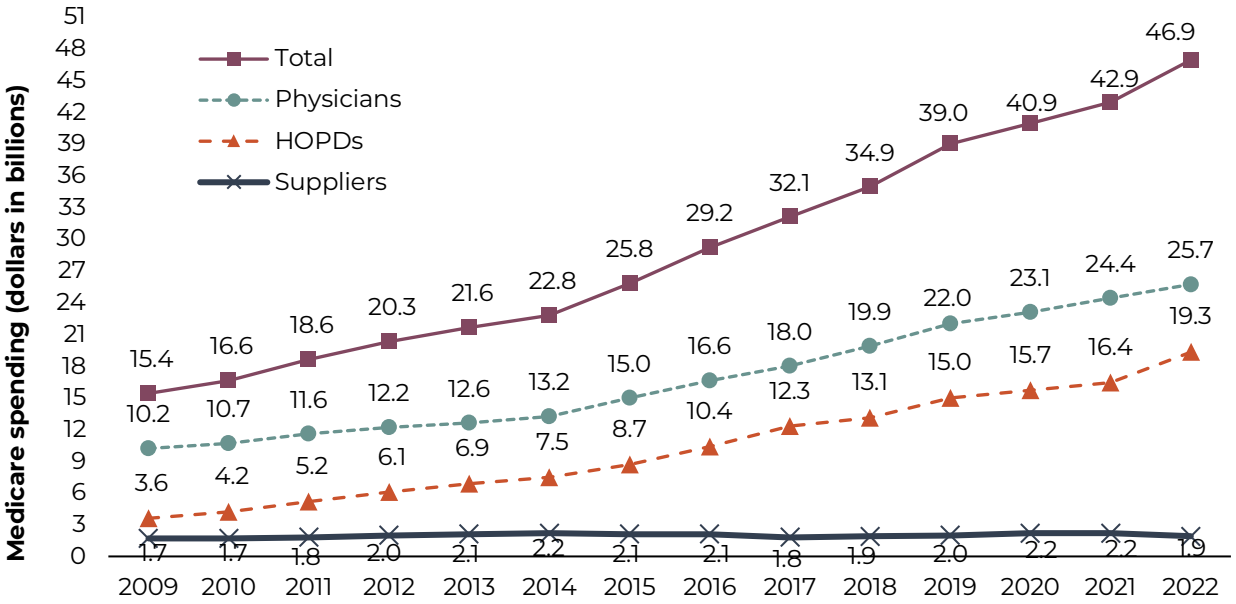
> The number of SNPs increased by 4 percent from February 2023 to February 2024 (data not shown). Dual-eligible SNPs increased by 7 percent, institutional SNPs decreased by 8 percent, and the number of chronic condition SNPs increased by 1 percent (data not shown).

SECTION

10

Prescription drugs

Chart 10-1 Medicare spending for Part B drugs furnished by physicians, hospital outpatient departments, and suppliers, 2009–2022



Note: HOPD (hospital outpatient department). Data include Part B–covered drugs furnished by several provider types, including physicians, suppliers, and HOPDs, and exclude those furnished by critical access hospitals, Maryland hospitals, and dialysis facilities. "Medicare spending" includes program payments and beneficiary cost sharing. Data reflect all Part B drugs whether they were paid based on the average sales price or other methods. Data exclude blood and blood products (other than clotting factor). Dollar amounts are nominal, not adjusted for inflation. Components may not sum to totals due to rounding.

Source: MedPAC and Acumen LLC analysis of Medicare claims data.

> Fee-for-service (FFS) Medicare and its beneficiaries spent nearly $47 billion on separately paid Part B drugs in 2022, with physician offices, HOPDs, and pharmacy suppliers accounting for 55 percent, 41 percent, and 4 percent of spending, respectively.

> Between 2009 and 2022, Part B drug spending grew 8.9 percent per year on average on a nominal basis. Over this period, spending grew more rapidly for HOPDs than for physicians and suppliers—at average annual rates of about 14 percent, 7 percent, and 1 percent, respectively.

> Between 2021 and 2022, FFS Part B drug spending increased 9.4 percent, with spending growing most rapidly (17.7 percent) in HOPDs, largely due to a change in payment rates for 340B hospitals.

> Medicare generally pays providers for Part B drugs based on the average sales price (ASP) plus 6 percent. Between 2018 and 2021, Medicare paid a reduced rate (ASP minus 22.5 percent) for hospitals participating in the 340B Drug Discount Program. In 2022, in response to a Supreme Court ruling, CMS increased the payment rate for 340B-acquired Part B drugs to ASP plus 6 percent. (CMS will make separate lump sum payments to 340B hospitals to compensate for reduced payments received in 2018 through 2021, but those amounts are not reflected in the chart).

> The data exclude Part B drugs furnished by critical access hospitals (CAHs) and Maryland hospitals, which are not paid under the general Part B drug ASP payment system. Medicare and beneficiaries spent about $1.3 billion in CAHs and $0.4 billion in Maryland hospitals for Part B drugs in 2022 (data not shown). Also, the data do not reflect Part B drugs paid as part of larger payment bundles (i.e., certain drugs furnished by HOPDs that are packaged into payment for other services and drugs furnished by dialysis facilities that are paid under the broader dialysis payment bundle).

Chart 10-2 Change in use of and Medicare payments for separately payable Part B drugs, 2009–2022

	2009	2022	Average annual growth 2009–2022
Total payments: Separately payable Part B drugs (in billions)	$11.5*	$43.5*	10.8%*
Total payments: All Part B drugs excluding vaccines (in billions)	$11.3	$42.1	10.7
Number of beneficiaries using a Part B drug (in millions)	2.4	3.7	3.2
Average number of Part B drugs per beneficiary	1.34	1.32	–0.1
Average annual payment per Part B drug per beneficiary	$3,422	$8,695	7.4
Total payments: Part B vaccines (in billions)	$0.2	$1.4	15.2
Number of beneficiaries using a Part B vaccine (in millions)	13.4	14.6	0.7
Average number of Part B vaccines per beneficiary	1.08	1.12	0.3
Average annual payment per Part B vaccine per beneficiary	$15	$83	14.1

Note: This analysis includes Part B drugs paid based on the average sales price as well as the small group of Part B drugs that are paid based on other methods. "Vaccines" refers to three Part B–covered preventive vaccines: influenza, pneumococcal, and hepatitis B. Data include Part B drugs furnished by physicians, hospitals paid under the outpatient prospective payment system, and suppliers and exclude data for critical access hospitals, Maryland hospitals, and dialysis facilities. Yearly figures presented in the table are rounded; the average annual growth rate was calculated using unrounded data. Dollar amounts are nominal, not adjusted for inflation.
*For purposes of this analysis, spending on separately payable Part B drugs excludes any drug that was bundled in 2009 or 2022 (i.e., drugs that were packaged under the outpatient prospective payment system in 2009 or 2022 were excluded from both years of the analysis, regardless of the setting in which the drug was administered), drugs billed under not-otherwise-classified billing codes, and blood and blood products (other than clotting factor). Without those exclusions, Part B drug spending was $15.4 billion in 2009 and $46.9 billion in 2022, as shown in Chart 10-1.

Source: MedPAC analysis of Medicare claims data for physicians, hospital outpatient departments, and suppliers.

> Total payments by the Medicare program and beneficiaries for separately payable Part B drugs increased 10.8 percent per year, on average, between 2009 and 2022 on a nominal basis.

> Medicare spending on separately payable Part B drugs excluding Part B–covered preventive vaccines grew at a similar rate (10.7 percent per year) between 2009 and 2022.

> Growth in the average price that Medicare Part B paid per drug was the largest factor contributing to increased spending for separately payable Part B drugs excluding vaccines between 2009 and 2022. During that period, the average annual payment per drug grew 7.4 percent per year on average, reflecting increases in the prices of existing drugs; the launch of new, higher-priced drugs; and shifts in the mix of drugs (data not shown). Growth in the number of beneficiaries using nonvaccine Part B drugs (about 3.2 percent per year on average) also contributed to increased spending. The number of Part B drugs received per user declined slightly.

> In 2022, Medicare and beneficiaries spent $1.4 billion on three Part B–covered preventive vaccines (influenza, pneumococcal, and hepatitis B) furnished by physicians, hospital outpatient departments, and pharmacy suppliers. Between 2009 and 2022, Part B vaccine spending grew 15 percent per year on average. Almost all of that growth was due to higher average payments per vaccine, which climbed at an average rate of 14 percent per year, reflecting higher launch prices for new influenza and pneumococcal vaccines and postlaunch price increases for vaccines. (Medicare Part B was not liable for the cost of COVID-19 vaccines purchased by the federal government.)

Chart 10-3 Top 20 Part B drugs, 2022

		2022			Percent change, 2021–2022		
		Total spending (billions)	Number of users	Average spending per user	Total spending	Number of users	Average spending per user
Keytruda	CA	4.9	67,400	$73,300	25%	7%	17%
Eylea	MD	3.5	341,300	10,400	4	9	–5
Prolia/Xgeva	CA SE, OS	2.0	655,200	3,100	12	4	8
Darzalex	CA	1.9	22,200	85,500	24	18	5
Opdivo	CA	1.9	27,200	68,200	18	6	11
Rituxan*	AR, CA, ID	1.0	60,500	17,300	–20	–7	–14
Orencia	AR	0.9	32,200	28,100	–9	1	–10
Lucentis*	MD	0.8	103,200	7,700	–24	–10	–15
Tecentriq	CA	0.8	12,900	60,300	19	2	17
Avastin*	CA, MD	0.7	180,100	3,900	–20	–6	–15
Ocrevus	MS	0.7	12,800	54,600	14	–1	15
Entyvio	ID	0.7	17,700	38,100	28	11	16
Gammagard	IMD, NE	0.6	21,900	28,900	25	17	7
Neulasta*	CA SE	0.6	81,800	7,700	–27	–4	–24
Remicade*	AR, ID	0.6	54,200	11,400	–4	1	–5
Soliris	AI	0.6	1,500	400,400	–4	–8	4
Imfinzi	CA	0.6	10.600	53,200	24	16	7
Fluzone HD	VA	0.5	8,000,300	67	13	5	7
Sandostatin	CA SE	0.5	9,200	49.700	6	–4	10
Zenith amniotic membrane	WC	0.5	4,100	111,800	**	**	**
Top 10 drugs		18.5					
Top 20 drugs		24.4					
All Part B drugs		46.9					

Note: CA (cancer), MD (macular degeneration and other eye disorders), SE (side effect), OS (osteoporosis), AR (arthritis), ID (inflammatory disorders), AI (autoimmune), MS (multiple sclerosis), IMD (immune deficiency), NE (neuropathy), VA (vaccine), HD (high-dose), WC (wound care). "Total drug spending" includes Medicare program payments and beneficiary cost sharing. The 20 drugs shown in the chart reflect the Part B drug billing codes with the highest Medicare expenditures in 2022. Data include Part B–covered drugs furnished by several provider types, including physicians, suppliers, and hospital outpatient departments, but exclude those furnished by critical access hospitals, Maryland hospitals, and dialysis facilities. Data exclude blood and blood products (other than clotting factor). Components do not always sum to totals due to rounding. Dollar amounts are nominal, not adjusted for inflation.
*For originator biologics that have biosimilar competitors, data in the table reflect both the originator biologic and biosimilars.
**Zenith amniotic membrane received its own billing code in the fourth quarter of 2021 and had very low utilization that quarter.

Source: MedPAC and Acumen LLC analysis of Medicare claims data.

> Part B drugs are billed using over 900 billing codes, but spending is concentrated. In 2022, Medicare spending (including beneficiary cost sharing) on the top 10 products accounted for $18.5 billion, or 39 percent of total Part B drug spending. Spending on the top 20 products accounted for $24.4 billion, or about 52 percent of total Part B drug spending.

(Chart continued next page)

Chart 10-3 Top 20 Part B drugs, 2022 (continued)

> The top 20 Part B drugs are concentrated in certain therapeutic areas. Seven of the top 20 drugs treat cancer, and three treat cancer side effects. The top 20 also include 3 products for macular degeneration and 4 products for rheumatoid arthritis or other inflammatory disorders.

> Seventeen of the top 20 Part B products are biologics. One product (Sandostatin) is a nonbiologic drug, one (Fluzone HD) is a preventive vaccine, and one (Zenith amniotic membrane) is a skin substitute considered a human cells, tissues, or cellular and tissue–based product.

> Among the top 20 highest-expenditure Part B drugs in 2022, average total spending per user varied. Of seven products used to treat cancer (excluding Avastin, for which costs vary substantially depending on whether it is used for cancer or macular degeneration), average spending per user ranged from $53,000 to $86,000. Average spending per user ranged from $11,000 to $38,000 for four drugs used to treat rheumatoid arthritis and other inflammatory conditions, and from $8,000 to $10,000 for two drugs used to treat macular degeneration (excluding Avastin). Soliris, a product used to treat rare autoimmune conditions, had the highest average cost per user among the top 20, $400,000. A skin substitute product (Zenith amniotic membrane) had average spending per user of about $112,000.

> Between 2021 and 2022, total spending increased for 13 of the top 20 Part B drugs and decreased for 7 drugs on a nominal basis. Five products experienced spending growth of more than 20 percent (Keytruda, Darzalex, Entyvio, Gammagard, and Imfinzi). In addition, Zenith amniotic membrane, which first received a billing code in the last quarter of 2021, had about $0.5 billion in spending in 2022. Among the products that experienced spending decreases in 2022, the most substantial decreases occurred among four products with biosimilar competition (Rituxan, Lucentis, Avastin, and Neulasta), ranging from 20 percent to 27 percent.

Chart 10-4 Growth in manufacturer prices for the 20 highest-expenditure Part B drugs, 2015–2024

	Average annual percentage change in average sales price 2015–2022	Percentage change in average sales price 2022–2023	Percentage change in average sales price 2023–2024
Keytruda	2.3%[c]	3.1%	3.4%
Eylea	–1.0	–1.9	–4.0
Prolia/Xgeva	5.4	8.8	9.2
Darzalex	4.0[d]	3.0	4.7
Opdivo	2.4[c]	2.6	3.6
Rituxan[a]	2.4	–4.5	–3.1
Orencia	4.3	–2.3	–0.8
Lucentis[a]	–3.6	–22.8	–20.9
Tecentriq	1.2[e]	1.5	5.2
Avastin[a]	0.0	4.3	4.7
Ocrevus	0.8[e]	1.3	0.2
Entyvio	3.8[c]	1.9	1.7
Gammagard	2.5	–2.4	–3.1
Neulasta[a]	–6.5	–25.7	–62.5
Remicade[a]	–9.2	–7.5	–7.7
Soliris	1.2	–0.8	–0.6
Imfinzi[f]	0.8	2.7	2.3
Fluzone HD[b]	10.1	7.2	4.9
Sandostatin	5.4	–0.4	2.5
Zenith amniotic membrane	N/A[g]	N/A[g]	N/A[g]
Consumer Price Index for All Urban Consumers	**2.7**	**6.4**	**3.1**

Note: N/A (not available). Growth rates are calculated for average sales price (ASP) from first quarter to first quarter of each year and for the Consumer Price Index for All Urban Consumers (CPI–U) from January to January of each year. For products that launched after 2015, the table displays average annual ASP growth between the earliest year that a first-quarter payment rate was available for the product and 2022. ASP at the billing-code level is calculated using the publicly available Part B drug payment rate data on CMS's website. Price growth is nominal, not adjusted for inflation.
[a]Indicates the product is an originator biologic that has experienced biosimilar entry. ASP trends are for the originator product only.
[b]For Fluzone HD, a preventive vaccine paid 95 percent of the average wholesale price, the table displays the percentage change in the actual payment rate rather than ASP.
[c]ASP growth from 2016 to 2022.
[d]ASP growth from 2017 to 2022.
[e]ASP growth from 2018 to 2022.
[f]ASP growth from 2020 to 2022.
[g]Zenith amniotic membrane received its own billing code in the fourth quarter of 2021 and did not have a published payment rate in January 2022 or January 2023.

Source: MedPAC analysis of CMS ASP payment rate files publicly available on the CMS website, CPI–U data from the Bureau of Labor Statistics, and MedPAC and Acumen LLC analysis of Medicare claims data.

(Chart continued next page)

Chart 10-4 Growth in manufacturer prices for the 20 highest-expenditure Part B drugs, 2015–2024 (continued)

> Medicare pays for most Part B drugs at a rate of 106 percent of the average sales price. ASP is the average price realized by the manufacturer for sales to most U.S. purchasers, net of rebates, discounts, and price concessions, with certain exceptions. For biologics, biosimilars, and brand-name drugs with no generic competitors, Medicare Part B pays each product an ASP-based rate under the product's own billing code, essentially paying whatever price the manufacturer establishes. For brand drugs with generic competitors, Medicare Part B assigns both the brand product and its generic equivalents to the same billing code and pays 106 percent of a volume-weighted ASP.

> Beginning January 1, 2023, manufacturers of Part B single-source drugs, biologics, and biosimilars are required to pay Medicare a quarterly rebate if their product's ASP grows faster than inflation. Beginning April 2023, for products that incur a rebate, beneficiary cost sharing is based on the lower, inflation-adjusted ASP. Certain types of products are excluded from the policy (e.g., low-cost drugs, preventive vaccines, drugs experiencing a shortage or supply chain disruption, and biosimilars meeting certain criteria). Whether a product incurs an inflation rebate is determined based on cumulative growth in the payment rate between a base period (generally from July 1, 2021) and a given quarter and how that compares to growth in the CPI–U over a specified period. Data on trends in ASP and CPI–U in this chart do not replicate the CMS rebate calculation.

> In the most recent year, among the top 20 highest-expenditure drugs, more products experienced a price increase than price decrease on a nominal basis. Prices increased for 11 products, with 7 of those products' prices increasing faster than the CPI–U between January 2023 and 2024.

> Since 2022, Prolia/Xgeva has experienced the greatest price growth among the 20 highest-expenditure Part B products, with its payment rate increasing about 9 percent each year between January 2022 and January 2024. Prolia/Xgeva was the only product among the top 20 that incurred an inflation rebate between the second quarter of 2023 and the first quarter of 2024 (as indicated by reduced beneficiary cost sharing based on the inflation-adjusted ASP) (data not shown). Across all Part B drugs, drugs in 51 Part B billing codes incurred an inflation rebate for one or more quarters over that period (data not shown).

> Between January 2023 and 2024, 8 of the top 20 products experienced a price decrease. Some of the price declines occurred among originator biologics facing biosimilar competition. Avastin, Neulasta, Lucentis, Remicade, and Rituxan all have biosimilar competitors. Prices for these originator biologics (except for Avastin) declined by 3 percent to 63 percent between 2023 and 2024. Originator Avastin's price increased about 4 percent in 2023 and 5 percent in 2024, despite facing biosimilar competition.

Chart 10-5 Top 10 Part B therapeutic classes of drugs, 2022

	Total Medicare payments in 2022 (in billions)	Percentage change in total Medicare payments 2021–2022
Antineoplastics	$18.5	11%
Ophthalmic agents	4.8	1
Endocrine agents	3.9	11
Hematological agents	3.4	–2
Analgesics, anti-inflammatories, or antipyretics	2.8	–4
Immune globulin agents	2.3	14
Skin substitutes	1.6	52
Respiratory therapy agents	1.5	–3
Vaccines	1.4	27
Neuromuscular and musculoskeletal therapy agents	1.4	3

Note: Therapeutic classes are ranked in order of 2022 total fee-for-service (FFS) Medicare spending. This analysis includes Part B drugs paid based on the average sales price as well as the small group of Part B drugs that are paid based on other methods. Drug spending includes Medicare program payments and beneficiary cost sharing. "Vaccines" includes both preventive vaccines (e.g., influenza) and other vaccines when used to treat an injury or direct exposure to a disease (e.g., hepatitis A).

Source: MedPAC analysis of Medicare claims data for physicians, hospital outpatient departments, and suppliers.

> In 2022, 10 drug therapeutic classes accounted for roughly 90 percent of total FFS Medicare spending for Part B drugs (calculation based on total Part B spending of $46.9 billion reported in Chart 10-1).

> Total spending by therapeutic class was somewhat concentrated. In 2022, antineoplastics (products used to treat cancer) accounted for roughly 40 percent, and the top three classes—antineoplastics, ophthalmic agents, and endocrine agents—accounted for roughly 60 percent of total Medicare spending.

> Between 2021 and 2022, the growth in total spending for five therapeutic classes—antineoplastics, endocrine agents, immune globulin agents, skin substitutes, and vaccines—exceeded the average annual growth across all Part B products (which averaged 9 percent during this period on a nominal basis (shown in Chart 10-1).

> Total spending on separately payable skin substitutes has been growing rapidly. Between 2021 and 2022, Medicare spending on skin substitutes grew by 52 percent, from $1.0 billion to $1.6 billion. This therapeutic class increased in rank by total Medicare spending from 10th in 2021 to 7th in 2022. Preliminary claims data for calendar year 2023 (claims processed through week 20 of 2024) indicate that spending on skin substitutes exceeded $4 billion that year, more than double the prior year's level (data not shown). In 2023, Medicare spending on one skin substitute product (Dual Layer Impax Membrane) exceeded $1.4 billion based on preliminary data.

Chart 10-6 Trends in Medicare Part B payment rates for originator biologics and their biosimilar products

	First biosimilar entry	Percentage change in originator biologic's payment rate		Biosimilar's payment rate as a percentage of originator biologic's payment rate (2024 Q1)	Biosimilar market share (2023 Q3)
		In 10 years before biosimilar entry	Since biosimilar entry (through 2024 Q1)		
Neupogen and biosimilars	2015 Q3	71%	–1%	30%–55%	79%
Remicade and biosimilars	2016 Q4	54%	–61%	44%–98%	29%
Neulasta and biosimilars	2018 Q3	117%	–87%	123%–648%	44%
Procrit/Epogen and biosimilars	2018 Q4	35%	–28%	88%	44%
Avastin and biosimilars	2019 Q3	42%	–9%	29%–98%	80%
Herceptin and biosimilars	2019 Q3	69%	–25%	17%–55%	79%
Rituxan and biosimilars	2019 Q4	68%	–16%	26%–52%	63%
Lucentis and biosimilars	2022 Q3	–31%	–32%	100%–140%	34%

Note: Q1 (first quarter), Q3 (third quarter), Q4 (fourth quarter). An originator biologic is a drug product derived from a living organism. A biosimilar product is a follow-on product that is approved by the Food and Drug Administration (FDA) based on the product being highly similar to the originator biologic. The biosimilars included in the analysis are Granix, Nivestym, Releuko, and Zarxio for originator Neupogen; Inflectra, Renflexis, and Avsola for originator Remicade; Fulphila, Fylnetra, Nyvepria, Stimufend, Udenyca, and Ziextenzo for originator Neulasta; Retacrit for originator Procrit/Epogen; Alymsys, Mvasi, Vegzelma, and Zirabev for originator Avastin; Ontruzant, Herzuma, Ogivri, Trazimera, and Kanjinti for originator Herceptin; Truxima, Ruxience, and Riabni for originator Rituxan; and Byooviz and Cimerli for originator Lucentis. Although Granix is not a biosimilar in the U.S. (because it was approved under the standard FDA approval process for new biologics), we include it here because it was approved as a biosimilar to Neupogen in Europe and it functions as a competitor to Neupogen in the U.S. market. "First biosimilar entry date" reflects the earliest market date for a product approved by the FDA as a biosimilar to the originator biologic. Growth in payment rates is nominal, not adjusted for inflation.

Source: MedPAC analysis of ASP payment rate files publicly available on the CMS website and product market date information from CMS's database on drug products in the Medicaid Drug Rebate Program and Acumen LLC analysis of Medicare claims data.

> Under Part B, Medicare pays for an originator biologic at 106 percent of its own ASP. For biosimilars, Medicare pays 100 percent of the biosimilar's ASP plus 6 percent or 8 percent of the originator product's ASP. Per the Inflation Reduction Act of 2022, for five years beginning October 2022, existing biosimilars and new biosimilars receive an 8 percent add-on, as long as the biosimilar's ASP does not exceed the originator's ASP.

(Chart continued next page)

Chart 10-6 Trends in Medicare Part B payment rates for originator biologics and their biosimilar products (continued)

> Biosimilar entry has generated savings for Medicare. For the eight biologics that had biosimilars on the market in 2022, Medicare spending on Part B originator biologics and their biosimilars declined on a nominal basis by about 20 percent, from $5.4 billion in 2021 to $4.3. billion in 2022 (data not shown). Pricing patterns and biosimilar uptake vary across products.

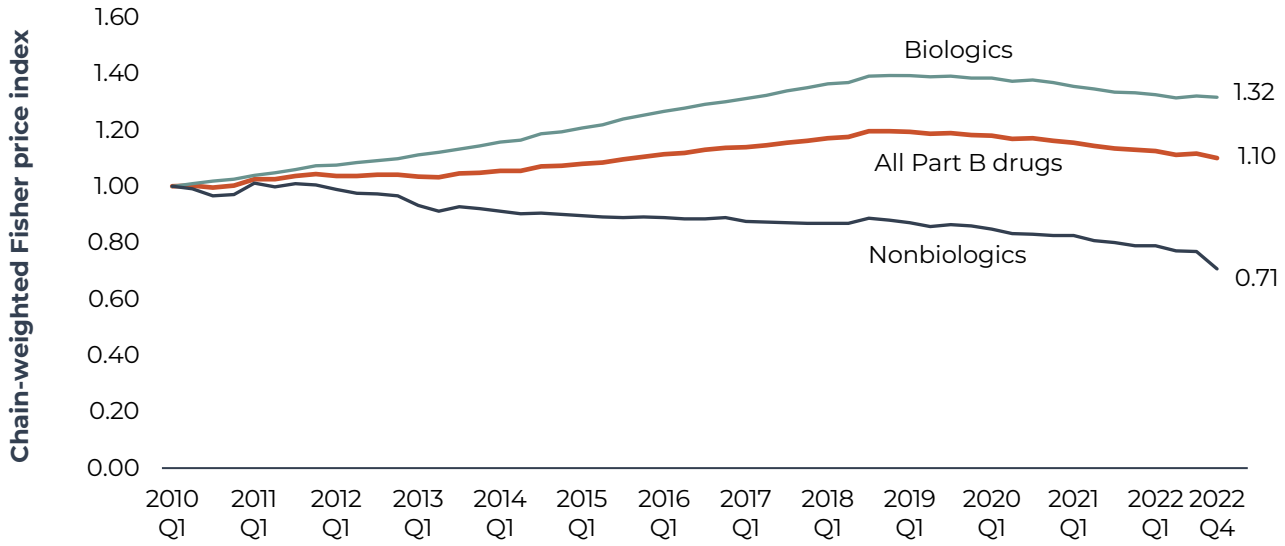
> For some products, biosimilars are priced substantially below originators, and biosimilar uptake has driven savings. For example, lower-price biosimilars now account for roughly 80 percent of the market share for Neupogen, Avastin, and Herceptin. These three originator products have reduced their prices only minimally or modestly (1 percent, 9 percent, and 25 percent, respectively) since biosimilar entry. Each of these products had at least one biosimilar on the market with a Medicare payment that was roughly 70 percent or 80 percent below the originator's payment rate.

> For other products, originator biologics have responded to biosimilar entry by lowering their prices, and savings have come from both the originator biologic and biosimilars. For example, the price of the originator Procrit/Epogen has fallen 28 percent since biosimilar entry. Medicare's payment rate for biosimilar Procrit/Epogen is 12 percent below the originator's payment rate as of the first quarter of 2024.

> In a few cases, originator biologics have reduced their prices by more than 50 percent in response to biosimilar entry. Originator Remicade's payment rate has declined 61 percent, and originator Neulasta's payment rate has declined 87 percent since biosimilar entry. As of the first quarter of 2024, Remicade had some biosimilar competitors on the market that were priced lower (as much as 56 percent below the originator's payment rate). In contrast, originator Neulasta had a lower Medicare payment rate than all of its biosimilar competitors as of the first quarter of 2024. Originators Remicade and Neulasta continue to retain the majority of market share as of the third quarter of 2024.

> Although biosimilar competition has resulted in reduced prices for originator biologics relative to the products' prices at the time of biosimilar entry, nearly all of these originator biologics experienced substantial price increases prior to biosimilar entry. With the exception of Lucentis, the originator biologics' cumulative growth in payment rates over the 10 years prior to biosimilar entry ranged from 35 percent to 117 percent. In contrast, Lucentis's payment rate declined 31 percent in the 10 years before biosimilar entry.

Chart 10-7 Postlaunch price indexes for Medicare Part B drugs, 2010–2022



Note: Q1 (first quarter), Q4 (fourth quarter). The price indexes are Fisher price indexes and reflect postlaunch price growth for individual Part B–covered drug products, measured in nominal terms (not adjusted for inflation). A product is defined as a Part B drug billing code (referred to as a Health Care Common Procedure Coding System billing code). Each Part B single-source drug, biologic, and biosimilar receives its own Part B drug billing code, while brand drugs with generic competitors are grouped together in the same billing code. The price index is different from the change in the aggregate average annual payment per Part B drug (Chart 10-2), which reflects changes in the prices of existing products, rising launch prices of new products, and shifts in utilization across products.

Source: Acumen LLC analysis for MedPAC.

> The Part B price indexes reflect growth in the Medicare payment rate (generally the average sales price (ASP) plus 6 percent) at the individual product level, which is a measure of average postlaunch price growth for Part B drugs. The price index is different from the change in the aggregate average annual payment per Part B drug (see Chart 10-2) which grew more than 7 percent per year on average between 2009 and 2022 and reflects a broader set of dynamics (including changes in the price of existing products, rising launch prices of new products compared with older products, and shifts in utilization across products).

> Measured by the change in the ASP of individual Part B–covered drugs, the prices of Part B–covered drugs rose by an average of 10 percent cumulatively between 2010 and 2022 (index of 1.10) on a nominal basis. Since the third quarter of 2018 through the end of 2022, the overall price index for Part B drugs has declined from 1.20 to 1.10, driven by a decline in the biologics' price index, coupled with the continued decline in the nonbiologics' price index.

> The price index for biologics increased cumulatively by 32 percent (index of 1.32) between 2010 and 2022, reaching a high of just over 1.39 in the fourth quarter of 2018 and the first quarter of 2019 and declining to 1.32 by the fourth quarter of 2022. Pricing trends differ for biologics that face biosimilar competition and biologics that do not. Between the first quarter of 2019 and the fourth quarter of 2022, the price index declined for biologics with recent biosimilar entry by about 42 percent and increased for biologics without biosimilar competition by about 5 percent (data not shown).

> The price index for nonbiologics declined 29 percent (index of 0.71) between 2010 and 2022, which in part reflects patent expiration and generic entry for some of these products. The design of the ASP payment system spurs price competition among generics and their associated brand products by paying them the same rate under a combined billing code.

Chart 10-8 Part D enrollment by plan type, 2014–2023

	2014	2022	2023	Average annual growth rate 2014–2023
Total Medicare enrollment, in millions	56.9	68.1	69.5	2.2%
Part D enrollment, in millions				
Part D plans	40.0	53.1	55.7	3.8
Non-Medicare employer plans under the RDS*	2.8	1.1	0.9	–101.3
Total Part D	42.8	54.2	56.7	3.2
Share of Medicare enrollees with Part D	*75%*	*79%*	*82%*	
LIS enrollment				
PDP	9.2	6.2	6.3	–4.2
MA–PD	3.6	8.5	9.0	10.8
Total LIS	12.8	14.8	15.3	2.0
Share of LIS enrollees in MA–PD	*28%*	*58%*	*59%*	
Share of Part D plan enrollees with LIS	*32%*	*28%*	*27%*	
EGWPs (PDPs and MA–PDs), in millions	7.0	7.9	8.1	1.7
EGWP share of total Part D enrollment	*16%*	*15%*	*14%*	
Non-EGWP Part D plans, in millions				
PDP	20.1	20.2	20.7	0.4
MA–PD	13.0	25.0	26.9	8.4
Share of non-EGWP plan enrollees in MA–PD	*39%*	*55%*	*56%*	

Note: RDS (retiree drug subsidy), LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), EGWP (employer group waiver plan). A beneficiary was classified as "LIS" if that individual received Part D's LIS at some point during the year. If a beneficiary was enrolled in both a PDP and an MA–PD during the year, that individual was classified into the type of plan with the greater number of enrollment months. Not all components sum to their respective totals due to rounding. The average annual growth rate is calculated on unrounded numbers. Figures include all beneficiaries with at least one month of enrollment.
*Excludes federal government and military retirees covered by either the Federal Employees Health Benefit Program or the TRICARE for Life program.

Source: MedPAC analysis of common Medicare environment file from CMS.

> In 2023, 82 percent of Medicare beneficiaries were enrolled in Part D plans for at least one month during the year or had prescription drug coverage through employer-sponsored plans that received Medicare's RDS. That share is up from 75 percent in 2014.

> Between 2014 and 2023, the number of enrollees receiving the LIS grew modestly (2 percent per year, on average) compared with the number of non-LIS enrollees (about 4.4 percent per year, on average; data not shown). Faster enrollment growth among non-LIS enrollees has resulted in a decline in the share of Part D enrollees who receive the LIS. In 2023, 27 percent of Part D enrollees received the LIS, a decrease from 32 percent in 2014. Over 59 percent of LIS beneficiaries were in MA–PDs.

> Employer and union health plans continue to be important sources of drug coverage for Medicare beneficiaries under Part D. In 2023, 8.1 million Medicare beneficiaries (14 percent of Part D plan enrollees) were in plans (including PDPs and MA–PDs) set up by employers or unions for their retirees. Under these EGWPs, Medicare is the primary payer for basic drug benefits, and typically the employer offers wraparound coverage. Separately, 0.9 million Medicare beneficiaries were in plans offered by employers that receive Medicare's RDS. (If an employer remains the primary payer of creditable drug coverage for its retirees, Medicare provides the employer with a tax-free subsidy for 28 percent of each eligible individual's drug costs that fall within a specified range of spending.)

> In 2023, among non-EGWP plans, 26.9 million (56 percent) were in MA–PDs and 20.7 million (44 percent) were in stand-alone PDPs. Over the 2014 to 2023 period, enrollment in PDPs remained flat while enrollment in MA–PDs rose by an annual average of 8.4 percent.

Chart 10-9 Characteristics of Part D plan enrollees, 2023

	All Medicare	Part D plans	Plan type		Subsidy status	
			PDP	MA–PD	LIS	Non-LIS
Beneficiaries* (in millions)	69.5	55.7	25.0	30.7	15.3	40.4
Percent of all Medicare	100%	80%	36%	44%	22%	58%
Gender						
Male	46%	44%	44%	44%	42%	45%
Female	54	56	56	56	58	55
Race/ethnicity						
White, non-Hispanic	73	72	79	66	52	80
Black, non-Hispanic	11	11	7	14	20	7
Hispanic	9	9	6	12	17	6
Asian	4	4	3	4	7	3
Other	1	1	1	1	1	1
Age (years)**						
<65	13	14	13	14	34	6
65–69	27	25	24	26	23	26
70–74	23	23	23	23	16	26
75–79	17	17	17	17	11	20
80+	21	21	22	20	16	23

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). Components may not sum to totals due to rounding.
*Figures for "All Medicare" and "Part D plans" include all beneficiaries with at least one month of enrollment in the respective program. A beneficiary was classified as "LIS" if that individual received Part D's LIS at some point during the year. For individuals who switched plan types during the year, classification into plan types was based on the greater number of enrollment months.
**Age as of July 2022.

Source: MedPAC analysis of the common Medicare environment file from CMS.

> In 2023, 55.7 million Medicare beneficiaries (80 percent) were enrolled in Part D plans at some point in the year. Less than half (25.0 million) were enrolled in stand-alone PDPs, and the rest were enrolled in MA–PDs (30.7 million). Just over 15 million enrollees received Part D's LIS.

> Demographic characteristics of Part D enrollees are generally similar to the overall Medicare population, though Part D enrollees are more likely to be female and less likely to fall in the 65–69 age bracket. MA–PD enrollees are more likely to be Hispanic or Black compared with PDP enrollees; LIS enrollees are more likely to be female, minority, and under age 65 (eligible for Medicare due to disability) compared with non-LIS enrollees.

Chart 10-10 Changes over time in the parameters of the Part D defined standard benefit, 2015–2024

	2015	2023	2024	Average annual change 2015–2024
Deductible	$320	$505	$545	6.1%
Initial coverage limit	2,960	4,660	5,030	6.1
Annual out-of-pocket threshold	4,700	7,400	8,000	6.1
Total covered drug spending at annual out-of-pocket threshold				
Enrollees eligible for manufacturers' coverage-gap discount	7,062	11,206	12,447	6.5
Other enrollees	6,680	10,516	11,477	6.2
Cost sharing for LIS beneficiaries:				
Copay for generic/preferred multisource drugs	2.65	4.15	4.50	6.1
Copay for other prescription drugs	6.60	10.35	11.20	6.1

Note: LIS (low-income subsidy). Under Part D's defined standard benefit, the enrollee pays the deductible and then 25 percent of covered drug spending (75 percent is paid by the plan) until total covered drug spending reaches the initial coverage limit. The amounts shown of total covered drug spending at the annual out-of-pocket (OOP) threshold are for individuals who have no source of supplemental coverage and an average mix of brand and generic spending. Cost sharing paid by most sources of supplemental coverage does not count toward this threshold. Above the OOP limit, prior to 2024, non-LIS enrollees paid 5 percent coinsurance or copay amounts set in law, whichever was greater. Dollar amounts are nominal figures, not adjusted for inflation.

Source: CMS Office of the Actuary.

> In 2024, Part D's defined standard benefit has a $545 deductible, 25 percent coinsurance on covered drugs until the enrollee reaches $5,030 in total covered drug spending, and then a coverage gap until OOP spending reaches the annual threshold. (The total dollar amount of drug spending at which a beneficiary reaches the OOP threshold varies from person to person, depending on the mix of brand-name and generic prescriptions filled. CMS estimates that in 2024, a person who does not receive Part D's LIS and has no supplemental coverage would, on average, reach the threshold at $12,447 in total drug spending.) Most enrollees pay about 25 percent cost sharing for brand or generic prescriptions filled in the coverage gap. Beneficiaries who do not receive the LIS are eligible for a 70 percent manufacturers' discount on brand prescriptions in the gap phase. Enrollees with drug spending that exceeds the annual threshold no longer pay any cost sharing in the catastrophic phase; plan sponsors are now responsible for covering costs previously borne by beneficiaries. CMS updates most parameters of this defined standard benefit structure each year by the annual change in average total drug expenses of Medicare beneficiaries enrolled in Part D.

> Within certain limits, sponsors may offer Part D plans that have the same actuarial value as the defined standard benefit but a different benefit structure. For example, a plan may use tiered copayments rather than 25 percent coinsurance or have no deductible but use cost-sharing requirements that are equivalent to a rate higher than 25 percent (see Chart 10-16). Defined standard benefit plans and plans that are actuarially equivalent to the defined standard benefit are both known as "basic benefits." Once a sponsoring organization offers one plan with basic benefits within a prescription drug plan region, it may also offer up to two plans with enhanced benefits—basic and supplemental coverage combined.

> Several changes to Part D's benefit design are underway as a result of enactment of the Budget Reconciliation Act of 2022. (See the Commission's March 2024 report for more details.) In 2025, Medicare will implement a redesign of the Part D benefit that will cap enrollees' OOP spending at $2,000, increase plan liability, and reduce Medicare's reinsurance subsidy. The OOP cap will be updated annually in the same manner as other Part D parameters.

Chart 10-11 Characteristics of stand-alone Medicare PDPs, 2023–2024

	2023				2024			
	Plans		Enrollees as of February 2023		Plans		Enrollees as of February 2024	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	804	100%	18.5	100%	709	100%	18.1	100%
Type of benefit								
Defined standard	0	0	0.0	0	0	0	0.0	0
Actuarially equivalent	305	38	7.9	43	266	38	7.0	39
Enhanced	499	62	10.6	57	443	62	11.0	61
Type of deductible								
Zero	133	17	2.6	14	103	15	2.3	13
Reduced	110	14	2.0	11	200	28	3.6	20
Defined standard*	561	70	13.9	75	406	57	12.2	67
Some formulary tiers not subject to a deductible	423	53	9.3	50	360	51	9.0	50

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. "Actuarially equivalent" includes both actuarially equivalent standard and basic alternative benefits. "Enhanced" refers to plans with basic plus supplemental coverage. Not all components sum to their respective totals or to 100 percent due to rounding.
*The defined standard benefit's deductible was $505 in 2023 and is $545 in 2024. Count of plans for 2024 includes some that have been sanctioned and terminated by CMS, making them no longer eligible for new enrollment or LIS autoenrollment.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

> Plan sponsors are offering 709 stand-alone PDPs to fee-for-service enrollees in 2024 compared with 804 in 2023—a decrease of 12 percent. Total enrollment in PDPs declined by 2.3 percent to 18.1 million beneficiaries in 2024 from 18.5 million in 2023 as enrollees shifted to MA–PDs (see Chart 10-8).

> For 2024, 62 percent of PDP offerings include enhanced benefits (basic plus supplemental coverage); this share has remained steady since 2019 (2019 data not shown). Enhanced plans have further increased their share of enrollment, reaching 61 percent in 2024.

> In 2024, the share of enrollees in plans with either no or a reduced deductible climbed to one-third, up from one-fourth in 2023, as the share of plans (and enrollees in such plans) with a defined standard benefit fell from 75 percent to 67 percent. Conversely, in 2024, the share of plans designating certain formulary tiers not subject to the deductible fell to 51 percent from 53 percent in 2023. If, for example, a PDP used such a designation for preferred generic drugs, an enrollee would pay just the plan's cost sharing for that tier rather than the full cost of the prescription up to the amount of the deductible. In 2024, 50 percent of PDP enrollees were in such plans, down from 63 percent in 2022 (data not shown).

Chart 10-12 Characteristics of general MA–PDs, 2023–2024

	2023				2024			
	Plans		Enrollees as of February 2023		Plans		Enrollees as of February 2024	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	3,540	100%	18.9	100%	3,511	100%	19.7	100%
Type of organization								
Local HMO	2,086	59	11.7	62	1,998	57	11.8	60
Local PPO	1,404	40	6.8	36	1,467	42	7.6	39
PFFS	17	0	0.0	0	14	0	0.0	0
Regional PPO	33	1	0.3	2	32	1	0.3	1
Type of benefit								
Defined standard	14	<0.5	0.0	<0.5	18	1	0.0	<0.5
Actuarially equivalent	57	2	0.1	1	54	2	0.1	1
Enhanced	3,469	98	18.7	99	3,439	98	19.5	99
Type of deductible								
Zero	2,337	66	14.3	76	2,300	66	15.2	77
Reduced	1,045	30	4.2	22	1,017	29	4.0	20
Defined standard*	158	4	0.3	2	194	4	0.5	3
Some formulary tiers not subject to a deductible	1,154	33	4.4	23	1,161	33	4.4	22

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, and Part B–only plans. Components may not sum to totals due to rounding. "Actuarially equivalent" includes both actuarially equivalent standard and basic alternative benefits. "Enhanced" refers to plans with basic plus supplemental coverage.
*The defined standard benefit's deductible was $505 in 2023 and is $545 in 2024.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

> Sponsors are offering 3,511 MA–PDs in 2024 compared with 3,540 in 2023 (1 percent fewer plans). The vast majority of MA sponsors offer MA–PDs that combine medical benefits with prescription drug benefits under Part D. Despite the slight reduction in the number of plans, enrollment in MA–PDs grew 3.9 percent from 18.9 million in 2023 to 19.7 million in 2024.

> For the first time since 2011, the number of drug plans offered by HMOs decreased modestly from 2,086 in 2023 to 1,998 in 2024, though HMO drug plans remain the dominant type of MA–PD, making up 57 percent of all offerings. Local PPOs continue to grow in popularity, with enrollment growing nearly 12 percent in 2024 to 7.6 million enrollees, up from 6.8 million in 2023.

> In 2024, 98 percent of MA–PDs have enhanced benefits compared with 62 percent of PDPs (see Chart 10-11). In 2024, those MA–PDs enrolled 99 percent of all MA–PD beneficiaries.

> Sixty-six percent of MA–PDs have no deductible for their Part D benefits in 2024, and those plans attracted more than three-fourths of all MA–PD enrollees, far more than the 15 percent of PDPs covering 13 percent of enrollees in such plans (see Chart 10-11). In addition, 22 percent of MA–PD enrollees are in plans that designate certain cost-sharing tiers of their formularies that are not subject to a deductible.

Chart 10-13 Characteristics of SNPs, 2023–2024

	2023				2024			
	Plans		Enrollees as of February 2023		Plans		Enrollees as of February 2024	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	1,254	100%	5.3	100%	1,311	100%	6.3	100%
Type of SNP								
Chronic condition	300	24	0.4	8	310	24	0.6	10
Dual eligible	765	61	4.7	90	828	63	5.6	88
Institutionalized	189	15	0.1	2	173	13	0.1	2
Type of benefit								
Defined standard	644	51	3.6	68	852	65	5.1	81
Actuarially equivalent	25	2	0.1	1	7	1	<0.5	<0.5
Enhanced	585	47	1.6	31	452	34	1.2	19
Type of deductible								
Zero	296	24	0.4	7	272	21	0.5	8
Reduced	57	5	0.2	4	47	4	0.1	2
Defined standard*	901	72	4.7	89	992	76	5.7	90
Some formulary tiers not subject to a deductible	130	10	0.4	8	111	8	0.5	7

Note: SNP (special needs plan). The plans and enrollment described here exclude plans offered in U.S. territories. Components may not sum to totals due to rounding. "Actuarially equivalent" includes both actuarially equivalent standard and basic alternative benefits. "Enhanced" refers to plans with basic plus supplemental coverage. *The defined standard benefit's deductible was $505 in 2023 and is $545 in 2024.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

> The number of SNPs (MA–PDs designed for certain groups of beneficiaries) has grown rapidly in recent years, though that growth slowed to 5 percent in 2024, after years of double-digit growth (data not shown). Growth in SNP enrollment slowed as well: SNP enrollment grew 13.6 percent in 2024 (from 5.3 million in 2023 to 6.3 million)—down from 29 percent growth in 2023.

> SNPs for individuals who are dually eligible for Medicare and Medicaid (D–SNPs) are the most popular type. In 2024, 63 percent of SNPs were D–SNPs, and they enrolled 88 percent of all SNP enrollees. The number of SNPs for individuals who have certain chronic conditions continued to grow slightly, reaching 310 in 2024; these SNPs enroll 10 percent of SNP enrollees. The number of SNPs for institutionalized beneficiaries decreased slightly to 173 in 2024 and continued to enroll 2 percent of all SNP enrollees.

> Compared with PDPs and MA–PDs, SNPs are much more likely to offer a defined standard benefit, with nearly two-thirds of SNPs now offering such coverage. In 2024, these plans enrolled 81 percent of SNP beneficiaries. There was a continued decline in the number of SNPs providing enhanced coverage in 2024, and enrollment in such plans fell to 19 percent of all SNP enrollees.

> Dually eligible beneficiaries automatically receive Part D's low-income subsidy, which means that most recipients pay nominal copayments while the subsidy pays the remainder of their plan's cost sharing. Thus, D–SNPs more frequently use Part D's defined standard benefit design and are less likely to have some formulary tiers that are not subject to a deductible.

Chart 10-14 Change in average Part D premiums, 2015–2024

	2015	2023	2024	Cumulative change in weighted average premium, 2015–2024
Base beneficiary premium	33.13	32.74	34.70	1.57
All plans	$30	$26	$27	–$3
Basic plans	26	35	41	15
Enhanced plans				
Basic benefits	27	13	14	–13
Supplemental benefits	6	9	7	1
Total premium	33	22	21	–12
All basic coverage	27	19	22	–7
PDPs	37	41	43	6
Basic plans	28	36	44	16
Enhanced plans				
Basic benefits	39	19	23	–16
Supplemental benefits	9	25	19	10
Total premium	48	44	42	–6
All basic coverage	33	26	31	–2
MA–PDs, including SNPs	18	15	15	–3
Basic plans	21	32	37	16
Enhanced plans				
Basic benefits	14	10	9	–5
Supplemental benefits	2	1	1	–1
Total premium	17	11	10	–7
All basic coverage	17	14	15	–2
Average MA–PD buy-down of basic premium	14	23	20	7
Average MA–PD buy-down of supplemental benefits	13	31	27	14

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNP (special needs plan). All calculations exclude employer-only groups and plans offered in U.S. territories. In addition, MA–PDs exclude Part B–only plans, demonstrations, and 1876 cost plans. The MA–PD data reflect the portion of Medicare Advantage plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage, as well as Part C rebate dollars that were used to offset Part D premium costs. The fact that average premiums for enhanced plans are lower than for basic plans could reflect several factors such as changes in enrollment among plan sponsors and differences in the average health status of plan enrollees. "All basic coverage" is a weighted average of the premiums for basic plans and the portion of premiums attributed to basic benefits in enhanced plans, for each respective plan type, or across all plan types in the case of the data presented under "all plans." Cumulative changes were calculated from unrounded data. Components may not sum to totals due to rounding. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of CMS landscape, plan report, enrollment data, and bid data.

> Part D enrollees can select between plans with basic or enhanced benefits (the latter combine basic and supplemental coverage). Medicare aims to subsidize 74.5 percent of the average cost of basic benefits; enrollees pay premiums for the remaining 25.5 percent and all of the cost of any supplemental benefits. (For more about how plan premiums are determined, see Part D *Payment Basics* at https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_PartD_FINAL_SEC.pdf.)

(Chart continued next page)

Chart 10-14 Change in average Part D premiums, 2015–2024 (continued)

> The overall average premium paid by enrollees for any type of Part D coverage increased slightly in 2024 from 2023, rounding up to $27 per month from less than $26 per month. Over the period from 2015 to 2024, year-to-year changes in average premiums have varied by type of benefit (premiums for basic plans have grown while premiums for enhanced plans have declined) and type of plan (PDP premium components have changed at slower rates than those for MA–PDs). The base beneficiary premium (BBP), a share of the nationwide average bid for basic Part D benefits, has fluctuated slightly over the years and is now 5 percent higher than it was in 2015, on a nominal basis. Beginning in 2024, a provision included in the Budget Reconciliation Act of 2022 limits the annual increase in the BBP to no more than 6 percent, and the Medicare program covers any cost beyond that limit through a higher subsidy; without this cap, the BBP would have been $39.35 per month in 2024. (For more information, see the Commission's 2024 March report to Congress at https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch11_MedPAC_Report_To_Congress_SEC.pdf.)

> Across all basic plans and the basic portion of enhanced plans, the average premium for basic benefits fell from $27 in 2015 to $22 per month in 2024, a cumulative decline of 19 percent (a decrease of $7). This decline occurred despite very rapid growth in spending for Part D's catastrophic phase of the benefit (data not shown). In the catastrophic phase, Medicare subsidizes 80 percent of enrollees' drug spending. (For more information about Medicare's Part D spending, see Chapter 11 of the Commission's March 2024 report to the Congress.)

> Between 2015 and 2024, the average premium for a basic plan in a PDP increased by nearly $16, though half of that increase occurred in the past year alone. The average enrollee premium for enhanced plans offered by PDPs, by contrast, declined from $44 in 2023 to $42 in 2024. Of the $42 average premium in 2023 among enhanced PDPs, $19 was for basic benefits and $23 was for supplemental benefits. For the first time in the past decade, the portion of enhanced premiums attributable to supplemental benefits declined in 2024 and the portion for basic benefits grew.

> From 2015 to 2024, the average premium for a basic plan in an MA–PD increased by $16 (or 77 percent), from $21 in 2015 to $37 per month in 2024. Most MA–PD enrollees, however, are in enhanced plans, where the average premium is down to $10 in 2024, a decrease of $7 since 2015. MA–PD sponsors typically use a portion of Medicare's Part C (Medicare Advantage) payments to "buy down" the premiums that plan enrollees would otherwise have to pay for Part D basic premiums and supplemental benefits. Because of those Part C payment "rebates," in 2024, MA–PD enrollees avoided having to pay $20 per month in basic premiums and an additional $27 per month for supplemental coverage, on average.

Chart 10-15 Part D benchmarks for LIS premiums and number of qualifying PDPs, by region

Region	State(s)	2015		2024		Cumulative change, 2015–2024	
		Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs
1	ME, NH	$30	9	$36	4	$6	–5
2	CT, MA, RI, VT	30	5	44	3	14	–2
3	NY	37	8	49	2	12	–6
4	NJ	38	10	46	2	8	–8
5	DC, DE, MD	31	10	41	4	10	–6
6	PA, WV	34	9	40	5	6	–4
7	VA	29	9	38	5	9	–4
8	NC	29	8	47	3	18	–5
9	SC	29	7	46	3	17	–4
10	GA	26	8	44	3	18	–5
11	FL	26	4	38	2	12	–2
12	AL, TN	30	12	41	5	11	–7
13	MI	31	10	36	5	5	–5
14	OH	29	8	41	2	12	–6
15	IN, KY	32	10	42	3	10	–7
16	WI	35	8	48	7	13	–1
17	IL	28	10	33	2	5	–8
18	MO	28	6	44	2	16	–4
19	AR	25	6	36	4	11	–2
20	MS	29	9	40	4	11	–5
21	LA	31	11	46	6	15	–5
22	TX	27	10	28	2	1	–8
23	OK	30	10	42	4	12	–6
24	KS	30	7	43	4	13	–3
25	IA, MN, MT, ND, NE, SD, WY	30	5	42	5	12	0
26	NM	21	7	36	5	15	–2
27	CO	29	7	47	4	18	–3
28	AZ	33	12	43	4	10	–8
29	NV	24	4	32	2	8	–2
30	OR, WA	34	10	41	4	7	–6
31	ID, UT	40	12	44	5	4	–7
32	CA	29	6	41	3	12	–3
33	HI	28	9	41	4	13	–5
34	AK	33	7	39	4	6	–3

Note: LIS (low-income subsidy), PDP (prescription drug plan). All calculations exclude plans offered in U.S. territories. Cumulative changes calculated from unrounded data.

Source: MedPAC analysis of CMS benchmark amounts and plan report data.

(Chart continued next page)

Chart 10-15 Part D benchmarks for LIS premiums and number of qualifying PDPs, by region (continued)

> Part D's LIS covers most premiums and cost sharing for enrollees with low incomes and assets. The LIS's coverage of premiums has a dollar limit, known as the benchmark, that encourages beneficiaries to enroll in lower-cost PDPs. Beneficiaries who enroll in plans with premiums that are less than the benchmark do not pay a premium; those who enroll in plans with higher premiums pay the difference. The PDPs for which LIS beneficiaries do not pay a premium are known as benchmark plans. When LIS beneficiaries do not select a PDP, Medicare automatically enrolls them in benchmark plans.

> The LIS benchmark equals the average premium for basic coverage in a region. CMS calculates it using a weighted average of both PDP and MA–PD premiums. For plans that offer enhanced coverage, CMS uses the portion of the plan's premium that reflects the cost of basic coverage only. For MA–PDs, CMS uses the amount of the premium for basic coverage before the plan sponsor has used any Part C (Medicare Advantage) rebates to reduce or eliminate the premium. The weight for each plan equals its share of LIS enrollment. CMS calculates separate benchmarks for each Part D region and updates them annually.

> In 2024, the lowest benchmark premium was $28, in Region 22 (Texas), for the fifth year in a row. Region 3 (New York) had the highest benchmark premium in 2024 at $49 per month.

> The average benchmark premium across regions (not weighted by numbers of enrollees) has risen slowly over the years, from $30 per month in 2015 to $41 in 2024 (on a nominal basis), an increase of 36 percent over 10 years (data not shown). This change contrasts with the average overall premium across all plans, weighted by enrollment, which decreased by 10 percent over the same period (see Chart 10-14).

> In 2015, the average number of benchmark plans in a region was eight; by 2024, that figure had dropped to four, a decline of 50 percent (data not shown). The number of benchmark plans has declined in every region over the past decade except Region 25 (Iowa, Minnesota, Montana, North Dakota, Nebraska, South Dakota, and Wyoming), which has the same number of plans (five) in 2024 as it did in 2015. The maximum number of benchmark plans in any region in 2024 is 7, compared with 12 in 2015.

Chart 10-16 In 2024, enrollees typically pay $0 for generic drugs listed on the lowest tier

	Benchmark PDP enrollees	PDP enrollees	MA–PD enrollees
5-tier formulary structure* (in percent)	100%	100%	99%
Drugs on formulary as percentage of all Part D drugs**	68%	73%	75%
Median cost-sharing amounts			
Tier 1: Generic drugs	$0	$0	$0
Tier 2: Other generic drugs	$5	$5	$5
Tier 3: Preferred brand-name drugs	21%	22%	$47
Tier 4: Nonpreferred drugs	41%	48%	$100
Tier 5: Specialty-tier drugs	25%	25%	33%
Drugs with utilization management requirement (in percent)			
Prior authorization	32%	32%	28%
Step therapy	0	0	1
Quantity limits	39	42	44
Any utilization management	50	54	55

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Figures exclude employer-only groups, plans under CMS sanction (or terminated plans), and plans offered in U.S. territories. In addition, MA–PDs in this table exclude demonstration programs, special needs plans, and 1876 cost plans. "Prior authorization" means that the enrollee must get preapproval from the plan before coverage. "Step therapy" refers to a requirement that the enrollee try specified drugs before being prescribed other drugs in the same therapeutic category. "Quantity limits" means that plans limit the number of doses of a drug available to the enrollee in a given time period.
*Includes formularies with an additional (sixth) tier for certain types of drugs (e.g., vaccines).
**Number of all Part D drugs is based on the counts of unique chemical entities listed on CMS's formulary reference file for the 2024 benefit year.

Source: MedPAC analysis of formularies submitted to CMS.

> In 2024, most Part D enrollees chose plans that have a five-tier structure: two generic, one preferred brand-name tier, one nonpreferred drug tier (which may include both brand-name and generic drugs), plus a specialty tier.

> The number of drugs listed on a plan's formulary affects a beneficiary's access to medications. In 2024, on average, PDP enrollees have access to 73 percent of all Part D–covered products, compared with 75 percent among MA–PD enrollees. That share was lower (68 percent) for beneficiaries enrolled in benchmark plans—basic PDPs for which enrollees with the low-income subsidy do not have to pay a premium.

> The median copay in 2024 is $0 for a generic drug on a lower tier and $5 for other generic drugs. Benchmark plans have formularies that are similar to other PDPs, with somewhat lower cost-sharing amounts for brand-name drugs. For 2024, most PDPs are using coinsurance (a percentage of the total payment) for preferred brand-name drugs and nonpreferred drug tiers, while most MA–PDs continue to use copayments (a fixed dollar amount per prescription). Both PDPs and MA–PDs use coinsurance (with median coinsurance rates of 25 percent and 33 percent, respectively) for specialty-tier drugs.

> Plans' processes for nonformulary exceptions and use of utilization management tools—prior authorization (preapproval for coverage), quantity limits (limitations on the number of doses of a particular drug covered in a given period), and step therapy requirements (enrollees being required to try specified drugs before being prescribed other drugs in the same therapeutic category)—can affect access to certain drugs. In 2024, both PDPs and MA–PDs typically use some form of utilization management for more than half of drugs listed on a plan's formulary.

Chart 10-17 Components of Part D spending growth, 2014–2022

	2014	2022	Average annual growth 2014–2022
Total gross spending (in billions)	$121.4	$240.5	8.9%
High-cost beneficiaries	64.6	153.2	11.4%
Lower-cost beneficiaries	56.7	87.3	5.5%
Number of beneficiaries using a Part D drug (in millions)	37.1	49.2	3.6%
High-cost beneficiaries	3.4	4.3	2.8%
Lower-cost beneficiaries	33.7	44.9	3.6%
Amount per beneficiary who used Part D drugs			
Gross drug spending per year	$3,267	$4,891	5.2%
Average price per 30-day prescription	$60	$86	4.5%
Number of 30-day prescriptions	54.5	57.2	0.6%
Amount per high-cost beneficiary who used Part D drugs			
Gross drug spending per year	$18,845	$35,856	8.4%
Average price per 30-day prescription	$166	$310	8.2%
Number of 30-day prescriptions per month	9.6	9.8	0.2%
Amount per lower-cost beneficiary who used Part D drugs			
Gross drug spending per year	$1,683	$1,944	1.8%
Average price per 30-day prescription	$35	$38	1.0%
Number of 30-day prescriptions per month	4.2	4.5	0.7%

Note: "High-cost beneficiaries" refers to individuals who incur spending high enough to reach the catastrophic phase of the benefit. "Gross spending" reflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Changes in the average price per prescription reflect both price inflation and changes in the mix of drugs used, including the adoption of new, higher-priced drugs. Dollar amounts are nominal figures, not adjusted for inflation. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Part D prescription drug event data and common Medicare environment file from CMS.

> Between 2014 and 2022, gross spending on drugs under the Part D program, on a nominal basis, grew by an annual average rate of 8.9 percent. The annual growth in spending was considerably higher (11.4 percent) among high-cost beneficiaries (individuals who incurred spending high enough to reach the catastrophic phase of the benefit) than among lower-cost beneficiaries (5.5 percent).

> During the 2014 through 2022 period, the number of high-cost beneficiaries grew more slowly (2.8 percent) compared with lower-cost beneficiaries (3.6 percent). The slower growth in the number of high-cost beneficiaries reflects the 25 percent increase in the out-of-pocket (OOP) threshold between 2019 and 2020. (For more information about the impact of the increase in the OOP threshold in 2020, see Chapter 13 of the Commission's March 2022 report to the Congress at https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch13_SEC.pdf.)

> The average price per 30-day prescription covered under Part D rose from $60 in 2014 to $86 in 2022. Overall, growth in price per prescription accounted for most (4.5 percentage points) of the 5.2 percent average annual growth in spending per beneficiary. Growth in prices per prescription reflects increases in the prices of existing drugs and changes in the mix of drugs.

> The average annual growth rate in overall spending per beneficiary reflects two distinct patterns of price and spending growth—one for high-cost beneficiaries and another for lower-cost beneficiaries. Among high-cost beneficiaries, annual growth in prices (8.2 percent) accounted for nearly all of the spending growth (8.4 percent) during this period. In contrast, among lower-cost beneficiaries, the increase in the number of prescriptions (0.7 percent) accounted for about 40 percent of the spending growth (1.8 percent).

Chart 10-18 Part D spending and use per enrollee, 2022

	Part D	Plan type		LIS status	
		PDP	MA–PD	LIS	Non-LIS
Total gross spending (billions)*	$240.5	$118.8	$121.7	$114.1	$126.4
Above OOP threshold (billions)	103.5	52.5	51.0	60.1	43.4
Share above OOP threshold	*43%*	*44%*	*42%*	*53%*	*34%*
Total number of prescriptions (billions)	2.8	1.3	1.5	0.9	1.9
Average spending per prescription	$86	$93	$80	$121	$68
Share of beneficiaries with no drug use	6%	6%	6%	8%	6%
Per enrollee per month					
Total spending	$398	$423	$377	$697	$287
OOP spending	31	40	23	4	40
Manufacturer gap discount	27	33	22	N/A	37
Plan liability	264	273	256	476	185
Low-income cost-sharing subsidy	58	54	62	215	N/A
Number of prescriptions	4.7	4.6	4.7	5.8	4.2

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy), OOP (out-of-pocket), N/A (not applicable). "Total gross spending" reflects payments from all payers, including beneficiaries (cost sharing) but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. "Plan liability" includes plan payments for drugs covered by both basic and supplemental (enhanced) benefits. "Number of prescriptions" is standardized to a 30-day supply. Components may not sum to totals due to rounding.
*"Total gross spending" includes $16.4 billion in manufacturer discounts for brand-name drugs and biologics filled by non-LIS enrollees during the coverage gap.

Source: MedPAC analysis of Medicare Part D prescription drug event data and common Medicare environment file from CMS.

> In 2022, gross spending on drugs for the Part D program totaled $240.5 billion, with just under half ($118.8 billion) accounted for by Medicare beneficiaries enrolled in stand-alone PDPs. Part D enrollees receiving the LIS accounted for about 47 percent ($114.1 billion) of the total.

> Overall, 43 percent of gross spending was incurred after a beneficiary reached the annual OOP threshold ($7,050 in 2021). That share was higher among those who received the LIS (53 percent) compared with other enrollees (34 percent).

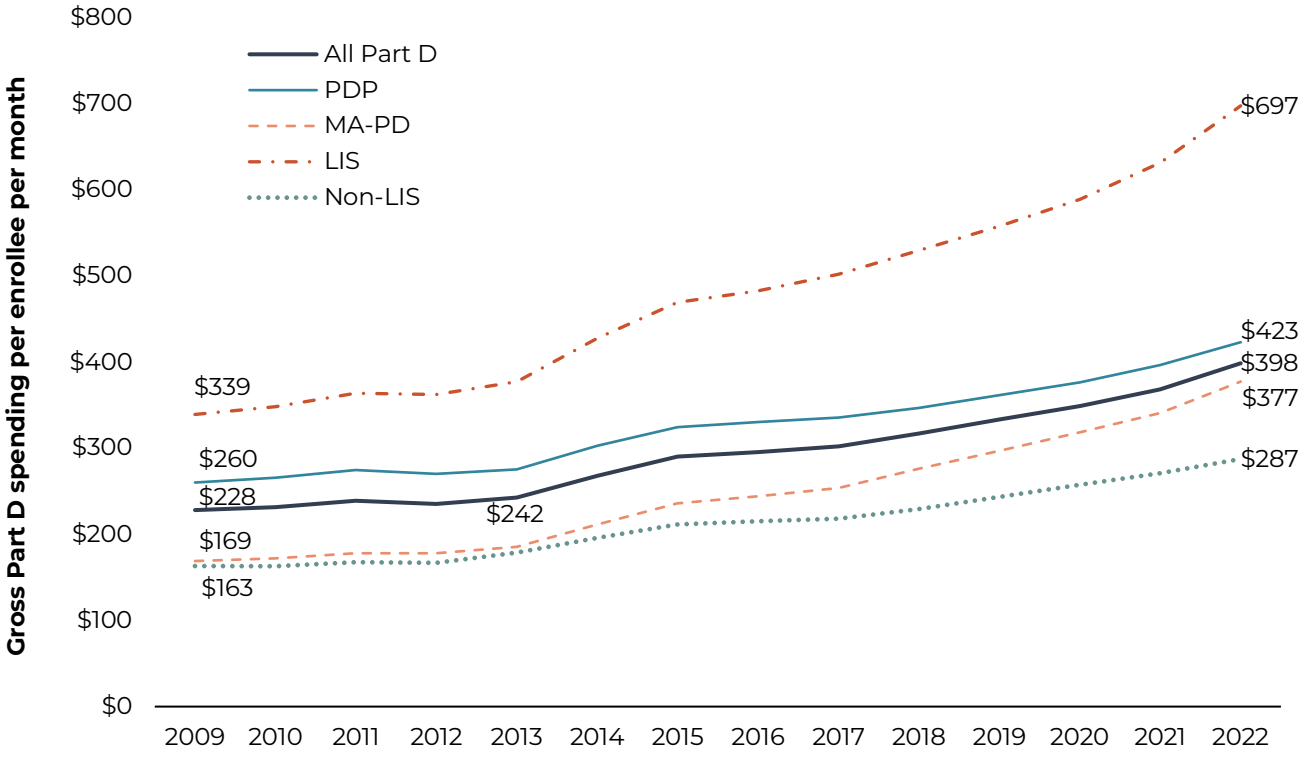
> The number of prescriptions filled by Part D enrollees totaled 2.8 billion, with 46 percent (1.28 billion) accounted for by PDP enrollees. The 27 percent of enrollees who received the LIS accounted for about 34 percent (945 million) of the total number of prescriptions filled. Overall, 6 percent of Part D enrollees did not fill any prescriptions during the year.

> In 2022, Part D enrollees filled 4.7 prescriptions at $398 per month on average, an increase from $368 per month (for 4.6 prescriptions) in 2021 (2021 data not shown). The average monthly plan liability for PDP enrollees ($273) was higher than that of MA–PD enrollees ($256). The average monthly OOP spending for enrollees was also higher in PDPs ($40) than in MA–PDs ($23). Medicare's average monthly low-income cost-sharing subsidy was higher for MA–PD enrollees ($62) than for PDP enrollees ($54).

> Average monthly spending per LIS enrollee ($697) was more than double that of a non-LIS enrollee ($287), and the average number of prescriptions filled per month by an LIS enrollee was 5.8 compared with 4.2 for a non-LIS enrollee. LIS enrollees had much lower monthly OOP spending, on average, than non-LIS enrollees ($4 vs. $40, respectively). Part D's LIS pays for most of the cost sharing for LIS enrollees, averaging $215 per month in 2022.

> Manufacturer discounts for brand-name drugs filled by non-LIS enrollees while they were in the coverage gap accounted for, on average, 6.8 percent of the total gross spending, or nearly 13 percent of the average gross spending by non-LIS enrollees.

Chart 10-19 Trends in Part D spending and use per enrollee per month, 2009–2022



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). "Spending" (gross) reflects payments from all payers, including beneficiaries (cost sharing) but does not include rebates and fees from manufacturers and pharmacies that are not reflected in prices at the pharmacies. Dollar amounts are nominal figures, not adjusted for inflation.

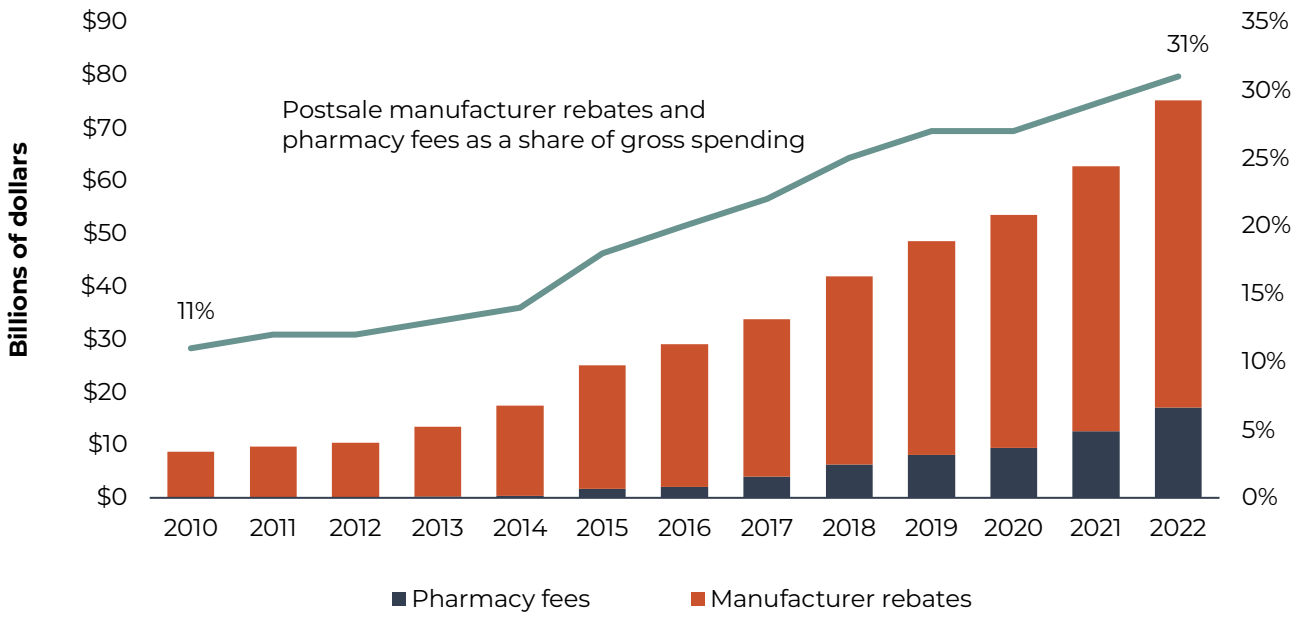
Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

> Between 2009 and 2022, average per capita spending per month for Part D–covered drugs grew from $228 to $398 on a nominal basis, an average growth rate of 4.4 percent annually, or about 75 percent cumulatively. The rate of growth in average per capita spending more than doubled after 2013, in part reflecting the introduction of new hepatitis C treatments in 2014 and other new expensive therapies in subsequent years.

> Between 2009 and 2022, monthly per capita spending for LIS enrollees grew faster than that for non-LIS enrollees, increasing from $339 to $697 (cumulative growth of over 105 percent) compared with an increase from $163 to $287 for non-LIS enrollees (cumulative growth of about 76 percent). The number of prescriptions filled by both LIS and non-LIS enrollees grew by about 16 percent and 17 percent, respectively, during this period (data not shown).

> The growth in monthly per capita drug spending among MA–PD enrollees exceeded that of PDP enrollees during the 2009 to 2022 period (annual average growth of 6.4 percent and 3.8 percent, respectively). The average per capita spending for MA–PD enrollees continued to be lower than that of PDP enrollees (by $46 per month in 2022); however, that difference has been declining since 2014.

Chart 10-20 Postsale manufacturer rebates and pharmacy fees expanded rapidly in Part D, 2010–2022



Note: CMS uses the term "direct and indirect remuneration" (DIR) to refer to all postsale rebates and fees that plan sponsors and their pharmacy benefit managers negotiate with drug manufacturers and pharmacies that lower the prices of drugs covered under Part D. "Gross spending" includes enrollee cost sharing and plan (and any other) payments to the pharmacy at the point of sale for both brand and generic prescriptions. Pharmacy fees consist of net postsale payments from pharmacies to plan sponsors and their pharmacy benefit managers.

Source: MedPAC analysis of prescription drug event data and DIR data.

> The final amounts that Part D plans pay for their enrollees' prescriptions are often lower than prices at the pharmacy because plan sponsors and their pharmacy benefit managers (PBMs) negotiate postsale rebates and fees from drug manufacturers and pharmacies; CMS refers to those amounts as direct and indirect remuneration (DIR). Medicare keeps a portion of DIR to offset some of its reinsurance subsidies to plans. While large rebates help to constrain premium increases, using rebates primarily to lower premiums also means that beneficiaries who use such drugs (or the Medicare program, in the case of Part D's low-income subsidy (LIS) enrollees) sometimes pay cost sharing that is a significant portion of—and may even be higher than—the drug's cost to the plan. For enrollees without the LIS, high cost sharing can affect whether they fill their prescriptions.

> Between 2010 and 2022, DIR ballooned from $8.6 billion to $75.3 billion. With manufacturer rebates accounting for roughly 24 percent of gross Part D spending in 2022 and pharmacy DIR another 7 percent, total DIR equaled about 31 percent, up from 11 percent in 2010.

> Multiple factors have contributed to growth in manufacturer rebates. For certain classes of drugs that lack of generic competition but have considerable rivalry among competing brands, manufacturers have chosen to raise gross prices and compete using postsale rebates. Due to Part D's unusual benefit design and its emphasis on premium competition, sponsors have had incentives to try to maximize rebates and keep premiums low. Vertically integrated insurers with their own PBMs and specialty and mail-order pharmacies have large market shares of enrollment and dispensing, which tend to provide those plan sponsors with greater bargaining leverage for postsale price concessions from both manufacturers and pharmacies.

Chart 10-21 Incidence of Part D spending by type of product, 2022

			Share of gross spending paid					
			Medicare (at risk)			Pharmaceutical manufacturers		
	Total gross spending	Part D plans (at risk)	Reinsurance	Low-income subsidy	Beneficiary cost sharing	Coverage gap discount	Postsale rebates and discounts	Pharmacy fees
Brand-name drugs	$148.6	13%	26%	14%	6%	8%	27%	7%
Biologics	49.6	6	30	12	4	8	33	7
Generic drugs	40.2	38	11	21	20	N/A	<1	9
All products covered under Part D*	240.5	15	24	15	8	7	24	7

Note: "Total gross spending" reflects payment from all payers, including beneficiaries (through cost sharing) before accounting for postsale rebates, discounts, and fees from pharmacies and manufacturers. "Biologics" includes spending for insulins.
*Includes some products that could not be classified as one of the three drug types shown (e.g., nondrug products such as syringes used for insulins).

Source: MedPAC analysis of prescription drug event data and direct and indirect remuneration data.

> In 2022, just over 80 percent of total gross Part D spending was for brand-name drugs ($148.6 billion, or 62 percent) or biologics ($49.6 billion, or 21 percent). Generic drugs accounted for about 17 percent ($40.2 billion) of gross spending.

> The incidence of Part D spending varied by drug type, with Medicare's reinsurance accounting for a larger share of spending for brand-name drugs and biologics compared with generic drugs. For example, plans were at risk for 6 percent of spending on biologics (including biosimilars), while Medicare covered 30 percent via Part D's reinsurance. In contrast, for generic drugs, Medicare's reinsurance accounted for 11 percent of gross spending compared with 38 percent for plans. Medicare's low-income subsidy, on average, accounted for a higher share of gross spending for generic drugs (21 percent) compared with brand-name drugs (14 percent) or biologics (12 percent).

> On average, beneficiaries' cost sharing accounted for 20 percent of gross spending for generic drugs compared with 6 percent for brand-name drugs and 4 percent for biologics. Cost sharing as a share of gross spending tends to be lower for brand-name drugs and biologics because these products are more likely to be filled in the catastrophic phase of the benefit, where a lower coinsurance rate applies (5 percent of gross prices at the pharmacy before January 1, 2024) than for other phases of the benefit (typically averaging 25 percent of gross prices at the pharmacy). (See Chart 10-10 for changes in benefit parameters.) However, because prices of brand-name drugs and biologics are much higher than those of generic drugs, the lower coinsurance rate could still result in substantially higher cost-sharing liability than for generic drugs.

> Coverage-gap discounts and postsale rebates and fees paid by pharmaceutical manufacturers accounted for 7 percent and 24 percent of gross spending, respectively, across all Part D–covered products. Nearly all of those payments were for brand-name drugs and biologics. Pharmacy fees accounted for the remaining 7 percent of gross spending. On average, pharmacy fees accounted for a higher share of gross spending for generic drugs (9 percent) than for brand-name drugs and biologics (7 percent).

Chart 10-22 Top 15 therapeutic classes of drugs covered under Part D, by spending, 2022

	Gross spending		Negotiated rebates as a share of gross spending	Coverage-gap discount (billions)
	Billions	Percent		
Diabetic therapy	$46.9	19.5%	≥50%	$6.2
Antineoplastics	32.1	13.4	<10%	0.9
Anticoagulants	21.7	9.0	40% to 49%	3.5
Asthma/COPD therapy agents	16.6	6.9	40% to 49%	1.4
Disease-modifying anti-rheumatoid drugs	11.9	4.9	20% to 29%	0.4
Antipsychotics (neuroleptics)	8.4	3.5	10% to 19%	0.1
Antiretrovirals	7.9	3.3	<10%	0.2
Antihypertensive therapy agents	7.6	3.2	10% to 19%	0.5
Ophthalmic agents	5.9	2.5	30% to 39%	0.4
Antihyperlipidemics	5.4	2.3	10% to 19%	0.3
Dermatological (antipsoriatics)	5.2	2.2	10% to 19%	0.1
Anticonvulsants	4.1	1.7	<10%	0.1
Multiple sclerosis agents	3.9	1.6	10% to 19%	0.1
Antidepressants	3.0	1.3	<10%	0.1
Urinary incontinence treatment agents	3.0	1.3	40% to 49%	0.3
Subtotal, top 15 drug classes	183.9	76.5	28%	14.6
Total, all drug classes	240.5	100.0	24%	16.4

Note: COPD (chronic obstructive pulmonary disease). "Gross spending" reflects payments from all payers, including beneficiaries (cost sharing) for both brand and generic drugs but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Part D prescription drug event and direct and indirect remuneration data from CMS.

> In 2022, the top 15 therapeutic classes by spending accounted for nearly 77 percent of the $240.5 billion spent on prescription drugs covered by Part D plans.

> In 2022, total manufacturer rebates as a share of gross spending ranged from less than 10 percent to more than 50 percent. Some of that variation reflects the degree of competition within each therapeutic class. Overall, rebates for the top 15 classes averaged 28 percent of gross spending, higher than the average of 24 percent for all Part D spending. Rebates were the highest (greater than or equal to 50 percent) for diabetic therapies, which accounted for more than 19 percent of total gross spending in Part D.

> In addition to negotiated rebates, manufacturers must provide discounts for brand-name drugs and biologics filled by non-LIS enrollees when they fill prescriptions in the coverage-gap phase of the benefit. In 2022, these top 15 classes accounted for 89 percent ($14.6 billion) of all coverage-gap discounts. Diabetic therapies alone accounted for 38 percent of all coverage-gap discounts.

Chart 10-23 Despite high generic use, brand-name drugs accounted for the majority of spending in the top 15 therapeutic classes by spending, 2022

	Prescriptions*		Generic dispensing rate	Brand share of gross spending	LIS share of prescriptions
	Millions	Percent			
Diabetic therapy	202.5	7.2%	60%	98%	31%
Antineoplastics	15.5	0.6	86	94	22
Anticoagulants	56.3	2.0	22	99	27
Asthma/COPD therapy agents	84.1	3.0	56	91	43
Disease modifying anti-rheumatoid drugs	2.9	0.1	34	100	49
Antipsychotics (neuroleptics)	35.0	1.2	90	81	69
Antiretrovirals	3.1	0.1	18	98	68
Antihypertensive therapy agents	286.4	10.2	98	67	18
Ophthalmic agents	61.7	2.2	82	77	26
Antihyperlipidemics	327.7	11.7	98	46	18
Dermatological (antipsoriatics)	0.8	<0.1	28	99	54
Anticonvulsants	107.1	3.8	98	44	45
Multiple sclerosis agents	0.7	<0.1	37	91	58
Antidepressants	182.4	6.5	99	26	32
Urinary incontinence treatment agents	20.5	0.7	71	84	36
Subtotal, top 15 drug classes	1,386.9	49.4	85	90	28
Total, all drug classes	2,809.6	100.0	90	82	27

Note: COPD (chronic obstructive pulmonary disease), LIS (low-income subsidy). "Gross spending" reflects payments from all payers, including beneficiaries (cost sharing) for both brand and generic drugs but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System. Components may not sum to totals due to rounding.
*Prescriptions are standardized to a 30-day supply.

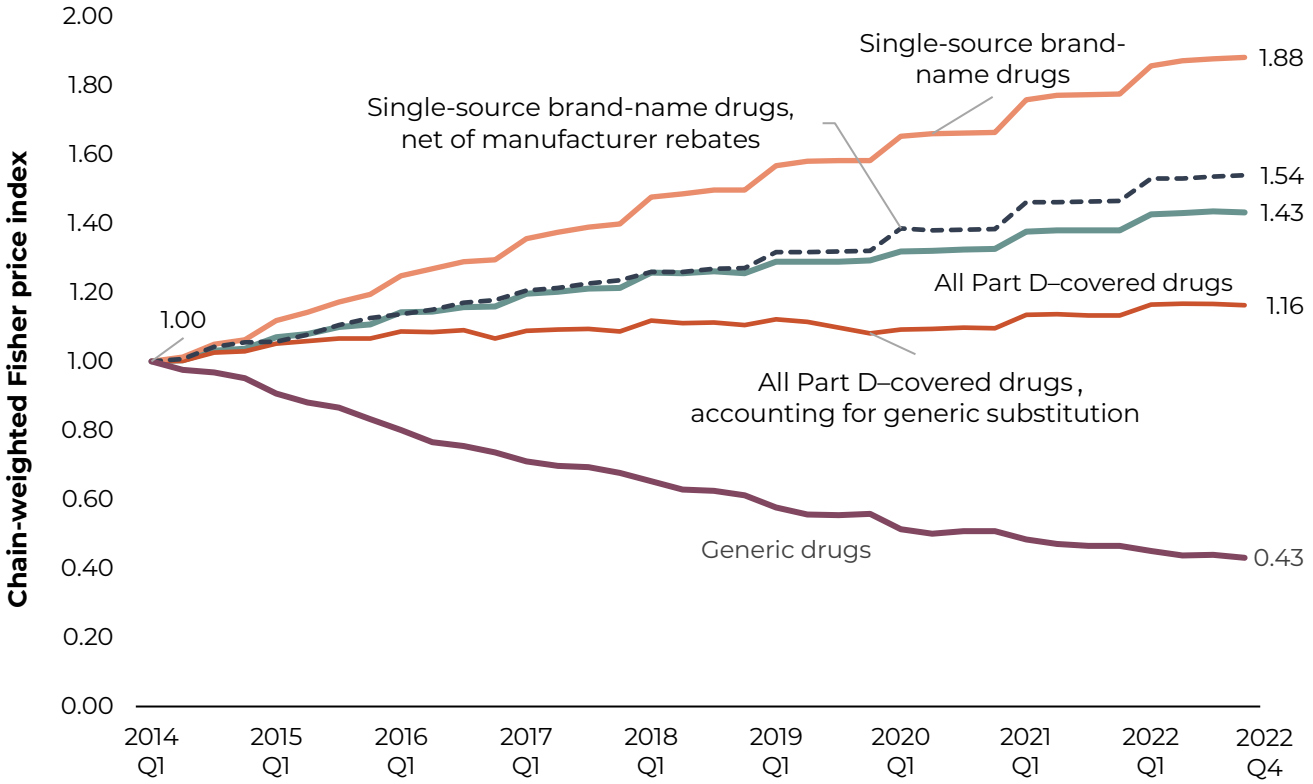
Source: MedPAC analysis of Medicare Part D prescription drug event and direct and indirect remuneration data from CMS.

> Prescriptions filled in the top 15 therapeutic classes by spending in 2022 (from Chart 10-22) totaled 1.39 billion prescriptions, accounting for nearly half of all prescriptions filled under Part D. While 85 percent of these prescriptions were for generic drugs, brand-name products accounted for 90 percent of the gross spending for these products in 2022.

> In 2022, LIS beneficiaries filled 28 percent of total prescriptions for products in these 15 classes, roughly equal to their share of prescriptions among all Part D drugs (27 percent). Nevertheless, LIS enrollees accounted for a disproportionate share of prescriptions in a few classes such as antipsychotics (69 percent) and antiretrovirals (68 percent).

> Even when generic drugs are widely used by Part D beneficiaries, for some therapeutic classes, brand-name drugs may still account for the vast majority of spending. For example, in 2022, generic drugs accounted for 86 percent of prescriptions for antineoplastics, but brand-name drugs accounted for 94 percent of gross spending for that class.

Chart 10-24 Postlaunch price growth for Part D–covered drugs, 2014–2022



Note: Q1 (first quarter), Q4 (fourth quarter). Unless otherwise noted, Part D indexes reflect total amounts paid to pharmacies and do not reflect retrospective rebates or discounts from manufacturers and pharmacies, with the exception of the index for single-source brand-name drugs, net of manufacturer rebates. The price indexes are Fisher price indexes and reflect percentage changes in the average price of Part D–covered drugs measured at the product level in nominal terms, not adjusted for inflation. A product is defined at the individual national drug code (NDC) level with the exception of the index accounting for generic substitution, which groups NDCs with the same active ingredient(s), dosage form, route of administration, and strength. Indexes do not reflect the effects of launch prices of new products or changes in average price levels resulting from a shift in utilization across products. The price index is different from the change in the average price of drugs covered under Part D (Chart 10-17), which reflects changes in the prices of existing products, the effects of launch prices of new products, and shifts in utilization across products.

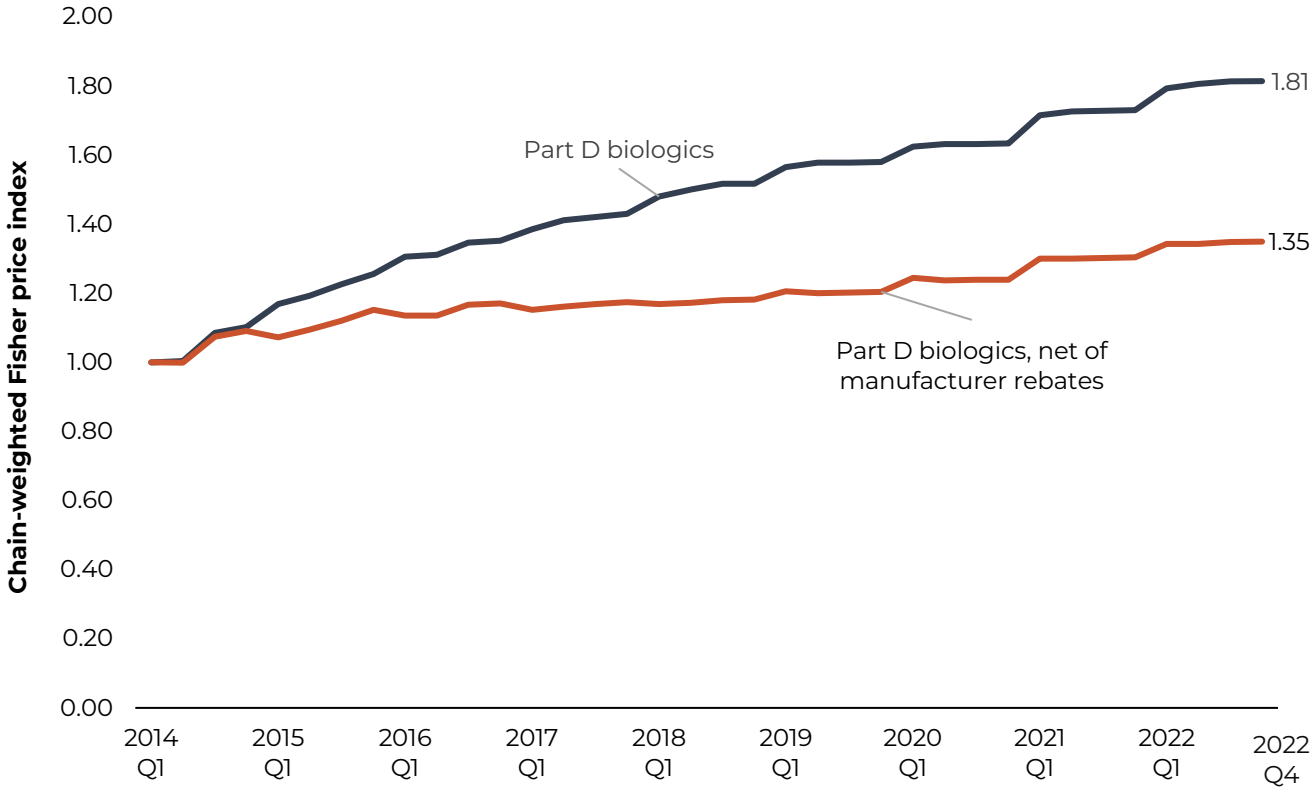
Source: Acumen LLC analysis for MedPAC.

> Measured by individual national drug codes, prices of drugs and biologics covered under Part D rose 43 percent cumulatively between 2014 and 2022 on a nominal basis (an index of 1.43). (Prices reflect total amounts paid to pharmacies and do not reflect retrospective rebates or discounts from manufacturers and pharmacies.)

> Overall, between 2014 and 2022, prices of generic drugs covered under Part D decreased to 43 percent of the average price observed at the beginning of 2014. As a result, when measured by a price index that takes generic substitution into account, Part D prices have remained relatively flat during this period, with cumulative increase in prices at the end of 2022 at 16 percent above the prices at the beginning of 2014 (an index of 1.16). New and increased generic competition for selected therapeutic classes, such as anticonvulsants, antineoplastics, and drugs for multiple sclerosis, played a key role in slowing the growth in overall Part D prices during this period.

> Between 2014 and 2022, prices for all single-source, brand-name drugs (drugs with no generic substitutes) grew by a cumulative 88 percent (an index value of 1.88), compared with 54 percent (an index value of 1.54) for prices net of manufacturer rebates.

Chart 10-25 Postlaunch price growth for biologics covered under Part D, 2014–2022



Note: Q1 (first quarter), Q4 (fourth quarter). The price indexes are Fisher price indexes and reflect percentage changes in the average price of Part D–covered biologic products measured at the product level in nominal terms, not adjusted for inflation. A product is defined at the individual national drug code (NDC) level with the exception of the index accounting for substitution with biosimilar products, which groups NDCs with the same active ingredient(s), dosage form, route of administration, and strength. Indexes do not reflect the effects of launch prices of new products or changes in average price levels resulting from shift in utilization across products. Biologics include insulins.

Source: Acumen LLC analysis for MedPAC.

> Measured by individual national drug codes, prices of biologics (without retrospective rebates, fees, or discounts) covered under Part D rose 81 percent cumulatively between 2014 and 2022 on a nominal basis (an index of 1.81). This increase is similar to the growth in prices for all single-source drugs and biologics (88 percent, or an index value of 1.88). (See Chart 10-24 for index measuring prices of all single-source drugs and biologics.)

> In comparison, between 2014 and 2022, prices of biologics net of retrospective rebates and discounts from manufacturers grew by a cumulative 35 percent (an index value of 1.35). The effect of manufacturer rebates on the prices of biologics was greater than that for all single-source drugs and biologics, which grew by a cumulative 54 percent (an index value of 1.54) for prices net of manufacturer rebates. (See Chart 10-24 for index measuring prices of all single-source drugs (including biologics) net of manufacturer rebates.)

> The prices of biologics are highly influenced by the prices of insulins. In 2022, insulins accounted for about 30 percent of total gross spending on biologics. Insulins and other antidiabetic therapies had some of the highest rebates, totaling more than 50 percent of gross spending for therapies in that class (see Chart 10-22).

Chart 10-26 Part B and Part D spending on products with a biosimilar pipeline, 2022

Brand name	Earliest biosimilar launch date (expected)	Number of biosimilars: Approved	Number of biosimilars: In pipeline	2022: Part B spending on originator product (millions)	2022: Part D spending on originator product (millions)	2022: Total Part B and Part D spending on biosimilars (millions)
Products with an approved biosimilar on the market						
Neupogen[a]	2015	4	1–3	$14.6	$11.2	$82.3
Remicade	2016	5	1–3	440.4	102.6	650.0
Procrit/Epogen	2018	1	1–3	57.1	144.6	106.2
Neulasta	2018	6	1–3	342.8	70.4	309.2
Humalog[a]	2018	2	4–6	**	1,744.8	205.5
Humalog Mix (75/25)[a]	2019	1		**	322.9	13.0
Rituxan	2019	3	1–3	581.3	46.1	487.3
Avastin	2019	5	4–6	253.4	14.0	464.5
Herceptin	2019	5	1–3	155.8	6.4	235.1
Lantus[ab]	2020	4	4–6	–	3,707.1	731.8
Novolog[a]	2020	1	7+	–	2,370.4	78.5
Novolog Mix (50/50)[a]	2020	1	1–3	–	434.9	12.1
Lucentis[b]	2022	2	1–3	795.4	5.4	1.1
Tresiba[a]	2022	1		–	1,697.3	0.3
Humira[b]	2023	14	4–6	–	5,426.4	–
Subtotal		*55*		*2,640.9*	*16,104.3*	*3,377.0*
Products with a biosimilar approved but not yet on the market						
Enbrel	(2028)	2	1–3	0.3	2,655.1	–
Stelara[b]	(2025)	2	7+	74.3	2,339.1	–
Actemra		2	1–3	344.4	254.2	–
Tysabri		1	1–3	206.5	45.8	–
Prolia/Xgeva[b]		2	7+	2,006.3	585.3	–
Subtotal		9		*2,631.8*	*5,879.4*	
Products with a biosimilar in development but none approved						
Toujeo			1–3	–	861.8	–
Soliris			1–3	619.1	266.3	–
Cimzia			1–3	431.7	251.1	–
Simponi			1–3	374.6	193.7	–
Xolair			4–6	420.5	208.2	–
Eylea			7+	3,544.0	68.3	–
Perjeta			1–3	318.1	9.5	
Opdivo			1–3	1,852.4	43.8	
Keytruda			1–3	4,943.9	91.1	
Entyvio			1–3	675.4	76.0	
Cosentyx			1–3	151.8	1,029.7	
Subtotal				*13,331.6*	*3,099.7*	–
Total		64	96	18,604.3	25,083.4	3,377.0

(Chart continued next page)

Chart 10-26 Part B and Part D spending on products with a biosimilar pipeline (continued)

Note: Products in this analysis include those approved or known to be in development as of April 2024.
[a]Authorized generics (AG), unbranded products, and follow-on products are included as biosimilars for purposes of this analysis. For a list of biosimilars currently on the market and available under Part B, refer to Chart 10-6 Others included in this analysis are, for Avastin: Avzivi; for Enbrel: Erelzi, Eticovo; for Humalog: Admelog, insulin lispro AG; for Humalog Mix (75/25): insulin lispro-protamine mix AG; for Humira: Abrilada (INT), Amjevita (2), Cyltezo (INT), Hadlima, Hadlima CF, Hulio, adalimumab-fkjp, Hyrimoz, adalimumab-adaz, Idacio, Simlandi (INT), Yuflyma, Yusimry; for Lantus: Basaglar, Semglee (INT), Rezvoglar, unbranded Lantus; for Novolog: insulin aspart AG; for Novolog Mix (50/50): insulin aspart protamine AG; for Remicade: Ixifi and infliximab AG; for Tresiba: unbranded Tresiba.
[b]At least one biosimilar for this reference product has been designated by the Food and Drug Administration as interchangeable (INT).
**Not able to distinguish spending on Humalog from other insulin lispro products in Part B.

Source: Part B spending based on MedPAC and Acumen LLC analysis of Medicare claims data, Part D spending based on MedPAC analysis of CMS Drug Spending Dashboard, Food and Drug Administration Purple Book, and U.S. Biosimilar Report from Cencora.

> The first biosimilar product licensed under the Public Health Service Act was launched in the U.S. in 2015. As of April 2024, the Food and Drug Administration (FDA) had approved 64 biological products to compete with innovator biologics (including biosimilars, follow-on products, authorized generics, and unbranded versions of reference products). Also as of April 2024, another 96 biosimilars were in development.

> Given that generic dispensing rates have plateaued since 2017 at roughly 90 percent, it is likely that any significant savings on drug spending in the future will come from the successful launch and adoption of biosimilars rather than increased use of traditional generic drugs. This chart shows the level of spending on biological products for which biosimilars have entered or may soon enter the market and offer competition.

> In 2022, Medicare spent $18,745.2 million ($2,640.9 million in Part B and $16,104.3 million in Part D) on originator drugs for which biosimilars are now available; this total includes spending on Lucentis and Humira, though their biosimilars did not become available in the U.S. market until June 2022 and January 2023, respectively.

> Medicare spent another $2,631.8 million in Part B and $5,879.4 million in Part D on drugs for which the FDA has approved biosimilars but manufacturers have not yet launched their products on the market.

> Spending on products for which biosimilars are in development but none are yet approved equaled $16,431.3 million ($13,331.6 million in Part B and $3,099.7 million in Part D). In 2022, these products combined accounted for 6 percent of all gross Medicare spending for separately payable drugs in Part B and Part D.

> In 2022, $3,377.0 million was spent on biosimilars; 63 percent ($2,141.5 million) of that spending (data not shown) occurred in Part B. With more biosimilars for top-selling Part D drugs launching recently (including Humira in 2023), this share is likely to shift somewhat; however, the current biosimilar pipeline still favors drugs predominantly covered under Part B.

SECTION

11

Other services

Dialysis
Hospice
Clinical laboratory

Chart 11-1 Number and capacity of freestanding and for-profit dialysis organizations increased, but growth rate was low between 2021 and 2022

	2022	Average annual percent change	
		2018–2021	2021–2022
Total number of:			
Dialysis facilities	7,865	2%	–0.2%
Hemodialysis stations	138,100	2	0.1
Mean number of hemodialysis stations per facility	18	0	0.3
	Share of total facilities		
Hospital based	5%	–1	–5
Freestanding	95	2	0.1
Urban	84	2	0.1
Rural, micropolitan	10	0.3	0
Rural, adjacent to urban	4	–0.3	–2
Rural, not adjacent to urban	2	–2	–2
Frontier	0.4	0	0
For profit	89	2	0.2
Nonprofit	11	–1	–2

Note: "Nonprofit" includes facilities designated as either nonprofit or government facilities. "Average annual percent change" is based on comparing 2018, 2021, and 2022 end-of-year files. Provider location reflects the county where the provider is located, in one of four categories (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. Frontier counties have six or fewer people per square mile. Components may not sum to totals due to rounding.

Source: Compiled by MedPAC from the institutional outpatient claims files and the Dialysis Compare files from CMS.

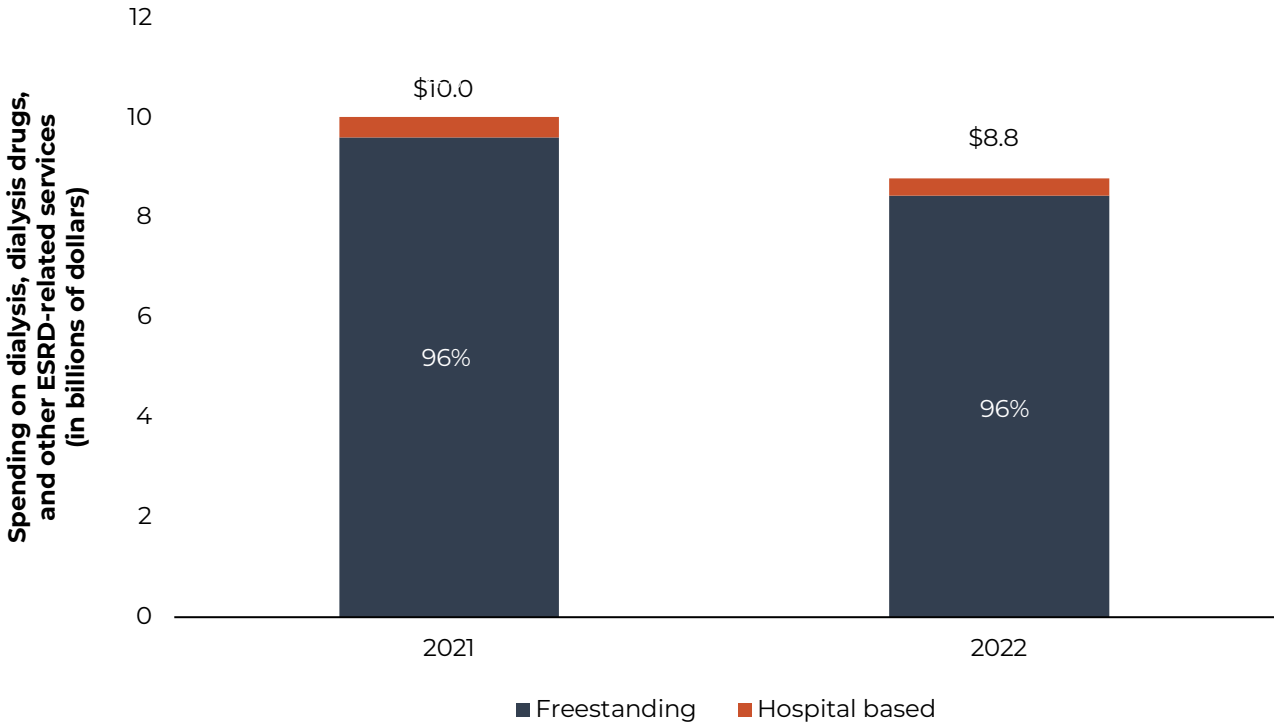
> Between 2018 and 2021, the number of facilities increased, on average, 2 percent per year, while between 2021 and 2022, the number of facilities declined by 0.2 percent. Facilities' capacity to provide care—as measured by hemodialysis treatment stations—grew more slowly between 2021 and 2022 compared with growth from 2018 through 2021 (0.1 percent per year vs. 2 percent per year, respectively).

> The recent decline in the total number of dialysis facilities may be attributable to factors such as (1) the decline in the rate of new end-stage renal disease (ESRD) cases and excess mortality of persons with ESRD due to the coronavirus pandemic; (2) the growing trend toward home dialysis; and (3) efforts by some dialysis providers to optimize their facilities' capacity utilization.

> The decline in rural capacity between 2021 and 2022 (data not shown) is also linked to facility size. Small dialysis facilities have been more likely to close, and rural facilities are, on average, smaller than urban facilities. The Commission's recommendation to replace the current low-volume payment adjustment and rural adjustment with a single low-volume and isolated adjustment would better protect isolated low-volume rural facilities that are necessary for beneficiary access.

> Between 2018 and 2021, the number of freestanding and for-profit facilities each increased by 2 percent per year. Hospital-based and nonprofit facilities have declined. The average size of a facility has remained relatively constant at 18 dialysis treatment stations per facility.

Chart 11-2 FFS Medicare spending for outpatient dialysis services furnished by freestanding and hospital-based dialysis facilities, 2021 and 2022



Note: FFS (fee-for-service), ESRD (end-stage renal disease). Dollar amounts are nominal figures, not adjusted for inflation.

Source: Compiled by MedPAC from the institutional outpatient claims files from CMS.

> In 2022, total FFS Medicare spending for dialysis, dialysis drugs, and ESRD-related clinical laboratory tests was $8.8 billion. Medicare paid all facilities under a prospective payment system that includes in the payment bundle certain dialysis drugs and ESRD-related clinical laboratory tests that were paid separately before 2011.

> Between 2021 and 2022, total FFS ESRD expenditures decreased by 12 percent on a nominal basis. The spending decline is due in large part to the increasing enrollment of dialysis beneficiaries in Medicare Advantage plans beginning in 2021. Specifically, between 2021 and 2022, the total number of FFS beneficiaries on dialysis and FFS treatments declined by 13 percent and 14 percent, respectively (data not shown).

> Freestanding dialysis facilities treated most dialysis beneficiaries and accounted for 96 percent of expenditures in 2021 and 2022.

Chart 11-3 The ESRD population is growing, and most patients with ESRD undergo dialysis

	2011		2021		2011–2021
	Patients (thousands)	Share of patients	Patients (thousands)	Share of patients	Average annual percent change
Total	615.2	100%	808.5	100%	3%
Dialysis	432.4	70	556.5	69	3
In-center hemodialysis	388.3	63	462.5	57	2
Home hemodialysis*	6.4	1	12.6	2	7
Peritoneal dialysis*,**	36.2	6	66.2	8	6
Other dialysis***	1.5	0.3	15.2	2	26
Functioning graft and kidney transplant	182.8	30	252.0	31	3

Note: ESRD (end-stage renal disease). Totals may not equal the sum of components due to rounding. Data include both Medicare (fee-for-service and Medicare Advantage) and non-Medicare patients. The "functioning graft and kidney transplant" category includes patients who had a functioning graft at the start of the year in question (i.e., 2011 or 2021) or received a transplant during the year in question.
*Home dialysis methods.
**"Peritoneal dialysis" refers to patients receiving either continuous ambulatory peritoneal dialysis or continuous cyclic peritoneal dialysis.
***"Other dialysis" includes other types of peritoneal dialysis methods and uncertain dialysis. U.S. Renal Data System suppressed the specific 2021 values for other types of peritoneal dialysis and for uncertain dialysis due to insufficient sample size.

Source: Compiled by MedPAC from the U.S. Renal Data System.

> People with ESRD require either dialysis or a kidney transplant to live. The total number of patients with ESRD increased on average by 3 percent per year between 2011 and 2021. However, between 2020 and 2021, the growth rate of the total number of patients with ESRD declined to 0.4 percent (data not shown).

> In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleansed by using the lining of their abdomen as a filter. Peritoneal dialysis is the most common form of home dialysis.

> In 2021, most people with ESRD (57 percent) underwent hemodialysis administered in a dialysis facility (usually three times a week). Between 2011 and 2021, the total number of in-center hemodialysis patients grew on average by 2 percent annually, while the total number of peritoneal dialysis patients increased on average by 6 percent annually. Although a smaller proportion of all dialysis patients undergo home hemodialysis, the number of these patients grew on average by 7 percent per year during this period.

> Patients with functioning grafts have had a successful kidney transplant. Patients undergoing a kidney transplant may receive either a living or deceased donor's kidney. In 2021, 23 percent of transplanted kidneys were from living donors, and the remainder were from cadaver donors (data not shown).

Chart 11-4 Asian Americans and Hispanics are among the fastest-growing segments of the ESRD population

	Share of total in 2021	Average annual percent change 2016–2021
Total (*N* = 808,536)	100%	2%
Age (years)		
0–17	1	1
18–44	14	1
45–64	42	1
65–79	34	3
80+	9	3
Sex		
Male	58	2
Female	42	2
Race/ethnicity		
White	43	1
Black	29	1
Native American	1	4
Asian American	7	5
Hispanic	19	4
Underlying cause of ESRD		
Diabetes	38	1
Hypertension	27	3
Glomerulonephritis	14	1
Other causes	21	3

Note: ESRD (end-stage renal disease). Totals may not equal the sum of the components due to rounding. ESRD patients include those who undergo maintenance dialysis and those who have a functioning kidney transplant. Data include both Medicare (fee-for-service and Medicare Advantage) and non-Medicare patients.

Source: Compiled by MedPAC from the U.S. Renal Data System.

> Among all patients with ESRD (including those who are not covered by Medicare), nearly 43 percent are over age 65. About 43 percent are White.

> Diabetes is the most common cause of renal failure.

> The number of patients with ESRD increased by 2 percent annually between 2016 and 2021. In 2021, among the fastest-growing groups were individuals of Native American, Asian, and Hispanic origins and individuals aged 65 and older.

Chart 11-5 Characteristics of Medicare fee-for-service dialysis patients, 2022

	Share of all FFS dialysis patients
Age (years)	
Under 45	10%
45–64	34
64–74	29
75–84	20
85+	7
Sex	
Male	57
Female	43
Race	
White	48
Black	31
Hispanic	8
Asian	5
All other	8
Residence	
Urban county	84
Rural county, micropolitan	9
Rural county, adjacent to urban	5
Rural county, not adjacent to urban	2
Frontier county	1
Prescription drug coverage status	
Enrolled in Part D plan	81
LIS	53
Dually eligible for Medicare and Medicaid	49

Note: FFS (fee-for-service), LIS (low-income subsidy). "Residence" reflects the beneficiary's county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. Frontier counties have six or fewer people per square mile. Components may not sum to 100 percent due to rounding.
*Data do not account for FFS beneficiaries with other sources of creditable coverage.

Source: MedPAC analysis of dialysis claims files and denominator files from CMS.

> Compared with all Medicare beneficiaries (see Chart 2-5), FFS beneficiaries on dialysis are disproportionately younger and Black.

> In 2022, about 16 percent of FFS beneficiaries on dialysis resided in a rural county.

> In 2022, 81 percent of FFS beneficiaries on dialysis were enrolled in Part D plans. In addition, 7 percent of FFS beneficiaries on dialysis had either obtained drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy or they had creditable drug coverage from other sources; 12 percent of FFS beneficiaries on dialysis had no coverage or coverage less generous than Part D (data not shown).

> About half of all beneficiaries on dialysis were dually eligible for Medicare and Medicaid services.

Chart 11-6 Aggregate FFS margins varied by type of freestanding dialysis facility, 2022

Type of facility	Share of freestanding dialysis treatments	Aggregate margin
All facilities	100%	–1.1%
Urban	88	0.4
Rural	12	–4.5
Treatment volume (quintile)		
Lowest	7	–24.1
Second	13	–13.4
Third	18	–5.0
Fourth	24	1.6
Highest	39	7.4

Note: FFS (fee-for-service). Pandemic-related federal relief funds are not accounted for in this table's data. Margins include payments and costs for dialysis services commonly provided under treatment, including injectable drugs and laboratory tests that were paid separately before 2011. The Commission's longstanding approach to calculating the Medicare end-stage renal disease (ESRD) prospective payment system (PPS) margin uses only Medicare-allowable costs for ESRD services. Such an approach is consistent with the methods we use to calculate the Medicare margin for other fee-for-service sectors. Treatment-volume components do not sum to 100 percent due to rounding.

Source: Compiled by MedPAC from cost reports and claims submitted by freestanding dialysis facilities to CMS and the Dialysis Compare database.

> For 2022, the aggregate FFS Medicare margin for dialysis-related services, including ESRD-related drugs and laboratory tests that were paid separately before 2011, was –1.1 percent.

> Between 2021 and 2022, the aggregate FFS Medicare margin decreased (from 2.3 percent to –1.1 percent (2021 data not shown)). This decline is partly attributable to growth in labor and capital costs, which both increased by 7 percent between 2021 and 2022, well above the historical average. In addition, both FFS treatment volume and total treatment volume declined between 2021 and 2022.

> Generally, freestanding dialysis facilities' margins vary by the size of the facility; facilities with greater treatment volume have higher margins on average. Differences in capacity and treatment volume explain some of the differences in the margins of urban facilities versus rural facilities. Urban facilities are larger on average than rural facilities with respect to the number of in-center hemodialysis treatment stations and Medicare treatments provided. Some rural facilities have benefited from the ESRD PPS's low-volume adjustment.

Chart 11-7 Dialysis quality of care: Some measures show progress, others need improvement, 2016–2021

Outcome measure	2016	2020	2021
Share of in-center hemodialysis patients:			
Receiving adequate dialysis	98%	98%	97%
Dialyzed with an AV fistula	64	62	61
Share of peritoneal dialysis patients receiving adequate dialysis	93	91	91
Share of all dialysis patients managing anemia			
Mean hemoglobin < 10 g/dL	29	30	31
Mean hemoglobin 10 to <12 g/dL	66	65	63
Mean hemoglobin ≥ 12 g/dL	5	5	6
Share of all dialysis patients wait-listed for a kidney	15.3	12.8	12.3
Renal transplant rate per 100 patient years	3.4	3.7	4.1
Annual mortality rate per 100 patient years*	16.6	18.9	18.9
Total hospital admissions per patient year*	1.7	1.6	1.6
Hospital days per patient year*	11.2	11.1	11.4

Note: AV (arteriovenous), g/dL (grams per deciliter [of blood]). The rate per patient year is calculated by dividing the total number of events by the fraction of the year that patients were followed. Analysis of data on dialysis adequacy is based on measures used by CMS in its ESRD [End-Stage Renal Disease] Quality Incentive Program. The U.S. Renal Data System (USRDS) adjusts hospitalization and mortality measures by age, gender, race, and primary diagnosis of ESRD.
*Lower values suggest higher quality.

Source: All measures except for share of patients receiving adequate dialysis and anemia management were compiled by MedPAC using data from the USRDS. Measure of share of patients receiving adequate dialysis and anemia management was compiled by MedPAC using data from CMS's 100 percent institutional outpatient files.

> Changes in the available quality of care measures are challenging to interpret due to the effects of the coronavirus pandemic on many of our quality measures. Sadly, patients with ESRD are at increased risk for COVID-19–associated morbidity and mortality.

> Between 2016 and 2021, anemia management and dialysis adequacy remained relatively steady.

> All hemodialysis patients require vascular access—the site on the patient's body where blood is removed and returned during dialysis. Use of arteriovenous fistulas, considered the best type of vascular access, declined between 2016 and 2021. Although the reasons for the changes in 2020 and 2021 are uncertain, the coronavirus pandemic was likely a factor.

> Mortality rates increased during 2020 and 2021 due to COVID-19 and possibly due to patient avoidance of health care for other illnesses, such as stroke (data not shown). The decline in all-cause admissions in 2020 and 2021 was also likely linked to the pandemic.

> We report access to kidney transplantation because it is widely believed to be the best treatment option for individuals with ESRD. Between 2016 and 2021, the share of dialysis patients accepted on the kidney transplant waiting list declined from 15.3 to 12.3, while the renal transplant rate per 100 dialysis-patient years increased from 3.4 to 4.1.

Chart 11-8 Hospice use increased in 2022

	2010	2019	2021	2022	Average annual change 2010–2021	Change 2021–2022
Medicare payments (in billions)	$12.9	$20.9	$23.1*	$23.7*	5.4%*	2.7%*
Beneficiaries in hospice (in millions)	1.15	1.61	1.71*	1.72*	3.7*	0.4*
Number of hospice days for all hospice beneficiaries (in millions)	81.6	121.8	127.6*	130.2*	4.2*	2.0*

Note: Total payments, number of hospice users, and number of hospice days displayed in the table are rounded; the percentage change in these figures is calculated using unrounded data. Dollar amounts are nominal figures, not adjusted for inflation.
*These estimates are based on Medicare-paid hospice claims, which exclude hospice care paid for by Medicare Advantage (MA) plans participating in the Center for Medicare & Medicaid Innovation hospice MA value-based insurance design hospice model beginning in 2021. According to CMS evaluation reports, 9,630 MA beneficiaries in 2021 and 19,065 MA beneficiaries in 2022 received hospice paid for by MA plans (Eibner, C., D. Khodyakov, E. A. Taylor, et al. 2023. Evaluation of phase II of the Medicare Advantage value-based insurance design model test: First three years of implementation (2020–2022). Report prepared for the Centers for Medicare & Medicaid Services, Center for Medicare & Medicaid Innovation: RAND Health Care. https://www.cms.gov/priorities/innovation/data-and-reports/2023/vbid-2nd-eval-report; Khodyakov, D., C. Eibner, E. A. Taylor, et al. 2022. Evaluation of phase II of the Medicare Advantage value-based insurance design model test: First two years of implementation (2020–2021). Report prepared for the Center for Medicare and Medicaid Innovation, Centers for Medicare & Medicaid Services. Santa Monica, CA: RAND Health Care. https://innovation.cms.gov/data-and-reports/2022/vbid-1st-report-2022.)

Source: MedPAC analysis of the Common Medicare Enrollment file and hospice claims data from CMS.

> Total Medicare payments to hospices were about $23.7 billion in 2022, about 2.7 percent higher on a nominal basis than the prior year.

> The number of Medicare beneficiaries receiving hospice services and the total number of days of hospice care increased in 2022.

Chart 11-9 The share of decedents using hospice increased in 2022 after declining in 2020 and 2021 due to the pandemic

	2010	2019	2021	2022	Average annual percent change 2010–2019	Average annual percent change 2019–2021	Percent change 2021–2022
Number of Medicare decedents (millions)	1.99	2.32	2.73	2.64	1.7%	8.4%	–3.5%
Number of Medicare decedents who used hospice (millions)	0.87	1.20	1.29	1.30	3.6	3.9	0.2
Share of decedents who used hospice	43.8%	51.6%	47.3%	49.1%			

Note: The "number of Medicare decedents who used hospice" reflects hospice use in the last calendar year of life. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit. Yearly figures presented in the table are rounded, but figures in the percent change columns were calculated using unrounded data.

Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

> In 2022, the share of decedents using hospice increased to 49.1 percent as deaths declined 3.5 percent, and the number of decedents using hospice increased 0.2 percent between 2021 and 2022.

> The 2022 increase in the hospice use rate followed a decline in hospice use rates in 2020 and 2021. That decline reflected the effects of the pandemic since elderly people who die of COVID-19, similar to those who die of pneumonia and influenza, have been much more likely to die in the hospital and less likely to die at home or in a nursing facility than elderly people who die of other illnesses (data not shown).

> Prior to the pandemic, hospice use rates among decedents increased substantially, rising from 43.8 percent in 2010 to 51.6 percent in 2019.

Chart 11-10 Share of decedents using hospice increased in 2022 among all beneficiary groups

	Share of decedents using hospice				Average annual percentage point change 2010–2021	Percentage point change 2021–2022
	2010	2019	2021	2022		
All	43.8%	51.6%	47.3%	49.1%	0.3	1.8
FFS beneficiaries	42.8	50.7	47.2	49.1	0.4	1.9
MA beneficiaries	47.2	53.2	47.4	49.2	0.0	1.8
Dual eligible	41.5	49.3	42.1	44.2	0.1	2.1
Non–dual eligible	44.5	52.4	49.2	50.9	0.4	1.7
Age (years)						
<65	25.7	29.5	25.0	26.6	–0.1	1.6
65–74	38.0	41.0	35.8	37.7	–0.2	1.9
75–84	44.8	52.2	47.9	49.4	0.3	1.5
85+	50.2	62.7	60.8	61.8	1.0	1.0
Race/ethnicity						
White	45.5	53.8	50.0	51.6	0.4	1.6
Black	34.2	40.8	35.6	37.4	0.1	1.8
Hispanic	36.7	42.7	34.2	38.3	–0.2	4.1
Asian American	30.0	39.8	36.2	38.1	0.6	1.9
North American Native	31.0	38.5	33.8	37.1	0.3	3.3
Gender						
Male	40.1	46.7	42.1	43.8	0.2	1.7
Female	47.0	56.3	52.5	54.3	0.5	1.8
Beneficiary location						
Urban county	45.6	52.8	48.5	50.2	0.3	1.7
Rural county, micropolitan	39.2	49.7	45.1	47.2	0.5	2.1
Rural county, adjacent to urban	39.0	49.5	44.9	47.8	0.5	2.9
Rural county, nonadjacent to urban	33.8	43.8	39.9	42.1	0.6	2.2
Frontier county	29.2	36.2	33.0	35.2	0.3	2.2

Note: FFS (fee-for-service), MA (Medicare Advantage). For each demographic group, the share of decedents who used hospice is calculated as follows: The number of beneficiaries in the group who both died and received hospice in a given year is divided by the total number of beneficiaries in the group who died in that year. Prior to 2021, the "MA beneficiaries" group received hospice paid for by the FFS program; beginning in 2021, most individuals in the "MA beneficiaries" group received hospice paid for by FFS, but a small number received hospice paid for by their MA plan under the MA value-based insurance design model. "Beneficiary location" reflects the beneficiary's county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes (UICs). This chart uses the 2013 UIC definitions. The frontier category is defined as population density less than or equal to six people per square mile and overlaps the beneficiary county of residence categories. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit.

Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

> In 2022, hospice use rates among decedents increased among all beneficiary groups examined.

> In 2022, hospice use continued to vary by demographic and beneficiary characteristics. Medicare decedents who were older, White, female, living in an urban area, or were not dual eligible were more likely to use hospice than their respective counterparts.

Chart 11-11 Number of hospice visits for beneficiaries receiving routine home care, 2019–2022

	2019	2020	2021	2022
Average number of visits per week				
All visits	4.3	3.6	3.8	3.9
Nurse visits	1.8	1.6	1.7	1.7
Aide visits	2.2	1.7	1.8	1.8
Social worker visits	0.3	0.2	0.3	0.3
Average length per visit (number of 15-minute increments)				
All visits	4.0	4.0	3.9	3.8
Nurse visits	3.8	3.8	3.7	3.6
Aide visits	4.2	4.3	4.1	4.0
Social worker visits	3.5	3.4	3.3	3.2
Average visit time per week (number of 15-minute increments)				
All visits	17.2	14.1	14.6	14.5
Nurse visits	7.0	6.2	6.3	6.2
Aide visits	9.1	7.2	7.4	7.4
Social worker visits	1.1	0.7	0.9	0.9

Note: Data are for patients receiving the hospice routine home care level of care. Average visits per week are calculated by computing average visits per day (total number of visits / total number of routine home care days) and multiplying by 7. "Visits" refers to in-person visits only. Nurse visits include both registered nurse and licensed practical nurse visits. Components of visits may not sum to total visits due to rounding.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data from CMS.

> In 2022, hospice enrollees received on average 3.9 visits per week, with nurse, aide, and social worker visits accounting for 1.7 visits, 1.8 visits, and 0.3 visits per week on average, respectively.

> The average length of hospice visits in 2022 was about 50 minutes to an hour, depending on type of visit (i.e., 3.2 to 4.0 fifteen-minute increments).

> Overall, the average amount of visit time hospice patients received per week in 2022 was about 3.6 hours (14.5 fifteen-minute increments). On average, hospice patients received 1.5 hours of nurse visits, 1.9 hours of aide visits, and 0.2 hours of social worker visits per week.

> The average number of visits per week increased in 2021 and 2022, although it remained below the prepandemic 2019 level (the largest difference between 2019 and 2022 was in the number of aide visits). The average length of each hospice visit declined from 2020 to 2022. As a result, average visit time per week remained below the 2019 level.

Chart 11-12 Number of Medicare-participating hospices increased due to growth in for-profit hospices, 2018–2022

	2018	2021	2022*
All hospices	4,639	5,358	5,899
For profit	3,234	4,008	4,414
Nonprofit	1,245	1,195	1,169
Government	159	143	141
Freestanding	3,701	4,511	4,919
Hospital based	453	396	383
Home health based	463	434	421
SNF based	22	17	17
Urban	3,762	4,505	5,006
Rural	871	845	827

Note: SNF (skilled nursing facility). Some categories do not sum to their total because of missing data for some providers. The rural and urban definitions in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census). Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report, or the hospice is included in the cost report of a hospital, home health agency, or skilled nursing facility).
*In 2022, data on ownership status, type of hospice, and urban/rural location are missing for more providers than usual due to a temporary pause in CMS's updating of the Provider of Services file data for hospices in 2022. While the total number of hospices providing care to Medicare beneficiaries in 2022 (5,899) is not affected by this issue, the table may understate the number of hospices in any ownership, hospice type, or urban/rural subgroup in 2022.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and the 100 percent standard analytic file of hospice claims from CMS.

> There were 5,899 Medicare-participating hospices in 2022, up 10 percent from 2021 and 27 percent since 2018.

> An issue of data availability in 2022 affects our estimates of the number of providers by ownership status, type of hospice, and urban/rural location. The number of hospices in any ownership, hospice type, or urban/rural subgroup may be understated in 2022.

>In 2022, the number of for-profit hospices grew by at least 10 percent. Between 2021 and 2022, the number of hospices with nonprofit ownership or government ownership appeared to decline, continuing the downward trend observed from 2018 to 2021.

> The number of freestanding providers increased at least 9 percent in 2022. The number of home health–based and hospital-based hospices appeared to decline in 2022, while the number of SNF-based providers was unchanged. (A hospice's status as freestanding, hospital based, home health based, or SNF based reflects the type of cost report submitted by the provider and does not necessarily reflect the location of care.)

> The number of hospices located in rural areas has declined in recent years, decreasing by about 1 percent per year between 2018 and 2021, and appears to have declined similarly in 2022. However, the number of providers located in rural areas is not necessarily an indicator of access to care because it does not capture the size of those hospice providers, their capacity to serve patients, or the size of their service area. Also, some urban hospices furnish services in rural areas. Indeed, despite the decline in the number of rural hospices since 2010 (data not shown), the share of rural decedents using hospice has grown overall since 2010 (see Chart 11-10).

Chart 11-13 Hospice cases by primary diagnosis, 2022

Diagnosis	Share of total cases
Alzheimer's, nervous system disorders, organic psychosis	25%
Cancer	23
Circulatory, except heart failure	22
Heart failure	8
Other	7
Respiratory disease	6
Chronic airway obstruction, NOS	4
Genitourinary disease	2
Digestive disease	2
COVID-19	1
All	100

Note: NOS (not otherwise specified). Cases include all patients who received hospice care in 2022, not just decedents. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim in 2022.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file from CMS and the Medicare Beneficiary Database.

> In 2022, the most common primary diagnoses among Medicare hospice patients were neurological conditions (Alzheimer's disease, nervous system disorders, and organic psychosis accounted for 25 percent of cases), cancer (23 percent of cases), and circulatory conditions other than heart failure (22 percent of cases).

> About 1 percent of Medicare hospice patients had COVID-19 as their hospice primary diagnosis in 2022. An additional 4 percent of hospice patients had COVID-19 as a secondary diagnosis on their hospice claims in 2022 (data not shown).

Chart 11-14 Hospice average length of stay among decedents increased in 2022

Year	Average length of stay (in days)	Percentiles of length of stay (in days)				
		10th	25th	50th	75th	90th
2010	87.0	3	6	18	78	242
2017	89.3	2	5	18	80	251
2018	90.3	2	5	18	82	255
2019	92.5	2	5	18	85	266
2020	97.0	2	5	18	87	287
2021	92.1	2	5	17	79	264
2022	95.3	2	5	18	84	275

Note: Lifetime length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime.

Source: MedPAC analysis of the Common Medicare Enrollment file and the Medicare Beneficiary Database from CMS.

> The average length of stay among decedents was 95.3 days in 2022, up about 3 days from 2021. In 2022, the length of stays at the 50th percentile (the median) increased slightly to 18 days from 17 days in 2021.

> Hospice lengths of stay vary broadly. In 2022, hospice length of stay among decedents ranged from 2 days at the 10th percentile to 275 days at the 90th percentile.

> Between 2010 and 2022, growth in the average length of stay among decedents has been the result of increases in length of stay for patients with the longest stays. Length of stay grew from 242 days to 275 days at the 90th percentile.

Chart 11-15 Hospice length of stay among decedents, by beneficiary and hospice characteristics, 2022

	Average length of stay (in days)	Percentiles of lengths of stay (in days)		
		10th	50th	90th
Beneficiary				
Diagnosis				
Cancer	52	3	16	127
Neurological	159	4	41	476
Heart/circulatory	106	2	19	317
COPD	135	3	31	392
Other	55	2	7	145
Site of service				
Home	98	4	25	270
Nursing facility	109	3	22	322
Assisted living facility	165	5	55	474
Hospice				
For profit	114	3	23	336
Nonprofit	72	2	13	198
Freestanding	97	2	18	282
Home health based	74	2	15	203
Hospital based	60	2	11	160

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2022 and used hospice that year and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime. The location categories reflect where the beneficiary spent the largest share of their days while enrolled in hospice. "Diagnosis" reflects the primary diagnosis on the beneficiary's last hospice claim.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data, Medicare Beneficiary Database, Medicare hospice cost reports, and Provider of Services file data from CMS.

> Hospice average length of stay among decedents varies by both beneficiary and provider characteristics. Most of this variation reflects differences in length of stay among patients with the longest stays (i.e., at the 90th percentile). Length of stay varies much less for patients with shorter stays (i.e., at the 10th or 50th percentile).

> Beneficiaries with neurological conditions and COPD have the longest stays, while beneficiaries with cancer have the shortest stays, on average.

> For beneficiaries with a hospice primary diagnosis of COVID-19, median length of stay was 3 days and average length of stay was 26 days (data not shown).

> Beneficiaries who receive hospice services in assisted living facilities have longer stays on average than beneficiaries who receive care at home or in a nursing facility.

> For-profit and freestanding hospices have longer average lengths of stay than nonprofit and provider-based (home health–based and hospital-based) hospices.

Chart 11-16 Nearly 60 percent of Medicare hospice spending in 2022 was for patients with stays exceeding 180 days

	Medicare hospice spending, 2022 (in billions)
All hospice users in 2022	$23.7
Beneficiaries with LOS > 180 days	14.1
Days 1–180	4.5
Days 181–365	4.3
Days 366+	5.3
Beneficiaries with LOS ≤ 180 days	9.6

Note: LOS (length of stay). "LOS" reflects the beneficiary's lifetime LOS as of the end of 2022 (or at the time of death or discharge in 2022 if the beneficiary was not enrolled in hospice at the end of 2022). All spending reflected in the chart occurred only in 2022. Components do not sum to total because of rounding.

Source: MedPAC analysis of 100 percent hospice claims standard analytical file and an Acumen LLC data file on hospice lifetime length of stay (which is based on an analysis of historical claims data).

> In 2022, Medicare hospice spending on patients with stays exceeding 180 days was about $14.1 billion, nearly 60 percent of all Medicare hospice spending that year.

> About $5.3 billion, or about 22 percent, of Medicare hospice spending in 2022 was on hospice care for patients who had already received at least one year of hospice.

Chart 11-17 Hospice Medicare aggregate margins, 2017–2021

	Share of hospices (2021)	Medicare margin				
		2017	2018	2019	2020	2021
All	100%	12.5%	12.4%	13.4%	14.2%	13.3%
Freestanding	84	15.3	15.1	16.2	16.7	15.5
Home health based	7	8.1	8.4	9.7	11.2	10.9
Hospital based	8	–13.8	–16.5	–18.4	–18.2	–15.6
For profit	75	20.0	19.0	19.2	20.5	19.2
Nonprofit	22	2.5	3.8	6.1	5.8	5.2
Government	3	N/A	N/A	N/A	N/A	N/A
Urban	84	12.9	12.6	13.6	14.3	13.4
Rural	16	8.9	10.3	11.5	13.5	12.3
Below cap	81	12.6	12.6	13.8	14.8	14.0
Above cap	19	12.1	10.3	10.0	7.7	2.5
Above cap (including cap overpayments)	19	21.9	21.8	22.5	22.8	21.8
Share of stays > 180 days						
Lowest quintile	20	–4.5	–3.0	–2.5	–0.4	0.0
Second quintile	20	7.0	8.5	10.3	11.8	11.1
Third quintile	20	17.1	16.8	19.9	20.0	20.5
Fourth quintile	20	22.1	20.8	22.8	24.1	22.2
Highest quintile	20	17.8	17.6	13.4	13.4	9.7

Note: N/A (not available). Medicare aggregate margins for all provider categories exclude overpayments to above-cap hospices except where specifically indicated (providers whose payments exceed the Medicare hospice aggregate cap are required to repay the excess to Medicare.) Medicare aggregate margins are calculated based on Medicare-allowable, reimbursable costs. Margin by hospice ownership status is based on hospices' ownership designation from the Medicare cost report. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census). Shares of hospices in the ownership category do not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims standard analytic file, and Medicare Provider of Services data from CMS.

> The fee-for-service aggregate Medicare margin was 13.3 percent in 2021, down slightly from 14.2 percent in 2020.

> In 2021, freestanding hospices had higher margins (15.5 percent) than home health–based (10.9 percent) and hospital-based hospices (–15.6 percent).

> The 2021 margin among for-profit hospices was high at 19.2 percent. Nonprofit hospices as a group had a margin of 5.2 percent in 2021, but the subset of nonprofit hospices that were freestanding had a higher margin, 8.5 percent (latter figure not shown).

> The aggregate 2021 margin was slightly higher for urban hospices (13.4 percent) than rural hospices (12.3 percent).

> Hospices that exceeded the cap (Medicare's aggregate average per beneficiary payment limit) had a 2021 margin of about 21.8 percent before and 2.5 percent after the return of the cap overpayments.

> Hospices with more patients whose stays were longer than 180 days generally had higher margins in 2021. Hospices in the lowest length-of-stay quintile had a margin of 0.0 percent, compared with a 22.2 percent margin for hospices in the second-highest length-of-stay quintile. Margins were somewhat lower in the highest length-of-stay quintile (9.7 percent) because some hospices in the highest quintile exceeded Medicare's aggregate payment cap and were required to repay the overage.

Chart 11-18 Hospices that exceeded Medicare's annual payment cap, 2017–2021

	2017	2018	2019	2020	2021
Share of hospices exceeding the cap	14.0%	16.3%	19.0%	18.6%	18.9%
Average payments over the cap per hospice exceeding the cap (in thousands)	$273	$334	$384	$422	$451
Payments over the cap as a share of overall Medicare hospice spending in cap year	1.0%	1.3%	1.7%	1.8%	2.0%

Note: The aggregate cap statistics reflect the Commission's estimates and may differ from CMS claims processing contractors' estimates. Our estimates assume all hospices use the proportional methodology and rely on claims data through 15 months after the end of each cap year. The claims processing contractors may reopen the hospice cap calculation for up to three years; the reopening process and timing vary across contractors. Spending in cap year 2017 reflects an 11-month period from November 1, 2016, to September 30, 2017. Beginning in 2018, the cap year is aligned with the federal fiscal year (October 1 to September 30 of the following year). Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data, Medicare hospice cost reports, and Medicare Provider of Services file data from CMS.

> An estimated 18.9 percent of hospices exceeded the aggregate cap in 2021, similar to the amount in 2020.

> On average, above-cap hospices exceeded the cap by approximately $451,000 per provider in 2021, up from about $422,000 per provider in 2020.

> Medicare payments over the cap represented 2.0 percent of total Medicare hospice spending in 2021.

Chart 11-19 Hospice live-discharge rates, 2020–2022

	2020	2021	2022
Live discharges as a share of all discharges, by reason for live discharge			
All live discharges	15.4%	17.2%	17.3%
No longer terminally ill	5.6	6.3	6.1
Beneficiary revocation	5.7	6.3	6.1
Transfer hospice providers	2.2	2.4	2.4
Move out of service area	1.6	2.0	2.3
Discharge for cause	0.3	0.3	0.3
Providers' overall rate of live discharge as a share of all discharges, by percentile (for providers with more than 30 discharges)			
10th percentile	7.5	8.5	8.3
25th percentile	10.9	12.5	12.2
50th percentile	16.9	19.1	19.2
75th percentile	26.6	30.2	29.9
90th percentile	43.3	50.0	49.9

Note: Percentages may not sum to totals due to rounding. "All discharges" includes patients discharged alive or deceased.

Source: MedPAC analysis of the 100 percent hospice claims standard analytical file, Medicare hospice cost reports, and Medicare Provider of Services file from CMS.

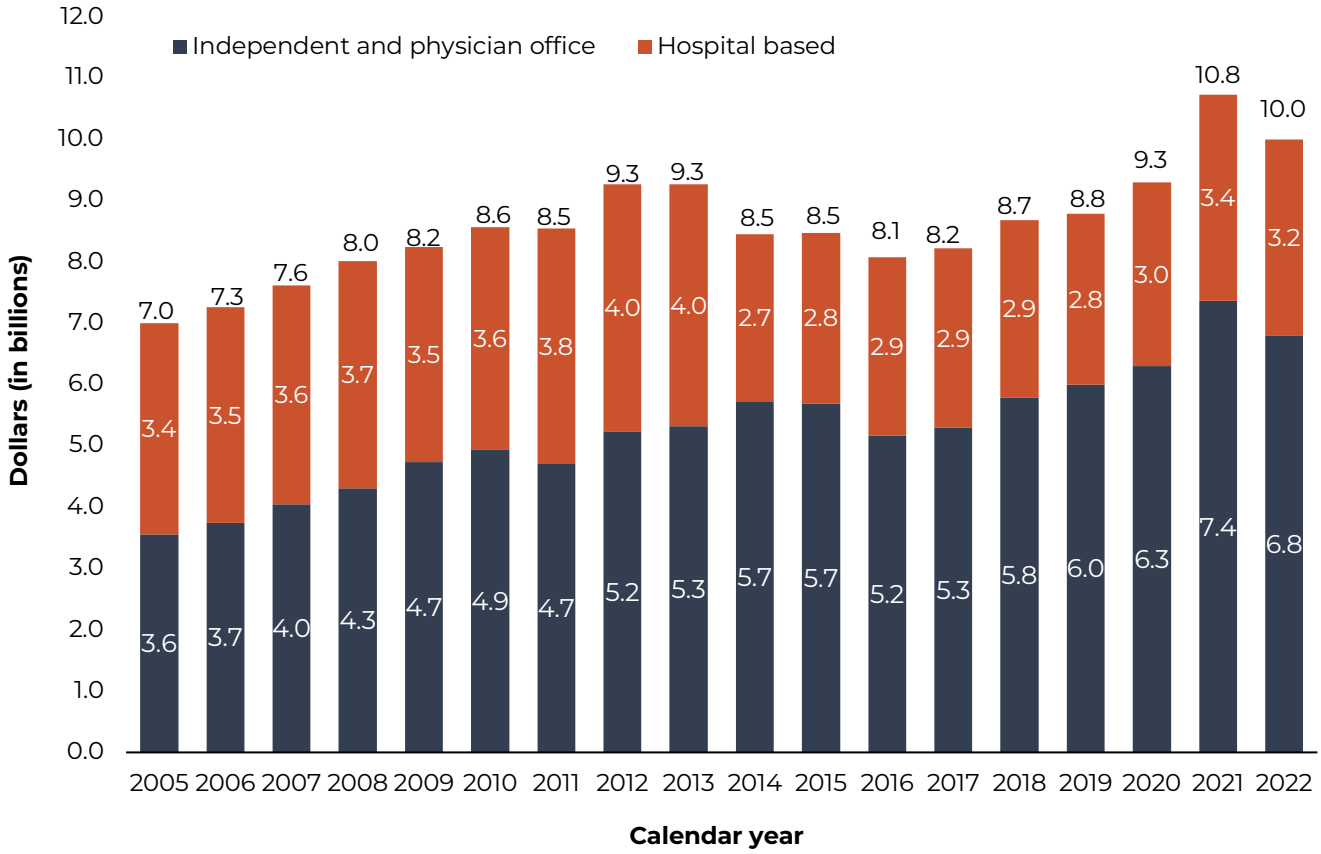
> In 2022, the overall live-discharge rate was 17.3 percent, similar to the rate in 2021.

> The most common reasons for live discharge were the beneficiary revoking the hospice benefit and the beneficiary no longer being terminally ill, each accounting for 6.1 percent of all discharges in 2022. Less frequent reasons for live discharges included a beneficiary transferring hospice providers, a beneficiary moving out of the service area, and a beneficiary being discharged for cause.

> Among providers with more than 30 discharges, 10 percent of providers had live-discharge rates of about 50 percent or more in 2022.

> Small hospices as a group have substantially higher live-discharge rates than larger hospices. In 2022, the aggregate live-discharge rate was 49 percent for hospices with 30 or fewer discharges, in contrast to a 17 percent aggregate live-discharge rate for all hospices (data for small hospices not shown).

Chart 11-20 Medicare spending for clinical laboratory tests, 2005–2022



Note: Spending is for services paid under the clinical laboratory fee schedule. Hospital-based services are furnished in laboratories owned or operated by hospitals. The components of each bar may not sum to the total at the top of each bar due to rounding. The spending data include only program payments; there is no beneficiary cost sharing for clinical laboratory tests. Dollar amounts are nominal figures, not adjusted for inflation.

Source: The annual report of the Boards of Trustees of the Medicare trust funds, 2015 and 2022.

> Medicare spending for clinical laboratory tests in all settings grew by an average of 3.6 percent per year between 2005 and 2013 on a nominal basis.

> From 2013 to 2014, Medicare spending for laboratory tests declined by about 9 percent because, beginning in 2014, many laboratory tests provided in hospital outpatient departments are no longer paid separately under the clinical laboratory fee schedule. Instead, many of these tests are packaged with their associated visits or procedures under the hospital outpatient prospective payment system.

> Medicare spending for laboratory tests decreased by an average of 0.9 percent per year from 2014 to 2017.

> Beginning in 2018, clinical laboratory fee schedule payment rates are based on private sector rates. From 2017 to 2019, Medicare spending for laboratory tests grew by an average of 5.2 percent per year.

> Largely due to the COVID-19 public health emergency, lab spending increased in 2020 and 2021, then declined by 6.5 percent in 2022.

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