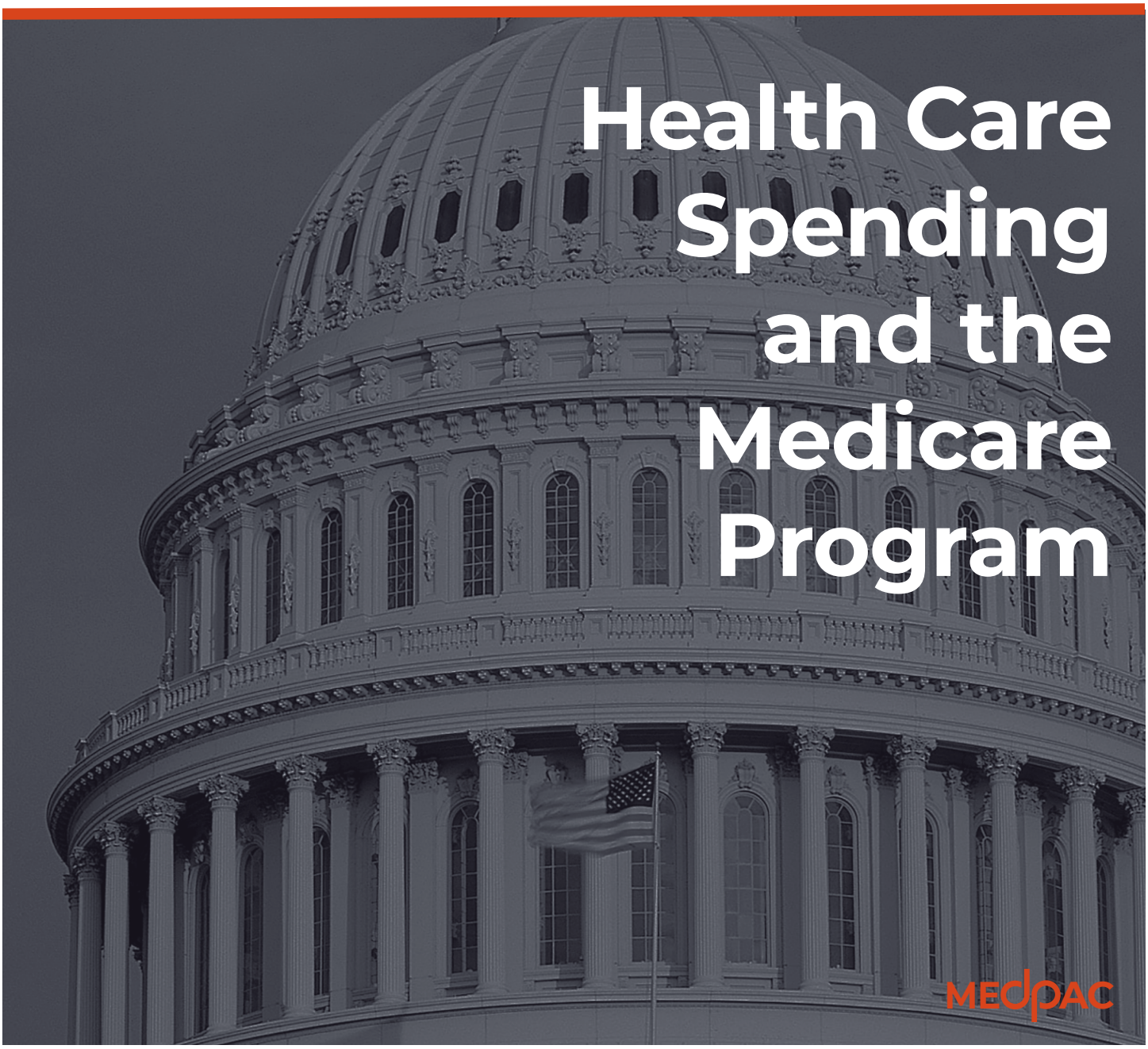
JULY 2025

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, dually 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.

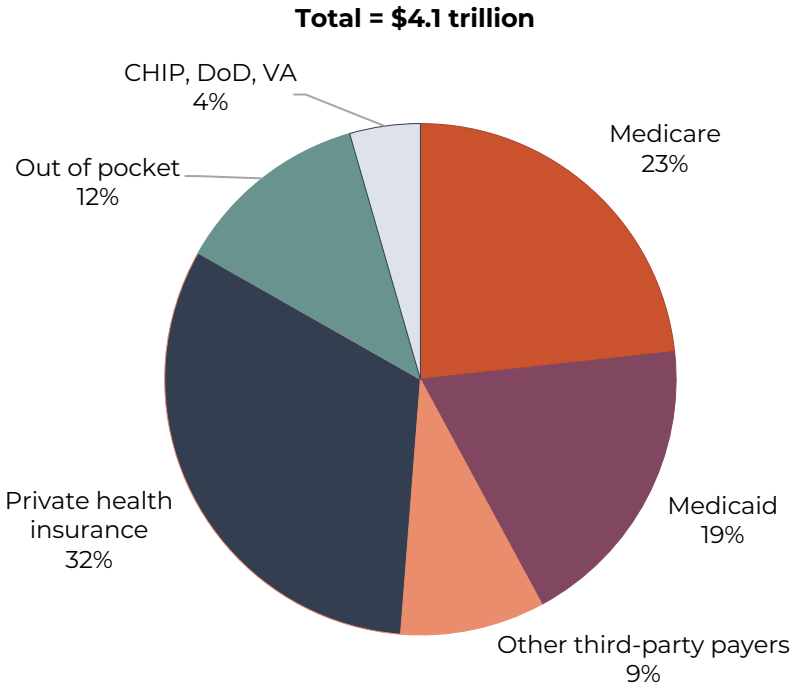
Table of contents

SECTION

1

National health care and Medicare spending

Chart 1-1 Medicare was the largest single purchaser of personal health care in the U.S., 2023



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, the Substance Abuse and Mental Health Services Administration, other state and local programs, and school health. Percentages do not sum to 100 percent due to rounding.

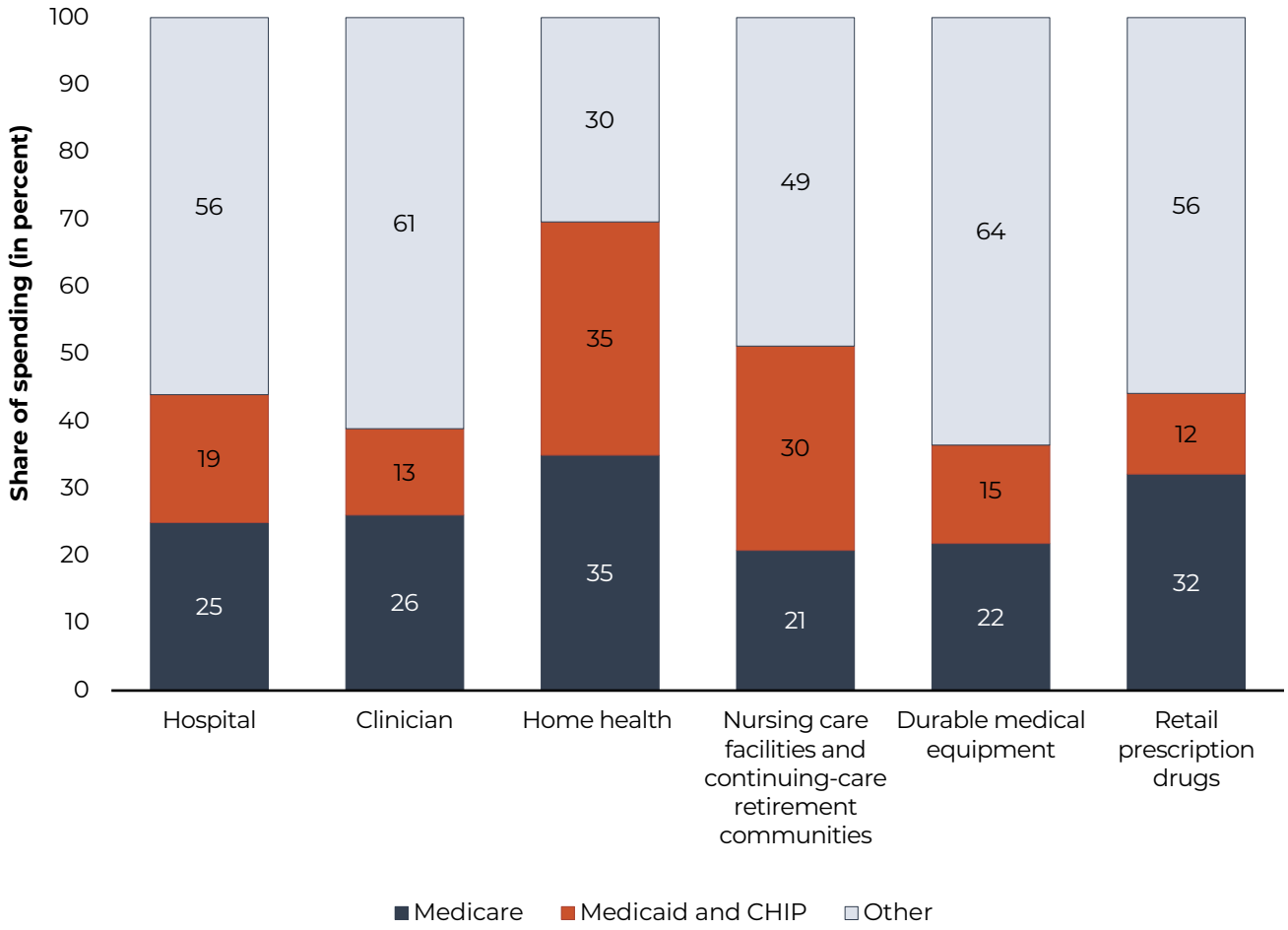
Source: CMS Office of the Actuary, Table 6: Personal Health Care Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2023, released December 2024, https://www.cms.gov/files/zip/nhe-tables.zip.

> 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; the category is composed of many private plans, including managed care, self-insured health plans, and indemnity plans.) Of the $4.1 trillion spent on personal health care in 2023, Medicare accounted for 23 percent, or $956 billion. This amount comprises spending on direct patient care and excludes administrative and business costs.

> Private health insurance plans financed 32 percent of total personal health care spending in the U.S., and consumer out-of-pocket spending (not including premiums) amounted to 12 percent.

> In this chart, enrollees' premium contributions are included in the spending category of their insurance type.

Chart 1-2 Medicare's share of national spending on personal health care varied by type of service, 2023



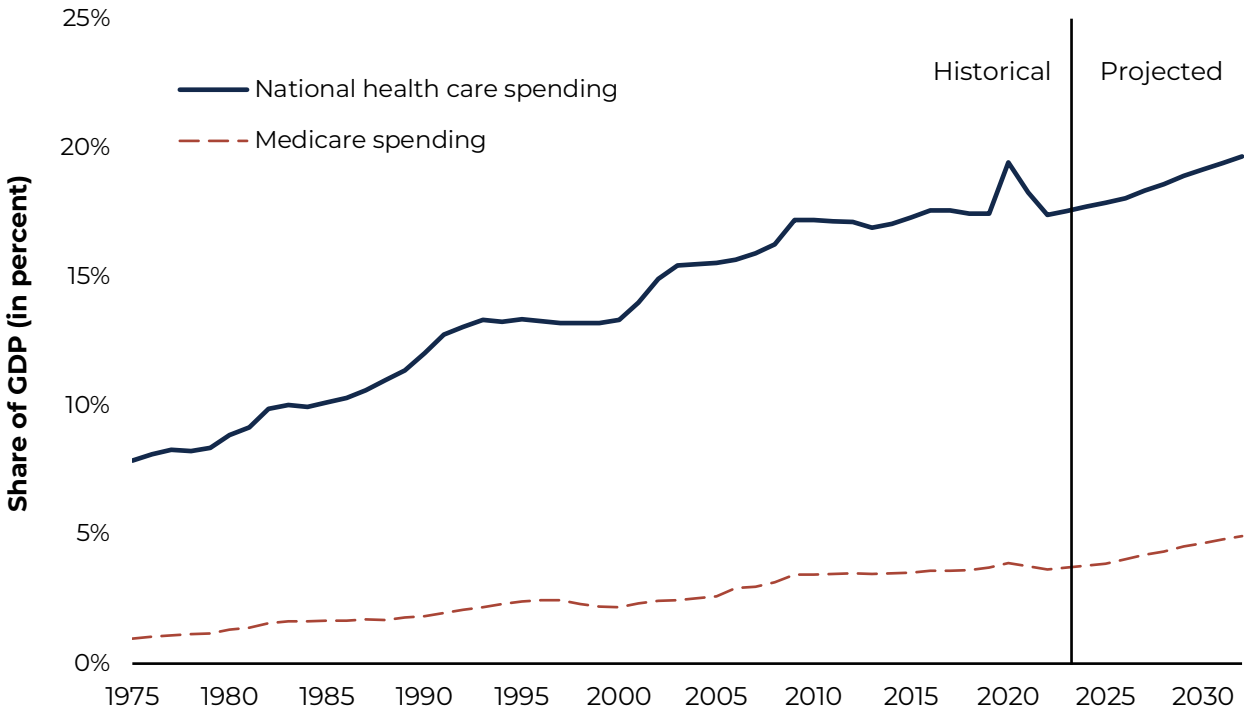
Note: CHIP (Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures that comprises spending for all medical goods and services that are provided for the treatment of an individual. "Other" includes private health insurance, out-of-pocket spending, and 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. Percentages may not sum to 100 percent due to rounding.

Source: CMS Office of the Actuary, National health expenditures by type of service and source of funds: Calendar years 1960 to 2023, released December 2024, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2023.zip.

> While Medicare's share of total personal health care spending was 23 percent in 2022 (see Chart 1-1), its share of spending by type of service varied, from 21 percent of spending on nursing care facilities and continuing-care retirement communities to 35 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 because Medicare pays only for nursing home services for Medicare beneficiaries who require skilled nursing or rehabilitation services. In contrast, Medicaid pays for custodial care (long-term 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 in the graph is 2024. 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 in June 2024 and historical data released in December 2024), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

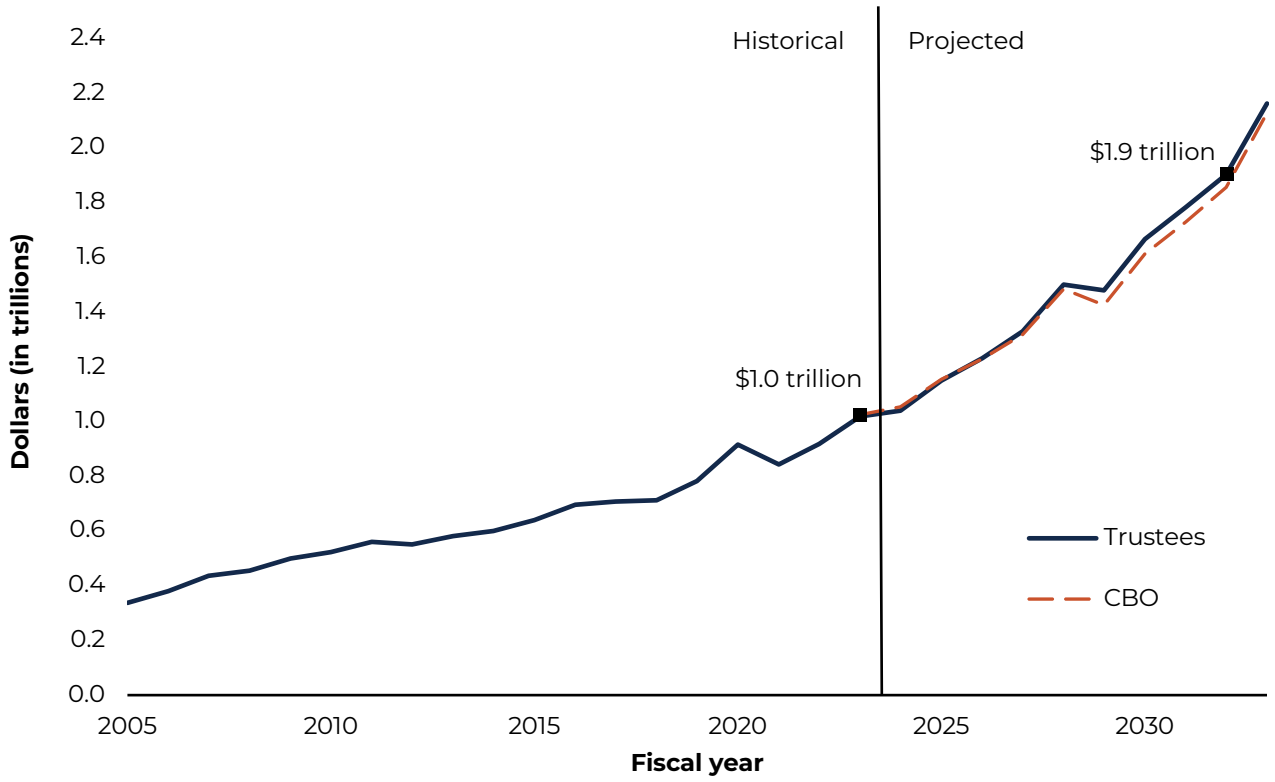
> In 2020, total health care spending increased sharply—reaching 19.5 percent of the country's GDP, or $4.2 trillion—due to one-time spending by the federal government on coronavirus pandemic relief funds for health care providers, a relaxation of Medicaid's eligibility rules during the pandemic, and an increase in spending on public health activities (e.g., for vaccine development). At the same time, the country's GDP shrank that year, causing a sharp increase in the share of GDP spent on health care that year.

> In 2021 and 2022, spending on health care increased at more typical rates as patients resumed receiving health care. Meanwhile, GDP expanded rapidly in these years. The net effect of these forces was a sharp decline in the share of GDP spent on health care in 2021 and 2022.

> In 2023, national health care spending grew more rapidly (by 8 percent) and GDP grew by a smaller share (7 percent), causing the share of GDP spent on health care to increase slightly.

> Over time, the share of GDP spent on Medicare has steadily increased. From 1 percent in 1975, it is projected to reach nearly 5 percent of GDP by 2032. Key drivers of Medicare's spending growth in coming years are identified in Chart 1-5.

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



Note: CBO (Congressional Budget Office). The first projected year in the graph is 2024. The sharp increase in spending in 2020 includes $104 billion in Medicare Accelerated and Advance Payments to providers, which were then recouped by the Medicare program in 2021, 2022, and 2023. The projected decline in spending in 2029 is due to a timing issue: When October 1 (the first day of the federal fiscal year) falls on a weekend, certain payments that would have ordinarily been made on that day are instead made at the end of September and thus are shifted into the previous fiscal year. Dollar amounts are nominal figures, not adjusted for inflation.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds, Table V.H4; CBO's June 2024 baseline projections for the Medicare program.

> Medicare spending doubled between 2010 and 2023, increasing from $0.5 trillion to $1 trillion on a nominal basis.

> Medicare spending is expected to again double between 2023 and 2032, when it is projected to reach nearly $2 trillion. The Medicare Trustees and the Congressional Budget Office expect Medicare spending to increase at an average annual rate of about 7 percent during this decade.

Chart 1-5 Factors contributing to Medicare's projected spending growth (after subtracting economy-wide inflation), 2024–2033

Medicare part	Average annual percent change in: Medicare prices (minus inflation)	Number of beneficiaries	Beneficiary demographic mix	Volume and intensity of services used	Medicare's projected spending (minus inflation)
Part A	0.1%	1.9%	–0.2%	1.6%	3.4%
Part B	–0.9	2.0	0.1	3.7	4.8
Part D	–0.4	2.7	–0.2	2.8	3.1
Total	–0.4	N/A*	–0.1	2.8	4.1

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. "Beneficiary demographic mix" adjusts for age, sex, and time to death. "Volume and intensity" refers to 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 its part's share of total Medicare spending in 2023.
* Not applicable because there is beneficiary overlap in enrollment in Part A, Part B, and Part D.

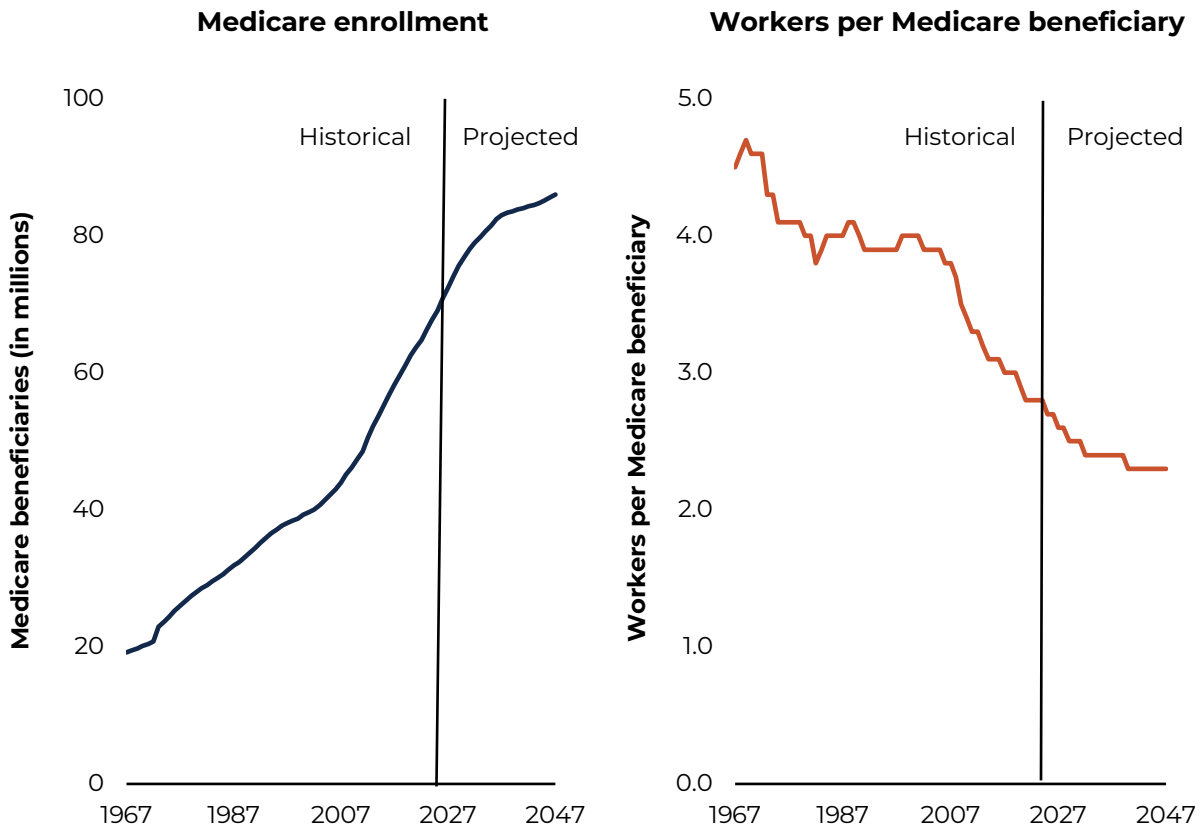
Source: MedPAC analysis of data from Tables II.D1 and V.B2 in the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> Medicare's spending is projected to grow by 4.1 percent per year, on average, between 2024 and 2033 (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 to 3 percent per year over this period as the baby-boom generation continues to retire) and growth in the volume and intensity of services delivered per beneficiary (expected to increase by 2.8 percent per year).

> 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 number of workers per Medicare beneficiary continues to decline



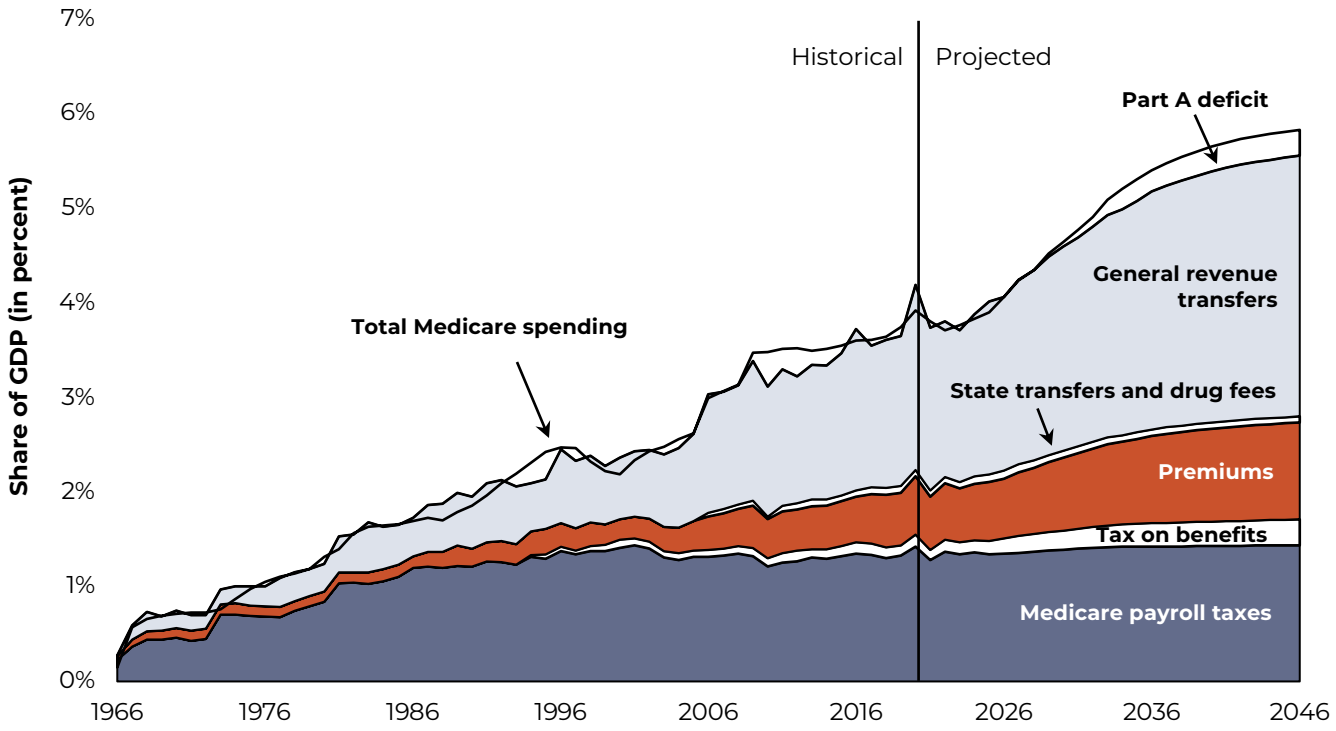
Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplemental Medical Insurance because Part A is usually available to beneficiaries at no cost. First projected year is 2024. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

Source: Expanded and supplementary tables and figures released with the 2024 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 76 million beneficiaries are expected to have Medicare Part A Hospital Insurance—up from 66 million beneficiaries in 2023.

> 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 2.8 workers per beneficiary in 2023 and is projected to fall to 2.5 workers per beneficiary by 2029.

Chart 1-7 Medicare's three main funding sources are general tax revenues, Medicare payroll tax revenues, and beneficiary premiums



Note: GDP (gross domestic product). First projected year is 2024. 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 (SMI) Trust Fund. Graph does not include interest earned on trust-fund investments (which makes up 1.4 percent of the Hospital Insurance Trust Fund's income and 0.7 percent of the SMI Trust Fund's income and is expected to decline in coming years as trust-fund assets decline).

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds, Figure II.D2.

> Medicare spending accounted for 3.8 percent of GDP in 2023. The Medicare Trustees have projected that Medicare's share of GDP will rise to 4.9 percent by 2032.

> 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 tax revenue transfers (which help finance Part B and Part D) became the largest source of Medicare funding. General tax 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 research and development, education, and transportation).

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 extend Hospital Insurance Trust Fund solvency for:	Increase 2.9% Medicare payroll tax to:	or	Decrease Part A spending by:
25 years (2024–2048)	3.35%		10.6%

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 the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

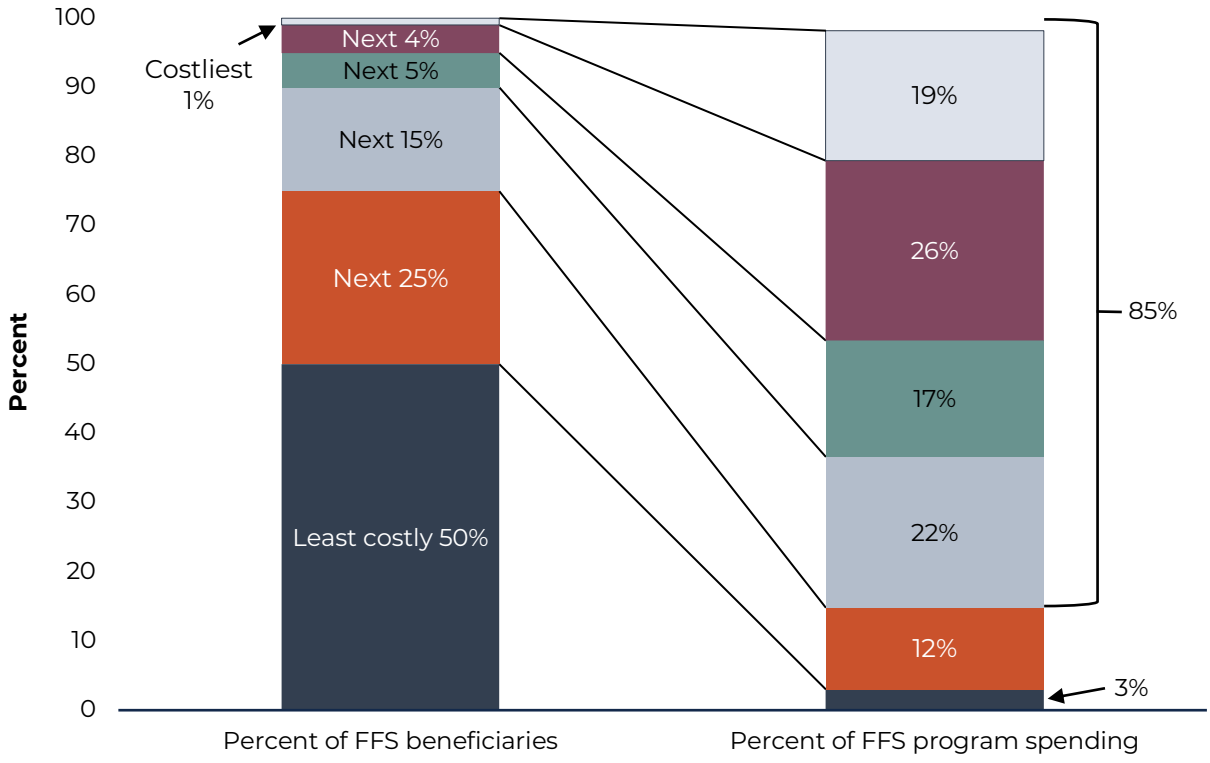
> Medicare's Hospital Insurance (HI) Trust Fund helps pay for Part A services such as inpatient hospital stays, post-acute care provided by skilled nursing facilities and home health agencies, and hospice services. The trust fund is mainly financed through a dedicated payroll tax (i.e., a tax on wage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

> In some years, such as 2023, 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 2023, annual trust fund revenues equaled $415 billion, but Part A spending amounted to $403 billion, yielding a surplus of $12 billion that year. This surplus increased the balance in the trust fund from $197 billion at the start of the year to $209 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 2024 report, Medicare's Trustees estimated that annual deficits in coming years would cause the HI Trust Fund's account balance to drop to $0 in 2036—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; in 2025, it projects that it would take much longer for the trust fund to become insolvent (until 2052).

> To extend the solvency of the HI Trust Fund, there are a number of options available to policymakers. Two that are highlighted above are to (1) increase the Medicare payroll tax from its current rate of 2.9 percent to 3.35 percent or (2) reduce Part A spending by 10.6 percent, which is equivalent to a reduction of about $45 billion in 2025, that would then need to be maintained in subsequent years. Either of these approaches would extend the solvency of the trust fund for an additional 25 years. A combination of more moderate spending reductions and revenue increases is another option. Another way to raise revenue for the HI Trust Fund is through the type of broad economic growth experienced in the past few years; this growth has helped extend the projected solvency of the trust fund by a number of years, as more people work (and pay Medicare payroll taxes) and people earn higher-than-expected wages (which results in more wages being taxable).

Chart 1-9 FFS program spending was highly concentrated among a small share of beneficiaries, 2022



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. Some percentages identified above are different from those mentioned below due to rounding.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, 2022.

> Medicare FFS spending is concentrated among a small number of beneficiaries. In 2022, 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 3 percent of FFS spending.

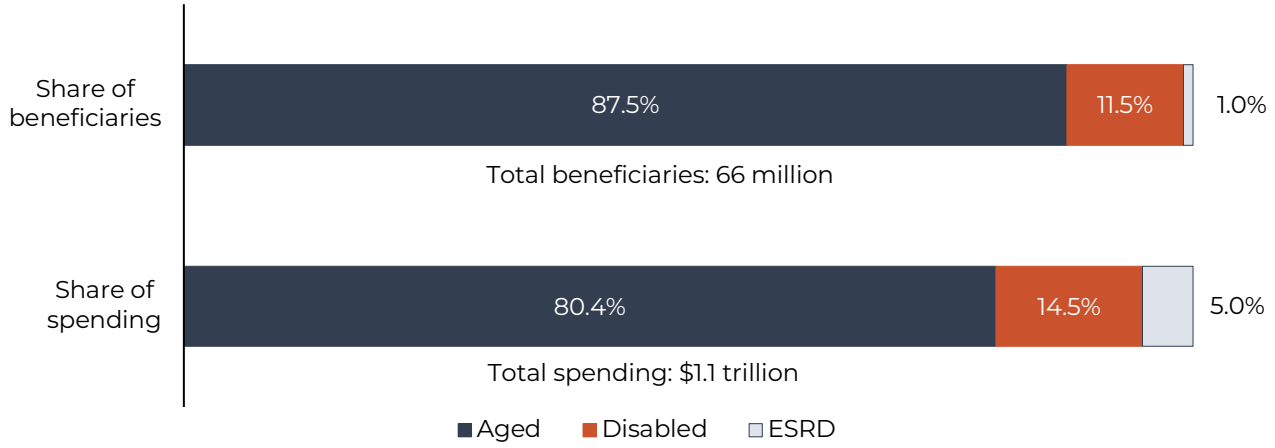
> Costly beneficiaries tend to be those who have multiple chronic conditions, are using inpatient hospital services, are eligible for Medicare due to disability or end-stage renal disease (as opposed to age), are dually eligible for Medicare and Medicaid, and are in the last year of life.

SECTION

2

Medicare beneficiary demographics

Chart 2-1 Aged beneficiaries accounted for the greatest share of the Medicare population and program spending, 2022



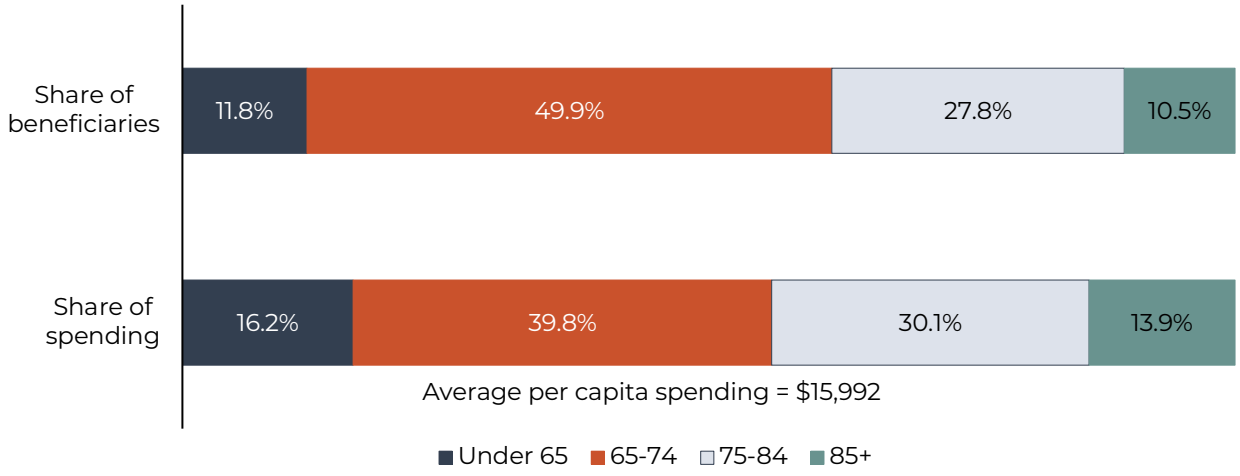
Note: ESRD (end-stage renal disease). The "aged" category comprises beneficiaries ages 65 and older without ESRD. The "disabled" category comprises beneficiaries under age 65 without ESRD. The "ESRD" category comprises beneficiaries with ESRD, regardless of age. Results include both community-dwelling and institutionalized beneficiaries enrolled in fee-for-service and Medicare Advantage plans. 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, 2022.

> In 2022, beneficiaries ages 65 and older without ESRD composed 87.5 percent of the beneficiary population and accounted for 80.4 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 more than 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, 2022



Note: The "65–74," "75–84," and "85+" categories comprise beneficiaries ages 65 and older without end-stage renal disease (ESRD). The "Under 65" category comprises beneficiaries under age 65 with and without ESRD. Results include both community-dwelling and institutionalized beneficiaries enrolled in fee-for-service and Medicare Advantage plans. 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, 2022.

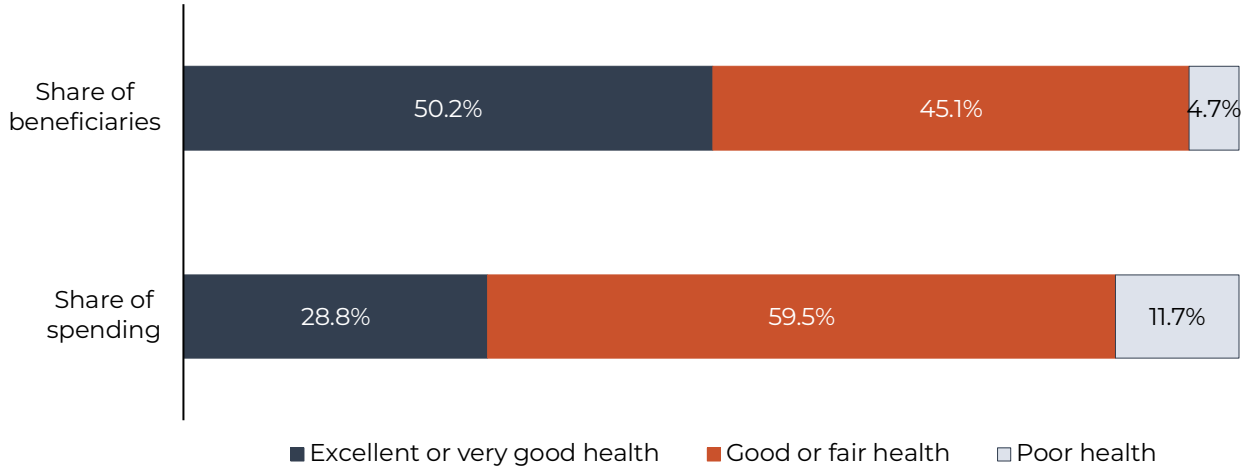
> Beneficiaries younger than 65 made up 11.8 percent of the beneficiary population in 2022 but accounted for 16.2 percent of Medicare spending.

> In 2022, average Medicare spending per beneficiary was $15,992.

> For the aged population (65 and older), per capita expenditures increase with age. In 2022, per capita expenditures were $12,749 for beneficiaries 65 to 74 years old, $17,336 for those 75 to 84 years old, and $21,116 for those 85 or older (data not shown).

> In 2022, per capita expenditures for Medicare beneficiaries under age 65 who were enrolled because of ESRD or disability were $21,954 (data not shown).

Chart 2-3 Beneficiaries who reported being in poor health accounted for a disproportionate share of Medicare spending, 2022



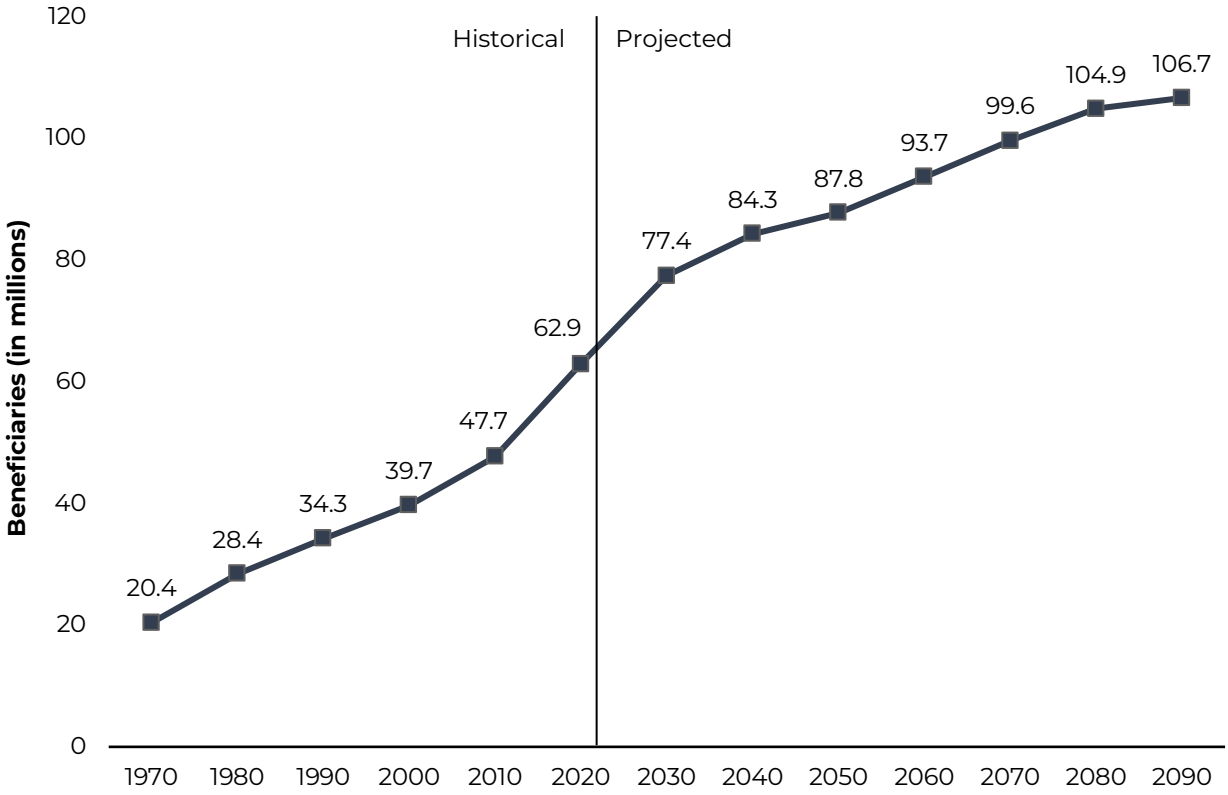
Note: Results include both community-dwelling and institutionalized beneficiaries enrolled in fee-for-service and Medicare Advantage plans. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Beneficiaries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

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file, 2022.

> In 2022, 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 2022, per capita expenditures were $8,879 for those who reported excellent or very good health, $20,365 for those who reported good or fair health, and $38,169 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 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> 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, 2022

Characteristic	Share of the Medicare population	Characteristic	Share of the Medicare population
Total (60.7 million)	100%	Living arrangement	
		Institution	2
Sex		Alone	30
Male	45	With spouse	47
Female	55	Other	21
Race/ethnicity		Education	
White, non-Hispanic	74	No high school diploma	12
Black, non-Hispanic	11	High school diploma only	24
Hispanic	9	Some college or more	62
Other	6		
		Income status	
Age		Below poverty	14
<65	12	100–125% of poverty	6
65–74	49	125–150% of poverty	6
75–84	30	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	45	Medicare managed care	47
Poor	6	Employer-sponsored insurance	20
		Medigap	20
Residence		Medigap with employer-sponsored insurance	1
Urban	83	Medicaid	6
Rural	17	Other	0

Note: Components may not sum to 100 percent due to rounding and exclusion of an "other" category not reflected in this chart. "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, 2022.

> A majority of Medicare beneficiaries are female (55 percent) and White (74 percent).

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

> Thirty percent of the Medicare population lives alone.

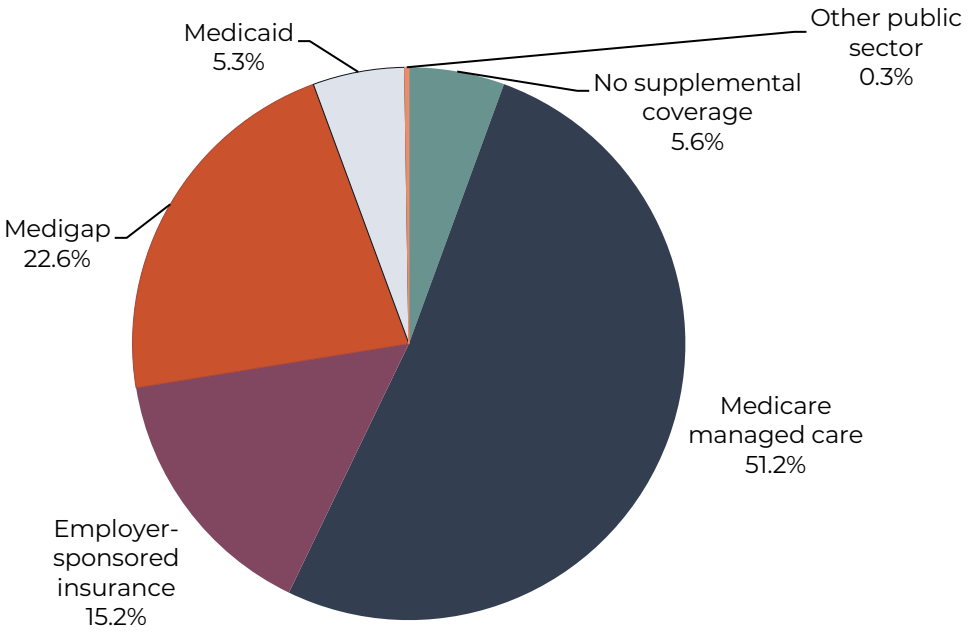
> Most Medicare beneficiaries have some source of supplemental insurance. Managed care plans are the most common source of supplemental coverage.

SECTION

3

Medicare beneficiary and other payer financial liability

Chart 3-1 Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2022



Note: We assigned beneficiaries to the supplemental coverage category in which they spent the most time in 2022. They could have had coverage in other categories during 2022. "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 2022 or who had Medicare as a secondary payer. The number of beneficiaries represented in this chart is 53.5 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, 2022.

> Most beneficiaries living in the community (noninstitutionalized beneficiaries) have coverage that supplements or replaces the Medicare benefit package. In 2022, about 94 percent of beneficiaries had supplemental coverage or participated in Medicare managed care.

> About 38 percent of beneficiaries were enrolled in the Medicare fee-for-service (FFS) program and had private sector supplemental coverage such as Medigap (about 23 percent) or employer-sponsored retiree coverage (15 percent). Beneficiaries in the Medigap category either had Medigap coverage exclusively or had both Medigap and employer-sponsored coverage. Beneficiaries in the "employer-sponsored insurance" category had employer-sponsored retiree coverage as their only source of supplemental insurance.

> About 6 percent of beneficiaries were enrolled in the FFS program and had public sector supplemental coverage, primarily Medicaid.

> Fifty-one percent of beneficiaries participated in Medicare managed care, which includes Medicare Advantage, health care prepayment, and cost plans. That total includes beneficiaries who were enrolled in both Medicare managed care and Medicaid. These types of arrangements generally replace Medicare's FFS 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, 2022

	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	53,491	15%	23%	5%	51%	0%	6%
Age							
<65	6,202	6	5	24	56	0	8
65–69	11,766	12	25	3	53	0	6
70–74	13,513	17	26	3	49	0	5
75–79	10,489	17	25	2	51	0	5
80–84	6,203	19	23	3	50	0	4
85+	5,318	20	23	4	48	0	5
Income-to-poverty ratio							
≤1.00	7,184	2	5	23	66	0	5
1.00 to 1.25	3,459	4	9	15	63	0	9
1.25 to 2.00	9,638	7	18	5	61	0	8
2.00 to 4.00	15,164	17	27	1	49	0	6
>4.00	18,045	26	31	0	40	0	4
Eligibility status							
Aged	46,984	16	25	3	50	0	5
Disabled	6,021	6	4	24	57	0	8
ESRD	485	6	17	31	39	0	7
Residence							
Urban	44,225	15	22	5	53	0	5
Rural	9,246	15	25	8	42	0	10
Sex							
Male	23,710	15	23	5	49	0	6
Female	29,781	15	22	5	53	0	5
Health status							
Excellent/ very good	26,841	18	26	3	48	0	6
Good/fair	23,773	13	19	7	54	0	6
Poor	2,706	8	13	16	57	0	6

Note: ESRD (end-stage renal disease). We assigned beneficiaries to the supplemental coverage category in which they spent the most time in 2022. 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 2022 or who had Medicare as a secondary payer. The number of beneficiaries in the "Age" and "Sex" groupings do not sum to the totals 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, 2022.

> 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 for beneficiaries without Medicare managed care 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 better than poor 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 (i.e., 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, and are rural dwelling.

Chart 3-3 Covered benefits and enrollment in standardized Medigap plans, 2024

	Medigap standardized plan type											
						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	134	405	146	4,932	152	40	5,069	69	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.

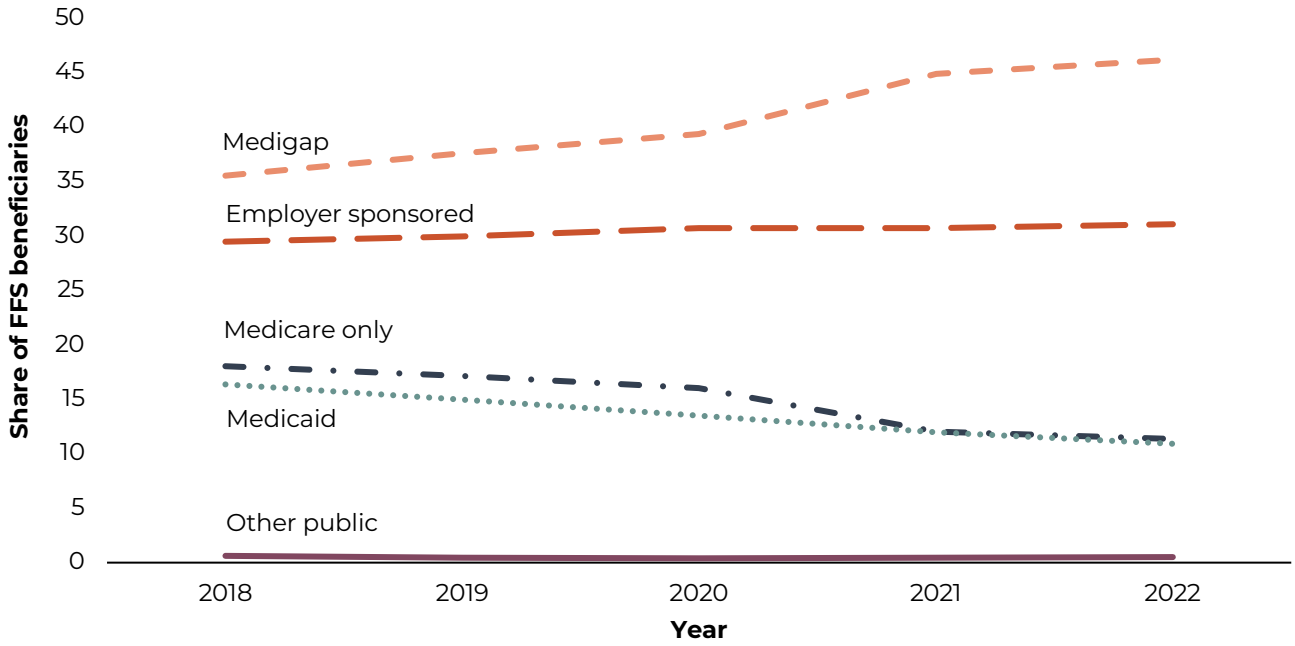
Source: MedPAC analysis of National Association of Insurance Commissioners data, 2024.

> 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.

> The non-high-deductible version of Plan G, which covers all Medicare cost sharing except the Part B deductible, is the most popular plan, with almost 5.1 million enrollees. In previous years, Plan F had been the most popular. 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 2024, 12.4 million beneficiaries enrolled in Medigap plans (including those in Massachusetts, Minnesota, and Wisconsin). Chart 3-2 indicates that about 12.1 million beneficiaries had Medigap coverage (23.5 percent of the 53.5 million beneficiaries included in that chart). The variance 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 2022 data, while Chart 3-3 is based on 2024 data).

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, 2018–2022



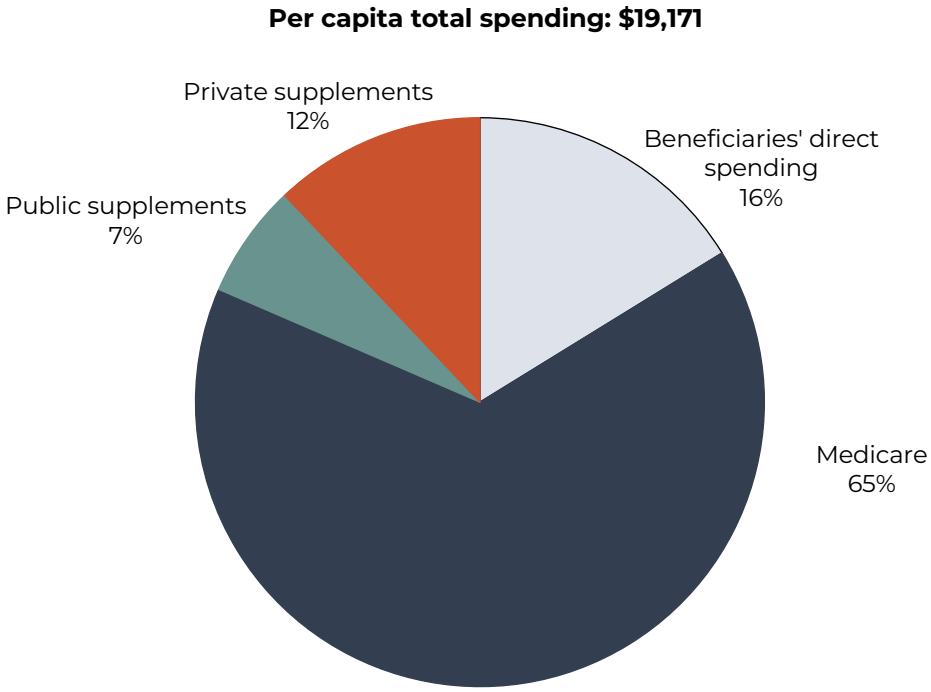
Note: FFS (fee-for-service). We assigned beneficiaries to the supplemental coverage category in which they spent the most time in 2022. They could have had coverage in other categories during that year. "Other public" includes federal and state programs not included in other categories. This analysis 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 2022 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, 2022.

> From 2018 to 2022, the share of FFS beneficiaries who had Medigap supplemental coverage rose from 36 percent to 46 percent. Over the same period, the share who had Medicaid coverage decreased from 16 percent to 11 percent, and the share who had no supplemental coverage ("Medicare only") dropped from 18 percent to 11 percent. The share with 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, 2022



Note: FFS (fee-for-service). "Per capita total spending" includes both health care services covered by Medicare (including hospital and physician care and prescription drugs) and services not covered by Medicare (such as dental care and over-the-counter medications). "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, 2022.

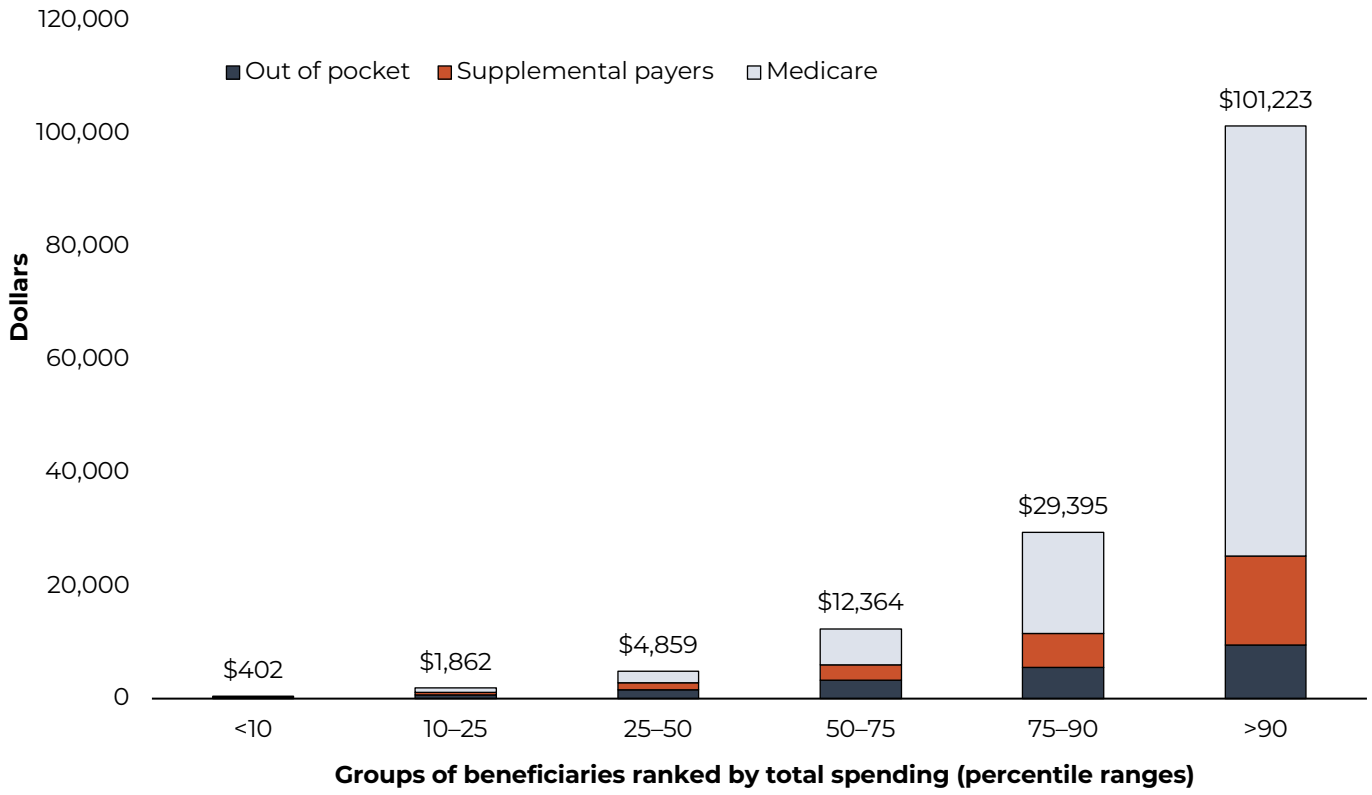
> Among FFS beneficiaries living in the community (rather than in an institution), the total cost of health care services (beneficiaries' direct spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) averaged about $19,000 in 2022 . That total includes both health care services covered by Medicare (including hospital and physician care, and prescription drugs) and services not covered by Medicare (such as dental care and over-the-counter medications). Medicare was the largest source of payment: It paid 65 percent of the health care costs for FFS beneficiaries living in the community, an average of $12,513 per beneficiary.

> Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and Medigap—paid about 12 percent of beneficiaries' costs, an average of $2,309 per beneficiary.

> Beneficiaries paid about 16 percent of their health care costs (not including supplemental insurance premiums) out of pocket, an average of $3,107 per beneficiary.

> Public sources of supplemental coverage—primarily Medicaid—paid less than 7 percent of beneficiaries' health care costs, an average of $1,240 per beneficiary.

Chart 3-6 Distribution of per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2022



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 cost sharing for Medicare-covered services and spending on noncovered services but not premium payments for supplemental coverage. "Supplemental payers" spending includes both public and private forms of supplemental coverage spending such as employer-sponsored plans, individually purchased coverage, Medicaid, Department of Veterans Affairs, and other forms of public coverage. 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, 2022.

> Total spending on health care services varied dramatically among FFS beneficiaries living in the community in 2022. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged $101,223. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged $402.

> 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 52 percent of total spending for beneficiaries in the 50th percentile to 75th percentile of total spending on health care services, while beneficiaries' out-of-pocket spending amounted to 27 percent of total spending for this group. Among FFS beneficiaries in the 90th percentile of total spending on health care services, Medicare paid for 75 percent of total spending, while out-of-pocket spending amounted to only 9 percent of total spending for this group.

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 paid $5,207 for Part A benefits and $6,757 for Part B benefits, 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).

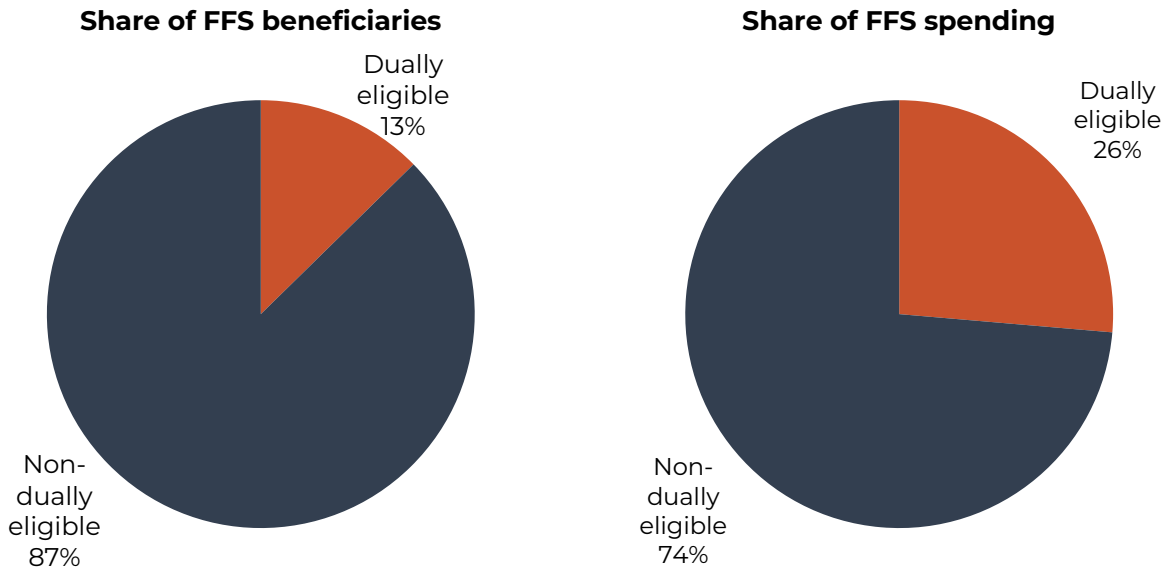
> The results in this chart are based on all Medicare FFS beneficiaries, while the results in Chart 3-5 and Chart 3-6 exclude the FFS Medicare beneficiaries who were living in institutions. Also, this chart includes only Medicare-covered services; Chart 3-5 and Chart 3-6 include both Medicare-covered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

SECTION

4

Dually eligible beneficiaries

Chart 4-1 Dually eligible beneficiaries accounted for a disproportionate share of Medicare spending, 2022



Note: FFS (fee-for-service). "Dually 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 some reported data is expected.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2022.

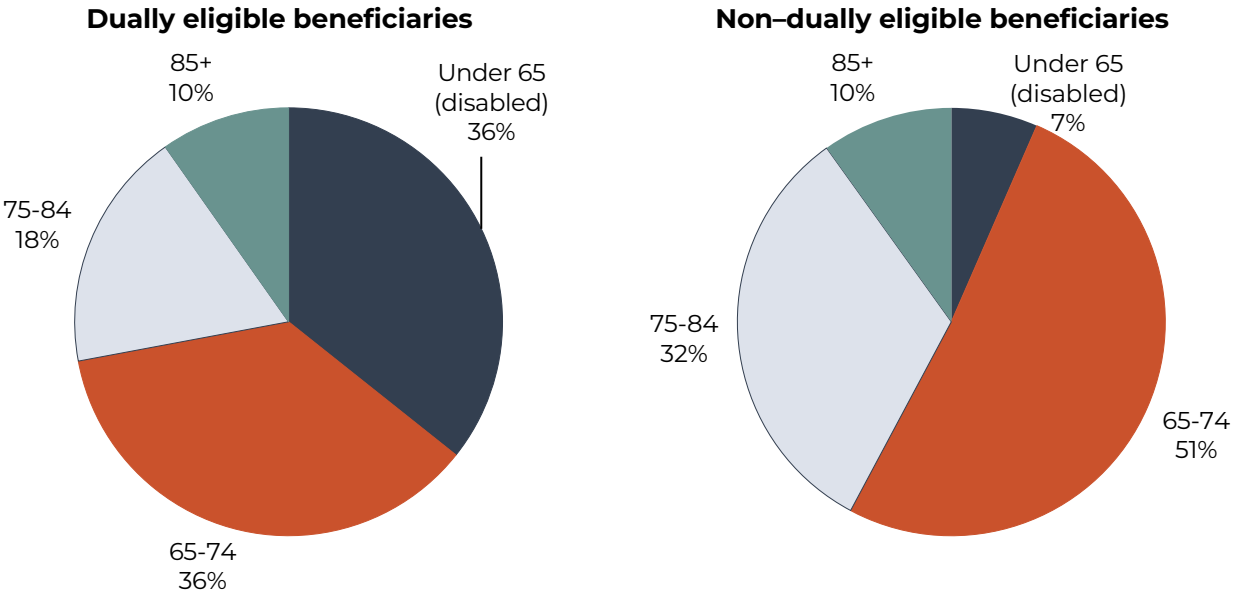
> Dually eligible beneficiaries are those who qualify for both Medicare and Medicaid. Medicaid is a joint federal and state program designed to help people with low incomes obtain the health care they need.

> Dually eligible beneficiaries account for a disproportionate share of FFS Medicare expenditures. Although they were 13 percent of the FFS Medicare population in 2022, they represented 26 percent of aggregate FFS Medicare spending.

> On average, FFS Medicare per capita spending is more than twice as high for dually eligible beneficiaries compared with non–dually eligible beneficiaries: In 2022, $28,699 was spent per dually eligible beneficiary and $11,619 was spent per non–dually eligible beneficiary (data not shown).

> In 2022, average total spending—which includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending across all payers—for dually eligible beneficiaries was $44,463 per beneficiary, more than twice the amount for other Medicare beneficiaries (data not shown).

Chart 4-2 Dually eligible beneficiaries were more likely than non–dually eligible beneficiaries to be under age 65 and have a disability, 2022



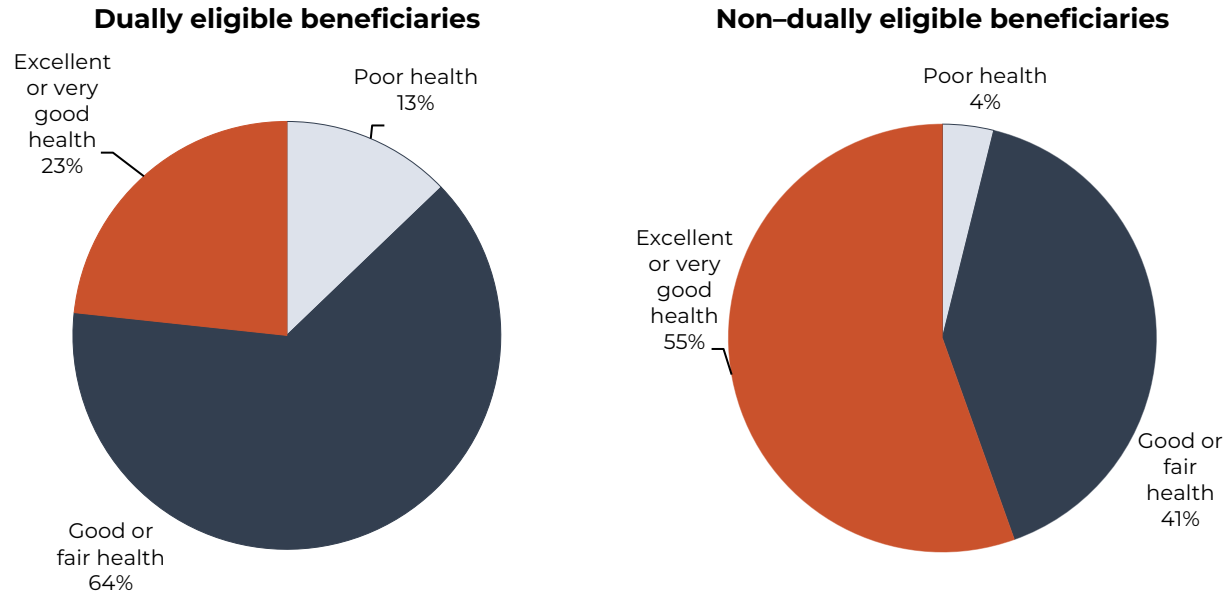
Note: Beneficiaries who are under age 65 generally qualify for Medicare because of disability. Once beneficiaries with disabilities reach age 65, they are counted as aged beneficiaries. "Dually eligible beneficiaries" are defined as beneficiaries who were eligible for both Medicare and Medicaid for at 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 some reported data is expected.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2022.

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

> Dually eligible beneficiaries are more likely than non–dually eligible beneficiaries to be under age 65 and have a disability. In 2022, 36 percent of dually eligible beneficiaries were under age 65 and had a disability compared with 7 percent of the non–dually eligible population.

Chart 4-3 Dually eligible beneficiaries were more likely than non–dually eligible beneficiaries to report being in poor health, 2022



Note: "Dually 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 some reported data is expected.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2022.

> Dually eligible beneficiaries are more likely than non–dually eligible beneficiaries to report being in poor health. In 2022, 13 percent of dually eligible beneficiaries reported being in poor health compared with 4 percent of non–dually eligible beneficiaries.

> Over half of non–dually eligible beneficiaries (55 percent) reported being in excellent or very good health in 2022. In comparison, less than one-quarter (23 percent) of dually eligible beneficiaries reported being in excellent or very good health.

Chart 4-4 Demographic differences between dually eligible beneficiaries and non–dually eligible beneficiaries, 2022

Characteristics	Share of dually eligible beneficiaries	Share of non–dually eligible beneficiaries
Sex		
Male	39%	47%
Female	61	53
Race/ethnicity		
White, non-Hispanic	46	81
Black, non-Hispanic	23	8
Hispanic	22	6
Other	9	6
Limitations in ADLs		
No limitations in ADLs	49	77
Limitations in 1–2 ADLs	25	16
Limitations in 3–6 ADLs	26	7
Residence		
Urban	80	84
Rural	20	16
Living arrangement		
Institution	8	1
Alone	36	28
With spouse	15	55
With children, nonrelatives, others	41	16
Education		
No high school diploma	35	7
High school diploma only	32	23
Some college or more	33	70
Income status		
Below poverty	56	4
100–125% of poverty	18	4
125–150% of poverty	9	5
150–200% of poverty	9	12
200–400% of poverty	7	32
Over 400% of poverty	<1	43
Supplemental insurance status		
Medicare or Medicare/Medicaid only	29	8
Medicare managed care	63	43
Employer-sponsored insurance	1	24
Medigap	4	24
Medigap/employer	<1	1
Other*	2	<1

Note: ADL (activity of daily living). "Dually eligible beneficiaries" are defined as beneficiaries who 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. Components may not sum to 100 percent due to rounding. The Medicare Current Beneficiary Survey is a point-in-time survey of a sample of beneficiaries; year-to-year variation in some data 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, 2022.

> Dually eligible beneficiaries qualify for Medicaid due in part to low incomes. In 2022, 56 percent of dually eligible beneficiaries lived below the poverty threshold, and 93 percent lived below 200 percent of the poverty threshold. Compared with non–dually eligible beneficiaries, dually 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 dually eligible beneficiaries and non–dually eligible beneficiaries, 2022

Service	Dually eligible beneficiaries	Non–dually eligible beneficiaries
Average FFS Medicare payments per capita		
All covered services	$26,538	$15,538
Inpatient hospital	6,665	3,562
Physician and other noninstitutional Part B services*	3,981	3,887
Outpatient hospital and other institutional Part B services**	3,490	2,955
Home health	871	453
Skilled nursing facility	2,304	588
Hospice	703	332
Prescription drugs (Part D)	8,525	3,761
Share of FFS beneficiaries using service		
Share using any type of service	93.8%	98.5%
Inpatient hospital	20.8	13.6
Physician and other noninstitutional Part B services*	89.3	96.9
Outpatient hospital and other institutional Part B services**	73.9	78.3
Home health	11.6	8.6
Skilled nursing facility	9.4	3.3
Hospice	4.5	2.6
Prescription drugs (Part D)	89.1	94.3

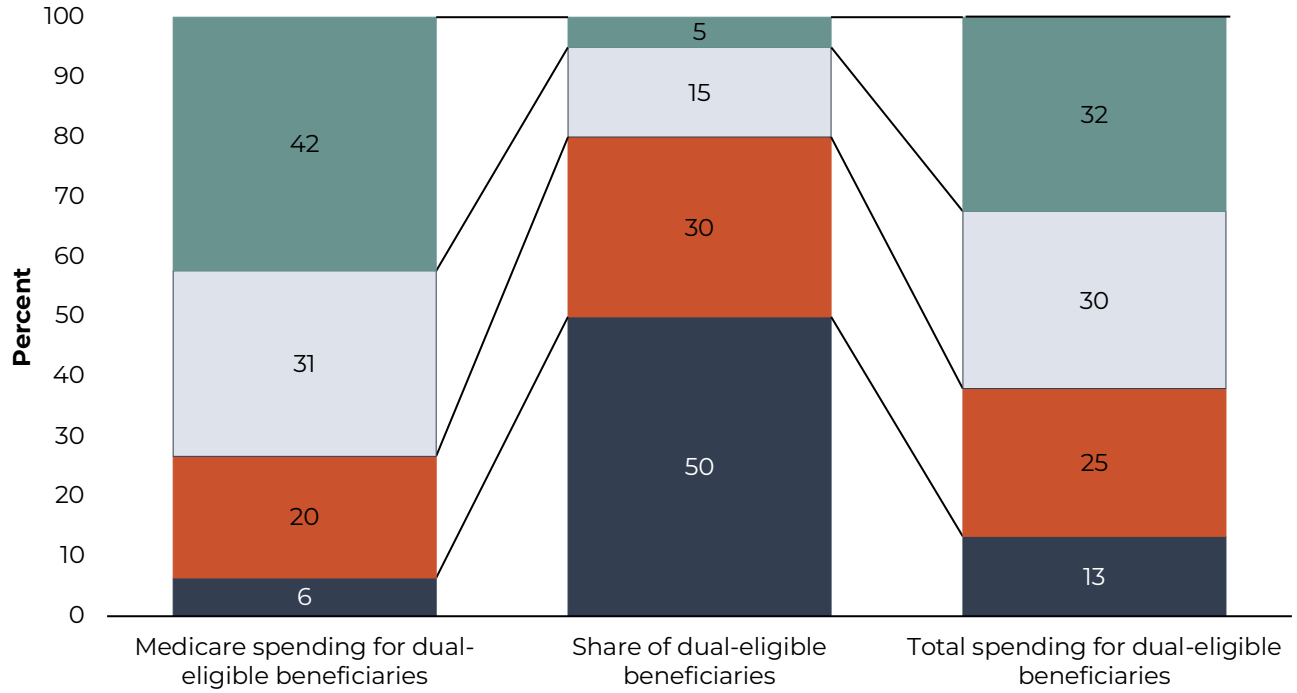
Note: FFS (fee-for-service). Data in this analysis are restricted to beneficiaries in FFS Medicare who had Part A, Part B, and Part D coverage. "Dually eligible beneficiaries" are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. Components may not sum to totals due to rounding.
* Includes a variety of medical services, equipment, and supplies.
** Includes dialysis facilities, ambulatory surgical centers, and clinics; does not include Part B–covered home health.

Source: MedPAC analysis of CMS's Medicare Beneficiary Summary File, 2022.

> In 2022, among beneficiaries who had Part A, Part B, and Part D coverage, average per capita FFS Medicare spending for dually eligible beneficiaries was about 70 percent higher than that for non–dually eligible beneficiaries—$26,538 compared with $15,538.

> For each type of service, average FFS Medicare per capita spending was higher for dually eligible beneficiaries than for non–dually eligible beneficiaries. Dually eligible beneficiaries are more likely than non–dually eligible beneficiaries to use Part A–covered services such as inpatient hospital and skilled nursing facility services but are slightly less likely to use Part B–covered services and Part D–covered prescription drugs.

Chart 4-6 **Both Medicare and total spending were concentrated among a small number of dually eligible beneficiaries, 2022**



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. "Dually eligible beneficiaries" are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. Components may not sum to totals 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 some reported data is expected.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2022.

> Annual FFS Medicare and total spending on dually eligible beneficiaries is concentrated among a small number of people. The costliest 5 percent of dually eligible beneficiaries accounted for 42 percent of Medicare spending and 32 percent of total spending on dually eligible beneficiaries in 2022. In contrast, the least costly 50 percent of dually eligible beneficiaries accounted for only 6 percent of FFS Medicare spending and 13 percent of total spending on dually eligible beneficiaries.

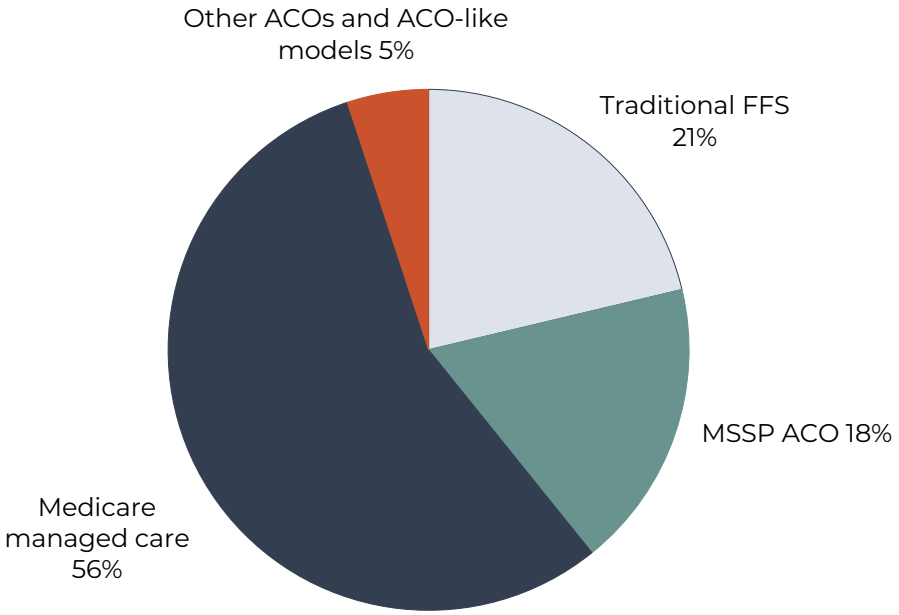
> On average, total spending (including Medicaid, Medigap, etc.) for dually eligible beneficiaries in 2022 was more than twice that for non–dually eligible beneficiaries—$44,463 compared with $19,362, respectively (data not shown).

SECTION

5

Alternative payment models

Chart 5-1 Most Medicare beneficiaries are in managed care plans or are assigned to accountable care organizations, 2025



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 2025. 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" includes 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 of 2015 (MACRA) bonus payments for participation in eligible alternative payment models.

Source: CMS January 2025 enrollment data, CMS Shared Savings Program January 2025 Fast Facts, CMS ACO REACH 2025 Fast Facts, and State of Vermont Green Mountain Care Board 2023 Medicare ACO settlement.

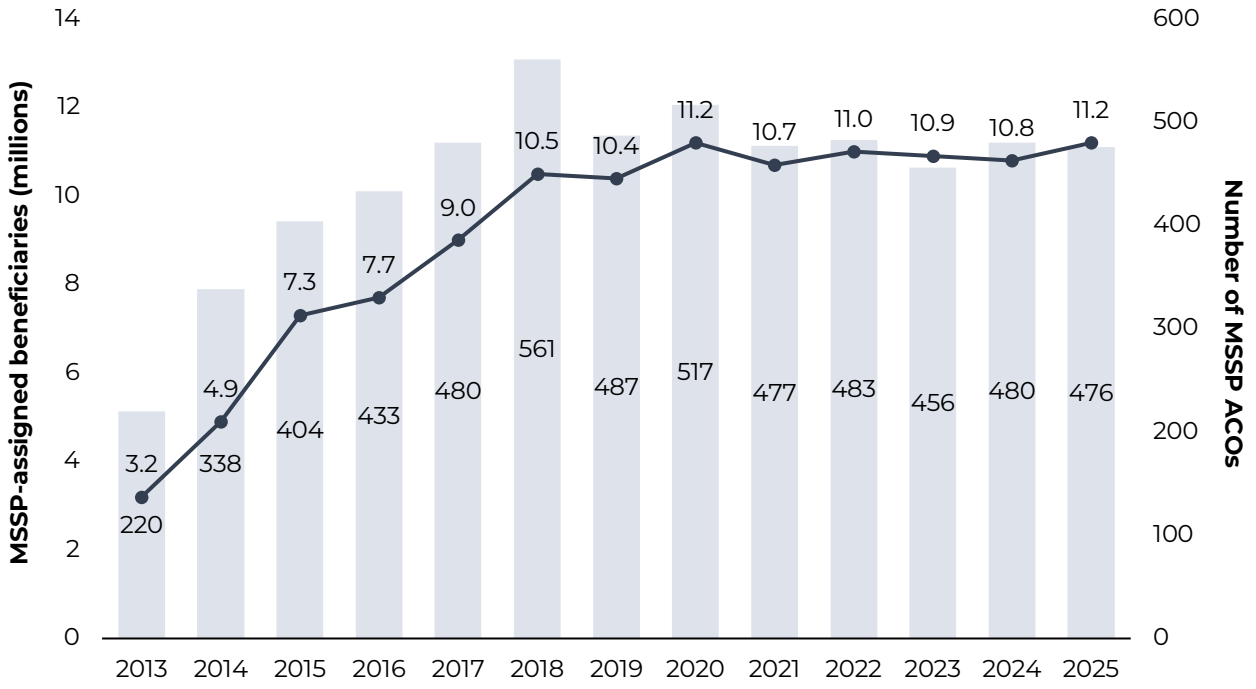
> Among the 62.5 million Medicare beneficiaries with both Part A and Part B coverage in 2025, more than three-fourths (79 percent) are in Medicare managed care (Medicare Advantage or other private plans) or ACO models.

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

> Only 21 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 2025 Fast Facts.

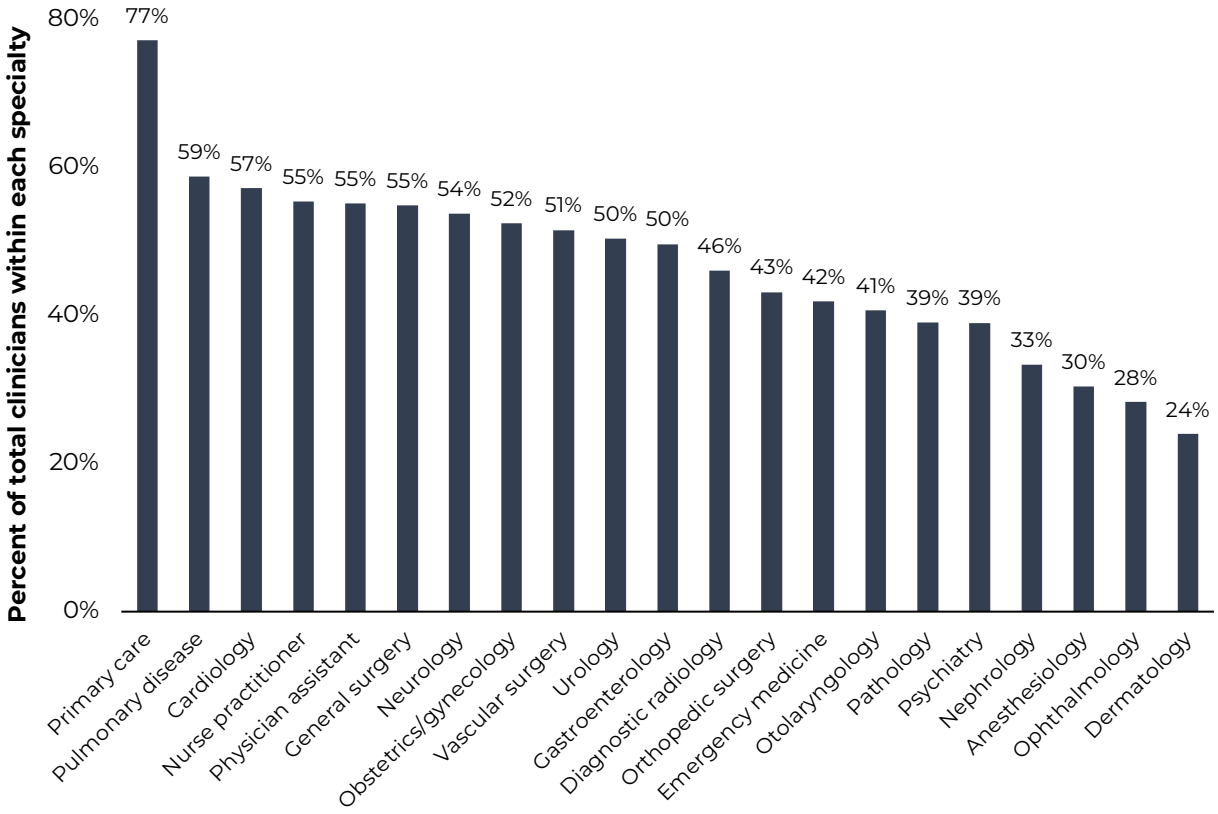
> The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 but has leveled off in recent years. In 2025, 18 percent of beneficiaries enrolled in both Part A and Part B were assigned to an MSSP ACO (see Chart 5-1).

> The number of ACOs peaked at 561 in 2018 and then declined to 487 in January 2019. In 2025, there were 476 ACOs—a slight decrease relative to 2024.

> At the end of 2018, CMS finalized changes to the MSSP 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 2025, the number of assigned beneficiaries (11.2 million) is similar to the amount in 2020.

Chart 5-3 Clinician 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 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.

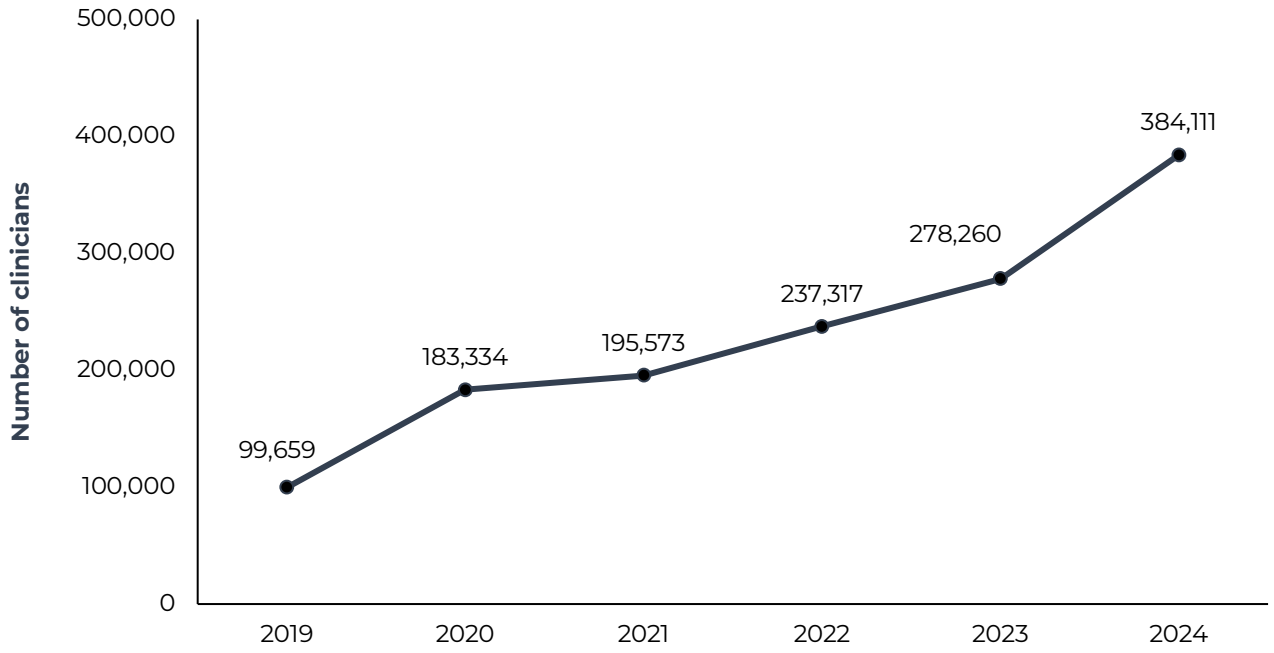
Source: Shared Savings Program Accountable Care Organizations public use files and research identifiable files from CMS; Carrier Standard Analytic File for 100 percent of Medicare beneficiaries from CMS.

> 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 fee-for-service (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 An increasing number of clinicians qualified for the A–APM participation bonus, 2019–2024



Note: A–APM (advanced alternative payment model). Numbers have been rounded to the nearest thousand. Figure shows the number of clinicians who qualified for the A–APM participation bonus in a given year (based on their A–APM participation two years prior), which may be higher than the number who actually received the bonus (e.g., due to retirement).

Source: MedPAC analysis of CMS data identifying the national provider identifiers of clinicians who qualified for the A–APM participation bonus linked to 100 percent of fee schedule claims.

> The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established bonus payments for clinicians who participate in A–APMs. A–APMs are models that require participating providers to take on a more-than-nominal amount of financial risk, tie bonuses to quality measures, and require the use of electronic health records that have been certified by the federal government. Clinicians are eligible to receive a participation bonus worth 5 percent of their Medicare payments for fee schedule services from 2019 through 2024, a bonus worth 3.5 percent of these payments in 2025, and a bonus worth 1.88 percent in 2026.

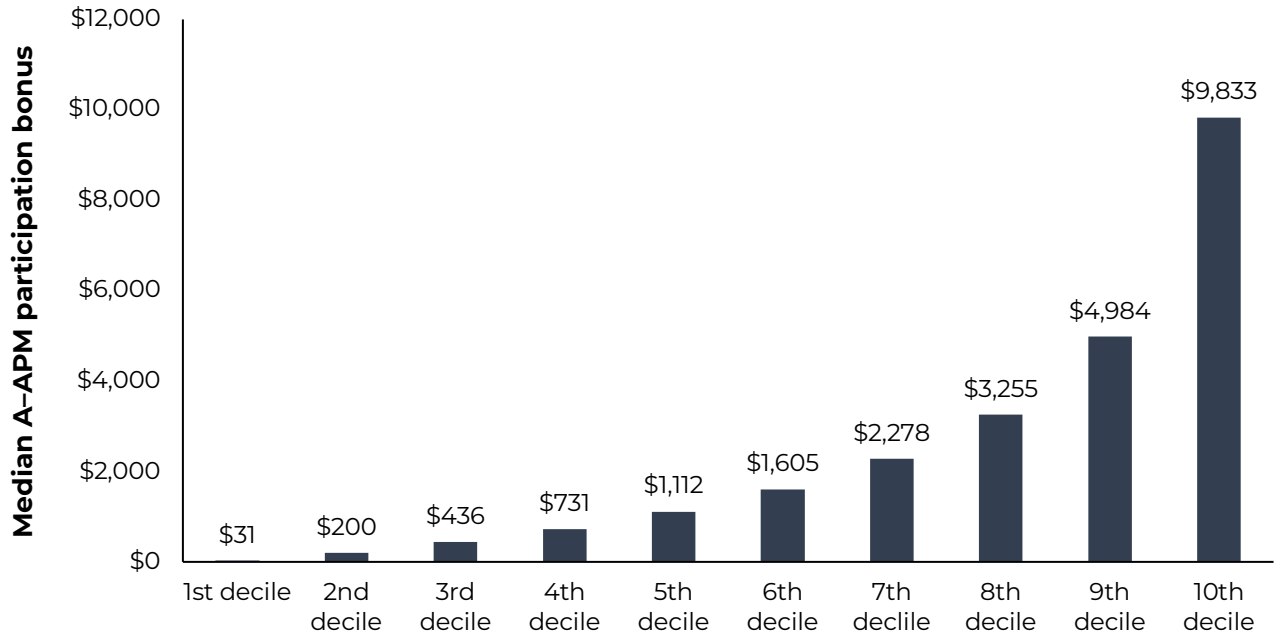
> Bonus payments are paid two years after the year in which a clinician participates in an A–APM.

> To qualify for the bonus payment in most of the years shown above, at least 50 percent of a clinician's FFS Medicare or multipayer payments had to be associated with an A–APM or at least 35 percent of a clinician's FFS Medicare or multipayer patients had to be participating in an A–APM.

> The number of clinicians who qualified for the A–APM participation bonus has increased steadily since it first became available in 2019 but has remained a minority of all clinicians. About one in three clinicians who billed the physician fee schedule received the bonus in 2024.

> We estimate that 34,000 clinicians participated in A–APMs in the 2024 payment year but did not qualify for the A–APM participation bonus due to an insufficient share of their payments or patients being in A–APMs (data not shown). Another 116,000 clinicians were in alternative payment models that did not meet MACRA's criteria to be considered an A–APM (e.g., they did not require clinicians to take on a sufficient degree of financial risk), so they were not eligible for MACRA's participation bonus.

Chart 5-5 The size of A–APM participation bonuses varied widely, 2023



Note: A–APM (advanced alternative payment model). Figure shows MedPAC's estimates of the median bonus amount at different deciles in the 2023 payment year. Bonuses were calculated based on A–APM participation from two years prior (2021) and Medicare payments from one year prior (2022). Bonuses totaled $607 million in our analysis, which is lower than the $644 million that CMS reported paying out in 2023 (Centers for Medicare & Medicaid Services 2023). Our estimates are slight underestimates of bonus sizes primarily because, when calculating bonuses, we did not include supplemental service payments that clinicians receive through A–APMs (e.g., capitated care-management fees).

Source: MedPAC analysis of CMS data identifying the national provider identifiers of clinicians who qualified for the A–APM participation bonus linked to 100 percent of physician fee schedule claims.

> The size of A–APM participation bonuses varies based on a clinician's total annual fee-for-service (FFS) Medicare payments for physician fee schedule services. By our estimates, the median size of all bonus payments in 2023 (when it was 5 percent of a clinician's fee schedule payments) was $1,287 (data not shown).

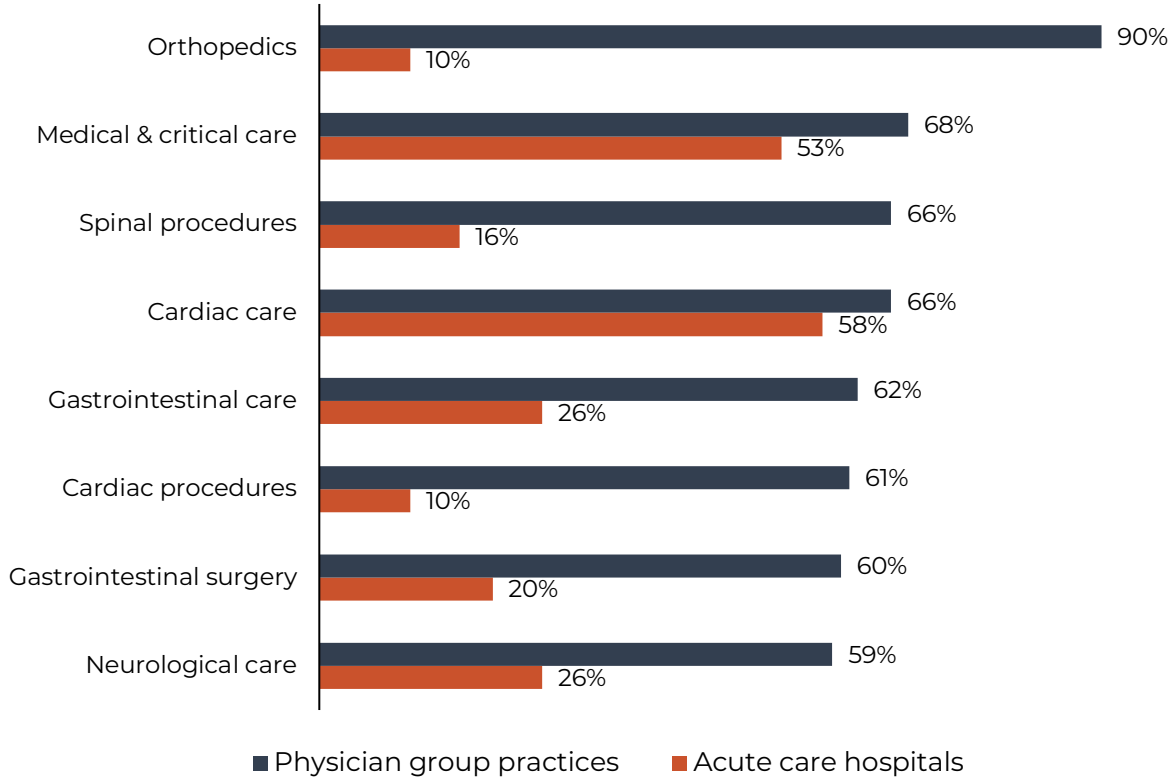
> Among the 10 percent of clinicians who received the smallest bonus, the median bonus was $31; among the 10 percent of clinicians who received the largest bonus, the median bonus was $9,833.

> Because of "incident to" billing rules, which allow physicians to bill for services furnished by advanced practice registered nurses (APRNs) and physician assistants (PAs), bonuses paid to a single physician may be partly based on services performed by these other types of clinicians.

> Specialists received larger A–APM participation bonuses than primary care physicians, APRNs and PAs, and other clinicians in 2023 because specialists tend to generate more annual FFS Medicare payments than other types of clinicians (not shown).

> All clinicians in advanced payment models are also eligible for payments available through these models (e.g., shared savings payments), which are not shown here.

Chart 5-6 Share of BPCI Advanced episode initiators accepting responsibility for each clinical-episode group, 2025



Note: BPCI (Bundled Payments for Care Improvement). BPCI Advanced participants can accept episode-based payments for multiple clinical-episode service-line groups. Some participants work with other acute care hospitals or physician group practices to initiate and manage episodes. The denominators for each group are 105 episode initiators among physician group practices and 103 episode initiators among acute care hospitals in 2025.

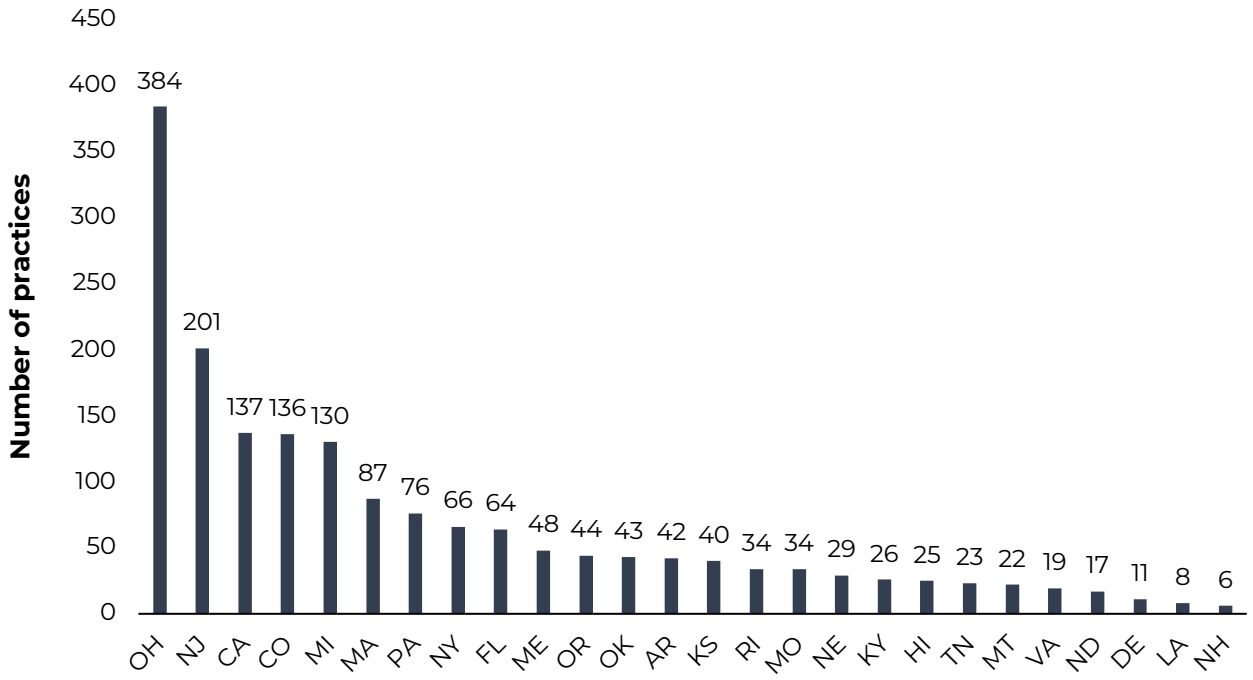
Source: List of clinical-episode service-line groups that each BPCI Advanced participating episode initiator agreed to take financial responsibility for in Model Year 8 (2025), downloaded from CMS's BPCI Advanced webpage (https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced).

> 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). Hospitals and physician practices select the service-line groups for which they will be financially responsible under the model.

> Among the 105 physician practices that initiate episodes in the model, 90 percent initiate episodes in the orthopedics service-line group, while 59 percent initiated episodes in the neurology care service line. Among participating hospitals, there is more variation. Of the 103 acute care hospitals that initiate episodes, 58 percent initiated episodes in the cardiac care service line, but only 10 percent initiated episodes in the orthopedics and cardiac procedure groups.

> Almost 60 percent of physician practices in the model initiate episodes in all eight service-line groups in 2025, which is substantially less than the 80 percent of practices that initiated episodes in all service-line groups in 2023 (data not shown). In 2025, no acute care hospitals initiated episodes in all eight service-line groups, and 90 percent initiated episodes in fewer than four service-line groups (data not shown).

Chart 5-7 About 1,750 practices in 26 states are testing the Primary Care First Model, 2025



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 as of March 2025 (https://innovation.cms.gov/innovation-models/primary-care-first-model-options).

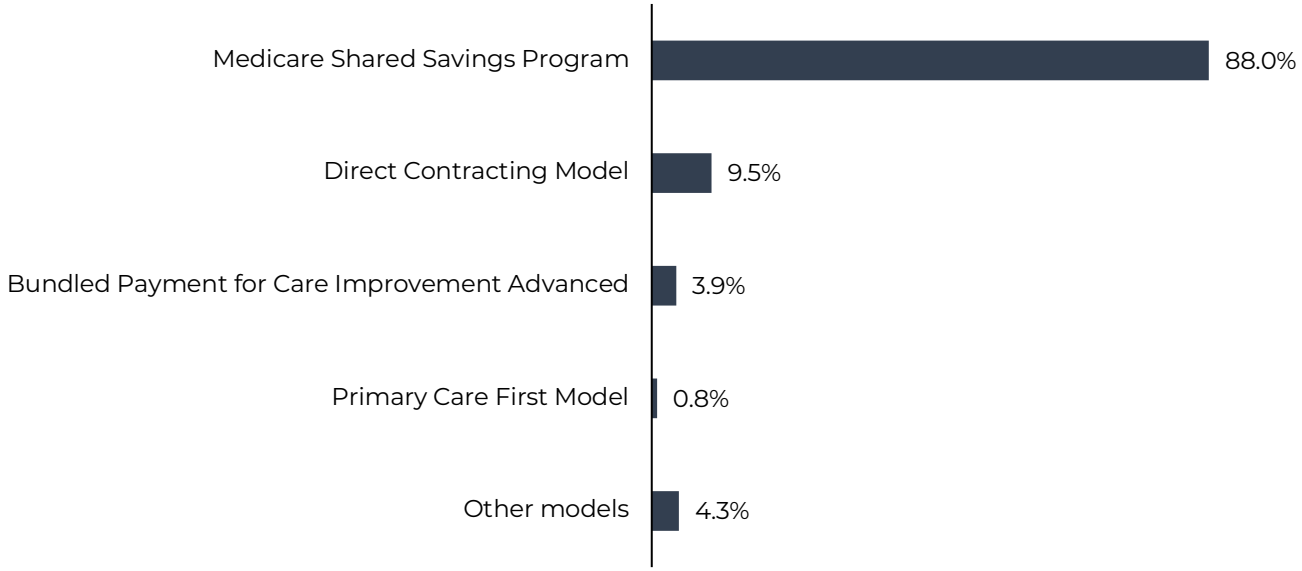
> CMS's Primary Care First is an advanced alternative payment model that has just over 1,750 participating practices in 26 states in 2025 (its final year). Substantially fewer practices participated in the model in 2025 than 2024, when participation was about 2,200 (data not shown).

> 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. Roughly 40 percent of practices in Primary Care First are located in three states (Ohio, New Jersey, and California), while 10 percent of participants are in 10 states (Nebraska, Kentucky, Hawaii, Tennessee, Montana, Virginia, North Dakota, Delaware, Louisiana, and New Hampshire).

Chart 5-8 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 determined 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 payments for professional services 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 the payments a clinician receives for their 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 Accountable Care Organization 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 are 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 Almost all FFS Medicare beneficiary inpatient stays were paid under IPPS, FY 2023

	Number of hospitals	All-payer inpatient stays	FFS Medicare inpatient stays
All	**4,305**	**29.5 million**	**6.8 million**
Share of total			
IPPS	68%	96%	94%
Ownership			
For profit	16	15	13
Nonprofit	42	68	70
Government	10	13	11
Geography*			
Metropolitan	53	90	86
Rural micropolitan	11	5	7
Other rural	4	1	1
DSH and teaching			
Both	28	67	61
DSH only	31	24	26
Teaching only	2	2	3
Neither	7	3	4
Critical access	30	2	3
Other	2	2	3

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), FY (fiscal year), DSH (disproportionate share). Data include all Subsection (d) and critical access hospitals that, as of our analysis, had a complete cost report with 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. Components may not sum to totals due to rounding.

* 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.

Source: MedPAC analysis of hospital cost-report data and census geographic data.

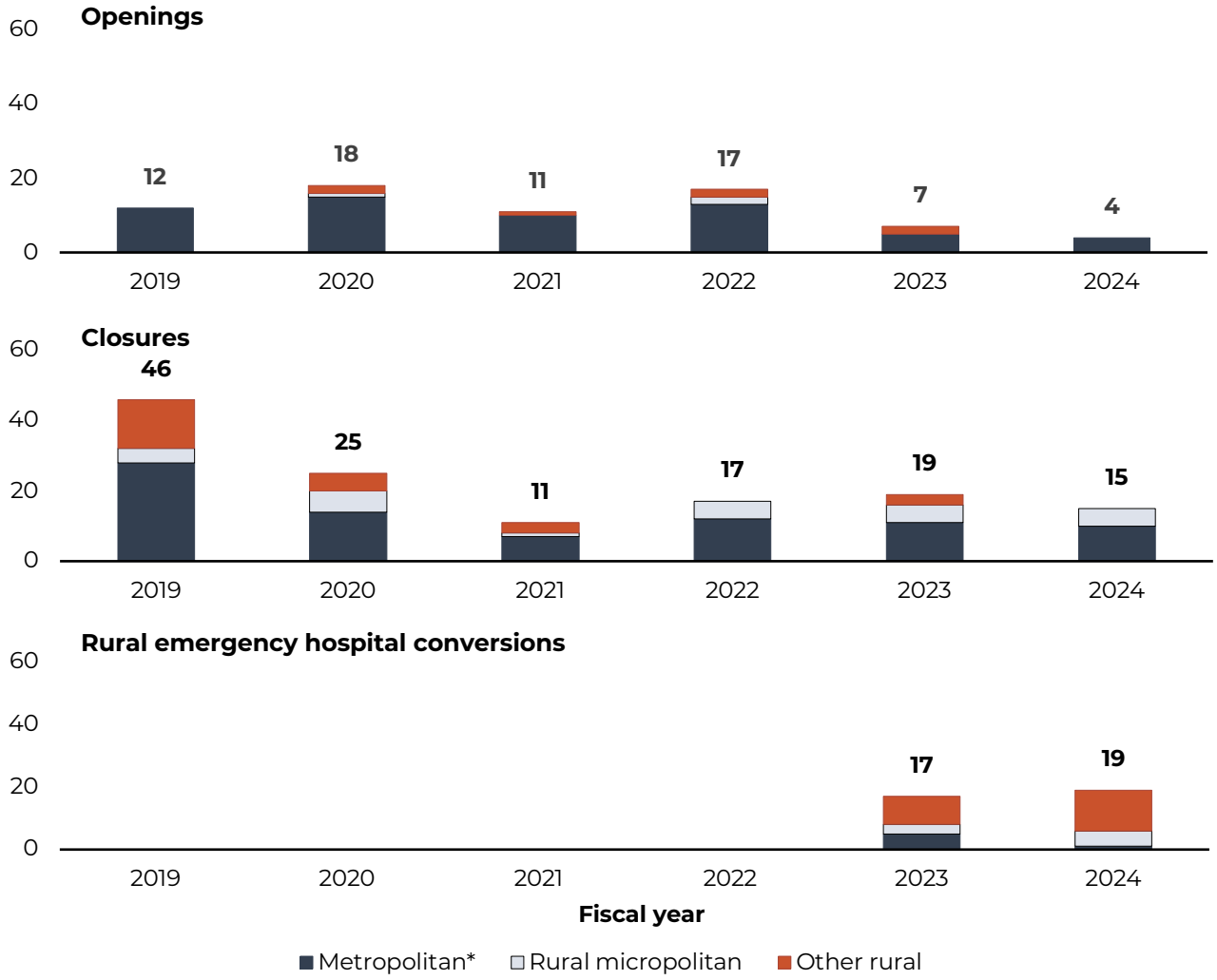
> In FY 2023, there were approximately 4,300 hospitals with complete cost reports as of our analysis, at which there were 29.5 million inpatient stays. Nearly a quarter of these stays (6.8 million) were by FFS Medicare beneficiaries.

> For about two-thirds of hospitals, FFS Medicare paid for inpatient stays under Medicare's IPPS. These hospitals accounted for nearly all inpatient stays and FFS Medicare inpatient stays.

> About 30 percent of hospitals were designated by Medicare as critical access hospitals (CAHs), which FFS Medicare pays on a cost basis. Because CAHs have 25 or fewer inpatient beds, only a very small share of inpatient stays were at CAHs. However, nearly 40 percent of inpatient stays at CAHs were by FFS Medicare beneficiaries.

> About 2 percent of hospitals were paid by FFS Medicare using other methodologies, such as hospitals participating in the Maryland Total Cost of Care Model or other demonstrations.

Chart 6-2 More hospitals closed than opened in FY 2024, and others converted to rural emergency hospitals



Note: FY (fiscal year). Data include all Subsection (d) and critical access hospitals. "Openings" refers to a new location for inpatient services, while "closures" refers to a hospital that ceased inpatient services and did not convert to a rural emergency hospital. The counts of openings and closures do not include the relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor do they include hospitals that both opened and closed within a five-year period. The number of closures and openings in a given year can differ from prior publications as hospitals reopen and newer data become available.
* 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.

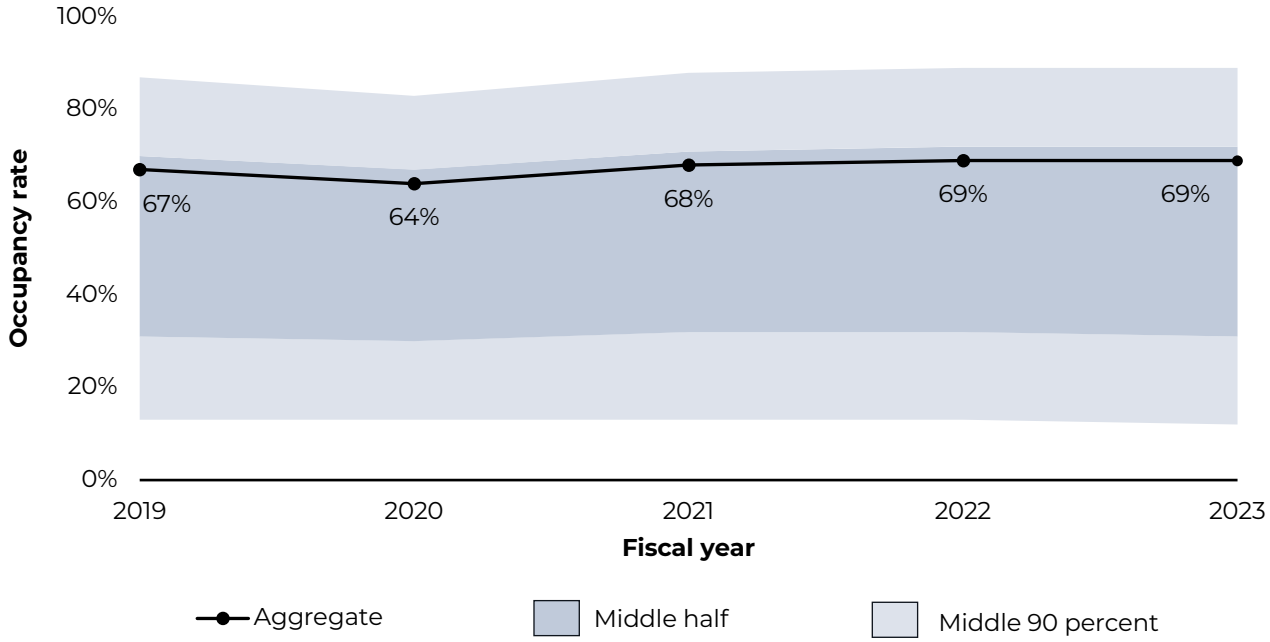
Source: MedPAC analysis of the CMS Provider of Services file, census geographic data, and internet searches.

> In FY 2024, 4 hospitals opened while 15 closed; another 19 converted to rural emergency hospitals (REHs). (The REH program is an outpatient-only hospital designation that first became available in 2023.)

> Consistent with prior years, the majority of openings and closures in FY 2024 were in urban (metropolitan) areas. The majority of REH conversions were in rural nonmicropolitan areas ("other rural" in the chart).

> In FY 2024, all closures but one were located less than 50 miles from another hospital (data not shown).

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



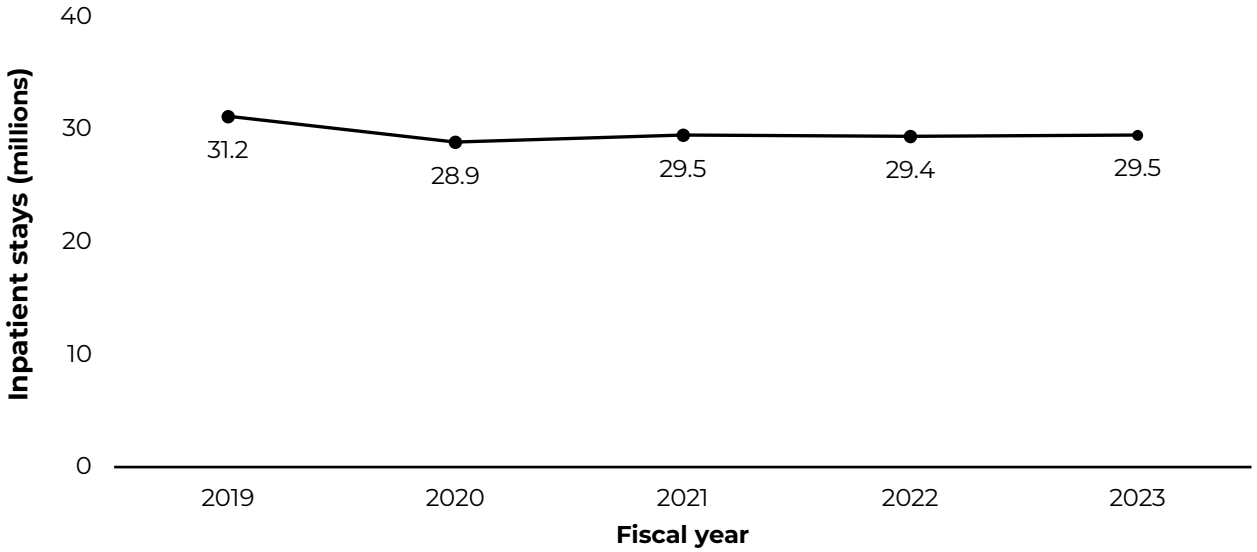
Note: Data include all Subsection (d) and critical access hospitals that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year and had non-outlier data. "Occupancy rate" refers to the share of inpatient bed days that were occupied by a patient (regardless of whether the patient was receiving inpatient, observation, or swing-bed services). The number of inpatient bed days available may be higher than staffed bed days. Results differ from those published last year because of newer data and methodological updates.

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

> In fiscal year (FY) 2023, hospitals continued to have available inpatient capacity in aggregate. Hospitals' occupancy rate was 69 percent in FY 2023, the same level as in FY 2022.

> However, as in past years, there was significant variation within these aggregates, with some hospitals having substantially higher available capacity while others faced capacity constraints. In FY 2023, 5 percent of hospitals had an occupancy rate under 12 percent, while another 5 percent had an occupancy rate over 89 percent.

Chart 6-4 All-payer inpatient stays remained steady in FY 2023 and below prepandemic level



Note: FY (fiscal year). Data include all Subsection (d) and critical access hospitals that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year. Results differ from those published last year because of changing the data source and limiting the data to Subsection (d) and critical access hospitals that had at least one fee-for-service Medicare stay.

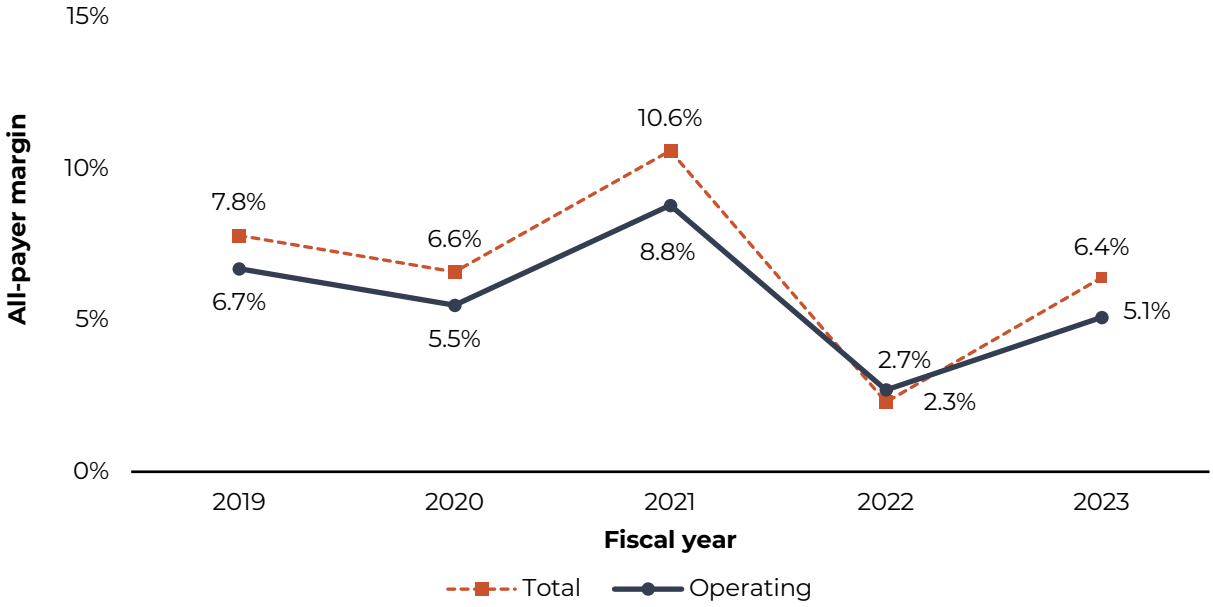
Source: MedPAC analysis of hospital cost-report data from CMS.

> In FY 2019, hospitals provided about 31 million inpatient stays, similar to the level since 2015 (latter data not shown).

> In FY 2020, the number of inpatient stays declined, reflecting delayed and forgone care during the start of the coronavirus public health emergency.

> Inpatient volume partially rebounded to 29.5 million stays in FY 2021 and remained at a similar level in FY 2022 and FY 2023.

Chart 6-5 Hospitals' all-payer margins increased in FY 2023 from relative lows in FY 2022



Note: FY (fiscal year). Data are for hospitals paid under the inpatient prospective payment systems that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year and had non-outlier data. Hospitals' all-payer total margin is an aggregate, calculated as the percentage of revenue from all payers and sources that is left as profit after accounting for costs. Hospitals' all-payer operating margin excludes investment and donation income. Results differ from those published last year because of newer data and methodological updates.

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

> Hospitals' all-payer total margin is an aggregate, calculated as the percentage of revenue from all payers and sources that is left as profit after accounting for costs. Hospitals' all-payer operating margin excludes investment and donation income.

> Among hospitals that Medicare pays under the inpatient prospective payment systems (IPPS), the all-payer total margin and all-payer operating margin both increased in FY 2023 from relative lows in FY 2022, despite a decline in coronavirus relief funds.

> Hospitals' all-payer total margin experienced a larger change than hospitals' operating margin because of changes in investment income: Hospitals reported about $7 billion in investment losses in FY 2022 but about $13 billion in investment income in FY 2023 (data not shown).

Chart 6-6 Hospitals' all-payer operating margin varied by type of hospital, including continued higher margin among for-profit hospitals

Hospital category	All-payer operating margin, by fiscal year				
	2019	2020	2021	2022	2023
Including relief funds					
IPPS					
Aggregate	6.7%	5.5%	8.8%	2.7%	5.1%
25th percentile	–1.5	–1.2	0.9	–5.5	–4.0
Median	4.3	4.6	7.2	1.6	2.8
75th percentile	11.0	11.3	14.9	9.8	10.4
Ownership					
For profit	12.5	13.0	15.4	12.9	12.9
Nonprofit	6.2	4.8	8.3	1.0	4.4
Geography*					
Metropolitan	6.9	5.5	8.8	2.8	5.3
Rural micropolitan	5.1	5.7	9.0	1.2	3.2
Other rural	0.9	3.9	7.7	0.9	–0.5
MSNI**					
Lowest quartile	N/S	N/S	11.6	5.9	7.6
2nd quartile	N/S	N/S	9.7	3.4	7.1
3rd quartile	N/S	N/S	8.7	4.3	5.7
Highest quartile	N/S	N/S	4.9	3.1	3.7
CAH					
Aggregate	3.1	5.2	11.1	4.2	4.2
25th percentile	–3.2	–1.3	4.3	–3.2	–3.8
Median	1.4	4.2	11.6	3.2	2.4
75th percentile	6.3	10.8	18.0	9.5	8.4
Excluding relief funds					
IPPS					
Aggregate	6.7	2.1	7.4	2.0	4.9
25th percentile	–1.5	–6.6	–1.8	–7.1	–4.5
Median	4.3	0.8	4.6	0.5	2.5
75th percentile	11.0	8.4	13.0	8.8	10.1
Ownership					
For profit	12.5	10.7	14.3	12.5	12.7
Nonprofit	6.2	1.2	7.0	0.2	4.1
Geography*					
Metropolitan	6.9	2.1	7.5	2.2	5.0
Rural micropolitan	5.1	1.2	6.5	–0.7	2.9
Other rural	0.9	–1.7	2.7	–2.5	–1.0
MSNI**					
Lowest quartile	N/S	N/S	10.5	5.4	7.4
2nd quartile	N/S	N/S	8.5	2.8	7.0
3rd quartile	N/S	N/S	7.3	3.4	5.3
Highest quartile	N/S	N/S	2.7	2.2	3.3
CAH					
Aggregate	3.1	0.5	6.2	2.4	3.7

(Chart continued next page)

Chart 6-6 Hospitals' all-payer operating margin varied by type of hospital, including continued higher margin among for-profit hospitals (continued)

Note: IPPS (inpatient prospective payment systems), MSNI (Medicare Safety-Net Index), N/S (not shown), CAH (critical access hospital). Data are for hospitals that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year and had non-outlier data. The all-payer operating margin excludes investment and donation income. "Relief funds" refers to federal or other coronavirus relief funds. Results differ from those published last year because of newer data and methodological updates, such as identification of statistical outliers and inclusion of other coronavirus relief funds.

* 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.

** The MSNI is a Commission-developed index that identifies financially vulnerable hospitals that serve large shares of low-income Medicare beneficiaries.

Source: MedPAC analysis of hospital cost reports, census geographic data, and MSNI data.

> Among hospitals paid under the IPPS, the all-payer operating margin continued to vary significantly: In fiscal year (FY) 2023, a quarter of hospitals had an all-payer operating margin at or below –4 percent, while another quarter had a margin above 10 percent.

> While there was variation within each group of IPPS hospitals, the FY 2023 all-payer operating margin continued to be much higher among for-profit hospitals than nonprofit hospitals, among hospitals located in urban areas than hospitals located in rural nonmicropolitan areas, and among hospitals that serve lower shares of low-income Medicare beneficiaries (as measured by the Commission-developed Medicare Safety-Net Index).

> Critical access hospitals' all-payer operating margin held steady from FY 2022 to FY 2023 but increased when calculated exclusive of coronavirus relief funds.

Chart 6-7 Hospitals' FFS Medicare margin excluding relief funds remained relatively stable in FY 2023, but significant variation persisted

Hospital category	FFS Medicare margin, by fiscal year				
	2019	2020	2021	2022	2023
Including relief funds					
IPPS					
Aggregate	–8.0%	–8.2%	–6.3%	–11.9%	–12.6%
25th percentile	–17.1	–17.2	–15.2	–21.5	–22.0
Median	–5.7	–4.4	–2.7	–8.7	–9.7
75th percentile	4.8	7.7	9.2	3.8	2.8
Ownership					
For profit	1.4	4.3	5.6	1.1	0.4
Nonprofit	–9.4	–10.2	–8.1	–13.6	–13.8
Geography*					
Metropolitan	–8.4	–8.8	–6.9	–12.3	–12.8
Rural micropolitan	–4.6	–2.7	–1.5	–8.7	–9.8
Other rural	0.4	5.1	8.1	0.1	–3.2
Fiscal pressure**					
Low pressure	–10.6	–10.8	–8.9	–13.9	–14.6
High pressure	4.0	7.5	5.8	–2.6	–4.3
MSNI***					
Lowest quartile	N/S	N/S	–10.0	–16.1	–16.8
2nd quartile	N/S	N/S	–9.5	–14.3	–14.7
3rd quartile	N/S	N/S	–4.2	–8.7	–10.1
Highest quartile	N/S	N/S	3.2	–3.6	–4.8
CAH					
Aggregate	–1.0	4.6	6.4	2.3	0.1
Excluding relief funds					
IPPS					
Aggregate	–8.0	–12.3	–8.3	–13.1	–13.0
25th percentile	–17.1	–22.2	–17.2	–22.7	–22.5
Median	–5.7	–8.6	–5.2	–10.2	–10.1
75th percentile	4.8	3.3	6.4	2.0	2.3
Ownership					
For profit	1.4	1.7	4.1	0.5	0.1
Nonprofit	–9.4	–14.6	–10.1	–14.7	–14.3
Geography*					
Metropolitan	–8.4	–12.8	–8.7	–13.3	–13.2
Rural micropolitan	–4.6	–7.8	–4.7	–11.3	–10.4
Other rural	0.4	–1.1	2.8	–4.1	–3.9
Fiscal pressure**					
Low pressure	–10.6	–14.4	–10.6	–14.9	–15.0
High pressure	4.0	1.4	2.5	–4.2	–5.1
MSNI***					
Lowest quartile	N/S	N/S	–11.7	–16.9	–17.2
2nd quartile	N/S	N/S	–11.3	–15.2	–15.0
3rd quartile	N/S	N/S	–6.1	–9.9	–10.7
Highest quartile	N/S	N/S	0.4	–5.2	–5.4
CAH					
Aggregate	–1.0	–0.2	0.7	0.3	–0.5

(Chart continued next page)

Chart 6-7 Hospitals' FFS Medicare margin excluding relief funds remained relatively stable in FY 2023, but significant variation persisted (continued)

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), FY (fiscal year), MSNI (Medicare Safety-Net Index), N/S (not shown), CAH (critical access hospital). Data are for hospitals that, as of our analysis, had a cost report with a midpoint in the specified fiscal year and had non-outlier data. For hospitals paid under the IPPS, the "FFS Medicare margin" is limited to revenue and costs for services included under the IPPS or outpatient prospective payment system, including separately payable drugs, including any reported discounts to drug costs under the 340B Drug Pricing Program. For CAHs, the "FFS Medicare margin" is limited to revenue and costs for inpatient, outpatient, and swing-bed skilled nursing services, with inpatient costs calculated by assigning inpatient routine costs per day equally across inpatient and swing-bed days. "Relief funds" refers to FFS Medicare's share of federal and other coronavirus relief funds. Results differ from those published last year because of newer data and methodological updates, such as narrowing the services included in the FFS Medicare margin, and identification of statistical outliers.

* 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.

** "Low [fiscal] pressure" hospitals are defined as those with a median non-FFS Medicare 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 FFS Medicare profits had been zero. "High [fiscal] pressure" hospitals are defined as those with a median non-FFS Medicare margin of 1 percent or less over five years and a net worth that would have grown by less than 1 percent per year.

*** "MSNI" refers to a Commission-developed index that identifies financially vulnerable hospitals that serve large shares of low-income Medicare beneficiaries.

Source: MedPAC analysis of hospital cost reports, census geographic data, and MSNI data.

> Hospitals' FFS Medicare margin is an aggregate, calculated as the percentage of revenue from FFS Medicare inpatient and outpatient services that is left as profit after accounting for the allowable costs of providing these services to FFS Medicare patients.

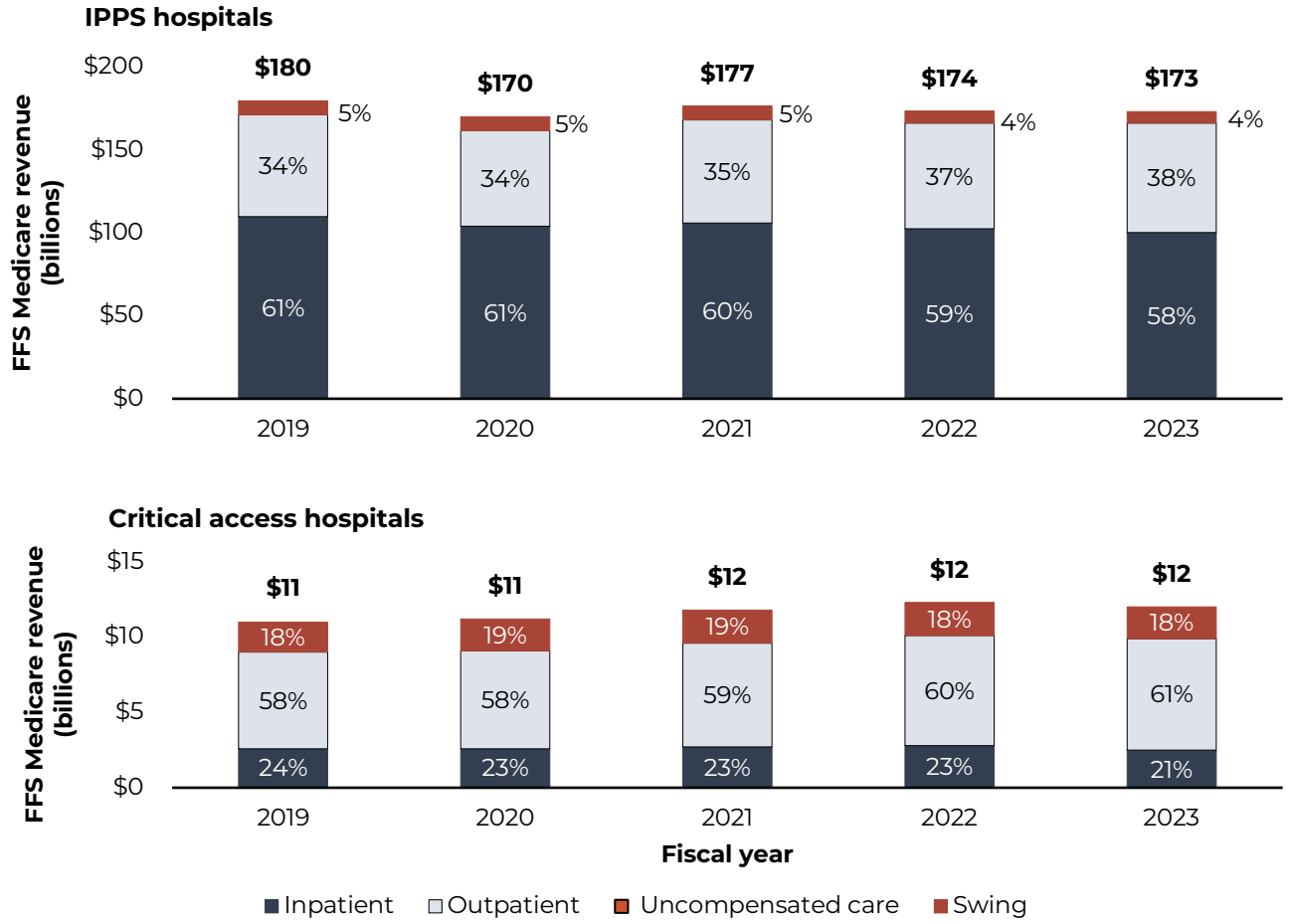
> Among hospitals paid under the IPPS, the FFS Medicare margin including coronavirus relief funds fell to –12.6 percent in FY 2023. However, exclusive of these funds, it remained steady at about –13 percent. The 0.7 percentage point decline in hospitals' FFS Medicare margin from FY 2022 to FY 2023 when including coronavirus relief funds was exclusively due to a decline in relief funds.

> As in prior years, there was significant variation within IPPS hospitals' aggregate margin in FY 2023: A quarter of hospitals had a FFS Medicare margin below –22 percent, while a quarter had a margin above 2 percent.

> While there was variation within each group of IPPS hospitals, hospitals' aggregate FFS Medicare margin remained higher at for-profit hospitals (relative to nonprofit hospitals); rural hospitals (relative to urban hospitals); hospitals under higher fiscal pressure (relative to those under low pressure); and hospitals that served larger shares of Medicare beneficiaries with low incomes (as measured by the Commmission's MSNI).

> Among critical access hospitals, the FFS Medicare margin declined to nearly 0 percent in FY 2023 when including relief funds and to a slightly negative margin when excluding relief funds.

Chart 6-8 Hospitals' revenue from FFS Medicare services continued to slowly shift toward outpatient services



Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems). Data are for hospitals that, as of our analysis, had a complete cost report with a midpoint in the specified fiscal year. For prospective payment system (PPS) hospitals, data are limited to revenue from inpatient and outpatient prospective payment services and uncompensated-care payments. For critical access hospitals, data are limited to revenue from inpatient, outpatient, and swing-bed skilled nursing services. Hospitals also receive payments from FFS Medicare that are not included in these totals, such as payments for post-acute care and other subproviders and pass-through amounts. The FFS Medicare share of coronavirus relief funds is not shown. Dollar amounts are nominal figures, not adjusted for inflation. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of hospital cost-report data.

> From fiscal year (FY) 2019 to FY 2023, hospitals' revenue from FFS Medicare services continued to slowly shift toward outpatient services and away from inpatient services.

> For PPS hospitals, revenue from inpatient and outpatient PPS services provided to FFS Medicare beneficiaries was $173 million in FY 2023, of which outpatient services accounted for 38 percent.

> For critical access hospitals, revenue from inpatient, outpatient, and swing-bed services provided to FFS Medicare beneficiaries was $12 billion in FY 2023, of which outpatient services accounted for 61 percent. Swing-bed services—skilled nursing services provided in an inpatient bed—accounted for another 18 percent.

Chart 6-9 Nearly 17 percent of IPPS payments in FY 2023 were from adjustments and additional payments

Hospital group	Share of IPPS payments for FFS Medicare inpatient services						
	Base PPS	Low income (DSH)*	Teaching (IME)	New technology	Outliers	Rural and/or isolated **	Quality ***
IPPS	83.3%	3.2%	7.6%	0.5%	4.4%	1.3%	–0.4%
Ownership							
For profit	89.0	3.5	4.7	0.2	2.0	1.0	–0.5
Nonprofit	83.7	3.1	7.5	0.5	4.3	1.3	–0.3
Government	75.3	3.9	11.3	0.7	7.3	1.7	–0.3
Geography****							
Metropolitan	83.3	3.3	7.9	0.5	4.6	0.7	–0.4
Micropolitan	82.4	2.4	3.2	0.4	2.0	9.9	–0.3
Other rural	78.6	2.2	0.9	0.4	1.6	16.6	–0.3
DSH and teaching*							
Both	80.2	3.5	10.4	0.5	5.1	0.6	–0.3
DSH only	90.6	3.1	0.0	0.4	2.6	3.6	–0.4
Teaching only	86.4	0.1	8.7	0.6	3.7	0.8	–0.3
Neither	94.2	0.1	0.0	0.4	2.3	2.8	–0.3
Rural and/or isolated							
Sole community	78.4	2.3	3.2	0.4	3.3	12.7	–0.3
Medicare dependent	80.0	1.6	2.0	0.3	1.1	15.3	–0.3
Low volume	78.1	2.0	0.6	0.4	1.4	17.5	–0.2

Note: IPPS (inpatient prospective payment systems), FY (fiscal year), FFS (fee-for-service), DSH (disproportionate share hospital), IME (indirect medical education). Data are for hospitals that, as of our analysis, had a complete cost report with a midpoint in FY 2023. Data exclude uncompensated-care payments. Row components may not sum to 100 percent due to rounding and not separately showing smaller components of IPPS payments.

* The "low income (DSH)" column includes inpatient operating and capital DSH payments, while the DSH categories are defined by receiving inpatient operating DSH payments.

** The "rural and/or isolated" column includes the payments above the otherwise applicable IPPS payments received by hospitals designated as sole community hospitals, Medicare dependent hospitals, and/or low-volume hospitals.

*** The "quality" column includes payments and penalties from the Value-Based Purchasing programs and penalties from the Hospital Readmissions Reduction Program and Hospital-Acquired Conditions Reduction Program.

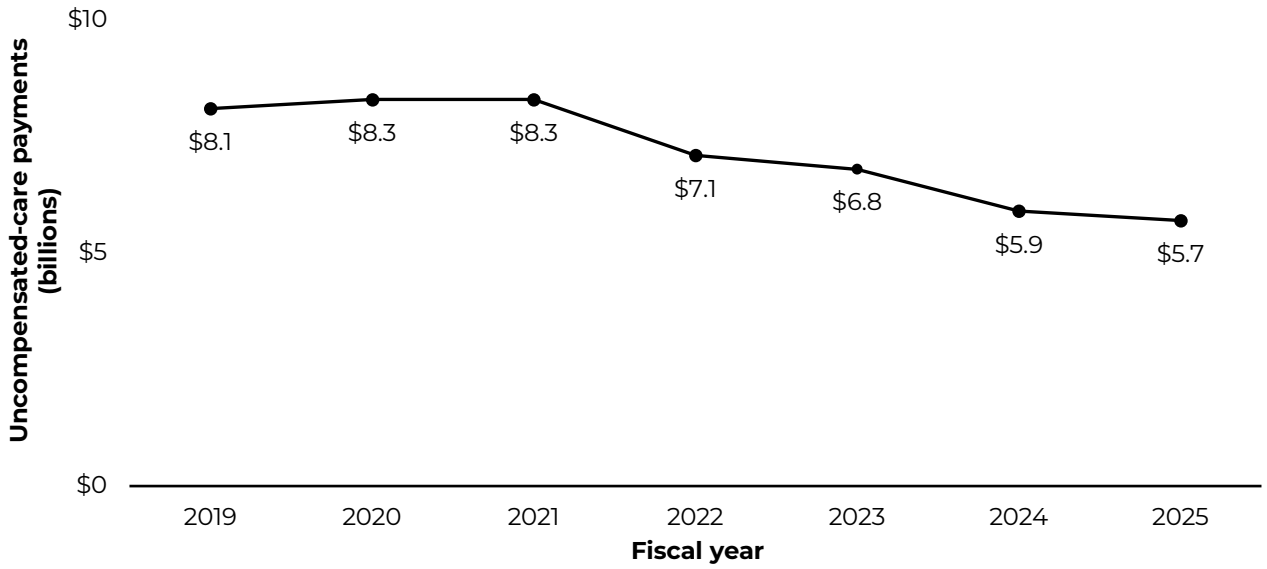
**** Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people.

Source: MedPAC analysis of hospital cost-report data and census geographic data.

> In FY 2023, base payments accounted for 83.3 percent of IPPS payments to hospitals for inpatient services provided to FFS Medicare beneficiaries.

> The remaining amount—nearly 17 percent—comprised adjustments to base rates targeted to certain hospitals or additional payments or penalties for certain services or quality levels. For example, among hospitals designated low-volume hospitals—which can receive an up to 25 percent increase to the otherwise applicable IPPS payments—over 17 percent of their IPPS payments were from additional payments under this and/or other rural designations. And among government hospitals, over 7 percent of IPPS payments were outlier payments—which are made for inpatient stays that are substantially more costly than the standard IPPS payment.

Chart 6-10 FFS Medicare's uncompensated-care payments fell between FY 2021 and FY 2025



Note: FFS (fee-for-service), FY (fiscal year). Uncompensated-care payments are presented postsequestration; the 2 percent sequestration of Medicare payments was suspended in May 2020 and reinstated in spring 2022. Beginning in FY 2023, figures include uncompensated-care supplemental payments to hospitals for Indian Health Service and tribal hospitals and Puerto Rican hospitals; in FY 2025, these payments totaled about $80 million (data not shown). Dollar amounts are nominal figures, not adjusted for inflation.

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

> As required by law, in FY 2014, Medicare reduced IPPS operating disproportionate share (DSH) hospital payments to 25 percent of prior law and introduced uncompensated-care payments.

> 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 DSH hospital payments under prior law and the uninsured rate as a percentage of the rate in 2013 (plus an additional reduction from FY 2014 to FY 2017). Therefore, when the rate of uninsured individuals increases and hospitals have greater losses on uncompensated care, the Medicare program makes higher uncompensated-care payments.

> For each fiscal year between 2019 and 2021, uncompensated-care payments were slightly over $8 billion dollars on a nominal basis.

> However, uncompensated-care payments fell each year from FY 2022 through FY 2025, down to $5.7 billion in 2025.

Chart 6-11 FFS Medicare inpatient stays per capita increased in FY 2023 but remained well below the FY 2019 level

Inpatient measure	Fiscal year					Average annual change	
	2019	2020	2021	2022	2023	2019–2022	2022–2023
Inpatient stays (in millions)	9.2	7.9	7.4	7.0	6.9	–6.9%	–1.3%
Inpatient stays per 1,000 beneficiaries	244.5	213.6	207.7	202.3	205.3	–4.3	1.5
Average length of stay (in days)	4.9	5.1	5.5	5.6	5.3	1.9	–4.1
Payments (in billions)*	$117.9	$110.5	$114.6	$110.8	$108.9	–2.0	–1.7
Payment per stay (in thousands)*	12.8	13.9	15.4	15.8	$15.7	5.3	–0.4

Note: FFS (fee-for-service), FY (fiscal year). Data include all Subsection (d) and critical access hospitals. FFS beneficiary enrollment is limited to those who resided in the U.S. and had Part A. Dollars are nominal, not adjusted for inflation. * Payments include FFS Medicare program payments and beneficiaries' cost-sharing liabilities. For hospitals paid under the inpatient prospective payment system, payments exclude uncompensated-care payments.

Source: MedPAC analysis of Medicare Provider Analysis and Review and Common Medicare Environment files.

> The volume of FFS Medicare inpatient stays fell in FY 2020, reflecting delayed and forgone care during the coronavirus public health emergency.

> While FFS Medicare inpatient stays per capita increased slightly in FY 2023 ("Inpatient stays per 1,000 beneficiaries" in the chart), it has not rebounded to the FY 2019 level. This finding is consistent with the trends in all-payer inpatient stays (see Chart 6-4).

> Payment per FFS Medicare stay increased in each fiscal year from 2020 through 2022 and then was relatively stable in FY 2023. However, because of the decline in volume, on an aggregate basis, payments for FFS Medicare inpatient stays were below the level in FY 2019.

Chart 6-12 Four major diagnostic categories accounted for over half of all FFS Medicare inpatient stays

Major diagnostic category	Share of FFS Medicare stays, by fiscal year				
	2019	2020	2021	2022	2023
Circulatory system	20.5%	20.0%	19.9%	20.1%	20.5%
Respiratory system	12.6	13.3	15.1	14.3	12.9
Infectious and parasitic	10.6	11.6	11.6	11.7	12.2
Musculoskeletal	13.5	12.4	10.8	10.7	10.9
Digestive system	9.7	9.5	9.5	9.5	9.5
Nervous system	7.9	8.0	8.2	8.4	8.5
Kidney and urinary	7.7	7.5	7.5	7.9	8.2
Endocrine, nutritional, and metabolic	3.9	4.0	4.0	4.1	4.0
Skin, subcutaneous, and breast	2.3	2.1	2.0	2.0	2.1
Blood and immunologic	1.4	1.5	1.5	1.4	1.5

Note: FFS (fee-for-service). Data include all Subsection (d) and critical access hospitals. Components do not sum to 100 percent because table shows only the top 10 by 2023 share.

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

> FFS Medicare categorizes each inpatient stay into a major diagnostic category (MDC), primarily based on the patient's principal diagnosis.

> In each fiscal year from 2019 through 2023, over half of all FFS Medicare inpatient stays were in one of four MDCs: diseases of the circulatory system, respiratory system, musculoskeletal system, and infectious and parasitic diseases.

> For most MDCs, the share of FFS Medicare inpatient stays has been relatively steady. For example, diseases of the circulatory system accounted for about 20 percent of inpatient stays in each fiscal year from 2019 through 2023.

> However, the share of FFS Medicare inpatient stays has been more variable for some MDCs. For example, the share of stays that were for diseases of the respiratory system rose during the coronavirus pandemic.

Chart 6-13 FFS Medicare inpatient stays slightly shifted away from the most resource-intensive stays in FY 2023

Resource weight	Share of FFS Medicare stays, by fiscal year				
	2019	2020	2021	2022	2023
Low (<1)	28.3%	26.0%	23.3%	22.4%	23.2%
1 up to 2	50.1	51.1	53.6	54.5	53.8
2 up to 3	10.0	9.9	5.5	9.2	10.0
High (≥3)	11.6	13.0	13.8	14.0	13.0

Note: FFS (fee-for-service), FY (fiscal year). Data include all Subsection (d) and critical access hospitals. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data and inpatient prospective payment systems final rules published by CMS.

> Most FFS Medicare payments for inpatient stays 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.

> In FY 2023, the most common MS–DRGs were:

>> resource weight less than 1: kidney and urinary tract infections without major complications or comorbidities

>> resource weight 1 up to 2: septicemia or sepsis without major complications or comorbidities

>> resource weight of 2 up to 3: hip and femur procedures except major joint with complications or comorbidities

>> resource weight greater or equal to 3: infectious and parasitic diseases with operating room procedures and major complications or comorbidities

> From FY 2019 through 2022, the share of FFS Medicare inpatient stays with a resource weight of less than 1 declined, while the share with a weight greater than 3 increased.

> In contrast, in FY 2023, FFS Medicare inpatient stays slightly shifted away from the most resource-intensive stays, though the share remained higher than in 2019.

Chart 6-14 FFS Medicare inpatient stays slightly shifted away from stays longer than one week in FY 2023

	Share of FFS Medicare stays, by fiscal year				
Length of stay	2019	2020	2021	2022	2023
1 day	14.1%	14.4%	13.9%	13.9%	14.5%
2 to 3 days	36.6	35.0	33.0	32.6	33.5
4 to 7 days	33.0	32.9	33.2	33.1	33.1
8 to 30 days	15.8	17.0	19.0	19.4	18.0
>30 days	0.6	0.7	0.9	1.0	0.8

Note: FFS (fee-for-service), FY (fiscal year). Data include all Subsection (d) and critical access hospitals. Components may not sum to 100 percent due to rounding.

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

> FFS Medicare inpatient stays can be very short (a minimum of one day) or very long (in rare cases, over one year).

> Since the start of the pandemic in 2020 through FY 2022, the share of short inpatient stays (one, two, or three days) decreased, while long FFS Medicare inpatient stays (of between one week and one month or greater than one month) increased.

> In contrast, in FY 2023, FFS Medicare stays shifted away from those longer than one week, though the share remained higher than in FY 2019. As a result, the average length of stay decreased in FY 2023 (see Chart 6-11).

Chart 6-15 Total number of Medicare-certified inpatient psychiatric facilities continued to decline in FY 2023, but the share of freestanding and for-profit facilities increased

	Fiscal year					Average annual change	
Type of IPF	2019	2020	2021	2022	2023	2019–2022	2022–2023
All	1,610	1,570	1,530	1,510	1,470	–2.2%	–2.3%
Share of all							
Urban	79%	79%	81%	81%	81%	0.4	0.5
Rural	20	20	19	19	19	–1.8	–2.2
Teaching	37	37	38	38	39	0.8	2.4
Nonteaching	63	63	62	62	61	–0.5	–1.5
Hospital-based units	65	64	63	61	61	–2.0	–1.3
Nonprofit	40	39	39	38	38	–1.3	–0.5
For profit	14	14	13	13	12	–3.9	–1.9
Government	12	11	11	11	10	–2.4	–3.3
Freestanding	35	36	37	39	39	3.7	2.0
Nonprofit	5	5	5	5	5	0.9	1.0
For profit	20	21	22	23	24	4.5	4.1
Government	9	10	10	10	10	3.1	–2.2

Note: FY (fiscal year), 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. 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.

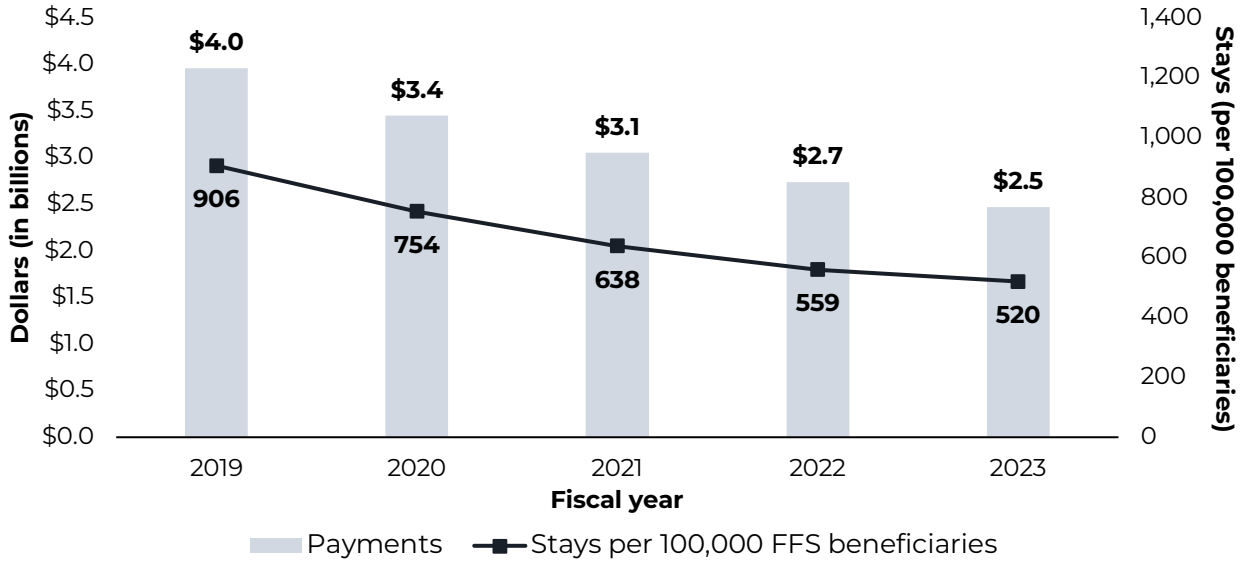
> In FY 2023, compared with the prior year, the number of IPFs nationwide decreased to 1,470 from 1,510 (2.3 percent decrease). This decline was similar to the decline observed from 2019 to 2022 (2.2 percent).

> Most IPFs are in urban areas (81 percent in FY 2023). Between FY 2019 and FY 2023, the share of IPFs in urban areas grew slightly and the share of IPFs in rural areas fell.

> In FY 2023, a majority of IPFs (61 percent) were hospital-based units; however, from FY 2019 to FY 2023, the share of hospital-based IPFs declined by 1.3 percent, while the share of freestanding IPFs grew by 2.0 percent.

> Almost a quarter of IPFs in FY 2023 were freestanding and for profit, up from about one-fifth of IPFs in 2019.

Chart 6-16 FFS Medicare inpatient psychiatric facility stays per capita and payments continued to decline in FY 2023



Note: FFS (fee-for-service), FY (fiscal year). The 2020 to 2023 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. 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 FY 2019 to FY 2023, FFS Medicare inpatient stays in IPFs decreased by 13 percent per year, on average, declining from 906 stays per 100,000 Medicare FFS beneficiaries to 520. Total (FFS Medicare plus beneficiary) payments for IPF PPS services decreased from $4.0 billion to $2.5 billion—equivalent to an 11 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 2023. 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 (MDC) of mental diseases and disorders (MDC 19). In FY 2023, 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 6-17 A growing share of Medicare FFS beneficiaries' stays at IPFs were for schizophrenia, FY 2020–2023

Psychiatric MS–DRG grouping	Fiscal year 2020	2021	2022	2023	Average annual change 2020–2023
Share of total					
Psychosis	74.4%	74.8%	75.1%	76.0%	0.7%
Mood disorders	37.5	36.9	36.8	37.0	–0.5
Schizophrenia and other non-mood psychotic disorders	36.9	37.9	38.3	38.9	1.8
Organic disturbances	6.9	6.8	7.0	6.0	–4.5
Alcohol/drug dependency	6.2	6.2	5.7	5.3	–4.8
Neurosis	4.2	3.9	4.0	4.1	–0.9
Nervous system disorder	5.4	5.3	5.2	5.5	0.8
Other psychiatric	1.9	2.0	2.0	2.0	0.9
Other nonpsychiatric	1.0	1.0	1.0	1.1	3.4

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), FY (fiscal year), 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); depressive neurosis and neurosis except 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). Totals may not sum to 100 percent due to rounding.

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

> FFS Medicare 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 FY 2023, 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 FY 2020 and FY 2023, the share of patients with non-mood psychotic disorders increased annually by 1.8 percent. Over the same time, the share of patients with mood disorders declined slightly.

> Between FY 2020 and FY 2023, patients with organic disturbances (which include diagnoses such as dementia) and alcohol/drug dependency MS–DRGs declined by nearly 5 percent annually. While these beneficiaries may be receiving care in other settings, the declines could also be related to difficulty in accessing inpatient psychiatric care due to the decreasing number of IPFs (see Chart 6-15).

Chart 6-18 FFS Medicare beneficiaries using IPFs tended to be disabled, under age 65, low income, and non-White, FY 2023

Characteristic	Share of all IPF users	Share of IPF users with more than one IPF stay	Share of all FFS beneficiaries
All	100%	26%	—
Current eligibility status and demographics			
Aged	48	34	90
Disabled	51	66	10
ESRD	0.1	<0.1	0.2
Female	49	45	53
Male	51	55	47
<45	24	34	3
45–64	27	32	8
65–79	35	27	67
80+	14	7	22
Non-Hispanic White	71	66	78
Black	15	19	8
Asian/Pacific Islander	2	2	3
Hispanic	7	8	6
American Indian/Alaska native	1	1	<1
Other or unknown	4	5	4
Urban	81	83	81
Rural	19	17	19
Dual eligibility or LIS during year			
No	36	23	84
Yes	64	77	16

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

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

> Of FFS Medicare beneficiaries who had at least one IPF stay in FY 2023, 51 percent qualified for Medicare because of a disability, compared with 10 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 FY 2023 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 6-19 Medicare beneficiaries near or reaching the lifetime coverage limit on care in freestanding IPFs were highly vulnerable, 2023

Characteristic	History of freestanding IPF use but not near the coverage limit	Within 15 days of reaching the coverage limit	Reached the coverage limit
Number of beneficiaries with any IPF use since Medicare enrollment	813,970	10,100	39,170
Current eligibility status and demographics (percentage)			
Aged	41%	29%	29%
Disabled	59	71	71
ESRD	<1	<1	<1
Female	49	39	39
Male	51	61	61
<45	17	18	17
45–64	42	53	54
65–79	32	27	23
80+	8	2	6
Non-Hispanic White	69	63	62
Black	18	26	27
Asian/Pacific Islander	1	2	3
Hispanic	8	7	7
American Indian/Alaska native	1	1	1
Other or unknown	2	1	1
Urban	83	88	86
Rural	17	12	14
Dual eligibility or LIS during year (percentage)			
No	28	14	16
Yes	72	86	84

Note: IPF (inpatient psychiatric facility), ESRD (end-stage renal disease), LIS (low-income subsidy). The "coverage limit" refers to Medicare's lifetime coverage limit of 190 days in freestanding IPFs. "History of freestanding IPF use but not near the coverage limit" refers to Medicare beneficiaries (fee-for-service and Medicare Advantage enrollees) who were alive through the end of 2023 and stayed for at least one day in a freestanding IPF from the time of Medicare enrollment through December 31, 2023. "Within 15 days of reaching the coverage limit" refers to Medicare beneficiaries who were alive through the end of 2023 and were within 1 to 15 days of reaching the 190-day coverage limit in freestanding IPFs as of December 31, 2023. "Reached the coverage limit" refers to Medicare beneficiaries who were alive through the end of 2023 and had reached or exceeded the 190-day limit as of December 31, 2023. Components may not sum to 100 percent due to rounding.

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, 2023, there were 813,970 Medicare (fee-for-service and Medicare Advantage) beneficiaries who had at least one day in a freestanding IPF since enrolling in Medicare. Of these beneficiaries, 49,270 (10,100 + 39,170) were within 15 days of reaching the 190-day limit or had reached the limit as of the end of 2023. 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).

SECTION

7

Ambulatory care

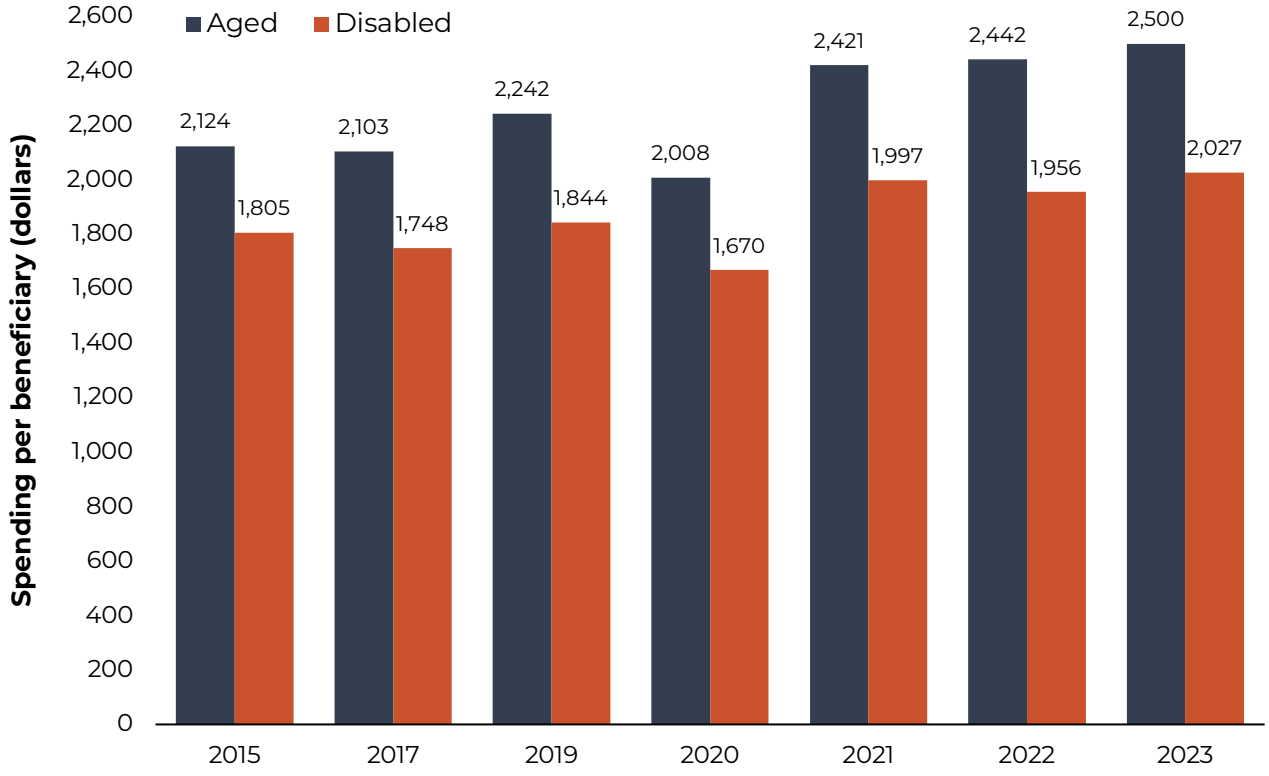
Physicians and other health professionals

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.

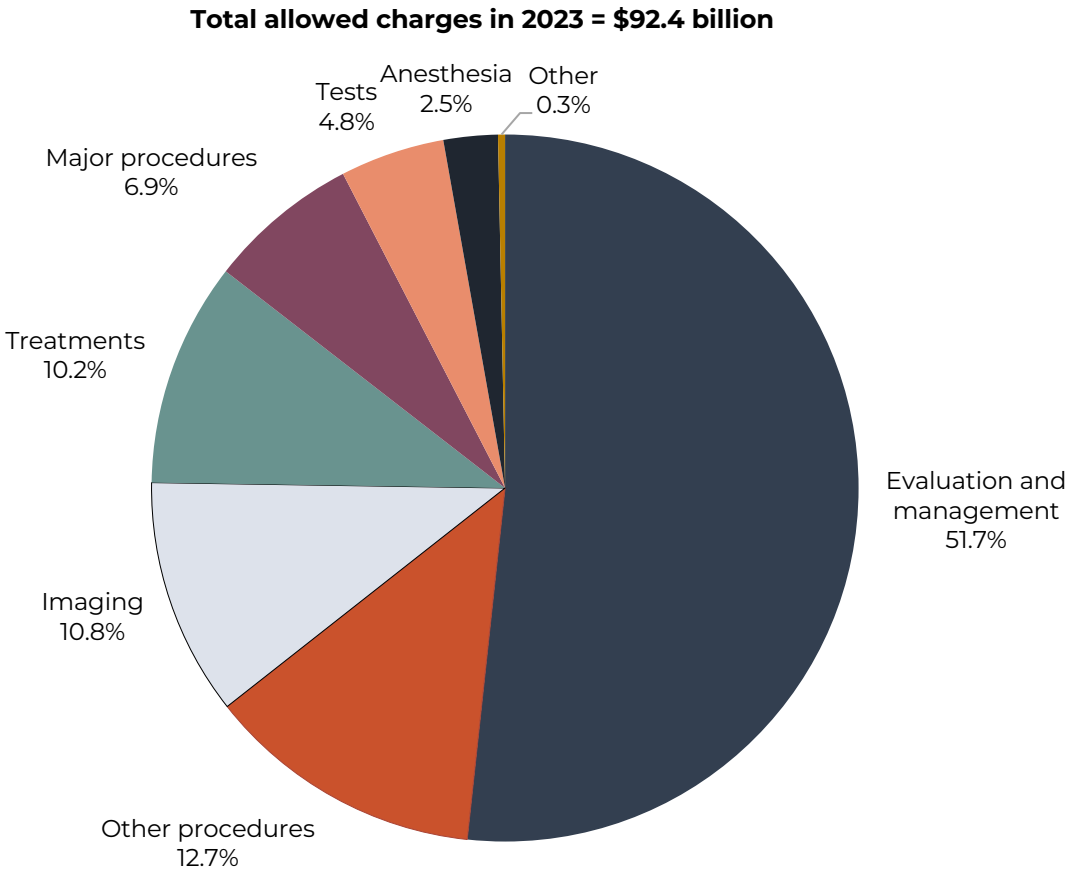
Source: The 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> 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 on fee schedule services for beneficiaries with disabilities (under age 65) is lower than that 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, 2023



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

> In 2023, allowed charges for physician fee schedule services totaled $92.4 billion. "Allowed charges" includes both program spending and beneficiary cost-sharing liability. Allowed charges increased by 0.7 percent from 2022 on a nominal basis (data not shown). That slow growth rate is partly attributable to a 3.3 percent decline in the number of beneficiaries enrolled in fee-for-service Medicare as enrollment in Medicare Advantage continues to grow.

> In 2023, 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 in 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 amount of the payment rate for each procedure and whether it is typically furnished in a facility setting.

Chart 7-3 Total number of encounters per FFS beneficiary was higher in 2023 compared with 2018, and the mix of clinicians furnishing them changed

	Encounters per beneficiary			Percent change in encounters per beneficiary	
Specialty category	2018	2022	2023	Average annual 2018–2022	2022–2023
Total (all clinicians)	21.8	22.3	23.2	0.5%	4.3%
Primary care physicians	4.0	3.1	3.1	–5.9	–0.1
Specialists	12.8	12.4	12.8	–0.6	2.7
APRNs/PAs	2.2	3.0	3.3	7.9	10.1
Other practitioners	3.3	3.7	4.0	3.1	8.6

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 2024 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 FFS beneficiary grew by 0.5 percent annually, on average, over the 2018 to 2022 period. The growth rate over that period was impacted by the coronavirus pandemic, which sharply reduced encounters in 2020, but includes a 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 0.6 percent per year between 2018 and 2022 but grew by 2.7 percent from 2022 to 2023.

> Encounters with APRNs and PAs grew rapidly from 2018 to 2023 (50 percent in total), and encounters with primary care physicians declined substantially (–22 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, 2018–2023

	Number (in thousands)					Number per 1,000 FFS 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
2018	139	462	237	174	1,012	4.2	13.9	7.1	5.2	30.4
2019	138	468	258	180	1,044	4.2	14.2	7.8	5.4	31.6
2020	135	468	268	172	1,043	4.2	14.5	8.3	5.3	32.3
2021	134	472	286	180	1,072	4.3	15.3	9.3	5.8	34.8
2022	133	477	308	184	1,102	4.5	16.1	10.4	6.2	37.2
2023	132	483	327	189	1,131	4.6	16.8	11.4	6.6	39.5

Note: FFS (fee-for-service), 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. Versions of this chart that were published before 2025 used beneficiary counts that included all beneficiaries enrolled in Part B, including both those in traditional FFS Medicare and Medicare Advantage. Numbers exclude nonperson providers such as clinical laboratories and independent diagnostic testing facilities. Components may not sum to totals due to rounding.

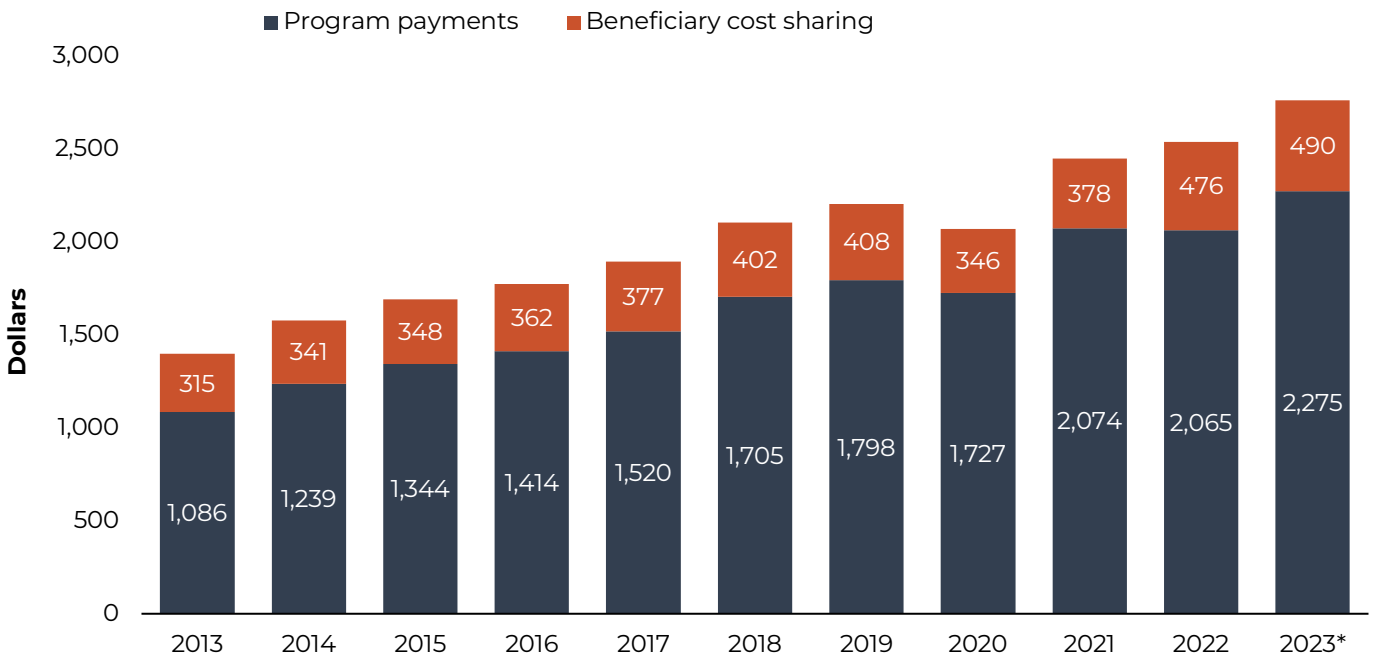
Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> From 2018 to 2023, the total number of clinicians billing the fee schedule grew in absolute terms and relative to the size of the FFS Medicare population.

> The total number of clinicians per 1,000 FFS beneficiaries increased from 30.4 to 39.5 over the 2018 to 2023 period, a total increase of 30 percent.

> Over the 2018 to 2023 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 2023. However, on a per FFS beneficiary basis, the number of primary care physicians grew over the same period. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 237,000 to 327,000. 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 per Part B FFS beneficiary on hospital outpatient services covered under the outpatient PPS increased, 2013–2023



Note: FFS (fee-for-service), 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 for 2023 are estimated.

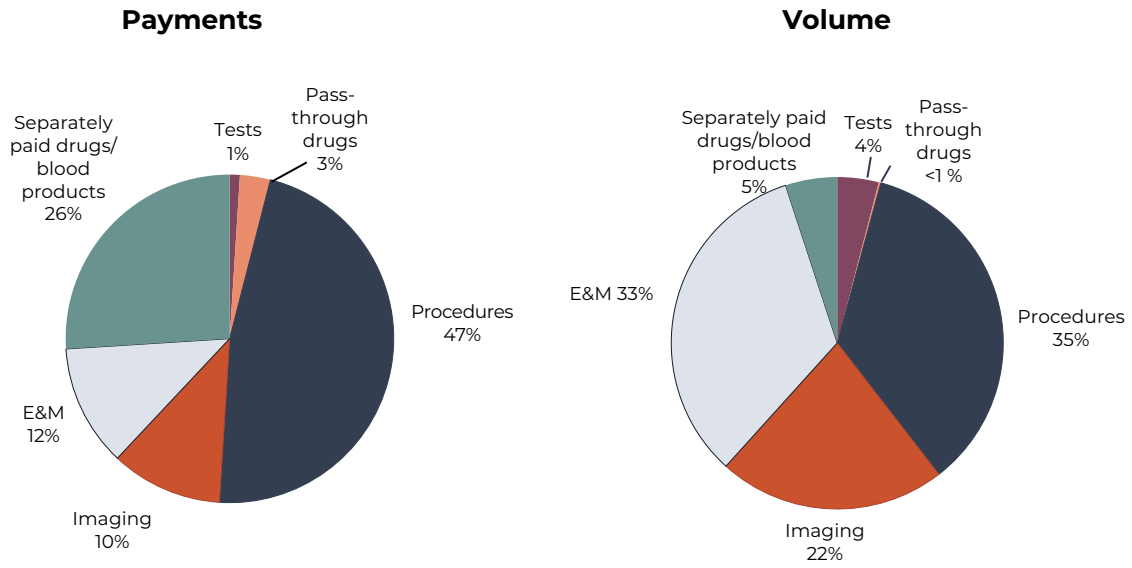
Source: CMS, Office of the Actuary.

> The Office of the Actuary estimates that spending per Part B FFS beneficiary under the outpatient PPS was $2,765 in 2023 ($2,275 in program spending, $490 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 2013 to 2023, overall spending per Part B FFS beneficiary by Medicare and beneficiaries on hospital outpatient services covered under the outpatient PPS increased by 97 percent, an average of 7.0 percent per year on a nominal basis. The Office of the Actuary projects continued growth in per capita total spending, averaging 8.0 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 Procedures were the type of service with the highest payments and volume under the Medicare hospital outpatient PPS, 2023



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

Source: MedPAC analysis of standard analytic file of outpatient claims for 2023.

> 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.

> Across services, payments are distributed differently from volume. For example, in 2023, procedures accounted for 47 percent of payments but only 35 percent of volume.

> Procedures (such as endoscopies, surgeries, and skin and musculoskeletal procedures) accounted for the greatest share of payments (47 percent) in 2023, followed by separately paid drugs and blood products (26 percent), E&M services (12 percent), and imaging services (10 percent).

Chart 7-7 Hospital outpatient services with the highest Medicare expenditures under the OPPS, 2023

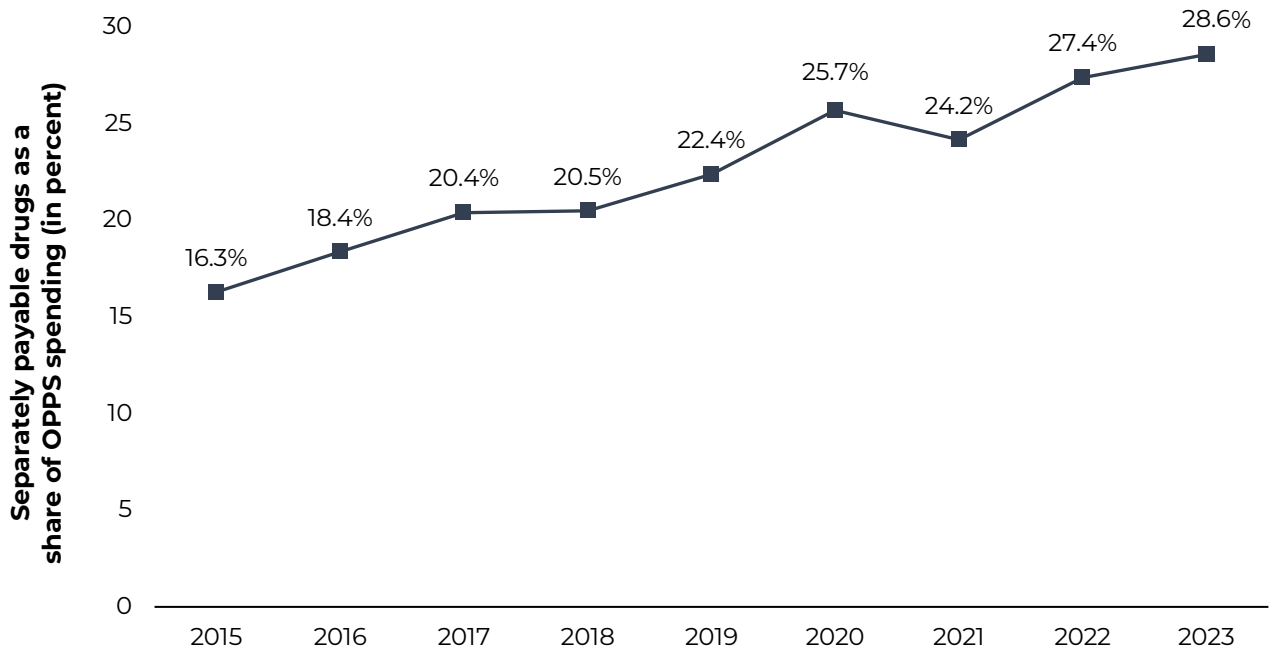
APC title	Share of Medicare expenditures	Volume (thousands)	Payment rate
Level 5 musculoskeletal procedures	8%	444	$13,048
All emergency visits	5	9,467	381
Clinic visits	4	27,486	121
Level 3 electrophysiologic procedures	3	97	23,481
Comprehensive observation services	3	863	2,439
Level 3 endovascular procedures	2	116	10,615
Level 4 musculoskeletal procedures	2	176	6,615
Level 3 drug administration	2	5,608	207
Level 3 radiation therapy	1	1,856	572
Level 1 laparoscopy and related procedures	1	176	5,212
Level 2 ICD and similar procedures	1	29	32,076
Level 4 imaging without contrast	1	1,768	503
Level 2 imaging with contrast	1	2,400	368
Level 1 endovascular procedures	1	293	2,958
Level 2 lower GI procedures	1	891	1,083
Level 2 imaging without contrast	1	7,585	107
Level 4 drug administration	1	2,340	333
Level 3 nuclear medicine and related services	1	593	1,327
Level 2 endovascular procedures	1	106	5,215
Level 4 nuclear medicine and related services	1	497	1,489
Level 3 pacemaker and similar procedures	1	69	10,329
Level 5 urology and related services	1	151	4,702
Level 3 imaging without contrast	1	2,925	234
Level 2 laparoscopy and related services	1	73	9,087
Level 1 intraocular procedures	1	301	2,159
Level 5 neurostimulator and related procedures	1	22	29,358
Level 1 imaging without contrast	1	6,797	87
Level 3 vascular procedures	1	189	2,979
Total	48		
Average for all APCs		604	$459

Note: OPPS (outpatient prospective payment system), 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). In the last row, the average volume is the sum of the volume across all APCs divided by the number of APCs, and the average payment rate is a weighted average of the payment rates for all APCs, where the weights are the volume of services for each APC.

Source: MedPAC analysis of 100 percent analytic files of outpatient claims for 2023 and Addendum B from the 2023 final rule for the OPPS and the payment system for ambulatory surgical centers.

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

Chart 7-8 Separately payable drugs have increased as a share of total spending in the OPPS, 2015–2023



Note: OPPS (outpatient prospective payment system). "Separately payable drugs" refers to drugs 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 2023.

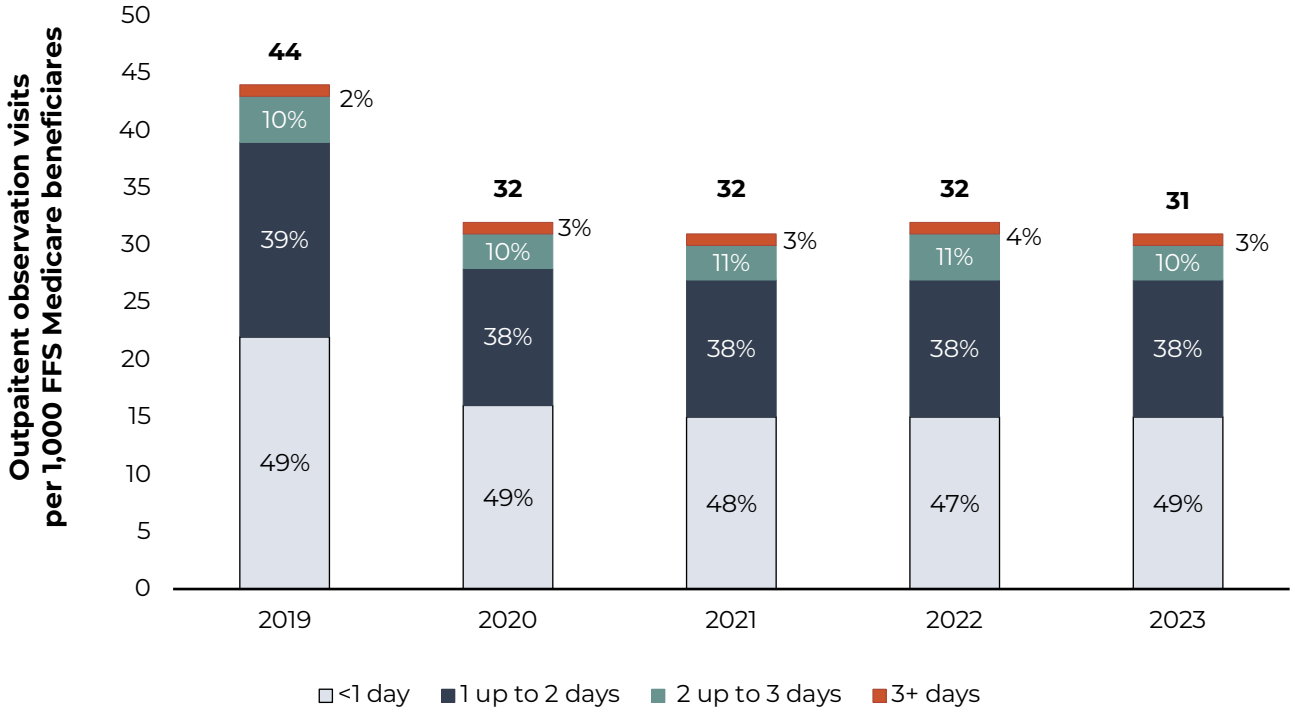
> Under the OPPS, most drugs are packaged, meaning their cost is reflected in the payment for the related services. However, drugs that are new to the market and established drugs that are relatively expensive are paid separately.

> Separately payable drugs have become an increasingly large share of OPPS spending, growing from 16.3 percent in 2015 to 28.6 percent in 2023.

> 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 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 7-9 Number of Medicare FFS outpatient observation visits per capita remained well below the 2019 level



Note: FFS (fee-for-service). "Observation visits" are separately payable visits under the outpatient prospective payment system. These visits last at least eight hours and do not result in an inpatient admission. Figures for FFS beneficiary enrollment are limited to those who resided in the U.S. and had Part B. Results differ from those published last year because of newer data and methodological updates, such as limiting beneficiary counts to beneficiaries residing in the U.S. 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 claims and Common Medicare Environment files.

> 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.

> In 2020, with the onset of the coronavirus pandemic, the number of observation visits per capita declined to 32 visits per 1,000 FFS Medicare beneficiaries (down from 44 visits per 1,000 beneficiaries in 2019). However, the distribution of the observation visits by length of stay remained relatively steady, with nearly half lasting less than one day, another nearly 40 percent lasting one up to two days, and about 13 percent lasting two or more days.

> The volume of observation visits per 1,000 FFS Medicare beneficiaries and the distribution of the length of those visits remained relatively steady from 2020 through 2023.

Chart 7-10 Number of Medicare-certified ASCs increased by 13 percent, 2017–2023

	2017	2018	2019	2020	2021	2022	2023
Medicare payments (billions of dollars)	$4.6	$4.9	$5.2	$4.9	$5.7	$6.1	$6.8
Percent growth in payments	7.4%	6.4%	7.3%	–6.4%	17.6%	5.8%	11.6%
New centers (during year)	215	231	239	186	264	223	252
Closed or merged centers (during year)	126	136	126	92	105	96	100
Net total number of centers (end of year)	5,559	5,654	5,767	5,861	6,020	6,147	6,299
Net percent growth in number of centers	1.6%	1.7%	2.0%	1.6%	2.7%	2.1%	2.5%
Volume per 1,000 FFS Part B beneficiaries	193	197	202	174	205	210	222
Share of all centers that are:							
Urban	93	93	93	93	93	93	93
Rural	7	7	7	7	7	7	7

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 7-11 in our 2024 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, 2024. 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 10 percent per year, on average, from 2017 through 2023 on a nominal basis (data not shown). From 2022 to 2023, total payments per FFS beneficiary rose 15 percent as the average complexity of services provided to FFS beneficiaries in ASCs increased and the number of services per FFS Medicare beneficiary increased (data not shown).

> The number of Medicare-certified ASCs grew at an average annual rate of 2.1 percent from 2017 through 2023. In this same period, an annual average of 230 new facilities entered the market, while an average of 112 closed or merged with other facilities.

Chart 7-11 Between 36 and 74 low-value services were provided per 100 FFS beneficiaries in 2023; Medicare spent between $2.0 billion and $5.9 billion on these services

Measure	Broader version of measure			Narrower version of 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	13.9	9.9%	$269	3.8	3.5%	$74
PSA screening at age > 75 years	11.1	7.5	97	6.5	5.2	57
Spinal injection for low back pain	6.8	3.8	1,293	2.5	1.5	478
PTH testing in early CKD	6.7	4.0	125	5.6	3.4	104
Colon cancer screening for older adults	6.0	5.8	431	0.2	0.2	2
T3 level testing for patients with hypothyroidism	5.9	3.5	35	5.9	3.5	35
Carotid artery disease screening in asymptomatic adults	4.2	3.9	223	3.5	3.2	182
Preoperative chest radiography	3.4	3.1	49	0.8	0.7	11
Head imaging for uncomplicated headache	3.3	3.0	218	2.1	1.9	137
Stress testing for stable coronary disease	3.0	2.8	834	0.3	0.3	92
Cervical cancer screening at age > 65 years	2.0	1.9	40	1.7	1.7	35
Homocysteine testing in cardiovascular disease	1.1	0.9	9	0.2	0.1	1
Head imaging for syncope	1.0	1.0	68	0.6	0.6	40
Preoperative echocardiography	1.1	1.1	87	0.3	0.3	28
BMD testing at frequent intervals	0.6	0.6	13	0.4	0.4	9
Preoperative stress testing	0.6	0.6	171	0.2	0.2	52
CT for uncomplicated rhinosinusitis	0.6	0.6	44	0.3	0.3	18
Vitamin D testing in absence of hypercalcemia or decreased kidney function	0.5	0.4	8	0.5	0.4	8
Imaging for plantar fasciitis	0.5	0.4	10	0.2	0.2	4
Screening for carotid artery disease for syncope	0.5	0.4	24	0.3	0.3	15
PCI/stenting for stable coronary disease	0.3	0.3	1,174	0.04	0.04	181
Cancer screening for patients with CKD on dialysis	0.3	0.2	7	0.1	0.1	1
Hypercoagulability testing after DVT	0.2	0.2	6	0.1	0.1	2
Vertebroplasty/kyphoplasty for osteoporotic vertebral fractures	0.2	0.1	308	0.2	0.1	303
Arthroscopic surgery for knee osteoarthritis	0.2	0.2	136	0.02	0.02	21
Preoperative PFT	0.2	0.2	2	0.1	0.1	1
IVC filter to prevent pulmonary embolism	0.1	0.1	15	0.1	0.1	15
Renal artery angioplasty/stenting	0.1	0.1	134	0.01	0.01	31
EEG for headache	0.04	0.04	2	0.02	0.02	1
Carotid endarterectomy for asymptomatic patients	0.05	0.05	124	0.02	0.02	50
Pulmonary artery catheterization in ICU	0.01	0.01	0.2	0.02	0.005	0.2
Total	74.2	37.5	5,929	36.3	23.5	1,990

(Chart continued next page)

Chart 7-11 Between 36 and 74 low-value services were provided per 100 FFS beneficiaries in 2023; Medicare spent between $2.0 billion and $5.9 billion on these services (continued)

Note: FFS (fee-for-service), PSA (prostate-specific antigen), PTH (parathyroid hormone), CKD (chronic kidney disease), BMD (bone mineral density), CT (computed tomography), PCI (percutaneous coronary intervention), DVT (deep vein thrombosis), PFT (pulmonary function test), IVC (inferior vena cava), EEG (electroencephalography), ICU (intensive care unit). Note that carotid endarterectomy now includes carotid stenting. "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) with updates to reflect changes to diagnosis and procedure coding over time. 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).

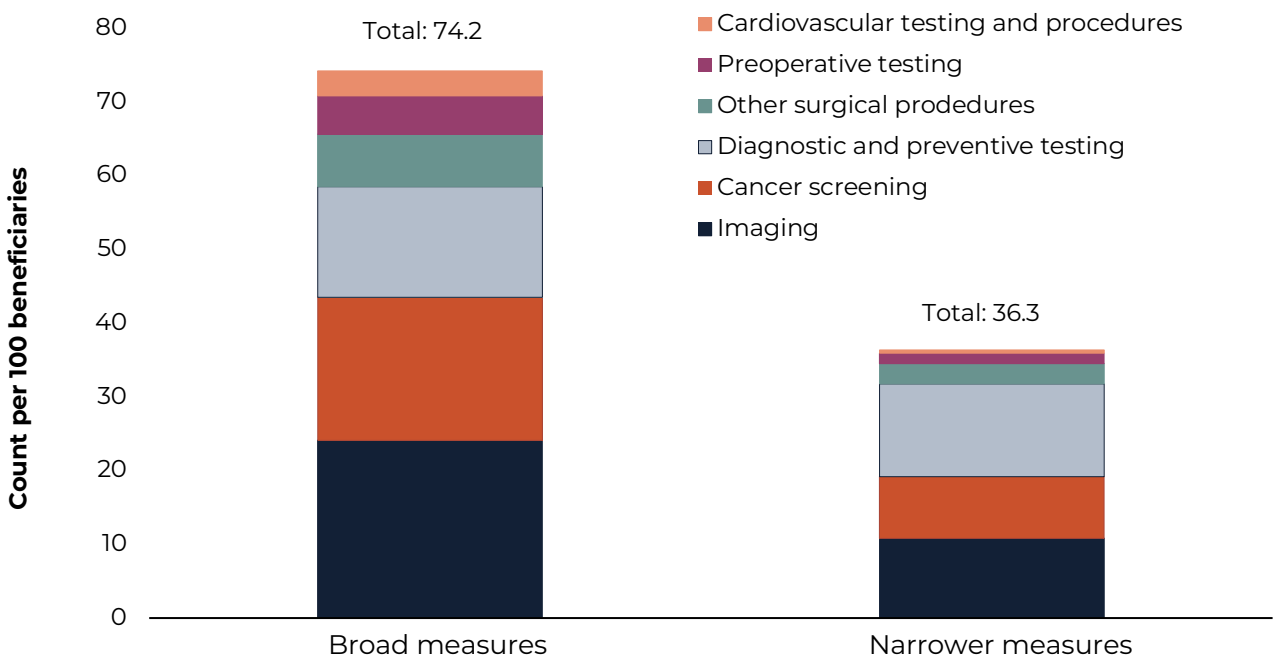
> Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.

> 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 2023. 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 74 instances of low-value care per 100 beneficiaries in 2023, with about 37 percent of beneficiaries receiving at least 1 low-value service that year. Medicare spending for these services was $5.9 billion. Based on the narrower versions of the measures, our analysis showed about 36 instances of low-value care per 100 beneficiaries, with 23 percent of beneficiaries receiving at least 1 low-value service. Medicare spending for these services totaled about $2.0 billion.

Chart 7-12 Imaging, cancer screening, and diagnostic and preventive testing accounted for most of the volume of low-value care in 2023



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

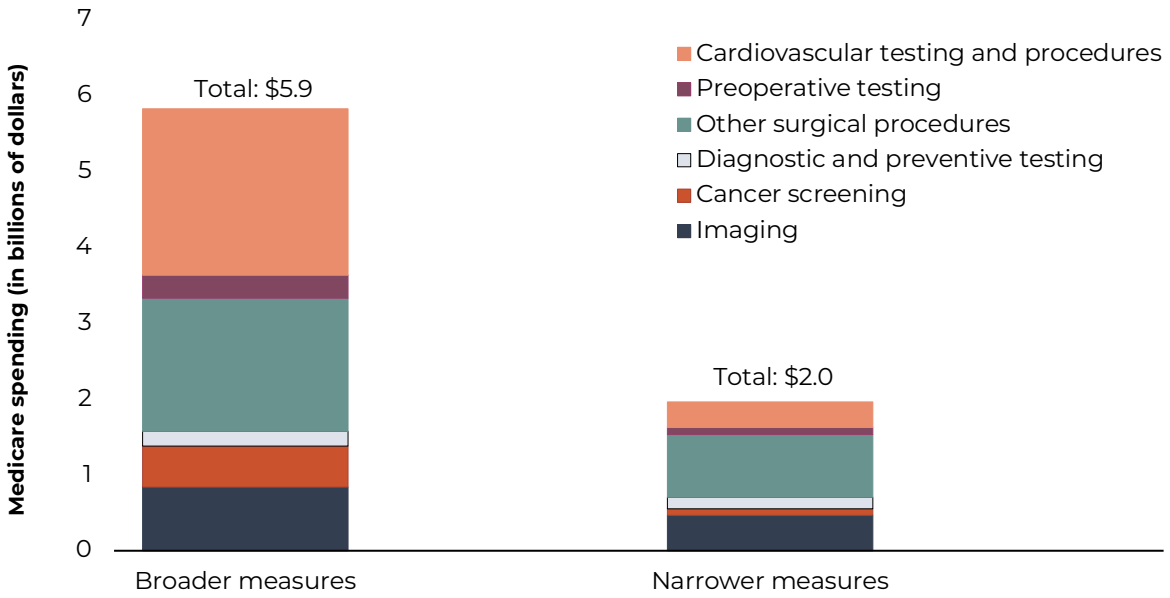
Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 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 7-11 to one of six clinical categories.

> Using the broader versions of the measures, imaging and cancer screening accounted for 59 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 64 percent of the volume of low-value care per 100 beneficiaries.

Chart 7-13 Cardiovascular testing and procedures, other surgical procedures, and imaging accounted for most spending on low-value care in 2023



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 2023. 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 67 percent of total spending on low-value care using the broader measures. Other surgical procedures and imaging made up 59 percent 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 7-14 In MedPAC's 2024 survey, Medicare beneficiaries were more likely to report being satisfied 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	95%*	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)	97*	93*
Very satisfied	82*	66*
Somewhat satisfied	15*	26*
Dissatisfied (net)	3*	7*
Somewhat dissatisfied	2*	6*
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)	88*	79*
Very satisfied	57*	40*
Somewhat satisfied	31*	39*
Dissatisfied (net)	12*	21*
Somewhat dissatisfied	8*	15*
Very dissatisfied	4*	6*

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> 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.

> In our 2024 survey, higher shares of Medicare beneficiaries reported receiving any health care in the past year (95 percent) compared with 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 (97 percent) compared with privately insured people (93 percent).

>> Higher shares of Medicare beneficiaries were satisfied with their ability to find providers that had appointments when needed (88 percent) compared with privately insured people (79 percent).

Chart 7-15 In MedPAC's 2024 survey, Medicare beneficiaries reported slightly better access to primary care providers than 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%*	91%*
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*	34*
For any of my primary care (net)	57*	61*
For some of my primary care	37	38
For all or most of my primary care	19*	23*
Don't know	3*	5*
Tried to get a new primary care provider: "In the past 12 months, have you tried to get a new primary care provider?"		
Yes	11%*	16%*
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	45* (5)	37* (6)
I wanted to change providers	31 (3*)	31 (5*)
I recently moved, so I needed to find a primary care provider in my area	13 (1)	12 (2)
I changed my health plan and had to find a new provider who participated in the new plan	8* (1*)	15* (2*)
My primary care provider was no longer accepting [Medicare / my insurance]	3 (0*)	6 (1*)

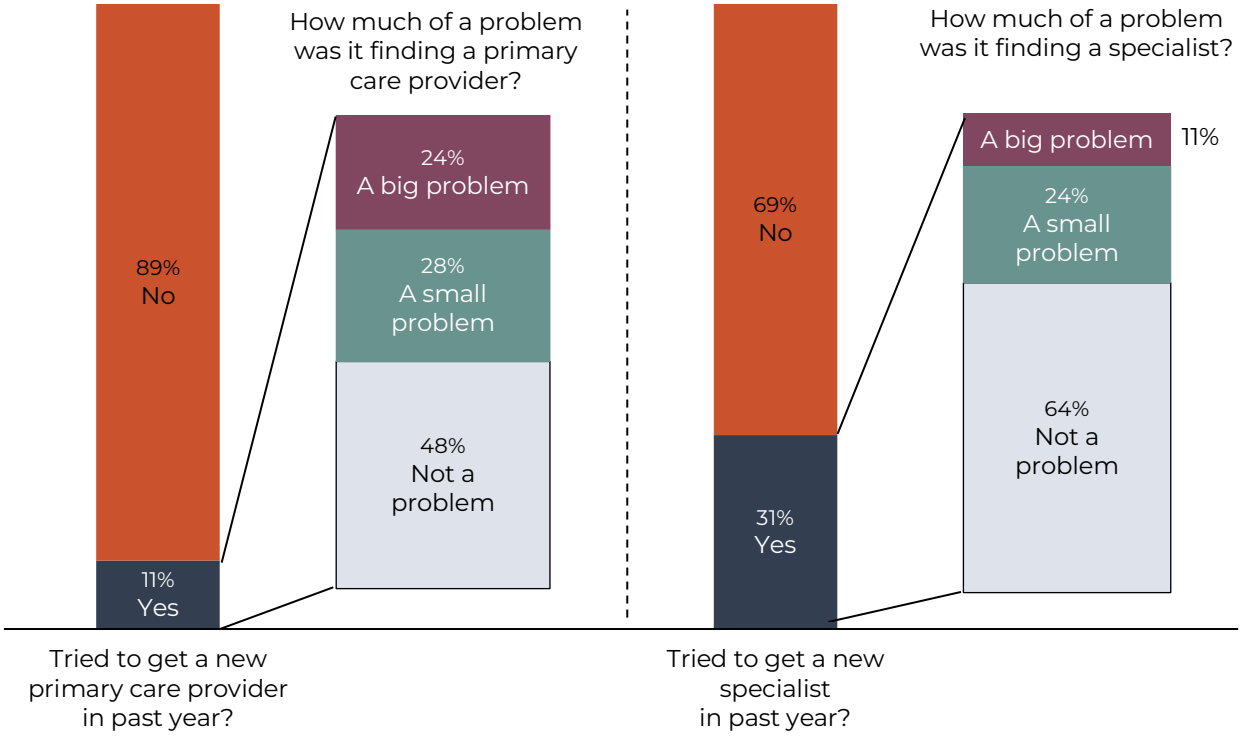
Note: NP (nurse practitioner), PA (physician assistant). We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 privately insured individuals. Sample sizes for individual questions varied. Surveys were completed by mail or online and in English or Spanish, depending on the respondent's preference. Survey data are weighted to produce nationally representative results. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "Overall share" refers to the share of all respondents with this insurance.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> In our 2024 survey, higher shares of Medicare beneficiaries reported having a primary care provider (PCP) (96 percent) compared with privately insured people (91 percent). Lower shares of Medicare beneficiaries reported needing to find a new PCP in the past year compared with privately insured people (11 percent vs. 16 percent).

> Among those looking for a new PCP, only 3 percent of Medicare beneficiaries and 6 percent of privately insured people did so because their existing PCP no longer accepted their insurance (equivalent to nearly 0 percent and 1 percent, respectively, of these groups overall). A more common reason for looking for a new PCP was that a PCP had retired or stopped practicing, which was reported by 45 percent of Medicare beneficiaries looking for a new PCP and 37 percent of privately insured people in this situation (equivalent to 5 percent and 6 percent, respectively, of these groups overall).

Chart 7-16 Beneficiaries looking for a new clinician reported more problems finding a new primary care provider than a new specialist



Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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 25 to September 9, 2024.

> In our 2024 survey, among the 11 percent of Medicare beneficiaries who tried to get a new primary care provider in the past year, 52 percent reported problems finding one: 24 percent reported "a big problem" finding a new one, and another 28 percent reported "a small problem." These figures, combined, are equivalent to 5 percent of Medicare beneficiaries reporting problems finding a new primary care provider in the past year overall (data not shown).

> A larger share of patients look for a new specialist each year: In 2024, 31 percent of Medicare beneficiaries tried to get a new specialist in the past year. Among these beneficiaries, 36 percent reported problems finding a new specialist: 11 percent reported "a big problem," and 24 percent reported "a small problem" finding one. Combined, these figures are equivalent to 11 percent of Medicare beneficiaries reporting problems finding a new specialist overall (data not shown).

> Privately insured people reported more problems finding a new clinician than did Medicare beneficiaries, as we show in the next chart.

Chart 7-17 In our 2024 survey, Medicare beneficiaries reported fewer problems finding a new clinician than younger 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	11%*	16%*
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)	52* (5*)	66* (10*)
A big problem	24* (2*)	31* (5*)
A small problem	28 (3*)	34 (5*)
Not a problem	48* (5)	34* (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	14* (1*)	27* (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	31	34
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*)	48* (16*)
A big problem	11* (3*)	18* (6*)
A small problem	24* (8*)	30* (10*)
Not a problem	64* (20*)	52* (17*)
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	13* (1*)	27* (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*	8*
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)	62 (2*)	74 (6*)
A big problem	37 (1*)	42 (3*)
A small problem	25 (1*)	32 (2*)
Not a problem	38 (1*)	26 (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	48 (1*)	45 (3*)

(Chart continued next page)

Chart 7-17 In our 2024 survey, Medicare beneficiaries reported fewer problems finding a new clinician than younger privately insured people (continued)

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "Overall share" refers to the share of all respondents with the respective insurance.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> Our 2024 survey found that Medicare beneficiaries were less likely to report trying to get a new primary care provider (PCP) in the past year compared with privately insured people (11 percent vs. 16 percent). In contrast, there was not a statistically significant difference in the shares of respondents who tried to get a new specialist in the past year (31 percent vs. 34 percent)

> Among those looking for a new PCP, privately insured people were more likely than Medicare beneficiaries to report problems finding one. In 2024, 66 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 52 percent of the Medicare beneficiaries who were looking for a new PCP reported problems (equivalent to 5 percent of all Medicare beneficiaries). Privately insured people also reported more problems finding specialists than did Medicare beneficiaries (48 percent vs. 36 percent, equivalent to 16 percent of privately insured people and 11 percent of Medicare beneficiaries overall).

> Privately insured people were twice as likely as Medicare beneficiaries to encounter a PCP or a specialist who did not accept their insurance. For example, among those looking for a new PCP, 14 percent of Medicare beneficiaries and 27 percent of privately insured people encountered a doctor's office that did not accept their insurance (equivalent to 1 percent of Medicare beneficiaries and 3 percent of privately insured people overall). Similar shares reported this experience when looking for a new specialist.

> Very few people reported looking for a new mental health professional in the past year, but privately insured people were more likely than Medicare beneficiaries to report looking for this type of health care professional (8 percent vs. 3 percent). A majority of both groups reported problems finding this type of clinician: 62 percent of Medicare beneficiaries who were looking for a mental health professional and 74 percent of privately insured people who were looking reported problems finding one, equivalent to 2 percent and 6 percent, respectively, of these groups overall. Among those looking for a new mental health professional, about half of both groups encountered a mental health professional who did not accept their insurance.

Chart 7-18 In our 2024 survey, Medicare beneficiaries ages 65+ were less interested in using telehealth than privately insured people ages 50–64

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)	33%	36%
Video visit	18*	26*
Telephone visit (audio only)	24*	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)	92	90
Very satisfied	61	57
Somewhat satisfied	31	33
Dissatisfied (net)	8	10
Somewhat dissatisfied	4	7
Very dissatisfied	3	3
Telephone visit(s)		
Satisfied (net)	93	93
Very satisfied	62*	53*
Somewhat satisfied	31*	40*
Dissatisfied (net)	7	7
Somewhat dissatisfied	5	5
Very dissatisfied	2	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)	44*	61*
Interested in video visits	28*	46*
Interested in telephone visits	27*	36*

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. 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 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

(Chart continued next page)

Chart 7-18 In our 2024 survey, Medicare beneficiaries ages 65+ were less interested in using telehealth than privately insured people ages 50–64 (continued)

> In our 2024 survey, about a third of Medicare beneficiaries and privately insured people 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 (24 percent vs. 20 percent).

>> Meanwhile, privately insured people were somewhat more likely to have had a video visit than Medicare beneficiaries (26 percent vs. 18 percent).

> Across insurance groups and types of telehealth visits, 90 percent or more of telehealth users reported being satisfied with their visits.

> A little under half (44 percent) of all Medicare beneficiaries were interested in having the option to use telehealth in the future, while a higher share (61 percent) of privately insured people were interested in having access to telehealth.

>> 28 percent of Medicare beneficiaries were interested in having access to video visits.

>> 27 percent of Medicare beneficiaries were interested in having access to audio-only telephone visits.

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

>> Telehealth visits were more commonly used by Medicare beneficiaries who lived in urban areas, had household incomes of at least $50,000, and were under the age of 75. These subgroups were also more interested in having access to telehealth in the future.

>> 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 7-19 In our 2024 survey, Medicare beneficiaries were less likely to report long waits for appointments than privately insured people

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?" (Overall share)		
For regular or routine care		
Never	51%* (48%*)	36%* (33%*)
Sometimes	37* (35*)	42* (40*)
Usually	9* (9*)	14* (13*)
Always	4* (4*)	8* (8*)
For an illness or injury		
Never	65* (54*)	54* (44*)
Sometimes	28* (24)	32* (26)
Usually	5* (4*)	9* (8*)
Always	2* (2*)	5* (4*)
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	82 (38*)	80 (48*)
Went to a walk-in clinic	10 (5*)	12 (7*)
Decided not to schedule the appointment	5 (2*)	6 (3*)
Went to a hospital emergency room	3 (1)	2 (1)
For an illness or injury		
Took the later appointment date	60* (18*)	55* (20*)
Went to a walk-in clinic	22* (6*)	30* (11*)
Decided not to schedule the appointment	5* (1*)	8* (3*)
Went to a hospital emergency room	13* (4*)	7* (3*)

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. 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 the respective insurance.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

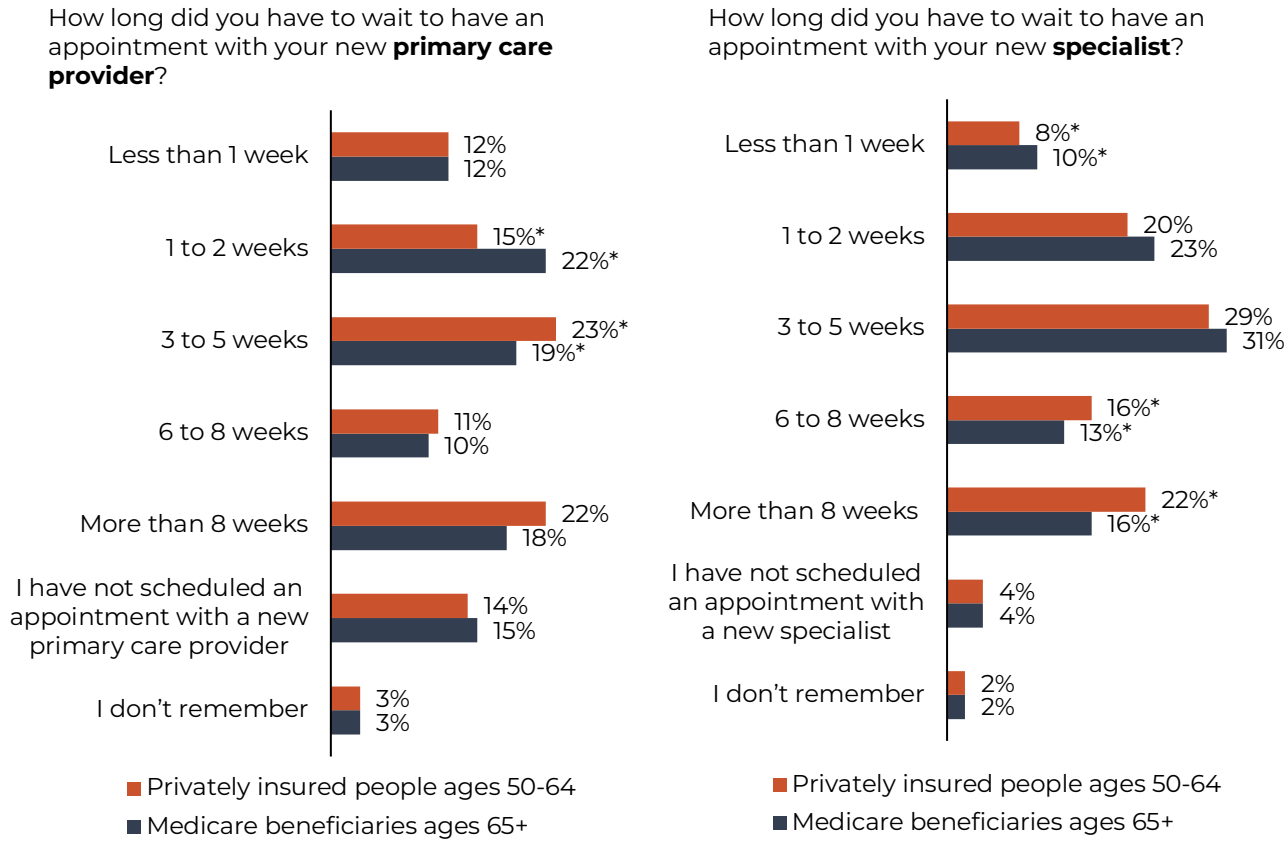
> In 2024, our survey found that Medicare beneficiaries were less likely than privately insured people to report having to wait longer than they wanted to get a doctor's appointment.

> Among those who needed appointments for routine care, about half (51 percent) of Medicare beneficiaries reported that they never had to wait longer than they wanted to get such an appointment, while only 36 percent of privately insured people reported never experiencing this problem.

> Among those who needed 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 an appointment, compared with 54 percent of privately insured people.

Chart 7-20 In our 2024 survey, Medicare beneficiaries and privately insured people reported similar wait times for a first appointment with a new clinician

Among those who tried to get a new [primary care provider/specialist] in the past 12 months . . .



Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> Among Medicare beneficiaries who tried to get a new primary care provider (PCP) in the past year, about a third (34 percent) reported waiting two weeks or less for their first appointment. Similarly, among those trying to get a new specialist, a third (33 percent) waited two weeks or less for their first appointment.

> Wait times reported by Medicare beneficiaries were comparable with or, in some cases, better than those reported by privately insured people.

>> Medicare beneficiaries were more likely to be seen by a new PCP in one to two weeks and less likely to be seen in three to five weeks compared with privately insured people.

>> Medicare beneficiaries were more likely to be seen by a new specialist in less than one week and less likely to wait six weeks or more for an appointment.

Chart 7-21 In our 2024 survey, Medicare beneficiaries were less likely to report forgoing care than privately insured people

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	18%*	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*)	24 (6*)
I didn't think the problem was serious	28* (5)	18* (5)
I couldn't get an appointment soon enough	22 (4*)	21 (6*)
I thought it would cost too much	7* (1*)	23* (6*)
I couldn't find a doctor who would treat me	4 (1)	4 (1)
I put it off because I was worried about catching COVID-19	1 (0)	0 (0)
Other	11 (2)	10 (3)

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. Components do not sum to 100 percent due to rounding. "Overall share" refers to the share of all respondents with the respective insurance.
* Statistically significant difference between Medicare and private insurance groups at 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

> In our 2024 survey, 18 percent of Medicare beneficiaries and 27 percent of privately insured people reported forgoing care that they thought they should have gotten in the past year.

> About half of care-forgoers did so because they "didn't think the problem was serious" or "just put it off" (55 percent of Medicare beneficiaries and 42 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 reason accounted for 22 percent of Medicare care-forgoers (equivalent to 4 percent of all Medicare beneficiaries) and 21 percent of privately insured care-forgoers (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: Only 7 percent of Medicare care-forgoers skipped care because they "thought it would cost too much" (equivalent to 1 percent of all Medicare beneficiaries), while 23 percent of privately insured care-forgoers skipped care for this reason (equivalent to 6 percent of all privately insured people).

Chart 7-22 In our 2024 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	92%[ab]	96%[ab]	97%[ab]	84%[ab]	92%[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	24[b]	16[ab]	15[ab]	28[b]	23[a]	21[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[b]	33[b]	39[b]	25[b]	32[b]	37[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	20[ab]	18[a]	16[ab]	30[a]	29[a]	26[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	24 (5)	35[a] (6)	27 (4[a])	21 (6)	21[a] (6)	26 (7[a])
I didn't think the problem was serious	26 (5)	29[a] (5)	28[a] (5)	18 (5)	17[a] (5)	19[a] (5)
I couldn't get an appointment soon enough	21 (4)	19 (3)	25 (4[a])	17 (5)	17 (5)	24 (6[a])
I thought it would cost too much	10[ab] (2[ab])	4[a] (1[a])	4[ab] (1[ab])	31[ab] (9[ab])	30[a] (8[a])	17[ab] (4[ab])
I couldn't find a doctor who would treat me	5 (1)	4 (1)	3 (0)	3 (1)	4 (1)	5 (1)
I put if off because I was worried about catching COVID-19	2 (0)	1 (0)	1 (0)	0 (0)	0 (0)	1 (0)
Other	11 (2)	7 (1[a])	13 (2)	10 (3)	12 (3[a])	9 (2)

Note: NP (nurse practitioner), PA (physician assistant). We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "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 the respective insurance.

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

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

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

(Chart continued next page)

Chart 7-22 In our 2024 survey, lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries (continued)

> In 2024, we found some differences in care patterns 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 92 percent of lower-income beneficiaries reported receiving any health care in the past year, compared with 97 percent of higher-income beneficiaries.

>> Higher shares of lower-income beneficiaries reported forgoing care in the past year (20 percent) compared with higher-income beneficiaries (16 percent).

> Medicare beneficiaries were less likely than privately insured people to report cost as a barrier to care: Among lower-income privately insured respondents 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, only 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 2024 survey, White, Black, and Hispanic Medicare beneficiaries generally reported comparable experiences accessing care

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50–64)		
	White	Black	Hispanic	White	Black	Hispanic
Received health care: "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]	94%	95%[a]	92%[ab]	89%	87%[ab]
Providers who accept their 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)	97[a]	97	95	92[a]	95	95
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)	88[a]	92	89	79[a]	85	81
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						
Usually or always	13[ab]	7[ab]	12	22[a]	17[a]	21
Sometimes or never	87[ab]	93[ab]	88	78[a]	83[a]	79
For an illness or injury						
Usually or always	7[a]	5	8	14[a]	10	16
Sometimes or never	93[a]	95	92	86[a]	90	84
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	18[a]	18	21	27[a]	23	32

Note: We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "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 the 95 percent confidence level).

[b] Statistically significant difference between White and Black or White and Hispanic within the same insurance category (at the 95 percent confidence level).

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024

> There were not statistically significant differences by race or ethnicity on most questions in our survey, including the shares of White and Black or Hispanic beneficiaries who:

>> had received health care in the past year,

>> were satisfied with their ability to find health care providers who accepted their insurance and had timely appointments available,

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

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

Chart 7-24 In our 2024 survey, rural Medicare beneficiaries were more likely to receive their primary care from a nonphysician than 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)	43%[ab]	30%[b]	36%[ab]	27%[b]
For any of my primary care (net)	54[ab]	66[b]	59[ab]	69[b]
For some of my primary care	38	37	39[b]	33[b]
For all or most of my primary care	17[ab]	30[b]	20[ab]	36[b]
Don't know	2[a]	3	5[a]	4
Wait time for appointment with new PCP: Among those who tried to get a new primary care provider in the past 12 months, "How long did you have to wait to have an appointment with your new primary care provider?"				
I have not scheduled an appointment with a new primary care provider	16	10	15	10
Less than 1 week	12	12	12	14
1 to 2 weeks	19[ab]	34[b]	13[ab]	27[b]
3 to 5 weeks	19	19	24	18
6 to 8 weeks	11	6	11	12
More than 8 weeks (2 months)	20	13	23	14
I don't remember	3	5	2	5
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[b]	26[b]	35[b]	28[b]
Long wait for a routine appointment: Among those who needed an appointment for regular or routine care in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"(Overall share)				
Never	49[ab] (47[ab])	57[ab] (54[ab])	34[ab] (31[ab])	45[ab] (43[ab])
Sometimes	38[a] (36[a])	33 (32)	43[a] (40[a])	37 (35)
Usually	9[a] (9[a])	8 (8)	15[a] (14[a])	10 (10)
Always	4[a] (4[a])	3[a] (3[a])	8[a] (8[a])	7[a] (7[a])

Note: NP (nurse practitioner), PA (physician assistant), PCP (primary care provider). We received completed surveys from 4,926 Medicare beneficiaries (including beneficiaries in both FFS Medicare and Medicare Advantage plans) and 5,200 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. All comparisons were adjusted for multiple pairwise testing using a Bonferroni correction. "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 privately insured people within the same area type (at the 95 percent confidence level).

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

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 25 to September 9, 2024.

(Chart continued next page)

Chart 7-24 In our 2024 survey, rural Medicare beneficiaries were more likely to receive their primary care from a nonphysician than urban beneficiaries (continued)

> Our survey found a few differences between rural and urban beneficiaries' experiences accessing care. In particular:

>> More rural beneficiaries reported receiving all or most of their primary care from an NP or PA (30 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 (57 percent) compared with urban beneficiaries (49 percent) among those who needed this type of appointment. This finding was also true among the privately insured.

>> More rural beneficiaries reported waiting only one to two weeks for their first appointment with a new primary care provider (34 percent) compared with urban beneficiaries (19 percent). This finding was also true among the privately insured.

>> Fewer rural beneficiaries reported looking for a new specialist in the past year (26 percent) compared with urban beneficiaries (33 percent). This finding was also true among the privately insured.

> 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, specialist, or mental health professional;

>> encountered a primary care or specialist practice that did not accept Medicare;

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

>> 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 2018–2022	Percent change 2022–2023
Skilled nursing facilities	15,359	15,305	15,173	15,098	14,973	14,800	–0.6%	–1.0%
Home health agencies	11,556	11,356	11,386	11,506	11,657	12,057	0.2	3.4
Inpatient rehabilitation facilities	1,170	1,152	1,159	1,181	1,181	1,206	0.2	2.1
Long-term care hospitals	386	371	351	345	341	338	–3.1	–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).

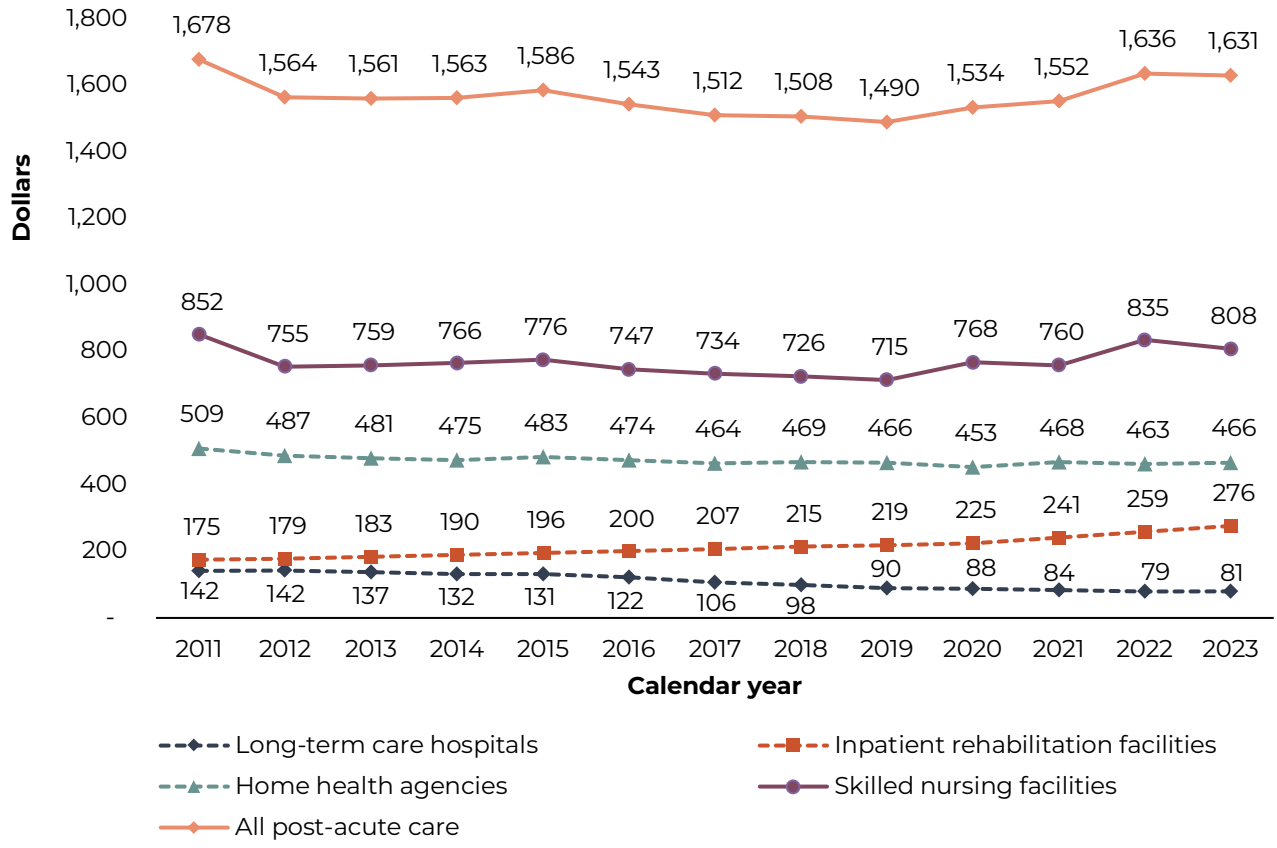
> The number of skilled nursing facilities decreased less than 1 percent per year between 2018 and 2022.

> 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 increased again 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 FFS Medicare spending per capita for post-acute care was relatively steady between 2011 and 2023 for skilled nursing facilities and home health agencies

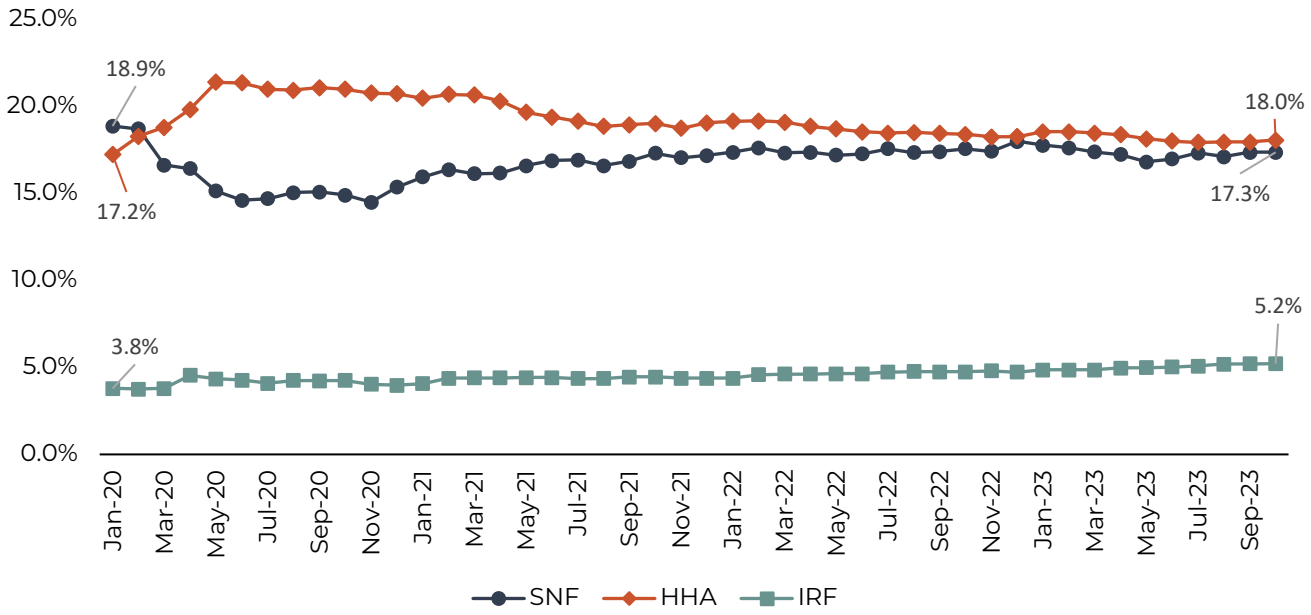


Note: FFS (fee-for-service). These calendar year–incurred data represent program spending only; they do not include beneficiary cost sharing. Dollar amounts are nominal figures, not adjusted for inflation.

Source: CMS Office of the Actuary, 2024.

> Between 2011 and 2023, per capita spending for FFS Medicare beneficiaries was relatively steady for skilled nursing facilities and home health agencies. Per capita spending for inpatient rehabilitation services increased, particularly in 2023; while per capita spending for long-term care hospitals has declined.

Chart 8-3 Between January 2020 and October 2023, SNFs lost and then gradually regained some of the share of IPPS discharges to PAC, while the share going to HHAs increased and then gradually declined



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 an 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 fell. At the same time, the share receiving services from HHAs and IRFs increased, with home health becoming the most commonly used PAC setting. Since then, the share of hospital discharges receiving home health care has declined steadily while the share using SNFs has increased, though home health remained the most commonly used PAC setting as of October 2023. The share of hospital discharges receiving IRF care, by contrast, remained higher than it was before the pandemic.

> Overall, about 41 percent of inpatient hospital discharges in 2021 through the first 10 months of 2023 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 the first 10 months of 2023, 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, FFS Medicare–covered stays, and FFS Medicare spending in 2023

Type of SNF	Facilities	FFS Medicare–covered stays	FFS Medicare payments
Totals	14,500	1,583,000	$25 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	85	87
Rural	27	15	13
For profit	73	75	79
Nonprofit	22	22	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 FFS Medicare 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 2023, freestanding facilities accounted for 98 percent of Medicare-covered SNF stays and 98 percent of FFS Medicare's payments to SNFs.

> In 2023, urban facilities accounted for 73 percent of facilities, 85 percent of FFS stays, and 87 percent of FFS Medicare payments.

> In 2023, for-profit facilities accounted for 73 percent of facilities, 75 percent of FFS stays, and 79 percent of FFS Medicare payments.

Chart 8-5 Per capita FFS SNF admissions increased in 2022 but fell in 2023

Volume measure	2019	2020	2021	2022	2023	Average annual change 2019–2022	Average annual change 2022–2023
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	47	–2.1%	–12%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,500	1,385	2.7	–8
Covered days per admission	26.1	28.5	28.0	28.0	29.0	0.2	5

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

Source: MedPAC analysis of 2019–2023 Medicare Provider Analysis and Review and Common Medicare Environment data.

> To control for changes in FFS enrollment, we examined service use per 1,000 FFS beneficiaries. Between 2022 and 2023, SNF admissions per 1,000 FFS beneficiaries decreased 12 percent. Between 2019 and 2022, SNF admissions decreased an average of 2.1 percent per year, while days per 1,000 beneficiaries increased an average of 2.7 percent per year. Compared with 2019, covered admissions per 1,000 FFS beneficiaries in 2023 were 14 percent lower, but covered days per admission were 11 percent higher due to longer stays.

Chart 8-6 FFS Medicare margins in freestanding SNFs remained high in 2023

	2021	2022	2023
All	22.1	22.9	21.9
Rural	21.8	22.1	20.3
Urban	22.2	23.0	22.2
Nonprofit	8.5	7.2	7.3
For profit	25.1	25.9	25.1

Note: FFS (fee-for-service), SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports and Minimum Data Set data.

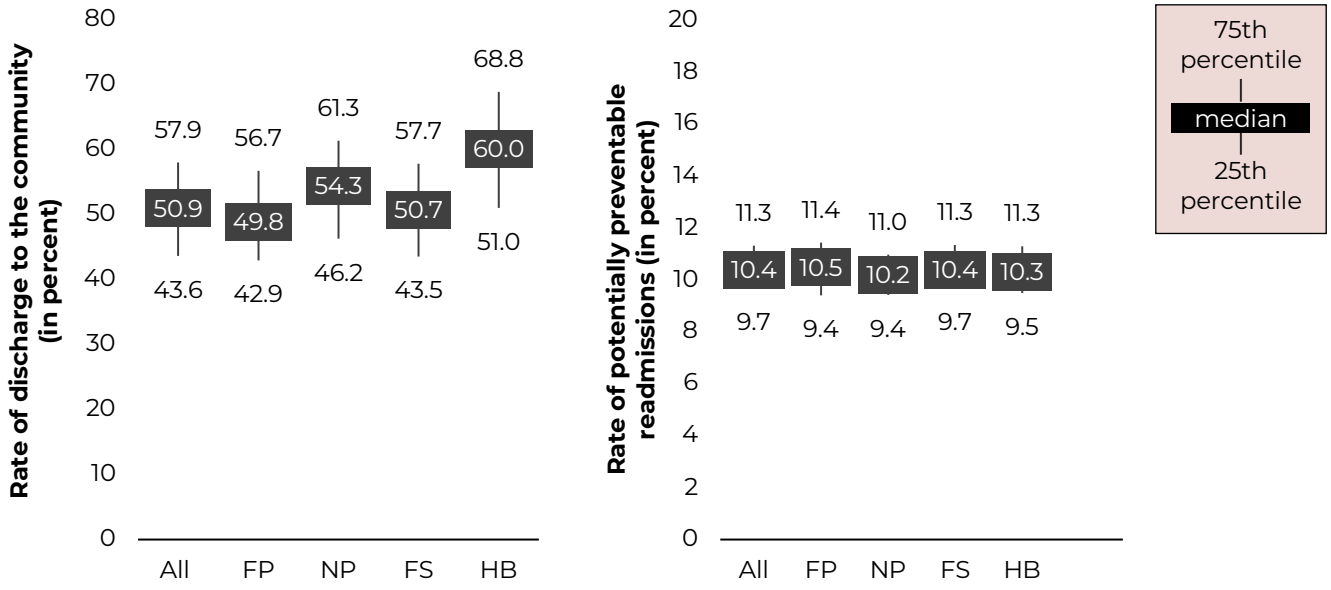
> The aggregate FFS Medicare margin for freestanding SNFs in 2023 (21.9 percent) exceeded 10 percent for the 24th consecutive year (not all years are shown). Had we considered an allocated share of the federal relief funds that providers received due to the coronavirus pandemic, we estimate the aggregate FFS margin in 2023 would have been even higher.

> The aggregate FFS Medicare margin decreased in 2023 because the average payment per day in freestanding SNFs increased 2.4 percent, while costs per day increased 3.8 percent (data not shown). The larger growth in costs per day in 2023 reflected growth in both routine and ancillary costs. This year was the first since the implementation of the Patient-Driven Payment Model that ancillary costs grew, driven by overall increases in per day costs of physical therapy, occupational therapy, and drugs.

> Aggregate FFS Medicare margins for freestanding SNFs varied widely: One-quarter of SNFs had FFS Medicare margins that were 32 percent or higher, and one-quarter had margins that were 10.6 percent or lower (data not shown). Consistent with the prepandemic years, urban SNFs had a higher aggregate FFS Medicare margin than rural SNFs in 2023. For-profit SNFs had a considerably higher aggregate FFS 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 2022 and 2023 (data not shown).

> In 2023, the average total margin (the margin across all payers and all lines of business) for freestanding SNFs was 0.4 percent, up from –1.3 percent in 2022 (data not shown). The improvement reflects an aggregate increase in Medicaid base rates.

Chart 8-7 SNF quality measures: Risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2022 and FY 2023



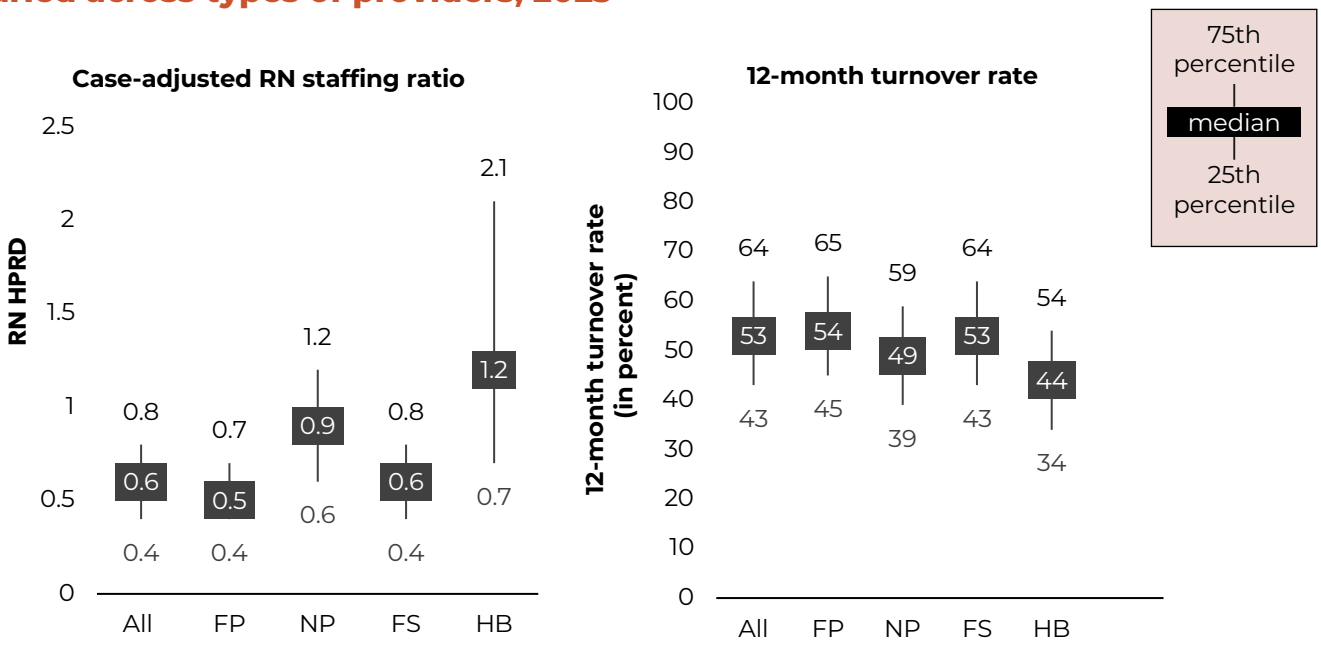
Note: SNF (skilled nursing facility), FY (fiscal year), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (FY 2022 and FY 2023 combined). Rates are computed from Medicare claims for eligible Medicare 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, FY 2022 through FY 2023.

> In FY 2022 and FY 2023 (combined), the median rate of discharge to the community from SNFs was 50.9 percent, similar to the combined FY 2021 and FY 2022 rate of 50.7 percent (latter data not shown). In FY 2022 and FY 2023, one-quarter of SNFs had rates above 57.9 percent and one-quarter had rates below 43.6 percent. The median rates of discharge to the community for nonprofit SNFs and hospital-based SNFs were higher than the median rates for for-profit SNFs and freestanding SNFs. Urban SNFs had higher rates of community discharge than rural SNFs (data not shown).

> In FY 2022 and FY 2023 (combined), 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 9.7 percent.

Chart 8-8 SNFs' RN staffing ratios and total nursing staff turnover rates varied across types of providers, 2023



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 2023, the median SNF provided 0.6 RN HPRD, identical to 2022 (latter data not shown). One-quarter of SNFs provided 0.8 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. Rural facilities had ratios similar to those of metropolitan facilities (data not shown). 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 2023, the 12-month nursing staff turnover rate was 53 percent for the median SNF, identical to 2022 (latter data not shown). 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. Turnover rates at urban facilities (53 percent) were similar to turnover rates at very rural facilities (51 percent), although RN-specific turnover was higher in urban facilities (51 percent) than in very rural facilities (44 percent) (data not shown).

Chart 8-9 Fee-for-service home health care use and spending declined in 2023

	2019	2020	2021	2022	2023	Average annual change 2019–2022	Average annual change 2022–2023
FFS Medicare home health users (millions)	3.3	3.1	3.0	2.8	2.7	–5.0	–4.4%
Share of FFS Medicare beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	7.8%	–1.9	–2.3
30-day periods (millions)	N/A	N/A	9.3	8.6	8.3	N/A	–3.9
30-day periods per 100 FFS Medicare beneficiaries	N/A	N/A	26	24	24	N/A	1.8
Total in-person visits (millions)	99.7	81.1	76.8	69.5	66.3	–11.3	–4.6
In-person visits per user	30.2	26.6	25.4	24.6	24.5	–6.7	–0.2

Note: FFS (fee-for-service), N/A (not available). Average annual changes are calculated using unrounded values and then rounded to the nearest tenth. The 30-day period was established as the unit of payment for home health care services on January 1, 2020, and consequently 30-day period data are not available for 2019 and 2020 (data for 2020 are affected because a portion of services in this year were paid under the prior unit of payment during the transition period).

Source: MedPAC analysis of home health standard analytic files from CMS and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2023, the number of FFS beneficiaries using covered home health care declined by 4.4 percent, reflecting both a decrease in the number of beneficiaries enrolled in FFS Medicare and a decline in the share of FFS beneficiaries using home health care. FFS home health utilization has 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 remained relatively steady in 2023, at 24 per 100 FFS beneficiaries. The number of in-person visits per home health user remained relatively steady in 2023, at 24.5.

> In 2023, about 1.2 percent of FFS-covered 30-day home health periods included a telehealth visit or remote patient monitoring, and about 14 percent of home health agencies (HHAs) provided at least one telehealth or remote patient-monitoring service to a FFS beneficiary (data not shown). Skilled nursing care accounted for about 80 percent of the telehealth visits provided in 2023. The small number of beneficiaries receiving these services, and the limited number of HHAs providing them, indicates that most clinical care in the home health benefit is still provided in person.

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

Type of 30-day period	2022	2023
Period by source of referral		
Preceded by hospitalization or institutional PAC	25.2%	25.3%
Community admitted	74.8	74.7
Period by timing of 30-day period		
Early	30.9	30.8
Late	69.1	69.2

Note: FFS (fee-for-service), 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 2023 home health standard analytic file.

> Most FFS-covered 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 30-day periods in 2022 and 2023.

> Under FFS Medicare's 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 2023 compared with the prior year. The mix of cases by clinical payment group also did not change significantly (data not shown).

Chart 8-11 FFS Medicare margins for freestanding home health agencies remained high in 2023

	2019	2020	2021	2022	2023	Share of home health agencies, 2023	Share of periods, 2023
All	15.4%	20.2%	24.9%	22.2%	20.2%	100%	100%
Geography							
Majority urban	16.1	20.0	24.8	22.3	20.2	86	87
Majority rural	14.2	21.6	25.2	22.0	20.1	14	13
Type of ownership							
For profit	17.4	22.7	26.1	23.6	21.5	93	87
Nonprofit	11.4	12.4	20.2	16.4	13.3	7	13
Volume quintile							
First (smallest)	9.7	11.6	14.0	13.7	12.6	20	3
Second	11.4	14.0	15.9	14.5	13.9	20	7
Third	13.3	17.0	19.3	17.0	15.0	20	11
Fourth	14.1	18.8	22.8	21.0	19.4	20	20
Fifth (largest)	17.5	22.4	28.3	24.8	22.4	20	60

Note: FFS (fee-for service). Home health agencies (HHAs) were classified as "majority urban" if they provided more than 50 percent of episodes to beneficiaries in urban counties, and they were classified as "majority rural" if they provided more than 50 percent of episodes to beneficiaries in rural counties. These data do not include federal provider relief funds that HHAs received due to the coronavirus pandemic. Percentage changes were calculated on unrounded data.

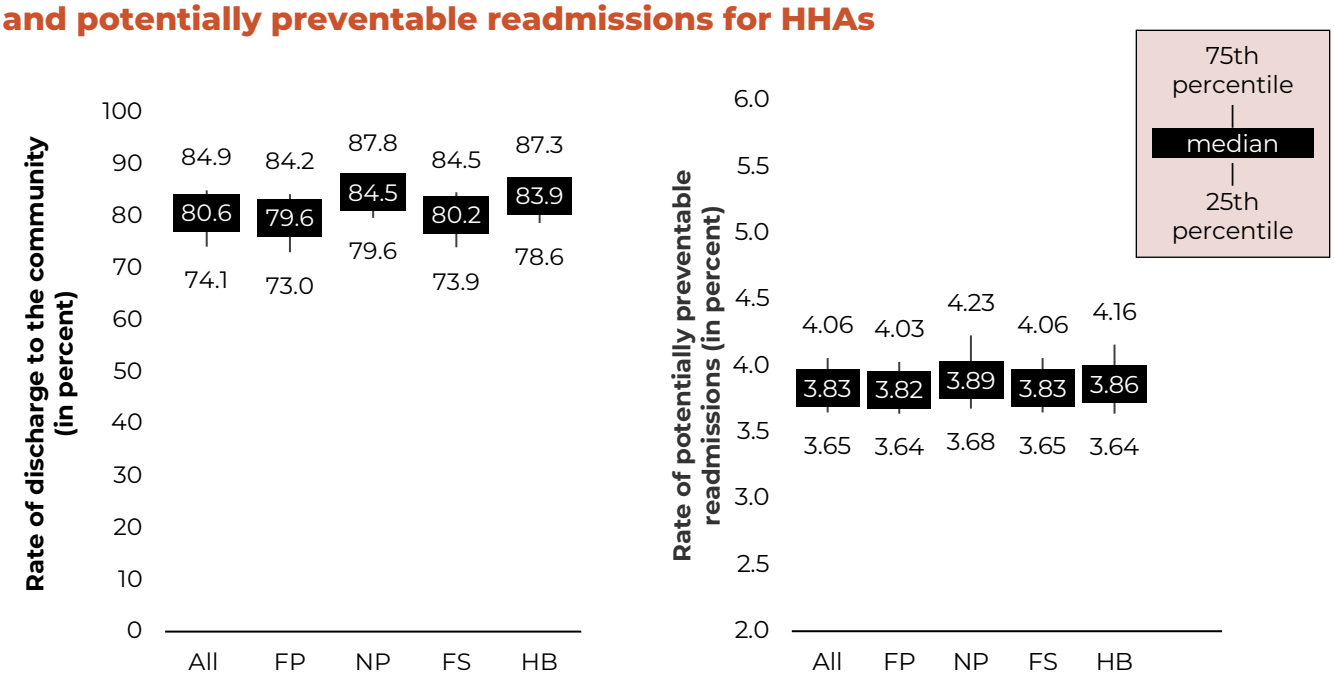
Source: MedPAC analysis of Medicare home health cost-report files from CMS.

> In 2023, freestanding HHAs (87 percent of all HHAs; data not shown) had an aggregate FFS Medicare margin of 20.2 percent. The 2023 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 2022 averaged 17.1 percent (not all data shown), indicating that most agencies have been paid well in excess of their costs for more than 20 years.

> For-profit agencies had an average FFS Medicare margin of 21.5 percent in 2023, compared with 13.3 percent for nonprofit agencies. There was little difference in the aggregate FFS Medicare margins of urban HHAs (20.2 percent) and rural HHAs (20.1 percent).

> Agencies with higher volumes of 30-day periods had higher FFS Medicare margins. The agencies in the lowest-volume quintile in 2023 had an aggregate FFS Medicare margin of 12.6 percent, compared with 22.4 percent for those in the highest-volume quintile.

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



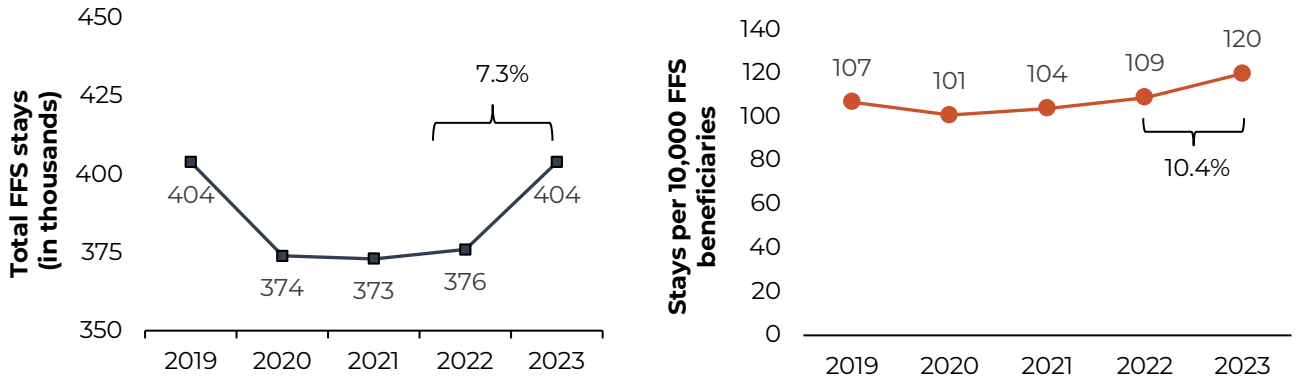
Note: HHA (home health agency), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). The measure of "discharge to the community" is an HHA's risk-standardized rate of fee-for-service (FFS) Medicare patients who were discharged to the community after a home health stay, did not have 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, 2022, to December 31, 2023; rates for potentially preventable readmissions are for the 36-month period from January 1, 2021, to December 31, 2023.

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 80.6 percent in the period from January 1, 2022, to December 31, 2023 (higher rates indicate better quality). For-profit providers had the lowest median rates of discharge to community during the period, while nonprofit providers had the highest rates. From January 1, 2022, to December 31, 2023, HHAs at the 25th percentile and 75th percentile had rates of 74.1 percent and 84.9 percent, respectively.

> For the 36-month period from January 1, 2021, to December 31, 2023, the median rate of home health stays with a potentially preventable readmission was 3.83. The median 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 3.65 percent and 4.06 percent, respectively.

Chart 8-13 In 2023, the number of FFS Medicare IRF stays grew substantially compared with prior years



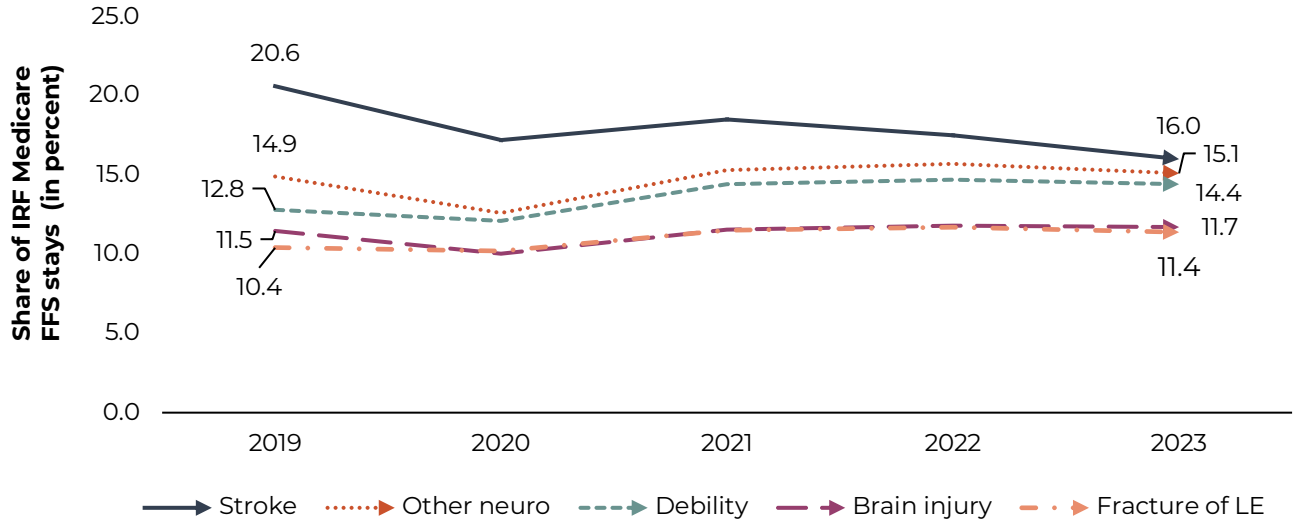
Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). The number of FFS stays and the number of beneficiaries are rounded.

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

> From 2022 to 2023, the number of FFS-covered IRF cases rose by 7.3 percent, to about 404,000 cases. When controlling for the number of FFS beneficiaries, the increase was even greater (10.4 percent).

> The average length of stay decreased slightly in 2023 to 12.5 days, a 2.3 percent reduction from 12.8 days in 2022 (data not shown).

Chart 8-14 Stroke, other neurological conditions, and debility remained the most common conditions for FFS beneficiaries in IRFs in 2023



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 percentages presented in this table are rounded. (The cases shown in 2023 represent about 70 percent of all FFS cases.)

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

> Stroke, "other neurological conditions" (such as multiple sclerosis and neuromuscular disorders), debility, brain injury, and fracture of the lower extremity continue to be the most common conditions among IRF stays. Since 2019, these conditions have steadily composed about 70 percent of IRF stays.

> Stroke continues to be the most common condition among IRF stays, accounting for 16.0 percent of FFS stays in 2023. However, the share of stroke stays has declined from 20.6 percent of stays in 2019. Between 2019 and 2023, IRF stays for debility have increased from 12.8 percent to 14.4 percent of IRF FFS stays.

Chart 8-15 IRFs' aggregate FFS Medicare margin increased to 14.8 percent in 2023

	2019	2020	2021	2022	2023
All IRFs	14.1%	13.3%	16.9%	13.7%	14.8%
Hospital based	1.7	1.4	5.7	0.8	1.0
Freestanding	24.6	23.4	25.9	23.3	24.2
Urban	14.5	13.6	17.3	14.1	15.0
Rural	7.6	9.0	11.7	7.7	11.2
Nonprofit	1.1	−0.3	5.3	−0.5	−0.2
For profit	24.2	23.4	25.3	22.7	23.5
Number of beds					
1–10	−9.1	−7.3	−2.7	−6.5	−5.3
11–24	1.6	2.2	5.7	1.1	1.0
25–64	15.8	14.8	18.6	15.0	16.6
65+	20.9	19.3	22.2	19.8	20.4

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").

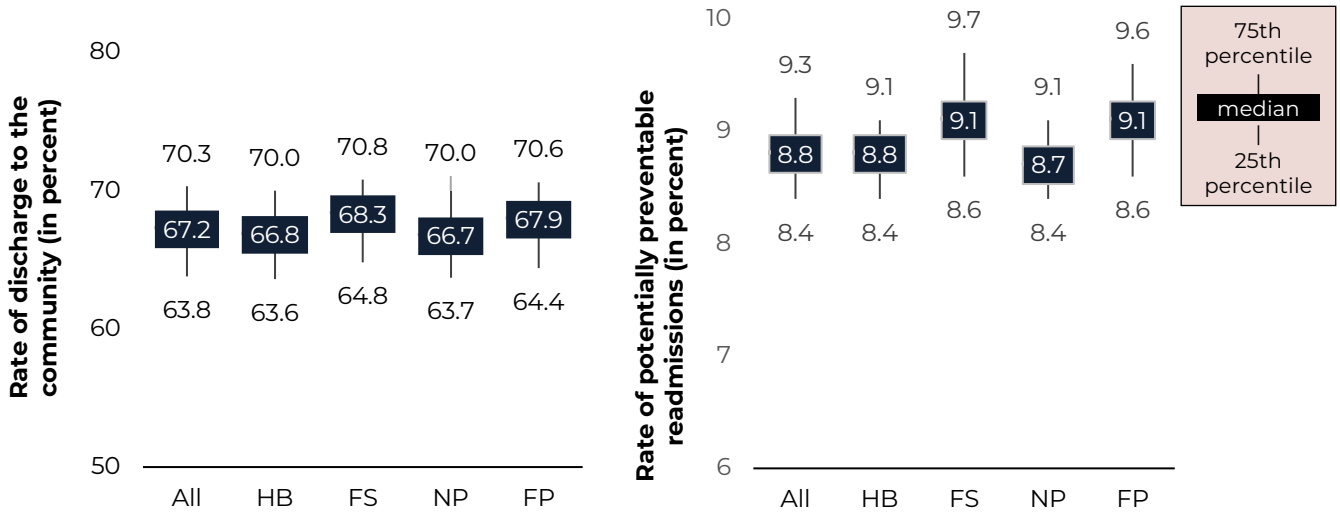
Source: MedPAC analysis of cost-report data from CMS.

> In 2023, IRFs' per case payments grew slightly while costs declined; as a result, the aggregate FFS Medicare margin increased, remaining strong at 14.8 percent (14.9 percent when including Medicare's share of federal relief funds; data not shown).

> FFS Medicare margins vary by IRF type. In 2023, freestanding IRFs and for-profit IRFs had substantially higher aggregate margins (24.2 percent and 23.5 percent, respectively) than hospital-based IRFs and nonprofit IRFs (1.0 percent and –0.2 percent, respectively).

> There are large differences in FFS Medicare margins by IRF size. In 2023, the aggregate FFS Medicare margin for IRFs with 10 or fewer beds was –5.3 percent. By contrast, the FFS Medicare margin for IRFs with 65 or more beds was 20.4 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 2022 and FY 2023



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 (FY 2021 and FY 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 FY 2022 and FY 2023, the median facility risk-adjusted rate of discharge to the community from IRFs was 67.2 percent, similar to the 67.3 percent from FY 2021 and FY 2022 (latter data not shown).

> The median facility risk-adjusted rate of potentially preventable readmission was 8.8 percent (similar to last year) and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers.

Chart 8-17 FFS Medicare inpatient stays at LTCHs remained relatively steady in FY 2023 and well below FY 2019 level

	LTCH FFS Medicare stays and payments, by fiscal year				
	2019	2020	2021	2022	2023
Stays (in thousands)					
All	91	78	70	60	59
Nonqualifying	23	19	20	19	17
Qualifying	68	59	50	41	42
Share of qualifying	75%	76%	71%	68%	71%
Stays per 10,000 FFS beneficiaries					
All	24	21	20	17	17
Nonqualifying	6	5	6	6	5
Qualifying	18	16	14	12	12
Payment per stay (in thousands)					
All	$41	$46	$49	$49	$49
Nonqualifying	$26	$32	$39	$39	$37
Qualifying	$47	$50	$53	$53	$53
Length of stay (in days)					
All	27	28	28	28	27
Nonqualifying	23	24	26	26	25
Qualifying	28	29	28	29	28

Note: FFS (fee-for-service), LTCH (long-term care hospital), FY (fiscal year). "Qualifying stay" 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 stays paid for by private plans. Dollar amounts are nominal figures, not adjusted for inflation. Results differ from those published in prior years because of newer data and methodological updates, such as enrollment counts.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and the 2024 report of the Boards of Trustees of the Medicare trust funds.

> Since FY 2016, FFS Medicare has differentiated between two types of stays at LTCHs: (1) those meeting criteria specified in law, which are paid at the standard LTCH prospective payment system rate, and (2) others, which are paid at a site-neutral rate. Stays that qualify for the standard rate are nonpsychiatric, nonrehabilitation stays that either:

>> immediately follow an acute care hospital stay that included three or more days in an intensive care unit or

>> include mechanical ventilation for at least 96 hours.

> From FY 2019 through FY 2022, the number of FFS Medicare–covered LTCH stays continued to decline, both on an absolute and per capita basis. In addition, the share of qualifying stays declined.

> In FY 2023, the volume of LTCH stays remained relatively steady but shifted toward qualifying stays.

> From January 2020 through May 2023, the application of site-neutral payment rates was waived due to the coronavirus public health emergency. As a result, the average LTCH payment rate per FFS stay increased part way through FY 2020 and further increased in FY 2021, when LTCHs were paid the higher LTCH rate for the entire fiscal year.

Chart 8-18 FFS Medicare LTCH stays continued to be concentrated in two MS–LTC–DRGs in FY 2023

MS–LTC–DRG	Description	DRG share of FFS Medicare LTCH stays, by fiscal year				
		2019	2020	2021	2022	2023
189	Pulmonary edema and respiratory failure	20.5%	19.4%	18.7%	22.9%	22.5%
207	Respiratory system diagnosis with ventilator support >96 hours	13.2	14.5	15.6	14.3	13.0
871	Septicemia without ventilator support >96 hours with MCC	5.5	5.1	3.9	3.2	3.1
208	Respiratory system diagnosis with ventilator support ≤96 hours	2.7	3.1	3.5	3.3	2.7
166	Other respiratory system OR procedures with MCC	2.3	2.5	2.8	2.6	2.6
177	Respiratory infections and inflammations with MCC	1.9	3.7	9.1	3.9	2.5
981	Extensive OR procedure unrelated to principal diagnosis with MCC	2.0	2.0	2.2	2.3	2.3
539	Osteomyelitis with MCC	1.8	1.5	1.7	1.9	2.2
949	Aftercare with CC/MCC	2.2	2.0	1.9	2.0	2.1
682	Renal failure with MCC	1.7	1.7	1.4	1.5	1.7

Note: FFS (fee-for-service), LTCH (long-term care hospital), MS–LTC–DRG (Medicare severity long-term-care diagnosis related group), FY (fiscal year), MCC (major complication or comorbidity), OR (operating room), CC (complication or comorbidity). MS–LTC–DRGs are used in the case-mix system for LTCHs. Shares for each MS–LTC–DRG presented in the table are rounded.

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

> FFS Medicare categorizes each inpatient stay at an LTCH into an MS–LTC–DRG, primarily based on the patient's principal diagnosis and the care provided.

> FFS Medicare inpatient stays at LTCHs continued to be concentrated into two MS–LTC–DRGs: pulmonary edema and respiratory failure (accounting for 22.5 percent of FFS Medicare stays in FY 2023) and respiratory system diagnosis with ventilator support >96 hours (which accounted for 13.0 percent of stays).

> Among nonqualifying stays—stays paid under the site-neutral rate when it is in effect (see Chart 8-17)—pulmonary edema and respiratory failure was still the most common MS–LTC–DRG, accounting for about 15 percent of FFS nonqualifying stays in FY 2023 (data not shown).

Chart 8-19 LTCHs' aggregate FFS Medicare margin increased in FY 2023 but remained negative

	LTCH FFS Medicare margin, by fiscal year				
	2019	2020	2021	2022	2023
All LTCHs	–2.0%	3.6%	6.0%	–1.8%	–0.7%
Nonprofit	–12.0	–11.3	–11.7	–23.2	–21.0
For profit	–0.1	6.0	8.5	1.4	2.3
Margin percentile					
25th percentile	–12.8	–6.9	–4.7	–13.6	–12.2
Median	0.2	5.0	6.1	–3.5	–1.1
75th percentile	8.5	12.3	15.2	8.2	8.9
Facility share of qualifying stays					
High share	3.0	6.3	5.2	–1.5	0.6
Low share	–8.2	0.3	6.4	–2.1	–1.3

Note: LTCH (long-term care hospital), FFS (fee-for-service), FY (fiscal year). "Qualifying stay" 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. Data are for LTCHs that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. Results differ from those published in prior years because of newer data and methodological updates, such as the incorporation of outlier reconciliation amounts.

Source: MedPAC analysis of hospital cost-report data and LTCH final-rule data files.

> When CMS implemented lower site-neutral payment rates for certain types of LTCH cases in fiscal year 2016, LTCHs' aggregate FFS Medicare margin fell from nearly 4 percent in FY 2016 to less than −2 percent in FY 2017 (data not shown). LTCH's FFS Medicare margin remained negative through FY 2019. The aggregate FFS Medicare margin jumped to 3.6 percent during the first year of the pandemic, when LTCH site-neutral payment rates were waived and all LTCH cases were paid at the higher, standard LTCH prospective payment rates. The aggregate FFS Medicare margin climbed further, to 6.0 percent in FY 2021.

> In FY 2022, LTCHs' FFS Medicare margin declined sharply, falling to −1.8 percent, despite the continued waiver of site-neutral payment rates. This decline was driven by large increases in LTCHs' cost per stay (see Chart 8-20).

> In FY 2023, LTCHs' FFS Medicare margin remained negative but increased about 1 percentage point to −0.7 percent, as costs per stay declined more than payments per stay (see Chart 8-20).

> FFS Medicare margins varied significantly across LTCHs. For-profit LTCHs consistently had a substantially higher FFS Medicare margin than nonprofit LTCHs. The difference in the FFS Medicare margin between LTCHs with a high share of qualifying stays and a low share narrowed during the waiver of site-neutral payment rates.

Chart 8-20 LTCH PPS payments per stay and LTCHs' costs per stay were relatively steady in FY 2023

	Percentage change from prior fiscal year				
	2019	2020	2021	2022	2023
Payments per stay					
All LTCHs	4.3%	9.2%	7.0%	0.3%	–0.2%
Share qualifying					
LTCHs with >85% qualifying stays	0.6	7.9	11.9	1.3	2.2
LTCHs with ≤85% qualifying stays	1.4	10.4	11.5	2.6	–1.5
Cost per stay					
All LTCHs	5.4	3.3	4.3	8.6	–1.3
Share qualifying					
LTCHs with >85% qualifying stays	2.1	4.2	13.2	8.5	0.1
LTCHs with ≤85% qualifying stays	4.2	1.8	4.7	11.9	–2.2

Note: LTCH (long-term care hospital), PPS (prospective payment system), FY (fiscal year). "Qualifying stay" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS. Data are for LTCHs that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. Results differ from those published in prior years because of newer data and methodological updates, such as the incorporation of outlier reconciliation amounts. Percentages reflect changes in nominal dollars, not adjusted for inflation.

Source: MedPAC analysis of hospital cost-report data and LTCH final-rule data files.

> LTCHs' PPS payments per stay increased rapidly in FY 2020 and FY 2021, reflecting the first year of the public health emergency–related waiver of site-neutral payment rates, and then payments held relatively steady in FY 2022 and FY 2023. In both FY 2022 and FY 2023, LTCHs' PPS payments per stay were about $48,000 per stay (data not shown).

> LTCHs' costs per stay increased more rapidly in FY 2022, reflecting higher-than-expected inflation and reduced volume. In both FY 2020 and FY 2023, LTCHs' cost per stay were about $49,000 per case (data not shown).

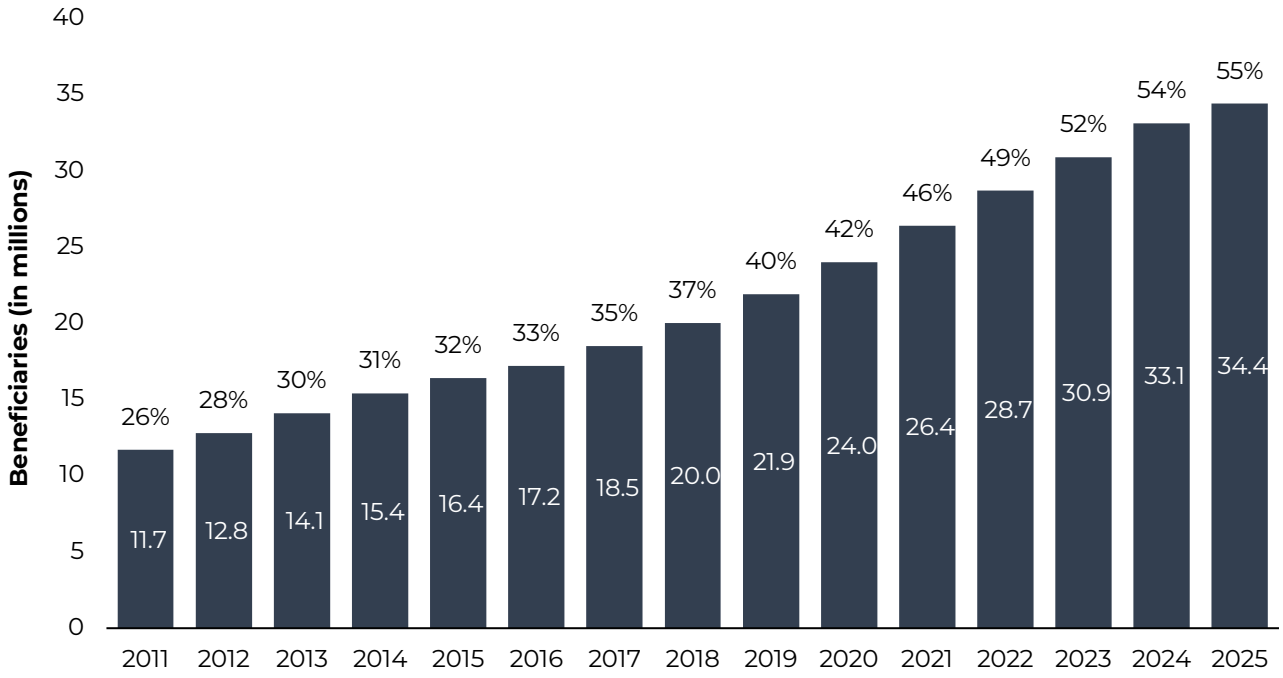
> In FY 2023, payments per stay grew faster among LTCHs with a higher share (>85 percent) of stays meeting the qualifying criteria for LTCH PPS standard rates than among all LTCHs. Among LTCHs with a higher share of qualifying stays, both payments and costs per stay were about $58,000 in FY 2023 (data not shown).

SECTION

9

Medicare Advantage

Chart 9-1 Enrollment in MA plans, 2011–2025

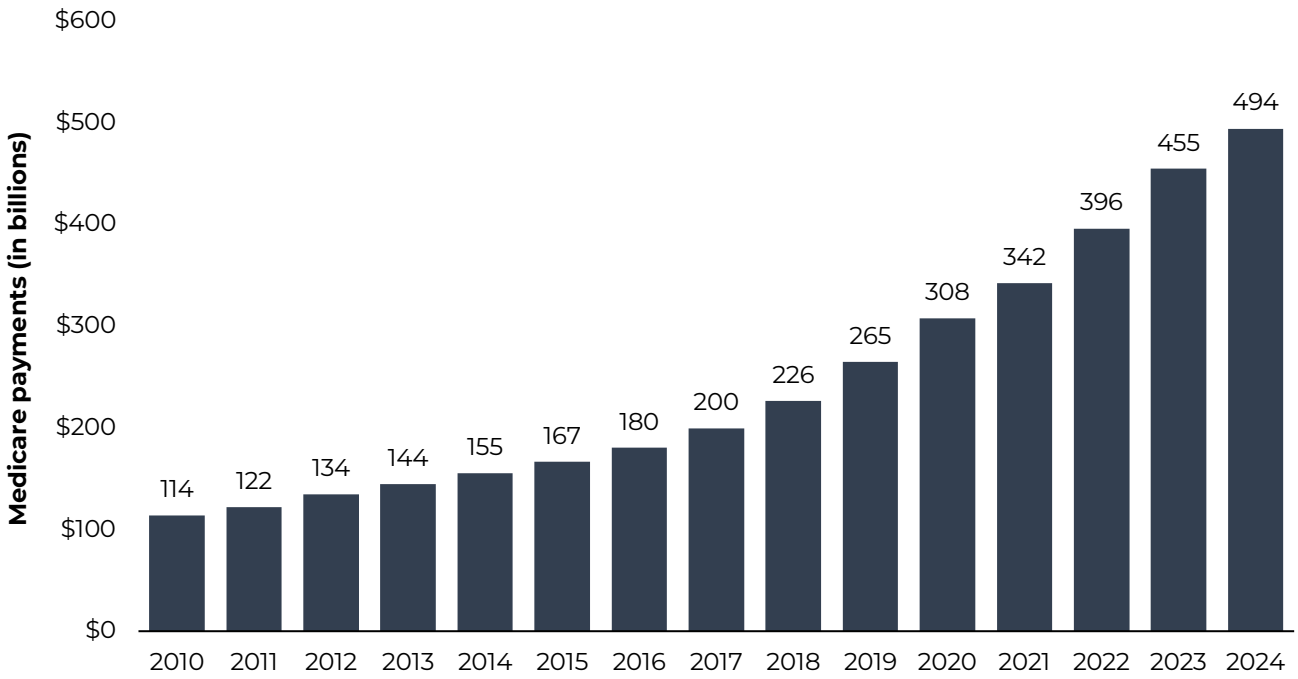


Note: MA (Medicare Advantage). Percentages indicate the share of total MA-eligible enrollment. We estimated February 2025 enrollment by using the ratio of January 2025 enrollment to January 2024 enrollment and applying that ratio to February 2024 enrollment data.

Source: CMS Medicare managed care contract reports and monthly summary reports, February 2011–2025.

> In February 2025, enrollment in MA plans, which are paid on a risk-adjusted basis, reached 34.4 million, or 55 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).

Chart 9-2 Medicare payments to MA plans, 2010–2024



Note: MA (Medicare Advantage). 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, 2020–2025.

> The Medicare program paid MA plans an estimated $494 billion in 2024 to cover Part A and Part B services for MA enrollees.

> From 2018 to 2024, total estimated payments to MA plans more than doubled on a nominal basis, reflecting in part the increase in the number of beneficiaries enrolled in MA (see Chart 9-1).

Chart 9-3 MA plans available to almost all Medicare beneficiaries, 2018–2025

	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	
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
2025	>99.5	68	>99.5	29	>99.5	42

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 2018 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, 2018–2025.

> 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 99 percent of Medicare private plan enrollees as of February 2025 (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 (not all data shown). In 2025, local CCPs are available to nearly 100 percent of eligible Medicare beneficiaries, and regional PPOs are available to 68 percent of beneficiaries.

> The number of plans from which beneficiaries may choose in 2025 is among the highest during the years examined. In 2025, beneficiaries can choose from an average of 42 plans operating in their counties and have access to plans offered by an average of eight insurers (latter data not shown).

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

Plan type	Total enrollees (in thousands)					Percent change 2024–2025
	2021	2022	2023	2024	2025	
Local CCPs	25,325	27,878	30,291	32,667	34,142	5%
Regional PPOs	1,003	756	534	385	235	–39
PFFS	61	48	37	32	38	19

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 2021–2025.

> 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. Though network requirements may be looser in regional PPOs and PFFS plans, enrollment in both types of plans declined between 2021 and 2024. From 2024 to 2025, enrollment in regional PPOs fell by 39 percent; enrollment in PFFS plans grew for the first time in several years, rising by 19 percent.

> Combined enrollment in the three types of plans grew by 4 percent from February 2024 to February 2025 (data not shown). Enrollment in local CCPs grew by 5 percent over the past year, and special-needs plans (SNPs) accounted for half of this growth (latter data not shown). Local PPOs grew by 4 percent over the past year and accounted for 39 percent of the growth in local CCP enrollment (data not shown). Most enrollment growth among HMOs (63 percent) occurred in SNPs (data not shown).

Chart 9-5 MA and cost-plan enrollment by state and type of plan, 2025

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	62,654	31%	24%	0%	0%	0%	55%
Alabama	1,040	28	37	0	0	0	65
Alaska	106	0	2	0	0	0	2
Arizona	1,395	39	16	0	0	0	55
Arkansas	635	17	31	1	0	0	49
California	6,421	49	7	0	0	0	56
Colorado	960	38	20	0	0	0	58
Connecticut	692	22	41	0	0	0	63
Delaware	230	13	22	0	0	0	35
Florida	4,860	38	22	1	0	0	61
Georgia	1,804	17	42	1	0	0	60
Hawaii	269	18	43	0	0	0	61
Idaho	373	37	17	0	0	0	54
Illinois	2,213	15	29	0	0	0	44
Indiana	1,298	24	30	1	0	0	55
Iowa	649	20	19	0	0	2	41
Kansas	550	13	23	0	0	0	36
Kentucky	919	30	28	1	0	0	59
Louisiana	881	45	16	0	0	0	61
Maine	354	39	24	0	0	0	63
Maryland	1,002	14	15	0	0	0	29
Massachusetts	1,327	18	18	0	0	0	36
Michigan	2,136	24	42	0	0	0	66
Minnesota	1,087	15	44	0	0	6	65
Mississippi	605	20	26	1	0	0	47
Missouri	1,250	32	25	1	0	0	58
Montana	246	5	27	0	0	0	32
Nebraska	358	19	17	0	0	1	37
Nevada	551	45	12	0	0	0	57
New Hampshire	314	11	28	0	0	0	39
New Jersey	1,592	12	34	0	0	0	46
New Mexico	428	25	29	0	0	0	54
New York	3,628	34	21	0	0	0	55
North Carolina	2,113	33	27	1	0	0	61
North Dakota	138	0	29	0	0	9	38
Ohio	2,372	38	21	0	0	0	59
Oklahoma	743	22	23	0	0	0	45
Oregon	883	37	22	0	0	0	59
Pennsylvania	2,738	29	30	0	0	0	59
Puerto Rico	695	94	1	0	0	0	95
Rhode Island	222	52	9	0	0	0	61
South Carolina	1,164	11	36	1	0	0	48
South Dakota	185	0	26	0	0	14	40
Tennessee	1,387	37	20	0	0	0	57
Texas	4,418	34	23	2	0	0	59
Utah	430	39	20	0	0	0	59
Vermont	154	1	31	0	0	0	32
Virgin Islands	19	0	29	0	0	0	29
Virginia	1,538	28	14	0	0	0	42
Washington	1,405	33	21	0	0	0	54
Washington, D.C.	81	12	29	0	0	0	41
West Virginia	425	9	46	0	0	4	59
Wisconsin	1,256	32	26	0	0	3	61
Wyoming	120	0	20	0	0	0	20

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. We estimated February 2025 enrollment by using the ratio of January 2025 enrollment to January 2024 enrollment and applying that ratio to February 2024 enrollment data. "U.S. total" 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 2025.

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
No dual eligibility	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. Dually eligible beneficiaries are eligible for Medicare and Medicaid. Data exclude Puerto Rico because enrollment data undercount dual-eligibility 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 dually eligible beneficiaries 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 partially dual-eligible beneficiaries (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 MA 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 what FFS spending would have been, 2025

	Share of FFS spending in 2025		
	Benchmarks	Bids	Payments
Overall estimate	130%*	100%*	120%
Estimated before coding and selection	108*	83*	100
Estimated coding effect	+10	+8	+10
Estimated selection effect	+11	+9	+11

Note: MA (Medicare Advantage), FFS (fee-for-service). "Benchmarks" are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. The "overall estimate" of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of the Commission's methodology for comparing payments: a base comparison of MA payments with FFS spending that standardizes for differences in risk scores and geography but does not account for the effects of coding intensity and favorable selection; an adjustment to that base comparison for favorable selection; and an adjustment for coding intensity. The values in the "estimated before coding and selection" row reflect estimates using only the base comparison, without adjusting for the effects of coding intensity and favorable selection. The values in the third and fourth rows are the additive adjustments to the base comparison for the effects of coding and selection. Estimates do not include beneficiaries with end-stage renal disease. Components may not sum to totals due to rounding. More details on our coding and selection analyses are found in the Chapter 11 Technical Appendix of our March 2025 report to the Congress. Components of the benchmark and payment columns do not sum to the total due to rounding.
* 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 costs 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 FFS Medicare 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).

> 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.

(Chart continued next page)

Chart 9-7 MA plan benchmarks, bids, and Medicare program payments relative to what FFS spending would have been, 2025 (continued)

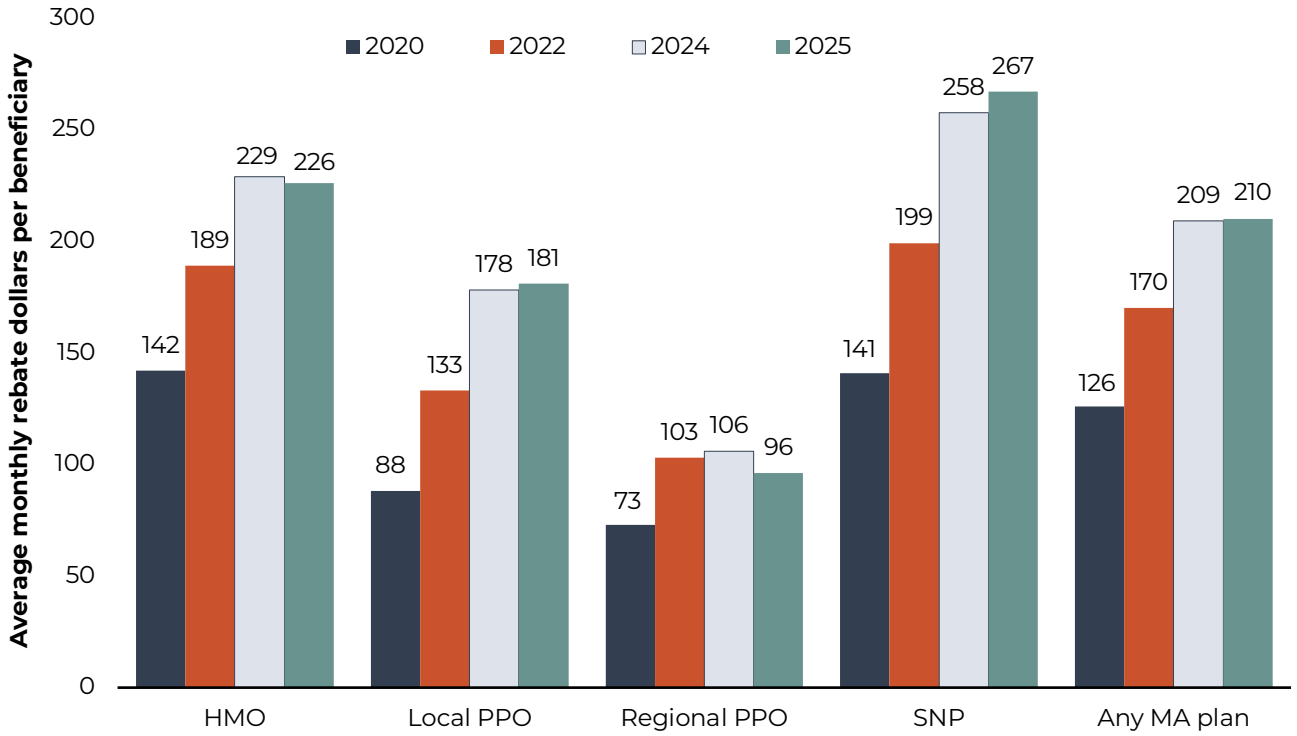
> If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it is typically 65 percent or 70 percent. After accounting for administrative 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 2025, 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 percent of FFS spending in 2025. After accounting for the effects of coding and selection, we estimate that MA benchmarks in 2025 will average 130 percent of what FFS spending would have been for MA beneficiaries.

> 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 about the same (100 percent), on average, as FFS spending for 2025. Not accounting for coding or selection, plan bids are estimated to average about 17 percent below FFS spending.

> Altogether, we estimate that MA payments are 20 percent higher than what Medicare would have spent to cover the same group of enrollees in FFS Medicare. 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, 2020–2025



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 supplemental 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 plans slightly increased to $210 per month per beneficiary for 2025.

> HMOs have had, by far, the highest rebates because they tend to bid lower than other types of plans. Average rebates for HMOs are $226 per month per beneficiary for 2025.

> Local PPOs' rebates have risen sharply in recent years, more than doubling since 2020.

> 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 $267 per month in 2025 (up from $258 per month in 2024). 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 both Medicare and 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, 2023

Beneficiary group	Coding intensity relative to FFS Medicare
All MA enrollees	17.3%
New enrollees	N/A
Long-term institutional	12.7
No Medicaid benefits	15.5
Partial Medicaid benefits	30.1
Full Medicaid benefits	20.8

Note: MA (Medicare Advantage), FFS (fee-for-service), N/A (not applicable). Coding-intensity estimates are reported before accounting for the application of the coding-intensity adjustment that reduced MA risk scores by 5.9 percent in 2023. 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 Appendix 11-B of our March 2025 report to the Congress for more information about our analysis using the DECI method.

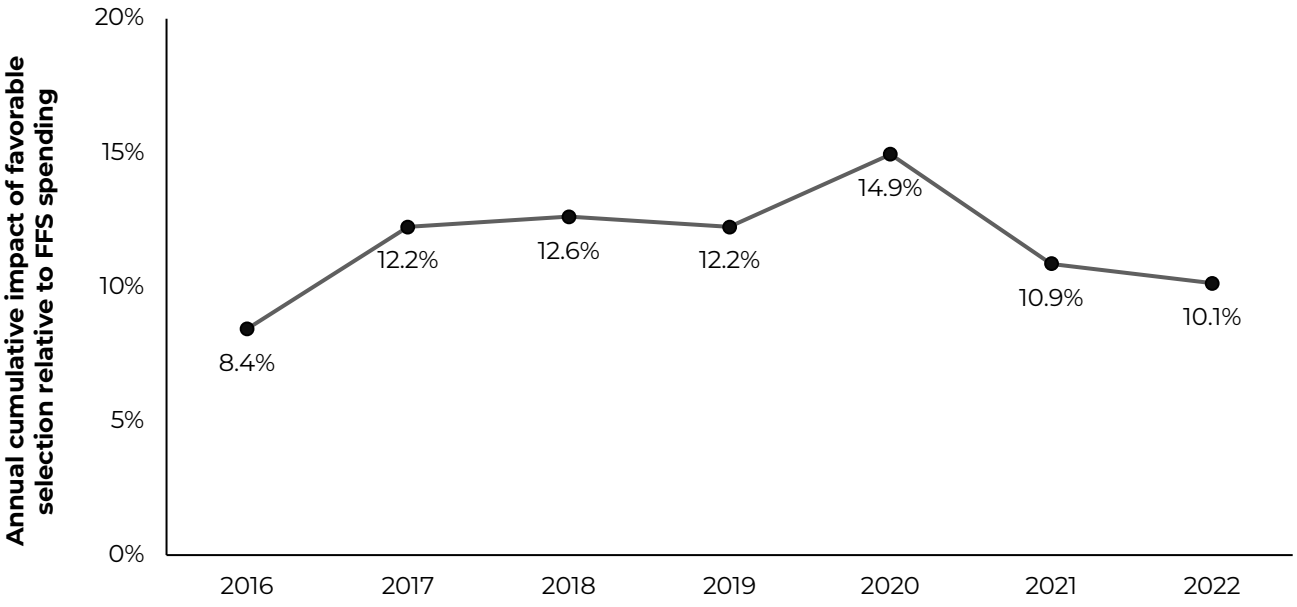
Source: MedPAC analysis of CMS enrollment and risk-score files, 2022 and 2023.

> Payments to MA plans are risk adjusted to account for differences in health spending risk. 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 that 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 2023, MA risk scores on average were an estimated 17.3 percent higher than risk scores for comparable FFS beneficiaries due to coding intensity.

> 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. Coding intensity for MA enrollees who were eligible for partial Medicaid benefits was 30.1 percent higher than for FFS beneficiaries who were eligible for partial Medicaid benefits. Coding intensity for MA enrollees who were eligible for full Medicaid benefits was 20.8 percent higher than FFS beneficiaries who were eligible for full Medicaid benefits. By contrast, coding intensity for MA enrollees who were not eligible for Medicaid was 15.5 percent higher than their FFS counterparts, and coding intensity for MA enrollees with long-term institutional status was 12.7 percent higher than their FFS counterparts.

Chart 9-10 Estimated impact of favorable selection, 2016–2022



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates were constructed using the Commission's comprehensive method for estimating favorable selection. Selection occurs when Medicare's risk-adjustment model overpredicts spending for MA enrollees when setting county benchmarks, even for beneficiaries with similar coding intensity. See Appendix 11-A of our March 2025 report to the Congress for more information about our analysis of favorable selection.

Source: MedPAC analysis of Medicare enrollment (2006–2022), Medicare claims spending (2007–2022), and risk-adjustment files (2007–2022).

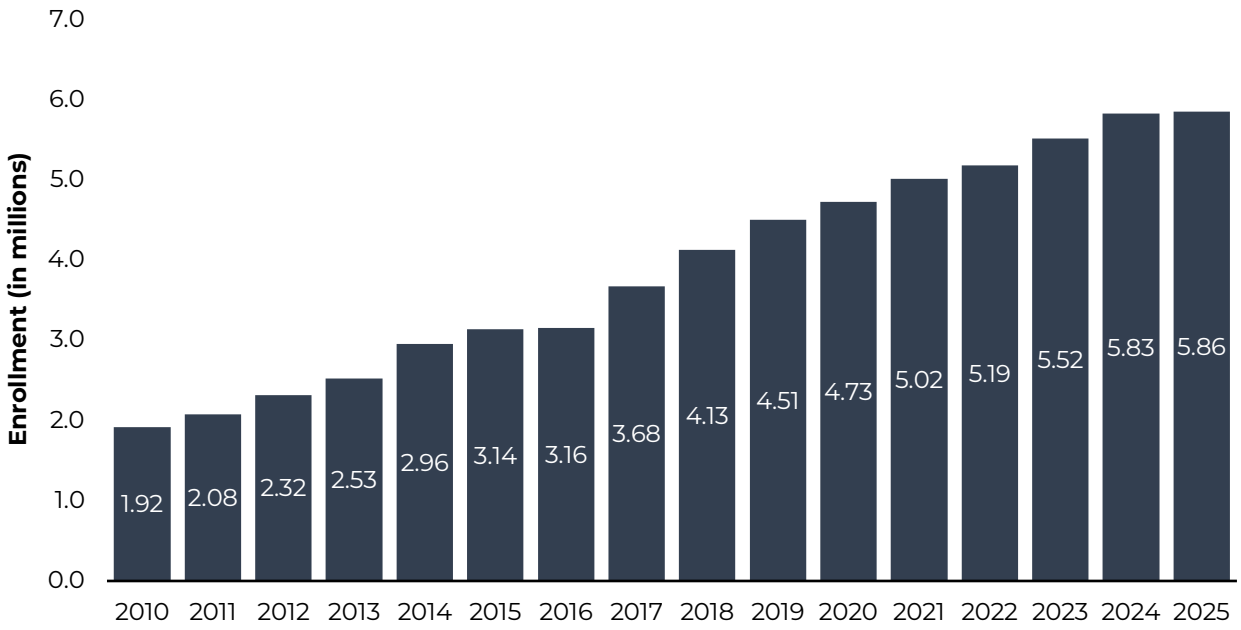
> When setting MA benchmarks and paying plans for each enrollee, CMS implicitly assumes that if MA enrollees were in FFS Medicare, their average Medicare spending would be equal to that of current FFS enrollees in the same county after adjusting for differences in risk scores. "Favorable selection" refers to the tendency for Medicare's risk-adjustment model to—on average—overpredict the spending that the MA-enrolled population would have had if they were enrolled in the FFS program, even for beneficiaries with similar coding intensity. Favorable selection can occur due to unmeasured differences in health status but can also result from factors such as differences in beneficiaries' propensities to seek care for reasons that are unrelated to their health.

> The estimated effect of favorable selection was substantial in every year during the 2016 to 2022 period, indicating that the spending that the FFS program would incur for the MA population would be lower than what would be predicted by their risk score.

> On net, favorable selection persisted throughout the study period even as a larger share of Medicare beneficiaries enrolled in MA (see Chart 9-1).

> In 2022, the effect of favorable selection alone resulted in MA payments that were 10.1 percent above what would have occurred in the FFS program.

Chart 9-11 Enrollment in employer group MA plans, 2010–2025



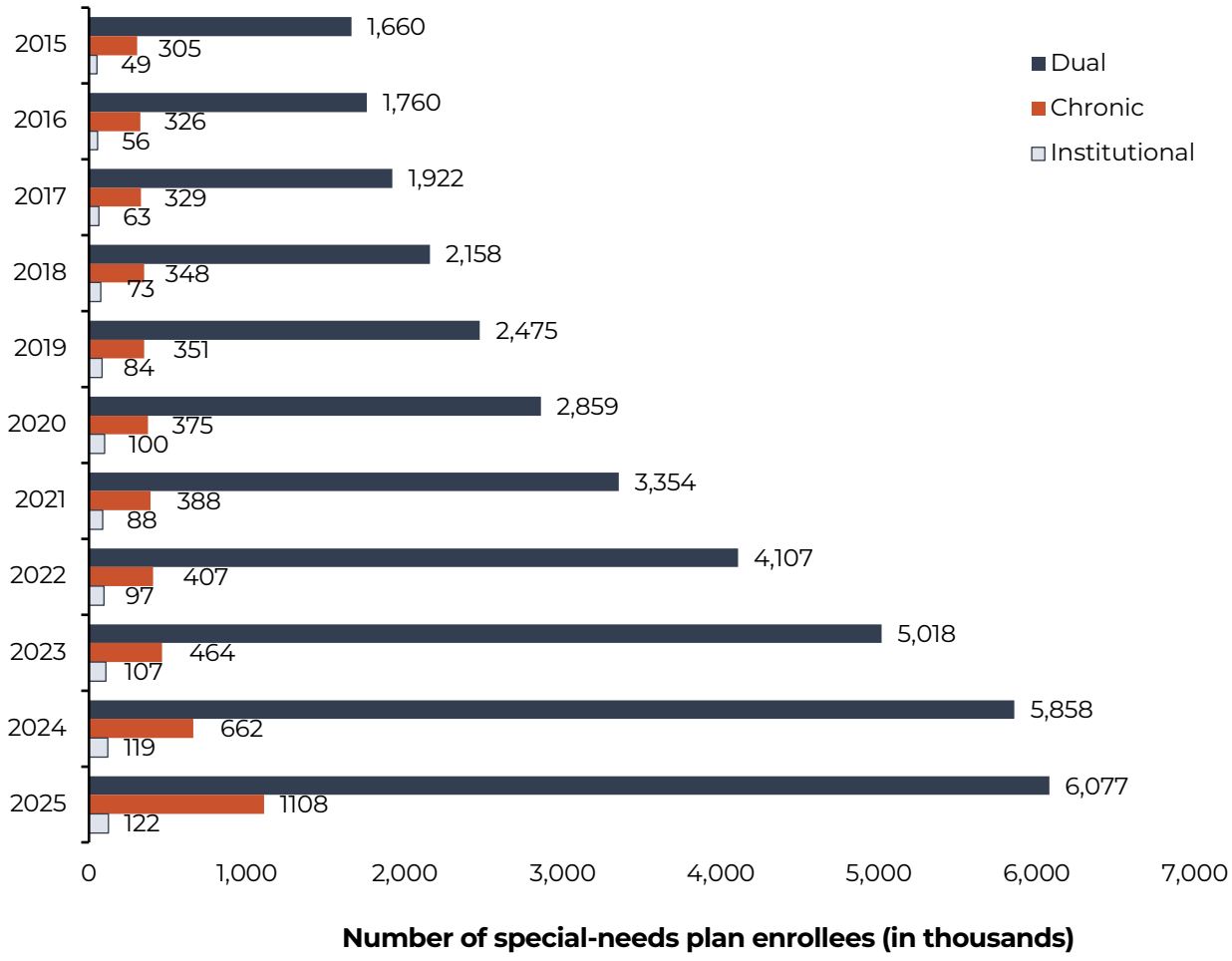
Note: MA (Medicare Advantage).

Source: CMS enrollment data, February 2010–2025.

> 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 2025, about 5.9 million enrollees were in employer group plans, or about 17 percent of all MA enrollees. Employer plan enrollment grew by 1 percent from 2024 and has more than doubled since 2013.

Chart 9-12 Number of enrollees in special-needs plans, 2015–2025



Source: CMS special-needs plans comprehensive reports, February 2015–2025.

> 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 (D–SNPs). Enrollment in D–SNPs has more than tripled since 2015, exceeding 6 million—about 18 percent of all MA enrollees—in 2025.

> Enrollment in chronic condition SNPs (C–SNPs) has grown at varying rates as plan requirements have changed, but it has generally risen annually since 2015. In 2025, about 1.1 million beneficiaries (about 3 percent of all MA enrollees) were enrolled in C–SNPs.

> Enrollment in institutional SNPs increased to its highest level ever in 2025 but accounts for less than 1 percent of all MA enrollees.

> The number of SNPs increased by 9 percent from February 2024 to February 2025 (data not shown). D–SNPs increased by 8 percent, I–SNPs decreased by 7 percent, and the number of C–SNPs increased by 21 percent (data not shown).

Chart 9-13 MA prior-authorization requests and outcomes, 2021–2023

	2021		2022		2023	
	PA decisions (in millions)	Share of total	PA decisions (in millions)	Share of total	PA decisions (in millions)	Share of total
Determinations	37.78	100%	45.70	100%	50.07	100%
Fully favorable	35.71	94.5	42.34	92.6	46.88	93.6
Partially favorable	0.41	1.1	0.82	1.8	0.60	1.2
Adverse	1.67	4.4	2.54	5.6	2.59	5.2
Reconsiderations	0.23	0.61	0.33	0.73	0.37	0.74
Fully favorable	0.18	80.4*	0.27	82.3*	0.30	80.6*
Partially favorable	0.002	1.1*	0.003	0.86*	0.004	1.2*
Adverse	0.04	18.5*	0.06	16.9*	0.07	18.2*

Note: MA (Medicare Advantage), PA (prior authorization). Percentages may not sum to 100 due to rounding.
* Due to small numbers, these percentages reflect reconsideration outcomes as a share of reconsiderations.

Source: MedPAC analysis of CMS Part C Reporting Requirements and MA enrollment data, 2021–2023.

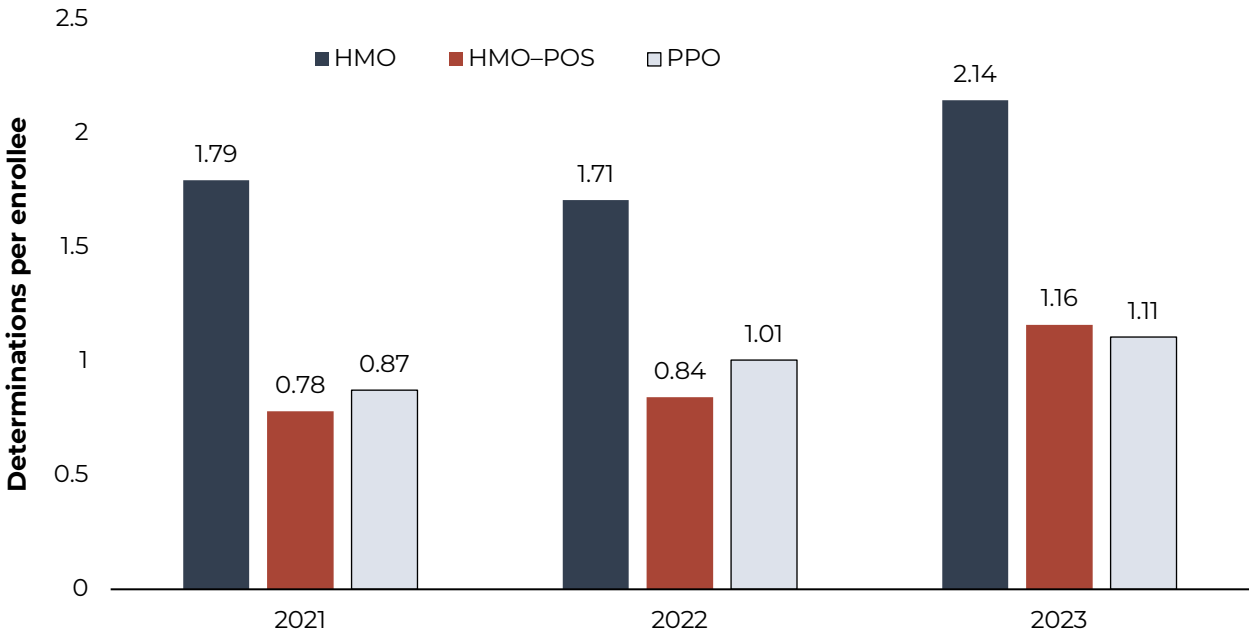
> PA requests from enrollees and providers to MA plans have been increasing steadily over time in aggregate, from approximately 37.8 million requests overall in 2021, to over 50 million requests in 2023. On an enrollment-weighted basis, MA contracts on average processed about 605,000 initial PA determinations in 2021, increasing to about 937,000 determinations in 2023 (data not shown).

> Prior authorizations are overwhelmingly approved by MA organizations in the first instance, known as the initial "determination" (about 93 percent of the time in 2022, and about 94 percent of the time in 2021 and 2023).

> "Partially favorable" outcomes—such as a requirement for step therapy or the approval of a fraction of the number of requested days for a hospital stay—are rare, occurring in just over 1 percent of cases in 2023.

> Less than 1 percent of PA determinations are appealed. First-level appeals are reviewed by the MA organization in a process called "reconsideration." Reconsiderations were also overwhelmingly approved. Despite a large increase in the volume of reconsiderations—from 229,000 in 2021 to 371,000 in 2023—outcomes were fully favorable in over 80 percent of cases in all three years.

Chart 9-14 Per capita prior-authorization requests by plan type, 2021–2023



Note: HMO (health maintenance organization), HMO–POS (HMO point of service), PPO (preferred provider organization).

Source: MedPAC analysis of CMS Part C Reporting Requirements and MA enrollment data, 2021–2023.

> Prior authorization was more common for people enrolled in HMOs than for those enrolled in HMO–POS and PPO plans. HMOs processed, on average, 2.1 determinations per enrollee in 2023, compared to 1.2 determinations per HMO–POS enrollee and 1.1 per PPO enrollee.

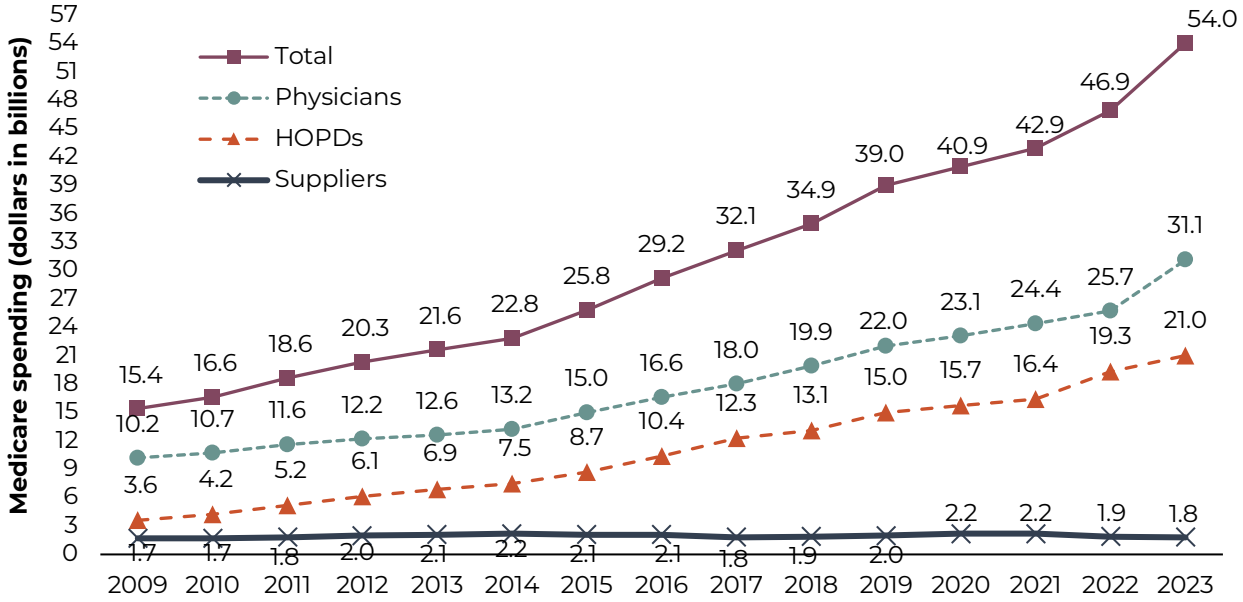
> Overall, per capita prior authorizations have increased, from 1.3 determinations per enrollee per year in 2021, to 1.5 determinations per enrollee in 2023 (data not shown).

SECTION

10

Prescription drugs

Chart 10-1 Medicare spending for Part B drugs furnished by physicians, hospital outpatient departments, and suppliers, 2009–2023



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.

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

> Fee-for-service (FFS) Medicare and its beneficiaries spent about $54 billion on separately paid Part B drugs in 2023, with physician offices, HOPDs, and pharmacy suppliers accounting for 57 percent, 39 percent, and 3 percent of spending, respectively.

> Between 2009 and 2023, Part B drug spending grew 9.4 percent per year on average on a nominal basis, not adjusted for inflation. Spending grew more rapidly for HOPDs than for physicians and suppliers—at average annual rates of about 14 percent, 8 percent, and 1 percent, respectively.

> Between 2022 and 2023, FFS Part B drug spending increased 9.7 percent, with spending growing most rapidly (21.0 percent) in physician offices, largely due to a growth in payment for COVID-19 vaccines and skin substitutes. See Charts 10-2, 10-5, and 10-6 for more discussion on payments for COVID-19 vaccines and skin substitutes, respectively.

> Medicare generally pays providers for Part B drugs based on the average sales price (ASP) + 6 percent. Between 2018 and 2021, Medicare paid a reduced rate (ASP – 22.5 percent) for hospitals participating in the 340B Drug Pricing Program. In 2022, in response to a Supreme Court ruling, CMS increased the payment rate for 340B-acquired Part B drugs to ASP + 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 $1.5 billion in CAHs and $0.4 billion in Maryland hospitals for Part B drugs in 2023 (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, 2009–2023

	2009	2023	Average annual growth 2009–2023
Total payments: Separately payable Part B drugs (in billions)	$11.3*	$47.8*	10.9%*
Total payments: All Part B drugs excluding vaccines (in billions)	$11.1	$45.4	10.6
Number of beneficiaries using a Part B drug (in millions)	2.5	3.7	2.9
Average number of Part B drugs per beneficiary	1.3	1.3	0.0
Average annual payment per Part B drug per beneficiary	$3,346	$9,243	7.5
Total payments: Part B preventive vaccines (in billions)	$0.2	$2.4	18.6
Number of beneficiaries using a Part B vaccine (in millions)	13.4	14.0	0.3
Average number of Part B vaccines per beneficiary	1.1	1.6	2.7
Average annual payment per Part B vaccine per beneficiary	$15	$109	15.1

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. "Preventive vaccines" refers to four Part B–covered preventive vaccines: COVID-19, 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 2023 (i.e., drugs that were packaged under the outpatient prospective payment system in 2009 or 2023 were excluded from both years of the analysis, regardless of the setting in which the drug was administered (e.g., skin substitutes are excluded from the analysis for this reason)), 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 $54.0 billion in 2023, 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 10.9 percent per year, on average, between 2009 and 2023 on a nominal basis.

> Medicare spending on separately payable Part B drugs excluding Part B–covered preventive vaccines grew at a similar rate (10.6 percent per year) between 2009 and 2023.

> 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 2023. During that period, the average annual payment per drug grew 7.5 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 2.9 percent per year on average) also contributed to increased spending. The number of Part B drugs received per user was stable.

> In 2023, Medicare and beneficiaries spent $2.4 billion on four Part B–covered preventive vaccines (COVID-19, influenza, pneumococcal, and hepatitis B) furnished by physicians, hospital outpatient departments, and pharmacy suppliers. Between 2009 and 2023, Part B vaccine spending grew by 2.2 billion (19 percent per year on average). A large portion of that growth was due to higher average payments per vaccine, which grew from $15 to $109 between 2009 and 2023, reflecting higher launch prices of COVID-19 vaccines and new pneumococcal and influenza vaccines. With the development of COVID-19 vaccines, the average number of vaccines per beneficiary who received a vaccine also increased over this period, contributing to spending growth. In 2023, the first year Medicare Part B was liable for the cost of COVID-19 vaccines, Medicare Part B spent over $900 million on COVID-19 vaccines. (Prior to that, COVID-19 vaccines were purchased directly by the federal government rather than paid for by providers and reimbursed by Medicare Part B).

Chart 10-3 Top 20 Part B drugs, 2023

		2023			Percent change, 2022–2023		
	Drug indication(s)	Total drug spending (billions)	Number of users	Average spending per user	Total drug spending	Number of users	Average spending per user
Keytruda	CA	$5.4	71,900	$75,500	10%	7%	3%
Eylea	MD	3.1	341,800	9,200	–11	0	–11
Darzalex*	CA	2.3	25,400	90,500	21	14	6
Prolia/Xgeva	CA SE, OS	2.2	677,400	3,200	9	3	5
Opdivo	CA	1.9	27,600	69,100	3	2	1
Dual Layer Impax	WC	1.4	5,100	278,500	N/A	N/A	N/A
Vabysmo	MD	1.3	112,600	11,500	N/A	N/A	N/A
Orencia	AR, AI	0.9	32,800	27,500	0	2	–2
Rituxan**	AR, AI, CA	0.8	59,000	14,100	–20	–2	–18
Tecentriq	CA	0.8	11,900	63,400	–3	–8	5
Gammagard	IMD, NE	0.7	25,100	29,500	17	15	2
Imfinzi	CA	0.7	13,300	55,600	31	26	4
Entyvio	IB	0.7	18,900	38,400	8	7	1
Ocrevus	MS	0.7	12,600	55,500	0	–1	2
Avastin**	CA, MD	0.6	161,500	3,700	–14	–10	–4
Prevnar 20	VA	0.6	2,054,300	300	66	64	1
Lucentis**	MD	0.5	91,600	5,900	–32	–11	–24
Remicade**	AR, IB	0.5	53,500	9,900	–14	–1	–13
Pluvicto	CA	0.5	3,900	133,700	N/A	N/A	N/A
Spikevax	VA	0.5	3,613,300	100	N/A	N/A	N/A
Top 10 drugs		20.2					
Top 20 drugs		26.3					
All Part B drugs		54.0					

Note: CA (cancer), MD (macular degeneration and other eye disorders), SE (side effect), OS (osteoporosis), WC (wound care), N/A (not applicable), AR (arthritis), AI (autoimmune disease), IMD (immune deficiency), NE (neuropathy), IB (inflammatory bowel disease), MS (multiple sclerosis), VA (vaccine). "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 2023. Percent change from 2022 to 2023 is not displayed for Dual Layer Impax, Vabysmo, Pluvicto, and Spikevax because there was little or no utilization in 2022 due to the product first receiving a billing code in mid-2022 or 2023. 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.
* Darzalex includes both intravenous and subcutaneous products.
** For originator biologics that have biosimilar competitors, data in the table reflect both the originator biologic and biosimilars.

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

> Part B drugs are billed using over 1,000 billing codes, but spending is concentrated. In 2023, Medicare spending (including beneficiary cost sharing) on the top 10 products accounted for $20.2 billion, or 37 percent of total Part B drug spending. Spending on the top 20 products accounted for $26.3 billion, or about 49 percent of total Part B drug spending.

(Chart continued next page)

Chart 10-3 Top 20 Part B drugs, 2023 (continued)

> The top 20 Part B drugs are concentrated in certain therapeutic areas. Eight of the top 20 drugs treat cancer, and one treats cancer side effects. The top 20 also include 4 products for macular degeneration and 4 products for arthritis, autoimmune disease, or inflammatory bowel disease.

> Sixteen of the top 20 Part B products are biologics. One product is a nonbiologic radiopharmaceutical (Pluvicto), and two products are vaccines (Prevnar 20 and Spikevax). Dual Layer Impax is a skin substitute that is considered to be human cells, tissues, or cellular and tissue-based product.

> Among the top 20 highest-expenditure Part B drugs in 2023, average total spending per user varied. Excluding Avastin (which has costs that vary substantially depending on whether it is used for cancer or macular degeneration), the remaining 7 drugs in the top 20 that treat cancer had average spending per user ranging from $14,000 to $134,000. Average spending per user ranged from $10,000 to $38,000 for four drugs used to treat arthritis, autoimmune disease, or inflammatory bowel disease, and from $6,000 to $12,000 for three drugs used to treat macular degeneration (excluding Avastin). Dual Layer Impax, a skin-substitute product, had the highest average spending per user among the top 20, at $279,000.

> Between 2022 and 2023, total spending increased for 12 of the top 20 Part B drugs, decreased for 6 drugs, and was unchanged for 2 drugs on a nominal basis (not adjusted for inflation). Three products experienced spending growth of more than 20 percent (Darzalex, Imfinzi, and Prevnar 20) and four products (Dual Layer Impax, Vabysmo, Pluvicto, and Spikevax) had substantial spending in 2023 after first receiving a billing code mid-2022 or 2023. Among the products that experienced spending decreases in 2022, the most substantial decreases occurred among four products with biosimilar competition (Rituxan, Avastin, Lucentis, and Remicade), ranging from 14 percent to 32 percent.

Chart 10-4 Growth in manufacturer prices for the 20 highest-expenditure Part B drugs, 2015–2025

	Average annual percentage change in average sales price 2015–2023	Percentage change in average sales price 2023–2024	Percentage change in average sales price 2024–2025
Keytruda	2.4%[c]	3.4%	3.4%
Eylea	–1.1	–4.0	–7.1
Darzalex	3.9[c]	4.7	5.9
Prolia/Xgeva	5.8	9.2	9.8
Opdivo	2.4[c]	3.6	3.9
Dual Layer Impax	N/A[d]	N/A[d]	–74.2
Vabysmo	N/A[e]	–4.2	–2.3
Orencia	3.5	–0.8	1.5
Rituxan[a]	1.5	–3.1	–3.1
Tecentriq	1.3[c]	5.2	3.8
Gammagard	1.9	–3.1	5.2
Imfinzi	1.4[c]	2.3	3.9
Entyvio	3.5[c]	1.7	–1.8
Ocrevus	0.9[c]	0.2	–1.6
Avastin[a]	0.5	4.7	–1.2
Prevnar 20[b,c]	7.2	1.7	3.2
Lucentis[a]	–6.2	–20.9	–33.9
Remicade[a]	–9.0	–7.7	–5.1
Pluvicto	N/A[f]	N/A[f]	N/A[f]
Spikevax[b]	N/A[g]	N/A[g]	10.8
Consumer Price Index for All Urban Consumers	**3.1**	**3.1**	**3.0**

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 2023. 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 Prevnar 20 and Spikevax, preventive vaccines paid at 95 percent of the average wholesale price, the table displays the percentage change in the actual payment rate, not ASP.
[c] Product was not available over the full time period, so average annual growth was calculated over a shorter period: from 2016 to 2023 (Keytruda, Opdivo, Entyvio), 2017 to 2023 (Darzalex), 2018 to 2023 (Tecentriq, Ocrevus), 2020 to 2023 (Imfinzi), or 2022 to 2023 (Prevnar 20).
[d] Dual Layer Impax first received a billing code in January 2023 and first had a published payment rate in October 2023.
[e] Vabysmo first received a billing code in October 2022.
[f] Pluvicto is a radiopharmaceutical that first received a billing code in October 2022 and that is not paid based on ASP in the physician office setting.
[g] Spikevax first received a billing code and published payment rate in September 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, 2015–2025 (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, beneficiary cost sharing for products that incur a rebate 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, 10 products experienced a price increase on a nominal basis, with 9 of those products' prices increasing faster than the CPI–U between January 2024 and 2025.

> Between January 2024 and 2025, Spikevax (a COVID-19 vaccine) and Prolia/Xgeva (a product for osteoporosis and cancer side effects) experienced the largest price growth, 11 percent and 10 percent, respectively. Between the second quarter of 2023 and the first quarter of 2025, Prolia/Xgeva was the only product among the top 20 to have reduced beneficiary cost sharing as a result of the ASP inflation rebate (data not shown).

> Between January 2024 and 2025, 9 of the top 20 products experienced a price decrease. Some of the price declines occurred among originator biologics facing biosimilar competition. Rituxan, Avastin, Lucentis, and Remicade all have biosimilar competitors. Prices for these originator biologics declined by 1 percent to 34 percent between 2024 and 2025.

Chart 10-5 Top 10 Part B therapeutic classes of drugs, 2023

	Total Medicare payments in 2023 (in billions)	Percentage change in total Medicare payments 2022–2023
Antineoplastics	$20.2	9%
Ophthalmic agents	5.3	11
Skin substitutes	4.4	184
Endocrine agents	4.3	9
Hematological agents	3.4	–2
Analgesics, anti-inflammatories, or antipyretics	2.8	–2
Immune globulin agents	2.5	11
Vaccines	2.5	74
Respiratory therapy agents	1.6	5
Neuromuscular and musculoskeletal therapy agents	1.4	3

Note: Therapeutic classes are ranked in order of 2023 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). Dollar amounts are nominal, not adjusted for inflation.

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

> In 2023, 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 $54.0 billion reported in Chart 10-1).

> Total spending by therapeutic class was somewhat concentrated. In 2023, antineoplastics (products used to treat cancer) accounted for 37 percent, and the top three classes—antineoplastics, ophthalmic agents, and skin substitutes—accounted for 56 percent of total Medicare spending.

> Between 2022 and 2023, the growth in total spending for four therapeutic classes—ophthalmic agents, skin substitutes, immune globulin agents, and vaccines—exceeded the average annual growth across all Part B products (which averaged 9.7 percent during this period on a nominal basis (shown in Chart 10-1)).

> Between 2022 and 2023, total spending for vaccines grew by 74 percent, largely due to the growth in payment for COVID-19 vaccines. Prior to 2023, COVID-19 vaccines were purchased directly by the federal government rather than purchased by providers and reimbursed by Medicare Part B.

> Total spending on separately payable skin substitutes has been growing rapidly. Between 2022 and 2023, Medicare spending on skin substitutes grew by 184 percent, from $1.6 billion (not shown) to $4.4 billion. This therapeutic class increased in rank by total Medicare spending from 10th in 2021, 7th in 2022, and 3rd in 2023. Preliminary claims data for calendar year 2024 (claims processed through week 20 of 2025) indicate that spending on skin substitutes was nearly $10.2 billion that year, more than double the prior year's level (see Chart 10-6) and that this therapeutic class ranked second in total 2024 spending (data not shown).

Chart 10-6 Change in spending for skin-substitute products, 2023–2024

	2024			2023		
	Total spending (billions)	Number of users	Average spending per user	Total spending (billions)	Number of users	Average spending per user
All skin-substitute products	$10.2	N/A	N/A	$4.4	N/A	N/A
Top 10 skin-substitute products, 2024						
Membrane Graft or Wrap	$1.5	10,500	$139,000	$0.3	3,200	$107,000
Complete FT	1.2	5,100	229,000	0.01	20	364,000
Esano ACA	0.9	1,900	493,000	*	*	*
Restorigin	0.7	5,300	140,000	0.002	40	56,000
Helicoll	0.6	2,400	266,000	0.1	600	93,000
Impax Dual Layer Membrane	0.3	1,700	190,000	1.4	5,100	279,000
Membrane Wrap-Hydro	0.3	1,800	173,000	N/A	N/A	N/A
AmnioCore Pro+	0.3	1,500	195,000	N/A	N/A	N/A
Neostim TL Membrane	0.3	1,200	230,000	N/A	N/A	N/A
Amnio Quad-core	0.3	1,400	179,000	N/A	N/A	N/A

Note: N/A (not available). Drug spending includes Medicare program payments and beneficiary cost sharing. Spending and utilization estimates for 2023 are based on claims with a 2023 date of service processed through week 26 of 2024. Spending and utilization estimates for 2024 are preliminary, based on claims with a 2024 date of service processed through week 20 of 2025. Yearly figures presented in the chart are rounded, but data for average spending per user were calculated using unrounded data. Per CMS, skin-substitute products include non-autologous human cellular or tissue products, nonhuman cellular and tissue products, or biological products that are used to treat chronic wounds (Centers for Medicare & Medicaid Services. 2024. LCD—Skin substitute grafts/cellular and tissue-based products for the treatment of diabetic foot ulcers and venous leg ulcers (L39828). Baltimore, MD: CMS.). Dollar amounts are nominal, not adjusted for inflation.
* Medicare use and spending data cannot be reported for Esano ACA in 2023 because the value is based on fewer than 11 observations in that year.

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

> According to CMS, skin-substitute products are a heterogeneous group that includes non-autologous human cellular or tissue products, nonhuman cellular and tissue products, or biological products that are used to treat chronic wounds (e.g., venous leg ulcer and diabetic foot ulcers).

> Under the physician fee schedule, skin-substitute products are generally paid average sales price (ASP) + 6 percent. Under the outpatient prospective payment system, payment for skin-substitute products that do not qualify for pass-through status are packaged into the payment for the associated skin-substitute application procedure into two groups: (1) high-cost skin-substitute products and (2) low-cost skin-substitute products. The above spending data do not reflect skin-substitute products paid as part of larger payment bundles (i.e., skin-substitute products furnished by hospital outpatient departments that are packaged into payment with other services and products).

> Spending on skin-substitute products is growing rapidly. Between 2021 and 2024, total spending increased in aggregate by 890 percent from $1.0 billion to $10.2 billion on a nominal basis (not all data shown). Most recently, spending on skin-substitute products increased by 130 percent from $4.4 billion in 2023 to $10.2 billion in 2024. In 2024, skin-substitute products accounted for 16 percent of all Part B drug spending (data not shown).

(Chart continued next page)

Chart 10-6 Change in spending for skin-substitute products, 2023–2024 (continued)

> Spending on skin-substitute products per user is also substantial and growing. In 2024, average spending per user for the top 10 products ranged from $139,000 to $493,000, and average cost-sharing liability per user ranged from $28,000 to $100,000 (data not shown). By comparison, in 2023, average spending per user for these products ranged from $56,000 to $364,000, and average cost sharing per user ranged from $11,000 to $74,000 (data not shown).

> Adoption of some skin-substitute products by providers has occurred rapidly. For example, between 2023 and 2024 the number of users grew from about 20 beneficiaries to 5,100 beneficiaries for Complete FT and from about 40 beneficiaries to 5,300 beneficiaries for Restorigin.

> Use of and spending on skin-substitute products is shifting over time. For example, in 2023, the three leading products as measured by total spending were Impax Dual Layer Membrane ($1.4 billion), Carepatch ($0.5 billion), and Woundfix ($0.4 billion) (Carepatch and Woundfix data not shown). By contrast, total spending in 2024 declined for each product, to $0.3 million for Impax Dual Layer Membrane (ranked 6th in total spending), $0.1 billion for Carepatch (ranked 25th in total spending), and $0.01 billion for Woundfix (ranked 64th in total spending). Between 2023 and 2024, both the price and use of these three products declined. Between October 2023 and 2024, the ASP payment rate declined by 69 percent for Impax Dual Layer Membrane, 56 percent for Carepatch, and 52 percent for Woundfix while the annual number of beneficiaries furnished each product in 2023 and 2024 declined by 67 percent, 73 percent, and 95 percent, respectively (data not shown).

> The increase in spending on skin-substitute products is associated with an increase in unique billing codes—Healthcare Common Procedure Coding System Level II coding request applications—for newly developed skin-substitute products. The number of skin-substitute products (as identified by a unique billing code in Medicare claims data) increased from 93 in 2021 to 101 in 2022, 113 in 2023, and 138 in 2024 (data not shown).

Chart 10-7 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 (2025 Q1)	Biosimilar market share (2024 Q3)
		In 10 years before biosimilar entry	Since biosimilar entry (through 2025 Q1)		
Neupogen and biosimilars	2015 Q3	71%	–1%	29%–46%	88%
Remicade and biosimilars	2016 Q4	54	–63	38–86	27
Neulasta and biosimilars	2018 Q3	117	–95	124–1,493	58
Procrit/Epogen and biosimilars	2018 Q4	35	–47	10–116	47
Avastin and biosimilars	2019 Q3	42	–10	31–71	85
Herceptin and biosimilars	2019 Q3	69	–28	25–93	80
Rituxan and biosimilars	2019 Q4	68	–19	31–48	65
Lucentis and biosimilars	2022 Q3	–31	–55	136	60
Actemra and biosimilars	2024 Q2	63	–1	69–101	N/A

Note: Q1 (first quarter), Q3 (third quarter), Q4 (fourth quarter), Q2 (second quarter), N/A (not available). 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; Byooviz and Cimerli for originator Lucentis; and Tyenne and Tofidence for Actemra. 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" 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 average sales price (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 + 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.

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Chart 10-7 Trends in Medicare Part B payment rates for originator biologics and their biosimilar products (continued)

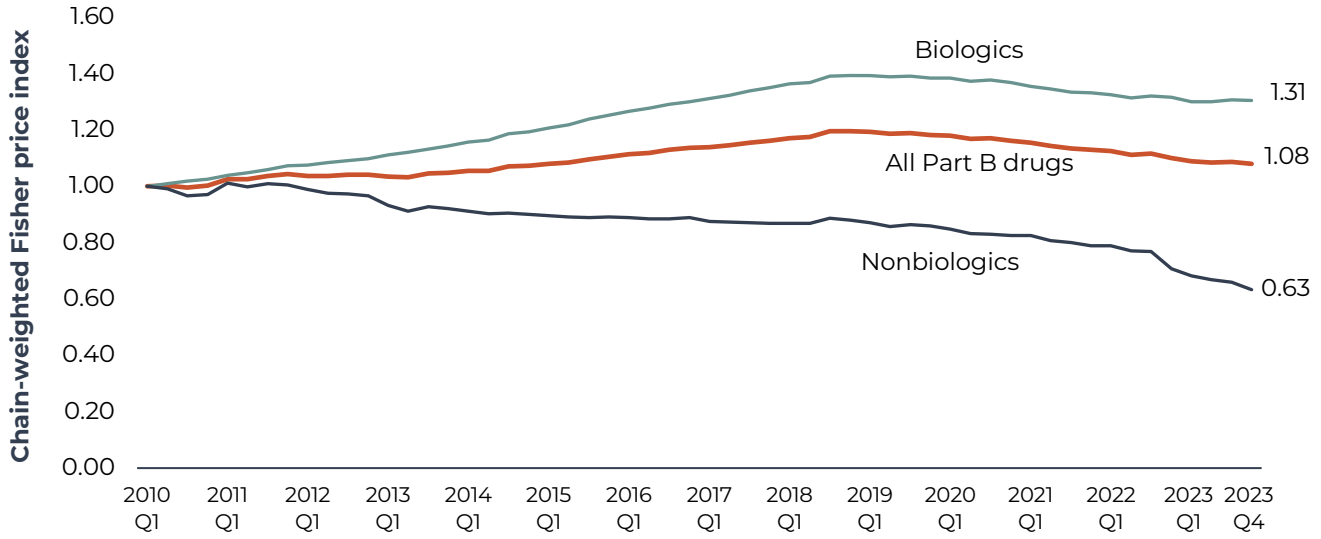
> Biosimilar entry has generated savings for Medicare. For the eight biologics that had biosimilars on the market in 2023, Medicare spending on Part B originator biologics and their biosimilars declined on a nominal basis by about 24 percent, from $4.3 billion in 2022 to $3.3. billion in 2023 (data not 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 80 percent or more of the market share for Neupogen, Avastin, and Herceptin and 65 percent of the market share for Rituxan. These four originator products have reduced their prices only minimally or modestly (1 percent, 10 percent, 28 percent, and 19 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 75 percent below the originator's payment rate.

> 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 63 percent, and originator Neulasta's payment rate has declined 95 percent since biosimilar entry. As of the first quarter of 2025, Remicade had some biosimilar competitors on the market that were priced lower (as much as 62 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 2025. Originator Remicade continues to retain the majority of market share as of the third quarter of 2025.

> 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 10-8 Postlaunch price indexes for Medicare Part B drugs, 2010–2023



Note: Q1 (first quarter), Q4 (fourth quarter). The 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 Healthcare 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.

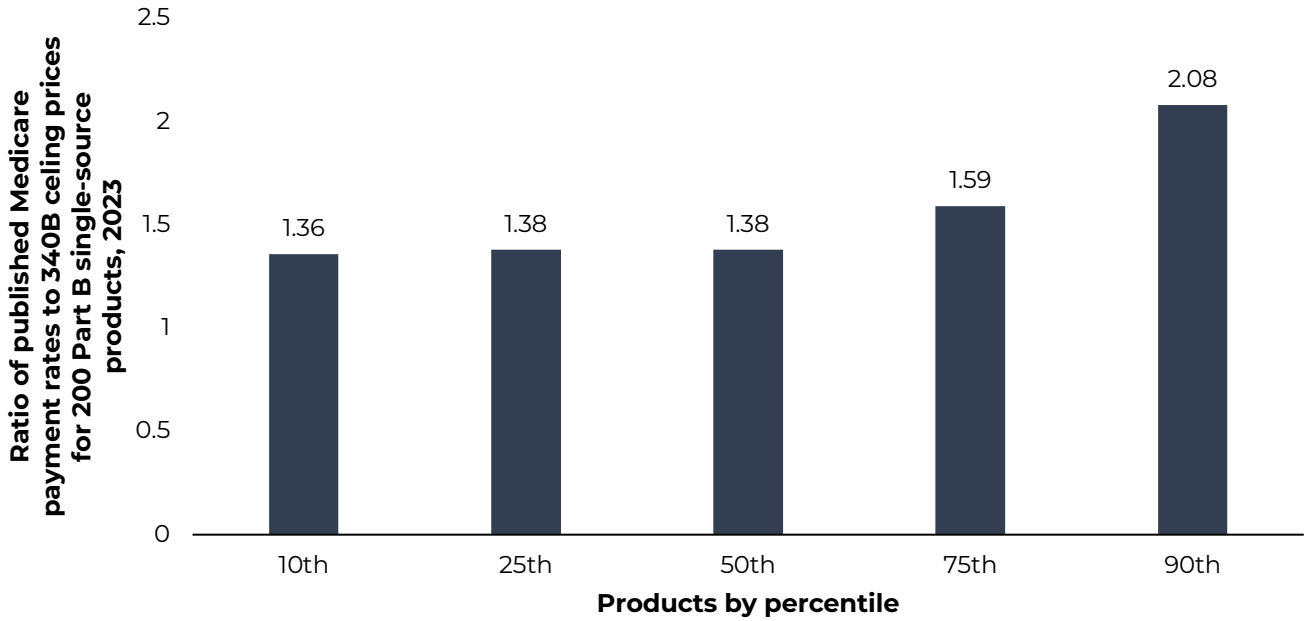
> The Part B price indexes reflect growth in the Medicare payment rate (generally the average sales price (ASP) + 6 percent) at the individual product level, which is a measure of average postlaunch price growth for Part B drugs. The price index is different from the change in the aggregate average annual payment per Part B drug (see Chart 10-2), which grew more than 7.5 percent per year on average between 2009 and 2023 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 8 percent cumulatively between 2010 and 2023 (index of 1.08) on a nominal basis. Since the third quarter of 2019 through the end of 2023, the overall price index for Part B drugs has declined from 1.19 to 1.08, driven by a decline in the nonbiologics' price index, coupled with the continued decline in the biologics' price index.

> The price index for biologics increased cumulatively by 31 percent (index of 1.31) between 2010 and 2023, reaching a high of just over 1.38 in the third quarter of 2018 and the first quarter of 2020 and declining to 1.31 by the fourth quarter of 2023. Pricing trends differ for biologics that face biosimilar competition and biologics that do not. Between the first quarter of 2020 and the fourth quarter of 2023, the price index declined for biologics with recent biosimilar entry by about 42 percent and increased for biologics without biosimilar competition by about 6 percent (data not shown).

> The price index for nonbiologics declined 37 percent (index of 0.63) between 2010 and 2023, 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 10-9 Comparisons of Medicare payment rates and 340B ceiling prices for Part B single-source products, 2023



Note: Medicare payment rates reflect published presequester payment rates (which include the Medicare program payment and beneficiary cost sharing) posted on CMS's website. Ceiling prices in the 340B program are MedPAC estimates based on analysis of data from the Medicaid rebate program. For each Part B drug billing code (which we refer to as "product"), the ratio of the Medicare payment rate to 340B ceiling price reflects the median ratio across the four quarters of 2023. First, we estimate 340B ceiling prices at the national drug code (NDC) level. Next, to estimate the average 340B ceiling price for each Part B drug billing code, we weight the 340B ceiling prices for each NDC associated with a given billing code by the manufacturer's reported market-wide utilization for the NDC (which is reported as part of the manufacturer's submission of average sales price data to CMS and includes Medicare and non-Medicare use of the NDC). All data for this analysis are aggregated to ensure confidentiality. Estimates are for 200 single-source drugs, biologics, or biosimilars billed by 340B hospitals under Medicare Part B and exclude drugs with generic competition. Estimates include outpatient prospective payment system (OPPS) hospitals that bill Medicare Part B for drugs acquired under the 340B program. We exclude hospitals paid under alternate payment systems (e.g., critical access hospitals, cancer hospitals, Indian Health Service hospitals, and Maryland hospitals). The 200 Part B single-source products were identified by focusing on Part B single-source products with at least $2 million in Part B OPPS payments (Medicare program payments and beneficiary cost sharing) for drugs acquired under the 340B program in 2023 and for which we were able to estimate 340B ceiling prices. Estimates do not reflect subceiling discounts, if any.

Source: MedPAC analysis of Medicare claims data, Part B drug payment-rate files, manufacturer-reported average sales price (ASP) and associated data, and Medicaid Drug Rebate Program data.

> Under the 340B Drug Pricing Program, nonprofit hospitals with high shares of Medicaid and low-income Medicare patients who participate in the program receive substantial discounts on outpatient drugs. Fee-for-service Medicare pays all providers the same rate for Part B drugs (generally the ASP + 6 percent), including 340B hospitals that acquire drugs at substantial discounts.

> Drug manufacturers are required to sell outpatient drugs to 340B hospitals for discounted prices that are no higher than the 340B ceiling price. The 340B ceiling price is the drug's average manufacturer price (AMP) less a unit rebate amount. For brand drugs, the unit rebate is the greater of 23.1 percent of AMP or the difference between AMP and best price, plus an additional inflation rebate if the product's price rises faster than inflation.

(Chart continued next page)

Chart 10-9 Comparisons of Medicare payment rates and 340B ceiling prices for Part B single-source products, 2023 (continued)

> To provide a sense of how Medicare payment rates compare to costs for 340B-purchased drugs, we estimated 340B ceiling prices for 200 Part B–covered single-source drugs, biologics, and biosimilars. These 200 single-source products accounted for 97 percent of Medicare spending on separately payable Part B drugs acquired under the 340B program by OPPS hospitals in 2023.

> Across the 200 single-source Part B products, Medicare payments exceeded the 340B ceiling price by 38 percent for the median product in 2023. The Medicare payment rate exceeded the 340B ceiling price by between 38 percent and 59 percent for half of products (25th percentile to 75th percentile), and by 108 percent or more for 10 percent of products (90th percentile).

> In 2023, Medicare and beneficiaries paid $13.8 billion for the 200 Part B–covered single-source products acquired under the 340B program by OPPS hospitals, while the estimated cost of these products at 340B ceiling prices was $9.5 billion (data not shown). Thus, aggregate payments exceeded 340B ceiling prices by an estimated 45 percent ($4.3 billion) in 2023. Ceiling-price costs equated to approximately ASP – 27 percent for the 200 single-source products in aggregate that year.

> The results of our analysis comparing the 2023 Medicare payment rate and 340B ceiling price at the billing-code level are similar to results from our 2022 analysis (data not shown). For example, in 2022, across 185 single-source products, we find that (1) for the median product, the Medicare payment rate exceeded the 340B ceiling price by 38 percent; (2) for half of products, the Medicare payment rate exceeded the ceiling price by 38 percent to 60 percent (25th percentile to 75th percentile); and (3) 10 percent of products had a Medicare payment rate at least 145 percent above the 340B ceiling price (90th percentile). We estimate that in 2022 aggregate payments exceeded 340B ceiling prices by an estimated 48 percent ($3.8 billion).

> Drug manufacturers can choose to sell products to 340B entities for prices lower than 340B ceiling prices (referred to as “subceiling prices”). Data are not available to determine the frequency of covered entities obtaining subceiling prices and the magnitude of subceiling prices. If 340B providers receive subceiling discounts for some products, discounts could be larger than we estimated.

Chart 10-10 Part D enrollment by plan type, 2015–2024

	2015	2023	2024	Average annual growth rate 2015–2024
Total Medicare enrollment, in millions	55.6	66.7	68.0	2.3%
Part D enrollment, in millions				
Part D plans	39.2	51.5	54.1	3.6
Non-Medicare employer plans under the RDS*	2.3	0.9	0.8	–11.1
Total Part D	41.5	52.4	54.9	3.1
Share of Medicare enrollees with Part D	*75%*	*79%*	*81%*	
LIS enrollment				
PDPs	8.0	5.2	4.7	–5.8
MA–PDs	3.7	8.6	9.3	10.8
Total LIS	11.7	13.8	14.0	2.0
Share of LIS enrollees in MA–PDs	*32%*	*58%*	*67%*	
Share of Part D plan enrollees with LIS	*30%*	*27%*	*26%*	
EGWPs (PDPs and MA–PDs), in millions	6.6	7.7	8.9	3.4
EGWP share of total Part D enrollment	*17%*	*15%*	*17%*	
Non-EGWP Part D plans, in millions				
PDPs	19.3	18.4	18.1	–0.7
MA–PDs	13.4	25.4	27.1	8.1
Share of non-EGWP plan enrollees in MA–PDs	*41%*	*58%*	*60%*	

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 in the month used for the analysis; similarly, while a beneficiary may be enrolled in both a PDP and an MA–PD during the year, that individual was classified into the type of plan in which they were enrolled during the month analyzed. Not all components sum to their respective totals due to rounding. The average annual growth rate is calculated on unrounded numbers. Enrollment counts exclude enrollees in U.S. territories.
* 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 monthly Medicare enrollment files from CMS and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2024, 81 percent of Medicare beneficiaries were enrolled in Part D plans in the month analyzed or had prescription drug coverage through employer-sponsored plans that received Medicare's RDS. That share is up from 75 percent in 2015. (The RDS is a tax-free subsidy paid to an employer who remains the primary payer of their retirees' creditable drug coverage when the enrollees' drug costs fall within a specified range of spending.)

> Between 2015 and 2024, the number of enrollees receiving the LIS grew modestly (2 percent per year, on average) compared with the number of non-LIS enrollees (about 4.3 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 2024, 26 percent of Part D enrollees received the LIS, a decrease from 30 percent in 2015. Two-thirds 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 2024, 8.9 million Medicare beneficiaries (17 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.

> In 2024, among non-EGWP plans, 27.1 million enrollees (60 percent) were in MA–PDs and 18.1 million enrollees (40 percent) were in stand-alone PDPs. Over the 2015 to 2024 period, enrollment in PDPs declined slightly, while enrollment in MA–PDs rose by an annual average of 8.1 percent.

Chart 10-11 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)	69.6	54.6	23.8	30.8	15.3	39.2
Percent of all Medicare	100%	78%	34%	44%	22%	56%
Gender						
Male	46%	44%	43%	44%	41%	44%
Female	54	56	57	56	58	56
Race/ethnicity						
White, non-Hispanic	72	72	80	66	52	80
Black, non-Hispanic	11	11	7	14	20	7
Hispanic	9	9	5	12	17	6
Asian	4	4	3	4	7	3
Other	4	4	4	4	5	4
Age (years)**						
<65	13	14	12	15	34	5
65–69	27	25	24	26	23	26
70–74	23	23	23	23	16	26
75–79	17	17	18	17	11	20
80+	20	21	23	19	17	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 2023.

Source: MedPAC analysis of the Common Medicare Environment file from CMS.

> In 2023, 54.6 million Medicare beneficiaries (78 percent) were enrolled in Part D plans at some point in the year. Less than half (23.8 million) were enrolled in stand-alone PDPs, and the rest were enrolled in MA–PDs (30.8 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 than PDP enrollees are; LIS enrollees are more likely to be female, non-White, and under age 65 (eligible for Medicare due to disability) compared with non-LIS enrollees.

Chart 10-12 Changes over time in the parameters of the Part D defined standard benefit, 2016–2025

	2016	2024	2025	Average annual change 2016–2025
Deductible	$360	$545	$590	5.6%
Initial coverage limit	3,310	5,030	N/A	N/A
Annual out-of-pocket threshold	4,850	8,000	2,000	–9.4
Total covered drug spending at annual out-of-pocket threshold:				
Enrollees eligible for manufacturers' coverage-gap discount	7,515	12,447	$6,230	–2.1
Other enrollees	7,063	11,477	$6,230	N/A
Cost sharing for LIS beneficiaries:				
Copay for generic/preferred multisource drugs	2.95	4.50	4.90	5.8
Copay for other prescription drugs	7.40	11.20	12.15	5.7

Note: LIS (low-income subsidy), N/A (not applicable). In 2025, under Part D's defined standard benefit, the enrollee pays the deductible and then 25 percent of covered drug spending until total covered drug spending reaches the out-of-pocket (OOP) coverage limit. The amounts shown of total covered drug spending at the spending thresholds 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 did not count toward these thresholds before 2025, but starting this year, the value of plans' supplemental coverage does count toward enrollees' OOP limit. Above the OOP limit, prior to 2024, non-LIS enrollees paid 5 percent coinsurance or copay amounts set in law, whichever was greater. As of 2025, the standard benefit has been redesigned such that there are now fewer benefit phases and a single coverage limit—the OOP cap—above the deductible. Dollar amounts are nominal figures, not adjusted for inflation.

Source: CMS Office of the Actuary.

> In 2025, Part D's defined standard benefit was redesigned, with two key changes for beneficiaries: the elimination of the coverage gap and the application of an OOP cap, such that beneficiaries now have a single benefit phase after the deductible and are no longer responsible for any cost sharing after reaching the catastrophic threshold. This year, the standard benefit has a $590 deductible, and enrollees pay 25 percent coinsurance on covered drugs until they reach the $2,000 threshold in annual OOP spending. (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 and whether they have supplemental coverage. CMS estimates that in 2025, a person who does not receive Part D's LIS and has no supplemental coverage would, on average, reach the threshold at $6,230 in total drug spending.) Beneficiaries who do not receive the LIS are eligible for a 10 percent manufacturers' discount on brand prescriptions in the initial coverage phase. Enrollees with drug spending that exceeds the annual OOP threshold no longer pay any cost sharing in the catastrophic phase. Manufacturers now must pay 20 percent of costs for brand-name drugs and biologics in the catastrophic phase, and Medicare pays 20 percent for such products and 40 percent for generics. Plan sponsors are now responsible for the remaining 60 percent. 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. (See MedPAC's March report 2025 for more details.)

> 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 10-18). 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.

Chart 10-13 Characteristics of stand-alone Medicare PDPs, 2024–2025

	2024				2025			
	Plans		Enrollees as of February 2024		Plans		Enrollees as of February 2025	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	709	100%	18.1	100%	464	100%	18.2	100%
Type of plan								
Benchmark	126	18	4.7	26	90	19	5.7	31
Nonbenchmark	583	82	13.4	74	374	81	12.5	69
Type of benefit								
Defined standard	0	0	0.0	0	0	0	0.0	0
Actuarially equivalent	266	38	7.0	39	196	42	7.8	43
Enhanced	443	62	11.0	61	268	58	10.5	57
Type of deductible								
Zero	103	15	2.3	13	79	17	2.8	16
Reduced	200	28	3.6	20	76	16	1.4	8
Defined standard*	406	57	12.2	67	309	67	14.0	77
Some formulary tiers not subject to a deductible	360	51	9.0	50	197	42	7.8	43

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 deductible for the defined standard benefit was $545 in 2024 and is $590 in 2025. The 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 auto-enrollment. Terminated plans have been excluded from the plan count in 2025.

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

> Plan sponsors are offering 464 stand-alone PDPs to fee-for-service enrollees in 2025 compared with 709 in 2024—a decrease of 35 percent. Total enrollment in PDPs increased slightly to 18.2 million beneficiaries in 2025 from 18.1 million in 2024, though PDP enrollment as a share of all Part D enrollment fell 1 percentage point to 42 percent as enrollment continues to shift to MA–PDs (see Chart 10-10).

> For 2025, 58 percent of PDP offerings include enhanced benefits (basic plus supplemental coverage); this share had been between 60 percent and 62 percent since 2019 (2019 data not shown). The share of PDP enrollees in enhanced plans similarly fell from 61 percent in 2024 to 57 percent in 2025.

> In 2025, the share of enrollees in plans with either no or a reduced deductible fell to 23 percent, down from 33 percent in 2024, as the share of plans (and enrollees in such plans) with a defined standard benefit increased from 67 percent to 77 percent. Similarly, in 2025, the share of plans designating certain formulary tiers not subject to the deductible fell from 51 percent in 2024 to 42 percent in 2025. 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 2025, 43 percent of PDP enrollees were in such plans, down from 63 percent in 2022 (latter data not shown).

Chart 10-14 Characteristics of conventional MA–PDs, 2024–2025

	2024				2025			
	Plans		Enrollees as of February 2024		Plans		Enrollees as of February 2025	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	3,507	100%	19.7	100%	3,246	100%	20.2	100%
Type of plan								
Local HMO	1,998	57	11.8	60	1,846	57	12.2	60
Local PPO	1,467	42	7.6	39	1,363	42	8.0	39
PFFS	14	0	0.0	0	12	0	0.0	0
Regional PPO	32	1	0.3	1	25	1	0.1	1
Type of drug benefit								
Defined standard	18	1	0.0	<0.5	27	1	0.1	<0.5
Actuarially equivalent	54	2	0.1	1	29	1	0.1	1
Enhanced	3,439	98	19.5	99	3,190	98	20.0	99
Type of drug deductible								
Zero	2,300	66	15.2	77	1,183	36	7.9	39
Reduced	1,017	29	4.0	20	1,362	42	9.9	49
Defined standard*	194	4	0.5	3	701	22	2.4	12
Some formulary tiers not subject to a deductible	1,161	33	4.4	22	2,027	62	12.2	61

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 $545 in 2024 and is $590 in 2025.

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

> Sponsors are offering 3,246 conventional MA–PDs in 2025 compared with 3,507 in 2024 (7.5 percent fewer plans). The vast majority of MA plans combine medical benefits with prescription drug benefits under Part D. Despite the reduction in the number of plans, enrollment in MA–PDs grew 2.8 percent from 19.7 million in 2024 to 20.2 million in 2025.

> For the second year in a row, the number of MA–PD plans offered as HMOs decreased modestly from 1,998 in 2024 to 1,846 in 2025, though HMO 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 17 percent over the past two years to 8.0 million enrollees in 2025.

> In 2025, 98 percent of MA–PDs have enhanced benefits compared with 58 percent of PDPs (see Chart 10-13). In 2025, those MA–PDs enrolled 99 percent of all MA–PD beneficiaries.

> This year, the first for the new Part D benefit design, plan sponsors made significant changes to the structure of their plan offerings. In 2025, just 36 percent of MA–PDs have no deductible for their Part D benefits, down from 66 percent in 2024, and those plans attracted just 39 percent of MA–PD enrollees, down from 77 percent in 2024, though still far more than the 16 percent of PDP enrollees in such plans (see Chart 10-13). While far fewer MA–PD enrollees have a plan with no deductible at all, relative to recent years, the share in plans that have some cost-sharing tiers of their formularies not subject to a deductible increased significantly from 22 percent in 2024 to 61 percent in 2025.

Chart 10-15 Characteristics of SNPs, 2024–2025

	2024				2025			
	Plans		Enrollees as of February 2024		Plans		Enrollees as of February 2025	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	1,306	100%	6.3	100%	1,417	100%	7.0	100%
Type of SNP								
Chronic condition	310	24	0.6	10	373	26	1.1	15
Dual eligible	828	63	5.6	88	884	62	5.8	83
Institutionalized	173	13	0.1	2	160	11	0.1	2
Type of drug benefit								
Defined standard	852	65	5.1	81	890	63	5.1	73
Actuarially equivalent	7	1	<0.5	<0.5	23	2	<0.5	1
Enhanced	452	34	1.2	19	504	36	1.9	27
Type of drug deductible								
Zero	272	21	0.5	8	205	14	0.4	6
Reduced	47	4	0.1	2	182	13	0.8	12
Defined standard*	992	76	5.7	90	1033	73	5.7	82
Some formulary tiers not subject to a deductible	111	8	0.5	7	252	18	0.9	13

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 $545 in 2024 and is $590 in 2025.

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, increasing 70 percent since 2020 to 1,417 in 2025 (2020 data not shown). SNP enrollment reached 7 million in 2025, growing more than 10 percent from 6.3 million in 2024.

> SNPs for individuals who are dually eligible for Medicare and Medicaid (D–SNPs) have the greatest enrollment, though their share of SNP enrollees declined slightly as more enrollees chose a plan specifically designated for individuals with certain chronic conditions (C–SNPs). In 2025, 62 percent of SNPs were D–SNPs, and they enrolled 83 percent of all SNP enrollees. The number of C–SNPs reached 373 in 2025; these SNPs enroll 15 percent of SNP enrollees, up from 10 percent in 2024. The number of SNPs for institutionalized beneficiaries decreased for the second year in a row to 160 in 2025 and continued to enroll just 2 percent of all SNP enrollees.

> Compared with PDPs and MA–PDs, SNPs are much more likely to offer a defined standard benefit, with 63 percent of SNPs offering such coverage. In 2025, these plans enrolled 73 percent of SNP beneficiaries, though this figure is significantly less than the 81 percent of SNP enrollees in such plans in 2024. The number of SNPs providing enhanced coverage in 2025 grew modestly, though enrollment in such plans increased from 19 percent to 27 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 Medicare pays the remainder of their plan's cost sharing. Thus, D–SNPs more frequently use Part D's defined standard benefit design (73 percent in 2025) and are less likely to have some formulary tiers that are not subject to a deductible.

Chart 10-16 Change in average Part D premiums, 2016–2025

	2016	2024	2025	Change in dollars, 2016–2025
Base beneficiary premium	34.10	34.70	36.78	2.68
All plans	$31	$27	$23	–$7
Basic plans	28	41	36	8
Enhanced plans				
Basic benefits	27	14	6	–21
Supplemental benefits	7	7	13	6
Total premium	33	21	18	–15
All basic coverage	27	22	14	–13
PDPs	39	43	39	0
Basic plans	29	44	35	5
Enhanced plans				
Basic benefits	41	23	17	–24
Supplemental benefits	12	19	26	14
Total premium	53	42	42	–11
All basic coverage	34	31	24	–10
MA–PDs, excluding SNPs	17	9	7	–10
Basic plans	18	33	31	13
Enhanced plans				
Basic benefits	15	8	1	–14
Supplemental benefits	2	1	6	4
Total premium	17	9	7	–10
All basic coverage	15	8	1	–14
SNPs	23	34	30	6
Basic plans	26	38	36	10
Enhanced plans				
Basic benefits	15	18	–2	–17
Supplemental benefits	0	2	14	14
Total premium	15	20	11	–4
All basic coverage	23	34	26	
Average MA–PD buy-down of basic premium	15	20	14	–1
Average MA–PD buy-down of supplemental benefits	14	27	23	9

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, after subtracting Part C rebate dollars that were used to offset Part D premium costs. All premiums are enrollment-weighted averages. "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." Changes were calculated on 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 files, plan report files, enrollment data, and bid data.

(Chart continued next page)

Chart 10-16 Change in average Part D premiums, 2016–2025 (continued)

> Part D enrollees can select between plans with basic or enhanced benefits (the latter combines basic and supplemental coverage). Medicare has traditionally aimed to subsidize 74.5 percent of the average cost of basic benefits, with enrollees paying premiums for the remaining 25.5 percent and all of the cost of any supplemental benefits. The Inflation Reduction Act of 2022 (IRA) imposed a 6 percent cap on annual increases in the base beneficiary premium (BBP), a share of the average total costs for basic Part D benefits. This cap has shifted the balance of subsidy and premiums: In 2025, Medicare is subsidizing an estimated 83 percent of the average cost of basic benefits. (For more about how plan premiums are determined and changes that were made by the IRA, see Part D *Payment Basics* at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_PartD_FINAL_SEC.pdf.)

> The overall average premium paid by enrollees for any type of Part D coverage decreased in 2025 from $27 per month in 2024 to $23 per month, despite the increased plan liability under the IRA's redesigned benefit structure. Without the IRA's cap on annual increases, the BBP would have been $55.98 per month in 2025. CMS also implemented a demonstration this year for stand-alone PDPs (nearly all of which chose to participate) to reduce their enrollees' monthly premiums by up to $15 per month and limit the annual increase in the plan's total monthly premium to no more than $35. (For more information on the demonstration, see the Commission's 2025 March report to the Congress at https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch12_MedPAC_Report_To_Congress_SEC.pdf.)

> Across all plans, the average premium for basic benefits has fallen from $27 in 2016 to $14 per month in 2025, a decline of 48 percent (a decrease of $13), largely due to the $21 reduction in the portion of the premium attributed to basic coverage in enhanced plans. This decline occurred despite very rapid growth in spending for Part D's catastrophic phase of the benefit (see Chart 10-20). Average premiums for basic plans (not including the cost of basic coverage in enhanced plans), however, have increased over this period from $28 in 2016 to $36 in 2025.

> The average premium for a basic plan offered by a PDP decreased to $35 after peaking at $44 last year. The average enrollee premium for enhanced plans offered by PDPs remained steady at $42 for the second year, down from $53 in 2016. Of the $42 average premium in 2025 among enhanced PDPs, $17 was for basic benefits and $26 was for supplemental benefits.

> The average basic premium for conventional MA–PDs is now just slightly lower than for PDPs at $31 per month. Nearly all MA–PD enrollees, however, are in enhanced plans, where the average premium is just $7 in 2025, a decrease of 58 percent since 2016. MA–PD sponsors typically use a portion of payments under Medicare Advantage, referred to as Part C rebates, to "buy down" Part D premiums. Because of those rebates, in 2025, MA–PD enrollees avoided having to pay $14 per month in basic premiums and an additional $23 per month for supplemental coverage, on average.

> Average premiums for SNPs are significantly higher than those for conventional MA–PDs at $30 per month in 2025. While average premiums for enhanced plans offered by SNPs are just $11, most SNP enrollees are dually eligible for Medicaid and Medicare and face very little cost sharing, reducing the value of an enhanced benefit; thus, most SNPs offered are basic plans with an average premium of $36, most or all of which is paid by Medicare's low-income subsidy.

Chart 10-17 Part D benchmarks for LIS premiums and number of qualifying PDPs, by region

Region	State(s)	2016		2025		Cumulative change, 2016–2025	
		Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs
1	ME, NH	$33	9	$34	3	$1	–6
2	CT, MA, RI, VT	31	6	53	3	21	–3
3	NY	40	7	72	3	33	–4
4	NJ	40	8	57	4	17	–4
5	DC, DE, MD	33	10	46	2	13	–8
6	PA, WV	35	9	48	2	13	–7
7	VA	33	7	31	3	–2	–4
8	NC	31	5	51	3	20	–2
9	SC	27	4	47	2	20	–2
10	GA	26	5	40	2	14	–3
11	FL	28	3	20	1	–8	–2
12	AL, TN	31	7	40	2	9	–5
13	MI	33	7	27	4	–7	–3
14	OH	30	5	39	2	10	–3
15	IN, KY	32	7	50	2	18	–5
16	WI	38	7	44	5	6	–2
17	IL	30	9	23	1	–7	–8
18	MO	26	4	51	2	25	–2
19	AR	21	4	21	3	0	–1
20	MS	28	6	47	3	19	–3
21	LA	32	7	56	3	24	–4
22	TX	28	7	18	1	–10	–6
23	OK	31	6	50	4	19	–2
24	KS	31	4	52	4	21	0
25	IA, MN, MT, ND, NE, SD, WY	31	5	51	3	20	–2
26	NM	21	8	16	4	–5	–4
27	CO	30	6	37	3	7	–3
28	AZ	33	10	30	2	–3	–8
29	NV	25	4	21	1	–4	–3
30	OR, WA	34	9	26	3	–8	–6
31	ID, UT	40	9	55	3	15	–6
32	CA	31	6	30	2	–1	–4
33	HI	26	2	48	3	21	1
34	AK	36	6	39	2	2	–4
Average		31	6	40	3	9	–3
Minimum		21	2	16	1	–5	–1
Maximum		40	10	72	5	32	–5

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

Source: MedPAC analysis of CMS benchmark amounts and plan landscape files.

(Chart continued next page)

Chart 10-17 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 or equal to 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 2025, the lowest benchmark premium was less than $16, in Region 26 (New Mexico), knocking Texas from this ranking after five consecutive years. Region 3 (New York) again had the highest benchmark premium in 2025 at $72 per month, significantly higher than the next highest benchmark of $57 in Region 4 (New Jersey).

> The average benchmark premium across regions (not weighted by numbers of enrollees) has risen slowly over the years, from $31 per month in 2016 to $40 in 2025 (on a nominal basis), an increase of 29 percent over 10 years. This change contrasts with the average overall premium across all plans, weighted by enrollment, which decreased by 23 percent over the same period (see Chart 10-16).

> In 2016, the average number of benchmark plans in a region was six; by 2025, that figure had dropped to three, a decline of 50 percent. The number of benchmark plans has declined in every region over the past decade except Region 24 (Kansas), which has the same number of plans (four) in 2025 as it did in 2016. There are four regions this year with just one benchmark plan (Region 1, Florida; Region 17, Illinois; Region 22, Texas; and Region 29, Nevada). The maximum number of benchmark plans in any region in 2025 is 5, compared with 10 in 2016.

Chart 10-18 In 2025, more enrollees are in plans that use coinsurance for brand-name and nonpreferred drug tiers

	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	66%	70%	74%
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%	21%	$47
Tier 4: Nonpreferred drugs	35%	40%	41%
Tier 5: Specialty-tier drugs	25%	25%	30%
Drugs with any utilization management	53%	53%	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. For the analysis in this table, a drug was defined based on the unique products listed on CMS's formulary reference file for the 2025 benefit year. "Utilization management" includes prior authorization, step therapy, and quantity limits. "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).

Source: MedPAC analysis of formularies submitted to CMS.

> In 2025, nearly all 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 2025, on average, PDP enrollees have access to 70 percent of all Part D–covered products, compared with 74 percent among MA–PD enrollees. That share was lower (66 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 2025 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 nonpreferred drugs. For 2025, most PDPs are continuing to use coinsurance (a percentage of the total payment) for preferred brand-name and nonpreferred drug tiers. While the majority of MA–PDs continue to use copayments (a fixed dollar amount per prescription) for preferred brand-name drug tier, an increasing share of MA–PDs are in plans that use coinsurance for preferred brand-name and nonpreferred drug tiers. In 2025, about 30 percent and 60 percent of MA–PD enrollees were in plans that use coinsurance for preferred brand-name and nonpreferred drug tiers, respectively, up from less than 5 percent in 2024 for both tiers (data not shown). Both PDPs and MA–PDs use coinsurance (with median coinsurance rates of 25 percent and 30 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 2025, both PDPs and MA–PDs typically use some form of utilization management for more than half of the drugs listed on a plan's formulary.

Chart 10-19 Components of Part D spending growth, 2014–2023

	2014	2023	Average annual growth 2014–2023
Total gross spending (in billions)	$121.4	$276.0	9.6%
High-cost beneficiaries	64.6	177.5	11.9
Lower-cost beneficiaries	56.7	98.4	6.3
Number of beneficiaries using a Part D drug (in millions)	37.1	50.8	3.5
High-cost beneficiaries	3.4	4.8	3.8
Lower-cost beneficiaries	33.7	46.0	3.5
Amount per beneficiary who used Part D drugs			
Gross drug spending per year	$3,267	$5,429	5.8
Average price per 30-day prescription	$60	$93	5.1
Number of 30-day prescriptions	54.5	58.1	0.7
Amount per high-cost beneficiary who used Part D drugs			
Gross drug spending per year	$18,845	$37,067	7.8
Average price per 30-day prescription	$166	$319	7.6
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	$2,137	2.7
Average price per 30-day prescription	$35	$41	1.9
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 point of sale. Changes in the average price per prescription, measured by gross spending at the point of sale, 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 2023, gross spending on drugs under the Part D program, on a nominal basis, grew by an annual average rate of 9.6 percent. The annual growth in spending was considerably higher (11.9 percent) among high-cost beneficiaries (individuals who incurred spending high enough to reach the catastrophic phase of the benefit) than among lower-cost beneficiaries (6.3 percent).

> During the 2014 through 2023 period, the number of high-cost beneficiaries grew more rapidly (3.8 percent) compared with lower-cost beneficiaries (3.5 percent), driven by the uptick in the number of high-cost beneficiaries in 2023.

> The average price per 30-day prescription covered under Part D rose from $60 in 2014 to $93 in 2023. Overall, growth in price per prescription accounted for most (5.1 percentage points) of the 5.8 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 (7.6 percent) accounted for nearly all of the spending growth (7.8 percent) during this period. In contrast, among lower-cost beneficiaries, the increase in the number of prescriptions (0.7 percent) accounted for over a quarter of the spending growth (2.7 percent).

Chart 10-20 Part D spending and use per enrollee, 2023

		Plan type		LIS status	
	Part D	PDP	MA–PD	LIS	Non-LIS
Total gross spending (billions)*	$276.0	$123.9	$152.1	$131.0	$144.9
Above OOP threshold (billions)	118.5	54.5	64.0	70.3	48.2
Share above OOP threshold	*43%*	*44%*	*42%*	*54%*	*33%*
Total number of prescriptions (billions)	3.0	1.2	1.7	1.0	2.0
Average spending per prescription	$93	$100	$89	$131	$74
Share of beneficiaries with no drug use	6%	6%	6%	6%	6%
Per enrollee per month					
Total gross spending	$443	$458	$431	$765	$321
OOP spending	30	41	22	3	40
Manufacturer gap discount	32	38	27	N/A	44
Plan liability	294	295	293	527	206
Low-income cost-sharing subsidy	64	56	70	232	N/A
Number of prescriptions	4.7	4.6	4.9	5.8	4.3

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 2023, gross spending on drugs for the Part D program totaled $276 billion, with about 45 percent ($123.9 billion) accounted for by Medicare beneficiaries enrolled in stand-alone PDPs. The 27 percent of Part D enrollees who received the LIS accounted for about 47 percent ($131 billion) of the total.

> Overall, 43 percent of gross spending was incurred after a beneficiary reached the annual OOP threshold ($7,400 in 2023). That share was higher among those who received the LIS (54 percent) compared with other enrollees (33 percent).

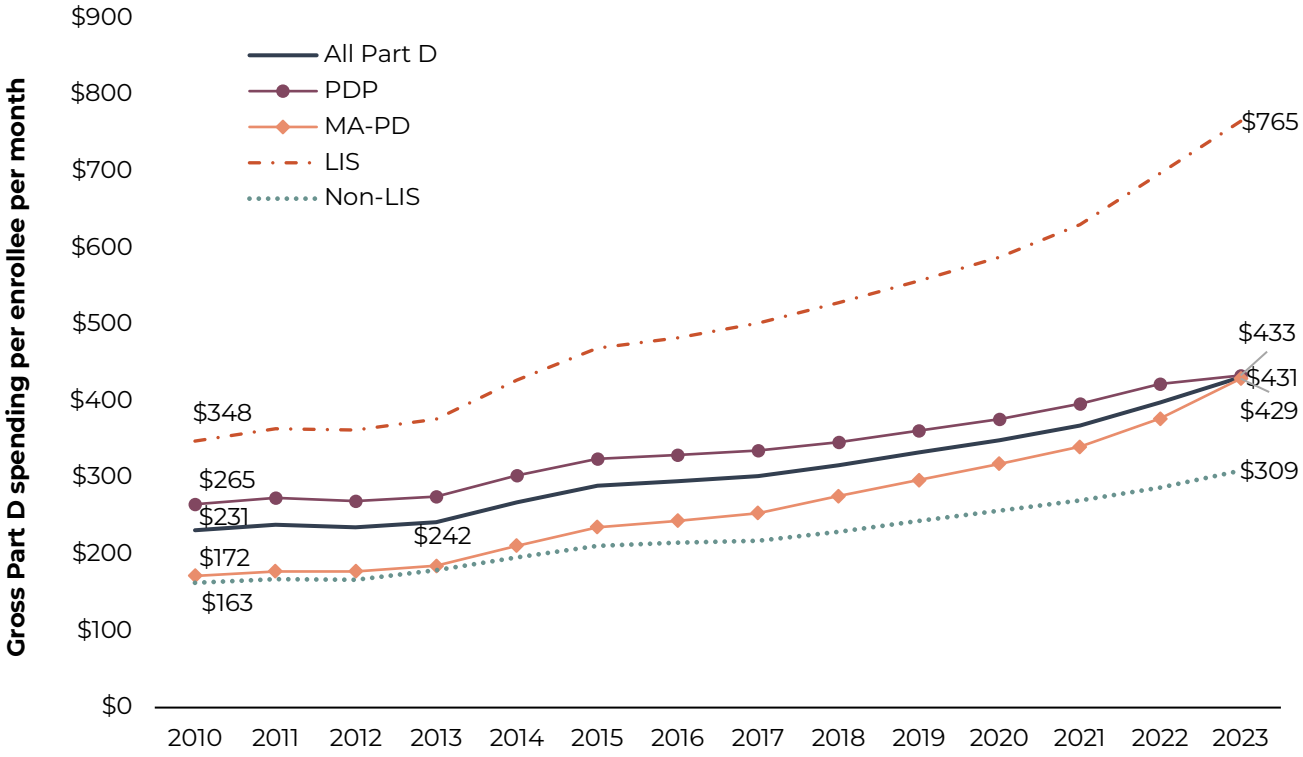
> The number of prescriptions filled by Part D enrollees totaled 3 billion, with 42 percent (1.2 billion) accounted for by PDP enrollees and about 34 percent (1 billion) accounted for by LIS enrollees. Overall, 6 percent of Part D enrollees did not fill any prescriptions during the year.

> In 2023, Part D enrollees filled 4.7 prescriptions at $443 per month on average, an increase from $398 per month (for 4.7 prescriptions) in 2022 (2022 data not shown). The average monthly plan liability for PDP enrollees ($295) was slightly higher than that of MA–PD enrollees ($293). The average monthly OOP spending for enrollees in PDPs ($41) was also higher than in MA–PDs ($22). Medicare's average monthly low-income cost-sharing subsidy was higher for MA–PD enrollees ($70) than for PDP enrollees ($56).

> Average monthly spending per LIS enrollee ($765) was more than double that of a non-LIS enrollee ($321), and the average number of prescriptions filled per month by an LIS enrollee was 5.8 compared with 4.3 for a non-LIS enrollee. LIS enrollees had much lower monthly OOP spending, on average, than non-LIS enrollees ($3 vs. $40, respectively). Part D's LIS pays for most of the cost sharing for LIS enrollees, averaging $232 per month in 2023.

> Manufacturer discounts for brand-name drugs filled by non-LIS enrollees while they were in the coverage gap accounted for, on average, 7.2 percent of the total gross spending, or nearly 13.7 percent of the average gross spending by non-LIS enrollees.

Chart 10-21 Trends in Part D spending per enrollee per month, 2010–2023



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 point of sale. Dollar amounts are nominal figures, not adjusted for inflation.

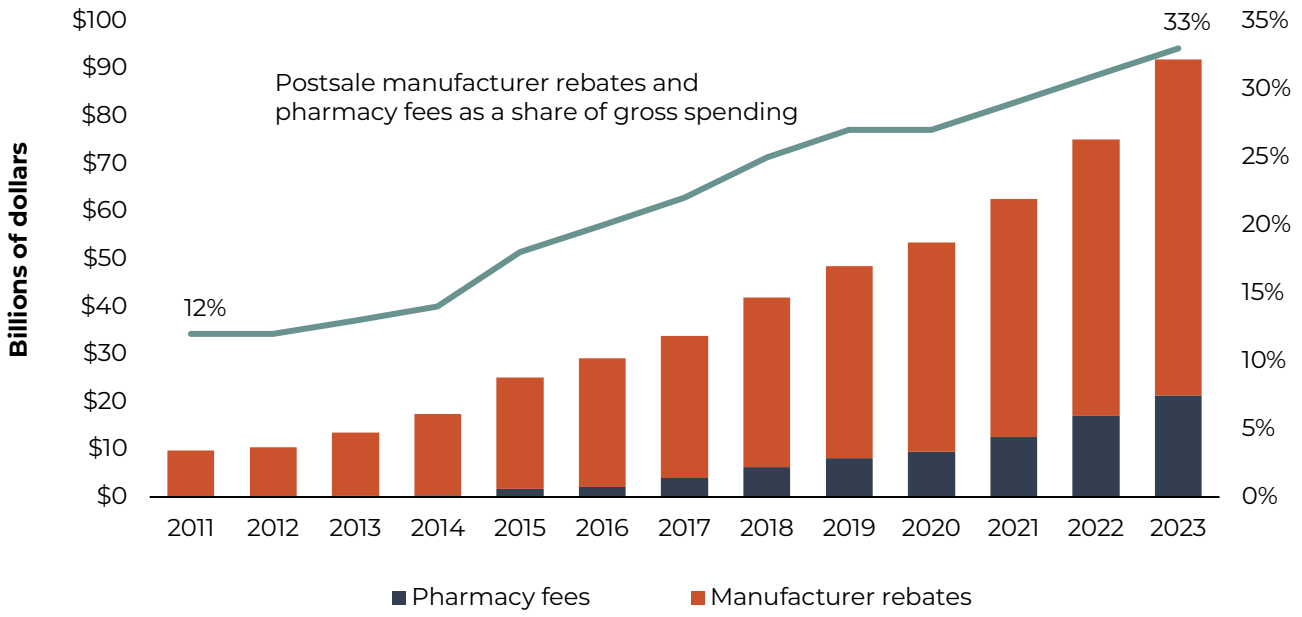
Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

> Between 2010 and 2023, average per capita spending per month for Part D–covered drugs grew from $231 to $431 on a nominal basis, an average growth rate of 4.9 percent annually, or about 86 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 2010 and 2023, monthly per capita spending for LIS enrollees grew faster than spending for non-LIS enrollees, increasing from $348 to $765 (cumulative growth of over 150 percent) compared with an increase from $163 to $309 for non-LIS enrollees (cumulative growth of about 90 percent). The number of standardized 30-day prescriptions filled by LIS and non-LIS enrollees grew by about 15 percent and 13 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 2010 to 2023 period (annual average growth of 7.3 percent and 3.8 percent, respectively). The average per capita spending for MA–PD enrollees continued to be lower than that of PDP enrollees. However, that difference has been declining since 2014. In 2023, the difference was $4 per month, down from $46 per month in 2022.

Chart 10-22 Postsale manufacturer rebates and pharmacy fees expanded rapidly in Part D, 2011–2023



Note: "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 2011 and 2023, DIR increased substantially from less than $10 billion to $92 billion. With manufacturer rebates accounting for roughly 25 percent of gross Part D spending in 2023 and pharmacy DIR accounting for another 8 percent, total DIR equaled about 33 percent, up from 12 percent in 2011.

> Multiple factors have contributed to growth in manufacturer rebates. For certain classes of drugs that lack 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 10-23 Incidence of Part D spending by type of product, 2023

			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	$171.2	12%	24%	14%	6%	9%	29%	7%
Biologics	60.0	6	29	12	5	8	32	8
Generic drugs	42.5	38	11	20	18	N/A	<1	12
All products covered under Part D*	276.0	15	23	14	8	7	25	8

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 2023, 84 percent of total gross Part D spending was for brand-name drugs ($171.2 billion, or 62 percent) or biologics ($60 billion, or 22 percent). Generic drugs accounted for about 15 percent ($42.5 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 29 percent through 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 (20 percent) compared with brand-name drugs (14 percent) or biologics (12 percent).

> On average, beneficiaries' cost sharing accounted for 18 percent of gross spending for generic drugs compared with 6 percent for brand-name drugs and 5 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 applied (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 10-12 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 25 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 8 percent of gross spending. On average, pharmacy fees accounted for a higher share of gross spending for generic drugs (12 percent) than for brand-name drugs and biologics (7 percent and 8 percent, respectively).

Chart 10-24 Top 15 therapeutic classes of drugs covered under Part D, by spending, 2023

	Gross spending		Negotiated rebates as a share of gross spending	Coverage-gap discount (billions)
	Billions	Percent		
Diabetic therapy	$60.7	22.0%	≥50%	$8.2
Antineoplastics	34.4	12.5	<10%	0.9
Anticoagulants	25.0	9.1	40% to 49%	4.0
Asthma/COPD therapy agents	17.9	6.5	40% to 49%	1.5
Disease-modifying anti-rheumatoid drugs	13.6	4.9	20% to 29%	0.5
Antihypertensive therapy agents	9.8	3.5	10% to 19%	0.6
Antiretrovirals	8.6	3.1	<10%	0.3
Antipsychotics (neuroleptics)	8.3	3.0	<10%	0.1
Dermatological (antipsoriatics)	7.0	2.5	10% to 19%	0.2
Ophthalmic agents	6.2	2.3	10% to 19%	0.4
Antihyperlipidemics	6.1	2.2	10% to 19%	0.4
Anticonvulsants	3.9	1.4	<10%	<0.1
Multiple sclerosis agents	3.5	1.3	10% to 19%	0.1
Urinary incontinence treatment agents	3.5	1.3	≥50%	0.3
Movement disorder drug therapy	3.0	1.1	40% to 49%	<0.1
Subtotal, top 15 drug classes	211.6	76.7	29%	17.6
Total, all drug classes	276.0	100.0	25%	19.8

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 2023, the top 15 therapeutic classes by gross spending accounted for nearly 77 percent of the $276 billion spent on prescription drugs covered by Part D plans. Diabetic therapies continued to be at the top of the list, accounting for 22 percent of total gross Part D spending, up from 19.5 percent in 2022 (latter data not shown). The uptick in spending for diabetic therapies is likely due, in part, to the increase in the use of drugs called glucagon-like peptide-1 receptor agonists.

> In 2023, 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 29 percent of gross spending, higher than the average of 25 percent for all Part D spending. Rebates were the highest (greater than or equal to 50 percent) for diabetic therapies and urinary incontinence treatment agents.

> In addition to negotiated rebates, before 2025, manufacturers were required to provide discounts for brand-name drugs and biologics filled by non-LIS enrollees when they filled prescriptions in the coverage-gap phase of the benefit. In 2023, these top 15 classes accounted for 89 percent ($17.6 billion) of all coverage-gap discounts. Diabetic therapies alone accounted for 42 percent of all coverage-gap discounts.

Chart 10-25 Despite high generic use, brand-name drugs accounted for the majority of spending in the top 15 therapeutic classes by spending, 2023

	Prescriptions*		Generic dispensing rate	Brand share of gross spending	LIS share of prescriptions
	Millions	Percent			
Diabetic therapy	219.8	7.4%	56%	98%	33%
Antineoplastics	16.1	0.5	87	90	22
Anticoagulants	58.9	2.0	19	99	28
Asthma/COPD therapy agents	88.4	3.0	58	91	43
Disease-modifying anti-rheumatoid drugs	3.1	0.1	35	100	49
Antihypertensive therapy agents	297.9	10.1	98	72	19
Antiretrovirals	3.1	0.1	18	98	67
Antipsychotics (neuroleptics)	36.2	1.2	91	80	68
Dermatological (antipsoriatics)	1.0	<0.1	24	99	54
Ophthalmic agents	65.1	2.2	84	75	26
Antihyperlipidemics	348.8	11.8	98	49	20
Anticonvulsants	110.4	3.7	99	41	44
Multiple sclerosis agents	0.7	<0.1	47	85	60
Urinary incontinence treatment agents	22.1	0.8	69	87	35
Movement disorder drug therapy	0.5	<0.1	6	98	76
Subtotal, top 15 drug classes	1,272.0	43.1	82	91	28
Total, all drug classes	2,952.0	100.0	89	84	28

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.

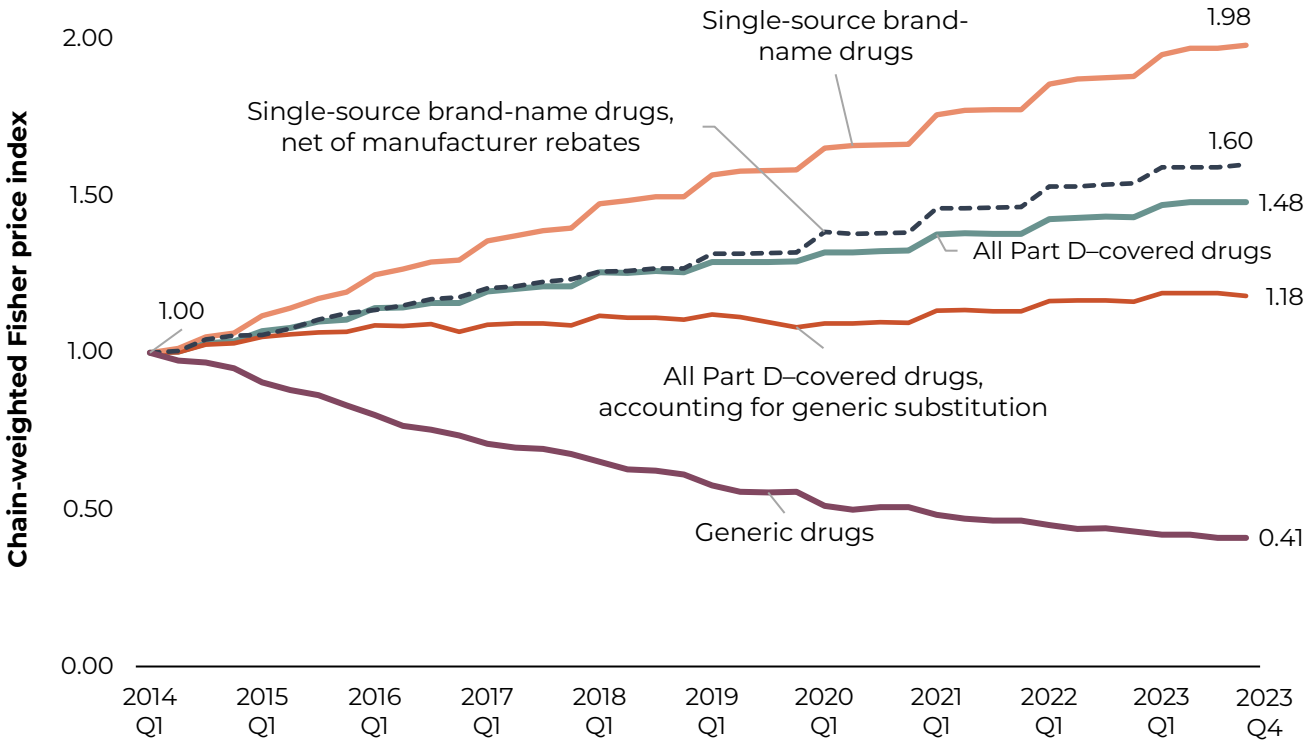
Source: MedPAC analysis of Medicare Part D prescription drug event and direct and indirect remuneration data from CMS.

> Filled prescriptions in the top 15 therapeutic classes by spending in 2023 (see Chart 10-24) totaled 1.27 billion prescriptions, accounting for 43 percent of all prescriptions filled under Part D. While 82 percent of these prescriptions were for generic drugs, brand-name products accounted for 91 percent of the gross spending for these products in 2023.

> In 2023, LIS beneficiaries filled 28 percent of total prescriptions for products in these 15 classes, which is identical to their share of prescriptions among all Part D drugs. Nevertheless, LIS enrollees accounted for a disproportionate share of prescriptions in a few classes such as antipsychotics (68 percent) and antiretrovirals (67 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 2023, generic drugs accounted for 87 percent of prescriptions for antineoplastics, but brand-name drugs accounted for 90 percent of gross spending for that class.

Chart 10-26 Postlaunch price growth for Part D–covered drugs, 2014–2023



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 (see Chart 10-19), which reflects changes in the prices of existing products, the effects of launch prices of new products, and shifts in utilization across products.

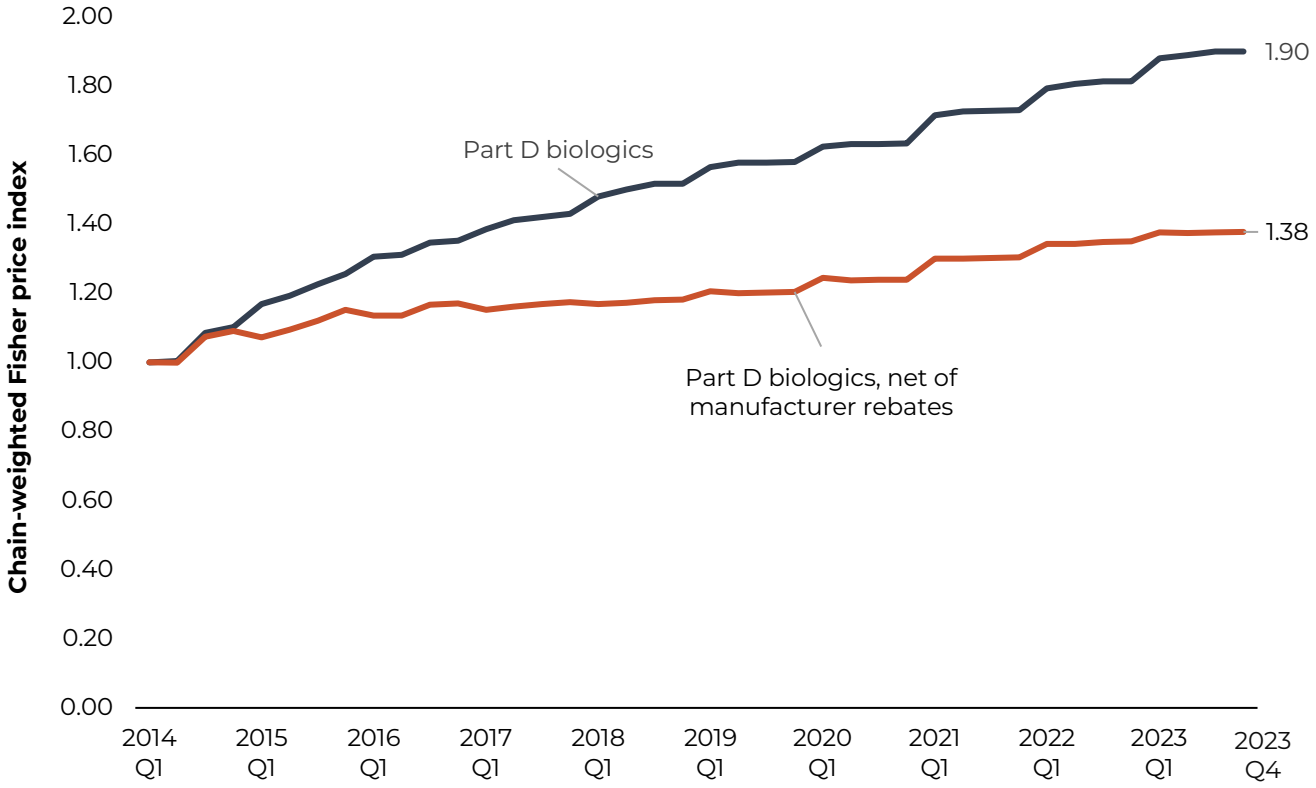
Source: Acumen LLC analysis for MedPAC.

> Measured by individual national drug codes, prices of drugs and biologics covered under Part D rose 48 percent cumulatively between 2014 and 2023 on a nominal basis (an index of 1.48). (Prices reflect total amounts paid to pharmacies and do not reflect retrospective rebates or discounts from manufacturers and pharmacies.)

> Overall, between 2014 and 2023, prices of generic drugs covered under Part D decreased to 41 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 a cumulative increase in prices at the end of 2023 at 18 percent above the prices at the beginning of 2014 (an index of 1.18). 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 2023, prices for all single-source, brand-name drugs (drugs with no generic substitutes) grew by a cumulative 98 percent (an index value of 1.98), compared with 60 percent (an index value of 1.60) for prices net of manufacturer rebates.

Chart 10-27 Postlaunch price growth for biologics covered under Part D, 2014–2023



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 a 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 90 percent cumulatively between 2014 and 2023 on a nominal basis (an index of 1.90). This increase is similar to the growth in prices for all single-source drugs and biologics (98 percent, or an index value of 1.98). (See Chart 10-26 for index measuring prices of all single-source drugs and biologics.)

> In comparison, between 2014 and 2023, prices of biologics net of retrospective rebates and discounts from manufacturers grew by a cumulative 38 percent (an index value of 1.38). 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 60 percent (an index value of 1.60) for prices net of manufacturer rebates. (See Chart 10-26 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 2023, insulins accounted for over a quarter 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 10-24).

SECTION

11

Other services

Dialysis
Hospice
Clinical laboratory

Chart 11-1 Low growth in the capacity of freestanding and for-profit dialysis organizations between 2022 and 2023

	2023	Average annual percent change	
		2019–2022	2022–2023
Total number of:			
Dialysis facilities	7,714	1%	–1.9%
Hemodialysis stations	138,500	1	0.3
Mean number of hemodialysis stations per facility	18	0	2.3
	Share of total facilities		
Hospital based	5%	–3	–2
Freestanding	95	1	–2
Urban	84	1	–2
Rural	16	–0.7	–3
For profit	90	1	–1.4
Nonprofit	10	–1	–7

Note: "Nonprofit" includes facilities designated as either nonprofit or government facilities. "Average annual percent change" is based on comparing 2019, 2022, and 2023 end-of-year files. Provider location reflects the county where the provider is located, urban or rural (the latter includes micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. 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.

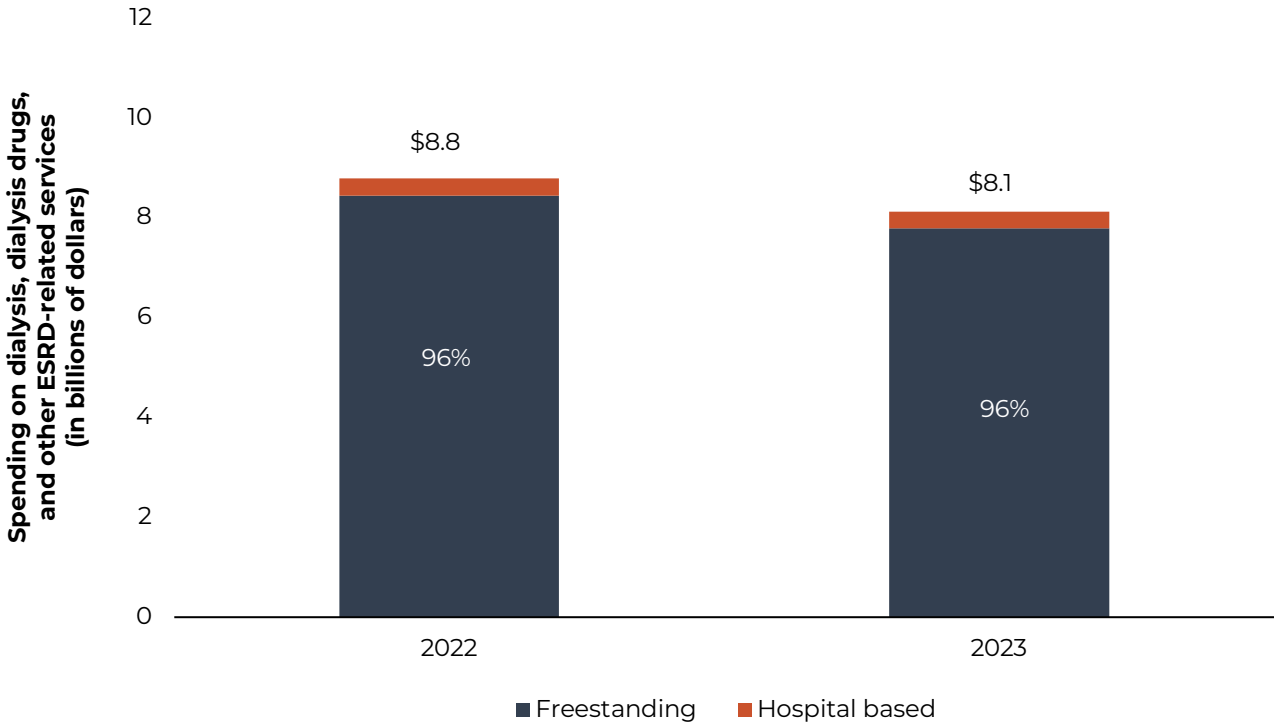
> After increasing 1 percent per year, on average, between 2019 and 2022, the number of dialysis facilities declined between 2022 and 2023 by 1.9 percent, though facilities' capacity to provide care—as measured by hemodialysis treatment stations—remained relatively steady.

> 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 2022 and 2023 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. In June 2020, the Commission recommended that CMS replace the current separate low-volume and rural payment adjustments with a single low-volume and isolated adjustment to better protect isolated low-volume rural facilities that are necessary for beneficiary access. Instead, in the ESRD prospective payment system final rule for 2025, CMS modified the current low-volume payment adjustment, creating different low-volume adjustments for facilities that furnish fewer than 3,000 treatments and for facilities that furnish between 3,000 and 3,999 treatments. CMS did not change the 0.8 percent rural-facility adjustment.

> Between 2022 and 2023, the number of for-profit and nonprofit facilities decreased by 1.4 percent and 7 percent, respectively. 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, 2022 and 2023



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 2023, total FFS Medicare spending for dialysis, dialysis drugs, and ESRD-related clinical laboratory tests was $8.1 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 2022 and 2023, total FFS ESRD expenditures decreased by 8 percent on a nominal basis. The spending decline is due in large part to the increasing enrollment of dialysis beneficiaries in Medicare Advantage (MA) plans beginning in 2021. As beneficiaries with ESRD shifted to MA in 2021 through 2023, the number of FFS beneficiaries on dialysis fell 10 percent per year, on average, and the number of FFS treatments fell 11 percent per year (data not shown).

> Freestanding dialysis facilities treated most FFS dialysis beneficiaries and accounted for 96 percent of FFS expenditures on outpatient dialysis in 2022 and 2023.

Chart 11-3 Increase in the number of patients with ESRD over the last decade, but low growth between 2021 and 2022

	2012		2022		2012–2022
	Patients (thousands)	Share of patients	Patients (thousands)	Share of patients	Average annual percent change
Total	637.7	100%	815.6	100%	2%
Dialysis	448.9	70	554.7	68	2
In-center hemodialysis	400.8	63	470.3	58	2
Home hemodialysis[a]	6.6	1	13.1	2	7
Peritoneal dialysis[a,b]	39.9	6	67.3	8	5
Other dialysis[c]	1.6	0.3	4.0	0	10
Functioning graft and kidney transplant	188.8	30	261.0	32	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., 2012 or 2022) or received a transplant during the year in question.
[a] Home dialysis methods.
[b] "Peritoneal dialysis" refers to patients receiving either continuous ambulatory peritoneal dialysis or continuous cyclic peritoneal dialysis.
[c] "Other dialysis" includes other types of peritoneal dialysis methods and uncertain dialysis.

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 2 percent per year between 2012 and 2022. Between 2021 and 2022, the growth rate of the total number of patients with ESRD was 0.9 percent (data not shown). Most patients with ESRD undergo dialysis.

> 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 2022, most people with ESRD (58 percent) underwent hemodialysis administered in a dialysis facility (usually three times a week). Between 2012 and 2022, 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 5 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 2022, 22 percent of transplanted kidneys were from living donors, and the remainder were from cadaver donors (data not shown).

Chart 11-4 Asian Americans are among the fastest-growing segments of the ESRD population

	Share of total in 2022	Average annual percent change 2017–2022
Total (*N* = 815,896)	100%	1%
Age (years)		
0–17	1	1
18–44	14	1
45–64	41	0
65–79	35	3
80+	9	2
Sex		
Male	59	2
Female	41	1
Race/ethnicity		
White	42	0
Black	29	1
Native American	1	3
Asian American	7	4
Hispanic	20	3
Underlying cause of ESRD		
Diabetes	37	0
Hypertension	27	2
Glomerulonephritis	14	0
Other causes	22	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 44 percent were over age 65 in 2022. About 42 percent were White.

> Diabetes is the most common cause of renal failure.

> The number of patients with ESRD increased by 1 percent annually between 2017 and 2022. In 2022, among the fastest-growing groups were individuals of Native American, Asian, and Hispanic origins and individuals ages 65 and older.

Chart 11-5 Characteristics of Medicare FFS dialysis patients, 2023

	Share of all FFS dialysis patients
Age (years)	
Under 45	10%
45–64	33
64–74	29
75–84	21
85+	7
Sex	
Male	58
Female	42
Race	
White	43
Black	29
Hispanic	15
Asian	6
All other	7
Residence, by type of county	
Urban	84
Rural	16
Prescription drug coverage status	
Enrolled in Part D plan*	81
LIS	52
Dually eligible for Medicare and Medicaid	39

Note: FFS (fee-for-service), LIS (low-income subsidy). "Residence" reflects the beneficiary's county of residence, urban or rural (the latter includes micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. 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 2023, about 16 percent of FFS beneficiaries on dialysis resided in a rural county.

> In 2023, 81 percent of FFS beneficiaries on dialysis were enrolled in Part D plans. In addition, 6 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; 13 percent of FFS beneficiaries on dialysis had no coverage or coverage less generous than Part D (data not shown).

> About two in five beneficiaries on dialysis were dually eligible for Medicare and Medicaid services.

Chart 11-6 A greater share of MA beneficiaries than FFS beneficiaries on dialysis are over age 65, Black, dually eligible for Medicare and Medicaid, and urban residents, 2023

	FFS beneficiaries on dialysis	MA beneficiaries on dialysis
Total	216,400	211,900
Age		
Under 45 years	10%	6%
45–64 years	34	31
65–74 years	28	33
75–84 years	21	24
85+ years	7	7
Sex		
Male	59	56
Female	41	44
Race/ethnicity		
White	43	33
Black	30	40
Hispanic	15	19
Asian	6	5
All others	6	3
Residence, by type of county		
Urban	83	87
Rural	16	13
Dual eligibility		
Fully dually eligible	38	39
Partially dually eligible	7	13
Not dually eligible	56	48
Part D enrollment		
Yes	73	98
No	27	2
New to dialysis	18	18
LDO	73	74
Non-LDO	27	26
Existing dialysis	83	82

Note: MA (Medicare Advantage), FFS (fee-for-service), LDO (large dialysis organization (DaVita and Fresenius)). Beneficiaries on dialysis were identified using the risk score file, and FFS versus MA enrollment was identified using CMS enrollment data. "Residence" reflects the beneficiary's county of residence in one of two categories, urban or rural (the latter category includes micropolitan, rural adjacent to urban, and rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. Data as of January 2023. Components may not sum to 100 percent due to rounding.

Source: Compiled by MedPAC from CMS enrollment data, risk-score file, U.S. Census delineation file, CMS-2728.

> Beginning in January 2021, the 21st Century Cures Act permitted beneficiaries on dialysis to enroll in MA plans without any restrictions. As a result of this statutory change, the share of beneficiaries on dialysis enrolled in MA plans increased rapidly from 25 percent in January 2020 to 52 percent by December 2023 (data not shown).

> Since the removal of enrollment barriers in 2021, a greater share of MA beneficiaries with ESRD in 2023 are under age 65 (a 12 percentage point increase since 2020), Black (a 7 percentage point increase), and dually eligible for Medicare and Medicaid (a 9 percentage point and 4 percentage point increase for full- and partial-benefit dually eligible beneficiaries, respectively; data not shown).

> In 2023, 63 percent of MA beneficiaries on dialysis were 65 years or older (of which 31 percent were 75 years or older), 40 percent were Black, 13 percent had partial dual eligibility, and 87 percent resided in urban areas. By comparison, among FFS beneficiaries on dialysis, 56 percent were 65 years or older (of which 28 percent were 75 years or older), 30 percent were Black, 7 percent had partial dual eligibility, and 83 percent resided in urban areas.

Chart 11-7 Aggregate FFS margins varied by type of freestanding dialysis facility, 2023

Type of freestanding facility	Share of dialysis treatments in freestanding facilities	Aggregate margin
All facilities	100%	–0.2%
Urban	88	0.6
Rural	12	–4.5
Treatment volume (quintile)		
Lowest	8	–19.0
Second	13	–11.2
Third	18	–3.3
Fourth	24	1.6
Highest	38	7.5

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 FFS 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 from the Dialysis Compare database.

> For 2023, the aggregate FFS Medicare margin for dialysis-related services, including ESRD-related drugs and laboratory tests that were paid separately before 2011, was –0.2 percent.

> Between 2022 and 2023, the aggregate FFS Medicare margin increased (from –1.1 percent to –0.2 percent (2022 data not shown)). The increased margin in 2023 was attributable to growth in payments per treatment that outpaced growth in costs, while per treatment capital and ESRD drug, lab, and supply costs declined and growth in per treatment labor costs slowed. Partially offsetting these factors were increases in overhead cost per treatment between 2022 and 2023 and declining total treatment volume between 2022 and 2023.

> 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 (data not shown). Some rural facilities have benefited from the ESRD PPS's low-volume adjustment.

Chart 11-8 Dialysis quality of care: Some measures show progress, others need improvement, 2017–2022

Outcome measure	2017	2021	2022
Share of in-center hemodialysis patients:			
Receiving adequate dialysis	98%	97%	97%
Dialyzed with an AV fistula	65	61	60
Share of peritoneal dialysis patients receiving adequate dialysis	93	91	91
Share of all dialysis patients managing anemia			
Mean hemoglobin < 10 g/dL	28	31	31
Mean hemoglobin 10 to <12 g/dL	67	63	63
Mean hemoglobin ≥ 12 g/dL	5	6	6
Share of all dialysis patients wait-listed for a kidney	14.3	12.4	12.1
Renal transplant rate per 100 patient years	3.5	4.1	4.2
Annual mortality rate per 100 patient years*	17.2	19.4	18.3
Total hospital admissions per patient year*	1.7	1.6	1.6
Hospital days per patient year*	11.4	11.5	11.8

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 the 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 have been at increased risk for COVID-19–associated morbidity and mortality.

> Between 2017 and 2022, 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 2017 and 2022. Although the reasons for the changes in 2021 and 2022 are uncertain, the coronavirus pandemic was likely a factor.

> Mortality rates decreased during 2021 and 2022 (data not shown). All-cause hospital admissions held steady between 2021 and 2022.

> We report access to kidney transplantation because it is widely believed to be the best treatment option for individuals with ESRD. Between 2017 and 2022, the share of dialysis patients accepted on the kidney transplant waiting list declined from 14.3 to 12.1, while the renal transplant rate per 100 dialysis-patient years increased from 3.5 to 4.2.

Chart 11-9 Hospice use increased in 2023

	2010	2019	2022	2023	Average annual change 2010–2022	Change 2022–2023
Medicare payments (in billions)	$12.9	$20.9	$23.7*	$25.7*	5.2%*	8.3%*
Beneficiaries in hospice (in millions)	1.15	1.61	1.72*	1.74*	3.4*	1.3*
Number of hospice days for all hospice beneficiaries (in millions)	81.6	121.8	130.2*	137.7*	4.0*	5.7*

Note: Total payments, number of hospice users, and number of hospice days displayed in the table are rounded; the percentage change 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 a CMS evaluation reports, 19,065 MA beneficiaries in 2022 and 23,828 MA beneficiaries in 2023 started hospice that year paid for by MA plans (Eibner, C., D. Khodyakov, E. A. Taylor, et al. 2025. *Evaluation of the Medicare Advantage value-based insurance design model test: 2020–2023*. 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/2025/vbid-2020-2023-eval-report.).

Source: MedPAC analysis of data from the Common Medicare Environment and hospice claims data from CMS.

> Total Medicare payments to hospices were about $25.7 billion in 2023, about 8 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 2023.

Chart 11-10 The share of decedents using hospice increased in 2023, returning to the prepandemic rate

	2010	2019	2022	2023	Average annual percent change 2010–2019	Average annual percent change 2019–2022	Percent change 2022–2023
Number of Medicare decedents (millions)	1.99	2.32	2.64	2.50	1.7%	4.3%	–5.2%
Number of Medicare decedents who used hospice (millions)	0.87	1.20	1.30	1.29	3.6	2.6	–0.3
Share of decedents who used hospice	43.8%	51.6%	49.1%	51.7%			

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 Environment and hospice claims data from CMS.

> In 2023, the share of decedents using hospice increased to 51.7 percent, as the number of beneficiaries who died in 2023 declined 5.2 percent and the number of decedents using hospice declined but to a lesser extent (0.3 percent).

> With the onset of the coronavirus pandemic, the hospice use rate declined in 2020 and 2021 but increased in 2022 and 2023. In 2023, the hospice use rate (51.7 percent) was similar to the prepandemic rate (51.6 percent in 2019).

> The decline in hospice use in 2020 and 2021 reflected the effects of the pandemic. 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 11-11 Share of decedents using hospice increased in 2023 among all beneficiary groups

	Share of decedents using hospice				Average annual percentage point change 2010–2022	Percentage point change 2022–2023
	2010	2019	2022	2023		
All	43.8%	51.6%	49.1%	51.7%	0.4	2.6
FFS beneficiaries	42.8	50.7	49.1	51.7	0.5	2.6
MA beneficiaries	47.2	53.2	49.2	51.7	0.2	2.5
Dually eligible	41.5	49.3	43.9	46.6	0.2	2.7
Non–dually eligible	44.5	52.4	51.1	53.6	0.6	2.5
Age (years)						
<65	25.7	29.5	26.6	28.6	0.1	2.0
65–74	38.0	41.0	37.7	40.2	0.0	2.5
75–84	44.8	52.2	49.4	51.9	0.4	2.5
85+	50.2	62.7	61.8	64.0	1.0	2.2
Race/ethnicity						
White	45.5	53.8	51.7	54.3	0.5	2.6
Black	34.2	40.8	37.4	39.7	0.3	2.3
Hispanic	36.7	42.7	38.2	40.4	0.1	2.2
Asian American	30.0	39.8	38.0	39.2	0.7	1.2
North American Native	31.0	38.5	37.2	39.4	0.5	2.2
Gender						
Male	40.1	46.7	43.9	46.3	0.3	2.4
Female	47.0	56.3	54.4	56.9	0.6	2.5
Beneficiary location						
Urban county	45.6	52.8	50.2	52.6	0.4	2.4
Rural county, micropolitan	39.2	49.7	47.3	50.1	0.7	2.8
Rural county, adjacent to urban	39.0	49.5	47.9	50.9	0.7	3.0
Rural county, nonadjacent to urban	33.8	43.8	42.1	44.9	0.7	2.8
Frontier county	29.2	36.2	35.3	37.1	0.5	1.8

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 Medicare, 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 Environment and hospice claims data from CMS.

> In 2023, hospice use rates among decedents increased among all beneficiary groups examined.

> In 2023, hospice use continued to vary by demographic and beneficiary characteristics. Medicare decedents who were older, White, female, living in an urban area, or not dually eligible were more likely to use hospice than their respective counterparts.

Chart 11-12 Number of hospice visits for beneficiaries receiving routine home care, 2019–2023

	2019	2021	2022	2023
Average number of visits per week				
All visits	4.3	3.8	3.9	3.9
Nurse visits	1.8	1.7	1.7	1.8
Aide visits	2.2	1.8	1.8	1.9
Social worker visits	0.3	0.3	0.3	0.3
Average length per visit (number of minutes)				
All visits	60	58	56	61
Nurse visits	57	55	54	61
Aide visits	63	61	60	61
Social worker visits	52	50	49	58
Average visit time per week (number of minutes)				
All visits	258	218	218	237
Nurse visits	104	94	93	107
Aide visits	137	111	111	116
Social worker visits	17	13	14	16

Note: Analysis includes only routine home care days and visits. "Visits" refers to in-person visits only and excludes postmortem visits. "Nurse visits" includes both registered nurse and licensed practical nurse visits. "Length per visit" is reported by providers in a number of 15-minute increments, rounded to the nearest 15-minute increment. We calculate visit time in minutes by multiplying the number of 15-minute increments by 15. Components of visits may not sum to total visits due to rounding.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file from CMS.

> In 2023, hospice enrollees received on average 3.9 visits per week, with nurse, aide, and social worker visits accounting for 1.8 visits, 1.9 visits, and 0.3 visits per week on average, respectively.

> The average length of hospice visits in 2023 was about an hour (61 minutes).

> Overall, the average amount of visit time hospice patients received per week in 2023 was about 237 minutes. On average, hospice patients received 107 minutes of nurse visits, 116 minutes of aide visits, and 16 minutes of social worker visits per week.

> The average number of in-person visits per week and/or length of visits generally declined during the pandemic. Subsequently, nurse and social worker visits rebounded to prepandemic levels, but the average number of aide visits per week in 2023 remained below the 2019 level.

Chart 11-13 Number of Medicare-participating hospices increased due to growth in for-profit hospices, 2019–2023

	2019	2022	2023
All hospices	4,840	5,899	6,535
For profit	3,434	4,581	5,068
Nonprofit	1,256	1,170	1,151
Government	148	138	136
Freestanding	3,937	5,076	5,567
Hospital based	428	382	365
Home health based	456	420	414
SNF based	19	17	17
Urban	3,973	5,051	5,701
Rural	861	834	833

Note: SNF (skilled nursing facility). 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). Some categories do not sum to totals because of missing data for some providers. Missing data on ownership and hospice type particularly affect the most recent year (2023), for which we lack data on ownership for 180 providers and the type of hospice for 172 providers.

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 6,535 Medicare-participating hospices in 2023, up nearly 11 percent from 2022 and 35 percent since 2019.

> In 2023, the number of for-profit hospices grew by more than 10 percent. Between 2022 and 2023, the number of hospices with nonprofit ownership or government ownership declined, continuing the downward trend observed from 2019 to 2022.

> The number of freestanding providers increased by almost 10 percent in 2023. The number of home health–based and hospital-based hospices declined in 2023, 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 was stable in 2023, after falling about 1 percent per year between 2019 and 2022. 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 overall 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 11-11).

Chart 11-14 Hospice cases by primary diagnosis, 2023

Diagnosis	Share of total cases
Alzheimer's, nervous system disorders, organic psychosis	23%
Cancer	23
Circulatory, except heart failure	22
Other	9
Heart failure	8
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 2023, not just decedents. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim in 2023. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file from CMS and the Medicare Beneficiary Database.

> In 2023, the most common primary diagnoses among Medicare hospice patients were neurological conditions (Alzheimer's disease, nervous system disorders, and organic psychosis accounted for 23 percent of cases), cancer (23 percent of cases), and circulatory conditions other than heart failure (22 percent of cases).

> Less than 1 percent of Medicare hospice patients had COVID-19 as their hospice primary diagnosis in 2023. An additional 3 percent of hospice patients had COVID-19 as a secondary diagnosis on their hospice claims in 2023 (data not shown).

Chart 11-15 Hospice average length of stay among decedents increased in 2023

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
2023	96.2	2	5	18	86	278

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 data from the Common Medicare Environment and the Medicare Beneficiary Database from CMS.

> The average length of stay among decedents was 96.2 days in 2023, up about 1 day from 2022. In 2023, the length of stay at the 50th percentile (the median) was stable at 18 days.

> Hospice lengths of stay vary broadly. In 2023, hospice length of stay among decedents ranged from 2 days at the 10th percentile to 278 days at the 90th percentile.

> Between 2010 and 2023, 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 278 days at the 90th percentile.

Chart 11-16 Hospice length of stay among decedents, by beneficiary and hospice characteristics, 2023

	Average length of stay (in days)	Percentiles of length of stay (in days)		
		10th	50th	90th
Beneficiary				
Diagnosis				
Cancer	51	3	15	124
Neurological	164	4	45	482
Heart/circulatory	106	2	19	317
COPD	131	3	30	381
Other	59	2	8	164
Site of service				
Home	97	4	25	265
Nursing facility	113	3	24	334
Assisted living facility	169	6	62	480
Hospice				
For profit	115	3	24	341
Nonprofit	72	2	13	198
Freestanding	98	2	19	287
Home health based	73	2	15	199
Hospital based	60	2	11	162

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2023 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, Medicare Beneficiary Database, Medicare hospice cost reports, and Provider of Services file 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.

> 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 11-17 About 60 percent of Medicare hospice spending in 2023 was for patients with stays exceeding 180 days

	Medicare hospice spending, 2023 (in billions)
All hospice users in 2023	$25.7
Beneficiaries with LOS > 180 days	15.6
Days 1–180	5.0
Days 181–365	4.8
Days 366+	5.8
Beneficiaries with LOS ≤ 180 days	10.1

Note: LOS (length of stay). "LOS" reflects the beneficiary's lifetime LOS as of the end of 2023 (or at the time of death or discharge in 2023 if the beneficiary was not enrolled in hospice at the end of 2023). All spending reflected in the chart occurred only in 2023.

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 2023, Medicare hospice spending on patients with stays exceeding 180 days was $15.6 billion, about 60 percent of all Medicare hospice spending that year.

> About $5.8 billion, or about 23 percent, of Medicare hospice spending in 2023 was on hospice care for patients who had already received at least one year of hospice.

Chart 11-18 Hospice Medicare aggregate margins, 2018–2022

	Share of hospices (2022)	Share of patients (2022)	Medicare margin				
			2018	2019	2020	2021	2022
All	100%	100%	12.4%	13.4%	14.2%	13.3%	9.8%
Freestanding	86	83	15.1	16.2	16.7	15.5	12.4
Home health based	7	9	8.4	9.7	11.2	10.9	3.8
Hospital based	6	8	–16.5	–18.4	–18.2	–15.6	–23.5
For profit	78	55	19.0	19.2	20.5	19.2	16.1
Nonprofit	20	43	3.8	6.1	5.8	5.2	0.3
Government	2	2	N/A	N/A	N/A	N/A	N/A
Urban	86	89	12.6	13.6	14.3	13.4	10.0
Rural	14	11	10.3	11.5	13.5	12.3	8.1
Below cap	77	94	12.6	13.8	14.8	14.0	10.8
Above cap	23	6	10.3	10.0	7.7	2.5	–1.6
Above cap (including cap overpayments)	23	6	21.8	22.5	22.8	21.8	18.5
Share of stays > 180 days							
Lowest quintile	20	27	–3.0	–2.5	–0.4	0.0	–4.1
Second quintile	20	29	8.5	10.3	11.8	11.1	8.2
Third quintile	20	20	16.8	19.9	20.0	20.5	17.8
Fourth quintile	20	17	20.8	22.8	24.1	22.2	18.6
Highest quintile	20	7	17.6	13.4	13.4	9.7	2.7

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).

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims standard analytic file, and Medicare Provider of Services file from CMS.

> The fee-for-service aggregate Medicare margin was 9.8 percent in 2022, down from 13.3 percent in 2021.

> In 2022, freestanding hospices had higher margins (12.4 percent) than home health–based (3.8 percent) and hospital-based (–23.5 percent) hospices.

> The 2022 margin among for-profit hospices was high at 16.1 percent. Nonprofit hospices as a group had a margin of 0.3 percent in 2022, but the subset of nonprofit hospices that were freestanding had a higher margin, 5.1 percent (latter figure not shown).

> The aggregate 2022 margin was slightly higher for urban hospices (10.0 percent) than rural hospices (8.1 percent).

> Hospices that exceeded the cap (Medicare's aggregate average per beneficiary payment limit) had a 2022 margin of about 18.5 percent before and –1.6 percent after the return of the cap overpayments.

> Hospices with more patients whose stays were longer than 180 days generally had higher margins in 2022. Hospices in the lowest length-of-stay quintile had a margin of –4.1 percent, compared with an 18.6 percent margin for hospices in the second-highest length-of-stay quintile. Margins were lower in the highest quintile (2.7 percent) because some hospices in this quintile exceeded Medicare's aggregate payment cap and were required to repay the overage.

Chart 11-19 Hospices that exceeded Medicare's annual payment cap, 2018–2022

	2018	2019	2020	2021	2022
Share of hospices exceeding the cap	16.3%	19.0%	18.6%	18.9%	22.6%
Average payments over the cap per hospice exceeding the cap (in thousands)	$334	$384	$422	$451	$419
Payments over the cap as a share of overall Medicare hospice spending in cap year	1.3%	1.7%	1.8%	2.0%	2.3%

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. 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, Medicare hospice cost reports, and Medicare Provider of Services file from CMS.

> The hospice aggregate cap is a limit on the average annual payment per beneficiary that a hospice provider can receive. If a hospice's total payments exceed its total number of Medicare patients multiplied by the cap amount ($34,465.34 for fiscal year 2025), it must repay the difference.

> An estimated 22.6 percent of hospices exceeded the aggregate cap in 2022, up from 18.9 percent in 2021.

> On average, above-cap hospices exceeded the cap by approximately $419,000 per provider in 2022, down from about $451,000 per provider in 2021.

> Medicare payments over the cap represented 2.3 percent of total Medicare hospice spending in 2022.

Chart 11-20 Hospice live-discharge rates, 2021–2023

	2021	2022	2023
Live discharges as a share of all discharges, by reason for live discharge			
All live discharges	17.2%	17.3%	18.5%
No longer terminally ill	6.3	6.1	6.2
Beneficiary revocation	6.3	6.1	6.7
Transfer hospice providers	2.4	2.4	2.6
Move out of service area	2.0	2.3	2.7
Discharge for cause	0.3	0.3	0.4
Providers' overall rate of live discharge as a share of all discharges, by percentile (for providers with more than 30 discharges)			
10th percentile	8.5	8.3	8.6
25th percentile	12.5	12.2	13.2
50th percentile	19.1	19.2	20.7
75th percentile	30.2	29.9	33.3
90th percentile	50.0	49.9	56.1

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.

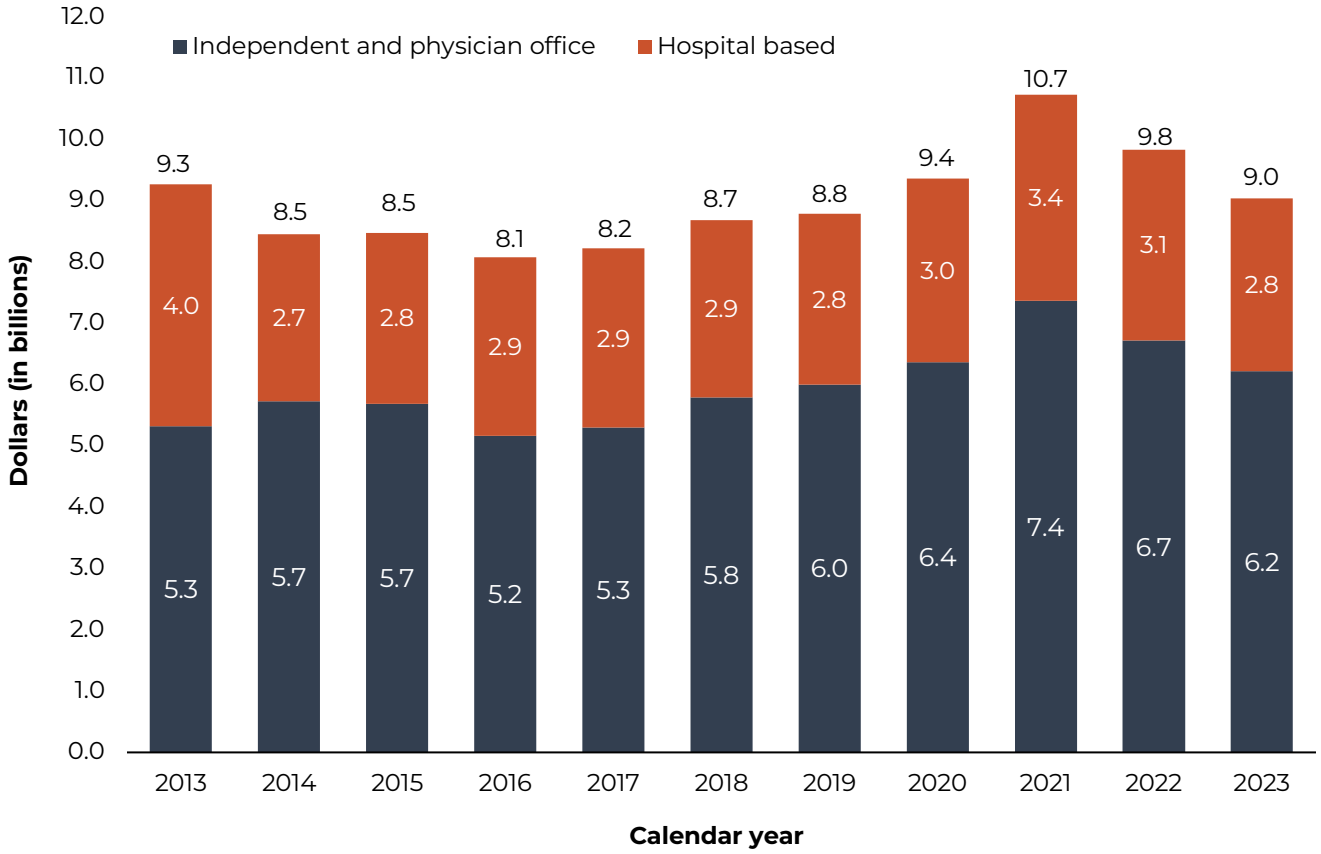
> In 2023, the overall live-discharge rate was 18.5 percent, up from 17.3 percent in 2022.

> The most common reasons for live discharge were the beneficiary revoking the hospice benefit and the beneficiary no longer being terminally ill, accounting for 6.7 percent and 6.2 percent of all discharges in 2023, respectively. 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 56.1 percent or more in 2023.

> Small hospices as a group have substantially higher live-discharge rates than larger hospices. In 2023, the aggregate live-discharge rate was 56.4 percent for hospices with 30 or fewer discharges, in contrast to a 18.5 percent aggregate live-discharge rate for all hospices (data for small hospices not shown).

Chart 11-21 Medicare spending for clinical laboratory tests, 2013–2023



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, 2022 and 2023.

> From 2013 to 2014, Medicare spending for laboratory tests declined by about 9 percent because, since 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 coronavirus public health emergency, lab spending increased in 2020 and 2021, then declined in later years.

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