MEDPAC

Advising the Congress on Medicare issues

Context for Medicare payment policy

Rachel Burton, Alexandra Harris, et al.

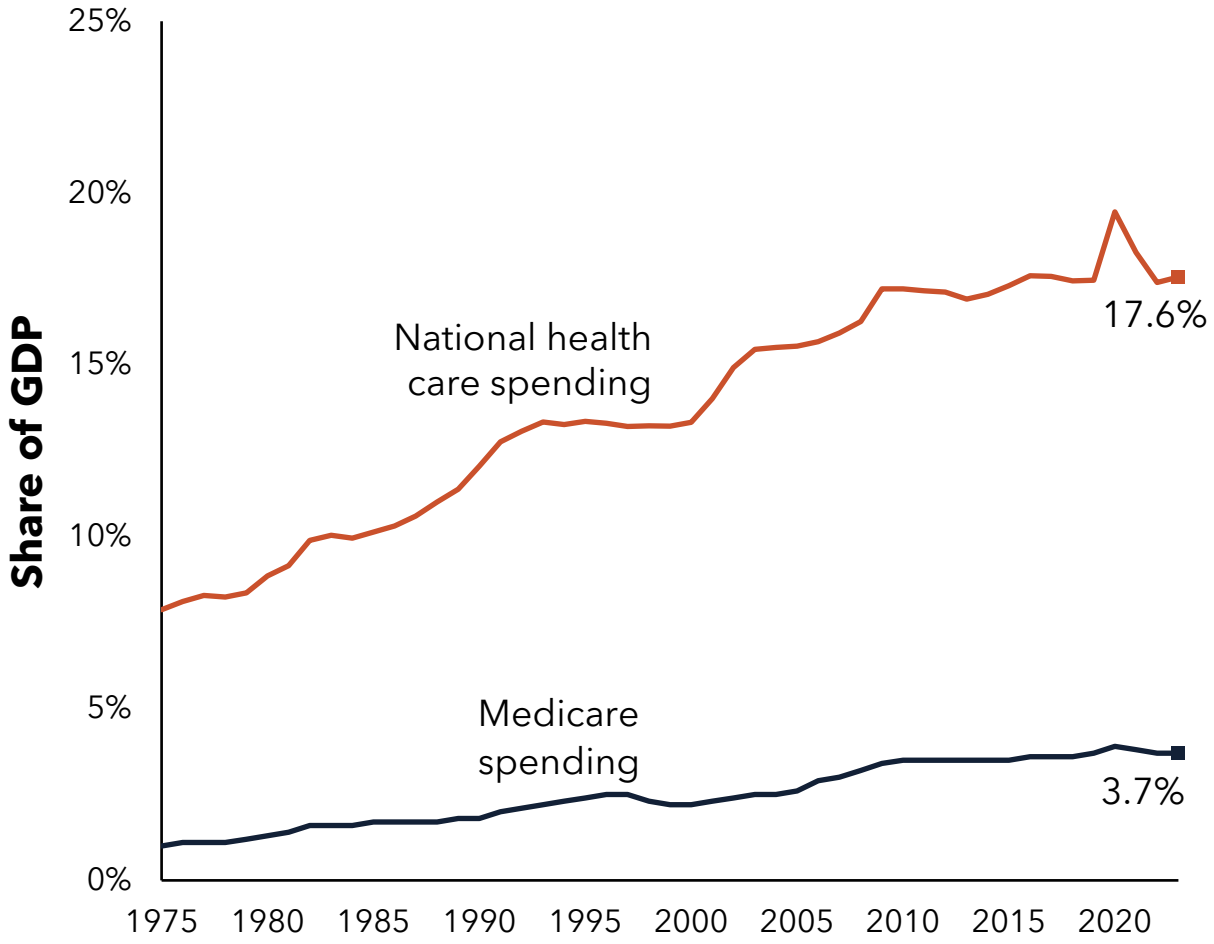
September 4, 2025

Presentation roadmap

1. Spending trends
2. Drivers of Medicare's spending growth
3. Medicare's funding sources
4. Provider consolidation continues to increase across sectors
5. The health care staff workforce
6. Discussion

Spending trends

In 2023, national health care spending returned to historical norms—growing faster than GDP

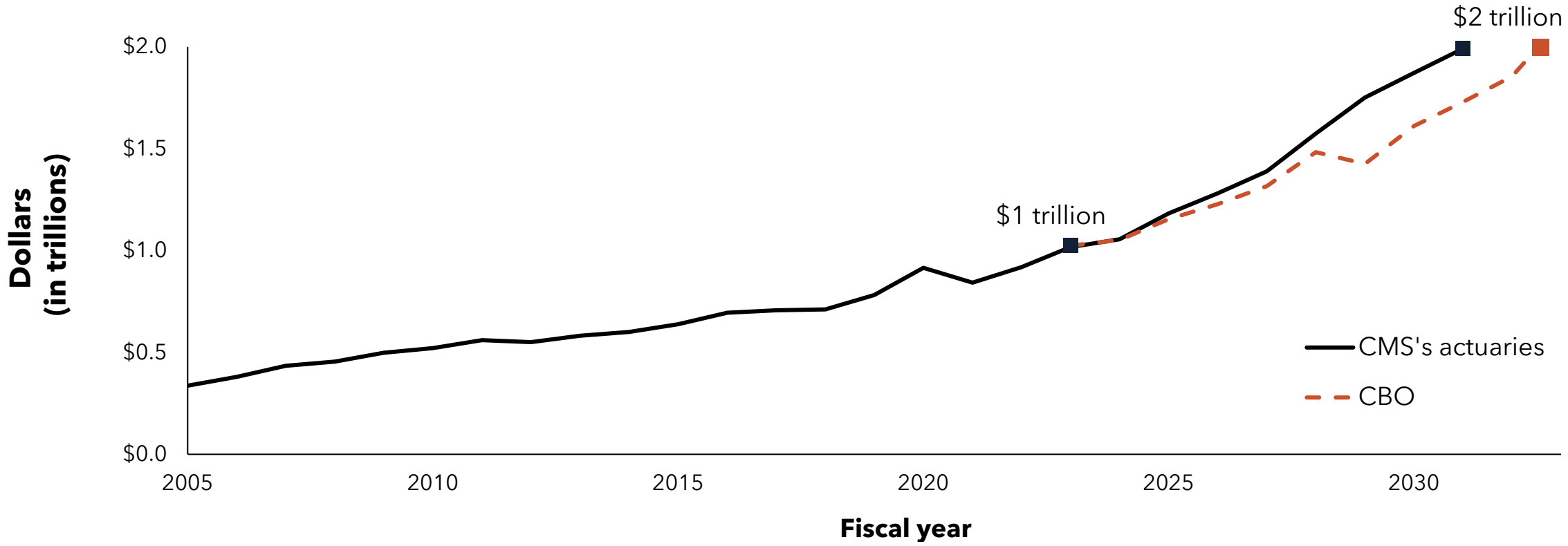


- In 2023, U.S. spent $5 trillion on health care (17.6% of GDP)
- National health care spending accelerated in 2023 because:
  - Share of U.S. with insurance reached all-time high of 92.5%
  - Volume and intensity of services delivered per patient grew
  - Service utilization rebounded after the pandemic

Note: GDP (gross domestic product). Medicare spending excludes COVID-19 Accelerated and Advance Payments (short-term loans) since this graph shows expenditures on an incurred basis rather than a cash basis.

Source: MedPAC analysis of CMS's national health expenditure data.

Medicare spending is projected to grow from $1 trillion in 2023 to $2 trillion by 2031 or 2033

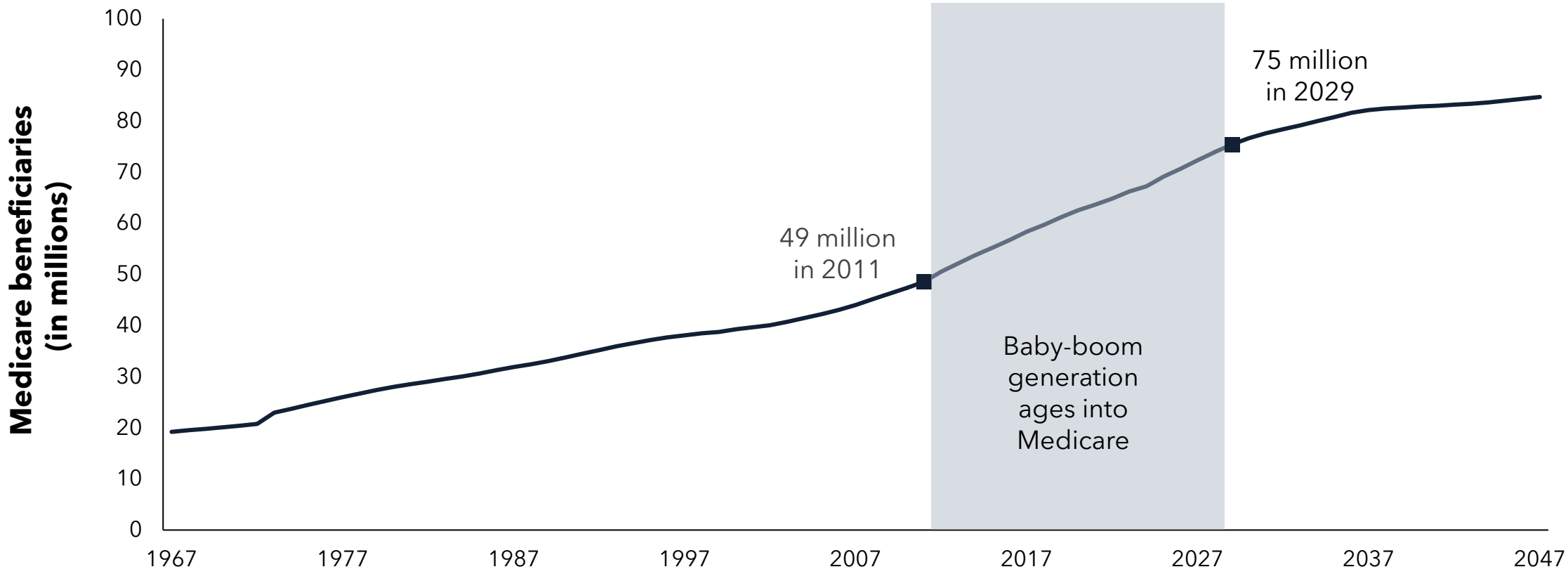


Note: CBO (Congressional Budget Office). The first projected year in the graph is 2024 for the CBO line and 2025 for the CMS's actuaries line. The sharp increase in spending in 2020 includes $104 billion in Medicare Accelerated and Advance Payments paid to providers that were then recouped by the Medicare program in 2021, 2022, and 2023. The 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. Amounts include Medicare program spending and beneficiaries' premiums but not beneficiaries' cost sharing.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds; CBO's June 2024 baseline projections for the Medicare program.

Drivers of Medicare's spending growth

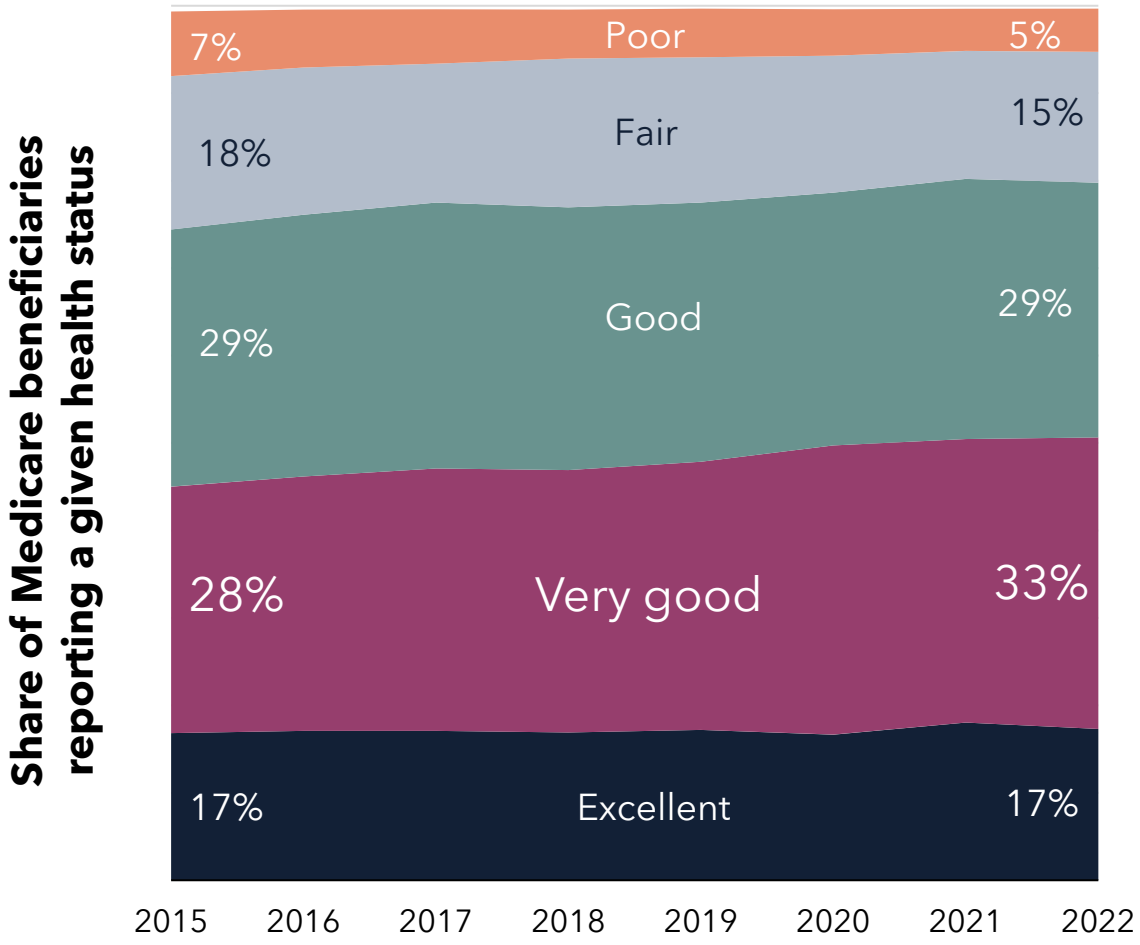
Medicare spending growth has been partly driven by the baby-boom generation aging into Medicare



Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). First projected year is 2025. In 2024, there were 67 million Medicare beneficiaries.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds.

Demographic mix of beneficiaries in Medicare has not been a driver of recent Medicare spending



- The average beneficiary who survived the pandemic is healthier than the average pre-pandemic beneficiary
- The average beneficiary has been getting younger and healthier
- A declining share of beneficiaries have been qualifying for Medicare due to disability

Note: Survey asked respondents to characterize their health compared with other people their age. The health status of beneficiaries residing in facilities was reported by a proxy respondent (e.g., a nurse). Includes beneficiaries in traditional fee-for-service Medicare and Medicare Advantage enrollees. Respondents who did not know their health status or refused to answer are not shown above but were included in the denominator of these percentages.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2015–2022.

Medicare price growth is not expected to be a major driver of Medicare spending growth

CMS actuaries' projections of drivers of Medicare's spending growth (not including inflation), 2025–2034

	Average annual percentage change in:				
	Medicare prices (minus inflation)	**Number of beneficiaries**	**Beneficiary demographic mix**	**Other (e.g., volume and intensity of services used)**	**Medicare's projected spending (minus inflation)**
Part A	–0.3%	1.8%	0.4%	1.8%	3.6%
Part B	–1.0	1.9	0.1	4.5	5.5
Part D	–1.3	2.0	–0.2	1.0	1.6
Total	–0.8	1.9*	0.2	3.0	4.3

Note: Includes fee-for-service and 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. "Other (e.g., volume and intensity of services used)" refers to the residual after the other three factors shown in the table (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 2024.
* Calculated by MedPAC; CMS actuaries do not calculate the average annual percentage change in the "number of beneficiaries" in the Trustees' report because there is beneficiary overlap in enrollment in Part A, Part B, and Part D.

Source: MedPAC analysis of data from the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

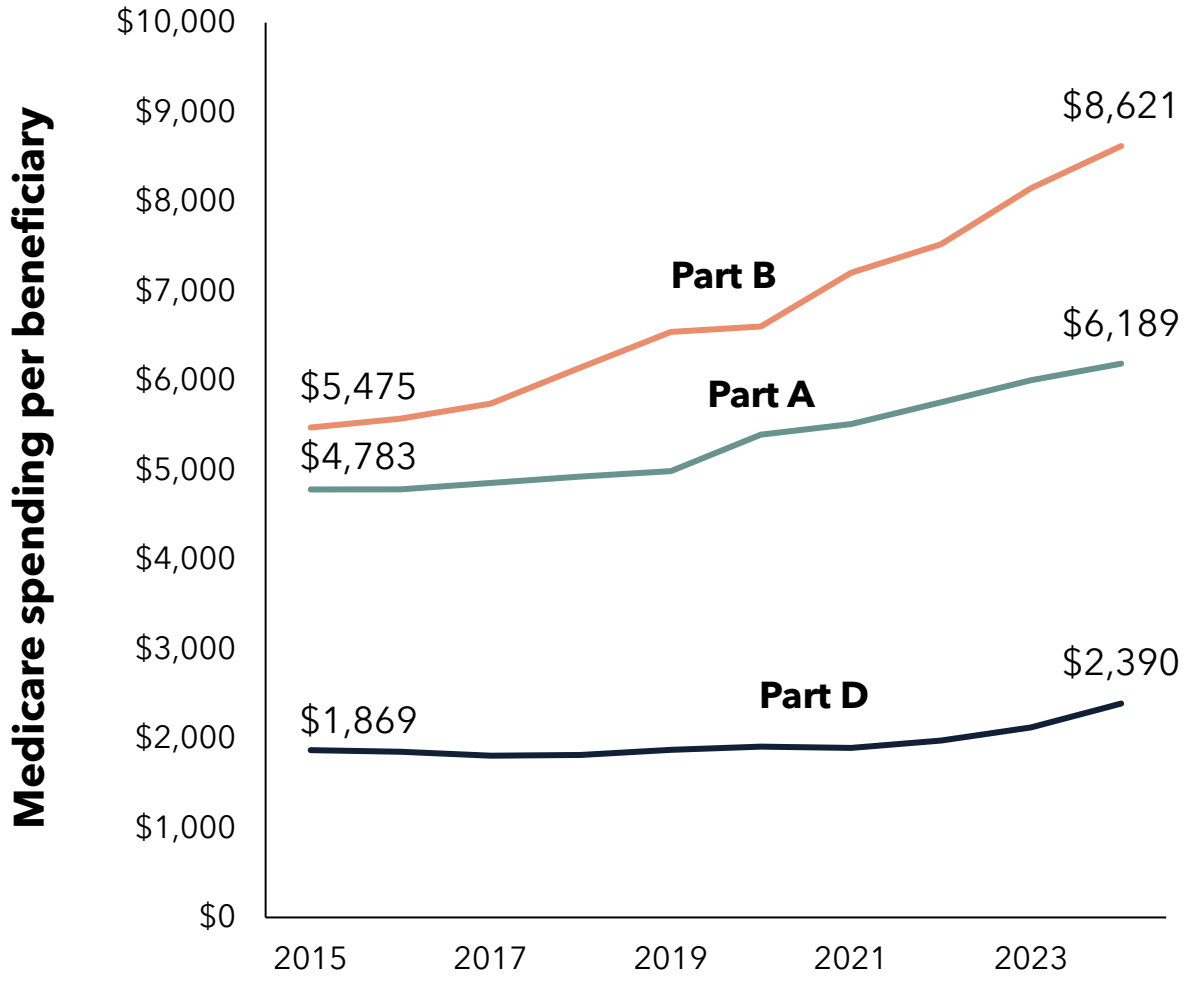
The volume and intensity of services delivered to Medicare beneficiaries

- In recent years, the volume of services delivered per beneficiary:
  - Increased for some Part B services (clinician services, Part B drugs)
  - Decreased for some Part A services (inpatient hospital stays, SNF care)
- "Intensity" is harder to measure, but includes when:
  - A more expensive drug is furnished instead of a less expensive option
  - A new technology uncovers more medical issues that are then worked up
- CMS actuaries project volume and intensity and other factors to increase by an average of 3% per year over the next decade

Note: SNF (skilled nursing facility).
Source: MedPAC. (2025). *Report to the Congress: Medicare payment policy*; the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

Medicare's funding sources

The mix of services Medicare beneficiaries receive has been shifting in recent years

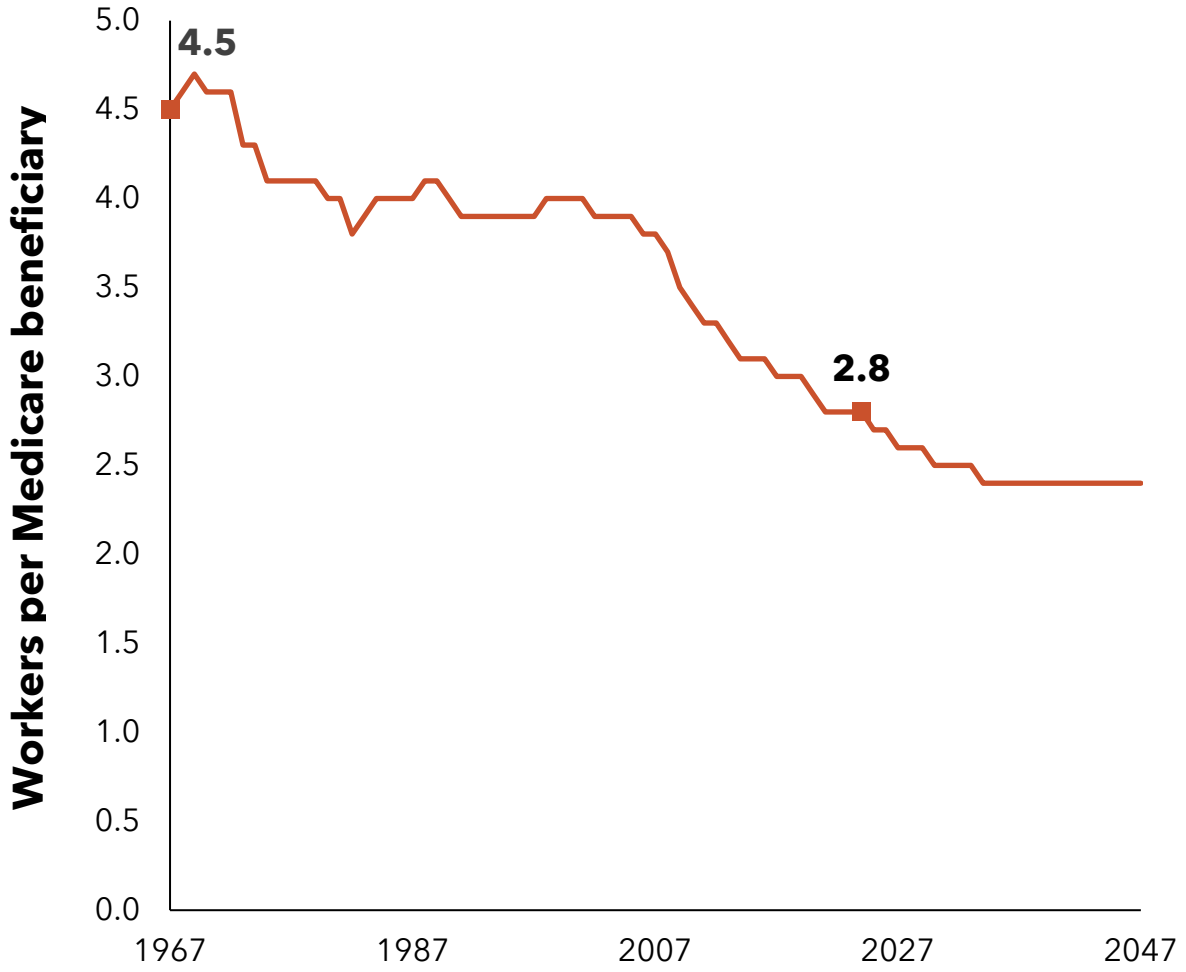


- Because different types of services are financed through different mechanisms:
  - As growth in spending on Part A slows, it reduces the share of Medicare spending funded by Medicare payroll taxes
  - As growth in spending on Part B accelerates, it increases the share of Medicare spending funded by general revenues and beneficiary premiums

Note: Includes enrollees in Medicare Advantage and fee-for-service Medicare. Calculated as nominal spending (not adjusted for inflation) for each respective Medicare part divided by the number of beneficiaries enrolled in that part.

Source: MedPAC analysis of data from the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

Slower growth in Part A means Medicare does not need to rely as much on the Medicare payroll tax

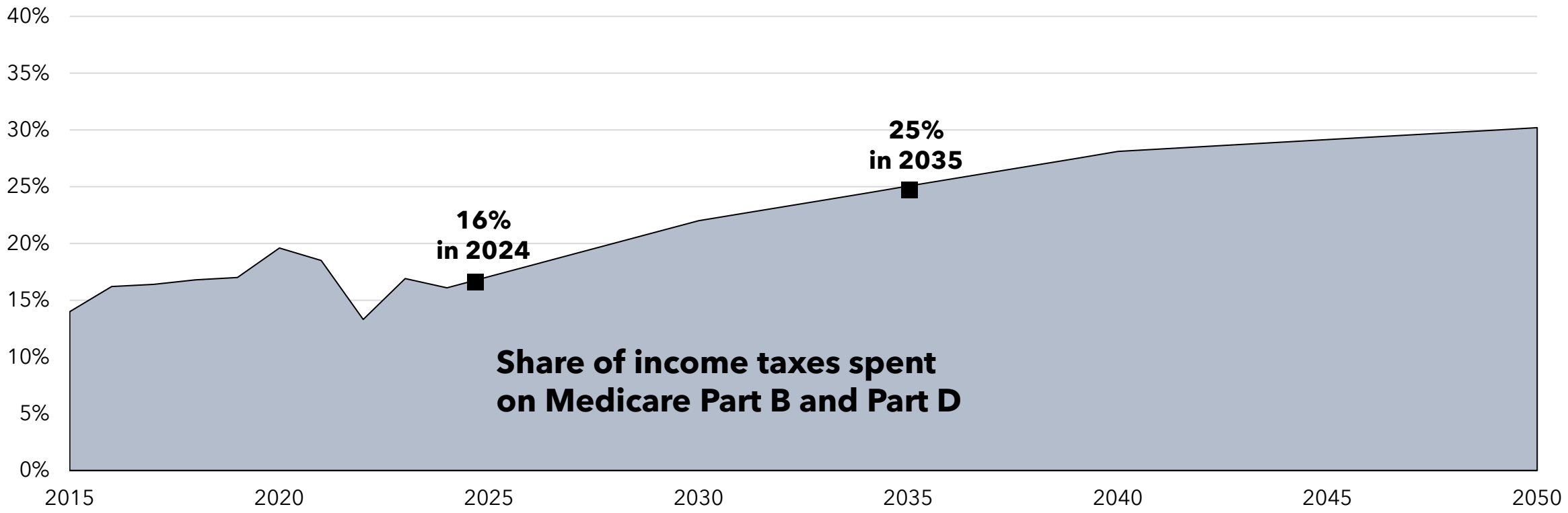


- Medicare's Part A trust fund projected to remain solvent until:
  - 2052 per CBO
  - 2033 per CMS actuaries
    - CMS actuaries assume Medicare spending will be 9% higher and Medicare income will be 1% lower in 2024–2034 than CBO does

Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). First projected year is 2025.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds; CBO (March 2025). *The long-term budget outlook: 2025 to 2055;* Spitalnic, P. (June 22, 2025). A summary of the 2025 Trustees report. https://www.aei.org/wp-content/uploads/2025/06/AEI-TR25.pptx?x85095.

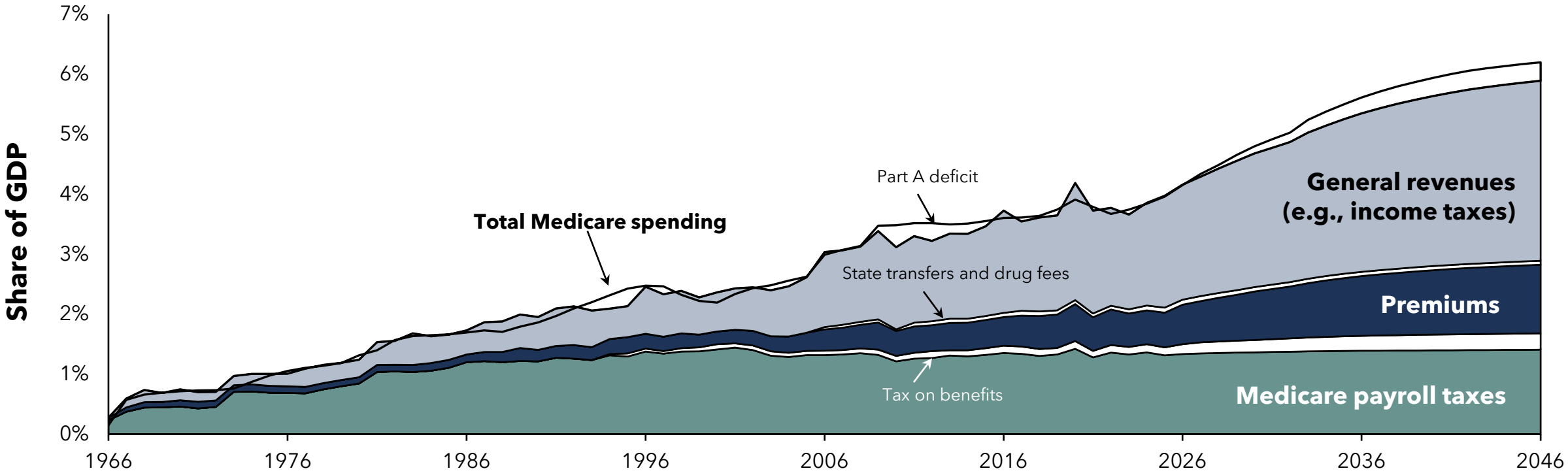
Growth in Part B spending requires a growing share of federal income taxes to pay for Medicare



Note: Includes both personal and corporate income tax revenues, which are the main source of general revenues. General revenues also include customs duties, leases of government-owned land and buildings, the sale of natural resources, usage and licensing fees, and payments to agencies. First projected year is 2025.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds, Table II.F3.

Growth in Part B spending has caused general revenues to become Medicare's largest funding source



Note: GDP (gross domestic product). First projected year is 2025. "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. Graph does not include interest earned on trust-fund investments.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds.

As Medicare Part B spending grows, beneficiaries' premiums and cost sharing go up

For a beneficiary in FFS Medicare:

$2,220	Part B premiums (2025)
$468	Part D premiums (2025)
$396	Part A cost sharing (2021)
$1,621	Part B cost sharing (2021)
$492	Part D cost sharing (2023)
~$5,000	Total premiums & cost sharing

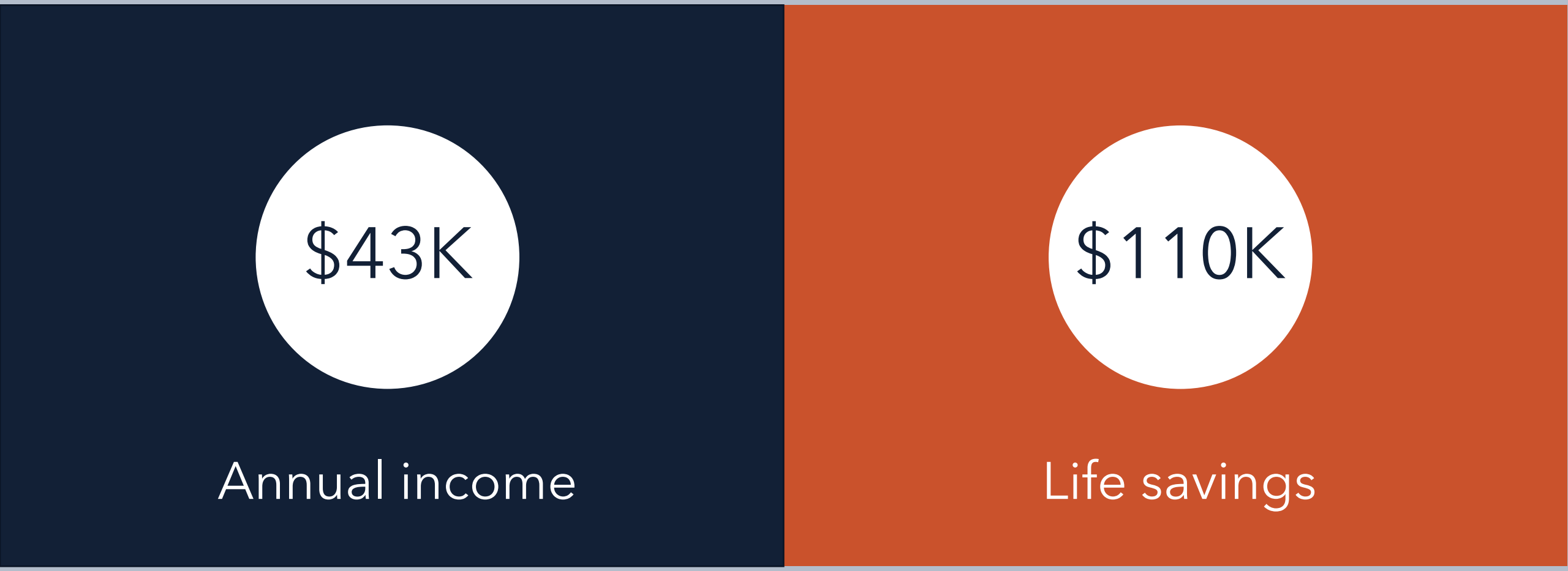
Note: FFS (fee-for-service). Most amounts are annual averages, but "Part B premiums" is the annual cost of the standard Part B premium (without the income-related adjustment that affects the highest-income 8% of beneficiaries with Part B).

Source: CMS. (2024). 2025 Medicare Parts A & B premiums and deductibles. https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles.

MedPAC. (2025). *A data book: Health care spending and the Medicare program*. https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_SEC.pdf.

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-programstatistics-medicare-part-a-part-b-all-types-of-service.

The typical beneficiary has relatively modest resources to draw on when paying premiums and cost sharing, 2024

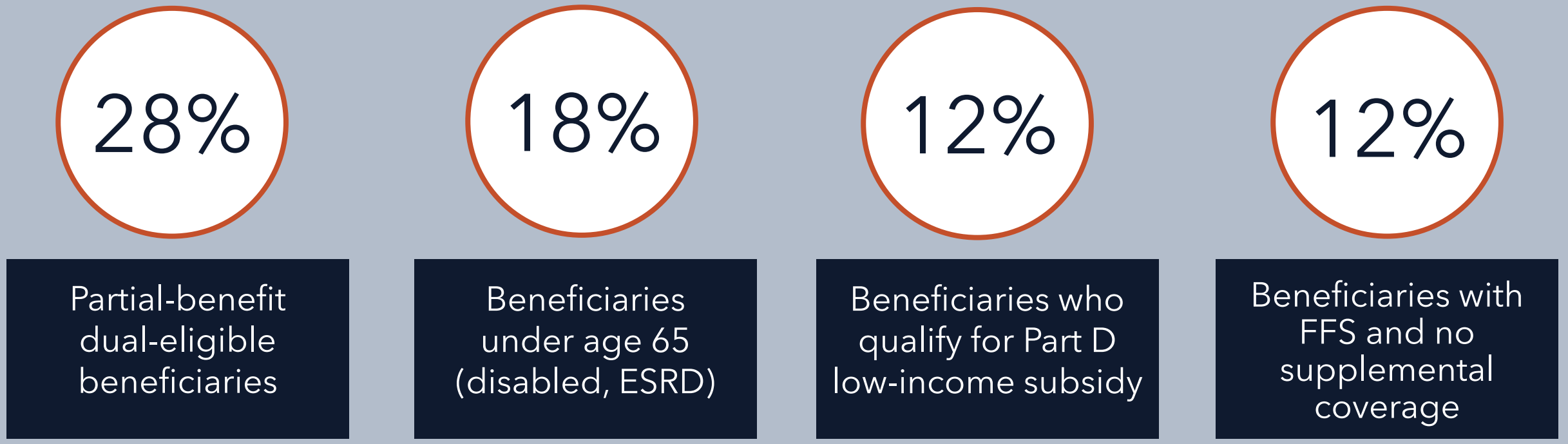


Note: Medians for all Medicare beneficiaries. Median home equity (not shown) is estimated to be $128K. Estimates were produced using the Urban Institute's DYNASIM model.

Source: Cottrill, A., J. Cubanski, T. Neuman, and Karen Smith (KFF). (2025). *Income and assets of Medicare beneficiaries in 2024.* https://www.kff.org/medicare/income-and-assets-of-medicare-beneficiaries.

Some beneficiaries have difficulty affording health care

Share of beneficiaries who reported a problem paying a medical bill, 2022



Note: ESRD (end-stage renal disease), FFS (fee-for-service). Partial-benefit dual-eligible beneficiaries receive Medicaid assistance with premiums and, in some cases, cost sharing but do not qualify for additional Medicaid benefits that full-benefit dual-eligible beneficiaries receive, such as dental care and nonemergency medical transportation. Beneficiaries qualify for the Part low-income subsidy if they receive full or partial Medicaid benefits or Supplemental Security Income payments and/or have income and assets below specified levels.

Source: MedPAC analysis of noninstitutionalized beneficiaries' experiences in CMS's 2022 Medicare Current Beneficiary Survey.


Provider consolidation
continues to increase
across sectors

Consolidation trends

- Horizontal mergers and vertical acquisitions continue:
  - As of 2024, 63% of hospital markets are "super concentrated," and only 42% of physician practices are owned solely by physicians
- Payers operating in MA and commercial markets are increasingly acquiring providers
- Growth of PE investment in provider organizations is notable:
  - PE firms appear to target high-revenue specialty practices
  - 44% increase in number of PE-owned physician practices from 2022 to 2024

Note: MA (Medicare Advantage), PE (private equity), PCP (primary care provider). "Super" concentrated markets have a Herfindahl–Hirschman Index above 5,000.
Sources: Abdelhadi et al. 2024. Private equity-acquired physician practices and market penetration increased substantially, 2012–21. *Health Affairs*; Adler et al. 2023. Measuring private equity penetration and consolidation in emergency medicine and anesthesiology. *Health Affairs Scholar*; Godwin et al. 2024. One or two health systems controlled the entire market for inpatient hospital care in nearly half of metropolitan areas in 2022. Washington, DC: KFF; Kane, CK. 2024. Physician practice characteristics in 2024: Private practices account for less than half of physicians in most specialties. American Medical Association; Singh et al. 2024. Life cycle of private equity investments in physician practices: An overview of private equity exits. *Health Affairs Scholar*.

Motivations for provider consolidation

- Consolidated providers gain bargaining power with commercial payers
- Some consolidated providers can leverage site-based payment differentials to maximize Medicare payments
- Payer–provider consolidation can generate more intense diagnosis coding, yielding higher payments to payers and providers in capitated models
- Consolidated providers may also:
  - Encourage patient referrals within integrated system
  - Improve care coordination and efficiency of care delivery

Note: MA (Medicare Advantage).
Source: Adler et al. 2023. Measuring private equity penetration and consolidation in emergency medicine and anesthesiology. *Health Affairs Scholar*; Berenson, RA. 2017. A physician's perspective on vertical integration. *Health Affairs;* Harris et al. 2025. Cost, quality, and utilization after hospital-physician and hospital-post acute care vertical integration: a systematic review. *Medical Care Research and Review*; Singh et al. 2024. Life cycle of private equity investments in physician practices: An overview of private equity exits. *Health Affairs Scholar*.

Consolidation leads to higher payment rates and spending

- Horizontal mergers and vertical acquisitions lead to higher payment rates:
  - Hospital–physician vertical integration results in higher Part B drug spending
- Payer–provider consolidation is associated with more intense diagnosis coding
- PE–provider consolidation is associated with higher commercial prices

Note: MA (Medicare Advantage), PE (private equity).
Source: Arnold et al. 2025. New evidence on the impacts of cross-market hospital mergers on commercial prices and measures of quality. *Health Services Research;* Curto et al. 2025. Coding intensity variation in Medicare Advantage. Health Affairs Scholar; Geruso and Layton, 2020. Upcoding: Evidence from Medicare on squishy risk adjustment. *Journal of Political Economy;* Jung et al. 2019. The impact of integration on outpatient chemotherapy use and spending in Medicare. *Health Economics;* Levin et al. 2025. Impact of hospital-physician vertical integration on physician-administered drug spending and utilization. *Health Economics;* Lin et al. 2023. Private equity and healthcare firm behavior: Evidence from ambulatory surgery centers. *Journal of Health Economics;* Singh et al. 2025. Growth of private equity and hospital consolidation in primary care and price implications. *JAMA Health Forum.*

Effect of consolidation on access to care

- Mixed, limited evidence on how consolidation impacts access to care:
  - Hospital–physician integration may improve access for medically complex and socioeconomically disadvantaged patients, but other studies have found no change in access
  - No evidence has been found of how payer–provider consolidation affects access
  - PE–provider consolidation increases some service lines (e.g., robotic surgery, hemodialysis, and physician-administered drugs) and reduces other services (e.g., outpatient psychiatric care, retinal detachment surgery)

Source: Alinezhad et al. 2024. Physician selection for hospital integration: Theoretical considerations and empirical findings. *Health Care Management Review*; Braun et al. 2024. Association of private equity firm acquisition of ophthalmology practices with Medicare spending and use of ophthalmology services. *Ophthalmology;* Cerullo et al. 2021. Private equity acquisition and responsiveness to service-line profitability at short-term acute care hospitals. *Health Affairs*; Post et al. 2025. Impact of hospital-physician integration on Medicare patient mix. *American Journal of Managed Care;* Singh et al. 2025. Private equity-owned physician practices decreased access to retinal detachment surgery, 2014–22. *Health Affairs*.

Effect of consolidation on quality remains ambiguous

- Hospital mergers generally associated with little to no effect on mortality but inconsistent findings across other outcomes
- Hospital–physician and hospital–PAC consolidation associated with modest improvements in condition-specific process measures but little to no effect on mortality, readmission, or ED visit rates
- Provider-owned MA plans associated with modest improvements in patient experience
- PE–provider consolidation associated with lower patient experience and no change in postoperative complication rates

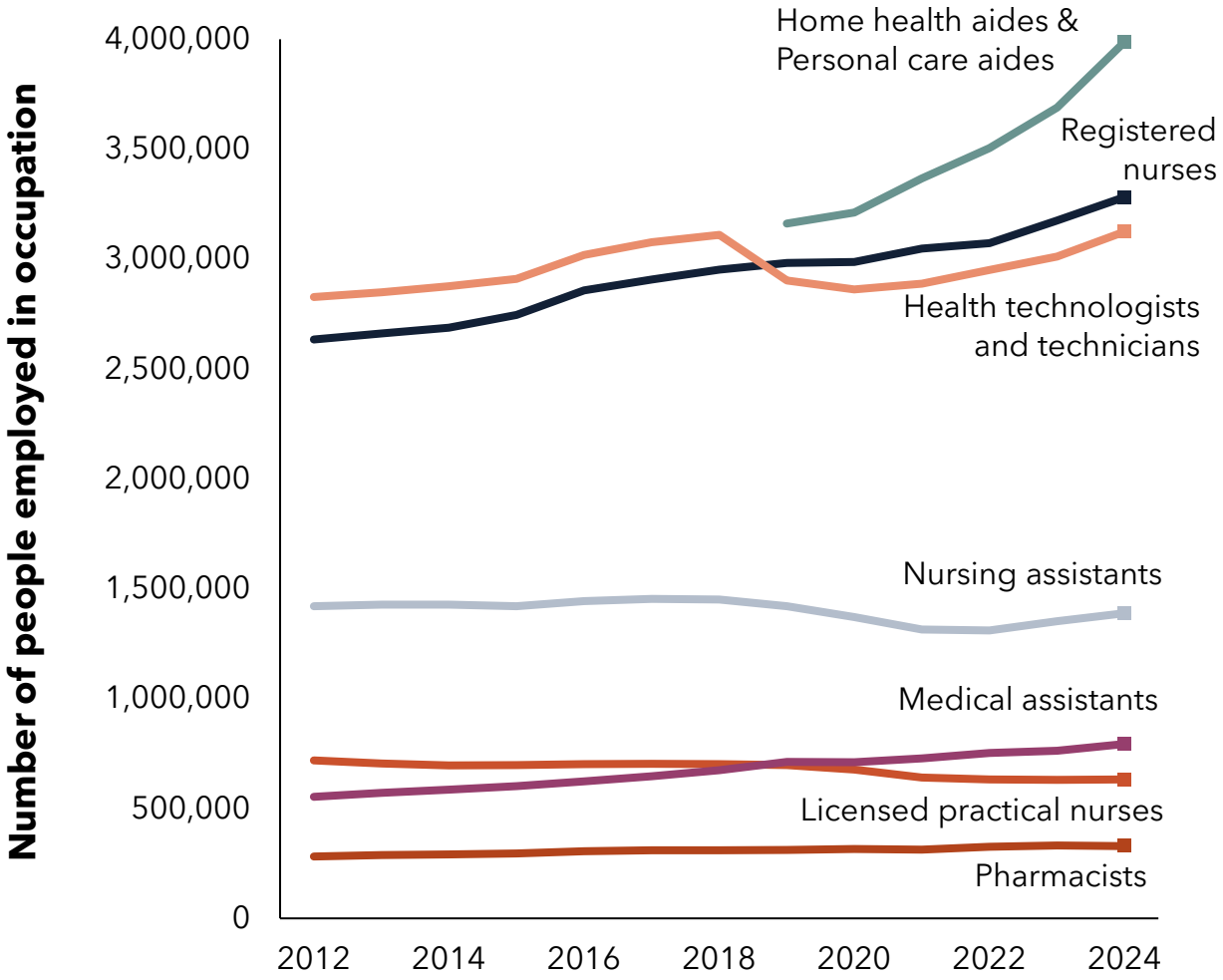
Note: PAC (post-acute care), ED (emergency department), MA (Medicare Advantage), PE (private equity).
Source: Arnold et al. 2025. Private equity acquisition of gastroenterology practices and colonoscopy price and quality. *JAMA Health Forum*; Beaulieu et al. 2020. Changes in quality of care after hospital mergers and acquisitions. *New England Journal of Medicine*; Bejarano et al. 2024. Medicare Advantage plan and health system vertical integration, 2011–2020. *JAMA Network Open;* Bhatla et al. 2025. Changes in patient care experience after private equity acquisition of U.S. hospitals. *JAMA;* Harris et al. 2025. Cost, quality, and utilization after hospital-physician and hospital-post acute care vertical integration: a systematic review. *Medical Care Research and Review;* Tsai et al. 2025. Clinical outcomes and profitability following rural hospital mergers and acquisitions. *Journal of Rural Health*.

The health care staff workforce

Nearly 2 million physicians and other practitioners work with over 14 million health care staff

- "Health care staff" here refers to:
  - Pharmacists
  - Therapists (physical, occupational, speech-language) in certain clinical settings
  - Nurses (registered nurses (RNs), licensed practical nurses (LPNs))
  - Health technicians and technologists (e.g., medical sonographers)
  - Direct care workers (nursing assistants, home health aides, personal care aides)
- Training requirements range from:
  - On-the-job training
  - Graduate degrees after college

Some occupations have grown more quickly than others

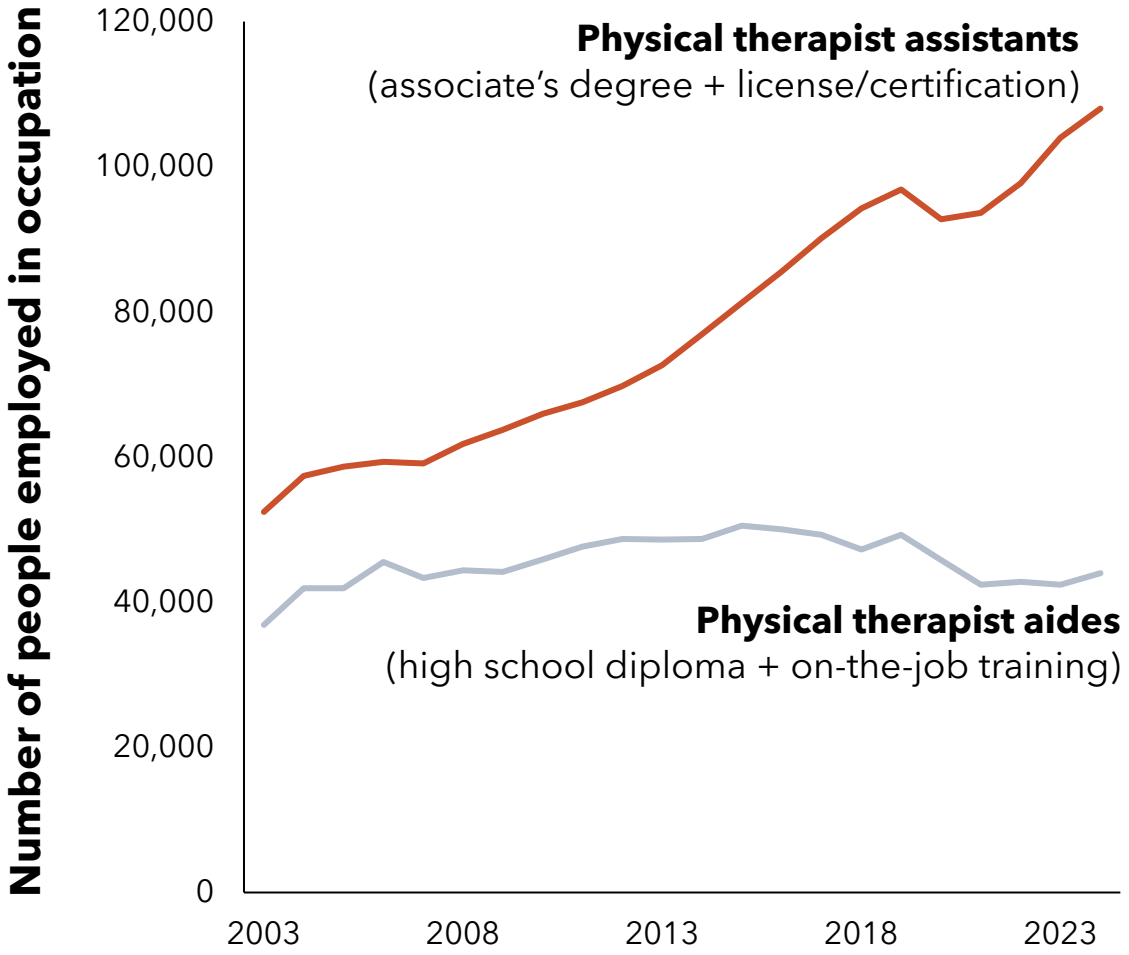


The composition of the health care staff workforce changes over time as the numbers of people employed in some occupations increase and the numbers in others decrease

Note: Occupations with fewer workers are not shown (e.g., physical therapists, 248,630; health care social workers, 185,940; speech–language pathologists, 178,790; occupational therapists, 152,280). "Licensed practical nurses" includes licensed vocational nurses. Before 2019, the numbers of home health aides and personal care aides were measured differently. "Nursing assistants" provide basic care (e.g., monitoring vital signs and reporting changes to a nurse) and assist with activities of daily living; "home health aides & personal care aides" help with these tasks as well as other tasks such as scheduling appointments, doing dishes and laundry, and shopping for groceries and preparing meals. Excludes self-employed workers.

Source: U.S. Bureau of Labor Statistics' Occupational Employment and Wage Statistics Tables for 2012–2024, https://www.bls.gov/oes/tables.htm.

Employers are increasingly hiring health care staff with more training



- Trend observed for:
  - Physical therapist assistants and physical therapist aides
  - Occupational therapist assistants and occupational therapist aides
  - Pharmacy technicians and pharmacy aides
  - Registered nurses and licensed practical nurses

Note: Physical therapist assistants usually have an associate's degree and a license or certification, while physical therapist aides usually have only a high school diploma and on-the-job training. Similar shifts have occurred for occupational therapist assistants and aides, pharmacy technicians and aides, and registered nurses and licensed practical nurses.

Source: U.S. Bureau of Labor Statistics' Occupational Employment and Wage Statistics Tables for 2012–2024, https://www.bls.gov/oes/tables.htm.

Wages vary by educational requirements, clinical setting, and geography

- Wages tend to be higher if more years of education are required (e.g., pharmacists)
- Some occupations' wages are higher in certain clinical settings:
  - Hospitals pay more than other settings for pharmacists, RNs, social workers, direct care workers
  - Skilled nursing facilities & home health agencies pay more for physical and occupational therapists, speech–language pathologists, LPNs
- Health care staff wages tend to be higher in high-cost areas (e.g., CA)
  - Unlike wages of physicians (e.g., ND, SD)

Source: U.S. Bureau of Labor Statistics (BLS), Occupational Employment and Wage Statistics Tables for 2012-2024; MedPAC analysis of BLS data on annual median wages for various types of health care support staff in different clinical settings (general medical and surgical hospitals, nursing care facilities (skilled nursing facilities), home health care services, and offices of physicians) and different geographic areas of the U.S.

Note: RN (registered nurse), LPN (licensed practical nurse).

Issue: High turnover among direct care workers, such as nursing assistants in nursing homes

- Direct care workers are a focus in the literature due to high turnover and the link between turnover and care quality:
  - 47% of nursing homes' nursing staff (mostly nursing assistants) leave their jobs in a given year
- Nursing assistants experience musculoskeletal disorders (which can be caused by physical strain) at one of the highest rates in U.S.
- Many states have passed laws intended to raise wages for direct care workers:
  - Despite gains, direct care workers' hourly wages remain several dollars below those of other entry-level workers (e.g., retail)

Source: Medicare's Care Compare website, https://www.medicare.gov/care-compare/?providerType=NursingHome; Bureau of Labor Statistics. (2020). Occupational injuries and illnesses resulting in musculoskeletal disorders. https://www.bls.gov/iif/factsheets/msds.htm; RTI International and HHS Office of the Assistant Secretary for Planning and Evaluation. (2024). *State efforts to improve direct care workforce wages: Final report*. https://aspe.hhs.gov/sites/default/files/documents/e88ca623469819d2444d07fe9564fb67/state-efforts-improve-dcw-wages-final.pdf.

Medicare generally pays for health care staff labor through packaged payments that incentivize efficiency

- Fee-for-service Medicare generally pays for the labor of health care staff through prospective payment systems:
  - Reflect typical types and amounts of health care staff labor and other expenses used to treat a given type of patient in a given type of facility
- Incentivize providers to use an efficient mix of health care staff
- Providers also have an incentive to provide adequate staffing:
  - Pay-for-performance programs
  - Health care–associated infections can increase a facility's costs

Note: Although Medicare's general approach is to pay for health care staff labor through flat prospective payment system (PPS) payments to facilities, there are a number of exceptions to this general approach. Some types of clinicians are paid through Medicare's physician fee schedule (PFS) in some settings and through a PPS in other settings. Some types of clinicians are paid through Medicare's PFS for some types of services and through a PPS for other types of services. And finally, some types of health care staff's services can be billed under the PFS by a physician or other billable practitioner when they are provided "incident to" services provided by that practitioner, while other services cannot. We also note that payments work differently when a practitioner furnishes services in a non-facility setting, such as an independent doctor's office: Medicare makes a single payment, through the physician fee schedule, but increases the size of that payment to pay for health care staff labor and all other types of practice expenses involved in delivering a service—operating in a similar fashion as prospective payment systems do for these expenses.

Medicare layers on some more direct staffing incentives for nursing homes

- Medicare publicly reports staffing and turnover statistics for each nursing home in the U.S. on its website
- Medicare's pay-for-performance program for nursing homes (funded by a 2% withhold) will start tying payments to staffing measures in 2026:
  - Average number of nursing hours per resident per day (adjusted for case mix)
  - Turnover rate among nursing staff (RNs, LPNs, nurse aides)
  - Rate of SNF health care–associated infections requiring hospitalization
  - Rate of SNF 30-day all-cause readmissions

Note: RN (registered nurse), LPN (licensed practical nurse), SNF (skilled nursing facility). Medicare's SNF Value-Based Payment (VBP) Program withholds 2% of SNFs' fee-for-service Medicare Part A payments; 40% of these payments are retained for Medicare as savings, and the remaining 60% are redistributed to SNFs based on their performance on quality measures.

Source: Medicare's Care Compare website, http://www.medicare.gov/care-compare; CMS, Skilled Nursing Facility Value-Based Purchasing Program: FY 2026 Program Year Fact Sheet, https://www.cms.gov/files/document/snf-vbp-fy2026-factsheet.pdf.

Discussion

Discussion

- Questions about the material?
- Other comments or guidance for the chapter?

MEDPAC

Advising the Congress on Medicare issues

Medicare Payment Advisory Commission

meetingcomments@medpac.gov

www.medpac.gov

@medicarepayment