MEDPAC

Advising the Congress on Medicare issues

Context for Medicare payment policy

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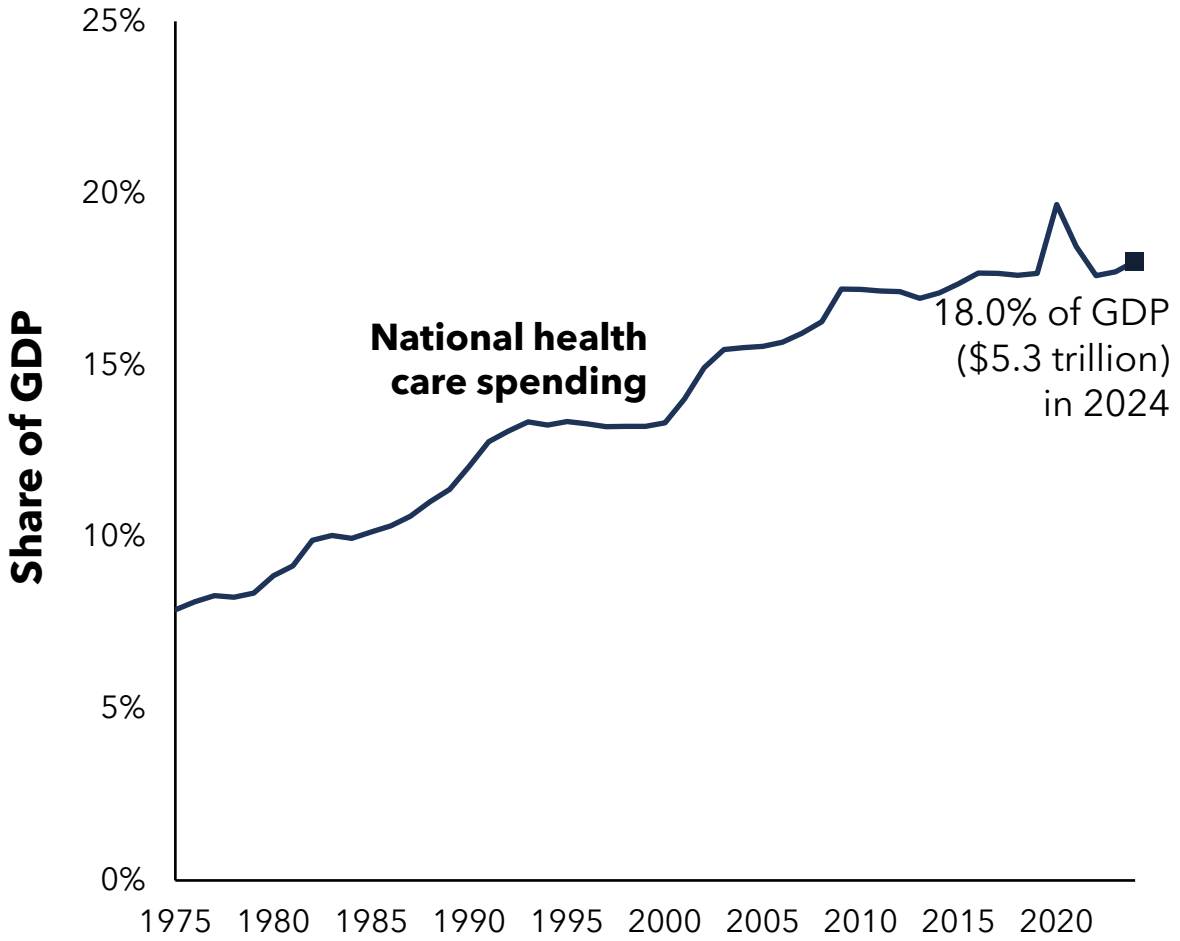
Presentation roadmap

1. Health care spending trends
2. Medicare beneficiaries' ability to pay for health care
3. Provider consolidation update
4. Discussion

Health care spending trends

National health care spending usually grows faster than GDP

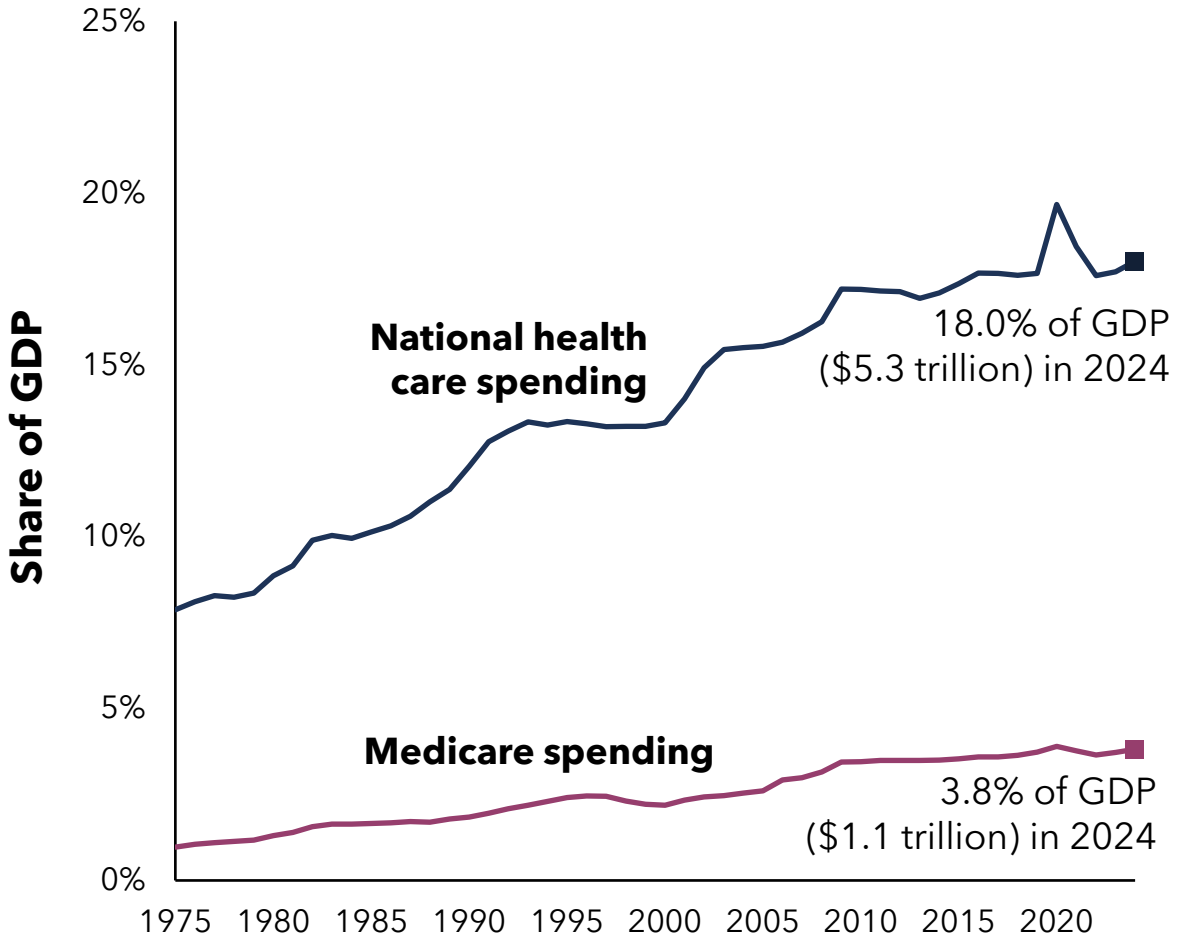


- After the COVID-19 pandemic, national health care spending rebounded strongly in 2023 and 2024 (+7%/year), due to growth in:
  - Volume and intensity of services & items furnished to patients
  - Share of population with health insurance (all-time high of 92%)
  - U.S. population
  - Economy-wide prices

Note: GDP (gross domestic product). GDP measures the value of all goods and services produced in a country in a given year.

Source: MedPAC analysis of CMS's national health expenditure data (historical data released January 2026).

Medicare spending often grows faster than national health care spending

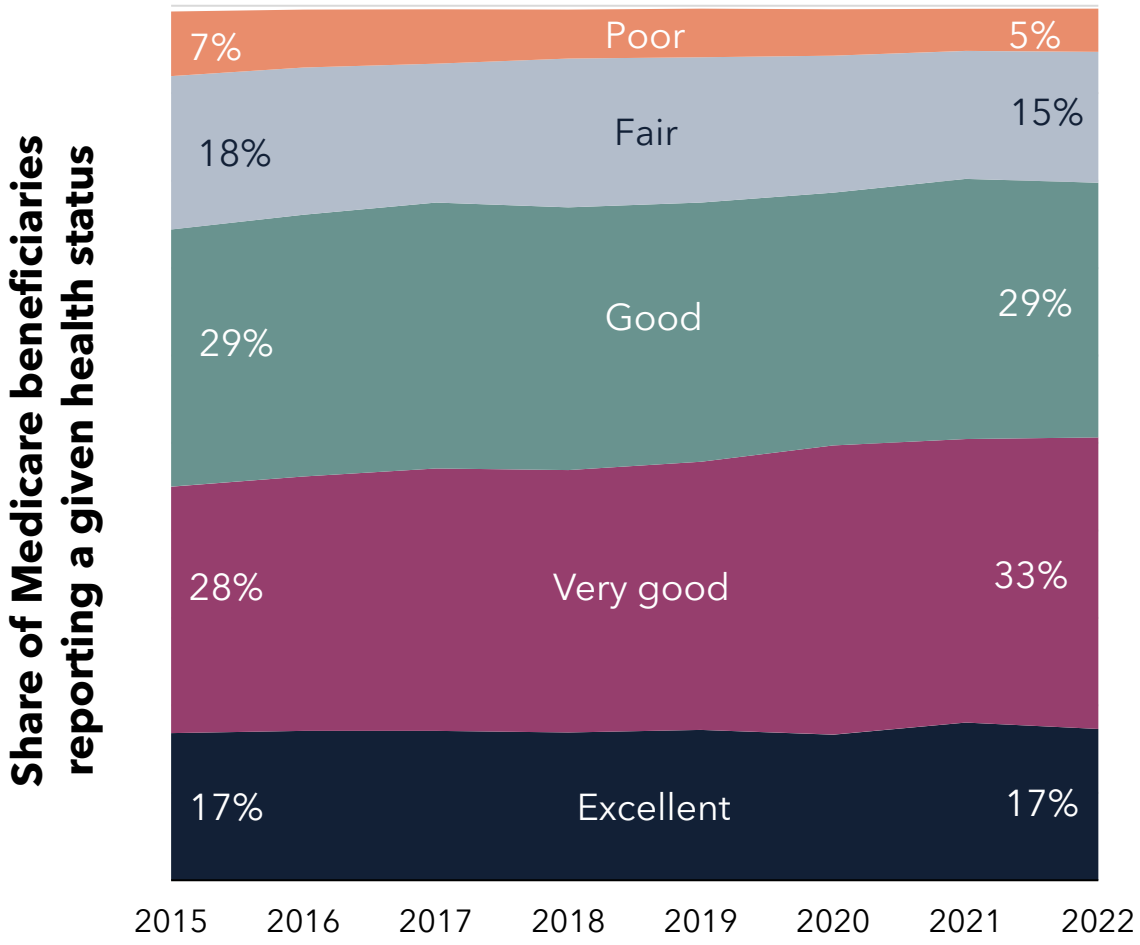


- Medicare spending has been growing even more quickly (+9% in 2023, +8% in 2024)
- Medicare spending is projected to grow faster than other payers over the next few years, as the baby boom generation continues to age into Medicare

Note: GDP (gross domestic product). GDP measures the value of all goods and services produced in the U.S. in a given year.

Source: MedPAC analysis of CMS's national health expenditure data (historical data released January 2026).

The average age of the beneficiary population has been declining, and average health status has been improving

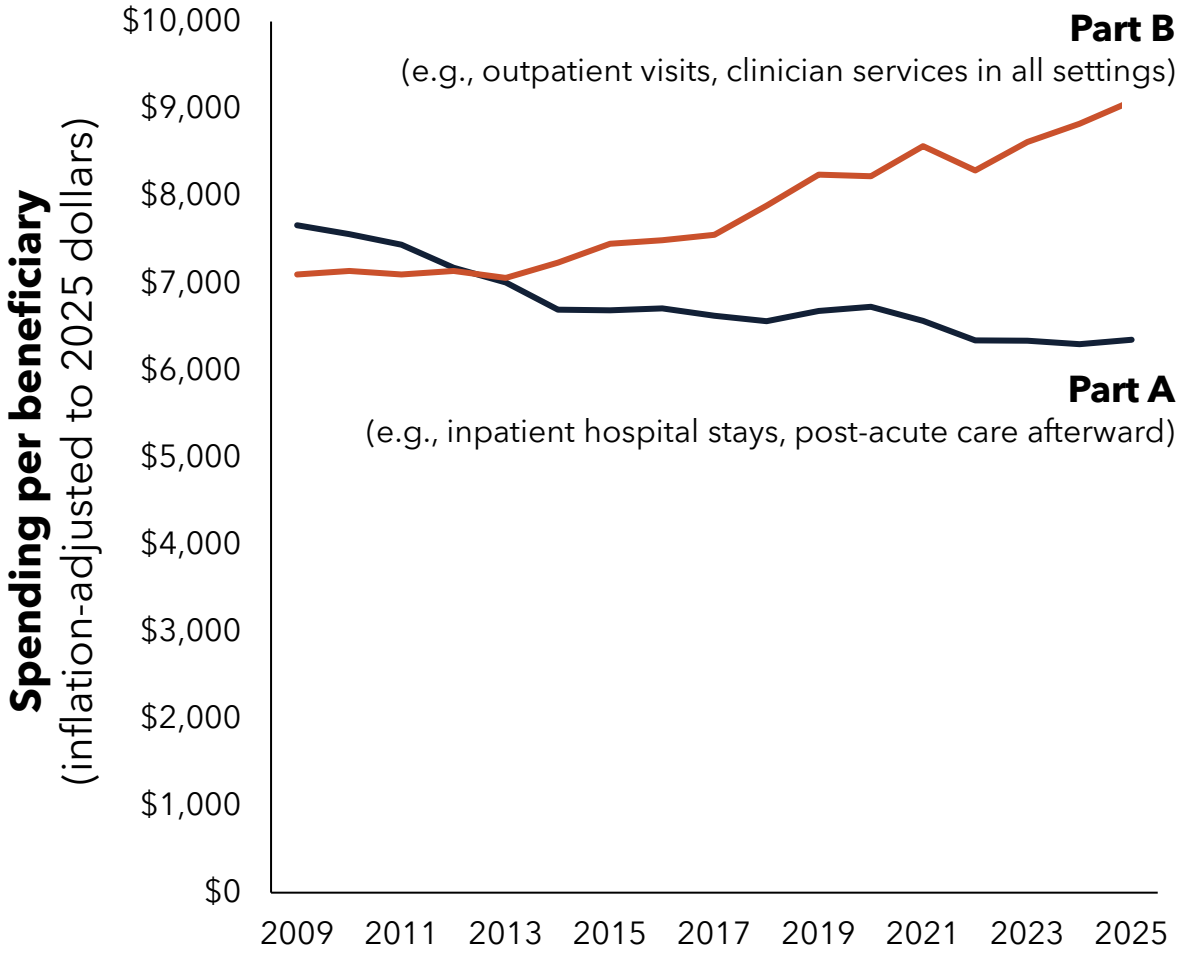


- Baby Boom generation's entry into the Medicare program has pulled down the average age of aged beneficiaries
- The average beneficiary who survived the pandemic is healthier than the average pre-pandemic beneficiary
- A declining share of beneficiaries has been qualifying for Medicare due to disability

Note: CMS's Medicare Current Beneficiary Survey asked respondents to characterize their health compared to 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.

Spending has shifted from the inpatient setting (Part A) to the outpatient setting (Part B)



Note: Figure includes enrollees in fee-for-service (FFS) Medicare and Medicare Advantage (MA). Shows Medicare program spending not including spending financed by beneficiary premiums or cost sharing. (The share of funds transferred from Part A and Part B to pay for MA is based on the shares of per capita FFS Medicare spending on Part A and Part B.) Percentages in parentheses are compound annual growth rates from 2009 to 2025.

Source: MedPAC analysis of data from 2026 annual report of the Boards of Trustees of the Medicare trust funds.

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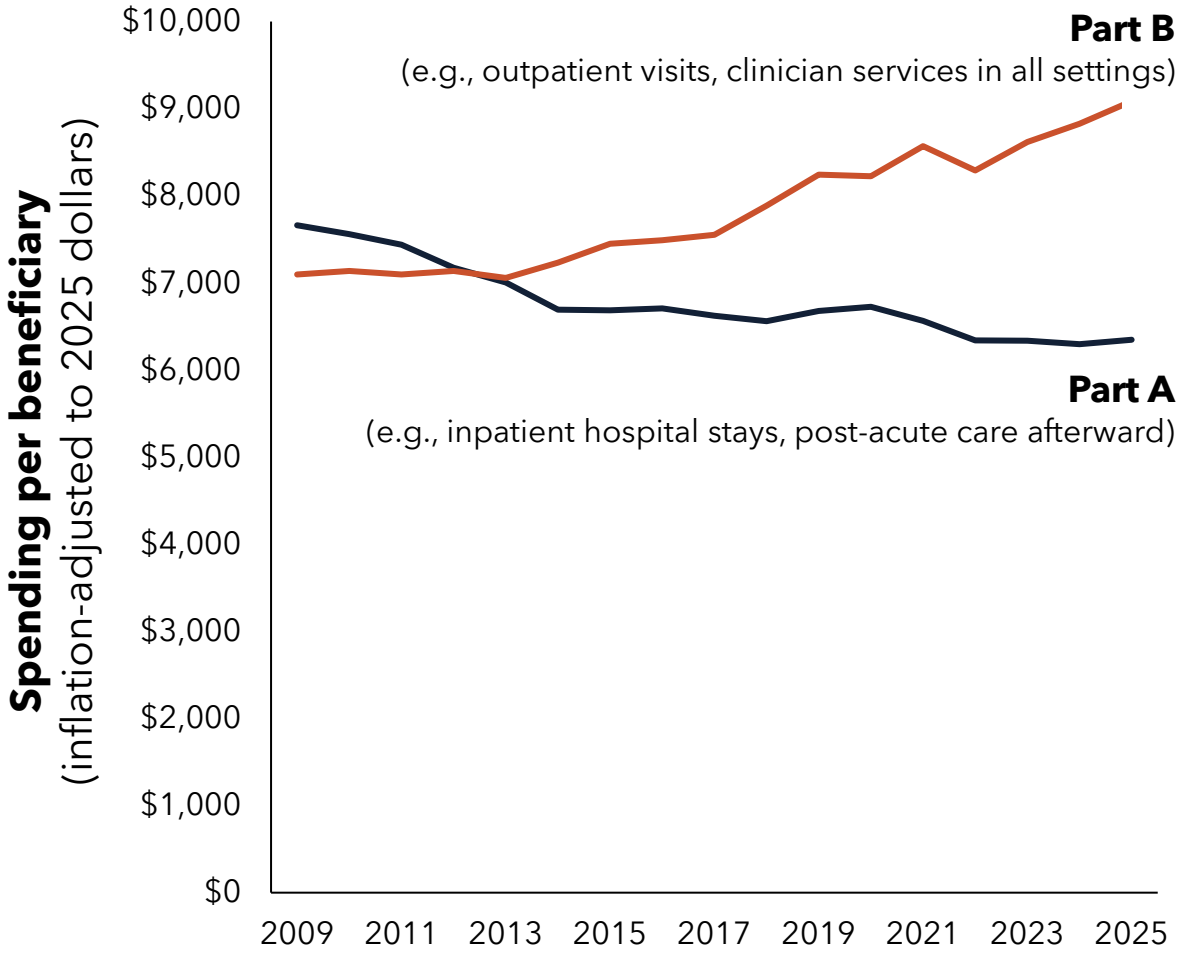

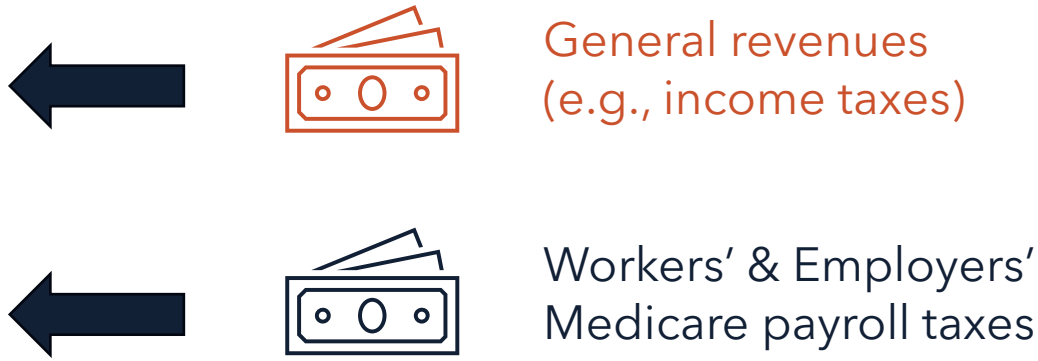

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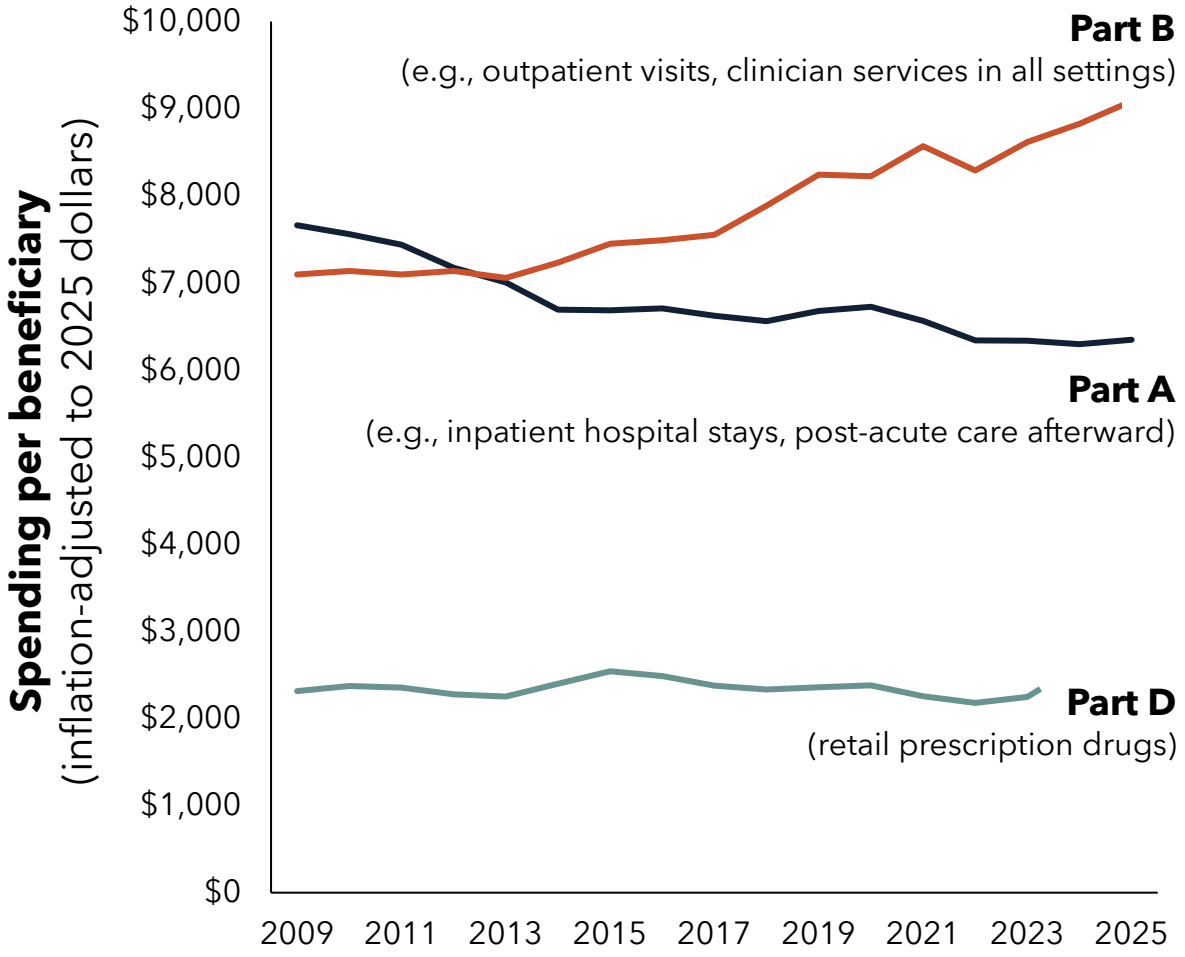
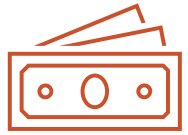
Source: MedPAC analysis of data from 2026 annual report of the Boards of Trustees of the Medicare trust funds.

Spending on Part D has been stable…



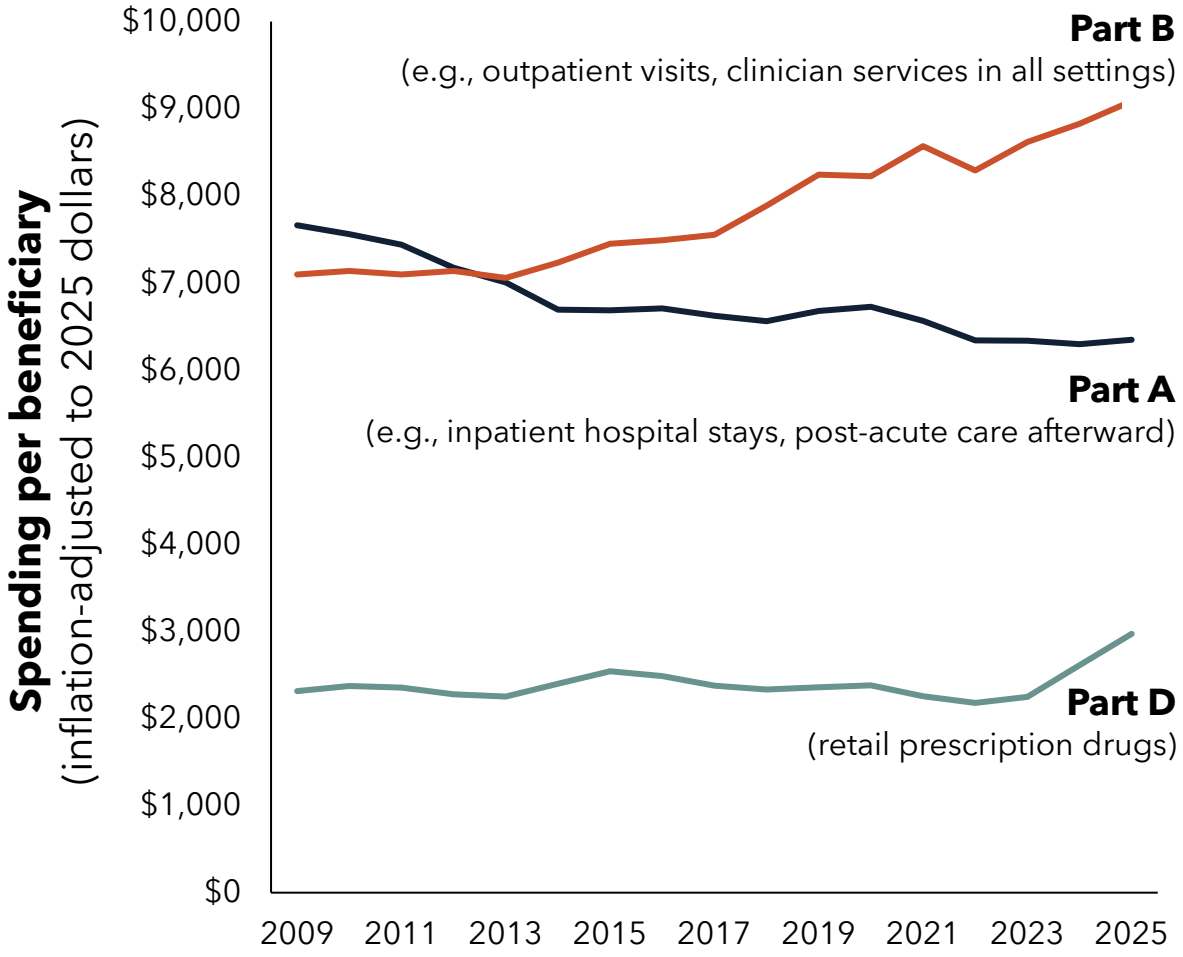


General revenues
(e.g., income taxes)

Note: Figure includes enrollees in fee-for-service (FFS) Medicare and Medicare Advantage (MA). Shows Medicare program spending not including spending financed by beneficiary premiums or cost sharing. (The share of funds transferred from Part A and Part B to pay for MA is based on the shares of per capita FFS Medicare spending on Part A and Part B.) Percentages in parentheses are compound annual growth rates from 2009 to 2025.

Source: MedPAC analysis of data from 2026 annual report of the Boards of Trustees of the Medicare trust funds.

Spending on Part D has been stable… until recently

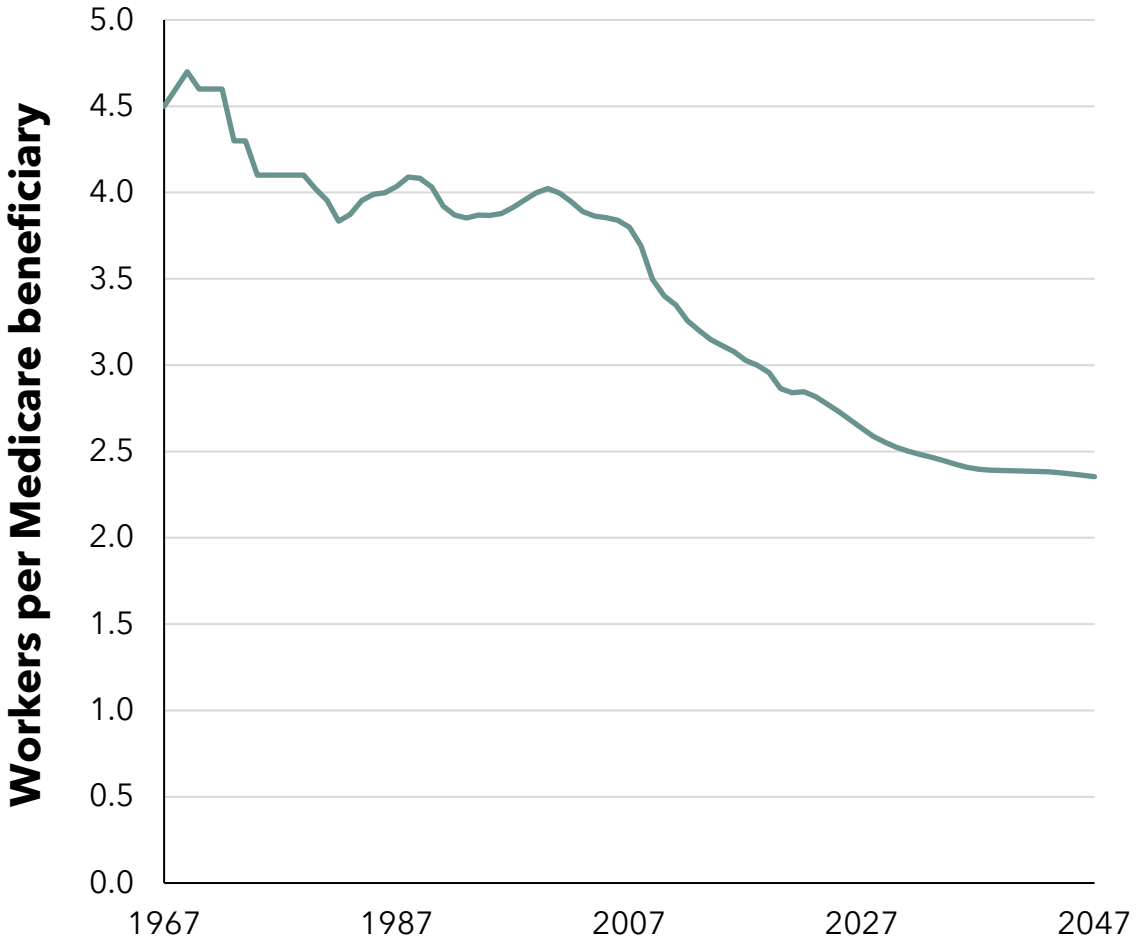


- Recent increase in **Part D** spending reflects:
  - Inflation Reduction Act of 2022 Part D redesign shifting a greater share of costs from beneficiaries to Medicare
  - Increase in utilization, potentially associated with the redesign's reduced cost sharing
  - Underlying pharmaceutical trends, including increased use of high-cost specialty drugs

Note: Figure includes enrollees in fee-for-service (FFS) Medicare and Medicare Advantage (MA). Shows Medicare program spending not including spending financed by beneficiary premiums or cost sharing. (The share of funds transferred from Part A and Part B to pay for MA is based on the shares of per capita FFS Medicare spending on Part A and Part B.) Percentages in parentheses are compound annual growth rates from 2009 to 2025.

Source: MedPAC analysis of data from 2026 annual report of the Boards of Trustees of the Medicare trust funds.

Paying for Medicare Part A is challenging because the number of workers per beneficiary has been declining

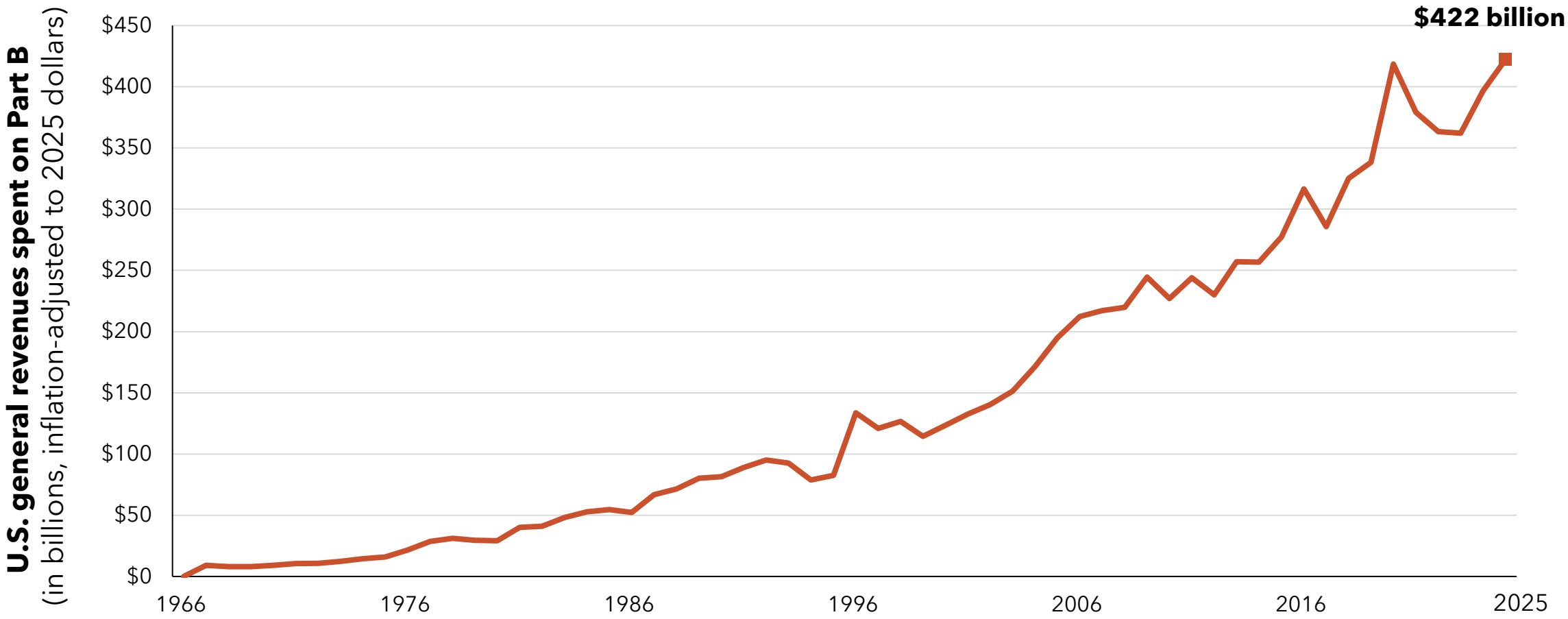


- Medicare payroll taxes paid by workers and employers are deposited into a trust fund that funds Part A
- This trust fund is projected to become insolvent in:
  - 2033 (Medicare Trustees)
  - 2040 (Congressional Budget Office)

Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). Part A services are financed primarily by Medicare payroll taxes and beneficiary cost sharing. First projected year is 2026.

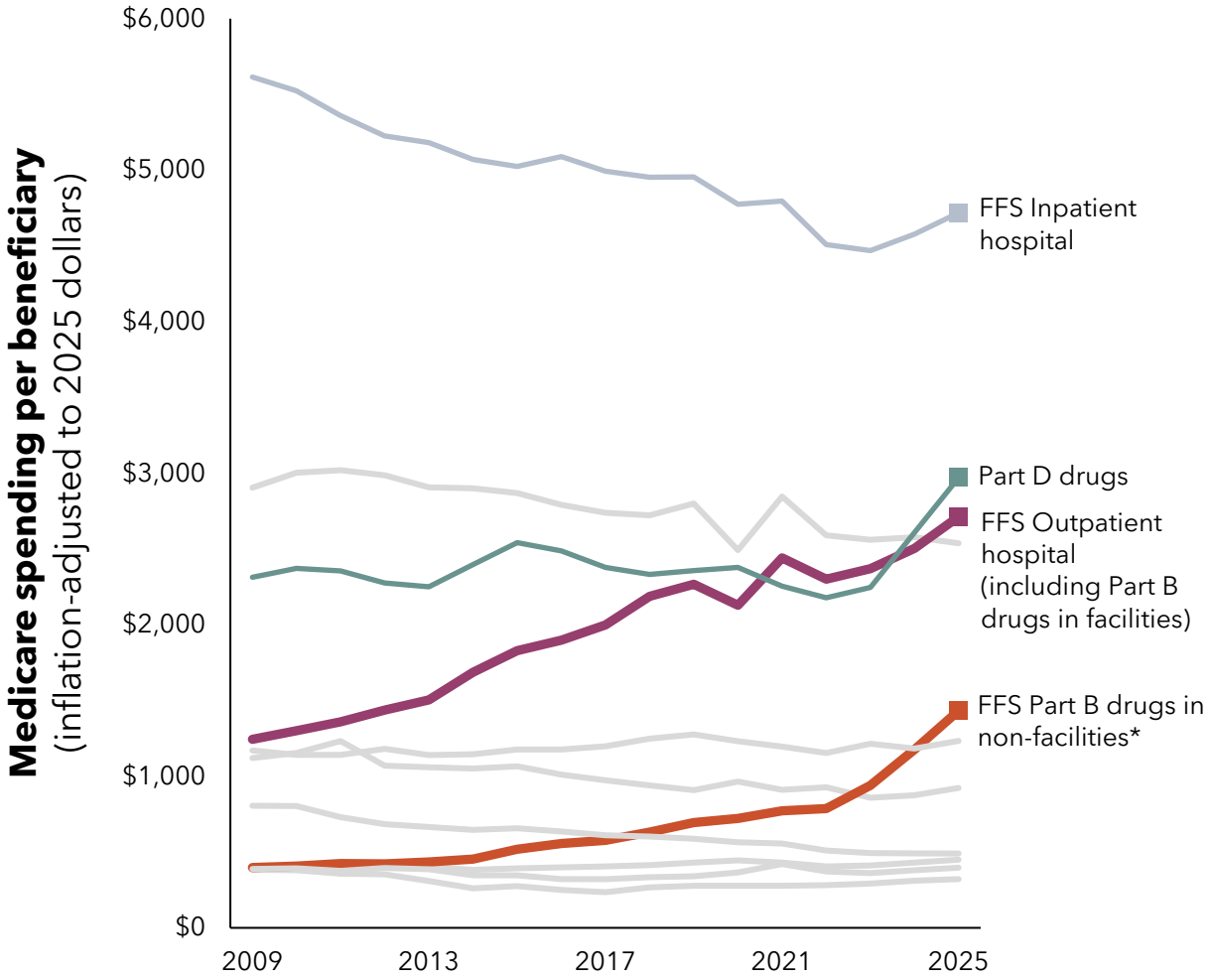
Source: 2026 annual report of the Boards of Trustees of the Medicare trust funds.

The federal government's spending on Part B has grown rapidly over time



Note: Dollar amounts are adjusted for inflation using the Consumer Price Index for All Urban Consumers. Amounts shown are only a portion of the total cost of Part B.
Source: MedPAC analysis of data released with the 2026 annual report of the Boards of Trustees of the Medicare trust funds.

Since 2009, spending on Part B clinician-administered drugs in non-facilities has grown the fastest



- Driven by a rise in the average price Medicare paid for Part B drugs, due to:
  - New, higher-priced drugs
  - Higher prices for existing products
  - Shifts in the mix of drugs furnished
- Recent rapid growth in spending on skin substitutes*

Note: FFS (fee-for-service). Figure shows Medicare spending not including spending financed by beneficiary premiums or cost sharing, inflation adjusted to 2025 dollars using the Consumer Price Index for All Urban Consumers. For the "FFS Inpatient hospital" line, the denominator is FFS beneficiaries enrolled in Part A; for the "FFS Part B drugs in non-facilities" and "FFS Outpatient hospital" lines, the denominator is FFS beneficiaries enrolled in Part B; for the "Part D drugs" line, the denominator is FFS and Medicare Advantage enrollees with Part D coverage. Part B drugs are drug administered by clinicians, as opposed to drugs obtained from retail pharmacies (covered under Part D). Grey lines are labeled and defined in paper circulated to commissioners.
*Spending on "FFS Part B drugs in nonfacilities" includes skin substitutes.

Source: MedPAC analysis of the 2026 annual report of the Boards of Trustees of the Medicare trust funds.

Continued growth in MA enrollment

- 55% of Medicare beneficiaries with Part A & Part B were enrolled in an MA plan in 2026
- The average beneficiary has 39 MA plans to choose from in 2026
- MedPAC estimates that in 2026 Medicare will spend 14% more on MA coverage than if current MA enrollees were instead in FFS Medicare, primarily due to risk-adjustment inaccuracies
- Increased payments to MA plans ($76 billion in 2026) help pay for supplemental benefits not available to FFS beneficiaries:
  - Non-Medicare services (e.g., vision, dental, hearing, gym memberships)
  - Lower cost sharing
  - Lower Part B & Part D premiums

Note: MA (Medicare Advantage), FFS (fee-for-service).
Source: MedPAC. 2026. "The Medicare Advantage program: Status report," in *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC, June. https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf.

Medicare beneficiaries' ability to pay for health care

Medicare premiums and cost sharing consume a substantial share of beneficiaries' incomes

- FFS Medicare beneficiaries without supplemental insurance:

	$2,435	Part B premiums (2026)
	$432	Part D premiums (2026)
	$425	Part A cost sharing (2022)
	$1,725	Part B cost sharing (2022)
+	$444	Part D cost sharing (2024)
	$5,461	Total annual cost

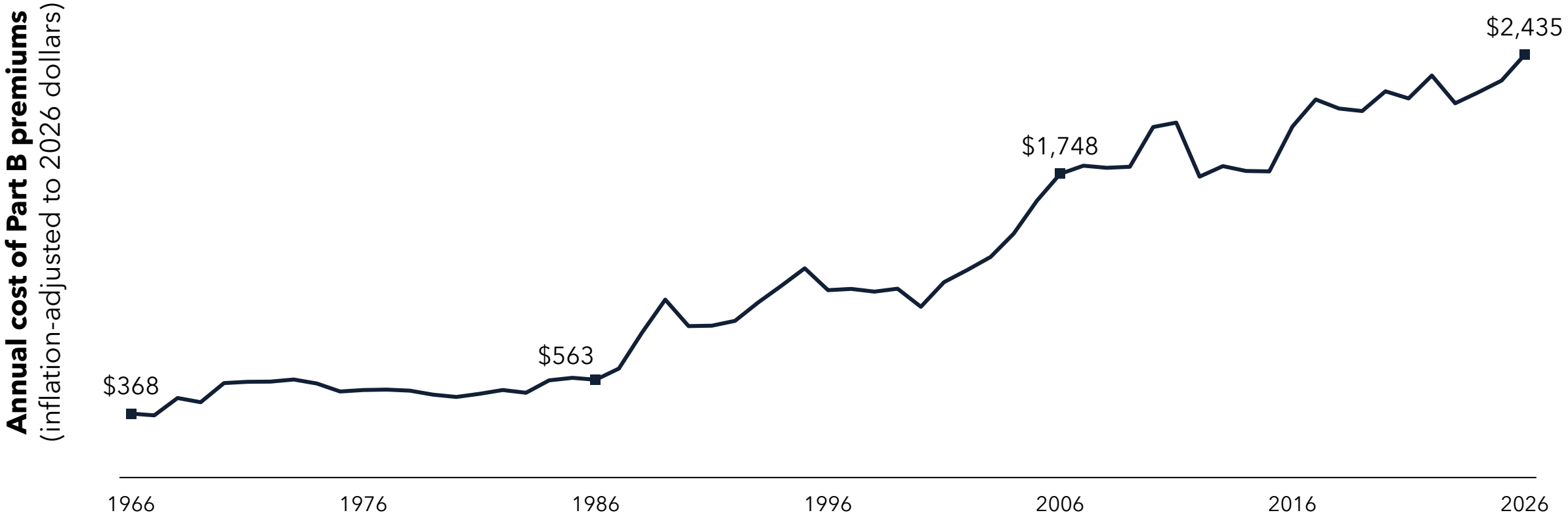
- Most FFS beneficiaries have private supplemental insurance, which pays for some or all of their cost sharing
- MA enrollees generally pay lower premiums and lower cost sharing
- Medicaid pays some beneficiaries' premiums (and for some, cost sharing)

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: MedPAC's 2026 *A Data Book: Health Care Spending and the Medicare Program,* https://www.medpac.gov/document/july-2026-data-book-health-care-spending-and-the-medicare-program/; CMS. Income and asset ownership. 2023. https://data.cms.gov/medicare-current-beneficiary-survey-mcbs/income-and-asset-ownership.

Median household income for community-dwelling beneficiaries is **$49,910** (in 2023)

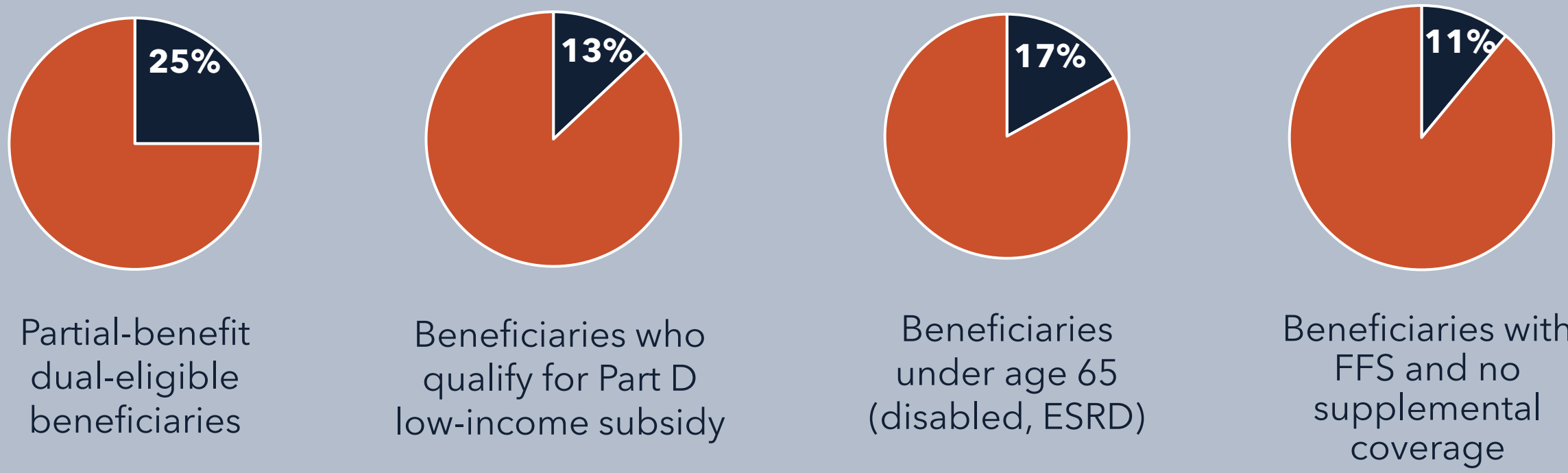
Medicare Part B premiums have increased rapidly over time



Note: Figure shows standard Part B premium amounts inflation-adjusted to 2026 dollars using Consumer Price Index-Urban.
Source: Congressional Research Service. 2022. *Medicare Part B: Enrollment and premiums*. R40082. Washington, DC: CRS. May 19; MedPAC analysis of the 2026 annual report of the Boards of Trustees of the Medicare trust funds.

Some beneficiaries have difficulty affording health care

% of ____ beneficiaries who reported a problem paying a medical bill, 2023



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 2023 Medicare Current Beneficiary Survey.

Provider consolidation

Provider consolidation continues to increase

- Provider consolidation is occurring between:
  - Like-type of providers (e.g., hospitals merging with hospitals)
  - Providers with referral relationships (e.g., hospitals acquiring physician practices)
  - Providers and nonprovider organizations (e.g., insurers, corporate entities, PE firms)
- Motivations include higher payment rates, patient self-referrals, more efficient care delivery, and gaining access to capital for infrastructure and technology

Note: PE (private equity).

Sources: 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*; Li, S. E., D. Jones, E. Rich, et al. 2025. How do hospitals exert market power? Evidence from health systems and commercial health plan prices. *Health Affairs Scholar* 3, no. 1 (January): qxae179; Whaley, C. M., R. Kerber, D. Wang, et al. 2024. *Prices paid to hospitals by private health plans: Findings from round 5 of an employer-led transparency initiative*. Santa Monica, CA: RAND. Young, G. J., D. Duran, I. Ratto, et al. 2026. Hospital system acquisition of physician practices. *JAMA Network Open*.

Summary of March 2026 report findings

- Researchers have generally found:
  - Consolidation between providers results in higher payments in both commercial and Medicare markets
  - Payer–provider consolidation may lead to greater coding intensity
  - PE–provider integration leads to higher payments
  - Relationship between provider consolidation and quality and access is mixed

Note: MA (Medicare Advantage), MLR (medical-loss-ratio), PE (private equity).
Sources: Medicare Payment Advisory Commission (2026). Report to the Congress: Medicare payment policy. Washington, DC, MedPAC.

Recent evidence finds consolidation leads to higher payment rates and spending

- Consolidation between providers leads to higher payment rates
- Some limited evidence assessing hospital–MA plan consolidation shows higher MLRs and varying prices
- PE–provider integration is associated with higher commercial prices across multiple specialties

Note: MA (Medicare Advantage), MLR (medical-loss-ratio), PE (private equity).

Sources: Bejarano, G., D. J. Meyers, M. B. Rosenthal, et al. 2026. Hospital-Medicare Advantage vertical integration and medical loss ratios. *Health Affairs Scholar;* Harris, A., N. Jordan, C. Barnard, et al. 2026a. The effect of hospital-physician vertical integration on utilization-driven changes in healthcare spending for an all-payer population with multiple chronic conditions. *Health Services Research;* Khunte, M., N. Radhakrishnan, C. Whaley, et al. 2025. Association of private equity and hospital consolidation and negotiated prices of radiologic services. *Journal of American College of Radiology;* Mackleby, G., G. Bejarano, M. K. Meiselbach, et al. 2026. *Most hospitals with vertically integrated MA plans charge similar prices to affiliated and unaffiliated plans. Health Affairs;* Philips, A. P., N. Radhakrishnan, C. M. Whaley, et al. 2025. Hospital- and private equity-affiliated specialty physicians negotiate higher prices than independent physicians. *Health Affairs.*

Recent literature on consolidation and access to care is mixed

- Mixed, limited evidence on the ways in which consolidation impacts access to care:
  - Higher intensity inpatient and non-emergency ambulatory care after hospital–physician vertical integration
  - Fewer prior authorization requirements for enrollees of system–affiliated MA plans
  - PE–provider integration may reduce ED and ICU staffing and increase transfers of those patients to other hospitals

Sources: Harris, A., B. Post, C. Barnard, et al. 2026b. Higher intensity care for patients with multiple chronic conditions after hospital-physician integration. *Health Affairs Scholar;* Kannan, S., J. D. Bruch, J. R. Zubizarreta, et al. 2025. Hospital staffing and patient outcomes after private equity acquisition. *Annals of Internal Medicine;* Shin, E. 2026. Health system integration and prior authorization in Medicare Advantage. *Health Services Research*.

Recent evidence of consolidation on quality is mixed

- Consolidation between providers:
  - Patients in markets with large increases in hospital consolidation had higher likelihood of early-stage diagnosis and improved survival
  - Complex FFS patients receiving care from integrated physicians had better perceptions of care coordination and quality
- Enrollees of hospital–owned MA plans had lower mortality, readmission, and postop complication rates
- Generally, higher mortality, admission, and postop complication rates after PE–hospital integration

Note: FFS (fee-for-service), MA (Medicare Advantage), PE (private equity).

Sources: Bejarano, G., M. N. Dixit, A. P. Philips, et al. 2025a. Hospital-Medicare Advantage vertical integration and cardiopulmonary care in integrated hospitals. *JAMA Health Forum;* Bejarano, G., A. P. Philips, D. J. Meyers, et al. 2025b. Surgical outcomes and Medicare Advantage payer-hospital integration. *JAMA Surgery;* Johnson, D. Y., M. Liu, V. L. Bartlett, et al. 2025. Heart failure care and outcomes after private equity acquisition of U.S. hospitals. *Journal of American College of Cardiology;* Kannan, S., J. D. Bruch, J. R. Zubizarreta, et al. 2025. Hospital staffing and patient outcomes after private equity acquisition. *Annals of Internal Medicine;* Mullens, C. L., M. Mead, M. Abid, et al. 2026. Surgical quality at rural hospitals after private equity acquisition. *Annals of Surgery;* Rashid, Z., M. Khalil, Z. S. Dawood, et al. 2026. Impact of private equity acquisition of hospitals on surgical outcomes. *Annals of Surgery.*

Discussion

Discussion

- Questions about the material?
- Guidance for the chapter?
- Planned for publication in March 2027 report

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