CHAPTER 1

Context for Medicare payment policy

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Chapter summary

Every March, the Commission reports to the Congress on Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. To provide context for the information presented in our report, this chapter describes Medicare's overall financial situation and some ways that Medicare affects, and is affected by, the broader health care sector.

National health care spending usually grows faster than GDP

National health care spending grew rapidly in 2023 and 2024, by 7 percent in each of these years. This growth was driven by a number of factors, including postpandemic rebounding growth in the volume and intensity of services and items furnished to patients, the share of the U.S. population with health insurance reaching an all-time high (of 92 percent in 2022 through 2024), population growth, and growth in medical prices (due to economy-wide price growth, as opposed to excess medical inflation). By 2024, national health care spending totaled $5.3 trillion. Health care spending has made up an increasing share of the country's gross domestic product (GDP) over time, rising from about 13 percent of GDP in 2000 to 18 percent in 2024.

In this chapter

Drivers of Medicare's spending growth

Medicare spending grew rapidly in 2023 and 2024 (by 9 percent and 8 percent, respectively), in part due to changes in Part D financing that shifted more of the cost of prescription drug coverage from beneficiaries to the federal government. By 2024, Medicare spending totaled $1.1 trillion—equivalent to 21 percent of national health care spending and 3.8 percent of GDP.

By the mid-2030s, Medicare spending is projected to double (in nominal terms, not adjusted for inflation) and be equivalent to over 5 percent of GDP. Continued growth in Medicare enrollment over the next decade contributes to Medicare's projected spending growth, as the baby-boom generation continues to reach Medicare's eligibility age.

Growth in the volume and intensity of the services and items delivered to patients and growth in the average price of Part B drugs administered by clinicians are also projected to drive up Medicare spending. (Spending on Part B drugs has been growing rapidly in recent years—by an average of 9 percent per year between 2009 and 2023.)

Provider consolidation has been increasing

A key contextual factor in the health care sector is the ongoing consolidation of health care providers. Historically, health care market consolidation has primarily involved like types of provider organizations (e.g., hospitals merging with other hospitals) or different types of providers that had referral relationships between them (e.g., hospitals acquiring physician practices). In recent years, however, consolidation has expanded beyond hospital mergers and vertically integrated arrangements between providers, with nonprovider organizations such as private insurers, corporate entities, and private equity (PE) firms now also acquiring provider organizations.

There are several economic motivations for health care market consolidation. In commercial markets, consolidated providers are often in a stronger bargaining position when negotiating payment rates with private insurers. Certain types of consolidation can also lead to higher Medicare payment rates through exploitation of site-based payment differentials—namely, when a hospital acquires a clinician practice, the hospital can sometimes bill a "facility" fee (in addition to the physician's fee) each time a Medicare beneficiary is seen or receives services in the hospital-owned practice. Employing clinicians also may enable insurance plans, including MA organizations, to generate more extensive diagnosis coding on claims, which can yield higher payments to

both insurers and providers in some capitated payment models. In addition, acquiring provider organizations may allow insurers operating in commercial and MA markets to shift profits to their providers to avoid the constraints of medical-loss-ratio regulations that limit the share of premiums that insurers are allowed to keep as profit.

Obtaining higher payment rates is not the only reason providers consolidate. When hospitals vertically integrate with other types of providers, they can encourage patient referrals within their integrated system. When insurers consolidate with providers, they may be able to better coordinate care and gain provider cooperation in cost-control efforts such as prescribing generic drugs and improving care coordination that is tied to quality bonuses, such as through MA star ratings. In the case of consolidation between insurers and pharmacy benefit managers (PBMs), PBMs may be able to steer some patients to their affiliated pharmacies, especially in commercial markets. From a clinician's perspective, more predictable and stable income and the greater ability to maintain patient volume and referral privileges may lead to vertical integration. Clinicians also report selling practices to hospitals or health systems to gain access to costly resources and to get help navigating regulatory and administrative requirements. Conceptually, provider consolidation may also improve care coordination and the efficiency of care delivery through economies of scale, electronic health record interoperability, improved adherence to clinical guidelines, and alignment with value-based payment programs.

Consolidation among providers has been shown to result in higher payments in both commercial and Medicare markets. However, there is no published empirical evidence evaluating the direct effect of payer–provider consolidation on payers' spending and only limited evidence of the effect of payer–PBM consolidation on spending. Literature assessing the effect of PE–provider consolidation on spending is emerging but generally shows higher payments. Evidence about the effects of consolidation on quality and access to care for Medicare beneficiaries is mixed, albeit limited.

Medicare draws on an increasing share of the country's tax revenues

Over the past decade, Medicare spending per beneficiary has been growing more quickly for items and services covered under Part B than under Part A or Part D. For example, there has been an increase in the number of clinician encounters per beneficiary (paid for under Part B), while there has been a

decline in the number of inpatient hospital and skilled nursing facility stays per beneficiary (paid for under Part A). As a result, Medicare Part A has constituted a declining share of Medicare spending while Part B has grown as a share of program spending. By 2024, Part B constituted 49 percent of Medicare spending (up from 45 percent in 2015), Part A constituted 38 percent (down from 43 percent in 2015), and Part D constituted 12 percent (similar to the 13 percent it constituted in 2015).

The shift in the mix of items and services that beneficiaries receive has reduced pressure on Medicare payroll tax revenues, which are deposited into Medicare's Hospital Insurance Trust Fund to pay for Medicare Part A. However, this shift has put more pressure on the country's general revenues (e.g., income taxes) and beneficiaries' premiums, which pay for Part B (and for drug coverage under Part D). Medicare's Trustees report that in 2024, an amount equivalent to 16 percent of federal income taxes was used to pay for Medicare Part B and Part D. As the amount of general revenues needed to finance Medicare increases, less revenue is available for other priorities, such as deficit reduction or investments in other priorities. The increasing amount of general revenues spent on the Medicare program also contributes to the nation's debt since the total amount the federal government spends per year (about $7 trillion in 2024) exceeds the amount it collects in revenues (about $5 trillion).

When Medicare spending increases, beneficiaries' costs also increase

Medicare spending growth affects beneficiaries' ability to afford health care by raising their premiums and cost sharing. The typical Medicare beneficiary has relatively modest resources to draw on when paying for premiums and cost sharing: According to CMS's Medicare Current Beneficiary Survey, beneficiaries' median household income (from all sources, including investments) was about $50,000 in 2023. CMS's survey also found that 18 percent of beneficiaries were food insecure.

In CMS's survey, some groups of beneficiaries reported affordability issues at higher rates than others—such as partial-benefit dually eligible beneficiaries (who do not qualify for the Medicaid benefits that full-benefit dually eligible beneficiaries do), beneficiaries under age 65 (most of whom are disabled), beneficiaries with low enough incomes to qualify for the Part D low-income subsidy, and beneficiaries enrolled in FFS Medicare without any supplemental coverage (e.g., without a Medigap plan or Medicaid). It is therefore important to keep in mind that when Medicare payment rates for providers increase,

premiums and cost sharing also increase for Medicare beneficiaries—some of whom already have a hard time affording health care.

The health care workforce plays an important role

Ensuring that beneficiaries have access to high-quality health care remains an important focus of the Commission. Because numerous studies have found a clear relationship between care quality and a sufficient supply of nurses, nursing assistants, and other types of health care staff, this year's chapter explores that workforce, which comprises over 14 million workers.

Among the workforce we call "health care staff," the most common and fastest growing occupation is home health or personal care aide, the occupation of nearly 4 million people in 2024, followed by registered nurse (RN) (3.3 million) and health technologist or technician (2.5 million). One trend in the workforce is the lack of growth in certain roles requiring minimal training. From 2003 to 2024, the number of physical therapist assistants (who usually have an associate's degree and a license or certification) grew rapidly, while the number of physical therapist aides (who usually have only a high school diploma and on-the-job training) remained flat and then began to decline. Similar trends have been observed among occupational therapist assistants and aides, pharmacy technicians and pharmacy aides, and RNs and licensed practical nurses (LPNs).

The Bureau of Labor Statistics projects that what it calls the "healthcare support" occupational group (a set of occupations similar to the ones we focus on) will grow the fastest of any occupational group between 2023 and 2033 as the baby-boom generation ages and their need for health care services increases. As this workforce grows, the U.S. is projected to experience shortages of some types of health care staff and surpluses of others. For example, over the next five years, the Department of Health & Human Services projects shortages of pharmacists, physical therapists, and diagnostic medical sonographers but surpluses of pharmacy technicians, physical therapy assistants, occupational therapists and occupational therapy assistants, speech–language pathologists, radiation therapists, and health care social workers. A shortage of RNs and LPNs is projected nationally, but the extent of the shortage will vary by state, with some states projected to have an oversupply of nurses.

Shortages of staff also vary by setting. In particular, nursing homes experience high staff turnover. According to Medicare's Care Compare website, about half of nursing homes' nursing staff (which primarily consists of nursing assistants)

leave their jobs in a given year. This statistic is concerning since researchers have found that nursing homes with higher staff turnover provide lower-quality care.

The Commission aims to improve value for taxpayers and beneficiaries

The Commission regularly makes recommendations on how to update Medicare payment rates for various types of providers; we also offer broader recommendations on restructuring Medicare's payment systems—for example, by adopting site-neutral payments and changing how payments for MA plans are calculated. A list of the Commission's recommendations, with links to relevant report chapters, is available at www.medpac.gov/recommendation. The evidence-based recommendations we formulate are intended to obtain good value for beneficiaries' and taxpayers' expenditures, which means maintaining or improving access to high-quality services while encouraging efficient use of resources. ■

Every March, the Commission reports to the Congress on Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. To provide context for the information presented in our report, this chapter describes Medicare's overall financial situation and describes some ways that Medicare affects, and is affected by, the broader health care sector.

National health care spending usually grows faster than GDP

In 2024, the U.S. spent $5.3 trillion on health care, constituting 18 percent of the country's gross domestic product (GDP) (Hartman et al. 2026). Since national health care spending usually grows faster than GDP, health care spending has made up an increasing share of GDP over time (Figure 1-1, p. 10).

National health care spending temporarily diverged from this historical trend during the recent coronavirus pandemic, sharply increasing as a share of GDP in 2020 due to new pandemic-related spending that occurred while the economy was shrinking. In 2021 and 2022, national health care spending as a share of GDP then sharply fell as health care spending increased modestly in the latter years of the pandemic while the economy grew rapidly (Hartman et al. 2024, Martin et al. 2025).

In 2023 and 2024, national health care spending rebounded strongly—growing by 7 percent per year—as growth in the volume and intensity of the services and items furnished to patients increased while GDP growth slowed to rates more consistent with prepandemic years. This reversal caused national health care spending as a share of GDP to again rise. One of the reasons health care spending has grown so rapidly in recent years is that the share of the population with health insurance reached an all-time high of 92 percent in 2022 through 2024. Population growth and growth in medical prices (due to economy-wide price growth, as opposed to excess medical inflation) also drove spending in these years (Hartman et al. 2026).

In 2025, CMS expects that national health care spending continued to experience robust growth (increasing by another 7 percent) because of continued high rates of insurance coverage that year and the rebound in service use continuing in 2025 after the somewhat suppressed growth observed during the pandemic (Keehan et al. 2025).

Drivers of Medicare's spending growth

Medicare spending totaled $1.1 trillion in 2024, equivalent to 21 percent of national health care spending and 3.8 percent of GDP (Figure 1-2, p. 11). By the mid-2030s, Medicare spending is projected to double (in nominal terms, not adjusted for inflation) and be equivalent to over 5 percent of GDP (Figure 1-2).

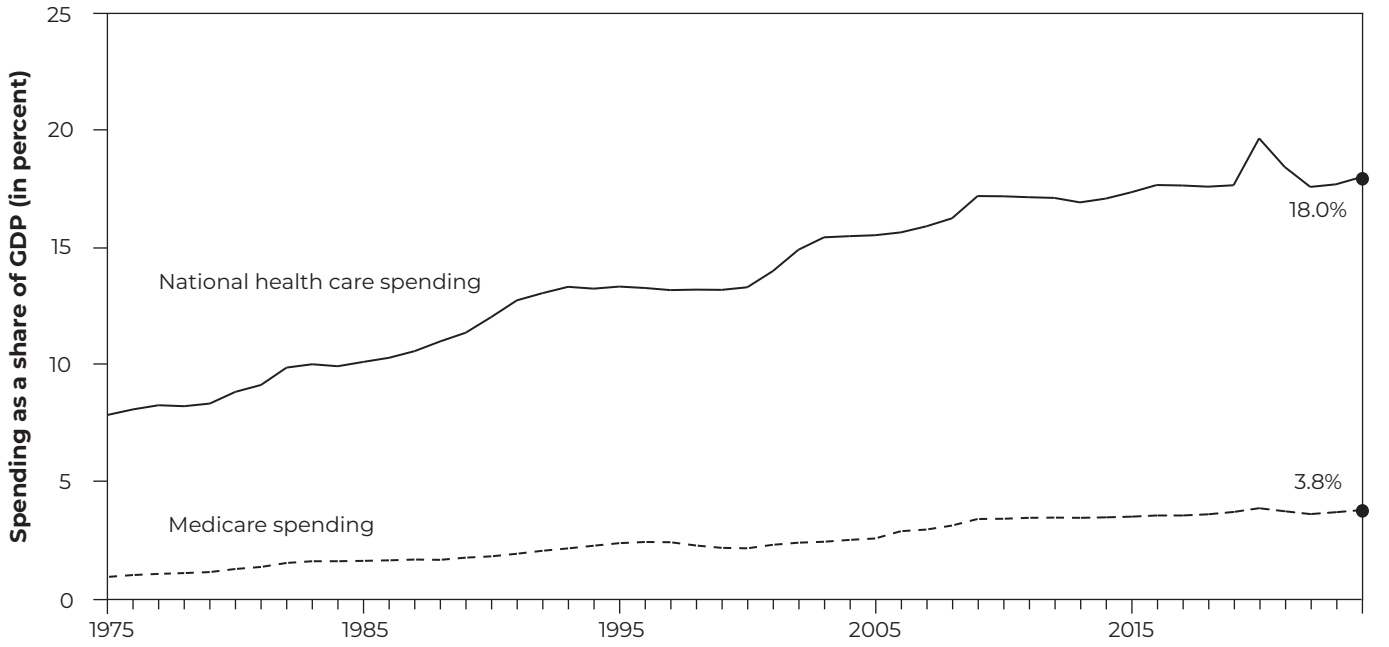
Medicare spending grew rapidly in 2023 and 2024 (by 9 percent and 8 percent, respectively), in part due to changes mandated by the Inflation Reduction Act of 2022 (IRA) that shifted more of the cost of Part D prescription drug coverage from beneficiaries to the federal government (Hartman et al. 2026).

Another driver of Medicare's projected spending growth is continued elevated enrollment in the program as the baby-boom generation continues to reach Medicare's eligibility age. By 2029, all members of the baby-boom generation will have reached age 65 and Medicare enrollment will reach 75 million, up from 49 million in 2011, when this generation first began to reach Medicare's eligibility age (Figure 1-3, p. 12). In 2024, 67 million beneficiaries were enrolled in Medicare.

When the Medicare Trustees decompose the drivers of Medicare spending growth, they find that factors other than enrollment growth, changing beneficiary demographics, and changes in the price of medical services are projected to be the main drivers of spending growth from 2025 to 2034 (shown in the "Other" column of Table 1-1, p. 12). As discussed below, examples of these "other" spending drivers include growth over time in the volume and intensity of services and items that clinicians prescribe and growth in the average price Medicare pays for Part B drugs and biologics. These other spending drivers are currently projected to increase by 3 percent per year over the next 10 years.

FIGURE 1–1

National health care spending has grown as a share of U.S. GDP



Note: GDP (gross domestic product). Pandemic relief funds are counted as national health care spending rather than Medicare spending because they were meant to offset pandemic-related revenue losses from all payers, not just Medicare. Medicare spending excludes COVID-19 Accelerated and Advance Payments (short-term loans paid to providers in 2020 that were subsequently repaid) since this graph shows expenditures on an incurred basis rather than a cash basis. Medicare spending includes spending for beneficiaries in both Medicare fee-for-service and Medicare Advantage.

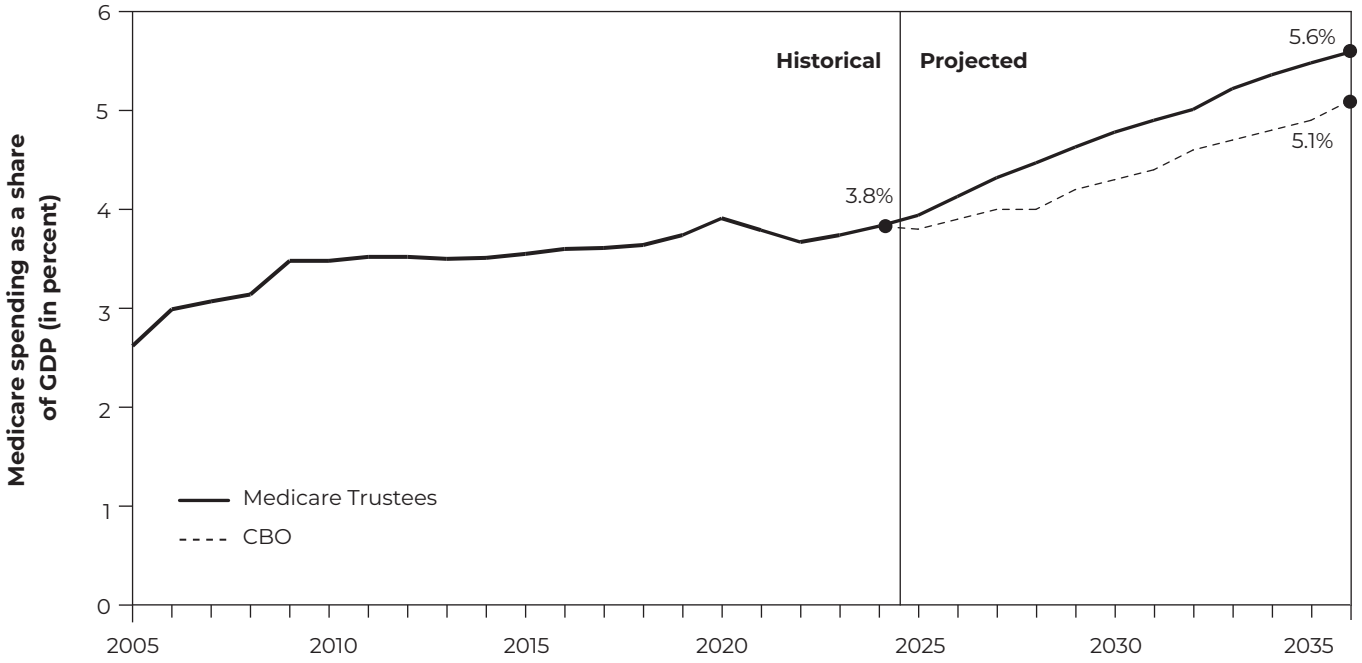
Source: MedPAC analysis of CMS's national health expenditure data (projected data released in June 2025 and historical data released in January 2026), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

The volume and intensity of services used by Medicare beneficiaries has varied over time and across settings. "Increasing volume" refers to an increase in the number of services furnished to beneficiaries. In recent years, the volume of services furnished per beneficiary has grown for some types of services (e.g., clinician encounters) and declined for others (e.g., inpatient hospital stays and skilled nursing facility care postdischarge) (Medicare Payment Advisory Commission 2025c). "Increasing intensity" refers to a change in the mix of services or items furnished as clinicians prescribe more complex services in place of less complex ones (e.g., nuclear medicine stress tests instead of electrocardiogram stress tests). Studies that have tried to understand whether higher service volume and intensity (as measured by Medicare spending) improve patient outcomes have produced mixed findings, sometimes finding improved outcomes and sometimes finding no relationship (Kaestner and Silber 2010, Likosky et al. 2018, Romley et al. 2013, Tsugawa et al. 2017).

Increased spending on drugs has also contributed to Medicare's overall spending growth. In 2023 and 2024, CMS observed rapid increases in the demand for glucagon-like peptide-1 receptor agonist (GLP-1) drugs, which are available under Medicare Part D to treat conditions like diabetes (Hartman et al. 2026).

FIGURE 1–2

Medicare spending is projected to constitute 5 percent of GDP by 2035

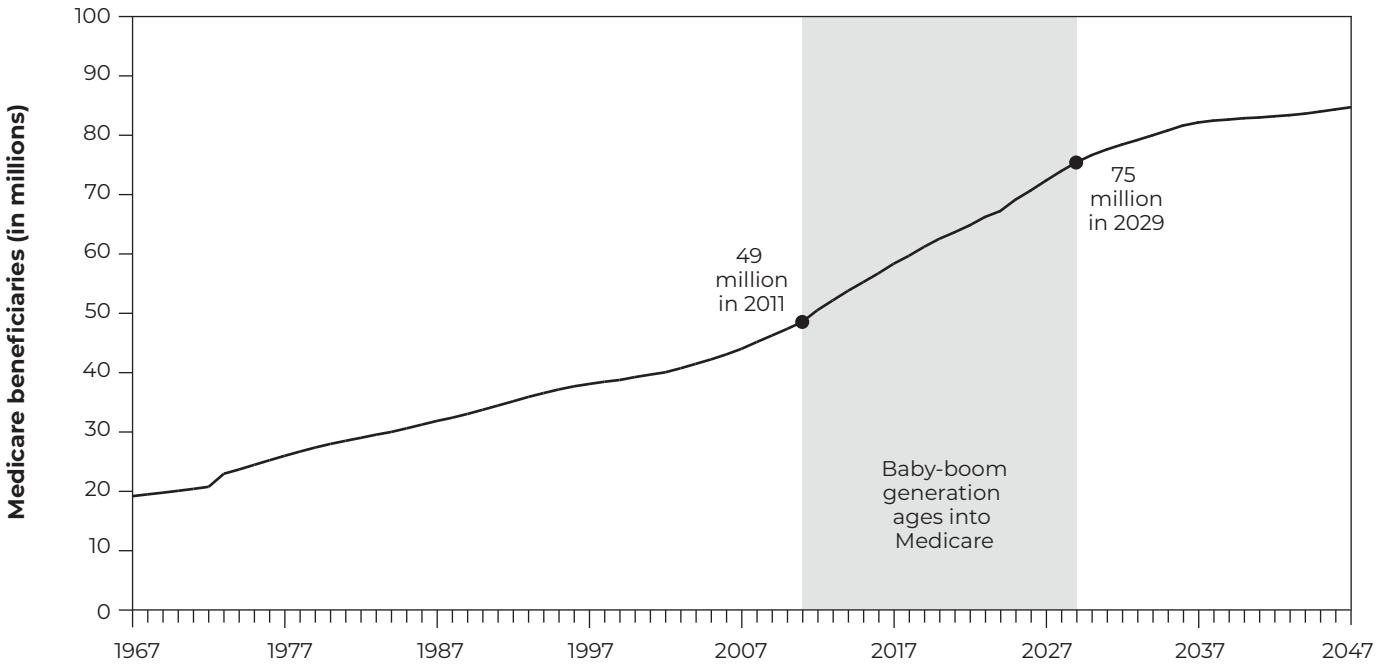


Note: GDP (gross domestic product), CBO (Congressional Budget Office). The CBO line reflects fiscal years, while the Medicare Trustees line reflects calendar years. The first projected year is 2025. Medicare spending includes program spending and spending financed by premiums and other offsetting receipts for beneficiaries in both fee-for-service Medicare and Medicare Advantage but does not include beneficiary cost sharing. 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.

Source: 2025 annual report of the Boards of Trustees of the Medicare trust funds, Figure II.D1; CBO's long-term budget projections released in March 2025.

Over the longer term, there has also been rapid growth in spending on drugs covered under Part B, which are typically administered in physician offices or hospital outpatient departments (as opposed to obtained by patients from retail pharmacies) and include drugs and biologics like cancer drugs and skin substitutes. Between 2009 and 2023, FFS Medicare spending on Part B drugs grew by an average of 9 percent per year, rising from $15 billion to $54 billion (Medicare Payment Advisory Commission 2025a). (By comparison, FFS Medicare's overall Part B spending grew by 7 percent per year over this period (Boards of Trustees 2025).) Part B drug spending growth was driven by a rise in the average price paid by Medicare for these products, due to the introduction of new, higher-priced drugs, increased prices for existing products, and shifts in the mix of drugs furnished to beneficiaries (Medicare Payment Advisory Commission 2025a). (Projections of continued growth in Part B drug prices are captured in the "Other" column of Table 1-1 (p. 12), along with projected growth in the volume and intensity of services and items that are furnished to beneficiaries, as well as other factors.) The Commission has expressed concern about the lack of price competition and high launch prices for some products under the current average sales price (ASP) payment system and has recommended improvements to Medicare's payment approach for Part B drugs (Medicare Payment Advisory Commission 2023a).[1]

FIGURE 1–3 **Medicare enrollment has accelerated as the baby-boom generation ages into Medicare**



Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplementary Medical Insurance because Part A is usually available to beneficiaries at no cost. The first projected year is 2025. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

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

TABLE 1–1 **Medicare Trustees' projections of the influence of different drivers of Medicare's projected spending growth (after accounting for inflation), 2025–2034**

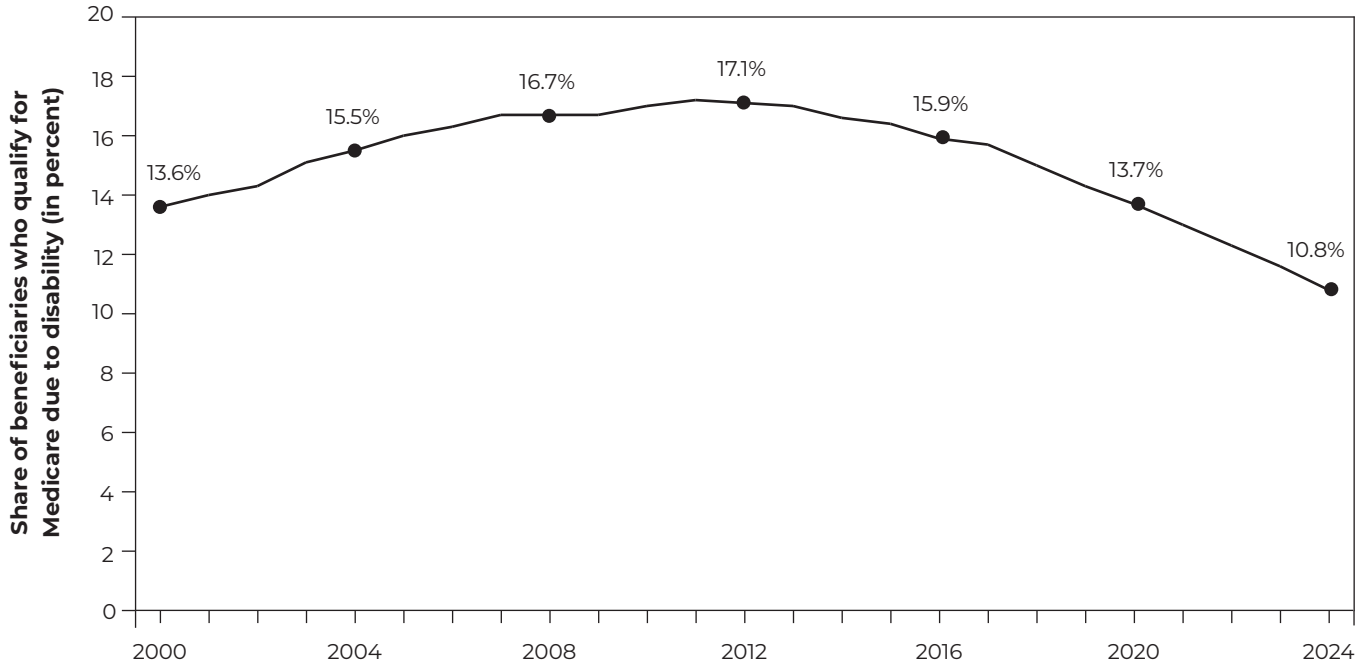
	Average annual percent change in:				
Medicare Part	**Medicare prices for services (minus inflation)**	**Number of beneficiaries**	**Beneficiary demographic mix**	**Other**	**Medicare's projected spending (minus inflation)**
Part A	–0.3%	1.8%	0.4%	1.8%	**3.6%**
Part B	–1.0	1.9	0.1	4.5	**5.5**
Part D	–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 for services (minus inflation)" 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" refers to the residual after the other three factors shown in the table (Medicare prices for services, number of beneficiaries, and beneficiary demographic mix) are removed. "Medicare's projected spending" is the product of the other columns in the table, but components may not produce totals in this column due to rounding. 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.

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

FIGURE 1–4

In recent years, a declining share of Medicare beneficiaries have qualified for the program due to disability



Note: The figure reflects beneficiaries enrolled in Part A and/or Part B, including beneficiaries enrolled in Medicare Advantage plans (who have both Part A and Part B). Beneficiaries who qualify for Medicare due to disability are under the age of 65.

Source: MedPAC analysis of data from annual reports of the Boards of Trustees of the Medicare trust funds and unpublished data from CMS's Office of the Actuary.

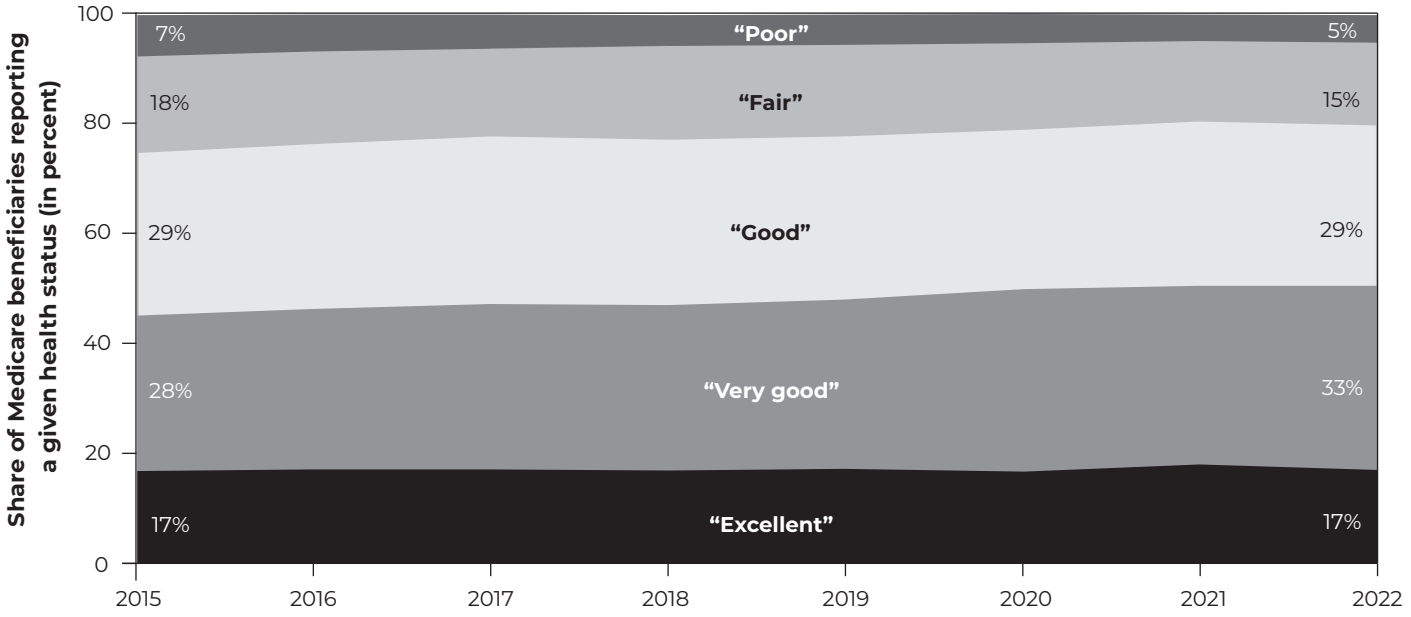
Medicare prices for services (captured in the first column of Table 1-1) are not expected to be a key driver of program spending growth in the next decade because these prices are generally set administratively by the program and are expected to grow at or below inflation. Medicare's constraint of most types of prices could be one reason why spending per enrollee for Medicare beneficiaries usually grows more slowly than for the privately insured—whose plans have less ability to set prices and instead must negotiate with providers (Martin et al. 2025, Martin et al. 2018).

The demographic mix of beneficiaries in the program (shown in the third column of Table 1-1) is also not expected to cause a significant increase in spending over the next 10 years. To the contrary, the average Medicare beneficiary has been getting younger and healthier in recent years as the baby-boom generation ages into Medicare (Boards of Trustees 2025). In addition, the Medicare beneficiaries who survived the recent coronavirus pandemic are now healthier, on average, than beneficiaries were before the pandemic began, which has reduced the Medicare Trustees' projections of Medicare's per capita spending through 2029 (Boards of Trustees 2025).

The health of the average beneficiary has also improved in recent years because a declining share of Medicare beneficiaries have been qualifying for the program due to disability (Figure 1-4). (Beneficiaries who qualify due to disability tend to be in worse health and generate more spending than those who qualify due to age (Medicare Payment Advisory Commission 2025a, Medicare Payment

FIGURE 1–5

An increasing share of Medicare beneficiaries report being in "very good" health, 2015-2022



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.

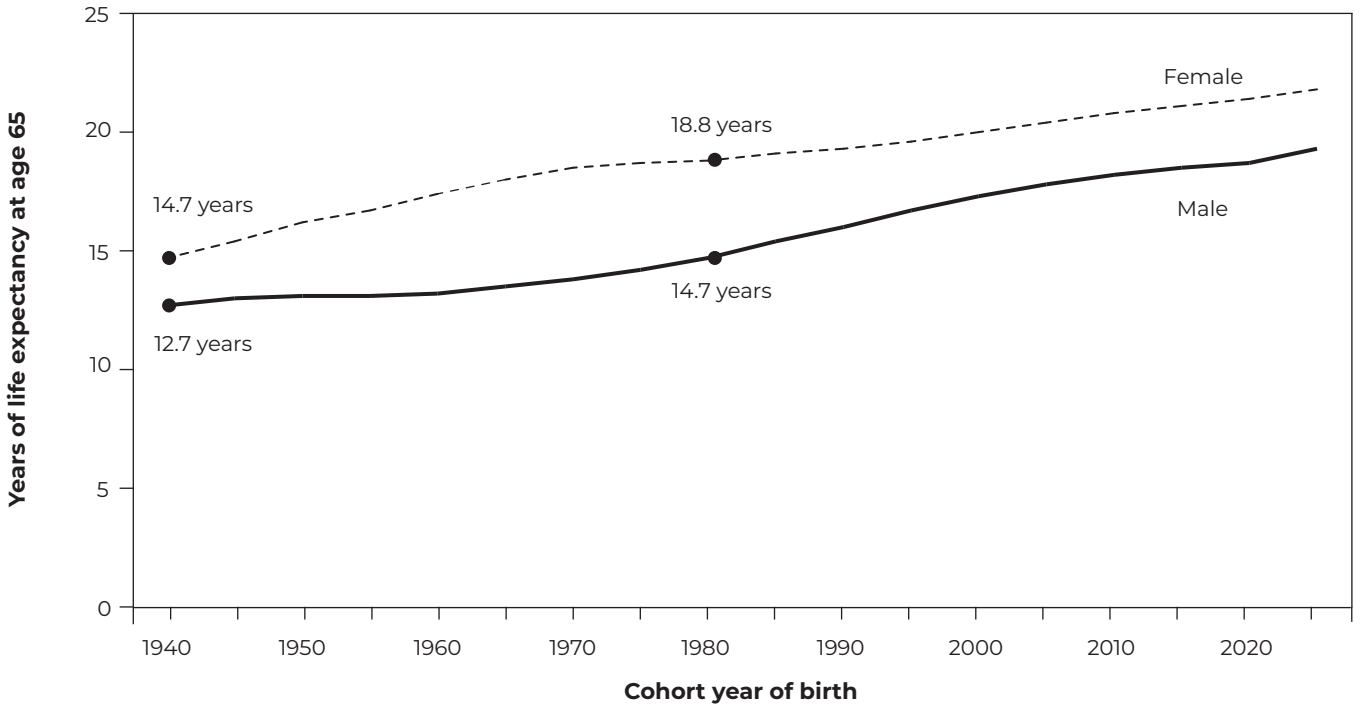
Advisory Commission 2023b).) A declining share of applications to the Social Security Administration (SSA) for disability payments have been approved since 1998, and a declining number of applications have been submitted to the SSA since 2010 (Social Security Administration 2025). These declines in turn are believed to be driven by factors like low unemployment rates, greater availability of health care because of the Affordable Care Act of 2010 (ACA), and employers increasingly offering job flexibility and accommodations to workers with impairments (Social Security Administration 2024).

As a result of these trends, the overall share of Medicare beneficiaries who report being in "very good" health in CMS's Medicare Current Beneficiary Survey has been increasing in recent years (Figure 1-5). (Studies have found that self-reported health status is a good predictor of health care spending (Cunningham 2017, DeSalvo et al. 2009).)

Looking to the more distant future, Medicare's Trustees predict the aging of the baby-boom generation to eventually increase spending growth per person through 2045 since older seniors tend to generate more health care spending than younger seniors (Boards of Trustees 2025). That said, the Trustees also predict a reduction in the share of Medicare beneficiaries who are closer to death at any given age thanks to improving mortality rates, which will partially offset increases in spending stemming from people living longer (Boards of Trustees 2025). (People who are closer to death have higher health spending, regardless of their age (Office of the Actuary 2025).) As shown in

FIGURE 1–6

People born in 1980 are projected to have several more years of life expectancy at age 65 than people born in 1940



Source: The 2025 annual report of the Boards of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.

Figure 1-6, among the cohort of people born in 1940 (who are currently Medicare beneficiaries), women who reach the age of 65 are projected to have nearly 15 years of additional life expectancy (living until age 80) and men are projected to have nearly 13 years of life expectancy (living until age 78). In contrast, among those born in 1980 (future Medicare beneficiaries), women who reach 65 are projected to have nearly 19 years of life expectancy (living until nearly 84) and men are projected to have nearly 15 years of life expectancy (living until nearly 80).

Provider consolidation has been increasing

A key contextual factor in the health care sector is the ongoing consolidation of health care providers. Over the last several decades, health care providers have pursued horizontal mergers and vertical acquisitions, in part to obtain higher payments both from Medicare and private payers. Historically, consolidation primarily involved like types of provider organizations (e.g., hospitals merging with other hospitals) or different types of providers that had referral relationships between them (e.g., hospitals acquiring physician practices). As a result of this consolidation, the share of hospital markets with a single dominant health system that accounted for a majority of hospital discharges rose from 47 percent in 2003 to 57 percent in 2017 (Medicare Payment Advisory Commission 2020). A more recent estimate from KFF suggests that nearly all (97 percent) markets of inpatient hospital care are highly concentrated (Godwin et al. 2024).[2] As local hospital markets have grown more concentrated, hospitals have shifted to consolidating across geographically separate areas (cross-market mergers). Moreover, the integration of physician practices with

hospitals has also increased. By 2024, only 42 percent of practices were owned solely by physicians (Kane 2025).

In recent years, consolidation has expanded beyond hospital mergers and vertically integrated arrangements between providers: Nonprovider organizations, such as private insurers, corporate entities, and private equity (PE) firms, have also acquired provider organizations. Private insurers, operating in both commercial and MA markets, have acquired or financially contracted with hospitals, physician groups, ambulatory surgical centers, and urgent care facilities (Herman 2022, Zhao et al. 2024). UnitedHealth Group's Optum Health is now reported to be the largest employer of clinicians in the U.S. and controls more than 2.7 percent of the Medicare primary care market by service volume (Adler et al. 2025, Emerson 2023, UnitedHealth Group 2023). Payer-operated practices in 2023 accounted for more than 4 percent of the national primary care market volume (albeit with considerable geographic variability), up from about 0.8 percent in 2016. Payers are especially likely to integrate with primary care practices in counties with high MA penetration (Adler et al. 2025).

Private insurers are also increasingly consolidating with pharmacies and with pharmacy benefit managers (PBMs) (which develop drug formularies, establish pharmacy networks, and negotiate rebates with pharmaceutical manufacturers) (Medicare Payment Advisory Commission 2023a). The largest insurers, including UnitedHealth, Humana, and CVS Health, are vertically integrated with PBMs and typically operate their own mail-order, specialty, and sometimes retail pharmacies (Medicare Payment Advisory Commission 2023a). As a result, PBMs now exercise significant influence over drug availability and prices for an increasing share of Medicare beneficiaries enrolled in a stand-alone prescription drug plan or Medicare Advantage Prescription Drug plan (Medicare Payment Advisory Commission 2025c).

Companies that have not traditionally participated in health care, such as Amazon, have also begun acquiring primary care practices, building pharmacy capabilities, and providing telehealth visits, although some, including Walmart, have stopped due to profitability concerns (Landi 2022, McMillon 2024).

Although not the dominant consolidation trend, the growth of PE investment in provider organizations is also notable. An American Medical Association (AMA) survey found that roughly 6.5 percent of physician practices were characterized as PE owned in 2024, up from 4.5 percent in 2022 (Kane 2025). While PE-owned physician practices remain a relatively small, albeit growing, share nationally, PE-provider consolidation may be more pronounced at the local level and within certain geographic markets. PE firms appear to be targeting high-revenue specialty practices (e.g., dermatology, gastroenterology, ophthalmology, cardiology, emergency medicine, and anesthesiology) in specific geographic markets (Abdelhadi et al. 2024, Adler et al. 2023, Bartlett et al. 2024, Torabzadeh and Singh 2025). One recent study found that 807 dermatology, ophthalmology, and gastroenterology practices were acquired by PE firms between 2016 and 2020—more than half of which were subsequently sold to larger PE firms within three years of acquisition. That same study found a 600 percent average increase in the number of physician practices affiliated with PE firms over this period, suggesting rapid consolidation (Singh et al. 2024). In addition to physician practices, a recent study evaluating trends in PE investment in home health agencies from 2006 to 2024 found substantial investment growth after 2017 (Zhu et al. 2025).

Motivations for consolidation

There are several economic motivations for health care provider consolidation. In commercial markets, consolidated providers are often in a stronger bargaining position when negotiating payment rates with private insurers, even in markets with a relatively high concentration of insurers (Chernew et al. 2020, Congressional Budget Office 2022, KFF 2020, Li et al. 2025, Whaley et al. 2024, Whaley et al. 2022). In fact, a 2024 AMA physician survey found that "the need to better negotiate higher payment rates with payers" was the most commonly cited driver of consolidation among physicians in consolidated practices (Kane 2025). When PE firms invest in providers, they often use a so-called roll-up strategy, which consists of acquiring a number of small practices in specific high-revenue specialties to form a larger group. This larger group establishes greater market power and is likely to negotiate higher payment rates with insurers.

Certain types of consolidation can also lead to higher Medicare payment rates through exploitation of site-based payment differentials—namely, when a

hospital acquires a clinician practice, the hospital can sometimes bill a "facility" fee (in addition to the physician's fee) each time a Medicare beneficiary is seen or receives services in the hospital-owned practice if it is located on the hospital campus or in an excepted off-campus facility (an off-campus facility that is excepted from the site-neutral payments required under Section 603 of the Bipartisan Budget Act of 2015). The combination of the facility fee and the physician's fee results in hospitals' on-campus and excepted off-campus physician practices receiving higher Medicare payment rates than independent physician practices. The Commission has recommended eliminating this payment differential by applying "site-neutral" payment rates for certain services provided in hospital outpatient practices (including on-campus and excepted off-campus practices). This change in payment policy would reduce incentives to shift the billing of Medicare services from low-cost settings to high-cost settings and would result in lower Medicare program spending and lower beneficiary cost sharing. A recent study showed that from 2017 to 2020, 87 percent of Medicare spending at hospital-owned practices was generated in on-campus practices and therefore exempted from current site-neutral policies (Post et al. 2025b).

When insurers consolidate with providers, they may be able to better coordinate care and gain provider cooperation in cost-control efforts including prescribing generic drugs and improving care coordination that is tied to quality bonuses, such as through MA star ratings. Improved quality may in turn attract new MA plan enrollees, leading to greater market share (Johnson et al. 2017). Employing providers also may enable plans to generate more extensive diagnosis coding in claims, which can yield higher payments to both insurers and providers in some capitated payment models. In addition, acquiring providers could allow insurers operating in commercial and MA markets to shift profits to their own providers, to avoid the constraints of medical-loss-ratio regulations that limit the share of premiums that insurers are allowed to keep as profit (Frank and Milhaupt 2023).

Obtaining higher payments is not the only reason providers consolidate. When hospitals vertically integrate with other types of providers, they can encourage patient referrals within their integrated system. These referrals can make it more difficult for new or competing providers to retain enough patient volume to be financially stable (Cooper et al. 2025, Harris et al. 2025, Richards et al. 2022). Moreover, more predictable and stable income and the greater ability to maintain patient volume and referral privileges may also lead certain physicians to vertically integrate (Alinezhad et al. 2024, Berenson 2017). Physicians also report selling practices to hospitals or health systems to gain access to costly resources and to get help navigating regulatory and administrative requirements (Berenson 2017, Kane 2025). Conceptually, provider consolidation, including payer–provider consolidation, may also increase access to intellectual and economic capital and improve care coordination and efficient care delivery through economies of scale, streamlined operations, electronic health record interoperability, improved adherence to clinical guidelines, and alignment with value-based payment programs (Berenson 2017, Harris et al. 2025). Finally, provider consolidation is occurring in a complex legal environment of federal, state, and local laws and regulations (e.g., the federal Physician Self-Referral Law (also known as the Stark law), state certificate-of-need laws), which can also influence health care providers' decisions about whether and how to consolidate with other entities.

In the case of payer–PBM consolidation, vertical integration of payers and PBMs (and in some cases, pharmacies) potentially creates conflicting incentives. Integrated payer–PBMs may improve efficiency by reducing transaction costs between upstream and downstream entities (Medicare Payment Advisory Commission 2023a). For example, PBMs may help payers negotiate rebates and discounts with pharmaceutical manufacturers, potentially reducing costs for payers and lowering premiums for beneficiaries. However, the degree to which integrated PBMs pass through these rebates and discounts to their integrated payers (and to nonintegrated payers they contract with) can be opaque (Gray et al. 2023). For example, specialty pharmacies that are owned by PBMs may receive discounts or fees that lower the cost of prescriptions. However, since these transactions are not visible to Medicare, payer–PBM integration diminishes price transparency and can increase costs to Medicare and its beneficiaries (Martin 2025,

Medicare Payment Advisory Commission 2025c).[3] Since integrated PBMs may also contract with nonintegrated payers, payer–PBM integration may create incentives to raise costs for those nonintegrated payers (and their beneficiaries) (Gray et al. 2023). Notably, the IRA is expected to affect the broader pharmaceutical industry, which may have implications for consolidation among pharmaceutical supply-chain participants (see Chapter 13 of this report).

Providers consolidating with PBMs may also designate preferred network pharmacies, which can steer patients to their affiliated pharmacies and away from nonaffiliated pharmacies (Federal Trade Commission 2024). Though there are regulations in place to prevent payer–PBMs from leaving pharmacies out of network and payers cannot require beneficiaries to fill their prescriptions at specific pharmacies, payer–PBMs can sometimes incentivize use of preferred network pharmacies by offering lower cost sharing at those pharmacies (Medicare Payment Advisory Commission 2025c).[4] As a result, if nonaffiliated pharmacies experience higher costs and/or lower drug volume, it may result in pharmacy closures and restrict pharmacy access for beneficiaries (Martin 2025). PBMs also help payers develop and maintain formularies, which directly affects beneficiaries' access to, and out-of-pocket spending on, drugs (Mattingly et al. 2023).

With respect to PE–provider consolidation, potential benefits include modernizing infrastructure and technology and improving operational efficiencies; however, PE firms' focus on short-term financial gain may hinder providers' ability to benefit from these efficiencies (Singh et al. 2022).

Consolidation leads to higher payment rates and spending

Research has shown that consolidation between providers leads to higher payments in both commercial and Medicare markets (Baker et al. 2014, Beaulieu et al. 2023, Beaulieu et al. 2020, Cooper et al. 2015, Gaynor and Town 2012, Government Accountability Office 2025a, Harris et al. 2025, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2017, Whaley et al. 2022). For example, this trend has been observed with Part B drug spending: Two studies using Medicare FFS claims have found that vertical integration shifted utilization of physician-administered drug spending from physician offices to hospital outpatient departments, which resulted in higher physician-administered drug spending (Jung et al. 2019, Levin et al. 2025). In commercial markets, cross-market mergers have also resulted in expanded market power with common customers and higher prices (Arnold et al. 2025b, Dafny et al. 2019, Fulton et al. 2022).

No published empirical evidence exists that evaluates the effect of payer–provider consolidation on insurers' spending to date. However, there is evidence that provider-owned MA plans are associated with greater coding intensity, which may lead to higher payments to insurers and providers (Curto et al. 2025, Geruso and Layton 2020). In part due to a lack of transparency and data, there is limited empirical evidence to date that assesses the effect of payer–PBM integration on Medicare spending. However, a recent report by the Federal Trade Commission (FTC) found that for Medicare Part D beneficiaries, there was substantial markup of, and higher payment rates for, specialty generic drugs at PBM-affiliated pharmacies (Federal Trade Commission 2025). Literature that assesses the effect of PE–provider consolidation on spending is emerging. Two studies using national commercial claims data to evaluate PE acquisitions of gastroenterology and primary care practices showed a 4.5 percent and 7.8 percent increase in commercial prices, respectively (Arnold et al. 2025a, Singh et al. 2025b). Another study using national claims data found that commercial prices increased $92 per gastroenterology claim after PE acquisition, driven by a 78 percent increase in professional fees (Singh et al. 2025c). Early results from PE acquisitions of ambulatory surgical centers have also shown a substantial increase in average charges per case (Lin et al. 2023).

Effect of consolidation on access to care appears minimal

There is mixed, albeit limited, evidence about the effects of consolidation on access to care. A recent study using FFS Medicare claims data found that physicians who became hospital integrated were more likely to treat medically complex beneficiaries and those who were more socioeconomically disadvantaged (Alinezhad et al. 2024), while another found no difference in FFS patient case mix after primary care physicians became hospital employed (Post et al. 2025a). Although clinicians' willingness to

accept Medicare patients remains high, the effect of payer–provider consolidation on access to care for Medicare beneficiaries is not well understood. Moreover, the effect of payer–PBM consolidation on access to care for Medicare beneficiaries is also not clear, though some evidence suggests that payer–PBM consolidation does lead to steerage of patients to the payer–PBM's own affiliated pharmacies—in part through manufacturers' use of limited distribution networks, which may constrain beneficiaries' pharmacy access (Kakani et al. 2025).

With respect to PE–provider consolidation, early research suggests that after such acquisitions, there is an increase in the provision of profitable service lines (e.g., robotic surgery, hemodialysis, cardiac catheterization, physician-administered drugs) and a reduction in the provision of some unprofitable, yet essential, services (e.g., outpatient psychiatric care, retinal detachment surgery) (Braun et al. 2024, Cerullo et al. 2021, Singh et al. 2025a).

Effect of consolidation on quality remains ambiguous

While some providers may be able to improve quality after integration, the overall effect of horizontal consolidation and vertical integration on quality remains ambiguous. Some have posited that the lack of clear quality improvement across different types of provider consolidation may be because financial integration does not necessarily translate into clinical integration (such as information sharing, care coordination, and efficient transitions of care) (Ridgely et al. 2020).

The effect of hospital mergers on quality outcomes is mixed. One study found hospital mergers resulted in higher mortality and lower patient-experience scores (Setzler 2025), while another study that examined the longitudinal effects of hospital mergers on quality found that "hospital acquisitions were associated with modestly worse patient experiences but had little to no effect on readmission rates, mortality rates, or other process measures" (Beaulieu et al. 2020). Results from studies of mergers involving rural hospitals are also ambiguous: One study found lower inpatient mortality and lower postoperative complications for elective surgeries in rural hospitals postmerger (Jiang et al. 2021), while another study found no difference in rural hospital mortality or patient satisfaction but modestly higher readmission rates postmerger (Tsai et al. 2025). With respect to vertical integration, a recent systematic review found some evidence that hospital–physician and hospital–post-acute care consolidation were associated with modest improvements in some condition-specific process measures but little to no effect on mortality, readmission, or emergency department visit rates (Harris et al. 2025). Another recent study found that while hospital employment of cardiologists nearly tripled from 2008 to 2019, there was minimal evidence to suggest commensurate quality improvements among heart-failure and acute myocardial infarction patients (Moghtaderi et al. 2025).

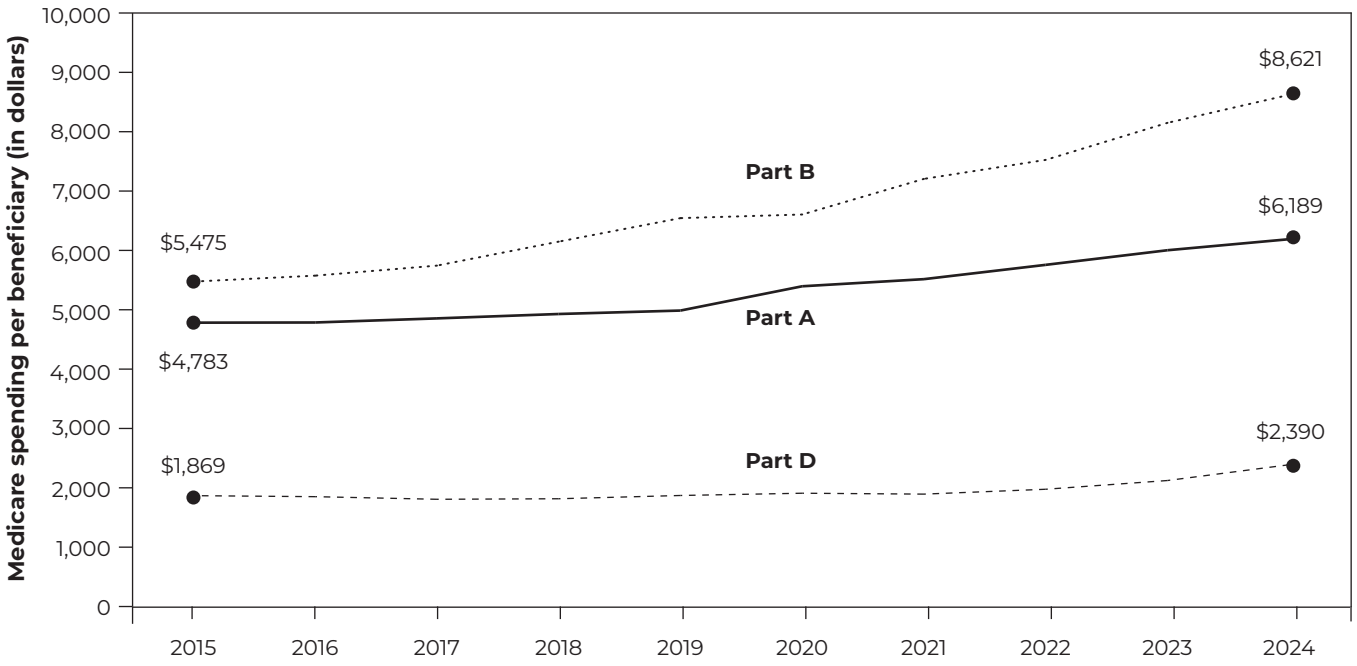
The effect of payer–provider and PE–provider consolidation on quality is also not clear. Recent literature has shown hospital–MA integrated plans to be associated with modest improvements in patient-experience measures; however, these improvements were generally limited to integrated plans offered by well-established managed care organizations, such as Kaiser Permanente (Bejarano et al. 2024). One older study also found hospital–MA integrated plans were associated with higher unadjusted quality ratings, primarily driven by better enrollee satisfaction; however, the magnitude of this effect diminished over the five-year study period (Johnson et al. 2017). Meanwhile, PE–hospital consolidation has been shown to result in declining patient experience, especially in the first three years following acquisition (Bhatla et al. 2025). For other specialty-specific quality outcomes, such as complications after a colonoscopy, evidence suggests no discernible change in quality after PE acquisition of physician practices (Arnold et al. 2025a).

Gaps remain in data about ownership of Medicare providers

To better understand the extent to which different types of provider consolidation are occurring and the impact on outcomes important to Medicare beneficiaries and taxpayers, better data on ownership and affiliation relationships are needed. Existing data sources, particularly those used to identify PE ownership of providers, are often incomplete or inaccurate and often do not capture the nuances of ownership (Government Accountability Office 2023). Greater ownership transparency may also be useful to beneficiaries when they choose where to seek care.

FIGURE 1–7

Medicare spending per beneficiary has grown faster for Part B than for Part A and Part D, 2015–2024



Note: Amounts were calculated as total nominal spending (not adjusted for inflation) on a Medicare part, divided by the number of beneficiaries enrolled in that part. Part B mainly covers physician-administered drugs, hospital outpatient fees, and clinician services in all settings. Figure includes enrollees in Medicare Advantage (MA) and fee-for-service (FFS) Medicare. The share of funds transferred from Part A and Part B to pay for MA enrollees' coverage is based on the shares of total FFS Medicare spending on Part A and Part B.

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

Medicare draws on an increasing share of the country's tax revenues

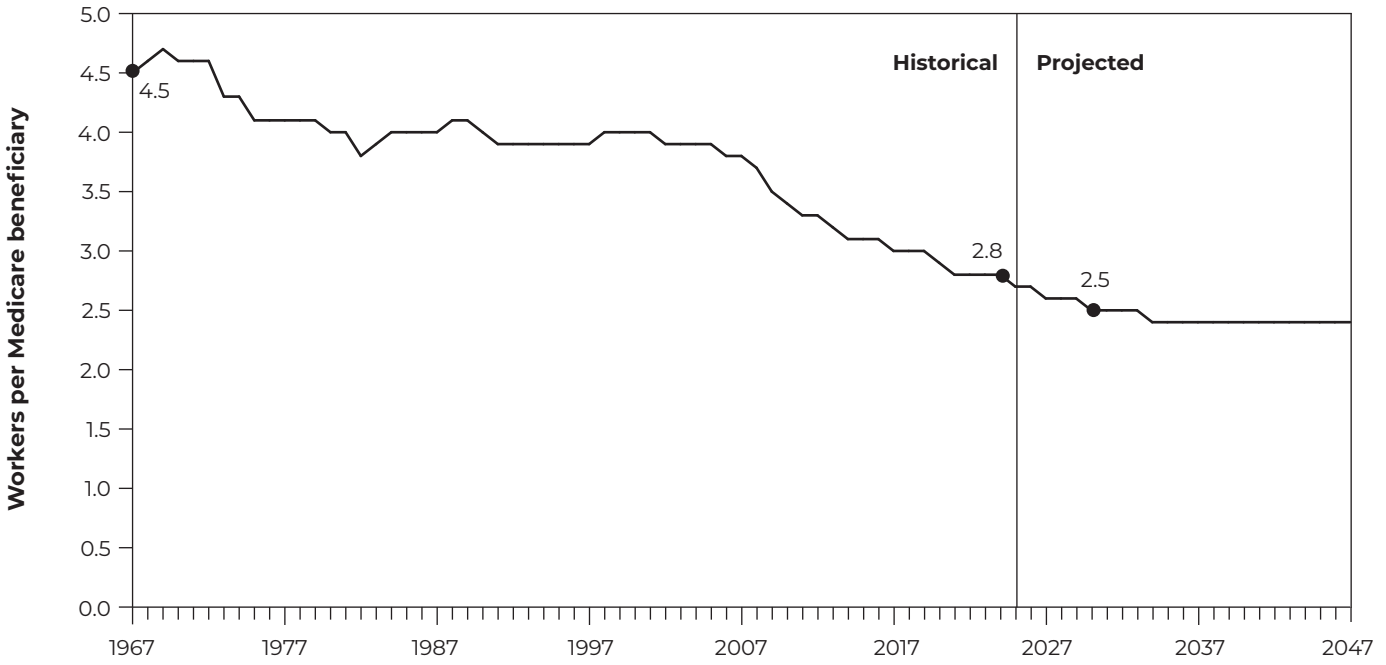
Over the past decade, Medicare spending per beneficiary has been growing more quickly for Part B than Part A or Part D (Figure 1-7). In addition to the rapid growth in spending on Part B drugs noted earlier (p. 11), there has been an increase in the number of clinician encounters per beneficiary (paid for under Part B) (see Chapter 4). In contrast, there has been a decline in the number of inpatient hospital stays and skilled nursing facility stays per beneficiary (paid for under Part A) (Chapters 3 and 7), and researchers have observed a shift from prescription to over-the-counter drugs in several categories and an increase in the prescribing of generic, rather than brand-name, drugs (paid for under Part D) in recent years (Glied and Lui 2026).

Observers have offered competing theories to explain recent changes in the mix of services and items used by Medicare beneficiaries, but alternative payment models are generally not thought to have driven these changes. Instead, observers tend to cite factors like a younger and healthier beneficiary pool and changes in the rate at which new technologies were adopted over this period (Glied and Lui 2026). (The ACA also reduced payment rates in a number of Medicare payment systems, which is widely credited for slowing growth in Medicare spending but is not believed to have changed the mix of services and items used (Glied and Lui 2026).)

As a result of the shift in the mix of items and services being used by beneficiaries, Medicare Part A (which mainly pays for inpatient hospital stays and post-acute care afterward) has constituted a declining share of

FIGURE 1–8

The number of workers per Medicare beneficiary is declining



Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplementary Medical Insurance because Part A is usually available to beneficiaries at no cost. First projected year is 2025. Part A services are financed primarily by Medicare payroll taxes (deposited into Medicare's Hospital Insurance Trust Fund) and beneficiary cost sharing.

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

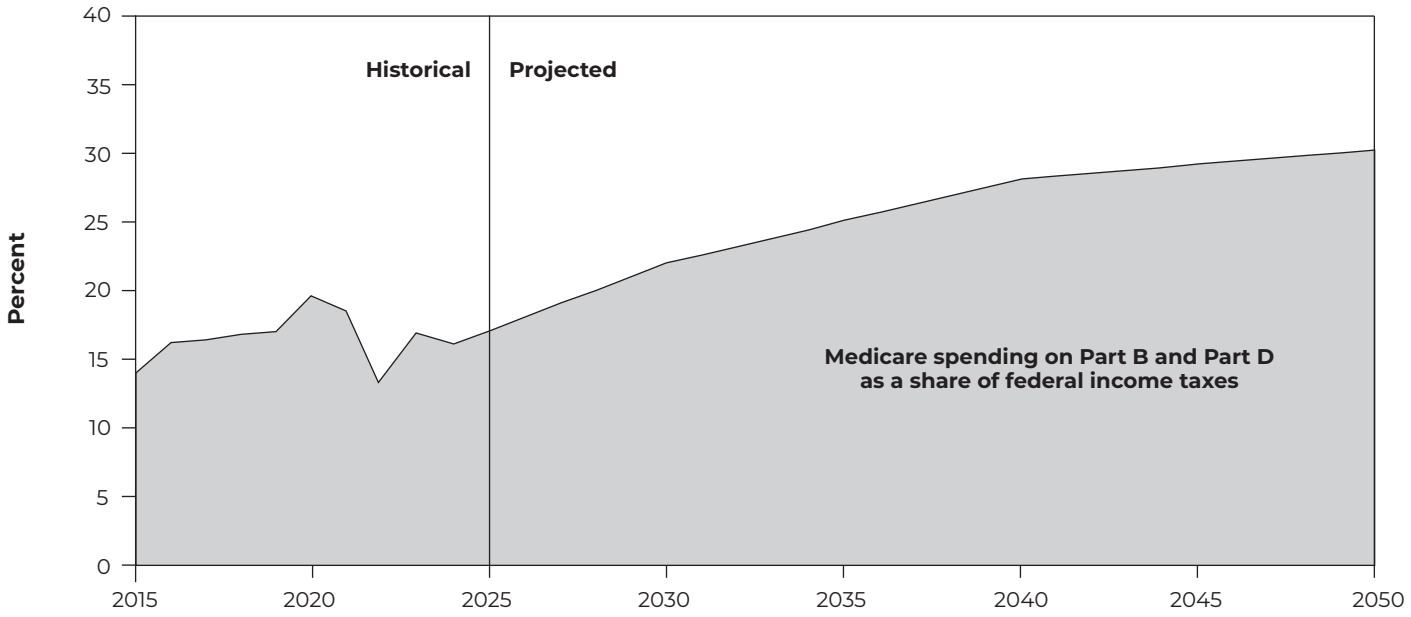
Medicare spending over time, while Part B (which mainly pays for physician fee schedule services in all settings, physician-administered drugs in outpatient settings, and outpatient facility fees) has grown as a share of program spending. By 2024, Part B constituted 49 percent of Medicare spending (up from 45 percent in 2015), Part A constituted 38 percent (down from 43 percent in 2015), and Part D constituted 12 percent (similar to the 13 percent it constituted in 2015) (Boards of Trustees 2025).

The shift in the mix of items and services furnished to beneficiaries has reduced pressure on Medicare payroll tax revenues, which are deposited into Medicare's Hospital Insurance Trust fund and pay for Medicare Part A.[5] In their most recent report, Medicare's Trustees estimated that the trust fund would remain solvent until 2033 (Boards of Trustees 2025, Office of the Actuary 2025).[6] (Some researchers have estimated that the subsequent passage of the One Big Beautiful Bill Act may have shortened this timeline by a year (Committee for a Responsible Federal Budget 2025).)

The relative slowdown in spending on Part A has somewhat eased a growing financing challenge for Medicare's Hospital Insurance Trust Fund: Revenue from workers' Medicare payroll taxes has not been growing as fast as overall Medicare spending for decades now (shown in Figure 1-10 (p. 23)).[7] The main driver of this trend is the continual decline in the ratio of workers relative to Medicare beneficiaries. As shown in Figure 1-8, around the time of Medicare's creation in 1967, there were 4.5 workers for each Medicare beneficiary, but by 2024 there were only 2.8 workers per beneficiary, and by 2030 there are expected to be only 2.5 workers per beneficiary.

FIGURE 1–9

Medicare spending on Part B and Part D is equivalent to a sizable share of federal income taxes



Note: Includes both personal and corporate income tax revenues. First projected year is 2025.

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

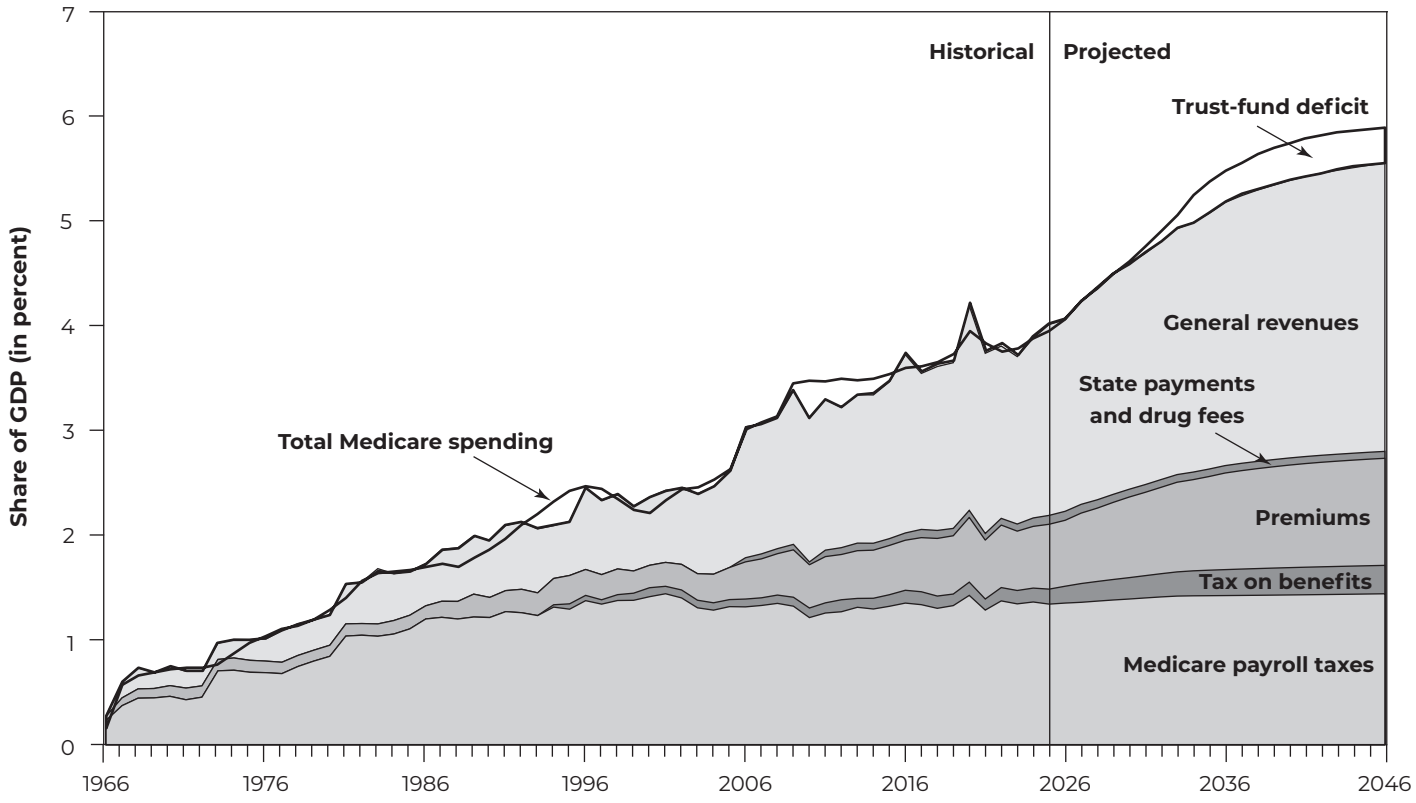
Meanwhile, the faster growth in spending on Part B is increasing pressure on the country's general revenues (e.g., income taxes) and beneficiary premiums, which pay for Part B (and for Part D drug coverage).[8] Medicare's Trustees report that in 2024, an amount equivalent to 16 percent of all personal and corporate income taxes collected by the federal government was used to pay for Part B and Part D (Boards of Trustees 2025). By 2028, 20 percent will be needed for this purpose (Figure 1-9). (See next section for a discussion of the impact of rising Medicare spending on beneficiaries' out-of-pocket spending.)

As the amount of general revenues needed to finance Medicare increases, less revenue is available for other priorities, such as deficit reduction or investments in other priorities.

The increasing amount of general revenues spent on the Medicare program (shown in Figure 1-10) is also a problem because the overall amount that the federal government spends per year (about $7 trillion in 2024) exceeds the amount it collects in revenues (about $5 trillion) (Department of Treasury 2025a, Department of Treasury 2025b). Whenever the U.S. spends more than it collects in revenues, it increases the size of the country's national debt. Given the amount of money the U.S. has borrowed to cover its debt ($30 trillion as of 2025), CBO estimates that the U.S. now spends $1 trillion per year on annual interest payments—about the same amount as is spent on the Medicare program (Congressional Budget Office 2025). CBO has noted that from 2027 on, interest costs as a share of GDP are expected to be higher than they have been since that statistic first began to be tracked in 1940 (Congressional Budget Office 2025). The Government Accountability Office has warned that the federal government is on an unsustainable fiscal path that poses serious economic, security, and social challenges (Government Accountability Office 2025b).

FIGURE 1–10

Medicare's largest funding source has shifted from Medicare payroll taxes to the U.S.'s general revenues



Note: GDP (gross domestic product). First projected year is 2025. 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 payments" refers to payments from the states to Medicare, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed by the Affordable Care Act of 2010 (ACA) on manufacturers and importers of brand-name prescription drugs; these fees are deposited in the Part B account of the Supplementary Medical Insurance Trust Fund. "Trust-fund deficit" refers to the shortfall when Medicare Part A spending exceeds the amount collected through Medicare payroll taxes and other trust-fund revenue sources. Graph does not include interest earned on trust-fund investments.

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

When Medicare spending increases, beneficiaries' costs also increase

When Medicare spending grows, it affects beneficiaries' ability to afford health care by raising their premiums and cost-sharing obligations.

Medicare beneficiaries typically do not pay premiums for Part A coverage, but the annual cost of Part B premiums was $2,220 in 2025 (Centers for Medicare & Medicaid Services 2024a).[9] The average annual cost of premiums for Part D prescription drug plans that year was $468 for stand-alone drug plans and $84 for drug coverage through an MA plan (since MA plans can use Part C rebates to "buy down" enrollees' Part D premiums) (Medicare Payment Advisory Commission 2025a).[10]

Cost-sharing liabilities for beneficiaries in FFS Medicare averaged $396 for Part A services and $1,621 for Part B services in 2021 (the most recent year of information available) (Medicare Payment Advisory Commission 2025a). (The amount of cost sharing that beneficiaries actually pay is lower when they have supplemental coverage such as through Medicaid or a Medigap plan.) Average annual cost sharing for prescription drugs was $492 for beneficiaries with stand-alone Part D plans and $264 for those with drug coverage through an MA plan in 2023, but these amounts are expected to be lower in coming years (Medicare Payment Advisory Commission 2025a).[11] (Starting in 2024, beneficiaries are no longer required to pay cost sharing when they reach the catastrophic phase of the Part D benefit; in 2025, out-of-pocket costs in Part D were capped at $2,000.)

The typical Medicare beneficiary has relatively modest resources to draw on when paying these various premiums and cost-sharing obligations. According to CMS's Medicare Current Beneficiary Survey, beneficiaries' median household income (from all sources, including investments) was about $50,000 in 2023. CMS's survey also found that 18 percent of beneficiaries (including nearly half of those under 65) were food insecure—meaning they reported that in the past year, food did not last and they had no money to buy more, they cut the size of meals or skipped meals, they ate less because they did not have enough money for food, they did not eat because they did not have enough money for food, and/or they could not afford balanced meals (Centers for Medicare & Medicaid Services 2025a).

Another way of assessing the affordability of Medicare's premiums and cost sharing is by comparing them with the average Social Security benefit received by people ages 65 and over. Medicare's Trustees estimate that beneficiary spending on the standard Medicare Part B premium, the average basic Part D premium, plus average cost sharing for Part B and Part D consumed 24 percent of the average Social Security benefit in 2025—up from 19 percent 20 years earlier (Boards of Trustees 2025). Although most people ages 65 and over supplement their Social Security benefits with income from pensions, withdrawals from individual retirement accounts, or other assets, a sizable minority rely on Social Security benefits as their primary source of income. For one in five people ages 65 and over, Social Security benefits make up three-quarters or more of their family income, and for one in seven, Social Security benefits make up 90 percent or more of their family income (Dushi and Trenkamp 2021).

Most beneficiaries try to reduce their total out-of-pocket spending by obtaining supplemental insurance coverage or opting out of FFS Medicare and into an MA plan, which is required to apply a cap on beneficiaries' out-of-pocket spending. In 2022, 43 percent of noninstitutionalized beneficiaries had FFS Medicare plus some type of supplemental coverage (obtained through Medicaid, a former employer, or a Medigap plan they purchased themselves). Another 51 percent were enrolled in an MA plan or other managed care plan (including some beneficiaries who were dually eligible for Medicare and Medicaid). The remaining 6 percent of beneficiaries had FFS Medicare without any supplemental coverage to reduce their cost sharing (Figure 1-11).[12] (Among the subset of beneficiaries with FFS Medicare, 11 percent of FFS Medicare beneficiaries have no supplemental coverage (data not shown).) For more information on Medicare beneficiaries' insurance enrollment options, see text box (pp. 26–28).

In 2024, 18 percent of Medicare beneficiaries received help paying their Part B premium (and, in some cases, their cost sharing) through their state's Medicaid program, and 21 percent received help with their drug costs through the Part D low-income subsidy (Centers for Medicare & Medicaid Services 2025g). When beneficiaries are covered through both Medicare and Medicaid at the same time, their out-of-pocket cost are reduced, but interactions between these two programs' payment policies can sometimes produce unintended incentives (see text box on interactions between Medicare and Medicaid payment policies, p. 30).

Only 7 percent of Medicare beneficiaries reported having problems paying a medical bill in CMS's 2023 Medicare Current Beneficiary Survey, but some beneficiary subpopulations experienced affordability issues at notably higher rates. For example:

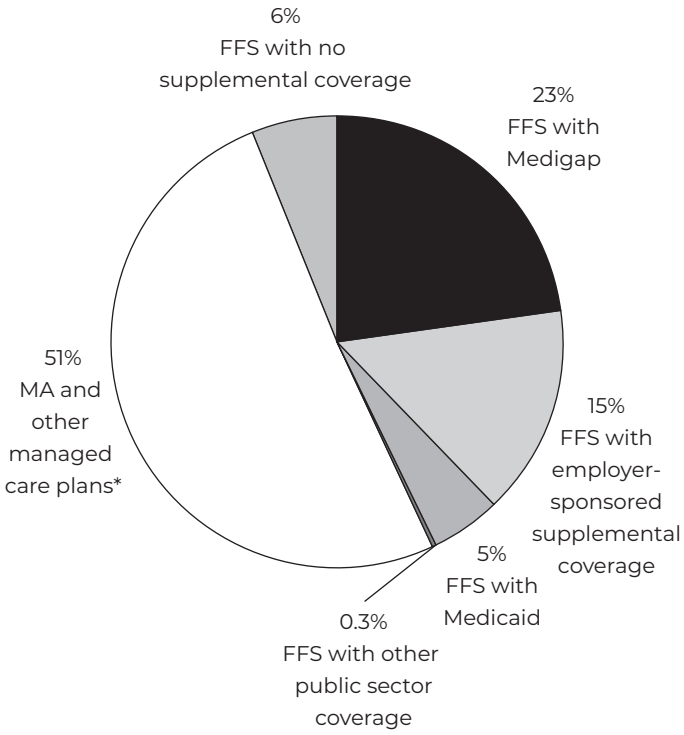
- Among partial-benefit dual-eligible beneficiaries, 25 percent reported a problem paying a medical bill. (These beneficiaries receive Medicaid assistance with premiums and, in some cases, cost sharing, but they do not qualify for additional

Medicaid benefits that full-benefit dually eligible beneficiaries receive, such as dental care and nonemergency medical transportation.)

- Among Medicare beneficiaries under the age of 65 (who are disabled or have end-stage renal disease), 17 percent reported a problem paying a medical bill. (Beneficiaries under 65 tend to require more health care services, have lower incomes, and face higher Medigap premiums than beneficiaries who have reached Medicare's eligibility age of 65 (Cottrill et al. 2024, Cubanski et al. 2016, Medicare Payment Advisory Commission 2025a).)
- Among beneficiaries who qualify for the Part D low-income subsidy, 13 percent reported a problem paying a medical bill. (Beneficiaries qualify for this extra help with their drug costs if they receive full or partial Medicaid benefits or Supplemental Security Income payments and/or, in 2026, have income below $23,940 (or $32,460 if married) and liquid assets below $16,590 (or $33,100 if married) (Centers for Medicare & Medicaid Services 2025h).)
- Among beneficiaries enrolled in FFS Medicare with no supplemental coverage, 11 percent reported a problem paying a medical bill.

Given these findings, it is important to keep in mind that when Medicare payment rates for providers increase, premiums and cost sharing also increase for Medicare beneficiaries, some of whom already have a hard time affording health care. Restraining the annual growth in Medicare spending can help beneficiaries better afford their health care, free up tax revenues for other purposes, and preserve the Medicare program for future generations.

FIGURE 1–11 **Most Medicare beneficiaries tried to reduce their cost sharing through supplemental coverage or enrollment in a Medicare Advantage plan, 2022**



Note: FFS (fee-for-service), MA (Medicare Advantage). Our analysis assigned beneficiaries to the coverage category in which they spent the most time in 2022; beneficiaries could have had coverage in other categories during 2022. The analysis is restricted to community-dwelling beneficiaries (not living in institutions such as nursing homes) who were enrolled in both Part A and Part B throughout their Medicare enrollment in 2022. It excludes beneficiaries who had Medicare as a secondary payer. The number of beneficiaries represented in this chart is 53.5 million.
* Includes plans for beneficiaries who are also eligible for Medicaid and plans sponsored by employers.

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

The health care workforce plays an important role

Ensuring that beneficiaries have access to high-quality care remains an important focus of the Commission. Since numerous studies have found a clear relationship between care quality and having a sufficient supply of nurses and other health care staff, we explore that workforce in this section (Aiken et al. 2010, Cimiotti et al. 2022, Dall'Ora et al. 2022, Harrison et al. 2019, Hyer et al. 2011, Kane et al. 2007, Kutney-Lee et al. 2009, Lasater et al. 2021a, Lasater et al. 2021b, McHugh et al. 2013, Mukamel et al. 2023, Park et al. 2014, Rosenbaum et al. 2024, Shen et al. 2023, Wiltse Nicely et al. 2013).

Almost 2 million physicians, nurse practitioners, physician assistants, psychologists, audiologists, chiropractors, optometrists, dietitians, and other types

Medicare beneficiaries have numerous enrollment options

Once an individual becomes eligible for Medicare, a number of enrollment options become available to them. (Individuals gain eligibility for Medicare either because they have turned 65, they are disabled and have received Social Security Disability Insurance payments for two years, they have just begun to receive disability payments and have a diagnosis of amyotrophic lateral sclerosis, or they have been diagnosed with end-stage renal disease.) As described below, initial decisions related to Medicare enrollment may have lifetime consequences since some choices can lead to late-enrollment penalties. Because of the complexity and multitude of plan choices, beneficiaries often rely on resources like family and friends, insurance agents and brokers, Medicare's hotline and website, and counselors from State Health Insurance Assistance Programs to help them make coverage decisions. (Additional information regarding the complexity of enrollment decisions and available information sources to assist beneficiaries will be included in our June report.)

Initially enrolling in coverage

People who reach Medicare's eligibility age and are already receiving Social Security benefits are automatically enrolled in Medicare Part A, which helps pay for inpatient hospital stays, post-acute care, and hospice care. Part A is available to 99 percent of Medicare beneficiaries without a monthly premium because they or their spouse paid Medicare payroll taxes for at least 10 years (Centers for Medicare & Medicaid Services 2024a).[13]

Individuals can also enroll in Medicare Part B, which helps pay for clinician services in all settings, outpatient facility fees, and physician-administered drugs. For most beneficiaries (including those in a Medicare Advantage (MA) plan), the Part B premium is deducted from their monthly Social Security checks.[14] In 2026, the standard Part B premium is $203 per month for beneficiaries with a modified adjusted gross annual income of up to $109,000 (or $218,000 for a married couple); beneficiaries with higher incomes pay higher Part B premiums (Centers for Medicare & Medicaid Services 2025b).[15]

Prescription drug coverage is available through Part D, either through stand-alone prescription drug plans or MA plans that include drug coverage. Part D enrollees with higher incomes are also required to pay higher premiums, based on the same thresholds used for Part B premiums. The average premium for a stand-alone Part D plan in 2025 was $39 per month, while the average cost of the Part D portion of an MA premium was $7 per month (Medicare Payment Advisory Commission 2025a).

Individuals who are under 65 and had a kidney transplant more than three years prior (and therefore no longer qualify for Medicare due to end-stage renal disease) can qualify for Medicare coverage of their immunosuppressive drugs under the Part B Immunosuppressive Drug Benefit (Part B–ID), which started in 2023 (Centers for Medicare & Medicaid Services 2023). Enrollees in Part B–ID who have higher incomes are required to pay higher premiums, based on the same thresholds used for Part B premiums. In 2026, the standard monthly Part B–ID premium is $122 (Centers for Medicare & Medicaid Services 2025b).

Late-enrollment penalties. Individuals who do not enroll in Part B or Part D when they reach Medicare's eligibility age will usually owe late-enrollment penalties if they eventually do enroll in coverage.[16] Late Part B enrollees have a life-long surcharge added to their Part B premiums that adds 10 percent for each year that they could have signed up but did not (Centers for Medicare & Medicaid Services 2024b). Late Part D enrollees have a life-long surcharge added to their Part D premiums that adds 1 percent of the Part D national base beneficiary premium for each uncovered month (Centers for Medicare & Medicaid Services 2024b).

Annual enrollment options

Beyond the initial decision of whether to enroll in Medicare, beneficiaries also make an annual decision about how to receive their benefits.

(continued next page)

Medicare beneficiaries have numerous enrollment options (cont.)

Fee-for-service Medicare. Unless they opt into an MA plan (described below), Medicare beneficiaries are covered through fee-for-service (FFS) Medicare, which allows them to obtain care from any health care provider who accepts Medicare. Beneficiaries in FFS Medicare owe 20 percent cost sharing for clinician services after they meet their annual Part B deductible (which is $283 in 2026); they also owe $1,736 for the first 60 days of each hospital admission, plus additional daily coinsurance amounts if they require a longer hospital stay. For beneficiaries with a skilled nursing facility stay that exceeds 20 days, the daily coinsurance after the first 20 days is $217 (Centers for Medicare & Medicaid Services 2025b).

Beneficiaries in FFS Medicare can obtain subsidized prescription drug coverage by purchasing a stand-alone Medicare Part D plan (see Chapter 13 for more on Part D).

Medigap. Beneficiaries who want to reduce their cost-sharing liability while maintaining broad access to providers can obtain a Medigap plan that wraps around FFS Medicare coverage. Medigap plans can be purchased by employers for their retired workers or by individuals for themselves. There are a number of standardized Medigap plans (e.g., Plan A, Plan B) that private insurers can offer, which must include the same benefits but can vary in price. The average monthly premium among Medigap policyholders was $217 in 2023 (Freed et al. 2024). (Subsidized supplemental coverage is available to low-income FFS beneficiaries through Medicaid, described below.) Beneficiaries who purchase a Medigap plan when they first reach age 65 are guaranteed the right to purchase any Medigap plan an insurer offers and the insurer cannot factor in the beneficiary's health status when setting the premium; beneficiaries who enroll in a Medigap plan when they first turn 65 can renew that plan indefinitely (Centers for Medicare & Medicaid Services 2025c).[17] In general, beneficiaries who are under the age of 65 or are over 65 and missed the six-month guaranteed-issue period are subject to medical underwriting in most states, which means they can face higher Medigap premiums or be denied a policy due to their health conditions.

Medicare Advantage. As an alternative to FFS Medicare, beneficiaries can opt to receive their Medicare benefits through an MA plan, which allows beneficiaries to lower their cost-sharing liability and receive additional benefits while often paying a relatively low, or no, additional monthly premium. (Aside from MA plan premiums, MA enrollees also pay the Part B premium mentioned earlier.) MA plans typically offer lower cost sharing if a beneficiary seeks care from a provider in a plan's provider network and higher cost sharing or no coverage if the beneficiary seeks care from a provider outside the plan's network.[18] MA plans also have an annual out-of-pocket limit on cost sharing for Part A and Part B services (and, as of 2024, for Part D). To manage costs, MA plans commonly engage in utilization-management strategies such as requiring beneficiaries to obtain a referral from a primary care clinician before seeing a specialist, requiring clinicians to obtain prior authorization from an insurer before furnishing certain services, and denying payment for some claims. MA plans often also offer beneficiaries prescription drug coverage as well as supplemental benefits not available in FFS Medicare (such as vision, dental, and hearing benefits and non–health care benefits such as gym memberships) (Medicare Payment Advisory Commission 2025b).

Medicare beneficiaries who wish to switch from an MA plan to FFS Medicare during Medicare's annual open enrollment period can do so but may face higher Medigap premiums and fewer Medigap plan options than individuals who enroll in a Medigap plan when they first reach age 65.[19] Most states' insurance regulations allow Medigap insurers to deny coverage or vary premiums based on a beneficiary's health status if the beneficiary is buying a Medigap plan after age 65 (Centers for Medicare & Medicaid Services 2025c).[20]

(continued next page)

Medicare beneficiaries have numerous enrollment options (cont.)

Employers can subsidize coverage for Medicare beneficiaries. Some employers help pay for their retired employees' health insurance by paying for Medigap plans, sponsoring their own Medigap-like coverage that wraps around the FFS Medicare benefit package, sponsoring their own prescription drug plans, or sponsoring their own MA plans (which can include or exclude prescription drug coverage). Medicare beneficiaries who served in the military can receive health care services subsidized by the Department of Veterans Affairs (VA) or the Department of Defense (TRICARE 2025). Depending on the circumstances of the retiree coverage, individuals with retiree coverage from a previous employer may be subject to late-enrollment penalties if they do not enroll in Part B or Part D when they first turn 65.

Additional assistance for low-income beneficiaries. Medicare beneficiaries with very low incomes and liquid assets can apply for Medicaid coverage that will pay their Medicare premiums (and, in some cases, their cost sharing).[21] Most individuals dually enrolled in Medicare and Medicaid qualify for additional benefits that are not available under FFS Medicare, such as long-term services and supports (e.g., nursing home care), vision and dental care, and nonemergency medical transportation to appointments. Dually eligible beneficiaries can obtain their Medicare benefits through FFS Medicare or an MA plan and can receive their Medicaid benefits through a FFS Medicaid program or a Medicaid managed care plan (depending on which option(s) their state offers). Some dual enrollees receive coordinated Medicare and Medicaid benefits through a single plan, although such plans are not widely available (Peña et al. 2024).

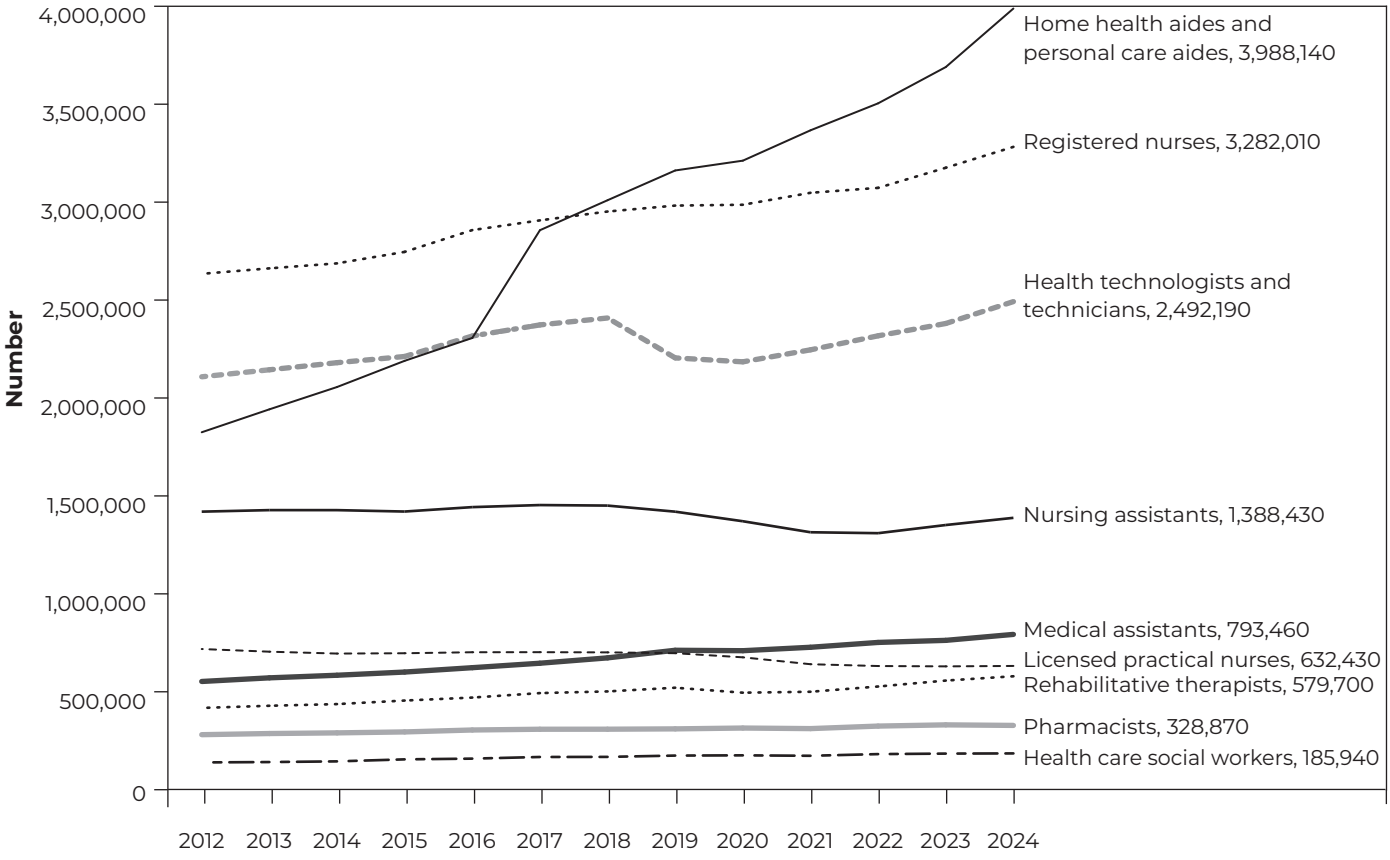
Low-income beneficiaries can also get financial assistance paying for their prescription drugs through Medicare's Part D low-income subsidy (LIS), which pays for a beneficiary's Part D premium and deductible and reduces their cost sharing for drugs.[22] Medicare beneficiaries are automatically enrolled in this program if they are enrolled in Medicaid or another state program that pays their Medicare Part B premium and/or if they receive Supplemental Security Income benefits due to low income. If they are not automatically enrolled in the Part D LIS, Medicare beneficiaries can apply for it if they have an income below $23,940 (or $32,460 for a married couple) and liquid assets below $16,590 (or $33,100 if married) in 2026 (Centers for Medicare & Medicaid Services 2025h).

Beneficiaries' enrollment decisions vary by income and race/ethnicity. According to our analysis of CMS's 2023 Medicare Current Beneficiary Survey, higher-income beneficiaries are more likely to enroll in FFS Medicare while lower-income beneficiaries tend to prefer MA plans. Among beneficiaries with household incomes of $80,000 or more, 61 percent were enrolled in FFS Medicare in 2023; the vast majority of these beneficiaries had private supplemental insurance (e.g., Medigap). Among those with household incomes under $50,000, MA was the more popular option, with 61 percent of these lower-income beneficiaries enrolled in such plans.

Since CMS's survey finds that White beneficiaries' incomes are twice as high as Black and Hispanic beneficiaries' incomes, we also see major differences in coverage selections by race and ethnicity. In CMS's 2023 survey, 51 percent of White beneficiaries had FFS Medicare compared with 25 percent of Black beneficiaries and 28 percent of Hispanic beneficiaries. White beneficiaries were also more likely to have FFS Medicare with some type of supplemental private insurance (obtained through an employer or purchased individually, such as a Medigap plan): 41 percent of White beneficiaries had this coverage combination compared with 11 percent of Black beneficiaries and 14 percent of Hispanic beneficiaries. Enrollment in MA plans was more common among Black and Hispanic beneficiaries: 70 percent of Black and Hispanic beneficiaries were in MA plans compared with 46 percent of White beneficiaries. Black and Hispanic beneficiaries were also more likely to be dually enrolled in Medicare and Medicaid and/or receiving the Part D LIS; for example, nearly half of Black and Hispanic beneficiaries received the LIS compared with 12 percent of White beneficiaries.[23] ■

FIGURE 1–12

Some health care staff occupations have grown faster than others, 2012–2024



Note: The Bureau of Labor Statistics includes licensed practical nurses (LPNs) in its "health technologists and technicians" group of occupations, but we have subtracted them from this group and show LPNs separately in this graph; "LPNs" includes licensed vocational nurses. "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 and 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. We have grouped together physical therapists, occupational therapists, and speech–language pathologists into a "rehabilitative therapists" group in this graph.

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

of practitioners bill Medicare directly for the health care services they provide (Centers for Medicare & Medicaid Services 2025f). This workforce is supported by over 14 million people who work with these practitioners to deliver care to Medicare beneficiaries (shown in Figure 1-12). This latter workforce (which we refer to as "health care staff") includes nurses (registered nurses (RNs) and licensed practical nurses (LPNs)), direct care workers (nursing assistants, home health aides, personal care aides), pharmacists, certain types of therapists (including physical therapists, occupational therapists, and speech–language pathologists) when they provide care in certain clinical settings, and other types of allied health professionals (including numerous types of health technicians and technologists).[24,25,26] The training required for health care staff occupations ranges from a few weeks of on-the-job training to graduate degrees after college, and their roles and responsibilities vary (and can overlap) (Medicare Payment Advisory Commission 2025c).

Interactions between Medicare and Medicaid payment policies

Both Medicare and Medicaid help pay for the cost of some low-income individuals' health care. For services covered by both programs (e.g., physician services), Medicare is the primary payer, while Medicaid may pay some of the cost sharing for dually eligible enrollees. For services covered only by Medicaid (e.g., long-term custodial care in a nursing home), Medicaid is the primary payer and Medicare does not contribute toward the cost of these services. Although these payment rules may appear clear cut, there are times when the interaction of Medicare's and Medicaid's payment policies produces unintended incentives for providers or state Medicaid programs.

One interaction exists in nursing homes that provide skilled nursing facility (SNF) care. Medicaid pays for long-term custodial care in nursing homes, but their payment rates are relatively low. Nursing homes receive higher payment rates if they are providing Medicare-covered skilled nursing care to a beneficiary, which often requires the beneficiary to have just returned from an inpatient hospital stay that lasted at least three days (Centers for Medicare & Medicaid Services 2025i). Nursing homes that qualify as SNFs therefore have an incentive to hospitalize their dually enrolled long-stay residents to requalify those with Medicare coverage for a higher-paying Medicare-covered stay once they return to the nursing home—even if the resident has a clinical condition that typically would not require hospitalization (Grabowski 2007).

Interactions between Medicare and Medicaid payment policies also affect payments to providers due to limits on Medicaid's coverage of Medicare cost sharing. For most dually eligible enrollees, Medicaid can cover a beneficiary's Medicare cost-sharing liability (e.g., 20 percent coinsurance for a physician visit), but states have the flexibility to pay only the cost sharing that would be owed if the provider received the Medicaid payment rate for that service, and most states use this approach (Roberts et al. 2020). Since states usually set Medicaid payment rates well below Medicare rates and providers are prohibited from billing dually eligible enrollees for unpaid cost sharing, the result is that providers may not receive the full amount allowed by Medicare (Roberts et al. 2020). (States have a particularly strong incentive to use this approach for services provided in facilities since Medicare reimburses facilities for 65 percent of any unpaid cost sharing as "bad debt.") The lower revenue that health care providers receive from dually eligible enrollees creates a disincentive for them to treat these enrollees compared with other Medicare beneficiaries (Hayford et al. 2025). (To help improve access to clinician services, MedPAC has recommended an add-on payment when a clinician provides services to dually eligible beneficiaries or other very-low-income beneficiaries (Medicare Payment Advisory Commission 2023b).)

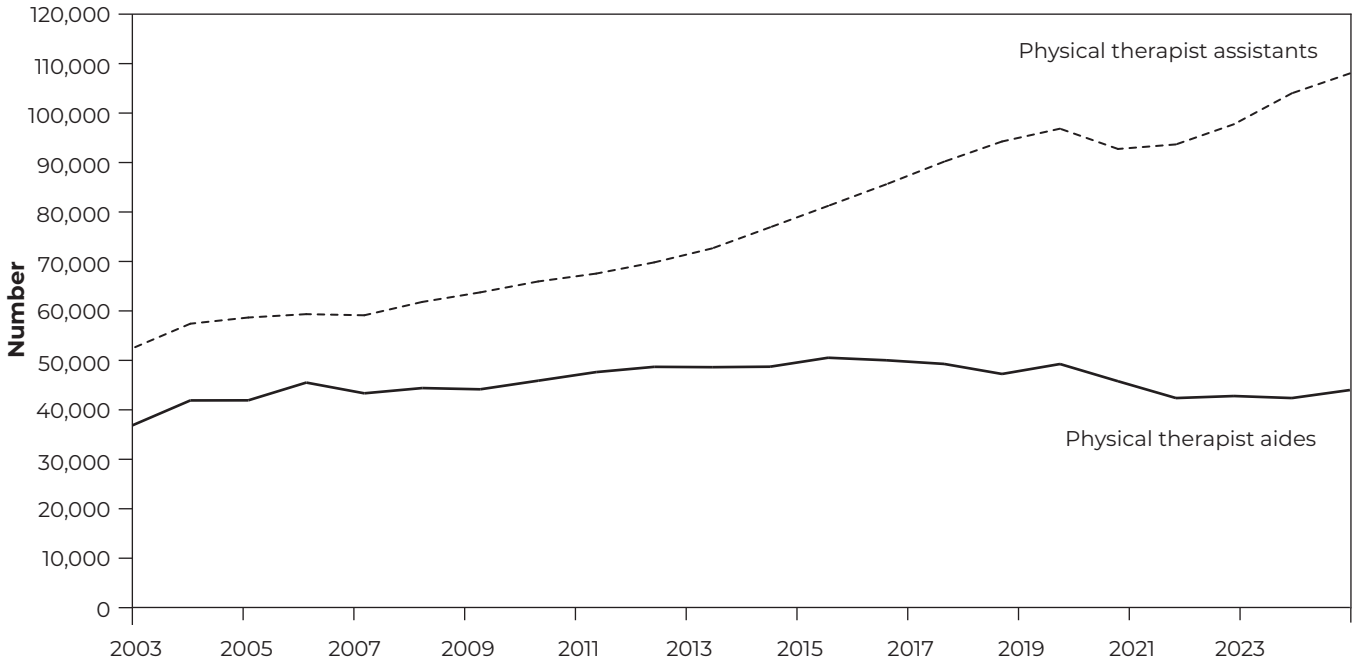
A third interaction affects payments to hospitals and (unlike the prior two examples) potentially improves, rather than impedes, dually eligible enrollees' access to care. Although Medicaid pays hospitals relatively low payment rates, these low payment rates are offset by Medicare disproportionate-share-hospital payments—which increase in size when very poor or disabled Medicare beneficiaries make up a greater share of a hospital's Medicare inpatient days (Centers for Medicare & Medicaid Services 2025d). This policy gives hospitals an incentive to treat such beneficiaries. ■

The health care staff workforce changes over time

The most common and fastest-growing health care staff occupation is home health or personal care aide, which was the occupation of nearly 4 million people in 2024 (Figure 1-12, p. 29).[27] These workers are primarily employed by individuals and families, but about 1 million are employed by home health agencies (Bureau of Labor Statistics 2025b). This occupation requires the least amount of training of the health

FIGURE 1–13

The number of physical therapist assistants has grown, while the number of physical therapy aides (who have less training) has remained flat



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 trends have been observed 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.

care staff occupations, with some aide positions not requiring a high school diploma and relying on on-the-job training (e.g., in housekeeping, cooking, what to do in an emergency, patients' personal hygiene, taking patients' vital signs, infection control, and basic nutrition) (Bureau of Labor Statistics 2025b). The growth in the number of home health and personal care aides coincides with Medicaid shifting to primarily paying for long-term services and supports in the home rather than in institutional settings (Medicaid and CHIP Payment and Access Commission 2024). (Medicaid is the main funder of home health aide services; Medicare's home health benefit covers home health aide services, but as discussed in Chapter 8, they are infrequently provided (averaging less than 0.5 home health aide visits per 30-day period).)

The next two most common health care staff occupations are RNs (3.3 million people's occupation in 2024) and health technologists or technicians (which is an umbrella term for a variety of occupations held by 2.5 million people).[28] The number of people working as RNs and health technologists or technicians has grown more quickly than most other health care staff occupations in recent years (Figure 1-12, p. 29).

One workforce trend is the lack of growth in certain low-training roles. From 2003 to 2024, the number of physical therapist assistants (who usually have an associate's degree and a license or certification) grew rapidly, while the number of physical therapist aides (who usually have only a high school diploma and on-the-job training) remained flat and then began to decline (Figure 1-13) (Bureau of Labor Statistics 2025e). Similar trends are seen among occupational therapist assistants and aides (Bureau of Labor Statistics 2025b). Over this period, we have also seen an increasing number of pharmacy technicians (who must usually

pass an exam or complete a formal education or training program) and a declining number of pharmacy aides (who have only on-the-job training and do not perform tasks related to medications) (Bureau of Labor Statistics 2025b, Bureau of Labor Statistics 2025d, PharmacyTechnician Education & Career Guide 2025). And in the nursing workforce, there has been strong growth in the number of RNs (who must complete a multiyear nursing education program before passing a national exam), while there has been a decline in the number of LPNs (who complete a one-year educational program before passing an exam) (shown earlier in Figure 1-12 (p. 29)).

The health care sector is sometimes referred to as "recession proof" since the number of health care workers tends to increase, even during recessions when other sectors' workforces are shrinking (Buerhaus et al. 2009, Dillender et al. 2021, Wood 2011). The unemployment rate in the health care sector is also consistently much lower than the unemployment rate in the broader U.S. economy (Woodward et al. 2025).

Researchers have also found a "countercyclical" relationship between the share of health care staff who leave their jobs for another industry and the national unemployment rate. During economic downturns, when the unemployment rate is high and it is difficult to find a job, the share of health care workers without a graduate or professional degree who leave the health care sector for a job in another industry is low. Conversely, during times of economic growth, when the unemployment rate is low and it is easier to find a job, the share of these health care workers who leave the health care sector for another industry (e.g., retail) increases (Woodward et al. 2025).

Wages vary by training requirements, geography, and clinical setting

In general, health care staff wages are higher for occupations that require more training (Figure 1-14). For example, in 2024, the highest-paid health care staff occupation was pharmacist (with an annual median wage of about $137,000); pharmacists must complete at least two years of prerequisite undergraduate coursework, a four-year doctor of pharmacy degree, and then pass two exams to become licensed (Bureau of Labor Statistics 2025c). In contrast, the lowest-paid occupation was home health or personal care aide, with annual median wages of about $35,000.

The wages of health care staff can vary based on geographic location and clinical setting. Wages for a given health care staff occupation tend to be higher in areas with higher costs of living (e.g., California).[29] This finding is in contrast to the wages of physicians, which are often higher in areas of the country with lower costs of living: For example, one recent analysis found the highest physician earnings in places like Indiana, Nebraska, North Dakota, and South Dakota (Gottlieb et al. 2025). Provider organizations in such areas may subsidize physician salaries as part of their recruitment efforts.

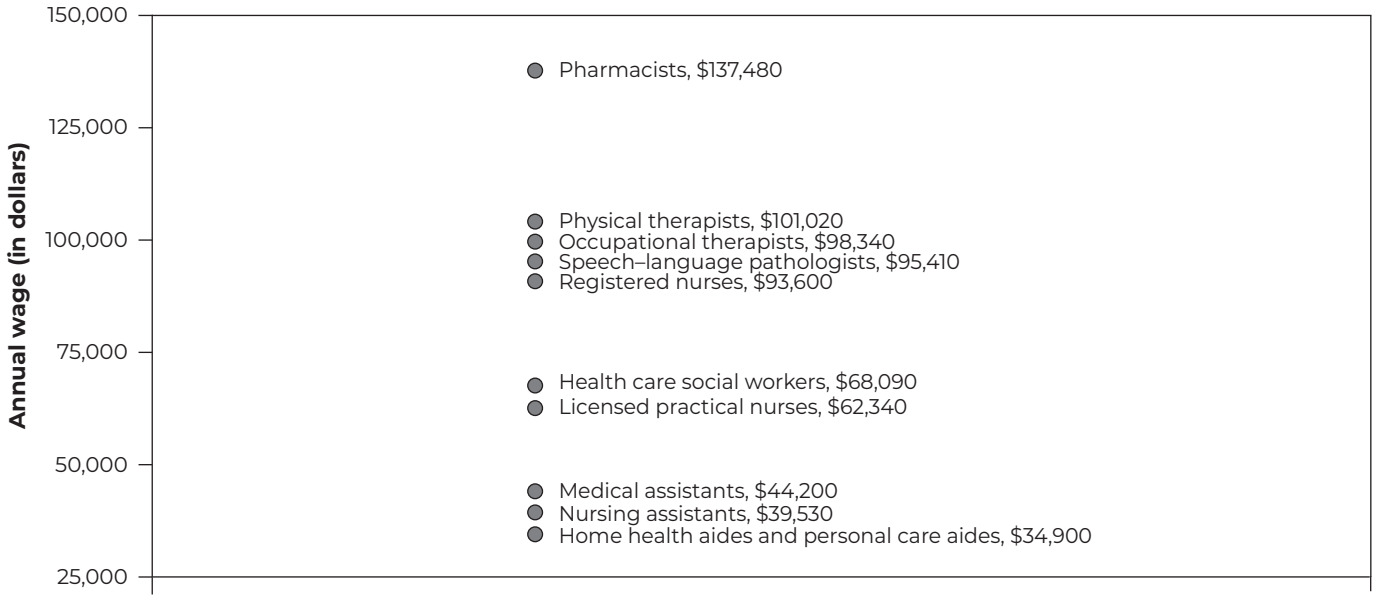
Some types of provider organizations pay particular types of health care staff higher wages than others, which may reflect in part how important certain occupations are in certain clinical settings. According to the U.S. Bureau of Labor Statistics (BLS), hospitals tend to pay more than other settings for RNs, direct care workers (home health aides, personal care aides, nursing assistants), pharmacists, and health care social workers. Skilled nursing facilities (SNFs) and home health agencies tend to pay more than other settings for physical therapists and physical therapy assistants, occupational therapists and occupational therapy assistants, speech–language pathologists, and LPNs. Physicians' offices, in contrast, tend to pay lower wages to their health care staff relative to providers in these other clinical settings.[30]

Assessing the size and stability of the health care staff workforce

It is difficult to project whether the supply of health care staff will be sufficient to meet demand. For one, demand for different health care staff roles can change over time, as described earlier. The supply of workers willing to fill low-wage health care jobs can also change when immigration laws or policies change (Azaroff et al. 2025, Chidambaram and Pillai 2025). In 2024, about one in four direct care workers (e.g., nursing assistants, home health aides) in the U.S. were foreign born (Azaroff et al. 2025, Bureau of Labor Statistics 2024a, Jun and Grabowski 2024, Zallman et al. 2019).

Overall, the BLS projects that what it calls the "healthcare support" occupational group (a similar set of occupations as the ones we focus on here) will grow the fastest of any occupational group between 2023 and 2033, as the baby-boom generation ages and their need for health care services increases (Bureau

FIGURE 1–14 **Annual wages are generally higher for occupations that require more training, 2024**



Note: Figure shows median annual wages. "Licensed practical nurses" includes licensed vocational nurses.

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

of Labor Statistics 2024b).[31] BLS projects home health aides and personal care aides, specifically, to be among the fastest-growing occupations in the U.S., accounting for one in eight new jobs between 2023 and 2033 (Bureau of Labor Statistics 2024b).

That said, the Department of Health & Human Services has projected that the U.S. will have shortages of some types of health care staff and surpluses of others. For example, over the next five years, the agency projects shortages of pharmacists, physical therapists, and diagnostic medical sonographers but surpluses of pharmacy technicians, physical therapy assistants, occupational therapists and occupational therapy assistants, speech–language pathologists, radiation therapists, and health care social workers (Health Resources & Services Administration 2024). RNs and LPNs are projected to be in shortage nationally, but this will vary by state, with some states projected to have an oversupply of nurses (National Center for Health Workforce Analysis 2024). The largest union of nurses has argued that there is not in fact a shortage of nurses—just a shortage of nurses willing to accept current working conditions (National Nurses United 2025). They note that over 1 million individuals currently have active RN licenses but are not working as RNs due to retirements, burnout, family obligations, and concerns about employers using insufficient staffing levels (Muir et al. 2024, National Council of State Boards of Nursing 2025, National Nurses United 2025).

Ensuring adequate care quality for Medicare beneficiaries not only requires having an adequately sized workforce; it also requires having a sufficiently stable workforce. According to Medicare's Care Compare website, nearly half of nursing homes' nursing staff (which primarily consists of nursing assistants) leave their jobs in a given year (Centers for Medicare & Medicaid Services 2025e). This finding is concerning since researchers have found that nursing homes with higher staff turnover provide lower-quality care (Gandhi et al. 2021, Mukamel et al. 2023, Shen et al. 2023).

A number of studies have tried to understand why turnover rates are so high among nursing assistants. One study asked both nursing assistants and nursing home leaders to identify the workplace factors that they viewed as most important for retaining nursing assistants. Both groups agreed that competitive pay, positive supervisor relationships, adequate staffing levels, and a sense of teamwork were important. Nursing assistants also prioritized some factors that management did not: the ability to safely perform their job, the nursing home's reputation for care quality, and access to continuing education (Lauver et al. 2024). Nursing assistants experience musculoskeletal disorders (which can be caused by physical strain) at one of the highest rates in the U.S. (Bureau of Labor Statistics 2025a). A national survey found that more than half of nursing assistants in nursing homes reported having at least one work-related injury in the past year (Squillace et al. 2009). (For more detailed analyses of staffing levels in nursing homes, see Chapter 7.)

How Medicare pays for health care staff labor

Medicare pays for the labor of health care staff differently than it pays for the labor of physicians and other billable practitioners. FFS Medicare pays most practitioners through the physician fee schedule, and generally pays more if a practitioner spends more time or effort delivering a service (e.g., if more minutes are spent delivering a visit or more services are provided during an encounter). In contrast, under FFS Medicare, payment for the labor of nurses and other types of health care staff is bundled into the payments made to clinicians through the physician fee schedule (for office-based services) or into the payments made to facilities through prospective payment systems (PPSs) (for services provided by hospitals, SNFs, home health agencies, and other providers).[32,33,34]

Medicare sometimes specifies what types of health care staff must be on duty in a given type of facility but usually does not specify how many of such staff must be on duty, thus giving facilities flexibility in how they structure their care teams. For example, hospitals are required to provide round-the-clock nursing services to patients using "adequate numbers" of RNs, LPNs, and other personnel "to provide nursing care to all patients as needed" (42 CFR Sec. 482.23). Home health agencies are required to employ an RN, a physical or occupational therapist, and a social worker, but there is no particular number of such staff that must be employed, and patient services can be delivered by other types of workers as long as they are supervised by these key staff (42 CFR Part 484). Hospices are required to have an interdisciplinary team that includes a doctor, an RN, a social worker or marriage and family therapist or mental health counselor, and a pastoral or other counselor, but they can also include other types of workers on their teams (42 CFR Sec. 418.56). (SNFs have more stringent staffing rules.)

The packaged nature of Medicare payments for health care staff, noted earlier, incentivizes facilities and clinician offices to maximize profit by using a less expensive mix of staff. Other aspects of Medicare's payment systems attempt to counter this incentive by tying a portion of payments to performance on measures of care quality, thereby encouraging providers to employ enough staff to deliver high-quality care. For example, many Medicare payment systems have pay-for-performance programs that provide additional payments to facilities or clinicians that meet or exceed certain quality-measure targets and penalize those that miss these targets. Providers also have an incentive to prevent adverse events from happening since such events can lengthen a beneficiary's stay (and a provider's associated costs) without increasing the size of the Medicare payment they receive.

Medicare also promotes adequate staffing by publicly reporting staffing levels in nursing homes that qualify as SNFs. CMS posts 5-star ratings of SNFs on the Medicare Care Compare website (https://www.medicare.gov/care-compare/), including an overall 5-star assessment of each SNF's staffing levels. This website also shows more specific staffing information for each SNF (e.g., the amounts of RN, LPN, and nursing-assistant care hours provided per resident per day and how these amounts compare to state and national averages). The Commission has reported on variation in RN staffing levels in SNFs and expressed interest in elevating the role of RN staffing in these facilities' overall quality ratings, given the link between staffing levels and health care quality outcomes in the research literature (Medicare Payment Advisory Commission 2025b, Medicare Payment Advisory Commission 2025c). In Chapter 7 of this report, we explore different weighting mechanisms for the staffing component of the SNF

5-star rating formula; these illustrative scenarios better align overall star ratings with staffing levels.

In 2026, when it changes the quality measures used in the Medicare SNF value-based purchasing (VBP) program, Medicare will begin tying SNF payments to facilities' performance on staffing measures. Under the SNF VBP program, Medicare withholds 2 percent of SNFs' FFS Medicare Part A payments; 40 percent of these payments are retained for Medicare as savings and the remaining 60 percent are redistributed to SNFs based on their performance on quality measures. In 2026, two of the SNF VBP program's measures directly measure staffing, and two others may be indirectly influenced by staffing levels. The direct staffing measures will assess the number of RN, LPNs, and nursing assistants that SNFs employ by measuring (1) the average number of case-mix-adjusted nursing staff hours provided per resident day and (2) the annual turnover rate among SNF staff. The other measures will assess a SNF's annual risk-standardized rates of (1) health care–associated infections requiring hospitalization and (2) unplanned all-cause hospital readmissions (Centers for Medicare & Medicaid Services 2025j).

State laws can affect staffing levels and wages

States can also give health care providers incentives to use an adequately trained and sized health care staff workforce. California passed a law in 1999 that established minimum nurse-to-patient staffing ratios for hospitals, and researchers have found that it resulted in an extra half-hour of nursing care being provided per patient per day (McHugh et al. 2011). A 2024 study found that six other states had adopted such laws (while one state, Idaho, had banned minimum nurse-to-patient ratios) (Krishnamurthy et al. 2024).

States have also passed laws intended to increase facilities' investments in health care staff, particularly direct care workers. (Research has found that higher minimum wages in the nursing home sector increase retention among low-wage employees and decrease inspection violations, adverse preventable health conditions, and resident mortality (Ruffini 2024).) A 2024 study found that 22 states have enacted "wage pass-through" laws, which can require a certain share of Medicaid payments to be used to compensate direct care workers, for example. That study counted another seven states that have passed laws requiring wages for direct care workers to be a certain amount above the minimum wage. Another five states have passed laws requiring direct care workers to be paid more if they complete various certifications or training programs (Assistant Secretary for Planning and Evaluation 2024). After implementation of these policies, the wages of direct care workers increased more quickly than the wages of other entry-level workers in many states, but the hourly wages of direct care workers remained several dollars lower than the wages of other entry-level workers in most states (Assistant Secretary for Planning and Evaluation 2024).

States may also influence the health care labor market via bans on noncompete agreements in employment contracts. Noncompete agreements prohibit departing staff from working for competitors, thereby curtailing employees' mobility and ability to negotiate better wages and employment terms. Almost all states have passed laws partially restricting the use of such agreements, and some states have gone further and completely banned them (e.g., Minnesota, Montana, Oklahoma) (Paycor 2025).

The Commission aims to improve value for taxpayers and beneficiaries

The Commission regularly makes recommendations to promote program efficiencies and beneficiaries' access to care in our annual March and June reports. Each year we recommend how to update Medicare payment rates for various types of providers; we also offer broader recommendations on restructuring Medicare's payment systems—for example, by adopting site-neutral payments and changing how payments for MA plans are calculated. We also continue to explore how Medicare affects, and is affected by, the broader health care sector. A list of the Commission's recommendations, with links to relevant report chapters, is available at http://www.medpac.gov/recommendation. The evidence-based recommendations we formulate are intended to obtain good value for beneficiaries' and taxpayers' expenditures, which means maintaining or improving access to high-quality services while encouraging efficient use of resources. ■

Endnotes

1 The recently enacted Inflation Reduction Act of 2022 (IRA) gave Medicare certain tools to influence the price that the program and beneficiaries pay for certain Part B–covered drugs. Beginning in 2028, the Secretary will have the authority to negotiate the price of certain high-expenditure single-source products that lack generic or biosimilar competitors and that have been on the market for at least 9 years for drugs or at least 13 years for biologics. In addition, effective January 2023, Part B drug manufacturers are required to pay Medicare a rebate if the price of their product increases faster than inflation. The legislation includes additional provisions that affect Part B drugs, such as limiting beneficiary cost sharing for Part B–covered insulin and certain changes to payment for biosimilars. However, some challenges remain. The program continues to lack tools to influence launch prices of new drugs, including those with limited clinical evidence. In addition, because Medicare pays for single-source drugs and biologics according to separate billing codes based on their own average sales price, concerns remain about a lack of price competition among products with similar health effects during the period before they are eligible for negotiation. With respect to Medicare's payment to providers, concerns remain that paying the average sales price plus a percentage add-on can create financial incentives that favor prescribing higher-priced drugs in some circumstances.

2 Market concentration is defined based on the Herfindahl–Hirschman Index (HHI) measure thresholds in the merger guidelines from the Federal Trade Commission and Department of Justice: not concentrated (HHI < 1,000), moderately concentrated (1,000–1,800), and highly concentrated (HHI > 1,800): https://www.justice.gov/atr/herfindahl-hirschman-index.

3 Currently, in commercial markets, pharmacy benefit managers (PBMs) are not required to disclose the drug rebates they negotiate with pharmaceutical manufacturers or the price difference between what insurers pay them to fill a prescription and how much the PBM actually pays the pharmacy to fill the prescription.

4 In Medicare Part D, the "any willing pharmacy" requirement prevents plans from leaving pharmacies out of network if they meet the plan's standard contracting terms and conditions, which must be "reasonable and relevant." See https://www.cms.gov/files/document/chapter-5-benefits-and-beneficiary-protection-v92011.pdf (Sec. 50.8.1)

5 Part A services are also funded by income from the taxation of higher-income individuals' Social Security benefits, interest earned on investments, premiums collected from voluntary participants, and other sources (Boards of Trustees 2025).

6 Once the Hospital Insurance Trust Fund's balance is depleted, the trust fund would be able to cover only 89 percent of the cost of scheduled Part A benefits (Boards of Trustees 2025).

7 Workers and their employers split the cost of the Medicare payroll tax (workers pay 1.45 percent and employers pay 1.45 percent). Meanwhile, self-employed people pay both the worker's and the employer's share of this tax, totaling 2.9 percent of their net earnings. High-income workers pay an additional 0.9 percent of their earnings above $200,000 for single workers or $250,000 for married couples (Boards of Trustees 2025).

8 General revenues primarily consist of individual and corporate taxes but also include customs duties, leases of government-owned land and buildings, the sale of natural resources, usage and licensing fees, and payments to agencies (Department of Treasury 2026).

9 Individuals with higher incomes pay a higher Part B premium. See Endnote 15.

10 The annual cost of premiums for stand-alone Part D drug plans mentioned in the text ($468 in 2025) was the average for all stand-alone Part D drug plans, including both basic and enhanced plans. The annual cost of drug coverage through a Medicare Advantage (MA) plan mentioned in the text ($84 in 2025) was the average cost for conventional MA plans with prescription drug coverage, excluding MA special-needs plans (which are for individuals who are institutionalized, dually enrolled in Medicare and Medicaid, or who have a severe or disabling chronic condition).

11 These amounts do not include cost-sharing liability paid by Medicare on behalf of Part D enrollees who receive the low-income subsidy.

12 The share of community-dwelling Medicare beneficiaries who report having FFS coverage with public or private supplemental coverage has declined from nearly three-quarters of beneficiaries in 2000 to nearly half of beneficiaries in 2022, according to our analysis of CMS's Medicare Current Beneficiary Survey data (Medicare Payment Advisory Commission 2025a, Medicare Payment Advisory Commission 2003).

13 Individuals paid the full Part A premium of $565 per month in 2026 if they were eligible for Medicare but they or their spouse did not pay Medicare payroll taxes for at least 7.5 years. Individuals paid a discounted Part A premium of $311 per month if they or their spouse paid Medicare payroll taxes for at least 7.5 years but less than 10 years (Centers for Medicare & Medicaid Services 2025b).

14 MA plans can reduce the amount deducted from enrollees' checks by "buying down" some or all of the standard Part B premium amount. In 2026, 29 percent of the beneficiaries enrolled in conventional MA plans are estimated to be in premium-reduction plans, with a median premium reduction of $61 per month. (See Chapter 12 for more on Medicare Advantage.)

15 In 2026, beneficiaries with an annual modified adjusted gross annual income (MAGI) of greater than $109,000 and less than or equal to $137,000 (or greater than $218,000 and less than or equal to $274,000 for a married couple) pay a monthly premium of $284. Beneficiaries with a MAGI of greater than $137,000 and less than or equal to $171,000 (or greater than $274,000 and less than or equal to $342,000 for a married couple) pay $406. Beneficiaries with a MAGI of greater than $171,000 and less than or equal to $205,000 (or greater than $342,000 and less than or equal to $410,000 for a married couple) pay $528. Beneficiaries with a MAGI of greater than $205,000 and less than $500,000 (or greater than $410,000 and less than $750,000, for a married couple) pay $649. Beneficiaries with a MAGI of $500,000 or more (or $750,000 or more for a married couple) pay $690 (Centers for Medicare & Medicaid Services 2025b).

16 Individuals who do not qualify for premium-free Part A are also subject to a late-enrollment penalty if the individual does not buy Part A when the individual is first eligible for Medicare. Medicare beneficiaries are exempt from Part A, Part B, and Part D late-enrollment penalties if they delayed enrolling in Medicare because they had comparable coverage through another source (e.g., an employer, TRICARE) or they missed a chance to sign up because they were impacted by a natural disaster or declared emergency, they were given inaccurate or misleading information from their health plan or employer, they were incarcerated, or they experienced other exceptional conditions (Centers for Medicare & Medicaid Services 2024c).

17 The initial six-month open enrollment period for Medigap starts the first month that a beneficiary is age 65 and has Medicare Part B.

18 MA enrollees in preferred provider organization plans or HMO point-of-service plans generally have some out-of-network coverage with up to 50 percent coinsurance, but out-of-network care is generally not covered in HMO plans except for emergency and urgently needed services. In cases where medically necessary care is not obtainable in network, all MA plans must allow enrollees to go out of network and pay in-network cost sharing. See Chapter 12 of this report for more information on MA plan types.

19 Medicare gives nursing home residents more flexibility than other beneficiaries: They can switch from FFS Medicare to an MA plan, from MA to FFS, or change their MA or stand-alone Part D plan on a monthly, rather than annual, basis. But, as with other types of beneficiaries, they may encounter higher Medigap premiums and fewer Medigap plan options if they switch from MA to FFS and try to buy a Medigap plan after their first year of Medicare eligibility.

20 However, we note that in the MA initial trial period, Medicare beneficiaries who were initially enrolled in a Medigap plan and switched to MA for the first time may return to FFS Medicare and their Medigap plan before the end of their first year of MA coverage without being subject to medical underwriting. In addition, beneficiaries who join MA for the first time when first eligible at age 65 may disenroll during the first 12 months for FFS Medicare and may obtain a Medigap plan.

21 In 2025, in general, beneficiaries with less than $15,900 in annual income and $9,660 in liquid assets (or $21,396 in income and $14,470 in assets if married) were able to sign up to have Medicaid pay their Medicare Part A (if needed) and Part B premiums and cost sharing; however, some states have set higher income and/or asset thresholds. Slightly higher–income beneficiaries can sign up to have Medicaid pay their Medicare Part A or Part B premiums.

22 Medicare will cover the premium for LIS beneficiaries up to the low-income premium subsidy amount (LIPSA) for the region in which the beneficiary resides. See Chapter 13 for more information regarding LIPSA.

23 The statistics in this paragraph are calculated using a different, simpler approach compared with the statistics shown earlier in Figure 1-11 (p. 25). The enrollment statistics in this paragraph are based on our analysis of the 2023 Medicare Current Beneficiary Survey's Survey file for noninstitutionalized beneficiaries enrolled in both Part A and Part B.

24 We use "licensed practical nurses" as a shorthand for licensed practical nurses and licensed vocational nurses.

25 We use "nursing assistants" as a shorthand for nursing assistants, certified nursing assistants, and nurse aides.

26 Physical therapists, occupational therapists, and speech–language pathologists are types of allied health professionals. They are identified separately here since they are used heavily in certain clinical settings.

27 Another fast-growing segment of the health care workforce is advanced practice registered nurses (APRNs) and physician assistants (PAs). Although many APRNs and PAs hold salaried positions within provider organizations, we consider them to be practitioners as opposed to health care staff. For more information on APRNs and PAs, see Chapter 4 of this report.

28 The Bureau of Labor Statistics' "health technologist and technician" category includes licensed practical nurses (LPNs), but we have subtracted LPNs from this category in this sentence and track them separately in Figure 1-12 (p. 29).

29 MedPAC analysis of Bureau of Labor Statistics data on annual median wages for various types of health care support staff in different geographic areas of the U.S. (Bureau of Labor Statistics 2025a).

30 MedPAC analysis of BLS data on annual median wages for various types of health care support staff in general medical and surgical hospitals, nursing care facilities (SNFs), home health care services, and offices of physicians (Bureau of Labor Statistics 2025a).

31 For example, in contrast with our definition of "health care staff," the BLS's "healthcare support" occupational group includes dental and veterinary assistants and excludes nurses, rehabilitative therapists, and pharmacists (Bureau of Labor Statistics 2023)

32 Payment for administrative staff, medical equipment and supplies, rent, health information technology, and other expenses is also bundled into FFS Medicare's base payment rates under the physician fee schedule and under Medicare's various PPSs.

33 PPS payments to facilities are adjusted for certain facility characteristics, relative area wages, and for differences in patients' expected costliness.

34 Although Medicare's general approach is to pay for health care staff labor through flat 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 in some settings but through a PPS in other settings: For example, physical therapists are paid directly through the physician fee schedule when they provide services in a hospital outpatient department, but when they provide services in a SNF, they are paid by the SNF, which receives a flat PPS payment intended to cover the cost of the physical therapy services provided in that setting. Some types of clinicians are paid through Medicare's physician fee schedule for some types of services and through a PPS for other types of services. For example, pharmacists can bill the physician fee schedule directly when they administer vaccines but not when they perform medication reconciliation (which is sometimes paid for through some other Medicare PPSs). And finally, some types of health care staff's services can be billed by a physician or other billable practitioner when they are provided "incident to" services provided by that practitioner, while other services cannot. For example, Medicare's physician fee schedule pays nurses to furnish the lowest-level evaluation and management office visit when it is billed by a physician under "incident to" rules but does not make separate payment to nurses when they take a patient's vitals as part of a more advanced evaluation and management visit.

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