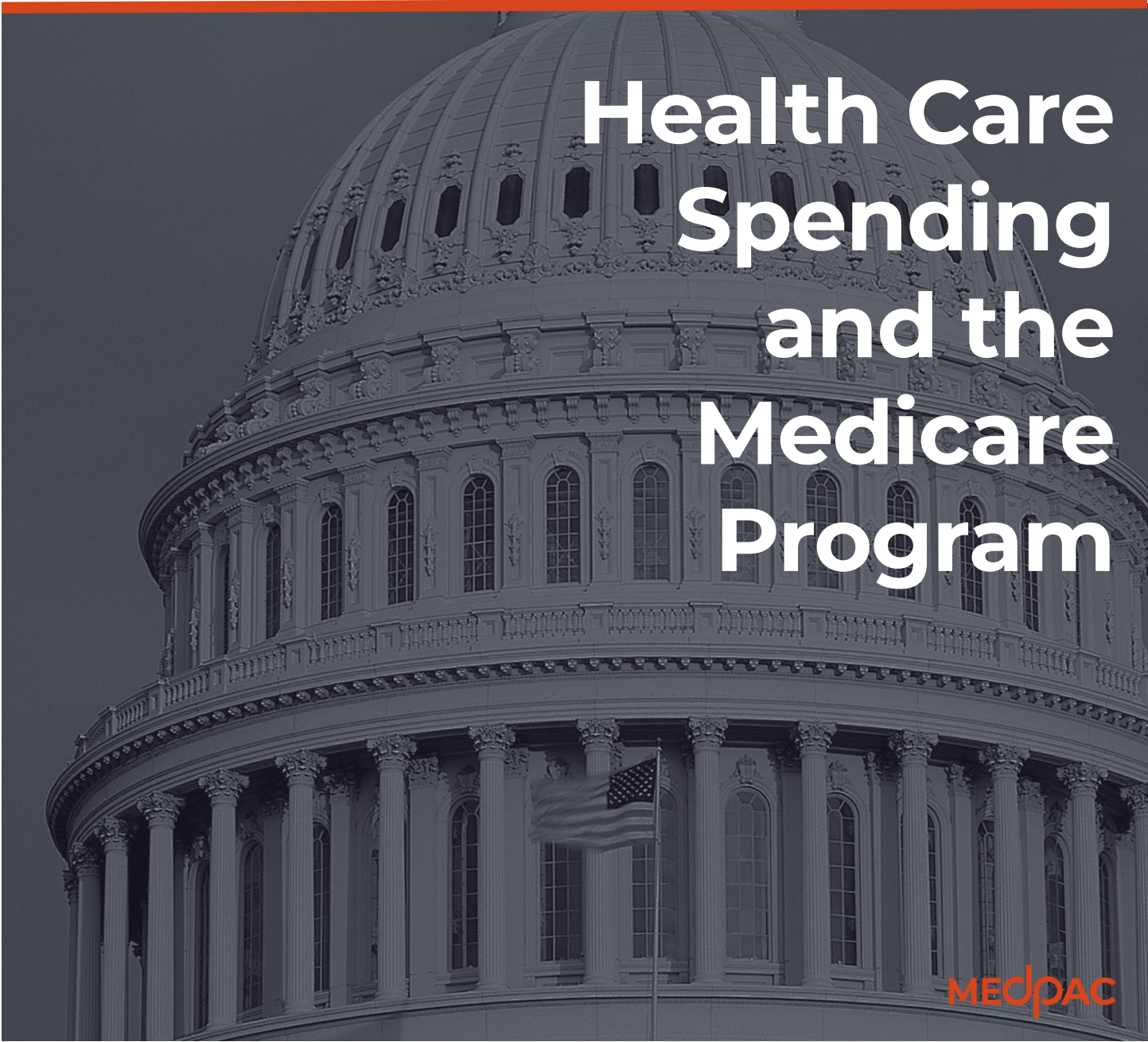




J U L Y 2 0 2 6

A Data Book



Health Care Spending and the Medicare Program

MECPAC

J U L Y 2 0 2 6

A DATA BOOK

Health Care Spending
and the
Medicare Program



Medicare Payment
Advisory Commission

Introduction

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

Notes on data

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

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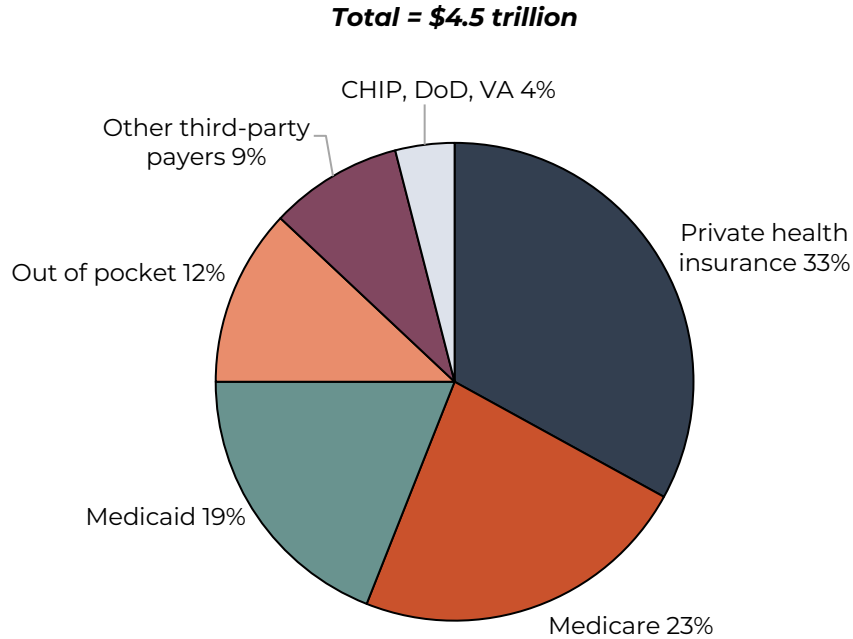
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SECTION

1

National health care and Medicare spending

Chart 1-1 Medicare paid for 23 percent of personal health care spending, 2024



Note: CHIP (Children's Health Insurance Program), DoD (Department of Defense), VA (Department of Veterans Affairs). "Personal health care" is a subset of national health expenditures that comprises spending for all medical goods and services provided to patients. "Out-of-pocket" spending includes cost sharing for both privately and publicly insured individuals. Premiums are included in the shares of each program (e.g., Medicare, private health insurance) rather than in the out-of-pocket category. "Other third-party payers" includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, the Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

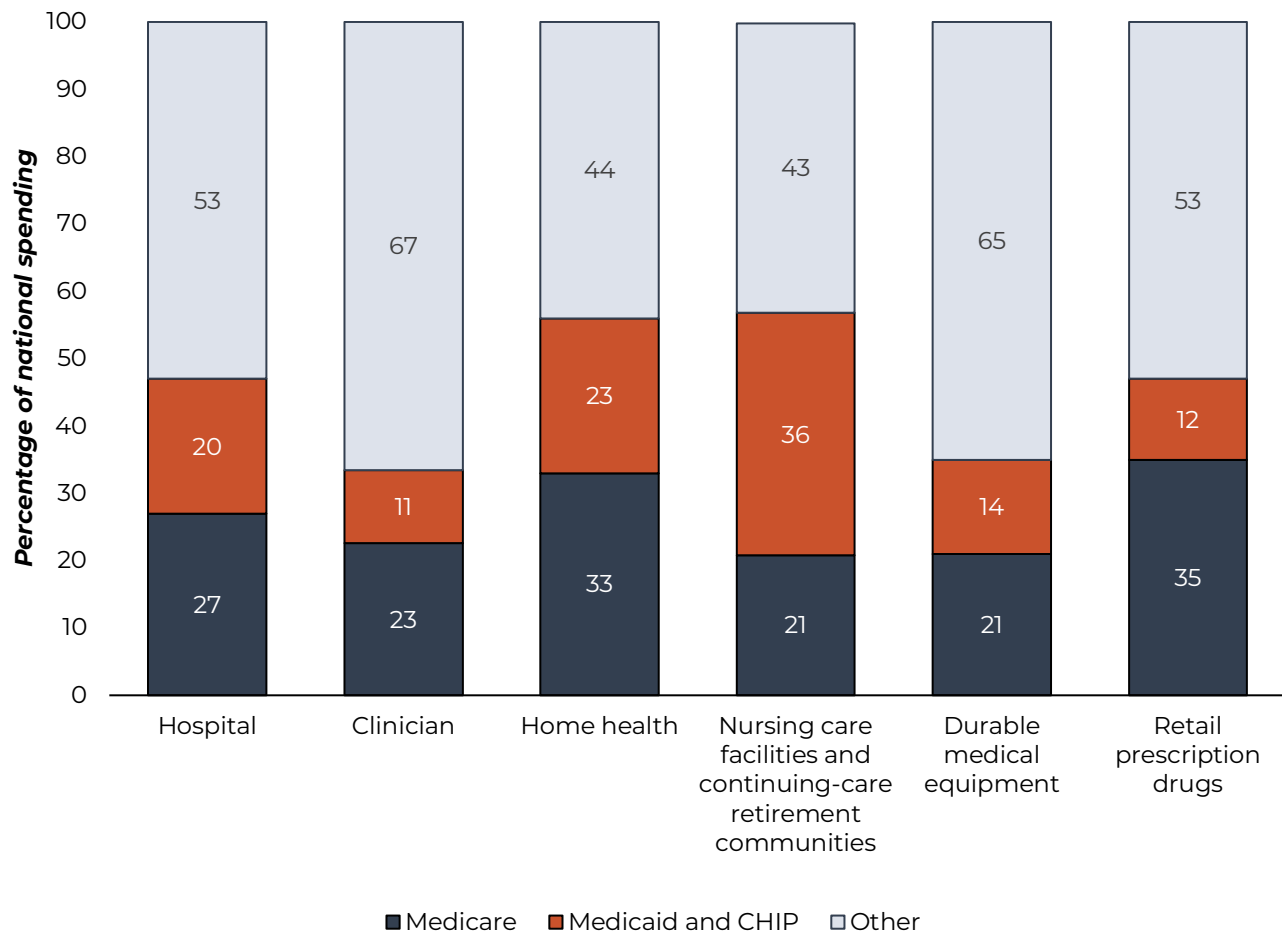
Source: CMS Office of the Actuary, NHE Tables (ZIP), released January 2026, <https://www.cms.gov/files/zip/nhe-tables.zip>.

> In 2024, \$4.5 trillion was spent on personal health care in the U.S.

> Medicare spent \$1 trillion on personal health care in 2024, representing 23 percent of national spending on personal health care. Medicare covered 16 percent of people in the U.S. in 2024 (data not shown). (Health care spending per person tends to be higher for Medicare beneficiaries than for younger and healthier people.)

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

Chart 1-2 Medicare's share of national spending on personal health care varied by type of service, 2024



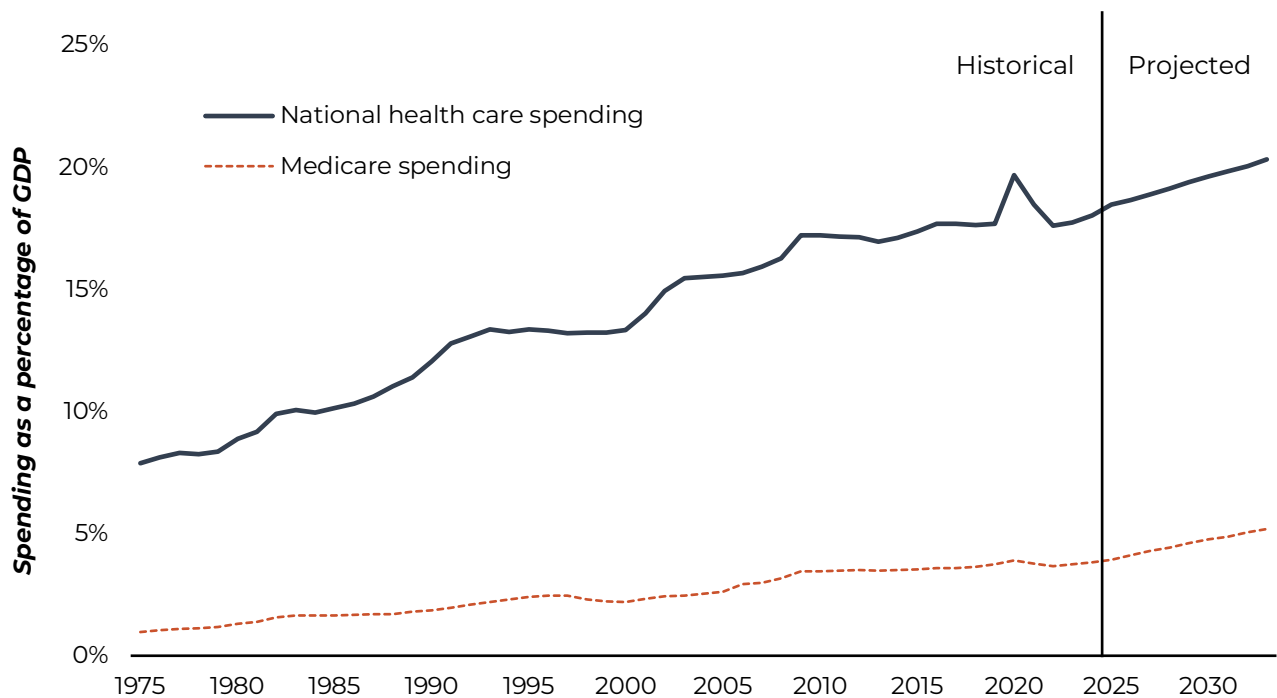
Note: CHIP (Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures that comprises spending for all medical goods and services that are provided for the treatment of an individual. "Other" includes private health insurance, out-of-pocket spending, and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

Source: CMS Office of the Actuary. National health expenditures by type of service and source of funds: Calendar years 1960 to 2024, released January 2026. <https://www.cms.gov/files/zip/national-health-expenditures-type-service-source-funds-cy-1960-2024.zip>.

> While Medicare's share of total personal health care spending was 23 percent in 2024 (see Chart 1-1), its share of spending by type of service varied, from only 21 percent of spending on durable medical equipment to 35 percent of spending on retail prescription drugs.

> Medicare's share of spending on nursing care facilities and continuing-care retirement communities was smaller than Medicaid's share because Medicare pays only for nursing home services for Medicare beneficiaries who require skilled nursing or rehabilitation services. In contrast, Medicaid pays for custodial care (long-term assistance with activities of daily living) provided in nursing homes for people with limited income and assets.

Chart 1-3 Health care spending has grown as a share of U.S. GDP

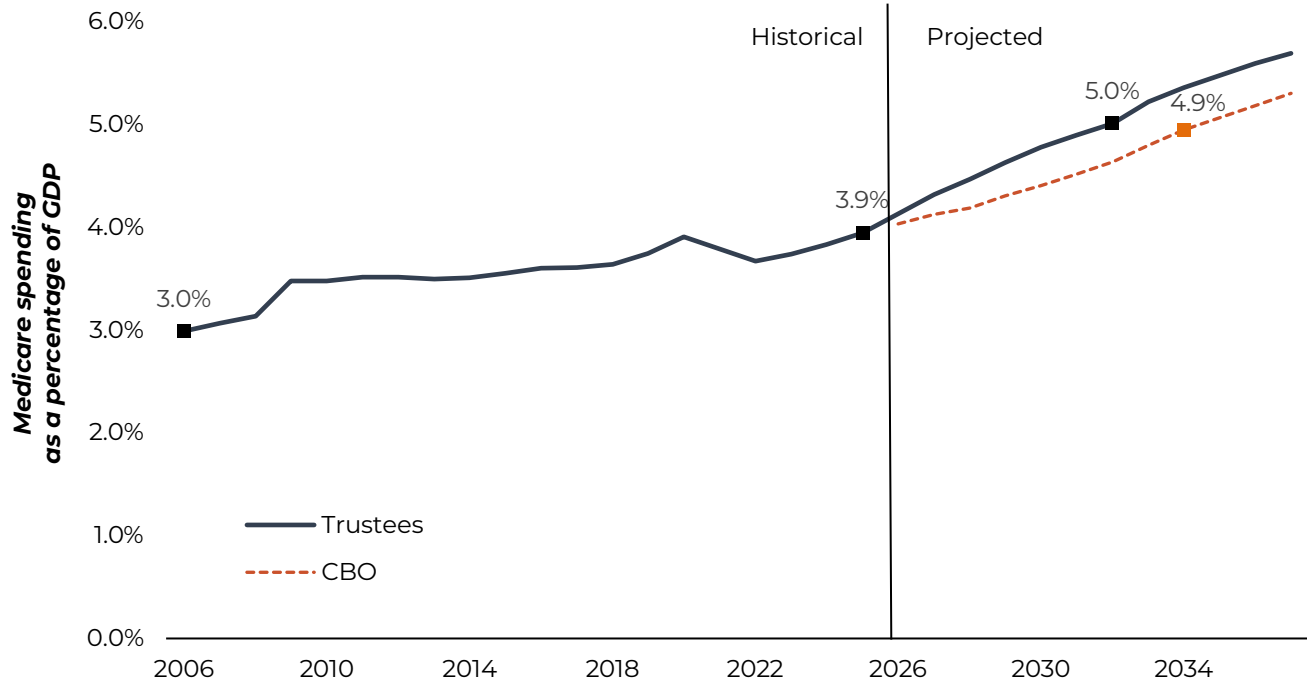


Note: GDP (gross domestic product). First projected year in the graph is 2025. Pandemic relief funds are counted as national health care spending rather than Medicare spending since they were meant to offset pandemic-related revenue losses from all payers, not just Medicare.

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

- > In 2020, two factors caused total health care spending as a share of GDP to sharply increase (reaching 19.7 percent of the country's GDP, or \$4.2 trillion). First, national health care spending increased 10 percent that year due to one-time spending by the federal government on coronavirus pandemic relief funds for health care providers, a relaxation of Medicaid's eligibility rules during the pandemic, and an increase in spending on public health activities (e.g., for vaccine development). Second, the country's GDP shrank by 1 percent that year.
- > In 2021 and 2022, spending on health care increased at more typical rates as patients resumed receiving health care. Meanwhile, GDP expanded rapidly in these years. The net effect of these forces was a sharp decline in the share of GDP spent on health care in 2021 and 2022.
- > In 2023, both national health care spending and GDP grew by 7 percent, causing no meaningful change in the share of GDP spent on health care that year.
- > In 2024, national health care spending grew by 7 percent and GDP grew by 5 percent, causing the share of GDP spent on health care to again increase.

Chart 1-4 Medicare spending constituted 3.9 percent of GDP in 2025



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 subsequent years.

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 February 2026.

> Medicare spending is expected to grow more rapidly in the coming years than it has in the past few decades. It took two decades for Medicare spending to increase from 3 percent to 4 percent of GDP, but it is expected to take just one decade to increase from 4 percent to 5 percent of GDP.

> The factors that are estimated to drive Medicare spending in the near term are identified in Chart 1-5.

Chart 1-5 Factors contributing to Medicare’s projected spending growth (after subtracting economy-wide inflation), 2025–2034

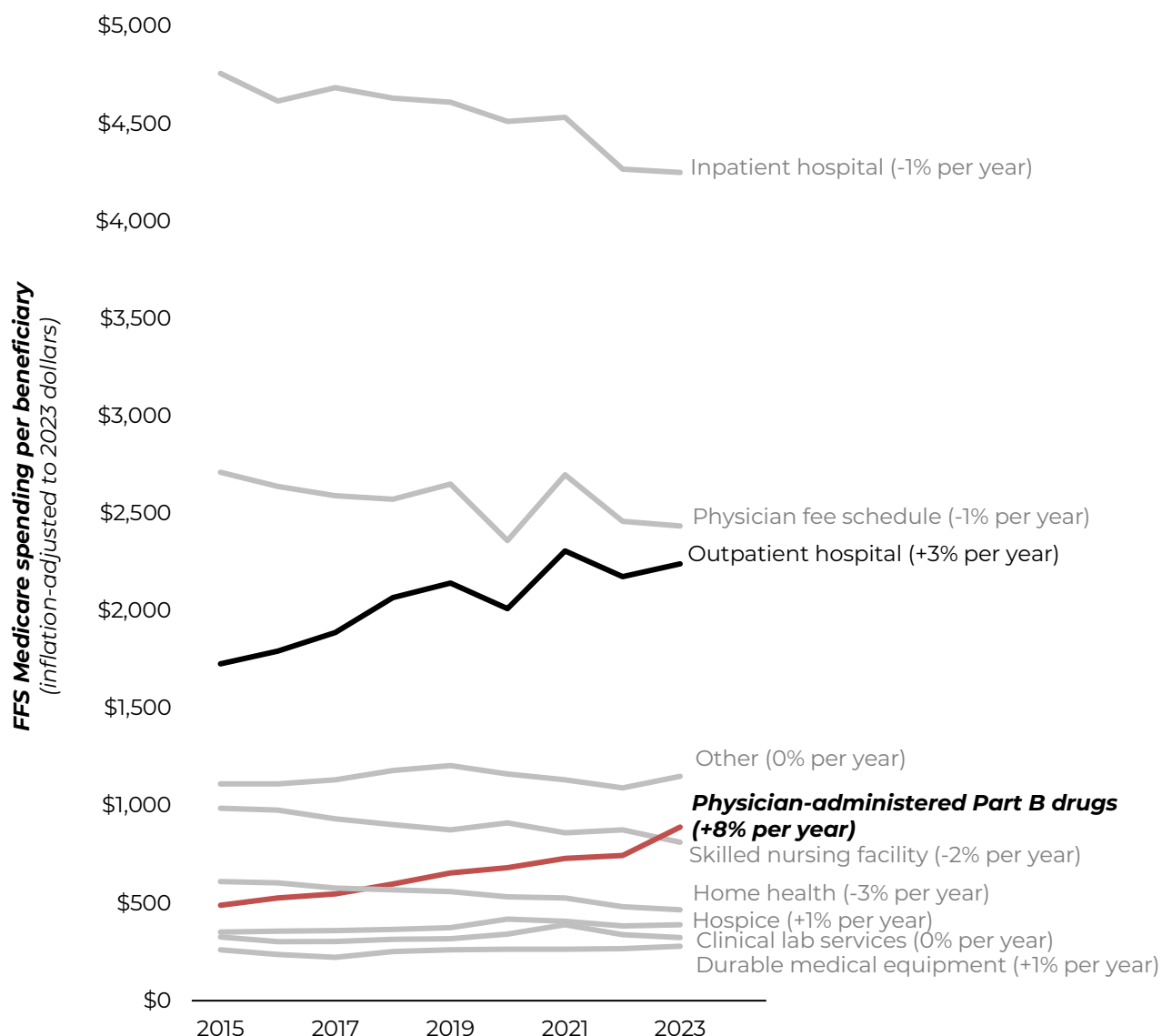
Medicare part	Average annual percentage change in:				Medicare’s projected spending (minus inflation)
	Medicare prices for services (minus inflation)	Number of beneficiaries	Beneficiary demographic mix	Other	
Part A	–0.3%	1.8%	0.4%	1.8%	3.6%
Part B	–1.0	1.9	0.1	4.5	5.5
Part D	–1.3	2.0	–0.2	1.0	1.6
Total	–0.8	1.9	0.2	3.0	4.3

Note: Includes fee-for-service Medicare 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 Tables II.D1 and V.B2 in the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

- > Several factors will contribute to expected increases in Medicare spending over the next decade.
- > One driver is general inflation, the projected effect of which is excluded from this table since it is not a factor that health policymakers can easily influence.
- > A second driver of Medicare’s projected spending growth is increasing enrollment in the program as the baby-boom generation continues to reach Medicare’s eligibility age.
- > Medicare’s prices are not projected to grow faster than inflation (shown by the fact that the numbers in the first column of the table are negative).
- > Changing beneficiary demographics are also not expected to be a driver of Medicare spending growth over the next decade (although demographics will eventually accelerate Medicare spending per beneficiary as enrollees from the baby-boom generation age; beneficiaries generate more spending per year as they age, as shown in Chart 2-2).
- > Instead, the table shows that the spending driver that is expected to exert the most influence in the next 10 years is growth in “other” factors—such as growth in the volume and intensity of the services and items that providers deliver, including growth in the average price Medicare pays for Part B drugs (see Chart 1-6).
- > In Chart 1-6, we show fee-for-service Medicare spending per beneficiary on different types of services and find that the fastest-growing type of spending is physician-administered drugs covered under Part B, which we discuss in greater detail in Chapter 10.

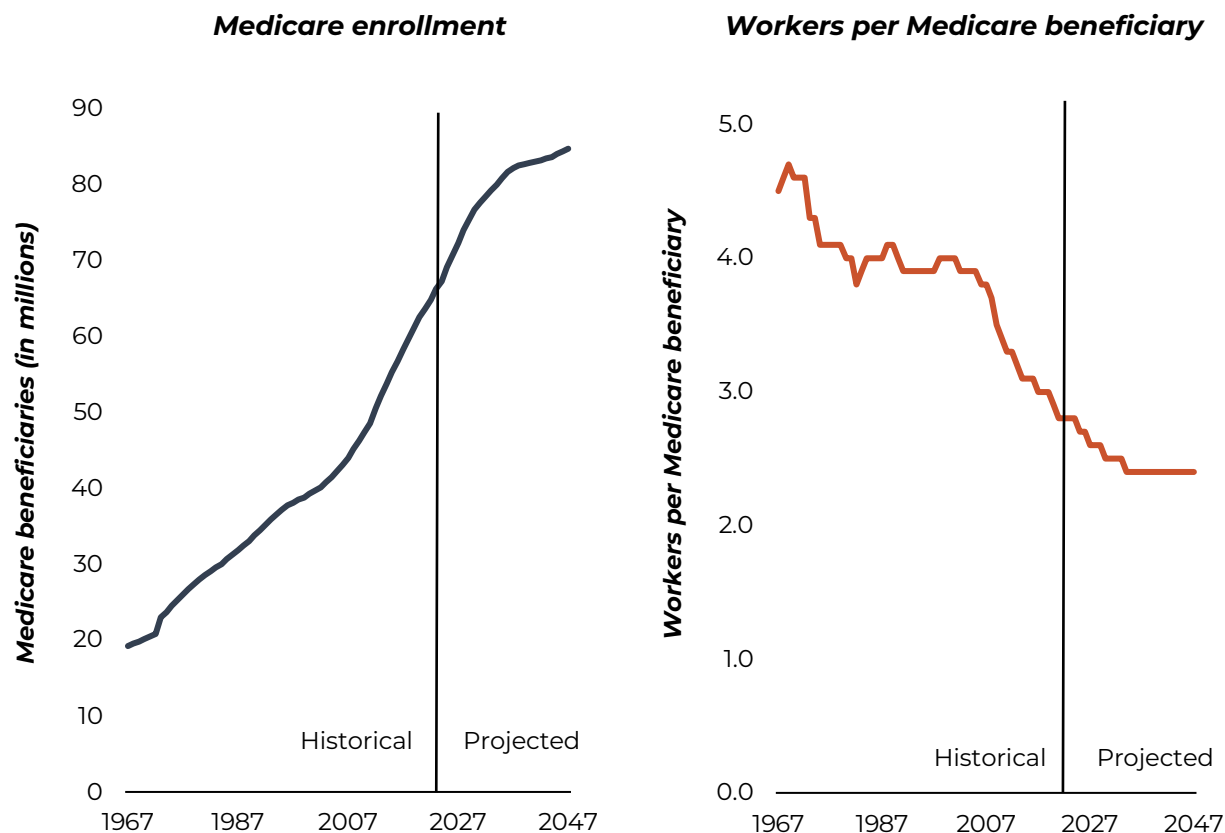
Chart 1-6 The fastest-growing type of FFS Medicare spending is physician-administered drugs covered under Part B



Note: FFS (fee-for-service). Each line in the figure shows annual FFS spending on a type of service or item (inflation adjusted to 2023 dollars using the Congressional Budget Office's annualized Consumer Price Index for All Urban Consumers), divided by the number of eligible FFS Medicare beneficiaries. (For the "inpatient hospital" and "skilled nursing facility" lines, the denominator is FFS beneficiaries enrolled in Part A; for the "physician fee schedule," "durable medical equipment," "clinical lab services," "physician-administered Part B drugs," "outpatient hospital," and "other" lines, the denominator is FFS beneficiaries enrolled in Part B; for the "home health" line, the denominator is all FFS beneficiaries enrolled in Part A and/or Part B; for the "hospice" line, the denominator is all Medicare beneficiaries enrolled in Part A, including both FFS and Medicare Advantage enrollees.) The "physician-administered Part B drugs" line does not include payments for Part B drugs furnished in outpatient hospitals; these payments are instead included in the "outpatient hospital" line. "Other" includes Part B payments to ambulatory surgical centers, ambulance providers and suppliers, federally qualified health centers, rural health clinics, critical access hospitals, and dialysis facilities, for example. Figure shows Medicare program spending, not including spending financed by beneficiary premiums or cost sharing. Percentages in parentheses are compound annual growth rates from 2015 to 2023.

Source: MedPAC analysis of spending amounts and beneficiary enrollment numbers in the 2025 annual report of the Boards of Trustees of the Medicare trust funds (Table IV.A3, Table IV.B6, Table IV.B10, and Table V.B3).

Chart 1-7 The number of workers per Medicare beneficiary has been declining since the program's inception



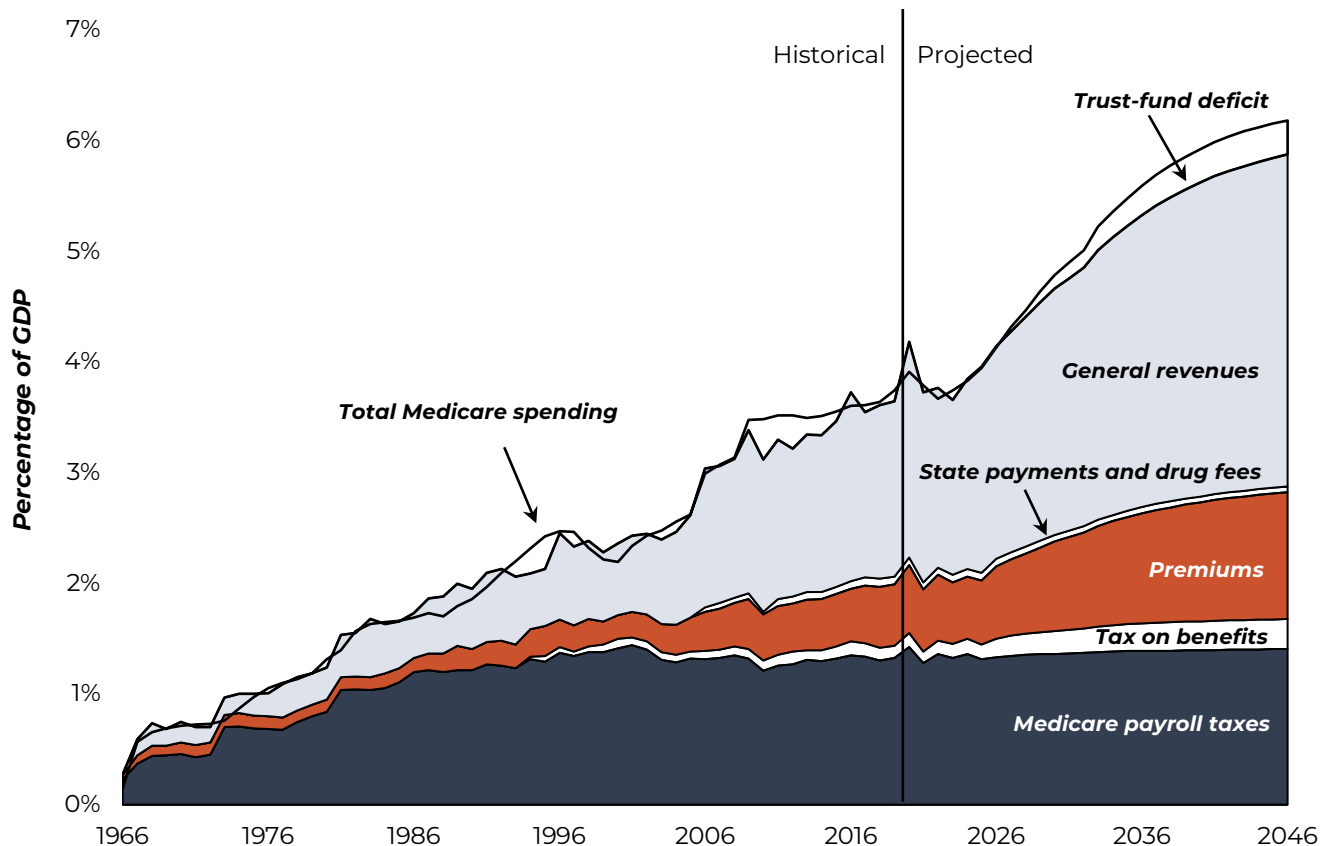
Note: “Medicare beneficiaries” refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplemental Medical Insurance because Part A is usually available to beneficiaries at no cost. 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.

> As the baby-boom generation ages, enrollment in the Medicare program is surging. By 2030, all baby boomers will have reached the age of eligibility for the Medicare program, and 75 million beneficiaries are expected to have Medicare Part A Hospital Insurance—up from 67 million beneficiaries in 2024.

> While Medicare enrollment is rising, the number of workers per beneficiary is rapidly declining. These diverging trends present a financing challenge for Medicare Part A since benefits paid for under this part are primarily financed by workers’ Medicare payroll taxes. The number of workers per Medicare beneficiary with Part A Hospital Insurance declined from 4.5 workers per beneficiary in 1967 to 2.8 workers per beneficiary in 2024 and is projected to fall to 2.6 workers per beneficiary by 2029.

Chart 1-8 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, 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 (SMI) 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.

> Medicare spending accounted for 3.8 percent of GDP in 2024.

> In the early years of the Medicare program, Medicare payroll taxes deposited into the Hospital Insurance Trust Fund (which finances Part A) were the main source of funding for the Medicare program, but beginning in 2009, general tax revenues (which help finance Part B and Part D) became the largest source of Medicare funding. This shift is due, in part, to spending per beneficiary growing more quickly for Part B than Part A (not shown).

> As increasing amounts of general tax revenues have been used to pay for Medicare Part B and Part D, less tax revenue has been available for other priorities such as deficit reduction or investments that could grow the economic output of the country (e.g., federal investments in research and development, education, and transportation).

Chart 1-9 A higher Medicare payroll tax or lower Medicare Part A spending would extend the solvency of Medicare’s Hospital Insurance Trust Fund

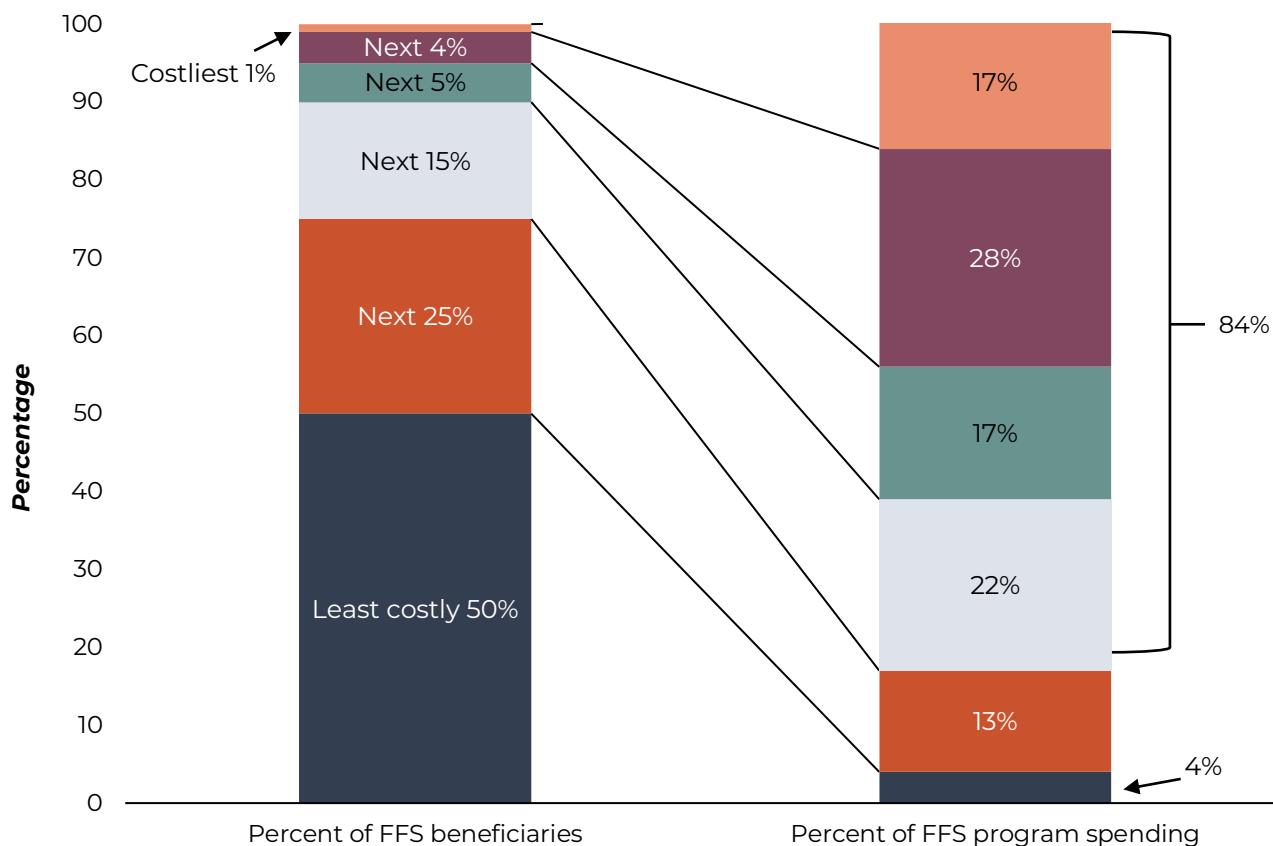
To extend Hospital Insurance Trust Fund solvency for:	Increase 2.9% Medicare payroll tax to:	or	Decrease Part A spending by:
25 years (2025–2049)	3.47%		12.9%

Note: “Part A spending” includes spending on inpatient hospital, skilled nursing facility, home health agency, and hospice services and includes spending for beneficiaries in fee-for-service Medicare and Medicare Advantage.

Source: MedPAC analysis of Table III.B8 in the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

- > Medicare’s Hospital Insurance (HI) Trust Fund helps pay for Part A services such as inpatient hospital stays, post-acute care provided by skilled nursing facilities and home health agencies, and hospice services. The trust fund is mainly financed through a dedicated payroll tax (i.e., a tax on wage earnings).
- > From Medicare’s inception through 2007, trust-fund revenues usually exceeded Part A spending—creating surpluses that increased the trust fund’s account balance over time. The trust fund also experienced surpluses in 2016 and 2017, in 2021 through 2023, and is expected to experience surpluses in 2025 through 2027.
- > Revenues from Medicare payroll taxes and other sources were less than Medicare Part A spending in 2008 through 2015, in 2018 through 2020, and in 2024—creating year-end deficits that reduced the trust fund’s account balance in those years.
- > Medicare’s Trustees expect HI Trust Fund deficits from 2028 onward. The Congressional Budget Office (CBO) projects deficits from 2032 onward.
- > Medicare’s Trustees expect the HI Trust Fund to no longer carry a positive balance starting in 2033—meaning that revenues coming in that year will provide only enough funds to cover 89 percent of Part A spending that year. CBO projects trust-fund insolvency in 2040.
- > To extend the solvency of the HI Trust Fund, there are a number of options available to policymakers. Two that are highlighted above are to (1) increase the Medicare payroll tax from its current rate of 2.9 percent to 3.47 percent or (2) reduce Part A spending by 12.9 percent, which is equivalent to a reduction of about \$62 billion in 2026, which would then need to be maintained in subsequent years. Either of these approaches would extend the solvency of the trust fund for an additional 25 years. A combination of more moderate spending reductions and revenue increases is another option. Another way to raise revenue for the HI Trust Fund is through the type of broad economic growth experienced in the past few years; this growth has helped extend the projected solvency of the trust fund by a number of years, as more people work (and pay Medicare payroll taxes) and people earn higher-than-expected wages (which results in more wages being taxable).

Chart 1-10 FFS program spending was highly concentrated among a small share of beneficiaries, 2023



Note: FFS (fee-for-service). Analysis excludes beneficiaries with any enrollment in a Medicare Advantage plan or other health plan that covers Part A and Part B services (e.g., Medicare cost plans, Medicare–Medicaid Plans, and Medicare and Medicaid’s Program of All-Inclusive Care for the Elderly (PACE)). Component percentages may not sum to 100 due to rounding. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Some percentages identified above are different from those mentioned below due to rounding.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

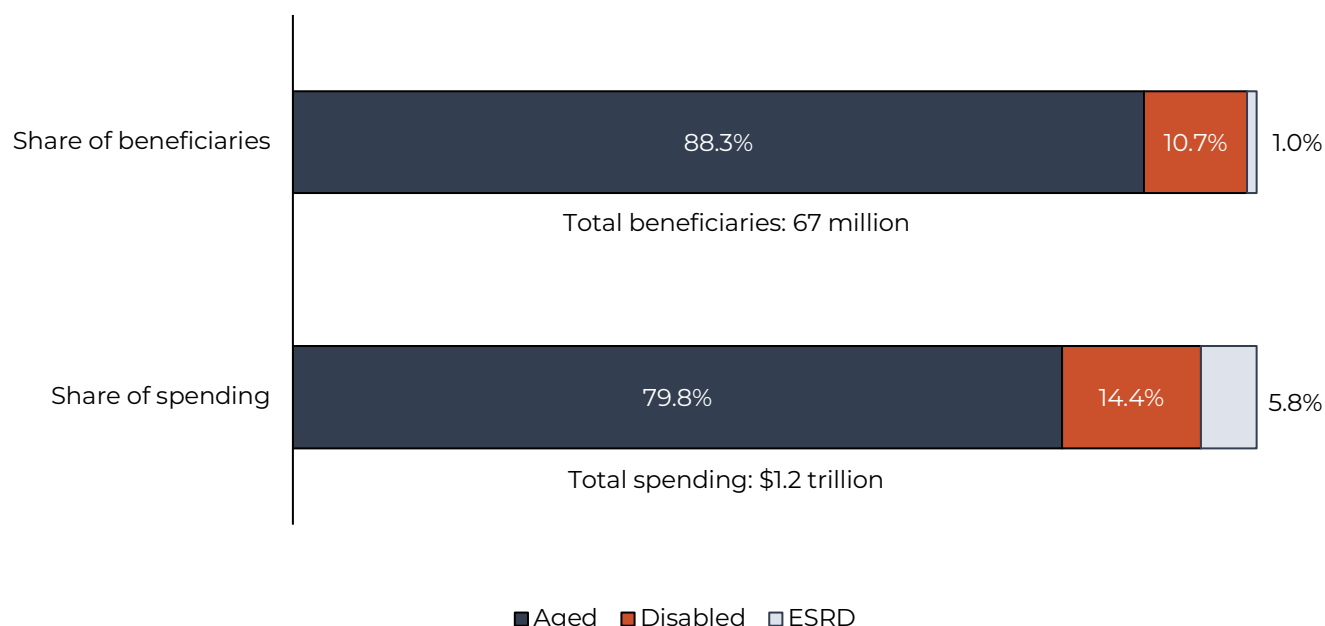
> Medicare FFS spending is concentrated among a small number of beneficiaries. In 2023, the costliest 5 percent of beneficiaries (i.e., the costliest 1 percent and the next-costliest 4 percent at the top of the bar at left) accounted for 45 percent of annual Medicare FFS spending. The costliest 25 percent of beneficiaries accounted for 84 percent of Medicare spending (indicated by the bracket at right).

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

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

Medicare beneficiary demographics

Chart 2-1 Aged beneficiaries accounted for the greatest share of the Medicare population and program spending, 2023



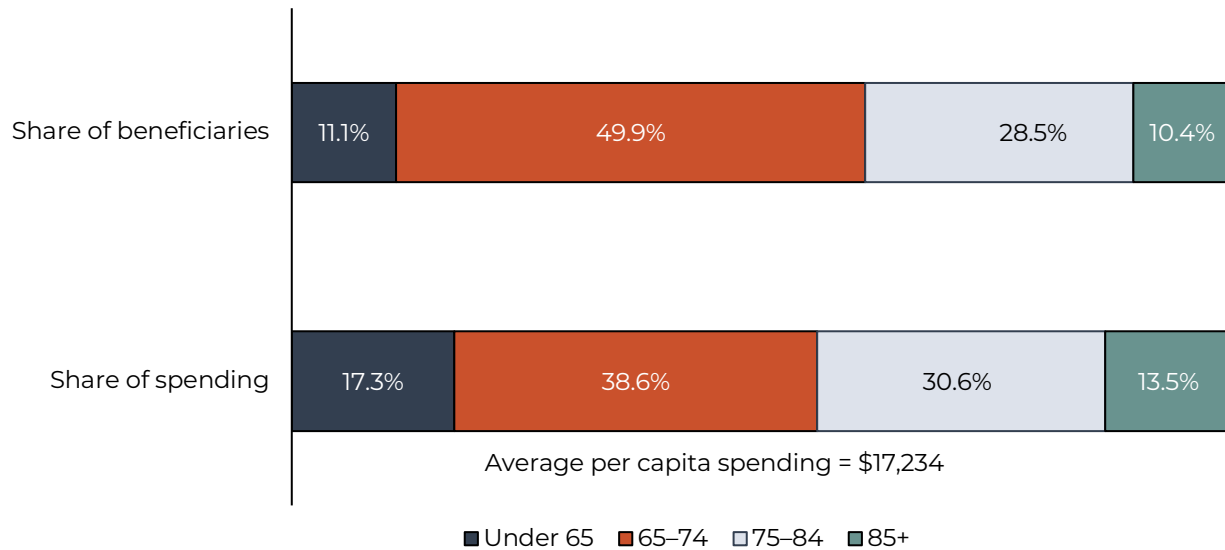
Note: ESRD (end-stage renal disease). The “aged” category comprises beneficiaries ages 65 and older without ESRD. The “disabled” category comprises beneficiaries under age 65 without ESRD. The “ESRD” category comprises beneficiaries with ESRD, regardless of age. Results include both community-dwelling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

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

> In 2023, beneficiaries ages 65 and older without ESRD composed 88.3 percent of the beneficiary population and accounted for 79.8 percent of Medicare spending. Beneficiaries under 65 with a disability and beneficiaries with ESRD accounted for the remaining population and spending.

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

Chart 2-2 Beneficiaries younger than 65 accounted for a disproportionate share of Medicare spending, 2023

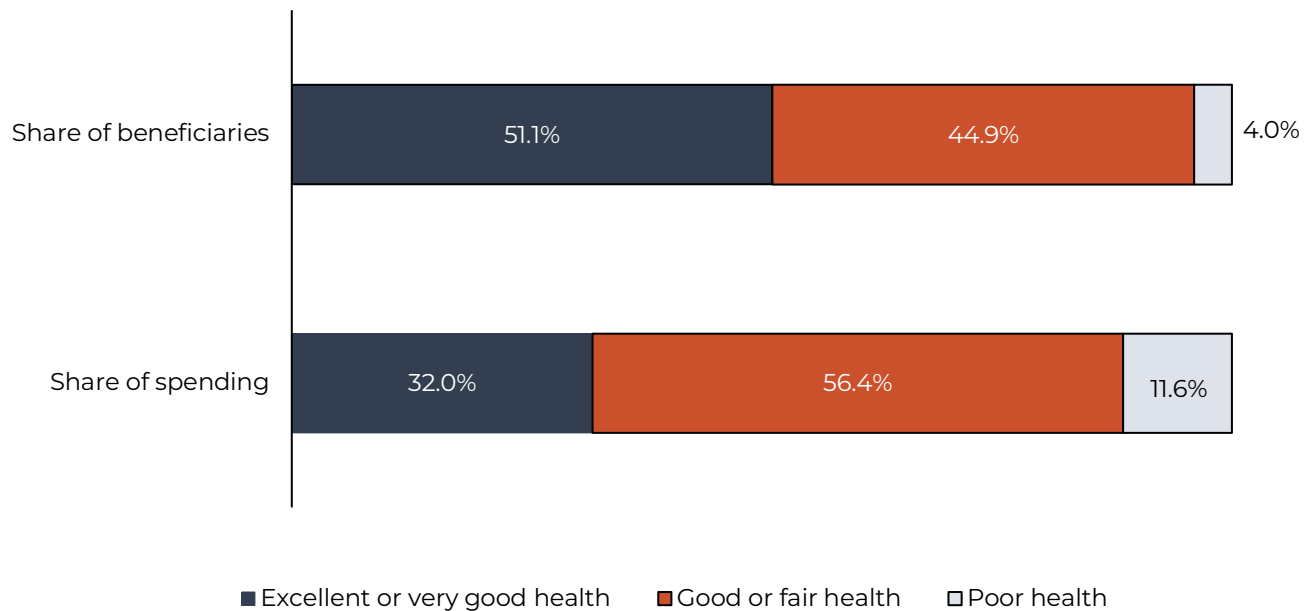


Note: The “65–74,” “75–84,” and “85+” categories comprise beneficiaries ages 65 and older without end-stage renal disease (ESRD). The “Under 65” category comprises beneficiaries under age 65 with and without ESRD. Results include both community-dwelling and institutionalized beneficiaries enrolled in Medicare fee-for-service and Medicare Advantage plans. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

- > Beneficiaries younger than 65 made up 11.1 percent of the beneficiary population in 2023 but accounted for 17.3 percent of Medicare spending.
- > In 2023, average Medicare spending per beneficiary was \$17,234.
- > For the aged population (65 and older), per capita expenditures increase with age. In 2023, per capita expenditures were \$13,334 for beneficiaries 65 to 74 years old, \$18,462 for those 75 to 84 years old, and \$22,326 for those 85 and older (data not shown).
- > In 2023, per capita expenditures for Medicare beneficiaries under age 65 who were enrolled because of ESRD or disability were \$26,781 (data not shown).

Chart 2-3 Beneficiaries who reported being in poor health accounted for a disproportionate share of Medicare spending, 2023



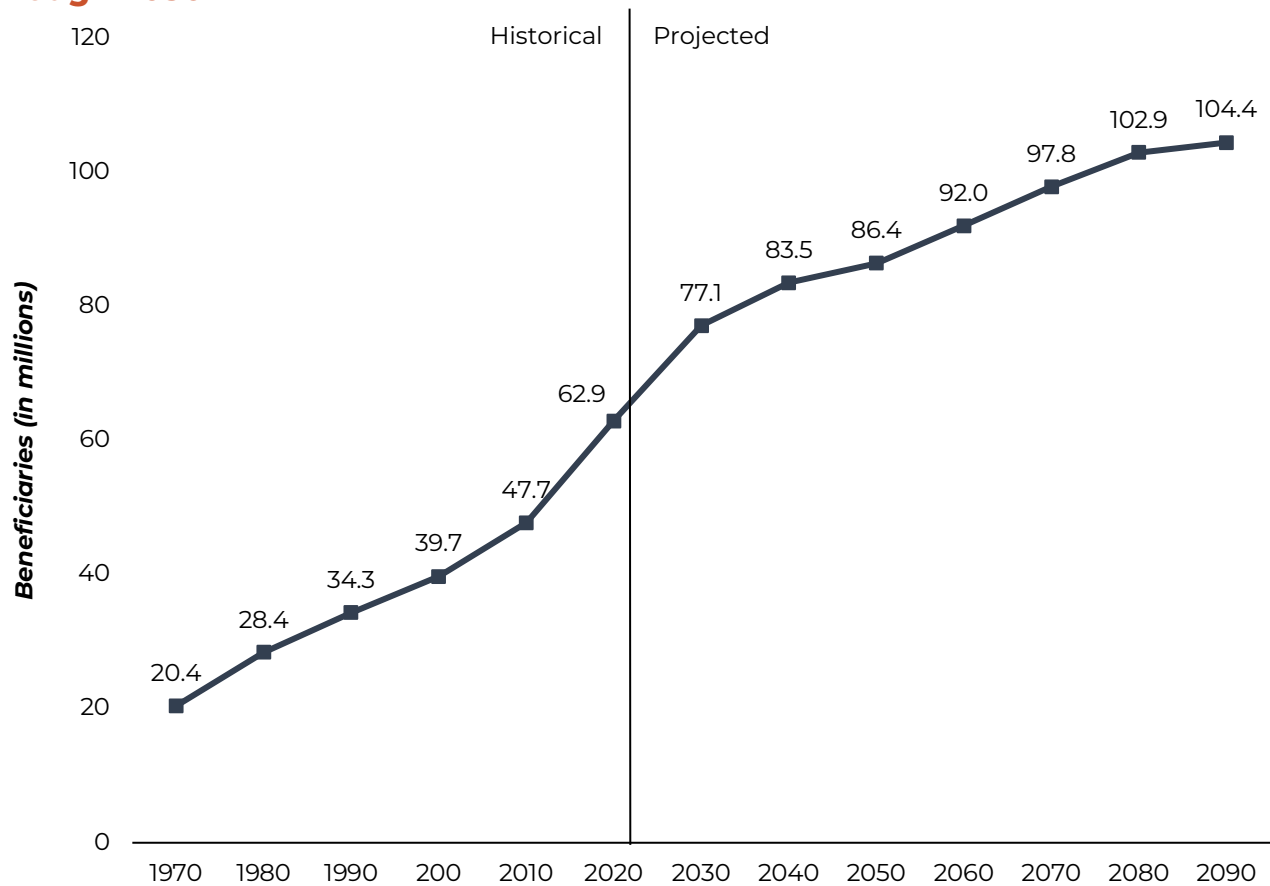
Note: Results include both community-dwelling and institutionalized beneficiaries enrolled in Medicare fee-for-service and Medicare Advantage plans. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.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

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

> In 2023, most beneficiaries reported fair to excellent health. Only 4.0 percent reported poor health.

> Medicare spending is strongly associated with self-reported health status. In 2023, per capita expenditures were \$10,526 for those who reported excellent or very good health, \$21,114 for those who reported good or fair health, and \$49,527 for those who reported poor health (data not shown).

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



Note: Enrollment numbers are based on Part A and/or Part B enrollment.

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

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

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

Chart 2-5 Characteristics of the Medicare population, 2023

Characteristic	Share of the Medicare population	Characteristic	Share of the Medicare population
Total (62.2 million)	100%	Living arrangement	
		Institution	2
Sex		Alone	30
Male	46	With spouse	47
Female	54	Other	21
Race/ethnicity		Education	
White, non-Hispanic	74	No high school diploma	12
Black, non-Hispanic	11	High school diploma only	24
Hispanic	9	Some college or more	63
Other	6		
		Income status	
Age		Below poverty	14
<65	11	100–125% of poverty	7
65–74	48	125–150% of poverty	6
75–84	30	150–200% of poverty	11
85+	10	200–400% of poverty	26
		Over 400% of poverty	35
Health status		Supplemental insurance status	
Excellent or very good	50	Medicare only	8
Good or fair	45	Medicare managed care	49
Poor	5	Employer-sponsored insurance	18
		Medigap	19
		Medigap with employer-sponsored insurance	0
Residence		Medicaid	6
Urban	84	Other	1
Rural	17		

Note: Components may not sum to 100 percent due to rounding and exclusion of an “other” category not reflected in this chart. “Urban” indicates beneficiaries living in metropolitan statistical areas (MSAs) as defined by the Office of Management and Budget. “Rural” indicates beneficiaries living outside MSAs. The income-status categories were modified from previous years to align with other charts in this publication. The “Medicare managed care” category includes Medicare Advantage, cost, and health care prepayment plans. Those in the “employer-sponsored insurance” category had employer-sponsored insurance as primary payer or they had employer-sponsored Medigap coverage. Those in the “Medigap with employer-sponsored insurance” category had both Medigap and employer-sponsored coverage. Some beneficiaries may have more than one type of supplemental insurance. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

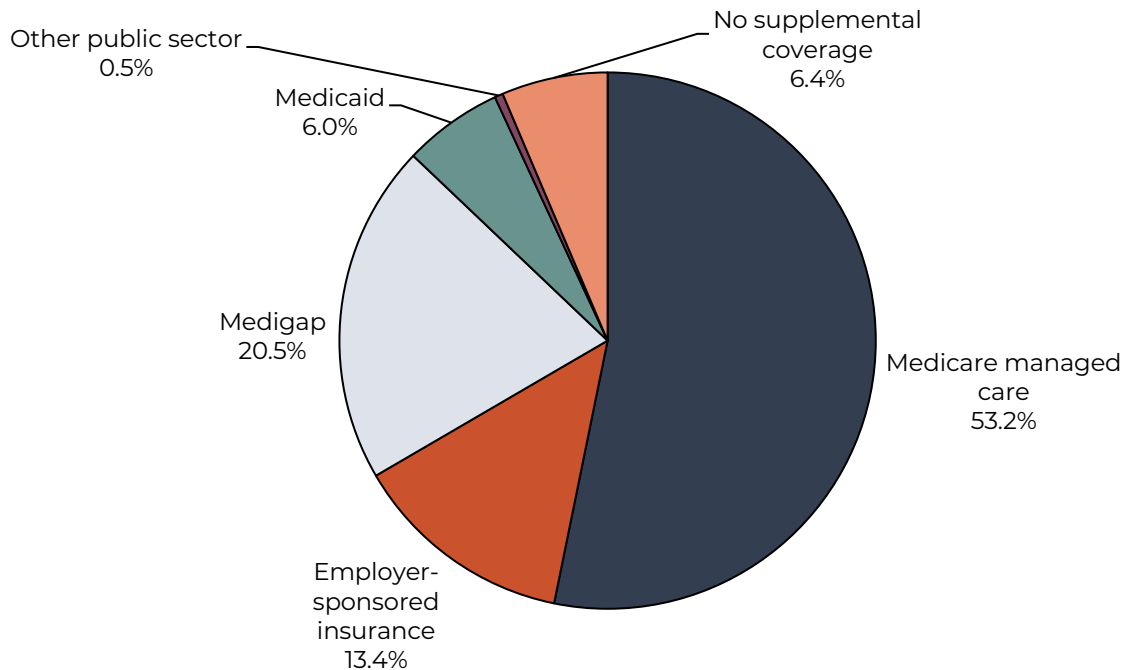
- > A majority of Medicare beneficiaries are female (54 percent) and White (74 percent).
- > About one-fifth of beneficiaries live in rural areas.
- > Thirty percent of the Medicare population lives alone.
- > Most Medicare beneficiaries have some source of supplemental insurance. Managed care plans are the most common source of supplemental coverage.

SECTION

3

Medicare beneficiaries' supplemental coverage and financial liability

Chart 3-1 Sources of supplemental coverage among Medicare beneficiaries, 2023



Note: We assigned beneficiaries to the supplemental-coverage category in which they spent the most time in 2023. They could have had coverage in other categories during 2023. “Other public sector” includes federal and state programs not included in other categories. This analysis excludes beneficiaries who were not in Part A and Part B throughout their Medicare enrollment in 2023 or who had Medicare as a secondary payer. The number of beneficiaries represented in this chart is 56 million. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

- > Most beneficiaries have coverage that supplements or replaces the Medicare benefit package. In 2023, about 94 percent of beneficiaries had supplemental coverage or participated in Medicare managed care.
- > Fifty-three percent of beneficiaries participated in Medicare managed care, which includes Medicare Advantage, health care prepayment, and cost plans. That total includes beneficiaries who were enrolled in both Medicare managed care and Medicaid. These types of arrangements generally replace Medicare’s FFS coverage and often provide more coverage.
- > The remaining roughly 47 percent of Medicare beneficiaries were enrolled in Medicare’s fee-for-service (FFS) program. About 34 percent of beneficiaries were enrolled in FFS Medicare and had private sector supplemental coverage such as Medigap (about 21 percent) or employer-sponsored retiree coverage (about 13 percent). Beneficiaries in the Medigap category either had Medigap coverage exclusively or had both Medigap and employer-sponsored coverage. Beneficiaries in the “employer-sponsored insurance” category had employer-sponsored retiree coverage as their only source of supplemental insurance.
- > About 7 percent of beneficiaries were enrolled in the FFS program and had public sector supplemental coverage, primarily Medicaid.
- > The numbers in this chart differ from those in Chart 2-5, Chart 4-1, and Chart 4-4 because of differences in the populations represented in the charts. This chart excludes beneficiaries who were not in Part A and Part B throughout their Medicare enrollment in 2023 or who had Medicare as a secondary payer, and Chart 4-1 excludes beneficiaries in Medicare Advantage.

Chart 3-2 Sources of supplemental coverage among Medicare beneficiaries, by beneficiaries' characteristics, 2023

	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	56,027	13%	21%	6%	53%	1%	6%
Age							
<65	6,205	4	3	25	61	0	7
65–69	11,907	11	22	5	56	0	7
70–74	13,981	14	25	3	52	0	7
75–79	10,907	16	23	3	51	1	6
80–84	7,006	17	23	3	51	1	5
85+	6,021	16	21	6	48	2	7
Income-to-poverty ratio							
≤1.00	8,347	2	4	23	67	0	5
1.00 to 1.25	3,895	3	10	15	67	0	5
1.25 to 2.00	10,441	5	17	7	63	1	8
2.00 to 4.00	15,032	14	25	1	52	1	8
>4.00	18,311	25	29	0	40	0	6
Eligibility status							
Aged	49,550	15	23	3	52	1	6
Disabled	5,977	4	3	25	61	0	7
ESRD	501	7	11	25	52	0	4
Residence							
Urban	46,425	13	20	6	55	1	6
Rural	9,602	14	23	8	46	1	9
Sex							
Male	25,090	14	21	6	51	0	8
Female	30,937	13	21	6	55	1	5
Health status							
Excellent/very good	27,520	16	25	3	50	0	6
Good/fair	24,617	11	18	7	57	0	6
Poor	2,595	8	12	15	59	0	6

Note: ESRD (end-stage renal disease). We assigned beneficiaries to the supplemental-coverage category in which they spent the most time in 2023. They could have had coverage in other categories during that year. “Medicare managed care” includes Medicare Advantage, cost, and health care prepayment plans. “Other public sector” includes federal and state programs not included in other categories. “Urban” indicates beneficiaries living in metropolitan statistical areas (MSAs), as defined by the Office of Management and Budget. “Rural” indicates beneficiaries living outside MSAs. Analysis excludes beneficiaries who were not in Part A and Part B throughout their Medicare enrollment in 2023 or who had Medicare as a secondary payer. The number of beneficiaries in the “Age” and “Sex” groupings do not sum to the totals because of rounding. The number of beneficiaries in the “Health status” grouping is less than the total because some beneficiaries had missing values. Numbers in some rows do not sum to 100 percent because of rounding. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

- > Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are ages 65 and older, have income above twice the poverty level, and report better than poor health.
- > Medigap is the most common source of supplemental coverage for beneficiaries without Medicare managed care among those who are ages 65 and older, have income higher than 1.25 times the poverty level, are eligible because of age, are rural dwelling, and report better than poor health.
- > Medicaid coverage is most common among those who are under age 65, have income lower than 1.25 times the poverty level, are eligible because of disability or ESRD, are rural dwelling, and report poor health.
- > Lack of supplemental coverage (i.e., Medicare coverage only) is most common among beneficiaries who have income higher than 1.25 times the poverty level, are eligible because of disability, and are rural dwelling.

Chart 3-3 Covered benefits and enrollment in standardized Medigap plans, 2025

Benefit	Medigap standardized plan type											
	High deductible											
	A	B	C*	D	F*	F	G	G	K	L	M	N
Part A hospital costs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B cost sharing	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	\$20/ \$50
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice cost sharing	✓	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
SNF coinsurance			✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible		✓	✓	✓	✓	✓	✓	✓	50%	75%	50 %	✓
Part B deductible			✓		✓	✓						
Part B excess charges					✓	✓	✓	✓				
Foreign travel emergency			✓	✓	✓	✓	✓	✓			✓	✓
Lives covered (in thousands)	54	101	283	86	4,005	180	70	6,308	52	23	0.6	1,544

Note: SNF (skilled nursing facility). Three states (Massachusetts, Minnesota, and Wisconsin) have different plan types and are not included in this chart. The second column of Plan F and the first column of Plan G are high-deductible versions of those respective plans. The ✓ indicates that the plan covers all cost sharing for that benefit. Percentages indicate that the plan covers that share of the total cost sharing. The "\$20/\$50" indicates that the plan covers all but \$20 for physician office visits and all but \$50 for emergency room visits.
* Beginning in 2020, new policies for Plan C or Plan F can no longer be sold, except to beneficiaries who turned 65 before 2020. However, beneficiaries who purchased C plans or F plans before 2020 will be able to continue to purchase those plans.

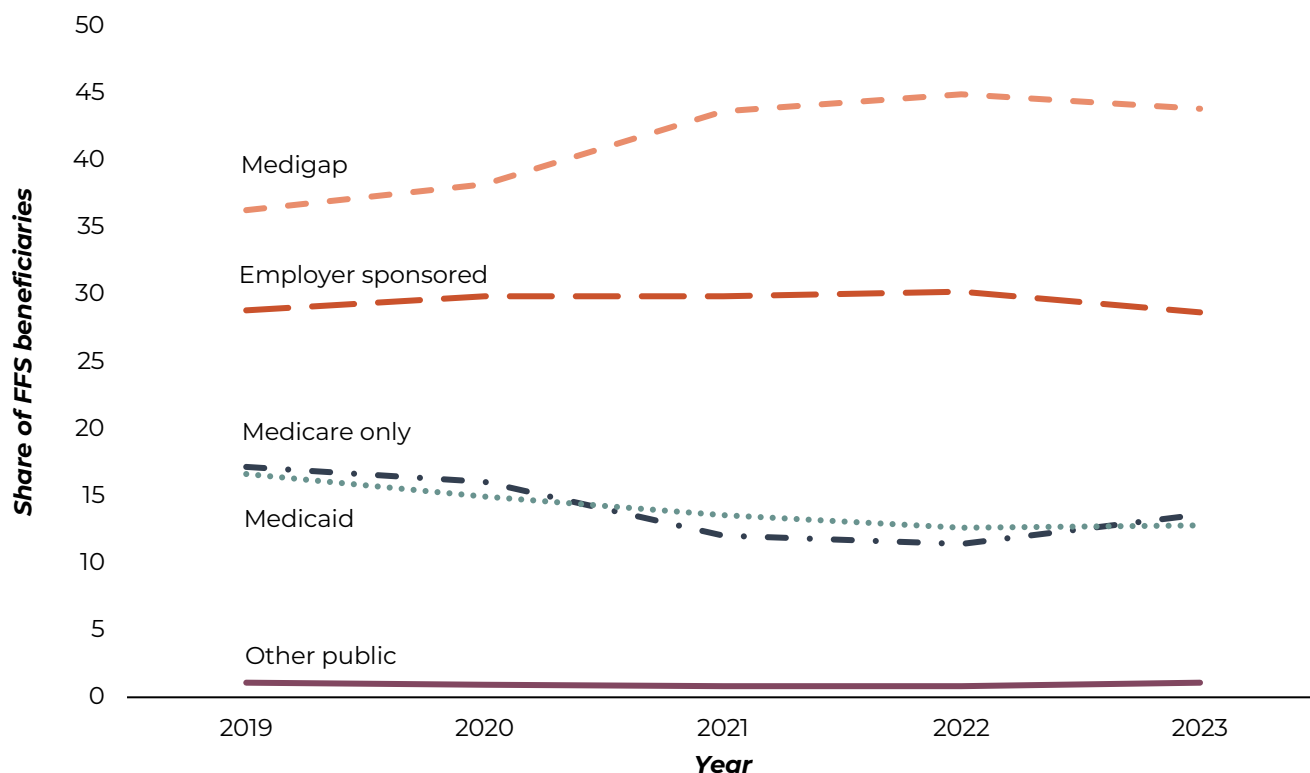
Source: MedPAC analysis of National Association of Insurance Commissioners data, 2025.

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

> The non-high-deductible version of Plan G, which covers all Medicare cost sharing except the Part B deductible, is the most popular plan, with 6.3 million enrollees. In previous years, the non-high-deductible version of Plan F had been the most popular. The Medicare statute prohibits the sale of new Plan F policies for beneficiaries turning 65 on or after January 1, 2020. As a result, beneficiaries have been selecting plan types that do not cover the Part B deductible, such as G and N plans.

> During 2025, 12.7 million beneficiaries enrolled in Medigap plans (including those in Massachusetts, Minnesota, and Wisconsin) (data not shown). Chart 3-2 indicates that about 11.5 million beneficiaries had Medigap coverage (20.5 percent of the 56 million beneficiaries included in that chart). The variance in Medigap enrollment between Chart 3-2 and Chart 3-3 is due to different data sources and different years evaluated (Chart 3-2 is based on 2023 data, while Chart 3-3 is based on 2025 data).

Chart 3-4 The share of FFS beneficiaries who had Medigap coverage increased, while the share who had Medicaid or had only Medicare coverage decreased, 2019–2023



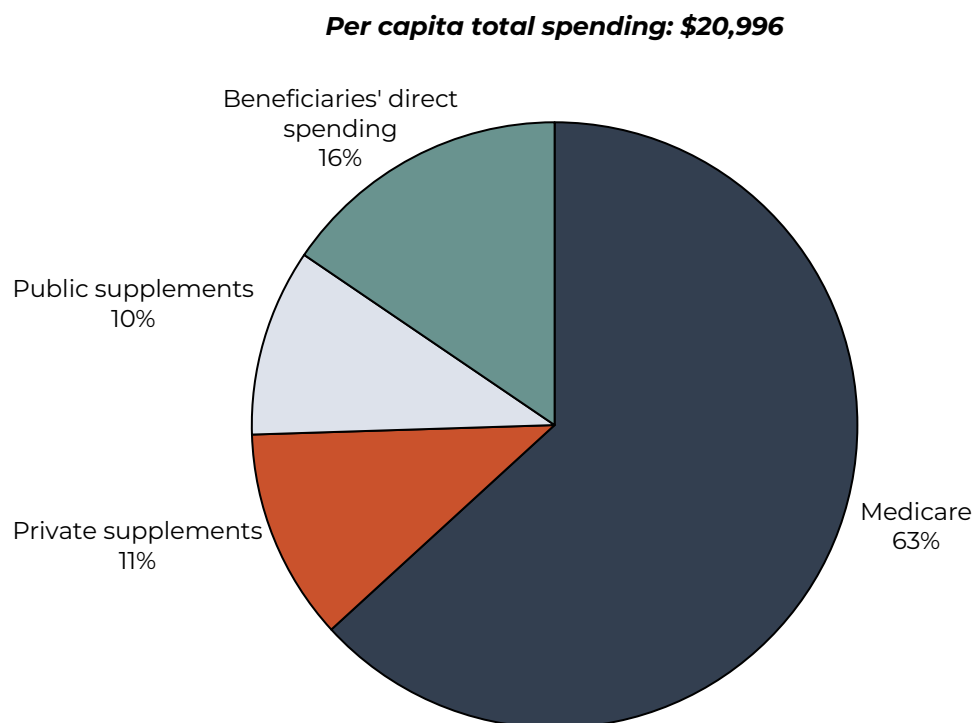
Note: FFS (fee-for-service). We assigned beneficiaries to the supplemental-coverage category in which they spent the most time. They could have had coverage in other categories during that year. “Other public” includes federal and state programs not included in other categories. This analysis excludes beneficiaries who were not in Part A and Part B throughout their Medicare enrollment or who had Medicare as a secondary payer. It also excludes beneficiaries in Medicare Advantage. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

> From 2019 to 2023, the share of FFS beneficiaries who had Medigap supplemental coverage rose from 36 percent to 44 percent. Over the same period, the share who had Medicaid coverage decreased from 17 percent to 13 percent, and the share who had no supplemental coverage (“Medicare only”) dropped from 17 percent to 14 percent. The share with employer-sponsored supplemental coverage stayed nearly constant at around 30 percent.

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

Chart 3-5 Total spending on health care services for FFS Medicare beneficiaries, by source of payment, 2023



Note: FFS (fee-for-service). “Per capita total spending” includes both health care services covered by Medicare (including hospital and physician care and prescription drugs) and services not covered by Medicare (such as dental care and over-the-counter medications). “Private supplements” includes employer-sponsored plans and individually purchased coverage. “Public supplements” includes Medicaid, Department of Veterans Affairs, and other public coverage. “Beneficiaries’ direct spending” includes Medicare cost sharing and spending on noncovered services but not supplemental premiums. Analysis excludes beneficiaries who are not in FFS Medicare. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

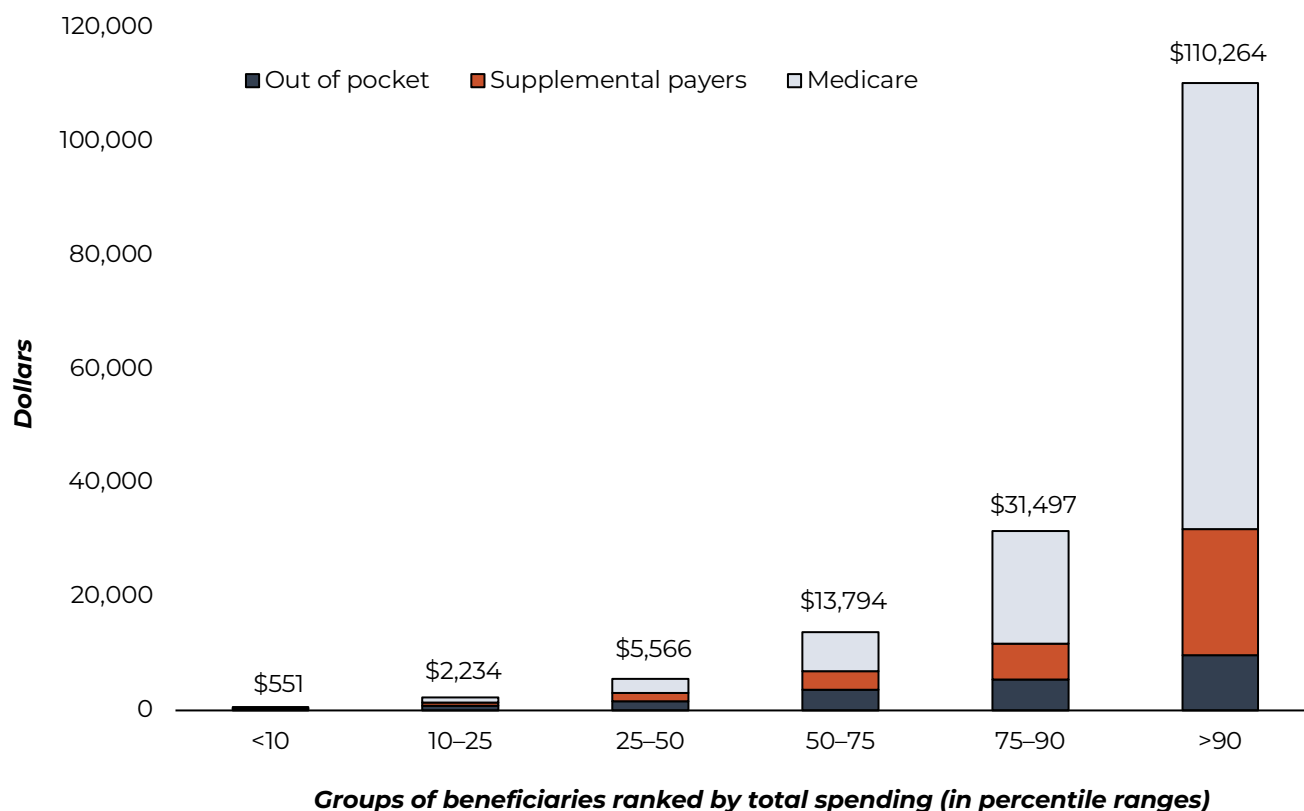
> Among FFS beneficiaries, the total cost of health care services (beneficiaries’ direct spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) averaged about \$21,000 in 2023. That total includes both health care services covered by Medicare (including hospital and physician care and prescription drugs) and services not covered by Medicare (such as dental care and over-the-counter medications). Medicare was the largest source of payment: It paid 63 percent of the health care costs for FFS beneficiaries, an average of \$13,268 per beneficiary.

> Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and Medigap—paid about 11 percent of beneficiaries’ costs, an average of \$2,374 per beneficiary.

> Public sources of supplemental coverage—primarily Medicaid—paid about 10 percent of beneficiaries’ health care costs, an average of \$2,103 per beneficiary.

> Beneficiaries paid about 16 percent of their health care costs (not including supplemental insurance premiums) out of pocket, an average of \$3,250 per beneficiary.

Chart 3-6 Distribution of per capita total spending on health care services among FFS beneficiaries, by source of payment, 2023



Note: FFS (fee-for-service). Analysis excludes beneficiaries who are not in FFS Medicare. “Out of pocket” spending includes cost sharing for Medicare-covered services and spending on noncovered services but not premium payments for supplemental coverage. “Supplemental payers” spending includes both public and private forms of supplemental-coverage spending such as employer-sponsored plans, individually purchased coverage, Medicaid, Department of Veterans Affairs, and other forms of public coverage. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

> Total spending on health care services varied dramatically among FFS beneficiaries in 2023. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged \$110,264. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged \$551.

> Among FFS beneficiaries, Medicare paid a larger share, and beneficiaries’ out-of-pocket spending was a smaller share, as total spending increased. For example, Medicare paid 50 percent of total spending for beneficiaries in the 50th percentile to 75th percentile of total spending on health care services, while beneficiaries’ out-of-pocket spending amounted to 26 percent of total spending for this group. Among FFS beneficiaries in the 90th percentile of total spending on health care services, Medicare paid for 71 percent of total spending, while out-of-pocket spending amounted to only 9 percent of total spending for this group.

Chart 3-7 Medicare Part A and Part B benefits and cost sharing per FFS beneficiary, 2022

	Average benefit (in dollars)	Average cost sharing (in dollars)
Part A	\$5,330	\$425
Part B	7,036	1,725

Note: FFS (fee-for-service). “Average benefit” represents amounts paid for covered services per FFS beneficiary and excludes administrative expenses. “Average cost sharing” represents the sum of deductibles, coinsurance, and balance billing paid for covered services per FFS beneficiary and excludes premiums.

Source: CMS, “Medicare Part A and Part B Summary Utilization, Program Payments, and Cost Sharing for All Original Medicare Beneficiaries, by Type of Coverage and Type of Service, Calendar Years 2018–2023,” <https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/cms-program-statistics-medicare-part-a-part-b-all-types-of-service>.

> In 2022, the Medicare program paid \$5,330 for Part A benefits and \$7,036 for Part B benefits, on average, per FFS beneficiary.

> FFS beneficiaries in 2022 owed an average of \$425 in cost sharing for Part A services (such as an inpatient hospital stay) and \$1,725 in cost sharing for Part B services (such as clinician services provided in any setting, including in hospitals). (“Cost sharing” in this chart does not include premiums.)

> To help cover cost-sharing obligations, 94 percent of beneficiaries had coverage that supplemented or replaced the Medicare benefit package in 2023, such as Medicare Advantage, Medigap coverage, supplemental coverage through a former employer, or Medicaid (data not shown; see Chart 3-1).

> This chart includes only Medicare-covered services; Chart 3-5 and Chart 3-6 include both Medicare-covered services and services not covered under FFS Medicare.

Chart 3-8 Distribution of cost-sharing liability for Part A and Part B services among FFS beneficiaries, 2023

Cost-sharing liability per beneficiary	Beneficiaries		Cost-sharing liability		
	Number (millions)	Share	Average liability per beneficiary	Aggregate liability (billions)	Share
\$0	2.3	8%	\$0	\$0	0%
\$1 to \$500	7.6	27	307	2.3	4
\$501 to \$1,000	5.5	19	719	3.9	6
\$1,001 to \$2,000	4.5	16	1,412	6.4	10
\$2,001 to \$5,000	5.4	19	3,184	17.1	27
\$5,001 or more	3.0	11	11,232	34.1	53
Total	28.4	100	2,252	63.9	100

Note: FFS (fee-for-service). Figures are based on beneficiaries who had Part A and Part B coverage and were not enrolled in a Medicare Advantage or other Medicare health plan at any point during the year. Most beneficiaries have some type of supplemental coverage that covers some or all of their cost-sharing liability. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS's Medicare Beneficiary Summary File, 2023.

> FFS beneficiaries are required to pay cost sharing for most Part A and Part B services. In 2023, the average cost-sharing liability per beneficiary was \$2,252 and the aggregate cost-sharing liability for all FFS beneficiaries was \$63.9 billion.

> Over half of beneficiaries (54 percent) had \$1,000 or less in cost-sharing liability, while 11 percent had more than \$5,000 in cost-sharing liability.

> Beneficiaries who had more than \$5,000 in liability accounted for 53 percent (\$34.1 billion) of the aggregate cost-sharing liability. That figure is based on their entire cost-sharing liability, which averaged \$11,232 per beneficiary. The portion of their cost-sharing liability that exceeded \$5,000, which averaged \$6,232 per beneficiary, accounted for 30 percent (\$18.9 billion) of the aggregate cost-sharing liability (data not shown).

> Most FFS beneficiaries have some type of supplemental coverage that covers some or all of their cost-sharing liability, so beneficiaries' out-of-pocket spending will typically be lower than the figures shown here (see Chart 3-1 and Chart 3-9).

Chart 3-9 Share of FFS beneficiaries with and without supplemental coverage and average out-of-pocket spending for Part A and Part B services, 2023

Cost-sharing liability per beneficiary	Beneficiaries with supplemental coverage		Beneficiaries without supplemental coverage	
	Share	Average out-of-pocket spending per beneficiary	Share	Average out-of-pocket spending per beneficiary
\$0	63%	\$0	37%	\$0
\$1 to \$500	83	88	17	131
\$501 to \$1,000	87	182	13	384
\$1,001 to \$2,000	89	366	11	737
\$2,001 to \$5,000	91	817	9	1,868
\$5,001 or more	92	2,388	8	5,883
Total	87	653	13	1,041

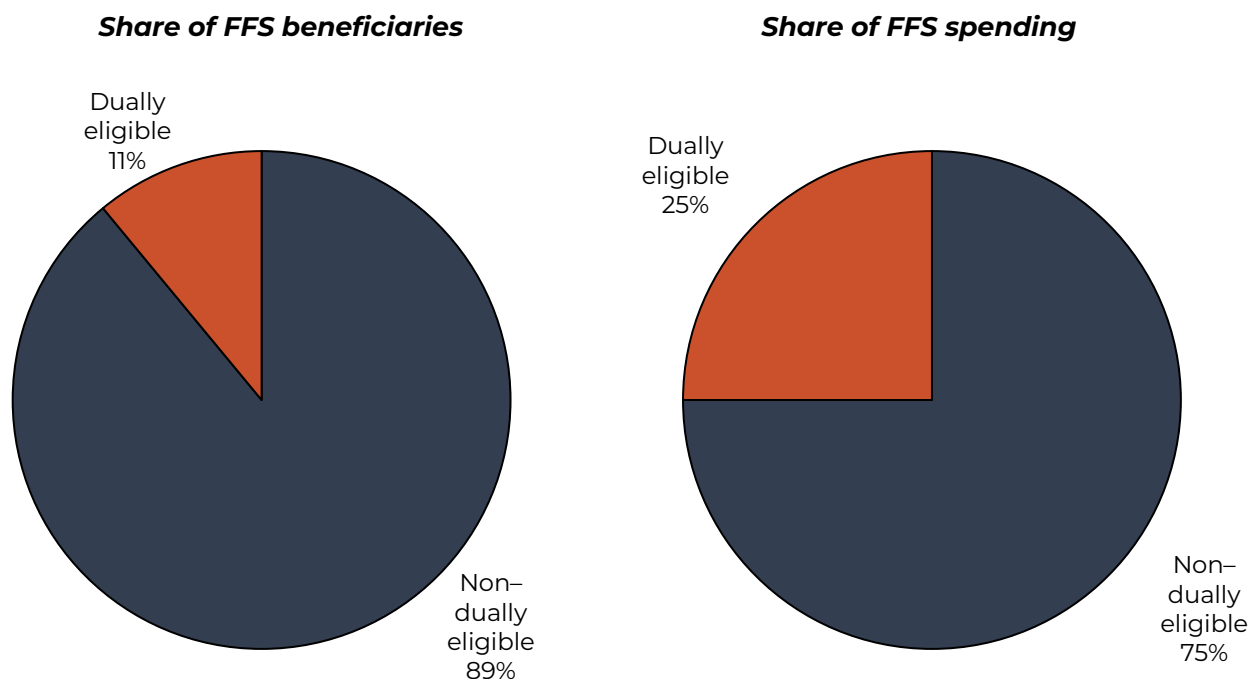
Note: FFS (fee-for-service). Figures are based on beneficiaries who had Part A and Part B coverage and were not enrolled in a Medicare Advantage or other Medicare health plan at any point during the year. "Out-of-pocket" spending is limited to cost sharing for Part A and Part B services and does not include Medicare premiums or premiums for supplemental coverage. "Supplemental coverage" includes both public and private forms of coverage such as employer-sponsored plans, individually purchased coverage, Medicaid, Department of Veterans Affairs, and other forms of public coverage. The Medicare Current Beneficiary Survey is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2023.

- > As shown in Chart 3-4, the vast majority of FFS beneficiaries have some form of supplemental coverage. Beneficiaries with no cost-sharing liability for Part A and Part B services were more likely to have no supplemental coverage than those with cost-sharing liability (37 percent vs. roughly 10 percent to 15 percent).
- > Beneficiaries with supplemental coverage had lower out-of-pocket spending, on average, than those without supplemental coverage (\$653 versus \$1,041). Those figures do not include spending on Medicare premiums or premiums for supplemental coverage.
- > Among beneficiaries with more than \$5,000 in cost-sharing liability, the average out-of-pocket spending for those with supplemental coverage was less than half of the average amount for those without supplemental coverage (\$2,388 versus \$5,883).

Dually eligible beneficiaries

Chart 4-1 Dually eligible beneficiaries accounted for a disproportionate share of FFS Medicare spending, 2023

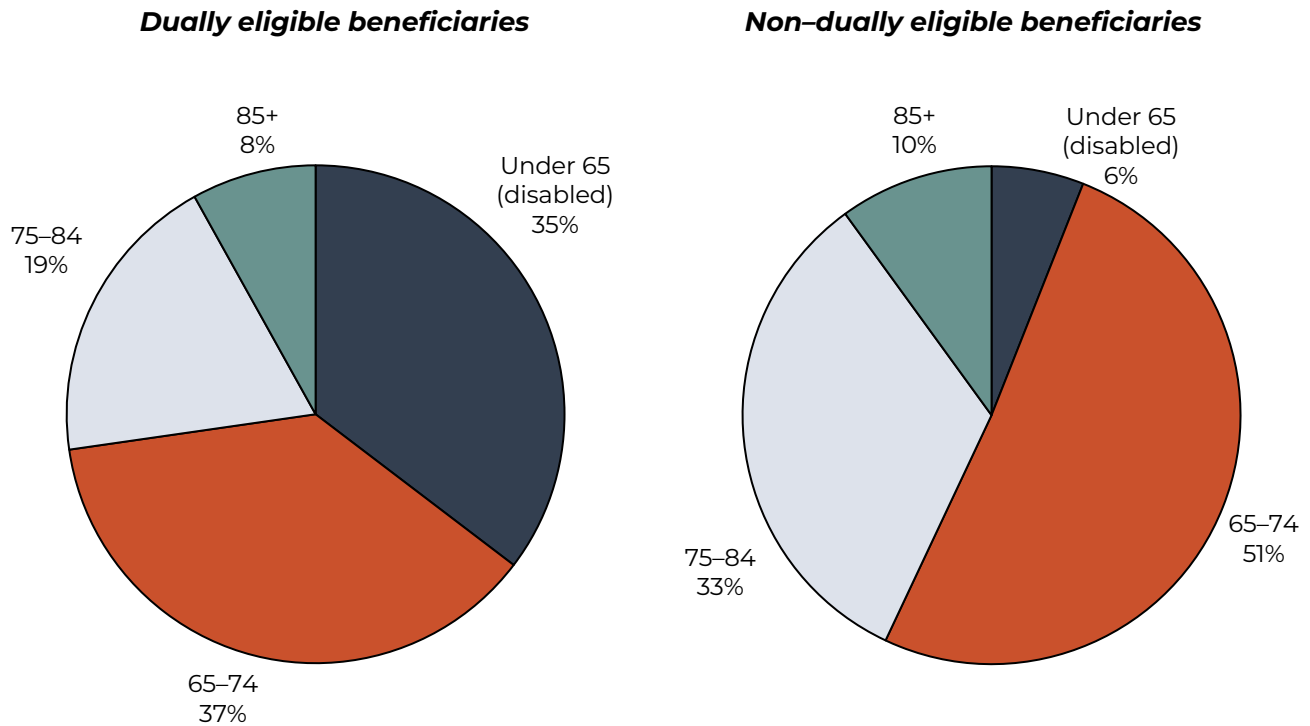


Note: FFS (fee-for-service). “Dually eligible beneficiaries” are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. Figures are based on beneficiaries in FFS Medicare. The Medicare Current Beneficiary Survey is a point-in-time survey from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

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

- > Dually eligible beneficiaries are those who qualify for both Medicare and Medicaid. Medicaid is a joint federal and state program designed to help people with low incomes obtain the health care they need.
- > Dually eligible beneficiaries account for a disproportionate share of FFS Medicare expenditures. Although they were 11 percent of the FFS Medicare population in 2023, they represented 25 percent of aggregate FFS Medicare spending.
- > On average, FFS Medicare per capita spending is more than twice as high for dually eligible beneficiaries compared with non-dually eligible beneficiaries: In 2023, \$29,701 was spent per dually eligible beneficiary and \$11,664 was spent per non-dually eligible beneficiary (data not shown).
- > In 2023, average total spending—which includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending across all payers—for dually eligible beneficiaries was \$51,919 per beneficiary, more than twice the amount for other Medicare beneficiaries (data not shown).

Chart 4-2 Dually eligible beneficiaries were more likely than non-dually eligible beneficiaries to be under age 65 and have a disability, 2023

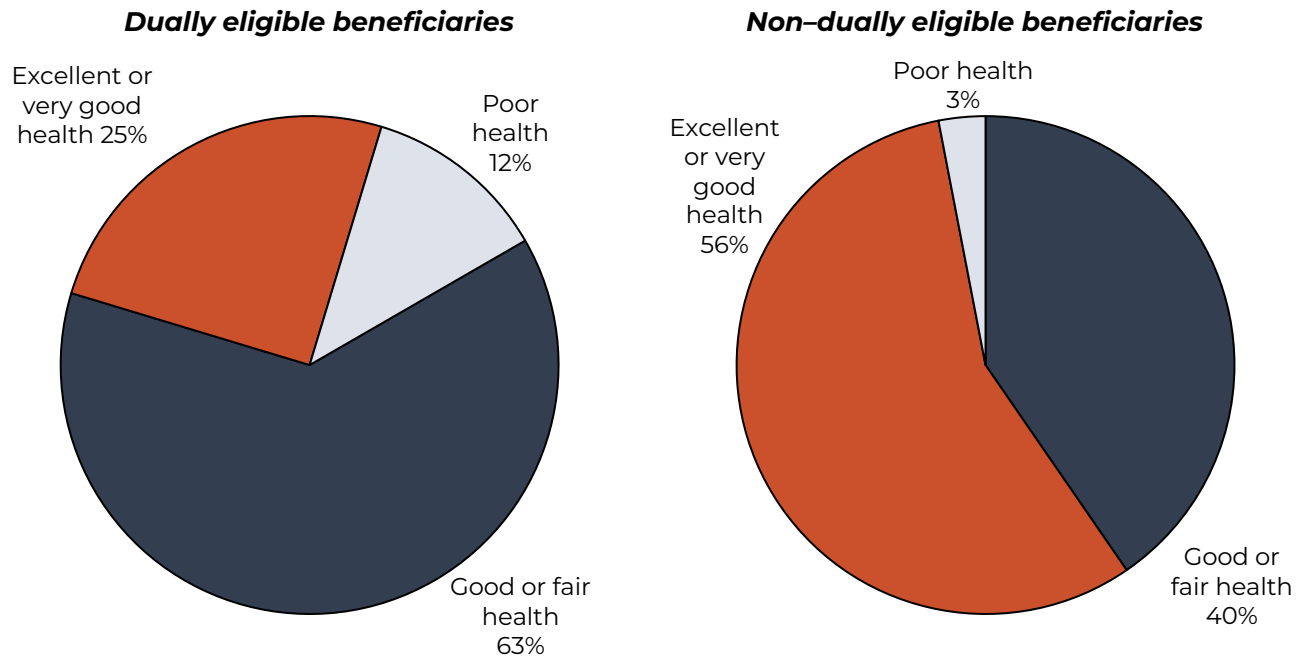


Note: Beneficiaries who are under age 65 generally qualify for Medicare because of disability. Once beneficiaries with disabilities reach age 65, they are counted as aged beneficiaries. “Dually eligible beneficiaries” are defined as beneficiaries who were eligible for both Medicare and Medicaid for at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

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

- > Disability is a pathway for individuals to become eligible for both Medicare and Medicaid benefits.
- > Dually eligible beneficiaries are more likely than non-dually eligible beneficiaries to be under age 65 and have a disability. In 2023, 35 percent of dually eligible beneficiaries were under age 65 and had a disability compared with 6 percent of the non-dually eligible population.

Chart 4-3 Dually eligible beneficiaries were more likely than non-dually eligible beneficiaries to report being in poor health, 2023



Note: “Dually eligible beneficiaries” are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. Figures are based on all Medicare beneficiaries. Components may not sum to 100 percent due to rounding. The Medicare Current Beneficiary Survey is a point-in-time survey from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

- > Dually eligible beneficiaries are more likely than non-dually eligible beneficiaries to report being in poor health. In 2023, 12 percent of dually eligible beneficiaries reported being in poor health compared with 3 percent of non-dually eligible beneficiaries.
- > Over half of non-dually eligible beneficiaries (56 percent) reported being in excellent or very good health in 2023. In comparison, only one-quarter (25 percent) of dually eligible beneficiaries reported being in excellent or very good health.

Chart 4-4 Demographic differences between dually eligible beneficiaries and non-dually eligible beneficiaries, 2023

Characteristics	Share of dually eligible beneficiaries	Share of non-dually eligible beneficiaries
Sex		
Male	41%	47%
Female	59	53
Race/ethnicity		
White, non-Hispanic	46	81
Black, non-Hispanic	23	8
Hispanic	22	6
Other	10	6
Limitations in ADLs		
No limitations in ADLs	54	78
Limitations in 1–2 ADLs	23	15
Limitations in 3–6 ADLs	23	7
Residence		
Urban	81	84
Rural	19	16
Living arrangement		
Institution	7	1
Alone	38	28
With spouse	15	55
With children, nonrelatives, others	39	17
Education		
No high school diploma	35	7
High school diploma only	31	23
Some college or more	34	70
Income status		
Below poverty threshold	56	4
100–125% of poverty threshold	18	4
125–150% of poverty threshold	11	5
150–200% of poverty threshold	9	12
200–400% of poverty threshold	5	31
Over 400% of poverty threshold	1	43
Supplemental insurance status		
Medicare or Medicare/Medicaid only	26	9
Medicare managed care	68	45
Employer-sponsored insurance	1	22
Medigap	4	23
Other*	1	1

Note: ADL (activity of daily living). “Dually eligible beneficiaries” are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. Figures are based on all Medicare beneficiaries. “Urban” indicates beneficiaries living in metropolitan statistical areas (MSAs). “Rural” indicates beneficiaries living outside of MSAs. Components may not sum to 100 percent due to rounding. The Medicare Current Beneficiary Survey is a point-in-time survey from a sample of beneficiaries; year-to-year variation in some data is expected.

* Includes public programs such as the Department of Veterans Affairs and state-sponsored drug plans.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

> Dually eligible beneficiaries qualify for Medicaid due in part to low incomes. In 2023, 56 percent of dually eligible beneficiaries lived below the poverty threshold, and 94 percent lived below 200 percent of the poverty threshold. Compared with non-dually eligible beneficiaries, dually eligible beneficiaries are more likely to be female, be Black or Hispanic, have greater limitations in activities of daily living, live in an institution, and lack a high school diploma. They are more likely to be enrolled in a Medicare managed care plan and less likely to have supplemental employer-sponsored or Medigap coverage.

Chart 4-5 Differences in FFS Medicare spending and service use between dually eligible beneficiaries and non-dually eligible beneficiaries, 2023

Service	Dually eligible beneficiaries	Non-dually eligible beneficiaries
Average FFS Medicare payments per capita		
All covered services	\$27,958	\$16,806
Inpatient hospital	6,812	3,715
Physician and other noninstitutional Part B services*	4,403	4,368
Outpatient hospital and other institutional Part B services**	3,640	3,174
Home health	921	460
Skilled nursing facility	2,126	602
Hospice	802	350
Prescription drugs (Part D)	9,255	4,138
Share of FFS beneficiaries using service		
Share using any type of service	93.0%	98.3%
Inpatient hospital	20.8	13.8
Physician and other noninstitutional Part B services*	88.3	96.7
Outpatient hospital and other institutional Part B services**	73.6	78.8
Home health	11.6	8.6
Skilled nursing facility	8.3	3.2
Hospice	4.8	2.6
Prescription drugs (Part D)	88.8	94.9

Note: FFS (fee-for-service). “Dually eligible beneficiaries” are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. Figures are based on beneficiaries in FFS Medicare who had Part A, Part B, and Part D. Components may not sum to totals due to rounding.

* Includes a variety of medical services, equipment, and supplies.

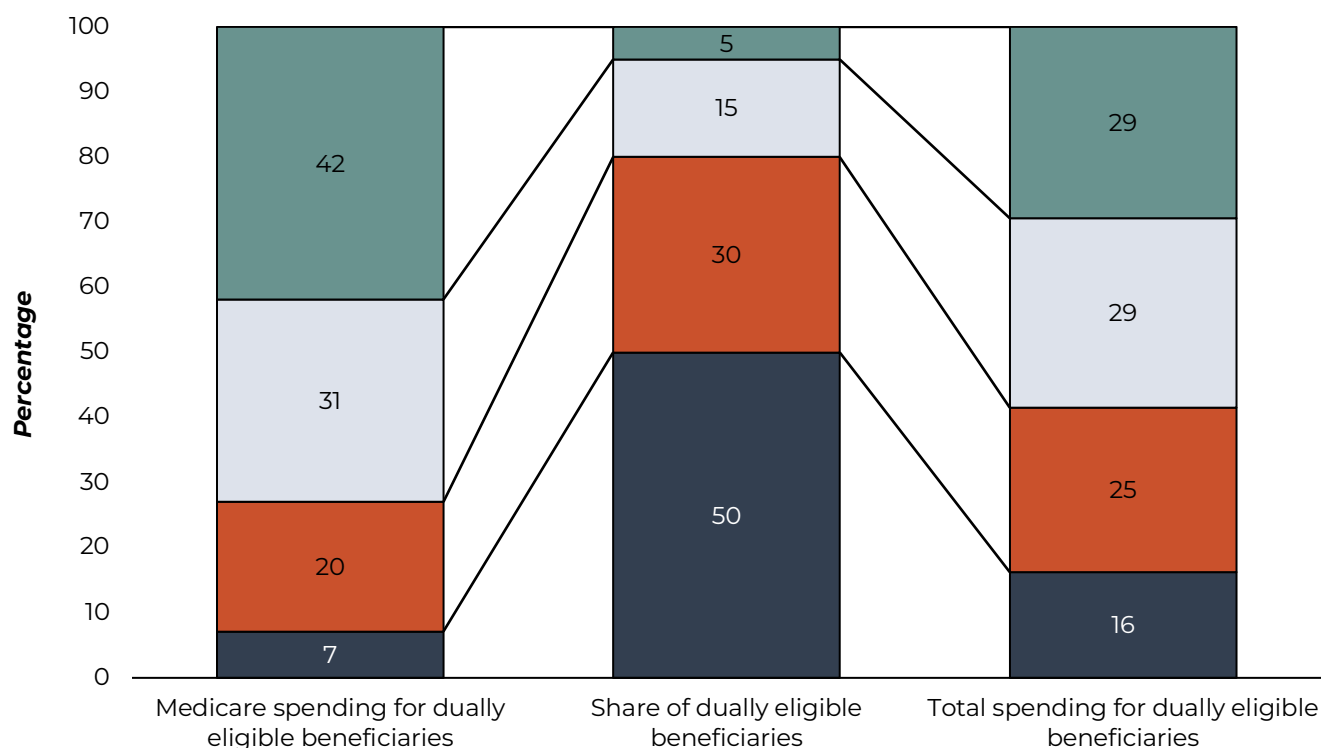
** Includes dialysis facilities, ambulatory surgical centers, and clinics; does not include Part B-covered home health.

Source: MedPAC analysis of CMS's Medicare Beneficiary Summary File, 2023.

> In 2023, among beneficiaries who had Part A, Part B, and Part D coverage, average per capita FFS Medicare spending for dually eligible beneficiaries was about 65 percent higher than that for non-dually eligible beneficiaries—\$27,958 compared with \$16,806.

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

Chart 4-6 Both Medicare and total spending were concentrated among a small number of dually eligible beneficiaries, 2023



Note: “Total spending” includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending. “Dually eligible beneficiaries” are defined as beneficiaries who were eligible for both Medicare and Medicaid for at least one month during the year. Figures are based on beneficiaries in fee-for-service (FFS) Medicare. Components may not sum to 100 percent due to rounding. The Medicare Current Beneficiary Survey is a point-in-time survey from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected.

Source: MedPAC analysis of CMS’s Medicare Current Beneficiary Survey, 2023.

> Annual FFS Medicare and total spending on dually eligible beneficiaries is concentrated among a small number of people. The costliest 5 percent of dually eligible beneficiaries accounted for 42 percent of Medicare spending and 29 percent of total spending on dually eligible beneficiaries in 2023. In contrast, the least costly 50 percent of dually eligible beneficiaries accounted for only 7 percent of FFS Medicare spending and 16 percent of total spending on dually eligible beneficiaries.

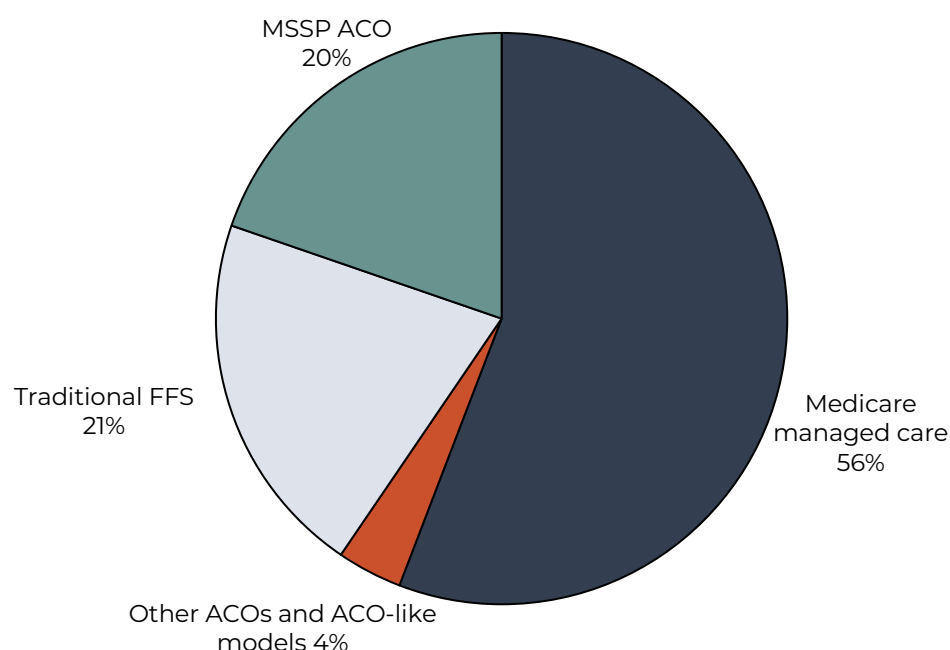
> On average, total spending (including Medicaid, Medigap, etc.) for dually eligible beneficiaries in 2023 was more than twice that for non-dually eligible beneficiaries—\$51,919 compared with \$19,908, respectively (data not shown).

SECTION

5

Alternative payment models

Chart 5-1 Most Medicare beneficiaries are in managed care plans or are assigned to accountable care organizations, 2026

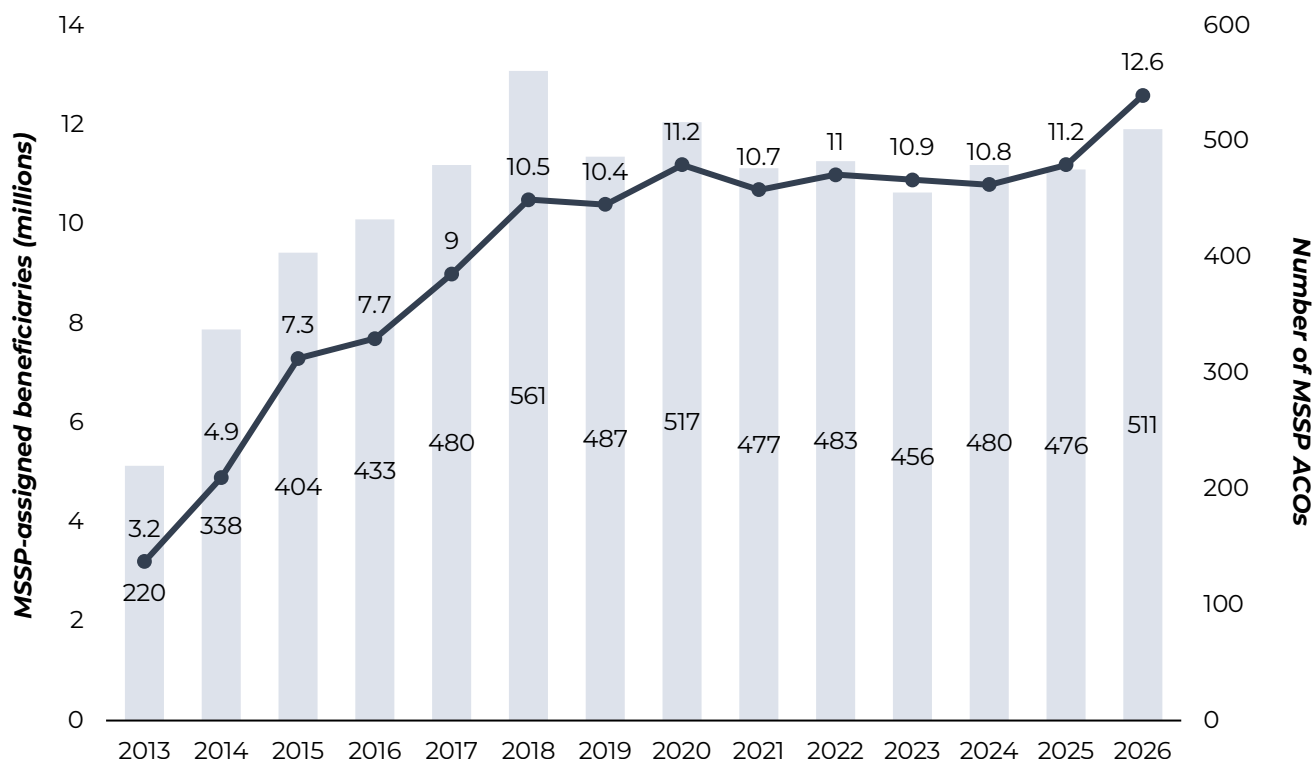


Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization), FFS (fee-for-service). This chart includes only beneficiaries enrolled in both Part A and Part B in January 2026. Both Part A and Part B coverage is necessary for either Medicare Advantage (MA) enrollment or ACO assignment. In general, Medicare managed care plans include MA plans as well as cost-reimbursed plans and Medicare–Medicaid demonstration plans. “Other ACOs and ACO-like models” includes the ACO Realizing Equity, Access, and Community Health (REACH) Model, the Maryland Total Cost of Care (TCOC) Model, and the Vermont All-Payer ACO. In the Maryland TCOC Model, all FFS beneficiaries are assigned to a hospital, and each hospital is responsible for all Part A and Part B spending for all Medicare beneficiaries in its market. This system creates ACO-like incentives for the hospitals and qualifies physicians affiliated with those hospitals for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) bonus payments for participation in eligible alternative payment models. Components may not sum to 100 percent due to rounding.

Source: CMS January 2026 enrollment data, CMS Shared Savings Program January 2026 Fast Facts, CMS ACO REACH 2026 Fast Facts, and State of Vermont Green Mountain Care Board 2024 Medicare ACO settlement.

- > Among the 63.9 million Medicare beneficiaries with both Part A and Part B coverage in 2026, more than three-fourths (79 percent) are in Medicare managed care (MA or other private plans) or ACO models.
- > The MSSP, a permanent ACO model established through the Affordable Care Act of 2010 (ACA), accounts for most of the beneficiaries assigned to ACO or ACO-like payment models. ACO models provide incentives for providers to manage beneficiaries' total annual spending.
- > Only 21 percent of Medicare beneficiaries with both Part A and Part B coverage are now in traditional FFS Medicare—a share that has declined in recent years.
- > Even among the share of beneficiaries in traditional FFS Medicare, some beneficiaries may be assigned to other alternative payments models such as the Bundled Payments for Care Improvement Advanced Model for a portion of their care.

Chart 5-2 The number of beneficiaries assigned to MSSP ACOs grew substantially in 2026



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

Source: CMS Shared Savings Program January 2026 Fast Facts.

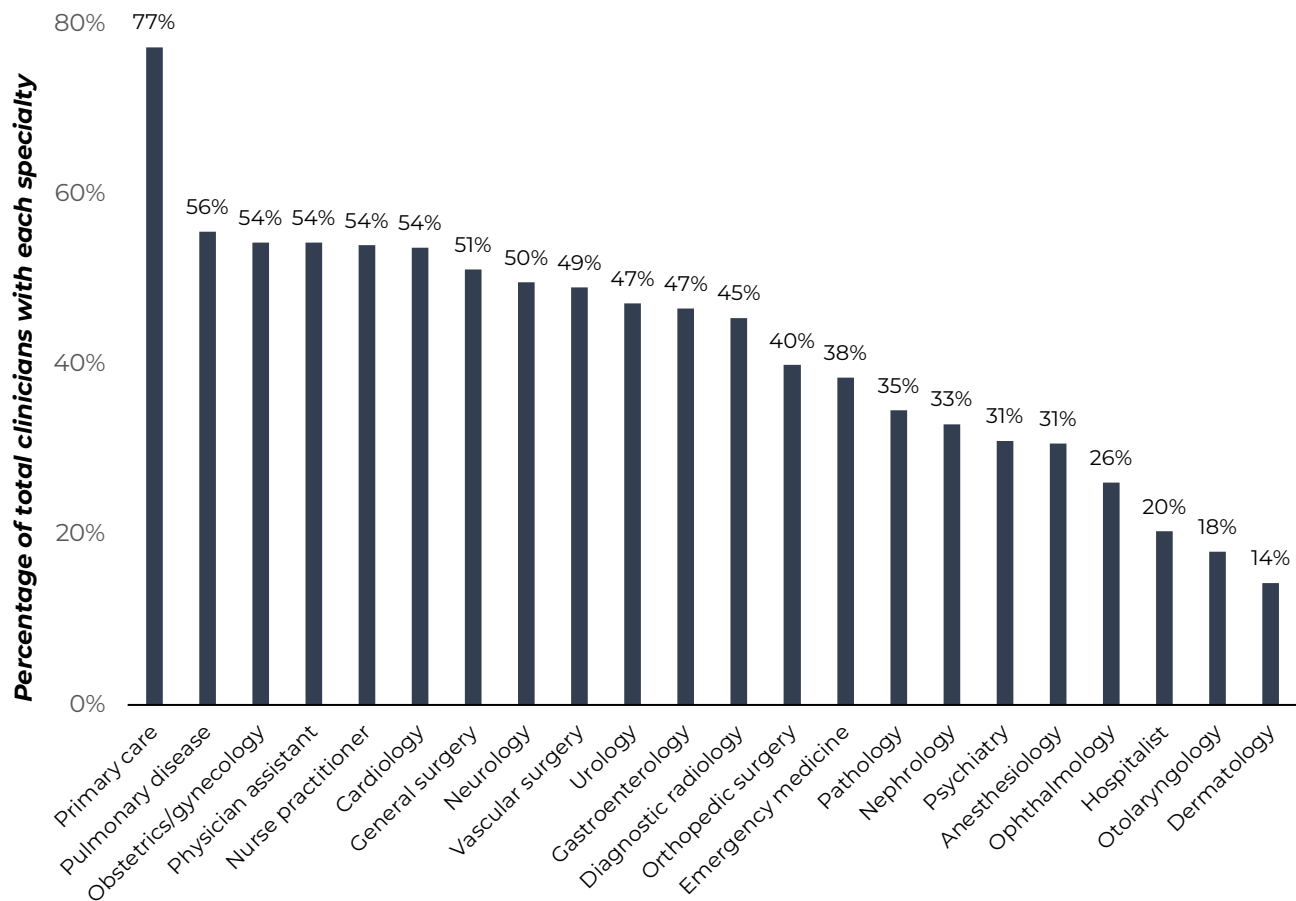
> After several years of relatively flat growth, the number of beneficiaries assigned to MSSP ACOs grew by about 13 percent from 2025 to 2026. In 2026, 20 percent of beneficiaries enrolled in both Part A and Part B were assigned to an MSSP ACO (see Chart 5-1).

> The number of ACOs peaked at 561 in 2018 and then declined to 487 in January 2019. In 2026, there were 511 ACOs—the most since 2020.

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

> In 2026, the number of assigned beneficiaries (12.6 million) is the largest in program history.

Chart 5-3 Clinician participation in MSSP ACOs among select specialties, 2023

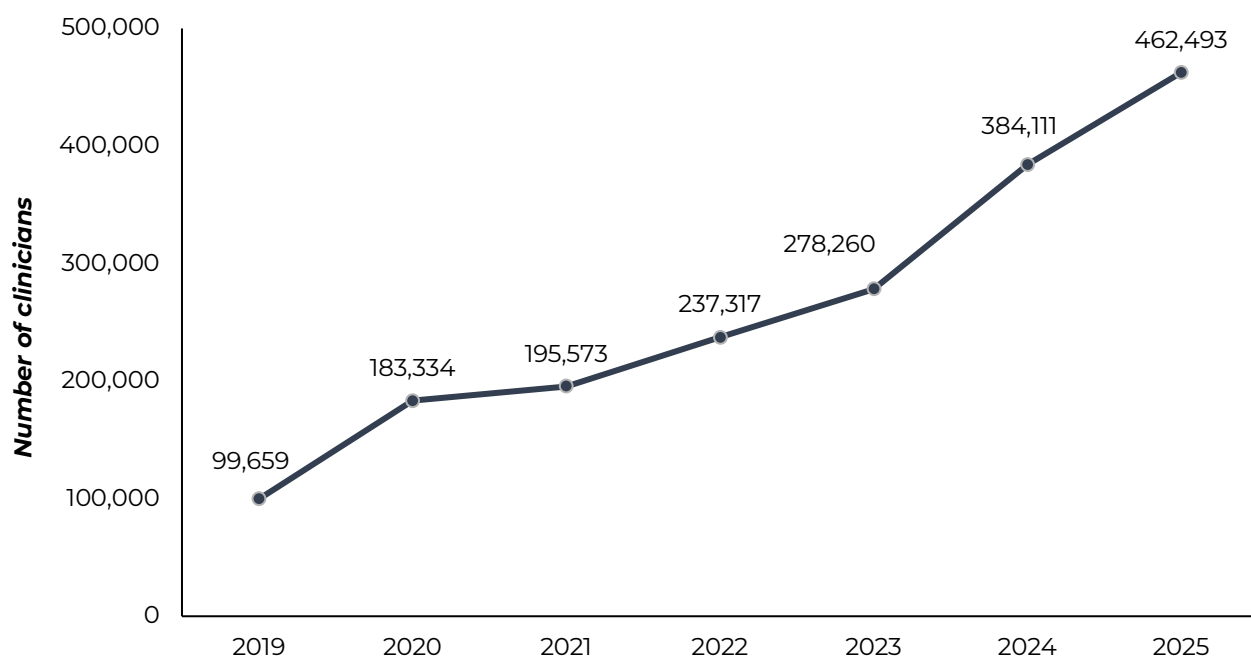


Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). “Total clinicians” includes all clinicians from each specialty who treated at least one Medicare fee-for-service (FFS) beneficiary in 2023, including those who participated in an MSSP ACO. “Primary care” includes physicians who specialize in internal medicine, family medicine, geriatric medicine, and pediatric medicine.

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

- > ACOs by design are oriented around primary care, but specialists also participate in these models. Most MSSP ACOs have a mix of physicians among various clinical specialties.
- > Among all primary care physicians who billed FFS Medicare in 2023, 77 percent participated in an MSSP ACO.
- > Among other specialties, participation in ACOs as a share of all clinicians within the specialty varies greatly. For example, 56 percent of all pulmonologists participating in FFS Medicare in 2023 also participated in an ACO. By contrast, less than 20 percent of otolaryngologists and dermatologists participated in an MSSP ACO.

Chart 5-4 An increasing number of clinicians qualified for the A-APM participation bonus, 2019–2025

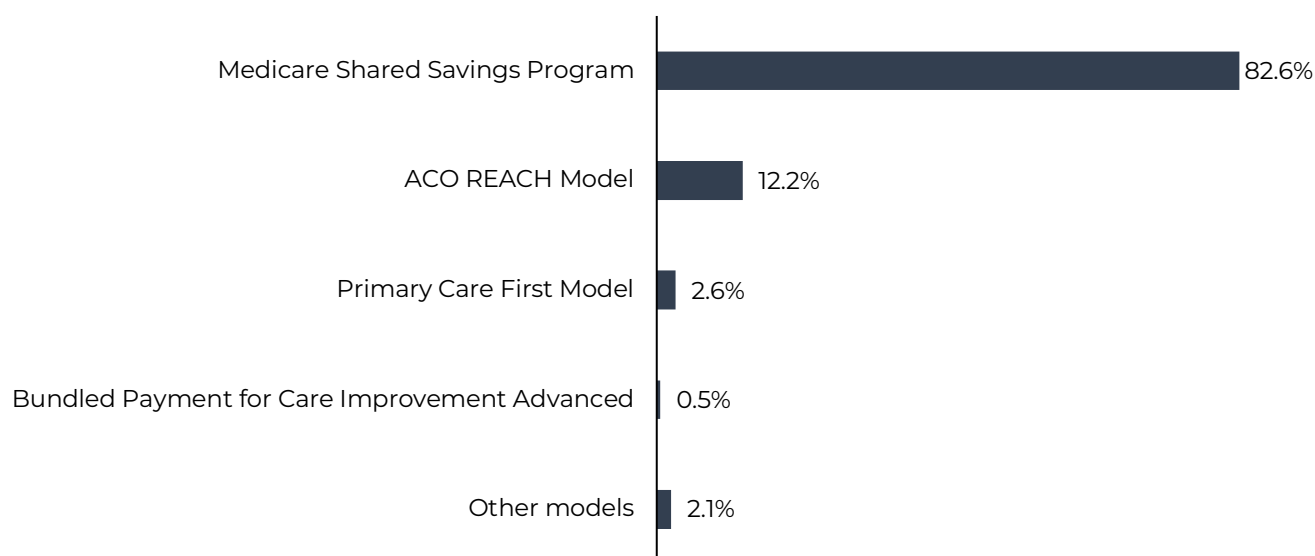


Note: A-APM (advanced alternative payment model). Numbers have been rounded to the nearest thousand. Figure shows the number of clinicians who qualified for the A-APM participation bonus in a given year (based on their A-APM participation two years prior), which may be higher than the number who actually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

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

- > The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established bonus payments for clinicians who participate in A-APMs. A-APMs are models that require participating providers to take on a more-than-nominal amount of financial risk, tie bonuses to quality measures, and require the use of electronic health records that have been certified by the federal government. Clinicians are eligible to receive a participation bonus worth 5 percent of their Medicare payments for fee schedule services from 2019 through 2024, a bonus worth 3.5 percent in 2025, and a bonus worth 1.88 percent in 2026.
- > Bonus payments are paid two years after the year in which a clinician participates in an A-APM.
- > To qualify for the bonus payment in most of the years shown above, at least 50 percent of a clinician's fee-for-service (FFS) Medicare or multipayer payments had to be associated with an A-APM or at least 35 percent of a clinician's FFS Medicare or multipayer patients had to be participating in an A-APM.
- > The number of clinicians who qualified for the A-APM participation bonus has increased steadily since it first became available in 2019 but has remained a minority of all clinicians. About one in three clinicians who billed the physician fee schedule received a bonus in 2025 (data not shown).
- > For payment year 2025, 269,000 clinicians were in alternative payment models (APMs) but did not qualify for a bonus payment (data not shown). These clinicians did not receive a bonus because either they were in an APM that did not meet MACRA's criteria to be considered an A-APM (e.g., they did not require clinicians to take on a sufficient degree of financial risk), so they were not eligible for MACRA's participation bonus, or they participated in an A-APM but did not qualify for a participation bonus due to an insufficient share of their payments or patients being in A-APMs.

Chart 5-5 More than 80 percent of the clinicians who qualified for an A-APM bonus in 2025 were in the Medicare Shared Savings Program



Note: A-APM (advanced alternative payment model), ACO (accountable care organization), REACH (Realizing Equity, Access, and Community Health). Clinicians' 2023 A-APM participation determined their 2025 bonuses. Shares do not sum to 100 percent because clinicians can participate in more than one A-APM simultaneously. To qualify for the A-APM bonus in 2025, clinicians had to receive 50 percent of their payments for professional services or provide 35 percent of their patients with professional services through an A-APM in 2023. The A-APM bonus was equal to 3.5 percent of the payments a clinician received for their professional services payments from Medicare (not including cost sharing paid by beneficiaries). "Other models" includes the Maryland Total Cost of Care Model, Comprehensive Care for Joint Replacement Model, Kidney Care Choices Model, Enhancing Oncology Care Model, and Vermont Accountable Care Organization Model. For the payment models shown, only those model tracks that require clinicians to take on some financial risk qualify as A-APMs (e.g., physicians participating in Track 1 of the Medicare Shared Savings Program did not qualify for A-APM bonuses because Track 1 involved no financial risk for participants).

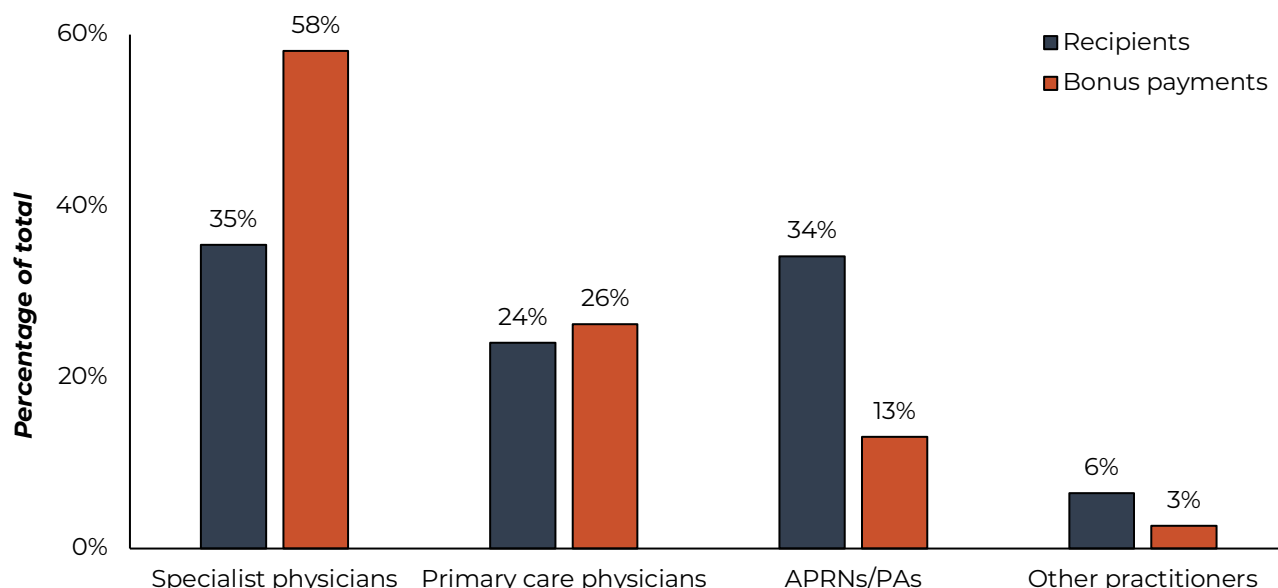
Source: CMS data on clinicians who qualified for the 3.5 percent bonus in 2025 are based on clinicians' 2023 model participation.

> The payment models that CMS has designated as A-APMs place health care providers at some financial risk for Medicare spending while expecting them to meet quality goals for a defined patient population.

> A-APM bonuses for qualifying clinicians equaled 3.5 percent of professional service payments in 2025 and equal 1.88 percent in 2026. From 2019 to 2024, clinicians who participated in A-APMs qualified for bonuses equal to 5 percent of their professional services payments from Medicare.

> In 2025, nearly 460,000 clinicians nationwide qualified for the A-APM bonus (based on 2023 A-APM participation) out of about 1.4 million who billed the Medicare physician fee schedule (data not shown). Roughly 95 percent of clinicians who qualified for an A-APM bonus participated in at least one of the ACO initiatives administered by CMS, which gives clinicians an opportunity to earn shared-savings payments from Medicare if they lower health care spending while meeting care quality standards.

Chart 5-6 Most A-APM participation bonus payments were paid to specialist physicians, 2025

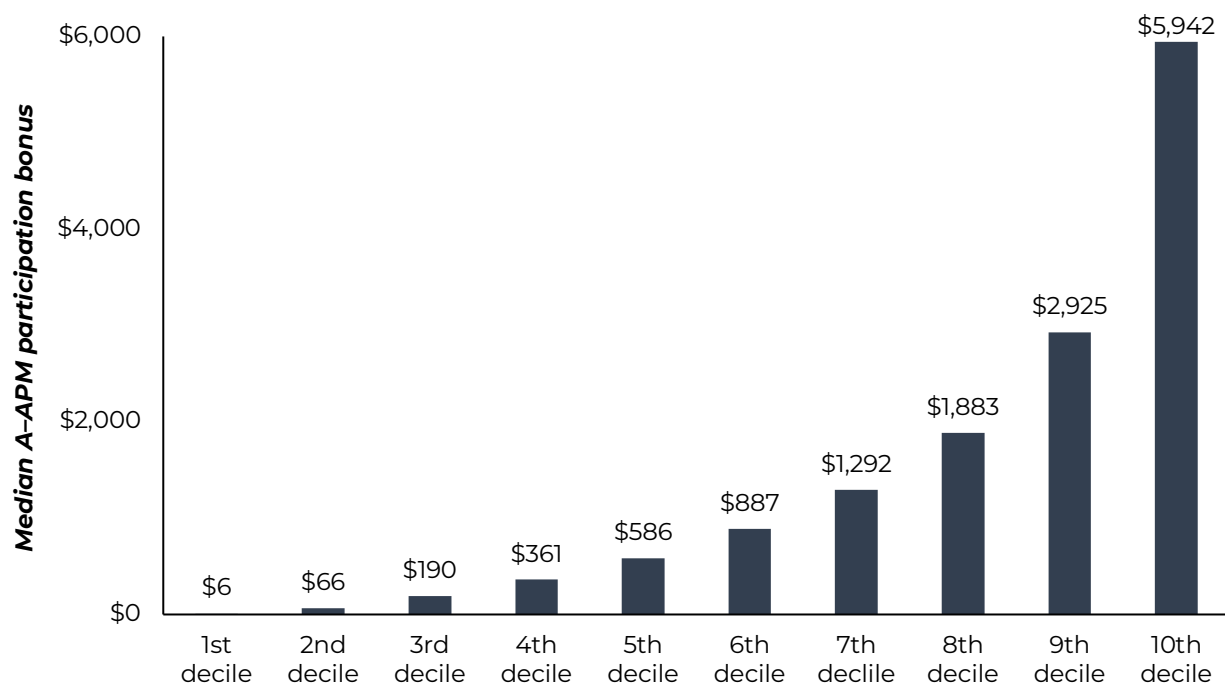


Note: A-APM (advanced alternative payment model), APRN (advanced practice registered nurse), PA (physician assistant). “Primary care physicians” includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. “Specialist physicians” includes cardiologists, dermatologists, and hospitalists. “Other practitioners” includes clinicians such as physical therapists, psychologists, and social workers. This category also includes podiatrists, optometrists, dental surgeons, and chiropractors, which are defined as physicians in Section 1861 of the Social Security Act. Components may not sum to 100 percent due to rounding.

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

- > In payment year 2025, qualifying clinicians were paid a total of \$678 million in A-APM participation bonus payments. Physicians in specialties other than primary care accounted for 35 percent of all clinicians who received a bonus payment, and 58 percent of total bonus payments went to those physicians. The size of each recipient’s participation bonus was based on 3.5 percent of the clinician’s total Medicare physician fee schedule revenue in 2024.
- > Physicians who specialize in primary care accounted for 24 percent of all recipients and received 26 percent of total bonus payments.
- > Specialists received larger A-APM participation bonuses than primary care physicians, APRNs and PAs, and other clinicians in 2025 because specialists tend to generate more annual fee-for-service Medicare payments than other types of clinicians. We calculate that the median bonus payment was \$1,596 for non-primary care physicians and was \$1,411 for primary care physicians (data not shown).
- > APRNs and PAs accounted for a relatively small share of bonus payments (13 percent) despite accounting for a large share of recipients (34 percent). This contrast is due in part to the fact that APRNs and PAs are paid 85 percent of standard fee schedule rates and they tend to perform services that have relatively low payment rates.
- > Because of “incident to” billing rules, which allow physicians to bill for services furnished by APRNs and PAs, bonuses paid to a single physician may be partly based on services performed by these other types of clinicians.

Chart 5-7 The size of A-APM participation bonuses varied widely, 2025



Note: A-APM (advanced alternative payment model). Figure shows MedPAC's estimates of the median bonus amount at different deciles in the 2025 payment year. Bonuses were calculated based on A-APM participation from two years prior (2023) and Medicare payments from one year prior (2024). Our estimates are slight underestimates of bonus sizes primarily because, when calculating bonuses, we did not include supplemental service payments that clinicians receive through A-APMs (e.g., capitated care-management fees).

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

- > The size of A-APM participation bonuses varies based on a clinician's total annual fee-for-service Medicare payments for physician fee schedule services.
- > The median size of all bonus payments in 2025 was \$936 (data not shown).
- > Among the 10 percent of clinicians who received the smallest bonus, the median bonus was \$6; among the 10 percent of clinicians who received the largest bonus, the median bonus was \$5,942.
- > By our estimates, bonuses totaled \$678 million in payment year 2025, which is less than the \$840 million that CMS reported paying out in 2024. The decrease is largely due to a reduction in the size of the bonus payment percentage from 5 percent of qualifying clinicians' Medicare fee schedule revenue in 2024 to 3.5 percent in 2025.
- > All clinicians in advanced payment models are also eligible for payments available through these models (e.g., shared savings payments), which are not included here.

Acute inpatient services

General acute care hospitals

**Inpatient prospective
payment systems hospitals**

Critical access hospitals

Inpatient psychiatric facilities

Chart 6-1 Almost all FFS Medicare beneficiary inpatient stays at general acute care hospitals were paid under the IPPS, FY 2024

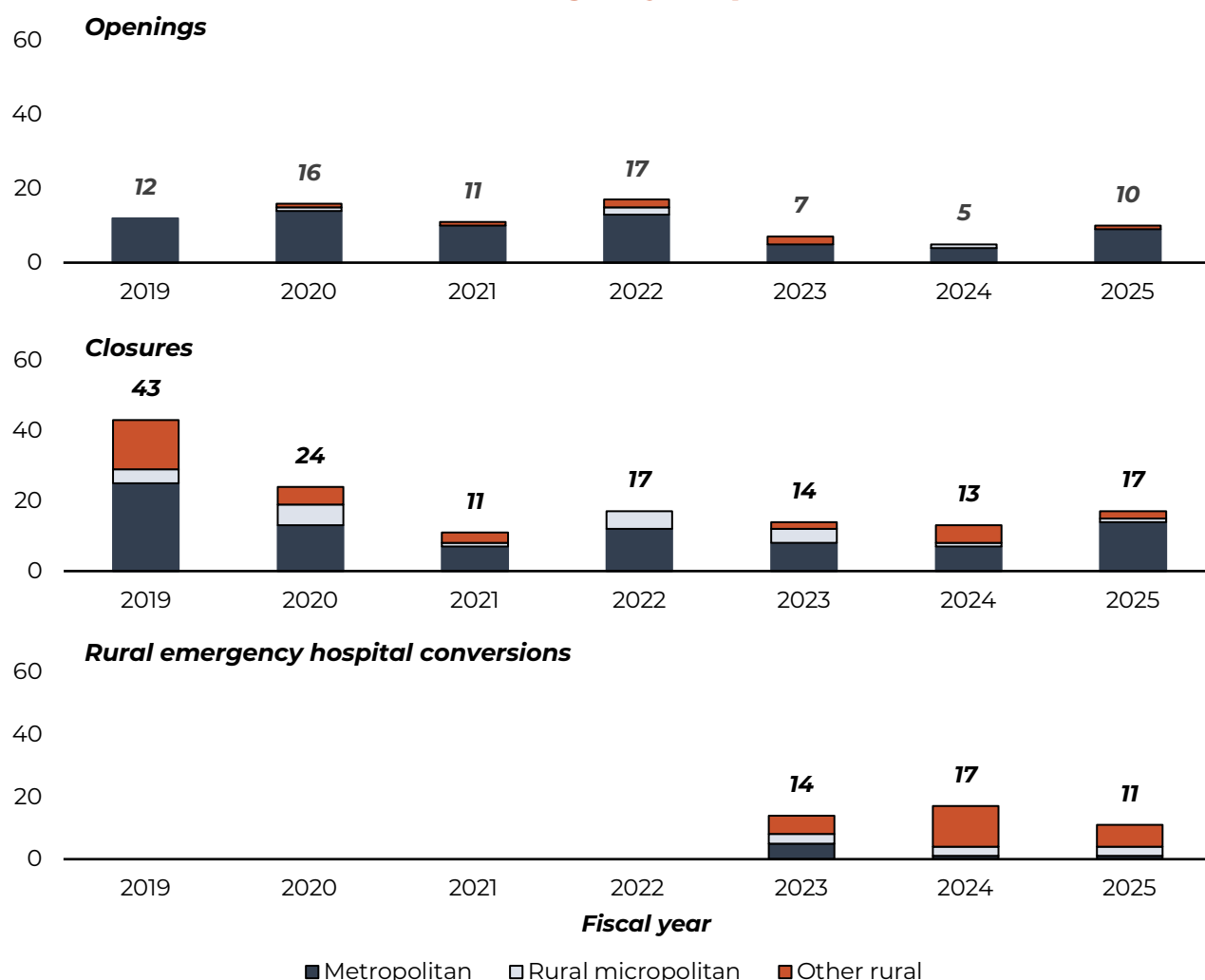
	Number of hospitals	All-payer inpatient stays	FFS Medicare inpatient stays
All	4,400	30.8 million	6.8 million
<i>Share of total</i>			
IPPS	68%	96%	94%
Ownership			
For profit	15	14	13
Nonprofit	43	69	70
Government	10	13	11
Geography			
Metropolitan	53	90	87
Rural micropolitan	11	6	7
Other rural	4	1	1
DSH and teaching			
Both	28	68	62
DSH only	29	22	24
Teaching only	2	3	4
Neither	8	3	4
Critical access	30	2	3
Other	2	2	3

Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), FY (fiscal year), DSH (disproportionate share). “General acute care hospitals” refers to Subsection (d) hospitals, critical access hospitals, and short-term acute care hospitals in territories; this table does not include rural emergency hospitals since they do not provide inpatient services. “Number of hospitals” is the number of Medicare provider numbers, rounded to the nearest 10; a provider number can represent multiple hospital locations. “Metropolitan” (urban) counties contain a cluster of 50,000 or more people; “micropolitan” rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as “other rural.” Components may not sum to totals due to rounding.

Source: MedPAC analysis of hospital cost-report and Provider of Services data from CMS and census geographic data.

- > In FY 2024, there were approximately 4,400 general acute care hospitals that provided at least one inpatient stay. The total number of inpatient stays at these hospitals was 30.8 million, and about a quarter of these stays (6.8 million) were by FFS Medicare beneficiaries.
- > For about two-thirds of these hospitals, FFS Medicare paid for inpatient stays under Medicare’s IPPS. About 30 percent of hospitals were designated as critical access hospitals (CAHs) by Medicare; FFS Medicare pays for inpatient stays in these hospitals on a cost basis. The remaining 2 percent of hospitals were paid by FFS Medicare using other methodologies, such as hospitals participating in the Maryland Total Cost of Care Model or other demonstrations.
- > Nearly all inpatient stays, including FFS Medicare inpatient stays, were provided in IPPS hospitals. Because CAHs have 25 or fewer inpatient beds, only a very small share of inpatient stays were at CAHs.
- > Not shown in the table are rural emergency hospitals (REHs). REHs do not furnish inpatient care, and they receive fixed monthly payments from Medicare as well as enhanced payments for emergency and outpatient services.

Chart 6-2 More general acute care hospitals closed than opened in FY 2025, and others converted to rural emergency hospitals



Note: FY (fiscal year). “General acute care hospitals” refers to Subsection (d) hospitals, critical access hospitals, short-term acute care hospitals in territories, and rural emergency hospitals. “Openings” refers to a new location that provided inpatient and outpatient services, while “closures” refers to a hospital location that ceased inpatient services and did not convert to a rural emergency hospital. “Metropolitan” (urban) counties contain a cluster of 50,000 or more people; “micropolitan” rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as “other rural.” The counts of openings and closures do not include the conversion of a short-term acute care hospital to or from a critical access hospital or rural emergency hospital, the relocation of inpatient services from one hospital to another under common ownership within 10 miles, or hospitals that both opened and closed within a five-year period. The number of hospital openings and closures in a given year can change from prior publications as hospitals reopen and newer data become available.

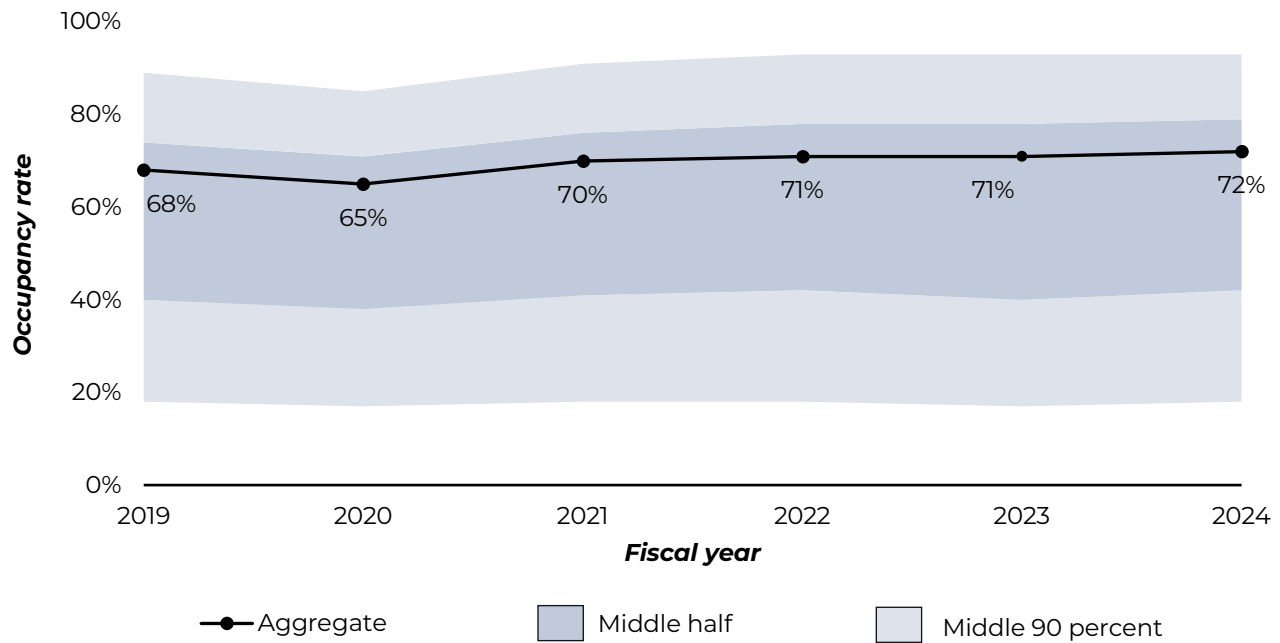
Source: MedPAC analysis of Provider of Services and census geographic data and internet searches.

> In FY 2025, 10 hospitals opened while 17 closed; another 11 converted to rural emergency hospitals (REHs). (The REH program is an outpatient-only hospital designation that first became available in 2023.)

> Consistent with prior years, the majority of openings and closures in FY 2025 were in urban (metropolitan) areas. None of the openings or closures in FY 2025 were critical access hospitals. The majority of REH conversions were in rural nonmicropolitan areas (“other rural” in the chart).

> In FY 2025, the average distance of closures to the next-nearest hospital was 11 miles (data not shown).

Chart 6-3 IPPS hospitals continued to have excess inpatient capacity in aggregate, but some hospitals faced capacity constraints



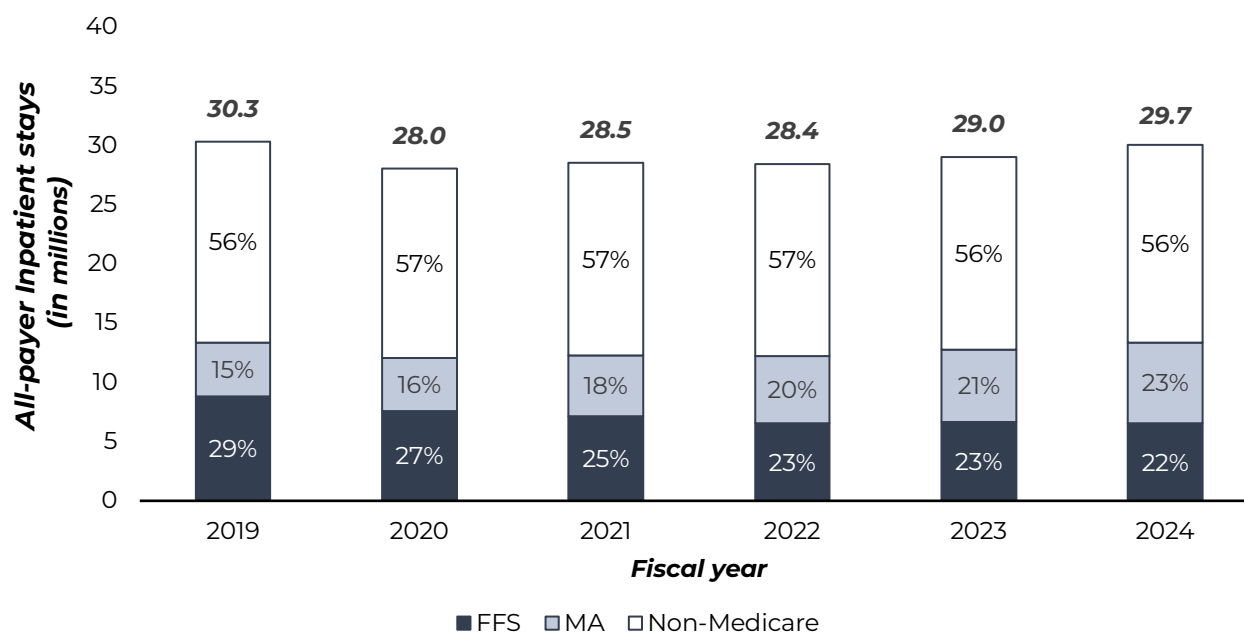
Note: IPPS (inpatient prospective payment systems). "Occupancy rate" refers to the share of bed days that were occupied by a patient (regardless of whether the patient was receiving inpatient, observation, or swing-bed services or the share of time the bed was staffed). Results differ from those published last year because this chart is limited to IPPS hospitals.

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

> IPPS hospitals continued to have available capacity in aggregate. However, there continued to be significant variation within these aggregates, with some hospitals having substantially higher available capacity while others faced capacity constraints.

> In FY 2024, IPPS hospitals' occupancy rate was 72 percent, a small increase from fiscal year 2023. However, 5 percent of hospitals had an occupancy rate under 18 percent, while another 5 percent had an occupancy rate over 93 percent.

Chart 6-4 IPPS hospitals' all-payer inpatient stays in FY 2024 neared the prepandemic level; FFS Medicare share continued to decline

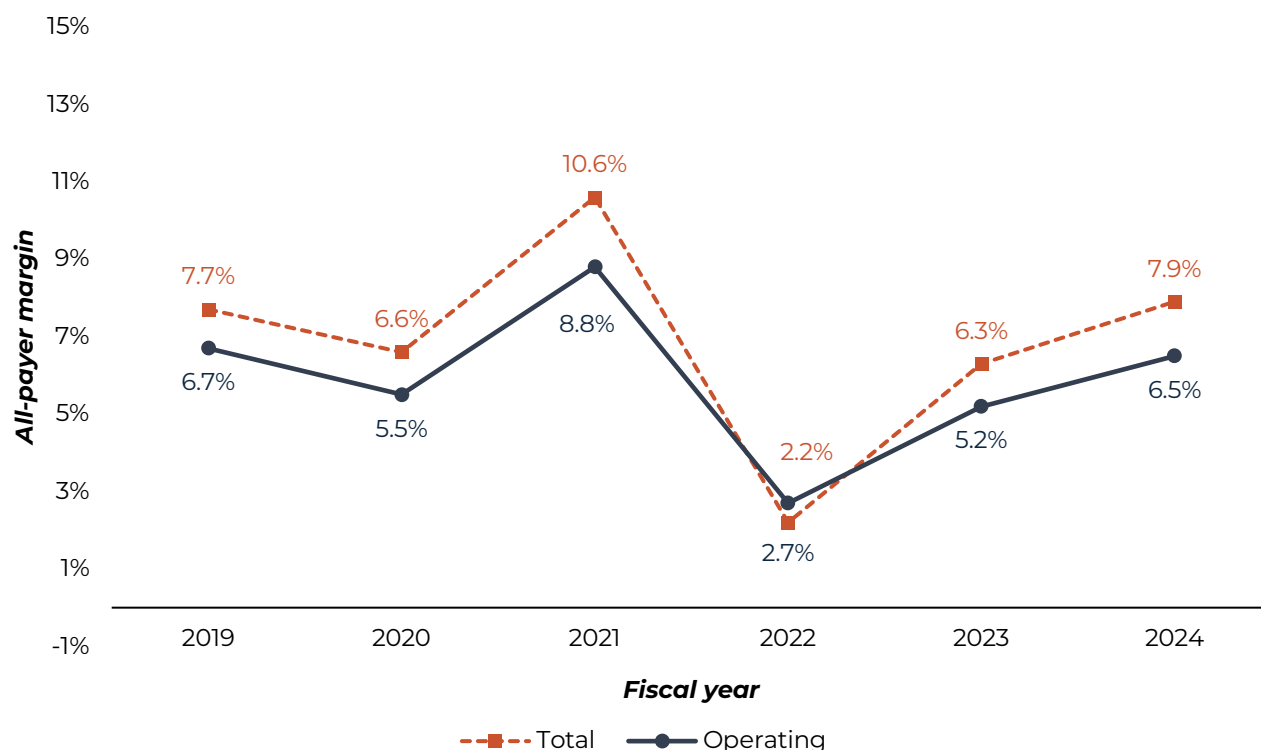


Note: IPPS (inpatient prospective payment systems), FY (fiscal year), FFS (fee-for-service), MA (Medicare Advantage). Results differ from those published last year and the first row of Chart 6-1 because this chart is limited to IPPS hospitals. Components may not sum to 100 percent due to rounding.

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

> In FY 2024, IPPS hospitals reported providing nearly 30 million inpatient stays, which neared the prepandemic level. Medicare beneficiaries continued to account for just under half of these inpatient stays; however, the share from FFS Medicare beneficiaries continued to decline, while the share from MA increased.

Chart 6-5 IPPS hospitals' all-payer total and operating margins increased in FY 2024 to near prepandemic levels



Note: IPPS (inpatient prospective payment systems), FY (fiscal year). “All-payer total margin” is the percentage of revenue from all payers and sources (including coronavirus relief funds) that is left as profit after accounting for all costs. “All-payer operating margin” excludes reported investment and donation income and is therefore often lower than hospitals’ total margin but is higher in years when investment losses exceed donation income.

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

> IPPS hospitals’ all-payer total and operating margins both increased in FY 2024, to 7.9 percent and 6.5 percent respectively. Both of these levels were similar to those in 2019.

> IPPS hospitals’ all-payer operating margin (including coronavirus relief funds) increased 1.3 percentage points in FY 2024 to 6.5 percent, indicating that hospitals had net operating profits that could be used for capital projects. Several factors contributed to this increase, including a one-time increase in revenue from 340B remedy payments and slower growth in hospitals’ labor costs (data not shown).

> IPPS hospitals’ all-payer total margin increased 1.6 percentage points in FY 2024, driven by a nearly 40 percent increase in reported investment income (data not shown).

Chart 6-6 **IPPS hospitals' all-payer operating margin increased across all hospital categories in FY 2024, though substantial variation persisted**

Margin type and hospital category	All-payer operating margin, by fiscal year					
	2019	2020	2021	2022	2023	2024
Including relief funds						
All	6.7%	5.5%	8.8%	2.7%	5.2%	6.5%
Ownership						
For profit	12.3	13.0	15.4	12.8	13.5	14.5
Nonprofit	6.2	4.8	8.3	0.9	4.4	5.9
Geography						
Metropolitan	6.8	5.5	8.8	2.8	5.4	6.6
Rural micropolitan	5.0	5.7	8.8	1.2	2.9	5.3
Other rural	1.3	3.9	7.8	0.9	-0.7	1.5
Excluding relief funds						
All	6.7	2.0	7.4	1.9	4.9	6.4
Ownership						
For profit	12.3	10.7	14.3	12.4	13.3	14.5
Nonprofit	6.2	1.2	6.9	0.1	4.1	5.8
Geography						
Metropolitan	6.8	2.1	7.5	2.1	5.1	6.5
Rural micropolitan	5.0	1.2	6.4	-0.7	2.5	5.1
Other rural	1.3	-1.8	2.9	-2.5	-1.3	1.3

Note: IPPS (inpatient prospective payment systems), FY (fiscal year). "All-payer operating margin" is the percentage of revenue from all payers and sources exclusive of investments and donations that is left as profit after accounting for all costs. "Relief funds" refers to federal or other coronavirus relief funds. "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." Government-owned hospitals operate in a different financial context from other hospitals, so their margin is not necessarily comparable; therefore, data for government-owned hospitals are not reported separately or included in the ownership rows (but are included in other rows).

Source: MedPAC analysis of hospital cost-report and Provider of Services data from CMS and census geographic data.

> IPPS hospitals' all-payer operating margin continued to vary across hospital categories in FY 2024. For-profit hospitals' all-payer operating margin continued to be substantially higher than nonprofit hospitals' margin; urban (metropolitan) hospitals' all-payer operating margin continued to be higher than rural micropolitan hospitals' or other rural hospitals' margin.

Chart 6-7 **IPPS hospitals' FFS Medicare margin increased in FY 2024 but remained substantially negative, and significant variation across hospitals persisted**

Hospital category	FFS Medicare margin, by fiscal year					
	2019	2020	2021	2022	2023	2024
Including relief funds						
All	-7.9%	-8.1%	-6.2%	-11.7%	-12.2%	-11.9%
Ownership						
For profit	1.3	4.6	5.7	0.8	0.7	1.6
Nonprofit	-9.4	-10.1	-8.1	-13.4	-13.7	-13.2
Geography						
Metropolitan	-8.3	-8.7	-6.8	-12.1	-12.5	-12.3
Rural micropolitan	-4.5	-2.5	-1.4	-8.1	-9.8	-7.1
Other rural	0.3	5.4	8.0	0.6	-3.8	-3.1
Fiscal pressure						
Low pressure	-10.9	-11.1	-8.8	-13.8	-14.2	-13.7
Medium pressure	-4.5	-4.4	-2.7	-8.0	-9.1	-8.8
High pressure	3.7	6.9	5.8	-3.2	-4.8	-6.2
Excluding relief funds						
All	-7.9	-12.2	-8.2	-12.8	-12.6	-12.1
Ownership						
For profit	1.3	1.9	4.2	0.3	0.4	1.1
Nonprofit	-9.4	-14.6	-10.1	-14.6	-14.2	-13.4
Geography						
Metropolitan	-8.3	-12.7	-8.6	-13.0	-12.9	-12.6
Rural micropolitan	-4.5	-7.6	-4.6	-10.7	-10.4	-7.3
Other rural	0.3	-0.6	2.6	-3.6	-4.7	-3.4
Fiscal pressure						
Low pressure	-10.9	-14.7	-10.5	-14.7	-14.5	-13.9
Medium pressure	-4.5	-8.9	-4.9	-9.3	-9.6	-9.1
High pressure	3.7	0.9	2.4	-4.8	-5.6	-6.6

Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service), FY (fiscal year). "Hospitals" refers to hospitals paid under the IPPS. "FFS Medicare margin" is the percentage of revenue from all FFS Medicare IPPS and outpatient prospective payment system services that is left as profit after accounting for the allowable costs of providing these services to FFS Medicare patients. The FFS Medicare margin includes uncompensated-care payments and revenue and costs of separately payable drugs, including any reported discounts to drug costs under the 340B Drug Pricing Program but not including the remedy payments that hospitals received in 2024 to offset lower payments for 340B drugs acquired in 2018 through 2021 (though higher payments for drugs on reprocessed claims in 2022 are included). "Relief funds" refers to FFS Medicare's share of federal and other coronavirus relief funds (with the share based on FFS Medicare's share of 2019 all-payer operating revenue). "Metropolitan" (urban) counties contain an urban cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." "Low [fiscal] pressure" hospitals are defined as those with a median non-FFS Medicare margin greater than 5 percent over five years and a net worth that would have grown by more than 1 percent per year over that period if the hospital's FFS Medicare profits had been zero. "High [fiscal] pressure" hospitals are defined as those with a median non-FFS Medicare margin of 1 percent or less over five years and a net worth that would have grown by less than 1 percent per year. All other hospitals with complete data are classified as "medium pressure." Government-owned hospitals operate in a different financial context from other hospitals, so their margin is not necessarily comparable; therefore, data for government-owned hospitals are not reported separately or included in the ownership rows (but are included in other rows).

Source: MedPAC analysis of hospital cost-report and Provider of Services data from CMS and census geographic data.

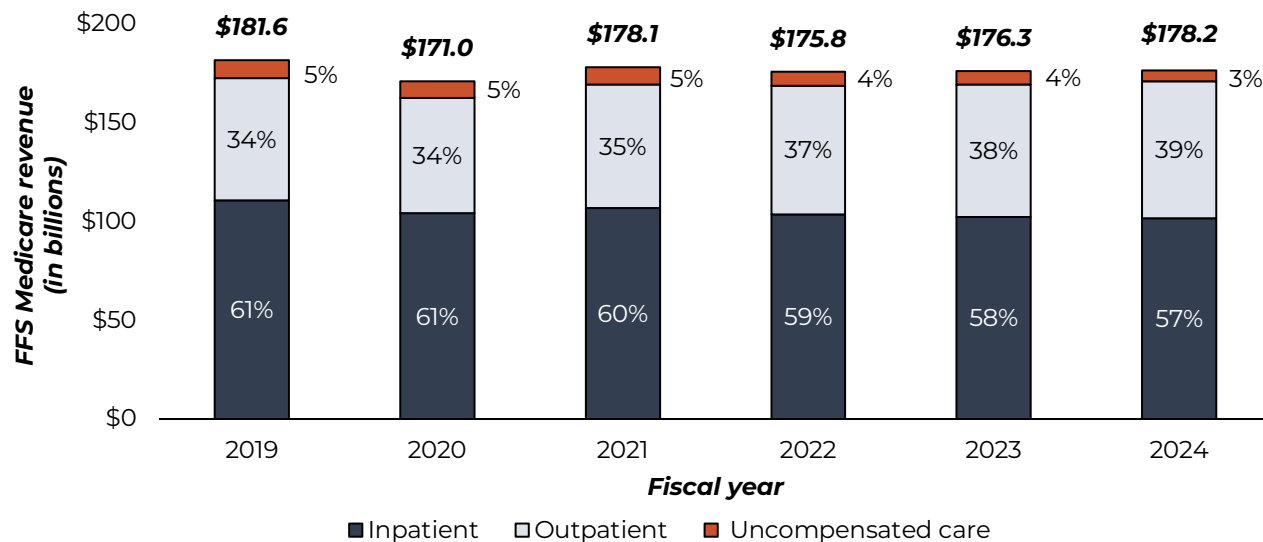
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Chart 6-7 IPPS hospitals' FFS Medicare margin increased in FY 2024 but remained substantially negative, and significant variation across hospitals persisted (continued)

> IPPS hospitals' FFS Medicare margin increased in FY 2024 but continued to be well below hospitals' costs in aggregate, at -12.1 percent (excluding coronavirus relief funds). This FY 2024 margin does not reflect the \$9 billion in one-time payments that Medicare paid hospitals in 2024 to offset lower payments for drugs acquired through the 340B Drug Pricing Program from 2018 to 2021. (We focus on IPPS hospitals' FFS Medicare margin exclusive of coronavirus relief funds; however, we also report a version including the FFS Medicare share of coronavirus relief funds because these funds were intended to cover lost revenue and higher costs—including those related to FFS Medicare patients.)

> IPPS hospitals' FFS Medicare margin continued to vary across hospital categories in FY 2024. For-profit hospitals' FFS Medicare margin continued to be substantially higher than nonprofit hospitals' margin; rural hospitals' FFS Medicare margin continued to exceed urban hospitals' margin; and hospitals under high fiscal pressure, and therefore under more pressure to constrain their costs, continued to have a higher margin than hospitals under low pressure.

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



Note: IPPS (inpatient prospective payment systems), FFS (fee-for-service). "Inpatient" refers to revenue for services covered under the IPPS and is reported exclusive of uncompensated-care payments, which are reported separately. "Outpatient" refers to revenue for services covered under the outpatient prospective payment system (OPPS). Hospitals also receive other revenue from providing services to FFS Medicare beneficiaries that are not included in these totals, such as revenue from services provided in nonexcepted off-campus provider-based departments and in post-acute care units. Dollar amounts are nominal figures, not adjusted for inflation. Components may not sum to 100 percent due to rounding.

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

- > In FY 2024, FFS Medicare (and its beneficiaries) paid IPPS hospitals \$178.2 billion for inpatient and outpatient PPS services, slightly below the prepandemic level.
- > However, the share of IPPS hospitals' FFS Medicare revenue from OPPS services has been steadily increasing, from 34 percent in FY 2019 to 39 percent in 2024.

Chart 6-9 About 16 percent of IPPS payments in FY 2024 were from adjustments targeted to specific hospitals or services

Hospital group	Share of IPPS payments (excluding uncompensated care)						
	Base PPS	Low income (DSH)	Teaching (IME)	New technology	Outliers	Rural and/or isolated	Quality
IPPS	83.6%	3.2%	7.8%	0.1%	4.3%	1.4%	-0.5%
Ownership							
For profit	88.8	3.3	5.3	0.1	1.9	1.0	-0.5
Nonprofit	84.0	3.0	7.6	0.1	4.3	1.4	-0.5
Government	75.9	4.0	11.5	0.2	6.8	1.9	-0.5
Geography							
Metropolitan	83.6	3.2	8.2	0.1	4.5	0.8	-0.5
Micropolitan	82.8	2.3	3.3	0.1	1.7	10.1	-0.4
Other rural	79.4	2.2	1.1	0.1	0.8	16.8	-0.4
DSH and teaching							
Both	80.7	3.5	10.5	0.1	5.0	0.7	-0.5
DSH only	87.3	0.1	8.3	0.1	3.3	0.9	-0.1
Teaching only	90.9	3.1	0.0	0.1	2.4	3.8	-0.4
Neither	93.9	0.1	0.0	0.1	2.0	2.7	-0.3
Rural and/or isolated							
Sole community	78.3	2.2	3.3	0.1	3.0	13.5	-0.3
Medicare dependent	79.6	1.4	2.0	0.1	1.2	16.0	-0.3
Low volume	79.2	1.8	0.7	0.0	1.0	17.2	-0.3

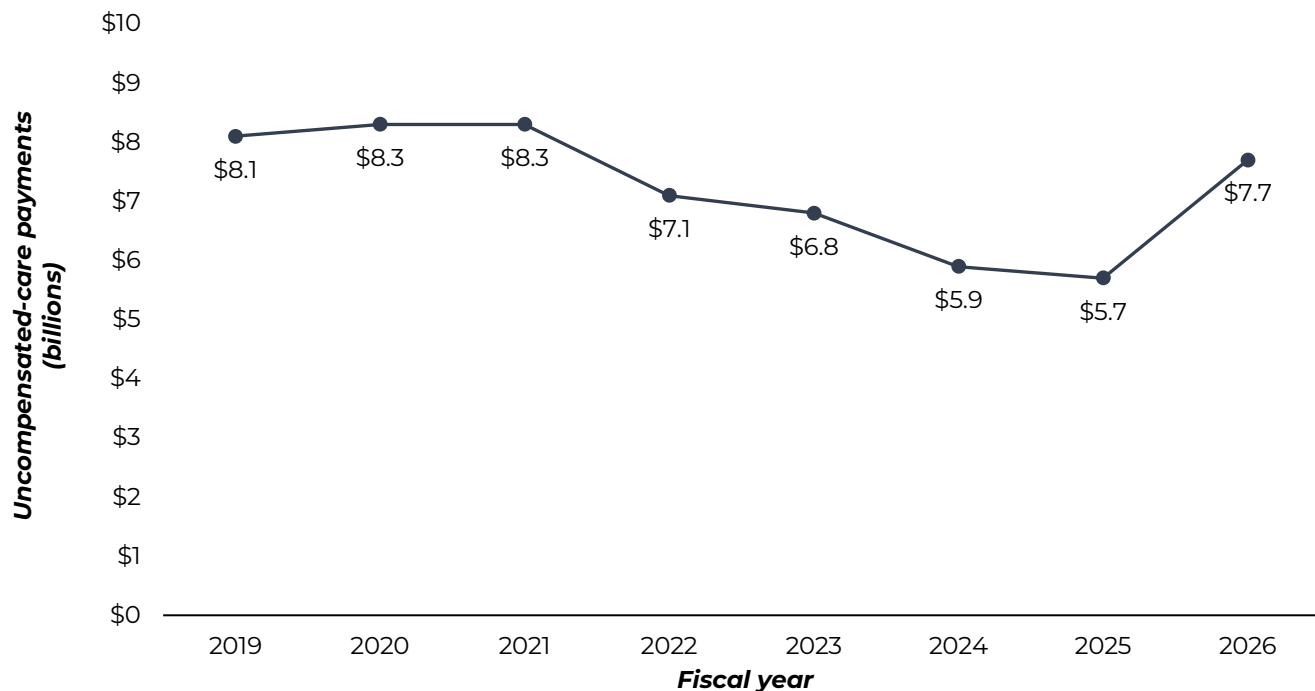
Note: IPPS (inpatient prospective payment systems), FY (fiscal year), DSH (disproportionate share hospital), IME (indirect medical education). "Rural and/or isolated" includes additional payments received by hospitals designated as sole community, Medicare-dependent, and/or low-volume hospitals. "Quality" includes payments and penalties from the value-based purchasing program and penalties from the Hospital Readmissions Reduction Program and Hospital-Acquired Conditions Reduction Program. "Metropolitan" (urban) counties contain a cluster of 50,000 or more people; "micropolitan" rural counties contain a cluster of 10,000 to 50,000 people; all other counties are classified as "other rural." The hospitals in the "DSH" and "teaching" rows are defined by receiving inpatient operating DSH and/or IME payments. Columns include applicable inpatient operating or capital prospective payment system payments, inclusive of beneficiary cost-sharing liabilities and exclusive of uncompensated-care payments. Components may not sum to 100 percent due to rounding and not separately showing smaller components of IPPS payments.

Source: MedPAC analysis of hospital cost-report and Provider of Services data from CMS and census geographic data.

> The largest component of IPPS payments are base payments, which are calculated using national operating and capital rates, adjusted for geographic factors and patient case mix. In FY 2024, 83.6 percent of IPPS payments were for base payments.

> The remaining amount—about 16 percent—comprised adjustments targeted to certain hospitals or services. The largest of these targeted payments on an aggregate basis were payments to teaching hospitals for their indirect costs of medical education; in FY 2024, these comprised nearly 8 percent of IPPS payments. However, for certain hospitals, targeted payments comprised a larger share of that group's IPPS payments. For example, among hospitals designated as low-volume hospitals—which can receive an up to 25 percent increase to their otherwise applicable IPPS payments—over 17 percent of their IPPS payments in FY 2024 were from additional payments under this and/or other rural designations.

Chart 6-10 FFS Medicare's uncompensated-care payments to IPPS hospitals increased in FY 2026, approaching the prepandemic level

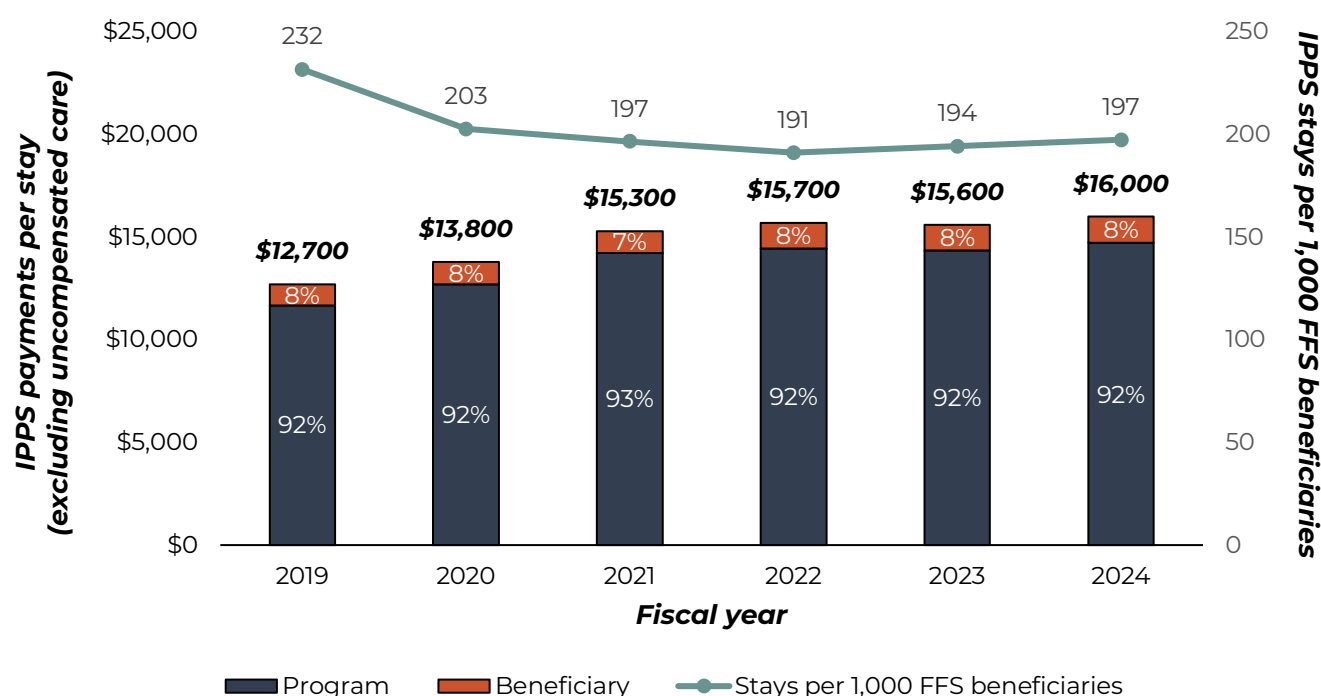


Note: FFS (fee-for-service), IPPS (inpatient prospective payment systems), FY (fiscal year). “Uncompensated-care payments” are presented postsequestration and inclusive of uncompensated-care supplemental payments to hospitals for Indian Health Service and tribal hospitals and Puerto Rican hospitals. In FY 2026, these supplemental payments totaled \$107 million (data not shown). Dollar amounts are nominal figures, not adjusted for inflation.

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

- > As required by law, in FY 2014, Medicare reduced IPPS operating disproportionate share (DSH) hospital payments to 25 percent of prior law and introduced uncompensated-care payments.
- > Aggregate uncompensated-care payments for a fiscal year are set prospectively as the product of two estimates for the upcoming payment year: 75 percent of the operating DSH hospital payments under prior law and the uninsured rate as a percentage of the rate in 2013 (plus an additional reduction from FY 2014 to FY 2017). Therefore, when the rate of uninsured individuals increases and hospitals have greater losses on uncompensated care, the Medicare program makes higher uncompensated-care payments to IPPS hospitals.
- > For each fiscal year between 2019 and 2021, uncompensated-care payments were slightly over \$8 billion dollars on a nominal basis.
- > Uncompensated-care payments fell each year from FY 2022 to FY 2025, down to \$5.7 billion in FY 2025.
- > In FY 2026, uncompensated-care payments increased substantially to \$7.7 billion dollars, approaching the prepandemic level. This growth was driven in part by an estimated increase in the uninsured rate, from 7.6 percent in 2025 to 8.7 percent in 2026 (data not shown).

Chart 6-11 Medicare's IPPS payments per stay in FY 2024 were well above pre-pandemic level, but stays per capita remained well below pre-pandemic level



Note: IPPS (inpatient prospective payment systems), FY (fiscal year), FFS (fee-for-service). "IPPS payments" includes FFS Medicare program payments and beneficiaries' cost-sharing liabilities and excludes uncompensated-care payments. "FFS beneficiaries" is limited to those who resided in the U.S. and had Part A. Dollars are nominal, not adjusted for inflation.

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

- > IPPS payments per stay increased in FY 2024 to \$16,000, well above the pre-pandemic level of \$12,700. The beneficiary cost-sharing liability share remained at around 8 percent.
- > In contrast, IPPS stays per FFS Medicare beneficiary in FY 2024 remained well below the pre-pandemic level. In FY 2024, there were 197 stays per 1,000 FFS Medicare beneficiaries, compared with 232 in FY 2019.
- > Since both the number of IPPS stays per FFS Medicare beneficiary and the number of FFS Medicare beneficiaries have declined from FY 2019 to FY 2024, aggregate IPPS payments also declined, falling to \$105 billion in FY 2024 (data not shown).

Chart 6-12 Seven major diagnostic categories continued to account for over four-fifths of IPPS stays

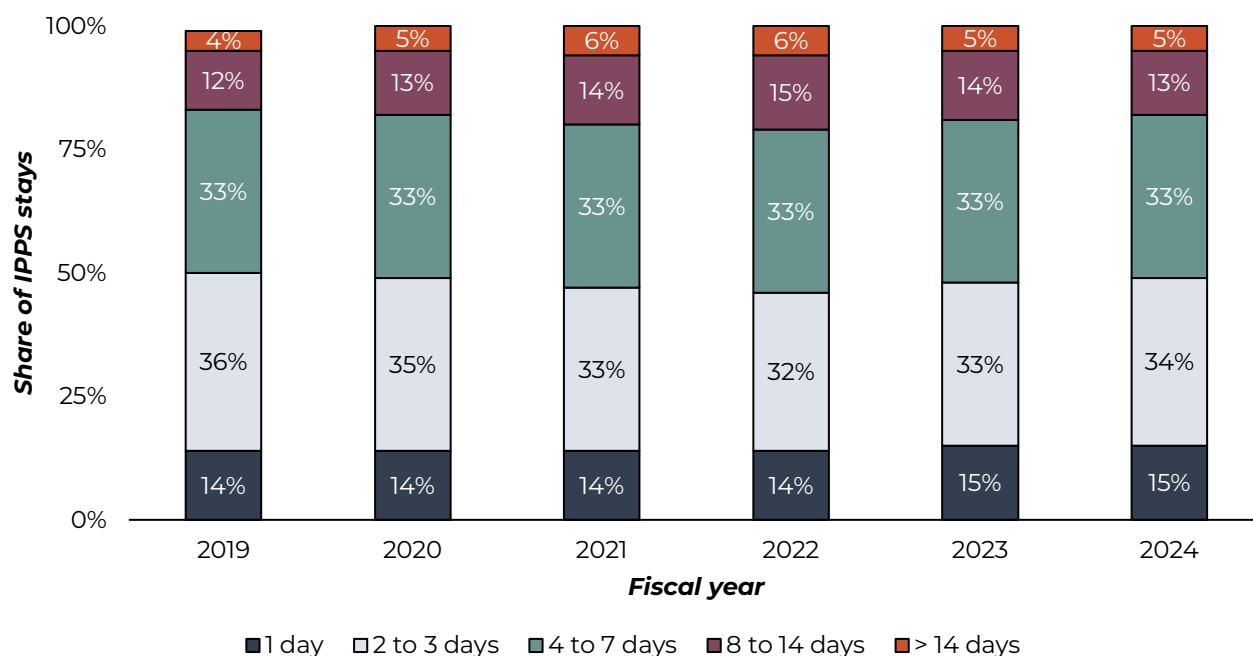
Major diagnostic category	Share of IPPS stays, by fiscal year					
	2019	2020	2021	2022	2023	2024
Circulatory	21%	20%	20%	20%	21%	20%
Infectious and parasitic	11	12	12	12	12	13
Musculoskeletal	14	12	11	11	11	11
Respiratory	12	13	15	14	12	12
Nervous	8	8	8	8	9	9
Digestive	10	10	10	10	10	9
Kidney and urinary	8	7	7	8	8	8
Other	17	18	17	17	17	17

Note: IPPS (inpatient prospective payment systems). Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review and IPPS final-rule data from CMS.

- > Under the IPPS, inpatient stays are categorized into one of about 800 Medicare severity diagnosis-related groups (MS-DRGs), primarily based on the patient's principal diagnosis. Each MS-DRG belongs to 1 of about 25 major diagnostic categories (MDCs).
- > In fiscal year (FY) 2024, seven MDCs continued to account for about four-fifths of IPPS stays, and the most common MDC continued to be diseases of the circulatory system, at about 20 percent.
- > The distribution of IPPS payments and inpatient days was similar to that of inpatient stays, with the same top seven major diagnostic categories (though in slightly different order). For example, in FY 2024, diseases of the circulatory system comprised the largest share of IPPS payments and days, at 23 percent and 18 percent respectively (data not shown).

Chart 6-13 Stays between 2 and 7 days continued to account for majority of IPPS stays



Note: IPPS (inpatient prospective payment systems). Length of stay calculated as the difference between the discharge and admission date or one day if the dates are the same. Components may not sum to 100 percent due to rounding.

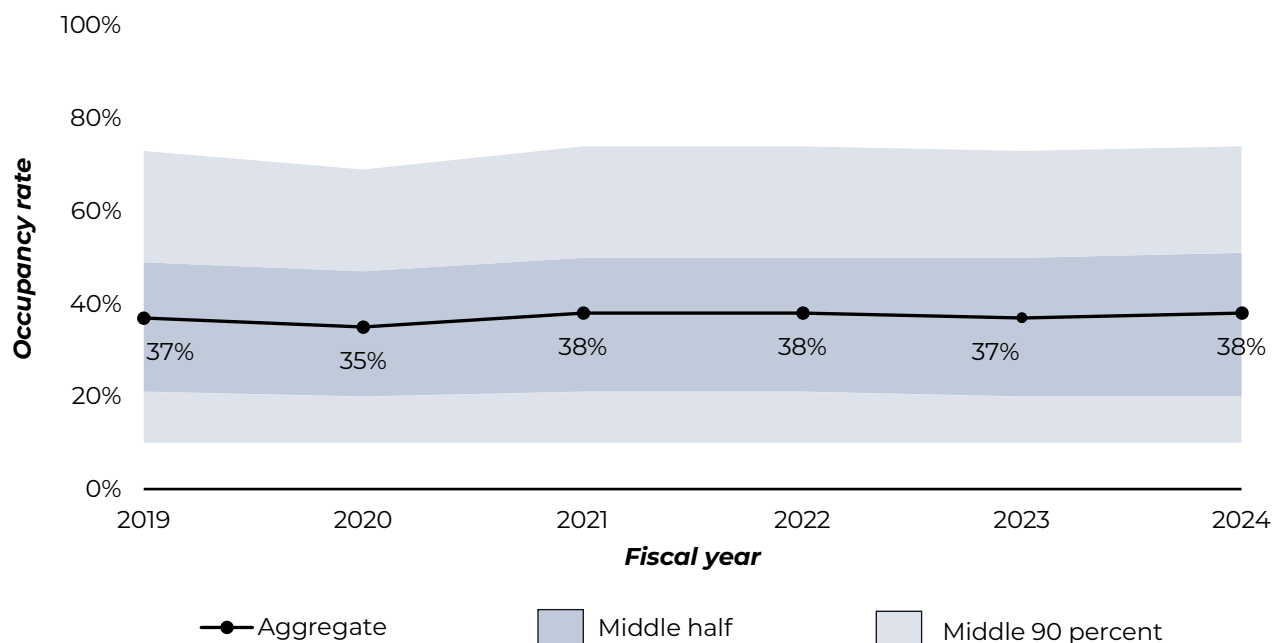
Source: MedPAC analysis of Medicare Provider and Review data from CMS.

> IPPS stays can be very short (a minimum of one day) or very long, but a majority last between two and seven days. The average length of an IPPS stay was 5.3 days in fiscal year (FY) 2024 (data not shown).

> The distribution of lengths of stay has been relatively steady since FY 2019, including during the pandemic.

> The distribution of IPPS payments and inpatient days were different from that of inpatient stays, with the longer stays representing a larger share of IPPS payments and days than of stays. For example, in FY 2024, IPPS stays of greater than 14 days comprised 5 percent of stays but 14 percent of IPPS payments and 23 percent of days (latter data not shown).

Chart 6-14 CAHs continued to have substantial excess inpatient capacity in aggregate, but some CAHs neared capacity



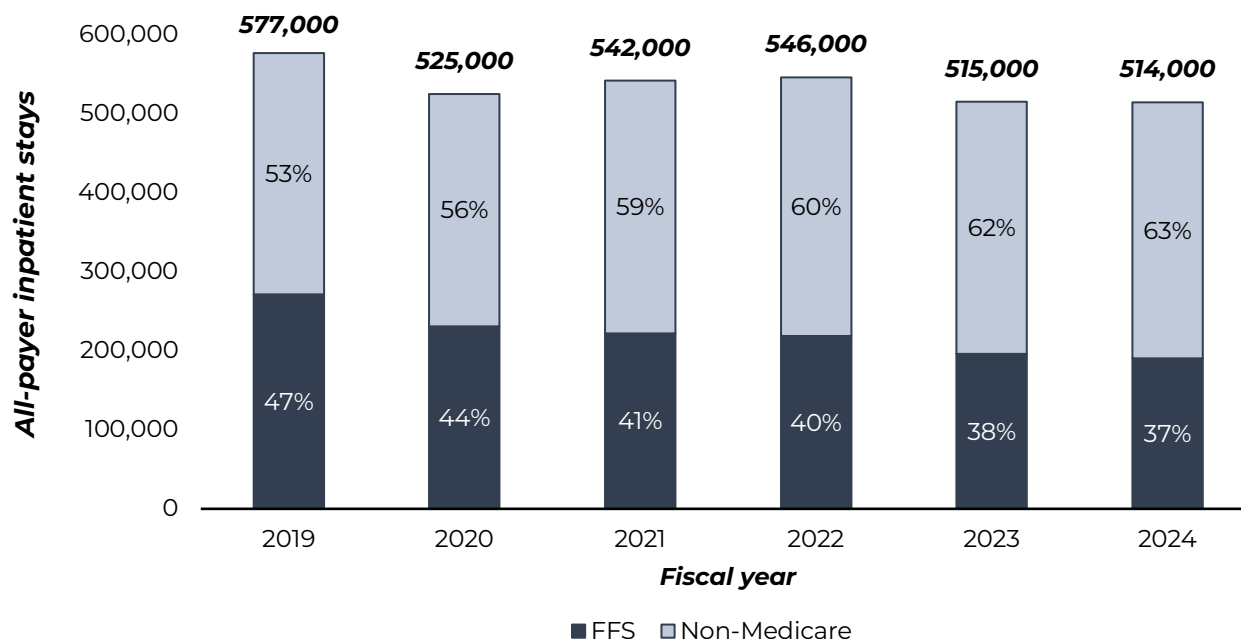
Note: CAH (critical access hospital). “Occupancy rate” refers to share of bed days that were occupied by a patient (regardless of whether the patient was receiving inpatient, observation, or swing-bed services or the share of time that the bed was staffed).

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

> CAHs continued to have substantial available capacity in aggregate. However, there continued to be significant variation within these aggregates, with some hospitals having substantially higher available capacity while others neared capacity constraints.

> In FY 2024, CAHs’ occupancy rate was 38 percent, similar to prior years. However, 5 percent of hospitals had an occupancy rate under 10 percent, while another 5 percent had an occupancy rate over 74 percent.

Chart 6-15 CAHs' all-payer inpatient stays continued to decline in FY 2024, as did the FFS Medicare share

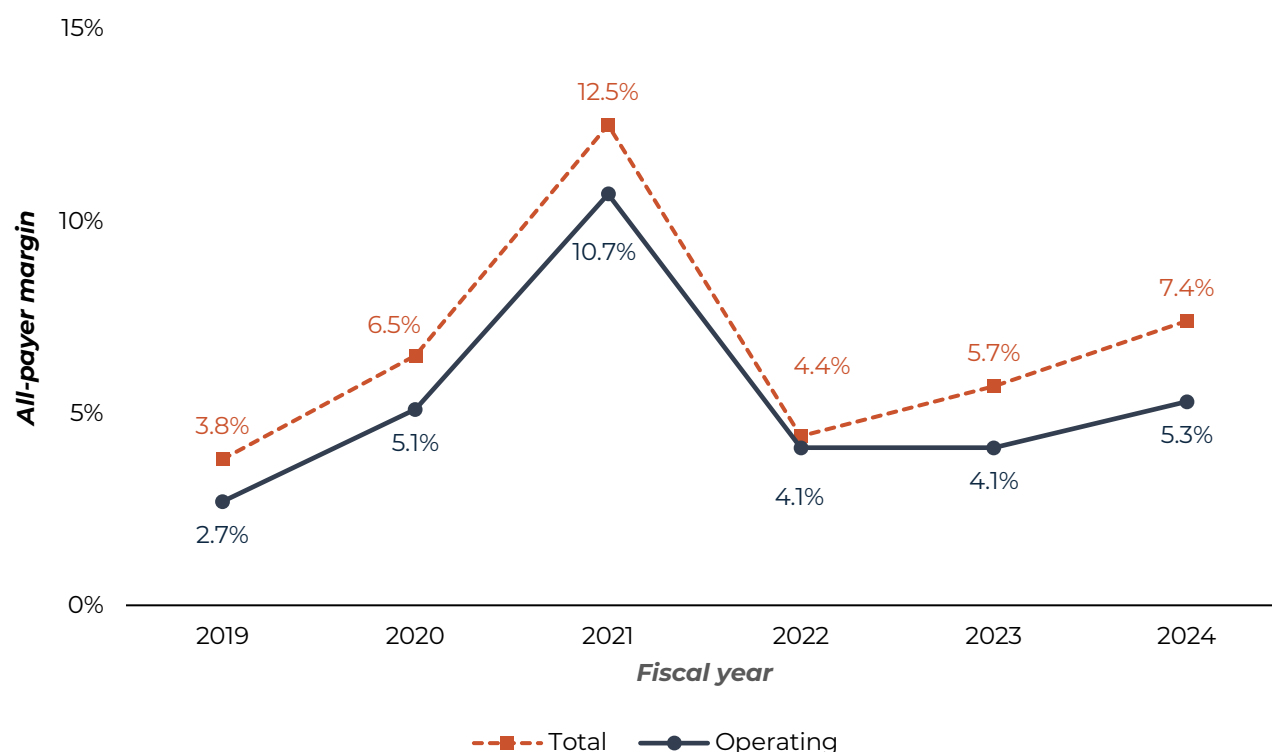


Note: CAH (critical access hospital), FY (fiscal year), FFS (fee-for-service). “Inpatient stays” refers to acute inpatient stays (and does not include observation or swing-bed stays). The Medicare Advantage (MA) share of inpatient stays is not shown because many CAHs did not separately report MA stays on their cost reports.

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

> In FY 2024, CAH hospitals provided about 514,000 inpatient stays, well below the level in 2019 and below the pandemic low in 2020. The share from FFS Medicare has also been declining, consistent with the increasing share of Medicare beneficiaries enrolling in MA. However, the FFS share of 37 percent was still a much higher share than in IPPS hospitals (22 percent) (see Chart 6-4).

Chart 6-16 CAHs' all-payer total and operating margins in FY 2024 exceeded prepandemic levels

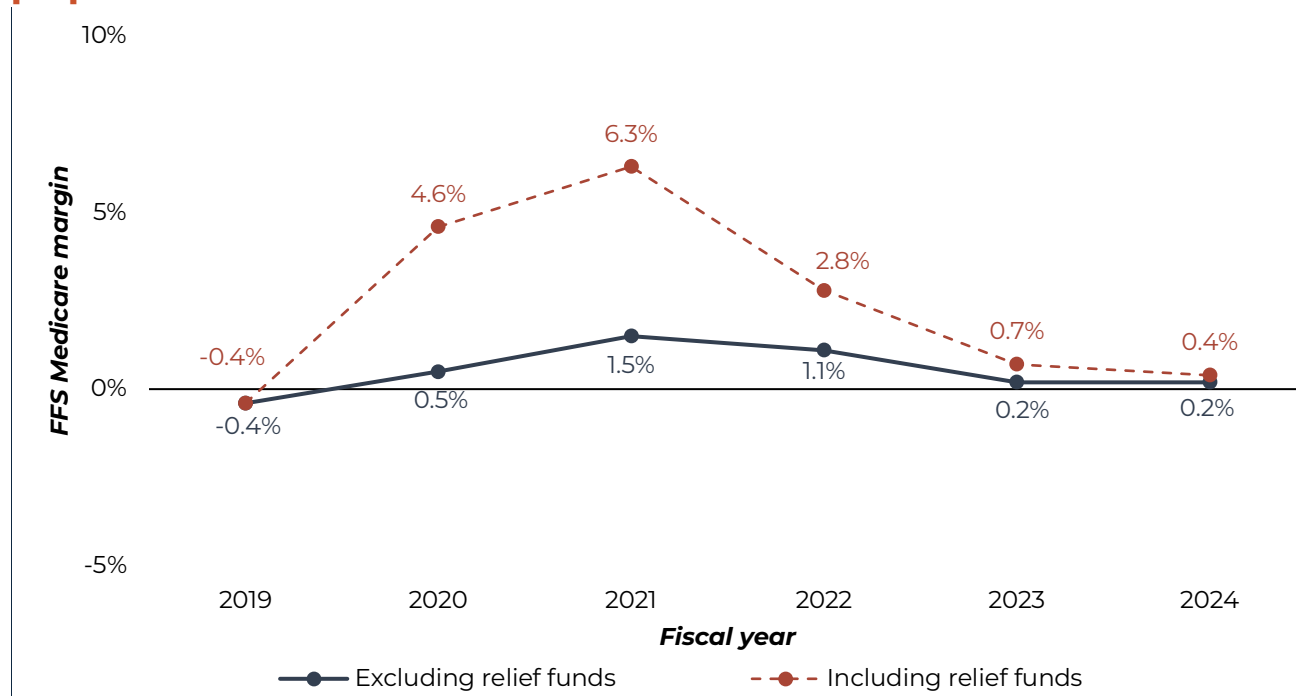


Note: CAH (critical access hospital), FY (fiscal year). “All-payer total margin” is the percentage of revenue from all payers and sources (including coronavirus relief funds) that is left as profit after accounting for all costs. “All-payer operating margin” excludes reported investment and donation income and is therefore often lower than hospitals’ total margin but is higher in years when investment losses exceed donation income.

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

> CAHs’ all-payer total and operating margins both increased in FY 2024, reaching 7.4 percent and 5.3 percent, respectively. Both of these levels exceeded the prepandemic levels in FY 2019.

Chart 6-17 CAHs' FFS Medicare margin in FY 2024 slightly exceeded the prepandemic level



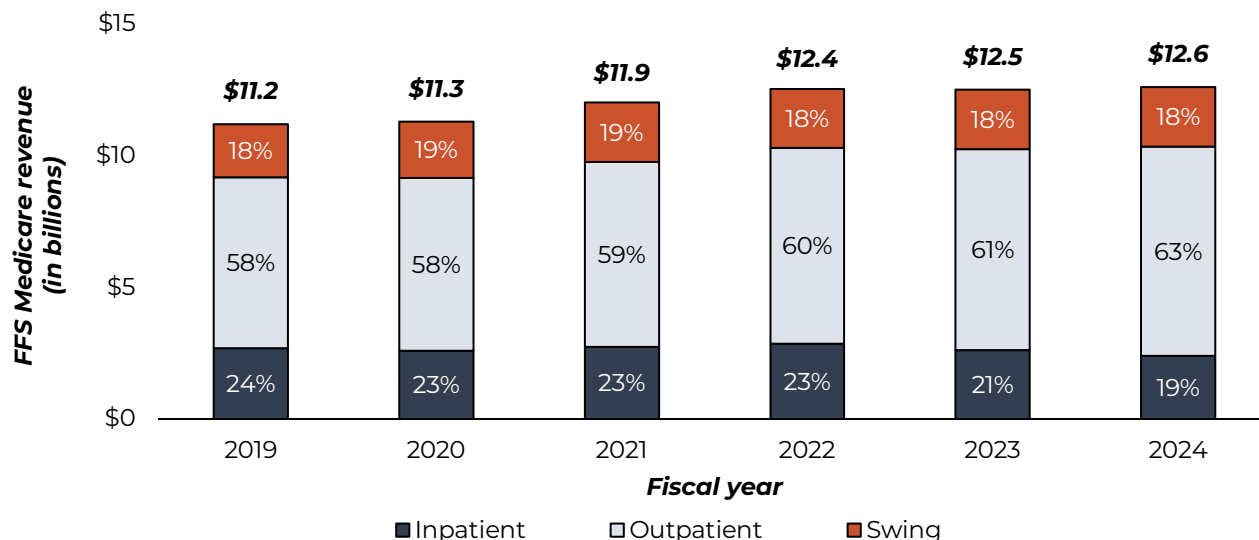
Note: CAH (critical access hospital), FFS (fee-for-service), FY (fiscal year). “FFS Medicare margin” includes inpatient, outpatient, and skilled nursing swing-bed services; the margin assigns all inpatient general routine costs equally per day across all days (regardless of whether the bed was used for inpatient, observation, or swing-bed nursing or skilled nursing care).

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

> FFS Medicare pays CAHs for inpatient, outpatient, and swing-bed services at 101 percent of their allowable costs. The calculation of allowable costs assumes that CAHs’ general inpatient costs of using inpatient beds to provide nursing facility care equals state Medicaid rates, which is likely an underestimate and more reflective of state Medicaid policies than CAHs’ costs, and then divides the remaining costs by inpatient, observation, and swing-bed skilled nursing days.

> Using an alternative calculation of allowable costs—that assigns a CAH’s general inpatient routine costs equally across all days the bed was occupied—results in a FFS Medicare margin (excluding relief funds) of 0.2 percent in FY 2024. This figure is above the prepandemic level but below the level in FYs 2020 through 2022 when the sequestration on FFS Medicare payments was partially or fully suspended. (We focus on CAHs’ FFS Medicare margin exclusive of coronavirus relief funds; however, we also report a version including the FFS Medicare share of coronavirus relief funds because these funds were intended to cover lost revenue and higher costs—including those related to FFS Medicare patients.)

Chart 6-18 CAHs' FFS Medicare revenue has been slowly increasing, driven by growth in outpatient services



Note: CAH (critical access hospital), FFS (fee-for-service). “Inpatient” refers to revenue for inpatient stays. “Outpatient” refers to revenue for outpatient services. “Swing” refers to skilled nursing services provided in inpatient beds, referred to as “swing beds.” Hospitals also receive other revenue from providing services to FFS Medicare beneficiaries that are not included in these totals, such as revenue from services provided in clinics and in post-acute care units. Components may not sum to 100 percent due to rounding.

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

> In FY 2024, FFS Medicare (and its beneficiaries) paid CAHs about \$12.6 billion for inpatient, outpatient, and swing services (skilled nursing services provided in an inpatient bed). CAHs' FFS Medicare revenue from these services has been steadily increasing despite a decline in the overall number of FFS Medicare beneficiaries.

> The growth in CAHs' FFS Medicare revenue has been driven by an increase in outpatient services, which grew from 58 percent in fiscal year (FY) 2019 to 63 percent in FY 2024. This outpatient share of FFS Medicare revenue is much higher than for IPPS hospitals (39 percent) (see Chart 6-8).

Chart 6-19 Total number of Medicare-certified inpatient psychiatric facilities continued to decline in FY 2024, while the share of freestanding facilities increased

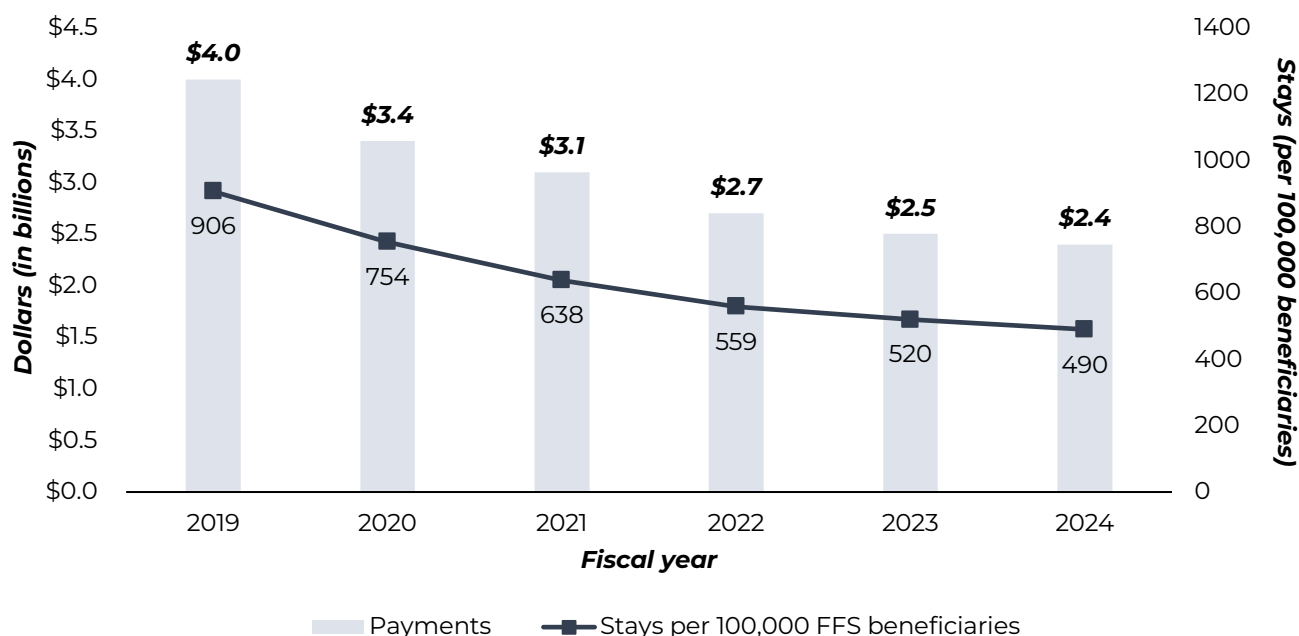
Type of IPF	Fiscal year						Average annual percentage change	
	2019	2020	2021	2022	2023	2024	2019–2023	2023–2024
All	1,610	1,570	1,530	1,510	1,470	1,430	–2.2%	–2.8%
Share of all								
Urban	80%	80%	81%	81%	81%	82%	0.4	0.8
Rural	20	20	19	19	19	18	–1.9	–3.4
Teaching	37	37	38	38	38	39	1.2	0.9
Nonteaching	63	63	62	62	62	61	–0.7	–0.6
Hospital-based units	65	64	63	61	61	59	–1.8	–2.4
Nonprofit	39	39	39	38	38	37	–0.9	–2.4
For profit	14	14	13	13	12	12	–3.7	–6.1
Government	12	11	11	11	10	11	–2.7	2.3
Freestanding	35	36	37	39	39	41	3.2	3.6
Nonprofit	5	5	5	5	5	5	0.9	7.2
For profit	20	21	22	23	24	26	4.4	5.8
Government	9	10	10	10	10	10	1.7	–3.3

Note: FY (fiscal year), IPF (inpatient psychiatric facility). “Average annual percent change” represents the change in the number of all IPFs in the first row and represents changes in shares of IPFs by type for all other rows. Components and annual changes may not match totals due to rounding.

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

- > Medicare beneficiaries experiencing an acute mental health or alcohol- or drug-related crisis can be treated in specialty IPFs that provide 24-hour care in a structured, intensive, and secure setting.
- > In FY 2024, compared with the prior year, the number of IPFs nationwide decreased to 1,430 from 1,470 (2.8 percent decrease). This decline was similar to the decline observed from 2019 to 2023 (2.2 percent annually).
- > Most IPFs are in urban areas (82 percent in FY 2024). Between FY 2019 and FY 2024, the share of IPFs in urban areas grew slightly and the share of IPFs in rural areas fell.
- > In FY 2024, a majority of IPFs (59 percent) were hospital-based units; however, from FY 2019 to FY 2024, the share of hospital-based IPFs declined by 2.0 percent annually, while the share of freestanding IPFs grew by 3.3 percent annually (data not shown).
- > Over a quarter of IPFs in FY 2024 were freestanding and for profit, up from about one-fifth of IPFs in 2019.

Chart 6-20 FFS Medicare inpatient psychiatric facility stays per capita and payments continued to decline in FY 2024



Note: FFS (fee-for-service), FY (fiscal year). Dollar amounts are nominal figures, not adjusted for inflation.

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

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

> From FY 2019 to FY 2024, FFS Medicare inpatient stays in IPFs decreased by 12 percent per year, on average, declining from 906 stays per 100,000 Medicare FFS beneficiaries to 490. Total (FFS Medicare plus beneficiary) payments for IPF PPS services decreased from \$4.0 billion to \$2.4 billion—equivalent to a 10 percent annual decrease on a nominal basis. Some of the decline in IPF use is likely related to avoidance or deferral of stays during the coronavirus pandemic, though the decline began before 2020 and continued into 2024. Some observers have suggested that IPFs faced staffing challenges after 2020 that may have limited bed capacity.

> Medicare beneficiaries may also receive inpatient psychiatric services in general acute care hospitals (sometimes referred to as “scatter-bed” stays). These cases are inpatient stays with a principal diagnosis in the major diagnostic category (MDC) of mental diseases and disorders (MDC 19). In FY 2024, about 30 percent of FFS Medicare inpatient psychiatric stays occurred in general acute care hospitals (the remaining 70 percent occurred in IPFs) (data not shown).

Chart 6-21 A growing share of FFS Medicare beneficiaries' stays at IPFs were for schizophrenia, FY 2019–2024

Psychiatric MS–DRG grouping	Fiscal year						Average annual percentage change
	2019	2020	2021	2022	2023	2024	2019–2024
<i>Share of total</i>							
Psychosis	73.4%	74.4%	74.8%	75.1%	76.0%	76.8%	0.9%
Mood disorders	38.6	37.5	36.9	36.8	37.0	37.7	–0.5
Schizophrenia and other non-mood psychotic disorders	34.8	36.9	37.9	38.3	38.9	39.1	2.4
Organic disturbances	7.0	6.9	6.8	7.0	6.0	5.7	–3.9
Alcohol/drug dependency	6.4	6.2	6.2	5.7	5.3	4.9	–5.2
Neurosis	4.5	4.2	3.9	4.0	4.1	4.0	–2.6
Nervous system disorder	5.9	5.4	5.3	5.2	5.5	5.5	–1.4
Other psychiatric	1.8	1.9	2.0	2.0	2.0	2.0	2.5
Other nonpsychiatric	1.0	1.0	1.0	0.9	1.1	1.1	2.3

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

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

> FFS Medicare patients in IPFs are generally assigned to 1 of 17 psychiatric MS–DRGs. However, the MS–DRG system does not differentiate well among Medicare beneficiaries in IPFs; in FY 2024, nearly 77 percent of cases were assigned to the psychosis MS–DRG.

> The psychosis MS–DRG is a broad category that includes patients with principal diagnoses of mood disorders (such as bipolar disorder and major depression) and non-mood psychotic disorders (such as schizophrenia). Between FY 2019 and FY 2024, the share of patients with non-mood psychotic disorders increased annually by 2.4 percent. Over the same time, the share of patients with mood disorders declined slightly.

> Between FY 2019 and FY 2024, patients with organic disturbances (which include diagnoses such as dementia) and alcohol/drug dependency MS–DRGs declined annually by 3.9 percent and 5.2 percent, respectively. While these beneficiaries may be receiving care in other settings, the declines could also be related to difficulty in accessing inpatient psychiatric care due to the decreasing number of IPFs (see Chart 6-19).

Chart 6-22 FFS Medicare beneficiaries using IPFs tended to be disabled, under age 65, low income, and non-White compared with all FFS beneficiaries, FY 2024

Characteristic	Share of all IPF users	Share of IPF users with more than one IPF stay	Share of all FFS beneficiaries
All	100%	26%	—
Current eligibility status and demographics			
Aged	51	37	91
Disabled	49	63	9
ESRD	0.1	<0.1	0.2
Female	49	45	53
Male	51	55	47
<45	24	33	3
45–64	26	31	7
65–79	36	28	68
80+	14	8	23
Non-Hispanic White	71	66	78
Black	15	18	8
Asian/Pacific Islander	2	2	4
Hispanic	7	8	6
American Indian/Alaska native	1	1	<1
Other or unknown	4	6	4
Urban	81	84	81
Rural	19	17	19
Dual eligibility or LIS during year			
No	36	24	85
Yes	64	76	15

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

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

> Of FFS Medicare beneficiaries who had at least one IPF stay in FY 2024, 63 percent qualified for Medicare because of a disability, compared with 9 percent across all FFS beneficiaries. Beneficiaries who used IPF care also tended to be younger and were more likely to have low incomes.

> About one-quarter of Medicare FFS beneficiaries who used an IPF in FY 2024 had more than one IPF stay during the year. These beneficiaries were even more likely than all IPF users to be disabled (often because of a psychiatric disorder), under age 65, low income, and non-White.

Chart 6-23 Medicare beneficiaries near or reaching the lifetime coverage limit on care in freestanding IPFs were highly vulnerable, 2024

Characteristic	History of freestanding IPF use but not near the coverage limit	Within 15 days of reaching the coverage limit	Reached the coverage limit
Number of beneficiaries with any IPF use since Medicare enrollment	820,330	10,060	39,240
Current eligibility status and demographics (percentage)			
Aged	45%	34%	33%
Disabled	55	66	67
ESRD	<1	<1	<1
Female	49	39	39
Male	51	61	61
<45	16	17	16
45–64	41	51	53
65–79	34	29	25
80+	9	2	6
Non-Hispanic White	69	63	62
Black	18	25	27
Asian/Pacific Islander	2	2	2
Hispanic	8	7	7
American Indian/Alaska native	1	1	1
Other or unknown	2	1	1
Urban	83	87	86
Rural	17	13	14
Dual eligibility or LIS during year (percentage)			
No	28	13	15
Yes	72	87	85

Note: IPF (inpatient psychiatric facility), ESRD (end-stage renal disease), LIS (low-income subsidy). The “coverage limit” refers to Medicare’s lifetime coverage limit of 190 days in freestanding IPFs. “History of freestanding IPF use but not near the coverage limit” refers to Medicare beneficiaries (fee-for-service and Medicare Advantage enrollees) who were enrolled in Medicare for at least one month in 2024 and stayed for at least one day in a freestanding IPF from the time of Medicare enrollment through July 31, 2025. “Within 15 days of reaching the coverage limit” refers to Medicare beneficiaries who were enrolled in Medicare for at least one month in 2024 and were within 15 days of reaching the 190-day coverage limit in freestanding IPFs as of July 2025. “Reached the coverage limit” refers to Medicare beneficiaries who were enrolled in Medicare for at least one month in 2024 and had reached or exceeded the 190-day limit as of July 2025. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare enrollment data from CMS.

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

> In 2024, 820,330 Medicare (fee-for-service and Medicare Advantage) beneficiaries had at least one day in a freestanding IPF since first enrolling in Medicare. Of these beneficiaries, 49,300 (10,060 + 39,240) were within 15 days of reaching the 190-day limit or had reached the limit as of the end of July 2025. These beneficiaries were highly vulnerable: The majority were disabled and had low incomes (as indicated by dual eligibility for Medicare and Medicaid or by having the LIS).

Ambulatory care

**Physicians and other
health professionals**

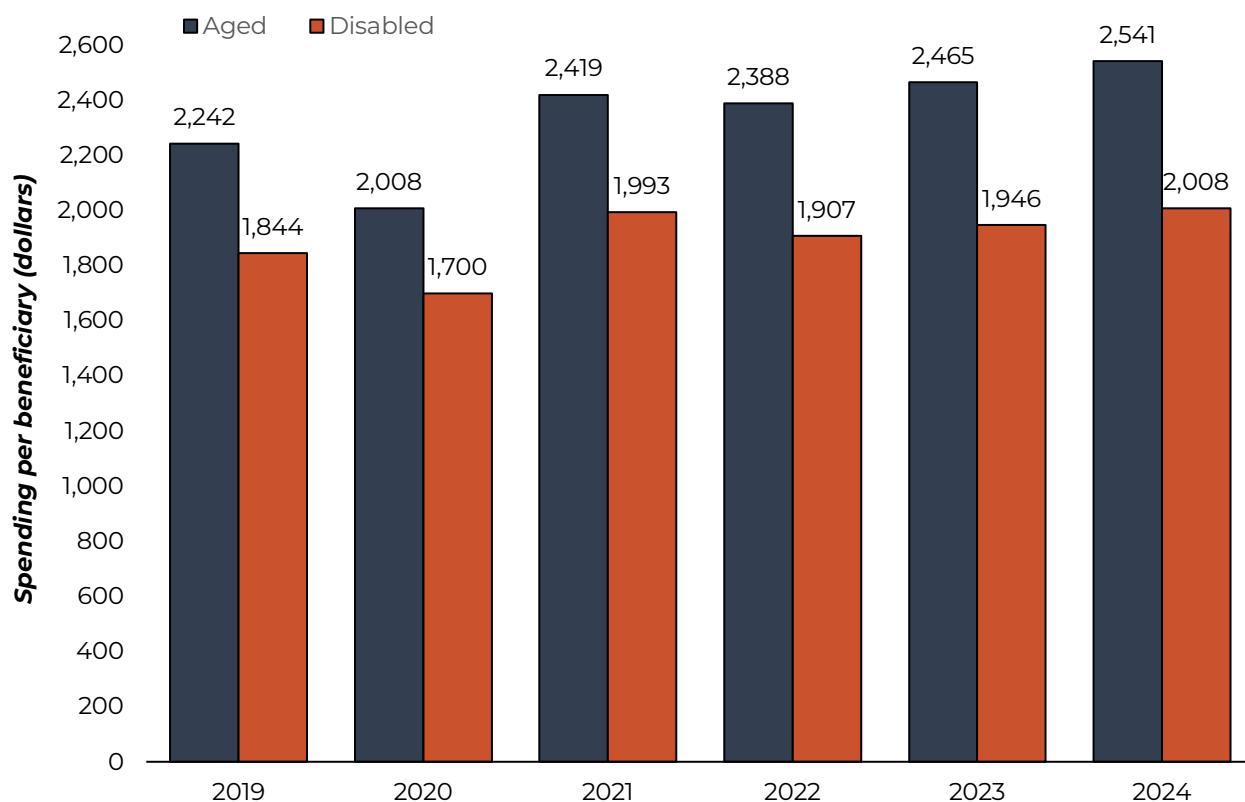
Hospital outpatient services

Ambulatory surgical centers

Low-value care

**Results of MedPAC's
access-to-care survey**

Chart 7-1 Medicare spending per FFS beneficiary on services in the physician fee schedule, 2019–2024



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

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

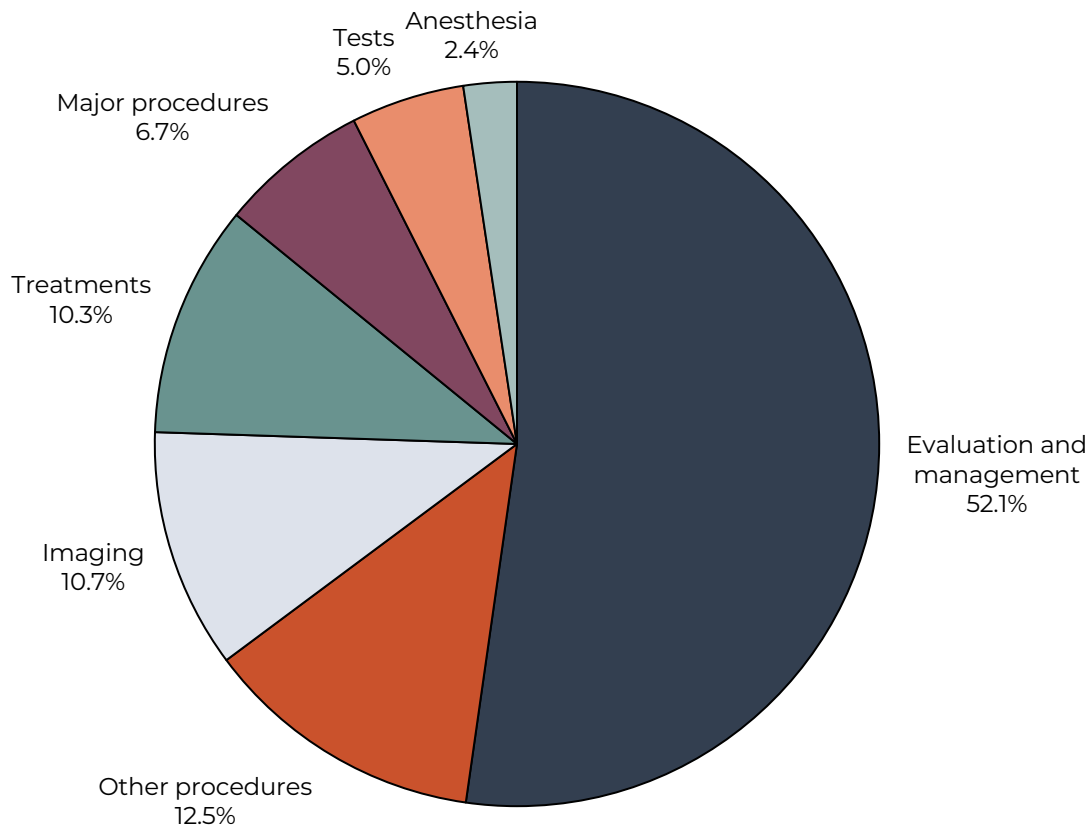
> The physician fee schedule includes a broad range of services, such as office visits, surgical procedures, and diagnostic and therapeutic services. Total fee schedule spending (excluding beneficiary cost sharing) was \$71.4 billion in 2024 (data not shown).

> Spending per FFS beneficiary for fee schedule services declined in 2020 due to the effects of the coronavirus pandemic but rebounded in 2021. From 2021 to 2024, spending per beneficiary grew slowly among aged beneficiaries and was flat for those with disabilities.

> Per capita spending on fee schedule services for beneficiaries with disabilities (under age 65) is lower than that for aged beneficiaries (ages 65 and over). In 2024, per capita spending for beneficiaries with disabilities was \$2,008 compared with \$2,541 for aged beneficiaries.

Chart 7-2 Physician fee schedule—allowed charges by type of service, 2024

Total allowed charges in 2024 = \$93.8 billion



Source: MedPAC analysis of CMS's Carrier Standard Analytic File for 100 percent of beneficiaries.

- > In 2024, allowed charges for physician fee schedule services totaled \$93.8 billion. “Allowed charges” includes both program spending and beneficiary cost-sharing liability. Allowed charges increased by 1.7 percent from 2023 on a nominal basis (data not shown). That slow growth rate is partly attributable to a 2.5 percent decline in the number of beneficiaries enrolled in fee-for-service Medicare as enrollment in Medicare Advantage continues to grow.
- > In 2024, more than half of all allowed charges were for evaluation and management (E&M) services.
- > Within the E&M category, about half of allowed charges were for office/outpatient visits (data not shown). The remaining allowed charges in the E&M category were for various types of services provided across a broad range of settings, including hospital inpatient departments, emergency departments, and nursing facilities (data not shown).
- > The “treatments” category includes physical therapy, cancer treatments, and dialysis. The two procedure categories (“major” and “other”) include various eye, cardiovascular, skin, and vascular procedures. The distinction between major procedures and other procedures is determined by the amount of the payment rate for each procedure and whether it is typically furnished in a facility setting.

Chart 7-3 Total number of encounters per FFS beneficiary was higher in 2024 compared with 2019, and the mix of clinicians furnishing them changed

Specialty category	Encounters per beneficiary						Percentage change in encounters per beneficiary		
	2019	2020	2021	2022	2023	2024	2019–2020	Average annual percent change 2020–2023	2023–2024
Total (all clinicians)	22.3	19.8	21.6	22.3	23.3	24.3	–11.2%	5.6%	4.3%
Primary care physicians	3.5	3.1	3.1	3.1	3.1	3.2	–10.2	0.1	1.7
Specialists	12.9	11.4	12.3	12.4	12.8	13.1	–12.0	4.0	2.8
APRNs/PAs	2.5	2.4	2.7	3.0	3.3	3.7	–2.8	11.5	11.8
Other practitioners	3.4	2.9	3.5	3.7	4.0	4.3	–15.2	11.4	6.1

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). We define “encounters” as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and the national provider identifiers of the clinicians who billed for the service. Figures do not account for “incident to” billing, meaning, for example, that encounters with APRNs/PAs that are billed under Medicare’s “incident to” rules are included in the physician totals. We use the number of FFS beneficiaries enrolled in Part B to define encounters per beneficiary. “Primary care physicians” includes family medicine, internal medicine, pediatric medicine, and geriatric medicine. “Specialists” includes physicians who specialize in areas such as cardiology, dermatology, and oncology. “Other practitioners” includes clinicians such as physical therapists, psychologists, and social workers. This category also includes podiatrists, optometrists, dental surgeons, and chiropractors, which are defined as physicians in Section 1861 of the Social Security Act. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS’s Carrier Standard Analytic File for 100 percent of beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

- > An “encounter” is a measure of beneficiary interaction with clinicians. For example, if a physician billed for an office visit and an X-ray on the same claim, we count that as one encounter.
- > Over the 2019 to 2024 period, the overall number of encounters per FFS beneficiary grew, on average, by 1.8 percent annually (data not shown). The growth rate over that period was impacted by the coronavirus pandemic, which reduced encounters by 11.2 percent in 2020, but includes a rebound that occurred after 2020, with an annual growth rate of 5.6 percent from 2020 to 2023.
- > Encounters with specialist physicians accounted for the majority of all encounters. These encounters fell by 12.0 percent in 2020 but increased by an average of 4.0 percent from 2020 to 2023 and grew by 2.8 percent in 2024.
- > In 2024, encounters with APRNs and PAs grew rapidly (11.8 percent), and encounters with primary care physicians grew more slowly (1.7 percent). These changes continue a longer-term trend of slow growth in services billed by primary care physicians and large increases in the number of services billed by APRNs and PAs.

Chart 7-4 The number of clinicians billing Medicare’s physician fee schedule increased, and the mix of clinicians changed, 2019–2024

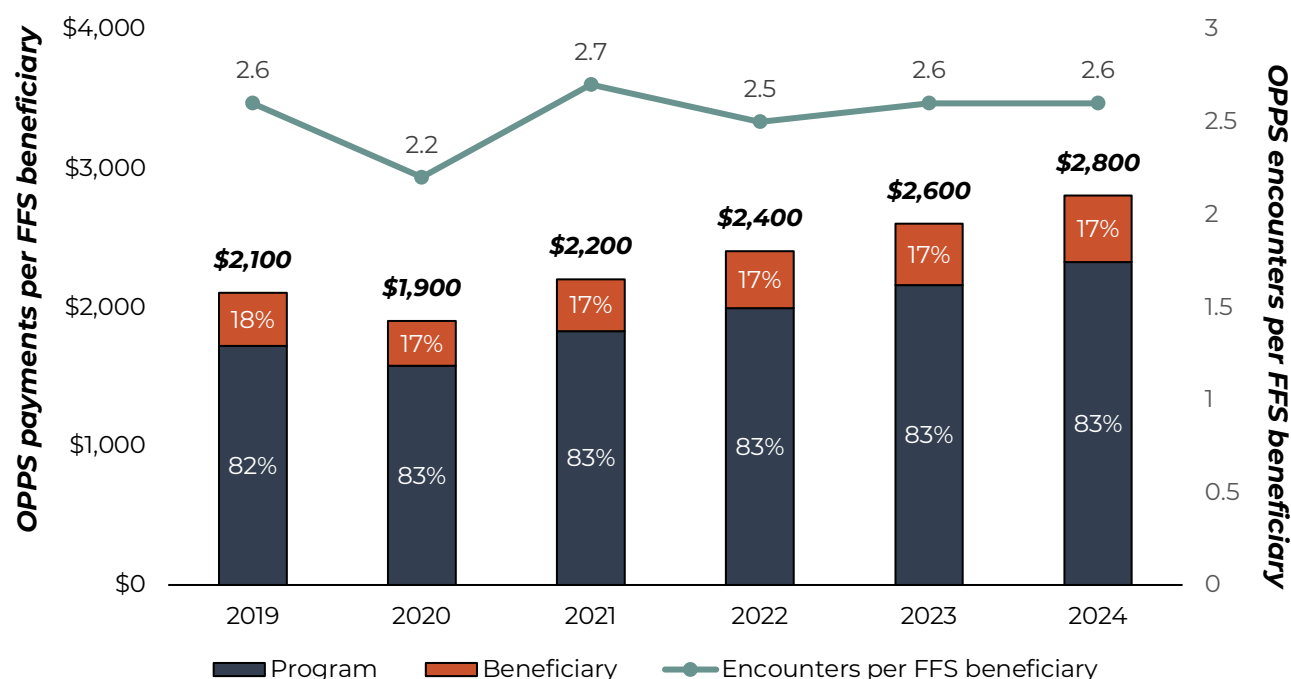
Year	Number (in thousands)					Number per 1,000 FFS beneficiaries				
	Physicians				Total	Physicians				Total
	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners		Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	
2019	138	468	258	180	1,044	4.2	14.2	7.8	5.4	31.6
2020	135	468	268	172	1,043	4.2	14.5	8.3	5.3	32.3
2021	134	472	286	180	1,072	4.3	15.3	9.3	5.8	34.8
2022	133	477	308	184	1,102	4.5	16.1	10.4	6.2	37.2
2023	132	483	327	189	1,131	4.6	16.9	11.4	6.8	39.5
2024	133	491	348	193	1,165	4.8	17.6	12.5	6.9	41.7

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). “Physicians” includes only clinicians who are licensed as a doctor of medicine or doctor of osteopathic medicine. “Primary care specialty” includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in “other specialties.” “Other practitioners” includes clinicians such as physical therapists, psychologists, and social workers. This category also includes podiatrists, optometrists, dental surgeons, and chiropractors, which are defined as physicians in Section 1861 of the Social Security Act. This table includes only physicians with a caseload of more than 15 FFS beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in FFS Medicare Part B. Numbers exclude nonperson providers, such as clinical laboratories and independent diagnostic-testing facilities. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS’s Standard Analytic File for 100 percent of beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

- > From 2019 to 2024, the total number of clinicians billing the fee schedule grew in absolute terms and relative to the size of the FFS Medicare population.
- > The total number of clinicians per 1,000 FFS beneficiaries increased from 31.6 to 41.7 over the 2019 to 2024 period, a total increase of 32 percent.
- > Over the 2019 to 2024 period, the number of primary care physicians billing the fee schedule slowly declined—yielding a net loss of about 5,000 primary care physicians by 2024. However, on a per FFS beneficiary basis, the number of primary care physicians grew over the same period. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 258,000 to 348,000. The number of specialist physicians and other practitioners, such as physical therapists and podiatrists, who billed the fee schedule increased at a steady pace.

Chart 7-5 OPPS spending per Part B FFS beneficiary has continued to grow, while the number of encounters per beneficiary has been steadier

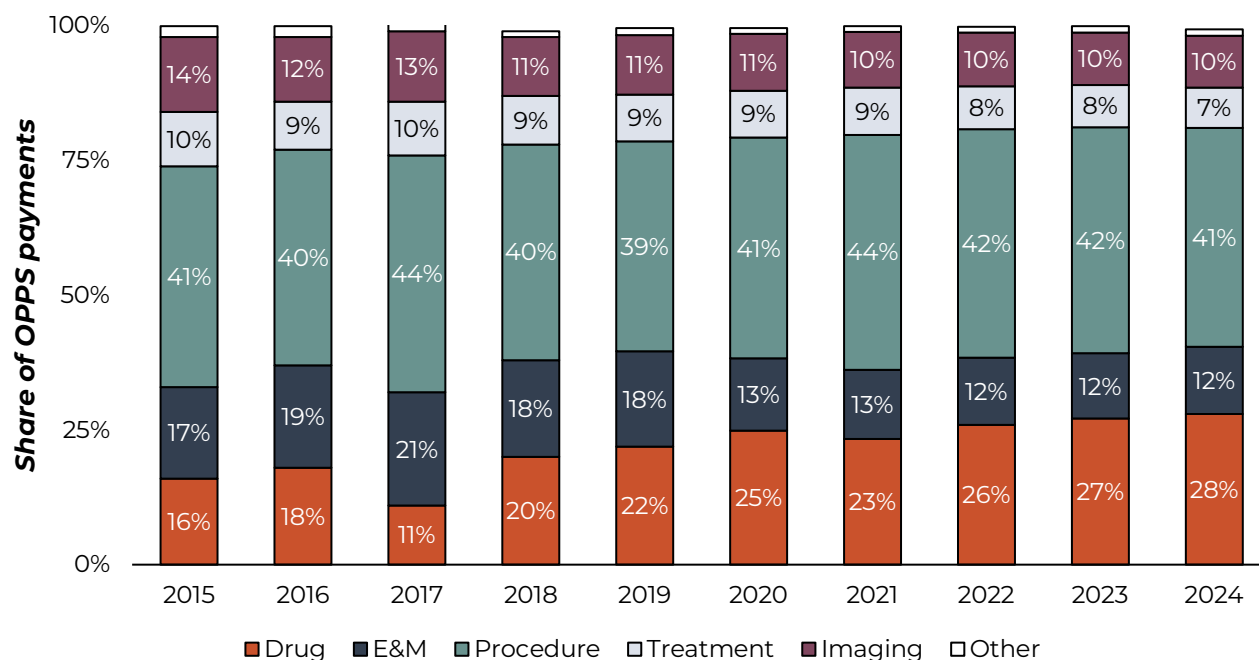


Note: OPPS (outpatient prospective payment system), FFS (fee-for-service). “OPPS payments” includes FFS Medicare program payments and beneficiaries’ cost-sharing liabilities. “FFS beneficiaries” is limited to those who resided in the U.S. and had Part B. “OPPS encounters” are unique combinations of claims, beneficiaries, and providers, regardless of the number of separately payable OPSS services provided in that encounter. Dollars are nominal, not adjusted for inflation.

Source: MedPAC analysis of outpatient claims data and enrollment data from CMS.

- > OPSS payments per FFS beneficiary increased in 2024 to \$2,800, well above the pre-pandemic level of \$2,100. Beneficiaries’ cost-sharing liability—which includes the Part B deductible and 20 percent coinsurance on most services—remained at about 17 percent.
- > In contrast, OPSS encounters per FFS Medicare beneficiary have been steadier, apart from a dip in 2020. In 2024, there were 2.6 OPSS encounters per FFS Medicare beneficiary, the same level as in 2019.
- > While the number of FFS Medicare beneficiaries declined from 2019 to 2024, OPSS payments per FFS beneficiary grew fast enough that aggregate OPSS payments rose to \$76.1 billion in 2024, or \$1,100 per encounter (data not shown).

Chart 7-6 Procedures accounted for the largest share of OPSS spending, but separately payable drugs have been the fastest growing, 2015–2024



Note: OPSS (outpatient prospective payment system), E&M (evaluation and management). “OPSS payments” includes fee-for-service Medicare program payments and beneficiaries’ cost-sharing liabilities. “Drugs” reflects separately payable drugs, identified by the status indicators G and K. All other categories reflect restructured Berenson-Eggers Type of Service (BETOS) classifications. The “other” category accounted for 2 percent or less of OPSS payments each year; components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of outpatient claims data from CMS.

- > Many types of outpatient services are covered under the OPSS.
- > Procedures such as hip and knee replacements continued to comprise the largest share of OPSS payments.
- > However, the fastest growing share of OPSS payments are separately payable drugs, which increased from 22 percent in 2019 to 28 percent in 2024. (For more information on Part B drugs across settings, see Chapter 10).
- > Over this same period, there were smaller declines in the share of OPSS payments E&M services (such as clinic visits and emergency department visits), treatments (such as injections of chemotherapy drugs), and imaging.
- > The volume of outpatient services is harder to compare given the wide variety of services, what counts as a single unit, and different levels of packaging. However, the most common OPSS services on a paid line-item basis were E&M, imaging, and treatment services.

Chart 7-7 The top 20 APCs comprised 44 percent of OPPS payments in 2024

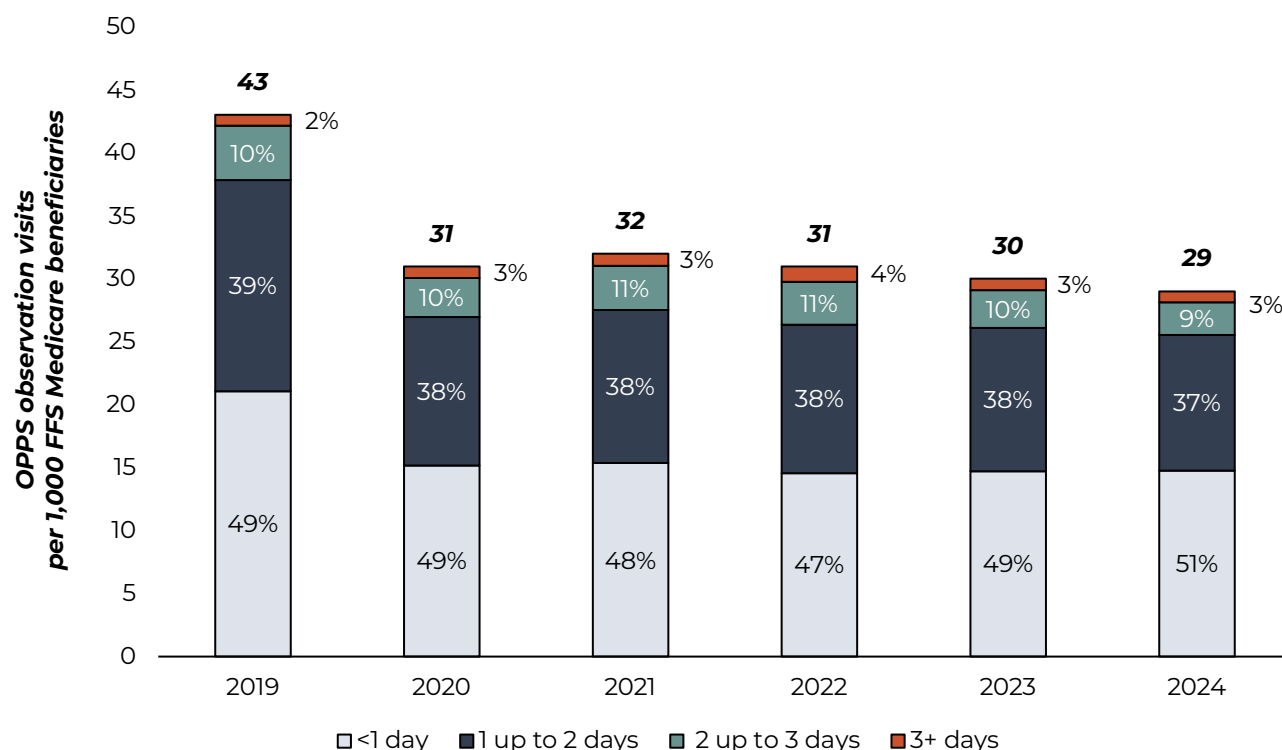
APC	APC title	OPPS payments (billions)	Share of OPPS payments
05115	Level 5 musculoskeletal procedures	\$4.6	6.2%
01490	Injection, pembrolizumab (Keytruda)	3.5	4.6
05012	Clinic visits and related services	2.7	3.6
05213	Level 3 electrophysiologic procedures	2.6	3.5
08011	Comprehensive observation services	2.1	2.8
05025	Level 5 Type A ED Visits	1.8	2.4
05024	Level 4 Type A ED Visits	1.5	2.0
09378	Daratumumab, hyaluronidase (Darzalex Faspro)	1.4	1.9
05116	Level 6 musculoskeletal procedures	1.4	1.9
05193	Level 3 endovascular procedures	1.3	1.8
05114	Level 4 musculoskeletal procedures	1.1	1.5
05693	Level 3 drug administration	1.1	1.5
09453	Injection, nivolumab (Opdivo)	1.1	1.4
05623	Level 3 radiation therapy	1.0	1.4
05361	Level 1 laparoscopy and related services	1.0	1.3
05524	Level 4 imaging without contrast	0.9	1.2
05572	Level 2 imaging with contrast	0.9	1.2
09272	Injection, denosumab (Prolia)	0.9	1.2
05191	Level 1 endovascular procedures	0.9	1.2
05312	Level 2 lower GI procedures	0.9	1.2

Note: APC (ambulatory payment classification), OPPS (outpatient prospective payment system), ED (emergency department), GI (gastrointestinal). "OPPS payments" includes fee-for-service Medicare program payments and beneficiaries' cost-sharing liabilities.

Source: MedPAC analysis of outpatient claims OPPS Addenda A data from CMS.

- > The unit of payment in the OPPS is the APC; in 2024, there were about 860 APCs. Some of these represent a single service, some a collection of services, and some separately payable drugs or devices.
- > OPPS payments were concentrated in a much smaller number of APCs. The top 20 APCs comprised 44 percent of OPPS payments in 2024, led by Level 5 musculoskeletal procedures (such as total knee and hip replacements), and Keytruda (a drug used to treat cancer).

Chart 7-8 Number of OPPS outpatient observation visits per 1,000 FFS Medicare beneficiaries in 2024 remained well below the prepandemic level



Note: OPPS (outpatient prospective payment system), FFS (fee-for-service). “OPPS observation visits” refers to separately payable visits under the OPPS; these visits last at least eight hours and do not result in an inpatient admission. “FFS beneficiaries” are limited to those who resided in the U.S. and had Part B. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of hospital outpatient claims and enrollment data from CMS.

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

> In 2020, with the onset of the coronavirus pandemic, the number of observation visits per capita declined to 31 visits per 1,000 FFS Medicare beneficiaries (down from 43 visits per 1,000 beneficiaries in 2019). However, the distribution of the observation visits by length of stay remained relatively steady, with nearly half lasting less than one day, another nearly 40 percent lasting one up to two days, about 10 percent lasting two to three days, and about 3 percent lasting three or more days.

> The volume of observation visits per 1,000 FFS Medicare beneficiaries and the distribution of the length of those visits remained relatively steady from 2020 through 2024.

Chart 7-9 Number of Medicare-certified ASCs, 2019–2024

	2019	2020	2021	2022	2023	2024	Average annual percentage change 2019–2024
Medicare payments (billions of dollars)	\$5.3	\$4.8	\$5.7	\$6.0	\$6.6	\$7.5	7.0%
New centers (during year)	243	189	266	225	256	248	N/A
Closed centers (during year)	128	92	108	95	105	108	N/A
Net total number of centers (end of year)	5,760	5,857	6,015	6,145	6,296	6,436	2.2
Volume per 1,000 FFS Part B beneficiaries	211	175	205	210	222	230	1.7
Share of all centers that are:							
Urban	96	93	93	94	94	94	N/A
Rural	4	7	7	6	6	6	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable), FFS (fee-for-service). “Medicare payments” includes program spending and beneficiary cost sharing for ASC facility services. “Closed” refers to an ASC that terminated operations, either because it closed operations or merged with another facility. Dollar amounts are nominal figures, not adjusted for inflation. Numbers may differ from prior years due to small methodological changes and updates to data.

Source: MedPAC analysis of Provider of Services file from CMS, 2025. Payment data are from MedPAC’s analysis of ASC claims from CMS’s Carrier Standard Analytic Files.

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

> Total Medicare payments per FFS Part B Medicare beneficiary for ASC services increased by approximately 11 percent per year, on average, from 2019 through 2024 on a nominal basis (data not shown). From 2023 to 2024, total payments per FFS Part B beneficiary rose 16 percent as the average complexity of ASC services provided increased (data not shown) and the number of services per FFS Part B Medicare beneficiary increased.

> The number of Medicare-certified ASCs grew at an average annual rate of 2.2 percent from 2019 through 2024. In this same period, an annual average of 238 new facilities entered the market, while an average of 106 closed or merged with other facilities (data not shown).

Chart 7-10 Between 36 and 74 low-value services were provided per 100 FFS beneficiaries in 2023; Medicare spent between about \$2.0 billion and \$5.9 billion on these services

Measure	Broader version of measure			Narrower version of measure		
	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)
Imaging for nonspecific low back pain	13.9	9.9%	\$269	3.8	3.5%	\$74
PSA screening at age >75 years	11.1	7.5	97	6.5	5.2	57
Spinal injection for low back pain	6.8	3.8	1,293	2.5	1.5	478
PTH testing in early CKD	6.7	4.0	125	5.6	3.4	104
Colon cancer screening for older adults	6.0	5.8	431	0.2	0.2	2
T3 level testing for patients with hypothyroidism	5.9	3.5	35	5.9	3.5	35
Carotid artery disease screening in asymptomatic adults	4.2	3.9	223	3.5	3.2	182
Preoperative chest radiography	3.4	3.1	49	0.8	0.7	11
Head imaging for uncomplicated headache	3.3	3.0	218	2.1	1.9	137
Stress testing for stable coronary disease	3.0	2.8	834	0.3	0.3	92
Cervical cancer screening at age >65 years	2.0	1.9	40	1.7	1.7	35
Homocysteine testing in cardiovascular disease	1.1	0.9	9	0.2	0.1	1
Head imaging for syncope	1.0	1.0	68	0.6	0.6	40
Preoperative echocardiography	1.1	1.1	87	0.3	0.3	28
BMD testing at frequent intervals	0.6	0.6	13	0.4	0.4	9
Preoperative stress testing	0.6	0.6	171	0.2	0.2	52
CT for uncomplicated rhinosinusitis	0.6	0.6	44	0.3	0.3	18
Vitamin D testing in absence of hypercalcemia or decreased kidney function	0.5	0.4	8	0.5	0.4	8
Imaging for plantar fasciitis	0.5	0.4	10	0.2	0.2	4
Screening for carotid artery disease for syncope	0.5	0.4	24	0.3	0.3	15
PCI/stenting for stable coronary disease	0.3	0.3	1,174	0.04	0.04	181
Cancer screening for patients with CKD on dialysis	0.3	0.2	7	0.1	0.1	1
Hypercoagulability testing after DVT	0.2	0.2	6	0.1	0.1	2
Vertebroplasty/kyphoplasty for osteoporotic vertebral fractures	0.2	0.1	308	0.2	0.1	303
Arthroscopic surgery for knee osteoarthritis	0.2	0.2	136	0.02	0.02	21
Preoperative PFT	0.2	0.2	2	0.1	0.1	1
IVC filter to prevent pulmonary embolism	0.1	0.1	15	0.1	0.1	15
Renal artery angioplasty/stenting	0.1	0.1	134	0.01	0.01	31
EEG for headache	0.04	0.04	2	0.02	0.02	1
Carotid endarterectomy for asymptomatic patients	0.05	0.05	124	0.02	0.02	50
Pulmonary artery catheterization in ICU	0.01	0.01	0.2	0.02	0.005	0.2
Total	74.2	37.5	5,929	36.3	23.5	1,990

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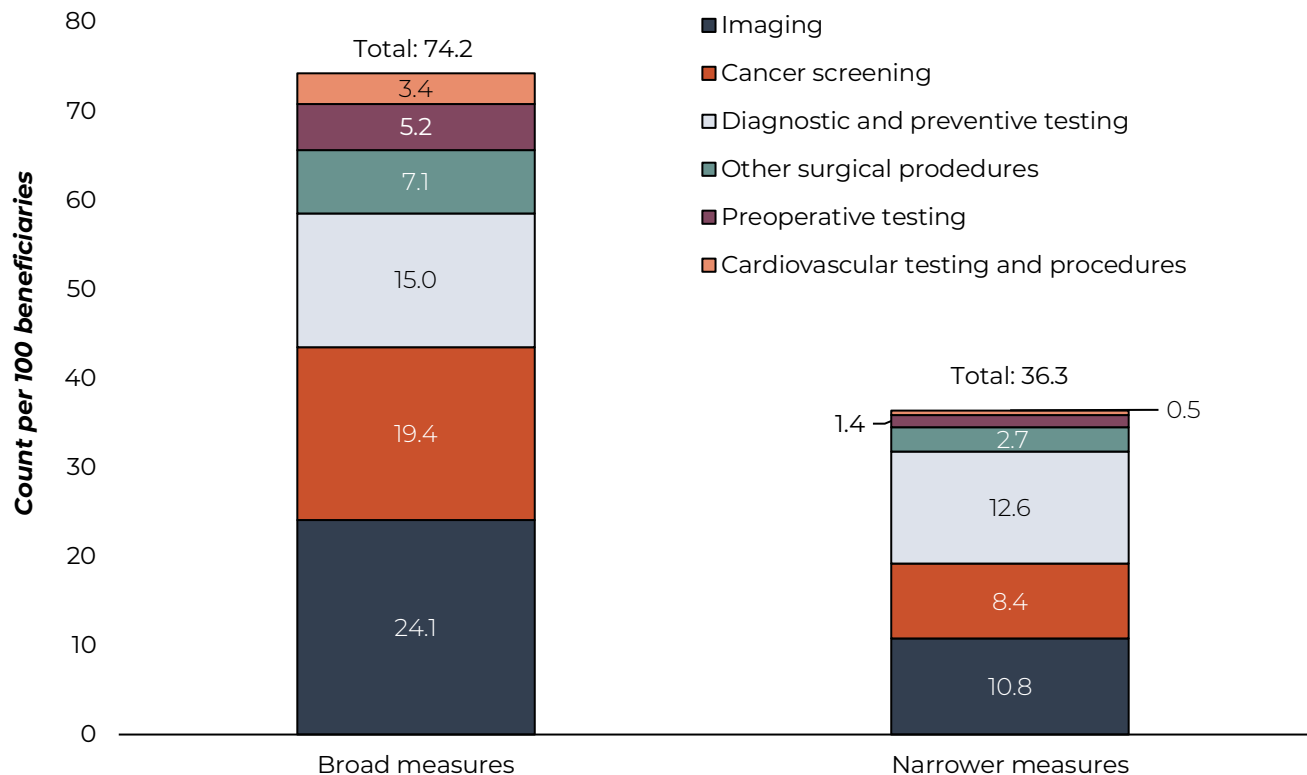
Chart 7-10 Between 36 and 74 low-value services were provided per 100 FFS beneficiaries in 2023; Medicare spent between about \$2.0 billion and \$5.9 billion on these services (continued)

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

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

- > Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.
- > The 31 measures of low-value care in this chart were developed by a team of researchers. The measures are drawn from evidence-based lists—such as Choosing Wisely—and the medical literature. We applied these measures to 100 percent of Medicare claims data from 2023. These 31 measures do not represent all instances of low-value care; the actual number (and corresponding spending) may be much higher.
- > The researchers developed two versions of each measure: a broad version (more sensitive, less specific) and a narrower version (less sensitive, more specific). Increasing the sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure’s specificity leads to less misclassification of appropriate use as inappropriate at the expense of potentially missing some instances of inappropriate use.
- > Based on the broad versions of the measures, our analysis found about 74 instances of low-value care per 100 beneficiaries in 2023, with about 37 percent of beneficiaries receiving at least 1 low-value service that year. Medicare spending for these services was \$5.9 billion. Based on the narrower versions of the measures, our analysis showed about 36 instances of low-value care per 100 beneficiaries, with 23 percent of beneficiaries receiving at least 1 low-value service. Medicare spending for these services totaled about \$2.0 billion.

Chart 7-11 Imaging, cancer screening, and diagnostic and preventive testing accounted for most of the volume of low-value care in 2023



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

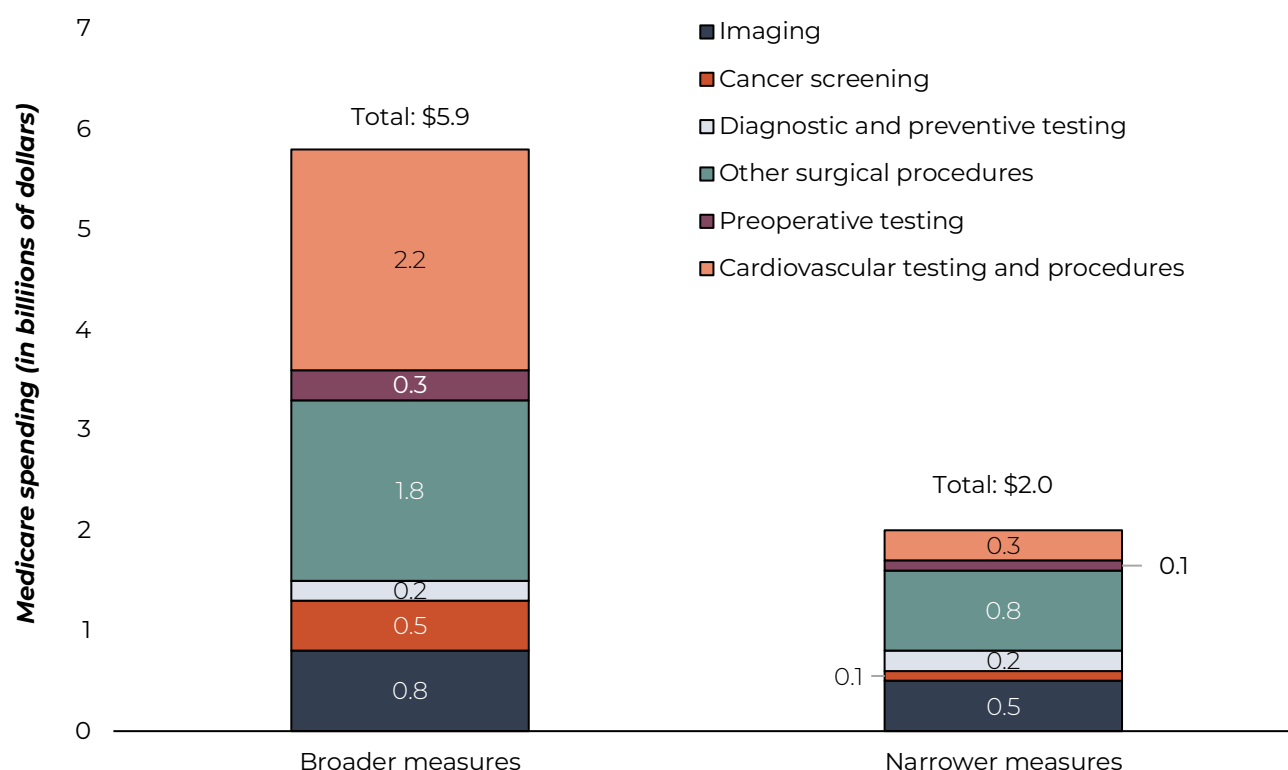
Source: MedPAC analysis of 100 percent of Medicare claims from CMS using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine*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

> We assigned each of the 31 measures of low-value care in Chart 7-10 to one of six clinical categories.

> Using the broader versions of the measures, imaging and cancer screening accounted for 59 percent of the volume of low-value care. The “imaging” category includes back imaging for patients with nonspecific low back pain and screening for carotid artery disease in asymptomatic adults. The “cancer screening” category includes prostate-specific antigen testing for men ages 75 and older and colorectal cancer screening for older adults.

> Using the narrower versions of the measures, imaging and diagnostic and preventive testing accounted for 64 percent of the volume of low-value care.

Chart 7-12 Cardiovascular testing and procedures, other surgical procedures, and imaging accounted for most spending on low-value care in 2023



Note: “Spending” includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2023. This method was developed by Schwartz et al. (2014).

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

> Cardiovascular testing and procedures and “other surgical procedures” accounted for about 67 percent of total spending on low-value care using the broader measures. Other surgical procedures and imaging made up 59 percent of spending on low-value care using the narrower measures.

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

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

Chart 7-13 In MedPAC's 2025 survey, Medicare beneficiaries were more likely to report being satisfied with their access to care than privately insured people

Survey question	Medicare beneficiaries (ages 65 and older)	Privately insured (ages 50–64)
Received health care in past year: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”		
Yes	94%*	92%*
Providers that accept your insurance: Among those who received health care, “In the past 12 months, how satisfied or dissatisfied have you been with your ability to find health care providers that accept [Medicare/your insurance]?”		
Satisfied (net)	97*	93*
Very satisfied	83*	66*
Somewhat satisfied	15*	28*
Dissatisfied (net)	3*	7*
Somewhat dissatisfied	2*	5*
Very dissatisfied	1*	2*
Providers with timely appointments: Among those who received health care, “In the past 12 months, how satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”		
Satisfied (net)	90*	81*
Very satisfied	58*	43*
Somewhat satisfied	32*	38*
Dissatisfied (net)	10*	19*
Somewhat dissatisfied	7*	14*
Very dissatisfied	3*	6*

Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data weighted to be nationally representative. Components may not sum to totals due to rounding.

* Statistically significant difference between Medicare beneficiaries and the privately insured at a 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

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

> In our 2025 survey, higher shares of Medicare beneficiaries reported receiving any health care in the past year (94 percent) compared with privately insured individuals (92 percent).

> Among those who received health care in the past year:

>> Higher shares of Medicare beneficiaries were satisfied with their ability to find health care providers that accepted their insurance (97 percent) compared with privately insured people (93 percent).

>> Higher shares of Medicare beneficiaries were satisfied with their ability to find providers that had appointments when needed (90 percent) compared with privately insured people (81 percent).

Chart 7-14 In MedPAC's 2025 survey, Medicare beneficiaries reported better access to primary care providers than privately insured people

Survey question	Medicare beneficiaries (ages 65 and older)	Privately insured (ages 50–64)
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”		
Yes	96%*	92%*
See an NP or PA for primary care: “People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?”		
For none of my primary care (I always see a doctor)	40*	37*
For any of my primary care (net)	58*	61*
For some of my primary care	39*	37*
For all or most of my primary care	19*	24*
I don't know	2	2
Tried to get a new primary care provider: “In the past 12 months, have you tried to get a new primary care provider?”		
Yes	12%*	14%*
Reason looked for new primary care provider: Among those who tried to get a new primary care provider, “Which of the following best describes the main reason you tried to get a new primary care provider in the last 12 months?” (Overall share)		
My provider retired or stopped practicing	47* (5)	35* (4)
I changed my health plan and had to find a new provider who participated in the new plan	10* (1*)	14* (2*)
I recently moved, so I needed to find a primary care provider in my area	9 (1*)	11 (1*)
My primary care provider was no longer accepting [Medicare/my insurance]	2* (0*)	7* (1*)
My primary care provider started charging a membership fee, and I didn't want to pay it	1* (0*)	3* (0*)
Other	31 (3)	30 (4)

Note: NP (nurse practitioner), PA (physician assistant). Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data weighted to be nationally representative. “Overall share” refers to the share of all respondents with this insurance.

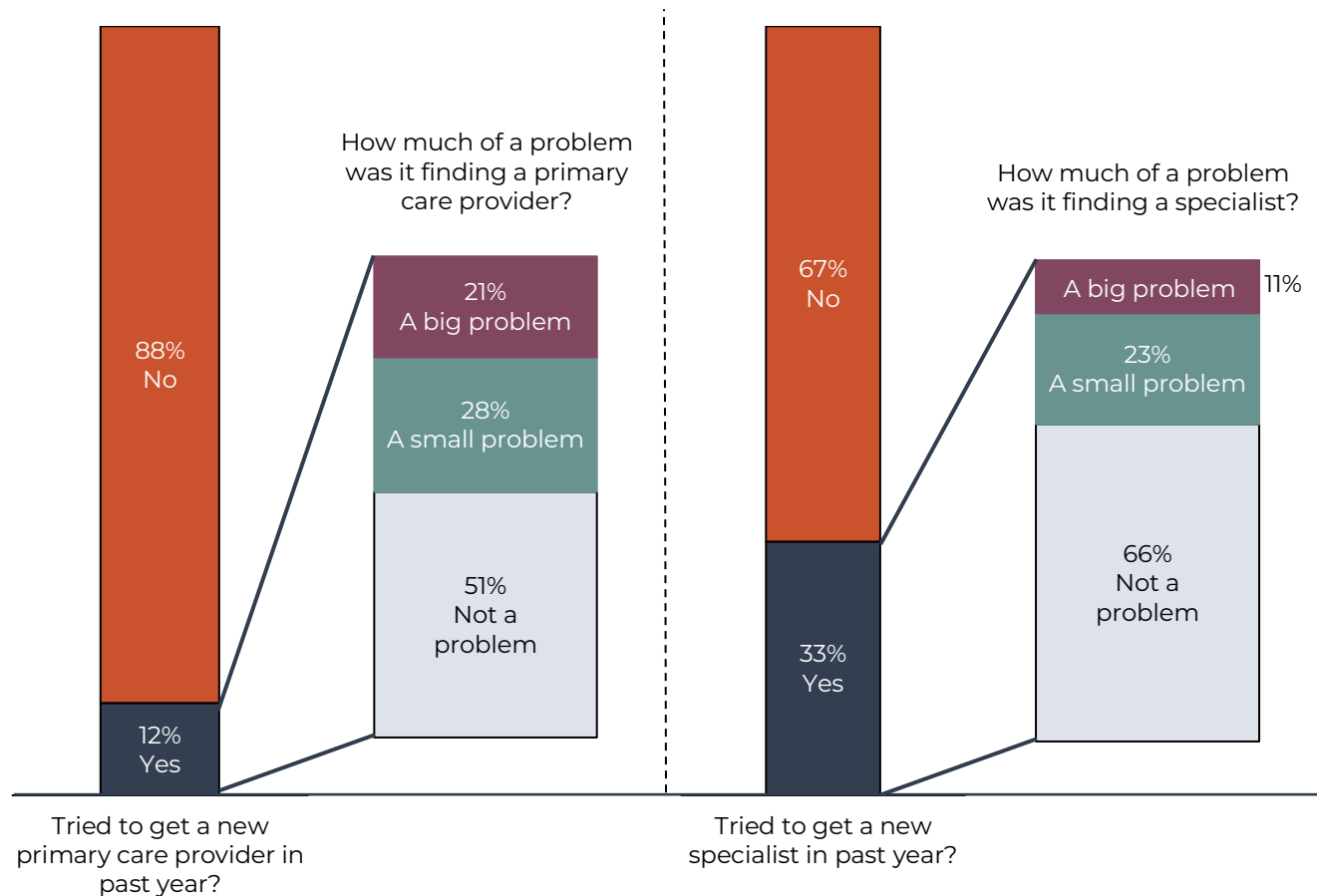
* Statistically significant difference between Medicare beneficiaries and the privately insured at a 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

> In our 2025 survey, higher shares of Medicare beneficiaries reported having a primary care provider (PCP) (96 percent) compared with privately insured people (92 percent).

> Small shares of Medicare beneficiaries and privately insured people reported needing to find a new PCP in the past year (12 percent and 14 percent, respectively). The most common reason for looking for a new PCP was that a PCP had retired or stopped practicing, which was reported by 47 percent of Medicare beneficiaries looking for a new PCP and 35 percent of privately insured people in this situation (equivalent to 5 percent and 4 percent, respectively, of these groups overall).

Chart 7-15 In MedPAC's 2025 survey, beneficiaries encountered more problems finding a new primary care provider than a new specialist



Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage). Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data weighted to be nationally representative.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

> In our 2025 survey, beneficiaries looking for a new primary care provider encountered more problems finding one than those looking for a new specialist. Among the 12 percent of Medicare beneficiaries who tried to get a new primary care provider in the past year, about half reported a problem finding a new one; by contrast, among the 33 percent of Medicare beneficiaries who looked for a new specialist, about a third reported a problem finding one.

> Because a larger share of patients look for a new specialist than look for a new primary care provider each year, the problems finding a new specialist affect more beneficiaries. Overall, we estimate that 11 percent of all Medicare beneficiaries had a problem finding a new specialist, while 6 percent of all beneficiaries had problems finding a new primary care provider (data not shown).

> Privately insured people reported more problems finding a new primary care provider or specialist than did Medicare beneficiaries, as shown in the next chart.

Chart 7-16 In MedPAC's 2025 survey, Medicare beneficiaries reported fewer problems finding a new clinician than privately insured people

Survey question	Medicare beneficiaries (ages 65 and older)	Privately insured (ages 50–64)
Get a new primary care provider: “In the past 12 months, have you tried to get a new primary care provider?”		
Yes	12%*	14%*
Problems finding a primary care provider: Among those who tried to get a new primary care provider, “How much of a problem was it finding a primary care provider who would treat you?” (Overall share)		
A problem (net)	49* (6*)	67* (9*)
A big problem	21* (2*)	28* (4*)
A small problem	28* (3*)	39* (5*)
Not a problem	51* (6*)	33* (5*)
Primary care providers not accepting your insurance: Among those who had a problem finding a new primary care provider, “Did anyone from a doctor’s office tell you they didn’t accept [Medicare/your insurance]?” (Overall share)		
Yes	17* (1*)	32* (3*)
Get a new specialist: “Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?”		
Yes	33	33
Problems finding a specialist: Among those who tried to get a new specialist, “How much of a problem was it finding a specialist who would treat you?” (Overall share)		
A problem (net)	34* (11*)	45* (14*)
A big problem	11* (4*)	17* (5*)
A small problem	23* (7*)	28* (9*)
Not a problem	66* (21*)	55* (18*)
Specialists not accepting your insurance: Among those who had a problem finding a new specialist, “Did anyone from a doctor’s office tell you they didn’t accept [Medicare/your insurance]?” (Overall share)		
Yes	14* (2*)	31* (4*)
Get a new mental health professional: “Some specialists and other clinicians focus on mental health. In the past 12 months, have you tried to get a new mental health professional?”		
Yes	3*	7*
Problems finding a mental health professional: Among those who tried to get a mental health professional, “How much of a problem was it finding a mental health professional who would treat you?” (Overall share)		
A problem (net)	59 (2*)	63 (5*)
A big problem	29 (1*)	36 (3*)
A small problem	30 (1*)	27 (2*)
Not a problem	41 (1*)	37 (3*)
Mental health professionals not accepting your insurance: Among those who had a problem finding a new mental health professional, “Did anyone from a mental health professional’s office tell you they didn’t accept [Medicare/your insurance]?” (Overall share)		
Yes	44 (1*)	48 (2*)

Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data weighted to be nationally representative. “Overall share” refers to the share of all respondents with the respective insurance.

* Statistically significant difference between Medicare beneficiaries and the privately insured at a 95 percent confidence level.

Source: MedPAC’s annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

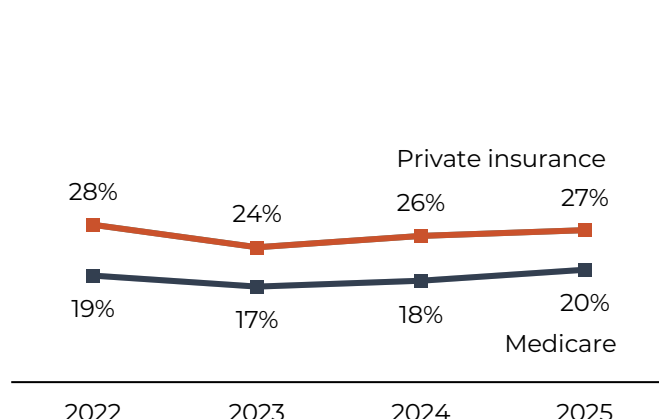
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Chart 7-16 In MedPAC's 2025 survey, Medicare beneficiaries reported fewer problems finding a new clinician than privately insured people (continued)

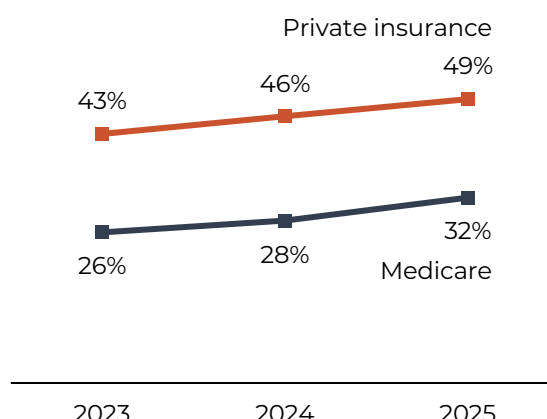
- > Our 2025 survey found that among those who tried to get a new primary care provider in the past year, privately insured people were more likely than Medicare beneficiaries to report problems finding one. In 2025, 67 percent of privately insured people who looked for a new primary care provider (PCP) in the past year reported problems finding one (equivalent to 9 percent of all privately insured people). In contrast, only 49 percent of the Medicare beneficiaries who looked for a new PCP reported problems finding one (equivalent to 6 percent of all Medicare beneficiaries).
- > Privately insured people also reported more problems finding specialists than did Medicare beneficiaries (45 percent vs. 34 percent, respectively, equivalent to 14 percent of privately insured people and 11 percent of Medicare beneficiaries overall).
- > Privately insured people were about twice as likely as Medicare beneficiaries to encounter a PCP or a specialist who did not accept their insurance. For example, among those looking for a new PCP, 17 percent of Medicare beneficiaries and 32 percent of privately insured people encountered a doctor's office that did not accept their insurance (equivalent to 1 percent of Medicare beneficiaries and 3 percent of privately insured people overall). Similar shares reported this experience when looking for a new specialist.
- > Very few people reported looking for a new mental health professional in the past year, but privately insured people were more likely than Medicare beneficiaries to report looking for this type of health care professional (7 percent vs. 3 percent). A majority of both groups reported problems finding this type of clinician: 59 percent of Medicare beneficiaries who were looking for a mental health professional and 63 percent of privately insured people who were looking reported problems finding one, equivalent to 2 percent and 5 percent, respectively, of these groups overall. Among those looking for a new mental health professional, about half of both insurance groups encountered a mental health professional who did not accept their insurance.

Chart 7-17 In MedPAC's annual surveys, Medicare beneficiaries ages 65+ reported using video visits less often than privately insured people ages 50–64 but used telephone visits more often

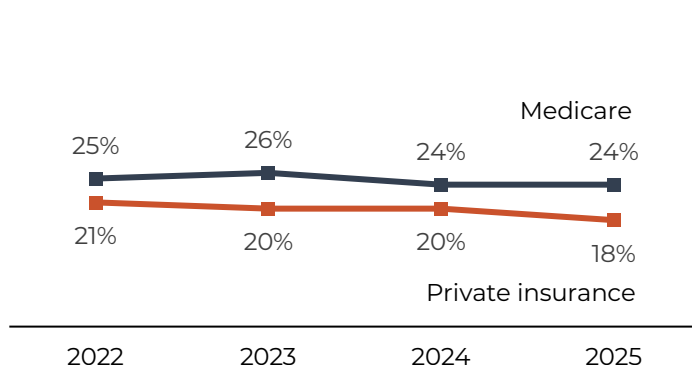
In the past 12 months, have you had a **video** visit?



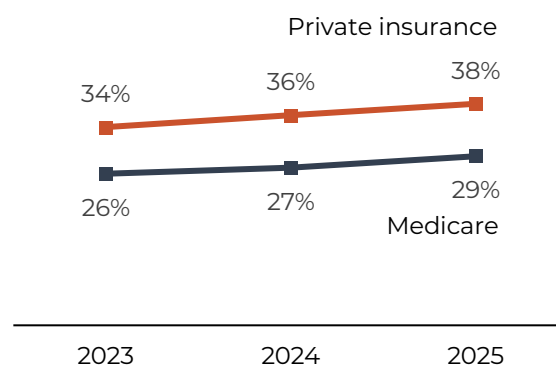
Would you be interested in having the option to use **video** visits in the future?



In the past 12 months, have you had a **telephone** visit?



Would you be interested in having the option to use **telephone** visits in the future?



Note: Survey completed by approximately 4,000 to 5,000 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 4,000 to 5,000 privately insured individuals each year. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data were weighted to be nationally representative. In our survey questions, video visits were defined as “using a smartphone, computer, or tablet” and telephone visits were defined as “a phone call with audio but no video,” and both questions asked about telehealth visits “with any type of health care provider.” In all years and questions shown above, the shares of Medicare beneficiaries and privately insured people who reported a given response are statistically significantly different from each other at a 95 percent confidence level.

Source: MedPAC's annual access-to-care surveys fielded by Gallup in the summers of 2022 through 2025.

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Chart 7-17 In MedPAC's annual surveys, Medicare beneficiaries ages 65+ reported using video visits less often than privately insured people ages 50–64 but used telephone visits more often (continued)

> In our 2025 survey, a third (35 percent) of Medicare beneficiaries ages 65 and over and a third (35 percent) of privately insured people ages 50 to 64 reported having had **some type of telehealth** visit(s) in the past year (data not shown).

>> Privately insured people were somewhat more likely to have had **video** visits than Medicare beneficiaries (27 percent vs. 20 percent).

>> Medicare beneficiaries were somewhat more likely than privately insured people to have had **audio-only telephone** visits (24 percent vs. 18 percent).

> Across insurance groups and types of telehealth visits, over 90 percent of telehealth users reported being satisfied with their visits (data not shown).

> A third (33 percent) of Medicare beneficiaries and half of privately insured people (49 percent) were interested in having the option to use **some type of telehealth** in the future (data not shown).

>> 32 percent of Medicare beneficiaries and 49 percent of privately insured people were interested in having access to **video** visits.

>> 29 percent of Medicare beneficiaries and 38 percent of privately insured people were interested in having access to audio-only **telephone** visits.

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

>> Medicare beneficiaries were more likely to report having used telehealth if they lived in an urban area or had a household income of at least \$50,000 per year.

>>> There were not statistically significant differences in reported telehealth use among Medicare beneficiaries of different races and ethnicities.

>> Medicare beneficiaries were more interested in continuing to have access to telehealth if they lived in an urban area, were under the age of 75, and had a household income of at least \$80,000.

Chart 7-18 In MedPAC's 2025 survey, Medicare beneficiaries were less likely to report long waits for appointments than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Long wait for an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment?” (Overall share)		
For regular or routine care		
Never	51%* (49%*)	38%* (36%*)
Sometimes	37* (36*)	42* (40*)
Usually	8* (8*)	12* (12*)
Always	3* (3*)	7* (7*)
For an illness or injury		
Never	65* (55*)	54* (44*)
Sometimes	28* (23*)	34* (27*)
Usually	5* (4*)	8* (6*)
Always	2* (2*)	5* (4*)
Response to long wait: Among those who had to wait longer than they wanted for an appointment, “What did you do?” (Overall share)		
For regular or routine care		
I took the later appointment date	84* (38*)	82* (47*)
I went to a walk-in clinic	9* (4*)	11* (6*)
I decided not to schedule the appointment	4* (2*)	6* (3*)
I went to a hospital emergency room	4* (2)	2* (1)
For an illness or injury		
I took the later appointment date	63* (18*)	53* (20*)
I went to a walk-in clinic	21* (6*)	31* (12*)
I decided not to schedule the appointment	5* (2*)	8* (3*)
I went to a hospital emergency room	12* (3)	8* (3)

Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data were weighted to produce nationally representative results. Instructions for questions shown above read: “For the next few questions, please think about the number of days or weeks you had to wait to get a doctor’s appointment. Do not include time spent on hold or in the waiting room” and “Please count video visits and phone visits as appointments.” “Overall share” refers to the share of all respondents with the respective insurance. Components may not sum to 100 percent due to rounding.

* Statistically significant difference between Medicare and private insurance groups at a 95 percent confidence level.

Source: MedPAC’s annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

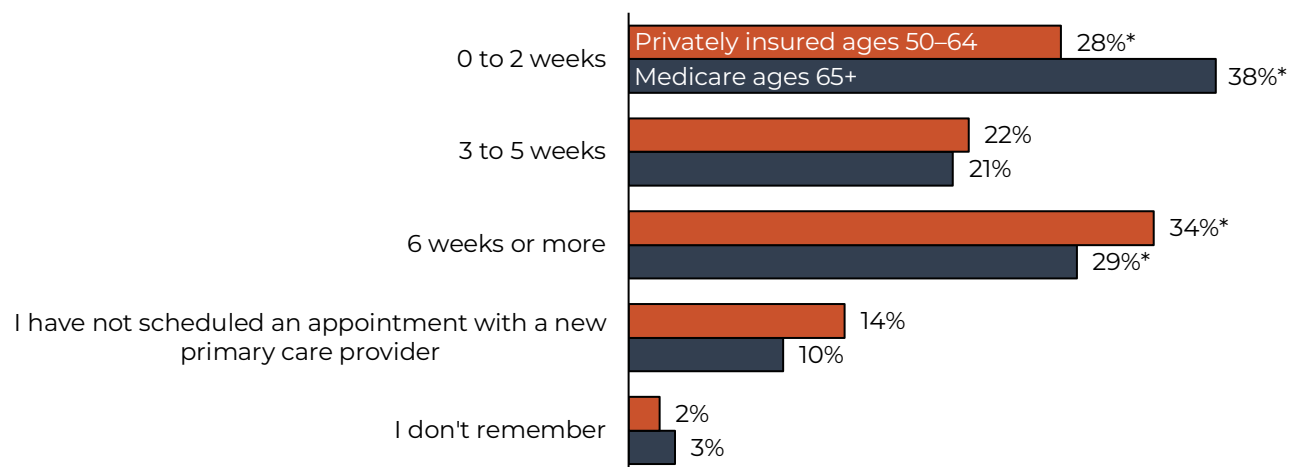
> In 2025, our survey found that among those Medicare beneficiaries who needed an appointment for routine care, half (51 percent) of Medicare beneficiaries reported that they never had to wait longer than they wanted to get such an appointment, while only 38 percent of privately insured people reported this.

> Among those who needed an appointment for an illness or injury, two-thirds (65 percent) of Medicare beneficiaries said they never had to wait longer than they wanted to get such an appointment, compared with 54 percent of privately insured people.

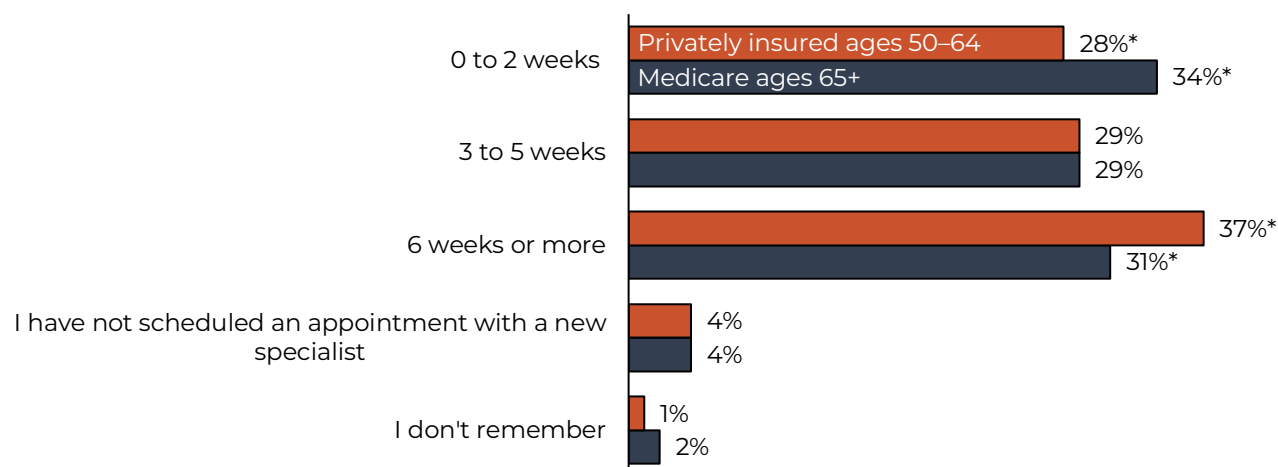
Chart 7-19 In our 2025 survey, Medicare beneficiaries waited slightly less time for their first appointment with a new clinician than privately insured people

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

How long did you have to wait to have an appointment with your new **primary care provider**?



How long did you have to wait to have an appointment with your new **specialist**?



Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Data were weighted to be nationally representative. Components may not sum to totals due to rounding.

* Statistically significant difference between Medicare beneficiaries and privately insured people (at a 95 percent confidence level).

Source: MedPAC's 2025 access-to-care survey, fielded by Gallup from July 18 to September 8, 2025.

> Among Medicare beneficiaries who tried to get a new primary care provider in the past year, a little over a third (38 percent) reported waiting two weeks or less for their first appointment. Similarly, among those trying to get a new specialist, a third (34 percent) waited two weeks or less for their first appointment.

> Privately insured people were slightly less likely to report being seen in two weeks or less and slightly more likely to report waiting six weeks or more for their first appointment with a new clinician.

Chart 7-20 In MedPAC's 2025 survey, Medicare beneficiaries were less likely to report forgoing care than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”		
Yes	17%*	27%*
Reason for forgoing care: “There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the main reason you did not see a doctor about this condition during the past 12 months?” (Overall share)		
I just put it off	29 (5*)	27 (7*)
I didn’t think the problem was serious	27* (4)	19* (5)
I couldn’t get an appointment soon enough	23 (4*)	21 (6*)
I thought it would cost too much	6* (1*)	20* (5*)
I couldn’t find a doctor who would treat me	5 (1)	4 (1)
Other	11 (2*)	9 (2*)

Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data were weighted to produce nationally representative results. “Overall share” refers to the share of all respondents with the respective insurance. Components do not sum to 100 percent due to rounding.

* Statistically significant difference between Medicare and private insurance groups at a 95 percent confidence level.

Source: MedPAC’s annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

> In our 2025 survey, 17 percent of Medicare beneficiaries and 27 percent of privately insured people reported forgoing care that they thought they should have gotten in the past year.

> About half of care forgoers did so because they “didn’t think the problem was serious” or “just put it off.”

> About one in five care forgoers skipped care because they could not get an appointment soon enough: This reason accounted for 23 percent of Medicare care forgoers (equivalent to 4 percent of all Medicare beneficiaries) and 21 percent of privately insured care forgoers (equivalent to 6 percent of all privately insured people).

> Medicare beneficiaries were much less likely to forgo care due to concerns about cost compared with privately insured people: Only 6 percent of Medicare care forgoers skipped care because they “thought it would cost too much” (equivalent to 1 percent of all Medicare beneficiaries), while 20 percent of privately insured care forgoers skipped care for this reason (equivalent to 5 percent of all privately insured people).

Chart 7-21 In MedPAC's 2025 survey, lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries

Survey question	Medicare (ages 65 or older)			Private insurance (ages 50-64)		
	Lower income	Middle income	Higher income	Lower income	Middle income	Higher income
Received health care: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"						
Yes	92% ^a	95% ^{ab}	97% ^{ab}	88% ^a	91% ^a	94% ^{ab}
Have a primary care provider: "A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?"						
Yes	95 ^a	96 ^a	98 ^{ab}	90 ^a	91 ^a	93 ^a
Tried to get a new clinician: "In the past 12 months, have you tried to get a new . . . ?" (Share answering "Yes")						
Primary care provider	12	12	11	15	14	13
Specialist	25	34 ^b	42 ^{ab}	24	29	36 ^{ab}
Problems finding a new clinician: Among those who tried to find a new clinician, "How much of a problem was it finding a [primary care provider/specialist] who would treat you?" (Overall share)						
"Big problem" finding a primary care provider	23 (3)	18 (2 ^a)	21 (2)	25 (4)	32 (4 ^a)	28 (4)
"Big problem" finding a specialist	12 (3)	11 (4)	10 ^a (4)	22 (5)	17 (5)	16 ^a (6)
Forgoing care: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Yes	19 ^a	17 ^a	14 ^{ab}	28 ^a	29 ^a	26 ^a

Note: "Lower income" refers to respondents with annual household incomes of \$0 to \$49,999; "middle income" refers to household incomes of \$50,000 to \$79,999; and "higher income" refers to household incomes of \$80,000 or more. Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data were weighted to produce nationally representative results. "Overall share" refers to the share of all respondents with the respective insurance. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "I don't remember" and "Refused."

^a Statistically significant difference between Medicare beneficiaries and the privately insured within the same income category (at a 95 percent confidence level).

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

Source: MedPAC's 2025 access-to-care survey, conducted July 18 to September 8, 2025.

> In 2025, we found some differences in care patterns for lower-income Medicare beneficiaries (with household incomes below \$50,000) and higher-income beneficiaries (with household incomes of \$80,000 or more). For example:

>> Only 92 percent of lower-income beneficiaries reported receiving any health care in the past year, compared with 97 percent of higher-income beneficiaries.

>> Lower-income beneficiaries were more likely to report forgoing care in the past year (19 percent) compared with higher-income beneficiaries (14 percent).

Chart 7-22 In our 2025 survey, few differences in urban and rural care access

Survey question	Medicare beneficiaries (ages 65 or older)		Privately insured (ages 50–64)	
	Urban	Rural	Urban	Rural
Received health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”				
Yes	95% ^{ab}	92% ^b	92% ^a	92%
Providers that accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept [Medicare/your insurance]?”				
Satisfied (“very” or “somewhat”)	97 ^a	98 ^a	93 ^a	92 ^a
Providers with timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”				
Satisfied (“very” or “somewhat”)	89 ^a	92 ^a	80 ^a	81 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”				
Yes	96 ^a	97 ^a	92 ^a	93 ^a
Tried to get a new clinician: “In the past 12 months, have you tried to get a new . . . ?” (Share answering “Yes”)				
Primary care provider	12 ^a	11	14 ^a	11
Specialist	34 ^b	28 ^b	34 ^b	26 ^b
Problems finding a new clinician: Among those who tried to find a new clinician, “How much of a problem was it finding a [primary care provider/specialist] who would treat you?” (Overall share)				
“Big problem” finding a primary care provider	22 ^a	16	30 ^a	20
“Big problem” finding a specialist	11 ^a	13	17 ^a	17
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, “How long did you have to wait to have an appointment with your new [primary care provider/specialist]?”				
Primary care provider				
0 to 2 weeks	33 ^{ab}	57 ^b	26 ^a	39
3 to 5 weeks	21	19	22	20
6 weeks or more	32 ^b	11 ^{ab}	35	34 ^a
I have not scheduled an appointment	10	11	15	7
Specialist				
0 to 2 weeks	34 ^a	32	29 ^a	28
3 to 5 weeks	29	31	29	27
6 weeks or more	31 ^a	30	37 ^a	40
I have not scheduled an appointment	4	4	4	4
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”				
Yes	17 ^a	19 ^a	27 ^a	26 ^a

Note: “Urban” respondents live in a metropolitan statistical area, while “rural” respondents do not. Survey completed by 4,788 Medicare beneficiaries and 5,079 privately insured individuals. “Overall share” refers to the share of all respondents with the respective insurance. Totals may not sum to 100 percent due to rounding and the exclusion of the following responses: “I don’t remember” and “Refused.”

^a Statistically significant difference between Medicare beneficiaries and the privately insured within the same area type (at a 95 percent confidence level).

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

Source: MedPAC’s 2025 access-to-care survey, conducted July 18 to September 8, 2025.

(Chart continued next page)

Chart 7-22 In our 2025 survey, few differences in urban and rural care access (continued)

> Our survey found only a few differences between rural and urban beneficiaries' experiences accessing care. For example:

- >> More rural beneficiaries reported waiting two weeks or less for their first appointment with a new primary care provider (57 percent) compared with urban beneficiaries (33 percent).
- >> More rural beneficiaries received all or most of their primary care from a nurse practitioner or physician assistant rather than a physician (28 percent) compared with urban beneficiaries (16 percent) (data not shown).
- >> More urban beneficiaries reported receiving any health care in the past year (95 percent) compared with rural beneficiaries and privately insured people living in any type of area (92 percent).

Chart 7-23 In MedPAC's 2025 survey, there were few differences in White, Black, and Hispanic beneficiaries' access to care

Survey question	Medicare beneficiaries (ages 65 or older)			Privately insured (ages 50–64)		
	White	Black	Hispanic	White	Black	Hispanic
Received health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”						
Yes	95 ^a	94	92 ^b	93 ^a	93	89 ^b
Providers that accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept [Medicare/your insurance]?”						
Satisfied (“very” or “somewhat”)	98 ^a	97	98 ^a	93 ^a	97	92 ^a
Providers with timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”						
Satisfied (“very” or “somewhat”)	89 ^a	95 ^{ab}	91 ^a	81 ^a	86 ^a	75 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”						
Yes	96 ^a	95	98 ^a	93 ^a	93	90 ^a
Tried to get a new clinician: “In the past 12 months, have you tried to get a new . . . ?” (Share answering “Yes”)						
Primary care provider	12	8 ^a	12	13	14 ^a	16
Specialist	35	20 ^b	25 ^b	34	25 ^b	32
Problems finding a new clinician: Among those who tried to find a new clinician, “How much of a problem was it finding a [primary care provider/specialist] who would treat you?” (Overall share)						
“Big problem” finding primary care provider	20 (2 ^a)	18 (1)	25 (3)	28 (4 ^a)	24 (3)	32 (5)
“Big problem” finding specialist	12 ^a (4)	11 (2)	15 (4)	16 ^a (5)	15 (4)	22 (7)
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, “How long did you have to wait to have an appointment with your new [primary care provider/specialist]?”						
Primary care provider						
0 to 2 weeks	38 ^a	32	46	26 ^a	37	29
3 to 5 weeks	20	19	24	22	21	26
6 weeks or more	30	22	18	35	32	31
I have not scheduled an appointment	9	16	12	15	10	12
Specialist						
0 to 2 weeks	33 ^a	43	44 ^b	26 ^a	39 ^b	34
3 to 5 weeks	28	20	30	30	25	24
6 weeks or more	32 ^a	27	22 ^a	40 ^a	21 ^b	37 ^a
I have not scheduled an appointment	4	7	4	4	11 ^b	4
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”						
Yes	17 ^a	14 ^a	17 ^a	26 ^a	26 ^a	26 ^a

Note: “Hispanic” refers to Hispanic respondents of any race. Survey completed by 4,788 Medicare beneficiaries and 5,079 privately insured individuals. “Overall share” refers to share of all respondents of the respective race/ethnicity and insurance type. Totals may not sum to 100 percent due to rounding and the exclusion of the following responses: “I don’t remember” and “Refused.”

^a Statistically significant difference between Medicare beneficiaries and the privately insured within the same race/ethnicity category (at a 95 percent confidence level).

^b Statistically significant difference between White and Black or White and Hispanic respondents within the same insurance group (at a 95 percent confidence level).

Source: MedPAC’s 2025 access-to-care survey, conducted July 18 to September 8, 2025.

(Chart continued next page)

Chart 7-23 In MedPAC's 2025 survey, there were few differences in White, Black, and Hispanic beneficiaries' access to care (continued)

> Our survey found only a few differences in Medicare beneficiaries' access to care by race and ethnicity. For example:

>> A slightly lower share of Hispanic beneficiaries reported receiving any health care in the past year (92 percent) compared with White (95 percent) and Black (94 percent) beneficiaries.

>> A higher share of Black beneficiaries reported being satisfied with their ability to find providers that have appointments when they need them (95 percent) compared with White (89 percent) and Hispanic (91 percent) beneficiaries.

>> A much higher share of White beneficiaries looked for a new specialist in the past year (35 percent) compared with Black (20 percent) and Hispanic (25 percent) beneficiaries. A lower share of White beneficiaries reported waiting only two weeks or less for their first appointment with a new specialist (33 percent) compared with Black (43 percent) and Hispanic (44 percent) beneficiaries.

Post-acute care

Skilled nursing facilities

Home health services

Inpatient rehabilitation facilities

Long-term care hospitals

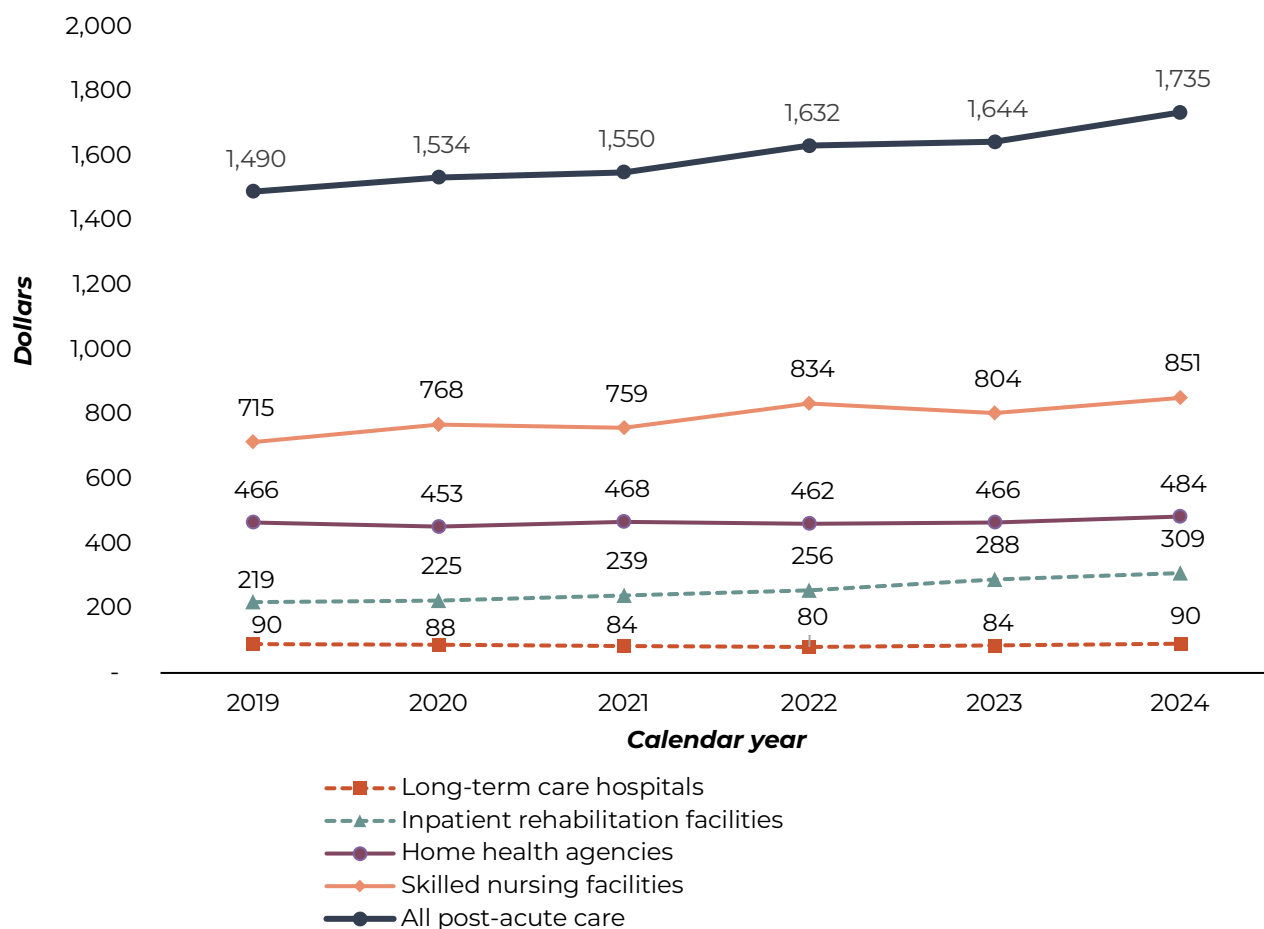
Chart 8-1 Change in the number of post-acute care providers in Medicare differed across sectors in 2024

	2019	2020	2021	2022	2023	2024	Average annual percentage change	
							2019–2023	2023–2024
Skilled nursing facilities	15,297	15,160	14,947	14,798	14,634	14,518	–1.1%	–0.8%
Home health agencies	11,356	11,386	11,506	11,657	12,057	12,234	1.5	1.5
Inpatient rehabilitation facilities	1,119	1,114	1,118	1,132	1,160	1,169	0.9%	0.8%
Long-term care hospitals	371	351	345	341	338	329	–2.3	–2.7

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

- > The number of skilled nursing facilities decreased by about 1 percent per year between 2019 and 2024.
- > The number of home health agencies increased between 2019 and 2024, but much of this growth has been concentrated in California, particularly Los Angeles County—an area previously identified by the California state auditor as a major hotspot for hospice fraud, waste, and abuse. Excluding California, the supply of home health agencies declined by about 1 percent between 2019 and 2024 (data not shown).
- > After declining for several years, the total number of inpatient rehabilitation facilities increased between 2021 and 2024.
- > After peaking in 2012 (data not shown), the number of long-term care hospitals (LTCHs) decreased. The decline became more rapid after the implementation of a dual payment-rate system that reduced payments for certain Medicare discharges from LTCHs beginning in fiscal year 2016.

Chart 8-2 An increase in SNF spending accounted for most of the growth in FFS Medicare spending per capita for post-acute care in 2019 to 2024

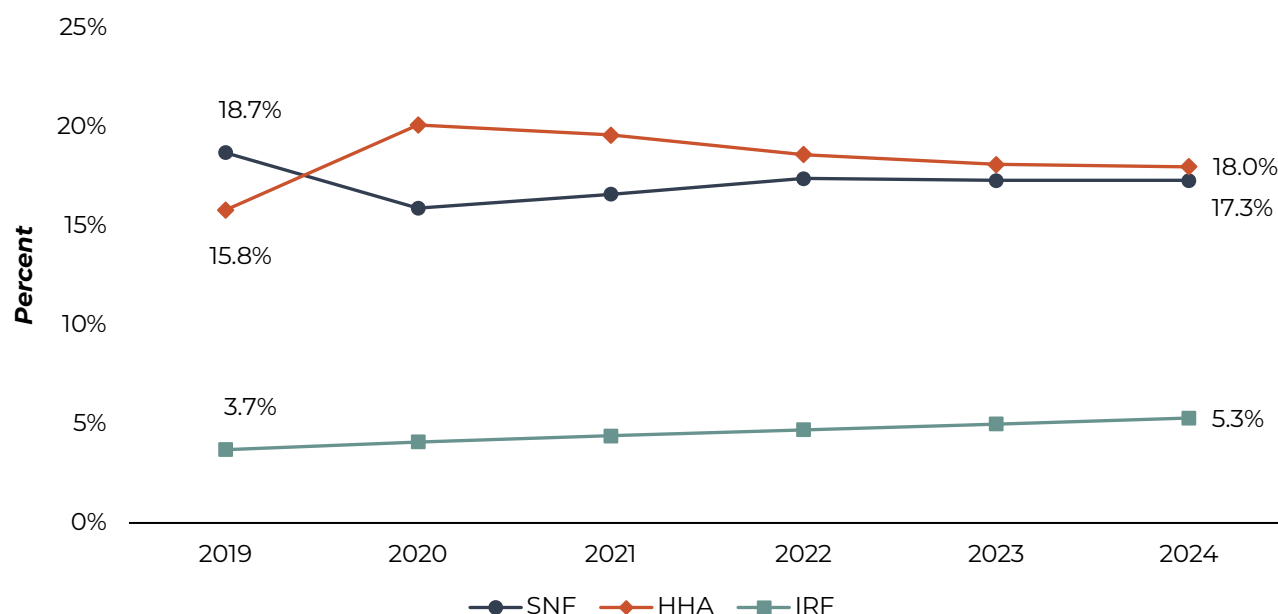


Note: SNF (skilled nursing facility), FFS (fee-for-service). These calendar year-incurred data represent program spending only; they do not include beneficiary cost sharing. Dollar amounts are nominal figures, not adjusted for inflation.

Source: CMS Office of the Actuary, 2025.

> Between 2019 and 2024, FFS Medicare per capita spending on post-acute care rose from \$1,490 to \$1,735. Per capita spending growth was driven primarily by skilled nursing facility services and inpatient rehabilitation facility services. Per capita spending growth was slower over the period for home health agency services and declined for long-term care hospital services.

Chart 8-3 Between 2019 and 2024, SNFs lost and then gradually regained some of the share of IPPS discharges to PAC, while the share going to HHAs increased and then gradually declined



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

Source: MedPAC analysis of Medicare claims data from CMS.

> Before the coronavirus public health emergency (PHE), SNFs were the most common PAC destination after discharge from an acute care hospital, with 18.7 percent of hospital discharges in 2019. HHAs accounted for 15.8 percent of discharges. However, SNF use dropped during the PHE, concurrent with the drop in hospital admissions, and while SNF volume rose in 2021 and 2022, it has not returned to prepandemic levels. During the PHE, HHAs' share of hospital discharges increased to 20.1 percent, and though it has declined since 2020, it remains the most common PAC setting. The share of hospital discharges going to IRFs has steadily increased since 2019 and in 2024 accounted for 5.3 percent of hospital discharges.

> Overall, about 41 percent of acute care hospital discharges in 2020 through 2024 were followed by services from a SNF, HHA, IRF, or long-term acute care hospital (data not shown). Use of PAC after hospital discharge varied depending on the condition or the treatment a patient received while hospitalized. For example, in 2024, the share of hospital discharges using PAC was 45 percent for postsurgical patients compared with about 40 percent for patients who received mostly medical services during their inpatient stay (data not shown).

Chart 8-4 Freestanding SNFs, urban SNFs, and for-profit SNFs accounted for the majority of facilities, FFS Medicare–covered stays, and FFS Medicare spending in 2024

Type of SNF	Facilities	FFS Medicare–covered stays	FFS Medicare payments
Totals	14,400	1,500,000	\$26 billion
Freestanding	97%	98%	98%
Hospital based	3	2	2
Urban	73	86	88
Rural	27	14	12
For profit	74	76	81
Nonprofit	20	21	17
Government	6	3	3

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

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

- > In 2024, freestanding facilities accounted for 98 percent of FFS Medicare–covered SNF stays and 98 percent of FFS Medicare’s payments to SNFs.
- > Urban facilities accounted for 73 percent of facilities in 2024, while accounting for 86 percent of FFS stays and 88 percent of FFS Medicare payments.
- > For-profit facilities accounted for 74 percent of facilities in 2024, 76 percent of FFS stays, and 81 percent of FFS Medicare payments.

Chart 8-5 Per capita FFS SNF admissions decreased in 2024, but covered days per admission continued to rise

Volume measure	2019	2020	2021	2022	2023	2024	Average annual percentage change	
							2019–2023	2023–2024
Covered admissions per 1,000 FFS beneficiaries	55	50	49	54	47	45	–4.6%	–3.8%
Covered days per 1,000 FFS beneficiaries	1,447	1,429	1,361	1,498	1,383	1,396	–0.8%	1.0%
Covered days per admission	26.1	28.5	28.0	28.0	29.2	30.7	4.1%	4.9%

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

Source: MedPAC analysis of 2019–2024 Medicare Provider Analysis and Review file and enrollment data from CMS.

> Between 2019 and 2023, SNF admissions per 1,000 FFS beneficiaries decreased 4.6 percent per year, on average, and declined another 3.8 percent in 2024. Covered days per 1,000 beneficiaries decreased 0.8 percent per year, on average, between 2019 and 2023 but increased 1.0 percent in 2024. Meanwhile, covered days per admission rose 4.1 percent per year, on average, between 2019 and 2023 and climbed almost 5 percent in 2024 as the average length of stay grew to 30.7 days.

Chart 8-6 FFS Medicare margins in freestanding SNFs remained high in 2024

	2021	2022	2023	2024
All	22.8%	23.5%	22.5%	24.4%
Rural	22.1	22.5	20.8	21.2
Urban	22.9	23.6	22.8	24.8
Nonprofit	9.9	9.2	8.2	10.8
For profit	25.5	26.1	25.5	27.2

Note: FFS (fee-for-service), SNF (skilled nursing facility). FFS Medicare margins do not reflect federal provider relief funds that SNFs received due to the coronavirus pandemic.

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

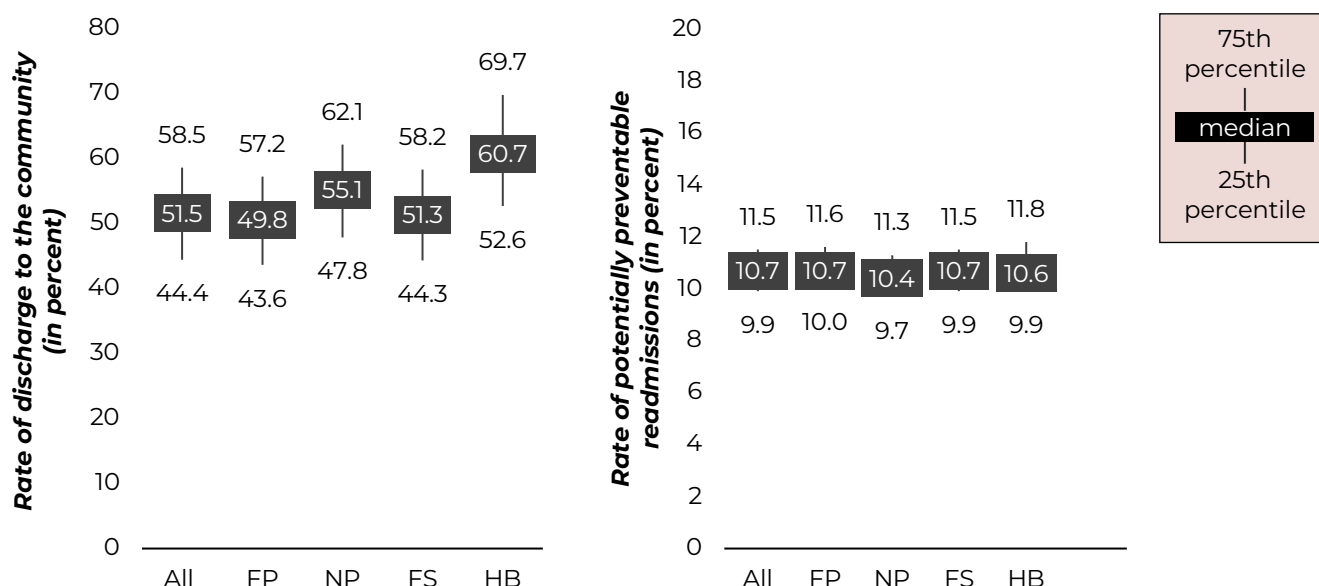
> The aggregate FFS Medicare margin for freestanding SNFs in 2024 (24.4 percent) exceeded 10 percent for the 25th consecutive year (not all years are shown). Had we considered an allocated share of the federal relief funds that providers received due to the public health emergency, we estimate the aggregate FFS margin during these years would have been even higher.

> The aggregate FFS Medicare margin increased in 2024 because the average payment per day in freestanding SNFs increased 4.9 percent while costs per day increased 2.3 percent (data not shown). Growth in costs per day in 2024 slowed as wage growth in the sector slowed compared with previous years, and ancillary costs (which include therapy) stabilized after rising in 2023 (data not shown).

> Aggregate FFS Medicare margins for freestanding SNFs varied widely: One-quarter of SNFs had FFS Medicare margins that were 34 percent or higher, and one-quarter had margins that were 13 percent or lower (data not shown). Consistent with the prepandemic years, urban SNFs had a higher aggregate FFS Medicare margin than rural SNFs in 2024 (prepandemic margins not shown). For-profit SNFs had a considerably higher aggregate FFS Medicare margin than nonprofit SNFs. Compared with for-profit SNFs, nonprofit facilities were smaller (fewer beds and lower volume) and had lower payments per day, higher costs per day, and higher growth in costs per day between 2023 and 2024 (data not shown).

> In 2024, the average total margin (the margin across all payers and all lines of business) for freestanding SNFs was 2.1 percent, up from 0.4 percent in 2023 (data not shown). The increase reflects an aggregate increase in Medicaid base rates.

Chart 8-7 SNF quality measures: Risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2023 and FY 2024



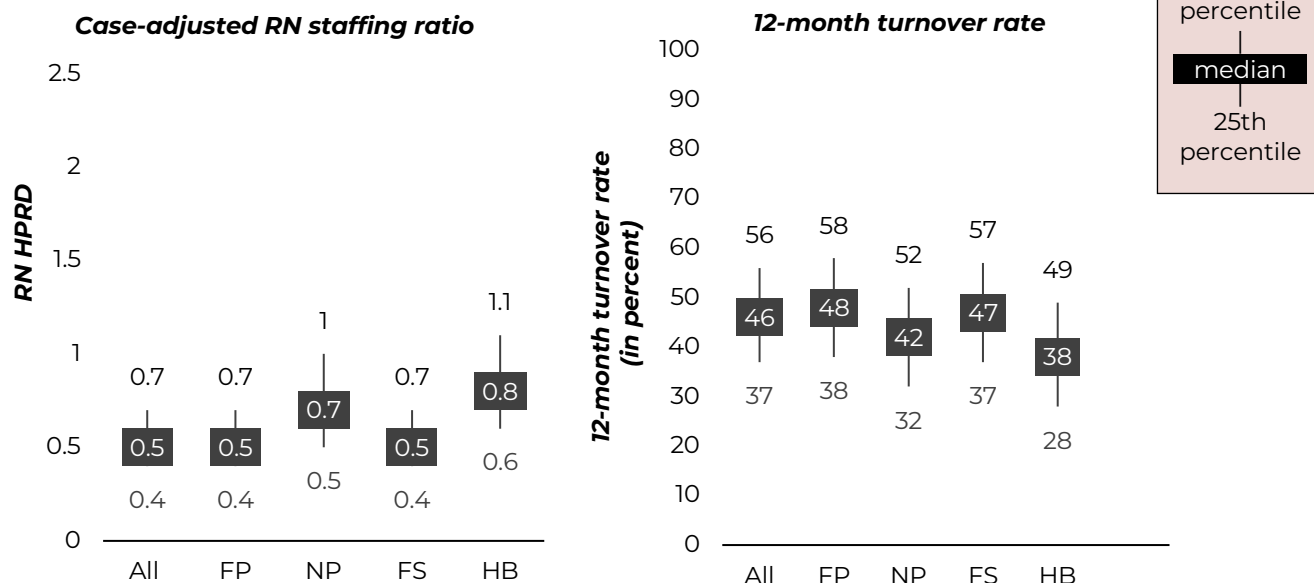
Note: SNF (skilled nursing facility), FY (fiscal year), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). Data include SNFs in the 50 states and the District of Columbia and cover 24 months (FY 2023 and FY 2024 combined). Rates are computed from Medicare claims for eligible Medicare Part A-covered SNF stays and do not include swing-bed stays. The measure of “discharge to the community” is a SNF’s risk-standardized rate of fee-for-service Medicare residents who were discharged to the community after a SNF stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of “potentially preventable readmissions” after discharge is calculated as the risk-adjusted percentage of patients discharged from a SNF stay who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better.

Source: MedPAC analysis of SNF claims-based outcome measures from CMS’s provider data catalog, FY 2023 through FY 2024.

> In FY 2023 and FY 2024 (combined), the median rate of discharge to the community from SNFs was 51.5 percent, similar to the combined FY 2022 and FY 2023 rate of 50.9 percent (latter data not shown). In FY 2023 and FY 2024, one-quarter of SNFs had rates above 58.5 percent and one-quarter had rates below 44.4 percent. The median rates of discharge to the community for nonprofit SNFs and hospital-based SNFs were higher than the median rates for for-profit SNFs and freestanding SNFs. Urban SNFs had higher rates of community discharge than rural SNFs (data not shown).

> In FY 2023 and FY 2024 (combined), SNFs’ median rate of potentially preventable readmissions to the hospital was 10.7 percent. (Lower rates indicate better quality.) One-quarter of SNFs had rates above 11.5 percent and one-quarter had rates below 9.9 percent.

Chart 8-8 SNFs' RN staffing ratios and total nursing staff turnover rates varied across types of providers, 2024



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

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

> In 2024, the median SNF provided 0.5 RN HPRD, similar to 2023 (latter data not shown). One-quarter of SNFs provided 0.7 or more HPRD, while one-quarter provided 0.4 or fewer HPRD. Freestanding SNFs had lower median case-mix-adjusted RN staffing than hospital-based SNFs, and for-profit SNFs had lower median case-mix-adjusted RN staffing than nonprofit SNFs. Rural facilities had ratios similar to those of urban facilities (data not shown). Although the staffing ratios are adjusted for acuity, some of the differences could reflect the mix of long-stay and short-stay patients in a facility.

> In 2024, the 12-month nursing staff turnover rate was 46 percent for the median SNF. Although a methodology change in the turnover calculation makes the 2024 rate not directly comparable with previous years, the 2023 rate of 49 percent represents an improvement from 2021 and 2022, when the rate was around 53 percent (data not shown). One-quarter of facilities had turnover rates greater than 56 percent, meaning that over half of their nursing staff left the facility in the 12-month period. For-profit SNFs and freestanding SNFs had higher turnover rates than nonprofit SNFs and hospital-based SNFs. Turnover rates at urban facilities (47 percent) were similar to turnover rates at very rural facilities (46 percent), although RN-specific turnover was higher in urban facilities (43 percent) than in rural facilities (40 percent) (data not shown).

Chart 8-9 Fee-for-service home health care use was steady in 2024

	2019	2020	2021	2022	2023	2024	Average annual change	
							2019–2023	2023–2024
FFS Medicare home health users (millions)	3.3	3.1	3.0	2.8	2.7	2.7	–4.7	–2.1
Share of FFS Medicare beneficiaries using home health care	8.5%	8.1%	8.3%	8.0%	7.9%	7.9%	–2.1	1.0
30-day periods (millions)	N/A	N/A	9.3	8.6	8.3	8.3	N/A	–0.5
30-day periods per 100 FFS Medicare beneficiaries	N/A	N/A	26	24	24	25	N/A	2.6
Total in-person visits (millions)	99.7	81.1	76.8	69.5	66.8	65.4	–9.5	–3.2
In-person visits per user	30.2	26.6	25.4	24.6	24.6	24.6	–5.0	<0.1

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

Source: MedPAC analysis of home health standard analytic files from CMS and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2024, the number of FFS beneficiaries using home health care declined by 2.1 percent, reflecting, at least in part, a decrease in the number of beneficiaries enrolled in FFS Medicare. FFS home health utilization has been declining for several years as more beneficiaries enroll in Medicare Advantage and per capita FFS hospitalizations—a common source of referral to home health care—have fallen. Controlling for the decline in FFS Medicare enrollment, the number of 30-day home health periods remained relatively steady in 2024, at 25 per 100 FFS beneficiaries. The number of in-person visits per home health user remained relatively steady in 2024, at 24.6.

> In 2024, about 2.2 percent of FFS-covered 30-day home health periods included a telehealth visit or remote patient monitoring, and about 12 percent of home health agencies (HHAs) provided at least one telehealth or remote patient-monitoring service to a FFS beneficiary (data not shown). Skilled nursing care accounted for about 80 percent of the telehealth visits provided in 2024. The small number of beneficiaries receiving these services, and the limited number of HHAs providing them, indicates that most clinical care in the home health benefit is still provided in person.

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

Type of 30-day period	2023	2024
Period by source of referral		
Preceded by hospitalization or institutional PAC	25.3%	25.0%
Community admitted	74.7	75.0
Period by timing of 30-day period		
Early	30.8	30.3
Late	69.2	69.7

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

Source: MedPAC analysis of 2023 and 2024 home health standard analytic files from CMS.

> Most FFS-covered home health periods were not preceded by a hospitalization or institutional PAC stay. "Community-admitted" home health periods accounted for about three-quarters of PAC 30-day periods in 2023 and 2024.

> Under FFS Medicare's home health payment system, home health periods for beneficiaries who have not received any home health care in the prior 60 days are classified as "early," while periods that are the second or later in a series of consecutive periods are classified as "late." The share of periods by timing or source of referral did not change substantially in 2024 compared with the prior year. The mix of cases by clinical payment group also did not change significantly (data not shown).

Chart 8-11 FFS Medicare margins for freestanding home health agencies remained high in 2024

	2019	2020	2021	2022	2023	2024	Share of home health agencies, 2024	Share of 30-day periods, 2024
All	15.4%	20.2%	24.9%	22.2%	19.8%	21.2%	100%	100%
Geography								
Majority urban	16.1	20.0	24.8	22.3	20.0	21.3	86	87
Majority rural	14.2	21.6	25.2	22.0	18.6	20.5	14	13
Type of ownership								
For profit	17.4	22.7	26.1	23.6	21.2	23.1	93	86
Nonprofit	11.4	12.4	20.2	16.4	13.3	12.2	7	14
Volume quintile								
First (smallest)	9.7	11.6	14.0	13.7	12.5	14.4	20	3
Second	11.4	14.0	15.9	14.5	13.7	15.1	20	7
Third	13.3	17.0	19.3	17.0	14.5	17.6	20	11
Fourth	14.1	18.8	22.8	21.0	19.0	20.3	20	19
Fifth (largest)	17.5	22.4	28.3	24.8	22.1	23.2	20	60

Note: FFS (fee-for service). Home health agencies (HHAs) were classified as “majority urban” if they provided more than 50 percent of episodes to beneficiaries in urban counties, and they were classified as “majority rural” if they provided more than 50 percent of episodes to beneficiaries in rural counties. FFS Medicare margins do not reflect federal provider relief funds that HHAs received due to the coronavirus pandemic.

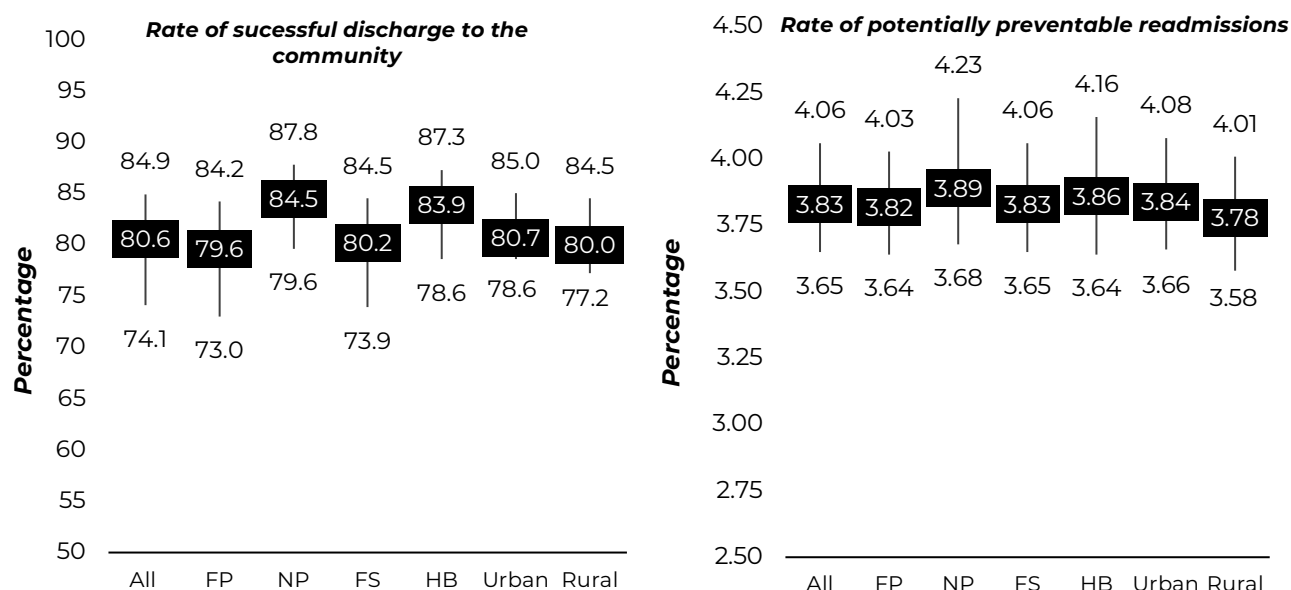
Source: MedPAC analysis of Medicare home health cost-report files from CMS.

> In 2024, freestanding HHAs (about 95 percent of all HHAs; data not shown) had an aggregate FFS Medicare margin of 21.2 percent. The 2024 margin is consistent with the historically high margins the home health industry has experienced since the prospective payment system (PPS) was implemented in 2000. The margins from 2001 to 2023 averaged 17.2 percent (not all data shown), indicating that most agencies have been paid well in excess of their costs for more than 20 years.

> For-profit agencies had an average FFS Medicare margin of 23.1 percent in 2024, compared with 12.2 percent for nonprofit agencies. There was little difference in the aggregate FFS Medicare margins of urban HHAs (21.3 percent) and rural HHAs (20.5 percent).

> Agencies with higher volumes of 30-day periods had higher FFS Medicare margins. The agencies in the lowest-volume quintile in 2024 had an aggregate FFS Medicare margin of 14.4 percent, compared with 23.2 percent for those in the highest-volume quintile.

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



Note: HHA (home health agency), FP (for profit), NP (nonprofit), FS (freestanding), HB (hospital based). The measure of “discharge to the community” is an HHA’s risk-standardized rate of fee-for-service (FFS) Medicare patients who were discharged to the community after a home health stay, did not have an unplanned readmission to an acute care or long-term care hospital in the 31 days following discharge to the community, and remained alive during those 31 days. Higher rates are better. The measure of “potentially preventable readmissions” after discharge is calculated as the risk-adjusted percentage of patients discharged from an HHA who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Rates are computed from Medicare claims for eligible Medicare Part A–covered home health stays in the 50 states and the District of Columbia, regardless of whether the home health stay was preceded by a hospitalization. Rates of successful discharge are for the 24-month period from January 1, 2022, to December 31, 2023; rates of potentially preventable readmissions are for the 36-month period from January 1, 2021, to December 31, 2023.

Source: MedPAC analysis of claims-based outcome measures from CMS’s Provider Data Catalog.

- > The median rate of discharge to the community from home health was 80.6 percent in the period from January 1, 2022, to December 31, 2023 (higher rates indicate better quality). For-profit providers had the lowest median rates of discharge to the community during the period, while nonprofit providers had the highest rates. From January 1, 2022, to December 31, 2023, HHAs at the 25th percentile and 75th percentile had rates of 74.1 percent and 84.9 percent, respectively.
- > For the 36-month period from January 1, 2021, to December 31, 2023, the median rate of home health stays with a potentially preventable readmission was 3.83. The median rates of potentially preventable rehospitalization did not differ significantly across ownership categories or facility type. In this same period, the HHAs at the 25th percentile and 75th percentile had potentially preventable rehospitalization rates of 3.65 percent and 4.06 percent, respectively.

Chart 8-13 In FY 2024, the number of FFS Medicare IRF stays grew substantially compared with growth in 2019 to 2023

	2019	2020	2021	2022	2023	2024	Average annual percentage change 2019–2023	Percentage change 2023–2024
IRF inpatient stays (thousands)	404	374	373	376	404	435	0.0%	7.7%
IRF inpatient stays per 10,000 beneficiaries	107	101	104	109	120	132	2.8	10.0
Average length of stay (days)	12.6	12.9	12.9	12.8	12.5	12.4	–0.2	–0.7

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

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

> From 2023 to 2024, the number of FFS-covered IRF cases rose by 7.6 percent, to about 435,000 cases. When controlling for the number of FFS beneficiaries, the increase was even greater (10.0 percent).

> The average length of stay decreased slightly in 2024 to 12.4 days, a 0.7 percent reduction from 12.5 days in 2023.

Chart 8-14 Stroke, neurological conditions, and debility remained the most common conditions for FFS beneficiaries in IRFs in FY 2024

	2019	2020	2021	2022	2023	2024
Stroke	19.8%	19.1%	18.1%	17.5%	15.9%	15.1%
Fracture of the lower extremity	10.0	11.3	11.2	11.7	11.4	11.4
Debility	12.3	13.5	14.0	14.7	14.2	14.7
Neurological conditions	14.4	14.0	14.9	15.7	14.7	15.0
Brain injury	11.0	11.2	11.3	11.8	11.5	11.9

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), FY (fiscal year). “Neurological conditions” includes multiple sclerosis, Parkinson’s disease, polyneuropathy, and neuromuscular disorders. “Fracture of the lower extremity” includes hip, pelvis, and femur fractures. Patients with “debility” have generalized deconditioning not attributable to other conditions. “Brain injury” includes both traumatic and nontraumatic injuries. All FFS Medicare IRF stays with valid patient-assessment information were included in this analysis. Yearly percentages presented in this table are rounded. (The cases shown in 2023 represent about 70 percent of all FFS cases.)

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

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

> Stroke continued to be the most common condition among IRF stays, accounting for 15.1 percent of FFS stays in 2024. However, that share has declined almost 5 percentage points since 2019. Between 2019 and 2024, IRF stays for debility increased from 12.3 percent to 14.7 percent of IRF FFS stays.

Chart 8-15 IRFs' aggregate FFS Medicare margin increased to 17.1 percent in FY 2024

IRF category	2019	2020	2021	2022	2023	2024
All	14.1%	13.5%	16.7%	13.7%	14.8%	17.1%
Type						
Freestanding	24.7	23.6	25.7	23.0	24.3	25.0
Hospital based	1.3	1.5	5.2	0.9	0.6	4.1
Ownership						
For profit	24.2	23.6	25.2	22.4	23.5	24.6
Nonprofit	0.7	-0.3	4.6	-0.1	-0.2	2.9
Geography						
Urban	14.5	13.8	17.0	14.1	15.0	17.3
Rural	7.3	8.5	11.7	7.7	10.6	12.5
Number of beds						
1 to 10	-9.6	-6.2	-3.3	-7.0	-6.4	-4.9
11 to 24	1.3	2.0	5.0	0.8	1.1	5.1
25 to 64	15.9	15.6	18.6	15.3	16.4	18.6
65 or more	21.0	18.6	21.9	19.4	20.5	22.0
FFS Medicare share of days						
<50%	4.0	6.3	11.4	7.0	7.0	10.2
50% to 75%	18.0	17.0	20.0	17.6	19.1	20.8
≥75%	17.9	21.1	20.5	21.7	21.8	22.1
Low-income patient share						
0% to <5%	18.2	15.7	20.0	16.8	18.4	21.3
5% to <10%	18.3	18.8	20.1	18.1	18.3	22.2
10% to <15%	13.7	12.6	16.9	13.8	14.5	14.3
15% to <20%	15.3	14.9	16.6	12.6	14.7	15.0
20% to <25%	2.3	8.3	14.1	6.6	12.5	12.7
25% or more	5.9	5.0	9.6	10.0	5.5	5.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), FY (fiscal year). FFS Medicare margins do not reflect federal provider relief funds that IRFs received due to the coronavirus pandemic.

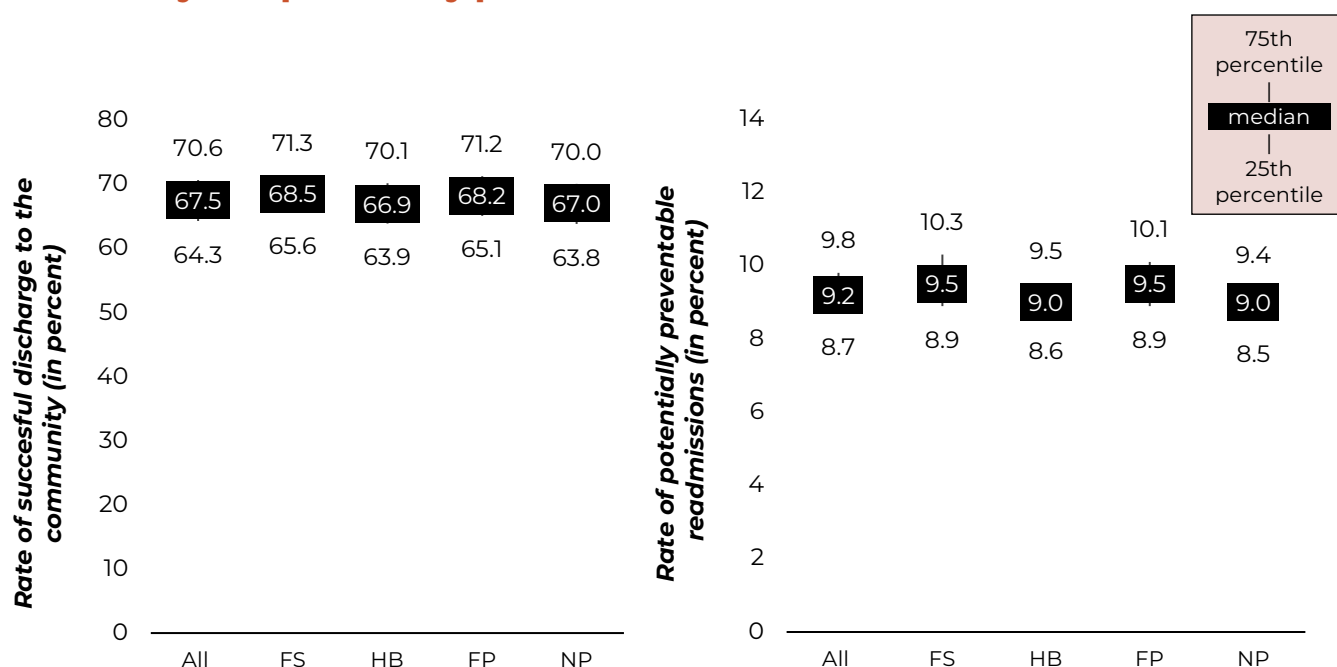
Source: MedPAC analysis of cost-report data from CMS.

> In 2024, growth in IRFs' per case payments was slow but outpaced growth in costs (data not shown); as a result, the FFS Medicare margin increased to 17.1 percent.

> FFS Medicare margins vary by IRF type. In 2024, freestanding IRFs and for-profit IRFs had substantially higher aggregate margins (25.0 percent and 24.6 percent, respectively) than hospital-based IRFs and nonprofit IRFs (4.1 percent and 2.9 percent, respectively).

> There are large differences in FFS Medicare margins by IRF size. In 2024, the aggregate FFS Medicare margin for IRFs with 10 or fewer beds was -4.9 percent. By contrast, the FFS Medicare margin for IRFs with 65 or more beds was 22.0 percent. These differences are in large measure due to economies of scale since smaller facilities have higher unit costs.

Chart 8-16 IRF quality measures: Risk-standardized rates of discharge to the community and potentially preventable readmissions in FY 2023 and FY 2024



Note: IRF (inpatient rehabilitation facility), FY (fiscal year), FS (freestanding), HB (hospital based), FP (for profit), NP (nonprofit). Data include IRFs in the 50 states and the District of Columbia and cover 24 months (FY 2023 and FY 2024 combined). The measure of “discharge to the community” includes beneficiaries discharged from an IRF to the community who did not have an unplanned hospitalization and/or die in the 31 days following discharge. Higher rates are better. The measure of “potentially preventable readmissions after discharge” is calculated as the risk-adjusted percentage of patients discharged from an IRF who were readmitted to a hospital within 30 days for a medical condition that might have been prevented. Lower rates are better. Providers with at least 25 stays in the year were included in calculating the average facility rate.

Source: Medicare IRF claims from CMS.

> In FY 2023 and FY 2024, the median facility risk-adjusted rate of discharge to the community from IRFs was 67.5 percent, similar to the 67.2 percent from FY 2022 and FY 2023 (latter data not shown).

> The median facility risk-adjusted rate of potentially preventable readmission was 9.2 percent and was higher (worse) for freestanding and for-profit providers than hospital-based and nonprofit providers.

Chart 8-17 FFS Medicare LTCH stays that qualified for the standard LTCH payment rate remained steady in FY 2024, while nonqualifying cases dropped sharply

	2019	2020	2021	2022	2023	2024	Percentage change 2023–2024
Stays (in thousands)							
All	91	78	70	60	59	47	–20%
Nonqualifying	23	19	20	19	17	5	–70
Qualifying	68	59	50	41	42	42	1
Share of qualifying	75%	76%	71%	68%	71%	89%	26
Stays per 10,000 FFS beneficiaries							
All	24	21	20	17	17	14	–17
Nonqualifying	6	5	6	6	5	2	–68
Qualifying	18	16	14	12	12	13	6
Payment per stay (in thousands)							
All	\$41	\$46	\$49	\$49	\$49	\$51	5
Nonqualifying	\$26	\$32	\$39	\$39	\$35	\$24	–32
Qualifying	\$47	\$50	\$53	\$53	\$53	\$55	3
Length of stay (in days)							
All	27	28	28	28	27	28	4
Nonqualifying	23	24	26	26	25	25	0
Qualifying	28	29	28	29	28	28	3

Note: FFS (fee-for-service), LTCH (long-term care hospital), FY (fiscal year). A “qualifying” stay is a Medicare case that meets the criteria specified in the Pathway for SGR Reform Act of 2013 for full payment under the LTCH prospective payment system. “Nonqualifying” LTCH stays are paid a (generally lower) “site-neutral” rate that is the lesser of Medicare’s acute care hospital payment for the case type or 100 percent of the costs of the stay. All counts are for stays covered by FFS Medicare and do not include stays paid for by private plans. Dollar amounts are nominal figures, not adjusted for inflation.

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

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

- >> immediately follow an acute care hospital stay that included three or more days in an intensive care unit or
- >> include mechanical ventilation for at least 96 hours.

> From January 2020 through May 2023, the application of site-neutral payment rates was waived due to the coronavirus public health emergency (PHE).

> The number of FFS Medicare-covered LTCH stays—both qualifying and nonqualifying—fell in FY 2020. Total stays continued to decline during the PHE, driven by a reduction in the number of qualifying LTCH stays, both on an absolute and per capita basis. The number of nonqualifying stays was relatively steady through the PHE.

> In FY 2024, the pattern changed, with the number of qualifying LTCH stays increasing while nonqualifying stays dropped sharply, falling about 70 percent on an absolute and a per capita basis. The drop in nonqualifying stays coincided with the reapplication of site-neutral payment rates for such cases.

During the PHE, the average LTCH payment rate per FFS stay increased as nonqualifying stays received higher LTCH payment rates. In FY 2024, payment per nonqualifying stay fell as site-neutral rates were reapplied, while payment per qualifying stay increased.

Chart 8-18 FFS Medicare LTCH stays continued to be concentrated in two MS-LTC-DRGs in FY 2024

MS-LTC-DRG	Description	Share of FFS Medicare LTCH stays					
		2019	2020	2021	2022	2023	2024
189	Pulmonary edema and respiratory failure	20.5%	19.4%	18.7%	22.9%	22.5%	24.3%
207	Respiratory-system diagnosis with ventilator support >96 hours	13.2	14.5	15.6	14.3	13.0	17.6
871	Septicemia without ventilator support >96 hours with MCC	5.5	5.1	3.9	3.2	3.1	2.7
208	Respiratory-system diagnosis with ventilator support ≤96 hours	2.7	3.1	3.5	3.3	2.7	2.6
166	Other respiratory system OR procedures with MCC	2.3	2.5	2.8	2.6	2.6	3.7
177	Respiratory infections and inflammations with MCC	1.9	3.7	9.1	3.9	2.5	2.6
981	Extensive OR procedure unrelated to principal diagnosis with MCC	2.0	2.0	2.2	2.3	2.3	3.1
539	Osteomyelitis with MCC	1.8	1.5	1.7	1.9	2.2	1.5
949	Aftercare with CC/MCC	2.2	2.0	1.9	2.0	2.1	2.4
682	Renal failure with MCC	1.7	1.7	1.4	1.5	1.7	1.7

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

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

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

> FFS Medicare inpatient stays at LTCHs continued to be concentrated in two MS-LTC-DRGs: pulmonary edema and respiratory failure (accounting for 24.3 percent of FFS Medicare stays in FY 2024) and respiratory-system diagnosis with ventilator support for more than 96 hours (accounting for 17.6 percent of stays).

> Among nonqualifying stays—stays paid under the site-neutral rate when it is in effect (see Chart 8-17)—pulmonary edema and respiratory failure was still the most common MS-LTC-DRG, accounting for about 17 percent of FFS nonqualifying stays in FY 2024 (data not shown).

Chart 8-19 LTCHs' aggregate FFS Medicare margin decreased in FY 2024

	LTCH FFS Medicare margin, by fiscal year					
	2019	2020	2021	2022	2023	2024
All LTCHs	-2.0%	3.6%	6.0%	-1.8%	-0.7%	-3.1%
Nonprofit	-12.0	-11.3	-11.7	-23.2	-21.0	-20.0
For profit	-0.1	6.0	8.5	1.4	2.3	-0.7
Margin percentile						
25th percentile	-12.8	-6.9	-4.7	-13.6	-12.2	-21.8
Median	0.2	5.0	6.1	-3.5	-1.1	-6.6
75th percentile	8.5	12.3	15.2	8.2	8.9	5.4
Facility share of qualifying stays						
High share	3.0	6.3	5.2	-1.5	0.6	-1.8
Low share	-8.2	0.3	6.4	-2.1	-1.3	-14.0

Note: LTCH (long-term care hospital), FFS (fee-for-service), FY (fiscal year). "Qualifying stay" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system. "High share" means more than 85 percent of a provider's cases were qualifying cases in the year. "Low share" means 85 percent or less of a provider's cases were qualifying cases in the year. FFS Medicare margins do not reflect federal provider relief funds that LTCHS received due to the coronavirus pandemic.

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

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

> In FY 2022, LTCHs' FFS Medicare margin declined sharply, falling to -1.8 percent, despite the continued waiver of site-neutral payment rates. In FY 2023, LTCHs' FFS Medicare margin remained negative but increased about 1 percentage point to -0.7 percent, as costs per stay declined more than payments per stay (see Chart 8-20).

> FY 2024 was the first full year after the expiration of the site-neutral payment-rate waiver, which had paid site-neutral stays the higher full payment rate, and LTCHs' FFS Medicare margin dropped to -3.1 percent.

> FFS Medicare margins varied significantly across LTCHs. For-profit LTCHs consistently had a substantially higher FFS Medicare margin than nonprofit LTCHs. The difference in the FFS Medicare margin between LTCHs with a high share of qualifying stays and a low share expanded after the waiver of site-neutral payment rates expired. High-share facilities had a margin of -1.8 percent, but low-share facilities had a margin of -14.0 percent. However, the number of low-share facilities also dropped dramatically since facilities billed far fewer nonqualifying cases than in previous years (see Chart 8-17).

Chart 8-20 LTCH PPS costs per stay increased faster than LTCHs' payments per stay in FY 2024

	Percentage change from prior fiscal year					
	2019	2020	2021	2022	2023	2024
Payments per stay						
All LTCHs	4.3%	9.2%	7.0%	0.3%	−0.2%	7.5%
Share qualifying						
LTCHs with >85% qualifying stays	0.6	7.9	11.9	1.3	2.2	−8.4
LTCHs with ≤85% qualifying stays	1.4	10.4	11.5	2.6	−1.5	−10.3
Cost per stay						
All LTCHs	5.4	3.3	4.3	8.6	−1.3	10.0%
Share qualifying						
LTCHs with >85% qualifying stays	2.1	4.2	13.2	8.5	0.1	−6.2
LTCHs with ≤85% qualifying stays	4.2	1.8	4.7	11.9	−2.2	1.0

Note: LTCH (long-term care hospital), PPS (prospective payment system), FY (fiscal year). “Qualifying stay” refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS. Data are for LTCHs that had a cost report that was valid as of our analysis and had a midpoint in the specified fiscal year. Percentages reflect changes in nominal dollars, not adjusted for inflation.

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

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

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

> In FY 2023, payments per stay grew 2.2 percent among LTCHs with a higher share (greater than 85 percent) of stays meeting the qualifying criteria for LTCH PPS standard rates, while payments per stay declined 1.5 percent, on average, among all other LTCHs. Among LTCHs with a higher share of qualifying stays, both payments and costs per stay were about \$58,000 in FY 2023 (data not shown).

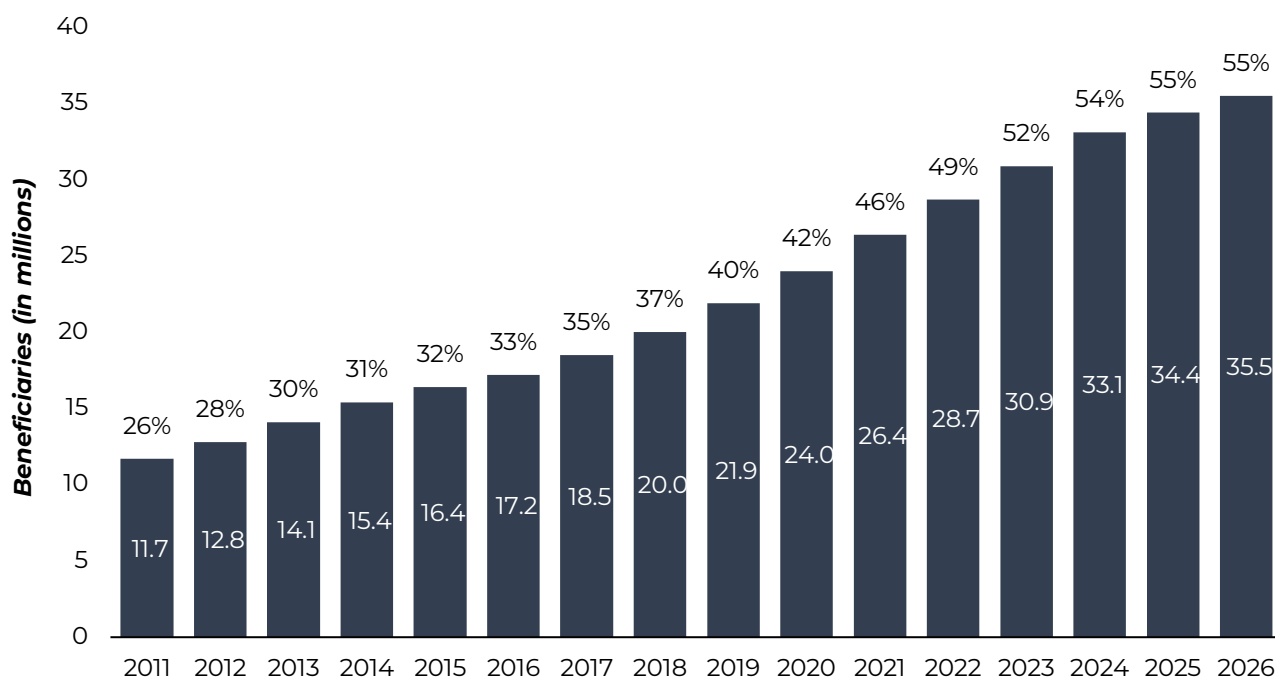
> In FY 2024, overall payments and costs per stay showed large increases, but these increases were attributable to the large drop in nonqualifying stays, which changed the overall mix of cases, as LTCHs trended toward higher-payment and higher-cost qualifying stays. LTCHs with high shares of qualifying stays saw payments drop by 8.4 percent to \$54,000, while costs dropped 6.2 percent to about \$55,000 (data not shown). The few LTCHs left with low shares of qualifying stays (roughly 15 percent of LTCHs) saw growth in cost per stay outpace growth in payments per stay.

SECTION

9

Medicare Advantage

Chart 9-1 Enrollment in MA plans, 2011–2026

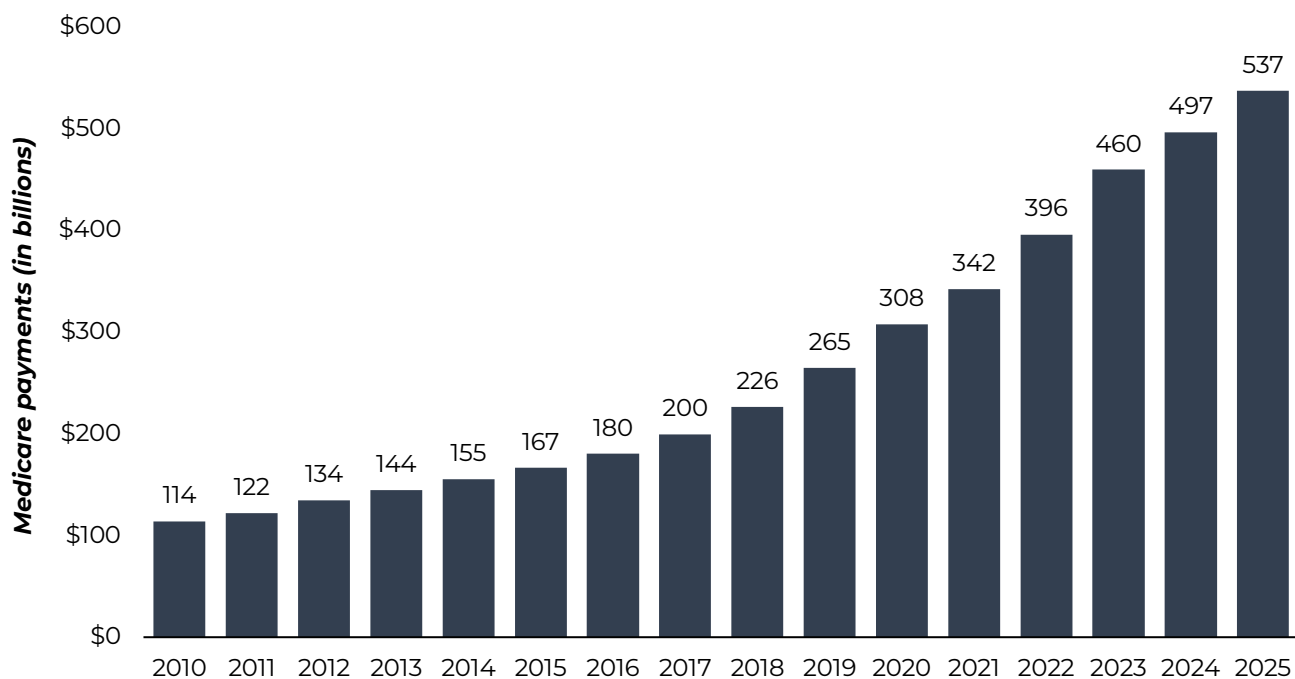


Note: MA (Medicare Advantage). Percentages indicate the share of total MA-eligible enrollment.

Source: Medicare enrollment data, February 2011–2026.

> In February 2026, enrollment in MA plans, which are paid on a risk-adjusted basis, reached 35.5 million, or 55 percent of all eligible Medicare beneficiaries (only beneficiaries enrolled in both Part A and Part B are eligible to enroll in an MA plan). An additional 1 percent of all Medicare beneficiaries with both Part A and Part B coverage are enrolled in other private plans such as cost plans and plans under the Program of All-Inclusive Care for the Elderly (PACE) (data not shown).

Chart 9-2 Medicare payments to MA plans, 2010–2025



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

Source: MedPAC estimates based on the reports of the Boards of Trustees of the Medicare trust funds, 2020–2025.

- > The Medicare program paid MA plans an estimated \$537 billion in 2025 to cover Part A and Part B services for MA enrollees.
- > From 2019 to 2025, total estimated payments to MA plans more than doubled on a nominal basis, reflecting in part the increase in the number of beneficiaries enrolled in MA (see Chart 9-1).

Chart 9-3 MA plans available to almost all Medicare beneficiaries, 2019–2026

	Share of Medicare beneficiaries living in counties with plans available					Average plan offerings per beneficiary
	CCPs			PFFS	Any MA plan	
	HMO or local PPO (local CCP)	Regional PPO	Any CCP			
2019	97	74	98	38	99	23
2020	98	73	99	36	99	27
2021	98	72	99	34	99	32
2022	99	74	99	35	99	36
2023	99	74	99	29	>99.5	41
2024	>99.5	74	>99.5	30	>99.5	43
2025	>99.5	68	>99.5	29	>99.5	42
2026	99	60	99	26	99	39

Note: MA (Medicare Advantage), CCP (coordinated-care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). These data do not include plans that have restricted enrollment (special-needs plans, employer plans) or are not paid based on MA rates (cost plans and certain demonstration plans). For 2019 through 2021, “share of Medicare beneficiaries” includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). As of 2022, “share of Medicare beneficiaries” includes only beneficiaries with both Part A and Part B coverage (i.e., MA-eligible beneficiaries).

Source: MedPAC analysis of plan bid data from CMS, 2019–2026.

> There are four types of MA plans, three of which are CCPs. Local CCPs include HMOs and local PPOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional PPOs cover one or more entire states and have networks that may be larger than those of local PPOs. CCPs accounted for 99 percent of Medicare private plan enrollees as of February 2026 (data not shown). Since 2011, PFFS plans are required to have networks in areas with two or more CCPs. In other areas, PFFS plans are not required to have networks and enrollees are free to use any Medicare provider.

> Since 2006, almost all Medicare beneficiaries have had MA plans available (not all data shown). In 2026, local CCPs are available to 99 percent of eligible Medicare beneficiaries, and regional PPOs are available to 60 percent of beneficiaries.

> The number of plans from which beneficiaries may choose in 2026 is slightly lower than recent years. In 2026, beneficiaries can choose from an average of 39 plans operating in their counties and have access to plans offered by an average of eight insurers (latter data not shown).

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

Plan type	Total enrollees (in thousands)					Percent change 2025–2026
	2022	2023	2024	2025	2026	
Local CCPs	27,878	30,291	32,667	34,142	35,295	3%
Regional PPOs	756	534	385	235	163	–31
PFFS	48	37	32	38	36	–5

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

Source: CMS health-plan monthly summary reports, February 2022–2026.

> Almost all Medicare Advantage (MA) enrollees (over 99 percent) choose local CCPs (HMOs or local PPOs), which limit or discourage use of out-of-network providers. Though network requirements may be less restrictive in regional PPOs and PFFS plans, enrollment in both types of plans declined between 2022 and 2026. From 2025 to 2026, enrollment in regional PPOs fell by 31 percent.

> Combined enrollment in the three types of plans grew by 3 percent from February 2025 to February 2026 (data not shown). Enrollment in local CCPs grew by 3 percent over the past year, and special-needs plans (SNPs) accounted for more than three-quarters of this growth (latter data not shown). Local PPO enrollment remained stable from 2025 to 2026 (data not shown). Most enrollment growth among HMOs (79 percent) occurred in SNPs (data not shown).

Chart 9-5 MA and cost-plan enrollment by state and type of plan, 2026

State or territory	All MA-eligible beneficiaries (in thousands)	Distribution (in percent) of beneficiaries by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	64,022	32%	23%	0%	0%	0%	55%
Alabama	1,052	31	35	0	0	0	66
Alaska	108	0	2	0	0	0	2
Arizona	1,429	41	15	0	0	0	56
Arkansas	644	18	32	1	0	0	51
California	6,580	50	6	0	0	0	56
Colorado	988	38	18	0	0	0	56
Connecticut	710	26	36	0	0	0	62
Delaware	237	16	19	0	0	0	35
Florida	4,964	39	22	1	0	0	62
Georgia	1,869	20	40	0	0	0	60
Hawaii	273	18	43	0	0	0	61
Idaho	385	32	17	0	0	0	49
Illinois	2,254	18	30	0	0	0	48
Indiana	1,321	22	32	1	0	0	55
Iowa	661	20	18	0	0	2	40
Kansas	560	15	21	0	0	0	36
Kentucky	930	28	31	1	0	0	60
Louisiana	895	47	14	0	0	0	61
Maine	361	37	26	0	0	0	63
Maryland	1,024	14	14	0	0	0	28
Massachusetts	1,360	25	14	0	0	0	39
Michigan	2,174	24	43	0	0	0	67
Minnesota	1,117	3	49	0	0	8	60
Mississippi	612	21	27	1	0	0	49
Missouri	1,271	34	24	0	0	0	58
Montana	251	5	26	0	1	0	32
Nebraska	366	18	18	0	0	1	37
Nevada	564	45	12	0	0	0	57
New Hampshire	322	11	23	0	0	0	34
New Jersey	1,628	12	34	0	0	0	46
New Mexico	434	25	30	0	0	0	55
New York	3,695	38	20	0	0	0	58
North Carolina	2,165	36	25	0	0	0	61
North Dakota	141	0	23	0	0	15	38
Ohio	2,412	39	22	0	0	0	61
Oklahoma	755	22	24	0	0	0	46
Oregon	898	37	21	0	0	0	58
Pennsylvania	2,791	31	27	0	0	0	58
Puerto Rico	704	95	1	0	0	0	96
Rhode Island	227	55	11	0	0	0	66
South Carolina	1,195	14	35	0	0	0	49
South Dakota	189	0	25	0	0	13	38
Tennessee	1,413	37	20	0	0	0	57
Texas	4,544	37	22	1	0	0	60
Utah	443	37	23	0	0	0	60
Vermont	156	0	13	0	0	0	13
Virgin Islands	19	0	29	0	0	0	29
Virginia	1,574	28	15	0	0	0	43
Washington	1,437	36	18	0	0	0	54
Washington, DC	82	12	29	0	0	0	41
West Virginia	428	10	47	0	0	3	60
Wisconsin	1,287	29	27	0	0	3	59
Wyoming	122	0	15	0	0	0	15

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

Source: CMS enrollment and population data, February 2026.

Chart 9-6 MA enrollment patterns, by age, dual-eligibility status, and ESRD status, June 2024

	All MA-eligible beneficiaries		FFS		MA		MA enrollment as a share of total MA-eligible category
	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	
Total	60.5	100%	27.6	100%	32.8	100%	54%
Aged (65 or older)	53.7	89	24.8	90	28.8	88	53
Under 65	6.8	11	2.8	10	4.0	12	58
No dual eligibility	49.1	81	23.8	86	25.3	77	51
Aged (65 or older)	46.1	76	22.5	81	23.6	72	51
Under 65	3.0	5	1.3	5	1.7	5	57
Full dual eligibility	8.0	13	3.1	11	4.9	15	59
Aged (65 or older)	5.3	9	1.9	7	3.4	10	62
Under 65	2.8	5	1.2	4	1.5	5	53
Partial dual eligibility	3.3	6	0.7	3	2.6	8	78
Aged (65 or older)	2.3	4	0.5	2	1.8	6	80
Under 65	1.0	2	0.3	1	0.8	2	75
Enrollment subcategories, all ages							
ESRD	0.4	1	0.2	1	0.2	1	50
Beneficiaries with partial dual eligibility							
QMB only	1.7	3	0.4	1	1.3	4	77
SLMB only	1.0	2	0.2	1	0.8	2	79
QI	0.6	1	0.1	<1	0.5	1	79

Note: MA (Medicare Advantage), ESRD (end-stage renal disease), FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualifying individual). Data for 2025 were not available as of the date of analysis. MA category does not include cost plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid Plans participating in CMS’s financial alignment demonstration. MA-eligible beneficiaries are Medicare beneficiaries with both Part A and Part B coverage. Dually eligible beneficiaries are eligible for Medicare and Medicaid. Data exclude Puerto Rico because enrollment data undercount dual-eligibility categories. In 2024, Puerto Rico had about 654,000 Medicare beneficiaries enrolled in MA plans, and about 302,000 were enrolled in dual-eligible special-needs plans. Figures may not sum to totals due to rounding.

Source: MedPAC analysis of 2024 CMS enrollment data.

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

> MA plan enrollment among dually eligible beneficiaries continues to increase. In 2024, 59 percent of fully dual-eligible beneficiaries were in MA plans (up from 58 percent in 2023), and 78 percent of partially dual-eligible beneficiaries were in MA plans (up from 76 percent in 2023) (2023 data not shown). QI and SLMB-only beneficiaries have the highest rates of MA enrollment among partially dual-eligible beneficiaries (79 percent). About 51 percent of Medicare beneficiaries who are not dually eligible for Medicaid were enrolled in an MA plan.

> A substantial share of the dually eligible population (35 percent; data not shown) are under the age of 65 and entitled to Medicare on the basis of disability or ESRD. Beneficiaries under age 65 who are fully dual eligible are less likely than aged fully dual-eligible beneficiaries to enroll in MA (53 percent vs. 62 percent, respectively). A higher share of MA enrollees are fully dual eligible compared with fee-for-service enrollees (15 percent vs. 11 percent, respectively).

> ESRD beneficiaries had higher rates of MA enrollment in 2024 (50 percent) compared with 2023 (47 percent; data not shown).

Chart 9-7 MA plan benchmarks, bids, and Medicare program payments relative to what FFS spending would have been, 2026

	Share of FFS spending in 2026		
	Benchmarks	Bids	Payments
Overall estimate	124%*	95%*	114%
Estimated before coding and selection	107*	83*	99
Estimated coding effect	+4	+3	+4
Estimated selection effect	+12	+9	+11

Note: MA (Medicare Advantage), FFS (fee-for-service). “Benchmarks” are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. The “overall estimate” of benchmarks, bids, and payments as a share of FFS spending incorporates all three components of the Commission’s methodology for comparing payments: a base comparison of MA payments with FFS spending that standardizes for differences in risk scores and geography but does not account for the effects of coding intensity and favorable selection; an adjustment to that base comparison for favorable selection; and an adjustment for coding intensity. The values in the “estimated before coding and selection” row reflect estimates using only the base comparison, without adjusting for the effects of coding intensity and favorable selection. The values in the third and fourth rows are the additive adjustments to the base comparison for the effects of coding and selection. Estimates of payments include beneficiaries enrolled in employer plans and beneficiaries with end-stage renal disease (ESRD). Components may not sum to totals due to rounding. More details on our coding and selection analyses are found in the Chapter 12 Technical Appendix of our March 2026 report to the Congress. Components of the benchmark and payment columns do not sum to the total due to rounding.

* Estimates of benchmarks and bids relative to FFS spending do not include employer plans or enrollees with ESRD because MA plans do not submit bids for those enrollees.

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

> Since 2006, plan bids have partly determined the Medicare payments that plans receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plans’ expected medical expenses, plus their administrative costs and profit that are not found in plan claims or provider incentive payments. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.

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

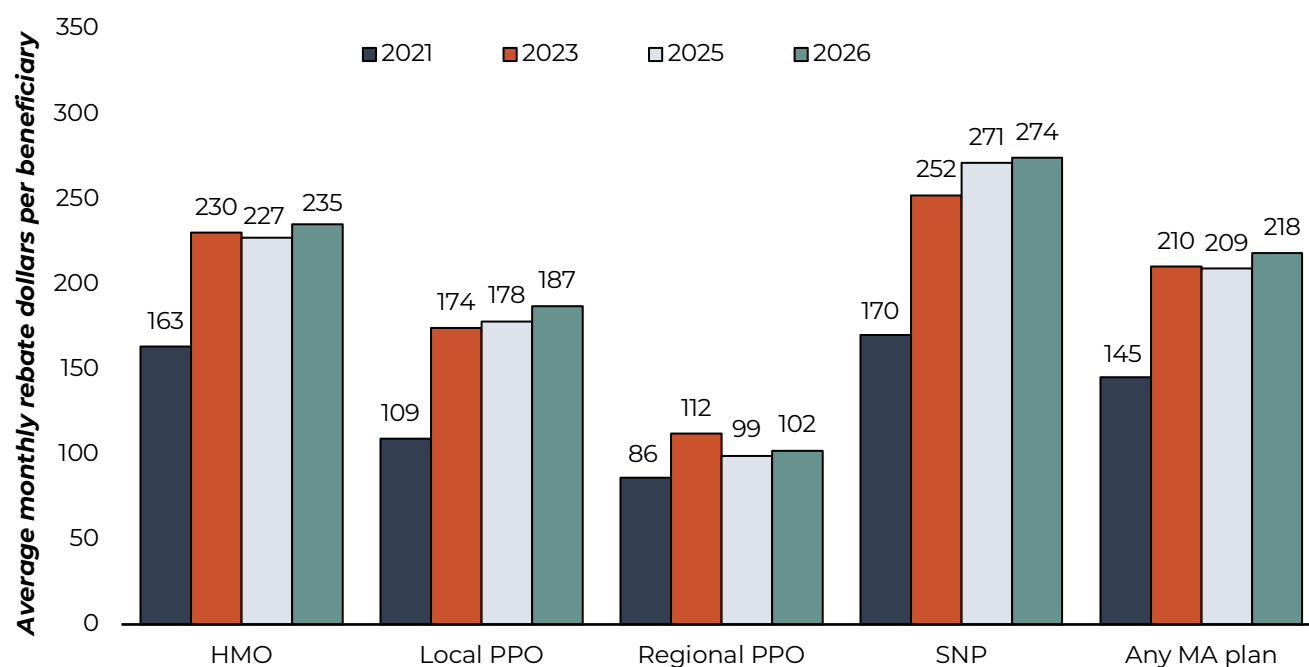
> The risk-adjustment model used by Medicare to adjust payments to plans is based on FFS data and therefore reflects the expected spending and diagnostic-coding patterns in FFS Medicare. The model accounts for differences in demographics and recorded diagnoses. The Commission’s comparisons use that risk-adjustment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

(Chart continued next page)

Chart 9-7 MA plan benchmarks, bids, and Medicare program payments relative to what FFS spending would have been, 2026 (continued)

- > If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it is typically 65 percent or 70 percent. After accounting for administrative expenses and profit, plans must return rebates to enrollees in the form of lower cost sharing, supplemental benefits not covered by FFS Medicare, or lower premiums. (If a plan's bid is above the benchmark, then the plan receives the benchmark amount as payment from Medicare and enrollees have to pay an additional premium that equals the difference; however, bidding over the benchmark is rare. For 2026, virtually all plans bid below their benchmarks.)
- > Using CMS's projections of FFS spending that do not fully account for the effects of coding or selection, we estimate that benchmarks will be an average of 107 percent of FFS spending in 2026. After accounting for the effects of coding and selection, we estimate that MA benchmarks in 2026 will average 124 percent of what FFS spending would have been for MA beneficiaries.
- > Plans have generally bid below benchmarks since the current system began, and the difference between bids and benchmarks has grown. We estimate plans' enrollment-weighted bids to be 77 percent of benchmarks in 2026 (data not shown). We estimate plans' enrollment-weighted bids to be 95 percent, on average, of FFS spending for 2026. Not accounting for coding or selection, plan bids are estimated to average about 17 percent below FFS spending.
- > Altogether, we estimate that MA payments are 14 percent higher than what Medicare would have spent to cover the same group of enrollees in FFS Medicare. That estimate incorporates adjustments for the effects of coding and selection. Before accounting for those effects, we estimate that payments to MA plans are about 99 percent of FFS spending.

Chart 9-8 Average monthly rebate payment, by plan type, 2021–2026



Note: HMO (health maintenance organization), PPO (preferred provider organization), SNP (special-needs plan), MA (Medicare Advantage). Employer group waiver plans are excluded. SNPs are a subset of HMO and PPO plans. Enrollment weights are based on months of enrollment for MA enrollees without end-stage renal disease (ESRD) since plans do not receive rebates for members with ESRD. We use data on plans' actual enrollment to calculate the enrollment weights. The enrollment data used as weights for 2025 and 2026 are adjusted using ESRD enrollment projections from plans' bids. In previous years, MedPAC used the enrollment projections from plan bids as weights for all years that were analyzed. As a result, estimates of average rebates for 2021, 2023, and 2025 reported in previous data books are slightly different from the estimates reported here. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of bid data from CMS.

- > The average rebate payment, which plans receive from Medicare to provide additional benefits that are not covered under Medicare Part A and Part B, is an important summary measure of plan generosity. Plans are awarded rebates for bidding below their benchmarks. The rebates must be returned to the plan members in the form of supplemental benefits (after accounting for plan margins and administrative costs). The extra benefits can include lower cost sharing, supplemental benefits not covered by Medicare, or lower premiums. The average rebate for all plans slightly increased on a nominal basis to \$218 per month per beneficiary for 2026.
- > HMOs have had higher rebates than PPOs because they tend to bid lower than PPOs. Average rebates for HMOs are \$235 per month per beneficiary for 2026.
- > Local PPOs' rebates have risen sharply, reaching \$187 per month per beneficiary for 2026.
- > In recent years, rebates grew particularly rapidly for SNPs, a subset of HMOs and PPOs that offer benefit packages tailored to specific populations (beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). Average rebates for SNPs rose to \$274 per month in 2026 (up from \$170 per month in 2021). The relatively large rebates for SNPs coincide with historically higher reported margins than conventional MA plans (data not shown) and higher relative coding intensity for beneficiaries who are dually eligible for both Medicare and Medicaid (see Chart 9-9).

Chart 9-9 Impact of diagnostic coding intensity on MA risk scores was larger for enrollees eligible for partial or full Medicaid benefits, 2024

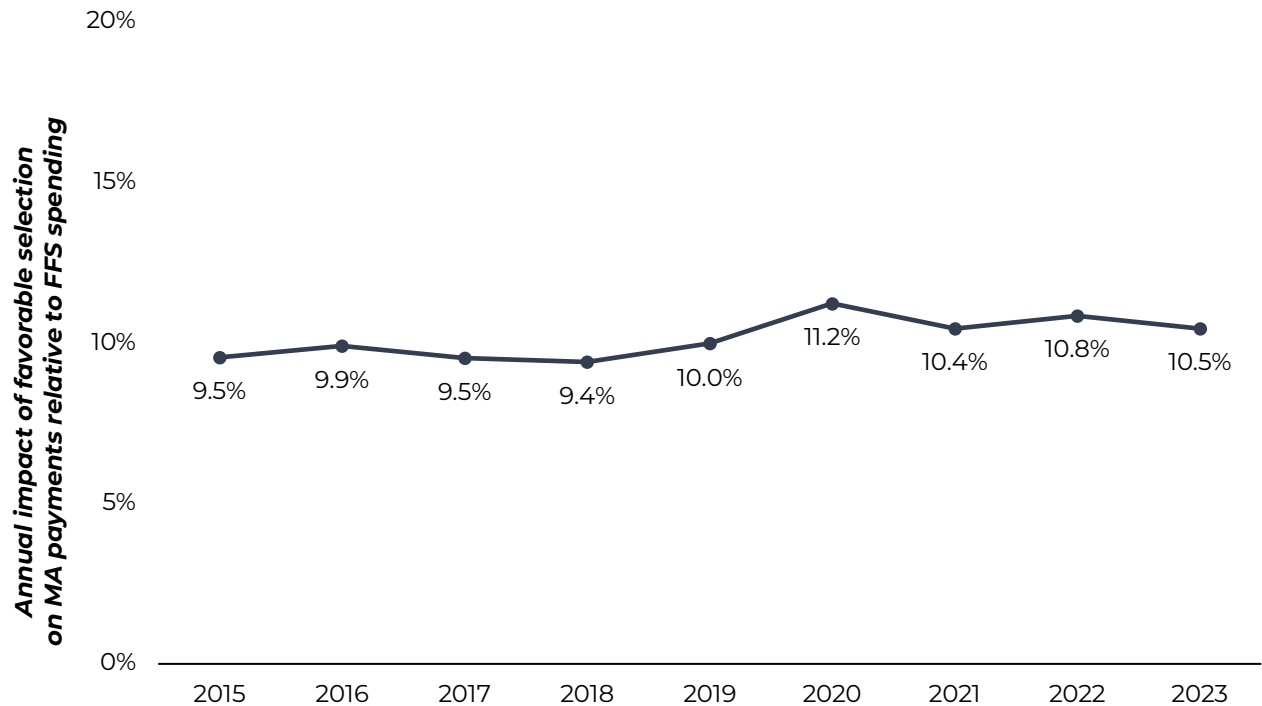
Beneficiary group	Coding intensity relative to FFS Medicare
All MA enrollees	14.7%
New enrollees	N/A
Long-term institutional	9.8
No Medicaid benefits	13.5
Partial Medicaid benefits	25.9
Full Medicaid benefits	18.4

Note: MA (Medicare Advantage), FFS (fee-for-service), N/A (not applicable). Coding-intensity estimates are reported before accounting for the application of the coding-intensity adjustment that reduced MA risk scores by 5.9 percent in 2024. Enrollees with end-stage renal disease (ESRD) are excluded. In this analysis, we first determined whether a beneficiary was a new enrollee, then we determined long-term institutional status (based on the presence of a 90-day Minimum Data Set assessment for nursing home residents), and then Medicaid eligibility. New enrollees have a risk score based only on demographic factors and therefore do not exhibit diagnostic coding intensity. Analysis uses the demographic estimate of coding intensity (DECI) method, which is the MA-to-FFS CMS hierarchical condition (HCC) risk-score ratio divided by the MA-to-FFS demographic risk-score ratio, estimated separately for each beneficiary group. MedPAC's DECI estimate for all MA enrollees accounts for differing shares of MA and FFS enrollment across the beneficiary groups by weighting MA enrollment for each group to calculate overall average MA and FFS CMS-HCC risk scores and demographic risk scores. See Appendix 12-C of our March 2026 report to the Congress for more information about our analysis using the DECI method.

Source: MedPAC analysis of CMS enrollment and risk-score files, 2023 and 2024.

- > Payments to MA plans are risk adjusted to account for differences in expected health spending. Risk adjustment increases payments to plans for enrollees with higher expected Medicare spending. An enrollee's risk score is based on demographic information and diagnoses that plans submit to CMS. Documenting additional diagnosis codes raises plan enrollees' risk scores, which increases the rebates that plans use to provide extra benefits to enrollees. Plans that document relatively more diagnosis codes therefore have a competitive advantage over other plans. In contrast, the payment policies in FFS Medicare offer relatively little incentive to code all diagnoses. This difference in coding incentives results in higher risk scores when a beneficiary enrolls in MA than if the same beneficiary had enrolled in FFS Medicare. As a result of higher MA coding intensity, the Medicare program pays more, on average, when a beneficiary enrolls in MA than it would if the same beneficiary were in FFS Medicare. This phenomenon is true both for beneficiaries who have higher-than-average and lower-than-average spending.
- > In 2024, for beneficiaries without ESRD, MA risk scores on average were an estimated 14.7 percent higher than risk scores for comparable FFS beneficiaries due to coding intensity. Those higher risk scores were partially offset by CMS's coding-intensity adjustment, which reduced MA risk scores by 5.9 percent. See Appendix 12-C of our March 2026 report to the Congress for information about coding intensity for MA enrollees with ESRD.
- > MA enrollees without ESRD who were eligible for full or partial Medicaid benefits had higher coding intensity relative to FFS than enrollees who were not eligible for Medicaid. Coding intensity for MA enrollees who were eligible for partial Medicaid benefits was 25.9 percent higher than for FFS beneficiaries who were eligible for partial Medicaid benefits. Coding intensity for MA enrollees who were eligible for full Medicaid benefits was 18.4 percent higher than for FFS beneficiaries who were eligible for full Medicaid benefits. By contrast, coding intensity for MA enrollees who were not eligible for Medicaid was 13.5 percent higher than their FFS counterparts, and coding intensity for MA enrollees with long-term institutional status was 9.8 percent higher than their FFS counterparts.

Chart 9-10 Estimated impact of favorable selection, 2015–2023



Note: MA (Medicare Advantage), FFS (fee-for-service). Estimates include both beneficiaries with and without end-stage renal disease (ESRD). Estimates for beneficiaries without ESRD were constructed using the Commission's comprehensive method for estimating favorable selection. Estimates for beneficiaries with ESRD were constructed using the Commission's simple method. Selection occurs when Medicare's risk-adjustment model overpredicts spending for MA enrollees when setting county benchmarks, even for beneficiaries with similar coding intensity. See Appendix 12-B of our March 2026 report to the Congress for more information about our analysis of favorable selection.

Source: MedPAC analysis of Medicare enrollment (2006–2023), Medicare claims spending (2007–2023), and risk-adjustment files (2007–2023).

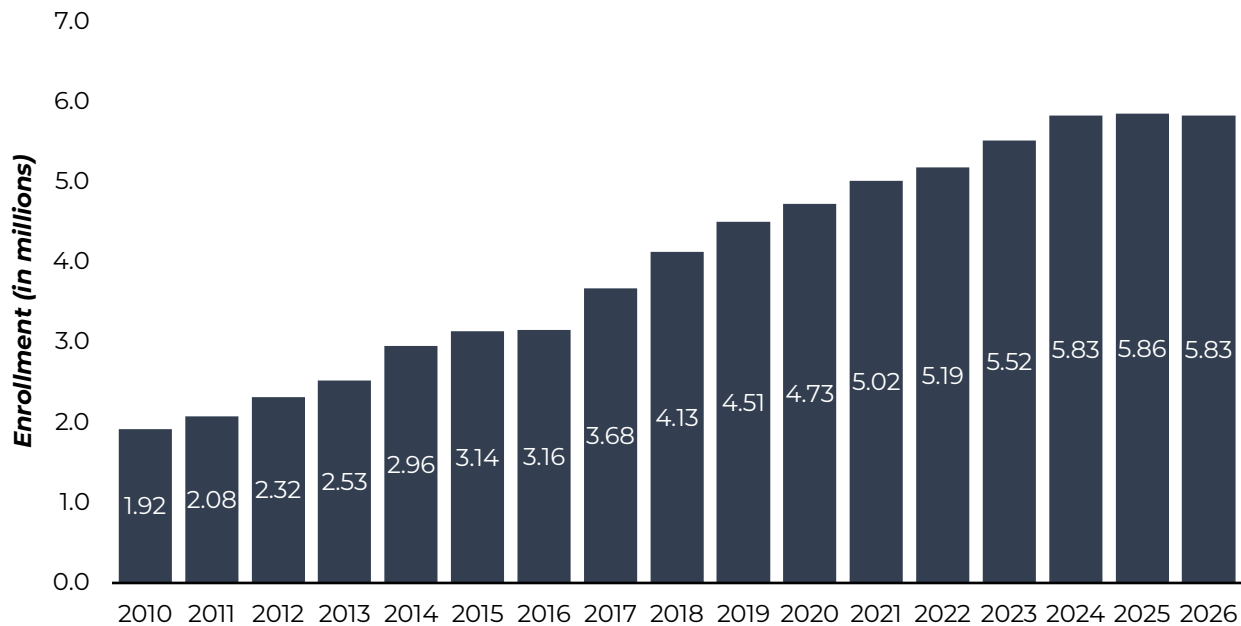
> When setting MA benchmarks and paying plans for each enrollee, CMS implicitly assumes that if MA enrollees were in FFS Medicare, their average Medicare spending would be equal to that of current FFS enrollees in the same county after adjusting for differences in risk scores. “Favorable selection” refers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

> The estimated effect of favorable selection was substantial in every year during the 2015 to 2023 period, indicating that the risk model overpredicted the spending that the MA population would have incurred in the FFS program by between about 9 percent and 11 percent.

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

> In 2023, the effect of favorable selection alone resulted in MA payments that were 10.5 percent above what would have occurred in the FFS program.

Chart 9-11 Enrollment in employer group MA plans, 2010–2026



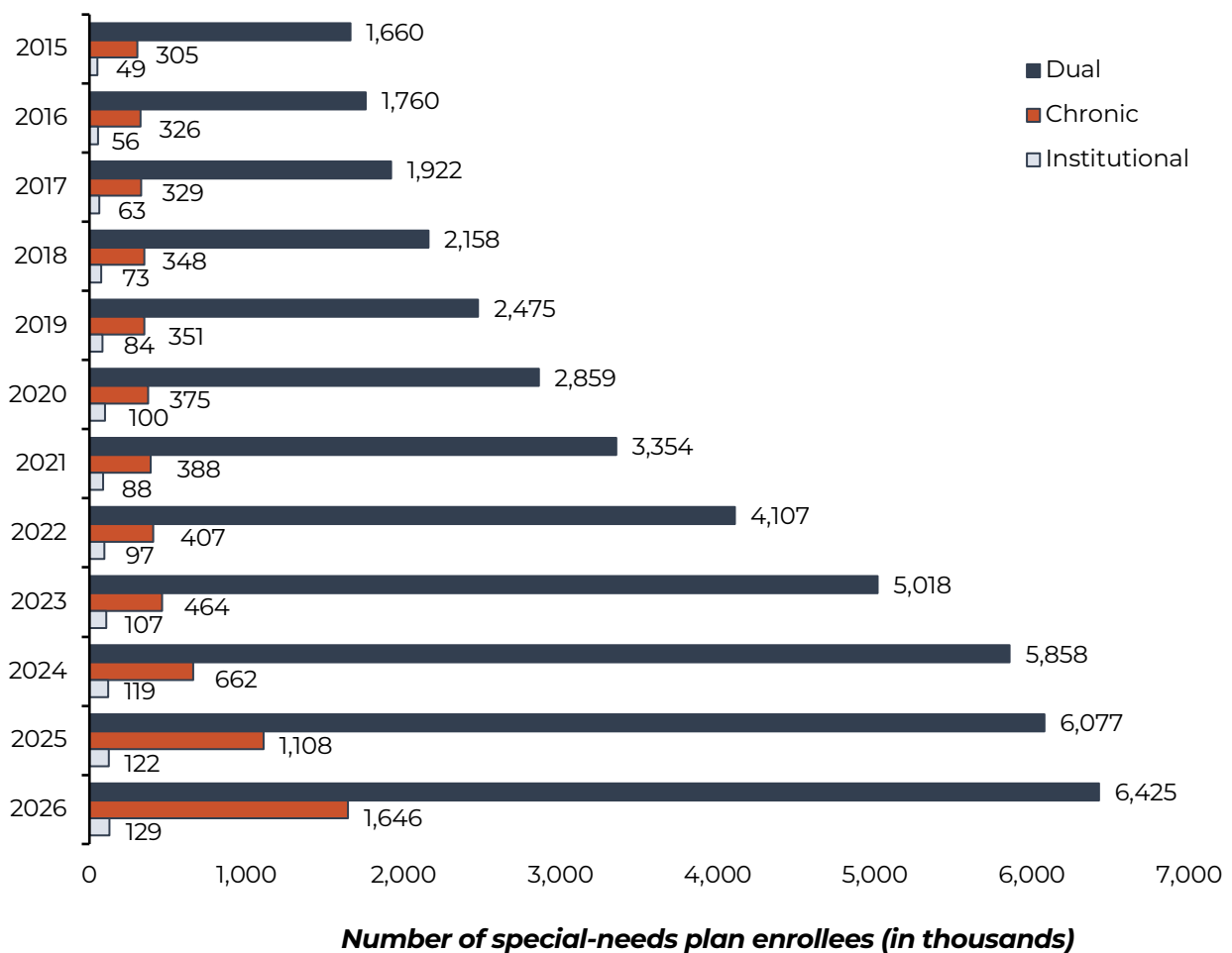
Note: MA (Medicare Advantage).

Source: CMS enrollment data, February 2010–2026.

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

> As of February 2026, about 5.8 million enrollees were in employer group plans, or about 16 percent of all MA enrollees. Employer plan enrollment decreased by less than 1 percent from 2025 but has more than doubled since 2013.

Chart 9-12 Number of enrollees in special-needs plans, 2015–2026



Source: CMS special-needs plans comprehensive reports, February 2015–2026.

- > Special-needs plans (SNPs) offer benefit packages that are tailored to specific populations. Dual-eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing home certified.
- > The vast majority of SNP enrollees are in dual-eligible SNPs (D-SNPs). Enrollment in D-SNPs has more than tripled since 2015, exceeding 6 million—about 18 percent of all MA enrollees—in 2026.
- > Enrollment in chronic condition SNPs (C-SNPs) has grown at varying rates as plan requirements have changed, but it has generally risen annually since 2015. In 2026, about 1.6 million beneficiaries (about 5 percent of all MA enrollees) were enrolled in C-SNPs.
- > Enrollment in institutional SNPs increased to its highest level ever in 2026 but accounts for less than 1 percent of all MA enrollees.
- > The number of SNPs increased by 19 percent from February 2025 to February 2026 (data not shown). D-SNPs increased by 12 percent, I-SNPs decreased by 5 percent, and the number of C-SNPs increased by 46 percent (data not shown).

Chart 9-13 **MA prior-authorization requests and outcomes, 2019–2024**

Number (in thousands)

	2019	2020	2021	2022	2023	2024
Initial determination	35,882.7	30,707.0	37,787.2	45,705.2	48,809.2	51,122.5
Fully favorable	33,855.2	29,083.7	35,705.1	42,339.3	45,700.1	47,198.1
Partially favorable	403.6	303.2	412.6	822.1	585.9	1,054.4
Adverse	1,623.9	1,320.1	1,669.6	2,543.9	2,523.1	2,870.0
Reconsideration	150.7	167.3	229.1	334.3	361.6	450.3
Fully favorable	121.7	134.3	184.2	275.0	290.8	357.8
Partially favorable	1.2	1.7	2.5	2.9	4.4	5.1
Adverse	27.9	31.3	42.3	56.4	66.4	87.4

Percentage

	2019	2020	2021	2022	2023	2024
Initial determination	100%	100%	100%	100%	100%	100%
Fully favorable	94.3	94.7	94.5	92.6	93.6	92.3
Partially favorable	1.1	1.0	1.1	1.8	1.2	2.1
Adverse	4.5	4.3	4.4	5.6	5.2	5.6
Reconsideration	0.4	0.5	0.6	0.7	0.7	0.9
Fully favorable	80.7*	80.3*	80.4*	82.3*	80.4*	79.5*
Partially favorable	0.8*	1.0*	1.1*	0.9*	1.2*	1.1*
Adverse	18.5*	18.7*	18.5*	16.9*	18.4*	19.4*

Note: MA (Medicare Advantage). Percentages may not sum to 100 due to rounding.

* Due to small numbers, these percentages reflect reconsideration outcomes as a share of reconsiderations.

Source: MedPAC analysis of CMS Part C reporting requirements and MA enrollment data, 2019–2024.

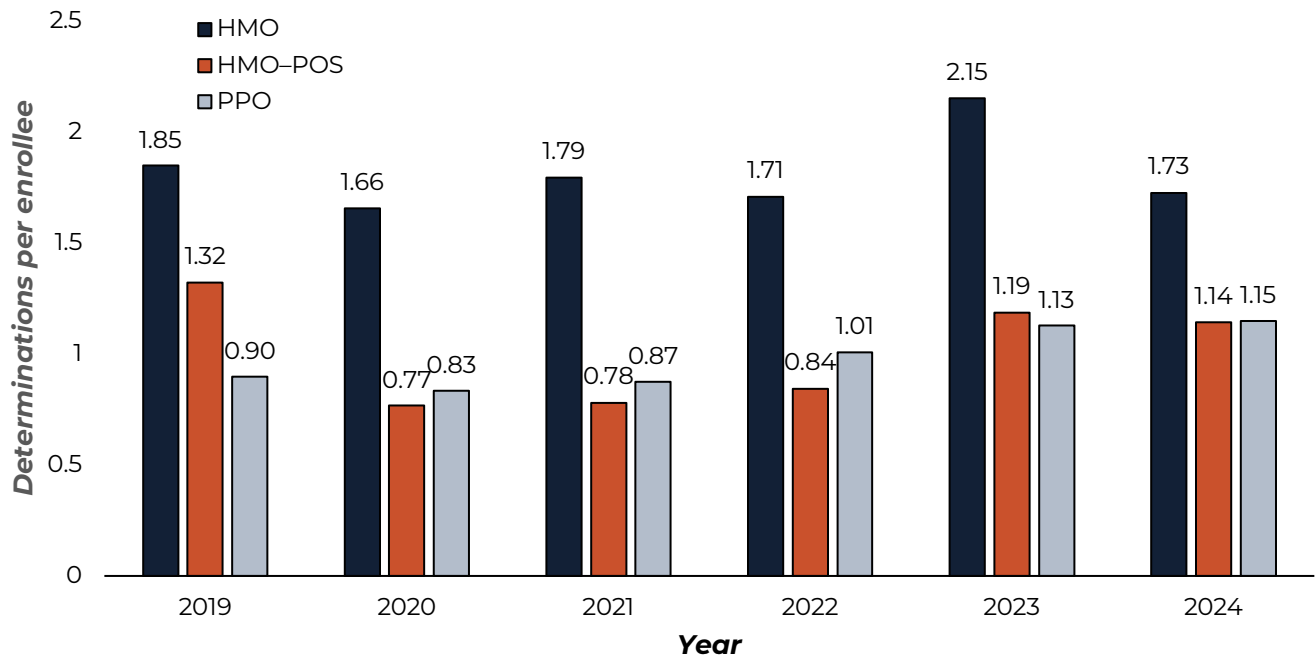
> Prior-authorization requests from enrollees and providers to MA plans have been increasing steadily over time in aggregate, from approximately 35.9 million requests overall in 2019 to over 51 million requests in 2024. The trend for per capita rate of prior authorizations has been less clear over time, with a rate of 1.49 in 2019 declining sharply to 1.25 in 2020, before rising steadily to a maximum of 1.55 in 2023 (data not shown). MA enrollees could expect about 1.38 prior authorizations per capita in 2024.

> Prior authorizations are overwhelmingly approved by MA organizations in the first instance, known as the initial determination (the outcome is fully favorable between 92 percent and 95 percent of the time, across 2019 to 2024).

> “Partially favorable” outcomes—such as a requirement for step therapy or the approval of a fraction of the number of requested days for a hospital stay—are rare, occurring in just over 1 percent of cases in 2023 but increasing to just over 2 percent of cases in 2024.

> Less than 1 percent of prior-authorization determinations are appealed. First-level appeals are reviewed by the MA organization in a process called “reconsideration.” Reconsiderations were also overwhelmingly approved. Despite a large increase in the volume of reconsiderations—from 151,000 in 2019 to 450,000 in 2024—outcomes were fully favorable in about 80 percent of cases or above in recent years.

Chart 9-14 Per capita prior-authorization requests by plan type, 2019–2024



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

Source: MedPAC analysis of CMS Part C Reporting Requirements and MA enrollment data, 2019–2024.

> Prior authorization was more common for people enrolled in HMOs than for those enrolled in HMO-POS and PPO plans. HMOs processed, on average, 1.7 determinations per enrollee in 2024, compared to 1.1 determinations per enrollee in HMO-POS and PPO plans.

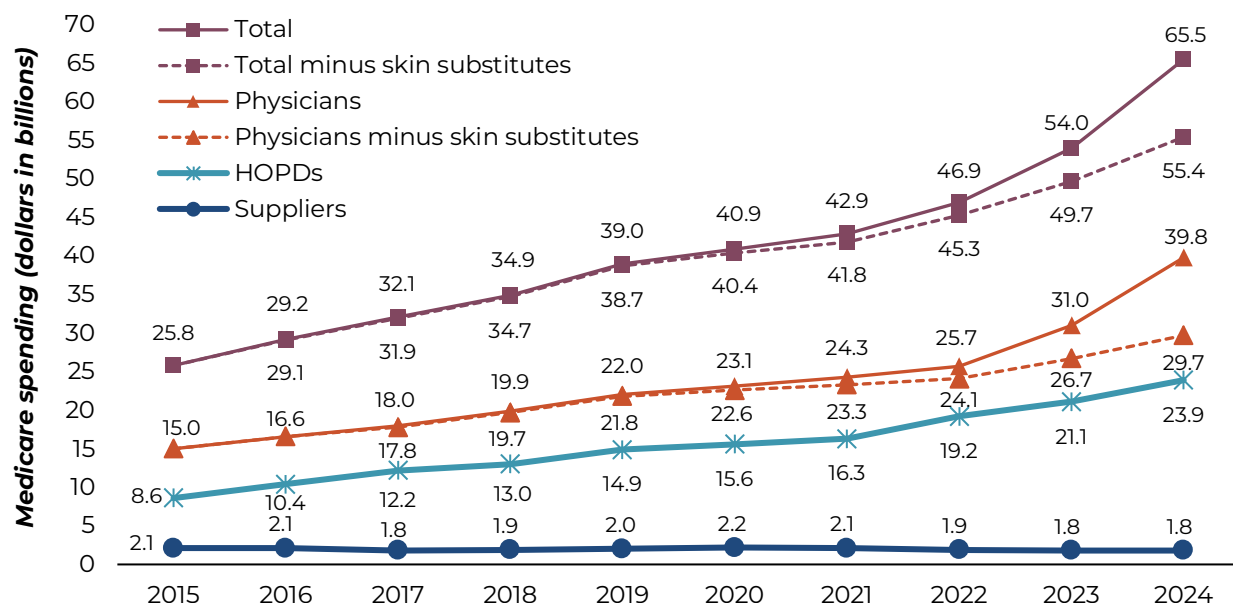
> There was a slight decline in prior authorizations per capita from 2023 across all plan types except PPOs, which exhibited a small increase from 1.13 to 1.15 initial determinations per enrollee. It is too early to determine whether this represents a peak in prior-authorization use by MA plans in 2023.

SECTION

10

Prescription drugs

Chart 10-1 FFS Medicare spending for Part B drugs, biologics, and other products furnished by physicians, hospital outpatient departments, and suppliers, 2015–2024



Note: FFS (fee-for-service), HOPD (hospital outpatient department). Data include Part B–covered drugs furnished by several provider types, including physicians, suppliers, and HOPDs, and exclude those furnished by critical access hospitals, Maryland hospitals, and dialysis facilities. “Medicare spending” includes program payments and beneficiary cost sharing for FFS beneficiaries. Data reflect all Part B drugs, whether they were paid based on the average sales price or other methods. Data exclude blood and blood products (other than clotting factor). Dollar amounts are nominal, not adjusted for inflation. The “HOPDs” spending line includes modest spending on skin substitutes; the “Suppliers” spending line does not include any spending on skin substitutes.

Source: MedPAC and Acumen analysis of Medicare claims data.

- > FFS Medicare and its beneficiaries spent about \$66 billion on separately paid Part B drugs, biologics, and other products paid under the Part B drug payment systems in 2024, with physician offices, HOPDs, and pharmacy suppliers accounting for 61 percent, 36 percent, and 3 percent of spending, respectively.
- > Between 2023 and 2024, Part B drug spending increased 21.3 percent, with spending growing most rapidly (28.4 percent) in physician offices, largely due to growth in payment for skin substitutes. Excluding Medicare spending for skin substitutes, total Part B drug spending increased 11.5 percent between 2023 and 2024, and spending growth in physician offices was similar (11.2 percent). (See Charts 10-3, 10-5, and 10-6 for more discussion on payments for skin substitutes.)
- > Between 2015 and 2024, Part B drug spending grew 10.9 percent per year on average on a nominal basis, not adjusted for inflation. Spending grew for HOPDs and physicians—at average annual rates of about 12 percent and 11 percent, respectively—while spending fell for suppliers at an average annual rate of about 2 percent. Excluding Medicare spending for skin substitutes, total Part B drug spending and spending for physicians grew at average annual rates of about 9 percent and 8 percent, respectively.

(Chart continued next page)

Chart 10-1 FFS Medicare spending for Part B drugs, biologics, and other products furnished by physicians, hospital outpatient departments, and suppliers, 2015–2024 (continued)

- > According to CMS, skin-substitute products are a heterogeneous group that includes nonautologous human cellular or tissue products, nonhuman cellular and tissue products, or biological products that are used to treat chronic wounds (e.g., venous leg ulcers and diabetic foot ulcers). In the nonfacility setting, CMS has historically paid for most skin substitutes under Medicare's Part B drug payment system based on each product's average sales price plus 6 percent (ASP + 6 percent). Beginning in 2026, CMS will no longer pay for skin substitutes that are not drugs or biologics based on ASP. Instead, CMS will pay for skin substitutes that are not drugs or biologics as incident to supplies under the physician fee schedule and the outpatient prospective payment system by grouping them into three Food and Drug Administration (FDA) regulatory categories (premarket approval applications; 510(k)s; and 361 human cells, tissues, and cellular and tissue-based products HCT/Ps) to set payment rates. CMS will continue to pay for any skin-substitute products that are approved by the FDA under Section 351 of the Public Health Service Act as biological products based on each product's ASP + 6 percent.
- > Medicare generally pays providers for Part B drugs based on the ASP + 6 percent. Between 2018 and 2021, Medicare paid a reduced rate (ASP – 22.5 percent) for hospitals participating in the 340B Drug Pricing Program. In 2022, in response to a Supreme Court ruling, CMS increased the payment rate for 340B-acquired Part B drugs to ASP + 6 percent. (CMS later made separate lump-sum payments to 340B hospitals to compensate for reduced payments received in 2018 through 2021, but those amounts are not reflected in the chart.)
- > The data exclude Part B drugs furnished by critical access hospitals (CAHs) and Maryland hospitals, which are not paid under the general Part B–drug ASP payment system. Medicare and beneficiaries spent about \$1.7 billion in CAHs and \$0.4 billion in Maryland hospitals for Part B drugs in 2024 (data not shown). Also, the data do not reflect Part B drugs paid as part of larger payment bundles (i.e., certain drugs furnished by HOPDs that are packaged into payment for other services and drugs furnished by dialysis facilities that are paid under the broader dialysis payment bundle).

Chart 10-2 Change in use of and FFS Medicare payments for separately payable Part B drugs, 2015–2024

	2015	2024	Average annual growth 2015–2024
Total payments: Separately payable Part B drugs (in billions)	\$23.0*	\$53.9*	9.9%*
Total payments: All Part B drugs excluding vaccines (in billions)	\$21.6	\$51.2	10.0
Number of beneficiaries using a Part B drug (in millions)	3.3	4.0	2.4
Average number of Part B drugs per user	1.3	1.4	0.5
Average annual payment per Part B drug	\$5,108	\$9,365	7.0
Total payments: Part B preventive vaccines (in billions)	\$1.4	\$2.7	7.6
Number of beneficiaries using a Part B vaccine (in millions)	16.2	13.2	–2.2
Average number of Part B vaccines per user	1.3	1.6	2.4
Average annual payment per Part B vaccine	\$63	\$126	8.0

Note: FFS (fee-for-service). This analysis includes Part B drugs paid based on the average sales price as well as the small group of Part B drugs that are paid based on other methods. “Preventive vaccines” refers to four Part B–covered preventive vaccines: COVID-19, influenza, pneumococcal, and hepatitis B. Data include Part B drugs furnished by physicians, hospitals paid under the outpatient prospective payment system, and suppliers and exclude data for critical access hospitals, Maryland hospitals, and dialysis facilities. Yearly figures presented in the table are rounded; the average annual growth rate was calculated using unrounded data. Dollar amounts are nominal, not adjusted for inflation.

* For purposes of this analysis, spending on separately payable Part B drugs excludes any drug that was bundled in 2015 or 2024 (i.e., drugs that were packaged under the outpatient prospective payment system in 2015 or 2024 were excluded from both years of the analysis, regardless of the setting in which the drug was administered (e.g., skin substitutes are excluded from the analysis for this reason)); drugs billed under not-otherwise-classified billing codes; and blood and blood products (other than clotting factor). Without those exclusions, Part B drug spending was \$25.8 billion in 2015 and \$65.5 billion in 2024, as shown in Chart 10-1.

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

- > Total payments by the FFS Medicare program and beneficiaries for separately payable Part B drugs increased 9.9 percent per year, on average, between 2015 and 2024 on a nominal basis.
- > Medicare spending on separately payable Part B drugs excluding Part B–covered preventive vaccines grew at a similar rate (10.0 percent per year) between 2015 and 2024.
- > Growth in the average price that Medicare Part B paid per drug was the largest factor contributing to increased spending for separately payable Part B drugs excluding vaccines between 2015 and 2024. During that period, the average annual payment per drug grew 7.0 percent per year on average, reflecting increases in the prices of existing drugs; the launch of new, higher-priced drugs; and shifts in the mix of drugs (data not shown). Growth in the number of beneficiaries using nonvaccine Part B drugs (about 2.4 percent per year on average) and the average number of Part B drugs per user (about 0.5 percent per year on average) also contributed to increased spending.
- > In 2024, Medicare and beneficiaries spent \$2.7 billion on four Part B–covered preventive vaccines (COVID-19, influenza, pneumococcal, and hepatitis B) furnished by physicians, hospital outpatient departments, and pharmacy suppliers. Between 2015 and 2024, Part B vaccine spending grew 7.6 percent per year on average. A large portion of that growth was due to higher average payments per vaccine, which grew at an average annual rate of 8 percent per year, partly reflecting higher launch prices of COVID-19 vaccines and new pneumococcal and influenza vaccines. Growth in the average number of Part B vaccines per user (2.4 percent per year on average) also contributed to vaccine spending growth. A decline in the number of FFS beneficiaries receiving Part B vaccines (2.2 percent per year on average) offset some of the spending growth, largely reflecting the decline in the FFS beneficiary population. The number FFS beneficiaries enrolled in Part B declined on average 1.9 percent per year from 2015 to 2024, based on our analysis of the 2025 Medicare Trustees’ report data.

Chart 10-3 Top 20 Part B drugs, biologics, and other products paid under Part B drug payment systems, 2024

	Drug indication(s)	2024			Percent change, 2023–2024		
		Total drug spending (billions)	Number of users	Average spending per user	Total drug spending	Number of users	Average spending per user
Keytruda	CA	\$6.0	75,900	\$78,900	10%	6%	4%
Eylea ^a	MD	3.0	329,500	9,200	–4	–4	0
Darzalex ^b	CA	2.7	28,600	93,600	17	13	3
Prolia/Xgeva	CA SE, OS	2.4	698,000	3,500	11	3	8
Opdivo	CA	1.9	27,200	71,100	1	–2	3
Vabysmo	MD	1.9	173,300	11,100	48	54	–4
Membrane Graft or Wrap	SS	1.4	10,500	137,800	325	229	29
Complete FT	SS	1.2	5,100	229,500	N/A	N/A	N/A
Orencia	AR, AI	0.9	33,500	27,800	3	2	1
Esano ACA	SS	0.9	1,900	484,400	N/A	N/A	N/A
Imfinzi	CA	0.8	14,900	56,500	14	12	2
Rituxan ^c	AR, AI, CA	0.8	60,100	13,100	–11	0	–11
Entyvio	IB	.8	19,900	38,600	6	5	0
Gammagard	IMD, NE	0.8	26,400	29,000	3	5	–1
Reblozyl	CA SE	0.8	6,500	116,400	68	58	6
Restorigin	SS	0.7	5,300	139,100	N/A	N/A	N/A
Comirnaty	VA	0.7	4,278,900	163	58	23	29
Tecentriq	CA	0.7	10,300	65,800	–10	–13	4
Ocrevus	MS	0.7	12,100	55,200	–4	–4	0
Padcev	CA	0.6	5,900	109,000	106	79	15
Top 10 drugs		22.4					
Top 20 drugs		29.7					
All Part B drugs		65.5					

Note: CA (cancer), MD (macular degeneration and other eye disorders), CA SE (cancer side effects), OS (osteoporosis), SS (skin substitutes used in wound care), N/A (not applicable), AR (arthritis), AI (autoimmune disease), IB (inflammatory bowel disease), IMD (immune deficiency), NE (neuropathy), VA (vaccine), MS (multiple sclerosis). “Total drug spending” includes Medicare program payments and beneficiary cost sharing for fee-for-service (FFS) beneficiaries. The 20 products shown in the chart reflect the Part B drug billing codes with the highest FFS Medicare expenditures in 2024. Percent change from 2023 to 2024 is not displayed for three skin substitute products - Complete FT, Esano ACA, and Restorigin - because there was little utilization in 2023 and thus the percent change in total spending between 2023 and 2024 is extremely large (i.e., greater than 1,000 percent). Data include Part B–covered drugs furnished by several provider types, including physicians, suppliers, and hospital outpatient departments but exclude those furnished by critical access hospitals, Maryland hospitals, and dialysis facilities. Data exclude blood and blood products (other than clotting factor). Components do not always sum to totals due to rounding. Dollar amounts are nominal, not adjusted for inflation.

^a Eylea includes both Eylea and Eylea HD.

^b Darzalex includes both Darzalex and Darzalex Faspro.

^c Rituxan includes Rituxan and its biosimilars and Rituxan Hycela.

Source: MedPAC and Acumen analysis of Medicare claims data.

(Chart continued next page)

Chart 10-3 Top 20 Part B drugs, biologics, and other products paid under Part B drug payment systems, 2024 (continued)

- > In 2024, Part B–covered drugs, biologics, and other products paid under Medicare’s Part B drug payment systems were billed using over 1,000 billing codes, but spending is concentrated. FFS Medicare spending (including beneficiary cost sharing) on the top 10 products accounted for \$22.4 billion, or 34 percent of total Part B drug spending. Spending on the top 20 products accounted for \$29.7 billion, or about 45 percent of total Part B drug spending.
- > The top 20 Part B drugs are concentrated in certain therapeutic areas. Seven of the top 20 drugs treat cancer, and two treat cancer side effects. The top 20 also include 3 products for arthritis, autoimmune disease, or inflammatory bowel disease and 2 products for macular degeneration.
- > Fifteen of the top 20 Part B products are biologics. One product is a vaccine (Comirnaty for COVID-19). Four products are skin substitutes (human cells, tissues, or cellular and tissue-based products) used in wound care, which Medicare paid for under the Part B drug payment systems in 2024.
- > Among the top 20 highest-expenditure Part B drugs in 2024, average total spending per user varied. The 7 drugs in the top 20 that treat cancer had average spending per user ranging from \$13,000 to \$109,000. Average spending per user ranged from \$13,000 to \$39,000 for three drugs used to treat arthritis, autoimmune disease, or inflammatory bowel disease, and from \$9,000 to \$11,000 for two drugs used to treat macular degeneration. The four skin-substitute products had the highest average spending per user among the top 20, ranging from \$138,000 to \$484,000.
- > Between 2023 and 2024, total spending increased for 16 of the top 20 Part B products and decreased for 4 products on a nominal basis (not adjusted for inflation). Five products experienced spending growth of more than 40 percent (Vabysmo, Membrane Graft or Wrap, Reblozyl, Comirnaty, and Padcev), and three products (Membrane Graft or Wrap, Complete FT, Restorigin) had substantial spending in 2024 after having little spending in 2023 (data not shown). Among the 4 products in the top 20 that experienced spending decreases in 2024, 3 products experienced a decline in the number of users and 1 product (Rituxan), which faced biosimilar competition, experienced a decline in the average payment per user.

Chart 10-4 Growth in manufacturer prices for the 20 highest-expenditure Part B drugs, biologics, and other products, 2015–2026

Top 20 products as of 2024	Average annual percentage change in average sales price, 2015–2024	Percentage change in average sales price, 2024–2025	Percentage change in average sales price, 2025–2026
Keytruda	2.5% ^a	3.4%	3.7%
Eylea ^b	–1.4	–7.1	–4.6
Darzalex ^c	4.0 ^a	5.9	8.4
Prolia/Xgeva ^b	6.2	9.8	6.5
Opdivo ^c	2.6 ^a	3.9	4.0
Vabysmo	–4.2 ^a	–2.3	–6.7
Membrane Graft or Wrap	N/A ^d	–20.8	N/A ^e
Complete FT	N/A ^d	N/A ^d	N/A ^e
Orencia	3.0	1.5	2.2
Esano ACA	N/A ^d	N/A ^d	N/A ^e
Imfinzi	1.7 ^a	3.9	2.8
Rituxan ^b	1.0	–3.1	–2.6
Entyvio ^a	3.3 ^a	–1.8	–1.4
Gammagard	1.3	5.2	1.8
Reblozyl	3.3 ^a	3.3	3.6
Restorigin	N/A ^d	–33.9	N/A ^e
Comirnaty ^f	N/A ^d	18.9	8.0
Tecentriq	1.9 ^a	3.8	6.4
Ocrevus	0.8 ^a	–1.6	0.9
Padcev	7.8 ^a	4.6	0.2
Consumer Price Index for All Urban Consumers	3.1	3.0	2.4

Note: N/A (not available). Growth rates are calculated for average sales price (ASP) from first quarter to first quarter of each year and for the Consumer Price Index for All Urban Consumers (CPI–U) from January to January of each year. For products that launched after 2015, the table displays average annual ASP growth between the earliest year that a first-quarter payment rate was available for the product. ASP at the billing-code level is calculated using the publicly available Part B drug payment-rate data on CMS’s website. Price growth is nominal, not adjusted for inflation.

^a Payment-rate data were not available over the full time period, so average annual growth was calculated over a shorter period: from 2016 to 2024 (Keytruda, Opdivo, Entyvio); 2017 to 2024 (Darzalex); 2018 to 2024 (Tecentriq, Ocrevus); 2020 to 2024 (Imfinzi); 2021 to 2024 (Reblozyl, Padcev); or 2023 to 2024 (Vabysmo).

^b Indicates that the product is an originator biologic that has experienced biosimilar entry by the first quarter of 2026. ASP trends are for the originator product only.

^c For Darzalex and Opdivo, ASP trend displayed is for the intravenous product.

^d Published payment rate was not available for the period. First published payment rate was the fourth quarter of 2023 (Membrane Graft or Wrap, Comirnaty); first quarter of 2024 (Restorigin); second quarter of 2024 (Complete FT); and second quarter of 2025 (Esano ACA).

^e Effective the first quarter of 2026, skin substitutes are no longer paid under the Part B drug payment system (unless the product is approved as a biologic by the Food and Drug Administration under Section 351 of the Public Health Service Act).

^f For Comirnaty, a preventive COVID-19 vaccine paid at 95 percent of the average wholesale price, the table displays the percentage change in the actual payment rate, not ASP.

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

(Chart continued next page)

Chart 10-4 Growth in manufacturer prices for the 20 highest-expenditure Part B drugs, biologics, and other products, 2015–2026 (continued)

- > Medicare pays for most Part B drugs at a rate of 106 percent of the average sales price. ASP is the average price realized by the manufacturer for sales to most U.S. purchasers, net of rebates, discounts, and price concessions, with certain exceptions. For biologics, biosimilars, and brand-name drugs with no generic competitors, Medicare Part B pays each product an ASP-based rate under the product's own billing code, essentially paying whatever price the manufacturer establishes. For brand drugs with generic competitors, Medicare Part B assigns both the brand product and its generic equivalents to the same billing code and pays 106 percent of a volume-weighted ASP.
- > Beginning January 1, 2023, manufacturers of Part B single-source drugs, biologics, and biosimilars are required to pay Medicare a quarterly rebate if their product's ASP grows faster than inflation. Beginning April 2023, beneficiary cost sharing for products that incur a rebate is based on the lower, inflation-adjusted ASP. Certain types of products are excluded from the policy (e.g., low-cost drugs, preventive vaccines, drugs experiencing a shortage or supply-chain disruption, and biosimilars meeting certain criteria). Whether a product incurs an inflation rebate is determined based on cumulative growth in the payment rate between a base period (generally from July 1, 2021) and a given quarter and how that compares with growth in the CPI-U over a specified period. Data on trends in ASP and CPI-U in this chart do not replicate the CMS rebate calculation.
- > Among the top 20 highest-expenditure products as of 2024, 16 products had a published payment rate under Medicare's Part B drug payment systems in the first quarter of 2026. Among those 16 products, 12 products experienced a price increase on a nominal basis between 2025 and 2026, with 8 of those products' prices increasing faster than the CPI-U over that period.
- > Between January 2025 and 2026, Darzalex (a product for multiple myeloma), Comirnaty (a COVID-19 vaccine), Prolia/Xgeva (a product for osteoporosis and cancer side effects), and Tecentriq (a product for several cancers) experienced the largest price growth, 8.4 percent, 8.0 percent, 6.5 percent, and 6.4 percent, respectively.
- > Between the second quarter of 2023 and the first quarter of 2026, 3 of the top 20 products—Padcev (from the second quarter of 2023 through the first quarter of 2026), Prolia/Xgeva (from the third quarter of 2023 through the first quarter of 2026) and Darzalex (in the fourth quarter of 2025)—had reduced beneficiary cost sharing as a result of the ASP inflation rebate (data not shown).
- > Between January 2025 and 2026, four products experienced a price decrease: Eylea, Vabysmo, Rituxan, and Entyvio. Two of these products have biosimilar competitors available as of 2026 (Eylea and Rituxan), and the other two products (Vabysmo and Entyvio) treat conditions for which other reference biologics with biosimilars are available.

Chart 10-5 Top 10 Part B therapeutic classes of drugs, biologics, and other products, 2024

	Total FFS Medicare payments in 2024 (in billions)	Percentage change in total FFS Medicare payments 2023–2024
Antineoplastics	\$22.7	12%
Skin substitutes	10.1	128
Ophthalmic agents	6.2	17
Endocrine agents	4.7	9
Hematological agents	3.8	13
Immune globulin agents	2.9	12
Vaccines	2.8	15
Analgesics, anti-inflammatories, or antipyretics	2.7	–0.4
Neuromuscular and musculoskeletal therapy agents	1.7	22
Respiratory therapy agents	1.6	5

Note: FFS (fee-for-service). Therapeutic classes are ranked in order of 2024 total fee-for-service (FFS) Medicare spending. This analysis includes Part B drugs, biologics, and other products paid based on the average sales price as well as the small group of Part B drugs that are paid based on other methods. "Total FFS Medicare payments" includes Medicare program payments and beneficiary cost sharing for FFS beneficiaries. "Vaccines" includes both preventive vaccines (e.g., influenza) and other vaccines when used to treat an injury or direct exposure to a disease (e.g., hepatitis A). Dollar amounts are nominal, not adjusted for inflation.

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

> In 2024, 10 drug therapeutic classes accounted for roughly 90 percent of total FFS Medicare spending for Part B drugs, biologics, and other products (calculation based on total Part B spending of \$65.5 billion reported in Chart 10-1).

> Total spending by therapeutic class was somewhat concentrated. In 2024, antineoplastics (products used to treat cancer) accounted for 35 percent, and the top three classes—antineoplastics, ophthalmic agents, and skin substitutes—accounted for 60 percent of total Medicare spending.

> Between 2023 and 2024, the growth in total spending for six therapeutic classes—antineoplastics, ophthalmic agents, hematological agents, immune globulin agents, vaccines, and neuromuscular and musculoskeletal therapy agents—exceeded the average annual growth across all Part B products excluding Medicare spending for skin substitutes (which averaged 11.5 percent during this period on a nominal basis (shown in Chart 10-1)).

> Total spending on separately payable skin substitutes has been growing rapidly. Between 2023 and 2024, Medicare spending on skin substitutes grew by 128 percent, from \$4.4 billion (not shown) to \$10.1 billion. This therapeutic class increased in rank by total Medicare spending from 10th in 2021, 7th in 2022, 3rd in 2023, and 2nd in 2024. Preliminary claims data for calendar year 2025 (claims processed through Week 20 of 2026) indicate that spending on skin substitutes was \$18.4 billion that year, an 82 percent increase compared with the prior year's level (see Chart 10-6) and that this therapeutic class ranked second in total 2025 spending (data not shown).

Chart 10-6 Change in FFS Medicare spending for skin-substitute products, 2024–2025

	2025			2024		
	Total spending (billions)	Number of users	Average spending per user	Total spending (billions)	Number of users	Average spending per user
All skin-substitute products	\$18.4	68,400	\$270,000	\$10.1	67,700	\$150,000
Top 10 skin-substitute products, 2025						
Amchoplast	\$3.0	4,400	\$681,000	\$0.1	100	\$501,000
Tri membrane wrap	1.8	4,100	451,000	*	*	*
Simplimax	1.6	3,500	455,000	*	*	*
Xcell amnio matrix	1.5	5,300	276,000	0.03	200	127,000
AmnioAMP-MP	1.1	2,900	395,000	0.2	1,300	132,000
Complete FT	0.8	4,700	167,000	1.2	5,100	230,000
Neostim TL	0.6	4,000	156,000	0.3	1,200	228,000
Membrane Graft or Wrap	0.6	3,800	153,000	1.4	10,500	138,000
Acapatch	0.6	2,200	261,000	N/A	N/A	N/A
Amnio burgeon xplus membrane and xplus hydromembrane	0.4	800	564,000	N/A	N/A	N/A

Note: FFS (fee-for-service), N/A (not available). “Total spending” includes Medicare program payments and beneficiary cost sharing for FFS beneficiaries. Spending and utilization estimates for 2024 are based on claims with a 2024 date of service processed through Week 26 of 2025. Spending and utilization estimates for 2025 are preliminary, based on claims with a 2025 date of service processed through Week 20 of 2026. Yearly figures presented in the chart are rounded, but data for average spending per user were calculated using unrounded data. Per CMS, skin-substitute products include nonautologous human cellular or tissue products, nonhuman cellular and tissue products, or biological products that are used to treat chronic wounds (Centers for Medicare & Medicaid Services. 2024. LCD—Skin substitute grafts/cellular and tissue-based products for the treatment of diabetic foot ulcers and venous leg ulcers (L39828). Baltimore, MD: CMS). Dollar amounts are nominal, not adjusted for inflation. * Medicare use and spending data cannot be reported because the value is based on fewer than 11 observations in that year.

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

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

> Before 2026, under the physician fee schedule, skin-substitute products were generally paid average sales price (ASP) + 6 percent. Under the outpatient prospective payment system before 2026, payment for skin-substitute products that do not qualify for pass-through status are packaged into the payment for the associated skin-substitute application procedure into two groups: (1) high-cost skin-substitute products and (2) low-cost skin-substitute products. The above spending data do not reflect skin-substitute products paid as part of larger payment bundles (i.e., skin-substitute products furnished by hospital outpatient departments that are packaged into payment with other services and products).

> Spending on skin-substitute products is growing rapidly. Between 2021 and 2025, total spending increased in aggregate by roughly 1,690 percent from \$1.0 billion to \$18.4 billion on a nominal basis (not all data shown). Most recently, spending on skin-substitute products increased by nearly 82 percent from \$10.1 billion in 2024 to an estimated \$18.4 billion in 2025 (spending based on preliminary claims with a 2025 date of service processed through Week 20 of 2026). In 2025, skin-substitute products accounted for 23 percent of all Part B drug spending (data not shown).

(Chart continued next page)

Chart 10-6 Change in FFS Medicare spending for skin-substitute products, 2024–2025 (continued)

- > Spending on skin-substitute products per user is also substantial and growing. In 2025, estimated average spending per user for the top 10 products ranged from \$153,000 to \$681,000, and estimated average cost-sharing liability per user ranged from \$31,000 to \$138,000 (data not shown) (2025 estimates based on preliminary claims data for calendar year 2025 (claims processed through Week 20 of 2026)). By comparison, in 2024, average spending per user for these products ranged from \$127,000 to \$501,000, and average cost sharing per user ranged from \$26,000 to \$102,000 (data not shown). Across all skin-substitute products, average spending per user increased from \$150,000 in 2024 to an estimated \$270,000 in 2025.
- > Providers' adoption of some skin-substitute products has occurred rapidly. For example, between 2024 and 2025, the number of users grew from fewer than 11 beneficiaries to 3,500 beneficiaries for Simplicmax and from fewer than 11 beneficiaries to about 4,100 beneficiaries for Tri membrane wrap.
- > Use of and spending on skin-substitute products is shifting over time. For example, in 2024, the three leading products as measured by total spending were Membrane Graft or Wrap (\$1.4 billion), Complete FT (\$1.2 billion), and Esano ACA (\$0.9 billion). In 2025, spending for these three products declined to \$0.6 billion, \$0.8 billion, and \$0.4 billion, respectively (spending data for Esano ACA not shown). Between 2024 and 2025, both the price and use of these three products declined. Between October 2024 and 2025, the ASP payment rate declined by 6 percent for Membrane Graft or Wrap and 28 percent for Complete FT (ASP data are not available for Esano ACA in 2024), while the annual number of beneficiaries who were furnished each product in 2024 and 2025 declined by 63 percent, 8 percent, and 22 percent, respectively (data not shown).
- > The increase in spending on skin-substitute products is associated with an increase in unique billing codes—Healthcare Common Procedure Coding System Level II coding-request applications—for newly developed skin-substitute products. The number of skin-substitute products (as identified by a unique billing code in Medicare claims data) increased from 93 in 2021 to 101 in 2022, 113 in 2023, and 138 in 2024 (data not shown). In 2025, the number of products declined slightly to 125 (data not shown).

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

	First biosimilar entry	Percentage change in originator biologic's payment rate		Biosimilar's payment rate as a percentage of originator biologic's payment rate (2026 Q1)	Biosimilar market share (2025 Q3)
		In 10 years before biosimilar entry	Since biosimilar entry (through 2026 Q1)		
Neupogen and biosimilars	2015 Q3	71%	0%	25%–100%	89%
Remicade and biosimilars	2016 Q4	54	–61	73–86	28
Neulasta and biosimilars	2018 Q3	117	–69	80–132	66
Procrit/Epogen and biosimilars	2018 Q4	35	–37	98	49
Avastin and biosimilars	2019 Q3	42	–9	32–52	88
Herceptin and biosimilars	2019 Q3	69	–31	11–75	84
Rituxan and biosimilars	2019 Q4	68	–21	18–40	63
Lucentis and biosimilars	2022 Q3	–31	–76	92–127	7
Actemra and biosimilars	2024 Q2	63	–7	75–100	8
Eylea and biosimilars	2024 Q4	–16	–7	113	31
Stelara and biosimilars	2025 Q1	N/A	–2	66–346	16
Soliris and biosimilars	2025 Q2	6	0	70–94	1
Prolia and biosimilars	2025 Q3	93	1	96	2

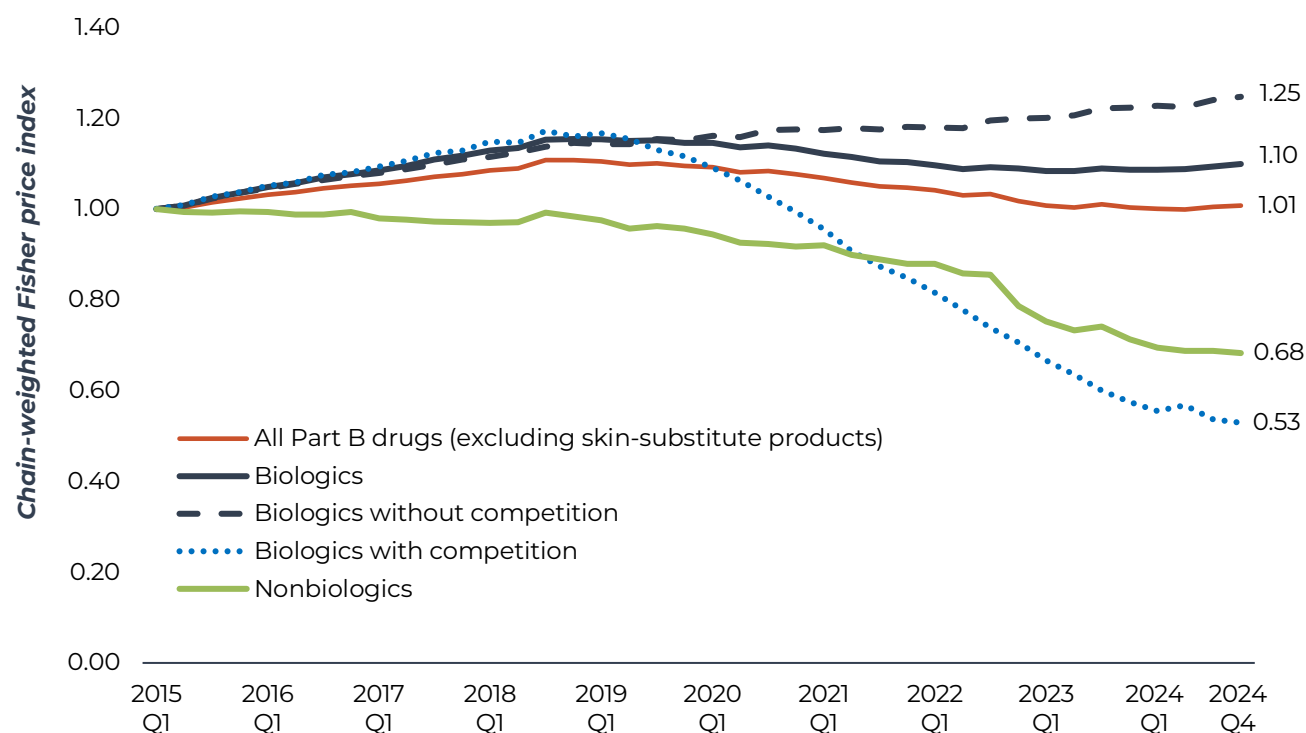
Note: Q1 (first quarter), Q3 (third quarter), Q4 (fourth quarter), Q2 (second quarter), N/A (not available). An originator biologic is a drug product derived from a living organism. A biosimilar product is a follow-on product that is approved by the Food and Drug Administration (FDA) based on the product being highly similar to the originator biologic. The biosimilars included in the analysis are Granix, Nivestym, Releuko, Zarxio, and Nypozi for originator Neupogen; Inflectra, Renflexis, and Avsola for originator Remicade; Fulphila, Fylnetra, Nyvepria, Stimufend, Udenyca, and Ziextenzo for originator Neulasta; Retacrit for originator Procrit/Epogen; Alymsys, Mvasi, Vegzelma, and Zirabev for originator Avastin; Ontruzant, Herzuma, Ogivri, Trazimera, Kanjinti, and Hercessi for originator Herceptin; Truxima, Ruxience, and Riabni for originator Rituxan; Byooviz and Cimerli for originator Lucentis; Tyenne and Tofidence for originator Actemra; Pavblu for originator Eylea; Steqeyma, Yesintek, Wezlana, Pyzchiva, Selarsdi, and Otulfi for originator Stelara; Epysqli and Bkmv for originator Soliris; and Jubbonti/Wyost for originator Prolia. Although Granix is not a biosimilar in the U.S. (because it was approved under the standard FDA approval process for new biologics), we include it here because it was approved as a biosimilar to Neupogen in Europe and it functions as a competitor to Neupogen in the U.S. market. We do not include Herceptin Hylecta and Rituxan Hycela (subcutaneous forms of the products) because these products do not currently have FDA-approved biosimilars. “First biosimilar entry” reflects the earliest market date for a product approved by the FDA as a biosimilar to the originator biologic. Growth in payment rates is nominal, not adjusted for inflation.

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

(Chart continued next page)

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

- > Under Part B, Medicare pays for an originator biologic at 106 percent of its own ASP. For biosimilars, Medicare pays 100 percent of the biosimilar's ASP + 6 percent or 8 percent of the originator product's ASP. Per the Inflation Reduction Act of 2022 (IRA), for five years beginning October 2022, existing biosimilars and new biosimilars receive an 8 percent add-on as long as the biosimilar's ASP does not exceed the originator's ASP.
- > Biosimilar entry has generated savings for Medicare. Pricing patterns and biosimilar uptake vary across products. For the nine biologics that had biosimilars on the market in 2024 (excluding Eylea because its biosimilar did not have a billing code until the second quarter of 2025), Medicare spending on Part B originator biologics and their biosimilars declined on a nominal basis by about 9 percent, from \$3.7 billion in 2023 to \$3.4 billion in 2024 (data not shown). The decline in spending between 2023 and 2024 reflects a mix of dynamics including a reduction in the number of users (by about 4 percent to 18 percent across the nine products and their biosimilars except Neupogen, Rituxan, and Actemra) and in average payments per user (by about 1 percent to 15 percent across these products except Avastin, Neulasta, and Actemra) (data not shown).
- > For some products, biosimilars are priced substantially below originators, and biosimilar uptake has driven savings. For example, lower-priced biosimilars now account for 84 percent or more of the market share for Neupogen, Avastin, and Herceptin and 63 percent of the market share for Rituxan. These four originator products have reduced their prices only minimally or modestly (0 percent, 9 percent, 31 percent, and 21 percent, respectively) since biosimilar entry. Each of these products had at least one biosimilar on the market with a Medicare payment that was roughly 70 percent or 90 percent below the originator's payment rate.
- > In a few cases, originator biologics have reduced their prices by more than 60 percent in response to biosimilar entry. Originator Remicade's payment rate has declined 61 percent, originator Neulasta's payment rate has declined 69 percent, and originator Lucentis's payment rate has declined 76 percent since biosimilar entry. As of the first quarter of 2026, Remicade had some biosimilar competitors on the market that were priced modestly lower (roughly 27 percent below the originator's payment rate). In contrast, originators Neulasta and Lucentis had lower Medicare payment rates than some of their biosimilar competitors as of the first quarter of 2026. Originators Remicade and Lucentis had the majority of market share as of the third quarter of 2025.
- > Although biosimilar competition has resulted in reduced prices for originator biologics relative to the products' prices at the time of biosimilar entry, nearly all of these originator biologics experienced substantial price increases before biosimilar entry. With the exception of Lucentis and Eylea, the originator biologics' cumulative growth in payment rates over the 10 years before biosimilar entry ranged from 6 percent to 117 percent. In contrast, Lucentis and Eylea's payment rates declined 31 percent and 16 percent, respectively, in the 10 years before biosimilar entry.

Chart 10-8 Postlaunch price indexes for Medicare Part B drugs, 2015–2024

Note: Q1 (first quarter), Q4 (fourth quarter). The indexes are Fisher price indexes and reflect postlaunch price growth for individual Part B–covered drug products, measured in nominal terms (not adjusted for inflation). A product is defined as a Part B drug billing code (referred to as a Healthcare Common Procedure Coding System billing code). Each Part B single-source drug, biologic, and biosimilar receives its own Part B drug billing code, while brand drugs with generic competitors are grouped together in the same billing code. The price index is different from the change in the aggregate average annual payment per Part B drug (Chart 10-2), which reflects changes in the prices of existing products, higher launch prices of new products, and shifts in utilization across products. The “biologics with competition” line represents originator biologics that faced biosimilar entry by the fourth quarter of 2024 (including the period before biosimilar entry that falls between 2015 and 2024) and their biosimilars. Skin-substitute products are excluded from this analysis.

Source: Acumen analysis for MedPAC.

> The Part B price indexes reflect growth in the Medicare payment rate (generally the average sales price (ASP) + 6 percent) at the individual product level, which is a measure of average postlaunch price growth for Part B drugs. The price index is different from the change in the aggregate average annual payment per Part B drug (see Chart 10-2), which grew more than 7.0 percent per year on average between 2015 and 2024 and reflects a broader set of dynamics (including changes in the price of existing products, higher launch prices of new products compared with older products, and shifts in utilization across products).

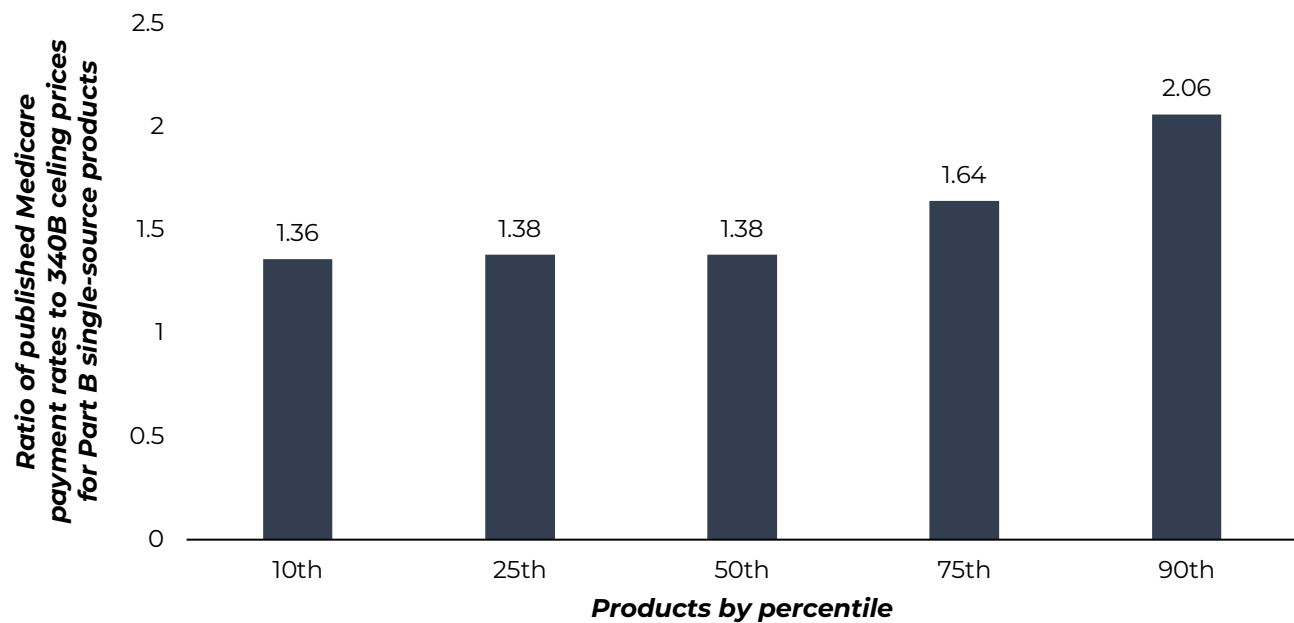
> Measured by the change in the ASP within individual Part B–covered drugs, the prices of Part B–covered drugs (excluding skin-substitute products) rose by an average of 1 percent cumulatively between 2015 and 2024 (index of 1.01) on a nominal basis. The overall price index for Part B drugs rose between 2015 and the first quarter of 2019 from 1.00 to 1.11, before declining through the end of 2024 to 1.01, driven by a decline in the nonbiologics’ price index, coupled with the decline in the price index for biologics with biosimilar competition.

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Chart 10-8 Postlaunch price indexes for Medicare Part B drugs, 2015–2024 (continued)

- > The price index for biologics increased cumulatively by 10 percent (index of 1.10) between 2015 and 2024, reaching a high of just over 1.15 in the third quarter of 2018 through the first quarter of 2020 and declining to 1.08 by the first quarter of 2023 before rising again to 1.10 by the fourth quarter of 2024. Pricing trends differ for biologics that face biosimilar competition and biologics that do not. While the price index for biologics without biosimilar competition increased continuously between 2015 and 2024 (reaching 1.25 by the fourth quarter of 2024), the price index for biologics with biosimilar competition increased between 2015 and the third quarter of 2018 (price index of 1.17), then subsequently declined to 0.53 by the fourth quarter of 2024. The decline in the price index for biologics that face biosimilar competition may be, in part, attributable to the first entry of biosimilar products for several originator biologics in 2018 and 2019 (Chart 10-7).
- > The price index for nonbiologics declined 32 percent (index of 0.68) between 2015 and 2024, which in part reflects patent expiration and generic entry for some of these products (e.g., pemetrexed). The design of the ASP payment system spurs price competition among generics and their associated brand products by paying them the same rate under a combined billing code.

Chart 10-9 Comparisons of Medicare payment rates and 340B ceiling prices for Part B single-source products, 2024



Note: Medicare payment rates reflect published presequencer payment rates (which include the Medicare program payment and beneficiary cost sharing) posted on CMS's website. Ceiling prices in the 340B program are MedPAC estimates based on analysis of data from the Medicaid rebate program. For each Part B drug billing code (which we refer to as "product"), the ratio of the Medicare payment rate to 340B ceiling price reflects the median ratio across the four quarters of 2024. First, we estimate 340B ceiling prices at the national drug code (NDC) level. Next, to estimate the average 340B ceiling price for each Part B drug billing code, we weight the 340B ceiling prices for each NDC associated with a given billing code by the manufacturer's reported market-wide utilization for the NDC (which is reported as part of the manufacturer's submission of average sales price (ASP) data to CMS and includes Medicare and non-Medicare use of the NDC). All data for this analysis are aggregated to ensure confidentiality. Estimates are for 211 single-source drugs, biologics, or biosimilars billed by 340B hospitals under Medicare Part B and exclude drugs with generic competition. Estimates include outpatient prospective payment system (OPPS) hospitals that bill Medicare Part B for drugs acquired under the 340B program. We exclude hospitals paid under alternate payment systems (e.g., critical access hospitals, cancer hospitals, Indian Health Service hospitals, and Maryland hospitals). The 211 Part B single-source products were identified by focusing on Part B single-source products with at least \$2 million in Part B OPPS payments (Medicare program payments and beneficiary cost sharing) for drugs acquired under the 340B program in 2024 and for which we were able to estimate 340B ceiling prices. Estimates do not reflect subceiling discounts, if any.

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

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

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

(Chart continued next page)

Chart 10-9 Comparisons of Medicare payment rates and 340B ceiling prices for Part B single-source products, 2024 (continued)

- > To provide a sense of how Medicare payment rates compare with costs for 340B-purchased drugs, we estimated 340B ceiling prices for 211 Part B–covered single-source drugs, biologics, and biosimilars. These 211 single-source products accounted for 97 percent of Medicare spending on separately payable Part B drugs acquired under the 340B program by OPPS hospitals in 2024.
- > Across the 211 single-source Part B products, Medicare payments exceeded the 340B ceiling price by 38 percent for the median product in 2024. The Medicare payment rate exceeded the 340B ceiling price by between 38 percent and 64 percent for half of products (25th percentile to 75th percentile) and by 106 percent or more for 10 percent of products (90th percentile).
- > In 2024, fee-for-service Medicare and beneficiaries paid \$15.9 billion for the 205 Part B–covered single-source products acquired under the 340B program by OPPS hospitals, while the estimated cost of these products at 340B ceiling prices was \$11.0 billion (data not shown). Thus, aggregate payments exceeded 340B ceiling prices by an estimated 44 percent (\$4.9 billion) in 2024. Ceiling-price costs equated to approximately ASP – 28 percent for the 211 single-source products in aggregate that year.
- > The results of our analysis comparing the 2024 Medicare payment rate and 340B ceiling price at the billing-code level are similar to results from our 2023 analysis (data not shown). For example, in 2023, across 200 single-source products, we found that (1) for the median product, the Medicare payment rate exceeded the 340B ceiling price by 38 percent; (2) for half of products, the Medicare payment rate exceeded the ceiling price by 38 percent to 59 percent (25th percentile to 75th percentile); and (3) 10 percent of products had a Medicare payment rate at least 108 percent above the 340B ceiling price (90th percentile). We estimated that in 2023 aggregate payments exceeded 340B ceiling prices by an estimated 45 percent (\$4.3 billion). Ceiling price costs equated to approximately ASP – 28 percent across the 200 products.
- > Drug manufacturers can choose to sell products to 340B entities for prices lower than 340B ceiling prices (referred to as “subceiling prices”). Data are not available to determine the frequency of covered entities obtaining subceiling prices and the magnitude of subceiling prices. If 340B providers receive subceiling discounts for some products, discounts could be larger than we estimated.

Chart 10-10 Part D enrollment by plan type, 2016–2025

	2016	2024	2025	Average annual growth rate 2016–2025
Total Medicare enrollment, in millions	57.1	68.0	69.5	2.2%
Part D enrollment, in millions				
Part D plans	41.0	54.1	55.8	3.5
Non-Medicare employer plans under the RDS*	<u>1.9</u>	<u>0.8</u>	<u>0.7</u>	–10.5
Total Part D	42.9	54.9	56.5	3.1
<i>Share of Medicare enrollees with Part D</i>	<i>75%</i>	<i>81%</i>	<i>82%</i>	
LIS enrollment				
PDPs	8.0	4.7	4.3	–6.6
MA–PDs	<u>4.0</u>	<u>9.4</u>	<u>9.3</u>	9.8
Total LIS	12.0	14.0	13.6	1.4
<i>Share of LIS enrollees in MA–PDs</i>	<i>34%</i>	<i>67%</i>	<i>68%</i>	
<i>Share of Part D plan enrollees with LIS</i>	<i>29%</i>	<i>26%</i>	<i>24%</i>	
EGWPs (PDPs and MA–PDs)	6.6	8.9	9.2	3.7
<i>EGWP share of total Part D enrollment</i>	<i>16%</i>	<i>17%</i>	<i>16%</i>	
Non-EGWP Part D plans, in millions				
PDPs	20.1	18.1	18.2	–1.1
MA–PDs	14.3	27.1	28.4	8.0
<i>Share of non-EGWP plan enrollees in MA–PDs</i>	<i>42%</i>	<i>60%</i>	<i>61%</i>	

Note: RDS (retiree drug subsidy), LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), EGWP (employer group waiver plan). A beneficiary was classified as “LIS” if that individual received Part D’s LIS in the month used for the analysis; similarly, while a beneficiary may be enrolled in both a PDP and an MA–PD during the year, that individual was classified into the type of plan in which they were enrolled during the month analyzed. Not all components sum to their respective totals due to rounding. The average annual growth rate is calculated on unrounded numbers.

Source: MedPAC analysis of monthly Medicare enrollment files from CMS and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2025, 82 percent of Medicare beneficiaries were enrolled in Part D plans or had prescription drug coverage through employer-sponsored plans that received Medicare’s RDS. That share is up from 75 percent in 2016. (The RDS is a tax-free subsidy paid to an employer who remains the primary payer of their retirees’ creditable drug coverage when the enrollees’ drug costs fall within a specified range of spending.)

> Between 2016 and 2025, the number of enrollees receiving the LIS grew modestly (1.4 percent per year, on average) compared with the number of non-LIS enrollees (about 4.3 percent per year, on average; data not shown). Faster enrollment growth among non-LIS enrollees has resulted in a decline in the share of Part D enrollees who receive the LIS. In 2025, 24 percent of Part D enrollees received the LIS, a decrease from 29 percent in 2016. More than two-thirds of LIS beneficiaries are now in MA–PDs, a reversal from 2016 when two-thirds were in PDPs.

> Employer and union health plans continue to be important sources of drug coverage for Medicare beneficiaries under Part D. In 2025, 9.2 million Medicare beneficiaries (16 percent of Part D plan enrollees) were in plans (including PDPs and MA–PDs) set up by employers or unions for their retirees. Under these EGWPs, Medicare is the primary payer for basic drug benefits, and typically the employer offers wraparound coverage.

> In 2025, among non-EGWP plans, 28.4 million enrollees (61 percent) were in MA–PDs and 18.2 million enrollees (39 percent) were in stand-alone PDPs. Over the 2016 to 2025 period, enrollment in PDPs declined slightly, while enrollment in MA–PDs rose by an annual average of 8.0 percent.

Chart 10-11 Characteristics of Part D plan enrollees, 2024

	All Medicare	Part D plans	Plan type		Subsidy status	
			PDP	MA-PD	LIS	Non-LIS
Beneficiaries* (in millions)	67.8	54.1	23.1	31.1	14.5	39.7
Percent of all Medicare	100%	80%	34%	46%	21%	59%
Sex						
Male	46%	44%	43%	44%	41%	44%
Female	54	56	57	56	59	56
Race/ethnicity						
White, non-Hispanic	72	72	81	66	51	80
Black, non-Hispanic	11	11	7	14	21	7
Hispanic	9	9	5	12	17	6
Asian	4	4	3	5	7	3
Other	4	4	4	3	4	3
Age (years)**						
<65	11	11	9	13	32	4
65–69	27	25	24	26	24	26
70–74	23	24	24	23	17	27
75–79	18	18	19	17	12	21
80+	21	21	23	20	16	23

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]), LIS (low-income subsidy). Components may not sum to totals due to rounding.

* Figures are based on enrollment as of April 2024.

** Age as of April 2024.

Source: MedPAC analysis of enrollment data from CMS.

> In 2024, 54.1 million Medicare beneficiaries (80 percent) were enrolled in Part D plans. Less than half (23.1 million) were enrolled in stand-alone PDPs, and the rest were enrolled in MA-PDs (31.1 million). About 14.5 million enrollees received Part D's LIS.

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

Chart 10-12 Changes over time in the parameters of the Part D defined standard benefit, 2017–2026

	2017	2025	2026	Average annual change 2017–2026
Deductible	\$400	\$590	\$615	4.9%
Initial coverage limit	3,700	N/A	N/A	N/A
Annual out-of-pocket threshold	4,950	2,000	2,100	–9.1
Total covered drug spending at annual out-of-pocket threshold:				
Enrollees eligible for manufacturers’ coverage-gap discount	8,071	\$6,230	\$6,555	–2.3
Other enrollees	7,425	\$6,230	\$6,555	–1.4
Cost sharing for LIS beneficiaries*:				
Copay for generic/preferred multisource drugs	3.30	4.90	5.10	5.0
Copay for other prescription drugs	8.25	12.15	12.65	4.9

Note: N/A (not applicable), LIS (low-income subsidy). In 2026, under Part D’s defined standard benefit, the enrollee pays the deductible and then 25 percent of covered drug spending until total covered drug spending reaches the out-of-pocket (OOP) coverage limit. The amounts shown of total covered drug spending at the spending thresholds are for individuals who have no source of supplemental coverage and an average mix of brand and generic spending. Cost sharing paid by most sources of supplemental coverage did not count toward these thresholds before 2025, but starting that year, the value of plans’ supplemental coverage does count toward enrollees’ OOP limit. Above the OOP limit, before 2024, non-LIS enrollees paid 5 percent coinsurance or copay amounts set in law, whichever was greater. As of 2025, the standard benefit has been redesigned such that there are now fewer benefit phases and a single coverage limit—the OOP cap—above the deductible. Dollar amounts are nominal figures, not adjusted for inflation. Cost-sharing amounts shown for LIS beneficiaries are for individuals with income between 100 percent and 150 percent of the federal poverty level (FPL). Cost-sharing for full-benefit beneficiaries with income at or below 100 percent of the FPL is capped at \$4.90.

Source: CMS Office of the Actuary.

> In 2026, Part D’s defined standard benefit has a \$615 deductible, and enrollees pay 25 percent coinsurance on covered drugs until they reach the \$2,100 threshold in annual OOP spending. (The total dollar amount of drug spending at which a beneficiary reaches the OOP threshold varies from person to person, depending on the mix of brand-name and generic prescriptions filled and whether they have supplemental coverage. CMS estimates that in 2026, a person who does not receive Part D’s LIS and has no supplemental coverage would, on average, reach the threshold at \$6,555 in total drug spending.) Beneficiaries who do not receive the LIS are eligible for a 10 percent manufacturers’ discount on brand prescriptions in the initial coverage phase. Enrollees with drug spending that exceeds the annual OOP threshold no longer pay any cost sharing in the catastrophic phase. Manufacturers now must pay 20 percent of costs for brand-name drugs and biologics in the catastrophic phase, and Medicare pays 20 percent for such products and 40 percent for generics. Plan sponsors are now responsible for the remaining 60 percent. CMS updates most parameters of this defined standard benefit structure each year by the annual change in average total drug expenses of Medicare beneficiaries enrolled in Part D. (See MedPAC’s March 2026 report for more details.)

> Within certain limits, sponsors may offer Part D plans that have the same actuarial value as the defined standard benefit but a different benefit structure. For example, a plan may use tiered copayments rather than 25 percent coinsurance or have no deductible but use cost-sharing requirements that are equivalent to a rate higher than 25 percent (see Chart 10-18). Defined standard benefit plans and plans that are actuarially equivalent to the defined standard benefit are both known as “basic benefits.” Once a sponsoring organization offers one plan with basic benefits within a prescription drug–plan region, it may also offer up to two plans with enhanced benefits—basic and supplemental coverage combined.

Chart 10-13 Characteristics of stand-alone Medicare PDPs available for general enrollment, 2025–2026

	2025				2026			
	Plans		Enrollees as of April 2025		Plans		Enrollees as of April 2026	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	464	100%	18.2	100%	360	100%	18.6	100%
Type of plan								
Benchmark	90	19	5.7	31	88	24	5.7	31
Nonbenchmark	374	81	12.5	69	272	76	12.9	69
Type of benefit								
Defined standard	0	0	0.0	0	1	<0.5	<0.1	<0.05
Actuarially equivalent	196	42	7.8	43	182	51	7.8	42
Enhanced	268	58	10.5	57	177	49	10.8	58
Type of deductible								
Zero	79	17	2.8	16	40	11	0.7	4
Reduced	76	16	1.4	8	71	20	3.4	18
Defined standard*	309	67	14.0	77	249	69	14.5	78
Some formulary tiers not subject to a deductible	197	42	7.8	43	142	39	10.4	56

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer group waiver plans and plans offered in U.S. territories. “Actuarially equivalent” includes both actuarially equivalent standard and basic alternative benefits. “Enhanced” refers to plans with basic plus supplemental coverage. Not all components sum to their respective totals or to 100 percent due to rounding.

* The deductible for the defined standard benefit was \$590 in 2025 and is \$615 in 2026.

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

> Plan sponsors are offering 360 stand-alone PDPs that are available to all fee-for-service enrollees in 2026 compared with 464 in 2025—a decrease of 22 percent, after a decrease of 35 percent the year prior. Total enrollment in PDPs increased for the second year in a row to 18.6 million beneficiaries in 2026 from 18.2 million in 2025, after five prior years of decline, though PDP enrollment as a share of all Part D enrollment remained at an historical low of 40 percent as non-employer group waiver plan (EGWP) enrollment continues to shift to MA-PDs (see Charts 10-10 and 10-11). (Enrollment among EGWP beneficiaries, on the other hand, increased significantly among PDPs in 2026, but their enrollment is not included here.)

> For 2026, for the first time since 2012, the share of PDP offerings including enhanced benefits (basic plus supplemental coverage) is less than half (49 percent); this share had been between 60 percent and 62 percent from 2019 to 2024 and fell slightly in 2025 (2019 to 2024 data not shown). The share of PDP enrollees in enhanced plans, however, increased slightly from 57 percent in 2025 to 58 percent in 2026.

> In 2026, the share of enrollees in plans with no deductible fell to 4 percent, down from 16 percent in 2025, as the share of plans (and enrollees in such plans) with a reduced deductible increased and the share of enrollees with a defined standard benefit remained relatively flat at 78 percent. The share of enrollees in plans designating certain formulary tiers not subject to the deductible increased significantly from 43 percent in 2025 to 56 percent in 2026. If, for example, a PDP used such a designation for preferred generic drugs, an enrollee would pay just the plan’s cost sharing for that tier rather than the full cost of the prescription up to the amount of the deductible.

Chart 10-14 Characteristics of conventional MA-PDs, 2025–2026

	2025				2026			
	Plans		Enrollees as of April 2025		Plans		Enrollees as of April 2026	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	3,246	100%	20.2	100%	2,967	100%	20.4	100%
Type of plan								
Local HMO	1,846	57	12.2	60	1,730	58	12.3	61
Local PPO	1,363	42	8.0	39	1,205	41	7.9	39
PFFS	12	0	0.0	0	11	0	0.0	0
Regional PPO	25	1	0.1	1	21	1	0.1	0.5
Type of drug benefit								
Defined standard	27	1	0.1	<0.5	27	1	<0.1	<0.5
Actuarially equivalent	29	1	0.1	1	39	1	0.2	1
Enhanced	3,190	98	20.0	99	2,901	98	20.1	98
Type of drug deductible								
Zero	1,183	36	7.9	39	440	15	3.5	17
Reduced	1,362	42	9.9	49	1,519	51	11.7	57
Defined standard*	701	22	2.4	12	1,008	34	5.2	25
Some formulary tiers not subject to a deductible	2,027	62	12.2	61	2,497	84	16.8	82

Note: MA-PD (Medicare Advantage Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). The MA-PDs and enrollment described here exclude employer group waiver plans, plans offered in U.S. territories, 1876 cost plans, special-needs plans, and Part B-only plans. Components may not sum to totals due to rounding. “Actuarially equivalent” includes both actuarially equivalent standard and basic alternative benefits. “Enhanced” refers to plans with basic plus supplemental coverage.

* The defined standard benefit’s deductible was \$590 in 2025 and is \$615 in 2026.

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

> Sponsors are offering 2,967 conventional MA-PDs in 2026 compared with 3,246 in 2025 (8.6 percent fewer plans), the third straight year of declines. The vast majority of MA plans combine medical benefits with prescription drug benefits under Part D. Enrollment in conventional MA-PDs grew slightly from 20.2 million in 2025 to 20.4 million in 2026 but declined as a share of all Part D enrollees, from 45 percent in 2025 to 43 percent in 2026 (latter data not shown).

> For the second year in a row, the number of MA-PD plans offered as HMOs decreased modestly, from 1,846 in 2025 to 1,730 in 2026, though HMO plans remain the dominant type of MA-PD, making up 58 percent of all offerings and enrolling 61 percent of MA-PD beneficiaries. Local PPO offerings and enrollment remained relatively flat from 2025.

> In 2026, 98 percent of conventional MA-PDs have enhanced benefits compared with 49 percent of PDPs (see Chart 10-13). In 2026, those MA-PDs enroll 98 percent of all conventional MA-PD beneficiaries.

> This year, the second for the new Part D benefit design, plan sponsors again made significant changes to the structure of their plan offerings. In 2026, just 15 percent of conventional MA-PDs have no deductible for their Part D benefits, down from 36 percent in 2025 and 66 percent in 2024, and those plans attracted just 17 percent of conventional MA-PD enrollees, down from 77 percent in 2024, though still far more than the 4 percent of PDP enrollees in such plans (2024 data not shown) (see Chart 10-13). While far fewer MA-PD enrollees have a plan with no deductible at all, relative to recent years, the share in plans that have some cost-sharing tiers of their formularies not subject to a deductible again increased significantly from 61 percent in 2025 to 82 percent in 2026.

Chart 10-15 Characteristics of SNPs, 2025–2026

	2025				2026			
	Plans		Enrollees as of April 2025		Plans		Enrollees as of April 2026	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	1,417	100%	7.0	100%	1,701	100%	7.9	100%
Type of SNP								
Chronic condition	373	26	1.1	15	544	32	1.6	21
Dual eligible	884	62	5.8	83	1,003	59	6.1	78
Institutionalized	160	11	0.1	2	154	9	0.1	2
Type of drug benefit								
Defined standard	890	63	5.1	73	242	14	0.7	8
Actuarially equivalent	23	2	<0.5	1	226	13	0.5	6
Enhanced	504	36	1.9	27	1,233	72	6.7	85
Type of drug deductible								
Zero	205	14	0.4	6	164	10	0.6	7
Reduced	182	13	0.8	12	296	17	1.6	20
Defined standard*	1,033	73	5.7	82	1,241	73	5.7	73
Some formulary tiers not subject to a deductible	252	18	0.9	13	1,271	75	6.6	83

Note: SNP (special-needs plan). The plans and enrollment described here exclude employer group waiver plans and plans offered in U.S. territories. Components may not sum to totals due to rounding. “Actuarially equivalent” includes both actuarially equivalent standard and basic alternative benefits. “Enhanced” refers to plans with basic plus supplemental coverage.

* The defined standard benefit’s deductible was \$590 in 2025 and \$615 in 2026.

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

> The number of SNPs (MA–PDs designed for certain groups of beneficiaries) has grown rapidly in recent years, more than doubling since 2020 to 1,701 in 2026 (2020 data not shown). SNP enrollment has grown similarly, reaching 7.9 million in 2026, accounting for 17 percent of all Part D enrollees, up from 8 percent in 2020 (latter data not shown).

> SNPs for individuals who are dually eligible for Medicare and Medicaid (D–SNPs) continue to have the greatest enrollment, though their share of SNP enrollees declined again as more enrollees chose a plan specifically designated for individuals with certain chronic conditions (C–SNPs). In 2026, 59 percent of SNPs were D–SNPs, and they enrolled 78 percent of all SNP enrollees, down from 83 percent last year. The number of C–SNPs grew again to 544 in 2026; these SNPs now enroll 21 percent of SNP enrollees, up from 10 percent in 2024 (2024 data not shown). The number of SNPs for institutionalized beneficiaries decreased for the third year in a row to 154 in 2026 and continued to enroll just 2 percent of all SNP enrollees.

> While SNPs were historically much more likely than PDPs and conventional MA–PDs to offer a defined standard benefit, that is no longer true: In 2026, 72 percent of SNPs now offer enhanced coverage, up from 36 percent in 2025. In 2025, 73 percent of SNP beneficiaries were enrolled in a defined standard plan; in 2026, just 8 percent of SNP enrollees are in a defined standard plan and another 6 percent are in plans actuarially equivalent to the standard benefit, reversing a long-standing trend of SNP enrollees primarily being in basic plans.

> Dually eligible beneficiaries automatically receive Part D’s low-income subsidy, which means that most recipients pay nominal copayments while Medicare pays the remainder of their plan’s cost sharing. Thus, historically, D–SNPs have more frequently used Part D’s defined standard benefit design (73 percent in 2025) and were less likely to have some formulary tiers that are not subject to a deductible. Following the end of the value-based insurance design demonstration in 2025, which allowed basic plans to include supplemental benefits, most basic SNPs have converted to enhanced plans to continue offering such benefits. This change can be seen in the increase in the share of SNP enrollees with some formulary tiers not subject to the deductible, growing from just 13 percent in 2025 to 83 percent in 2026.

Chart 10-16 Change in average Part D premiums, 2017–2026

	2017	2025	2026	Change in dollars, 2017–2026
Base beneficiary premium	\$35.63	\$36.78	\$38.99	4.89
All plans	\$32	\$23	\$21	–\$11
Basic plans	30	35	30	–0.5
Enhanced plans				
Basic benefits	27	5	7	–20
Supplemental benefits	6	13	11	6
Total premium	33	18	18	–15
All basic coverage	29	14	11	–17
PDPs	40	39	36	–5
Basic plans	31	35	31	0
Enhanced plans				
Basic benefits	42	16	15	–28
Supplemental benefits	11	25	25	13
Total premium	54	42	39	–14
All basic coverage	36	24	21	–14
MA–PDPs, excluding SNPs	19	7	8	–10
Basic plans	25	32	16	–8
Enhanced plans				
Basic benefits	16	0	2	–13
Supplemental benefits	2	6	6	4
Total premium	17	7	8	–9
All basic coverage	17	1	3	–14
Average buy-down of basic premium	16	15	30	13
Average buy-down of supplemental premium	15	28	21	7
SNPs	25	30	16	–9
Basic plans	29	37	27	–2
Enhanced plans				
Basic benefits	17	–2	8	–9
Supplemental benefits	0	13	7	7
Total premium	17	11	14	–2
All basic coverage	25	26	11	–15
Average buy-down of basic premium	13	12	11	–2
Average buy-down of supplemental premium	8	9	13	6

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), SNP (special-needs plan). Calculations include PDPs and MA–PDs that are open to individual enrollment offered in the 50 states and Washington, DC. We exclude employer group waiver plans, Part B–only plans, demonstrations, and 1876 cost plans. The MA–PD data reflect the portion of MA plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage, after subtracting Part C rebate dollars that were used to offset Part D premium costs. The average dollar values of the Part C rebates used to reduce Part D premiums are shown in the rows labeled "Average buy-down of basic/supplemental premiums." Average premiums are weighted by enrollment as of April 2026. "All basic coverage" reflects an average of the premiums for basic plans and the portion of premiums attributed to basic benefits in enhanced plans. Changes were calculated on unrounded data. Components may not sum to totals due to rounding. Dollar amounts are nominal figures, not adjusted for inflation. Figures differ from those reported in the March 2026 report to the Congress on Medicare payment policy (Chapter 13) because that analysis used 2025 enrollment for 2026 plan premiums due to data availability.

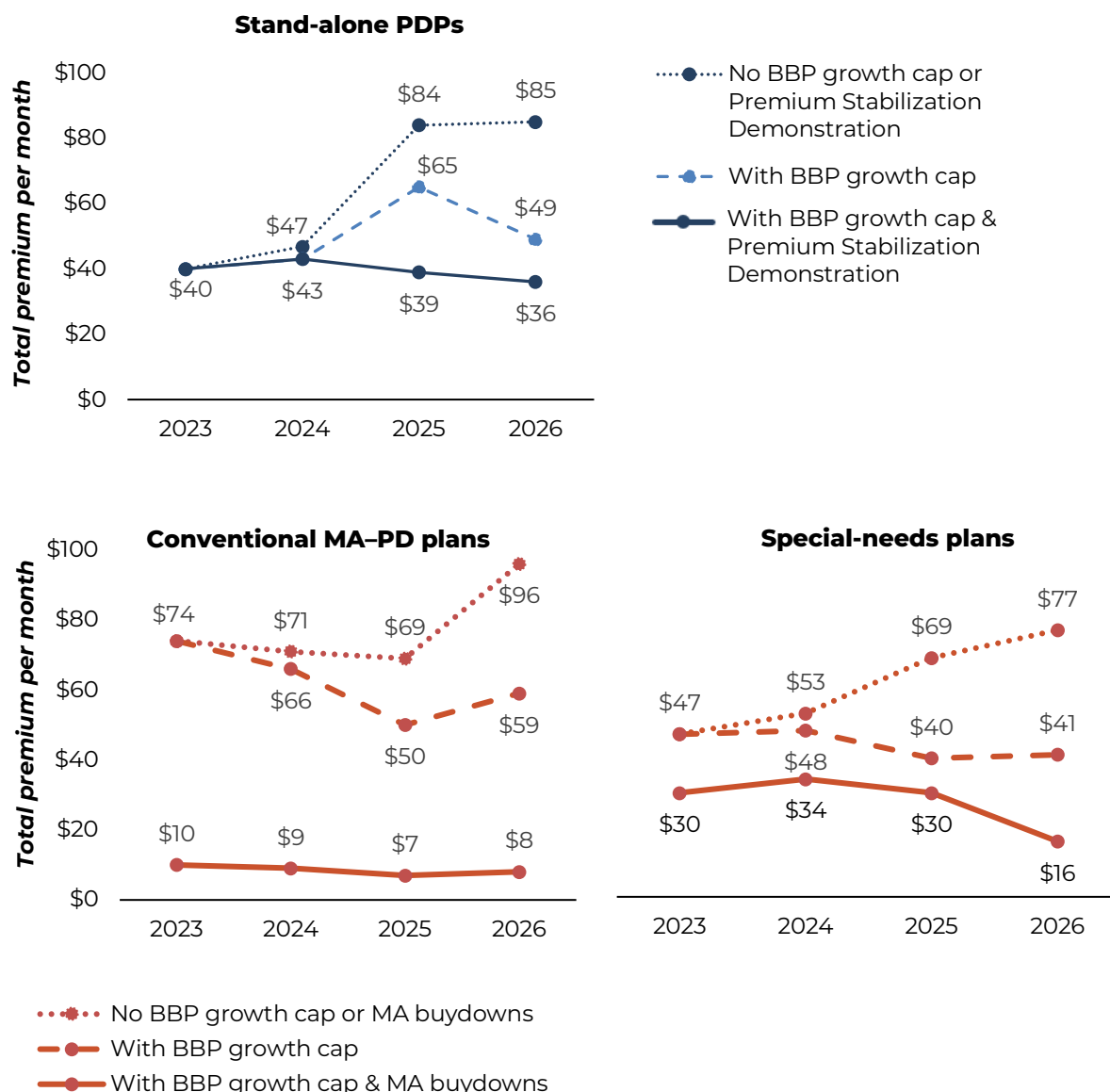
Source: MedPAC analysis of CMS landscape files, plan report files, enrollment data, and bid data.

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Chart 10-16 Change in average Part D premiums, 2017–2026 (continued)

- > Part D enrollees can select between plans with basic or enhanced benefits (the latter combines basic and supplemental coverage). Medicare has traditionally aimed to subsidize 74.5 percent of the average cost of basic benefits, with enrollees paying premiums for the remaining 25.5 percent and all of the cost of any supplemental benefits. The Inflation Reduction Act of 2022 (IRA) imposed a 6 percent cap on annual increases in the base beneficiary premium (BBP), a share of the average total costs for basic Part D benefits. This cap has shifted the balance of subsidy and premiums: In 2026, Medicare is subsidizing an estimated 87 percent of the average cost of basic benefits. (For more about how plan premiums are determined and about changes that were made by the IRA, see the March 2026 report to the Congress at https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch13_MedPAC_Report_To_Congress_SEC.pdf.)
- > The overall average premium paid by enrollees for any type of Part D coverage decreased in 2026 from \$23 per month in 2025 to \$21 per month. Without the IRA's cap on annual increases, the BBP would have been \$75.38 per month in 2026 (instead of \$38.99). CMS also continued a demonstration, first implemented in 2025, for stand-alone PDPs (nearly all of which chose to participate) to reduce their enrollees' monthly premiums by up to \$10 per month this year and limit the annual increase in the plan's total monthly premium to no more than \$50. (For more information on the demonstration, see the Commission's 2026 March report to the Congress at https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch13_MedPAC_Report_To_Congress_SEC.pdf.)
- > Across all plans, the average premium for basic benefits has fallen from \$29 in 2017 to \$11 per month in 2026, a decline of about 60 percent, largely due to the \$20 reduction in the portion of the premium attributed to basic coverage in enhanced plans. This decline occurred despite very rapid growth in spending for Part D's catastrophic phase of the benefit (see Chart 10-21). Average premiums for basic plans (not including the cost of basic coverage in enhanced plans) had increased over much of this period, but in 2026 returned to \$30, the same as the 2017 premium.
- > The average premium for a basic plan offered by a PDP decreased to \$31 after peaking at \$44 in 2024 (data not shown). The average enrollee premium for enhanced plans offered by PDPs declined from \$42 in 2025 to \$39, with \$15 attributed to basic benefits and \$25 for supplemental benefits.
- > The average premium for a basic conventional MA–PD plan is now roughly half that of PDPs at \$16 per month. Nearly all MA–PD enrollees, however, are in enhanced plans, for which the average premium is just \$8 in 2026, a decrease of about 50 percent since 2017. MA–PD sponsors typically use a portion of payments under MA, referred to as Part C rebates, to “buy down” Part D premiums. Because of those rebates, in 2026, MA–PD enrollees avoided having to pay \$30 per month in basic premiums and an additional \$21 per month for supplemental coverage, on average.
- > Average premiums for SNPs are higher than those for conventional MA–PDs at \$16 per month in 2026, but they are still below PDP premiums. Average premiums for enhanced plans offered by SNPs are just \$14. While most SNP enrollees are dually eligible for Medicaid and Medicare and have historically primarily enrolled in basic plans, that changed in 2026 (see Chart 10-15); basic plan premiums this year average \$27, most or all of which is paid by Medicare's low-income subsidy. Average buy-downs among SNPs were \$11 for basic benefits and \$13 for supplemental coverage.

Chart 10-17 Part D premiums have been substantially lowered by Medicare policies, 2023–2026



Note: PDP (prescription drug plan), BBP (base beneficiary premium), MA-PD (Medicare Advantage Prescription Drug [plan]), MA (Medicare Advantage). Calculations include PDPs and MA-PDs that are open to individual enrollment offered in the 50 states and Washington, DC. We exclude employer group waiver plans, Part B-only plans, demonstrations, and 1876 cost plans. The “BBP growth cap” is a provision in the Inflation Reduction Act of 2022 (IRA) that limits annual growth in the BBP to no more than 6 percent, starting in 2024. The “Premium Stabilization Demonstration” refers to the Part D Premium Stabilization Demonstration that began in 2025 for PDPs whereby CMS provides additional subsidies to participating PDPs to decrease total premiums and caps year-over-year premium growth. For MA-PD plans, the “Total premium per month” refers to the Part D portion of the MA-PD premiums. Beneficiaries enrolled in MA-PDs may pay a separate premium for their MA benefits. “MA buydown” refers to MA plans’ use of Part C rebates to lower Part D premiums for their enrollees. Dollar amounts are nominal figures, not adjusted for inflation. Figures differ from those reported in the March 2026 report to the Congress on Medicare payment policy (Chapter 13) because that analysis used 2025 enrollment for 2026 plan premiums due to data availability.

Source: Part D and MA bid pricing tool data, Part D landscape files, and Part D enrollment data from CMS.

(Chart continued next page)

Chart 10-17 Part D premiums have been substantially lowered by Medicare policies, 2023–2026 (continued)

- > Multiple policies play a role in lowering enrollees' premiums. As the IRA redesign was expected to increase benefit costs and therefore premiums, the law specified a limit in the annual growth of the average basic Part D premium (or BBP) to 6 percent. Historically, the BBP was set to be 25.5 percent of basic benefit costs. Since the cap was implemented in 2024, it has been binding each year. Absent the cap, average premiums would have risen sharply, as illustrated by the upper dotted lines in each chart.
- > CMS implemented the Part D Premium Stabilization Demonstration in 2025 in response to large increases and variation in PDP bids. The demonstration reduced participating PDPs' total premiums by up to \$15 per member per month and limited annual premium increases to \$35. It also narrowed risk corridors to provide more generous protection against losses. In 2026, the second year of the demonstration, CMS reduced participating PDPs' premiums by up to \$10, capped annual increases in their total monthly premiums at \$50, and returned risk corridors to their original parameters. As shown by comparing the top and middle lines of the top graph, the demonstration materially lowered premiums. In 2026, absent the demonstration, the average PDP premium would have been \$49, but instead it averaged \$36.
- > MA-PDs have long reduced Part D premiums for their enrollees through "MA buydowns" financed by MA rebates. As the bottom-left chart shows, the average conventional MA-PD premium in 2026 would have been \$59 in the absence of buydowns, but buydowns reduced it to \$8. Special-needs plans make less use of MA buydowns to reduce Part D premiums, reflecting their high share of beneficiaries receiving the low-income subsidy, under which Medicare pays most of the Part D premium through the low-income premium subsidy amount.

Chart 10-18 Part D benchmarks for LIS premiums and number of qualifying PDPs, by region

Region	State(s)	2017		2026		Cumulative change, 2017–2026	
		Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs
1	ME, NH	\$33	8	\$22	3	–\$11	–5
2	CT, MA, RI, VT	35	7	36	4	1	–3
3	NY	41	8	59	2	18	–6
4	NJ	41	8	54	2	13	–6
5	DC, DE, MD	33	10	31	2	–2	–8
6	PA, WV	39	9	33	3	–7	–6
7	VA	33	7	25	2	–8	–5
8	NC	31	7	36	2	5	–5
9	SC	26	6	36	2	10	–4
10	GA	26	4	25	2	–1	–2
11	FL	29	3	5	1	–24	–2
12	AL, TN	32	7	28	2	–4	–5
13	MI	34	8	9	3	–25	–5
14	OH	32	6	31	2	–1	–4
15	IN, KY	32	7	38	3	6	–4
16	WI	40	7	21	4	–19	–3
17	IL	29	9	15	2	–13	–7
18	MO	30	4	43	2	13	–2
19	AR	23	5	9	3	–14	–2
20	MS	27	7	24	2	–3	–5
21	LA	33	7	33	2	0	–5
22	TX	27	6	5	1	–23	–5
23	OK	31	7	28	3	–3	–4
24	KS	30	5	55	4	25	–1
25	IA, MN, MT, ND, NE, SD, WY	34	6	41	4	7	–2
26	NM	23	9	0	4	–23	–5
27	CO	32	7	35	2	3	–5
28	AZ	35	10	17	3	–18	–7
29	NV	27	4	9	2	–18	–2
30	OR, WA	35	8	10	3	–24	–5
31	ID, UT	40	9	38	3	–2	–6
32	CA	36	6	12	2	–24	–4
33	HI	27	5	46	4	–19	–1
34	AK	34	5	0	3	–34	–2
Average		32	7	27	3	–5	–4
Minimum		23	3	0	1	–23	–2
Maximum		41	10	59	4	18	–6

Note: LIS (low-income subsidy), PDP (prescription drug plan). All calculations exclude plans offered in U.S. territories. Cumulative changes were calculated on unrounded data. Dollar amounts are nominal figures, not adjusted for inflation.

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

(Chart continued next page)

Chart 10-18 Part D benchmarks for LIS premiums and number of qualifying PDPs, by region (continued)

- > Part D's LIS covers most premiums and cost sharing for enrollees with low incomes and assets. The LIS's coverage of premiums has a dollar limit, known as the low-income premium subsidy amount (LIPSA), that encourages beneficiaries to enroll in lower-cost PDPs. Beneficiaries who enroll in plans with premiums that are less than or equal to the LIPSA do not pay a premium; those who enroll in plans with higher premiums pay the difference. The PDPs for which LIS beneficiaries do not pay a premium are known as "benchmark plans." When LIS beneficiaries do not select a PDP, Medicare automatically enrolls them in benchmark plans.
- > The LIS benchmark equals the LIS enrollment-weighted average premium for basic coverage in a region. CMS calculates it using a weighted average of both PDP and MA-PD premiums. For plans that offer enhanced coverage, CMS uses the portion of the plan's premium that reflects the cost of basic coverage only. For MA-PDs, CMS uses the amount of the premium for basic coverage before the plan sponsor has used any Part C (Medicare Advantage) rebates to reduce or eliminate the premium. The weight for each plan equals its share of LIS enrollment. CMS calculates separate benchmarks for each Part D region and updates them annually. If there is no basic PDP in a region with a premium below the benchmark, the LIPSA will equal that of the lowest-premium basic PDP; if there is a basic PDP with a premium below the benchmark, the LIPSA will equal the benchmark.
- > In 2026, the lowest LIPSA was \$0, in Region 26 (New Mexico) and Region 34 (Alaska), the first time a LIPSA has been \$0. Region 3 (New York) again had the highest benchmark premium in 2026 at \$59 per month.
- > The average benchmark premium across regions (not weighted by numbers of enrollees) had risen slowly over the years, from \$32 per month in 2017 to \$40 in 2025 (on a nominal basis, data not shown), but fell significantly in 2026 to \$27.
- > In 2017, the average number of benchmark plans in a region was seven; by 2026, that figure had dropped to three, a decline of more than 50 percent. The number of benchmark plans has declined in every region over the past decade. This year, there are two regions with just one benchmark plan (Region 11, Florida, and Region 22, Texas), both of which also had just one benchmark plan in 2025. The maximum number of benchmark plans in any region in 2026 is 4, compared with 10 in 2017.

Chart 10-19 In 2026, more enrollees are in plans that use coinsurance for brand-name and nonpreferred drug tiers

	Benchmark PDP enrollees	PDP enrollees	MA-PD enrollees
5-tier formulary structure* (in percent)	100%	100%	99%
Drugs on formulary as percentage of all Part D drugs	63%	66%	72%
Median cost-sharing amounts			
Tier 1: Generic drugs	\$0	\$0	\$0
Tier 2: Other generic drugs	\$10	\$3	\$5
Tier 3: Preferred brand-name drugs	25%	25%	21%
Tier 4: Nonpreferred drugs	31%	34%	38%
Tier 5: Specialty-tier drugs	25%	25%	28%
Drugs with any utilization management	53%	53%	55%

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]). Figures exclude employer group waiver plans, plans under CMS sanction, and plans offered in U.S. territories. In addition, MA-PDs exclude demonstration programs, special-needs plans, and 1876 cost plans. A drug was defined based on the unique products listed on CMS's formulary reference file for the 2026 benefit year. "Utilization management" includes prior authorization, step therapy, and quantity limits. "Prior authorization" means that the enrollee must get preapproval from the plan before coverage. "Step therapy" refers to a requirement that the enrollee try specified drugs before being prescribed another drug in the same therapeutic class. "Quantity limit" means that plans limit the number of doses of a drug available to the enrollee in a given time period. Results are weighted by plan enrollment.
* Includes formularies with an additional (sixth) tier for specific medications (e.g., generic drugs for certain chronic conditions) offered at \$0 or low cost sharing.

Source: MedPAC analysis of formularies submitted to CMS.

> In 2026, nearly all Part D enrollees chose plans that have a five-tier structure: two generic, one preferred brand-name tier, one nonpreferred drug tier (which may include both brand-name and generic drugs), plus a specialty tier.

> The number of drugs listed on a plan's formulary affects a beneficiary's access to medications. In 2026, on average, PDP enrollees have access to 66 percent of all Part D-covered products, compared with 72 percent among MA-PD enrollees. That share was lower (63 percent) for beneficiaries enrolled in benchmark plans—a subset of basic PDPs for which enrollees with the low-income subsidy do not have to pay a premium. This difference likely reflects the fact that nearly all MA-PD enrollees are in enhanced plans that offer more generous benefits than basic plans compared with just 57 percent of PDP enrollees (see Chart 10-13 and Chart 10-14).

> The median copay in 2026 is \$0 for a generic drug on a lower tier and between \$3 and \$10 for other generic drugs. The use of coinsurance (a percentage of the total payment) for the preferred brand-name drug tier has risen in recent years, with nearly all PDP enrollees and 57 percent of MA-PD enrollees in such plans in 2026, up from 84 percent and about 30 percent in 2025, respectively (data not shown). For PDP enrollees, the median coinsurance rate for the preferred brand-name drug tier rose to 25 percent, up from 21 percent in 2025, while the median coinsurance rates for nonpreferred drugs declined by 6 percentage points and 3 percentage points for PDPs and MA-PDs, respectively, in 2026 (2025 data not shown). The median coinsurance rates for specialty-tier drugs averaged 25 percent and 28 percent for PDPs and MA-PDs, respectively.

> Plans' processes for nonformulary exceptions and use of utilization-management tools—prior authorization (preapproval for coverage), quantity limits (limitations on the number of doses of a particular drug covered in a given period), and step-therapy requirements (enrollees being required to try specified drugs before being prescribed other drugs in the same therapeutic category)—can affect access to certain drugs. In 2026, both PDPs and MA-PDs typically use some form of utilization management for more than half of plans' formulary drugs, averaging 53 percent and 55 percent, respectively.

Chart 10-20 Components of Part D spending growth, 2015–2024

	2015	2024	Average annual growth 2015–2024
Total gross spending (in billions)	\$137.4	\$288.9	8.6%
High-cost beneficiaries	78.9	184.3	9.9
Lower-cost beneficiaries	58.5	104.5	6.7
Number of beneficiaries using a Part D drug (in millions)	38.9	53.3	3.6
High-cost beneficiaries	3.6	4.4	2.1
Lower-cost beneficiaries	35.3	48.9	3.7
Amount per beneficiary who used Part D drugs			
Gross drug spending per year	\$3,531	\$5,422	4.9
Average price per 30-day prescription	\$66	\$92	3.8
Number of 30-day prescriptions	53.7	59.0	1.1
Amount per high-cost beneficiary who used Part D drugs			
Gross drug spending per year	\$21,642	\$41,949	7.6
Average price per 30-day prescription	\$193	\$356	7.0
Number of 30-day prescriptions per month	9.5	10.0	0.6
Amount per lower-cost beneficiary who used Part D drugs			
Gross drug spending per year	\$1,658	\$2,139	2.9
Average price per 30-day prescription	\$34	\$40	1.7
Number of 30-day prescriptions per month	4.3	4.7	1.1

Note: “High-cost beneficiaries” refers to individuals who incur spending high enough to reach the catastrophic phase of the benefit. “Gross spending” reflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the point of sale (POS). Changes in the average price per prescription, measured by gross spending at the POS, reflect both price inflation and changes in the mix of drugs used, including the adoption of new, higher-priced drugs. Dollar amounts are nominal figures, not adjusted for inflation. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Part D prescription drug event data and enrollment data from CMS.

- > Between 2015 and 2024, gross spending on drugs covered under the Part D program grew by an annual average rate of 8.6 percent on a nominal basis. The annual growth in spending was considerably higher (9.9 percent) among high-cost beneficiaries (individuals who incurred spending high enough to reach the catastrophic phase of the benefit) than among lower-cost beneficiaries (6.7 percent).
- > Between 2023 and 2024, the number of high-cost beneficiaries declined, reversing the trends of faster growth among high-cost beneficiaries through 2023. As a result, for the 2015 to 2024 period, the number of high-cost beneficiaries grew more slowly (2.1 percent) than lower-cost beneficiaries (3.7 percent). This shift likely reflects implementation of the policy to reflect pharmacy fees at the POS beginning in 2024, which slowed progression to the catastrophic phase of the benefit.
- > The average price per 30-day prescription covered under Part D rose from \$66 in 2015 to \$92 in 2024. Overall, growth in price per prescription accounted for most (3.8 percentage points) of the 4.9 percent average annual growth in spending per beneficiary. Growth in prices per prescription reflects increases in the prices of existing drugs and changes in the mix of drugs.
- > The average annual growth rate in overall spending per beneficiary reflects two distinct patterns of price and spending growth—one for high-cost beneficiaries and another for lower-cost beneficiaries. Among high-cost beneficiaries, annual growth in prices (7.0 percent) accounted for nearly all of the spending growth (7.6 percent). In contrast, among lower-cost beneficiaries, the increase in the number of prescriptions (1.1 percent) accounted for over a third of the spending growth (2.9 percent).

Chart 10-21 Part D spending and use per enrollee, 2024

	Part D	Plan type		LIS status	
		PDP	MA-PD	LIS	Non-LIS
Total gross spending (billions)	\$288.9	\$124.5	\$164.4	\$129.3	\$159.5
Above OOP threshold (billions)	125.3	55.2	70.2	66.8	58.5
Share above OOP threshold	43%	44%	43%	52%	37%
Total number of prescriptions (billions)	3.1	1.3	1.9	1.1	2.1
Average spending per prescription	\$92	\$97	\$88	\$122	\$76
Share of beneficiaries with no drug use	6%	6%	6%	8%	5%
Per enrollee per month					
Total gross spending*	\$442	\$448	\$438	\$723	\$337
OOP spending	27	37	20	3	36
Manufacturer gap discount	32	39	27	N/A	44
Plan liability	307	303	310	515	228
Low-income cost-sharing subsidy	55	42	65	201	N/A
Number of prescriptions	4.8	4.6	5.0	5.9	4.4

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]), LIS (low-income subsidy), OOP (out-of-pocket), N/A (not applicable). "Total gross spending" reflects payments from all payers, including beneficiaries (cost sharing) but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. "Plan liability" includes plan payments for drugs covered by both basic and supplemental (enhanced) benefits. "Number of prescriptions" is standardized to a 30-day supply. Components may not sum to totals due to rounding and the exclusion of the Patient Liability Reduction Due to Other Payer (PLRO) amount. LIS status is based on receipt of the LIS at any point during the year.

* Total gross spending includes the portion of prescription drug costs covered by secondary, non-Medicare payers, referred to as the PLRO. The average PLRO amount was about \$22 in 2024.

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

> In 2024, gross spending on drugs covered under the Part D program totaled about \$289 billion, with 43 percent (\$124.5 billion) accounted for by Medicare beneficiaries enrolled in PDPs. Beneficiaries who receive the LIS (about 27 percent) accounted for about 45 percent (\$129 billion) of the total. About 43 percent of gross spending was incurred after a beneficiary reached the annual OOP threshold (\$8,000 in 2024). This share was higher among LIS enrollees (52 percent) compared with other enrollees (37 percent).

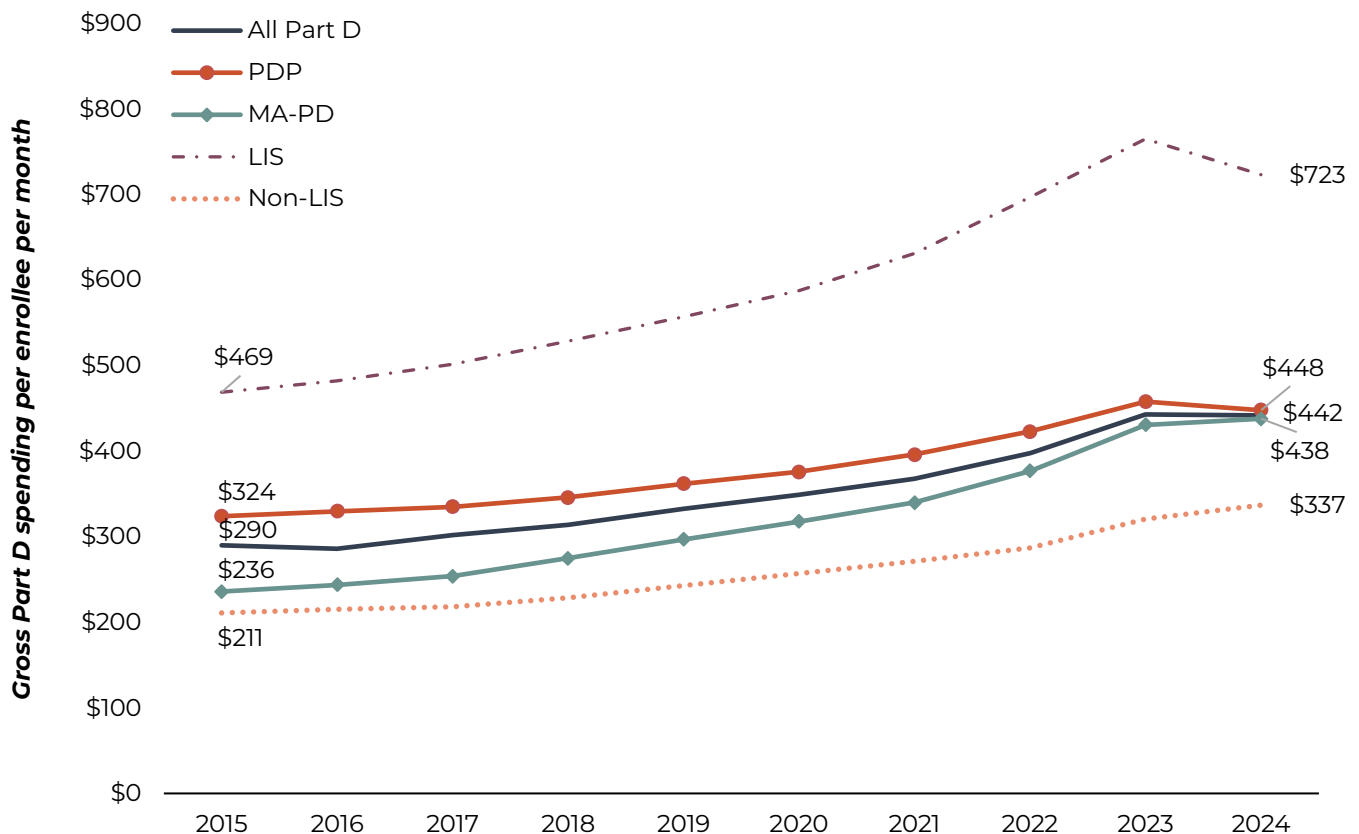
> The number of prescriptions filled by Part D enrollees totaled 3.1 billion, with 41 percent (1.3 billion) accounted for by PDP enrollees and about 34 percent (1.1 billion) accounted for by LIS enrollees. Overall, 6 percent of Part D enrollees did not fill any prescriptions during the year.

> In 2024, Part D enrollees filled 4.8 prescriptions at \$442 per month on average, a slight decrease from \$443 per month (for 4.7 prescriptions) in 2023 (2023 data not shown). The average monthly plan liability for PDP enrollees (\$303) was lower than that of MA-PD enrollees (\$310), reversing the pattern observed since the program began in 2006. The average monthly OOP spending for enrollees in PDPs (\$37) was higher than in MA-PDs (\$20), likely reflecting the fact that most MA-PDs offer supplemental benefits that reduce enrollee cost sharing. Medicare's monthly low-income cost-sharing subsidy per enrollee was higher for MA-PDs (\$65) than for PDPs (\$42), reflecting the greater share of MA-PD enrollees receiving the LIS.

> Average monthly spending per LIS enrollee (\$723) was more than double that of a non-LIS enrollee (\$337), and the average number of prescriptions filled per month by an LIS enrollee was 5.9 compared with 4.4 for a non-LIS enrollee. LIS enrollees had much lower monthly OOP spending, on average, than non-LIS enrollees (\$3 vs. \$36, respectively). Part D's LIS pays for most of the cost sharing for LIS enrollees, averaging \$201 per month in 2024, down from \$232 in 2023 (2023 data not shown).

> Manufacturer discounts for brand-name drugs filled by non-LIS enrollees while they were in the coverage gap accounted for, on average, 7.2 percent of total gross spending (\$32 per enrollee per month), or nearly 13 percent of the average gross spending by non-LIS enrollees.

Chart 10-22 Trends in Part D spending per enrollee per month, 2015–2024



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage Prescription Drug [plan]), LIS (low-income subsidy). “Spending” (gross) reflects payments from all payers, including beneficiaries (cost sharing) but does not include rebates and fees from manufacturers and pharmacies that are not reflected in prices at the point of sale. Dollar amounts are nominal figures, not adjusted for inflation.

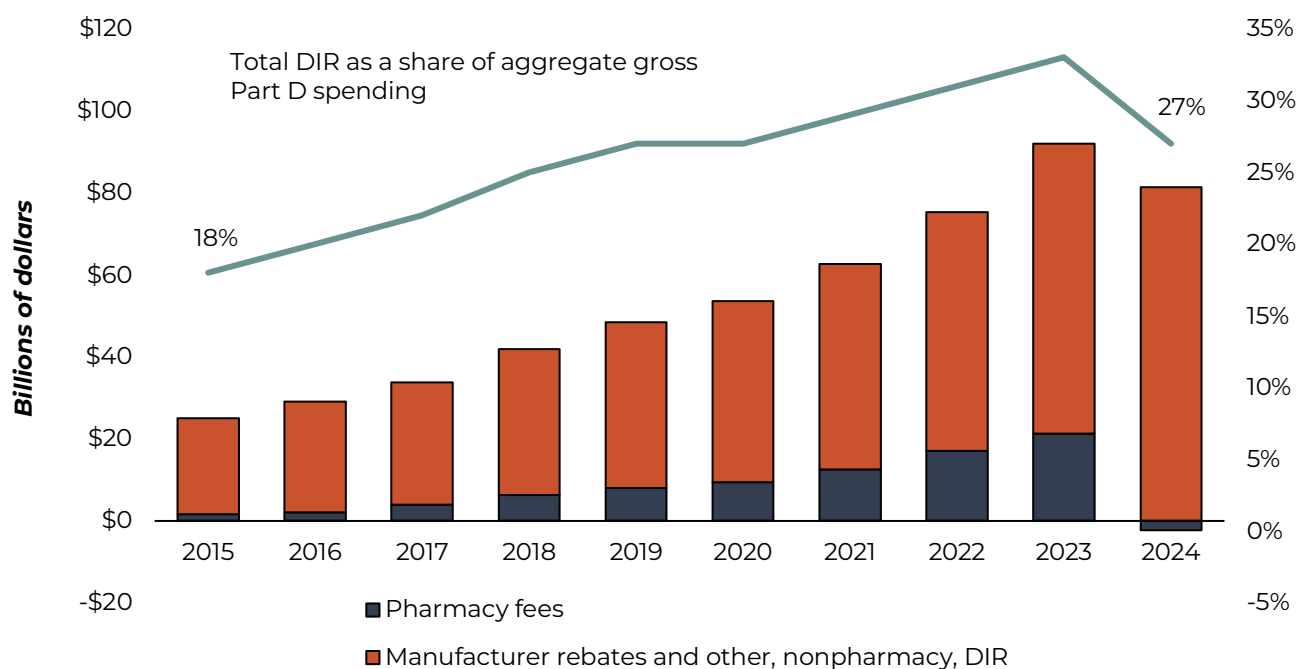
Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

> Between 2015 and 2024, per capita spending per month for Part D–covered drugs grew from \$290 to \$442 on a nominal basis, an average growth rate of 4.8 percent annually, or about 53 percent cumulatively.

> The flattening of growth between 2023 and 2024 reflects divergent spending trends between LIS and non-LIS enrollees. Monthly per capita spending for LIS enrollees declined from \$765 in 2023 to \$723 in 2024. In contrast, spending for non-LIS enrollees continued to increase to \$337 in 2024. These differences reflect 2024 policies that lowered prices by applying pharmacy fees at the point of sale and eliminated cost sharing in the catastrophic phase of the benefit. The latter affected only non-LIS enrollees who, before 2024, paid 5 percent coinsurance for prescriptions filled in the catastrophic phase of the benefit. The net effect of these two policies was per capita spending growth of about 5 percent among non-LIS enrollees, compared with a decline of over 5 percent for LIS enrollees. The number of standardized 30-day prescriptions filled by LIS and non-LIS enrollees grew by about 8 percent and 9 percent, respectively, during this period (data not shown).

> The growth in monthly per capita drug spending among MA-PD enrollees exceeded that of PDP enrollees during the 2015 to 2024 period (annual average growth of 7.1 percent and 3.7 percent, respectively). The average per capita spending for MA-PD enrollees continued to be lower than that of PDP enrollees. However, that difference has been declining since 2014. In 2024, the difference was \$10 per month, down from \$27 per month in 2023.

Chart 10-23 Postsale manufacturer rebates and pharmacy fees expanded rapidly in Part D, 2015–2024



Note: DIR (direct and indirect remuneration). "Gross Part D spending" includes enrollee cost sharing and plan (and any other) payments to the pharmacy at the point of sale for both brand and generic prescriptions. Pharmacy fees consist of net postsale payments from pharmacies to plan sponsors and their pharmacy benefit managers. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of prescription drug event data and DIR data.

> The final amounts that Part D plans pay for their enrollees' prescriptions are often lower than prices at the pharmacy because plan sponsors and their pharmacy benefit managers (PBMs) negotiate postsale rebates and fees from drug manufacturers and pharmacies; CMS refers to those amounts as "direct and indirect remuneration." Medicare keeps a portion of DIR to offset some of its reinsurance subsidies to plans. While large rebates help to constrain premium increases, using DIR primarily to lower premiums also means that beneficiaries who use such drugs (or the Medicare program, in the case of Part D's low-income subsidy (LIS) enrollees) sometimes pay cost sharing that is a significant portion of—and may even be higher than—the drug's cost to the plan. For enrollees without the LIS, high cost sharing can affect whether they fill their prescriptions.

> Between 2015 and 2024, DIR increased substantially from about \$25 billion to \$92 billion in 2023, before declining to about \$79 billion in 2024. This decline reflects the new requirement to reflect pharmacy DIR at the point of sale beginning in 2024. As a result of this policy change, plans, on net, paid pharmacies about \$2.2 billion as part of the postsale adjustments, resulting in total DIR accounting for about 27 percent of gross Part D spending, down from 33 percent in 2023.

> Multiple factors have contributed to growth in manufacturer rebates. For certain classes of drugs that lack generic competition but have considerable rivalry among competing brands, manufacturers have chosen to raise gross prices and compete using postsale rebates. Due to Part D's unusual benefit design and its emphasis on premium competition, sponsors have had incentives to try to maximize rebates and keep premiums low. Vertically integrated insurers with their own PBMs and specialty and mail-order pharmacies have large market shares of enrollment and dispensing, which tend to provide those plan sponsors with greater bargaining leverage for postsale price concessions from both manufacturers and pharmacies.

Chart 10-24 Incidence of Part D spending by type of product, 2024

	Total gross spending	Part D plans (at risk)	Share of gross spending paid					
			Medicare (at risk)			Pharmaceutical manufacturers		
			Reinsurance	Low-income subsidy	Beneficiary cost sharing	Coverage-gap discount	Postsale rebates and discounts	Retroactive pharmacy fees*
Brand-name drugs	\$195.6	18%	24%	12%	5%	9%	31%	1%
Biologics	54.4	16	37	9	3	7	28	<1
Generic drugs	36.1	49	15	18	19	N/A	<1	-1
All products covered under Part D**	288.9	21	25	12	6	7	27	1

Note: "Total gross spending" reflects payment from all payers, including beneficiaries (through cost sharing) before accounting for postsale rebates, discounts, and fees from pharmacies and manufacturers. "Biologics" includes spending for insulins.

* Beginning in 2024, payments to pharmacies must reflect the lowest possible negotiated rates, requiring Part D plans to apply the maximum possible pharmacy fees at the point of sale. Accordingly, retroactive pharmacy fees are expected to be near zero or negative, though they were positive for brand-name drugs and biologics. One possibility is that the positive amounts reflect pharmacy fees collected for prior-year claims.

** Includes some products that could not be classified as one of the three drug types shown (e.g., nondrug products such as syringes used for insulins).

Source: MedPAC analysis of prescription drug event data and direct and indirect remuneration data.

> In 2024, over 86 percent of total gross Part D spending was for brand-name drugs (\$195.6 billion, or nearly 68 percent) or biologics (\$54.4 billion, or about 19 percent). Generic drugs accounted for 12.5 percent (\$36.1 billion) of gross spending. The requirement to apply pharmacy fees at the point of sale (POS) beginning in 2024 put downward pressure on gross prices and eliminated nearly all retroactive pharmacy fees, which totaled just under 1 percent of gross spending at the POS, down from 8 percent in 2023 (2023 data not shown). However, the impact of this policy change differed across drug types. For example, in 2023, pharmacy fees accounted for a larger share of gross spending for generic drugs (12 percent) compared with brand-name drugs (7 percent) (data not shown).

> The incidence of Part D spending varied by drug type, with Medicare's reinsurance accounting for a larger share of spending for brand-name drugs and biologics compared with generic drugs. For example, plans were at risk for 16 percent of spending on biologics (including biosimilars), while Medicare covered 37 percent through Part D's reinsurance. In contrast, for generic drugs, Medicare's reinsurance accounted for 15 percent of gross spending compared with 49 percent for plans. Medicare's low-income subsidy, on average, accounted for a higher share of gross spending for generic drugs (18 percent) compared with brand-name drugs (12 percent) or biologics (9 percent).

> On average, beneficiaries' cost sharing accounted for 19 percent of gross spending for generic drugs compared with 5 percent for brand-name drugs and 3 percent for biologics. Cost sharing as a share of gross spending was substantially lower for brand-name drugs and biologics in part because these products are more likely to be filled in the catastrophic phase of the benefit, in which, beginning in 2024, beneficiaries pay no cost sharing. (See Chart 10-12 for changes in benefit parameters.)

> Coverage-gap discounts and postsale rebates and fees paid by pharmaceutical manufacturers accounted for 7 percent and 27 percent of gross spending, respectively, across all Part D-covered products. Nearly all of those payments were for brand-name drugs and biologics.

Chart 10-25 Top 15 therapeutic classes of drugs covered under Part D, by gross spending, 2024

	Gross spending		Negotiated rebates as a share of gross spending	Coverage-gap discount (billions)
	Billions	Percent		
Antineoplastics	\$42.8	14.8%	<10%	\$1.3
Antidiabetic agents—injectable	34.9	12.1	40–49	5.4
Anticoagulants	27.4	9.5	40–49	3.9
Antidiabetic agents—oral	25.4	8.8	≥50	3.2
Asthma/COPD therapy agents	16.4	5.7	40–49	1.3
Disease-modifying anti-rheumatoid drugs	14.6	5.0	30–40	0.6
Antihypertensive therapy agents	10.8	3.7	10–19	0.8
Antiretrovirals	8.7	3.0	<10	0.3
Dermatological (antipsoriatics)	8.6	3.0	20–29	0.2
Antipsychotics (neuroleptics)	8.2	2.9	<10	0.1
Ophthalmic agents	6.1	2.1	30–40	0.4
Antihyperlipidemics	5.7	2.0	20–29	0.5
Movement-disorder drug therapy	3.7	1.3	<10	0.1
Urinary incontinence treatment agents	3.7	1.3	≥50	0.3
Anticonvulsants	3.4	1.2	<10	<0.1
Subtotal, top 15 drug classes	220.2	76.2	30%	18.4
Total, all drug classes	288.9	100.0	27%	20.9

Note: COPD (chronic obstructive pulmonary disease). “Gross spending” reflects payments from all payers, including beneficiaries (cost sharing) for both brand and generic drugs but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System. Components may not sum to totals due to rounding.

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

> In 2024, the top 15 therapeutic classes by gross spending accounted for about 76 percent of the \$289 billion spent on prescription drugs covered by Part D plans. Antineoplastics topped the list, with spending totaling \$42.8 billion, up 24 percent from \$34.4 billion in 2023 (latter data not shown). Diabetic therapies—which include injectable antidiabetic agents (12.1 percent), such as insulins and glucagon-like peptide-1 receptor agonists, and oral antidiabetic agents (8.8 percent)—continued to dominate the list, accounting for just over 20 percent of total gross Part D spending.

> In 2024, total manufacturer rebates as a share of gross spending ranged from less than 10 percent to more than 50 percent. Some of that variation reflects the degree of competition within each therapeutic class. Overall, rebates for the top 15 classes averaged 30 percent of gross spending, higher than the average of 27 percent for all Part D spending. Rebates were the highest (greater than or equal to 50 percent) for diabetic therapies and urinary incontinence treatment agents.

> In addition to negotiated rebates, before 2025, manufacturers were required to provide discounts for brand-name drugs and biologics filled by non-LIS enrollees when they filled prescriptions in the coverage-gap phase of the benefit. In 2024, these top 15 classes accounted for 88 percent (\$18.4 billion) of all coverage-gap discounts. Diabetic therapies alone accounted for 41 percent of all coverage-gap discounts.

Chart 10-26 Despite high generic use, brand-name drugs accounted for the majority of spending in the top 15 therapeutic classes by spending, 2024

	Prescriptions*		Generic dispensing rate	Brand share of gross spending	LIS share of prescriptions
	Millions	Percent			
Antineoplastics	17.7	0.6%	84%	91%	24%
Antidiabetic agents—injectable	68.9	2.2	5	99	46
Anticoagulants	63.3	2.0	17	99	30
Antidiabetic agents—oral	170.0	5.4	73	97	36
Asthma/COPD therapy agents	93.4	3.0	63	89	45
Disease-modifying anti-rheumatoid drugs	3.5	0.1	35	100	47
Antihypertensive therapy agents	315.2	10.0	97	81	27
Antiretrovirals	3.2	0.1	19	98	66
Dermatological (antipsoriatics)	1.2	<0.1	21	99	51
Antipsychotics (neuroleptics)	38.1	1.2	91	85	71
Ophthalmic agents	69.9	2.2	86	78	30
Antihyperlipidemics	378.4	12.0	98	60	26
Movement-disorder drug therapy	0.6	<0.1	5	99	76
Urinary incontinence treatment agents	24.3	0.8	69	88	37
Anticonvulsants	116.6	3.7	99	46	48
Subtotal, top 15 drug classes	1,364.2	43.4	82	92	34
Total, all drug classes	3,145.6	100.0	90	87	34

Note: LIS (low-income subsidy), COPD (chronic obstructive pulmonary disease). “Gross spending” reflects payments from all payers, including beneficiaries (cost sharing) for both brand and generic drugs but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System. The calculation of the overall generic dispensing rate excludes non-prescription drug items (e.g., insulin needles). Components may not sum to totals due to rounding.

* Prescriptions are standardized to a 30-day supply.

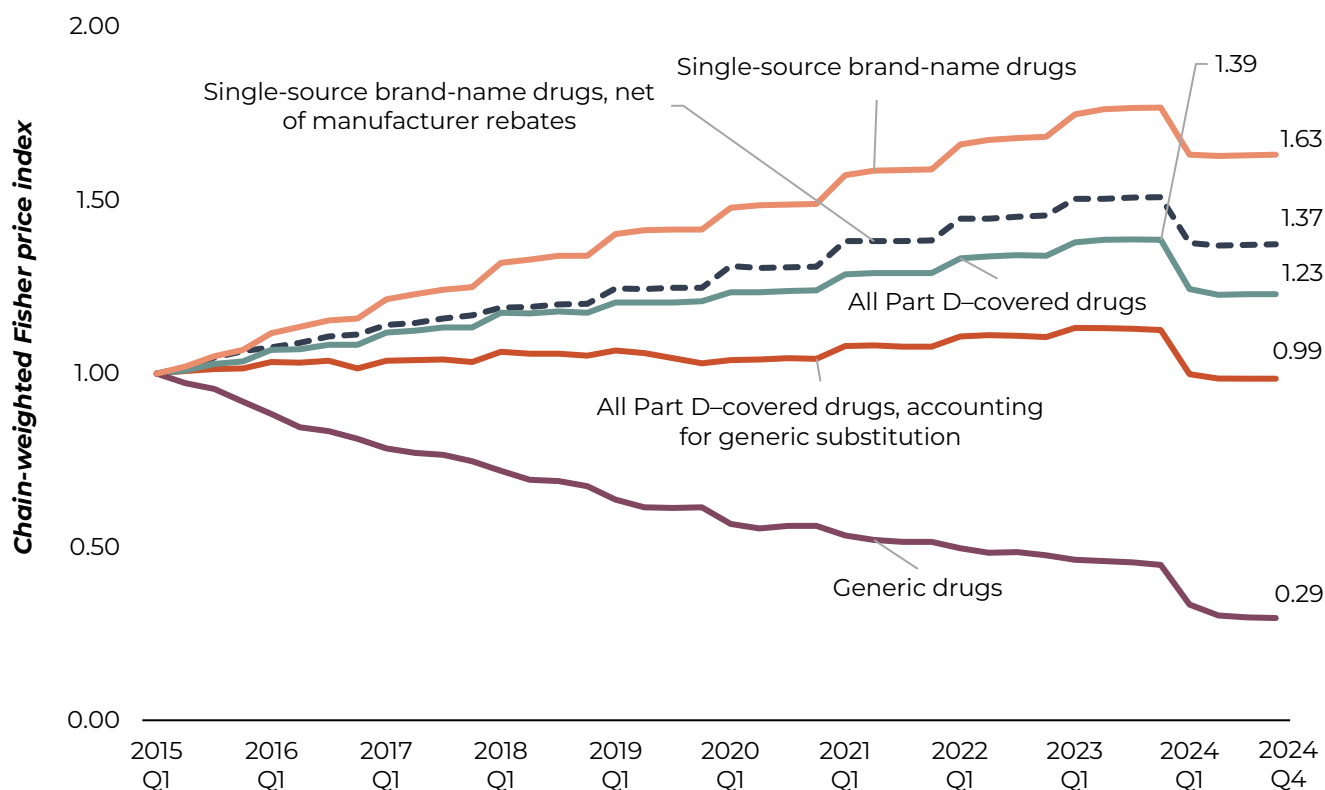
Source: MedPAC analysis of Medicare Part D prescription drug event and direct and indirect remuneration data from CMS.

> Filled prescriptions in the top 15 therapeutic classes by spending in 2024 (see Chart 10-25) totaled 1.36 billion prescriptions, accounting for 43 percent of all prescriptions filled under Part D. While 82 percent of these prescriptions were for generic drugs, brand-name products accounted for 92 percent of the gross spending for these products in 2024.

> In 2024, LIS beneficiaries filled 34 percent of total prescriptions for products in these 15 classes, which is identical to their share of prescriptions among all Part D drugs. Nevertheless, LIS enrollees accounted for a disproportionate share of prescriptions in a few classes such as antiretrovirals (66 percent), antipsychotics (71 percent), and movement-disorder drug therapy (76 percent).

> Even when generic drugs are widely used by Part D beneficiaries, for some therapeutic classes, brand-name drugs may still account for the vast majority of spending. For example, in 2024, generic drugs accounted for 84 percent of prescriptions for antineoplastics, but brand-name drugs accounted for 91 percent of gross spending for that class.

Chart 10-27 Postlaunch price growth for Part D-covered drugs, 2015–2024



Note: Q1 (first quarter), Q4 (fourth quarter). Unless otherwise noted, Part D indexes reflect total amounts paid to pharmacies and do not reflect retrospective rebates or discounts from manufacturers and pharmacies, with the exception of the index for single-source brand-name drugs, net of manufacturer rebates. The price indexes are Fisher price indexes and reflect percentage changes in the average price of Part D-covered drugs measured at the product level in nominal terms, not adjusted for inflation. A product is defined at the individual national drug code (NDC) level with the exception of the index accounting for generic substitution, which groups NDCs with the same active ingredient(s), dosage form, route of administration, and strength. Indexes do not reflect the effects of launch prices of new products or changes in average price levels resulting from a shift in utilization across products. The price index is different from the change in the average price of drugs covered under Part D (see Chart 10-20), which reflects changes in the prices of existing products, the effects of launch prices of new products, and shifts in utilization across products.

Source: Acumen analysis for MedPAC.

> Measured by individual NDCs, prices of drugs and biologics covered under Part D rose 39 percent cumulatively between 2015 and 2023 on a nominal basis (an index of 1.39) before declining by 16 percentage points, from 1.39 to 1.23 in 2024. Much of this decline likely reflects the implementation of the requirements to reflect pharmacy fees at the point of sale beginning in 2024. (Prices reflect total amounts paid to pharmacies and do not reflect retrospective rebates or discounts from manufacturers or postsale pharmacy fee adjustments.)

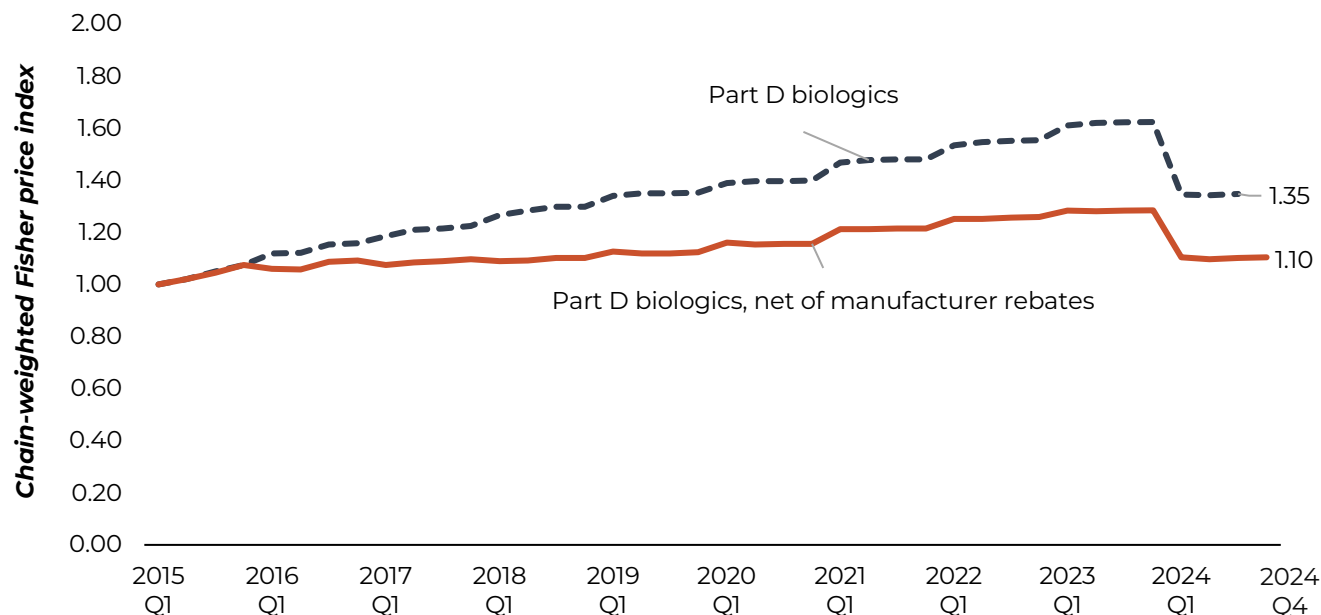
> Overall, between 2015 and 2024, prices of generic drugs covered under Part D fell to 29 percent of the average price observed at the beginning of 2015. While generic prices have historically declined over time, the magnitude of the decrease between 2023 and 2024 represented a departure from recent trends, likely owing to the implementation of the policy related to pharmacy fees.

(Chart continued next page)

Chart 10-27 **Postlaunch price growth for Part D–covered drugs, 2015–2024**
(continued)

- > When measured by a price index that takes generic substitution into account, Part D prices have remained relatively flat during this period, with prices at the end of 2024 about 1 percent below the prices at the beginning of 2015 (an index of 0.99). New and increased generic competition for selected therapeutic classes—such as anticonvulsants, antineoplastics, and drugs for multiple sclerosis—as well as this policy related to pharmacy fees played a key role in slowing the growth in overall Part D prices during this period.
- > Between 2015 and 2024, prices for all single-source, brand-name drugs (drugs with no generic substitutes) grew by a cumulative 63 percent (an index value of 1.63), compared with 37 percent (an index value of 1.37) for prices net of manufacturer rebates.

Chart 10-28 Postlaunch price growth for biologics covered under Part D, 2015–2024



Note: Q1 (first quarter), Q4 (fourth quarter). The price indexes are Fisher price indexes and reflect percentage changes in the average price of Part D–covered biologic products measured at the product level in nominal terms, not adjusted for inflation. A product is defined at the individual national drug code (NDC) level. Indexes do not reflect the effects of launch prices of new products or changes in average price levels resulting from a shift in utilization across products. Biologics include insulins.

Source: Acumen analysis for MedPAC.

> Measured by individual NDCs, prices of biologics (without retrospective rebates, fees, or discounts) covered under Part D rose 62 percent cumulatively between 2015 and 2023 on a nominal basis (an index of 1.62), before declining by 27 percentage points, from 1.62 to 1.35 in 2024. In comparison, between 2015 and 2023, prices of biologics net of retrospective rebates and discounts from manufacturers grew by a cumulative 28 percent (an index value of 1.28), before declining by 18 percentage points, from 1.28 to 1.10 in 2024. These declines likely reflect the effects of a policy related to pharmacy fees (see Chart 10-27) as well as a substantial drop in insulin prices at the point of sale between 2023 and 2024 (from an index of 1.60 to 0.73) (data not shown).

> The prices of biologics are highly influenced by the prices of insulins. In 2023, insulins accounted for over a quarter of total gross spending on biologics. In 2024, that share declined to about 14 percent, primarily as a result of lower point-of-sale prices for insulins (data not shown).

Other services

Dialysis

Hospice

Clinical laboratory

Chart 11-1 The capacity of dialysis organizations declined between 2023 and 2024

	2024	Average annual percent change	
		2019–2023	2023–2024
Total number of:			
Dialysis facilities	7,605	0.2%	–1.4%
Hemodialysis stations	137,200	0.8	–1.0
Mean number of hemodialysis stations per facility	18		
	Share of total facilities		
Hospital based	5%	–2.5	–0.9
Freestanding	95	0.3	–1.4
Urban	84	0.4	–1.2
Rural	16	–1.3	–1.2
For profit	90	0.5	–0.8
Nonprofit	10	–2.5	–6.8

Note: “Nonprofit” includes facilities designated as either nonprofit or government facilities. “Average annual percent change” is based on comparing 2019, 2023, and 2024 end-of-year files. Provider location reflects the county where the provider is located, urban or rural (the latter includes micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes.

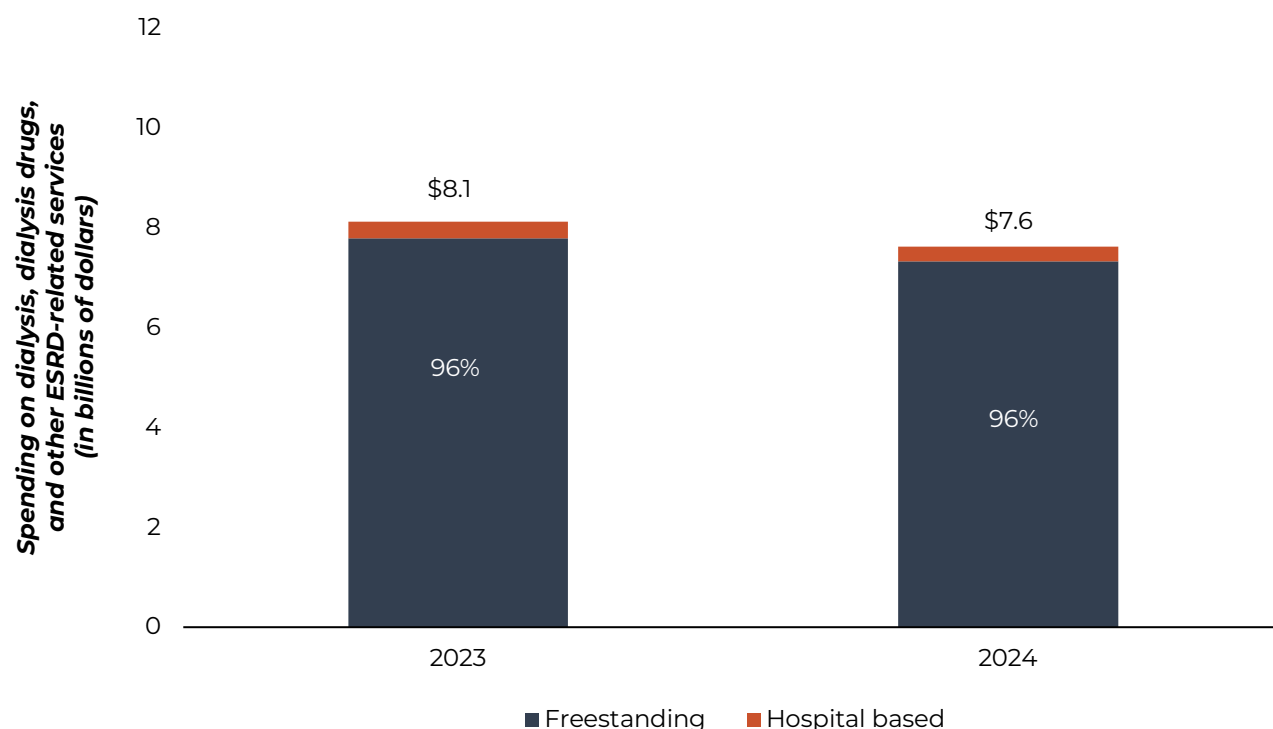
Source: Compiled by MedPAC from the institutional outpatient claims files and the Dialysis Compare files from CMS.

> Between 2019 and 2023, growth in the number of dialysis facilities and in-center treatment stations exceeded growth in the number of patients on dialysis, across fee-for-service (FFS) Medicare and Medicare Advantage (MA). During that period, the number of facilities and their capacity to provide care—as measured by hemodialysis stations—both grew, by 0.2 percent and 0.8 percent annually, respectively. By comparison, the number of Medicare beneficiaries on dialysis (in FFS Medicare and MA combined) declined by 1 percent per year between 2019 and 2023 (data not shown).

> Between 2023 and 2024, however, the number of facilities’ in-center hemodialysis stations declined by 1 percent, while the number of beneficiaries on dialysis, across FFS Medicare and MA, also declined by 1 percent (latter data not shown). The recent decline in the total number of dialysis facilities may be attributable to factors such as (1) the decline in the rate of new end-stage renal disease (ESRD) cases and excess mortality of persons with ESRD due to the coronavirus pandemic; (2) slower growth in the number of individuals newly diagnosed with ESRD; (3) the growing trend toward home dialysis; and (4) efforts by some dialysis providers to optimize their facilities’ capacity utilization.

> Between 2023 and 2024, the number of for-profit and nonprofit facilities decreased by 0.8 percent and 6.8 percent, respectively. The average size of a facility has remained relatively constant at 18 dialysis treatment stations per facility.

Chart 11-2 FFS Medicare spending for outpatient dialysis services furnished by freestanding and hospital-based dialysis facilities, 2023 and 2024



Note: FFS (fee-for-service), ESRD (end-stage renal disease). Dollar amounts are nominal figures, not adjusted for inflation.

Source: Compiled by MedPAC from the institutional outpatient claims files from CMS.

- > In 2024, total FFS Medicare spending for dialysis, dialysis drugs, and ESRD-related clinical laboratory tests was \$7.6 billion. Medicare paid all facilities under a prospective payment system that includes in the payment bundle certain dialysis drugs and ESRD-related clinical laboratory tests that were paid separately before 2011.
- > Between 2023 and 2024, total FFS ESRD expenditures decreased by 6 percent on a nominal basis. The spending decline is due in large part to the increasing enrollment of dialysis beneficiaries in MA plans beginning in 2021. As beneficiaries with ESRD shifted to MA in 2021 through 2024, the number of FFS beneficiaries on dialysis fell 12 percent per year, on average, between 2021 and 2023, and by 7 percent between 2023 and 2024. The number of FFS treatments fell 11 percent per year (data not shown).
- > Freestanding dialysis facilities treated most FFS dialysis beneficiaries and accounted for 96 percent of FFS expenditures on outpatient dialysis in 2023 and 2024.

Chart 11-3 Small increase in the number of patients with ESRD over the last decade

	2013		2023		2013–2023
	Patients (thousands)	Share of patients	Patients (thousands)	Share of patients	Average annual percent change
Total	661.9	100%	830.9	100%	2%
Dialysis	467.3	71	557.9	67	2
In-center hemodialysis	414.7	63	472.1	57	1
Home hemodialysis ^a	7.0	1	13.7	2	7
Peritoneal dialysis ^{a,b}	44.0	7	67.9	8	4
Other dialysis ^c	1.6	0.2	4.2	0.5	10
Functioning graft and kidney transplant	194.6	29	273.0	33	3

Note: ESRD (end-stage renal disease). Totals may not equal the sum of components due to rounding. Data include both Medicare (fee-for-service and Medicare Advantage) and non-Medicare patients. The “functioning graft and kidney transplant” category includes patients who had a functioning graft at the start of the year in question (i.e., 2013 or 2023) or received a transplant during the year in question.

^a Home dialysis methods.

^b “Peritoneal dialysis” refers to patients receiving either continuous ambulatory peritoneal dialysis or continuous cyclic peritoneal dialysis.

^c “Other dialysis” includes other types of peritoneal dialysis methods and “uncertain dialysis.”

Source: Compiled by MedPAC from the U.S. Renal Data System.

> People with ESRD require either dialysis or a kidney transplant to live. The total number of patients with ESRD increased on average by 2 percent per year between 2013 and 2023. Between 2022 and 2023, the growth rate of the total number of patients with ESRD on dialysis was 1 percent, while the growth rate for those with functioning graft and kidney transplant was 5 percent (data not shown). Most patients with ESRD undergo dialysis.

> In hemodialysis, a patient’s blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient’s blood is cleansed by using the lining of their abdomen as a filter. Peritoneal dialysis is the most common form of home dialysis.

> In 2023, most people with ESRD (57 percent) underwent hemodialysis administered in a dialysis facility (usually three times a week). Between 2013 and 2023, the total number of in-center hemodialysis patients grew on average by 1 percent annually, while the total number of peritoneal dialysis patients increased on average by 4 percent annually. Although a smaller proportion of all dialysis patients undergo home hemodialysis, the number of these patients grew on average by 7 percent per year during this period.

> Patients with functioning grafts have had a successful kidney transplant. Patients undergoing a kidney transplant may receive either a living or deceased donor’s kidney. In 2023, 23 percent of transplanted kidneys were from living donors and the remainder were from cadaver donors (data not shown).

Chart 11-4 The number of White patients with ESRD declined between 2019 and 2023, while the number of other racial and ethnic groups increased

	Share of total in 2023	Average annual percent change 2019–2023
Total (N = 815,896)	100%	1%
Age (years)		
0–17	1	1
18–44	14	1
45–64	41	0
65–79	35	2
80+	9	1
Sex		
Male	59	1
Female	41	0
Race/ethnicity		
White	41	–1
Black	29	1
Native American	1	3
Asian American	7	3
Hispanic	20	3
Underlying cause of ESRD		
Diabetes	37	–1
Hypertension	27	2
Glomerulonephritis	14	0
Other causes	22	3

Note: ESRD (end-stage renal disease). ESRD patients include those who undergo maintenance dialysis and those who have a functioning kidney transplant. Data include both Medicare (fee-for-service and Medicare Advantage) and non-Medicare patients. Components may not sum to totals due to rounding.

Source: Compiled by MedPAC from the U.S. Renal Data System.

> Among all patients with ESRD (including those who are not covered by Medicare), nearly 44 percent were over age 65 in 2023. About 41 percent were White.

> Diabetes is the most common cause of renal failure.

> The number of patients with ESRD increased by 1 percent annually between 2019 and 2023. The number of individuals of Native American, Asian, and Hispanic origins with ESRD increased by 3 percent annually between 2019 and 2023, compared with a 1 percent annual increase in the number of Black individuals with ESRD. In contrast, the number of White patients with ESRD decreased by 1 percent annually during that period.

Chart 11-5 A greater share of MA beneficiaries than FFS beneficiaries on dialysis are over age 65, Black, dually eligible for Medicare and Medicaid, and urban residents, 2024

	FFS beneficiaries on dialysis	MA beneficiaries on dialysis
Total	195,800	224,100
Age		
Under 45 years	10%	6%
45–64 years	33	31
65–74 years	28	32
75–84 years	22	24
85+ years	8	7
Sex		
Male	59	56
Female	41	44
Race/ethnicity		
White	45	33
Black	28	40
Hispanic	16	19
Asian	6	5
All others	6	4
Residence, by type of county		
Urban	84	86
Rural	16	14
Dual eligibility		
Fully dually eligible	34	38
Partially dually eligible	6	13
Not dually eligible	60	49
Part D enrollment		
Yes	75	98
No	25	2
New to dialysis	18	18
LDO	73	74
Non-LDO	27	26
Existing dialysis	82	82

Note: MA (Medicare Advantage), FFS (fee-for-service), LDO (large dialysis organization (DaVita and Fresenius)). Beneficiaries on dialysis were identified using the risk-score file, and FFS versus MA enrollment was identified using CMS enrollment data during January 2024. “Residence” reflects the beneficiary’s county of residence in one of two categories, urban or rural (the latter category includes micropolitan, rural adjacent to urban, and rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. Data as of January 2024. Components may not sum to 100 percent due to rounding.

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

> Beginning in January 2021, the 21st Century Cures Act permitted beneficiaries on dialysis to enroll in MA plans without any restrictions. As a result of this statutory change, the share of beneficiaries on dialysis enrolled in MA plans increased rapidly from 25 percent in January 2020 to 55 percent by December 2024 (data not shown).

> In 2024, 63 percent of MA beneficiaries on dialysis were 65 years or older (of which 31 percent were 75 years or older), 40 percent were Black, 13 percent had partial dual eligibility, and 86 percent resided in urban areas. By comparison, among FFS beneficiaries on dialysis, 58 percent were 65 years or older (of which 30 percent were 75 years or older), 28 percent were Black, 6 percent had partial dual eligibility, and 84 percent resided in urban areas.

Chart 11-6 Dialysis quality of care: Some measures show progress, others need improvement, 2019–2023

Outcome measure	2019	2022	2023
Share of in-center hemodialysis patients:			
Receiving adequate dialysis	98%	97%	97%
Dialyzed with an AV fistula	63	60	59
Share of peritoneal dialysis patients receiving adequate dialysis	91	91	91
Share of all dialysis patients managing anemia			
Mean hemoglobin < 10 g/dL	30	31	31
Mean hemoglobin 10 to <12 g/dL	65	63	63
Mean hemoglobin ≥ 12 g/dL	5	6	6
Share of all dialysis patients wait-listed for a kidney	13	12	12
Renal transplant rate per 100 patient years	3.9	4.2	4.5
Annual mortality rate per 100 patient years*	16.6	18.3	17.1
Total hospital admissions per patient year*	1.7	1.6	1.7
Hospital days per patient year*	11.4	11.8	11.7

Note: AV (arteriovenous), g/dL (grams per deciliter [of blood]). The rate per patient year is calculated by dividing the total number of events by the fraction of the year that patients were followed. Analysis of data on dialysis adequacy is based on measures used by CMS in its ESRD [End-Stage Renal Disease] Quality Incentive Program. The U.S. Renal Data System (USRDS) adjusts hospitalization and mortality measures by age, gender, race/ethnicity, and primary diagnosis of ESRD.

* Lower values suggest higher quality.

Source: All measures except the share of patients receiving adequate dialysis and anemia management were compiled by MedPAC using data from the USRDS. Measure of share of patients receiving adequate dialysis and anemia management was compiled by MedPAC using data from CMS's 100 percent institutional outpatient files.

> Changes in the available quality-of-care measures are challenging to interpret due to the effects of the coronavirus pandemic on many of our quality measures. Sadly, patients with ESRD have been at increased risk for COVID-19-associated morbidity and mortality.

> Between 2019 and 2023, anemia management and dialysis adequacy remained relatively steady.

> All hemodialysis patients require vascular access—the site on the patient's body where blood is removed and returned during dialysis. Use of arteriovenous fistulas, considered the best type of vascular access, declined between 2019 and 2023.

> Annual mortality rates decreased during 2022 and 2023. All-cause hospital admissions held steady between 2022 and 2023.

> We report access to kidney transplantation because it is widely believed to be the best treatment option for individuals with ESRD. Between 2019 and 2023, the share of dialysis patients accepted on the kidney-transplant waiting list declined from 13 percent to 12 percent, while the renal transplant rate per 100 dialysis-patient years increased from 3.9 to 4.5.

Chart 11-7 Hospice use increased in 2024

	2019	2022	2023	2024	Average annual change 2019–2023	Change 2023–2024
Medicare payments (in billions)	\$20.9	\$23.7*	\$25.7*	\$28.3*	5.3%*	10.4%*
Beneficiaries in hospice (in millions)	1.61	1.72*	1.74*	1.82*	2.0*	4.6*
Number of hospice days for all hospice beneficiaries (in millions)	121.8	130.2*	137.7*	148.2*	3.1*	7.7*

Note: Total payments, number of hospice users, and number of hospice days displayed in the table are rounded; the percentage change is calculated using unrounded data. Dollar amounts are nominal figures, not adjusted for inflation.

* These estimates are based on Medicare-paid hospice claims, which exclude hospice care paid for by Medicare Advantage (MA) plans participating in the Center for Medicare & Medicaid Innovation's hospice MA value-based insurance design hospice model from 2021 to 2024. According to a CMS evaluation report, 19,065 MA beneficiaries in 2022 and 23,828 MA beneficiaries in 2023 started hospice that year paid for by MA plans (similar data for 2024 are not available) (Eibner, C., D. Khodyakov, E. A. Taylor, et al. 2025. *Evaluation of the Medicare Advantage value-based insurance design model test: 2020–2023*. Report prepared for the Centers for Medicare & Medicaid Services, Center for Medicare & Medicaid Innovation: RAND Health Care. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/vbid-2020-2023-eval-report>).

Source: MedPAC analysis of Medicare hospice claims data from CMS.

> Total Medicare payments to hospices were about \$28.3 billion in 2024, about 10 percent higher on a nominal basis than the prior year.

> The number of Medicare beneficiaries receiving hospice services and the total number of days of hospice care increased in 2024.

Chart 11-8 The share of decedents using hospice increased in 2024, reaching a new high

	2019	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
Number of Medicare decedents (millions)	2.32	2.64	2.50	2.52	1.8%	0.7%
Number of Medicare decedents who used hospice (millions)	1.20	1.30	1.29	1.33	1.9	3.0
Share of decedents who used hospice	51.6%	49.1%	51.7%	52.9%		

Note: The "number of Medicare decedents who used hospice" reflects hospice use in the last calendar year of life. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit. Yearly figures presented in the table are rounded, but figures in the percent change columns were calculated using unrounded data.

Source: MedPAC analysis of data from enrollment files and Medicare hospice claims data from CMS.

> In 2024, the share of decedents using hospice increased to 52.9 percent as the number of beneficiaries who died in 2024 increased 0.7 percent and the number of decedents using hospice increased to a greater extent (3.0 percent).

> With the onset of the coronavirus pandemic, the hospice use rate declined in 2020 and 2021 but has increased since 2022 (data not shown). In 2024, the hospice use rate reached a new high, 52.9 percent.

> The decline in hospice use in 2020 and 2021 reflected the effects of the pandemic. Elderly people who die of COVID-19, similar to those who die of pneumonia and influenza, have been much more likely to die in the hospital and less likely to die at home or in a nursing facility than elderly people who die of other illnesses (data not shown).

Chart 11-9 Share of decedents using hospice increased in 2024 among all beneficiary groups

	2019	2022	2023	2024	Percentage point change 2019–2023	Percentage point change 2023–2024
All	51.6%	49.1%	51.7%	52.9%	0.1	1.2
FFS beneficiaries	50.7	49.1	51.7	52.9	1.0	1.2
MA beneficiaries	53.2	49.2	51.7	52.9	–1.5	1.2
Dually eligible	49.3	43.9	46.7	48.1	–2.6	1.4
Non-dually eligible	52.4	51.1	53.6	54.6	1.2	1.0
Age (years)						
<65	29.5	26.6	28.6	29.8	–0.9	1.2
65–74	41.0	37.7	40.3	41.1	–0.7	0.8
75–84	52.2	49.4	51.9	52.9	–0.3	1.0
85+	62.7	61.8	64.1	65.2	1.4	1.1
Race/ethnicity						
White	53.8	51.7	54.3	55.6	0.5	1.3
Black	40.8	37.4	39.7	40.9	–1.1	1.2
Hispanic	42.7	38.2	40.0	40.4	–2.7	0.4
Asian American	39.8	38.0	39.0	39.7	–0.8	0.7
North American Native	38.5	37.2	39.3	41.0	0.8	1.7
Gender						
Male	46.7	43.9	46.4	47.6	–0.3	1.2
Female	56.3	54.4	56.9	58.1	0.6	1.2
Beneficiary location						
Urban county	52.8	50.2	52.7	53.8	–0.1	1.1
Rural county, micropolitan	49.7	47.3	50.2	51.6	0.5	1.4
Rural county, adjacent to urban	49.5	47.9	50.9	52.6	1.4	1.7
Rural county, nonadjacent to urban	43.8	42.1	44.9	46.5	1.1	1.6
Frontier county	36.2	35.3	37.1	38.8	0.9	1.7

Note: FFS (fee-for-service), MA (Medicare Advantage). For each demographic group, the share of decedents who used hospice is calculated as follows: The number of beneficiaries in the group who both died and received hospice in a given year is divided by the total number of beneficiaries in the group who died in that year. Before 2021, the “MA beneficiaries” group received hospice paid for by the FFS program; from 2021 to 2024, most individuals in the MA beneficiaries group received hospice paid for by FFS Medicare, but a small number received hospice paid for by their MA plan under the MA value-based insurance design model. “Beneficiary location” reflects the beneficiary’s county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes (UICs). This chart uses the 2013 UIC definitions. The “frontier” category is defined as population density less than or equal to six people per square mile and overlaps the beneficiary county-of-residence categories. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit.

Source: MedPAC analysis of data from enrollment files and Medicare hospice claims data from CMS.

> Between 2023 and 2024, hospice use rates among decedents increased among all beneficiary groups examined. By 2024, hospice use rates had rebounded from pandemic declines and exceeded prepandemic (2019) levels for many groups. However, hospice use rates in 2024 were lower than 2019 levels for Hispanic beneficiaries (by 2.3 percentage points), dually eligible beneficiaries (1.2 percentage points), MA enrollees (0.3 percentage points), and Asian Americans (0.1 percentage points)

> In 2024, hospice use continued to vary by demographic and beneficiary characteristics. Medicare decedents who were older, White, female, living in an urban area, or not dually eligible were more likely to use hospice than their respective counterparts.

Chart 11-10 Number of hospice visits for beneficiaries receiving routine home care, 2019–2024

	2019	2022	2023	2024
Average number of visits per week				
All visits	4.3	3.9	3.9	3.9
Nurse visits	1.8	1.7	1.8	1.8
Aide visits	2.2	1.8	1.9	1.9
Social worker visits	0.3	0.3	0.3	0.3
Average length per visit (number of minutes)				
All visits	58	56	56	55
Nurse visits	56	53	52	52
Aide visits	62	60	60	60
Social worker visits	50	48	47	47
Average visit time per week (number of minutes)				
All visits	252	215	217	218
Nurse visits	102	91	92	92
Aide visits	133	110	111	112
Social worker visits	16	13	13	13

Note: Analysis includes only routine home care days and visits. “Visits” refers to in-person visits only and excludes postmortem visits. “Nurse visits” includes both registered nurse and licensed practical nurse visits. “Visit length” is reported by providers in the number of 15-minute increments, rounded to the nearest increment. We calculate minutes per visit by multiplying the number of 15-minute increments by 15. Components may not sum to totals due to rounding. Data displayed in table on visit frequency and time are rounded. Estimates of length of visits and total visit time for 2023 and earlier years differ from those in our prior reports due to refinements in methodology.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

- > In 2024, hospice enrollees received on average 3.9 visits per week, with nurse, aide, and social worker visits accounting for 1.8 visits, 1.9 visits, and 0.3 visits per week, respectively, on average.
- > The average length of hospice visits in 2024 was about an hour (55 minutes), with aide visits being slightly longer on average than nurse and social worker visits.
- > Overall, the average amount of visit time that hospice patients received per week in 2024 was about 218 minutes. On average, hospice patients received 92 minutes of nurse visits, 112 minutes of aide visits, and 13 minutes of social worker visits per week.
- > The number and length of in-person nurse, aide, and social worker visits were stable between 2023 and 2024. In 2024, the average number of aide visits and the average total visit time per week for nurse, aide, and social worker visits remained below the prepandemic (2019) levels.

Chart 11-11 Number of Medicare-participating hospices increased due to growth in for-profit hospices, 2019–2024

	2019	2022	2023	2024	Average annual percent change 2019–2023	Percent change 2023–2024
All hospices	4,840	5,899	6,535	6,706	7.8%	2.6%
For profit	3,435	4,581	5,243	5,497	11.2	4.8
Nonprofit	1,254	1,172	1,155	1,070	–2.0	–7.4
Government	149	138	136	130	–2.3	–4.4
Freestanding	3,942	5,074	5,695	5,740	9.6	0.8
Hospital based	430	383	365	350	–4.0	–4.1
Home health based	449	421	415	415	–1.9	0.0
SNF based	19	17	17	16	–2.7	–5.9
Urban	3,973	5,051	5,701	5,877	9.4	3.1
Rural	861	834	833	829	–0.8	–0.5

Note: SNF (skilled nursing facility). The providers included in this analysis submitted at least one paid hospice claim in a given year. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census) and reflect the hospice's office location. Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report or the hospice is included in the cost report of a hospital, home health agency, or SNF). Some categories do not sum to totals because of missing data for some providers. Missing data on hospice type particularly affect the most recent year (2024), for which we lack data on this characteristic for 185 providers. Numbers for 2023 and earlier years in certain categories may differ from those in our prior reports due to refinements in methodology and/or use of updated data.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, Hospice Enrollments dataset, and Medicare hospice claims data from CMS.

- > There were 6,706 Medicare-participating hospices in 2024, up by about 3 percent from 2023 and 39 percent since 2019.
- > In 2024, the number of for-profit hospices grew by about 5 percent. Between 2023 and 2024, the number of hospices with nonprofit ownership or government ownership declined, continuing the downward trend observed from 2019 to 2023.
- > In 2024, the number of freestanding providers increased, while the number of home health–based hospices was unchanged and the number of hospital-based and SNF-based hospices declined. (A hospice's status as freestanding, hospital based, home health based, or SNF based reflects the type of cost report submitted by the provider and does not necessarily reflect the location of care.)
- > The number of hospices located in rural areas declined in 2024 by 0.5 percent, continuing the trend of falling (by just under 1 percent per year between 2019 and 2023). The number of providers located in rural areas is not necessarily an indicator of access to care because it does not capture the size of those hospice providers, their capacity to serve patients, or the size of their service area. Also, some urban hospices furnish services in rural areas. Indeed, despite the overall decline in the number of rural hospices between 2019 and 2024, the share of rural decedents using hospice grew over that period (see Chart 11-9).

Chart 11-12 Hospice cases by primary diagnosis, 2024

Diagnosis	Share of total cases
Cancer	23%
Circulatory, except heart failure	23
Alzheimer's, nervous system disorders, organic psychosis	22
Other	11
Heart failure	8
Respiratory disease	6
Chronic airway obstruction, NOS	4
Genitourinary disease	2
Digestive disease	2
All	100

Note: NOS (not otherwise specified). Cases include all patients who received hospice care in 2024, not just decedents. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim in 2024. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

> In 2024, the most common primary diagnoses among Medicare hospice patients were cancer (23 percent), circulatory conditions other than heart failure (23 percent) and neurological conditions such as Alzheimer's disease, nervous system disorders, and organic psychosis (22 percent).

Chart 11-13 Hospice average length of stay among decedents increased in 2024

Year	Average lifetime length of stay (in days)	Percentiles of lifetime length of stay (in days)				
		10th	25th	50th	75th	90th
2019	92.5	2	5	18	85	266
2020	97.0	2	5	18	87	287
2021	92.1	2	5	17	79	264
2022	95.3	2	5	18	84	275
2023	96.2	2	5	18	86	278
2024	99.6	2	5	19	90	291

Note: “Lifetime length of stay” is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime.

Source: MedPAC analysis of data from enrollment files and the Medicare Beneficiary Database from CMS.

> The average length of stay among decedents was 99.6 days in 2024, up more than 3 days from 2023. In 2024, the length of stay at the 50th percentile (the median) increased slightly from 18 to 19 days.

> Hospice lengths of stay vary broadly. In 2024, hospice length of stay among decedents ranged from 2 days at the 10th percentile to 291 days at the 90th percentile.

> Between 2019 and 2024, growth in the average length of stay among decedents has been the result of increases in length of stay for patients with the longest stays. Length of stay grew from 266 days to 291 days at the 90th percentile.

Chart 11-14 Hospice length of stay among decedents, by beneficiary and hospice characteristics, 2024

	Average length of stay (in days)	Percentiles of length of stay (in days)		
		10th	50th	90th
Beneficiary				
Diagnosis				
Cancer	51	3	15	124
Neurological	169	4	47	501
Heart/circulatory	111	2	21	336
COPD	133	3	32	389
Other	69	2	9	196
Site of service				
Home	100	4	26	274
Nursing facility	120	3	25	360
Assisted living facility	174	6	63	494
Hospice				
For profit	120	3	25	359
Nonprofit	71	2	13	195
Freestanding	102	2	19	300
Home health based	74	2	15	205
Hospital based	60	2	12	161

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2024 and used hospice that year and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime. The “site of service” categories reflect where the beneficiary spent the largest share of their days while enrolled in hospice. “Diagnosis” reflects the primary diagnosis on the beneficiary’s last hospice claim.

Source: MedPAC analysis of Medicare hospice claims data, Medicare hospice cost reports, and Provider of Services file from CMS.

- > Hospice average length of stay among decedents varies by both beneficiary and provider characteristics. Most of this variation reflects differences in length of stay among patients with the longest stays (i.e., at the 90th percentile). Length of stay varies much less for patients with shorter stays (i.e., at the 10th percentile or 50th percentile).
- > Beneficiaries with neurological conditions and COPD have the longest stays, while beneficiaries with cancer have the shortest stays, on average.
- > Beneficiaries who receive hospice services in assisted living facilities have longer stays on average than beneficiaries who receive care at home or in a nursing facility.
- > For-profit and freestanding hospices have longer average lengths of stay than nonprofit and provider-based (home health–based and hospital-based) hospices.

Chart 11-15 Over 60 percent of Medicare hospice spending in 2024 was for patients with stays exceeding 180 days

	Medicare hospice spending, 2024 (in billions)
All hospice users in 2024	\$28.3
Beneficiaries with LOS > 180 days	17.5
Days 1–180	5.6
Days 181–365	5.3
Days 366+	6.6
Beneficiaries with LOS ≤ 180 days	10.9

Note: LOS (length of stay). “LOS” reflects the beneficiary’s lifetime LOS as of the end of 2024 (or at the time of death or discharge in 2024 if the beneficiary was not enrolled in hospice at the end of 2024). All spending reflected in the chart occurred only in 2024. Components may not sum to total due to rounding.

Source: MedPAC analysis of Medicare hospice claims data and an Acumen data file on hospice lifetime length of stay (which is based on an analysis of historical claims data).

> In 2024, Medicare hospice spending on patients with stays exceeding 180 days was \$17.5 billion, just over 60 percent of all Medicare hospice spending that year.

> About \$6.6 billion, or about 23 percent, of Medicare hospice spending in 2024 was on hospice care for patients who had already received at least one year of hospice.

Chart 11-16 Hospice FFS Medicare aggregate margins, 2019–2023

	Share of hospices (2023)	Share of patients (2023)	Medicare margin				
			2019	2020	2021	2022	2023
All	100%	100%	13.4%	14.2%	13.3%	9.8%	8.0%
Freestanding	88	84	16.2	16.7	15.5	12.4	10.2
Home health based	6	9	9.7	11.2	10.9	3.8	4.4
Hospital based	6	7	–18.4	–18.2	–15.6	–23.5	–25.6
For profit	80	57	19.2	20.5	19.2	16.1	13.7
Nonprofit	18	42	6.1	5.8	5.2	0.3	–1.3
Government	2	1	N/A	N/A	N/A	N/A	N/A
Urban	87	90	13.6	14.3	13.4	10.0	8.3
Rural	13	10	11.5	13.5	12.3	8.1	5.3
Below cap	72	92	13.8	14.8	14.0	10.8	9.0
Above cap	28	8	10.0	7.7	2.5	–1.6	–1.4
Above cap (including cap overpayments)	28	8	22.5	22.8	21.8	18.5	17.8
Share of stays > 180 days							
Lowest quintile	20	31	–2.5	–0.4	0.0	–4.1	–4.8
Second quintile	20	28	10.3	11.8	11.1	8.2	7.6
Third quintile	20	19	19.9	20.0	20.5	17.8	16.7
Fourth quintile	20	17	22.8	24.1	22.2	18.6	15.9
Highest quintile	20	6	13.4	13.4	9.7	2.7	–1.1

Note: FFS (fee-for-service), N/A (not available). Medicare aggregate margins for all provider categories exclude overpayments to above-cap hospices except where specifically indicated (providers whose payments exceed the Medicare hospice aggregate cap are required to repay the excess to Medicare). Medicare aggregate margins are calculated based on Medicare-allowable, reimbursable costs. Margin by hospice ownership status is based on hospices' ownership designation from the Medicare cost report. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census). Government-owned hospices operate in a different financial context from other hospices, so their margin is not necessarily comparable; therefore, data for government-owned hospices are not reported separately or included in the ownership rows (but are included in other rows). Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare hospice cost reports, Medicare hospice claims data, and Medicare Provider of Services file from CMS.

- > The FFS aggregate Medicare margin was 8.0 percent in 2023, down from 9.8 percent in 2022.
- > In 2023, freestanding hospices had higher margins (10.2 percent) than home health–based (4.4 percent) and hospital-based (–25.6 percent) hospices.
- > The 2023 margin among for-profit hospices was high at 13.7 percent. Nonprofit hospices as a group had a margin of –1.3 percent in 2023, but the subset of nonprofit hospices that were freestanding had a higher margin, 2.6 percent (latter figure not shown).
- > The aggregate 2023 margin was slightly higher for urban hospices (8.3 percent) than rural hospices (5.3 percent).
- > Hospices that exceeded the cap (Medicare's aggregate average per beneficiary payment limit) had a 2023 margin of about 17.8 percent before and –1.4 percent after the return of the cap overpayments.
- > Hospices with more patients whose stays were longer than 180 days generally had higher margins in 2023. Hospices in the lowest length-of-stay quintile had a margin of about –5 percent, compared with margins of about 17 percent and 16 percent for hospices in the third and fourth length-of-stay quintiles, respectively. Margins were lower in the highest quintile (about –1 percent) because some hospices in this quintile exceeded Medicare's aggregate payment cap and were required to repay the overage.

Chart 11-17 Hospices that exceeded Medicare's annual payment cap, 2019–2023

	2019	2020	2021	2022	2023
Share of hospices exceeding the cap	19%	19%	19%	23%	28%
Average payments over the cap per hospice exceeding the cap (in thousands)	\$384	\$422	\$451	\$419	\$410
Payments over the cap as a share of overall Medicare hospice spending in cap year	1.7%	1.8%	2.0%	2.3%	2.9%

Note: The aggregate-cap statistics reflect the Commission's estimates and may differ from CMS claims-processing contractors' estimates. Our estimates assume all hospices use the proportional methodology and rely on claims data through 15 months after the end of each cap year. The claims-processing contractors may reopen the hospice-cap calculation for up to three years; the reopening process and timing vary across contractors. The cap years for 2019 through 2023 are aligned with the federal fiscal year (October 1 to September 30 of the following year). Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of Medicare hospice claims data and Medicare Provider of Services file from CMS.

- > The hospice aggregate cap is a limit on the average annual payment per beneficiary that a hospice provider can receive. If a hospice's total payments exceed its total number of Medicare patients multiplied by the cap amount (\$35,361.44 for fiscal year 2026), it must repay the difference.
- > An estimated 28 percent of hospices exceeded the aggregate cap in 2023, up from 23 percent in 2022.
- > Hospices that exceeded the cap were disproportionately located in four states—Arizona, California, Nevada, and Texas. Excluding these four states, an estimated 6 percent of hospices exceeded the cap in 2023, up slightly from 5 percent in 2022 (data not shown).
- > On average, above-cap hospices exceeded the cap by approximately \$410,000 per provider in 2023, down slightly from about \$419,000 per provider in 2022.
- > Medicare payments over the cap represented 2.9 percent of total Medicare hospice spending in 2023.

Chart 11-18 Hospice live-discharge rates, 2022–2024

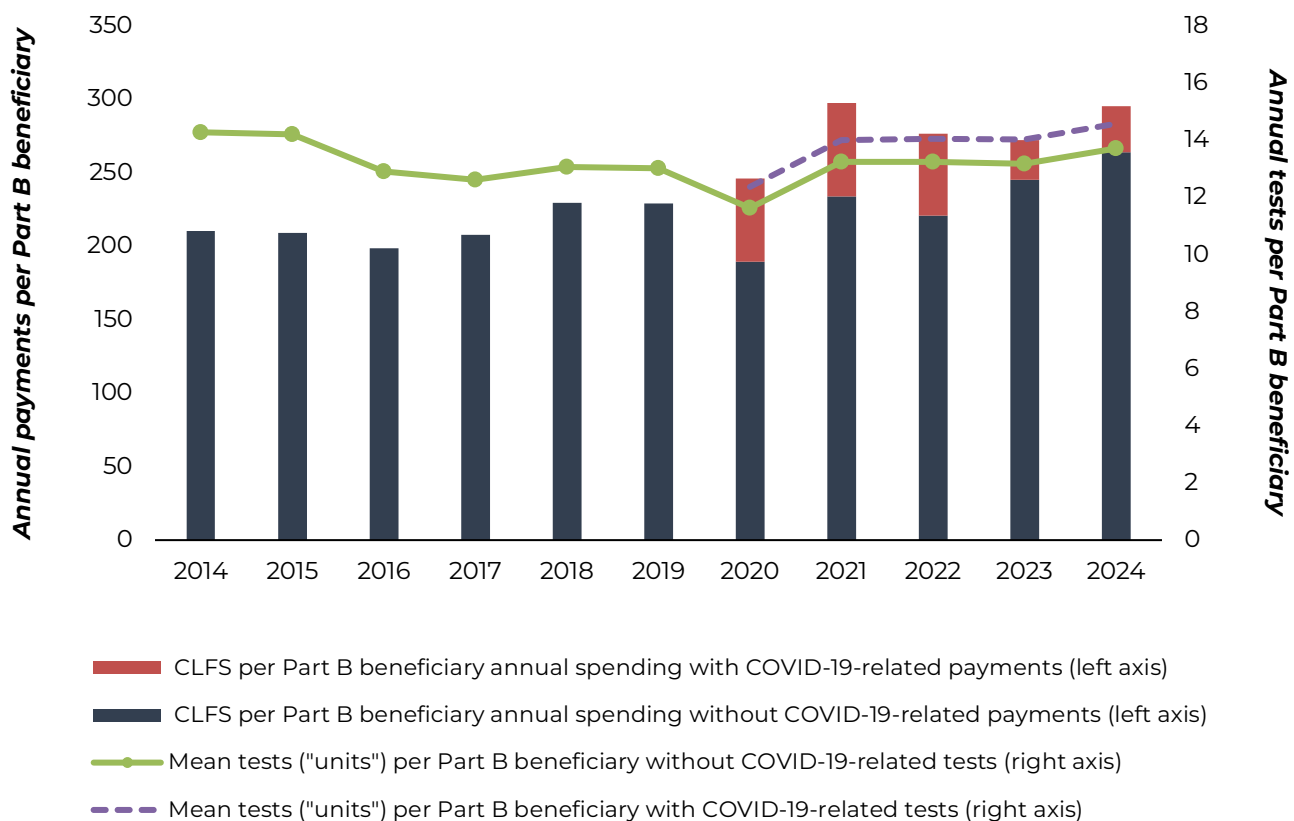
	2022	2023	2024
Live discharges as a share of all discharges, by reason for live discharge			
All live discharges	17.3%	18.5%	19.1%
No longer terminally ill	6.1	6.2	6.1
Beneficiary revocation	6.1	6.7	7.1
Transfer hospice providers	2.4	2.6	2.6
Move out of service area	2.3	2.7	3.0
Discharge for cause	0.3	0.4	0.3
Providers' overall rate of live discharge as a share of all discharges, by percentile (for providers with more than 30 discharges)			
10th percentile	8.3	8.6	8.8
25th percentile	12.2	13.2	13.5
50th percentile	19.2	20.7	21.7
75th percentile	29.9	33.3	35.7
90th percentile	49.9	56.1	65.2

Note: Percentages may not sum to totals due to rounding. "All discharges" includes patients discharged alive or deceased.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

- > In 2024, the overall live-discharge rate was 19.1 percent, up from 18.5 percent in 2023.
- > The most common reasons for live discharge were the beneficiary revoking the hospice benefit and the beneficiary no longer being terminally ill, accounting for 7.1 percent and 6.1 percent, respectively, of all discharges in 2024. Less frequent reasons for live discharges included a beneficiary moving out of the service area, a beneficiary transferring hospice providers, and a beneficiary being discharged for cause.
- > Among providers with more than 30 discharges, 10 percent of providers had live-discharge rates of about 65 percent or more in 2024.
- > Small hospices as a group have substantially higher live-discharge rates than larger hospices. In 2024, the aggregate live-discharge rate was 60 percent for hospices with 30 or fewer discharges, in contrast to 19 percent for all hospices (data for small hospices not shown).

Chart 11-19 Medicare spending for clinical laboratory tests, 2014–2024



Note: CLFS (clinical laboratory fee schedule). Spending is for services paid under the CLFS. The spending data include only program payments; there is no beneficiary cost sharing for clinical laboratory tests. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of the CLFS claims standard analytic file from CMS and annual reports of the Boards of Trustees of the Medicare trust funds (2020 and 2025).

> Medicare pays for laboratory services furnished to fee-for-service beneficiaries under the CLFS. Beginning in 2018, CLFS payment rates are based on private sector rates. Before the changes, CLFS spending per Part B beneficiary was declining, falling by 0.4 percent a year from 2014 to 2017. From 2017 to 2024, CLFS spending per Part B beneficiary increased by 5.1 per year in spite of rate reductions in 2018 to 2020 and flat rates (no increase) in 2021 to 2024. The higher per beneficiary spending in 2019 to 2024 reflects several factors, including the impact of additional volume, which includes COVID-19-related laboratory tests and increases in the utilization of genetic and molecular laboratory tests.

> The number of lab “units” (an approximate measure of the number of tests a beneficiary receives) per Part B beneficiary were declining before 2017. However, the average number of CLFS tests per Part B beneficiary has generally been higher since then, reaching 14.6 in 2024—an increase of 15.6 percent compared with 2017.

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