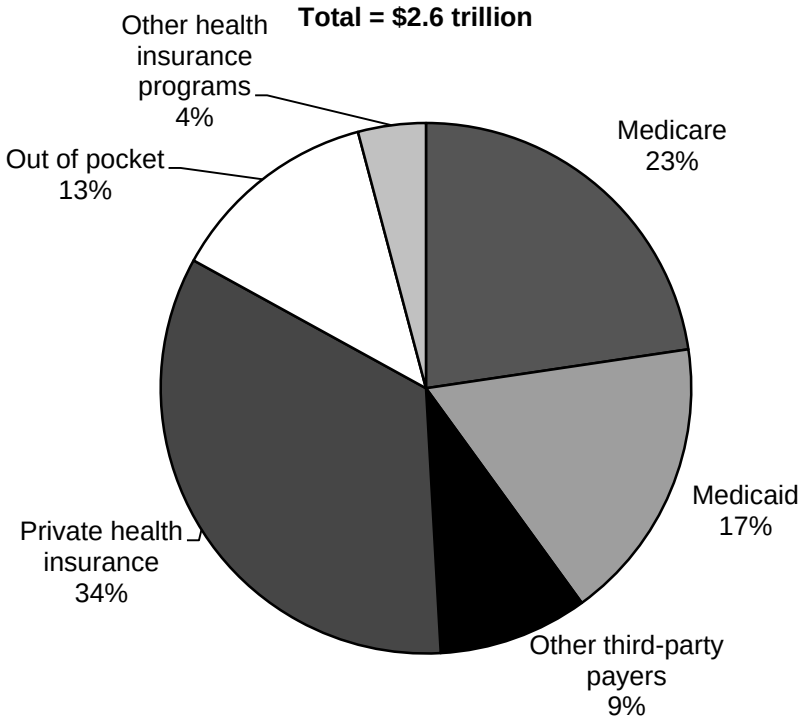
SECTION 1

National health care and Medicare spending

Chart 1-1. Medicare was the largest single purchaser of personal health care, 2014



Note: "Personal health care" is a subset of national health expenditures. It includes spending for all medical goods and services that are provided for the treatment of an individual and excludes other spending, such as government administration, the net cost of health insurance, public health, and investment. "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 share of the out-of-pocket category. "Other health insurance programs" includes the Children's Health Insurance Program, Department of Defense, and Department of Veterans Affairs. "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, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

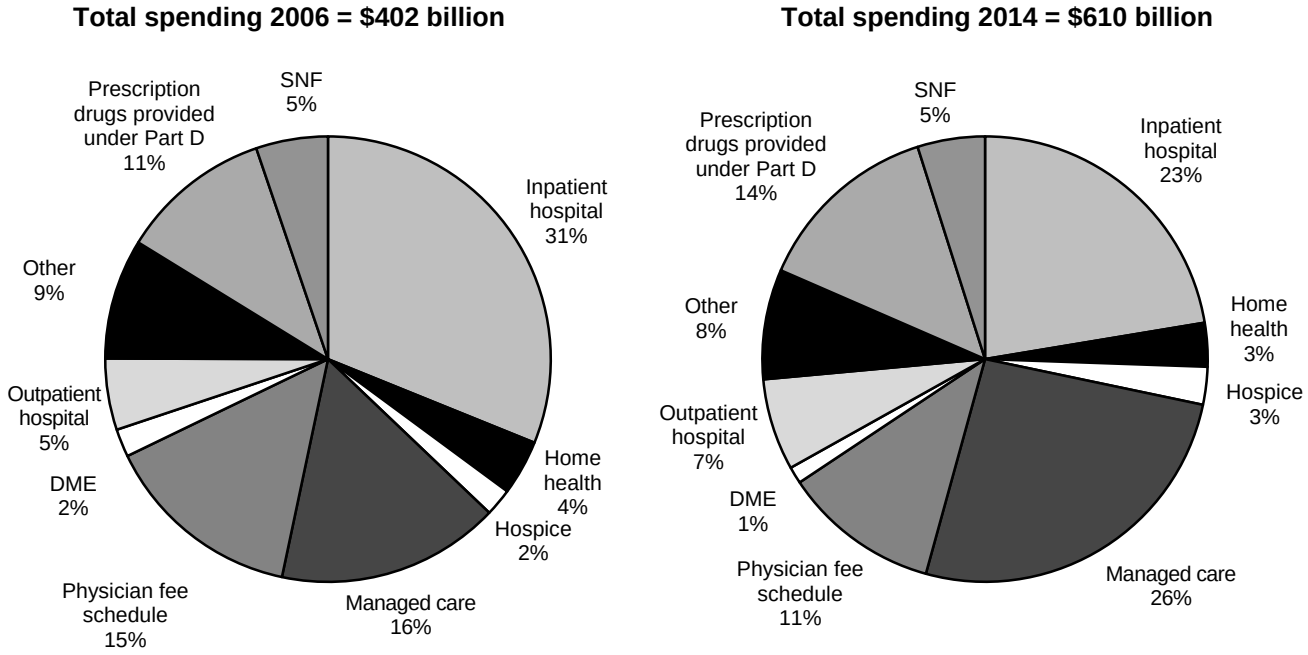
Source: CMS Office of the Actuary, National Health Expenditure Accounts, "Table 6: Personal Health Care Expenditures; Levels, Percent Change and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2014," released December 2015.

- Medicare is the largest single purchaser of health care in the United States. (The share of spending accounted for by private health insurance (34 percent in 2014) is greater than Medicare's share (23 percent in 2014). However, private health insurance is not a single purchaser of health care; rather, it includes many private plans, including traditional managed care, self-insured health plans, and indemnity plans.) Of the $2.6 trillion spent on personal health care in 2014, Medicare accounted for 23 percent, or $580 billion (as noted above, this amount includes spending on direct patient care and excludes certain administrative and business costs).

- Thirty-four percent of spending was financed through private health insurance payers, and 13 percent was from consumer out-of-pocket spending.

- Medicare and private health insurance spending includes premium contributions from enrollees.

Chart 1-2. Medicare spending is concentrated in certain services and has shifted over time



Note: SNF (skilled nursing facility), DME (durable medical equipment). All data are by calendar year. Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. "Other" includes items such as laboratory services, physician-administered drugs, renal dialysis performed in freestanding dialysis facilities, services provided in freestanding ambulatory surgical center facilities, and ambulance. Totals may not sum to 100 percent due to rounding.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2015.
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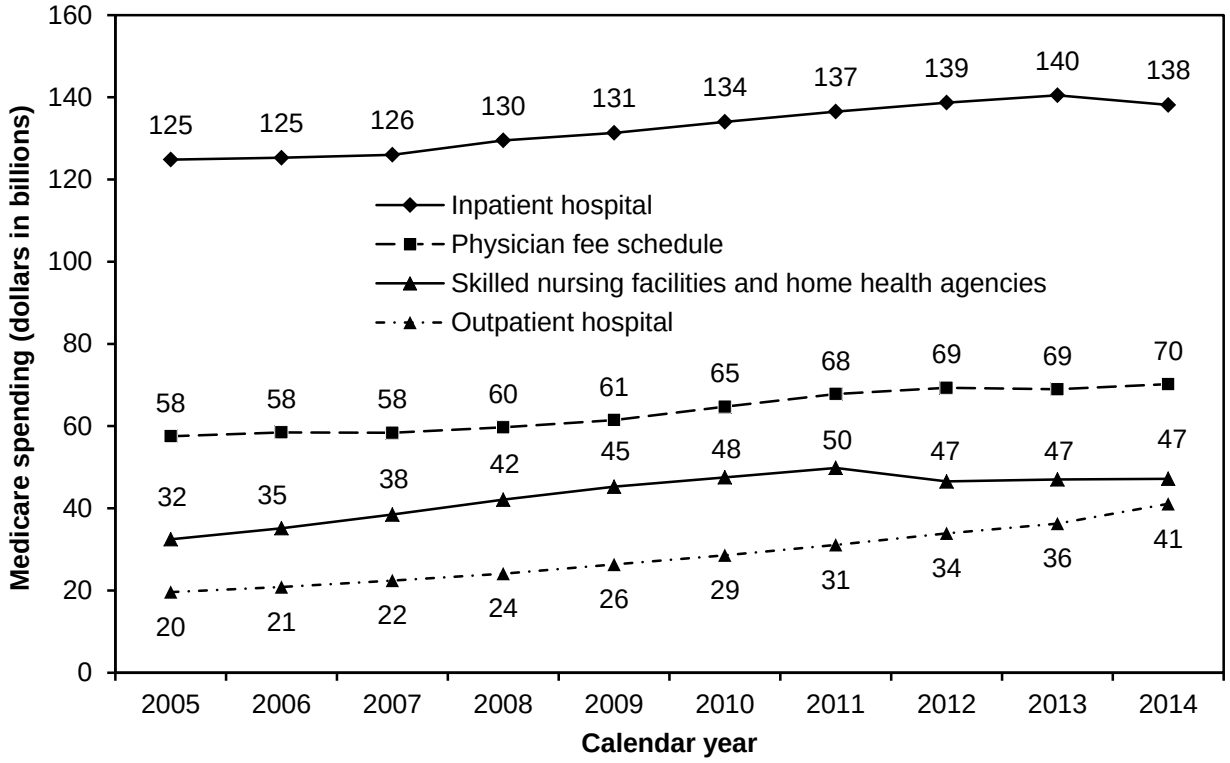
- The distribution of Medicare spending among services has changed over time.
- In 2014, Medicare spending totaled $610 billion for benefit expenses. Managed care was the largest spending category (26 percent), followed by inpatient hospital services (23 percent), prescription drugs provided under Part D (14 percent), services reimbursed under the physician fee schedule (11 percent), and services provided in other settings (8 percent).
- Spending for inpatient hospital services was a smaller share of total Medicare spending in 2014 than it was in 2006, falling from 31 percent to 23 percent. Spending on beneficiaries enrolled in managed care plans grew from 16 percent to 26 percent over the same period. Medicare managed care enrollment increased 129 percent over the same period (data not shown).

Chart 1-3. Aggregate Medicare spending for FFS beneficiaries, by sector, 2005–2014



Note: FFS (fee-for-service). "Physician fee schedule" includes spending on services provided by physicians and other health professionals such as nurse practitioners, physician assistants, and physical therapists. Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. Spending for Medicare Advantage enrollees is also not included.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2015.
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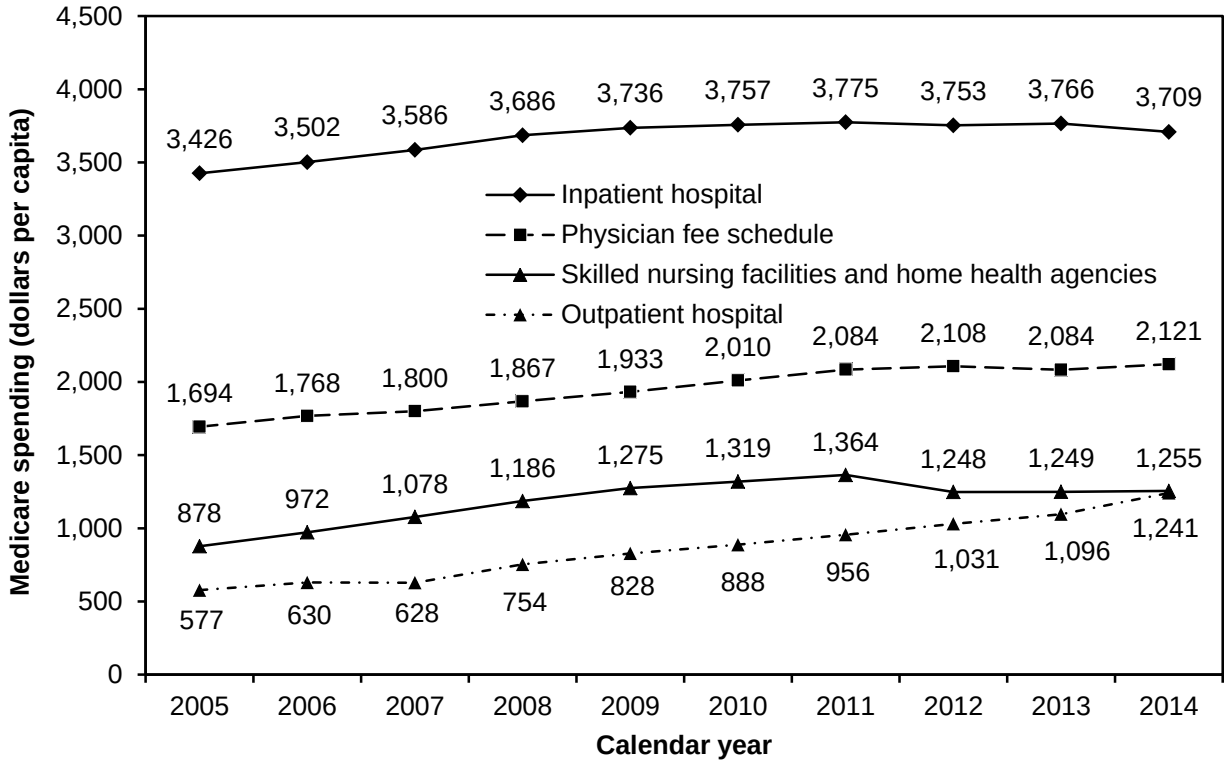
- Medicare spending among FFS beneficiaries has increased significantly since 2005 across all sectors, even though spending growth has slowed recently. The slowdown in spending growth is partly attributable to a decline in the growth of FFS enrollment since the number of Medicare Advantage enrollees has increased.

- Spending growth for inpatient hospital services, the sector with the highest level of spending, averaged 1.5 percent per year from 2005 to 2013. Spending then declined by 1.7 percent between 2013 and 2014 (calculated on unrounded numbers). The decline in the last year is partly attributable to a shift in service volume from the inpatient setting to the outpatient setting and to the decline in the growth of FFS enrollment, but it may also reflect broader economic conditions. Despite the slowdown, spending on inpatient hospital services increased, on aggregate, 11 percent from 2005 to 2014.

- Spending growth for outpatient hospital services remained strong throughout the period, averaging 9 percent per year from 2005 to 2014. Aggregate spending on outpatient hospital services increased 110 percent from 2005 to 2014.

Chart 1-4. Per capita Medicare spending for FFS beneficiaries, by sector, 2005–2014



Note: FFS (fee-for-service). "Physician fee schedule" includes spending on services provided by physicians and other health professionals such as nurse practitioners, physician assistants, and physical therapists. Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. Spending for Medicare Advantage enrollees is also not included. Spending per beneficiary for inpatient hospital services equals spending for the sector (see Chart 1-3) divided by FFS enrollment in Part A. Spending per beneficiary for physician fee schedule services and outpatient hospital services equals spending for the sector (see Chart 1-3) divided by FFS enrollment in Part B. Spending per beneficiary for skilled nursing facilities and home health agencies equals spending for those sectors (see Chart 1-3) divided by total FFS enrollment.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2015.
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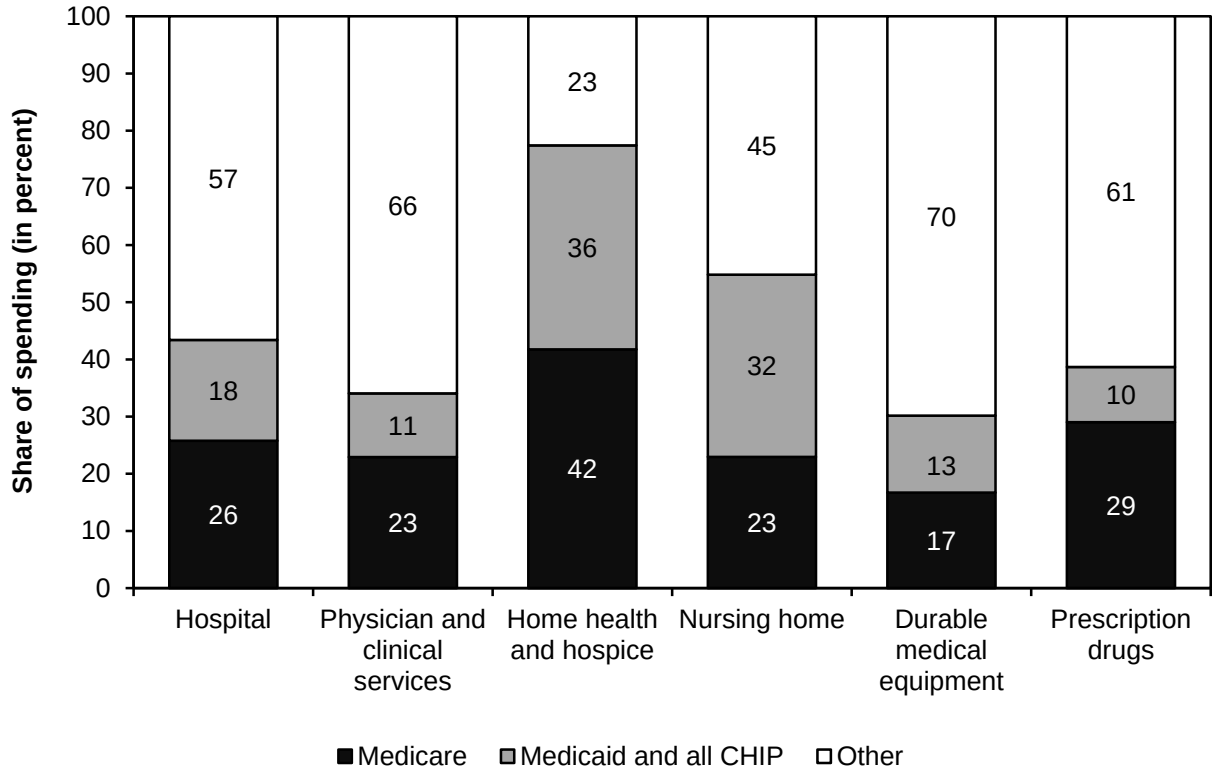
- Medicare spending per beneficiary in FFS Medicare has increased substantially since 2005 across all sectors, despite slowing down or declining recently in some sectors.

- Growth in spending per beneficiary for inpatient hospital services, the sector with the highest level of spending, averaged 3 percent per year from 2005 to 2008 and 1 percent per year from 2008 to 2011. It declined by an average of 1 percent per year from 2011 to 2014. Despite the slowdown in recent years, spending per beneficiary for inpatient hospital services increased, on aggregate, 8 percent from 2005 to 2014.

- Growth in spending per beneficiary for outpatient hospital services remained strong throughout the period, averaging 9 percent per year from 2005 to 2014. Spending per beneficiary for outpatient hospital services increased, on aggregate, 115 percent from 2005 to 2014.

Chart 1-5. Medicare's share of spending on personal health care varied by type of service, 2014



Note: CHIP (Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures. It includes spending for all medical goods and services that are provided for the treatment of an individual and excludes other spending, such as government administration, the net cost of health insurance, public health, and investment. "Other" includes private health insurance, out-of-pocket spending, and other private and public spending. Bars may not total 100 percent because of rounding.

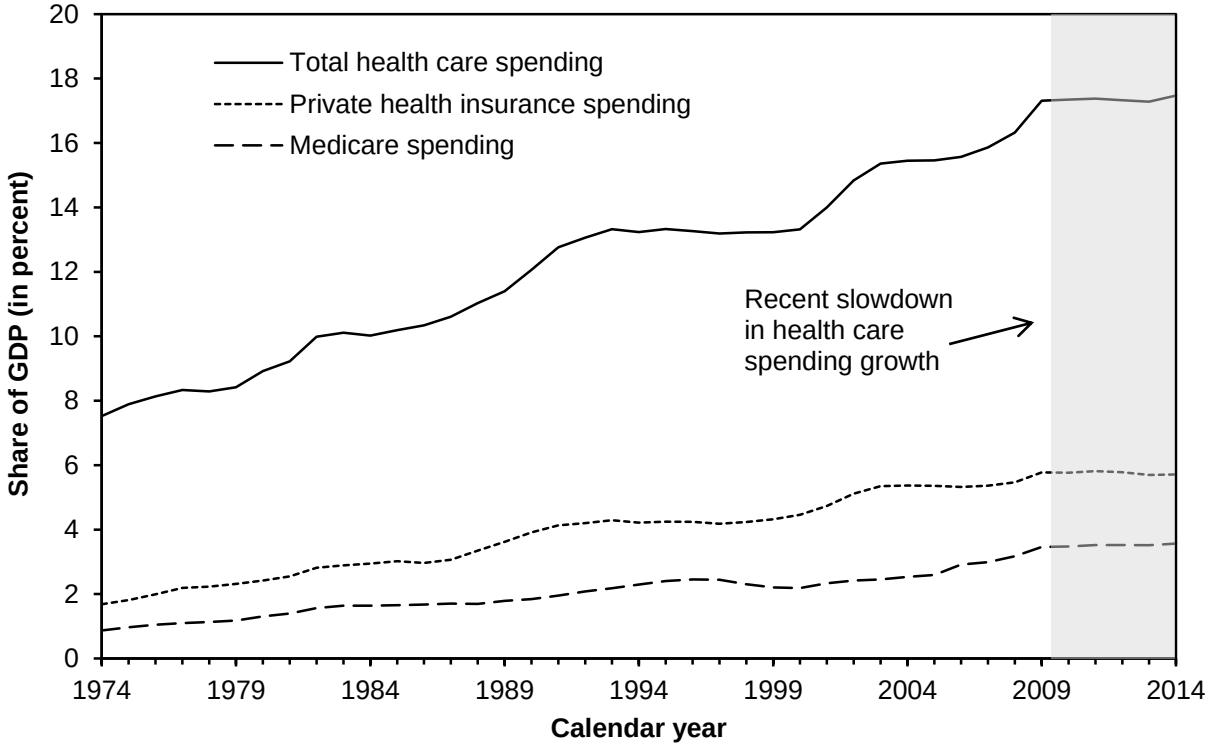
Source: CMS Office of the Actuary, National Health Expenditure Accounts, "Table 19: National Health Expenditures by Type of Expenditure and Program: Calendar Year 2014," released December 2015.

- While Medicare's share of total personal health care spending was 23 percent in 2014 (see Chart 1-1), its share of spending by type of service varied, with a slightly higher share of spending on hospital care (26 percent) and prescription drugs (29 percent) and a much higher share of spending on home health and hospice services (42 percent).

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

- In 2014, Medicare accounted for 26 percent of spending on hospital care, 23 percent of physician and clinical services, 42 percent of home health and hospice services, 23 percent of nursing home care, 17 percent of durable medical equipment, and 29 percent of prescription drugs.

Chart 1-6. Historically, health care spending has risen as a share of GDP; recently, its growth has slowed



Note: GDP (gross domestic product).

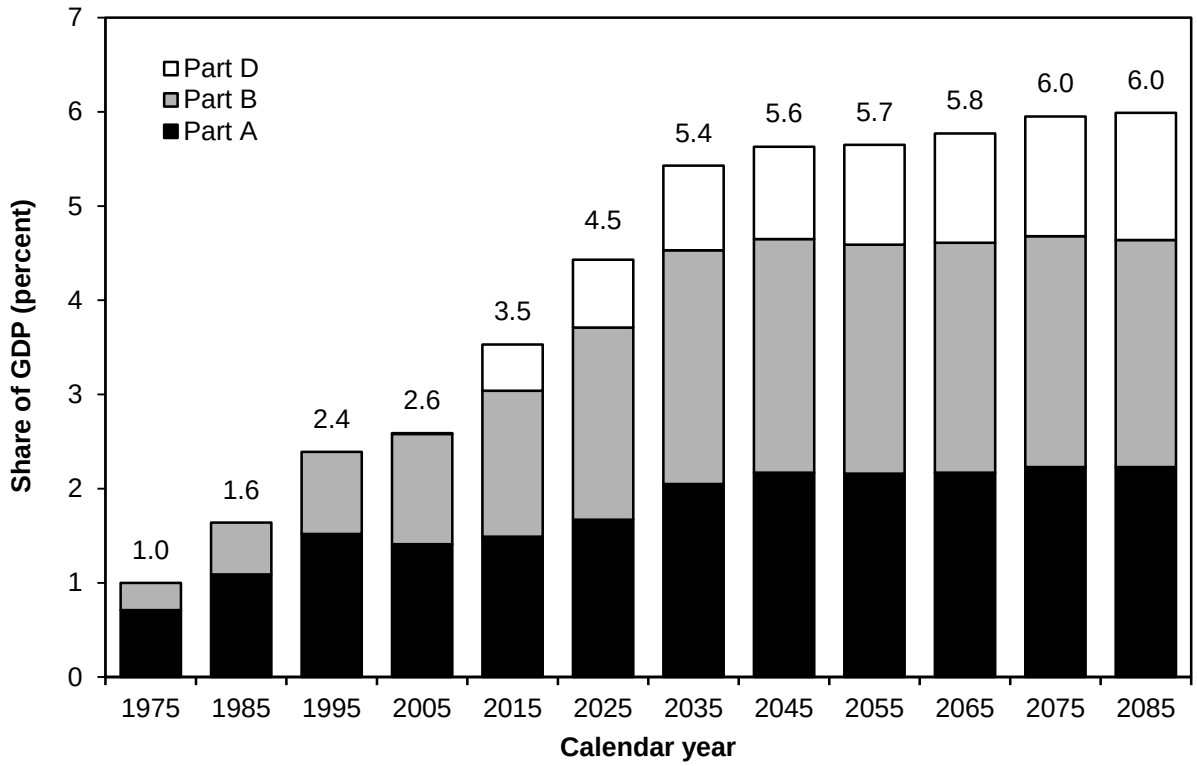
Source: CMS Office of the Actuary, National Health Expenditure Accounts 2014.

- Historically, health care spending has risen as a share of GDP, but recently its growth rate has slowed. That general trend is true for health care spending by private sector payers as well as by Medicare.

- As a share of GDP, total health care spending more than doubled from 1974 to 2014, increasing from 7.5 percent to 17.5 percent. As a share of GDP, private health insurance spending more than tripled over that same time period, increasing from 1.7 percent to 5.7 percent. As a share of GDP, Medicare spending went up by a factor of almost five, increasing from 0.9 percent to 3.6 percent.

- However, as seen in the chart above, health care spending as a share of GDP has remained relatively constant since 2009.

Chart 1-7. Trustees project Medicare spending to continue to increase as a share of GDP



Note: GDP (gross domestic product). Shares for year 2015 and later are projections and based on the Trustees' intermediate set of assumptions.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2015.
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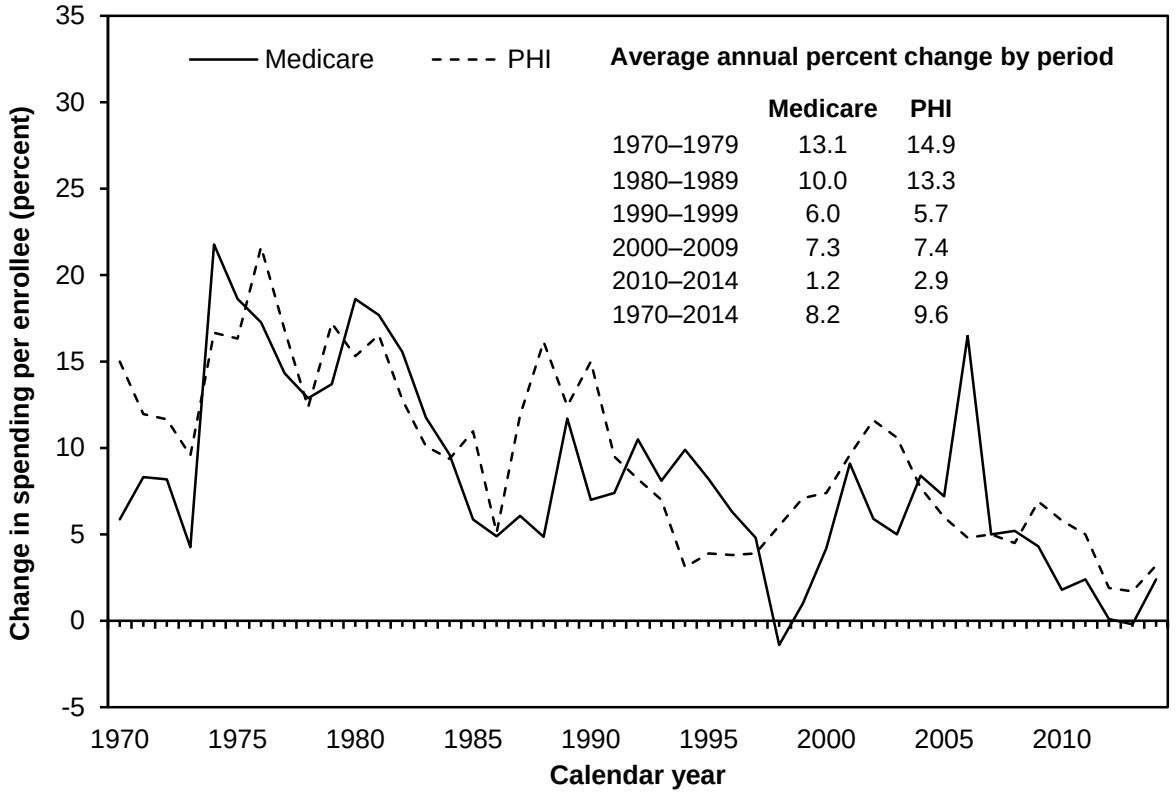
- Over time, Medicare spending has accounted for an increasing share of GDP. From 1 percent in 1975, it is projected to reach 6 percent of GDP in 2075.

- The Medicare Trustees project that spending will rise from 3.5 percent of GDP in 2015 to 5.4 percent of GDP by 2035, largely because of rapid growth in the number of beneficiaries, and then to 6.0 percent of GDP in 2075, with growth in spending per beneficiary becoming the greater factor in later years of the forecast. The rapid growth in the number of beneficiaries began in 2011 and will continue through 2030 as members of the baby-boom generation reach age 65 and become eligible to receive benefits.

- Medicare spending is projected to continue rising as a share of GDP, but at a slower pace than in the past. Nominal Medicare spending grew on average 9.7 percent per year over the period from 1975 to 2014, considerably faster than nominal growth in the economy, which averaged 6.2 percent per year over the same time frame. Future Medicare spending is projected to continue growing faster than GDP, averaging 5.3 percent per year between 2014 and 2085 compared with an annual average growth rate of 4.5 percent for the economy as a whole.

Chart 1-8. Changes in spending per enrollee, Medicare and private health insurance



Note: PHI (private health insurance). Medicare expenditures include both fee-for-service and Medicare Advantage plans.

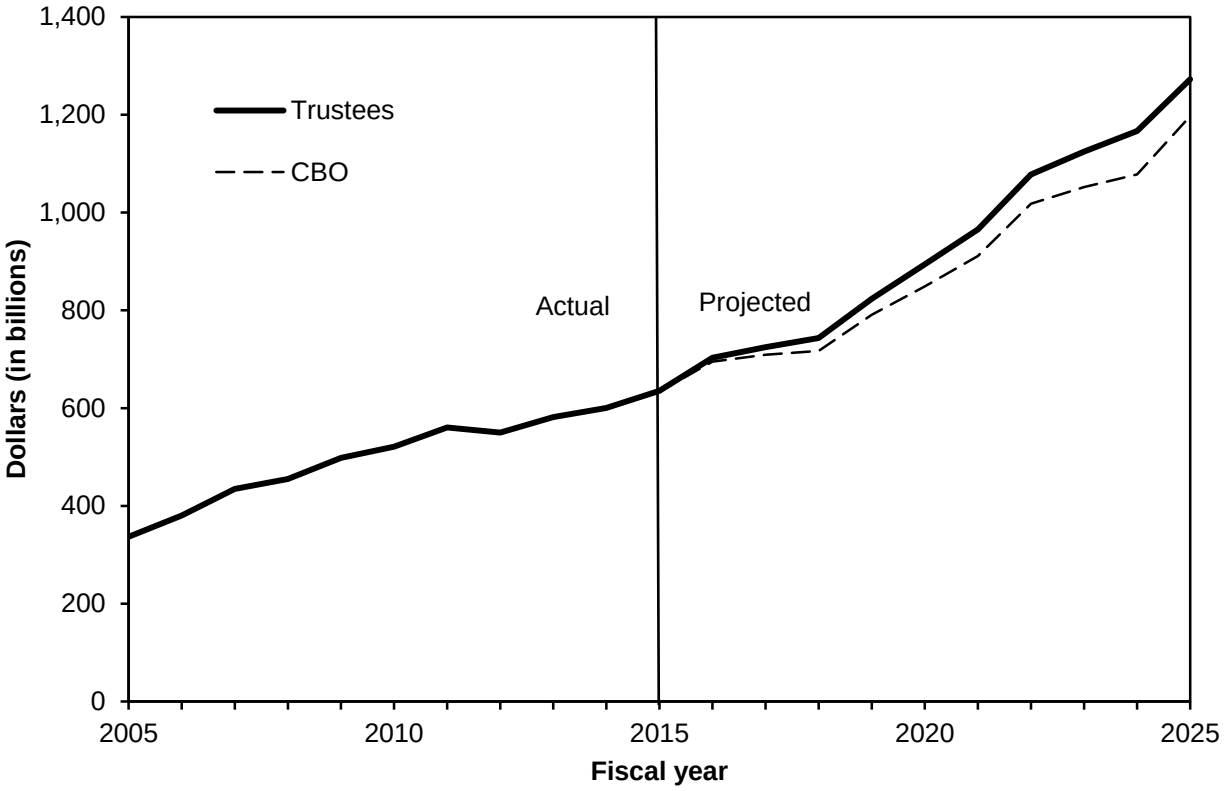
Source: CMS Office of the Actuary, National Health Expenditure Accounts 2013 and 2014.

- Rates of growth in per capita spending for Medicare and private health insurance have followed a similar pattern over the last four decades. For the past several years, rates of growth in per capita spending have slowed for both Medicare and private health insurance; however, rates are beginning to increase.

- Differences between the rates of growth do appear to be more pronounced since the mid-1980s. Some analysts believe that those differences are attributable to the introduction of the prospective payment system for hospital inpatient services that began in 1985. In their view, that payment system has allowed Medicare greater success than private payers in containing spending growth. Others maintain that the differences are due to the expansion of benefits offered by private insurers and to a decline in cost-sharing requirements. More recently, cost-sharing requirements have increased, coinciding with a decline in the growth of per capita spending for private payers.

- Comparisons are problematic because private insurers and Medicare do not buy the same mix of services and Medicare covers an older population, which tends to be more costly. In addition, spending trends are also affected by changes in the generosity of covered benefits and changes in enrollees' out-of-pocket spending.

Chart 1-9. Trustees and CBO project Medicare spending to exceed $1 trillion by the early part of the next decade



Note: CBO (Congressional Budget Office). All data are nominal, mandatory outlays (benefit payments plus mandatory administrative expenses) by fiscal year.

Source: CBO 2015 Baseline; the annual report of the Boards of Trustees of the Medicare trust funds 2015.
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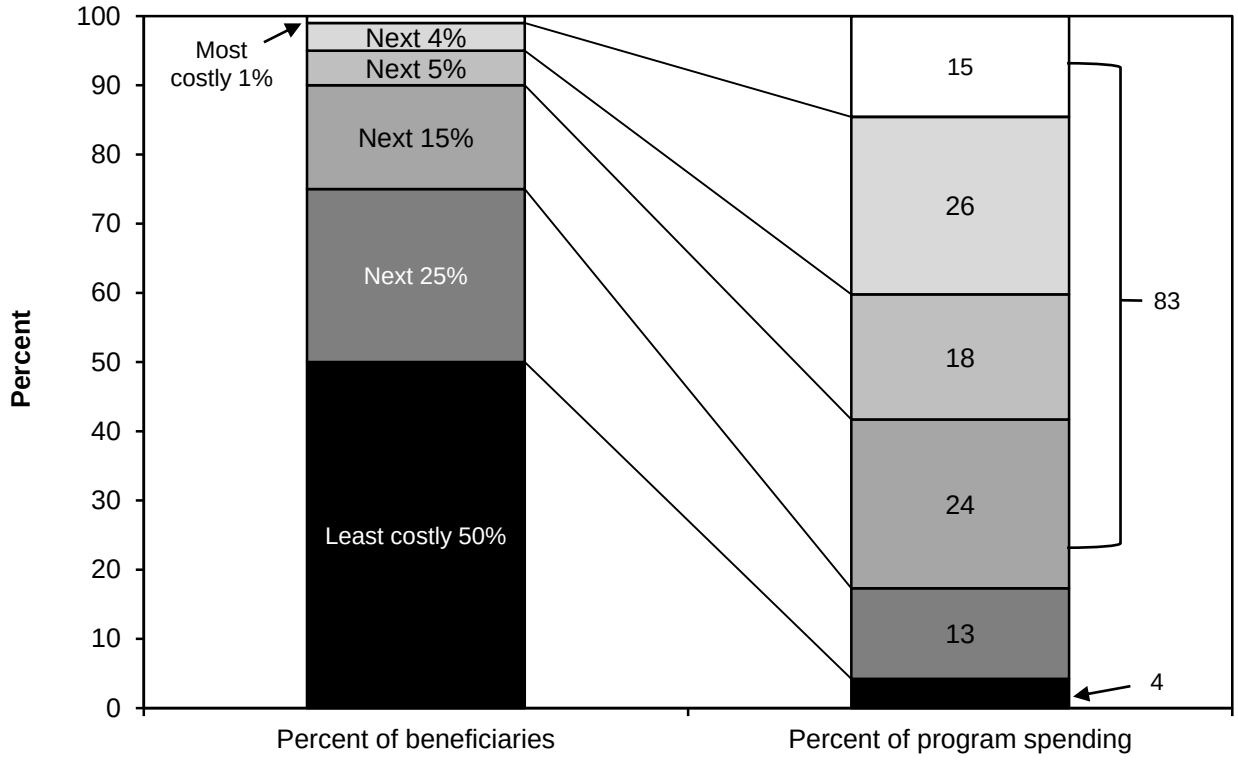
- Medicare spending has nearly doubled since 2005, increasing from $337 billion to $635 billion by 2015 (these data are by fiscal year and include benefit payments and mandatory administrative expenses).
- The Medicare Trustees and CBO project that spending for Medicare between 2015 and 2025 will grow at an average annual rate of 7.2 percent or 6.6 percent, respectively. Medicare spending will reach $1 trillion in 2022 under both the Trustees' and CBO's projections.
- Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy (which affect annual updates to provider payments) and about growth in the volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 1-10. FFS program spending was highly concentrated in a small group of beneficiaries, 2012



Note: FFS (fee-for-service). All data are for calendar year 2012. Analysis excludes beneficiaries with any group health enrollment during the year.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files 2012.

- Medicare FFS spending is concentrated among a small number of beneficiaries. In 2012, the costliest 5 percent of beneficiaries accounted for 41 percent of annual Medicare FFS spending, and the costliest 25 percent accounted for 83 percent. By contrast, the least costly 50 percent of beneficiaries accounted for only 4 percent of FFS spending.

- Costly beneficiaries tend to include those who have multiple chronic conditions, are using inpatient hospital services, are dually eligible for Medicare and Medicaid, and are in the last year of life.

Chart 1-11. Medicare HI trust fund is projected to be insolvent in 2030 under Trustees' intermediate assumptions

Cost assumptions	Years costs exceed income	Years costs remain below income	Year HI trust fund assets exhausted
High	2008–2022	——	2022
Intermediate	2008–2014, 2024–2030	2015–2023	2030
Low	2008–2014	2015–2089*	Never**

Note: HI (Hospital Insurance). All years represent calendar years. The primary source of income for HI is the payroll tax on covered earnings. Other HI income sources include (a) a portion of the federal income taxes that Social Security recipients with incomes above certain thresholds pay on their benefits and (b) interest paid on the U.S. Treasury securities held in the HI trust fund.
*75-year projection period
**Under the low-cost assumption, trust fund assets would start to increase in 2015 and continue to increase throughout the projection period.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2015.
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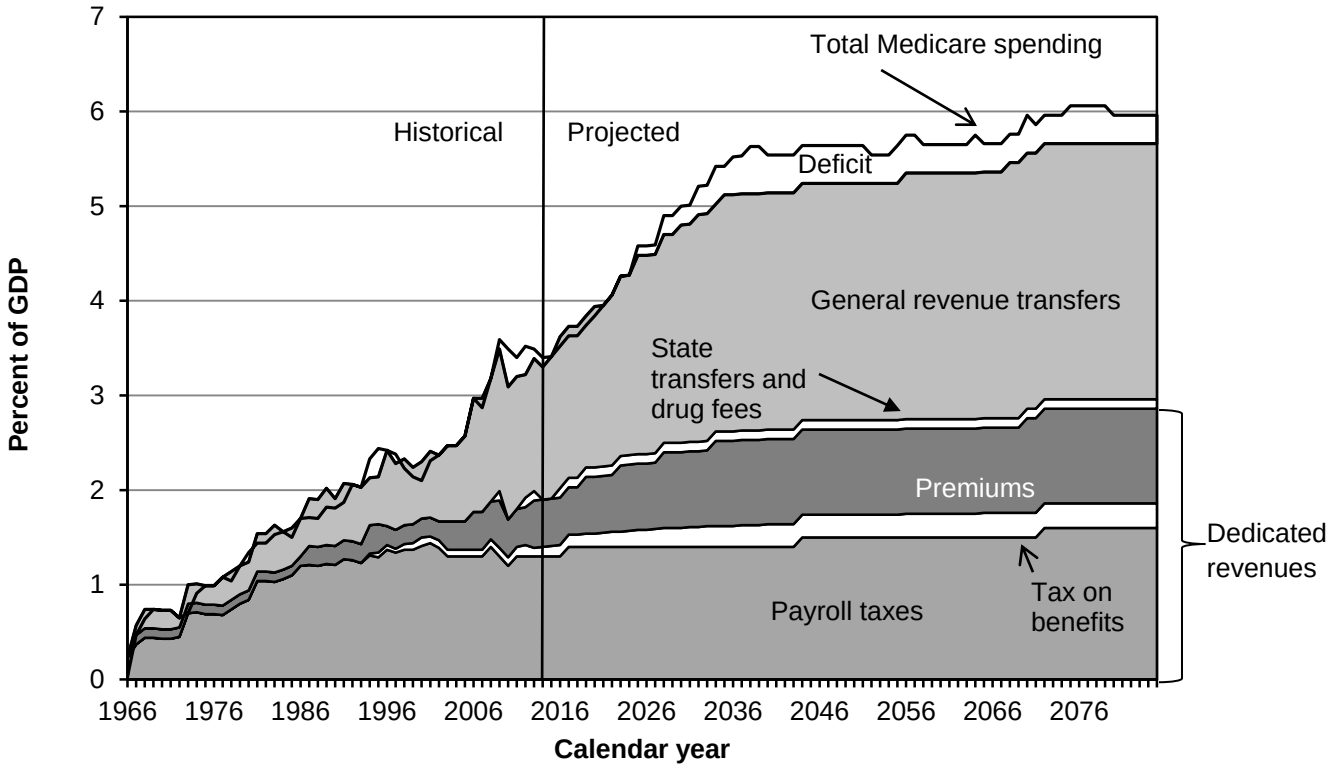
- The HI trust fund funds Part A, which helps pay for inpatient hospital stays and post-acute care such as skilled nursing facilities and hospice. Part A is funded through a dedicated payroll tax (i.e., a tax on wage earnings).

- Since 2008, the HI trust fund has run an annual deficit (i.e., paid more in benefits than it collects in payroll taxes). The trust fund still has interest income generated from loaning funds to other parts of the government during times of surplus, but those assets are projected to be exhausted by 2030 under the Trustees' intermediate assumptions. Under high-cost assumptions, the HI trust fund could be exhausted as early as 2022. Under low-cost assumptions, it would remain able to pay full benefits indefinitely.

- The Trustees estimate that the payroll tax would immediately need to be increased from its current rate of 2.9 percent to 3.6 percent to balance the HI trust fund over the next 75 years. Alternatively, Part A spending would immediately need to be reduced by 15 percent.

Chart 1-12. General revenue is paying for a growing share of Medicare spending



Note: GDP (gross domestic product). These projections are based on the Trustees' intermediate set of assumptions. "Tax on benefits" refers to the portion of income taxes that higher income individuals pay on Social Security benefits, which is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. The "drug fee" is the fee imposed in the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance trust fund.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2015.
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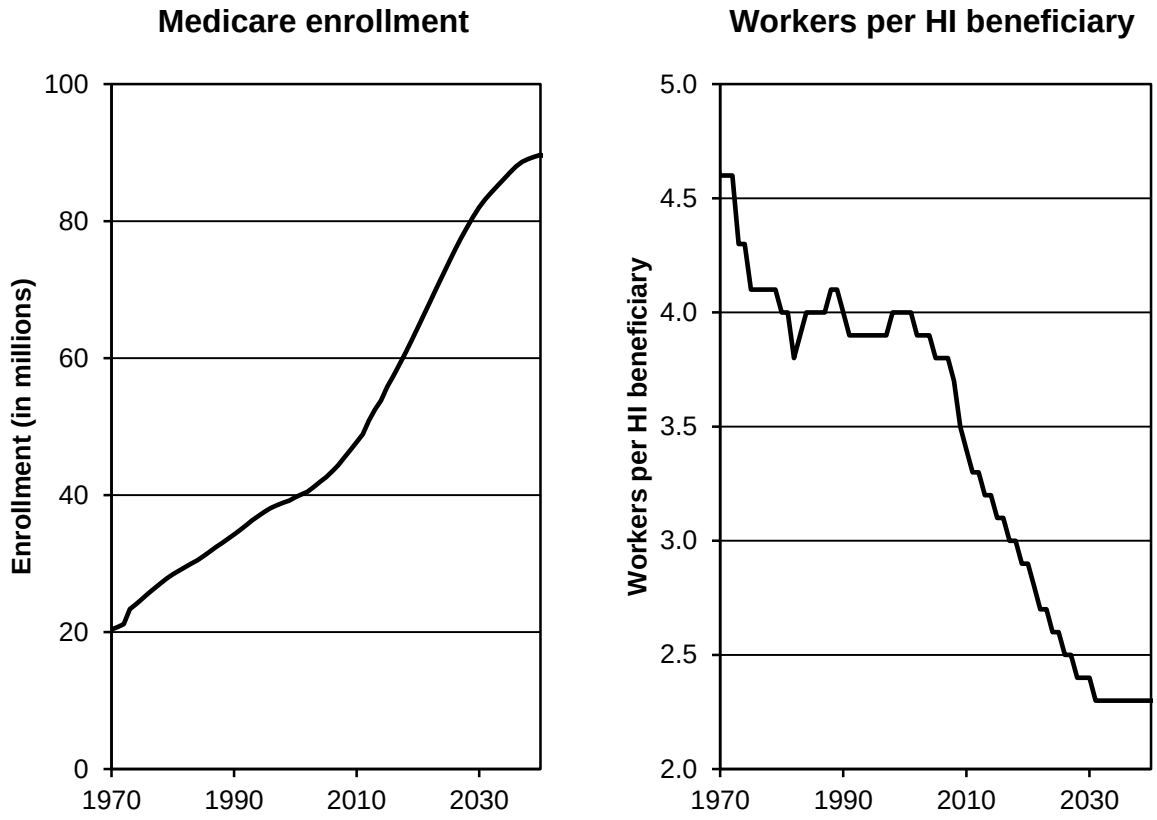
- The Medicare Trustees project that Medicare's share of GDP will rise to 5.5 percent by 2040 and to 6.0 percent by 2085.
- Beginning in 2009, general revenue transfers became the largest single source of Medicare income. They are expected to remain level as a share of Medicare financing, about 44 percent, through 2023 and then grow to about 48 percent by 2037.
- As Medicare becomes more dependent on general revenues, fewer resources will be available to invest in growing the economic output of the future or in other national priorities.

Chart 1-13. Medicare enrollment is rising while the number of workers per HI beneficiary is declining



Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2015.
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- As the baby-boom generation ages, enrollment in the Medicare program will surge. In 15 years, Medicare is projected to have over 80 million beneficiaries—up from 57 million beneficiaries today.

- While Medicare enrollment is rising, the number of workers per beneficiary is rapidly declining. Workers pay for Medicare spending through payroll taxes and income taxes. However, the number of workers per Medicare beneficiary declined from 4.6 during the early years of the program to 3.1 today and is projected by the Medicare Trustees to fall to 2.4 by 2030.

- These demographics threaten the financial stability of the Medicare program.

Chart 1-14. Medicare HI and SMI benefits and cost sharing per FFS beneficiary

	Average benefit in 2014 (in dollars)	Average cost sharing in 2012* (in dollars)
HI	$4,927	$422
SMI	5,334	1,278

Note: HI (Hospital Insurance), SMI (Supplementary Medical Insurance), FFS (fee-for-service). Dollar amounts are nominal for FFS Medicare only and do not include Part D. "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.
*Data for average cost sharing in 2013 is not yet available from CMS.

Source: CMS Office of the Actuary, 2015 annual report of the Boards of Trustees of the Medicare trust funds, Medicare and Medicaid Statistical Supplement 2013, CMS Office of Information Services.
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- In calendar year 2014, the Medicare program made $4,927 in HI (Part A) benefit payments and $5,334 in SMI (Part B) benefit payments on average per fee-for-service beneficiary.
- Beneficiaries owed an average of $422 in cost sharing for HI and $1,278 in cost sharing for SMI in calendar year 2012 (the latest year for which such data are available).
- To cover some of those cost-sharing requirements, about 90 percent of beneficiaries have coverage that supplements or replaces the Medicare benefit package, such as Medicare Advantage, Medicaid, supplemental coverage through former employers, and medigap coverage.