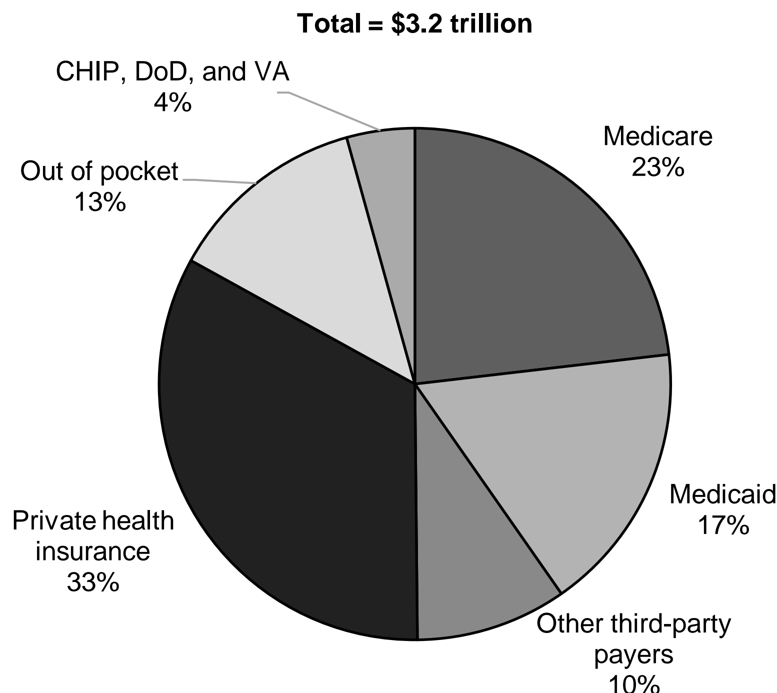
SECTION 1

National health care and Medicare spending

Chart 1-1. Medicare was the largest single purchaser of personal health care, 2019



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. 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 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.

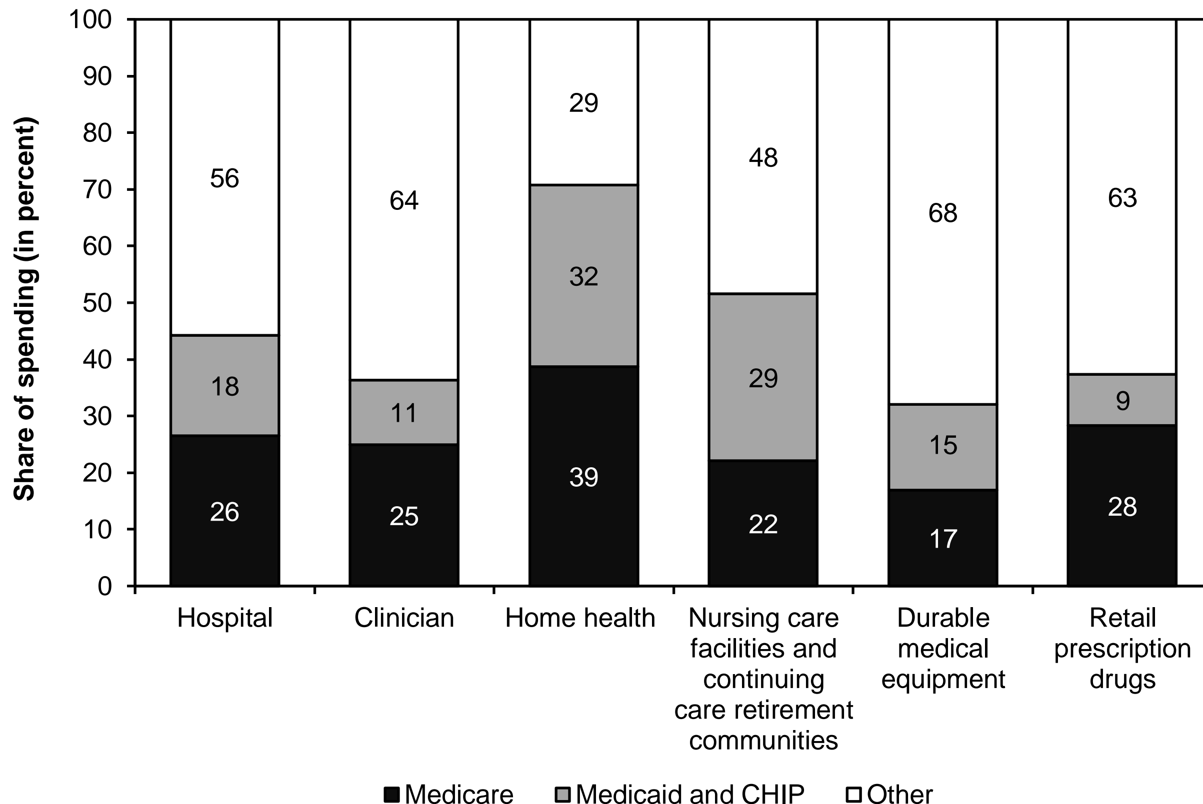
Source: CMS Office of the Actuary, National Health Expenditure Accounts, "Table 6: Personal Health Care Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2019," released December 2020.

- Medicare is the largest single purchaser of health care in the U.S. (Although the share of spending accounted for by private health insurance is greater than Medicare's share, private health insurance is not a single purchaser of health care; rather, it includes many private plans, including managed care, self-insured health plans, and indemnity plans.) Of the $3.2 trillion spent on personal health care in 2019, Medicare accounted for 23 percent, or $743 billion. This amount includes spending on direct patient care and excludes certain administrative and business costs.

- Private health insurance plans financed 33 percent of personal health care spending, and consumer out-of-pocket spending (not including premiums) amounted to 13 percent of the total.

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

Chart 1-2. Medicare's share of spending on personal health care varied by type of service, 2019



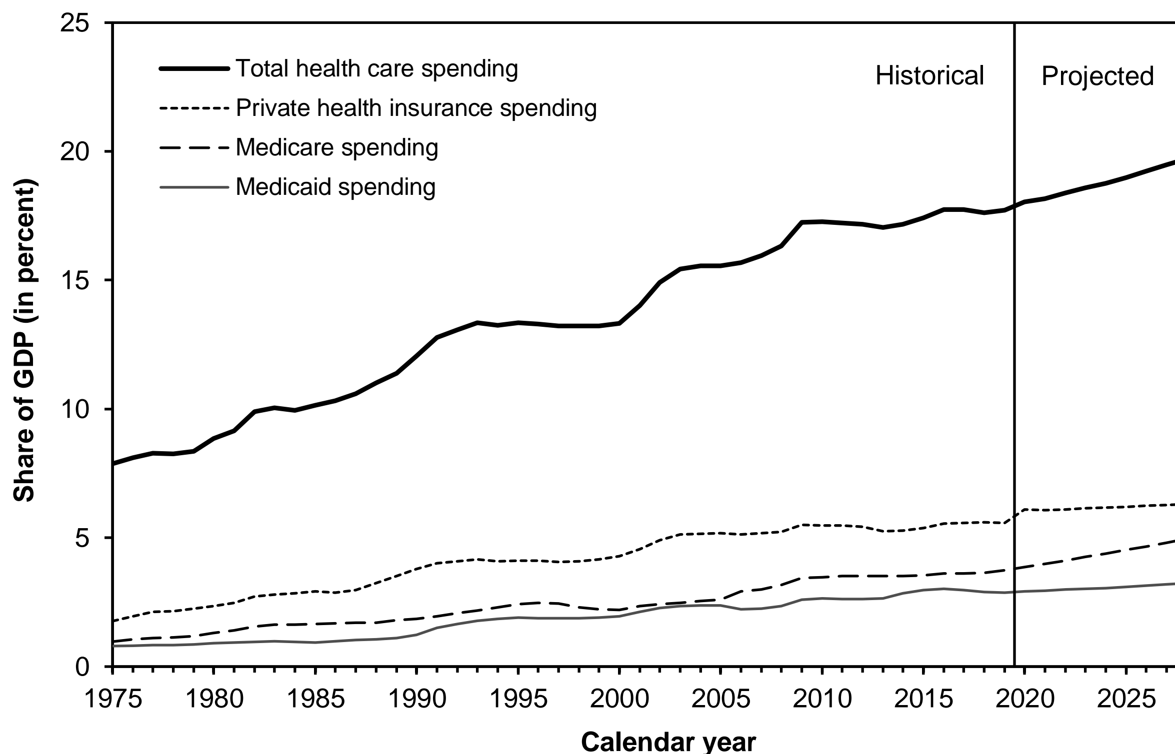
Note: CHIP (Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures. It includes spending for all medical goods and services that are provided for the treatment of an individual and excludes other spending such as government administration, the net cost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

Source: CMS Office of the Actuary, National Health Expenditure Accounts, historical data released December 2020.

- While Medicare's share of total personal health care spending was 23 percent in 2019 (see Chart 1-1), its share of spending by type of service varied, from 17 percent of spending on durable medical equipment to 39 percent of spending on home health care.

- Medicare's share of spending on nursing care facilities and continuing care retirement communities was smaller than Medicaid's share. 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.

Chart 1-3. Health care spending has consumed an increasing share of the country's GDP



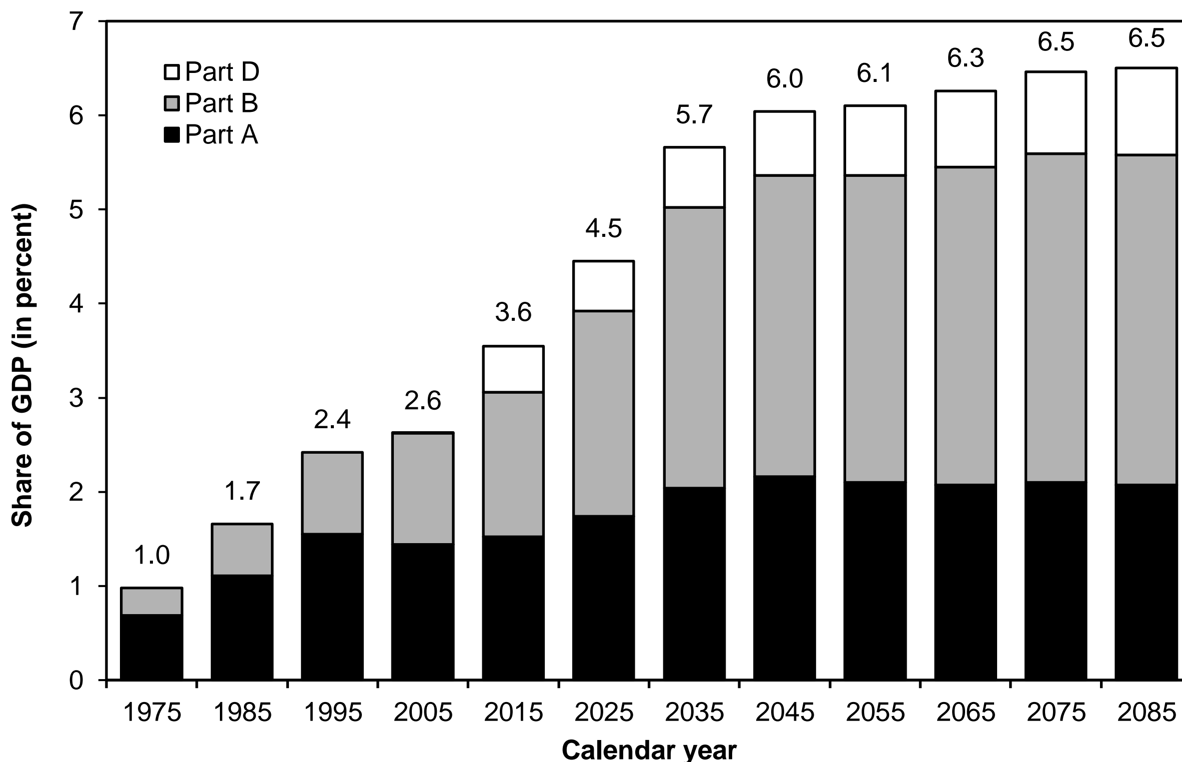
Note: GDP (gross domestic product). The potential effects of the coronavirus pandemic are not reflected in these projections.

Source: CMS Office of the Actuary, National Health Expenditure Accounts, historical data released December 2020 and projections released April 2020.

- In 2019, total health care spending made up 17.7 percent of the country's GDP. Private health insurance spending constituted 5.6 percent of GDP spending, Medicare constituted 3.7 percent, and Medicaid constituted 2.9 percent.

- Health care spending as a share of GDP more than doubled from 1975 to 2019, increasing from 7.9 percent to 17.7 percent. Over this period, spending on private health insurance, Medicare, and Medicaid grew even faster: Each more than tripled as a share of GDP. Spending on private health insurance increased from 1.8 percent to 5.6 percent of GDP, Medicare increased from 1.0 percent to 3.7 percent of GDP, and Medicaid increased from 0.8 percent to 2.9 percent of GDP.

Chart 1-4. Trustees project Medicare spending to continue to increase as a share of GDP

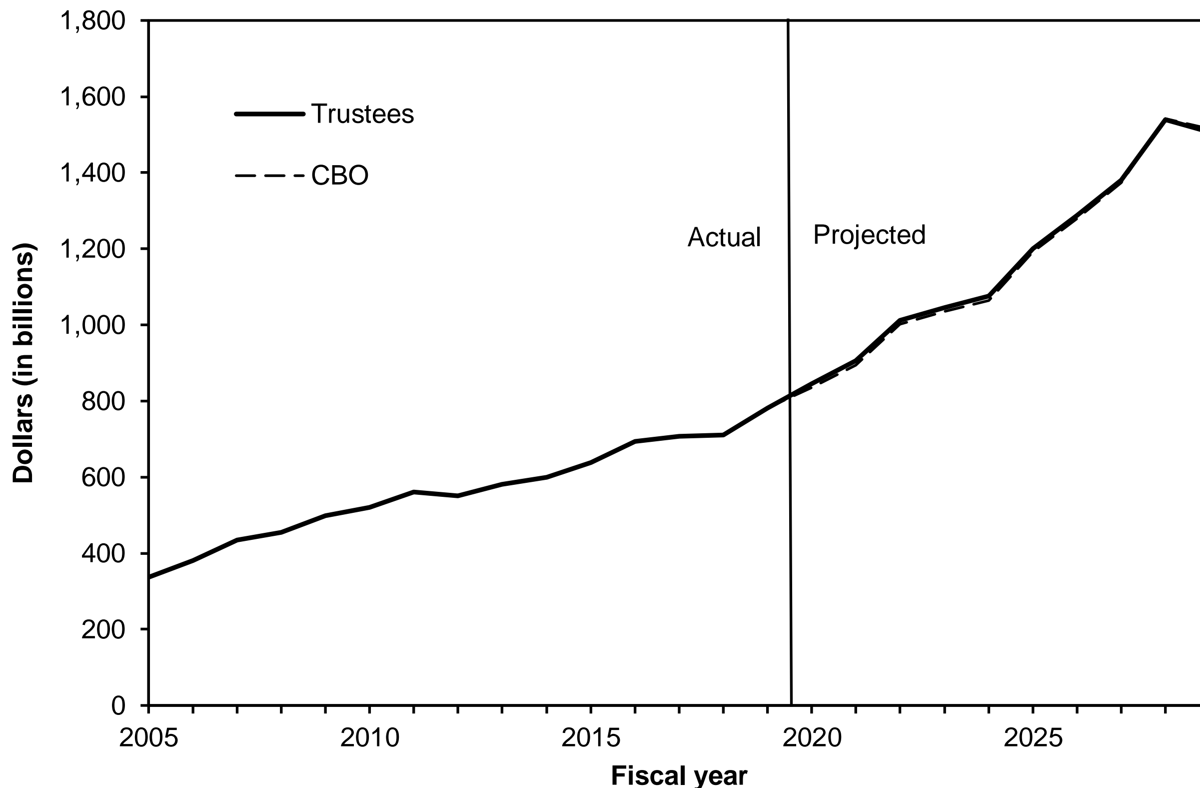


Note: GDP (gross domestic product). The Part D benefit began in 2006. Shares for 2025 and later are projections based on the Trustees' intermediate set of assumptions. The potential effects of the coronavirus pandemic are not reflected in these projections.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- 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 2045.
- The Medicare Trustees project that spending will rise from 3.6 percent of GDP in 2015 to 5.7 percent of GDP by 2035, largely because of rapid growth in the number of beneficiaries, and then to 6.5 percent of GDP by 2075, with growth in spending per beneficiary becoming the greater factor in the 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 enroll in Medicare.
- In the later decades of the Trustees' forecast, Medicare spending is projected to continue rising as a share of GDP, but at a slower pace than in the past.
- Drug costs are projected to grow faster than Part A and Part B expenditures and to account for 14 percent of Medicare expenditures by 2085.

Chart 1-5. Trustees and CBO project Medicare spending to exceed $1 trillion by 2022



Note: CBO (Congressional Budget Office). The potential effects of the coronavirus pandemic are not reflected in these projections. All data are nominal, mandatory outlays (benefit payments plus mandatory administrative expenses) by fiscal year.

Source: Congressional Budget Office's March 2020 baseline spending projections for Medicare; the annual report of the Boards of Trustees of the Medicare trust funds 2020.

- Medicare spending has more than doubled since 2005, increasing from $337 billion to $782 billion by 2019. (These data are by fiscal year and include benefit payments and mandatory administrative expenses. They do not reflect the potential effects of the coronavirus pandemic.)
- The Medicare Trustees and CBO both project that spending for Medicare between 2019 and 2029 will grow at an average annual rate of 6.8 percent. Medicare spending will reach $1 trillion in 2022 under both sets of projections.
- Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy that in turn affect annual updates to provider payments and the number of workers paying Medicare payroll taxes. In addition, forecasts can assume different amounts of growth in the volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 1-6. Factors contributing to Medicare's projected spending growth from 2020 to 2029 (not including general economy-wide inflation)

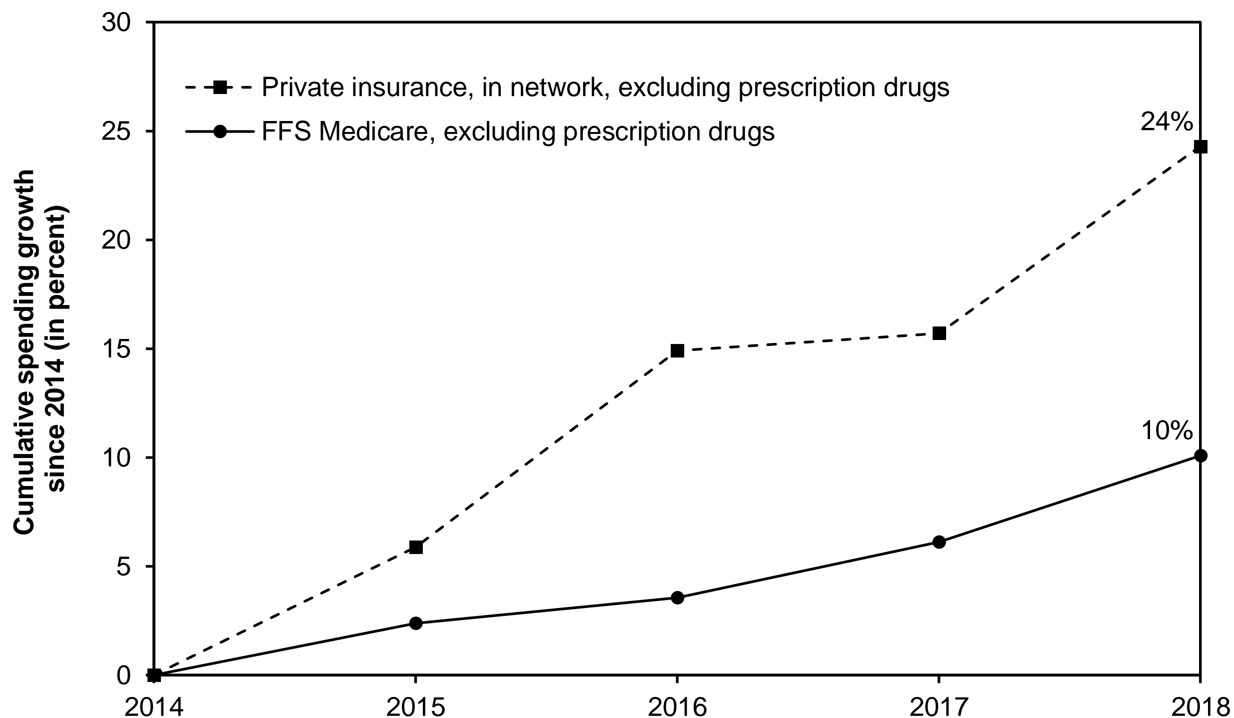
	Average annual percent change in:				
Medicare part	Medicare prices	Number of beneficiaries	Beneficiary demographic mix	Volume and intensity of services used	Medicare's projected spending
Part A	0.2%	2.3%	0.1%	1.2%	3.8%
Part B	–0.7	2.3	0.0	4.0	5.7
Part D	–0.4	2.6	–0.1	1.8	3.9
Total*	–0.3	N/A**	0.0	2.6	4.7

Note: N/A (not available). Includes Medicare Advantage enrollees. Price increases reflect Medicare's annual updates to payment rates (not including inflation, as measured by the consumer price index), multifactor productivity reductions, and any other reductions required by law or regulation (including a statutorily required 2 percent sequester to Medicare benefit payments, which was scheduled to increase to 4 percent for a six-month period in 2029 at the time these projections were developed, but has since been delayed). Part A prices are expected to rise faster than economy-wide inflation in the 2020s in part due to statutorily required increases. Specifically, in each of fiscal years 2020 through 2023, there is a statutory 0.5 percent increase in inpatient operating payments due to unwinding a temporary reduction in payments that was put in place to recoup past overpayments resulting from changes in providers' documentation and coding. Volume and intensity together are the residual after the other three factors shown in the table (Medicare price increases, the increase in the number of beneficiaries, and changes in beneficiary demographic mix) are removed. Much of the 1.2 percent projected increase in Part A volume and intensity may be due to increased coding of hospital severity of illness, which may reflect real changes in patients' needs and/or coding changes; we do not expect the 1.2 percent to reflect increases in volume per capita given that the number of discharges per beneficiary has declined for several decades and fell by 6.1 percent from 2015 to 2019. The "Medicare's projected spending" column is the product of the other columns in the table. Any potential effects of the coronavirus pandemic are not reflected in these projections.
*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 2019 (as measured by shares of gross domestic product).
**We are unable to calculate the total contribution of the increasing number of beneficiaries to projected spending growth because there is beneficiary overlap in enrollment in Part A, Part B, and Part D.

Source: MedPAC analysis of data from the annual report of the Boards of Trustees of the Medicare trust funds 2020.

- Medicare's spending is projected to grow 4.7 percent per year, on average, between 2020 and 2029 (not including growth due to general economy-wide inflation).
- Medicare's projected spending growth is driven by growth in the number of beneficiaries (expected to increase by a little more than 2 percent per year over this period) and growth in the volume and intensity of services delivered per beneficiary (expected to rise by 2.6 percent per year).
- Unlike in the private health care sector, price growth is not expected to drive Medicare's increased spending because Medicare is able to unilaterally set prices for many health care providers.

Chart 1-7. Health care spending per enrollee grew faster for those who were privately insured than for beneficiaries in traditional FFS Medicare, 2014–2018



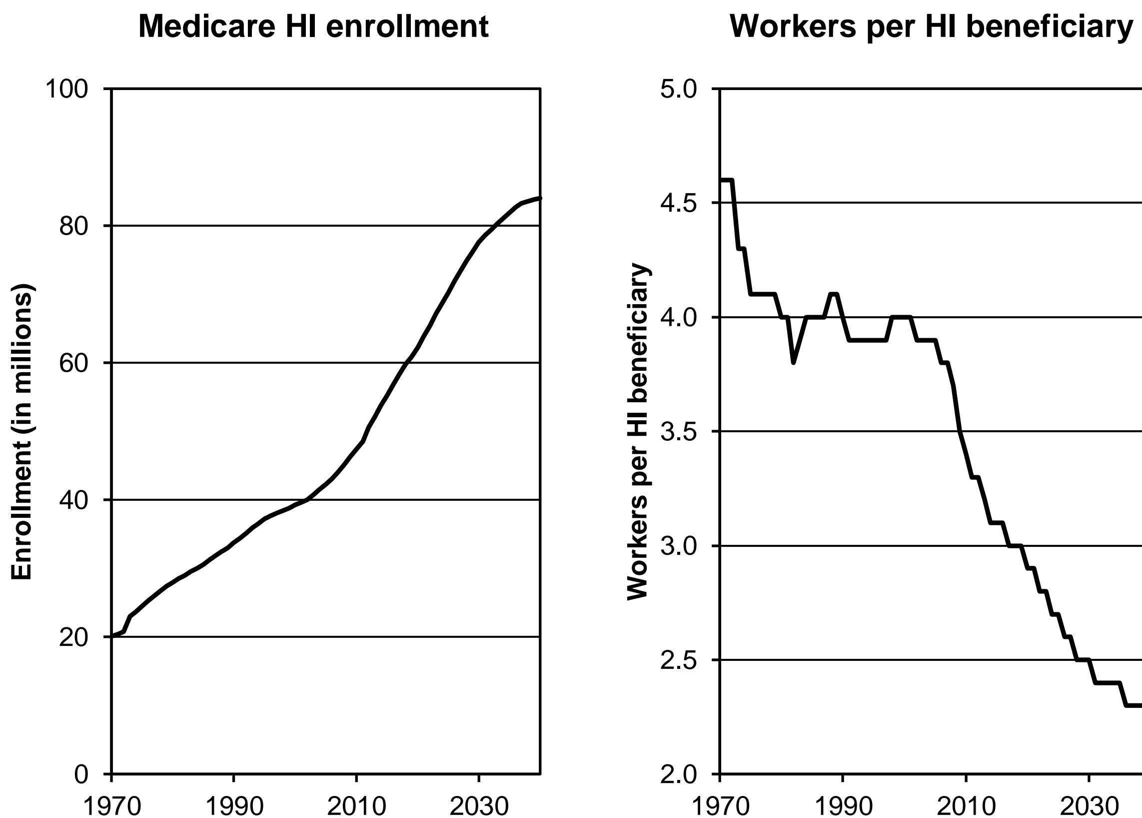
Note: FFS (fee-for-service). The figure shows cumulative spending growth since 2014. It reflects payments to providers from health insurers and patients (i.e., cost sharing) but not payments from other sources (e.g., workers' compensation or auto insurance). Spending on retail prescription drugs is not available for those who are privately insured, so it is excluded from both lines in this graph. Spending on out-of-network services for those who are privately insured is not available and thus not included in this graph. "Private insurance" reflects spending contributed by national and regional plans and third-party administrators nationwide for adults ages 18 to 64 in self-insured plans (i.e., employer self-funded plans) and fully insured plans, including individual and group plans, marketplace plans, and Medicare Advantage plans for non-elderly disabled individuals. The figure reflects spending for individuals with full-year insurance coverage (including individuals with $0 of health care spending).

Source: MedPAC analysis of Medicare's Master Beneficiary Summary File; FAIR Health analysis of its National Private Insurance Claims database (which reflects 150 million covered lives) for the subset of enrollees ages 18 to 64.

- Between 2014 and 2018, total health care spending per enrollee (including cost sharing) grew 24 percent for those who were privately insured, compared with 10 percent for beneficiaries in traditional fee-for-service Medicare.

- Increased prices were largely responsible for spending growth in the private sector. One key driver of the private sector's higher prices has been provider market power. Hospitals and physician groups have increasingly consolidated, in part to gain leverage over insurers in negotiating higher payment rates. By 2017, 57 percent of hospital markets were so concentrated that one health system produced a majority of hospital discharges (data not shown). Studies have found that prices paid by private payers tend to increase as provider consolidation increases.

Chart 1-8. Medicare enrollment is rising while the number of workers per HI beneficiary is declining

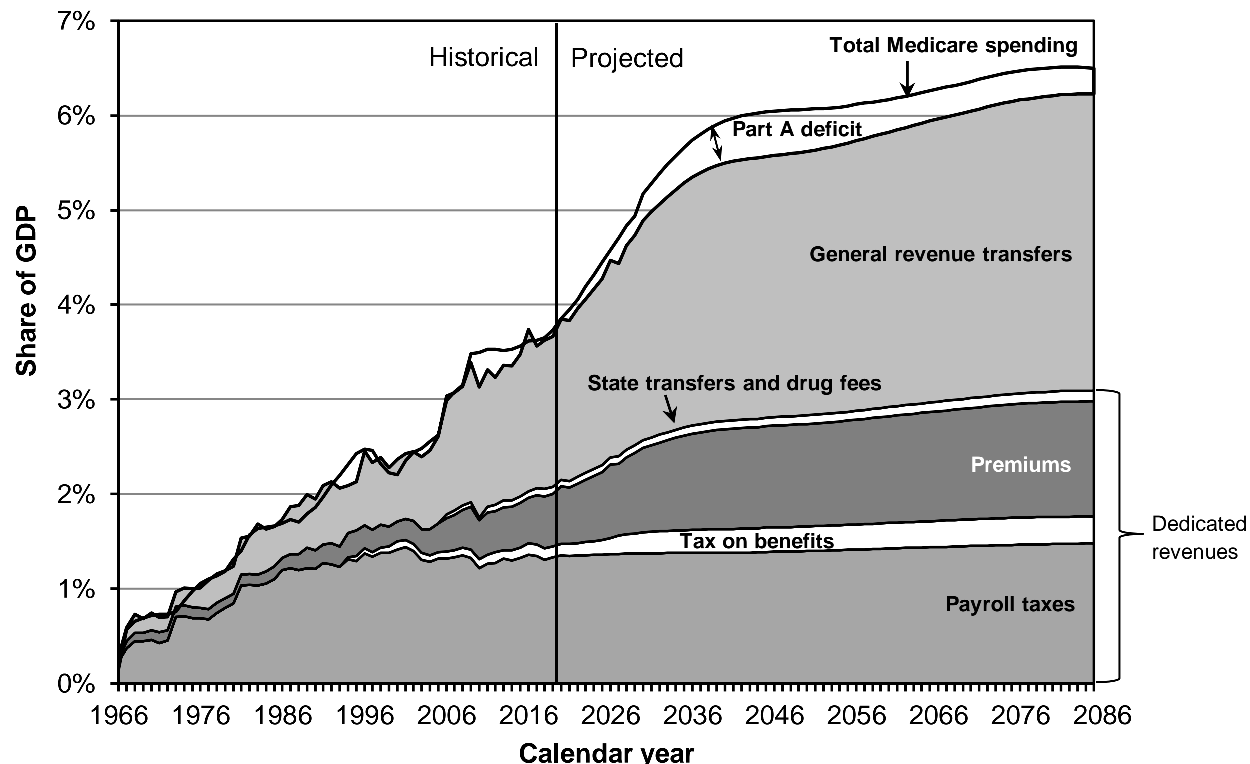


Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A. The potential effects of the coronavirus pandemic are not included in these projections.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- As the baby-boom generation ages, enrollment in the Medicare program is surging. By 2033, Medicare is projected to have 80 million beneficiaries—up from 62 million beneficiaries in 2020.
- While Medicare enrollment is rising, the number of workers per beneficiary is rapidly declining. Workers are the primary funder of Medicare's HI Trust Fund, which they fund through payroll taxes. However, the number of workers per Medicare beneficiary has declined from 4.6 during the early years of the program to 2.9 in 2020 and is projected by the Medicare Trustees to fall to 2.5 by 2028.
- These demographics threaten the financial stability of the Medicare program.

Chart 1-9. General revenues have overtaken Medicare payroll taxes as the largest source of Medicare funding



Note: GDP (gross domestic product). These projections are based on the Trustees' intermediate set of assumptions and do not reflect the potential effects of the coronavirus pandemic. "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 from the states to Medicare for assuming primary responsibility for prescription drug spending that were mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. "Drug fees" refers to the fee imposed by the 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 2020.

- Medicare spending accounted for 3.7 percent of GDP in 2019. The Medicare Trustees project that Medicare's share of GDP will rise to 5.5 percent by 2033 and to 5.9 percent by 2038.
- In the early years of the Medicare program, payroll taxes deposited into Medicare's Hospital Insurance Trust Fund (which finances Part A) were the main source of funding for the program, but beginning in 2009, general revenue transfers (which help finance Part B and Part D) became the largest single source of Medicare funding. General revenue transfers are expected to continue to be a substantial share of Medicare financing, growing to about 49 percent by 2034, then remaining stable through the rest of the century.
- As more general revenues are devoted to Medicare, fewer resources will be available to invest in growing the economic output of the future or in supporting other national priorities.

Chart 1-10. Increases in payroll tax or decreases in Part A spending needed to maintain HI Trust Fund solvency for certain amounts of time

To maintain HI Trust Fund solvency for:	Increase 2.9% payroll tax to:	Or decrease Part A spending by:
25 years (2020–2044)	3.67%	17.1%
50 years (2020–2069)	3.71	17.3
75 years (2020–2094)	3.66	16.0

Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A. The potential effects of the coronavirus pandemic are not reflected in these projections.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- The HI Trust Fund, which helps pay for Part A services such as inpatient hospital stays and post-acute care provided by skilled nursing facilities and hospice, is mainly financed through a dedicated payroll tax (i.e., a tax on wage earnings).

- From 2008 to 2015, the HI Trust Fund ran an annual deficit (i.e., paid more in benefits than it collected in payroll taxes) (data not shown). In 2016 and 2017, the HI Trust Fund ran a surplus (data not shown). However, deficits returned in 2018 and 2019 and are projected to continue until trust fund assets are depleted in 2026 (under the Trustees' intermediate assumptions). Under high-cost assumptions, the HI Trust Fund could be depleted as early as 2023. Under low-cost assumptions, it would remain able to pay full benefits indefinitely.

- To keep the HI Trust Fund solvent over the next 25 years, the Medicare Trustees estimate that either the payroll tax would need to be increased immediately from its current rate of 2.9 percent to about 3.7 percent, or Part A spending would need to be permanently reduced by about 17 percent (about $62 billion in 2021). Alternatively, some combination of smaller tax increases and smaller spending reductions could be used to achieve solvency.

Chart 1-11. Medicare Part A and Part B benefits and cost sharing per FFS beneficiary, 2019

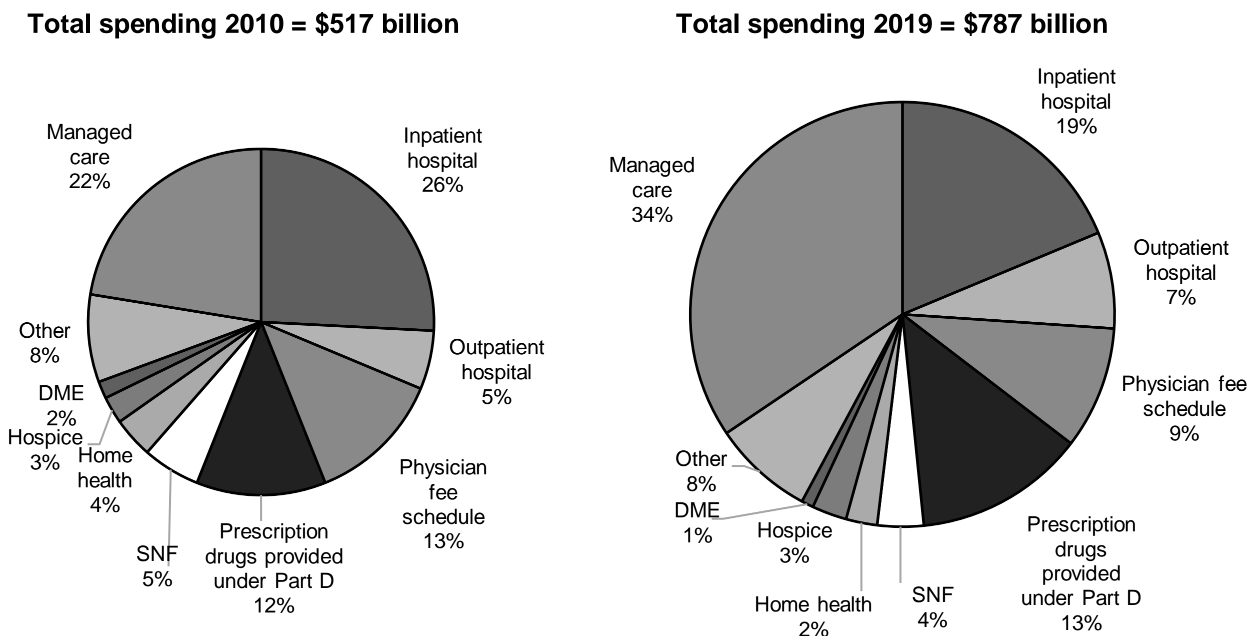
	Average benefit in 2019 (in dollars)	Average cost sharing in 2019 (in dollars)
Part A	$5,051	$406
Part B	6,258	1,582

Note: 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 and excludes all monthly premiums. The "Part A" row reflects spending for 38 million beneficiaries with Part A, and the "Part B" row reflects spending for 33 million beneficiaries with Part B.

Source: CMS Office of Enterprise Data and Analytics, CMS Program Statistics, Medicare Utilization and Payments, 2019.

- In calendar year 2019, the Medicare program made $5,051 in Part A benefit payments and $6,258 in Part B benefit payments, on average, per FFS beneficiary.
- Beneficiaries owed an average of $406 in cost sharing for Part A and $1,582 in cost sharing for Part B in calendar year 2019. (Cost sharing excludes all monthly premiums.)
- To cover some of those cost-sharing requirements, 89 percent of FFS beneficiaries had coverage that supplemented or replaced the Medicare benefit package in 2018, such as Medicare Advantage, Medigap coverage, supplemental coverage through former employers, or Medicaid (see Chart 3-1).

Chart 1-12. Medicare spending is concentrated in certain services and has shifted over time



Note: DME (durable medical equipment), SNF (skilled nursing facility). 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 services. Components may not total 100 percent because of rounding.

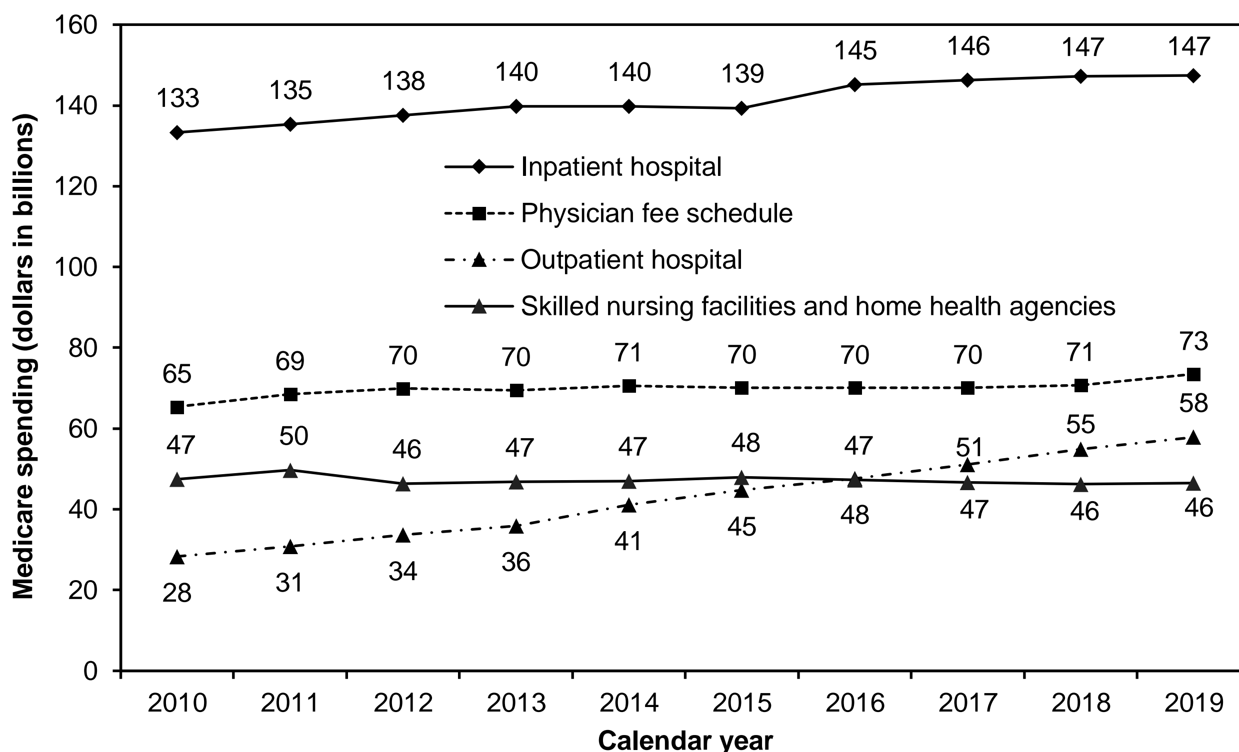
Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- In 2019, Medicare spent $787 billion on benefits. Managed care (Medicare Advantage) was the largest spending category (34 percent), followed by FFS inpatient hospital services (19 percent), prescription drugs provided under Part D (13 percent), and FFS services reimbursed under the physician fee schedule (9 percent). Spending on managed care included spending on health care services and items purchased through these plans.

- The distribution of Medicare spending among services has changed over time. Spending on managed care plans has grown from 22 percent of Medicare spending in 2010 to 34 percent in 2019. This growth is largely because the number of beneficiaries enrolled in Medicare Advantage nearly doubled over this period (data not shown). Meanwhile, the number of beneficiaries in fee-for-service (FFS) Medicare has stayed relatively flat (data not shown).

- Spending on FFS inpatient hospital services has declined as a share of total Medicare spending, falling from 26 percent in 2010 to 19 percent in 2019. Spending on physician fee schedule services has also declined as a share of Medicare spending, falling from 13 percent to 9 percent over this period. At the same time, spending on FFS outpatient services has grown (from 5 percent to 7 percent of Medicare spending), partly due to physician practices being acquired by hospitals and beginning to bill under the outpatient payment system.

Chart 1-13. Aggregate Medicare spending for FFS beneficiaries, by sector, 2010–2019



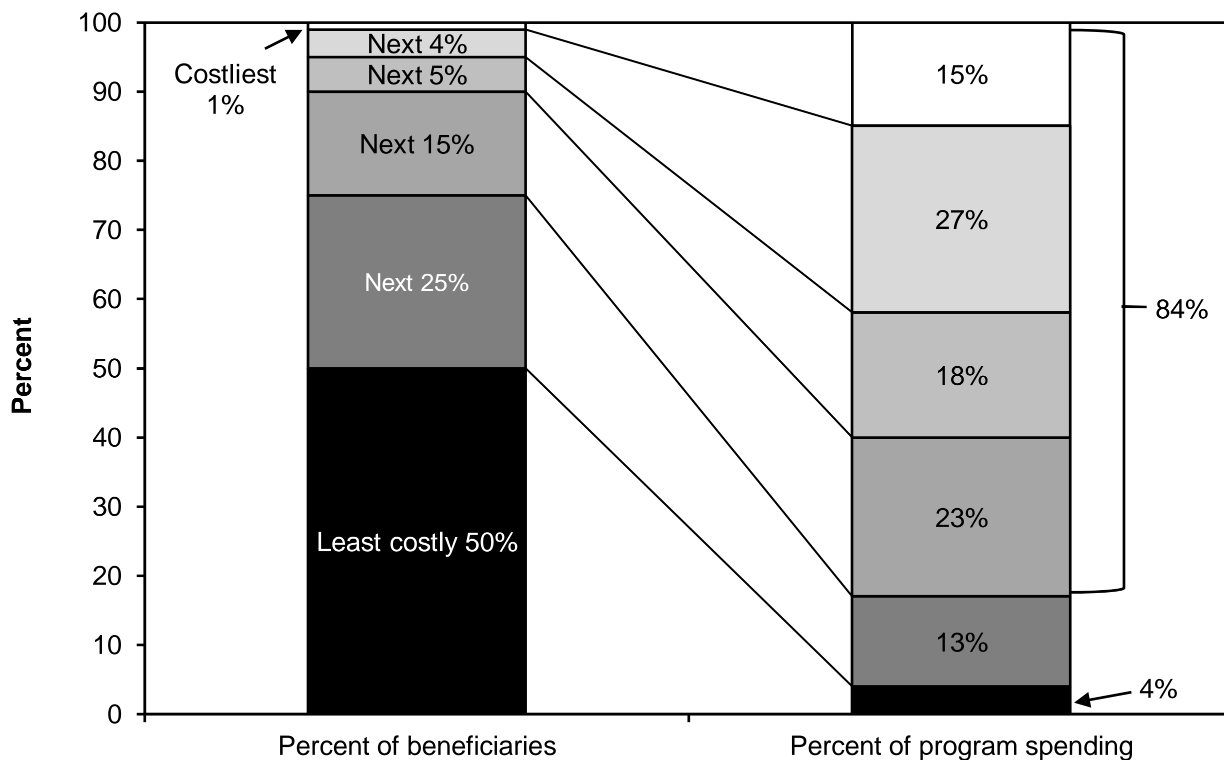
Note: FFS (fee-for-service). "Physician fee schedule" includes spending on services provided by physicians and other health professionals such as nurse practitioners, physician assistants, and physical therapists. Dollar amounts are Medicare spending for FFS beneficiaries only and do not include beneficiary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

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2020.

- Medicare fee-for-service spending on inpatient hospital services and physician fee schedule services increased modestly from 2010 to 2019, averaging 1.1 percent and 1.3 percent growth per year, respectively. Spending on skilled nursing facilities and home health services decreased over this period, contracting by –0.2 percent per year on average.

- In contrast, spending on outpatient hospital services doubled during this period (averaging growth of 8.3 percent per year from 2010 to 2019) as more physician practices were acquired by hospitals and began billing Medicare's outpatient payment system.

Chart 1-14. FFS program spending was highly concentrated in a small group of beneficiaries, 2018



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]).

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, 2018.

- Medicare FFS spending is concentrated among a small number of beneficiaries. In 2018, the costliest 5 percent of beneficiaries (i.e., adding the costliest 1 percent and the next-costliest 4 percent at the top of the bar at left) accounted for 43 percent of annual Medicare FFS spending (calculated on unrounded numbers). The costliest 25 percent of beneficiaries accounted for 84 percent of Medicare spending (calculated on unrounded numbers). 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 dually eligible for Medicare and Medicaid, and are in the last year of life.