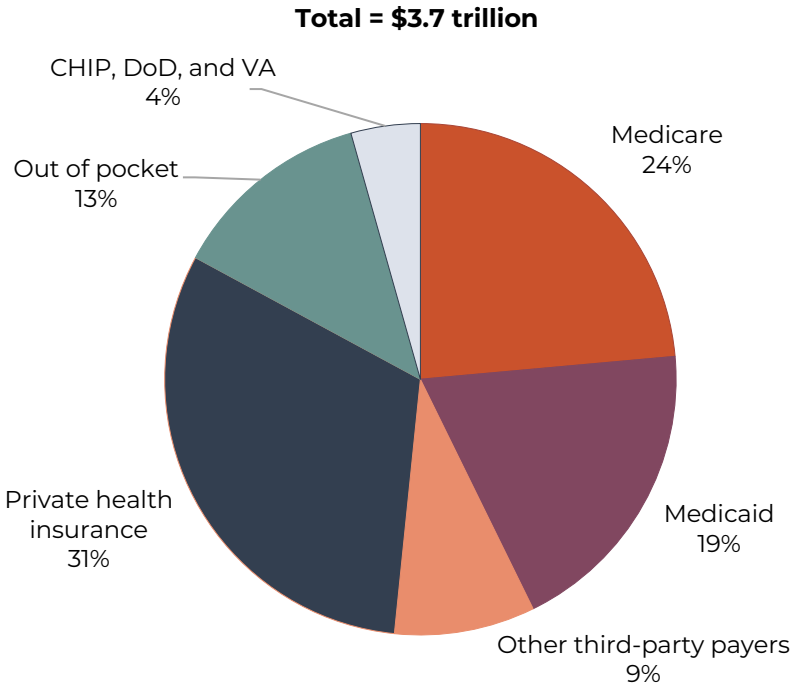
SECTION

1

National health care and Medicare spending

Chart 1-1 Medicare was the largest single purchaser of personal health care in the U.S., 2022



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 that are provided for the treatment of an individual. "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 (including COVID-19 Paycheck Protection Program loans and the Provider Relief Fund), the Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

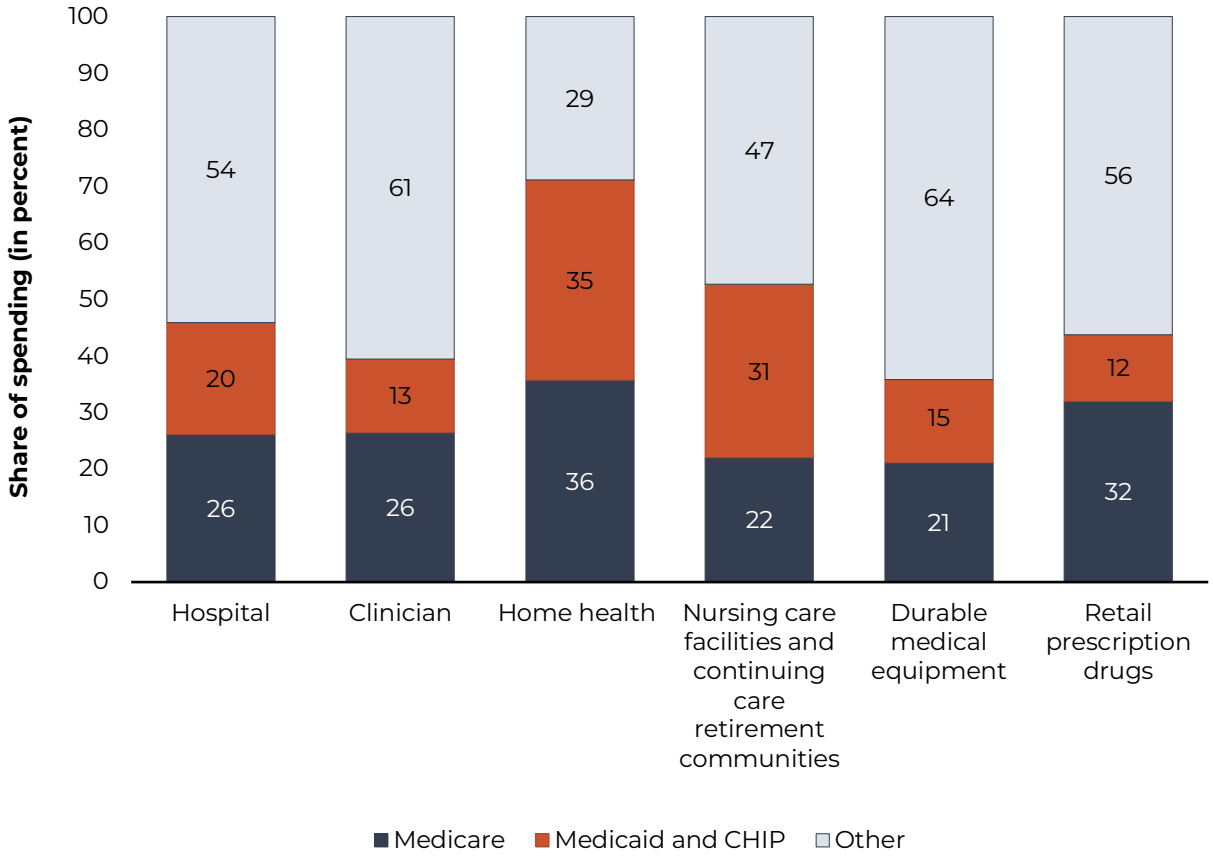
Source: CMS Office of the Actuary, Table 6: Personal Health Care Expenditures; Levels, Percent Change, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970–2022, released December 2023, https://www.cms.gov/files/zip/nhe-tables.zip.

> 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, the category is composed of many private plans, including managed care, self-insured health plans, and indemnity plans.) Of the $3.7 trillion spent on personal health care in 2022, Medicare accounted for 24 percent, or $873 billion. This amount comprises spending on direct patient care and excludes administrative and business costs.

> Private health insurance plans financed 31 percent of total personal health care spending, and consumer out-of-pocket spending (not including premiums) amounted to 13 percent.

> 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, 2022



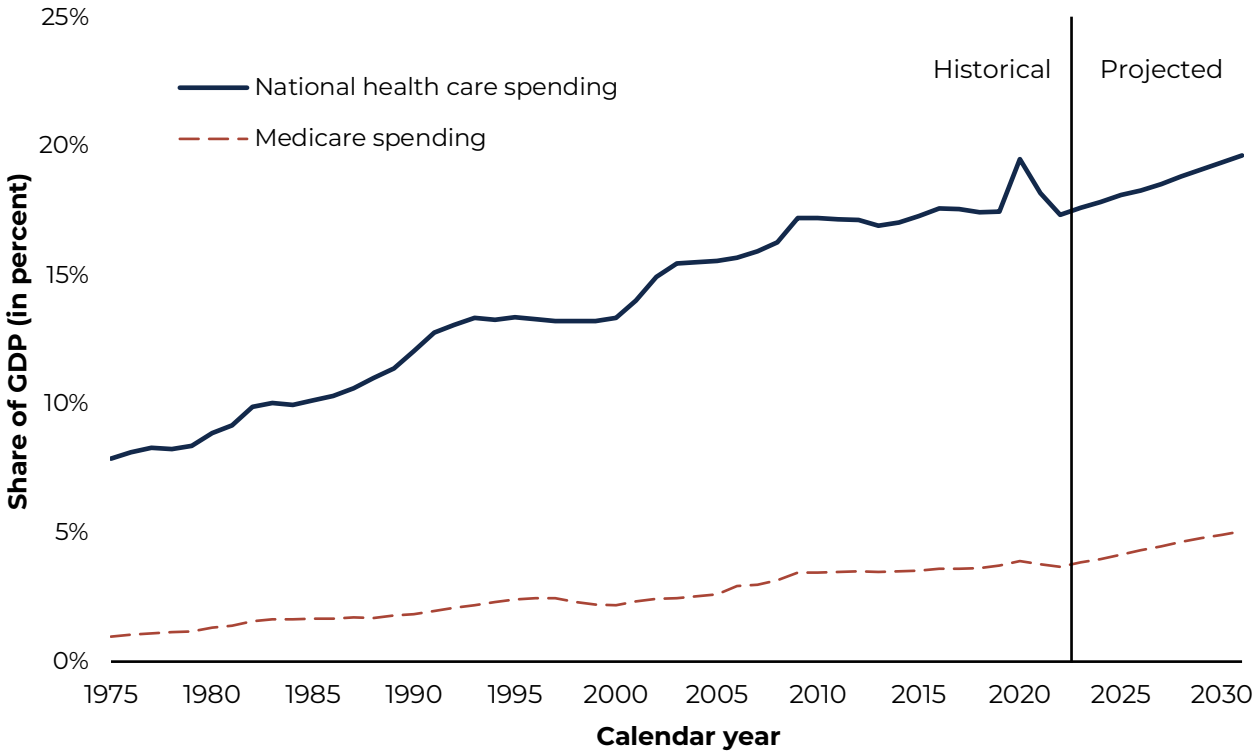
Note: CHIP (Children's Health Insurance Program). "Personal health care" is a subset of national health expenditures that comprises spending for all medical goods and services that are provided for the treatment of an individual. "Other" includes private health insurance, out-of-pocket spending, and other private and public spending. 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 products.

Source: CMS Office of the Actuary, National health expenditures by type of service and source of funds: Calendar years 1960 to 2022, released December 2023, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2022.zip.

> While Medicare's share of total personal health care spending was 24 percent in 2022 (see Chart 1-1), its share of spending by type of service varied, from 21 percent of spending on durable medical equipment to 36 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 grown as a share of the country's GDP



Note: GDP (gross domestic product). First projected year is 2023. 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 June 2023 and historical data released in December 2023), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

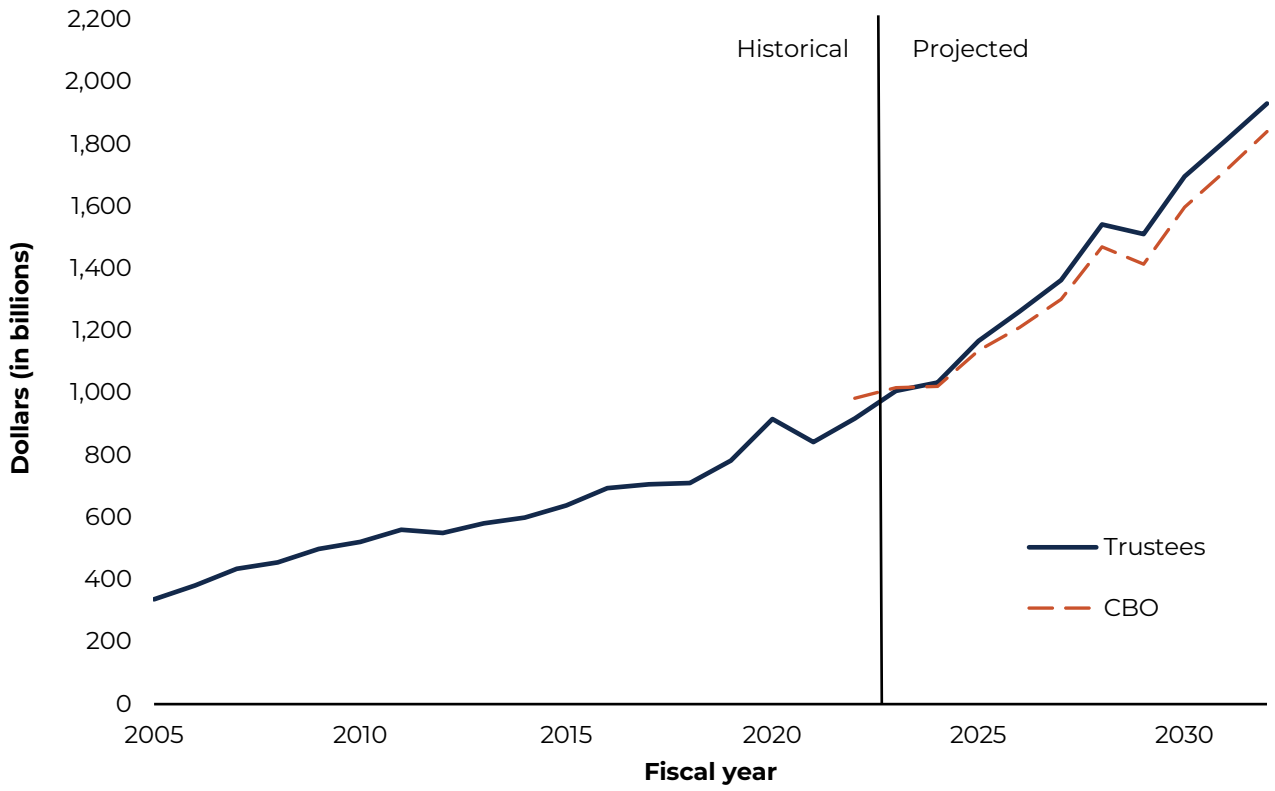
> In 2020, total health care spending increased sharply—reaching 19.5 percent of the country's GDP, or $4.2 trillion—due to one-time spending by the federal government on coronavirus pandemic relief funds for health care providers, a relaxation of Medicaid's eligibility rules during the pandemic, and an increase in spending on public health activities (e.g., for vaccine development) at a time when the country's GDP was shrinking.

> In 2021, the federal government continued to distribute pandemic relief funds but at much lower levels. Meanwhile, payers' spending on health care increased as patients resumed receiving health care and GDP expanded rapidly. The net effect of these forces was a sharp decline in national health care spending as a share of GDP. At 18.2 percent, this amount was still a larger share of GDP than in 2019.

> Over time, Medicare spending has accounted for an increasing share of GDP. From 1 percent in 1975, it is projected to reach nearly 5 percent of GDP by 2030.

> One of the drivers of Medicare spending growth between now and 2030 is the continued aging of the baby-boom generation into the Medicare program. By 2030, all baby boomers will have reached Medicare's age of eligibility.

Chart 1-4 Medicare spending is expected to double in the next 10 years



Note: CBO (Congressional Budget Office). First projected year is 2023. The sharp increase in spending in 2020 includes Medicare Accelerated and Advance Payments paid to providers—payments that were then recouped by the Medicare program in 2021 and 2022. Dollar amounts are nominal figures, not adjusted for inflation.

Source: 2023 annual report of the Boards of Trustees of the Medicare trust funds, Table V.H4; CBO's May 2023 baseline projections for the Medicare program, https://www.cbo.gov/system/files?file=2023-05/51302-2023-05-medicare.xlsx.

> Medicare spending doubled between 2008 and 2022, increasing from $455 billion to $918 billion on a nominal basis.

> Medicare spending is expected to again double between 2022 and 2032, when the Trustees estimate it will reach $1.9 trillion. The Trustees expect Medicare spending to increase at an average annual rate of 7.5 percent over the next 10 years.

> The Medicare Trustees and CBO estimate that by 2023, Medicare spending reached $1 trillion.

Chart 1-5 Factors contributing to projected spending growth for Medicare Part A and Part B, 2023–2032 (after subtracting economy-wide inflation)

	Average annual percent change in:				
Medicare part	Medicare prices (minus inflation)	Number of beneficiaries	Beneficiary demographic mix	Volume and intensity of services used	Medicare's projected spending (minus inflation)
Part A	–0.2%	1.9%	0.1%	1.8%	3.7%
Part B	–1.1	2.0	0.1	4.2	5.1
Total	–0.7	N/A*	0.1	3.1	4.5

Note: N/A (not applicable). Includes Medicare Advantage enrollees. "Medicare prices" 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. "Volume and intensity" is the residual after the other three factors shown in the table (growth in Medicare prices, number of beneficiaries, and beneficiary demographic mix) are removed. "Medicare's projected spending" is the product of the other columns in the table. The "Total" row is the sum of the other rows of the table, each weighted by their part's share of total (Part A plus Part B) Medicare spending in 2022 (as measured by shares of gross domestic product). Part D spending growth is not shown.
*Not applicable because there is beneficiary overlap in Part A and Part B enrollment.

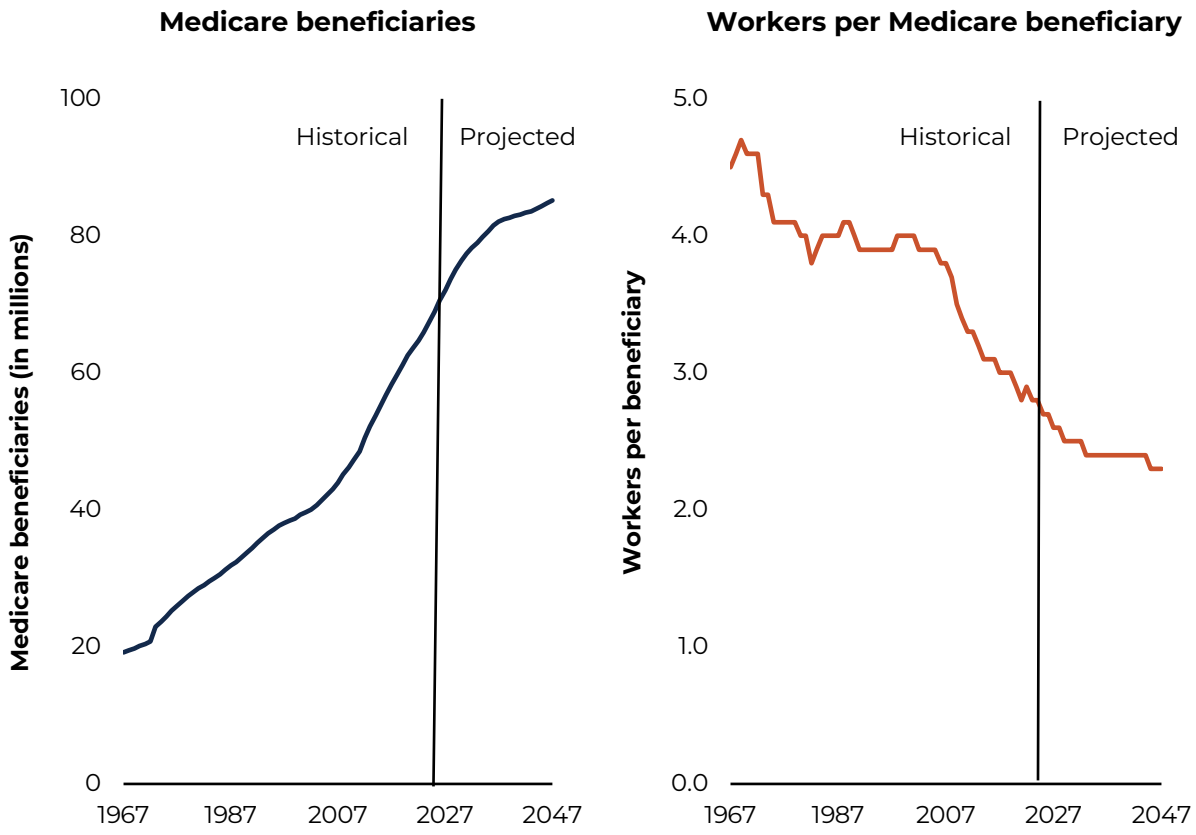
Source: MedPAC analysis of data from the 2023 annual report of the Boards of Trustees of the Medicare trust funds.

> Medicare's spending on Part A and Part B services and items for beneficiaries in traditional Medicare and Medicare Advantage plans is projected to grow 4.5 percent per year, on average, between 2023 and 2032 (not including growth due to general economy-wide inflation).

> Medicare's projected spending growth over this period is driven by growth in the number of beneficiaries (expected to increase by about 2 percent per year over this period) and growth in the volume and intensity of services delivered per beneficiary (expected to rise by 1.8 percent per year for Part A spending and by 4.2 percent per year for Part B spending).

> Price growth is not expected to drive Medicare's increased spending because, unlike in the private health care sector, Medicare is able to administratively set prices for many health care providers.

Chart 1-6 The declining ratio of workers to Medicare beneficiaries threatens the Medicare program's financial sustainability



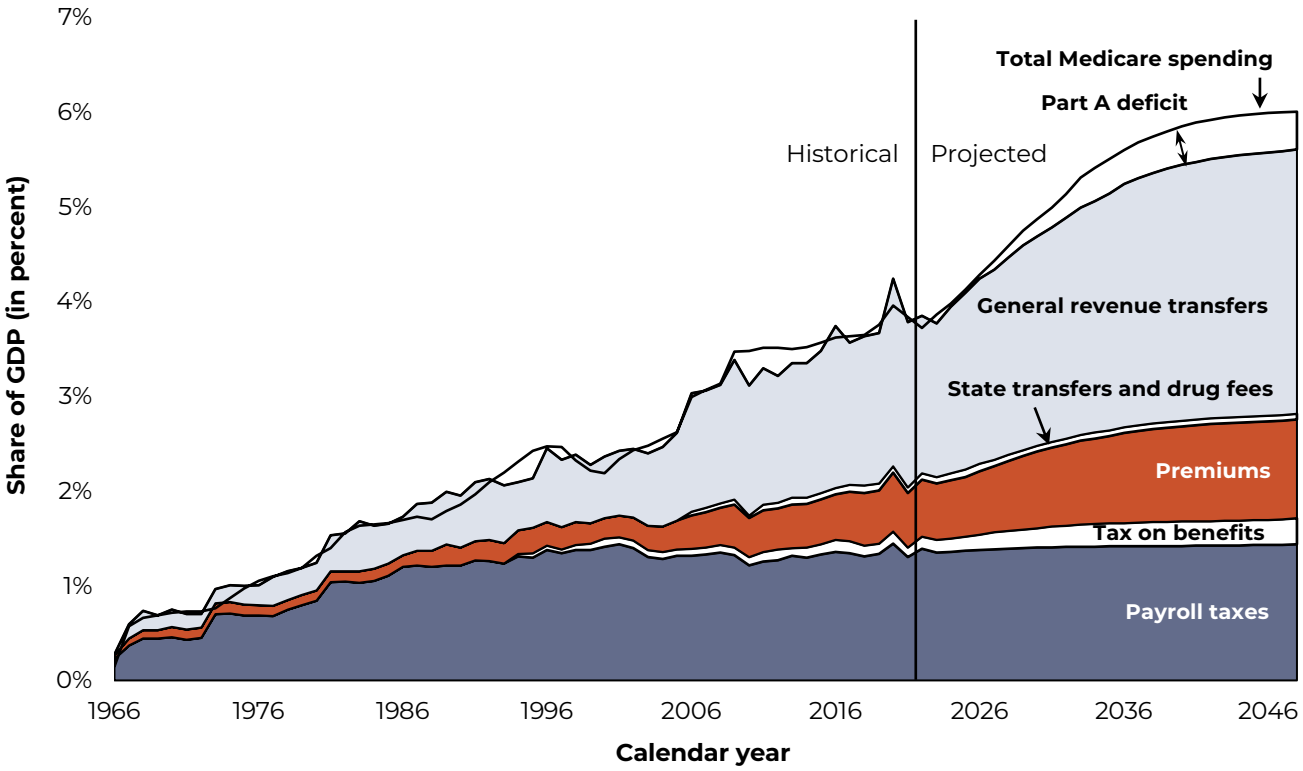
Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplemental Medical Insurance because Part A is usually available to beneficiaries at no cost. First projected year is 2023. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

Source: 2023 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 2029, 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 65 million beneficiaries in 2022.

> While Medicare enrollment is rising, the number of workers per beneficiary is rapidly declining. These diverging trends present a financing challenge for Medicare because Part A Hospital Insurance is 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 Medicare beneficiary at the program's inception in 1967 to 2.9 workers per beneficiary in 2022 and is projected to fall to 2.5 workers per beneficiary by 2029.

Chart 1-7 General revenues are the largest source of Medicare funding



Note: GDP (gross domestic product). First projected year is 2023. 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" 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 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. Graph does not include interest earned on trust fund investments (which makes up 1 percent of the Hospital Insurance Trust Fund's income and is expected to decline in coming years as trust fund assets decline).

Source: 2023 annual report of the Boards of Trustees of the Medicare trust funds.

> Medicare spending accounted for 3.7 percent of GDP in 2022. By 2031, the Medicare Trustees have projected that Medicare's share of GDP will rise to 5.0 percent.

> 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 revenue transfers (which help finance Part B and Part D) became the largest single source of Medicare funding. General revenue transfers currently pay for nearly half of Medicare spending and are expected to continue to do so in future decades.

> As increasing amounts of general tax revenues have been devoted to Medicare, 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 education, transportation, and research and development).

Chart 1-8 A higher Medicare payroll tax or lower Medicare Part A spending would extend the solvency of Medicare's Hospital Insurance Trust Fund by 25 years

To maintain Hospital Insurance Trust Fund solvency for:	Increase 2.9% payroll tax to:	Or decrease Part A spending by:
25 years (2023–2047)	3.6%	15.6%

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 2023 annual report of the Boards of Trustees of the Medicare trust funds.

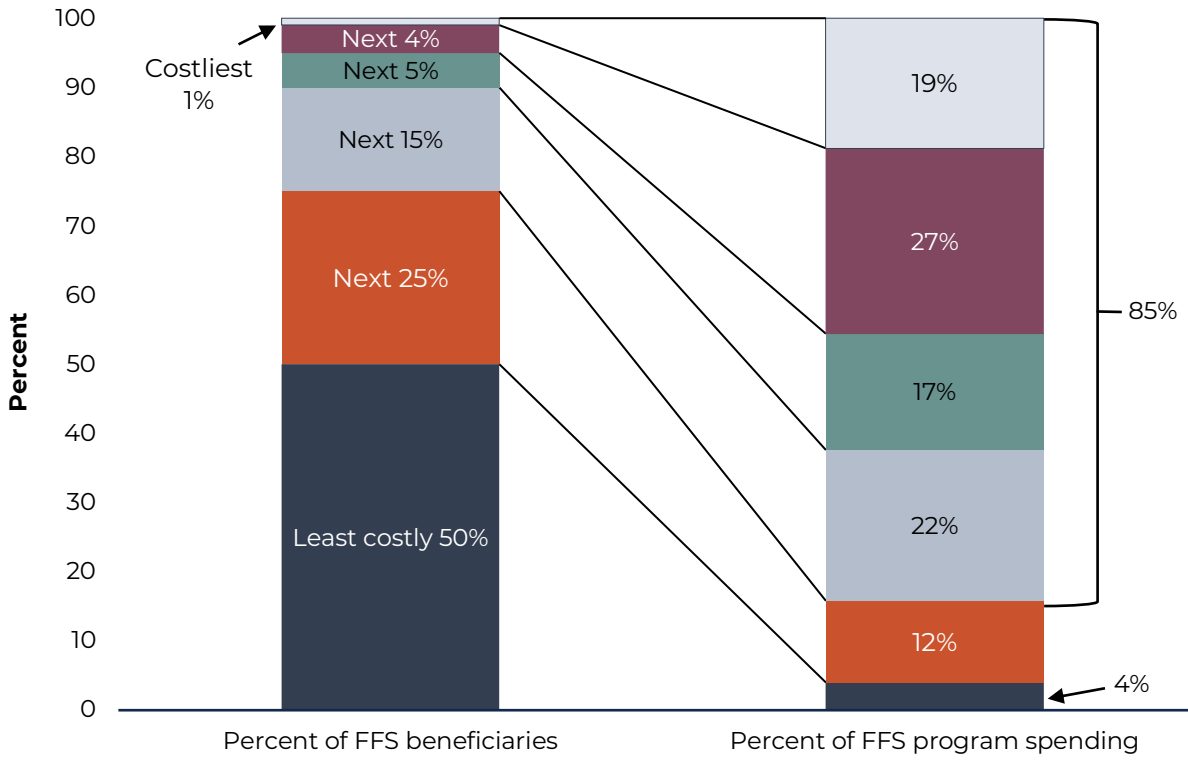
> Medicare's Hospital Insurance Trust Fund helps pay for Part A services such as inpatient hospital stays, post-acute care provided by skilled nursing facilities, and hospice services. The trust fund is mainly financed through a dedicated payroll tax (i.e., a tax on wage earnings).

> In some years, such as 2022, trust fund revenues exceed Part A spending—creating a surplus that increases the trust fund's account balance. (For example, the Trustees have reported that in 2022, annual trust fund revenues equaled $397 billion but Part A spending amounted to $343 billion, thus yielding a surplus of $54 billion that year. This surplus increased the balance in the trust fund from $143 billion at the start of the year to $197 billion by the end of the year.)

> In other years, payroll tax revenues are less than Medicare Part A spending—creating a deficit that causes the trust fund's account balance to decline. In their 2023 report, Medicare's Trustees estimated that annual deficits in coming years would cause the Hospital Insurance Trust Fund's account balance to drop to zero dollars in 2031—leaving Medicare with enough funds to cover only 89 percent of its incurred Part A costs that year. The Congressional Budget Office also tracks the trust fund's financial status; it projects that it will take longer for the trust fund to become insolvent (until 2035).

> To keep the trust fund solvent over the next 25 years, the Medicare Trustees have estimated that either the Medicare payroll tax would need to be increased immediately from its current rate of 2.9 percent to about 3.6 percent or Part A spending would need to be permanently reduced by 15.6 percent (about $65 billion in 2024). Alternatively, some combination of smaller tax increases and smaller spending reductions could be used to achieve solvency.

Chart 1-9 FFS program spending was highly concentrated on a small share of beneficiaries, 2021



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.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, 2021.

> Medicare FFS spending is concentrated among a small number of beneficiaries.

>> In 2021, 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 46 percent of annual Medicare FFS spending.

>> The costliest 25 percent of beneficiaries accounted for 85 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 dually eligible for Medicare and Medicaid, and are in the last year of life.