CHAPTER 1

Context for Medicare payment policy

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Chapter summary

Each March, the Commission reports to the Congress on Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. To provide context for the information presented in this report, this chapter describes Medicare's overall financial situation and highlights factors contributing to growth in Medicare spending.

Trends in national health care and Medicare spending

Both national health care spending and Medicare spending tend to grow more quickly than the U.S. gross domestic product (GDP)—causing spending in both sectors to consume growing shares of GDP over time. In 2023, $4.9 trillion was spent on health care in the U.S. (equivalent to 17.6 percent of GDP); Medicare spending made up about $1.0 trillion of this spending (equivalent to 3.7 percent of GDP).

During the first year of the recent coronavirus pandemic, Medicare spending grew more slowly than usual (if short-term loans paid by CMS to providers are not included). Although spending increased on COVID-19 testing and treatment and on services that were made more widely available through waivers of Medicare's usual payment rules, the increase was more than offset by decreased spending on non-COVID-19

In this chapter

- National health care spending usually grows faster than GDP
- Medicare spending is projected to double in the next 10 years
- Medicare faces a financing challenge
- As Medicare spending increases, so too do beneficiaries' costs
- Differences in beneficiaries' access to care and health outcomes
- The Commission's recommendations to slow the growth in Medicare spending and improve beneficiary access to care

care. Since then, Medicare beneficiaries' health care spending has generally returned to more typical levels. Looking ahead, CMS expects Medicare spending to grow by about 4 percent per year between now and the early 2030s, after accounting for economy-wide price inflation. This increased spending is driven by Medicare enrollment growth and growth in the volume and intensity of services clinicians deliver per beneficiary. Medicare prices are not a significant driver of spending growth since they are projected to grow more slowly than inflation.

A longer-term trend contributing to increased Medicare spending is the growing enrollment in MA plans. MA plans may be attractive to beneficiaries because they can offer reduced cost sharing for many services, a cap on enrollees' annual out-of-pocket spending for covered services, and coverage of some items and services that are not covered by FFS Medicare—often at no additional premium beyond beneficiaries' Part B premiums. But the Commission estimates that in 2025 Medicare will spend an estimated 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare. The features of MA payment policy that drive those relatively higher payments may contribute to increased Medicare spending in the future.

Medicare's financial outlook has recently improved despite challenges

Although Medicare spending is projected to grow in the coming years, the program finds itself in a better position financially than a few years ago. After an initial economic slowdown at the start of the pandemic, the U.S. economy subsequently experienced strong growth, yielding higher-than-expected Medicare payroll-tax revenues. At the same time, Medicare beneficiaries used a lower-than-expected volume of Part A services during the pandemic, and future Part A spending (on hospital inpatient and skilled nursing facility care) is now projected to be lower than previously estimated. As a result, the Part A trust fund is now projected to be able to pay for its share of Part A services for a decade longer than was projected before the pandemic—until 2036, according to the Medicare Board of Trustees, or 2035, according to the Congressional Budget Office.

Yet pressure to restrain the growth in Medicare's overall spending remains. A growing share of federal revenues must be transferred to Medicare's Supplementary Medical Insurance (SMI) Trust Fund to help pay for spending on Part B (clinician services and outpatient fees) and Part D (prescription drug coverage). For example, the share of personal and corporate income taxes collected by the federal government that was transferred to the SMI Trust Fund to pay for Part B and Part D was 17 percent in 2023 and is projected to increase to 22 percent by 2030, according to Medicare's Trustees.

Increasing Medicare spending puts pressure on beneficiaries

In 2023, Medicare spent an average of $16,710 per beneficiary on Part A, Part B, and Part D benefits—almost $3,000 more than in 2019 according to the Medicare Trustees. As Medicare spending grows, it affects beneficiaries' ability to afford health care by raising their premiums and cost sharing. The Medicare Trustees estimate that spending by FFS beneficiaries on Medicare Part B and Part D premiums and cost sharing consumed 26 percent of the average Social Security benefit in 2024—up from 17 percent 20 years earlier, in 2004. Although only 6 percent of Medicare beneficiaries reported having problems paying a medical bill according to CMS's 2022 Medicare Current Beneficiary Survey (which includes enrollees in both FFS Medicare and MA), some subpopulations experience affordability issues at higher rates. For example, among beneficiaries under the age of 65 (most of whom are disabled), 18 percent reported problems paying a medical bill. Among partial-benefit dually eligible beneficiaries (who do not qualify for the same Medicaid benefits that full-benefit dually eligible beneficiaries receive), 28 percent reported this problem. And among beneficiaries enrolled in FFS Medicare with no supplemental coverage, 12 percent reported this difficulty. Since a notable share of beneficiaries already report having a hard time affording health care, it is important for policymakers to consider the effect of raising Medicare's payments to providers and plans on beneficiaries' premiums and cost-sharing liabilities. Restraining the annual growth in Medicare payments to providers and plans can help beneficiaries better afford their health care.

The Commission's recommendations aim to obtain good value for the program's expenditures

One way the Medicare program has kept spending growth relatively low is by setting payment rates in certain sectors. The Commission's annual March report recommends updates to Medicare payment rates for various types of providers for a given year. These recommended updates can be positive, neutral, or negative, depending on our assessment of the adequacy of Medicare payments in a given sector. Our annual June report typically offers broader recommendations aimed at restructuring the way Medicare's payment systems work. For example, we have recommended changing how payments for MA plans are calculated and adopting site-neutral payments for services that can safely be provided in more than one clinical setting. A list of the Commission's recommendations, with links to relevant report chapters, is available at www.medpac.gov/recommendation. The Commission's recommendations are based on our review of the latest available data and aim to obtain good value for expenditures—which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. ■

Introduction

Every March, the Commission reports to the Congress on Medicare's various fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare Part D prescription drug program. To provide context for the information presented in this report, this chapter describes Medicare's overall financial situation and highlights factors contributing to Medicare's spending growth.

National health care spending usually grows faster than GDP

In 2023, the U.S. spent $4.9 trillion on health care (Martin et al. 2025). Since national health care spending usually grows faster than the U.S. gross domestic product (GDP), it has made up an increasing share of GDP over time (Figure 1-1, p. 8).

National health care spending temporarily diverged from this historical trend during the recent coronavirus pandemic—sharply increasing as a share of GDP in 2020 before falling just as sharply in 2021 and 2022 (reflected in the spike in Figure 1-1, p. 8). The sharp increase in 2020 occurred because national health care spending increased by 10.4 percent that year—largely due to one-time federal spending for vaccine development and health facility preparedness and to provide additional support for health care providers—while the country's GDP shrank (Hartman et al. 2024, Martin et al. 2025). In 2021 and 2022, national health care spending as a share of GDP then fell as GDP grew rapidly and pandemic-related funding tapered off (Martin et al. 2025).

In 2023, spending trends began to return to historical norms, with national health care spending growing faster (7.5 percent) than GDP (6.6 percent)—causing health care spending to rise from 17.4 to 17.6 percent of GDP (Martin et al. 2025). Health care spending growth accelerated in 2023 in part because the share of the population with health insurance reached an all-time high of 92.5 percent (Martin et al. 2025). Coverage gains were driven by a substantial increase (5.8 million people) in the number of people with direct-purchase Marketplace plans from 2020 to 2023, which was facilitated by the availability of enhanced subsidies beginning partway through this period. An even larger number of people (15.5 million people) gained coverage through Medicaid from 2020 to 2023 due to a change in law that allowed states to keep people continuously enrolled in Medicaid during the pandemic.[1] The overall share of the U.S. population with health insurance is expected to decline by 1 percentage point to 2 percentage points in coming years as this Medicaid policy expires and as subsidies for direct-purchase Marketplace plans are scaled back (Centers for Medicare & Medicaid Services 2024i, Fiore et al. 2024).[2]

Another driver of growth in national health care spending in 2023 was the increasing volume and intensity of health care services used per patient that year (particularly hospital care and clinician services) among both Medicare beneficiaries and the privately insured (Martin et al. 2025). Consumers also used a more expensive mix of retail prescription drugs in 2023, with more higher-cost and newer brand-name drugs, and drug prices increased faster in 2023 than in 2022, in general (Martin et al. 2025). Consistent with most years in the prior decade and a half, in 2023 spending per person grew faster for privately insured people (9.7 percent) than for Medicare beneficiaries (5.9 percent) (Centers for Medicare & Medicaid Services 2024h).

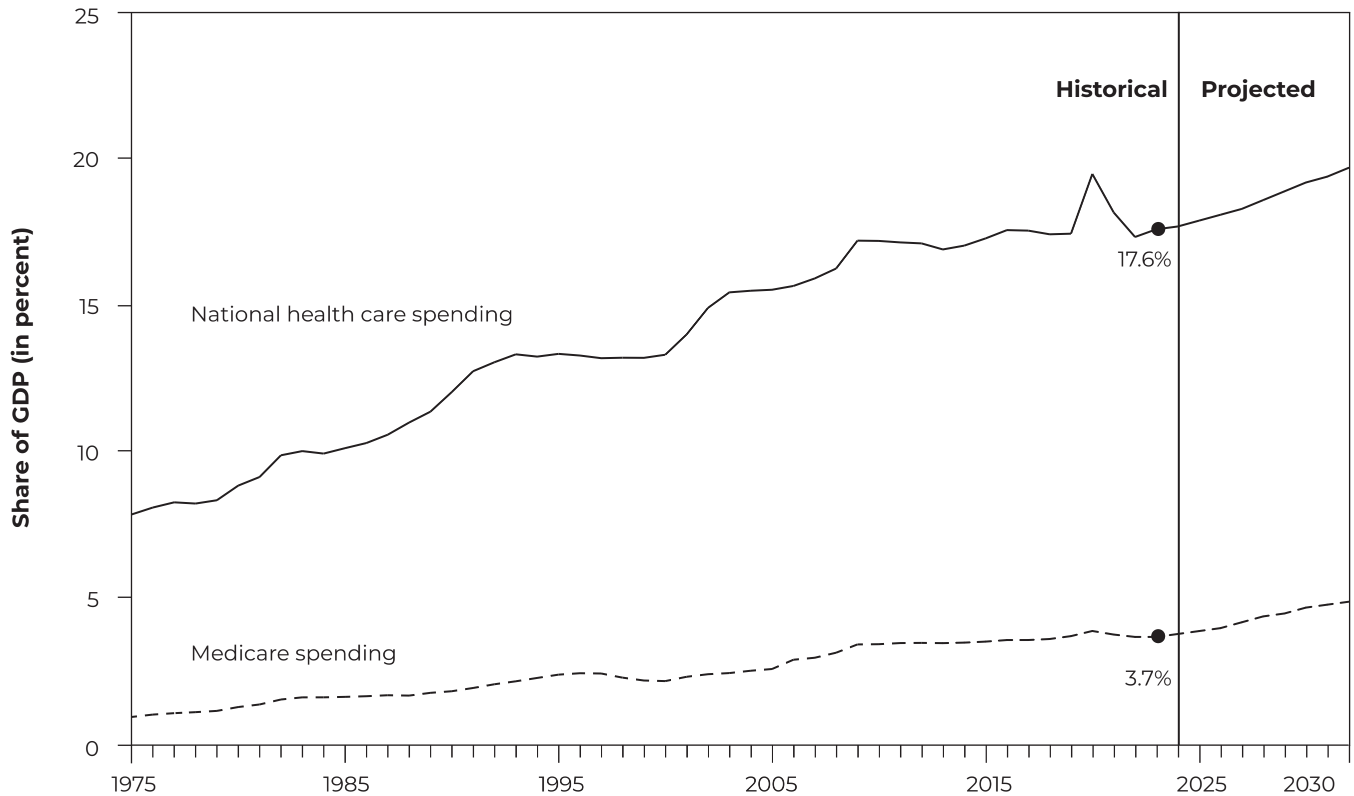
Looking ahead, national health care spending is projected to continue to outpace growth in GDP during the next decade, in part because medical prices are expected to grow faster than economy-wide prices over the period (Fiore et al. 2024). (For a discussion of the role played by provider consolidation in increasing health care prices, see the text box (pp. 9–11).) Other drivers of growth in health care spending in the coming decade are the aging of the U.S. population and demand for health care that is expected to outpace income growth (Fiore et al. 2024).

Medicare spending is projected to double in the next 10 years

During the first year of the coronavirus pandemic, Medicare spending grew more slowly than usual (by 3.7 percent) (Martin et al. 2025). Although spending increased on COVID-19 testing and treatment and on services that were made more widely available through

FIGURE 1–1

Health care spending has grown as a share of the country's GDP



Note: GDP (gross domestic product). The first projected year in the graph is 2024. Pandemic relief funds are counted as national health care spending rather than Medicare spending because they were meant to offset pandemic-related revenue losses from all payers, not just Medicare. Medicare spending excludes COVID-19 Accelerated and Advance Payments (short-term loans paid to providers in 2020 that were subsequently repaid) since this graph shows expenditures on an incurred basis rather than a cash basis.

Source: MedPAC analysis of CMS's national health expenditure data (projected data released in June 2024 and historical data released in December 2024), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

waivers of Medicare's usual payment rules, the increase was more than offset by decreased spending on non–COVID-19 care (Boards of Trustees 2024, Hartman et al. 2022). Medicare spending then grew at higher rates in subsequent years (by 7.3 percent in 2021, 6.4 percent in 2022, and 8.1 percent in 2023), as Medicare beneficiaries' use of most types of health care services rebounded (Martin et al. 2025). In 2023, growth in Medicare spending was also driven by provisions in the Inflation Reduction Act of 2022 (IRA) that increased the generosity of the Part D benefit by limiting beneficiary cost sharing for insulins and requiring coverage of vaccines with no cost sharing (Martin et al. 2025). (We say more about the expected effects of this law's changes to Part D later in this chapter.) Other factors that contributed to Medicare spending growth in 2023 were increasing use of outpatient hospital services, increases in Medicare's payment rates for inpatient and outpatient hospital services, and a rapid increase in the use of brand-name antidiabetic drugs (Martin et al. 2025).

In recent years, FFS Medicare enrollment has declined and enrollment in MA plans (which cost the Medicare program more per beneficiary than FFS coverage) has rapidly increased. As a result of this shift, by 2023 MA plans covered 48 percent of Medicare beneficiaries and constituted 52 percent of Medicare spending (up from

Health care providers continue to consolidate and obtain higher prices

Over the last several decades, health care providers have pursued horizontal mergers and vertical acquisitions—in part to obtain higher payment rates both from Medicare and private payers.

Consolidation can lead to higher payment rates from Medicare because when a hospital acquires a clinician practice, the hospital can sometimes bill a "facility" fee (in addition to the physician's fee) each time a Medicare beneficiary is seen in the hospital-owned practice located on the hospital campus. The combination of the facility fee and the physician's fee results in hospitals' on-campus physician practices receiving higher Medicare rates than independent physician practices. The Commission has recommended eliminating this payment differential by applying "site-neutral" payment rates for certain services provided in hospitals' on-campus practices, which would reduce incentives to shift the billing of Medicare services from low-cost settings to high-cost settings and would result in lower Medicare program spending and lower beneficiary cost sharing. Hospitals and physician practices could still vertically integrate if they believed integration would create true efficiencies that improve quality or lower provider costs.

Consolidation can also lead to higher payment rates from private payers, by increasing a provider's market power. Consolidated providers are often in a stronger bargaining position when negotiating rates with private insurers (Baker et al. 2014, Beaulieu et al. 2023, Beaulieu et al. 2020, Cooper et al. 2015, Gaynor and Town 2012, Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2017, Whaley et al. 2022). When hospitals acquire physician practices and create a vertically integrated entity, it can also make it more difficult for competing hospitals to enter the market since the new hospital does not have a built-in network of practices referring patients to them. Some have also argued that tying physician and hospital services together can create shared market power and thus increase commercial payment rates (Curto et al. 2022). While market power and commercial-insurer payment rates vary widely from market to market and even from hospital to hospital within a market, commercial hospital prices average more than twice Medicare rates, and commercial physician rates are in the range of 20 percent to 60 percent above Medicare rates (Chernew et al. 2020, Congressional Budget Office 2022, KFF 2020, Medicare Payment Advisory Commission 2017, Whaley et al. 2024, Whaley et al. 2022).

Obtaining higher payment rates is not the only reason providers consolidate. According to a 2022 survey by the American Medical Association (AMA), physicians also sell practices to hospitals or health systems to gain access to costly resources and to get help meeting regulatory and administrative requirements (Kane 2023).

While market forces have resulted in commercial insurers' prices being significantly above Medicare rates, physicians nevertheless accept Medicare and commercial patients at comparable rates (American Medical Association 2023b, Schappert and Santo 2023). Clinicians may accept fee-for-service (FFS) Medicare despite lower payment rates because FFS Medicare patients make up a large share of physicians' patients and clinicians often face fewer administrative burdens from FFS Medicare than from private payers. A recent AMA survey found that physicians complete an average of 45 prior authorization requests per week, requiring 14 hours per week of staff time, and 35 percent of physicians have dedicated staff who work exclusively on completing prior authorizations (American Medical Association 2023a). In contrast, FFS Medicare generally requires no prior authorization for services and is known as a prompt payer since it is required to pay "clean" claims within 30 days and must pay providers interest on any late payments. The relative lack of utilization management and the administrative simplicity of billing FFS Medicare may help offset the program's lower payment rates. Another factor that may boost Medicare's acceptance rates is that almost all hospitals accept

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Health care providers continue to consolidate and obtain higher prices (cont.)

Medicare patients, and hospitals may expect their employed physicians to take Medicare patients given the important role these patients play in hospitals' missions and revenue streams.

An increasing array of entities are acquiring provider organizations

In previous decades, provider consolidation mainly involved like-types of provider organizations (e.g., hospitals merging with other hospitals) or different types of provider organizations that had referral relationships between them (e.g., hospitals acquiring physician practices in their area). As we noted in our March 2020 report to the Congress, the share of hospital markets that were "super" concentrated—with a single dominant health system that accounted for a majority of hospital discharges—rose from 47 percent in 2003 to 57 percent in 2017 (Medicare Payment Advisory Commission 2020).[3] And by 2021, 52 percent of all physicians were affiliated with a health system (Contreary et al. 2023). Hospitals have also been consolidating across markets, which could also increase market power with common customers across markets (Fulton et al. 2022).

In recent years, nonprovider organizations have also acquired provider organizations. Private insurers have acquired physician groups, medical centers, and urgent care facilities as well as their own pharmacy benefit managers, pharmacies, and data analytic firms (Herman 2022). UnitedHealth Group's Optum Health is now reported to be the largest employer of clinicians in the U.S., with 130,000 employed or aligned clinicians (Emerson 2023, UnitedHealth Group 2023). By employing physicians, insurers may be able to better coordinate care and gain physician cooperation in cost-control efforts such as prescribing generic drugs. They also may be able to generate more extensive diagnosis coding, which can yield higher payments to both insurers and physicians in some capitated payment models. In addition, buying physician practices could allow insurers to shift profits to owned physician practices as a way to avoid being constrained by medical-loss-ratio regulations that limit the share of premiums that insurers are allowed to keep as profit (Frank and Milhaupt 2023).

Companies that have not traditionally participated in health care, such as Amazon, have also begun acquiring primary care practices and providing telehealth visits (Landi 2022). It remains to be seen whether these types of nontraditional players will remain in the health care industry long term. Walmart recently closed all of its primary care clinics, stating that it did not "see a path to achieving an acceptable level of profitability" (McMillon 2024).

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covering 37 percent of enrollees and constituting 39 percent of Medicare's spending in 2019 (Martin et al. 2025, Martin et al. 2021)).[4]

Looking ahead, Medicare spending is projected to grow faster than spending by all other types of payers over the next decade: Between now and the early 2030s, CMS expects Medicare spending to grow by 7 percent to 8 percent per year (Fiore et al. 2024). This increase will cause Medicare spending to nearly double over a 10-year period—growing from $1.0 trillion in 2023 to $1.9 trillion in 2032 (Figure 1-2, p. 12). (These amounts include Medicare program spending and beneficiaries' premiums but not beneficiaries' cost sharing.)

A number of factors are expected to affect Medicare spending in the coming years. For one, Medicare enrollment in Part A and Part B will increase by about 2 percent per year as the baby-boom generation continues to age into the Medicare program

Health care providers continue to consolidate and obtain higher prices (cont.)

Private-equity funds have been investing in provider organizations as well, targeting certain specialties in certain geographic markets. One report suggests a dramatic increase in private-equity deals, from 75 practice acquisitions in 2012 to 484 deals in 2021 (Scheffler et al. 2023). That study found that in 108 markets, a private-equity company's physician practices had a 30 percent or larger market share. It is possible that the so-called "roll-up" of small practices in specific specialties (combining independent practices into a larger group) could result in greater market power and profits. However, past efforts of private equity to employ emergency department physicians have not always been financially successful (Knauth 2023).

Effect of provider consolidation on quality is unclear

There is limited information on the effects of horizontal consolidation and vertical integration on quality. Most of the older literature suggests that consolidation increases prices without improving quality. Some literature suggests a lack of competition may hurt quality (Gaynor et al. 2017). However, the effect of horizontal consolidation and vertical integration on quality is less clear than the effect of consolidation on price. A study that examined the longitudinal effects of hospital mergers on quality found that "hospital acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates. Effects on process measures of quality were inconclusive" (Beaulieu et al. 2020). Meanwhile, a cross-sectional comparison of vertically integrated practices and independent physician practices found that physicians employed by a hospital system received substantially higher prices from commercial insurers (12 percent to 26 percent higher, on average, depending on the service) and had "marginally better" performance on clinical process and patient-experience measures than independent practices (Beaulieu et al. 2023). For example, 77.3 percent of system physicians' patients rated their physician a 9 or a 10 on a 10-point scale compared with 76.0 percent of patients seeing independent physicians (a difference that was statistically significant ($p < 0.001$)). Given the design of the study, we do not know whether the large systems' slightly better performance on process and patient-experience measures is due to the structure and size of the integrated systems or due to the systems' selection of clinicians. ■

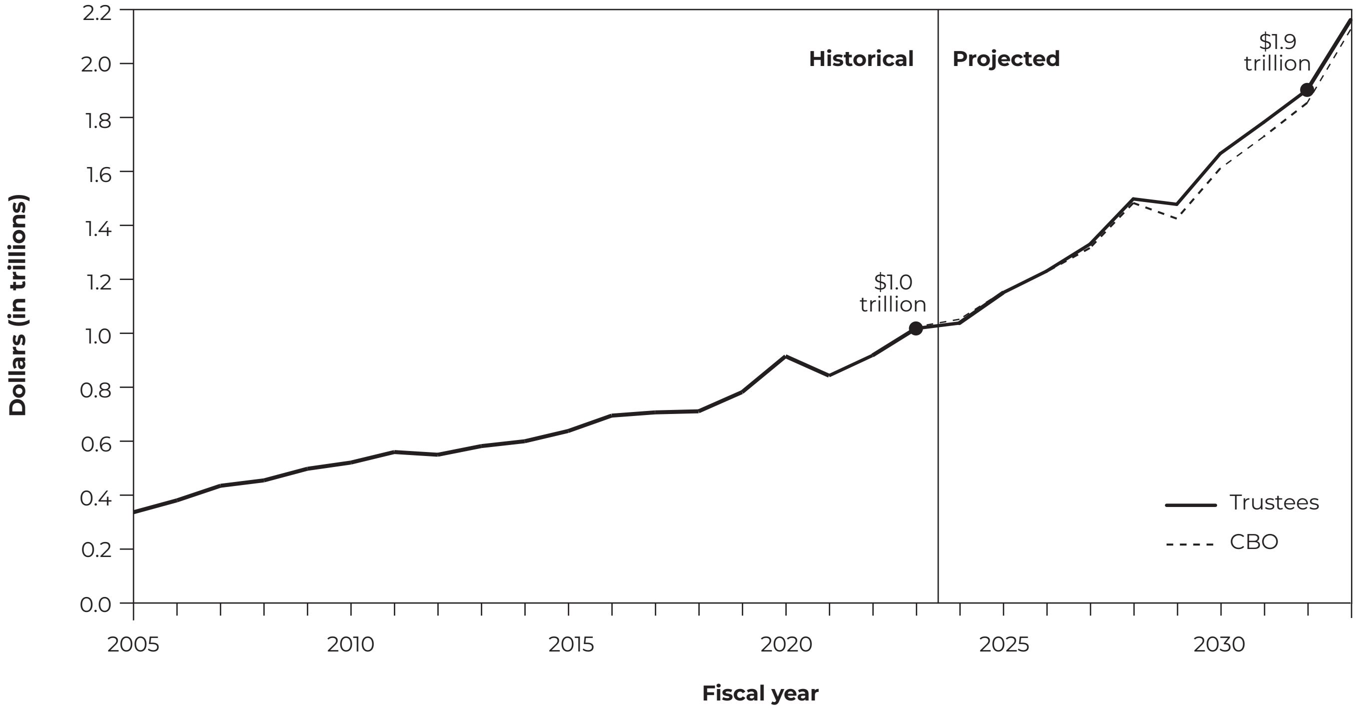
(Table 1-1, p. 13). During this same period, the number of people with private health insurance is expected to decline and Medicaid enrollment is expected to grow slightly (Fiore et al. 2024)).

Medicare spending is also expected to grow due to an increase in the volume and intensity of services delivered per beneficiary, which is projected to rise by an average of 2.8 percent per year in the coming years (Table 1-1, p. 13). An example of increasing volume and intensity of service delivery is when newer, higher-resolution computed tomography (CT) scans identify potential issues that might not have been identified by lower-resolution CT scans, and those issues are then pursued through additional clinical workup. Intensity can also increase when providers furnish more complex, higher-priced services in place of less complex, lower-priced services. For example, analyses of claims data show an increase in recent years in the share of visits billed as involving a "moderate" level of medical decision-making rather than a "low" level of medical decision-making, shown in Figure 1-3 (p. 13).[5]

The demographic mix of beneficiaries in the program is not expected to cause a significant increase in spending over the next 10 years (shown in Table 1-1, p. 13). To the

FIGURE 1–2

Medicare spending is projected to double in the next 10 years



Note: CBO (Congressional Budget Office). The first projected year in the graph is 2024. The sharp increase in spending in 2020 includes $104 billion in Medicare Accelerated and Advance Payments paid to providers that were then recouped by the Medicare program in 2021, 2022, and 2023. The decline in spending in 2029 is due to a timing issue: When October 1 (the first day of the federal fiscal year) falls on a weekend, certain payments that would have ordinarily been made on that day are instead made at the end of September and thus are shifted into the previous fiscal year.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds, Table V.H4; CBO's June 2024 baseline projections for the Medicare program.

contrary, the average Medicare beneficiary has been getting younger and healthier in recent years, as the baby-boom generation ages into Medicare (Boards of Trustees 2024). And the Medicare beneficiaries who survived the recent coronavirus pandemic are now healthier, on average, than beneficiaries before the pandemic began—which has lowered actuaries' projections of Medicare's per capita spending through 2029 (Boards of Trustees 2024).

But in the 2030s, as the baby-boom generation begins to reach older ages, this demographic shift will contribute to increased spending per beneficiary since spending generally increases with age (Medicare Payment Advisory Commission 2024a). The aging of the baby-boom generation will contribute to increased spending per beneficiary through about 2045 (Boards of Trustees 2024).

Medicare spending projections are also influenced by the IRA's prescription drug provisions—some of which are expected to increase Medicare spending and some of which are expected to decrease it.[6] In 2025, the redesigned Part D benefit is expected to lower beneficiaries' out-of-pocket costs, on average—which is expected to put upward pressure on Medicare spending and premiums. Other changes in this law increase plan sponsors' share of insurance risk, which, in turn, could result in stronger incentives for plans to manage drug spending. (For a detailed status report on the Part D program, see Chapter 12.) In addition, beginning in 2026, the point-of-sale prices paid by

TABLE 1–1

Factors contributing to Medicare's projected spending growth, 2024–2033 (after subtracting economy-wide inflation)

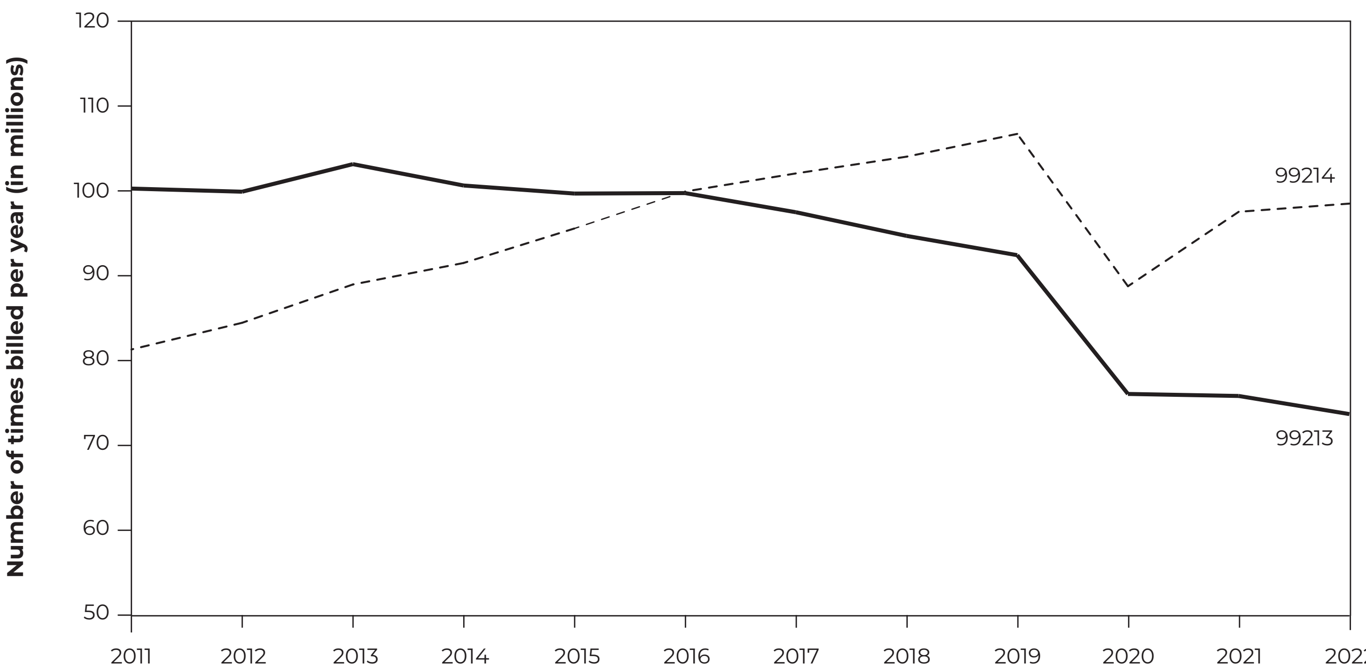
Medicare Part	Medicare prices (minus inflation)	Number of beneficiaries	Beneficiary demographic mix	Volume and intensity of services used	Medicare's projected spending (minus inflation)
	Average annual percent change in:				
Part A	0.1%	1.9%	–0.2%	1.6%	3.4%
Part B	–0.9	2.0	0.1	3.7	4.8
Part D	–0.4	2.7	–0.2	2.8	3.1
Total	–0.4	N/A*	–0.1	2.8	4.1

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. "Beneficiary demographic mix" adjusts for age, sex, and time to death. "Volume and intensity" refers to 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 its part's share of total Medicare spending in 2023.
* Not applicable because there is beneficiary overlap in enrollment in Part A, Part B, and Part D.

Source: MedPAC analysis of data from the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

FIGURE 1–3

Clinicians increasingly use billing code 99214 instead of 99213



Note: Current Procedural Terminology (CPT) codes 99213 and 99214 pertain to office/outpatient visits with established patients that involve a medically appropriate history and/or examination; CPT code 99213 refers to visits involving a "low" level of medical decision-making and/or 20–29 minutes of practitioner time, while CPT code 99214 refers to visits involving a "moderate" level of medical decision-making and/or 30–39 minutes of clinician time. Before 2021, code definitions were more prescriptive about the content of these visits and did not allow time alone to justify the use of one of these codes.

Source: Part B National Summary Data Files, 2011–2022, from CMS.

Expanded coverage of GLP-1 drugs is expected to increase Part D spending

A class of drugs called glucagon-like peptide-1 receptor agonists (GLP-1s) is garnering increased attention from the public and policymakers, with several products in the class recently approved by the Food and Drug Administration (FDA) to support weight loss and reduce the risk of adverse cardiovascular events (NovoMedLink 2024c). The first GLP-1 prescription medication was initially approved in 2005 to assist with glycemic control in individuals with Type 2 diabetes. Over time, several more GLP-1s were approved, and developers realized that at higher doses, these products could assist with weight loss. Currently, there are three drugs that have both a low-dose version for glycemic control in patients with Type 2 diabetes and a second, higher-dose version (typically with a different name) approved for weight loss.[7]

In clinical trials, patients on newer versions of these medications have achieved an average weight loss of between 17 percent and 21 percent compared with 7 percent for the first GLP-1 drug (Lilly Medicine 2024, NovoMedLink 2024a, NovoMedLink 2024b, Rodriguez et al. 2024). Early evidence, however, suggests that some patients may stop use of such products before achieving clinically meaningful results.[8]

By statute, Medicare Part D is prohibited from covering drugs for weight loss, so GLP-1s have been available only for the treatment of Type 2 diabetes so far (P.L. 108–173).[9] However, recent approvals of new indications by the FDA are expected to increase access to GLP-1s for Part D enrollees. The new indications would allow Medicare to cover GLP-1s when used to reduce the risk of cardiovascular death, heart attack, and stroke and to treat moderate to severe obstructive sleep apnea in adults with obesity or overweight (Cubanski et al. 2024, Food and Drug Administration 2024a, Food and Drug Administration 2024b, Frieden 2024). Medicare coverage of GLP-1s could be expanded to other indications in the coming years: A recent clinical trial showed significant risk reduction for major kidney disease (American Diabetes Association 2024), and another study has shown a reduction in the risk of developing various obesity-related cancers in

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Part D plans and coinsurance paid by beneficiaries for drugs selected under the Medicare Drug Price Negotiation Program will reflect discounts negotiated by the Secretary of Health and Human Services (see text box, pp. 437–439, in Chapter 12). Medicare's Trustees expect the net effect of the various provisions in this law to lower Part D spending from 2031 onward. Beginning in 2028, spending on drugs administered by clinicians (covered under Part B) is also expected to decline (Boards of Trustees 2024).

Future growth in Part D spending will also be affected by new developments in coverage policies or therapies that treat conditions that affect Medicare beneficiaries. One such case is a class of drugs called glucagon-like peptide-1 receptor agonists (GLP-1s) (Centers for Medicare & Medicaid Services 2024e, Congressional Budget Office 2024b). For years, GLP-1s have been used to treat patients with Type 2 diabetes, although they have recently gained attention for their weight-loss effectiveness. Recent approval of new indications for some GLP-1 drugs, including to reduce the risk of adverse cardiovascular events, is expected to increase these drugs' uptake among Part D enrollees, even if the statutory exclusion of weight-loss drugs from coverage under Part D remains in place (see text box on coverage of GLP-1 drugs). Clinical guidelines and coverage policies concerning GLP-1s are changing rapidly, and we will continue to monitor and update in future work.

A longer-term trend contributing to increased Medicare spending is the growing enrollment in MA

Expanded coverage of GLP-1 drugs is expected to increase Part D spending (cont.)

adults with obesity or overweight (Lin et al. 2024). Given that tens of millions of Medicare beneficiaries have been diagnosed with diabetes, heart disease, obesity, or kidney disease, the number of potential users of such medicines is sizable (Centers for Disease Control and Prevention 2024b).[10,11] Changes in Medicare's policy to allow Part D plans to cover GLP-1s for weight loss would further expand access to these drugs (Assistant Secretary for Planning and Evaluation 2024, Centers for Medicare & Medicaid Services 2024e).

Part D enrollees' increased use of GLP-1s (with list prices of roughly $1,000 per month) is expected to put upward pressure on Part D spending (Amin et al. 2023, Congressional Budget Office 2024b). In fact, the Medicare Trustees noted in their 2024 report that overall drug expenditures in 2023 were 4.4 percent higher than anticipated because of the unexpected and rapid increase in the use of antidiabetic drugs, which includes GLP-1s (Boards of Trustees 2024). Further, true demand may have been dampened by the shortages of many of these products (Food and Drug Administration 2024c).

Spending on these drugs could be partially offset by savings if patients who take these drugs lose weight and consequently do not need more expensive medical care, though these drugs are relatively new and respective spending data are limited. Last year, CBO raised its projection of Medicare Part D outlays for the 2025 to 2034 period by $36 billion, in part because of a newly approved indication that expanded coverage of GLP-1s under Part D (Congressional Budget Office 2024d).

At the same time, spending on GLP-1s will also be affected by rebates and discounts negotiated by Part D plans as well as discounts negotiated by the Secretary of Health and Human Services under the Medicare Drug Negotiation Program (see text box on the program in Chapter 12, pp. 437–439).

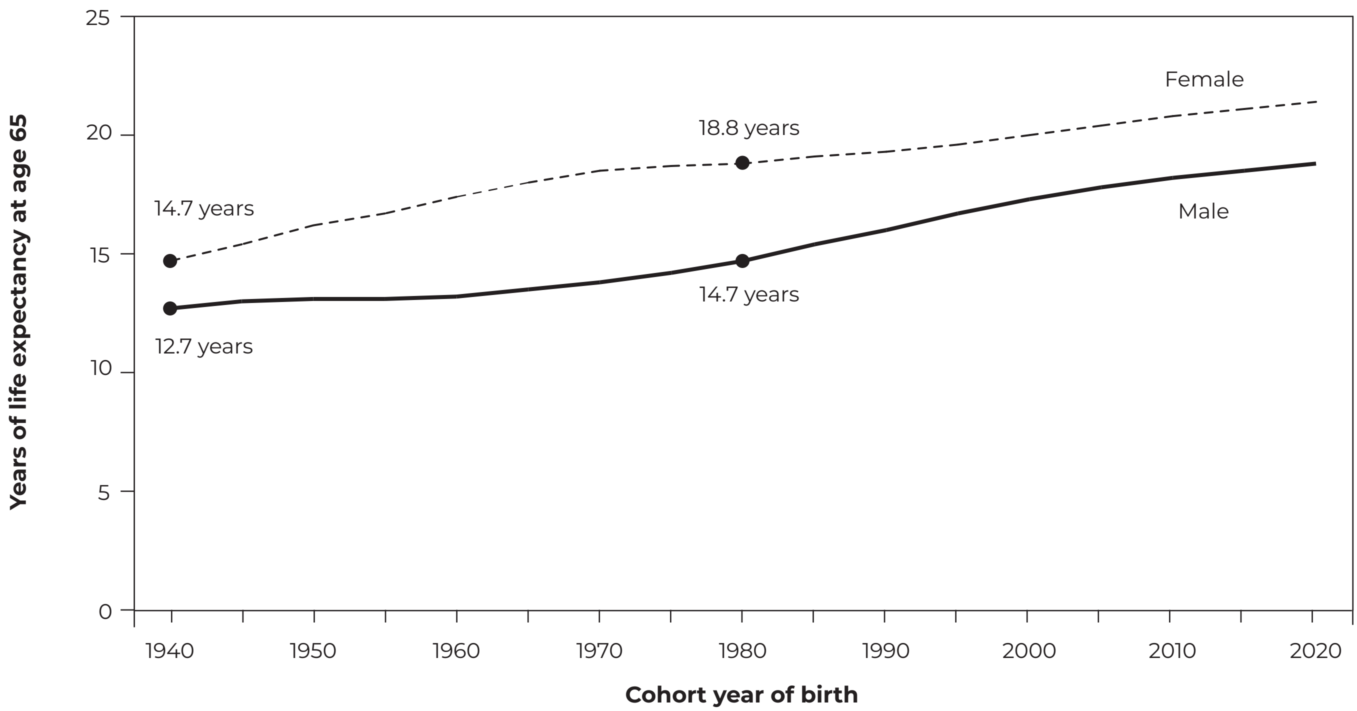
Part D plans may apply utilization management such as prior authorization to ensure that the drug is covered only for FDA-approved indications. Beyond price, length of treatment and adherence will also be major factors in overall spending on GLP-1 drugs (Congressional Budget Office 2024a). ■

plans, noted earlier (Martin et al. 2025). MA plans may be attractive to beneficiaries because they can offer reduced cost sharing for many services, a cap on enrollees' annual out-of-pocket spending for covered services, and coverage for some items and services that are not covered by FFS Medicare—often at no additional premium beyond beneficiaries' Part B premiums. (For information on MA plan benefits, see text box on p. 24.) But Medicare spends an estimated 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare—a difference that translates into a projected $84 billion in additional spending in 2025 alone. (For more on MA, see Chapter 11.) That extra spending is financed by taxpayers and by beneficiaries enrolled in FFS Medicare and MA in the form of higher Part B premiums.

Two main factors contribute to the Commission's estimate of higher spending on MA: (1) the increased number of diagnoses recorded by MA plans (which increases payments to the respective MA plan) and (2) the favorable selection that MA plans experience because MA payments are based on beneficiary predicted costs and beneficiaries with lower-than-predicted spending are more likely to enroll in these plans—potentially because such beneficiaries are less averse to plans' limited networks and utilization management efforts. The Commission has made several recommendations to improve the MA

FIGURE 1–4

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



Source: The 2024 annual report of the Boards of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds.

program and believes a major overhaul of MA policies is needed (Medicare Payment Advisory Commission 2024c).

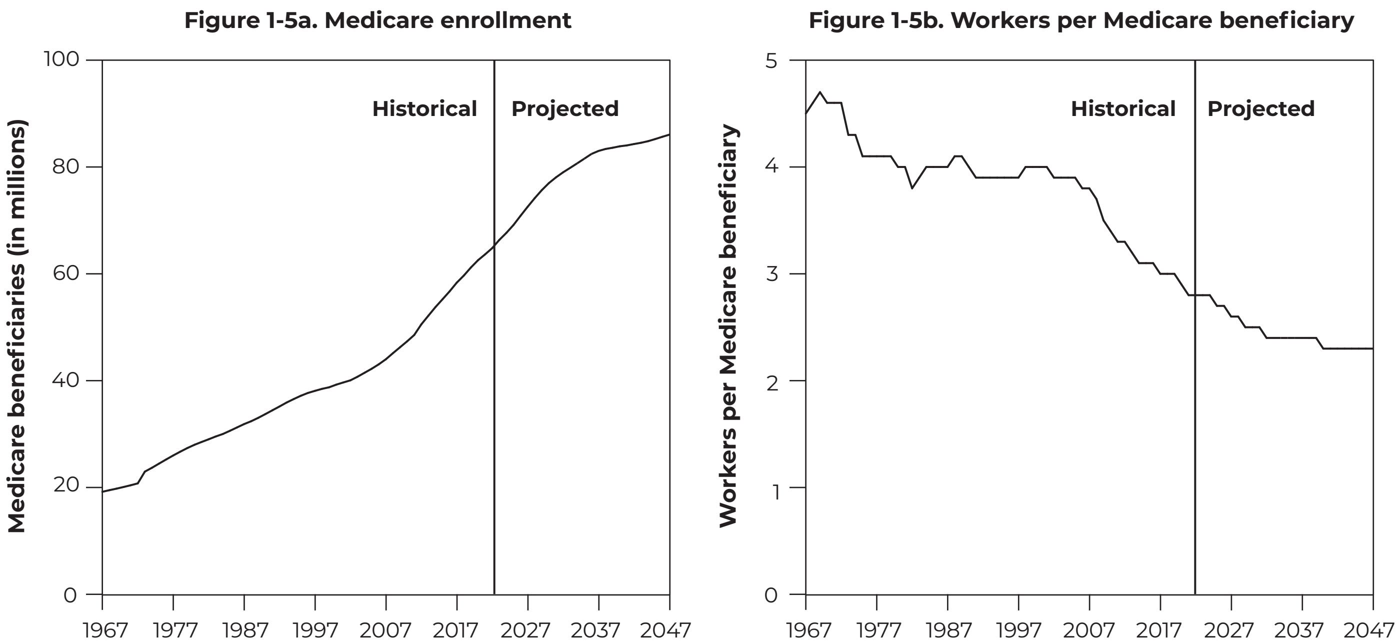
Looking to the more distant future, increasing life expectancy is projected to increase Medicare spending later in this century (Figure 1-4). Among the cohort of people born in 1940 (who are currently Medicare beneficiaries), women who reach the age of 65 are projected to have 14.7 years of additional life expectancy and men are projected to have 12.7 years of life expectancy (meaning they are expected to live until ages 80 and 78, respectively). Among those born in 1980 (future Medicare beneficiaries), women who reach 65 are projected to have 18.8 years of life expectancy and men are projected to have 14.7 years of life expectancy (meaning they are expected to live until about ages 84 and 80, respectively).

Medicare faces a financing challenge

The entire baby-boom generation will be old enough to enroll in Medicare by 2029 (Fiore et al. 2024). By that time, Medicare is projected to have 75 million beneficiaries—up from 65 million beneficiaries in 2022 (Figure 1-5a). Meanwhile, the ratio of workers helping to finance Medicare through payroll and income taxes relative to the number of Medicare beneficiaries has been declining over time and is expected to continue to do so. As shown in Figure 1-5b, around the time of Medicare's creation, there were 4.5 workers for each Medicare beneficiary, but by 2023 there were only 2.8 workers per beneficiary, and by 2029 there are expected to be only 2.5 workers per beneficiary.

FIGURE 1–5

Medicare enrollment is rising, while the number of workers per Medicare beneficiary is declining



Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplementary Medical Insurance because Part A is usually available to beneficiaries at no cost. First projected year is 2024. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds.

The declining ratio of workers to Medicare beneficiaries creates a financing challenge for the Medicare program. Medicare Part A (which covers inpatient hospital stays, post-acute care following those stays, and hospice care) is mainly financed through current workers' Medicare payroll taxes, which are deposited into Medicare's Hospital Insurance (HI) Trust Fund.[12,13] In some years, Medicare has spent more on Part A services than it has collected through HI Trust Fund revenues—creating annual deficits that cause the trust fund's year-end account balance to decline. In other years, trust-fund revenues have exceeded Part A spending (including in 2023)—creating annual surpluses that increase the trust fund's account balance. Medicare's Trustees currently estimate that the trust fund's balance will rise through 2029 and then decline from 2030 on, and by 2036 the trust fund will no longer carry a positive year-end balance (Boards of Trustees 2024). At that point, Part A services would be paid only from annual trust-fund revenues, which would be sufficient to cover only 89 percent of scheduled benefits (Boards of Trustees 2024). (The Congressional Budget Office (CBO) also tracks the trust fund's financial status and projects that it will be depleted in a similar time frame—by 2035 (Congressional Budget Office 2024c).)

These time horizons are a decade longer than were projected before the pandemic (Boards of Trustees 2019, Congressional Budget Office 2019). The projection changed because trust-fund revenues are now expected to be higher than previously estimated and Part A spending is expected to be lower than previously estimated. On the revenue side of the ledger, Medicare's Trustees predict that more Medicare payroll-tax revenues will be collected

TABLE 1–2

Higher Medicare payroll tax or lower Medicare Part A spending needed to extend 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 (2024–2048)	3.35%		10.6%

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 the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

in coming years due to both the number of workers paying payroll taxes and their average wages being higher than previously projected. (For the third year in a row, the Trustees have increased their projections of the amount of payroll-tax revenues that will be collected in the coming years.) On the spending side of the ledger, the Trustees expect Part A spending to be lower than previously estimated due to (1) a correction to MA benchmark calculations (which now excludes medical education expenses associated with MA enrollees from the FFS per capita costs used in the determination of MA payments) and (2) lower projected spending on inpatient hospital and home health services, based on recent utilization trends (Boards of Trustees 2024).[14]

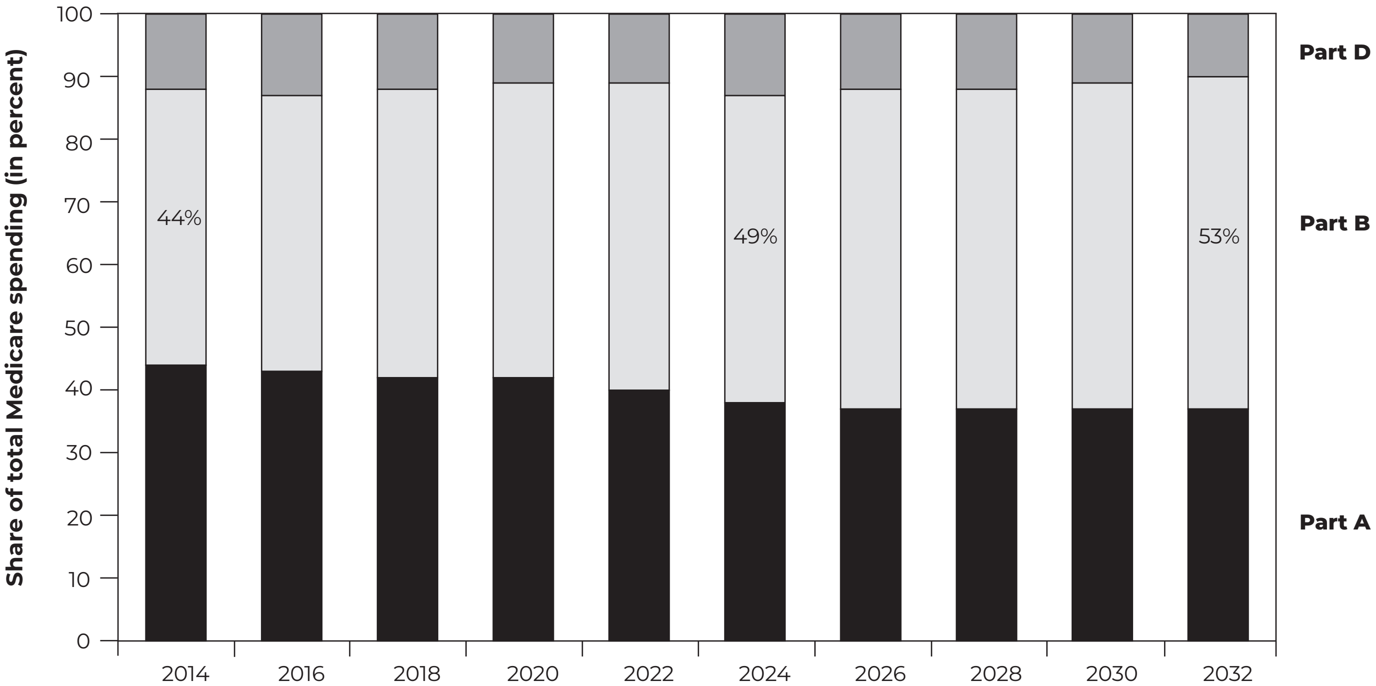
To extend the solvency of the HI Trust Fund beyond the mid-2030s, there are a number of options available to policymakers. Two that are mentioned by Medicare's Trustees are to (1) increase the Medicare payroll tax from its current rate of 2.9 percent to 3.35 percent or (2) reduce Part A spending by 10.6 percent (Table 1-2), which is equivalent to a reduction of about $45 billion in 2025, which would then need to be maintained in subsequent years (Boards of Trustees 2024). Either of these approaches would extend the solvency of the trust fund by 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; as mentioned, the trust fund's solvency has recently been extended due to more people working (and paying Medicare payroll taxes) and people earning higher-than-expected wages (which results in more wages being taxable).

The rest of Medicare spending—under Part B (which covers clinician and outpatient services) and Part D (which covers retail prescription drugs)—is financed through the Supplementary Medical Insurance (SMI) Trust Fund. Part B spending, in particular, has been consuming a growing share of Medicare spending over time, as care has shifted from the inpatient setting (paid for by Part A) to the outpatient setting (paid for by Part B). For example, spending on Part B consumed 44 percent of Medicare spending in 2014 but is estimated to have grown to 49 percent of Medicare spending in 2024; by 2032, it is projected to make up 53 percent of Medicare spending (Figure 1-6). The shift from inpatient to outpatient settings is in part related to CMS removing certain services from its "inpatient-only" list thanks to technological advancements (such as the use of cameras and robots) that have allowed procedures to be conducted using smaller incisions and less invasive approaches in a wider array of settings.

Part B and Part D benefits are paid for by the SMI Trust Fund, which in turn is mainly financed through transfers from the general fund of the Treasury (which made up 69 percent of this trust fund's revenues in 2023) and premiums paid by beneficiaries (which made up 24 percent of revenues) (Boards of Trustees 2024).[15] Although there is no risk of the SMI Trust Fund becoming insolvent (since premiums and revenue transfers are intentionally set to cover the following year's estimated spending), there are other reasons to try to limit growth in the spending paid

FIGURE 1–6

The share of Medicare spending on Part B has been increasing as care has shifted from the inpatient to the outpatient setting



Note: In this graph, "total Medicare spending" refers to the sum of reimbursement amounts on an incurred basis for Part A, Part B, and Part D. Graph does not include spending financed by beneficiary premiums. First projected year is 2024.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds.

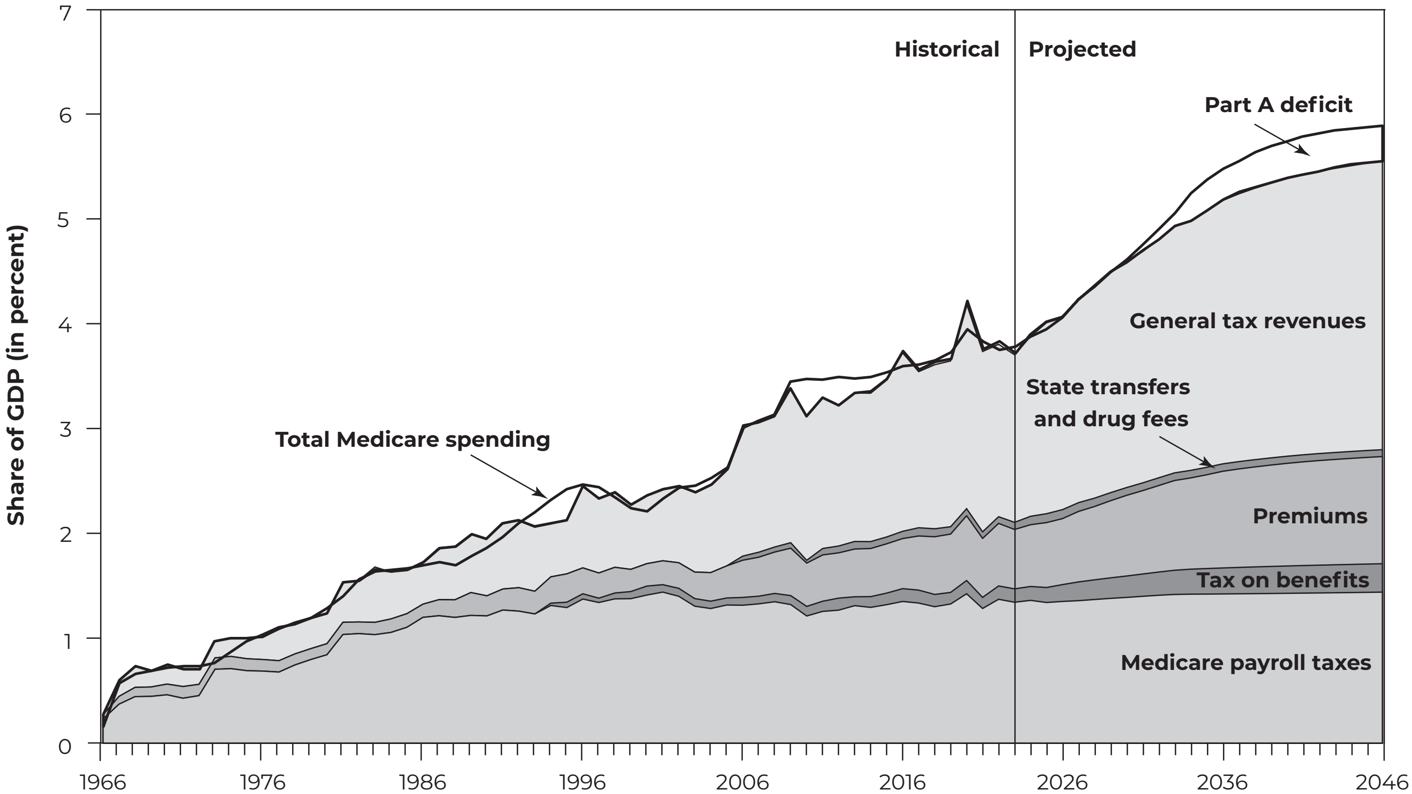
for through this trust fund. As spending on Part B grows, the federal revenues that are transferred to the SMI Trust Fund grow: In 2023, 17 percent of all personal and corporate income taxes collected by the federal government were transferred to Medicare's SMI Trust Fund to pay for Part B and Part D, and this share is projected to increase to 22 percent by 2030 (Boards of Trustees 2024). As the amount of general revenues needed to finance Medicare increases, fewer government resources will be available for other priorities, such as deficit reduction or investments that could expand future economic output (e.g., federal investments in education, transportation, and research and development).

The increasing amount of general revenues spent on the Medicare program (as shown in Figure 1-7, p. 20) is also a problem because the federal government already spends more than it collects in revenues each year (Figure 1-8, p. 21). The line at the top of Figure 1-8 represents total federal spending as a share of GDP; the line below it represents total federal revenues. The difference between these two lines represents the budget deficit, which must be covered by federal borrowing. The stacked layers in Figure 1-8 depict federal spending by program. By 2044, federal spending on Medicare and the other health insurance programs shown in the figure (Medicaid, Children's Health Insurance Program (CHIP), etc.) plus Social Security and interest payments are projected to exceed federal revenues. At that point, all other federal spending will need to be financed through federal borrowing.

While these projections are sobering, CMS actuaries caution that they may actually be "overly optimistic"

FIGURE 1–7

Medicare's three main funding sources are general tax revenues, Medicare payroll-tax revenues, and beneficiary premiums



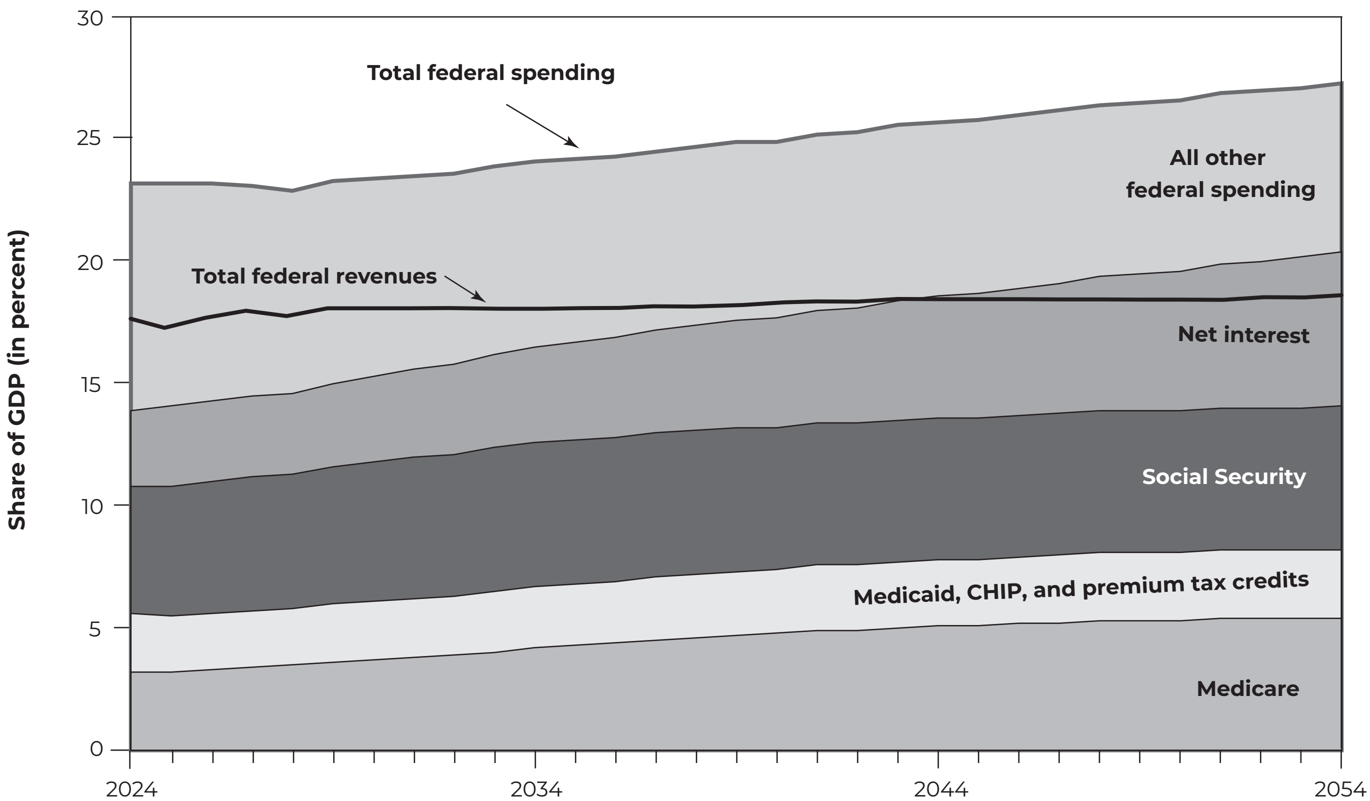
Note: GDP (gross domestic product). First projected year is 2024. Projections are based on the Trustees' intermediate set of assumptions. "Tax on benefits" refers to the portion of income taxes that higher-income individuals pay on Social Security benefits, which is designated for Medicare. "State transfers" 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 (SMI) Trust Fund. Graph does not include interest earned on trust-fund investments (which makes up 1.4 percent of the HI Trust Fund's income and 0.7 percent of the SMI Trust Fund's income and is expected to decline in coming years as trust-fund assets decline).

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds.

(Office of the Actuary 2024). Medicare spending as a share of GDP is projected to grow rapidly through 2040, then grow at a slower rate in subsequent decades because of various cost-reduction measures specified in current law.[16] CMS actuaries note that if these cost-reduction measures are replaced with more generous payment policies, Medicare spending from 2040 onward will increase at a higher rate that is more in line with past spending growth. Such growth would mean that by 2060, Medicare spending would constitute 6.8 percent of GDP, rather than 6.0 percent (Boards of Trustees 2024). It would also mean that a larger payroll-tax increase or Part A–spending decrease would be needed to extend the solvency of Medicare's HI Trust Fund (shown earlier in Table 1-2, p. 18). The Medicare Trustees' long-term spending projections therefore "should not be interpreted as the most likely expectation of actual Medicare financial operations in the future," according to CMS actuaries (Office of the Actuary 2024).

FIGURE 1–8

Spending on Medicare, Medicaid, CHIP, premium tax credits, Social Security, and interest is projected to exceed total federal revenues by 2044



Note: CHIP (Children's Health Insurance Program), GDP (gross domestic product). "Premium tax credits" were referred to as "ACA [Affordable Care Act of 2010] Marketplace subsidies" in previous years.

Source: Congressional Budget Office's long-term budget projections, published March 2024.

As Medicare spending increases, so too do beneficiaries' costs

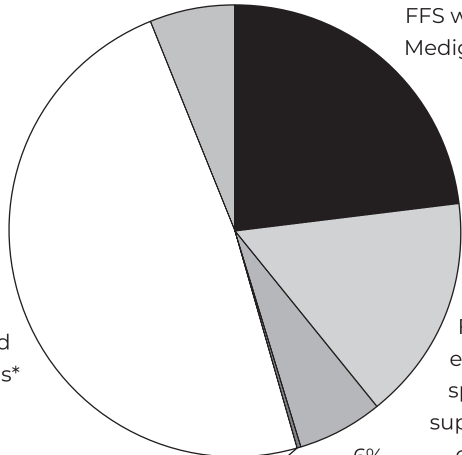
In 2023, the Medicare program spent an average of $16,710 per beneficiary on Part A, Part B, and Part D benefits—almost $3,000 more than in 2019 (Boards of Trustees 2024, Boards of Trustees 2020). As Medicare spending grows, it affects beneficiaries' ability to afford health care by raising their premiums and cost sharing. Medicare beneficiaries typically do not pay premiums for Part A coverage, but the annual cost of Part B premiums was $2,096 in 2024 (Centers for Medicare & Medicaid Services 2023a).

The average annual cost of Part D prescription drug plan premiums in 2024 was $516 for stand-alone drug plans and $180 for drug coverage through an MA plan (since MA plans can use Part C rebates to "buy down" enrollees' Part D premiums) (Medicare Payment Advisory Commission 2024a).

Cost-sharing liabilities for beneficiaries in FFS Medicare averaged $396 for Part A services and $1,621 for Part B services in 2021 (the most recent year available for this information) (Medicare Payment Advisory Commission 2024a). (The amount of cost sharing that beneficiaries actually pay is lower when they have supplemental coverage such as a

FIGURE 1–9

Most Medicare beneficiaries reduced their cost sharing through supplemental coverage or enrollment in a Medicare Advantage plan in 2021



Note: FFS (fee-for-service), MA (Medicare Advantage). Our analysis assigned beneficiaries to the supplemental coverage category they were in for the most time in 2021; beneficiaries could have had coverage in other categories during 2021. The analysis includes only beneficiaries not living in institutions such as nursing homes who were enrolled in Medicare for at least one month in 2021. It excludes beneficiaries who were not in both Part A and Part B throughout their Medicare enrollment in 2021 or who had Medicare as a secondary payer. The number of beneficiaries represented in this chart is 52.5 million.
* Includes plans for beneficiaries who are also eligible for Medicaid and plans sponsored by employers.

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

Medigap plan.) Average annual cost sharing for retail prescription drugs in 2022 was $480 for beneficiaries with stand-alone Part D plans and $276 for those with drug coverage through an MA plan, but these amounts are expected to be lower in coming years (Medicare Payment Advisory Commission 2024a).[17] (Starting in 2024, beneficiaries are no longer required to pay cost sharing when they reach the catastrophic phase of the Part D benefit; in 2025, out-of-pocket costs in Part D will be capped at $2,000.)

The typical Medicare beneficiary has relatively modest resources to draw on when paying for premiums and cost sharing: Researchers estimate that in 2023, the median Medicare beneficiary had an annual income of $36,000 and savings of $103,800 (Cottrill et al. 2024).

Another way of looking at the affordability of Medicare's premiums and cost sharing is by comparing them with the average Social Security benefit received by people ages 65 and over. The Medicare Trustees estimate that spending per FFS beneficiary on Medicare Part B and Part D premiums and cost sharing consumed 26 percent of the average Social Security benefit in 2024—up from 17 percent 20 years earlier, in 2004 (Boards of Trustees 2024).[18]

Most beneficiaries reduce their out-of-pocket spending by obtaining supplemental insurance coverage or by opting out of FFS Medicare and into an MA plan. In 2021, nearly half of all community-dwelling beneficiaries had FFS Medicare plus supplemental coverage (commonly obtained through Medicaid, a former employer, and/or a Medigap plan they purchased themselves). Another 48 percent were enrolled in an MA plan or other managed care plan (including some who were dually eligible for Medicare and Medicaid). Only 6 percent of beneficiaries were in FFS Medicare without any supplemental coverage to reduce their cost sharing (Figure 1-9).[19]

Approximately one in five Medicare beneficiaries receives help paying their Part B premium (and, in some cases, their cost sharing) through their state's Medicaid program (Boards of Trustees 2024, Centers for Medicare & Medicaid Services 2024b). Approximately one in four Medicare Part D enrollees receives help with their out-of-pocket retail prescription drug costs through the Part D low-income subsidy (Boards of Trustees 2024, Medicare Payment Advisory Commission 2024a). For more information on the various types of coverage that Medicare beneficiaries can enroll in, see text box (pp. 24–26).

Cost sharing is a barrier for some beneficiaries. Among all Medicare beneficiaries, 6 percent reported having problems paying a medical bill, according to our analysis of CMS's 2022 Medicare Current Beneficiary Survey, but some subpopulations experienced affordability issues at notably higher rates. For example:

- Among beneficiaries under the age of 65 (most of whom are disabled), 18 percent reported problems paying a medical bill. Beneficiaries under age 65 tend to require more health care services than beneficiaries ages 65 and over, have lower incomes, and generally face higher Medigap premiums than beneficiaries who have reached Medicare's eligibility age of 65 (Cottrill et al. 2024, Cubanski et al. 2016, Medicare Payment Advisory Commission 2024a).
- Among partial-benefit dual-eligible beneficiaries, 28 percent reported problems paying a medical bill. (These beneficiaries receive Medicaid assistance with premiums and, in some cases, cost sharing, but do not qualify for additional Medicaid benefits that full-benefit dual-eligible beneficiaries receive, such as dental care and nonemergency medical transportation.)
- Among beneficiaries enrolled in FFS Medicare with no supplemental coverage, 12 percent reported problems paying a medical bill.

Given these findings, it is important to keep in mind that when Medicare payment rates for providers increase, premiums and cost sharing also increase for Medicare beneficiaries—some of whom already have a hard time affording health care. Restraining the annual growth in Medicare spending can help beneficiaries afford their health care since it results in lower premiums and cost sharing.

Differences in beneficiaries' access to care and health outcomes

In response to commissioner interest, the Commission reports on differences in Medicare beneficiaries' access to care and health outcomes. Research has shown that some beneficiaries have more difficulties accessing care and experience worse outcomes than others. In this section, we take a closer look at the extent to which there are differences among beneficiaries with different income levels and among those of different races and ethnicities (focusing on the three largest racial and ethnic groups, due to data availability).

Medicare beneficiaries with incomes and assets low enough to qualify for Part D's low-income subsidy (LIS) report more problems accessing care than other beneficiaries, according to CMS's Medicare Current Beneficiary Survey. (Beneficiaries qualify for the LIS if they receive full or partial Medicaid benefits and/or, in 2024, had incomes below $22,590 (or $30,660 if married) and liquid assets below $17,220 (or $34,360 if married).)[20] In an analysis of CMS's beneficiary survey from 2019 (before the recent coronavirus pandemic temporarily disrupted care patterns), we found that much higher shares of LIS beneficiaries reported forgoing care that they thought they should have gotten (18 percent) compared with non-LIS beneficiaries (6 percent), and much higher shares of LIS beneficiaries reported delaying care due to cost (29 percent) compared with non-LIS beneficiaries (8 percent) (Medicare Payment Advisory Commission 2023b).

We also observed differences between LIS and non-LIS beneficiaries in our analysis of health outcomes using 2019 claims data. For example, LIS beneficiaries had higher rates of ambulatory care–sensitive hospitalizations (55.9 per 1,000 FFS beneficiaries) than non-LIS beneficiaries (41.7). LIS beneficiaries had higher rates of ambulatory care–sensitive emergency department visits (89.6 such visits per 1,000 FFS beneficiaries) compared with non-LIS beneficiaries (61.7). Among beneficiaries discharged from a hospital, LIS beneficiaries were more likely to experience a readmission (17.2 percent) than non-LIS beneficiaries (14.6 percent). And among beneficiaries with a skilled nursing facility stay, LIS beneficiaries had lower rates of successful discharge to the community (defined as not having an unplanned hospitalization or death in the next 30 days) (35 percent) compared with non-LIS beneficiaries (54 percent) (Medicare Payment Advisory Commission 2023a).

Concerns about access to care for LIS beneficiaries motivated the Commission to recommend in 2023 and 2024 and in this year's report that the Congress increase Medicare payment rates to many providers who serve LIS beneficiaries, including beneficiaries who receive full or partial Medicaid benefits (Medicare Payment Advisory Commission 2024c, Medicare Payment Advisory Commission 2023b). These recommendations would address problems with the formulas currently used to distribute safety-net payments to hospitals and would help address the issue that clinicians who serve Medicare

Medicare beneficiaries have numerous enrollment options

Once an individual becomes eligible for Medicare—either because they are age 65, they have received Social Security Disability Insurance payments for two years, or they have been diagnosed with end-stage renal disease or amyotrophic lateral sclerosis (ALS)—they must make a number of enrollment decisions.

Initially enrolling in coverage

Individuals can choose to enroll in Medicare Part A, which helps pay for inpatient hospital stays, post-acute care following those hospital stays, and hospice care. Part A is available to 99 percent of Medicare beneficiaries without a monthly premium because they or their spouse paid Medicare payroll taxes for at least 10 years (Centers for Medicare & Medicaid Services 2023a).

Individuals can also enroll in Medicare Part B, which helps pay for clinicians' services and outpatient fees. For most beneficiaries (including those in a Medicare Advantage (MA) plan), the premium for Part B is deducted from their monthly Social Security checks.[21] In 2024, the standard Part B premium was $174.70 per month for beneficiaries with a modified adjusted gross annual income of up to $103,000 for a single person or $206,000 for a married couple; beneficiaries with higher incomes pay higher Part B premiums (Centers for Medicare & Medicaid Services 2023a).

Prescription drug coverage is available through Part D, either through stand-alone plans or MA plans that include drug coverage. Part D enrollees with higher incomes are also required to pay higher premiums, based on the same thresholds noted for Part B coverage.

Late-enrollment penalties Individuals who do not enroll in Part B or Part D when they reach Medicare's eligibility age will usually owe late-enrollment penalties if they eventually do enroll in coverage.[22] For example, late Part B enrollees have a life-long surcharge added to their Part B premiums that adds 10 percent for each year that they could have signed up but did not (Centers for Medicare & Medicaid Services 2024a).

Annual enrollment options

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

Fee-for-service Medicare Unless they opt into an MA plan (described below), Medicare beneficiaries are covered through fee-for-service (FFS) Medicare, which allows them to obtain care from any health care provider who accepts Medicare. In 2024, beneficiaries in FFS Medicare owed 20 percent cost sharing for clinician services after they met their annual Part B deductible of $240; they also owed $1,632 for the first 60 days of each hospital admission, plus additional amounts if they required a longer hospital stay or a skilled nursing facility stay that exceeded 20 days (Centers for Medicare & Medicaid Services 2023a).

Beneficiaries in FFS Medicare can obtain subsidized prescription drug coverage by purchasing a stand-alone Medicare Part D plan. In 2024, the average premium for this type of plan was $43 per month (see Chapter 12 for more on Part D).

Medigap Beneficiaries who want to reduce their cost-sharing liability while maintaining broad access to providers can obtain a Medigap plan, which wraps around FFS Medicare coverage. Medigap plans can be purchased by employers for their retired workers or by individuals for themselves. There are a number of standardized Medigap plans (e.g., Plan A, Plan B) that private insurers can offer, which must include the same benefits but can vary in price. The average monthly premium among current Medigap policyholders was $217 in 2023 (Freed et al. 2024). (Subsidized supplemental coverage is available to low-income FFS beneficiaries through Medicaid, described later.) Beneficiaries who purchase a Medigap plan when they first reach age 65 are guaranteed the right to purchase any Medigap plan an insurer offers and the insurer cannot factor in

(continued next page)

Medicare beneficiaries have numerous enrollment options (cont.)

the beneficiary's health status when setting the premium;[23] beneficiaries who enroll in a Medigap plan when they first turn 65 can renew that plan indefinitely (Centers for Medicare & Medicaid Services 2023b). In general, beneficiaries who are under the age of 65 or who are over 65 and missed the six-month guaranteed-issue period are subject to underwriting in most states, which means they can face higher Medigap premiums or be denied a policy.

Medicare Advantage As an alternative to FFS Medicare, beneficiaries can opt to receive their Medicare benefits through an MA plan, which allows beneficiaries to lower their cost-sharing liability and receive additional benefits while often paying a relatively low or no additional monthly premium for their MA plan. (Aside from MA plan premiums, MA enrollees also pay the same Part B premium that beneficiaries in FFS Medicare pay.) MA plans typically offer lower cost sharing if a beneficiary seeks care from a provider in a plan's network and higher out-of-pocket costs or no coverage if they seek care from a provider outside of the plan's network.[24] MA plans also have an annual out-of-pocket limit on cost sharing for Part A and Part B services and, as of 2024, for Part D. To try to hold down costs, MA plans commonly engage in utilization-management strategies such as requiring beneficiaries to obtain a referral from a primary care clinician before seeing a specialist, requiring clinicians to obtain prior authorization from an insurer before furnishing certain services, and denying payment for some claims. MA plans often also offer beneficiaries prescription drug coverage as well as supplemental benefits not available in FFS Medicare such as vision, dental, and hearing benefits and non–health care benefits such as gym memberships.

Medicare beneficiaries who wish to switch from an MA plan to FFS Medicare during Medicare's annual open enrollment period can do so but will likely face higher Medigap premiums and fewer plan options than individuals who enroll in a Medigap plan when they first reach age 65. Most states' insurance regulations allow Medigap insurers to deny coverage or vary premiums based on a beneficiary's health status if the beneficiary is buying a Medigap plan after age 65 (Centers for Medicare & Medicaid Services 2023b).[25]

Employers can subsidize coverage for Medicare beneficiaries Some employers help pay for their retired employees' health insurance by paying for Medigap plans, sponsoring their own Medigap-like coverage that wraps around the FFS Medicare benefit package, sponsoring their own prescription drug plans, or sponsoring their own MA plans (which can include or exclude prescription drug coverage). Medicare beneficiaries who served in the military can receive health care services subsidized by the Department of Veterans Affairs (VA) or the Department of Defense (Department of Veterans Affairs 2024, TRICARE 2024).

Additional assistance for low-income beneficiaries Medicare beneficiaries with very low incomes and liquid assets can apply for Medicaid coverage that will pay their Medicare premiums (and, in some cases, their cost sharing).[26] Most individuals dually enrolled in Medicare and Medicaid qualify for additional benefits that are not available under FFS Medicare, such as long-term services and supports (e.g., nursing home care), vision and dental care, and nonemergency medical transportation to appointments. Dually eligible beneficiaries can obtain their Medicare benefits through FFS Medicare or an MA plan and can receive their Medicaid benefits through a FFS Medicaid program or a Medicaid managed care plan (depending on which option their state offers). Some dual enrollees receive coordinated Medicare and Medicaid benefits through a single plan, although such plans are not widely available.

Low-income beneficiaries can also get financial assistance paying for their prescription drugs through Medicare's Part D low-income subsidy (LIS), which pays for a beneficiary's Part D premium and deductible and reduces their cost sharing for drugs.

(continued next page)

Medicare beneficiaries have numerous enrollment options (cont.)

Medicare beneficiaries are automatically enrolled in this program if they are enrolled in Medicaid or another state program that pays their Medicare Part B premium or if they receive Supplemental Security Income benefits due to low income. If they are not automatically enrolled in the Part D LIS, Medicare beneficiaries can apply for it if they have an income below $22,590 (or $30,660 if married) and liquid assets below $17,220 (or $34,360 if married) in 2024 (Centers for Medicare & Medicaid Services 2024c).

Beneficiaries' enrollment decisions vary by race and ethnicity According to our analysis of CMS's 2022 Medicare Current Beneficiary Survey, White beneficiaries were much more likely than Black and Hispanic beneficiaries to have FFS Medicare with some type of private health insurance (obtained through an employer or purchased individually, such as a Medigap plan): 42 percent of White beneficiaries had this combination of coverage, compared with 15 percent of Black beneficiaries and 13 percent of Hispanic beneficiaries. (Medigap is also more common among beneficiaries who have high incomes, are in excellent or very good health, are eligible for Medicare due to age rather than disability, and live in a rural area (Medicare Payment Advisory Commission 2024a).) Meanwhile, enrollment in MA plans was more common among Black and Hispanic beneficiaries: 67 percent of Black beneficiaries and 65 percent of Hispanic beneficiaries were in MA plans, compared with 46 percent of White beneficiaries. Black and Hispanic beneficiaries were also more likely to be dually enrolled in Medicare and Medicaid and/or receiving the Part D LIS. For example, nearly half of Black and Hispanic beneficiaries received the LIS, compared with 12 percent of White beneficiaries. And among beneficiaries dually enrolled in Medicare and Medicaid, Black beneficiaries were four times more likely to enroll in an MA plan than FFS coverage, Hispanic beneficiaries were three times more likely to enroll in MA rather than FFS, and White beneficiaries were twice as likely to enroll in MA rather than FFS.[27] There were not meaningful differences in the shares of White, Black, and Hispanic beneficiaries who had FFS Medicare with no supplemental coverage, but beneficiaries with FFS and no supplemental coverage were more likely to be under age 65, live in a rural area, and have a relatively low income of between 125 and 200 percent of the federal poverty level (Medicare Payment Advisory Commission 2024a). Differences in White, Black, and Hispanic beneficiaries' enrollment selections lead to differences by race and ethnicity in the average amount beneficiaries spend on their health insurance premiums: According to CMS's 2022 survey, White beneficiaries spent $3,853, on average, for their health insurance premiums, while Hispanic beneficiaries spent $2,935 and Black beneficiaries spent $2,704.

The Commission has recommended redesigning the FFS Medicare benefit package

The Commission has recommended capping FFS beneficiaries' total out-of-pocket spending for Part A and Part B services and replacing beneficiaries' coinsurance liabilities with copayments that could vary by type of service and provider (and could be reduced or eliminated for high-value services). We have also recommended imposing an additional charge on supplemental insurance (e.g., Medigap plans) since such plans shield beneficiaries from cost sharing and thus may contribute to overuse of services (Medicare Payment Advisory Commission 2012). ■

beneficiaries who are also enrolled in Medicaid are often unable to collect the cost-sharing amounts they otherwise would. (State Medicaid programs can cover cost sharing for most dually eligible beneficiaries but typically do not cover the full amount, and clinicians cannot bill beneficiaries for any remaining unpaid amounts.) Specifically, the Commission has recommended overhauling how safety-net payments to hospitals are distributed and increasing them: A new add-on payment would be applied to payments for hospital inpatient and outpatient services and would vary in size based on a hospital's position on the Medicare Safety-Net Index, which is a new measure developed by the Commission that would factor in the degree to which a hospital serves beneficiaries who are dually enrolled in Medicare and Medicaid and/or receive the LIS.[28] Our other recommendation would increase Medicare's payment rates for physician fee schedule services by different percentages, depending on a clinician's specialty: Primary care providers' rates would increase by 15 percent, and all other clinicians' rates would increase by 5 percent when they furnish services to Medicare beneficiaries who are also enrolled in Medicaid and/or receive the LIS. (This recommendation would likely give health care providers an incentive to make their low-income Medicare patients aware of, and help them enroll in, Medicaid and the LIS.) Targeted payment increases can improve access to care for beneficiaries with lower incomes; they can also be used to influence the size and composition of the health care workforce (see text box, pp. 29–33).

The data show fewer differences in reported access to care among beneficiaries of different races and ethnicities. For example, in CMS's 2022 Medicare Current Beneficiary Survey, we found no statistically significant differences between the shares of White, Black, and Hispanic beneficiaries who had a usual source of care, saw their usual care provider in the previous 12 months, had trouble getting health care, reported forgoing care that they thought they should have gotten, or were satisfied with the ease with which they could get to a doctor from where they live. Similarly, in the Commission's 2024 survey, which was fielded among about 5,000 Medicare beneficiaries, we found that Black and Hispanic beneficiaries had similar care experiences as White beneficiaries, according to most questions in our survey. (For more detailed results from our survey, see Chapter 4.)

One of the few differences found in CMS's survey was that higher shares of Black beneficiaries (12 percent) and Hispanic beneficiaries (9 percent) reported problems paying a medical bill compared with White beneficiaries (6 percent). This finding is likely related to Medicare beneficiaries' differing access to funds to pay for health care (Cottrill et al. 2024).

Despite similarities in reported access to care, Medicare beneficiaries of different races and ethnicities have different health outcomes. Differences in mortality rates are particularly pronounced: After adjusting for age, there were 1,263 deaths per 100,000 people among Black men in 2022, compared with 972 deaths among White men and 774 deaths among Hispanic men (Kochanek et al. 2024). (Death rates for women followed this same trend but were all lower (Kochanek et al. 2024).) We also observed differences in health outcomes among beneficiaries of different races and ethnicities in our analysis of 2019 claims data. For example, Black beneficiaries had higher rates of ambulatory care–sensitive (potentially preventable) hospitalizations (57.7 per 1,000 FFS beneficiaries) compared with Hispanic beneficiaries (48.6) and White beneficiaries (44.9). Black beneficiaries had higher rates of ambulatory care–sensitive emergency department visits (96.2 per 1,000 FFS beneficiaries) compared with Hispanic beneficiaries (84.7) and White beneficiaries (67.1). Among beneficiaries who had recently been admitted to the hospital, Black beneficiaries had higher 30-day readmission rates (17.1 percent) compared with Hispanic beneficiaries (16.3 percent) and White beneficiaries (15.0 percent). Among beneficiaries with a skilled nursing facility stay, Black and Hispanic beneficiaries had lower rates of successful discharge to the community (defined as not having an unplanned hospitalization or death in the next 30 days) (45 percent) compared with White beneficiaries (48 percent). And among beneficiaries treated by home health agencies, lower shares of Black beneficiaries (72 percent) and Hispanic beneficiaries (73 percent) were successfully discharged to the community compared with White beneficiaries (75 percent) (Medicare Payment Advisory Commission 2023a).

The Commission's recommendations to slow the growth in Medicare spending and improve beneficiary access to care

Several aspects of Medicare's payment systems hamper the program's ability to promote program efficiencies and beneficiaries' access to care. The Commission regularly makes recommendations to address these issues. Our annual March report recommends updates to Medicare payment rates for various types of providers, which can be positive, neutral, or negative, depending on our assessment of the adequacy of Medicare payments in a given sector. Our annual June report typically offers broader recommendations aimed at restructuring the way Medicare's payment systems work. For example, we have recommended changing how payments to MA plans are calculated and adopting site-neutral payments for services that can safely be provided in more than one clinical setting. A list of the Commission's recommendations, with links to relevant report chapters, is available at medpac.gov/recommendation. The Commission's recommendations are based on our review of the latest available data and are aimed at obtaining good value for the Medicare program's expenditures—which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. ■

The health care workforce and Medicare's role in shaping it

Medicare has a role—albeit, a somewhat indirect one—in assuring access to high-quality health care through an adequately sized and well-trained workforce. The supply of health care workers has been found to affect quality of care. For example, the number of registered nurses in hospitals has been documented to affect outcomes such as mortality and readmissions (Lasater et al. 2024, Lee and Dahinten 2020, McHugh et al. 2021), and studies find that performance on hospital quality measures such as mortality and hospital-acquired infections is influenced by the number of nurses a hospital employs (Oner et al. 2021). At the population level, the supply of primary care physicians has also been documented as affecting health outcomes (Basu et al. 2019, Pierard 2014).

Is the size of the current health care workforce sufficient to meet the goal of providing Medicare beneficiaries with access to high-quality health care? Even counting the number of health care workers is complicated. Sources differ; counts can be based on full-time-equivalent positions, professional licenses, or individual workers. (Figure 1-10 provides one estimate of the number of selected health care workers in 2022.) And due to variability in geographic and specialty distributions of health care workers, national totals can mask shortages in particular geographic areas or medical specialties.

Half a century ago, health care workers' roles were generally differentiated, but today, some of their responsibilities overlap. Physicians can diagnose,

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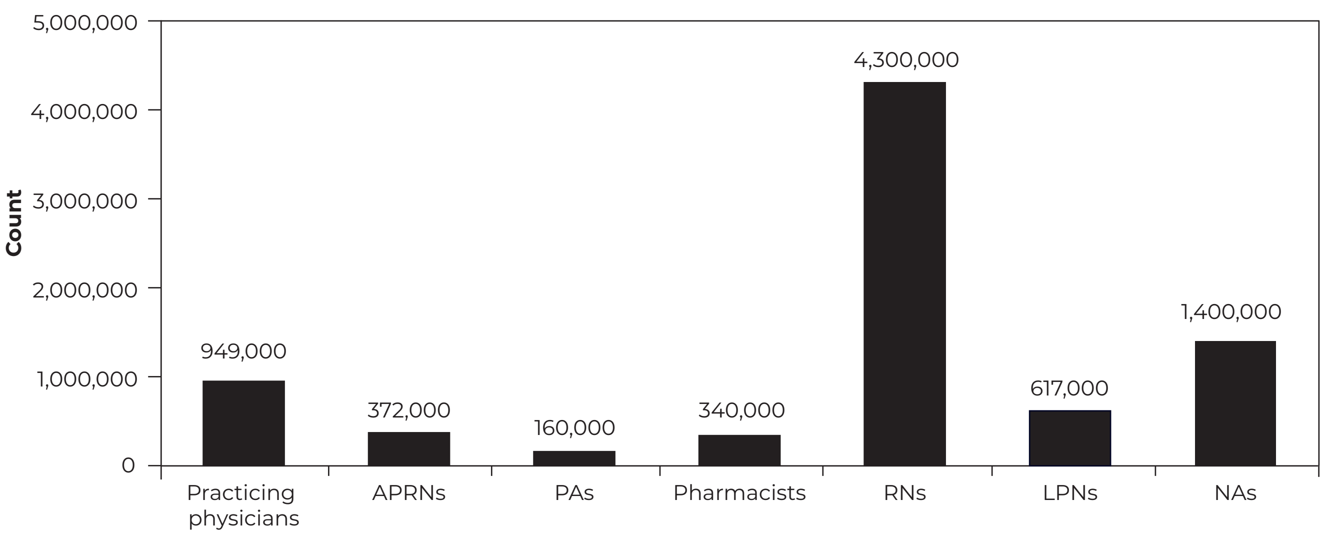
FIGURE 1–10

National counts of selected types of health care workers in 2022



Note: APRN (advanced practice registered nurse), PA (physician assistant), RN (registered nurse), LPN (licensed practical nurse), NA (nursing assistant or nursing aide). The physician count is the number of active physicians; most other bars (APRNs, PAs, pharmacists, RNs, LPNs) are the number of workers active in the workforce, which consists of people working and people actively seeking employment; the NA count is a count of persons employed in the field. The number of practicing physicians shown above (per the Association of American Medical Colleges) is different from the number that the Health Resources and Services Administration (HRSA) counts as professionally active (897,000); among HRSA's count of professional active physicians, 777,000 provide patient care.

Source: Association of American Medical Colleges, 2024. U.S. physician workforce data dashboard, https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard; HRSA's Workforce projections, https://data.hrsa.gov/topics/health-workforce/workforce-projections; Bureau of Labor Statistics' Nursing assistants and orderlies, https://www.bls.gov/ooh/Healthcare/Nursing-assistants.htm.

The health care workforce and Medicare's role in shaping it (cont.)

order testing, and treat patients, which can include performing invasive procedures. Physician assistants (PAs) and advanced practice registered nurses (APRNs, which includes nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and nurse midwives) can also perform these functions, including a range of invasive procedures, but sometimes with physician supervision. Pharmacists' roles have begun to overlap with traditional physician and NP/PA roles: Pharmacists can administer some vaccines without physician supervision, and in some states they can prescribe medications for certain conditions (Adams et al. 2023). Pharmacists bill Medicare for administering vaccines; their other services are included in payments for medications they dispense or are paid as "incident-to" services (although some Medicaid programs will pay pharmacists for patient care services in the ambulatory setting).

The responsibilities of different types of nursing professionals also overlap now. Registered nurses (RNs) organize care for patients and provide direct patient care; they also can order tests with physician, NP, or PA authorization, although they typically do not bill directly for their services. RNs have completed either a bachelor of science degree in nursing or a registered nurse associate-degree program or other credential; RNs must also pass a national examination to become licensed. RNs can supervise licensed practical nurses (LPNs—also known as licensed vocational nurses in a few states), home health aides, and nursing assistants (NAs—also known as nursing aides); alternatively, RNs in some settings such as home health care can be responsible for care at all levels. LPNs can perform some of the same duties as RNs, such as recording vital signs, collecting samples, providing wound care, and, in some states, administering medications. LPNs complete a certificate program and are licensed after passing a national examination. NAs provide care that requires less medical knowledge, such as measuring a patient's pulse or temperature, repositioning a patient in bed, or feeding and bathing patients; NAs typically are required to complete a formal training program, and many states use examinations to determine their competency; Medicare requires 75 hours of training for certified NAs (RegisteredNursing 2024).

To understand whether the health care workforce is adequately sized and allocated across settings, we need to understand where different types of health care personnel work (Bureau of Labor Statistics 2023b). Nurses work in all health care settings. RNs seem to work in the widest range of settings, from schools and public health agencies to hospitals, nursing facilities, physician offices, and other outpatient settings; they also work for home health agencies, hospices, and home infusion suppliers. Data from the Bureau of Labor Statistics on nurses' most common employment settings show that hospitals employ about 56 percent of RNs, but physician offices, home health agencies, and outpatient centers account for another 17 percent, and nursing homes another 4 percent (Bureau of Labor Statistics 2022). Among LPNs, 27 percent work in nursing homes, 13 percent work in hospitals, and 12 percent work in home health care (Bureau of Labor Statistics 2023a). Among NAs, 34 percent work in nursing homes and another 21 percent work in hospitals (Bureau of Labor Statistics 2023b). Physicians, APRNs, and PAs work in all types of health care settings. Among pharmacists, 65 percent work in retail locations and 32 percent work in hospitals (Bureau of Labor Statistics 2023c).

Overlapping scopes of practice complicate efforts to assess whether there is an insufficient number of health care workers to meet the demand for services. For example, some sources report a shortage of physicians in the U.S. (Health Resources & Services Administration 2023). The Health Resources and Services Administration (HRSA) has projected a shortage of 107,850 physicians in 2026 and an expected shortage of 134,000 physicians by 2031, but the number of APRNs and PAs has been growing rapidly, thus supplementing the physician

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workforce (Bruza-Augatis et al. 2024). The most critical shortages of physicians are in primary care (family practice, internal medicine, pediatrics, and geriatrics) and psychiatry (Association of American Medical Colleges 2024, Medicare Payment Advisory Commission 2023b). The shortage of psychiatrists is exacerbated by fewer psychiatrists accepting health insurance than other physicians (Carlo et al. 2024). While HRSA data show that nonmetropolitan areas have shortages of physicians (Health Resources & Services Administration 2024b), APRNs and PAs have filled this gap to some extent by locating in rural and underserved areas (National Center for Health Workforce Analysis 2024b, Zhang et al. 2020). HRSA data suggest essentially no nationwide shortages in the total number of RNs and LPNs, but some states have apparent excesses, and nine states have shortages of 20 percent or more, so the aggregate numbers provide an incomplete picture (National Center for Health Workforce Analysis 2024a). Foreign-trained nurses add an estimated 500,000 to the supply (Pillai et al. 2024). HRSA does not track the demand or supply of NAs, but employment data from the Department of Labor show over 200,000 job openings for NAs, suggesting a mismatch between the demand and supply of this type of worker (Bureau of Labor Statistics 2024). A complete description of worker shortages requires local data and an understanding of the potential substitution among the professions. Further, it remains to be seen what impact interprofessional teams, telehealth, and even artificial intelligence could have on workforce shortages.

The number of health care workers is affected by the resources available to train them. Over the past four decades, the number of first-year students in allopathic medical schools has grown relatively slowly (increasing from 17,000 in 1980 to 23,000 in 2022). The number of first-year students in osteopathic medical schools has grown quickly but is still a smaller share of physicians (rising from 1,500 first-year students in 1980 to 10,000 in 2022) (Medicare Payment Advisory Commission 2024b). Currently, including all years of medical school students, about 94,000 students are enrolled in allopathic medical schools and 35,000 are in osteopathic schools (American Association of Colleges of Osteopathic Medicine 2024, Association of American Medical Colleges 2022a). Federal support for physician training typically begins after graduation from medical or osteopathic school through residency programs at hospitals, health centers, and other health care provider organizations. Physicians can be licensed after completing medical school plus one additional year of clinical training (referred to as their "internship" or "first-year residency") and passing a national licensure examination, but most go on to pursue multiple years of residency training, and some obtain additional training through fellowships after residency. Physicians educated in American and Canadian medical schools filled 77 percent of residency positions in 2023; the remainder were filled by graduates of international medical schools (Association of American Medical Colleges 2023). The residency programs that have the most difficulty filling all their available positions tend to be lower-paid specialties—like family medicine, internal medicine, and pediatrics—as well as emergency medicine; these specialties end up filling many of their residency positions with international medical school graduates (Murphy 2024, National Resident Matching Program 2024).

Medicare contributes to the cost of physician training at the residency and fellowship levels through two funding mechanisms. Hospitals and certain other provider organizations that train physicians receive direct graduate medical education (DGME) payments, which are generally based on the product of three factors: their historic per resident amount (updated for inflation), their historic number of residents, and their current Medicare (fee-for-service (FFS) and Medicare Advantage (MA)) share of patient days. In addition, certain types of teaching hospitals receive a percentage increase in their prospective

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The health care workforce and Medicare's role in shaping it (cont.)

payment system rates for care provided to FFS and MA beneficiaries, referred to as indirect medical education (IME) payments, which are based on allowed residents per bed or per occupied bed. Medicare paid $19 billion for DGME and IME in 2022.[29] Medicare generally does not try to influence which specialties should be trained with these funds or in which parts of the country these physicians should be trained. Additional support for training physicians comes from Medicaid, the Department of Veterans Affairs, the Department of Defense, HRSA, and teaching hospitals themselves.

Medicare does not currently support APRN or PA training.[30] APRNs and PAs both typically require a master's degree. APRNs are required to obtain a minimum of 500 hours of clinical training, with many programs requiring at least 750 hours, and states have variable additional requirements. APRNs with doctoral degrees obtain 1,000 hours of clinical training. PAs generally have 1,500 hours or more of clinical training. Medicare's payment rates for services provided by APRNs and PAs are 85 percent to 100 percent of physicians' payment rates, but provider organizations generally pay these types of clinicians much less than physicians, which creates strong incentives for organizations to hire (and, if needed, train) APRNs and PAs (Medicare Payment Advisory Commission 2023b). This financial incentive may help explain the strong growth observed in the number of APRNs and PAs in recent years. For example, from 2017 to 2022, the number of APRNs and PAs who billed Medicare for more than 15 FFS Medicare beneficiaries climbed more than 40 percent, increasing from 218,000 to 308,000 (Medicare Payment Advisory Commission 2024c). As a result of this rapid increase, HRSA has estimated that the supply of APRNs and PAs now exceeds the demand for this type of clinician (Health Resources & Services Administration 2024b).

Medicare does not provide financial support for pharmacist training, which typically involves a bachelor's or prepharmacy degree and a four-year doctorate in pharmacy; pharmacists must also pass a national licensure examination and then meet additional requirements for state licensure (Virginia Health Workforce Development Authority 2024). HRSA projects that the supply of pharmacists almost fully met the demand for this type of health care professional in 2024 and will continue to do so in the future (Health Resources & Services Administration 2024b).

Beyond training an adequate supply of health professionals is the challenge of maintaining them in the workforce and in shortage locations. Physicians and RNs in the workforce are aging. The average age of practicing physicians was 54 in 2023 (DefinitiveHealthcare 2023); almost half of active physicians were 55 or older in 2021 (Association of American Medical Colleges 2022b), and 20 percent were 65 or older. A third of nurses are age 55 or older, so retirement will be a predictable drain on the workforce (Health Resources & Services Administration 2024a).

Several sources express concerns that health professionals are leaving the health care workforce midcareer. In 2022, the surgeon general created an advisory and video to inform the public of his concern about burnout in health care workers (Department of Health and Human Services 2022). A recent study using U.S. census data on health care workers reported that the exit rate in 2018 was 6 percent per quarter, but this increased to 7.7 percent per quarter by the end of 2021, with variation among states and specific demographic groups (Frogner and Dill 2022, Shen et al. 2024).

Commentators report that physician and nurse shortages predated the coronavirus pandemic but have continued to increase. Stresses during the pandemic included shortages of staff and supplies (especially personal protective equipment), lack of knowledge and experience in treating a condition with high mortality, and concern about the spread of COVID-19 to health care workers and their families

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The health care workforce and Medicare's role in shaping it (cont.)

(Biber et al. 2022, Park et al. 2023, Prasad et al. 2021). A variety of stresses that existed before the pandemic and have continued in the postpandemic period may be contributing to workers leaving their health care positions. Changes in the structure of the health care system that started well before the pandemic have led to increased pressure for documentation and other tasks besides providing direct care to patients. Physicians increasingly have contractual obligations tied to their employment that create pressures beyond simply providing good patient care (Mayes et al. 2024). For their part, nurses often express concerns about patient-to-nurse staffing ratios that they believe are unsafe (New York State Nurses Association 2024). In recent years, nurses and medical residents are increasingly unionizing, with the expectation that unions can more effectively represent their interests to the organizations employing them. Shortages of NAs may be linked to the availability of jobs in other industries that pay similar, or better, wages (Snyder et al. 2023), but these workers might return to health care jobs for higher salaries. In 2024, CMS finalized a rule that revised the nurse staffing requirements for nursing homes, with implementation beginning in May 2026 (Centers for Medicare & Medicaid Services 2024f). Many providers will need to hire additional nursing staff to meet the new requirements and improve retention of the staff they currently employ.

In addition to Medicare's substantial investment in training physicians, the program has taken some limited steps to try to incentivize physicians to practice in shortage areas. Medicare pays a 10 percent bonus on physician fee schedule payments to physicians serving in HRSA-designated health professional shortage areas, and some of Medicare's advanced payment models provide financial incentives to practitioners in rural and underserved areas. Hospitals also receive additional payments when located in underserved areas, but it is unclear whether these increased payments to hospitals lead to better nurse staffing, higher salaries, or greater retention.

The Commission reviewed Medicare payments for DGME and IME in 2010 and 2021. In 2010, the Commission recommended that the Secretary analyze the number of residents needed by specialty and whether all specialties should be supported equally; establish standards for distributing funding for medical education, including goals for practice-based learning and integration of community-based care; and use a reduction in IME payments to empirically justified levels to fund a new performance-based GME program tied to institutions' performance on these standards. In 2021, the Commission recommended that IME payments be restructured to be made for both inpatient and outpatient services and to be transitioned to empirically justified levels.

But Medicare has relatively few tools with which to influence the health care workforce. Since our past analyses have found no clear relationship between changes to Medicare payment rates and the number of people who apply to medical school (Medicare Payment Advisory Commission 2024b), increasing payment rates for all clinicians is not likely to increase the supply of in-demand types of health care professionals. One approach might be to increase Medicare funding for medical education or implement more targeted Medicare policies aimed at clinicians in particular medical specialties or working in particular geographic areas, but such efforts to shape the composition of the workforce or alleviate personnel shortages could take years to reach fruition, given education and training requirements and the fact that Medicare is just one payer among many. ■

Endnotes

1 The number of people with different types of health insurance in the U.S. in 2023 was as follows: 175.6 million people had private insurance obtained through an employer; 16.2 million people had an individual health insurance plan purchased through a Marketplace; 4.0 million had some other type of individual insurance plan; 99.0 million had coverage through Medicaid or the Children's Health Insurance Program (CHIP); 65.1 million people had coverage through Medicare (including some who were also enrolled in Medicaid and 12.4 million who supplemented their Medicare coverage with a Medigap plan); 14.6 million people had some other type of public insurance (e.g., through the Department of Veterans Affairs or the Department of Defense); and 24.9 million people had no health insurance (Centers for Medicare & Medicaid Services 2024h).

2 The American Rescue Plan Act of 2021 increased federal subsidies of Marketplace plans in 2021 and 2022. The Budget Reconciliation Act of 2022 (P.L. 117-169) then extended these enhanced subsidies through 2025. These laws also created and extended a new monthly special enrollment period (SEP) for people eligible for advance payment of the premium tax credit who have a projected household income of 150 percent of the federal poverty level or less. The so-called "150% SEP" is available to consumers in states that operate under the Health Insurance Marketplace and use HealthCare.gov or an approved direct enrollment or enhanced direct enrollment platform; state-based Marketplaces that operate their own eligibility and enrollment platforms also have the option to offer this special enrollment period. Consumers who qualify for the 150% SEP can sign up for coverage in any calendar month through 2025, rather than being eligible to sign up for coverage only during the annual open enrollment period (November 1 through December 15) or following a qualifying life event (e.g., having a baby).

3 "Super" concentrated markets have a Herfindahl–Hirschman Index above 5,000.

4 Among beneficiaries eligible to receive their coverage through an MA plan (because they were enrolled in both Medicare Part A and Part B), 52 percent were in an MA plan in 2023. For more information on MA, see Chapter 11.

5 We do not see dramatic shifts in the use of other, less frequently used codes in the office/outpatient evaluation and management code set for new and established patients.

6 The Budget Reconciliation Act of 2022 (P.L. 117-169) is often referred to as the Inflation Reduction Act of 2022 (or IRA).

7 Victoza/Saxenda; Ozempic/Wegovy; Mounjaro/Zepbound.

8 Patients may discontinue use for various reasons, including, for example, undesirable side effects, cost, or supply shortages (BlueCross BlueShield 2024, Cohen 2024, Do et al. 2024).

9 Statutory text excludes Medicare coverage of drugs that may be excluded under the Medicaid drug-rebate program, which includes, among others, drugs for anorexia, weight loss, or weight gain.

10 In 2022, 26 percent of FFS Medicare beneficiaries had a claim for diabetes, 22 percent had one for ischemic heart disease, 20 percent had one for obesity, 19 percent had one for chronic kidney disease, and 6 percent had one for stroke (Centers for Medicare & Medicaid Services 2024d, Chronic Condition Warehouse 2024).

11 This analysis does not distinguish between Type 1 and Type 2 diabetes, but the Centers for Disease Control and Prevention estimates that 90 percent to 95 percent of people with diabetes have Type 2, and Type 2 diabetes is much more likely to develop in older individuals (Centers for Disease Control and Prevention 2024a, Centers for Disease Control and Prevention 2024c, Chronic Condition Warehouse 2024).

12 Workers and their employers split the cost of the Medicare payroll tax (workers pay 1.45 percent and employers pay the remaining 1.45 percent). Meanwhile, self-employed people pay both the worker's and the employer's share of this tax, totaling 2.9 percent of their net earnings. High-income workers pay an additional 0.9 percent of their earnings above $200,000 for single workers or $250,000 for married couples (Boards of Trustees 2024).

13 The HI Trust Fund's income derives from several sources, including payroll taxes (which made up 88 percent of the trust fund's income in 2023), taxation of higher-income individuals' Social Security benefits (8 percent), interest earned on trust fund investments (1 percent), and premiums collected from voluntary participants (1 percent) (Boards of Trustees 2024).

14 The Trustees have made three pandemic-related adjustments to their Medicare spending projections. These adjustments account for (1) the improved morbidity in the surviving population; (2) the ending of a waiver regarding the three-day inpatient stay requirement to receive skilled nursing facility (SNF) services, which they expect to decrease SNF spending and increase inpatient spending; (3) home health spending that is significantly lower than was estimated before the pandemic (Boards of Trustees 2024).

15 General revenues primarily consist of individual and corporate taxes but also include customs duties, leases of government-owned land and buildings, the sale of natural resources, usage and licensing fees, and payments to agencies (Department of Treasury 2022).

16 Medicare's Trustees assume that starting in 2026, clinicians who are not in advanced alternative payment models (A–APMs) will receive lower annual updates to their Medicare physician fee schedule payment rates (0.25 percent per year) than clinicians who are in A–APMs (0.75 percent per year) and that these updates will not be replaced with updates that are more reflective of medical inflation (which is projected to average 2 percent per year in the long term). Medicare's Trustees also assume that bonuses that clinicians currently receive for participating in A–APMs will end after 2025 and that positive adjustments to payment rates that clinicians receive if they demonstrate "exceptional" performance under the Merit-based Incentive Payment System will end after 2024—and not be extended through legislative intervention. The Trustees also assume that annual updates to payment rates under certain Medicare payment systems will continue to be discounted by an adjustment reflective of economy-wide productivity, rather than an adjustment reflective of the lower productivity gains achieved in the health care industry (Boards of Trustees 2024).

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

18 Although most people ages 65 and over supplement their Social Security benefits with income from pensions, withdrawals from individual retirement accounts, or other assets, a sizable minority rely on Social Security benefits as their primary source of income. For one in five people ages 65 and over, Social Security benefits make up three-quarters or more of their family income, and for one in seven, Social Security benefits make up 90 percent or more of their family income (Dushi and Trenkamp 2021).

19 The share of community-dwelling Medicare beneficiaries who report having FFS coverage with public or private supplemental coverage has declined from nearly three-quarters of beneficiaries in 2000 to nearly half of beneficiaries in 2021, according to our analysis of CMS's Medicare Current Beneficiary Survey data (Medicare Payment Advisory Commission 2024a, Medicare Payment Advisory Commission 2003).

20 Beneficiaries dually enrolled in Medicare and Medicaid are automatically enrolled in Part D and receive the low-income subsidy (LIS), but other LIS-eligible individuals must apply for the LIS through the Social Security Administration.

21 MA plans can reduce the amount deducted from enrollees' checks by "buying down" some or all of the standard Part B premium amount, but most enrollees are in plans that do not offer this benefit.

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

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

24 MA enrollees in preferred provider organization plans or HMO point-of-service plans generally have some out-of-network coverage with up to 50 percent coinsurance, but out-of-network care is generally not covered in HMO plans except for emergency and urgently needed services. In cases where medically necessary care is not obtainable in network, all MA plans must allow enrollees to go out of network and pay in-network cost sharing. See Chapter 11 of this report for more information on MA plan types.

25 However, we note that in the Medicare Advantage initial trial period, Medicare beneficiaries who were initially enrolled in a Medigap plan and switch to MA may return to FFS Medicare and their Medigap plan before the end of their first year of MA coverage without being subject to medical underwriting.

26 Beneficiaries with less than $15,300 in annual income and $9,430 in liquid assets (or $20,688 in income and $14,130 in assets if married) can sign up to have Medicaid pay their Medicare Part A (if needed) and Part B premiums and cost sharing. Slightly higher-income beneficiaries with income or assets above these limits but with an income below $20,580 (or $27,840 if married) can sign up to have Medicaid pay their Medicare Part B premiums (Centers for Medicare & Medicaid Services 2024g).

27 The enrollment statistics in this paragraph are based on our analysis of the 2022 Medicare Current Beneficiary Survey's survey file for noninstitutionalized beneficiaries enrolled in both Part A and Part B. The statistics in this paragraph are calculated using a different, simpler approach compared with the statistics shown earlier in Figure 1-9 (p. 22).

28 Each hospital's Medicare Safety-Net Index value would be computed using three components: (1) the share of its Medicare volume associated with beneficiaries enrolled in the LIS and/or Medicaid; (2) the share of all-payer revenue the hospital spends on uncompensated care; and (3) half of the share of total volume associated with Medicare beneficiaries.

29 In 2022, Medicare made DGME payments of $5.6 billion and IME payments of $13.4 billion; these amounts include costs for training dentists and podiatrists. Both DGME and IME payments are made on behalf of both FFS and MA beneficiaries and paid directly to organizations such as teaching hospitals (rather than included in payments made to MA plans). DGME payments are funded through both the Hospital Insurance (HI) and Supplementary Medical Insurance Trust Funds, while IME payments are funded only through the HI Trust Fund.

30 Section 5508 of the Affordable Care Act of 2010 authorized a five-year demonstration of support for graduate nursing education. The demonstration occurred at five sites for five years between 2012 and 2017. A report to the Congress was sent in 2017. A final evaluation released in 2019 is on the CMS website, and legislation has been proposed to continue this program.

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