Context for Medicare payment policy

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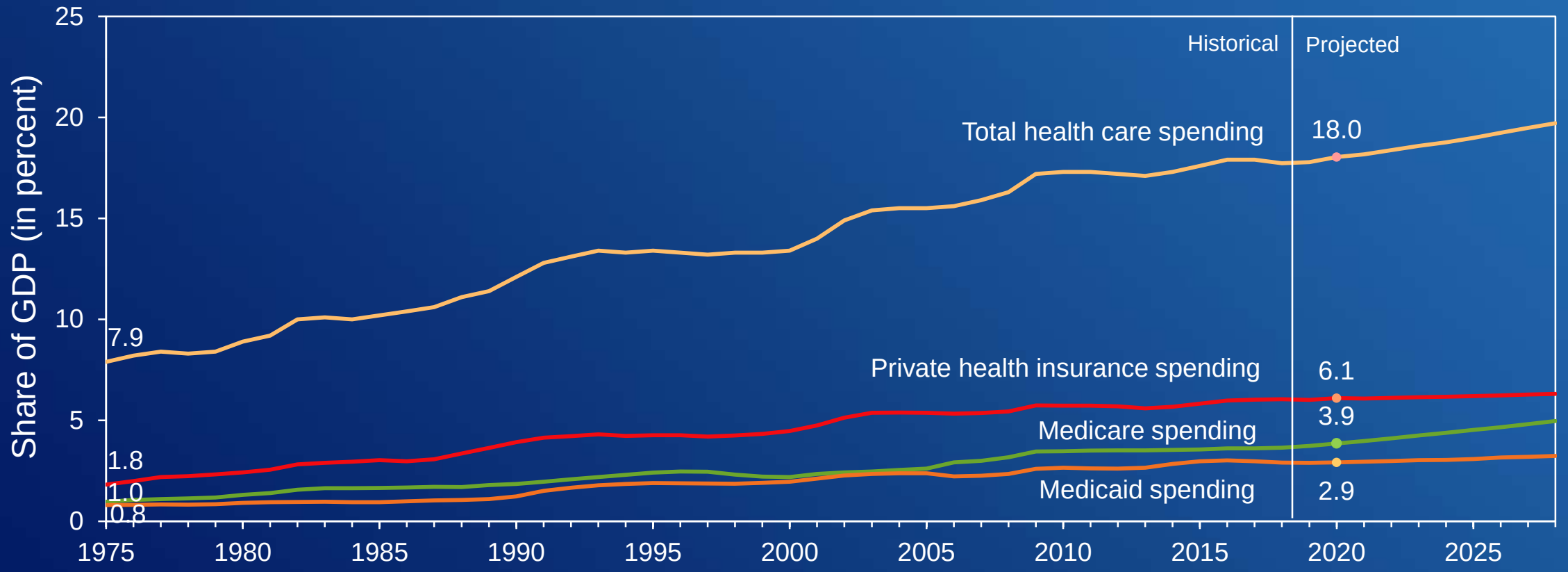
Overview

- Overall health care spending trends
- Medicare spending trends
- Spending trajectories for Medicare's three main funding sources
- Drivers of Medicare's spending growth

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



Note: GDP (gross domestic product). First projected year is 2019. Percentages labeled on graph are for 2020. Beginning in 2014, private health insurance spending includes federal subsidies for both premiums and cost sharing for the health insurance marketplaces created by the Affordable Care Act of 2020. Health care spending also includes the following expenditures (not shown): out-of-pocket spending; spending by other health insurance programs (the Children's Health Insurance Program (CHIP), the Department of Veterans Affairs, and the Department of Defense); and other third-party payers and programs and public health activity (including Indian Health Service; Substance Abuse and Mental Health Services Administration; maternal and child health; school health; workers' compensation; worksite health care; vocational rehabilitation; and other federal, state, and local programs). The potential effects of the coronavirus pandemic are not reflected in these projections. Data are preliminary and subject to change.
Source: MedPAC analysis of CMS's National Health Expenditure Accounts, historical data released December 2019 and projections released March 2020.

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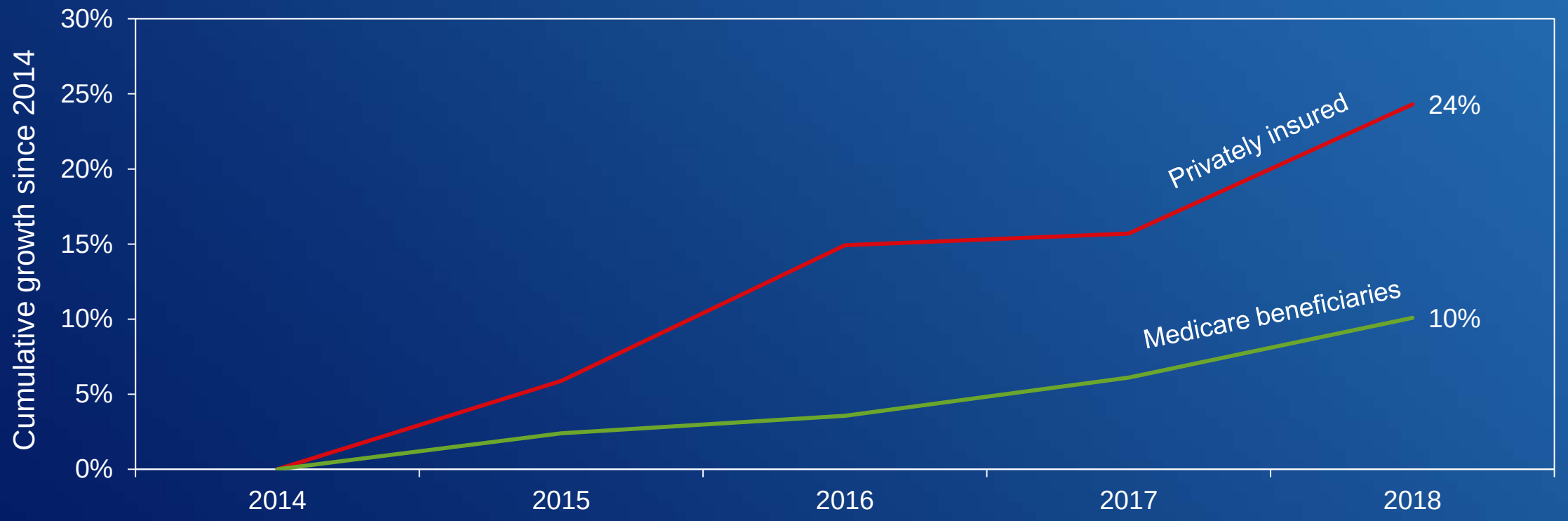
Growth in spending per enrollee has grown faster for the privately insured than for Medicare beneficiaries



Note: Shows cumulative growth since 2014. Reflects payments to providers from health insurers and patients (i.e., cost-sharing), but not payments from other sources (e.g., worker's compensation or auto insurance). Spending on retail prescription drugs is not available for the privately insured, so it is excluded from both lines in this graph. Spending on out-of-network services is not available for the privately insured and thus not included in this graph. Reflects spending for individuals with full-year insurance coverage (including individuals with $0 of health care spending). “Private insurance” reflects spending for individuals age 18 to 64 in fully insured and self-insured plans (i.e., employer self-funded plans) contributed by national and regional plans and third-party administrators nationwide; it includes claims from individual and group plans, as well as Marketplace plans and Medicare Advantage plans for non-elderly disabled individuals. Data are preliminary and subject to change.
Source: FAIR Health analysis of its National Private Insurance Claims database (which reflects 150 million covered lives) for the subset of enrollees aged 18 to 64; and MedPAC analysis of Medicare's Master Beneficiary Summary File.

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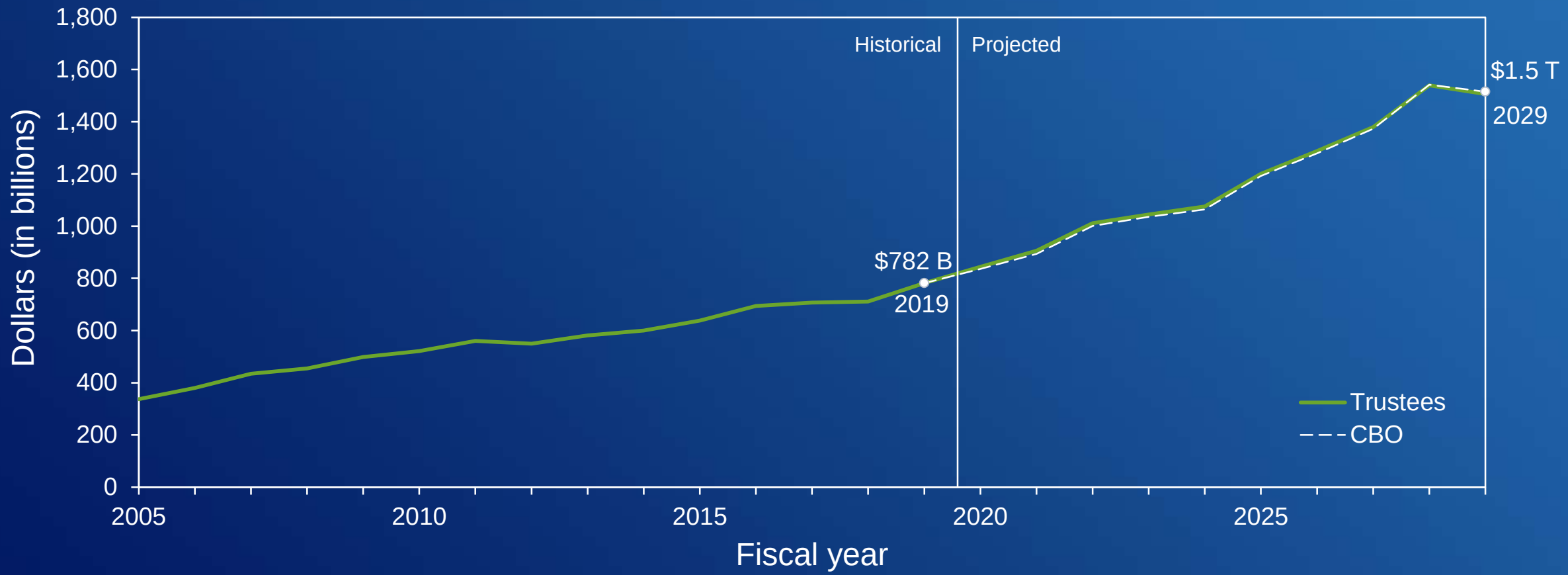
Medicare spending is expected to double in the next 10 years



Note: CBO (Congressional Budget Office). The potential effects of the coronavirus pandemic are not reflected in these projections. Data are preliminary and subject to change.
Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds and CBO's March 2020 Medicare baseline.

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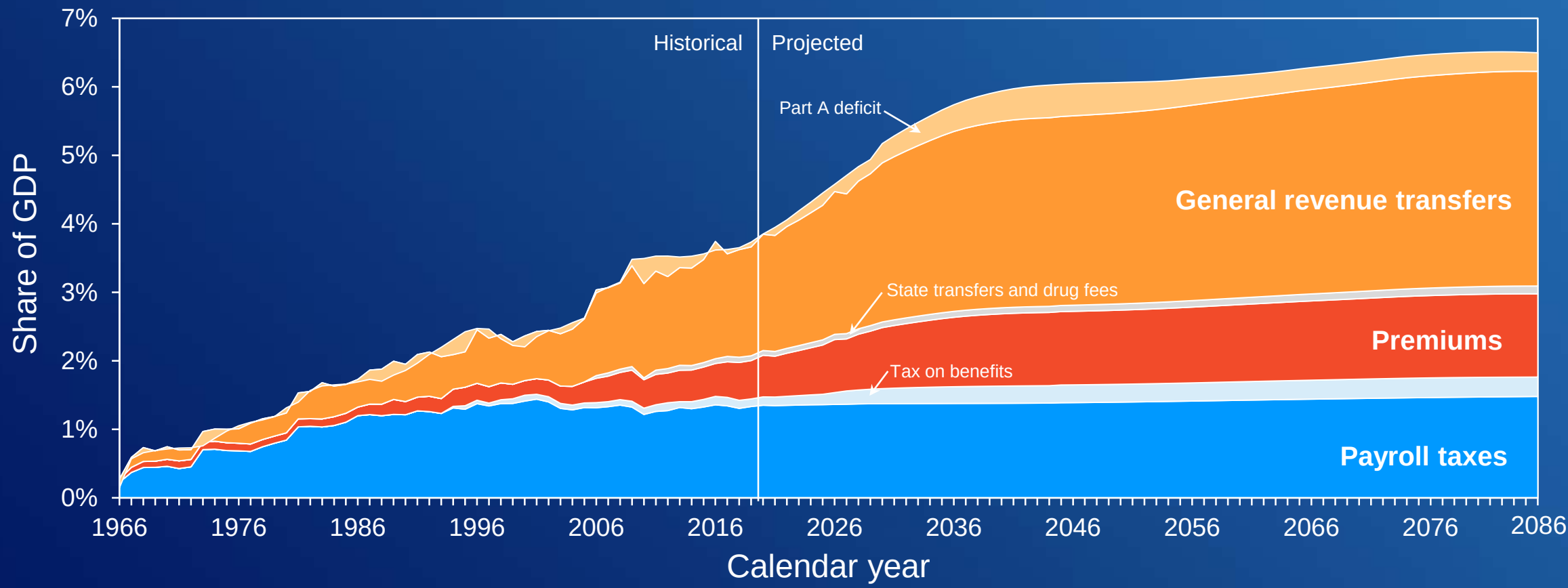
Medicare's funding sources



Note: GDP (gross domestic product). These projections are based on the Trustees' intermediate set of assumptions and do not reflect the potential effects of the coronavirus pandemic. "Tax on benefits" refers to the portion of income taxes that higher-income individuals pay on Social Security benefits, which is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments from the states to Medicare, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed by the Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance Trust Fund. Data are preliminary and subject to change.
Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds.

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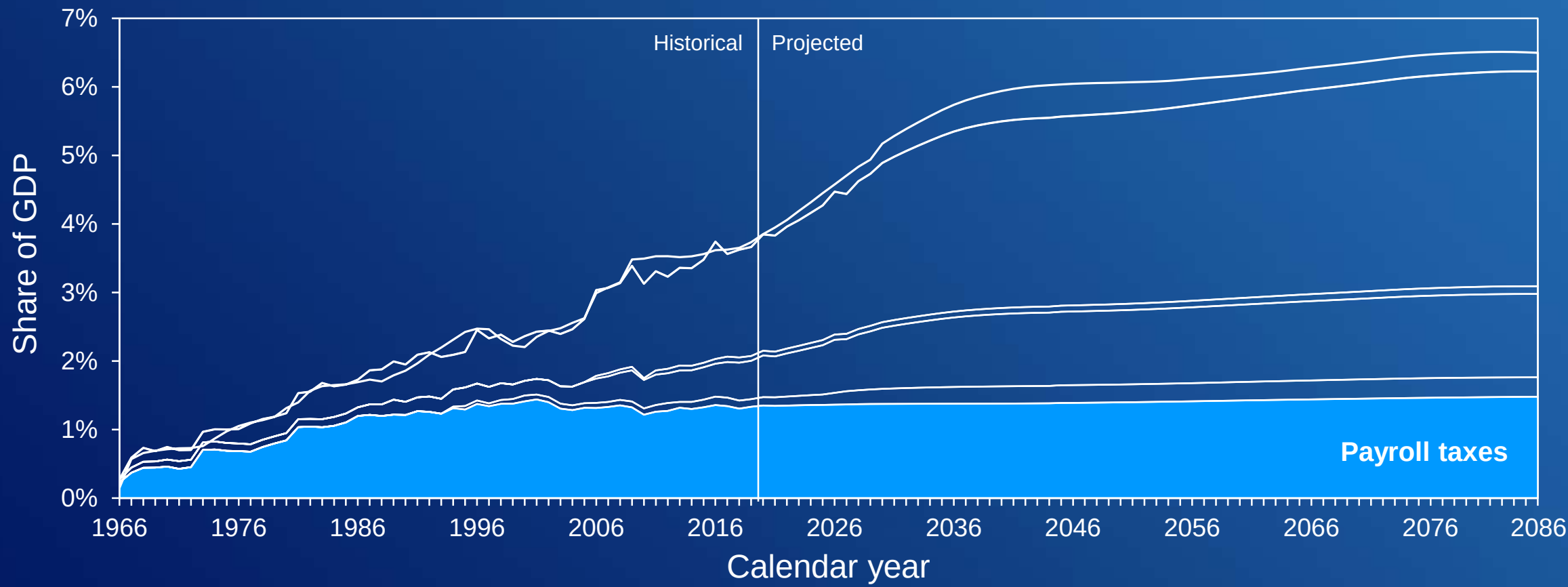
Primary funding source #1: Medicare payroll taxes



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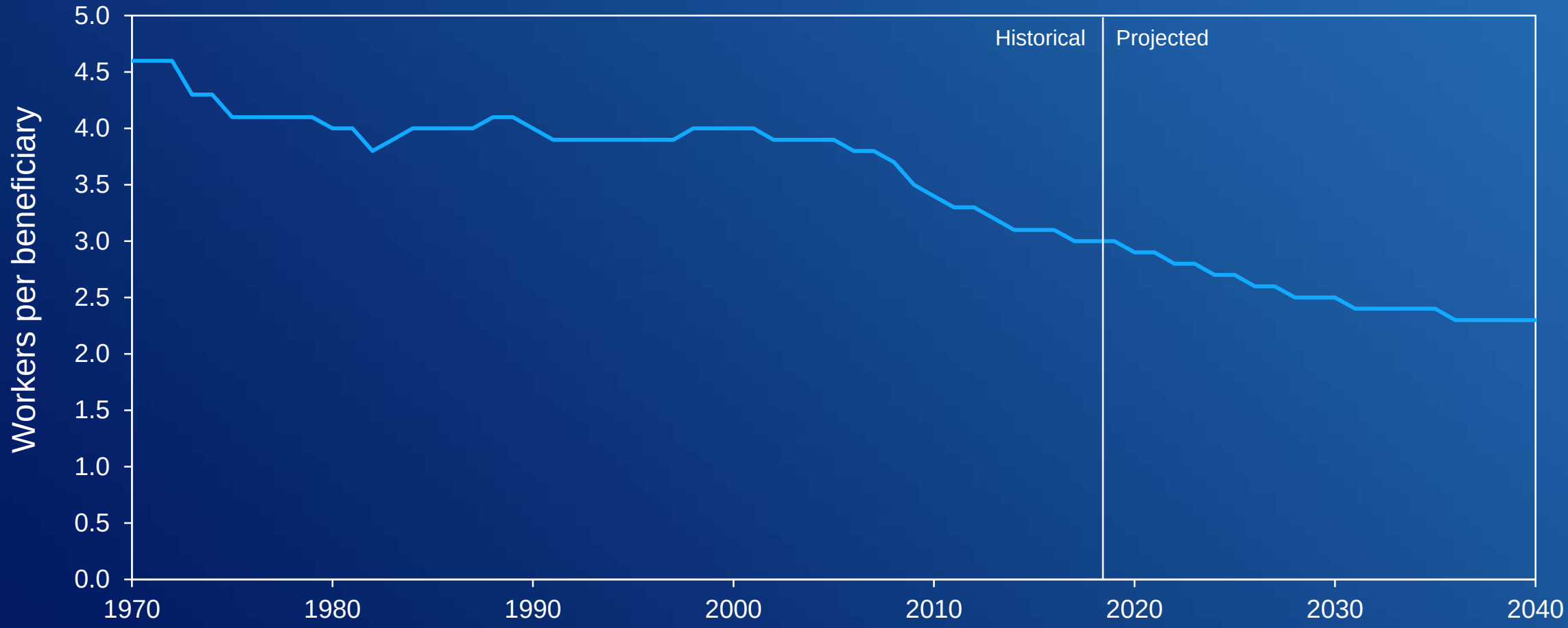
Number of workers per Medicare beneficiary is declining



Note: “Beneficiaries” are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). The potential effects of the COVID-19 pandemic are not included in these projections. Data are preliminary and subject to change.
Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds.

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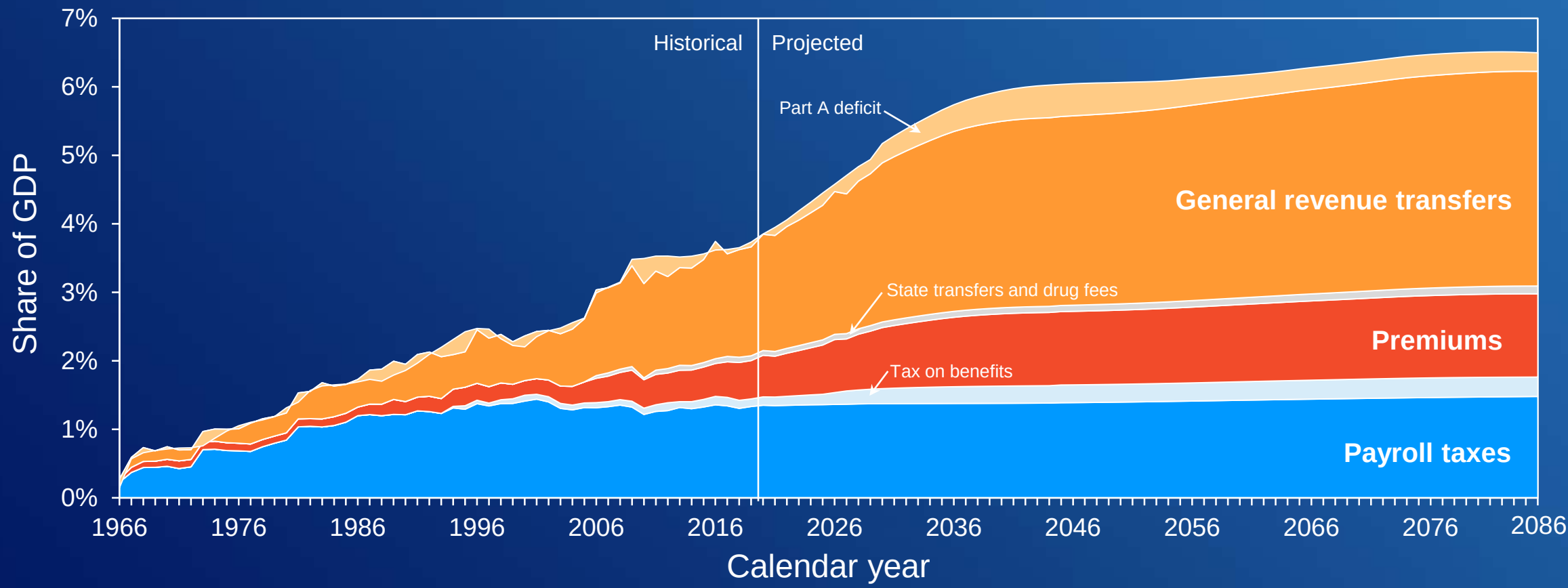
Medicare's Hospital Insurance Trust Fund will be insolvent in 2026

- The trust fund already spends more than it collects each year
  - Has remained solvent thanks to prior years' surpluses
- By 2026 the Hospital Insurance Trust Fund will be insolvent
- To keep the trust fund solvent for another 25 years:
  - Increase payroll tax: 2.9% → 3.7%
  - Decrease Part A spending: 17% ($1,000 per beneficiary per year)

Note: Data are preliminary and subject to change.

Medicare's funding sources



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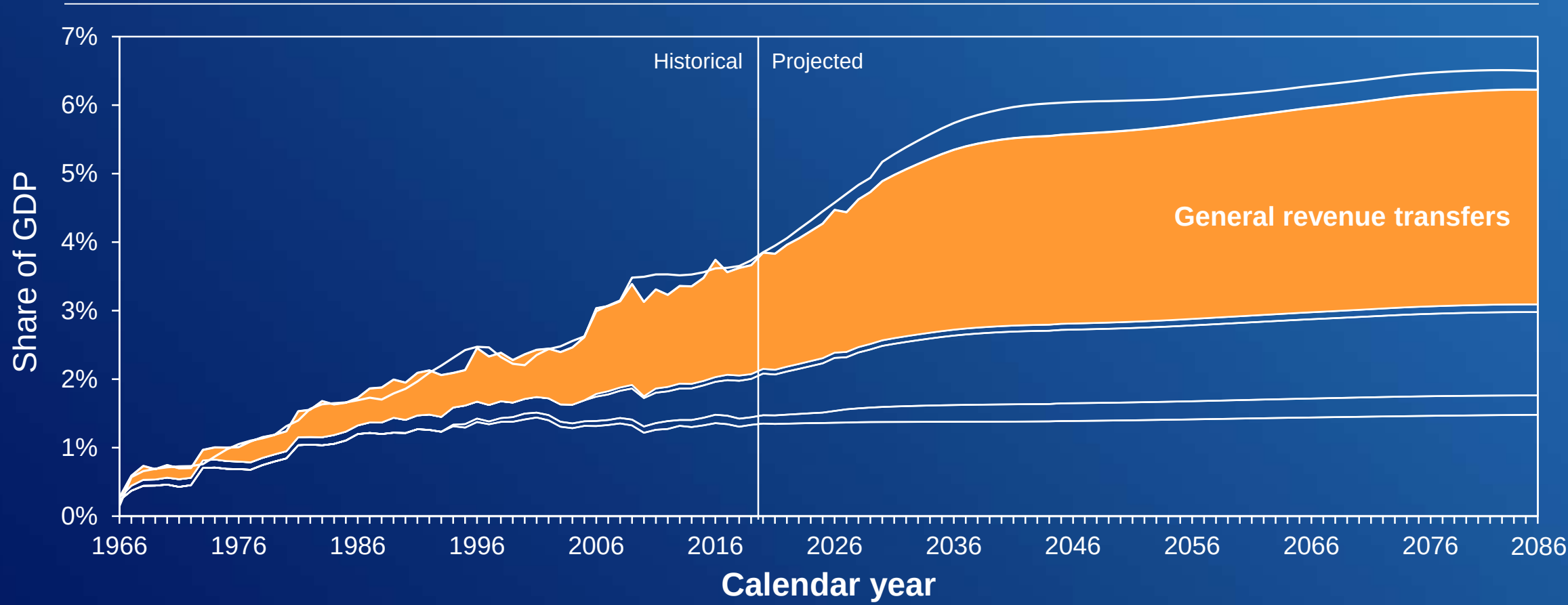
Primary funding source #2: General tax revenues



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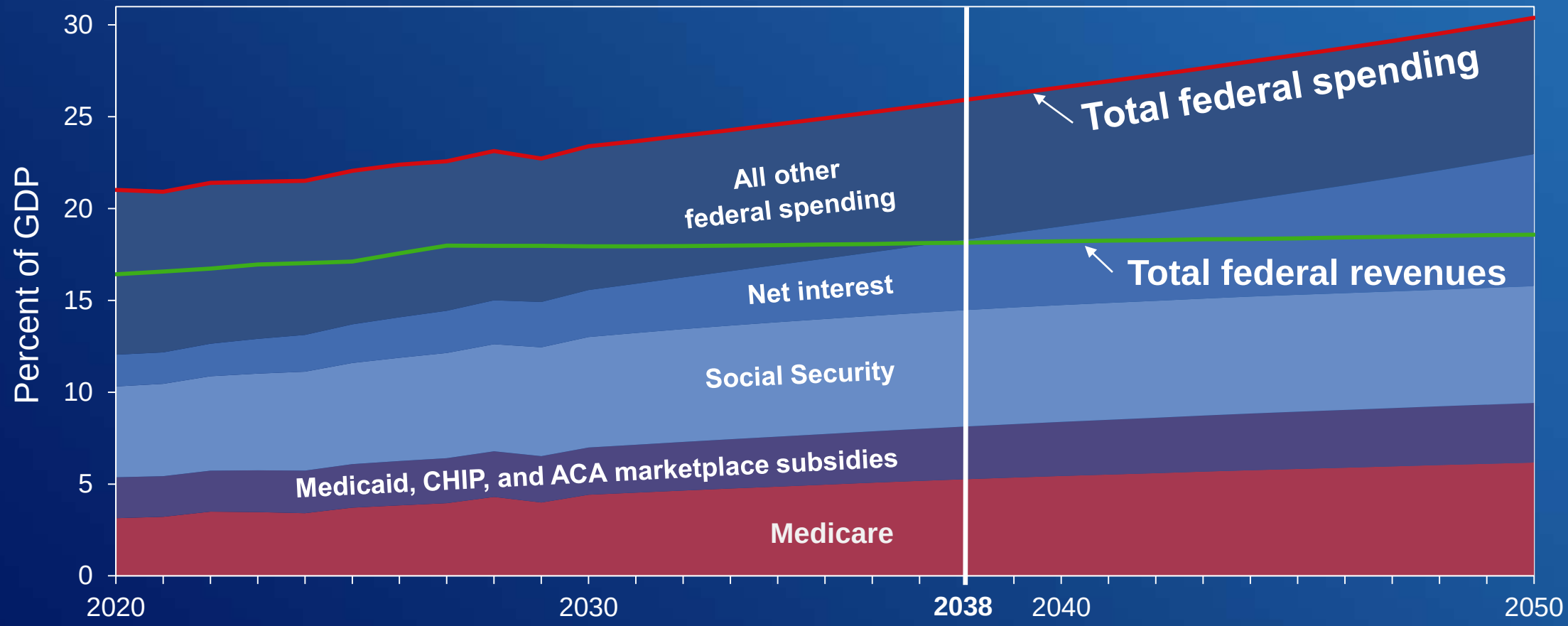
Medicare, other health programs, Social Security, and net interest to exceed federal revenues by 2038



Note: GDP (gross domestic product), CHIP (Children's Health Insurance Program), ACA (Affordable Care Act). The potential effects of the COVID-19 pandemic are not included in these projections. Data are preliminary and subject to change.
Source: Congressional Budget Office's Long-Term Budget Projections (published January 2020).

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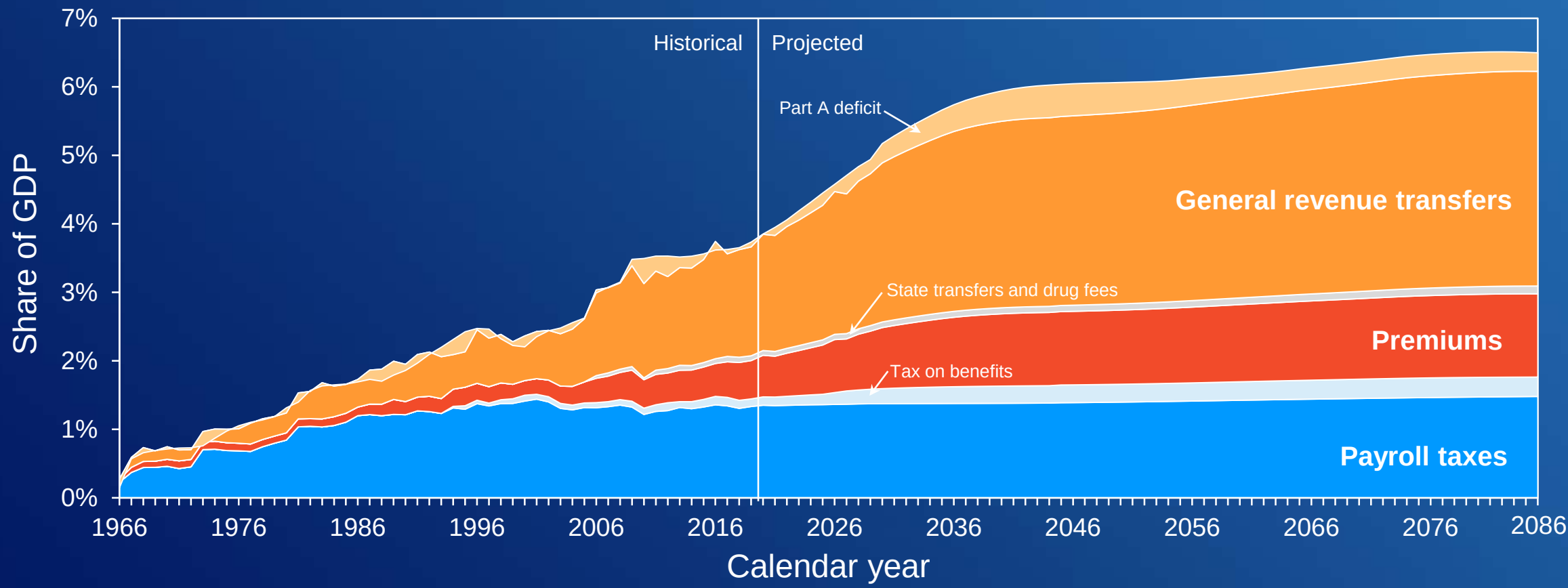
Medicare's funding sources



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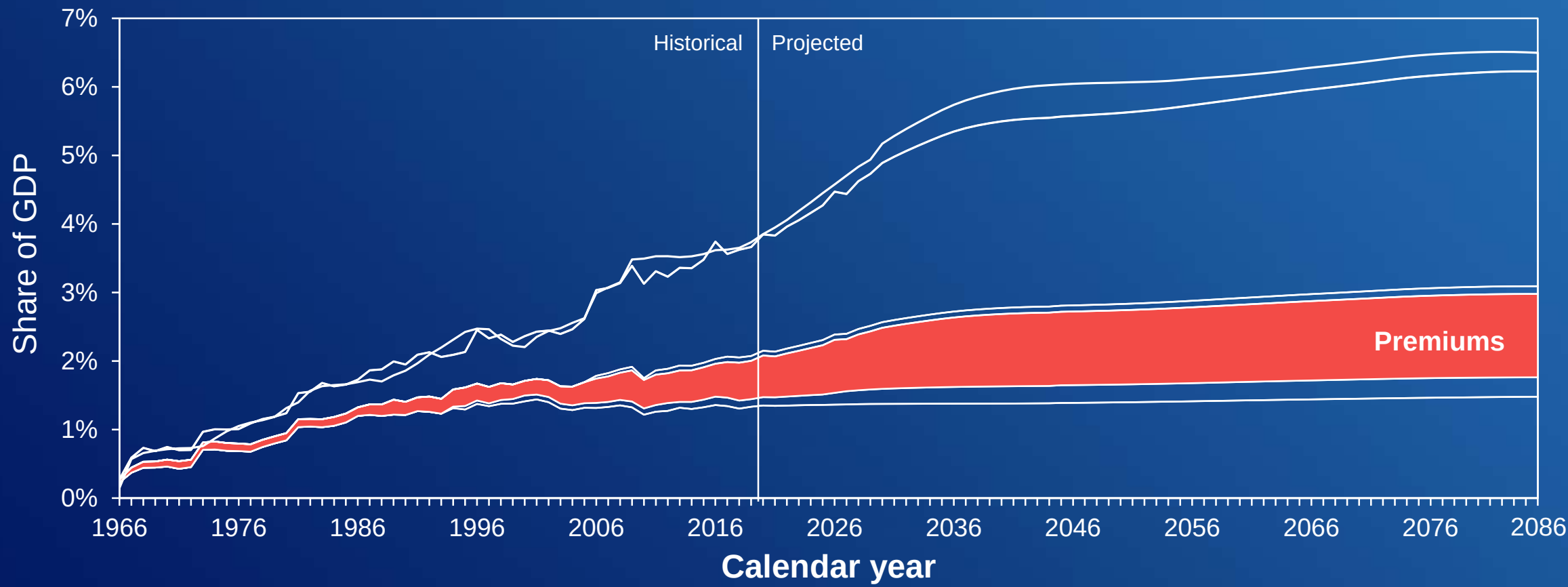
Primary funding source #3: Beneficiary premiums



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

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Beneficiary premiums and cost sharing consume a growing share of Social Security benefits

- Premiums (annually, in 2020):
  - Part A: $0
  - Part B: $1,735
  - Part D: $372
- Cost sharing (annually, in 2018):
  - Part A: $415
  - Part B: $1,513
  - Part D: $432
- Consume 24% of the average Social Security benefit (2020)

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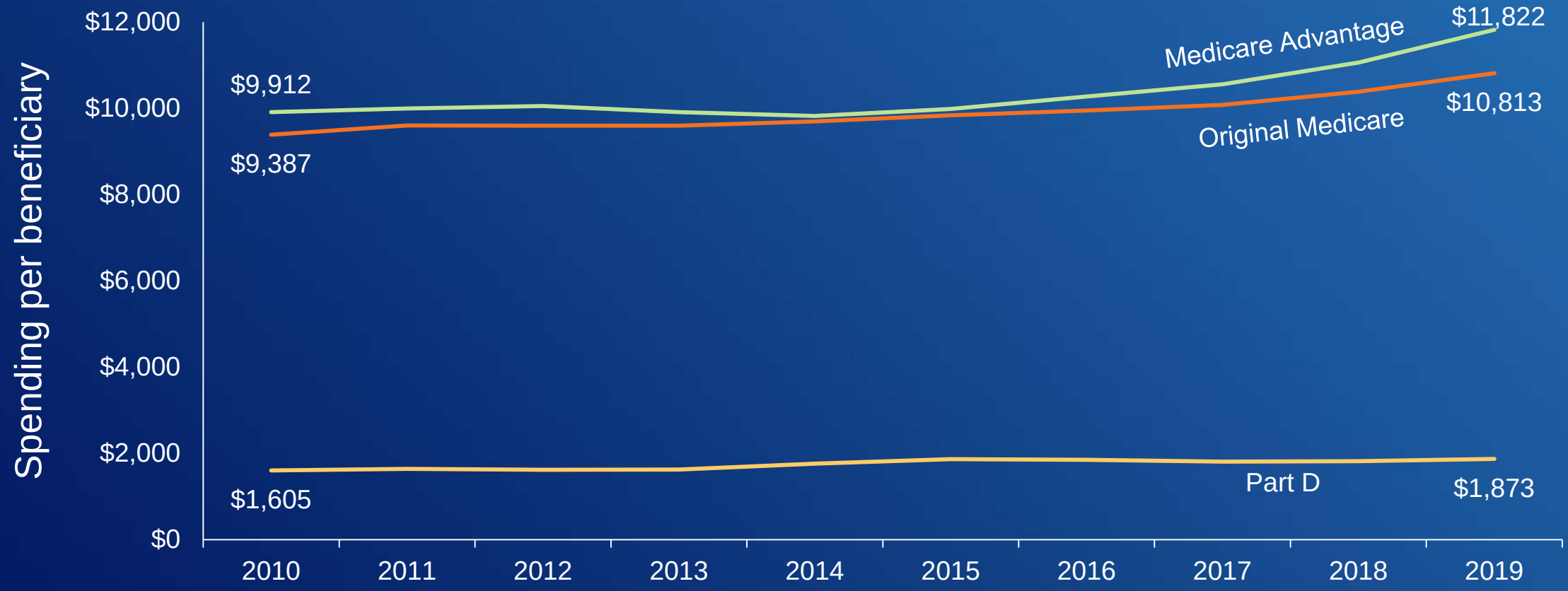
Note: Data are preliminary and subject to change.
Source: MedPAC's 2020 *Data Book;* 2020 annual report of the Boards of Trustees of the Medicare trust funds.

Spending per beneficiary on Medicare Advantage is growing faster than Original Medicare or Part D



Note: MA (Medicare Advantage). Spending is on an incurred basis. Part D spending excludes total premiums paid to Part D plans by enrollees. We calculate per beneficiary spending by dividing total spending for each category reported in the Trustees report by the appropriate enrollment number (i.e., for Part A, Part B, or Part D) reported in the Trustees report. Data are preliminary and subject to change.
Source: MedPAC analysis of data from the 2020 annual report of the Boards of Trustees of the Medicare trust funds.

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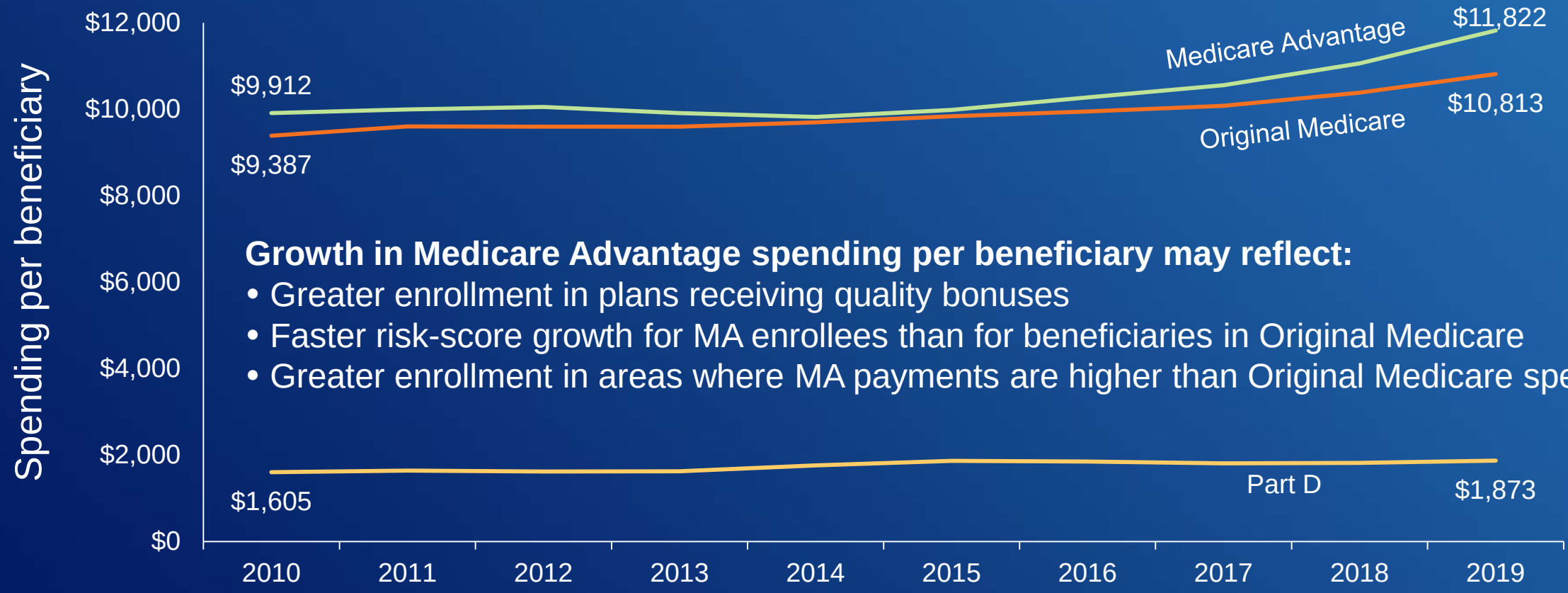

Growth in Medicare Advantage spending per beneficiary may reflect:

- Greater enrollment in plans receiving quality bonuses
- Faster risk-score growth for MA enrollees than for beneficiaries in Original Medicare
- Greater enrollment in areas where MA payments are higher than Original Medicare spending

Note: MA (Medicare Advantage). Spending is on an incurred basis. Part D spending excludes total premiums paid to Part D plans by enrollees. We calculate per beneficiary spending by dividing total spending for each category reported in the Trustees report by the appropriate enrollment number (i.e., for Part A, Part B, or Part D) reported in the Trustees report. Data are preliminary and subject to change.
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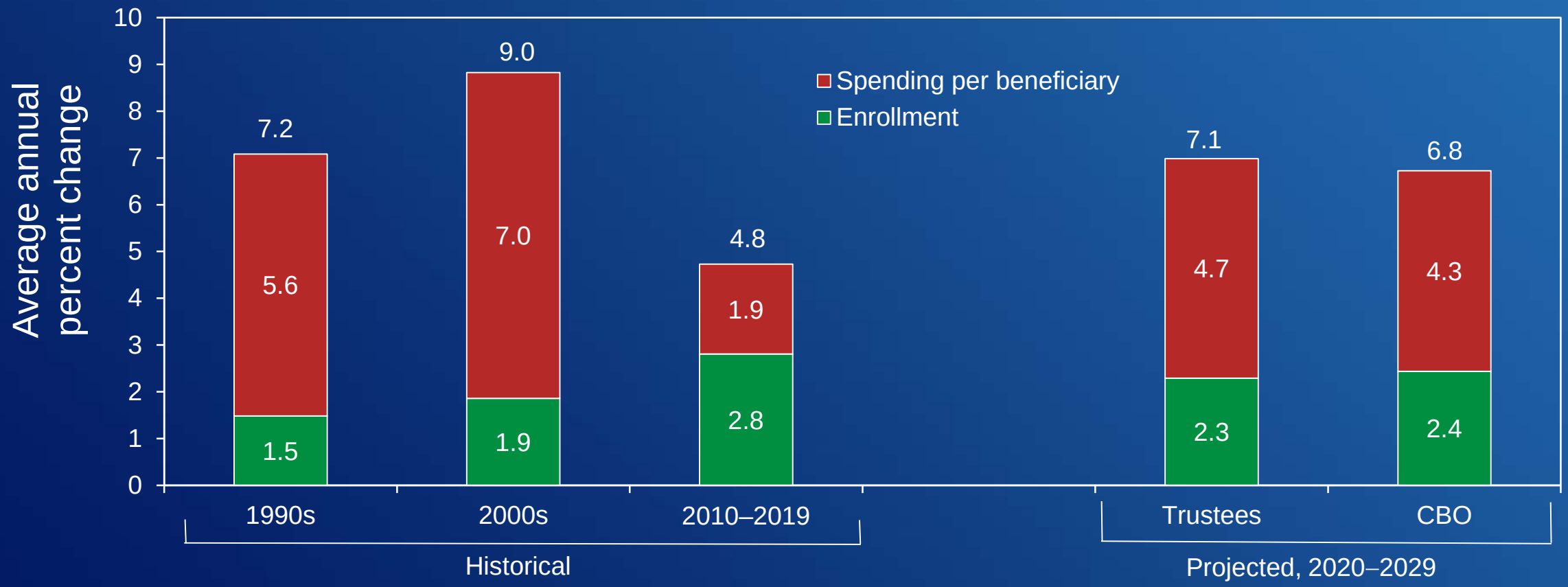
Spending per beneficiary is projected to be a larger driver of Medicare spending than enrollment growth



Note: CBO (Congressional Budget Office). Bar totals reflect average annual increase in total Medicare spending (including both fee-for-service and Medicare Advantage enrollees) and may, because of rounding, differ from the sum of the average annual increase in spending per beneficiary and the average annual increase in Medicare enrollment. Trustees' numbers are reported by calendar year; CBO's numbers are reported by fiscal year. The potential effects of the COVID-19 pandemic are not reflected in these projections. Data are preliminary and subject to change.
Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds and CBO's March 2020 Medicare baseline.

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Alternative payment models (APMs) give providers incentives to practice more efficiently

- Layered on top of Original Medicare's fee-for-service payment systems
- Usually voluntary for providers
- Three most prominent types of APMs:
  - Accountable care organizations (ACOs)
  - Bundled payment models
  - Primary care models

Discussion

- Questions?
- Further guidance as we finalize the chapter?