Advising the Congress on Medicare issues

Context for Medicare payment policy

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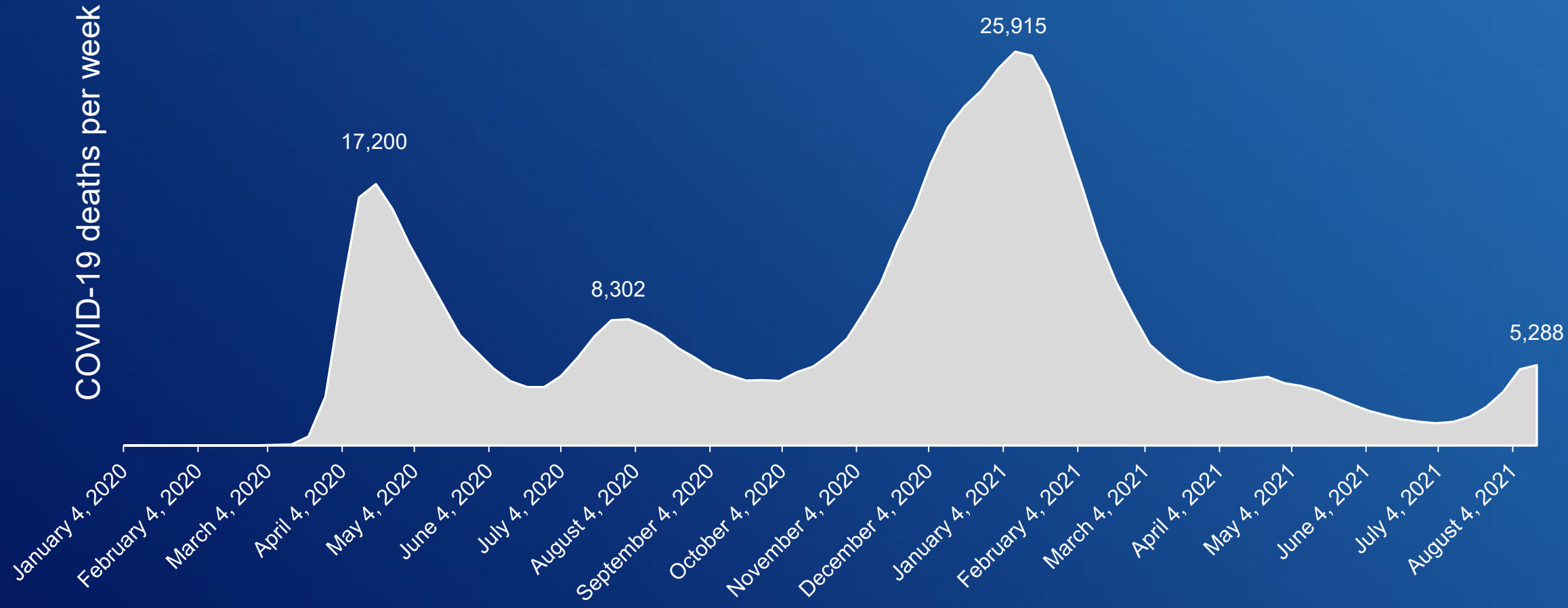
Overview

- Short-term context
  - The impact of COVID-19 on beneficiaries
- Long-term context
  - National health care spending trends
  - Medicare spending trends

The short-term context: COVID-19 pandemic

To date, 600,000+ people have died of COVID-19 in the U.S.



Note: The last week reflected in the graph is the week ending August 14, 2021, when there were 5,288 deaths. Data are preliminary and subject to change.

Source: Centers for Disease Control and Prevention's COVID-19 Death Data and Resources: Daily Updates of Totals by Week and State, as of August 19, 2021. https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm.

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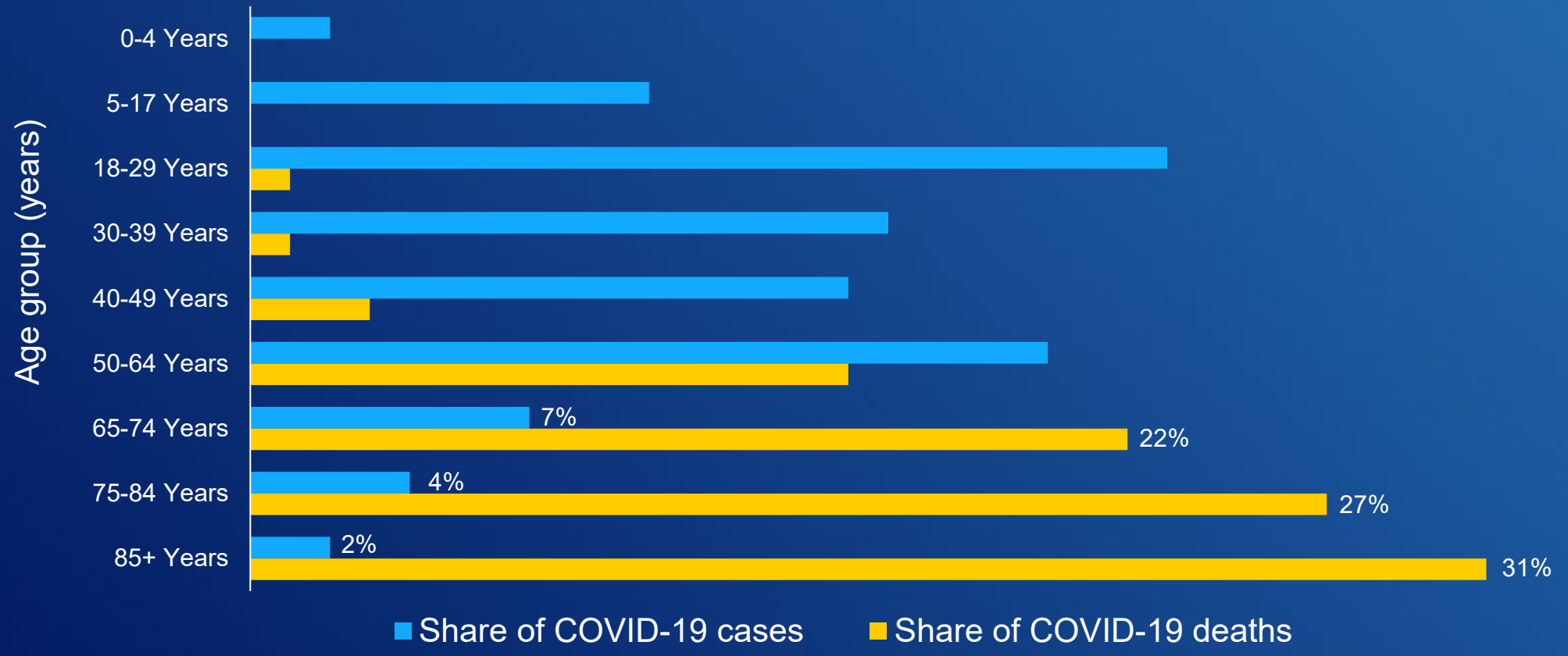
People ages 65+ made up 14% of COVID-19 cases but 80% of COVID-19 deaths



Note: Percentages do not sum to totals in title due to rounding in the figure. Reflects age distribution of 27,113,501 cases and 490,775 deaths reported to the CDC as of June 29, 2021. Age was available for 99 percent of cases and deaths reported to the CDC. Data are preliminary and subject to change.

Source: The Centers for Disease Control and Prevention's COVID Data Tracker: Demographic trends of COVID-19 cases and deaths in the US reported to CDC, as of June 29, 2021. https://covid.cdc.gov/covid-data-tracker/#demographics.

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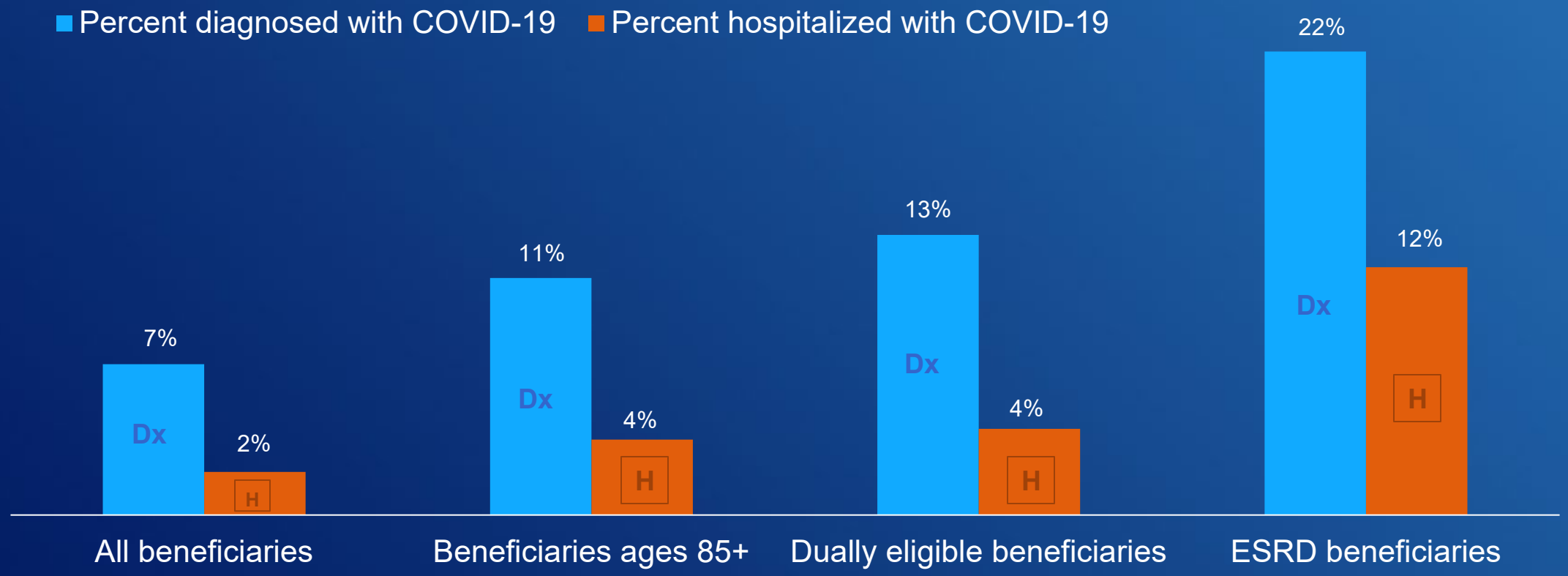
Some Medicare subgroups have had disproportionately high rates of COVID-19



Note: End-stage renal disease (ESRD). Data are preliminary and subject to change.

Source: Centers for Medicare & Medicaid Services' Preliminary Medicare COVID-19 data snapshot: Medicare claims and encounter data: January 1, 2020 to June 19, 2021, received by July 16, 2021. https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf.

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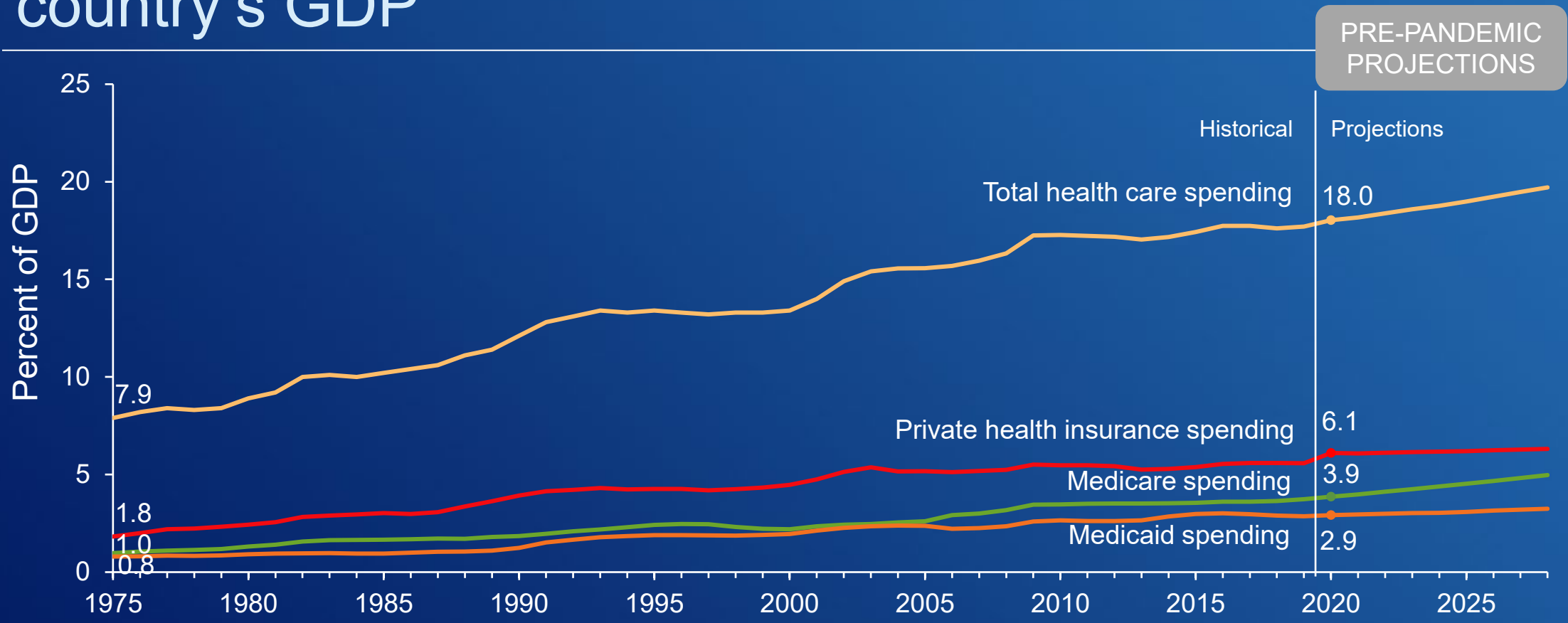
The pandemic's effect on Medicare beneficiaries is diminishing

- 81% of people ages 65+ now fully vaccinated
- Access to care largely maintained during the pandemic
  - Share of people foregoing or delaying care "in the past month" has declined over the pandemic
  - Share of aged beneficiaries foregoing care "in the past year" has been the same as pre-pandemic levels
- But the pandemic is not yet over

Source: Centers for Disease Control and Prevention, COVID-19 vaccinations in the United States, 2021, https://covid.cdc.gov/covid-data-tracker/#vaccinations; National Center for Health Statistics, Reduced access to care: Household Pulse Survey, 2021, https://www.cdc.gov/nchs/covid19/pulse/reduced-access-to-care.htm; Medicare Payment Advisory Commission, *Report to the Congress: Medicare payment policy, 2021*, http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch4_sec.pdf?sfvrsn=0.

The long-term context: Health care spending trends

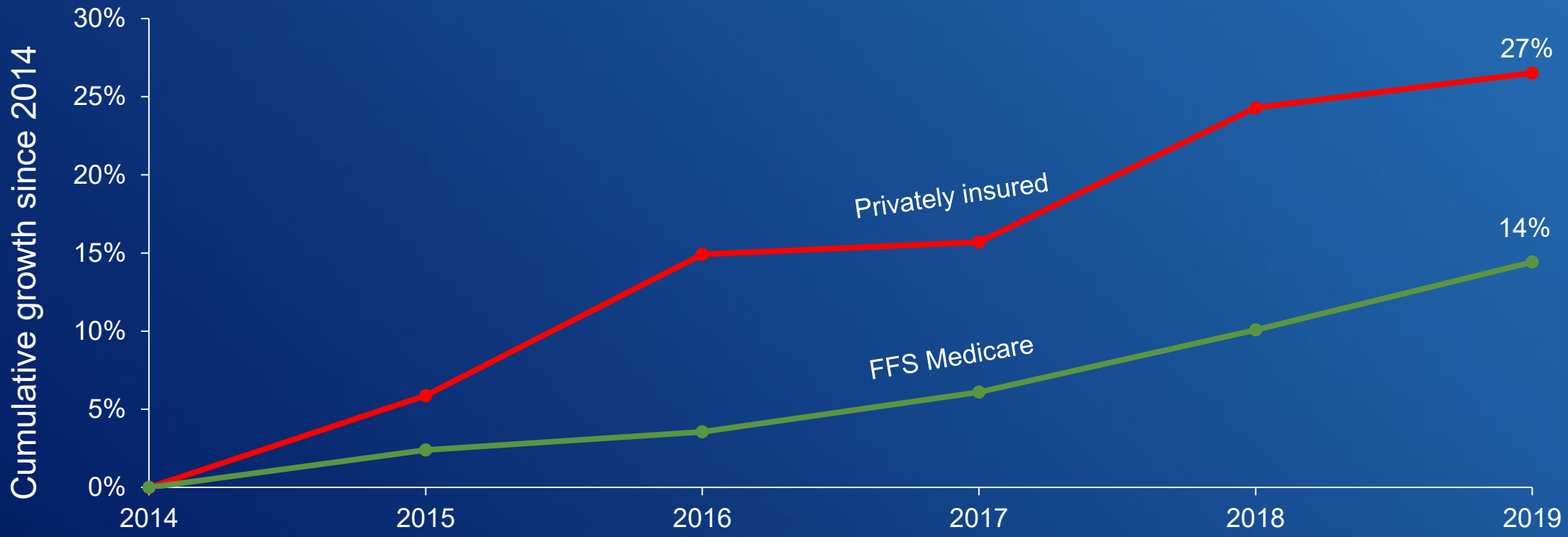
Health care spending has grown as a share of the country's GDP



Note: GDP (gross domestic product). First projected year is 2020. Percentages labeled on graph are for 1975 and 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 2010. 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, 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 COVID-19 pandemic are not reflected in these projections.

Source: MedPAC analysis of CMS's National Health Expenditure Accounts, projections released April 2020 and historical data released December 2020.

Health care spending per person has grown faster for the privately insured than for FFS Medicare beneficiaries



Note: FFS (fee-for-service). The figure 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 for the privately insured is not available for that group and thus is not included in this graph. “Private insurance” reflects spending contributed by national and regional plans and third-party administrators nationwide for adults ages 18 to 64 in self-insured plans (i.e., employer self-funded plans) and fully insured plans, including individual and group plans, marketplace plans, and Medicare Advantage plans for non-elderly disabled individuals. The figure reflects spending for individuals with full-year insurance coverage (including individuals with $0 of health care spending). Data are preliminary and subject to change.

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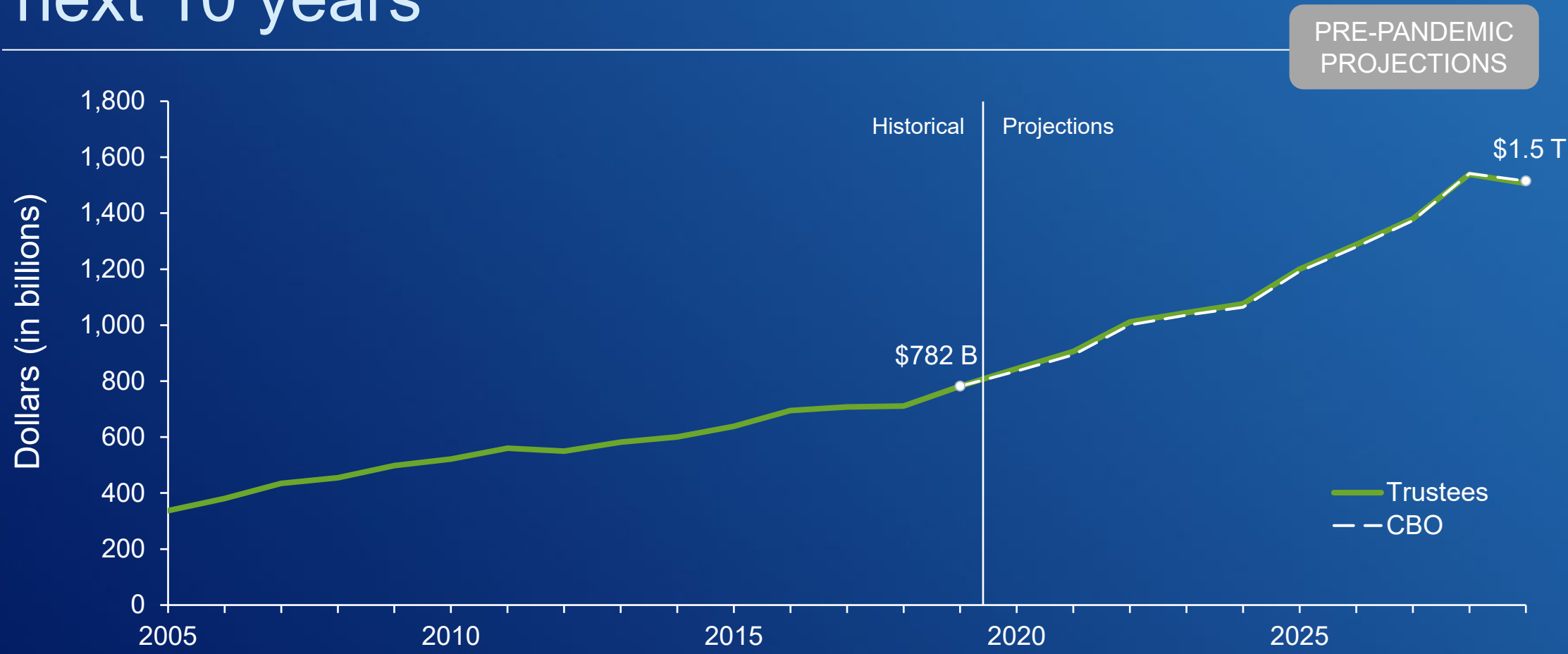
Source: MedPAC analysis of Medicare’s Master Beneficiary Summary File; FAIR Health analysis of its National Private Insurance Claims database (which reflects 150 million covered lives) for the subset of enrollees ages 18 to 64.

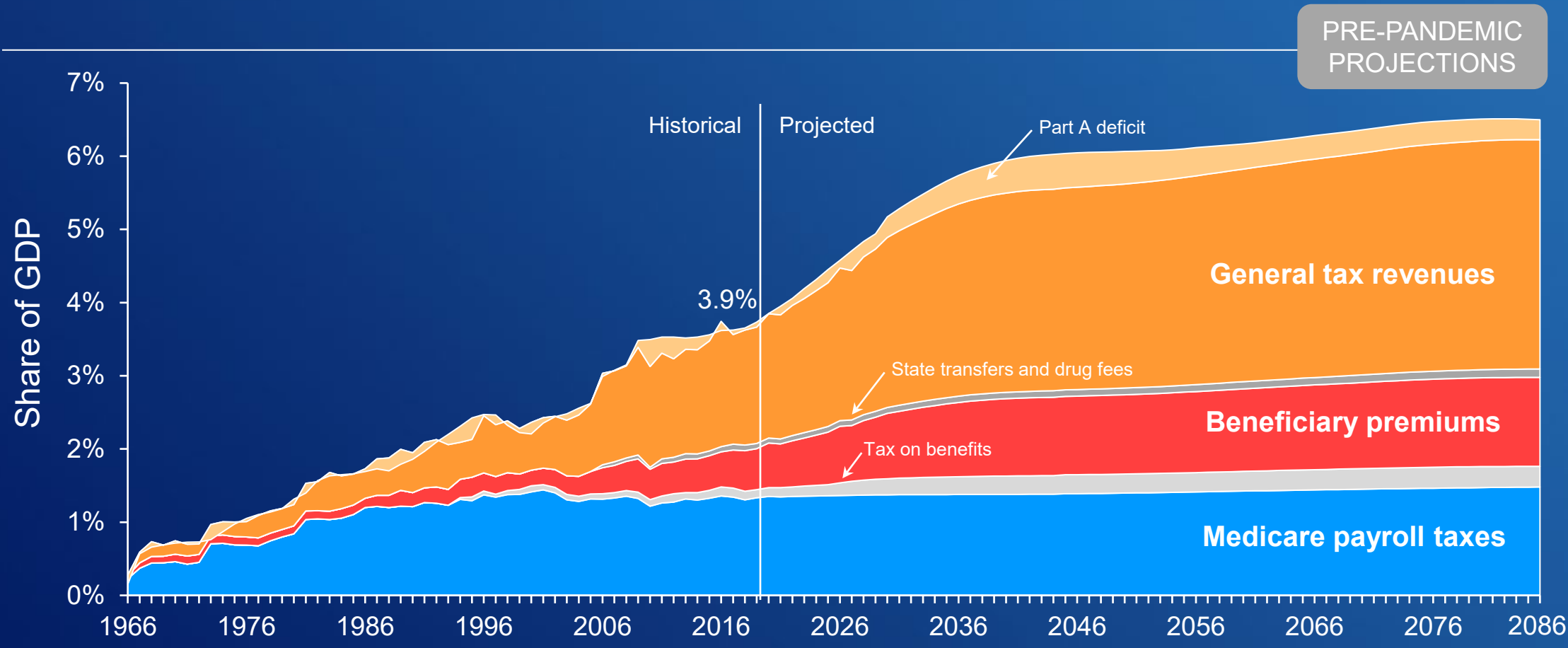
Medicare spending is expected to double in the next 10 years



Note: CBO (Congressional Budget Office). Figure shows spending per fiscal year (as opposed to calendar year). The potential effects of the COVID-19 pandemic are not reflected in these projections. At the time these projections were developed, a statutorily required sequestration was scheduled to increase in size in 2029 (growing from the current 2 percent reduction to benefit payments to a 4 percent reduction for the period from April 1, 2029 through September 30, 2029). Subsequent legislation delayed the 4 percent sequester past 2029 (not reflected above). 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.

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 COVID-19 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.

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

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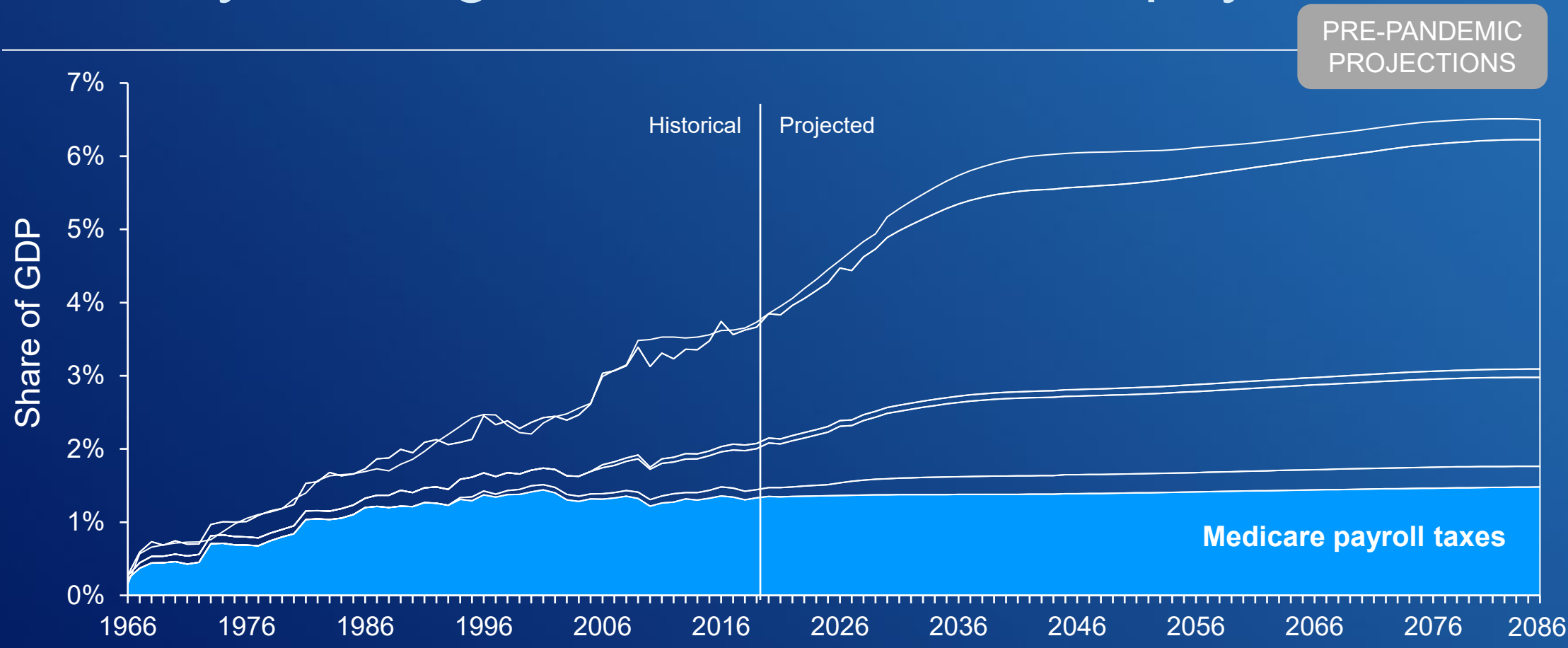
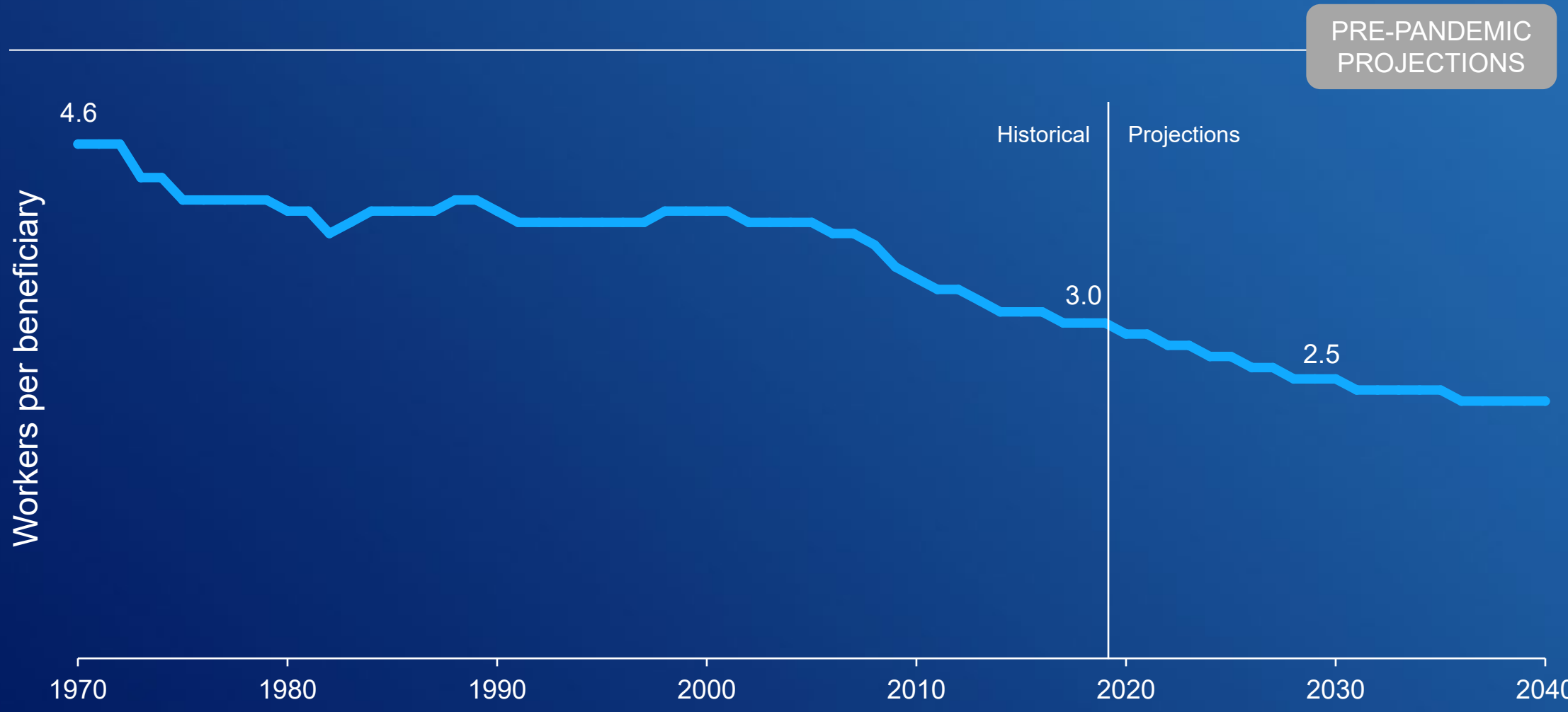
Primary funding source #1: Medicare payroll taxes



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 COVID-19 pandemic.

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

The ratio of workers per Medicare beneficiary is declining



Note: "Beneficiaries" referenced in these graphs are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). Part A is financed in part by Medicare's Hospital Insurance Trust Fund. The potential effects of the COVID-19 pandemic are not included in these projections.

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

Medicare's Hospital Insurance Trust Fund projected to be insolvent in 2026

REFLECTS PANDEMIC

- Trust fund already spends more than it collects
  - Has remained solvent due to prior years' surpluses
- To extend the trust fund's solvency for another 25 years, Trustees estimate:
  - Increase payroll tax: 2.9% → 3.7%
  - Decrease Part A spending: 18% ($70 billion)

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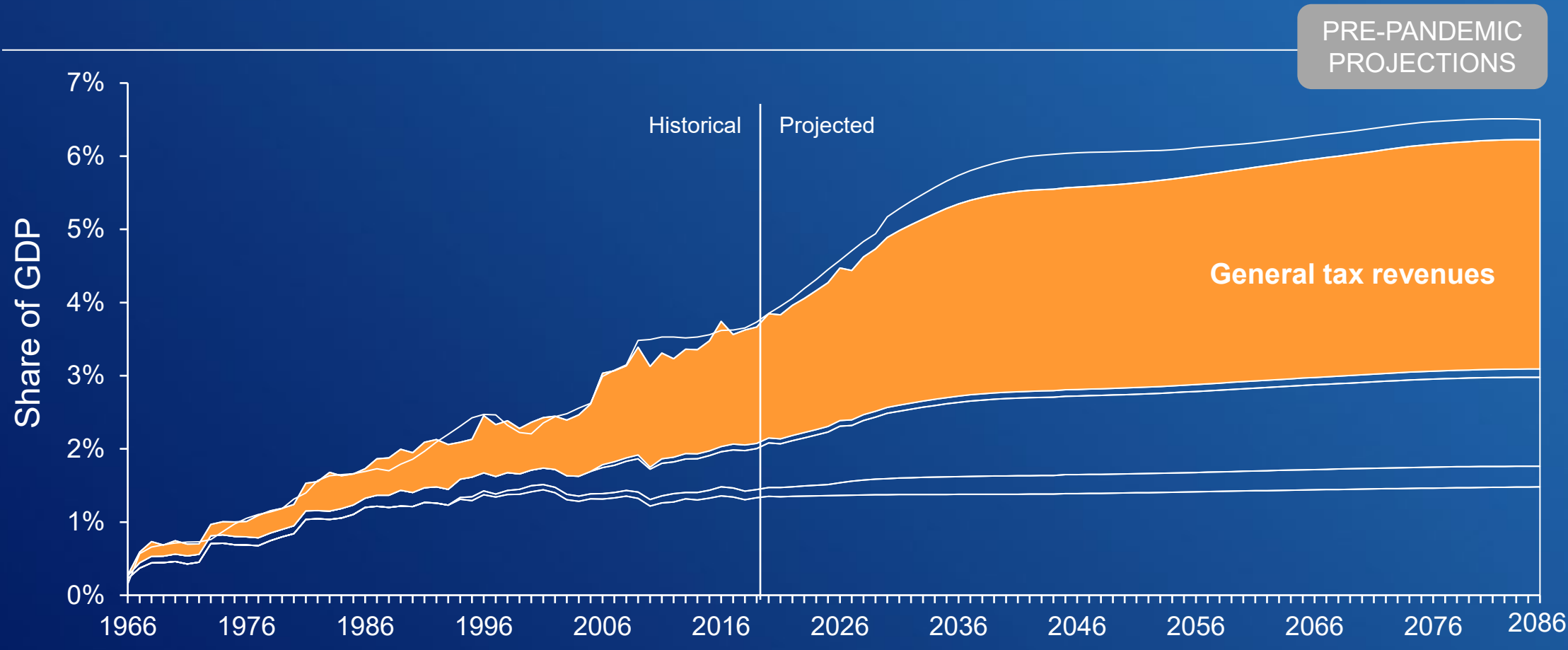
Source: MedPAC analysis of data from the 2021 annual report of the Boards of Trustees of the Medicare trust funds.

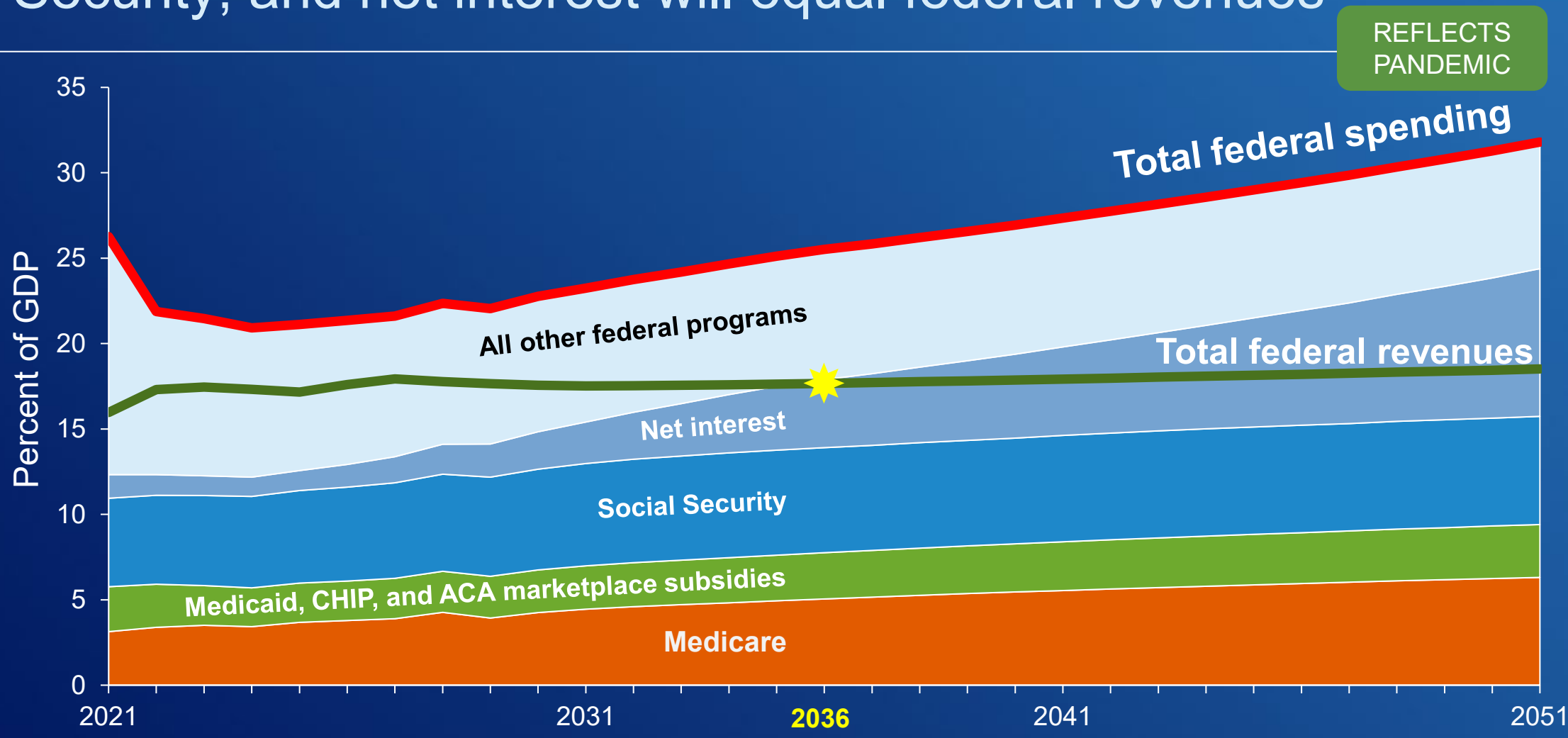
Primary funding source #2: General tax revenues



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 COVID-19 pandemic.

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

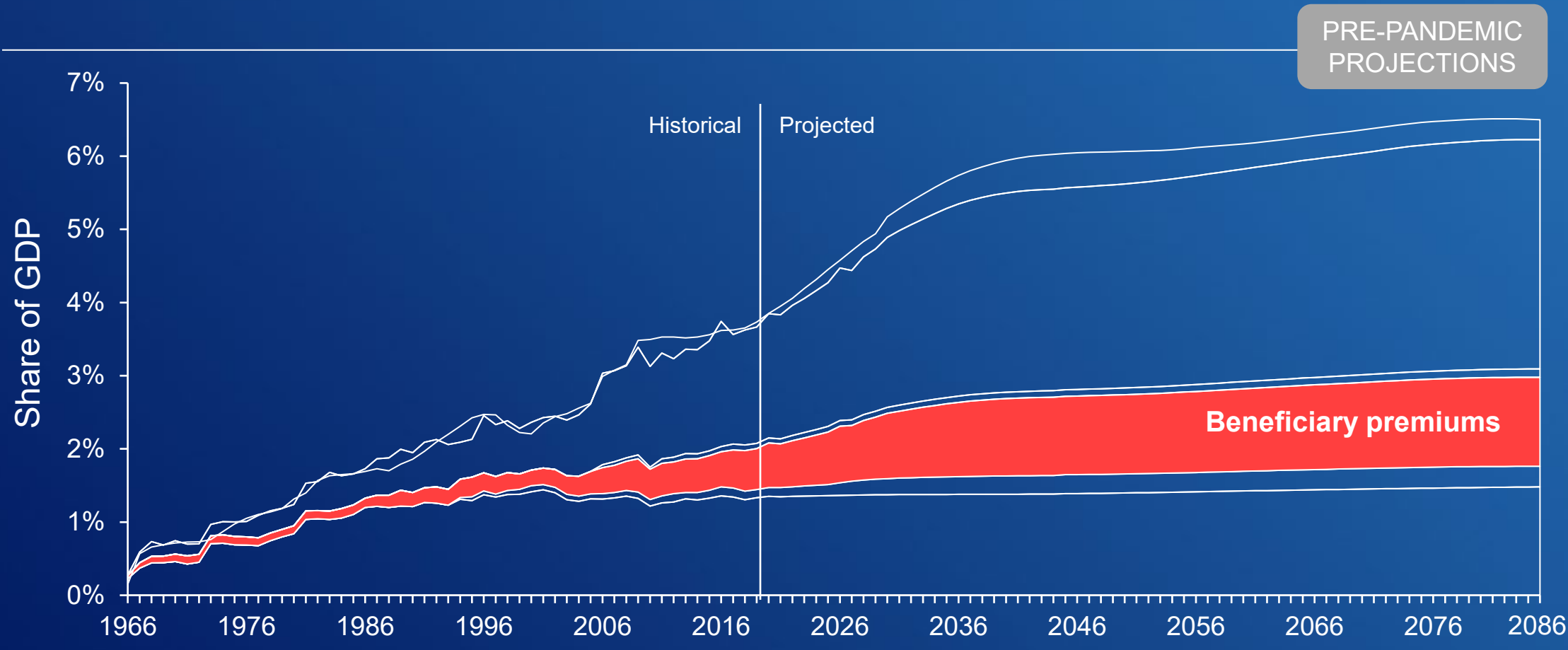
By 2036, spending on Medicare, other health programs, Social Security, and net interest will equal federal revenues



Note: GDP (gross domestic product), CHIP (Children's Health Insurance Program), ACA (Affordable Care Act of 2010). Data are preliminary and subject to change.

Source: Congressional Budget Office's long-term budget projections, published March 2021.

Primary funding source #3: Beneficiary premiums



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 COVID-19 pandemic.

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

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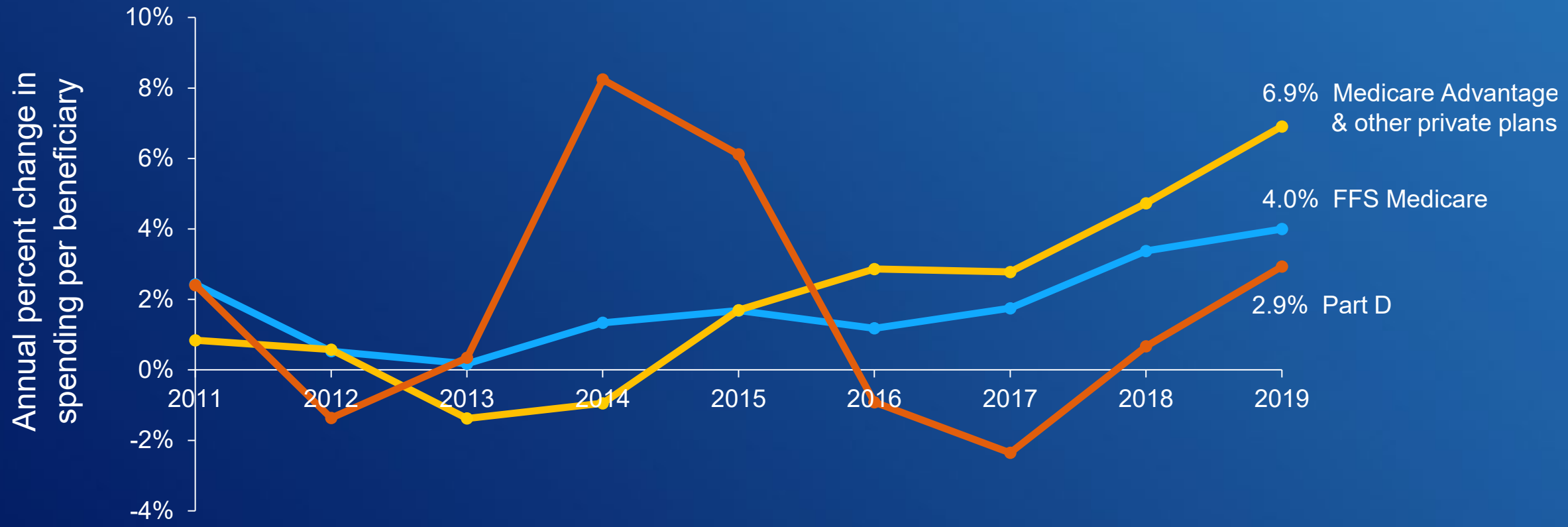
Medicare premiums and cost sharing consume a growing share of Social Security benefits

- Medicare premiums (annually, in 2021):
  - Part A: $0
  - Part B: $1,782
  - Part D: $456
- Medicare cost sharing (annually, in 2019):
  - Part A: $406
  - Part B: $1,582
  - Part D: $432
- Consumed 24% of the average Social Security benefit (in 2020)

Note: Data are preliminary and subject to change.

Source: MedPAC's 2021 *Data Book;* 2020 annual report of the Boards of Trustees of the Medicare trust funds.

Spending per beneficiary is growing faster in Medicare Advantage than FFS Medicare and Part D



Note: FFS (fee-for-service). Percent change is calculated using annual spending on an incurred basis that is not risk standardized. Private plans include Medicare Advantage plans, Medicare–Medicaid plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and cost-based (as opposed to capitated) plans. Spending per beneficiary on Medicare Advantage and other private plans is calculated by summing Part A spending on private health plans and Part B spending on private health plans, then dividing that by the number of enrollees in Part C (in private health plans). FFS Medicare spending per beneficiary is calculated by summing (1) Part A FFS spending divided by Part A FFS enrollees and (2) Part B FFS spending divided by Part B FFS enrollees. Part D is calculated by taking total Part D spending, subtracting premiums (mostly paid by enrollees), then dividing that by the number of enrollees in Part D. For more information on Medicare Advantage spending trends, see Chapter 12 of MedPAC's March 2021 report.

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

Future Medicare spending growth driven by increases in enrollment and service intensity

PRE-PANDEMIC PROJECTIONS

- Between 2020 and 2029, Medicare's spending is projected to increase by an average of 4.7% per year (beyond spending growth due to inflation)
  - Driven by growth in:
    - Number of Medicare beneficiaries (2+% per year)
    - Volume & intensity of services provided per beneficiary (2.6% per year)
- Spending growth could be slowed by reducing low-value care

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

Discussion

- Does anything in the chapter need to be clarified?
- Guidance as we finalize the chapter?