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Center for Health Systems
and Policy Modeling

Key Medicare Policy Issues:
Research Insights from the Center for Health Systems and Policy Modeling

The Medicare program accounted for 13.8 percent of the federal budget in 2023,[1] and its costs are projected to continue to grow in future years due to increasing numbers of enrollees, the aging of the population, changing health care utilization, and other shifts in health care provider and system behavior.

Key policy considerations for Medicare include managing rising health care costs, maintaining payment adequacy and access to care, ensuring the program's financial sustainability, and addressing evolving health care needs of an aging population.

The Center for Health Systems and Policy Modeling at Johns Hopkins University conducts research in the key areas outlined in this report, reflecting our mission to advance understanding of the U.S. health care system and inform policy decisions. Through interdisciplinary research, microsimulation, predictive modeling, and policy analysis, we aim to improve health care delivery, outcomes, and affordability. Our work provides critical insights into Medicare's financial sustainability, payment structures, and evolving health care needs, helping to shape evidence-based policy solutions.

[1] Congressional Budget Office. The Federal Budget in Fiscal Year 2023: An Infographic. 2024. https://www.cbo.gov/publication/59727

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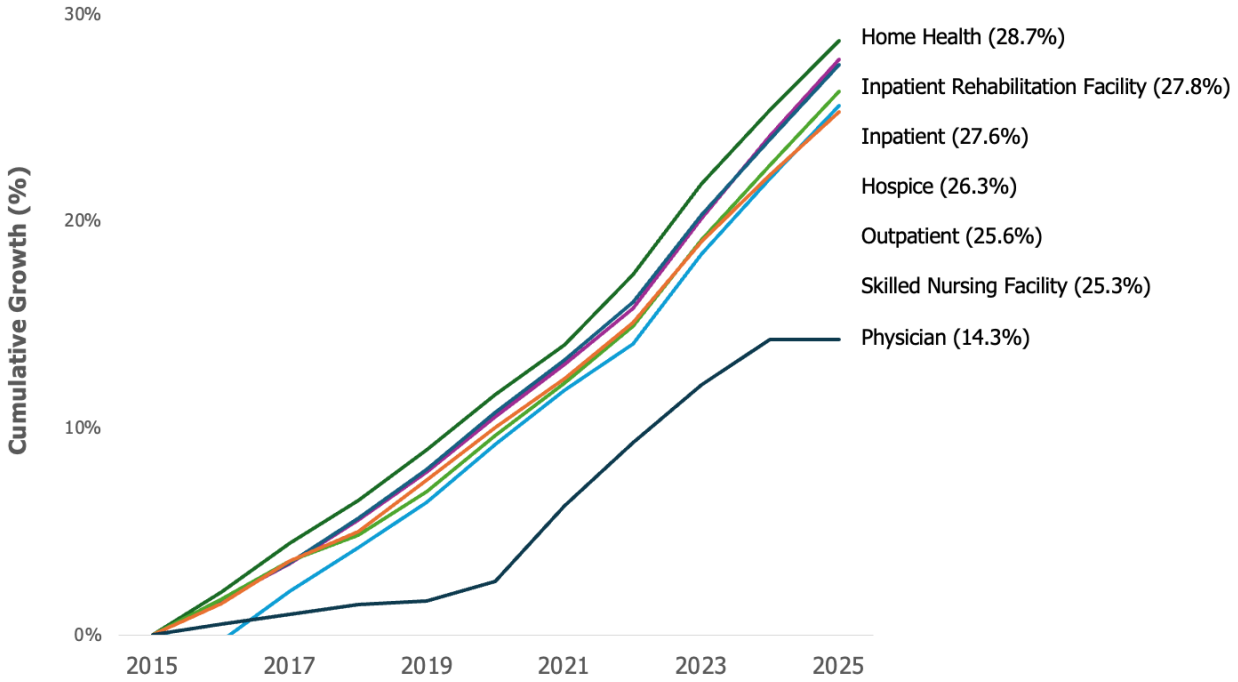
Medicare Payment Rates

Medicare is a federal health insurance program designed to provide coverage for Americans aged 65 and older, as well as younger individuals with disabilities or specific medical conditions. Established in 1965 as part of the Social Security Act, the program aims to ensure health care access for populations that might otherwise struggle to obtain affordable health coverage.

The Medicare program is structured into four separate parts that collectively provide coverage for hospital care, medical services, private insurance plan alternatives, and prescription medications.

Services in the home health care (28.7 percent) and physician (14.3 percent) sectors had the largest and smallest cumulative increases in Medicare payment rates, respectively, from 2015 to 2024, trends that are expected to continue in 2025.



However, per capita spending remained flat during the period.

Note: Market basket updates used in payment index construction also take into account adjustments – including Affordable Care Act-related reductions, productivity adjustments, forecast error adjustments, and one-time COVID increases – mandated by Congress or the Centers for Medicare & Medicaid Services.

Data from: Payment system Final Rules provided by the Federal Register and Centers for Medicare & Medicaid Services

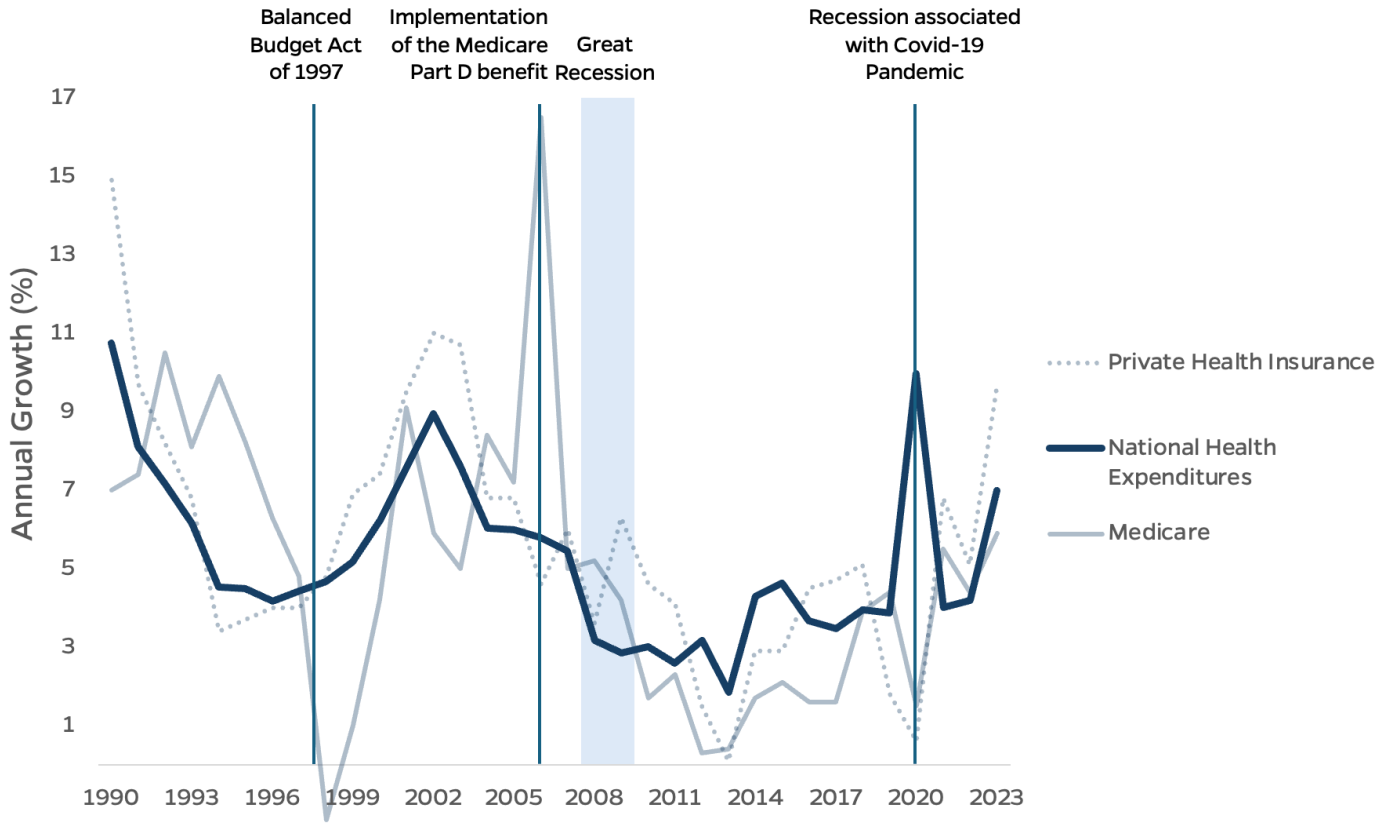
Analysis from: Johns Hopkins University Center for Health Systems and Policy Modeling

Medicare Payment Systems

Medicare employs 10 major payment systems to reimburse different types of health care providers and services.

These are the Inpatient Prospective Payment System (IPPS); Outpatient Prospective Payment System (OPPS); Physician Fee Schedule (PFS); Skilled Nursing Facility Prospective Payment System (SNF PPS); Home Health Prospective Payment System (HH PPS); Medicare Advantage (Part C) Payment System; End-Stage Renal Disease Prospective Payment System (ESRD PPS); Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program; Hospice Payment System; and Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS).

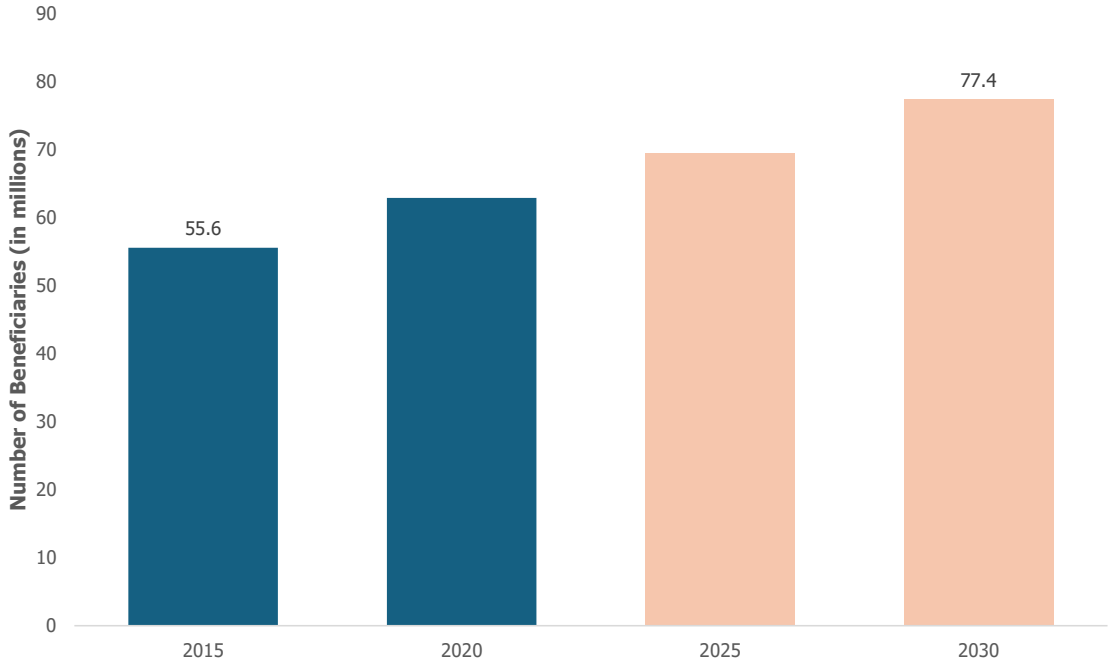
Low growth in Medicare spending, by historical standards, has persisted for nearly two decades. This can be explained by lower payment rates, shifting demographics, and an emphasis on value in the Medicare program.



Source: Buntin et al. (2025)

Enrollment Trends

Baby boomers will have all reached age 65 by 2030, and total Medicare enrollment is projected to grow to 77.4M beneficiaries by then.



Data from: Medicare Trustees Report (2024)

Notes: Baby boomers are defined as the age group born 1946–64. Blue bars show historical estimates and orange bars show projections.

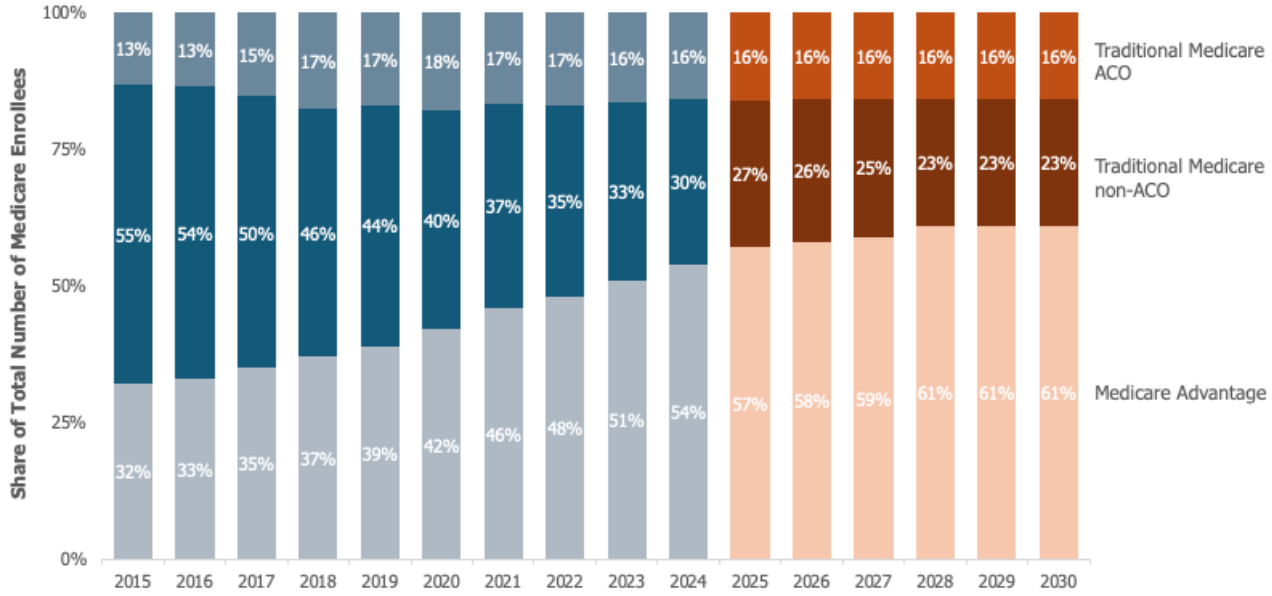
Key Terms

Fee-for-service Medicare (also known as "Traditional Medicare") and Medicare Advantage represent two distinct approaches to health care coverage.

Traditional Medicare, administered directly by the federal government, allows beneficiaries to visit any doctor or hospital that accepts Medicare, with Part A covering hospital stays and Part B covering outpatient services. Patients typically pay premiums and can add separate Part D prescription drug coverage and supplemental Medigap insurance. Medicare pays providers for each service delivered.

Medicare Advantage (Part C) is offered by private insurance companies that contract with Medicare, providing an all-in-one alternative that usually includes prescription drug coverage, and often additional benefits like dental, vision, and hearing services. Insurers receive monthly risk-adjusted payments per beneficiary ("capitated payments") and manage all care within this fixed budget.

Enrollment in Medicare Advantage is projected to reach 57 percent in 2025 and is projected to climb to 61 percent by 2030.



Note: Blue bars are based on historical data; orange bars are projections. Projections assume that net Accountable Care Organization (ACO) enrollment will remain constant as a percentage of the Medicare population given that there are models ending (REACH, PCF and MCP) that will likely cause a decline in ACO numbers but new models under consideration that would replace them.

Data from: Medicare Trustees Report (2024); Kaiser Family Foundation; Centers for Medicare & Medicaid Services

The Medicare Advantage category in the figure includes beneficiaries enrolled in all private health plans, including Medicare Cost Plans, Demonstrations/Pilots, Program of All-inclusive Care for the Elderly (PACE), and Medicare Advantage.

Key Term

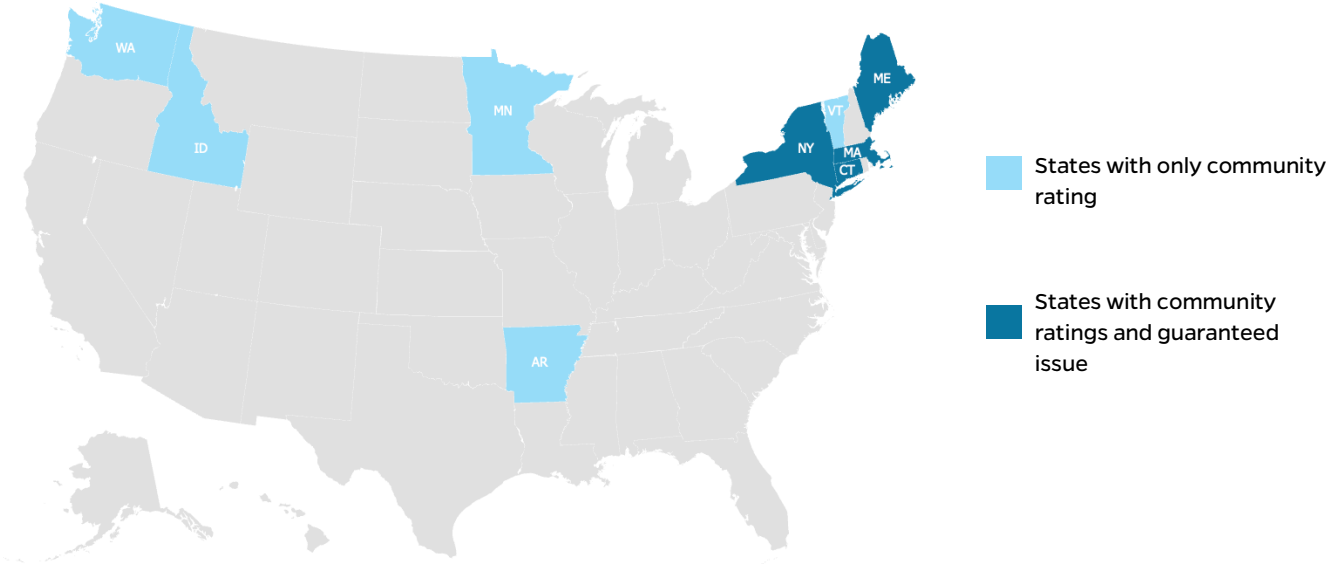
Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve. Providers in ACOs are paid based on their meeting of set cost-savings goals, encouraging a focus toward value-based care rather than volume-based care (CMS 2025).

Medigap

Medigap (also called Medicare Supplement Insurance) is private health insurance designed to help pay for costs that Traditional Medicare does not cover. A beneficiary has the option to buy a Medigap policy from a private insurance company as a supplement to Traditional Medicare coverage. When a medical service is provided, Medicare pays its share first, then the Medigap policy pays its share. Employer-sponsored Medigap plans also provide supplemental coverage but through group arrangements, often offering broader benefits and lower premiums than individual Medigap plans, highlighting disparities in financial protections based on retiree status.

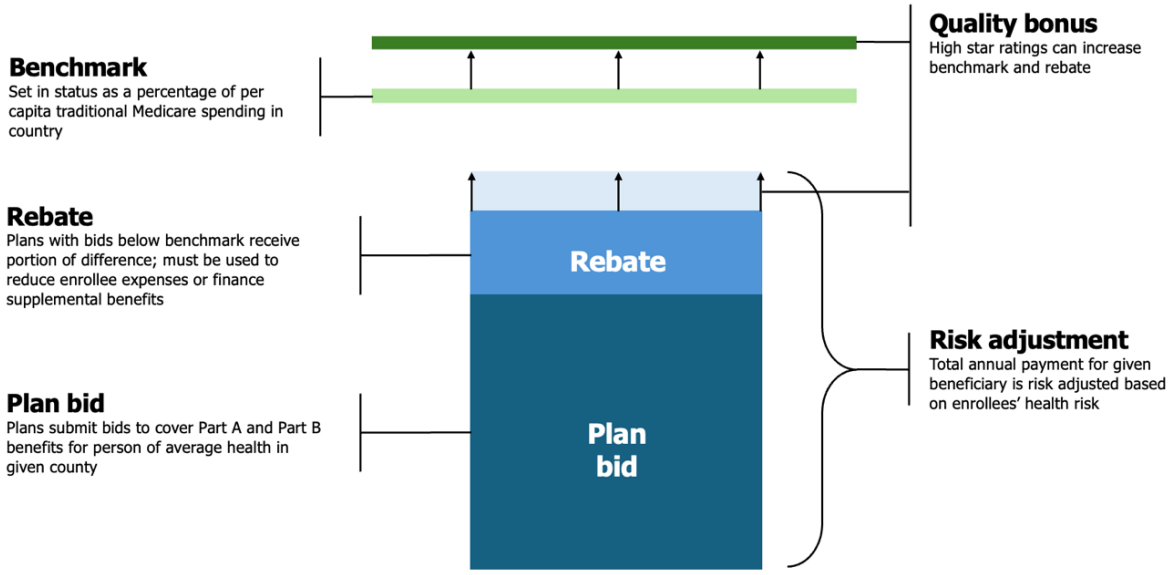
- **Standardized Plans:** Medigap policies are standardized into plans labeled A through N (though not all letters are used). Each plan offers a different set of benefits, but any plan with the same letter must offer identical core benefits regardless of which insurance company sells it.
- **Monthly Premium:** Beneficiaries pay a monthly premium for Medigap in addition to their Medicare Part B premium.
- **One-Time Enrollment Period:** Traditional Medicare beneficiaries are generally granted a one-time 6-month enrollment window to purchase a Medigap plan at a community-rate. After this initial period, insurers in most states can individually rate beneficiaries or deny coverage altogether.

As of 2025, nine states require Medigap premiums to be community-rated, meaning all policyholders within the same geographic area pay the same premium regardless of age or health status. **Four states additionally require guaranteed issue Medigap**, meaning insurers are required to sell Medigap to the beneficiary. Some other states provide additional consumer protections, such as annual open enrollment periods or guaranteed issue rights under specific circumstances, such as when a beneficiary switches from a Medicare Advantage plan during their one-year trial period.



Medicare Advantage

Medicare Advantage (MA) payments are based on a plan's bid relative to a spending benchmark and a plan's quality rating.



Source: Ramsay et al. (2024)

Benchmarks and rebates incentivize MA plans to lower bids and achieve higher quality ratings; plans use rebates to enhance benefits and reduce costs for enrollees.

MA benchmarks are the maximum amount Medicare will pay MA plans per enrollee in a county. They are set at a percentage (95–115 percent) of Traditional Medicare's per-capita costs in that county, with additional adjustments for quality ratings and other factors.

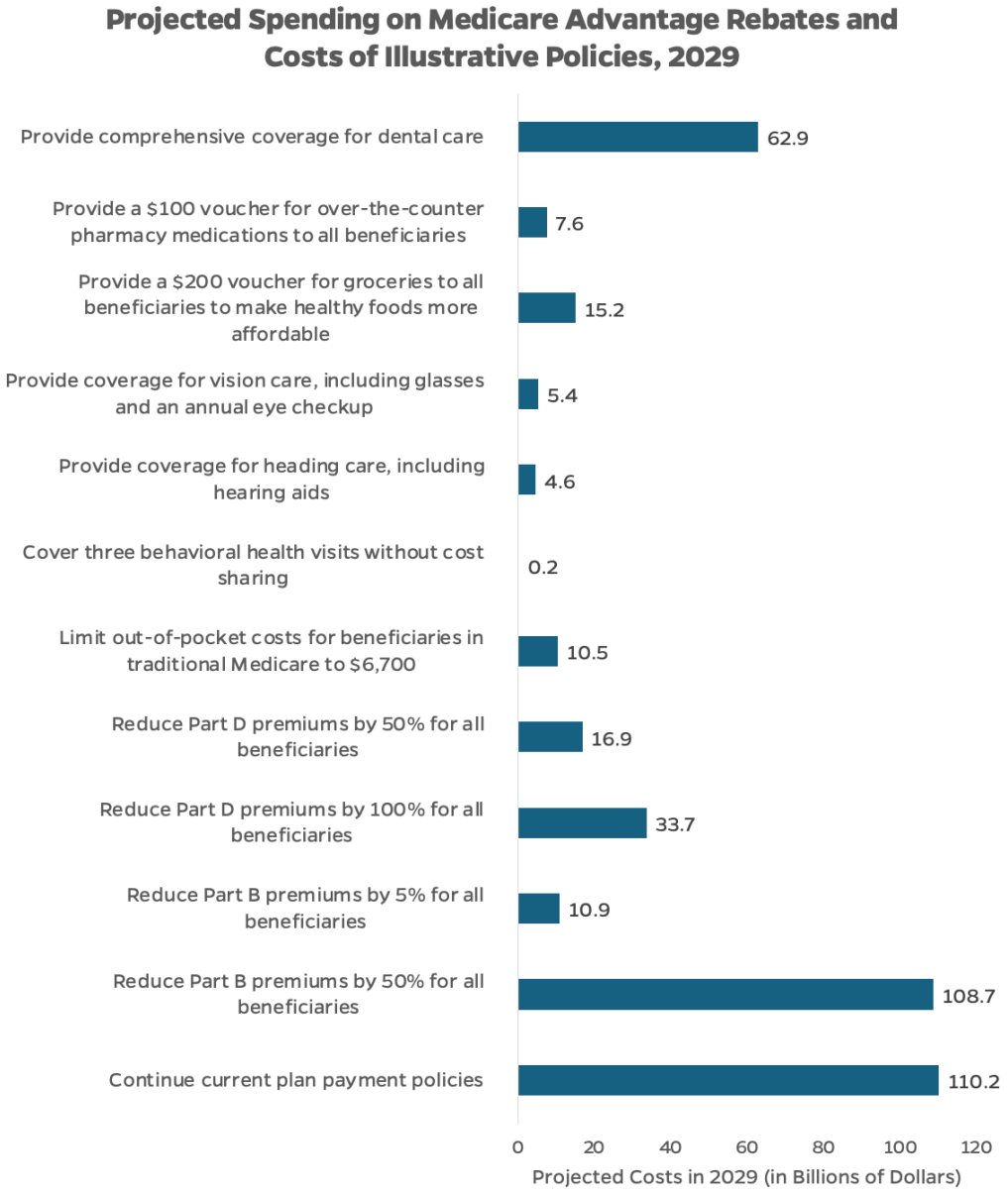
Plans submit bids representing their projected costs for providing Medicare Part A and B benefits. If a plan's bid is below the benchmark, it receives its bid amount plus a "rebate" equal to a percentage (50–70 percent, based on quality rating) of the difference between the bid and benchmark. Plans must use rebates to provide supplemental benefits or reduce cost-sharing for enrollees.

Benchmarks are often set higher than actual costs in an area. This allows plans to bid higher costs than warranted and receive inflated rebates, reducing incentives for efficiency. MA payments per enrollee exceeded Traditional Medicare spending per enrollee by 22 percent ($83 billion) in 2024 (MedPAC 2024).

Reforming how benchmarks are set could better incentivize plans to minimize costs and save the program money, but plans may also provide fewer additional benefits to enrollees.

MA is intended to be more efficient and less expensive than Traditional Medicare, but the federal government in fact spends more per enrollee in MA than in Traditional Medicare.

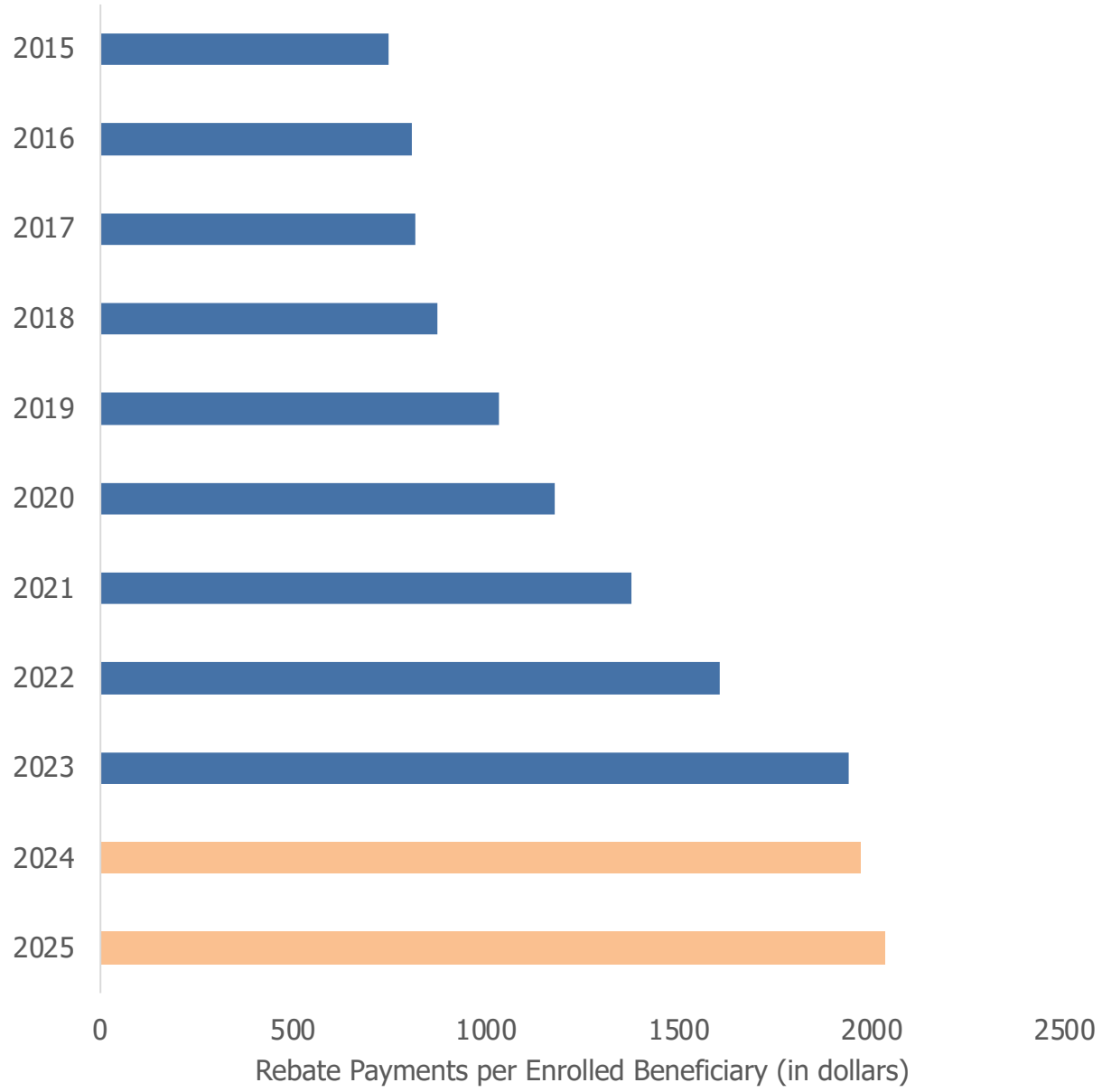
A package of expanded benefits (including dental, vision, hearing care, reduced Part D premiums, etc.) could be made available to all Medicare beneficiaries for less than the projected spending on rebates to MA plans in 2029.



Source: Uccello et al. (2024)

Congress could review MA payment methods and consider more intentional ways to provide supplemental benefits that improve outcomes while enhancing Medicare's financial sustainability.

The rebate portion of Medicare payments to MA plans, which must be used to cover the cost of additional benefits not available to Traditional Medicare beneficiaries, is projected to grow to $71.6 billion (13.1 percent of total MA spending) in 2025.

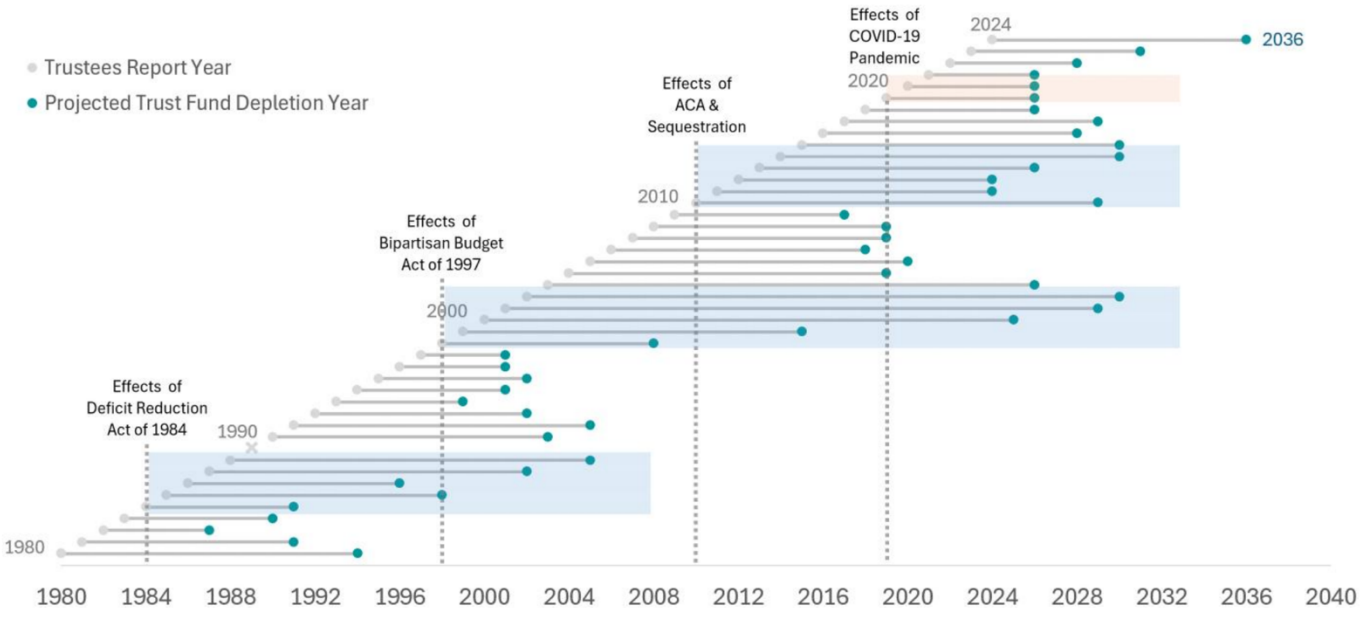


Data from: Medicare Trustees Report (2024)

Solvency of the Medicare Hospital Insurance Trust Fund

The Hospital Insurance (HI) Trust Fund supports Medicare Part A benefits. Reforms across Parts A, B, and C of Medicare influence the HI Trust Fund balance.

- The Medicare trustees estimate the HI Trust Fund will become insolvent in 2036.
- Insolvency means the HI Trust will no longer have the assets to pay for beneficiaries' care at current levels.



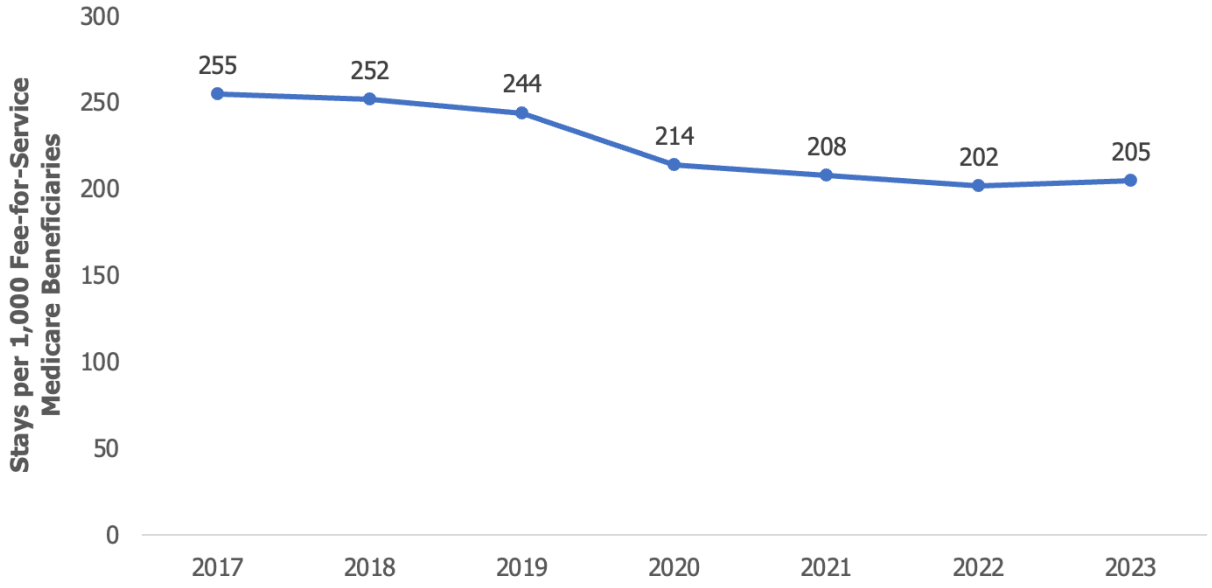
Note: The Medicare Trustees provided no updated insolvency date estimate in their 1989 report.

Source: Lou et al. (2025)

Historically, substantial reforms have been needed to produce meaningful improvements to solvency and ensure that Medicare benefits are not interrupted.

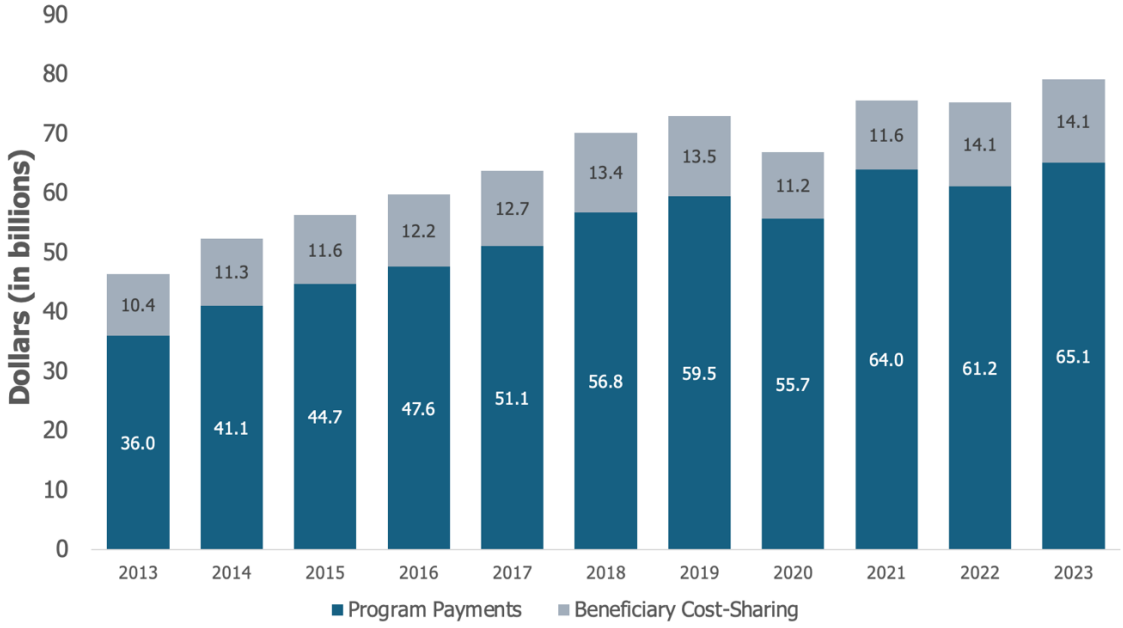
Site-Neutral Payment

Inpatient stays per fee-for-service Medicare beneficiary declined between 2017–2023, with a portion of these services shifting to outpatient settings.



Data from: Medicare Payment Advisory Commission public meetings and reports

Over the past decade, outpatient prospective payment system (OPPS) spending by Traditional Medicare increased 71 percent and the proportion of annual total outpatient spending attributed to OPPS payments grew 4.6 percent.



Data from: Medicare Payment Advisory Commission Databook (Jul 2024)

Historically, Traditional Medicare payments for outpatient service delivery varied based on site of service, but patient clinical differences across facility types did not uniformly support these payment differences.

Hospital Outpatient Departments (HOPD) $$$

- HCPCS codes billed are grouped into Ambulatory Payment Classification (APC) codes
- APCs paid according to the Outpatient Prospective Payment System (OPPS)

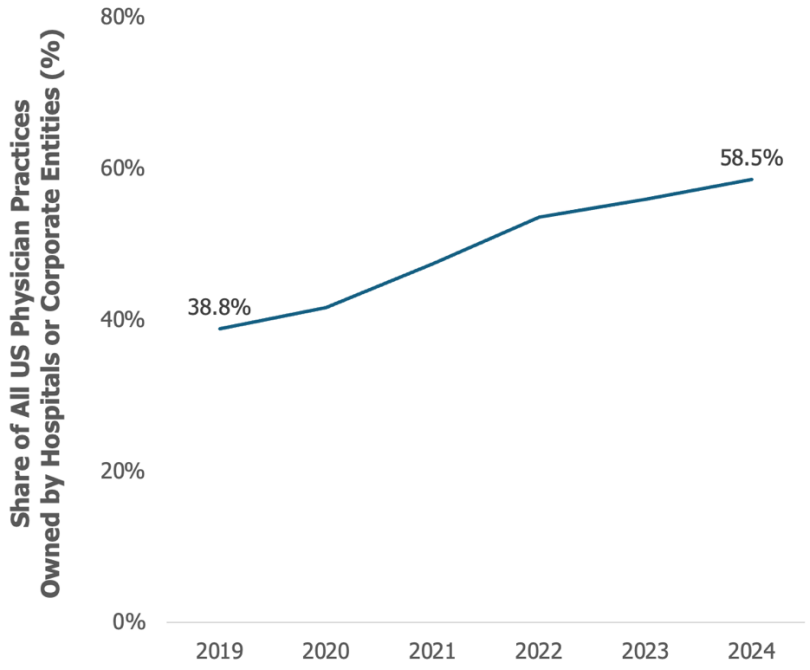
Ambulatory Surgical Center (ASC) $$

- HCPCS codes billed are grouped into APC codes
- APCs paid according to rates set under the ASC Fee Schedule

Physician Office $

- Paid according to rates set under the Physician Fee Schedule (PFS)

These payment differences have encouraged hospitals to acquire physician practices and convert them to Hospital Outpatient Department (HOPD) status to receive higher Medicare payments.



Data from: Physicians Advocacy Institute (2024)

Hospital acquisitions of physician practices have shifted service volume to outpatient settings and driven up Medicare spending and beneficiary out-of-pocket costs.

When hospitals acquire physician practices and convert them to a provider-based hospital department, they can submit claims for their services under the OPPS.

Current Payment

Epidural injection into the lumbar or sacral regions, 2023

Hospital Outpatient Department (HOPD)

Physician Work		$ 59.51
Facility Practice Expense (PE)	+	$ 31.08
Professional Liability Insurance		$ 5.95
Payment to Physician		$ 96.54
Payment to HOPD (OPPS rate)	+	$ 644.34
Total Payment		**$ 744.38**

Physician's Office

Physician Work		$ 59.51
Non-facility Practice Expense (PE)	+	$ 190.43
Professional Liability Insurance		$ 5.95
Total Payment		**$ 255.89**

Site-neutral payments would result in savings for the Medicare program and the beneficiaries it serves, assuming Congress would not implement policy in a budget-neutral manner.

Site-Neutral Aligned Payment

Epidural injection into the lumbar or sacral regions, 2023

Hospital Outpatient Department (HOPD)

Physician Work		$ 59.51
Facility PE	+	$ 31.08
Professional Liability Insurance		$ 5.95
Payment to Physician		$ 96.54
Payment to HOPD (non-facility PE - facility PE)	+	$ 159.35
Total Payment		**$ 255.89**

Physician's Office

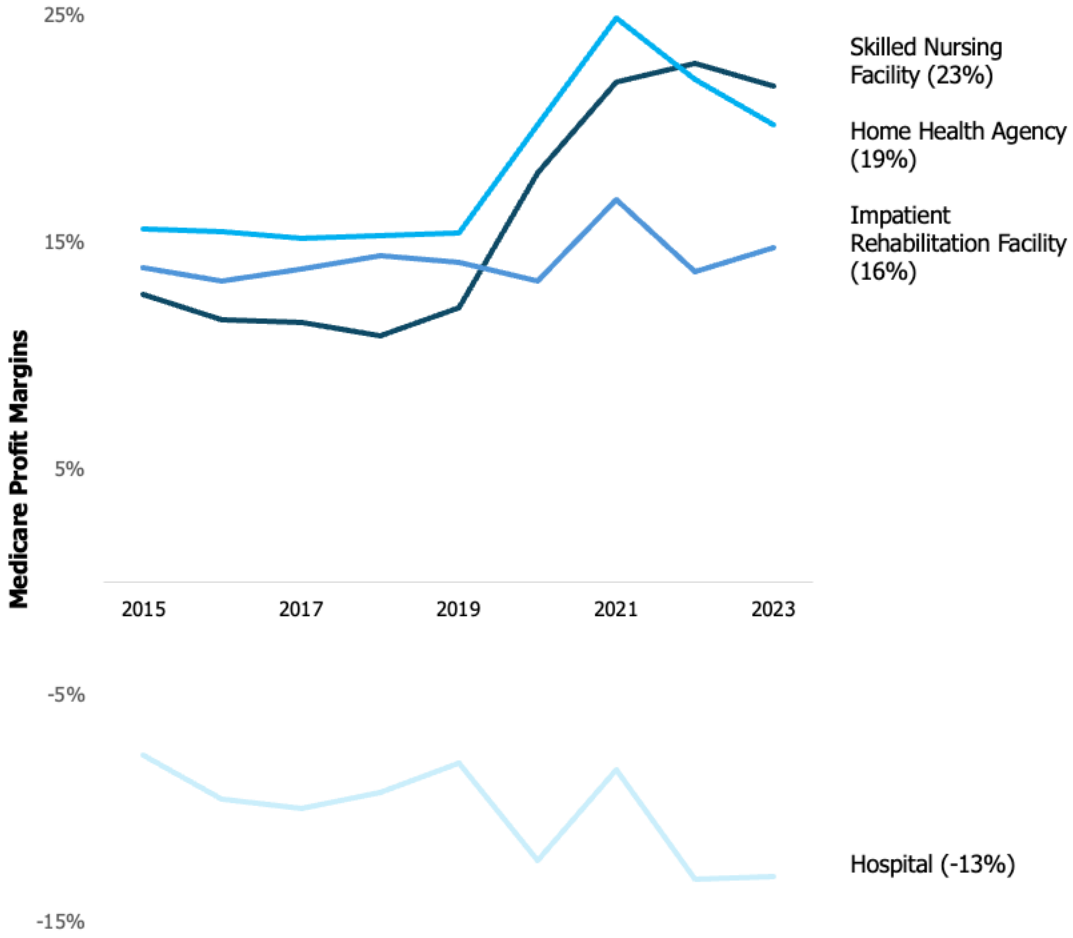
Physician Work		$ 59.51
Non-facility PE	+	$ 190.43
Professional Liability Insurance		$ 5.95
Total Payment		**$ 255.89**

Data from: Medicare Payment Advisory Commission (Jun 2023)

Not all health services can be safely performed in a physician office. The selection of services for site-neutral payment reductions should be evaluated for clinical appropriateness. For selected services, HOPDs would be paid the same rate as physician offices, which on average is approximately 40 percent of the OPPS rate.

Medicare Payments to Providers Versus Costs of Providers

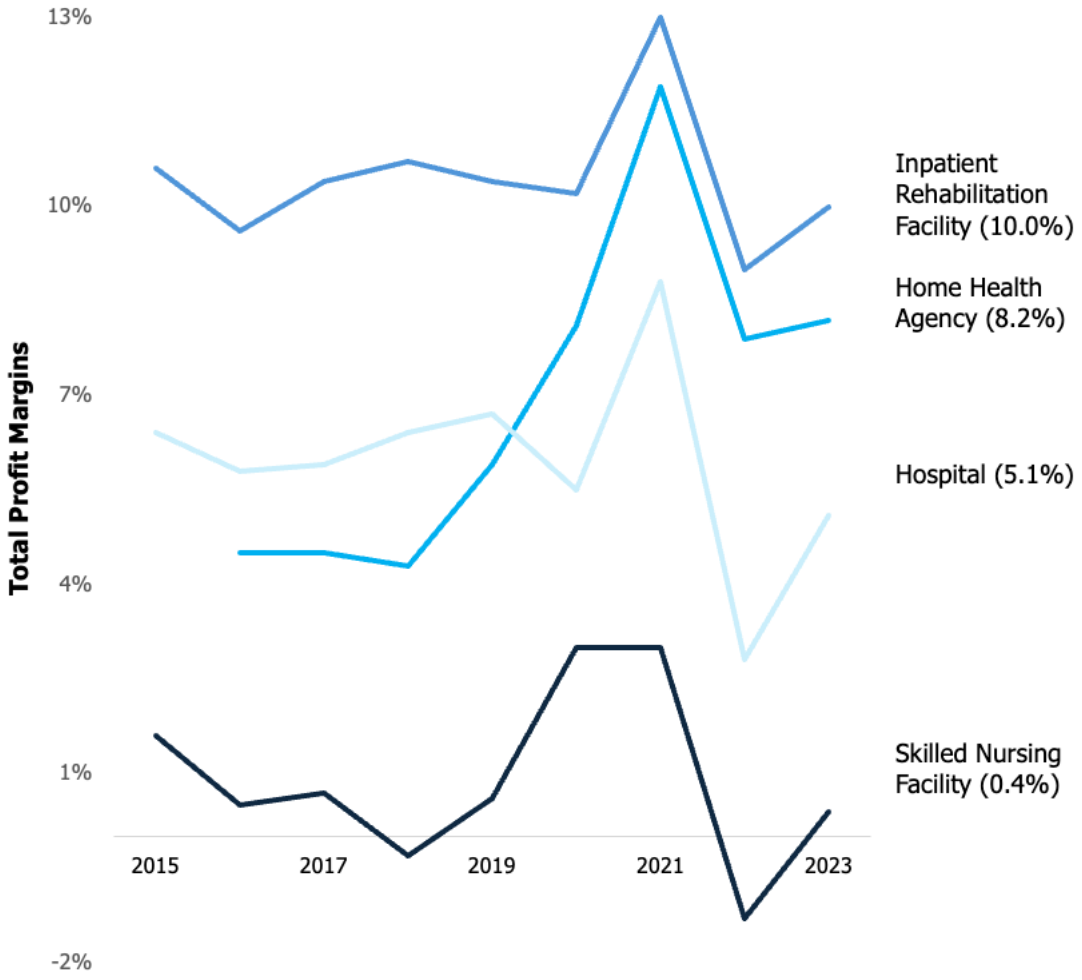
Continuing historical trends, aggregate Medicare payments for post-acute care (PAC) are projected to exceed PAC providers' aggregate costs for Medicare patients in 2025, but Medicare payments to hospitals are projected to fall short of hospital costs for Medicare patients. Individual provider margins within each sector vary reflecting differences in input costs, provider efficiency, and economies of scale.



Data from: Medicare Payment Advisory Commission public meetings and reports

Notes: "Hospital" includes acute care hospitals paid under Medicare's IPPS. Hospital margins are for all lines of Medicare business in the hospital.

Total profit margins, reflecting the profits on all payers and lines of business, are a function of other payers' rates and the payer mix in each sector.



Data from: Medicare Payment Advisory Commission public meetings and reports

Sectors' total profit margins reflect profits on all payers and lines of business and are a function of other payers' rates and the payer mix in each sector.

Medicare payment rates to hospitals are lower than rates paid by private insurers, while Medicare payments rates to skilled nursing facilities (SNFs) are higher than rates paid by states' Medicaid programs.

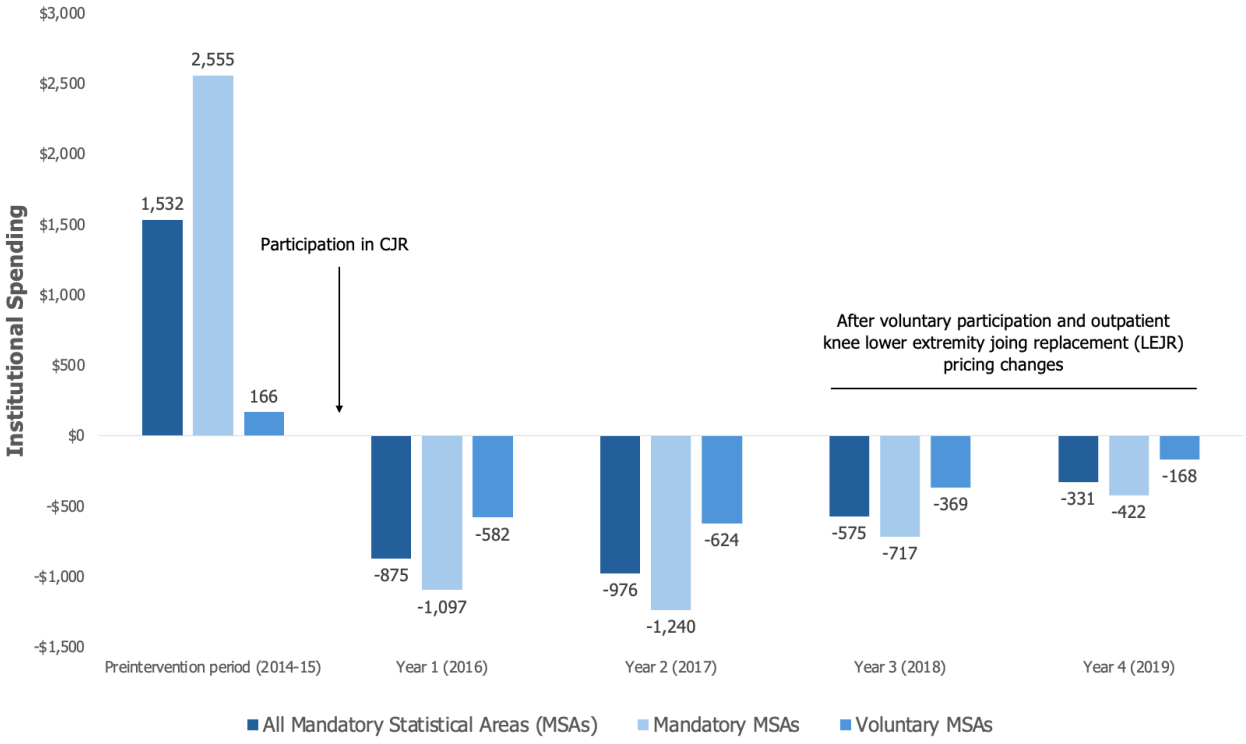
PAC margins are total margins from all payers on all lines of business. Data are not available for HHAs in 2014 or 2015. Hospital margins are operating margins (total margin, excluding investment income).

Bundled Payments

There is evidence that bundled payments for episodes of care, which include hospital and PAC, create gross savings for the Medicare program.

Hospital participation in the Comprehensive Care for Joint Replacement (CJR) demonstration was associated with a decrease in institutional PAC spending compared to non-participating hospitals from years 1-4 of participation.

- Participation was mandatory for hospitals in selected Metropolitan Statistical Areas (MSAs) in years 1-2.
- Starting in year 3, hospitals in some selected MSAs were allowed to choose to participate voluntarily in the demonstration while some other MSAs had mandatory participation in the demonstration.



Analysis from: Wilcock et al. (2021)

Early participation in the Bundled Payments for Care Improvement (BPCI) initiative was also associated with more significant changes in mean episode spending by providers than later participation.

In 2026, the Centers for Medicare & Medicaid Services (CMS) will launch the Transforming Episode Accountability Model (TEAM) which builds on prior bundled payment models.

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