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UTAH/FEDERAL GOVERNMENT NEXUS

Medicare

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Nearly 130 years ago, Utah became the 45th state in the nation. This long battle for statehood set in motion a beneficial and, at times, tumultuous relationship between the U.S. government and the Beehive State. Among other national contributions, Utah settled vast acreages of land, led out on women's suffrage, provided raw materials, served as the connection point for the transcontinental railroad, supported two World Wars, and, more recently, emerged as one of the nation's most successful and dynamic economies. As the federal government reinvents itself through significant policy changes and cost-cutting measures, decision-makers will benefit from a data summary of the key economic linkages between Utah and the federal government. This data summary presents the Utah-federal government nexus for Medicare, the federal health insurance program serving nearly half a million older adults and individuals with disabilities in Utah.

Size and Composition

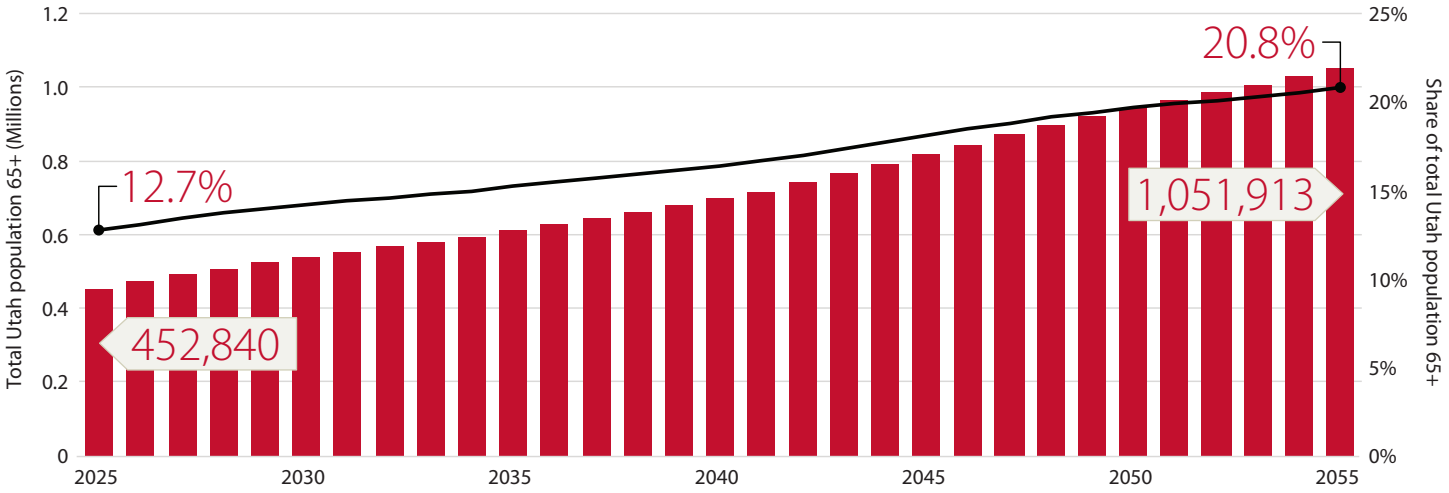
Medicare provides federal health insurance for adults age 65 and older, as well as younger individuals with disabilities or certain health conditions. The program provides health insurance coverage to nearly half a million Utahns and represents the largest source of federal health care funds flowing into the state (an estimated $6 billion in 2024).[1]

Utah's Medicare enrollment more than doubled since 2000, increasing from approximately 206,000 beneficiaries to nearly 490,000 in 2026. As Utah's population ages, Medicare enrollment could more than double, exceeding 1 million within the next three decades (Figure 1).[2]

The federal government solely funds Medicare, with program administration handled by the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services. These federal dollars support hospitals, physician practices, clinics, pharmacies, home health agencies, behavioral health providers, and other health care organizations across the state.

Medicare funding comes primarily from federal general revenue (government contributions), payroll taxes paid by employers and workers, and premiums paid by Medicare beneficiaries (Figure 2). Other sources include Social Security benefit taxes, state payments, and interest payments.

Figure 1: Projected Number and Share of Utah's Population Age 65+, 2025–2055



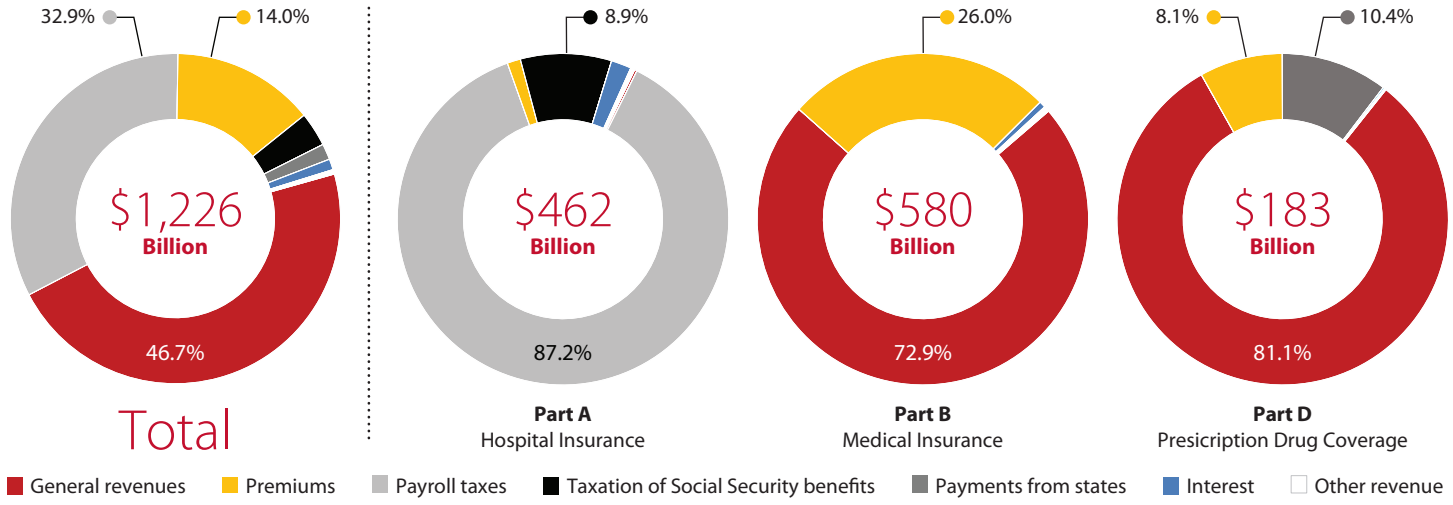
Note: Medicare primarily serves adults age 65 and older, although younger individuals with qualifying disabilities or certain medical conditions may also be eligible.
Source: Kem C. Gardner Policy Institute, 2065 Long-Term Planning Projections

Medicare's share of total U.S. health care spending has increased over time, with projections showing the share to continue to grow from 21.2% in 2025 to 26.2% by 2034 (Figure 3). Average Medicare spending per beneficiary also increased from about $8,300 per beneficiary in 2014 to $12,500 in 2025.[3,4]

Medicare beneficiaries receive benefits through Original Medicare or private Medicare Advantage plans (Table 1). Both coverage options provide the same core Medicare benefits but differ in how they administer services, structure provider access, and manage beneficiary costs.

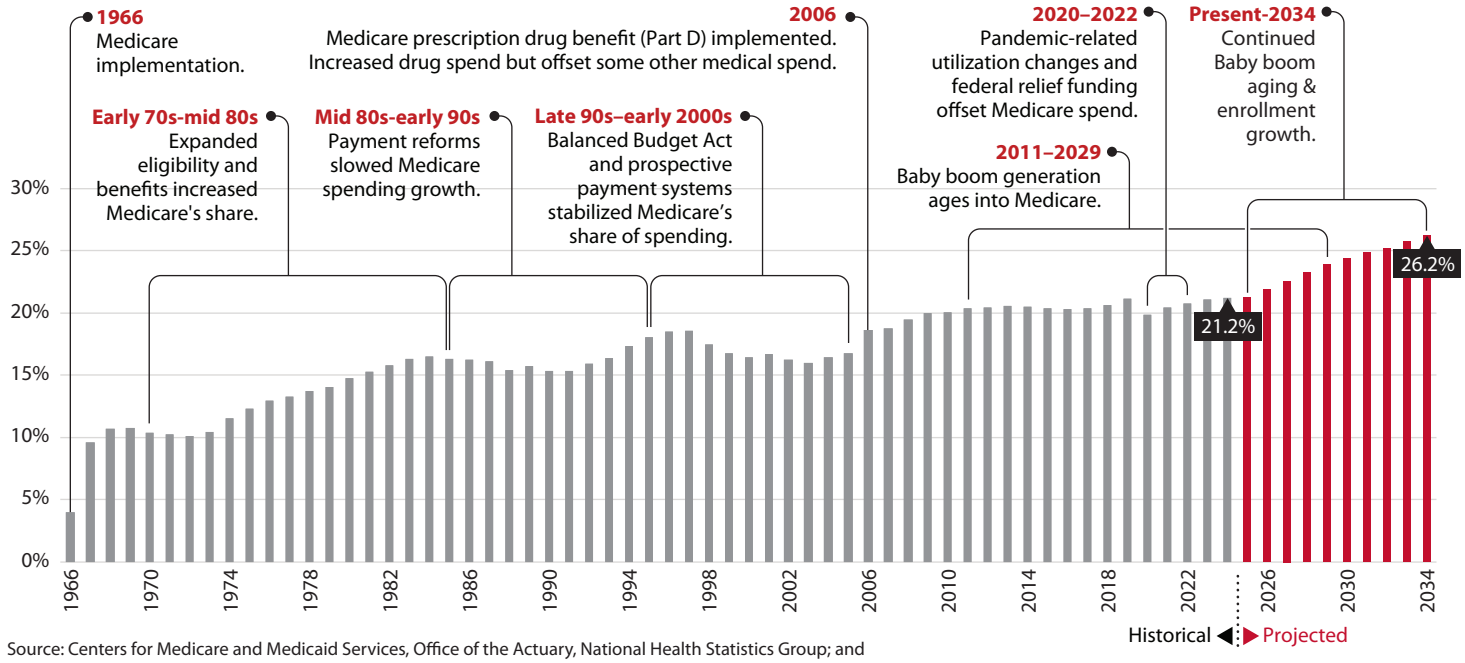
CMS administers Original Medicare directly. It provides beneficiaries with nationwide access to Medicare-participating providers. Private insurers administer Medicare Advantage plans, which establish provider networks, determine plan-specific cost-sharing requirements, and frequently include prescription drug coverage and supplemental benefits. These and other differences (Table 2) create tradeoffs for beneficiaries that impact provider access, prior authorization for services, supplemental benefits, out-of-pocket limits, and other cost-sharing approaches.

Figure 2: National Medicare Funding by Source, 2025



Note: See table 1 for more information about Medicare Parts.
Source: 2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

Figure 3: National Medicare Expenditures as a Share of Total National Health Expenditures, 1966–2034 (Projected)



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Census Bureau

Table 1: Medicare Parts, Covered Benefits, and Funding Flows

Medicare Part	Covered Benefits	Original Medicare	Medicare Advantage (Part C)
Part A Hospital Insurance	Inpatient hospital care, skilled nursing facility care, hospice, and limited home health services	Medicare pays Part A service providers directly from the Hospital Insurance (HI) Trust Fund.	CMS pays Medicare Advantage plans using funds from the Hospital Insurance (HI) Trust Fund. Plans then reimburse providers at negotiated rates.
Part B Medical Insurance	Physician services, outpatient care, preventive services, durable medical equipment, and many home health services	Medicare pays Part B service providers directly from the Supplementary Medical Insurance (SMI) Trust Fund, which is financed through general federal revenues and beneficiary premiums.	CMS pays Medicare Advantage plans using funds from the SMI Trust Fund. Plans then reimburse providers at negotiated rates.
Part D Prescription Drug Coverage	Outpatient prescription drug coverage	Stand-alone Part D plans receive payments from the SMI Trust Fund, beneficiary premiums, and other federal subsidies to administer prescription drug coverage.	Medicare Advantage plans that include prescription drug coverage (MA-PDs) receive Part D payments from the SMI Trust Fund, beneficiary premiums, and other federal subsidies.

Source: Centers for Medicare and Medicaid Services, 2025, November 19

Table 2: Original Medicare and Medicare Advantage Coverage and Cost Details

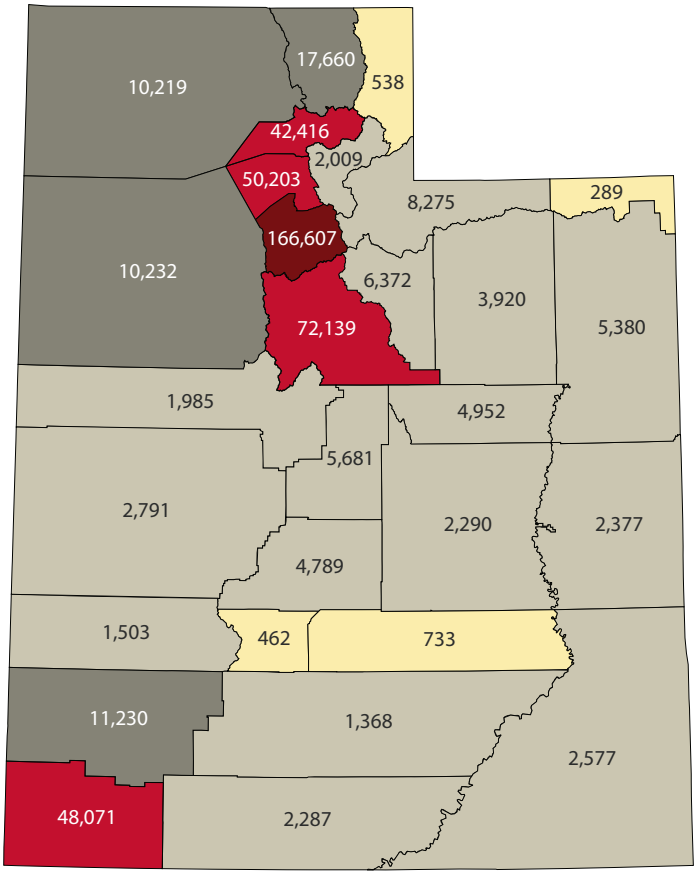
	Original Medicare	Medicare Advantage
Doctor and hospital choice	Medicare beneficiaries can receive covered services from any Medicare-participating provider nationwide. Medicare generally reimburses providers directly for covered services.	Medicare Advantage plans establish provider networks and reimburse participating providers at negotiated rates. Some plans cover out-of-network services, with higher beneficiary cost sharing.
	Specialists are accessible without a referral.	Medicare Advantage plans may require referrals for specialty care or prior authorization before accessing certain services.
Cost	Beneficiaries pay a monthly Part B premium but must purchase prescription drug coverage separately through a stand-alone Medicare Part D plan.	Beneficiaries pay the monthly Part B premium and may also pay a Medicare Advantage premium. Some plans have a $0 premium and may help beneficiaries pay for all or part of their Part B premium. Most plans include Medicare Part D prescription drug coverage.
	For Part B-covered services, beneficiaries usually pay 20% of the Medicare-approved amount after meeting their deductible. This 20% is called "coinsurance." Original Medicare does not include an annual limit on beneficiary out-of-pocket spending for covered services. Some beneficiaries choose to buy Medigap or use coverage from a current or former employer, union, or Medicaid to help pay for out-of-pocket costs and coinsurance.	Out-of-pocket costs vary by plan, with different out-of-pocket costs for certain services. Medicare Advantage plans include an annual limit on beneficiary out-of-pocket spending for covered services. These limits may differ for in-network and out-of-network services. Once the limit is reached, a beneficiary pays nothing for covered services for the remainder of the year.
Coverage	Covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare does not cover some services, like routine physical exams, eye exams, and most dental care. Original Medicare also does not cover long-term care that helps with activities of daily living, such as care provided in a nursing home or assisted living center.	Medicare Advantage plans are required to cover all medically necessary services covered by Original Medicare. Plans may also cover extra benefits such as vision, routine dental, and hearing care not covered by Original Medicare.
	Original Medicare does not require approval or prior authorization for services and supplies (in most cases).	Medicare Advantage plans may require beneficiaries to receive approval or prior authorization before the plan covers certain services or supplies.
	To access Medicare drug coverage (Part D), beneficiaries can join a separate Medicare drug plan.	Most Medicare Advantage plans also include Part D coverage.

Source: Compare Original Medicare and Medicare Advantage, Medicare.gov, July 2026

Location

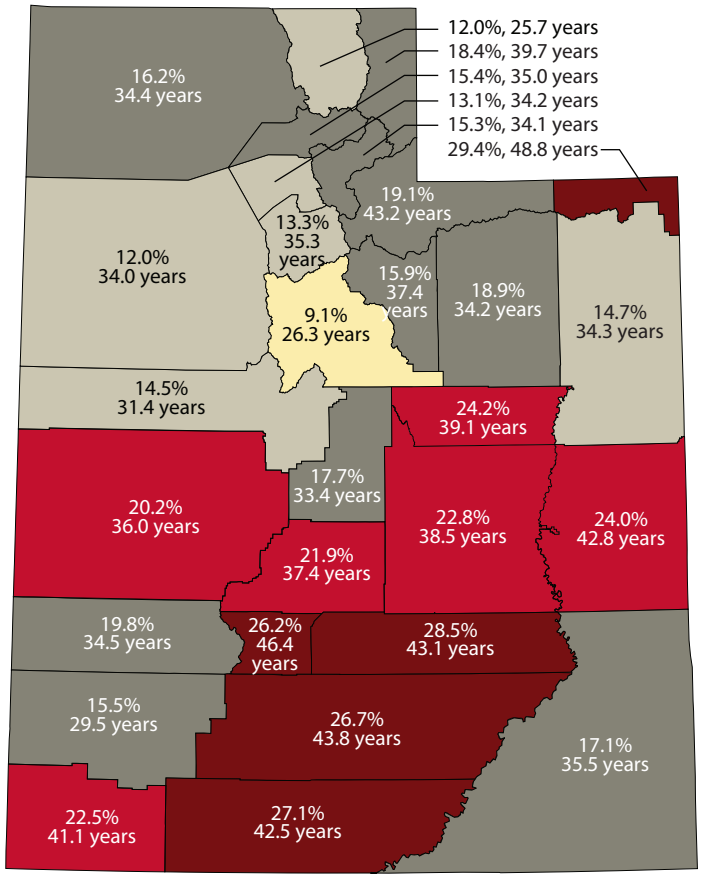
Medicare enrollment varies across Utah counties. Counties with larger populations generally exhibit the highest enrollment, with Salt Lake County home to over 34% of the state's Medicare population (Figure 4). When viewed as a share of each county's population, Medicare enrollment is highest in Daggett, Wayne, and Kane counties and lowest in Utah, Cache, and Tooele counties (Figure 5).

Figure 4: Number of Utah Medicare Beneficiaries by County, June 2026



Source: Centers for Medicare and Medicaid Services, Monthly Medicare Enrollment State/County/Plan Type, June 2026

Figure 5: Share of County Population Enrolled in Medicare (June 2026) and County Median Age (2025)



Source: Centers for Medicare and Medicaid Services, Monthly Medicare Enrollment State/County/Plan Type, June 2026. County population and median age estimates from Kem C. Gardner Policy Institute

Historical Context

Congress established Medicare in 1965 to provide health insurance coverage to older adults and certain individuals with disabilities. The program originally operated as a federal fee-for-service system that paid providers directly for covered services.

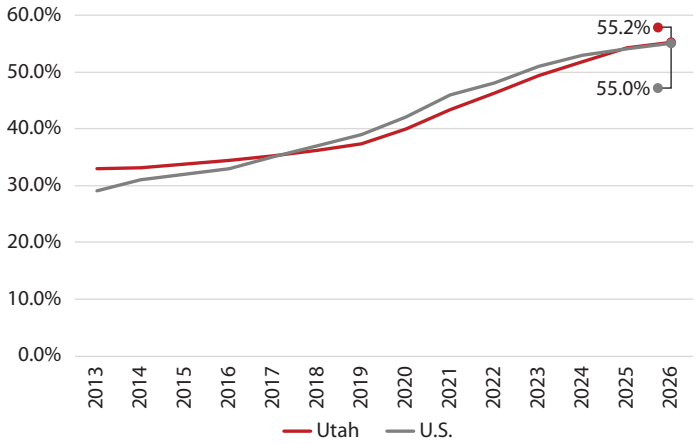
Over time, Congress expanded opportunities for beneficiaries to receive Medicare benefits through private health plans. The Balanced Budget Act of 1997 created Medicare Part C, allowing beneficiaries to enroll in private health plans as an alternative to Original Medicare.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 renamed Medicare Part C as Medicare Advantage. The law also created Medicare Part D prescription drug coverage.

Enrollment in Medicare Advantage plans increased steadily in both Utah and nationally since the creation of Medicare Advantage (Figure 6). More than half (55.2%) of Utah Medicare beneficiaries were enrolled in Medicare Advantage plans in 2026.

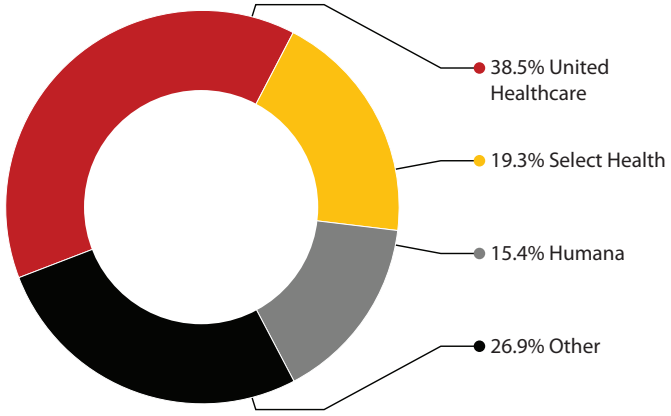
Several private insurers participate in Utah's Medicare Advantage market, although enrollment concentrates among a relatively small number of plans (Figure 7). UnitedHealthcare enrolls 38.5% of Utah Medicare Advantage beneficiaries, followed by Select Health (19.3%) and Humana (15.4%).

Figure 6: Medicare Advantage Enrollment as a Share of Total Medicare Enrollment, 2013–2026



Source: U.S. data from KFF analysis of CMS Medicare Advantage Enrollment Files, 2013–2026. Utah data from KFF analysis (2013–2024) and Gardner Institute analysis (2025–2026) of Centers for Medicare and Medicaid Services, State/County Penetration Medicare Advantage files

Figure 7: Utah Medicare Advantage Plan Market Share, June 2026



Source: Centers for Medicare and Medicaid Services MA Monthly Enrollment State/County/Contract files, June 2026

Impact on Utah's Economy

Impact from Federal Dollars

Medicare represents one of the largest federal investments in Utah's health care system. Federal Medicare spending totaled an estimated $6 billion in Utah in 2024, supporting health care services for nearly half a million beneficiaries.

These federal dollars flow throughout Utah's economy. Medicare reimburses hospitals, physician practices, pharmacies, skilled nursing facilities, home health agencies, behavioral health providers, and other health care organizations that provide services to Medicare beneficiaries.

The program also supports employment across Utah's health care sector while generating additional economic activity throughout the state. For example, each dollar spent on health care services in Utah generates an estimated $2.16 in economic activity, compared with $2.03 across all Utah industries.[5]

Impact from Utah's Aging Population

As Utah's population continues to age, Medicare will account for a growing share of health care coverage, payments, and federal health care dollars flowing into the state.

Population growth among older adults will also increase the number of Utahns living with chronic health conditions, further increasing demand for health care services.

Assuming current prevalence rates remain constant, the number of Utah adults age 65 and older living with conditions such as arthritis, diabetes, heart conditions, and cancer could more than double by 2055 (Table 3).

Impact on Provider Payments

As the population ages, Utah's health care system will shift to more Medicare reimbursement. This reimbursement shift could impact provider payments as more services will be paid at Medicare rates rather than higher commercial rates. Nationally, commercial health insurers pay an average of 150%–250% more than what Original Medicare pays for the same hospital services.[6,7] As a result, total provider payments could decrease, or providers and health systems could increase rates for other populations and services to offset the decline. The size of this effect will depend partly on Medicare Advantage. Medicare Advantage plans negotiate their own payment rates with hospitals and physicians, and these rates can differ from Original Medicare rates.

Given Medicare's large, and growing, role in Utah's health care system, changes in federal Medicare policy—including adjustments to payment rates, covered benefits, and Medicare Advantage regulations—have implications for Utah beneficiaries, health care providers, insurers, and the state's broader health care economy.

Table 3: Projected Number of Utah Older Adults (Age 65+) with Select Chronic Conditions, 2024 to 2055

Chronic Conditions	Prevalence of chronic conditions for age 65+	Estimated number of adults age 65+ with chronic conditions			
	2024	2024	2035	2045	2055
Alzheimer's (2020)	10.0%	43,481	61,004	81,648	105,191
Arthritis	50.4%	219,145	307,461	411,505	530,164
Cancer (skin)	20.5%	89,136	125,058	167,378	215,642
Cancer (all other)	22.7%	98,702	138,479	185,341	238,784
Chronic Obstructive Pulmonary Disease (COPD)	8.1%	35,220	49,413	66,135	85,205
Diabetes	20.4%	88,702	124,448	166,562	214,590
Depressive Disorder	15.6%	67,831	95,166	127,371	164,098
Heart Conditions	20.2%	87,832	123,228	164,929	212,486
Kidney Disease	9.8%	42,612	59,784	80,015	103,087
Poor Oral Health	23.6%	102,616	143,970	192,689	248,251

Note: "Heart Conditions" includes adults who have ever suffered a stroke, from angina/coronary heart disease, and/or a heart attack. "Poor Oral Health" consists of adults aged 65+ who have lost six or more teeth due to tooth decay or gum disease. The estimated increase is solely a function of population growth and does not account for possible increases or decreases in the prevalence of chronic conditions over time that could result from changes in the health or demographics of the state's population, improvements in medical therapy, or the implementation of state or system level policies and programs that promote healthy behaviors.
Source: Kem C. Gardner Policy Institute analysis of Utah Behavioral Risk Factor Surveillance System data, Office of Public Health Assessment, Utah Department of Health and Kem C. Gardner Policy Institute, 2065 Long-Term Planning Projections

Key Concepts

- **Medicare** – Federal health insurance program for adults age 65 and older and younger individuals with disabilities or certain health conditions.
- **Original Medicare** – Traditional Medicare administered directly by the federal government. Includes Medicare Part A (hospital insurance) and Part B (medical insurance). Most beneficiaries do not pay a monthly premium for Part A if they have sufficient work history. Beneficiaries typically pay a monthly Part B premium and may also pay deductibles and coinsurance.
- **Medicare Advantage (Part C)** – Private health insurance plans approved by Medicare to administer Medicare Part A and Part B benefits on behalf of the federal government. Most plans also include Medicare Part D prescription drug coverage and may offer supplemental benefits. Beneficiaries continue to pay the monthly Part B premium and may also pay a Medicare Advantage plan premium, depending on the plan.
- **Medicare Part D** – Outpatient prescription drug coverage available through stand-alone prescription drug plans or as part of most Medicare Advantage plans.
- **Medigap** – Supplemental private insurance available to beneficiaries enrolled in Original Medicare. Beneficiaries purchase Medigap policies to help cover deductibles, coinsurance, copayments, and other out-of-pocket costs not paid by Original Medicare. Medigap policies require a separate monthly premium and cannot be used with Medicare Advantage.
- **Dual-eligible beneficiary** – An individual enrolled in both Medicare and Medicaid. Medicare generally serves as the primary payer, while Medicaid helps cover Medicare premiums, beneficiary cost sharing, and some additional services.
- **Hospital Insurance (HI) Trust Fund** – Federal trust fund that finances Medicare Part A benefits. The HI Trust Fund pays for Part A benefits under both Original Medicare and Medicare Advantage. Payroll taxes provide the primary funding for the HI Trust Fund.
- **Supplementary Medical Insurance (SMI) Trust Fund** – Federal trust fund that finances Medicare Part B and Part D benefits. The SMI Trust Fund pays for Part B and Part D benefits under both Original Medicare and Medicare Advantage. General federal revenues and beneficiary premiums, including the monthly Part B premium, provide the primary funding for the SMI Trust Fund.
- **Coinsurance** – The share of the cost of a covered health care service that a beneficiary pays after meeting their deductible.
- **Prior authorization** – A requirement that a health care provider must obtain Medicare Advantage plan approval for certain services, procedures, or medications. Benefit-related costs are only paid if the medical care has been pre-approved. Medicare Advantage plans may require prior authorization for some services, while Original Medicare generally does not. Prior authorization requirements vary by Medicare Advantage plan.
- **In-network provider** – A hospital, physician, or other health care provider that has contracted with a Medicare Advantage plan to provide covered services at negotiated rates.
- **Out-of-network provider** – A provider that does not participate in a Medicare Advantage plan's network. Coverage and beneficiary cost sharing for out-of-network services vary by plan, and some plans may not cover non-emergency out-of-network care.

Endnotes

1. This estimate applies CMS's standardized per-beneficiary Medicare spending to the total number of Medicare beneficiaries in Utah. CMS's standardized spending measure derives from Original Medicare claims and does not directly measure Medicare Advantage payments. As a result, this estimate assumes similar average federal spending per beneficiary across Original Medicare and Medicare Advantage enrollees. Source: Medicare Geographic Variation—by National, State & County, Centers for Medicare & Medicaid Services, 2024. Retrieved from: https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-geographic-comparisons/medicare-geographic-variation-by-national-state-county
2. Kem C. Gardner Policy Institute Long-Term Population Projections
3. Centers for Medicare and Medicaid Services. National health expenditure projections 2034. U.S. Department of Health and Human Services.
4. Beneficiary spending is not adjusted for inflation.
5. The $2.16 multiplier estimates total statewide economic output associated with each dollar paid for health care services. It reflects transactions among in-state health care providers, suppliers, workers, and households. This health care multiplier represents a weighted average of published multipliers for three industries—ambulatory health care services, hospitals, and nursing and residential care facilities. The average is weighted by the component industries' 2024 shares of total health care output in Utah. The $2.03 multiplier for all industries in the private sector is also a weighted average based on output. Source: U.S. Bureau of Economic Analysis, RIMS II statewide Type II final demand output multiplier; REMI PI+ economic model, output by industry.
6. Whaley, C. M., Kerber, R., Wang, D., and Kofner, A. (2024). Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative. Santa Monica, CA: RAND Corporation.
7. Congressional Budget Office. (2022). The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services. Washington, DC: Congressional Budget Office.

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