Spending trends in Medicare

Mark E. Miller, PhD
Executive Director
September 28, 2012
Medicare Payment Advisory Commission

- Independent, nonpartisan, Congressional support agency
- 17 national experts selected for expertise, not representation
- Appointed by Comptroller General for 3-year terms (can be reappointed)
- Make recommendations to the Congress and the Secretary of HHS
- Vote on recommendations in public
Outline

- Budget picture
- Overview of spending trends
- Primer on spending in Medicare
- Fiscal pressures and costs
Medicare is reliant on general revenues

Share of GDP

8%

Source: Board of Trustees, 2012 Report of the Hospital Insurance and Supplementary Medical Insurance Trust Funds.
The federal budget picture

- Federal debt doubled in the past 4 years
  - 36% of GDP in 2007 to 73% in 2012
- Social Security, Medicare, Medicaid, other health insurance programs and net interest will be more than 16 percent of GDP in ten years
  - Total federal spending has averaged 18.5 percent of GDP over the past 40 years
- Spending for all other parts of the budget (e.g., defense, education, food safety, transportation and homeland security) are capped by law over the next ten years
Historical trends in Medicare per beneficiary spending—1.3% faster than GDP per capita

Note: Cumulative growth since 1970.
Source: Centers for Medicare & Medicaid Services, National Health Expenditures, 2012.
Recent slowdown

<table>
<thead>
<tr>
<th>Year</th>
<th>Per beneficiary growth</th>
<th>Enrollment growth</th>
<th>Total Medicare spending growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970-2010</td>
<td>8.9%</td>
<td>2.1%</td>
<td>11.2%</td>
</tr>
<tr>
<td>2007</td>
<td>3.5%</td>
<td>2.1%</td>
<td>5.7%</td>
</tr>
<tr>
<td>2008</td>
<td>5.8%</td>
<td>2.6%</td>
<td>8.5%</td>
</tr>
<tr>
<td>2009</td>
<td>6.1%</td>
<td>2.4%</td>
<td>8.7%</td>
</tr>
<tr>
<td>2010</td>
<td>0.4%</td>
<td>2.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>2011</td>
<td>2.9%</td>
<td>2.1%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

2012-2021, current law (SGR)

<table>
<thead>
<tr>
<th>Year</th>
<th>Per beneficiary growth</th>
<th>Enrollment growth</th>
<th>Total Medicare spending growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2021</td>
<td>3.1%</td>
<td>2.9%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

2012-2021, annual physician update of 1%

<table>
<thead>
<tr>
<th>Year</th>
<th>Per beneficiary growth</th>
<th>Enrollment growth</th>
<th>Total Medicare spending growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-2021</td>
<td>3.8%</td>
<td>2.9%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

Note: Current law assume a 27% cut in physician payments in 2013.
Source: 2012 Trustees Report, Tables VB1 and VB3
Evidence of a sustained trend?

- Medicare
  - Some sectors show evidence of slowdown in use
  - In 2009 and 2010, physician volume growth slowed, 2011 and 2012 trend unclear

- Private sector
  - Most sources indicate private and public slowdown in use in 2009 and 2010
  - 2011 and 2012 less clear, some increases
  - Some analysts find slowdown pre-dates recession

- CBO and Medicare actuaries assume economic recovery will increase spending, but not to historical highs
Summary

- Past Medicare spending trends
  - Per beneficiary growth faster than GDP
- Near-term Medicare projections
  - Beneficiary growth and per beneficiary growth contribute about equally
  - Recent slowdown in both Medicare and private health care spending
  - Persistence of slowdown unclear
Components of Medicare spending growth

Medicare spending = Beneficiaries x number of services x price per service

- Users per beneficiary
- Number of services: volume and intensity
- Prices: generally set administratively in Medicare (exceptions: Parts C and D)
Utilization: Because of volume growth, physician spending has increased faster than input prices and updates.

Note: MEI (Medicare Economic Index).
Utilization: growth in the volume of physician services per beneficiary

Note: E&M (evaluation and management). Volume growth for E&M and all services is through 2009 only due to change in payment policy for consultations.
Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.
### Utilization trends in other sectors

<table>
<thead>
<tr>
<th>Total FFS spending in 2010</th>
<th>Utilization, average annual growth rate (note differences in time periods)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital</td>
<td>$116 billion Inpatient discharges per beneficiary, 2004-2010 -1.0%</td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td>$37 billion Outpatient services per beneficiary, 2004-2010 4.2%</td>
</tr>
<tr>
<td>SNF</td>
<td>$26 billion SNF covered days, 2006-2010 2.4%</td>
</tr>
<tr>
<td>Home health</td>
<td>$19 billion Home health episodes per beneficiary, 2002-2010 6.3%</td>
</tr>
<tr>
<td>Hospice</td>
<td>$13 billion Beneficiaries in hospice, 2000-2009 8.7%</td>
</tr>
<tr>
<td>Part D</td>
<td>$56 billion Average prescription use per Part D beneficiary, 2007-2009 2.8%</td>
</tr>
</tbody>
</table>

Sources: MedPAC 2012 Report to Congress on Medicare payment policy, 2012 databook
“Cost shift” argument

- The “cost shift” argument assumes that costs are fixed
- Negative Medicare margins indicate that Medicare payments are inadequate
- Providers shift costs to private insurers to make up for the shortfall
MedPAC hypothesis: costs are associated with revenues

Substantive financial resources → High cost structure → Lower Medicare margins

Limited financial resources → Low cost structure → Higher Medicare margins
Hospitals under financial pressure tend to keep their costs down

<table>
<thead>
<tr>
<th>Financial pressure</th>
<th>2004 to 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High pressure*</td>
</tr>
<tr>
<td>Number of hospitals</td>
<td>756</td>
</tr>
<tr>
<td>Relative 2009</td>
<td>92%</td>
</tr>
<tr>
<td>standardized cost</td>
<td></td>
</tr>
<tr>
<td>per discharge</td>
<td></td>
</tr>
<tr>
<td>2009 overall</td>
<td></td>
</tr>
<tr>
<td>Medicare margin</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

* High pressure hospitals have a non-Medicare margin <1% and stagnant or falling net worth.
**Low pressure hospitals have a non-Medicare margin >5% and growing net worth.
Effects of provider power

- Market power leads to higher private prices and to higher costs
- Other evidence:
  - Melnick (Health Affairs, 2011)
  - Robinson (Health Affairs, 2011)
  - Ginsburg (Health System Change, 2010)
Summary

- Medicare FFS must focus on both the prices it pays and managing utilization
- Market consolidation of providers appears to be related to higher private sector prices and to higher costs
- MedPAC: Costs are not immutable
  - Fiscal pressure on prices can constrain costs
  - Some providers consistently constrain costs and deliver high quality
Utilization: Recent changes in the volume of imaging services are small relative to large increases during the past decade.

Note: Nuclear medicine includes positron emission tomography (PET).
Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.