Context for Medicare payment policy

Maggie Herman and Jennifer Podulka

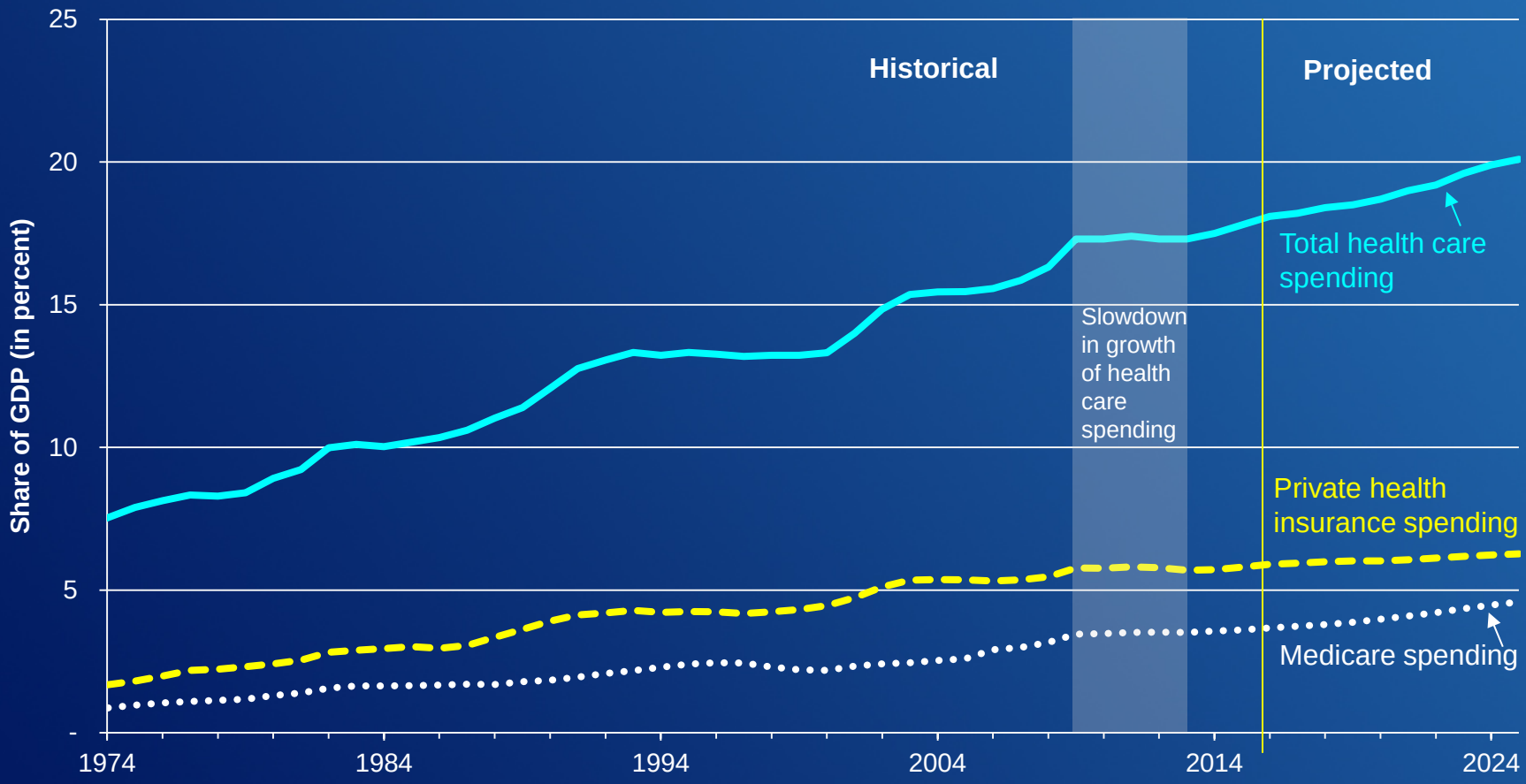
September 8, 2016

MEDPAC

Today's presentation

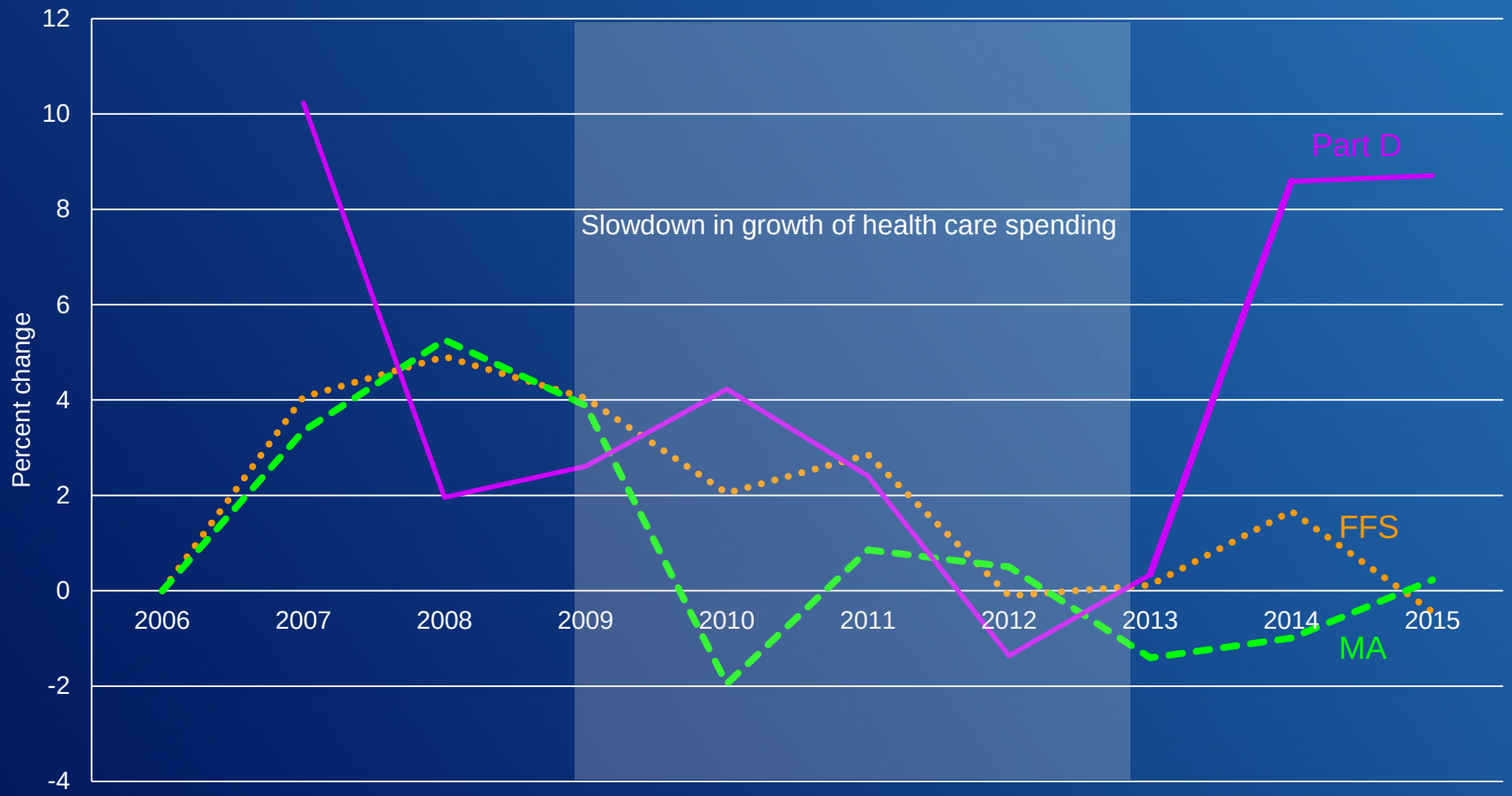
- Health care spending growth and recent slowdown
- Medicare spending trends in detail
- Medicare spending projections
- Medicare's effect on the federal budget
- Future Medicare beneficiaries and burden of Medicare and health care spending on households
- Evidence of inefficient spending and challenges faced by Medicare

Recent historically low growth rates of health care spending have begun to gradually increase



Source: MedPAC analysis of National Health Expenditure Accounts from CMS, historical data released December 2015, projected data released July 2016.

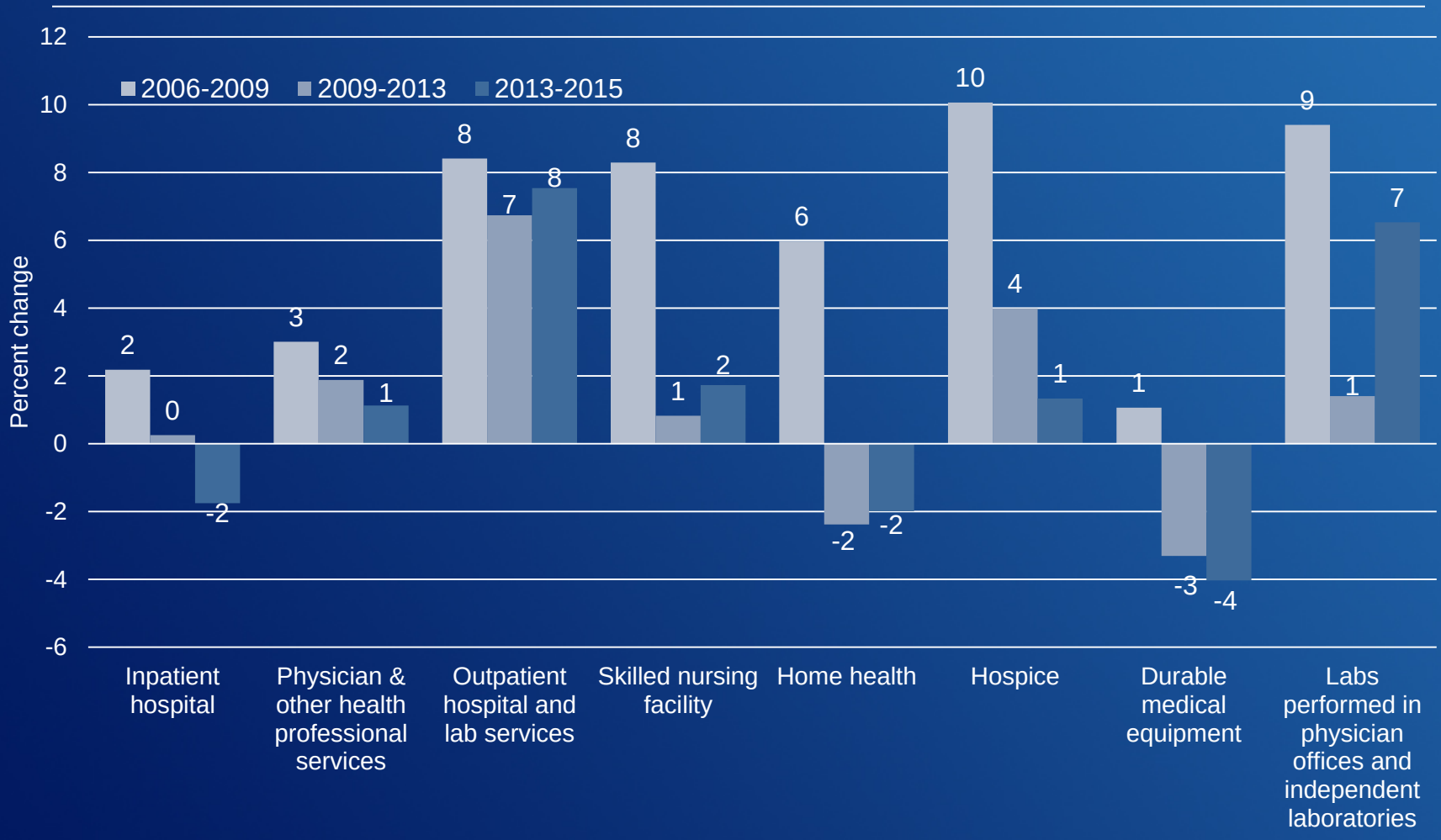
Year-to-year change in per beneficiary Medicare spending, 2006–2015



Note: FFS (fee-for-service), MA (Medicare Advantage). Part D annual change for 2006 is not shown because the program began in 2006.
Source: 2016 annual report of the Boards of Trustees of the Medicare trust funds.

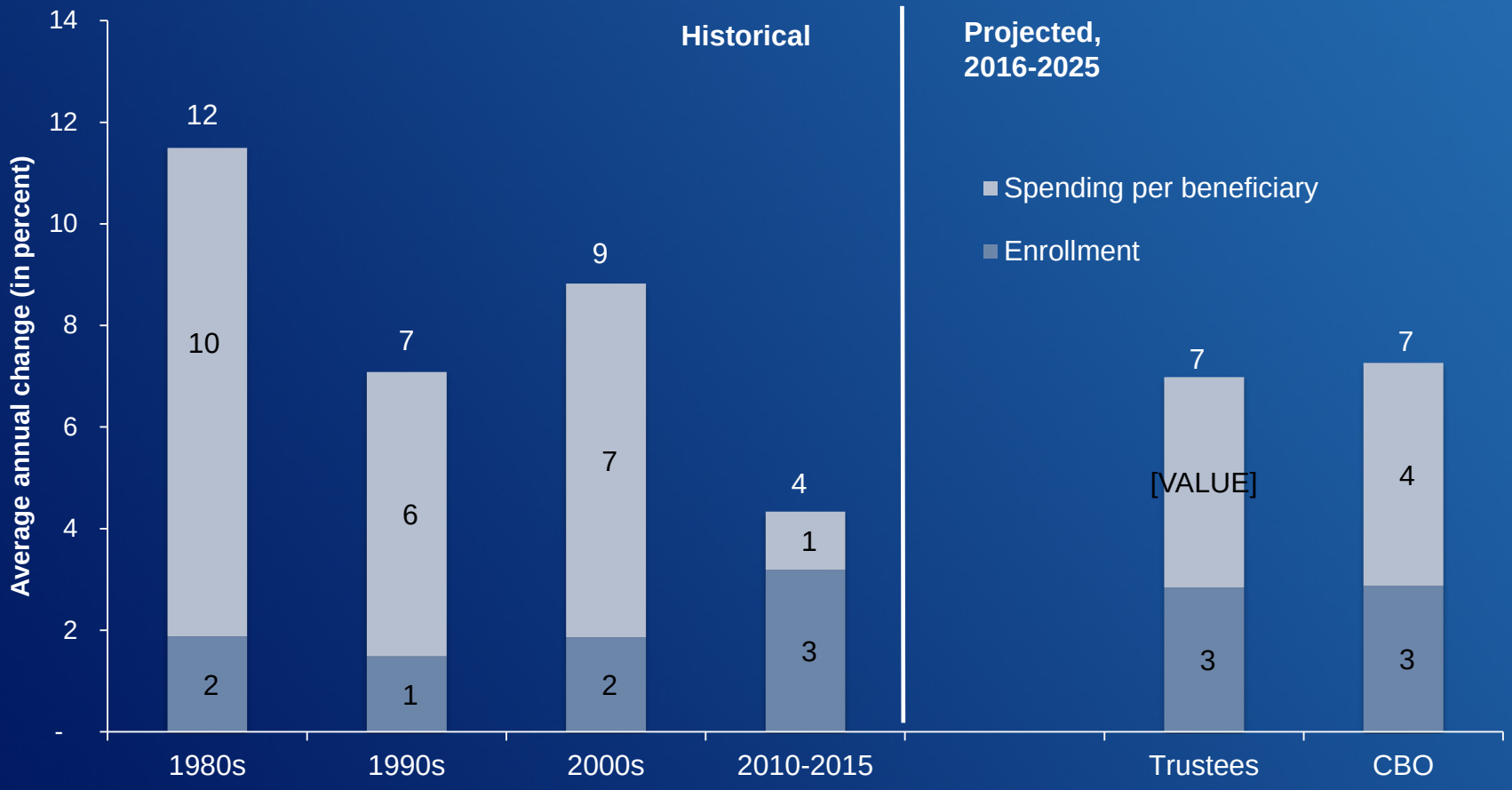
MEDPAC

Per beneficiary spending growth remained high in some FFS settings despite slowdown



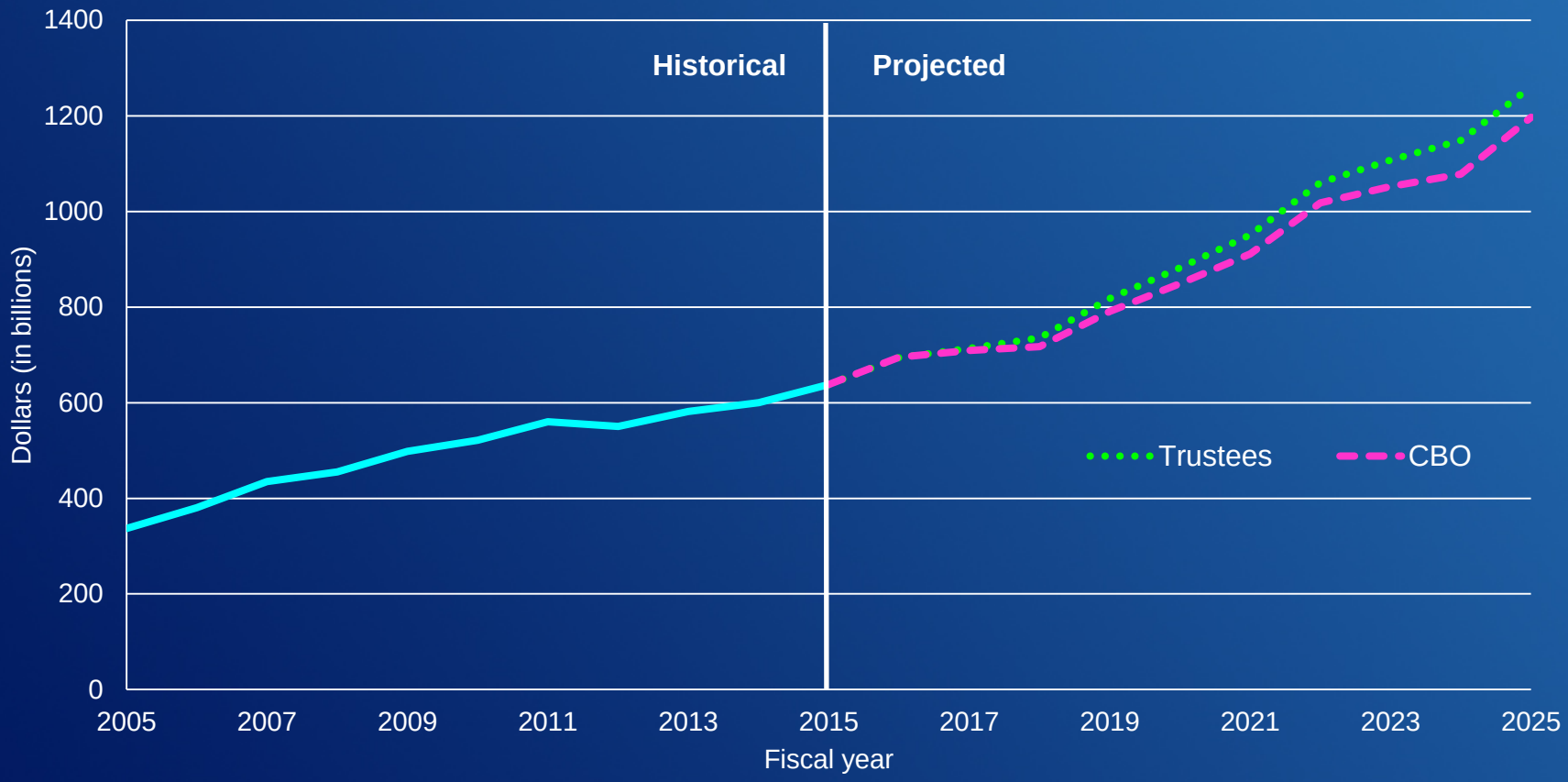
Note: FFS (fee-for-service). Outpatient hospital services and outpatient lab services are combined in the figure because a large portion of outpatient laboratory services were bundled into the outpatient prospective payment system effective January 1, 2014.
Source: 2016 annual report of the Boards of Trustees of the Medicare trust funds.

Per beneficiary spending growth and total Medicare spending growth projected to rise



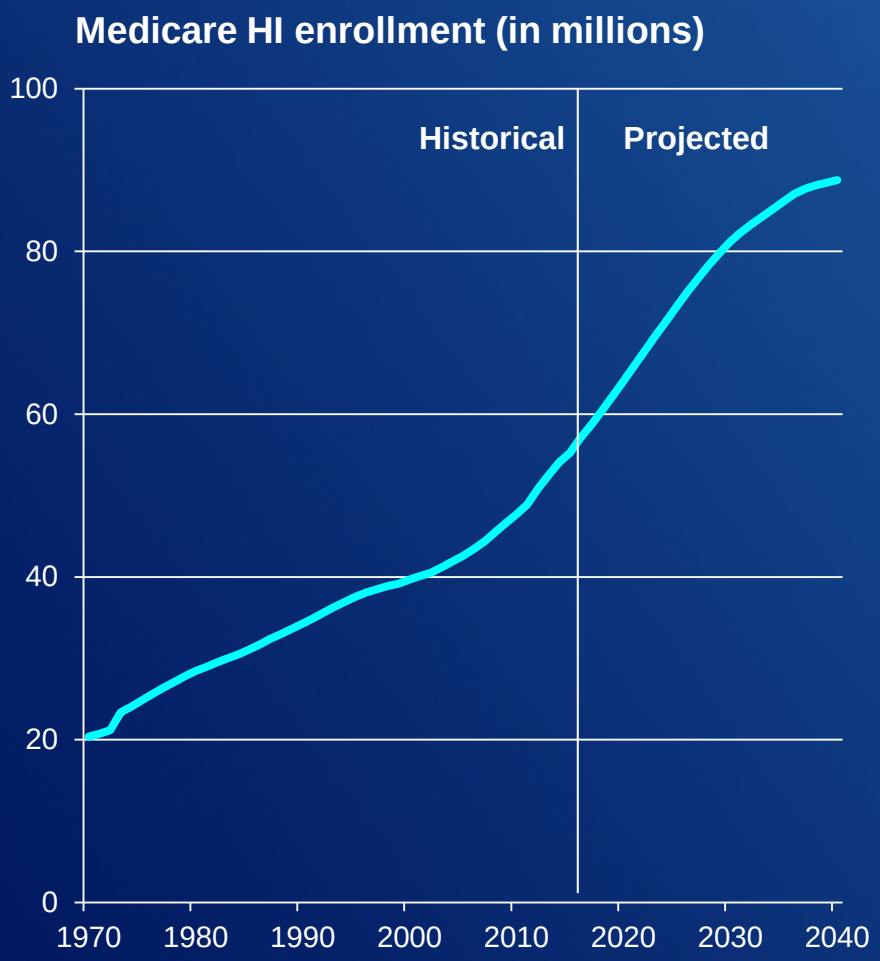
Note: CBO (Congressional Budget Office).
Source: 2016 annual report of the Boards of Trustees of the Medicare Trust Funds and CBO report Updated Budget Projections: for selected programs 2015 to 2025, released March 2016.

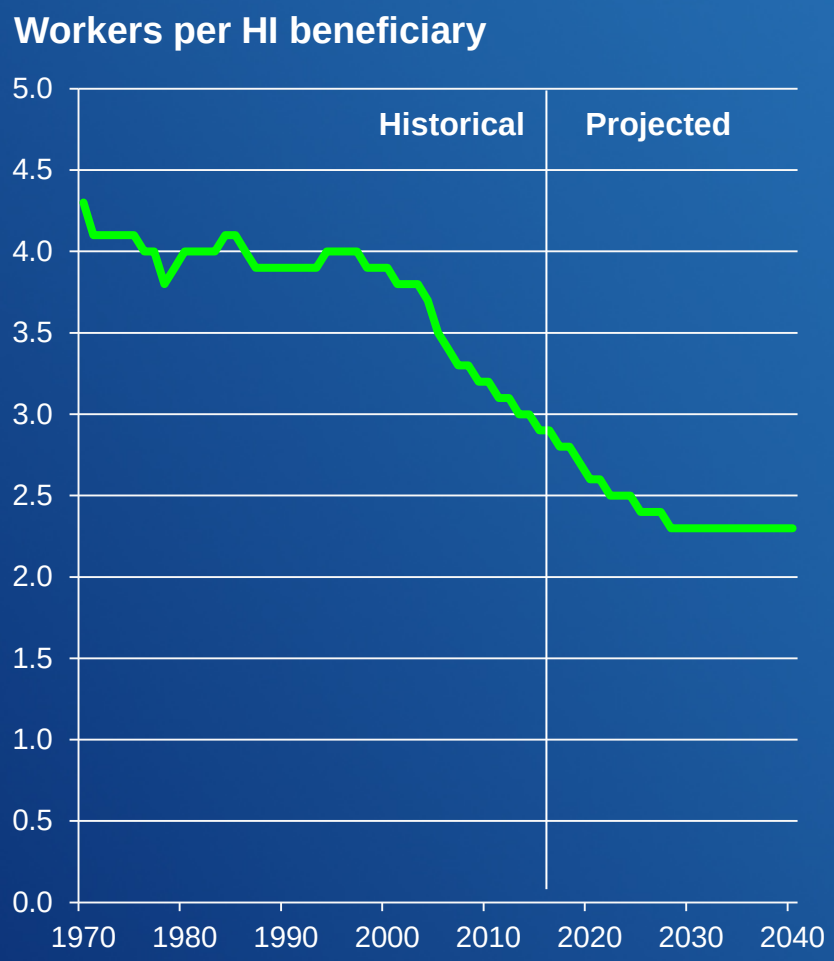
Trustees and CBO project Medicare spending to reach 1 trillion dollars by 2022



Note: CBO (Congressional Budget Office).
Source: 2016 annual report of the Boards of Trustees of the Medicare Trust Funds and CBO updated budget projections for selected programs 2015 to 2025 released in March 2016

Medicare enrollment projected to grow rapidly while workers per HI beneficiary decline



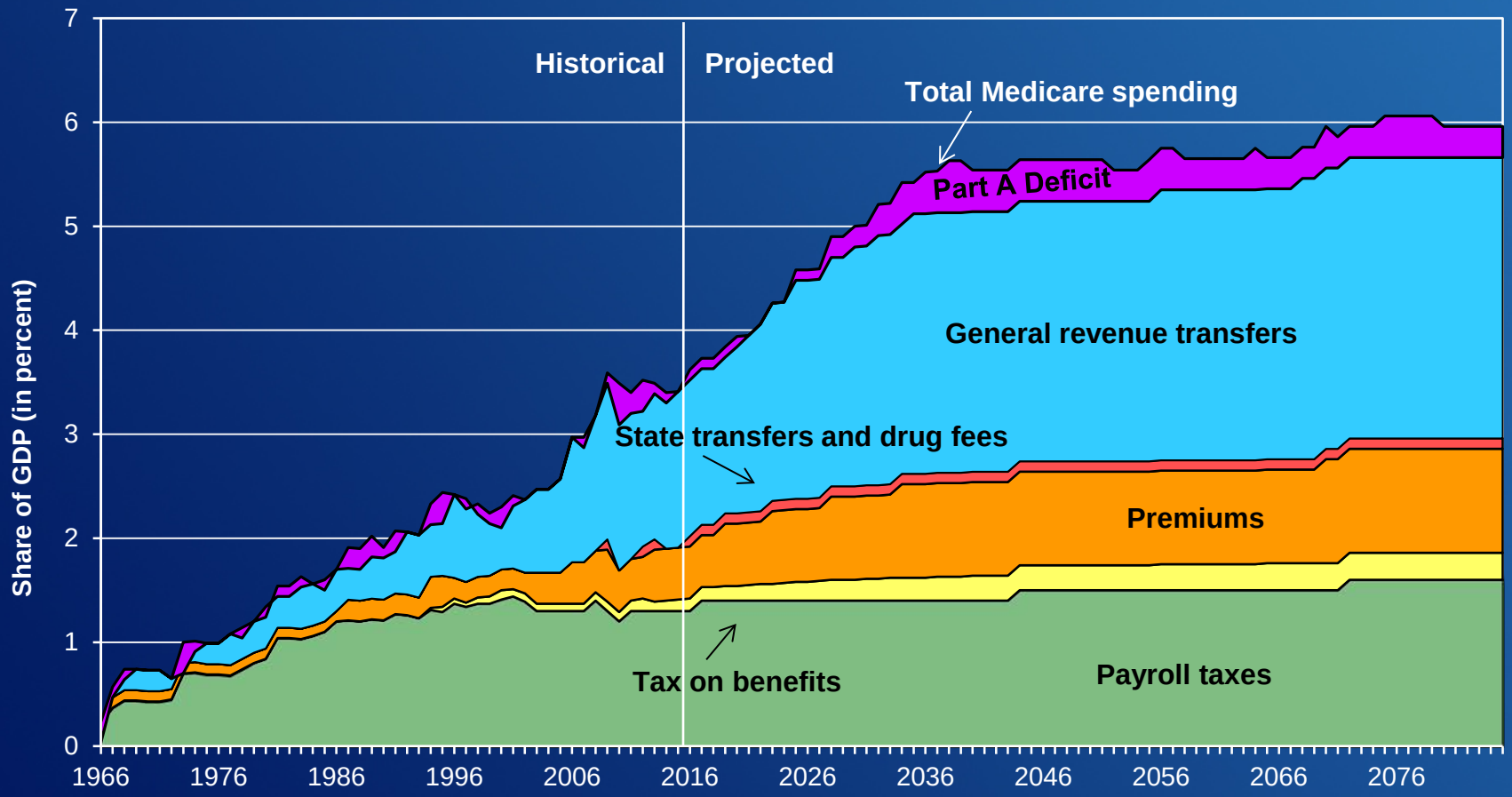


Note: HI (Hospital Insurance).
Source: 2016 annual report of the Boards of Trustees of the Medicare Trust Funds

Medicare Trust Funds and their shares of total spending

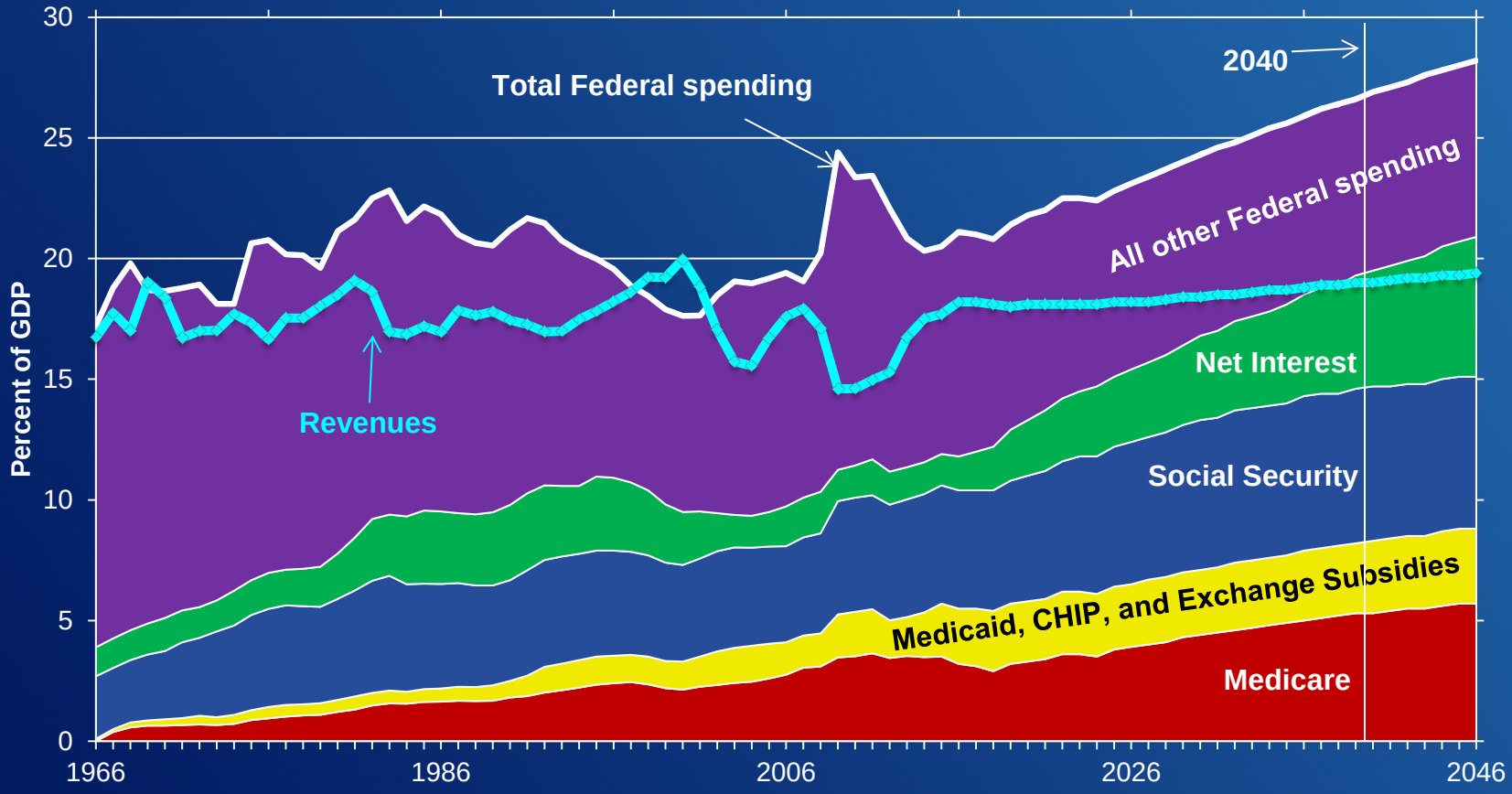
- Hospital Insurance (HI) Trust Fund (43%)
  - Part A – inpatient hospital stays, skilled nursing facility
  - Financed by payroll tax
  - Insolvent in 2028 (projection)
- Supplementary Medical Insurance (SMI) Trust Fund (57%)
  - Part B – physician, hospital outpatient departments
  - Part D – prescription drug coverage
  - Financed by general tax revenues ($^{3}/_{4}$) and premiums ($^{1}/_{4}$)
  - Solvency not an issue for SMI Trust Fund

General revenue paying for growing share of Medicare spending



Note: GDP (Gross domestic product).
Source: 2016 annual report of the Boards of Trustees of the Medicare Trust Funds

Spending on Medicare, other major health programs, Social Security, and net interest is projected to exceed total federal revenues in 25 years (by 2040)



Note: GDP (gross domestic product), CHIP (Children's health insurance program).
Source: Congressional Budget Office 2015.

Future Medicare beneficiaries

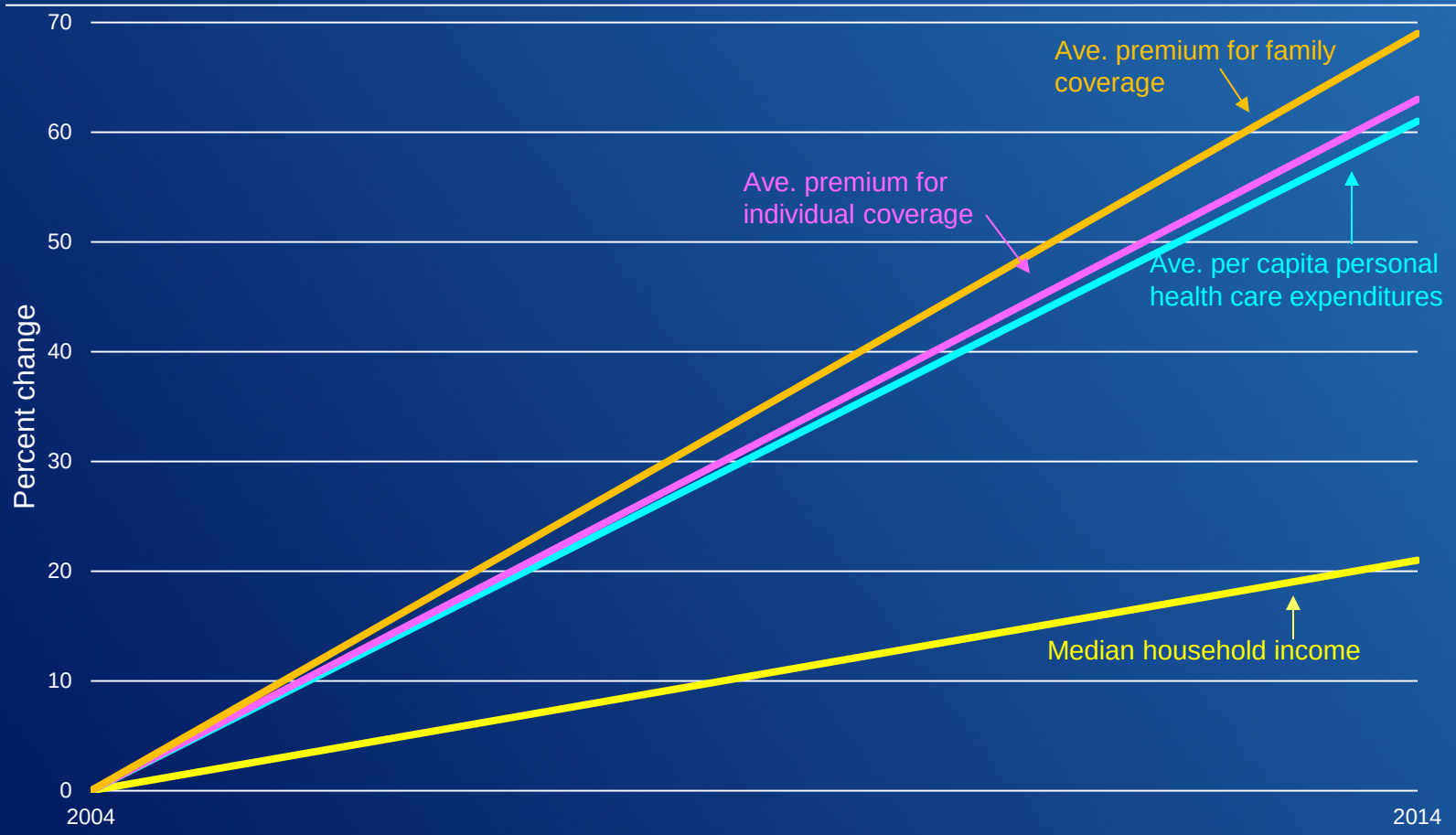
- Health status of 50–64 year olds in 2014 compared to their predecessors:
  - + Smoke 50% less,
  - – 55% higher prevalence of diabetes,
  - – 25% higher prevalence of obesity, and
  - – 9% lower prevalence of very good or excellent health status
  - ≈ higher rates of some diseases and chronic conditions, but more likely under control

Burden of out-of-pocket Medicare spending on households

- New Medicare beneficiaries may be less financially secure than their predecessors
  - In 2014, 55–64 year olds' real median household income had fallen 4% over the decade
  - In 2013, 55–64 year olds' real median family net worth had fallen 42% over the previous 6 years
- Out-of-pocket costs for Medicare beneficiaries growing faster than Social Security benefits

Data are preliminary and subject to change

Burden of out-of-pocket health care spending on households



Note: Household income, health expenditures, and premiums all measured in nominal dollars. Average premiums for individual and family coverage are for employer-sponsored health insurance and include contributions from workers and employers.
Sources: MedPAC analysis of Census Bureau, Current Population Survey, Annual Social and Economic Supplements 2015, National Health Expenditure Accounts from CMS 2015, Kaiser Family Foundation and Health Research & Educational Trust 2015.

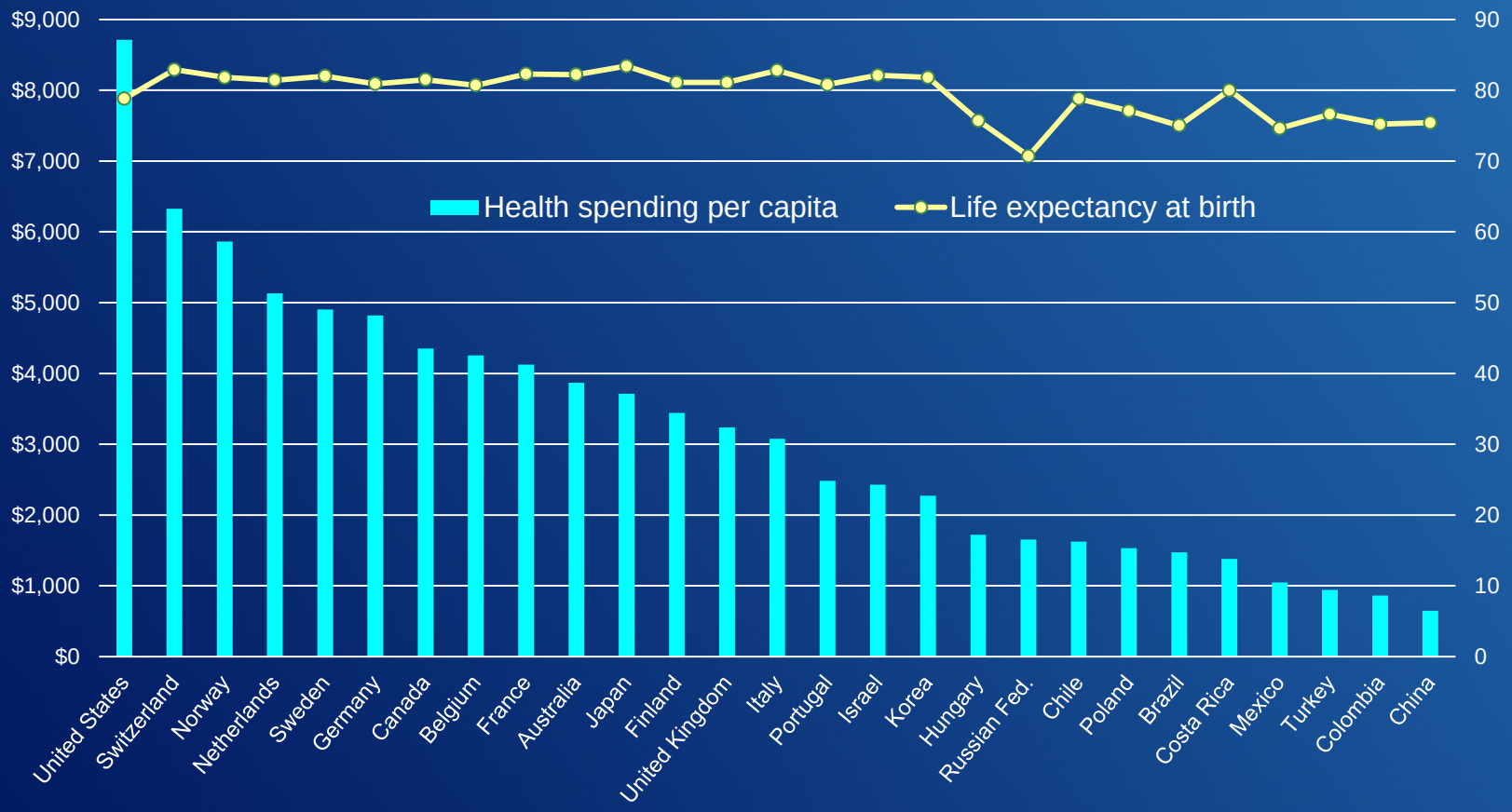
The Independent Payment Advisory Board (IPAB)

Who?	15 appointed expert advisors
What?	IPAB would have broad authority to propose Medicare payment policies to reduce Medicare spending growth
When?	The IPAB process is triggered in a year that the Medicare actuaries determine that projected Medicare spending growth exceeds a specified target.
And Then?	The IPAB (or Secretary's) savings proposal automatically becomes law unless Congress acts under specified circumstances and within a set time period. Congress' alternative must produce at least as much savings.

Evidence of health care inefficiency and misspending

- Geographic variation
  - Higher use ≠ improved patient outcomes
  - Low-value services continue to be performed
- International comparison
  - U.S. spends significantly more than any other country in the world
  - U.S. ranks poorly on indicators of efficiency and outcomes
  - Life expectancy has increased more slowly than in other OECD countries

Out of 44 OECD and related countries, the United States ranks first on health care spending but 28th on life expectancy, 2013



Note: OECD (Organisation for Economic Co-operation and Development). In addition to the 34 OECD countries, there are 10 candidate and key partner countries (Brazil, China, Colombia, Costa Rica, India, Indonesia, Latvia, Lithuania, the Russian Federation, and South Africa). Selected OECD and related countries shown. Health care spending data for Australia as of 2012. Life expectancy for Canada as of 2011.

Source: Organisation for Economic Co-operation and Development 2015.

MEDPAC

Medicare's challenges

- Fragmented payment system
- Limited tools to restrain fraud/overuse
- Benefit design
- Different prices across settings
- Undervalued and overvalued services

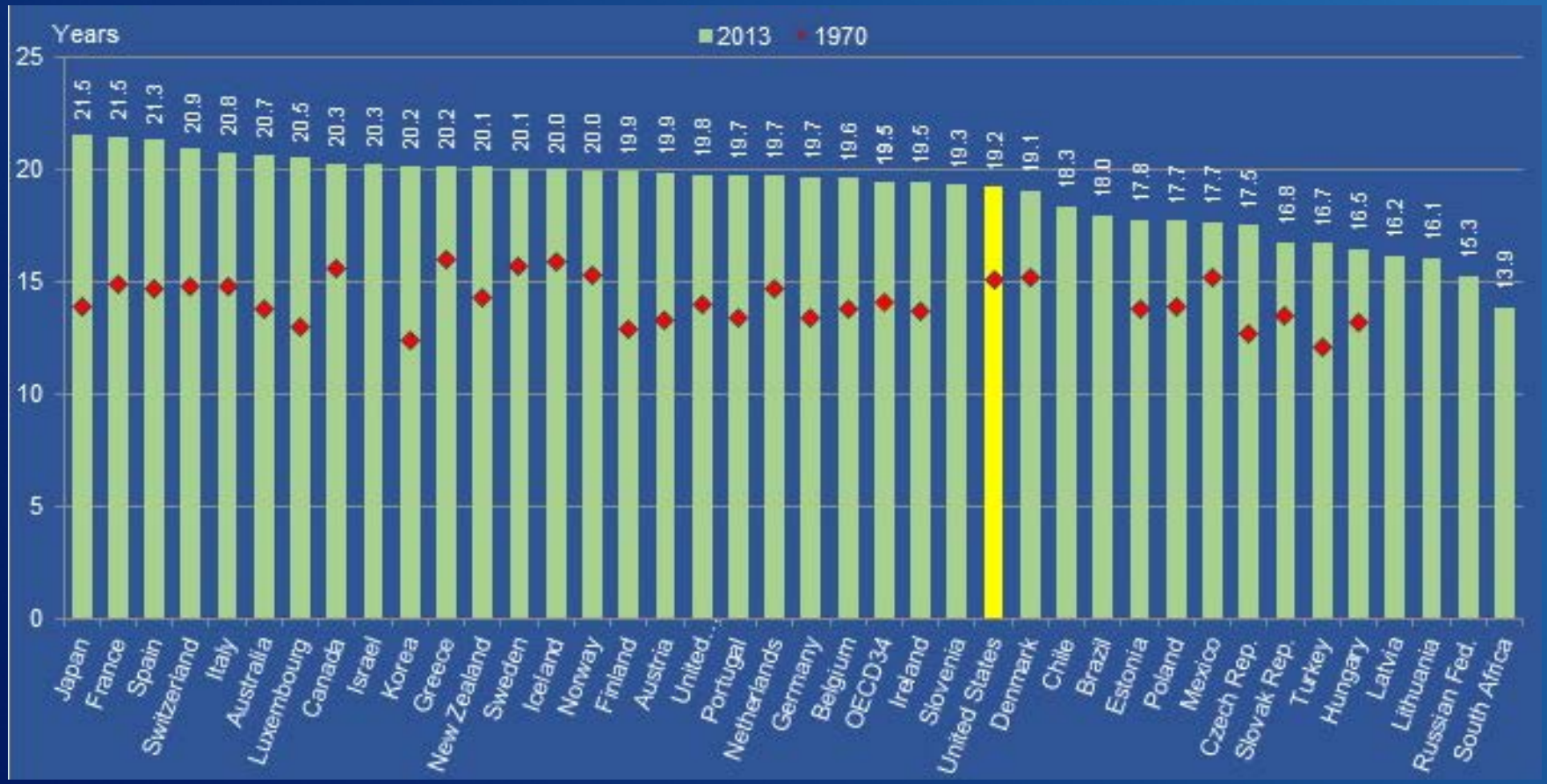
The Commission's approach to addressing challenges

- Payment accuracy and efficiency
- Quality and coordination
- Information for beneficiaries and providers
- Aligned health care workforce
- Engaged beneficiaries

Discussion

- Questions?
- Comments on scope, substance, or tone

Life expectancy at age 65 has increased less in the United States than in other OECD countries, 1970–2013



MEDPAC

Note: OECD (Organisation for Economic Co-operation and Development). Selected OECD countries shown. Life expectancy for Canada as of 1971 and 2011. Life expectancy for Finland as of 1971.

Source: Organisation for Economic Co-operation and Development 2015.

Leading causes of death at birth, 1980 and 2014

Cause of death, 1980	Percent of deaths	Cause of death, 2014	Percent of deaths
1. Heart disease	38.2	1. Heart disease	23.4
2. Cancer	20.9	2. Cancer	22.5
3. Stroke	8.6	3. Chronic lower respiratory diseases	5.6
4. Unintentional injuries	5.3	4. Unintentional injuries	5.2
5. Chronic obstructive pulmonary diseases	2.8	5. Stroke	5.1
6. Pneumonia and influenza	2.7	6. Alzheimer's disease	3.6
7. Diabetes	1.8	7. Diabetes	2.9
8. Chronic liver disease and cirrhosis	1.5	8. Influenza and pneumonia	2.1
9. Atherosclerosis	1.5	9. Nephritis, nephrotic syndrome, and nephrosis	1.8
10. Suicide	1.4	10. Suicide	1.6

Source: National Center for Health Statistics 2016.

Data are preliminary and subject to change.

Leading cause of death at age 65, 1980 and 2014

Cause of death, 1980	Percent of deaths	Cause of death, 2014	Percent of deaths
1. Heart disease	44.4	1. Heart disease	25.5
2. Cancer	19.3	2. Cancer	21.5
3. Stroke	10.9	3. Chronic lower respiratory diseases	6.5
4. Pneumonia and influenza	3.4	4. Stroke	5.9
5. Chronic obstructive pulmonary diseases	3.2	5. Alzheimer's disease	4.8
6. Atherosclerosis	2.1	6. Diabetes mellitus	2.8
7. Diabetes mellitus	1.9	7. Unintentional injuries	2.5
8. Unintentional injuries	1.9	8. Influenza and pneumonia	2.3
9. Nephritis, nephrotic syndrome, and nephrosis	1.0	9. Nephritis, nephrotic syndrome and nephrosis	2.1
10. Chronic liver disease and cirrhosis	0.7	10. Septicemia	1.5

Source: National Center for Health Statistics 2016.

Data are preliminary and subject to change.