Context for Medicare payment policy

Jennifer Podulka and Olivia Berci

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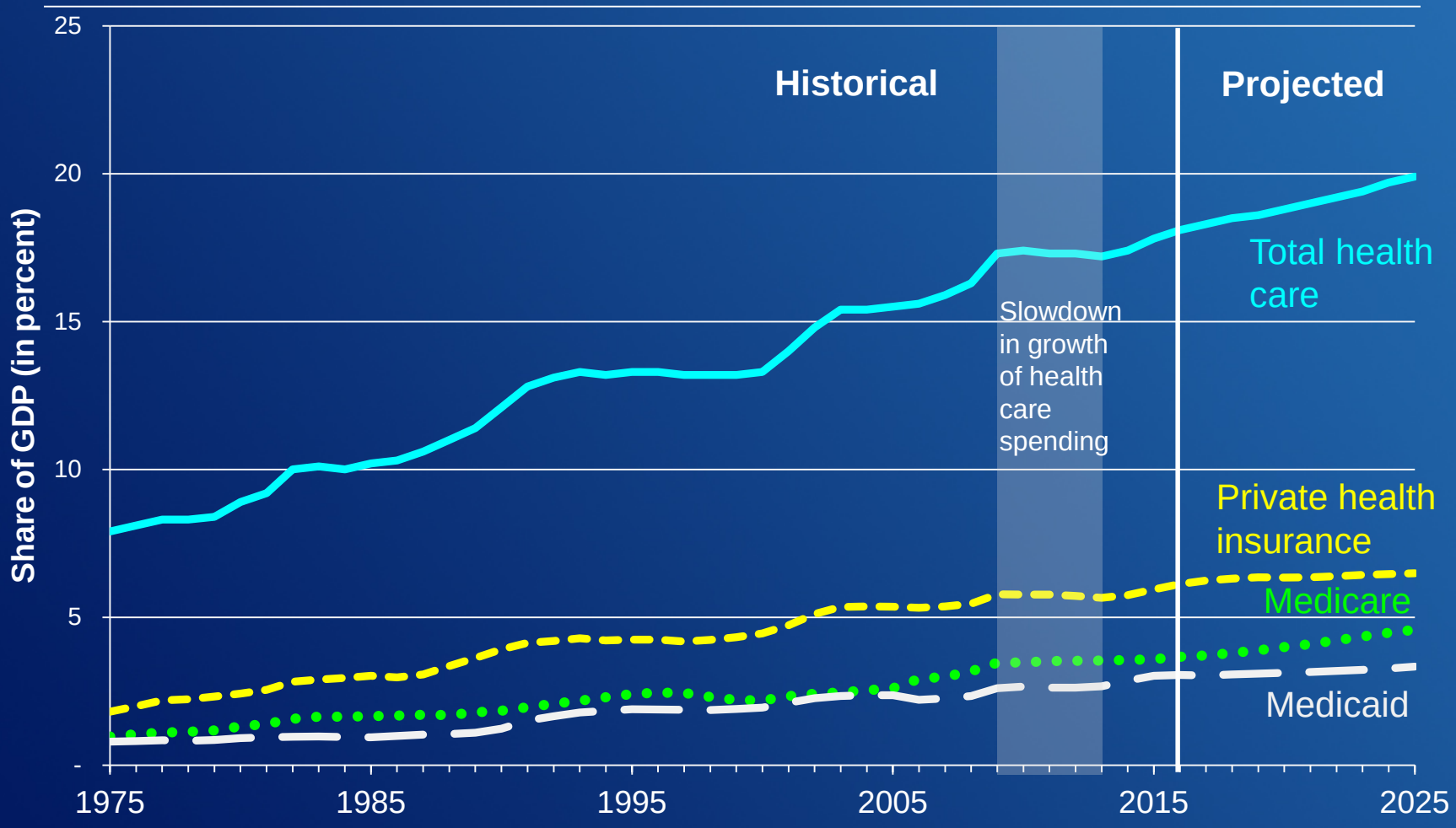
Today's presentation

- 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



Data are preliminary and subject to change.
Source: MedPAC analysis of National Health Expenditure Accounts from CMS, historical data released December 2016, projected data released March 2017.

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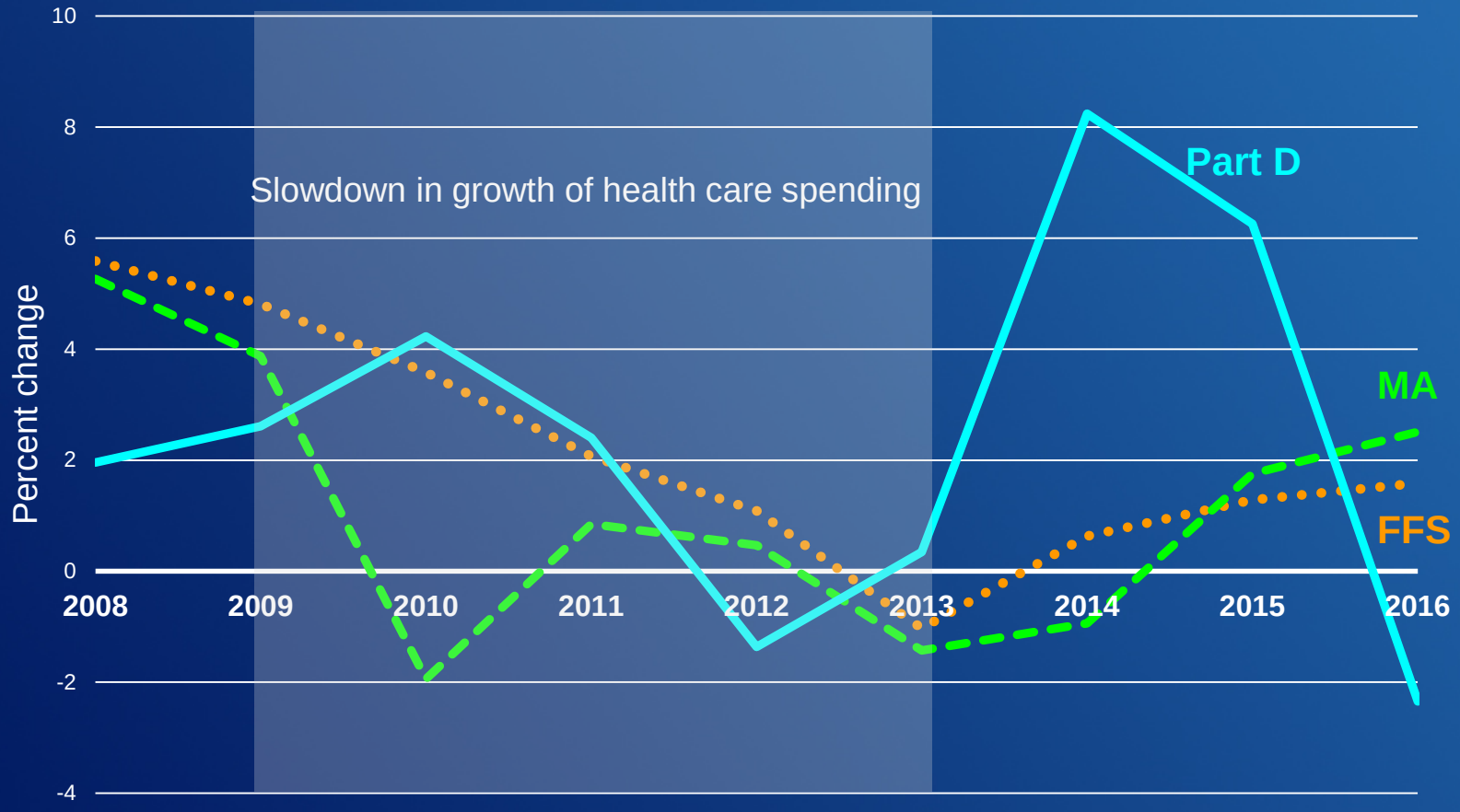
Growth in per beneficiary Medicare spending was slow between 2009 and 2013 and mixed between 2014 and 2016



Data are preliminary and subject to change.

Note: FFS (fee-for-service), MA (Medicare Advantage). Spending is on an incurred basis. Part D spending excludes total premiums paid to Part D plans by enrollees.

Source: 2017 annual report of the Boards of Trustees of the Medicare trust funds.

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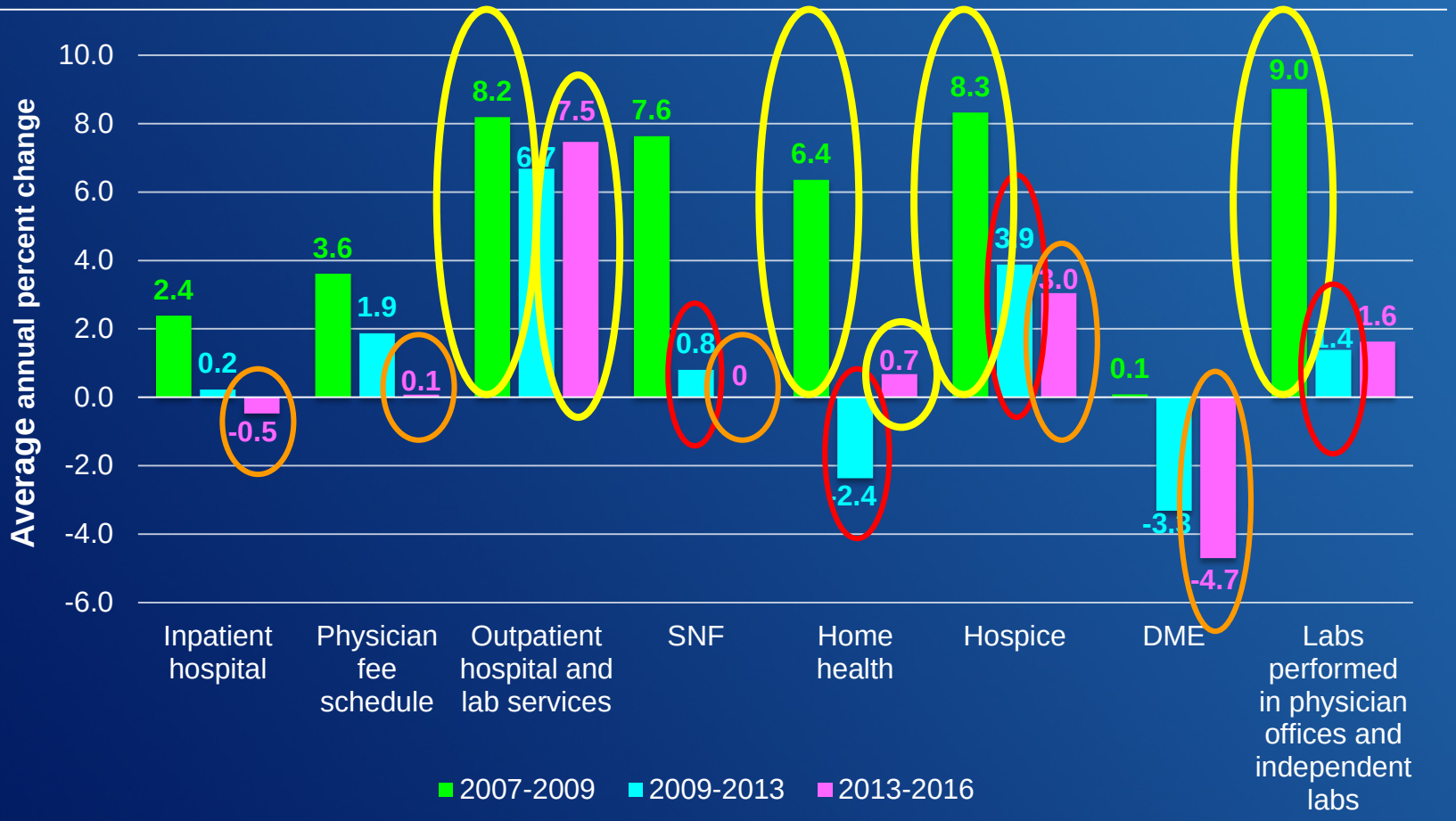
Per beneficiary spending growth remained high in some FFS settings despite slowdown



Data are preliminary and subject to change.

Note: FFS (fee-for-service). The "slowdown in growth of health care spending" period of 2009–2013 corresponds with the middle bar. 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: 2017 annual report of the Boards of Trustees of the Medicare trust funds.

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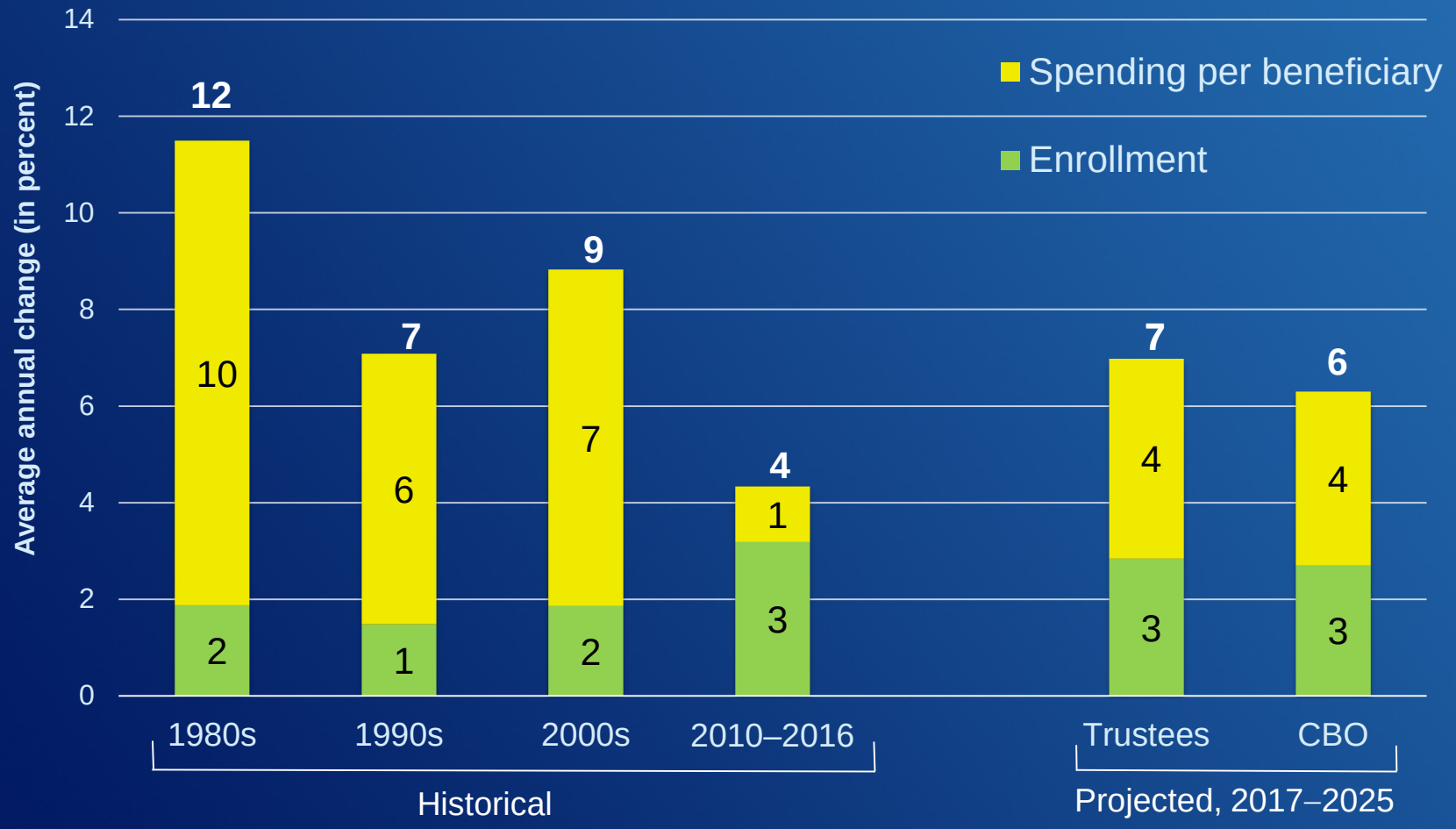
Per beneficiary spending growth and total Medicare spending growth projected to rise



Data are preliminary and subject to change.

Note: CBO (Congressional Budget Office). Average annual change in total spending may not appear to equal the sum of the average annual change in enrollment and spending per beneficiary due to rounding.

Source: 2017 annual report of the Boards of Trustees of the Medicare Trust Funds and CBO's Medicare – June 2017 Baseline.

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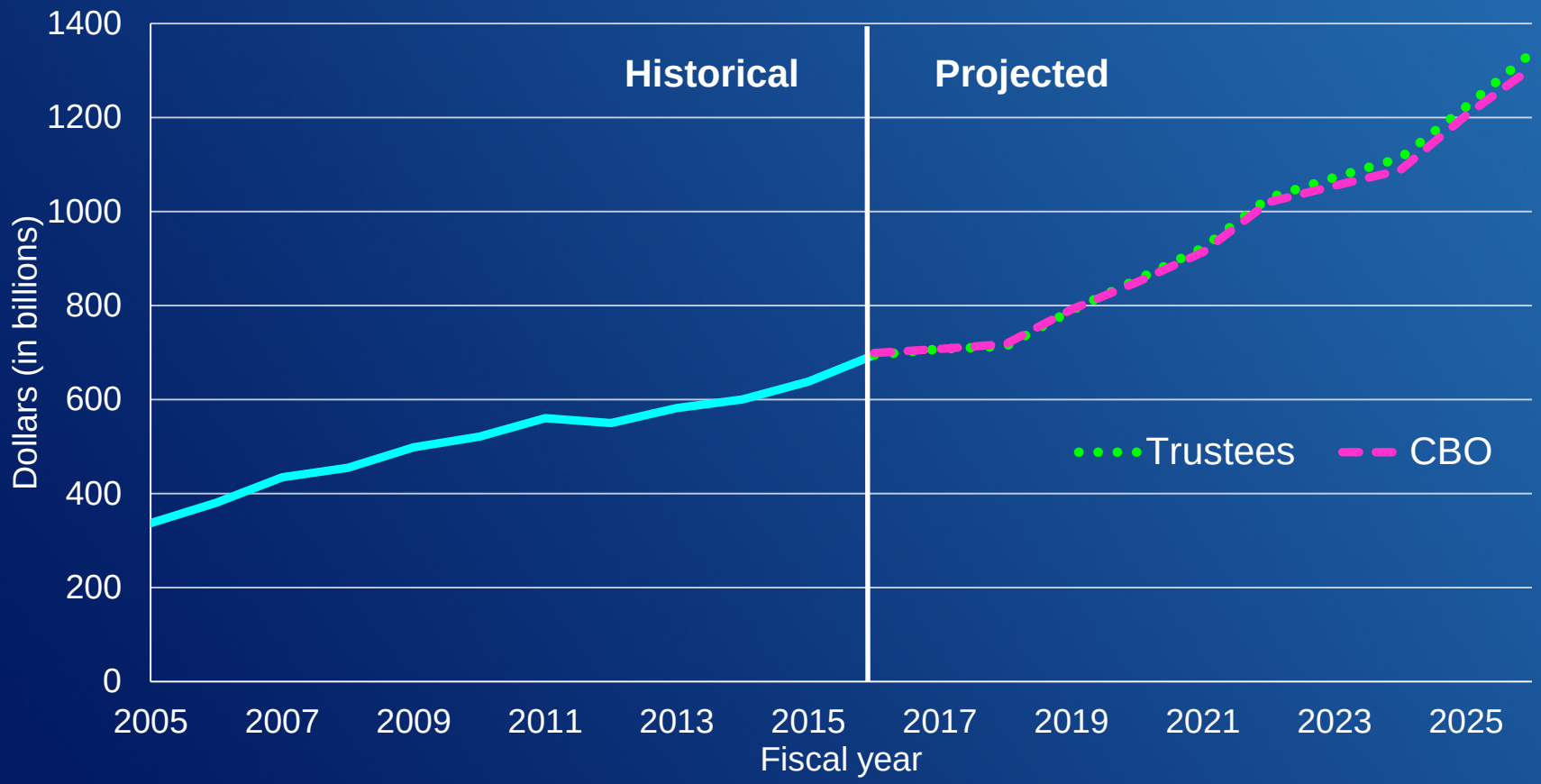
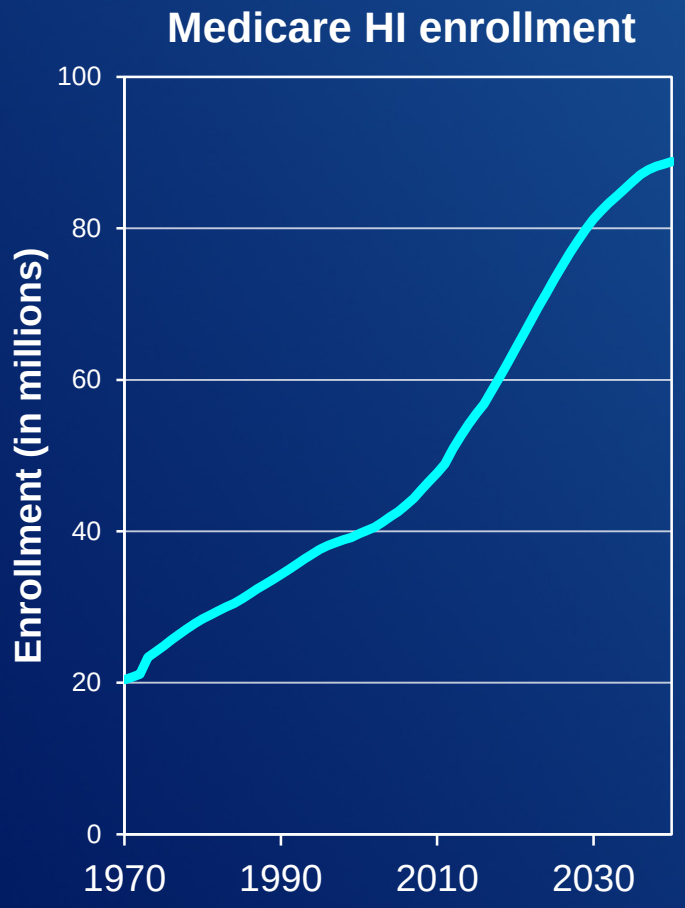
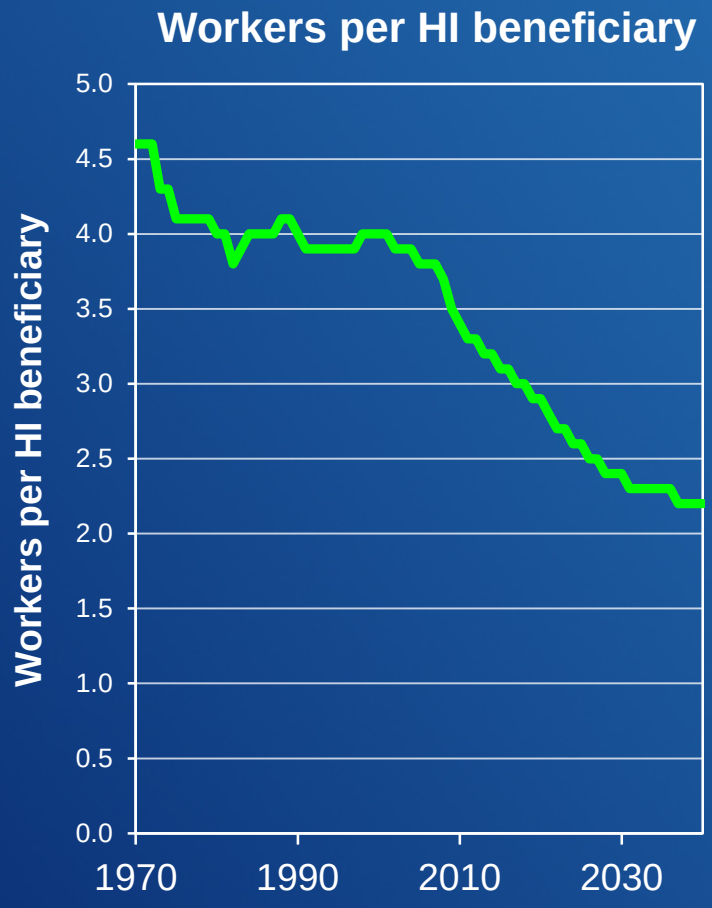
Trustees and CBO project Medicare spending to reach 1 trillion dollars by 2022



Data are preliminary and subject to change.
Note: CBO (Congressional Budget Office).
Source: 2017 annual report of the Boards of Trustees of the Medicare Trust Funds and CBO's Medicare – June 2017. Baseline

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





Data are preliminary and subject to change.
Note: HI (Hospital Insurance).
Source: 2017 annual report of the Boards of Trustees of the Medicare Trust Funds

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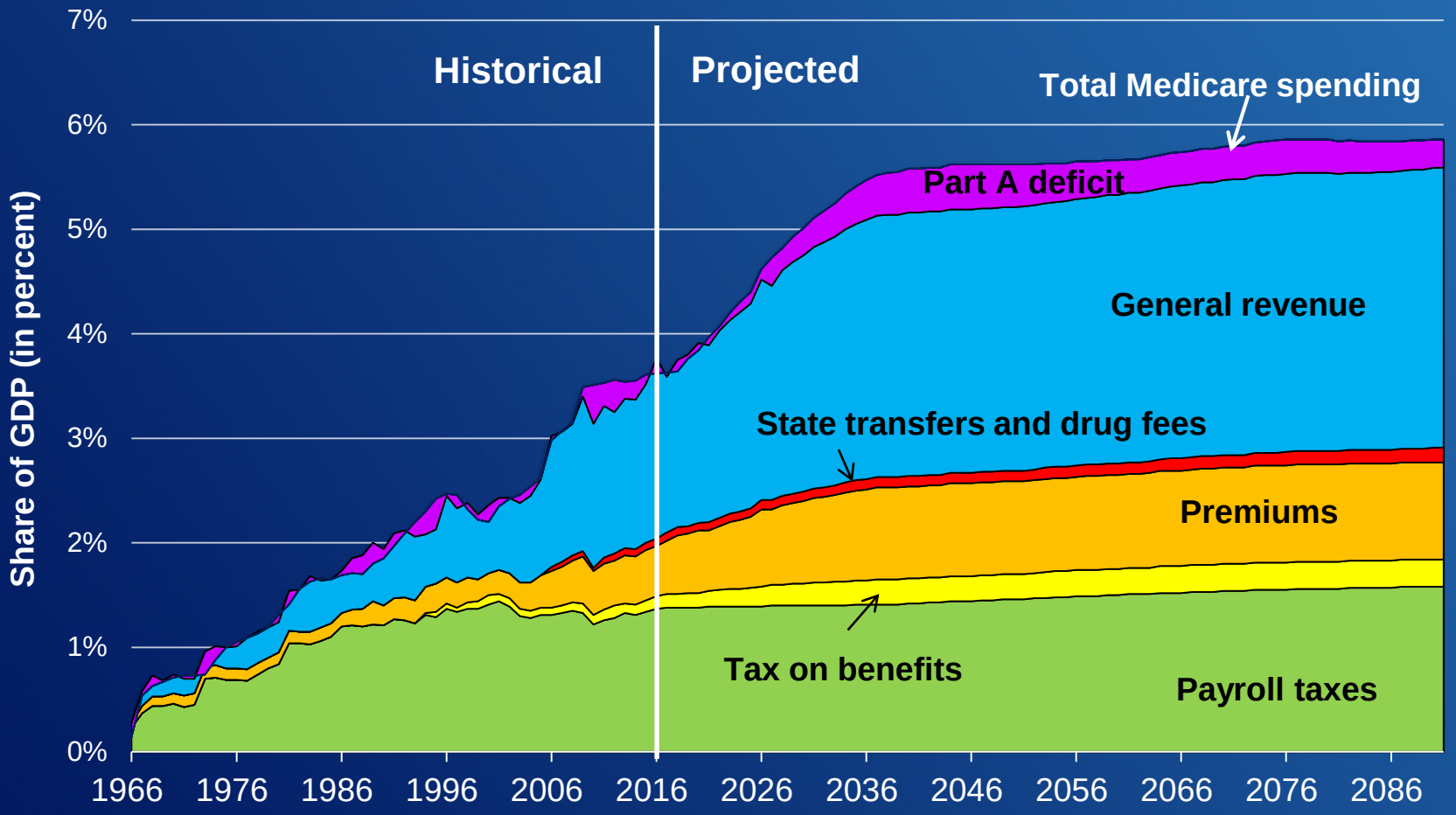
Medicare Trust Funds and their shares of total spending

- Hospital Insurance (HI) Trust Fund (43%)
  - Part A – inpatient hospital stays, skilled nursing facility
  - Financed by payroll tax
  - Insolvent in 2029 (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 ($^1/_4$)
  - SMI Trust Fund solvent only because income is increased each year to cover spending

General revenue paying for growing share of Medicare spending



Data are preliminary and subject to change.

Note: GDP (Gross domestic product).
Source: 2017 annual report of the Boards of Trustees of the Medicare Trust Funds

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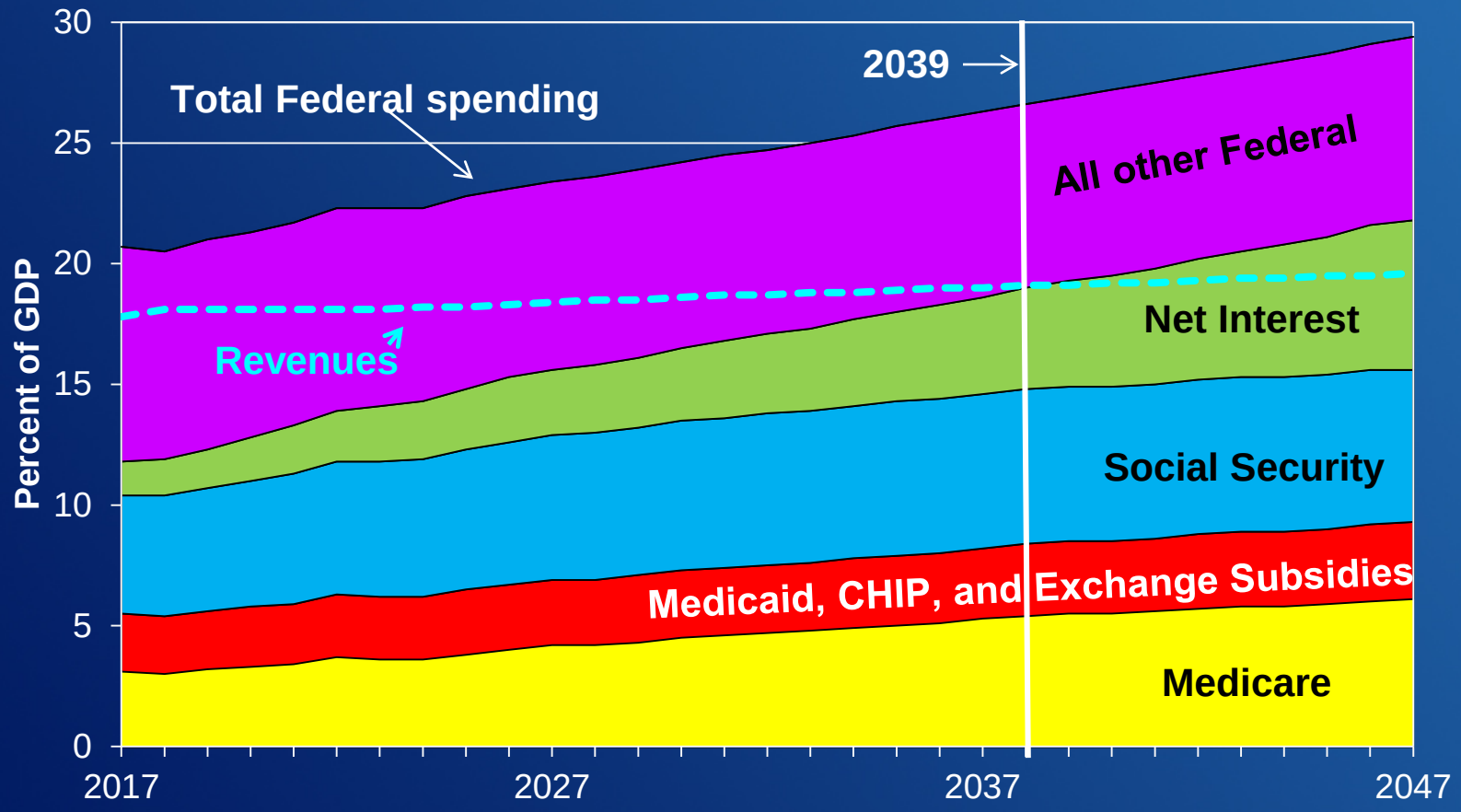
Spending on Medicare, other major health programs, Social Security, and net interest is projected to exceed total federal revenues in 22 years (by 2039)



Data are preliminary and subject to change.
Note: GDP (gross domestic product), CHIP (Children's Health Insurance Program).
Source: Congressional Budget Office 2017.

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Future Medicare beneficiaries

- Health status of 50-64 year-olds in 2014 compared to their predecessors (in 1999):
  - \+ 50% less likely to smoke,
  - \- 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

Data are preliminary and subject to change.
Source: United Health Foundation. 2016. *America's Health Rankings senior report.* Minnetonka, MN: United Health Foundation.

New Medicare beneficiaries may be less financially secure than their predecessors

- Real median household income for 55–64 year olds
  - 2004 – 2014 - 4%
  - 1994 – 2004 + 13%
- Real median family net worth for 55–64 year olds
  - 2007 – 2013 - 42%
  - 1998 – 2004 + 70%
- Average SMI out-of-pocket costs consuming a growing share of Social Security benefits
  - 2017 24%
  - 2039 30%

Data are preliminary and subject to change.
Source: Census Bureau, Current Population Survey, 2015 Annual Social and Economic Supplements, released June 2016, Federal Reserve, 2013 Survey of Consumer Finances, released September 2014, and 2017 annual report of the Boards of Trustees of the Medicare Trust Funds

Growth in health care spending and premiums outpaced growth in household income, 2005-2015

	2005	2015	Change
Average premium for individual coverage	$4,024	$6,251	+55%
Average premium for family coverage	$10,880	$17,545	+61%
Per capita personal health care expenditures	$5,744	$8,468	+47%
Median household income	$46,326	$56,516	+22%

Data are preliminary and subject to change.

Note: Household income, health expenditures, and premiums are 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.

Source: MedPAC analysis of Census Bureau, Current Population Survey, Annual Social and Economic Supplements 2016; National Health Expenditure Accounts from CMS 2016; and Kaiser Family Foundation and Health Research & Educational Trust 2015 survey of employer health benefits.

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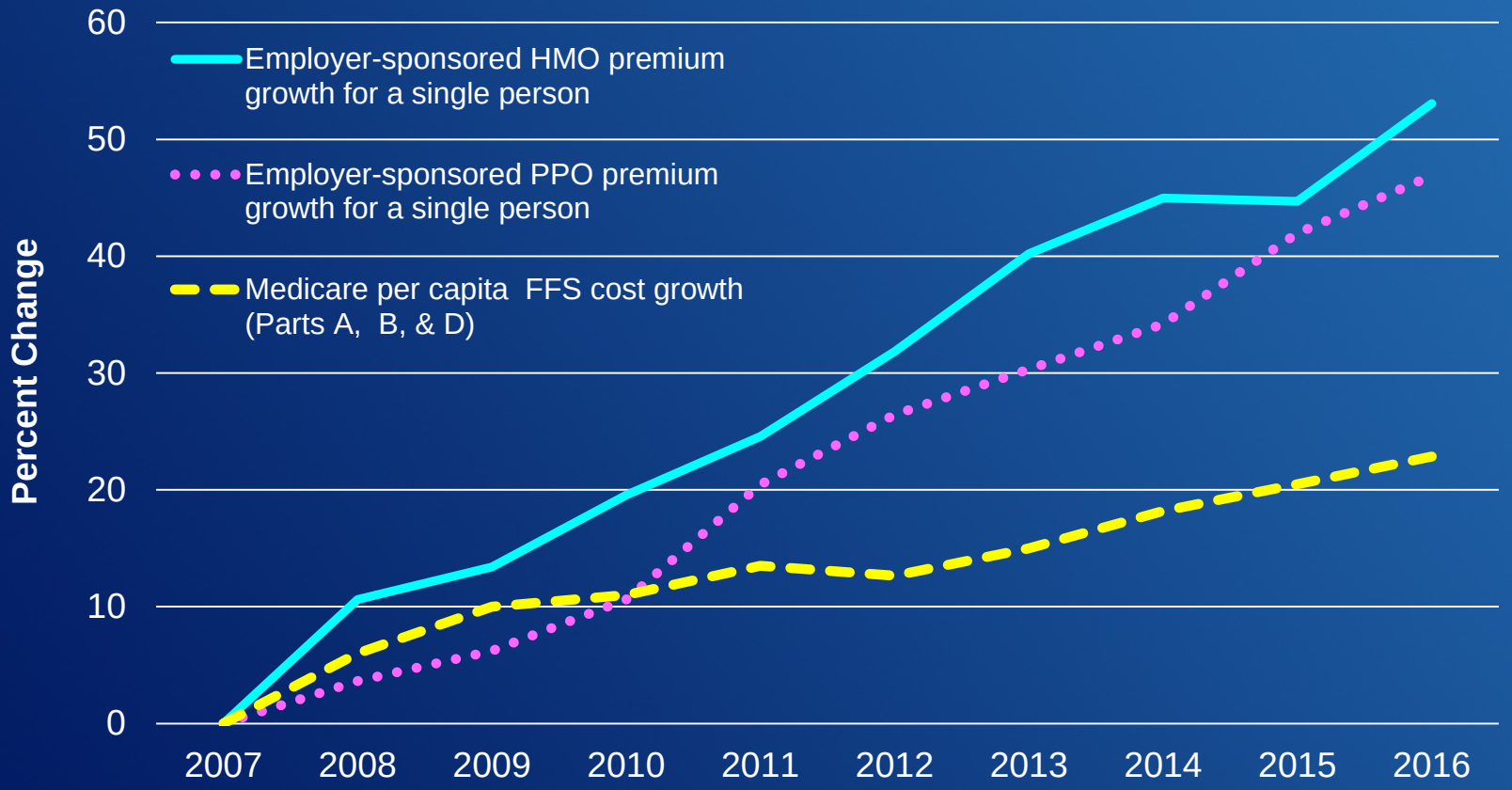
Cost of commercial insurance has grown twice as fast as Medicare costs



Data are preliminary and subject to change.

Note: HMO (health maintenance organization), PPO (preferred provider organization), FFS (fee-for-service).

Source: Employer-sponsored premium data from Kaiser Family Foundation surveys, 2007 through 2016. Medicare spending figures from Part A and Part B spending data from CMS actuaries; Part D spending per capita figures through 2015 from MedPAC analysis of claims and reinsurance data for individuals with Part D coverage. Part D spending for 2016 is a projection based on MedPAC analysis.

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Evidence of health care inefficiency and misspending

- Geographic variation
  - Higher use ≠ improved patient outcomes
  - Low-value services continue to be provided
- 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 at 65 is lower and has increased more slowly than in other OECD countries

Medicare's challenges

- Medicare just one payer in the overall, multi-payer health care system
- 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
- Align medical education with delivery system reform
- Engaged beneficiaries

Discussion

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