

CHAPTER

1

Context for Medicare payment policy

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Chapter summary

Part of the Commission’s mandate is to consider the effect of its recommendations on the federal budget and to view Medicare in the context of the broader health care system. To help meet its mandate, this chapter examines health care spending growth—for the nation at large and Medicare in particular—and considers its effect on the federal budget as well as individuals and families. This chapter also reviews in detail the profile of the Medicare beneficiary, evidence of wasteful health care spending, and structural features of the Medicare program that contribute to wasteful spending.

Historically, health care spending has risen as a share of gross domestic product (GDP), but within the last five years its growth rate has slowed, in both private sector and Medicare spending. This slowdown, however, came after a significant increase in spending. As a share of GDP, Medicare spending went up by a factor of almost five from 1973 through 2013, increasing from 0.8 percent to 3.5 percent, and has stayed constant as a share of GDP for only the past four years.

The cause of the system-wide slowdown in spending growth is still a matter of speculation. A variety of factors could have contributed—weak economic conditions, payment and delivery system reforms, a slowdown in the introduction of new medical technologies, and a shift to less generous

In this chapter

- National health care spending
- Medicare spending
- Medicare’s financing challenge
- Health care spending consumes growing shares of federal and state budgets and the budgets of individuals and families
- Changes in the Medicare-eligible population
- How quickly will health care spending grow in the coming years?
- Conclusion

insurance coverage. The slowdown in Medicare is significant: Over the past three years, per beneficiary spending grew less than 1 percent per year on average, declining from a growth rate over the last four decades of about 8 percent per year on average.

Despite the slowdown in per beneficiary spending, aggregate Medicare spending is projected to increase 5 percent to 7 percent annually over the next decade as the baby-boom generation ages into Medicare. Over the next few years, both the Medicare Trustees and the Congressional Budget Office project growth in spending per beneficiary to rebound somewhat from the recent very low rates but remain below the high rates of the past several decades.

The persistent imbalance between Medicare's spending and income remains despite the recent slow growth in per beneficiary spending. Part A of Medicare, which is financed largely through a payroll tax, is currently estimated to become insolvent in 2030. Part B of Medicare is financed largely through general revenues and thus cannot become insolvent. However, Medicare's reliance on general revenues will increase (from 41 percent of program costs today to 45 percent of program costs in about 15 years), and as a result there will be fewer resources available to finance other federal priorities and greater pressure to reduce spending or increase taxes. The overall budget picture will continue to shift from other priorities to Medicare, Medicaid, Social Security, and other health spending.

The growth in health care spending also affects individuals and families, including Medicare beneficiaries. Increases in private insurance premiums have outpaced the growth of family incomes over the past decade, and cost sharing for Medicare beneficiaries has also increased.

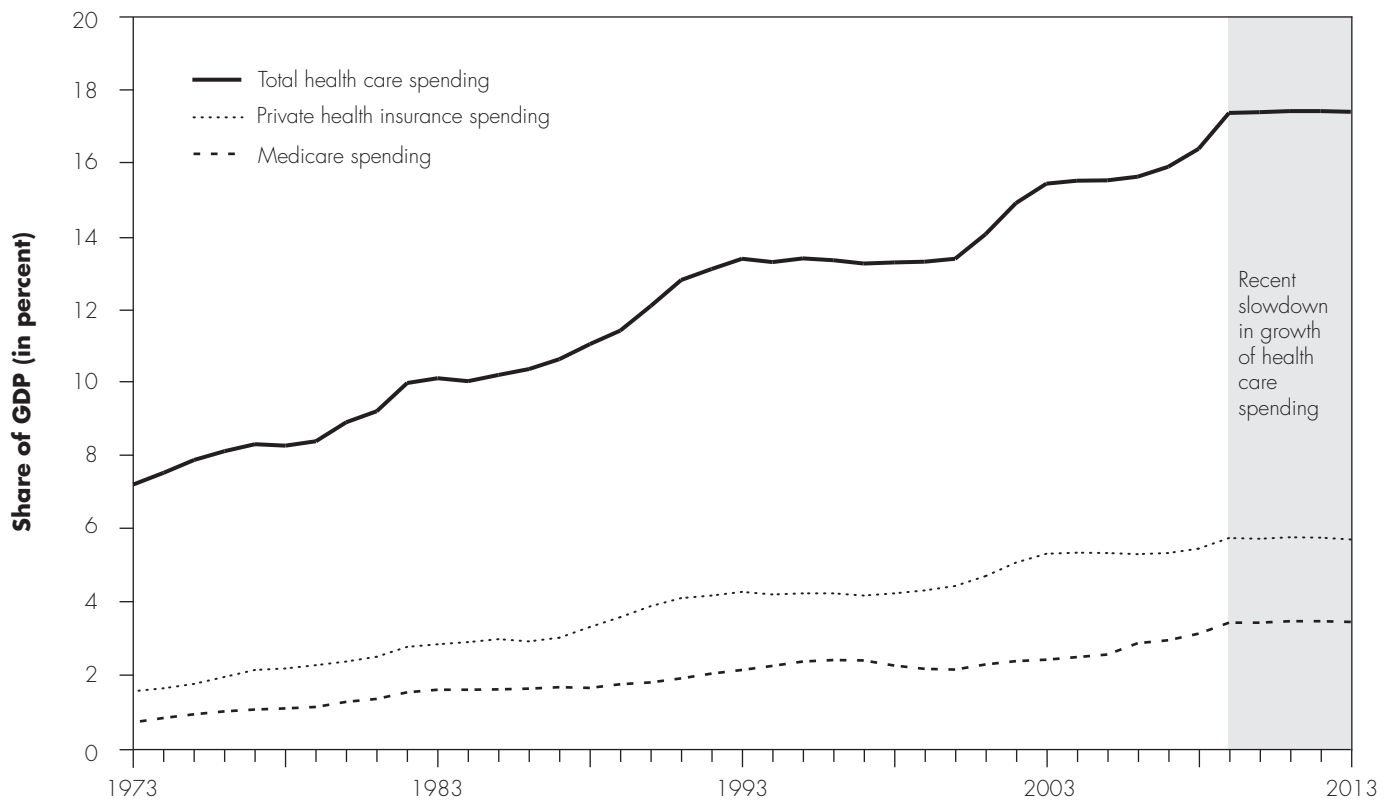
The Medicare population is projected to increase from 54 million beneficiaries today to over 80 million beneficiaries by 2030, significantly changing the population's makeup. Among seniors currently entering Medicare, there is a higher prevalence of multiple chronic conditions than in the past, and as this cohort ages, the prevalence of these conditions will increase. These new beneficiaries may also enter Medicare having had types of health insurance coverage that differ from coverage in the past, and those differences may shape beneficiaries' choices and expectations about their Medicare benefit.

Some health care spending is inefficient and wasteful. For Medicare, if such spending can be identified and eliminated, it would improve the program's fiscal sustainability, reduce federal budget pressures, and result in each Medicare dollar that is spent better improving beneficiary health. Another important consideration

in setting payment policy is evidence of the relationship between the level of spending and increases in health care spending and health care outcomes. Over time, outcomes for the overall population (such as life expectancy) have improved, although questions remain about the value of the marginal health care dollar. Certain structural features of the Medicare program pose challenges for targeting wasteful spending, and the Commission has made recommendations to address those challenges. ■

**FIGURE
1-1**

Historically, health care spending has risen as a share of GDP; recently, its growth has slowed



Note: GDP (gross domestic product). Total health care spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: MedPAC analysis of National Health Expenditures Accounts from CMS 2014.

Introduction

The Medicare program lies at the junction between the national health care system as a whole and the federal government. For this reason, it is important to review the following context in which Medicare operates to understand the payment policies discussed in the rest of this report:

- national health care spending and Medicare spending;
- impact of Medicare spending on the federal budget;
- effects of health care spending growth on individuals and families;
- current and future Medicare beneficiary populations; and
- health care spending drivers and wasteful spending.

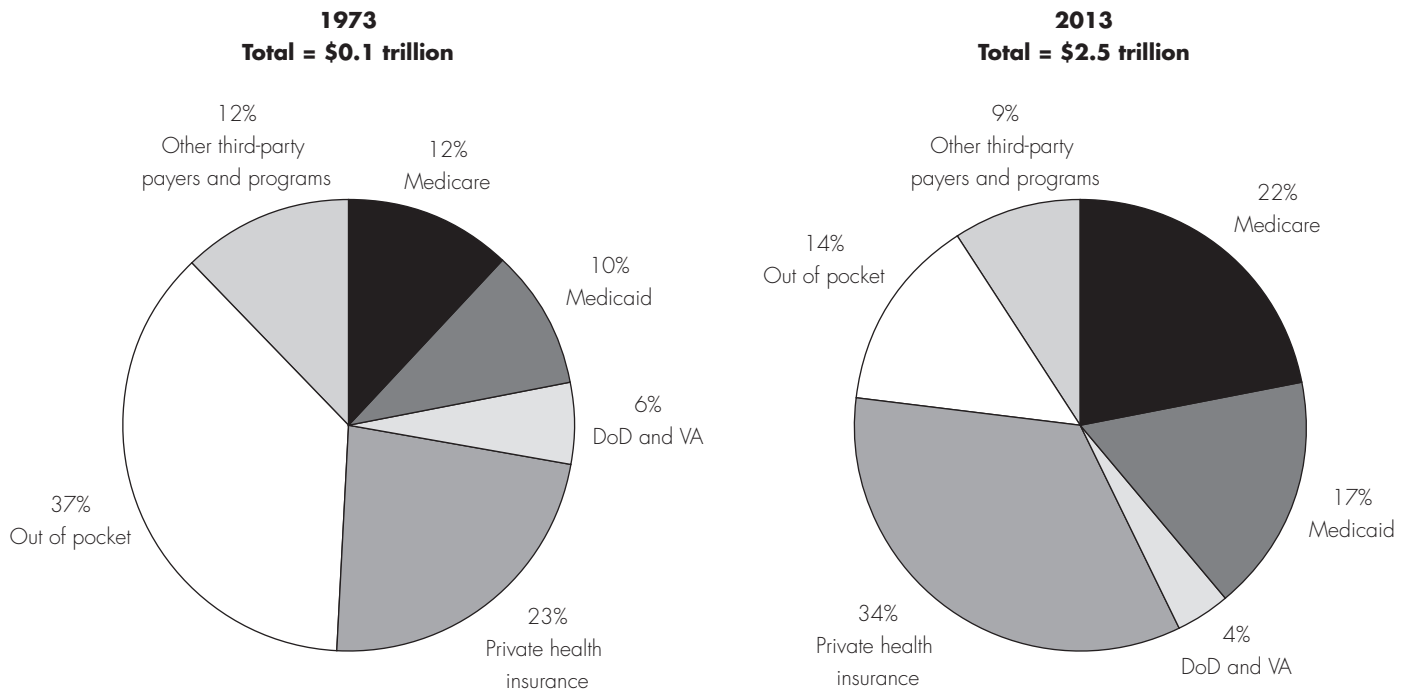
This chapter also reviews the challenges that Medicare in particular faces and the Commission's principles for constructing sound recommendations to address those challenges.

National health care spending

Historically, health care spending has risen every year as a share of gross domestic product (GDP), but recently its growth rate has slowed. That general trend is true for health care spending by private sector payers as well as Medicare (Figure 1-1). As a share of GDP, total health care spending more than doubled from 1973 to 2013, increasing from 7.2 percent to 17.4 percent. As a share of GDP, private health insurance spending more than tripled over that same time period, from 1.6 percent to 5.7 percent. Medicare spending as a share of GDP went

**FIGURE
1-2**

Out-of-pocket spending's share of personal health care spending declined while private and federal health insurance spending's share increased, 1973-2013



Note: DoD (Department of Defense), VA (Department of Veterans Affairs). Private health insurance accounted for a greater share of spending than Medicare (34 percent vs. 22 percent in 2013), but private health insurance is not a single purchaser of health care; it includes many private plans such as traditional managed care, self-insured health plans, and indemnity plans. "Out-of-pocket spending" includes cost sharing for both privately and publicly insured individuals. Premiums are included in the shares of each program (e.g., Medicare, private insurance) rather than in the out-of-pocket share category. Medicaid includes the Children's Health Insurance Program. "Other third-party payers and programs" includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs such as the Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

Source: MedPAC analysis of National Health Expenditures Accounts from CMS 2014.

up by a factor of almost five, increasing from 0.8 percent to 3.5 percent. However, as seen in Figure 1-1, health care spending as a share of GDP has remained relatively constant for the past several years (Centers for Medicare & Medicaid Services 2014).

Health care spending that rises faster than GDP is generally considered unsustainable because it cannot ultimately consume the entire economy and replace the consumption of all other goods and services. However, which factors drove spending to rise faster than GDP is not well understood. The emergence and increasing use of new medical technologies, rising personal income, declining share of health care costs that people paid out of pocket, and market power of providers and insurers appear to have all played a role (Cutler 1995, Newhouse 1992, Smith et al. 2009). The recent slowdown in the

rate of growth in health care spending also has not been fully explained. Contributing factors could include weak economic conditions, payment and delivery system reforms, a slowdown in the introduction of new medical technologies, and increasing use of generic drugs as top-selling brand drugs lose patent protection.

To better understand who is paying for health care, we focus on personal health care spending—all medical goods and services provided for an individual's treatment. Often, spending by several types of payers and programs combine to pay for an individual's health care, including out-of-pocket spending, public and private health insurance, and other third-party payers and programs. Personal health care spending excludes spending on government public health activities (e.g., epidemiological surveillance and disease prevention programs), administration of private

and public health insurance, and investments in medical research, equipment, and structures. In 2013, personal health care spending accounted for 85 percent of total health care spending.

Over the past four decades, total personal health care spending increased from \$0.1 trillion to \$2.5 trillion. On a per person basis, spending increased from \$397 in 1973 to \$7,826 in 2013, an 8 percent increase per year on average. During this period, out-of-pocket spending (e.g., cost sharing, deductibles, and health care services not covered by insurance) as a share of total personal health care spending declined from 37 percent to 14 percent, while the shares accounted for by private health insurance, Medicare, and Medicaid all increased (Figure 1-2). At the same time, Medicare has remained the largest single purchaser of health care in the United States (Centers for Medicare & Medicaid Services 2014).¹

In 2013, Medicare covered 52 million people, Medicaid covered 59 million people, private health insurance covered 189 million people, and about 44 million people were uninsured (Boards of Trustees 2014, Centers for Medicare & Medicaid Services 2014). Some people have coverage from more than one source. In 2013, 11.1 million people were enrolled in both Medicare and Medicaid (Boards of Trustees 2014). Medicaid pays for either a portion or all of the Medicare premium and out-of-pocket health care expenses for those enrollees who qualify for dual enrollment based on limited income and resources. Enrollees in private health insurance may also be enrolled in other third-party health insurance programs. For example, Medicare beneficiaries may also have supplemental insurance sold by private companies.

The decline in the share of health care spending paid directly out of pocket by individuals and the increase in the share of health care spending paid by private and public insurance do not mean that people have experienced similar declines in the share of the health care costs they pay. First, people also pay premiums, which are not included in the out-of-pocket category but, rather, the private health insurance and Medicare categories. Second, people receive lower salaries and reduced benefits in exchange for employer-sponsored health insurance. When an employer contributes to premiums, most economists agree that salary and other benefits are reduced to offset the employer contribution.

In 2013 as well as in 1973, the largest shares of personal health care spending were for hospital care and physician

and clinical services. In 2013, hospital care accounted for 38 percent of spending, or \$937 billion, while physician and clinical services accounted for 24 percent of spending, or \$587 billion (Figure 1-3, p. 10). Smaller shares in 2013 went to spending on prescription drugs (11 percent, or \$271 billion), nursing care facilities (6 percent, or \$156 billion), and home health care services (3 percent, or \$80 billion).

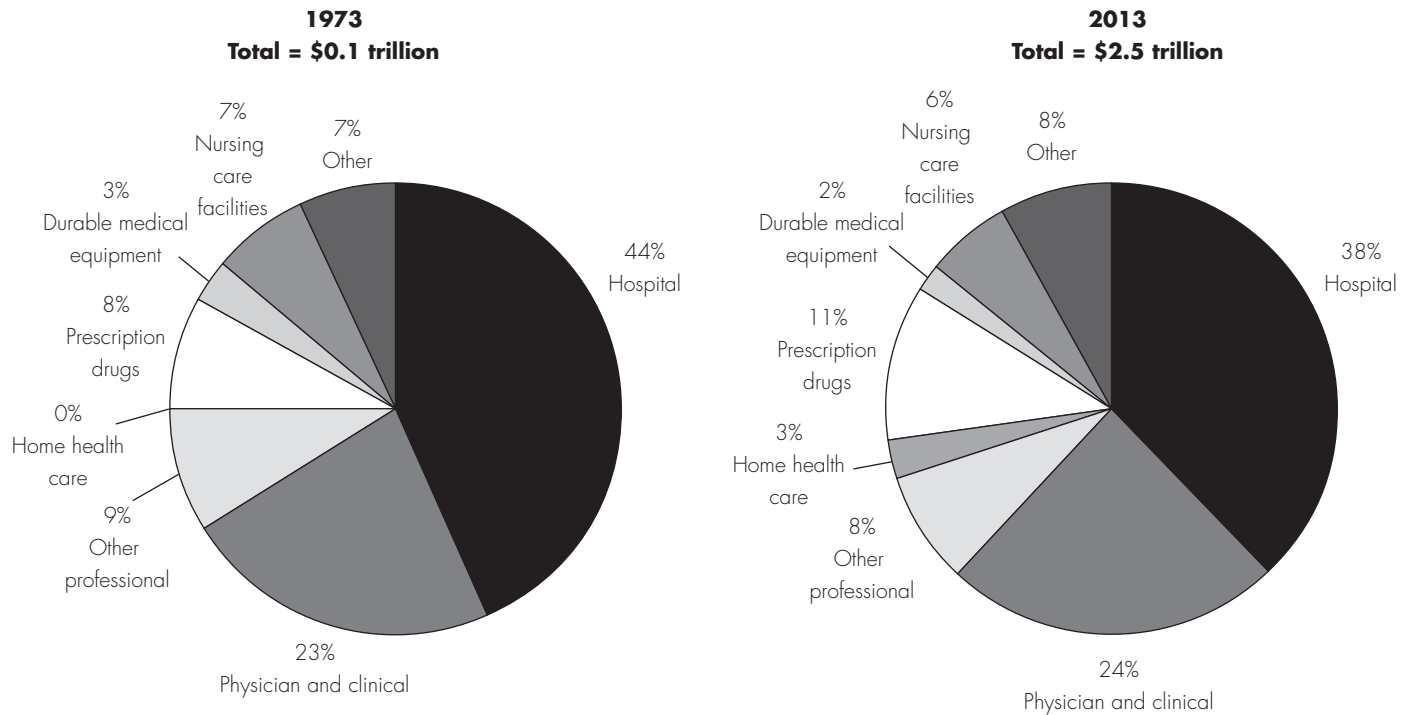
Between 1973 and 2013, the share of spending on hospital care declined from 44 percent to 38 percent, and the share of spending for prescription drugs increased from 8 percent to 11 percent (Centers for Medicare & Medicaid Services 2014). Medicare accounted for 22 percent of spending for all services in 2013, but its share varied by type of service. For example, Medicare spending on home health care services accounted for over 40 percent (Table 1-1, p. 10).

Medicare spending

Like overall health care spending, Medicare spending experienced rapid growth in the past four decades but a slowdown in recent years. Between 1973 and 2013, Medicare spending grew at an average rate of 11 percent annually but has slowed to 4 percent per year since 2010. This slowdown is attributable to a slowdown in the growth of per beneficiary spending—from an average of 8 percent per year between 1973 and 2013 to less than 1 percent per year since 2010 (Boards of Trustees 2014).

Medicare spending can be divided into three program components: the traditional fee-for-service (FFS) program, the Medicare Advantage (MA) program, and the Part D prescription drug program.

- **Medicare's traditional fee-for-service program.** In FFS, Medicare pays health care providers directly for health care goods and services furnished to Medicare FFS beneficiaries at prices set through legislation and regulation.
- **Medicare Advantage program.** As an alternative to FFS, beneficiaries can choose to enroll in MA, which consists of private health plans that receive capitated payments for providing health care coverage to enrollees. MA plans pay health care providers for health care goods and services furnished to their enrollees at prices negotiated between the plans and providers.

**FIGURE
1-3****Hospital care and physician services accounted for the largest shares of personal health care spending in 1973 and 2013**

Note: "Other" includes expenditures on nondurable medical products and other health, residential, and personal care. "Other professional" includes expenditures on dental and other professional services.

Source: MedPAC analysis of National Health Expenditures Accounts from CMS 2014.

**TABLE
1-1****Total health care spending in selected sectors and Medicare's share, 2013**

	Total spending	Medicare spending	Medicare's share of total sector spending
	Dollars in billions		Percentage
Total spending on personal health care	\$2,469	\$551	22%
Hospital	937	243	26
Physician and clinical services	587	130	22
Other professional	191	19	10
Home health care	80	34	43
Prescription drugs	271	75	28
Durable medical equipment	43	8	18
Nursing care facilities	156	35	22
Other	204	8	4

Note: "Other professional" includes expenditures on dental and other professional services. "Other" includes expenditures on nondurable medical products and other health, residential, and personal care.

Source: MedPAC analysis of National Health Expenditures Accounts from CMS 2014.

- **Medicare Part D prescription drug program.**
Through Part D, beneficiaries can obtain subsidized prescription drug coverage by voluntarily purchasing insurance policies from private stand-alone drug plans or MA plans. Medicare heavily subsidizes the premiums established by those plans.

The growth in per beneficiary spending has slowed for all three programs; Figure 1-4 presents average annual growth rates for the last decade (from 2004 to 2013) in three-year periods. Per beneficiary spending growth was particularly low in the last period (from 2010 to 2013). The lower growth rates were generally due to both decreased use of health care services and restrained payment rate increases.

In FFS, per beneficiary growth averaged 1 percent annually from 2010 to 2013 (the last period). In addition to decreased use, the Patient Protection and Affordable Care Act of 2010 (PPACA) reduced annual payment rate updates for many types of providers (other than physicians) beginning in 2012.

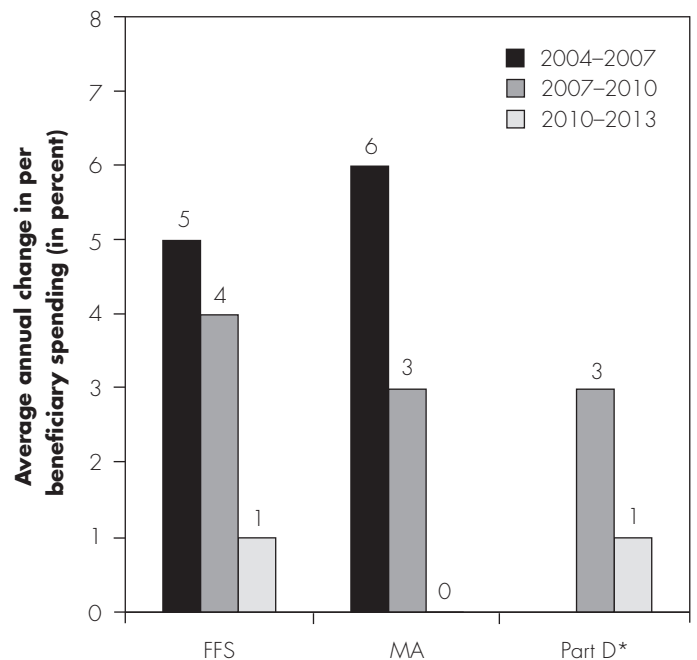
In MA, per beneficiary growth averaged 0 percent annually from 2010 to 2013 (the last period). PPACA reduced payments to MA plans to bring costs more in line with costs in FFS. The growth rate would have been lower, but the PPACA payment reductions were offset somewhat by quality bonus payments and plans' increased coding (when compared with coding for similar FFS beneficiaries), which increases a beneficiary's risk score and thus increases Medicare's payments to MA plans, all other things being equal.

Last, in Part D, per beneficiary growth averaged 1 percent annually from 2010 to 2013. The slowdown in Part D spending was in part due to the increase in low-priced generic drugs on the market and to the efforts of plans to steer beneficiaries to generics and other low-priced drugs.

Figure 1-5 (p. 12) provides a more detailed look at FFS. Generally, we see a slowdown in spending across all settings; however, the impact is not uniform. For example, for inpatient hospital care, the average annual growth in per beneficiary spending fell from 3 percent in the first two periods to -1 percent in the last period. The growth in outpatient hospital care declined but was still growing robustly in the last period at 9 percent annually, in part because of shifts in site of care from both the inpatient hospital setting and physician offices to the outpatient hospital setting.

FIGURE 1-4

Per beneficiary spending growth slowed in FFS, MA, and Part D



Note: FFS (fee-for-service), MA (Medicare Advantage).

*Part D average annual change from 2004-2007 is not shown because the program began in 2006.

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

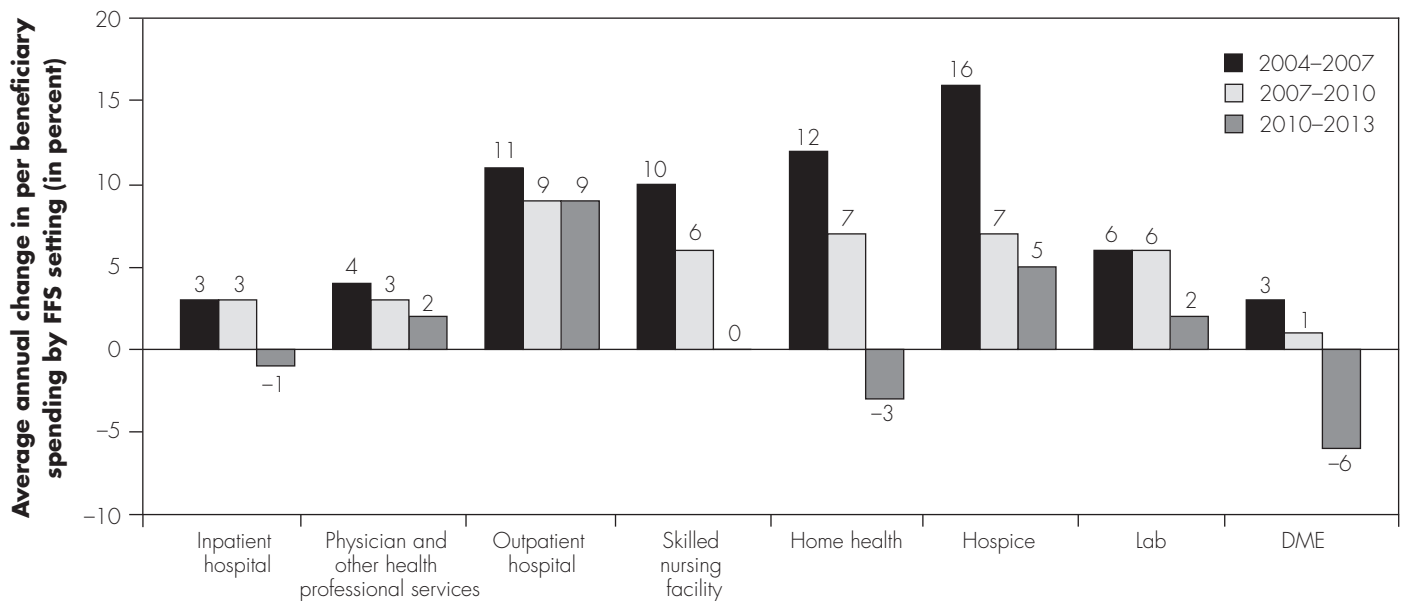
Despite the recent slowing of annual growth rates, cumulative growth in per beneficiary spending over the last decade has increased in almost all settings and quite substantially in some settings (Figure 1-6, p. 12). For example, per beneficiary spending on hospital outpatient services grew 126 percent over the last decade, while per beneficiary spending on inpatient care grew 14 percent.

A comparison of private sector and Medicare spending trends

The growth of per capita spending has also slowed recently in the private sector according to a Health Care Cost Institute analysis of private sector claims data for people younger than 65 covered by employer-sponsored private health insurance (Health Care Cost Institute 2014). Also like Medicare, the private sector experienced a greater slowdown for inpatient hospital care, while outpatient hospital care continued to grow at relatively high rates. However, the slowdown in the private sector

**FIGURE
1-5**

Per beneficiary spending growth in some FFS settings remained strong

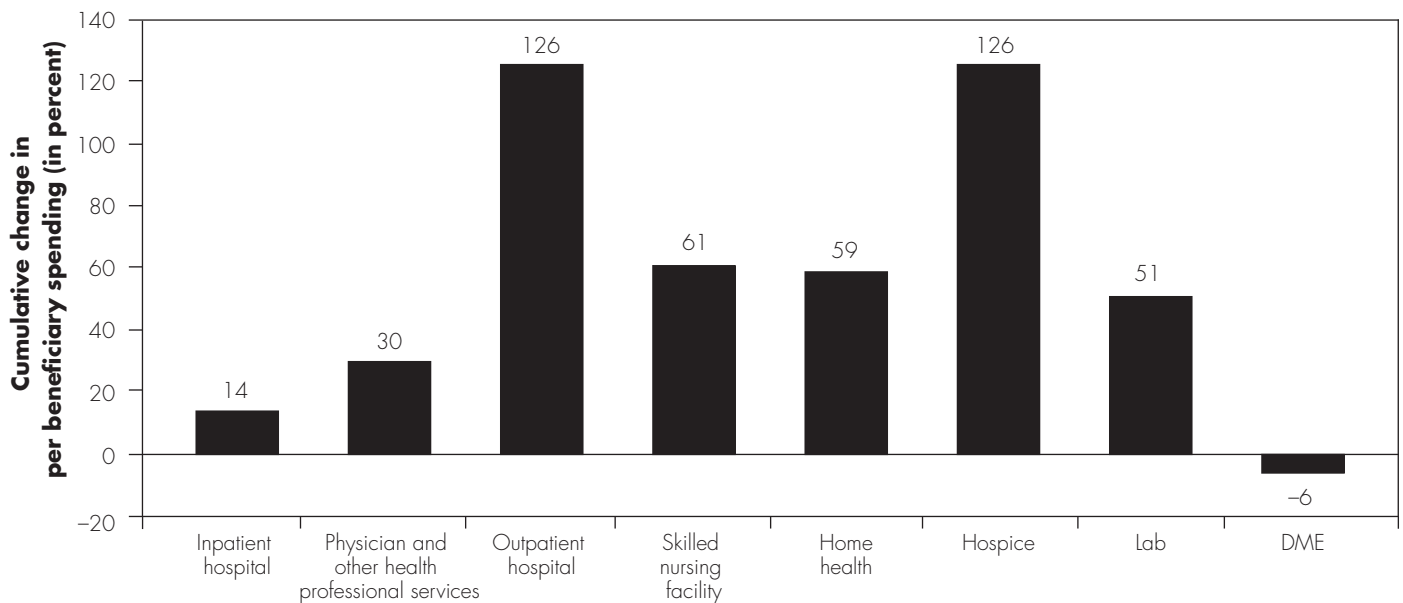


Note: FFS (fee-for-service), DME (durable medical equipment).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

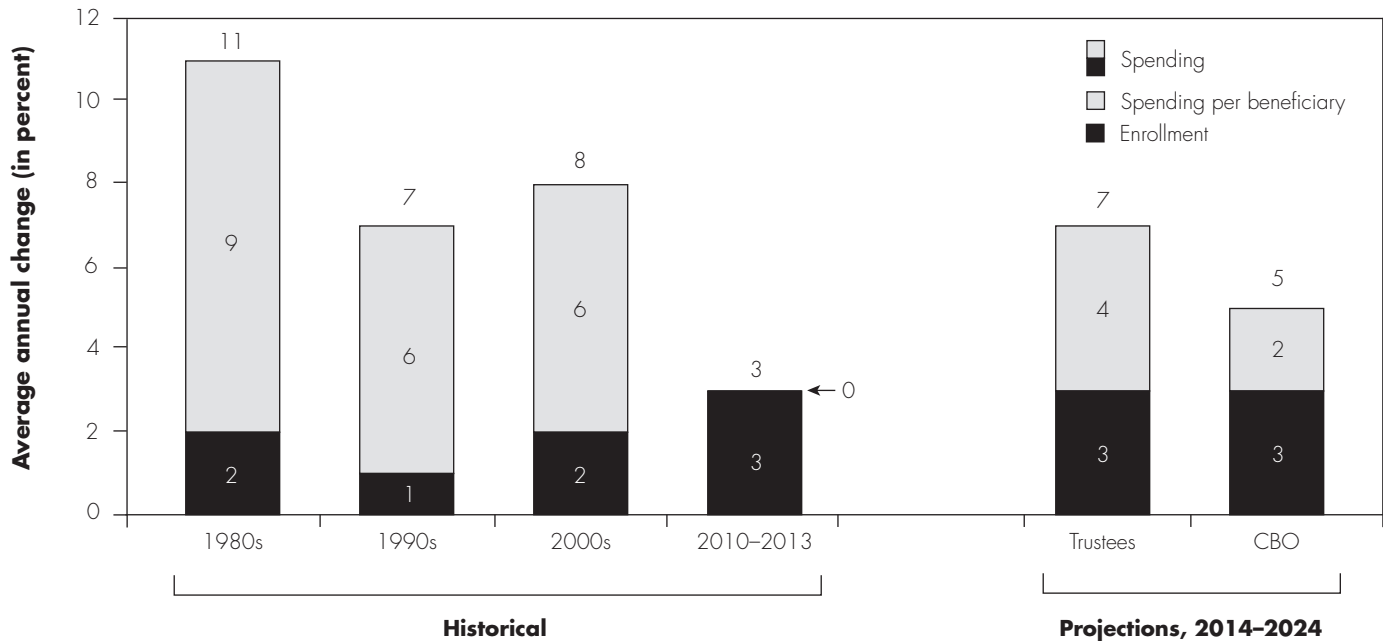
**FIGURE
1-6**

Per beneficiary spending grew over the decade in almost all settings, 2004-2013



Note: DME (durable medical equipment).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

**FIGURE
1-7****Despite slowdown in per beneficiary spending,
total Medicare spending continues to rise**

Note: CBO (Congressional Budget Office). CBO's 10-year projection is based on current law (as required by its mandate), which includes a scheduled payment rate reduction for services furnished by physicians and other health professionals of about 20 percent in April 2015. The Trustees assume the payment rate update for physicians and other health professionals will equal the recent historical average (0.6 percent per year).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds and CBO report *The 2014 Long-Term Budget Outlook*.

was primarily due to a slowdown in the growth rate of health care usage and occurred despite robust price growth.

One key driver of higher prices in the private sector is provider market power (Baker et al. 2014a, Baker et al. 2014b, Gaynor and Town 2012, Robinson and Miller 2014). Hospitals and physician groups are increasingly consolidating, in part to gain market power over insurers with the goal of negotiating higher payment rates. For the private sector, that trend resulted in per capita spending growth of about 4 percent annually from 2009 to 2012.

By comparison, per beneficiary spending for Medicare increased by about 1 percent annually over that period. So while both Medicare and the private sector experienced low growth in the use of health care services, Medicare also experienced restrained increases in payment rates, contributing to its lower growth rate.

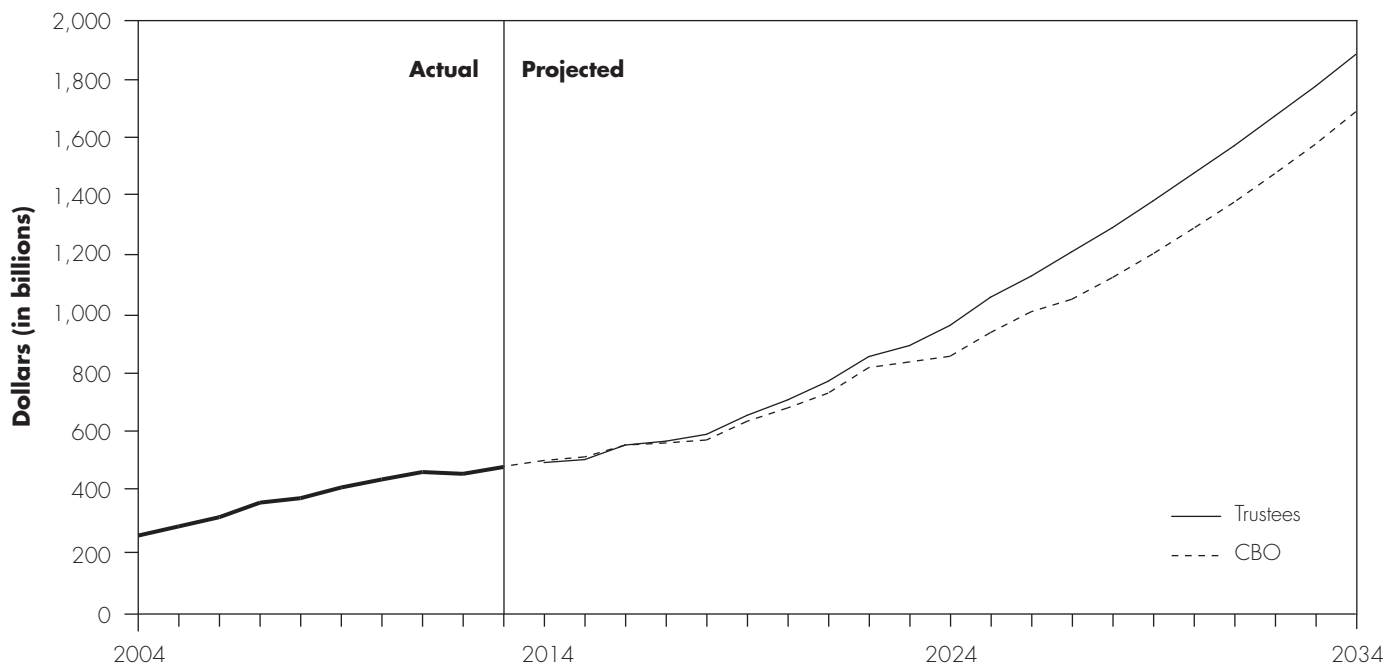
Over the long term, trends in the private sector can influence trends in Medicare. If the private sector is unable

to constrain price growth, the profitability of caring for commercially insured patients will increase relative to the profitability of caring for Medicare beneficiaries, potentially impeding access to care for Medicare beneficiaries and exerting pressure on the Medicare program to increase its payment rates (Medicare Payment Advisory Commission 2009, Stensland et al. 2010, White and Wu 2014).

Medicare spending projections

What do these current trends portend for Medicare? The slowdown in per beneficiary spending has received much attention in the news media. The growth in Medicare's per beneficiary spending has fallen from average annual rates of 9 percent in the 1980s and 6 percent in the 1990s and 2000s to 0 percent over the last three years (Figure 1-7).

For the next 10 years, the Trustees and the Congressional Budget Office (CBO) project that growth in per beneficiary spending will be higher than the recent lows but lower than the historic highs, with an average annual

**FIGURE
1-8****Trustees and CBO project Medicare spending to reach 1 trillion dollars by 2025 or 2026**

Note: CBO (Congressional Budget Office).

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds and CBO report *The 2014 Long-Term Budget Outlook*.

growth rate of 4 percent according to the Trustees and 2 percent according to CBO (Figure 1-7, p. 13) (Boards of Trustees 2014, Congressional Budget Office 2014a).²

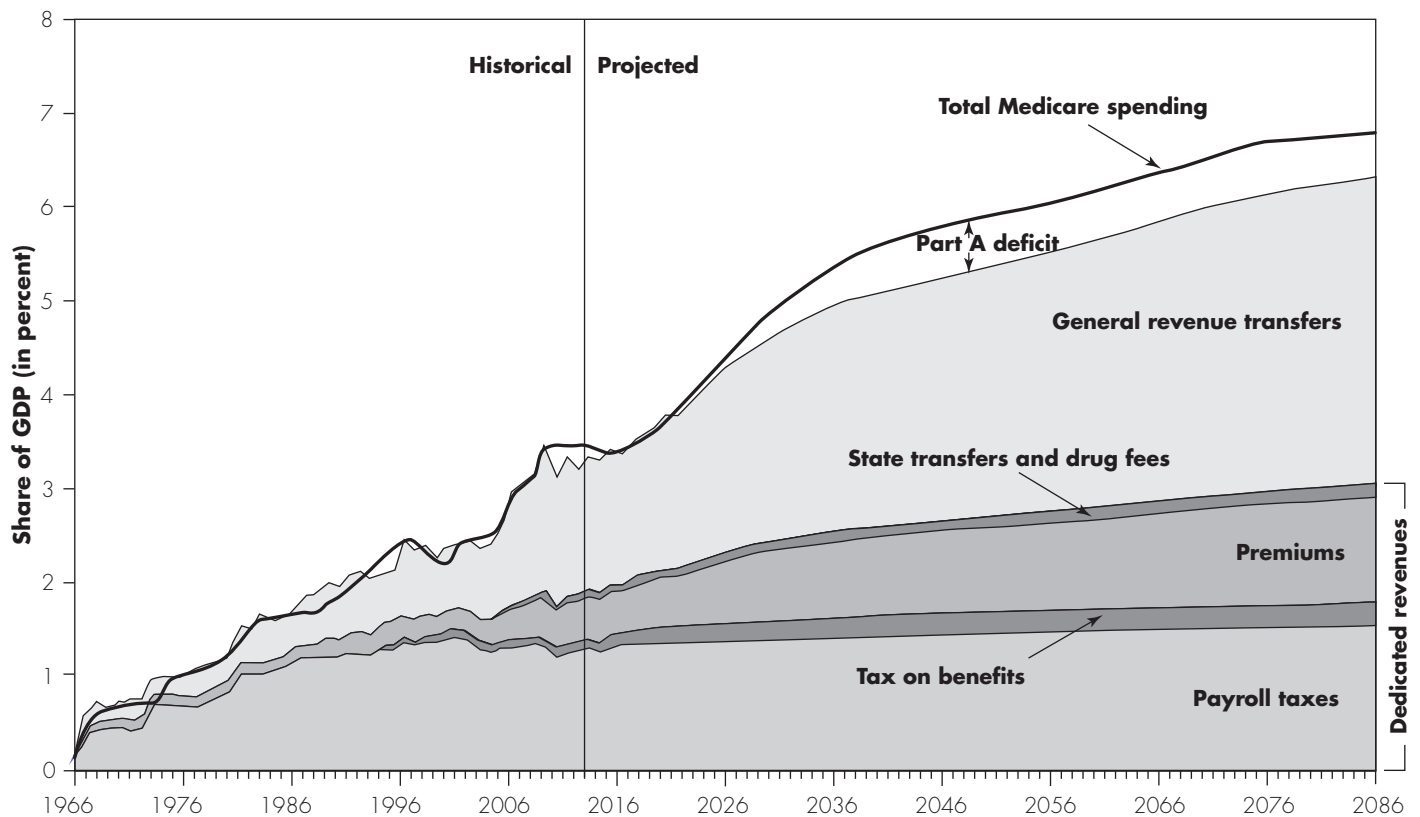
What probably has not received as much media attention is increasing growth in enrollment, from about 2 percent per year historically to 3 percent. That increase occurred over the last few years and is projected to continue throughout the next decade as the baby-boom generation continues to age into the Medicare program. So despite the slowdown in spending per beneficiary, the Trustees project annual growth in total spending to average 7 percent over the next decade, and CBO projects 5 percent. Since GDP is projected to grow at about 4 percent per year over the next decade, Medicare spending is projected to grow 1 percent to 3 percent faster than GDP.

At those rates, total Medicare spending would rise from about \$500 billion today to 1 trillion dollars in the coming decade (by 2025 under the Trustees' projection or by 2026 under CBO's projection) (Figure 1-8) (Boards of Trustees 2014, Congressional Budget Office 2014a).

Medicare's financing challenge

The Medicare Trustees project that Medicare's share of GDP will rise to 5.6 percent in 2040 and to 6.9 percent in 2086 (Figure 1-9). As spending grows, financing from general revenues will grow as a share of total Medicare financing. In this chapter, the term *general revenues* includes both tax revenue not dedicated to a specific purpose and federal borrowing, since federal spending, with few exceptions, has exceeded federal revenues since the Great Depression. As Medicare becomes more dependent on general revenues, fewer resources will be available to finance other priorities such as education and investment in infrastructure and scientific research, resulting in greater pressure to reduce federal spending or increase federal taxes.

Medicare is financed by two trust funds. The Hospital Insurance (HI) Trust Fund covers Part A services, which include inpatient hospital stays and post-acute care like skilled nursing facilities and hospice. The HI Trust Fund

**FIGURE
1-9****General revenue paying for growing share of Medicare spending**

Note: GDP (gross domestic product). "Tax on benefits" refers to the portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed in the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance trust fund.

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

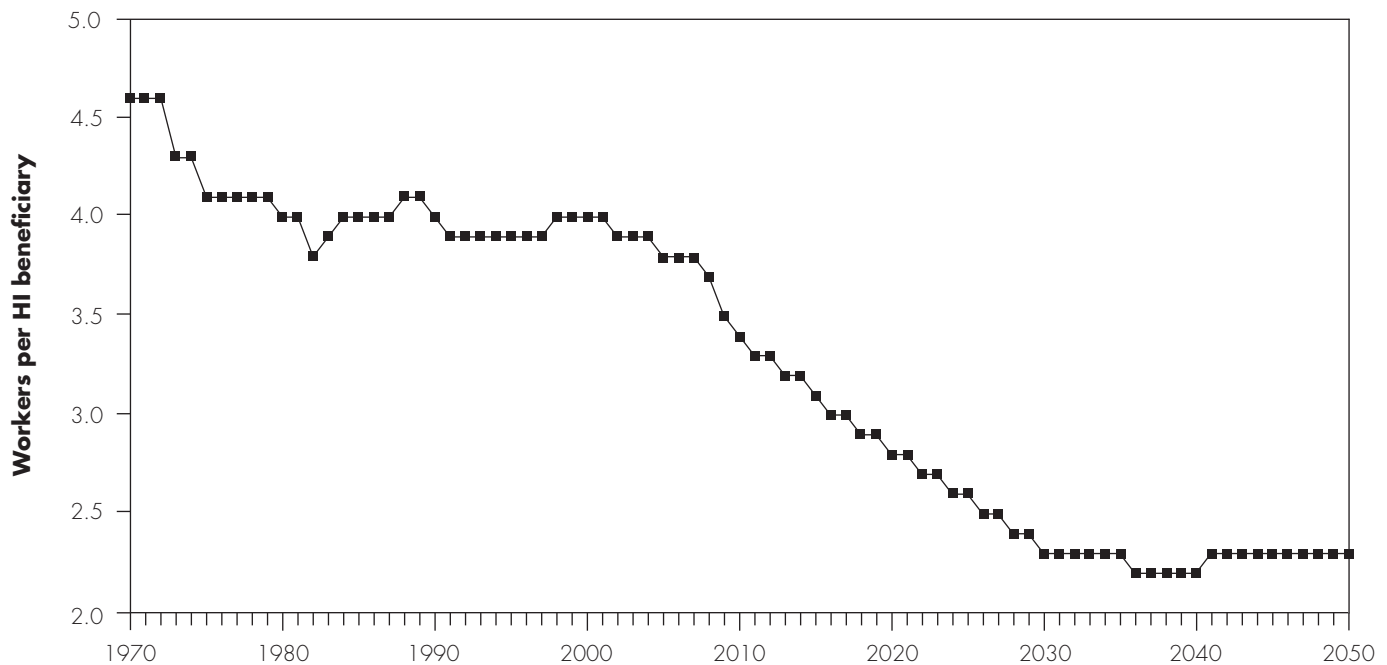
receives financing through a dedicated payroll tax (i.e., a tax on wage earnings). Payroll taxes are projected to grow only slightly faster than GDP because the growth rate is based on earnings growth and because the ratio of workers to retirees is declining with the retirement of the baby-boom generation (Figure 1-10, p. 16).

The number of workers per Medicare beneficiary declined from 4.6 in 1970 to 3.1 today. By 2030, the Trustees project there will be just 2.3 workers for every beneficiary.

Since 2008, the HI Trust Fund (Part A) has run an annual deficit (i.e., paid more in benefits than it collected in

payroll taxes, indicated by the top white layer in Figure 1-9. The Trust Fund still has interest income generated from loaning funds to other parts of the government during times of surplus, but those assets are projected to be exhausted by 2030. The Trustees estimate that the payroll tax would need to be increased from its current rate of 2.9 percent to 3.8 percent to balance the HI Trust Fund over the next 75 years. Otherwise, Part A spending would need to be reduced by 19 percent (Boards of Trustees 2014).

The Supplementary Medical Insurance (SMI) Trust Fund covers services under Part B and Part D. Part B helps pay for physician services and other ambulatory care, such

**FIGURE
1-10****The number of workers per HI beneficiary is projected to decline rapidly**

Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A.

Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

as services received in hospital outpatient departments. Part D helps pay for prescription drug coverage. The SMI Trust Fund is financed by general revenues and premiums. Beneficiaries pay for about 25 percent of Part B and Part D spending through annual premiums. The other 75 percent is paid by taxpayers through general revenues. Because general revenue transfers and premiums are reset each year to match expected Part B and Part D spending, they grow at the same rate as Part B and Part D spending. While that framework technically guarantees that the SMI Trust Fund is balanced, it also increases transfers from the general fund of the Treasury to the Medicare program, thus increasing deficits and the debt.

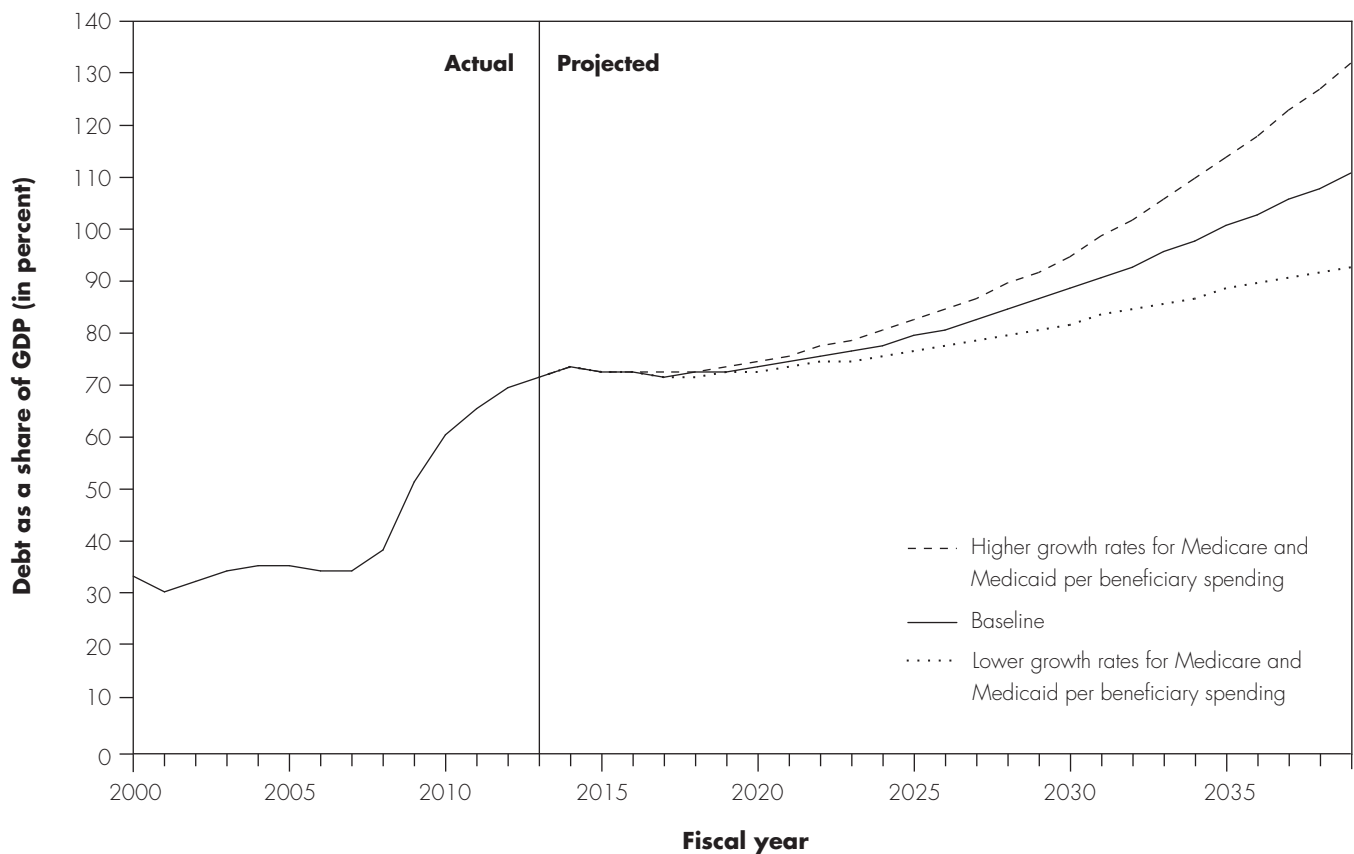
Thus, Medicare's financial challenge includes not only the Part A deficit but also the share of spending financed through general revenue (Figure 1-9, p. 15). Currently, general revenue makes up a little over 40 percent of Medicare income, and the Trustees project that share to continue to grow, adding significantly to federal budget pressures. The projected growth in premiums will also strain household budgets.

Health care spending consumes growing shares of federal and state budgets and the budgets of individuals and families

Because general revenues finance a large share of Medicare and because Medicare is a significant share of the federal budget, Medicare's fiscal sustainability is tightly linked to that of the overall federal budget and vice versa. Similarly, states bear a significant share of Medicaid costs, so rising health care spending also has implications for state budgets. For individuals and families, increases in premiums and cost sharing have negated real income growth in the past decade. Likewise, premiums and cost sharing for Medicare beneficiaries are projected to grow faster than Social Security benefits.

Health care spending and the federal budget

Medicare spending is projected to consume 14 percent of the federal budget this year, and Medicare and Medicaid spending combined is projected to consume 23 percent

**FIGURE
1-11****Health care spending growth affects future debt levels**

Note: GDP (gross domestic product). The higher growth rate of per beneficiary spending on Medicare and Medicaid is 0.75 percentage point per year higher than under the baseline assumptions; the lower growth rate is 0.75 percentage point per year lower than under the baseline assumptions.

Source: Congressional Budget Office report *The 2014 Long-Term Budget Outlook*.

(Congressional Budget Office 2014b). With their reliance on general tax dollars and federal deficit spending, those health care programs have a substantial effect on the federal debt.³

Debt equaled 35 percent of GDP at the end of 2007 as the economy entered the last recession (Figure 1-11). In response to the recession, the debt soared, reaching 72 percent of GDP in 2013—a higher percentage than at any point in U.S. history except briefly around World War II. Under baseline assumptions, which reflect current law, CBO projects the debt will reach 100 percent of GDP in about two decades (or by 2035).

However, the CBO baseline assumes that per beneficiary spending for Medicare and Medicaid increases more slowly in the future than it has during the past several

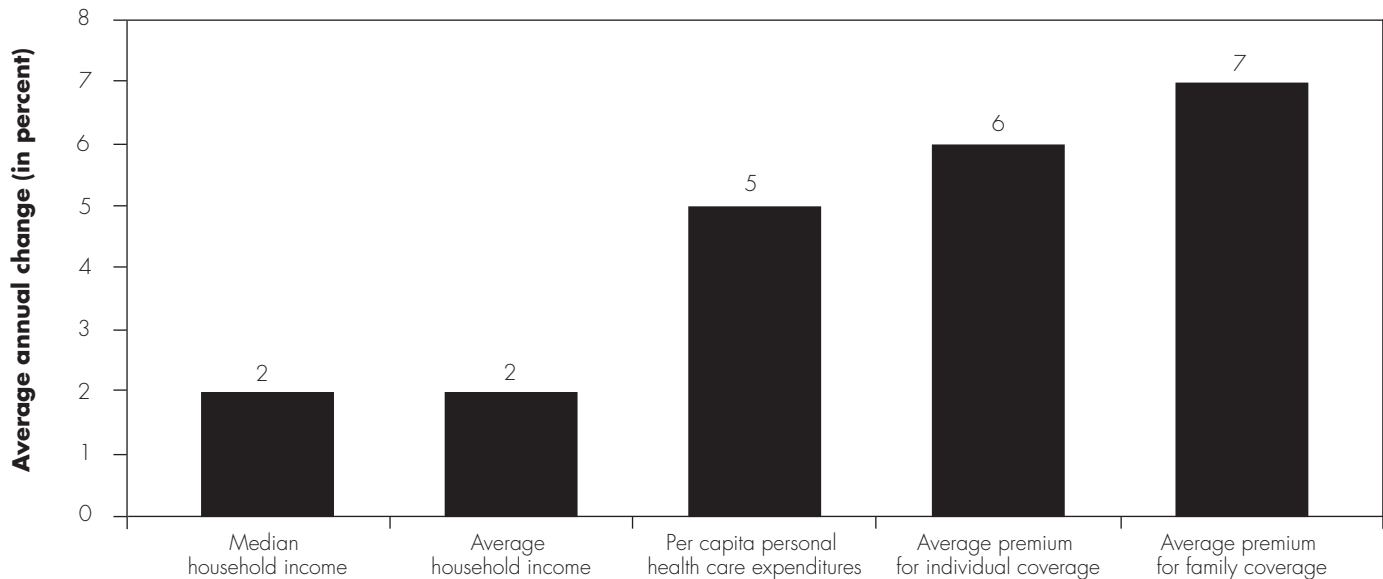
decades (Congressional Budget Office 2014a). If per beneficiary spending growth were three-quarters of a percentage point higher than that of the baseline, then the federal debt would be 114 percent of GDP by 2035. On the other hand, if per beneficiary spending growth were three-quarters of a percentage point lower, then the federal debt would be 89 percent of GDP by 2035. Still, under all three scenarios, the debt projections are at levels not seen since the aftermath of WWII (Figure 1-11).

Health care spending and state budgets

States' liabilities for health care costs include their share of Medicaid spending, which generally covers health care services for low-income children, adults, individuals who are blind or disabled, and some long-term care services for those who are aged and disabled. In 2012, before the

**FIGURE
1-12**

**Growth in health care spending and premiums
outpaced growth in household income, 2002–2012**



Note: Household income, health expenditures, and premiums are all measured in nominal dollars.

Source: Census Bureau, Current Population Survey, Annual Social and Economic Supplements 2013. MedPAC analysis of National Health Expenditures Accounts from CMS 2014, and Kaiser Family Foundation and Health Research & Educational Trust 2014.

coverage expansions made by PPACA, monthly enrollment in Medicaid averaged about 59 million people, and total spending was \$432 billion (Truffer et al. 2013). States and the federal government jointly finance Medicaid; in 2012, before the coverage expansions made by PPACA, the federal share was 58 percent (Truffer et al. 2013).

Under PPACA, states are given the option to expand Medicaid coverage to nonelderly individuals with a family income of less than 138 percent of the federal poverty threshold. States receive full federal financing to cover this expansion population in 2014, phasing down to 90 percent federal financing by 2020.

PPACA also increased the payment amount primary care providers receive for seeing Medicaid patients so that it equaled the Medicare payment in 2013 and 2014. This policy represents a significant increase in payments to providers—the two-year provision increased spending by \$11 billion—with the federal government incurring the cost. The provision expires at the end of 2014. In a recent survey, 15 states indicated that they will continue the higher rates (without federal funding), at least partly, after the provision expires, while 24 states indicated that they

would not continue the rate increase. Some states were undecided at the time of the survey (Smith et al. 2014).

A provision also established under PPACA authority allows state demonstrations for beneficiaries dually eligible for Medicare and Medicaid. In 2011, the Medicare–Medicaid Coordination Office at CMS announced a financial alignment demonstration through which states can develop integrated care programs for full-benefit dual-eligible beneficiaries. States have the option to implement a capitated model, a managed fee-for-service model, or both. Under the capitated model, a health plan receives Medicare and Medicaid capitation payments to cover all Medicare and Medicaid services. As of August 2014, 10 states signed a memorandum of understanding (MOU) with CMS to administer the capitated model, and two states signed MOUs to administer the FFS model (including one state that is also administering the capitated model). Finally, one state is adopting an alternative model.

Health care spending and individual and family budgets

For individuals and families, growth in health care spending means higher health insurance premiums

and higher taxes devoted to health care (Auerbach and Kellerman 2011). For those covered by employer-sponsored health insurance, an increase in premiums also results in lower wage growth because employers offset their increased costs of providing health insurance to their employees (Baicker and Chandra 2006, Gruber 2000, Steuerle 2013). As health care spending increases, an increasing share of income from individuals and families is transferred to hospitals, physicians, and other providers of health care services.

In the last decade, per capita health spending and premiums have grown much more rapidly than median and average household incomes (Figure 1-12). From 2002 to 2012, before the coverage expansions made by PPACA, per capita personal health care spending grew at an average annual rate of 5 percent, while the average annual rates of premiums for individuals and families grew 6 percent and 7 percent, respectively (Centers for Medicare & Medicaid Services 2014, Kaiser Family Foundation and Health Research & Educational Trust 2014). In contrast, during this period, median and average household incomes grew at an average annual rate of just 2 percent (DeNavas-Walt et al. 2013).

Medicare beneficiaries are not exempt from the financial challenges of the program's ever-growing cost-sharing liabilities. In 2012, SMI (Medicare Part B and Part D) premiums and cost sharing consumed 23 percent of the average Social Security benefit (Boards of Trustees 2014). (Those percentages do not include beneficiary spending on premiums for Medicare supplemental insurance.) The Medicare Trustees estimate that those costs will consume 30 percent of the average Social Security benefit by 2031. In 2012, Social Security benefits accounted for about 70 percent of income for seniors, on average. For more than one-fifth of seniors, Social Security benefits account for 100 percent of income (Social Security Administration 2012).

Changes in the Medicare-eligible population

The Medicare population is projected to increase from 54 million beneficiaries at the time of this writing to over 80 million beneficiaries in about 15 years (by 2030) as the baby-boom generation ages into Medicare eligibility. This expansion will bring changes to the Medicare population. First, the average age of the Medicare

population will initially skew younger than in the recent past but then grow rapidly older as the number and share of beneficiaries ages 85 and older increases. Second, more so than previous cohorts of enrollees, members of the baby-boom population will enter Medicare with multiple chronic conditions, a prevalence that is likely to increase in the Medicare population as the baby-boom generation grows older. Those trends will likely exert upward pressure on Medicare spending. Third, beneficiaries entering the program over the next several years will have had very different experiences with employer-sponsored and other forms of health care coverage because of significant changes that have taken place and continue in the private and non-Medicare public health insurance markets.

Age and demographic changes

Enrollment in the Medicare program is projected to grow rapidly over the next two decades as members of the baby-boom generation age into the program (Figure 1-13, p. 20). (Medicare enrollment also includes individuals under age 65 who qualify for Medicare based on disability status. See text box on p. 21.) These individuals began aging into Medicare in 2011 at an average rate of 10,000 people per day. By 2030, Medicare is projected to have over 80 million beneficiaries—up from 54 million beneficiaries today—almost entirely made up of baby boomers (Figure 1-14, p. 20) (Census Bureau 2012).

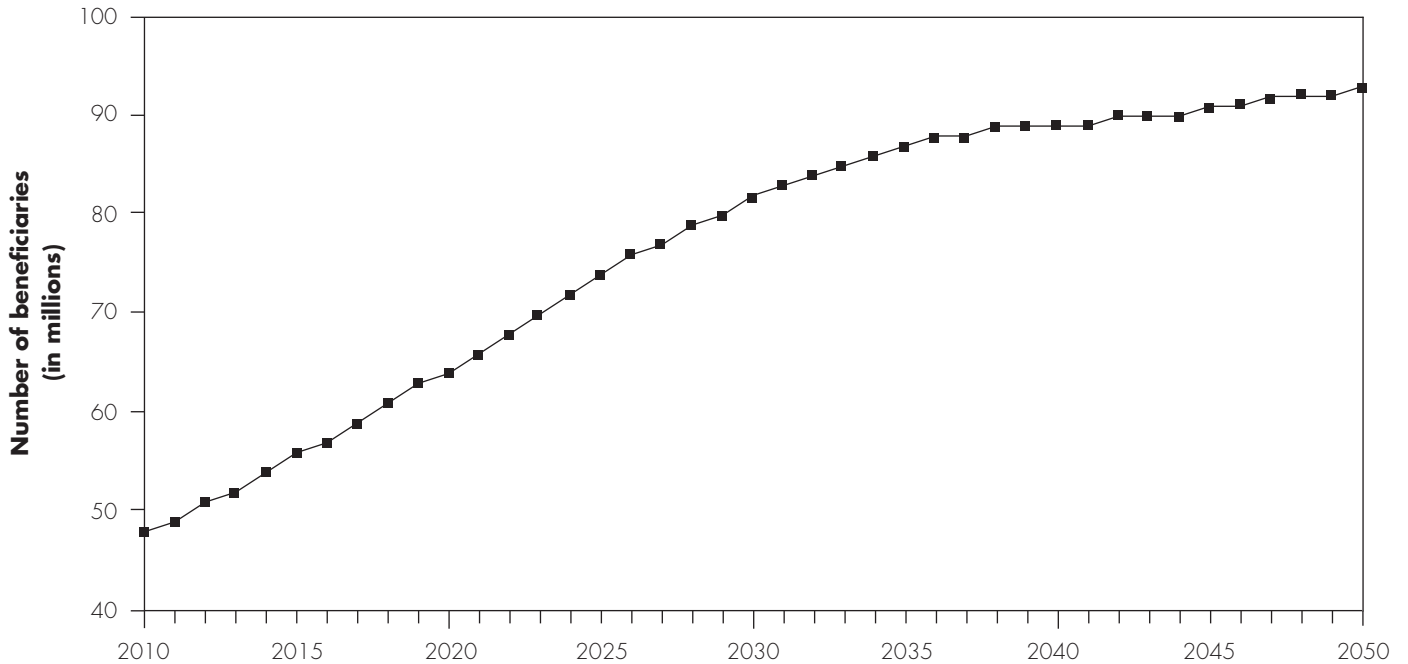
The Medicare population over the next 15 years will be relatively younger as members of the baby-boom generation join its ranks and increase the number of beneficiaries in younger age categories. (Figure 1-15, p. 21). The share of the Medicare population ages 85 years or more is projected to decline slightly through 2025. After 2025, that older share is projected to grow as the baby-boom generation continues to age (Boards of Trustees 2014, Census Bureau 2012).

The older population is, and will be for some time, less diverse racially and ethnically than the total population (Figure 1-16, p. 22). As a proportion of the older population, Whites will remain a majority through 2060 (Figure 1-16, left-side graph). In contrast, as a proportion of the total population, Whites will no longer be a majority by 2043 (Figure 1-16, right-side graph).

There are two main reasons why the racial and ethnic diversity of the older population lags behind the total population. First, when baby boomers were born, almost 90 percent of the total U.S. population was White.

**FIGURE
1-13**

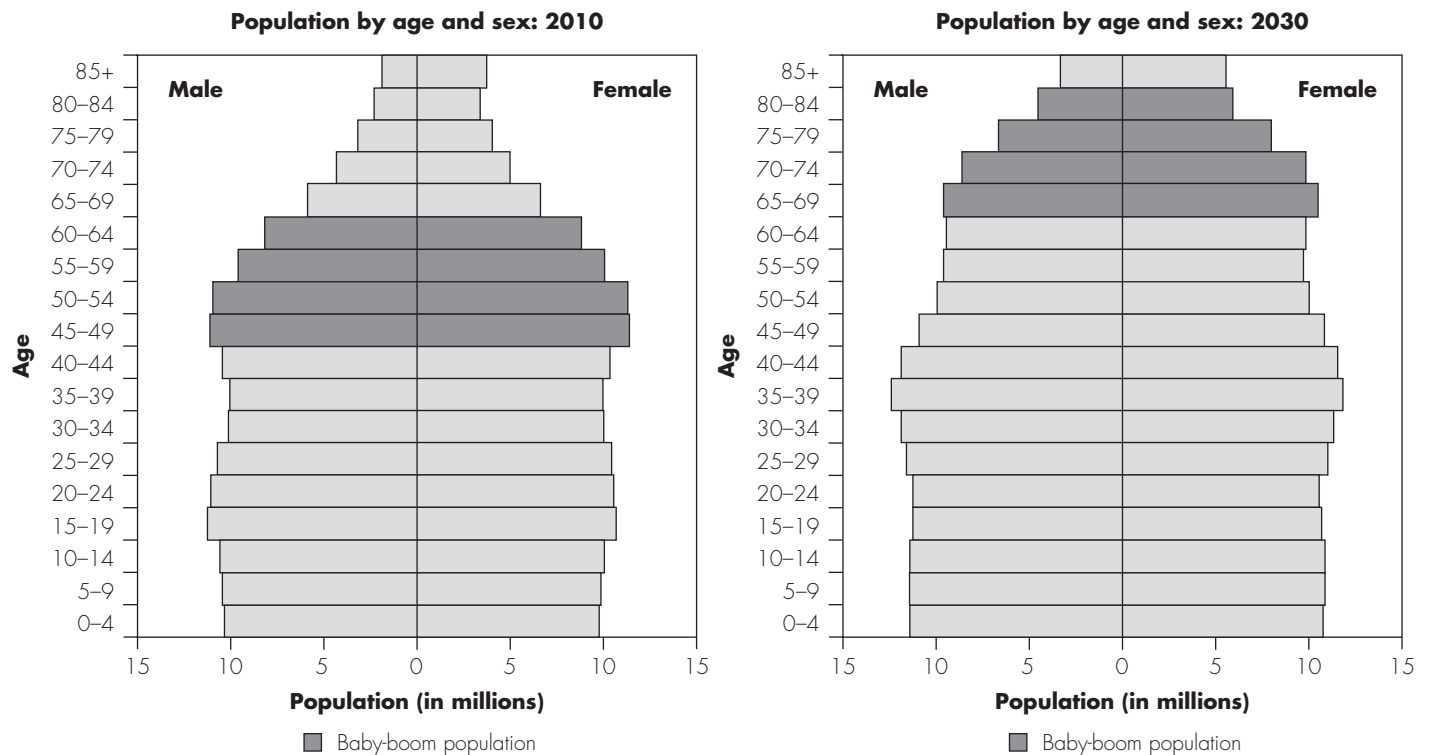
Medicare enrollment projected to grow rapidly as members of the baby-boom generation age into the program



Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds.

**FIGURE
1-14**

By 2030, the entire baby-boom generation will be eligible for Medicare



Source: Census Bureau, 2010 Census and 2012 National Population Projections, middle series.

Disabled Medicare enrollees under the age of 65

Nearly 9 million people under the age of 65 are receiving Medicare because they are entitled to Social Security Disability Insurance (SSDI). They become eligible for Medicare 24 months after their disability begins. Disabled beneficiaries have grown as a share of the Medicare population, reaching 17 percent in 2012. Total Medicare FFS spending in 2012 on the under-65 disabled population was about \$80 billion (or about 17 percent of total FFS spending).

Per beneficiary spending is comparable for the disabled and the aged, although disabled beneficiaries

use lower levels of post-acute care and relatively higher amounts of ambulatory and hospital care. Disabled beneficiaries report more trouble accessing health care services, although this difficulty may be partly because of their relatively low incomes overall (almost half of all disabled beneficiaries are dually entitled to Medicaid). The average age of disabled Medicare beneficiaries is a little over 50; thus they receive Medicare for 15 years before they would have become eligible by turning age 65. ■

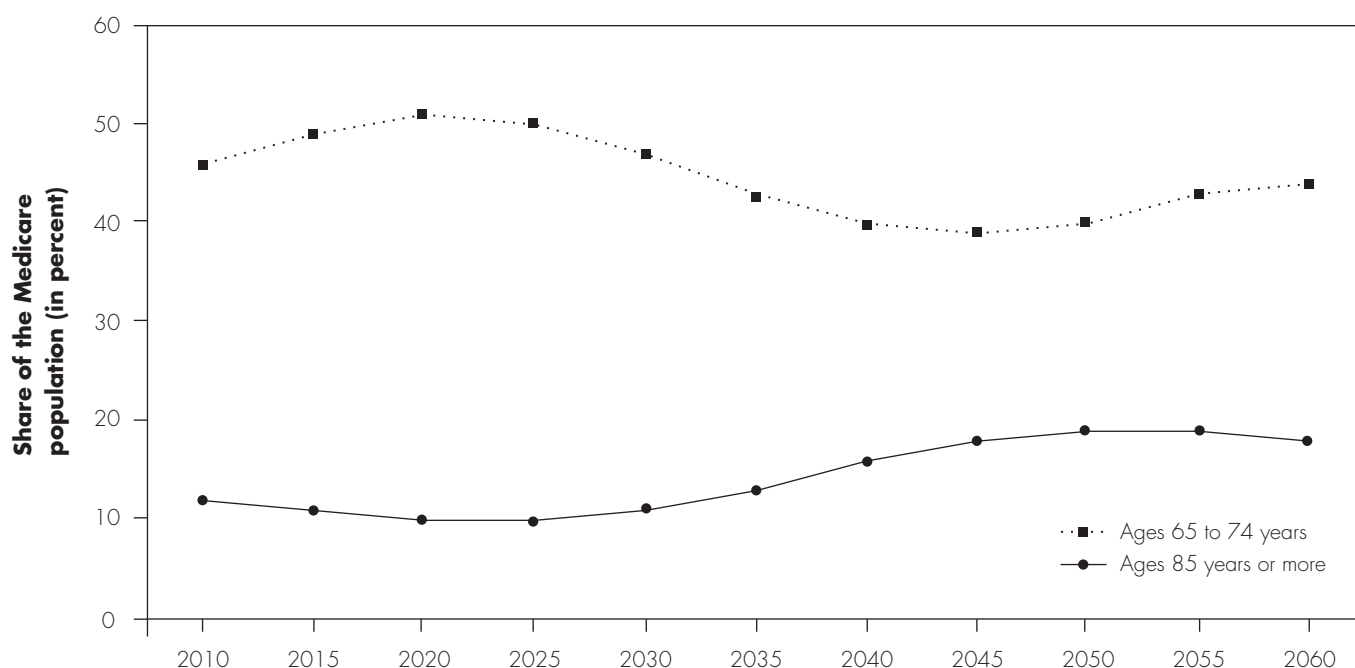
Second, since then, the nation's population has become increasingly diverse through increases in immigration and minority births. However, recent immigration does not have much of an effect on the age structure of the older population because most immigrants are under the age of 40 when they arrive in the United States. (Census Bureau 2012).

Disease burden and prevalence of multiple chronic conditions

Chronic conditions such as high blood pressure, high cholesterol, heart disease, and diabetes are highly prevalent among today's Medicare beneficiaries. In 2010, almost 60 percent had high blood pressure; 45 percent had high cholesterol; and almost one-third had ischemic heart

FIGURE 1-15

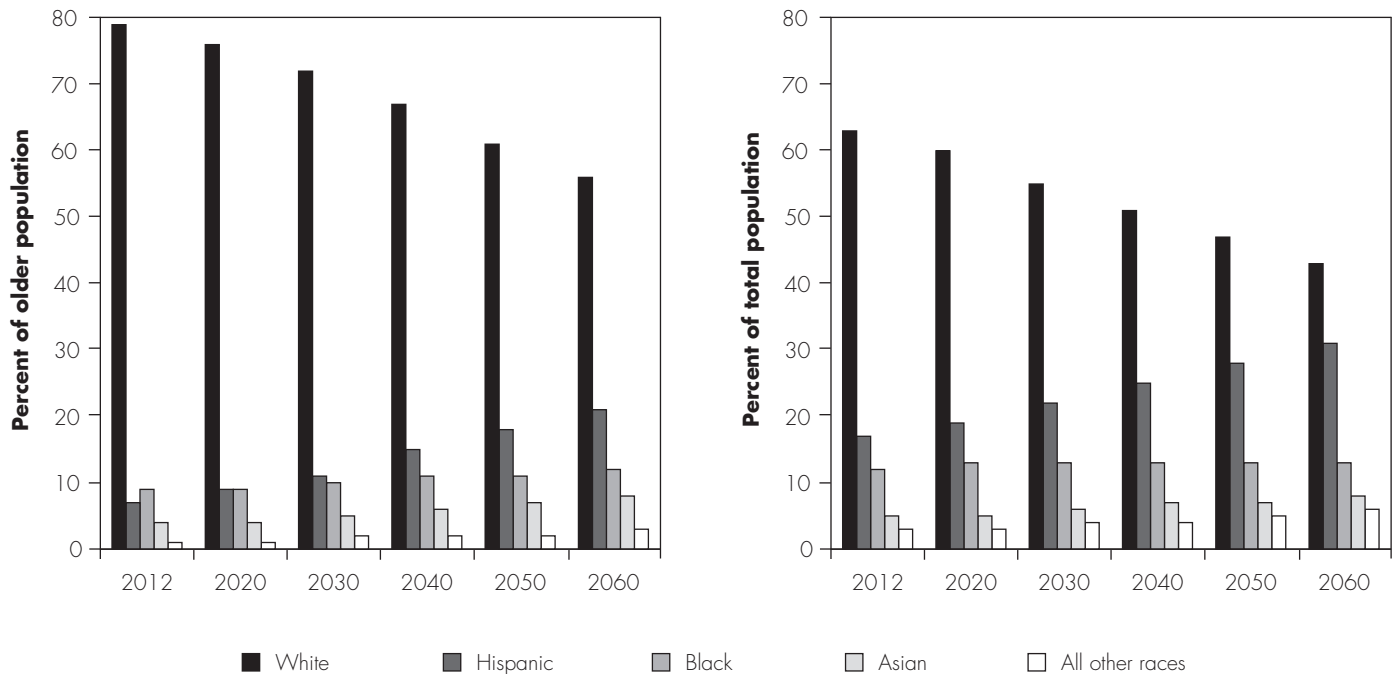
The Medicare population will become younger and then older



Source: 2014 annual report of the Boards of Trustees of the Medicare trust funds and Census Bureau, 2012 National Population Projections.

**FIGURE
1-16**

The older population (ages 65 and older) is less racially and ethnically diverse than the total population



Note: "All other races" includes American Indian and Alaska Native and multiracial.

Source: Census Bureau, 2012 National Population Projections.

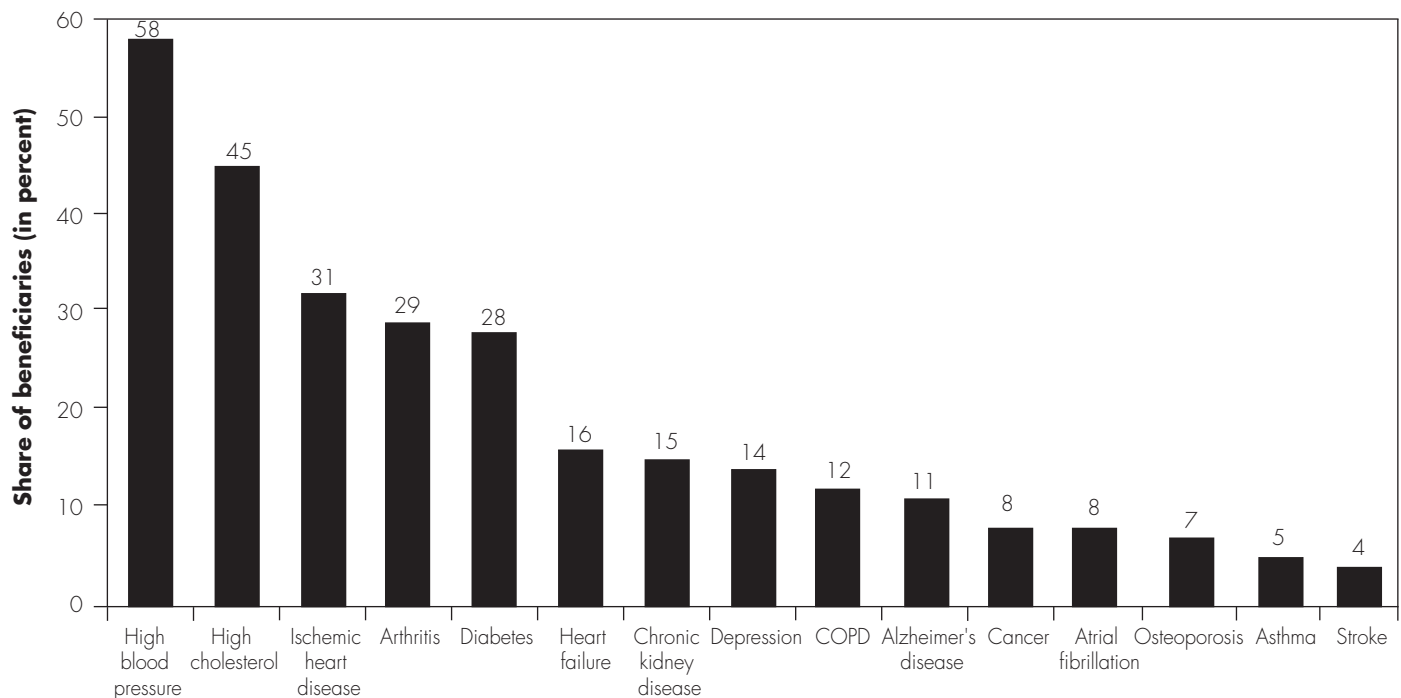
disease, arthritis, or diabetes (Figure 1-17) (Centers for Medicare & Medicaid Services 2012). However, not all chronic conditions have the same effect on per beneficiary spending. While high blood pressure and high cholesterol were the two most prevalent chronic conditions, stroke, chronic kidney disease, asthma, and chronic obstructive pulmonary disease were among the chronic conditions associated with the highest per beneficiary spending.

Today's Medicare beneficiaries are also likely to have multiple (two or more) chronic conditions. In 2010, more than two-thirds of Medicare beneficiaries had multiple chronic conditions, and 14 percent had six or more chronic conditions (Figure 1-18, p. 24). Beneficiaries with six or more chronic conditions accounted for over 40 percent of Medicare spending in 2010, while beneficiaries with one chronic condition or none made up about one-third of the Medicare population, yet accounted for just 7 percent of total Medicare spending. In 2010, Medicare spent an average of \$32,658 per beneficiary with six or more chronic conditions compared with an average of \$9,738

across all FFS Medicare enrollees (Centers for Medicare & Medicaid Services 2012).

Another recent study estimated that in 2010 nearly 15 percent of people older than age 70 (or about 3.8 million people) have dementia—a broad category that includes Alzheimer's disease as one of its forms (Hurd et al. 2013). Medicare beneficiaries with dementia suffer from loss of memory, reasoning, speech, and other cognitive functions, making it difficult for them to make decisions and perform the activities of daily living.

How will the health of the Medicare population change over the next couple of decades as the baby-boom generation ages into the program? An analysis of 2001–2010 National Health Interview Survey data by researchers at the Centers for Disease Control and Prevention (CDC) showed a statistically significant trend from 2007 through 2010 of increasing numbers of adults ages 45 to 64 years with two or three chronic conditions, and a significant increase in the prevalence of four or more

**FIGURE
1-17****Share of Medicare FFS beneficiaries with any of 15 selected chronic conditions, 2010**

Note: FFS (fee-for-service), COPD (chronic obstructive pulmonary disease). The percentages sum to more than 100 percent because beneficiaries may have multiple chronic conditions.

Source: Centers for Medicare & Medicaid Services 2012.

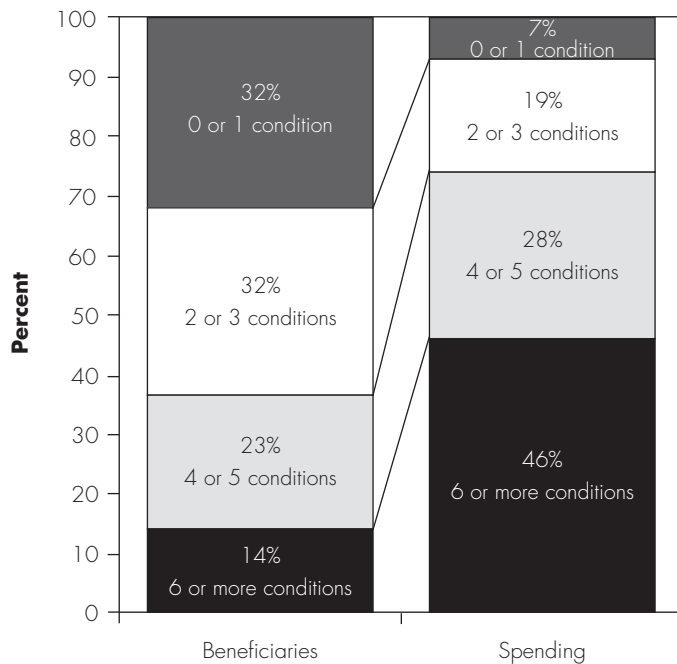
chronic conditions from 2001 through 2010 among the same age cohort (Ward and Schiller 2013). This finding means that a higher share of the baby-boom generation reported having multiple chronic conditions compared with shares of previous generations. The CDC also showed that a higher share of this age cohort reported having had a stroke or having had cancer (which could reflect changes in the use of cancer diagnostic procedures over the period), but a slightly lower share reported having heart disease compared with the shares of previous generations (National Center for Health Statistics 2014).

Because health care service use and costs increase as an individual's number of chronic conditions increases, it is reasonable to expect that these trends mean higher Medicare spending (Anderson 2010, Centers for Medicare & Medicaid Services 2012, Machlin and Soni 2013). In addition, since older beneficiaries are more likely to have multiple chronic conditions (Table 1-2, p. 25), the overall aging of the comparatively larger Medicare population

will almost certainly magnify trends in the prevalence of multiple chronic conditions.

Experience with private health insurance coverage

Changes in the private health insurance market may affect new Medicare beneficiaries' familiarity with different types of coverage and their expectations about out-of-pocket costs. For example, workers covered by private health insurance today are accustomed to receiving health care from a network of participating providers rather than from an unconstrained array of unaffiliated providers. Adults approaching Medicare eligibility who have worked for large employers often have chosen coverage from a range of plans during their working years and, in the future, those purchasing individual health insurance may also gain experience in choosing plans through the new state and federal health insurance exchanges that began in 2014. Those experiences may increase the likelihood that an incoming beneficiary has experience choosing among

**FIGURE
1-18****Medicare spending is concentrated among beneficiaries with multiple chronic conditions, 2010**

Note: Data based on Chronic Condition Warehouse definitions of chronic conditions.

Source: Centers for Medicare & Medicaid Services 2012.

coverage options and increase the willingness of future Medicare beneficiaries to enroll in Medicare Advantage plans or other alternatives to traditional fee-for-service Medicare.

Workers covered by private health insurance today have also experienced rapid growth in premiums and other out-of-pocket costs. Premiums for family coverage increased 80 percent between 2003 and 2013 (Kaiser Family Foundation and Health Research & Educational Trust 2014). Enrollment in high-deductible health plans—plans that have lower premiums than traditional plans but require the enrollee to spend down a large deductible before receiving insurance benefits—has also increased dramatically. In 2013, 20 percent of workers covered by private health insurance were enrolled in a high-deductible health plan that offered some sort of tax-preferred savings account to pay for the deductible compared with just 4 percent in 2006 (Kaiser Family Foundation and Health Research & Educational Trust 2014).

How quickly will health care spending grow in the coming years?

Despite disagreements among researchers about what share of the health care spending slowdown can be attributed to the recession, nearly all agree that the economic contraction starting in 2007 played a role, and many expect that health care spending may reaccelerate as the economy expands (Martin et al. 2014, Ryu et al. 2013, Sisko et al. 2014).

Exploring the factors behind health care spending can help explain why spending growth accelerates or decelerates. But the question of whether health care spending will continue to grow at the rates seen in the last decade or at rates closer to the three previous decades is still unanswerable.

The Commission maintains that past trends will not necessarily carry into the future, regardless of whether they were caused by economic fluctuations or by structural changes. As an example, in the mid-1990s, health care spending slowed dramatically, in part because of a structural change—the rise of managed care plans—but then spending ramped up again as providers and beneficiaries rejected those plans. Similarly, poor economic conditions over the last decade may have exerted pressure on providers to reduce costs, but as the economy recovers and payment pressure diminishes, costs could increase.

Moreover, despite the slowdown, there is still low-value and wasteful care. If wasteful spending can be identified and eliminated, it may be possible to slow the growth in health care spending. Ideally, the elimination of system inefficiencies and waste could result in each Medicare dollar spent better improving beneficiary health, supporting the program's fiscal sustainability and reducing federal budget pressures. Certain aspects of the Medicare program pose challenges to reducing wasteful spending, and the Commission has made recommendations to address some of those challenges.

Factors affecting health care spending

Factors that affect health care spending include technology, health insurance (both having insurance and the nature of that insurance), consolidation of health care providers, and demographics and patient characteristics (particularly income). The factors are also intertwined; for example, one study has posited that the spread of health insurance between 1950 and 1990 increased the demand

**TABLE
1-2**

Older beneficiaries are more likely to have multiple chronic conditions, 2010

Number of chronic conditions	Age (in years)			
	Less than 65	65 to 74	75 to 84	85 and older
0 to 1	47%	37%	23%	17%
2 to 3	28	34	33	29
4 to 5	17	20	27	29
6 and more	9	9	18	25

Note: Number of chronic conditions is based on counts of 15 selected conditions using the Chronic Condition Warehouse definitions. Totals may not sum to 100 percent because of rounding.

Source: Centers for Medicare & Medicaid Services 2012.

for health care, which in turn, induced hospitals and doctors to adopt new medical technologies because more people could afford them. The author estimates that the combined effect accounted for 50 percent of health care spending growth over that time (Finkelstein 2007).

- **Technology** is credited in some studies as having the largest single effect on growth in health care spending (Cutler 1995, Newhouse 1992, Smith et al. 2009). Caution must be taken when interpreting these studies, however. In most studies, analysts have not measured technology's effect on health care spending directly because it is difficult to do so. Instead, analysts have estimated the contributions of other measurable demographic and economic factors and attributed the unexplained portion of spending growth, or residual, to technology. Therefore, depending on the study, the term *technology* can be interpreted broadly to mean any factor that cannot be measured, making it a catch-all term that could include the technology's adoption, diffusion, substitution, and potentially inappropriate application, but also other changes in medical practice. Technology can refer to new procedures and treatments but also to old procedures and treatments applied to a different population or for a purpose different from what was originally intended (Ginsburg 2008). While expensive new technology can improve health and may be of high value, there is also concern that technological advances expand even beyond cases for which they show efficacy, which increases spending without improving patient outcomes (Baicker and Chandra 2011, Garber et al. 2007, Redberg 2011, Welch 2012). Although technological

advances can sometimes decrease spending (for example, an innovation that more effectively treats a condition at a lower cost), in the practice of medicine, such advances and the resulting changes in clinical practice have generally increased total spending.

- **Health insurance coverage**—while increasing access to health care and protecting beneficiaries against the risk of financial hardship when they need expensive care—reduces the incentive for insured individuals to seek the lowest priced effective service. Researchers suggest that population-level changes in insurance coverage may be responsible for up to half of the increase in per capita health care spending since 1950 (Finkelstein 2007, Peden and Freeland 1995). Studies of Oregon's experiment in extending Medicaid coverage by lottery showed that people randomly chosen for Medicaid coverage used services more—an estimated 25 percent more than the uninsured control group (Baicker and Finkelstein 2011, Finkelstein et al. 2012). More recently, shifting health care costs to insurers has slowed because of rising coinsurance, copayments, and deductibles, likely contributing to the recent slowing of the growth in health care spending (Kaiser Family Foundation and Health Research & Educational Trust 2014).
- **Consolidation** of health care providers has been found to increase spending growth, whereas insurer consolidation has been found to have only a modest effect, which can be positive or negative. Market consolidation among providers increases the rates that providers can negotiate from private payers

(Baker et al. 2014a, Baker et al. 2014b, Gaynor and Town 2012, Robinson and Miller 2014). Hospital purchasing of physician practices, in particular, may be occurring in part because of the disparity between higher payment rates for services provided in the hospital outpatient department than the same service provided in a physician office (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013). By contrast, insurer consolidation tends to lower prices paid to providers because providers may be less able to negotiate high prices if there is a dominant insurer (Moriya et al. 2010). However, those lower prices may not be passed on to consumers in the form of lower premiums if there is not enough competition among insurers for consumers. Studies have shown both modest increases and modest decreases in premiums resulting from insurer consolidation (Dafny et al. 2012, Medicare Payment Advisory Commission 2013).

- ***Demographics and patient characteristics*** affect spending growth, but to a lesser extent than might be expected. Among demographic factors, income and wealth are the primary drivers. People who have more expendable income and wealth will use more of it on health care services. Income and wealth also interact with technology; that is, companies may increase their investments in new health care technologies as the market for these services expands. Along these lines, one study posits that the recent slowdown in health care spending is a result not only of the more recent acute recession but also of the relatively sluggish wage growth for many workers during the 2000s. From this viewpoint, while structural changes (such as payment rate cuts in Medicare, growth in beneficiary cost sharing, and state efforts to contain Medicaid costs) also occurred, these factors were in response to the decade-long period of slow economic growth from 2000 to 2011 (Holahan and McMorro 2013). Stagnant wage growth also may explain why health care spending has not rebounded during the economic recovery.

Patient characteristics such as age or disease burden can also affect health care spending, but most studies have assigned a relatively small share of national health care spending growth to changes in the overall health and aging of the population (Congressional Budget Office 2008, Cutler 1995, Gaynor and Town 2012, Newhouse 1992, Smith et al. 2000).

Evidence of wasteful spending suggests that Medicare could spend less without compromising beneficiaries' health care

While analysts debate the causes of slowing health care spending and whether it will be sustained or transient, there is no evidence that the spending slowdown affected only unnecessary care. The Commission believes it is still important to focus on the sizeable share of current health care spending that is inappropriate, unnecessary, or wasteful.

Geographic variation within and outside the United States indicates that some share of spending is not spent effectively

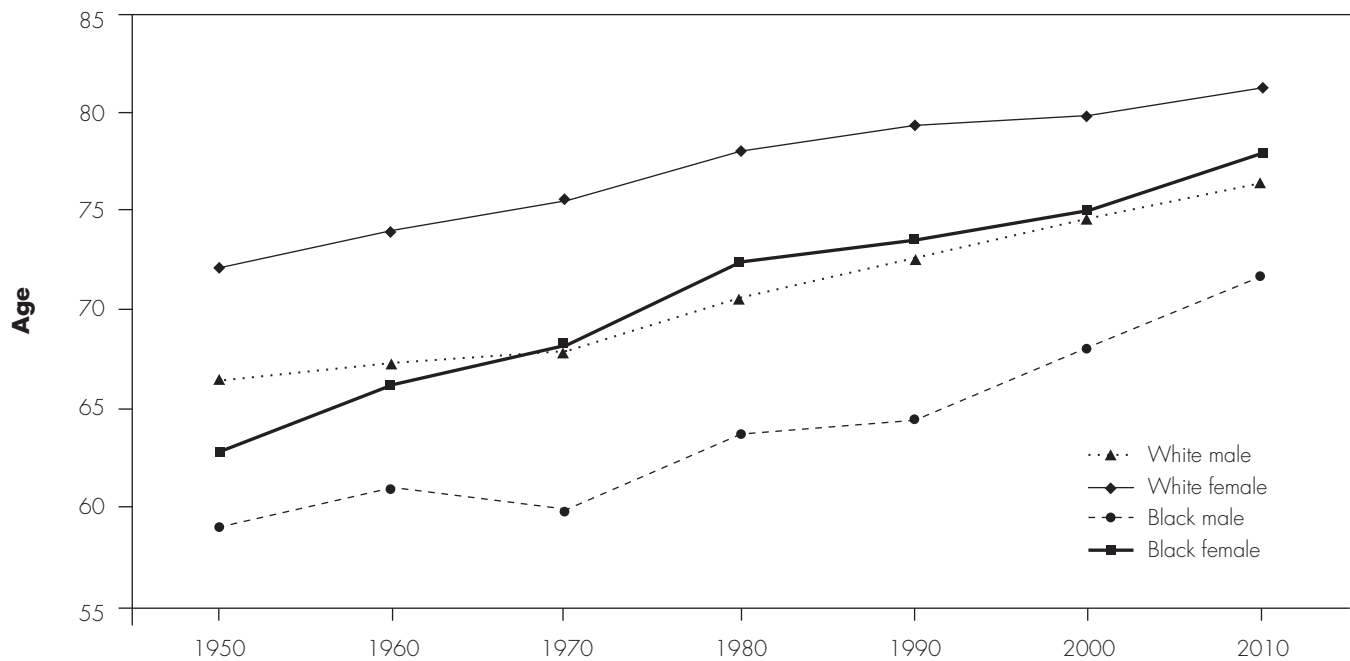
Researchers have documented notable geographic variation (both within the United States and internationally) in health care spending that does not correlate to improved patient outcomes. Certain services that have been widely recognized as low value continue to be performed regularly (Schwartz et al. 2014).

Research on Medicare spending shows that areas with higher spending or more intensive use of services do not have higher quality of care or improved patient outcomes (Fisher et al. 2003a, Fisher et al. 2003b, Institute of Medicine 2013). Even measures of service use, adjusted for health status and standardized prices, show considerable variation (Medicare Payment Advisory Commission 2011b). Even in low-spending areas, some share of health care spending is inappropriate (Leape et al. 1990).

The United States spends more on health care, both per capita and as a share of GDP, than any of the 34 member countries of the Organisation for Economic Co-operation and Development (OECD). However, it is also worth noting that prices are significantly higher for services in the United States as compared with other countries, even when adjusted for purchasing power (Anderson et al. 2003, Laugesen and Glied 2011, Squires 2014, Squires 2012, White 2007). These higher health care spending levels are not accompanied by improved ultimate outcomes; rates of infant mortality and life expectancy are worse in the United States than in most other OECD countries.

Trends in health care quality and outcomes

Other factors for consideration are the trends in health care quality and outcomes and the relationship between these trends and developments in the health care system overall. Life expectancy has improved significantly for

**FIGURE
1-19****Life expectancy at birth, by race and gender**

Source: Centers for Disease Control and Prevention, *Health, United States*, 2013.

the overall population over the past century, although the gains were most striking from 1900 to 1950, during which life expectancy at birth improved by more than 20 years. The gains were also significant in the second part of the 20th century, but to a lesser degree. Over the past decade (from 2000 to 2010), life expectancy at birth improved by an additional two years, to 79 (Xu et al. 2014). However, gains in life expectancy (as well as the starting level) varied by racial and ethnic groups (Figure 1-19). Research also suggests that medical care contributes relatively little to life expectancy gains, on average. When reviewing cross-sectional data on Medicare spending and outcomes, there is little evidence that greater amounts of health care service use or spending result in better quality of care for Medicare beneficiaries.

For some selected diseases, there have been improvements in decreasing mortality for some conditions that are amenable to health care. For example, deaths due to heart disease fell from 590 per 100,000 residents to 180 per 100,000 residents between 1950 and 2010. Similarly, deaths due to cerebrovascular conditions (such as stroke) fell from 180 per 100,000 residents to 39 per 100,000

residents over the same period (National Center for Health Statistics 2014). Rising health care spending may have played a role in these improved outcomes.

Challenges specific to Medicare

The Medicare program is a complex and fragmented system, consisting of multiple paths to entitlement; multiple types of coverage (Part A, Part B, Part C, and Part D); multiple payment systems; and different rules for each setting. The Medicare program must set prices for thousands of discrete services at different levels of aggregation (e.g., inpatient hospital payments are paid based on the stay, while physician payments are based on the service) and in different labor markets across the country. The Medicare program statute and rulemaking include a substantial number of exceptions, adjustments, and modifications to its general policies. Several of Medicare's structural features specifically result in inefficient spending:

- **Fragmented payment system across multiple settings.** The program sets payment rates each year for at least nine different health care settings: inpatient

and outpatient hospitals, physician and other health professional offices, home health agencies, skilled nursing facilities, long-term care facilities, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and end-stage renal disease facilities. In addition to this yearly rulemaking, administrators oversee other parts of the program that may operate on fee schedules (ambulances, outpatient lab facilities), or on cost-based payment (rural health centers, critical access hospitals). Payment rates for Part C (Medicare Advantage) are set using administrative pricing based on a competitive process, and Part D payments (prescription drugs) are set generally by market rates. But all parts of the Medicare program require significant CMS oversight and administration.

- **Coverage of services delivered by any willing provider.** Under Medicare's statute, the program generally covers all medically necessary services in each benefit category that are delivered by any willing provider (any provider that is willing to meet Medicare's rules). As a result, Medicare does not have the authority to develop provider networks or credential providers, tools that private payers often use to reduce the potential for fraud and abuse. In some cases, the Medicare program even has difficulty removing providers or suppliers whose claims histories clearly demonstrate aberrant patterns.
- **The program's benefit design.** Beneficiaries face differential cost sharing by service (for example, coinsurance for physician services is 20 percent, while home health has no coinsurance); in addition, the cost-sharing amounts, percentages, and deductibles vary by setting, and some services are not covered altogether (for example, Medicare does not generally cover long-term care). Medicare Part A and Part B lack a cap on out-of-pocket costs, a feature that exists in nearly all private insurance policies. In response, many beneficiaries purchase supplemental coverage that includes an out-of-pocket maximum. Most supplemental policies also substantially reduce or eliminate most of the beneficiary liability for coinsurance and deductibles, thereby blunting the impact of cost sharing. As a result, there is little incentive for beneficiaries to be cost-conscious—that is, to select only those services that are necessary and choose providers who use efficient clinical practices (Medicare Payment Advisory Commission 2012).

- **Different prices for the same or similar services.** Given the different settings under which services are delivered, the Medicare program in some cases has different prices for the same or similar services. Under these circumstances, providers have an incentive to shift care to the higher paid setting, which leads to increased program spending and higher beneficiary cost sharing.
- **Undervalued and overvalued services.** In the process of setting prices for thousands of services, certain services are undervalued relative to others. For example, the Commission has raised concerns that the Medicare fee schedule overpays for services provided by clinicians in procedural specialties and underpays for services provided by clinicians in primary care specialties (Medicare Payment Advisory Commission 2011a). The result of this imbalance is significantly higher income for procedural specialties relative to primary care specialties, contributing to a corresponding imbalance in clinician supply.
- **Prompt payment standards.** The Medicare program also follows prompt payment standards, requiring contractors by law to pay claims within 30 days of receipt of a clean claim—one that appears to meet Medicare's rules—or else Medicare will be liable for interest. This emphasis on timely payment means that, in many cases, the claim may be paid and only thereafter identified as potentially fraudulent or erroneous.
- **Vulnerability to patient selection, steering, and overuse.** Another consequence of Medicare's payment structure is its vulnerability to patient selection, steering, and overuse. For example, with some payment systems it is financially advantageous for providers to treat certain kinds of beneficiaries and avoid others, provide certain types of services over others, or treat beneficiaries in a higher paid setting. In addition, in Medicare's fee-for-service system, providers may be able to increase their revenue by increasing the volume of services they provide without commensurate value to the beneficiary. Clinicians also may make referrals to a source of care in which they hold a financial interest or for a service, device, or drug for which they have received payment from the manufacturer.

These features make the program vulnerable to inappropriate care, waste, and fraud. In recent years,

CMS has gained new authorities to exclude potentially fraudulent providers from the program and apply different levels of scrutiny to new providers based on their fraud potential. CMS also has further developed its ability to identify potentially fraudulent billing patterns. However, all of CMS's activities in this area are constrained by resources and subject to statutory requirements that limit its ability to use the same tools to reduce fraud as private insurers (Government Accountability Office 2013).

The Commission's approach to addressing these challenges

Medicare's goal should be to obtain the greatest possible value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging their efficient use. However, managing payment rates alone will not address the Medicare FFS system's key challenge—that providers are paid more for doing more services and are not held accountable for the overall outcomes of their patients. Changing this situation will require both payment and delivery system reform.

The Commission's work can be categorized in the following domains: (1) payment accuracy and efficiency, (2) care coordination and quality, (3) information for patients and providers, (4) engaged beneficiaries, and (5) aligned health care workforce. Regardless of the issue, the Commission always considers the interests of three main actors: the beneficiary—access to high-quality, efficient care; the provider—fair and equitable pay; and the taxpayer—the most prudent and valuable use of the public's dollar.

- ***Payment accuracy and encouraging efficiency.*** In Medicare's payment systems, the payment rates for individual products and services may not accurately reflect the cost of furnishing the product or service. Inaccurate payment rates create incentives for higher volume growth for certain services, thereby unduly disadvantaging some providers and unintentionally rewarding others. The Commission pursues payment accuracy in its update recommendations as well as other policy recommendations, with a focus on ensuring that payment is adequate for the efficient provision of care.
- ***Care coordination and quality.*** Providers may provide quality care to uphold professional standards and to have satisfied patients, but until recently Medicare did not have the authority to hold them accountable for or otherwise provide incentives to

improve the quality of care they provide. Similarly, few structures exist in Medicare to hold providers accountable for the full spectrum of care a beneficiary may use, even when they make the referrals that dictate additional resource use. The Commission has supported policies that move Medicare beyond FFS into payment systems that make a provider responsible for the patient's entire episode of care to help address these gaps between settings.

- ***Broadening information available to patients and providers.*** Medicare and its providers lack the information and tools needed to improve quality and use program resources efficiently. For example, Medicare lacks quality data from many settings of care and does not have timely cost or market data to set accurate prices. In addition, beneficiaries now are being called on to make complex choices among delivery systems, drug plans, and providers. Medicare has started to make information available for beneficiaries that could help them choose higher quality providers or lower cost treatments and improve their satisfaction. The Commission has supported policies that promote comparative effectiveness, disclosure of physician financial relationships, and public reporting of quality information.
- ***Engaging beneficiaries.*** While much of the Commission's work focuses on providers and their payment incentives, how beneficiaries view the Medicare program and how they make decisions about their health care are vital to the program's success. Developing policies that engage the beneficiary along with the provider has the potential to improve health, improve the experience of health care provided through Medicare, and control costs for the beneficiary and the taxpayer alike. The Commission has supported reforming the current benefit design and promoted shared decision making.
- ***Aligning the health care workforce.*** Our nation's system of medical education and graduate training is not aligned with the delivery system reforms essential for increasing the value of health care in the United States. The Commission has pursued policies that increase the incentives for residency programs to focus on quality, efficiency, and accountability so that the future clinician workforce can better address the needs of beneficiaries.

Conclusion

The level and growth of health care spending as a share of the economy indicate that an ever-increasing amount of the country's economic activity will be dedicated to purchasing health care. Medicare is the single largest payer in the health care sector and will expand with the aging of the baby-boom generation, greatly increasing program spending. Significant cross-sectional variation in use and spending, which do not correspond to better quality, raise concern that higher health care use and spending are not improving overall health and are putting beneficiaries at risk, both medically and financially.

Because of its size, and because other payers use its payment methods, Medicare has an important influence on the nation's health care delivery system and its evolution. Reciprocally, trends in the private health care insurance

market can influence whether Medicare's payment reforms are ultimately successful. Because of this interaction between public and private payers, the alignment of incentives across payers is an important consideration for delivery system reforms.

Despite the relatively lower rates of spending growth recently experienced by and projected for the Medicare program under current law, the program will continue to absorb increasing amounts of federal revenues. Other public investments such as education and infrastructure will be crowded out by high and growing levels of health care spending. State and federal budgets face continued fiscal pressure, effects intensified by the trends in health care spending. In light of strained federal budgets and the downward trend in personal income, the Medicare program must be vigilant in pursuing reforms that decrease spending and improve quality. ■

Endnotes

- 1 Figure 1-2 shows that the share of spending accounted for by private health insurance (34 percent in 2013) is greater than Medicare's share (22 percent in 2013). However, private health insurance is not a single purchaser of health care; rather, it includes many private plans, including traditional managed care, self-insured health plans, and indemnity plans.
- 2 A small portion of the difference between the Trustees' and CBO's projections is that CBO's 10-year projection is based on current law (as required by its mandate), which includes a scheduled payment rate reduction for services furnished by physicians and other health professionals of about 20 percent in April 2015. Although that reduction is specified under current law, lawmakers have overridden it every year beginning with 2003 and are expected to continue to do so. The Trustees' 10-year projection assumes the payment rate update for physicians and other health professionals will equal the recent historical average (0.6 percent per year).
- 3 As explained in the next section, states and the federal government jointly finance Medicaid, and federal funding comes from general revenues.

References

- Anderson, G. 2010. *Chronic care: Making the case for ongoing care*. Princeton, NJ: Robert Wood Johnson Foundation.
- Anderson, G. F., U. E. Reinhardt, P. S. Hussey, et al. 2003. It's the prices, stupid: Why the United States is so different from other countries. *Health Affairs* 22, no. 3 (May–June): 89–105.
- Auerbach, D. I., and A. L. Kellermann. 2011. A decade of health care cost growth has wiped out real income gains for an average U.S. family. *Health Affairs* 30, no. 9 (September): 1630–1636.
- Baicker, K., and A. Chandra. 2011. *Aspirin, angioplasty, and proton beam therapy: The economics of smarter health care spending*. Cambridge, MA: National Bureau of Economic Research.
- Baicker, K., and A. Chandra. 2006. The labor market effects of rising health insurance premiums. *Journal of Labor Economics* 24, no. 3: 609–634.
- Baicker, K., and A. Finkelstein. 2011. The effects of Medicaid coverage—Learning from the Oregon experiment. *New England Journal of Medicine* 365, no. 8 (August 25): 683–685.
- Baker, L. C., M. K. Bundorf, and D. P. Kessler. 2014a. Vertical integration: Hospital ownership of physician practices is associated with higher prices and spending. *Health Affairs* 33, no. 5 (May): 756–763.
- Baker, L. C., M. K. Bundorf, A. B. Royalty, et al. 2014b. Physician practice competition and prices paid by private insurers for office visits. *Journal of the American Medical Association* 312, no. 16 (October 22–29): 1653–1662.
- Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2014. *2014 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds*. Washington, DC: Boards of Trustees.
- Census Bureau. 2012. National population projections: Downloadable files: Table 1. Projected population by single year of age, sex, race, and Hispanic origin for the United States, 2012 to 2060: Middle series. http://www.census.gov/population/projections/files/downloadables/NP2012_D1.csv.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014. National health expenditures, 2014 historical data. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012. *Chronic conditions among Medicare beneficiaries. Chartbook: 2012 edition*. Baltimore, MD: CMS.
- Congressional Budget Office. 2014a. *The 2014 long-term budget outlook*. Washington, DC: CBO.
- Congressional Budget Office. 2014b. *An update to the budget and economic outlook: 2014 to 2024*. Washington, DC: CBO.
- Congressional Budget Office. 2008. *Technological change and the growth of health care spending*. Washington, DC: CBO.
- Cutler, D. M. 1995. *Technology, health costs and the NIH*. Paper prepared for the National Institutes of Health Economics Roundtable on Biomedical Research. Cambridge, MA: National Institutes of Health Economics Roundtable on Biomedical Research.
- Dafny, L., M. Duggan, and S. Ramanarayanan. 2012. Paying a premium on your premium? Consolidation in the U.S. health insurance industry. *American Economic Review* 102, no. 2: 1161–1185.
- DeNavas-Walt, C., B. Proctor, and J. Smith. 2013. *Income, poverty, and health insurance coverage in the United States: 2012*. P60–245. Washington, DC: Census Bureau.
- Finkelstein, A. 2007. The aggregate effects of health insurance: Evidence from the introduction of Medicare. *Quarterly Journal of Economics* 122, no. 1: 1–37.
- Finkelstein, A., S. Taubman, B. Wright, et al. 2012. The Oregon health insurance experiment: Evidence from the first year. *Quarterly Journal of Economics* 127, no. 3: 1057–1106.
- Fisher, E. S., D. E. Wennberg, T. A. Stukel, et al. 2003a. The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. *Annals of Internal Medicine* 138, no. 4 (February 18): 273–287.
- Fisher, E. S., D. E. Wennberg, T. A. Stukel, et al. 2003b. The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care. *Annals of Internal Medicine* 138, no. 4 (February 18): 288–298.
- Garber, A., D. P. Goldman, and A. B. Jena. 2007. The promise of health care cost containment. *Health Affairs* 26, no. 6 (November–December): 1545–1547.
- Gaynor, M., and R. Town. 2012. *The impact of hospital consolidation — Update*. The Synthesis Project, policy brief no. 9. Princeton, NJ: Robert Wood Johnson Foundation.

- Ginsburg, P. B. 2008. *High and rising health care costs: Demystifying U.S. health care spending*. Princeton, NJ: Robert Wood Johnson Foundation, The Synthesis Project.
- Government Accountability Office. 2013. *High-risk series: An update*. Washington, DC: GAO.
- Gruber, J. 2000. Health insurance and the labor market. In *Handbook of Health Economics*, vol. 1, edited by A. J. Culyer and J. P. Newhouse. New York, NY: Elsevier Science.
- Health Care Cost Institute. 2014. *2013 health care cost and utilization report*. Washington, DC: HCCI.
- Holahan, J., and S. McMorrow. 2013. *What drove the recent slowdown in health spending growth and can it continue?* Washington, DC: Urban Institute.
- Hurd, M. D., P. Martorell, A. Delavande, et al. 2013. Monetary costs of dementia in the United States. *New England Journal of Medicine* 368, no. 14 (April 4): 1326–1334.
- Institute of Medicine. 2013. *Interim report of the committee on geographic variation in health care spending and promotion of high-value care: Preliminary committee observations*. Washington, DC: The National Academies Press.
- Kaiser Family Foundation and Health Research & Educational Trust. 2014. *Employer health benefits: 2014 annual survey*. Menlo Park, CA: Kaiser Family Foundation/HRET.
- Laugesen, M. J., and S. A. Glied. 2011. Higher fees paid to US physicians drive higher spending for physician services compared to other countries. *Health Affairs* 30, no. 9 (September): 1647–1656.
- Leape, L. L., R. E. Park, D. H. Solomon, et al. 1990. Does inappropriate use explain small-area variations in the use of health care services? *Journal of the American Medical Association* 263, no. 5 (February 2): 669–672.
- Machlin, S. R., and A. Soni. 2013. Health care expenditures for adults with multiple treated chronic conditions: Estimates from the Medical Expenditure Panel Survey, 2009. *Preventing Chronic Disease* 10: E63.
- Martin, A. B., M. Hartman, L. Whittle, et al. 2014. National health spending in 2012: Rate of health spending growth remained low for the fourth consecutive year. *Health Affairs* 33, no. 1 (January): 67–77.
- Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2011a. Moving forward from the sustainable growth rate (SGR) system. Letter to the Congress. October 14.
- Medicare Payment Advisory Commission. 2011b. *Report to the Congress: Regional variation in Medicare service use*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2009. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Moriya, A. S., W. B. Vogt, and M. Gaynor. 2010. Hospital prices and market structure in the hospital and insurance industries. *Health Economics, Policy and Law* 5, no. 4 (October): 459–479.
- National Center for Health Statistics. 2014. *Health, United States, 2013: With special feature on prescription drugs*. Hyattsville, MD: NCHS.
- Newhouse, J. P. 1992. Medical care costs: How much welfare loss? *Journal of Economic Perspectives* 6, no. 3 (Summer): 3–21.
- Peden, E. A., and M. S. Freeland. 1995. A historical analysis of medical spending growth, 1960–1993. *Health Affairs* 14, no. 2: 235–247.
- Redberg, R. 2011. Squandering Medicare’s money. *New York Times*, May 25.
- Robinson, J. C., and K. Miller. 2014. Total expenditures per patient in hospital-owned and physician-owned physician organizations in California. *Journal of the American Medical Association* 312, no. 16 (October 22–29): 1663–1669.
- Ryu, A. J., T. B. Gibson, M. R. McKellar, et al. 2013. The slowdown in health care spending in 2009–11 reflected factors other than the weak economy and thus may persist. *Health Affairs* 32, no. 5 (May): 835–840.
- Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174, no. 7 (July): 1067–1076.
- Sisko, A. M., S. P. Keehan, G. A. Cuckler, et al. 2014. National health expenditure projections, 2013–23: Faster growth expected with expanded coverage and improving economy. *Health Affairs* 33, no. 10 (October 1): 1841–1850.

Smith, S., J. P. Newhouse, and M. S. Freeland. 2009. Income, insurance, and technology: Why does health spending outpace economic growth? *Health Affairs* 28, no. 5 (September–October): 1276–1284.

Smith, S. D., S. K. Heffler, and M. S. Freeland. 2000. *The impact of technological change on health care cost spending: An evaluation of the literature*. Baltimore, MD: Health Care Financing Administration.

Smith, V. K., K. Gifford, E. Ellis, et al. 2014. *Medicaid in an era of health & delivery system reform: Results from a 50-state Medicaid budget survey for state fiscal years 2014 and 2015*. Menlo Park, CA: Kaiser Family Foundation. <http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/>.

Social Security Administration. 2012. Income of the population 55 or older. Baltimore, MD: SSA. http://www.ssa.gov/policy/docs/statcomps/income_pop55/index.html.

Squires, D. 2014. *Multinational comparisons of health systems data, 2013*. New York: Commonwealth Fund. <http://www.commonwealthfund.org/publications/chartbooks/2014/multinational-comparisons>.

Squires, D. A. 2012. *Explaining high health care spending in the United States: An international comparison of supply, utilization, prices, and quality*. Issue brief. New York: The Commonwealth Fund.

Stensland, J., Z. R. Gaumer, and M. E. Miller. 2010. Private-payer profits can induce negative Medicare margins. *Health Affairs* 29, no. 5 (May): 1045–1051.

Steuerle, G. 2013. Growth in income and health care costs. The Government We Deserve. June 4. <http://blog.governmentwedeserve.org>.

Truffer, C. J., J. D. Klemm, C. J. Wolfe, et al., Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. *2013 actuarial report of the financial outlook for Medicaid*. Washington, DC: Office of the Actuary.

Ward, B. W., and J. S. Schiller. 2013. Prevalence of multiple chronic conditions among U.S. adults: Estimates from the National Health Interview Survey, 2010. *Preventing Chronic Disease* 10: E65.

Welch, G. 2012. Testing what we think we know. *New York Times*, August 19.

White, C. 2007. Health care spending growth: How different is the United States from the rest of the OECD? *Health Affairs* 26, no. 1 (January–February): 154–161.

White, C., and V. Y. Wu. 2014. How do hospitals cope with sustained slow growth in Medicare prices? *Health Services Research* 49, no. 1 (February): 11–31.

Xu, J., K. D. Kochanek, S. L. Murphy, et al. 2014. *Mortality in the United States, 2012*. NCHS data brief, no. 168. Hyattsville, MD: National Center for Health Statistics. <http://www.cdc.gov/nchs/data/databriefs/db168.htm>.