Advising the Congress on Medicare issues

Context for Medicare payment policy

MedPAC staff

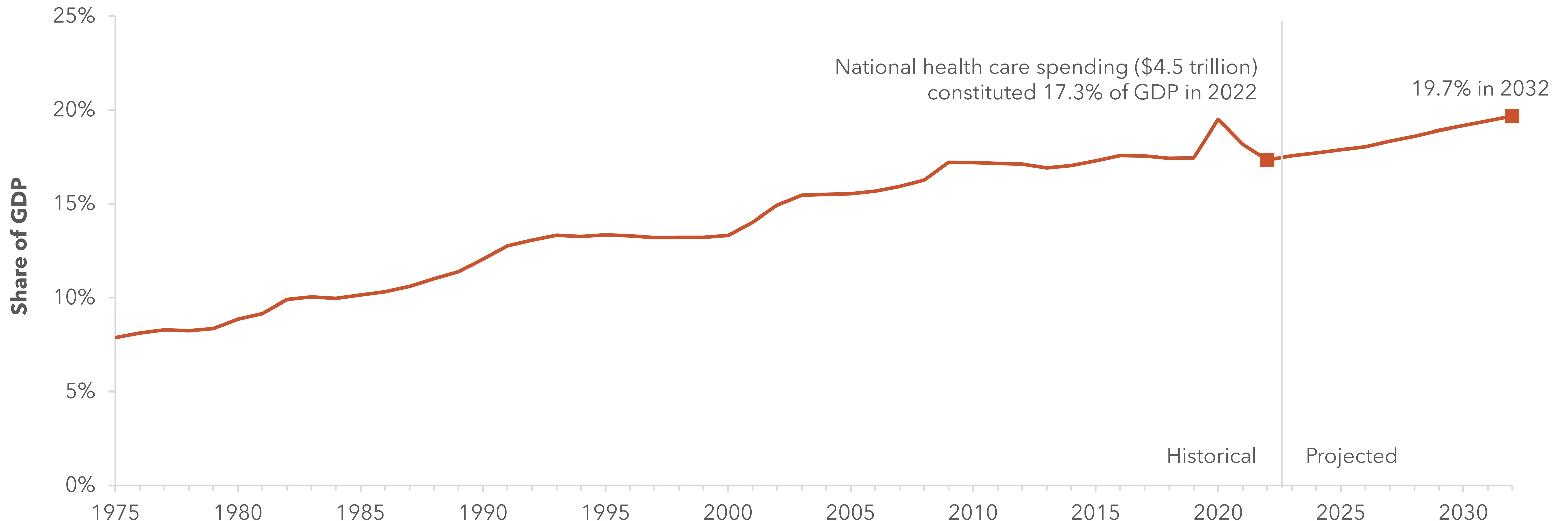
September 5, 2024

Presentation roadmap

1. **Recent spending trends**
2. **Factors influencing projected Medicare spending**
3. **Financial status of Medicare's two trust funds**
4. **Beneficiaries' enrollment options, financial obligations, care disparities**
5. **Medicare's role in shaping the health care workforce**

Recent spending trends

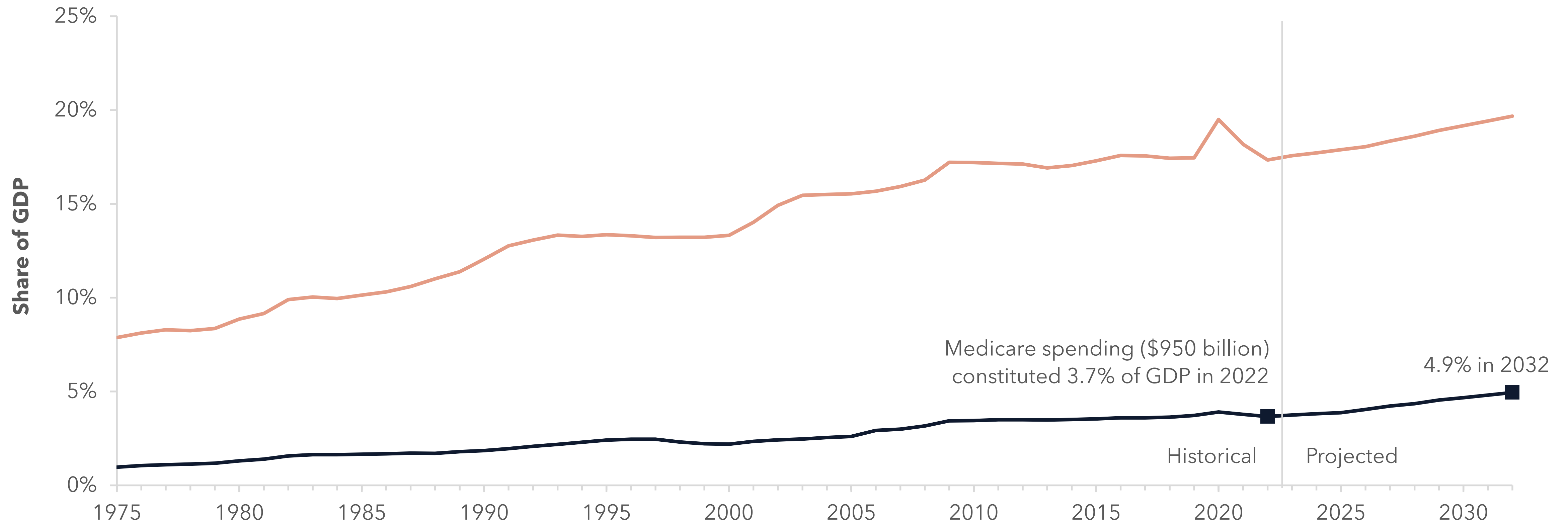
Recent trends in national health care spending



Note: GDP (gross domestic product). The first projected year in the graph is 2023. Pandemic relief funds are counted as national health care spending rather than Medicare spending because they were meant to offset pandemic-related revenue losses from all payers, not just Medicare.

Source: MedPAC analysis of CMS's national health expenditure data (projected data released in June 2024 and historical data released in December 2023), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

Recent trends in Medicare spending

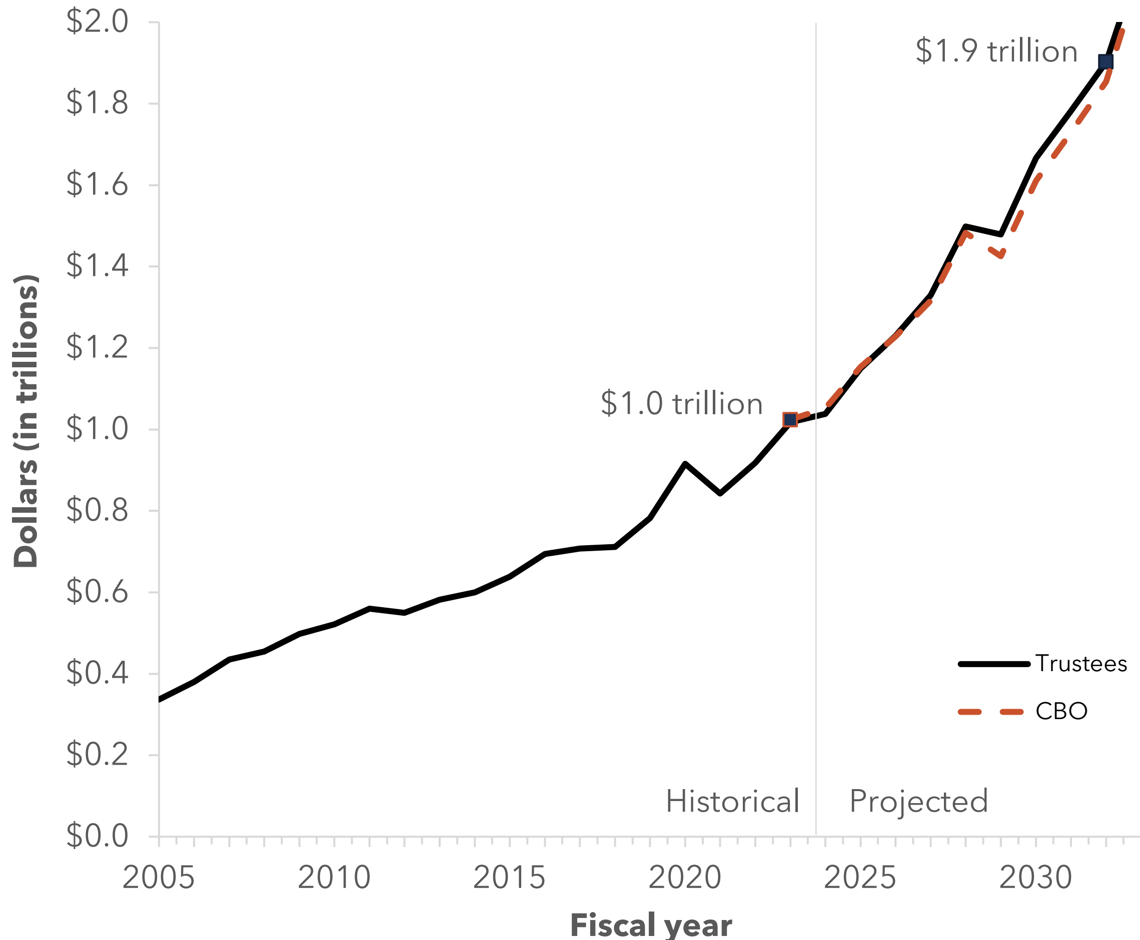


Note: GDP (gross domestic product). The first projected year in the graph is 2023. Medicare spending excludes COVID-19 Accelerated and Advance payments (short-term loans paid to providers in 2020 that were subsequently repaid) since this graph shows expenditures on an incurred basis, rather than a cash basis.

Source: MedPAC analysis of CMS's national health expenditure data (projected data released in June 2024 and historical data released in December 2023), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

Factors influencing projected Medicare spending

Key factors influencing Medicare spending growth



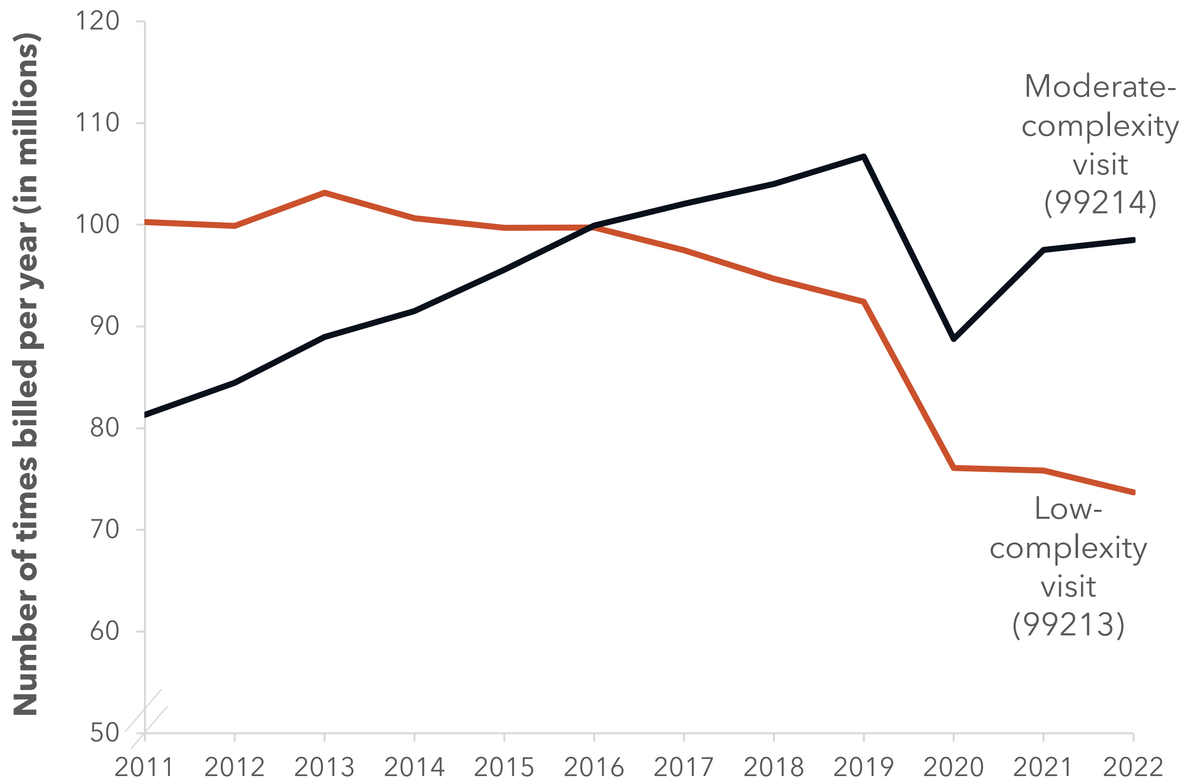
- Medicare spending growth is driven by three factors:
  - Economy-wide price inflation (+3%/year)
  - Growth in the number of Medicare beneficiaries (+2%/year)
  - Growth in the volume and intensity of services delivered per beneficiary (+3%/year)

Note: CBO (Congressional Budget Office). The first projected year in the graph is 2024. The sharp increase in spending in 2020 includes $104 billion in Medicare Accelerated and Advance Payments paid to providers that were then recouped by the Medicare program in 2021, 2022, and 2023.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds; CBO's June 2024 baseline projections for the Medicare program.

One factor influencing Medicare's future spending: Medicare is paying for a more "intense" mix of services

Clinicians increasingly use billing code 99214 instead of 99213 for office visits



- Service "intensity" increases when providers furnish more expensive services instead of less expensive ones
  - e.g., moderate-complexity office visits instead of low-complexity office visits

Note: Current Procedural Terminology codes 99213 and 99214 pertain to office/outpatient evaluation and management (E&M) visits with established patients that involve a medically appropriate history and/or examination; 99213 refers to visits involving a "low" level of medical decision-making and/or 20–29 minutes of practitioner time, while 99214 refers to visits involving a "moderate" level of medical decision-making and/or 30–39 minutes of clinician time. Before 2021, code definitions were more prescriptive about the content of these visits and did not allow time alone to justify the use of one of these codes.

Source: Centers for Medicare and Medicaid Services. Part B National Summary Data Files, 2011–2022. https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-National-Summary-Data-File/Overview.

Part D spending is expected to increase due to expanded coverage of GLP-1 drugs

- Medicare Part D statute prohibits covering drugs for weight loss
- In 2024, FDA approved a GLP-1 to reduce risk of death, heart attack, or stroke in patients with cardiovascular disease and obesity or overweight
- CBO expects Medicare coverage of GLP-1s for this indication to increase Medicare Part D spending by $36 billion over 10 years
- If FDA approves GLP-1s for additional indications, projected spending could increase further
- Medicare spending on GLP-1s will also depend on:
  - Patient adherence
  - Degree to which plans employ utilization management tools (e.g., prior authorization)
  - Changes in prices of GLP-1s

Financial status of
Medicare’s two trust funds

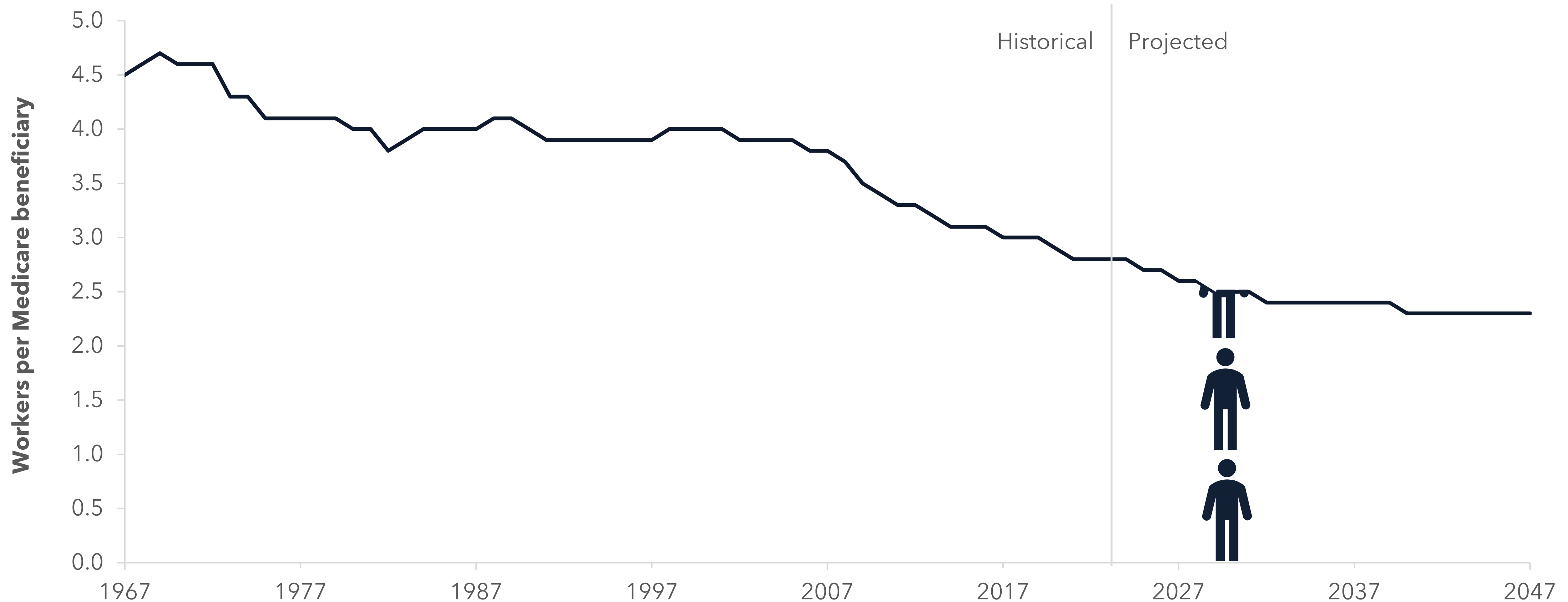
Medicare's HI Trust Fund is projected to remain solvent until 2035 or 2036

- Finances Part A services (e.g., inpatient hospital stays)
- Projected to remain solvent until 2035 (CBO) or 2036 (Medicare Trustees)—a decade longer than was projected before the pandemic
- Medicare's Trustees attribute this improved financial situation to:
  - More Medicare payroll taxes being collected
    - More workers paying taxes than previously estimated
    - Higher wages than previously expected
  - Lower Medicare Part A spending, due to
    - Lower projected spending on inpatient hospital and home health services, based on recent utilization trends
    - A correction CMS made to how it calculates MA benchmarks

Note: HI (Hospital Insurance), CBO (Congressional Budget Office). The correction to Medicare Advantage (MA) benchmark calculations now excludes medical education expenses associated with MA enrollees from the fee-for-service costs per capita that are used in the development of MA spending.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds, https://www.cms.gov/oact/tr/2024; CBO's *The long-term budget outlook: 2024 to 2054*, https://www.cbo.gov/system/files/2024-03/59711-Long-Term-Outlook-2024.pdf.

The ratio of workers per beneficiary is declining, creating a challenge for the HI Trust Fund

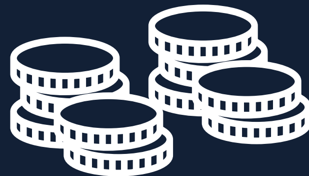


Note: "Medicare beneficiaries" refers to beneficiaries covered by Medicare Part A (including beneficiaries enrolled in Medicare Advantage plans). More beneficiaries have Part A Hospital Insurance than Part B Supplementary Medical Insurance because Part A is usually available to beneficiaries at no cost. First projected year is 2024. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds.

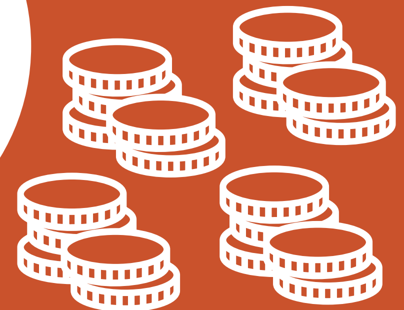
Medicare's SMI Trust Fund automatically remains solvent, but constitutes a growing share of federal revenues

17%



of federal income taxes in 2023

22%



of federal income taxes in 2030

Note: SMI (Supplementary Medical Insurance). Medicare's Supplementary Medical Insurance Trust Fund helps pay for Part B clinician and outpatient services and Part D prescription drug coverage. General revenues collected by the federal government primarily consist of individual and corporate taxes but also include customs duties, leases of government-owned land and buildings, the sale of natural resources, usage and licensing fees, and payments to agencies (not included above).

Source: 2024 annual report of the Boards of Trustees of the Medicare trust funds, https://www.cms.gov/oact/tr/2024.

Beneficiaries' enrollment options, financial obligations, and care disparities

Medicare beneficiaries' enrollment options

- Commonly misunderstood/unknown facts:
  - Part B premiums deducted from FFS and MA enrollees' social security checks
    - MA plans can reduce the amount deducted by "buying down" beneficiaries' premium
  - Late-enrollment penalties for beneficiaries who don't enroll at age 65
  - Enrolling in Medigap is typically a one-time decision, made at age 65
  - Medigap is not subsidized by the government
  - Employers can subsidize retirees' Medigap, Part D, or MA plans

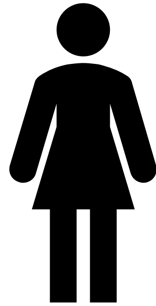
Note: FFS (fee-for-service), MA (Medicare Advantage).

Racial/ethnic differences in the types of coverage beneficiaries enroll in

- According to CMS's 2021 Medicare Current Beneficiary Survey:
  - White beneficiaries much more likely to have FFS + supplemental insurance
  - Hispanic and Black beneficiaries much more likely to enroll in an MA plan
  - Hispanic and Black beneficiaries much more likely to be dually enrolled in Medicaid or receive the Part D low-income subsidy

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, 2021.

The median Medicare beneficiary has modest resources to draw on when paying for premiums and cost sharing



Median beneficiary in 2023

$36,000 annual income
+ $104,000 life savings

$2,100	Part B premiums (2024)
$500	Part D premiums (2024 avg.)
$400	Part A cost sharing (2021 avg.)
$1,600	Part B cost sharing (2021 avg.)
$500	Part D cost sharing (2021 avg.)

Note: Numbers have been rounded to nearest thousand for beneficiary income and savings and nearest hundred for annual premiums and cost sharing. Actual premiums and cost sharing owed will vary based on beneficiaries' circumstances and the type(s) of coverage in which they enroll.

Source: KFF, *Income and assets of Medicare beneficiaries in 2023,* https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-in-2023; MedPAC's 2024 *Data Book*, https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf.

Percent of Medicare beneficiaries who report problems paying a medical bill

7%	14%	20%	23%
All Medicare beneficiaries	Beneficiaries with FFS and no supplemental coverage	Beneficiaries under age 65 (disabled, ESRD)	Partial-benefit dual-eligible beneficiaries

Note: ESRD (end-stage renal disease), FFS (fee-for-service). Partial-benefit dual-eligible beneficiaries receive Medicaid assistance with premiums and, in some cases, cost sharing, but do not qualify for additional Medicaid benefits that full-benefit dual-eligible beneficiaries receive, such as dental care and non-emergency medical transportation.

Source: MedPAC analysis of non-institutionalized beneficiaries' experiences in CMS's 2021 Medicare Current Beneficiary Survey.

- **When Medicare increases payment rates for providers, it increases premiums and cost sharing for beneficiaries—some of whom already have a hard time affording health care**

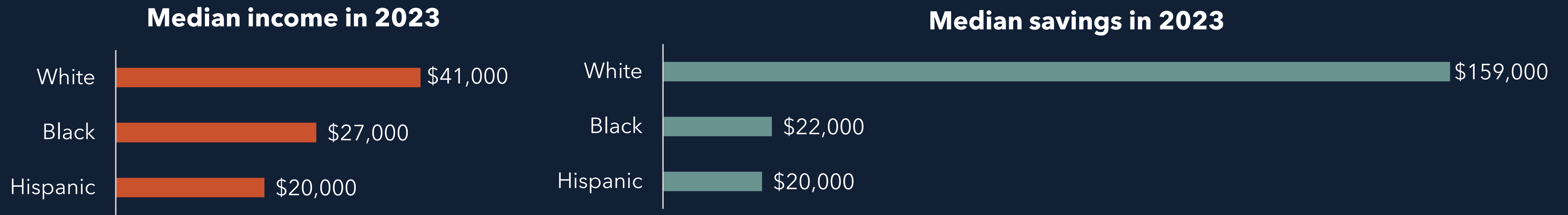
Disparities in health outcomes for beneficiaries of different races/ethnicities

- Black individuals have much higher age-adjusted mortality rates than White and Hispanic individuals
- Black and Hispanic people age 65+ are more likely to report being in poor health, more likely to have hypertension and diabetes
- Black and Hispanic beneficiaries are more likely to receive care from a hospital or SNF with a 1-star quality rating
- Black beneficiaries have worse rates of ambulatory care-sensitive (potentially preventable) hospitalizations and ED visits
- BUT: Very few differences in reported experiences accessing care, according to beneficiary surveys

Note: SNF (skilled nursing facility), ED (emergency department).
Source: CDC, *Mortality in the United States, 2022*, https://www.cdc.gov/nchs/data/databriefs/db492.pdf; KFF, *Racial and ethnic health inequities and Medicare*, 2021, https://files.kff.org/attachment/Report-Racial-and-Ethnic-Health-Inequities-and-Medicare.pdf; Zuckerman et al, "The five-star skilled nursing facility rating system and care of disadvantaged populations," in *Journal of the American Geriatric Society*, 2019; MedPAC's June 2023 and March 2024 reports to the Congress.

Race/ethnicity disparities likely related to disparities in beneficiaries' income and assets

- White beneficiaries have greater access to funds to pay for care



- Beneficiaries with very low incomes and assets (low enough to qualify for the Part D low-income subsidy) are more likely to:
  - Report forgoing care they thought they needed and delaying care due to cost in surveys
  - Experience ambulatory care-sensitive (potentially preventable) hospitalizations and ED visits

Note: Beneficiaries qualify for the Part D low-income subsidy if they have incomes below $22,590 ($30,660 if married) and liquid assets below $17,220 ($34,360 if married) in 2024.
Source: KFF, *Income and assets of Medicare beneficiaries in 2023*, https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-in-2023/; MedPAC's March and June 2023 reports to the Congress.

The health care workforce and Medicare’s role in shaping it

Assessing whether there are shortages of particular types of health care workers is complicated

- Generally speaking, studies find that "more is more":
  - Hospitals with more RNs: better rates of hospital-acquired infections, readmissions, mortality
  - Populations in areas with more primary care physicians per capita: longer life expectancy, better health status
- Difficult to assess whether there are shortages of certain types of workers because the responsibilities of different types of health care workers overlap
  - APRNs (e.g., NPs) and PAs can provide many services that physicians provide
  - Among nurses, LPNs can provide many services that RNs can provide
- National counts of different types of health care workers can mask shortages (or excesses) in particular geographic areas and medical specialties
  - e.g., there are 4.3 million RNs and 600,000 LPNs in the U.S.
    - HRSA: Essentially no national shortage; but some states have excesses, others have shortages

Note: RN (registered nurse), APRN (advanced practice registered nurse), NP (nurse practitioner), PA (physician assistant), LPN (licensed practical nurse).
Source: Lasater et al 2024, Lee and Dahinten 2020, McHugh et al 2021, Oner et al 2021, Basu et al 2019, Pierard 2014, Health Resources & Services Administration's Workforce projections, https://data.hrsa.gov/topics/health-workforce/workforce-projections.

How Medicare influences the composition of the health care workforce

- U.S. does not produce enough medical school grads to fill all of the post-medical school training positions offered in the U.S. (residencies, fellowships)
  - 23% filled by grads of international medical schools in 2023
- Medicare helps subsidize residencies and fellowships
  - Medicare generally does not specify where or in which specialties physicians are trained
- Medicare pays APRN and PAs 85% or 100% of physicians' payment rates, but provider organizations pay them much less than physicians
  - Creates strong incentives for organizations to hire (and, if needed, train) APRNs and PAs
    - From 2017-2022, number of APRNs & PAs who billed Medicare for >15 FFS beneficiaries increased 40%
- Medicare's targeted policies to attract clinicians to rural/underserved areas:
  - 10% bonus to physicians in health professional shortage areas
  - Higher payments for hospitals in underserved areas
  - Special incentives for providers in underserved areas in some alternative payment models

Source: Association of American Medical Colleges' 2023 *Report on residents,* https://www.aamc.org/data-reports/students-residents/data/report-residents/2023/executive-summary; MedPAC's March 2024 report to the Congress.

Discussion

Discussion

- Clarifying questions about the material?
- Other comments, questions, or guidance for the chapter?

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