Tackling The Cost Conundrum

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Founding Editor
Health Affairs
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For Its Generous Support Of Health Affairs’ May 2013 Thematic Issue, “Tackling The Cost Conundrum”
Opening Remarks

Michael W. Painter
Senior Program Officer
Robert Wood Johnson Foundation

Health Affairs
Panel One: Is The Slowdown In Spending Permanent?
Is The Health Care Cost Slowdown Structural?

David Cutler & Nikhil Sahni
Harvard University
May 7, 2013

We are grateful to the National Institutes on Aging for research support.
Medical Spending Increases Have Been Very Low In Recent Years

Annual real, per capita medical spending growth

Percent

Source: Authors’ calculations based on data from the Bureau of Economic Analysis and the Centers for Medicare and Medicaid Services
The Recession Is Only About One-third Of The Slowdown

Real, per capita medical spending
In 2005 dollars

Source: Authors’ calculations based on data from the Bureau of Economic Analysis and the Centers for Medicare and Medicaid Services
Structural Factors 1: Slowing Of Technology

The Sharp Slowdown In Growth Of Medical Imaging: An Early Analysis Suggests Combination Of Policies Was The Cause
Health Affairs

Failure To Launch: A Slew Of Disappointing Product Launches Suggest Biotech Companies Are Ill Prepared To Navigate An Increasingly Parsimonious Reimbursement Environment
Nature Biotechnology

The Global Use Of Medicines: Outlook Through 2015
IMS Institute For Healthcare Informatics
Structural Factors 2: Higher Cost Sharing

Covered Workers Enrolled in Plan with Deductible ≥$1,000

Percent

Source: Kaiser Family Foundation 2012 Employer Health Benefits Survey
Structural Factors 3: Greater Provider Efficiency

Acute Care Hospital Readmission Rates

Percent

Source: Centers for Medicare and Medicaid Services, Office of Enterprise Management
Forecasts Have Incorporated These Trends, But Only For The Next Few Years

<table>
<thead>
<tr>
<th>National Health Expenditures Per Capita</th>
<th>Medicare Per Beneficiary</th>
</tr>
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<tbody>
<tr>
<td>CAGR, Percent</td>
<td>CAGR, Percent</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>1970-2003</td>
<td>2.5%</td>
</tr>
<tr>
<td>2003-2012</td>
<td>1.3%&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>2012-2018</td>
<td>0.6%</td>
</tr>
<tr>
<td>2018-2021</td>
<td>1.8%</td>
</tr>
<tr>
<td></td>
<td>2.8%</td>
</tr>
<tr>
<td></td>
<td>2.0%&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2.9%&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>-1.4%&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>0.7%</td>
</tr>
</tbody>
</table>

1. Growth rate for 2011–12 was estimated using BEA National Income and Product Accounts (NIPA) tables
2. Part D was removed by holding the 2005–06 growth rate constant at the 2004–05 growth rate
3. Growth rate for 2011–12 was estimated using monthly Treasury statements
4. The Sustainable Growth Rate cut for 2013 was removed from the forecast

Source: Authors’ calculations based on data from the Bureau of Economic Analysis, Centers for Medicare and Medicaid Services, and Department of the Treasury
If These Trends Continue, Savings Will Be Large

Projected Real, Per Capita Medical Spending
In 2011 Dollars

Source: Authors’ calculations based on data from the Bureau of Economic Analysis and the Centers for Medicare and Medicaid Services
What Should We Conclude?

1. The evidence is at least as strong for structural changes as for purely cyclical factors.

2. The impact of sustained low growth would be enormous.
   - Gov’t savings as much as 20% of the projected deficit in 2021.
Is The Slowdown In Spending Permanent?

Michael Chernew, PhD
Harvard Medical School
It's Harder To Look Forward Than Backwards
Why Might Spending Growth Slow?

• Direct recession effects
  – Job loss
  – Reductions in benefit generosity

• Indirect recession effects
  – Stock market drop
  – Job insecurity

• Structural change (temporary and permanent)
  – Culture
  – Technology
Summary

- Spending growth slowed
- Mostly due to indirect and/or structural factors (which may or may not be permanent)
- Do not declare victory and go home!
  - We should improve efficiency even if spending growth is low
  - Continued efforts likely needed to extend success
Why The Recent Slowdown In Health Spending Growth And Can It Continue?¹

John Holahan
The Urban Institute
May 7, 2013

More Than The Recession

- Recession has been important, but not the major cause of the slowdown
- Fundamental change does seem to be occurring
- Decade-long economic slowdown and substantial changes in insurance coverage caused systematic changes
Slowdown Started Well Before The Recession

- Private spending slowed in 2002
  - Drop in employer coverage
  - Higher deductibles and tiered networks slowed per capita growth
- Medicare growth began to slow in 2004
  - Enrollment growth among younger, less costly beneficiaries
  - Payment policies
- Medicaid spending driven by enrollment increases, spending per enrollee relatively slow
  - Enrollment growth averaged about 5% per year
  - Spending per enrollee averaged less than 2.5% per year
A Decade of Slow Economic Growth

- Two recessions during decade, with modest recovery in the middle
- Real median household income declined by 10% over decade; real per capita income fell by 5%
- Drop in employer sponsored insurance from 69% to 58%
- Medicaid rolls increased by 19 million; uninsured by 12 million
System Responded To Revenue Constraints

• Providers have sought efficiencies in many different ways

• Hospital and physician consolidation, more salaried employment

• More recently – medical homes, accountable care organizations, bundled payments

• Reductions in hospital cost per admission, in physician incomes over most of the decade

• Reductions in prescription drug spending by all payers – fewer new drugs, tiered formularies, generic drugs
The Future

- Higher growth in health spending could return with economic recovery and health reform
- But slow economic growth forecast for rest of the decade
- New coverage from the ACA is largely in Medicaid and competitive exchange plans
- Medicare payment policies and demonstrations
- We conclude with cautious optimism that growth rate has slowed
Break

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Panel Two: How To Make Medicare Sustainable
Average Annual Medicare per beneficiary Spending Growth 1980-2011

Note: Average annual growth in nominal Medicare expenditures per beneficiary
Average Annual Medicare Excess Spending Growth 1980-2011

Note: Excess spending growth was calculated as average annual growth in nominal Medicare expenditures per beneficiary minus average annual growth in nominal GDP per capita.
## Exhibit 1

Medicare As A Share Of Gross Domestic Product (GDP) In The Context Of Reduced Excess Spending Growth

<table>
<thead>
<tr>
<th>Excess spending growth per beneficiary (percentage points)</th>
<th>Medicare share of GDP in 2035 (%)&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0</td>
<td>7.9</td>
</tr>
<tr>
<td>1.0</td>
<td>6.4</td>
</tr>
<tr>
<td>0.5</td>
<td>5.7</td>
</tr>
<tr>
<td>0.0</td>
<td>5.1</td>
</tr>
</tbody>
</table>

**Source** Congressional Budget Office: (1) The budget and economic outlook: fiscal years 2013 to 2023 (Note 15 in text); and (2) Long-term budget outlook 2012. Washington (DC): CBO; 2012. <sup>a</sup>Share in 2013 projected to be 3.7 percent. To remain at 3.7 percent of GDP in 2035, Medicare needs to grow at a rate of 1.5 percentage points below GDP. Faster GDP growth would imply slightly lower Medicare shares for any amount of excess spending growth.
Ways To Reduce Spending Growth

• Cut fees
• Shift costs to beneficiaries
• Fundamental reform
  – Reform payment models
  – Redesign benefits
  – Rely more on competition
Medicare Essential: An Option To Promote Better Care And Curb Spending Growth

Karen Davis
Eugene and Mildred Lipitz Professor
Director, Roger C. Lipitz Center for Integrated Health Care
Department of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health
kadavis@jhsph.edu
Current Medicare Core Benefit – Fragmented And Complex

- Beneficiaries buy 3 policies - Medicare, Medigap, Part D; complex, confusing, opportunities for risk selection
- High administrative costs
- Barrier to more integrated design with incentives to seek high-value care, primary care teams and accountable care networks
- Rationale for reform:
  - Savings opportunities for beneficiaries and payers while continuing to ensure access and financial protection for beneficiaries
  - Medicare can be a major force for payment and delivery system reform to improve outcomes, quality, and lower costs
  - Improve return on investment in health care, while freeing up resources for other societal priorities
Medicare Essential: A New Option To Enhance Value

1. Single plan with comprehensive benefits, one premium, and lower administrative costs (replaces Part A, Part B, Part D, and supplemental coverage); default option beginning in 2014; Medicare Advantage and traditional Medicare continue; Medi-Gap minimum $250 deductible

2. Comprehensive benefits with reduced and rationalized cost-sharing; single deductible ($250) for hospital, physician, and other A/B services; $20/$40/$50 copayment for primary care, specialty care, ED use; limit on patient costs ($3400)

3. Single Rx formulary and pharmaceutical benefits manager negotiating drug prices; lower cost-sharing for generic and essential medications

4. Provider payment reform – blended/bundled/global provider payment options with value based-purchasing, shared savings

5. Reduced beneficiary cost-sharing for selecting high-value patient-centered medical homes and health systems.
Estimated Total Monthly Out-of-pocket Costs For A Typical Medicare Beneficiary With Medicare Essential (Using Standard Providers And Using High-value Providers), Compared With Traditional Medicare With Medigap And Part D, 2014

<table>
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<tbody>
<tr>
<td>Out-of-Pocket Costs for Medicare Covered Services:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--Medical Care (Parts A and B)</td>
<td>$0</td>
<td>$80</td>
<td>$80</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>--Prescription Drug (Part D)</td>
<td>$48</td>
<td>$36</td>
<td>-$12</td>
<td>$8</td>
<td>-$40</td>
</tr>
<tr>
<td>Premiums:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--Part B</td>
<td>$127</td>
<td>$127</td>
<td>$0</td>
<td>$127</td>
<td>$0</td>
</tr>
<tr>
<td>--Part D</td>
<td>$35</td>
<td>$0</td>
<td>-$35</td>
<td>$0</td>
<td>-$35</td>
</tr>
<tr>
<td>--Medigap Plan F</td>
<td>$217</td>
<td>$0</td>
<td>-$217</td>
<td>$0</td>
<td>-$217</td>
</tr>
<tr>
<td>--Medicare Essential</td>
<td>$0</td>
<td>$111</td>
<td>$111</td>
<td>$79</td>
<td>$79</td>
</tr>
<tr>
<td><strong>Monthly Cost: Premiums plus Out-of-Pocket</strong></td>
<td><strong>$427</strong></td>
<td><strong>$354</strong></td>
<td><strong>-$73</strong></td>
<td><strong>$254</strong></td>
<td><strong>-$173</strong></td>
</tr>
</tbody>
</table>

Notes: Estimates reflect full implementation of Medicare Essential in 2014.
Source: Estimates provided by Actuarial Research Corporation based on ARC Medicare micro-model.
## Changes In Health Expenditures With Medicare Essential Compared To Projected Spending, By Payer Source, $ Billions

<table>
<thead>
<tr>
<th></th>
<th>2014-2018</th>
<th>2014-2023</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Health Expenditures</strong></td>
<td>-$12.9</td>
<td>-$179.9</td>
</tr>
<tr>
<td><strong>Federal Government</strong></td>
<td>32.6</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>State and Local Government</strong></td>
<td>-8.1</td>
<td>-27.0</td>
</tr>
<tr>
<td><strong>Private Employers</strong></td>
<td>-27.1</td>
<td>-89.9</td>
</tr>
<tr>
<td><strong>Households/Beneficiaries</strong></td>
<td>-10.3</td>
<td>-63.1</td>
</tr>
</tbody>
</table>

Notes: Projected spending under current law assumes replacement of sustainable growth rate formula with freeze of Medicare physician fees throughout the ten-year period. Assumes increased participation in Medicare Essential over time compared to traditional Medicare, with 90% of those in Medicare core program selecting the option by the end of the decade. Share of Medicare Advantage enrollment is assumed unchanged.

Source: Estimates provided to authors by Actuarial Research Corporation based on ARC Medicare micro-model.
Conclusion And Discussion

• Potential to simplify and lower costs for beneficiaries
• Lower administrative costs and complexity
• Better financial protection for beneficiaries
• Creates incentives for beneficiaries to choose lower-cost, higher quality care
  – Supports spread of care system innovation
• Potential to reduce retiree-benefit costs for employers
• New choice to compete on level playing field with Medicare Advantage plans
• Inefficient Medigap plans likely to decline overtime
Thank you!

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Panel Three: What Are The Major Cost Drivers (In And Out Of Medicare)?
The Role Of Rising Prevalence Of Treated Disease, Spending Per Case Treated, Obesity And Treatment Intensity On The Growth In Health Care Spending

Kenneth E. Thorpe, Ph.D
Emory University
kthorpe@emory.edu
Change In Total Spending

- Examined change in total health care spending 1987-2009
- Change in Medicare and private insurance examined separately
Decomposition

• Examined role of rising obesity (holding treatment intensity and care patterns at 1987 levels)

• And role of rising treatment intensity (holding obesity at 1987 levels) over time in the growth in spending
Decomposition

- Change in Treated Prevalence of Disease
- Change in spending per case treated
- Interaction of the two (joint effect)
Issues

Treated prevalence could rise for good reasons (more aggressive management of CV risk factors, and changes in clinical thresholds for treatment) and BAD reasons (rising obesity and chronic disease prevalence)

Same issues face spending per case treated
Percentage of Health Care Spending Growth due to Treated Prevalence and Spending per case by Payer, 1987-2009.

- Treated Prevalence:
  - Total Spending: 50.8%
  - Medicare: 77.7%
  - Private Insurance: 33.5%

- Spending by Case:
  - Total Spending: 39.0%
  - Medicare: 14.1%
  - Private Insurance: 53.6%

- Joint Effect:
  - Total Spending: 10.2%
  - Medicare: 8.2%
  - Private Insurance: 12.9%
Percent Change In Real Per Capita Health Care Spending Associated With Obesity Increased Treatment Intensity And Both Obesity And Treatment Intensity 1987-2009
Conclusions

Treated prevalence assumes varying role by payer—dominates the growth in Medicare spending

Ex. 27% of seniors are diabetic, 50% prediabetic. Has doubled since the 1980s virtually all due to rising obesity
Conclusions

• Heavy concentration of Medicare spend on patients with 5 or more chronic conditions (nearly 80%)

• Entitlement reform options need to include lifestyle programs like DPP, and comprehensive care coordination, payment reforms in Medicare

• Today does not provide for either.
Contrary To Cost-Shift Theory, Lower Medicare Hospital Payment Rates For Inpatient Care Lead To Lower Private Payment Rates

Chapin White
May 7, 2013
“It’s the Prices, Stupid”

Inpatient Hospital Prices

- Private: +57%
- Medicare: +45%

Prices:
- $6,000
- $8,000
- $10,000
- $12,000
- $14,000
- $16,000
- $18,000
Hospitals say ...
• Medicare underpays

MedPAC says ...
• High private prices → high costs

CBO says ...
A Tale of Three (groups of) Markets...

inpatient hospital price growth, 1995-2009, annual

Slow

Medium

Fast

Private Medicare
Implications

- High prices, who’s to blame

- Medicare spillovers affect whole system

- Repeal ACA → even higher prices
For more, ...

National Institute for Health Care Reform (http://www.nihcr.org/)

Center for Studying Health System Change (http://www.hschange.org/)

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Remarks

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Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute
Remarks

Robert D. Reischauer
President Emeritus
The Urban Institute
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