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Gustav O. Lienhard Award Lecture

NATIONAL ACADEMY OF MEDICINE

The Growing Gap Between Medicare and Commercial Hospital Payments: *Should We Be Concerned**

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Medicare Program Established in 1965

Medicare Beneficiaries Would Have Complete Access to All Approved Hospitals

Medicare Hospital Payment System

Paid Hospitals Based on a Modified Blue Cross Cost Reporting System---Rates Similar To Those Paid By Commercial Payers

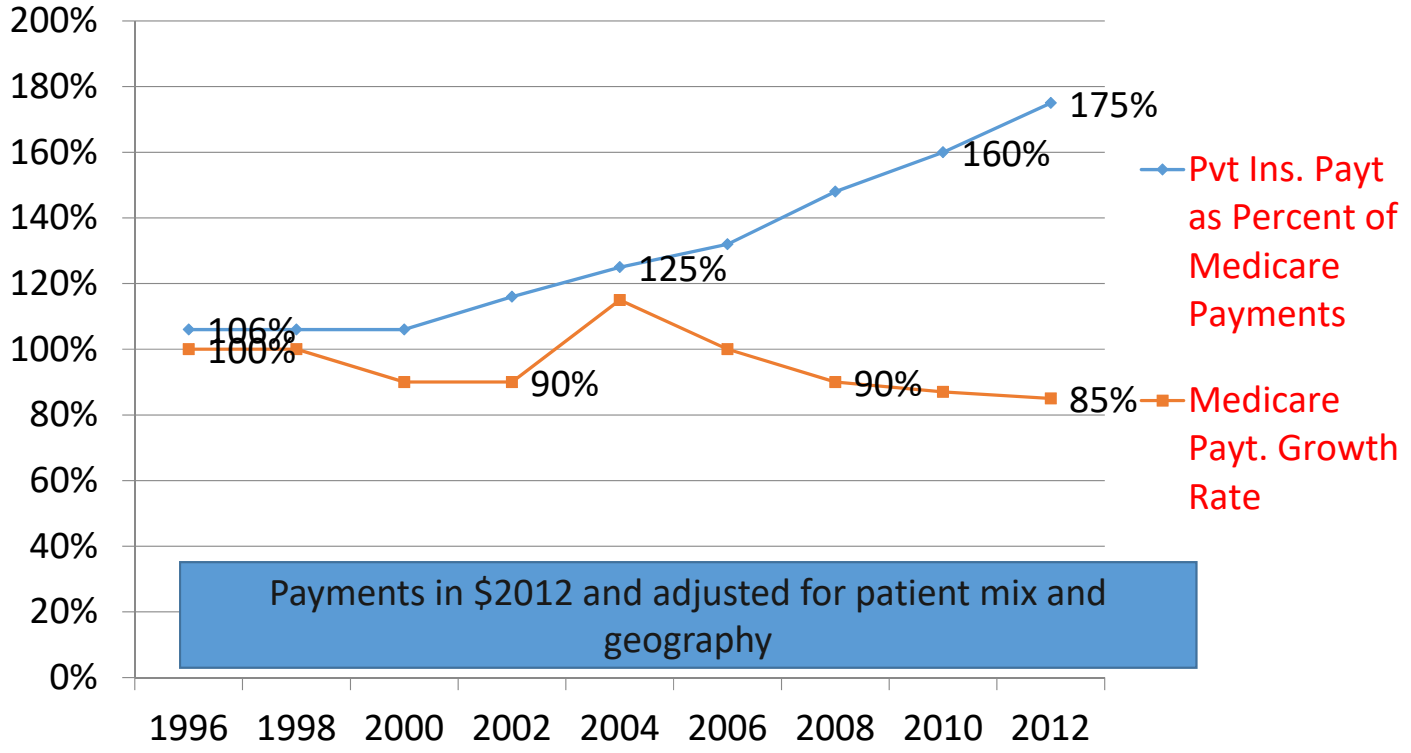
Medicare Hospital Payment System Changed in 1983 to a Pre-Determined DRG System

But Total Hospital Payments Set to Closely Follow Amounts Paid Under Previous Cost-Based System

Prior To Passage of 1997 Balanced Budget Act

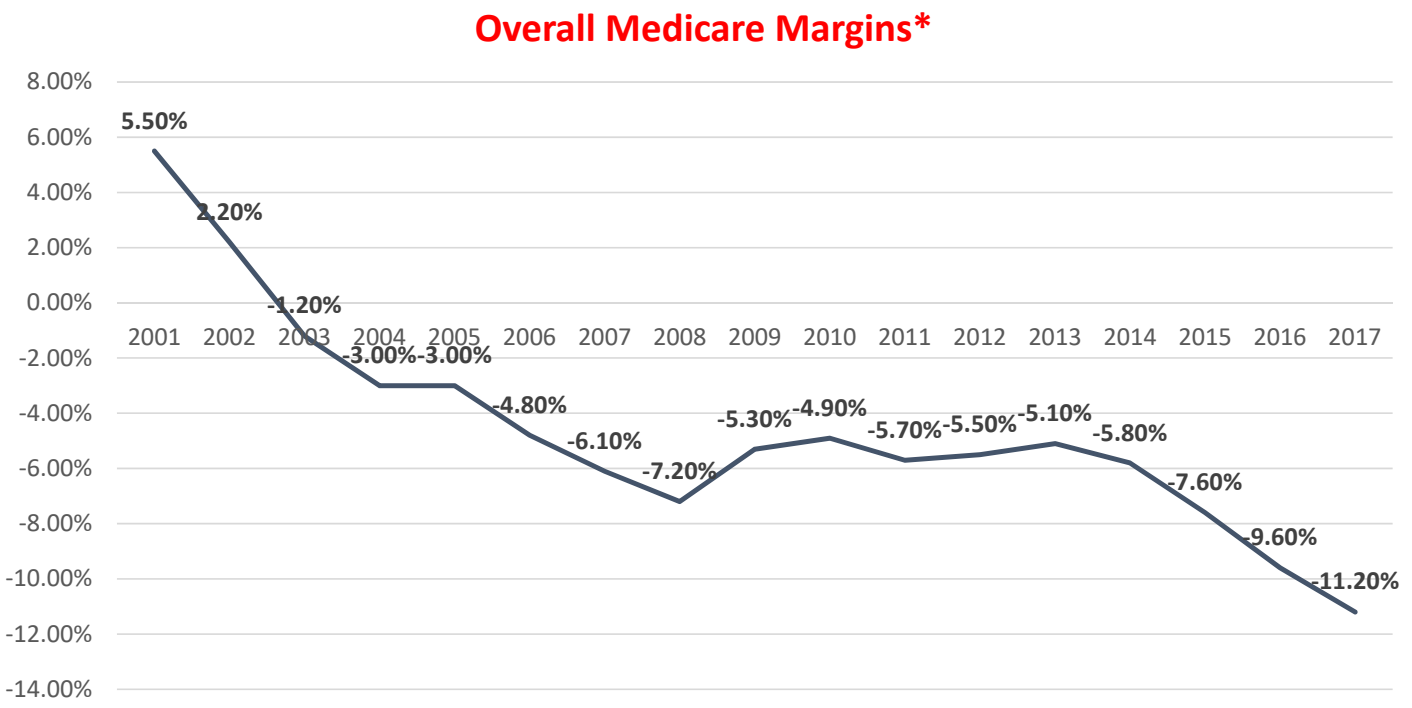
Medicare and Commercial Hospital Rates Were Similar and Close to Hospital Average Costs

Hospital Now Paid Significantly Lower Amounts By Medicare and Medicaid



Seiden et al, Health Affairs December 2015

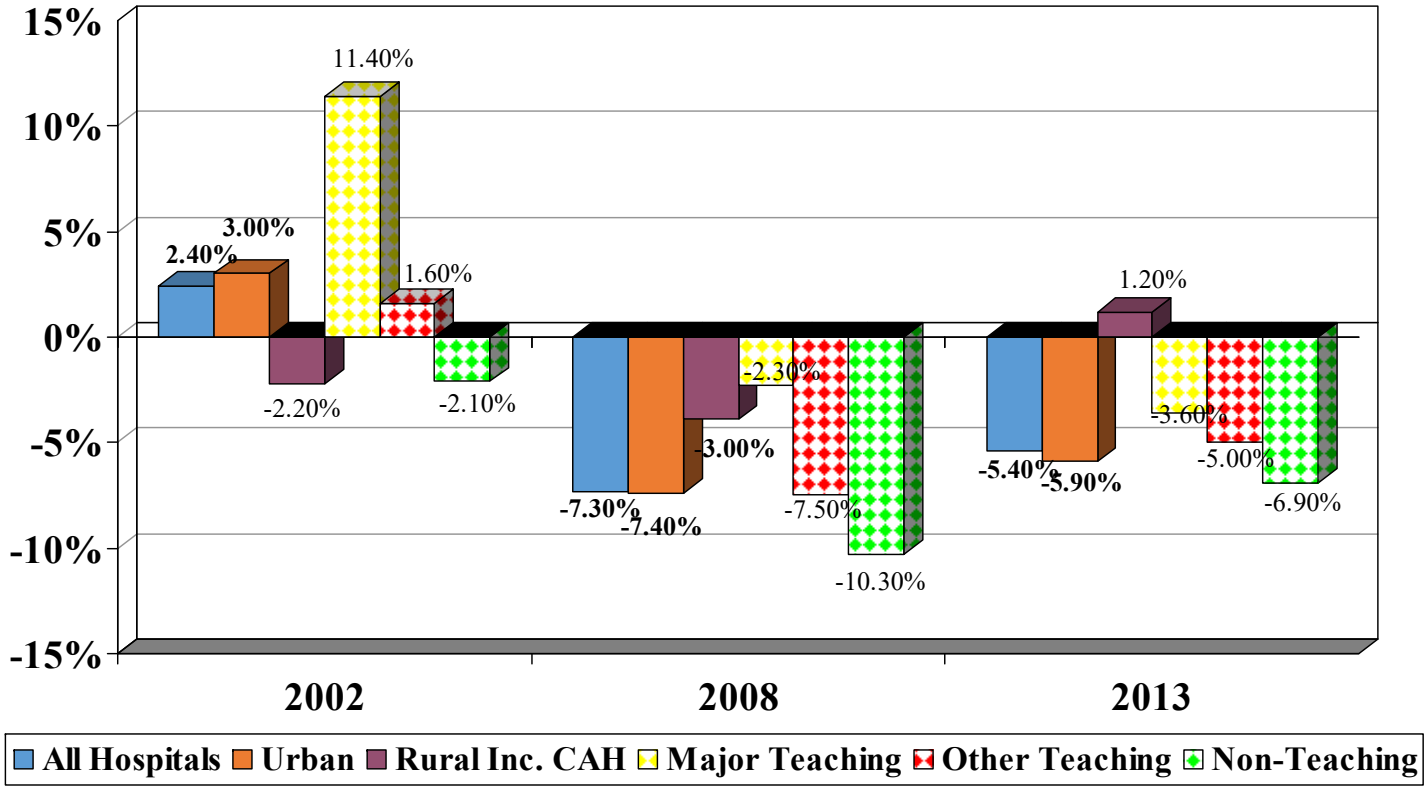
Since 2000 Medicare Hospital Margins Show Steep Declines: *Almost All Hospitals Now Lose Money on Medicare Patients (Using Average Total Costs)**



* Still Profitable for Hospitals to See Additional Medicare Patients (Higher Marginal Revenues than Marginal Costs)

Even Teaching Hospitals Which Had Significant Positive Medicare Margins Now Show Loses

Only Rural Hospitals With "CAH Payments" Have Positive Medicare Margins in 2013



SO– Should We Be Concerned?

Are Hospitals In Financial Trouble?

Are There Winners and Losers With Current Hospital Payment System?

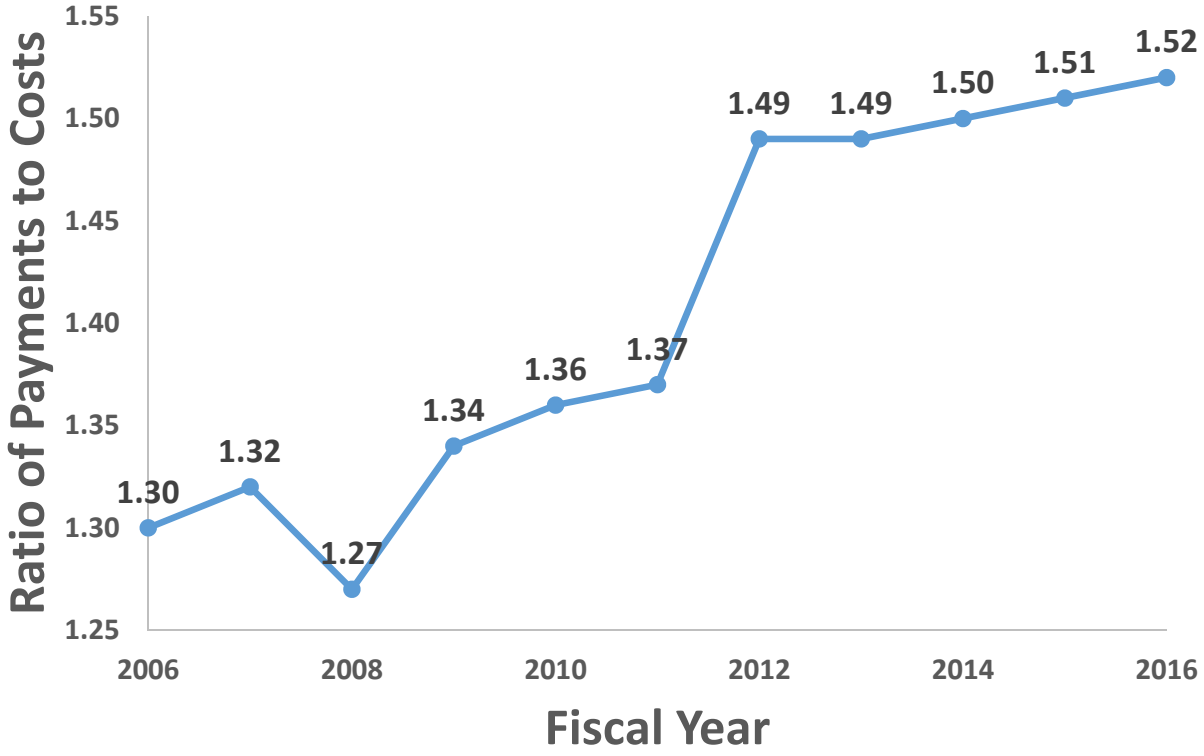
Are Medicare Beneficiaries Being Denied Services in Some Hospitals?

High Private Insurance Payments Relative to Costs Keep Hospital Systems Profitable!

YES I KNOW---Hospital Cost Shifting Doesn't Exist

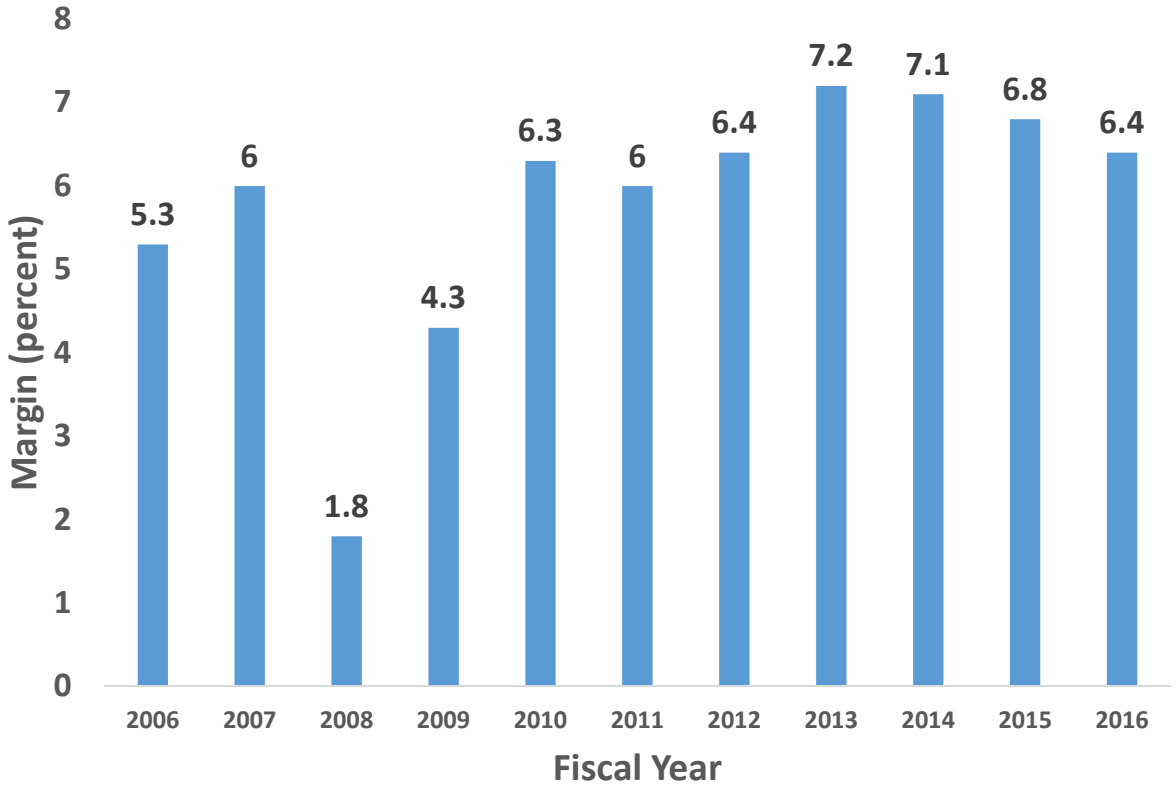
And If Medicare Paid More Its Unlikely That It Would Lower Private Payments

Change in the Private-Payer Ratio of Payments to Costs for Hospital Services 2006-2016



SOURCE: MedPAC analysis of Medicare cost report data from CMS, MedPAC June 2018 report.

Hospital Total All-Payer Margin 2006-2016



SOURCE: MedPAC analysis of Medicare cost report data from CMS, MedPAC June 2018 report.

Growth In Private Insurance Spending Dominated By Hospital Price Growth 2007-2014*

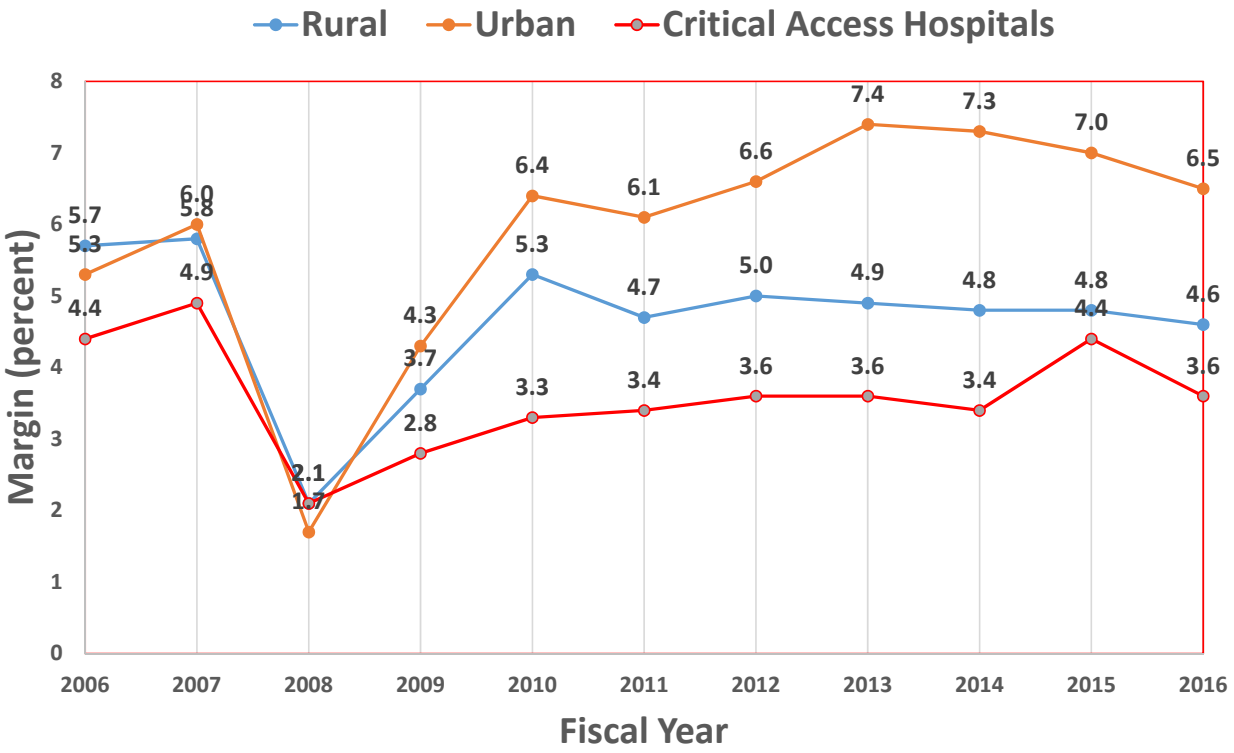
Hospital		Percent Growth
	Inpatient	42%
	Outpatient	25%
Physician		
	Inpatient	18%
	Outpatient	6%

*Z. Cooper et al, Hospital Prices Grew Substantially Faster Than Physician Prices For Hospital Based Care in 2007-14, Health Affairs February 2019

But The Growing Asymmetry Between Government and Private Payments Does Affect Different Types of Hospitals Differently

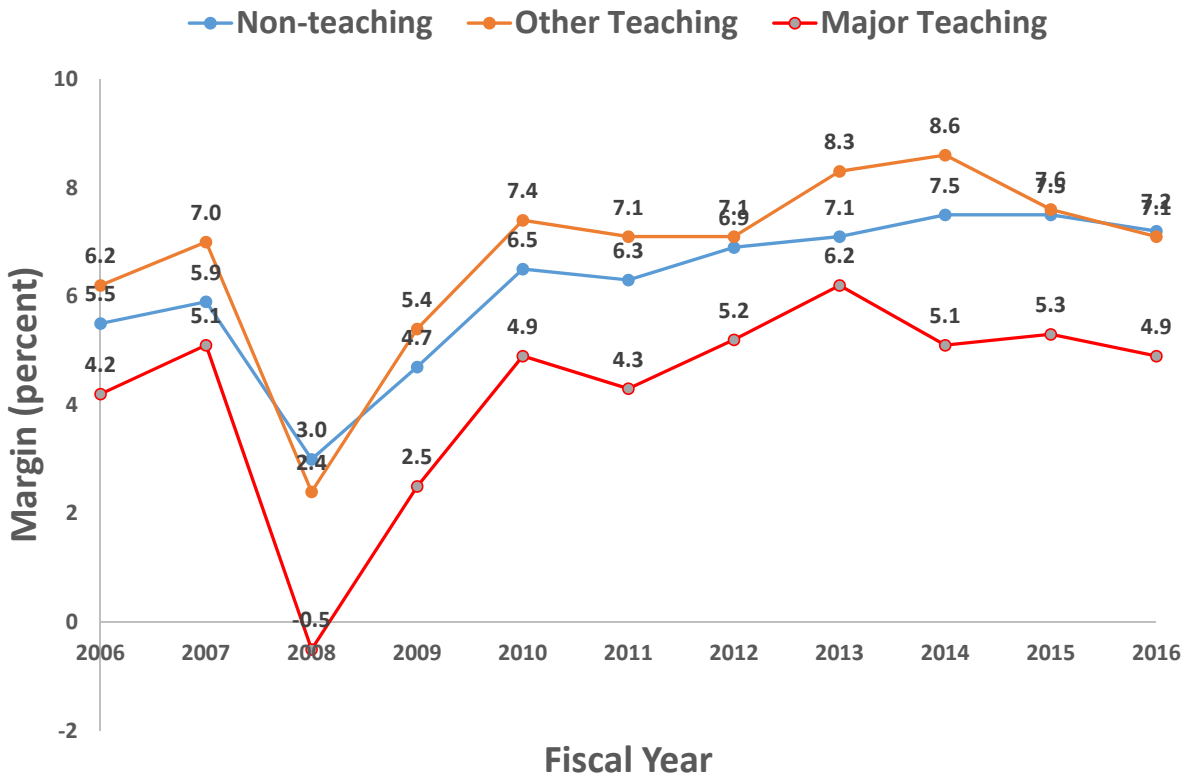
Also Ratio of Private to Medicare Hospital Payments Are Significantly Different in Different Regions

Hospital Total All-Payer Margin by Urban and Rural Location and Critical Access Hospitals 2006-2016



SOURCE: MedPAC analysis of Medicare cost report data from CMS, MedPAC June 2018 report.

Hospital Total All-Payer Margin by Teaching Status 2006-2016



SOURCE: MedPAC analysis of Medicare cost report data from CMS, MedPAC June 2018 report.

CBO Analysis of 2013 Data Showed Smallest Regional Difference of 44% and Highest 148%*

*Jared Lane Maeda and Lyle Nelson, “An Analysis of Hospital Prices for Commercial and Medicare Advantage Plans”, Paper Presented at 2017 Academy Health Meeting

Financial Survivability of Hospitals

- As Gap Widens Financial Survivability Less Depended on Efficiency and More on Patient Mix and Regional Power Over Pvt. Insurance Companies

  In 2013*

  -55% of Highly Profitable Hospitals Were For-Profit (25% of Total Hospitals)

  -But Many Not-for-Profit Also Highly Profitable (7 of 10 Most Profitable)

  -Having Strong Regional Power Key to Profitability

  -2 of 10 Most Profitable Were Big Teaching Although Most Are Lower Profit

  -Hospital in Systems Do Much Better Than Independent Institutions

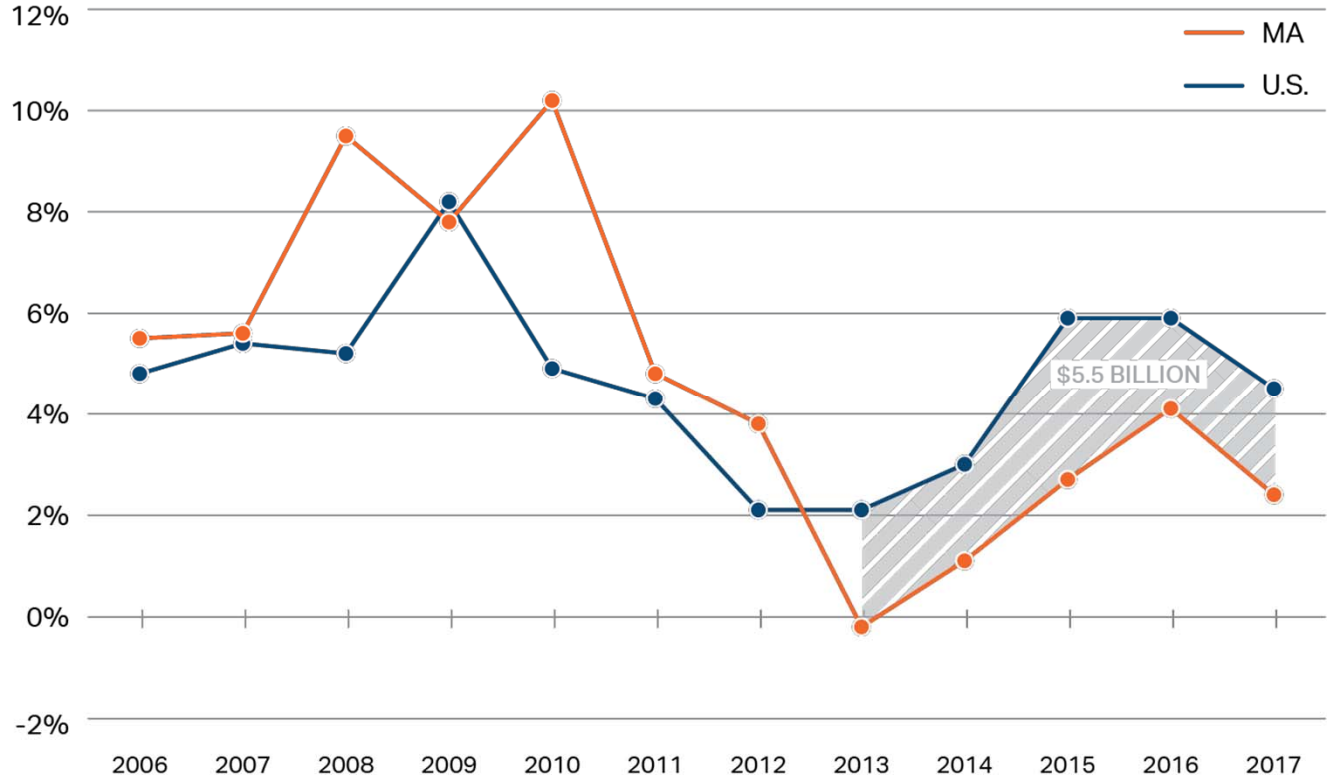
  -Public and Rural Hospitals Have The Highest Loses

*Bai and Anderson, “A More Detailed Understanding Of Factors Associated With Hospital Profitability”, Health Affairs May 2016

In Massachusetts Which Has Had High Private Rates But Constrained Growth in Rates in Recent Years Gap was 57% in 2016

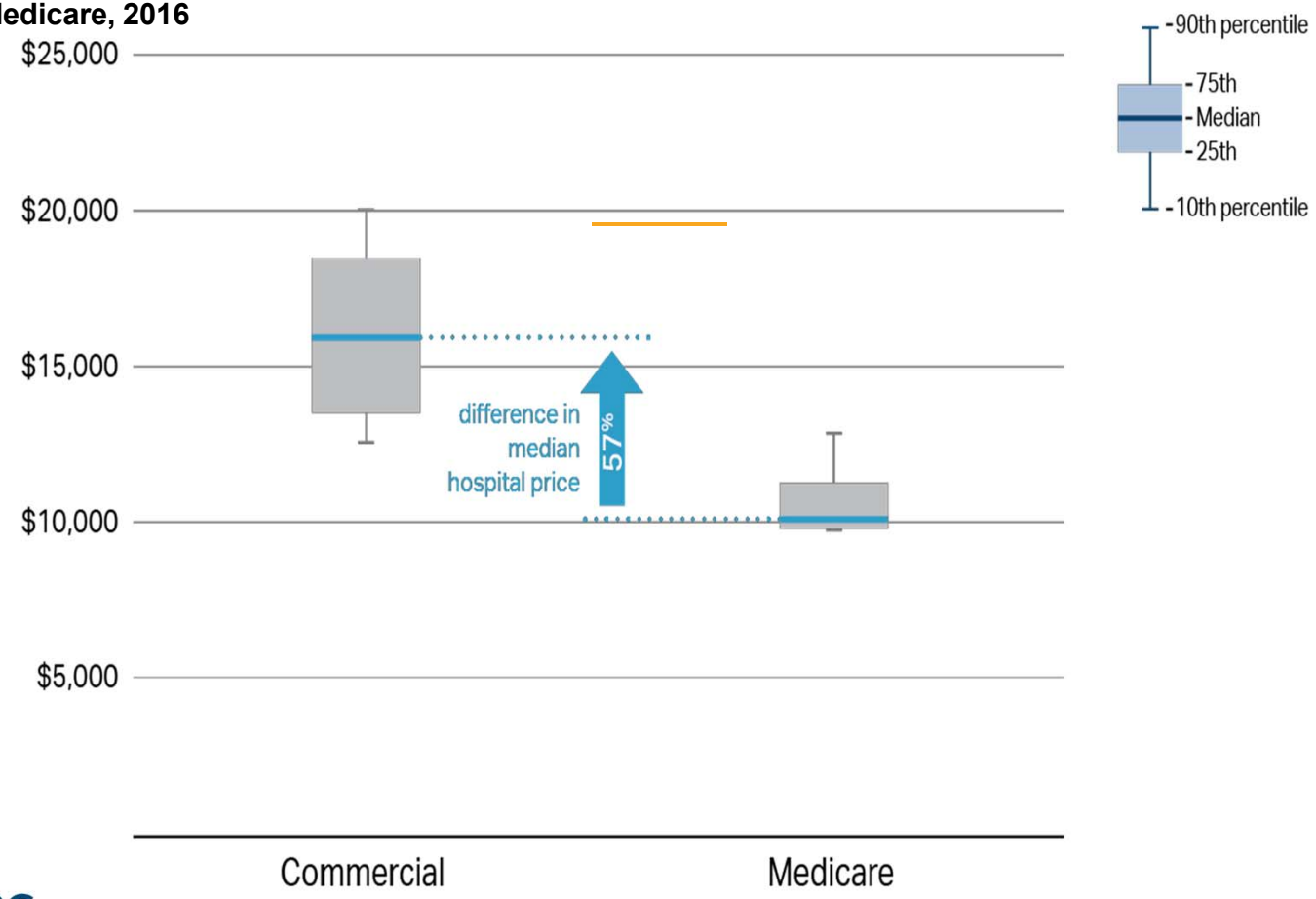
Differences in Rates Vary By Type of Procedure and Higher for Outpatient Services

Annual growth in commercial spending per enrollee, MA and the U.S., 2006-2017



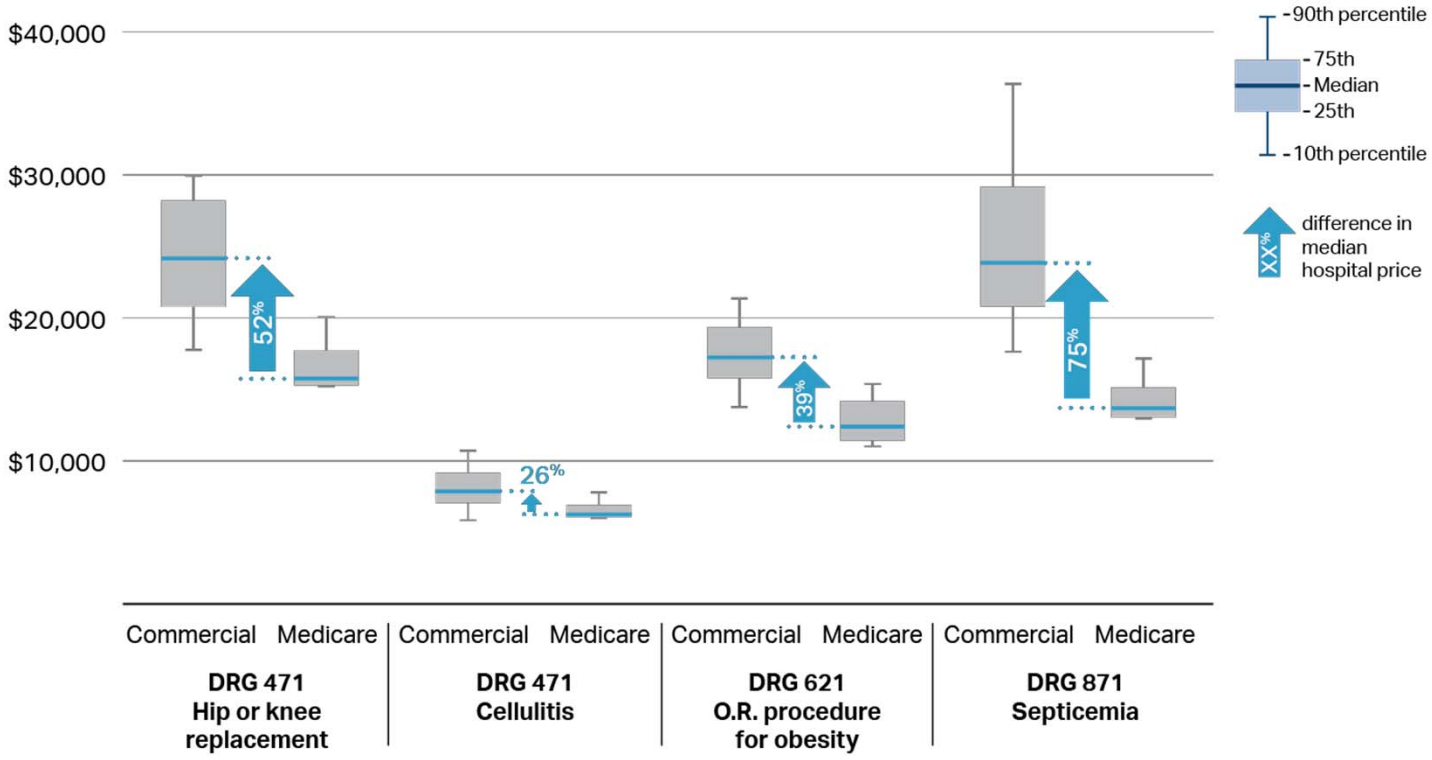
Notes: U.S. data includes Massachusetts. MA figure for 2017 is preliminary. Center for Health Information and Analysis data are for the fully-insured market only.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data (U.S. 2014-2017), and State Healthcare Expenditure Accounts (U.S. 2005-2014 and MA 2005-2014); Center for Health Information and Analysis Annual Reports (MA 2014-2017)

Distribution of average hospital facility payments per discharge, commercial and Medicare, 2016



Notes: Analysis includes facility payments only, excluding professional services. Analysis excludes claims with invalid payment codes and excludes outlier claims at each hospital. Excludes some maternity claims for which discharge of mother and newborn cannot be distinguished. Commercial average payment per

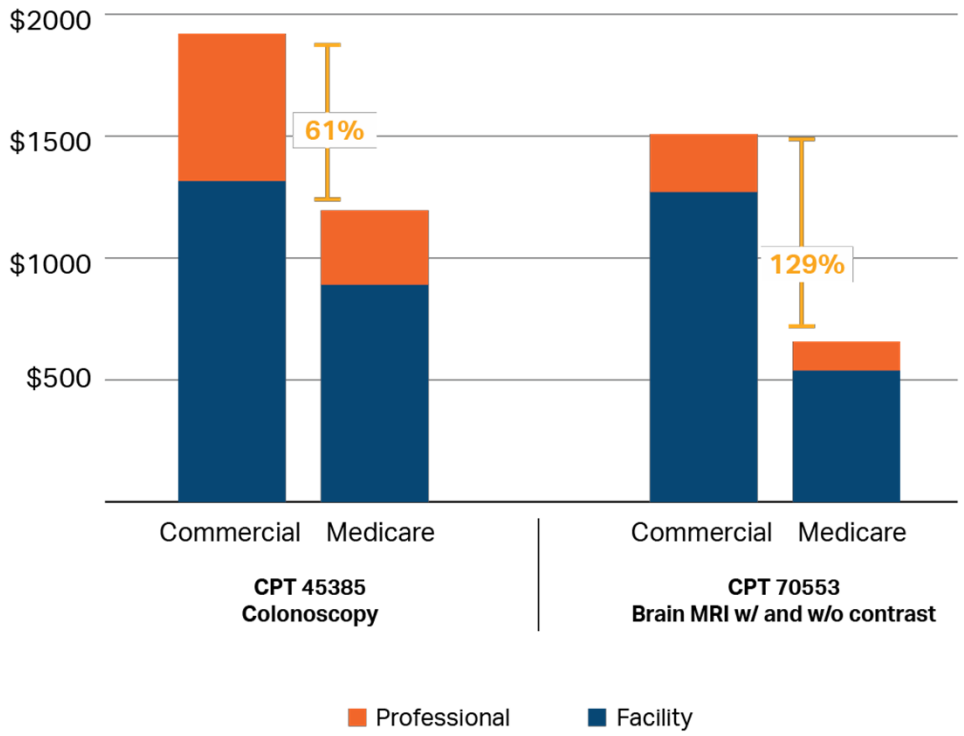
Distribution of average hospital facility payments per discharge, commercial and Medicare, select diagnoses, 2016



Notes: Analysis includes facility payments only, excluding professional services. Analysis excludes claims with invalid payment codes and excludes outlier claims at each hospital. Commercial average payment per discharge is adjusted for case weight across hospitals; Medicare averages are calculated according to Medicare payment rules, including DSH and teaching hospital adjustments, and assume the same acuity and patient distribution as commercial discharges. Excludes hospitals not paid under Medicare's Inpatient Prospective Payment System, including Critical Access Hospitals and certain specialty hospitals.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; Medicare Impact File 2016 and FY 2016 Final Rules Tables, Table 1A-1E.

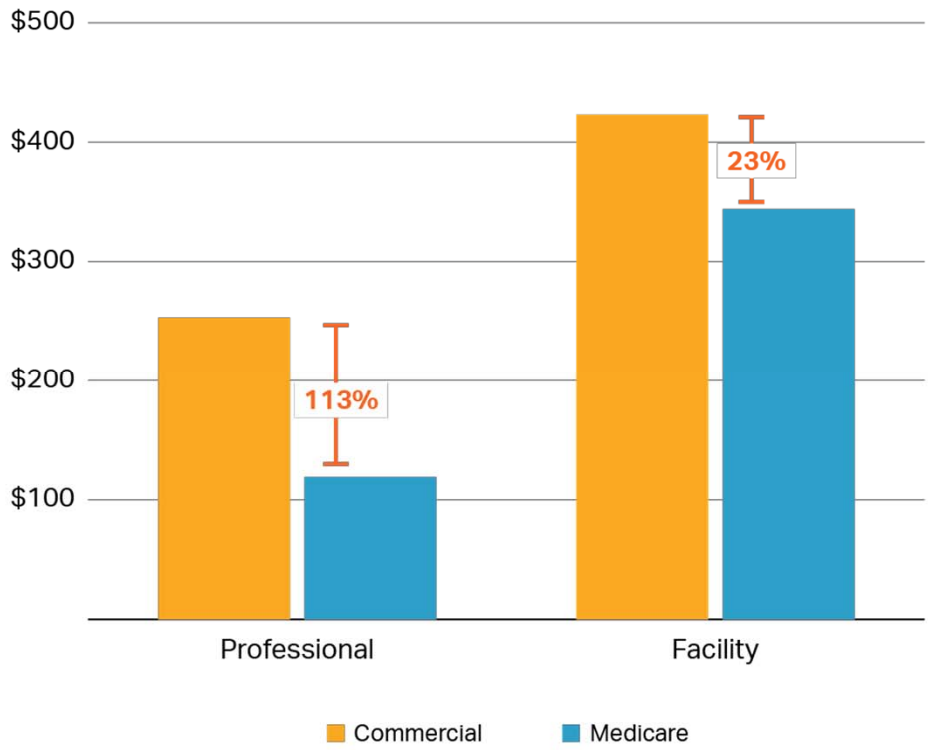
Average payment per hospital outpatient department visit, commercialand Medicare, for colonoscopy and brain MRI, 2016



Notes: Commercial averages weighted by hospital volume, and exclude claims with invalid payment codes and outlier claims at each hospital. Medicare professional averages are based on statewide average payments for these services; Medicare facility averages are calculated according to Medicare payment rules, including DSH and teaching hospital adjustments, and assume the same patient distribution as commercial visits. Facility amounts exclude hospitals not paid under Medicare's Outpatient Prospective Payment System, including Critical Access Hospitals and certain specialty hospitals.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; Medicare Impact File 2016; Medicare Outpatient Prospective Payment Addendum B 2016.

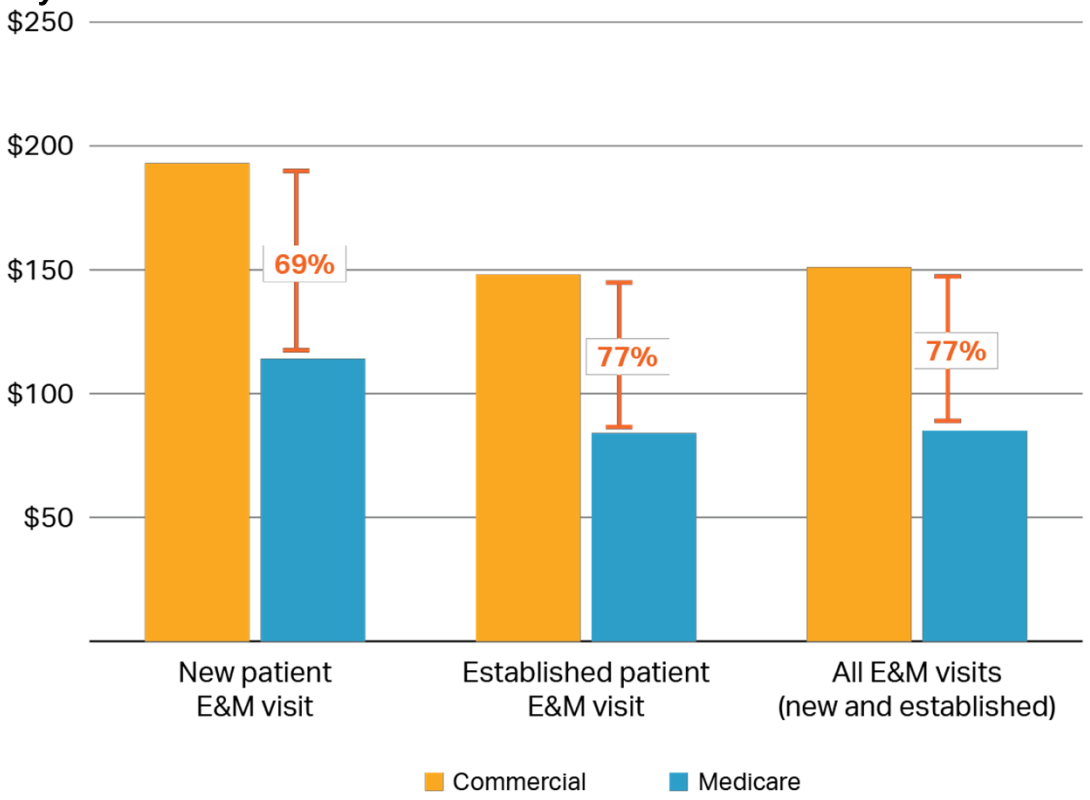
Average payment per hospital emergency department visit (evaluation and management portion only), commercial and Medicare



Notes: Commercial professional average includes all commercial claims for E&M codes billed in hospital emergency departments with valid payment amounts; Medicare professional average based on statewide average payments for E&M codes, weighted by volume of commercial codes at each hospital. Commercial facility average excludes claims with invalid payment codes; Medicare facility average calculated according to Medicare payment rules, including DSH and teaching hospital adjustments, and assume the same patient distribution and mix of procedure codes as commercial visits. Facility amounts exclude hospitals not paid under Medicare's Outpatient Prospective Payment System, including Critical Access Hospitals and certain specialty hospitals.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; Medicare Impact File 2016; Medicare Outpatient Prospective Payment Addendum B 2016.

Average payment per primary care office visit, commercial and Medicare, evaluation and management portion only



Notes: Analysis includes only claims for adult patients receiving care from primary care providers, and excludes outlier claims. Medicare averages are calculated according to Medicare payment rules, and assume the same patient distribution and mix of procedure codes as commercial visits.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; primary care providers identified using HPC Registration of Provider Organizations filings and SK&A provider database; Medicare State HCPCS Aggregate Summary Table CY2016

For Medicare Patients: *No Cause for Concern* **NOW**

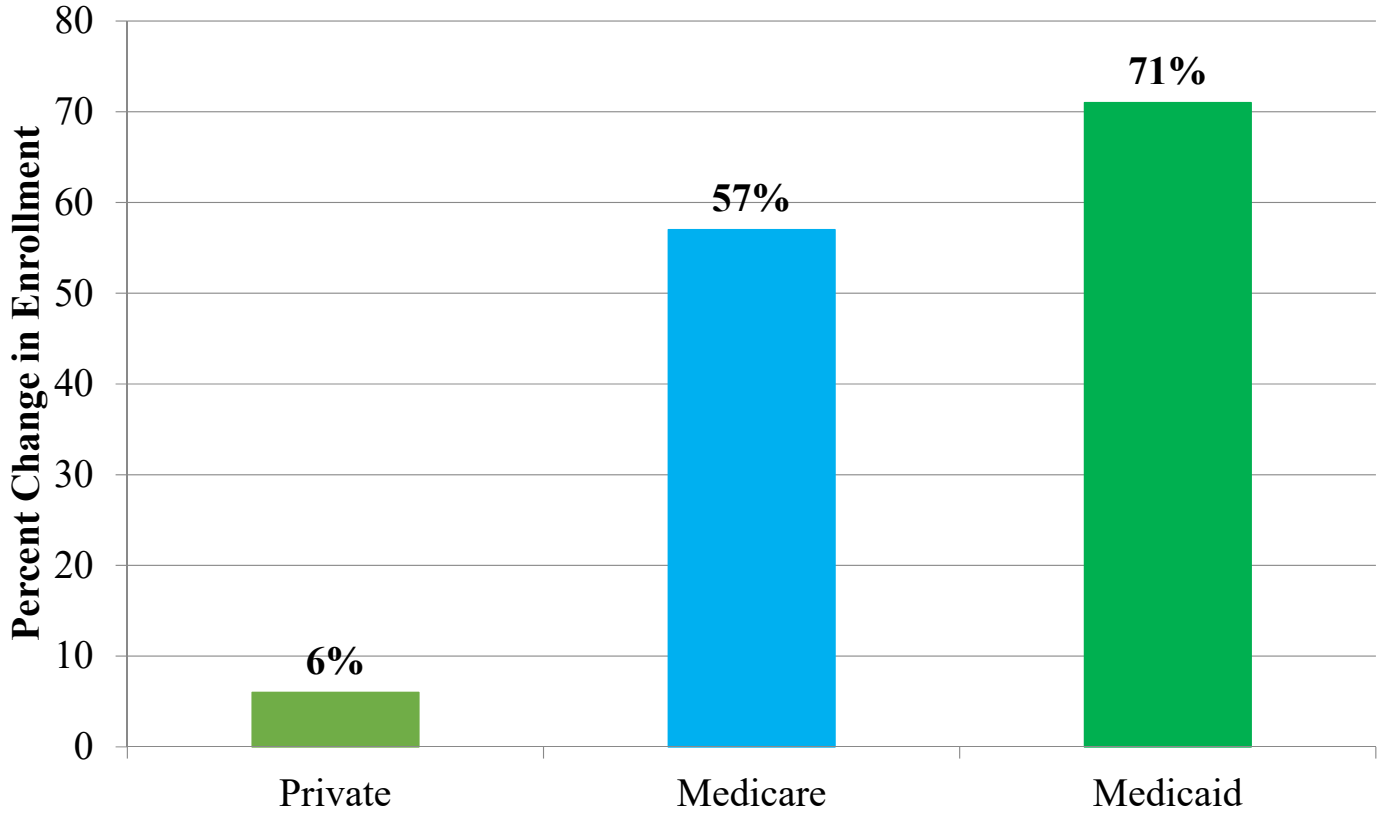
"Most of our payment adequacy indicators for hospitals are positive but 2016 Medicare margins remain negative for most hospitals and were -1.0 percent for median relatively efficient providers" (Medpac March 2018 Report)

What About Going Forward?

Hospitals Face Growing Government and Declining Pvt. Patient Growth

Will This Lead to Less Growth in Revenue and Constraints on Hospital Cost Growth or More Focused Emphasis on Services for Private Patients?

Growth in Enrollment by Payer Source, 2006 - 2022



CMS, National Health Expenditure Projections, 2012 to 2022, January 2013.

If Medicare Payments Continue to Be Constrained and Pvt. Payments Grow--- *Could There Be Access Limits for Medicare Patients?*

The Growing Use of Restrictions on Physician Coverage for Medicare Patients--- *"Concierge Care"* --- Could be Just The Beginning

Let Me Be Very Clear---*I am NOT Advocating for Higher Hospital Payments*

I Believe as Do Many Economists That Health Care Spending Can Only Be Constrained by Reducing The Growth in Revenues

But Should Constraints Only Come From Lower Government Payments and Should Government Ignore The Growth of Relative Private Rates---In Three States---Maryland and Massachusetts and Rhode Island The Answer is NO!