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Partner Insight Series:

Highlights of MedPAC's Report to Congress

April 3, 2023

How will MedPAC's Recommendations Affect Providers?

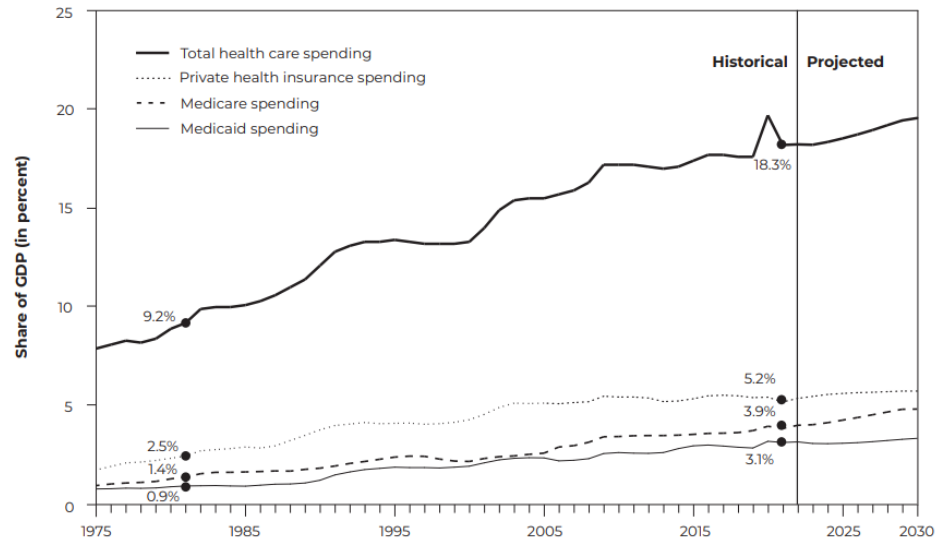
To understand the implications of the Medicare Payment Advisory Commission's (MedPAC) recent report, it's important to first understand what MedPAC is and what they aim to accomplish. MedPAC is a nonpartisan independent legislative branch agency that provide the U.S. Congress with analysis and policy advice on the Medicare program. Each March, the agency releases a report with recommendations to Congress regarding Medicare payment policy. Funded by U.S. taxpayers, the group conducts research into Medicare payment trends and possible issues that may arise in the future. MedPAC is tasked with making recommendations "aimed at obtaining good for the Medicare program's expenditures – which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources." Congress has the option to adopt MedPAC's recommendations or ignore them entirely. In developing its recommendations, MedPAC also must consider budget neutrality requirements where applicable. In this edition of JTaylor's Partner Insights Series, we highlight some of the trends MedPAC has uncovered and discuss the implications if Congress adopts these recommendations.

Healthcare Spending has Grown Faster than GDP

While the report notes that healthcare spending has grown faster than the nation's gross domestic product (GDP), this is not a new trend. Healthcare spending as a percentage of GDP has been steadily increasing from 9.2% in 1981 to 18.3% in 2021. As shown in the graph below, national healthcare spending growth rates have varied year to year (particularly in 2020 in connection with various COVID relief programs), but in the aggregate, healthcare spending as a percent of GDP has continued to increase.

FIGURE 1–1

Health care spending has grown as a share of the country's GDP



Note: GDP (gross domestic product). First projected year in graph is 2022. Beginning in 2014, private health insurance spending includes federal subsidies for both premiums and cost sharing for the health insurance marketplaces created by the Affordable Care Act of 2010. Health care spending also includes the following expenditures (not shown): out-of-pocket spending; spending by other health insurance programs (the Children's Health Insurance Program, the Department of Veterans Affairs, and the Department of Defense); and other third-party payers and programs (including Indian Health Service; Substance Abuse and Mental Health Services Administration; maternal and child health; school health; workers' compensation; worksite health care; vocational rehabilitation; other federal programs; other state and local programs; other private revenues; and general assistance) and public health activity. Pandemic relief funds are not considered Medicare spending since they are 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 April 2022 and historical data released in December 2022), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

Health care spending grew by 4.6% in 2022, fueled by a variety of factors including high demand for services, high inflation, and provider consolidation. MedPAC expects historic trends to return by 2024, with health care spending continuing to outpace GDP but at a slightly lower rate than the recent pattern.

Medicare Spending is Projected to Double by 2031

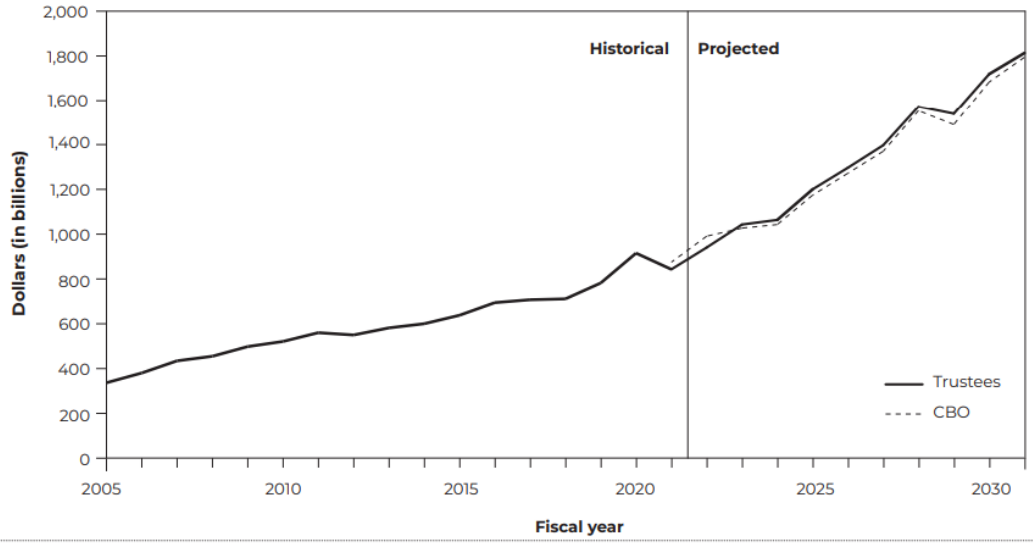
Medicare spending grew by only 3.6% in 2020, which is around half of what is normally expected. However, as patients resumed care after the pandemic began to subside, Medicare spending drastically accelerated to 8.4% growth in 2021. The suspension of the 2% payment sequestration contributed to the growth, along with a 3.75% temporary increase to physician reimbursement rates. Medicare spending growth is expected to return to the originally estimated rate of 6% to 7% annually, and will cause Medicare spending to double from $875 billion in 2021 to $1.8 trillion by 2031. MedPAC attributes two main factors to the growth of Medicare spending over the next ten years:

1. The increase in the number of beneficiaries as the baby-boom generation ages and becomes Medicare-eligible. The number of Medicare beneficiaries is expected to grow at least 2% annually for the foreseeable future.

2. The increase in both volume and intensity of services rendered. The largest contributor to this is new technology and more expensive drugs. As technological advances bring about better quality of care, the price of those services escalates.

This dynamic of more beneficiaries and a higher cost per beneficiary drives the overall costs to increase at an increasing pace.

FIGURE 1–3 **Medicare spending is expected to double in the next 10 years**



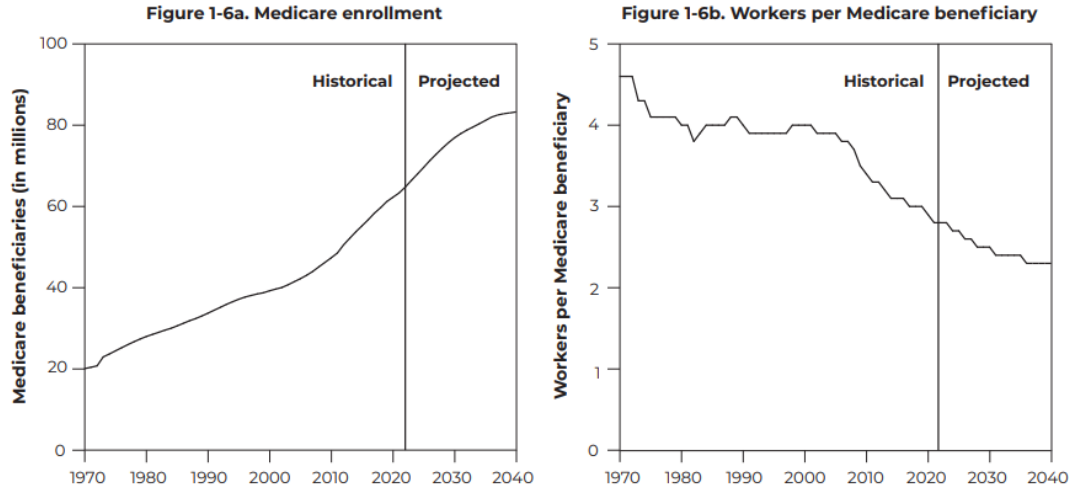
Note: CBO (Congressional Budget Office). First projected year in graph is 2022. The sharp increase in spending in 2020 includes $103.9 billion in Medicare Accelerated and Advance Payments paid to providers that year; these payments were expected to be repaid to the Medicare program in 2021 and 2022.

Source: 2022 annual report of the Boards of Trustees of the Medicare trust funds, Table V.H4; CBO's May 2022 baseline projections for the Medicare program.

Financing Challenges for Medicare

As noted above, the baby-boom generation is drastically increasing the number of Americans eligible for Medicare. By 2029, Medicare is projected to have 76 million beneficiaries — a 20% increase from the 63 million beneficiaries in 2021. However, the number of workers to fund Medicare through payroll taxes is not keeping pace. Put more simply, there are fewer workers paying payroll taxes per Medicare beneficiary. Today, there are about 2.9 workers per Medicare user, compared to 4.6 at the inception of the Medicare program. By 2031, this number is expected to fall to around 2.5. This disparity is causing Medicare spending to exceed funding, which will eventually lead to the full depletion of Medicare resources if nothing changes. As it stands currently, the Medicare Hospital Insurance (HI) Trust Fund is expected to be depleted in 2028.

FIGURE 1–6 **Medicare enrollment is rising, while number of workers per beneficiary is declining**



Note: "Beneficiaries" referenced in these graphs are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). First projected year is 2022. Part A services are financed by Medicare's Hospital Insurance Trust Fund and beneficiary cost sharing.

Source: 2022 annual report of the Boards of Trustees of the Medicare trust funds.

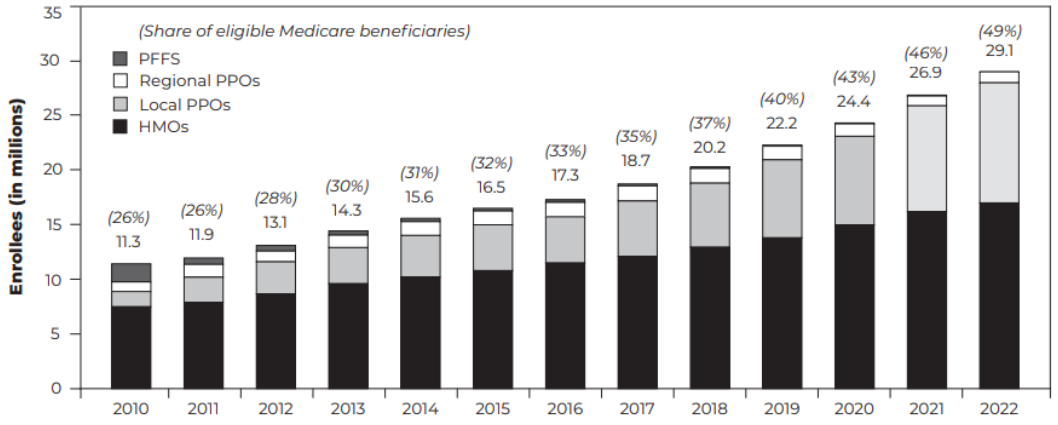
MedPAC offers some possible solutions to extend the solvency of the HI trust fund. One option is to raise the payroll tax rate from 2.90% to 3.66% to help compensate for the declining ratio of workers to Medicare beneficiaries. Alternatively, Medicare spending would need to be permanently reduced by 16.9% — a tall task, particularly given the increased cost associated with new technology and medical advances. Reducing Medicare Part A (hospital) spending by this much — $69 billion in 2023 alone — would require more than simply updating the Medicare payment policy. Rather, a substantial structural overhaul would be necessary.

Medicare Advantage

Further exacerbating the financial challenge is the shift from traditional Medicare to Medicare Advantage (MA). MA enrollment has more than doubled since 2013, and now constitutes almost half of Medicare beneficiaries.

FIGURE 11–1

Enrollment in MA has more than doubled since 2013



Note: MA (Medicare Advantage), PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). Beneficiaries must have both Part A and Part B coverage to enroll in a Medicare Advantage plan; therefore, beneficiaries who have Part A only or Part B only are not included in the denominator of eligible Medicare beneficiaries.

Source: MedPAC analysis of CMS enrollment files, July 2010–2022.

MedPAC noted that growth in MA plans and enrollment has not generated overall savings to Medicare. Conversely, it is estimated that in 2023, Medicare will spend 6% more per beneficiary for MA as compared to participants in traditional Medicare. Clearly, if enrollment continues to grow and MA spending continues to outpace traditional fee-for-service Medicare, the overall financial stability of Medicare will be further eroded.

What does this mean for Providers?

In light of the various trends noted above and other relevant factors, MedPAC's key recommendations for 2024 included the following:

- **Hospital Inpatient and Outpatient Services**
    - Update the base payment rates for general acute care hospitals by the amount specified in current law plus 1%.
    - Add $2 billion to current disproportionate share and uncompensated care payments and distribute these funds to hospitals using a Medicare Safety Net Index.
- **Physician and Other Professional Services**
    - Update the payment rate by 50% of the projected increase in the Medicare Economic Index, which would yield a payment increase of about 1.45%, resulting in a total increase in spending of $750 million in 2024. (This recommendation is interesting as this is the first time MedPAC has tied physician payments to an inflation measure.)

    - Make add-on payments of 15% for primary care and 5% to others for providing services to low-income Medicare beneficiaries, which is expected to yield a $2 billion overall payment increase in 2024.

- **Outpatient Dialysis** – No change from current law, which would be a 1.8% base payment increase.
- **Skilled Nursing Facilities** – Reduce the base payment rate by 3%.
- **Home Health** – Reduce the base payment rate by 7%.
- **Inpatient Rehab** – Reduce the base payment rate by 3%.
- **Hospice** – No change in base payment rates from current law (expected to be 2.9% increase), but wage-adjust and reduce the aggregate cap by 20%.

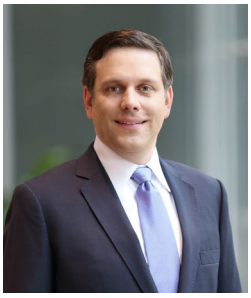
Advocacy groups had a mixed response, with the American Medical Association applauding MedPAC's recommendation to tie to the payment rate to inflation for the first time as a "critical first step." However, the AMA and 134 organizations that collectively represent 900,000 physicians also sent a letter to members of Congress urging them to provide an annual inflation update based on the full MEI rather than the 50% recommended by MedPAC in order to combat rising inflation and practice costs and preserve Medicare beneficiaries' access to care. Likewise, the American Hospital Association claims that MedPAC's suggested payment adjustment for hospitals is "totally insufficient and out of touch with reality, given the rising costs for hospitals."

In short, the current structure of the Medicare program is unsustainable, and there are no short-term solutions that will appease all parties. As the cost of providing care continues to rise and Medicare enrollment grows with an aging population, while the tax revenue to fund Medicare programs declines due to a shrinking workforce in relation to Medicare beneficiaries, there is simply not enough funding to increase Medicare payments to the levels desired by providers. Most Medicare programs are bound by budget neutrality laws, so Congress will have to intervene to increase payments beyond those statutory parameters. That said, the providers' claims of shrinking margins are real, and if reimbursement doesn't keep pace there will be repercussions for Medicare participants in the form of hospital closures and physicians limiting the number of Medicare patients they will accept. Unfortunately, Congress and the executive branch has shown no willingness to tackle the known structural funding problems with Medicare and for now has left the issue for future legislatures and administrations to solve.

Medicare payment and funding challenges are a known problem that providers, policy makers, and dealmakers in health care will have to contend. Below are some of our thoughts regarding how these challenges will impact the industry:

- Health care providers will have to find ways to improve efficiency and reduce costs where possible, because operating costs will likely continue to outpace reimbursement rate increases in the near term.
- Providers will also need to be more aggressive in negotiating with commercial payers to ensure overall revenue streams are optimized.
- Healthcare revenue analyses, forecasts, and valuations should take a detailed look at a provider's Medicare payer mix and make sure the financial risks associated with Medicare are properly reflected in the analysis.

The longer Medicare's funding and structural problems are not addressed by Congress, the probability of incremental changes and program fixes decreases, and the likelihood of drastic reimbursement cuts or structural changes increases. It is critical that healthcare providers and dealmakers understand the complexities and importance of this issue.



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Herd has over 20 years of experience serving clients in the healthcare, non-profit, and investor-owned sectors. He has extensive experience in strategic planning, including joint ventures, business acquisition, due diligence services, and managed care contracting support. He also draws upon his healthcare and finance background to provide business enterprise and compensation valuation services. His clients include large multi-hospital health systems, physician-owned hospitals, entrepreneurs, and attorneys.

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Note: All graphs contained herein were obtained from the MedPAC *Report to the Congress: Medicare Payment Policy* (2023, March).