Issues

- Hospital consolidation
- Shift to more expensive sites of ambulatory care
- Geographic variation in post-acute care spending
- Increases in Medicare Advantage coding intensity
- Rapid growth in Part D reinsurance payments

Consolidation and its impact on costs

- There has been substantial hospital consolidation over the last two decades
- Consolidation leads to increased market power, and in turn, higher private sector prices and commercial payment rates for health care services
  - Further, there has been limited evidence of increased quality
- Hospitals have continued to obtain higher commercial rates despite slower wage growth and declines in uncompensated care

Consolidation and it impacts on costs cont.

- Higher commercial rates lead to higher costs per case: MedPAC analysis finds that hospitals with less financial pressure (i.e., higher commercial reimbursements) have higher costs
- The hospitals with higher all-payer margins have very low Medicare margins

Consolidation and its impact on hospital market competition

- On average, commercial payment rates are more than 50% higher than costs (some have found 75% above costs)
- Hospital all-payer profit margins reached a 30-year high in 2014, averaging 7.3 percent nationwide
- Both media and academic sources report wide payment variation for identical services within and between markets

Consolidation and its impact on beneficiary access

- Higher private prices creates a disparity in payment rates and some have raised access issues
- However, we do not expect near-term access issues
  - Inpatient admissions are declining while outpatient visits are rapidly increasing
  - Occupancy rates are declining (urban 61%; rural 41%) leaving excess capacity
  - Medicare margins still sufficient to generate a 10% marginal profit on each additional Medicare patient
- Further, some hospitals currently accept discounts on Medicare rates from Medicare Select medigap plans and certain Medicare demonstrations

Growth of hospital employment of physicians

- Number of physicians employed by hospitals increased by 25.5% from 2010–2014 (Bureau of Labor Statistics)
- Share of cardiologists employed by hospitals grew from 11% to 35% from 2007–2012 (ACC survey)
- Recent SK&A data shows large 1-year increases in employment

Number of services per beneficiary growing faster in OPDs than freestanding offices, 2010–2011

Type of service	Growth in freestanding office	Growth in OPD	Share of services in OPDs, 2011
E&M office visits	–0.2%	7.8%	9.7%
Echocardiogram (without contrast)	–6.3	17.6	29.6
Nuclear cardiology	–12.0	13.6	33.0

Note: E&M (evaluation and management). Data are preliminary and subject to change
Source: MedPAC analysis of Medicare claims, 2010–2011

If migration to OPDs continues at current rate…

- Medicare spending on E&M visits would be $1.2 billion higher per year by 2021 due to shift in site of care; beneficiary cost sharing would be $310 million higher
- Medicare spending on echocardiograms and nuclear cardiology studies would be $1.1 billion higher per year by 2021; cost sharing would be $285 million higher

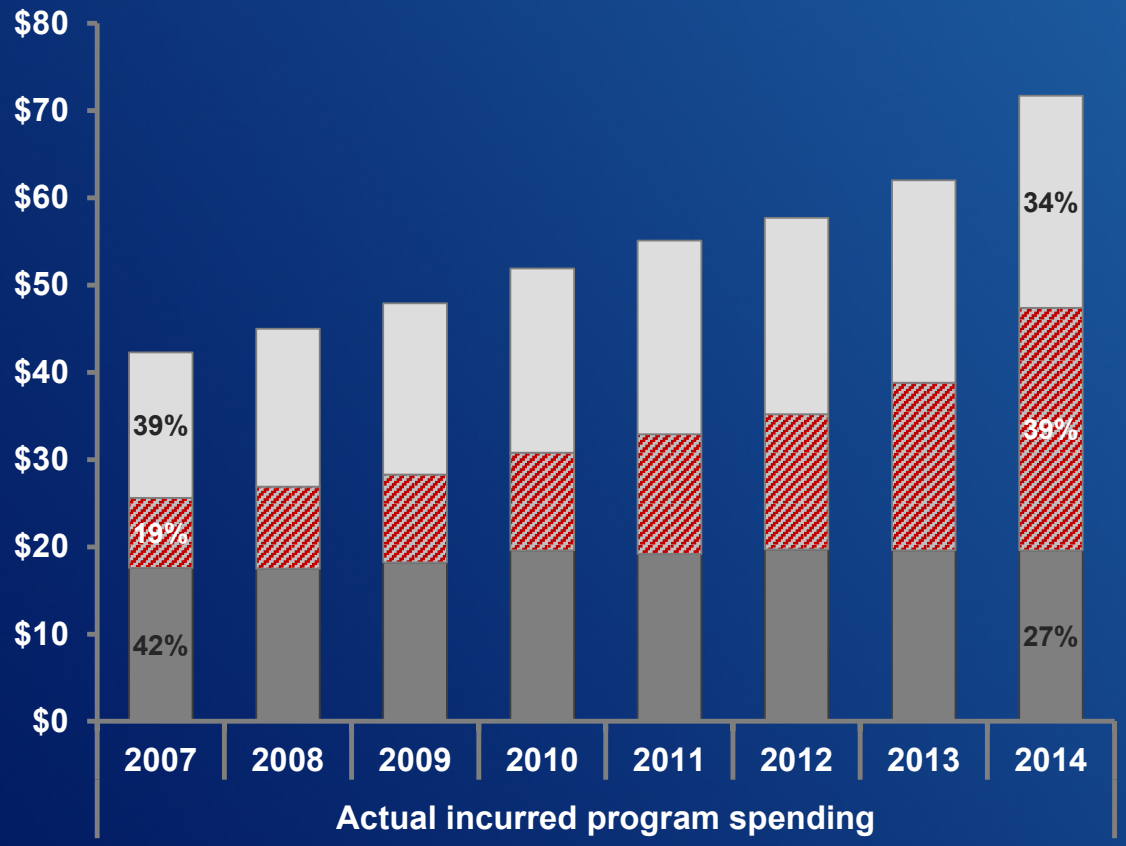
Data are preliminary and subject to change

Medicare Advantage coding intensity

- MA risk score growth higher than FFS growth
  - 8% in 2013 and 9% in 2014, cumulative
- 2017 coding intensity impact will be 10%
- CMS has applied the minimum adjustment required by law in prior 3 years
  - Minimum adjustment for 2017 is 5.66 percent

Reinsurance has become the largest component of Part D spending

In billions of dollars



Cumulative growth 2007–2014

- Low-income subsidy
- Reinsurance
- Direct subsidy net of risk-corridor payments

Reinsurance payments:

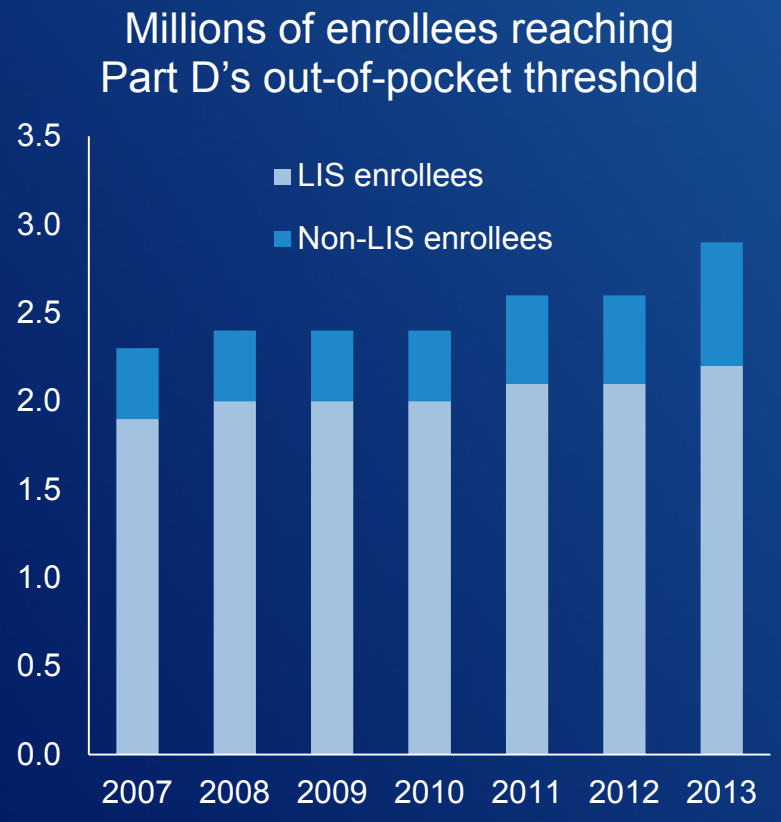
- Double-digit average annual growth
- Became the largest component of program spending in 2014

Source: MedPAC based on Table IV.B.10 of the Medicare Board of Trustees' report for 2015.

Note: Data are preliminary and subject to change.

MEDPAC

Growing share of Part D spending is for high-cost enrollees



- 2.9 million (7.6%) of enrollees reached OOP threshold in 2013
- Among these "high-cost enrollees," non-LIS growing faster than LIS
- High-cost enrollees accounted for 47% of spending in 2013 (up from 40% in 2011)
- Recent growth in their spending driven by prices

Source: MedPAC analysis of Part D prescription drug event data.
Note: Data are preliminary and subject to change.

Upward pressure on prices

- Fewer patent expirations
- Some sharp increases in generic prices
- Drug pipeline includes many higher-priced biologics and specialty drugs
- Unprecedented launch prices, some for therapies that treat broad populations

Use of higher-cost drugs poses challenges for Part D

- Share of high-cost enrollees who filled at least one prescription for a biologic product grew from 8% in 2009 to 12% in 2013*
- Spending for new hepatitis C therapies has led to a large spike (15% increase) in Part D spending in 2014**
- As more expensive therapies become available, more beneficiaries will likely reach the catastrophic phase of the benefit

* MedPAC analysis of Part D prescription drug event data. Data are preliminary and subject to change.

** Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2015. *2015 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds*. Washington, DC: Boards of Trustees.