A View from MedPAC

Massachusetts Association of Health Plans

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MEDPAC

MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- 17 national experts selected by Comptroller General for expertise, not representation
  - Includes providers, payers, economists, beneficiary-focused individuals
  - Serve 3 year terms, can be reappointed
  - Meets in public 7x a year, votes in public

MedPAC's principles of Medicare payment

- Ensure beneficiary access to high quality care in an appropriate setting
- Give providers an incentive to supply effective, appropriate care and pay equitably
- Assure best use of taxpayer dollars

The difference in Medicare and commercial rates paid to hospitals

- Commercial rates paid to hospitals are at least 50% higher than Medicare rates *(Cooper et al. 2015, HCCI 2014, MedPAC 2016, Selden et al. 2015)*
- MedPAC: 50% above Medicare rates; Selden et al.: 75% above Medicare rates
- Aetna and Blue Cross of California paid rates 200-300% higher than Medicare *(California Department of Insurance 2014)*

High hospital prices: horizontal consolidation

- Most hospital markets are highly consolidated
- Consolidation leads to higher hospital prices, without clear evidence of quality improvement *(Cooper et al. 2015, Gaynor et al. 2014, Melnick et al. 2011, White et al. 2012)*
- Prices commercial insurers pay hospitals can vary by a factor of five for the same service *(Ginsburg 2010, MedPAC 2016, Reinhardt 2012)*

Analysis of financial pressure: hospital costs are not immutable

- High pressure= low cost
  - The 25% of hospitals under the most financial pressure had median Medicare costs per case 8% lower than the national median
  - Hospitals under pressure generated median Medicare profit margins of about 4%
- Low pressure= high cost
  - The 61% of hospitals that were under a low level of financial pressure had median Medicare costs per case 2% above the national median
  - These hospitals had median Medicare profit margins of -9%

(MedPAC 2009, 2016; Stensland et al. 2010)

Analysis of financial pressure: hospital costs are not immutable (cont.)

- Other sources suggest costs are not immutable *(Robinson 2011, White and Wu 2014)*
- Between 2004-2014, per capita out-of-pocket (OOP) spending grew 58% while median household income grew only 21% *(Census Bureau 2015, CMS 2015)*

High physician prices: physician-hospital consolidation

- One source of high physician prices:
  - Hospitals buy physician practices
  - Bill physician services as hospital outpatient (HOPD) services
- Medicare: Facility fees result in higher Medicare spending
- Commercial: Higher negotiated prices

Impact of restraining Medicare prices

- No material reductions in beneficiary access:
  - Occupancy is low: 61% on average; 41% at rural hospitals *(MedPAC 2016)*
  - Medicare rates generate ~10% marginal profit *(MedPAC 2016)*
  - Some hospitals accept discounts on Medicare rates from medigap plans to gain Medicare market share *(Huang et al. 2013, Lee et al. 1997, OIG 2015)*

Part B drugs: background

- In 2015, Part B drug spending was $26 billion (up from $23 billion in 2014).
  - $21 billion program spending
  - $5 billion beneficiary spending
- Part B drug spending has grown 9 percent per year since 2009
- Medicare pays physicians and HOPDs for most Part B drugs at 106% of ASP
  - ASP = average price realized by manufacturer for sales to all purchasers (with exceptions) net of rebates and discounts
  - The prices individual providers pay for a drug may differ from ASP for a variety of reasons (e.g., price variation across purchasers, 2-quarter lag in ASP payment rates, etc.)

Data are preliminary and subject to change

MedPAC recommendation: Part B drugs, policy details

- Reform “buy-and-bill” ASP System
  - Inflation rebate
  - Consolidated billing codes
  - Reduce WAC+6%
  - Reduce ASP+6%
- Implement Drug Value Program
  - Voluntary, market-based
  - Formulary, other tools, exceptions process
  - Opportunity for shared savings

MedPAC recommendation: Part B drugs, implications

- Reduced cost-sharing for beneficiaries
- Reduced spending for Medicare program
- Opportunity for shared savings for providers
- Not expected to affect beneficiaries' access to medicines

Future challenges require changes to Part D's structure

- Growing Medicare population
- Unsustainable trends in program spending
  - Spending growth increasingly driven by enrollees who reach out-of-pocket (OOP) threshold
  - About 70% of program spending for the 30% of enrollees who receive the low-income subsidy (LIS)
  - Price growth for older drugs and high launch prices
  - Reinsurance spending has grown at about 20% per year
  - Plan bids and reconciled payments have led to higher subsidy rate than the 74.5% in law
- Need to balance beneficiary access to drugs with financial sustainability for taxpayers

Summary of MedPAC Part D recommendations

- Change Part D to:
  - Transition Medicare's reinsurance from 80% to 20% of catastrophic spending and keep Medicare's overall subsidy at 74.5%
  - Exclude manufacturers' discounts in the coverage gap from enrollees' "true OOP" spending
  - Eliminate cost sharing above the OOP threshold
- Make moderate changes to LIS cost sharing to encourage use of generics and biosimilars
- Greater flexibility to use formulary tools