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WHY DID MEDICARE SPENDING GROWTH SLOW DOWN?

Chapin White, Ph.D.

Health Affairs
May/June 2008
27(3):793–802

An abstract is available at:
http://content.healthaffairs.org/cgi/content/abstract/27/3/793

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Commonwealth Fund Pub. 1156
August 2008

In the Literature presents brief summaries of Commonwealth Fund–supported research recently published in professional journals.

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Key changes in Medicare payment policy—not increases in Medicare managed care, changes in beneficiary cost-sharing, or other explanations—have been responsible for slowing Medicare spending growth and curtailing so-called excess spending growth, finds a study in *Health Affairs*.

New prospective payment systems for hospitals and postacute care providers, as well as controls on aggregate Medicare physician spending, have reduced Medicare excess spending over the last three decades from 5.6 percent to 0.5 percent, writes Chapin White, Ph.D., a former Commonwealth Fund researcher, in "Why Did Medicare Spending Growth Slow Down?" (*Health Affairs*, May/June 2008).

Linking specific changes in Medicare's payment policy to the observed slowdown in the program's spending growth, White makes the case that "[h]istorical trends in Medicare spending show . . . that spending growth is entirely amenable to policy interventions."

Rates of Spending Growth

Focusing on the period 1975 to 2005, the study examined the Medicare program's excess growth—or spending growth beyond that attributable to general economic growth and changes in beneficiaries' age composition—related to Medicare-covered services, excluding beneficiary cost-sharing and third-party payments. The annual rate of excess growth fell from 5.6 percent during 1975–1983, to 2.1 percent during 1983–1997, to 0.5 percent during 1997–2005.

In 2005, Medicare spending accounted for 2.7 percent of gross domestic product (GDP). "If, beginning in 2005, excess growth in Medicare spending matched the 1975–1983 rate, Medicare spending would reach 15.4 percent of GDP in 2030, an almost sixfold increase," writes White. "If, instead, excess growth from 2005 on matched the 1997–2005 rate, Medicare spending as a share of GDP would equal 4.5 percent in 2030. The difference in projected GDP of 10.9 percentage points is more than half as large as current total federal outlays as a share of GDP (19.9%)."

Changes in Provider Payment Policies

Real medical spending per beneficiary on personal health care increased from $1,855 in 1975 to $7,817 in 2005, an annual growth rate of 4.9 percent. Of that, 2.6 percentage points represent excess growth. Growth trends in each category have slowed overall following payment reforms:

- *Hospital care:* Excess growth in this category ran quite high from the 1970s through the mid-1980s, but has since fluctuated around zero. An inpatient prospective payment system was implemented in 1983, switching cost-based reimbursement to payment on a fixed-rate-per-discharge basis, adjusted for patient diagnosis. The payment switch "coincided with a substantial and sustained reduction in Medicare hospital spending," notes White.
- *Physician and clinical services:* Excess spending growth on these services ranged between 3 percent and 8 percent during the 1970s and 1980s. It began to moderate around 1984, and since 1992 has ranged between zero and 4 percent. Medicare payments to physicians have been tightened in several stages. After

1975, annual fee increases were limited to general inflation, but spending continued to increase because of volume. Congress froze fee levels from 1984 to 1986 and later reduced fees for certain procedures. These changes coincided with a slowdown in excess spending growth. In 1992, a fee schedule and spending targets were introduced. Congress, over the years, has overridden the system that was designed to keep excess Medicare physician growth to zero.

- *Postacute care:* Accounting for a small share of Medicare spending, this category experienced volatile trends, with extremely high rates during the early 1990s, followed by negative excess growth in the late 1990s, before a recent uptick. "Spending trends in postacute care are highly sensitive to Medicare's payment and regulatory policies," writes White. For example, the Balanced Budget Act of 1997 constrained Medicare payments and mandated a new prospective payment system for skilled nursing facilities and home health agencies. Excess growth declined in postacute care after these changes, but more recently they have climbed, driven in part by so-called "givebacks" to providers in the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000.

Looking at research on alternative explanations for Medicare's spending slowdown against the historical spending trends, White concludes that managed care, changes in cost-sharing, and an overall slowing in systemwide trends are either too small, run counter to Medicare trends, or are not consistent to the timing of the Medicare spending slowdown.

Conclusions

Historical trends in Medicare spending hold key implications. First, spending growth is amendable to policy changes. Second, not all prospective payment systems work equally well, with Medicare's prospective payment system for inpatient hospitals showing greater success than its efforts with physicians. And third, increased cost-sharing is not the only remedy to curtailing spending growth. "If we acknowledge and accept that trends in Medicare spending are under our control, then we can move on to the more meaningful questions of what those trends should look like, and how public funds can be spent more beneficially," White concludes.