Weekly Checkup

Geographical Payment Discrepancies: Yet Another Medicare Challenge

CHRISTOPHER HOLT | SEPTEMBER 10, 2021

This week, the House started work on a gargantuan $3.5 trillion expansion of the federal government that Democrats hope to pass by the end of the month and ultimately enact using budget reconciliation. **One particular area of focus for progressives is expanding the Medicare program**, both by adding new dental, vision, and hearing coverage, and by lowering the Medicare eligibility age to 60. As discussed in the previous edition of the Weekly Checkup, **these efforts will only exacerbate the existing Medicare funding shortfall**. But a new paper from AAF's Jackson Hammond, examining geographic payment adjustments in Medicare, drives home another point: Even as Medicare spending outstrips revenue, the program already frequently fails to pay providers equivalent to their costs.

As Hammond explains, Medicare uses a variety of tools to equalize payments across geographic areas to account for variations in operating costs, but there is reason to doubt that the adjustments fully account for geographic variation in costs of operation. It's commonly accepted that rural hospitals in particular struggle with reimbursement levels well below costs incurred. Policymakers and advocates regularly raise concerns about rural hospitals' ability to remain open.

In a far less well-known twist, Hammond's research notes that providers in high-cost urban areas face similar, if not more severe, challenges with Medicare reimbursements coming in well below their operating costs. For example, the two worst Medicare margins (the percent of costs that Medicare payments cover) for short-term care hospitals in the country are in the Seattle area (-27.7 percent) and the San Francisco area (-41.2 percent). Further, both regions get insufficient adjustment via the Hospital Wage Index (HWI). While San Francisco hospitals might see a Medicare margin deficit over four times the national average, its HWI bump is only two times the national average, and Seattle hospitals have an HWI adjustment that barely surpasses the national average.

Medicare margin deficits aren't just a problem for rural hospitals and extremely high-cost urban areas. Nationally, Medicare pays hospitals about 9 percent less than their reported costs, on average. The main takeaway from Hammond's paper is that Medicare's attempts to adjust hospital payments for geographic cost variation "suffer from limited data and decades-old assumptions." Of note, however, even if the adjustments could be made perfect, most Medicare payment adjustments must be budget-neutral, or in other words, it can't pay one hospital more without paying another hospital less. So, **many providers are already losing money on Medicare patients, and, as the Medicare Trustees recently reminded us, Medicare doesn't have enough revenue to cover its existing commitments. Attempting to make matters worse, progressives are pushing to expand what and who Medicare covers—and we haven't even touched on the implications of the real progressive holy grail of Medicare for All.** One of the arguments for doing away with private health insurance and extending Medicare to cover all Americans is that Medicare coverage is more efficient than private insurance because Medicare does a better job of constraining cost growth. If, however, that's simply a product of paying providers less than health care costs, expanding underpayment to all patients would seem unwise.

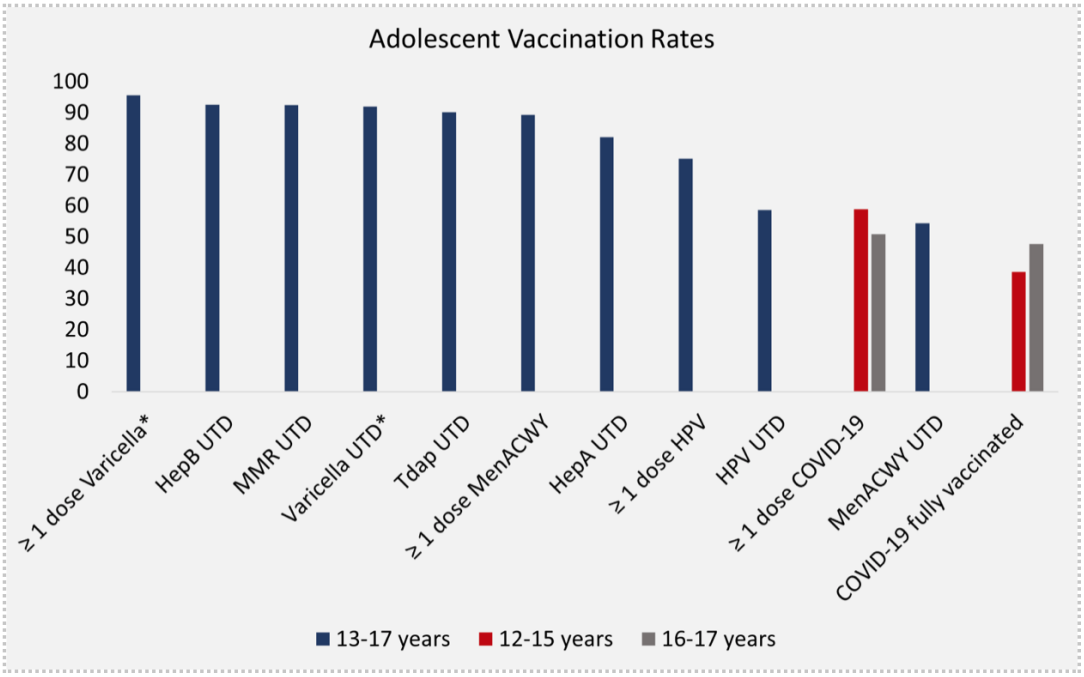
Medicare's problems are well documented and vast; policymakers would face more than enough challenges if they simply tried to repair the existing program (which, to be clear, they seem to have no interest in doing). The continual push to expand the set of problems by expanding Medicare makes little sense. **To put it biblical terms,"sufficient unto the day is the evil thereof," or to paraphrase, we've got enough problems in front of us; don't addmore.**

Chart Review: Adolescent Vaccination? Rates

Margaret Barnhorst, Health Care Policy Fellow

The? Centers for Disease Control and Prevention (CDC) ?released ?data ?last week ?on ?vaccination coverage ? for ?adolescents aged 13-17 years, based on results from the 2020 National Immunization Survey—Teen.? The? report ?includes? coverage for? vaccines? that ?adolescents received throughout their lifetime, including ? tetanus, diphtheria, and acellular pertussis (Tdap); ?quadrivalent ?meningococcal conjugate ?(MenACWY); ? human papillomavirus (HPV); ?measles, mumps, and rubella (MMR); ?Hepatitis A? (HepA) ; ?Hepatitis B (HepB); ?and Varicella—al l?of which the ?CDC ?recommends for adolescents.

While the CDC now ?recommends ?the ?COVID-19 vaccine for individuals aged 12 and older, ?the ?Food and Drug Administration (FDA) ?only began emergency use authorization for those ?aged 16 years or older ?in ? December 2020, and ?for ?those ?aged 12-15 years ?in May 2021. ?In August, the FDA ?fully ?approved ?the Pfizer/BioNTech ?COVID-19 vaccine ?for all individuals aged 16 or older. The agency has yet to ?fully ? approve ?a COVID-19 ?vaccine outside of the emergency use authorization for those aged 15 ?and under, ? potentially raising concerns for parents. These factors may contribute to the relatively low adolescent vaccination rate for COVID-19 compared to other vaccines, seen in the chart below. While ?58.9 ?percent ?of ? adolescents aged 12-15 years ?and 50.8 ?percent ?of ?those ?aged 16-17 years ?have received at least? one ? dose of a COVID-19 vaccine, ?only 38.6 ?percent ?of ?adolescents aged ?12-15 years ?and 47.6 ?percent ?of ? those ?aged 16-17 years are considered fully vaccinated.



*Varicella ?vaccination rates are among adolescents with no history of varicella disease.

UTD: Up to date with ?recommended ?doses according to ?current CDC ?guidelines.
COVID-19 vaccination rates ?obtained from? CDC COVID Data Tracker, all other vaccination rates obtained from ?CDC Morbidity and Mortality Weekly Report.

Tracking COVID-19 Cases and Vaccinations

Jackson Hammond, Health Care Policy Analyst

To track the progress in vaccinations, the Weekly Checkup will compile the most relevant statistics for the week, with the seven-day period ending on the Wednesday of each week.

Week Ending:	New COVID-19 Cases: 7-day average	Newly Fully Vaccinated: 7-Day Average	Daily Deaths: 7-Day Average
8-Sep-21	136,558	220,095	1,076
1-Sep-21	156,340	369,263	1,214
25-Aug-21	152,754	351,383	1,173

18-Aug-21	142,220	303,666	983
11-Aug-21	123,381	242,281	756
4-Aug-21	100,473	214,400	522
28-Jul-21	70,788	207,221	366
21-Jul-21	45,042	226,201	275
14-Jul-21	29,403	247,590	233
7-Jul-21	16,607	243,550	194
30-Jun-21	13,920	323,561	233
23-Jun-21	11,967	409,209	252
16-Jun-21	12,362	630,243	293
9-Jun-21	15,313	734,940	357
2-Jun-21	15,002	527,059	389
26-May-21	22,266	826,895	445
19-May-21	27,914	1,070,133	519
12-May-21	34,877	1,282,418	556
5-May-21	45,476	1,480,759	587
28-Apr-21	52,025	1,515,972	619
21-Apr-21	61,015	1,535,807	632

14-Apr-21	68,639	1,790,651	640
7-Apr-21	64,579	1,615,765	621
31-Mar-21	64,403	1,399,413	701
24-Mar-21	57,293	985,064	737
17-Mar-21	53,667	1,041,405	860
10-Mar-21	54,212	972,857	1,121
3-Mar-21	61,016	931,635	1,357
24-Feb-21	64,942	857,454	1,727
17-Feb-21	73,546	754,996	1,911
10-Feb-21	100,647	713,442	2,358
3-Feb-21	129,499	492,506	2,725
27-Jan-21	159,886	341,228	3,175

Sources: Centers for Disease Control and Prevention Trends in COVID-19 Cases and Deaths in the US, and Trends in COVID-19 Vaccinations in the US.

Note: The U.S. population is 332,721,914.