How Statutory Management of Healthcare Inflation Impacts Providers

Introduction

As inflation dominates headlines in 2022, healthcare stakeholders should understand how general inflation differs from healthcare inflation, as well as how cost indices and payment schedules do and do not reflect inflation. The cost of both medical goods and services has risen much faster than general inflation over the past several decades while reimbursement has lagged behind it. These trends disadvantage certain healthcare providers, as their ability to set prices and pass costs through to consumers is limited by both public and private forces. Although the trend of consistent healthcare inflation may suggest stability over time, bureaucratic management of that inflation reduces the sector's ability to react in real time to changing market dynamics. Physician payments are particularly exposed to legislative, regulatory, and economic fluctuations.

Measuring Healthcare and Non-Healthcare Inflation

CPI and CPI-U

The Consumer Price Index (CPI) is the standard benchmark used to measure inflation and deflation, and the CPI for All Urban Consumers (CPI-U) is informed by the prices that consumers pay for goods and services in urban areas. For the purposes of the CPI-U, the total population of urban consumers includes urban households in all metropolitan statistical areas and urban locales of at least 2,500 people; the CPI-U thus represents greater than 90% of the US population.[1] Expressed as a percentage, the CPI is updated monthly to reflect changes in prices over the preceding 12-month period.

CPI Medical Care Market Basket

The Bureau of Labor Statistics (BLS), which administers the CPI, categorizes hundreds of item types into 8 major groups, or market baskets, one of which is medical care.[2] The medical care market basket includes 2 main components: services and commodities. Medical care services comprise the more heavily weighted component and include professional services, hospital and related services, and health insurance; commodities include drugs as well as medical equipment and supplies. The CPI is based on out-of-pocket consumer spending; for the medical care market basket, this spending includes direct payments made by patients for goods and services, as well as health insurance premiums, including Part B premiums and paycheck deductions.[3] According to BLS's latest monthly report, CPI increases for the 12-month period ending April 2022 (inclusive) were 3.5% for medical care services and 2.1% for medical commodities, compared to 8.3% overall inflation.[4]

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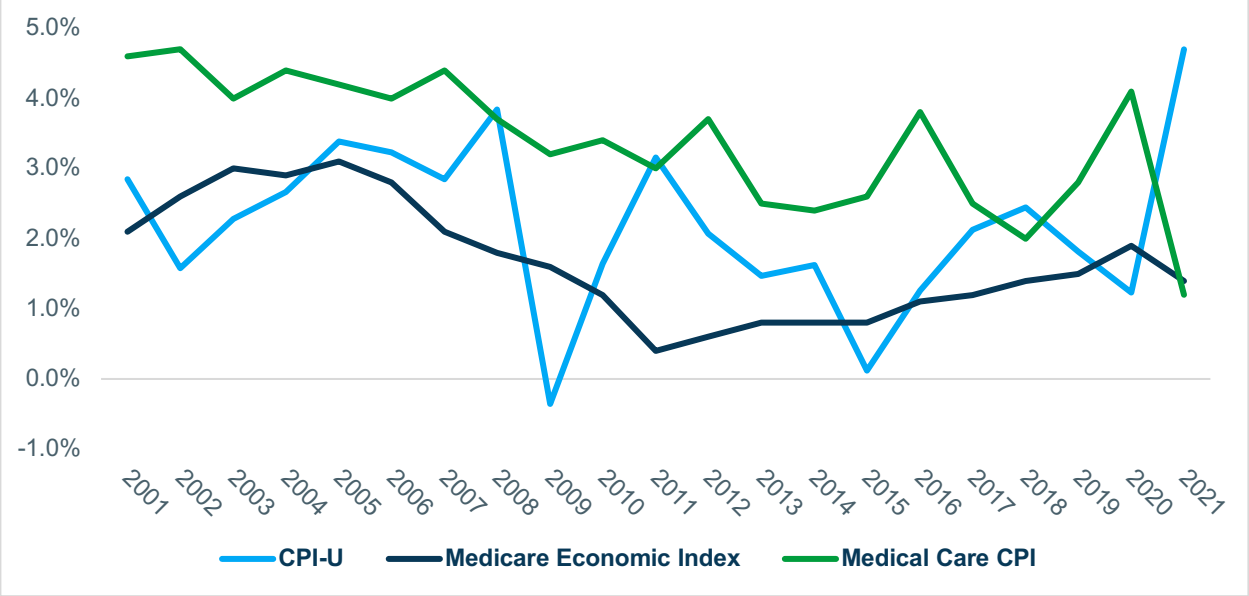
[1] Bureau of Labor Statistics. "Consumer Price Indexes Overview." January 10, 2020.
[2] Bureau of Labor Statistics. "Consumer Price Index Frequently Asked Questions." March 23, 2022.
[3] Bureau of Labor Statistics. "Measuring Price Change in the CPI: Medical care." March 16, 2022.
[4] Bureau of Labor Statistics. "Consumer Price Index Summary." May 11, 2022.

Medicare Economic Index

The Medicare Economic Index (MEI) is a measure of physician practice-related inflation that tracks year-over-year changes to costs and earnings. The MEI is based on inputs such as salary and the price of supplies and equipment, but it is also adjusted for multifactor productivity, a measure of general (not healthcare-specific) economic productivity that assumes increased physician productivity. This adjustment partially "nets out" price and wage increases.[5] The MEI historically informed the Sustainable Growth Rate (SGR)—a rate the Centers for Medicare & Medicaid Services (CMS) used to calibrate physician payment with Medicare spending targets—until 2015, when the Medicare Access and CHIP Reauthorization Act (MACRA) phased out the SGR and introduced the Merit Based Incentive Payment System.[6] Although the MEI no longer informs payment rates, it remains a useful point of comparison for physician compensation: the magnitude of the difference between inflation and the MEI can broadly indicate the degree to which physician labor and practice costs are undercompensated (Figure 1).[7]

Figure 1. Historic Inflation Rate by Metric, 2001–2021



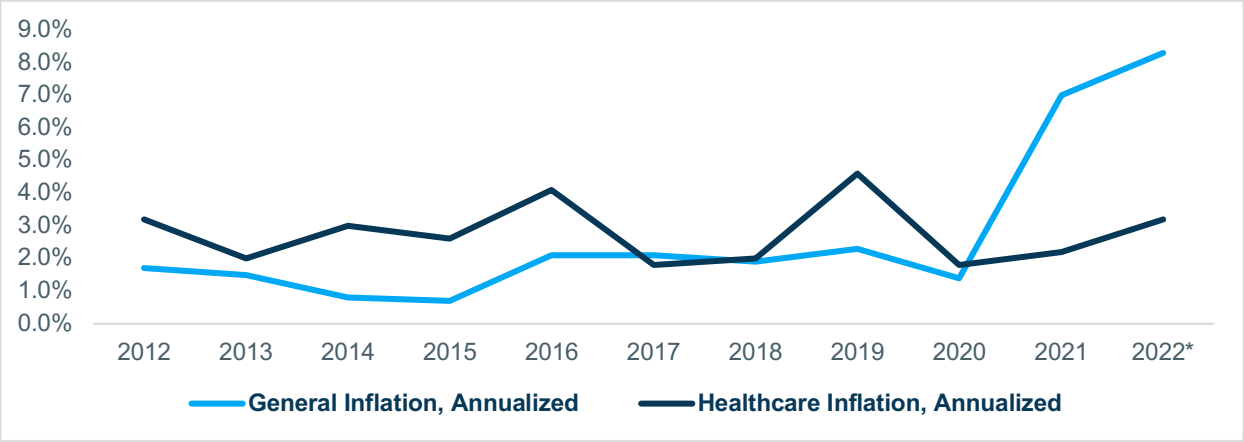
Source: BLS; the CMS

Healthcare versus General Inflation

The value of the CPI for medical care services first exceeded that of the CPI for medical care commodities in the early 1990s. Over the past 3 decades, the services component of the CPI has increased by roughly 255%, while the commodities component has increased by roughly 132%.[8] Both of these figures exceed the general inflation of roughly 120% that occurred over the same period.[9] Analysis of year-over-year inflation during the last decade does not reveal a clear or consistent relationship between general inflation and inflation in healthcare (Figure 2).

[5] Healthcare Economist. "History of the Medicare Economic Index (MEI)." January 27, 2011.
[6] CMS. "MACRA." April 1, 2022.
[7] American Enterprise Institute. "Medicare and Inflation." April 18, 2022.
[8] Statista. "Consumer price index for medical care services and commodities in the U.S. from 1960 to 2021." January 14, 2022.
[9] Bureau of Labor Statistics. "CPI Inflation Calculator."

Figure 2. Inflation Trends, 2012–2022



Source: US Inflation Calculator. "Current US Inflation Rates: 2000-2022" and "Health Care Inflation in the United States (1948-2022)." May 2022. The data points for 2022 represent the 12-month period ending in April 2022 (inclusive) rather than an annualized rate.

Healthcare Inflation and Physician Payment Rates

Conversion Factor and Relative Value Units

Measures of inflation have an indirect impact on physician payment rates. Reimbursement for a given Current Procedural Terminology code is determined by multiplying the Medicare Physician Fee Schedule (MPFS) conversion factor by the number of relative value units (RVUs) assigned to that service. There are 3 types of RVUs: (1) work RVUs, which account for the time and intensity of physician labor and just over 50% of the total RVUs; (2) practice expense (PE) RVUs, which account for nonclinical labor and office-related expenses and roughly 45% of the total RVUs; and (3) malpractice (MP) RVUs, which account for malpractice insurance expenses and roughly 4% of total RVUs. Each RVU component is weighted by a geographic practice cost index (GPCI).

Medicare Payment Rate Calculation

$$\text{Payment} = \text{Conversion Factor} * ((RVU_{work} * GPCI_{work}) + (RVU_{PE} * GPCI_{PE}) + (RVU_{MP} * GPCI_{MP}))$$[10]

Since MACRA was passed in 2015, annual changes to the conversion factor have been set in statute. For 2016 through 2019, the change was set at +0.5%; for 2020 through 2025, the change was set at 0.0%; and starting in 2026, there will be one conversion factor for qualifying alternative payment model participants and another conversion factor nonqualifying providers, which will be subject to annual increases of 0.75% and 0.25%, respectively.[11] However, the conversion factor is still subject to adjustments that account for budget neutrality and other factors, meaning that the real increase is often less than that prescribed by the statute. For example, the value of the conversion factor decreased from 2015 to 2016 and increased by less than the intended 0.5% for each of the following 3 years.[12]

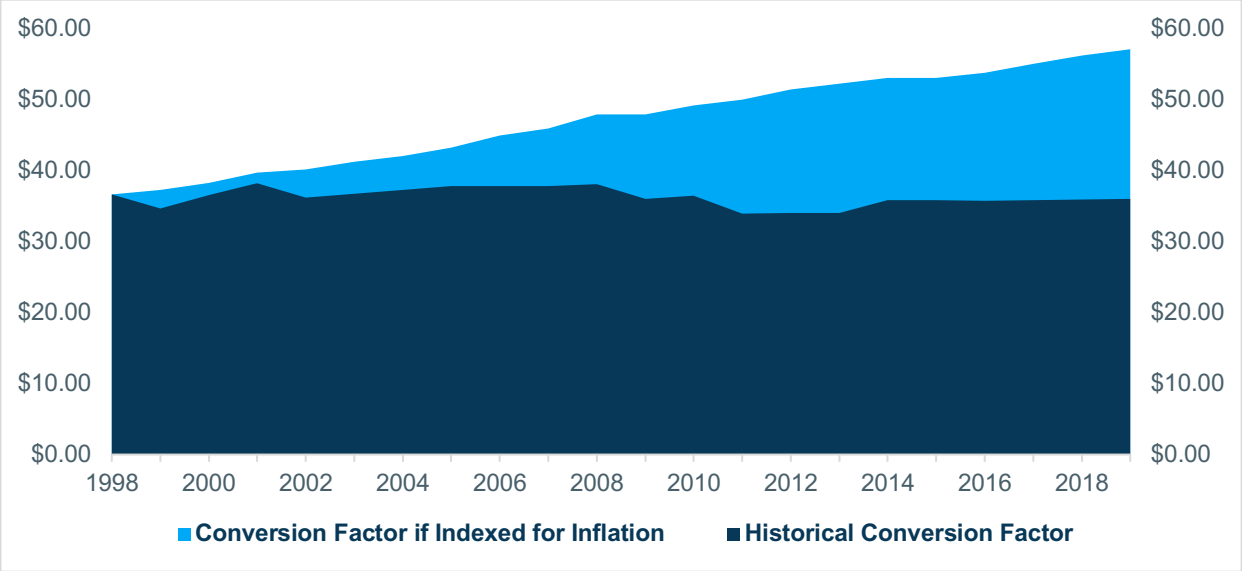
[10] Anesthesia has its own conversion factor and relative value units.
[11] Congress. "Medicare Access and CHIP Reauthorization Act of 2015." April 16, 2015.
[12] American College of Surgeons. "Medicare physician payment on the decline: It's not your imagination." September 1, 2019.

The COVID-19 pandemic coincided with the beginning of the 6-year period during which no increase to the conversion factor was set.[13] Had conversion factor increases occurred as described by MACRA, the current value of the conversion factor would be $36.6577, which it would have attained in 2019. However, because of other adjustments, the conversion factor was only $36.0391 in 2019—1.7% lower than projected. That rate would have remained unchanged until 2025, but further adjustments during the pandemic have reduced the conversion factor to $34.6062 in 2022, a 4.0% decrease from 2019 and 5.6% lower than projected by MACRA. The way that the CMS calculates and adjusts the conversion factor and RVUs thus corrects for inflation rather than reflecting it.[14]

Although medical inflation has outpaced overall inflation over the past 30 years, the conversion factor has remained virtually unchanged since its introduction in 1992 when its value was $31.0010. In 2021, the conversion factor was $34.8931, representing a net increase of just 12.5% compared to 176.4% medical inflation and 101.9% general inflation[15] during the same period. In fact, the value of the conversion factor *decreased* by 4.9% between 1998[16] and 2021, while medical and general inflation were 116.9% and 72.5%, respectively. If the conversion factor had tracked general inflation since 1998, its current value would be over $57 (Figure 3).

In summary, although the cost growth of medical goods and services has consistently outpaced general inflation over the past several decades, the conversion factor underrepresents that inflation by such a margin that current rates represent a real decrease in consumer buying power and provider compensation over time.

Figure 3. Medicare Physician Fee Schedule Conversion Factor Benchmarked Against Inflation, 1998–2019



Source: American College of Surgeons. "Medicare physician payment on the decline: It's not your imagination." September 1, 2019.

[13] The Consolidated Appropriations Act, 2021 approved a temporary increase of 3.75% to fee schedule payments for CY 2021 that expired January 1, 2022.
[14] Employ America. "Offsetting Persistent Inflationary Pressures with Disinflationary Healthcare Policy." October 27, 2021.
[15] Official Data. "Medical Care Inflation Calculator." Bureau of Labor Statistics. "CPI Inflation Calculator."
[16] From 1993 to 1997, different conversion factors were used for primary care, surgical care, and other nonsurgical care. When a common conversion factor was reestablished in 1998, its value was $36.6873.

Historical Trends and Near-Term Projections

Healthcare inflation tends to persist even amid drastic changes in the broader market. For example, the only year since 1990 during which deflation occurred (as measured by a negative CPI for the entire year) was 2009, when the annualized CPI was -0.4%. That year, the annualized medical care CPI was 3.2%. This value represented a deceleration of growth from the previous year, albeit a modest one (the annualized CPI for 2008 was 3.7%). Healthcare deflation has not occurred during any month from 1990 to the present.

The modest but consistent rate of healthcare inflation over the past several decades may not be reflected in the conversion factor, but that does not mean that reimbursement rates have stagnated. Without meaningful adjustment of the conversion factor, increased RVU values can drive up reimbursement. However, absent code-specific advocacy, the Relative Value Scale Update Committee might only review RVUs every 5 years, potentially creating a significant lag between increased costs and any reflection of those costs in the work, practice expense, and malpractice RVUs. GPCIs are reviewed at least every 3 years, and both RVUs and GPCIs were last evaluated in 2020. Accordingly, 2023 through 2025 should occasion piecemeal updates to various payment rate inputs that theoretically reflect inflation.

Cost increases are now occurring that may result in the delayed appearance of inflation. Labor shortages, demand for increased wages, and supply chain issues are all driving up prices. Because current reimbursement rates are informed in part by pre-pandemic data, providers are being paid less on average than the current real cost of goods and services. In response to public comment, the CMS implemented in 2022 a 4-year transition process to phase in updated clinical labor pricing over time, aiming to stabilize payments and maintain beneficiaries' access to care.[17] This incremental strategy may also help protect specialties with especially high or low clinical labor costs from being disproportionately affected by payment model changes.[18]

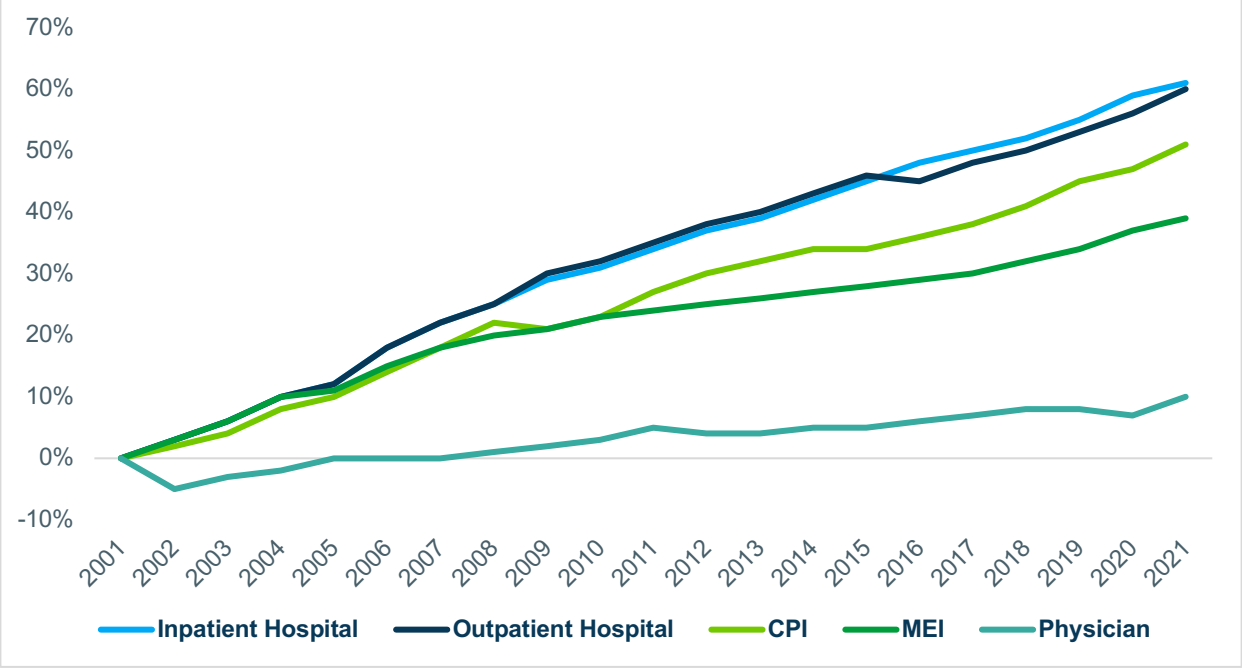
As RVUs and other inputs to payment rates are reevaluated, provider demand for higher payment and the continued rise in practice expenses will create pressure to establish values that account for the acute rise in costs. As providers negotiate higher rates from insurers, some of those costs may be passed through to consumers in the form of rising insurance premiums.[19] Some commercial contracts are benchmarked to the MPFS, so if Medicare reimbursement rises, those contracts' payment rates will rise accordingly. Even when rates are not directly locked to the fee schedule, many multi-year commercial contracts are linked to proprietary fee schedules based on the MPFS; most include a modest annual rate increase for the duration of the contract, which insurers design in part to account for inflation. Physicians are expected to advocate for higher initial rates as new contracts or renewals are negotiated, whether or not rate increases have been reflected in the MPFS.

[17] CMS. "Calendar Year (CY) 2022 Medicare Physician Fee Schedule Final Rule." November 2, 2021.
[18] Physician's Weekly. "AMA Calls on Congress to Halt Medicare Pay Cuts in 2022 PFS Final Rule." November 8, 2021.
[19] Axios. "Why inflation hasn't hit health care the same way." February 6, 2022.

Other Payment Systems

Other payment systems incorporate inflation in different ways. For example, the CMS annually updates the Inpatient Prospective Payment System (IPPS), which sets payment rates for diagnosis-related groups under Part A. The 2023 IPPS proposed rule includes updates to fee-for-service payment rates for inpatient and long-term care hospitals. The CMS proposes to resume its normal practice of using the most recent available data[20]—which currently consist of 2021 Medicare Provider Analysis and Review claims and 2020 cost reports—to inform its 2023 rates. To account for any discrepant COVID-19-related data, the rule proposes to use charge inflation factors and cost-to-charge adjustment factors to better estimate the increase in costs between 2021 and 2023. This revised methodology assumes that pandemic-era inflation will not continue as the number of COVID-19 cases and hospitalizations continues to decline. The proposed rule also suggests the continuation of 2020 policies that address the impact of wage index fluctuation on hospitals, limiting the year-over-year wage index decrease to 5%. The IPPS proposed rule thus contains measures aimed at addressing inflation, but the rule's provisions may change after the comment period. Overall, payments to facilities have tended to correspond more meaningfully to inflation than have payments to physicians (Figure 4), a discrepancy that both reflects the trend of provider consolidation and suggests its continuation.

Figure 4. Medicare Updates Compared to Inflation, 2001–2021



Source: American Medical Association. "Medicare Updates Compared to Inflation (2001-2021)." October 2021.

[20] Due to decreased utilization, slightly different data had been used during the pandemic.

Conclusion

The CMS expects national health expenditures to grow by 5.4% annually, on average, from 2019 to 2028. By 2028, it expects healthcare to account for 19.7% of GDP, an increase of 2% over the preceding decade. These pressures will be especially relevant to facility-based providers, who—in addition to rising wages—will need to finance increasingly expensive overhead, capital, and maintenance costs to remain in practice. Providers' ability to respond to rising costs is limited because of both insurance contracts and statutory control over payment rates. Consequently, they cannot pass costs through to the government agencies and commercial plans that pay them, leading to chronic underpayment relative to inflation. Pressure currently felt by providers will not be reflected in rates and reimbursements until 2-3 years from now, when the fee schedule includes data from this period of inflation and as providers renegotiate contracts to better align payment rates with costs. As general inflation eventually moderates, the new baseline established by renegotiated rates will help close the gap between costs and reimbursement, but stakeholders should expect steady healthcare inflation to persist.

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Legislation, regulation, and ever-changing market trends have both acute and longitudinal impact on businesses across the healthcare sector. If your organization wants to better understand how inflation factors into prudent go-forward strategy, connect with us.