

Taking Account...

Price indexes for Medicare Advantage enrollees

The measurement of inflation and output in the economically critical health care sector is of vital concern to policymakers and the public. To encourage enhanced measures, the Committee on National Statistics of the National Research Council recommended in 2010 that government agencies explore methods for new disease-based measures, not service price-based measures.

The advantage is that such an approach captures shifts in treatments across industries within health care due to technological improvements. For example, numerous surgeries have shifted from being performed in hospitals to being performed in outpatient clinics. Treatments for various other medical conditions have also shifted from treatment by procedures to treatment by drugs.

In recent years, researchers at the Bureau of Economic Analysis (BEA) have constructed disease-based price measures. They typically used encounter-based methods for creating indexes in which spending is assigned to a condition by the diagnosis attached to a particular claim.

This approach worked well for creating output and price indexes for Medicare beneficiaries, for which the necessary source data exist. However, for Medicare private plan (Medicare Advantage) enrollees, the necessary data are lacking. Through

the Medicare Advantage program, private insurance plans contract with Medicare to provide health insurance to Medicare beneficiaries. This program accounts for a growing share of all Medicare enrollees.

To create price measures for patients in this program, Anne E. Hall, an economist at BEA, computed regression-based indexes from diagnosis and spending data in the Medicare Current Beneficiary Survey (MCBS).

The MCBS is conducted by the Center for Medicare and Medicaid Services on a representative sample of Medicare beneficiaries. The MCBS collects all of its respondents' medical spending and, in addition, conducts an annual in-person survey that includes questions about what diagnoses they have received over the past year.

The number of Medicare Advantage enrollees in the MCBS is considerably larger than the number in other surveys. For example, the Medical Expenditure Panel Survey (MEPS) only contains a few hundred Medicare Advantage enrollees per year.

A regression-based medical expenditure index models annual spending as a function of each beneficiary's diagnoses that year, uses the coefficients on the diagnoses to divide each beneficiary's spending among their conditions, and from those, creates average per case expenditures that are inputs to a medical expenditure index. As such, it can be created with data that do

not attach a diagnosis separately to each claim or event but instead only requires diagnosis and spending data at an annual level, which the MCBS provides.

Hall based her indexes for Medicare Advantage enrollees on a generalized linear model of health care spending. The indexes found that inflation from 2001–2003 to 2007–2009 increased at 5.7 percent rate annually. By comparison, medical inflation in the Medicare fee-for-service (FFS) population was 4.5 percent annually.

Hall concludes that the difference is partly due to differential reporting of drug and nondrug spending in the MCBS for fee-for-service beneficiaries. Once this is corrected for, inflation among FFS beneficiaries is 5 percent. The remaining difference results from drug spending that increased more rapidly among Medicare Advantage enrollees.

Prescription drug coverage during this period expanded with the introduction of Medicare Part D. Medicare Advantage enrollees had a higher utilization response to that expansion. Although the vast majority of Medicare Advantage enrollees had prescription drug coverage before the advent of Part D, the pattern of their drug spending and previous research both suggest that their coverage was not very generous and that Part D would have represented a considerable coverage increase for them.