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EDITORIAL

Putting Medicare Spending for COVID-19 Into Perspective

A new study from researchers at the Centers for Disease Control and Prevention (1) used Medicare claims data to examine the characteristics and medical spending of older adults who were diagnosed with COVID-19 from April through December 2020. The study sheds light on the effect of COVID-19 on medical care for some of the most vulnerable people in our society and helps to put the financial burden of the pandemic into perspective. It also lays important groundwork for future research on the cost-effectiveness of vaccines and other treatments for COVID-19.

The researchers' analysis indicated, perhaps surprisingly, that COVID-19 did not have a major financial impact on Medicare in 2020. They found that the average cost of treatment was considerable among those who were hospitalized, but the costs for milder cases—which represented the majority—were relatively small. In total, the study estimated that traditional Medicare spending for COVID-19–related hospital and outpatient care was $6.3 billion, or $5334 per person presenting for treatment of COVID-19. The estimate does not include spending for patients in Medicare Advantage plans because Medicare Advantage claims data are not available.

An important limitation of the study is that it did not include Medicare spending for posthospitalization rehabilitative care received at a skilled-nursing facility or at home. These expenses could significantly add to the total Medicare spending for people with COVID-19. Yet, even if rehabilitation spending caused reported per capita Medicare expenditures to double (not unreasonable by our own rough estimates), COVID-19 would have accounted for about 3% of spending for traditional Medicare in 2020. In addition, the per capita Medicare expenditures for COVID-19 would be lower than for other conditions that are common among older adults, such as heart disease, diabetes, cancer, asthma, and chronic obstructive pulmonary disease (Blumenthal D, Jacobson GA. Calculations based on traditional Medicare claims data for 2020.). Medicare spending for these other conditions also may have been lower than usual in 2020 because of postponed or forgone care during the pandemic, implying that the true difference in spending between people with COVID-19 and those with other conditions may be even larger.

An added benefit of the study is that it confirms patterns observed in epidemiologic data. It adds to the substantial evidence that people of color accounted for a disproportionate share of hospitalizations and deaths during the pandemic. Claims data also provide insights into the severity and treatment of conditions in a way that raw counts of hospitalizations and deaths cannot. For example, the study found that Black, Hispanic, and Asian/Pacific Islander older adults were more likely to receive ventilator support during hospitalization than non-Hispanic White patients.

Despite their important contribution, claims data cannot substitute for well-functioning public health reporting as a tool for tracking and combating a pandemic. They tend to lag real-world events by at least 3 months—far too long for effective public responses to an ongoing public health emergency. Moreover, people who were infected but asymptomatic or did not seek medical care for COVID-19 would not be captured in claims data. Thus, calls for upgrading and modernizing our public health information systems remain relevant as Congress considers next steps in preparing the country for new health threats (2).

Though limited as a means of tracking unfolding emergencies, claims data and their analysis do serve one very important function that epidemiologic data do not: They can provide useful estimates of the financial benefits of preventing an illness and the corresponding costs of treating it. This information allows calculations of the comparative costs and benefits of different approaches to preventing and treating COVID-19 and how these investments compare in value with investments in preventing and treating other illnesses. Such evidence can be extremely helpful as private and public decision makers decide where to direct spending to get the greatest health benefit per dollar invested.

The current study may be reassuring on the financial effects of COVID-19 for the Medicare program, but that is cold comfort given the huge human costs of the pandemic, which caused about 300 000 deaths and incalculable suffering for adults older than 65 years and their loved ones in the United States in 2020. The pain and suffering caused by COVID-19 continue to this day—though, thankfully, at lower rates because of the extraordinary effectiveness of available vaccines.

Overall, Tsai and colleagues' study is a useful addition to what is likely to be a growing literature on the effects of COVID-19 not only on the nation's health but also on its economy, social and governing structures, and enduring racial inequities. It is essential that we learn all of the many lessons that COVID-19 and our response to it have to offer. Pandemics can change the history of nations, and we are just beginning to understand how COVID-19 may be changing ours.

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