



Advising the Congress on Medicare issues

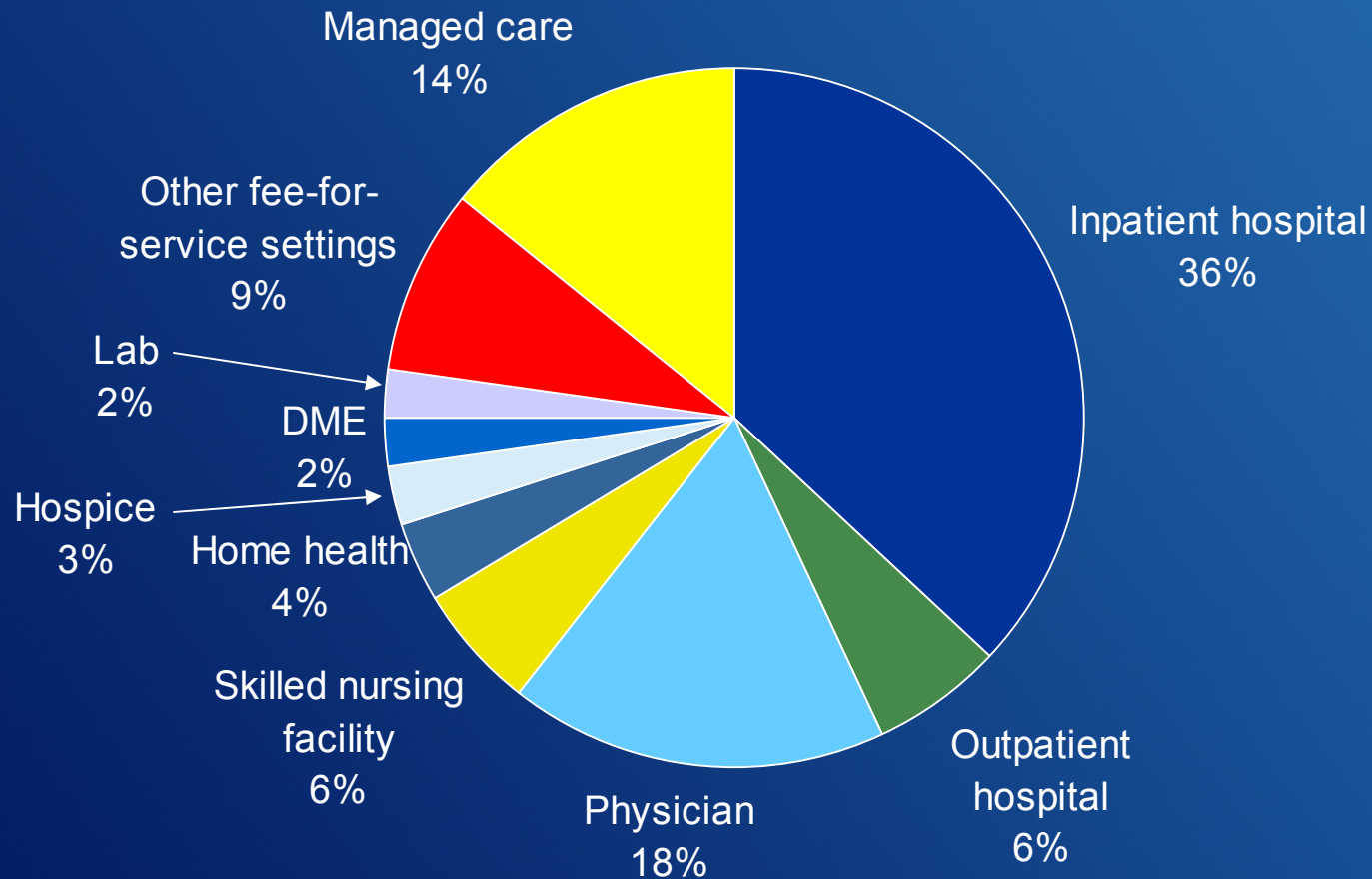
The future of Medicare fee-for-service

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Medicare's balancing act

- Be fiscally responsible
- Ensure beneficiary access to quality care

Total benefit spending for CY2005=\$330.3 billion



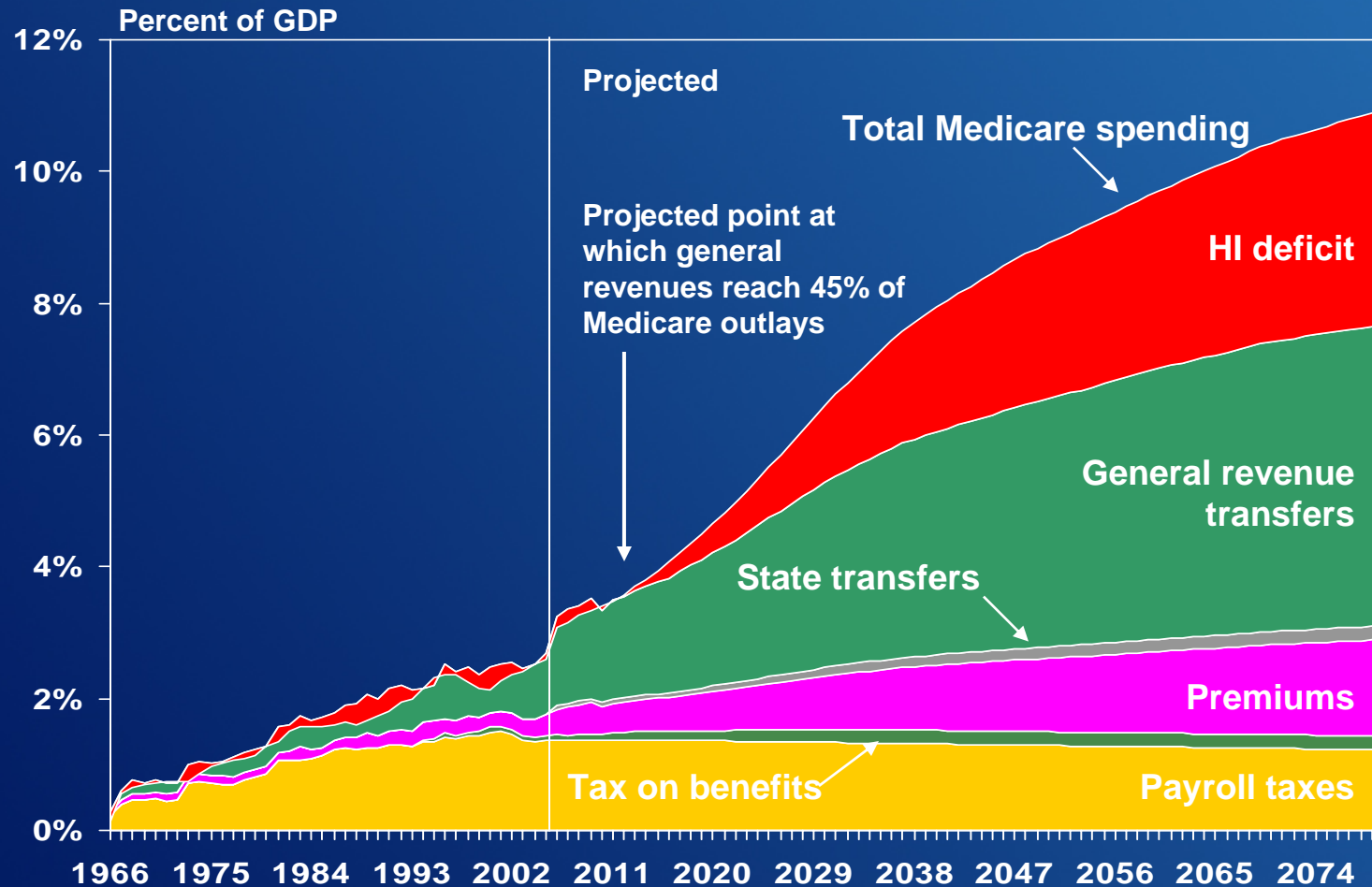
Medicare spending in selected settings

Type	Number of providers	2005 Medicare program spending
Hospital inpatient	PPS: 3,500 CAH: 1,280	\$121 billion
Hospital outpatient	PPS: 4,000	\$20 billion
Physicians/LLP*	620,000	\$57 billion
Home health	8,100	\$13 billion
SNF	15,600	\$18 billion

Medicare Trustees' findings for 2006

- In absence of steps to slow spending:
 - HI trust fund will be exhausted in 2018, will require major new sources of financing
 - SMI will require increasing shares of resources
 - More rapid growth in beneficiary premiums and cost sharing than incomes
- 45% trigger will likely lead to discussion about Medicare financing by spring 2008

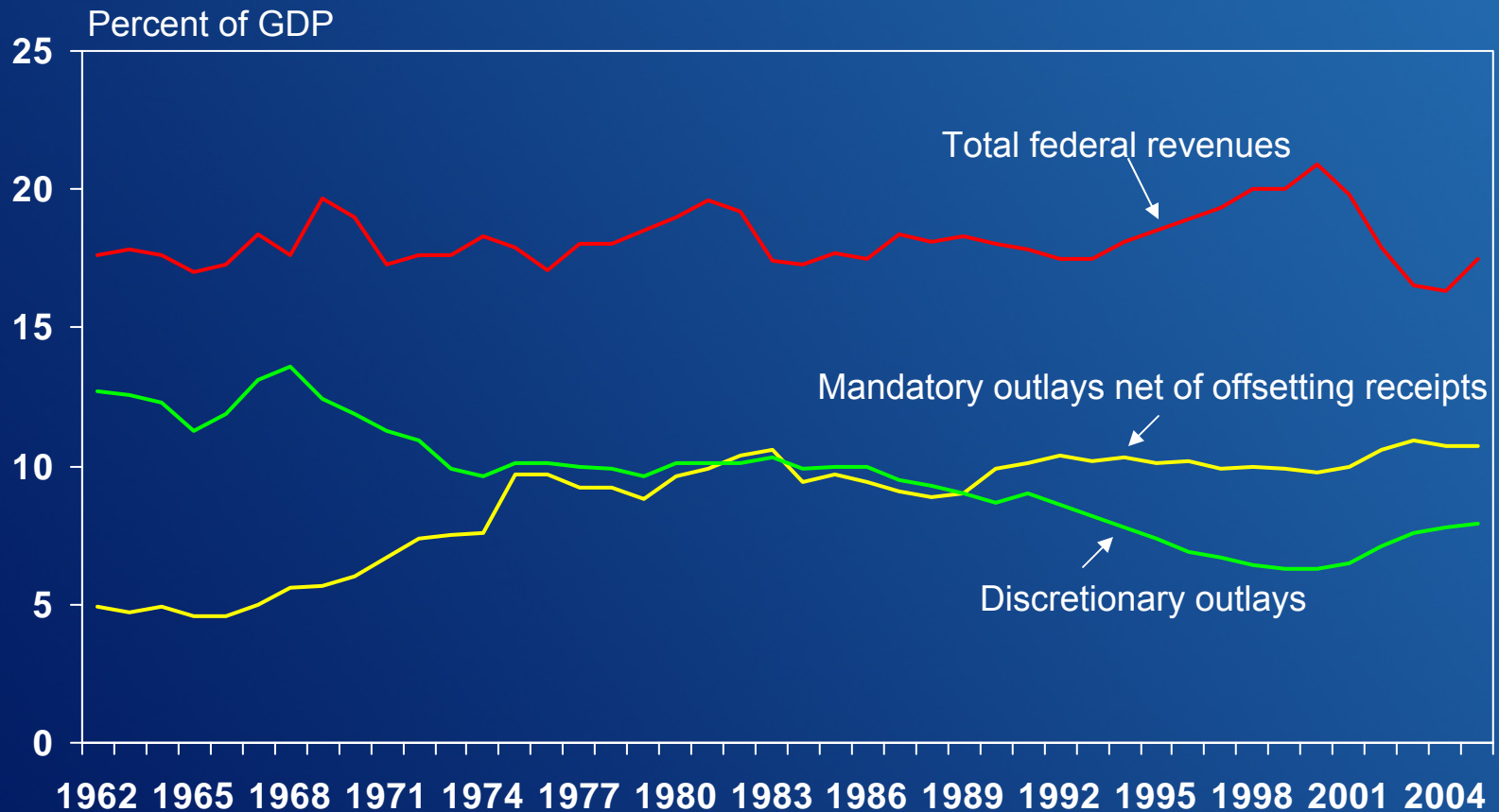
Medicare faces serious challenges with long-term financing



Financial effect on beneficiaries

- Combination of SMI premiums plus cost sharing has grown faster than average Social Security benefit
- Trustees project trend will continue, even though Part D lowers out-of-pocket spending on prescription drugs for many enrollees

Federal revenues have averaged 18 percent of GDP



Source: Congressional Budget Office.

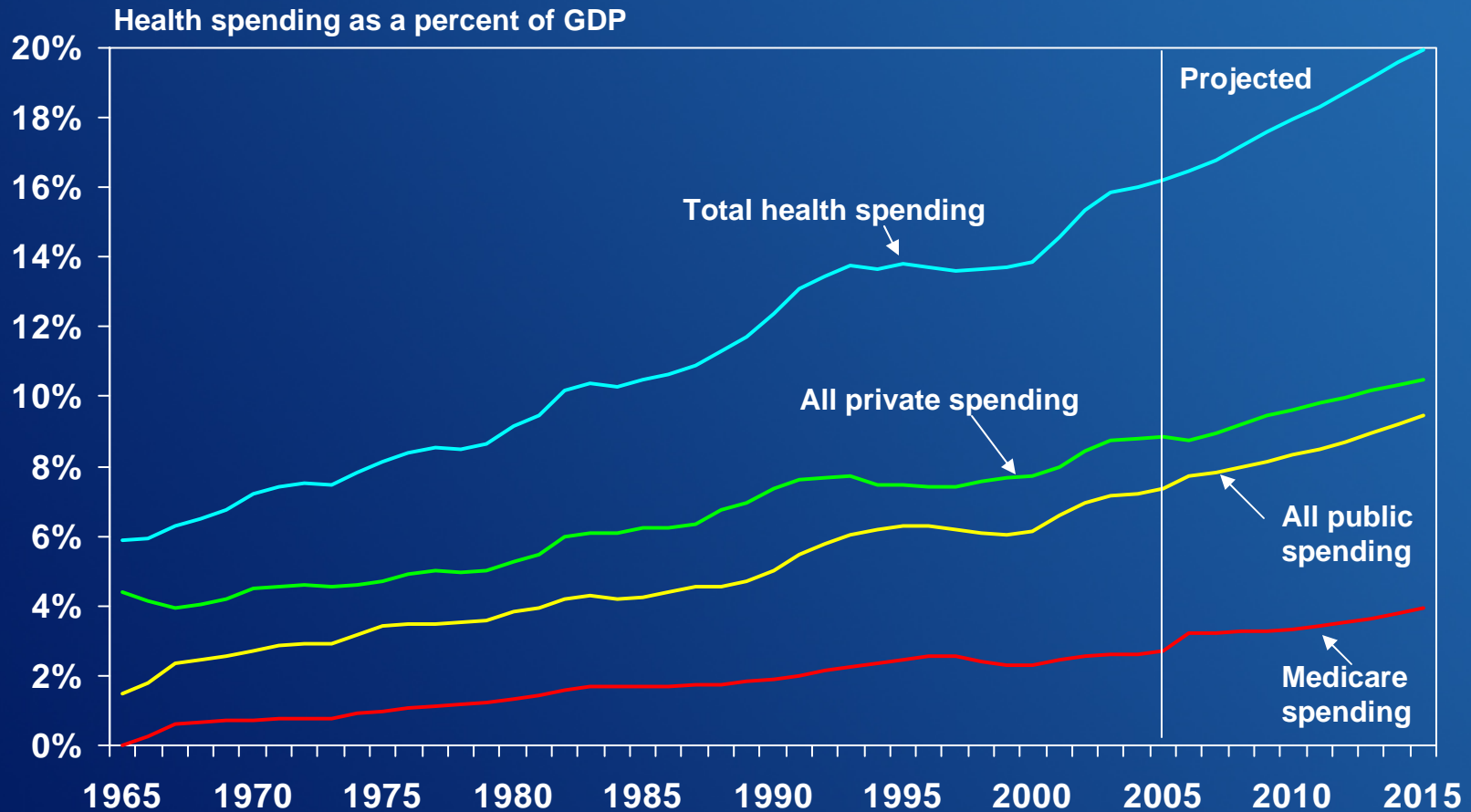
“Medicare funding warning”

- Percent of funding from general revenue is increasing
- 2006 and 2007 Trustees Reports will both hit 45% threshold

Variation in healthcare

- Fisher and colleagues (2003) found significant regional variation in the amount & type of services beneficiaries receive
- Higher spending regions have:
 - More supply-sensitive care: more hospital stays, visits, specialist use, tests
 - Areas with higher volume and more specialists do not have better access, quality, or patient satisfaction, and may be worse

Health care spending has grown more rapidly than GDP, with public financing making up nearly half of all funding



Note: GDP (gross domestic product). Total health spending is the sum of all private and public spending. Medicare spending is one component of all public spending.

Source: CMS, Office of the Actuary, National Health Expenditure Accounts, 2006.

Factors related to U.S. health spending

- Income effect – richer societies spend a larger proportion of income on health
- Fragmentation of care, but concentration of provider market power
- Technological improvements
- Lack of free market or other cost-containment mechanisms

Drivers of growth in health spending

- Among all payers:
 - Rate of technology adoption and diffusion
 - Base of evidence for assessing relative value of new drugs, devices, procedures often lacking
 - Use of insurance
 - Poor incentives within payment systems
 - Nation's lifestyle and underlying health status
- Additional factors specific to Medicare:
 - Retirement of baby boomers
 - New prescription drug benefit

Broad options for sustainability

- Raise revenues
- Increase eligibility age
- Increase beneficiary responsibilities
- Means testing
- Redefine benefits and coverage policy
- Control volume
- Slow provider payment rate growth

Mid-range changes in Medicare fee-for-service

- Pricing reforms
- Changes in incentives
- Improvements in accountability

Pricing

- Making Medicare payments more precise:
 - Inpatient hospital DRG reform
 - Physician payment reform
 - Part B drug payment reforms
 - Competitive bidding

Changes in incentives

- Bundling services
- Care coordination across settings
 - Episodes/capitation
 - Chronic condition management
- Gainsharing

Improvements in accountability

- Pay for performance — quality
- Measuring resource use
- Provider certification: imaging
- Comparative and cost effectiveness
- Program integrity