

Section 14

CATEGORY I PANEL DISCUSSION TEMPLATE #8

The Future of Healthcare Financing

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Key Trends in Medicare Payment Policies

Understanding Medicare's long-term challenges is critical for executives.

The White House, in its fiscal year (FY) 2007 federal budget plan, calls for Congress to enact legislation to reduce net spending for Medicare and Medicaid. These reductions are expected to be \$2.5 billion for Medicare and \$1.3 billion for Medicaid in FY 2007 and nearly \$39 billion and \$12.3 billion respectively over the five-year period FY 2007 through FY 2011. The president's budget is built on increased national security spending and domestic programs cuts designed to reign in the budget deficit and pay for making tax cuts permanent.

It appears unlikely that the proposed healthcare cuts in the administration's FY 2007 budget plan will be enacted, at least as presented in the president's budget plan, for a number of reasons. First, Congress recently passed the Deficit Reduction Act of 2005 by a narrow margin, which cut about \$11.1 billion from Medicare and Medicaid over the next five years. Most observers feel that the drawn-out struggle to pass this legislation (by two votes in the House of Representatives and one vote in the Senate) is a clear signal that lawmakers will not support an additional round of cuts so soon. Second, legislators are focusing their energies on the upcoming "off-year" November elections. The majority of voters in these elections tend to be

older—the same demographics most likely to be affected by Medicare cuts.

Such proposed cuts to Medicare and Medicaid, however, still loom large over a program that is at risk of being tapped in the future. A key component of the deficit reduction theme is the mentality that Medicare's growth must be trimmed. It is important for healthcare executives to understand pressures that will influence, if not drive, future Medicare payment policies because, regardless of which party is in power, these pressures will force Congress and the administration to continually look for ways to control Medicare spending. Most of these efforts will likely target provider payments.

The Medicare Payment Advisory Commission (MedPAC) said in its March 1, 2006, Report to Congress, "[t]he Medicare program faces powerful upward pressures on health spending that policymakers will find difficult to staunch." MedPAC notes that the interaction between the broad use of new medical technologies and health insurance coverage, which keeps patients from incurring the full cost of healthcare services, is the primary reason that healthcare spending has risen much more rapidly than growth in national income for many decades.

All indications are that such trends will continue well into the future. MedPAC went on to note that the continuation of these patterns, combined with the retirement of the baby boomers and the new Medicare drug benefit, will require that Medicare assume an unprecedented share of federal spending. In the 2005 Medicare Trustees Report, using intermediate assumptions, the trustees projected that by 2036 federal program spending for Medicare will grow to nearly 8 percent of gross domestic product (GDP) and reach nearly 14 percent by 2078—spending currently makes up less than 3 percent of GDP. These estimates are based on the fairly optimistic assumption that healthcare spending per person will grow only one percentage point faster than the per capita GDP growth.

Given this projection, policy-makers need to take steps to slow growth in Medicare spending to permit more gradual changes. Four basic strategies are available: constraining payments to healthcare providers, limiting benefits, increasing the program's financing and encouraging greater efficiency from healthcare providers. Obviously providers would push back strongly on further payment cuts. Meanwhile beneficiaries would exert equal if not more effective pressure against benefit reduction, and policy-makers would want to avoid increasing taxes. Thus, the strategy to encourage greater provider efficiency is the most preferred for a number of reasons. One is that it would enable Medicare to do more with its resources. From the providers' perspective, such a strategy could provide market opportunities, whereas use of the strategy to constrain providers' payments would offer little, if any, opportunities.

Medicare's long-term financing problems will become more prominent to policy-makers over the next few years because of a warning system established in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). With the warning system, if two consecutive annual reports by the Medicare trustees project that general revenue will fund 45 percent or more of Medicare outlays in any given year over a seven-year window, then the president must propose and Congress must consider legislation to bring such spending below this threshold. Given current trends, projections could reach 45 percent within the seven-year window in the trustees' 2006 and 2007 annual reports. The

MMA, however, did not include a default action if Congress failed to act.

The president's FY 2007 budget would correct this apparent oversight. It would establish an automatic annual 0.4 percent payment reduction that would take effect in absence of other congressional action. While the warning is tied to general revenue spending, the budget's provision does not appear to limit its automatic reduction proposal to Medicare Part B spending. As a consequence, this proposal would have the effect of permanently lowering the Medicare baseline, meaning a full market basket update would be considered new spending.

Further, the rapid growth in Medicare spending also will get the attention of beneficiaries and taxpayers because both groups finance the program. Although premiums paid by Medicare beneficiaries are projected to make up a steady 12 percent to 13 percent of total program revenue, the dollar amount of those premiums will require growing shares of beneficiaries' income. Between 2003 and 2006, beneficiaries have faced an average annual increase in the Part B premium of nearly 15 percent compared to only a 3 percent annual growth rate for Social Security benefits over the same period.

Policy-makers view of encouraging providers to improve their efficiency as extremely important to address Medicare's long-term problems; such an approach would lessen the need to limit benefits or raise taxes. About 84 percent of Medicare beneficiaries are enrolled in traditional Medicare, accounting for the bulk of spending. For this reason, analysts point out

that fee for service Medicare needs to become more of a strategic purchaser than a payer of claims.

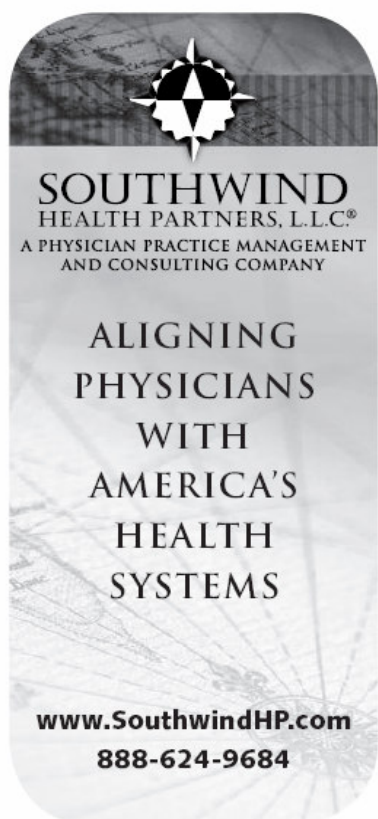
Given this direction and based on current criticism of the existing fee for service payment system, healthcare executives can expect such initiatives as refining the prospective payment systems to provide differential payments for the relative quality of care, providing financial incentives for care coordination, recalibrating the patient classification systems using much more current data and rewarding providers for offering only value-producing services.

Other initiatives will include integrating pay-for-performance on a broad scale and adopting incentives to use information technology and systems engineering methods to increase efficiency while improving the safety and quality of healthcare providers' services. Executives can also expect a wider use of competitive bidding approaches, for Medicare's new drug benefit. Initial returns look promising, but whether competitive bidding will bring long-term results remains unknown.

These are among the myriad issues healthcare executives need to consider. They should assess the implications for their organization and determine how to prepare for such payment policy changes. ▲

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