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Medicare Part D Spending Projections Down Again, Part A and Part B Increases Highlight Need for Further Reforms

Summary

Medicare Part D expenditures are now projected to be \$34 billion lower over 5 years (2006-2010) than in the President's Budget, and \$110 billion lower than in the Mid-Session Review one year ago. The average Part D premium is almost 40 percent lower than had been projected a year ago as a result of strong competition, and 90 percent of Medicare beneficiaries are receiving prescription drug coverage.

Medicare Part A and Part B expenditures are higher, primarily because of continuing rapid growth in the use of Medicare services. Part A projected expenditures over 5 years (2006-2010) are \$17 billion higher and Part B projected expenditures over 5 years are \$30 billion higher than in the President's Budget. Rapid growth in physician-related services and hospital outpatient services are the main factors responsible for a projected increase in the Medicare Part B premium of 11 percent for next year.

The continued rising costs in Medicare Part A and Part B highlight the need for reform of the original Medicare program to pay more accurately and especially to pay more for better care, not simply more services. The President's Budget proposed building on MedPAC's recommendations for more accurate payments to health care providers, and the adoption of performance-based payment systems.

Part D

The costs of Medicare Part D continue to turn out to be much lower than had been expected. Since the President's Budget in February, projected Federal costs for the Part D program have declined again, by roughly \$34 billion for 2006-11 and \$76 billion for fiscal years 2006-2016. The reductions since last year's Mid-Session review are much larger, \$110 and \$302 billion, in part reflecting lower costs per beneficiary enrolled in the program than had been expected. The drug plans competing for Medicare beneficiaries have been able to establish greater than expected savings from aggressive price negotiation, very low-cost coverage for generic drugs and less costly brand-name drugs, and other steps to keep drug costs down.

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In addition, beneficiaries have overwhelmingly selected less costly drug plans. While the average premium expected a year ago was \$37, enrollees are actually paying premiums that average less than \$24. Some of the estimated cost reductions result from more refined enrollment assumptions, which take into account actual Part D participation rates for 2006. As of June 11, 2006, more than 38.2 million people with Medicare were receiving coverage for prescription drugs through Part D or other plans that provide coverage as good as or better than Part D. Thus, 90 percent of all Medicare beneficiaries have good drug coverage, including 3.5 million Federal retirees (in the Federal Employees Health Benefits program and TRICARE) and 5.4 million beneficiaries who are continuing other sources of coverage (such as job-related coverage and VA coverage). Finally, the lower Part D cost estimates also reflect lower actual growth in drug costs in 2004 and 2005 than had been expected, with single-digit percentage increases for the first time in more than a decade and a continued expectation of slower growth in actual drug prices and costs in the next few years, as more generic drugs become available and aggressive steps to keep down drug costs continue.

State payments for a portion of the costs for drug coverage for Medicare-Medicaid “dual eligible” beneficiaries that the states would have incurred under Medicaid are projected to be more than 25 percent lower than had been projected one year ago. State payments are now estimated to be \$111 billion for fiscal years 2006-2016, which is about \$2 billion lower than the estimates in the President's Budget and about \$45 billion lower than last year's MSR.

Part A

In contrast to the continuing reductions in projected Part D expenditures, where major new competitive initiatives are being implemented, Part A and Part B spending estimates for the original Medicare program continue to rise. Overall spending on Part A services increased by more than 7 percent in 2005. Inpatient hospital services represent the largest share of Part A spending and increased by 5 percent. The rate of overall hospital spending growth has slowed because of administrative payment reforms implemented by Medicare to address very rapid and nationally uneven growth in long term care hospital and inpatient rehabilitation facilities. The table below shows the impact of payment reforms implemented over the past 2 years on these types of specialty hospitals. The increase in spending over the prior year has been brought more in line with that of the acute care hospitals.

	Percent Increase in Hospital Spending				
	2002	2003	2004	2005	2006 (est.)
Long Term Care Hospitals	22%	19%	21%	17%	7%
Inpatient Rehabilitation Facilities	21%	10%	4%	1%	1%
Inpatient Acute Hospitals	7%	3%	7%	4%	3%

Source: Office of the Actuary

Spending on Skilled Nursing Facilities (SNFs), which accounts for the next highest share of Part A spending, increased by 4 percent in 2005. Other Part A spending includes Part A home health, which increased by 10 percent, and hospice, which increased by 14 percent. Medicare intends to evaluate the rapid growth in costs for hospice services more closely.

While growth in long-term care hospitals and inpatient rehabilitation facilities has moderated as a result of recent payment reforms, the substantial growth in Part A expenditures highlights the need for appropriate incremental reforms now. Reflecting MedPAC recommendations, the President's budget proposed a limited reduction in payment growth rates for hospitals and SNFs, and performance-based payment reforms to promote quality care with fewer costly complications and unnecessary services. Medicare is also working to implement post-acute payment reforms, to promote effective, well-coordinated care in a broad range of settings that are contributing to rapid growth in Part A costs.

Part B

Medicare Part B expenditures are now projected to be significantly higher, as a result of rapid growth in the use of both physician-related services and hospital outpatient services in the original Medicare fee-for-service program. Overall, Part B spending increased by 11 percent in 2005. Expenditures for physicians' services grew by 10 percent in 2005 and expenditures for outpatient hospital services grew by 11 percent. The main reason for these increases in total expenditures is increases in the volume and intensity of physician and outpatient hospital services over the last several years, as noted in the table below.

	Percent Increase in Volume/Intensity				
	2002	2003	2004	2005 (est.)	2006 (est.)
Physicians' Services	6%	5%	6%	7%	6%
Outpatient Hospital Services	3%	2%	8%	8%	10%

Source: Office of the Actuary

For physicians' services, increases in volume and intensity are estimated to be 7 percent for 2005, and projected to be 6 percent for 2006. This continued growth in the volume and intensity of physicians' services, combined with legislative action to eliminate the "sustainable growth rate" reduction in physician payment rates this year, account for the significant increase in projected expenditures in 2006. As indicated in a letter from CMS to MedPAC on April 7 (http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/MedPAC_Letter_Estimated_2007.pdf), this rapid growth in services administered in physicians' offices is driven by more use of more intensive physicians' services, including imaging, physician-administered drugs, minor procedures, physical therapy, dermatology, lab tests, and evaluation and management services. Use of many of these services varies substantially across practices and geographic areas, with no clear impacts on patient health.

For hospital outpatient services, as a result of the accelerating trend in use of services, volume and intensity is projected to continue to increase rapidly, at a rate of 10 percent in 2006. Payment rate increases for hospital outpatient services are also contributing to the spending growth, and combined with the rapid growth in utilization, spending for outpatient services is projected to account for almost as much of the total premium increase as physicians' services.

Many other types of Part B services, which account for smaller shares of Part B spending, also have had rapid growth in expenditures. For example, estimated spending on Part B home health services increased 10 percent. As noted previously, estimated diagnostic lab test spending

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increased by 10 percent (all of which was due to greater volume and intensity, since Medicare payments for such services were frozen in 2005 at the prior year level). The volume and intensity of therapy services also increased substantially.

The continuing rapid growth in utilization and thus in spending on Part B services will lead to a substantial increase in the 2007 Part B premium. The current estimate is \$98.40, very similar to the Trustee's Report estimate of \$98.20. The main drivers continue to be higher spending levels, particularly increases in volume and intensity of services as outlined above, together with the need to restore the assets of the Part B trust fund account to a more adequate level. The attached table summarizes all of the factors contributing to the expected Part B premium increase.

The rapid growth in physician and outpatient services highlight the need for Part B payment reforms. Medicare is already implementing competitive reforms in the payment of many Part B services, which are leading to lower spending for Part B-covered drugs, and Medicare Advantage plans are providing more beneficiaries with access to more comprehensive benefits at a lower cost to enrollees. However, continuing rapid growth in utilization of Part A and especially Part B services in the original Medicare fee-for-service program shows that Medicare needs to do more to move away from a system that pays simply for more services, regardless of their quality or impact on beneficiary health.

As proposed in the President's budget, Medicare payments should provide more effective financial support to doctors and other health professionals in their efforts to achieve better health outcomes for Medicare beneficiaries at a lower cost. CMS is working closely with the medical community and Congress to provide better financial support for high-quality, efficient physician services without increasing overall Medicare costs. During 2006, we are conducting a physician voluntary reporting program to allow physicians to report some existing quality measures and to allow us to test administrative mechanisms for reporting such measures. We are also working with the physician community and other groups to develop quality measures that would cover a broad group of physician specialties and practice areas, to allow physician quality reporting beginning in 2007. In addition, the recent very rapid growth in hospital outpatient expenditures indicates the need to consider further reform steps in outpatient payment, beyond the proposed modest reduction in payment growth proposed in the President's budget. CMS intends to seek comment on such further payment reforms in the upcoming Hospital Outpatient Prospective Payment System proposed rule for 2007 payments.

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