Administration Offers Plan to Shore Up Medicare

BY MARY ELLEN SCHNEIDER
New York Bureau

In response to a warning that the Medicare trust fund is in financial trouble, the Bush administration recently proposed legislation that would tie physician payments to quality, cap medical liability damages, and encourage nationwide adoption of electronic health records.

Health and Human Services Secretary Mike Leavitt submitted the proposed legislation to Congress last month, in response to the Medicare Trustees' warning for the second year in a row that general federal revenue would be needed to pay for more than 45% of program expenditures. Mr. Leavitt was required to submit the proposal under a cost-saving measure included in the Medicare Modernization Act of 2003.

"The Medicare program is on an unsustainable path, driven by two principal factors: projected growth in its per-capita costs, and increases in the beneficiary population as a result of population aging," Mr. Leavitt said in a letter to House Speaker Nancy Pelosi (D-Calif.). "Excess cost growth will not be brought under control until there is comprehensive reform changing Medicare's underlying structure."

Under the proposal, the HHS secretary would design and implement a system to tie a portion of the Medicare payment to providers to performance on quality and efficiency measures. Implementation would start in areas with well-accepted measures for example hospitals, physician offices, home health agencies, skilled nursing facilities, and renal dialysis facilities.

The legislation also would limit the length of time individuals have to sue for medical malpractice; cap noneconomic damages at $250,000 and punitive damages at $250,000 or twice the economic damages (whichever is greater); and limit contingency fees paid to plaintiffs' attorneys. The HHS estimates defensive medicine raises the cost of care in Medicare, Medicaid, and Veterans Affairs by about $28 billion a year.

Starting in 2009, the administration's proposal would also increase premiums for Part D prescription drug coverage for single beneficiaries earning more than $82,000 a year and also for couples earning more than $164,000. HHS said the change could save more than $900 million in 2009 and nearly $3.2 billion over 5 years.

'Excess cost growth will not be brought under control until there is comprehensive reform.'

MR. LEAVITT

The legislative proposal also requires the HHS secretary to develop a system to encourage the nationwide adoption and use of interoperable electronic health records and to make personal health records available to Medicare beneficiaries.

Mr. Leavitt urged Congress to adopt the proposed changes in conjunction with the administration's fiscal year 2009 budget proposal, which includes legislative and administrative proposals that would cut $12.8 billion from the Medicare program in fiscal year 2009 and about $183 billion over the next 5 years.

But the administration may have trouble getting its proposals through Congress.

Sen. Edward Kennedy (D-Mass.), chair of the Senate Health, Education, Labor, and Pensions Committee, said "The administration has trumped up a phony crisis in Medicare to justify proposing deep cuts in quality health care for seniors while giving massive subsidies to HMOs and other insurance companies."

Physicians' groups were also critical of the plan. Dr. James King, president of the American Academy of Family Physicians, said he was disappointed that the Medicare proposal failed to address the approximate 10% Medicare payment cut facing physicians this summer. He also questioned the administration's proposal to move ahead with "value-based" payments to physicians under a plan that appears not to include additional money for incentives. Any pay-for-performance system should use a bonus payment, not withhold payments, he said.

Though the AAFP supports the proposed cap on noneconomic damages in medical liability suits, Dr. King said he doubted the proposal would gain any traction in the current Congress. ■

Health Costs to Hit $4.3 Trillion in 2017

BY MARY ELLEN SCHNEIDER
New York Bureau

Health care spending in the United States is projected to consume nearly 20% of the gross domestic product by 2017, according to estimates from economists at the Centers for Medicare and Medicaid Services.

Health spending growth is expected to remain steady at about 6.7% a year through 2017, with spending estimated to nearly double to $4.3 trillion by 2017, the CMS analysts said in an online report in the journal Health Affairs.

The 10-year projections come from the National Health Statistics Group, part of the CMS Office of the Actuary, and are based on historical trends, projected economic conditions, and provisions of current law.

The analysts project that spending for private sector health care will slow toward the end of the projection period, while spending in the public sector, including Medicare and Medicaid, will increase, fueled by the first wave of baby boomers entering Medicare in 2011. The increase in the number of Medicare enrollees is projected to add 2.9% to growth in Medicare spending by 2017.

The CMS economists projected growth in spending on physician services would average about 5.9% per year through 2017, versus 6.6% from 1995 to 2006. If Congress were to provide a 0% update over the next decade, the average annual growth from 2007 to 2017 would rise to 6.2%, according to the report.

On the hospital side, growth in spending is projected to accelerate at the beginning of the projection period because of higher Medicaid payments but to slow toward the end as a result of projected lower growth in income.

Home health care will likely be one of the fastest growing sectors in health care from 2007 through 2017, with an average annual spending growth rate of 7.7%.

Growth in prescription drug spending is expected to accelerate overall through 2017, because of increased utilization, new drugs entering the market, and a leveling-off of the growth in generics. The analysts reported Medicare Part D would have "little impact on overall health spending growth" through 2017. ■

Evidence Doesn't Back Coverage Decisions

BY LEANNE SULLIVAN
Associate Editor

Data reviewed by the Centers for Medicaid and Medicare Services to inform Medicare treatment coverage decisions reflect populations that are significantly different from the Medicare beneficiary population, a recent analysis has shown.

In 1998, the CMS established a panel of physicians and other professionals to review the evidence base before the agency makes national Medicare coverage decisions. The independent panel, now called the Medicare Evidence Development and Coverage Advisory Committee (MedCAC), reviews the literature described in a technology assessment and votes on the evidence to determine the health benefit of the medical procedure or device, wrote Sanket S. Dhruva and Dr. Rita F. Redberg, both of the University of California, San Francisco, which, along with the Robert Wood Johnson Foundation, provided support for the study. Dr. Redberg is a member of MedCAC, but had no financial conflicts of interest to disclose.

To examine whether the data used by MedCAC were generalizable to the Medicare population, Mr. Dhruva and Dr. Redberg looked at all six MedCAC decisions involving a cardiovascular product or service and analyzed the sample size, participant demographics, inclusion criteria, study location, and outcome stratification of the relevant technology assessments. The data in the technology assessments used for these six decisions included 141 peer-reviewed reports and 40,009 patients (Arch. Intern. Med. 2008;168:136-40).

Significant differences were found between the study and Medicare populations. Trial participants described in the technology assessments were significantly younger than were most Medicare beneficiaries (mean ages, 60.1 years and 70.8 years, respectively). Several trials excluded older patients, but "the mean age in studies with explicit age exclusions (59.0 years) and those without such exclusions (60.9 years) did not differ," the authors wrote.

"Studies for each cardiovascular [technology assessment] also differed significantly from the Medicare population in terms of sex," they continued. Of the study participants, 75.4% were men, compared with 43.7% of Medicare beneficiaries. Several of the studies had excluded women, but none excluded men.

Clinical trial location also was not representative of the Medicare population. Of 135 studies that reported location, 37% took place at least partly in the United States. However, most (51.1%) were done in Europe, 8.9% in Asia, and 6.7% in other locations. Overall, 40% of the technology assessment study participants were U.S. residents, compared with 100% of the Medicare population.

The clinical trial data used by CMS in its coverage decisions often underrepresented women and the elderly.

DR. REDBURG

In addition, many of the trials excluded patients with conditions like renal insufficiency, arrhythmias, and diabetes that are common in the Medicare population.

The researchers concluded that the data used by MedCAC as evidence on which to base national treatment coverage decisions "are derived from populations that differ significantly from the Medicare beneficiary population in terms of age, sex, country of residence, and comorbid conditions." The trial populations are "younger, healthier, male, non-U.S. populations," reflecting a "persistent underrepresentation of women and elderly people" in clinical trials in general, the authors noted.

To improve the relevance of the data used for coverage decisions, the authors suggested that all future studies include demographic information, as "the accuracy and risk-benefit profiles of many diagnostic tests and therapies differ substantially by age and often by sex." They also suggested that the CMS adopt a policy requiring data on women and the elderly, which would encourage trial investigators to include such data. An alternative approach would be for the CMS to issue coverage decisions dependent on the addition of subgroup data within a specified period of time.

"Closer linkage of evidence to coverage would promote better value and improved outcomes" for Medicare patients, the researchers concluded. ■