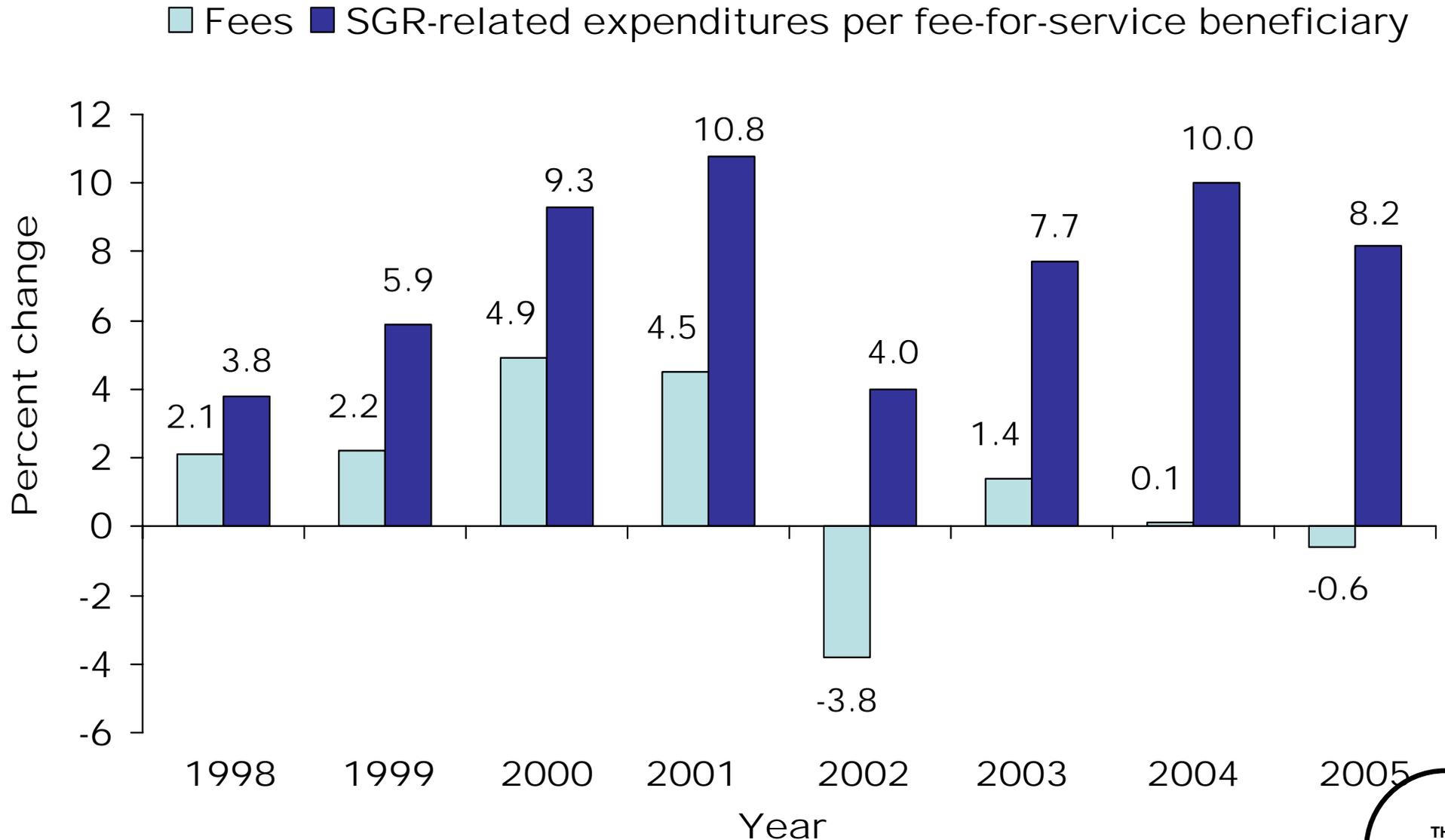
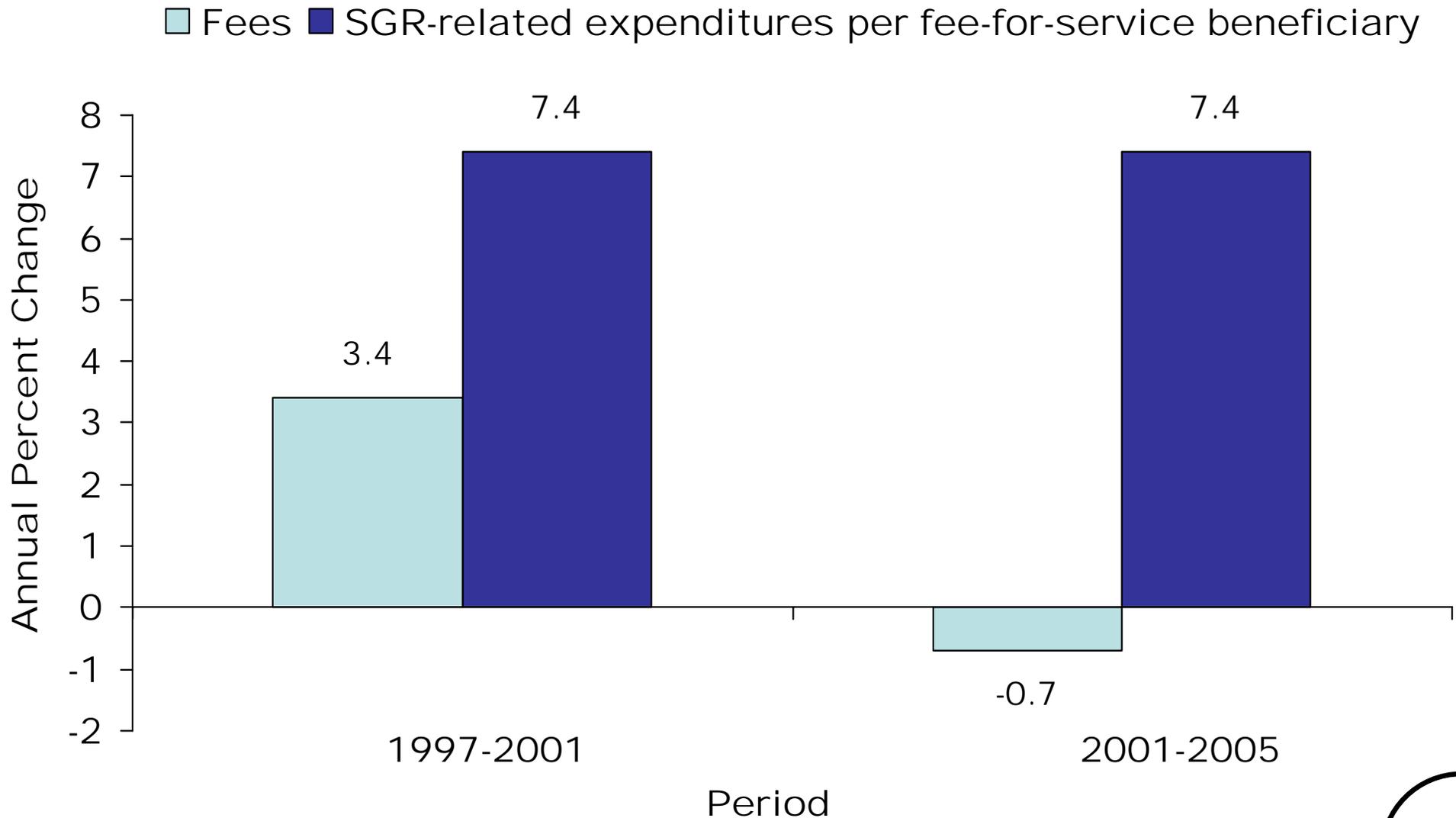


Figure 1. Annual Increases in Physician Fees and SGR-Related Expenditures Per Fee-for-Service Beneficiary, 1998-2005



Source: Letter to Glenn M. Hackbarth, Chair, Medicare Payment Advisory Commission, from Herb B. Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, dated April 7, 2006.

Figure 2. Annual Rates of Increase in Physician Fees and SGR-Related Expenditures Per Fee-for-Service Beneficiary, 1997-2001 and 2001-2005

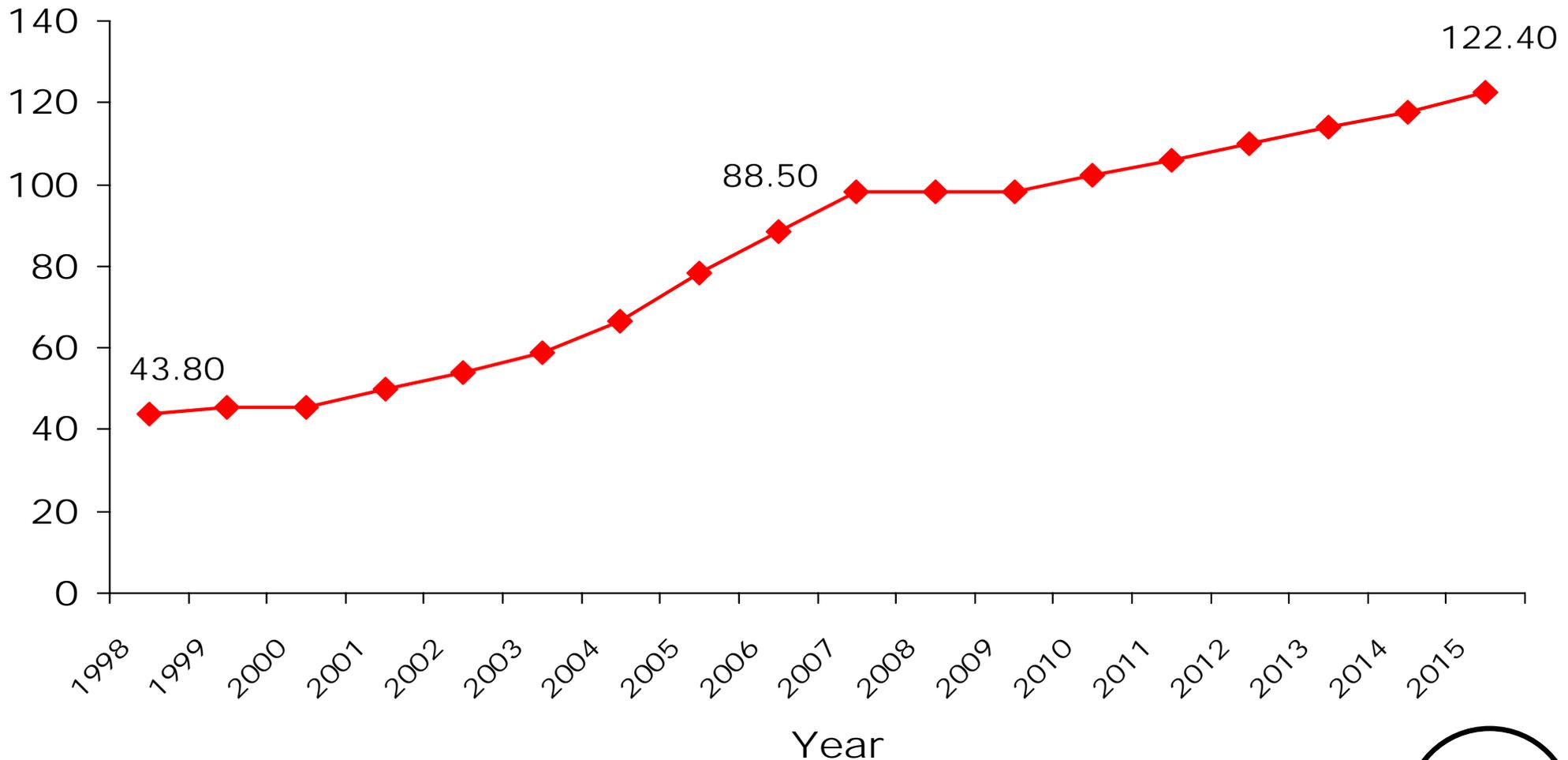


Source: Letter to Glenn M. Hackbarth, Chair, Medicare Payment Advisory Commission, from Herb B. Kuhn, Director, Center for Medicare Management, Centers for Medicare and Medicaid Services, dated April 7, 2006.



Figure 3. Medicare Part B Premium (Monthly), 1998-2006 (Actual) and 2007-2015 (Projected)

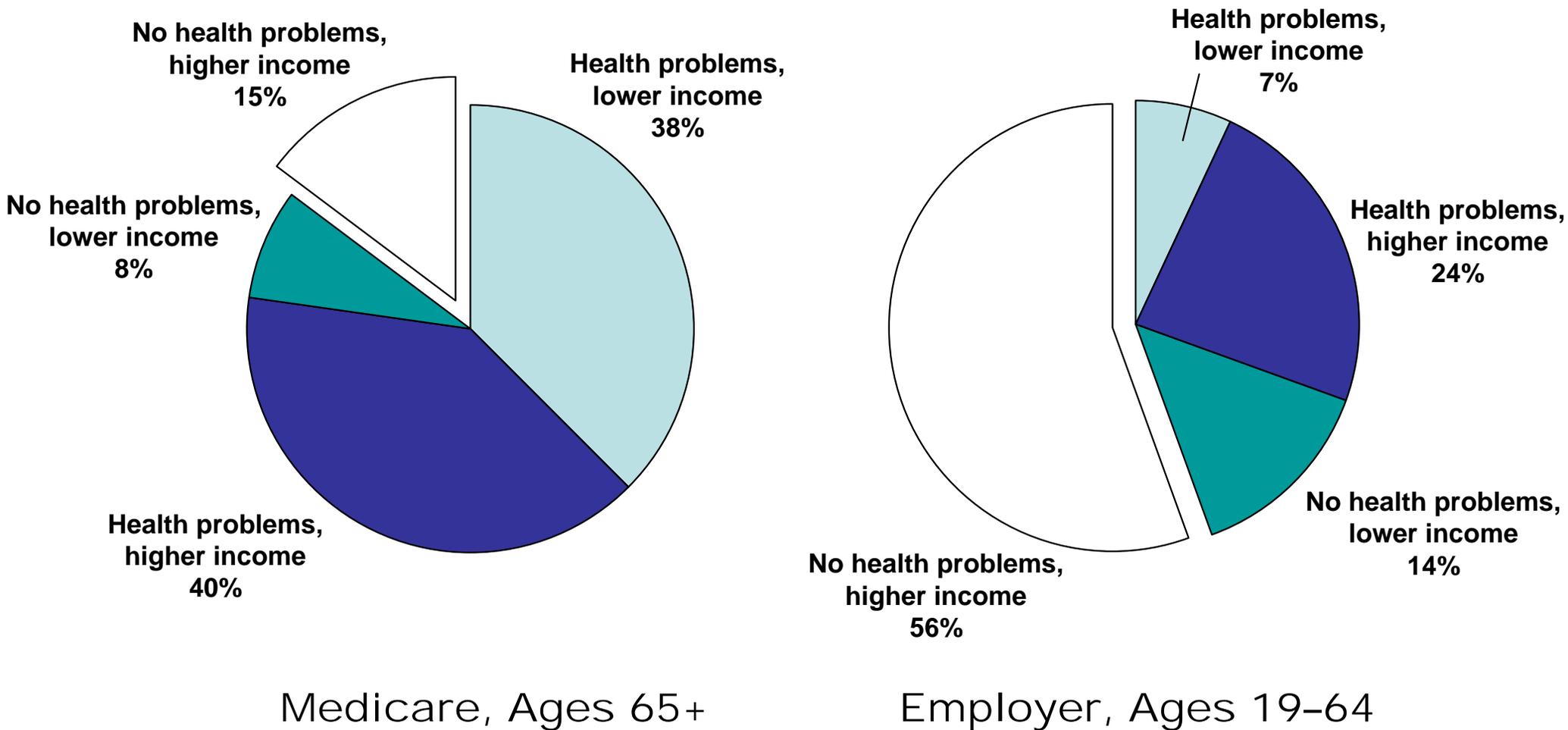
Part B Premium



Source: Board of Trustees, Federal HI and Federal SMI Trust Funds, *2006 Annual Report*.



Figure 4. Profile of Medicare Elderly Beneficiaries and Employer Coverage Nonelderly, by Poverty and Health Status, 2003



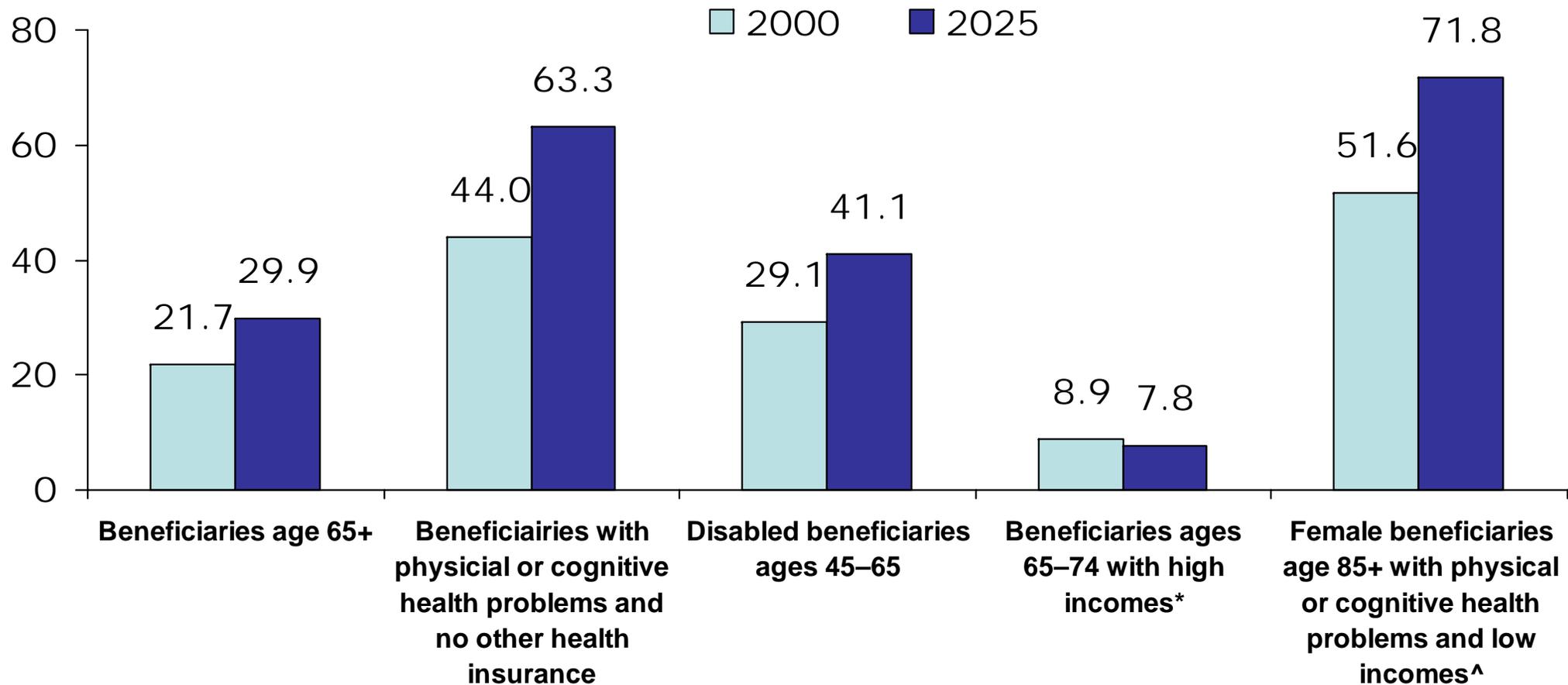
Note: Respondents with undesignated poverty were not included; lower income defined as $\leq 200\%$ of poverty; health problems defined as fair or poor health, any chronic condition (cancer, diabetes, heart attack/disease, and arthritis), or disability .

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).



Figure 5. Projected Out-of-Pocket Spending As a Share of Income Among Groups of Medicare Beneficiaries, 2000 and 2005

Out-of-pocket spending as percent of income



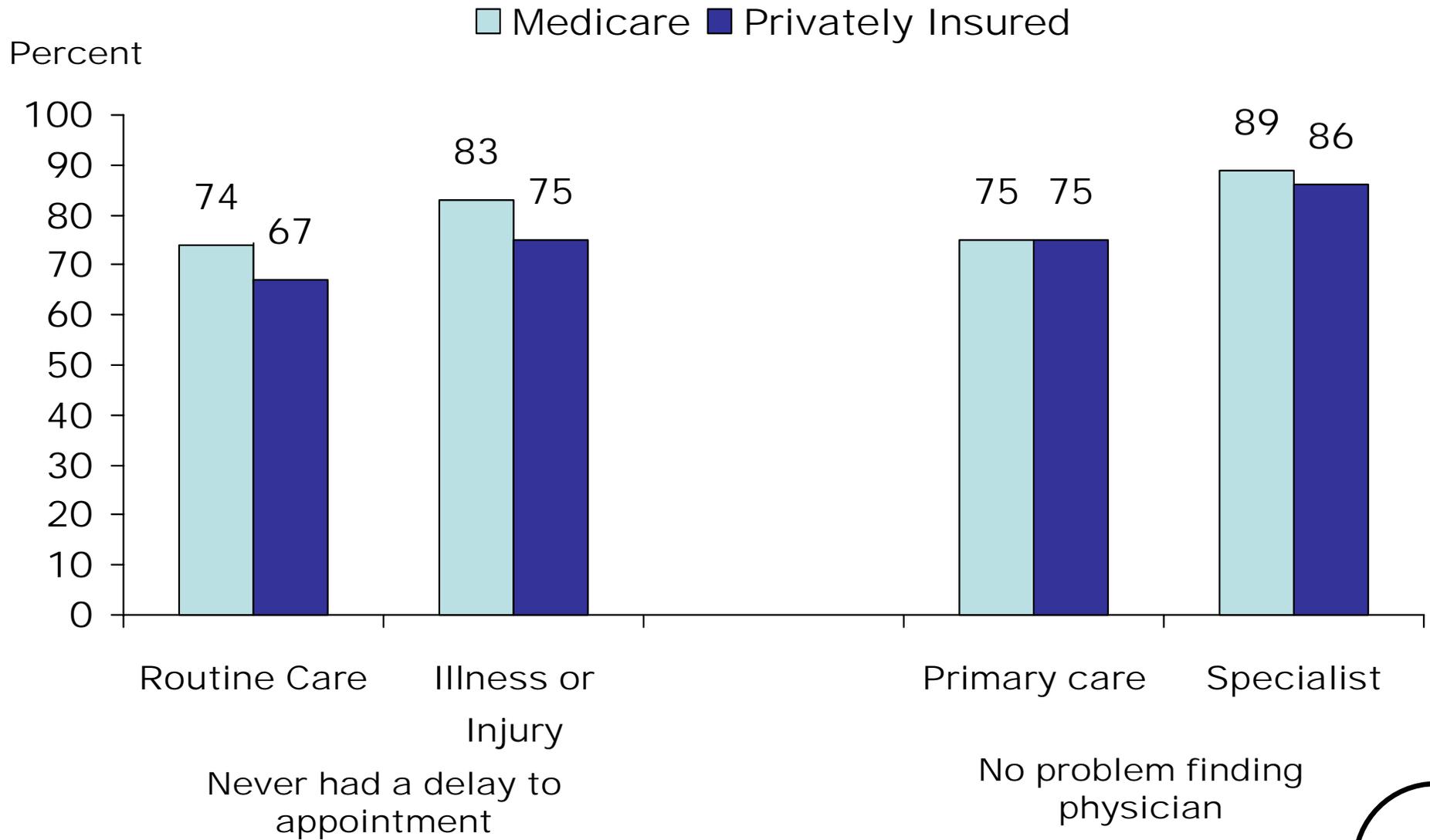
* Annual household incomes of \$50,000 or more.

^ Annual household incomes of \$5,000 to \$20,000.

Source: S. Maxwell, M. Moon, and M. Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*, The Commonwealth Fund, January 2001 as reported in R. Friedland and L. Summer, *Demography Is Not Destiny, Revisited*, The Commonwealth Fund, March 2005.



Figure 6. Access to Physicians for Medicare Beneficiaries and Privately Insured People, 2005

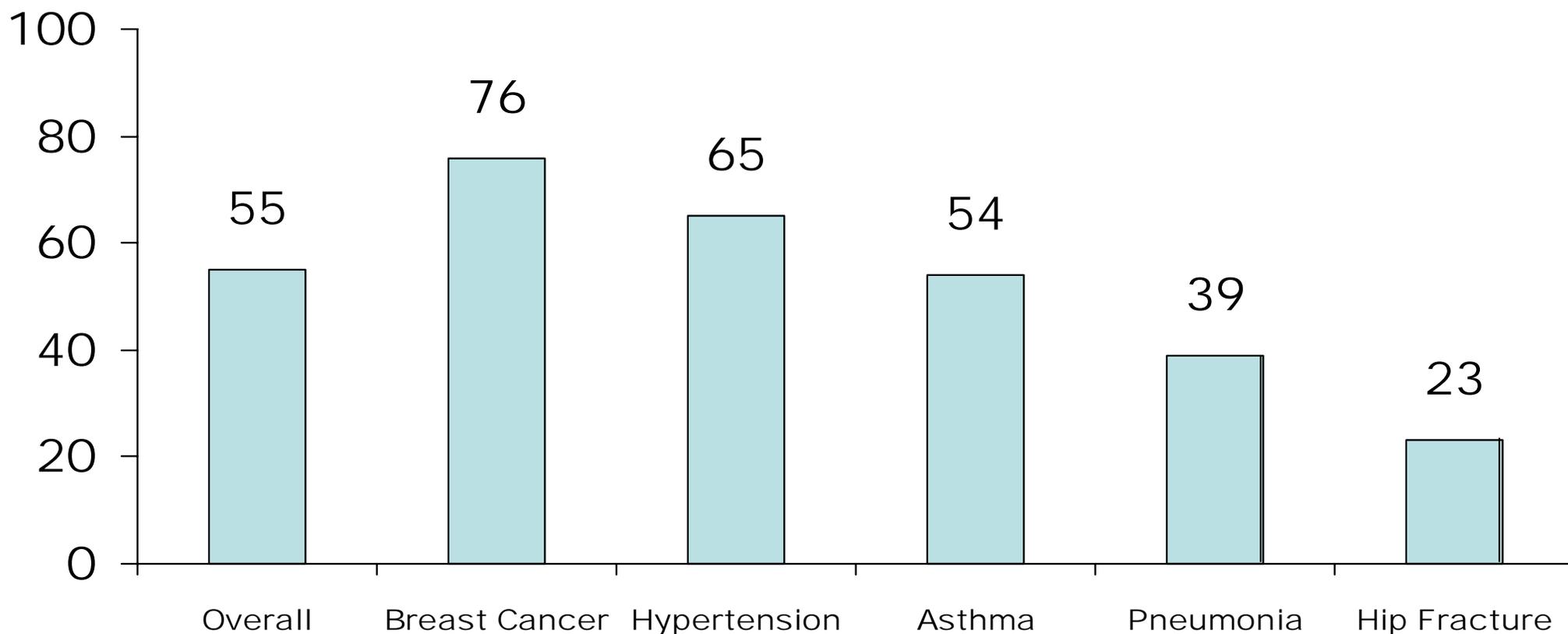


Source: MedPAC Report to the Congress: Medicare Payment Policy, March 2006, p. 85.



Figure 7. Proportion of Recommended Care Received by U.S. Adults, by Selected Conditions

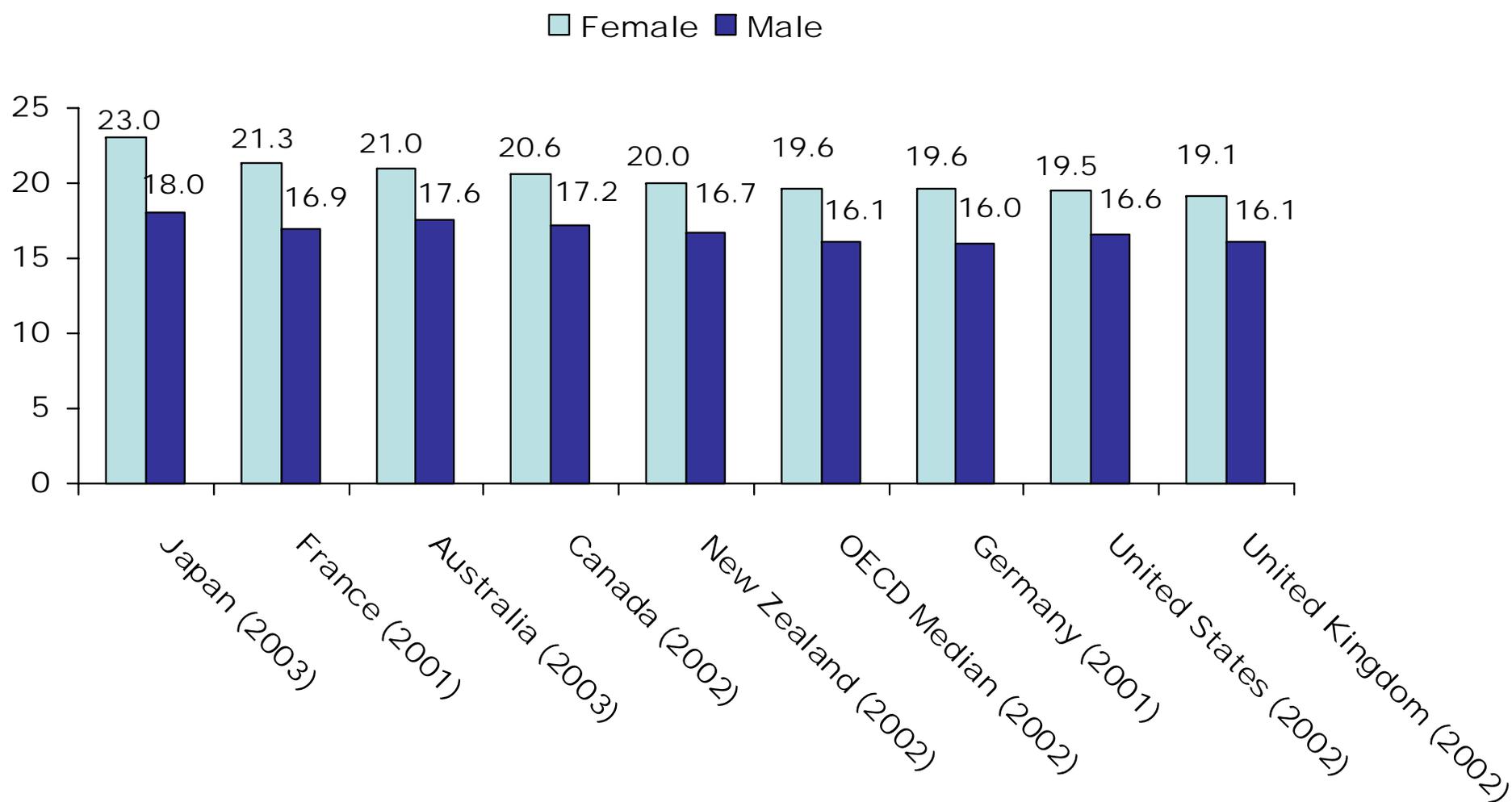
Percent of recommended care received



Source: McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003): 2635–2645.



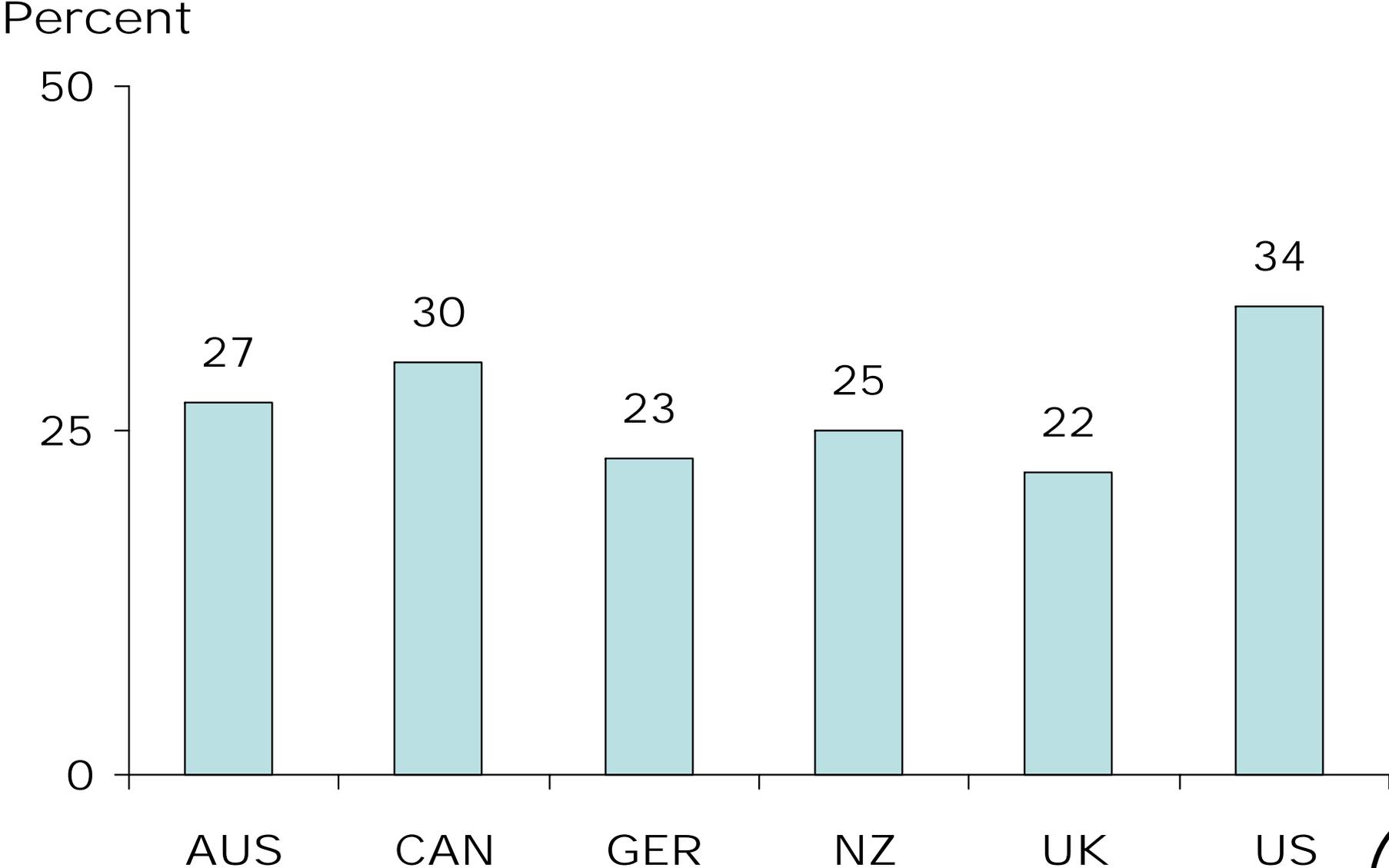
Figure 8. Life Expectancy at Age 65



Source: OECD Health Data, 2005.



Figure 9. Patient Reported Medical Mistake, Medication Error, or Test Error in Past 2 Years

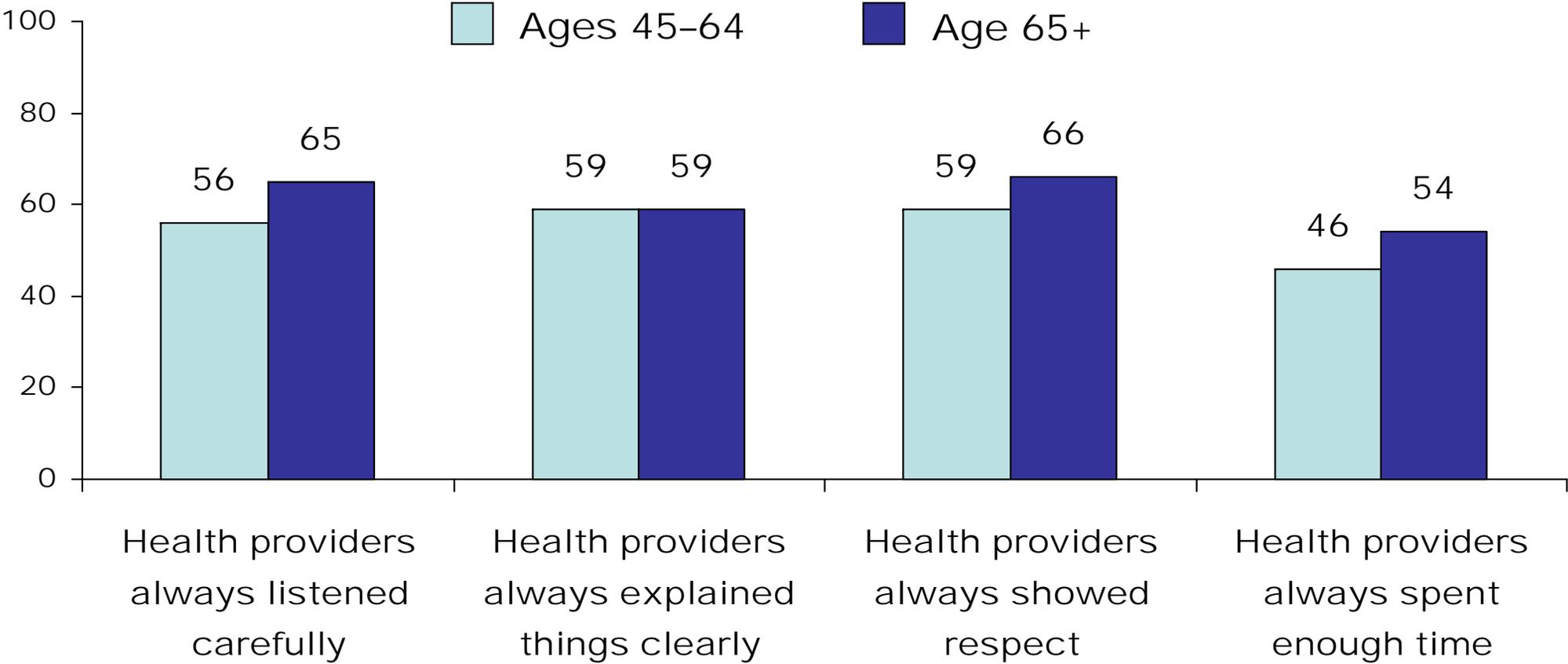


Source: 2005 Commonwealth Fund International Health Policy Survey.



Figure 10. Interpersonal Quality of Care Is Lacking

Percent of community-dwelling adults in 2001 who visited doctor's office in past year



Source: S. Leatherman and D. McCarthy, *Quality of Health Care for Medicare Beneficiaries: A Chartbook, 2005*, The Commonwealth Fund. www.cmwf.org; Medical Expenditure Panel Survey (AHRQ 2005).



Figure 11. Communication With Physicians Views of Sicker Adults

In the past 2 years:	AUS	CAN	NZ	UK	US
Left a doctor's office without getting important questions answered	21	25	20	19	31
Did not follow a doctor's advice	31	31	27	21	39

Source: 2002 Commonwealth Fund International Health Policy Survey.



Figure 12. Deficiencies in Care Coordination

Percent saying in the past 2 years:	AUS	CAN	GER	NZ	UK	US
Test results or records not available at time of appointment	12	19	11	16	16	23
Duplicate tests: doctor ordered test that had already been done	11	10	20	9	6	18
Percent who experienced either coordination problem	19	24	26	21	19	33

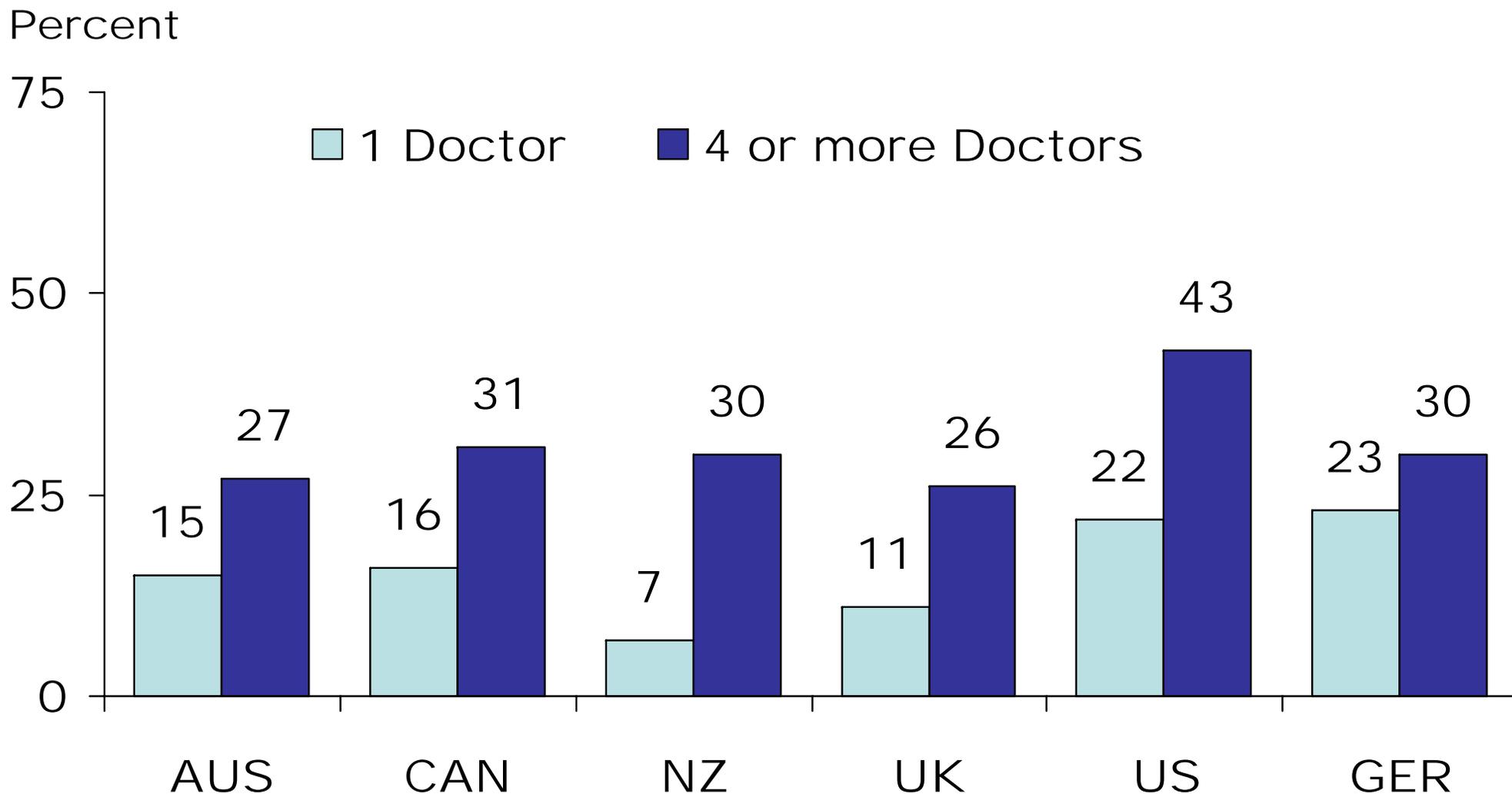


Figure 13. Continuity of Care with Same Physician

Percent:	AUS	CAN	GER	NZ	UK	US
Has regular doctor	92	92	97	94	96	84
--5 years or more	56	60	76	57	66	42
No regular doctor	8	8	3	6	4	16



Figure 14. Coordination Problems by Number of Doctors

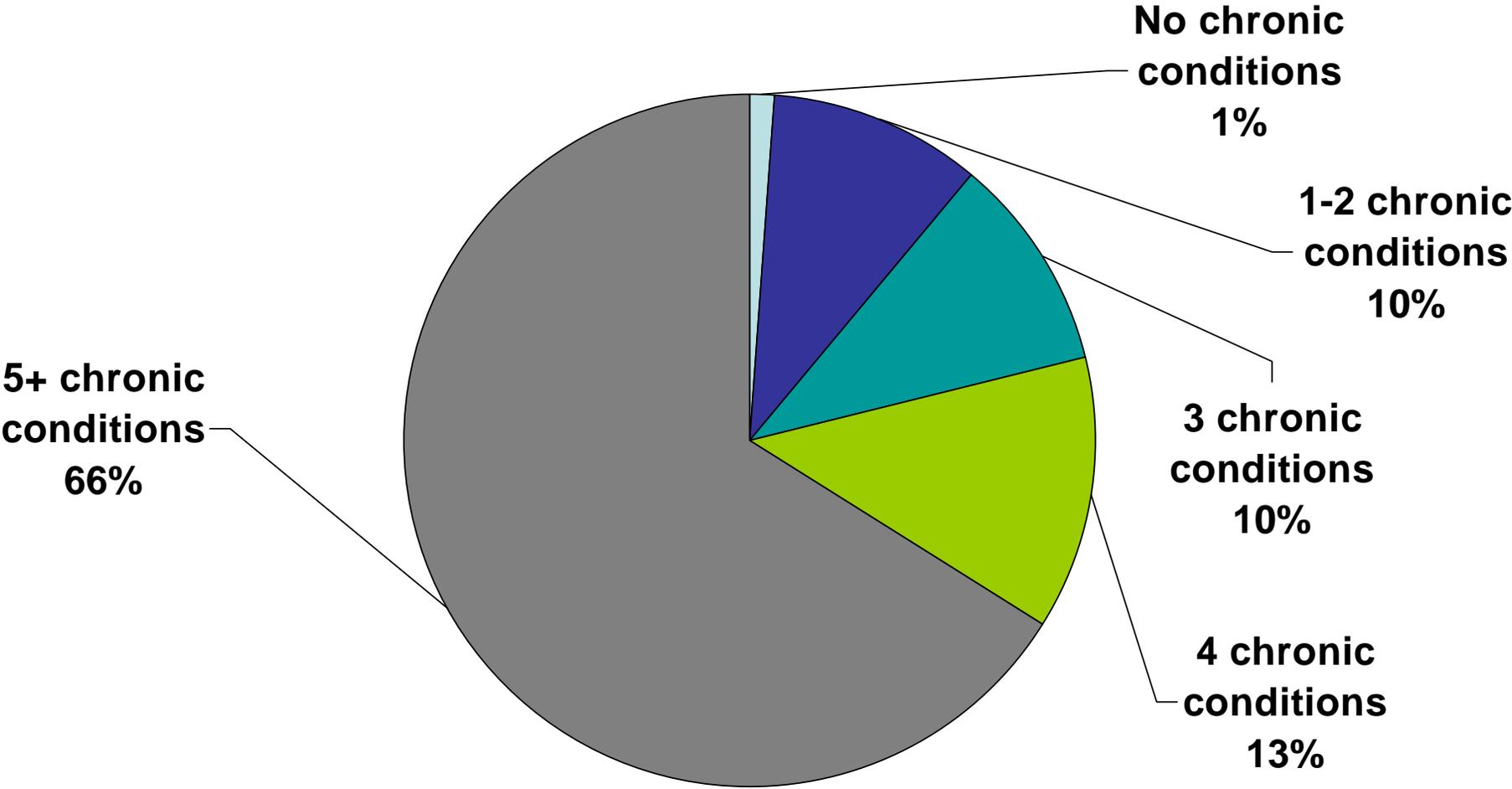


*Either records/results did not reach doctors office in time for appointment or doctors ordered a duplicate medical test

Source: C. Schoen et al., "Taking the Pulse: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (November 3, 2005). Based on the 2005 Commonwealth Fund International Health Policy Survey.



Figure 15. Two-Thirds of Medicare Spending is for People With Five or More Chronic Conditions

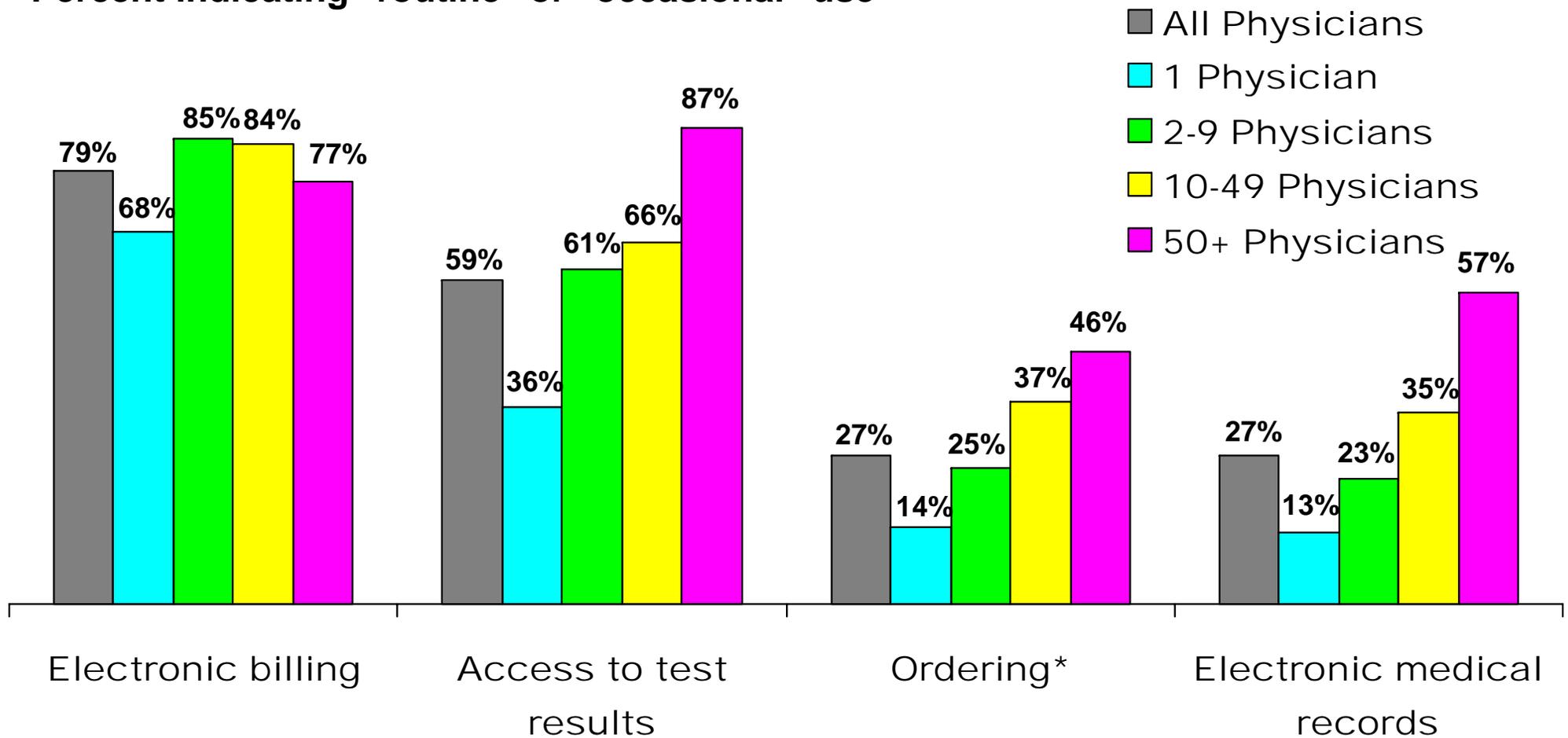


Source: G. Anderson and J. Horvath, *Chronic Conditions: Making the Case for Ongoing Care* (Baltimore, MD: Partnership for Solutions, December 2002)



Figure 16. Physician Use of Electronic Technology Varies by Application

Percent indicating "routine" or "occasional" use



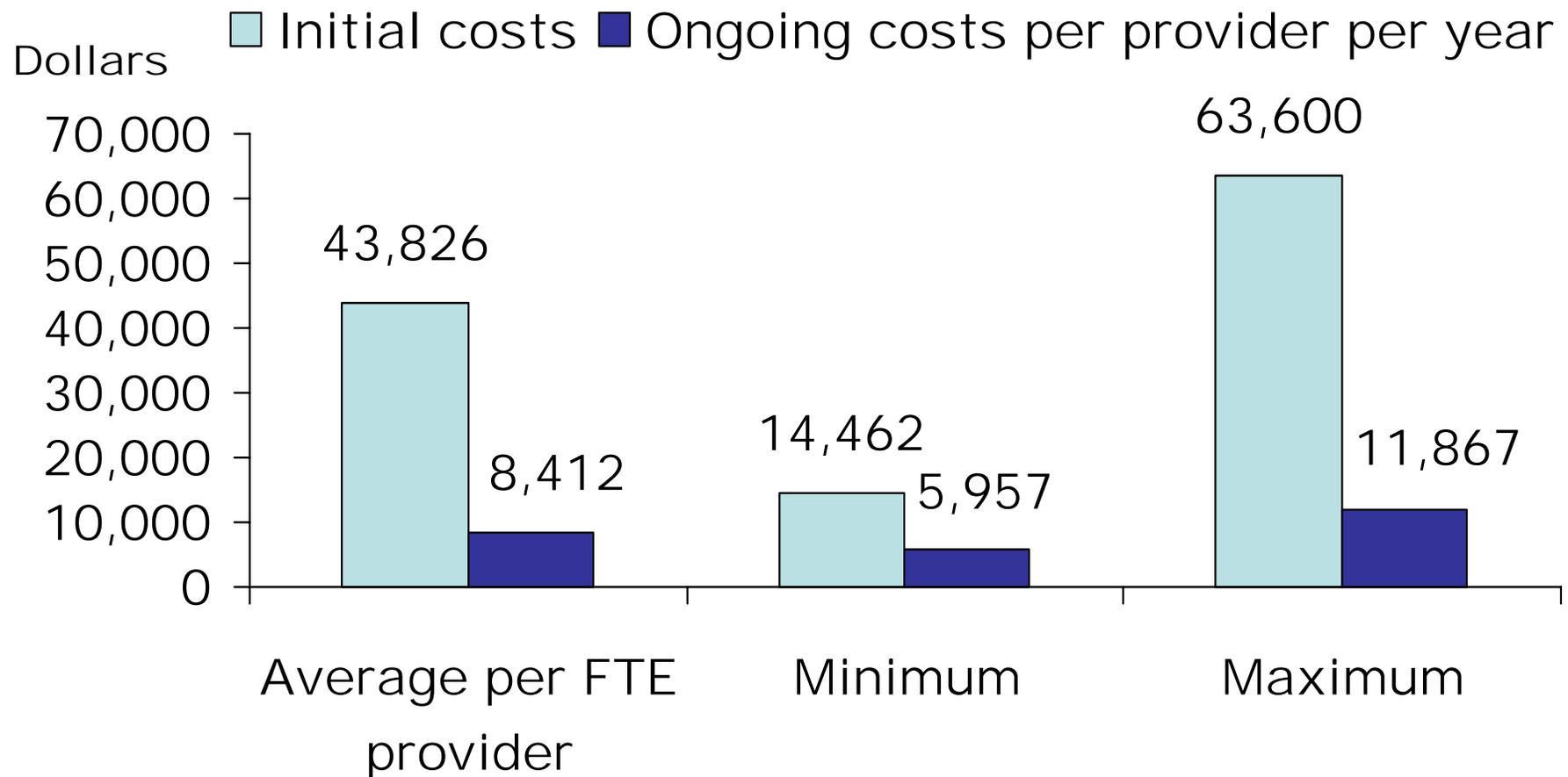
* Electronic ordering of tests, procedures, or drugs.

Source: Commonwealth Fund 2003 National Survey of Physicians and Quality of Care.



Figure 17. Electronic Health Records (EHR) in Solo or Small Group Practices: A Case Study

EHR Financial Costs Per FTE Provider For 14 Practices, 2004-2005

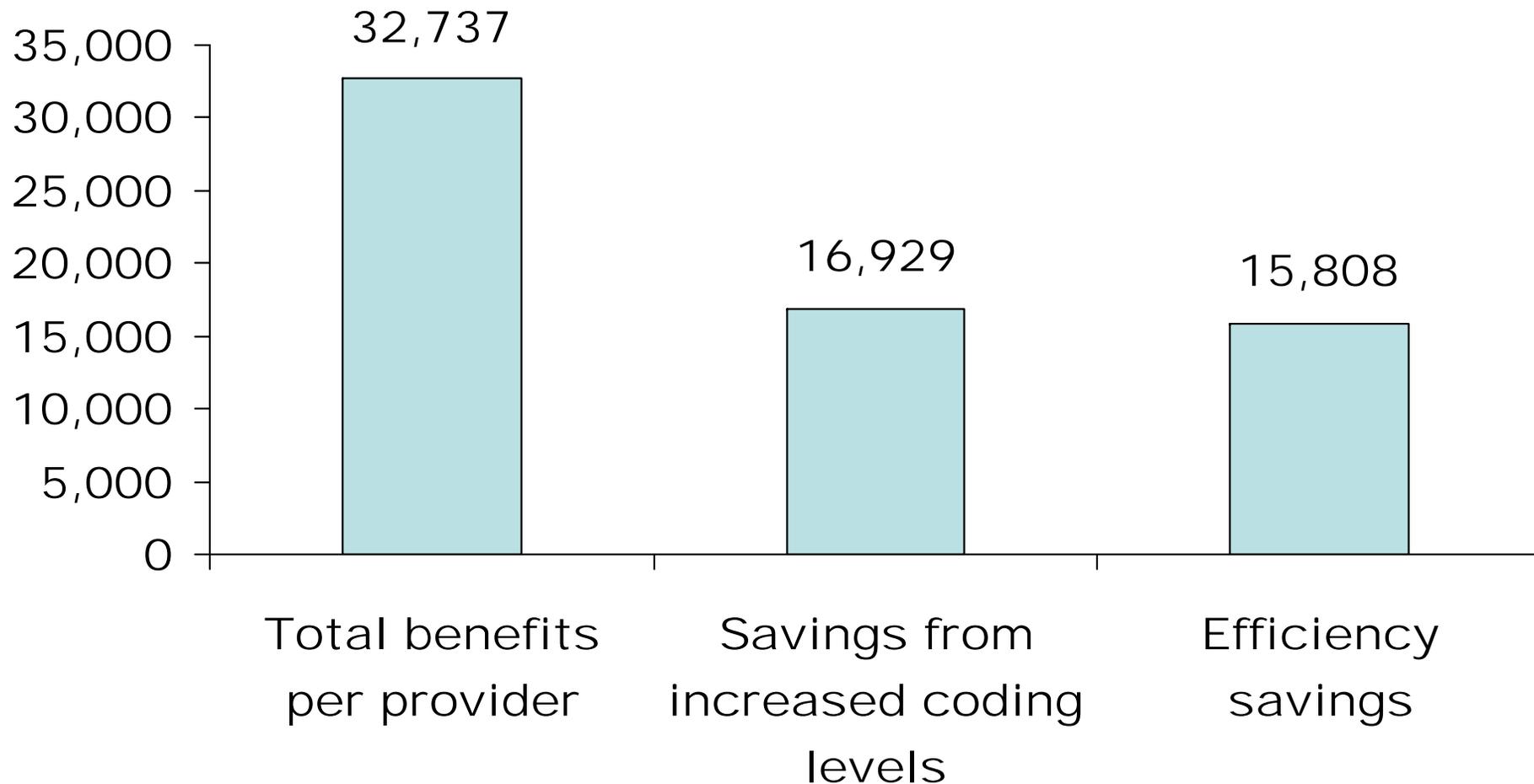


Source: R. Miller, et al. "The Value of Electronic Health Records in Solo or Small Group Practices." *Health Affairs*. 24(5). (September/October 2005): 1127.



Figure 18. EHR Financial Benefits Per FTE Provider, For 14 Solo/Small Group Practices, 2004-2005

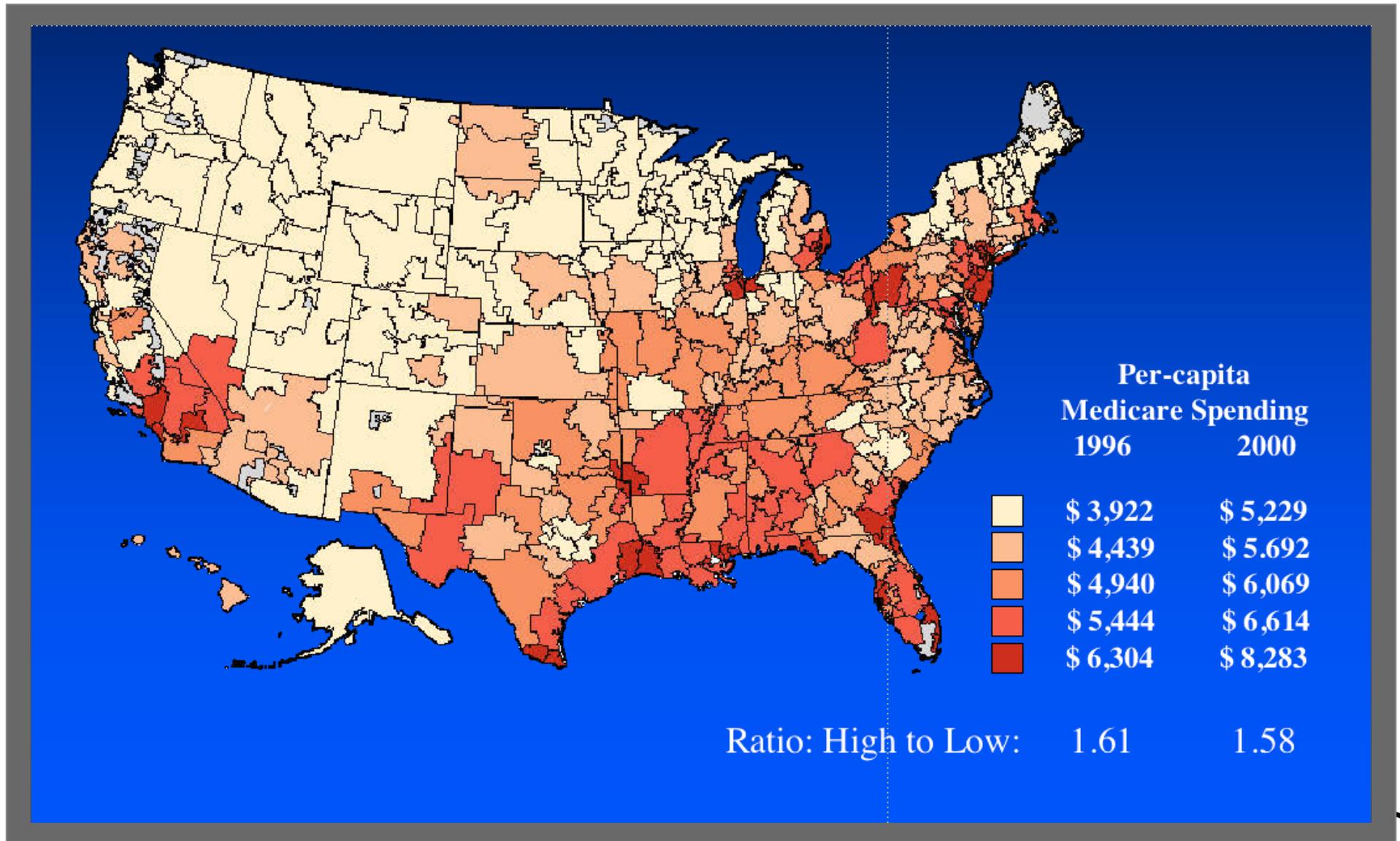
Average per FTE provider (\$)



Source: R. Miller, et al. "The Value of Electronic Health Records in Solo or Small Group Practices." *Health Affairs*. 24(5). (September/October 2005): 1127.



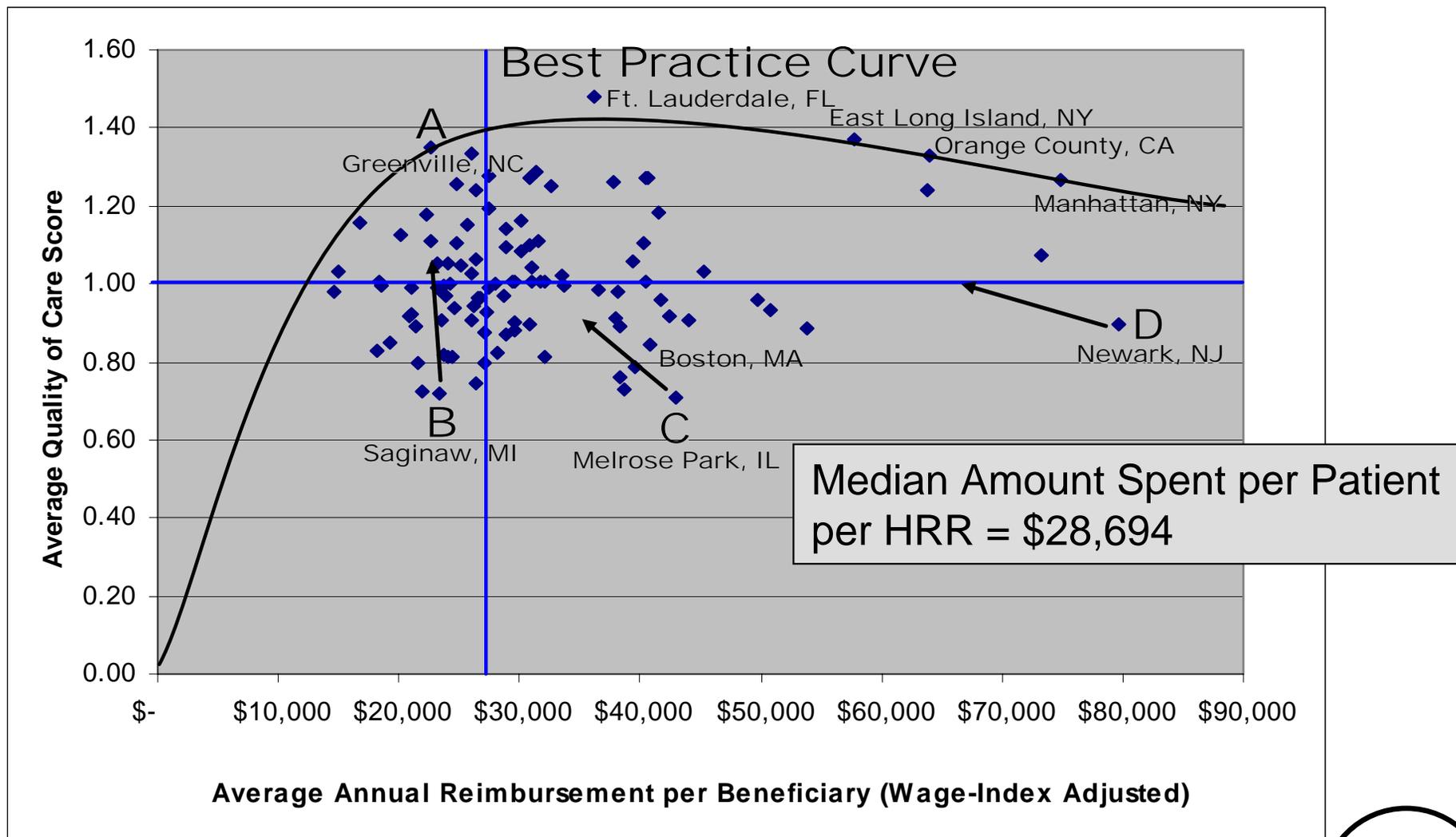
Figure 19. Variation in Per Capita Medicare Spending by Hospital Referral Region, 2000



Source: Eliot Fisher, presentation at AcademyHealth Annual Research Meeting, June 2006.

Figure 20. Variation in Annual Total Cost and Quality for Chronic Disease Patients

Quality of Care* and Medicare Spending for Beneficiaries with Three Chronic Conditions, by Hospital Referral Region



* Based on percent of beneficiaries with three conditions (diabetes, chronic obstructive pulmonary disease, and congestive heart failure) who had a doctor's visit four weeks after hospitalization, a doctor's visit every six months, annual cholesterol test, annual flu shot, annual eye exam, annual HbA1C test, and annual nephrology test.

Source: G. Anderson and R. Herbert for The Commonwealth Fund, Medicare Standard Analytical File 5% 2001 data.

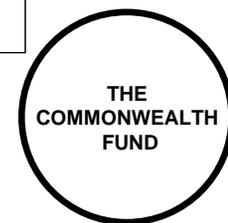
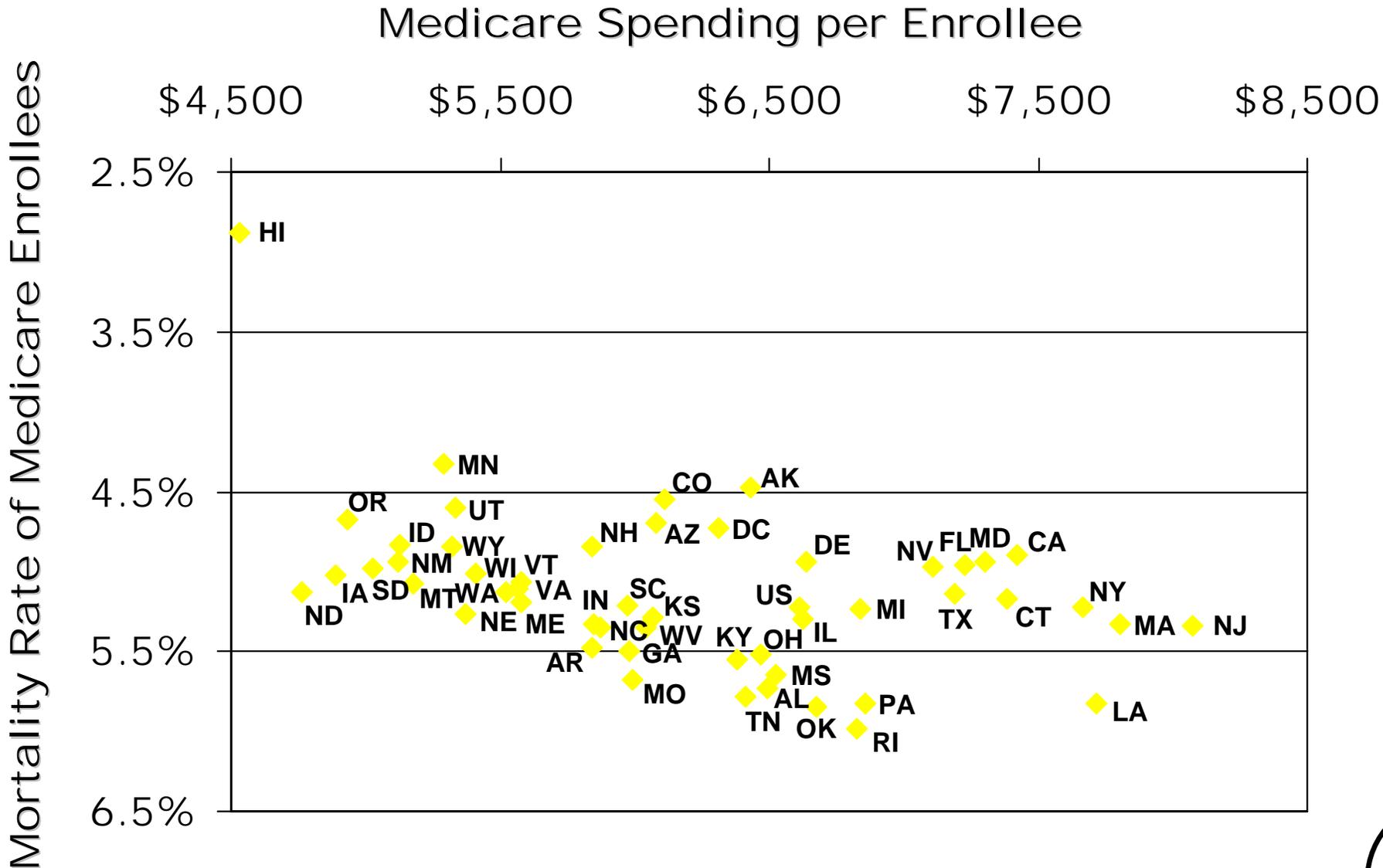


Figure 21. Medicare Spending Per Enrollee and Mortality Rate by State, 2003

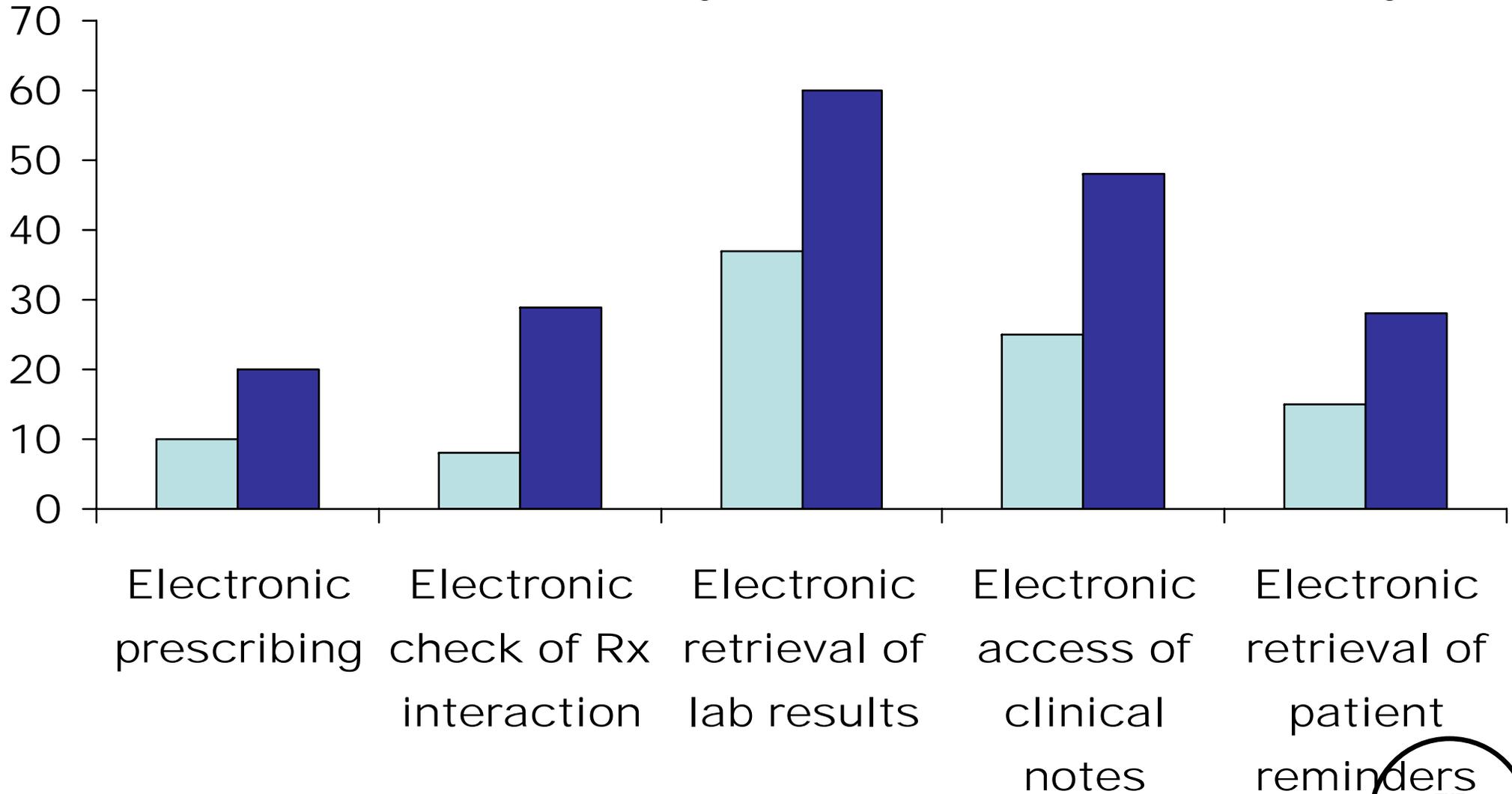


Source: Data from *The Dartmouth Atlas of Health Care*, www.dartmouthatlas.org

Figure 22. IHA Trends in Point-of-Care Technology

Percent

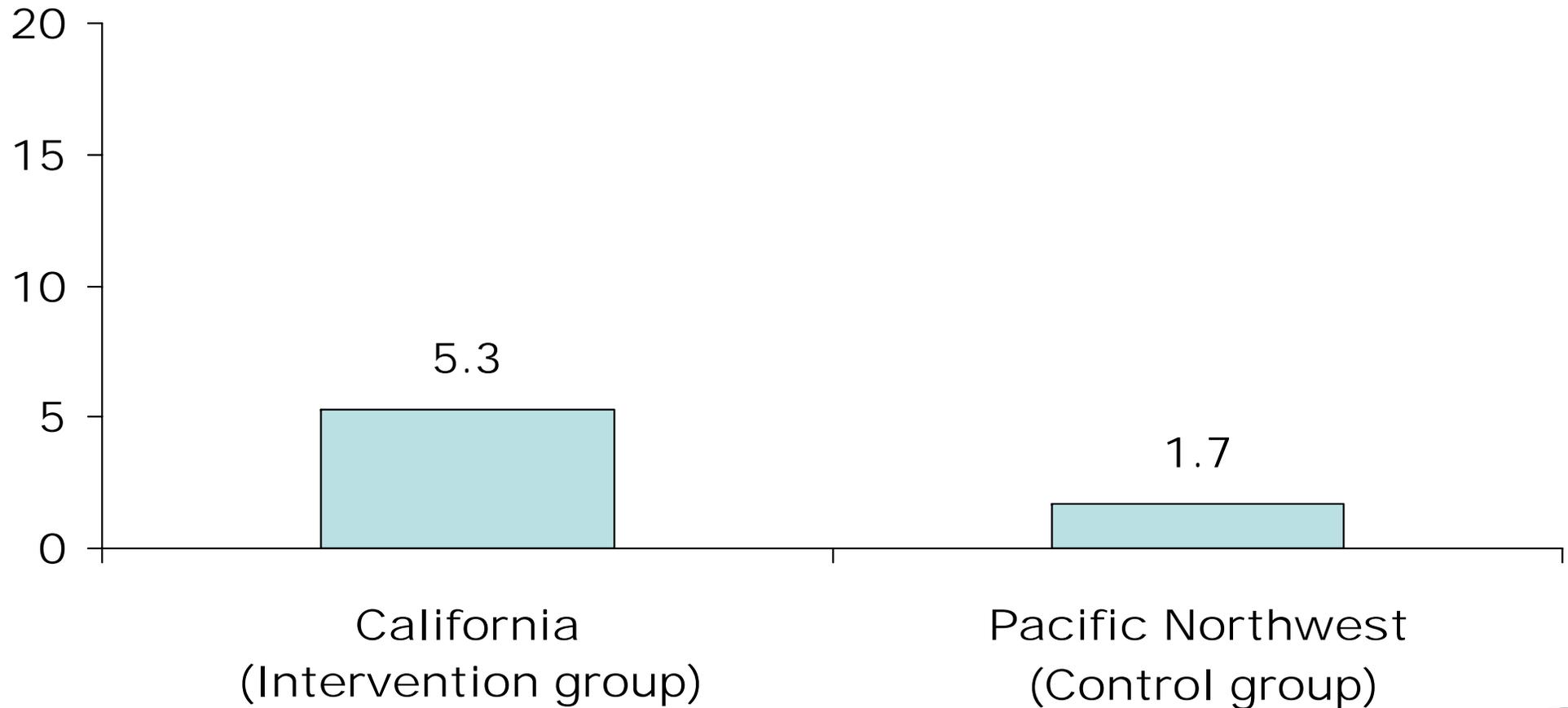
■ 2003 measurement year ■ 2004 measurement year



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Figure 23. Evaluation of PacifiCare Pay for Performance: Improvement in Cervical Cancer Screening

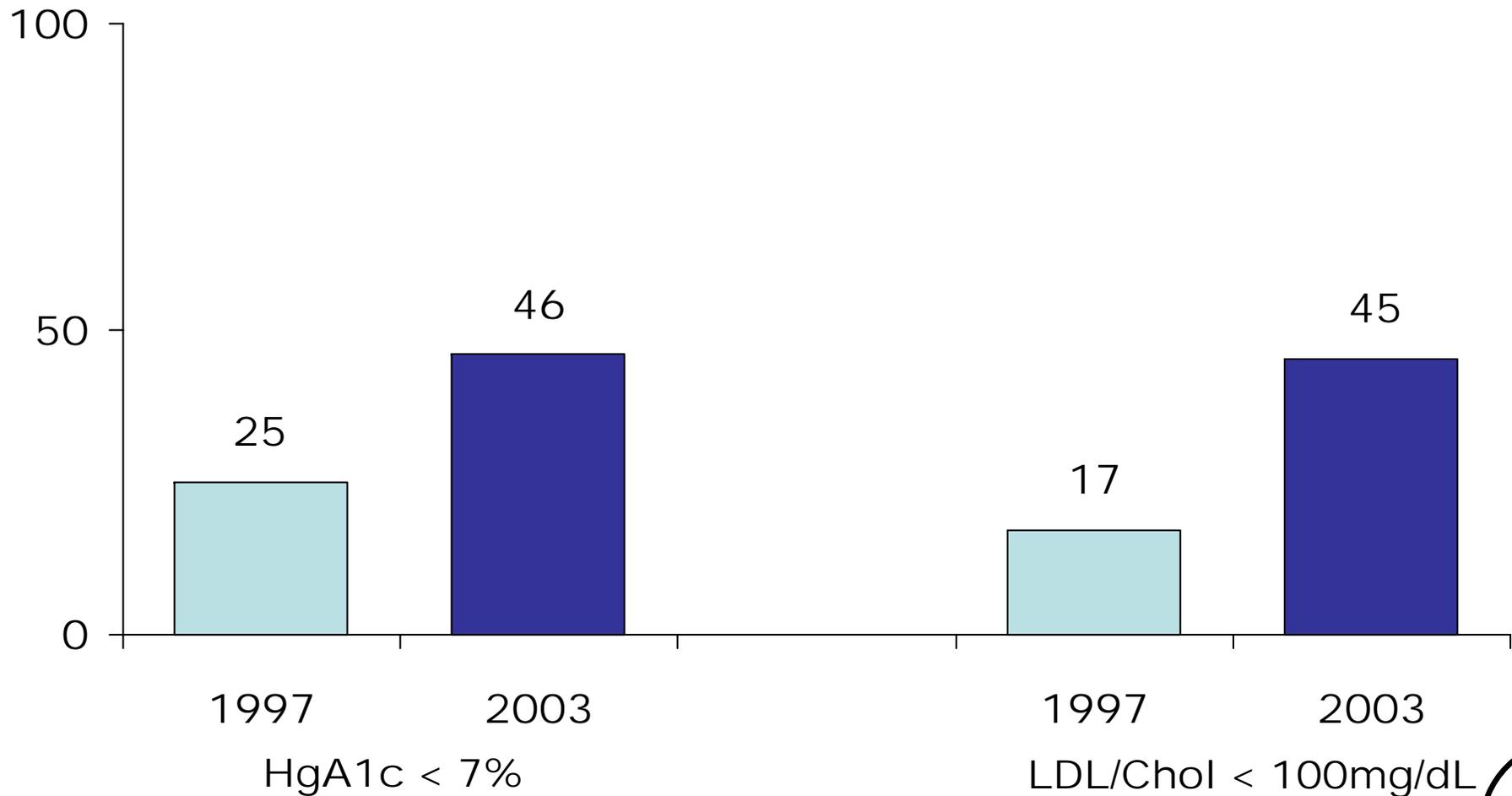
Percent improvement in cervical cancer screening rates among physician groups



Source: M.B. Rosenthal et al., "Early Experience with Pay-for-Performance: From Concept to Practice," *JAMA* 294, no. 14 (October 12, 2005): 1788-93.

Figure 24. Physicians Participating in the Diabetic Care Program From 1997 to 2003 Showed Significant Improvement in Performance

Percent of patients reaching quality target



Source: National Committee for Quality Assurance web site, www.ncqa.org/dprp.



Figure 25. Medicare Premier Hospital Demonstration: Higher Quality Hospitals Have Fewer Readmissions

Readmission Rates by Pneumonia Quality Ranking (Percent)

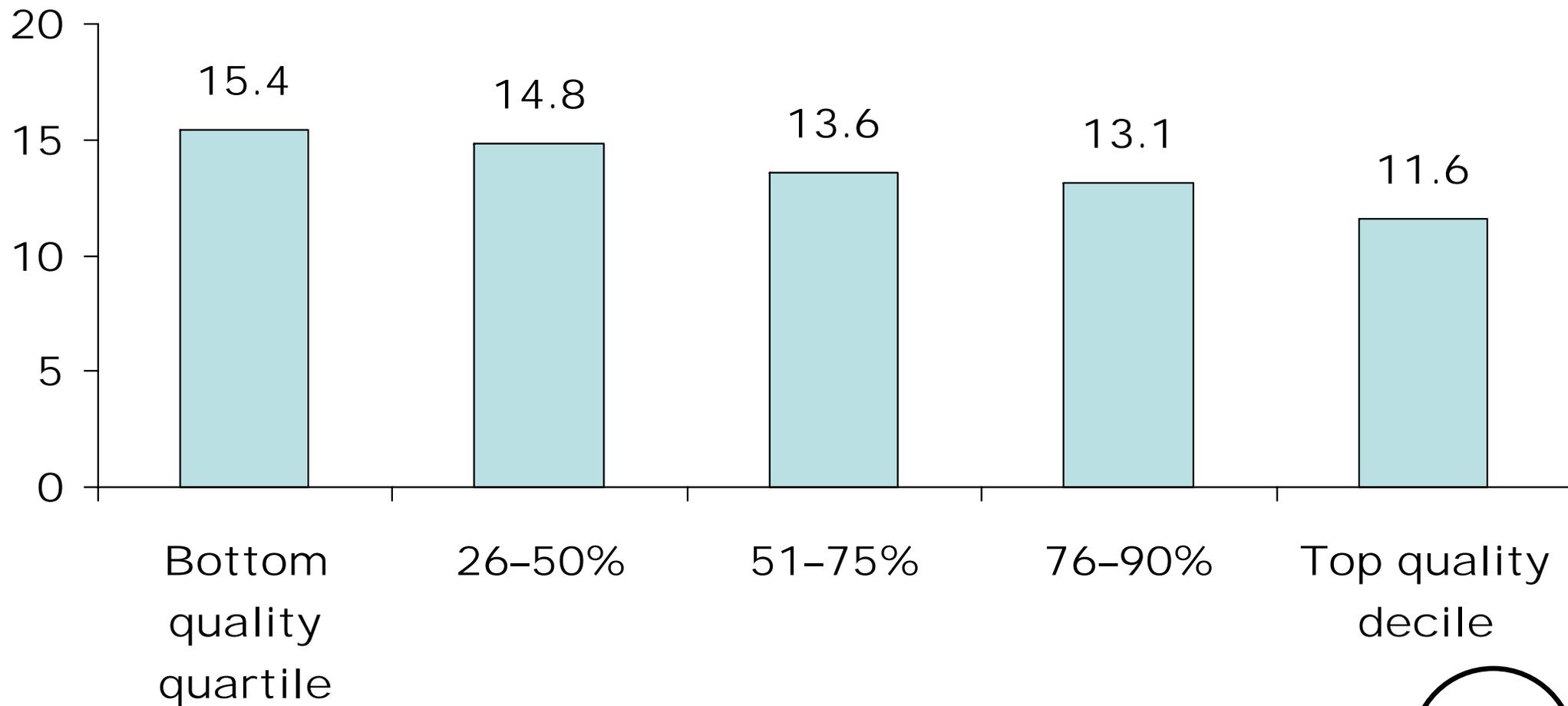
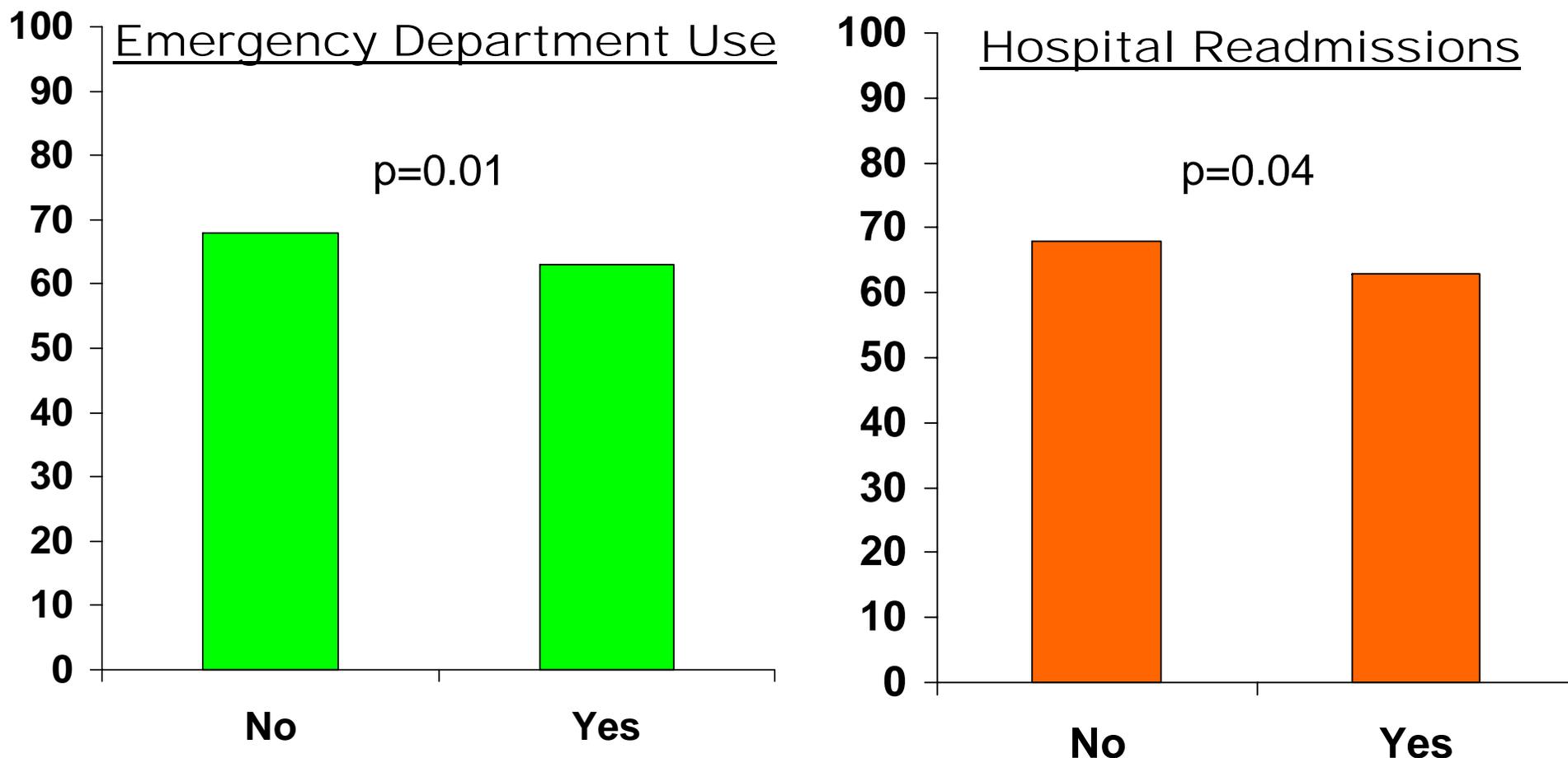


Figure 26. Coordination Across Sites of Care: Care Transition Measure Scores,* Emergency Department Use, and Hospital Readmissions



* When I left the hospital, I had a good understanding of the things I was responsible for in managing my health; when I left the hospital, I clearly understood the purpose for taking each of my medications; The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.

Source: E.A. Coleman, "Windows of Opportunity for Improving Transitional Care," Presentation to The Commonwealth Fund Commission on a High Performance Health System, March 30, 2006.

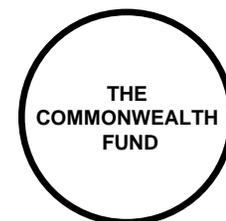
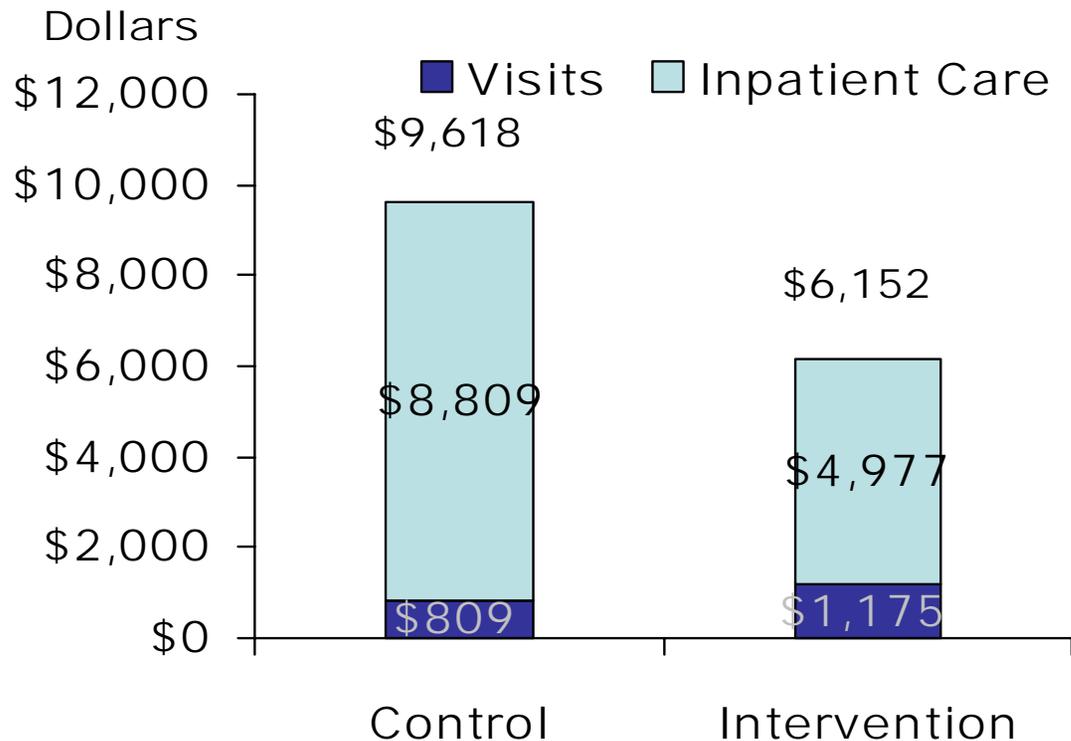


Figure 27. Improving Care Coordination and Reducing Cost

Effect of Advanced Practice Nurse Care on Congestive Heart Failure Patients' Average Per Capita Expenditures

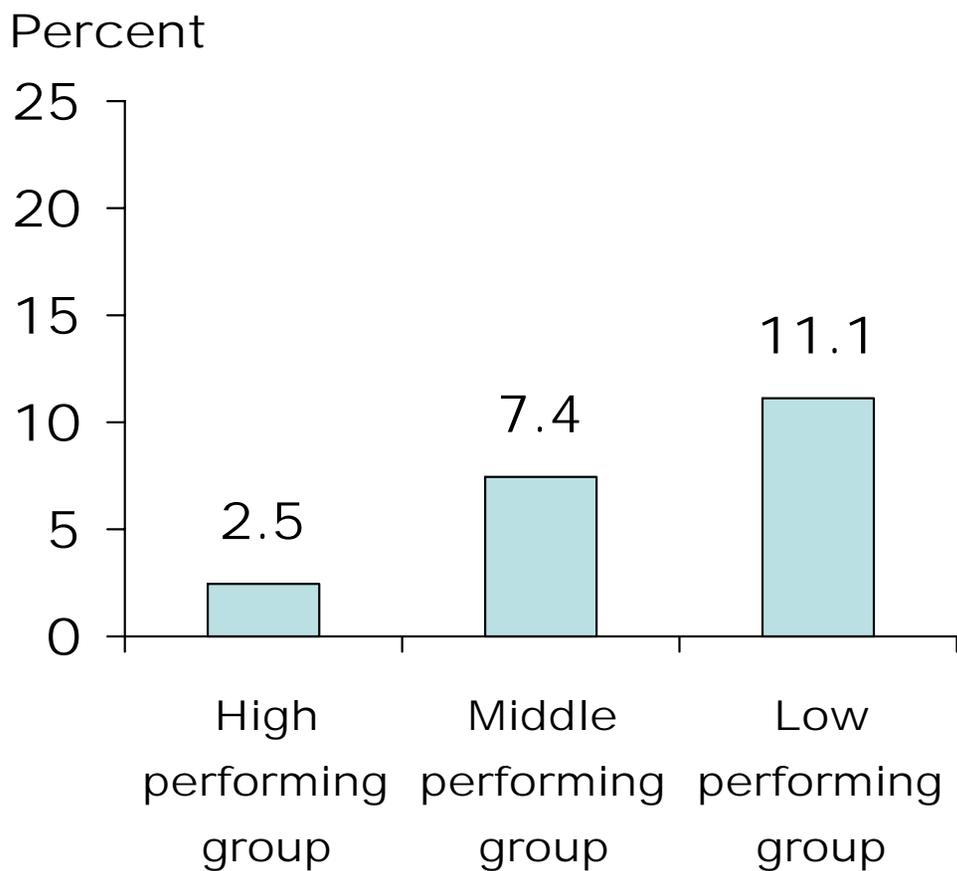


- Importance of improving transitions in care, doctor to doctor, and post-hospital
- Follow-up care following hospital discharge could reduce rehospitalization
- High cost care management could reduce errors and lower costs
- Will require restructuring Medicare benefits and incentives

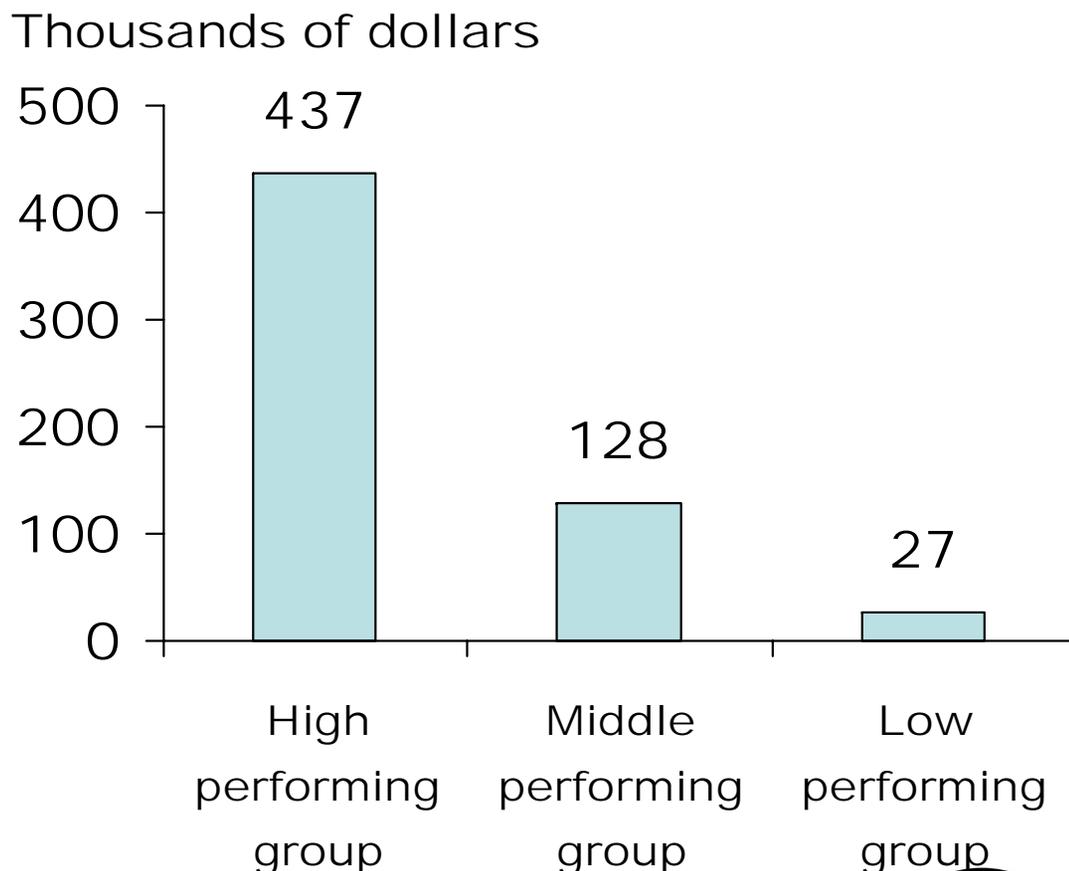


Figure 28. Improvement in Doctors' Cervical Cancer Screening Rates Compared to Bonus Payments After Implementation of Quality Incentive Program

Improvement in Screening Rates



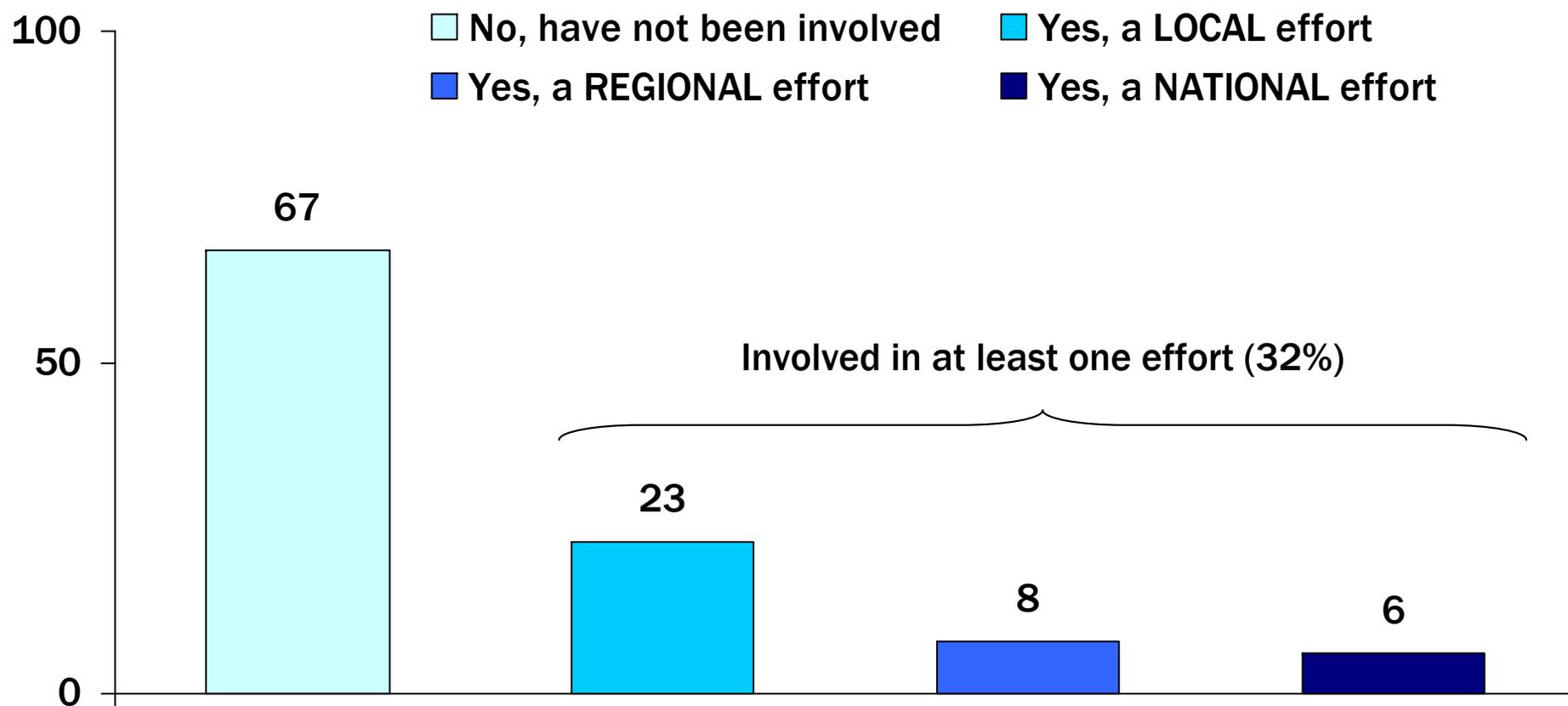
Bonuses Received



Source: M.B. Rosenthal et al., "Early Experience with Pay-for-Performance: From Concept to Practice," *JAMA* 294, no. 14 (October 7, 2004): 1788-93.

Figure 29. Most Physicians Have Not Been Involved in Collaborative Efforts to Improve Quality of Care

Percent indicating involvement in any collaborative efforts in past two years*

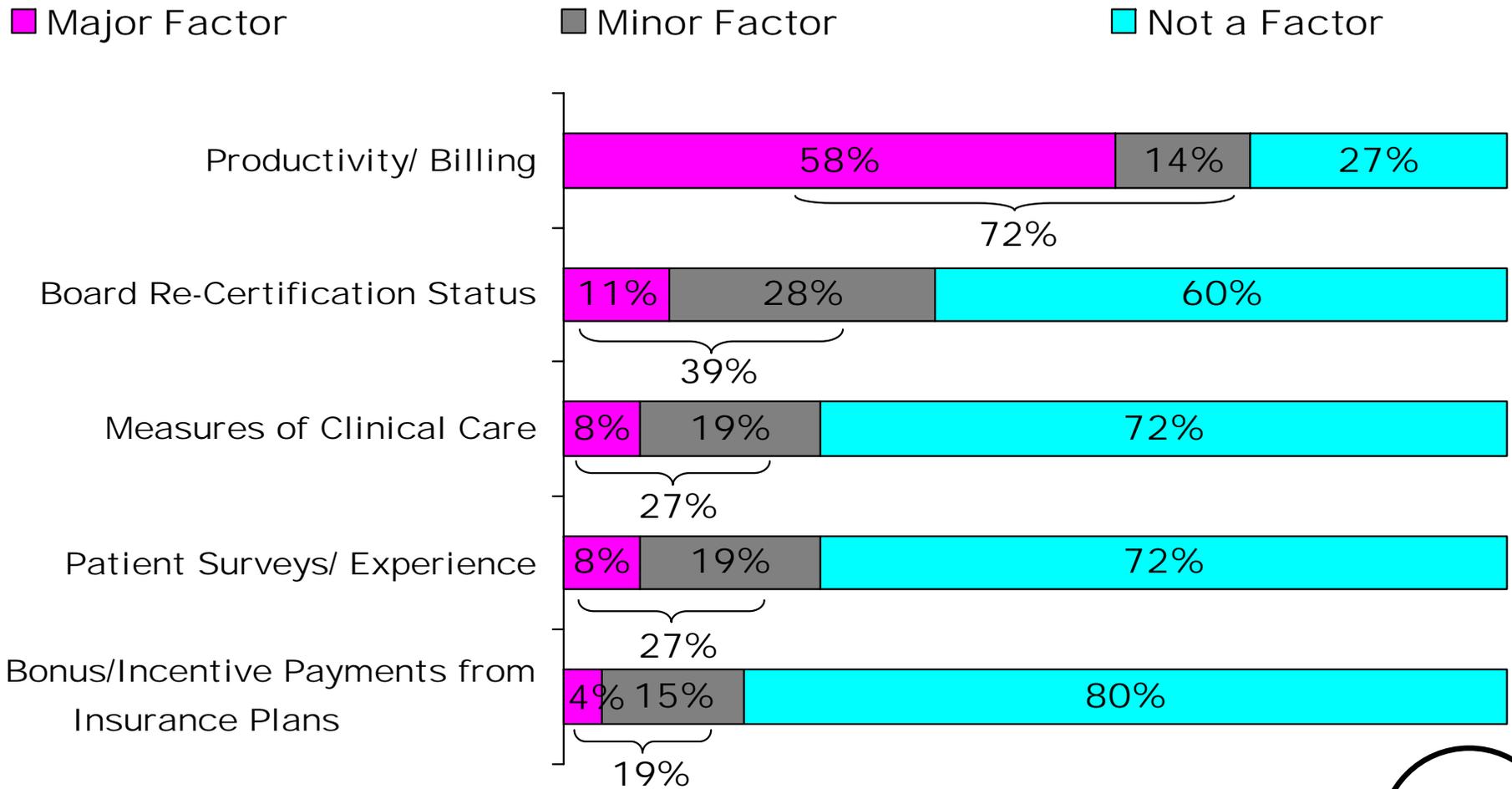


* Multiple answers possible.

Source: The Commonwealth Fund National Survey of Physicians and Quality of Care.



Figure 30. Current Factors Affecting Physicians' Compensation



Source: The Commonwealth Fund 2003 National Survey of Physicians and Quality of Care.