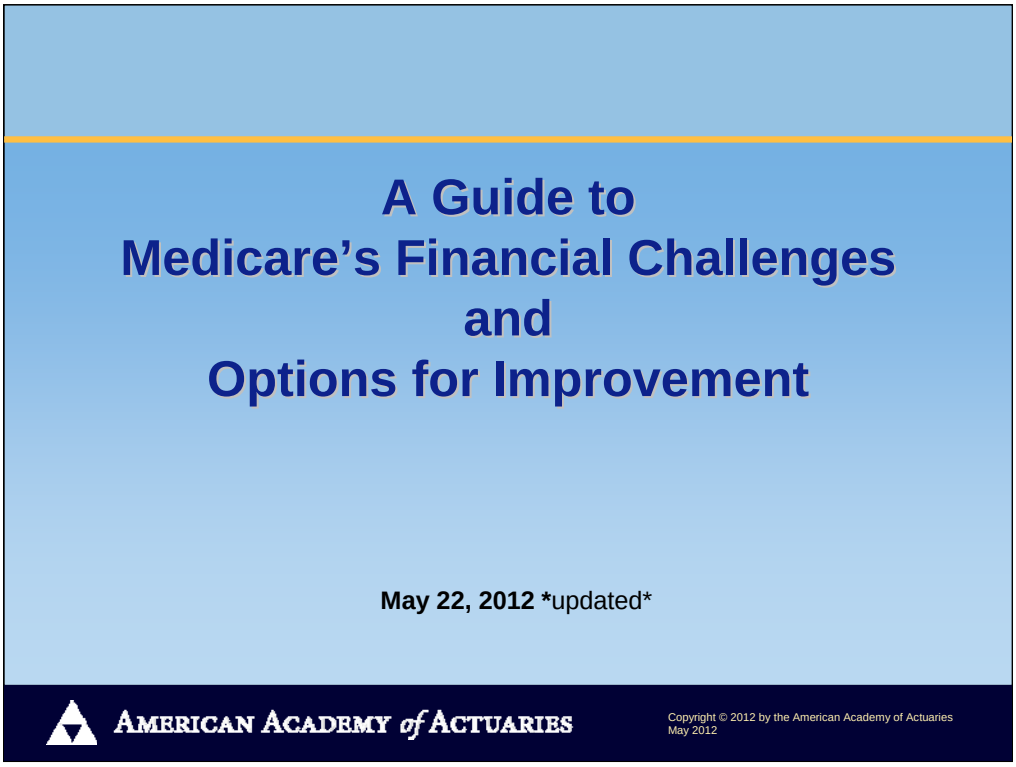


Notes for speakers:

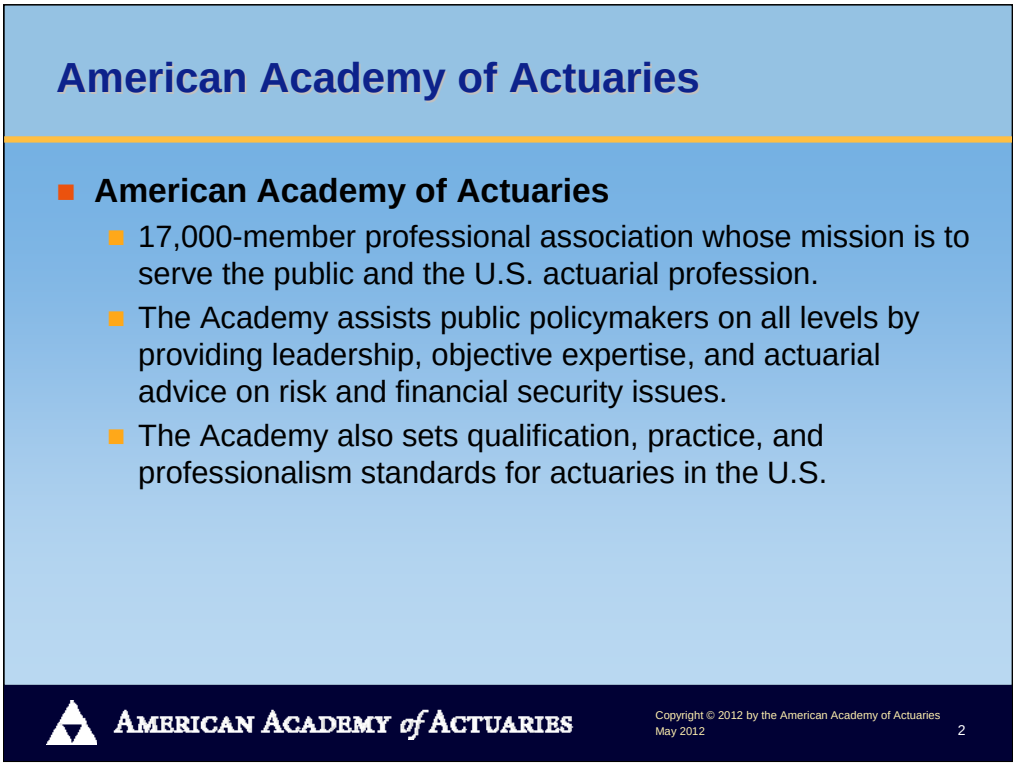
Presentation of the full slide deck will take approximately 25 to 30 minutes, allowing for a moderate amount of audience participation during the presentation.

If the time available for presentation is limited to 15 to 20 minutes, we suggest using slides 1 through 12 only; slides 11 and 12 provide the basis for a short oral summary of the various reform options that have been proposed.

If the time available is less than 15 minutes, we recommend using slides 1 through 10 and focusing the presentation solely on Medicare's financial problems and the need for prompt and decisive action to address them.

Before presenting this material, we strongly recommend that the speaker read the following two Academy issue briefs:

- Medicare's Financial Condition: Beyond Actuarial Balance (May 2012) http://www.actuary.org/pdf/health/Medicare%20Trustees%20IB%20FINAL%20052112.pdf
- An Actuarial Perspective on Proposals to Improve Medicare's Financial Condition (May 2011) http://www.actuary.org/pdf/Medicare_Financial_IB_Final_051211.pdf



Notes for speakers:

***Key concept*:** The Academy is a *non-partisan* organization, meaning our goal is to provide *objective* information on public policy issues to policymakers, regulators, the media, and the public.

Understanding Medicare's current challenges: three things you need to know

- How Medicare is financed
- The facts about Medicare's financial condition (findings from the 2012 Medicare Trustees Report)
- Some current proposals for improving Medicare's financial condition

Structure of the Medicare trust funds

	Hospital Insurance trust fund (HI)	Supplementary Medical Insurance trust fund (SMI)
Benefits	Part A inpatient hospital care	Part B physician and outpatient care; Part D prescription drug benefit
Financing	Payroll taxes	Beneficiary premiums and general tax revenues

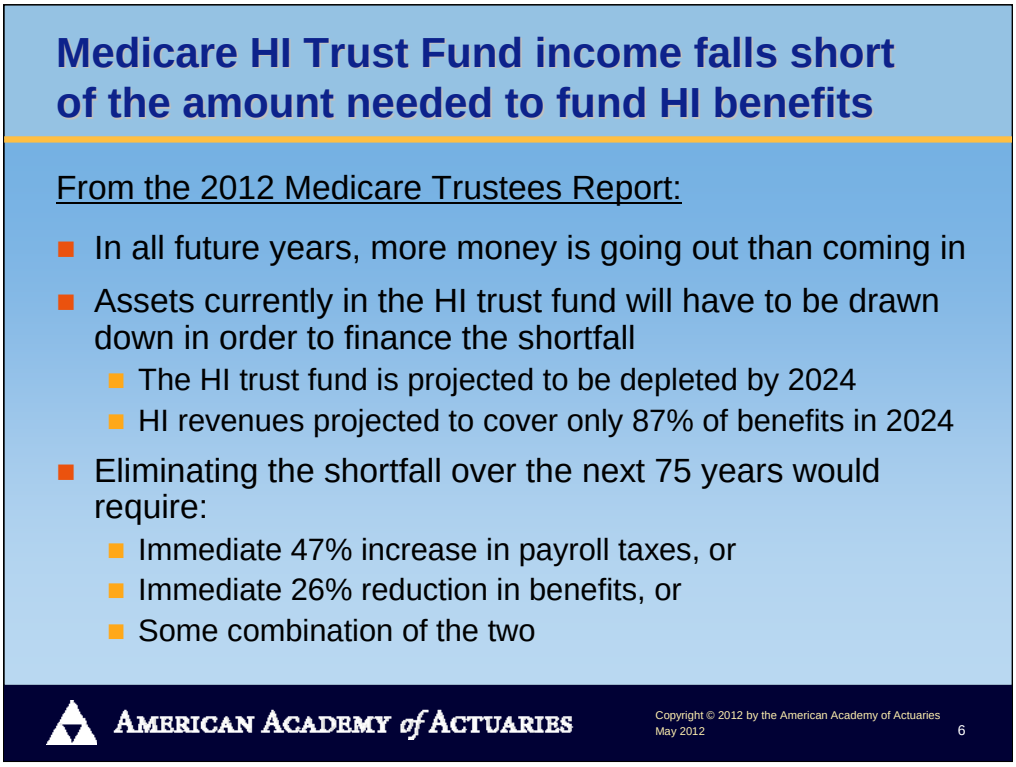
Note: Medicare Advantage (MA) plans, also known as Medicare Part C, cover inpatient hospital care as well as physician and outpatient care. They can also cover prescription drugs. MA plans are funded through both the HI and SMI trust funds.

Notes for speakers:

***Key concept*:** Medicare's funding is structured around two separate trust funds and that the two are financed very differently.

What is Medicare's financial condition?

- Income to the HI trust fund is not enough to cover the HI portion of Medicare benefits
- Increases in SMI spending will increase both beneficiary premiums and the cost to the federal government
- Increases in overall Medicare spending threaten the program's sustainability

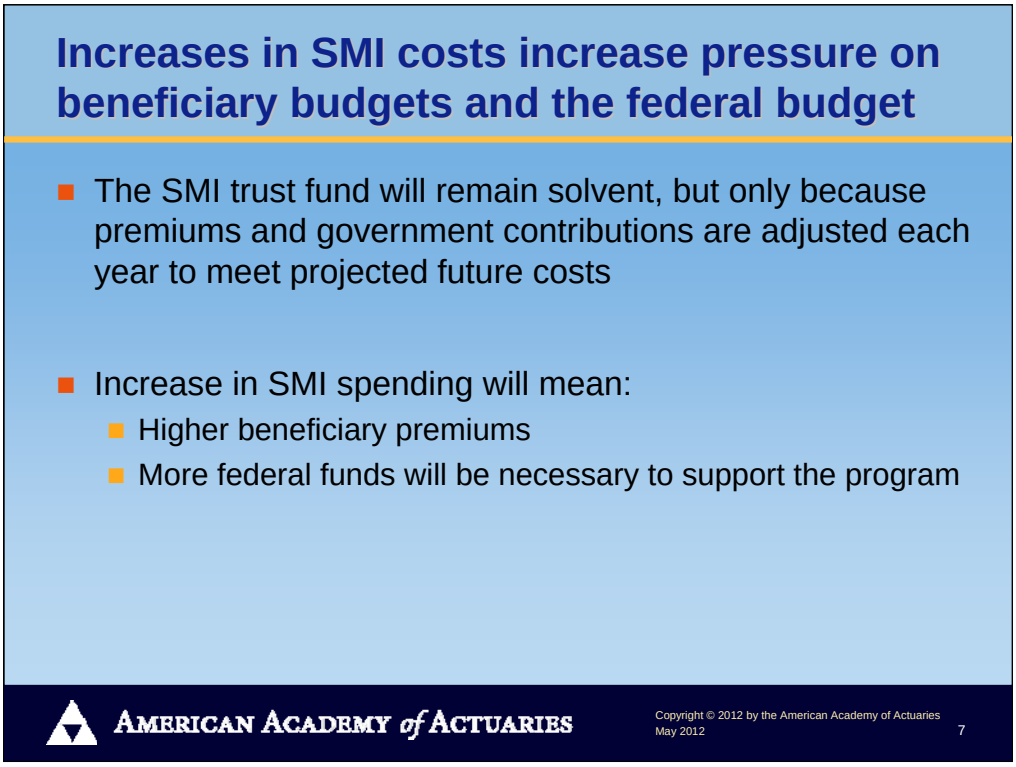


Notes for speakers:

Key concept: The longer we wait, the worse the financial condition of the program becomes, and the more drastic any fix will have to be.

Additional points not included on the slide:

- The funding deficit over the next 75 years is 1.35% of taxable payroll. The current Medicare payroll tax rate is 1.45% of payroll for both employees and employers. The self-employed pay 2.90% of payroll. Beginning in 2013, earnings exceeding $200,000 for individuals and $250,000 for couples are subject to additional HI tax of 0.9%.
- The trustees' report projections must be based on *current-law* benefits and revenues. The recent health care reform law (the Affordable Care Act or ACA) includes provisions intended to limit the growth of provider payments to reflect productivity improvements. Projections under a Centers for Medicare and Medicaid Services (CMS) alternative analysis illustrate the results if these reductions are not fully implemented.
- Under the illustrative alternative scenario:
    - The ACA-required downward adjustments to provider payment increases are phased down from about 1.1% to 0.4%.
    - HI trust fund would be depleted a few months earlier in 2024.
    - HI deficit over the next 75 years = 2.43% of taxable payroll (vs. 1.35% under current law).



Notes for speakers:

Key concept: Automatically resetting the funding each year does *not* mean that the level of SMI spending doesn't matter.

Additional points not included on the slide:

- CMS projects SMI spending to grow from 2.0% of GDP in 2011 to 4.0% in 2085.
- Current-law projections likely understate SMI expenditures.
- There is an existing mechanism, the Sustainable Growth Rate (SGR) formula, that is intended to limit the growth in physician payments.
- Congress has a history of overriding scheduled SGR reductions in physician payment rates.
- SMI projections under CMS alternative analysis:
  - Replace SGR reductions in physician payment rates with 1% increases throughout the short range projection period thereafter transitioning to the rate of per capita growth in health expenditures.
  - The ACA-required downward adjustments to provider payment increases are phased down from about 1.1% to 0.4%.
  - The alternative projections show SMI spending growing from 2.0% of GDP in 2011 to 6.0% in 2085.

Increases in total Medicare spending threaten the program's sustainability

- Medicare spending is expected to grow faster than the Gross Domestic Product (GDP), which means that more of the U.S. economy will be devoted to Medicare over time
  - According to the Medicare trustees, Medicare spending is projected to increase from 3.7% of GDP in 2011 to 5.3% in 2030, and to 6.7% in 2085
- A smaller part of the economy will be available for other priorities

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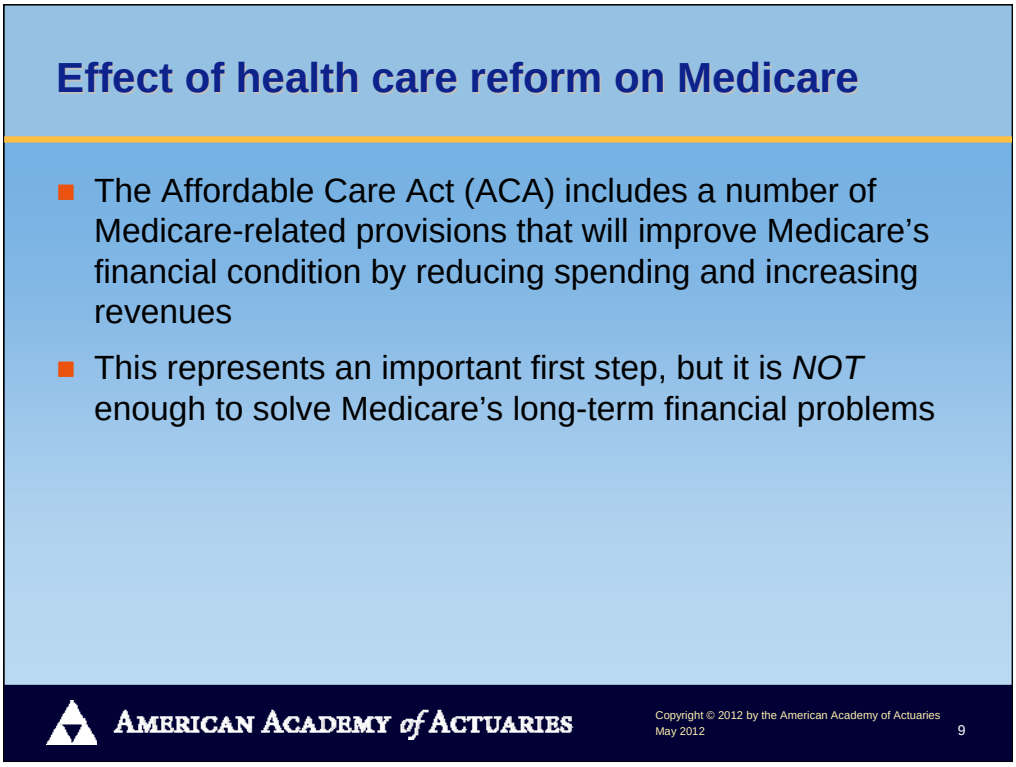
Notes for speakers:

CMS alternative projections, which assume that provider payment reductions will not be fully implemented, show total Medicare spending rising from 3.7% of GDP in 2011 to 5.8% in 2030, and to 10.3% of GDP in 2085.



Notes for speakers:

Major Medicare provisions of the Affordable Care Act (ACA):

- A reduction in the growth in provider payments to reflect increases in productivity.
- A phase down in Medicare Advantage plan payments to reflect fee-for-service costs.
- Health care payment and delivery system improvements (e.g., bundled payments, accountable care organizations).
- An authorization to create the Independent Payment Advisory Board (IPAB).
- An increase in Medicare revenues (e.g., HI payroll tax increases for earnings above threshold, income-related Part D premiums).

We need action now

- Medicare continues to face serious long-term financial challenges
- Improving Medicare's financial condition will require:
  - Increasing revenues,
  - Reducing spending, or
  - Some combination of both

"The sooner solutions are enacted, the more flexible and gradual they can be."

--2012 Medicare Trustees Report

What are some of the specific options?

- Limit the growth in health spending
- Transition to a premium support or voucher program
- Expand the authority of the Independent Payment Advisory Board (IPAB) established by the ACA
- Reform the Sustainable Growth Rate system
- Reduce spending for prescription drugs
- Revise the "traditional Medicare" fee-for-service (FFS) benefit design and cost-sharing requirements
- Raise the Medicare eligibility age
- Increase Medicare Part B premiums

Notes for speakers:

These options are all taken from the Medicare-related provisions included in recent debt- and deficit-reduction proposals.

Choosing among the options

- How can we evaluate a proposal for improving Medicare's financial condition? Some criteria include:
  - How it affects the cost of the program
  - How it affects beneficiaries' access to care
  - How it affects the quality of care
  - Whether it slows the growth in health spending, rather than just shifting costs from one payer to another
  - Whether it gives health care providers, and their patients, incentives that encourage the kind of integrated and coordinated care that could help both control costs and improve quality

Option: Limit the growth in health spending

- Set spending targets for Medicare or for all health spending that trigger automatic cuts to benefits or provider payments if exceeded
- Cost:
  - Medicare savings would depend on how aggressively (i.e., low) spending targets are set
  - Savings would be offset to the extent that costs are shifted to other payers
- Access/Quality: Depends on the specific recommendation

Option: Transition to a premium support or voucher program

- Federal government would limit amount it contributes toward Medicare coverage (or private plans)
- Beneficiaries would pay the difference between plan premiums and the government contribution
- Cost: Depending on how contribution is set, federal Medicare spending could be lower than currently projected
  - Beneficiaries could face higher premiums and cost sharing
  - Could lower spending growth by reducing utilization
- Access/Quality:
  - Access to coverage may decline if beneficiaries have to pay higher premiums
  - To bring costs down, care quality might be compromised

Option: Expand the authority of the Independent Payment Advisory Board (IPAB)

- IPAB is charged with making recommendations to reduce growth in Medicare spending if spending exceeds a targeted growth rate
- This option would remove some restrictions on IPAB's recommendations and/or give it authority over all federal health spending
- Cost: To the extent that spending growth targets are lowered, more cost savings could be achieved
- Access/Quality: Depends on specific recommendations

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Notes for speakers:

IPAB recommendations are implemented automatically unless Congress enacts comparable reductions.

- The IPAB *cannot* propose to raise revenues, increase beneficiary premiums or cost sharing, or otherwise restrict benefits or modify eligibility criteria.
- The IPAB *can* make proposals related to payments to Medicare Advantage plans, prescription drug prices, provider payment methods and rates (hospital payment changes cannot be made until 2020+).

Option: Reform the Sustainable Growth Rate (SGR) system

- SGR formula reduces physician fees if cumulative spending exceeds a specified target
- Physician fee cuts of 31% estimated for 2013
  - Scheduled fee cuts are usually overridden, but overrides are becoming more expensive
  - Large fee cuts could threaten access to care
- Option would eliminate SGR and develop a new physician payment system

Option: Reform the Sustainable Growth Rate (SGR) system (cont.)

- Cost: Eliminating SGR would increase Medicare spending projections unless offset by other spending reductions
- Access/Quality:
  - Could help maintain access to care
  - New payment system could better align payments with provision of high-value care

Option: Reduce spending for prescription drugs

- Options include:
  - Require Medicare to negotiate drug prices under Part D
  - Expand drug rebates
  - Establish a government-run Part D drug plan option
- Cost: By reducing prescription drug prices, would lower Part D spending and beneficiary premiums
- Access/Quality:
  - Could reduce pharmaceutical research and development
  - Government-run Part D option could lead to private plans leaving the market, reducing enrollee choice

Option: Revise fee-for-service (FFS) benefit design and cost-sharing requirements

- Concerns regarding current FFS plan design:
  - Deductibles are higher for inpatient care
  - Most beneficiaries have supplemental policies, reducing the financial incentive to seek cost-effective care
  - No limit on what a beneficiary may have to pay in a year
- Options include:
  - Combine Parts A and B cost-sharing and add a limit on beneficiaries' annual "out-of-pocket" spending
  - Eliminate first-dollar coverage in Medigap plans or levy excise tax on plans with first-dollar coverage

Option: Revise FFS benefit design and cost-sharing requirements (cont.)

- Cost:
  - Increasing cost-sharing requirements could reduce Medicare spending, but shift costs to beneficiaries
  - Savings also from reduced utilization
- Access/Quality:
  - Could better align beneficiary incentives for high-quality, cost-effective care
  - Low-income and chronically ill more sensitive to cost-sharing increases

Option: Raise the Medicare eligibility age

- Options include increasing Medicare eligibility age from 65 to 67 or higher and/or index it for increased longevity
- Cost:
  - Would reduce Medicare costs, but savings would be offset by increased federal spending in other areas (e.g., premium subsidies through health insurance exchanges, Medicaid)
- Access/Quality:
  - People between age 65 and new eligibility age would have to find new source of coverage
  - ACA provisions would increase the availability of other coverage sources

Option: Increase Part B premiums

- Current premiums set at 25% of costs
  - Beginning in 2007, higher-income beneficiaries pay between 35% and 80% of costs, depending on income
- Part B premiums could be increased for everyone, or raised even more for higher-income beneficiaries
- Cost: Would increase Medicare revenues by shifting costs to beneficiaries; would not affect Medicare spending
- Access/Quality: Beneficiaries unwilling or unable to pay higher Part B premiums might face reduced access to care

The bottom line

- Sooner is better than later
- Improving Medicare's long-term solvency and sustainability will ultimately require slowing the growth in health spending rather than just shifting costs from one payer to another
- Slowing the growth in health spending, while maintaining quality, will require provider payment and health care delivery systems that encourage integrated and coordinated care

What can you do?

- Understand that **there is no silver bullet**
  - There is no one, simple solution for shoring up Medicare
  - Ensuring that Medicare benefits are payable in the future will almost certainly require shared responsibility from Medicare beneficiaries, taxpayers, and health care providers
- **Learn as much as you can** about the Medicare program and its financial challenges
- **Urge your elected officials to act now** to put Medicare on a sound financial footing

Selected resources from the American Academy of Actuaries

- Medicare's financial condition
  - *Medicare's Financial Condition: Beyond Actuarial Balance* (Issue brief, May 2012)
  - *Revising Medicare's Fee-For-Service Benefit Structure* (Issue brief, March 2012)
  - *An Actuarial Perspective on Proposals to Improve Medicare's Financial Condition* (Issue brief, May 2011)
- Other related publications
  - *An Actuarial Perspective on Accountable Care Organizations* (Issue brief, June 2011)
  - *Health Insurance Coverage and Reimbursement Decisions: Implications for Increased Comparative Effectiveness Research* (Issue brief, Sept 2008)
  - *Value-based Insurance Design* (Issue brief, June 2009)

Resources from the American Academy of Actuaries (cont.)

- All publications from the American Academy of Actuaries are available at www.actuary.org
- For further information, contact:

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