An Actuarial Perspective on the 2011 Medicare Trustees' Report

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Session agenda

- Review of Medicare financing structure
- Findings from the 2011 Medicare Trustees' Report
- Medicare-related provisions in recent debt- and deficit-reduction proposals

Medicare trust fund structure

	Hospital Insurance (HI)	Supplementary Medical Insurance (SMI)
Benefits	Inpatient hospital care	Physician and outpatient care; Part D prescription drug benefit
Financing	Payroll taxes	Beneficiary premiums and general tax revenues

Medicare financing challenges

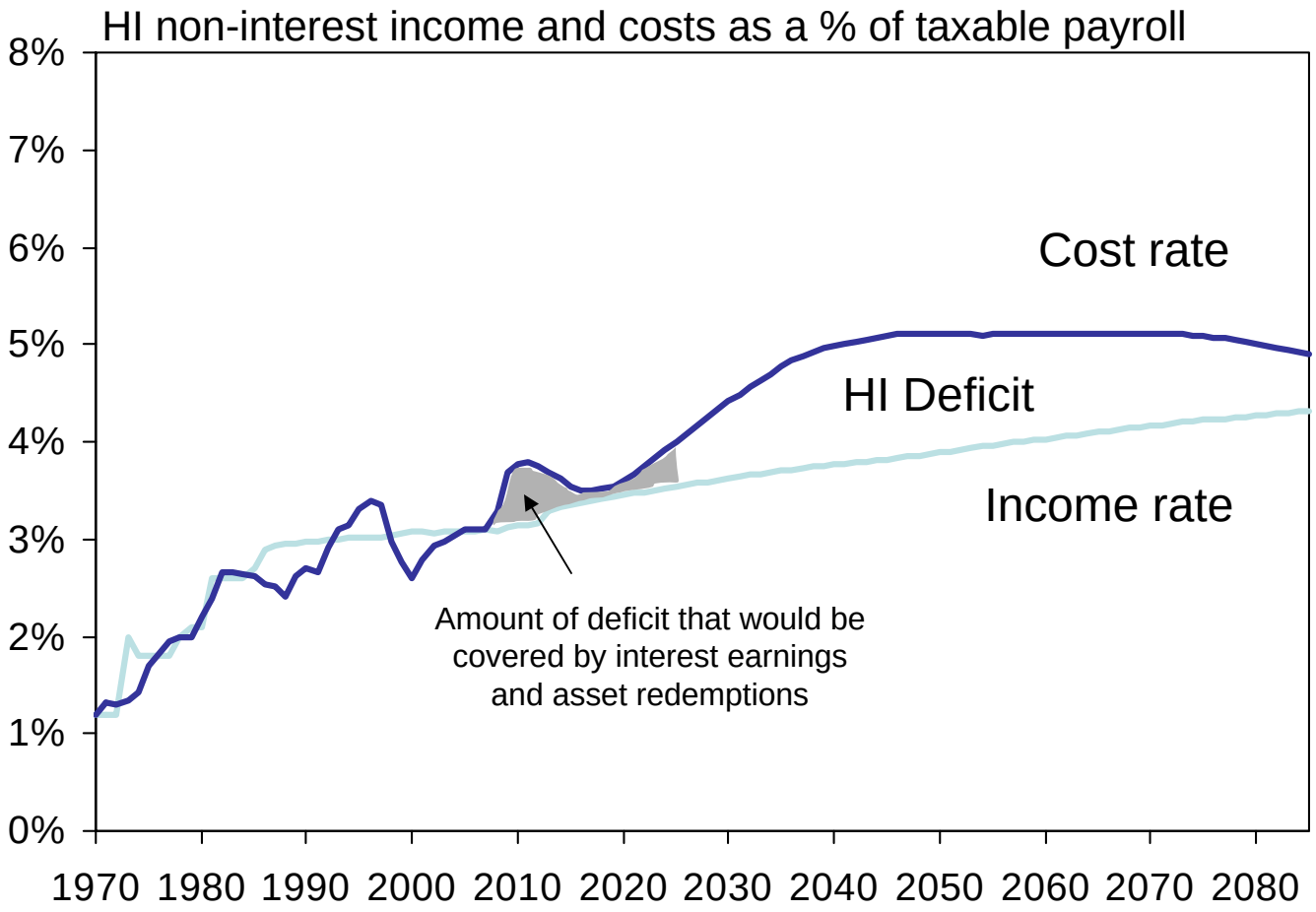
- Income to the HI trust fund is not adequate to fund the HI portion of Medicare benefits
- Increases in SMI costs increase pressure on beneficiary household budgets and the federal budget
- Increases in total Medicare spending threaten the program's sustainability

Medicare HI Trust Fund income falls short of the amount needed to fund HI benefits

From the 2011 report:

- In all future years, more money is going out than coming in
- Trust fund depletion is projected by 2024
- This is five years earlier than 2010 projection due to:
  - Lower real payroll tax revenues due to a slower assumed economic recovery
  - Higher real expenditures due to higher assumed near-term wage growth

Long-term HI costs and income



Source: 2011 Medicare Trustees Report

Bottom line for HI trust fund: current-law projections

- HI tax revenues will cover 90% of benefits in 2024, when trust fund assets are projected to be depleted
- HI deficit over the next 75 years = 0.79% of taxable payroll
- Eliminating 75-year deficit would require:
  - Immediate 24% increase in payroll taxes, or
  - Immediate 17% reduction in benefits, or
  - Some combination

HI trust fund projections worsen under illustrative alternative scenario

- Trustees' report projections must be based on current-law benefits and revenues
- Projections under a CMS alternative analysis assume the Affordable Care Act (ACA)-required reductions in provider payment updates to reflect productivity adjustments will be phased out
- Under the illustrative alternative scenario:
  - HI trust fund would be depleted in 2024
  - HI deficit over the next 75 years = 2.15% of taxable payroll (vs. 0.79% under current law)

Increases in SMI costs increase pressure on beneficiary budgets and the federal budget

- The SMI trust fund will remain solvent, but only because its financing is reset each year to meet projected future costs

- Projected increases in SMI expenditures will require significant increases in beneficiary premiums and general revenue contributions

Current-law projections likely understate SMI expenditures

- Scheduled physician payment reductions in accordance with the sustainable growth rate (SGR) mechanism are unlikely to occur
- Reductions in provider payment updates to reflect productivity improvements may not be sustainable
- SMI projections under CMS alternative analysis:
  - Phase out the ACA-required productivity adjustments to provider payment updates
  - Replace SGR reductions in physician payment rates with updates based on the Medicare Economic Index

SMI expenditures as a percent of GDP

Calendar Year	2011 Trustees Report (current law)	2011 Alternative Projection
2010	1.9	1.9
2020	2.3	2.6
2030	3.1	3.7
2040	3.5	4.5
2050	3.6	5.0
2060	3.8	5.5
2070	4.0	6.0
2080	4.1	6.4

Sources: 2011 Medicare Trustees' Report; CMS Office of the Actuary

Increases in total Medicare spending threaten the program's sustainability

- Because Medicare spending is expected to grow faster than GDP, greater shares of the economy will be devoted to Medicare over time

- Fewer shares of the economy will be available for other priorities

Total Medicare expenditures as a percent of GDP

Calendar Year	2011 Trustees Report (current law)	2011 Alternative Projection
2010	3.6	3.6
2020	4.0	4.3
2030	5.2	5.9
2040	5.8	7.1
2050	5.9	8.0
2060	6.1	8.8
2070	6.2	9.6
2080	6.3	10.4

Sources: 2011 Medicare Trustees' Report; CMS Office of the Actuary

Policymakers should implement reforms to improve Medicare's outlook

- The ACA contains provisions designed to reduce costs, increase revenues, and develop new health care delivery systems and payment models that improve health care quality and cost efficiency
- Additional steps are needed to solve Medicare's financial challenges
- The sooner corrective measures are enacted, the more flexible the approach and the more gradual the implementation can be

Options to improve Medicare's financial condition

- Medicare-related provisions in recent debt- and deficit-reduction proposals:
  - Limit growth in health spending
  - Transition to a premium support or voucher program
  - Expand authority of the Independent Payment Advisory Board (IPAB)
  - Reform the SGR system
  - Revise fee-for-service (FFS) benefit design and cost-sharing requirements
  - Raise Medicare eligibility age
  - Increase Medicare Part B premiums

Considerations when evaluating options to improve Medicare's financial condition

- Impact on cost, access, and quality
- Improving long-term sustainability requires slowing the growth in health spending—rather than shifting costs from one payer to another
- Payment and delivery systems that better align incentives to encourage integrated and coordinated care have the potential to control costs and improve quality

Option: Limit the growth in health spending

- Set spending targets (e.g., GDP+1%) for Medicare or for all health spending
- If targets exceeded, certain actions are triggered (e.g., automatically reduce benefits or provider payments)
- Cost:
  - Medicare savings would depend on how aggressively spending targets are set
  - Savings would be offset to the extent that costs are shifted to other payers
- Access/Quality: Would depend on the specific recommendations made

Option: Transition to a premium support or voucher program

- Would change Medicare from defined benefit plan to defined contribution plan
- Government would limit amount it contributes toward Medicare coverage (or private plans)
- Beneficiaries would pay the difference between plan premiums and the government contribution

Option: Transition to a premium support or voucher program (cont.)

- Cost: Depending on how government contribution is set, federal Medicare spending could be lower than currently projected
  - To extent spending growth exceeds increase in government contribution, costs shifted to beneficiaries through higher premiums/cost sharing
  - Could lower spending growth due to reduced utilization
- Access/Quality:
  - Access to coverage depends on difference between government contribution and premium
  - To bring costs down, care quality might be compromised

Option: Expand the authority of the IPAB

- IPAB is charged with making recommendations to reduce growth in Medicare per capita expenditures if spending exceeds a targeted growth rate
- IPAB is fairly restricted
- Option would expand scope of the IPAB, by removing some restrictions on its recommendations and/or giving it authority over all federal health spending
  - Expansion of scope could be tied to more ambitious spending targets

Option: Expand the authority of the IPAB (cont.)

- Cost: To the extent that spending growth targets are tightened, more cost savings could be achieved
- Access/Quality: Depends on specific recommendations made

Option: Reform the SGR system

- SGR formula adjusts physician payment updates by comparing actual cumulative physician spending to a specified target
- Physician fee cuts of 29% scheduled for 2012
- Concerns regarding SGR system include:
  - Reduced beneficiary access under large fee cuts
  - Provider frustration over short-term nature of payment fixes
  - Growing budgetary costs of further overrides
- Option would eliminate SGR and develop a new physician payment system

Option: Reform the SGR (cont.)

- Cost: Eliminating SGR would increase Medicare spending over baseline 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
  - Extend drug rebates to dual eligibles
  - Establish a government-run Part D 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 FFS benefit design and cost-sharing requirements

- Concerns regarding current FFS plan design:
  - Cost-sharing requirements skewed toward less discretionary services
  - Most beneficiaries have supplemental policies, reducing incentives to seek cost-effective care
  - Lack of out-of-pocket (OOP) limit
- Options include:
  - Combine Parts A and B cost-sharing and add OOP limit
  - Eliminate first-dollar coverage in Medigap plans
  - Move more toward value-based insurance design

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

- Normal retirement age for Social Security has been increased to age 67 and some proposals would increase it further
- Similar options would increase Medicare eligibility age and/or index it for increased longevity

Option: Raise the Medicare eligibility age (cont.)

- Cost:
  - Would reduce Medicare costs
  - Savings would be offset by increased federal spending in other areas (e.g., premium subsidies through 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
- Options would increase Part B premiums for those not already subject to higher premiums or raise them higher for those who are
- 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

Academy Next Steps

- The Academy's Medicare Steering Committee plans to explore many of these and other options

- We'll also examine new ACA programs intended to jumpstart reforms to the payment and delivery systems

Key considerations

- Improving long-term sustainability requires slowing the growth in health spending rather than shifting costs from one payer to another

- Payment and delivery systems that better align incentives to encourage integrated and coordinated care have the potential to control costs and improve quality

Questions/Comments

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