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2011 Medicare Trustees Report

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On behalf of the American Academy of Actuaries' Health Practice Council, we appreciate the opportunity to comment on the 2011 Medicare Trustees Report. We first discuss the trustees' findings and then provide insights on several Medicare-related provisions included in various debt- and deficit-reduction proposals.[1] We will highlight the following key points:

- The Medicare program has three fundamental long-range financing challenges:
  - ⇒ Income to Medicare's Hospital Insurance (HI) Trust Fund is not adequate to fund the HI portion of Medicare benefits;
  - ⇒ Increases in Medicare's Supplementary Medical Insurance (SMI) costs increase pressure on beneficiary household budgets and the federal budget; and
  - ⇒ Increases in total Medicare spending threaten the program's sustainability.

- We strongly recommend that policymakers implement changes to improve Medicare's financial outlook. The sooner such corrective measures are enacted, the more flexible the approach and the more gradual the implementation can be. Failure to act now will necessitate far more drastic actions later.

- When evaluating proposals to improve Medicare's financial condition, it is important to recognize that improving the sustainability of the health system as a whole requires slowing the growth in overall health spending rather than shifting costs from one payer to another.

MEDICARE'S FINANCIAL CONDITION

Each year, the Boards of Trustees of the Federal Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds report to Congress on the Medicare program's financial condition. The Medicare program provides health coverage for the aged and for certain individuals with disabilities.

The trustees' report is the primary source of information on the status of the Medicare program, and the Academy proudly recognizes the contribution that members of the actuarial profession have made in preparing the report and educating the public about this important issue.

The projected financial condition of Medicare in the 2011 Medicare trustees' report has deteriorated compared with the projections in the 2010 report. According to this year's report, the HI trust fund will be depleted in 2024, five years earlier than was projected a year ago. HI expenditures are expected to exceed HI revenues for every year in the projection period. Medicare expenditures will consume an increasing share of federal outlays and the gross domestic product (GDP).

According to statutory requirements, the trustees' projections of Medicare's financial outlook must be based on benefits and revenues scheduled under current law. The trustees acknowledge, however, that these estimates likely understate the seriousness of Medicare's financial condition. In the Statement of Actuarial Opinion that is required by law, Richard Foster, the chief actuary of the Centers for Medicare & Medicaid Services (CMS), specifically notes that actual Medicare expenses are likely to exceed the current-law projections. He states, "the financial projections

[1] This testimony is based on two Academy issue briefs, *Medicare's Financial Condition: Beyond Actuarial Balance* and *An Actuarial Perspective on Proposals to Improve Medicare's Financial Condition*.

shown in [the] report for Medicare do not represent a reasonable expectation for actual program operations in either the short range…or the long range…" In particular, the trustees and the chief actuary point to scheduled reductions in provider payments that are unlikely to occur. Current law requires downward adjustments in provider payment updates to reflect productivity improvements; these adjustments might not be sustainable in the long term. In addition, currently scheduled physician payment reductions in accordance with the sustainable growth rate (SGR) mechanism are considered likely to be overridden by Congress.

At the request of the trustees, the CMS Office of the Actuary developed an alternative analysis that provides an illustration of the potential understatement of current-law Medicare cost projections if the productivity adjustments are phased out and the physician payment reductions are overridden. Although the illustrative alternative projections are not intended to be interpreted as the official best estimates of future Medicare costs, they do, as noted in the alternative analysis, "help to quantify and underscore the likely understatement of the current-law projections shown in the 2011 trustees' report." This statement presents projections based on both the current law and the illustrative alternative projections.[2]

The trustees conclude: "The projections in this year's [trustees'] report continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected exhaustion of the HI trust fund, this fund's long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare are overridden, the financial challenges in the long range would be much more severe."

Because Medicare plays a critically important role in ensuring that older and disabled Americans have access to health care, the American Academy of Actuaries' Health Practice Council urges action to restore the long-term solvency and financial sustainability of the program. The sooner such corrective measures are enacted, the more flexible the approach and the more gradual the implementation can be. Failure to act now will necessitate far more drastic actions later.

Medicare Financing Problems

The Medicare program has three fundamental long-range financing challenges:

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

Each of these problems is discussed in more detail below.

Medicare HI Trust Fund Income Falls Short of the Amount Needed To Fund HI Benefits

Like the Social Security program, Medicare relies on trust funds to account for all income and expenditures. The HI and SMI programs operate separate trust funds with different financing

[2] Both the 2011 Medicare Trustees Report and the CMS Office of the Actuary's illustrative alternative scenario analysis are available at: http://www.cms.gov/ReportsTrustFunds/.

mechanisms. General revenues, payroll taxes, premiums, and other income are credited to the trust funds, which are used to pay benefits and administrative costs. Any unused income is required by law to be invested in U.S. government securities for use in future years. In effect, the trust fund assets represent loans to the U.S. Treasury's general fund. The HI trust fund (Part A), which pays for hospital services, is funded primarily through earmarked payroll taxes.

The trustees' report's projections of Medicare's financial outlook must be based on current law. Under these current-law projections, the financial condition of the HI trust fund has deteriorated since the 2010 trustees' report. This deterioration results from lower real (inflation-adjusted) payroll tax revenues due to a slower assumed economic recovery, and from higher real expenditures due to higher assumed near-term wage growth. The projected trust fund exhaustion date is five years earlier than in last year's report, and the 75-year HI deficit increased from 0.66 percent of taxable payroll to 0.79 percent.

- HI expenditures currently exceed HI revenues. Although the gap is projected to narrow over the next few years, HI expenditures are expected to exceed revenues, including interest income, throughout the 75-year projection period. The HI trust fund assets, therefore, will need to be redeemed. If the federal government is experiencing unified budget deficits, funding the redemptions will require that additional money be borrowed from the public, thereby increasing the federal debt.

- The HI trust fund is projected to be depleted in 2024. At that time, payroll tax revenues are projected to cover only 90 percent of program costs, with the share declining to 76 percent in 2050 but then increasing to 88 percent by 2085. There is no current provision for general fund transfers to cover HI expenditures in excess of dedicated revenues.

- The projected HI deficit over the next 75 years is 0.79 percent of taxable payroll. Eliminating this deficit would require an immediate 24 percent increase in payroll taxes or a 17 percent reduction in benefits—or some combination of the two. Delaying action would require more drastic changes in the future.

Current-law projections, however, likely understate the fiscal challenges to the Medicare HI trust fund. In particular, the scheduled reductions in provider payment rate updates to reflect productivity adjustments may not be sustainable in the long term. At the request of the trustees, the CMS Office of the Actuary provided an illustrative alternative analysis that phases out the productivity adjustments gradually over 16 years, beginning in 2020.

Under the illustrative alternative scenario, the HI trust fund also would be depleted in 2024, but the projected deficit over the next 75 years would be 2.15 percent of taxable payroll—nearly triple that under current-law projections. Eliminating this deficit would require an immediate 74 percent increase in payroll taxes or a 36 percent reduction in benefits—or some combination of the two.

Increases in SMI Costs Increase Pressure on Beneficiary Household Budgets and the Federal Budget

The SMI trust fund includes accounts for the Part B program, which covers physician and outpatient hospital services, and the Part D program, which covers the prescription drug

program. Approximately one-quarter of SMI spending is financed through beneficiary premiums, with federal general tax revenues covering the remaining three-quarters.[3]

The SMI trust fund is expected to remain solvent because its financing is reset each year to meet projected future costs. As a result, increases in SMI costs will require increases in beneficiary premiums and general revenue contributions. Increases in general revenue contributions will put more pressure on the federal budget.

Similarly, premium increases will place pressure on beneficiaries, particularly in conjunction with increasing beneficiary cost-sharing expenses. The average beneficiary expenses (premiums and cost sharing) for Parts B and D combined currently are 27 percent of the average Social Security benefit. These expenses are projected to increase to 46 percent of the average Social Security benefit by 2085. These expenses do not include cost sharing under Part A.

The 2011 trustees' report projects that under current law, SMI spending will continue to grow faster than GDP, increasing from 1.9 percent of GDP in 2010 to 3.1 percent of GDP in 2030, and to 4.1 percent of GDP in 2085.

The current-law projections likely understate the increases in Part B spending. Given that SGR-related physician payment reductions have been overridden every year since 2003, it is considered unlikely that future scheduled reductions will take effect in full.[4] In addition, the scheduled reductions in non-physician provider payment rate updates to reflect productivity adjustments might not be sustainable in the long term. The CMS Office of the Actuary's illustrative alternative analysis sets physician payment updates according to the increase in the Medicare Economic Index, which averages approximately 2 percent per year—rather than assuming that the SGR-related reductions take effect. In addition, the alternative analysis assumes a phasing out of the productivity adjustments gradually over 16 years, beginning in 2020. The alternative scenario projections assume no changes to the current-law Part D projections.

Under the illustrative alternative scenario projections, SMI spending would increase from 1.9 percent of GDP in 2010 to 3.7 percent of GDP in 2030, and to 6.6 percent of GDP in 2085.

[3] Part B beneficiaries pay monthly premiums covering approximately 25 percent of program costs; general revenues cover the remaining 75 percent of costs. Part D premiums are set at approximately 25 percent of Part D costs. Because of low-income premium subsidies, however, beneficiary premiums will cover only approximately 11 percent of total Part D costs in 2011. State payments on behalf of certain beneficiaries will cover approximately 11 percent of costs and general revenues will cover the remaining 78 percent of costs.

[4] The sustainable growth rate (SGR) system was enacted as part of the Balanced Budget Act of 1997 to limit the growth in spending for physician services. The system compares actual cumulative spending to a specified spending target. If actual spending exceeds the target, then physician payment updates are adjusted downward. A cumulative reduction of 30 percent is estimated over the next two years.

Table 1: SMI Expenditures as a Percent of GDP

Calendar Year	2011 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
2085	4.1	6.6

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

Increases in Total Medicare Spending Threaten the Program's Sustainability

A broader issue related to Medicare's financial condition is whether the economy can sustain Medicare spending in the long run. To help gauge the future sustainability of the Medicare program, we point to the share of GDP that will be consumed by Medicare. Because Medicare spending is expected to continue growing faster than GDP, greater shares of the economy will be devoted to Medicare over time, meaning smaller shares of the economy will be available for other priorities.

According to the current-law projections, Medicare expenditures as a percentage of GDP will grow from 3.6 percent of GDP in 2010 to 6.2 percent of GDP in 2085. Under the CMS Office of the Actuary alternative scenario, however, total Medicare expenditures would nearly triple to 10.7 percent of GDP in 2080.

Table 2: Total Medicare Expenditures as a Percent of GDP

Calendar Year	2011 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
2085	6.2	10.7

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

Action Is Needed to Improve Medicare Solvency and Sustainability
The Affordable Care Act (ACA) contains numerous provisions designed to reduce Medicare costs, increase Medicare revenues, and develop new health care delivery systems and payment models that improve health care quality and cost efficiency. Additional steps need to be taken, however, to address the long-term financial challenges to Medicare.

The HI trust fund is projected to be depleted in 2024, and Medicare spending will continue to grow faster than the economy—increasing the pressure on beneficiary household budgets and the federal budget and threatening the program's sustainability. If Medicare projections are calculated using assumptions that productivity adjustments are phased out and physician payment reductions are overridden, Medicare's financial condition is shown to be even worse than under current-law projections.

Even under the current-law projections, there are still significant concerns about Medicare's sustainability. As such, it is important for policymakers to implement changes to improve Medicare's financial outlook.

We agree with the 2011 trustees when they say:

> *We believe that solutions can and must be found to ensure the financial integrity of HI in the short and long term and to reduce the rate of growth in Medicare costs through viable means, building on the measures enacted as part of the Affordable Care Act. Consideration of such further reforms should occur in the near future. The sooner the solutions are enacted, the more flexible and gradual they can be. Moreover, the early introduction of reforms increases the time available for affected individuals and organizations—including health care providers, beneficiaries, and taxpayers—to adjust their expectations. We believe that prompt action is necessary to address these challenges.*

And we wish to underscore this call for action.

OPTIONS TO REFORM MEDICARE

Improving Medicare's financial condition requires efforts beyond those already enacted in the ACA. Slowing the growth in health spending is needed not only to improve the program's solvency and sustainability, but also to help put the country on a more sustainable fiscal path. To this end, debt- and deficit-reduction proposals put forward by various groups, such as the National Commission on Fiscal Responsibility and Reform, include provisions to control health spending.[5] Some of the Medicare-related provisions in these proposals are outlined below, including a summary of key cost, access, and quality issues from an actuarial perspective.

When evaluating proposals to improve Medicare's financial condition, it is important to recognize that improving the sustainability of the health system as a whole requires slowing the growth in overall health spending rather than shifting costs from one payer to another. So unless

[5] See The Henry J. Kaiser Family Foundation, "Comparison of Medicare Provisions in Deficit-Reduction Proposals," (last modified April 4, 2011) for a side-by-side comparison of key Medicare changes recommended by various debt and deficit reduction proposals.

system-wide spending is addressed, implementing options to control Medicare spending will have limited long-term effectiveness.

Limit the Growth in Medicare Spending

Some recent proposals would set spending targets, either for Medicare in particular, or for federal health spending in total. Exceeding those targets could trigger specific actions, such as automatically reducing benefits or increasing revenues. The trigger, alternatively, could be structured to require the president or a commission to submit proposals that would be considered by Congress on an expedited basis.[6] One approach, for instance, would set target spending for all federal health expenditures at the growth in gross domestic product (GDP) plus 1 percent. If the target is exceeded, the president would be required to submit proposals to reduce spending. Another approach automatically would reduce fee-for-service provider payments by 1 percent if general revenue contributions to Medicare exceed 45 percent of Medicare funding. (As discussed below, the ACA created the Independent Payment Advisory Board, or IPAB, which focuses on reducing Medicare spending if it exceeds a targeted growth rate. As currently structured, the IPAB is somewhat restricted on what options it can recommend.)

Cost: Medicare savings would depend on how aggressively the spending targets are set. Savings to the health system overall, however, would be offset to the extent that costs are instead shifted to Medicare beneficiaries or other payers.

Access/Quality: The impact on the access to and quality of care would depend on the specific recommendations made. Depending on how the reductions are structured, reducing provider payment rates could reduce beneficiary access to care and/or the quality of care. Other specific options for reducing benefit costs or increasing revenues are examined in other sections of this testimony.

Transition to a Premium Support or Voucher Program

Some proposals would transition Medicare to a premium support or voucher program, while others offer such an approach as an option if certain measures to reduce Medicare spending growth are not deemed adequate. These approaches would change the Medicare program from a defined benefit plan to a defined contribution plan.

Under a premium support approach, the federal government would limit the amount it contributes toward Medicare coverage, with beneficiaries paying additional premiums to cover any difference between plan premiums and the government contribution. The growth in government contributions would be indexed by inflation or some other factor. Under a voucher-type approach, individuals would receive a voucher to purchase private health insurance. The voucher could be adjusted by various beneficiary characteristics—such as age, health status, geographic location, and/or income—and would be indexed by inflation or some other factor.

[6] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established one type of trigger. If in two consecutive trustees' reports general funding sources are projected to account for more than 45 percent of Medicare spending within the next seven years, the administration would be required to recommend ways to reduce this percentage. Congress is required to consider the legislation on an expedited basis. There is no requirement, however, that any legislation be enacted. The 2011 trustees' report finds that for the sixth consecutive year, the funding warning was triggered.

Cost: Moving to a defined contribution approach would shift the risk of health spending growth away from the federal government and toward beneficiaries. Depending on how the government contribution is set, federal Medicare spending could be lower than currently projected. To the extent that health spending growth exceeds the increase in the government contribution, costs would be shifted to beneficiaries through higher premiums and/or higher cost sharing. As discussed below, increased cost-sharing requirements could lower spending growth due to reduced utilization. The impact of such an approach on overall health spending would also depend on how utilization management, administrative costs, and provider payment rates under private plans would compare to those under traditional Medicare.

Access/Quality: Access to Medicare or private insurance would depend on the difference between the government contribution and the premium. The greater the share of costs that are shifted from the government to beneficiary premiums, the more likely that beneficiaries will opt for less generous plans. Although this could encourage beneficiaries to seek more cost-effective care, some may forgo needed care. In addition, to bring costs down, care quality might be compromised. Such a system, for instance, might lead to a less-expensive second tier delivery system, which may be much more limited in the types of providers available.

Expand the Authority of the Independent Payment Advisory Board (IPAB)

The ACA created the IPAB, which is similar to the Medicare Payment Advisory Commission (MedPAC).[7] The IPAB is charged with preparing recommendations to reduce the growth in Medicare per capita expenditures if spending exceeds a targeted growth rate. The targets are based on inflation until 2019, and on GDP plus 1 percent thereafter. Unlike MedPAC recommendations, IPAB recommendations would be implemented automatically unless the Congress passes legislation producing comparable reductions. The board is somewhat restricted in its recommendations--it cannot propose to ration health care, raise revenues, increase beneficiary premiums or cost sharing, or otherwise restrict benefits or modify eligibility criteria.[8] In addition, until 2020 most hospital services are excluded from the scope of payment changes that can be recommended.

Provisions included in various fiscal proposals would expand the scope of the IPAB, by eliminating the temporary carve-outs for hospital services, allowing options related to cost sharing and benefit design, and giving it authority over all federal health spending. The expansion of scope could be tied to directing IPAB to meet more ambitious spending growth targets.

Cost: To the extent that the spending growth targets are tightened, additional Medicare cost savings could be achieved, compared to current law. However, total savings would be offset to the extent that costs are shifted to beneficiaries.

Access/Quality: The impact on the access to and quality of care would depend on the specific recommendations made. Options to revise Medicare's plan design are examined in more detail below.

[7] MedPAC would continue its role as advisor to Congress on issues affecting the Medicare program and would review any IPAB proposals.

[8] Section 3403 of the Affordable Care Act: http://docs.house.gov/energycommerce/ppacacon.pdf.

Reform the Sustainable Growth Rate System

The sustainable growth rate (SGR) system was enacted as part of the Balanced Budget Act of 1997 to limit the growth in spending for Medicare physician services. The system compares actual cumulative spending for Medicare physician services to a specified spending target. If actual spending exceeds the target, then physician payment updates are adjusted downward. With the exception of 2002, the first year that physician fee cuts were called for under the SGR formula, the fee cuts have been temporarily overridden each year (i.e., the "doc fix"). As a result of the cumulative shortfall, physician payment rates will be reduced by nearly 30 percent in 2012, barring another override.

By putting pressure on physician payment updates, the SGR system might have resulted in slower growth in physician payment updates than would have occurred otherwise. There are calls, nevertheless, to reform or eliminate the SGR system due to concerns regarding beneficiary access to care under large fee cuts, provider frustration regarding the short-term nature of payment fixes, the growing budgetary costs of further overrides, and the way the system's across-the-board fee cuts poorly target those providers with the highest volume increases.[9,10] One approach would eliminate the SGR, temporarily freeze physician payments, and develop a new physician payment system. The proposal would pay for the elimination of the SGR by other reductions in Medicare and Medicaid spending.

Cost: Officially eliminating the SGR would increase Medicare spending over baseline projections including the SGR, unless offset by other spending reductions.

Access/Quality: Eliminating the SGR could help maintain beneficiaries' access to care. Depending on how a new physician payment system would be developed, it could better align payments with the provision of high-value care.

Reduce Spending for Prescription Drugs

Provisions included in various proposals would reduce payments for prescription drugs. One option would be to increase drug rebates by requiring Medicare to use its bargaining power to negotiate drug prices under the Part D program. Another option would extend drug rebates to those eligible for both Medicare and Medicaid.

Another approach would establish a federal government-run Part D option that would be offered alongside Part D private plans. The Centers for Medicare and Medicaid (CMS) would negotiate prices with prescription drug companies. However, as with Medicare Parts A and B, this ultimately could lead to CMS setting prescription drug prices.

Cost: By reducing the prices paid for prescription drugs, these options would lower Part D spending and reduce its rate of spending growth. To the extent that prescription drug companies can respond by increasing their prices in the private sector, costs would be shifted from Medicare to the private sector.

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[9] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy* (Chapter 4), March 2011.

[10] The Congressional Budget Office (CBO) estimates that replacing the SGR with a 10-year physician payment freeze would cost about $250 billion; if payments were increased over time, the cost would be even greater. (*The Budget and Economic Outlook: Fiscal Years 2011 to 2021*, January 2011.)

Lowering Part D spending would also reduce beneficiary premiums for Part D plans. In some cases the copayments for some prescription drugs could also be reduced.

Access/Quality: Reducing the prices paid for prescription drugs potentially could reduce research and development in the pharmaceutical industry. Introducing a government-run Part D option could lead to some current Part D providers leaving the market, especially if the government-run plan sets drug prices—thereby reducing the choices available to enrollees.

Revise Medicare's Fee-For-Service (FFS) Benefit Design and Cost-Sharing Requirements
Medicare, like most other health insurance plans, uses patient cost-sharing requirements (e.g., deductibles, copayments, coinsurance) to help balance plan affordability with the comprehensiveness of coverage. Patient cost sharing directly lowers Medicare spending by shifting a share of medical costs to the beneficiary. In addition, cost sharing can lower spending overall by reducing utilization. Patient cost-sharing requirements ideally align beneficiary incentives with program goals to provide quality and cost-effective care. However, Medicare's FFS cost-sharing requirements are not currently structured to meet these goals. In particular:

- The FFS cost-sharing requirements are skewed more toward less discretionary services, with high deductibles for Part A inpatient services and lower deductibles for Part B physician and outpatient services;
- Most beneficiaries have supplemental policies to fill in most or all FFS cost-sharing requirements, thereby reducing the incentives for beneficiaries to seek cost-effective care;[11] and
- The lack of an out-of-pocket maximum under FFS leaves beneficiaries unprotected against catastrophic health costs.

Provisions in various proposals would increase and/or restructure Medicare's cost-sharing requirements. A number of proposals would combine or restructure the Part A and Part B cost-sharing requirements and add a new maximum out-of-pocket limit. (Medicare Advantage plans have some flexibility on how to structure cost-sharing requirements, but as of 2011, are required to cap out-of-pocket spending.) Some of these proposals would also eliminate first-dollar coverage in Medigap plans and/or prohibit supplemental insurance from covering any new or increased cost-sharing amounts. Taken together, these changes could help encourage Medicare beneficiaries to seek cost-effective care. A value-based insurance design (VBID) also could encourage the use of cost-effective care. A VBID approach would lower the cost sharing for high-value services and increase the cost sharing for low-value services. The ACA moved Medicare in this direction by covering certain preventive services with no cost sharing. Comparative effectiveness research can facilitate the identification of low- and high-value services.

Cost: Increasing Medicare's cost-sharing requirements would reduce Medicare spending by shifting more of the costs to beneficiaries. Savings could also result by lowering utilization, especially if supplemental plans are prohibited from covering the difference. Adding an out-of-

[11] MedPAC reports that 89 percent of FFS beneficiaries in 2005 had supplemental coverage: 33 percent had individually purchased Medigap coverage, 37 percent had employer-sponsored coverage, 17 percent had Medicaid, and 2 percent had other public coverage. See *Report to the Congress: Improving Incentives in the Medicare Program* (Chapter 6), June 2009.

pocket cap would offset cost savings. Adjusting cost sharing to align incentives with effective use of services has shown promise in reducing spending in the non-Medicare market—most often for prescription drugs.[12]

Access/Quality: A restructuring of Medicare's cost-sharing requirements could better align beneficiary incentives for high-quality and cost-effective care. In addition, incorporating a maximum out-of-pocket limit would provide the catastrophic protection that the FFS program currently lacks. Such a restructuring would increase out-of-pocket spending for many beneficiaries, but decrease it for those with the greatest health care needs.

Broad increases in cost sharing, rather than targeted increases, have been shown to reduce not only unnecessary care, but also necessary care, especially among the low income and chronically ill. For this reason, some proposals would exempt lower-income beneficiaries from cost sharing increases. In addition, a VBID approach could incorporate lower cost-sharing requirements for chronic treatments.

Raise the Medicare Eligibility Age

Since the program began in 1965, beneficiaries have been eligible for full Medicare benefits at age 65, consistent with Social Security's normal retirement age at that time. Since that time, the normal retirement age for Social Security has been increased to age 67 and there are currently proposals to increase it beyond 67. Similarly, there are proposals to gradually increase the Medicare eligibility age (e.g., to age 67 or 69), and some also would index the eligibility age for increased longevity.

Cost: Raising the Medicare eligibility age would reduce the cost of the Medicare program and could increase payroll tax revenues by encouraging individuals to work beyond age 65. However, the increased revenues would be offset by increased federal spending to the extent that individuals between age 65 and the new eligibility age receive premium subsidies through the health insurance exchanges or coverage through Medicaid. In addition, some costs would be shifted to employers, states, and individuals.

Access/Quality: People between age 65 and the new eligibility age would have to find a new source of health insurance—through employer coverage, the individual market or health insurance exchanges, or other public coverage such as Medicaid—or go uninsured. Provisions in the ACA increase the availability of other coverage sources. In particular, beginning in 2014, the ACA requires that private health insurance coverage be offered on a guaranteed-issue basis, prohibits preexisting condition exclusions, and limits premium variations by age. Low- and moderate-income individuals may be eligible for premium and cost-sharing subsidies or Medicaid coverage.

Shifting individuals between age 65 and the new eligibility age into private plans would increase average premiums for private plans. This could potentially reduce insurance coverage among younger individuals if their premiums increase as a result.

[12] See for instance, "Evidence That Value-Based Insurance Can Be Effective," Michael E. Chernew, et al. Health Affairs 29(3): 530-536, March 2010.

Increase Medicare Part B Premiums
Medicare Part B premiums, initially set at 50 percent of Part B costs, currently are set at 25 percent of costs. Beginning in 2007, premiums for higher-income beneficiaries were raised to between 35 and 80 percent of costs, depending on income. The ACA temporarily freezes the index on income thresholds used to determine the premiums, which means more beneficiaries will be subject to higher premiums over time. Some proposals would increase the Part B premiums for those not already subject to higher premiums or raise them higher for those already subject to higher premiums.

Cost: Increasing Medicare premiums would increase program revenues by shifting costs to beneficiaries. But it would not reduce Medicare spending (unless some beneficiaries decide to opt out of Medicare Part B due to the higher premiums).

Access/Quality: Beneficiaries who are unwilling or unable to pay higher Part B premiums may face reduced access to care.

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The American Academy of Actuaries' Health Practice Council welcomes the opportunity to serve as an ongoing resource to policymakers and the public as solutions to Medicare's financing challenges are considered.