

A PUBLIC POLICY MONOGRAPH

Medicare Reform Options

June 2007

Medicare Steering Committee
of the Health Practice Council



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The Academy's Medicare Steering Committee, whose charge is to provide an oversight role for task forces and work groups established to address Medicare reform initiatives on behalf of the Health Practice Council, prepared this monograph. This report provides an overview of proposed reforms to the Medicare program. The intent is not to support any particular proposal, but to provide a clear, objective analysis of the options and assist the public policy process.

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MEDICARE REFORM OPTIONS

Medicare provides substantial support to older and disabled Americans in meeting their health care needs and forms a key component of the U.S. health care system. Nearly the entire population age 65 years or older is covered by Medicare. However, the Medicare program faces serious short-term and long-term financing problems. Due to the large number of Americans covered by Medicare and the considerable financial challenges facing the program, policymakers continue to debate how Medicare should be modified in response to the changing health care environment and financial needs of the program.

In terms of financing, the Medicare program is composed of two trust funds – the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. The HI trust fund covers spending for inpatient hospital services and is funded primarily through payroll taxes and interest income on trust fund assets. According to the 2007 Medicare trustees' report, HI revenues are projected to fall below HI spending in 2007, and the assets accumulated over the past years of the HI program are projected to be depleted as soon as 2019.

The SMI trust fund covers spending for physician and hospital outpatient services, as well as the new prescription drug program, and is funded through beneficiary premiums and general revenues. It is expected to remain solvent, but only because its financing is reset each year to meet projected future costs—beneficiary premiums and the amount required from general federal revenues are increased based on projected SMI costs. The increased reliance on general revenues will place increasing strains on the federal budget. In addition, as total Medicare costs increase, the program's sustainability is in question, as currently scheduled benefits will consume increasing shares of both GDP and total federal revenues.

The American Academy of Actuaries' Medicare Steering Committee recommends that policymakers implement changes to improve Medicare's long-term financial outlook. To that end, reforms are needed to effectively deal with the projected shortfall between Medicare income and spending, putting the Medicare program on sound financial ground. 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 likely necessitate far more onerous actions later.

To help policymakers explore the options available, this monograph presents various potential approaches for addressing Medicare's financial problems, along with their strengths and weaknesses. Before turning to specific options, however, the paper first provides an overview of how the Medicare program is funded and its current financial status.

OVERVIEW OF MEDICARE'S FINANCING

A comprehensive understanding of the way in which the current Medicare financing mechanisms operate is needed to understand the likely impact of different reform proposals, as well as the rationale behind them.

Both the benefit and financing structures of the Medicare program are fairly complex. In terms of benefits, traditional Medicare has two parts—Part A covers inpatient hospital services and Part B

covers physician and outpatient services. Almost everyone is automatically eligible for Medicare Part A upon reaching age 65. Others become eligible before then if they are disabled and have met certain requirements. Enrollment in Part B is optional, but the vast majority of Medicare beneficiaries choose to participate.

Traditional Medicare does not cover all health care-related services and products and requires patient cost sharing. Medicare beneficiaries can choose to forgo traditional Parts A and B coverage and opt instead for a Medicare Advantage (MA) plan (Part C), which covers both hospital and physician services. Medicare Advantage plans can offer enhanced benefits and lower cost-sharing requirements relative to traditional Medicare, but enrollees may be restricted in their choice of doctors and hospitals. The recently added Medicare Part D covers prescription drugs. Medicare beneficiaries can voluntarily purchase Part D coverage through private prescription drug plans (PDPs) or through a Medicare Advantage plan (MA-PD).¹

In terms of financing, the Medicare program has two trust funds that are financed through different methods. The Hospital Insurance (HI) trust fund pays for inpatient hospital services and is financed through earmarked payroll taxes paid by workers and their employers. The Supplementary Medical Insurance (SMI) trust fund pays for physician services, outpatient hospital services, and prescription drugs, and is financed through beneficiary premiums and general income tax revenues. (The Medicare Advantage program is financed by revenues through both the HI and SMI trust funds.) Each year, revenues into the program are deposited into the respective trust fund, and balances in the trust funds are used to pay benefits. Trust fund assets are invested in special-issue U.S. government securities that represent loans to the U.S. Treasury's general fund. As a result, the build-up of Medicare trust funds is essentially used to fund other government spending. If the federal government is experiencing unified budget deficits at the time the trust fund assets need to be drawn down, either additional taxes will need to be levied to fund the redemptions, or additional money will need to be borrowed from the public, thereby increasing the public debt.

Hospital Insurance Trust Fund

Similar to the Social Security system, the HI program is intended to be self-supporting, and is financed entirely through dedicated sources of income rather than relying on general tax revenues. Program benefits are funded primarily through:²

- Earmarked payroll taxes—\$181 billion (86 percent of HI revenues) in 2006
- Interest income from assets accumulated in the HI trust fund—\$16 billion (7 percent of HI revenues) in 2006
- A portion of the federal income taxes paid on Social Security benefits—\$10 billion (5 percent of HI revenues) in 2006
- Premiums paid by beneficiaries who voluntarily participate in the program—\$3 billion (1 percent of HI revenues) in 2006

The vast majority of HI financing comes from dedicated revenues, payroll taxes in particular. The current HI payroll tax rate is 1.45 percent of taxable earnings, payable by both employees and their employers for a total of 2.90 percent. Self-employed individuals pay both shares. Unlike the Social Security payroll tax, there is no annual limit on the earnings subject to the HI

payroll tax. Unlike the other sources of HI revenues, interest income on trust fund assets is not a dedicated revenue source but instead is a general revenue source of income.

No fail-safe mechanism exists to ensure that the HI program has enough money to continue paying scheduled benefits. The payroll tax rate, which can be changed only by an act of Congress, has been adjusted periodically to maintain the financial adequacy of the program. No changes are scheduled in current law for the HI tax rate.

Supplementary Medical Insurance Trust Fund

Unlike the HI program, the SMI program is not intended to be fully supported through dedicated sources of income. Instead, it relies heavily on general tax revenues. Beneficiaries are required to pay a monthly premium that covers about 25 percent of the costs of Part B. General tax revenues of the federal government finance the remaining 75 percent. Premiums for the voluntary Part D program are set to cover 25 percent of standard benefit costs. Because of premium subsidies and other subsidies to low-income enrollees, total Part D premiums paid by enrollees covered only 7 percent of total program costs in 2006. State payment transfers on behalf of certain low-income beneficiaries account for 11 percent of total program costs, and general revenues account for the remainder.

As with the HI trust fund, any SMI revenues that exceed SMI spending accumulate in the SMI trust fund. SMI trust fund balances are fairly small, however, and interest income generated on these balances amounted to less than one percent of total SMI trust fund revenues in 2006.³

Because the federal government bases both its contributions and the amount of premiums paid by beneficiaries on the projected cost of the program for each year, contributions into the SMI trust fund are automatically updated annually to ensure that the program has enough money to continue operating. As with HI payroll tax rates, the basic structure of this financing system can be changed only through an act of Congress.

MEDICARE'S FINANCIAL STATUS

Medicare faces serious financing problems. The HI trust fund is expected to be depleted by 2019, and at that point, income is projected to cover only 79 percent of the HI scheduled benefits. In addition, Medicare spending will comprise larger shares of the federal budget and the economy as a whole, potentially affecting funding available for other needs.

Trust Fund Solvency

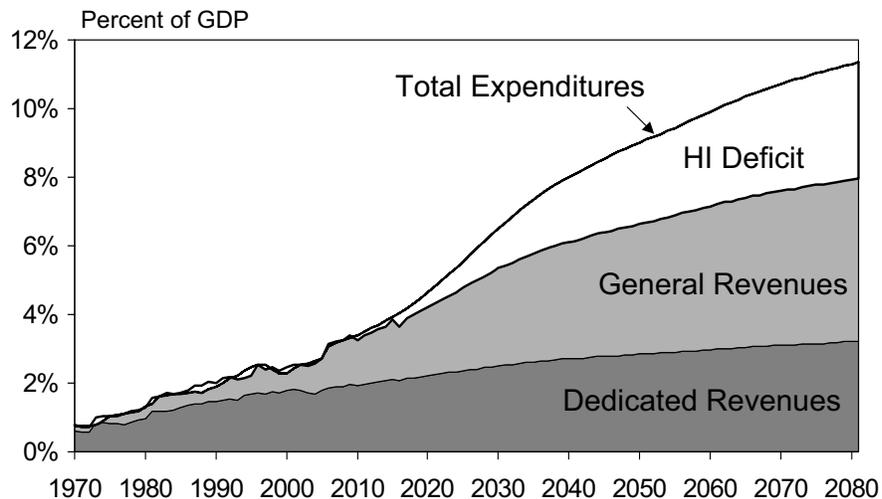
The status of the HI trust fund has fluctuated over time, in response to the strength of the economy, legislated changes made to the Medicare program, and health care cost and utilization trends. Nevertheless, over at least the past 10 years, the HI trust fund has been projected to run out of money within the next few decades. Current projections estimate that HI expenditures will exceed non-interest revenues coming into the program this year. Over the next few years, interest income on the trust fund assets will be enough to make up for the deficit. By 2011, however, HI expenditures will exceed all revenues into the program, including interest income. At that point, the HI trust fund will need to begin redeeming its assets—U.S. government securities—in order to pay for benefits. If the federal government is experiencing unified budget deficits at the time

these securities need to be redeemed, either additional taxes will need to be levied to fund the redemptions, or additional money will need to be borrowed from the public, thereby increasing the public debt.

In 2019, the trust fund assets are expected to be depleted, and no benefits can be paid until more revenue is received. Projected payroll taxes going into the program will cover only 79 percent of benefit costs in 2019, and less thereafter. Unless action is taken to eliminate this deficit, full Medicare benefits cannot continue to be paid. There is no automatic provision to shore up the deficit with other government funds.

Figure 1 shows Medicare’s actual and projected expenditures and non-interest revenues. Any excess in projected spending over revenues represents the HI deficit. (As mentioned above, the SMI trust fund will remain solvent over time, but only because its financing is reset each year to meet future costs.) The value in today’s dollars of the HI deficit over the next 75 years is \$12 trillion. Eliminating this deficit would require an immediate 122 percent increase in payroll taxes (i.e., from a combined payroll tax rate of 2.90 percent to 6.41 percent), an immediate 51 percent reduction in benefits, or some combination of the two. Delaying action would require more drastic tax increases or benefit reductions.

Figure 1. Total Medicare Expenditures and Non-Interest Income as a Percent of GDP



Source: American Academy of Actuaries calculations based on the 2007 Medicare Trustees’ Report
 Note: Dedicated Revenues include payroll taxes, premiums, tax on benefits, and state transfers.

Medicare Costs Are a Growing Share of the Economy and Federal Budget

In 2006, Medicare expenditures totaled \$402 billion, or 3.1 percent of the nation’s Gross Domestic Product (GDP). In other words, Medicare spending represented 3.1 percent of all goods and services produced in the country. Because Medicare spending is projected to continue to grow faster than the economy as a whole, Medicare spending will make up an ever-increasing

share of the economy. As a greater share of the economy is devoted to Medicare, a diminished share will be available for other purposes.

The Medicare program is also becoming a larger part of the federal budget. In 2006, about one out of every six federal revenue dollars (including income taxes, payroll taxes, and other federal government receipts) was used for Medicare.⁴ If no changes are made to the Medicare program and total federal revenues remain at their current share of GDP, by 2050, spending on Medicare could consume nearly one out of every two federal revenue dollars. By 2080, spending on Medicare and Social Security combined could grow to about 90 percent of all federal revenues. This increased spending for Medicare (and Social Security) will likely crowd out funds available for other federal programs, unless total federal revenues are increased.

Medicare's Early-Warning System

A provision of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA) intends to address some of Medicare's financial challenges. The MMA requires that the president propose legislation to reduce the share of Medicare funding that comes from general revenues if and when general revenue funding sources are projected to account for more than 45 percent of Medicare spending within the subsequent seven years. More specifically, a determination of "excess general funding" is triggered if for two consecutive trustees' reports the difference between Medicare outlays and dedicated financing sources (HI payroll taxes, HI share of income taxes on Social Security benefits, Part D state transfers, and beneficiary premiums) exceeds 45 percent of Medicare outlays within seven years of the projection.

Options would include reducing spending, increasing revenues, or some combination of the two. The president's proposal must come within 15 days of the next budget submission, and Congress must consider the proposal on an expedited basis. There is no requirement, however, that any legislation be enacted. The 2007 Medicare trustees' report projects that the 45 percent threshold will first be reached in 2013. Because last year's report also projected that the threshold would be reached within seven years, the requirement is triggered this year.

Depending on what action, if any, is taken regarding the limit on general revenue funding, other financing problems could remain. For instance, reducing general revenue funding might not have an impact on overall Medicare solvency.

MEDICARE REFORM OPTIONS

There are numerous reform options that could help improve Medicare's financial condition. The reform options fall generally into two broad categories—those that will increase the income to the Medicare program and those that will decrease program spending. In some cases the options may include elements that both increase income and reduce spending. We have tried to be comprehensive in our list of options; inclusion of a reform option should not be taken as our endorsement of any approach.

Options to Increase Medicare Revenues

This section outlines many of the options available to increase Medicare revenues. When evaluating these options, it is important to consider not only the impact on the HI deficit, but also whether Medicare's pressure on the federal budget and the economy would be reduced.

Increase the HI Payroll Tax Rate

As noted, the Medicare payroll tax is the primary source of revenues for HI expenditures. The payroll tax rate is currently set at 1.45 percent of taxable earnings, payable by both employees and employers for a total of 2.90 percent. The amount is no longer subject to an annual maximum (before 1997, the wages over and above the maximum Social Security taxable wage base were not taxable).

For two reasons, payroll tax revenues are increasing more slowly than HI expenditures, and this trend is projected to continue. First, the aging of the population means that fewer workers will be paying into the HI program for each beneficiary. In addition, medical spending increases faster than the rate of wage increases. These dynamics imply that adequately funding currently scheduled HI benefits requires that the payroll tax rate keep pace with the decline in the ratio of workers to beneficiaries and any excess in the rate of HI benefit cost increases over the rate of wage increases.

According to the trustees' report, a 122 percent increase in the payroll tax rate, from a combined rate of 2.90 percent to 6.41 percent, would eliminate the HI deficit over the next 75 years. Such an increase has significant financial implications for both workers and businesses, which should be considered. Similarly, the impact of an increased payroll tax burden on the overall economy should also be considered.

Make the HI Payroll Tax Progressive

The current payroll tax structure does not vary the tax rates with earnings. The payroll tax could be made progressive so that those with lower earnings would face lower payroll tax rates and those with higher earnings would face higher tax rates. To provide any funding relief for Medicare, the revenue lost by reducing the payroll taxes for those with lower earnings would have to be more than offset by increasing the payroll taxes for those with higher earnings. Not indexing the tax rate earning thresholds would generate higher tax revenues over time, as more earnings would be subject to the higher tax rates. However, this would also reduce progressivity. If a policy of progressive payroll tax rates is pursued, it will need to be determined whether differential tax rates will be applied to both the employee and employer shares or to the employee share only. As with an increase in the payroll tax rate, the impact of changes in the tax rate structure on wages and economic output would need to be considered.

Increase General Revenue Funding

Although general revenue is used as a funding source for the SMI trust fund, historically, general revenues have not been a funding source for the HI program. Allocation of general revenues to the HI program could be used to supplement the existing funding sources. Because the HI deficit is projected to increase over time, general revenue contributions to shore up the deficit would need to increase over time as well—from 0.4 percent of GDP in 2019, the year trust fund assets are expected to be depleted, to 3.4 percent in 2080.⁵ When added to the amount of general

revenue needed to cover the 75 percent share of SMI funding, the portion of general revenues required to support Medicare under this funding scenario increases from 2.3 percent of GDP in 2019 to 8.1 percent of GDP in 2080. Such an increase in general revenue funding would put increased pressure on the federal budget and could result in larger federal budget deficits or necessitate income tax increases.

An increase in general revenue funding could include some of the following features:

- Create an earmarked Medicare tax based on adjusted gross income similar to our current income tax. This could be made progressive, just as the basic income tax is.
- Create an earmarked Medicare tax as part of the corporate income tax.
- Earmark the excess of the Alternative Minimum Tax (AMT) over the regular income tax as a Medicare tax.
- Reduce or eliminate the Medicare payroll tax. Although this by itself would increase the Medicare funding shortfall, rather than decrease it, coupling it with increased general revenue funding could provide tax relief for workers with low incomes.

Increase Beneficiary Premiums

Approximately 25 percent of SMI revenue is from beneficiary premiums. Originally, the Part B premium was set at 50 percent of the average program cost for Medicare Part B enrollees. That share has fallen over the years, and today the Part B premium stands at 25 percent of the average program cost for aged Medicare beneficiaries. Increasing Part B premiums to a larger share of total Part B expenditures would help reduce Medicare's reliance on general revenues, thus reducing some of the program's strain on the federal budget. Similarly, increasing Part D premiums, which together with state transfers for low-income beneficiaries, cover almost 25 percent of Part D costs, would reduce Medicare's reliance on general revenues.

However, Part B premiums are already increasing as a share of average Social Security benefits, because Part B per-capita costs are increasing faster than average earnings. Increasing the Part B premium as a share of total Part B spending would further increase the share of Social Security benefits devoted to Medicare premiums.

Due to a provision in the Medicare Modernization Act of 2003, Part B premiums are increasing for those with higher incomes. Beginning in 2007, certain higher-income individuals will pay a higher Part B premium. The income threshold, which will be indexed annually to inflation, is \$80,000 for individuals and \$160,000 for couples in 2007. By the end of the three-year phase-in period, individuals exceeding the income threshold will pay premiums ranging from 35 percent to 80 percent of the average program cost, depending on their income, rather than 25 percent of the average program cost for individuals with incomes below the threshold. Estimates from the Congressional Budget Office (CBO) suggest that the income-related premiums will affect about 6 percent of beneficiaries when fully phased in and will reduce the general revenue funding requirements for Part B by about 2 percent.⁶ Therefore, attaining more significant reductions in general revenue contributions would require larger premium increases or premium increases for a broader share of Part B enrollees.

There is currently a statutory limit regarding Part B premium increases—the increase is limited to the increase in each individual's Social Security cost-of-living adjustment (COLA).⁷

Policymakers proposing to increase Part B premiums may want to revisit this provision to determine whether it should be revised. Otherwise, the impact of increasing Part B premiums may be limited.

Instead of, or in addition to, raising Part B and/or Part D premiums, a beneficiary premium requirement could be added to the HI program. And similar to the new provisions for an income-related Part B premium, such a premium could be income-related. This would shift some of the HI financing burden from workers to beneficiaries. Although a premium requirement could reduce the HI deficit, it could also reduce participation in Part A. If the premium is set too high, adverse selection could occur, potentially leading to even higher premiums if they are set as a share of per capita costs. The nearly universal acceptance of the voluntary Part B program, however, suggests that it may be possible to implement some level of Part A premium without a substantial impact on participation.

Investment of Trust Fund Assets

Medicare trust fund assets are invested almost entirely in non-marketable special-issue U.S. government securities that represent loans to the U.S. Treasury's general fund. Those bonds pay market rates of interest. But many analysts believe that greater returns could be achieved, on average, in the more volatile equity markets. This has been one of the options put forward to reduce the deficit in the Social Security system. For example, investing 40 percent of trust fund assets in equities, phased in over 15 years, would reduce the 75-year Social Security deficit by about 45 percent, assuming a 6.5 percent real rate of return over the long term.⁸

A similar strategy for investing the Medicare trust fund assets would have a much smaller impact, however, because the Medicare trust fund assets, as of the end of 2005, were only one-sixth the size of the Social Security trust fund assets, and the 75-year Medicare deficit is more than twice that of Social Security. Furthermore, Medicare trust fund assets are projected to be drawn down beginning in 2011 and to be depleted in 2019, leaving little time to generate larger investment returns.

Options to Reduce Medicare Spending

This section outlines many of the options available to reduce Medicare spending. Some of these options would reduce overall health care spending among the elderly. Others would simply shift costs to other payers. For instance, if Medicare reimbursement rates are reduced, providers may shift costs to the private sector. Although this would improve Medicare's financial condition, it would not necessarily reduce overall health spending as a share of the economy.

Reduce Provider and Plan Payments

Slow the Growth of Provider Payments

Medicare payment policies control the amount health care providers get paid for the services they provide to Medicare beneficiaries. Fee schedules or payment schedules exist for nearly all types of care: inpatient stays, outpatient services, physician services, home health care visits, etc. Payment policies require setting payments high enough to assure beneficiaries have adequate access to care while at the same time limiting overall program costs. Historically, reductions in provider payments have been the principal means of slowing the growth of Medicare spending.

Further reducing, or limiting the growth in, provider payments may be an option for reducing Medicare spending. Options include:

- Reducing unit costs (lowering the fee schedules, payments per episode, etc.)
- Restructuring the payment mechanisms to encourage efficient use of services
- Minimizing inappropriate claims associated with fixed schedules

One area where payment cuts are typically considered is in the physician payment system. Over the past several years, Medicare spending for physician services has grown at an average rate of almost 10 percent per year.⁹ This is in spite of an automatic update feature to the payment schedule that is intended to limit the growth in physician spending. In particular, the Sustainable Growth Rate (SGR) system sets an overall spending target, and then updates payment rates annually to reflect the differences between actual and target spending. However, Congress has typically overridden the update factor, thus allowing physician payments to grow faster than they would have otherwise. (Nevertheless, the Medicare trustees report projections incorporate payment reductions scheduled in current law, even if it is likely that Congress will override them.)

When addressing the physician payment system, more focus should be paid to whether appropriate payment levels are set for procedures and that physicians are discouraged from providing inappropriate or unnecessary care. Some proposals to overhaul Medicare's physician payment system would tie physician payments to quality performance measures. Pay-for-performance options will be discussed in more detail below.

As the largest Medicare spending category, hospital payments represent another potential target for cost cutting. In 2006, spending on hospital care made up about 36 percent of total Medicare spending, with the majority being for inpatient care.¹⁰ Hospital spending has grown more slowly than physician spending, however, averaging about 6 percent for the past several years.

Reduce Payments to Medicare Advantage Plans

The Medicare Modernization Act of 2003 introduced new changes to the Medicare program and created a new version of private Medicare plans—Medicare Advantage (MA). In addition to creating new offerings and modifying the payment structures (e.g., by adding a bidding process), payments to the health plans were increased to encourage expansion of the program and to reverse the trend of declining enrollment. In doing so, the payments to health plans exceed what would be paid through the traditional fee-for-service (FFS) Medicare program. The Medicare Payment Advisory Committee (MedPAC) estimated that for 2006, MA plans were paid on average 12 percent more than FFS spending.¹¹ The Deficit Reduction Act of 2005 and the Tax Relief and Health Care Act of 2006 contain provisions to reduce payments to MA plans. Nevertheless, depending on future plan bids, payments to MA plans could continue to exceed those that would be made under FFS.¹² Further reductions to MA plan payments may be warranted to achieve financial neutrality between the MA program and traditional Medicare. However, any impacts on the availability of MA plans would need to be considered.

Benefit Cuts/Increase Costs to Beneficiaries

Increase the Eligibility Age

Although the Social Security normal retirement age is increasing gradually from age 65 to age 67, the Medicare eligibility age is not scheduled to increase. Increasing the Medicare eligibility age in conjunction with the Social Security normal retirement age would reduce Medicare expenditures and would also increase Medicare payroll tax revenues to the extent that workers are encouraged to remain in the workforce longer. Nevertheless, increasing the Medicare eligibility age would result in fairly modest reductions in net Medicare costs. On average, younger Medicare beneficiaries cost less than older beneficiaries, and some of those who are high cost would be able to obtain Medicare coverage, even with a higher eligibility age, if they qualify for Social Security Disability Insurance. Previous estimates suggest that increasing the eligibility age gradually to age 67 by 2022 would reduce net Medicare costs by about 4 percent after being fully implemented.¹³ Increasing the eligibility age further, to age 70 by 2040, would save about 8 percent.

Delaying Medicare eligibility to age 67 or older would likely result in some people being uninsured. Many would be retired with no access to employer-sponsored coverage and could face high premiums in the individual market. To help address this potential problem, the Medicare program could be expanded on a buy-in basis to offer Medicare benefits to those between age 65 and the new eligibility age. Premiums paid by buy-in enrollees would cover full costs of coverage. To keep premiums manageable, however, the costs could be structured such that they would be payable over the lifetime of the beneficiary, rather than solely during the buy-in years. In other words, in exchange for a lower buy-in premium, enrollees would pay a higher Medicare premium upon reaching Medicare eligibility age. Keeping buy-in premiums at affordable levels would help encourage healthier individuals to participate, thus reducing adverse selection. Premiums could be subsidized for lower-income individuals, which would reduce the cost savings to Medicare. A Medicare buy-in program could also be extended to individuals younger than age 65, as older adults not yet eligible for Medicare are particularly vulnerable to lacking health insurance.

Increase Beneficiaries' Cost Sharing Requirements

Traditional Medicare imposes cost-sharing requirements on both the Part A and Part B programs. Beneficiaries must pay a per-episode inpatient hospital deductible of \$992 (in 2007) and additional copayments for hospital stays lasting beyond 60 days. Beneficiaries must also pay an annual Part B deductible of \$131 (in 2007) as well as 20 percent coinsurance for most outpatient and physician services.¹⁴ The deductible levels are indexed annually. Notably, traditional Medicare does not limit beneficiary out-of-pocket expenses. Medicare Advantage plans may set lower cost-sharing requirements and may also set annual out-of-pocket limits.

Imposing higher cost-sharing requirements would reduce Medicare expenditures, not only by shifting more costs to beneficiaries, but also by reducing overall health spending, as beneficiaries decide to forgo some services. However, most beneficiaries have some sort of supplemental coverage that pays for Medicare deductibles and coinsurance, such as Medigap coverage, retiree health coverage, or Medicaid. These beneficiaries are insulated to some extent from Medicare's cost-sharing requirements, thus potentially limiting the impact of higher cost-sharing

requirements. An option for addressing this would be to eliminate first-dollar coverage for Medicare Supplement policies, which will be discussed in more detail below.

Although the goal of higher cost sharing would be to reduce utilization of unnecessary services, some necessary care would also undoubtedly be reduced. As a result, spending might be reduced by less than anticipated if beneficiaries forgo necessary care and suffer adverse health effects that lead to higher future spending. This would be a particular issue for low-income beneficiaries. However, the poorest Medicare beneficiaries already qualify for financial assistance with their cost sharing. About 17 percent of Medicare beneficiaries are also eligible for Medicaid, with most of these dual eligibles qualifying for cost sharing assistance.¹⁵ Nevertheless, policymakers may want to consider expanding the eligibility for financial assistance if cost-sharing requirements are increased dramatically.

Alternatively, Medicare cost-sharing requirements could be more directly tied to income—increased for beneficiaries with higher incomes and reduced for those with lower incomes.¹⁶ Progressive cost sharing could help increase price sensitivity for those who could afford it without reducing the access to necessary care for those who cannot. Implementation of progressive cost sharing could be difficult, however.

Also, regardless of income level, an increase in cost sharing will affect those with high health costs, and may pose too great a financial burden on those who have significant and/or frequent need for medical care. Therefore, it may be appropriate to couple any increase in beneficiary cost sharing with an annual limit on out-of-pocket spending.

Eliminate First-Dollar Medicare Supplement Coverage

In a variety of insured populations, actuaries have observed that enrollees with more generous coverage (including first-dollar coverage and other supplemental benefits) have higher total health spending than those with less generous coverage. At least one study suggests that this is also the case for Medicare enrollees who have supplemental coverage (e.g., Medigap, employer coverage).¹⁷ There are at least a couple of reasons why this may be the case. First, those in poorer health may be more likely to recognize the value of supplemental insurance and thus more likely to purchase and retain their coverage. Second, the absence of cost sharing may entice some to seek care when they otherwise would not. To the extent that the latter causes any additional spending, savings may be realized in the Medicare program by reducing the first-dollar coverage provided by Medicare supplement coverage.

The 2003 Medicare Modernization Act took one step in this direction by requiring the development of two new Medigap plans that do not provide first-dollar coverage. Enrollment in these new plans (plans K and L), however, has been low. Therefore, making such coverage available on a voluntary basis may not be enough; eliminating first-dollar coverage would likely require banning first-dollar coverage among all Medigap plans. Another option would be to ban Medicare supplemental coverage altogether.

These changes would require action on the part of Congress, the National Association of Insurance Commissioners (NAIC), and the states. In making any changes, it would have to be considered that about one-fifth of Medicare enrollees have Medigap coverage, and another one-

third of enrollees have retiree health coverage through a former employer.¹⁸ Also, as discussed above, in the absence of first-dollar coverage, cost sharing may cause some individuals to forgo care, necessary and unnecessary. This may cause the unintended consequence of increased spending in later, more intense health care encounters.

Reduce or Eliminate Some Covered Services

Reducing or eliminating Medicare coverage for some health services could play a role in ensuring the adequacy of financing of the Medicare program. To have a significant impact, the services reduced or eliminated would have to be of considerable cost. One of the perils of reducing or eliminating coverage of significant services, however, is the inducement of offsetting costs. Medicare-covered services are interrelated, and coverage of any particular health care service is likely to result in some savings in other services.

Coverage of home health agency and skilled nursing facility services, for example, would probably result in some reduction in inpatient hospital stays. Similarly, the advent of the prescription drug benefit may or may not result in reduced costs for certain types of treatment. Evaluation of emerging experience will be critical in identifying areas in which reduced coverage for some services may be warranted.

In addition to, or in place of, eliminating covered services, policymakers may wish to consider whether to develop rules for providing care to terminally ill patients. This consideration may also include developing specific guidelines for determining when to cover heroic care or including formal ways to advise patients, advocates, and relatives of choices available.

Covered services continue to expand as the Centers for Medicare and Medicaid Services (CMS) approves payment for new medical technologies. Because emerging medical technologies contribute greatly to the rate of general medical inflation, cost-containment efforts should include critical assessment of the process used to make these coverage determinations. Delayed approval of coverage for costly new medical technologies when there is not a clear improvement in medical outcomes would help contain Medicare spending growth. Potential negative effects on a beneficiary's health status should be considered in any decision to delay approval of payment for new medical technology.

Improve Delivery Efficiencies / Quality

Providing the right incentives for efficient and quality care is a key to improving the Medicare delivery system, and the health care system as a whole. There is much evidence to suggest that individuals are not receiving the most appropriate care. For instance, the amount of care that Medicare enrollees receive can vary dramatically by geographic region, and enrollees in high-spending areas receive much more care than those in other areas, but do not have better quality or outcomes of care.¹⁹ In some cases, more care can actually lead to worse outcomes. In these instances, quality could be improved at the same time as spending is reduced. Many individuals, however, are not receiving all the care they should. For instance, one study has found that American adults received just over half of the care they should receive for basic care needs.²⁰ Mechanisms to improve both the quality and the efficiency of health care delivery should be pursued.

Capture Delivery Management Efficiencies

CMS is pursuing strategies to pay for the most effective care delivered at the most appropriate time and to reduce spending for care currently being delivered otherwise. For instance, CMS is in the early stages of working with the health care industry to develop quality improvement programs that pay providers more for better quality and less for poor quality. MA plans, hospitals, and physicians should expect future payments to be linked to quality. CMS is also administering disease management demonstration projects in traditional Medicare. Pay for performance initiatives are discussed in more detail below.

Overall provider payment mechanisms should also be structured to encourage efficient and effective health care delivery. Medicare's various provider payment mechanisms have been modified over time to slow spending growth and, in theory, encourage care delivery efficiencies. Medicare's prospective payment systems for hospital inpatient, hospital outpatient, home health care, and skilled nursing care facility services have realized mixed success in capturing the cost savings associated with delivery management efficiencies. Generally, traditional Medicare does not pay providers to deliver care most efficiently. For instance, the outpatient hospital and physician payment systems encourage providers to perform more services to receive more payments.

While efforts to date have had their challenges, the MA program, Part D, and several demonstration projects provide potential for producing delivery management efficiencies within Medicare. Under the MA program, risk-bearing organizations are paid a capitation based on the health status of their members, published payment rates, and their bid for traditional Medicare benefits. To the extent an organization projects it can provide traditional Medicare benefits for less than the risk-adjusted payment rates, CMS retains 25 percent of the difference. The remaining 75 percent of savings goes to the MA organization as a rebate, which must be used by the MA plan to provide additional benefits. Organizations that provide additional benefits beyond that funded by the rebate must charge a member premium to cover any shortfall.

Because MA organizations compete for members, in large part, based on benefit levels and corresponding member premiums, those that can deliver care most effectively and efficiently should have a competitive advantage, in that they will be able to offer more attractive benefit/premium packages than their competitors. While this approach provides an incentive for MA plans to manage members' health and health care, and pay providers in ways that facilitate effective and efficient care, additional savings to Medicare could be achieved. For instance, all of the savings from low bids could be returned to Medicare. Alternatively, the benchmark for which "savings" are determined could be set in different ways to yield potentially greater savings for Medicare (e.g., low price bid from one plan, next to lowest bid, weighted average bid, or median bid).

Part D coverage for prescription drugs is provided through competitive bidding by stand-alone PDPs and MA plans. Plans with the lowest bids will have the lowest member premiums and will have a price advantage in the market. Thus, under the privatized Part D program, the plans that can best realize prescription drug management efficiencies should be best positioned to attract members. The various competitors are expected to strive continually to achieve best practices to improve and/or maintain their market position. Additionally, for some Medicare beneficiaries,

Part D coverage of their prescription drugs will improve their compliance with appropriate drug regimens and may avoid costly care under Parts A and B.

With both private health plans and Part D providers, complexity is added to the once defined-benefit Medicare program. While bidding strategies may encourage delivery efficiencies, it may be difficult for Medicare beneficiaries to recognize the trade-offs between benefits, premiums, and (in some cases) rebates. Other issues related to competitive bidding that would need to be considered include benefit standardization, continuity of care, communication with beneficiaries, beneficiary mobility, and coordination of state and federal regulation.

In addition to pursuing competitive bidding strategies for plans, CMS has implemented competitive bidding demonstration projects for narrow sets of services. CMS expects program savings in the traditional Medicare program as they use the competitive market as the lever to improve delivery system efficiency. Lessons learned from these demonstration projects will provide guidance if broader competitive bidding strategies are pursued.

Incorporate Pay-for-Performance

A key goal for pay-for-performance programs is to improve the quality of patient care through cost-effective means. Increasing the emphasis on value can perhaps also result in some cost savings. Structuring provider practices around evidence-based practice models can potentially produce better patient outcomes, increased patient satisfaction, and reductions in unnecessary spending.

Early steps in this process involve the research and evaluation of the ability of various treatment methods to enhance quality and reduce costs. Comparative effectiveness analysis would help determine whether the value of new medical procedures and technologies exceeds those already existing. Because data is critical to the evaluation process, initial pay-for-performance incentives have been structured around the collection of complete and consistent data. Demonstration projects involving controlled trials also play a key role in establishing best practices.

CMS has already initiated some efforts in this area. For instance, it is pursuing gain-sharing demonstration projects, which will allow savings for improved quality to be shared with physicians. CMS expects to incorporate lessons learned from the demonstration projects in future Medicare program provider payment methodology changes. CMS also has a demonstration project on hospital quality that involves hospitals reporting on a defined set of quality measures, which gives them the opportunity to improve their Medicare reimbursement for good performance.

Data is beginning to emerge from the pay-for-performance initiatives, and definitive steps should be taken to optimize the value of the programs. Next steps should focus on a limited set of conditions and treatment protocol, to be chosen as indicated by sound data, in order to evaluate the effectiveness of the program under real-life conditions, before expanding into more controversial treatment areas. CMS should coordinate, to the extent possible, with other agencies and organizations working on quality and pay-for-performance issues to help ensure the proper evaluation of results.

A key factor and challenge in the success of pay-for-performance will be determining the appropriate metrics necessary to improve health care while reducing the cost to the Medicare program. Each metric should relate to improvements in the quality and/or cost of care, with the best scores for improvements in both measures.

In order to gain acceptance by the medical community, pay-for-performance initiatives must maintain the independence of providers to treat patients according to their professional judgment. Optimal results, however, will dictate a mandatory, rather than voluntary, pay-for-performance system for providers who receive Medicare funds. Grievance procedures for providers who deviate from pay-for-performance indicators will be needed, as well as metrics for determining the optimal balance of pay-for-performance savings versus professional judgment allowances. This will involve a delicate balancing act between data analysis and practitioner independence.

Defined Contribution or Premium Support Approaches to Funding

As an alternative to adjusting benefits, the focus of the Medicare program could change to providing a level of funding, which is affordable to the program, for Medicare beneficiaries. As currently structured, Medicare defines the benefits provided to Medicare beneficiaries. Total spending under the program depends on the benefits defined and the marketplace dynamics for use, service mix, and fee levels. A defined contribution approach to Medicare would change the relationship between benefits and costs. Rather than defining the benefits, Congress would define the level of Medicare funding. Available benefits would then be determined based on what could be purchased for an acceptable cost. Beneficiaries would be responsible for any difference between the cost of the benefit package they select and the government contribution. Such a structure could encourage enrollees to be cost conscious when choosing their health plan.

The MA plan already incorporates several defined-contribution elements. Congress has defined the contribution the federal government will make on behalf of any MA enrollee, based on the cost to provide these benefits under traditional fee-for-service Medicare. The traditional fee-for-service Medicare option is still a defined benefit, however, so as long as the federal contribution to an MA plan is tied to fee-for-service costs, it is still ultimately determined on a defined-benefit basis. MA plans themselves also have defined-benefit features. Most notably, the benefits provided are required to be at least as great as those provided under traditional Medicare.

Setting the government contribution level on some basis other than a specified set of benefits is a key element of a defined-contribution approach. So, too, is determining what types of plans the contribution can be used for. Potential options range from comprehensive plans, two-tier plans, high-deductible health plans, or some combination of these. These will be discussed in more detail below.

Regardless of what types of plans are used, however, many important issues must be considered when evaluating proposals to move the Medicare program from a defined-benefit approach toward a defined-contribution approach. For instance, although a defined-contribution approach could make future federal outlays for Medicare more predictable and controllable, government contributions would not necessarily keep up with increases in the cost of coverage. This could

reduce beneficiary support for the program and necessitate increased funding for low-income premium and/or cost-sharing subsidies.

On the other hand, a defined-contribution approach could encourage greater emphasis on cost management. A defined-contribution approach would facilitate a transition to increased control by individual Medicare beneficiaries over the benefits they receive, and greater personal involvement in the cost of their coverage and the cost of the health care they receive. This increased control could encourage greater cost consciousness among enrollees when they are receiving health care. To be effective, however, such an approach to Medicare would require an extensive education program of beneficiaries so they could make appropriate medical care choices.

Offering individual enrollees a choice between multiple coverage options, particularly when cost and benefit levels vary significantly among them, would create the potential for adverse selection against one or more of the options. Risk-sharing provisions may be needed to assure equity among insurers and health care organizations.

Current Fee-For-Service and Medicare Advantage Plans

One option would be for the government to set its contribution level, and then for beneficiaries to use this toward the cost of coverage under the traditional fee-for-service program or for an MA plan. These plans would set their premium costs, and any difference between the government contribution and the premiums would have to be paid by the enrollee. In effect, this would result in more competition between traditional Medicare and Medicare's private plans. This option could be accompanied by a change in the structure of the traditional Medicare program by changing the cost-sharing requirements, for instance.

High-Deductible Health Plans with Medical Savings Accounts

Some of the private plans currently available under Medicare Advantage are high-deductible health maintenance organizations (HMO) or preferred provider organizations (PPO), along with a medical savings account (MSA), although enrollment in these plans is quite low. Medicare beneficiaries enrolled in an MSA plan pay the Part B premium and receive an annual deposit into an account from CMS, which can be used to pay for health services. This deposit is tied to the difference between the insurer's bid for the plan and the CMS capitation rate. After reaching the deductible amount, which increases each year, the plan is responsible for all Medicare-covered costs. In addition to the regular MSA plan, CMS is also offering demonstration MSAs that provide more plan flexibility than the regular MSAs, including allowing for coverage of preventive care before the deductible is reached and enrollee cost-sharing after the deductible is reached.

Structuring a defined-contribution approach around MSA-type plans would offer two ways the government could set contribution levels—for the plan premiums and for the deposit into the MSA. Movement to this type of approach would likely require more coordination with health savings accounts (HSAs), which are available to individuals not participating in Medicare. This would help increase the continuity before and after Medicare enrollment.

Two-tier Medicare Option

A two-tier benefit plan structure could be implemented within the Medicare program. The first tier would be a standard benefits package, with the second tier being an optional enhanced-benefit package. The standard benefit package could be structured to offer the same benefits as the current Medicare benefit package, or could be structured to provide catastrophic coverage along with preventive care. Alternatively, the generosity of the basic benefit package could be tied to the funding available. The enhanced-benefit package would then provide some coverage in the coverage gaps. The standard benefit could be financed consistent with current Medicare financing and the enhanced benefits could be self-supporting through enrollee premiums. Funding for the enhanced benefit could potentially include a pre-funding mechanism through a type of HSA.

Automatic Adjustments to Revenues and/or Spending

Rather than making ad hoc adjustments to increase revenue sources or decrease spending, automatic adjustments could be imposed. These adjustments could be triggered when particular funding shortfall thresholds are exceeded and/or when spending growth exceeds particular levels. The adjustments could entail automatic increases in revenue sources (e.g., payroll taxes, beneficiary premiums), automatic decreases in provider payments, and/or increased beneficiary costs (e.g., through benefit cuts or increased cost sharing). This would minimize the need to make periodic determinations regarding corrective action. Automatic corrective adjustments already have been attempted with the conversion factors used for payment of physician services. However, the automatic adjustments have often been postponed or overridden, negating the improvement in Medicare's financial outlook envisioned at the time they were enacted. Based on this history, any attempts to impose automatic adjustments should include provisions that limit the ability of policymakers to override the adjustments.

SUMMARY

The Medicare program faces serious financial problems. The HI trust fund is expected to run out of money in just over 10 years, at which point the program will be unable to pay for all Medicare benefits. In addition, the increase in Medicare expenditures will put a strain on the federal budget and perhaps the economy as a whole. Reforms to the Medicare program are needed, and the sooner the better. There is no simple solution, however, to Medicare's challenges. Viable options will likely require shared burden among taxpayers, Medicare beneficiaries, and health care providers.

In this monograph, the American Academy of Actuaries' Medicare Steering Committee outlines various options for addressing Medicare's financial condition. These range from increasing Medicare revenues (including increasing the payroll tax rate, increasing general revenue funding, and increasing beneficiary premiums), to reducing Medicare spending (including reducing provider payments, increasing costs to beneficiaries, improving health care delivery efficiencies and quality, and moving to a more defined-contribution approach to benefits). Since few of these choices would solve Medicare's financing problems alone, it is more likely that a combination of options will be necessary.

When considering the options, it is important to consider not only the impact on Medicare solvency, but also the impact on the federal budget and the U.S. economy. For instance, although using general revenues to shore up the HI trust fund could keep Medicare solvent, Medicare's strain on the budget would increase. It is also important to recognize that the problem of rising health care spending in the Medicare program reflects spending growth in the U.S. health system as a whole. Therefore, unless spending in the health system as a whole is addressed, implementing options to improve Medicare financing may have limited effectiveness.

Related Publications from the American Academy of Actuaries' Health Practice Council

- Medicare's Financial Condition: Beyond Solvency (April 2007 issue brief; updated annually)
- Medicare: Next Steps (February 2005 issue brief)
- Medicare Reform: Using Private-Sector Competition Strategies (April 2000 monograph)
- Pay for Performance: Rewarding Improvements in the Quality of Health Care (October 2005 issue brief)

ENDNOTES

¹ Under Part D, the federal government also provides subsidies to certain employers that provide prescription drug benefits to their retirees.

² *2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April 23, 2007, p. 5, Table II.B.1.

³ *2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April 23, 2007, p. 5, Table II.B.1.

⁴ According to CBO, federal receipts in 2006 totaled 18.4 percent of GDP.

⁵ *2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April 23, 2007, p. 12, data underlying Table II.D.2.

⁶ Congressional Research Service. "Medicare: Part B Premiums," September 14, 2004. Congressional Budget Office. "CBO Estimate of Effect on Direct Spending and Revenues of Conference Agreement on H.R.1," November 20, 2003 letter to the Honorable William M Thomas.

⁷ For instance, the Part B monthly premium increased by \$5 in 2007, from \$89 to \$94. Anyone whose COLA increased by less than \$5 would not have to pay the full increase in the Part B premium. Note that according to the Social Security Administration, in January 2007, the estimated average monthly Social Security benefit was \$1,011 before the 3.3 percent COLA and \$1,044 after the COLA, a difference of \$33. For the average Social Security retired worker recipient, the part B premium increased from 8.8 percent of Social Security benefits in 2006 to 9.0 percent in 2007, because the Part B premium increased faster than the Social Security COLA.

⁸ Social Security Administration, Office of the Chief Actuary. "Provisions Affecting Trust Fund Investment in Equities," available at <http://www.ssa.gov/OACT/solvency/provisions/investequities.html> (version referenced last updated May 3, 2006).

⁹ Medicare Payment Advisory Commission (MedPAC). *A Data Book: Healthcare Spending and the Medicare Program*, June 2006, p. 109.

¹⁰ *2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, April 23, 2007, p. 5, Table II.B.1.

¹¹ MedPAC. "Medicare Payment Policy," report to Congress, March 1, 2007.

¹² MedPAC. "Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-For-Service Spending," June 9, 2006.

¹³ David C. Wittenburg, David C. Stapleton, and Scott B. Scrivner. "How Raising the Age of Eligibility for Social Security and Medicare Might Affect the Disability Insurance and Medicare Programs," *Social Security Bulletin* 63(4): 17-26. 2000.

¹⁴ In addition, cost sharing is required for skilled nursing facility stays beyond 20 days, hospice care, and durable medical equipment.

¹⁵ The Henry J. Kaiser Family Foundation. *Medicare Chartbook*. Third Edition. Summer 2005.

¹⁶ See, for example, Jason Furman. "The Promise of Progressive Cost Consciousness in Health-care Reform." The Hamilton Project Discussion Paper 2007-05. The Brookings Institution, 2007.

¹⁷ Sandra Christensen and Judy Shinogle. "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," *Health Care Financing Review* 19(1): 5-17. 1997.

¹⁸ The Henry J. Kaiser Family Foundation. *Medicare Chartbook*. Third Edition. Summer 2005.

¹⁹ Elliot S. Fisher, et al. "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* 138(4): 288-322. 2003.

²⁰ Elizabeth McGlynn. "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348 (26): 2635-2645. 2003.