February 2005

ISSUE BRIEF
AMERICAN ACADEMY of ACTUARIES

Medicare: Next Steps

The passage of the Medicare Modernization Act of 2003 made some of the most significant changes to the Medicare program since its inception. The new law adds a prescription drug benefit to Medicare, creates the Medicare Advantage program to replace the Medicare+Choice program, and establishes a demonstration program to test competition between Medicare and private plans. Many concerns regarding the Medicare program remain, however. This issue brief outlines four of the areas where further action could be taken:

- *Long-term financing problems*
- *Balancing access to care while avoiding unnecessary utilization*
- *Private sector competition strategies*
- *Insurance needs of individuals age 55 to 64*

Medicare Faces Long-Term Financing Problems

Medicare faces serious long-term financing problems due to the declining ratio of workers to retirees and health care costs that are growing faster than the rest of the economy. Unless Medicare undergoes fundamental change, the program will face increasing financial pressures and ultimately won't have enough money to pay full benefits.

The Medicare trust funds face increasing financial pressures. For financing purposes, Medicare consists of two parts, each of which is financed through a separate trust fund. Hospital Insurance (HI) pays primarily for inpatient hospital care and Supplementary Medical Insurance (SMI) pays primarily for physician and outpatient care, as well as the new prescription drug benefit. Taxes, premiums, and other income are credited to the trust funds for each program and are used to pay benefits and administrative costs. Any unused trust fund income is invested in U.S. government securities.

The principal author of this issue brief was Cori E. Uccello, M.A.A.A., F.S.A., Senior Health Fellow at the American Academy of Actuaries. Thomas F. Wildsmith, M.A.A.A., F.S.A., Chairperson of the Medicare Steering Committee, provided valuable input. This issue brief is based in part on the Academy's 2004 issue guide, "The Questions Candidates Should Answer About Medicare Reform," which was co-authored by Ms. Uccello and Mr. Wildsmith.

AMERICAN ACADEMY of ACTUARIES

1100 Seventeenth Street NW Seventh Floor Washington, DC 20036
Tel 202 223 8196 Fax 202 872 1948
www.actuary.org

Noel Card, Director of Communications
Craig Hanna, Director of Public Policy
Cori E. Uccello, Senior Health Fellow
Holly Kwiatkowski, Senior Health Policy Analyst, Federal

The HI program is funded primarily through earmarked payroll taxes. In the past several years, HI payroll taxes and other non-interest income have exceeded benefits paid, and the HI trust fund has been accumulating assets. According to last year's Medicare Trustees' Report, however, HI expenditures were projected to exceed HI payroll taxes beginning in 2004. And beginning in 2010, HI expenditures are projected to exceed all HI income, including interest. At that point, the trust fund will need to begin redeeming its assets in order to pay for benefits. By 2019, when trust fund assets are projected to be depleted, payroll tax revenues would cover only about 80 percent of program costs, and the share covered by payroll taxes is projected to decrease further thereafter.

The SMI program is financed through beneficiary premiums, which cover about one-fourth of the cost, and federal general tax revenues, which cover the remaining three-fourths. Because beneficiary premiums and general revenues allocated to the program are increased annually to meet projected future costs, the SMI trust fund is expected to remain solvent. However, SMI costs are growing faster than HI costs, meaning that continuing the current funding arrangements will result in general revenues financing increasing shares of total Medicare spending over time.

Medicare expenditures will place increasing strains on the economy. Due to the rising number of beneficiaries and increases in both the use and cost of health care per beneficiary, Medicare costs will consume greater shares of the nation's financial resources. In 2003, Medicare spending amounted to 2.6 percent of Gross Domestic Product (GDP). This share is expected to increase to 3.4 percent in 2006, due in large part to the addition of the prescription drug benefit. It is expected to rise to 7.0 percent of GDP in 2030 and 10.9 percent of GDP in 2060. Considering Medicare spending in conjunction with Social Security's further highlights the strain these programs place on the economy. Combined, Medicare and Social Security expenditures equaled 7.0 percent of GDP in 2003. This share of GDP will increase considerably to a projected 13.3 percent in 2030 and 17.4 percent in 2060.

The new Medicare law attempts to address some Medicare funding concerns, but major financing problems remain. The new Medicare law attempts to limit the share of Medicare spending that is financed by general tax revenues, thereby reducing the demand on the federal budget. If general tax revenues account for more than 45 percent of Medicare spending within the next seven years, the president would be required to recommend ways to reduce this share. Options would include reducing benefits, raising beneficiary premiums, or raising payroll taxes. Congress then could implement the recommendations, but would not be required to do so.

In 2003, general tax revenues accounted for about 31 percent of Medicare spending. The 2004 Medicare Trustees' report projects that the 45 percent threshold will be reached in 2012, more than seven years into the projection period. Therefore, while the requirement that the president propose reforms to reduce costs will not be triggered this year, it could be triggered within the next few years.

This provision draws attention to the need to manage the burden Medicare places on the federal budget and sets the stage for future congressional debate about corrective action to limit the burden the program places on general tax revenues. Congressional action is not guaranteed, however, and as mentioned above, other financing problems remain.

Balancing Access to Care with Incentives to Avoid Unnecessary Utilization

The Medicare benefit package should be comprehensive enough to ensure that seniors have adequate access to health care, but at the same time provide the proper incentives to discourage unnecessary care. Like typical private health insurance plans for the nonelderly, Medicare covers inpatient and outpatient hospital care and physician visits. However, the structure of the traditional Medicare fee-for-service benefit package bears little resemblance to private plans.[1] Medicare Part A, which covers inpatient hospital care, requires a deductible ($876 in 2004) for each hospital stay, and additional copayments for stays last-

ing beyond 60 days. Medicare Part B covers primarily physician and outpatient hospital services and requires an annual deductible ($110 in 2005) and 20 percent cost-sharing after the deductible is met. In contrast, private plans typically require a combined deductible that applies to both inpatient and outpatient hospital services, and nominal copayments for each physician office visit. Unlike most private plans, Medicare does not limit a patient's out-of-pocket costs. And until the passage of the Medicare Modernization Act of 2003, outpatient prescription drug benefits were not available through the traditional Medicare program.[2]

The traditional Medicare benefit package covers only about one-half of a beneficiary's health care costs, leaving beneficiaries a sizeable share of health care costs. Not only does Medicare impose cost sharing, but some products and services are not covered. For instance, although Medicare does cover skilled nursing care to some extent, it does not cover custodial nursing care, which makes up the bulk of long-term care spending. Moreover, Medicare does not cap beneficiary out-of-pocket costs. And although outpatient prescription drug coverage will be available beginning in 2006, the benefit is expected to cover only about one quarter of total prescription drug spending among the elderly over the next 10 years.

To fill in the gaps in Medicare's coverage, one-third of Medicare beneficiaries have supplemental coverage through an employer and one-fourth have coverage through a Medigap plan. These plans may cover the Part A and Part B deductibles and copayments, provider charges that exceed the Medicare approved amount, preventive care, and prescription drugs. The ten standard Medigap plans –A through J—differ in which of the Medicare deductibles and copayments they cover and what additional benefits they provide. Almost another one-third of Medicare beneficiaries has supplemental coverage through Medicaid, a Medicare Advantage plan, or through another public plan. Only about one in eight Medicare beneficiaries has traditional Medicare only, without any supplemental coverage.

Even beneficiaries with supplemental coverage could bear significant out-of-pocket costs, because supplemental coverage often limits prescription drug benefits and excludes long-term care. On the other hand, supplemental coverage can result in almost first-dollar coverage for Part A and Part B services, thus reducing the effectiveness of these cost control incentives. The new Medicare law directs the National Association of Insurance Commissioners (NAIC) to define two new Medigap packages that would provide partial coverage of Medicare Part A and Part B cost-sharing and also would limit annual out-of-pocket costs. The plans would not cover the Part B deductible, thereby partially addressing concerns that by providing first- dollar coverage, Medigap plans give beneficiaries little incentive to be cost conscious when making their health care decisions. The NAIC is also charged with reviewing and revising the standards for all Medigap benefit packages.

Even with potential revisions to Medigap benefit packages, further changes to the Medicare benefit package may be in order. For instance, the current cost-sharing mechanisms for traditional Medicare are somewhat skewed toward nondiscretionary care. In particular, inpatient care requires higher cost sharing than outpatient care. Adjusting the relative copayment requirements between inpatient and outpatient care might better align consumer incentives for avoiding unnecessary care. Combining Parts A and B of the benefit package, similar to Medicare Advantage plans, has also been suggested, as well as capping beneficiary out-of-pocket costs.

1. Medicare Advantage plans are private Medicare plans that more resemble typical private plans. They are discussed in the private plan section below.

2. The new law creates a new prescription drug benefit, available to Medicare beneficiaries on a voluntary basis through private plans, beginning in 2006. For 2006, the standard prescription drug plan will have a deductible of $250, 25 percent coinsurance up to the initial coverage limit ($2,250 in total spending), then no coverage until the beneficiary reaches $3,600 in out-of-pocket spending ($5,100 total spending). After meeting this maximum, all drug costs are covered, with nominal cost sharing.

Private Plans and Private Sector Competition Strategies

Rather than enrolling in the traditional Medicare fee-for-service plan, Medicare beneficiaries have the option of enrolling in a private Medicare plan. The goals of Medicare private plans include giving enrollees more choices, modernizing benefits, and helping to control costs. The Medicare+Choice (M+C) program was established in 1997 as a significant attempt to provide Medicare benefits through private health plans. M+C private plans included local managed care plans, which covered not only all of the traditional Medicare Part A and Part B services, but could also have provided additional benefits and lower cost-sharing requirements (often at an additional premium cost to the enrollee). Participation in M+C plans was somewhat disappointing, however, enrolling only about 5 million (12 percent) of Medicare enrollees in 2002 (many plans withdrew from the program due to concerns of insufficient payments).

The Medicare Modernization Act of 2003 expands Medicare's use of private plans by replacing M+C plans with Medicare Advantage plans, which will now include regional managed care plans. Medicare Advantage plan payments will increase to encourage more private plan participation. In addition, new prescription drug benefits will be available through private stand-alone prescription drug plans or through Medicare Advantage plans.

In addition to introducing more private plans into Medicare, the new law also introduces some competitive elements into the plan payment system. Previously, Medicare managed care plans were paid an area-specific capitation rate; all Medicare managed care plans in that area received the same payment for each of its enrollees. Beginning in 2006, however, payments to plans will vary based on a comparison of plan bids to a benchmark.[3] Plans with bids below the benchmark will receive payments equal to their bid plus a rebate equal to three-quarters of the difference between their bid and the benchmark. Plans with bids above the benchmark will need to charge enrollees premiums equal to the difference between their bid and the benchmark.

These new competitive elements serve to increase the competition among private Medicare plans. The new Medicare law also moves toward implementing competition between traditional Medicare and private plans through a six-year demonstration program beginning in 2010. In up to six metropolitan areas, Medicare enrollees will be given a choice between private plans and the traditional program. If traditional Medicare can provide benefits at a lower cost than private plans, traditional plan premiums will be lower than those for the private plans, and vice versa.

Introducing additional competitive elements into Medicare has been suggested as a way to help control future Medicare costs. For instance, the demonstration projects mentioned above could be a first step toward a more defined contribution (or premium support) approach to Medicare. The essential change would be that Congress would define the level of Medicare funding provided to Medicare beneficiaries rather than to define the level of benefits provided. Conceptually, it would shift the program's focus away from guaranteeing enrollees a defined set of benefits (with the Medicare trust funds and federal government responsible for any funding shortfall) toward providing a fixed government contribution that enrollees could apply toward purchasing health care coverage (with the enrollees responsible for making up the difference between the government contribution and the cost of the benefits they select). Typically, proposals for such an approach would make the traditional fee-for-service Medicare one of the options available. Steps may need to be taken to ensure a level playing field between private plans and the traditional fee-for-service program.

3. Bids and benchmarks will be risk adjusted.

Addressing the Insurance Needs of Individuals Ages 55 to 64

Some policy-makers have suggested addressing the health care needs of individuals age 55 to 64 through an expansion of Medicare. Individuals who are not yet eligible for Medicare are particularly vulnerable to lacking health insurance. According to the U.S. Census Bureau, approximately 13 percent of adults age 55 to 64 lack health insurance. Although uninsured rates for these older adults who are not yet Medicare eligible are lower than those for younger adults, being uninsured can be particularly problematic for this group because health problems tend to increase with age.

Declines in employer-sponsored retiree health insurance coverage could exacerbate this problem. Early retirees, that is workers who retire before age 65 (the Medicare eligibility age), often rely on retiree health insurance coverage from a former employer for their health insurance needs. However, access to retiree health coverage has declined dramatically in recent years. For instance, Hewitt Associates found that the share of large employers offering health insurance coverage to their pre-Medicare retirees declined from 88 percent in 1991 to 76 percent in 1999. Moreover, employers who continue to offer coverage have been increasing the premiums and/or cost sharing requirements, forcing some retirees to forgo coverage.

The new Medicare law provides incentives to encourage employers to retain retiree health insurance. In particular, it would provide subsidies to employers who provide prescription drug coverage to retirees. However, these subsidies apply only to retirees who are eligible for Medicare. They do not apply to coverage for pre-Medicare retirees.

Reducing the costs of coverage is key to addressing the decline in retiree health insurance. Without stemming this growth in costs, firms will continue to reduce or eliminate coverage. Providing tax incentives to employers for pre-funding retiree health insurance is one way to reduce the decline in coverage. Although this approach might help a little, employers might be wary of the reduced flexibility that would likely accompany such subsidies.

These concerns that individuals approaching age 65 are less likely than younger adults to have access to health coverage through employment and that, due to deteriorating health, they may be less able to purchase individual health insurance, have led some policy-makers to propose expanding the Medicare program to allow certain individuals between the ages of 55 and 64 to participate on a voluntary "buy in" basis. General considerations for Medicare buy-in programs include:

- The costs of such a program would be strongly influenced by the health status of those who choose to participate. To keep per-enrollee costs at manageable levels, it is important to attract as many healthy individuals as possible.
- Even with provisions designed to attract healthy individuals, some degree of adverse selection is inevitable. An innovative, but unproven, way to recapture increased costs due to adverse selection is to increase Medicare premiums from age 65 to 85 for buy-in participants.
- Although subsidizing premiums could increase participation, this would increase the costs of the program to taxpayers.

Summary

The passage of the Medicare Modernization Act of 2003 made some of the most significant changes to the Medicare program since its inception. Many concerns regarding the Medicare program remain, however. This issue brief outlines four areas where further action by policy-makers may be warranted. First, Medicare faces serious long-term financing problems. Not only will the Medicare trust funds face increasing financial pressures, but Medicare expenditures will also place increasing strains on the economy. Second, Medicare's benefit package and cost-sharing requirements should ensure a proper balance between providing seniors with adequate access to health care and discouraging unnecessary care. Third, introducing additional competitive elements into Medicare can be explored as a method of controlling costs. Finally, expanding Medicare may be an option for addressing the insurance needs of individuals ages 55 to 64.

Related Resources from the American Academy of Actuaries

Medicare's Financial Condition
Medicare's Financial Condition: Beyond Actuarial Balance (March 2004)
What is the Role of the Federal Medicare Actuary? (January 2002)
How is Medicare Financed? (Fall 2001)

Balancing Access to Care with Incentives to Avoid Unnecessary Utilization
Report on Medicare Supplement Experience, 1996-2000 (February 2003)

Private Plans and Private Sector Competition Strategies
Applying the Defined Contribution Approach to Medicare: A Primer (July 2002)
Medicare Reform: Using Private Sector Competition Strategies (April 2000)

Addressing the Insurance Needs of Individuals Ages 55 to 64
Actuarial Issues in Medicare Expansion (Spring 1998)

AMERICAN ACADEMY *of* ACTUARIES

1100 Seventeenth Street NW
Seventh Floor
Washington, DC 20036
www.actuary.org