

**Conference of Consulting Actuaries  
Session 51**

## Medicare Futures

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**November 4, 2009**

## Today's agenda

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- Medicare's current state
  - The participant experience
  - Funding and cost
  - Payment policy
- Changes on the horizon
  - Medicare initiatives
  - Broader health care reform
- Implications of potential changes
  - On Medicare participants and providers
  - For employer sponsored post-65 retiree medical
  - For active health care
- Please....ask questions as we go
  - We want this to be a dialog (without the rancor of Town Hall meetings!)
  - Any cynical comments by facilitators are solely the responsibility of the speaker and do not reflect official Towers Perrin views!

## Medicare's current state

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- Popular with seniors
- Funding challenges
- Laboratory for changes in provider payment policy

## “Don’t replace my Medicare with socialized health care!!”

### ■ Seniors like Medicare

- Over 45m aged and disabled beneficiaries
- Unlike Social Security, full benefits at 65
- Significant coverage gap filled with Part D
- Broad access to virtually all hospitals and doctors
- Predictable and stable coverage
- Relatively smooth hassle free claim process
- No utilization management intervening in doctor/patient relationship
- No rationing!
- Solid majority have supplemental coverage in some form (plan/members)

MA	11m
Medigap	7-8m
Medicaid	6m
Employer (RDS)	6m

### ■ Secure and safe haven

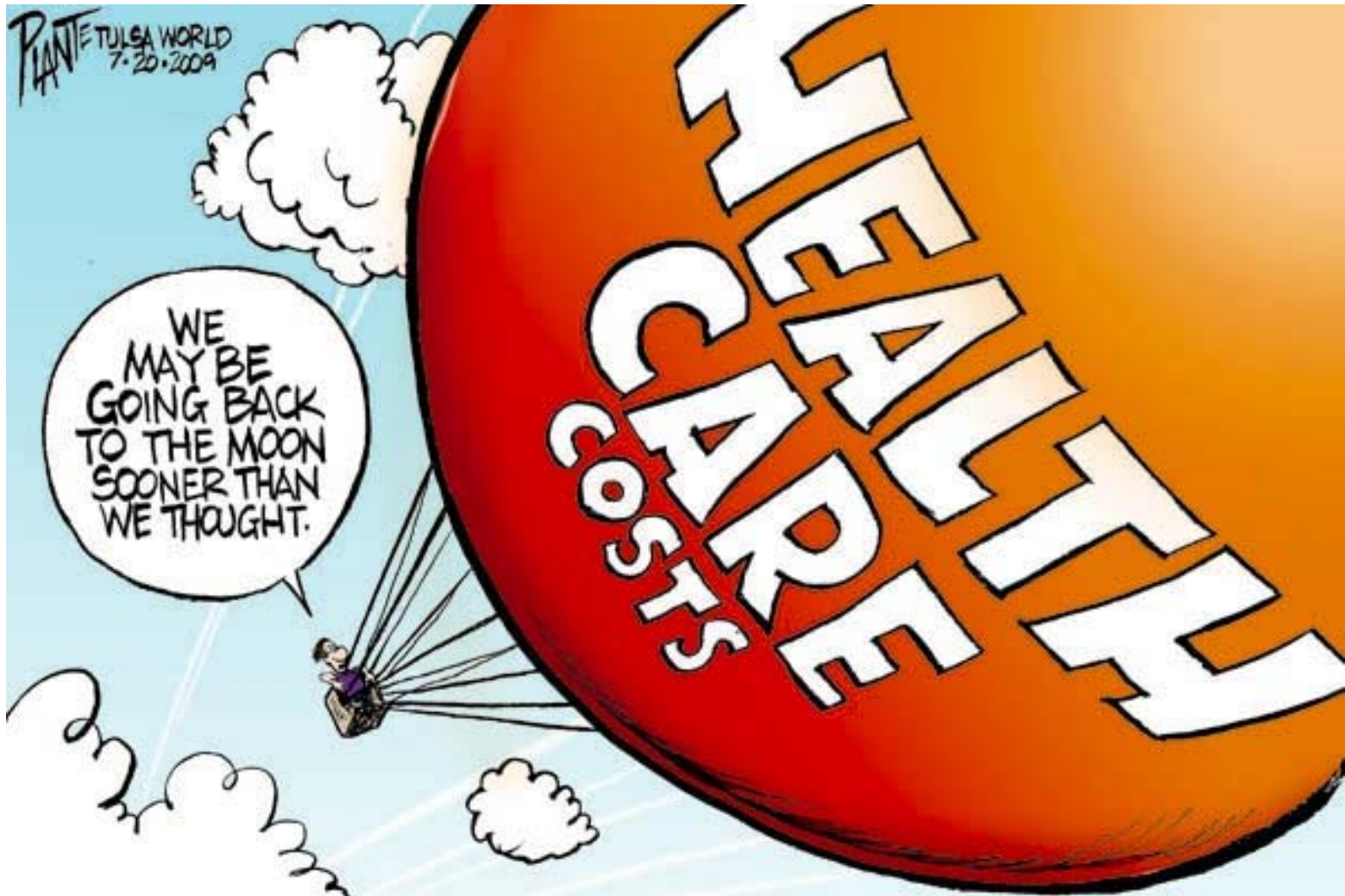
- Voting constituency
- Strong lobby (e.g., AARP)

## Key 2010 provisions

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- Part A deductible \$1,100
- Part B deductible \$155
- Part B premiums
  - Base rate \$110.50
  - To remain at \$96.40 for large majority of seniors subject to Social Security “hold harmless” provision (no SS COLA)
  - Higher premium for income over \$85,000
- Part D
  - Benefit provisions indexed about 5%
  - Average premiums expected to increase from \$35 to \$39 (weighted by enrollment)

Continuing cost escalation.....



## Funding challenges

- History of federal outlays (cost/share of federal spending)\*

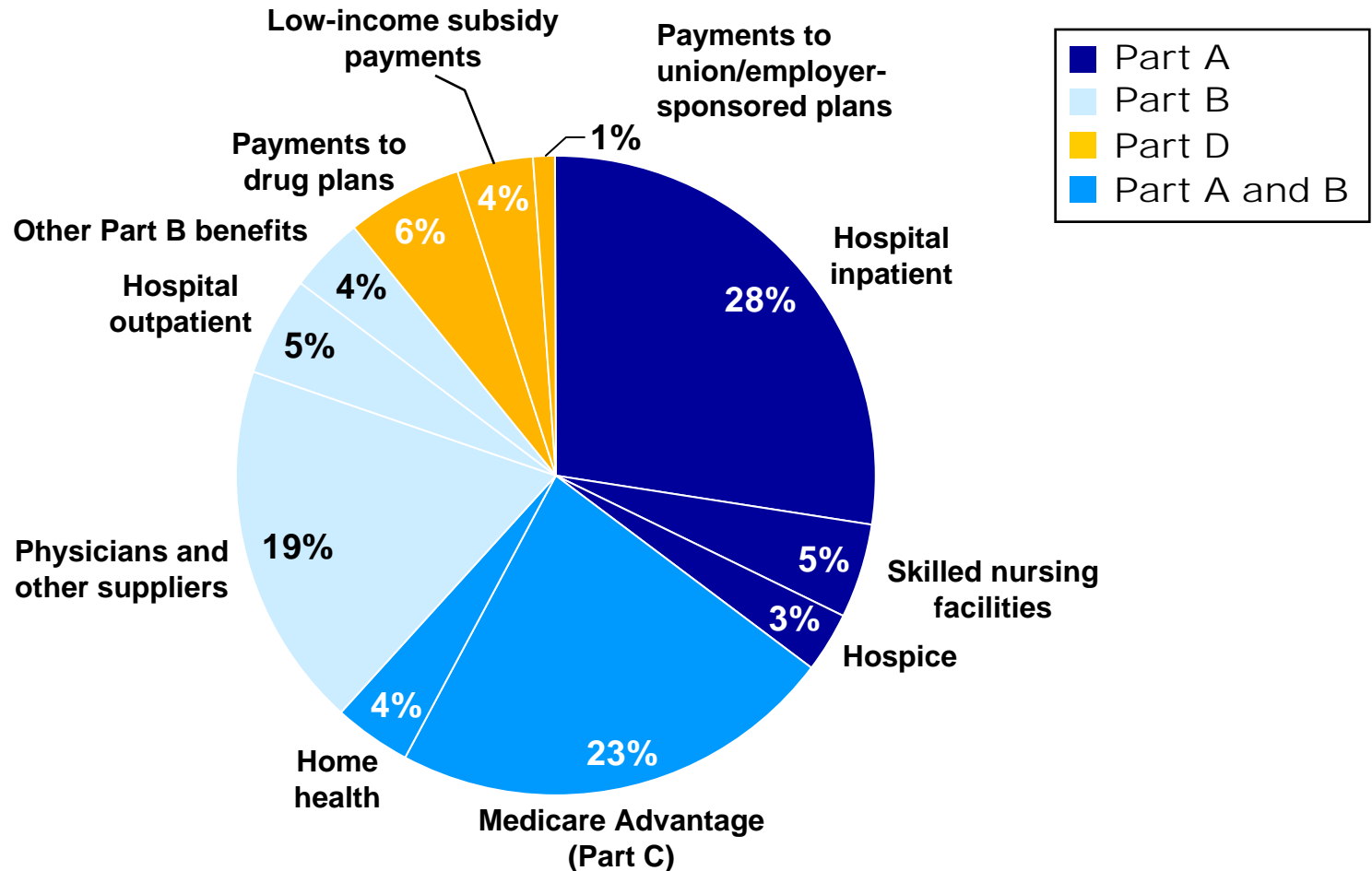
1970	\$7B	4%
1980	\$35B	6%
1990	\$110B	9%
2000	\$219B	12%
2009	\$511B	--
2018	\$926B	--

Actuarial quiz: first to compute CAGR from 1970 to 2018 wins a free pocket protector!

- Share of GDP projected to rise from 3.5% in 2010 to 6.4% in 2030
- Part A Trust Fund exhaustion projected by 2017
- Who pays?
  - 40% via active payroll tax (MICA – Part A)
  - 39% through general revenues (75% of Parts B and D)
  - 12% from beneficiary premiums (Parts B and D)
  - 9% other
  - Federal share growing
- Boomer retirements to drive participant count toward 77m by 2040

\* Source: 2009 Trustees report via Kaiser Family Foundation

## How the money is spent - by type of service, 2009



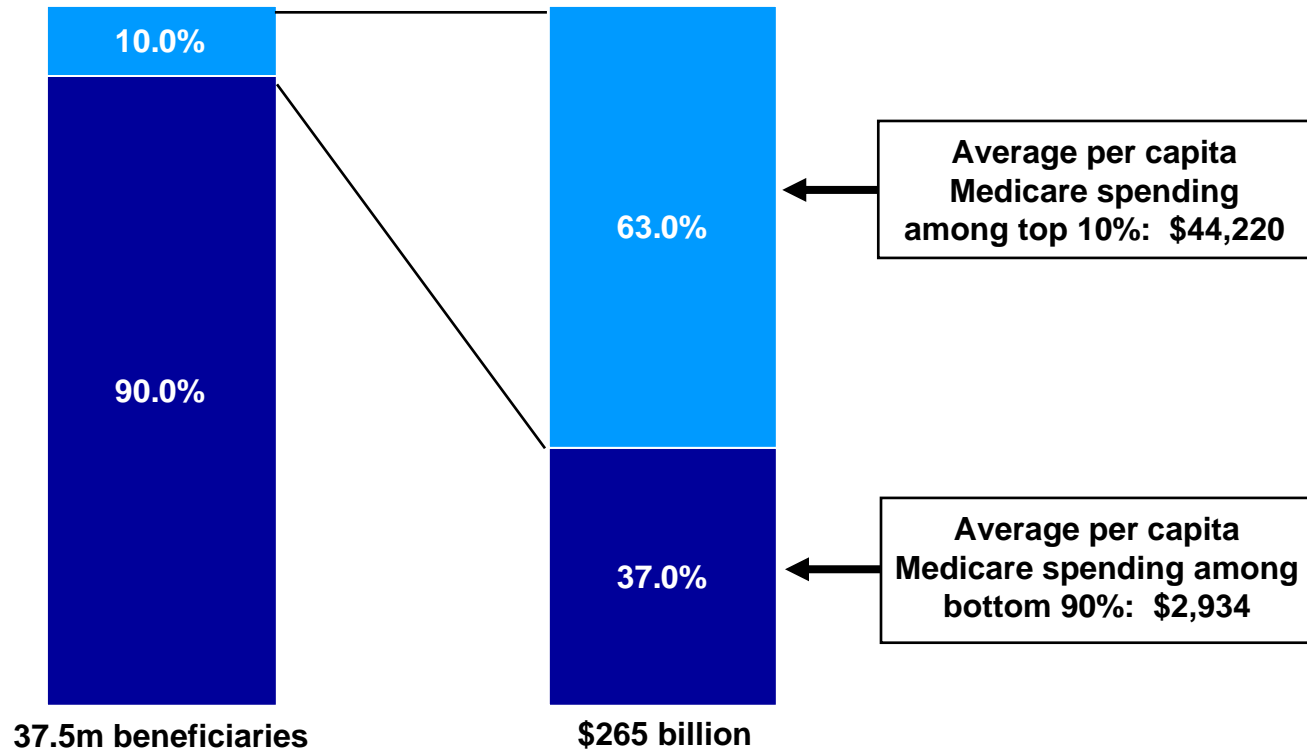
Total Annual Benefit Payments = \$484 billion

Notes: Total does not include \$2.5 billion in administrative expenses such as spending for implementation of the Medicare drug benefit and the Medicare Advantage program. Total is net of \$9.4 billion in recoveries for 2009.

Source: Congressional Budget office, Medicare Baseline, March 2009.

# How the money is spent - by participant utilization

## Distribution of Medicare enrollment and spending – 2005



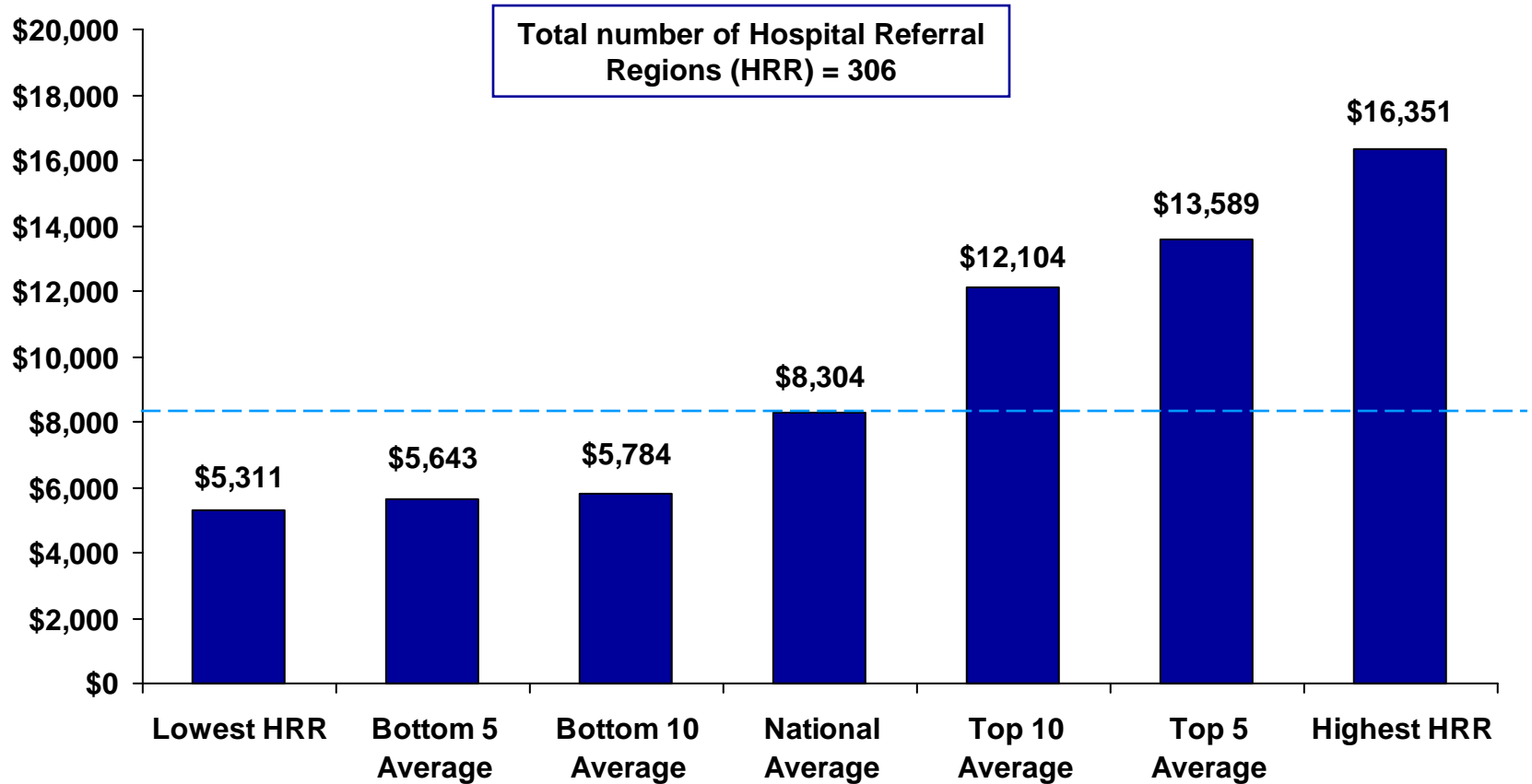
Notes: Analysis excludes Medicare Advantage enrollees.

Source: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost & Use file, 2005.

## How the money is spent – by region

### Geographic variation in Medicare spending – 2006

*Total Medicare Reimbursements per Enrollee (Part A and B)*

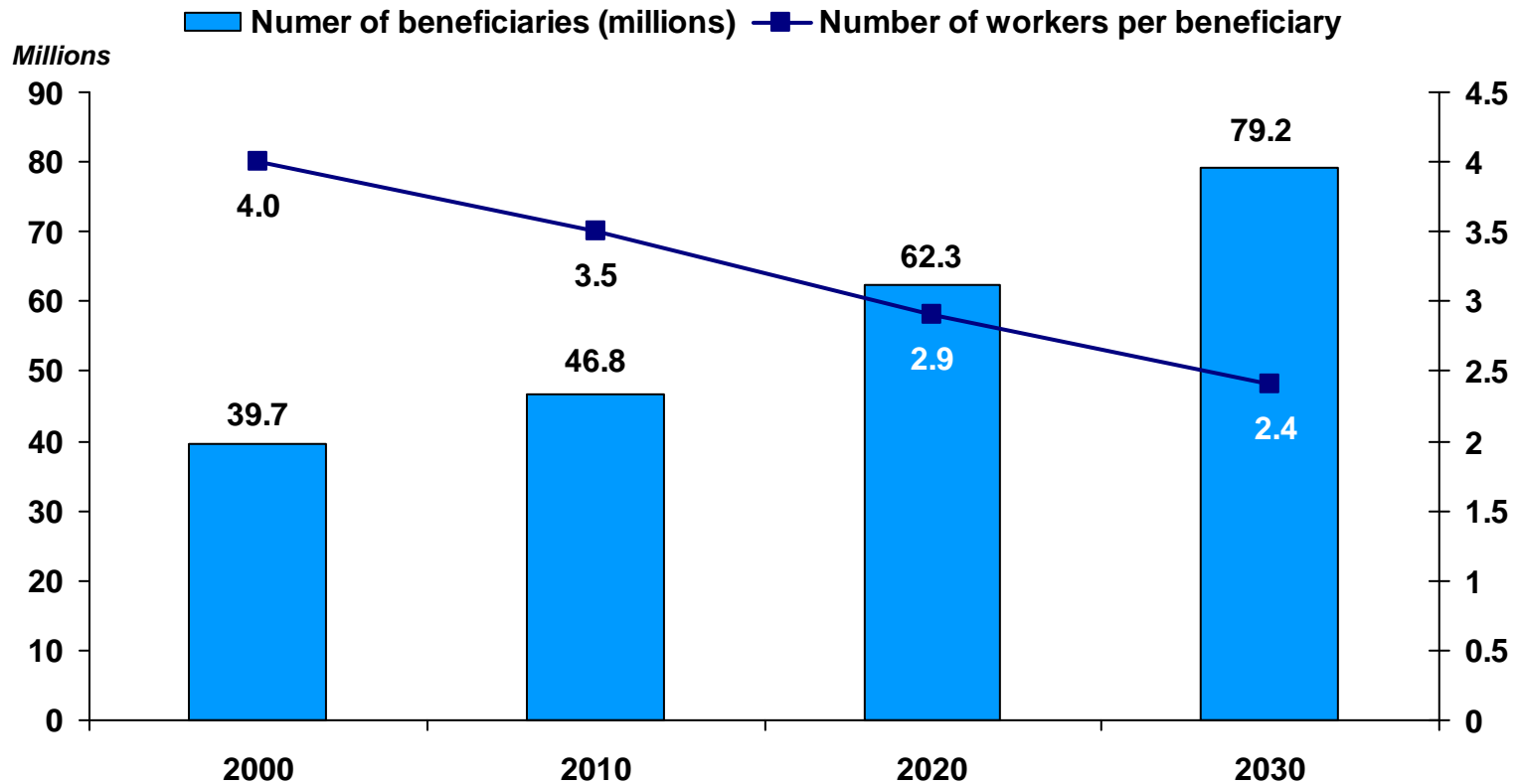


Note: Hospital Referral Regions (HRRs) represent regional health care markets for tertiary medical care. Each HRR contains at least one hospital that performed major cardiovascular procedures and neurosurgery.

Source: Kaiser Family Foundation based on the Dartmouth Atlas of Health Care, Selected Medicare Reimbursement measures

## Declining worker/beneficiary ratio increases funding stress

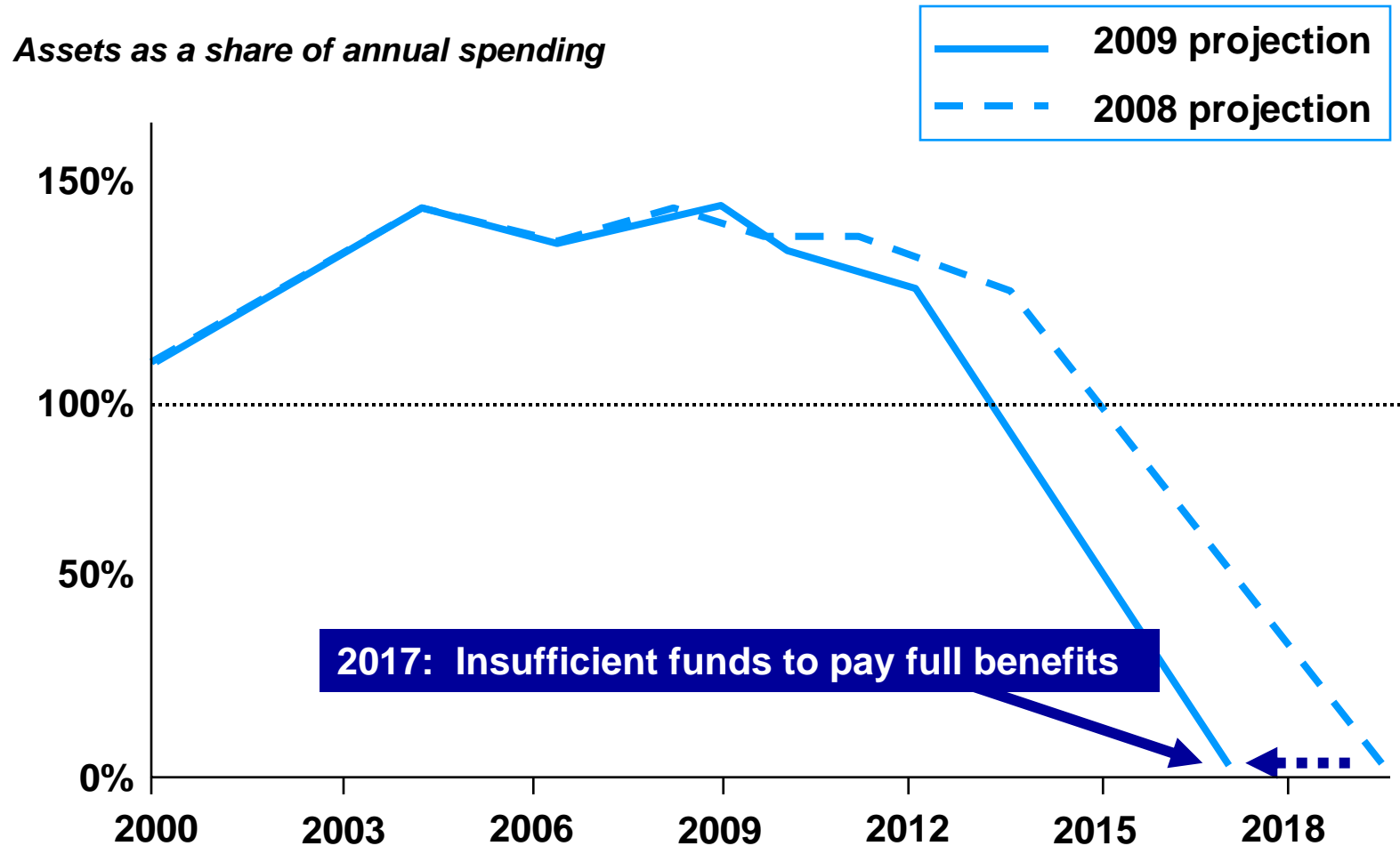
### Change in Medicare population and number of workers per beneficiary



Source: Kaiser Family Foundation based on the 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

## Trajectory of Part A Trust Fund solvency

**Medicare's Part A Trust Fund will not have sufficient funds to pay full benefits in 2017**



## Political pressures worsen funding challenges

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- MICA tax insufficient for long term Part A trust solvency
- No Social Security COLA, so no Part B increase for most seniors
- Annual cuts to Part B fee schedule under SGR fought (successfully, so far) by doctors claiming threat to senior access as physicians stop accepting new patients
- Cuts to Part A payments?
  - Hospitals already paid less under Medicare than under managed care
- Generally good news on Part D front
  - Actual costs less than originally expected
  - But strong pressure to enhance coverage in donut hole
    - See health care reform!
- Something for everyone, and let the rich pay for it all!
  - Payroll cap lifted on MICA tax
  - Part B means testing in effect since 2007
    - Part B “hold harmless” does not apply for income above \$85,000
  - Part D means testing on the way?

## Provider payment policy

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- Medicare as a forerunner in provider payment innovation
  - Inpatient
    - DRG prospective payment system rewards efficiency
    - Payment withhold for adverse events (e.g., readmissions)
  - Part B
    - RBRVS intended, in part, to rebalance payments toward primary care
    - SGR intended to control long term spending (*how's that working?*)
  - Changes in payment methodology for other services (e.g., outpatient hospitalization, home health, oncology infusion drugs)
  - Part D via private insurer competition (*how long will that last?*)
  - Managed care tends to follow Medicare's lead (at a safe distance...)
    - Inpatient per diems
    - Fee schedules based on RBRVS

## Changes on the horizon

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- Medicare initiatives
- Health care reform

## What's in store for Medicare? Some ideas under consideration

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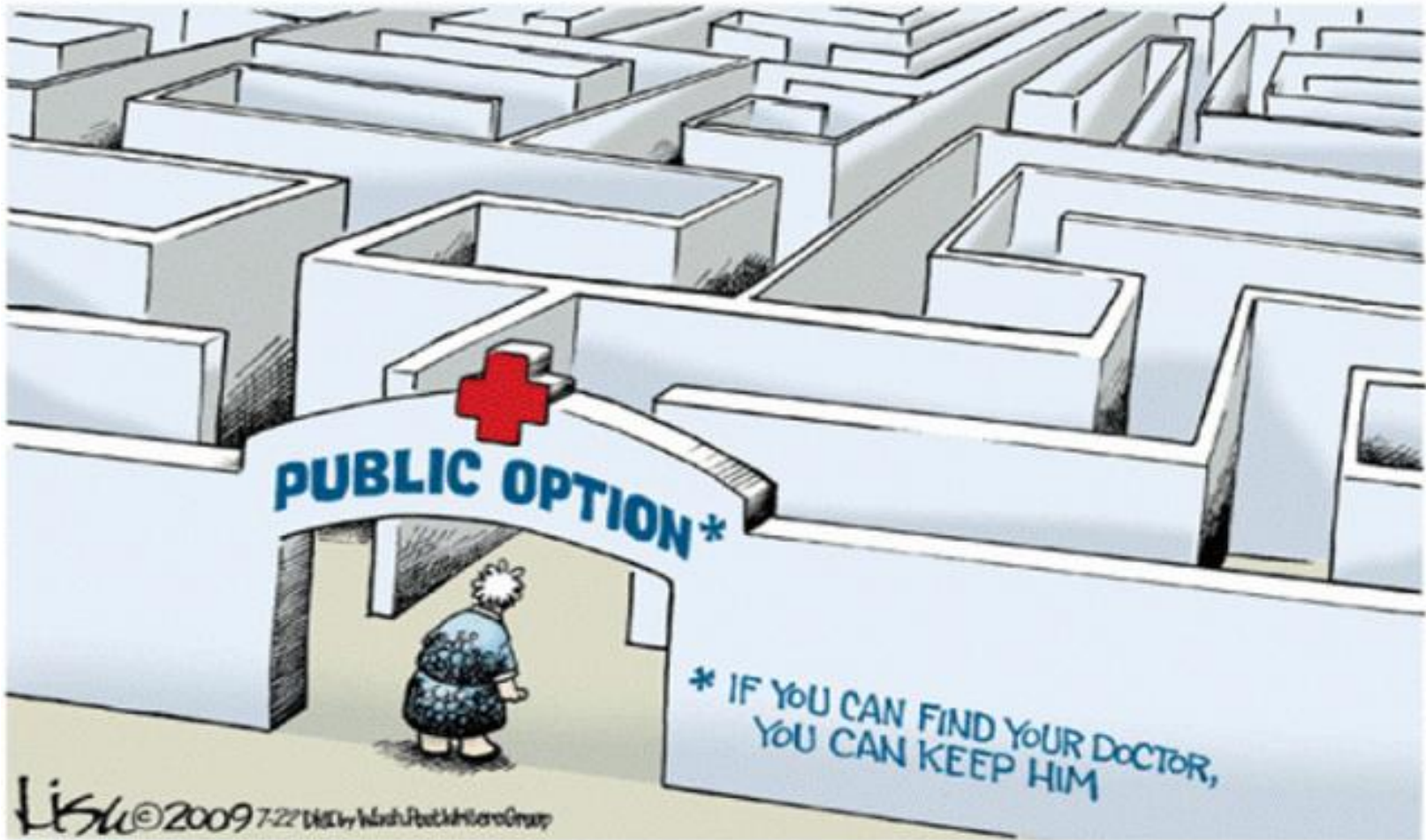
- Part A
  - Non-payment for avoidable inpatient readmissions
  - Hospital value based purchasing (VBP) under SFC version of HCR
- Part B
  - Rebalancing Part B payments toward primary care
  - Fixing SGR
  - Further improvements in preventive care coverage
- Part C
  - Killing off PFFS for 2011
    - Fallout beginning with 2010 carrier withdrawals
  - Starving off the rest of MA via payment reform
- Part D
  - Means testing for premiums a la Part B
  - Government “negotiation” of drug prices
  - End of private insurer role?
  - Filling in the donut hole
  - RDS tax break reduced

## Parallels with health care reform

Likely reform element	Current Medicare Status
■ Mandated coverage	✓
■ Federal low income subsidies	✓
■ Guaranteed issue	✓
■ No pre-existing condition exclusion	✓
■ Public option	✓
■ Minimum benefits	✓
■ Employer pay or play mandate	✓ (sort of - RDS is “pay to play”)
■ Death panels	✓ (no, not really!)
■ Comparative effectiveness research	✓ (but not used for anything)
■ Private insurer role	✓ (but stay tuned re MA funding)
■ Regional insurance exchange	Not exactly, but see Medicare Coordinator

So national health care reform 2009 style encompasses most of the same elements of Medicare circa 1965!

Access continues to be a priority



## Wild card components of health care reform

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- Pay for performance (P4P)
  - Medicare physician payments based on quality and costs
    - Value based and budget neutral
  - Hospital value-based purchasing – payments tied to quality and costs
  - Physician quality reporting initiative – incentives for those voluntarily reporting data
    - Penalties for Medicare physicians who don't report
- Payment reform
  - Accountable care organizations – improve quality, keep portion of savings
  - Permanent independent commission to recommend Medicare payment reductions (except for hospitals)
  - CMS innovation center – assess different payment structures to slow cost growth
    - Global payments, care coordination models, others
    - Pilot program based on episodes of care that would eventually become part of Medicare

## Wild card components of health care reform

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- Health information technology
  - Encourage increased use of EMR
  - Demonstration project to develop best practices for using HIT in nursing homes
  - Use HIT to collect and disseminate comparative effectiveness research findings
- Medical home/primary care
  - PCP in areas where shortages exist would receive Medicare bonus payments
    - Across the board reduction in payments for all other Medicare services
  - Workforce advisory committee – recruit, train, and retain sufficient health care workforce
  - Teaching health centers receive grants to train PCPs
  - Medicare chronic care home demonstration project
- Miscellaneous
  - Price and quality transparency
  - Comparative effectiveness research (CER) studies
  - Evidence based medicine
  - Health and wellness promotion – incentives

**continued**

## What might all this mean? Thinking ahead

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- For Medicare participants and providers
- For employers
- For active health care

## For Medicare participants and providers

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- Can cuts to Medicare ( \$400B to help pay for HCR) be realized without impacting seniors?
  - Provider payments already fall below managed care payment levels
    - Fear of a public option based on Medicare payment levels
  - Is there enough WFA to pay for dramatic expansion of access?
    - Waste, fraud and abuse: easy to criticize, hard to root out
    - One person's WFA is another's livelihood
- Hospitals
  - Offered \$155B in savings under health care reform
    - Banking on reduced cost for uncompensated care
  - Cuts to hospital payments can impact quality and access
    - Nursing care as largest variable cost
- What about physicians?
  - Shortage of primary care, especially in rural areas
    - NP/PA as the new primary care
  - Changes in RBRVS can impact provider access
    - What will replace the ineffectual SGR system?

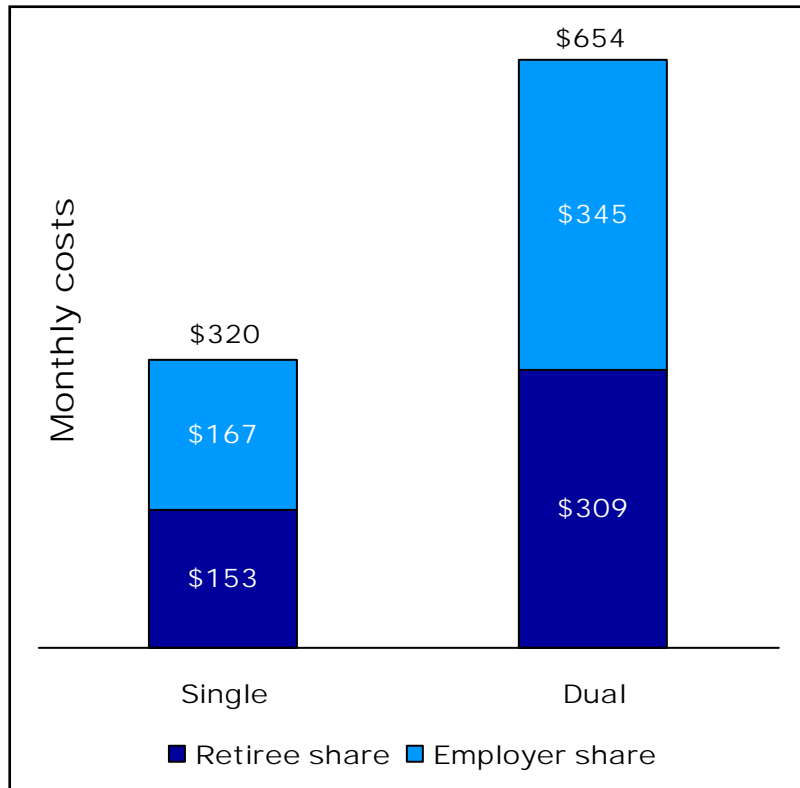
## For Medicare participants and providers

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- Medicare Advantage
  - The rise and fall....and resurrection...and another fall coming?
  - 2010 benefit cuts under MA due to reduced capitation payments
    - 11m seniors enjoy enhanced benefits
  - PFFS fading before its effective elimination in 2011
  - Prospects for a continuing private insurer role
- Pharmaceuticals
  - Offered \$80B in savings over 10 years under health care reform to help fill Part D donut hole (via 50% discount on brand drugs)
  - Additional assessment of \$22B over 10 years
- Health insurers - \$60B assessment over 10 years
  - Likely to be transferred or built in to cost structure
- Medical device manufacturers - \$39B over 10 years
  - Transferred through increases in costs

## Post-65 program cost

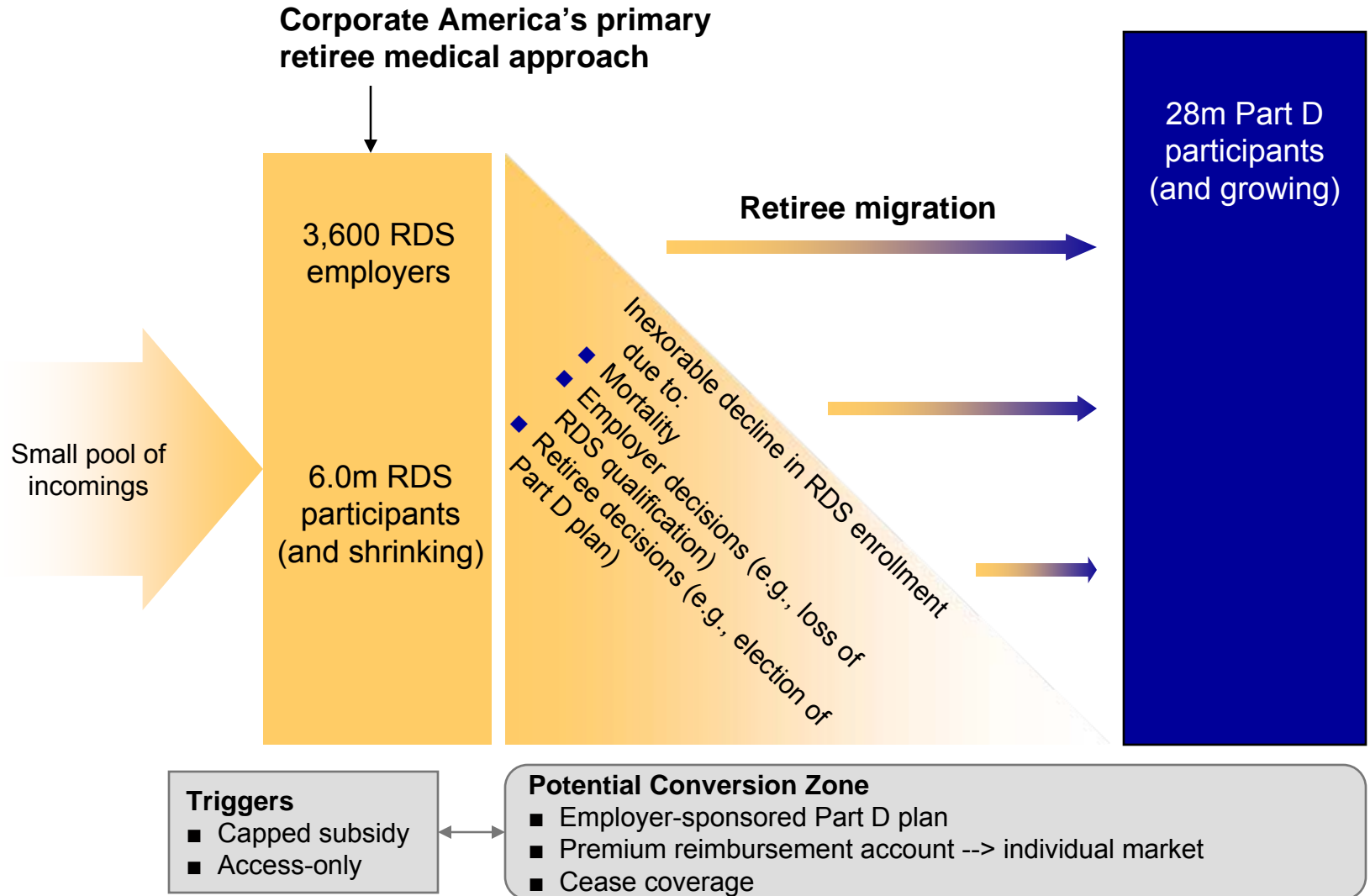
### Towers Perrin 2010 Health Care Cost Survey



### Post-65 retiree medical issues

- Overall, Medicare covers about two-thirds of total medical/Rx cost, leaving almost \$5,000 in uncovered cost per year
- Rx typically accounts for 50% to 70% of employer plan cost
- For most plans collecting Part D RDS payments, net employer cost reduced by RDS payment plus associated tax benefit
- Employer sponsored post-65 retiree medical is a (slowly) dying business
  - Driven in part by growing RDS infeasibility or ineligibility

# Shift influenced by employer and retiree decisions



## For employers (and insurers)

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- Continuing erosion of employer role in sponsorship and subsidization of post-65 coverage
  - 1990s: FAS 106 leads to subsidy caps, benefit reductions, eligibility cuts (often prospective, with results hitting today)
  - Early 2000s: employers stay the course in a strong economy without good alternatives to employer role
  - Post-65 coverage simply not part of the future rewards package
    - Restructured to encourage employees to save for retiree medical
- MMA 2006 changes the dynamic with dramatic expansion of Medicare options
  - Introduction of Part D
  - Reinvigoration of Medicare Advantage
  - Ample federal funding promotes competition....of a sort
  - RDS as employer “pay to play” initiative
- 2009: economic conditions drive acceleration of employer exit trend
- Rise of the Medicare Coordinator (e.g., Extend Health, UHC)
  - Parallel to health insurance exchange
  - Provides answer to employer exit dilemma (how can we end group plan sponsorship in a socially responsible manner?)

## For employers (and insurers)

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- Employer exit seen in
  - Declining RDS participation
    - 2007 6.9m
    - 2008 6.7m
    - 2009 under 6m
  - And in movement toward individual market alternatives, via Medicare Coordinator
    - Extend Health
    - UHC's Medicare Connector
    - MA membership exceeding 11m
      - Individual membership over 9m
    - Medigap as secure hedge against MA funding cuts
- All of this underscores continuing opportunity for carriers serving the individual market to experience substantial revenue growth
  - Premium revenues range from \$1,500 to \$3,000 per year for Medigap, Part D to \$9,000 - \$10,000 per year for MA

## For active health care

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- Managed care tends to follow many Medicare practices
  - Prospective payment (e.g., inpatient care)
  - Fee schedule (RBRVS)
  - Use of incentives (for care quality, following EBM guidelines, promoting primary care, and so on)
  - Accountable care organizations or Integrated delivery systems
  - P4P, global payments, episodes of care.....
- Medicare Coordinator as model for regional (optional) insurance exchanges
  - Individuals purchase coverage from a menu of options from multiple carriers
- Some employers may choose to exit active health care for the same reasons other employers exit their post-65 role
  - Employees gain access to subsidized individual coverage on guaranteed issue basis, thereby negating value of employer's role
  - Employers take opportunity to cut cost and reduce administration
    - Will employers compensate employees for the reduced value of the total compensation package? How could this be done considering employer value differences by waiver/enrollee and tier of coverage?

Questions ?

