Medicare Outlook

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Employment-Based Retiree Health Benefit Trends

• Fewer employers offering benefits.
• When offered, retirees paying more.
  – Benefits.
  – Health care services.
• Higher age and service requirements.
• Employers reaching spending caps.
• Defined contribution approaches.
• Access-only plans.
• New hires often not eligible.
• Fundamentals of the financial status of Medicare remain[s] problematic under intermediate economic and demographic assumptions.”

• “Financial outlook for the Medicare HI Trust Fund … has deteriorated significantly from last year, with annual cash flow deficits beginning this year.”
Trustees Report

• Exhaustion date of trust fund moved up from 2026 to 2019.
• “do not believe the currently projected long run growth rates of … Medicare [is] sustainable”
• “Medicare’s financial difficulties come sooner-and are more severe-than those confronting Social Security”
HI Trust Fund Balance

Source: Unpublished data from CMS.
Factors Accounting for 1-Year Difference

- Lower projected payroll tax income.
- Higher than anticipated expenditures for inpatient hospital care.
- Increased payments to rural hospitals.
- Increased payments to private health plans as a result of provisions in the MMA.
Short-Term Financial Health Test

- Ratio of trust fund assets at the beginning of the year to expenditures during the year.
- For 2003, ratio was 152% - means trust fund assets exceeded expenditures by 52%.
- Ratio is at or above 100% each year over 2004-2013.
- Trust fund assets will start to decline in 2009.
Long-Term Financial Status

• Trustees examine 25, 50 & 75 year estimates.
• Tax income and costs are expressed as a percentage of taxable payroll.
  – Income rate.
  – Cost rate.
Projected Cost and Income Rates of HI Program

Source: CMS.
Medicare as a Share of GDP

Source: CMS.
## Medicare – Unfunded Liability

<table>
<thead>
<tr>
<th>Benefit Payments</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future Part A benefit payments</td>
<td>$8.2 trillion</td>
</tr>
<tr>
<td>Future Part B benefit payments</td>
<td>$11.4 trillion</td>
</tr>
<tr>
<td>Future Part D benefit payments</td>
<td>$8.1 trillion</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$27.7 trillion</strong></td>
</tr>
</tbody>
</table>

Net of debt held by the trust funds and represents net present value estimates over a 75-year period.

Source: GAO.
Drivers

- Demographics
- Health care costs
Number of Medicare Beneficiaries, 1970-2030

* Numbers may not sum due to rounding.

Source: CMS, Office of the Actuary.
Medicare Beneficiaries as a % of the Population, 1970-2030

Source: Social Security Administration, Office of the Actuary.
Life Expectancy at Age 65
Worker to Retiree Imbalance

- Ratio of workers to beneficiaries will steadily decline
- 4 workers per retiree in 2003; 2.4 workers per retiree in 2030; 2 workers per beneficiary in 2078
  - Baby boom generation will retire.
  - Life expectancy will improve.
  - Birth rates will not increase.
Raise Taxes or Cut Benefits?

• Choices to correct the financial imbalance:
  – Immediate payroll tax increase from 2.9% to 6.02% (108% increase).
  – Immediate 48% reduction in Part A benefits.
  – Some combination of payroll tax increase or benefit reduction.
Part B Trust Fund

• Trust fund always adequately funded.
• Concern about rate of growth of spending.
  – Part B: Expected annual 6.6% growth rate through 2013.
  – Part D: Expected annual 9.7% growth rate through 2013.
• Growth due to increase in volume and intensity of services, and demographics.
Part B Premium and Annual Increase in Premium

Source: CMS.
SMI as a % of GDP, Federal Taxes, & SS Benefits, 2003-2080

Source: CMS.
Uncertainty Regarding Part B and Part D Projections

• Cost projections are probably too low in the near term because current law provides for large negative physician payment updates for the several years after 2005 that are politically unrealistic.
Excess Cost Growth

• Average annual difference between growth in national health spending and growth in GDP has declined but is expected to increase
  • 1960-2001 2.5%
  • 1970-2001 2.3%
  • 1980-2001 2.3%
  • 1990-2001 1.5%
Excess Cost Growth Outlook

- SSA assumes excess cost growth of about 2% between 2000-2009, but less than 1% after that.
- CBO concludes that there is no evidence to suggest that excess cost growth will disappear rapidly.
  - It is likely to continue, to some degree, for some time to come.
- We haven’t seen such low excess cost growth for at least 44 years.
## Medicare Spending Per Beneficiary, 2000

<table>
<thead>
<tr>
<th>Highest</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miami, FL</td>
<td>Santa Fe, NM</td>
</tr>
<tr>
<td>$9,200</td>
<td>$3,500</td>
</tr>
<tr>
<td>New York, NY</td>
<td>Salem, OR</td>
</tr>
<tr>
<td>$8,000</td>
<td>$3,500</td>
</tr>
<tr>
<td>New Orleans, LA</td>
<td>Sheboygan, WI</td>
</tr>
<tr>
<td>$7,600</td>
<td>$3,700</td>
</tr>
<tr>
<td>Fort Lauderdale, FL</td>
<td>Green Bay, WI</td>
</tr>
<tr>
<td>$7,560</td>
<td>$3,700</td>
</tr>
<tr>
<td>Philadelphia, PA</td>
<td>Albuquerque, NM</td>
</tr>
<tr>
<td>$7,200</td>
<td>$3,700</td>
</tr>
<tr>
<td>Los Angeles, CA</td>
<td>National Average</td>
</tr>
<tr>
<td>$7,150</td>
<td>$5,360</td>
</tr>
</tbody>
</table>

Source: CMS and NHPF.
Research Findings on Spending Difference

- Difference in spending is related more to physician practice patterns and consumer expectations.
- Difference in spending not due to beneficiary health status.
- Substantially higher per capita spending results in no positive difference in quality, access or patient satisfaction with care.
Highlights from Dartmouth Group Studies

- Residents in higher-spending regions received 60% more care than those in lower-spending regions.
- Higher physician visits, use of specialists, and use of hospital accounted for higher spending.
- Higher-spending regions had more beds and doctors.
- Quality of care was slightly lower in higher-spending regions.
- Health outcomes were no better or worse.
- **Conclusion:** 30% reduction in spending if all regions adopted practice pattern of lower-spending regions.

Policy Options

- Provider education on evidence-based medicine.
- Public reporting of quality and cost data.
- Supply of beds and providers.
- Raise payments to rural hospitals and providers.
- Pay for performance.
- Disease and chronic-care management.
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