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# Medicare Outlook

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EBRI Policy Forum
December 2, 2004

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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.

# Board of Trustees 2004 Report

- 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."

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# 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”

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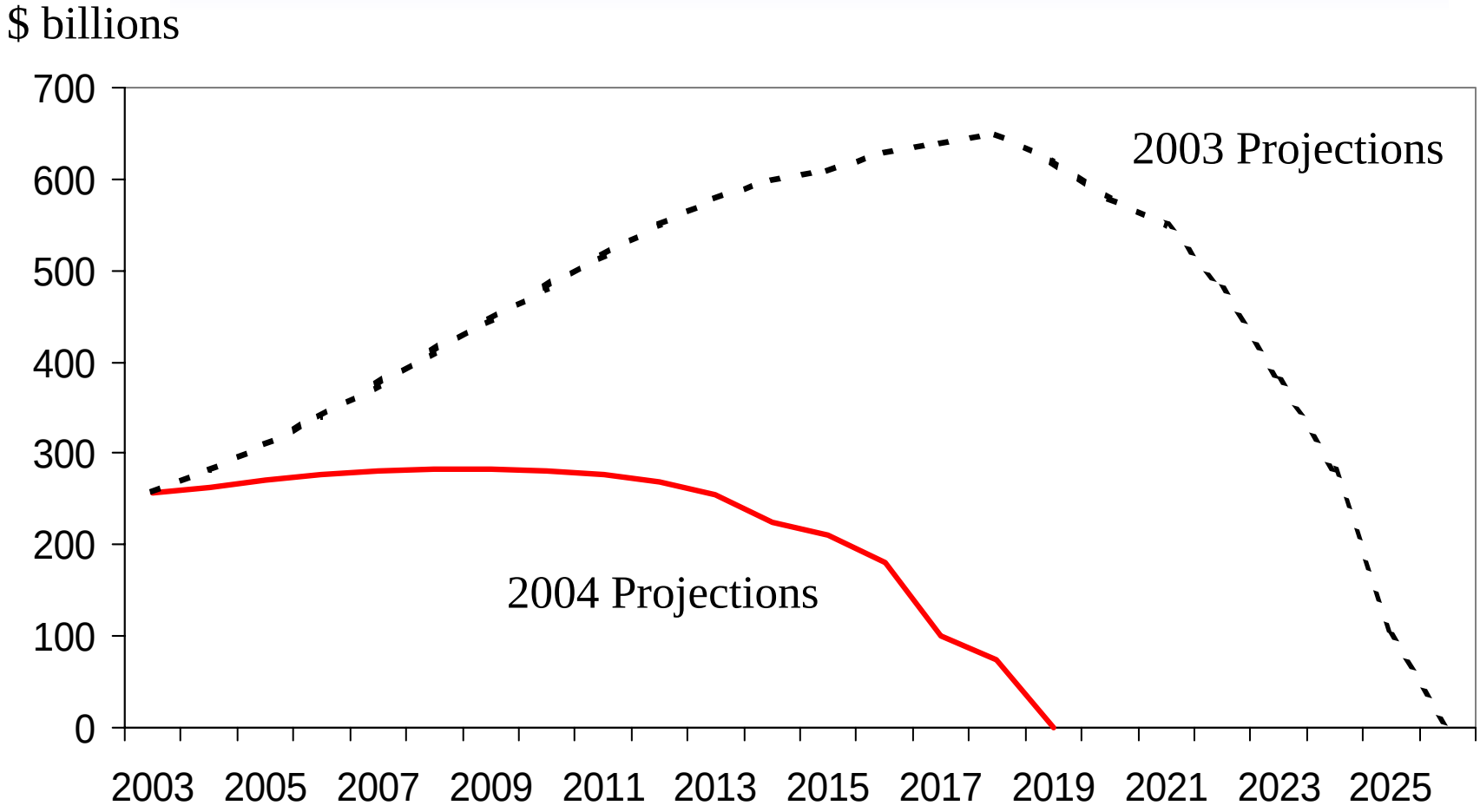
# HI Trust Fund Balance




Source: Unpublished data from CMS.

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# 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.

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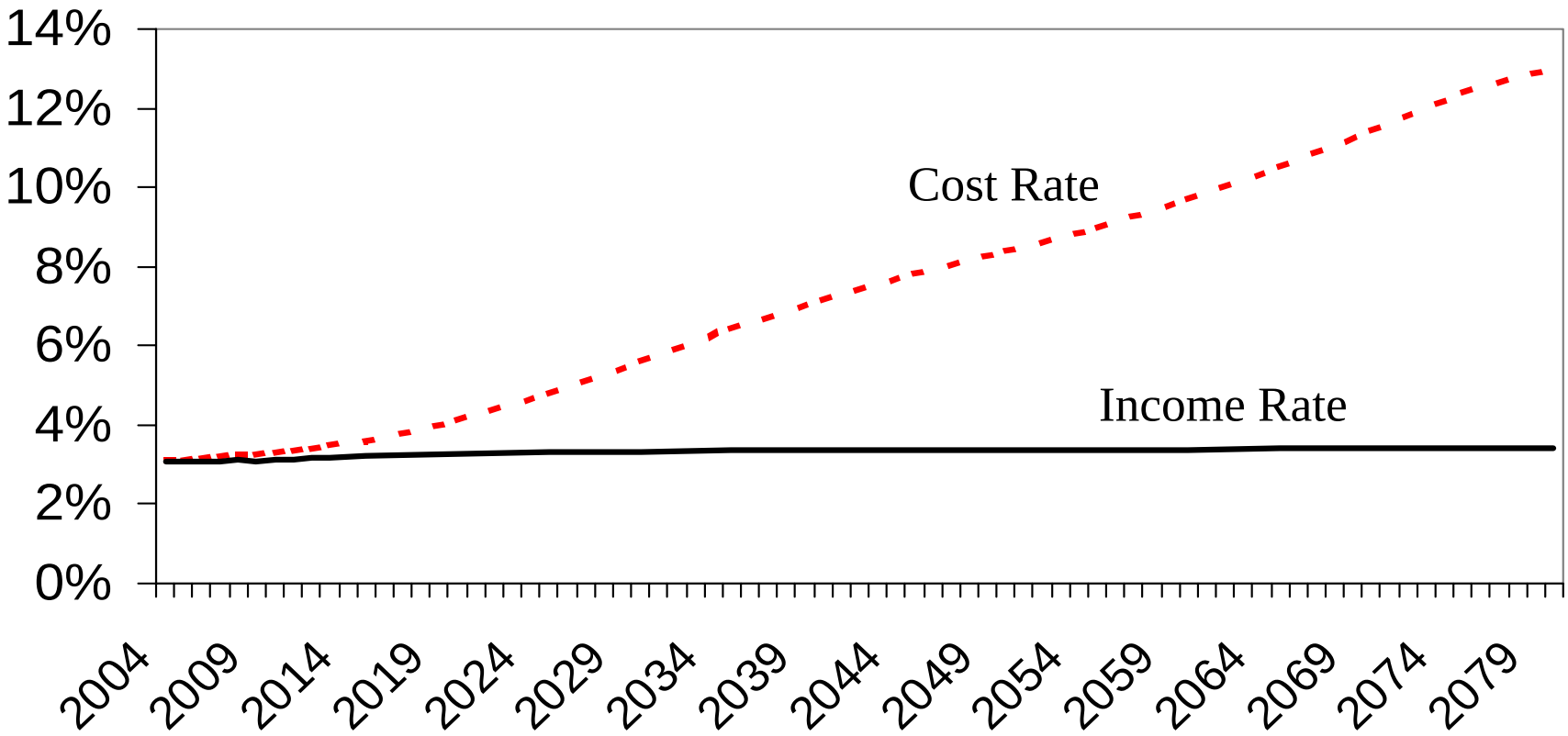
# Long-Term Financial Status

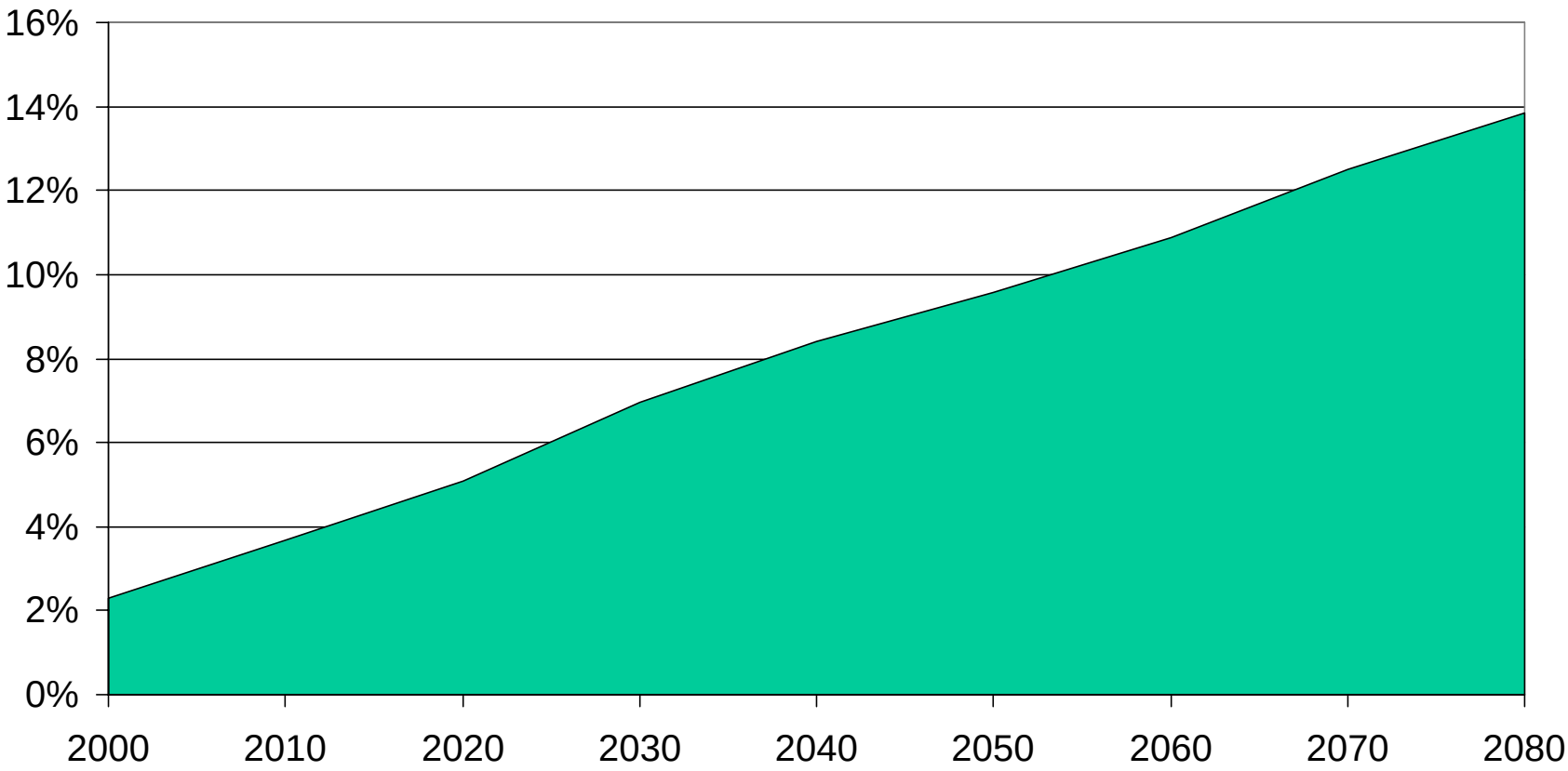
- Trustees examine 25, 50 & 75 year estimates.
- Tax income and costs are expressed as a percentage of taxable payroll.
  - Income rate.
  - Cost rate.

# Projected Cost and Income Rates of HI Program




Source: CMS.

# Medicare as a Share of GDP




Source: CMS.

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# Medicare – Unfunded Liability

| | |
|---|---|
| Future Part A benefit payments | $8.2 trillion |
| Future Part B benefit payments | $11.4 trillion |
| Future Part D benefit payments | $8.1 trillion |
| Total | $27.7 trillion |

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

Source: GAO.

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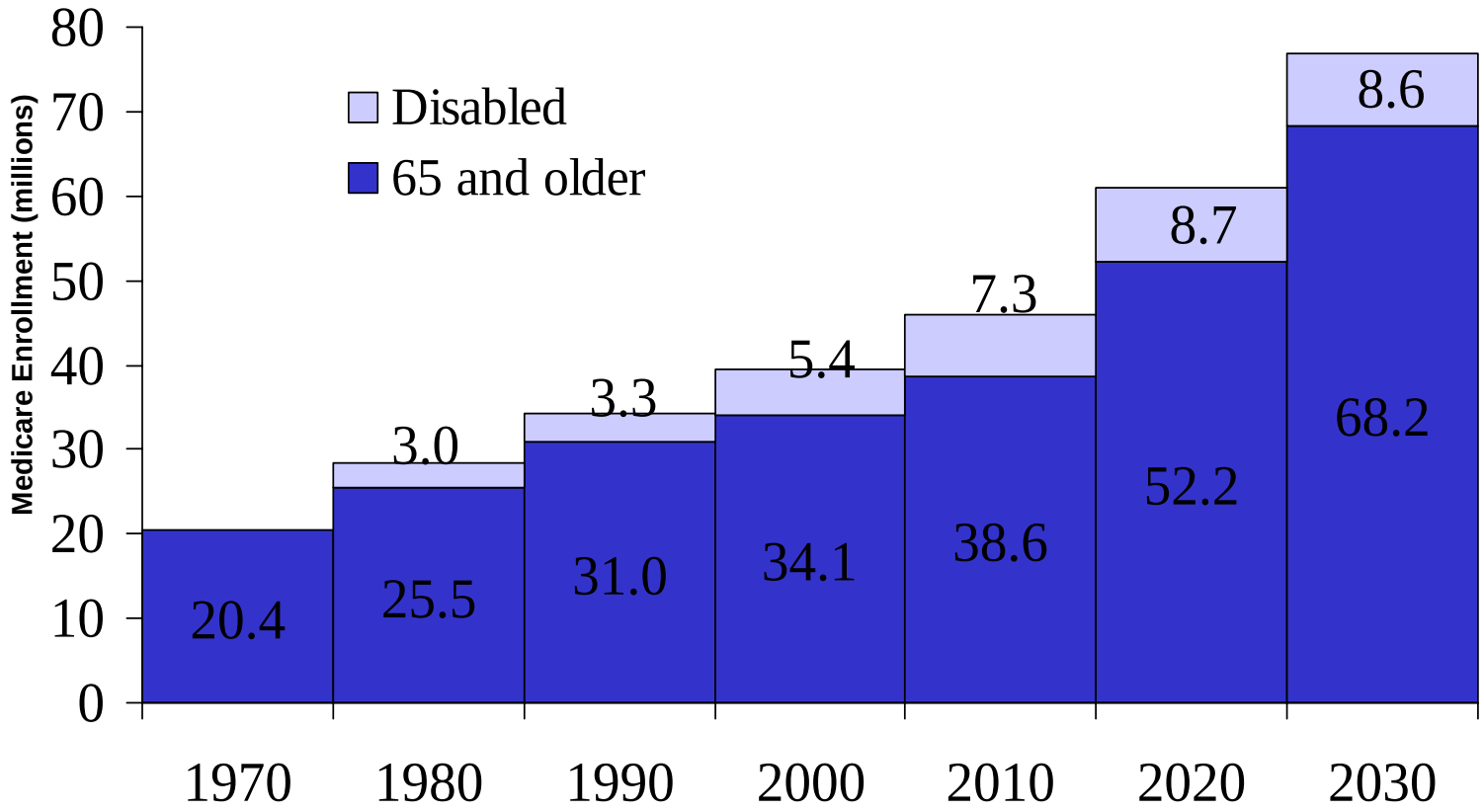
# Drivers

- Demographics
- Health care costs

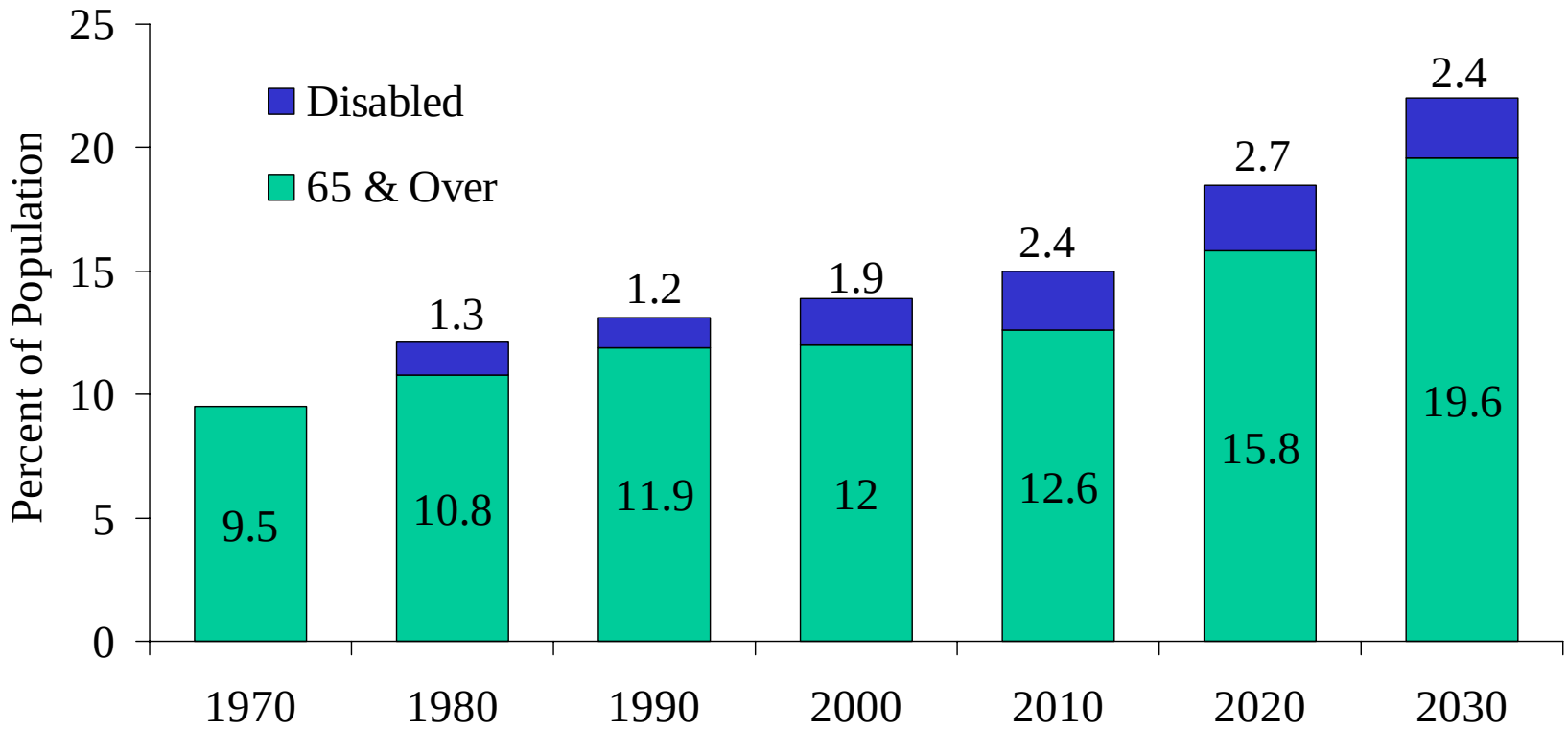
# Number of Medicare Beneficiaries, 1970-2030




* 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.

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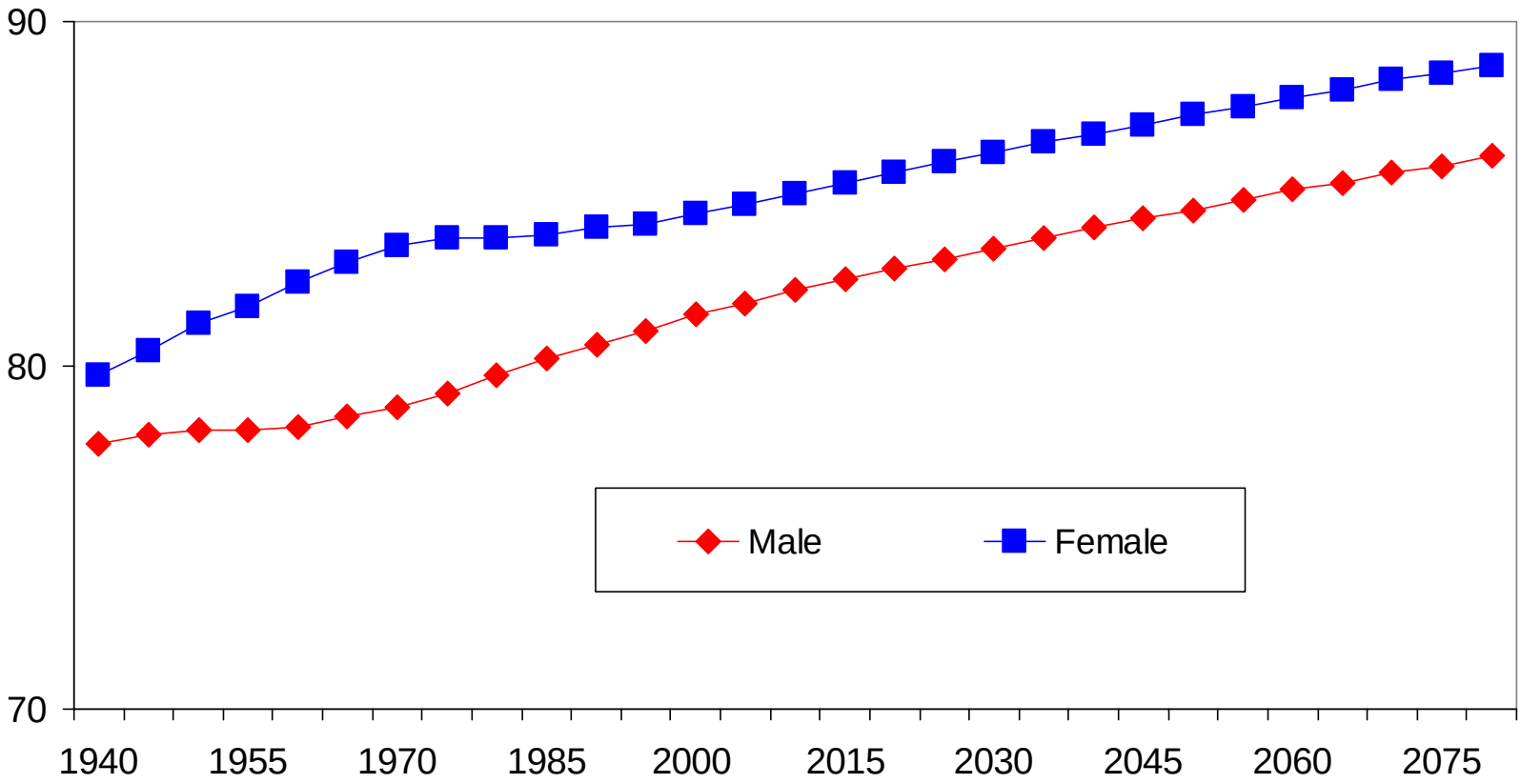
# Life Expectancy at Age 65



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# 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.

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# 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.

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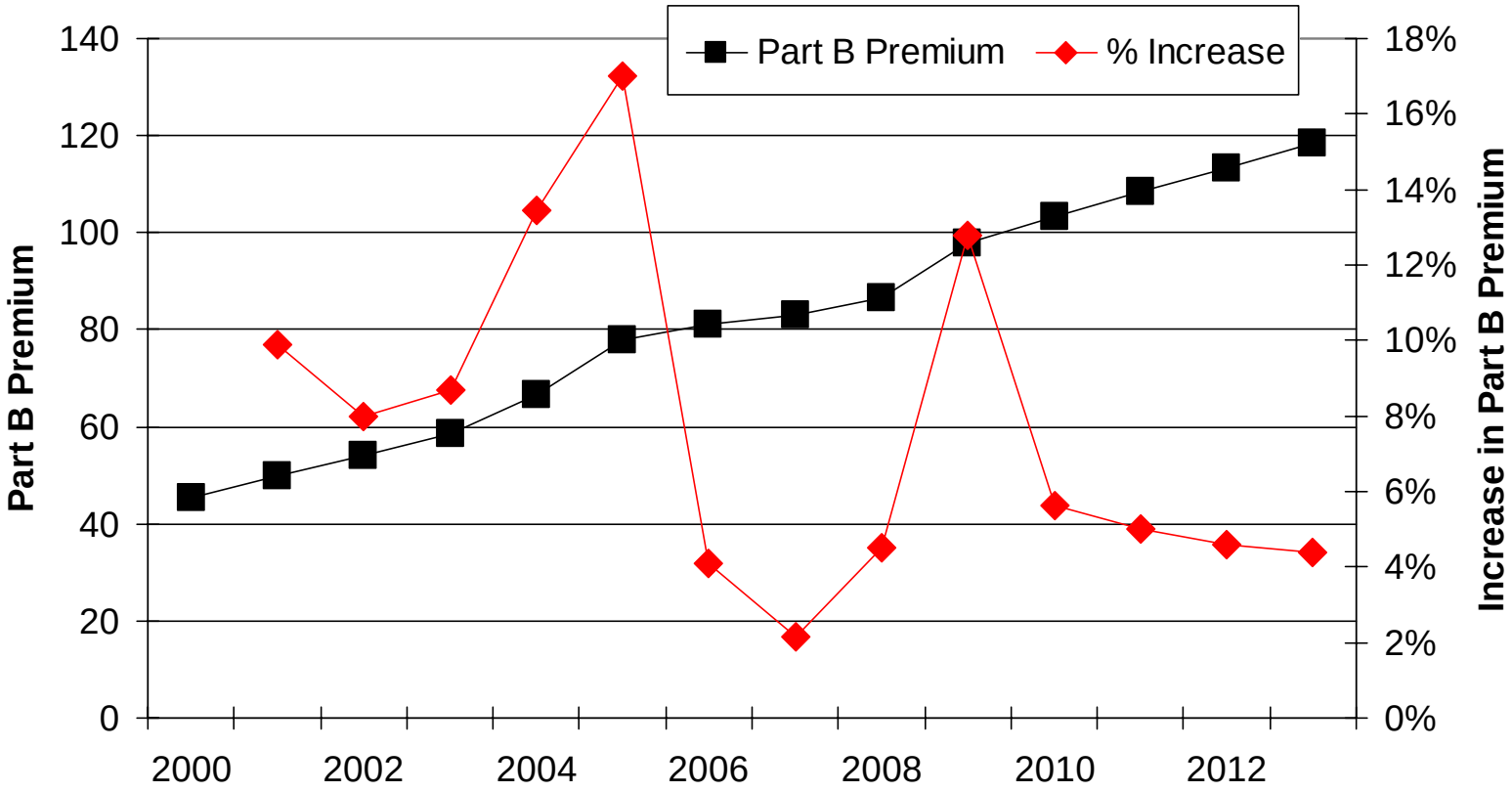
# Part B Premium and Annual Increase in Premium




Source: CMS.

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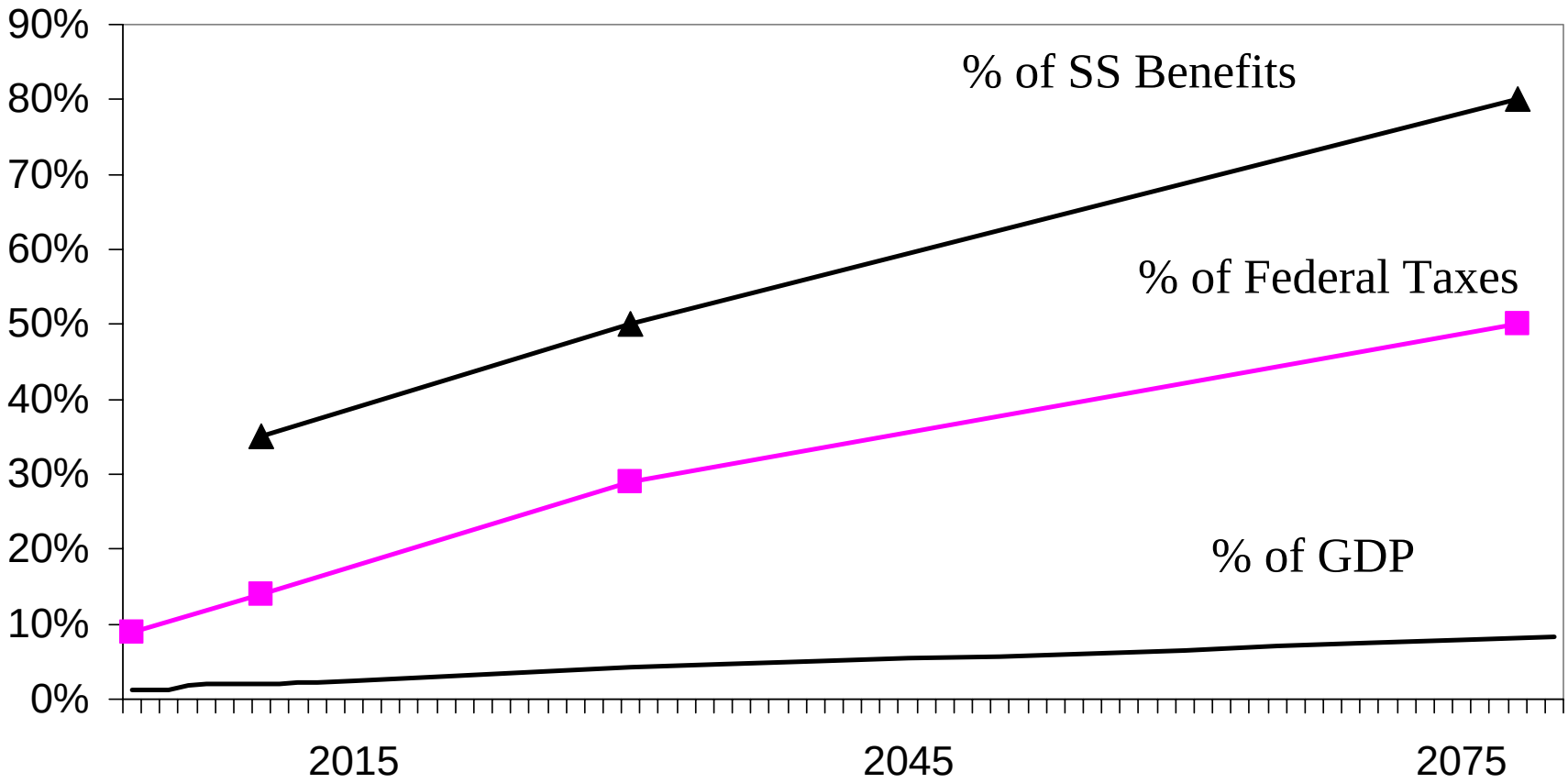
# SMI as a % of GDP, Federal Taxes, & SS Benefits, 2003-2080




Source: CMS.

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# 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.

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# 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%

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# 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.

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# Medicare Spending Per Beneficiary, 2000

| Highest | | Lowest | |
|---|---|---|---|
| Miami, FL | $9,200 | Santa Fe, NM | $3,500 |
| New York, NY | $8,000 | Salem, OR | $3,500 |
| New Orleans, LA | $7,600 | Sheboygan, WI | $3,700 |
| Fort Lauderdale, FL | $7,560 | Green Bay, WI | $3,700 |
| Philadelphia, PA | $7,200 | Albuquerque, NM | $3,700 |
| Los Angeles, CA | $7,150 | National Average | $5,360 |

Source: CMS and NHPF.

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# 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.

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# 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.

Source: Annals of Internal Medicine, 2003, and NHPF, 2003.

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# 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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