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# THE AFFORDABLE CARE ACT, MEDICARE COSTS, AND RETIREMENT SECURITY

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## Introduction

Rising Medicare costs have been a major contributor to projected long-run budget deficits, and rising out-of-pocket costs have become an increasing challenge to individuals' retirement security. The 2010 Patient Protection and Affordable Care Act (ACA) made substantial changes to Medicare, designed both to improve the program's finances and to reduce the out-of-pocket costs faced by retirees. However, the Office of the Actuary (OACT) at the Centers for Medicare & Medicaid Services (CMS) warns that the assumed impact of the ACA may be overly optimistic and that realized savings may be far more muted. As a result, since 2010, OACT each year has released a set of alternative projections to illustrate Medicare expenditures if current-law payment reductions are not sustained. This *brief* compares the baseline projections in the annual *Medicare Trustees Report* with OACT's alternative projections.

The discussion proceeds as follows. The first section discusses the ACA changes and the projected decline in Medicare expenditures. The second section examines how the reductions in expenditures translate into lower out-of-pocket spending for beneficiaries. The third section outlines the key differences in assumptions between the *Medicare Trustees Report* and OACT's alternative projections. The fourth sec-

tion examines how the two sets of projections have changed over time. The conclusion is that they have been converging, suggesting increasing agreement that the ACA will significantly reduce long-run Medicare costs.

## The ACA's Impact on Medicare Spending, Taxes, and Premiums

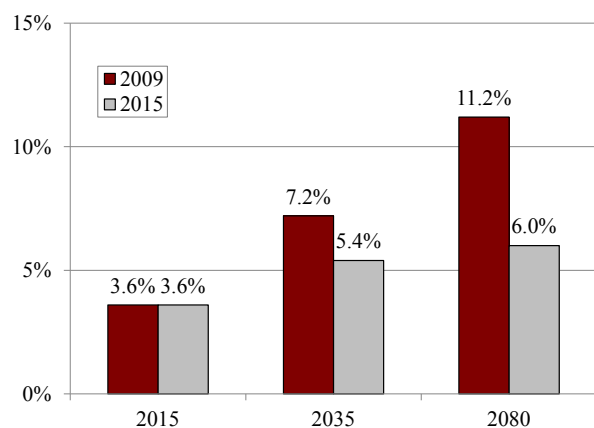
Medicare is composed of two programs. The Hospital Insurance (HI) program, Part A, covers inpatient hospital services, skilled nursing facilities, home health care, and hospice care. HI is financed by a 2.9 percent payroll tax, shared equally by employers and employees. The Supplementary Medical Insurance (SMI) program consists of two separate accounts: Part B, which covers physician and outpatient hospital services, and Part D, which was enacted in 2003 and covers prescription drugs. About 75 percent of the costs of Parts B and D are paid from the government's general revenues, which come from the personal income tax, corporate income tax, etc. The other 25 percent is paid from monthly premiums charged to

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beneficiaries, which typically are deducted from Social Security benefits before they are sent to the recipient.<sup>1</sup> In addition to monthly premiums, beneficiaries are also responsible for covering co-payments and other out-of-pocket health care expenses.

In 2010, Congress passed the ACA, which contained roughly 165 provisions aimed at reducing costs, increasing revenues, eliminating fraud and waste, and developing research and technological enhancements in the Medicare program.<sup>2</sup> Since the enactment of these far-reaching changes, the official cost projections in the *Trustees Report* have declined dramatically as a percentage of GDP. Between the 2009 and 2015 *Reports*, projected costs as a percentage of GDP for 2035 dropped from 7.2 percent to 5.4 percent and, for 2080, from 11.2 percent to 6.0 percent (see Figure 1).<sup>3</sup>

FIGURE 1. PROJECTED MEDICARE SPENDING AS PERCENTAGE OF GDP IN 2015, 2035, 2080 FROM THE 2009 AND 2015 TRUSTEES' REPORTS



Sources: Centers for Medicare & Medicaid Services (2009 and 2015).

In addition to reducing total expenditures, the ACA also increased taxes and premiums for high-income Medicare beneficiaries. Income-related premiums were first introduced for Part B in 2007, but the ACA froze the income thresholds at 2010 levels through 2019 and extended income testing to Part D premiums (see Box). The Medicare Access and CHIP Reauthorization Act of 2015 further increased premiums for those with the highest incomes.

On the tax side, the ACA increased HI trust fund revenues with a 0.9-percent payroll tax on individual earnings of more than \$200,000 (\$250,000 for married couples). These thresholds are not indexed for price or wage increases so that, over time, a growing proportion of workers will become subject to the additional 0.9-percent tax.<sup>4</sup>

## Box: Income-Related Medicare Premiums

Income-related SMI premiums were first established in the Medicare Modernization Act of 2003. These means-tested premiums required higher-income individuals to pay a greater portion of per capita Part B costs. The ACA applied the same income-related premium thresholds to Part D premiums and froze the income thresholds at 2010 levels through 2019. As a result, growth in incomes will push a larger share of beneficiaries above these static thresholds. The Medicare Access and CHIP Reauthorization Act of 2015 (discussed below) contains further provisions that will increase the share of beneficiaries who fall into the higher premium brackets, effective 2018. The table below shows these income thresholds for SMI premium brackets.

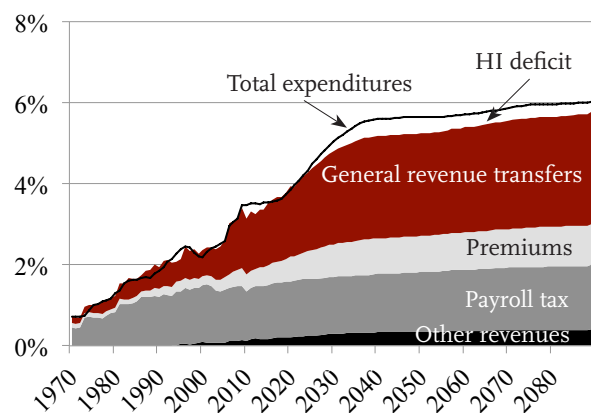
TABLE. INCOME THRESHOLDS FOR SMI PREMIUMS IN 2015 AND 2018, BY MARITAL STATUS

	Single	Married	Percentage of per capita SMI costs	
			2015	2018
≤ \$85,000	≤ \$170,000		25 %	25 %
85,000-107,000	170,000-267,000		35	35
107,000-133,500	214,000-267,000		50	50
133,500-160,000	267,000-320,000		50	65
160,000-214,000	320,000-428,000		65	80
> 214,000	> 428,000		80	80

Source: Centers for Medicare & Medicaid Services (2015).

Going forward, the additional 0.9-percent tax is projected to boost payroll tax revenues relative to GDP (see Figure 2). Even growing revenues, however, will not be sufficient to cover HI outlays, and the deficit remains a steady percentage of GDP as shown at the top of the figure. In contrast to HI, by law SMI is fully funded through premiums and general revenues. Because SMI revenues increase at the same rate as expenditures, the premiums and general revenue transfers will increase relative to GDP. Growth in general revenue financing as a share of GDP puts pressure on the federal budget, and rising SMI premiums place a growing burden on beneficiaries.

FIGURE 2. MEDICARE SPENDING AND SOURCES OF NON-INTEREST INCOME, AS PERCENTAGE OF GDP, 1970-2088

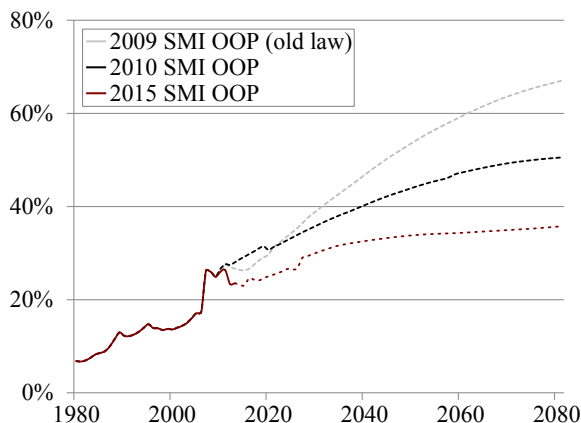


Source: Centers for Medicare & Medicaid Services (2015).

## Medicare Out-of-Pocket Spending

The decline in Medicare expenditure growth means that retirees will, relative to pre-ACA projections, spend a smaller percentage of their Social Security benefit on out-of-pocket Medicare costs and, as a result, have more disposable income for non-healthcare expenditures. Projections of out-of-pocket health expenses as a percentage of the average Social Security benefit have declined sharply from 2009 – before the ACA – to 2010 – immediately after ACA passage – to 2015 (see Figure 3).

FIGURE 3. SMI OUT-OF-POCKET (OOP) EXPENSES AS PERCENTAGE OF AVERAGE SOCIAL SECURITY BENEFIT IN 2014 DOLLARS, 2009, 2010, 2015



Sources: Centers for Medicare & Medicaid Services (2009, 2010, and 2015).

In 2014, the average beneficiary spent 23 percent of his Social Security benefit on out-of-pocket Medicare costs – 3 percentage points less than the historical peak of 26 percent in 2011. According to the 2015 official projections, this ratio will increase slowly but remain well below 40 percent, instead of approaching 70 percent as in the pre-ACA projection.

## Alternative Medicare Projections

This story all seems to be great news. The ACA has, either directly or indirectly, helped to reduce long-run aggregate and per capita health cost projections. However, long-range projections are highly sensitive to the chosen assumptions, and critics are uncertain about the sustainability of Medicare payment reductions in the future.

Beginning in 2010, in the Statement of Actuarial Opinion that concludes the annual *Medicare Trustees Report*, OACT has stated that actual costs are likely to exceed the projections shown in the *Report*. To promote awareness, OACT releases an accompanying set of alternative projections to illustrate Medicare expenditures if payment reductions under the ACA are not sustained. The *2015 Trustees Report* projections are further complicated by provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The major reasons for the difference between the *Trustees Report* projections and OACT's alternative projections fall under three headings: 1) payments to physicians; 2) productivity assumptions; and 3) the Independent Payment Advisory Board.

### Physician Payments

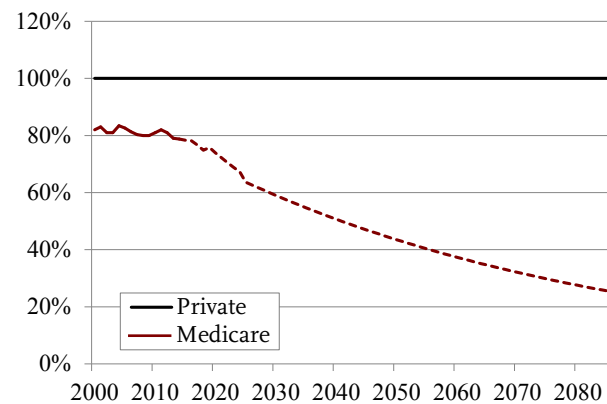
In April 2015, Congress passed the MACRA, which repealed the Medicare 'Doc Fix' law and prevented a 21-percent cut in Medicare physician rates. The 'Doc Fix' woes arose from the Sustainable Growth Rate (SGR) reimbursement formula in the 1997 Balanced Budget Act. The SGR set target levels for Medicare expenditures. If physicians did not exceed these targets, they would receive modest pay increases. If they did exceed the targets, their reimbursement rates would be cut. In fact, physicians continuously exceeded the targets, but every year Congress postponed the cuts in their payments. By 2015, physicians were facing a 21-percent cut, an implausible number since physicians would just cease to accept Medicare patients.

The MACRA replaces the SGR with a new payment system that eliminates the need for annual legislative overrides. A key feature of the new system, which will be phased in gradually, is an emphasis on measuring and rewarding the quality, rather than quantity, of health care services. From 2016-2019, physician payments will increase by 0.5 percent annually. Beginning in 2019, in addition to this baseline payment increase, physicians will be eligible to receive incentive payments under one of two tracks: the Alternative Payment Model (APM) or the Merit-Based Incentive Payment System (MIPS).<sup>5</sup> From 2020-2025, baseline payment levels will be frozen at the 2019 level. Beginning in 2026, physicians in the APM track will receive a 0.75-percent annual increase while those in the MIPS track will receive a 0.25-percent increase.

While the MACRA avoids the significant short-run payment issues that arose under the SGR approach, it does raise long-run concerns. Specifically, the payment rates are not expected to keep pace with the increase in physician costs, and the payment rates under the MACRA will be below what they would have been under the SGR by 2048. The result is that Medicare payment rates will fall far below private health in-

surance payment rates from about 80 percent today to about 25 percent (see Figure 4). If physician compensation lags significantly, access to Medicare physicians could become a serious problem, which would likely result in significant pressure to raise the rates.

FIGURE 4. MEDICARE AND PRIVATE INSURANCE PAYMENTS FOR PHYSICIAN SERVICES UNDER CURRENT LAW, 2000-2085

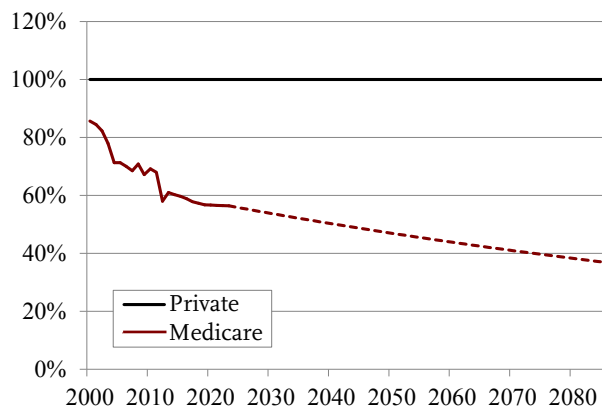


Source: Shatto and Clemens (2015).

### Productivity Adjustments

Similar to physicians, the other services covered by the Medicare fee-for-service program (including inpatient and outpatient hospital services) also receive annual payment increases. The ACA introduced cost-saving measures that would reduce these annual increases by the percentage increase in the 10-year moving average of economy-wide productivity.<sup>6</sup> The goal was to create strong incentives for providers to improve efficiency. In the *2015 Trustees Report*, productivity is estimated to increase by 1.1 percent per year. Given the labor-intensive nature of the health sector, measured productivity gains are expected to be much smaller.<sup>7</sup> As a result, the reductions in compensation will exceed productivity gains and cut into providers' earnings. Eventually, Medicare payment rates for inpatient hospital services would fall from about 60 percent of the average level for private insurance today to below 40 percent (see Figure 5 on the next page).

FIGURE 5. MEDICARE AND PRIVATE INSURANCE PAYMENTS FOR INPATIENT HOSPITAL SERVICES UNDER CURRENT LAW, 2000-2085



Source: Shatto and Clemens (2015).

### Independent Payment Advisory Board

In addition to reductions in physician and provider payment updates, the Independent Payment Advisory Board – which has not yet been established – is supposed to propose reductions in Medicare spending if cost growth surpasses GDP growth by more than 1.0 percentage point.<sup>8</sup> These proposals would automatically take effect in the absence of a legislative override.

### Alternative Estimates

Given that future Medicare payments are likely to be inadequate, OACT developed alternative projections for Medicare Parts A and B. The alternative assumes that: 1) starting in 2024, physician payments transition from a period of no increase in the Medical Expenditure Index to an increase of 2.3 percent by 2039; and 2) starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent until the Medicare price updates equal those assumed for private health plans in 2034. In addition, the projections assume that the Independent Payment Advisory Board requirements will not be implemented. On average, under this alternative, the long-range per beneficiary growth rate for all Medicare services would be similar to the long-range growth rate

assumed for the overall health sector. Not surprisingly, the alternative assumptions show a substantial increase in expenditures as a percent of GDP for both Medicare Part A and Part B (see Table 1).

TABLE 1. 2015 PROJECTIONS OF MEDICARE PART A AND PART B SPENDING AS PERCENTAGE OF GDP, TRUSTEES REPORT AND OACT ALTERNATIVE IN SELECTED YEARS

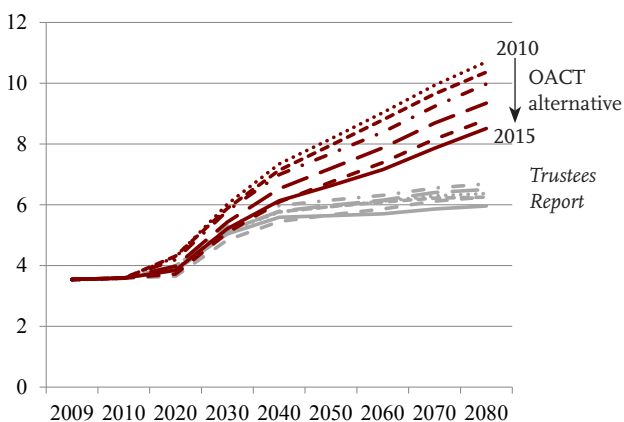
Year	Part A		Part B	
	Trustees	Alternative	Trustees	Alternative
2020	1.53	1.53	1.71	1.71
2040	2.13	2.38	2.51	2.79
2060	2.15	2.81	2.44	3.23
2080	2.23	3.40	2.43	3.79

Source: Shatto and Clemens (2015).

## A Longer Perspective

With six years of Trustees’ and alternative projections available for comparison, an interesting question is whether the projections are converging or diverging over time and whether the changes are coming from the Trustees’ estimates or from OACT’s alternative scenarios. Figure 6, which shows projected costs as a percentage of GDP for the last six years, indicates that the gap between the Trustees’ projections and OACT’s

FIGURE 6. PROJECTED MEDICARE SPENDING AS PERCENTAGE OF GDP FROM 2010-2015 TRUSTEES REPORT AND OACT ALTERNATIVE, 2009-2080



Source: Shatto and Clemens (2010-2015).

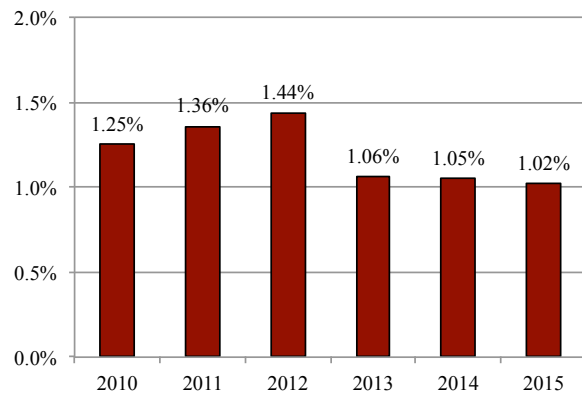
alternative projections is narrowing. Interestingly, this narrowing is the result of OACT's alternative projections decreasing, while the Trustees' projections have held relatively steady.

The same narrowing of estimates can be seen by looking at the projected deficit in the HI trust fund. In 2015, the 75-year deficit in the alternative scenario exceeded the Trustees' deficit by 1.02 percentage points, which – while significant – was the smallest difference in the six-year period (see Figure 7).

## Conclusion

Since the ACA's enactment, Medicare expenditure projections have dropped significantly, which will mean relatively lower out-of-pocket health costs for current and future retirees. However, this sense of progress must be moderated by the uncertainty involved in long-range projections. The substantial gap in cost rates that still remains between the Medicare Trustees' projections and OACT's alternative projections underscores the continued uncertainty about future Medicare costs.

FIGURE 7. PERCENTAGE-POINT DIFFERENCE IN 75-YEAR DEFICIT OF HI TRUST FUND BETWEEN OACT ALTERNATIVE AND TRUSTEES' PROJECTIONS, 2010-2015



Source: Authors' calculations from Shatto and Clemens (2010-2015).

## Endnotes

- 1 Part D enrollees may elect to waive this deduction and pay their premiums via other mechanisms.
- 2 The main provisions for restraining cost growth include reducing provider payment updates – partly due to assumed improvements in productivity – and aligning payments for Medicare Advantage plans with payments under traditional Medicare
- 3 Under both pre- and post-ACA projections, total Medicare expenditures increase at a faster pace than both aggregate workers' earnings and the overall economy due to: 1) the number of beneficiaries increasing more rapidly than the number of workers; and 2) the growth in beneficiary expenditures exceeding the growth in per capita GDP.
- 4 The ACA also specifies that individuals with incomes above \$200,000 per year and couples above \$250,000 pay an additional Medicare contribution of 3.8 percent on some or all of their non-work income (such as investment earnings). However, the revenues from this tax are not allocated to the Medicare trust funds.
- 5 Incentive payments under the APM apply only through 2025, while the separate incentive payments under the MIPS continue. For more details on the new payment system and the two separate tracks, see Bloniarz and Glass (2015).
- 6 Payment updates are normally indexed to statutory input price indices. These price indices are determined by measuring the increase in the prices of goods and services a provider must pay to provide care for their patients.
- 7 In recent years, hospital productivity averaged around 0.4 percent per year. Skilled nursing facilities experienced close to zero annual productivity gains.
- 8 From 2013-2017, the per-capita Medicare spending growth rate threshold is set to the averages of the increase in the Consumer Price Index for All Urban Consumers (CPI-U) and the Average Medical Care Expenditure category of the CPI-U. After 2017, Independent Payment Advisory Board proposals are required.

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