



Office of External Affairs

MEDICARE FACT SHEET

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CONTACT: CMS Media Affairs
(202) 690-6145

MEDICARE TRUSTEES REPORT

Medicare's Financial Outlook

With continued growth in Medicare program expenditures and the retirement of the “baby boom” generation, Medicare faces growing strains on its financing sources. The 2006 Medicare Trustees Report emphasizes the importance of taking measured and reasonable action now to reduce Medicare spending growth. The President’s Fiscal Year 2007 Budget proposes steps to reduce spending growth, building on the up-to-date benefits and the new programs to improve disease prevention and quality of care in Medicare.

Controlling health care costs while supporting high-quality care that prevents costly disease complications and unnecessary costs is critical to putting Medicare on a steady path to long-term fiscal sustainability. The Medicare Modernization Act (MMA) provides a foundation for such Medicare coverage. In addition to bringing Medicare’s benefits up-to-date, the law created new tools to monitor and strengthen the Medicare program. As required by the MMA, the Trustees Report presents a unified summary of Medicare’s overall projected expenditures and dedicated revenue sources, and the general revenue that is required to fill the gap between spending and dedicated revenue. Based on this unified approach, the Trustees Report projects that the difference between outlays and dedicated revenues is expected to exceed 45 percent of total Medicare expenditures in 2012. This falls within the first seven years of the projection (2006-2012) period, triggering a determination of “excess general revenue Medicare funding”—the first time that such a determination has been required under the MMA.

As the Trustees note in this report, “These projections demonstrate the need for timely and effective action to address Medicare’s financial challenges. Consideration of such reforms should occur in the relatively near future. The sooner the solutions are enacted, the more flexible and gradual they can be.” To illustrate, the 2006 Medicare Trustees Report notes that reducing the projected growth in per beneficiary health care costs by one percentage point would reduce the 75-year actuarial imbalance for the Hospital Insurance trust fund by almost two-thirds.

Medicare is already taking important steps to reduce long-term health care costs. Medicare now provides up-to-date preventive benefits and has begun to pay for programs that lower overall costs for beneficiaries with chronic illnesses by preventing complications. To support the transparency needed for patients to choose the best care at the lowest cost, Medicare is also developing better information on quality and costs of health care. These quality and efficiency measures are being used in pilot-testing methods to pay more for better results rather than more

-- More --

services, and have been shown in many instances to significantly reduce costs. A key part of improving quality and reducing overall health care costs involves greater access to Medicare Advantage plans, which save beneficiaries around \$100 a month through promoting care coordination and prevention. Medicare is also promoting the adoption of interoperable health information technology, and will make available Health Savings Accounts in 2007. Through these steps, Medicare is shifting its focus to preventing costly complications, and getting the right care to each patient, rather than paying more for more complications and more medical services.

Most importantly, Medicare is now providing prescription drug coverage that improves access to medications that have been proven to prevent hospitalizations and other costly consequences of illnesses. Because of slower drug cost growth in 2004 and 2005, and strong competition among the Medicare drug plans leading to lower negotiated drug payments, the cost of this coverage is now projected to be much lower than in last year's Trustees Report. In this competitive approach, beneficiaries and their caregivers, with support from Medicare and many local partners around the country, are using information on prices and coverage to choose better benefits at a much lower cost than had been expected. In addition, many beneficiaries are continuing their existing drug coverage, helping to keep Part D costs down. Competition with good information on quality and price has the potential to lead to cost savings in many other aspects of Medicare, and Medicare is beginning to implement competitive reforms in durable medical equipment, Part B drug pricing, and other areas.

The MMA also mandates that a "Medicare funding warning" occurs when two successive Trustees Reports project that general revenue financing will exceed 45 percent of total Medicare expenditures within seven years. Such a warning triggers an expedited process to reduce general revenue financing, in which the President is required to propose legislation to address the issue in the next Budget, and Congress is required to consider the proposal on an expedited basis.

The President is not waiting for such a warning to build on the steps in the MMA to get better value and avoid unnecessary costs in the Medicare program. The President's Fiscal Year 2007 Budget recognizes that, by taking incremental steps now, we can forestall the otherwise inevitable need for drastic action later. The Budget proposals significantly improve Medicare's financial outlook through steps that reduce cost growth incrementally. They include modest reductions in price increases for some providers, reflecting recommendations by the nonpartisan Medicare Payment Advisory Commission (MedPAC), and gradual limits on the rising Medicare subsidy payments received by the highest-income Medicare beneficiaries. These proposals would improve Medicare's financial outlook, helping to push back the occurrence of an "excess general revenue Medicare funding" determination and the insolvency of the Hospital Insurance trust fund.

In later years, to ensure that steady, measured steps for Medicare sustainability continue, the Budget proposes further limits on provider payment increases if necessary to keep general revenue financing below 45 percent of outlays. The President's Budget proposed 0.4 percent reductions each year below what the level of Medicare payments would otherwise have been, if Congress does not pass a specific alternative proposal to achieve equivalent improvements in sustainability. The President's Budget notes that a range of approaches could be used to achieve this ongoing steady progress for sustainability: "If Congress preferred to enact more specific sustainability reforms in lieu of these modest trends, expedited procedures would facilitate

consideration.” The President has proposed a bipartisan commission on entitlement reform that could help develop such longer-term proposals.

Background

In 2005, Medicare provided coverage to 42.5 million people, spending \$330 billion on benefits. These benefit payments are funded from two trust funds—the Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) trust fund. The HI trust fund pays for a portion of the costs of inpatient hospital services and related care furnished under Part A of the Medicare program. The HI trust fund is primarily financed through payroll taxes, plus a relatively small amount of interest, income taxes on Social Security benefits, and other revenues. The SMI trust fund pays for a portion of the costs of physicians' services, outpatient hospital services, and other related medical and health services furnished under Part B of the program. In addition, as of 2006, the SMI trust fund pays for private prescription drug insurance plans to provide drug coverage under Part D of the program. The separate Part B and Part D accounts in the SMI trust fund are financed through general revenues, beneficiary premiums, and interest income and, in the case of Part D, special payments from the States.

Taken together, total expenditures from the HI and SMI trust funds are projected to increase at a significant pace in the absence of further reforms. Total Medicare expenditures are estimated to be 3.2 percent of gross domestic product (GDP) in 2006, reaching 11.0 percent in 2080. These increases reflect growth in medical prices and the volume and intensity of services. In addition, the retirement and aging of the “baby boom” generation will also increase expenditure growth rates for Medicare.

Hospital Insurance (HI) Trust Fund

The Trustees estimate that the HI trust fund will remain solvent until the year 2018, two years earlier than the forecast of 2020 made by the Trustees last year. By 2010, the trust fund expenditures are projected to exceed annual income from all sources. The change in the solvency date results from somewhat higher actual spending due to greater growth in utilization than expected in 2005 for skilled nursing facility services, and also upward revisions in short-range assumptions about continuing growth in the volume and intensity of home health and skilled nursing facility services. Expenditures for other post-acute services are also growing at double-digit rates because of rapid growth in utilization. For example, growth in long-term acute care hospital spending exceeded 20 percent in 2004 and 2005. Part A expenditures on Medicare Advantage were also higher than expected, because of the increasing severity of illness of patients enrolled in Medicare Advantage plans.

The serious long-range financial outlook of the HI trust fund requires action now to slow down spending growth. The proportion of HI costs that can be met by HI tax income is projected to decline steadily over time as costs continue to grow rapidly. This cost growth is due to continuing increases in medical utilization and intensity of services, as noted above. It is also due to the retirement of the “baby boom” generation, which will result in the number of Medicare beneficiaries increasing much more rapidly than the number of workers. Today, there are 3.9 workers for every beneficiary; by 2030, there will only be about 2.4 workers for every beneficiary.

Supplementary Medical Insurance (SMI) Trust Fund

Part B Account

Because Part B premiums and transfers from general revenues are established each year to match the following year's estimated costs, the Part B account will remain in financial balance under present law. However, Part B expenditures have grown significantly faster than GDP, leading to increasing general revenue requirements, and this trend is projected to continue. As with the HI trust fund, the Part B cost growth reflects increases in the volume and intensity of services, increases in medical prices, and the retirement and aging of the "baby boom" generation. Also, because Part B program expenditures for 2005 were higher than had been projected last year, in part due to payment changes for physicians, trust fund assets at the end of the year will be well below the preferred range for the Part B account.

The Part B expenditure projections in the Trustees Report are based on current law. Under the "sustainable growth rate" formula used in current law, the Trustees project that physician payment rates would have to be reduced by 4 to 5 percent each year through at least 2015. This outcome is likely to be addressed through further Congressional action. The President's Budget notes that the Administration supports reforms in physician payment that provide better support for increasing quality and reducing overall health care costs, without adding to Medicare expenditures. Without such action, the Trustees warn that the Part B projections in the Medicare report substantially understate the likely actual future costs.

As a result of the higher spending levels and reduced assets, it is expected that the Part B monthly premium rate will need to be increased by roughly 11 percent for 2007, to \$98.20. Estimated Part B expenditures for 2006 are higher than the estimate of such expenditures when the 2006 Part B premium was set last year for several reasons:

- (1) The volume and intensity of services paid under the physician fee schedule was 7.3 percent higher in 2005, continuing a trend of rapid volume and intensity growth in recent years, leading to an upward revision of the projected growth in 2006 to 5.7 percent. In addition, Congress overrode the negative 4.4 percent physician fee update that would have occurred by freezing the conversion factor used to determine physician payment rates. More details on recent trends in utilization and spending are described in the Centers for Medicare & Medicaid Services' April 7 letter to MedPAC.
- (2) The volume and intensity of hospital outpatient department services was 7.8 percent higher in 2005 and is estimated to be 7.5 percent higher in 2006.
- (3) Spending on Part B drugs is higher than previously estimated, with growth in volume and intensity in physician-administered drugs exceeding 20 percent in 2005.
- (4) Spending on therapy services is higher as a result of the Deficit Reduction Act (DRA) provision, which creates an exceptions process for services that would otherwise be subject to the therapy caps.
- (5) The contingency margin for the Part B trust fund needs to be replenished, and may require more funding in the event of further physician payment increases without other

cost-reducing reforms. Premium funds that had been intended to replenish the existing margin (accounting for about \$1.10 in the 2006 premium increase) are now being used to pay for the 2006 physician update provision in the DRA that maintains physician fee levels at 2005 levels.

Additional details on the components of the projected Part B premium increase are in the attached table.

Part D Account

The Part D cost projections in the 2006 Medicare Trustees Report are significantly lower than in the 2005 Report. These lower projected costs reflect slower-than-expected drug spending growth in 2004 and 2005, greater savings from manufacturer rebates and other discounts, utilization management projected to be achieved by Part D plans in the first few years, and preliminary data on actual Part D enrollment for 2006. The Report projects that by May 15, 31.4 million beneficiaries will be enrolled in coverage through a Part D prescription drug plan or a retiree plan that collects the Part D retiree drug subsidy. Approximately 3.5 million more beneficiaries have drug coverage through FEHBP or TriCare that could qualify for a retiree subsidy; however, the Federal government is not making the technical accounting transfer to pay a subsidy to itself. As of April 15, there were 30.1 million beneficiaries who were either enrolled in prescription drug plans (stand-alone and Medicare Advantage), members of plans receiving the Medicare Retiree Drug Subsidy, or covered by FEHB or TriCare (and would qualify for the retiree subsidy were it not for the “internal subsidy” issue). In addition, another 5.8 million Medicare beneficiaries receive creditable coverage through other sources, such as their current jobs (for the working aged), the Veteran’s Administration, the Indian Health Service, or a private employer outside of the Medicare Retiree Drug Subsidy.

Compared to last year’s Trustees Report, projected net Medicare spending for Part D from 2006-15 is roughly 20 percent lower. Over the long-term, income and expenditures for the Part D account are projected to grow at an average annual rate of 11.5 percent for the 9-year period 2006-2015, reflecting enrollment growth and per capita drug cost increases. As noted in February, national prescription drug expenditures in 2006 are expected to grow at a slower rate than they would in the absence of Part D. This is because drug prices are sufficiently lower such that, even with the significant increase in utilization of drugs as a result of the drug benefit, total drug expenditures are still lower. Part D is funded through a system of flexible appropriations from general revenues, so that appropriations automatically match expenditures, eliminating the need for any contingency reserve to cover unexpectedly high costs.

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Analysis of 2007 Part B Premium Rate Increase

	Change in CY 2006 growth estimates from last year ¹	Growth in estimated spending from CY 2006 to CY 2007			Total spending increase: CY 2007 (current estimates) vs. CY 2006 (last year's est.)	Share of premium increase
		Price change ²	All other factors ³	Total increase		
Physician fee schedule ⁵	6.4%	-4.7%	4.8%	-0.1%	6.3%	2.3%
DME ⁶	4.3%	-2.3%	3.8%	1.4%	5.8%	0.3%
Physician/Independent Lab ⁷	4.7%	0.0%	5.9%	5.9%	10.8%	0.2%
Physician-administered drugs,						
ASC ⁷ , ambulance, & other	4.9%	3.3%	8.3%	11.8%	17.3%	1.7%
Outpatient hospital	6.0%	4.0%	8.2%	12.5%	19.3%	2.3%
Outpatient Lab ⁷	2.8%	0.0%	3.9%	3.9%	6.9%	0.1%
Other hospital	5.9%	4.0%	6.1%	10.4%	16.9%	0.2%
Home health	-0.3%	3.7%	3.9%	7.8%	7.5%	0.3%
Dialysis, therapy & other ⁸	20.0%	(⁴)	(⁴)	-2.7%	16.7%	1.0%
Total fee-for-service	6.5%	(⁴)	(⁴)	4.0%	10.8%	8.4%
Managed care	-2.7%	(⁴)	(⁴)	1.6%	-1.2%	-0.2%
Total Part B benefit increase	4.4%	(⁴)	(⁴)	3.6%	8.2%	8.2%
Interest on Assets and Administrative Expenses						<u>-0.4%</u>
Total Part B increase before margin						<u>7.7%</u>
Change in premium contingency margin ⁹						<u>3.0%</u>
Part B premium increase (\$98.20 from \$88.50 in 2006)						<u>11.0%</u>

¹ These changes reflects non-price factors only, such as utilization and intensity of services. Except for physicians' services, actual payment updates for 2006 were known last year when the 2006 Part B premium was determined. Spending figures in this table are per beneficiary.

² These changes represents actual or estimated weighted average Medicare payment update for category of services shown.

³ These changes represent the estimated impact of all non-price factors, including changes in the utilization and intensity of services.

⁴ Separate price and non-price factors cannot be determined.

⁵ For physicians' services, the change reflects the 2006 freeze on the conversion factor used to determine physician payment rates and the estimated -4.7 percent current law update for 2007 as well as the DRA imaging provision and the sunset of MMA GPCI floor on the physician work component of the fee schedule.

⁶ For DME, these changes reflect the MMA update freeze, the MMA competitive bidding provision, and the DRA oxygen and DME rental cap provisions.

⁷ These reflect freeze in update from the MMA for lab services and ASCs.

⁸ These reflect DRA 2006 provisions on therapy caps and the 1.6 percent update for dialysis payments.

⁹ To help restore adequate assets levels in the Part B account.

Data Source: Office of the Actuary