



# MASS-CARE

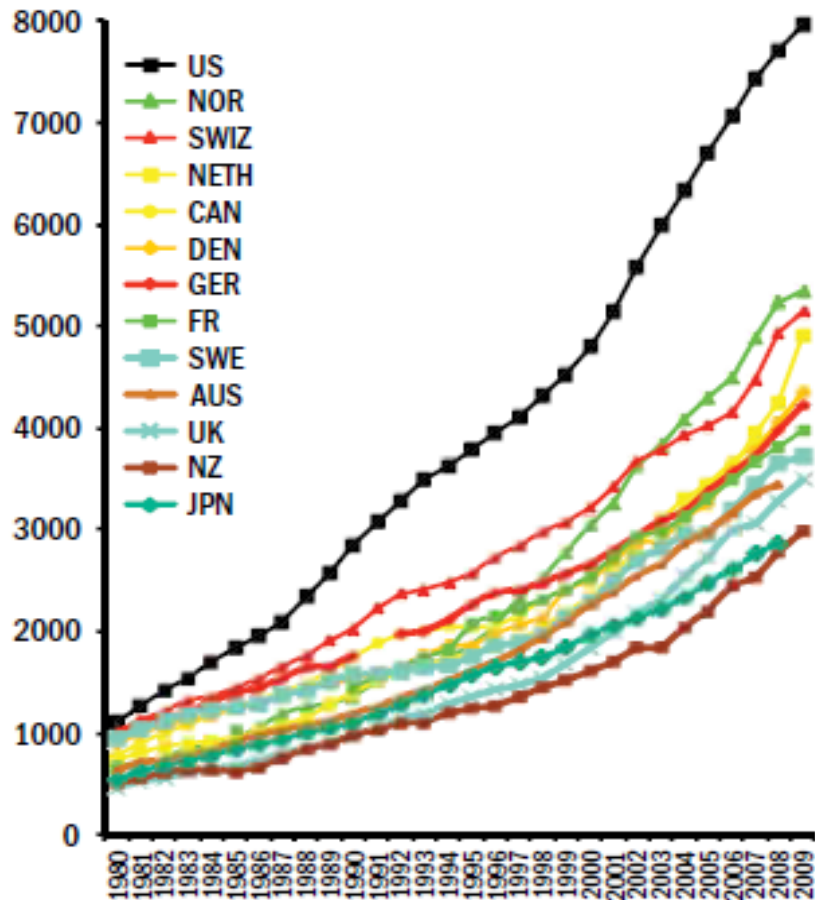
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## **The Future of Medicare:** Democratic and Republican Proposals

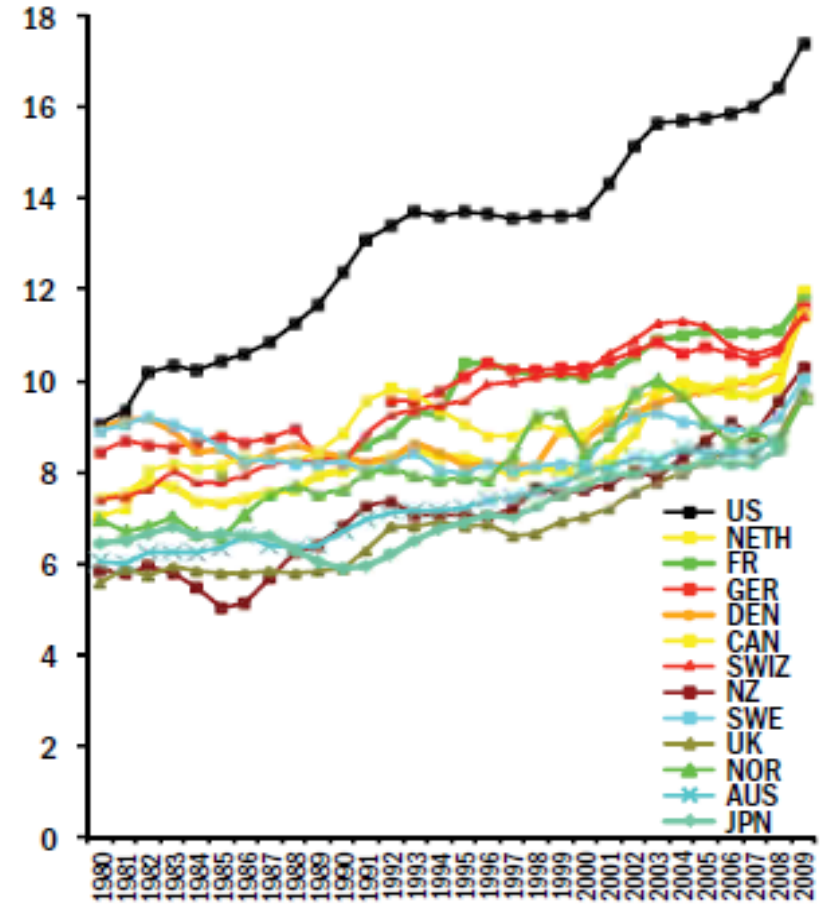
<http://masscare.org>

# U.S. Spends Almost Double Next Highest Spending Country

Average spending on health per capita (\$US PPP)



Total expenditures on health as percent of GDP

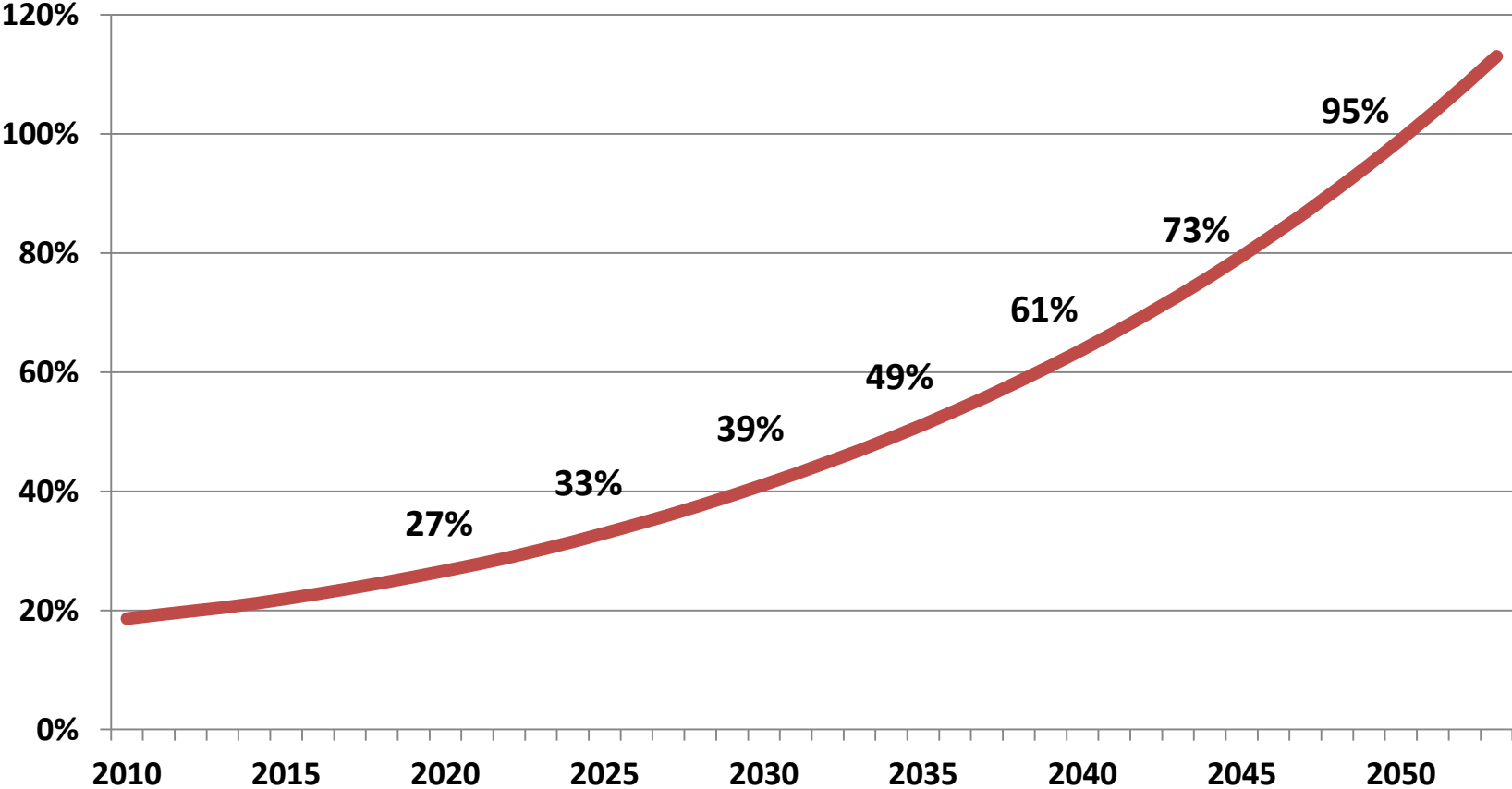


# U.S. Health Care System the Sixth Largest Economy in the World

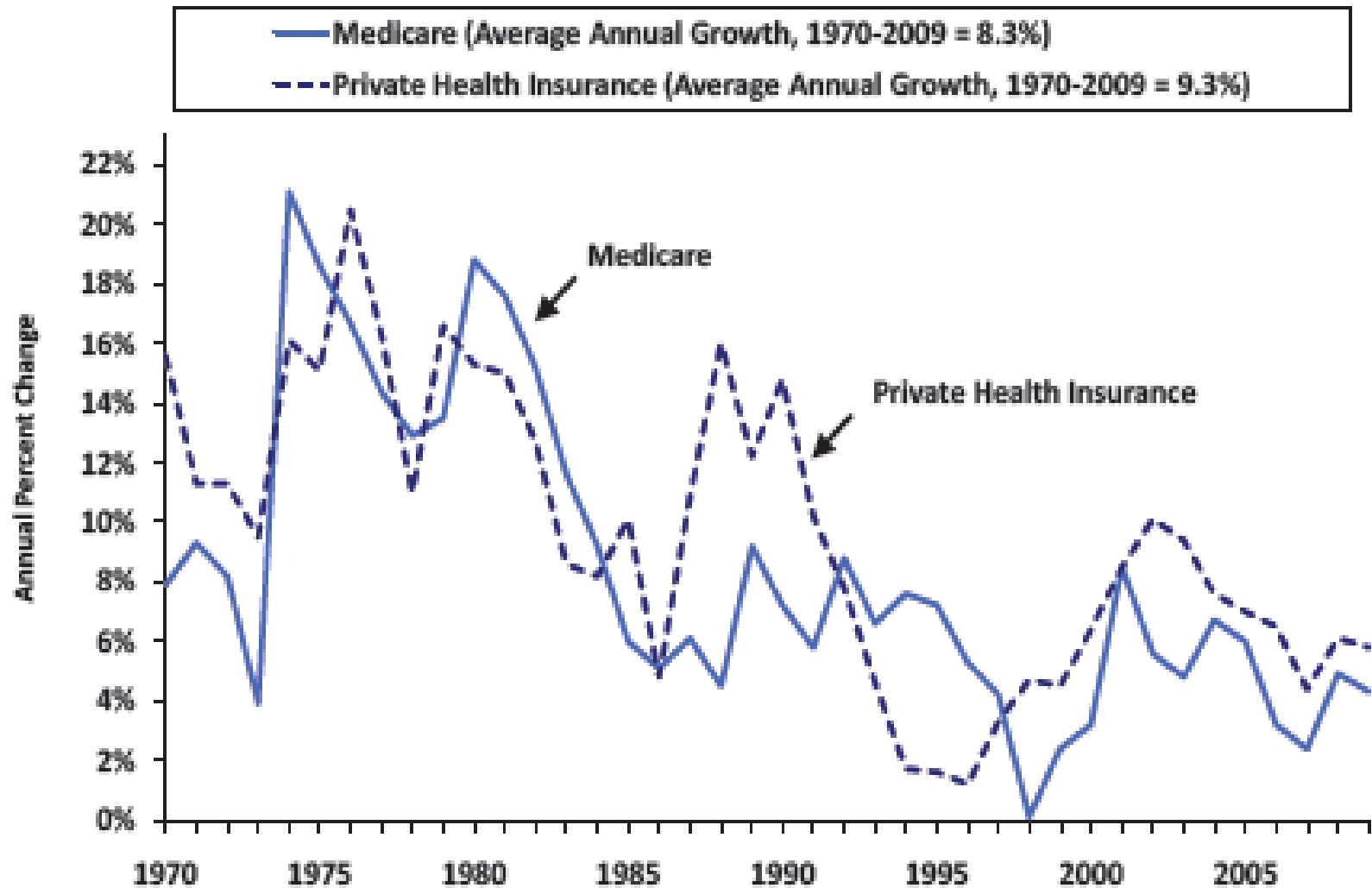
Country	2010 GDP
United States	\$14,447,100
China	\$5,739,358
Japan	\$5,458,873
Germany	\$3,280,334
France	\$2,559,850
<b>U.S. Health Care System</b>	<b>\$2,542,690</b>
United Kingdom	\$2,253,552

# Health Care Spending Will Consume the *Entire* Economy by 2052

Health Care Spending as % of Gross Domestic Product



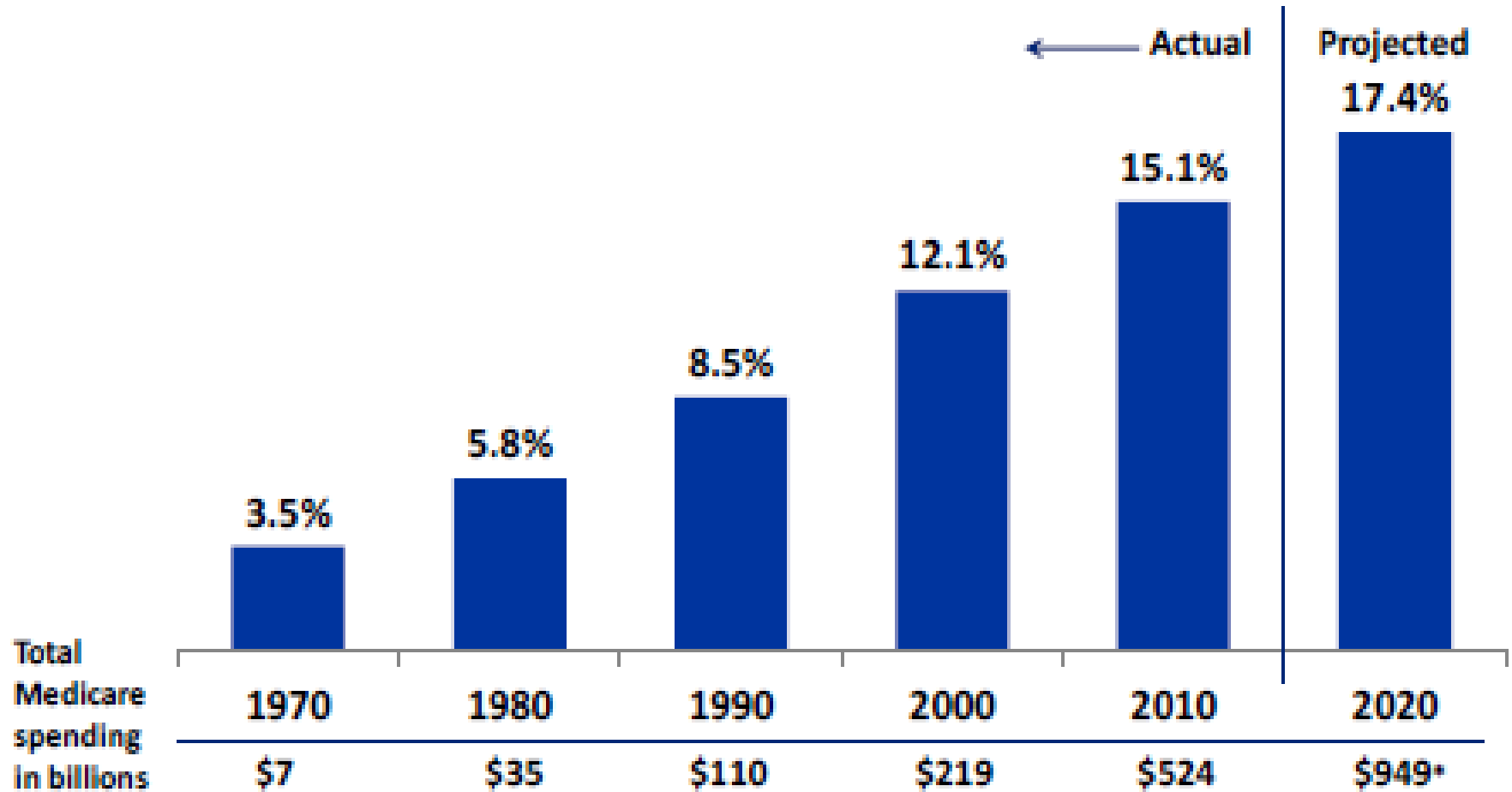
# Annual Change in Medicare and Private Health Insurance Spending, 1970-2009



SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, 2011.

Graph source: *Medicare Spending and Financing: A Primer*, Kaiser Family Foundation, 2011.

# Medicare Spending as a Share of Federal Budget Outlays, 1970-2020



SOURCE: Congressional Budget Office, Budget and Economic Outlook, January 2010 (for 1970 data) and January 2011 (for 1980-2020 data, except 2010 which comes from CBO August 2010 Baseline: Medicare). Historical total spending for 1970-2000 from 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

NOTE: \*Estimates for 1970-2010 represent total Medicare outlays, estimate for 2020 represents projection of mandatory Medicare outlays. CBO (August 2010) projects discretionary Medicare outlays will be \$9 billion in 2020.

# Causes of Medicare's Rising Costs

## 1. Aging Population →

### Increased Enrollment, Falling Revenue:

2010 – 3.4 workers per Medicare beneficiary

2030 – 2.3 workers per beneficiary

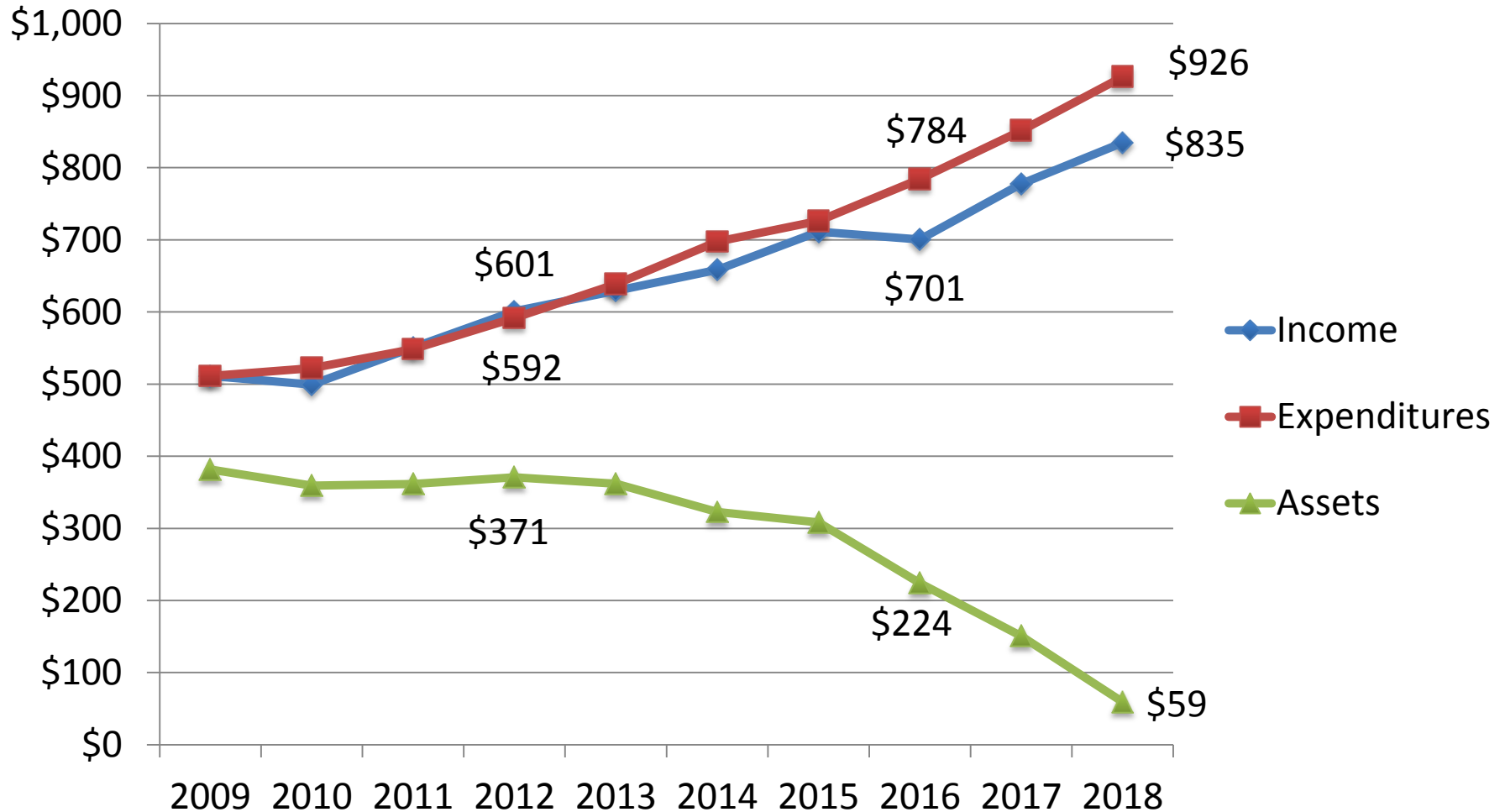
2080 – 2.1 workers per beneficiary

## 2. Rising Costs of Health Care

Kaiser: “The contribution of increased enrollment and an aging population to growing Medicare spending... is modest relative to the effects of rising health care costs.”

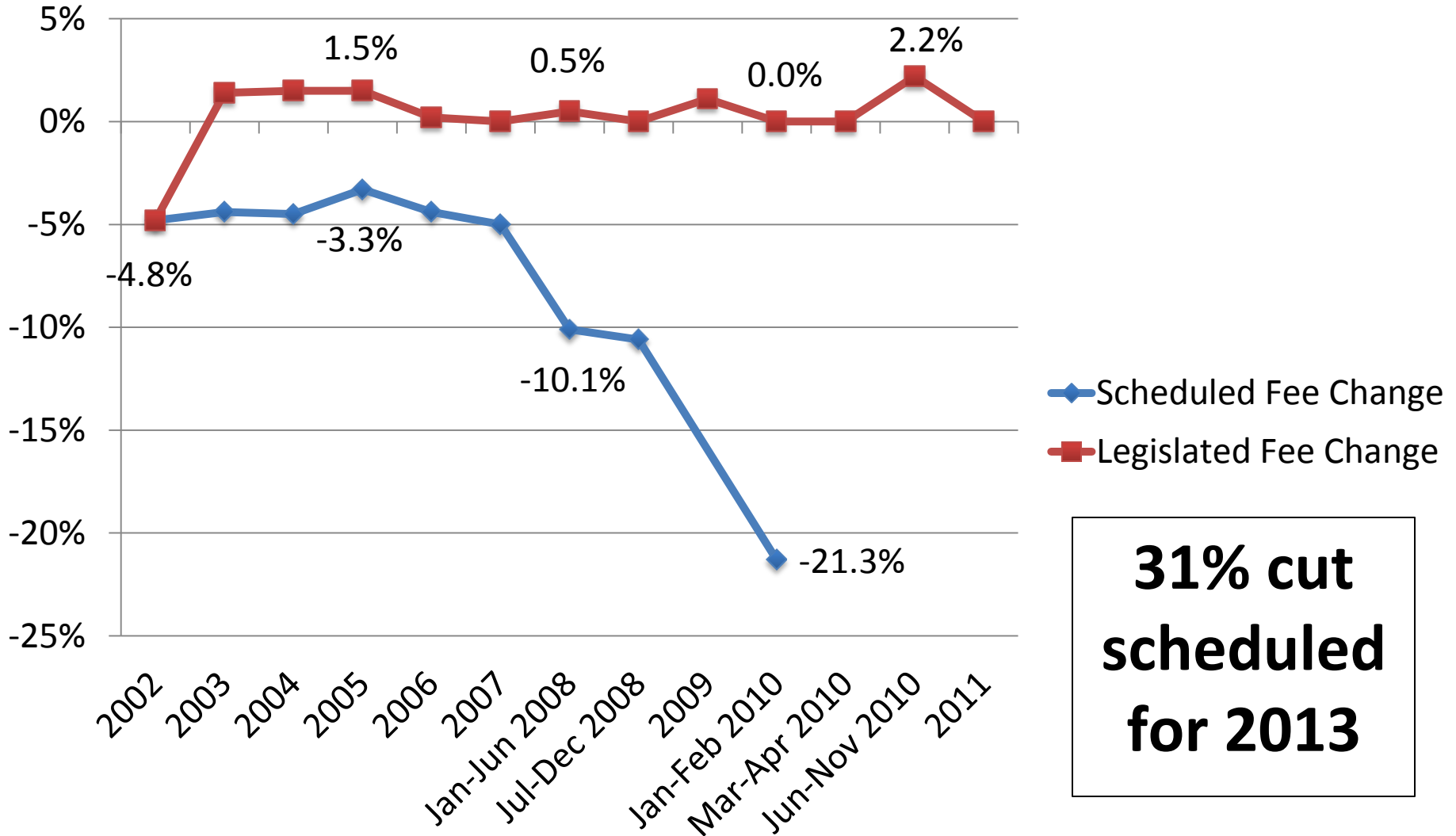
**(Aging = 4% of GDP in 2020, 5% in 2035;  
rising costs = 7% of GDP in 2035.)**

# 2009 Medicare Trustees Report: Insolvency by 2018 (\$billions)





# Scheduled vs. Actual Physician Fee Adjustments Under SGR Formula



# Cost to Medicare Enrollees

**In 2006, public Medicare spending covered only 48% of enrollees' health care costs on average**

- **Part B Premium:** \$115.40 per month, and for high-income beneficiaries up to \$369.10 per month.
- **Part D Premium:** average \$30/month, but vary depending on private plan chosen.
- **Part A deductible** for inpatient hospital: \$1,132.
- **Part B deductible and coinsurance:** \$162 deductible, and 20% coinsurance for some services.
- **“Balanced billing”** charges from some physicians.
- **Services not covered by Medicare:** most vision, dental, and hearing services and long-term care.

**2010 (actual) Part B and D premiums/cost sharing = 27% of SS benefits; 2030 (projected) = 36% of SS benefits.**

# The Democratic Proposal for Medicare Reform: PPACA



# Increased Access Under PPACA

- Closing the Part D “Doughnut Hole” gradually by 2019
- Providing for a free, annual “wellness visit.”

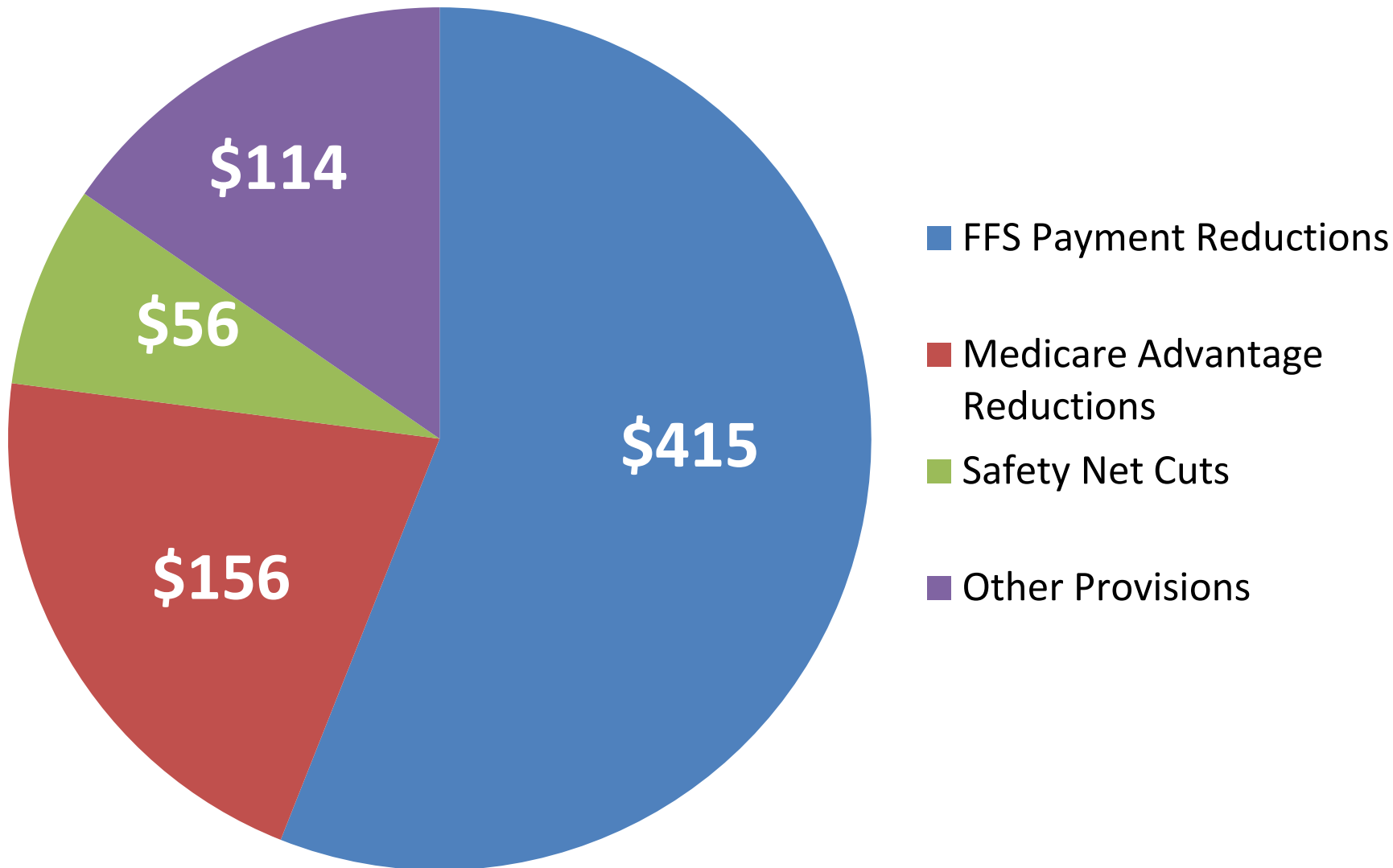
# New Revenue Under PPACA

- Increases share of enrollees paying higher Part B premiums from 5% to 14% by 2019 (\$25b)
- Imposes higher Part D premiums on those paying a higher Part B premium.
- New Hospital Insurance tax on incomes over \$200/\$250k (\$87b from 2013-19).
- New tax on investment income (\$129b over 10 years)
- Excise tax on high-premium insurance plans.
- Other revenues not linked to Medicare...

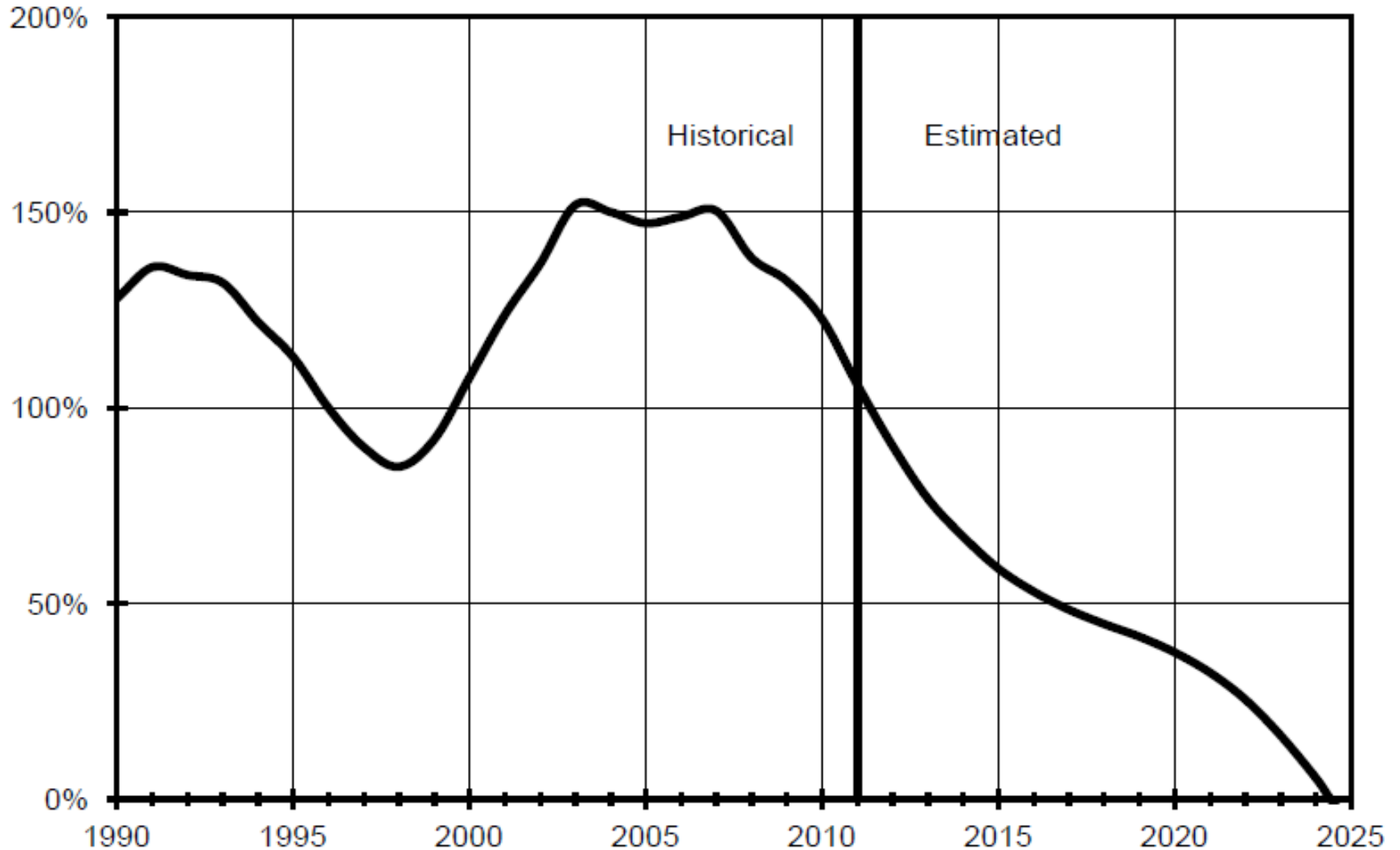
# Savings/Cuts Under PPACA

- **New fee-for-service formula**, linking fee increases to national productivity growth (\$196.3 billion over 10 years)
- **Reducing overpayments to Medicare Advantage plans** (\$135 billion over 10 years)
- **2015 trigger creates Independent Payment Advisory Board (IPAB)**, additional payment cuts (\$16 billion)
- **Cutting DSH payments to safety-net hospitals by 25% starting 2014** (\$22 billion)

# Share of Savings from PPACA, 2013-2022 (\$billions)

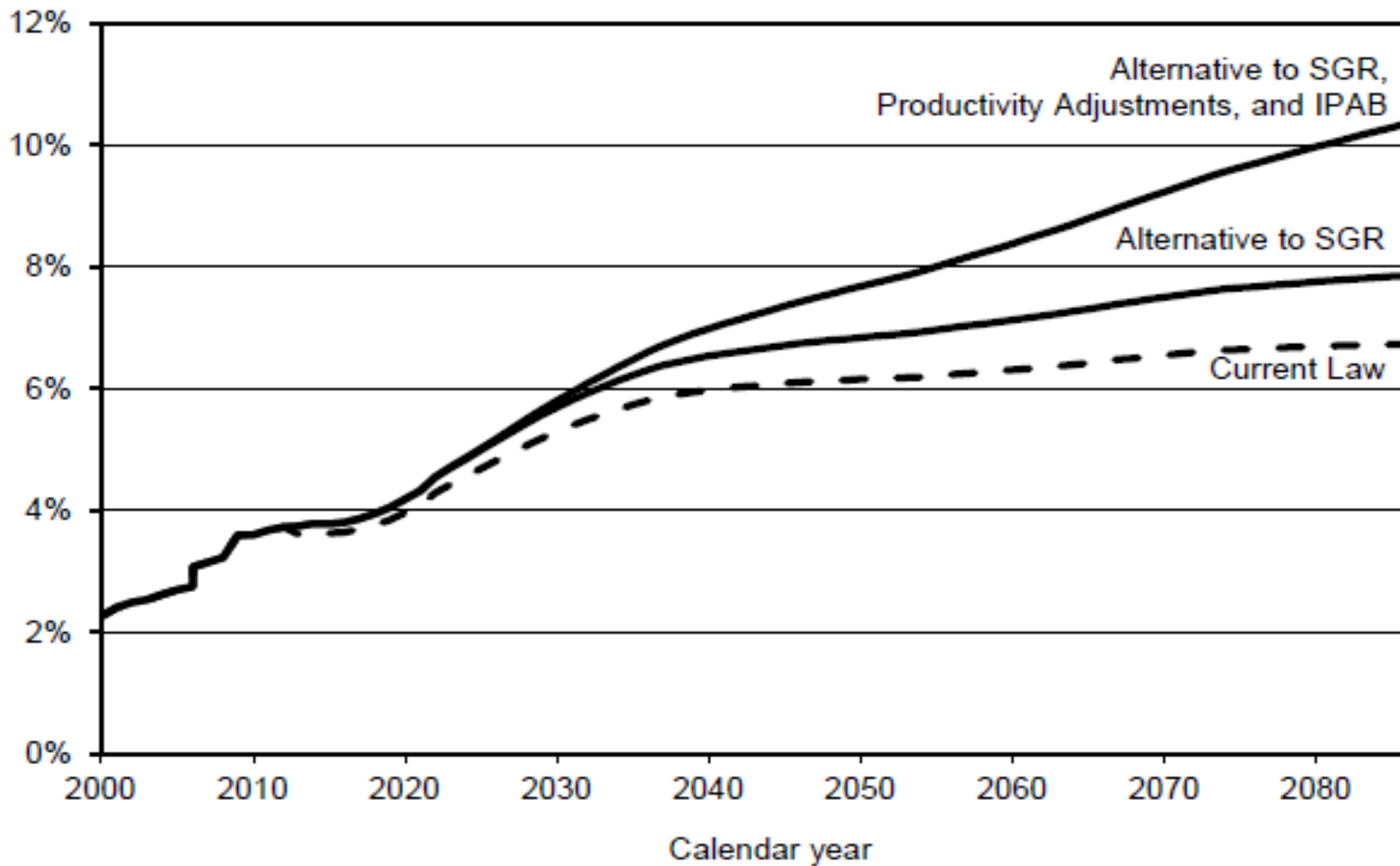


# Under PPACA: Part A Trust Fund Exhausted in 2024 (early as 2017)

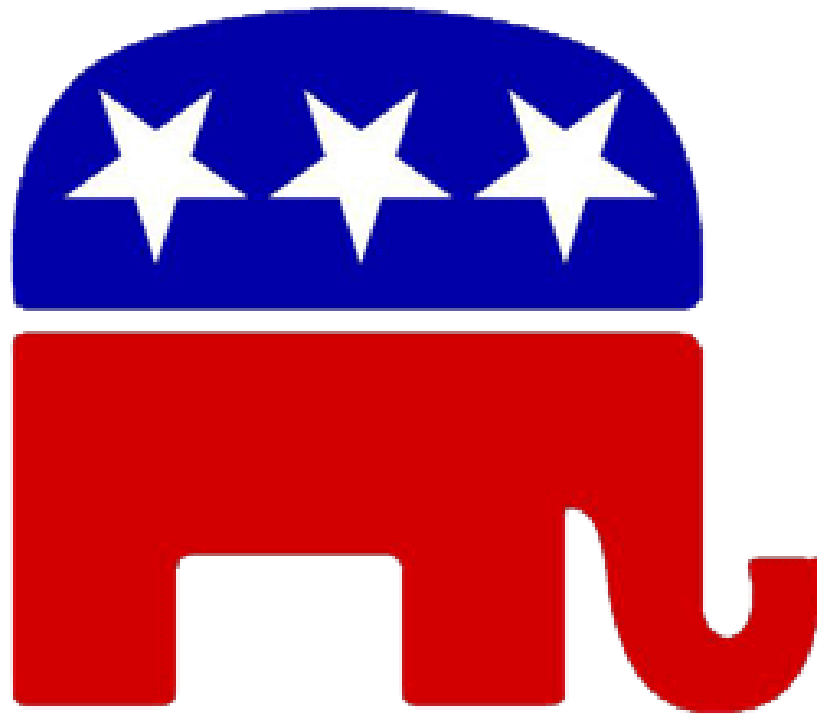




# SGR Cuts and New Physician Fee Schedule Likely to Be Overridden



# The Republican Proposal for Medicare Reform: Vouchers/Premium Support



# Recent History of Republican Proposals: The Wyden-Ryan Proposal of 2011

- For those 55 and younger: **Medicare premium support/vouchers**, to choose between traditional Medicare and private insurance;
- Creation of “**Medicare Exchanges**,” private plans must submit bids, provide at least same benefits as traditional Medicare, no pre-existing condition exclusions;
- **Price of voucher** equivalent to second cheapest plan;
- Maintain subsidies for low-income seniors, **cut Medicare payments to higher-income seniors**, risk-adjustment of premium support; and
- **If spending exceeds inflation plus 1%** starting 2023, difference will be met through reduced spending on “the sectors most responsible for cost-growth, including providers, drug companies, and means-tested premiums.”

# Recent History of Republican Proposals: “Path to Prosperity” Budgets, FY 2012-13

- Largely identical to Wyden-Ryan Proposal; but
- Proposes **raising Medicare eligibility age from 65 to 67**, or higher;
- **Caps Medicare growth at inflation plus 0.5%** , instead of 1%, starting in 2023, ambiguity about where excess spending is cut from; and
- **Premium support rises annually with inflation** and age of enrollee;
- CBO estimates would at least double premium and out-of-pocket costs to beneficiaries by 2030.

# Recent History of Republican Proposals: Mitt Romney's Campaign Materials

- Refers frequently to the Wyden-Ryan Proposal, but not to the House Republican “Path to Prosperity” budgets;
- Romney has separately endorsed raising the Social Security eligibility age, aide has stated he supports raising Medicare eligibility age as well;
- No discussion of how value of premium support would be set, or limited if spending goals are not met;